ESSEX COUNTY, NY

Community Health Assessment, 2025

Community Health Improvement Plan, 2026-2030

Essex County Health Partners

Essex County Health Department
University of Vermont Health - Elizabethtown Community Hospital
Adirondack Health

REPORT DATE:
DECEMBER 2025

2025 Essex County Community Health Assessment
2026-2030 Community Health Improvement Plan

County Covered: Essex
A **Joint Plan** created by the following Health Partners:

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Executive Summary

The Essex County, New York 2025 Community Health Assessment (CHA) and 2026–2030 Community Health Improvement Plan (CHIP) are designed to present a shared, comprehensive understanding of the most significant health needs affecting Essex County residents, as well as the coordinated actions required to address identified gaps.

Health needs were identified through a systematic review and analysis of multiple data sources, including health indicator data, community and stakeholder input, and demographic, socioeconomic, and environmental factors that influence health and contribute to inequities and disparities in health outcomes.

Prevention Agenda Priorities and Disparities

The identification and prioritization of health needs and disparities addressed in the CHIP followed an iterative process that included data review and analysis, application of a well-established prioritization methodology assessing both magnitude of need and feasibility, and the sharing of preliminary findings to solicit feedback from community members and stakeholders. This approach ensured that selected priorities reflect both data-driven evidence and community-identified concerns.

Guided by the *New York State Prevention Agenda 2025-2030* framework, which consists of five domains and 24 priority areas, the Essex County Health Partners (ECHP) selected the following four domains and eleven priority areas for inclusion in the Community Health Improvement Plan:

Economic Stability

- Poverty
- Unemployment
- Nutrition Security
- Housing Stability & Affordability

Social and Community Context

- Depression
- Primary Prevention, Substance Misuse, and Overdose Prevention
- Tobacco/E-Cigarette Use
- Adverse Childhood Experiences
- Healthy Eating

Neighborhood and Built Environment

- Access to Community Services and Support

Health Care Access and Quality

- Preventative Services for Chronic Disease Prevention and Control

Key disparities in the county include **age** (high proportion of older adults living in the county), **income** (increasing income inequality), **access to care** (higher population to provider ratios for all areas of care), and **geography** (rural area where distance and transportation can impact health outcomes). Additional disparities are noted in the CHIP Work Plan, as appropriate.

Data Review

Health needs identification and community health improvement planning were informed by a combination of primary and secondary data sources.

Primary Data Sources (Examples):
2025 Essex County Community Survey
2025 ARHN Stakeholder Survey Summary
Selected ECHD programs and services data

Secondary Data Sources (Examples):
2025 ARHN Stakeholder Survey and Survey Analysis
ARHN Essex County Community Profile Data Sheets
NYS Prevention Agenda Dashboard

ECHP built upon and enhanced an established deliberative process to compile and review primary data while also analyzing secondary data. This included distributed community surveys, an asset mapping initiative, and a review of reports and studies from local agencies and organizations. The community survey yielded 562 responses, and the asset mapping effort identified and categorized more than 100 organizations, agencies, coalitions, committees, programs, and resources available to support CHIP implementation.

Partners and Roles

The development of the CHA and CHIP was guided by a structured community engagement process based on the Association for Community Health Improvement's *Community Health Assessment Toolkit*, supported by the Centers for Disease Control and Prevention through an agreement with the Public Health Foundation. The toolkit's nine-step framework places community engagement at the center of the assessment and planning process, ensuring meaningful collaboration and maximizing value for hospitals, local health departments, and the community.

The lead partners responsible for conducting the CHA and implementing the CHIP are collectively known as the Essex County Health Partners (ECHP), which include:

Essex County Health Department (ECHD)
University of Vermont Health – Elizabethtown Community Hospital (UVMH-ECH)
Adirondack Health (AH)

These partners also participated in a regional collaboration through the Adirondack Health Institute's Adirondack Regional Health Network (ARHN). ARHN is a seven-county, multi-stakeholder coalition dedicated to supporting the New York State Prevention Agenda and is responsible for coordinating data collection and analysis, conducting stakeholder surveys, informing prioritization methodologies, and establishing regional health priorities and initiatives. ARHN leads the Community Health Assessment (CHA) Committee, which consists of 13 hospitals and county health departments from Clinton, Franklin, Essex, Fulton, Warren, Washington, and Hamilton counties. To engage the broad community, the CHA Committee created a list of community stakeholders, including professionals from health care, social services, educational, and government institutions, as well as community members. A stakeholder survey, developed by the CHA Committee to garner constructive feedback, was sent to the 889 identified stakeholders, and was comprised of 14 community health questions and several demographic questions.

The stakeholder survey was conducted to gather information from a variety of fields and perspectives to provide valuable insight into the community's needs from a wide-angle lens, focusing on the ARHN service area. Individual analyses for each member county were also included.

At the local level, ECHP led a parallel, county-focused engagement process survey community residents, involve Essex County agencies and organizations, identify community-identified trends, issues, and concerns, and develop meaningful, effective solutions. This work emphasized addressing the root causes of health challenges. Broad, multi-sector participation was achieved through the establishment of the Community Health Coalition of Essex County and by leveraging existing committees and coalitions, including:

Essex County Board of Supervisors/Board of Health via the Human Services Committee
Essex County Public Health Advisory Committee
Essex County Community Services Board
UVMHN-ECH Board of Directors
Adirondack Health Board of Directors

Longstanding relationships, strong cross-sector collaboration, and a history of successful shared initiatives informed the CHA process, helped identify community assets and service gaps, and guided the selection of partners best aligned with CHIP strategies and interventions.

Interventions and Strategies

The selection of evidence-based strategies to address the identified priority areas and disparities was guided by collaboration among the Community Health Coalition of Essex County and existing ECHP committees, coalitions, and internal workgroups. This approach ensured alignment between the CHIP and current, ongoing, or planned initiatives led by partner organizations, thereby maximizing impact and reducing duplication of effort.

Committees and workgroups were presented with CHA findings and the Prevention Agenda framework, including the five domains, 24 priority areas, and relevant objectives and strategies associated with identified indicators of concern. CHIP development discussions emphasized the effective and efficient use of existing resources and community assets to target areas of greatest need while minimizing redundancy. Shared awareness of countywide health needs and proposed strategies strengthened coordination and collaboration among participating agencies.

A summary of the CHIP interventions is provided in the tables including on the following page*.

*Note:
Partners for all Domain Action Plans Can Include: Essex County Health Department, UVMH-ECH, Adirondack Helath, Essex County Department of Social Services (DSS), Essex County Mental Health, Mental Health Association in Essex County, Heart Network, Well Fed Collaborative, The Prevention Team, Healthy Families NY, ACAP - Head Start/Early Head Start, Schools, Cancer Services Program of the North Country
Refer to the CHIP Work Plan for complete details regarding partner activities.

DOMAIN: Economic Stability

Priority: POVERTY

Interventions

1. Increase access to supplental nutrition programs; and
2. Conduct regular/standardized SDOH screenings for patients

Priority: UNEMPLOYMENT

Interventions

1. Engage in multi-sector collaborations to highlight the health burden of unemployment/underemployment.
2. Strengthen partnerships with BOCES and area schools to expand training programs and employment opportunities.

Priority: NUTRITION SECURITY

Interventions

Promote and expand the availability of fruit and vegetable incentive programs.

Priority: HOUSING STABILITY & AFFORDABILITY

Interventions

1. Collaborate with new and current partners to increase access to safe and affordable housing.
2. Provide Supported Housing Program to individuals with serious or persistent mental illness.

DOMAIN: Social and Community Context

Priority: DEPRESSION

Interventions

Implement and promote Mental Health First Aid training.

Priority: PRIMARY PREVENTION, SUBSTANCE MISUSE, AND OVERDOSE PREVENTION

Interventions

Increase community access to naloxone.

Priority: TOBACCO/E-CIGARETTE USE

Interventions

1. Provide access to tobacco cessation treatments.
2. Implement screening for tobacco use.
3. Advance community-wide support for restricting minors' access to tobacco products.

Priority: ADVERSE CHILDHOOD EXPERIENCES

Interventions

1. Strengthen community partnerships to support education, case coordination, and referrals of at-risk families to local health departments, hospitals, and other community-based organizations to increase participation in home visiting programs.
2. Perform ACEs screening during new client intake.

Priority: HEALTHY EATING

Interventions

Expand Food as Medicine program.

DOMAIN: Neighborhood and Built Environment

Priority: ACCESS TO COMMUNITY SERVICES & SUPOORT

Interventions

1. Educate policymakers and healthcare leaders on promoting age-friendly practices in health care and community infrastructures.
2. Promote and prioritize age-friendly initiatives by educating primary care providers

DOMAIN: Health Care Access and Quality

Priority: PREVENTIVE SERVICES FOR CHRONIC DISEASE PREVENTION & CONTROL

Interventions

Increase cancer screenings, and screenings for hypertension and diabetes.

Progress and Evaluation

Lead partners for each intervention will be identified to monitor implementation progress and provide status updates to the Essex County Health Partners (ECHP), as requested. The ECHP have committed to ongoing communication and collaboration and will convene at least quarterly (via pre-established mechanims, such as ARHN and/or CHA Committee meetings) to:

- assess and measure progress on activities outlined in the CHIP work plan;
- identify barriers to implementation;
- develop strategies to address barriers and/or modify activities to improve effectiveness; and
- recommend revisions, additions, or deletions to the CHIP work plan as new or updated data, indicators, or information become available, or as partner capacity changes.

Each intervention includes defined process measures, which may include, but are not limited to:

- number of trainings planned or delivered;
- percent increase in number of individuals or groups reached;
- number of media campaigns conducted and/or engagement activities completed;
- number of policies or plans adopted, revised, or updated;
- number of healthcare practices conducting screening or making referrals;
- number of coalition or committee meetings held or attended; and
- percent increase or number of programs offered and/or residents served.

Progress will be documented through annual updates (at a minimum) to the CHIP work plan.

Report Overview

Purpose

A Community Health (Needs) Assessment (CHA) gives organizations comprehensive information about the following:

- a community's current health status, needs, and issues;
- contributing factors to health risks and outcomes; and
- community resources and assets that can be mobilized to improve population health.

The comprehensive CHA is the basis for the Community Health Improvement (Service Plan) (CHIP), justifying how and where resources should be allocated to best meet community needs. The CHIP is a later part of this report.

Guidance, Requirements, and Standards

NYSDOH Guidance

The framework for conducting this CHA is derived from guidance provided in the New York State Department of Health (NYSDOH) Prevention Agenda (1). The Prevention Agenda is the state's health improvement plan and serves as a blueprint for local action to improve health and well-being for all and promote health equity in populations experiencing disparities. It provides resources for data collection and analysis and includes standards of adhering to evidence-based interventions.

This CHA is designed to meet requirements as set forth in the NYSDOH Article 6 - State Aid for General Public Health Work Program Guidance Document for Community Health Assessment and Community Health Improvement Plan for local health departments and similar needs assessment requirements for hospitals.

Federal Requirements

This CHA follows guiding principles of the federal Affordable Care Act's provisions applicable for non-profit hospitals seeking federal tax-exempt status (2).

National Accreditation Standards

This CHA has been conducted in a manner that strives to align with Public Health Accreditation Board (PHAB) standards; version 2022 (3).

Methodology

Collaborative Process Model

The collaborative process used to develop this CHA and CHIP is the Association for Community Health Improvement's (ACHI) Community Health Assessment Toolkit. The toolkit offers a nine-step pathway for conducting a CHA and developing implementation strategies documented in the CHIP.

The Community Health Assessment Toolkit is endorsed by the American Hospital Association and is designed for hospitals to meet Community Health (Needs) Assessment requirements. Essex County Health Partners selected this collaborative process model because it makes community engagement a central component of the community health assessment process, which is universally beneficial to health departments, hospitals, and communities.

Steps 1 - 6 cover the CHA.

Steps 7 - 9 cover the CHIP.

Reading This Report

Moving through this report, readers will find data expressed as percent, rate, or ratio and analysis in the form of text, tables, charts, maps, and other visualizations. Following are explanations of how data is expressed and how to interpret elements of data analysis that appear in the report.

References to Sources

References to sources (data and otherwise) used to inform this report are expressed as a footnote immediately following a point of reference, within text, tables, charts, or figures. A general source list is included in Step 4.

Report Sections

Each major section of this report corresponds to a step in the Community Health Assessment Toolkit process (page 3). Section headers are labeled with the icon that represents the process step, along with a description of the step. For example, Step 1 of the process will be highlighted in the report as follows:

Understanding Percent Expressions

A percent is expressed as a portion of 100%.
For example, if 500 people were surveyed and 125 answered a certain way (yes), than 25% of the people said yes to this question.
Data compared to a noted target, benchmark, or previous value is expressed as the percent difference (increase, decrease, more than, less than, etc.).
For example, if the smoking rate in Essex County is 16% in 2022 and was 22% in 2018, the smoking rate decreased by 27% during that time period.

