Community Health Needs Assessment

Community Health Services Plan

2025-2027

Cobleskill Regional Hospital

Bassett Healthcare Network

Carolyn Lewis, Director
Legislative Affairs & Grants
607-547-6912
www.bassett.org

Bassett Healthcare Network
1 Atwell Rd
Cooperstown, NY 13326

ACKNOWLEDGEMENTS

The Community Health Assessment (CHA) is the result of a collaborative effort among community partners, stakeholders, and public health professionals. We extend our gratitude to everyone who contributed their time, expertise, and insight to this important work. We are grateful to community members whose perspectives and participation were essential in shaping the priorities identified in this assessment. The following organizations were central to gathering data, engaging stakeholders, and guiding the development of this report:

Bassett Healthcare Network

Carolyn Lewis, Director Legislative Affairs and Grants

Diane Cusworth, RN, BSN, MSHA Community Health

Cobleskill Regional Hospital

Board of Trustees

TABLE OF CONTENTS

Community Health Service Plan

Executive Summary

Introduction

Cobleskill Regional Hospital (CRH), in partnership with Bassett Healthcare Network (BHN) completed a comprehensive Community Health Assessment (CHA) and developed a corresponding Community Health Service Plan (CSP) for the current Prevention Agenda cycle. The 2025-2030 NYSPA organizes statewide priorities within five domains: Economic Stability, Education Access and Quality, Social and Community Context, Neighborhood and Built Environment, and Healthcare Access and Quality. These domains reflect the social and structural conditions that influence health and guide local planning. The CHA identifies the county's major health needs using primary and secondary data, and the CSP outlines interventions selected in alignment with the New York State Prevention Agenda (NYSPA).

This Community Health Needs Assessment (CHNA) serves as a strategic framework for improving health outcomes in Schoharie County, and supports Cobleskill Regional Hospital's mission to deliver patient-centered care while fostering a healthier, more resilient community. It provides a detailed analysis of current health indicators, demographic trends, and social determinants of health, offering actionable insights for Cobleskill Regional Hospital and its community partners.

The 2025 assessment identifies critical areas of concern, including mental health challenges such as suicide risk and the growing prevalence of chronic disease, all of which are compounded by rural access barriers and socioeconomic disparities. To address these issues, Cobleskill Regional Hospital (CRH) is implementing evidence-based strategies and collaborative initiatives designed to improve access, strengthen behavioral health supports, and advance health equity.

Key initiatives include the **Food is Medicine Program**, which provides medically tailored meals and nutrition counseling to individuals with chronic conditions, improving nutrition and reducing complications among low-income patients. The **Promise to Talk Program** launches a community-wide campaign to encourage open conversations about mental health, reducing stigma and promoting help-seeking behaviors. To enhance crisis response, CRH is introducing **Suicide Prevention Training for Staff**, equipping healthcare providers and frontline staff with the skills to identify and respond to suicide risk. Additionally, **Educational Sessions and Support Groups for Older Adults** aim to reduce loneliness and social isolation among seniors, improving mental well-being and fostering community connections.

Through these initiatives, CRH seeks to expand access to high-quality care, address behavioral health needs, and reduce disparities linked to income, transportation, geographic isolation, and nutrition security. By tailoring resources to priority populations and leveraging strong community partnerships, CRH is committed to building a healthier, more resilient Schoharie County.

Prevention Agenda Priorities and Disparities

Cobleskill Regional Hospital (CRH) serves a predominantly rural region in Schoharie County, where health disparities are shaped by geographic isolation, socioeconomic challenges, and systemic gaps in care. CRH's priorities focus on addressing these barriers to improve access, equity, and health outcomes for vulnerable populations.

Access to Care

Behavioral Health

Mental health needs are acute due to provider shortages, lack of crisis response infrastructure, and cultural stigma. CRH aims to enhance behavioral health capacity by advocating for mobile crisis units, integrating behavioral health into primary care, and promoting community education to reduce stigma and encourage help-seeking.

Oral Health

Oral health disparities persist due to limited Medicaid-accepting dentists and absence of preventive programs in schools and rural areas. CRH prioritizes collaboration with dental providers and exploration of mobile clinics to deliver preventive and restorative care to underserved populations.

Chronic Disease Management

High poverty rates, food insecurity, and housing instability contribute to poor nutrition and chronic conditions such as diabetes and cardiovascular disease. CRH addresses these disparities through community partnerships, health education, and initiatives targeting social determinants of health (SDOH), including nutrition support and housing resources.

Digital and Infrastructure Gaps

Broadband limitations and low digital literacy hinder telehealth utilization and access to online health resources. CRH prioritizes digital inclusion efforts, including patient education and advocacy for improved broadband coverage, to bridge the technology gap.

Equity and Vulnerable Populations

Older adults, low-income families, and individuals with limited mobility face compounded barriers to care. CRH's approach emphasizes equity-driven strategies, such as targeted outreach, transportation assistance, and culturally competent care models.

Data Review

The 2025–2030 CHA process incorporated both primary and secondary data to identify and validate local health priorities. Primary data included an online community survey and stakeholder survey. These primary findings were complemented by a review of secondary data from the U.S. Census Bureau, American Community Survey (ACS), NYSDOH Community Health Indicator Reports (CHIRS), Behavioral Risk Factor Surveillance System (BRFSS), and the Centers for Disease Control and Prevention's (CDC) Social Vulnerability Index (SVI) (Appendix A). Together, these data sources provided a comprehensive assessment of community conditions. By combining secondary data from state, national, and local sources with primary data collected directly from residents and stakeholders, the CHNA provides a robust and balanced picture of the health status of Schoharie County. This mixed-methods approach ensures that both quantitative indicators and qualitative community perspectives inform the identification of health needs, disparities, and opportunities for intervention.

The assessment and planning processes were collaborative and community-driven. BHN led the CHA and CSP processes, including data collection, analysis, community engagement, and coordination with partners. BHN and Cobleskill Regional Hospital supported the CHA by sharing data, assisting with outreach, and participating in planning discussions.

Broad community engagement was incorporated by inviting residents, stakeholders, and service providers to contribute feedback on local needs, barriers, and system gaps via an on-line survey. Their perspectives informed the interpretation of data and helped determine which priorities required targeted intervention.

Going forward, partners supporting CSP implementation will include: Schoharie County Health Department, OFA and Community based organizations. Collectively, these partners support screening and navigation for social and behavioral health needs, outreach to priority populations, referral coordination, and community-level promotion of CSP interventions. This structure enables coordinated implementation and ensures that partner and community perspectives remain integrated throughout the Prevention Agenda cycle.

Evidence-Based Interventions and Strategies

The Community Service Plan (CSP) incorporates four evidence-based interventions designed to address the priority areas identified through the Community Health Assessment (CHA). Each intervention is fully aligned with the New York State Prevention Agenda (NYSPA) 2025–2030 framework and directly targets documented health disparities impacting low-income households, older adults, rural communities, and other at-risk populations.

CRH selected its strategies based on four guiding principles: ensuring alignment with the most pressing health needs documented in Schoharie County, prioritizing interventions that address identified gaps in care and service shortages, leveraging existing resources and partnerships to ensure feasibility and maximize impact, and choosing approaches supported by evidence for improving population health and reducing inequities. This strategic alignment ensures that the CSP not only meets state-level objectives but also reflects the unique needs and challenges of the local community.

The following tables provide a detailed overview of each intervention, including:

- Specific Strategies: Action steps to achieve measurable outcomes.
- Target Populations: Groups most affected by health disparities.
- Process Measures: Indicators to monitor implementation and progress.
- Health Equity Impacts: Expected contributions toward reducing disparities.
- Partner Roles: Collaborative responsibilities across healthcare, public health, and community organizations.
- By integrating these components, the CSP establishes a clear roadmap for improving access, enhancing quality of care, and advancing health equity throughout the Prevention Agenda cycle.

Initiative 1: Food is Medicine Program

Strategy	Target Population	Process Measures	Health Equity Impact	Partner Roles
Provide medically tailored meals and nutrition counseling	Individuals with chronic conditions	Number of meal components provided and counseling sessions	Improved nutrition and reduced complications among low-income patients	CRH, Local Food Banks, Local Farms, Dietitians

Initiative 2: Promise to Talk Program

Strategy	Target Population	Process Measures	Health Equity Impact	Partner Roles
Launch community campaign encouraging open conversations about mental health	General population with focus on rural communities	Engagement metrics (social media reach, event participation)	Reduced stigma and increased help-seeking behaviors	CRH, Mental Health Advocates, Community Organizations

Initiative 3: Suicide Prevention Training for Staff

Strategy	Target Population	Process Measures	Health Equity Impact	Partner Roles
Train healthcare staff in suicide prevention and crisis intervention	Healthcare providers and frontline staff	Number of staff trained and competency assessments	Enhanced capacity to identify and respond to suicide risk	CRH, Behavioral Health Specialists

Initiative 4: Educational Sessions & Support Groups for Older Adults

Strategy	Target Population	Process Measures	Health Equity Impact	Partner Roles
Conduct group sessions and workshops to reduce loneliness and social isolation	Older adults (65+)	Attendance rates and participant feedback	Improved mental well-being and reduced isolation among seniors	CRH, Senior Centers, Community Volunteers

NYSPA Domain: Economic Stability NYSPA Priority: Nutrition Security		
Intervention: Food Is Medicine Program that provides access to nutritious foods.		
Target Demographic: patients at risk of diet-related chronic conditions that are in need of access to nutritious food and education as part of their healthcare experience.		
Geographic Focus: Countywide, with targeted outreach in rural areas where resource access is limited.		
Health Equity Impact: This initiative will improve chronic disease management, reduce healthcare costs, and advance health equity by addressing a key social determinant of health—nutrition.		
Process Measures	**Intended Impact**	**Partner Roles and Resources**
• Number of individuals screened for nutrition security. • Number of referrals submitted. Food vouchers provided. • Number of successful referral closures. • Volume of screenings among adults 65+ in rural communities.	• Increased identification of unmet basic needs • Improved access to food, nutrition and disease management. • Reduced socioeconomic-related barriers to health and stability. • Strengthened coordination among service providers.	BHN to provide support for partnership with area food pantries and voucher distribution. BHN Primary Care Clinic Providers: Referrals and support regarding prescription-based food process. Area food pantries, farm cooperatives for food distribution. Ability to provide food items directly on site at time of discharge.

NYSPA Domain: Social and Community Context NYSPA Priority: Mental Health and Emotional Well-Being		
Intervention: Launch the ***Promise to Talk*** campaign in collaboration with community-based organizations, the Office for the Aging (OFA), and The Gathering Place. This initiative will focus on outreach efforts to recruit and train volunteers to facilitate meaningful conversations, distribute educational materials, and host community events. The *Promise to Talk* campaign aims to foster open dialogue about mental health and reduce stigma across the region.		
Target Demographic: Elderly population, Individuals experiencing anxiety and stress, depression		
Geographic Focus: Countywide		
Health Equity Impact: Expanding access to mental health resources addresses service gaps in Schoharie County and promotes equitable care. Early identification of social-emotional concerns within rural communities helps reduce disparities in timely evaluation and access to mental health services.		
Process Measures	**Intended Impact**	**Partner Roles and Resources**
• Number of contacts made via program criteria. • Number of referrals made to other services. • Number and percentage of referrals successfully connected to services. • Number of individuals receiving support resources through the program.	• Earlier Identification: Implement screening protocols to detect mental health and social-emotional concerns at the earliest stages. • Improved Access: Expand pathways for timely assessment, early intervention, and comprehensive family and individual support services. • Enhanced Coordination: Strengthen collaboration among mental health systems, healthcare providers, and community-based agencies to ensure integrated care. • Equity in Care: Reduce disparities in mental health screening and referral processes, ensuring equitable access to evaluation and treatment services.	**Community Organizations** Support program promotion and facilitate access to training and service delivery. **Cobleskill Regional Hospital (CRH)** Lead program implementation, establish requirements, and coordinate training sessions. **Behavioral Health Network (BHN)** Manage referrals for follow-up, conduct evaluations as needed, and collaborate on care coordination.

NYSPA Domain: Social and Community Context NYSPA: Suicide		
Intervention: Train all clinical staff to provide universal suicide risk screening using the Columbia Protocol at intake and administer the full Columbia-Suicide Severity Rating Scale C-SSRS for those who screen positive at ED and In-Patient admissions.		
Target Demographic: All individuals at risk		
Geographic Focus: CRH's Service area		
Health Equity Impact: By providing suicide risk screening and follow-up assessment within CRH's service area, this intervention reduces geographic and financial barriers for rural and low-income families and improves timely access to mental health services. It strengthens early identification and connects individuals to care that may have been previously difficult to obtain locally.		
Process Measures	**Intended Impact**	**Partner Roles and Resources**
• Number of brief C-SSRS screenings completed. • Number and percentage of individuals with a positive brief C-SSRS screen. • Number of full C-SSRS assessments completed following a positive screen or clinical concern. • Number and percentage of documented follow-up or service connection.	• Earlier and more consistent identification of suicide risk among High-Risk individuals that present at the ED and In Patient. • Reduced delays between identification of risk and connection to appropriate services. • Improved coordination between screening, risk assessment, safety planning, and ongoing care. • Strengthened local capacity to monitor and address suicide risk.	• **CRH:** Leads program development and operations; oversees staffing, service delivery, ASQ-SR screening, and data monitoring; coordinates follow-up and care transitions. Provides care coordination and family support; assists with referrals and ongoing engagement. • **BHN (Primary Care Clinic):** Identifies those needing services; makes referrals; collaborates on care transitions between primary care and the Hospital.

NYSPA Domain: Social and Community Context NYSPA Priority: Social Isolation and Loneliness		
Intervention: Reduce social isolation and loneliness among older adults in Schoharie County by expanding access to community-based engagement, substance misuse prevention education and access to needed resources.		
Target Demographic: Senior population that self-identify as being socially isolated		
Geographic Focus: Include equity measures to ensure outreach to low-income, disabled, and geographically isolated seniors.		
Health Equity Impact: This intervention prioritizes adults aged 65+, and rural residents who face higher rates of unmet basic needs and limited access to services. Expanding outreach, screening and navigation improves equitable access to services and stability supports across the county.		
Process Measures	**Intended Impact**	**Partner Roles and Resources**
• Number of individuals screened for loneliness and isolation • Number of referrals submitted. • Number of successful referral closures. • Volume of screenings among adults 65+ in northern rural communities.	• Increased identification of unmet basic needs. • Improved access to social resources and supports. • Reduced socioeconomic-related barriers to health and stability. • Strengthened coordination among service providers.	**Cobleskill Regional Hospital (CRH)** Conducts mental health screenings and navigation services; delivers educational programs such as “Lunch and Learn” sessions at senior centers. **Behavioral Health Network (BHN)** Provides access to support groups for individuals managing cancer, heart disease, and diabetes. **Office for the Aging (OFA)** Promotes educational programs and facilitates engagement with older adults. **The Gathering Place** Hosts community events and provides a welcoming environment for outreach, education, and mental health awareness activities.

Progress and Evaluation

Cobleskill Regional Hospital (CRH) will implement a robust monitoring and evaluation framework to ensure effective execution of the Community Service Plan (CSP). Progress will be tracked using clearly defined process measures across all four priority interventions. These measures will include:

- Screening Volume: Number of individuals screened for targeted conditions.
- Referral Activity: Frequency and appropriateness of referrals to specialty or supportive services.
- Service Connection: Percentage of referred individuals successfully connected to care.
- Timeliness of Access: Average time from referral to service initiation.

