2025 Community Health Needs Assessment

Garnet Health
MEDICAL CENTER
Catskills

- CHNA Executive Summary
- About our Community
- Key Health Indicators
- Community Input
- Prioritized Health Needs

Garnet Health Medical Center – Catskills 2025 CHNA

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

Garnet Health is one of the largest healthcare providers in the tri-county area and is dedicated to developing specialty services, medical programs and needed healthcare services that allow residents to remain close to home to receive quality care. GHMC's mission is to improve the health of our community by providing exceptional healthcare.

GHMC – C desires to continue providing clinical programs and services to meet community needs, while also pursuing continuous improvement in existing and future programs to improve the overall health of the community it serves. As such, GHMC – C partnered with Crowe LLP to conduct a Community Health Needs Assessment (CHNA) from May 2025 through October 2025, using primary and secondary data, to ensure community benefit programs and resources are focused on significant health needs as perceived by the community at large, as well as alignment with GHMC – C's mission, services and strategic priorities.

To comply with Section 501(r) of the Internal Revenue Code, the following pages describe the CHNA process and findings for GHMC – C . The community served by GHMC – C is defined primarily as Sullivan County in New York. Approximately 93% of GHMC – C's patients reside within Sullivan County. Defining the CHNA community as its primary service area will allow GHMC – C to more effectively focus its resources to address identified significant health needs, targeting areas of greatest need and health disparities.

GHMC – C obtained input through two focus groups whose participants were leaders representing those with expertise in public health, healthcare organizations, social services, seniors and community leaders. Specifically these focus groups were designed to take into account community input from individuals who represent the broad interests of the community including those with knowledge or expertise in public health. In addition, focus groups included members of medically underserved, low-income and minority populations. Primary input was also obtained by conducting community health survey with members of the community. The organization took steps to ensure that primary input was gathered from members of medically underserved, low-income and minority populations.

To complement the primary data, secondary data was reviewed and analyzed from the US Census Bureau, Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services, and other publicly available data sources. Quantitative data were analyzed to identify trends in health indicators, access to care, and social determinants of health. Qualitative data from focus groups and open-ended survey responses were reviewed to identify recurring community concerns and potential drivers of health disparities. Comparative analysis was conducted between GHMC – C's service area and state and national benchmarks to determine areas of significant need.

Garnet Health 2025 CHNA

GHMC-C identified and prioritized community health needs through a collaborative, data-driven process that included analysis of quantitative and qualitative data from local, state, and national sources; feedback from community surveys, focus groups, and the Orange County Health Summit; consultation with public health agencies, community-based organizations, and representatives of underserved populations; and alignment with the New York State Department of Health Prevention Agenda. GHMC-C recognizes that the local public health timeline differs from the hospital's CHNA cycle and that priorities may be refined as new data become available. The selected priority areas—Social and Community Context and Health Care Access and Quality—were chosen based on current findings, alignment with community and state priorities, and GHMC-C's capacity to meaningfully address these needs through programs and partnerships. These priorities will be reassessed in March 2026, and updated by July 2026 if needed, to ensure continued responsiveness to community health needs.

Social & Community Context

Health Care Access & Quality

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

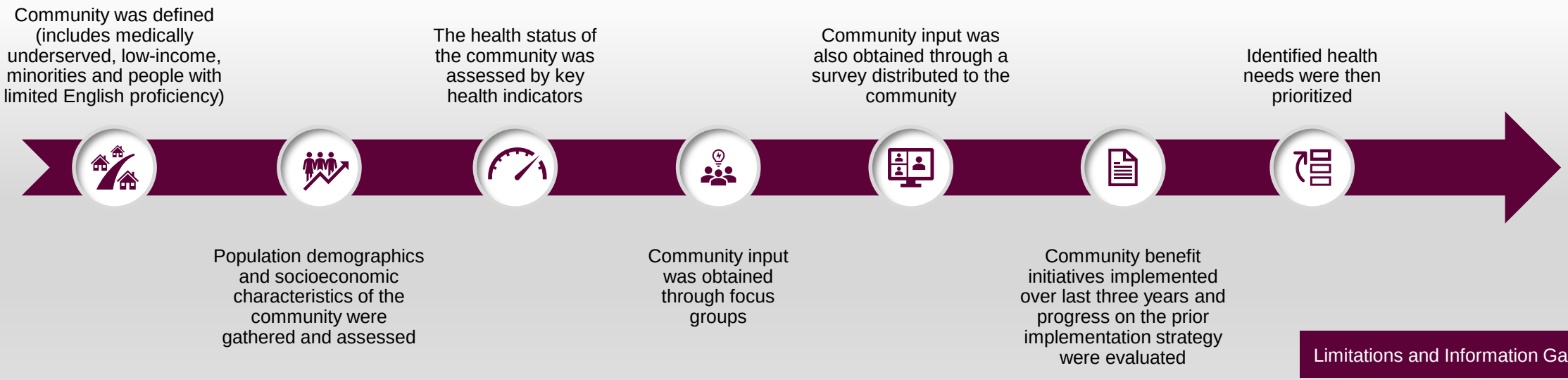
Delilah Socci
Community Health Manager
dsocci@garnethealth.org

How the Assessment was Conducted

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

- ✓ Identify and prioritize health issues in GHMC – C's primary service area, particularly for vulnerable and under-represented populations.
- ✓ Ensure that programs and services closely match the priorities and needs of the community.
- ✓ Strategically address those needs to improve the health of the communities served by GHMC – C.
- ✓ Include input from individuals who represent the broad interests of the community – including those with expertise in public health and members of medically-underserved, low income and minority populations.

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



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

GHMC-C is affiliated with Garnet Health. Providing healthcare to approximately 500,000 residents in Orange, Sullivan and Ulster Counties, Garnet Health was designed to improve the quality, stability and efficiency of healthcare services in the mid-Hudson and Catskill region. Garnet Health employs over 4,300 professionals and has over 1,200 medical staff members. An academic affiliate of the Touro College of Osteopathic Medicine, Garnet Health retains compassionate professionals who continually strive toward the hospital's mission to improve the health of our community by providing exceptional health care. GHMC is a Level II Trauma Center, designated stroke center, and has a pediatric ready emergency department.

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

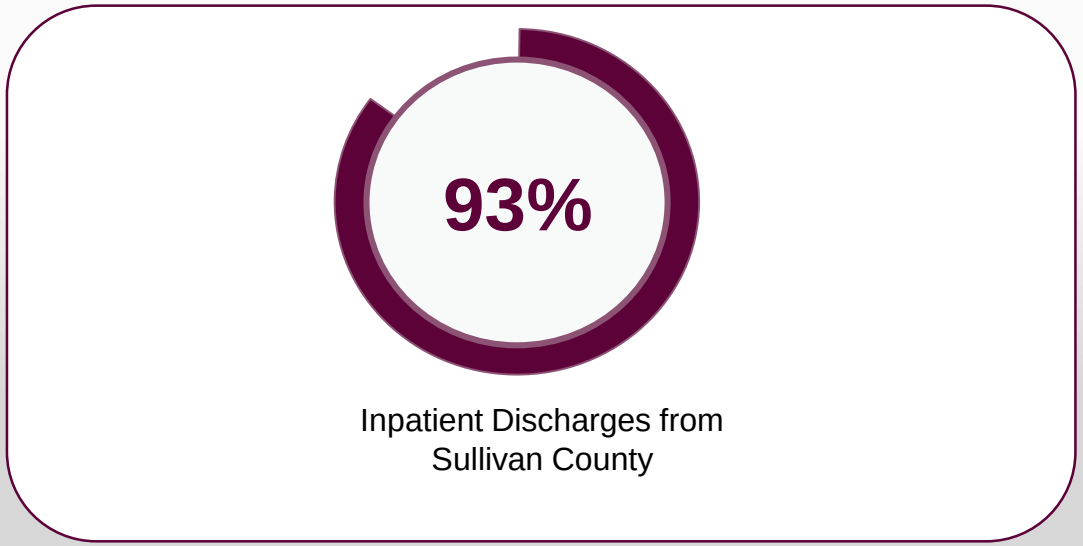
- Ambulatory surgery services
- Bariatric Surgery Center of Excellence
- Birthing centers
- Cardiology services, including emergency care and a broad range of elective procedures
- Community screenings and support groups
- Comprehensive oncology services
- CT surgery
- Emergency medicine, including pediatrics Emergency Department
- Hospitalist services
- Inpatient and outpatient mental health and chemical-dependency services
- Neonatal Intensive Care Unit
- Neurology services
- Orthopedic services, including joint replacements
- Outpatient diagnostic imaging
- Outpatient infusion services
- Pediatrics
- Inpatient and outpatient physical, occupational and speech therapies
- Primary and specialty care practices
- Sleep service
- Structural Heart Services
- Surgical services
- Trauma services
- Wound Healing and Hyperbaric Centers
- Urgent care

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

Who We Serve

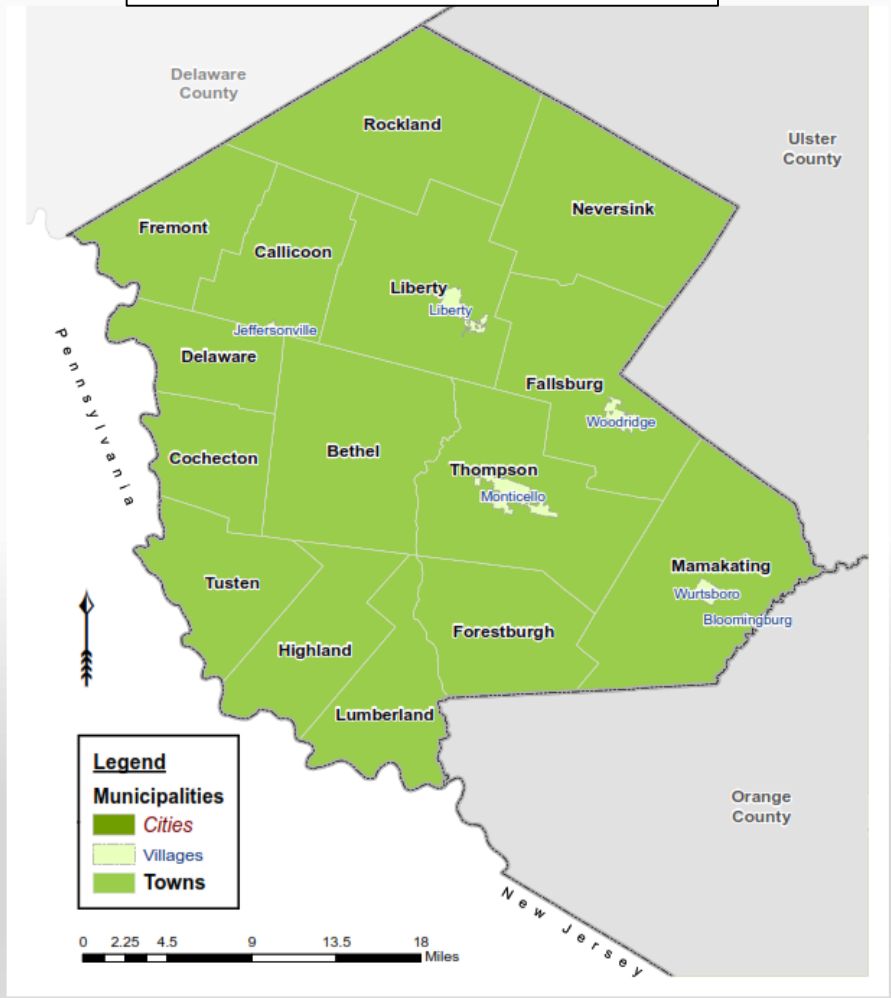
A majority of the patients served by the hospital reside in Sullivan County New York. Sullivan County makes up 997 square miles and is the 33rd largest county out of 62 counties in the state of New York.