Understanding Rate Expressions

Rates are expressed as per (/) 1,000 (1K); 10,000 (10K); or 100,000 (100K). For example, if there are 25 lung cancer deaths in one year in a population of 30,000, then the mortality rate for that population is 83 per 100,000 (83/100K). Wherever rates are cited in this report, the population size will be specified.

Report Terminology

For the purposes of this shared report of the Essex County Health Partners, the term Community Health Assessment (CHA) is interchangeable with the term Community Health Needs Assessment (CHNA) and either might be used in this document. The same is true for the terms Community Health Improvement Plan (CHIP) and Community Service Plan (CSP) - either might appear in this document and are meant to refer to the same thing.

Data Discrepancies

Depending on the data source cited, readers may notice discrepancies in values for certain indicators. For example, the smoking rate for adults in Essex County might be reported as 18% when using County Health Rankings (CHR) data; however, when citing the Behavioral Risk Factor Surveillance System (BRFSS), it could be reported as 16%. This is due to the fact that the CHR uses complex statistical modeling to create comparable metrics for comparison across counties and states. Another reason is that some indicator values may be aggregated over several years (e.g. 2019 - 2021) rather than single year data. Sources and data time frames are listed for each value reported.

Trending/Comparing Data

Data for the same indicator should not be compared or trended between different sources. Readers should exercise extreme caution even when comparing data points for the same indicator from the same source, across different years, as often there are methodological changes or updates to modeling procedures from one year to the next.

Map Development

Community health improvement is an ongoing process. Before beginning a new assessment, reviewing earlier Community Health Assessments to identify what worked well, what processes could improve and whether your implementation strategies have achieved their objectives

Three years ago, the Essex County Health Partners (ECHP)[1] developed the 2022 Community Health Assessment (CHA) and 2022-2024 Community Health Improvement Plan (CHIP). The *NYS Prevention Agenda 2019-2024* served as the framework for these documents.[2]

The 2019-2024 iteration of the *Prevention Agenda* incorporated a "Health Across All Policies" approach, calling on all State agencies to identify and strengthen the ways in which their policies and programs could have a positive impact on health. It also embraced healthy aging to support New York's commitment as the first age-friendly state. The *Prevention Agenda 2019-2024* delivered five priority action plans in the following areas:

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

The comprehensive health assessment conducted throughout 2022 explored the following aspects related to health in Essex County:

1. Health status of residents;
2. Needs, issues, and contributing factors to health risks and outcomes; and
3. Community assets and resources to mobilize for action to improve health.

Because of this endeavor, ECHP identified these 3 health priorities and 10 corresponding focus areas:

- **Prevent Chronic Disease**
  Healthy Eating & Food Security
  Physical Activity
  Tobacco Prevention
  Preventive Care & Management
- **Promote Well-Being and Prevent Mental and Substance Use Disorders**
  Promote Well-Being
  Prevent Mental Health & Substance Use Disorders
- **Promote Healthy Women, Infants, and Children**
  Maternal & Women's Health
  Perinatal & Infant Health
  Child & Adolescent Health
  Cross Cutting Healthy Women, Infants, and Children

Collaboration with community based organizations and agencies led to the 2022-2024 CHIP, which defined 34 interventions across the 10 focus areas listed above. The figures below depict the "final"

[1] 2022 Essex County Health Partners included Essex County Health Department, UVMHN – Elizabethtown Community Hospital and Adirondack Health

[2] https://health.ny.gov/prevention/prevention_agenda/2019-2024/

status of this effort, separated by priority area (and as reported to the New York State Department of Health at the end of 2024), though it is important to note that many of these initiatives remain ongoing.

Priority Areas & Status in Focus Areas:

RED (Not Started) | YELLOW (Partially Met) | BLUE (Mostly Met) | GREEN (Met)

Chronic Diseases

Focus Area	Intervention	Lead	Partner(s)	Status
	Quality nutrition & physical activity in early learning & childcare centers	ECHD	K-12 Schools	
Health Eating & Food Security	Physical activity & nutrition before, during, & after school	ECHD	K-12 Schools	
	Fruit & vegetable incentive programs	ECHD	K-12 Schools	
Physical Activity	Community physical activity programs	ECHD	Media	
	Facilitate tobacco dependence treatment	NCHHN	Providers	
	Promote treatment of tobacco dependence	ECHD/AH	Media/CBO's	
Tobacco Prevention	Healthcare provider involvement in quit attempts	ECHD	Providers	
	Policy action to reduce tobacco marketing	CVFC	Students	
	Decrease availability of flavored tobacco products	CVFC	Businesses	
	Systems change for cancer screening reminders	AH	CBO's	
Preventative Care & Management	Remove barriers to cancer screening	UVMHN-ECH		
	Increase colorectal cancer screening	ECHD	Media	

Priority Areas & Status in Focus Areas:

RED (Not Started)

YELLOW (Implementation)

BLUE (Mostly Met)

GREEN (Met)

Well-Being & Substance Use & Mental Health Disorders

Focus Area	Intervention	Lead	Partner(s)	Status
	Evidence-based home visiting programs	ECHD	Media	
Promote Well-Being	Promote inclusion, integration, and competence	UVMHN-ECH		
	Thoughtful messaging on mental illness & substance use	ECHD	Media	
	School-based prevention	The Prevention Team	K-12 Schools	
	SBIRT	UVMHN-ECH		
	Trauma informed approaches in prevention programs	ECMH	CBOs	
	Access to MOUD	UVMHN-ECH		
	Access to overdose reversal	Alliance for Positive Health	Pharmacies	
Prevent Mental Health & Substance Use Disorders	Opioid Stewardship	UVMHN-ECH		
	Safe disposal for Rx drugs	AH	CBOs	
	Trauma informed approaches	ECHD	Providers	
	ACEs screening in primary care	UVMHN-ECH		
	Evidence-based home visiting programs	ECHD	Providers	
	Multi-level intervention model	ECMH	CVFC	
	Concurrent therapy for mental illness and nicotine addiction	ECMH	CVFC	

Priority Areas & Status in Focus Areas:

RED	YELLOW	BLUE	GREEN
(Not Started)	(Implementation)	(Mostly Met)	(Met)

Healthy Women, Infants & Children

Focus Area	Intervention	Lead	Partner(s)	Status
Maternal & Women's Health	Preventive medical visits for women	UVMHN-ECH		
	Depression screening for pregnant & postpartum women	ECHD		
	Access to breastfeeding support	ECHD	Providers	
Perinatal & Infant Health	Increase breastfeeding support	UVMHN-ECH		
	Capacity of home visiting programs	ECHD / Healthy Families North Country		
Child & Adolescent Health	Family-centered services for supporting children with special healthcare needs	ECHD	Providers	
Cross Cutting Healthy Women, Infants & Children	Collaboration with providers that serve women infants and children	ECHD	CBO & Providers	

2022-2024 Essex County Community Health Improvement Plan – RESULTS SUMMARY

<u>34 Interventions</u>

- 18 with goals & objectives met
- 6 with goals & objectives mostly met
- 7 in progress
- 3 not started

While the *Prevention Agenda 2019-2024* considered social determinants of health and encouraged cross-sector partnerships to address these determinants, most of the priority areas and resulting objectives were grounded in core (existing) public health programming. Those priority and focus areas that did not fall under core public health programs were at least public health adjacent, involving agencies ECHP were familiar working with, or those with which ECHP had existing partnerships.

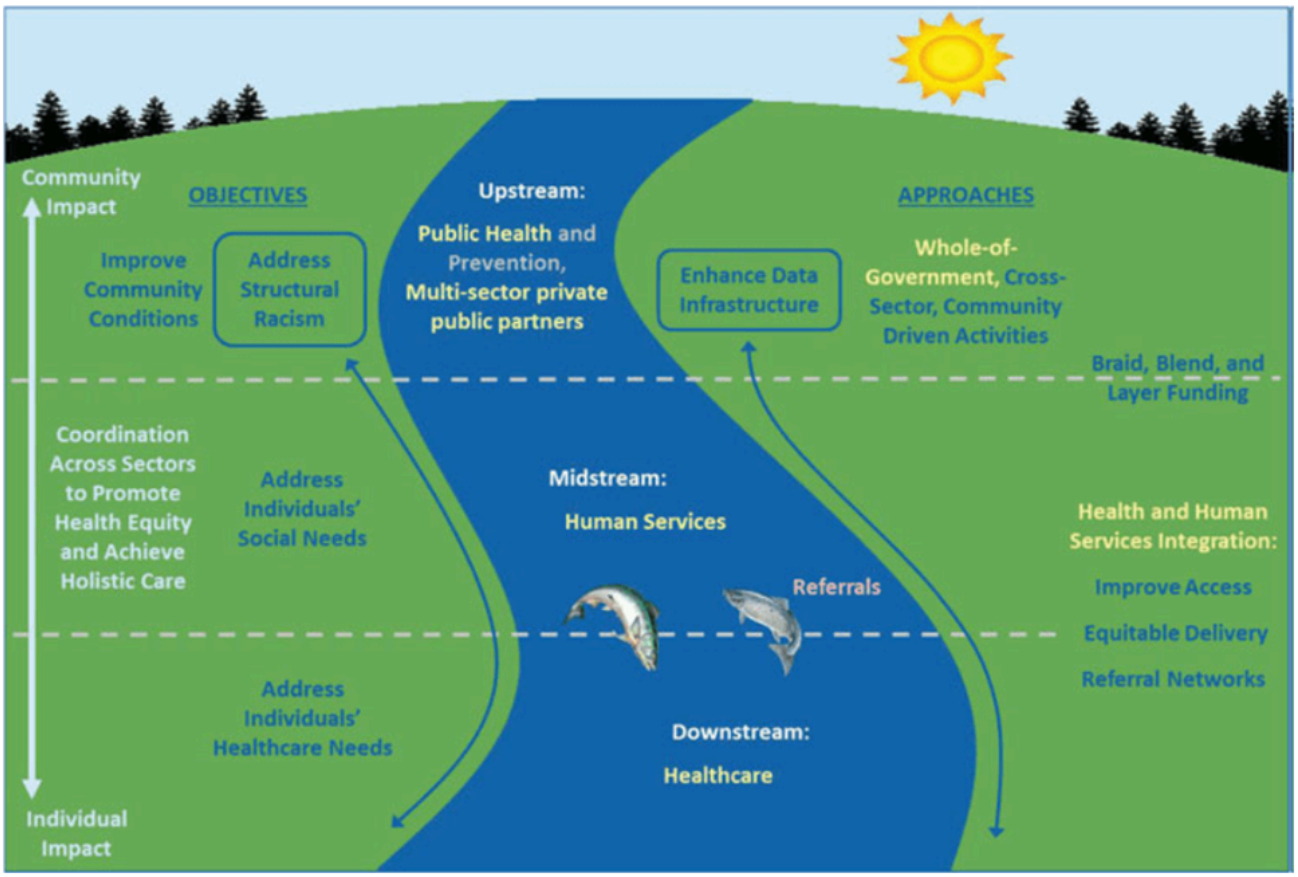
The *NYS Prevention Agenda 2025-2030* adopts a broader perspective, emphasizing factors that influence health beyond traditional health outcomes, prevention strategies, medical care, and public health systems. The 2025-2030 Prevention Agenda outlines 24 key priorities to address health conditions, behaviors, and systemic issues such as poverty, education, housing, and access to quality healthcare. Addressing these issues is crucial for reducing health disparities.[3]

These 24 priorities are featured across **five domains**, based on *Healthy People 2030's* Social Determinants of Health[4]:

- Economic Stability
- Social and Community Context
- Neighborhood and Built Environment
- Health Care Access and Quality
- Education Access and Quality

Many of these priority areas require that ECHP consider less traditional partnerships and engage with sectors that have not operated through a lens of health before. As more and more factors are linked to negative health outcomes or are labeled a public health issue, public health and health care face ever-expanding roles and competing priorities. The ECHP are keeping these considerations in focus as we make strategic decisions during improvement planning. Ultimately, the goal will be to develop a manageable plan, which centers on moving toward a few quality upstream approaches for greater community impact, while continuing to operate with and within systems that address the down and mid-stream environments.

[3] https://www.health.ny.gov/prevention/prevention_agenda/2025-2030
[4] https://odphp.health.gov/healthypeople



Social Determinants of Health Ecosystem, Adapted from Castrucci and Auerbach, as featured in CDC's Approach to Social Determinants of Health[5]

As the ECHP conduct the Community Health Assessment through synthesis and analysis of a broad range of health indicators, it is important to mention that addressing the social determinants (root causes) of health will lead to greater improvements in health outcomes overall. In other words, while the assessment may point to individual areas of need (e.g. high obesity, rising rates of diabetes, increases in drug overdose) which dictate prioritization of those needs, the improvement plan will prioritize addressing the systemic issues - e.g. poverty, housing instability, unemployment, lack of health care access - that lead to the health conditions in our communities. Following the latest iteration of the Prevention Agenda, ECHP and community partners will coordinate interventions across sectors that have community and individual level impacts.

