# 2022 Community Health Needs Assessment

Garnet Health Medical Center- Catskills, Harris Campus
Garnet Health Medical Center- Catskills, Callicoon

Garnet Health
MEDICAL CENTER
Catskills

CHNA Executive Summary

About our Community

Key Health Indicators

Community Input

Prioritized Health Needs

# Garnet Health Medical Center – Catskills 2022 CHNA

Garnet Health Medical Center - Catskills' (hereafter referred to as "GHMC – C") main Harris campus is a 154-bed facility. As a community hospital in tune with public health needs, we also provide access to education and training for our health care workers and members of the community. We are committed to delivering patient-centered quality health care in a healing environment, and the hospital's compassionate staff provides attentively to the needs of patients and their families. GHMC – C also includes the Grover M. Hermann Hospital division with is located 2 miles south of the village of Callicoon. Garnet Health Medical Center - C's Grover M. Hermann Hospital (Callicoon campus) is a 15-bed facility.

GHMC – C's mission is to improve the health of our community by providing exceptional healthcare. GHMC – C fulfills its mission by focusing on the following core values in order to be recognized as the leading health care organization in the region: Patients and families first, Respect and Civility

GHMC – C desires to continue providing clinical programs and services to meet community needs, while also pursuing continuous improvement in existing and future programs to improve the overall health of the community it serves. As such, GHMC – C partnered with HealthConnections and Crowe LLP to conduct a Community Health Needs Assessment (CHNA) from May 2022 through October 2022, using primary and secondary data, to ensure community benefit programs and resources are focused on significant health needs as perceived by the community at large, as well as alignment with GHMC – C's mission, services and strategic priorities.

The community served by GHMC – C is defined primarily by Sullivan County in New York. Defining the CHNA community similarly to its service areas will allow GHMC – C to more effectively focus its resources to address identified significant health needs, targeting areas of greatest need and health disparities.

GHMC – C obtained input through five focus groups whose participants were leaders representing public health, healthcare organizations, social services, seniors and community leaders. Primary input was also obtained by conducting community health survey with members of the community.

Secondary data was assessed including:

- Demographics (population, age, sex, race)
- Socioeconomic indicators (household income, poverty, unemployment, educational attainment)
- Key health indicators

Information gathered in the above steps was reviewed and analyzed to identify health issues in the community.

# Garnet Health 2022 CHNA

The process identified the following health issues listed in alphabetical order:

- Access to Medical Services
- Cancer
- Community Safety
- Heart Disease
- High Blood Pressure
- Inadequate Childcare
- Lack of Affordable Housing
- Lack of Healthy Nutrition
- Lack of Preventative Care
- Late or No Prenatal Care
- Mental Health
- Obesity
- Poverty
- Substance Abuse
- Transportation
- Unintentional Injuries

Health needs were prioritized with input from a broad base of members of GHMC – C's management team.

A review of existing community benefit and outreach programs was also conducted as part of this process and opportunities for increased community collaboration were explored.

Based on the information gathered through this community health needs assessment and the prioritization process described above, GHMC – C chose the needs below to address over the next three years. Opportunities for health improvement exist in each area. GHMC – C will work to identify areas where it can most effectively focus its resources to have significant impact and develop an Implementation Strategy for fiscal years ending 2023-2025.

**Prevention of Chronic Diseases**

**Improve Mental Health and Prevention of Substance Use**

Written comments regarding the health needs that have been identified in the current community health needs assessment should be directed to:

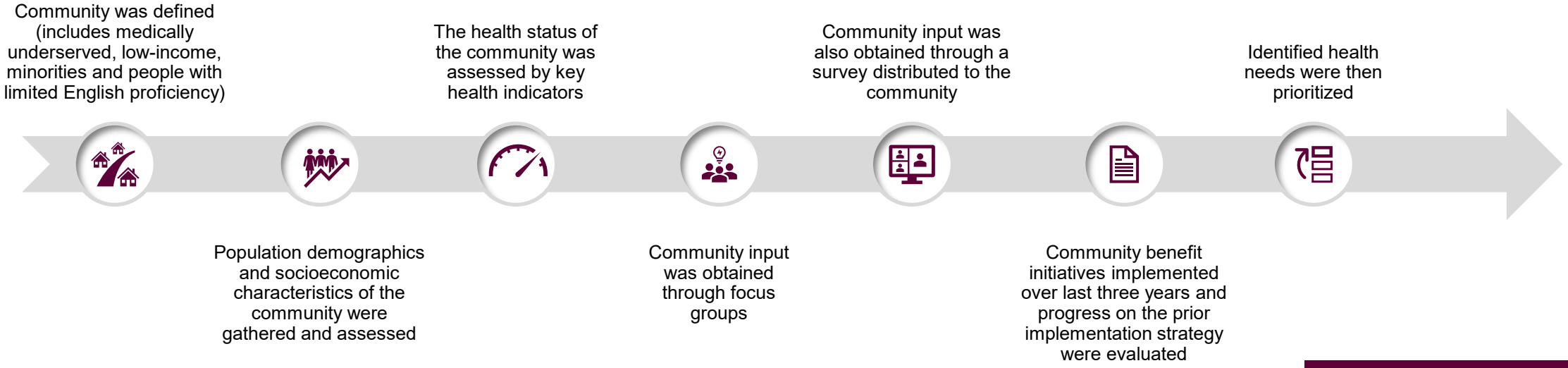
**Moira Mencher**
Manager of Physician Relations & Community Health
mmencher@garnethealth.org.

# How the Assessment was Conducted

GHMC – C conducted a community health needs assessment (CHNA) to support its mission and to fulfill the requirements established by the Patient Protection and Affordable Care Act of 2010 and comply with federal tax-exemption requirements. This is the fourth CHNA conducted by GHMC – C. The goals were to:

- ✓ Identify and prioritize health issues in GHMC – C's primary service area, particularly for vulnerable and under-represented populations.
- ✓ Ensure that programs and services closely match the priorities and needs of the community.
- ✓ Strategically address those needs to improve the health of the communities served by GHMC – C.

Based on current literature and other guidance from the United States Department of the Treasury, the following steps were conducted as part of GHMC – C's CHNA:




Limitations and Information Gaps

# General Description of Garnet Health and Garnet Health Medical Center - Catskills

GHMC – C  is affiliated with Garnet Health. Providing healthcare to approximately 450,000 residents in Orange, Sullivan and Ulster Counties, Garnet Health was designed to improve the quality, stability and efficiency of healthcare services in the mid-Hudson and Catskill region. Garnet Health provides services by more than 4,000 employed professionals and over 850 medical staff members and is recognized by Ethisphere as one of the 2018 and 2019 World's Most Ethical Companies. An academic affiliate of the Touro College of Osteopathic Medicine, Garnet Health retains compassionate professionals who continually strive toward the hospital's mission to improve the health of our community by providing exceptional health care.

The System's three hospital campuses, plus several outpatient facilities, offer a broad spectrum of care including:

- Emergency medicine
- Surgical & ambulatory surgery services
- Skilled nursing units
- Cardiology services including emergency and elective angioplasty
- Oncology services from diagnosis to treatment
- Orthopedic services including joint replacements
- Bariatric Surgery Center of Excellence
- Birthing centers
- Neonatal Intensive Care Unit
- Outpatient diagnostic imaging
- Primary and family care practices
- Mental health and chemical dependency programs
- Diabetes program
- Wound care
- Rehabilitation services including: physical, occupational and speech therapy
- Hospitalist services
- Community programs and support groups


A member of Garnet Health, GHMC – C is dedicated to providing quality health care to residents of Sullivan County, New York and neighboring communities at its main hospital campus in Harris, New York. GHMC – C's main Harris campus is a 154-bed facility.

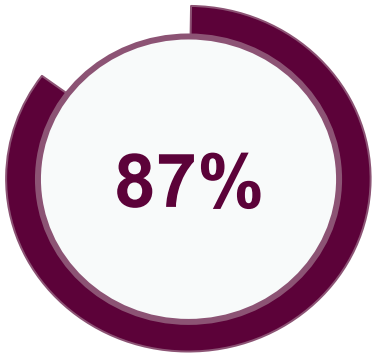
Garnet Health Medical Center - Catskills' Grover M. Hermann Hospital (Callicoon campus) is a 15-bed facility and primarily serves patients within western Sullivan County.

# Who We Serve

A majority of the patients served by the hospital reside in Sullivan County New York. Sullivan County makes up 997 square miles and is the 36th largest county out of 62 counties in the state of New York.

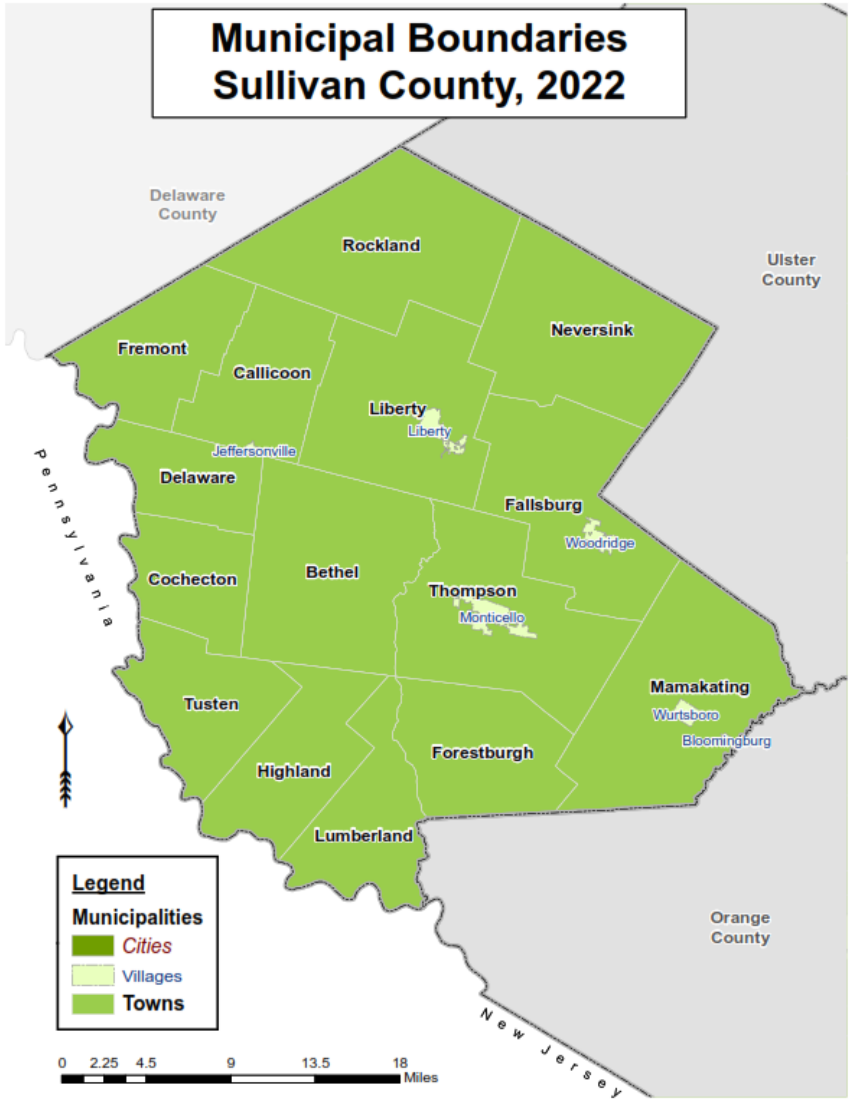
The community served by GHMC – C is defined primarily by Sullivan County in New York; therefore, demographic and health indicators are presented for Sullivan County. Within the data presented in the CHNA, county level data is used to report information for the service area.

## CHNA Community




Inpatient Discharges from CHNA Community (Sullivan County)


Outpatient Visits from CHNA Community (Sullivan County)



# Community Overview

## Demographic Data

To understand the profile of GHMC – C 's CHNA community, the demographic and health indicator data were analyzed for the population within the defined CHNA Community (Sullivan County).

The CHNA community has a total population of 75,329 according to the U.S. Census Bureau American Community Survey 2016-2020 5-year estimates. The percentage of population by combined race and ethnicity is made up of 70.55% Non-Hispanic White, 16.36% Hispanic or Latino, 7.71% Non-Hispanic Black, 1.62% Non-Hispanic Asian and 3.76% Non-Hispanic some other race. The demographic makeup of the CHNA community is as follows:

**$81,398**

Average Household Income

**27%**

People 25+ with a Bachelor's Degree or Higher

**13%**

of people are living in poverty (9,698 persons)

**6%**

Population without Health Insurance Coverage (4,192 persons)

**58%**

Population 16+ in Civilian Labor Force

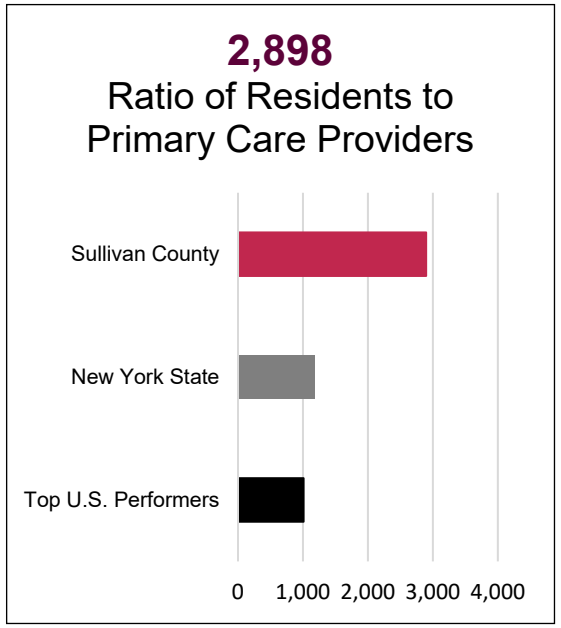
**6%**

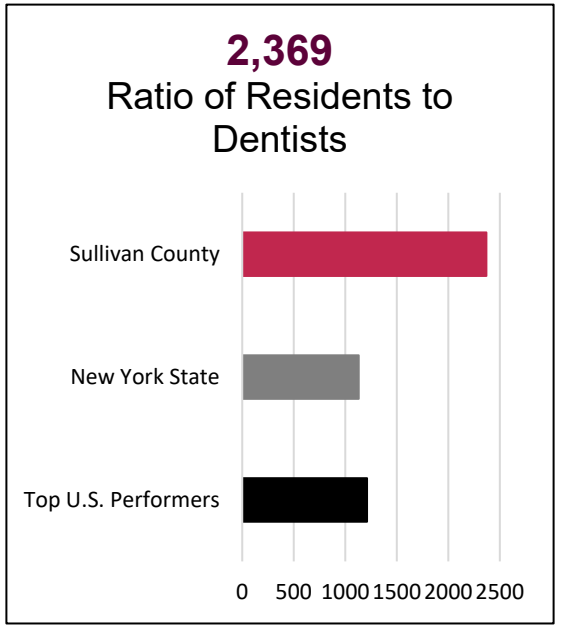
4,073 persons living in Limited English speaking households