Performance data will be reviewed regularly in collaboration with community partners to assess reach, identify service gaps, and evaluate whether interventions are improving access and reducing health disparities among priority populations.

CRH will document progress through annual CSP reports and conduct a mid-cycle assessment in 2027 to measure outcomes and inform strategic adjustments. Findings will guide refinements to intervention strategies, ensuring responsiveness to emerging needs and alignment with the NYS Prevention Agenda objectives.

To promote transparency and accountability, CRH will share evaluation results publicly through community forums, digital platforms, and stakeholder reports. This approach supports continuous quality improvement and reinforces CRH’s commitment to equitable health outcomes throughout the Prevention Agenda cycle.

Community Health Assessment (CHA)

Community Description

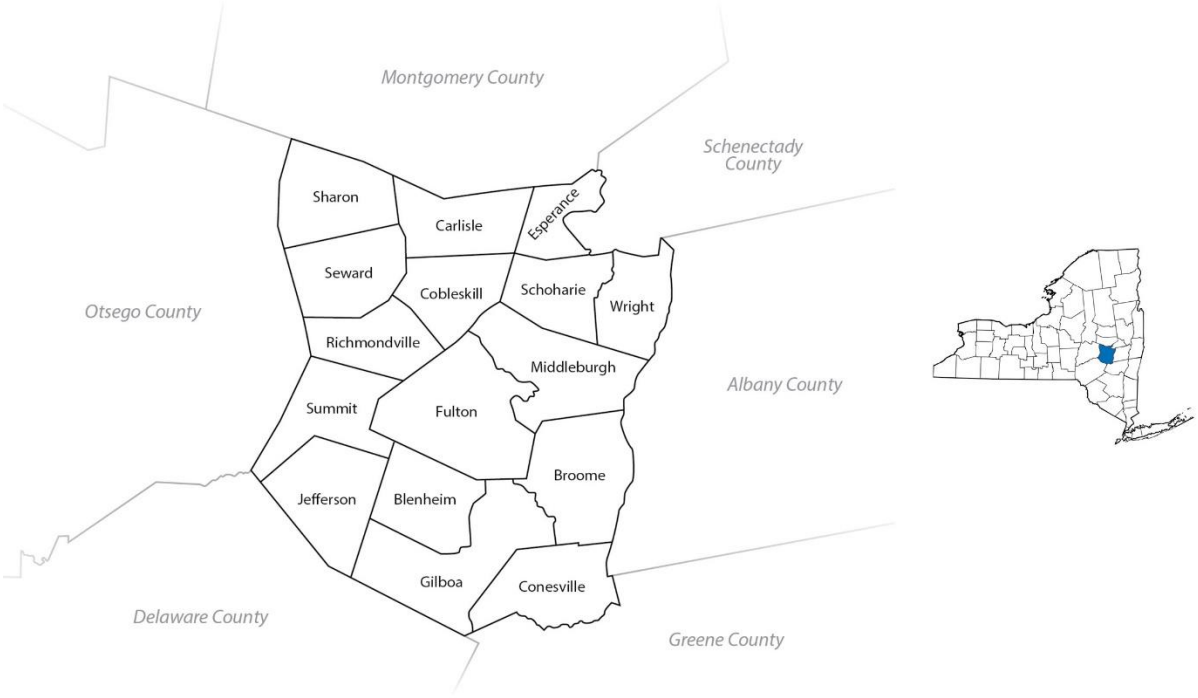
Cobleskill Regional Hospital (CRH), part of the Bassett Healthcare Network, serves as the primary acute care provider for Schoharie County, New York. The hospital's service area is rural, encompassing small towns and villages such as Cobleskill, Middleburgh, and Schoharie. With a county population of approximately **29,700 residents** spread across 622 square miles, the community is characterized by low population density, limited public transportation, and longer travel times to healthcare services compared to urban centers (U.S. Census Bureau, 2023; Schoharie Community Hub, 2024). CRH's primary service area includes towns such as Cobleskill, Carlisle, Sharon, Jefferson, Richmondville, Esperance, and Middleburgh, while its secondary service area extends into portions of adjacent counties—Otsego, Montgomery, and Delaware—particularly for specialty care and emergency services through Bassett Healthcare Network's integrated system (Bassett Healthcare Network, 2024).

Hospital Service Area

Cobleskill Regional Hospital is a 25-bed not-for-profit Critical Access Hospital founded by the people of Schoharie County in 1956. Cobleskill Regional Hospital is Schoharie County's only provider of acute inpatient medical care, emergency care, short-stay inpatient rehabilitation, and many other diagnostic and therapeutic healthcare services. Cobleskill Regional Hospital offers a broad range of inpatient and outpatient services, including an emergency department staffed around-the-clock by board certified physicians, inpatient care for medical conditions, outpatient surgery, short-stay inpatient rehabilitation, outpatient rehabilitative services (including physical therapy), open MRI and state-of-the-art medical imaging, comprehensive laboratory services, a Sleep Disorder Center, and approximately 20 specialty services in areas such as cardiology, women's health, orthopedics, and more. Cobleskill Regional Hospital has been affiliated with Bassett Healthcare Network since 1994. Their mission is to serve the community by providing excellent health care in partnership with Bassett Healthcare Network.

Cobleskill Hospital's Primary Service Region equates to all of Schoharie County:

Town	Zip Code	County
Carlisle	12031	Schoharie
Central Bridge	12035	Schoharie
Charlottesville	12036	Schoharie
Cobleskill	12043	Schoharie
Esperance	12066	Schoharie
Fultonham	12071	Schoharie
Gallupville	12073	Schoharie
Gilboa	12076	Schoharie
Howes Cave	12092	Schoharie
Jefferson	12093	Schoharie
Middleburgh	12122	Schoharie
North Blenheim	12131	Schoharie
Richmondville	12149	Schoharie
Schoharie	12157	Schoharie
Sloansville	12160	Schoharie
Summit	12175	Schoharie
Warnerville	12187	Schoharie
West Fulton	12194	Schoharie
Sharon Springs	13459	Schoharie



Demographics

The demographic profile reflects both the challenges and strengths of rural living. The population is predominantly White (over 89%), with growing diversity among Hispanic/Latino and other racial groups (Data USA, 2023). Nearly 25% of residents are age 65 or older, underscoring the importance of geriatric and chronic disease care, while children under 18 comprise about 17% of the population (Schoharie Community Hub, 2024). Median household income is approximately $71,188, below the New York State average, and poverty affects 10–14% of residents, with higher rates among minority populations (U.S. Census Bureau, 2023; Feeding America, 2024).

Category	Value
Population	29,700
Area (sq mi)	622
Age 65+	25%
Under 18	17%
White	89%
Median Income	$71,188
Poverty Rate	10-14%

Health indicators reveal concerning trends. Adults reporting their health as “poor” or “fair” exceed state averages, and leading causes of death include heart disease, cancer, chronic lower respiratory disease, and stroke (NYSDOH CHIRS Dashboard, 2024). Chronic conditions such as obesity, diabetes, and hypertension are prevalent, while behavioral health concerns—particularly depression and anxiety—are widespread. Suicide rates in the county surpass state benchmarks, and substance use, including alcohol misuse and opioid-related issues, remains a persistent challenge (CDC, 2025; NYS Suicide Prevention Center, 2024).

Access to care is constrained by provider shortages, especially in primary care, dental, and behavioral health. Few dental providers accept Medicaid, and there are no mobile clinics or school-based oral health programs, contributing to preventable oral health issues (NYSDOH Oral Health Surveillance, 2024). Recruitment and retention of clinicians remain difficult in rural settings, limiting specialty services such as oncology, cardiology, and endocrinology. While telehealth offers potential solutions, broadband gaps and low digital literacy hinder adoption (FCC Broadband Map, 2024; Schoharie County Connect ALL Grant Report, 2024).

Social determinants of health further compound these challenges. Food insecurity affects 11–12% of residents, with higher rates among children and seniors, contributing to poor nutrition and chronic disease risk (Feeding America, 2024). Housing instability and transportation barriers remain among the most cited obstacles to accessing timely care, particularly for older adults and low-income families (Rural Health Information Hub, 2024). Educational attainment lags behind state averages, impacting health literacy and

employment opportunities. Environmental health risks, including radon exposure and aging housing stock, add to community vulnerabilities (EPA, 2024; NYSDOH Radon Data, 2024).

Summary

Despite these challenges, Schoharie County demonstrates resilience through strong local identity, engaged public health leadership, and partnerships with Bassett Healthcare Network. These assets provide a foundation for addressing inequities and improving health outcomes through coordinated, evidence-based strategies.

Cobleskill Regional Hospital serves a community that is aging, economically constrained, and geographically dispersed, yet resilient and deeply connected. Health disparities in chronic disease, behavioral health, oral health, and food insecurity are compounded by socioeconomic, educational, and environmental barriers. Despite these challenges, strong local identity, engaged public health leadership, and Bassett Healthcare Network partnerships provide a foundation for addressing inequities and improving health outcomes across Schoharie County.

References

- *Bassett Healthcare Network. Cobleskill Regional Hospital Profile, 2024.*
- *U.S. Census Bureau. American Community Survey, 2023.*
- *Schoharie Community Hub. Demographics Dashboard, 2024.*
- *Data USA. Schoharie County Profile, 2023.*
- *NYSDOH. Community Health Indicator Reports (CHIRS), 2024.*
- *CDC. Suicide Data and Statistics, 2025.*
- *NYS Suicide Prevention Center. County-Level Suicide Data, 2024.*
- *Feeding America. Map the Meal Gap: Schoharie County, 2024.*
- *FCC. National Broadband Map, 2024.*
- *Schoharie County Board of Supervisors. ConnectALL Broadband Grant Resolution, 2024.*
- *NYSDOH. Oral Health Surveillance System, 2024.*
- *EPA. Radon Health Risk and Environmental Data, 2024.*

Health Status Description

The primary contributors to health challenges within Cobleskill Regional Hospital's (CRH) service area are deeply rooted in socioeconomic and structural barriers. Poverty, rural isolation, limited transportation options, provider shortages, and gaps in behavioral and oral health infrastructure intersect to create significant obstacles to care and exacerbate chronic disease outcomes (New York State Department of Health [NYSDOH], 2024; U.S. Census Bureau, 2023).

Overall health status indicators reveal concerning trends. A notable percentage of adults report their health as "poor" or "fair," exceeding state averages (NYSDOH, 2024). Leading causes of death include heart disease, cancer, chronic lower respiratory disease, and stroke (Centers for Disease Control and Prevention [CDC], 2023). Chronic conditions such as obesity, diabetes, and hypertension are prevalent, while behavioral health concerns—particularly depression and anxiety—are widespread. Suicide rates surpass state benchmarks, and substance use, including alcohol misuse and opioid-related issues, remains a persistent challenge (New York State Opioid Annual Report, 2024).

Schoharie County's rural landscape and low population density limit access to healthcare facilities, particularly specialty services. A growing proportion of the older adult population face mobility challenges, chronic conditions, and social isolation, further complicating care delivery and increasing demand for health and support services (Administration for Community Living, 2023).

Nearly 13% of residents live below the poverty line, with higher rates among children and seniors (U.S. Census Bureau, 2023). Food insecurity and housing instability contribute to poor nutrition, increased risk of chronic disease, and heightened mental health concerns (Feeding America, 2024). These factors collectively undermine health equity and access to preventive care.

Transportation challenges remain one of the most cited obstacles to accessing timely care, driven by the absence of robust public transit and shortages in volunteer driver programs (Rural Health Information Hub, 2024). Mental health services are constrained by a shortage of providers, particularly those accepting Medicaid. The lack of mobile crisis units and school-based behavioral health programs limits early intervention opportunities, while cultural stigma and low awareness further discourage help-seeking behaviors (National Alliance on Mental Illness [NAMI], 2024).

Access to dental care is limited, with few providers accepting Medicaid and no mobile clinics or school-based screenings. These gaps contribute to preventable oral health issues and associated chronic conditions (American Dental Association, 2024). Recruitment and retention of clinicians remain difficult in rural settings, resulting in limited specialty services such as oncology, cardiology, and endocrinology. While telehealth

offers potential solutions, broadband gaps and digital literacy barriers hinder adoption (Federal Communications Commission [FCC], 2024).

Lower educational attainment, limited digital access, and environmental risks such as radon and lead exposure compound health disparities. These determinants influence health behaviors, access to resources, and overall community well-being (Environmental Protection Agency [EPA], 2024).

CRH Service Area — Health Challenges & Determinants

Domain	Primary Contributors / Challenges	Impact on Health Outcomes	Key Indicators / Notes	Sources
Structural & Socioeconomic Determinants	Poverty; rural isolation; limited transportation; provider shortages; gaps in behavioral & oral health infrastructure	Reduced access to timely, coordinated care; worsened chronic disease outcomes	~13% below poverty line; structural barriers across service area	NYSDOH (2024); U.S. Census Bureau (2023)
Overall Health Status & Mortality	Higher share of adults reporting “poor” or “fair” health than state average	Elevated all-cause morbidity; excess mortality	Leading causes of death: heart disease, cancer, chronic lower respiratory disease (CLRD), stroke	NYSDOH (2024); CDC (2023)
Chronic Conditions	High prevalence of obesity, diabetes, hypertension	Increased need for long-term management; complications and hospitalizations	Ongoing preventive-care and disease-management gaps	NYSDOH (2024)
Behavioral Health	Widespread depression/anxiety; suicide rates above state benchmarks; substance use (alcohol, opioids)	Higher emergency utilization; unmet mental-health needs; overdose risk	Limited early intervention and crisis response capacity	NYS Opioid Annual Report (2024); NAMI (2024)
Access & Geography (Rurality)	Low population density; geographic dispersion of services	Longer travel times; reduced access to specialty care	Mobility challenges among older adults; social isolation	Administration for Community Living (2023)
Poverty, Food & Housing	Economic insecurity; food insecurity; housing instability	Poor nutrition; heightened chronic disease risk; mental health strain	Higher poverty among children and seniors	U.S. Census Bureau (2023); Feeding America (2024)
Transportation	Lack of robust public transit; shortages in volunteer driver programs	Missed appointments; delayed care; reduced preventive services	Most-cited obstacle for accessing timely care	

References

- *New York State Department of Health (NYSDOH). Prevention Agenda Data Dashboard, 2024.*
- *U.S. Census Bureau. American Community Survey, 2023.*
- *Centers for Disease Control and Prevention (CDC). Leading Causes of Death, 2023.*
- *New York State Opioid Annual Report, 2024.*
- *Administration for Community Living. Profile of Older Americans, 2023.*
- *Feeding America. Map the Meal Gap, 2024.*
- *Rural Health Information Hub. Transportation Barriers in Rural Areas, 2024.*
- *National Alliance on Mental Illness (NAMI). Mental Health in Rural Communities, 2024.*
- *American Dental Association. Access to Dental Care Report, 2024.*
- *Federal Communications Commission (FCC). Broadband Deployment Report, 2024.*
- *Environmental Protection Agency (EPA). Radon and Lead Exposure Data, 2024.*

Data Sources and Methodology

To develop a comprehensive understanding of the health status and needs of the population served by Cobleskill Regional Hospital (CRH), the Community Health Needs Assessment (CHNA) employed a mixed-methods approach, incorporating both primary and secondary data sources. This approach ensured that quantitative indicators were complemented by qualitative insights, providing a robust and balanced picture of community health.

