2021 COMMUNITY HEALTH NEEDS ASSESSMENT

Fulton & Montgomery Counties, New York

Sponsored by

St. Mary's Healthcare Amsterdam

2021-0769-02

Prepared by PRC

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TABLE OF CONTENTS

INTRODUCTION

PROJECT OVERVIEW

Project Goals

This Community Health Needs Assessment, a follow-up to similar studies conducted in 2012, 2015, and 2018, is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of St. Mary's Healthcare. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

- To improve residents' health status, increase their life spans, and elevate their overall quality of life. A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.
- To reduce the health disparities among residents. By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors that historically have had a negative impact on residents' health.
- To increase accessibility to preventive services for all community residents. More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

This assessment was conducted on behalf of St. Mary's Healthcare by PRC, a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for trending and comparison to benchmark data at the state and national levels.

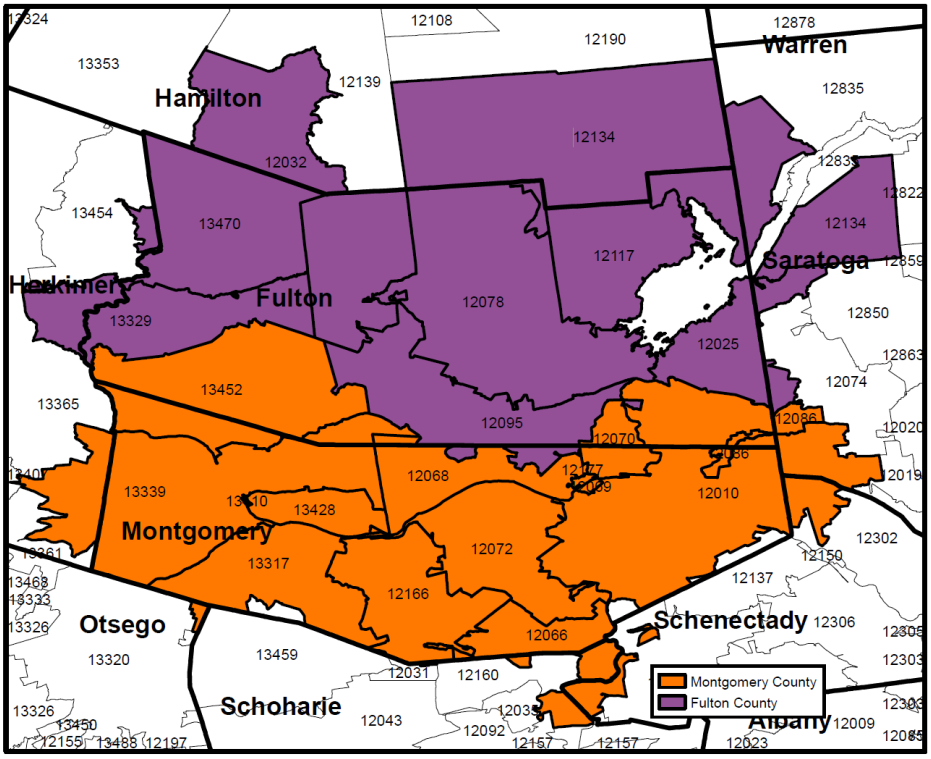
PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by St. Mary's Healthcare and PRC and is similar to the previous surveys used in the region, allowing for data trending.

Community Defined for This Assessment

The study area for the survey effort (referred to as the “St. Mary’s Healthcare Service Area” in this report) is comprised of Fulton and Montgomery counties in New York. This community definition, determined based on the ZIP Codes of residence of recent patients of St. Mary’s Healthcare, is illustrated in the following map.

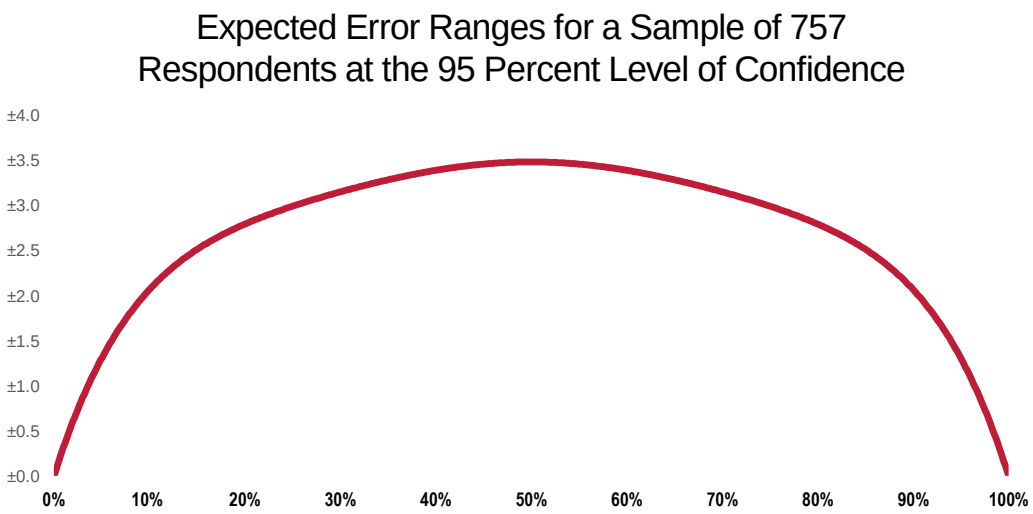


Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed a mixed-mode methodology was implemented. This included surveys conducted via telephone (landline and cell phone), as well as through online questionnaires.

In all, 757 surveys were conducted for this study among individuals age 18 and older in the St. Mary’s Healthcare Service Area, including 356 in Fulton County and 401 in Montgomery County. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the St. Mary’s Healthcare Service Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 757 respondents is ±3.5% at the 95 percent confidence level.



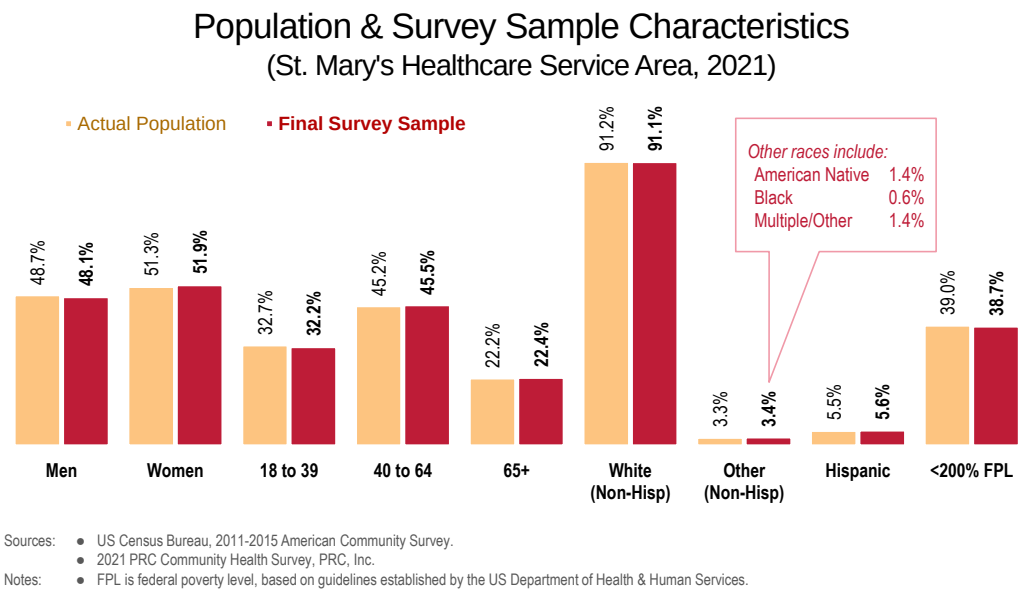
Note:
- The "response rate" (the percentage of a population giving a particular response) determines the error rate associated with that response. A "95 percent level of confidence" indicates that responses would fall within the expected error range on 95 out of 100 trials.

Examples:
- If 10% of the sample of 757 respondents answered a certain question with a "yes," it can be asserted that between 7.9% and 12.1% (10% ± 2.1%) of the total population would offer this response.
- If 50% of respondents said "yes," one could be certain with a 95 percent level of confidence that between 46.5% and 53.5% (50% ± 3.5%) of the total population would respond "yes" if asked this question.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely sex, age, race, ethnicity, and poverty status), and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual’s responses is maintained, one respondent’s responses may contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents.

The following chart outlines the characteristics of the St. Mary’s Healthcare Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child’s health care needs, and these children are not represented demographically in this chart.]



The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

INCOME & RACE/ETHNICITY

INCOME ► Poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2020 guidelines place the poverty threshold for a family of four at $26,200 annual household income or lower). In sample segmentation: "low income" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► While the survey data are representative of the racial and ethnic makeup of the population, the samples for Hispanic and non-White race groups were not of sufficient size for independent analysis.

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by St. Mary's Healthcare; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 105 community stakeholders took part in the Online Key Informant Survey, as outlined in the following table:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	6
Public Health Representatives	1
Other Health Providers	27
Social Services Providers	26
Other Community Leaders	45

Final participation included representatives of the organizations outlined below.

- Alpin Haus
- Amsterdam Free Library
- Amsterdam Housing Authority
- Amsterdam Police Department
- Arkell Center
- Berkshire Farm Center & Services for Youth
- Canajoharie Family Health Center (St. Mary's Healthcare)
- Catholic Charities
- College of St. Rose, Monroe Community College & Finger Lakes Community College
- Community Health Center
- Department of Social Services, Montgomery County
- Director Specialty Care St. Mary's Healthcare
- Fulmont Head Start
- Fulton County Office for the Aging
- Fulton County Public Health
- Fulton/Montgomery Chamber of Commerce
- Fulton Montgomery Community College
- Greater Amsterdam School District
- Haven of Hope & Fonda Reformed Church
- HFM Prevention Council
- Hillcrest Spring Assisted Living Facility
- Home Health Care Partners
- Interfaith Partnership
- Judith Ann Realty
- KCS Abstract
- LCS and Z Accounting
- Lexington
- Liberty ARC
- Mental Health Association
- Montgomery County Department of Social Services
- Montgomery County Office for the Aging
- Montgomery County Youth Services
- Myczek Law Firm
- NBT Bank
- New York State Troopers
- Planned Parenthood
- Resource Center for Independent Living
- Schwartz Law Firm
- State Farm
- St. John's Episcopal Church
- St. Mary's Healthcare
- St. Mary's Healthcare Board of Trustees
- St. Mary's Healthcare Foundation Board Member
- St. Mary's Healthcare: Memorial Campus
- St. Mary's Healthcare: Memorial Campus (PROS program)
- Walmart
- Walter Elwood Museum
- West and Company CPAs
- Wilkinson Residential Facility

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations.

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input regarding participants' opinions and perceptions of the health needs of the residents in the area.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the St. Mary's Healthcare Service Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that secondary data reflect Fulton and Montgomery County data.

Benchmark Data

Trending

Similar surveys were administered in the St. Mary's Healthcare Service Area in 2012, 2015, and 2018 by PRC on behalf of St. Mary's Healthcare. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

New York Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2020 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

Healthy People 2030's overarching goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the U.S. Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/ transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

St. Mary's Healthcare made its prior Community Health Needs Assessment (CHNA) report publicly available through its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, St. Mary's Healthcare had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. St. Mary's Healthcare will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

IRS FORM 990, SCHEDULE H COMPLIANCE

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2019)	See Report Page
Part V Section B Line 3a *A definition of the community served by the hospital facility*	7
Part V Section B Line 3b *Demographics of the community*	34
Part V Section B Line 3c *Existing health care facilities and resources within the community that are available to respond to the health needs of the community*	178
Part V Section B Line 3d *How data was obtained*	6
Part V Section B Line 3e *The significant health needs of the community*	15
Part V Section B Line 3f *Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups*	Addressed Throughout
Part V Section B Line 3g *The process for identifying and prioritizing community health needs and services to meet the community health needs*	16
Part V Section B Line 3h *The process for consulting with persons representing the community's interests*	9
Part V Section B Line 3i *The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)*	185

SUMMARY OF FINDINGS

Significant Health Needs of the Community

The following “Areas of Opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community stakeholders (key informants) giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Barriers to Access – Appointment Availability – Finding a Physician – Lack of Transportation ▪ Primary Care Physician Ratio ▪ Specific Source of Ongoing Medical Care ▪ Ratings of Local Health Care
CANCER	▪ Leading Cause of Death – Lung Cancer Deaths ▪ Cancer Incidence – Including Lung Cancer and Colorectal Cancer
DIABETES	▪ Diabetes Deaths ▪ Diabetes Prevalence ▪ Blood Sugar Testing [Non-Diabetics] ▪ Key Informants: Diabetes ranked as a top concern.
HEART DISEASE & STROKE	▪ Leading Cause of Death ▪ Overall Cardiovascular Risk
INFANT HEALTH & FAMILY PLANNING	▪ Teen Births
INJURY & VIOLENCE	▪ Unintentional Injury Deaths
KIDNEY DISEASE	▪ Kidney Disease Deaths ▪ Kidney Disease Prevalence

—continued on the next page—

AREAS OF OPPORTUNITY (continued)	
MENTAL HEALTH	▪ "Fair/Poor" Mental Health ▪ Diagnosed Depression ▪ Suicide Deaths ▪ Receiving Treatment for Mental Health ▪ Difficulty Obtaining Mental Health Services ▪ Key Informants: Mental health ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Fruit/Vegetable Consumption ▪ Access to Recreation/Fitness Facilities ▪ Overweight & Obesity [Adults] ▪ Key Informants: Nutrition, physical activity, and weight ranked as a top concern.
POTENTIALLY DISABLING CONDITIONS	▪ Multiple Chronic Conditions ▪ Activity Limitations ▪ High-Impact Chronic Pain ▪ Caregiving
RESPIRATORY DISEASE	▪ Lung Disease Deaths ▪ Pneumonia/Influenza Deaths ▪ Asthma Prevalence [Adults] ▪ Chronic Obstructive Pulmonary Disease (COPD) Prevalence
SUBSTANCE ABUSE	▪ Unintentional Drug-Related Deaths ▪ Key Informants: Substance abuse ranked as a top concern.
TOBACCO USE	▪ Key Informants: Tobacco use ranked as a top concern.

Community Feedback on Prioritization of Health Needs

On January 13, 2022, St. Mary's Healthcare convened a group of community stakeholders (representing a cross-section of community-based agencies and organizations) to evaluate, discuss and prioritize health issues for the community, based on findings of this Community Health Needs Assessment (CHNA). PRC began the meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Areas of Opportunity above). Following the data review, PRC answered any questions. Finally, participants were provided an overview of the prioritization exercise that followed.

In order to assign priority to the identified health needs (i.e., Areas of Opportunity), a wireless audience response system was used in which each participant was able to register his/her ratings using a small remote keypad. The participants were asked to evaluate each health issue along two criteria:

- **Scope & Severity** — The first rating was to gauge the magnitude of the problem in consideration of the following:
    - *How many people are affected?*
    - *How does the local community data compare to state or national levels, or Healthy People 2020 targets?*
    - *To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?*

  Ratings were entered on a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).

- **Ability to Impact** — A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

Individuals' ratings for each criteria were averaged for each tested health issue, and then these composite criteria scores were averaged to produce an overall score. This process yielded the following prioritized list of community health needs:

1. Nutrition, Physical Activity & Weight
2. Mental Health
3. Substance Abuse
4. Tobacco Use
5. Heart Disease & Stroke
6. Diabetes
7. Cancer
8. Access to Health Care Services
9. Respiratory Disease
10. Infant Health & Family Planning
11. Kidney Disease
12. Potentially Disabling Conditions
13. Injury

Hospital Implementation Strategy

St. Mary's Healthcare will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

Summary Tables:
Comparisons With Benchmark Data

Reading the Summary Tables

In the following tables, St. Mary's Healthcare Service Area results are shown in the larger, gray column.

The columns to the left of the St. Mary's Healthcare Service Area column provide comparisons between the two counties, identifying differences for each as "better than" (), "worse than" (), or "similar to" () the opposing county.

The columns to the right of the St. Mary's Healthcare Service Area column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Again, symbols indicate whether the St. Mary's Healthcare Service Area compares favorably (), unfavorably (), or comparably () to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.

TREND SUMMARY
(Current vs. Baseline Data)

SURVEY DATA INDICATORS:
Trends for survey-derived indicators represent significant changes since 2012 (or earliest available data). Note that survey data reflect the ZIP Code-defined St. Mary's Healthcare Service Area.

OTHER (SECONDARY) DATA INDICATORS:
Trends for other indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade).

SOCIAL DETERMINANTS	DISPARITY BETWEEN COUNTIES		St. Mary's HC Service Area	SERVICE AREA vs. BENCHMARKS			
	Fulton County	Montgomery County		vs. NY	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)	0.3	2.6	1.4	7.3	4.3		
Population in Poverty (Percent)	14.9	19.8	17.2	14.1	13.4	8.0	
Children in Poverty (Percent)	21.4	33.1	27.4	19.6	18.5	8.0	
No High School Diploma (Age 25+, Percent)	12.7	13.2	12.9	13.2	12.0		
% Unable to Pay Cash for a $400 Emergency Expense	15.9	21.6	18.9		24.6		
% Worry/Stress Over Rent/Mortgage in Past Year	18.8	22.5	20.8		32.2		31.3
% Unhealthy/Unsafe Housing Conditions	10.6	8.6	9.5		12.2		
% Food Insecure	15.7	23.2	19.6		34.1		23.3

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

OVERALL HEALTH	DISPARITY BETWEEN COUNTIES: Fulton County	DISPARITY BETWEEN COUNTIES: Montgomery County	St. Mary's HC Service Area	SERVICE AREA vs. BENCHMARKS: vs. NY	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	19.9	16.7	18.2	17.3	12.6		17.1

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

ACCESS TO HEALTH CARE	DISPARITY BETWEEN COUNTIES: Fulton County	DISPARITY BETWEEN COUNTIES: Montgomery County	St. Mary's HC Service Area	SERVICE AREA vs. BENCHMARKS: vs. NY	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	12.3	3.6	7.8	13.6	8.7	7.9	10.5
% Difficulty Accessing Health Care in Past Year (Composite)	38.5	36.1	37.3		35.0		38.0
% Cost Prevented Physician Visit in Past Year	6.1	7.8	7.0	11.5	12.9		13.4
% Cost Prevented Getting Prescription in Past Year	11.1	8.3	9.6		12.8		15.2
% Difficulty Getting Appointment in Past Year	25.6	18.0	21.6		14.5		13.5
% Inconvenient Hrs Prevented Dr Visit in Past Year	9.0	13.0	11.1		12.5		16.0
% Difficulty Finding Physician in Past Year	17.6	10.6	13.9		9.4		7.8
% Transportation Hindered Dr Visit in Past Year	10.8	10.2	10.5		8.9		6.9

ACCESS TO HEALTH CARE (continued)	DISPARITY BETWEEN COUNTIES		St. Mary's HC Service Area	SERVICE AREA vs. BENCHMARKS			
	Fulton County	Montgomery County		vs. NY	vs. US	vs. HP2030	TREND
% Language/Culture Prevented Care in Past Year	0.3	1.2	**0.8**		2.8		2.1
% Skipped Prescription Doses to Save Costs	11.2	9.2	**10.1**		12.7		15.8
% Difficulty Getting Child's Health Care in Past Year			**10.1**		8.0		4.2
Primary Care Doctors per 100,000	35.5	52.6	**43.7**	83.8	75.8		
% Have a Specific Source of Ongoing Care	69.9	79.4	**74.9**		74.2	84.0	79.3
% Have Had Routine Checkup in Past Year	74.2	77.7	**76.1**	81.8	70.5		75.6
% Child Has Had Checkup in Past Year			**87.3**		77.4		93.7
% Two or More ER Visits in Past Year	11.2	12.7	**12.0**		10.1		11.6
% Eye Exam in Past 2 Years	55.3	57.8	**56.6**		61.0	61.1	57.0
% Rate Local Health Care "Fair/Poor"	16.4	9.9	**13.0**		8.0		19.1

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better | similar | worse

	DISPARITY BETWEEN COUNTIES			SERVICE AREA vs. BENCHMARKS			
CANCER	Fulton County	Montgomery County	St. Mary's HC Service Area	vs. NY	vs. US	vs. HP2030	TREND
Cancer (Age-Adjusted Death Rate)	162.8	168.8	165.8	137.4	149.3	122.7	172.2
Lung Cancer (Age-Adjusted Death Rate)			48.2	30.2	34.9	25.1	
Prostate Cancer (Age-Adjusted Death Rate)			16.8	16.9	18.6	16.9	
Female Breast Cancer (Age-Adjusted Death Rate)			19.4	18.5	19.7	15.3	
Colorectal Cancer (Age-Adjusted Death Rate)			13.3	12.2	13.4	8.9	
Cancer Incidence Rate (All Sites)	543.1	507.5	526.3	485.2	448.7		
Female Breast Cancer Incidence Rate	122.6	122.0	122.3	132.8	125.9		
Prostate Cancer Incidence Rate	120.9	104.5	113.1	125.0	104.5		
Lung Cancer Incidence Rate	88.6	74.1	81.7	58.7	58.3		
Colorectal Cancer Incidence Rate	43.2	48.6	45.7	38.7	38.4		
% Cancer	8.0	10.9	9.5	10.0	10.0		

CANCER (continued)	DISPARITY BETWEEN COUNTIES		St. Mary's HC Service Area	SERVICE AREA vs. BENCHMARKS			
	Fulton County	Montgomery County		vs. NY	vs. US	vs. HP2030	TREND
% [Women 50-74] Mammogram in Past 2 Years	72.6	80.0	76.5	82.1	76.1	77.1	81.9
% [Women 21-65] Cervical Cancer Screening	77.6	81.1	79.5	80.9	73.8	84.3	84.8
% [Age 50-75] Colorectal Cancer Screening	71.1	77.0	74.2	70.5	77.4	74.4	73.2

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

DIABETES	DISPARITY BETWEEN COUNTIES		St. Mary's HC Service Area	SERVICE AREA vs. BENCHMARKS			
	Fulton County	Montgomery County		vs. NY	vs. US	vs. HP2030	TREND
Diabetes (Age-Adjusted Death Rate)	24.4	25.0	24.7	17.7	21.5		17.7
% Diabetes/High Blood Sugar	13.5	15.3	14.4	10.5	13.8		10.5
% Borderline/Pre-Diabetes	5.5	8.2	6.9		9.7		6.0
% [Non-Diabetics] Blood Sugar Tested in Past 3 Years	41.1	43.9	42.6		43.3		57.0

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

HEART DISEASE & STROKE	DISPARITY BETWEEN COUNTIES		St. Mary's HC Service Area	SERVICE AREA vs. BENCHMARKS			
	Fulton County	Montgomery County		vs. NY	vs. US	vs. HP2030	TREND
Diseases of the Heart (Age-Adjusted Death Rate)	184.0	190.8	187.5	169.9	163.4	127.4	223.2
% Heart Disease (Heart Attack, Angina, Coronary Disease)	11.2	6.1	8.5	6.1	6.1		9.1
Stroke (Age-Adjusted Death Rate)	28.1	28.0	28.4	24.3	37.2	33.4	31.4
% Stroke	3.1	4.1	3.6	3.0	4.3		3.3
% Told Have High Blood Pressure	37.8	41.2	39.6	29.6	36.9	27.7	39.3
% Told Have High Cholesterol	41.2	32.1	36.4		32.7		34.2
% 1+ Cardiovascular Risk Factor	91.7	91.2	91.5		84.6		89.2

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

INFANT HEALTH & FAMILY PLANNING	DISPARITY BETWEEN COUNTIES		St. Mary's HC Service Area	SERVICE AREA vs. BENCHMARKS			
	Fulton County	Montgomery County		vs. NY	vs. US	vs. HP2030	TREND
Low Birthweight Births (Percent)	7.6	7.6	7.6	12.6	12.3		
Infant Death Rate			4.6	4.3	5.6	5.0	4.9
Births to Adolescents Age 15 to 19 (Rate per 1,000)	58.0	12.1	35.1	7.8	12.7	31.4	

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

INJURY & VIOLENCE	DISPARITY BETWEEN COUNTIES		St. Mary's HC Service Area	SERVICE AREA vs. BENCHMARKS			
	Fulton County	Montgomery County		vs. NY	vs. US	vs. HP2030	TREND
Unintentional Injury (Age-Adjusted Death Rate)	32.6	40.4	36.4	34.7	48.9	43.2	30.9
Motor Vehicle Crashes (Age-Adjusted Death Rate)			9.0	5.1	11.3	10.1	
[65+] Falls (Age-Adjusted Death Rate)			37.7	43.6	65.1	63.4	
Firearm-Related Deaths (Age-Adjusted Death Rate)			6.8	3.9	11.9	10.7	
Violent Crime Rate	242.7	175.7	210.8	536.9	416.0		

INJURY & VIOLENCE (continued)	DISPARITY BETWEEN COUNTIES		St. Mary's HC Service Area	SERVICE AREA vs. BENCHMARKS			
	Fulton County	Montgomery County		vs. NY	vs. US	vs. HP2030	TREND
% Victim of Violent Crime in Past 5 Years	2.7	5.5	4.2		6.2		2.9
% Victim of Intimate Partner Violence	14.4	13.6	14.0		13.7		15.9

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

KIDNEY DISEASE	DISPARITY BETWEEN COUNTIES		St. Mary's HC Service Area	SERVICE AREA vs. BENCHMARKS			
	Fulton County	Montgomery County		vs. NY	vs. US	vs. HP2030	TREND
Kidney Disease (Age-Adjusted Death Rate)	16.4	20.4	18.1	9.5	12.9		17.7
% Kidney Disease	8.1	4.5	6.2	2.5	5.0		3.0

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

MENTAL HEALTH	DISPARITY BETWEEN COUNTIES		St. Mary's HC Service Area	SERVICE AREA vs. BENCHMARKS			
	Fulton County	Montgomery County		vs. NY	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	22.4	20.7	21.6		13.4		12.9
% Diagnosed Depression	25.4	26.3	25.9	15.3	20.6		17.5
% Symptoms of Chronic Depression (2+ Years)	33.6	33.4	33.5		30.3		29.2
% Typical Day Is "Extremely/Very" Stressful	7.6	8.2	7.9		16.1		13.0
Suicide (Age-Adjusted Death Rate)			14.4	8.2	14.0	12.8	11.6
Mental Health Providers per 100,000	124.5	57.0	92.3	89.1	58.0		
% Taking Rx/Receiving Mental Health Trtmt	23.5	20.1	21.7		16.8		18.6
% Unable to Get Mental Health Svcs in Past Yr	10.1	11.6	10.9		7.8		6.3

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	DISPARITY BETWEEN COUNTIES		St. Mary's HC Service Area	SERVICE AREA vs. BENCHMARKS			
	Fulton County	Montgomery County		vs. NY	vs. US	vs. HP2030	TREND
Population With Low Food Access (Percent)	12.6	38.0	**24.6**	12.0	22.2		
% "Very/Somewhat" Difficult to Buy Fresh Produce	24.0	13.7	**18.6**		21.1		20.6
% 5+ Servings of Fruits/Vegetables per Day	29.4	34.5	**32.0**		32.7		40.6
% No Leisure-Time Physical Activity	21.5	25.8	**23.7**	27.2	31.3	21.2	25.7
% Meeting Physical Activity Guidelines	18.6	19.2	**18.9**	24.1	21.4	28.4	17.7
% Child [Age 2-17] Physically Active 1+ Hours per Day			**64.5**		33.0		60.7
Recreation/Fitness Facilities per 100,000			**2.8**	13.7	12.2		
% Overweight (BMI 25+)	72.0	72.5	**72.2**	63.2	61.0		70.3
% Obese (BMI 30+)	35.4	44.7	**40.3**	27.1	31.3	36.0	33.0
% Children [Age 5-17] Overweight (85th Percentile)			**37.8**		32.3		37.7
% Children [Age 5-17] Obese (95th Percentile)			**26.6**		16.0	15.5	27.4

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

ORAL HEALTH	DISPARITY BETWEEN COUNTIES: Fulton County	DISPARITY BETWEEN COUNTIES: Montgomery County	St. Mary's HC Service Area	SERVICE AREA vs. BENCHMARKS: vs. NY	SERVICE AREA vs. BENCHMARKS: vs. US	SERVICE AREA vs. BENCHMARKS: vs. HP2030	SERVICE AREA vs. BENCHMARKS: TREND
% Have Dental Insurance	69.4	74.7	72.2		68.7	59.8	61.9
% [Age 18+] Dental Visit in Past Year	58.8	58.2	58.5	69.8	62.0	45.0	62.7
% Child [Age 2-17] Dental Visit in Past Year			85.5		72.1	45.0	83.3

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

POTENTIALLY DISABLING CONDITIONS	DISPARITY BETWEEN COUNTIES: Fulton County	DISPARITY BETWEEN COUNTIES: Montgomery County	St. Mary's HC Service Area	SERVICE AREA vs. BENCHMARKS: vs. NY	SERVICE AREA vs. BENCHMARKS: vs. US	SERVICE AREA vs. BENCHMARKS: vs. HP2030	SERVICE AREA vs. BENCHMARKS: TREND
% 3+ Chronic Conditions	37.8	40.7	39.3		32.5		50.8
% Activity Limitations	32.7	31.5	32.1		24.0		23.4
% With High-Impact Chronic Pain	21.7	21.9	21.8		14.1	7.0	
Alzheimer's Disease (Age-Adjusted Death Rate)	20.2	21.1	20.5	13.6	30.4		39.0
% Caregiver to a Friend/Family Member	30.3	24.7	27.4		22.6		28.6

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

RESPIRATORY DISEASE	DISPARITY BETWEEN COUNTIES: Fulton County	DISPARITY BETWEEN COUNTIES: Montgomery County	St. Mary's HC Service Area	SERVICE AREA vs. BENCHMARKS: vs. NY	SERVICE AREA vs. BENCHMARKS: vs. US	SERVICE AREA vs. BENCHMARKS: vs. HP2030	SERVICE AREA vs. BENCHMARKS: TREND
CLRD (Age-Adjusted Death Rate)	53.6	43.2	48.8	28.3	39.6		57.3
Pneumonia/Influenza (Age-Adjusted Death Rate)	32.9	25.0	29.1	17.5	13.8		16.5
% [Age 65+] Flu Vaccine in Past Year	74.7	72.4	73.5	61.3	71.0		61.0
% [Adult] Asthma	16.8	16.7	16.7	9.3	12.9		10.4
% [Child 0-17] Asthma			11.3		7.8		12.4
% COPD (Lung Disease)	12.0	10.5	11.2	5.8	6.4		13.1

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

SEXUAL HEALTH	DISPARITY BETWEEN COUNTIES: Fulton County	DISPARITY BETWEEN COUNTIES: Montgomery County	St. Mary's HC Service Area	SERVICE AREA vs. BENCHMARKS: vs. NY	SERVICE AREA vs. BENCHMARKS: vs. US	SERVICE AREA vs. BENCHMARKS: vs. HP2030	SERVICE AREA vs. BENCHMARKS: TREND
HIV Prevalence Rate	156.2	166.5	161.1	765.3	372.8		
Chlamydia Incidence Rate	395.3	310.6	354.9	602.4	539.9		
Gonorrhea Incidence Rate	59.4	58.9	59.1	187.7	179.1		

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

SUBSTANCE ABUSE	DISPARITY BETWEEN COUNTIES		St. Mary's HC Service Area	SERVICE AREA vs. BENCHMARKS			
	Fulton County	Montgomery County		vs. NY	vs. US	vs. HP2030	TREND
Cirrhosis/Liver Disease (Age-Adjusted Death Rate)			**9.9**	7.0	11.1	10.9	10.2
% Excessive Drinker	22.1	23.8	**23.0**	18.2	27.2		21.2
Unintentional Drug-Related Deaths (Age-Adjusted Death Rate)			**12.0**	16.8	18.8		7.2
% Illicit Drug Use in Past Month	2.7	1.7	**2.2**		2.0	12.0	3.1
% Used a Prescription Opioid in Past Year	14.5	9.2	**11.7**		12.9		
% Ever Sought Help for Alcohol or Drug Problem	4.7	5.7	**5.3**		5.4		4.5
% Personally Impacted by Substance Abuse	38.3	30.2	**34.0**		35.8		36.8

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

TOBACCO USE	DISPARITY BETWEEN COUNTIES		St. Mary's HC Service Area	SERVICE AREA vs. BENCHMARKS			
	Fulton County	Montgomery County		vs. NY	vs. US	vs. HP2030	TREND
% Current Smoker	25.6	13.6	19.3	12.7	17.4	5.0	22.7
% Someone Smokes at Home	15.1	16.1	15.6		14.6		19.6
% [Household With Children] Someone Smokes in the Home			19.0		17.4		21.4
% [Smokers] Have Quit Smoking 1+ Days in Past Year			47.4	55.7	42.8	65.7	50.6
% [Smokers] Received Advice to Quit Smoking			67.4		59.6	66.6	71.7
% Currently Use Vaping Products	3.4	7.5	5.5	3.8	8.9		3.6

Note: Throughout these tables, a blank or empty cell indicates that data are not available for this indicator or that sample sizes are too small to provide meaningful results.

better similar worse

COMMUNITY DESCRIPTION

POPULATION CHARACTERISTICS

Total Population

Fulton and Montgomery counties (which approximate the St. Mary's Healthcare Service Area) comprise the focus of this Community Health Needs Assessment, encompassing 898.58 square miles and housing a total population of 102,948 residents, according to latest census estimates.

Total Population
(Estimated Population, 2015-2019)

	TOTAL POPULATION	TOTAL LAND AREA (square miles)	POPULATION DENSITY (per square mile)
Fulton County	53,646	495.46	108.28
Montgomery County	49,302	403.12	122.30
St. Mary's Healthcare Service Area	102,948	898.58	114.57
New York	19,572,319	47,124.95	415.33
United States	324,697,795	3,532,068.58	91.93

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

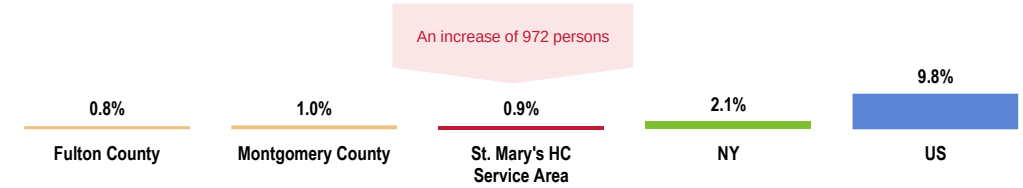
Population Change 2000-2010

A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources.

Between the 2000 and 2010 US Censuses, the population of the St. Mary's Healthcare Service Area increased by 972 persons, or 0.9%.

BENCHMARK ► Lower than the statewide increase and much lower than the national increase.

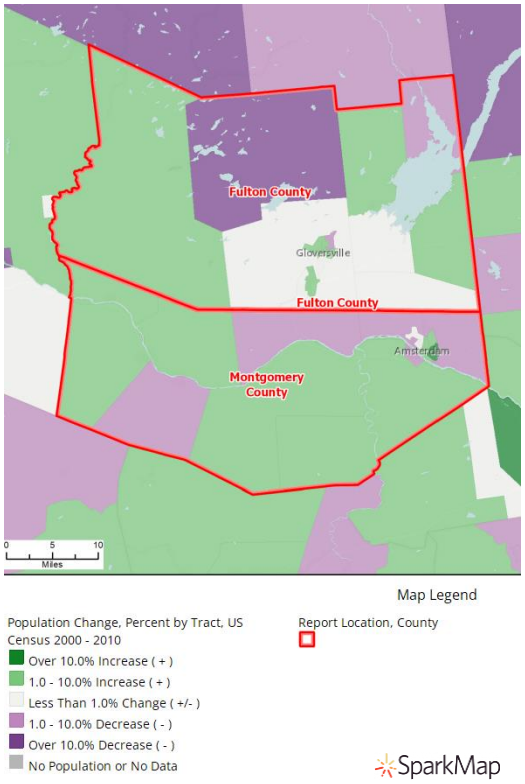
Change in Total Population
(Percentage Change Between 2000 and 2010)



Sources:
- US Census Bureau Decennial Census (2000-2010).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

Notes:
- A significant positive or negative shift in total population over time impacts health care providers and the utilization of community resources.

This map shows the areas of greatest increase or decrease in population between 2000 and 2010.



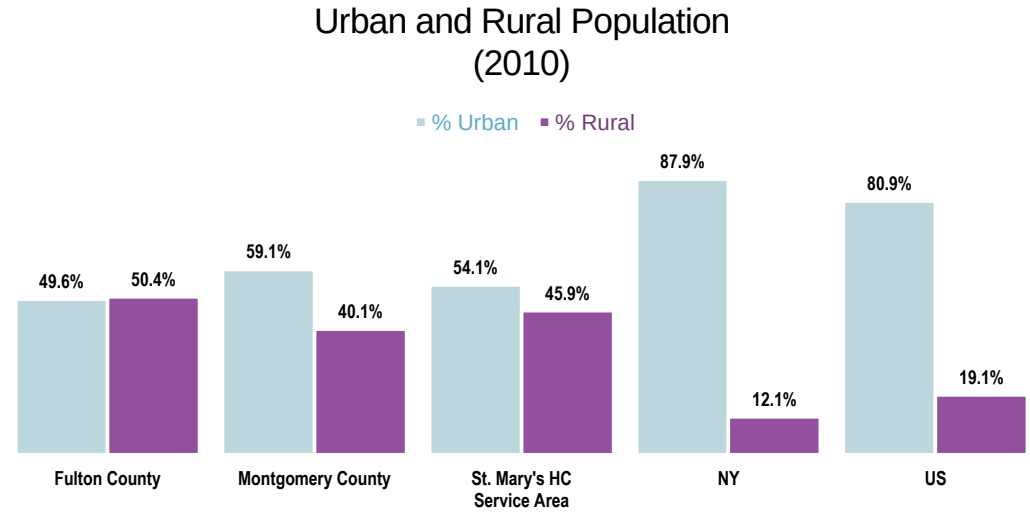
Urban/Rural Population

Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

The service area is slightly more urban, with 54.1% of the population living in areas designated as urban.

BENCHMARK ► Much more rural than statewide and national proportions.

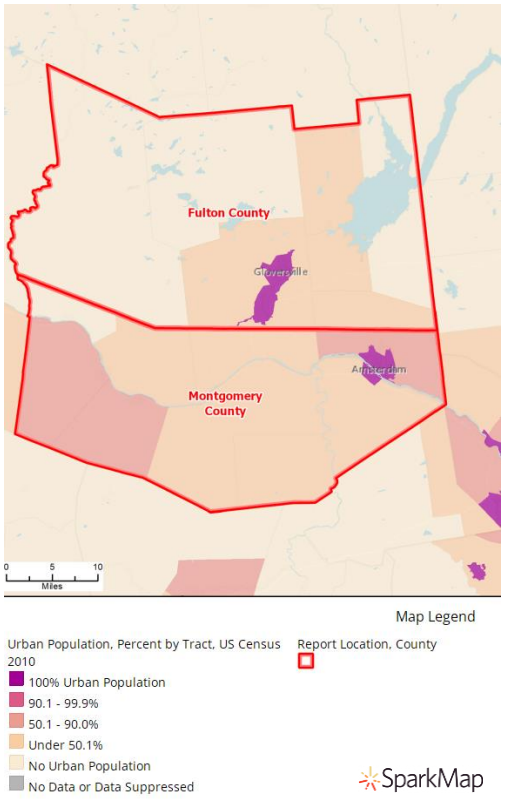
DISPARITY ► The urban-rural gap is more pronounced in Montgomery County.



Sources:
- US Census Bureau Decennial Census.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of population living in urban and rural areas. Urban areas are identified using population density, count, and size thresholds. Urban areas also include territory with a high degree of impervious surface (development). Rural areas are all areas that are not urban.

Note the following map, outlining the urban population in the St. Mary's Healthcare Service Area.



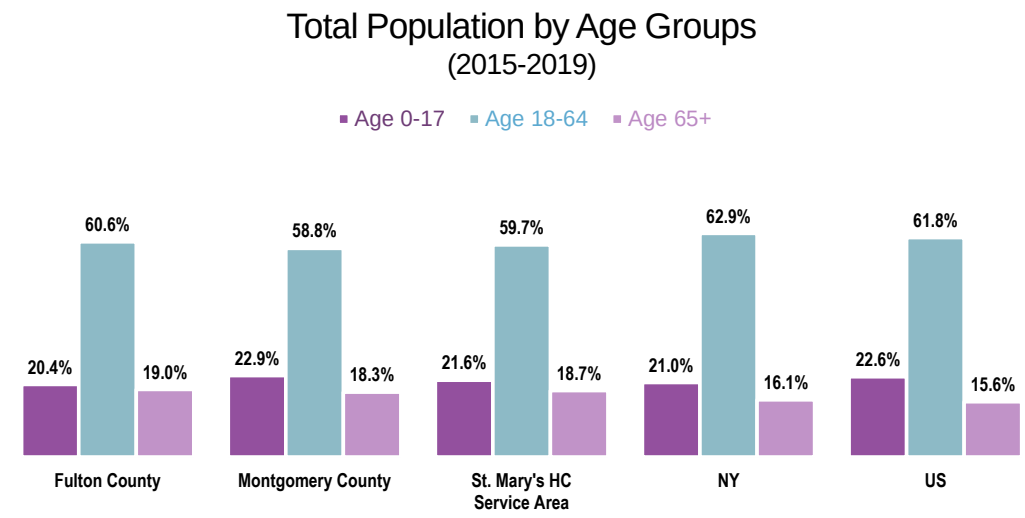
Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.

In the St. Mary's Healthcare Service Area, 21.6% of the population are children age 0-17; another 59.7% are age 18 to 64; while 18.7% are age 65 and older.

BENCHMARK ► The service area has a higher proportion of seniors (age 65+) than is found across New York and the US.

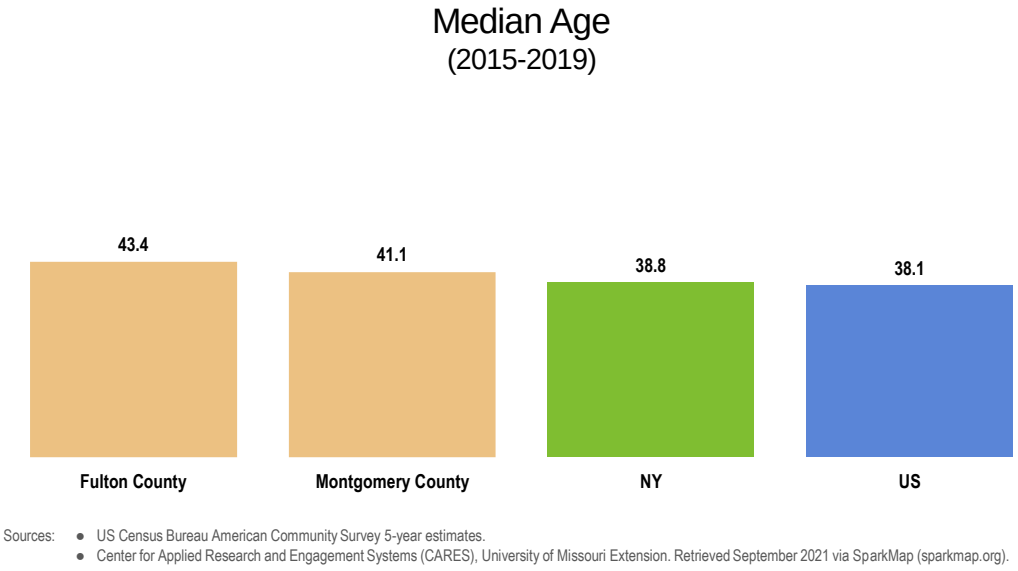
DISPARITY ► Fulton County has a lower proportion of children than Montgomery County.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

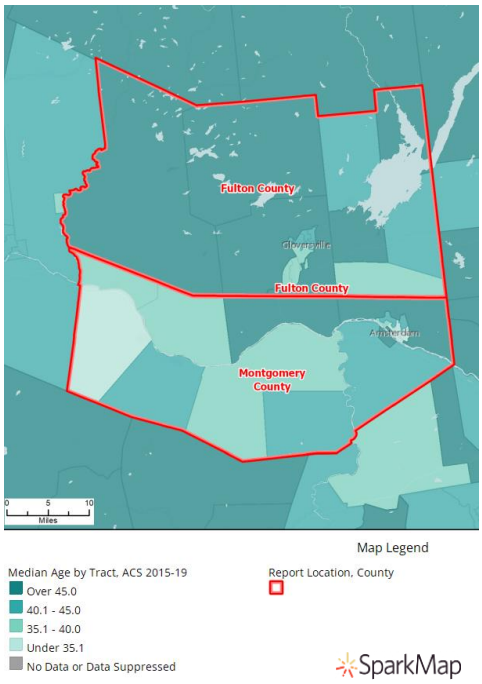
Median Age

Fulton and Montgomery counties are "older" than the state and the nation in that their median ages are higher.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

The following map provides an illustration of the median age in the St. Mary's Healthcare Service Area.