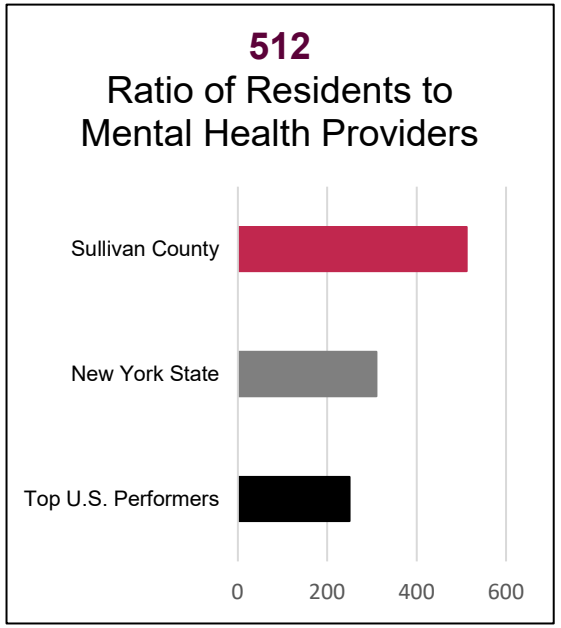
# Access to Services

Data Tables

A lack of access to care presents barriers to good health. The supply and accessibility of facilities and physicians affect access. As shown below, the rate of health care providers within Sullivan County is less favorable to state benchmarks.



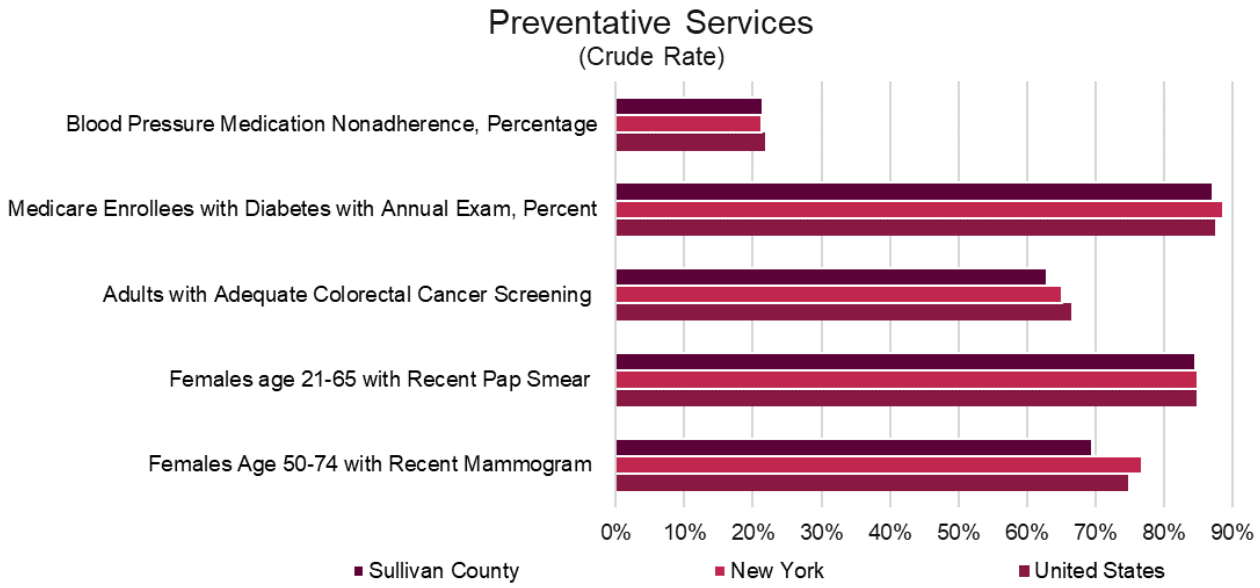



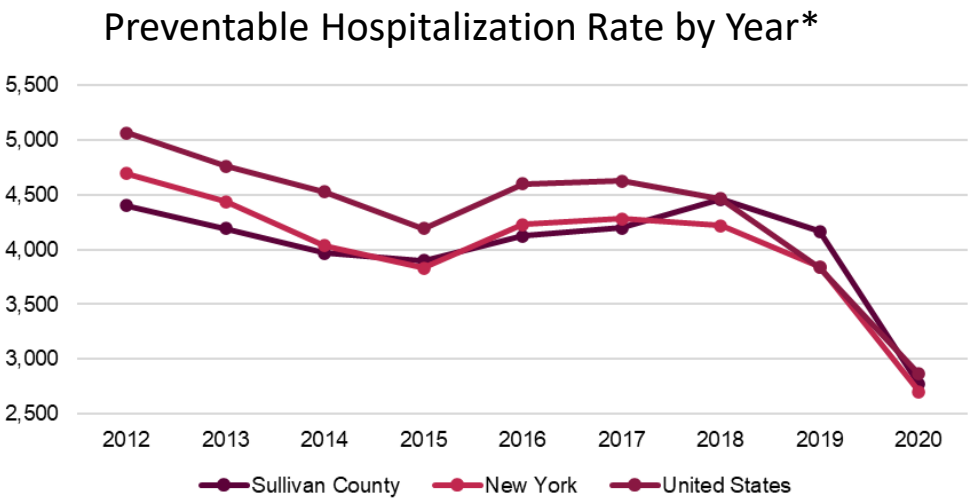
# Clinical Preventative Services

Rates of morbidity, mortality, and emergency hospitalizations can be reduced if community residents access services such as health screenings, routine tests, and vaccinations. Prevention indicators can call attention to a lack of access or knowledge regarding one or more health issues and can inform program interventions

**21.2%** of women 65+ in the community are up-to-date with core preventative services compared to the national benchmark of 28.4%.*

**23.5%** of men 65+ in the community are up-to-date with core preventative services compared to the national benchmark of 32.4%.*




Preventable hospitalizations include hospital admissions for one or more of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infection.

The rate for preventable hospitalizations in the CHNA Community is generally favorable to state and national rates and the rate has significantly improved since 2018.

Data Tables

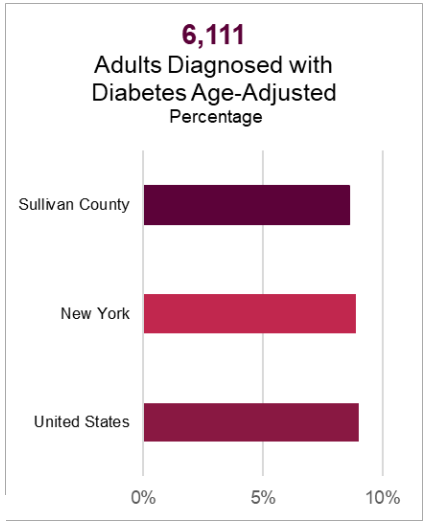
** Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2018. Source geography: Tract*
***Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2020. Source geography: County*

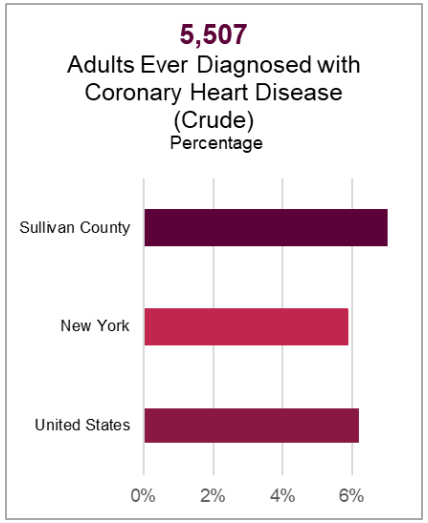
# Health Outcomes & Mortality

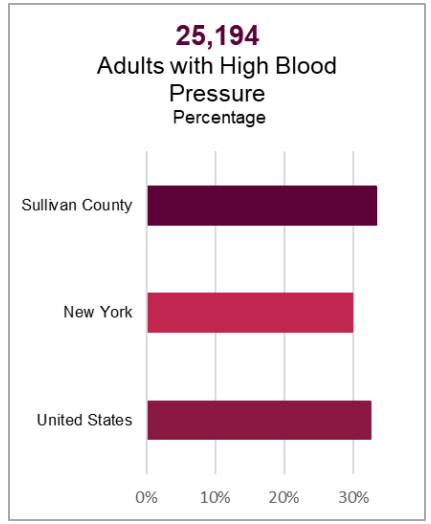
GHMC – C 's CHNA Community has a significant number of adults who have been diagnosed with chronic illnesses. The prevalence of chronic diseases in the CHNA community is fairly consistent with state and national percentages, with slightly higher rates compared to the state and national benchmarks. Over 33% of the population, 25,194 adults, have high blood pressure.

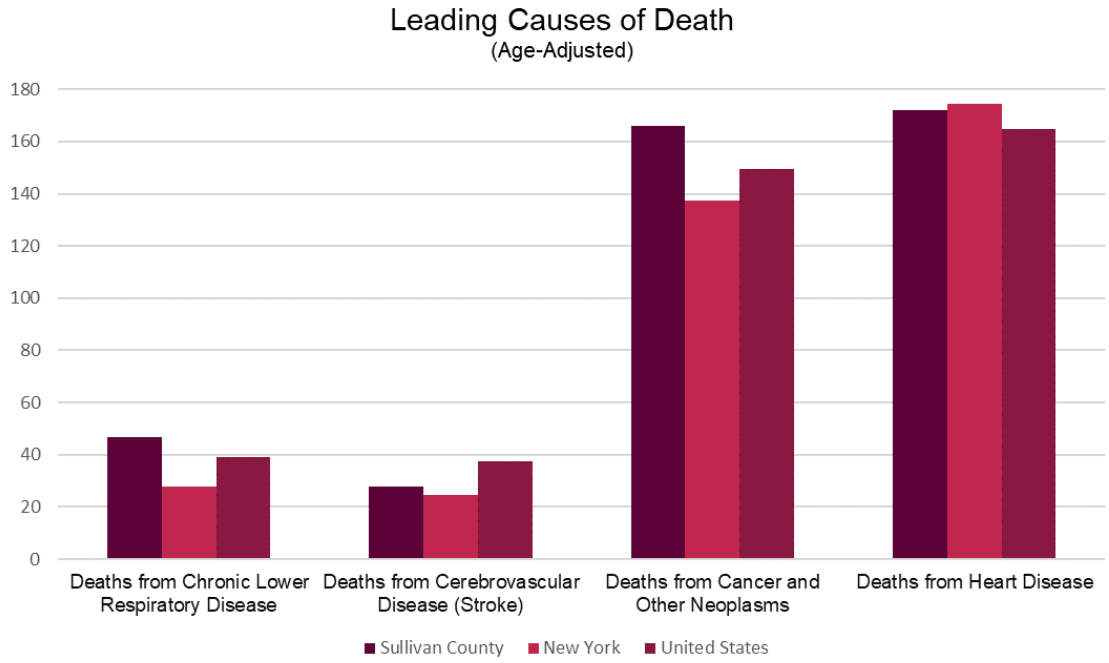
Coronary heart disease, cancer, lung disease and stroke are leading causes of death in the United States. Adjusted death rates for the community are primarily less favorable than state rates.