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



Inpatient Discharges from Sullivan County

Municipal Boundaries Sullivan County, 2025



Community Overview

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

The CHNA community has a total population of 79,147 according to the U.S. Census Bureau American Community Survey 2019-2023 5-year estimates. The percentage of population by combined race and ethnicity is made up of 67.15% Non-Hispanic White, 18.38% Hispanic or Latino, 7.91% Non-Hispanic African American, 2% Non-Hispanic Asian and 4.56% Non-Hispanic some other race. The demographic makeup of the CHNA community is as follows:

$69,826

Median Household Income

5%

Adults age 18-64 without Health Insurance Coverage

59%

Population 16+ in Civilian Labor Force

30%

People 25+ with a Bachelor's Degree or Higher

15%

of people are living in poverty (11,547 persons)

4%

2,951 persons living in Limited English speaking households

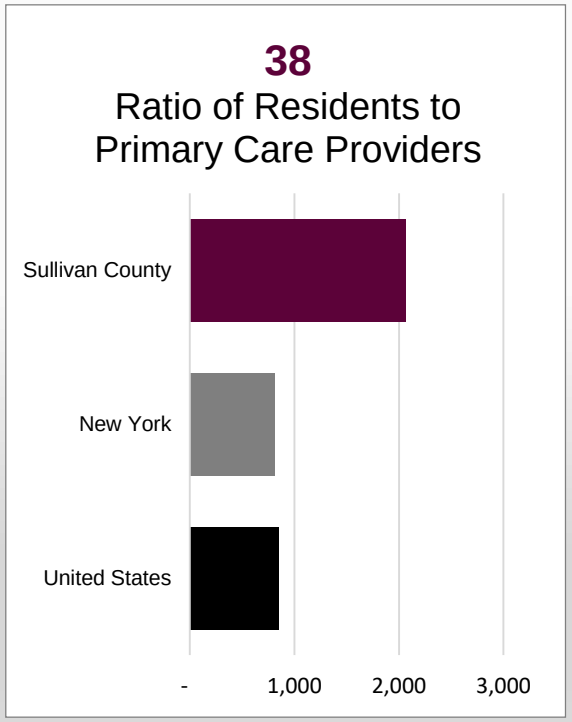
Access to Services

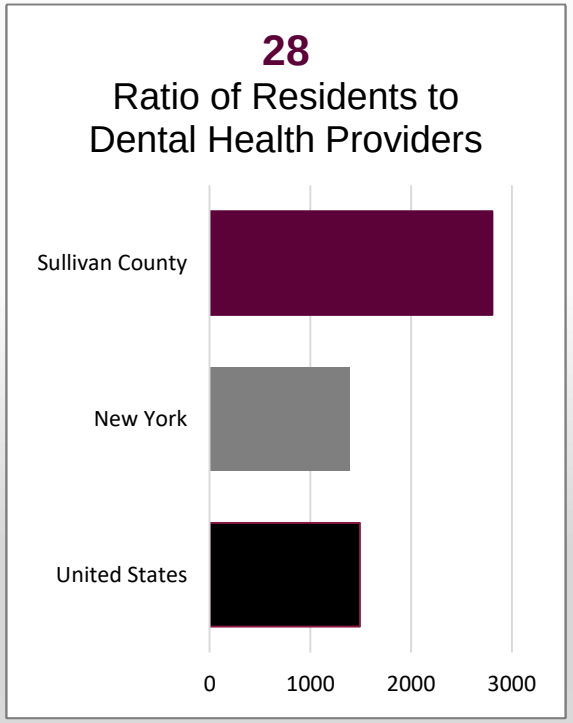
Data Tables

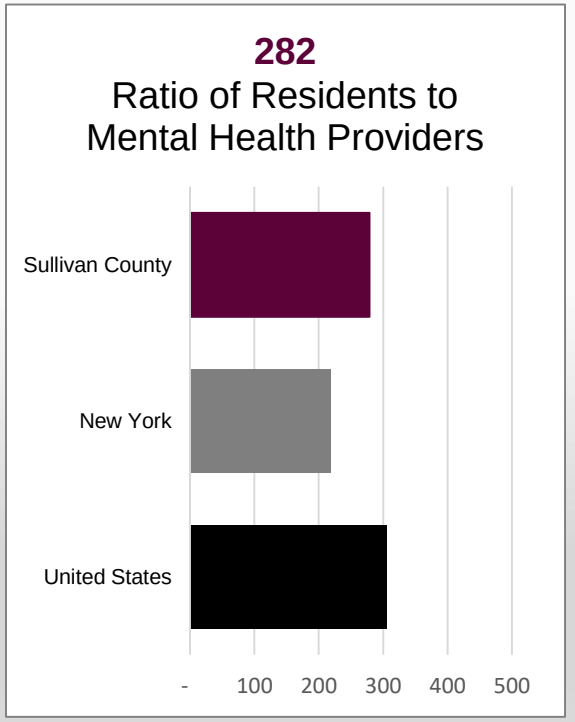
A lack of access to care presents barriers to good health. The supply and accessibility of facilities and physicians affect access. As shown below, the rate of health care providers within Sullivan County is less favorable to state benchmarks.

Medically Underserved Areas

County	Area Name	Designation Type	IMU* Score
Sullivan	Low Income – Monticello	MUP Low Income	61.4
Sullivan	Low Income – Wawarsing/Fallsburg Service Area	MUP Low Income	61.8
Sullivan	Low Income – Western Sullivan Service Area	MUP Low Income	59.3





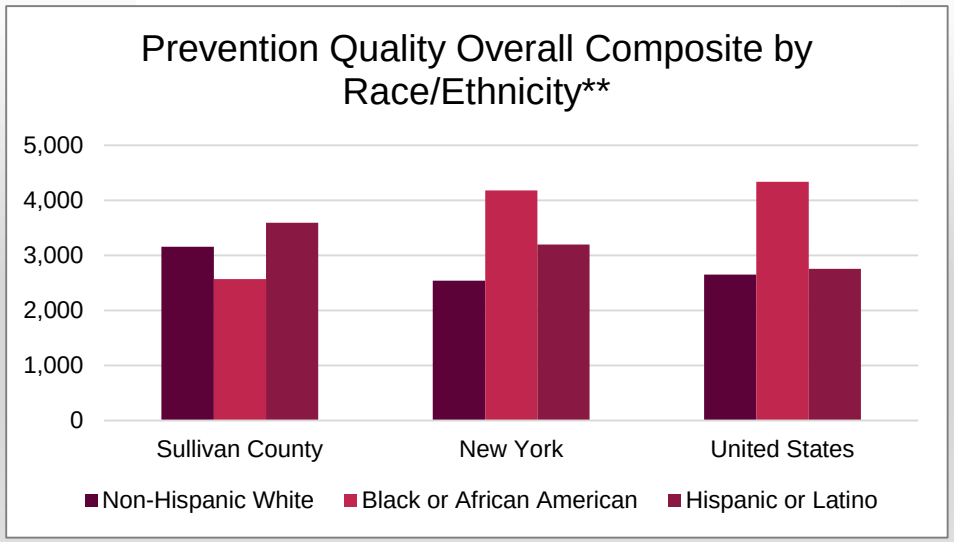


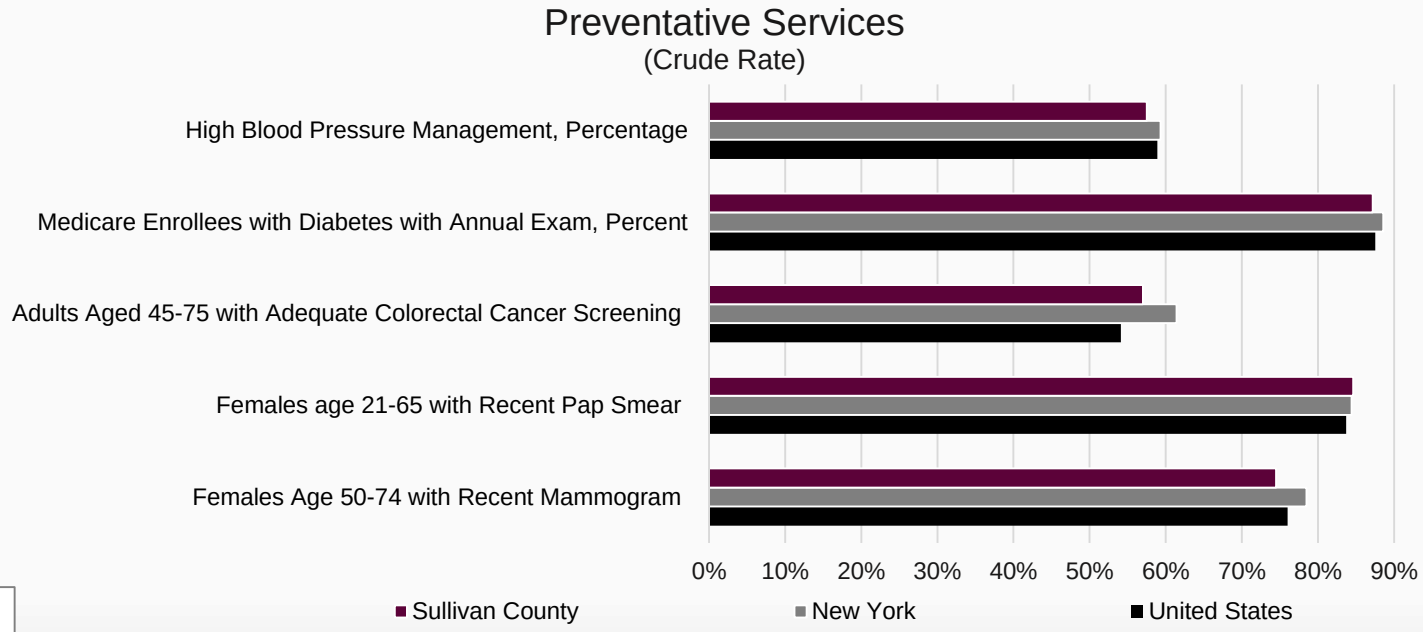
Clinical Preventative Services

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

37.1% of women 65+ in the community are up-to-date with core preventative services compared to the national benchmark of 37.4%.*

46.6% of men 65+ in the community are up-to-date with core preventative services compared to the national benchmark of 44%.*





The chart to the left reports the unsmoothed age-adjusted rate of Prevention Quality Overall Composite (PQI #90) per 100,000 by race and ethnicity for Medicare FFS population in 2023. This indicator can call attention to a lack of access or knowledge regarding one or more health issues and can inform program interventions. In Sullivan County the PQI is highest for the Hispanic or Latino population.

Data Tables

** Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2020. Source geography: Tract*
***Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2022. Source geography: County*

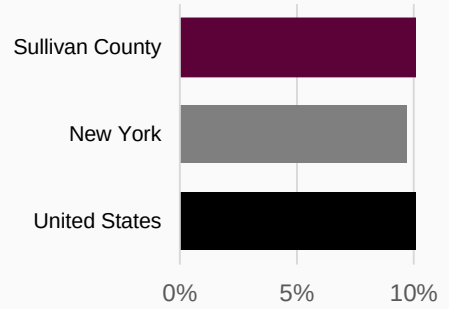
Health Outcomes & Mortality

GHMC – C 's CHNA Community has a significant number of adults who have been diagnosed with chronic illnesses. The prevalence of chronic diseases in the CHNA community is fairly consistent with state and national percentages, with slightly higher rates compared to the state and national benchmarks. Over 28% of the population, 17,665 adults, have high blood pressure.

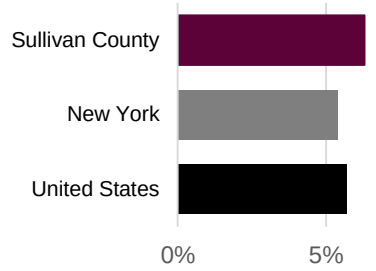
Coronary heart disease, cancer, lung disease and stroke are leading causes of death in the United States. Adjusted death rates for the community are primarily less favorable than state rates.