Primary Data

Primary data were collected directly from community members and stakeholders to capture lived experiences and perceptions of health needs. Methods included:

- Community Surveys distributed to residents to assess health behaviors, barriers to care, and service utilization.
- Focus Groups with older adults, parents, and vulnerable populations to explore challenges such as food insecurity, behavioral health, and transportation.
- Key Informant Interviews with healthcare providers, school officials, social service agencies, and coalition leaders to identify gaps in services and emerging needs.
- Hospital Stakeholder Input from CRH staff and Bassett Healthcare Network leadership regarding patient trends and system capacity.

These qualitative findings provided essential context to supplement quantitative data, ensuring that community voices were represented in the assessment.

Secondary Data

Secondary data were compiled from reliable sources to provide insights into demographics, health outcomes, and social determinants of health. Sources included:

- Public Health Data: New York State Department of Health vital statistics, hospital discharge data, and county-level health indicators.
- National Data Sets: U.S. Census Bureau (American Community Survey), Centers for Disease Control and Prevention (CDC), and Behavioral Risk Factor Surveillance System (BRFSS).
- Local Reports: Schoharie County Public Health Department assessments, Bassett Healthcare Network utilization data, and regional planning documents.
- Education & Environmental Data: New York State Education Department statistics, Environmental Protection Agency (EPA) data, and local housing and transportation reports.

These data provided a baseline picture of population demographics, socioeconomic conditions, chronic disease prevalence, behavioral health trends, and environmental factors influencing health.

Data Analysis
Collected data were analyzed using the following approaches:

- Integration of Sources: Comparing primary and secondary data to identify consistent themes and disparities.
- Trend Analysis: Tracking health indicators over time to highlight changes in chronic disease rates, behavioral health needs, and access to care.
- Equity Lens: Disaggregating data by age, race/ethnicity, income, and geography to identify populations disproportionately affected by poor health outcomes.
- Community Prioritization: Sharing findings with local coalitions and hospital leadership to validate priorities and guide resource allocation.

Timeframe
The most recent CHNA for CRH covers 2022–2025, aligning with the New York State Prevention Agenda cycle. Secondary data were drawn primarily from 2018–2021 datasets, ensuring trend analysis and comparability. Primary data collection—including surveys, interviews, and focus groups—occurred during 2021–2022, prior to finalizing the CHNA and Community Health Improvement Plan.

Summary

By combining secondary data from state, national, and local sources with primary data collected directly from residents and stakeholders, the CHNA provides a comprehensive understanding of health status, disparities, and social determinants in Schoharie County and CRH's service area. This mixed-methods approach ensures that both quantitative indicators and qualitative community perspectives inform the identification of health needs, disparities, and opportunities for intervention

Community Engagement and Collaborative Partners

The CRH Community Health Needs Assessment (CHNA) was developed through a highly collaborative process that prioritized community engagement and cross-sector partnerships. The assessment reflects input from local residents, health professionals, and organizations committed to improving health outcomes across the county.

Community Engagement Approach:

- Public Input: Community voices were gathered through surveys, and stakeholder interviews to identify health priorities and barriers to care.
- Inclusive Participation: Efforts were made to include diverse populations, including rural residents, older adults, families, and individuals experiencing socioeconomic challenges.
- Transparency and Communication: Findings and progress updates were shared through public meetings, the Schoharie Community Hub, and partner websites to ensure accountability and encourage feedback.

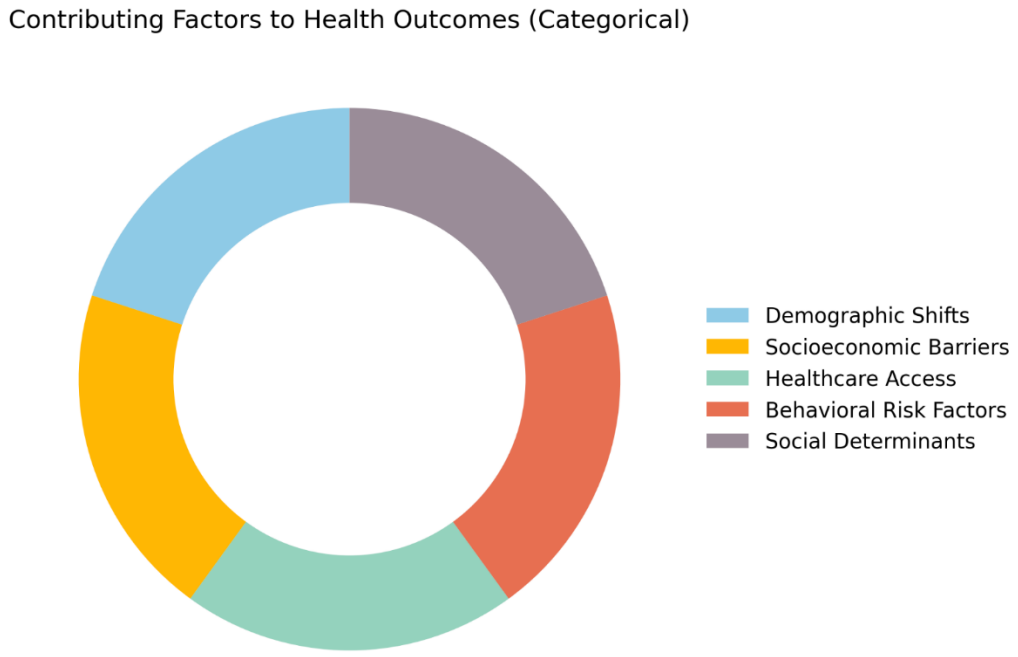
Collaborative Partners Involved:

- Cobleskill Regional Hospital
  Lead role in coordinating assessment activities and aligning with state Prevention Agenda priorities.
- Bassett Healthcare Network & Cobleskill Regional Hospital
  Provided clinical data, expertise in population health, and facilitated community forums.
- Community-Based Organizations: The Gathering Place
  Engaged leadership and member input and provided insight on social determinants of health. Local coalitions, councils, and human service agencies
  Collaborated to share resources and avoid duplication of services.
- Educational Institutions & Faith-Based Groups:
  Supported outreach and engagement in rural communities.
- Residents and Key Stakeholders:
  Participated in surveys and focus groups to ensure community priorities were represented.

This collaborative framework ensured that the CHNA was not only data-driven but also grounded in the lived experiences of Schoharie County residents. The partnerships formed during this process will continue to guide implementation of the Community Health Services Plan (CSP) and related initiatives. [bassett.org], [Schoharie...ityhub.org], [sccapinc.org]

Relevant Changes in Community Health Status and Influencing Factors

Recent changes in community health status and key influencing factors have necessitated adjustments to the ongoing workplan. Emerging trends such as rising rates of chronic disease, persistent mental health challenges, and evolving social determinants of health—including housing instability, food insecurity, and broadband access—have shifted community priorities (Schoharie Community Hub, 2024; SEECNY, 2024). Additionally, demographic changes, economic pressures, and the impact of statewide policy initiatives have influenced resource allocation and program feasibility (Bassett Healthcare Network, 2024). These factors require CRH to reassess strategies, strengthen partnerships, and refine interventions to ensure alignment with current needs, maximize impact, and maintain consistency with state and national health objectives (NYSDOH, 2024).



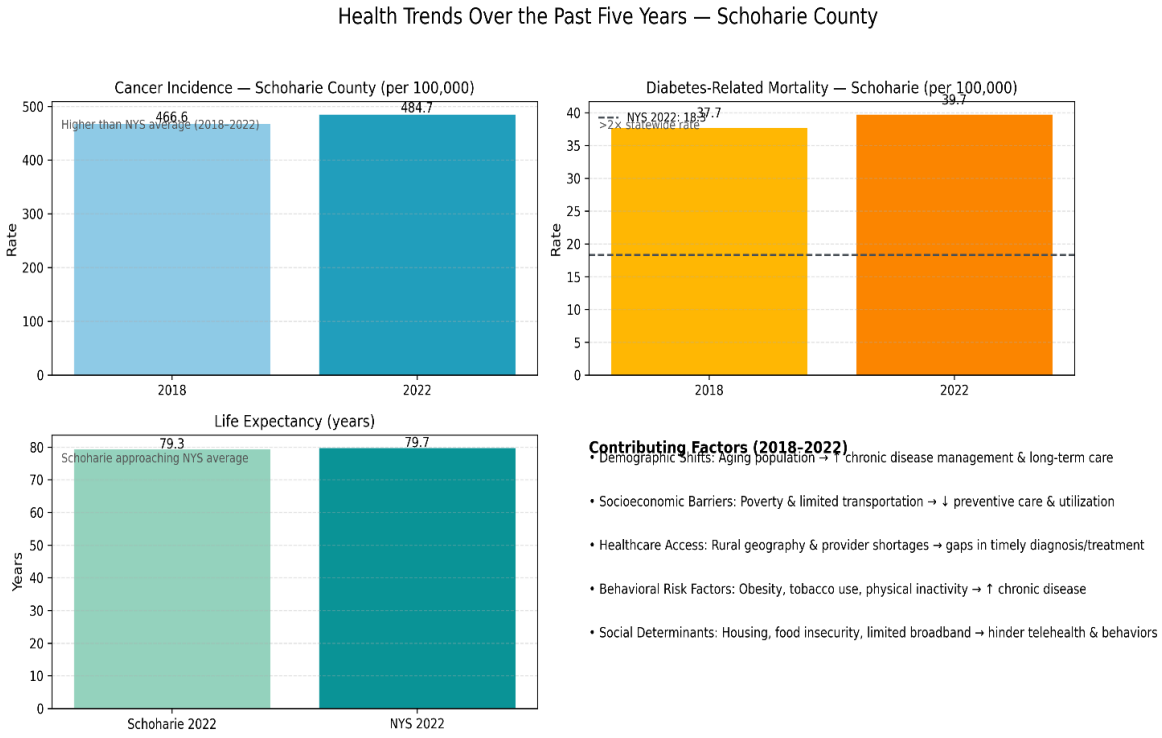
Note: Equal slice sizes reflect categories; quantitative weights not provided.
Sources: Advancing States (2024); Census Reporter (2024); Bassett Healthcare Network (2024); NYSDOH (2024); SEECNY (2024).

Health Trends Over the Past Five Years

Over the past five years, Schoharie County has experienced notable shifts in health outcomes and risk factors that reflect both progress and persistent challenges. Cancer incidence rates increased from 466.6 to 484.7 per 100,000 between 2018 and 2022, consistently higher than the New York State average (Schoharie Community Hub, 2024). Similarly, diabetes-related mortality rose slightly from 37.7 to 39.7 per 100,000, more than double the statewide rate of approximately 18.3 (NYSDOH, 2024). These trends underscore the need for targeted prevention and management strategies.

Despite these challenges, life expectancy improved modestly to 79.3 years in 2022, approaching the state average of 79.7 years (Census Reporter, 2024). This suggests that while overall longevity is improving, disparities in disease-specific outcomes persist. Several factors contribute to these patterns:

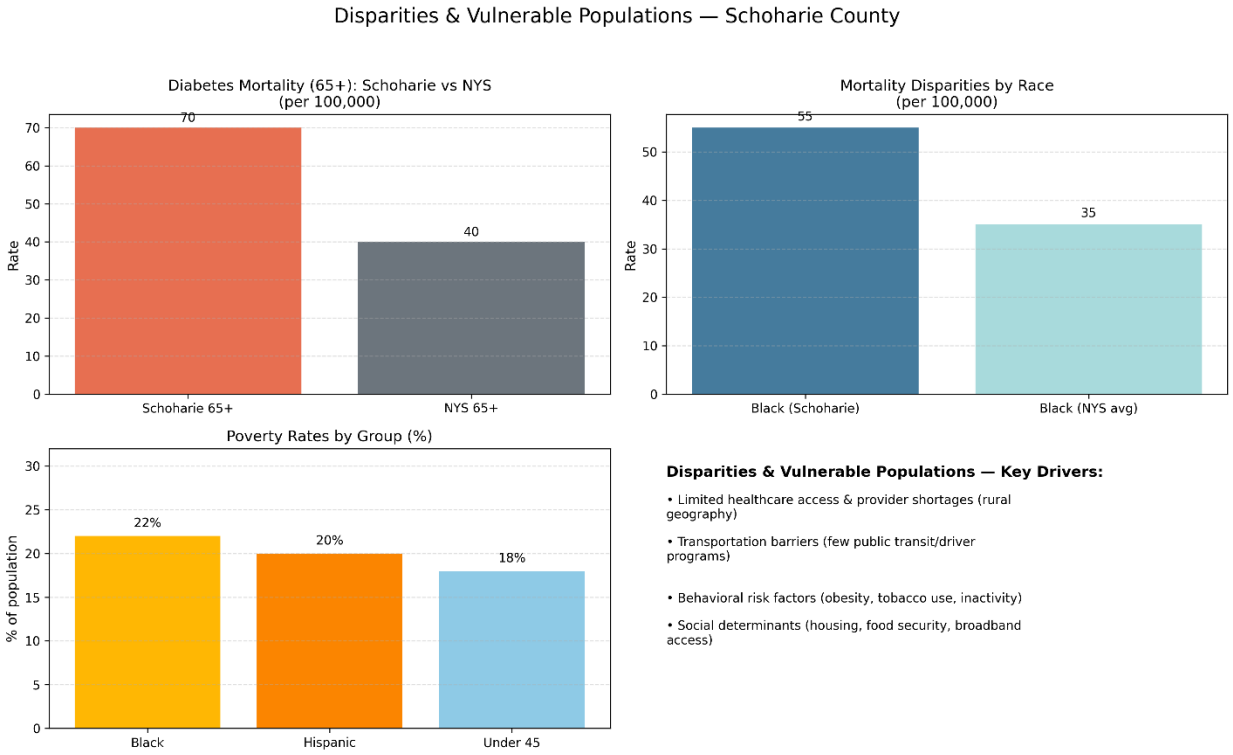
- Demographic Shifts: An aging population increases demand for chronic disease management and long-term care (Advancing States, 2024).
- Socioeconomic Barriers: Higher rates of poverty and limited transportation affect healthcare utilization and preventive care (Census Reporter, 2024).
- Healthcare Access: Rural geography and provider shortages create gaps in timely diagnosis and treatment (Bassett Healthcare Network, 2024).
- Behavioral Risk Factors: Elevated rates of obesity, tobacco use, and physical inactivity continue to drive chronic disease prevalence (NYSDOH, 2024).
- Social Determinants of Health: Housing instability, food insecurity, and limited broadband access impact health behaviors and telehealth access (SEECNY, 2024)



Disparities and Vulnerable Populations

When compared to statewide data, Schoharie County exhibits greater disparities in chronic disease mortality and incidence, particularly among older adults and low-income populations (Schoharie Community Hub, 2024). Preliminary analysis also suggests racial and ethnic disparities, though small population sizes limit robustness.

- Diabetes Mortality: Highest among older adults (65+) at 70 per 100,000, compared to 40 per 100,000 statewide (NYSDOH, 2024).
- Racial Disparities: Black residents experience mortality rates of 55 per 100,000, well above the NYS average of 35; Hispanic residents also show elevated rates (NYSDOH, 2024).
- Socioeconomic Barriers: Poverty rates disproportionately affect minority groups (22% for Black residents, 20% for Hispanic residents) and younger populations (18% for those under 45) (Census Reporter, 2024).
- Influencing Factors: Limited healthcare access, rural transportation challenges, and behavioral risk factors are concentrated in vulnerable groups (Bassett Healthcare Network, 2024).
- Social Determinants: Housing instability, food insecurity, and broadband limitations further restrict access to care and telehealth services (SEECNY, 2024).