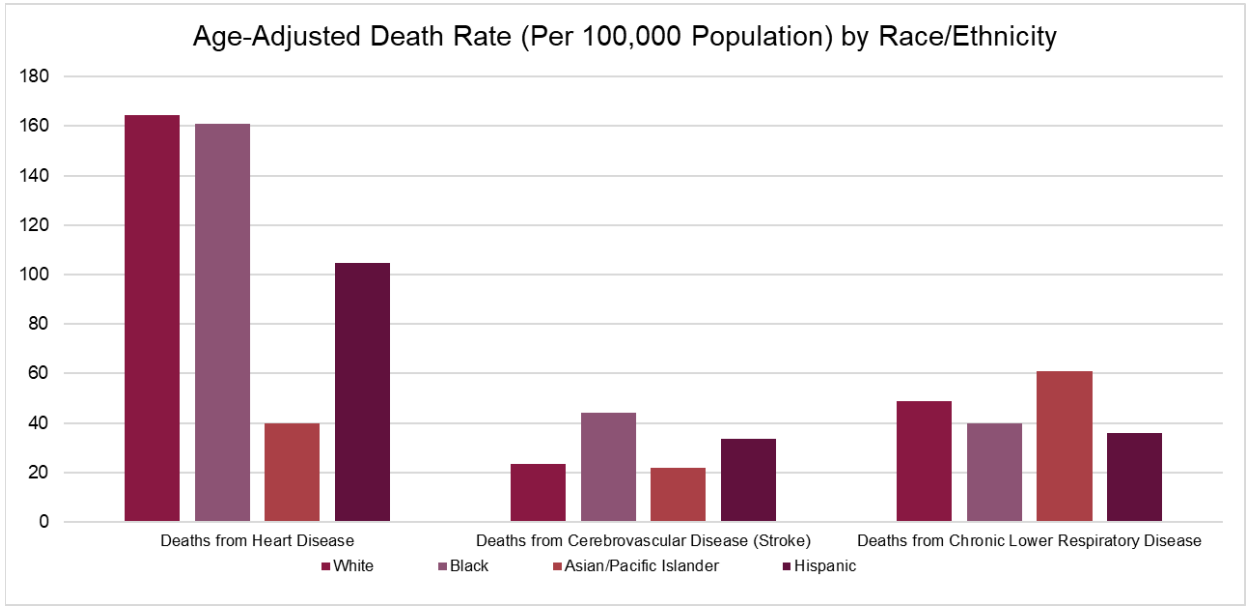
**Data Tables**



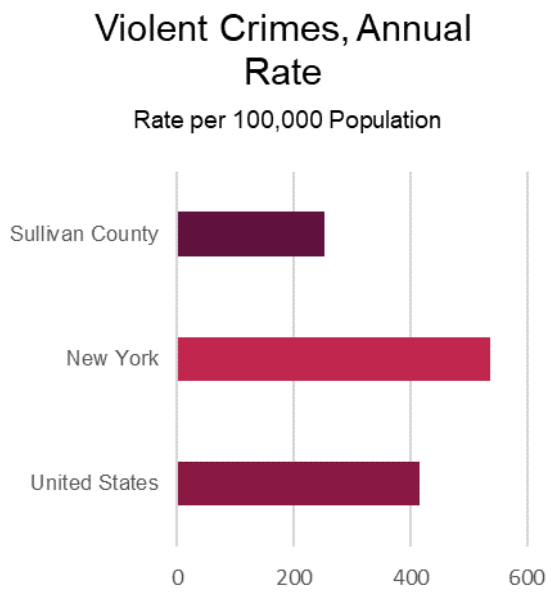



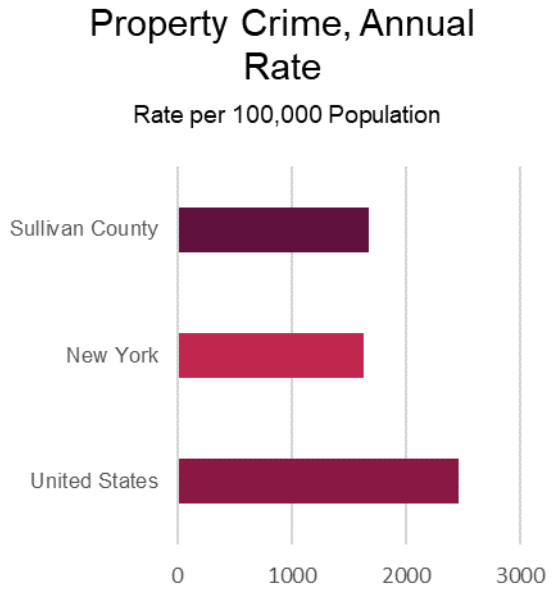

*Data Source: https://www.health.ny.gov/statistics/community/minority/county/sullivan.htm*

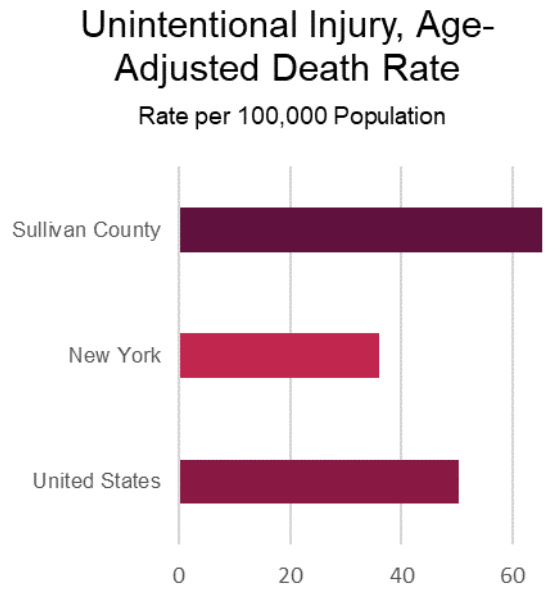
# Injury and Violence

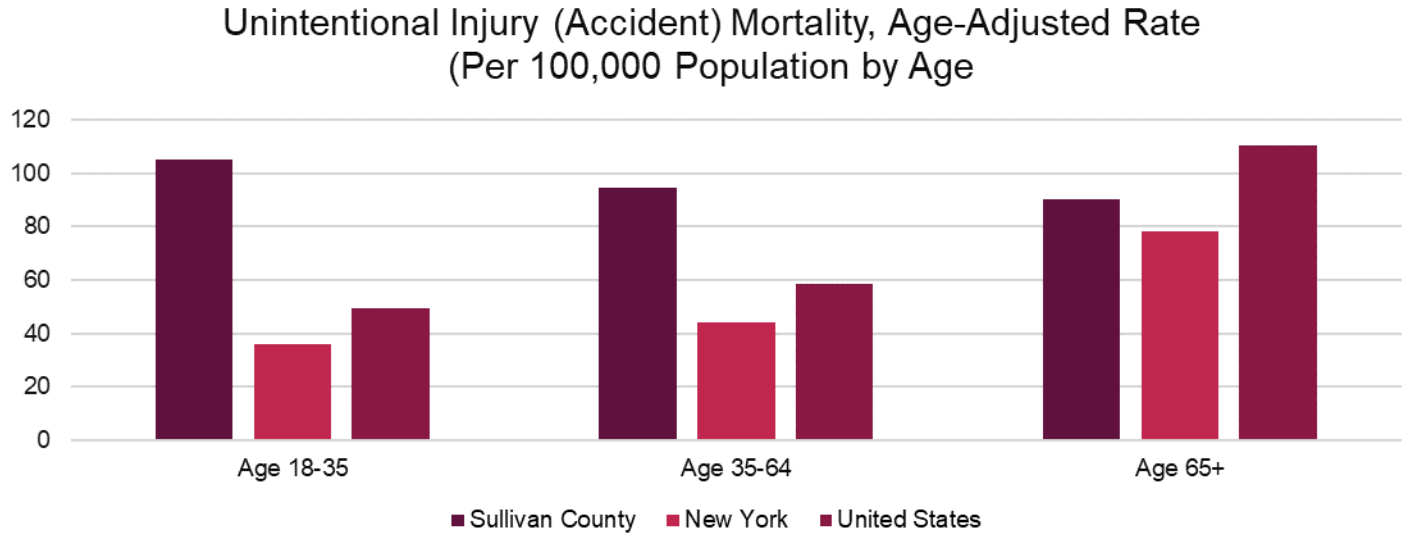
Crime rates for Sullivan County are favorable state and national rates, whereas, unintentional injury rates for Sullivan County are unfavorable to state and national rates. As shown in the chart below, deaths from unintentional injury for persons aged 18-35 are significantly higher than state and national benchmarks.

**Data Tables**



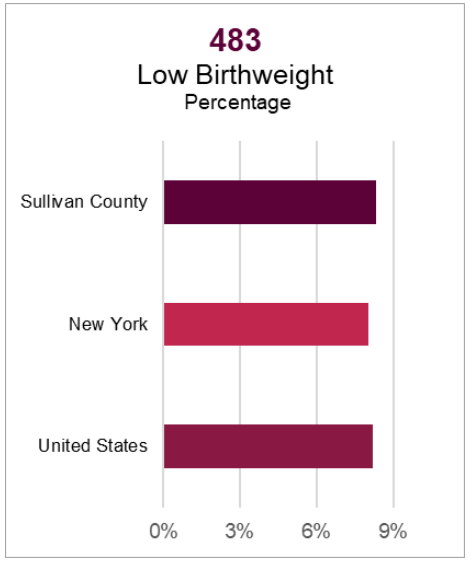



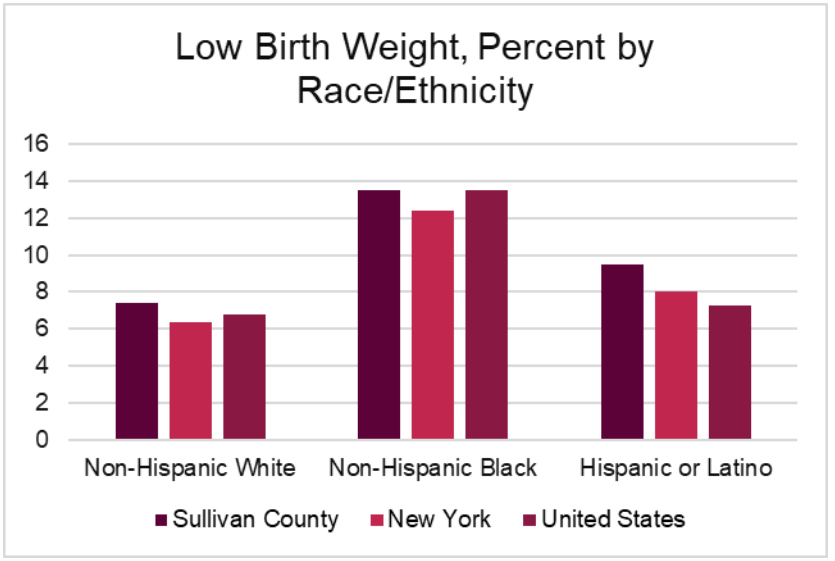
# Maternal, Infant and Child Health

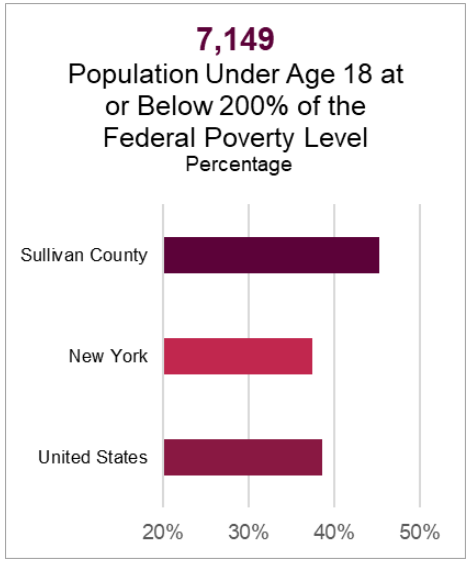
Engaging in prenatal care decreases the likelihood of maternal and infant health risks such as low birth weight. 20% of women in Sullivan County had no prenatal care in the first trimester. Rates for low birth weight and infant mortality indicate significantly higher rates for Non-Hispanic Black population and rates for Sullivan County are unfavorable to state and national rates.

Selected indicators from the Maternal and Child Health Dashboard maintained by the New York State Department of Health are provided in the table below for Sullivan County and New York State. The dashboard indicates a higher rate of child mortality in Sullivan County as compared to New York State and a significantly higher rate of newborns with neonatal withdrawal symptoms and/or affected by maternal use of drugs of addiction in Sullivan County as compared to New York State.

**Data Tables**





Women giving birth in Sullivan County had no prenatal care in the first trimester

**Maternal and Child Health (MCH) (Selected Indicators)**

| Health Indicator | Sullivan County Percentage (or) Rate (or) Ratio | New York State Percentage (or) Rate (or) Ratio |
|---|---|---|
| Infant mortality rate per 1,000 live births | 3.5 | 4.3 |
| Percentage of preterm births (less than 37 weeks gestation) | 9.3 | 9.0 |
| Newborns with neonatal withdrawal symptoms and/or affected by maternal use of drugs of addiction (any diagnosis), crude rate per 1,000 newborn discharges | 43.6 | 9.0 |
| Child mortality rate per 100,000 children ages 1-9 years | 29.7 | 13.4 |
| Percentage of NYS residents served by community water systems that have optimally fluoridated water | 16.9 | 71.2 |

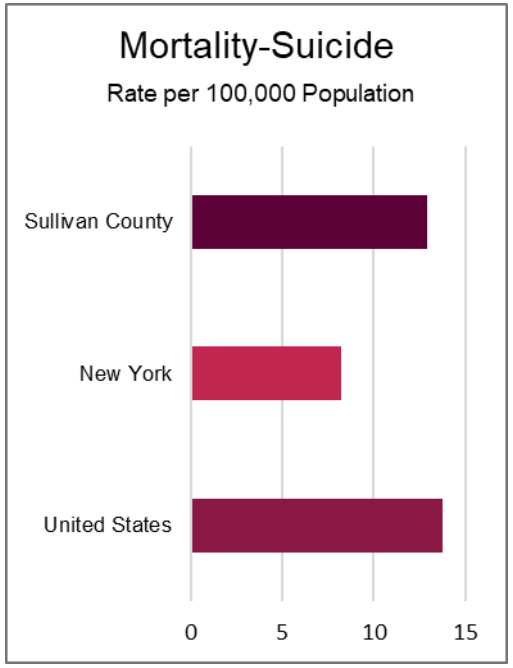
*Data Source: https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/mch_dashboard/mch_dashboard&p=ct&cos=48*

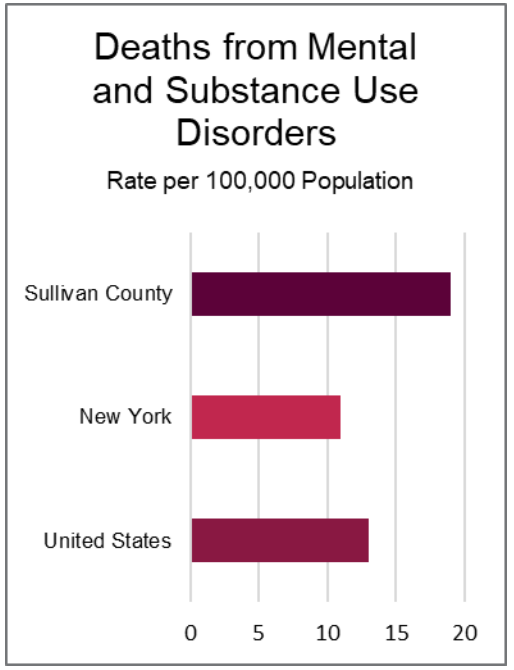
# Mental Health

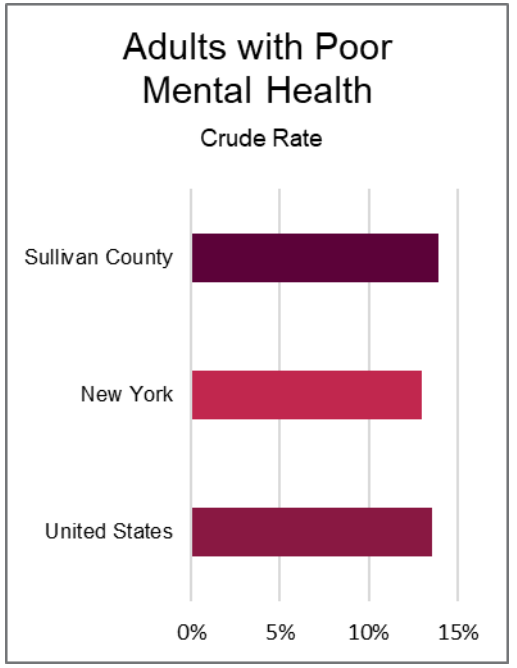
Suicide is an indicator of poor mental health. Suicide rates for Sullivan County are unfavorable to state rates and favorable to national rates, whereas, deaths from mental and substance use disorders rates in Sullivan County are unfavorable to both state and national rates.