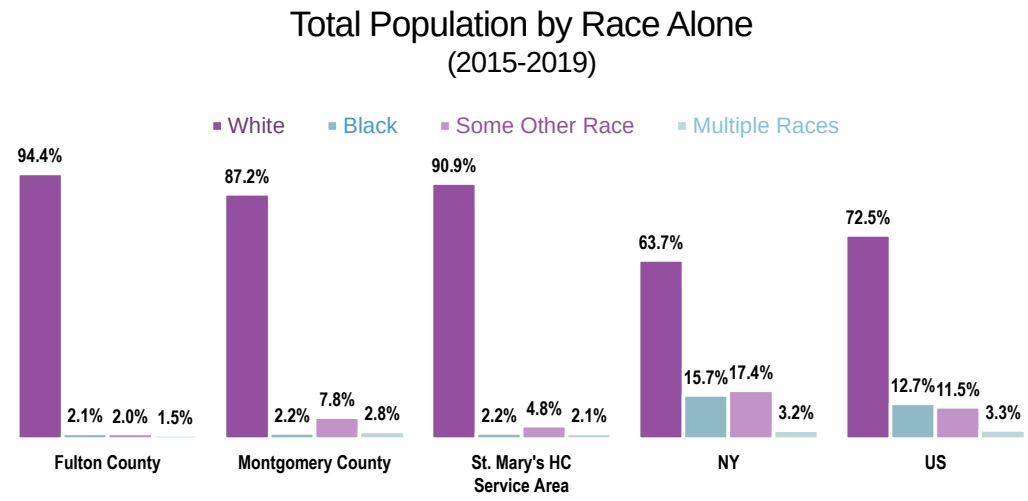
Race & Ethnicity

Race

In looking at race independent of ethnicity (Hispanic or Latino origin), 90.9% of residents of the St. Mary's Healthcare Service Area are White and 2.2% are Black.

BENCHMARK ► Less diverse than the state and US.

DISPARITY ► Montgomery County is more diverse than Fulton County.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

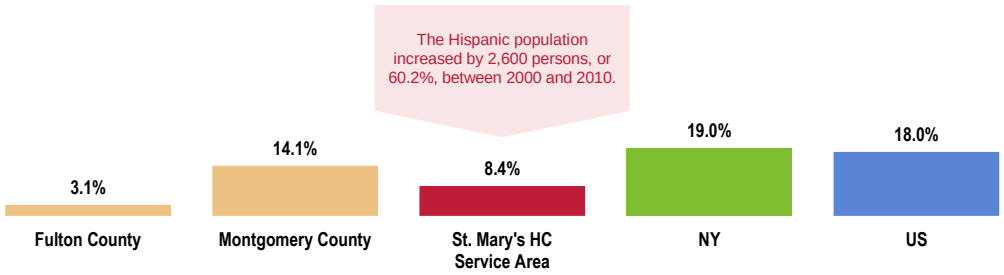
Ethnicity

A total of 8.4% of St. Mary's Healthcare Service Area residents are Hispanic or Latino.

BENCHMARK ► Despite an increase in population, the proportion of Hispanic residents within the service area still is much lower than was found across the state and nation.

DISPARITY ► Montgomery County has a much higher proportion of Hispanic residents than Fulton County.

Hispanic Population
(2015-2019)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

Notes:
- Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

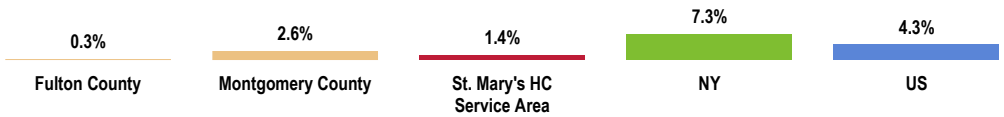
Linguistic Isolation

A total of 1.4% of the St. Mary's Healthcare Service Area population age 5 and older live in a home in which no person age 14 or older is proficient in English (speaking only English or speaking English "very well").

BENCHMARK ► More favorable than found across New York and the US.

DISPARITY ► Higher in Montgomery County.

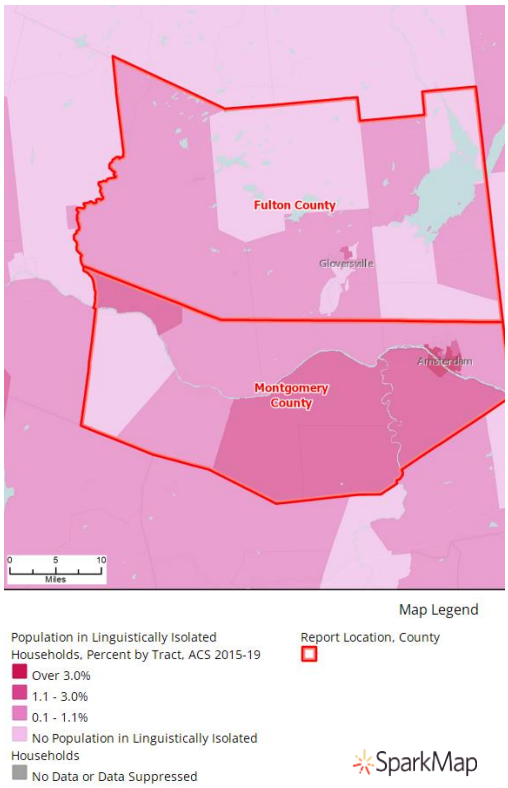
Linguistically Isolated Population
(2015-2019)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the population age 5+ who live in a home in which no person age 14+ speaks only English, or in which no person age 14+ speak a non-English language and speak English "very well."

Note the following map illustrating linguistic isolation throughout the St. Mary's Healthcare Service Area.



SOCIAL DETERMINANTS OF HEALTH

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

- Healthy People 2030 (https://health.gov/healthypeople)

Poverty

The latest census estimate shows 17.2% of the St. Mary's Healthcare Service Area total population living below the federal poverty level.

BENCHMARK ► Worse than state and national percentages. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Lower in Fulton County.

Among just children (ages 0 to 17), this percentage in the St. Mary's Healthcare Service Area is 27.4% (representing an estimated 5,879 children).

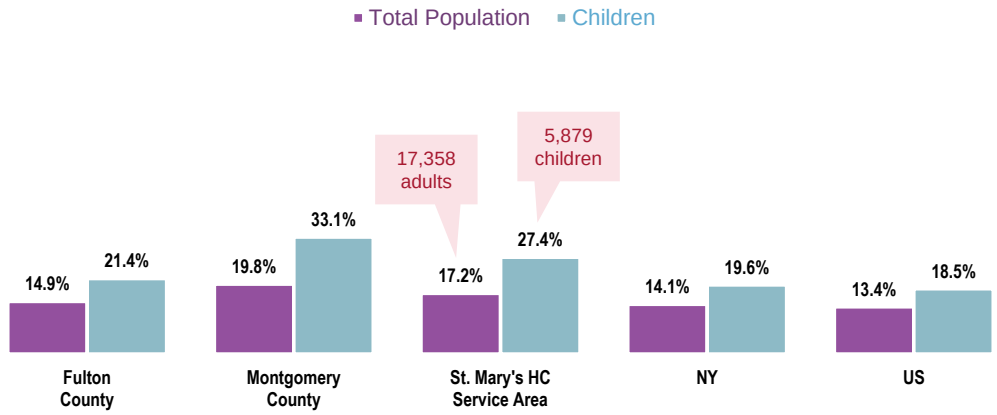
BENCHMARK ► Much higher than state and national percentages. Far from satisfying the Healthy People 2030 objective.

DISPARITY ► Unfavorably high in Montgomery County.

Population in Poverty

(Populations Living Below the Poverty Level; 2015-2019)

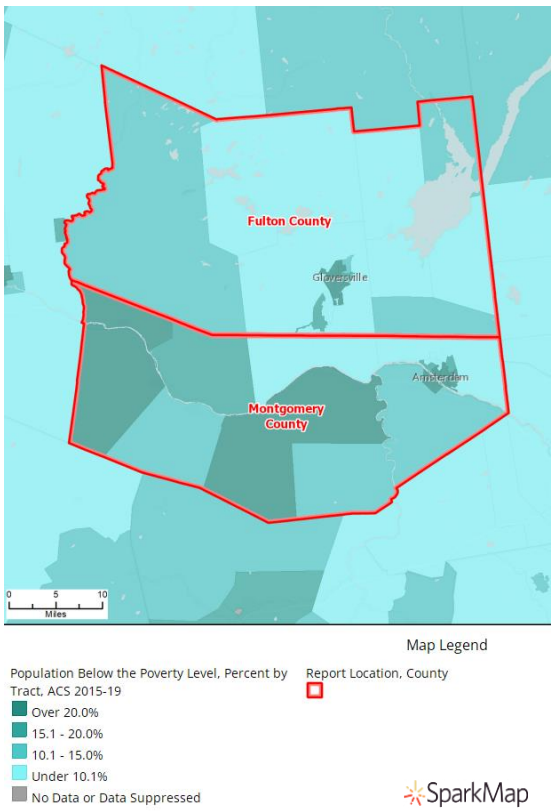
Healthy People 2030 = 8.0% or Lower

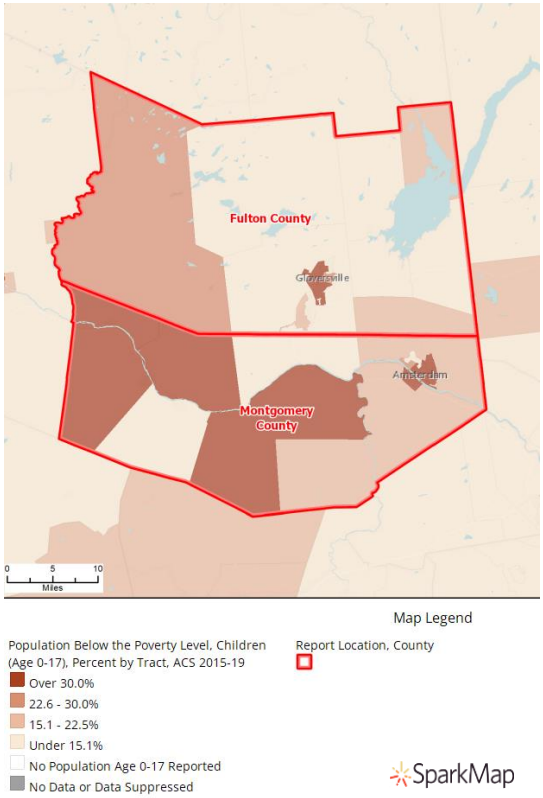


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

The following maps highlight concentrations of persons living below the federal poverty level.



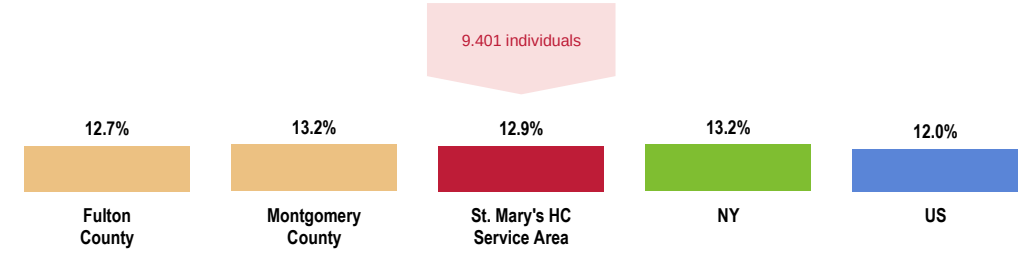


Education

Among the St. Mary's Healthcare Service Area population age 25 and older, an estimated 12.9% (over 9,400 people) do not have a high school education.

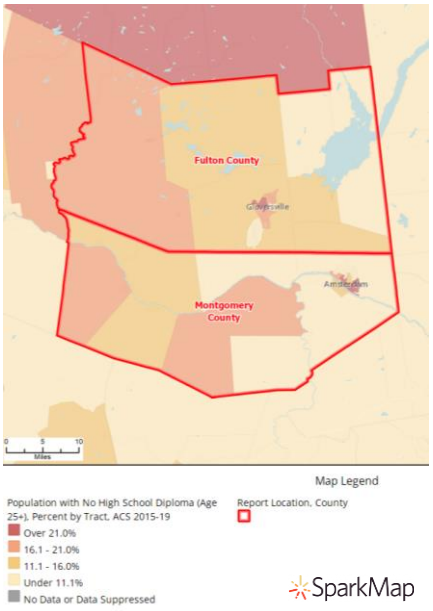
Population With No High School Diploma

(Population Age 25+ Without a High School Diploma or Equivalent, 2015-2019)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.



Financial Resilience

NOTE: For indicators derived from the population-based survey administered as part of this project, text describes significant differences determined through statistical testing. The reader can assume that differences (against or among local findings) that are not mentioned are ones that are not statistically significant.

A total of 18.9% of St. Mary's Healthcare Service Area residents would <u>not</u> be able to afford an unexpected $400 expense without going into debt.

BENCHMARK ► More favorable than the US percentage.

DISPARITY ► Higher in Montgomery County. More often reported among women, young adults, and especially low-income adults.

Do Not Have Cash on Hand to Cover a $400 Emergency Expense

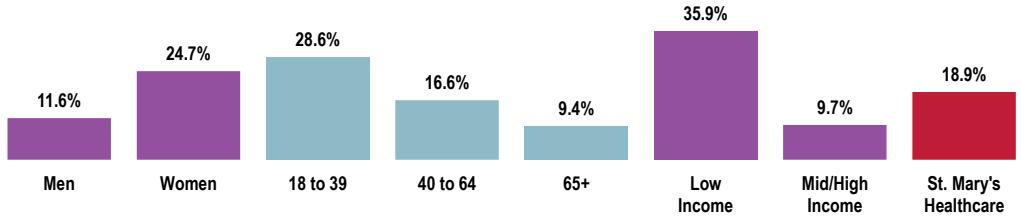
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 63]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

Charts throughout this report (such as that here) detail survey findings among key demographic groups – namely by sex, age groupings, income (based on poverty status), and race/ethnicity.

Here, "low income" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

Do Not Have Cash on Hand to Cover a $400 Emergency Expense
(St. Mary's Healthcare Service Area, 2021)



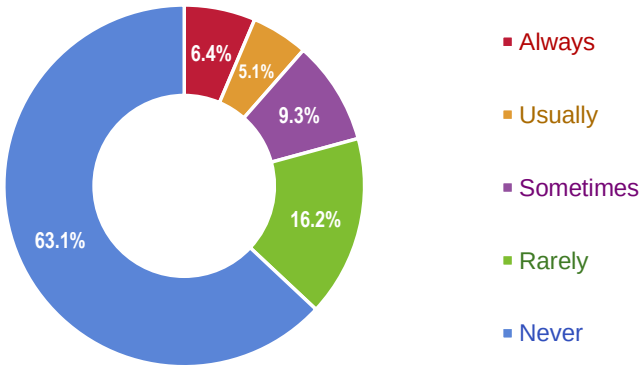
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 63]
Notes: ● Asked of all respondents.
● Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

Housing

Housing Insecurity

Most surveyed adults rarely, if ever, worry about the cost of housing.

Frequency of Worry or Stress Over Paying Rent or Mortgage in the Past Year
(St. Mary's Healthcare Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: ● Asked of all respondents.

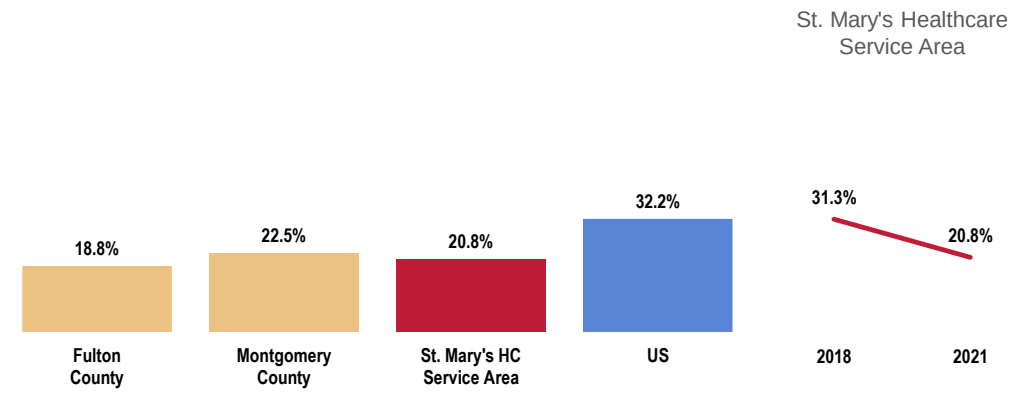
However, a considerable share (20.8%) report that they were "sometimes," "usually," or "always" worried or stressed about having enough money to pay their rent or mortgage in the past year.

BENCHMARK ► Much lower than the US percentage.

TREND ► A significant improvement from the previous survey.

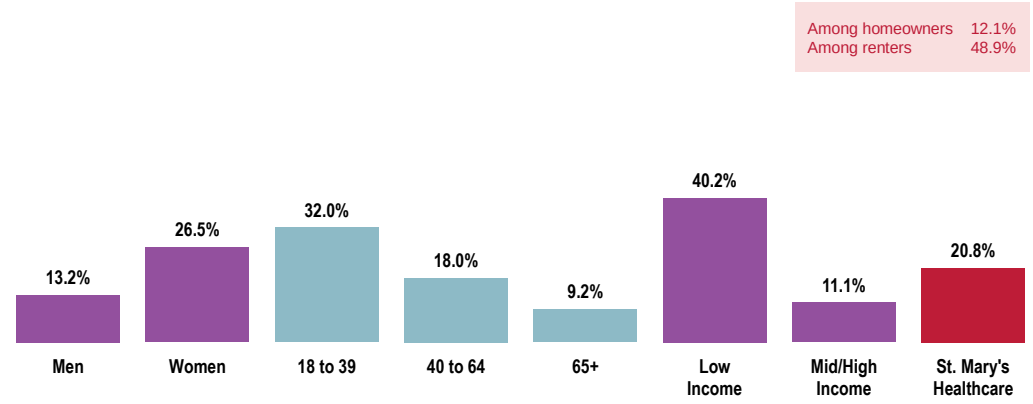
DISPARITY ► More often reported among women, young adults, and especially low-income residents and renters.

"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 66]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

"Always/Usually/Sometimes" Worried About Paying Rent/Mortgage in the Past Year
(St. Mary's Healthcare Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: ● Asked of all respondents.

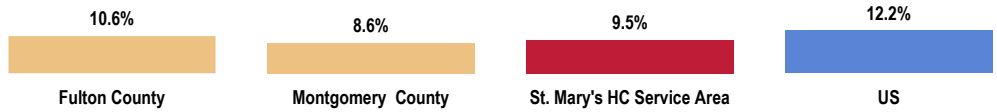
Unhealthy or Unsafe Housing

A total of 9.5% of St. Mary's Healthcare Service Area residents report living in unhealthy or unsafe housing conditions during the past year.

DISPARITY ► More often reported among young adults, lower-income adults, and renters.

Respondents were asked: "Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"

Unhealthy or Unsafe Housing Conditions in the Past Year

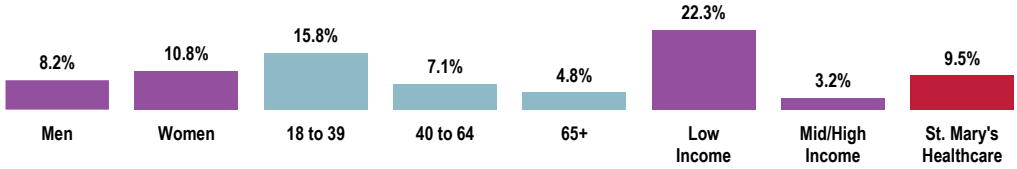


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 65]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Unhealthy or Unsafe Housing Conditions in the Past Year
(St. Mary's Healthcare Service Area, 2021)

Among homeowners	4.4%
Among renters	24.6%



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 65]

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Food Access

Low Food Access

Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store.

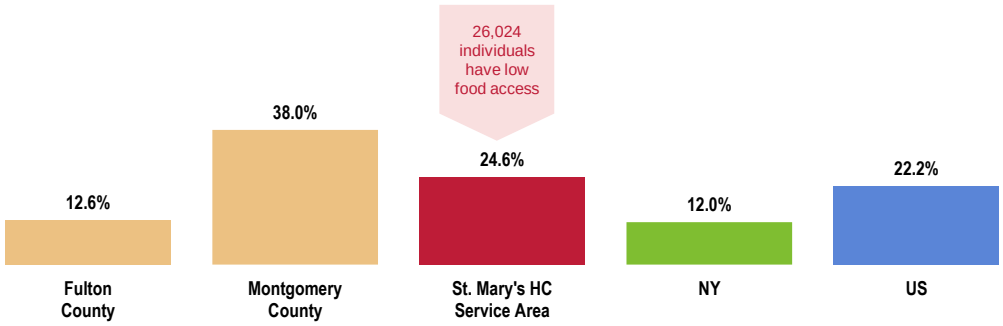
RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* in the **Modifiable Health Risks** section of this report.

US Department of Agriculture data show that 24.6% of the St. Mary's Healthcare Service Area population (representing over 26,000 residents) have low food access, meaning that they do not live near a supermarket or large grocery store.

BENCHMARK ► Worse than found statewide.

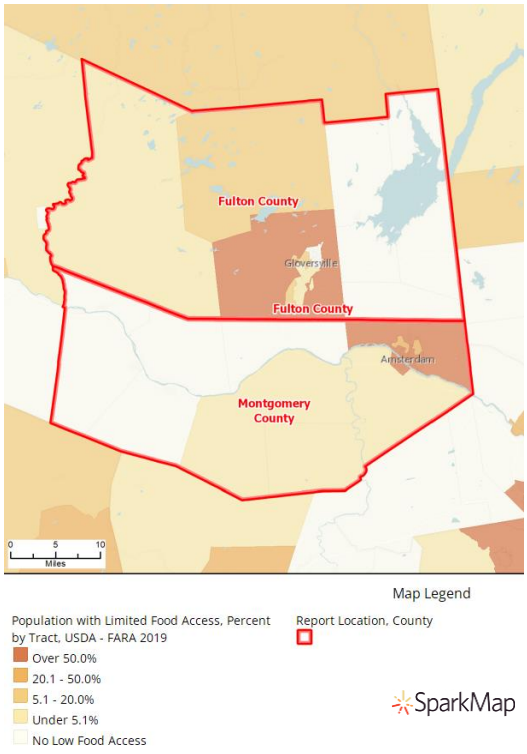
DISPARITY ► Unfavorably high in Montgomery County.

Population With Low Food Access
(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2019)



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.



Food Insecurity

Surveyed adults were asked: "Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was "Often True," "Sometimes True," or "Never True" for you in the past 12 months:

- I worried about whether our food would run out before we got money to buy more.
- The food that we bought just did not last, and we did not have money to get more."

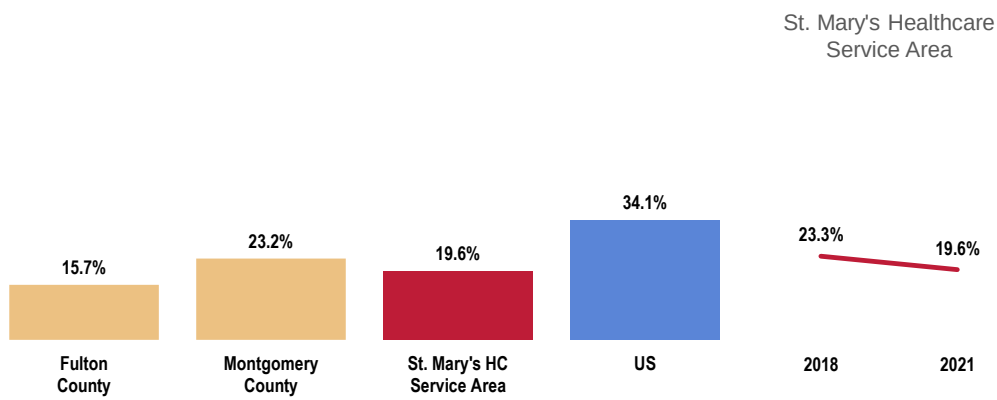
Those answering "Often" or "Sometimes True" for either statement are considered to be food insecure.

Overall, 19.6% of community residents are determined to be "food insecure," having run out of food in the past year and/or been worried about running out of food.

BENCHMARK ► Favorably much lower than the national percentage.

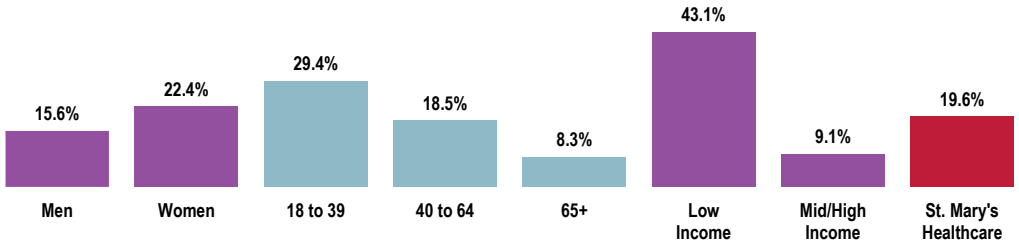
DISPARITY ► Higher in Montgomery County. More often reported among women, adults younger than 65, and especially low-income respondents.

Food Insecurity



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 112]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Food Insecurity
(St. Mary's Healthcare Service Area, 2021)



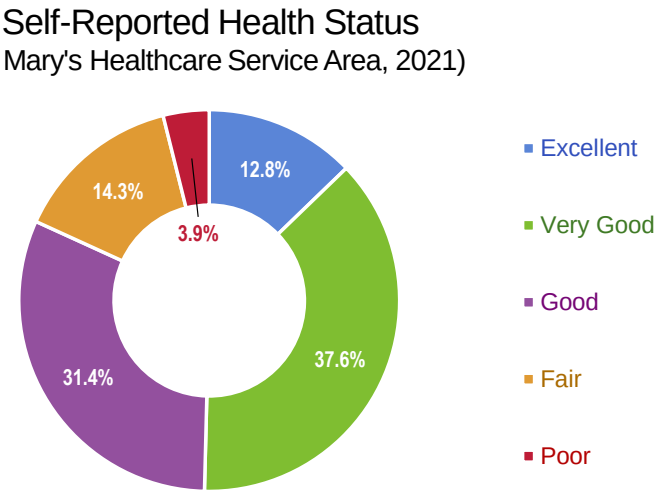
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 112]
Notes: ● Asked of all respondents.
● Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

HEALTH STATUS

OVERALL HEALTH STATUS

The initial inquiry of the PRC Community Health Survey asked: "Would you say that in general your health is: Excellent, Very Good, Good, Fair, or Poor?"

Most St. Mary's Healthcare Service Area residents rate their overall health favorably (responding "excellent," "very good," or "good").

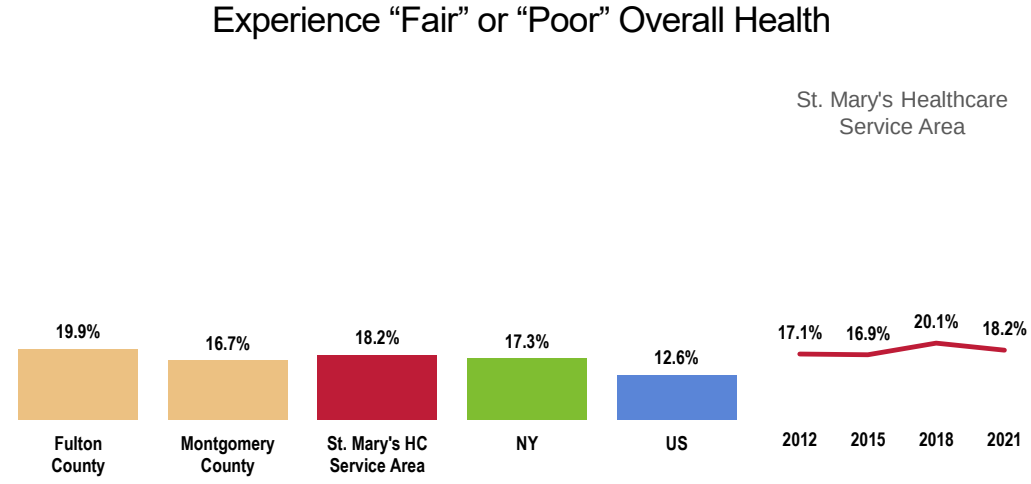


Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: ● Asked of all respondents.

However, 18.2% of St. Mary's Healthcare Service Area adults believe that their overall health is "fair" or "poor."

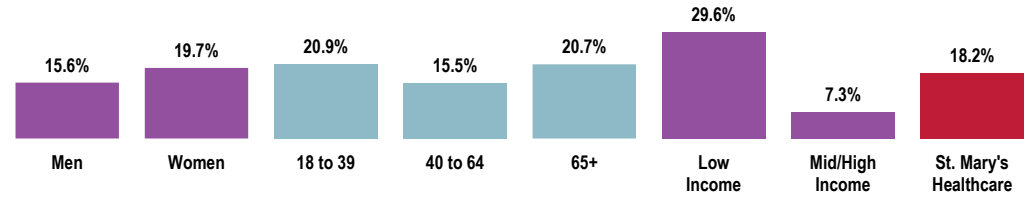
BENCHMARK ► Higher (less favorable) than was found nationally.

DISPARITY ► Especially high among low-income adults.



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 New York data.
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(St. Mary's Healthcare Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: • Asked of all respondents.

MENTAL HEALTH

ABOUT MENTAL HEALTH & MENTAL DISORDERS

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

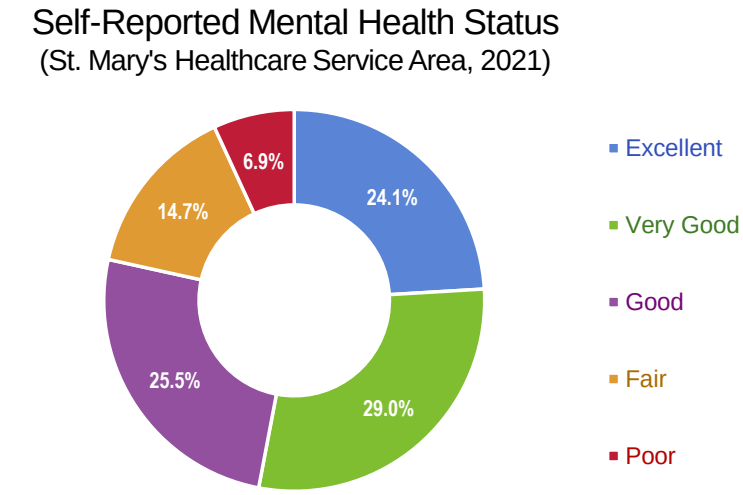
In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Mental Health Status

"Now thinking about your mental health, which includes stress, depression, and problems with emotions, would you say that, in general, your mental health is: Excellent, Very Good, Good, Fair, or Poor?"

Most St. Mary's Healthcare Service Area adults rate their overall mental health favorably ("excellent," "very good," or "good").



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 90]
Notes: ● Asked of all respondents.

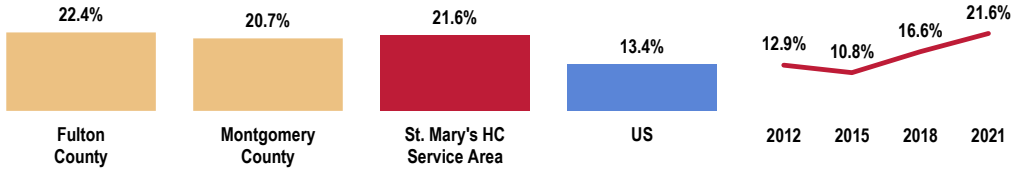
However, 21.6% believe that their overall mental health is "fair" or "poor."

BENCHMARK ► Worse than the national finding.

TREND ► Marks an all-time high in the service area.

Experience "Fair" or "Poor" Mental Health

St. Mary's Healthcare Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 90]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Depression

Diagnosed Depression

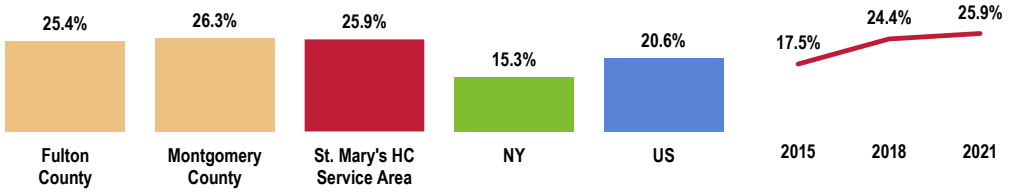
A total of 25.9% of St. Mary's Healthcare Service Area adults have been diagnosed by a physician as having a depressive disorder (such as depression, major depression, dysthymia, or minor depression).

BENCHMARK ► Higher than state and national levels.

TREND ► Denotes a significant increase from the 2015 survey.

Have Been Diagnosed With a Depressive Disorder

St. Mary's Healthcare Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 93]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 New York data.
- 2020 PRC National Health Survey, PRC, Inc.

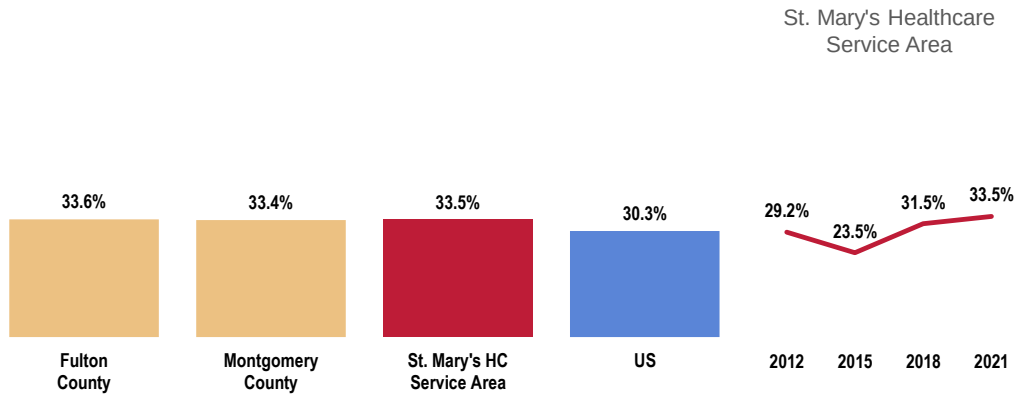
Notes:
- Asked of all respondents; depressive disorders include depression, major depression, dysthymia, or minor depression.

Symptoms of Chronic Depression

A total of 33.5% of St. Mary's Healthcare Service Area adults have had two or more years in their lives when they felt depressed or sad on most days, although they may have felt okay sometimes (symptoms of chronic depression).

DISPARITY ► More often reported among women, young adults, and particularly low-income respondents.

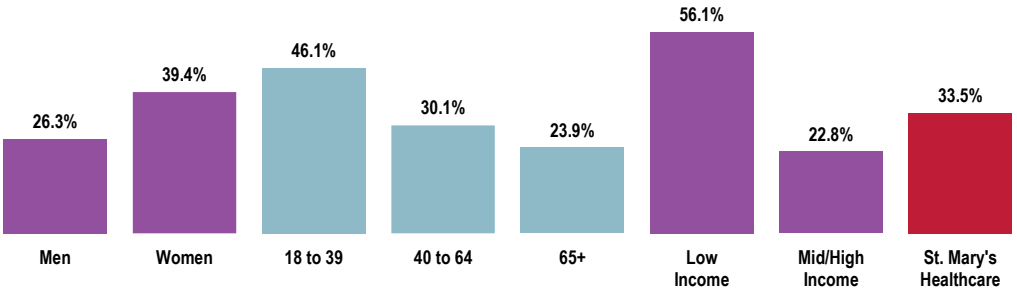
Have Experienced Symptoms of Chronic Depression



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 91]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Have Experienced Symptoms of Chronic Depression
(St. Mary's Healthcare Service Area, 2021)

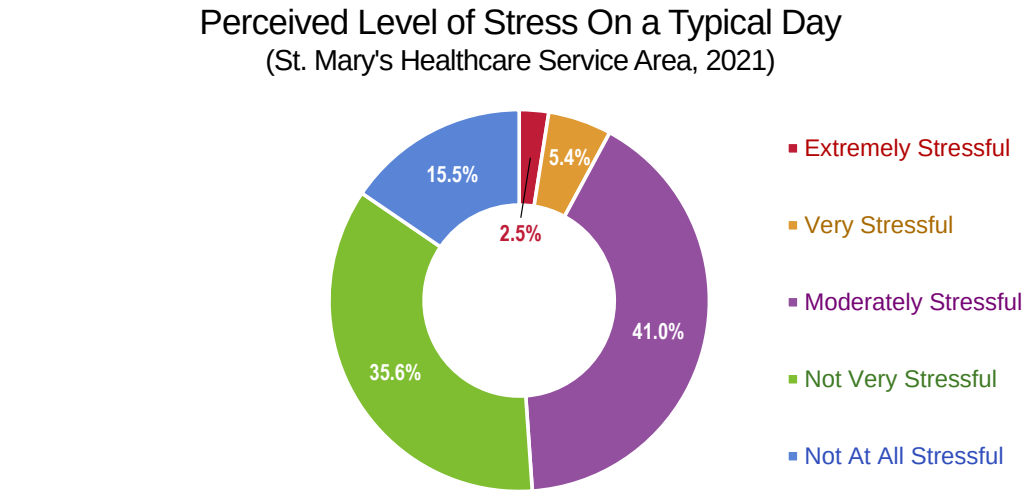


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 91]

Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Stress

Most surveyed adults characterize most days as no more than "moderately" stressful.



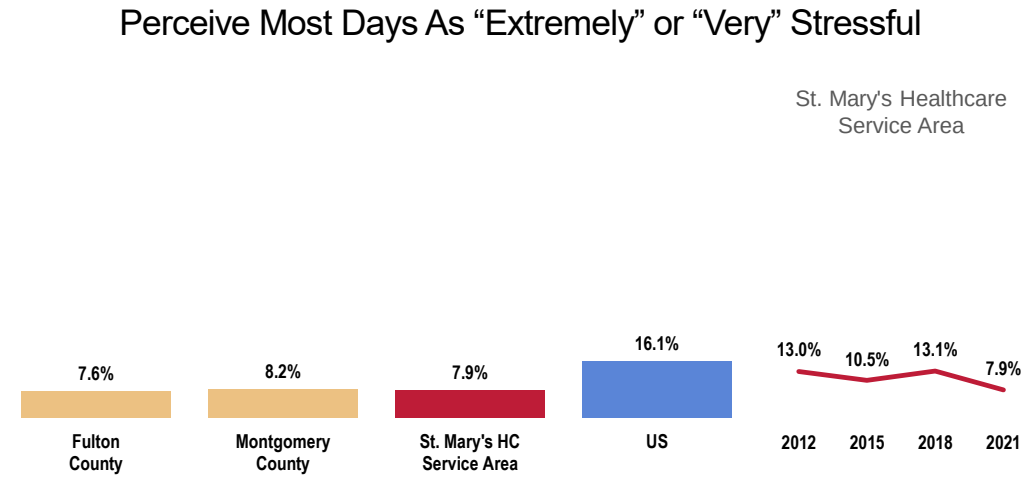
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 92]
Notes: ● Asked of all respondents.

In contrast, 7.9% of St. Mary's Healthcare Service Area adults feel that most days for them are "very" or "extremely" stressful.

BENCHMARK ► Better than the national percentage.

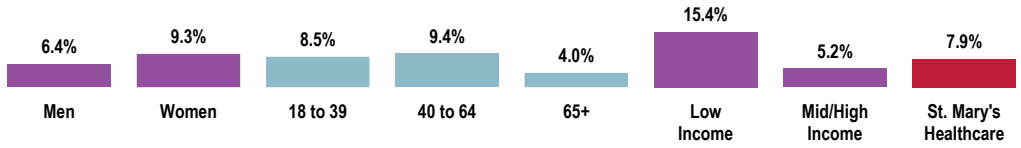
TREND ► Represents a significant decrease.

DISPARITY ► Highest among low-income residents.



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 92]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Perceive Most Days as “Extremely” or “Very” Stressful
(St. Mary's Healthcare Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 92]
Notes: ● Asked of all respondents.

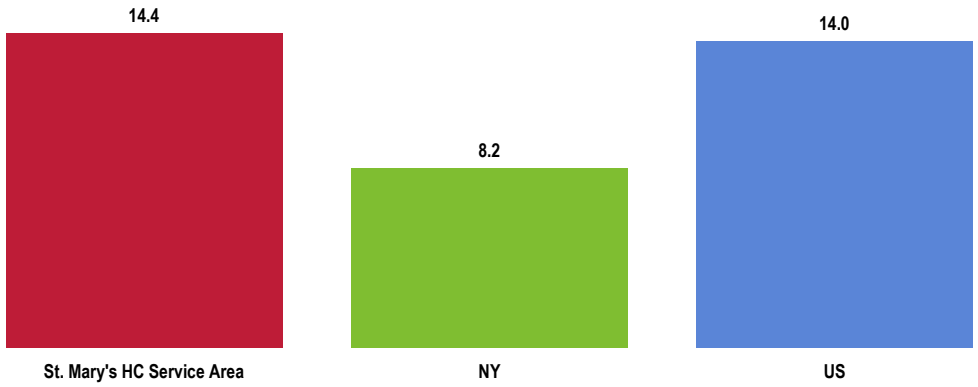
Suicide

In the St. Mary’s Healthcare Service Area, there were 14.4 suicides per 100,000 population (2017-2019 annual average age-adjusted rate).

BENCHMARK ► Worse than the statewide rate.

TREND ► Trending significantly higher within the service area.

Suicide: Age-Adjusted Mortality
(2017–2019 Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 12.8 or Lower

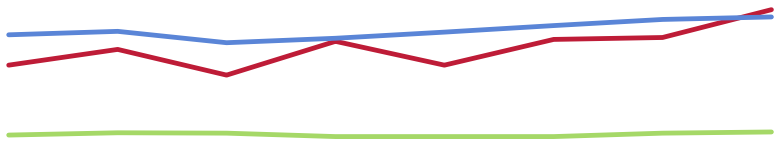


Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.
● US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Suicide: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 12.8 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
St. Mary's HC	11.6	12.4	11.1	12.8	11.6	12.9	13.0	14.4
NY	8.1	8.2	8.2	8.0	8.0	8.0	8.2	8.2
US	13.1	13.3	12.7	13.0	13.3	13.6	13.9	14.0

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Mental Health Treatment

Mental Health Providers

In the St. Mary's Healthcare Service Area in 2021, there were 92.3 mental health providers for every 100,000 population.

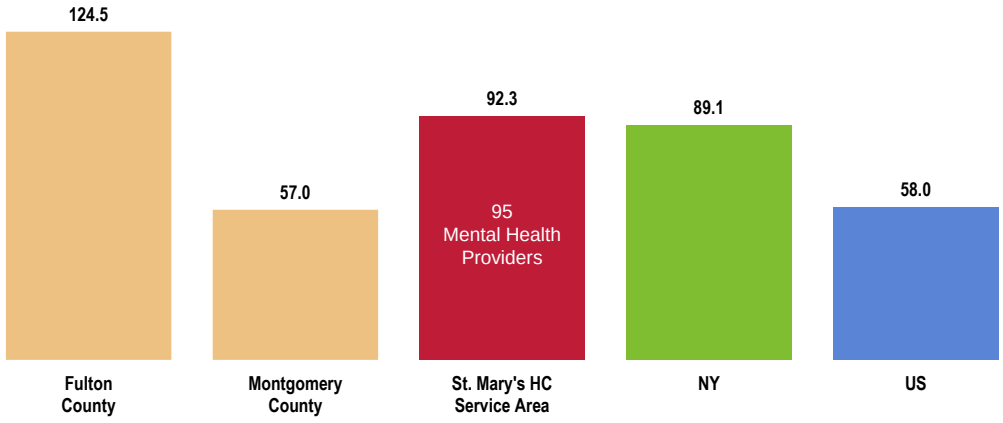
BENCHMARK ► Better than the national proportion.

DISPARITY ► Much lower in Montgomery County than in Fulton County.

Here, "mental health providers" includes psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care. Note that this indicator only reflects providers practicing in the St. Mary's Healthcare Service Area and residents in the St. Mary's Healthcare Service Area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

Access to Mental Health Providers

(Number of Mental Health Providers per 100,000 Population, 2021)



Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

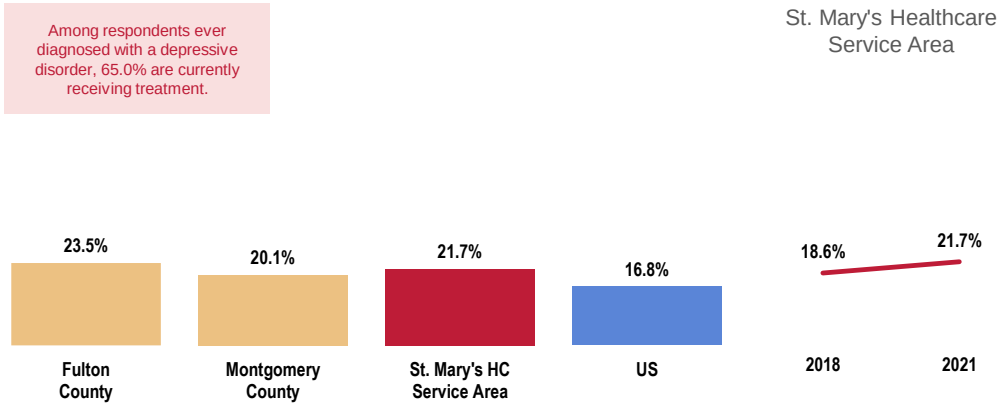
Currently Receiving Treatment

A total of 21.7% of surveyed adults are currently taking medication or otherwise receiving treatment from a doctor or other health professional for some type of mental health condition or emotional problem.

BENCHMARK ► Higher than was found across the US.

Currently Receiving Mental Health Treatment

Among respondents ever diagnosed with a depressive disorder, 65.0% are currently receiving treatment.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 94]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- "Treatment" can include taking medications for mental health.

Difficulty Accessing Mental Health Services

A total of 10.9% of St. Mary's Healthcare Service Area adults report a time in the past year when they needed mental health services but were not able to get them.