Conclusion

These trends highlight the importance of multi-sector collaboration to address underlying social determinants, expand preventive services, and improve care coordination for vulnerable populations.

References

1. *Schoharie Community Hub. Community Health Indicators and Mental Health Index. Retrieved from schohariecommunityhub.org*
2. *Bassett Healthcare Network. Schoharie County Community Health Needs Assessment 2022–2024. Retrieved from bassett.org*
3. *New York State Department of Health (NYSDOH). Prevention Agenda Indicators – Schoharie County. Retrieved from health.state.ny.us*
4. *SEECNY. Broadband Coverage and Digital Equity in Schoharie County. Retrieved from seecny.org*
5. *Census Reporter. Schoharie County Demographic and Socioeconomic Profile. Retrieved from censusreporter.org*
6. *Advancing States. Rural Health Access and Aging Services. Retrieved from advancingstates.org*

Health Challenges and Associated Risk Factors

Health challenges within Cobleskill Regional Hospital's (CRH) service area are shaped by a combination of socioeconomic, geographic, and systemic factors. Poverty, rural isolation, limited transportation, provider shortages, and gaps in behavioral and oral health infrastructure intersect to create significant barriers to care and contribute to poor health outcomes, particularly in chronic disease management.

Schoharie County's rural setting and low population density limit access to healthcare facilities, especially specialty care. A growing proportion of older adults face mobility challenges, chronic conditions, and social isolation, further complicating care delivery and increasing demand for health and support services.

Nearly 13% of residents live below the poverty line, with higher rates among children and seniors. Food insecurity and housing instability exacerbate physical and mental health risks, contributing to obesity, diabetes, and poor oral health outcomes.

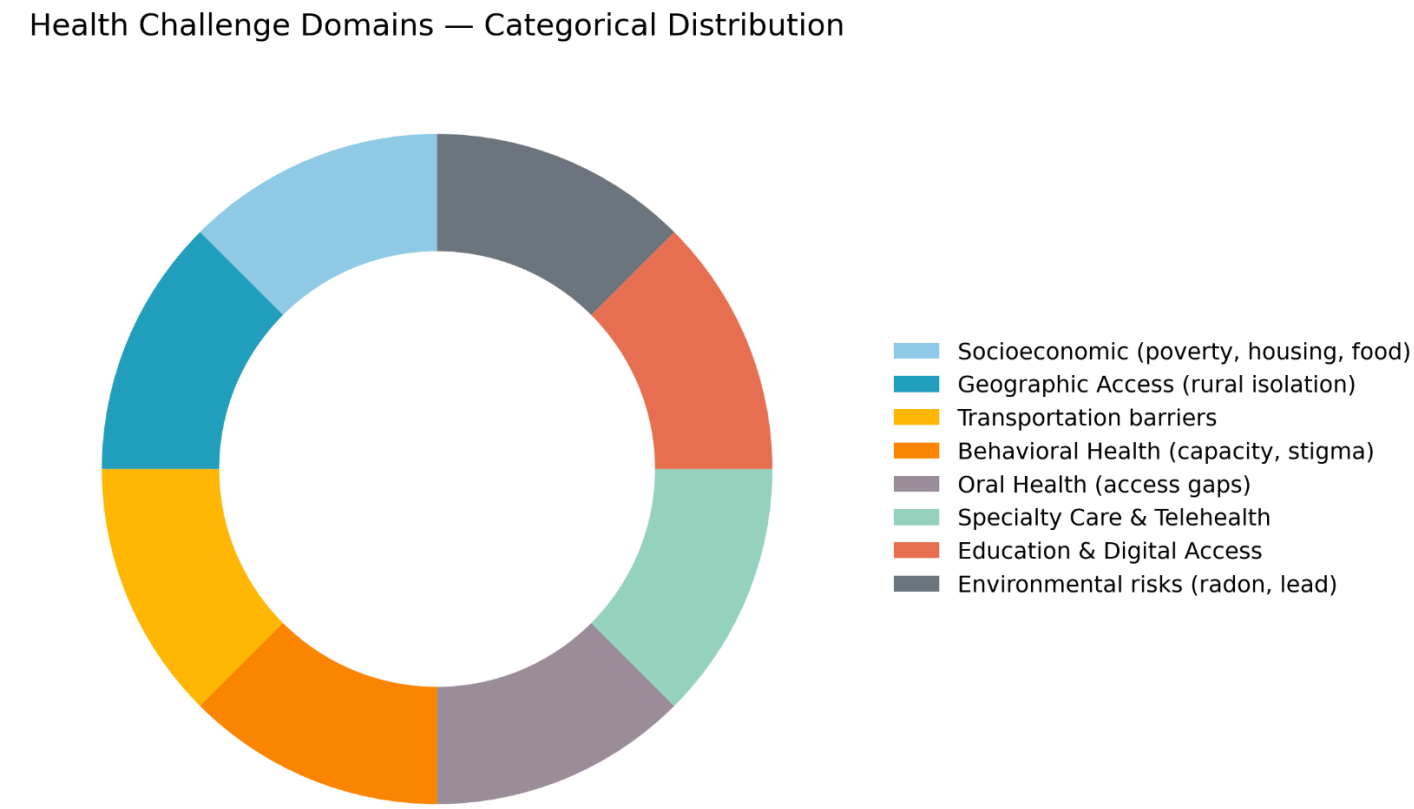
The absence of robust public transit and shortages in volunteer driver programs create significant obstacles to accessing medical appointments, particularly for older adults and low-income families.

Mental health services are constrained by a shortage of providers, especially those accepting Medicaid. The lack of mobile crisis units and school-based behavioral health programs limits early intervention opportunities, while stigma and low awareness discourage help-seeking behaviors.

Access to dental care is limited, with few providers accepting Medicaid and no mobile clinics or school-based screenings. These gaps contribute to preventable oral health issues and associated chronic conditions.

Recruitment and retention of clinicians remain difficult in rural settings, resulting in limited specialty services such as oncology, cardiology, and endocrinology. Telehealth adoption is underutilized due to broadband gaps and digital literacy barriers.

Lower educational attainment, limited digital access, and environmental risks such as radon and lead exposure compound health disparities. These determinants influence health behaviors, access to resources, and overall community well-being.



Equal slice sizes reflect categorical emphasis; quantitative weights not provided.

Community Assets and Resources

1. Healthcare Facilities
    - Cobleskill Regional Hospital (Bassett Healthcare Network) – Provides inpatient, outpatient, and emergency care.
    - Bassett Medical Group Clinics – Primary care and specialty services. [bassett.org]
2. Public Health Infrastructure
    - Schoharie County Department of Public Health – Immunizations, chronic disease prevention, environmental health, emergency preparedness. [www4.schoh...nty-ny.gov]
    - Community Health Hub – Collaborative platform for health equity, data sharing, and education. [schohariec...ityhub.org]
3. Behavioral Services
    - Schoharie County Mental Health Clinic and Chemical Dependency Clinic.
    - Mobile Crisis Assessment Team (24/7). [sccasa518.org]
4. Community-Based Organizations
    - SCCAP (Schoharie County Community Action Program) – Housing, food security, WIC, family support.
    - Catholic Charities, SCCASA – Substance abuse prevention and recovery. [sccapinc.org]
5. Preventive Programs

    Rabies clinics, flu vaccination drives, early intervention for children. [www4.schoh...nty-ny.gov]

Needed Community Assets

- Expanded Primary Care & Specialty Services
    - Recruit more providers and telehealth options.
    - Increase hospital bed capacity and urgent care centers.
- Behavioral Health Expansion
    - More outpatient mental health clinics.
    - School-based counseling and substance abuse prevention programs.
- Transportation Solutions
    - Improve rural transit for medical appointments.
- Preventive Health Programs
    - Community fitness initiatives, chronic disease self-management workshops.
    - Dental health programs for children.
- Social Support & Equity
    - Food security programs, housing stability initiatives.
    - Outreach to Amish and other underserved populations.

Schoharie County has a foundational network of healthcare and community resources, including Cobleskill Regional Hospital, Bassett Medical Group clinics, and public health services through the County Department of Public Health and the Community Health Hub. Behavioral health needs are addressed by the County Mental Health Clinic, chemical dependency services, and a 24/7 Mobile Crisis Team. Community-based organizations such as SCCAP, Catholic Charities, and SCCASA provide essential social support, housing assistance, and substance abuse prevention. Preventive programs like rabies clinics, flu vaccination drives, and early childhood interventions further strengthen public health efforts.

While the county benefits from a strong foundation of healthcare and social services, gaps remain in access and capacity. Key areas for improvement include:

- Expanded primary and specialty care, including telehealth and urgent care options.
- Behavioral health services, particularly outpatient clinics and school-based programs.
- Transportation solutions to improve access for rural residents.
- Preventive health initiatives, such as fitness programs, chronic disease management, and dental care for children.
- Social support and equity efforts, focusing on food security, housing stability, and outreach to underserved populations like the Amish community.

Addressing these needs will enhance health equity, improve service accessibility, and strengthen overall community well-being.

Community Health Service Plan

Major Community Health Needs

Schoharie County, a rural region served by Cobleskill Regional Hospital (CRH)—the county's only acute care facility and part of Bassett Healthcare Network—faces significant health challenges shaped by geographic isolation, socioeconomic disparities, and limited healthcare infrastructure. According to the Community Health Needs Assessment (CHNA) 2025 the following priority areas are identified. [bassett.org]

Chronic conditions remain a leading cause of morbidity and mortality in Schoharie County. Cancer incidence is 484.7 cases per 100,000, which is above the New York State (NYS) average of 465.1 (Schoharie Community Hub, 2024). Diabetes mortality is 39.7 per 100,000, more than double the NYS rate of 18.3 (Schoharie Community Hub, 2024). Risk factors such as adult smoking prevalence (24.3%) and high obesity rates contribute significantly to cardiovascular disease (NY State Department of Health, 2024).
Access challenges are amplified by rural geography. Provider shortages persist, with Cobleskill Regional Hospital (CRH) as the sole hospital in the county, offering inpatient, emergency, and limited specialty services (Bassett Healthcare Network, 2024). Transportation barriers, including limited public transit options, hinder timely care. Telehealth adoption is growing, but broadband gaps remain despite efforts to achieve 100% coverage by 2026 (SEECNY, 2024).

Behavioral health needs are escalating. Schoharie County's Mental Health Index score is 87, with the Cobleskill ZIP code (12043) at 90.1, indicating severe need (Schoharie Community Hub, 2024). Opioid concerns persist, and the county is investing opioid settlement funds in prevention and recovery programs (Schoharie County Government, 2024). Workforce shortages and stigma remain significant barriers to care (Find Recovery Center, 2024).

Maternal and child health indicators show mixed progress. Early prenatal care is received by 80.6% of births, slightly above state averages (Schoharie Community Hub, 2024). However, childhood immunization and lead screening rates lag behind state targets (NY State Department of Health, 2024).

Socioeconomic factors significantly impact health outcomes. 10.8% of residents live below the poverty line, with higher rates among Black (12.1%) and Hispanic (6.9%) populations (NY State Department of Health, 2024; Census Reporter, 2024). Housing instability and food insecurity remain pressing concerns. Broadband access is improving, but underserved pockets persist despite county goals for full coverage by 2026 (Schoharie Community Hub, 2024; SEECNY, 2024).

Persistent disparities affect vulnerable groups. Older adults (65+) experience the highest diabetes mortality and elevated cardiovascular risk (Schoharie Community Hub, 2024). Black and Hispanic residents face disproportionate chronic disease burdens and poverty-related barriers (NY State Department of Health, 2024). Rural isolation exacerbates

access challenges, reinforcing the need for mobile health solutions (Advancing States, 2024).

Role of Cobleskill Regional Hospital

CRH, recognized as a **Top 20 Critical Access Hospital nationally**, is central to addressing these needs. As the county's only hospital, CRH provides acute inpatient care, emergency services, and specialty clinics, while partnering with Bassett Healthcare Network to expand telehealth, school-based health centers, and community outreach programs (Bassett Healthcare Network, 2024).

References

1. *Bassett Healthcare Network. Schoharie County Community Health Needs Assessment 2022–2024. Retrieved from bassett.org*
2. *Schoharie Community Hub. Mental Health Index and Health Indicators. Retrieved from schohariecommunityhub.org*
3. *New York State Department of Health. Prevention Agenda Indicators – Schoharie County. Retrieved from health.state.ny.us*
4. *SEECNY. Broadband Coverage in Schoharie County. Retrieved from seecny.org*
5. *Schoharie County Government. Opioid Settlement Funds and Recovery Programs. Retrieved from schohariecounty-ny.gov*
6. *Census Reporter. Schoharie County Profile. Retrieved from censusreporter.org*
7. *Advancing States. Rural Health Access Solutions. Retrieved from advancingstates.org*
8. *Find Recovery Center. Behavioral Health Workforce Challenges. Retrieved from findrecoverycenter.com*

CRH Process for Identifying Health Priorities

Cobleskill Regional Hospital (CRH), as part of its Community Health Needs Assessment (CHNA), employed a structured, evidence-based process to determine priority health issues for Schoharie County. This process integrated quantitative data analysis, stakeholder engagement, and alignment with state and national health objectives. The following criteria guided the prioritization:

To determine the magnitude of the problem CRH assessed the prevalence, incidence, and mortality rates of key health conditions, comparing Schoharie County data to New York State benchmarks. Conditions with significantly higher local rates such as cancer (484.7 per 100,000) and diabetes mortality (39.7 per 100,000)—were flagged as high-priority concerns. The team evaluated the potential impact on quality of life, economic burden, and long-term health outcomes to determine the severity and impact of these priorities. Chronic diseases and mental health issues were prioritized due to their substantial effect on daily functioning, healthcare costs, and community well-being.

CRH considered the degree to which health issues disproportionately affected vulnerable populations, including older adults, rural residents, and minority groups. For example, diabetes mortality was highest among adults aged 65+, and poverty rates were elevated among Black and Hispanic populations. Community input was gathered through surveys, community held focus groups, and stakeholder meetings. Issues such as mental health access, substance use, and transportation barriers emerged as top concerns among residents and local organizations. The hospital assessed the availability of resources, evidence-based interventions, and organizational capacity to address each issue. Feasibility included evaluating partnerships with Schoharie County Departments, Bassett Healthcare Network, local agencies, and state programs to ensure sustainable implementation.

Priorities were cross-referenced with the New York State Prevention Agenda and Healthy People 2030 objectives to ensure consistency with broader public health strategies. This alignment supports funding opportunities and policy advocacy. CRH selected priorities with clear, measurable indicators to track progress over the CHNA cycle. Metrics such as cancer screening rates, diabetes management outcomes, and mental health service utilization were identified for ongoing evaluation. Using these criteria, CRH identified six major health priorities:

- Chronic Disease Prevention and Management
- Access to Healthcare
- Mental Health and Substance Use
- Maternal and Child Health
- Social Determinants of Health
- Health Disparities

Justification for Unaddressed Health Needs

The Community Health Needs Assessment (CHNA) identified additional areas of concern, including health care access, substance misuse, oral health needs, and maternal and child health supports. These needs were not selected as primary Community Service Plan (CSP) interventions because substantial work is already underway through existing county and regional initiatives.