The number of adults with poor mental health in Sullivan County is unfavorable to state and national benchmarks. The map to the left reports the percentage of adults (ages 18 years and older) reporting 14 days or more of poor mental health per month in Sullivan County.

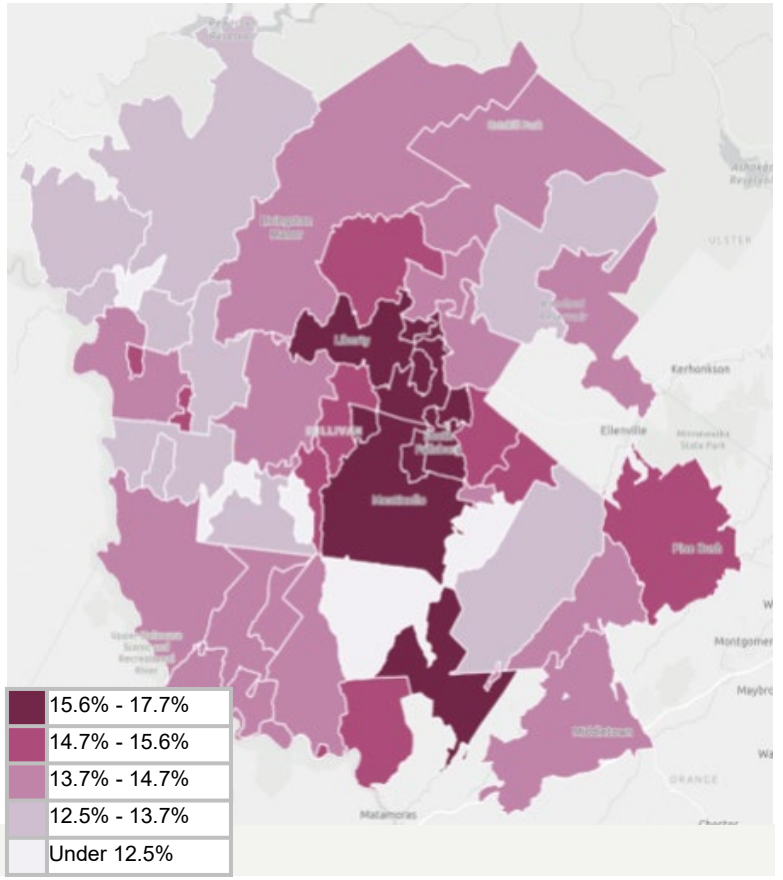
**Data Tables**




**Frequent Mental Distress**




*Data Source: Centers for Disease Control (CDC), CDC PLACES: Local Data for Better Health (2020)*

# Nutrition, Physical Activity and Obesity

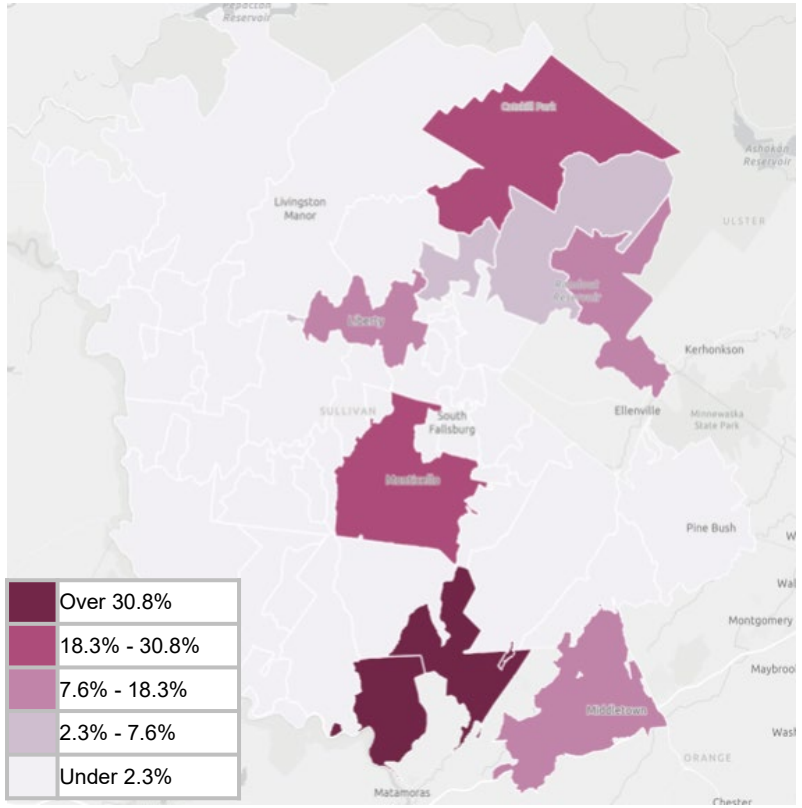
Healthy diets and physical activity contribute to healthy lifestyles and overall well-being. These factors are relevant because current behaviors are determinants of future health and well-being and these indicators may be linked to significant health issues, such as obesity and poor cardiovascular health.

- Over 8% of the census tracts are designated as food deserts, meaning the census tract lacks healthy food sources due to income level, distance to supermarkets, or vehicle access. Over 10% of the population (8,120 persons) live with food insecurity in Sullivan County.
- 19,776 persons, or 34% of adults, are obese in Sullivan County. Obesity rates for Sullivan County has steadily been increasing since 2004, however, there was a decrease seen from the all time high in 2018 to 2019.
- 28% of adults, age 20 and older, self-report no active leisure time physical activity.
- Approximately 57.91% of public-school students in Sullivan County are eligible for free or reduced-price lunch program, which is higher than the state average for New York of 56.35%

The map to the right reports the percentage of the low-income population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket or large grocery store. The low-income population with low food access in Sullivan County is approximately 2,220 persons with the following zip codes having the highest percentages: 12729, 12780, and 12785.

Data Tables

**Population with Limited Food Access, Low Income Percent by Tract**




**11.5%**
Food Insecure Population

**34%**
Adults with BMI>30 (Obese)

**56%**
Students Eligible for Free or Reduced- Price Lunch

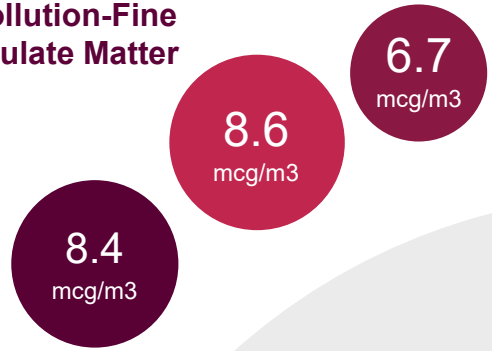
# Physical Environment

The structure of housing and families and the condition and quality of housing units and residential neighborhoods are important because housing issues like overcrowding and affordability have been linked to multiple health outcomes, including infectious disease, injuries, and mental disorders.

Over 40% of seniors in the community, age 65+, live alone. This is important because older adults who live alone may have challenges accessing basic needs, including health needs.

**Data Tables**

## Air Pollution-Fine Particulate Matter




- Top U.S. Benchmark
- New York
- Sullivan County

**30.75%** of households in Sullivan County, 8,845 households, are cost burdened households meaning housing costs exceed 30% of household income. **3,966** households have housing costs that **exceed 50%** of household income.

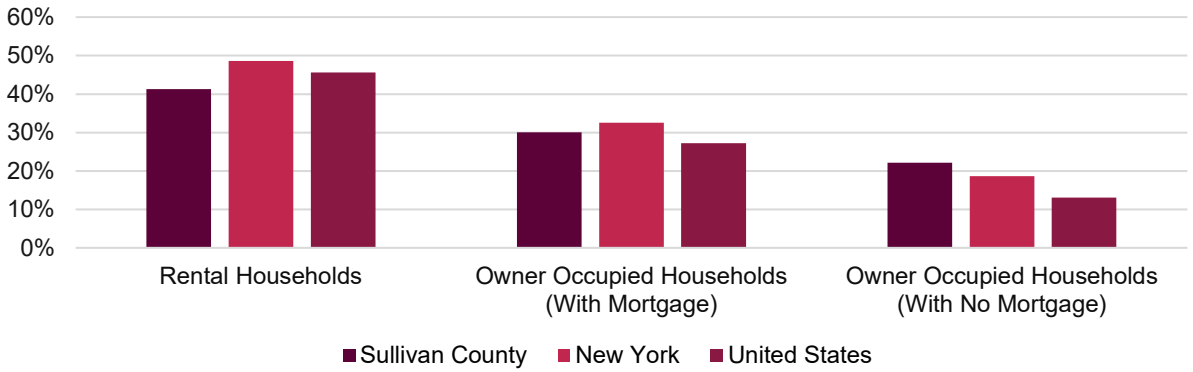
**4,331 Seniors** (age 65+) live alone.

**30.8%** of housing units have one or more substandard conditions.

It is estimated that **over 17%** of households within the community have no or slow internet.

**22%** of the community live within half a mile of a park. This indicator is relevant because access to outdoor recreation encourages physical activity and other healthy behaviors.

## Cost Burdened Households (Percentage of Tenure)



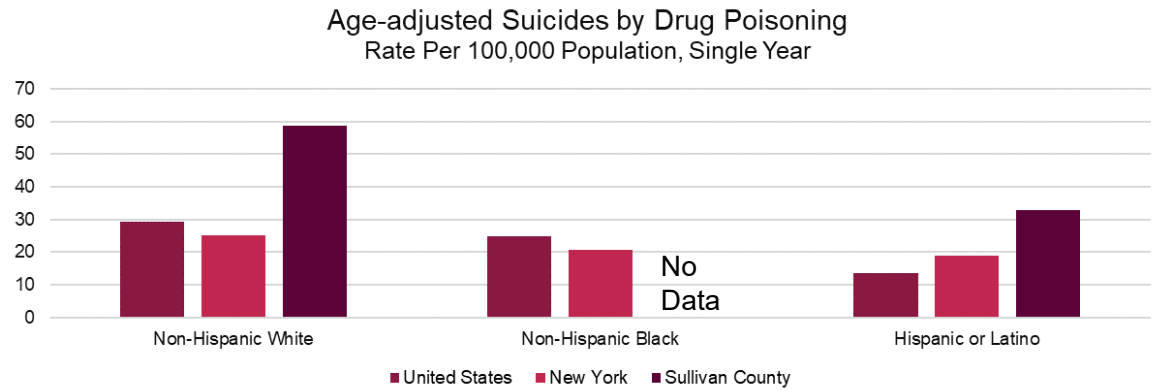
# Substance Abuse

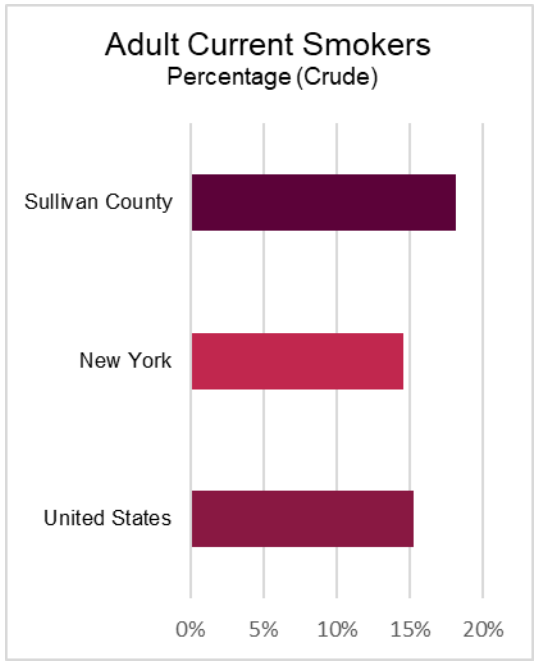
The percentage of adults in Sullivan County who currently smoke is 18.2% and is unfavorable to state and national benchmarks.

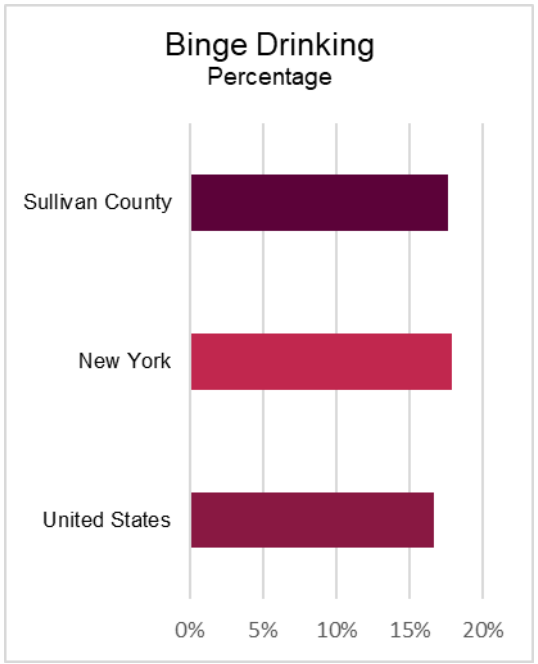
Binge drinking, having more five or more drinks (men) and four or more drinks (women) on an occasion in the past 30 days, is higher in Sullivan County compared to the national rate of 16.7%.