Data Tables

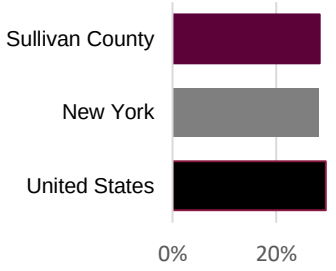
6,593
Adults Diagnosed with Diabetes (Age-Adjusted)
Percentage



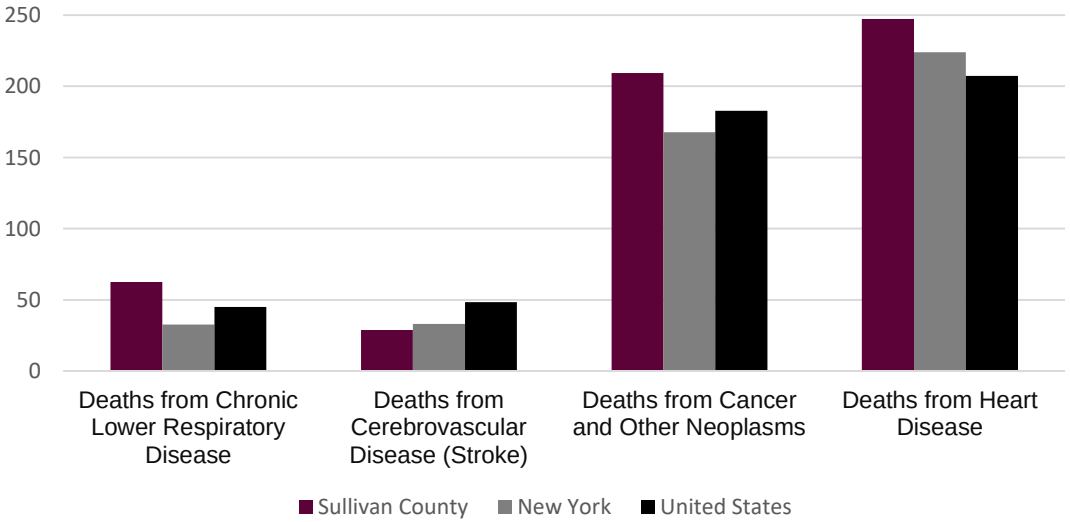
3,919
Adults Ever Diagnosed with Coronary Heart Disease (Age-Adjusted)
Percentage



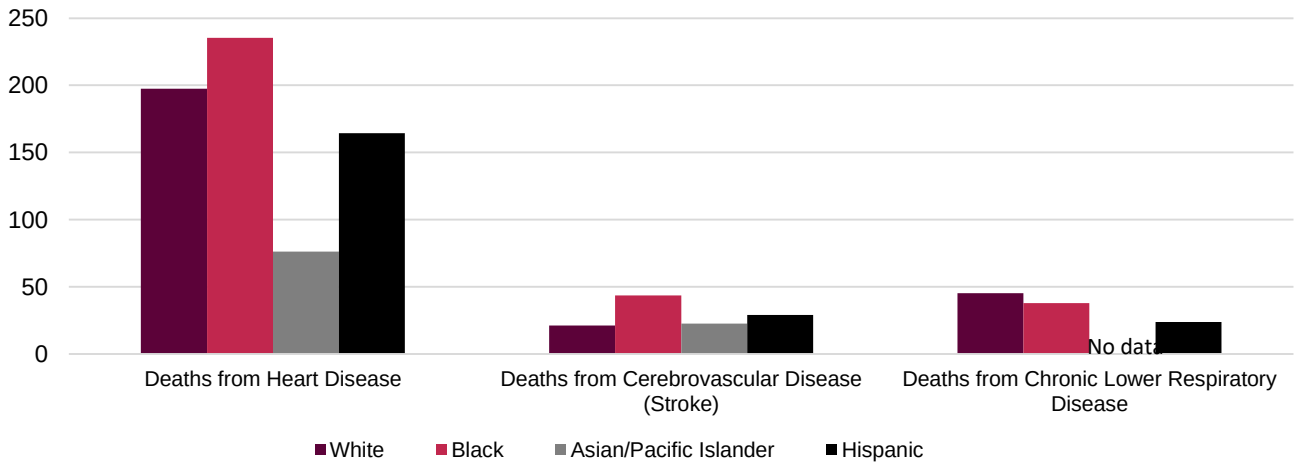
17,665
Adults with High Blood Pressure (Age-Adjusted)
Percentage



Leading Causes of Death
(Age-Adjusted)



Age-Adjusted Death Rate by Race/Ethnicity
(Per 100,000 Population)



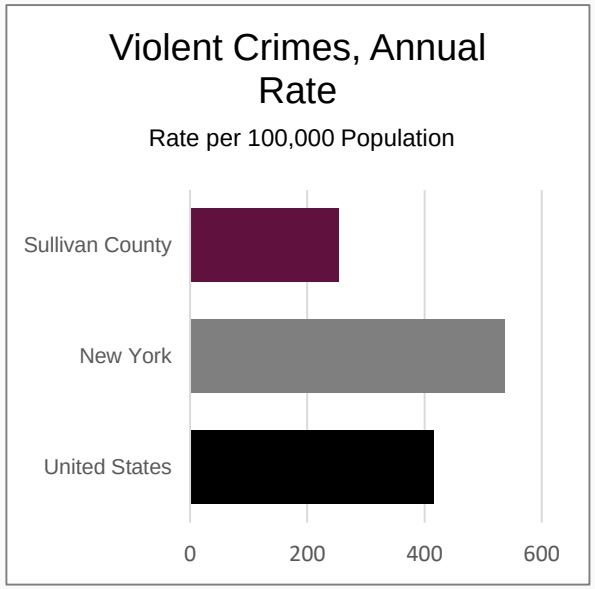
Data Source: https://www.health.ny.gov/community/health_equity/reports/county/sullivan.htm

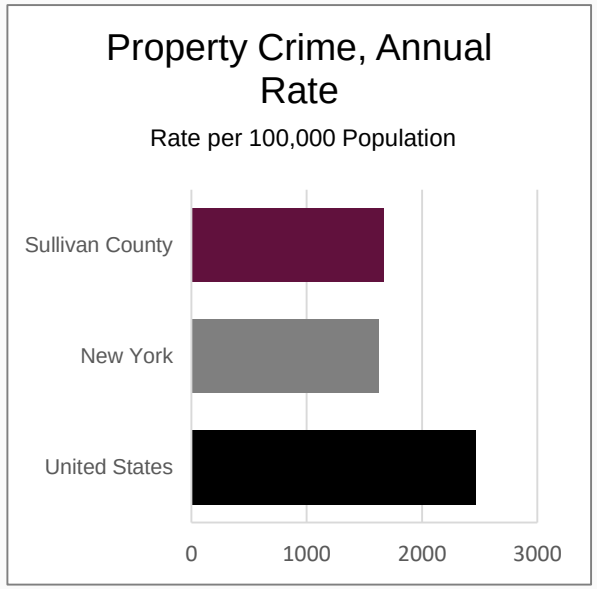
Injury and Violence

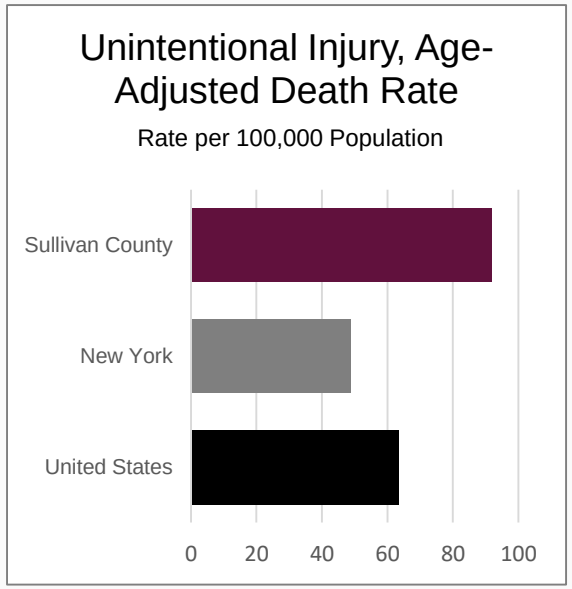
Violent crime rates for Sullivan County are favorable to state and national rates, whereas unintentional injury rates for Sullivan County are unfavorable to state and national rates.

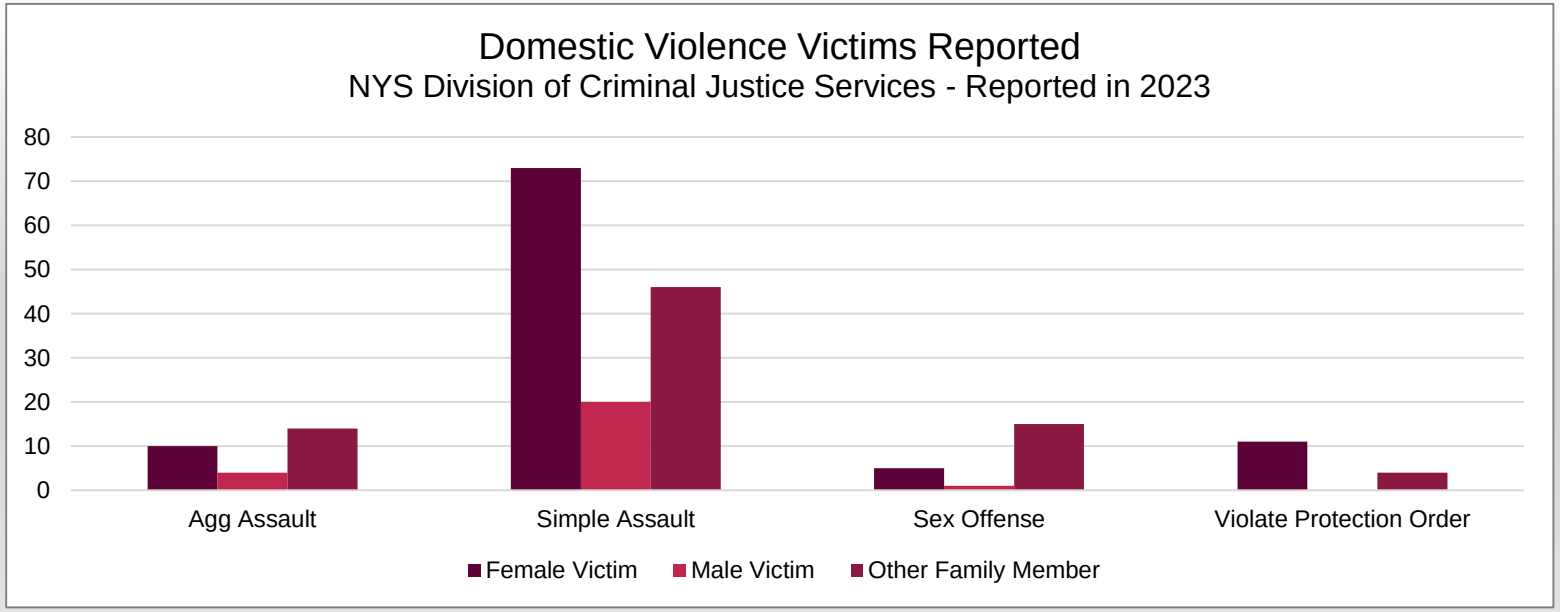
Domestic violence is abusive behavior by one intimate partner against another that may include physical violence, sexual violence, threats, and economic, emotional, and/or psychological aggression.