[5] https://jphmpdirect.com/cdcs-approach-to-social-determinants-of-health/

Build Relationships

Building trusting relationships with individuals and organizations in the community fosters a welcoming environment that promotes a sense of joint ownership of the CHA process. Such trust can ultimately contribute to better health outcomes when strategically applied to shared goals. Although trusting relationships are central throughout the CHA process, this particular step focuses on how to build those essential relationships and in turn develop the CHA and sustain those relationships over time.

The release of a new Prevention Agenda for this CHA/CHIP cycle necessitated greater stakeholder engagement over the course of 2025 than in the previous cycle. With new domains and priority areas, it was essential to communicate the changes broadly, expand data collection efforts to adequately assess the new domains, and identify ways to establish new partnerships across different sectors. Stakeholder engagement is crucial to ensure assessments are effective, inclusive, and address true community needs. It involves the participation of diverse groups such as community members, healthcare providers, and local organizations to build trust, gain comprehensive insights, and ensure buy-in for health initiatives.

While stakeholder engagement is a necessary early step of community health assessment and improvement planning, it continues during the entire process, including throughout the implementation and execution of the CHIP. Stakeholder engagement is also revisited in the Step 6: Document and Communicate Results section.

Local **Regional** **State**

Committee / Coalition	Meeting Date(s) and/or Frequency	Participant Organizations	Lead/Host Organization
Community Health Coalition of Essex County	**Quarterly** June 23, 2025 September 8, 2025 December 8, 2025	Hospital(s), Health Centers, Government Agencies, Community Based Organizations, and Local Health Department in Essex County	UVMH-ECH and ECHD
ECPH CHA/CHIP	**Monthly or Quarterly*** 2023 - 2025	UVMH-ECH and ECHD	UVMH-ECH and ECHD
Community Health Assessment (CHA) Committee	**Quarterly** 2023 – 2025	Hospitals and Local Health Departments	Adirondack Health Institute
Adirondack Rural Health Network	**Quarterly** 2023 – 2025	Hospitals, Local Health Departments, Community Based Organizations	Adirondack Health Institute
CHA Data Sub-Committee	**Monthly** January 2024 – August 2024, December 2024, February 2025 – June 2025	Hospitals and Local Health Departments	Adirondack Health Institute

*Meeting frequency based on need

Table continued on next page

Local Regional State

Committee/Coalition	Meeting Date(s) and/or Frequency	Participant Organizations	Lead/Host Organization
NYS Prevention Agenda Workgroup (Domain 1)	**Weekly** September 27, 2024 – November 19, 2024	NYSDOH, New York State Office of Temporary and Disability Assistance (OTDA), Mount Sinai Health System, ECHD, Healthcare Association of New York State (HANYS), Champlain Valley Family Center, New York State Community Action Association, Westchester County Department of Health, Broadview Federal Credit Union, Human Services Coalition of Tompkins County, Westchester Medical Center Health Network (WMCHealth), New York State Academy of Family Physicians	NYSDOH
CHA/CHIP Workgroup	**Monthly** June 2025 – December 2025	Local Health Departments	New York State Association of County Health Officials (NYSACHO)

Note: Some of these committees/coalitions have been long-standing and information about meeting dates/frequency prior to 2023 pertains to previous CHA/CHIP cycles.

Local Stakeholder Engagement

The primary partners/lead agencies engaged in the development of the CHA and CHIP are, as previously noted, identified as the Essex County Health Partners and include:

- Essex County Health Department (ECHD)
- UVMH – Elizabethtown Community Hospital (ECH)
- Adirondack Health (AH)

In addition to the ECHP convening as needed, each of the partners making up ECHP leads or participates in several locally based coalitions/committees that help inform the health assessment and improvement planning. These coalitions and committees are listed on the Asset Matrix (page 26-28).

Local Data Gathering and Analysis

At the local level, data collection efforts include the following:

- **2025 Stakeholder Survey Summary**
  - o ECHP analyzed the 2025 Stakeholder Survey to develop a summary that highlights the key findings for Essex County. This analysis includes the identification of themes, disparities, top issues, contributing factors, and priorities as they align with the NYS Prevention Agenda 2025-2030. The Stakeholder Survey Summary is on page 98.

- **2024-2025 Community Survey**
  o The community served by the ECPH can also be considered a collective stakeholder. A months-long effort to garner community feedback commenced in November 2024 and concluded in May 2025. Over 560 responses were received, a 16% increase in engagement from the previous survey, conducted in 2022. A summary of the survey results is included on page 97 and the full survey report is in Appendix 1.

- **Review of relevant ECHD programs and services data**
  o ECHD collects and aggregates primary data across a variety of programs and services that will be included in the data analysis section of this report, where appropriate.

- **Review of other available local health and human service agency annual reports, plans, and/or data**
  o Community agencies, government organizations, and other groups provide a wealth of information and data in various annual reports, plans, and/or studies either conducted by or commissioned for these entities. Examples of such information includes:
    1. *Essex County Prevention Needs Assessment 2025*, sponsored by the Essex County Youth Bureau and prepared by Bach Harrison, L.L.C
    2. *From Barriers to Opportunity: Confronting Systemic Barriers to Early Childhood and Poverty-Reduction Programs, October 2024*, prepared by Raising New York
    3. *Adirondack Community Action Programs (ACAP) Community Assessment Update, 2023*
    4. *Essex County demographic and housing report with town profiles*. Asterhill Research Company. May 24, 2022.
    5. *An analysis of residential market potential for primary and second/weekend/vacation units in Essex County, New York*. Zimmerman/Volk Associates, Inc, 2025.

- **Asset Mapping**
  o Related to stakeholder engagement, asset mapping is process of identifying, documenting, and often visualizing the strengths and resources within a community to build upon existing assets. The process of asset mapping supports community health improvement planning because it reveals:
    1. Assets that are ready to be mobilized to address needs
    2. Gaps in programs and services might be bridged through health planning efforts
  The 2025 Asset Matrix is included in this report on pages 26-28.

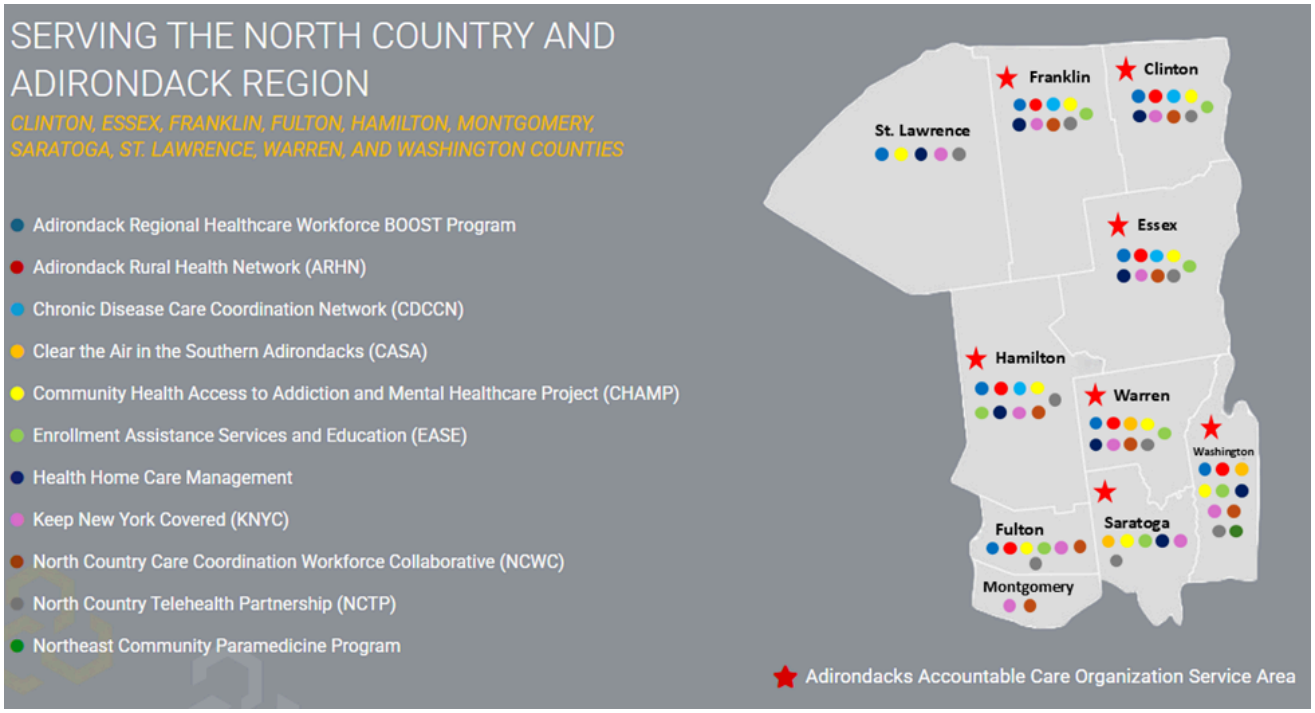
Regional Stakeholder Engagement

The Adirondack Health Institute (AHI) is an independent, non-profit organization advancing equity, quality, access, and affordability of health and healthcare services. AHI facilitates regional collaboration between local health departments and hospital partners.

AHI's vision is that every individual in the region reaches their fullest potential and lives their healthiest possible life.

AHI's mission is that their team leads transformative work with clinical and community partners to advance equity, quality, access, and affordability of health and healthcare services.
AHI works to achieve their mission and vision through the administration of various programs and services, as indicated in the image on page 21.

Adirondack Health Institute Programs & Services[1]:



Adirondack Rural Health Network

The Adirondack Rural Health Network (ARHN) (a program of AHI) provides a forum for public health leaders, community health centers, hospitals, behavioral health organizations, emergency medical services, and other community-based organizations to assess regional population health needs and develop collaborative responses to priorities. As a multi-stakeholder regional coalition, ARHN informs on planning assessment, provides education and training to further the New York State Department of Health (NYSDOH) Prevention Agenda, and offers other resources that support the development of the regional health care system. The ARHN region is comprised of Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.

Community Health Assessment (CHA) Committee

The Community Health Assessment (CHA) Committee, facilitated by ARHN, is a multi-county, regional stakeholder group that convenes to support ongoing health planning and assessment by working collaboratively on interventions, and developing the planning documents required by the NYSDOH and the Internal Revenue Service (IRS) to advance the New York State Prevention Agenda. The CHA Committee includes representatives from:

Clinton County Health Department
Essex County Health Department
Franklin County Public Health
Fulton County Public Health
Hamilton County Public Health and Nursing Services
Warren County Health Services
Washington County Public Health

[1]https://ahihealth.org/about-us/

Adirondack Health
UVMHN – Elizabethtown Community Hospital
UVMHN – Champlain Valley Physician's Hospital
UVMHN – Alice Hyde Medical Center
Glens Falls Hospital
Nathan Littauer Hospital

CHA Committee: Ad Hoc Data Sub-Committee

As in the previous CHA cycles, the CHA Committee reconvened the ad hoc Data Sub-Committee in 2024 to discuss, refine, and improve data collection and dissemination processes.

Regional Data Gathering and Analysis

Major components of regional stakeholder engagement include:

- **ARHN Stakeholder Survey Summary Report** (Appendix 2)
  To engage the broad community, the CHA Committee created a list of community stakeholders, including professionals from health care, social services, educational, and governmental institutions as well as community members. A stakeholder survey, developed by the CHA Committee to garner constructive feedback, was sent to the 889 identified stakeholders, and was comprised of 14 community health questions and several demographic questions.
  The stakeholder survey was conducted to gather information from a variety of fields and perspectives to provide valuable insight into the community's needs. The survey summary provided a regional look at the results through a wide-angle lens, focusing on the Adirondack Rural Health Network (ARHN) service area. It provided individual analyses of Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.
  The results enable the CHA Committee to guide strategic planning throughout the Adirondack region, for partners who serve individual counties, and those whose footprint covers multiple counties.
- **ARHN County Community Profile Data Sheets** (Appendix 3)
  o **Demographic Profile**
  Demographic data was primarily taken from the United States Census Bureau 2023 American Consumer Survey 5-year estimates. Additional sources include the 2020 Census Estimate: Census Quick Stats, and United States Department of Agriculture (USDA) Farm Service Agency (FSA) Crop Acreage Data Reported to FSA. Information included in the demographic profile includes square mileage, population, family status, poverty, immigrant status, housing, vehicle accessibility education, and employment status/sector.
  o **Health System Profile**
  The Health System Profile data includes hospital, nursing home, and adult care facilities, bed counts, physician data, and licensure data. Data on facilities is sourced from the NYS Department of Health, NYS Health Profiles, covering profiles for hospitals, nursing homes, and adult care facilities. Licensure data is pulled from the NYS Education Department (NYSED).
  o **Education Profile**
  The Education Profile is comprised of two parts:
  1) Education System Information
  Includes student enrollment, student to teacher ratios, English proficiency rates, free lunch eligibility rates, as well as high school graduate statistics. Data was sourced from the NYSED and the National Center for Education Statistics (NCES).