The Schoharie County Office for the Aging and the county's Age-Friendly Initiative lead multiple programs addressing aging, caregiver support, social connection, home safety, and chronic disease management. Likewise, the Schoharie County Community Hub focuses on community-based social determinants of health (SDOH) initiatives. During the planning process, CRH and Bassett Healthcare Networks' RHENSOM reviewed their respective roles to ensure that key needs were addressed across both plans without duplicating efforts or dispersing limited resources.

Substance misuse, while distinct, overlaps with the broader mental health concerns prioritized in the assessment. Schoharie County and its partners already operate extensive prevention, treatment, and harm-reduction programs, and these efforts continue to expand.

Access-to-care challenges—such as provider availability, timely appointments, and care delivery—are currently being addressed through county-level initiatives and Bassett Healthcare Networks' regional strategies.
Maternal and child health needs, including prenatal care access and childhood immunization coverage, are being addressed through county health department programs and Bassett's school-based health centers. These initiatives provide comprehensive preventive care and outreach, reducing the need for additional CSP interventions during this cycle.

By selecting chronic disease management through medically tailored diets and the Food is Medicine program, Suicide Prevention Training and the Promise to Talk campaign, and behavioral health initiatives addressing social isolation and loneliness as CSP priorities, CRH is able to focus on areas where new coordination and hospital leadership are most needed. This approach ensures that other identified needs remain actively addressed through established partner initiatives, while maximizing impact and resource efficiency. This systematic approach ensures that resources are directed toward issues with the greatest impact, feasibility, and potential for measurable improvement.

Action Plan

Evidence-Based Interventions in the CSP

The Community Service Plan (CSP) incorporates four evidence-based interventions designed to address the priority areas identified through the Community Health Assessment (CHA). Each intervention is fully aligned with the New York State Prevention Agenda (NYSPA) 2025–2030 framework and directly targets documented health disparities impacting low-income households, older adults, rural communities, and other at-risk populations.

Interventions were selected through a rigorous process that considered:

- Strength of Local Data: Ensuring strategies respond to the most pressing health needs documented in Schoharie County.
- Relevance to Identified Gaps: Prioritizing interventions that address barriers to care and service shortages.
- Feasibility within Existing Capacity: Leveraging current resources and partnerships to maximize impact.
- Demonstrated Effectiveness: Choosing approaches supported by evidence for improving population health and reducing inequities.

This strategic alignment ensures that the CSP not only meets state-level objectives but also reflects the unique needs and challenges of the local community. By integrating these components, the CSP establishes a clear roadmap for improving access, enhancing quality of care, and advancing health equity throughout the Prevention Agenda cycle.

The following tables provide a detailed overview of each intervention, including:

- Specific Strategies: Action steps to achieve measurable outcomes.
- Target Populations: Groups most affected by health disparities.
- Process Measures: Indicators to monitor implementation and progress.
- Health Equity Impacts: Expected contributions toward reducing disparities.
- Partner Roles: Collaborative responsibilities across healthcare, public health, and community organizations.

- ## Initiative 1: Food is Medicine Program

Strategy	Target Population	Process Measures	Health Equity Impact	Partner Roles
Provide medically tailored meals and nutrition counseling	Individuals with chronic conditions	Number of meal components provided and counseling sessions	Improved nutrition and reduced complications among low-income patients	CRH, Local Food Banks, Local Farms, Dietitians

- ## Initiative 2: Promise to Talk Program

Strategy	Target Population	Process Measures	Health Equity Impact	Partner Roles
Launch community campaign encouraging open conversations about mental health	General population with focus on rural communities	Engagement metrics (social media reach, event participation)	Reduced stigma and increased help-seeking behaviors	CRH, Mental Health Advocates, Community Organizations

- ## Initiative 3: Suicide Prevention Training for Staff

Strategy	Target Population	Process Measures	Health Equity Impact	Partner Roles
Train healthcare staff in suicide prevention and crisis intervention	Healthcare providers and frontline staff	Number of staff trained and competency assessments	Enhanced capacity to identify and respond to suicide risk	CRH, Behavioral Health Specialists

- ## Initiative 4: Educational Sessions & Support Groups for Older Adults

Strategy	Target Population	Process Measures	Health Equity Impact	Partner Roles
Conduct group sessions and workshops to reduce loneliness and social isolation	Older adults (65+)	Attendance rates and participant feedback	Improved mental well-being and reduced isolation among seniors	CRH, Senior Centers, Community Volunteers

Action Plan Development

Initiative 1. Food Is Medicine Program

The Food Is Medicine initiative is designed to address nutrition security as a critical social determinant of health within the NYSPA Domain of Economic Stability. This program integrates access to nutritious foods and education into the healthcare experience for patients at risk of diet-related chronic conditions such as diabetes, hypertension, and cardiovascular disease. By embedding food access into clinical workflows, the initiative aims to improve chronic disease management, reduce healthcare costs, and advance health equity across Schoharie County.

The program will operate countywide, with targeted outreach in rural areas where access to resources is limited. Clinical teams in BHN Primary Care will conduct standardized nutrition security screenings during patient visits and discharge planning. Patients identified as food insecure will receive referrals, food prescriptions, and vouchers redeemable at local food pantries and farm cooperatives. Additionally, medically tailored food boxes will be available for patients with specific dietary needs, and hospitals will provide immediate food items at discharge to reduce gaps in care.

Education is a core component of the intervention. Providers will deliver brief nutrition counseling during visits, and patients will have access to chronic disease self-management workshops, including virtual options for rural residents. To overcome transportation barriers, the program will host mobile pantry events and coordinate home delivery for homebound patients.

The intended impact includes increased identification of unmet nutrition needs, improved access to healthy foods, and reduced socioeconomic barriers to health. These efforts will strengthen coordination among healthcare providers and community organizations, ensuring a seamless referral process and better patient outcomes.

Key partners include CRH, which will assist with program coordination, voucher management and data collection; BHN Primary Care providers, who will conduct screenings and referrals; local food pantries and farm cooperatives, which will assist with food vouchers and mobile events; and CRH, which will provide medically tailored food at discharge. The Community Health Hub and Public Health Department will support data sharing, outreach, and equity monitoring.

Resource commitments include staffing for program coordination and data analysis, a budget for food vouchers and inventory, and logistical support for storage and delivery. The program embeds health equity strategies by prioritizing rural residents, older adults, and underserved populations, offering culturally relevant education, and monitoring disparities in screening and referral completion.

Implementation will occur in phases: planning and partner agreements in the first two months, pilot launch in select clinics by month four, countywide rollout by month eight, and optimization with outcome reporting by the end of the first year. By addressing nutrition insecurity through clinical and community collaboration, the Food Is Medicine program will create a sustainable pathway to better health outcomes and economic stability for vulnerable populations in Schoharie County.

NYSPA Domain: Economic Stability			
Priority: Nutrition Security			
Goal: Provide medically tailored meals to those in need with chronic disease management needs.			
Objective: Decrease the incidence of chronic health conditions			
Intervention: Food Is Medicine Program that provides access to medically tailored nutritious foods.			
Target Demographic: patients at risk of diet-related chronic conditions that are in need of access to nutritious food and education as part of their healthcare experience			
Geographic Focus: Countywide, with targeted outreach in rural areas where resource access is limited			
Health Equity Impact: This initiative will improve chronic disease management, reduce healthcare costs, and advance health equity by addressing a key social determinant of health—nutrition.			
Actions	**Process Measures**	**Intended Impact**	**Partner Roles and Resources**
Screen all individuals arriving via referral from a provider indicating a need for medically tailored nutrition services. Provide counseling and diet information applicable to the patient's needs. Provide access to food along with nutrition counseling from a dietician, tangible food items, vouchers to farmers market and list of foods to obtain at local food pantries.	• Number of individuals screened for nutrition security. • Number of referrals submitted. Food vouchers provided. • Number of successful referral closures. Volume of screenings among adults 65+ in rural communities	• Increased identification of unmet basic needs • Improved access to food, nutrition and disease management. Reduced socioeconomic-related barriers to health and stability • Strengthened coordination among service providers	**Bassett Healthcare Network** to provide support for partnership with area food pantries and voucher distribution. **BHN Primary Care Clinic Providers:** Referrals and support regarding prescription-based food process. **Area food pantries, farm cooperatives for food distribution.** **CRH** Ability to provide food items directly on site at time of discharge.

NYSPA Domain: Economic Stability			
Priority: Nutrition Security			
Goal: Provide medically tailored meals to those in need with chronic disease management needs.			
Objective: Decrease the incidence of chronic health conditions			
Intervention: Food Is Medicine Program that provides access to medically tailored nutritious foods.			
Target Demographic: patients at risk of diet-related chronic conditions that are in need of access to nutritious food and education as part of their healthcare experience			
Geographic Focus: Countywide, with targeted outreach in rural areas where resource access is limited			
Health Equity Impact: This initiative will improve chronic disease management, reduce healthcare costs, and advance health equity by addressing a key social determinant of health—nutrition.			
Actions	**Process Measures**	**Intended Impact**	**Partner Roles and Resources**
Screen all individuals arriving via referral from a provider indicating a need for medically tailored nutrition services. Provide counseling and diet information applicable to the patient's needs. Provide access to food along with nutrition counseling from a dietician, tangible food items, vouchers to farmers market and list of foods to obtain at local food pantries.	• Number of individuals screened for nutrition security. • Number of referrals submitted. Food vouchers provided. • Number of successful referral closures. Volume of screenings among adults 65+ in rural communities	• Increased identification of unmet basic needs • Improved access to food, nutrition and disease management. Reduced socioeconomic-related barriers to health and stability • Strengthened coordination among service providers	**Bassett Healthcare Network** to provide support for partnership with area food pantries and voucher distribution. **BHN Primary Care Clinic Providers:** Referrals and support regarding prescription-based food process. **Area food pantries, farm cooperatives for food distribution.** **CRH** Ability to provide food items directly on site at time of discharge.

Initiative 2: Promise to Talk Campaign

The Promise to Talk campaign is a countywide initiative under the NYSPA Domain: Social and Community Context and Priority: Mental Health and Emotional Well-Being. Its primary goal is to foster open dialogue about mental health, reduce stigma, and expand access to emotional support resources across Schoharie County. By leveraging partnerships with community-based organizations, the Office for the Aging (OFA), and The Gathering Place, the program will recruit and train volunteers to facilitate meaningful conversations, distribute educational materials, and host community events that promote mental health awareness.

The campaign targets the elderly population and individuals experiencing anxiety, stress, or depression, with a strong emphasis on early identification of social-emotional concerns. Outreach efforts will include implementing screening protocols, connecting individuals to appropriate services, and providing resources that support mental health and well-being. These activities aim to improve access to timely assessment and intervention, strengthen coordination among mental health systems and community agencies, and reduce disparities in care for rural residents.

Intended impact includes earlier detection of mental health concerns, expanded pathways for intervention, and enhanced collaboration between healthcare providers and community organizations. Process measures will track the number of contacts made, referrals submitted, successful service connections, and individuals receiving support resources. Key partners will play critical roles: community organizations will promote the program and facilitate training; Cobleskill Regional Hospital will lead implementation and coordinate volunteer training; and the Behavioral Health Network (BHN) will manage referrals, conduct evaluations, and ensure integrated care.

By addressing stigma and creating accessible, community-driven support systems, the Promise to Talk campaign advances health equity and strengthens mental health resources for vulnerable populations in Schoharie County.

NYSPA Domain: Social and Community Context			
Priority: Mental Health and Emotional Well Being			
Goal: Engage individuals in meaningful discussions to address mental health concerns and provide resource assistance.			
Objective: 7.0 Reduce the percentage of adults with a major depressive episode during the past year from 6.7% to 5.7%.			
Intervention: Launch the ***Promise to Talk*** campaign in collaboration with community-based organizations, the Office for the Aging (OFA), and The Gathering Place. This initiative will focus on outreach efforts to recruit and train volunteers to facilitate meaningful conversations, distribute educational materials, and host community events. The *Promise to Talk* campaign aims to foster open dialogue about mental health and reduce stigma across the region.			
Target Demographic: Individuals experiencing anxiety and stress, depression			
Geographic Focus: Countywide			
Health Equity Impact: Expanding access to mental health resources addresses service gaps in Schoharie County and promotes equitable care. Early identification of social-emotional concerns within rural communities helps reduce disparities in timely evaluation and access to mental health services			
Actions	**Process Measures**	**Intended Impact**	**Partner Roles and Resources**
Program Planning & Alignment 1.**Define objectives**: Clarify the program's goals (e.g., reduce stigma, promote mental health conversations). Secure leadership buy-in: Present the program benefits to CRH leadership for approval and support. Identify key stakeholders: Include clinical staff, HR, communications, and community partners. 2. **Training & Education** Develop training materials: Create or source content on mental health awareness and conversation techniques. Train ambassadors: Select staff champions to lead and model conversations. Schedule staff workshops: Offer sessions on how to initiate and sustain mental health discussions. 3. **Communication & Awareness** Launch internal campaign: Use posters, emails, and intranet to introduce the program. Create branded materials: Develop flyers, badges, and digital assets with the Promise to Talk message. Host kickoff event: Organize a launch meeting or webinar to explain the program and its importance. 4**. Resource Integration** Compile resource directory: List internal and external mental health services. Create referral process: Ensure staff know how to connect individuals to appropriate help. Develop quick-access tools: QR codes or links for easy resource access. **5. Monitoring & Evaluation** Set success metrics: Track participation, number of conversations, and referrals. Collect feedback: Use surveys to measure staff confidence and program impact. Report outcomes: Share progress with leadership and staff regularly.	• Number of contacts made via program criteria. • Number of referrals made to other services. • Number and percentage of referrals successfully connected to services.	• Earlier Identification: Implement screening protocols to detect mental health and social-emotional concerns at the earliest stages. • Improved Access: Expand pathways for timely assessment, early intervention, and comprehensive family and individual support services. • Enhanced Coordination: Strengthen collaboration among mental health systems, healthcare providers, and community-based agencies to ensure integrated care. • Equity in Care: Reduce disparities in mental health screening and referral processes, ensuring equitable access to evaluation and treatment services.	**Community Organizations** Support program promotion and facilitate access to training and service delivery. **Cobleskill Regional Hospital (CRH)** Lead program implementation, establish requirements, and coordinate training sessions. **Bassett Healthcare Network (BHN)** Manage referrals for follow-up, conduct evaluations as needed, and collaborate on care coordination.

Initiative 3: Suicide Prevention Training

CRH is implementing a comprehensive suicide prevention initiative within its service area, focusing on early identification and timely intervention for individuals at risk. The program centers on training all clinical staff to conduct universal suicide risk screening at intake using the Columbia Protocol. For individuals who screen positive, the full Columbia-Suicide Severity Rating Scale (C-SSRS) will be administered during Emergency Department (ED) and inpatient admissions. This approach ensures consistent and evidence-based assessment of suicide risk across care settings.

The target population includes all individuals at risk, with a particular emphasis on improving access for rural and low-income families. By embedding screening and follow-up assessments within CRH's service area, the intervention addresses geographic and financial barriers, enabling timely connection to mental health services that may have previously been difficult to obtain locally. This effort strengthens early identification, safety planning, and care coordination, ultimately reducing delays between risk detection and service engagement.