Data Tables









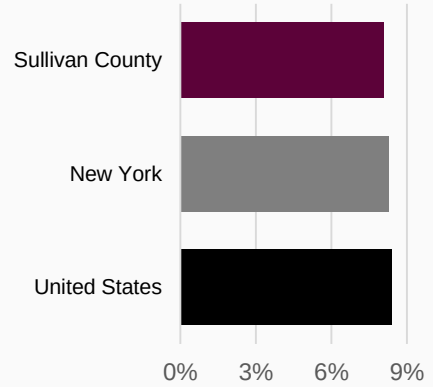
Maternal, Infant and Child Health

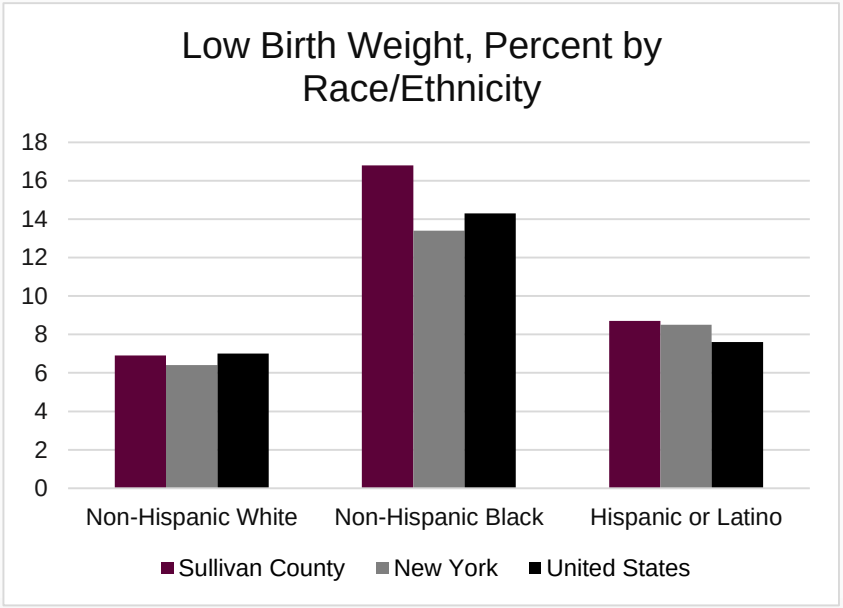
Engaging in prenatal care decreases the likelihood of maternal and infant health risks such as low birth weight. 30% of women in Sullivan County had no prenatal care in the first trimester. Rates for low birth weight and infant mortality indicate significantly higher rates for Non-Hispanic Black population and rates for Sullivan County are unfavorable to state and national rates.

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

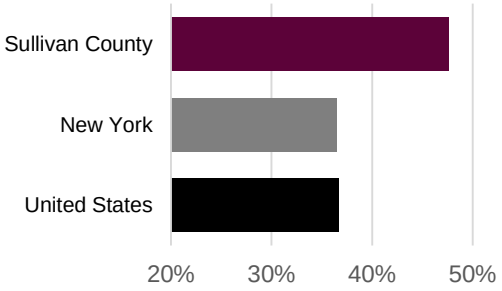
Data Tables

510
Low Birthweight
Percentage





7,843
Population Under Age 18 at or Below 200% of the Federal Poverty Level
Percentage



30%

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

Maternal and Child Health (MCH) (Selected Indicators)

Health Indicator	Sullivan County Percentage (or) Rate (or) Ratio	New York State Percentage (or) Rate (or) Ratio
Infant mortality rate per 1,000 live births	6.2	4.2
Percentage of preterm births (less than 37 weeks gestation)	10.2	9.4
Newborns with neonatal withdrawal symptoms and/or affected by maternal use of drugs of addiction (any diagnosis), crude rate per 1,000 newborn discharges	20.1	6.0
Child mortality rate per 100,000 children ages 1-9 years	16.1	15.1
Percentage of NYS residents served by community water systems that have optimally fluoridated water	16.3	71.6

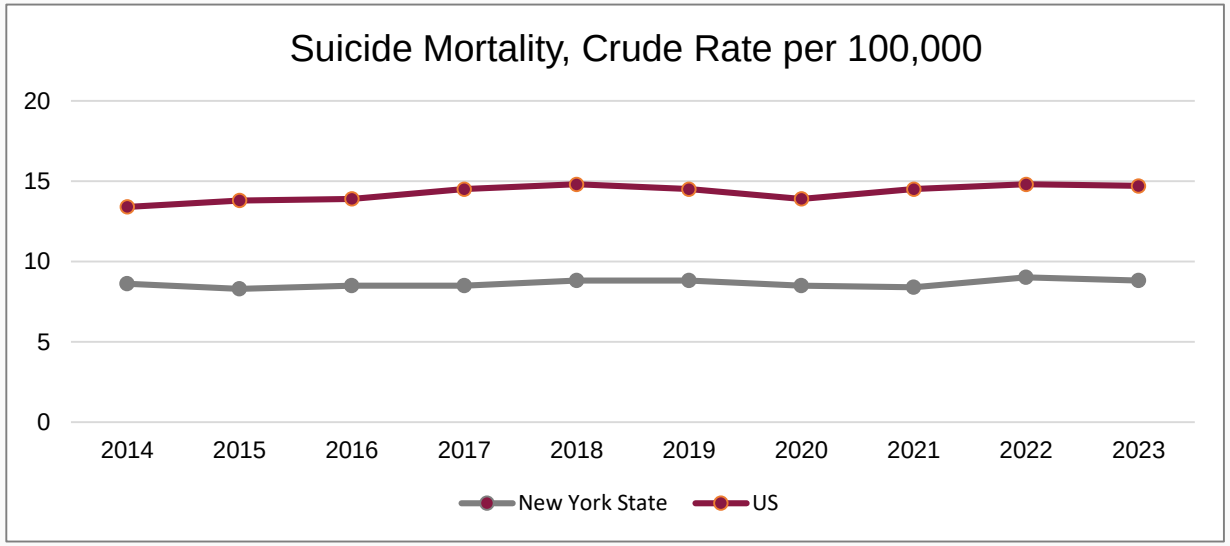
Data Source: https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/mch_dashboard/mch_dashboard&p=ct&cos=48

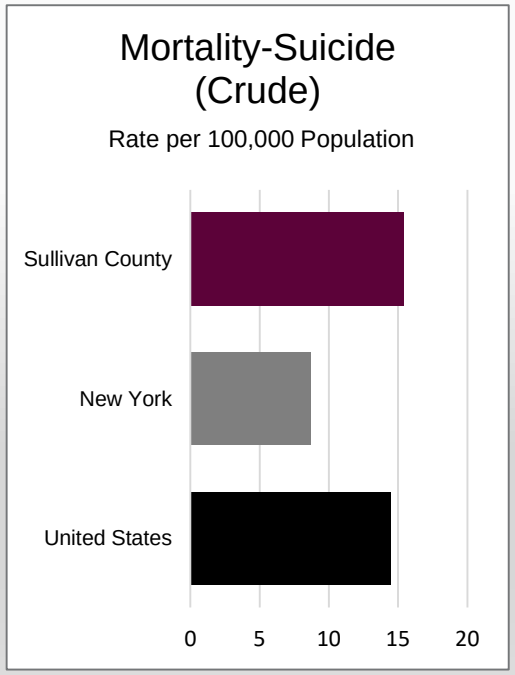
Mental Health

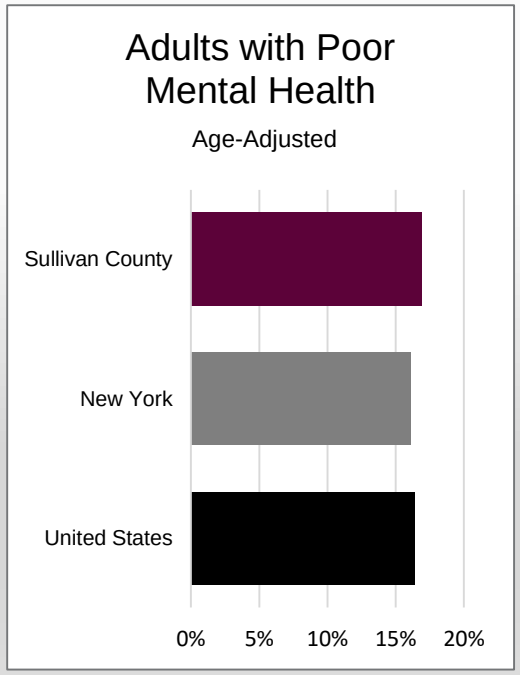
Suicide is an indicator of poor mental health. Suicide rates for Sullivan County are unfavorable to both state and national rates, likewise, deaths from mental and substance use disorders rates in Sullivan County are unfavorable to both state and national rates.

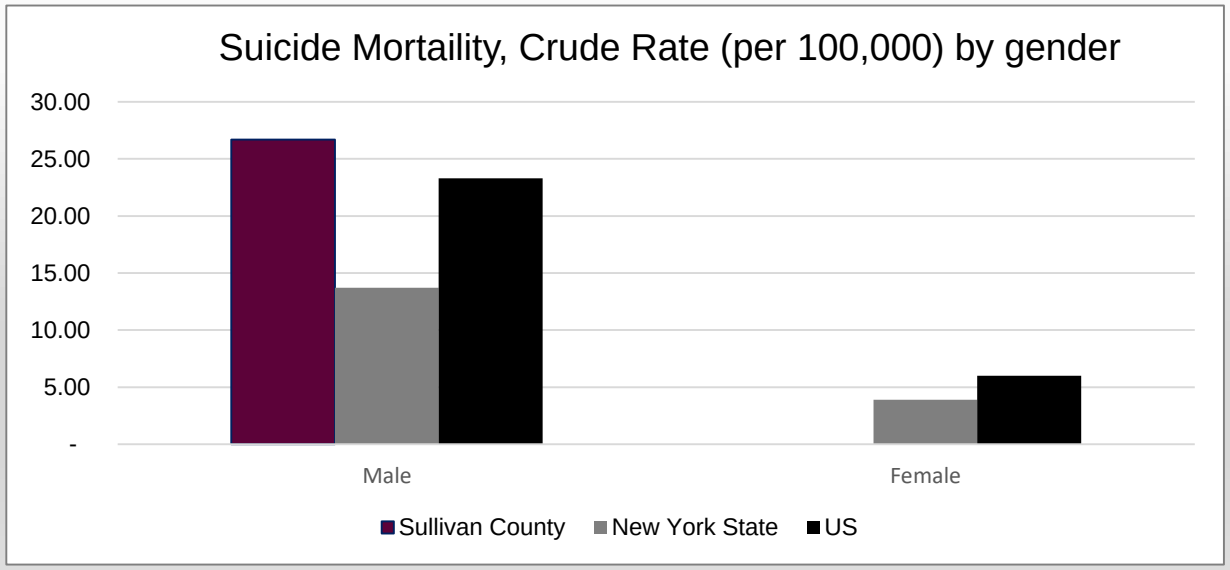
The number of adults with poor mental health in Sullivan County is unfavorable to state and national benchmarks. The map to the right reports the percentage of adults (ages 18 years and older) reporting 14 days or more of poor mental health per month in Sullivan County.

Data Tables









Nutrition, Physical Activity and Obesity

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

- Over 8% of the census tracts are designated as food deserts, meaning the census tract lacks healthy food sources due to income level, distance to supermarkets, or vehicle access. Over 13% of the population (10,310 persons) live with food insecurity in Sullivan County.
- 21,646 persons, or 34.8% of adults, are obese in Sullivan County. Obesity rates for Sullivan County has steadily been increasing since 2004, however, there was a decrease seen from the all time high in 2018 to 2019 and again from 2021 to 2022.
- 25% of adults, age 20 and older, self-report no leisure time physical activity.
- Approximately 57.8% of public-school students in Sullivan County are eligible for free or reduced-price lunch program, which is higher than the state average for New York of 54.5%

The map to the right reports the percentage of the low-income population with low food access. Low food access is defined as living more than 1 mile (urban) or 10 miles (rural) from the nearest supermarket, supercenter, or large grocery store. The low-income population with low food access in Sullivan County is approximately 2,207 persons with the following zip codes having the highest percentages: 12729, 12780, and 12785.