2) School Districts by County identifies all the school districts in each county, sourced from the National Center for Education Statistics (NCES).

o **Asset Limited, Income Constrained, Employed (ALICE) Profile**

ALICE profile data includes total households, ALICE households over 65 years, ALICE households by race/ethnicity, poverty/ALICE percentages within each county, unemployment rates, percent of residents with health insurance, and median household income. All ALICE data is reflective of data presented in the ALICE profile originated from the 2024 ALICE report (www.unitedforalice.org/new-york). Within the ALICE report, data was pulled from the 2022 American Community Survey, 2022 ALICE Threshold and ALICE county demographics.

o **County Health Rankings (CHR) Profile**

The County Health Rankings profile includes indicators from the 2025 CHR release, with focuses on Population Health and Well-Being and Community Conditions. The population health and well-being section focuses on length of life and quality of life indicators. The community conditions section focuses on health infrastructure, physical environment, and social and economic factors.

The County Health Rankings identifies the two focus areas as:

· Population health and well-being is something we create as a society, not something an individual can attain in a clinic or be responsible for alone. Health is more than being free from disease and pain; health is the ability to thrive. Well-being covers both quality of life and the ability of people and communities to contribute to the world. Population health involves optimal physical, mental, spiritual and social well-being.

· Community conditions include the social and economic factors, physical environment and health infrastructure in which people are born, live, learn, work, play, worship and age. Community conditions are also referred to as the social determinants of health.

**All data included in the writing analysis relating to the County Health Rankings section is pulled from the website directly and does not reflect analysis completed by ARHN. Strengths and areas for improvement are identified by County Health Rankings.*

- **ARHN CHA Data Den/Dashboard** (formerly County Health Indicator Data Sheets

  The Data Dashboard, compiled of 355 data indicators, provides an overview of population health as compared to the ARHN region, Upstate New York region, Prevention Agenda Benchmark and/or NYS. Each source file has visualization aspects to better depict data, as well as a deep dive tab that provides a table with a benchmark comparison, color-coded to identify where the county rate falls in comparison. The Data Dashboard is composed of 10 sources, each with their own overview and deep dive tab. These sources are described in further detail in Appendix 4.

State Stakeholder Engagement

NYS Prevention Agenda Workgroup (Domain 1)

An Ad Hoc Committee to Lead the State Health Improvement Plan (SHIP) played an essential role in the development of the new 2025-2030 Prevention Agenda. The committee established workgroups based on the domain priority areas of the Prevention Agenda framework. The domain workgroup members were comprised of experts in Social Determinants of Health, health equity, health disparities, and community members. Together, members formulated the goals, objectives, and interventions that make up the bulk of the Prevention Agenda. Additionally, many New York State Department of Health staff provided subject matter expertise, supported action plan development, and contributed baseline data.

NYSACHO CHA/CHIP Workgroup

In mid-2025, NYSACHO established a CHA/CHIP workgroup for local health departments to meet monthly to share updates, exchange ideas, and collaborate on their CHA/CHIP efforts for the 2025 – 2030 cycle. Topics were broad, including CHIP engagement strategies, methods for organizing data sources, handling data discrepancies, aligning state dashboards for CHA/CHIP planning, etc.

Data Sources

The data sources used to compile this report are cited throughout the document. Footnotes are used in each discrete section of the report and correspond only with that section (i.e. footnote numbers start over at #1 at the beginning of each new section and for each DOMAIN). A general list of data sources is as follows:

- U.S. Census Bureau, U.S. Department of Commerce, American Community Survey

1. Selected Economic Characteristics
2. Selected Social Characteristics in the United States
3. Medicaid/Means-Tested Public Coverage by Sex by Age
4. Poverty Status in the Past 12 Months

- United State Department of Agriculture (USDA) FSA Crop Acreage Data
- NYS Department of Health, NYS Health Profiles

1. Hospital Profile
2. Nursing Homes Profile
3. Adult Care Facilities Profile

- NYS Education Department (NYSED)

1. Licensed Professions
2. Enrollment Database Report
3. Student and Educator Database Report
4. Enrollment Data by County Report
5. High School Graduation Rate Report

- National Center for Education Statistics
- United for ALICE
- Community Health Indicator Reports (CHIRs)
- NYS Department of Health, Wadsworth Center
- Division of Criminal Justice Services Index, Property, and Violent Crime Report
- NYS Behavioral Risk Factor Surveillance System (BRFSS)
- Institute for Traffic Safety Report (ITSMR), Traffic Safety Statistical Repository
- Prevention Agenda Dashboard
- Student Weight Status Category Reporting System (SWSCRS)
- USDA Food Environment Atlas
- Essex County Health Department Program Data

Data Collection Methods

Some of the data collection methods are described above under the Local and Regional Stakeholder engagement sections on pages 19 - 23 for secondary data sources and a more complete description is included in Appendix 4.

For primary data sources - those gathered by the Essex County Health Department (ECHD) - data from ECHD programs and services is tabulated on a monthly basis for the purpose of sharing with local stakeholders and for quality assessment and performance management initiatives. This data was aggregated and utilized where appropriate in this report to augment existing secondary data and/or provide a more up-to-date picture of community conditions and population health.

Asset Matrix	KEY: Engaged in the development of the CHA & CHIP		KEY: Resources available to mobilize in addressing community health				
			Prevention Agenda Domains				
Asset Type	Name	Description	Economic Stability	Social & Community Context	Neighborhood & Built Environment	Health Care Access & Quality	Education Access & Quality
Healthcare System	Adirondack Health-Adirondack Medical Center	Population Health Committee	■	■	■	■	■
		Decker Learning Center for Health Education				■	■
		Health Centers - Providers & Wellness Coaches	■	■	■	■	
		Physical, Occupation & Speech Therapy Programs		■	■	■	
		Women's Health Clinic		■	■	■	
		Breast Program: Breast Health Navigator			■	■	
		Certified Lactation Consultants		■		■	
		Antibiotic Stewardship Program		■		■	
		OD Reversal Prescriptions		■		■	
		Opioid Stewardship program		■		■	
		Medication Drop Box		■		■	
		Dr. First Pharmacist-Led Medication Reconciliation		■		■	
		Respiratory Therapy Program			■	■	
		Cancer screenings & the Merrill Center for Oncology			■	■	
		Weight Management Program			■	■	
		Medical Fitness Program			■	■	
		Fit for Life (Medically-Supervised Activity)			■	■	
	University of Vermont Health - Elizabethtown Community Hospital	Population Health Committee	■	■	■	■	■
		Health Centers - Providers & Social Workers	■			■	
		Diabetes Educator, Prevention Program, Support Group		■	■	■	
		Cancer Screenings & Events; Chemo Infusion Therapy			■	■	
		Physical, Occupation & Speech Therapy Programs			■	■	
		Nutritionist, Wellness Rx Program & co-located food pantries	■			■	
		Wellness Program		■	■	■	
		Pulmonary & Cardiac Rehabilitation Programs			■	■	
		Breastfeeding- Friendly Health System		■		■	
		Stop Domestic Violence Program	■	■	■	■	
		Specialty Care Outpatient Clinics		■	■	■	
		Opioid Stewardship & MAT		■		■	
		Medication Drop Box and Community Narcan distribution		■		■	
		Antibiotic Stewardship Program				■	
	Hudson Headwaters Healthcare Network		■	■	■	■	■
	Pharmacies		■	■		■	
	Essex County Health Department	Public Health Advisory Board	■	■	■	■	■
		Public Health Programs	■	■	■	■	■
		Children's Services	■	■	■	■	■
		WIC	■	■		■	
		Home Health			■	■	■
	Adirondack Health Institute (AHI)	Adirondack Rural Health Network	■	■	■	■	■
		Community Health Assessment Committee	■	■	■	■	■
Adult Care Facilities				■		■	
Nursing Homes				■		■	
Senior Living Facilities				■		■	

Asset Matrix	KEY: Engaged in the development of the CHA & CHIP		KEY: Resources available to mobilize in addressing community health				
			Prevention Agenda Domains				
Asset Type	Name	Description	Economic Stability	Social & Community Context	Neighborhood & Built Environment	Health Care Access & Quality	Education Access & Quality
Coalitions/Committees	Adirondack Birth to Three Alliance		■	■		■	■
	Essex County Bright Futures Coalition		■	■	■		
	BRIEF - System of Care		■	■	■	■	■
	Essex County Drug Court		■	■	■		
	Essex County Mental Health Court		■	■	■	■	
	Essex County Heroin & Other Prevention Coalition (ECHO)		■	■	■	■	
	Essex County Suicide Prevention Coalition			■			
	Essex County Community Services Board		■	■	■	■	■
	Essex County Human Services Committee	Sub-Committee of the Board of Supervisors	■	■	■	■	■
	North Country Immunization Action Plan Coalition		■			■	
	North Country Lead Coalition		■			■	
	Safe Kids Adirondack		■		■		
	Local Emergency Planning Committee		■		■		
	North Country Chronic Disease Prevention Coalition		■	■	■	■	
	Housing Coalition		■				
	Stethoscoop			■		■	■
	Local Early Intervention Coordinating Council		■			■	■
	Tobacco Use Reduction Network (TURN)			■		■	
	Caregivers Work Group			■	■	■	
	Well Fed		■	■	■	■	
	Long Term Care Committee		■		■	■	
County Government Departments	Mental Health		■	■	■	■	■
	Department of Social Services		■	■	■		
	District Attorney				■		
	Office for the Aging		■	■	■	■	■
	Public Works		■		■		
	Sheriff		■	■	■		
	Emergency Services & EMS		■	■	■	■	
	Community Resources/Planning		■	■	■	■	■
	Youth Bureau		■	■			■
	Transportation		■				
	Veteran's Services		■	■	■	■	■
Local Government	Towns & Villages	Boards, Planning, Zoning	■	■	■	■	■
Media		Print, Radio, TV, Social	■	■	■	■	■
Law Enforcement		NYSPD, Essex County Sheriff, Local	■	■	■		
Community-Based Organizations	Alliance for Positive Health		■	■			
	Adirondack Foundation		■	■	■	■	■
	The Prevention Team			■			■
	Mental Health Association in Essex County		■	■	■	■	■
	Planned Parenthood	(2 Locations serving Essex County)	■			■	
	Adirondack Community Action Program (ACAP)	Human Services Coalition, Health Advisory Committee, Head Start/Early Head Start	■	■	■	■	■
	Families First		■	■	■	■	■
	Heart Network			■		■	
	Retired Senior Volunteer Program (RSVP)				■		
	Citizen's Advocates/St. Joe's Treatment Centers			■		■	
	Behavioral Health Services North			■		■	
	Tri-Lakes Center for Independent Living				■		
	Mountain Lake Services				■		
	Cornell Cooperative Extension		■	■			■

Asset Matrix	KEY: Engaged in the development of the CHA & CHIP		KEY: Resources available to mobilize in addressing community health				
			Prevention Agenda Domains				
Asset Type	Name	Description	Economic Stability	Social & Community Context	Neighborhood & Built Environment	Health Care Access & Quality	Education Access & Quality
Community-Based Organizations (cont'd)	Industrial Development Association		■				
	Adirondack Roots		■				
	Literacy Volunteers of Essex & Franklin Counties				■		■
	Chambers of Commerce	Local & Regional	■				■
	Businesses		■				■
	United Way of Clinton, Essex, Franklin County		■	■	■	■	■
	Healthy Families North Country		■	■	■	■	
	North Country Rural Development Coalition		■	■	■		■
	One Work Source		■				■
	Mercy Care for the Adirondacks		■				■
	Champlain Valley Family Center			■			
Schools		Public, Private, BOCES, Colleges	■	■	■	■	■
Religious Groups	Churches, Ecumenical Societies, etc.		■	■	■	■	
Local Programs/Grants	Opioid Settlement Funds		■	■	■	■	■
	JUUL Settlement Funds		■	■		■	■
	Cancer Services Program of Northeastern NY		■		■	■	
Preparedness	Eastern Border Health Initiative		■		■	■	
	Health Emergency Preparedness Coalition		■		■	■	
	Volunteer Organizations Active in Disaster		■		■	■	
New York State (NYS)	NYS Association of Counties (NYSAC)		■	■	■	■	■
	NYS Association of County & City Health Officials (NYSACHO)		■	■	■	■	■
	NYS Public Health Association (NYSPHA)		■	■	■	■	■
	Healthcare Association of New York State (HANYS)		■	■		■	■
	Home Care Association of New York State (HCA-NYS)		■	■		■	■
	NYS Department of Health (NYSDOH)		■	■	■	■	■
Advisory Boards - Essex County Director of Public Health Participation	North Country Community College Advisory Board		■				■
	University of Albany - Strengthening Public Health Workforce Advisory Board		■				■
	Opioid Settlement Fund Advisory Board		■	■	■	■	■
	NY Health Foundation Community Advisory Committee		■	■	■	■	■

Develop the Community Profile

Service Area: Essex County

Geography

Essex County is the 2nd largest county in New York State geographically. The county is comprised of 18 towns and two (2) villages. The village of Lake Placid is located in the town of North Elba. The other village, Saranac Lake, is situated partially in Essex County and partially in Franklin County to the west.