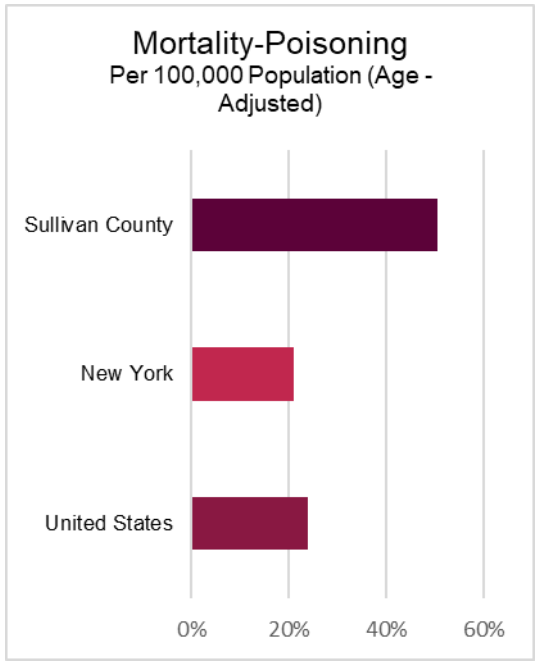
Poisoning deaths, especially from drug overdose, are a national public health emergency. Poisoning deaths are significantly higher in Sullivan County compared to the state and national rates.

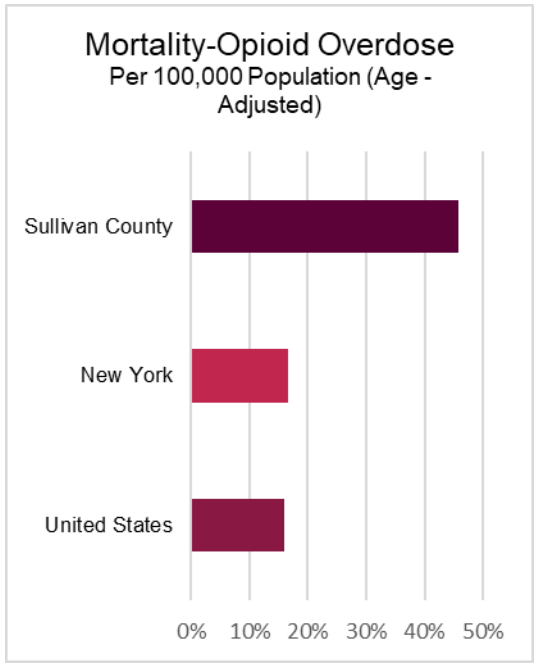
**Data Tables**



# Key Stakeholder Focus Groups

Garnet Health obtained input from leaders representing public health, healthcare providers, social services, seniors and local government leaders through five focus groups conducted during June and July of 2022. Three focus groups (Rockland Seniors, Monticello Seniors and SUNY) explored the questions below. Two focus groups (Sullivan 180 Advisory Board and HSAB) conducted a Forces of Change assessment; findings are included on the following page.

## What assets do we have that contribute to improving community health?

- Home care visiting nurse/physical therapy services
- Active health education
- Public transportation is getting better
- Urgent care facilities are plentiful
- Fresh air/parks
- Farmers markets
- Natural beauty of landscape
- Parks and places to walk

## What do you see as the biggest challenges facing Sullivan County residents regarding improving its overall health status?

- Lack of permanent doctors in the community
- Lack of availability of medical services after 5:00 pm
- Navigating the healthcare/insurance system
- Transportation
- Smoking
- Drugs
- Legalization of marijuana
- Domestic abuse
- Violence
- Obesity/Unhealthy eating habits
- Lack of fitness facilities

## What one issue should Sullivan County invest in?

- Health Resources/More Good Doctors
- Senior Transportation
- Better Cell Service
- Attracting Employers to Sullivan County
- Socialization Groups for Seniors
- Umbrella Agency for Coordination of Services for All County Residents
- Opioid Crisis
- Housing for Homeless Population

# Key Stakeholder Focus Groups – Forces of Change

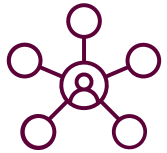
| | Physical Environment | Social Determinants | Health Behaviors | Clinical Care |
|---|---|---|---|---|
| What is affecting our local public health system or community? | COVID Pandemic/ Vaccines<br>Sullivan 180 Creation<br>Legalization of Cannabis<br>Increased Use of Social Media | Lack of Transportation Options<br>Housing Affordability<br>Increase in Poverty and Homelessness<br>Under-employment<br>Nutrition for Our Youth<br>Expansion of Mobile Farmer's Markets<br>Lack of Transportation (T) | Worsening Mental Health Issues<br>Increase use of Drugs | Shortage of Healthcare Workforce<br>Lack of Access to Services<br>Increase in Substance Use Providers |
| Threats/Opportunities | Lots of Recreational Areas (O)<br>Gun Control Laws (O)<br>Telehealth/ Remote Access (O)<br>Collaborative Community Spirit (O) | | | |
| What may occur or has occurred that may pose a barrier to achieving the shared vision? | | Culture/ Language Barriers<br>Food Insecurity<br>Increasing Cost of Living<br>Lack of Funding | | Reduction of Services Provided by Medicaid<br>Shortage of Healthcare Professionals |

# Key Stakeholder Focus Groups

## Major Findings

- Lack of medical services and providers was an area of concern for focus group participants. Consolidation of medical providers into medical care organizations has left many rural areas of the county without basic medical access. Providers are leaving Sullivan County and access to specialty services requires travel out of county, which creates a barrier to access. Also, providers that remain in Sullivan County often have only have office hours during regular business hours. For those who may not be able to take time off from work, this makes accessing health care or well visits difficult.
- Transportation is also another major barrier to accessing services. While “Move Sullivan” has increased transportation options to the major hubs of Sullivan County (Monticello, Liberty, Fallsburg) access to public transportation in the more rural areas of Sullivan County remains difficult. The rising cost of gas is also affecting the ability and willingness to drive to appointments and errands for everyday items.
- The lack of affordable housing was identified by participants as a barrier to improving health in Sullivan County. Lack of affordable housing inventory due to population growth, and the increasing cost of housing create economic strain for many residents. Along with the cost of housing, inflation is increasing the cost of healthy food, pharmaceuticals, health care products and services, and utilities, widening the financial and health disparity gaps already seen in Sullivan County.
- High taxes, lack of return on investment from taxes, lack of good paying jobs, and a lack of educational opportunities were all identified as barriers to health equity and better health
- The increase in substance use, alcohol use, legalization of marijuana, suicide, and mental health issues were all identified by participants as concerns in Sullivan.
- Difficulties in hiring and retaining staff was also identified by several community partners.

## Specific Recommendations from Key Stakeholder Focus Groups



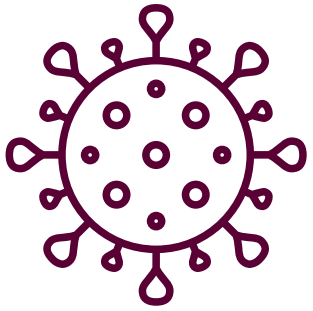
Improving communication between agencies and the community to improve the knowledge of resources available to the community and find solutions that are effective and efficient.

A single, umbrella agency to coordinate services for all residents.

Improved access to health care by having more providers with offices in Sullivan County, not just referral services to Orange County, as well as ensuring the local hospital remains open and offers more surgeries and procedures so residents do not have to travel.

The development of a cancer support group in Sullivan County.

# Impact of COVID-19 on Community Health



The COVID-19 pandemic has had significant and widespread impact on health within the community. Input from key stakeholders has been provided on how the pandemic influenced related health factors.

## Physical Health

Physical health has declined during the pandemic—due to, among other things, a lack of screening services and delayed health screenings (sometimes even if there are symptoms present). Providers noted that population health programs have been modified as a result of COVID and many are still being conducted with decreased frequency or online.

## Mental Health

As a result of the COVID pandemic, some of the existing issues in mental health have worsened. Available mental health providers have declined while mental health issues among the community have increased.

## Telehealth

The COVID pandemic has also opened the door to virtual appointments for healthcare. While this has its benefits, there are also drawbacks to the lack of face-to-face interaction that comes with an in person visit. Many residents are hesitant to come in person due to COVID concerns and/or they enjoy the convenience of not having to leave home. Providers are also hesitant to bring too many people into the office for fear of spreading COVID, as well as entering the homes of their patients for in home care.

## Opioid Related Overdoses

It is widely believed that the additional health, behavioral health and social determinant of health challenges engendered by the COVID pandemic; challenges such as increased social isolation, financial insecurity, food insecurity, housing insecurity, access to transportation and treatment and support services, and others, had a significant impact on people experiencing Opioid Use Disorder.

# Community Survey

In order to develop a broad understanding of community health needs, Garnet conducted a community survey during January and February of 2022. A link to the survey was distributed via e-mail, social media and word of mouth to the community at-large. A total of 641 surveys were completed.

The majority of respondents were White/Caucasian (75%).

Respondents by age group were as follows:

| Age Group | Percent of Total Respondents |
|---|---|
| 18-34 | 25% |
| 35-49 | 27% |
| 50-64 | 25% |
| 65 and older | 23% |

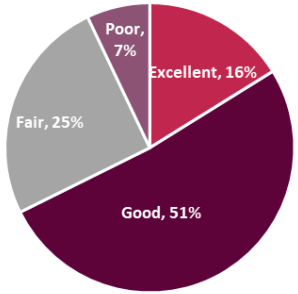
Females represented 47% of the respondents while males represented 50%. The remaining 1% of respondents identified as other genders or chose not to answer.

The percentage of respondents based on household income is provided below:

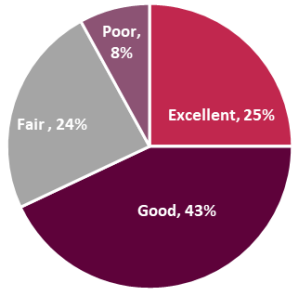
| | |
|---|---|
| Less than $25,000 | 16% |
| $25,000 to just under $50,000 | 24% |
| $50,000 to just under $100,000 | 27% |
| $100,000 to just under $150,000 | 15% |
| $150,000 or more | 10% |
| Chose not to answer | 8% |

Survey respondents were asked to rate the current status of their health. The majority of the respondents indicated the status of their health was good.

**How would you rate your physical health?**




**How would you rate your overall mental health?**



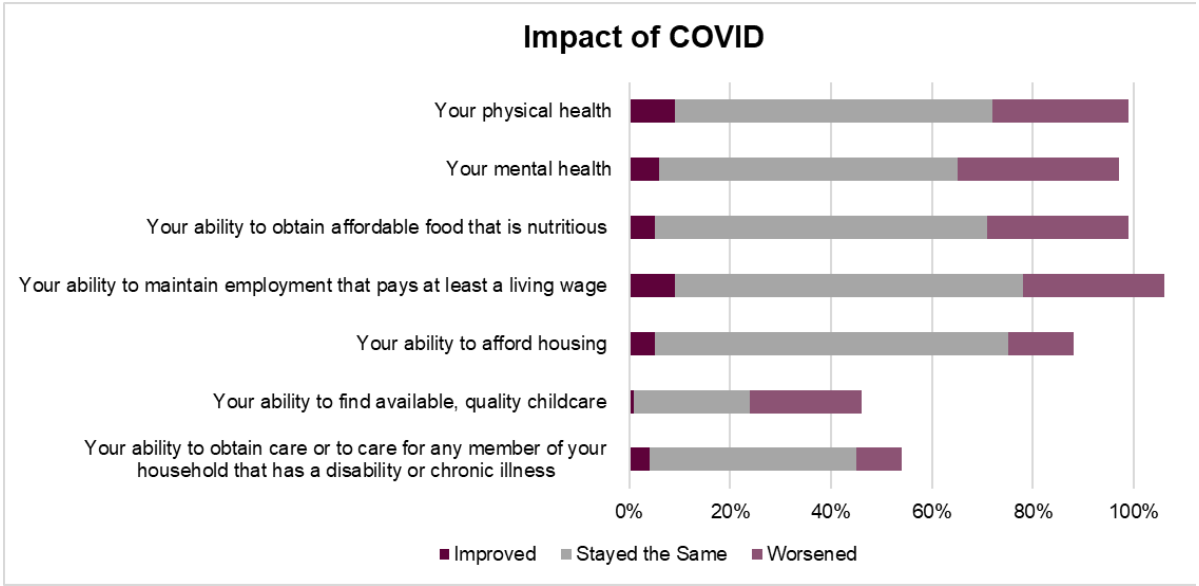

Link to Community Survey Summary

# Community Survey

## Health Behaviors

- **26%** of survey respondents indicated they eat a balanced, healthy diet 7 days per week.
- Approximately **34%** of respondents, exercise at least 30 minutes a day, four or more days a week.
- **70%** of survey respondents indicated they feel somewhat stressed or very stressed.
- 9% of survey respondents indicated they drink alcohol daily.
- The majority of respondents, **74%,** have had a routine physical in the last year. Significantly less, **57%**, have had a routine dental checkup on the last 12 months.
- Respondents indicated the biggest reason for not visiting their primary care provider and dentist was due to lack of time.