Data Tables

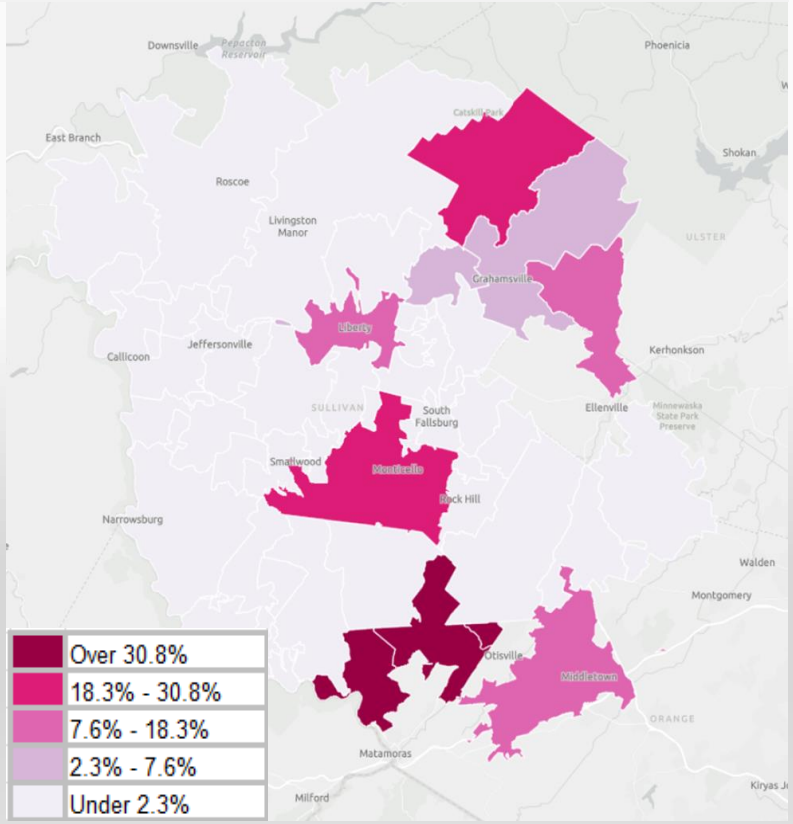
13.1%
Percentage of Population with Food Insecurity

34.8%
Percentage of Adults who are Obese

57.8%
Percentage of Students Eligible for Free or Reduced-Price Lunch

Limited access to healthy foods measures the percentage of the population that is low-income and does not live close to a grocery store. Low-income status is determined by poverty rates or median family income in each census tract.

Population with Limited Food Access, Low Income Percent by Tract



Physical Environment

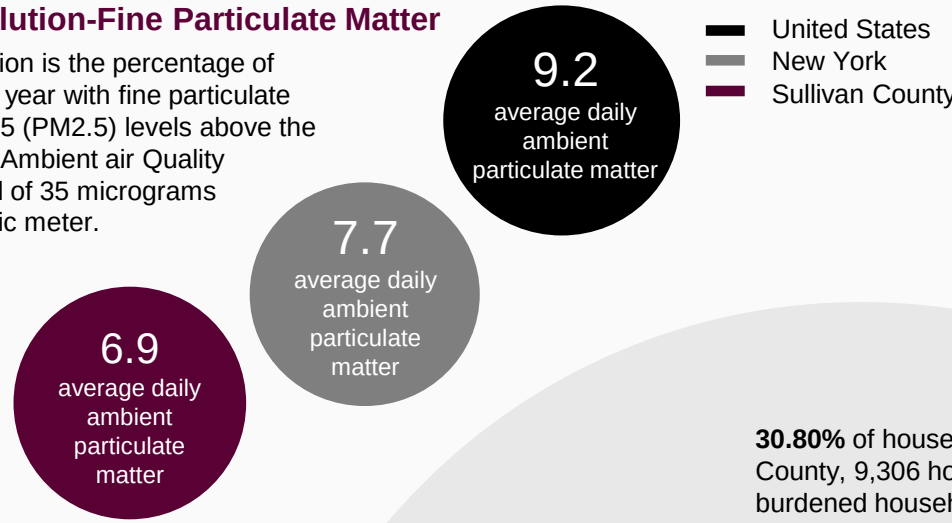
The structure of housing and families and the condition and quality of housing units and residential neighborhoods are important because housing issues like overcrowding and affordability have been linked to multiple health outcomes, including infectious disease, injuries, and mental disorders.

14% of households in Sullivan County have housing costs that exceed 50% of household income.

Over 33% of seniors in the community, age 65+, live alone. This is important because older adults who live alone may have challenges accessing basic needs, including health needs.

Air Pollution-Fine Particulate Matter

Air pollution is the percentage of days per year with fine particulate matter 2.5 (PM2.5) levels above the National Ambient air Quality Standard of 35 micrograms pers cubic meter.



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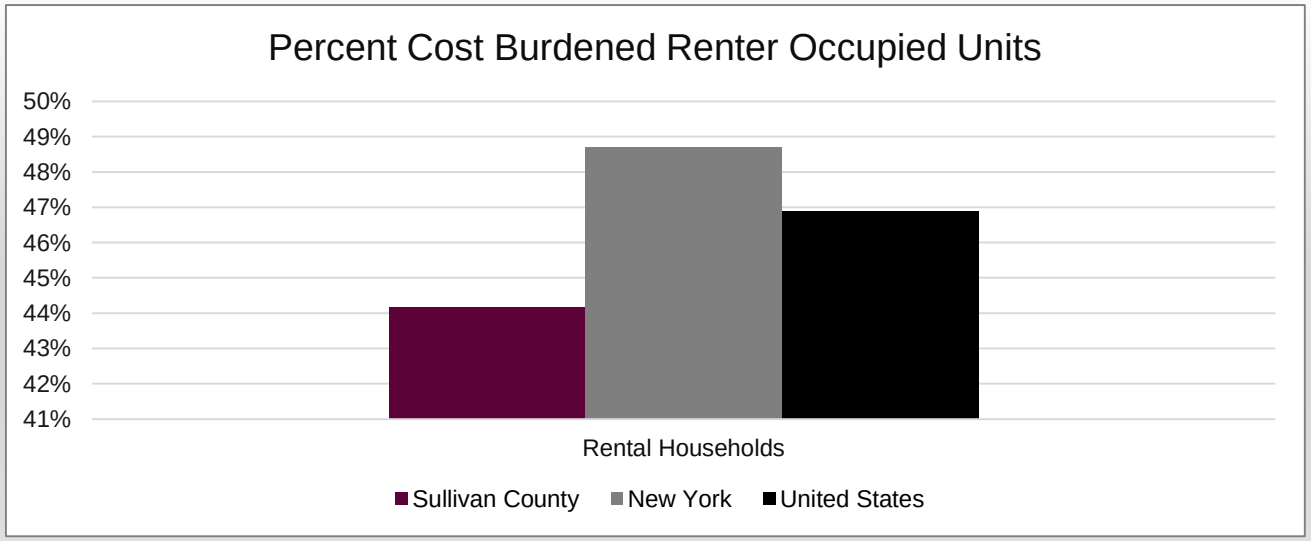


30.80% of households in Sullivan County, 9,306 households, are cost burdened households meaning housing costs exceed 30% of household income. **4,315** households have housing costs that **exceed 50%** of household income.

29% - The median percentage of household income spent on rent Sullivan County.

It is estimated that **over 12%** of households within the community have no or slow internet.

Approximately **4,970** households are occupied by seniors living alone (age 65+).

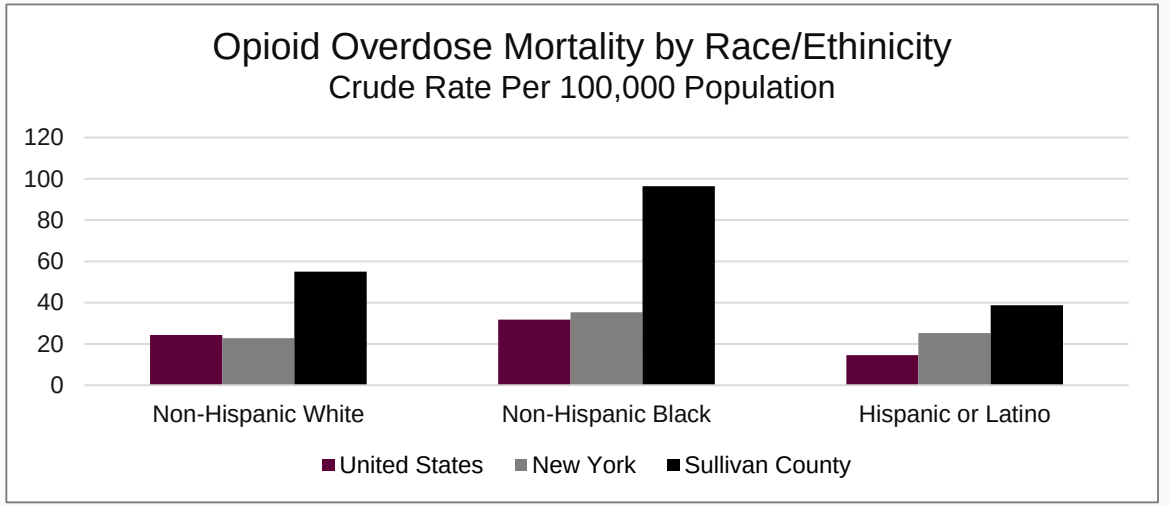
Substance Abuse

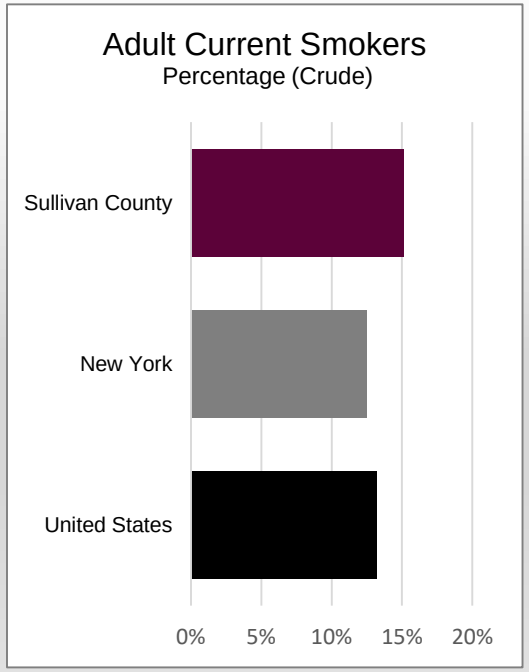
The percentage of adults in Sullivan County who currently smoke is 15.1% and is unfavorable to state and national benchmarks.

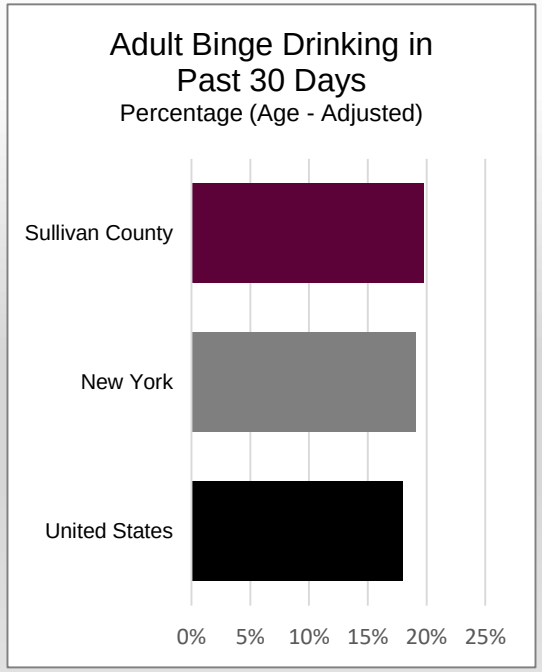
Binge drinking, having more five or more drinks (men) and four or more drinks (women) on an occasion in the past 30 days, is higher in Sullivan County compared to the national rate of 18%.

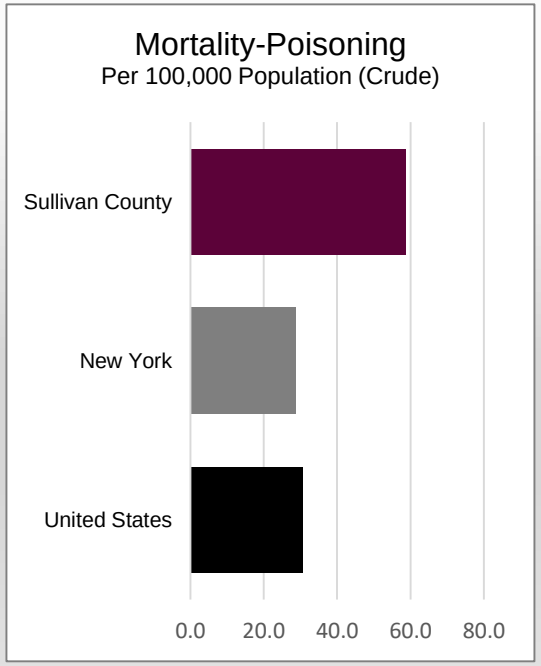
Poisoning deaths, especially from drug overdose, are a national public health emergency. Poisoning deaths are significantly higher in Sullivan County compared to the state and national rates.