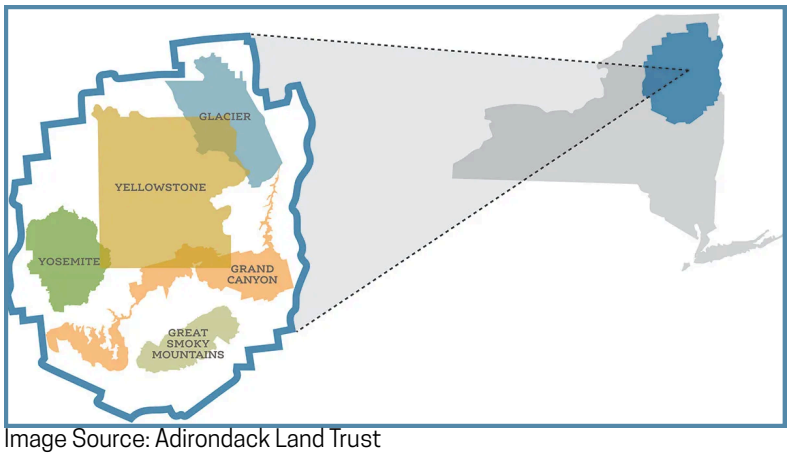
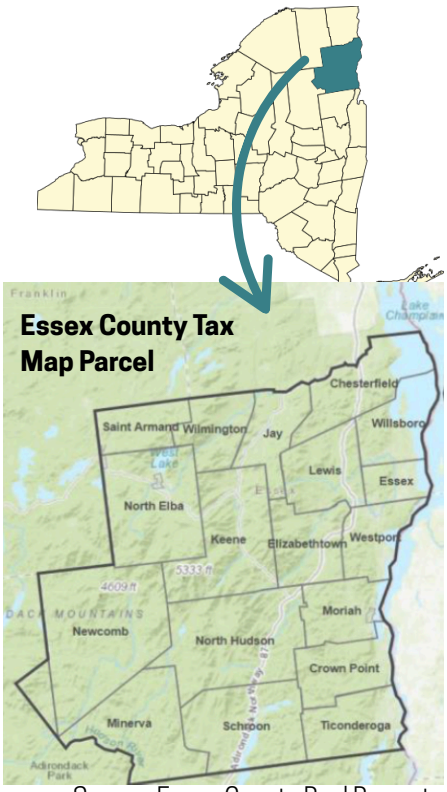


Image Source: Adirondack Land Trust



Source: Essex County Real Property

Essex County sits entirely within the "blue line" defined as the Adirondack Park. The Adirondack Park was established in upstate New York in 1892 as one of the first Forever Wild Forest Preserves in the nation. At 6 million acres, it is the largest publicly protected area in the contiguous United States. Of this 6 million acres, 2.6 million are owned by New York State. The remaining 3.4 million acres are privately owned. The publicly owned lands are constitutionally protected as "Forever Wild" and must be maintained according to that designation. The Adirondack region contributes to the geography and rurality of Essex County.

Population

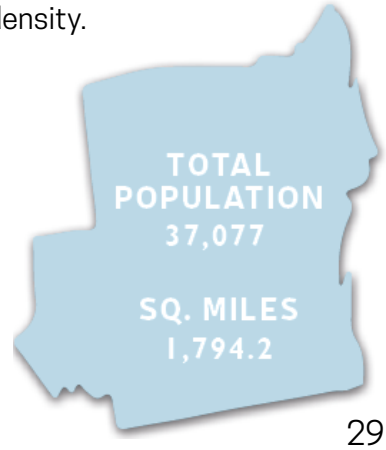
Density

Although Essex County is the 2nd largest county geographically, it is the 2nd least densely populated county in the state, with only Hamilton County having a lower population density.

Least Densely Populated Counties in NYS		Most Densely Populated Counties in NYS (excluding NYC)	
Hamilton	2.97	Erie	915.13
Essex	**20.84**	Monroe	1156.03
Lewis	20.85	Suffolk	1674.67
Franklin	29.19	Rockland	1950.65
Delaware	30.71	Westchester	2332.02
St. Lawrence	40.49	Nassau	4905.34

Data Source: 2020 Census

Density = people/sq. mile



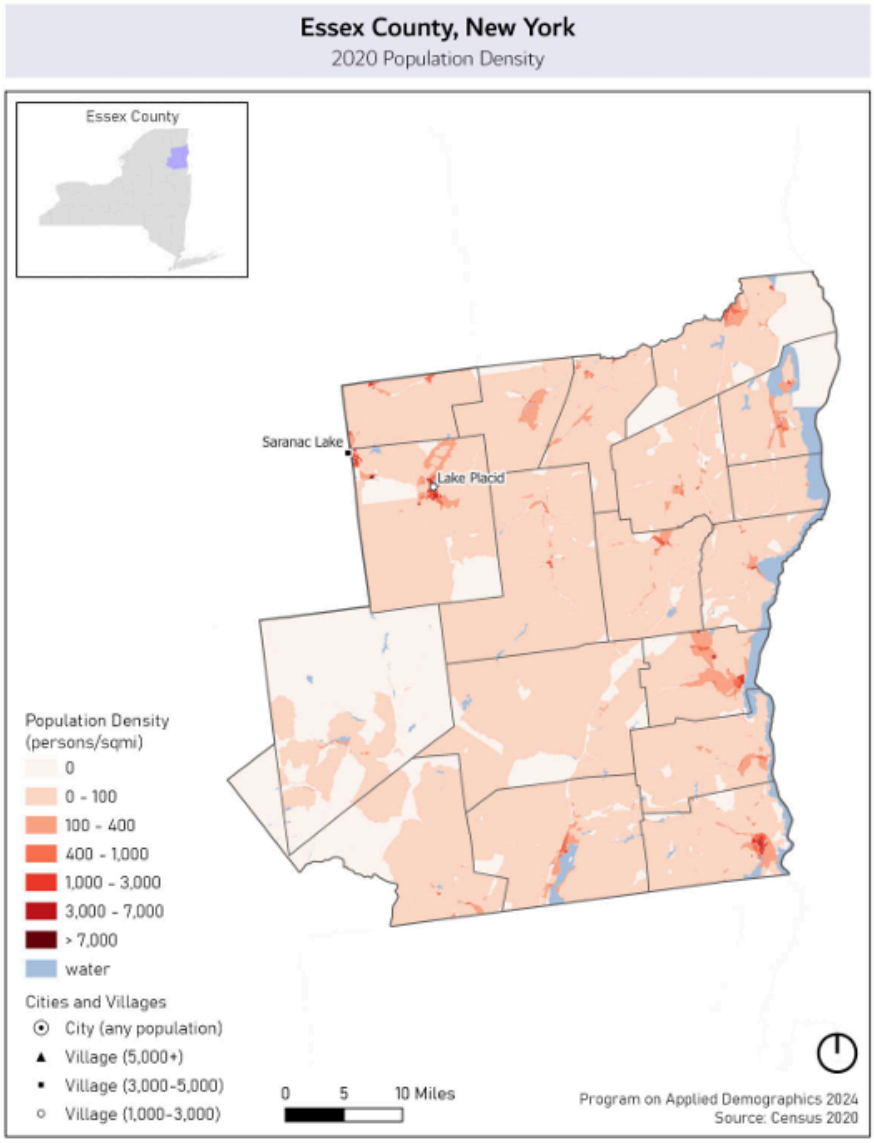


Image Source: Cornell Population Center, Cornell University, February 2024

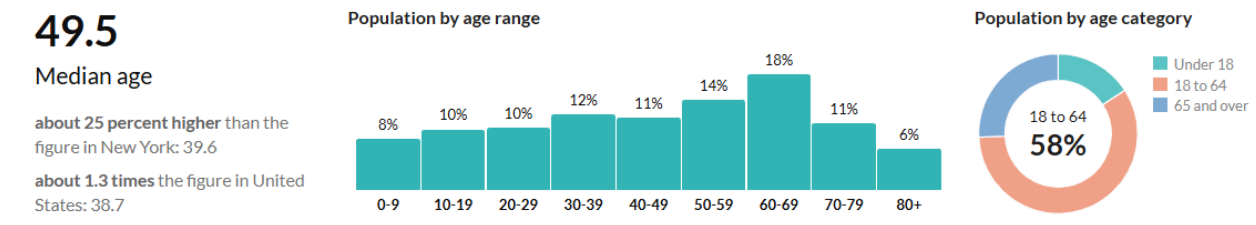
Given the size and geography of Essex County, the population is spread out across a wide geographic area, with larger population centers in Ticonderoga, North Elba (Lake Placid/Saranac Lake), Moriah, and Chesterfield. The town of Elizabethtown is the County Seat. County government employment, as well as the site of the only critical access hospital in the county, bring significant people to Elizabethtown during the week. Other areas with slightly higher population densities include Willsboro, Crown Point, Jay/Wilmington, and Schroon Lake.

Total Population

The total population in Essex County is 37,077, according to the US Census Bureau, American Community Survey (ACS) 5-Year Estimates, 2023. This represents a 5.1% decline since the 2010 census and an almost 6% decline since the last decennial census was conducted in 2020.

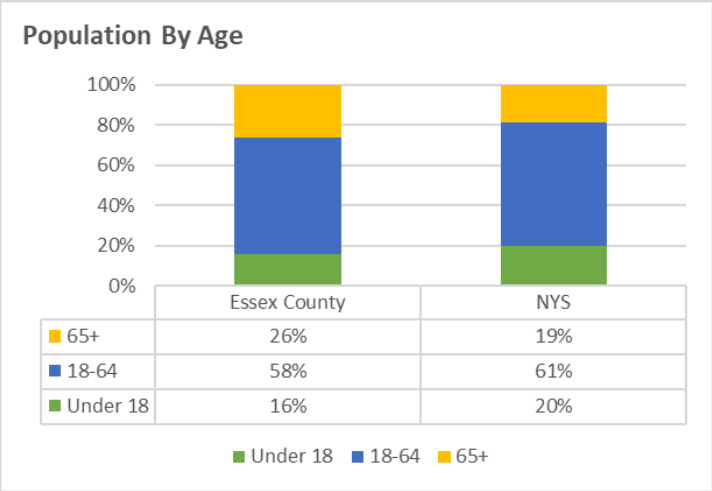
Age

In addition to the population declining in Essex County, the percent of the population aged 65 years and older is increasing.



Source: U.S. Census Bureau (2023). American Community Survey 5-year estimates. Retrieved from Census Reporter Profile page for Essex County, NY <http://censusreporter.org/profiles/05000US36031-essex-county-ny/>

The median age in Essex County was 48.3 years of age and almost 25% of residents were 65 or older in 2020. In 2023, the median age was 49.5, with 26% of residents 65+. Essex County has a significantly higher aging population than New York State as a whole, though New York ranks fourth in the nation in the number of individuals aged 60 and over, at 4.8 million. By 2030, this population is expected to reach 5.3 million. This has serious implications for Essex County and the state, including an increased strain on healthcare systems and government social programs like Social Security and Medicare. It leads to an economic shift with a smaller workforce, potentially slower economic growth, and changes in consumer spending patterns and the labor market. Furthermore, it creates social challenges such as the need for more caregivers, shifts in family dynamics, and a greater risk of loneliness and social isolation for older adults.