The initiative aims to achieve earlier and more consistent identification of suicide risk among high-risk individuals presenting at ED and inpatient settings. It seeks to reduce delays in connecting individuals to appropriate services, improve coordination between screening, assessment, and ongoing care, and build local capacity to monitor and address suicide risk effectively. Progress will be tracked through key indicators, including:

- Number of brief C-SSRS screenings completed
- Number and percentage of positive screens
- Number of full C-SSRS assessments following positive screens or clinical concern
- Number and percentage of documented follow-up or service connections

CRH will lead program development and operations, oversee staffing and service delivery, manage ASQ-SR screening, monitor data, and coordinate follow-up and care transitions. Behavioral Health Network (BHN) will identify individuals needing services, make referrals, and collaborate on care transitions between primary care and hospital settings.

NYSPA Domain: Social and Community Context			
Priority: Suicide			
Goal: Provide comprehensive suicide prevention and assessment training for all clinical staff at CRH to enhance their ability to identify individuals experiencing suicidal ideation and connect them with appropriate resources.			
Objective: 7.0 Reduce the percentage of adults with a major depressive episode during the past year from 6.7% to 5.7%.			
Intervention: Train all clinical staff to provide universal suicide risk screening using the Columbia Protocol at intake and administer the full Columbia-Suicide Severity Rating Scale C-SSRS for those who screen positive at ED and In-Patient admissions.			
Target Demographic: All individuals at risk			
Geographic Focus: Countywide			
Health Equity Impact: By providing suicide risk screening and follow-up assessment within CRH's service area, this intervention reduces geographic and financial barriers for rural and low-income families and improves timely access to mental health services. It strengthens early identification and connects individuals to care that may have been previously difficult to obtain locally			
Actions	**Process Measures**	**Intended Impact**	**Partner Roles and Resources**
1. Program Design & Approval: Define training objectives: Focus on suicide risk assessment, intervention strategies, and resource referral. Select evidence-based curriculum: Choose a recognized program (e.g., QPR, ASIST, or Zero Suicide framework). Obtain leadership approval: Present the plan to CRH leadership for endorsement and funding. 2. Resource & Logistics Planning: Identify trainers: Engage certified instructors or partner with mental health organizations. Schedule sessions: Determine dates, times, and formats (in-person, virtual, hybrid). Allocate budget: Cover training materials, facilitator fees, and staff time. 3. Staff Engagement: Communicate program details: Send announcements via email, intranet, and staff meetings. Create registration process: Use an online sign-up system for easy tracking. Incentivize participation: Offer continuing education credits or recognition. 4. Training Delivery: Conduct initial sessions: Start with high-risk departments (ER, behavioral health). Provide practical tools: Distribute screening guides, referral protocols, and resource lists. Include role-play scenarios: Build confidence in assessing and responding to suicidal ideation. 5. Post-Training Support: Develop follow-up resources: Quick-reference guides and hotline numbers. Create peer support network: Encourage ongoing discussion and skill reinforcement. Monitor compliance: Track completion rates and maintain records for accreditation. 6. Evaluation & Continuous Improvement Collect feedback: Use surveys to assess training effectiveness and staff confidence. Measure outcomes: Monitor suicide risk assessments and referrals over time. Update training annually: Incorporate new best practices and refresh staff skills.	Number of brief C-SSRS screenings completed. Number and percentage of individuals with a positive brief C-SSRS screen. Number of full C-SSRS assessments completed following a positive screen or clinical concern. Number and percentage of documented follow-up or service connection.	Earlier and more consistent identification of suicide risk among High-Risk individuals that present at the ED and In Patient. Reduced delays between identification of risk and connection to appropriate services. Improved coordination between screening, risk assessment, safety planning, and ongoing care. Strengthened local capacity to monitor and address suicide risk . •	• CRH: Leads program development and operations; oversees staffing, service delivery, ASQ-SR screening, and data monitoring; coordinates follow-up and care transitions. Provides care coordination and family support; assists with referrals and ongoing engagement. • BHN (Primary Care Clinic): Identifies those needing services; makes referrals; collaborates on care transitions between primary care and the Hospital.

Initiative 4: Social Isolation and Loneliness

Cobleskill Regional Hospital (CRH) is committed to reducing social isolation and loneliness among older adults in Schoharie County by expanding access to community-based engagement opportunities, substance misuse prevention education, and essential resources. This intervention specifically targets seniors who self-identify as socially isolated, with an emphasis on equity measures to reach low-income, disabled, and geographically isolated individuals.

The Health Equity Impact will target older adults, particularly those aged 65 and above living in rural areas, that face disproportionate challenges related to unmet basic needs and limited access to services. By enhancing outreach, screening, and navigation support, this initiative promotes equitable access to social resources and stability supports across the county. The approach addresses socioeconomic barriers and strengthens local capacity to connect seniors with meaningful engagement opportunities and health-related services. The Process Measures to be used will include Number of individuals screened for loneliness and isolation, Number of referrals submitted, Number of successful referral closures, and Volume of screenings among adults 65+ in northern rural communities. The Intended Impact will be Increased identification of unmet basic needs, improved access to social resources and supports, reduced socioeconomic-related barriers to health and stability, and strengthened coordination among service providers.

NYSPA Domain: Social and Community Context			
Priority: Social Isolation and Loneliness			
Goal: Facilitate access to programs and tools that help older individuals engage socially and combat isolation.			
Objective: 5.0 Decrease the percentage of adults who experience frequent mental distress from 13.4% to 12.0%.			
Intervention: Reduce social isolation and loneliness among older adults in Schoharie County by expanding access to community-based engagement, substance misuse prevention education and access to needed resources.			
Target Demographic: Senior population that self-identify as being socially isolated			
Geographic Focus: Include equity measures to ensure outreach to low-income, disabled, and geographically isolated seniors			
Health Equity Impact: This intervention prioritizes adults aged 65+, and rural residents who face higher rates of unmet basic needs and limited access to services. Expanding outreach, screening and navigation improves equitable access to services and stability supports across the county.			
Actions	**Process Measures**	**Intended Impact**	**Partner Roles and Resources**
Compile a directory of local programs, senior centers, and social activities. Distribute resource guides through healthcare providers, community centers, and local media. Collaborate with the Office for the Aging, faith-based groups, and nonprofits to expand outreach. Engage volunteers and community leaders to connect with isolated individuals. Increase Access to Social Opportunities Organize group activities such as exercise classes, hobby clubs, and community events. Develop intergenerational programs to foster meaningful connections. Address Transportation Barriers Coordinate with local transit providers or volunteer driver programs to assist seniors in attending activities. Monitor and Evaluate Track participation and engagement in programs. Collect feedback to improve offerings and ensure needs are met.	• Number of individuals screened for loneliness and isolation • Number of referrals submitted. • Number of successful referral closures. Volume of screenings among adults 65+ in rural communities.	• Earlier Identification: Implement screening protocols to detect mental health and social-emotional concerns at the earliest stages. • Improved Access: Expand pathways for timely assessment, early intervention, and comprehensive family and individual support services. • Enhanced Coordination: Strengthen collaboration among mental health systems, healthcare providers, and community-based agencies to ensure integrated care. • Equity in Care: Reduce disparities in mental health screening and referral processes, ensuring equitable access to evaluation and treatment services.	**Cobleskill Regional Hospital (CRH)** Conducts mental health screenings and navigation services; delivers educational programs such as "Lunch and Learn" sessions at senior centers. **Behavioral Health Network (BHN)** Provides access to support groups for individuals managing cancer, heart disease, and diabetes. **Office for the Aging (OFA)** Promotes educational programs and facilitates engagement with older adults. **The Gathering Place** Hosts community events and provides a welcoming environment for outreach, education, and mental health awareness activities.

Monitoring and Evaluation of CSP Implementation, Partner Engagement, and Findings Dissemination

Cobleskill Regional Hospital (CRH) will establish a comprehensive monitoring and evaluation framework to ensure the effective implementation of the Community Service Plan (CSP) and alignment with the New York State Prevention Agenda objectives. This framework will utilize clearly defined process measures across all four priority interventions, including:

- **Screening Volume:** Total number of individuals screened for targeted conditions.
- **Referral Activity:** Frequency and appropriateness of referrals to specialty or supportive services.
- **Service Connection:** Percentage of referred individuals successfully linked to care.
- **Timeliness of Access:** Average time from referral to initiation of services.

Performance data will be reviewed on a regular basis in collaboration with community partners to assess program reach, identify service gaps, and evaluate the effectiveness of interventions in improving access and reducing health disparities among priority populations.

CRH will document progress through annual CSP reports and conduct a mid-cycle evaluation in 2027 to measure outcomes and inform strategic adjustments. Findings from these evaluations will guide refinements to intervention strategies, ensuring responsiveness to emerging needs and maintaining alignment with state health priorities.

To promote transparency and accountability, CRH will disseminate evaluation results through community forums, digital platforms, and stakeholder reports. This approach reinforces CRH’s commitment to continuous quality improvement and equitable health outcomes throughout the Prevention Agenda cycle.

APPENDIXES

APPENDIX A: References

- *Bassett Healthcare Network. Cobleskill Regional Hospital Profile, 2024.*
- *U.S. Census Bureau. American Community Survey, 2023.*
- *Schoharie Community Hub. Demographics Dashboard, 2024.*
- *Data USA. Schoharie County Profile, 2023.*
- *NYSDOH. Community Health Indicator Reports (CHIRS), 2024.*
- *CDC. Suicide Data and Statistics, 2025.*
- *NYS Suicide Prevention Center. County-Level Suicide Data, 2024.*
- *Feeding America. Map the Meal Gap: Schoharie County, 2024.*
- *FCC. National Broadband Map, 2024.*
- *Schoharie County Board of Supervisors. Connect ALL Broadband Grant Resolution, 2024.*
- *NYSDOH. Oral Health Surveillance System, 2024.*
- *EPA. Radon Health Risk and Environmental Data, 2024.*
- *New York State Department of Health (NYSDOH). Prevention Agenda Data Dashboard, 2024.*
- *U.S. Census Bureau. American Community Survey, 2023.*
- *Centers for Disease Control and Prevention (CDC). Leading Causes of Death, 2023.*
- *New York State Opioid Annual Report, 2024.*
- *Administration for Community Living. Profile of Older Americans, 2023.*
- *Feeding America. Map the Meal Gap, 2024.*
- *Rural Health Information Hub. Transportation Barriers in Rural Areas, 2024.*
- *National Alliance on Mental Illness (NAMI). Mental Health in Rural Com Schoharie Community Hub. Community Health Indicators and Mental Health Index. Retrieved from schohariecommunityhub.org*
- *Bassett Healthcare Network. Schoharie County Community Health Needs Assessment 2022–2024. Retrieved from bassett.org*
- *New York State Department of Health (NYSDOH). Prevention Agenda Indicators – Schoharie County. Retrieved from health.state.ny.us*
- *SEECNY. Broadband Coverage and Digital Equity in Schoharie County. Retrieved from seecny.org*
- *Census Reporter. Schoharie County Demographic and Socioeconomic Profile. Retrieved from censusreporter.org*
- *Advancing States. Rural Health Access and Aging Services. Retrieved from advancing states. communities, 2024.*
- *American Dental Association. Access to Dental Care Report, 2024.*
- *Federal Communications Commission (FCC). Broadband Deployment Report, 2024.*
- *Environmental Protection Agency (EPA). Radon and Lead Exposure Data, 2024.*
- *Schoharie Community Hub. Community Health Indicators and Mental Health Index. Retrieved from schohariecommunityhub.org*
- *Bassett Healthcare Network. Schoharie County Community Health Needs Assessment 2022–2024. Retrieved from bassett.org*
- *New York State Department of Health (NYSDOH). Prevention Agenda Indicators – Schoharie County. Retrieved from health.state.ny.us*
- *SEECNY. Broadband Coverage and Digital Equity in Schoharie County. Retrieved from seecny.org*
- *Census Reporter. Schoharie County Demographic and Socioeconomic Profile. Retrieved from censusreporter.org*
- *Advancing States. Rural Health Access and Aging Services. Retrieved from advancingstates.org*

APPENDIX B: Community Survey Questions

1. What County do you live in?
[] Otsego County [ ] Herkimer County [ ] Delaware County [ ] Schoharie County
[ ] Prefer not to answer

2. Do you live in the selected county year-round?
[ ] Yes – I am a year-round resident [ ] Yes – I live here seasonally for 4 or more months of the year
[ ] No – I vacation here 3 months or less per year [ ] No – I do not live in any of these counties
[ ] Prefer not to answer

3. What zip code is your primary residence located in? _____

4. What is your age (in years)?
[ ] 18–25 [ ] 26–35 [ ] 36–45 [ ] 46–55 [ ] 56–65 [ ] Over 65 [ ] Prefer not to answer

5. What is your race?
[ ] White [ ] Black/African American [ ] Asian [ ] Native American/Alaskan Native
[ ] Native Hawaiian/Pacific Islander [ ] Multiple races [ ] Don't know [ ] Prefer not to answer
[ ]Other: _____

6. What is your ethnicity?
[ ] Hispanic or Latinx [ ] Not Hispanic or Latinx [ ] Don't know [ ] Prefer not to answer

7. How would you describe your gender?
[ ] Female [ ] Male [ ] Gender non-conforming [ ] Transgender Female [ ] Transgender Male
[ ] Genderqueer/Non-Binary [ ] Prefer not to answer [ ] Other: _____

8. What is your highest level of education?
[ ] Less than high school [ ] High school/GED [ ] Some college , no degree [ ] 2-year degree
[ ] 4-year degree [ ] Graduate degree [ ] Trade school [ ] Prefer not to answer

9. How would you describe your employment status (check all that apply):
[ ] Full-time [ ] Part-time [ ] Multiple jobs [ ] Student [ ] Homemaker
[ ] Unemployed–looking for work [ ] Unemployed–disabled [ ] Retired [ ] Prefer not to answer

10. In the past month, did poor physical health prevent you from doing usual activities?
[ ] Yes [ ] No [ ] Prefer not to answer

11. In the past month, did poor mental health prevent you from doing usual activities?
[ ] Yes [ ] No [ ] Prefer not to answer

12. What is your current housing situation?
[ ] I own my home [ ] I rent my home
[ ] I live in shared housing (living in a shelter, outside, in a case, park, or other temporary shelter such as a tent or camper)
[ ] My housing is a secondary, such as a vacation home, Airbnb, or traveling professional accommodations
[ ] Prefer not to answer [ ] Other: _____

13. Are you worried that in the next few months, you may not have safe housing? (Include housing that you own, rent, or share)
[ ] Yes [ ] No [ ] Prefer not to answer

14. In the past year, have you been unable to get or pay for any of the following items when they were needed? (Check all that apply):
[ ] Food [ ] Clothing [ ] Transportation [ ] Childcare
[ ] Medicine, including prescription medicines and over-the-counter medicines like Benadryl or Tylenol
[ ] Healthcare (medical, dental, vision, mental health) [ ] Utilities [ ] Phone [ ] Internet
[ ] N/A- I have gotten everything I have needed [ ] Prefer not [ ] Other

15. How often do you see or talk to people that you care about and feel close to?
[ ] Less than once per week [ ] 1–2 times per week [ ] 3–5 times per week
[ ] 5 or more times a week [ ] Never [ ] Prefer not to answer

16. What is your normal mode of transportation? [
[ ] Personal vehicle [ ] Taxi [ ] Public transportation (OTP/Bernie Bus)
[ ] Community/County Agency [ ] Friend or relative drives me [ ] Walk/bike
[ ] Prefer not [ ] Other