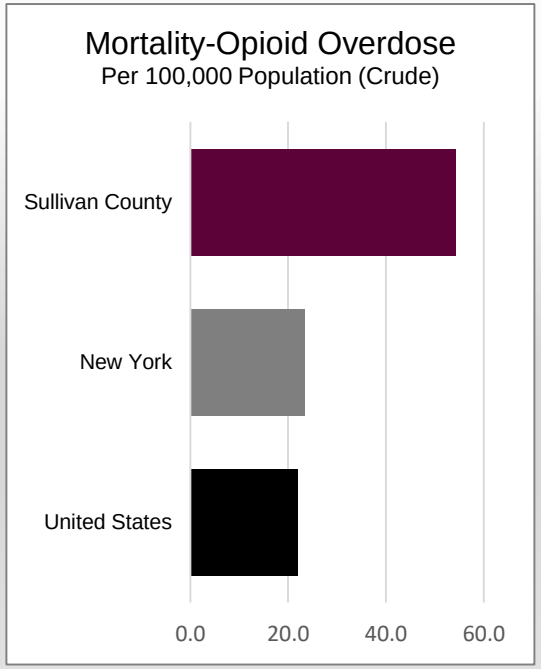
Data Tables











Key Stakeholder Focus Groups

Garnet Health obtained input from leaders representing public health, healthcare providers, social services, seniors and local government leaders through two focus groups conducted during December 2024. The findings are included on the following pages.

What are important issues you face when trying to keep yourself and your family healthy?

- Affordable housing
- Affordable daycare
- Affordable and healthier food
- Lack of activities
- Security and safety
- Youth drug/smoking

What are the most important unmet needs impacting your health and the health of families in your community?

- Mental Health
- Food prices
- Time
- Transportation

If there was one thing that could improve the health of yourself, your family, and those in your community, what would it be?

- Better means of communication
- Mental health resources
- Relatable and fair decision-makers
- More assistance

Key Stakeholder Focus Groups

Major Findings

- **Affordable Housing**: Families face displacement and financial strain as rent prices have skyrocketed, with some apartments more than doubling since the pandemic, making stable housing unattainable for many.
- **Mental Health**: Access to mental health services is severely limited, with long wait times, lack of school-based resources, and stigma around seeking help, leaving both youth and adults without adequate support.
- **Transportation:** Public transportation is scarce and unreliable, with limited routes and schedules, creating barriers to accessing jobs, healthcare, and community resources.
- **Activities for Youth**: A lack of safe and engaging activities for children and teens pushes many toward negative influences, while parents and community members stress the need for more programs, recreation, and after-school opportunities.
- **Healthier Food**: Families struggle with limited access to affordable, nutritious food, noting high prices, poor quality options (including unappealing school lunches), and a need for more variety such as farmers markets and health-focused stores.
- **Better Parks & Recreation:** Community members emphasized the need for safer, more inclusive parks and recreational spaces with facilities for all ages, such as exercise equipment, walking trails, and activities that encourage both adults and children to engage in healthy lifestyles.

Specific Recommendations from Key Stakeholder Focus Groups

Develop a wellness complex or community center to offer activities, safety, and social connection. Increase after-school and weekend programs for children and teens, including sports, library programming, and school-based activities.

Implement rent caps, support for first-time homebuyers, ensure affordable housing options, and increase access to Section 8 housing.

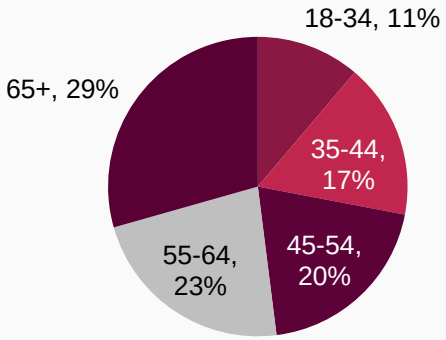
Improve ambulance services and ensure better-equipped emergency response. Shorten wait times for mental health and dental services (currently 4–6 months).

Expand public transportation, especially to rural areas. Advocate for state ambulance funding, as reliance on volunteer corps poses risks.

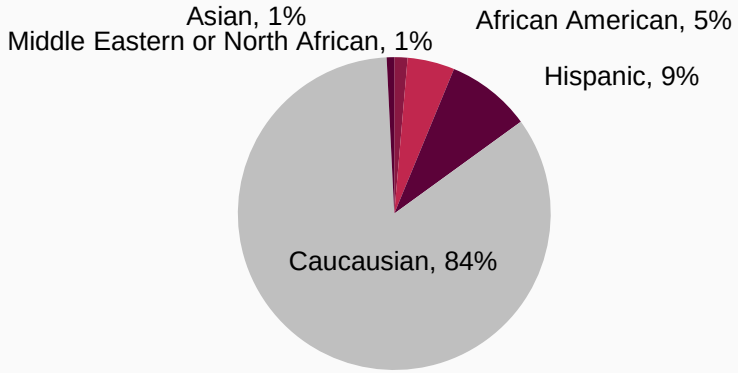
Community Survey

In order to develop a broad understanding of community health needs, Garnet conducted a community survey during May to July of 2025. A link to the survey was distributed via e-mail, social media and word of mouth to the community at-large. A total of 698 surveys were completed.

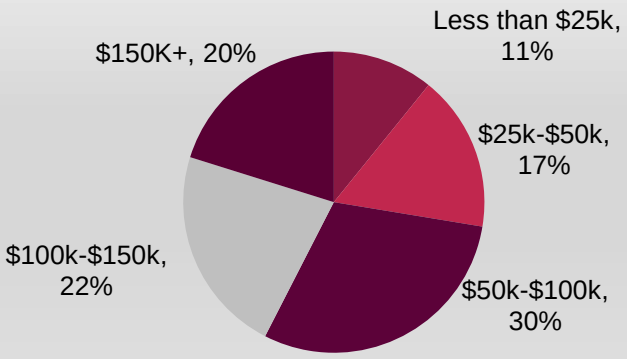
Age of Respondents



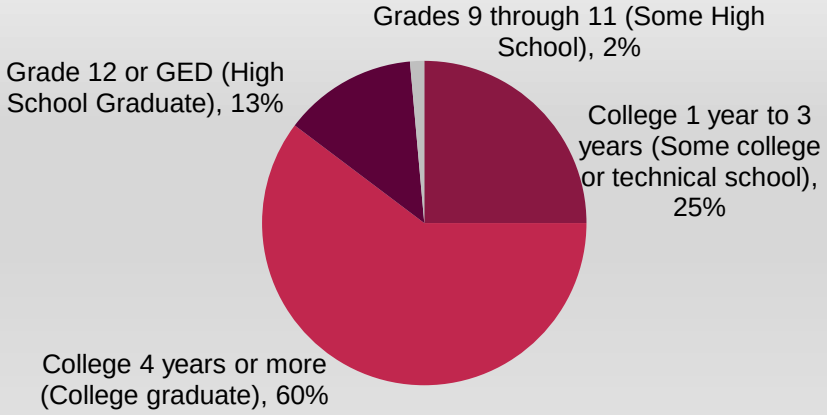
Race and Ethnicity of Respondents



Income of Respondents



Education of Respondents



Health Insurance Source	Percent
A plan purchased through an employer or union (including plans purchased through another person's employer)	53%
A private nongovernmental plan that you or another family member buys on your own	2%
Children's Health Insurance Program (CHIP)	1%
Medicaid	10%
Medicare	25%
Medigap	0%
Military related health care: TRICARE (CHAMPUS) /VA health care /CHAMP-VA	1%
No coverage of any type	2%
Other government program	1%
State sponsored health plan	4%

Employment Status	Percent
Employed for wages	60%
Self-employed	8%
Out of work for 1 year or more	1%
Out of work for less than 1 year	1%
A homemaker	2%
A student	0%
Retired	24%
Unable to work	3%

Community Survey

Community Health Needs Ranked by Importance

Top Choices (1st – 3rd)

- Dental Care
- Obesity
- Heart Disease

Second Choices (4th – 7th)

- Falls among elderly
- High Blood Pressure
- Infectious Diseases
- Cancer

Third Choices (8th – 11th)

- Women and maternal health care
- Job Training Programs
- Asthma and lung disease
- Job Placement

Community Survey

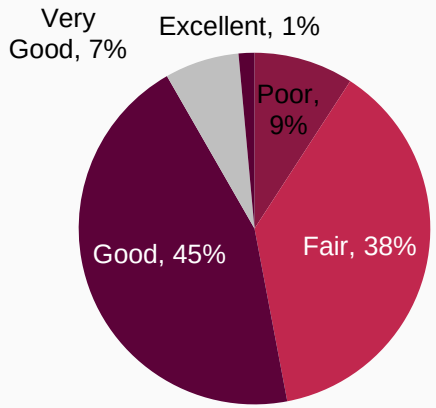
Long-term COVID Effects

- **53%** of survey respondents indicated they have tested positive for COVID-19 at least once
- Approximately **9%** of respondents currently have symptoms lasting 3 months or longer that weren't present prior to having COVID-19.
- **7%** of survey respondents indicated their long-term COVID-19 symptoms reduce their ability to carry out day-to-date activities.

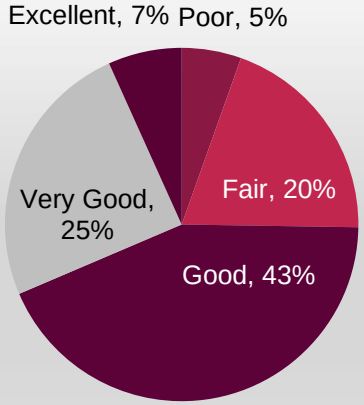
Access to Resources

- **6%** of survey respondents indicated they received foot stamps, also called SNAP, the Supplemental Nutrition Assistance Program, in the last 12 months.
- Approximately **12%** of respondents, indicated within the last 12 months the food they bought didn't last and they didn't have money to buy more food.
- **18%** of survey respondents indicated they were not able to pay their mortgage, rent, or utility bill in the past 12 months.

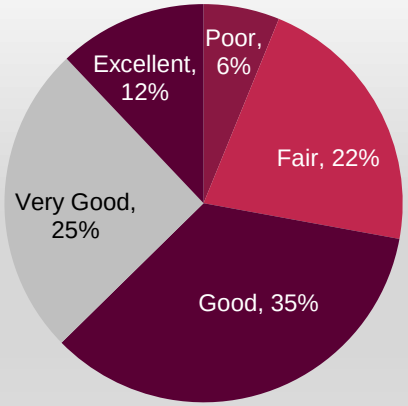
How is the overall health of the people in your neighborhood?



How would you rate your physical health?



How would you rate your mental health?



Evaluation of the Impact of Actions Taken Since the Last CHNA

Garnet Health provides a broad array of services that provide benefit to the community. Below is a summary of some of Garnet's significant community benefit initiatives taken since the last CHNA.

Prevention of Chronic Disease

Warrior Kids - In conjunction with the Snap-Ed and Eat Smart New York - Cornell Cooperative Extension, Garnet Health has developed a program called Warrior Kids which is designed to inspire children to develop lifelong healthy habits through education, fitness and fun! The program had 379 participants from 2023-2025.

Garnet Health Medical Center Lung Disease Support - The newly established free support group, Just Breathtaking, offers information, education, and a space for discussion about living with chronic lung disease. It also explores strategies for coping with the anxiety and depression that may accompany the condition.

Food Farmacy - To help reduce food insecurity among our patients and address social determinants of health such as access to nutritious food, Garnet Health has partnered with the Regional Food Bank of Northeastern New York to provide diet-friendly food bags to those in need. Between 2023-2025, more than 4,000 patients were screened for food insecurities and more than 500 bags of food were distributed.

FreshRx Produce Prescription Program - Garnet Health, in partnership with Cornell Cooperative Extension Sullivan County, offers the FreshRx Produce Prescription Program to eligible community members in Sullivan and Orange counties. This ongoing program aims to increase fresh produce consumption and empower participants with the knowledge to make lasting, healthy lifestyle changes.

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

Speakers Bureau – Garnet Health maintains a speaker's bureau composed of skilled presenters who provide education presentations and share information that supports the community.

Diabetes Prevention Program – Participants in the year-long program receive vouchers for produce at local farmers markets or freshly pre-packaged boxes of produce and can enroll in physical activity and nutrition classes.