## Impact of COVID-19




Link to Community Survey Summary

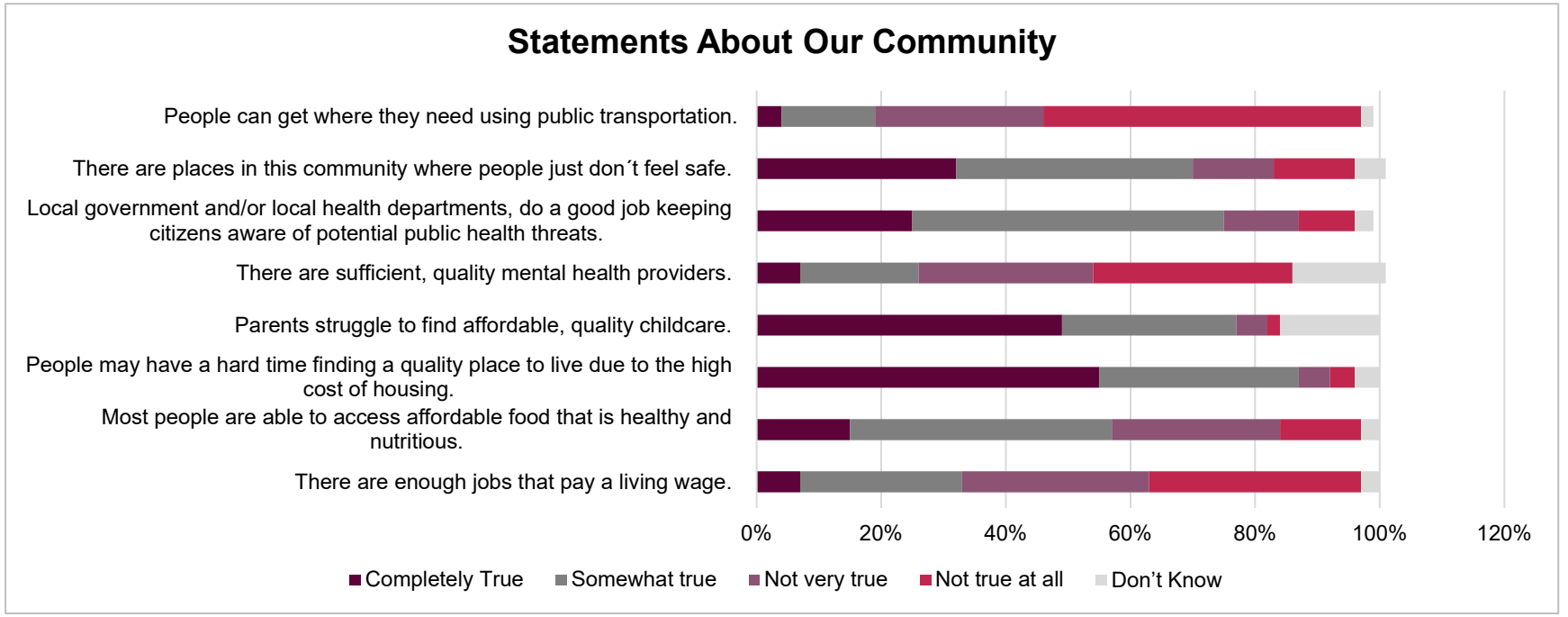
# Community Survey

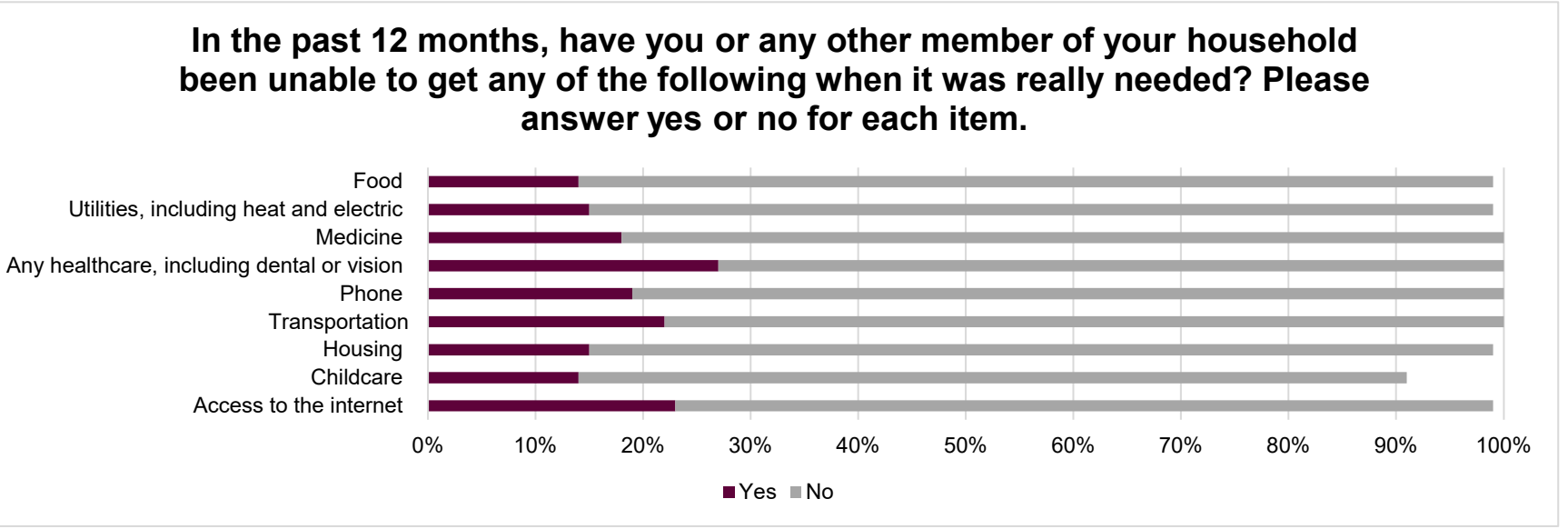
## Statements About Our Community

- 87% of respondents believed people may have a hard time finding a quality place to live due to the high cost of housing.
- 77% of respondents believed parents struggle to find affordable, quality childcare.
- 78% did not believe people can get where they need to go using public transportation.
- 28% replied their ability to obtain affordable food that is nutritious.

## Access to Resources

- 26% of respondents did not visit a primary care doctor in the past 12 months for a routine physical or a check-up.
- 43% of respondents did not see a dentist in the past 12 months for a routine check-up or cleaning. 26% of those who didn't go to the dentist stated they didn't go because they didn't have insurance .



# Evaluation of the Impact of Actions Taken Since the Last CHNA

Garnet Health provides a broad array of services that provide benefit to the community. Below is a summary of some of Garnet's significant community benefit initiatives taken since the 2019 CHNA aimed at addressing the priority focus areas.

## Prevention of Chronic Disease

Diabetes Education- The team in the Diabetes Center has been engaged in the Diabetes Prevention Programs 3 times a year in Sullivan and Orange County. Support groups and programing for those who are pre-diabetic or diabetic are also offered in person, hybrid and virtually.

Farmers Market Participation- Garnet Health actively participates in multiple farmers markets from May to November in community. Garnet Health invites many departments such as the Diabetes Center at each Garnet Health location, the Breast Centers, stroke teams, cardiac services teams and wound care services to provide community Health Education. We activity engage Family Medicine and transitional year Residents to provide blood pressure screenings and general health education each weekend.

Warrior Kids School Program- A fun and engaging 4-week program for second to fifth graders that education on healthy eating, physical activity, limiting screen time and limiting sugary beverages in an exciting and playful way.

Health Eating & Food Security- Garnet Health over the years as participated in FreshRx Programs with our community partners which provides coupons from our doctor's offices to redeemable at 9 different farmers markets. Garnet Health has also implemented a screening tool, referred to as the Hunger Vital Signs. Each patient is screened using a questionnaire and if applicable is discharged with up to-date Food Pantry lists. This screening is conducted inpatient and outpatient.

Healthy Heart Program- Garnet Health provides healthy heart screenings via a finger stick at community events and local businesses. This screening provides community participants with quick blood results that includes total Cholesterols, HDL Cholesterol, Triglycerides, LDL Cholesterol and Glucose. Participants are educated on their results and referred to services as appropriate.

Free Prostate Cancer Screenings and Mammograms Events- Community Health, the Cancer Center and the Breast Centers of Garnet Health offers free Prostate screenings, breast and mammogram events for the uninsured and under-insured.

# Evaluation of the Impact of Actions Taken Since the Last CHNA (continued)

## Prevention of Communicable Disease

COVID Prevention education & Vaccination clinicals: Throughout the pandemic and all the months/ years that have followed, Garnet Health has offered several community-oriented vaccination and booster clinics. Garnet Health has continued to provide safety and prevention education for communicable diseases.

Community Network Participation: Garnet health proudly services on multiple Networks, taskforce and collaborations to combine resources with community Partners to address the needs outlined and the improvement plan activities. Some networks and taskforces include, the Rural Health Network, Making Healthful Decisions Conference Collaborative, Sullivan Transportation Health Accessibility and Reliability Taskforce (STHART), and many more. Each of these networks have been developed to not only address our CHIP but also the social determines of health factors that affect care in our communities.

## Improve Mental Health and Prevention of Substance Abuse

Self-Care Forums: Virtual selfcare forums have been hosted by Garnet Health and have invited community partners and medical professions to address self-care and major health topics. Some topics include: Heart Health, Women's Heart Health, Stroke, Mental Health, Men's Health, Oral Head and Neck Cancer and General Healthy eating and nutrition.

Youth Mental Health & First Aid: Garnet Health has provided youth mental health and first aid training to the community school districts over the years in an effort to improve the mental health of students.

Support Groups: Garnet Health has a variety of support groups that address the mental health component of chronic diseases and caregiver support of the community and patients we serve.

Tobacco Prevention: Freedom from Smoking is offered multiple times a year and addresses behavior changes to help participants quit smoking and live healthier life styles.

# Prioritization of Identified Health Needs

Primary and secondary data was gathered and compiled from May 2022 to September 2022. Based on the information gathered through the CHNA process, the following summary list of needs was identified. Identified health needs are listed in alphabetical order.

- Access to Medical Services
- Cancer
- Community Safety
- Heart Disease
- High Blood Pressure
- Inadequate Childcare
- Lack of Affordable Housing
- Lack of Healthy Nutrition
- Lack of Preventative Care
- Late or No Prenatal Care
- Mental Health
- Obesity
- Poverty
- Substance Abuse
- Transportation
- Unintentional Injuries


Health needs were prioritized with input from a broad base of members of Garnet Health's Leadership Team.

Based on the information gathered through this Community Health Needs Assessment and the prioritization process described above, Garnet Health chose the needs below to address over the next three years.

- Prevention of Chronic Diseases
- Improve Mental Health and Prevention of Substance Use

# Appendix A

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## Population by Age & Gender

| | Age 0-17 | Age 18-24 | Age 25-34 | Age 35-44 | Age 45-54 | Age 55-64 | Age 65+ | Total |
|---|---|---|---|---|---|---|---|---|
| **Sullivan County** | **16,012** | **6,002** | **9,083** | **8,349** | **10,394** | **11,234** | **14,255** | **75,329** |
| New York | 4,071,142 | 1,794,550 | 2,865,358 | 2,428,957 | 2,548,713 | 2,584,427 | 3,221,702 | 19,514,849 |
| United States | 73,296,738 | 30,435,736 | 45,485,165 | 41,346,677 | 41,540,736 | 42,101,439 | 52,362,817 | 326,569,308 |

| | Male | Female |
|---|---|---|
| **Sullivan County** | **38,595** | **36,734** |
| New York | 9,474,184 | 10,040,665 |
| United States | 160,818,530 | 165,750,778 |

| | Age 0-17 | Age 18-24 | Age 25-34 | Age 35-44 | Age 45-54 | Age 55-64 | Age 65+ | Total |
|---|---|---|---|---|---|---|---|---|
| **Sullivan County** | **21.3%** | **8.0%** | **12.0%** | **11.1%** | **13.8%** | **14.9%** | **18.9%** | **100.0%** |
| New York | 20.9% | 9.2% | 14.7% | 12.5% | 13.0% | 13.2% | 16.5% | 100.0% |
| United States | 22.5% | 9.3% | 13.9% | 12.7% | 12.7% | 12.9% | 16.0% | 100.0% |

| | Male | Female |
|---|---|---|
| **Sullivan County** | **51.2%** | **48.9$** |
| New York | 48.6% | 51.4% |
| United States | 49.2% | 50.8% |

Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

# Population by Combined Race & Ethnicity

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| | Non-Hispanic White | Hispanic or Latino | Non-Hispanic Black | Non-Hispanic Asian | Non-Hispanic Other Race | Non-Hispanic Multiple Races | Total |
|---|---|---|---|---|---|---|---|
| **Sullivan County** | **53,182** | **12,279** | **5,800** | **1,205** | **829** | **2,034** | **75,329** |
| New York | 10,752,682 | 3,727,336 | 2,732,079 | 1,658,762 | 175,634 | 468,356 | 19,514,849 |
| United States | 196,268,154 | 59,435,614 | 40,168,025 | 17,961,312 | 3,592,262 | 9,143,941 | 326,569,308 |

| | Non-Hispanic White | Hispanic or Latino | Non-Hispanic Black | Non-Hispanic Asian | Non-Hispanic Other Race | Non-Hispanic Multiple Races | Total |
|---|---|---|---|---|---|---|---|
| **Sullivan County** | **70.6%** | **16.3%** | **7.7%** | **1.6%** | **1.1%** | **2.7%** | **100.0%** |
| New York | 55.1% | 19.1% | 14.0% | 8.5% | .9% | 2.4% | 100.0% |
| United States | 60.1% | 18.2% | 12.3% | 5.5% | 1.1% | 2.8% | 100.0% |

Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

# Household Income and Poverty

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**Average Household Income**
This indicator reports median household income based on the latest 5-year American Community Survey estimates. This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not.