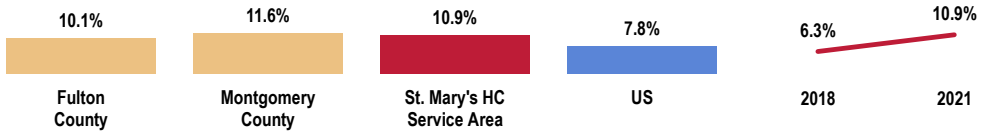
BENCHMARK ► Higher than the national finding.

TREND ► A significant increase from the previous survey.

DISPARITY ► Especially high among young adults and low-income residents.

Unable to Get Mental Health Services When Needed in the Past Year

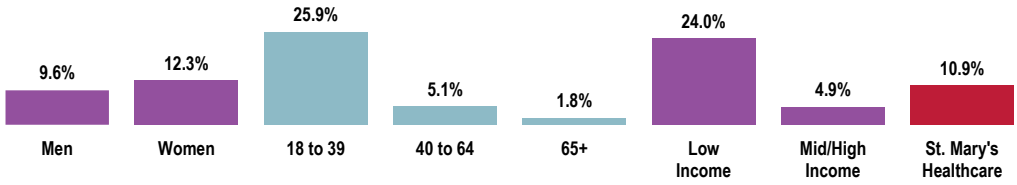
St. Mary's Healthcare Service Area



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 95]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Unable to Get Mental Health Services When Needed in the Past Year

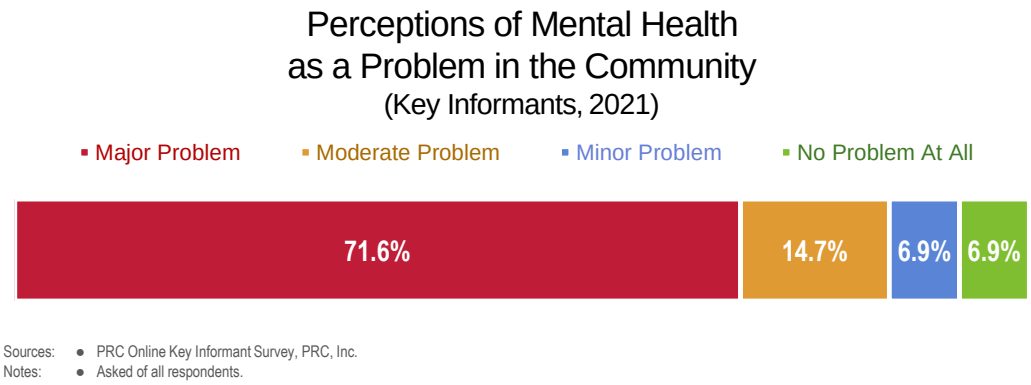
(St. Mary's Healthcare Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 95]
Notes: ● Asked of all respondents.

Key Informant Input: Mental Health

The greatest share of key informants taking part in an online survey characterized *Mental Health* as a "major problem" in the community.



Sources: PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

It is a long wait to get evaluated i.e. months long wait for even an initial meeting. This becomes frustrating for parents who need to know how to work with their child who may have behavioral issues etc. On another note, Mental health resources need to be stronger and talked about more. I wouldn't even know what we have in this area without having to search for it. It should be talked more positively about in the community so people know it is okay to get help and where they can. – Other Health Provider

Not getting appointment in timely manner. No case management follow up. Not being able to navigate MH on their own, need constant reminders and assistance. – Community/Business Leaders

Not enough services to meet the needs. Privilege. Not all community agencies speak the same language. – Social Services Provider

Being able to connect to mental health supports/providers-long waiting lists, lack of transportation or knowledge on how to access/arrange Medicaid transportation. Those with mental health diagnosis being able to clearly state and document their wishes as it relates to their chronic medical conditions. Those in advanced age requiring nursing home that have a behavioral health diagnosis are often looked over for bed offers. – Social Services Provider

Not being able to access counseling, medication, housing. – Social Services Provider

Availability of services, long wait when services are available, sometimes stigmas attached to seeking help. – Social Services Provider

There are not enough mental health workers. They are overworked and under paid. – Other Health Provider

There is a very big challenge to finding crisis support for people with developmental disabilities. Due to bed limitations and perhaps misperceptions of what agencies can provide the local hospital are reluctant to admit a person for inpatient services unless the situation is out of control. – Other Health Provider

Getting prompt treatment when they seek help, shortage of Spanish-speaking therapists, apathy in regard to seeking help. – Social Services Provider

STIGMA, shame, denial, ignorance. People with a mental health disorder are often reluctant to seek treatment because there is a lack of understanding by family, friends, co-workers or others. Fewer opportunities for work or social activities. Often difficult to find housing. Health insurance can be an obstacle. Lack of mental health professionals. – Community/Business Leaders

Stigma, lack of services for children, lack of respite, lack of providers and stigma. Again, even amongst our own health care community. – Other Health Provider

Stigma of the diagnosis, access to care. – Community/Business Leaders

Undiagnosed individuals with Mental Health issues (many times w a duo dx of DD & MH) and their day to day struggles specially the ones that are impacted by the judicial system. The judicial system will benefit from identifying these individuals in their computer data that could alarmed and prepare them as to how to proceed. – Other Health Provider

I see one of the biggest challenges in mental health as compliance with treatment, I think transportation concerns also contribute. I also do feel it is partly due to people not even really wanting assistance in some ways. I do not feel like this is the majority of the reason but there have been a few patients here or there that feels embarrassed about their mental health and what is going on and can deter people from seeking assistance at time.s – Other Health Provider

Lack of stability in the home. Lack of local programs for children and teens. Length of time to get an appointment. – Other Health Provider

Limited family or other social supports to assist them with childcare, transportation, communication, and other factors of daily life that can be impacted by variable mental health functioning. Poor ability to balance other areas of life in order to maintain consistent involvement in mental health or other self- care. Prioritization of the medication management element of mental health care. – Social Services Provider

The support they need to get themselves as balanced as possible through regular mental health professionals (psychologist/therapist) and regular monitoring of how medications are/are not helping. Severe cases have literally nowhere to go, calling the police is NOT the solution. If there was some type of hotline that helps public-facing organizations with advice and/or back-up would be great. There are times when we don't know how to handle a situation and have no one to turn to for help. – Community/Business Leaders

Lack of housing, lack of providers, and lack of specialty providers. – Other Health Provider

Housing, food insecurity, assess to reliable transportation. – Social Services Provider

Substance abuse and finding a counselor and local provider without a waiting list. – Community/Business Leaders

Help is available at St. Mary's Healthcare/Rao Pavilion. Perhaps the biggest challenge is to educate those who are psychologically disabled to get proper treatment. – Community/Business Leaders

Co-existing substance abuse, transportation, housing, and employment needs in addition to cooperation with health care, in general. – Other Health Provider

Transportation issues. Limited access to services. Poor communication of services. Distance of travel to access services. Services for youth/adolescents. – Social Services Provider

Access to Care/Services

Access to MH providers. – Other Health Provider

Adequate ongoing care that is inexpensive and consistent. – Community/Business Leaders

Access to resources and the desire to reach out to get help. – Community/Business Leaders

Significant delays in access, especially for emergent situations. There are not enough mental health providers, especially in pediatrics. Therefore, there is often waiting list of several months for somebody to be referred and seen by a mental health counselor. – Physician

Access to services in a timely fashion. – Physician

Lack of resources. – Other Health Provider

Failure to be able to access services in a timely fashion. Large waiting list and takes several weeks to get in to see someone. – Community/Business Leaders

Availability of qualified providers. – Community/Business Leaders

Unfortunately, there are a number of elements in this area. They include: quality of care, accessibility, and availability of services. – Other Health Provider

Long waiting list to access the programs. – Other Health Provider

Access to outpatient treatment. There are very long waits for appointment times. – Other Health Provider

Access to therapy, tools to cope, options besides substance abuse. – Social Services Provider

There are waiting lists to receive services and lack of providers. – Community/Business Leaders

Long waiting lists for therapy and lack of prescribers. – Other Health Provider

Access to care. – Community/Business Leaders

Lack of supportive services because agencies are unable to find qualified staff. Need to provide local training to persons to provide these supportive services. – Social Services Provider

Timely access for appointments. – Community/Business Leaders

Availability in Mental Health counselors and resources. New patients that are looking for support are often met with a waiting list for weeks, in which time they may escalate and become in crisis. – Social Services Provider

Long wait times, lack of in person services. – Social Services Provider

More outpatient services are needed. – Social Services Provider

Lack of access, long wait times to see providers or intake. Limited mental health providers available. – Social Services Provider

Need of more services, as in all communities, this is a problem that needs to be addressed. More resources are needed. – Community/Business Leaders

> Easy access and transportation limitations, particularly for people in more rural outlying areas. – Social Services Provider
>
> Not enough practitioners, causing delay in care. – Other Health Provider
>
> There are a limited number of providers and all of the providers have extensive wait lists. Some providers are still not doing in person visits which is making the services subpar. It is also difficult to get med providers for mental health and any inpatient services especially for children. – Social Services Provider
>
> There are not enough providers. – Social Services Provider
>
> Lack of mental health providers who accept Medicaid. – Community/Business Leaders

Denial/Stigma

> Getting beyond the stigma of mental health and allowing themselves to seek the help they need. – Community/Business Leaders
>
> I think it is still something that individuals aren't ready to admit. – Community/Business Leaders
>
> It's not always taken seriously. – Social Services Provider
>
> The stigma that surrounds mental health and fear of being judged by their family or friends can prevent them from seeking help. – Other Health Provider

Diagnosis/Treatment

> Treatment and follow-up. – Community/Business Leaders
>
> Attending treatment consistently. – Social Services Provider

Follow-Up/Support

> Supportive services to assist in daily living/coping activities. – Community/Business Leaders

Comorbidities

> The biggest challenge I see specifically for the people I work with is when there are other disabilities the person has. Mental health is sometimes looked at secondarily when a person has other disabilities. When in fact their mental health status is the primary issue and not necessarily the other disabilities the person has. – Other Health Provider

Due to COVID-19

> We are very fortunate to have many levels of behavioral health services throughout our service area, but there still exists a problem, especially after COVID. Many of those services were halted or became virtual. – Public Health Representative

Income/Poverty

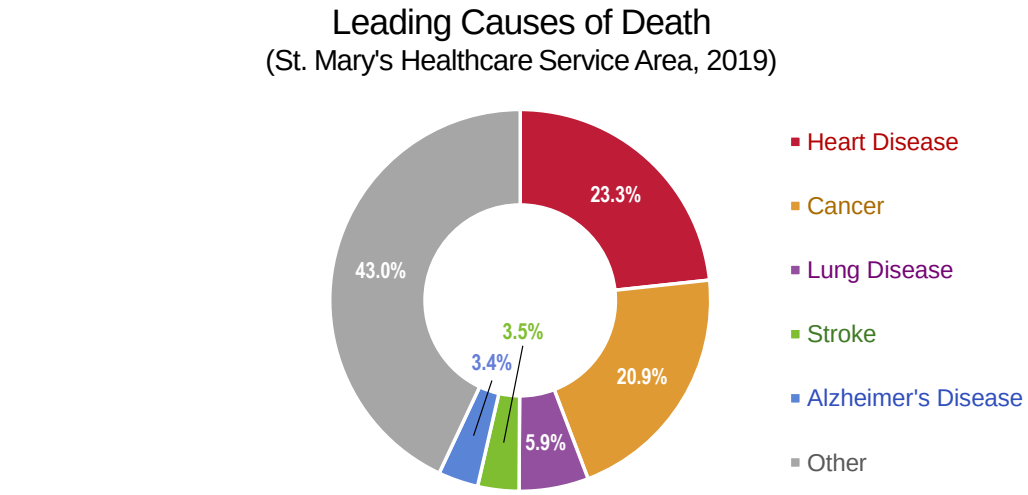
> Significant issues of parity remain. Interventions to address mental health are reimbursed significantly lower than physical health procedures. – Social Services Provider

DEATH, DISEASE & CHRONIC CONDITIONS

LEADING CAUSES OF DEATH

Distribution of Deaths by Cause

Together, heart disease and cancers accounted for approximately 44% of all deaths in the St. Mary's Healthcare Service Area in 2019.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.
Notes: ● Lung disease is CLRD, or chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

AGE-ADJUSTED DEATH RATES

In order to compare mortality in the region with other localities (in this case, New York and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these "age-adjusted" rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.

Note that deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

The following chart outlines 2017-2019 annual average age-adjusted death rates per 100,000 population for selected causes of death in the St. Mary's Healthcare Service Area.

Each of these is discussed in greater detail in subsequent sections of this report.

For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.

Age-Adjusted Death Rates for Selected Causes
(2017–2019 Deaths per 100,000 Population)

	St. Mary's Healthcare Service Area	NY	US	HP2030
Diseases of the Heart	187.5	169.9	163.4	127.4*
Malignant Neoplasms (Cancers)	165.8	137.4	149.3	122.7
Chronic Lower Respiratory Disease (CLRD)	48.8	28.3	39.6	—
Falls [Age 65+]	37.7	43.6	65.1	63.4
Unintentional Injuries	36.4	34.7	48.9	43.2
Pneumonia/Influenza	29.1	17.5	13.8	—
Cerebrovascular Disease (Stroke)	28.4	24.3	37.2	33.4
Diabetes	24.7	17.7	21.5	—
Alzheimer's Disease	20.5	13.6	30.4	—
Kidney Disease	18.1	9.5	12.9	—
Intentional Self-Harm (Suicide)	14.4	8.2	14.0	12.8
Unintentional Drug-Related Deaths	12.0	16.8	18.8	—
Cirrhosis/Liver Disease	9.9	7.0	11.1	10.9
Motor Vehicle Deaths	9.0	5.1	11.3	10.1
Firearm-Related	6.8	3.9	11.9	10.7

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov.

Note:
- *The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

CARDIOVASCULAR DISEASE

ABOUT HEART DISEASE & STROKE

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. …Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Heart Disease & Stroke Deaths

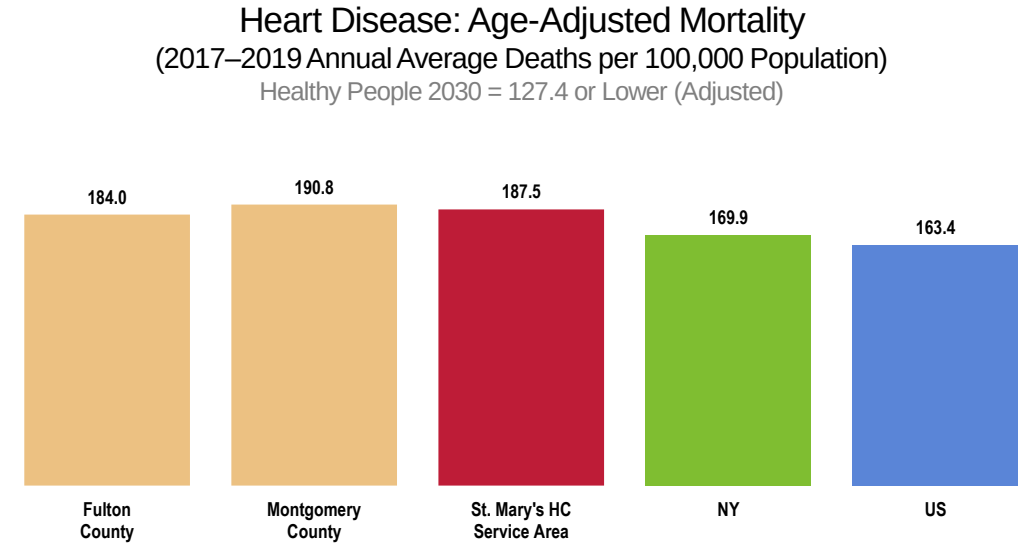
Heart Disease Deaths

The greatest share of cardiovascular deaths is attributed to heart disease.

Between 2017 and 2019, there was an annual average age-adjusted heart disease mortality rate of 187.5 deaths per 100,000 population in the St. Mary's Healthcare Service Area.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

TREND ► Represents an all-time low in the service area.



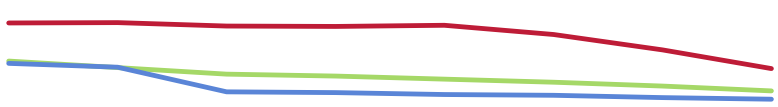
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

Heart Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
St. Mary's HC	223.2	223.6	220.8	220.5	221.6	214.2	202.2	187.5
NY	193.4	188.4	183.2	181.6	179.2	176.9	173.6	169.9
US	191.6	188.5	169.1	168.4	167.0	166.3	164.7	163.4

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

Stroke Deaths

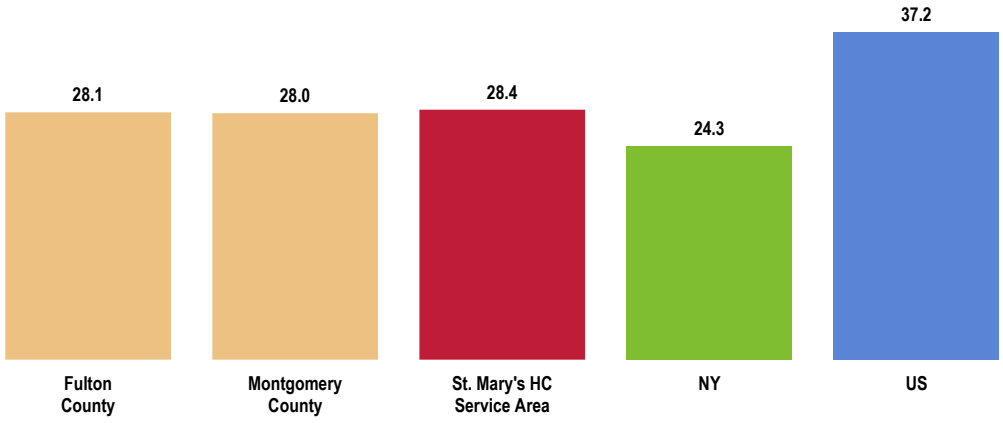
Between 2017 and 2019, there was an annual average age-adjusted stroke mortality rate of 28.4 deaths per 100,000 population in the St. Mary's Healthcare Service Area.

BENCHMARK ► Lower than the national rate. Satisfies the Healthy People 2030 objective.

Stroke: Age-Adjusted Mortality

(2017–2019 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower

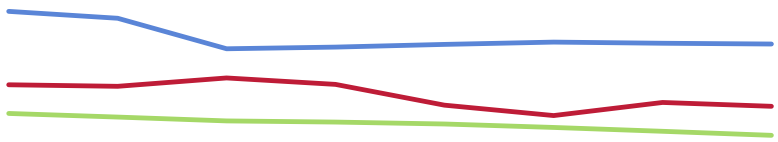


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
St. Mary's HC	31.4	31.2	32.4	31.5	28.6	27.1	28.9	28.4
NY	27.4	26.8	26.3	26.1	25.9	25.4	24.8	24.3
US	41.8	40.9	36.5	36.8	37.1	37.5	37.3	37.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Prevalence of Heart Disease & Stroke

Prevalence of Heart Disease

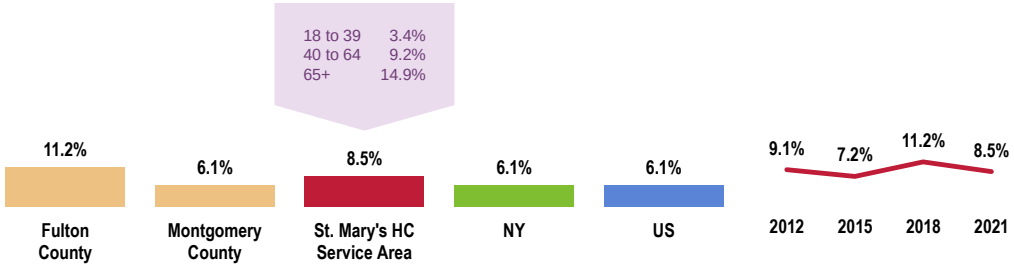
A total of 8.5% of surveyed adults report that they suffer from or have been diagnosed with heart disease, such as coronary heart disease, angina, or heart attack.

BENCHMARK ► Higher than the statewide percentage.

DISPARITY ► Unfavorably high in Fulton County. Positively correlated with age.

Prevalence of Heart Disease

St. Mary's Healthcare Service Area

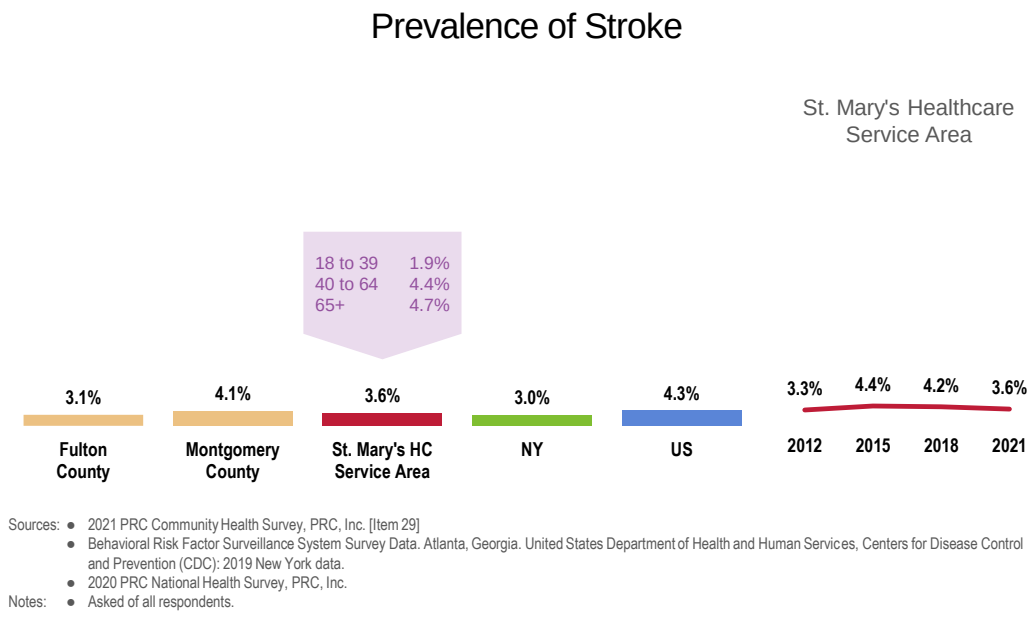


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 114]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 New York data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina, or coronary heart disease.

Prevalence of Stroke

A total of 3.6% of surveyed adults report that they suffer from or have been diagnosed with cerebrovascular disease (a stroke).



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 29]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 New York data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

Blood Pressure & Cholesterol

A total of 39.6% of St. Mary's Healthcare Service Area adults have been told by a health professional at some point that their blood pressure was high.

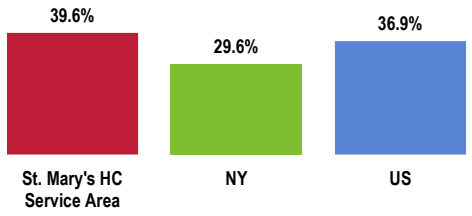
BENCHMARK ▶ Worse than the state finding. Fails to satisfy the Healthy People 2030 objective.

A total of 36.4% of adults have been told by a health professional that their cholesterol level was high.

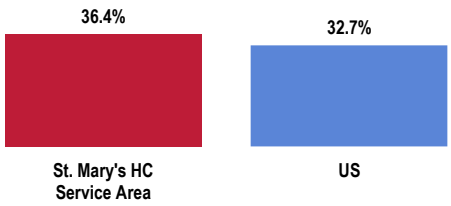
DISPARITY ▶ Higher in Fulton County (not shown).

Prevalence of High Blood Pressure

Healthy People 2030 = 27.7% or Lower



Prevalence of High Blood Cholesterol

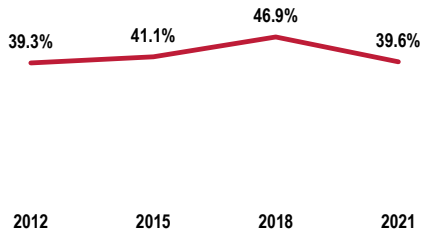


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 35-36]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 New York data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

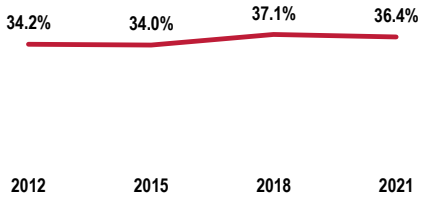
Notes:
- Asked of all respondents.

Prevalence of High Blood Pressure (St. Mary's Healthcare Service Area)

Healthy People 2030 = 27.4% or Lower



Prevalence of High Blood Cholesterol (St. Mary's Healthcare Service Area)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 35-36]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Total Cardiovascular Risk

Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

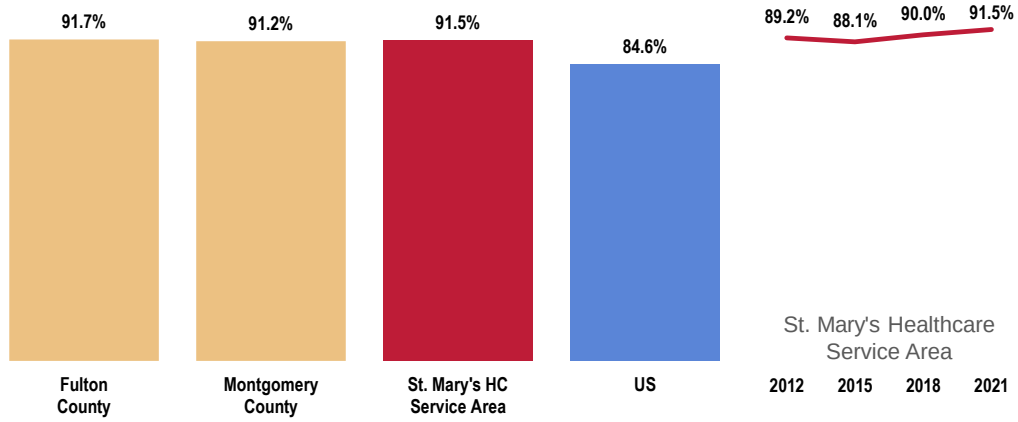
Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

A total of 91.5% of St. Mary's Healthcare Service Area adults report one or more cardiovascular risk factors, such as being overweight, smoking cigarettes, being physically inactive, or having high blood pressure or cholesterol.

BENCHMARK ► Higher than was found across the US.

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

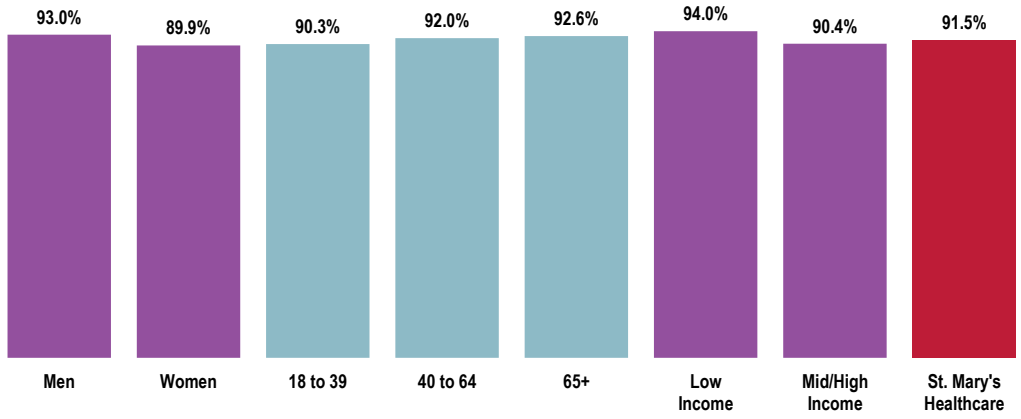
Present One or More Cardiovascular Risks or Behaviors



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 115]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Present One or More Cardiovascular Risks or Behaviors
(St. Mary's Healthcare Service Area, 2021)



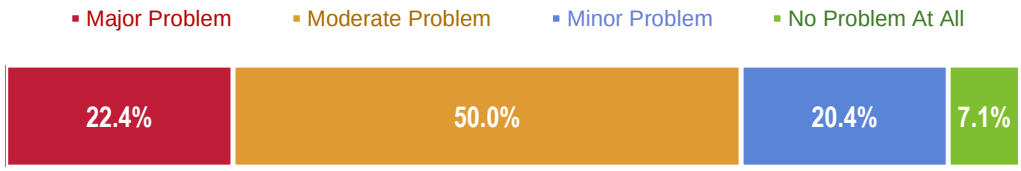
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 115]

Notes:
- Reflects all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

Key Informant Input: Heart Disease & Stroke

The greatest share of key informants taking part in an online survey characterized *Heart Disease & Stroke* as a "moderate problem" in the community.

Perceptions of Heart Disease and Stroke as a Problem in the Community
(Key Informants, 2021)



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> Unhealthy eating/living. Lack of resources, non-compliance/lack of education. – Other Health Provider
>
> Not exclusive to our community but overeating, eating the wrongs foods, living stressful lives all lead to heart disease and strokes. Three out of four of my grandparents died due to heart disease. My husband has had heart disease for most of his life from a poor family history. He had his first heart attack at 34. He was a runner, ate well and was in excellent physical condition. He has had triple bypass surgery at 28. Again, he exercised regularly and ate well. Since then he has had five stents at different times inserted into his arteries surrounding his heart. Fortunately, he is aware of his signs and symptoms. His last round needing stents he went to the ER three times in two weeks and saw his cardiologist twice in that time. Everyone kept saying he was fine. His last visit to the ER he was finally sent to Ellis Cardiac care where they discovered he had 95% blockage in his artery and that artery alone required three stents. Medical professionals need to listen to the patient. – Community/Business Leaders
>
> Many are overweight and are smokers. More support groups are needed for educating them on way to prevent these health issues. – Other Health Provider

> Poor nutrition, obesity, high rate of tobacco/nicotine products. – Social Services Provider
>
> Heart and stroke issues are commonly seen coming through the Emergency Department. Modifiable risk factors, like obesity and alcoholism, seem to be contributing factors. – Other Health Provider
>
> Lack of proper dietary guidance. Poverty. Increase use of tobacco, inactive lifestyles. – Community/Business Leaders
>
> I believe lack of access to healthy food choices as well as obesity and sedentary lifestyles has caused heart disease and stroke to be major problems in our community. Widespread tobacco use has also contributed to this. – Other Health Provider
>
> We lack access to healthy foods, beverages, etc. Plus, we have a high number of substance abusers in this area. – Public Health Representative
>
> Possibly hereditary or lifestyle choices leading to heart disease. Lack of connectivity to health care or low health literacy on importance of eating healthy to prevent these disease processes. Lack of ability to afford "healthy" foods and easy to access unhealthy foods that contribute to increased incidences of heart disease and stroke. – Social Services Provider

Incidence/Prevalence

> A lot of people are dying from heart attacks and stroke. – Social Services Provider
>
> In the University of Wisconsin Population Health Institute's County Health Rankings, Montgomery and Fulton Counties have a higher than average prevalence of this condition. – Community/Business Leaders
>
> I am familiar with a number of people who have experienced one or the other. The community has a high percentage of elderly residents and these events are common in elderly people. – Community/Business Leaders

Awareness/Education

> Lack of understanding by the general population. Lack of proper nutrition and physical care. – Community/Business Leaders
>
> I think the difficulty I see is that there is the education and supports in the community however it is getting people to take what they hear and follow it – what it means to live a healthier lifestyle. changing people's habits and behaviors is probably the most difficult thing to do in my opinion. – Other Health Provider

Nutrition

> Poor diet, lack of healthy habits. – Social Services Provider
>
> Diet is a huge factor. – Community/Business Leaders

Tobacco Use

> On a daily basis I see so many people still smoking or vaping. The health choices and diets people have are the root cause to the heart disease and it increases their risk of stroke. – Community/Business Leaders
>
> High percentage of heart disease due to smoking. High percentage of stroke due to other health issues. – Social Services Provider

Access to Care/Services

> You need to go down to Sch'dy or Albany to get sufficient services. – Community/Business Leaders

Due to COVID-19

> Especially during COVID, patients were not attending routine medical appointments, yearly cardiology testing. – Social Services Provider

Prevention/Screenings

> Lack of preventative health care and unwillingness of patient population to change smoking, exercise and eating habits. – Other Health Provider

Vulnerable Populations

> Minority population and low-income levels increase these problems. – Community/Business Leaders

CANCER

ABOUT CANCER

Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

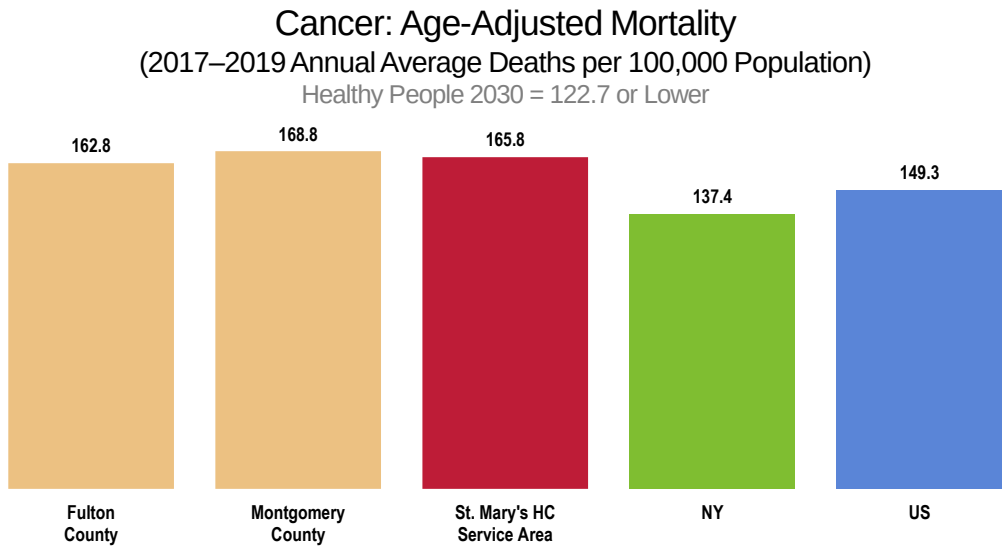
– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Cancer Deaths

All Cancer Deaths

Between 2017 and 2019, there was an annual average age-adjusted cancer mortality rate of 165.8 deaths per 100,000 population in the St. Mary's Healthcare Service Area.

BENCHMARK ► Worse than was found across New York. Fails to satisfy the Healthy People 2030 objective.



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cancer: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 122.7 or Lower

	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
St. Mary's HC	172.2	177.6	173.8	169.1	161.4	164.1	164.3	165.8
NY	161.0	158.6	155.7	152.0	149.2	145.7	142.3	137.4
US	174.8	171.6	163.6	161.0	158.5	155.6	152.5	149.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cancer Deaths by Site

Lung cancer is by far the leading cause of cancer deaths in the service area.

Other leading sites include female breast cancer, prostate cancer, and colorectal cancer (both sexes).

BENCHMARK

Lung Cancer ► Higher than both state and national rates. Fails to satisfy the Healthy People 2030 objective.

Female Breast Cancer ► Fails to satisfy the Healthy People 2030 objective.

Colorectal Cancer ► Fails to satisfy the Healthy People 2030 objective.

Age-Adjusted Cancer Death Rates by Site
(2017–2019 Annual Average Deaths per 100,000 Population)

	St. Mary's Healthcare Service Area	NY	US	HP2030
ALL CANCERS	**165.8**	**137.4**	**149.3**	**122.7**
Lung Cancer	**48.2**	**30.2**	**34.9**	**25.1**
Female Breast Cancer	**19.4**	**18.5**	**19.7**	**15.3**
Prostate Cancer	**16.8**	**16.9**	**18.6**	**16.9**
Colorectal Cancer	**13.3**	**12.2**	**13.4**	**8.9**

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cancer Incidence

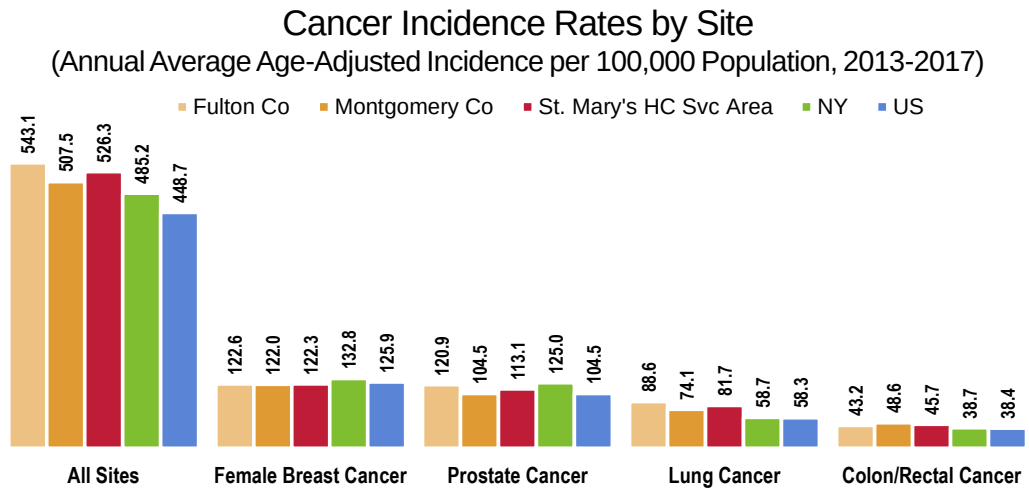
"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year.

The highest cancer incidence rates are for female breast cancer and prostate cancer.

BENCHMARK

Lung Cancer ► Higher than both state and national rates.

Colorectal Cancer ► Higher than both state and national rates.



Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Prevalence of Cancer

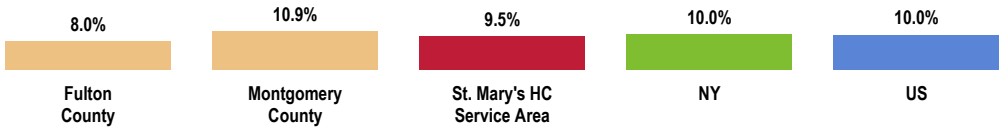
A total of 9.5% of surveyed St. Mary's Healthcare Service Area adults report having ever been diagnosed with cancer. The most common types include skin cancer, breast cancer, and colorectal cancer.

DISPARITY ► Especially high among seniors (age 65+).

Prevalence of Cancer

The most common types of cancers cited locally include:

1) Skin Cancer 19.1%
2) Breast Cancer 17.8%
3) Colorectal Cancer 10.8%

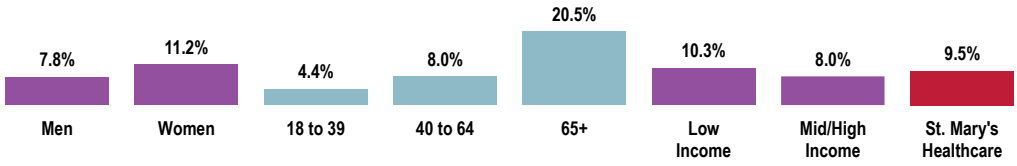


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 25-26]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 New York data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.

Prevalence of Cancer
(St. Mary's Healthcare Service Area, 2021)

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 25]

Notes:
- Reflects all respondents.

ABOUT CANCER RISK

Reducing the nation's cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.

– National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.
Screening levels in the community were measured in the PRC Community Health Survey relative to three cancer sites: female breast cancer (mammography); cervical cancer (Pap smear/HPV testing); and colorectal cancer (colonoscopy/sigmoidoscopy and fecal occult blood testing).

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Among women age 50-74, 76.5% have had a mammogram within the past 2 years.

BENCHMARK ► Lower than the statewide percentage. Similar to the Healthy People 2030 objective.

"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65. Women 21 to 65 with hysterectomy are excluded.

Among St. Mary's Healthcare Service Area women age 21 to 65, 79.5% have had appropriate cervical cancer screening.

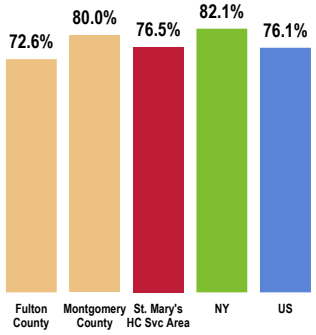
BENCHMARK ► Similar to the Healthy People 2030 objective.

Among all adults age 50-75, 74.2% have had appropriate colorectal cancer screening.

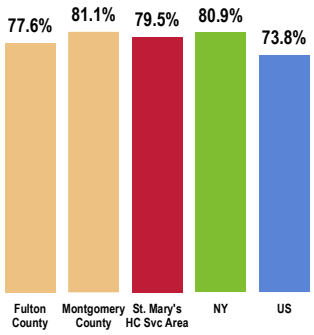
BENCHMARK ► Similar to the Healthy People 2030 objective.

"Appropriate colorectal cancer screening" includes a fecal occult blood test within the past year and/or a lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.

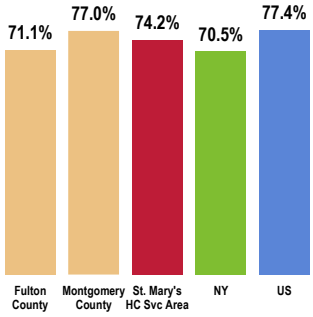
Breast Cancer Screening
(Women Age 50-74)
Healthy People 2030 = 77.1% or Higher



Cervical Cancer Screening
(Women Age 21-65)
Healthy People 2030 = 84.3% or Higher



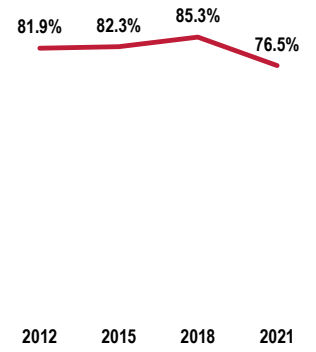
Colorectal Cancer Screening
(All Adults Age 50-75)
Healthy People 2030 = 74.4% or Higher



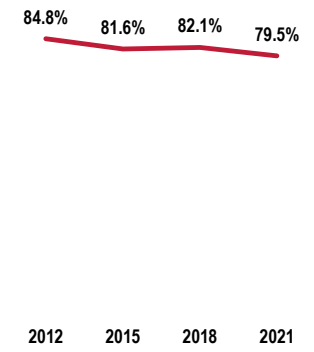
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 116-118]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 New York data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Each indicator is shown among the gender and/or age group specified.

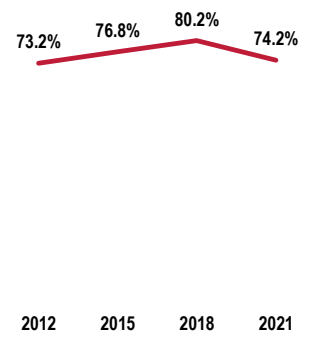
Breast Cancer Screening
(Women Age 50-74)
Healthy People 2030 = 77.1% or Higher



Cervical Cancer Screening
(Women Age 21-65)
Healthy People 2030 = 84.3% or Higher



Colorectal Cancer Screening
(All Adults Age 50-75)
Healthy People 2030 = 74.4% or Higher

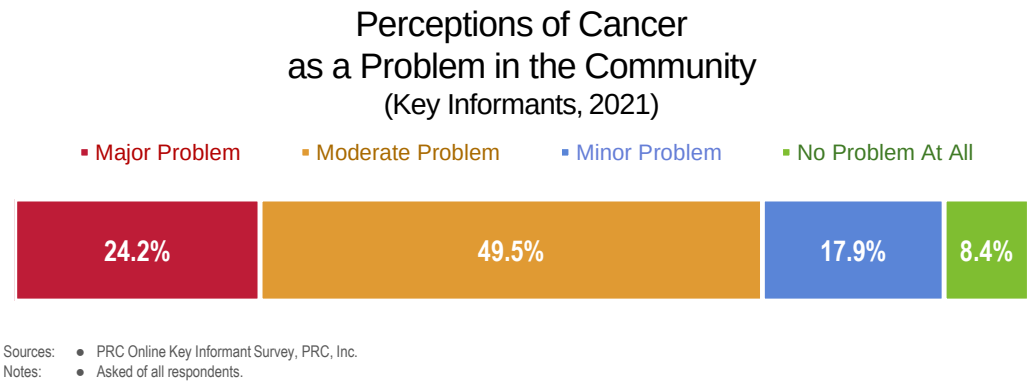


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 116-118]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Each indicator is shown among the gender and/or age group specified.

Key Informant Input: Cancer

The greatest share of key informants taking part in an online survey characterized *Cancer* as a "moderate problem" in the community.