	Essex County	NYS
65+	26%	19%
18-64	58%	61%
Under 18	16%	20%

Source: US Census Bureau, ACS 5-Year Estimates, 2023

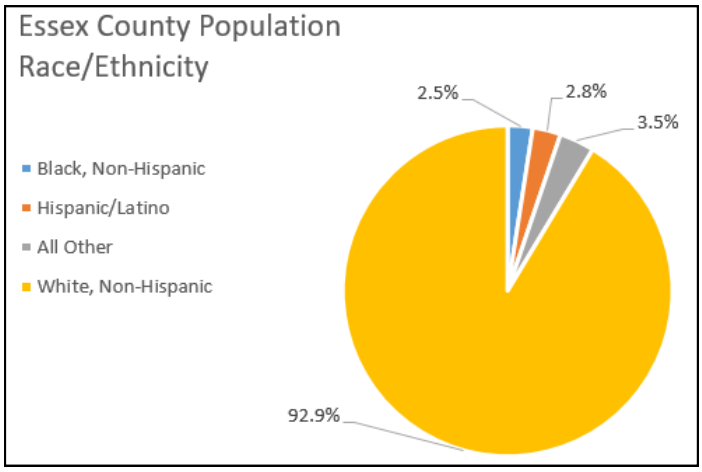
Policy adaptations that address community infrastructure in the areas of transportation, housing, and social program administration can mitigate some of the impacts of an aging population - and benefit people of all ages. New York State has developed a Master Plan for Aging, which outlines over 100 proposals that "*explore multiple approaches that address the built environment and infrastructure, transportation and transit, financing of care and services, recruitment and retention of the long term care workforce, [...] and many more*".[1]

Race and Ethnicity

Essex County has historically lacked racial and ethnic diversity, with the population being predominantly white, non-Hispanic (92.9%). Certain pockets of the county are slightly more diverse than others (e.g. Lake Placid, Saranac Lake, Schroon Lake).

New York State (excluding New York City), in comparison, has the following racial/ethnic make-up:
White, non-Hispanic: 70.7%
Black, non-Hispanic: 8.7%
Hispanic/Latino: 13.5%
All Other: 14.1%

The "All Other" category includes Asian, Native Hawaiian, Pacific Islander, Alaskan Native, American Indian, and two or more races.

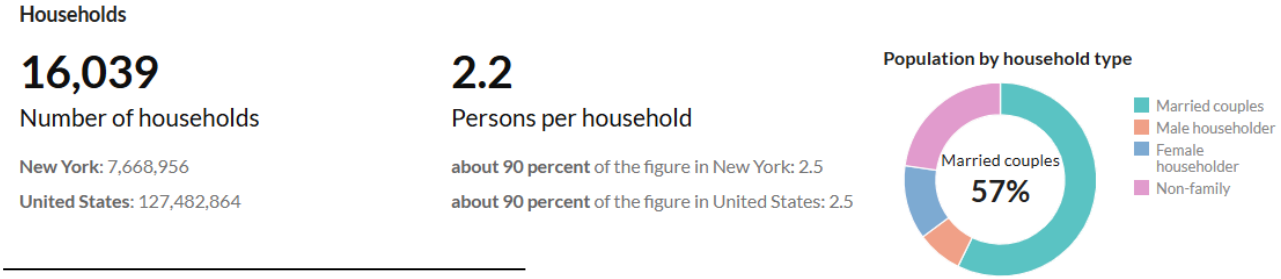


Source: US Census Bureau, ACS 5-Year Estimates, 2023

[1] New York State Governor's Press Office. (2025, June 30). Governor Hochul releases first-ever Master Plan for Aging, offering roadmap for aging New Yorkers [Press Release]. https://www.governor.ny.gov/news/governor-hochul-releases-first-ever-master-plan-aging-offering-roadmap-aging-new-yorkers

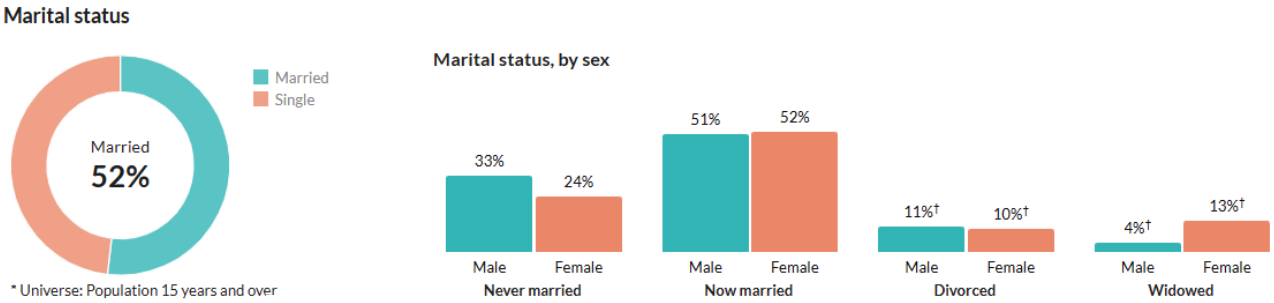
Family Status

Essex County households are smaller in size than the average household in NYS and the US. Married couples make up the majority of households, at 57%. The next largest category in Essex County is non-family households (23%), defined by the US Census Bureau as *a householder living alone (a one-person household) or where the householder shares the home only with people to whom he/she is not related (e.g., a roomate)*. This is higher than the NYS rate of 19%. There are fewer single-parent households in Essex County (4.8%) than in Upstate NY (5.3%) or NYS (6.0%).



Source: U.S. Census Bureau (2023). American Community Survey 5-year estimates. Retrieved from Census Reporter Profile page for Essex County, NY <http://censusreporter.org/profiles/05000US36031-essex-county-ny/>

Essex County has more married couples (52%) and fewer single individuals (48%) than NYS (47% and 53%, respectively), with the rates almost exactly reversed.

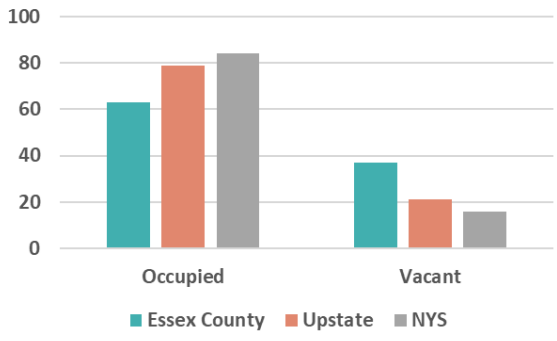


Source: U.S. Census Bureau (2023). American Community Survey 5-year estimates. Retrieved from Census Reporter Profile page for Essex County, NY <http://censusreporter.org/profiles/05000US36031-essex-county-ny/>

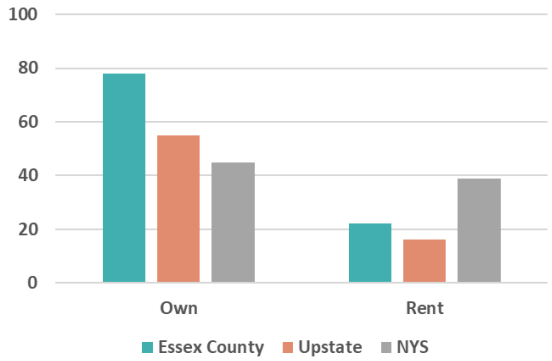
Housing

Essex County has a significantly higher housing vacancy rate than either Upstate NY or NYS as a whole. Of the occupied housing units, more are owner occupied versus renter occupied in Essex County when compared with Upstate and NYS.

Occupied vs. Vacant



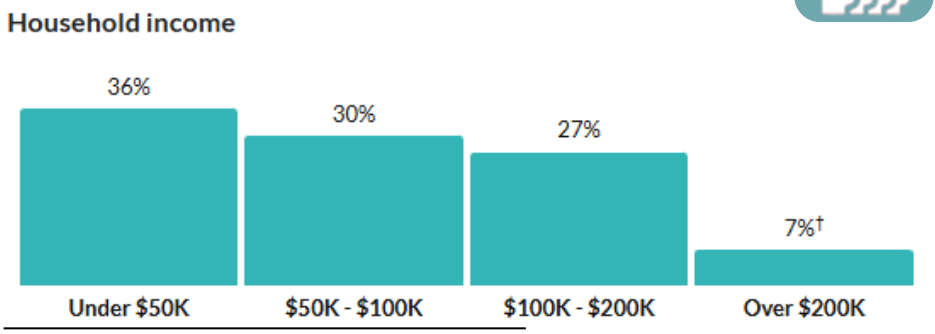
Own vs. Rent



Source: US Census Bureau, ACS 5-Year Estimates, 2023

Income & Poverty

The median household income in Essex County is $70,215. The median household income for NYS is $84,578. The per capita income for Essex County residents is $40,807 compared to NY's $48,847.



Source: U.S. Census Bureau (2023). American Community Survey 5-year estimates. Retrieved from Census Reporter Profile page for Essex County, NY <http://censusreporter.org/profiles/05000US36031-essex-county-ny/>

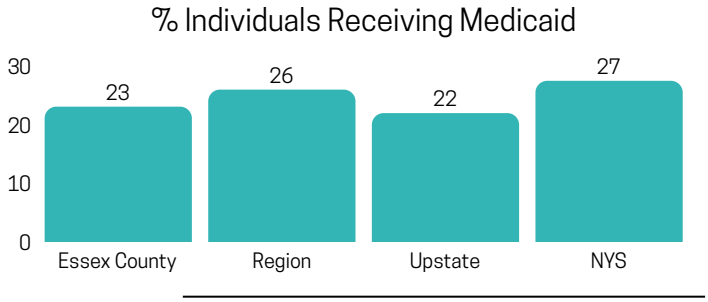
In Essex County, 11.8% of the population live below the poverty line. This is lower than both the regional rate (12.6%) and NYS rate (13.7%); however, it is higher than the Upstate rate of 11.1%.
More children live in poverty - almost 17% - than other populations in Essex County.

Poverty **11.8%** in Essex County

Medicaid Recipients **23.3%** in Essex County

Medicaid is a joint federal and state program that provides health coverage to low-income individuals and families, pregnant women, the elderly, and people with disabilities. Almost one quarter of residents in Essex County are receiving Medicaid.

Even at 23.3%, Medicaid coverage is lower in Essex County when compared to regional or state rates, but higher than the Upstate rate of 22%.

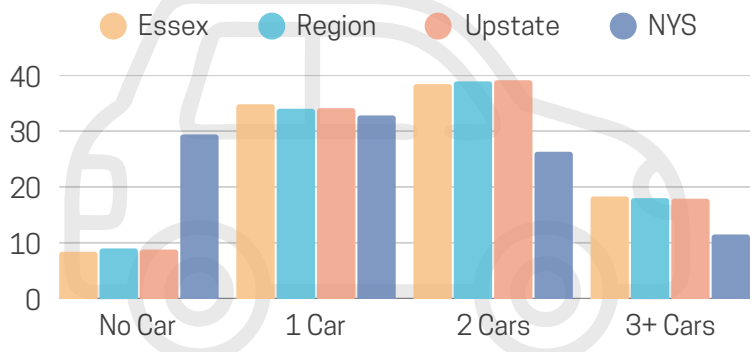


Source: US Census Bureau, ACS 5-Year Estimates, 2023

Transportation

Resident access to vehicles in Essex County is comparable to what other residents experience in most of New York State. A much higher proportion of New York City (NYC) residents (represented in the NYS category below) lack access to a vehicle; however, public transportation and walkable communities are features in NYC that Essex County lacks.

Availability of Vehicles



Source: US Census Bureau, ACS 5-Year Estimates, 2023

Public transportation in Essex County is limited and is primarily handled by Essex County Public Transportation (ECPT), which provides fixed-route bus service on weekdays and a demand-responsive "Transportation Service" for older adults, veterans, and those with medical needs. The county's bus services are mostly local, but connections are available to neighboring Clinton and Franklin counties.