From 2023–2025, Garnet Health's programs advanced community health and wellness. Warrior Kids engaged 379 children in nutrition and fitness education. Just Breathtaking supported patients with chronic lung disease, addressing physical and emotional needs. Food Farmacy screened over 4,000 patients and distributed 500 diet-appropriate food bags, totaling approximately $20,000 in value. FreshRx promoted healthy eating, free cancer screenings improved preventive care access, and the Speakers Bureau extended health education. Programs emphasized culturally competent, accessible approaches to foster lasting behavior change.

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

Prevention of Chronic Disease

Know Your Numbers (KYN) -The "Know Your Numbers" program is designed to provide early screening of key health indicators, including Total Cholesterol, HDL Cholesterol, Triglycerides, LDL Cholesterol, and glucose. The screening aims to detect potential risks and provide education on lifestyle changes that may help reduce the likelihood of coronary heart disease, diabetes, and stroke. Between 2023-2025 we served over 600 participants.

Heart Disease – In 2023, Garnet Health announced the launch of its new open-heart surgery program. As part of its commitment to advancing care for patients with complex cardiovascular conditions, the health system also introduced a state-of-the-art hybrid surgical suite at its Middletown, New York campus.

Improve Mental Health and Prevention of Substance Abuse

Outpatient Behavioral Health – Garnet Health added a Practice Manager of Behavioral Health in 2024 to “develop and implement vision, strategy and objectives for behavioral health outpatient services,” coordinating clinical, regulatory and quality activities system-wide.

Support Groups: Garnet Health provides dedicated space to support groups outside of its establishment, fostering a welcoming environment for community-based gatherings. Additionally, we offer a variety of virtual seminars designed to educate the community on important health topics. Our organization hosts a diverse range of support groups that specifically address the mental health aspects of chronic diseases, as well as caregiver support for both patients and the broader community we serve. Furthermore, we maintain an online archive of past self-help seminars, featuring valuable content on mental health, self-help strategies, and self-care techniques, making these resources accessible to individuals at any time.

Counseling – Garnet Health offers education group sessions for men and women coping with substance abuse and mental health issues where participants learn recovery strategies and skills geared towards maintaining optimal physical, emotional and spiritual health. Garnet Health also offers individual counseling and is licensed by both the New York State Office of Mental Health and the Office of Alcoholism and Substance Abuse Services.

No written comments were received on the 2022 CHNA.

Prioritization of Identified Health Needs

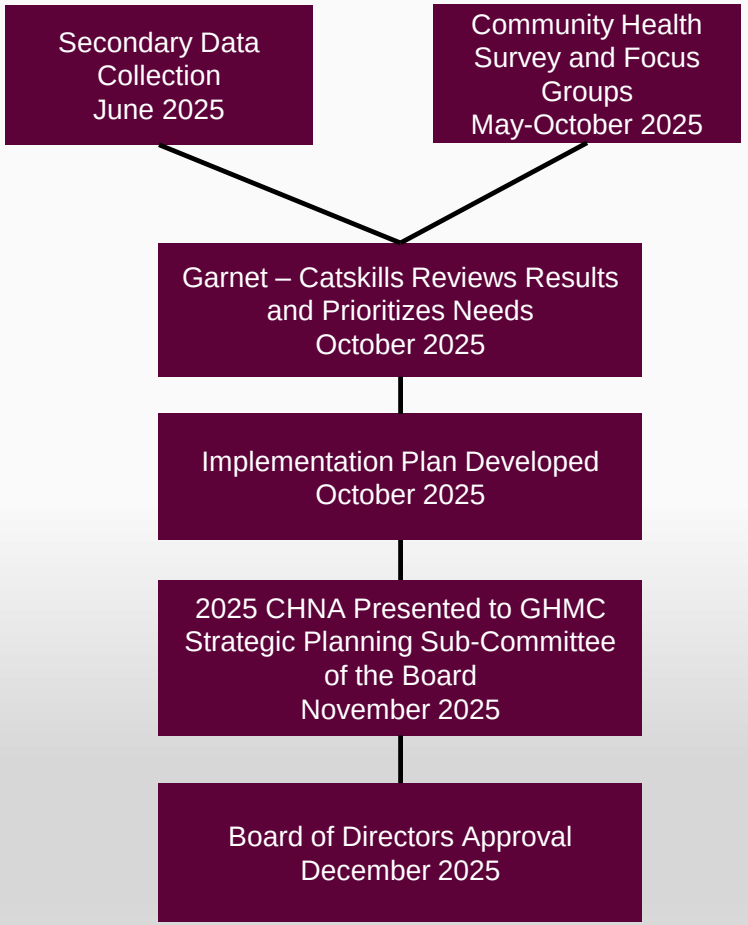
Primary and secondary data was gathered and compiled from May 2025 to October 2025. Based on the information gathered through the CHNA process, the following summary list of needs was identified. Identified health needs are listed in alphabetical order.

- Asthma and Lung Disease
- Cancer
- Dental Care
- Falls
- Heart Disease
- High Blood Pressure
- Infectious Disease
- Job Training Programs
- Job Placement
- Obesity
- Women and Maternal Health Care

GHMC-C identified and prioritized community health needs through a collaborative, data-driven process that included analysis of quantitative and qualitative data from local, state, and national sources; feedback from community surveys, focus groups, and the Orange County Health Summit; consultation with public health agencies, community-based organizations, and representatives of underserved populations; and alignment with the New York State Department of Health Prevention Agenda. GHMC recognizes that the local public health timeline differs from the hospital's CHNA cycle and that priorities may be refined as new data become available. The selected priority areas—Social and Community Context and Health Care Access and Quality—were chosen based on current findings, alignment with community and state priorities, and GHMC's capacity to meaningfully address these needs through programs and partnerships. These priorities will be reassessed in March 2026, and updated by July 2026 if needed, to ensure continued responsiveness to community health needs.

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

- Social & Community Contest
- Health Care Access & Quality



Available Resources

While not all-encompassing, the following is a list of several valued community agencies that address those prioritized and non-prioritized needs. The resources listed below represent community and institutional assets available to help address the priority health needs identified through the CHNA. GHMC - C also contributes to these efforts through its own clinical programs and community partnerships.

Identified health need	Local community resources addressing need
Asthma and Lung Disease	Hudson Valley Asthma Coalition New York State Children's Asthma Initiative Asthma and Allergy Foundation of America
Cancer	Catskill Regional Medical Center – Grover M. Herman Hospital Hudson Valley Cancer American Cancer Society New York Cancer Foundation Breast Cancer Options Allyson Whitney Foundation
Dental Care	PRASAD Children's Dental Health Program Various FQHC locations throughout the region – Cornerstone Family Health Centers and Sun River Health
Falls	Sullivan County Office for the Aging Occupational Therapy Geriatric Group, University at Buffalo Sullivan County Caregiver Resource Center
Heart Disease	Nuvance Health American Heart Association Various FQHC locations throughout the region – Cornerstone Family Health Centers and Sun River Health
High Blood Pressure	Various FQHC locations throughout the region – Cornerstone Family Health Centers and Sun River Health

Available Resources

Identified health need	Local community resources addressing need
Infectious Disease	Various FQHC locations throughout the region – Cornerstone Family Health Centers and Sun River Health Nuvance Health Sullivan County Public Health The Center for Discovery
Job Training Programs / Job Placement	New Hope Community Literacy Volunteers of Sullivan County Sullivan County Career Center The Arc Greater Hudson Valley Sullivan County Center for Workforce Development
Obesity	Sullivan 180 New York State Department of Health Various FQHC locations throughout the region – Cornerstone Family Health Centers and Sun River Health
Women and Maternal Health Care	Sullivan 180 Various FQHC locations throughout the region – Cornerstone Family Health Centers and Sun River Health Sullivan County Regional Health Department

Limitations and Information Gaps

Return to Report

As with all data collection efforts, there are several limitations related to the assessment's research methods that should be acknowledged. Years of the most current data available differ by data source. In some instances, 2023 may be the most current year available for data, while 2019 may be the most current year for other sources. Likewise, survey data based on self-reports, such as the Behavioral Risk Factor Surveillance Survey (BRFSS), should be interpreted with particular caution. In some instances, respondents may over or under report behaviors and illnesses based on fear of social stigma or misunderstanding the question being asked.

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

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

Appendix A

Return to Report

Population by Age & Gender

	Age 0-17	Age 18-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65+	Total		Male	Female
Sullivan County	**16,947**	**6,439**	**9,592**	**9,640**	**9,895**	**11,576**	**15,058**	**79,147**	**Sullivan County**	**40,993**	**38,154**
New York	4,109,277	1,766,904	2,835,463	2,554,229	2,474,561	2,670,699	3,461,186	19,872,319	New York	9,702,417	10,169,902
United States	73,645,238	30,307,641	45,497,632	43,492,887	40,847,713	42,626,382	55,970,047	332,387,540	United States	164,545,087	167,842,453

	Age 0-17	Age 18-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65+	Total		Male	Female
Sullivan County	**21.4%**	**8.1%**	**12.1%**	**12.2%**	**12.5%**	**14.6%**	**19.0%**	**100.0%**	**Sullivan County**	**51.8%**	**48.2%**
New York	20.7%	8.9%	14.3%	12.9%	12.5%	13.4%	17.4%	100.0%	New York	48.8%	51.2%
United States	22.2%	9.1%	13.7%	13.1%	12.3%	12.8%	16.8%	100.0%	United States	49.5%	50.5%

Data Source: US Census Bureau, American Community Survey. 2019-23. Source geography: Tract

Population by Combined Race & Ethnicity

Return to Report

	Non-Hispanic White	Hispanic or Latino	Non-Hispanic Black	Non-Hispanic Asian	Non-Hispanic Other Race	Non-Hispanic Multiple Races	Total
Sullivan County	**53,147**	**14,547**	**6,261**	**1,583**	**665**	**2,944**	**79,147**
New York	10,609,831	3,898,949	2,708,597	1,754,726	220,583	679,633	19,872,319
United States	193,349,832	63,120,394	39,986,221	19,112,284	3,955,412	12,863,398	332,387,540

	Non-Hispanic White	Hispanic or Latino	Non-Hispanic Black	Non-Hispanic Asian	Non-Hispanic Other Race	Non-Hispanic Multiple Races	Total
Sullivan County	**67.2%**	**18.4%**	**7.9%**	**2.0%**	**0.8%**	**3.7%**	**100.0%**
New York	53.4%	19.6%	13.6%	8.8%	1.1%	3.4%	100.0%
United States	58.2%	19.0%	12.0%	5.8%	1.2%	3.9%	100.0%

Data Source: US Census Bureau, American Community Survey. 2019-23. Source geography: Tract

Household Income and Poverty

Return to Report

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

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

	Population Below 100% FPL	Percentage of Population Below 100% FPL	Percentage of Population under Age 18 in Poverty	Average Household Income	Percentage of Children Eligible for Free/Reduced Price Lunch
Sullivan County	**11,547**	**15.19%**	**22.02%**	**$101,841**	**57.8%**
New York	2,656,674	13.70%	18.16%	$125,909	54.5%
United States	40,390,045	12.44%	16.32%	$110,491	53.5%

Data Source: US Census Bureau, American Community Survey. 2019-23. Source geography: Tract

Data Source for Free/Reduced Price Lunch: National Center for Education Statistics, NCES – Common Core of Data. 2022-2023.