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> The disease appears to be more prevalent in the Mohawk Valley than in other areas. – Community/Business Leaders
>
> I believe there has been a large increase in patients with cancer over the years that I have been working at St. Mary's Hospital. – Social Services Provider
>
> It seems like more and more people are getting cancer. – Social Services Provider
>
> Fulton County is rated as the fifth county in New York State for new cancer onsets out of 62 counties. – Social Services Provider
>
> I work at a Cancer Center, I feel that we have a large amount of cancer in this area, possibly lifestyle, family history and environmental. – Other Health Provider
>
> I know several people personally who have been diagnosed and treated for cancer in our community. A far larger number than any other disease that I can name. – Community/Business Leaders
>
> Many cases. Many different types. – Community/Business Leaders
>
> In the University of Wisconsin Population Health Institute's County Health Rankings, Montgomery and Fulton Counties have a higher than average prevalence of this condition. – Community/Business Leaders
>
> There are so many types of cancer and so many individuals who have it at all ages. – Community/Business Leaders
>
> It is afflicting many of varying ages. – Community/Business Leaders
>
> High rate of cancer due to other health problems and/or exposure to cancer causing substances. – Social Services Provider

Contributing Factors

> High numbers of people affected by cancer in this area. Limited support systems to assist them during required treatment and lack of social work support during medical oncology/radiation oncology treatment. – Social Services Provider
>
> Cancer care in our community is limited and accessibility to certain providers whom would identify those cancers is difficult. With COVID-19 regular screenings were avoided and cancers may have gone unidentified and allowed to grow and progress into a worse form/stage. – Community/Business Leaders
>
> As the population exposed to factories and high-risk jobs ages as does the rate of increasing cancer diagnosis. We are not only an aging community but also a community that has low health literacy and while prevention efforts are out there it is hard to know if people are accessing. – Other Health Provider

Prevention/Screenings

> Many people are not seeking routine screening/preventative care and a moderate to large amount of good health and lifestyle habits. – Other Health Provider

> Not enough early testing. I believe everyone has cancer, however, it is not determined or diagnosed in the early stages. Insurance problems, don't want to pay. – Community/Business Leaders

Awareness/Education

> I believe it is lack of understanding and the need for more cancer education. When we would go to community events and talk with people the vast majority just didn't think it could happen to them and they had no concerns although through asking questions about their family history they would say that they had family, mom, dad, sister who had cancer, they are smokers, overweight, etc. Although these factors don't mean that you will get cancer it is a huge factor and prevention is key. Stressing to them that being proactive and getting screened is your best defense against cancer. – Other Health Provider

Environmental Contributors

> Our historic environmental issues have made cancer a problem that effects all ages and socioeconomic people. – Community/Business Leaders
>
> Environmental and/or water source factors. – Community/Business Leaders

RESPIRATORY DISEASE

ABOUT RESPIRATORY DISEASE

Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

Interventions tailored to at-risk groups can also help prevent and treat other respiratory diseases — for example, pneumonia in older adults and pneumoconiosis in coal miners. And increasing lung cancer screening rates can help reduce deaths from lung cancer through early detection and treatment.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Respiratory Disease Deaths

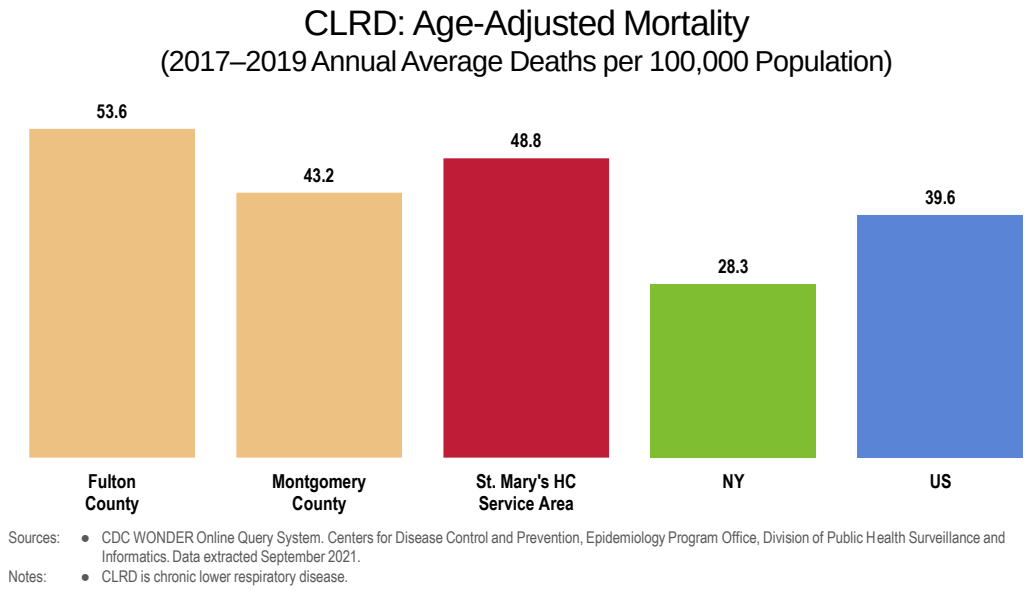
Chronic Lower Respiratory Disease Deaths (CLRD)

Note: Chronic lower respiratory disease (CLRD) includes lung diseases such as emphysema, chronic bronchitis, and asthma.

Between 2017 and 2019, there was an annual average age-adjusted CLRD mortality rate of 48.8 deaths per 100,000 population in the St. Mary's Healthcare Service Area.

BENCHMARK ► Worse than state and national rates.

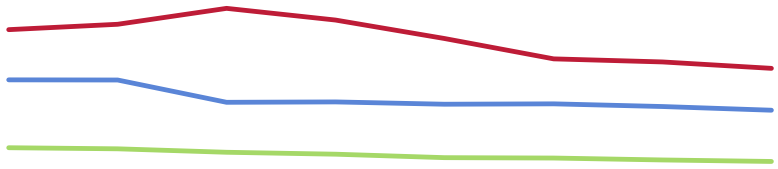
TREND ► Marks an all-time low in the service area.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.

Notes: • CLRD is chronic lower respiratory disease.

CLRD: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
St. Mary's HC	57.3	58.5	62.1	59.5	55.4	51.0	50.2	48.8
NY	31.3	31.1	30.3	29.9	29.1	29.1	28.6	28.3
US	46.3	46.3	41.4	41.4	40.9	41.0	40.4	39.6

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.
Notes: • CLRD is chronic lower respiratory disease.

Pneumonia/Influenza Deaths

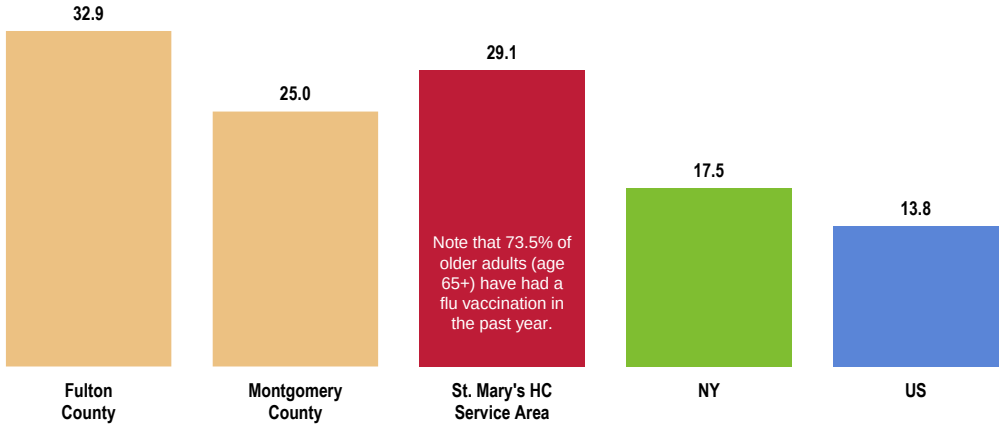
Between 2017 and 2019, the St. Mary's Healthcare Service Area reported an annual average age-adjusted pneumonia influenza mortality rate of 29.1 deaths per 100,000 population.

BENCHMARK ► Higher than the statewide rate and more than twice the national rate.

TREND ► Continuing an upward trend in the service area to an all-time high.

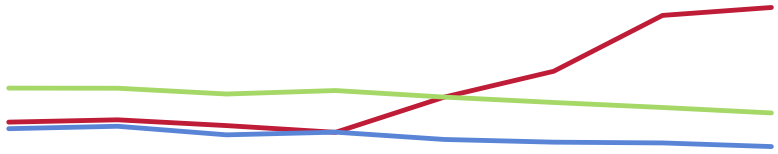
DISPARITY ► Favorably low in Montgomery County.

Pneumonia/Influenza: Age-Adjusted Mortality
(2017–2019 Annual Average Deaths per 100,000 Population)



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.

Pneumonia/Influenza: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
St. Mary's HC	16.5	16.8	16.1	15.4	19.3	22.1	28.3	29.1
NY	20.3	20.2	19.6	20.0	19.3	18.7	18.1	17.5
US	15.8	16.1	15.1	15.4	14.6	14.3	14.2	13.8

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.

Prevalence of Respiratory Disease

Asthma

Adults

Survey respondents were asked to indicate whether they suffer from or have been diagnosed with various respiratory conditions, including asthma and COPD.

A total of 16.7% of St. Mary's Healthcare Service Area adults currently suffer from asthma.

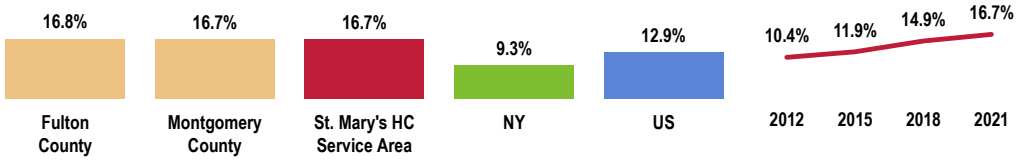
BENCHMARK ► Worse than state and national findings.

TREND ► Increasing significantly over time.

DISPARITY ► Higher among women and young adults.

Prevalence of Asthma

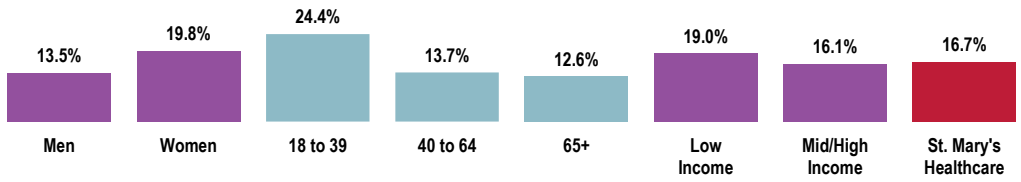
St. Mary's Healthcare Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 119]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 New York data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those who have ever been diagnosed with asthma and report that they still have asthma.

Prevalence of Asthma
(St. Mary's Healthcare Service Area, 2021)



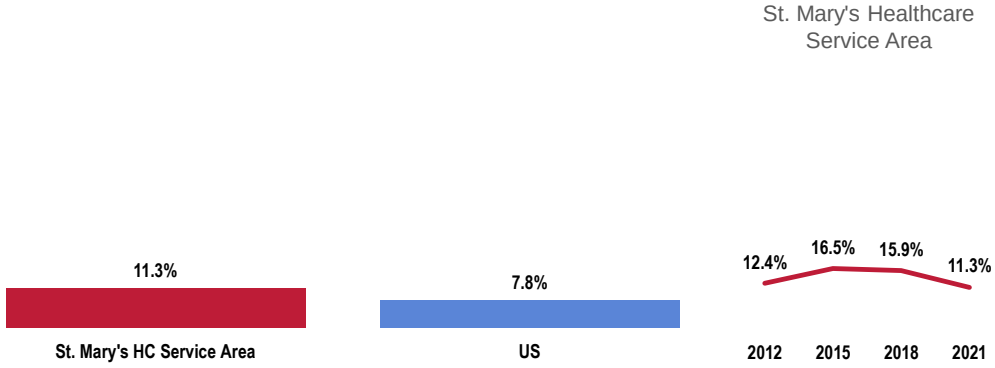
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 119]

Notes:
- Asked of all respondents.
- Includes those who have ever been diagnosed with asthma and report that they still have asthma.

Children

Among St. Mary's Healthcare Service Area children under age 18, 11.3% currently have asthma.

Prevalence of Asthma in Children
(Parents of Children Age 0-17)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 120]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.
- Includes children who have ever been diagnosed with asthma and are reported to still have asthma.

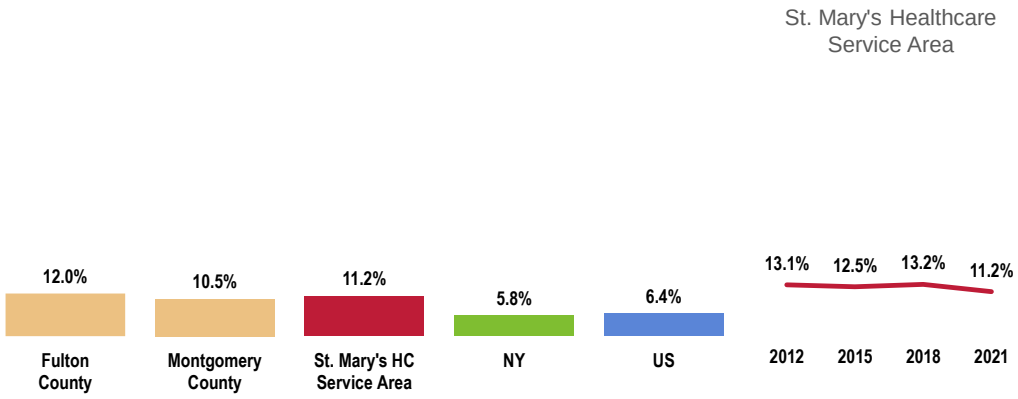
Chronic Obstructive Pulmonary Disease (COPD)

Note: COPD includes lung diseases such as emphysema and chronic bronchitis.

A total of 11.2% of St. Mary's Healthcare Service Area adults suffer from chronic obstructive pulmonary disease (COPD, including emphysema and bronchitis).

BENCHMARK ► Higher than the state and national rates.

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)

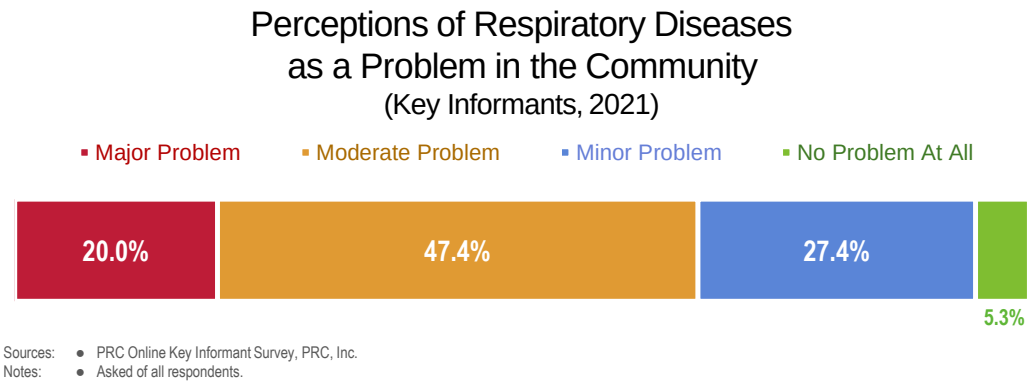


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 23]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 New York data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

Key Informant Input: Respiratory Disease

The greatest share of key informants taking part in an online survey characterized *Respiratory Disease* as a "moderate problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Due to a large percentage of patients coming into the hospital having a diagnosis of some respiratory disease (asthma, COPD) as well as large tobacco use. – Social Services Provider
>
> I have encountered a number of children with asthma. – Social Services Provider
>
> According to our 2015 CHNA, childhood asthma/respiratory disease had higher on average rates in our service area than they were in the entire state of NY and the USA. – Public Health Representative
>
> There is a high rate of COPD, CHF, smoking, obesity, etc. in our communities. – Other Health Provider
>
> Lung cancer due to environmental or occupational exposure. The CT Low Dose Cancer Screening Exam is only covered by insurance for smokers or those with a history of smoking. Major medical insurance doesn't cover the exam for environmental or occupational exposures. – Social Services Provider
>
> In the University of Wisconsin Population Health Institute's County Health Rankings, Montgomery and Fulton Counties have a higher than average prevalence of this condition. – Community/Business Leaders

Tobacco Use

> Smoking. – Social Services Provider
>
> Many people are smokers, overweight. – Other Health Provider
>
> Widespread tobacco use and poorly controlled asthma. – Other Health Provider
>
> Smoking of cigarettes and marijuana. – Community/Business Leaders
>
> Our county has a very high percentage of the population of people that smoke or vape tobacco. Our region has so many vape and tobacco shops. Stewarts shops sell more tobacco products in NYS then any other retailer. I have personally lost several family members that have died at young ages due to respiratory disease and cancer from smoking. – Community/Business Leaders

Contributing Factors

> Increasing number of patients with COPD/respiratory issues, high admissions to hospitals, high readmissions, lack of understanding of disease and misunderstanding of treatments/prognosis. – Other Health Provider
>
> Smoking. Those working in leather mills/factories that had environmental exposures that lead to chronic respiratory disease. Uncontrolled asthma due to lack of health literacy. – Social Services Provider

Access to Care/Services

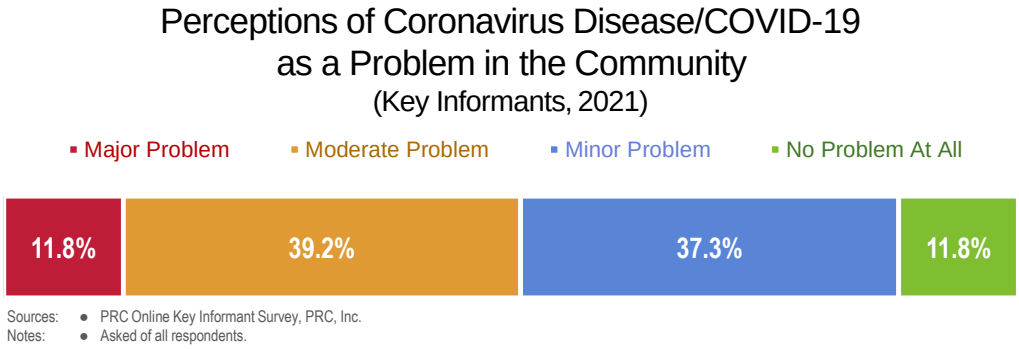
> For major respiratory problems, Montgomery and Fulton county facilities are lacking expertise. – Community/Business Leaders

Environmental Contributors

> Polluted air, asbestos in old buildings, poor overall health. – Community/Business Leaders

Key Informant Input: Coronavirus Disease/COVID-19

The greatest share of key informants taking part in an online survey characterized *Coronavirus Disease/COVID-19* as a "moderate problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Vaccinations

> Low vaccination rates for the counties. This may in part be due to lack of information and transportation to vaccination sites. – Social Services Provider
>
> As much as any agencies have done over the last year to educate- recruit – offer opportunities for the vaccines, the percentage of people who actually are fully vaccinated is low. For the most part believe that it's individual's belief that COVID is not real. – Social Services Provider
>
> Not enough people getting vaccinated. No education. Too much misinformation. – Other Health Provider
>
> There are still many people who are not vaccinated. Many have stopped or never wore a mask and just have overall lack of respect for keeping a safe distance from others. – Other Health Provider
>
> Our community had a high population of those not willing to get the vaccine. As we are seeing in the news, there is a resurgence of infected and the majority are unvaccinated. This puts our youth and immunocompromised individuals at an increased risk. – Community/Business Leaders
>
> The residents in our community either believe that COVID is real or they don't. We have a very rural community and vaccinating the population is a complex task for various reasons. Access to vaccine is another issue. The Primary Cares in the area are not offering COVID vaccine so that is a missed opportunity when patients are coming in for visits. – Community/Business Leaders
>
> The availability of the vaccine is an issue. – Social Services Provider
>
> Individuals not adhering to guidelines, not interested in getting vaccine. – Community/Business Leaders

Seniors

> Since COVID – Depression is top of the list. Some of the facilities are still not back to normal operation and this affects the community as a whole. The nursing homes and Senior living facilities in our area are still limited to # of people allowed in the facility – distance each person needs to be – masks – We need to move forward especially if everyone in the facilities is vaccinated. Some places have done well in this area and are still categorized in the same grouping as the places that are not fully vaccinated. Also because of these restrictions my Community Center which has been used by the Senior living facility cannot reopen to the public, limiting programming etc. People need people and we need to get together again. – Community/Business Leaders

Awareness/Education

> People's irrational fear and misconception of the severity. – Community/Business Leaders

Transportation

> We live in a small, rural area where transportation and other needs by individuals can't be met. – Community/Business Leaders

INJURY & VIOLENCE

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

Between 2017 and 2019, there was an annual average age-adjusted unintentional injury mortality rate of 36.4 deaths per 100,000 population in the St. Mary's Healthcare Service Area.

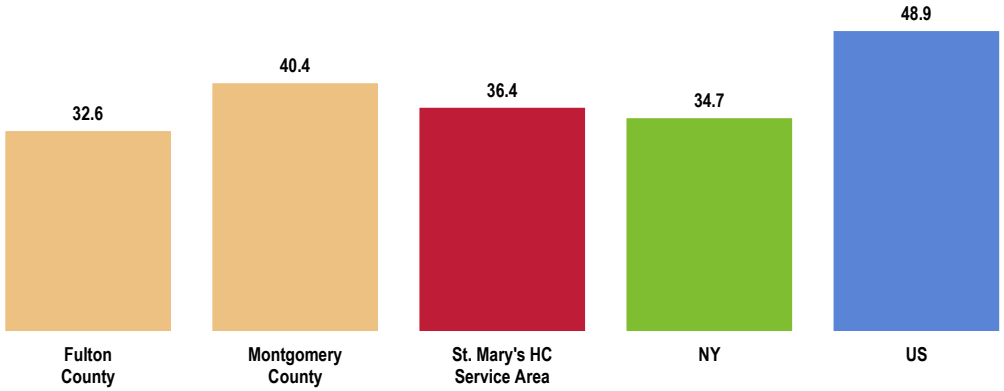
BENCHMARK ► Better than the US rate. Satisfies the Healthy People 2030 objective.

TREND ► Appears to be stabilizing after increases in the early 2010s.

Unintentional Injuries: Age-Adjusted Mortality

(2017–2019 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower

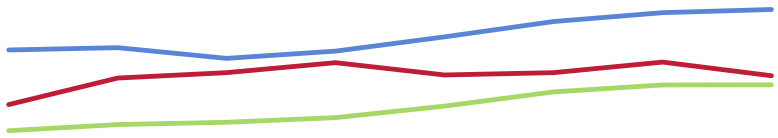


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Unintentional Injuries: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 43.2 or Lower



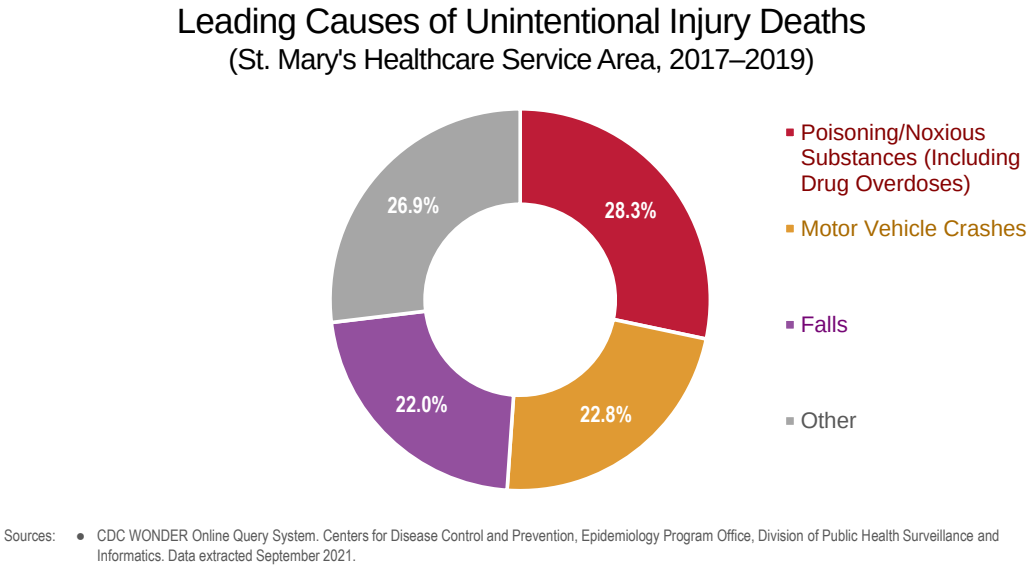
	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
St. Mary's HC	30.9	35.9	37.0	38.8	36.6	37.0	39.0	36.4
NY	26.0	27.2	27.6	28.5	30.7	33.3	34.6	34.7
US	41.2	41.7	39.7	41.0	43.7	46.7	48.3	48.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Leading Causes of Unintentional Injury Deaths

RELATED ISSUE
For more information about unintentional drug-related deaths, see also *Substance Abuse* in the **Modifiable Health Risks** section of this report.

Poisoning (including unintentional drug overdose), motor vehicle crashes, and falls accounted for most unintentional injury deaths in the St. Mary's Healthcare Service Area between 2017 and 2019.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.

Intentional Injury (Violence)

Violent Crime

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

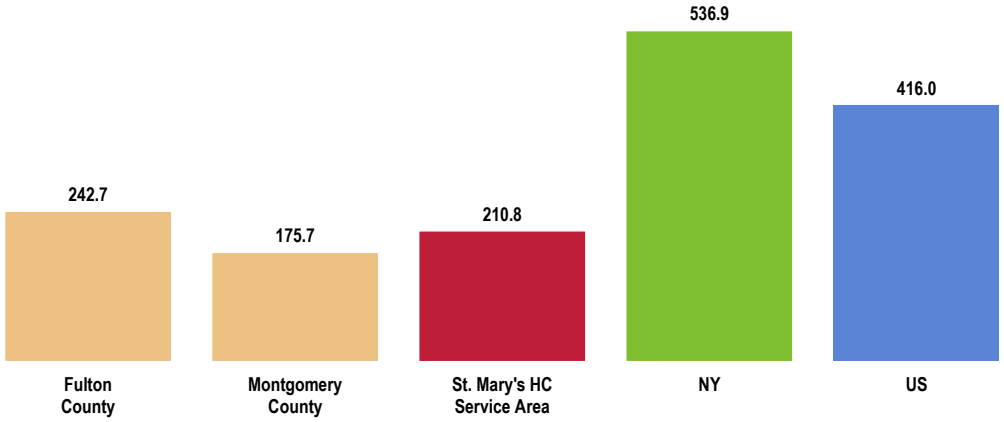
Violent Crime Rates

Between 2014 and 2016, there were a reported 210.8 violent crimes per 100,000 population in the St. Mary's Healthcare Service Area.

BENCHMARK ► Considerably lower than was found across New York and the US.

DISPARITY ► Favorably low in Montgomery County.

Violent Crime
(Rate per 100,000 Population, 2014-2016)



Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

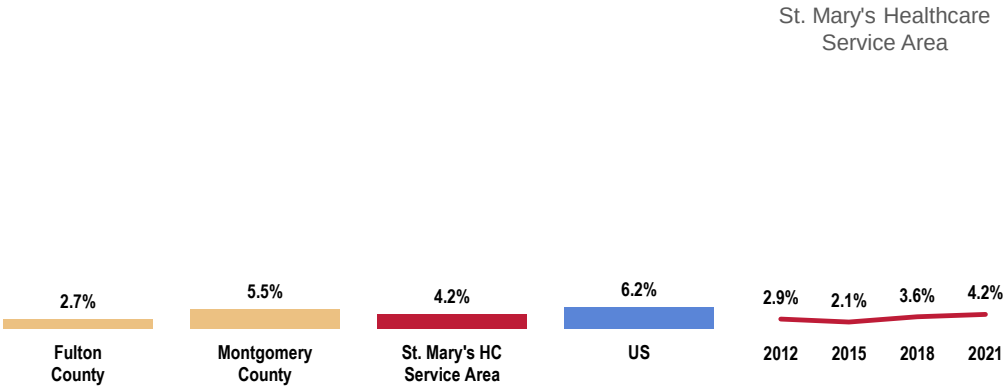
Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

Community Violence

A total of 4.2% of surveyed St. Mary's Healthcare Service Area adults acknowledge being the victim of a violent crime in the area in the past five years.

DISPARITY ► Higher in Montgomery County. More often reported among young adults and low-income residents.

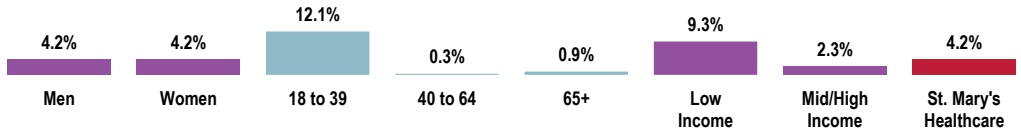
Victim of a Violent Crime in the Past Five Years



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 38]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Victim of a Violent Crime in the Past Five Years
(St. Mary's Healthcare Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 38]
Notes: • Asked of all respondents.

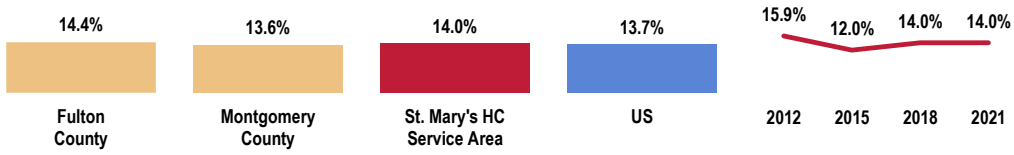
Family Violence

Respondents were read: "By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with would also be considered an intimate partner."

A total of 14.0% of St. Mary's Healthcare Service Area adults acknowledge that they have ever been hit, slapped, pushed, kicked, or otherwise hurt by an intimate partner.

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner

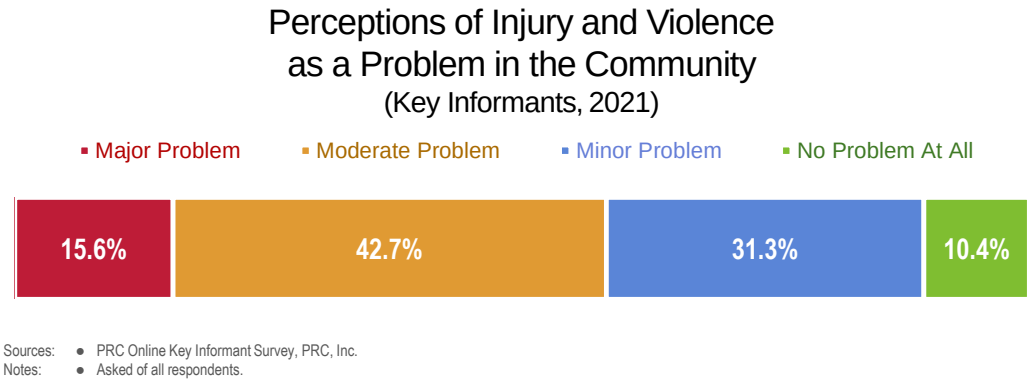
St. Mary's Healthcare Service Area



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 39]
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

Key Informant Input: Injury & Violence

The largest share of key informants taking part in an online survey characterized *Injury & Violence* as a "moderate problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> ER and police records would likely support this. Local youth program established to help address violence prevention. Safety equipment, such as helmets for bike riding, often not utilized. Poverty, drug abuse, and racial dissension are significant issues which can lead to violence. – Social Services Provider
>
> Uptick in serious crimes, people do not always feel safe in their own communities, parks, etc. If people don't feel safe to enjoy time in their communities, they are less likely to exercise, walk, shop downtown, etc. – Social Services Provider
>
> Violence is a major issue within both counties because there has been an increase in gang related activity, drugs activity, bail reforms, and lack of support from the Social Services Departments. – Other Health Provider
>
> I am looking at it from the poor population perspective. They live in poor housing conditions. Do not get good nutrition. People fight and steal from one another. There is a big substance abuse problem in the county and no help for it. – Social Services Provider
>
> Challenges facing the community, poverty, general lack of empathy, drugs. – Community/Business Leaders
>
> Broken Windows Theory. When infrastructure isn't fixed over many years, it can lead to severe crime. – Public Health Representative
>
> Suicide instances and domestic violence are on the rise in the area since the pandemic began. – Social Services Provider

Incidence/Prevalence

> Violent crimes have increased significantly in the last two years. – Community/Business Leaders
>
> Many people are coming from outside of the area, bringing crime to our communities. – Other Health Provider
>
> In the University of Wisconsin Population Health Institute's County Health Rankings, Montgomery and Fulton Counties have a higher than average prevalence of this condition. – Community/Business Leaders

Alcohol/Drug Use

> Drug use and mental health is on the rise, which causes injury and violence. – Community/Business Leaders

Anger

> Anger. – Community/Business Leaders

Gun Violence

> High numbers of shootings. High numbers of drug use. High numbers of illegal guns. – Social Services Provider

DIABETES

ABOUT DIABETES

More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

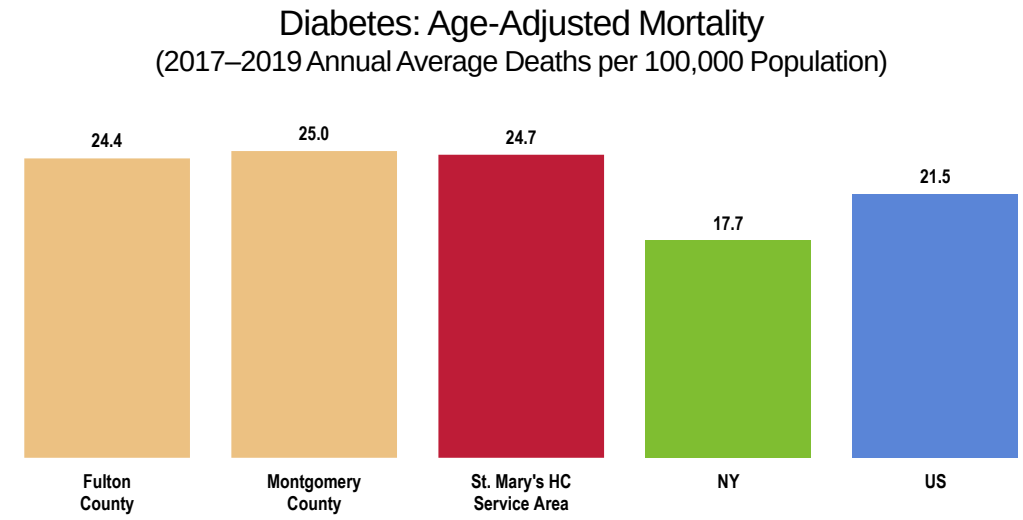
– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Diabetes Deaths

Between 2017 and 2019, there was an annual average age-adjusted diabetes mortality rate of 24.7 deaths per 100,000 population in the St. Mary's Healthcare Service Area.

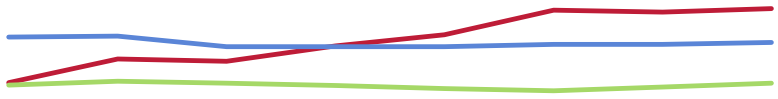
BENCHMARK ► Worse than the statewide rate.

TREND ► Trending upward to an all-time high in the service area.



Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.

Diabetes: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
St. Mary's HC	17.7	19.9	19.7	21.2	22.2	24.5	24.4	24.7
NY	17.5	17.8	17.6	17.4	17.1	16.9	17.3	17.7
US	22.0	22.1	21.1	21.1	21.1	21.3	21.3	21.5

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.

Prevalence of Diabetes

A total of 14.4% of St. Mary's Healthcare Service Area adults report having been diagnosed with diabetes.

BENCHMARK ► Worse than the statewide percentage.

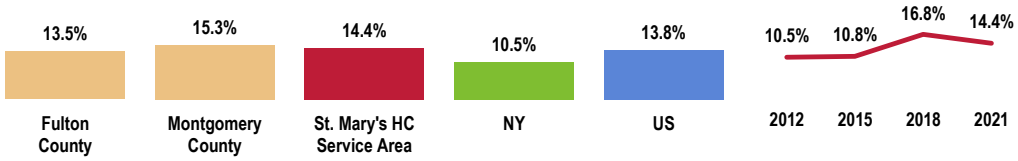
TREND ► Significantly higher than the 2012 baseline.

DISPARITY ► More often reported among adults age 65+ and low-income adults.

Prevalence of Diabetes

Another 6.9% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

St. Mary's Healthcare Service Area

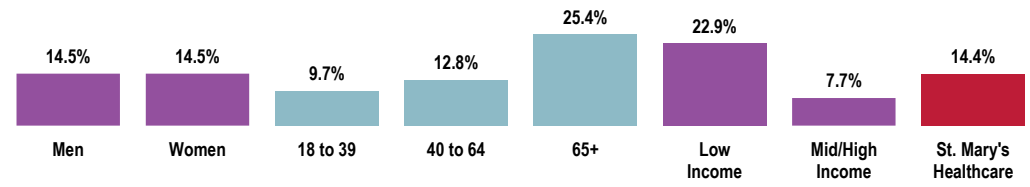


Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 121]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 New York data.
● 2020 PRC National Health Survey, PRC, Inc.

Notes: ● Asked of all respondents.

Prevalence of Diabetes
(St. Mary's Healthcare Service Area, 2021)

Note that among adults who have not been diagnosed with diabetes, 42.6% report having had their blood sugar level tested within the past three years.

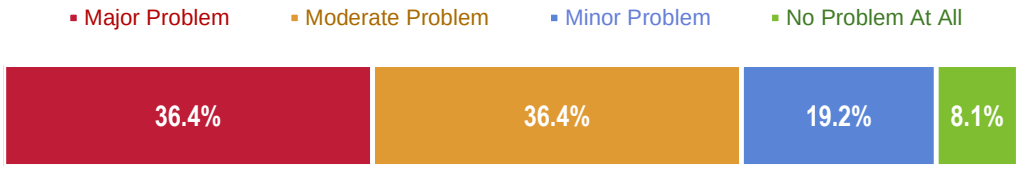


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Items 33, 121]
Notes: • Asked of all respondents.
• Excludes gestational diabetes (occurring only during pregnancy).

Key Informant Input: Diabetes

Key informants taking part in an online survey were equally likely to give "major" and "moderate" ratings of *Diabetes* as a community issue.

Perceptions of Diabetes as a Problem in the Community
(Key Informants, 2021)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> Nutrition information and access to affordable healthy foods. – Community/Business Leaders
>
> Our county has a very high percentage of people that are overweight. This is leading to so many chronic conditions including type 2 diabetes. So many people are making poor nutrition choices each day, and our region is saturated with so many fast food restaurants. Education and getting people to realize their choices they are making will have a big impact on their health and their families. – Community/Business Leaders
>
> Type 2 Diabetes: Our community is riddled with overweight people. As an educator in the community I know firsthand that our poverty rate among students is 75%. Healthy food such as fruits and vegetables are more expensive than fast food or prepackaged foods. our community has way too many fast food options. Lack of exercise and few activities available for children and seniors also makes keeping in physical shape difficult. My mom became diabetic with medication. My husband became diabetic with a kidney transplant. Type 1: Family history, genes – Community/Business Leaders

> We have a high rate of overweight/obese residents in our service area. Diabetes has been identified as one of our top 3 problems from the last few CHNA's. I think access to healthy foods and beverages is a huge barrier for our folks. Also, a lack of knowledge on how to properly prepare healthy foods. – Public Health Representative
>
> Obesity. More push for medication rather than changing habits for a healthier life. Referrals for wellness, not medication. Classes can be offered and attended that the hospital has, along with other groups. – Community/Business Leaders
>
> Lack of access to healthy food options, lack of compliance in care, poor education about disease process due to lack of compliance, affordability of medications. – Social Services Provider
>
> Healthy dieting, exercise. Poverty levels foster affordable foods that are not conducive to healthy eating habits. Pasta and processed foods are cheaper than fresh foods. – Social Services Provider
>
> Diet, cost of insulin. – Community/Business Leaders
>
> Desire to achieve a healthy lifestyle, enough nutritional education, access to information/education in Spanish and adaptations for diets/food ways of Puerto Ricans, Guatemalans, etc. – Social Services Provider
>
> Lack of compliance. Lack of resources for healthy eating. Low income. – Other Health Provider
>
> Access to Endocrinology because of lack of transportation/not Medicaid eligible. Lack of education about the disease process, possibly due to low health literacy. Lack of support systems (formal and informal) for those dealing with diabetes. – Social Services Provider
>
> For a while it was difficult for them to get to dialysis—NLH now has that service too. Other difficulties include but not limited to: few specific providers available, transportation to/from doctors, access to good nutrition not always available, transportation – Social Services Provider

Awareness/Education

> The biggest challenge is nutrition education for people with developmental disabilities and their support staff. The staff need a great deal of education to support people. – Other Health Provider
>
> Education related to cause and effect. Many people with diabetes think, "oh I can have sugar-free-whatever and carry on with my life," not realizing that it's a larger nutritional issue regarding how fats, sugars and grains can combine and cause problems, as well as carbohydrate amounts in foods and daily intakes. – Community/ Business Leaders
>
> Diabetic counseling and education. – Other Health Provider
>
> Lack of health education regarding the importance of eating healthy to prevent and reverse diabetes. – Other Health Provider
>
> Learning to eat healthy. – Other Health Provider

Access to Affordable Healthy Food

> Access to and the ability to prepare healthy foods. There are many food deserts in our service area as well as an overall lack of awareness of appropriate food choices. – Other Health Provider
>
> Affordable prices for a healthy nutrition. – Other Health Provider
>
> The ability to afford healthy food, as it is expensive to eat healthy. – Other Health Provider

Disease Management

> Chronic disease management in the home, more focus on prevention, education and good management. There is value to virtual visits and home care assisting with the management of diabetes. – Other Health Provider
>
> Controlling weight and exercising, adhering to medication regimes to control and meeting the goals recommended for control. – Physician

Nutrition

> Proper nutrition and affordable care. – Social Services Provider
>
> Help with managing their numbers through diet. – Social Services Provider

Affordable Medication/Supplies

> Prescription prices and follow-up care. – Social Services Provider
>
> Diabetes medications are very expensive and often a struggle to get coverage. – Other Health Provider

Transportation

> Transportation to health care providers and having the knowledge to take care of themselves. – Community/Business Leaders

Obesity

> The general population is obese. – Community/Business Leaders

Diagnosis/Treatment

> Endocrinologist knowledge of insulin pumps. – Other Health Provider

Income/Poverty

> Poverty. – Community/Business Leaders

Lack of Providers

> No local endocrinologist, patients need to travel outside of the area for care. – Other Health Provider

Prevention/Screenings

> Lack of preventative health care and not enough formal diabetic teaching once diagnosed. – Other Health Provider

KIDNEY DISEASE

ABOUT KIDNEY DISEASE

More than 1 in 7 adults in the United States may have chronic kidney disease (CKD), with higher rates in low-income and racial/ethnic minority groups. And most people with CKD don't know they have it. …People with CKD are more likely to have heart disease and stroke — and to die early. Managing risk factors like diabetes and high blood pressure can help prevent or delay CKD. Strategies to make sure more people with CKD are diagnosed early can help people get the treatment they need.

Recommended tests can help identify people with CKD to make sure they get treatments and education that may help prevent or delay kidney failure and end-stage kidney disease (ESKD). In addition, strategies to make sure more people with ESKD get kidney transplants can increase survival rates and improve quality of life.

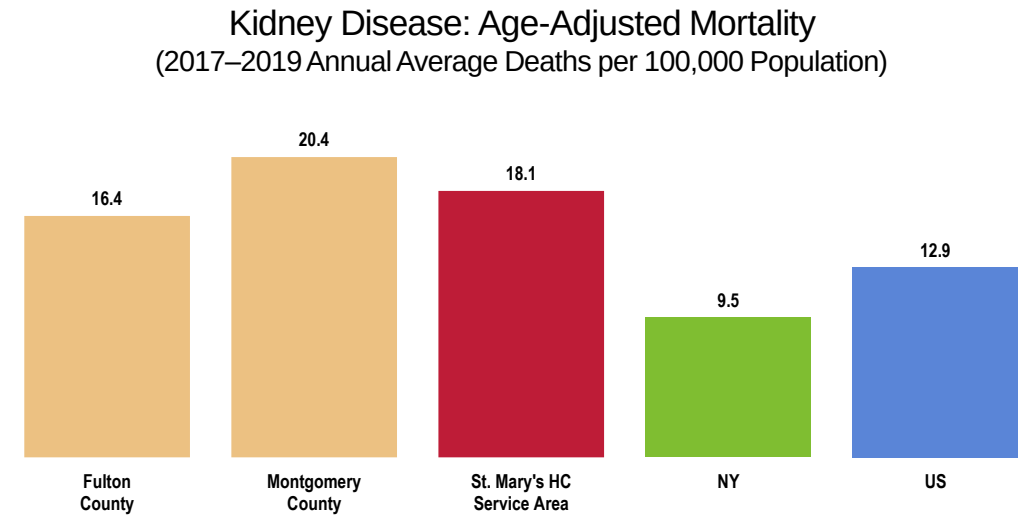
– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Kidney Disease Deaths

Between 2017 and 2019, there was an annual average age-adjusted kidney disease mortality rate of 18.1 deaths per 100,000 population in the St. Mary's Healthcare Service Area.

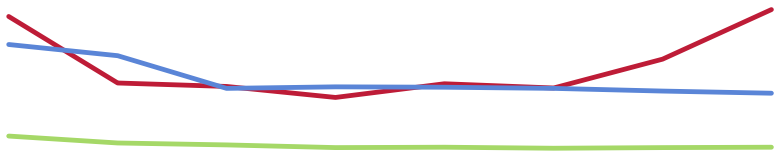
BENCHMARK ► Much higher than state and national rates.

TREND ► Trending upward in reversal of a previous downward trend.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.

Kidney Disease: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
St. Mary's HC	17.7	13.5	13.3	12.6	13.5	13.2	15.0	18.1
NY	10.2	9.7	9.6	9.4	9.5	9.4	9.4	9.5
US	15.9	15.2	13.2	13.3	13.2	13.2	13.0	12.9

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.