**Children Eligible for Free/Reduced Price Lunch**
Free or reduced price lunches are served to qualifying students in families with income between under 185 percent (reduced price) or under 130% (free lunch) of the US federal poverty threshold as part of the federal National School Lunch Program (NSLP).

| | Population Below 100% FPL | Percentage of Population Below 100% FPL | Percentage of Population under Age 18 in Poverty | Average Household Income | Percentage of Children Eligible for Free/Reduced Price Lunch |
|---|---|---|---|---|---|
| **Sullivan County** | **9,698** | **13.32%** | **18.30%** | **$81,398** | **57.91%** |
| New York | 2,581,048 | 13.58% | 18.68% | $71,117 | 56.35% |
| United States | 40,910,326 | 12.84% | 17.48% | $64,994 | 42.16% |

Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

# Uninsured Adults

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**Uninsured Population**
This indicator reports the percentage of civilian non-institutionalized population without health insurance coverage. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

| | Total Population (For Whom Insurance Status is Determined) | Uninsured Adults | Uninsured Population, Percent |
|---|---|---|---|
| **Sullivan County** | **73,222** | **4,192** | **5.7%** |
| New York | 19,276,809 | 1,037,271 | 5.4% |
| United States | 321,525,041 | 28,058,903 | 8.7% |

Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

# Population in Limited English Households

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**Limited English Households**
This indicator reports the percentage of the population aged 5 years and older living in Limited English speaking households. A limited English speaking household is one in which no household member 14 years old and over speaks only English at home, or no household member speaks a language other than English at home and speaks English "very well".

| | Total Population Age 5+ | Population in Limited English Households | Percentage of Population in Limited English Household |
|---|---|---|---|
| **Sullivan County** | **70,956** | **4,073** | **5.7%** |
| New York | 18,374,180 | 2,404,020 | 13.1% |
| United States | 306,919,116 | 35,312,024 | 8.3 |

Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

# Educational Attainment

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**Education**
Education metrics can be used to describe variation in population access, proficiency, and attainment throughout the education system, from access to pre-kindergarten through advanced degree attainment. These indicators are important because education is closely tied to health outcomes and economic opportunity.

| | Population Age 25+ with No High School Diploma | Population Age 25+ with No High School Diploma, Percent | Population Age 25+ with Bachelor's Degree or Higher, Percent |
|---|---|---|---|
| **Sullivan County** | **6,952** | **13.04%** | **26.56%** |
| New York | 1,743,890 | 12.78% | 37.46% |
| United States | 25,562,680 | 11.47% | 32.92% |

Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

# Areas Affected by a Health Professional Shortage Area (HPSA)

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**Areas Affected by a Health Professional Shortage Area**
This indicator reports the percentage of the population that is living in a geographic area designated as a "Health Professional Shortage Area" (HPSA), defined as having a shortage of primary medical care, dental or mental health professionals. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

| | Population Living in an Area Affected by a HPSA | Total Population (5 year estimate) | Percentage of Population Living in an Area Affected by a HPSA |
|---|---|---|---|
| **Sullivan County** | **25,923** | **75,329** | **34.41%** |
| New York | 5,259,306 | 19,514,849 | 26.95% |
| United States | 73,467,356 | 326,569,308 | 22.50% |

Data Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database. May 2021. Source geography: HPSA

# Access to Healthcare Services

Return to Report

| | Dental Care | | Mental Care | | Primary Care | |
|---|---|---|---|---|---|---|
| | Ratio of Residents to Dental Health Providers | Dental Health Providers | Ratio of Residents to Mental Health Providers | Mental Health Providers | Ratio of Residents to Primary Care Providers | Primary Care Providers |
| **Sullivan County** | **2,369** | **15** | **512** | **120** | **2,898** | **42** |
| New York State | 1,129 | 7,654 | 310 | 40,239 | 1,180 | 22,450 |
| Top U.S. Performers | 1,210 | 114,524 | 250 | 442,757 | 1,010 | 349,603 |

Dental Care Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), July 2022. Source geography: Address

Mental Care Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), July 2022. Source geography: County

Primary Care Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), July 2022. Source geography: County

**Dental Care**
This indicator reports the number of oral health care providers with a CMS National Provider Identifier (NPI). Providers included in this summary are those who list "dentist", "general practice dentist", or "pediatric dentistry" as their primary practice classification, regardless of sub-specialty. Data are from the latest Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) downloadable file.

**Mental Care**
This indicator reports the number of mental health providers in the report area as a rate per 100,000 total area population. Mental health providers include psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care. Data from the 2020 Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) downloadable file are used in the 2021 County Health Rankings.

**Primary Care**
This indicator reports the number of primary care physicians per 100,000 population. 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 aged 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.

# Preventative Services – Core Preventable Services

Return to Report

| | Percentage of Males age 65+ Up to Date on Core Preventative Services | Percentage of Females age 65+ Up to Date on Core Preventative Services |
|---|---|---|
| **Sullivan County** | **23.5%** | **21.2%** |
| New York | 23.6% | 23.7% |
| United States | 32.4% | 28.4% |

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2018. Source geography: Tract

**Male Preventative Services**
This indicator reports the percentage of males age 65 years and older who report that they are up to date on a core set of clinical preventive services. Services include: an influenza vaccination in the past year; a PPV ever; and either a fecal occult blood test (FOBT) within the past year, a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or a colonoscopy within the past 10 years.

**Female Preventative Services**
This indicator reports the percentage of females age 65 years and older who report that they are up to date on a core set of clinical preventive services. Services include: an influenza vaccination in the past year; a pneumococcal vaccination (PPV) ever; either a fecal occult blood test (FOBT) within the past year, a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or a colonoscopy within the previous 10 years; and a mammogram in the past 2 years.

# Preventative Services – Blood Pressure, Diabetes, and Preventable Hospitalizations

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| | Blood Pressure Medication Nonadherence | Medicare Enrollees with Diabetes with Annual Exam | Preventable Hospitalizations per 100,000 Beneficiaries |
|---|---|---|---|
| **Sullivan County** | **21.5%** | **87.2%** | **2,771** |
| New York | 21.2% | 88.6% | 2,704 |
| United States | 21.8% | 87.5% | 2,865 |

Blood Pressure Medication Nonadherence Data Source: Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke . 2018. Source geography: County

Diabetes Annual Exam Data Source: Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care. 2019. Source geography: County

Preventable Hospitalizations Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2020. Source geography: County

**Blood Pressure**
This indicator reports the number and percentage of Medicare beneficiaries not adhering to blood pressure medication schedules. Nonadherence is defined having medication coverage days at less than 80%.

**Diabetes Annual Exam**
This indicator reports the percentage of diabetic Medicare patients who have had a hemoglobin A1c (hA1c) test, a blood test which measures blood sugar levels, administered by a health care professional in the past year. This indicator is relevant because engaging in preventive behaviors allows for early detection and treatment of health problems. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

**Preventable Hospitalizations**
This indicator reports the preventable hospitalization rate among Medicare beneficiaries for the latest reporting period. Preventable hospitalizations include hospital admissions for one or more of the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, bacterial pneumonia, or urinary tract infection. Rates are presented per 100,000 beneficiaries.

# Preventative Services – Cancer Screenings

Return to Report

| | Adults with Adequate Colorectal Cancer Screening | Females age 21-65 with Recent Pap Smear | Females Age 50-74 with Recent Mammogram |
|---|---|---|---|
| **Sullivan County** | **61.4%** | **85.3%** | **69.3%** |
| New York | 64.0% | 85.6% | 76.4% |
| United States | 65.0% | 85.5% | 77.8% |

Colorectal Cancer Screening Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2018.

Pap Smear Screening Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2018.

Mammogram Screening Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2018.

**Colorectal Cancer Screening**
This indicator reports the percentage of adults with adequate colorectal cancer screening.

**Pap Smear Screening**
This indicator reports the percentage of females age 21–65 years who report having had a Papanicolaou (Pap) smear within the previous 3 years.

**Mammogram Screening**
This indicator reports the percentage of females age 50-74 years who report having had a mammogram within the previous 2 years.

# Health Outcomes and Mortality – Cancer Incidence Rates

Return to Report

**Cancer Incidence Rates**
These indicators report the age adjusted incidence rate (cases per 100,000 population per year) of individuals with cancer adjusted to 2000 U.S. standard population age groups (Under Age 1, 1-4, 5-9, ..., 80-84, 85 and older).

| | Breast Cancer Incidence Rate (Per 100,000 Population) | Colorectal Cancer Incidence Rate (Per 100,000 Population) | Lung Cancer Incidence Rate (Per 100,000 Population) | Prostate Cancer Incidence Rate (Per 100,000 Population) |
|---|---|---|---|---|
| **Sullivan County** | **115.6** | **40.8** | **66.1** | **79.8** |
| New York | 139.9 | 38.1 | 58.0 | 126.5 |
| United States | 126.8 | 38.0 | 57.3 | 106.2 |

| | Breast Cancer New Cases Annual Average | Colorectal Cancer New Cases Annual Average | Lung Cancer New Cases Annual Average | Prostate Cancer New Cases Annual Average |
|---|---|---|---|---|
| **Sullivan County** | **58** | **40** | **71** | **45** |
| New York | 16,483 | 8,979 | 14,069 | 14,479 |
| United States | 249,261 | 143,200 | 222,811 | 200,677 |

Data Source: State Cancer Profiles. 2014-18. Source geography: County

# Health Outcomes and Mortality – Chronic Conditions

Return to Report

| | Percentage of Adults with Diagnosed Diabetes | Percentage of Adults Ever Diagnosed with Coronary Heart Disease (Crude) | Percentage of Adults with High Blood Pressure |
|---|---|---|---|
| **Sullivan County** | **8.6%** | **7.3%** | **33.4%** |
| New York | 8.9% | 5.9% | 29.9% |
| United States | 9.0% | 6.2% | 32.6% |

Diabetes Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2019. Source geography: County

Coronary Heart Disease and High Blood Pressure Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2019

**Diabetes**
This indicator reports the number and percentage of adults age 20 and older who have ever been told by a doctor that they have diabetes. This indicator is relevant because diabetes is a prevalent problem in the U.S.; it may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

**Coronary Heart Disease**
This indicator reports the percentage of adults age 18 and older who report ever having been told by a doctor, nurse, or other health professional that they had angina or coronary heart disease.

**High Blood Pressure**
This indicator reports the percentage of adults age 18 who report ever having been told by a doctor, nurse, or other health professional that they have high blood pressure. Women who were told high blood pressure only during pregnancy and those who were told they had borderline hypertension were not included.

# Health Outcomes and Mortality – Mortality

Return to Report

**Cancer Deaths**
This indicator reports the 2016-2020 five-year average rate of death due to malignant neoplasm (cancer) per 100,000 population.

**Heart Disease Deaths**
This indicator reports the 2016-2020 five-year average rate of death due to heart disease (ICD10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population.

**Lung Disease Deaths**
This indicator reports the 2016-2020 five-year average rate of death due to chronic lower respiratory disease per 100,000 population.

| | Cancer Death Rate (Per 100,000 Population) | Heart Disease Death Rate (Per 100,000 Population) | Lung Disease Death Rate (Per 100,000 Population) | Stroke Death Rate (Per 100,000 Population) |
|---|---|---|---|---|
| **Sullivan County** | **165.8** | **171.9** | **46.8** | **27.7** |
| New York | 137.5 | 174.3 | 27.7 | 24.6 |
| United States | 149.4 | 164.8 | 39.1 | 37.6 |

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

# Injury and Violence – Unintentional Injuries

Return to Report

**Death due to Unintentional Injury (Accident)**
This indicator reports the 2016-2020 five-year average rate of death due to unintentional injury (accident) per 100,000 population.

| | Unintentional Injury Death Rate (Per 100,000 Population) | Unintentional Injury Five Year Total Deaths, 2016-2020 Total |
|---|---|---|
| **Sullivan County** | **76.8** | **294** |
| New York | 36.0 | 38,602 |
| United States | 50.4 | 872,432 |

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

# Injury and Violence – Violent Crime and Property Crime

Return to Report

**Violent Crime**
Violent crime includes homicide, rape, robbery, and aggravated assault.

**Property Crime**
This indicator reports the rate of property crime offenses reported by law enforcement per 100,000 residents. Property crimes include burglary, larceny-theft, motor vehicle theft, and arson. This indicator is relevant because it assesses community safety.

| | Violent Crimes, Annual Rate (Per 100,000 Pop.) | Violent Crimes, 3-year Total | Property Crimes, Annual Rate (Per 100,000 Pop.) | Property Crimes, Annual Average |
|---|---|---|---|---|
| **Sullivan County** | **253.80** | **683** | **1672.7** | **1,258** |
| New York | 536.90 | 968,353 | 1,629.3 | 321,704 |
| United States | 416.00 | 4,579,031 | 2,466.1 | 7,915,583 |

Data Source: Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2015 - 2017. Source geography: County

# Maternal, Infant, and Child Care – Infant Deaths, Low Weight Births, Birth Care

Return to Report

| | Number of Infant Deaths | Infant Deaths per 1,000 Live Births | Number of Low Birthweight Births | Low Birthweight Births, Percentage | Number of Births with Late/No Care | Births with Late/No Care, Percentage |
|---|---|---|---|---|---|---|
| **Sullivan County** | **23** | **4.0** | **492** | **8.5%** | **No Data** | **No Data** |
| New York | 7,073 | 4.4 | 127,453 | 8.0% | 32,799 | 4.8% |
| United States | 154,135 | 5.7 | 2,303,029 | 8.2% | 697,581 | 6.1% |

Infant Deaths and Low Birthweight Births Data Source: University of Wisconsin Population Health Institute, County Health Rankings. 2014-2020. Source geography: County

Births with Late/No Care Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research. 2019. Source geography: County

**Infant Deaths**
This indicator reports information about infant mortality, which is defined as the number of all infant deaths (within 1 year) per 1,000 live births.

**Low Birthweight Births**
This indicator reports the percentage of live births where the infant weighed less than 2,500 grams (approximately 5 lbs., 8 oz.). These data are reported for a 7-year aggregated time period.

**Births with Late/No Care**
This indicator reports the percentage of women who did not obtain prenatal care until the 7th month (or later) of pregnancy or who didn't have any prenatal care, as of all who gave birth during the three-year period from 2017 to 2019. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health knowledge, insufficient provider outreach, and/or social barriers preventing utilization of services.

# Mental Health – Adult Mental Health

Return to Report

| | Adults with Poor Mental Health Percent | Suicide Rate (Per 100,000 Population) | Suicide Five Year Total, 2016-2020 |
|---|---|---|---|
| **Sullivan County** | **13.9%** | **15.8** | **56** |
| New York | 12.9% | 86 | 8,445 |
| United States | 13.6% | 14.3 | 233,972 |

Poor Mental Health Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2019. Source geography: Tract

Suicide Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

**Poor Mental Health**
This indicator reports the percentage of adults age 18 and older who report 14 or more days during the past 30 days during which their mental health was not good.

**Suicides**
This indicator reports the 2016-2020 five-year average rate of death due to intentional self-harm (suicide) per 100,000 population.

# Nutrition, Physical Inactivity Obesity – Food Environment

Return to Report

**Food Deserts**
This indicator reports the number of neighborhoods in the report area that are within food deserts. The USDA Food Access Research Atlas defines a food desert as any neighborhood that lacks healthy food sources due to income level, distance to supermarkets, or vehicle access.