Education

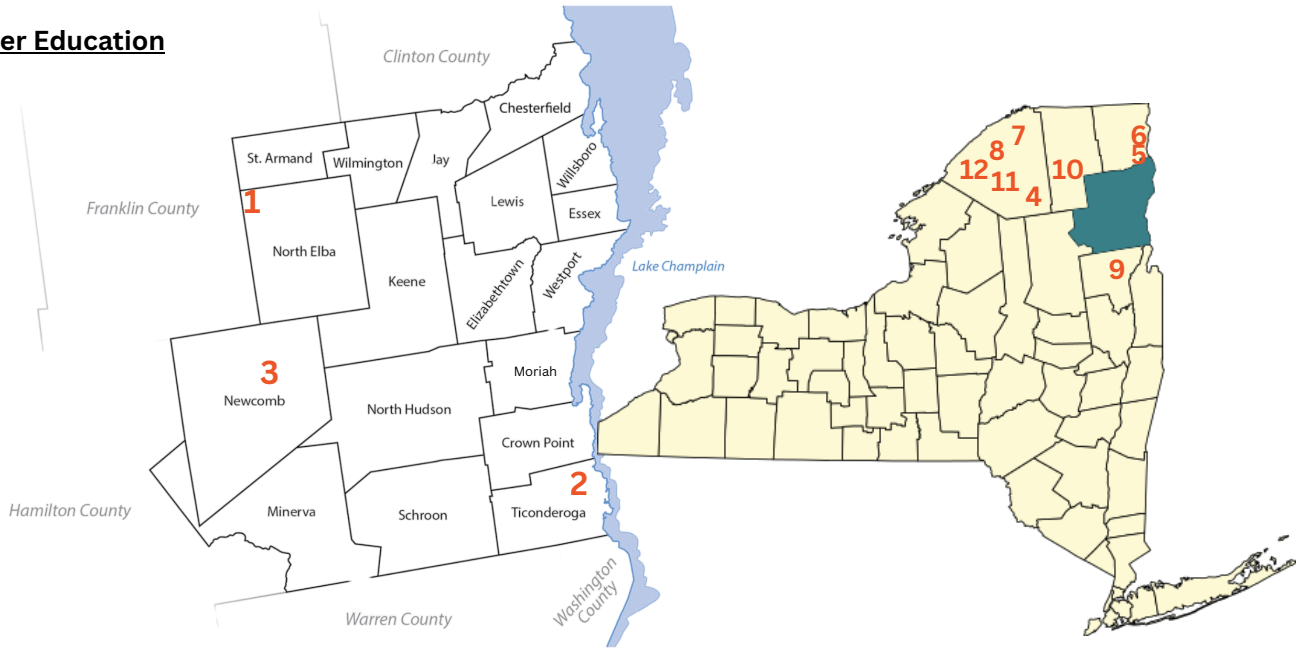
K-12 Schools

There are 10 public K-12 schools in Essex County and 5 private schools, serving various grades. Some of the public and private schools offer pre-school programs as well.

During the 2023-2024 school year, there was a total of 3,352 students across the 10 public school districts, approximately 480 students enrolled at the 5 private schools.

The four year graduation rate outcome as of August 2021 for a 9th grade cohort was 91% in Essex County, compared to 86% for NYS.

Higher Education



SUNY Colleges/Universities

North Country Community College

1 • Saranac Lake - Main Campus
2 • Ticonderoga - Extension

College of Environmental Science & Forestry

3 • Newcomb Campus
4 • Ranger School at Wanakena

5 Clinton Community College
6 Plattsburgh
7 Canton
8 Potsdam
9 Adirondack

Private Colleges/Universities

10 Paul Smith's College
11 St. Lawrence University
12 Clarkson University

North Country Community College (NCCC) is the only institution of higher learning based in Essex County. Proximity to population centers within the county is satisfied through the main campus in Saranac Lake and an extension campus in Ticonderoga. Other State University of New York (SUNY) campuses and private colleges/universities are located in nearby counties.

Vermont offers a few public and private colleges/universities at fairly close proximity to Essex County; however, out-of-state tuition can be a significant barrier to attending.

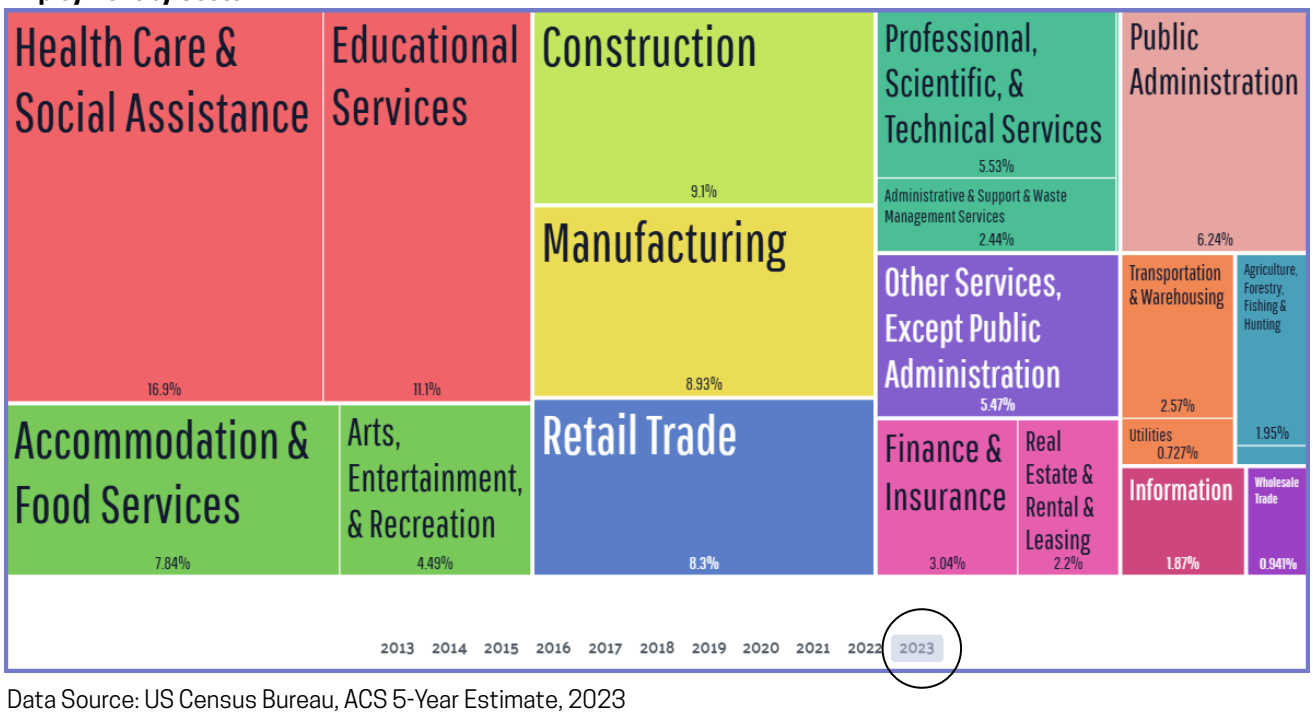
Employment

% Unemployed

2.8

After briefly reaching a high of 19.2% during the COVID-19 pandemic, the unemployment rate in Essex County has steadily declined to 30-year lows - fluctuating between 2.5-5.0% since 2021.[2-3] The labor force participation rate for individuals 16 years of age and older is 55.1%.[3] This is lower than the NYS rate of 61.1%, but is not unexpected due to the higher proportion of older adults that live here.

Employment by Sector

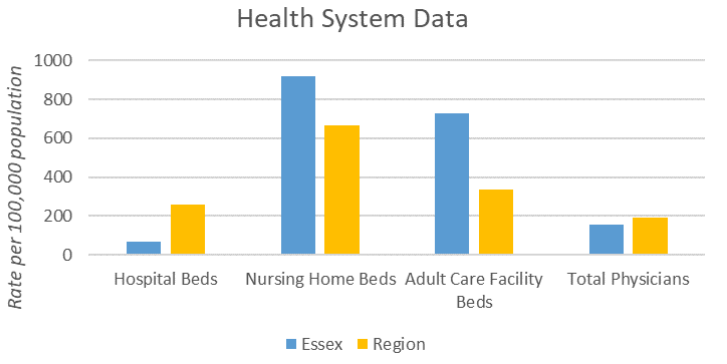


Data Source: US Census Bureau, ACS 5-Year Estimate, 2023
Image Source: Data USA

The most common employment sectors for those who live in Essex County, NY, are Health Care & Social Assistance, Educational Services, and Construction. When taken as a group though, Arts, Entertainment, Recreation, Hotel & Food Service (also known as hotel, restaurant, and tourism) is the second largest sector at 12.3%. The chart above shows the share breakdown of the primary industries for residents of Essex County, NY, though some of these residents may live in Essex County, NY and work somewhere else. Census data is tagged to a residential address, not a work address.

Health Care

With only one critical access hospital within its borders, Essex County has fewer hospital beds per 100,000 population than the regional average. Essex County also has fewer physicians than most counties in the region; however, there is good access to nursing home and adult care facility beds.



Source: US Census Bureau, ACS 5-Year Estimates, 2023
NYS Licensed Professions, NYSED, Office of Professions, January 2025
NYSDOH, NYS Health Profiles, May 2025

[2] https://fred.stlouisfed.org/series/NYESSE1URN
[3] US Census Bureau, ACS 5-Year Estimates, 2023

Access to primary care has improved considerably over the years in Essex County, with health centers located in the majority of towns (12 out of 18).

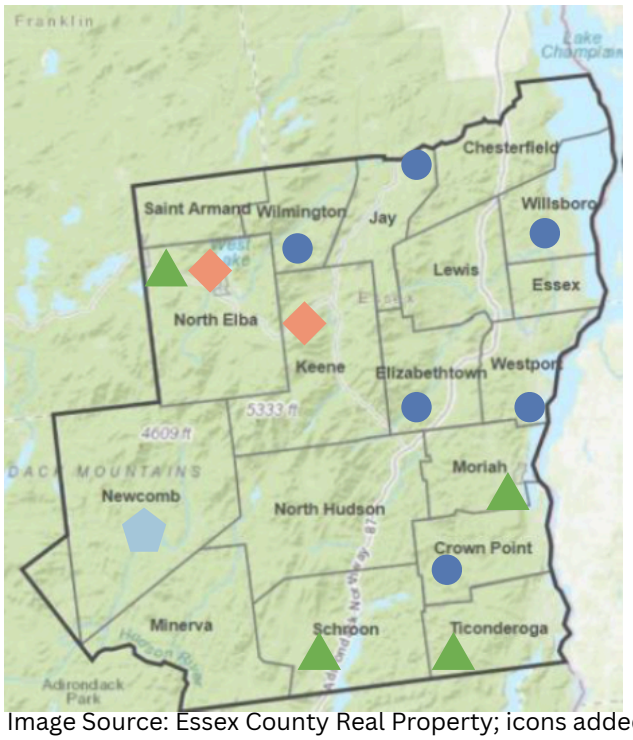


Image Source: Essex County Real Property; icons added

- University of Vermont Health - Elizabethtown Community Hospital - Health Centers
  - Ausable Forks (Town of Jay)
  - Crown Point
  - Elizabethtown
  - Westport
  - Willsboro
  - Wilmington
- Hudson Headwaters Health Network - Health Centers
  - Lake Placid (Town of North Elba)
  - Moriah
  - Schroon
  - Ticonderoga
- Adirondack Health - Health Centers
  - Keene
  - Lake Placid (Town of North Elba)
- Private Practice - Health Centers
  - Newcomb

Population Health Status Overview

2025 County Health Rankings[4]

County Health Rankings & Roadmaps (CHR&R) - or Rankings as noted here - a program of the University of Wisconsin Population Health Institute, draws attention to why there are differences in health within and across communities.

The County Health Snapshots (next page) provide two graphics displaying summaries of the county's **Population Health and Well-being** and **Community Conditions**. Each county in a state is represented by a dot, placed on a continuum from least healthy to healthiest in the nation. The color of each dot represents Health Groups, CHR&R's data-informed groupings of counties nationwide with similar Community Conditions or Population Health and Well-being.

These graphics indicate how a county fares relative to other counties in the state. They also indicate how counties fare on a national continuum of health.

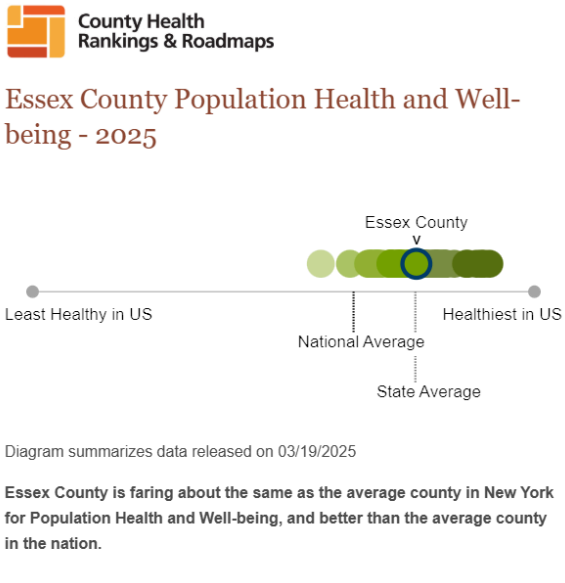
The Rankings have evolved over time. In previous years, the Rankings provided a numerical value for the categories of **Health Outcomes** and **Contributing Factors**. These numerical values ranged from 1 to 62 (number of counties in NYS), with 1 being the best ranking and 62 being the worst.

*Data Limitations: many of the indicators considered as part of the Rankings cannot be compared/trended from year-to-year because the Rankings use US Census Bureau vintage population estimates, which are updated each year, for the years between the official decennial census.

[4]University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2025. www.countyhealthrankings.org.

The 2025 Rankings place Essex County close to the state average for overall **Population Health and Well-Being** - and better than the average county when compared on a national scale.

For **Community Conditions**, Essex County performs slightly better than the average county in New York State and does better than the average county at the national level.