Prevalence of Kidney Disease

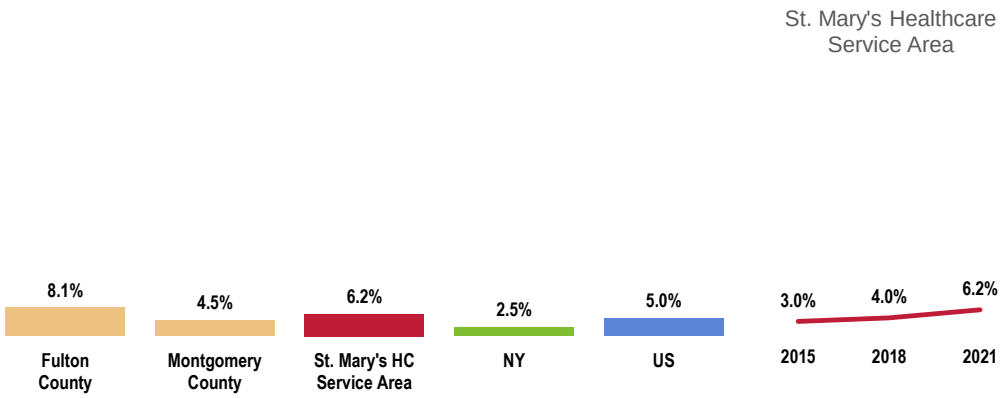
A total of 6.2% of St. Mary's Healthcare Service Area adults report having been diagnosed with kidney disease.

BENCHMARK ► Higher than the statewide percentage.

TREND ► Denotes a significant increase.

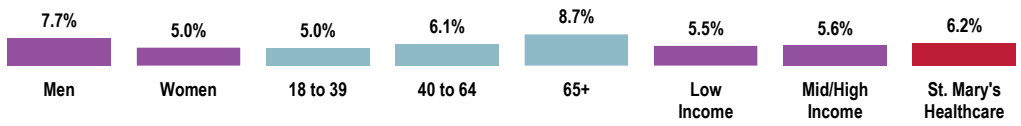
DISPARITY ► Unfavorably high in Fulton County.

Prevalence of Kidney Disease



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 24]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 New York data.
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Prevalence of Kidney Disease
(St. Mary's Healthcare Service Area, 2021)

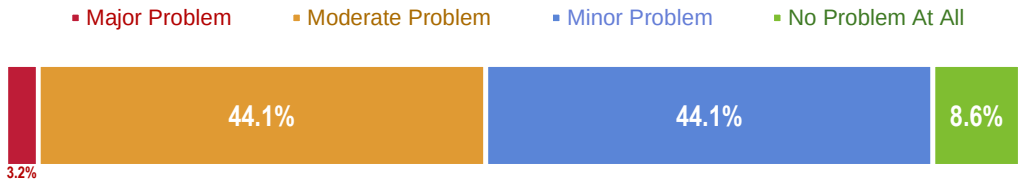


Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 24]
Notes: ● Asked of all respondents.

Key Informant Input: Kidney Disease

Key informants taking part in an online survey were equally likely to give "moderate" and "minor" ratings of *Kidney Disease* as a community issue.

Perceptions of Kidney Disease as a Problem in the Community
(Key Informants, 2021)



Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Limited urology/nephrology services, long wait lists. – Social Services Provider

Comorbidities

> Lack of control of other chronic diseases (diabetes, hypertension) leading to increased incidences of kidney disease. – Social Services Provider

Incidence/Prevalence

> In the University of Wisconsin Population Health Institute's County Health Rankings, Montgomery and Fulton Counties have a higher than average prevalence of this condition. – Community/Business Leaders

POTENTIALLY DISABLING CONDITIONS

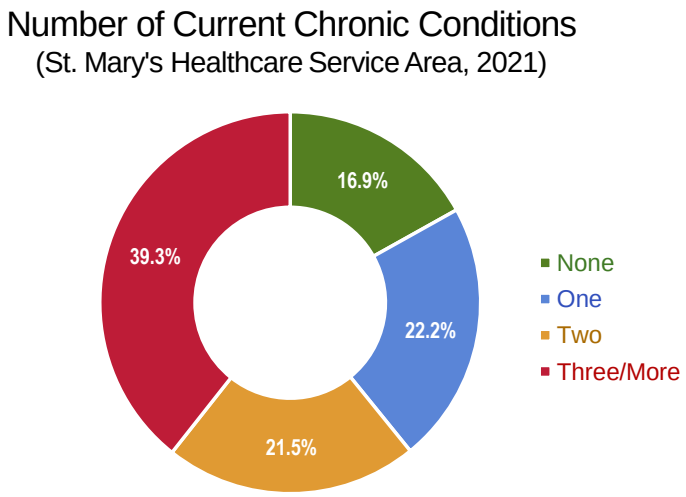
Multiple Chronic Conditions

For the purposes of this assessment, chronic conditions include:

- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart attack/angina
- High blood cholesterol
- High blood pressure
- Kidney disease
- Lung disease
- Obesity
- Stroke

Multiple chronic conditions are concurrent conditions.

Among St. Mary's Healthcare Service Area survey respondents, most report currently having at least one chronic health condition.



Sources: 2021 PRC Community Health Survey, PRC, Inc. [Item 123]
Notes: Asked of all respondents.
In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

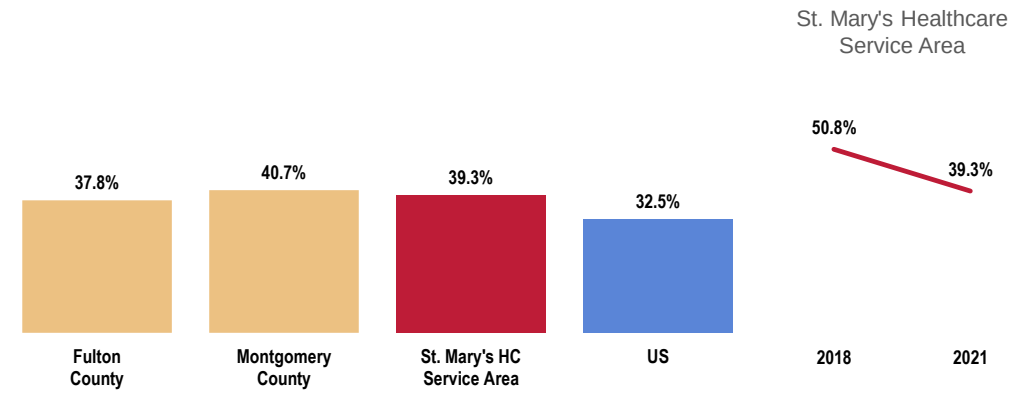
In fact, 39.3% of St. Mary's Healthcare Service Area adults report having three or more chronic conditions.

BENCHMARK ► Worse than the national finding.

TREND ► A significant decrease from the previous survey.

DISPARITY ► Higher among seniors (age 65+) and lower-income adults.

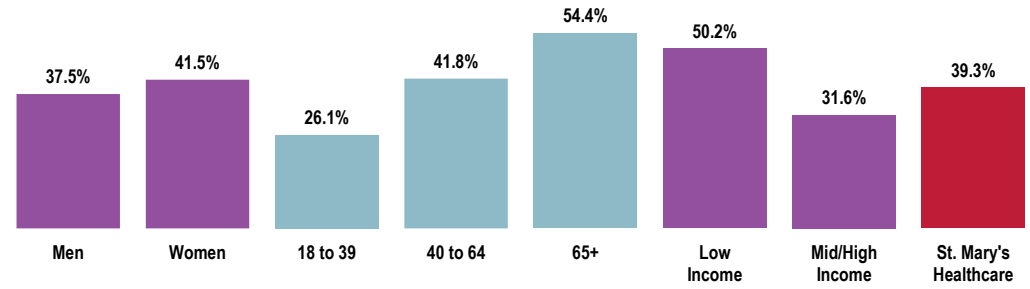
Currently Have Three or More Chronic Conditions



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 123]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

Currently Have Three or More Chronic Conditions
(St. Mary's Healthcare Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 123]

Notes:
- Asked of all respondents.
- In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, obesity, and/or diagnosed depression.

Activity Limitations

ABOUT DISABILITY & HEALTH

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

– Healthy People 2030 (https://health.gov/healthypeople)

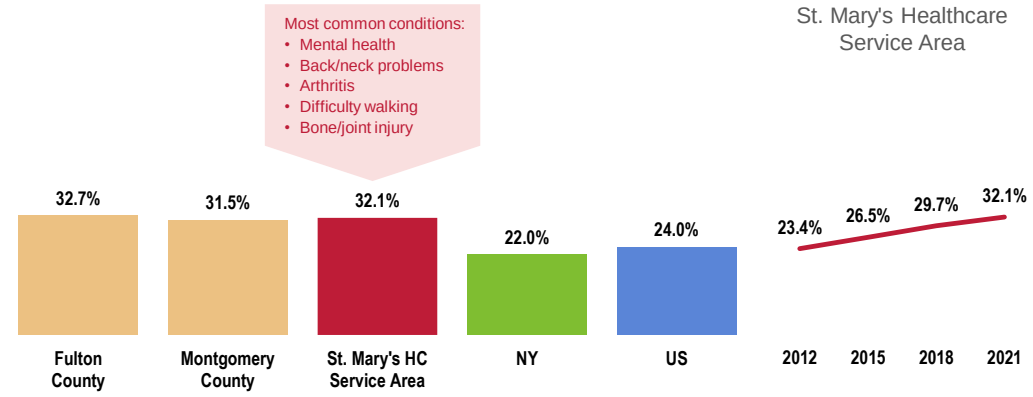
A total of 32.1% of St. Mary's Healthcare Service Area adults are limited in some way in some activities due to a physical, mental, or emotional problem.

BENCHMARK ► Higher than the US percentage.

TREND ► Increasing significantly over time.

DISPARITY ► Especially high among lower-income adults.

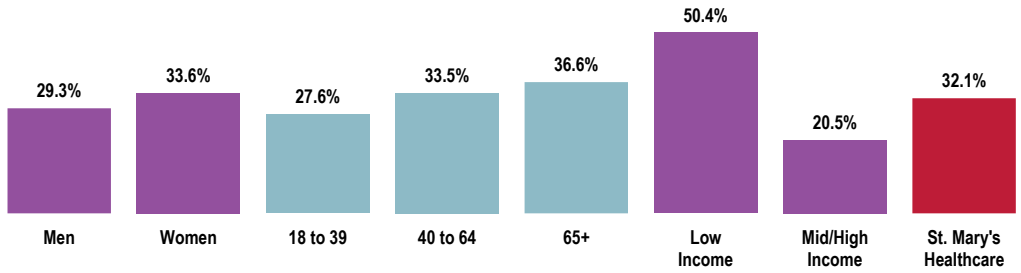
Limited in Activities in Some Way Due to a Physical, Mental, or Emotional Problem



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 96-97]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Limited in Activities in Some Way Due to a Physical, Mental, or Emotional Problem

(St. Mary's Healthcare Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 96]
Notes: ● Asked of all respondents.

Chronic Pain

A total of 21.8% of St. Mary's Healthcare Service Area adults experience high-impact chronic pain, meaning physical pain that has limited their life or work activities "every day" or "most days" during the past six months.

BENCHMARK ► Higher than the national finding. Far from satisfying the Healthy People 2030 objective.

DISPARITY ► More often reported among adults age 40+ and those with lower incomes.

Experience High-Impact Chronic Pain

Healthy People 2030 = 7.0% or Lower

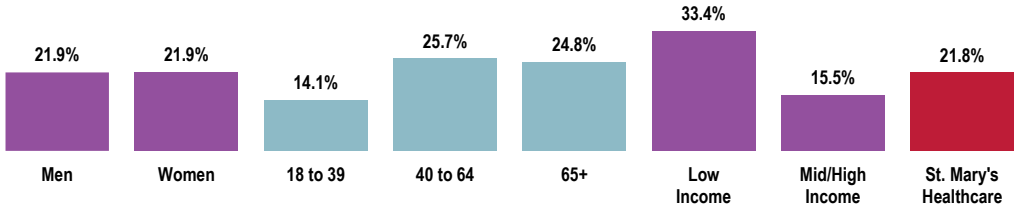
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 37]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Experience High-Impact Chronic Pain

(St. Mary's Healthcare Service Area, 2021)

Healthy People 2030 = 7.0% or Lower

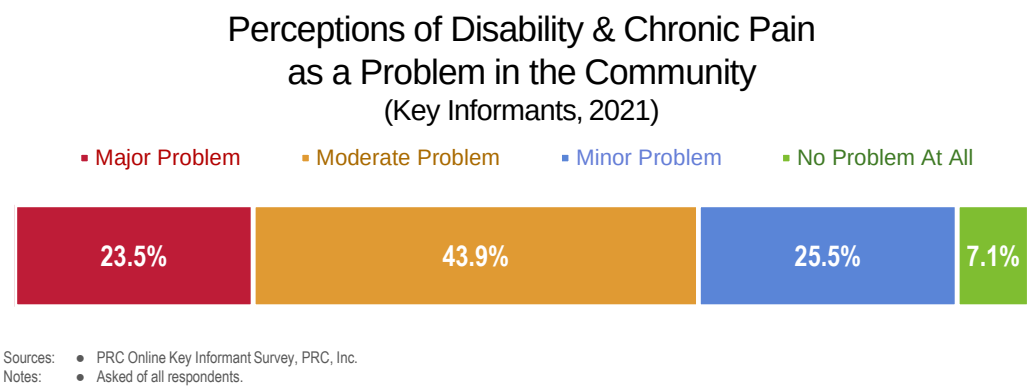


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 37]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

Key Informant Input: Disability & Chronic Pain

Key informants taking part in an online survey most often characterized *Disability & Chronic Pain* as a "moderate problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> High numbers of individuals disabled and on Medicare and Medicaid. Possibly a lack of access to behavioral health supports leads to use of opioids/illicit drugs and leads to higher incidences of substance use disorder that leads to disability. Need a program that supports those with chronic processes to find ways to function in the community and when able participate in employment in some capacity – Social Services Provider
>
> High number of obese residents. High number of arthritis diagnoses. Many residents living at ARC . – Social Services Provider
>
> Obesity is a growing problem, leads to many issues and can be linked to chronic pain. Along with chronic pain, rather than referring people to programs, people are prescribed medication. – Community/Business Leaders
>
> Fulton/Montgomery counties have a high rate of co-morbidities in the resident population; disability and chronic pain frequently occur with these co-morbidities such as obesity, COPD, CHF, diabetes, etc. There are no pain management centers in our counties. Pain management centers are located in Oneida and Saratoga counties. There also are no integrative medicine practices associated with either hospital. – Other Health Provider
>
> These are issues that are often associated with other chronic conditions and/or BH conditions. There may be depression/anxiety present in the setting of a chronic illness. Also chronic pain that is not treated properly by a healthcare provider could lead to opioid or other substance abuse. – Other Health Provider

Work Related

> We live in rural communities where most employment is centered around manual labor- farming, automotive, construction etc. These professions take a toll on the body over the years and in these communities these professions tend to be generational. Families passing down farms etc. – Other Health Provider
>
> Jobs in physical labor are common. Injuries on job or chronic physical exertion can lead to ongoing pain complaints. Poor physical health and obesity can also lead to chronic pain complaints. "Simple solutions," including med seeking, may be common. – Social Services Provider

Incidence/Prevalence

> I both encounter and observe people affected by chronic pain. – Social Services Provider
>
> I frequently hear people complaining about experiencing one or the other. – Community/Business Leaders

Access to Care/Services

> Lack of pain management programs. Lack of such programs leads to reliance on pharmaceutical interventions and possible addiction. – Social Services Provider
>
> Many tenants/participants request reasonable accommodations due to disabilities that limit major life activities. Services to assist with these disabilities within the community difficult to find. – Community/Business Leaders

Income/Poverty

> Low income. – Community/Business Leaders
>
> Poverty. – Community/Business Leaders

Aging Population

> I believe much of this has to do with our large elderly population. – Public Health Representative

Impact on Quality of Life

> Many of the clients that we see in our office have a disability and/or chronic pain that affects their lives on a daily basis. – Social Services Provider

Insufficient Physical Activity

> With the poor health outcomes people are faced with comes with the chronic pain. Many people do not get enough exercise, there are many with back, knee, and foot pain. Many times, the root cause is due to obesity and lack of exercise. – Community/Business Leaders

Lack of Providers

> Need pain management specialist. – Physician

Prevention/Screenings

> I believe that they are asking for information that could lead to preventing this during their doctor visits. – Other Health Provider

Alzheimer’s Disease

ABOUT DEMENTIA

Alzheimer’s disease is the most common cause of dementia and the sixth leading cause of death in U.S. adults.1 Nearly 6 million people in the United States have Alzheimer’s, and that number will increase as the population ages.

Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there’s no cure for Alzheimer’s disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

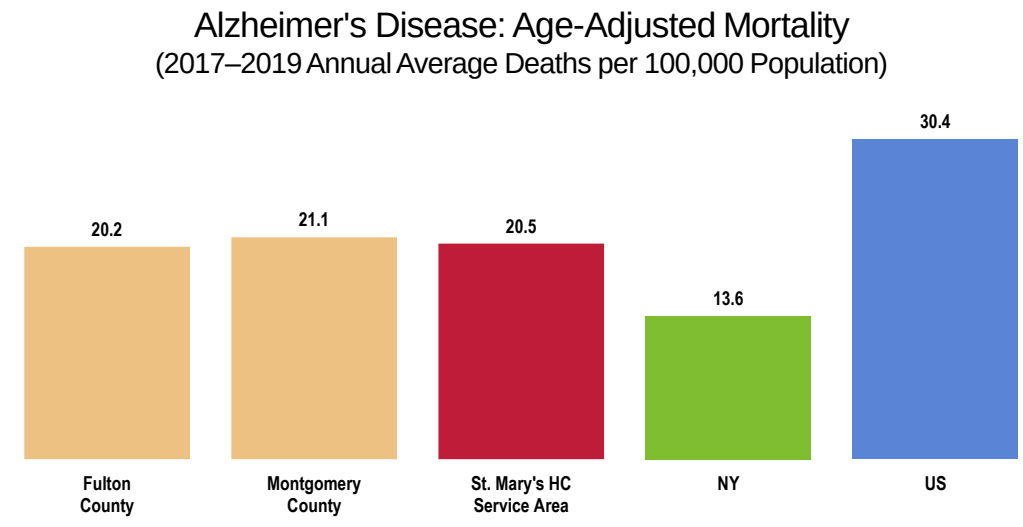
– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Alzheimer’s Disease Deaths

Between 2017 and 2019, there was an annual average age-adjusted Alzheimer’s disease mortality rate of 20.5 deaths per 100,000 population in the St. Mary’s Healthcare Service Area.

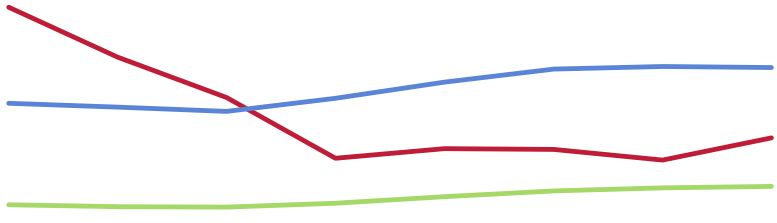
BENCHMARK ► Worse than the state rate but better than the national rate.

TREND ► Significantly lower than the 2010-2012 baseline.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.

Alzheimer's Disease: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)



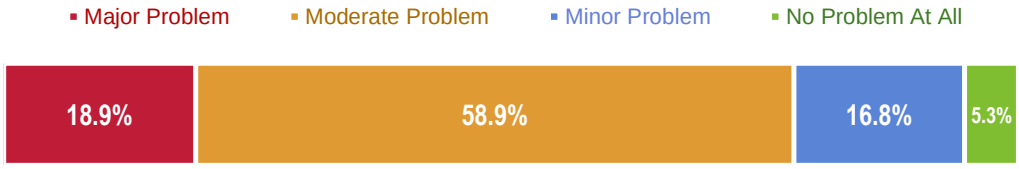
	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
St. Mary's HC	39.0	31.9	26.2	17.6	19.0	18.8	17.3	20.5
NY	11.0	10.7	10.7	11.2	12.1	13.0	13.4	13.6
US	25.4	24.8	24.2	26.1	28.4	30.2	30.6	30.4

Sources: • CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.

Key Informant Input: Dementia/Alzheimer's Disease

Key informants taking part in an online survey are most likely to consider *Dementia/ Alzheimer's Disease* as a "moderate problem" in the community.

Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community
(Key Informants, 2021)



Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> There are very little services available. There is not any type of day programs specifically for Alzheimer's. Very limited availability of aides to provide care at home. Very few assisted living residences are able to accommodate the dementia population unless you are able to pay privately. Therefore any individual who is on Medicaid is not able to access these facilities. – Social Services Provider
>
> I believe this a problem because I do not feel patients and families that wish to keep their loved ones home with this illness have the resources they need to do so as this is not an acute disorder it is chronic. Getting assistance at home for a chronic illness is limited and costly. – Other Health Provider
>
> We are seeing increased incidences of Dementia/Alzheimer's disease and it seems to be affecting people at a younger age. Many residents in our area have very limited support systems, they do not have advance directives in place nor POA's and therefore end up in crisis situations in which they are needing a higher level of care and there is no payment source in place. We have several skilled nursing facilities that do not specialize in the care and treatment of Dementia/Alzheimer's related "symptoms" and "behaviors" and are often declined bed offers because of this. We do not have access to gerontologist to manage the disease process, neurology is out of the area. many of our assisted living facilities do not accommodate individuals that "wander" and therefore, many have to be placed out of the area. – Social Services Provider

> The number of individuals with brain diseases increases annually. There is no treatment. There are few specific service types available. – Social Services Provider
>
> My mother was diagnosed with early onset Alzheimer's when in her late 60's. I am in my late 50's now and the majority of my friends who grew up in this community has had at least one parent who also were diagnosed with Alzheimer's. Our parent (s) are/were all around the same age. The majority of us needed to seek care for our parent out of Amsterdam. It is a slow and terrible way to say "good-bye" to your parent. My mother has been living with it for almost 20 years and for the past 8 years has needed to be with around-the-clock care. Our family is fortunate that she had long-term health insurance. Not everyone has that luxury. As the family caregiver we feel helpless. – Community/Business Leaders
>
> One of the highest aging populations in NYS. Little in the area for education and resources to support and address this chronic disease, lack of neurology is a major issue and we have an untapped resource in education and support with our Palliative Care team. – Other Health Provider
>
> Labor shortages and reimbursement. – Community/Business Leaders
>
> Growing concern that has attention on the problem. I don't think primary cares offer enough support to families or patients, especially if the patient isn't aware or doesn't want to admit they might have a problem. Prevention work needs to be done. – Community/Business Leaders

Access to Care/Services

> Lack of memory care facilities locally results in family member being placed in facilities out of the area. Also, lack of facilities with a mental health diagnosis, addictions/criminal history in addition to Alzheimer's/dementia. – Social Services Provider
>
> The availability of care providers in our community. Assistance for family members that are caring for a family member. – Social Services Provider
>
> In the area that we live in, the availability of memory care living is limited. – Community/Business Leaders

Incidence/Prevalence

> Between Fulton and Montgomery counties there are several Assisted Living Programs (ALP) and Nursing Homes (NH) with great population with a diagnosis of Dementia (Alzheimer's type symptoms) and the number continues to grow based on diagnosis upon admissions. – Other Health Provider
>
> It seems that more individuals are being diagnosed with some form of dementia and most caregivers are unaware of the services that are available. – Community/Business Leaders

Aging Population

> We have one of the largest elderly populations in the state. One in 5 seniors will develop Alzheimer's or some kind of dementia. We do not have a dementia specialist in our area who can properly diagnose the kind of dementia a patient is potentially dealing with. – Public Health Representative

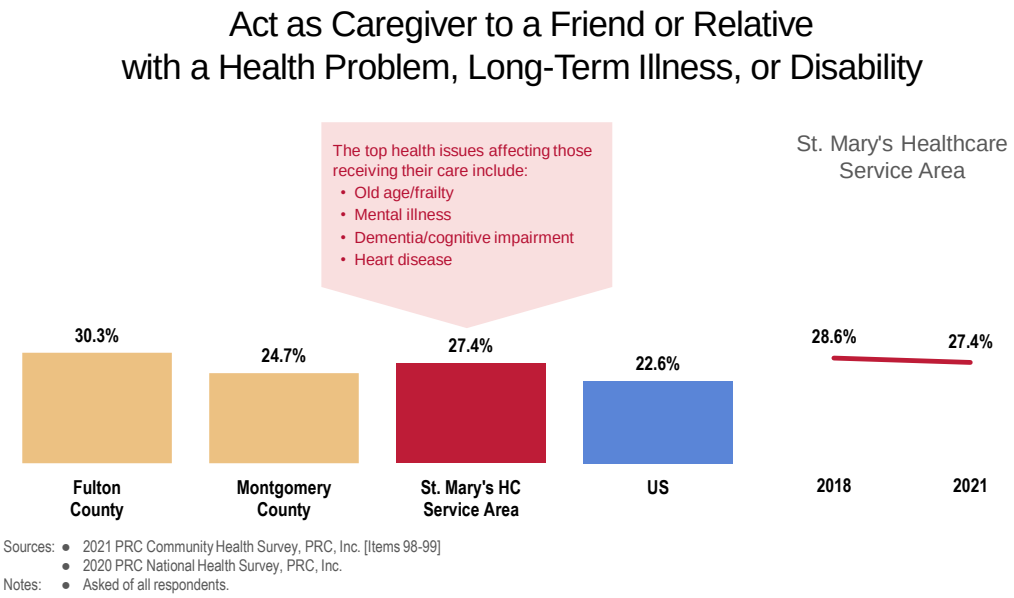
Diagnosis/Treatment

> Individuals with dementia characteristics are often seen at our office or in the community and many times are not in treatment of any kind and have not been diagnosed. – Social Services Provider

Caregiving

A total of 27.4% of St. Mary's Healthcare Service Area adults currently provide care or assistance to a friend or family member who has a health problem, long-term illness, or disability.

BENCHMARK ► Higher than was found across the US.



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Items 98-99]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

BIRTHS

BIRTH OUTCOMES & RISKS

Low-Weight Births

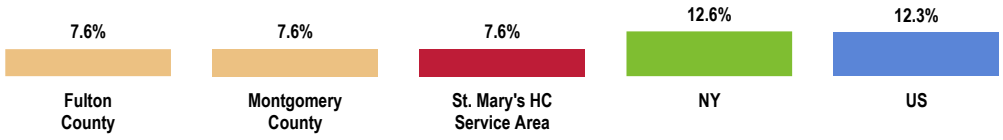
Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

A total of 7.6% of 2013-2019 St. Mary's Healthcare Service Area births were low-weight.

BENCHMARK ► Better than state and national findings.

Low-Weight Births
(Percent of Live Births, 2013–2019)



Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

Note:
- This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births.

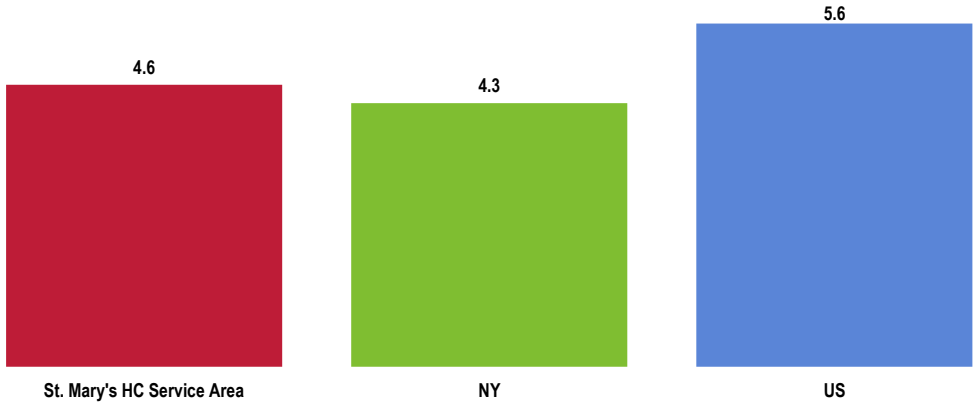
Between 2017 and 2019, there was an annual average of 4.6 infant deaths per 1,000 live births.

BENCHMARK ► Lower than the national rate. Similar to the Healthy People 2030 objective.

Infant Mortality Rate

(Annual Average Infant Deaths per 1,000 Live Births, 2017-2019)

Healthy People 2030 = 5.0 or Lower



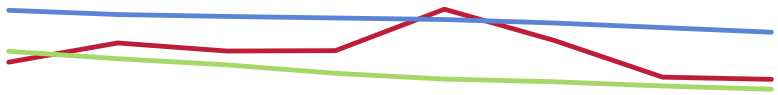
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted September 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Infant deaths include deaths of children under 1 year old.
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

Infant Mortality Trends

(Annual Average Infant Deaths per 1,000 Live Births)

Healthy People 2030 = 5.0 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
St. Mary's HC	4.9	5.4	5.2	5.2	6.1	5.4	4.6	4.6
NY	5.2	5.0	4.9	4.7	4.6	4.5	4.4	4.3
US	6.1	6.0	5.9	5.9	5.9	5.8	5.7	5.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted September 2021.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Rates are three-year averages of deaths of children under 1 year old per 1,000 live births.

FAMILY PLANNING

ABOUT FAMILY PLANNING

Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

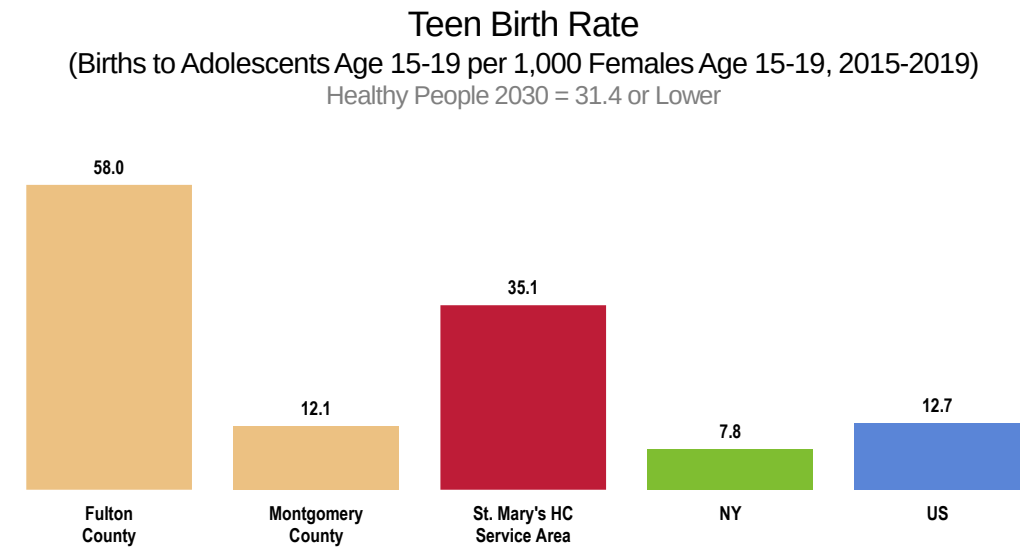
– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

Between 2015 and 2019, there were 35.1 births to adolescents age 15 to 19 per 1,000 women age 15 to 19 in the St. Mary's Healthcare Service Area.

BENCHMARK ► Considerably higher than state and national rates. Similar to the Healthy People 2030 objective.

DISPARITY ► Particularly high in Fulton County.

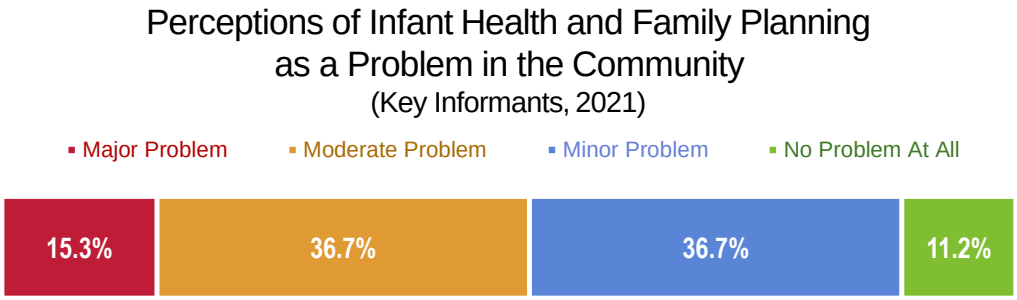


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

Key Informant Input: Infant Health & Family Planning

Key informants taking part in an online survey were equally likely to give "moderate" and "minor" ratings of *Infant Health & Family Planning* as a community issue.



Sources: PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> Persons don't access prenatal services. High rate of unprotected sex. High rate of underage persons engaging in sexual activities. High rate of sexual predators, abusers, lack knowledge that force isn't acceptable. – Social Services Provider
>
> Similar to limitations in preventive care, limited prenatal care sought. High instances of mental health disorder, poverty, and addictions in community leading to more unplanned or high risk pregnancies. Fear of criticism or charges of abuse/neglect can impede willingness to seek regular supports. – Social Services Provider
>
> Working in the school district provides me with opportunities to meet our families. Many children are born into single parent households to young women who have not had prenatal care. Many unwed mother's in school. Young girls dropping out of High School because they have a baby and no one to care for the baby. Difficult for the young mother/father to get employment especially without a high school degree. – Community/Business Leaders
>
> Value on having a doctor is not there. People do not regularly see their HCP and talk about family planning. Infant health is not always a priority unless something is severely wrong and an Emergency Room visit is made. – Community/Business Leaders

Awareness/Education

> Lack of education regarding comprehensive sex education, only one or two Planned Parenthoods exist in the area. – Public Health Representative
>
> Lack of prenatal education. – Other Health Provider
>
> Lack of family planning and education. – Community/Business Leaders

Access to Care/Services

> The number of family planning facilities and pediatricians in Mont Co. – Social Services Provider

Cultural/Personal Beliefs

> Cultural norm for young pregnancy. – Social Services Provider

Impact on Quality of Life

> Without family planning, a young person has little independence and less quality of life. Unintended pregnancies lock young people into a difficult life with less successful outcomes for mom and baby. Teen pregnancies perpetuate generational poverty. – Social Services Provider

Incidence/Prevalence

> In the University of Wisconsin Population Health Institute's County Health Rankings, Montgomery and Fulton Counties have a higher than average prevalence of this condition. – Community/Business Leaders

Vaccine Hesitancy

> Vaccine hesitancy and resistance (by parents for routine/recommended childhood and adolescent vaccines). – Physician

MODIFIABLE HEALTH RISKS

NUTRITION

ABOUT NUTRITION & HEALTHY EATING

Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

Daily Recommendation of Fruits/Vegetables

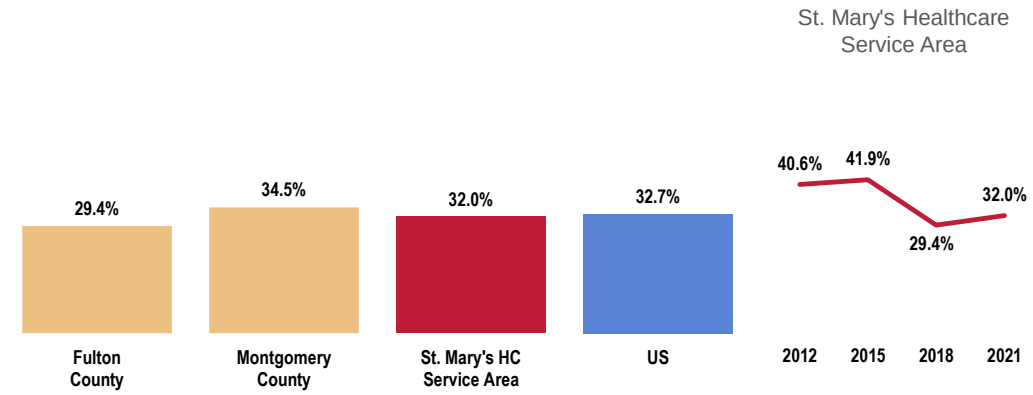
To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

A total of 32.0% of St. Mary's Healthcare Service Area adults report eating five or more servings of fruits and/or vegetables per day.

BENCHMARK ► Significantly lower (worse) than the 2012 baseline.

DISPARITY ► Significantly lower among men than women.

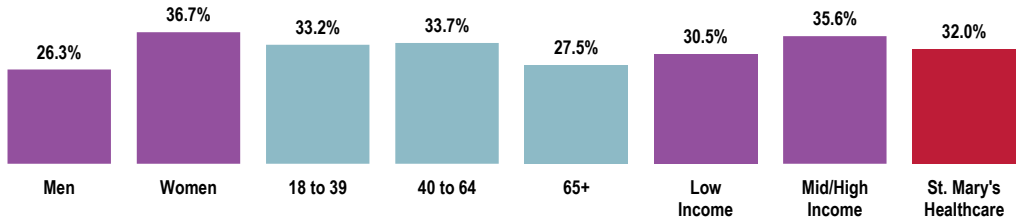
Consume Five or More Servings of Fruits/Vegetables Per Day



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 125]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- For this issue, respondents were asked to recall their food intake on the previous day.

Consume Five or More Servings of Fruits/Vegetables Per Day
(St. Mary's Healthcare Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 125]
Notes: • Asked of all respondents.
• For this issue, respondents were asked to recall their food intake on the previous day.

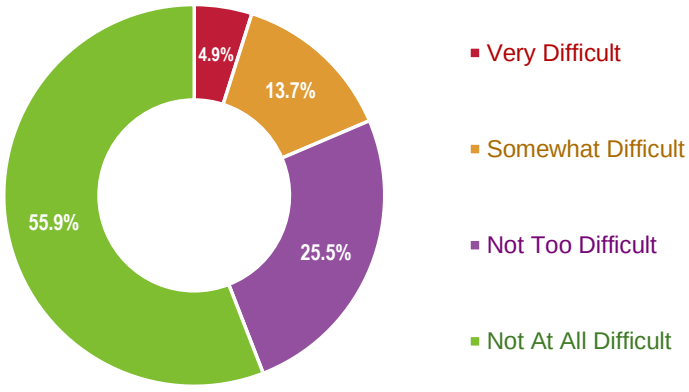
Difficulty Accessing Fresh Produce

Most St. Mary's Healthcare Service Area adults report little or no difficulty buying fresh produce at a price they can afford.

Respondents were asked: "How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford? Would you say: Very Difficult, Somewhat Difficult, Not Too Difficult, or Not At All Difficult?"

RELATED ISSUE
See also *Food Access* in the **Social Determinants of Health** section of this report.

Level of Difficulty Finding Fresh Produce at an Affordable Price
(St. Mary's Healthcare Service Area, 2021)

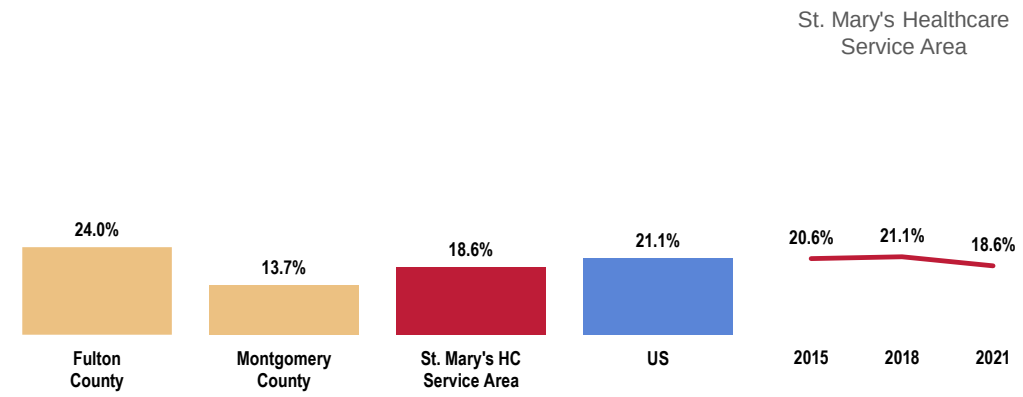


Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 79]
Notes: • Asked of all respondents.

However, 18.6% of St. Mary's Healthcare Service Area adults find it "very" or "somewhat" difficult to access affordable fresh fruits and vegetables.

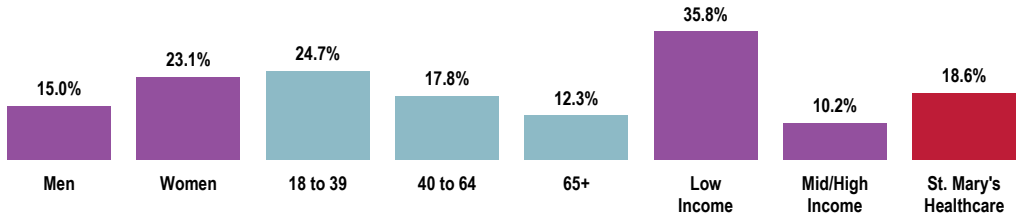
DISPARITY ► Unfavorably high in Fulton County. More often reported among women, adults younger than 65, and households with lower incomes.

Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 79]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Find It "Very" or "Somewhat" Difficult to Buy Affordable Fresh Produce
(St. Mary's Healthcare Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 79]
Notes: ● Asked of all respondents.

PHYSICAL ACTIVITY

ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

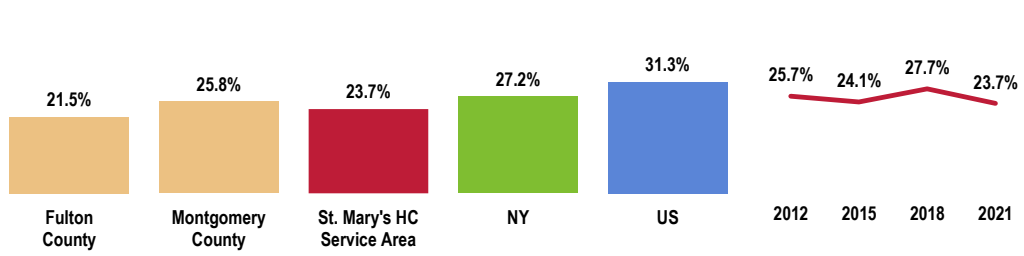
Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

A total of 23.7% of St. Mary's Healthcare Service Area adults report no leisure-time physical activity in the past month.

BENCHMARK ► Better than was found across the state and nation. Similar to the Healthy People 2030 objective.

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.2% or Lower



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 82]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 New York data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Activity Levels

Adults

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity **aerobic** physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. The guidelines also recommend that adults do **muscle-strengthening** activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

A total of 18.9% of St. Mary's Healthcare Service Area adults regularly participate in adequate levels of both aerobic and strengthening activities (meeting physical activity recommendations).

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activities:

Aerobic activity is one of the following: at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous activity, or an equivalent combination of both.

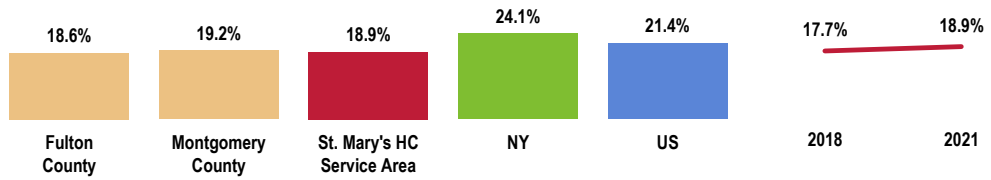
Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.

BENCHMARK ► Less favorable than the statewide percentage. Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Those less likely to meet the recommendations include women, adults age 65 and older, and lower-income adults.

Meets Physical Activity Recommendations

Healthy People 2030 = 28.4% or Higher



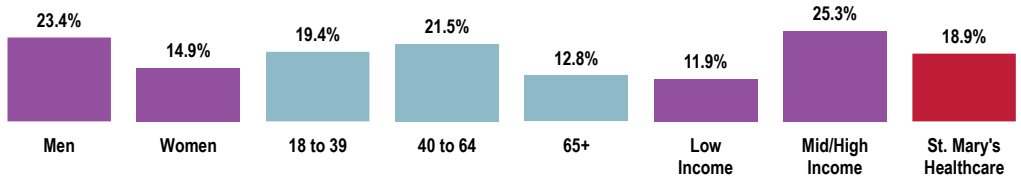
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 126]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 New York data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity and report doing physical activities specifically designed to strengthen muscles at least twice per week.

Meets Physical Activity Recommendations

(St. Mary's Healthcare Service Area, 2021)

Healthy People 2030 = 28.4% or Higher



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 126]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity *and* report doing physical activities specifically designed to strengthen muscles at least twice per week.

Children

CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

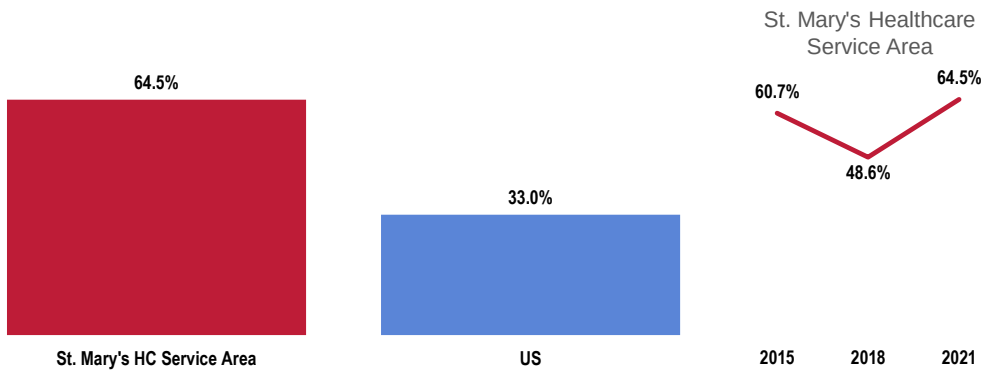
– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

Among St. Mary's Healthcare Service Area children age 2 to 17, 64.5% are reported to have had 60 minutes of physical activity on <u>each</u> of the seven days preceding the interview (1+ hours per day).

BENCHMARK ► Considerably higher than the national percentage.

TREND ► Marks a significant increase since the 2018 survey.