**Low Food Access**
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.

**SNAP Authorized Retailers**
This indicator reports the number of SNAP-authorized food stores as a rate per 10,000 population. SNAP-authorized stores include grocery stores as well as supercenters, specialty food stores, and convenience stores that are authorized to accept SNAP (Supplemental Nutrition Assistance Program) benefits.

| | Total Population (2010) | Food Desert Population | Food Desert Population, Percent | Population with Low Food Access | Population with Low Food Access, Percent | Total SNAP-Authorized Retailers | SNAP-Authorized Retailers per 10,000 Population |
|---|---|---|---|---|---|---|---|
| **Sullivan County** | **77,547** | **11,166** | **14.4%** | **3,605** | **4.6%** | **113** | **14.91** |
| New York | 19,378,201 | 757,797 | 3.9% | 2,316,550 | 11.9% | 16,549 | 8.58 |
| United States | 308,745,538 | 39,074,974 | 12.7% | 68,611,398 | 22.2% | 248,526 | 7.47 |

Food Desert and Low Food Access Data Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2019. Source geography: Tract
SNAP Authorized Retailers Data Source: US Department of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator. Additional data analysis by CARES. 2021. Source geography: Tract

# Nutrition, Physical Inactivity Obesity – Obesity and Physical Activity

Return to Report

| | Population Age 20+ | Adults with BMI > 30.0 | Adults with BMI > 30.0, Percent | Adults with No Leisure Time Physical Activity | Adults with No Leisure Time Physical Activity, Percent |
|---|---|---|---|---|---|
| **Sullivan County** | **57,825** | **19,776** | **33.9%** | **16,967** | **27.9%** |
| New York | 14,929,831 | 3,987,638 | 26.6% | 3,559,756 | 23.2% |
| United States | 239,867,275 | 69,961,348 | 29.0% | 54,200,862 | 22.0% |

Obesity Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2019. Source geography: County

Physical Activity Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2019. Source geography: County

**Obesity**
This indicator reports the number and percentage of adults aged 20 and older self-report having a Body Mass Index (BMI) greater than 30.0 (obese). Body mass index (weight [kg]/height [m]2) was derived from self-report of height and weight. Excess weight may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

**Physical Activity**
This indicator is based on the question: "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?" This indicator is relevant because current behaviors are determinants of future health and this indicator may illustrate a cause of significant health issues, such as obesity and poor cardiovascular health.

# Physical Environment – Cost Burdened Households

Return to Report

**Cost Burdened Households**
This indicator reports the percentage of the households where housing costs are 30% or more total household income. This indicator provides information on the cost of monthly housing expenses for owners and renters. The information offers a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing programs to meet the needs of people at different economic levels. The following zip codes have the highest percentage of households with severe cost burden of housing.

| | Total Households | Cost Burdened Households (30%) | Percentage of Cost Burdened Households |
|---|---|---|---|
| **Sullivan County** | **28,762** | **8,845** | **30.75%** |
| New York | 7,417,224 | 2,737,641 | 36.91% |
| United States | 122,354,219 | 37,128,748 | 30.35% |

Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

# Physical Environment – Housing

Return to Report

| | Households with No or Slow Internet, Percent | Substandard Housing Conditions, Percent |
|---|---|---|
| **Sullivan County** | **17.5%** | **30.8%** |
| New York | 14.8% | 38.5% |
| United States | 14.8% | 31.5% |

Internet Access Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

Substandard Housing Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

**Internet Access**
This indicator reports the percentage of households who either use dial-up as their only way of internet connection or have internet access but don't pay for the service, or have no internet access in their home, based on the 2014-2019 American Community Survey estimates.

**Substandard Housing**
This indicator reports the percentage of owner- and renter-occupied housing units having at least one of the following conditions: 1) lacking complete plumbing facilities, 2) lacking complete kitchen facilities, 3) with 1 or more occupants per room, 4) selected monthly owner costs as a percentage of household income greater than 30%, and 5) gross rent as a percentage of household income greater than 30%. Selected conditions provide information in assessing the quality of the housing inventory and its occupants. This data is used to easily identify homes where the quality of living and housing can be considered substandard.

# Physical Environment – Environment and Housing

Return to Report

| | Percent Population within 1/2 Mile of a Park | Percent Population Using Public Transit for Commute to Work |
|---|---|---|
| **Sullivan County** | **22%** | **1.97%** |
| New York | 57% | 26.23% |
| United States | 46% | 4.58% |

Living Near a Park Data Source: Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking Network. 2015. Source geography: Tract

Public Transit Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

**Living Near a Park**
This indicator reports the percentage of population living within 1/2 mile of a park. This indicator is relevant because access to outdoor recreation encourages physical activity and other healthy behaviors.

**Public Transit**
This indicator reports the percentage of population using public transportation as their primary means of commuting to work. Public transportation includes buses or trolley buses, streetcars or trolley cars, subway or elevated rails, and ferryboats.

# Substance Abuse – Adult Alcohol and Tobacco Use

Return to Report

| | Percentage of Adults Binge Drinking in the Past 30 Days | Percentage of Adult Current Smokers |
|---|---|---|
| **Sullivan County** | 17.6% | 18.7% |
| New York | 17.9% | 15.0% |
| United States | 16.7% | 15.7% |

Alcohol Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2019. Source geography: Tract

Tobacco Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the 500 Cities Data Portal. 2019. Source geography: Tract

**Adult Alcohol Use**
This indicator reports the percentage of adults age 18 and older who report having five or more drinks (men) or four or more drinks (women) on an occasion in the past 30 days.

**Adult Tobacco Use**
This indicator reports the percentage of adults age 18 and older who report having smoked at least 100 cigarettes in their lifetime and currently smoke every day or some days.

# Substance Abuse – Opioid Overdose

Return to Report

**Opioid Overdose**
This indicator reports the 2016-2020 five-year average rate of death due to opioid drug overdose per 100,000 population. Rates are resummarized for report areas from county level data, only where data is available. This indicator is relevant because opioid drug overdose is the leading cause of injury deaths in the United States, and they have increased dramatically in recent years.

| | Five Year Total Deaths, 2016-2020 Total | Age-Adjusted Death Rate (Per 100,000 Population) |
|---|---|---|
| **Sullivan County** | **162** | **45.9** |
| New York | 16,467 | 16.5 |
| United States | 256,428 | 16.0 |

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2016-2020. Source geography: County

# Appendix B – Available Resources

Return to Report

The listing below, while not all-inclusive of every available resource Sullivan County, provides information on some of the resources in the community available to address the health needs.

**Hospitals:**

**Garnet Health Medical Center – Catskills**

68 Harris-**B**ushville Road
Monticello, NY 12742
(845) 794-3300

**Catskill Regional Medical Center – Grover M. Herman Hospital**

8881 State Route 97
Callicoon, NY 12723
(845) 887-5530

**Federally Qualified Health Centers:**

**Monticello:**

- ODA Monticello Primary Care Health Care Center – 60 Jefferson Street, Suite 1, Monticello 718-260-4600
- Cornerstone MAT at HVCS – 20 Crystal Street, Monticello 845-791-8871
- HRHCare Monticello – 19 Lakewood Avenue, Monticello 845-794-2010
- Hudson River HealthCare Monticello - 23 Lakewood Avenue, Monticello 845-794-2010

**South Fallsburg Health Center:**

- ODA Monticello – 36 Laurel Avenue, South Fallsburg 845-482-9394

**Public Health:**

**Sullivan County Health Department**
100 North Street
Monticello, New York 12701
845.794.3000

https://sullivanny.us/Departments/Publichealth

**Substance Abuse and Mental Health Services:**

Sullivan County Department of Community Resources
https://sullivanny.us/Departments/CommunityServices
Catholic Charities
http://www.cccsos.org/about/locations/
Lexington Center for Recovery
https://lexingtonctr.org/locations/sullivan-county/

# Appendix B – Available Resources

Return to Report

## Other Resources:

Catskills, New York Non-Profit Agencies
http://catskillsny.chambermaster.com/list/category/non-profit-agencies-8300

## Food Pantries:

**Bloomingburg**

**Our Lady of Assumption / EMERGENCY ONLY** — High Street Saturday 10:00am
Call for appointment by 12:00pm Wednesday: 733-1477

**Blessing Pantry Callicoon Methodist Church Pantry** — 9290 Route 97 1st and 3rd Wednesday 1:00pm-3:30pm Walk-In with I.D. (845) 887-5112

**Claryville**

**Claryville Reformed Church Claryville** — Road Tuesday and Thursday 10:00am-2:00pm
For information call: 985-2041 Walk-In no I.D. required

**Grahamsville**

**United Methodist Church** — 356 Route 55 Anytime by appointment: 985-2283

**Hankins**

**Hankins Assembly of God** — 14 Country Road 132 Wednesday call for times: 887-4597
Walk-In with I.D.

**Hurleyville**

**United Methodist Church** — Main Street Thursday 6:00pm-7:00pm
434-5097 Walk-In no I.D. required

**Jeffersonville**

**First Presbyterian Church (For Residents Of Immediate Area Only)** — Main Street next to Firehouse Usually 3rd Saturday 9:00am-11:00am
Pearl Gain for information 796-8786 (cell) Janet Nystrom 482-3188

**Liberty**

**Soul Food Café @ United Methodist Church** — 170 N. Main Street
Food Prayer Fellowship Monday Night Dinners 5:00pm-6:30pm 292-6243

# Appendix B – Available Resources

Return to Report

## Food Pantries (continued):

| | |
|---|---|
| **Holy Harry's Food Pantry** | **85 Academy Street, Liberty, NY 12754. Contact number: Bud Leconey (845) 313-1204. (Mondays 1pm – 3pm)** |
| **Lighthouse Ministries** | 23 Triangle Road, Liberty, NY 12754. Contact number: (845) 985-7026 (3rd Thursday 11:00am - 2:00pm). Call for emergencies |
| **Vine & Branch** | 2535 Rt. 52 Call For Pantry Days<br>(3RD Sunday of Every Month 1:00pm-3:00pm)<br>Pastor Ed or Bob 292-5227 |
| **Livingston Manor** | |
| **United Methodist Church :** | 89 Pearl Street and Old Route 17 3rd Thursday 6:00pm-7:00pm Call for information: 607-498-5153 / 845-439-5134 |
| **Monticello** | |
| **Federation for the Homeless :** | 9 Monticello Street, Monticello, NY 12701. Contact number: (845) 794-2604. MUST REGISTER to obtain yellow card for access to food pantry. Bring I.D.<br>Food Pantry open on Fridays 11:30am-1:00pm<br>Breakfast served Mon-Fri 8:30am-9:30am<br>Lunch served Mon-Fri 11:30am-1:00pm |
| **St. John's Episcopal Church :** | **15 St. John Street**<br>**Open on the 1st,2nd,3rd & 4th Tuesday Each Month 4:00pm-6:00pm**<br>**(Closed on the 5th Tuesday) Call for information: 794-8111** |
| **Hudson Valley Community Services :** | 20 Crystal Street, Monticello, NY<br>(HVCS) Food Pantry for clients 791-8871 |
| **United Way of Sullivan County Emergency Food :** | 33 Lakewood Avenue Call for availability: 794-1771 |
| **Ulster County Community Action / C.A.C.H.E. :** | 318 E. Broadway, Suite 102 Call for availability: 794-4228 |
| **Mongaup Valley** | |
| **Methodist Church** | Route 17B<br>Non-Perishable Only 3rd Saturday 10am-12pm<br>Vicki Simpson 583-5149<br>Food & Clothing Give-Away |
| **Narrowsburg** | |
| **Ecumenical Food Pantry** | 151 Bridge Street, Narrowsburg, NY 12764. Contact number: (845) 252-6761. (Thursdays 4:30pm-5:30pm) |
| **Pond Eddy** | |
| **United Methodist Church :** | Church and Berme Roads<br>Call for information: 856-1129 - 858-1192 |
| **Rock Hill** | 210 Katrina Falls Road |
| **Church of Nazarene :** | Anytime by appointment: 796-3729 |

# Appendix B – Available Resources

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## Food Pantries (continued):

| | |
|---|---|
| **United Methodist Church :** | **410 Rock Hill Drive**<br>**Call for information: 796-3833** |
| **Roscoe** | |
| **Roscoe Presbyterian Church / EMERGENCY ONLY:** | Route 17 Anytime by appointment: Helen Stewart 607-498-5409 |
| **United Church of Roscoe :** | 2 Church Street, Roscoe, NY 12779. Contact number: (607) 498-4108 or (607) 498-5153. (3rd Wednesday of each month 2pm-4pm) |
| **South Fallsburg** | |
| **St. Andrews Episcopal Church** | 5277 NY-42, South Fallsburg, NY, 12779. Contact number: (845) 436-7539. (2nd and 4th Friday of the month 5:00 PM - 7:00 PM). Walk-in /No I.D. required |
| **Sullivan County Senior Citizens Meals On Wheels** | Call: Office Of The Aging: 807-0241 |
| **Summitville** | |
| **Mamakating United Methodist Church :** | Anytime by appointment 657-7255 |
| **White Lake** | |
| **Faith Ministries of White Lake** | 2nd Thursday 10:00am-12:00pm |
| **Reformed Presbyterian Church and** | 4th Thursday 5:00pm-6:00pm |
| **Blessing Shephard's Pantry :** | Coralie Bloom 583-5885 - 707-2333 |

# Limitations and Information Gaps

Return to Report

As with all data collection efforts, there are several limitations related to the assessment's research methods that should be acknowledged. Years of the most current data available differ by data source. In some instances, 2021 may be the most current year available for data, while 2014 may be the most current year for other sources. Likewise, survey data based on self-reports, such as the Behavioral Risk Factor Surveillance Survey (BRFSS), should be interpreted with particular caution. In some instances, respondents may over or under report behaviors and illnesses based on fear of social stigma or misunderstanding the question being asked.

In addition, respondents may be prone to recall bias – that is, they may attempt to answer accurately, but they remember incorrectly. In some surveys, reporting and recall bias may differ according to a risk factor or health outcome of interest. Despite these limitations, most of the self-report surveys analyzed in this CHNA benefit from large sample sizes and repeated administrations, enabling comparison over time. Similarly, while the qualitative data collected for this study provide valuable insights, results are not statistically representative of a larger population due to nonrandom recruiting techniques and a small sample size. Data were collected at one point in time and among a limited number of individuals.

Therefore, findings, while directional and descriptive, should not be interpreted as definitive.