Uninsured Adults

Return to Report

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

	Total Population (For Whom Insurance Status is Determined)	Uninsured Adults	Uninsured Population, Percent
Sullivan County	**44,373**	**3,333**	**7.5%**
New York	11,635,301	791,544	6.8%
United States	197,624,923	21,777,817	11.0%

Data Source: US Census Bureau, Small Area Health Insurance Estimates. 2023. Source geography: Tract

Population in Limited English Households

Return to Report

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

	Total Population Age 5+	Population in Limited English Households	Percentage of Population in Limited English Household
Sullivan County	**74,491**	**2,951**	**4.0%**
New York	18,769,358	1,273,118	6.8%
United States	313,447,641	12,348,861	4.0%

Data Source: US Census Bureau, American Community Survey. 2019-23. Source geography: Tract

Educational Attainment

Return to Report

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

	Population Age 25+ with No High School Diploma	Population Age 25+ with No High School Diploma, Percent	Population Age 25+ with Bachelor's Degree or Higher, Percent
Sullivan County	**6,884**	**12.35%**	**29.69%**
New York	1,698,537	12.14%	39.55%
United States	24,230,217	10.61%	35.00%

Data Source: US Census Bureau, American Community Survey. 2019-23. Source geography: Tract

Areas Affected by a Health Professional Shortage Area (HPSA)

Return to Report

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

	Population Living in an Area Affected by a HPSA	Total Population (5-year estimate)	Percentage of Population Living in an Area Affected by a HPSA
Sullivan County	**79,147**	**79,147**	**100.00%**
New York	9,397,778	19,872,319	47.29%
United States	146,130,680	332,387,540	43.90%

Data Source: US Department of Health & Human Services, Health Resources and Services Administration, HRSA - Health Professional Shortage Areas Database. 2025. Source geography: HPSA

Access to Healthcare Services

Return to Report

	Dental Care		Mental Care		Primary Care	
	Providers per 100,000 Population	Dental Health Providers	Providers per 100,000 Population	Mental Health Providers	Providers per 100,000 Population	Primary Care Providers
Sullivan County	**35.61**	**28**	**358.67**	**282**	**47.06**	**37**
New York	72.10	14,566	461.56	93,241	124.31	25,112
United States	67.95	227,446	329.85	1,104,134	118.80	397,680

Dental Care Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), 2024. Source geography: Address

Mental Care Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), September 2025. Source geography: County

Primary Care Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES), September 2025. Source geography: County

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

Mental Care
This indicator reports the number of mental health providers in the report area as a rate per 100,000 total area population. Mental health providers include psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

Primary Care
This indicator reports the number of primary care physicians per 100,000 population. Doctors classified as "primary care physicians" by the AMA include General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs and General Pediatrics MDs. Physicians aged 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Preventative Services – Core Preventable Services

Return to Report

	Percentage of Males age 65+ Up to Date on Core Preventative Services	Percentage of Females age 65+ Up to Date on Core Preventative Services
Sullivan County	**46.6%**	**37.1%**
New York	42.1%	37.5%
United States	44.0%	37.4%

Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2020. Source geography: Tract

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

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

Preventative Services – Blood Pressure, Diabetes, and Preventable Hospitalizations

Return to Report

	Blood Pressure Medication Nonadherence	Medicare Enrollees with Diabetes with Annual Exam	Preventable Hospitalizations per 100,000 Beneficiaries
Sullivan County	**22.2%**	**87.2%**	**3,163**
New York	20.7%	88.6%	2,733
United States	21.1%	87.5%	2,769

Blood Pressure Medication Nonadherence Data Source: Centers for Disease Control and Prevention, CDC - Atlas of Heart Disease and Stroke . 2019-2021. Source geography: County

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

Preventable Hospitalizations Data Source: Centers for Medicare and Medicaid Services, Mapping Medicare Disparities Tool. 2022. Source geography: County

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

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

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

Preventative Services – Cancer Screenings

Return to Report

	Adults with Adequate Colorectal Cancer Screening	Females age 21-65 with Recent Pap Smear	Females Age 50-74 with Recent Mammogram
Sullivan County	**57.0%**	**84.6%**	**74.5%**
New York	61,4%	84.4%	78.5%
United States	54.1%	83.7%	76.0%

Colorectal Cancer Screening Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022.

Pap Smear Screening Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2020.

Mammogram Screening Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022.

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

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

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

Health Outcomes and Mortality – Cancer Incidence Rates

Return to Report

Cancer Incidence Rates

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

	Breast Cancer Incidence Rate (Per 100,000 Population)	Colorectal Cancer Incidence Rate (Per 100,000 Population)	Lung Cancer Incidence Rate (Per 100,000 Population)	Prostate Cancer Incidence Rate (Per 100,000 Population)
Sullivan County	**117.2**	**38.0**	**62.2**	**87.0**
New York	134.1	35.7	53.5	131.2
United States	129.8	36.4	53.1	113.2

	Breast Cancer New Cases Annual Average	Colorectal Cancer New Cases Annual Average	Lung Cancer New Cases Annual Average	Prostate Cancer New Cases Annual Average
Sullivan County	**57**	**40**	**70**	**52**
New York	17,074	8,808	13,922	16,267
United States	258,398	140,088	216,523	224,883

Data Source: State Cancer Profiles. 2017-21. Source geography: County

Health Outcomes and Mortality – Chronic Conditions

Return to Report

	Percentage of Adults with Diagnosed Diabetes	Percentage of Adults Ever Diagnosed with Coronary Heart Disease	Percentage of Adults with High Blood Pressure
Sullivan County	**10.6%**	**6.3%**	**28.4%**
New York	9.7%	5.4%	28.3%
United States	10.4%	5.7%	29.6%

Diabetes Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2022. Source geography: County

Coronary Heart Disease Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022.

High Blood Pressure Data Source: Centers for Disease Control and Prevention, Behavioral Risk-Factor Surveillance System. Accessed via the PLACES Data Portal. 2021.

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

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

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

Health Outcomes and Mortality – Mortality

Return to Report

Cancer Deaths
This indicator reports the 2019-2023 five-year average rate of death due to malignant neoplasm (cancer) per 100,000 population.

Heart Disease Deaths
This indicator reports the 2019-2023 five-year average rate of death due to heart disease (ICD10 Codes I00-I09, I11, I13, I20-I151) per 100,000 population.

Lung Disease Deaths
This indicator reports the 2019-2023 five-year average rate of death due to chronic lower respiratory disease per 100,000 population.

	Cancer Death Rate (Per 100,000 Population)	Heart Disease Death Rate (Per 100,000 Population)	Lung Disease Death Rate (Per 100,000 Population)	Stroke Death Rate (Per 100,000 Population)
Sullivan County	**209.4**	**247.3**	**62.5**	**28.9**
New York	167.7	224.0	32.6	33.1
United States	182.7	207.2	44.9	48.3

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2019-2023. Source geography: County

Injury and Violence – Unintentional Injuries

Return to Report

Death due to Unintentional Injury (Accident)
This indicator reports the 2019-2023 five-year average rate of death due to unintentional injury (accident) per 100,000 population.

	Unintentional Injury Death Rate (Per 100,000 Population)	Unintentional Injury Five Year Total Deaths, 2019-2023 Total
Sullivan County	**91.7**	**358**
New York	48.9	47,851
United States	63.3	1,048,667

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2019-2023. Source geography: County

Injury and Violence – Violent Crime and Property Crime

Return to Report

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

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

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

Data Source: Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2014 - 2017. Source geography: County

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

Return to Report

	Number of Infant Deaths	Infant Deaths per 1,000 Live Births	Number of Low Birthweight Births	Low Birthweight Births, Percentage	Number of Births with Late/No Care	Births with Late/No Care, Percentage
Sullivan County	**28**	**5.0**	**510**	**8.1%**	**No Data**	**No Data**
New York	6,628	4.0	124,445	8.3%	32,799	4.8%
United States	147,939	5.6	2,176,957	8.4%	697,581	6.1%

Infant Deaths Data Source: University of Wisconsin Population Health Institute, County Health Rankings. 2016-2022. Source geography: County

Low Birthweight Births Data Source: University of Wisconsin Population Health Institute, County Health Rankings. 2017-2023.Source geography: County

Births with Late/No Care Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research. 2017-2019. Source geography: County

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

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

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

Mental Health – Adult Mental Health

Return to Report

	Adults with Poor Mental Health Percent	Suicide Rate (Per 100,000 Population)	Suicide Five Year Total, 2019-2023
Sullivan County	**16.9%**	**15.4**	**60**
New York	16.1%	8.7	8,489
United States	16.4%	14.5	240,465

Poor Mental Health Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022. Source geography: Tract

Suicide Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2019-2023. Source geography: County

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

Suicides
This indicator reports the 2019-2023 five-year average rate of death due to intentional self-harm (suicide) per 100,000 population.

Nutrition, Physical Inactivity Obesity – Food Environment

Return to Report

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

Low Food Access
This indicator reports the percentage of the population with low food access. Low food access is defined as living more than 1 mile (urban) or 10 miles (rural) from the nearest supermarket, supercenter, or large grocery store.

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

	Total Population (2010)	Food Desert Population	Food Desert Population, Percent	Population with Low Food Access	Population with Low Food Access, Percent	Total SNAP-Authorized Retailers	SNAP-Authorized Retailers per 10,000 Population
Sullivan County	**77,547**	**11,166**	**14.4%**	**3,605**	**4.6%**	**120**	**15.16**
New York	19,378,201	757,797	3.9%	2,316,550	11.9%	17,361	8.77
United States	308,745,538	39,074,974	12.7%	68,611,398	22.2%	264,826	7.89

Food Desert and Low Food Access Data Source: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2019. Source geography: Tract
SNAP Authorized Retailers Data Source: US Department of Agriculture, Food and Nutrition Service, USDA - SNAP Retailer Locator. Additional data analysis by CARES. 2025. Source geography: Tract

Nutrition, Physical Inactivity Obesity – Obesity and Physical Activity

Return to Report

	Population Age 20+	Adults with BMI > 30.0	Adults with BMI > 30.0, Percent	Adults with No Leisure Time Physical Activity	Adults with No Leisure Time Physical Activity, Percent
Sullivan County	**61,111**	**22,672**	**37.0%**	**16,224**	**25.0%**
New York	15,227,308	4,343,543	28.5%	3,502,065	22.2%
United States	232,757,930	70,168,831	30.1%	47,072,403	19.5%

Obesity Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2021. Source geography: County

Physical Activity Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 2021. Source geography: County

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

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

Physical Environment – Cost Burdened Households

Return to Report

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

	Total Households	Cost Burdened Households (30%)	Percentage of Cost Burdened Households
Sullivan County	**30,215**	**9,306**	**30.80%**
New York	7,668,956	2,705,255	35.28%
United States	127,482,865	37,330,839	29.28%

Data Source: US Census Bureau, American Community Survey. 2019-23. Source geography: Tract

Physical Environment – Housing

Return to Report

	Households with No or Slow Internet, Percent	Substandard Housing Conditions, Percent
Sullivan County	**12.40%**	**33.36%**
New York	10.44%	38.76%
United States	10.29%	31.98%

Internet Access Data Source: US Census Bureau, American Community Survey. 2019-23. Source geography: Tract

Substandard Housing Data Source: US Census Bureau, American Community Survey. 2019-23. Source geography: Tract

Internet Access
This indicator reports the percentage of households who either use dial-up as their only way of internet connection or have internet access but don't pay for the service, or have no internet access in their home, based on the 2019-2023 American Community Survey estimates.

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

Physical Environment – Environment and Housing

Return to Report

	Percent Population within 1/2 Mile of a Park	Percent Population Using Public Transit for Commute to Work
Sullivan County	**26.1%**	**1.23%**
New York	82.2%	22.39%
United States	61.0%	3.51%

Living Near a Park Data Source: Centers for Disease Control and Prevention, CDC - National Environmental Public Health Tracking Network. 2020. Source geography: Tract

Public Transit Data Source: US Census Bureau, American Community Survey. 2019-23. Source geography: Tract

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

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

Substance Abuse – Adult Alcohol and Tobacco Use

Return to Report

	Percentage of Adults Binge Drinking in the Past 30 Days	Percentage of Adult Current Smokers
Sullivan County	19.8%	15.1%
New York	19.1%	12.5%
United States	18.0%	13.2%

Alcohol Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022. Source geography: Tract

Tobacco Data Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal. 2022. Source geography: Tract

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

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

Substance Abuse – Opioid Overdose

Return to Report

Opioid Overdose
This indicator reports the 2019-2023 five-year average rate of death due to opioid drug overdose per 100,000 population. Rates are re-summarized for report areas from county level data, only where data is available. This indicator is relevant because opioid drug overdose is the leading cause of injury deaths in the United States, and they have increased dramatically in recent years.

	Five Year Total Deaths, 2019-2023 Total	Age-Adjusted Death Rate (Per 100,000 Population)
Sullivan County	**212**	**54.3**
New York	22,957	23.5
United States	364,717	22.0

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2019-2023. Source geography: County