Child Is Physically Active for One or More Hours per Day
(Parents of Children Age 2-17)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 109]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 2-17 at home.
- Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

Access to Physical Activity

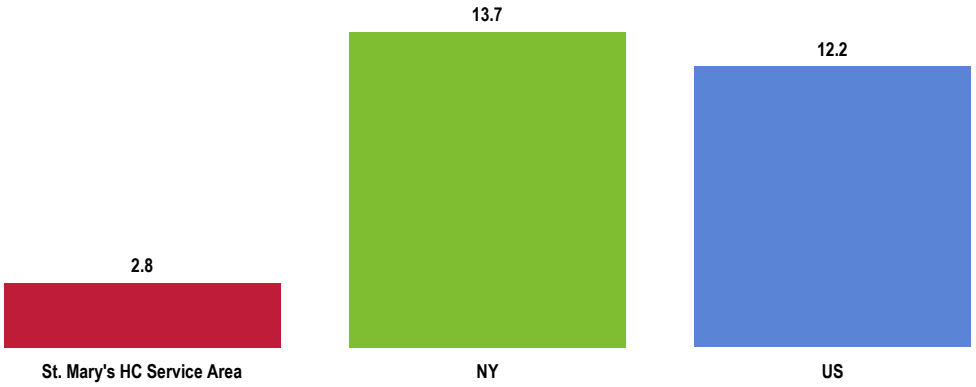
In 2019, there were 2.8 recreation/fitness facilities for every 100,000 population in the St. Mary's Healthcare Service Area.

BENCHMARK ► Considerably lower than was found across the state and nation.

Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

Population With Recreation & Fitness Facility Access
(Number of Recreation & Fitness Facilities per 100,000 Population, 2019)



Sources:
- US Census Bureau, County Business Patterns. Additional data analysis by CARES.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

Notes:
- Recreation and fitness facilities are defined by North American Industry Classification System (NAICS) Code 713940 , which include *Establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities." Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.* This indicator is relevant because access to recreation and fitness facilities encourages physical activity and other healthy behaviors.

WEIGHT STATUS

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Normal	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

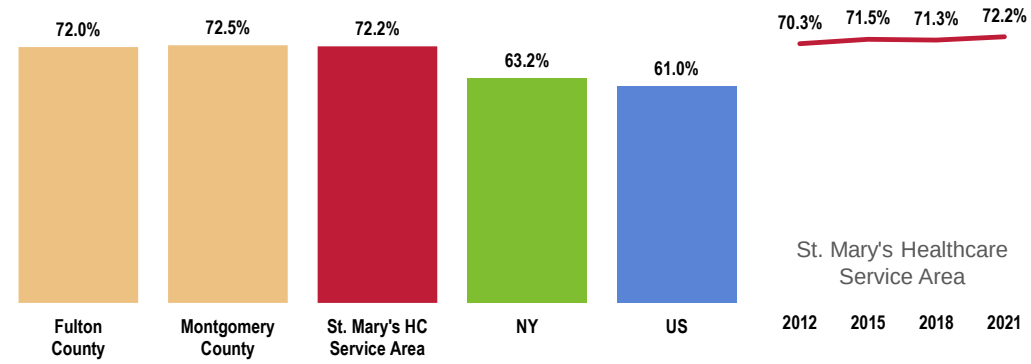
Overweight Status

Here, "overweight" includes those respondents with a BMI value ≥25.

A total of 7 in 10 St. Mary's Healthcare Service Area adults (72.2%) are overweight.

BENCHMARK ► Worse than state and national percentages.

Prevalence of Total Overweight (Overweight and Obese)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 New York data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

"Obese" (also included in overweight prevalence discussed previously) includes respondents with a BMI value ≥30.

The overweight prevalence above includes 40.3% of St. Mary's Healthcare Service Area adults who are obese.

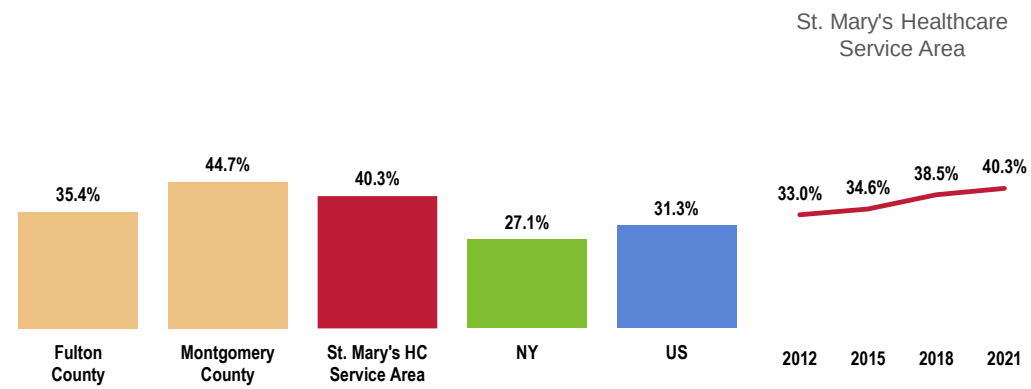
BENCHMARK ► Much higher than state and US percentages. Fails to satisfy the Healthy People 2030 objective.

TREND ► Increasing significantly in the service area.

DISPARITY ► Unfavorably high in Montgomery County. Adults age 18 to 64 are more likely to report being obese.

Prevalence of Obesity

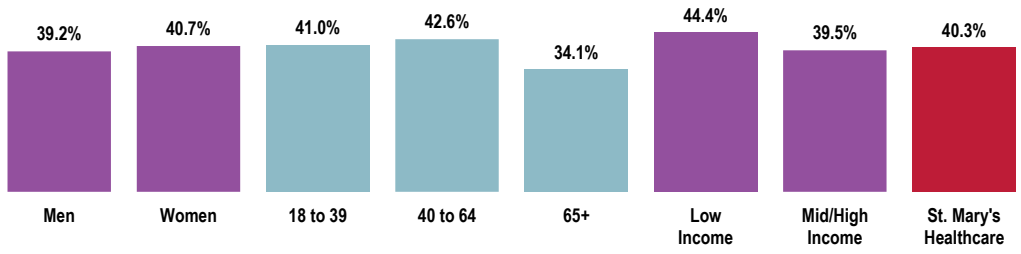
Healthy People 2030 = 36.0% or Lower



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 New York data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Prevalence of Obesity
(St. Mary's Healthcare Service Area, 2021)
Healthy People 2030 = 36.0% or Lower



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 128]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

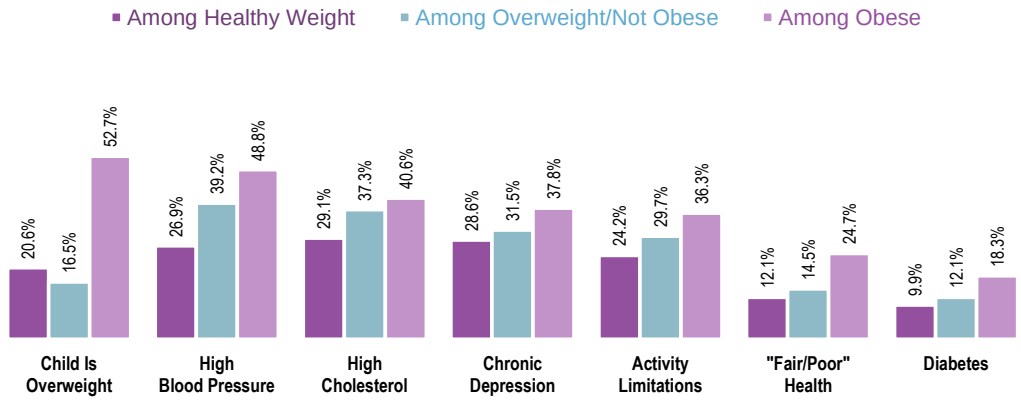
Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Relationship of Overweight With Other Health Issues

Overweight and obese adults are more likely to report a number of adverse health conditions, as outlined in the following chart.

The correlation between overweight and various health issues cannot be disputed.

Relationship of Overweight With Other Health Issues
(St. Mary's Healthcare Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 128]

Notes:
- Based on reported heights and weights, asked of all respondents.

Children's Weight Status

ABOUT WEIGHT STATUS IN CHILDREN & TEENS

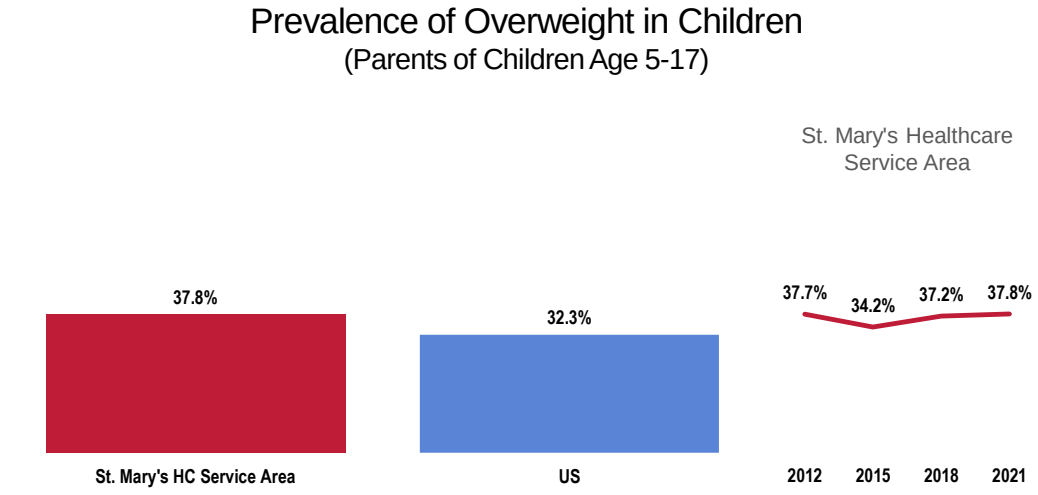
In children and teens, body mass index (BMI) is used to assess weight status – underweight, healthy weight, overweight, or obese. After BMI is calculated for children and teens, the BMI number is plotted on the CDC BMI-for-age growth charts (for either girls or boys) to obtain a percentile ranking. Percentiles are the most commonly used indicator to assess the size and growth patterns of individual children in the United States. The percentile indicates the relative position of the child's BMI number among children of the same sex and age.

BMI-for-age weight status categories and the corresponding percentiles are shown below:

- Underweight <5th percentile
- Healthy Weight ≥5th and <85th percentile
- Overweight ≥85th and <95th percentile
- Obese ≥95th percentile

– Centers for Disease Control and Prevention

Based on the heights/weights reported by surveyed parents, 37.8% of St. Mary's Healthcare Service Area children age 5 to 17 are overweight or obese (≥85th percentile).

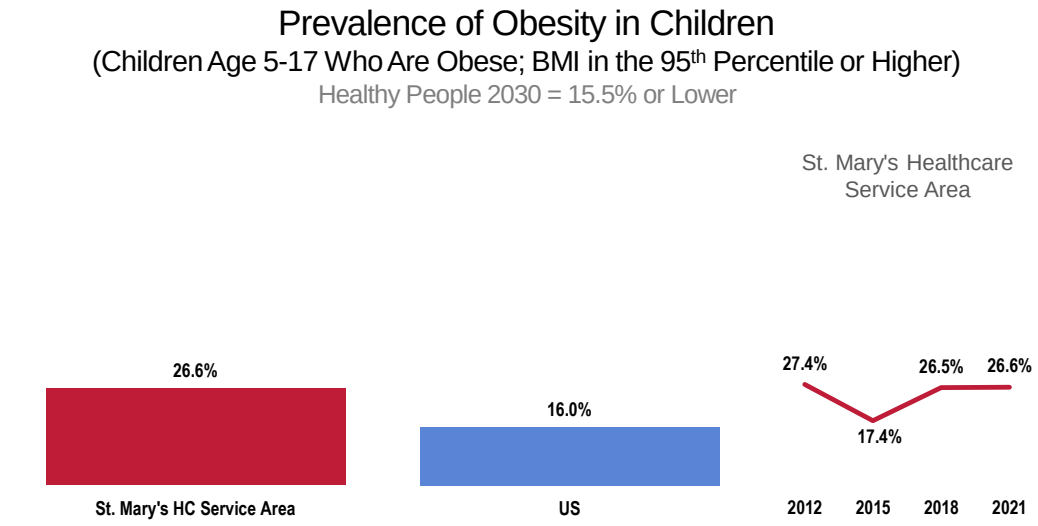


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 131]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 5-17 at home.
- Overweight among children is determined by children's Body Mass Index status at or above the 85th percentile of US growth charts by gender and age.

The childhood overweight prevalence above includes 26.6% of area children age 5 to 17 who are obese (≥95th percentile).

BENCHMARK ► Similar to the Healthy People 2030 objective.

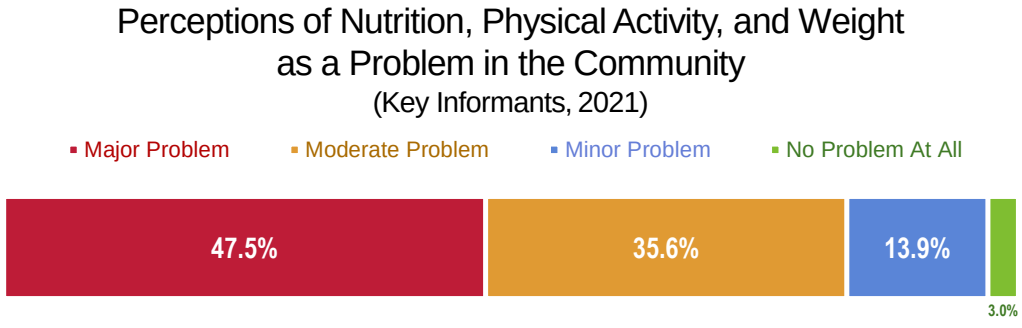


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 131]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents with children age 5-17 at home.
- Obesity among children is determined by children's Body Mass Index status equal to or above the 95th percentile of US growth charts by gender and age.

Key Informant Input: Nutrition, Physical Activity & Weight

Key informants taking part in an online survey most often characterized *Nutrition, Physical Activity & Weight* as a "major problem" in the community.



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

> Most people cannot afford healthy foods and there is a need for more education beginning at an early age and throughout all levels of school. Society including our schools is overloaded with unhealthy, high fat/calorie, processed foods and very little physical activity. – Social Services Provider

Access to healthy food options, variety of physical activities options. – Community/Business Leaders

Access and affordability to food that is healthy, gym costs are increasing and not covered by insurance completely, lack of knowledge. – Community/Business Leaders

Fast pace community, everyone wants everything now and also lacks the education to cook. – Community/ Business Leaders

Lack of education and poverty. Laziness. – Community/Business Leaders

Education is a key component to getting to the root cause of why so many people are making poor choices about their diet. The choices they are making each day for their families and themselves will have long term impacts on health for themselves and their families. Population health should be the biggest focus our elected leaders and trustees should be addressing. At the 2015 HANYS conference at the Sagamore in Lake George the NYS Health Commissioner opened the conference with the following: "For the first time in history, more people in the world are dying from overeating then starvation. The rest of the conference focused on Population health and how it can be improved. – Community/Business Leaders

Overweight persons due to substance abuse, poor self-image, mental illness, poor role models, lacking other coping mechanisms. – Social Services Provider

Overweight persons due to substance abuse, poor self-image, mental illness, poor role models, lacking other coping mechanisms. – Social Services Provider

Lack of creativity when presenting or maintaining a healthy diet. Nobody likes to "diet. Therefore, creative ways in helping people understand how to do it or maintain a balanced diet without people realizing they are doing it would be beneficial. – Other Health Provider

Lack of health literacy. Lack of access to education on importance of physical activity to maintain weight and strength. Lack of family support to encourage nutrition and physical activity and weight. Gym memberships are expensive, personal trainers expensive, those that are unemployed do not have benefits that assist with nutrition education, physical activity supports and weight management programs. Those suffering with chronic pain, behavioral health have added challenging in engaging in overall wellness. – Social Services Provider

There is a high rate of morbid obesity in our counties; there are fresh food deserts with limited public transportation in populated and rural areas; there is easy access to processed and fast food in both counties. Education and accessibility are critical. – Other Health Provider

There is a very large percentage of overweight, obese patients. Challenges include – Genetics, poor examples (of proper nutrition and exercise) by parents/adults. Many patients/families just do not care about good nutrition and exercise (nor think it is important). – Physician

Obesity remains a significant problem in our area, the causes of which are multifactorial. Poor education, lack of recognition of appropriate weight and the consequences of being overweight, untreated depression and generalized anxiety disorders leading to poor food choices (pleasure foods). Overweight leading to inability to exercise due to joint and muscle pains or previous injuries from falls. – Physician

In America and our community most people are overweight and do not even realize. People do not eat a healthy diet nor know what is healthy for that matter. The average person does not exercise on a regular basis. Too much fast food and processed food is consumed. Also too much sugar and white flour. – Community/ Business Leaders

Poverty and transportation issues can limit access to healthy foods. Fewer safe and/or low-cost opportunities for involvement in physical activities. Video games and other sedentary activities override desire for social and physical outlets. – Social Services Provider

Socioeconomic issues. Addiction issues pertaining to computers and cell phones. Children/adults and fast foods. Lack of exercise in general. – Community/Business Leaders

Food deserts. Lack of access to healthy fresh food. – Other Health Provider

Lack of motivation and access to education/programs, almost non-existent public transportation. – Social Services Provider

Motivation to be well, consistent income with the ability to earn enough for nutritious food, lack of education, easier access to processed. – Social Services Provider

There is no grocery store in the city of Amsterdam, which happens to be the poorest neighborhoods. People on a tight budget cannot afford to spend money on transportation to stores that are miles away, which is the only access to fresh fruits and veg. Packaged, processed foods are easily found near them, which are much cheaper and more filling. – Community/Business Leaders

Remaining active all year (winter). The price of healthy food is a lot more than unhealthy food, which definitely plays a role in the underserved population. – Community/Business Leaders

Lack of physical exercise together with unhealthy food choices, both in type of food and amount. – Physician

Access to Affordable Healthy Food

Lack of access to and awareness about healthy food choices. – Other Health Provider

Cost of healthy foods. Lack of motivation. Lack of access to healthy foods. – Social Services Provider

Lack of access to healthy foods in city areas and food insecurity. – Community/Business Leaders

> Amsterdam has been labeled a "food desert" because of our lack of healthy food and beverage options in the city. Our FPL is over 50% in the city, as well. As we know, the cost of healthy food options is expensive. – Public Health Representative

Nutrition

> Proper nutrition and exercise are the biggest factors. – Social Services Provider
>
> Access to good nutrition and knowledge of good nutrition is hard in certain areas due to lack of grocery stores and lack of education. – Social Services Provider
>
> Many of the people we serve do not eat healthy. Nutritious food is expensive. People we deal with like immediate gratification and therefore choose fast food to eat. This type of food puts weight on people. – Social Services Provider
>
> Many unhealthy options available in stores and restaurants, portion control is a struggle, limited available exercise options without cost. – Community/Business Leaders

Awareness/Education

> Lack of education. – Community/Business Leaders
>
> Auto-Immune diseases and the knowledge around it. Being sent to the pharmacy for medicine versus having nutritional counseling. It seems many primary doctors have not been "continuing ed" and of course they are not specialists in the field but they are quick to jump to providing medicine. For auto-immune diseases and chronic conditions change in diet and eliminating certain foods may not be a cure but it helps with symptoms, pain, etc. For example; I personally went 10-15 years being misdiagnosed with an autoimmune disease because of the lack of research and attention to what was really going on. I was never suggested to change my diet. I had to figure it out for myself. I have a lot of people asking me for questions when they have issues because they aren't getting answers from their doctors. If we want to keep our community going to our local hospitals and physicians, being up to date on research surrounding autoimmune and having more dietician/nutrition resources would be huge. – Other Health Provider
>
> Understanding and making healthy choices. – Community/Business Leaders

Income/Poverty

> We have a large socially and economically disadvantaged population, which includes food insecurities. Nutritionists are not readily available. – Other Health Provider
>
> Poverty and lifestyle within the community. – Community/Business Leaders
>
> Low income population and poor food choices. – Other Health Provider

Obesity

> Obesity among school children. – Other Health Provider
>
> Obesity and under-activity seem to be growing at an alarming rate. – Community/Business Leaders
>
> Obesity and poor nutrition. – Community/Business Leaders

Availability of Services

> Lack of community activities that are accessible and affordable. – Social Services Provider
>
> Low cost recreational activities, facilities, or parks for outdoor use. Accessible weight loss programs. – Social Services Provider

Denial/Stigma

> People often times do not want to be honest or open about weight and nutrition due to feeling judged, but I think it's something we don't really talk about enough because it is a difficult subject to discuss. However, it does provide challenges and concerns especially in my field of prenatal care and how the pregnancy is affected. Obesity is a country wide problem also and becoming more and more of a problem, not even just in our communities. Sometimes I also feel people don't realize the true repercussions and results of poor weight and nutrition – Other Health Provider
>
> Individuals' willingness to address their weight issues. – Social Services Provider

Vulnerable Populations

> We are a senior and minority community. We need better programs and state or federal aid. – Community/Business Leaders

Incidence/Prevalence

> In the University of Wisconsin Population Health Institute's County Health Rankings, Montgomery and Fulton Counties have a higher than average prevalence of this condition. – Community/Business Leaders

Infrastructure

> Need more walking and bike trails that are easily accessible areas. The current resources are very limited. – Physician

Prevention/Screenings

> More programs are needed that focus on prevention and good health. – Social Services Provider

SUBSTANCE ABUSE

ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

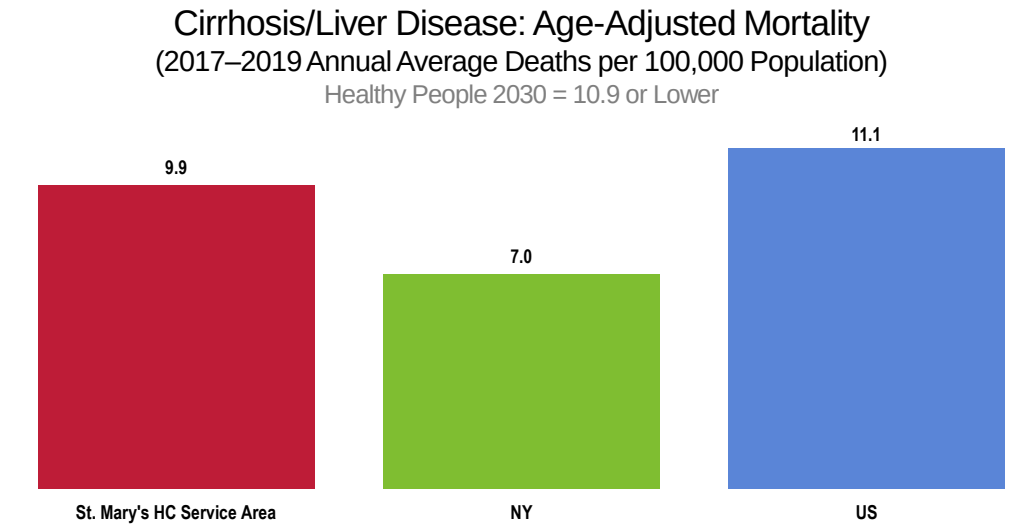
Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Cirrhosis/Liver Disease Deaths

Between 2017 and 2019, the St. Mary's Healthcare Service Area reported an annual average age-adjusted cirrhosis/liver disease mortality rate of 9.9 deaths per 100,000 population.

BENCHMARK ► Worse than was found across New York. Satisfies the Healthy People 2030 objective.

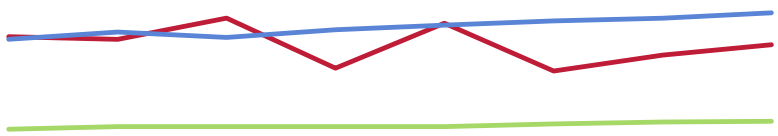


Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Cirrhosis/Liver Disease: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 10.9 or Lower



	2010-2012	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
St. Mary's HC	10.2	10.1	10.9	9.0	10.7	8.9	9.5	9.9
NY	6.7	6.8	6.8	6.8	6.8	6.9	7.0	7.0
US	10.1	10.4	10.2	10.5	10.6	10.8	10.9	11.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Alcohol Use

Excessive Drinking

Excessive drinking includes heavy and/or binge drinkers:

- HEAVY DRINKERS ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKERS ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

A total of 23.0% of area adults are excessive drinkers (heavy and/or binge drinkers).

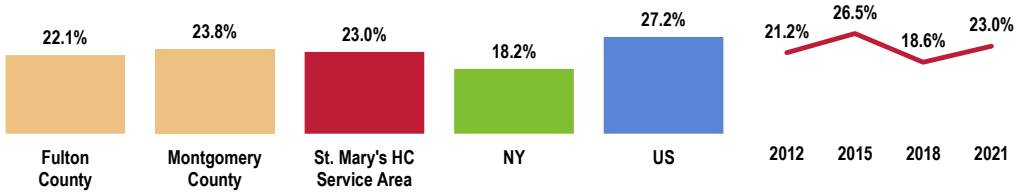
BENCHMARK ► Worse than the state finding but better than the national finding.

TREND ► Represents a significant increase from the 2018 survey (although closer to prior findings).

DISPARITY ► More often reported among men and adults younger than 65.

Excessive Drinkers

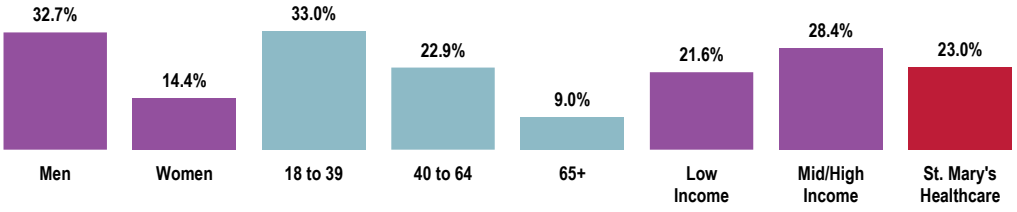
St. Mary's Healthcare Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 136]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 New York data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Excessive Drinkers
(St. Mary's Healthcare Service Area, 2021)



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 136]

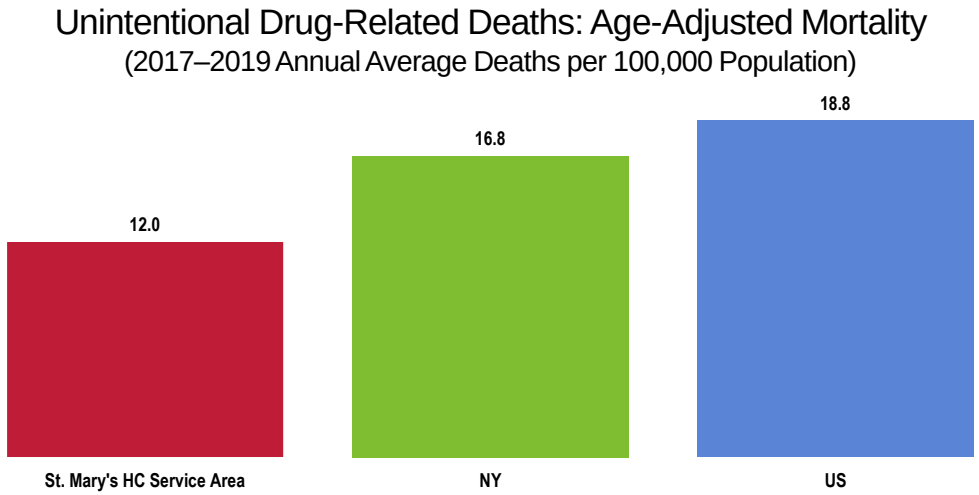
Notes:
- Asked of all respondents.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Age-Adjusted Unintentional Drug-Related Deaths

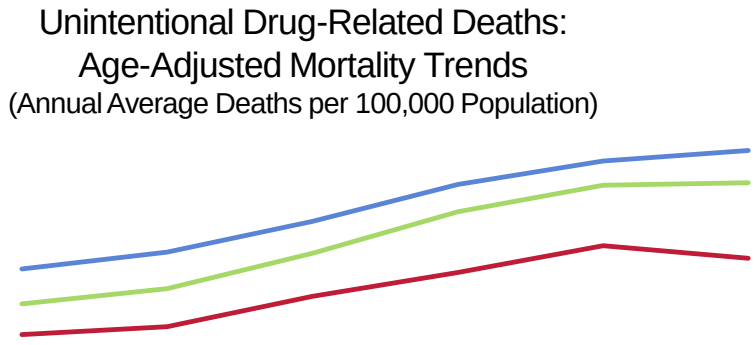
Between 2017 and 2019, there was an annual average age-adjusted unintentional drug-related mortality rate of 12.0 deaths per 100,000 population in the St. Mary's Healthcare Service Area.

BENCHMARK ► Better than state and US rates.

TREND ► Significantly higher than the 2012-2014 baseline.



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.



	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
St. Mary's HC	7.2	7.7	9.6	11.1	12.8	12.0
NY	9.1	10.1	12.3	14.9	16.6	16.8
US	11.3	12.4	14.3	16.7	18.1	18.8

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2021.

Illicit Drug Use

For the purposes of this survey, "illicit drug use" includes use of illegal substances or of prescription drugs taken without a physician's order.

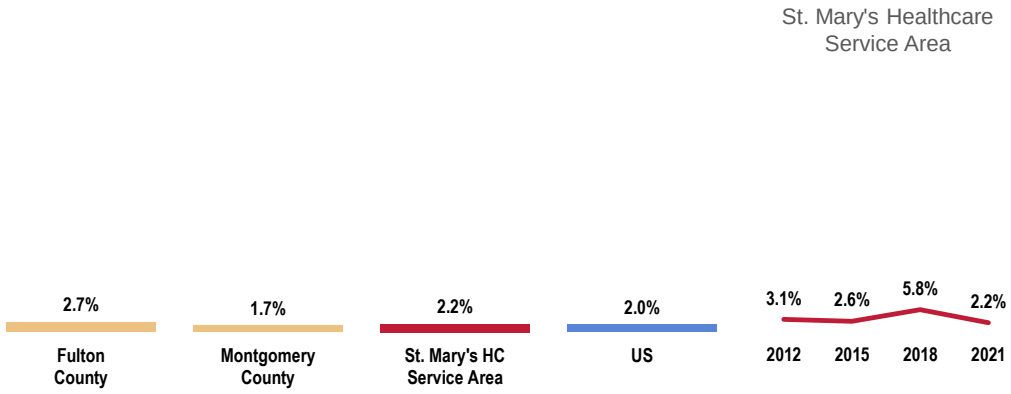
Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

A total of 2.2% of St. Mary's Healthcare Service Area adults acknowledge using an illicit drug in the past month.

BENCHMARK ► Satisfies the Healthy People 2030 objective.

Illicit Drug Use in the Past Month

Healthy People 2030 = 12.0% or Lower



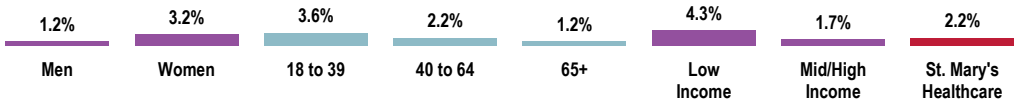
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 49]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Illicit Drug Use in the Past Month

(St. Mary's Healthcare Service Area, 2021)

Healthy People 2030 = 12.0% or Lower



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 49]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

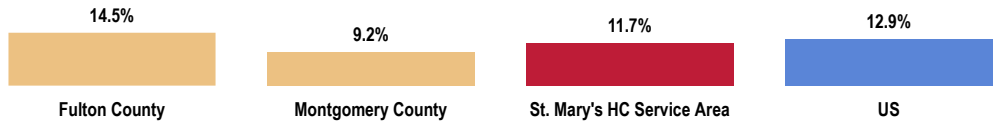
Use of Prescription Opioids

Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

A total of 11.7% of St. Mary's Healthcare Service Area report using a prescription opioid drug in the past year.

DISPARITY ► Unfavorably high in Fulton County. More often reported among lower-income adults.

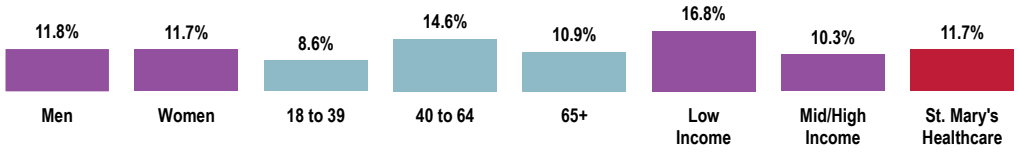
Used a Prescription Opioid in the Past Year



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 50]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Used a Prescription Opioid in the Past Year
(St. Mary's Healthcare Service Area, 2021)



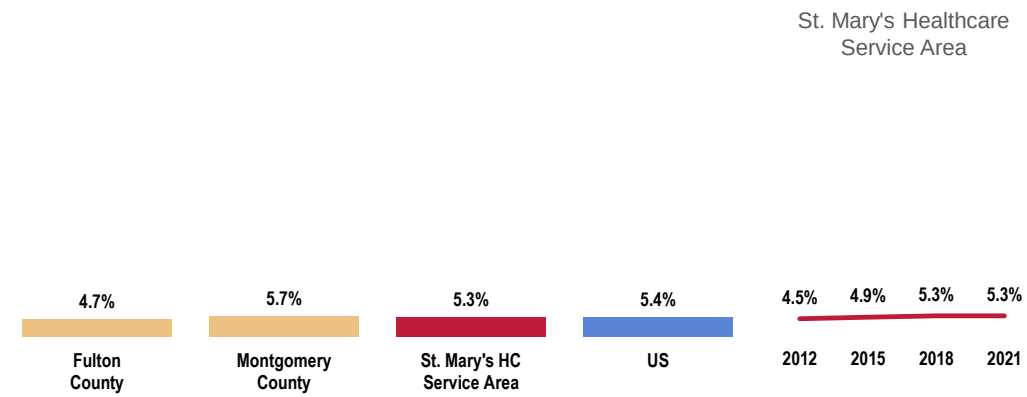
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 50]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Alcohol & Drug Treatment

A total of 5.3% of St. Mary's Healthcare Service Area adults report that they have sought professional help for an alcohol or drug problem at some point in their lives.

Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem



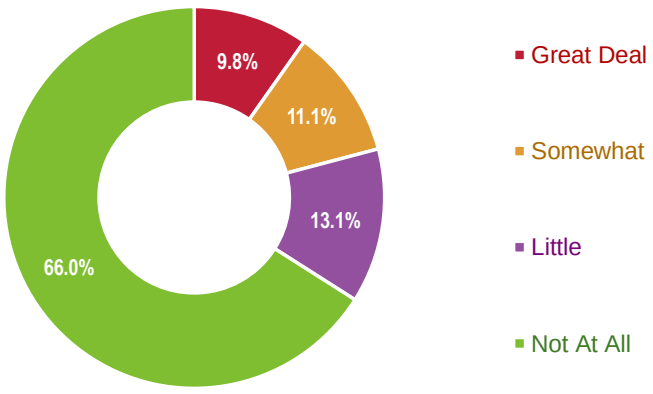
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 51]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Personal Impact From Substance Abuse

Area adults were also asked to what degree their lives have been impacted by substance abuse (whether their own abuse or that of another).

A majority of St. Mary's Healthcare Service Area residents' lives have <u>not</u> been negatively affected by substance abuse (either their own or someone else's).

Degree to Which Life Has Been Negatively Affected by Substance Abuse (Self or Other's)
(St. Mary's Healthcare Service Area, 2021)

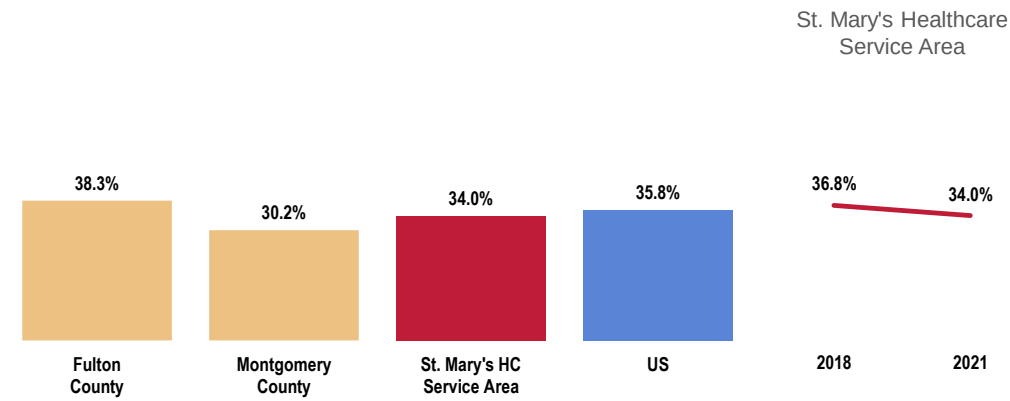


Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 52]
Notes: ● Asked of all respondents.

However, 34.0% have felt a personal impact to some degree ("a little," "somewhat," or "a great deal").

DISPARITY ► Higher in Fulton County. More often reported among adults younger than 65 and those with lower incomes.

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)

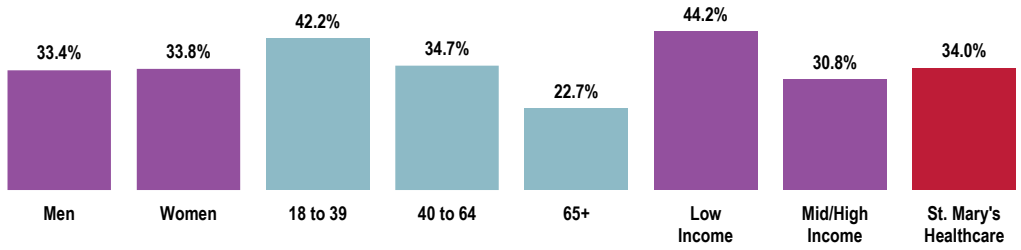


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 52]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes response of "a great deal," "somewhat," and "a little."

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)

(St. Mary's Healthcare Service Area, 2021)

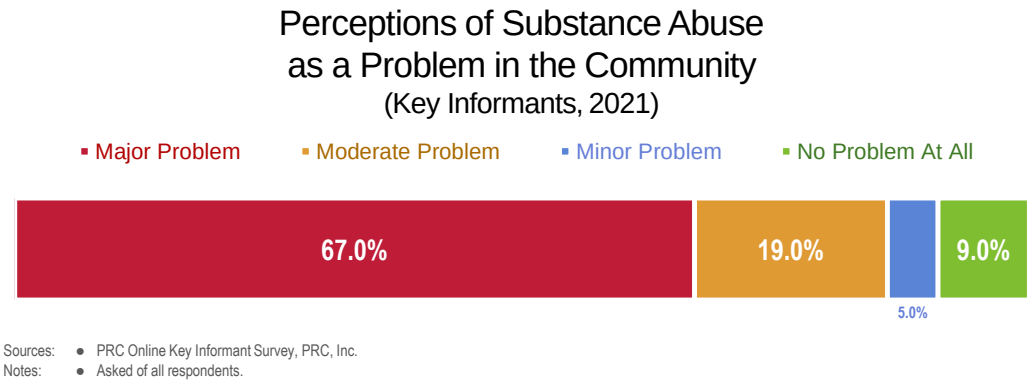


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 52]

Notes:
- Asked of all respondents.
- Includes response of "a great deal," "somewhat," and "a little."

Key Informant Input: Substance Abuse

The greatest share of key informants taking part in an online survey characterized *Substance Abuse* as a "major problem" in the community.



Sources: PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Contributing Factors

Not enough services, providers, there is no adolescent treatment. Often people need to go to other, larger metropolitan areas to access services and this can be a problem with transportation. – Social Services Provider

A structured program large enough to take in all of the individuals in need of treatment. This treatment also needs to be paired with mental health services as a large percentage are abusing substances for specific reasons. – Community/Business Leaders

Appointment in timely manner. Case management has to be more intense for some individuals. More inpatient stays to address current use. Individuals selling medication taken home (Suboxone). – Community/Business Leaders

Alcohol abuse is a big problem and not enough assistance. There are too many rules around accessing treatment. If you can get an individual to agree they need to be able to talk to someone immediately if not the more time that passes they change their mind. – Social Services Provider

Substance abuse has a stigma and often those suffering from substance abuse cannot afford treatment. Such as being out of work to get continuous treatment or no insurance coverage. – Other Health Provider

Stigma surrounding it and transportation to the clinics that are available or lack of knowledge of where they are. – Other Health Provider

Shame, lack of facilities to support a person in crisis. Ignorance from the community as well as the emergency personnel. More trauma informed training needs to be done to help patients in these situations. – Community/ Business Leaders

Willingness of addicted individuals to seek help. Non-punitive resources are key and law enforcement in general has come a long way in addressing addiction (Narcan, etc.). – Community/Business Leaders

Willingness to seek help, financial abilities, transportation. – Social Services Provider

I feel a big part of the barriers is patient's choices, many are not interested in help. I do also feel like, especially with the pandemic, there are increased and still increasing instances of mental illness, mental health concerns and substance abuse so our facilities who provide these services are recently becoming very overwhelmed – Other Health Provider

Transportation, the lack of motivation to complete any rehabilitation programs, lack of creativity. – Other Health Provider

Lack of service providers, transportation services. – Community/Business Leaders

More providers with X licenses are needed to be willing to take on a caseload. We also need to remove the stigma and create a seamless pathway and a no wrong door approach that is available seven days a week. – Other Health Provider

Very high rate of substance abuse (due to multiple reasons, poor socio-economic status, parents/family members with addictions, etc.). – Physician

Again, there are a number of elements related to this area. They include: quality of care, bail reform, availability of services. – Other Health Provider

Limited family and social supports. Transportation and employment issues. Fear of legal or social services repercussions. – Social Services Provider

State or program restrictions, regulations. Fear of someone knowing who individual is, if they attend some program. – Social Services Provider

CFR Part 2 is an obstacle to critical sharing of treatment information. – Social Services Provider

Access to Care/Services

Not enough facilities or education to serve those in need. – Community/Business Leaders

Not enough services to meet the needs. – Social Services Provider

Timely appointments. – Community/Business Leaders

Inpatient and outpatient treatment options and limited capacity to serve. – Other Health Provider

In person meetings needed. – Social Services Provider

Availability of quick response and ease of access to the services requested. – Physician

I think access is adequate, I am not sure. Need more services for limited English speakers/Spanish-language speakers across the board. – Social Services Provider

Biggest barrier to treating substance abuse is financial resources and insurance to cover the cost of addiction treatment. – Community/Business Leaders

Lack of providers, long wait lists, lack of emergency or crisis services/beds. – Other Health Provider

Long waiting lists. Lack of transportation/knowledge on how to access Medicaid transportation. Lack of desire to change habits. Those dealing with SUD and behavioral health and managing both disease processes. – Social Services Provider

Availability of providers 24/7. – Community/Business Leaders

Only one treatment program and it typically is full and has a waiting list. – Community/Business Leaders

There are not enough treatment facilities to manage the significant numbers of substance abuse. – Social Services Provider

Availability of inpatient services locally, availability of meeting on a regular basis, transportation. – Social Services Provider

There is no longer term care in Mont County. St. Mary's Hospital only offers limited services. – Social Services Provider

Labeling, more resources needed. – Community/Business Leaders

Denial/Stigma

Stigma. – Other Health Provider

Stigma. – Social Services Provider

Confidentiality and/or anonymity of services. – Community/Business Leaders

Desire of the individual to be clean and sober. Stigma placed on this illness. Limited number of providers in Addictionology. – Other Health Provider

People having limited insight or interest in recovery. – Social Services Provider

Stigma of this diagnosis, people are ashamed to seek help. – Community/Business Leaders

Being identified at such facility. – Community/Business Leaders

Individuals are in denial and thus don't seek treatment, or they are surrounded by the wrong influencers. Pride gets in the way and fear of judgement. – Community/Business Leaders

Transportation

Availability, transportation. – Community/Business Leaders

Transportation. – Social Services Provider

Transportation and understanding their own need to get treatment. – Other Health Provider

Transportation and availability. – Social Services Provider

Lack of Providers

Not enough providers. – Social Services Provider

Awareness/Education

Lack of understanding. – Community/Business Leaders

Education, underlying mental health needs, community outreach/prevention. – Other Health Provider

Due to COVID-19

> Substance Abuse disorders have become more prevalent since the pandemic. We're seeing an increase in patients from FY20 to FY21 (125,000 vs. 115,000 discharges) and I believe much of that had to do with the fact that we had to halt services during the height of the pandemic and close the inpatient chemical dependency unit for quite some time in 2020. – Public Health Representative

Income/Poverty

> Socioeconomic barriers. Addiction. – Community/Business Leaders

Access for Medicare/Medicaid Patients

> Lack of providers who accept Medicaid. – Community/Business Leaders

Most Problematic Substances

Key informants (who rated this as a "major problem") clearly identified **alcohol** as causing the most problems in the community, followed by **heroin/other opioids** and **cocaine or crack**.