17. How far from your home are you capable of traveling for your basic needs, such as groceries, health care, basic clothing, and other daily living essentials?
[ ] Less than 10 minutes [ ] 10–20 minutes [ ] 20–30 minutes [ ] 30 minutes or more
[ ] Prefer not to answer [ ] Other

18. What barriers do you have when it comes to transportation? (Check all that apply):
[ ] Health/medical related [ ] General comfort with driving certain places/distances
[ ] No vehicle [ ] Don't know how to use/access public transportation [ ] No driver's license
[ ] N/A [ ] Prefer not. [ ] Other

19. Which of the following is the most important to you when it comes to the PEOPLE in your community?

[ ] Community is socially and culturally diverse or becoming more diverse
[ ] Feeling connected to people who live here [ ] Local government is accessible
[ ] People are friendly, helpful, supportive [ ] People who live here are involved in the community
[ ] People are tolerant, inclusive, and open-minded [ ] People are involved in local decision making
[ ] Prefer not to answer [ ] Other

20. Thinking about the SERVICES AND RESOURCES in your community, the thing you consider to be the best is:

[ ] Availability of healthy foods [ ] Active faith community [ ] Access to local businesses (restaurants, shops, etc.) [ ] Community groups, clubs, or other social activities
[ ] Healthcare [ ] Opportunities for education or job training [ ] Public transportation
[ ] Youth programs and activities [ ] Quality school system [ ] Affordable childcare
[ ] Social policies and programs (parental leave, social security, employment health insurance, etc.)
[ ] Prefer not to answer [ ] Other

21. Considering the QUALITY OF LIFE in your community, the best thing is:

[ ] Close to work and activities [ ] Family-friendly; good place to raise kids
[ ] Informal, simple, laidback lifestyle [ ] Job opportunities or economic opportunities
[ ] Safe place to live; little or no crime [ ] Prefer not [ ] Other

22. Thinking about the ACTIVITIES in your community, the best thing is:

[ ] Activities for families and youth [ ] Arts and cultural activities [ ] Local events and festivals
[ ] Recreational and sports activities [ ] Year-round access to fitness and exercise opportunities
[ ] Prefer not to answer [ ] Other

23. Thinking about the COMMUNITY SOCIAL AND ENVIRONMENTAL HEALTH in your community, the thing you are most concerned about is:

[ ] Crime and safety [ ] Not enough jobs with livable wages, not enough to live on
[ ] Water quality (well water, lakes, streams, rivers) [ ] Not enough affordable housing/homelessness [ ] Attracting and retaining young families [ ] Poverty
[ ] Racisms, prejudice, hate, discrimination [ ] Traffic safety, including speeding, road safety, seatbelt use, and drunk/distracted driving [ ] Not enough public transportation options/ cost of public transportation [ ] Changes in population size (increasing or decreasing)
[ ] Not enough places for exercise and wellness activities [ ] Social isolation [ ] Having enough childcare/ daycare services [ ] Litter (amount of litter, adequate garbage collection)
[ ] Having enough quality school resources [ ] Food insecurity [ ] Bullying/Cyber-bullying
[ ] Physical violence, domestic violence, sexual abuse [ ] Child abuse [ ] Elder abuse. [ ] Air quality
[ ] Prefer not to answer

24. Thinking about the AVAILABILITY/DELIVERY OF HEALTH SERVICES in your community, the thing you are most concerned about is:

[ ] Ability to get appointments for health services within 48 hours [ ] Ability to get healthcare services during non-business hours, such as evenings and weekends [ ] Avilability of primary care providers and nurses [ ] Availability of home health services [ ] Availability of specialists [ ] Not enough wellness and disease prevention services [ ] Not enough mental health services [ ] Availability of substance use disorder treatment/services [ ]Availability of hospice care [ ] Availability of dental/vision care [ ] Availability of emergency services (911, EMS, ambulances) [ ] Cost of prescription drugs [ ] Cost of healthcare [ ] Quality of care [ ] Adequacy of health insurance [ ] Understanding how and where to get health insurance [ ] Transportation to and from medical appointments [ ] Ability to use and access electronic portals and telehealth services [ ] Prefer not to answer [ ] Other

25. Thinking about the YOUTH POPULATION in your community, the thing you are most concerned about is:

[ ] Alcohol use/abuse [ ] Substance use, including misuse of prescription medications [ ] Smoking, vaping, and exposure to second-hand smoke [ ] Marijuana use and exposure to second-hand marijuana smoke [ ] Overweight/obesity/diabetes [ ] Mental health [ ] Suicide [ ] Teen pregnancy [ ] Not enough activities for children and youth [ ] Sexual health [ ] Wellness and disease prevention, including vaccine-preventable diseases [ ] Not getting enough exercise/physical activity [ ] Hunger, poor nutrition [ ] Eating disorders [ ] Crime [ ] Dropping out of school [ ] Overuse/misuse of social media/technology/internet [ ] Availability of disability services [ ] Prefer not to answer [ ] Other

26. Thinking about the ADULT POPULATION in your community, the thing you are most concerned about is:

[ ] Alcohol use/abuse [ ] Substance use, including misuse of prescription medications [ ] Smoking, vaping, and exposure to second-hand smoke [ ] Marijuana use and exposure to second-hand marijuana smoke [ ] Overweight/obesity [ ] Mental health [ ] Suicide [ ] Sexual health [ ] Wellness and disease prevention, including vaccine-preventable diseases [ ] Not getting enough exercise/physical activity [ ] Hunger, poor nutrition [ ] Availability of disability services [ ] Prefer not to answer [ ] Other

27. Thinking about the SENIOR POPULATION in your community, the thing you are most concerned about is:

[ ] Ability to meet needs of older population [ ] Long-term/nursing home care options [ ] Assisted living options [ ] Availability of resources to help the elderly stay in their homes [ ] Availability/cost of activities for seniors [ ] Availability of resources for family and friends caring for elders [ ] Quality of elder care [ ] Cost of long-term/nursing home care

[ ] Mental health/social isolation. [ ] Ability to access and use electronic portals and telehealth services [ ] Substance use, including misuse of prescription medications and alcohol [ ] Elder abuse [ ] Hunger, poor nutrition [ ] Prefer not to answer [ ] Other

28. What single issue do you feel is the biggest challenge affecting your community? _____

29. What single issue do you feel is the biggest challenge affecting YOU? _____

30. Overall, how would you rate the health of the community in which you live?
[ ] Very healthy [ ] Healthy [ ] Unhealthy [ ] Very unhealthy [ ] Prefer not to answer

31. Overall, how would you rate the health of the county you live in?
[ ] Very healthy [ ] Healthy [ ] Unhealthy [ ] Very unhealthy [ ] Prefer not to answer

32. Overall, how would you rate your health?
[ ] Very healthy [ ] Healthy [ ] Unhealthy. [ ] Very unhealthy [ ] Prefer not to answer

33. Which healthcare system do you use for primary healthcare needs?
[ ] Bassett Healthcare Network [ ] United Health Services (UHS) [ ] Mohawk Valley Health System (MVHS) [ ] A community health center [ ] Veterans Affairs (VA) [ ] Do not have a primary care provider. [ ] Don't know [ ] Prefer not to answer [ ] Other

34. Which of the below do you feel like are the top 3 health system issues in your county?
[ ] Access to a dentist [ ] Access to a regular doctor or health care provider
[ ] Access to drug or alcohol abuse treatment [ ] Access to language translators
[ ] Access to mental health services [ ] Access to services that can prevent disease or find it earlier (vaccines, screening tests, etc.) [ ] Discrimination or bias from medical providers/lack of empathy
[ ] High cost of prescription medications [ ] Lack of health insurance coverage
[ ] Lack of transportation to medical appointments [ ] High cost of healthcare
[ ] Not understanding health information from a medical provider [ ] Prefer not to answer [ ] Other

35. Difficulty or not getting to a medical appointment due to:
[ ] Lack of transportation [ ] Provider location [ ] Lack of childcare
[ ] Not having sick leave at work [ ] Provider office hours [ ] Provider rescheduling
[ ] Lack of available provider [ ] Prefer not to answer [ ] Other

36. Felt like your provider:
[ ] does not understand you or your experiences [ ] is not listening
[ ] is not spending enough time with you [ ] is not providing a clear explanation of health information [ ] is not providing language or translation needs

[ ] is judging you (stigma or discrimination [ ] is not providing continuous care from the same provider at each visit [ ] Prefer not to answer [ ] Other

37. Had difficulty seeking care because:

[ ] not having health insurance [ ] couldn't find a provider who accepts your insurance [ ] high cost
[ ] wait time in providers' office impacted your ability to meet your obligations (work, family, etc.) [ ] too long of a wait to get an appointment [ ] telehealth/technology challenges
[ ] don't know about or are unsure of local services [ ] Prefer not to answer [ ] Other

38. What additional health services would you like to see in your county?

39. How do you usually get your health information? (Check all that apply)

[ ] Social media (Facebook, X, Instagram, etc.) [ ] Newspaper, magazines, or other printed materials [ ] Internet [ ] 24-hour television news outlet (Fox, CNN, MSNBC, etc)
[ ] Local news outlet (WSKG, WBNG, Spectrum, etc.) [ ] Conversations with my doctor/nurse
[ ] Hospital/county website [ ] Conversations with friends and family
[ ] Prefer not to answer [ ] Other

40. What is the best way to share health information with you?

[ ] Email [ ] Tv/radio [ ]Mailed to your home [ ] Social media posts[ ]
[ ] Prefer not to answer [ ] Other

41. Please provide us with any additional information that you feel would be useful for us to know in regard to the health status of you or our community.

Appendix C: Stakeholder Survey Questions

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

1. **Organization/Agency name:**
2. **Your name (Please provide first and last name):**
3. **Your job title/role:**
4. **Your email address:**
5. **Indicate the one community sector that best describes your organization/agency:**

[ ] Business [ ] Health Care Provider [ ] Housing [ ] Social Services [ ] Public Health
[ ] Seniors/Elderly [ ] Disability Services [ ] Mental, Emotional, Behavioral Health Provider
[ ] Civic Association [ ] College/University [ ] Early Childhood [ ] Economic Development
[ ] Employment/Job Training [ ] Faith-Based [ ] Food/Nutrition [ ] Foundation/Philanthropy
[ ] Transportation [ ] Health-Based CBO [ ] Health Insurance Plan
[ ] Law Enforcement/Corrections [ ] Local Government [ ] Media [ ] Recreation
[ ] School (K-12) [ ] Tribal Government [ ] Veterans [ ] Other (please specify)

Health Priorities, Concerns, and Factors

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

6. **Please rank, by indicating 1 through 5, the priority areas that, if addressed locally, would have the greatest to smallest impact on improving the health and well-being of the clients your organization/agency serves. (#1 ranked priority area would have the most impact; #5 ranked priority area would have the least impact)**
    - Promote Healthy Women, Infants, and Children
    - Prevent Communicable Diseases
    - Promote a Healthy and Safe Environment
    - Promote Well-Being and Prevent Mental and Substance Use Disorders
    - Prevent Chronic Diseases

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

[ ] Adverse childhood experiences [ ] Alzheimer's disease/Dementia [ ] Arthritis [ ] Autism
[ ] Cancers [ ] Child/Adolescent physical health [ ] Child/Adolescent emotional health
[ ] Diabetes/Overweight or obesity [ ] Disability [ ] Dental health [ ] Domestic abuse/violence
[ ] Drinking water quality [ ] Emerging infectious diseases (Ebola, Zika virus, tick/mosquito transmitted),
[ ] Exposure to air and water pollutants/hazardous materials [ ] Falls [ ] Food safety
[ ] Heart disease [ ] Hepatitis C [ ] High blood pressure [ ] HIV/AIDS [ ] Hunger

[ ] Infant health [ ] Infectious disease [ ] LGBT health [ ] Maternal health
[ ] Mental health conditions [ ] Motor vehicle safety impaired/distracted driving
[ ] Opioid use/Prescription drug abuse/Substance use
[ ] Pedestrian/bicyclist accidents [ ] Respiratory disease (asthma, COPD, etc.)
[ ] Senior health [ ] Sexual assault/rape [ ] Sexually transmitted infections
[ ] Social connectedness [ ] Stroke [ ] Suicide
[ ] Tobacco use/nicotine addiction-smoking/vaping/chewing
[ ] Underage drinking/excessive adult drinking [ ] Unintended/teen pregnancy
[ ] Violence (assault, firearm-related) [ ] Other (please specify): _____

8. In your opinion, what are the top five (5) contributing factors to the health concerns you chose in the question before?

[ ] Addiction to alcohol [ ] Addiction to illicit drugs [ ] Addiction to nicotine
[ ] Age of residents [ ] Changing family structures (increased foster care, grandparents as parents, etc.). [ ] Crime/violence/community blight [ ] Deteriorating infrastructure (roads, bridges, water systems, etc.). [ ] Discrimination/racism [ ] Domestic violence and abuse
[ ] Environmental quality [ ] Excessive screen time [ ] Exposure to tobacco smoke/emissions from electronic vapor products [ ] Food insecurity [ ] Health care costs [ ] Homelessness
[ ] Inadequate physical activity [ ] Inadequate sleep. [ ] Inadequate/unaffordable housing options [ ] Lack of chronic disease screening, treatment, and self-management services
[ ] Lack of cultural and enrichment programs [ ] Lack of dental/oral health care services
[ ] Lack of educational opportunities for people of all ages.
[ ] Lack of educational, vocational, or job-training options for adults
[ ] Lack of employment options [ ] Lack of health education programs [ ] Lack of health insurance
[ ] Lack of intergenerational connections within communities [ ] Lack of mental health services
[ ] Lack of opportunities for health for people with physical limitations or disabilities
[ ] Lack of preventive/primary health care services (screenings, annual check-ups)
[ ] Lack of social support for community residents
[ ] Lack of speciality care and treatment [ ] Lack of substance use disorder services.
[ ] Late or no prenatal care [ ] Pedestrian safety (roads, sidewalks, buildings, etc.)
[ ] Poor access to healthy food and beverage options
[ ] Poor access to public places for physical activity and recreation
[ ] Poor educational attainment [ ] Poor community engagement and connectivity
[ ] Poor eating/dietary practices [ ] Poor health literacy (ability to comprehend health information)
[ ] Poor referrals to health care, specialty care, and community-based support services
[ ] Poverty [ ] Problems with internet access (absent, unreliable, unaffordable)
[ ] Quality of schools [ ] Religious or spiritual values
[ ] Shortage of childcare options [ ] Stress (work, family, school, etc.)
[ ] Transportation problems (unreliable, unaffordable, etc.). [ ] Unemployment/low wages

[ ] Other (please specify): _____

9. Social determinants of health are conditions in the place where people live, learn, work, and play that affect a wide range of health risks and outcomes. Which ONE of the following five sections do you believe represents the biggest barrier your clients face?