SUBSTANCES VIEWED AS MOST PROBLEMATIC IN THE COMMUNITY (Among Key Informants Rating Substance Abuse as a "Major Problem")	
ALCOHOL	45.0%
HEROIN OR OTHER OPIOIDS	26.7%
COCAINE OR CRACK	8.3%
PRESCRIPTION MEDICATIONS	5.0%
MARIJUANA	5.0%
OVER-THE-COUNTER MEDICATIONS	3.3%
CLUB DRUGS (e.g. MDMA, GHB, Ecstasy, Molly)	3.3%
HALLUCINOGENS OR DISSOCIATIVE DRUGS (e.g. Ketamine, PCP, LSD, DXM)	1.7%
METHAMPHETAMINE OR OTHER AMPHETAMINES	1.7%

TOBACCO USE

ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

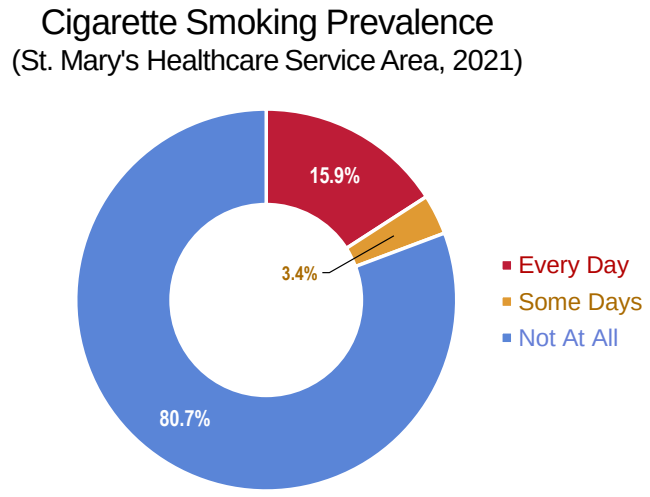
Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

Cigarette Smoking

Cigarette Smoking Prevalence

A total of 19.3% of St. Mary's Healthcare Service Area adults currently smoke cigarettes, either regularly (every day) or occasionally (on some days).



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 40]
Notes: ● Asked of all respondents.

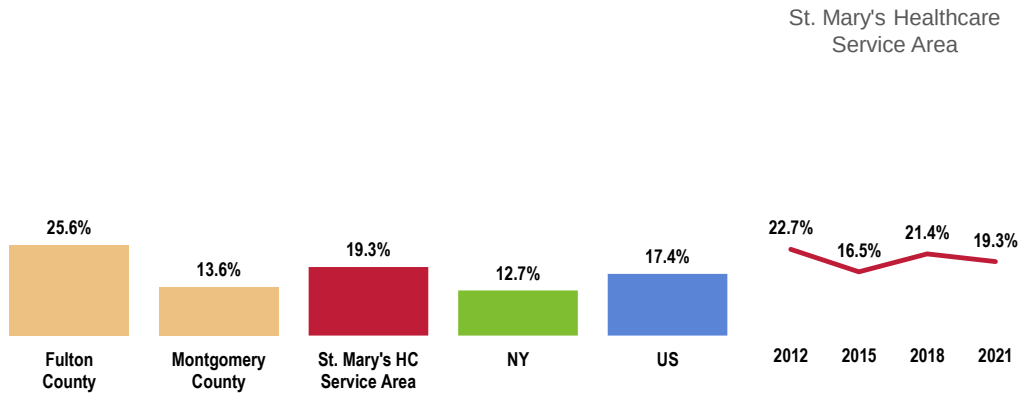
Note the following findings related to cigarette smoking prevalence in the St. Mary's Healthcare Service Area:

BENCHMARK ► Cigarette smoking prevalence in the service area is higher than was found across New York and fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Unfavorably high in Fulton County. Women, adults younger than 65, and lower-income adults are more likely to report that they smoke.

Current Smokers

Healthy People 2030 = 5.0% or Lower



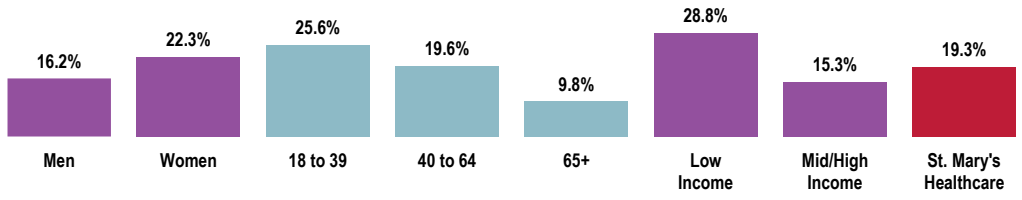
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 40]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 New York data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

Current Smokers

(St. Mary's Healthcare Service Area, 2021)

Healthy People 2030 = 5.0% or Lower



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 40]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

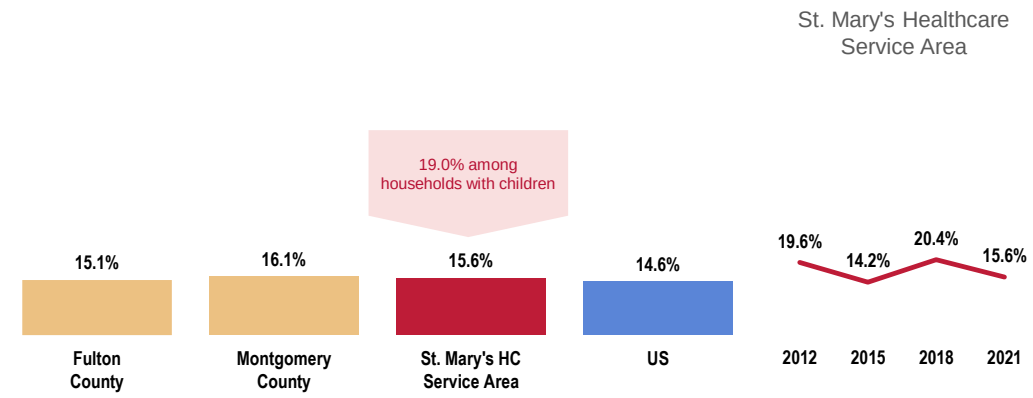
Notes:
- Asked of all respondents.
- Includes regular and occasion smokers (every day and some days).

Environmental Tobacco Smoke

Among all surveyed households in the St. Mary's Healthcare Service Area, 15.6% report that someone has smoked cigarettes in their home on an average of four or more times per week over the past month.

TREND ► No clear trend, but lower than found in the 2012 and 2018 surveys.

Member of Household Smokes at Home



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 43, 134]
- 2020 PRC National Health Survey, PRC, Inc.

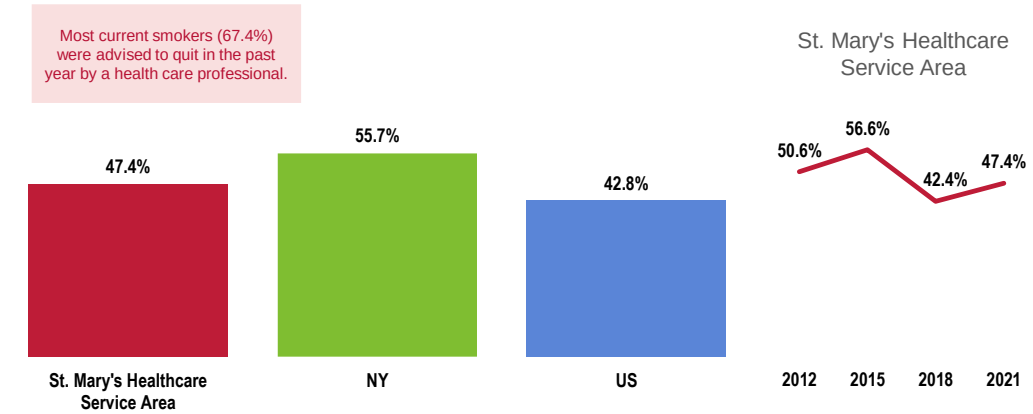
Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

Smoking Cessation

Nearly one-half of regular smokers (47.4%) went without smoking for one day or longer in the past year because they were trying to quit smoking.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

Have Stopped Smoking for One Day or Longer in the Past Year
(Everyday Smokers)
Healthy People 2030 = 65.7% or Higher



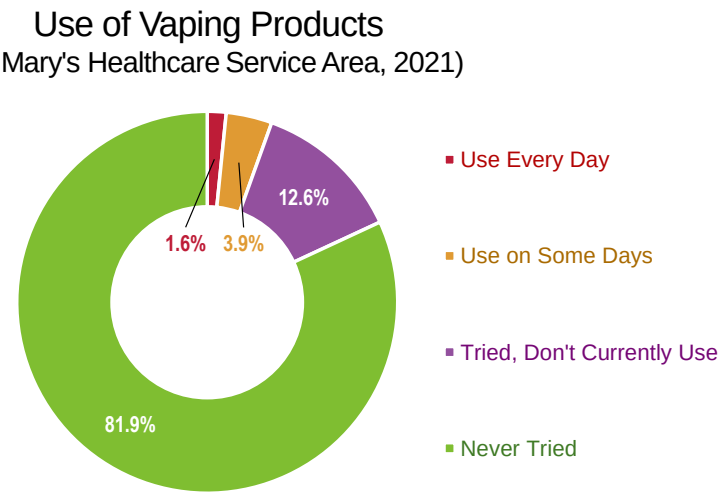
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 41-42]
- 2020 PRC National Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 New York data.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of respondents who smoke cigarettes every day.

Other Tobacco Use

Use of Vaping Products

Most St. Mary's Healthcare Service Area adults have never tried electronic cigarettes (e-cigarettes) or other electronic vaping products.

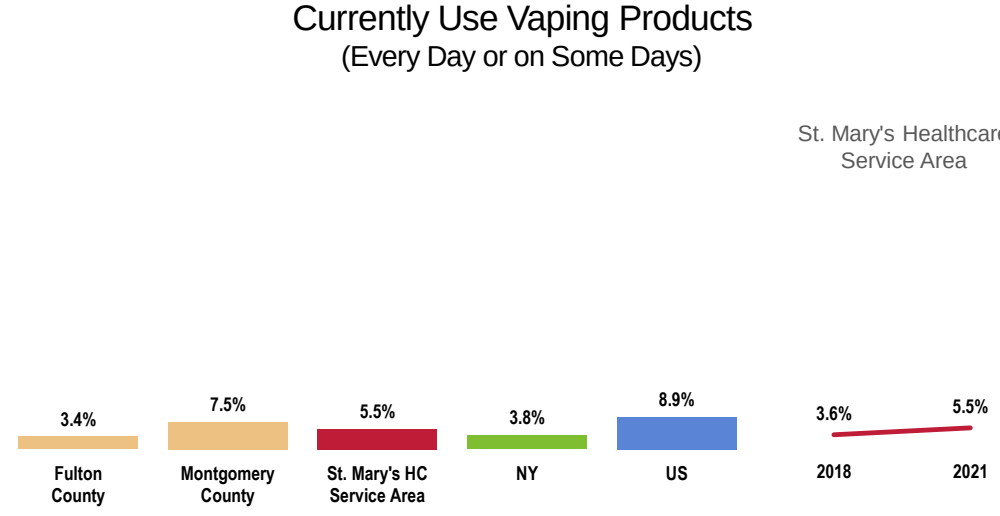


Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 135]
Notes: ● Asked of all respondents.

However, 5.5% currently use vaping products either regularly (every day) or occasionally (on some days).

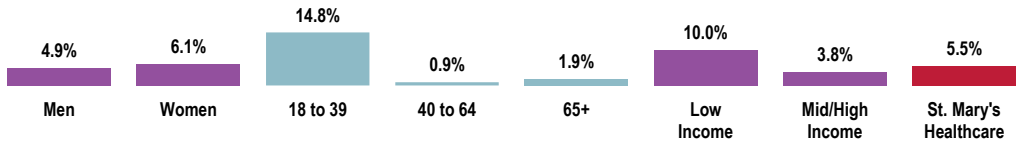
BENCHMARK ► Higher than the statewide percentage but lower than the national percentage.

DISPARITY ► Higher in Montgomery County. More often reported among young adults and those with lower incomes.



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 135]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Currently Use Vaping Products
(St. Mary's Healthcare Service Area, 2021)

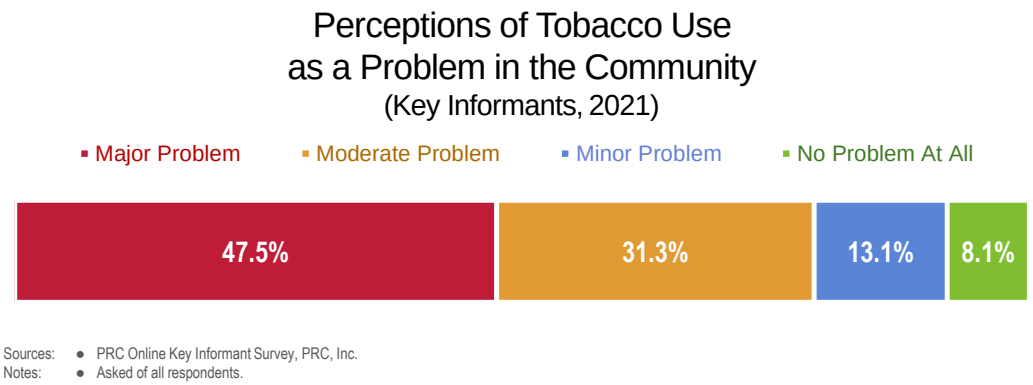


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 135]

Notes:
- Asked of all respondents.
- Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

Key Informant Input: Tobacco Use

The greatest share of key informants taking part in an online survey characterized *Tobacco Use* as a "major problem" in the community.



Sources: PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> Despite all the education and outreach agencies do, the number of smokers continues to rise. – Social Services Provider
>
> A high percentage of the population use tobacco products and there are related health issues. – Community/ Business Leaders
>
> In the University of Wisconsin Population Health Institute's County Health Rankings, Montgomery and Fulton Counties have a higher than average prevalence of this condition. – Community/Business Leaders
>
> Due to the prevalent use of tobacco products. – Social Services Provider
>
> Widespread tobacco is prevalent in our community. Vaping is also widespread, especially with the younger population. – Other Health Provider
>
> Tobacco use has always been high in this county. Not sure why, but seems even more people are smoking now. – Social Services Provider
>
> Observation or people actively smoking in the community. – Social Services Provider

Contributing Factors

> Lack of health literacy related to the use/outcomes of chronic tobacco use. Social groups that are smoking making it challenging to change lifestyle and maintain social groups. Trading smoking for ceasing alcohol or drug use.... being seen as the lesser harming substance – Social Services Provider
>
> Not enough education. Too many retailers. Underserved population. – Social Services Provider
>
> Tobacco use is a major problem because many people who start using become quickly addicted and can't quit. It is also a combination of education and in many cases smoking is still acceptable to many people. – Community/Business Leaders
>
> Again, rural area and tobacco seems to be a generational thing. Peer pressure. – Other Health Provider
>
> Lower income communities, mental health disorders. – Other Health Provider

Co-Occurrences

> There remains a very high incidence of premature lung and vascular disease in our community related to tobacco use. – Physician
>
> Many people with mental health issues smoke. Cigarettes are very expensive, and people would rather spend money on cigarettes than purchase food or pay rent. – Social Services Provider
>
> Fulton County has high instances of lung cancer due to tobacco use. – Social Services Provider
>
> Cancer is prevalent in countries. – Community/Business Leaders

Social Norms/Community Attitude

> People use smoking for socialization, managing stressors, etc. – Social Services Provider

> Tobacco and marijuana are considered socially appropriate "addictions" and means for stress reduction. – Social Services Provider
>
> No desire to quit. – Other Health Provider
>
> Cultural norm. – Social Services Provider

E-Cigarettes

> Prevalent and kids using vape pens. – Community/Business Leaders
>
> I see a lot of young people turning to e-cigarettes. Many high school and some middle school students seem to think it is "harmless," no matter what they are told. – Community/Business Leaders
>
> While there have been efforts to reduce the number of public smoking areas in the community, vaping has become a more prevalent issue, especially amongst our younger population. The belief exists that somehow it is healthier than smoking cigarettes, when in actuality, it is not. – Public Health Representative

Comorbidities

> People aren't worried about side effects or health. Secondhand smoke for people/kids who have no choice. – Community/Business Leaders
>
> My father was a heavy smoker for my whole life and passed away in 2005 from complications related to throat cancer. – Community/Business Leaders

Easy Access

> Access is readily available at every corner store within walking distance for most. – Other Health Provider

Teen/Young Adult Usage

> Nicotine products are too enticing to youth, getting them addicted at an early age. – Social Services Provider

SEXUAL HEALTH

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

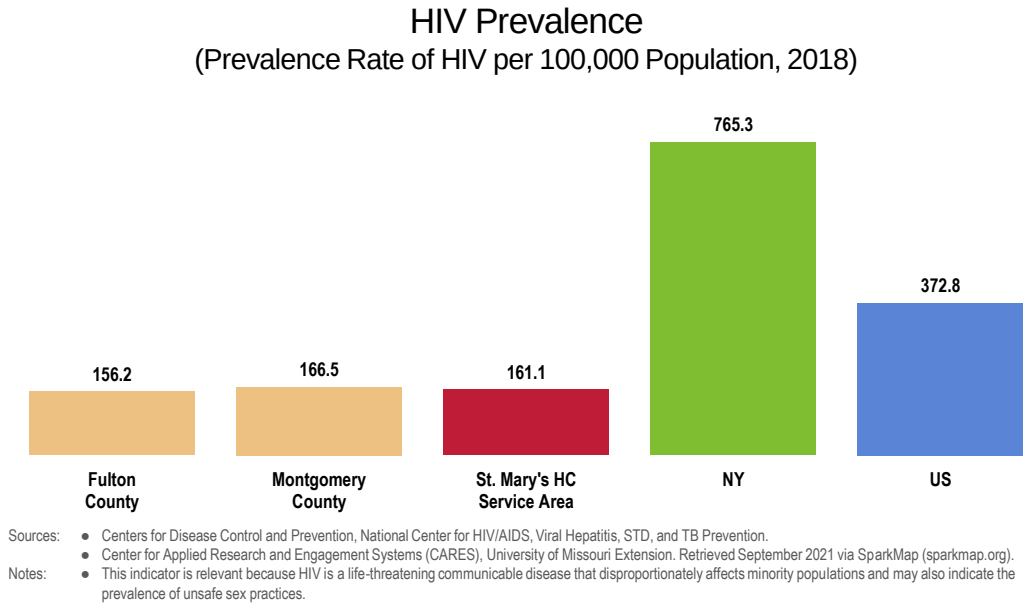
– Healthy People 2030 (https://health.gov/healthypeople)

HIV

HIV Prevalence

In 2018, there was a prevalence of 161.1 HIV cases per 100,000 population in the St. Mary's Healthcare Service Area.

BENCHMARK ► Considerably lower than the New York and US rates.



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

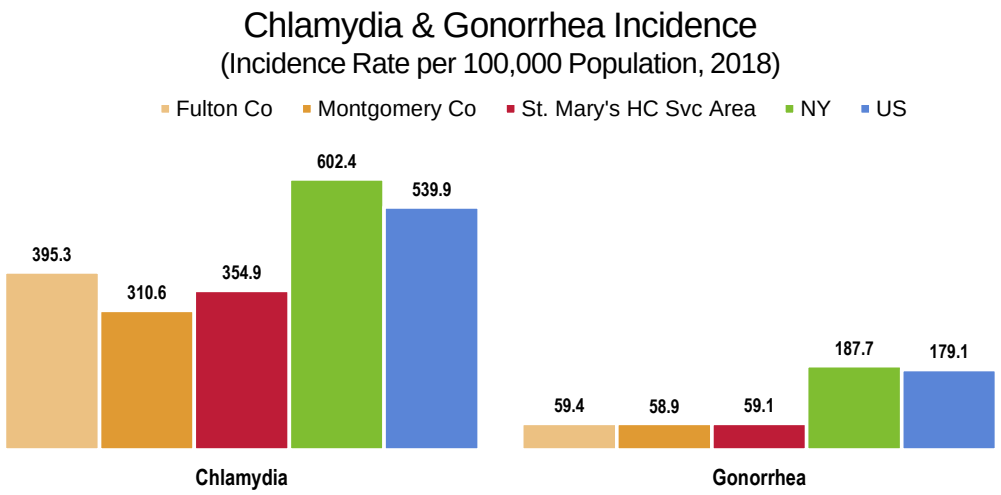
Sexually Transmitted Infections (STIs)

Chlamydia & Gonorrhea

In 2018, the chlamydia incidence rate in the St. Mary's Healthcare Service Area was 354.9 cases per 100,000 population.

The St. Mary's Healthcare Service Area gonorrhea incidence rate in 2018 was 59.1 cases per 100,000 population.

BENCHMARK ► Each service area rate is more favorable than the corresponding state and national rates.

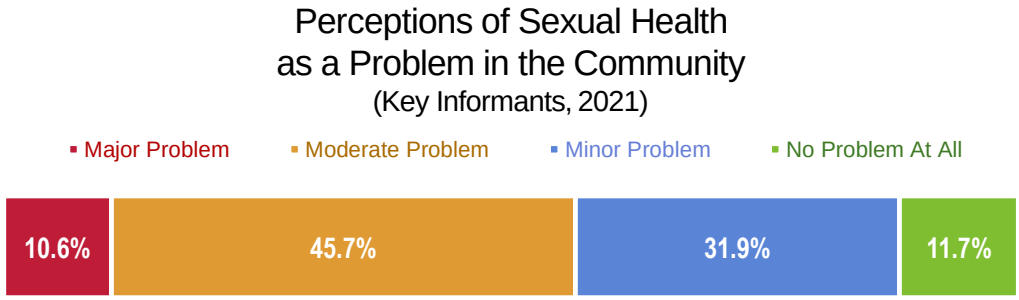


Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Key Informant Input: Sexual Health

A plurality of key informants taking part in an online survey characterized *Sexual Health* as a "moderate problem" in the community.



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Contributing Factors

> High risk individuals, drug use, access to doctors. – Community/Business Leaders
>
> Young generation not caring, other populations don't see importance. – Community/Business Leaders
>
> High rates of sexual abuse in community. Youth become sexually active early. Limited education about relationships, risk behaviors, etc. Some cultural groups encourage early sexual relationships. Poor use of or access to contraception. High alcohol and drug use. – Social Services Provider

Awareness/Education

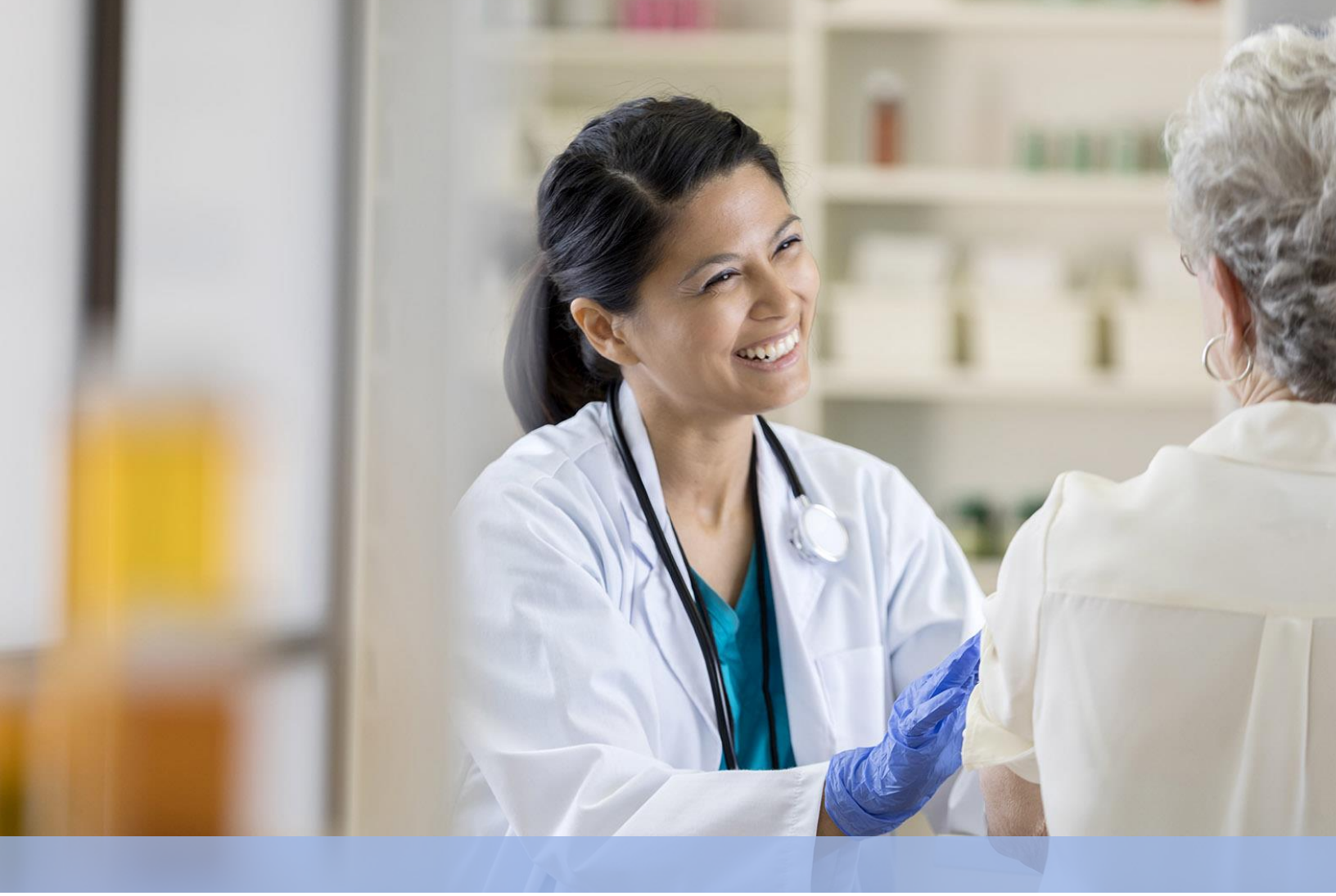
> Lack of education to the public on disease prevention. – Other Health Provider
>
> Lack of STD education and sexual education in schools. – Community/Business Leaders

Access to Care/Services

> There is no specialty care in this area. Pelvic Floor health/needs cannot be addressed in this area. Patients must travel to Albany for urology/gyn care. There also is no Planned Parenthood in Montgomery county – this is a problem because of transportation; patients must go to Johnstown (Fulton County) for Planned Parenthood services. – Other Health Provider

Incidence/Prevalence

> Montgomery and Fulton counties have a higher than average prevalence of this condition. – Community/Business Leaders



ACCESS TO HEALTH CARE

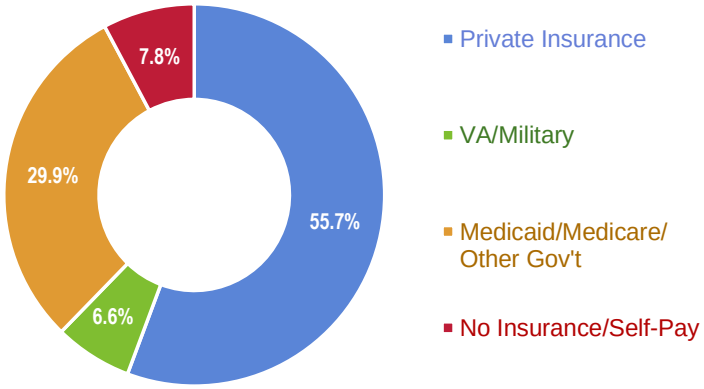
HEALTH INSURANCE COVERAGE

Type of Health Care Coverage

Survey respondents were asked a series of questions to determine their health care insurance coverage, if any, from either private or government-sponsored sources.

A total of 55.7% of St. Mary's Healthcare Service Area adults age 18 to 64 report having health care coverage through private insurance. Another 36.5% report coverage through a government-sponsored program (e.g., Medicaid, Medicare, military benefits).

Health Care Insurance Coverage
(Adults Age 18-64; St. Mary's Healthcare Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 137]
Notes: • Reflects respondents age 18 to 64.

Lack of Health Insurance Coverage

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus, excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

Among adults age 18 to 64, 7.8% report having no insurance coverage for health care expenses.

BENCHMARK ► Better than was found statewide. Satisfies the Healthy People 2030 objective.

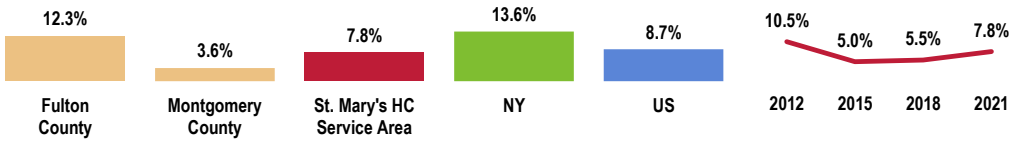
DISPARITY ► Higher in Fulton County. More often reported among male respondents, younger adults, and lower-income residents.

Lack of Health Care Insurance Coverage

(Adults Age 18-64)

Healthy People 2030 = 7.9% or Lower

St. Mary's Healthcare Service Area



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 137]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 New York data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents under the age of 65.

Lack of Health Care Insurance Coverage

(Adults Age 18-64; St. Mary's Healthcare Service Area, 2021)

Healthy People 2030 = 7.9% or Lower

Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 137]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents under the age of 65.

DIFFICULTIES ACCESSING HEALTH CARE

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Difficulties Accessing Services

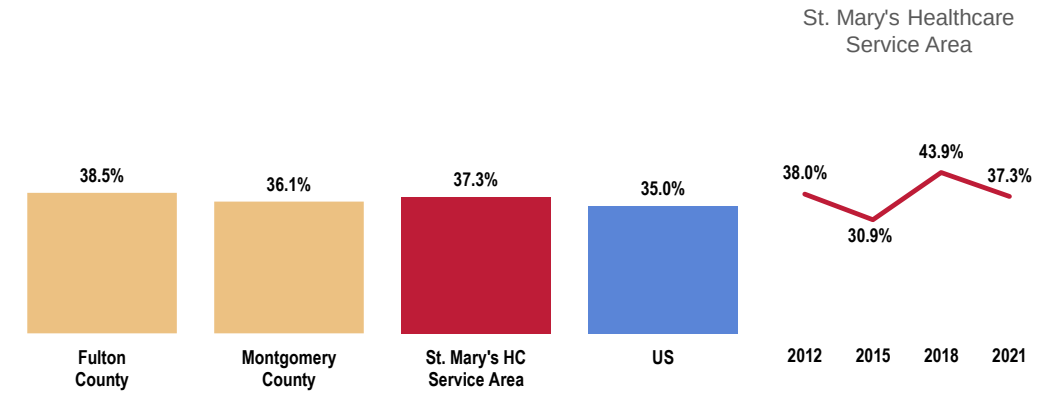
This indicator reflects the percentage of the total population experiencing problems accessing health care in the past year, regardless of whether they needed or sought care. It is based on reports of the barriers outlined in the following section.

A total of 37.3% of St. Mary's Healthcare Service Area adults report some type of difficulty or delay in obtaining health care services in the past year.

TREND ► Similar to baseline findings, but marks a significant decrease from the 2018 survey.

DISPARITY ► More often reported among women, young adults, and low-income residents.

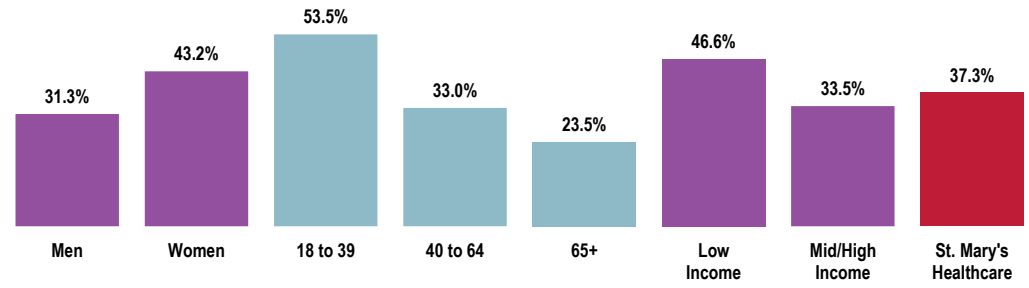
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 140]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Experienced Difficulties or Delays of Some Kind
in Receiving Needed Health Care in the Past Year
(St. Mary's Healthcare Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 140]
Notes: • Asked of all respondents.
• Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months.

Barriers to Health Care Access

To better understand health care access barriers, survey participants were asked whether any of seven types of barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

Again, these percentages reflect the total population, regardless of whether medical care was needed or sought.

Of the tested barriers, appointment availability impacted the greatest share of St. Mary's Healthcare Service Area adults.

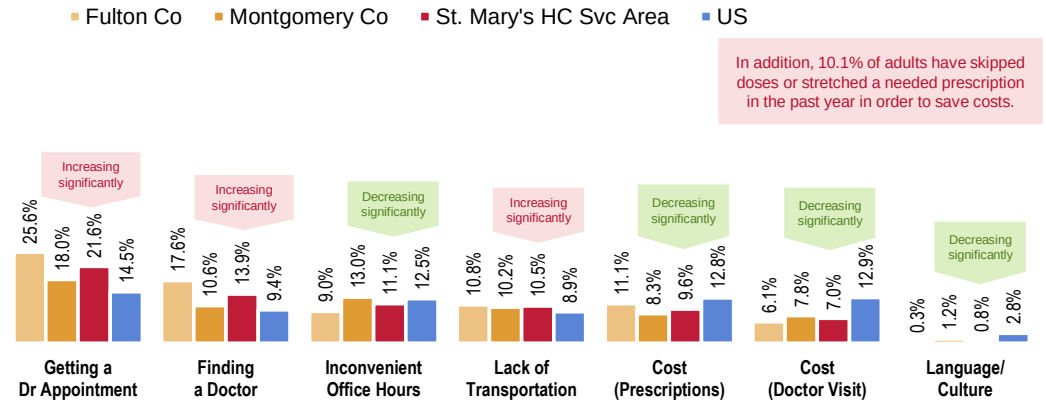
BENCHMARK ► Within the service area, three barriers compared favorably to corresponding national percentages: **cost of prescriptions**, **cost of a physician visit**, and **language/culture**. Two barriers compared unfavorably to national percentages: **appointment availability** and difficulty **finding a physician**.

TREND ► Since 2012, three barriers have worsened considerably (**appointment availability**, difficulty **finding a physician**, and lack of **transportation**), while three have improved considerably (inconvenient **office hours**, **cost of prescriptions**, and **cost of a physician visit**). Since 2018, **language/culture** as a barrier has improved.

DISPARITY ► Two barriers were unfavorably high in Fulton County: **appointment availability** and difficulty **finding a physician**.

Note also the percentage of adults who have skipped or reduced medication doses in the past year in order to stretch a prescription and save costs.

Barriers to Access Have Prevented Medical Care in the Past Year



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Items 7-14]
- 2020 PRC National Health Survey, PRC, Inc.

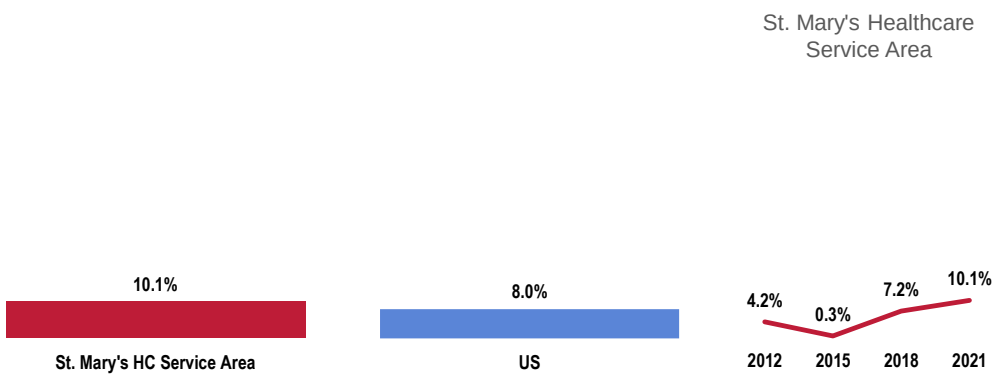
Notes:
- Asked of all respondents.

Accessing Health Care for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly selected child in their household.

A total of 10.1% of parents say there was a time in the past year when they needed medical care for their child but were unable to get it.

Had Trouble Obtaining Medical Care for Child in the Past Year
(Parents of Children 0-17)

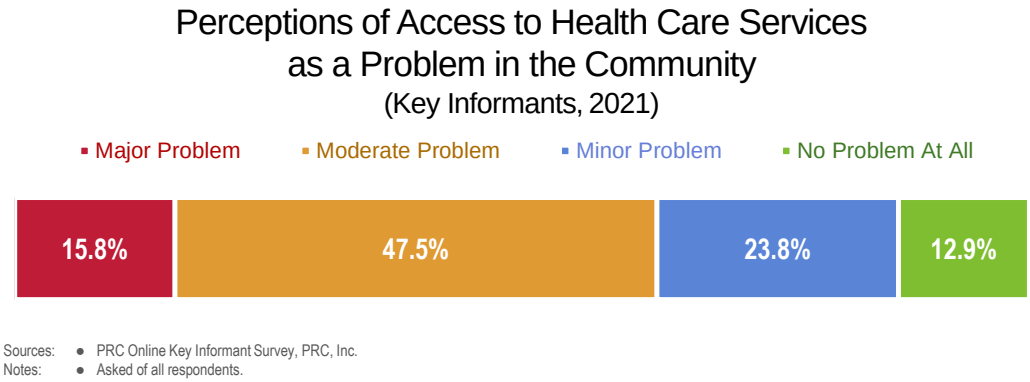


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 104]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

Key Informant Input: Access to Health Care Services

Key informants taking part in an online survey most often characterized *Access to Health Care Services* as a "moderate problem" in the community.



Among those rating this issue as a "major problem," reasons related to the following:

Transportation

> Transportation is a huge barrier to healthcare and patients complying with healthcare. – Other Health Provider
>
> Transportation to healthcare appointments or to the pharmacy for those without Medicaid benefits. Patients that fall out of the Medicaid eligibility limits or elderly do not have transportation to pick up their medications from the pharmacy or to medical appointments. – Social Services Provider
>
> Access to major medical services that require travel to the Capital District to obtain. – Community/Business Leaders
>
> Lack of public transportation is a huge issue that prevents people from being able to access their doctors. – Other Health Provider
>
> Transportation. – Community/Business Leaders
>
> Transportation is a big issue in our community. Many times people have difficulty getting to appointments. – Other Health Provider
>
> Transportation is our biggest barrier in our service area, especially in Amsterdam. There is no public transportation, other than taxis, and the taxi services are far too expensive for our poor and vulnerable population. We have taxi vouchers in the Mission office of St. Mary's, thankfully, and we are able to help many of our patients get back and forth to their appointments. – Public Health Representative
>
> In Montgomery County there is no public transportation and people share with me they do not feel comfortable calling a taxi service. They also see challenges or too many steps in calling their medical insurance to cover the cost of the taxi service and don't want to bother with the extra steps it takes. – Social Services Provider

Contributing Factors

> Access to health care due to lack of transportation and translation services (in person). Regarding immigrants, the fear to be reported to authorities. And overall, lack of education about the importance of Health Education and its impact in the long term. – Other Health Provider
>
> Transportation and understanding the healthcare system and medical terminology. – Other Health Provider
>
> Services are too rigid for our patient population to access. Our services should be set up to cater to the patient not for them to have to navigate our systems. Examples are the double registration (called prior to appointment and then registered with the same questions at time of visit.) Primary care should be set up as urgent cares to meet patient at their time of need and reduce the need for having two different service lines which can be confusing for patients. We should be asking patients about any transportation issues prior to their appointment to ensure there are no barriers to them coming, also ask if they have any financial concerns such as not being able to pay co-pays or recent loss of insurance. – Other Health Provider
>
> Timely access to health care, especially specialty care is an issue. Some of the delay is residually related to COVID shutdowns over the past year.; other delays are related to workforce shortages. With delay comes the complexity of presenting conditions seen by providers, especially in younger adult age groupings. – Other Health Provider

> Helping low income/high needs families to prioritize regular and preventive intervention. Access to health care is often "crisis-based" and, therefore, may not address broader issues or preventive care. Beliefs about medical care are based more on individual experiences or social interactions than they are on science and data. High need for education and cultural sensitivity in engaging others in health care. Utilize partnerships and trusted services. – Social Services Provider
>
> Pediatric services for Mental Health Issues. Not enough providers. Not enough trauma informed practitioners. Not enough variations on types of medication and treatment. Not enough in-patient services for adolescents and young children. Not enough out-patient interventions to support families and to help them learn ways of coping with their own mental health issues as well as their child's mental health. – Community/Business Leaders

Access to Care/Services

> More of an Emergency Room or Urgent Care problem for the sick. – Community/Business Leaders
>
> Uninsured and underinsured people, where have all the enrollment facilitators gone? – Community/Business Leaders
>
> Metal Health intake waiting periods are way too long. I took a woman to ER in June; intake appointment is end of October. I have a client who has just left rehab and is off suboxone for the first time and she can't find an in-person NA meeting in Montgomery or Fulton county. Zoom isn't enough for her. – Social Services Provider
>
> The process is too difficult, several calls, call backs, reschedules. – Social Services Provider
>
> Getting timely appointments. – Community/Business Leaders
>
> We continue to see issues with availability of specialists and delays to see them. We also have to travel an hour away many times for medical appts. Multiple transfers from Nathan Littauer Hospital to higher level care as they are not able to meet the patient needs. – Other Health Provider

Specialty Care

> Our region does not have a dermatologist and they are hard to recruit to our rural upstate county. – Community/Business Leaders
>
> Dermatology. – Physician
>
> Endocrinology. – Social Services Provider

Affordable Care/Services

> Cost and availability. – Community/Business Leaders
>
> Regular health care providers are costly and not always available to individuals. – Community/Business Leaders

Health Literacy

> Medical illiteracy mostly due to a low socioeconomic area. – Other Health Provider

Language Barriers

> Persons who do not speak English have great barriers to obtaining care, e.g. mothers who cannot call and make an appointment for their children or explain why the child needs to be seen if they don't speak English. – Social Services Provider

Vulnerable Populations

> Seniors that have had a health problem or who have been drained of all their financial resources don't really have a strong advocate to go to and get results, only sympathy. – Community/Business Leaders

Poverty

> Poverty. It can lead to all the other health issues mentioned in this survey. – Community/Business Leaders

PRIMARY CARE SERVICES

ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

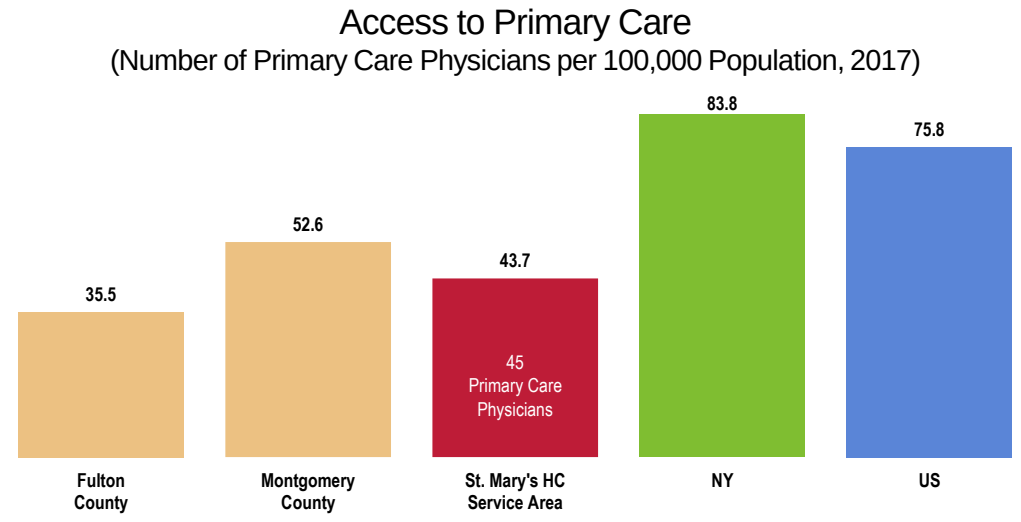
– Healthy People 2030 (https://health.gov/healthypeople)

Access to Primary Care

In 2017, there were 45 primary care physicians in the St. Mary's Healthcare Service Area, translating to a rate of 43.7 primary care physicians per 100,000 population.

BENCHMARK ► Much lower than state and national proportions.

DISPARITY ► Lowest in Fulton County.



Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved September 2021 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Specific Source of Ongoing Care

Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of "patient-centered medical homes" (PCMH).

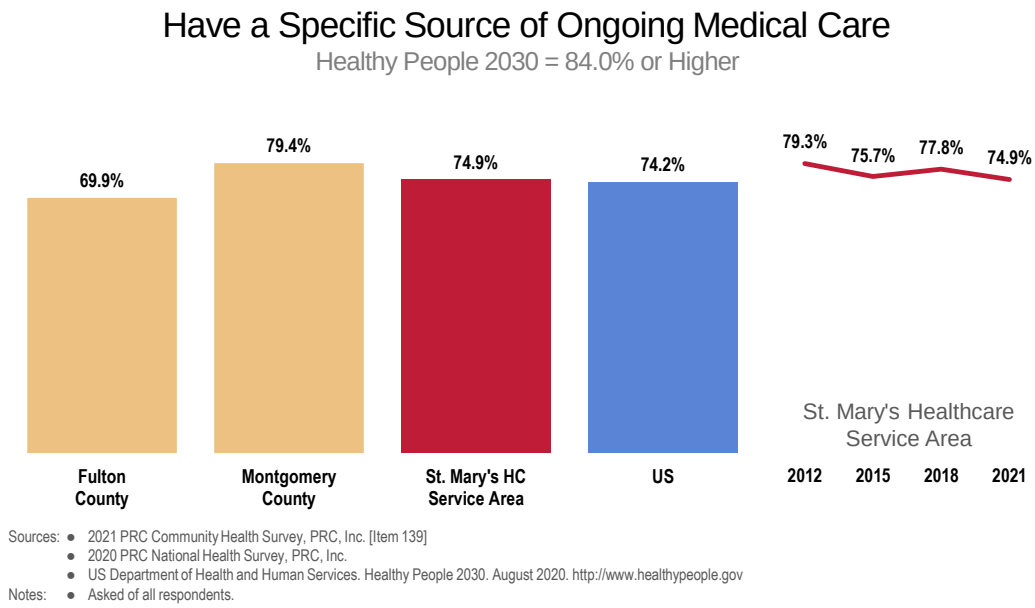
A hospital emergency room is not considered a specific source of ongoing care in this instance.

A total of 74.9% of St. Mary's Healthcare Service Area adults were determined to have a specific source of ongoing medical care.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

TREND ► Significantly lower than the 2012 benchmark.

DISPARITY ► Lower in Fulton County.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 139]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Utilization of Primary Care Services

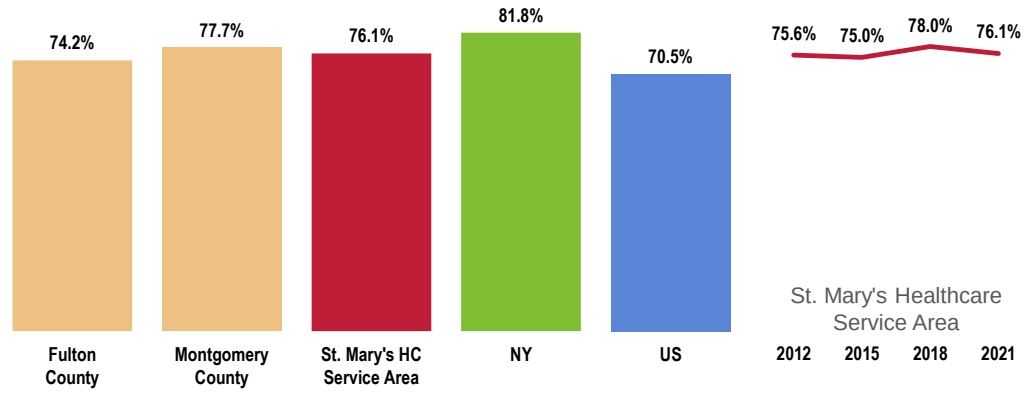
Adults

More than three-fourths of adults (76.1%) visited a physician for a routine checkup in the past year.

BENCHMARK ► Less favorable than the statewide percentage but more favorable than the national percentage.

DISPARITY ► Those less likely to report having a checkup include adults younger than 65 and those with lower incomes.

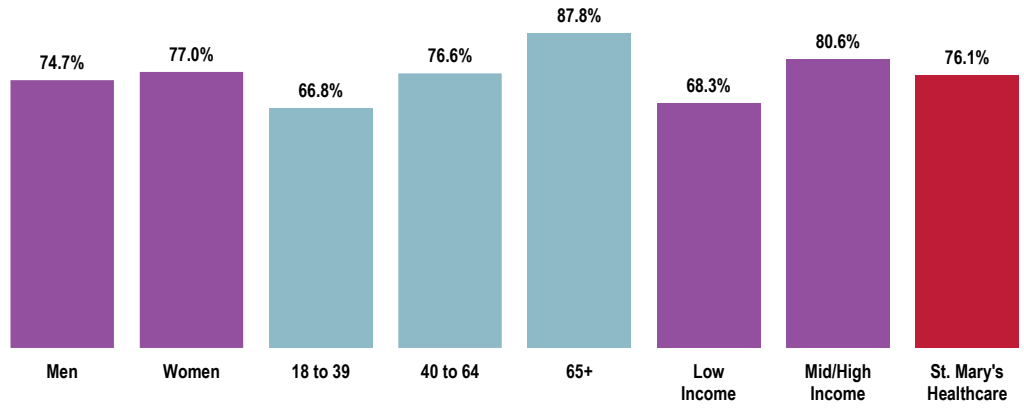
Have Visited a Physician for a Checkup in the Past Year



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 18]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 New York data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Have Visited a Physician for a Checkup in the Past Year
(St. Mary's Healthcare Service Area, 2021)



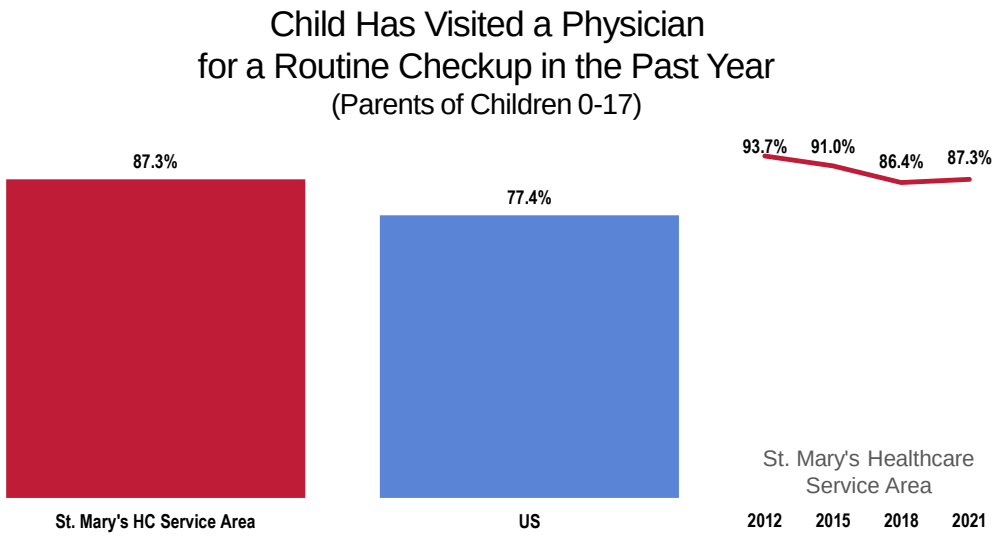
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 18]

Notes:
- Asked of all respondents.

Children

Among surveyed parents, 87.3% report that their child has had a routine checkup in the past year.

BENCHMARK ► Better than was found across the US.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 105]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

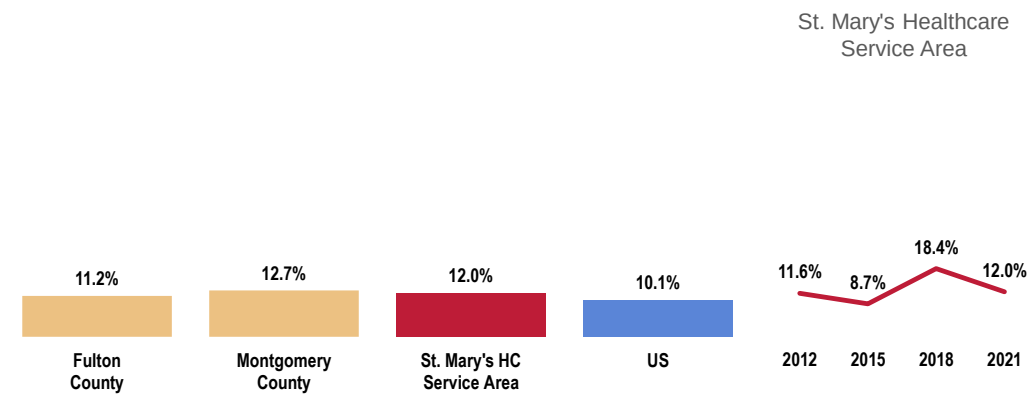
EMERGENCY ROOM UTILIZATION

A total of 12.0% of St. Mary's Healthcare Service Area adults have gone to a hospital emergency room more than once in the past year about their own health.

TREND ► Similar to baseline findings, but denotes a significant decrease since 2018.

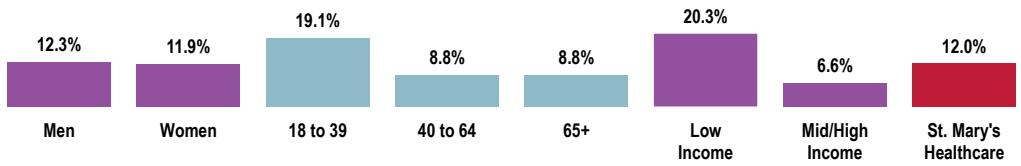
DISPARITY ► ER utilization was higher among young adults and lower-income residents.

Have Used a Hospital Emergency Room More Than Once in the Past Year



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 22]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Have Used a Hospital Emergency Room More Than Once in the Past Year
(St. Mary's Healthcare Service Area, 2021)



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 22]
Notes: ● Asked of all respondents.

ORAL HEALTH

ABOUT ORAL HEALTH

Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

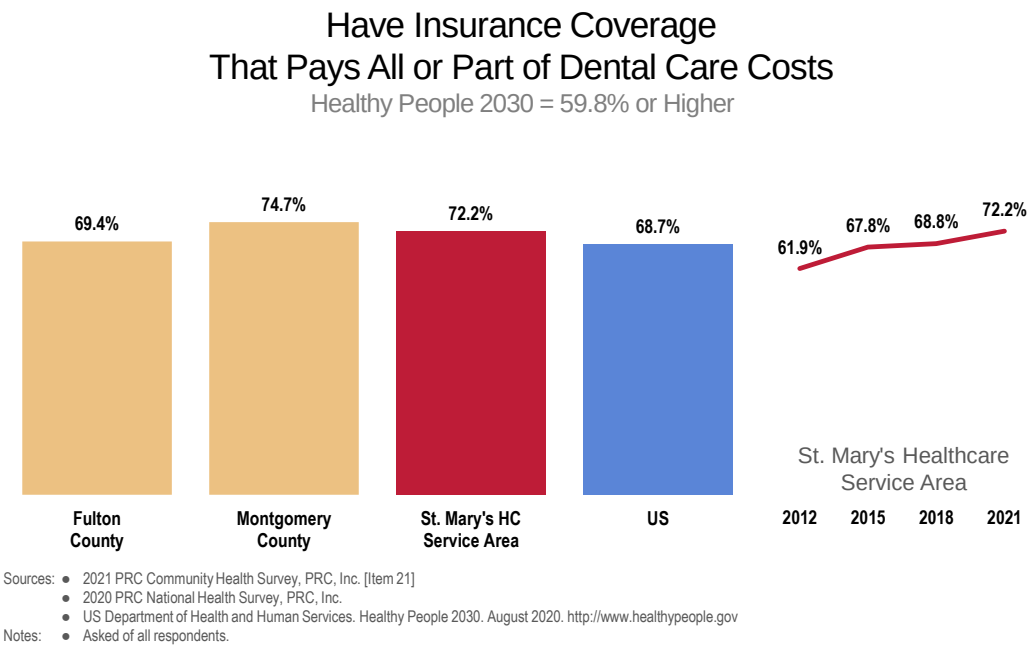
– Healthy People 2030 (https://health.gov/healthypeople)

Dental Insurance

Nearly three-fourths of St. Mary's Healthcare Service Area adults (72.2%) have dental insurance that covers all or part of their dental care costs.

BENCHMARK ► Satisfies the Healthy People 2030 objective.

TREND ► Rising favorably within the service area.



Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 21]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Dental Care

Adults

A total of 58.5% of St. Mary's Healthcare Service Area adults have visited a dentist or dental clinic (for any reason) in the past year.

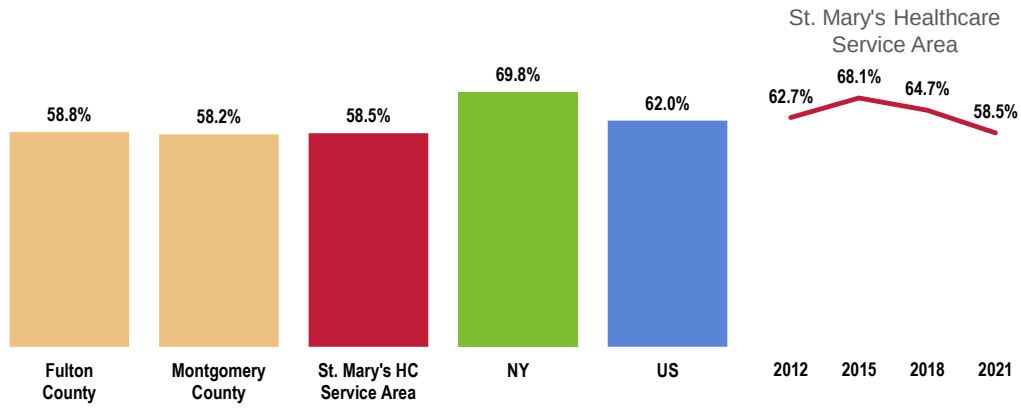
BENCHMARK ► Less favorable than the state figure. Satisfies the Healthy People 2030 objective.

TREND ► Continuing a significant decline within the service area.

DISPARITY ► Those less likely to receive dental care include lower-income adults and those without dental insurance.

Have Visited a Dentist or Dental Clinic Within the Past Year

Healthy People 2030 = 45.0% or Higher



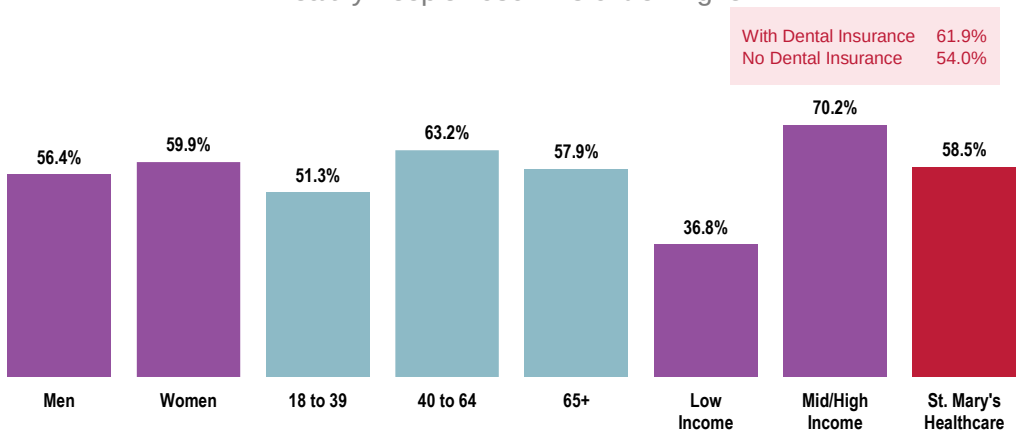
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 20]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 New York data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Have Visited a Dentist or Dental Clinic Within the Past Year

(St. Mary's Healthcare Service Area, 2021)

Healthy People 2030 = 45.0% or Higher



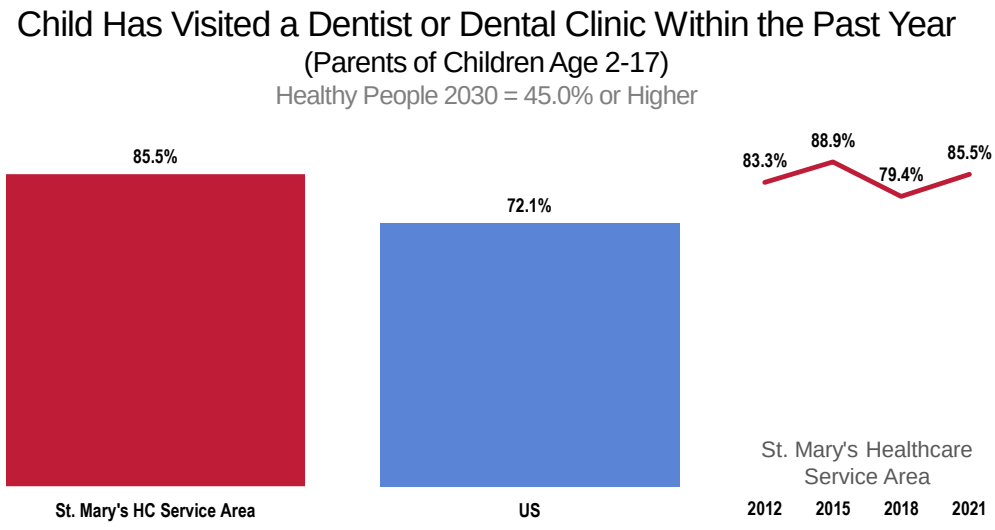
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 20]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Children

A total of 85.5% of parents report that their child (age 2 to 17) has been to a dentist or dental clinic within the past year.

BENCHMARK ► Better than was found across the US. Satisfies the Healthy People 2030 objective.

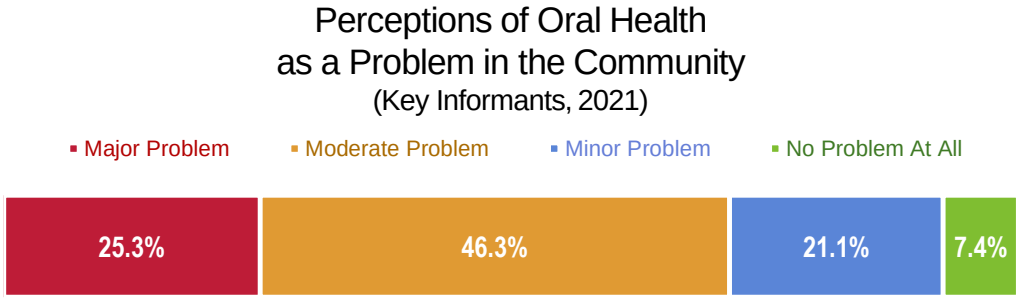


Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 108]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents with children age 2 through 17.

Key Informant Input: Oral Health

Key informants taking part in an online survey most often characterized *Oral Health* as a "moderate problem" in the community.



Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

Access for Medicare/Medicaid Patients

> Not enough providers that accept Medicaid. – Social Services Provider
>
> People with Medicaid don't have access to dentists. Currently there is one place that accepts Medicaid for dental work. It is my understanding that appointments are hard to get as the dentist is there on a limited basis. – Social Services Provider
>
> Lack of providers who accept Medicaid. – Social Services Provider
>
> Lack of access to dentists that accept Medicaid. Cost of care for privately insured. – Social Services Provider
>
> Lack of dentists who accept Medicaid. – Community/Business Leaders
>
> There is a very limited number of providers that take Medicaid for oral health services. – Other Health Provider

Contributing Factors

> I only know of one low-cost dental facility covering an area with a high percentage of people receiving Medicaid. People cannot afford to pay out of pocket for dental services when they are on a tight/fixed budget...feeding the family and keeping the heat on is more important. The cost of dental care is ridiculous. Also, more focus needs to be put on infants and young children through educating their parents on how important oral health is for whole-body health. I believe this is a generational issue and people are merely living what they have been taught, we need to try to break the cycle. – Community/Business Leaders
>
> I have referred persons for dental care at the FQHC in Amsterdam and they are scheduling new patients more than four months out. – Social Services Provider
>
> Lack of fluoride in the water and lack of good oral hygiene. – Physician
>
> Not important to many people. – Community/Business Leaders
>
> Many of the families I have worked with do not get preventive oral care for their children until major dental issues occur. Waitlists for dental care in this region are long. – Social Services Provider

Affordable Care/Services

> Lack of affordable dental care. – Social Services Provider
>
> Dental care is very expensive and most insurances do not cover it fully. – Community/Business Leaders

Awareness/Education

> Lack of health education on oral health and how it can also affect other parts of your body. – Other Health Provider
>
> I do not believe there's enough education overall on the importance of oral hygiene and how it leads to cardiovascular disease, stroke, etc. We certainly do not do enough education on it in this community. – Public Health Representative

Access to Care for Uninsured/Underinsured

> Lack of insurance, providers not taking new patients. – Community/Business Leaders

Incidence/Prevalence

> Oral cancer is on the rise. – Social Services Provider

VISION CARE

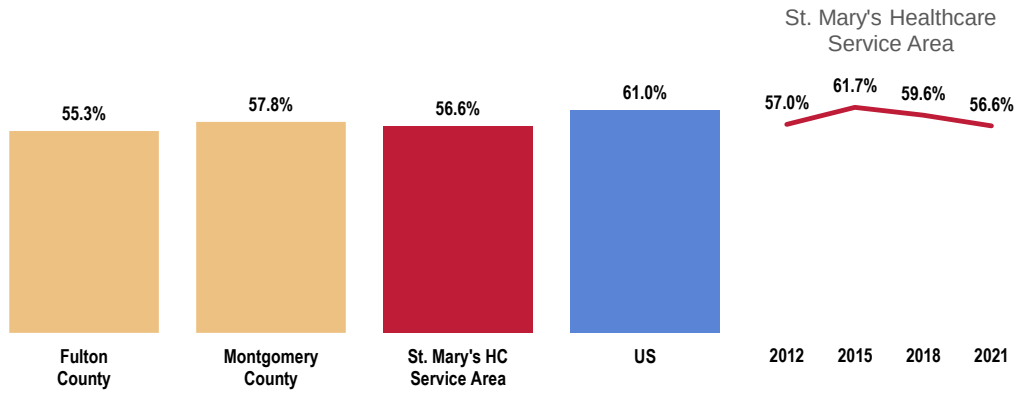
A total of 56.6% of St. Mary's Healthcare Service Area residents had an eye exam in the past two years during which their pupils were dilated.

BENCHMARK ► Fails to satisfy the Healthy People 2030 objective.

DISPARITY ► Those less likely to receive vision care include men and adults younger than 65.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

Healthy People 2030 = 61.1% or Higher



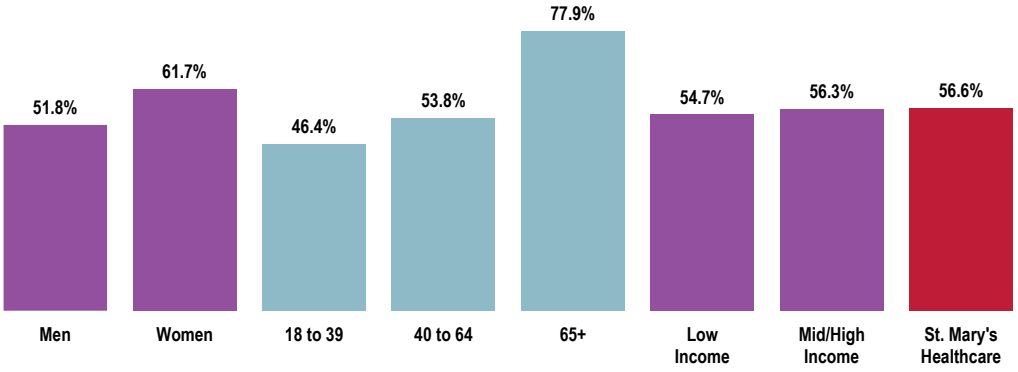
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 19]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated

(St. Mary's Healthcare Service Area, 2021)

Healthy People 2030 = 61.1% or Higher



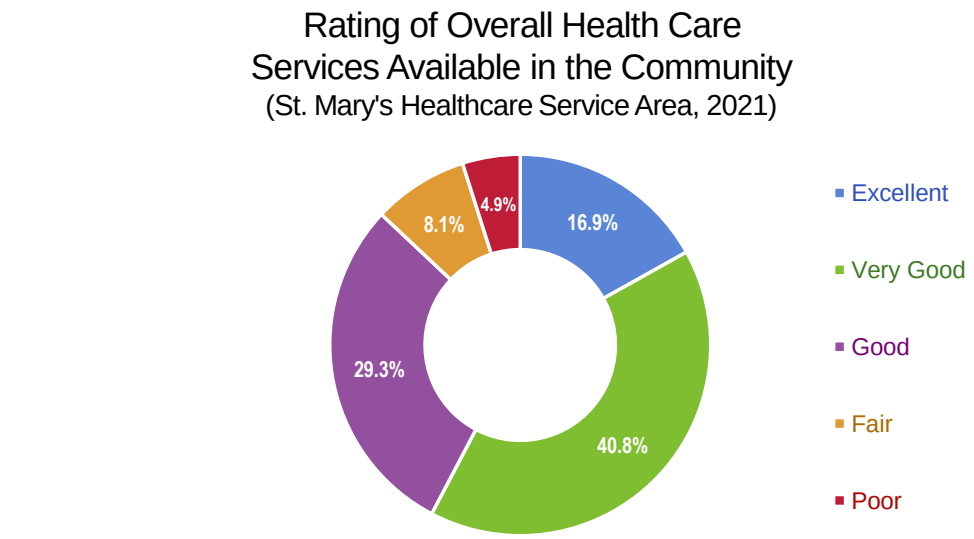
Sources:
- 2021 PRC Community Health Survey, PRC, Inc. [Item 19]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

LOCAL RESOURCES

PERCEPTIONS OF LOCAL HEALTH CARE SERVICES

A majority of St. Mary's Healthcare Service Area adults rate the overall health care services available in their community as "excellent" or "very good."



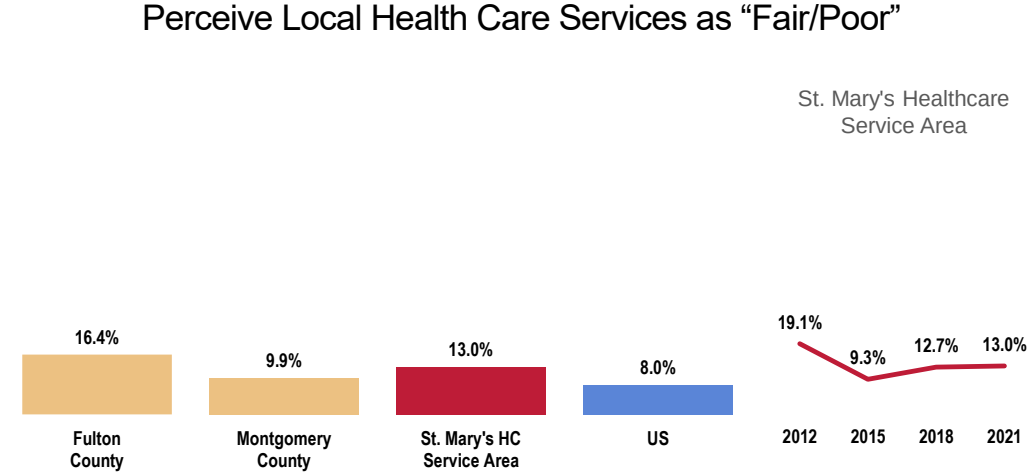
Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 6]
Notes: ● Asked of all respondents.

However, 13.0% of residents characterize local health care services as "fair" or "poor."

BENCHMARK ► Worse than the national percentage.

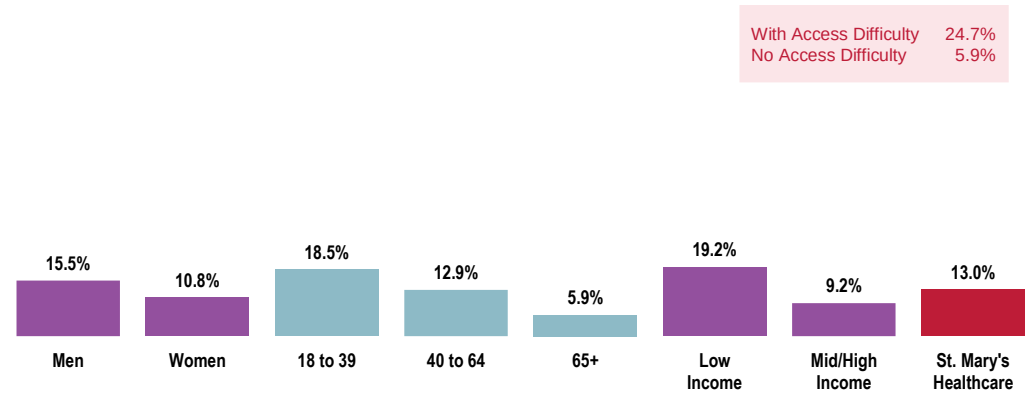
TREND ► Significantly lower than the 2012 benchmark.

DISPARITY ► Unfavorably high in Fulton County. "Fair" and "poor" ratings were more often reported among adults younger than 65, lower-income households, and those who have difficulty accessing services.



Sources: ● 2021 PRC Community Health Survey, PRC, Inc. [Item 6]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Perceive Local Health Care Services as “Fair/Poor”
(St. Mary's Healthcare Service Area, 2021)



Sources: • 2021 PRC Community Health Survey, PRC, Inc. [Item 6]
Notes: • Asked of all respondents.

Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- Access Transportation Services
- American Heart Association
- Case Management
- Catholic Charities
- CC Moves
- Centro Civico
- Doctor's Offices
- Family Counseling Center
- Family Health Center
- Four Winds Psychiatric Hospital
- Fulmont Community Action Agency
- Fulton/Montgomery County Mental Health
- Hospitals
- Medicaid Transportation
- Medical Village at Rao Outpatient Pavilion
- Mental Health Association
- Montgomery County Department of Social Services
- Montgomery County Office For the Aging
- Nathan Littauer Hospital
- New Dimensions
- Office For the Aging
- Red Cross
- School System
- Social Workers
- St. Mary's Healthcare Diabetes Center
- St. Mary's Healthcare Mental Health
- St. Mary's Healthcare Mission Department
- St. Mary's Hospital
- The ARC Lexington

Cancer

- American Cancer Society
- Cancer Center, Roa Pavilion
- Cancer Prevention in Action
- Cancer Prevention Services
- Cancer Screening Services
- Cancer Services of Fulton, Montgomery, Schenectady
- Doctor's Offices
- Free Mammogram Program
- Healthlink
- Hospice
- Hospitals
- New York Oncology and Hematology
- Nathan Littauer Hospital
- New York Oncology Hematology
- Oncology Hematology Associates
- Rao Cancer Center
- St. Mary's Healthcare
- St. Mary's Healthcare Cancer Center
- Tesiero Cancer Center

Coronavirus

- Area Agency on Aging
- Centro Civico
- Community Health Center
- Community Leaders
- Doctor's Offices
- Employers
- Fulton County Public Health
- Fulton/Montgomery County Public Health Department
- Health Home Care Management
- Hospitals
- Local Government
- Montgomery County Public Health
- New York State Department of Health
- New York State Hotline
- Nathan Littauer Hospital
- Office For the Aging
- Palmer Pharmacy
- Pharmacies
- Public Health Department
- Rite Aid Pharmacy
- St. Mary's Healthcare
- Volunteers
- Walmart

Chronic Kidney Disease

- Dialysis Services
- Nathan Littauer Hospital

Dementia/Alzheimer's Disease

- Albany Neurology Group
- Alzheimer's Association
- Alzheimer's Association of NENY
- Alzheimers.org
- Area Agency on Aging
- Capstone Nursing Home
- Catholic Charities
- Community Health Center
- Dementia Care Group
- Eddy's Alzheimer's Services
- Fulton County Office For the Aging
- Healthlink
- Home Care
- Hospitals
- Memory Care Facilities
- Mental Health Association
- Nathan Littauer Hospital
- Nathan Littauer Hospital
- Nursing Home Transition and Diversion Program
- Office For the Aging
- Resource Center for Independent Living
- River Ridge Nursing Home
- St. Johnsville Nursing Home
- St. Mary's Healthcare
- St. Mary's Healthcare Mobile Geriatric Program
- St. Mary's Healthcare Palliative Care
- Support Groups
- Wells Nursing Home
- Wilkinson Residential Health Care Facility

Diabetes

- Albany Endocrine Specialty
- Amsterdam Dialysis
- Amsterdam Family Practice
- Amsterdam Minority Health Task Force
- Area Agency on Aging
- Catholic Charities
- CC Moves
- Centro Civico
- Churches
- Community Food Drops
- Community Health Center
- Diabetes and Medical Nutrition Services
- Diabetes and Nutrition Education Center
- Diabetes Center
- Diabetes Center at Memorial Campus
- Diabetes Education
- Diabetes Prevention Program
- Diabetes Support Group
- Dialysis Services
- Doctor's Offices
- Ellis Hospital
- Farmer's Markets
- Food Distributions
- Food Farmacy
- Greater Amsterdam School District
- Health Department
- Healthlink
- Home Health Care Partners
- Hospitals
- Indigent Programs From the Manufacturer
- Integrated Care Model
- Mental Health Services
- Montgomery County Office For the Aging
- Montgomery County Public Health
- Nathan Littauer Hospital
- Pharmacies
- Public Health Department
- School System
- St. Mary's Healthcare
- St. Mary's Healthcare Diabetes Center
- St. Mary's Healthcare Primary Care
- St. Mary's Healthcare Teaching Kitchen
- St. Mary's Hospital
- The ARC Lexington
- WIC

Disabilities

- Albany Med Neurology
- Alpin Haus
- Chiropractic and Massage Services
- Doctor's Offices
- Fleming Physical Therapy
- Healthlink
- Home Care
- Lexington
- Liberty
- Mohawk Valley Orthopedics
- Nathan Littauer
- Nathan Littauer Hospital
- Palliative Care
- Physical Therapy
- Planet Fitness
- RCIL/LIFE
- Resource Center for Independent Living
- St. Mary's Healthcare
- St. Mary's Healthcare Behavioral Health
- St. Mary's Healthcare Primary Care
- St. Mary's Hospital
- Support Groups

Infant Health and Family Planning

- Abbey Ballard's Religious Organization

- Alpha Pregnancy Center
- Amsterdam OBGYN
- Catholic Charities
- Court Appointed Parenting Classes
- Creative Connections Clubhouse
- Department of Health
- Doctor's Offices
- Family Care Program
- Fulmont Community Action Agency
- Hospitals
- Nathan Littauer Hospital
- Planned Parenthood
- St. Mary's Healthcare
- St. Mary's Hospital
- WIC
- Women's Health

Heart Disease

- Alpin Haus
- American Heart Association
- Cardiac Rehabilitation Program
- Community Food Drops
- Department of Health
- Diabetes and Nutrition Education Center
- Diabetes Prevention Program
- Doctor's Offices
- Ellis Cardiac Care Center
- Ellis Stroke Center
- Food Farmacy
- Healthlink
- Hospitals
- Montgomery County Public Health
- Nathan Littauer Hospital
- Project Action
- Schenectady Cardiology
- St. Mary's Healthcare
- St. Mary's Healthcare Outpatient Cardiac Rehab
- St. Mary's Hospital
- Walking Program

Injury and Violence

- 911
- Amsterdam Police
- Catholic Charities
- Community Events
- Counseling Center
- Counseling Services
- Creative Connections Clubhouse
- DA Offices
- Department of Health
- Family Counseling Center
- Fulton/Montgomery County Mental Health
- HFM Prevention
- Hospitals
- Law Enforcement
- Mental Health Services
- Montgomery County Public Health
- School System
- St. Mary's Healthcare
- St. Mary's Healthcare Mental Health

Mental Health

- Addiction Center
- Adult Behavioral Health Clinic
- Amsterdam Police
- Bassett Hospital
- Behavioral Health Services
- Berkshire Farm Family Support
- Catholic Charities
- Centro Civico
- Children's Behavioral Health Clinic
- Collaborative Care
- Coordinated Children's Services Initiative
- Cornerstone Counseling
- Counseling Services
- Crisis Hotline
- Danielle's House
- Department of Health
- Doctor's Offices
- Employee Assistance Program
- Ellis Hospital
- Employers
- Family Counseling Center
- Friends/Family
- Fulton County Addiction Program
- Fulton County Mental Health
- Fulton Family Center
- Fulton/Montgomery Co Directors of Community Services
- Fulton/Montgomery County Mental Health
- Health Home Program
- HFM Prevention
- Hospitals
- Law Enforcement
- Liberty ARC of Montgomery County
- Managed Care Plan Behavioral Health Programs
- Mental Health Association
- Mental Health Services
- Montgomery County Addiction Program
- Montgomery County Mental Health
- Montgomery County Public Health
- Montgomery Transitional Services
- NAMI

- Office of Mental Health
- Private Therapists
- School System
- Social Services
- Single Point of Accountability
- St. Mary's Healthcare
- St. Mary's Healthcare Addiction Programs
- St. Mary's Healthcare Behavioral Health
- St. Mary's Healthcare Home Program
- St. Mary's Healthcare Mental Health
- St. Mary's Healthcare Mobile Geriatric Program
- St. Mary's Healthcare PROS Program
- St. Mary's Hospital
- The ARC Lexington

Nutrition, Physical Activity, and Weight

- Alpin Haus
- Blooming Lotus Yoga
- Boxing Program at Clock Tower
- Catholic Charities
- Creative Connections Clubhouse
- Department of Health
- Diabetes and Nutrition Education Center
- Diabetes Prevention Program
- Doctor's Offices
- Farmer's Markets
- Fitness Centers/Gyms
- Food Banks
- Food Drives
- Food Farmacy
- Food Pantries
- Gateway Bridge and Veteran's Field
- Greater Amsterdam School District
- Healthlink
- Hospitals
- Inman Center
- Mohawk Harvest Market
- Montgomery County Office For the Aging
- Montgomery County Public Health
- Nathan Littauer Hospital
- Nutrition Services
- Office for the Aging
- Parks and Recreation
- Planet Fitness
- Public Health Department
- Regional Food Bank
- Rogers Orchard
- School System
- Senior Centers
- Sports Leagues
- St. Mary's Healthcare
- St. Mary's Healthcare Diabetes Center
- St. Mary's Healthcare Food Pantry
- St. Mary's Healthcare Mental Health
- St. Mary's Healthcare Primary Care
- St. Mary's Healthcare Teaching Kitchen
- St. Mary's Hospital
- TOPS, Inc.
- Tribe Fitness
- Weight Watchers
- WIC
- YMCA

Oral Health

- Aspen Dental
- Cancer Prevention in Action
- Dentist's Offices
- Doctor's Offices
- Medicaid
- New Dimensions
- Perth Dental
- Primary Teeth
- Smile Lodge

Respiratory Diseases

- Adirondack Air
- Centro Civico
- Community Health Center
- Doctor's Offices
- Greater Amsterdam School District
- Health Home Program
- Montgomery County Public Health
- New York State Smoke Free Coalition
- Nathan Littauer Hospital
- Project Action
- Respiratory Therapy
- Schenectady Pulmonology
- Schenectady Respiratory Care
- St. Mary's Healthcare
- St. Mary's Healthcare Primary Care
- St. Mary's Healthcare Pulmonary Rehab
- St. Mary's Hospital
- The Butt Stops Here

Sexual Health

- Captain's Community/Street Outreach
- Centro Civico
- Doctor's Offices
- Hometown Health
- Nathan Littauer Hospital Primary Care
- Planned Parenthood
- School System

- St. Mary's Healthcare
- St. Mary's Healthcare Primary Care

Substance Abuse

- AA/NA
- Ambulatory Withdrawal Program
- Care Management Services
- Catholic Charities
- Conifer Park
- Doctor's Offices
- Drug Court
- Family Counseling Center
- Fulton County Addiction Program
- Healthlink
- HFM Prevention
- Hope House
- Hospitality House
- Hospitals
- Inpatient Addiction Services
- Law Enforcement
- Medi-Cab Services
- Memorial Campus
- Mental Health Association
- Mental Health Services
- Methadone Clinic
- Montgomery County Addiction Program
- Montgomery County Public Health
- Nathan Littauer Hospital
- New Choices
- OASAS
- Private Cab Services
- Rob Constantine Recovery Center
- School System
- Social Services
- St. Mary's Healthcare
- St. Mary's Healthcare Addiction Programs
- St. Mary's Healthcare Behavioral Health
- St. Mary's Healthcare Mental Health
- St. Mary's Healthcare Primary Care
- St. Mary's Healthcare PROS Program
- St. Mary's Hospital
- Suboxone Clinic

Tobacco Use

- Advancing Tobacco-Free Communities
- Catholic Charities
- Churches
- Community Outreach Program
- Doctor's Offices
- Family Counseling Center
- Healthlink
- HFM Prevention
- Hospitals
- Hypnotist
- Mental Health Association
- New York State Smoke Free Coalition
- Pharmacies
- Project Action
- School System
- Smoking Cessation Programs
- St. Mary's Healthcare
- St. Mary's Healthcare Addiction Programs
- The Butt Stops Here
- Tobacco Free Coalition
- Vaping Stores

APPENDIX

EVALUATION OF PAST ACTIVITIES

Addressing Significant Health Needs

St. Mary's Healthcare conducted its last CHNA in 2018 and reviewed the health priorities identified through that assessment. Taking into account the top-identified needs — as well as hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined at that time that St Mary's Healthcare would focus on developing and/or supporting strategies and initiatives to improve:

- Substance Abuse/Mental Health
- Nutrition, Physical Activity, and Weight (Prevent Diabetes)

Strategies for addressing these needs were outlined in St. Mary's Healthcare's Implementation Strategy. Pursuant to IRS requirements, the following sections provide an evaluation of the impact of the actions taken by St. Mary's Healthcare to address these significant health needs in our community.

Evaluation of Impact

Priority Area: Substance Abuse/Mental Health	
Community Health Need	Improve mental health services in Primary Care and Behavioral Health.
Goal(s)	Utilize a trauma-informed model of care approach to promote, support, and treat patients across the continuum of care with collaboration among Behavioral Health, Substance Abuse, and Primary Care Providers.

Strategy 1: Expand Collaboration to become a Trauma Informed Community to promote well-being	
Strategy Was Implemented?	Yes
Target Population(s)	Patients affected by Mental, Emotional, and Behavioral (MEB) Disorders
Partnering Organization(s)	• Montgomery County Social Services • Mental Health Association of Fulton and Montgomery Counties • Fulton and Montgomery Departments of Public Health • City of Amsterdam • The Alliance for Better Health • Catholic Charities of Fulton and Montgomery Counties
Results/Impact	• Our Amsterdam and Johnstown Family Health Centers have adopted a Collaborative Care Approach for Behavioral Health. Behavior health care managers help to coordinate behavioral health appointments and communicate patient needs to primary care providers to ensure that patients' physical and behavioral health needs are being met. • The social determinants of health (SDoH),PHQ-2 and PHQ-9 screening tools have been incorporated into Primary Care Clinics workflow to better address patients' mental health needs. Patients are asked the SDoH questionnaire at initial appointments, whereas PH-2 and PHQ-9 screening occurring at every visit. • Trauma Informed Care Collaborative meetings were being held monthly, however, due to the COVID-19 Public Health Emergency, they were put on hold. Training in the delivery of Trauma Informed Care Model was still completed. A total of 20 RNs in the Nurse Residency program have been trained in the delivery of Trauma Informed Care Model.

Strategy 2: Collaborate with community partners to provide treatment referrals, peer and recovery coach support, and relapse prevention and aftercare to patients using harm-reduction health resources.	
Strategy Was Implemented?	Yes
Target Population(s)	Persons impacted by overdose including non-medical use of prescription drugs
Partnering Organization(s)	• Montgomery County Public Health • Catholic Charities of Fulton and Montgomery Counties • Amsterdam Police Department • Mental Health Association of Fulton and Montgomery Counties • Prevention Council of Hamilton, Fulton, and Montgomery Counties • Montgomery County Allies in Prevention • Centro Civico • Montgomery County Emergency Management • Montgomery County Department of Social Services • Fulton County Department of Social Services • Montgomery County Office of the Aging
Results/Impact	• St. Mary's walk-in outpatient detox program located in the Memorial Campus has helped to increase the access to Medication-assisted treatment (MAT) and overdose reversal (Naloxone). This outpatient detox program has also increased the availability of/access to overdose reversal training to prescribers, pharmacists, and consumers. • St. Mary's participates in the Overdose Task Force led by Montgomery County Public Health to better coordinate efforts to reduce drug overdoses and drug-related deaths in Montgomery County. • Although St. Mary's does not have established permanent safe disposal sites for prescription drugs, behavioral health staff will direct any patient inquiries to the Amsterdam Police Department for safe disposal sites.

Priority Area: Nutrition, Physical Activity, and Weight (Prevent Diabetes)	
Community Health Need	Improve access to nutrition education programs in Fulton/Montgomery Counties.
Goal(s)	• Decrease obesity and Diabetes

Strategy 1: Increase availability of, access to, and enrollment in evidence-based diabetes prevention lifestyle change program (Diabetes Prevention Program-DPP)	
Strategy Was Implemented?	Yes
Target Population(s)	Adults with diagnosis of pre-diabetes or adults at high risk for type 2 diabetes
Partnering Organization(s)	Internal: • St. Mary's Healthcare Primary Care Clinics External: • Fulton and Montgomery County Health Departments • Montgomery County Office of the Aging • Catholic Charities of Fulton and Montgomery Counties
Results/Impact	• St. Mary's Healthcare Diabetes Prevention Program's first cohort had a total of 7 participants complete the year long lifestyle change program. Participants lost a total of 113 pounds (Loss of 6% total baseline body weight) • Throughout the program, participants learned how to make healthy food choices, ways to increase physical activity levels, and manage stress to overall prevent or delay the Development of Type 2 Diabetes. • Participants reported at the end of the program that physical activity is a part of their daily routine and that they make healthier food and beverage choices to help reduce the risk of developing type 2 diabetes. • St. Mary's Healthcare Diabetes Prevention Program was awarded with Full Recognition Status from the CDC in January 2021.

Strategy 2: Create community environments that support physical activity and healthy food and beverage choices	
Strategy Was Implemented?	Yes
Target Population(s)	Community members in neighborhoods without access to health food- adults and children
Partnering Organization(s)	External: • Catholic Charities of Fulton and Montgomery Counties • Peer Educators- New York State Department of Health • Montgomery office of the aging • City of Amsterdam • Fulmont Community Action Agency • Fulton and Montgomery Counties Departments of Social Services • Fulton and Montgomery Counties Department of Public Health
Results/Impact	• The Cancer Peer Education Walking Program encourages a healthier lifestyle though walking in a monitored group setting. Additional resources related to cardiac rehab, diabetes prevention/nutrition, sports medicine and cancer peer education were provided at these weekly sessions. Healthy snacks and beverages offered to participants as well. • St. Mary's Healthcare's Teaching Kitchen was established to help our community to learn how to prepare healthy meals for themselves and their families. Cooking Demos were held in collaboration with our Diabetes Prevention Program, along with Catholic Charities Food Farmacy. • The Catholic Charities Food Farmacy located in the St. Mary's Memorial Campus is intended to provide temporary food assistance to those identified as being at risk for food insecurity. The Food Farmacy is staffed with a Registered Dietitian to provide clients with nutrition education and a Case Manager to help connect clients with additional resources within the community.