[ ] Economic Stability (poverty, employment, food security, housing stability)
[ ] Education (high school graduation, higher education, literacy, early childhood development)
[ ] Social and Community Context (social cohesion, civic participation, discrimination/equity, incarceration)
[ ] Neighborhood and Built Environment (access to healthy foods, housing quality, crime/violence, environmental conditions, transportation)
[ ] Health and Health Care (access to primary/specialty care, health literacy)

10. In your opinion, what population experiences the poorest health outcomes?

[ ] Specific racial or ethnic groups [ ] Children/Adolescents [ ] Females of reproductive age
[ ] Individuals with disability [ ] Individuals near federal poverty level
[ ] Individuals with mental health issues [ ] Individuals living in rural areas
[ ] Individuals with substance abuse issues [ ] Migrant workers [ ] Seniors/Elderly
[ ] Other (please specify): _____

Improving Health and Well-Being (Select the top 3 goals your organization/agency can assist with)

11. Prevent Chronic Diseases (select up to 3)

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

12. Promote Healthy Women, Infants, and Children (select up to 3)

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

13. Promote a Healthy and Safe Environment (select up to 3)

[ ] Reduce falls among vulnerable populations
[ ] Reduce violence by targeting prevention programs to the highest risk populations
[ ] Reduce occupational injury and illness
[ ] Reduce traffic-related injuries for pedestrians and bicyclists
[ ] Reduce exposure to outdoor air pollutants
[ ] Improve design and maintenance of the built environment ot promote health lifestyles, sustainability, and adaptation to climate change
[ ] Promote healthy home/school environments
[ ] Protect water sources and ensure quality drinking water
[ ] Protect vulnerable waterbodies to reduce potential public health risks associated with exposure to recreational water
[ ] Raise awareness of the potential presence of chemical contaminants and promote strategies to reduce exposure
[ ] Improve food safety management

14. Promote Well-Being and Prevent Mental and Substance Use Disorders (select up to 3)

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

15. Prevent Communicable Diseases (select up to 3)

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

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

17. Additional comments/recommendations:
18. 18. What are the most significant mental health needs not being adequately addressed

Appendix D: NYSPA f2025-2030 Domains and Priorities

NYSPA 2025-2030		
Domain	Priority	
Economic Stability	• Poverty • Nutrition Security	• Unemployment • Housing Stability and Affordability
Social and Community Context	• Anxiety and Stress • Depression • Suicide • Primary Prevention, Substance Misuse, and Overdose Prevention	• Tobacco/E-Cigarette Use • Alcohol Use • Adverse Childhood Experiences • Healthy Eating
Neighborhood and Built Environment	Opportunities for Active Transportation and Physical Activity Injuries and Violence	Access to Community Services and Support
Health Care Access and Quality	• Access to and Use of Prenatal Care • Prevention of Infant and Maternal Mortality • Preventive Services for Chronic Disease Prevention and Control	• Preventive Services • Early Intervention • Childhood Behavioral Health • Oral Health Care
Education Access and Quality	• Health and Wellness Promoting Schools	• Opportunities for Continued Education

NYSDOH, NYSPA (2025)

Appendix E: NYSPA 2025-2030 Priorities and Objectives

NYSPA 2025-2030 Domains, Priorities, and Objectives	
Economic Stability	**Priority: Poverty** **Objective 1.0:** Reduce the percentage of people living in poverty from 13.6% to 12.5% **Objective 1.1:** Reduce the percentage of people aged 65 years and older living in poverty from 12.2% to 11%
	Priority: Unemployment **Objective 2.0:** Reduce unemployment among individuals aged 16 years and older from 6.2% to 5.5%. **Objective 2.1:** Reduce unemployment among Black residents from 9.3%to 7.9%.
	Priority: Nutrition Security **Objective 3.0:** Increase consistent household food security from 71.1% to 75.9% **Objective 3.1:** Increase food security in households with an annual total income less than $25,000 from 42% to 51.1%.
	Priority: Housing Stability and Affordability **Objective 4.0:** Increase the number of people living in HUD-subsidized housing from 987,957 to 1,092,000. **Objective 4.1:** Increase the percentage of adults, with an annual income of less than $25,000, who were able to pay their mortgage, rent, or utility bills in the past 12 months from 85.1% to 89.4%.
Social and Community Context	**Priority: Anxiety and Stress** **Objective 5.0:** Decrease the percentage of adults who experience frequent mental distress from 13.4% to 12.0% **Objective 5.1:** Decrease the percentage of adults in households with an annual income of less than $25,000 who experience frequent mental distress from 21.0% to 18.9%.
	Priority: Suicide **Objective 6.0:** Reduce the suicide mortality rate from 7.9% to 6.7%. **Objective 6.1:** Reduce adolescent suicide attempts from 13.6% to 12.2% (New York City). **Objective 6.2:** Reduce adolescent suicide attempts from 9.4% to 8.5% (New York State outside New York City).
	Priority: Depression **Objective 7.0:** Reduce the percentage of adults with a major depressive episode during the past year from 6.7% to 5.7%.

	Objective 7.1: Increase the percentage of postpartum birthing persons who seek counseling after being told they have depression from 53.1% to 62.0%. **Objective 7.2:** Increase the percentage of postpartum birthing persons who receive a medication prescription after being told they have depression from 61.7% to 70.0%.
Social and Community Context	**Priority: Primary Prevention, Substance Misuse, and Overdose Prevention** **Objective 8.0:** Reduce the percentage of high school students reporting alcohol use before the age of 13 from 17.2% to 15.5% (New York City). **Objective 8.1:** Reduce the percentage of high school students reporting alcohol use before the age of 13 from 13.6% to 12.2% (New York State outside New York City). **Objective 9.0:** Decrease episodes when an opioid-naïve patient received an initial opioid prescription, rate per 1,000 person-years from 86.5 to 77.9. **Objective 9.1:** Decrease the percentage of episodes when patients were opioid-naïve and received an opioid prescription of more than seven days per 1,000 person-years from 15.1 to 13.6. **Objective 10.0:** Increase the number of unique individuals enrolled in OASAS treatment programs from 1,107.8 to 1,218.6. **Objective 10.1:** Increase the number of unique individuals enrolled in OASAS treatment programs, who reported any opioid as the primary substance at admission from 465.2 to 511.7. **Objective 10.2:** Increase the number of unique individuals enrolled in OASAS treatment programs, who reported alcohol as the primary substance at admission from 402.8 to 443.1. **Objective 11.0:** Increase the crude rate of patients per 100,000 population who received at least one buprenorphine prescription for opioid use disorder from 446.0 to 490.6. **Objective 12.0:** Reduce the crude rate of overdose deaths involving drugs, per 100,000 population, from 32.3 to 22.6. **Objective 12.1:** Reduce the crude rate of overdose deaths for Black, non-Hispanic residents, per 100,000 population, from 59.2 to 35.5. **Objective 13.0:**Increase the number of naloxone kits distributed from 397,620 to 596,430.
	Priority: Tobacco/ E-Cigarette Use **Objective 14.0:** Reduce the percentage of adults who use tobacco products from 9.3% to 7.9%. **Objective 14.1:** Reduce the percentage of high school students who use tobacco products from 17.0% to 14.5%.
	Priority: Alcohol Use **Objective 15.0:** Decrease the prevalence of binge or heavy drinking among all adults aged 18 years and older from 16.2% to 14.6%. **Objective 15.1:** Decrease the prevalence of drinking by high school students from 16.8% to 13.4% (New York City). **Objective 15.2:** Decrease the prevalence of drinking by high school students from 23.9% to 19.1% (New York State outside New York City).

Social and Community Context	**Priority: Adverse Childhood Experiences**
	Objective 16.0: Increase the percentage of adults who, as a child, always had an adult in the household who made them feel safe and protected and tried hard to make sure their basic needs were met from 65.1% to 66.9%.
	Objective 16.1: Increase the percentage of Hispanic adults who, as a child, always had an adult in the household who made them feel safe and protected and tried hard to make sure their basic needs were met from 51.0% to 52.7% **Objective 17.0**: Reduce the percentage of adults who, as a child, experienced three or more adverse childhood experiences (ACEs) from 25.3% to 23.8%. **Objective 17.1:** Reduce the percentage of Black, non-Hispanic adults who, as a child, experienced three or more adverse childhood experiences (ACEs) from 29.0% to 27.5%. **Objective 17.2:** Reduce the percentage of Hispanic adults who, as a child, experienced three or more adverse childhood experiences (ACEs) from 28.5% to 26.1%. **Objective 18.0:** Reduce the rate of indicated reports of abuse/maltreatment per 1,000 children and youth aged 0-17 years from 11.3 to 9.8. **Objective 18.1:** Reduce the rate of indicated reports of abuse/maltreatment per 1,000 Black, non-Hispanic children and youth from 21.8 to 19.9. **Objective 18.2:** Reduce the rate of indicated reports of abuse/maltreatment per 1,000 Hispanic children and youth from 13.9 to 12.5.
	Priority: Healthy Eating
	Objective 19.0: Decrease the percentage of adults who consume no fruits or vegetables daily from 28.4% to 27.0%. **Objective 19.1:** Decrease the percentage of adults with an annual household income less than $50,000 who consume no fruits or vegetables daily from 31.7% to 30.1%. **Objective 20.0:** Increase the percentage of infants who are exclusively breastfed in the hospital from 45.9% to 48.2%. **Objective 20.1:** Increase the percentage of Black, non-Hispanic infants who are exclusively breastfed in the hospital from 34.1% to 35.8%.
Neighborhood and Build Environment	**Priority: Opportunities for Active Transportation and Physical Activity**
	Objective 21.0: Increase the prevalence of physical activity among all adults aged 18 years and older from 73.9% to 77.6%. **Objective 21.1:** Increase the prevalence of physical activity among all adults aged 18 years and older with an annual household income less than $25,000 from 56.7% to 59.5%.
	Priority Access to Community Services and Supports
	Objective 22.0: Increase the number of completed Climate Smart Community Actions related to community resilience from 363 to 382. **Objective 22.1:** Increase the percentage of higher vulnerability areas that have a cooling center from 24.5% to 27.0%.
	Priority: Injuries and Violence

Neighborhood and Build Environment	**Objective 23.0:** Decrease the rate of emergency department visits of motor vehicle-related pedestrian injuries per 10,000 people from 3.4 to 3.2 **Objective 23.1:** Decrease the ratio of motor vehicle-related pedestrian injury emergency department visits of Black, non-Hispanic persons compared to White, non-Hispanic persons from 4.0 to 3.8. **Objective 24.0:** Decrease the rate of emergency department visits of assault-related injuries per 10,000 people from 32.1 to 30.5. **Objective 24.1:** Decrease the ratio of assault-related emergency department visits of Black, non-Hispanic persons compared to White, non-Hispanic persons from 4.2 to 4.0.
Health Care Access and Quality	**Priority: Access to and Use of Prenatal Care** **Objective 25.0:** Increase the percentage of birthing persons who receive prenatal care during the first trimester from 80.7% to 83.0%. **Objective 25.1:** Increase the percentage of uninsured birthing persons who receive prenatal care during the first trimester from 41.4% to 45.0%.
	Priority: Prevention of Infant and Maternal Mortality **Objective 26.0:** Decrease the rate of infant mortality per 1,000 live births from 4.3 to 3.5. **Objective 27.0:** Decrease the rate of maternal mortality per 100,000 live births from 19.8 to 16.1. **Objective 27.1:** Decrease the rate of maternal mortality per 100,000 live births among Black, non-Hispanic birthing persons from 65.2 to 55.0. **Objective 28.0:** Decrease percentage of birthing persons who experience depressive symptoms during pregnancy from 12.4% to 11.5%. **Objective 28.1:** Decrease percentage of birthing persons aged 20-24 years who experience depressive symptoms during pregnancy from 26.2% to 19.0%. **Objective 29.0:** Decrease percentage of birthing persons who experience depressive symptoms after birth from 11.9% to 9.9%. **Objective 29.1:** Decrease percentage of birthing persons aged 20-24 years who experience depressive symptoms after birth from 19.2% to 18.0%.
	Priority: Preventive Services for Chronic Disease Prevention and Control **Objective 30.0:** Increase the percentage of adults aged 35 years and older who had a test for high blood sugar in the past year from 78.1% to 82.4%. **Objective 30.1:** Increase the percentage of younger adults aged 35-44 years who had a test for high blood sugar in the past year from 62.4% to 65.5%. **Objective 31.0:** Decrease the asthma emergency department visit rate per 10,000 among children aged 0-17 years from 93.8 to 89.1. **Objective 31.1:** Decrease the asthma emergency department visit rate per 10,000 among Black, non-Hispanic children aged 0-17 years from 235.9 to 212.3. **Objective 32.0:** Increase the percentage of adults aged 18 years and older with hypertension who are currently taking medication to manage their high blood pressure from 77.0% to 81.7%. **Objective 32.1:** Increase the percentage of adult Medicaid members aged 18 years and older with hypertension who are currently taking medication to manage their high blood pressure from 66.9% to 75.5%.

Health Care Access and Quality	**Objective 33.0:** Increase the percentage of adults aged 45 to 75 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 73.7% to 82.3%. **Objective 33.1:** Increase the percentage of adults aged 45 to 54 years who are up to date on their colorectal cancer screening based on the most recent guidelines from 55.8% to 63.4%.
	Priority: Oral Health Care
	Objective 34.0: Increase the percentage of Medicaid enrollees with at least one preventive dental visit within the last year from 20.3% to 21.3%. **Objective 34.1:** Increase the percentage of Medicaid enrollees aged 2-20 years with at least one preventive dental visit within the last year from 39.1% to 41.1%.
	Priority Preventive Services
	Objective 35.0: Increase the percentage of infants who received a diagnostic hearing evaluation after not passing their newborn hearing screening from 23.4% to 35.1%. **Objective 35.1:** Increase the percentage of infants who received a diagnostic hearing evaluation after not passing their newborn hearing screening by 3 months of age from 15.6% to 23.4%. **Objective 36.0:** Increase the up to date seven-vaccine immunization rate for children aged 24-35 months from 59.3% to 62.3%. **Objective 37.0:** Increase the percentage of 13-year-old adolescents with a complete Human Papillomavirus (HPV) vaccine series from 25.7% to 28.7%. **Objective 38.0:** Increase the percentage of children in a single birth cohort year tested at least twice for lead before 36 months of age from 61.0% to 70.0%.
	Priority: Early Intervention
	Objective 39.0: Increase the percentage of children under 3 years old who have Individual Family Service Plans (IFSPs) from 8.3% to 11.0%. **Objective 39.1:** Increase the percentage of Black, non-Hispanic children under 3 years old who have Individual Family Service Plans (IFSPs) from 7.0% to 10.0%.
	Priority : Childhood Behavioral Health
	Objective 40.0: Increase the percent of children aged 0-5 years who are reported by their parent as exhibiting all 4 flourishing criteria from 72.2% to 79.4%. **Objective 40.1:** Increase the percent of children aged 0-5 years who live at 0-99% of the poverty level who are reported by their parent as exhibiting all 4 flourishing criteria from 58.8% to 67.6%.
Education Access and Quality	**Priority: Health and Wellness Promoting Schools**
	Objective 41.0: Decrease the percentage of chronic absenteeism (defined as missing more than 18 days (>10%) per academic year) among public school students in grades K-8 from 26.4% to 18.5%. **Objective 41.1:** Decrease the percentage of chronic absenteeism (defined as missing more than 18 days (>10%) per academic year) among public school students in grades K-8 who are economically disadvantaged from 34.9% to 24.4%.

	Opportunities for Continued Education
	Objective 42.0: Increase the percentage of high school seniors that attend a 2- or 4-year college from 70.2% to 77.0%. **Objective 42.1:** Increase the percentage of high school seniors who are economically disadvantaged that attend a 2- or 4-year college from 63.1% to 69.4%.