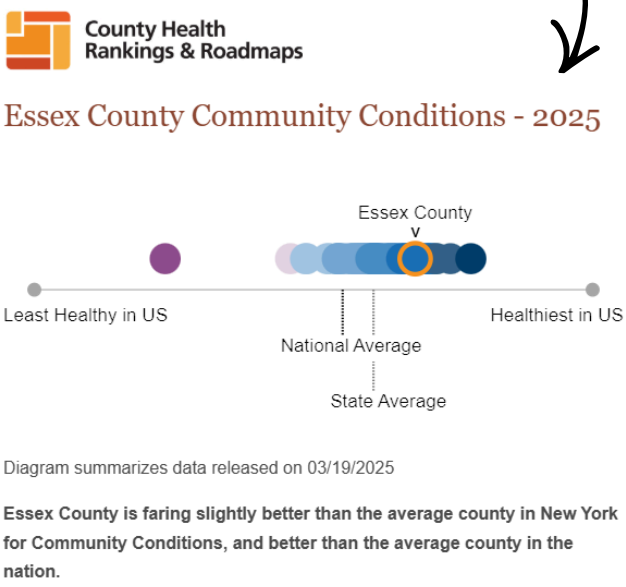


Image Source: www.countyhealthrankings.org

The tables below and on the next page list some select indicators reported in the Rankings, along with a comparison to the NYS value (percent, rate, ratio, etc.). The comparison is not meant to evaluate whether Essex County's indicator values are "good" or "bad", just how they compare to rest of state.

County Health Rankings Community Conditions Profile			
Indicator	**Essex**	**NYS**	**Comparison**
Health Infrastructure/Access			
% of fee-for-service Medicare enrollees who had an annual flu vaccination	51%	51%	=
% population with adequate access to locations for physical activity	100%	93%	↑
Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best)	8.8	8.7	↑
Ratio of population to primary care physicians	1960:1	1240:1	↑
Ratio of population to mental health providers	490:1	260:1	↑
Ratio of population to dentists	3690:1	1200:1	↑
Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees	2,018	2,595	↓
% of female Medicare enrollees ages 65-74 who received an annual mammography screening	43%	44%	↓
% of population under age 65 without health insurance	5%	6%	↓

Legend:

- ↑ Higher than state value
- ↓ Lower than state value
- = Equal to state value
- ● Worse than state value
- ● Better than state value

Data Source: www.countyhealthrankings.org

Table cont'd on next page

County Health Rankings Community Conditions Profile			
Indicator	**Essex**	**NYS**	**Comparison**
Physical Environment			
% of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities	11%	23%	⬇
% of the workforce that drives alone to work	73%	50%	⬆
Among workers who commute in their car alone, the percentage that communte more than 30 minutes	31%	39%	⬇
Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	3.2	6.9	⬇
Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation.	Yes	N/A	N/A
% of households with broadband internet connection	89%	90%	⬇
Library visits per person living within the library service area per year	2	3	⬇
Social & Economic Factors			
% of adults ages 25-44 with some post-secondary education	58%	71%	⬇
% of adults ages 25 and over with a high school diploma or equivalent	92%	88%	⬆
% of populaiton ages 16 and older unemployed but seeking work	3.8%	4.20%	⬇
Ratio of household income at the 80th percentile to income at the 20th percentile	4.4	5.8	⬇
% of people under age 18 in poverty	17%	19%	⬇
Number of deaths due to injury per 100,000 population	71	60	⬆
Number of membership associations per 10,000 population	14.9	7.9	⬆
Child care costs for a household with two children as a percent of the median household income	35%	38%	⬇

Data Source: www.countyhealthrankings.org

Legend:

- ⬆ Higher than state value
- ⬇ Lower than state value
- = Equal to state value
- 🔴 Worse than state value
- 🟢 Better than state value

Leading Causes of Death

The top two leading causes of death in Essex County for the past 5 years (2018-2022) have been heart disease and cancer. Chronic lower respiratory disease (CLRD) has been the 3rd or 4th leading cause of death in all five years. Diabetes, cerebrovascular disease (e.g. stroke), COVID-19, and unintentional injury have all made the top five causes, ranked 3 - 5, depending on the year; although diabetes and cerebrovascular disease have not made the top 5 causes in the last two years where data is available.

		Number of deaths and age-adjusted death rate					
		Total Deaths	#1 Cause of Death	#2 Cause of Death	#3 Cause of Death	#4 Cause of Death	#5 Cause of Death
Essex	2022	Total Deaths 514 796.7 per 100,000	Heart Disease 109 160.9 per 100,000	Cancer 97 141.1 per 100,000	CLRD 29 42.7 per 100,000	Unintentional Injury 28 59.0 per 100,000	COVID-19 21 29.4 per 100,000
	2021	Total Deaths 490 791.8 per 100,000	Heart Disease 94 144.4 per 100,000	Cancer 93 137.4 per 100,000	COVID-19 33 52.9 per 100,000	CLRD 26 37.6 per 100,000	Unintentional Injury 25 61.2 per 100,000
	2020	Total Deaths 468 749.9 per 100,000	Heart Disease 116 179.6 per 100,000	Cancer 88 137.3 per 100,000	CLRD 36 56.0 per 100,000	Cerebrovascular Disease 21 31.0 per 100,000	Diabetes 17 27.1 per 100,000
	2019	Total Deaths 487 780.8 per 100,000	Cancer 134 210.1 per 100,000	Heart Disease 86 135.0 per 100,000	Cerebrovascular Disease 24 35.0 per 100,000	CLRD 24 34.8 per 100,000	Diabetes 22 42.2 per 100,000
	2018	Total Deaths 407 653.4 per 100,000	Cancer 92 145.3 per 100,000	Heart Disease 83 132.8 per 100,000	CLRD 29 43.5 per 100,000	Unintentional Injury 18 35.5 per 100,000	Diabetes 15 21.9 per 100,000

Data Source: https://apps.health.ny.gov/public/tabvis/PHIG_Public/lcd/reports/#county

Increase Equity with Data

A Community Health Assessment integrates a combination of data that reflects and describes the characteristics, experiences, priorities and culture of the communities we serve[1]. A comprehensive CHA includes a combination of internal data from the health department and hospital systems, as well as external or community data from a variety of sources at the local, state and national levels.

This data analysis section is divided out by the Healthy People 2030 Social Determinants of Health Categories (image below), which are the basis for the five **Domains** of the NYS Prevention Agenda 2025-2030.

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

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

SDOH also contribute to wide health disparities and inequities.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments."[2]

In 2021 The Centers for Disease Control & Prevention (CDC) led a national effort to devise cross-cutting strategies for addressing SDOH. This effort resulted in a framework comprised of six pillars, pictured in image to the right.[3]

Currently, public health funding streams are not often tied to the underlying economic or social conditions that lead to poor health; therefore, this framework provides local health departments the mechanisms to work with community partners on SDOH issues while advocating for changes in how appropriations are made.

[1] Association for Community Health Improvement. (2020). *Community Health Assessment Toolkit*. American Hospital Association. Retrieved December 1, 2025 from https://www.healthycommunities.org/resources/toolkit/files/step4-collect-analyze

[2] Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved December 2, 2025, from https://health.gov/healthypeople/priority-areas/social-determinants-health

[3] Hacker K, Houry D. Social needs and social determinants: the role of the Centers for Disease Control and Prevention and public health. Public Health Rep. 2022; Sep 9:00333549221120244.

DOMAIN 1: ECONOMIC STABILITY

The Economic Stability domain encompasses the following priority areas:

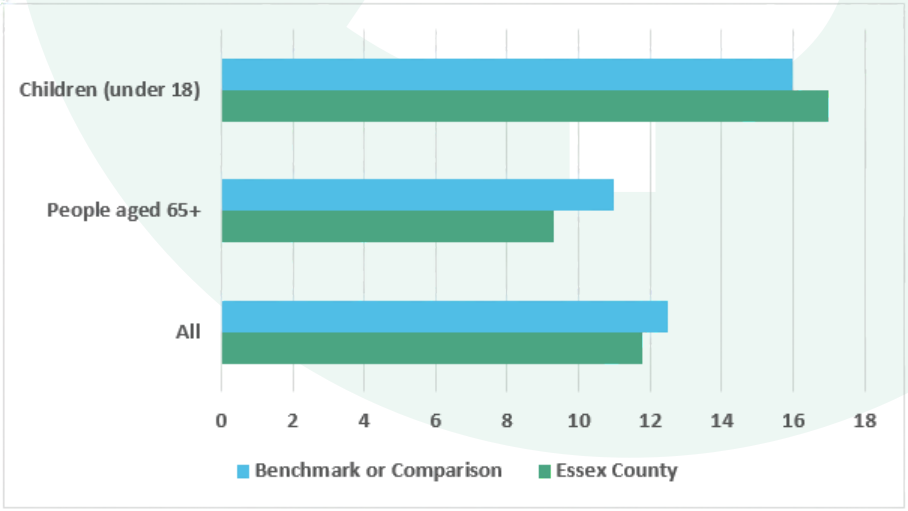
- Poverty
- Housing Stability & Affordability
- Unemployment
- Nutrition Security

Poverty

Poverty tends to be concentrated in distinct pockets - neighborhoods, regions, counties - where conditions like poor housing, higher crime, and more limited educational opportunities perpetuate circumstances beyond individual control.[4] Americans with lower incomes face bigger hurdles to accessing health care, paying for treatment and medications, and experience higher rates of chronic illness than those with higher incomes.[5] Across the U.S., children are more likely to live in poverty than adults aged 18-64 and those aged 65 and older.[6]

In Essex County, the poverty rate is 11.8%, which is below the *Healthy People 2030* target of 12.5%. The poverty rate for adults 65 years of age and older is 9.3%, which is below the Healthy People 2030 target of 11.0%. The rate of children in poverty in Essex County is almost 17%, or close to one in five. While there is no benchmark or target for this population, the national rate is 16.0%. Children who experience early and/or sustained poverty, are at risk of adverse health and developmental outcomes, such as low birth weight, infant mortality, language development, chronic illness, environmental exposure, nutrition, and injury. [7]

Figure 1: Percent of persons living below the poverty line



[4] U.S. Department of Agriculture, Economic Research Service. (n.d.) Rural poverty & well-being. Retrieved December 2, 2025, from https://www.ers.usda.gov/topics/rural-economy-population/rural-poverty-well-being/

[5] Khullar, D., & Chokshi, D. A. (2018). Health, income, & poverty: Where we are & what could help. Health Affairs Health Policy Brief. https://doi.org/10.1377/hpb20180817.901935

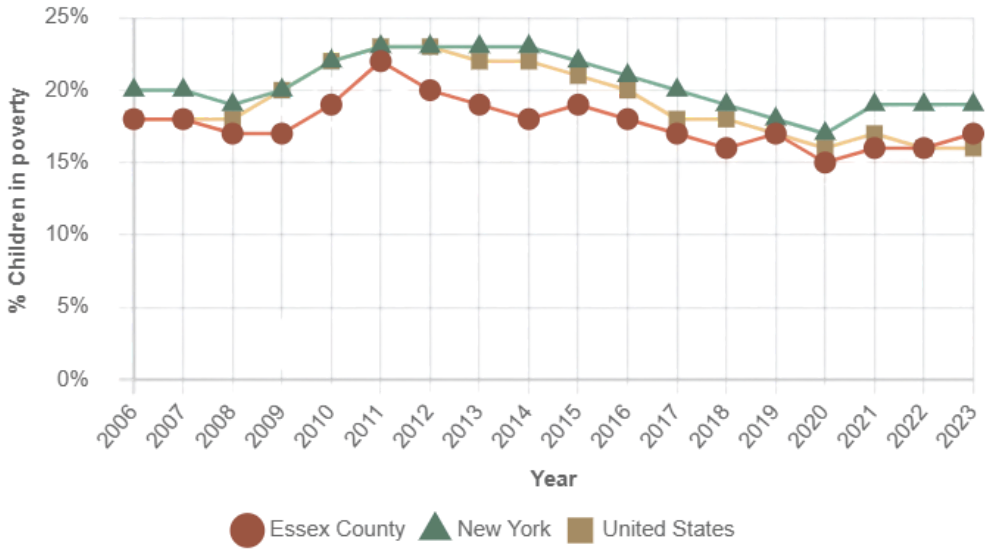
[6] Kaiser Family Foundation. (n.d.). Poverty rate by age. https://www.kff.org/other/state-indicator/poverty-rate-by-age/

[7] Council on Community Pediatrics, Gitterman, B. A., Flanagan, P. J., Cotton, W. H., Dilley, K. J., Duffee, J. H., Green, A. E., Keane, V. A., Krugman, S. D., Linton, J. M., McKelvey, C. D., & Nelson, J. L. (2016). Poverty and child health in the United States. Pediatrics, 137(4), e20160339. https://doi.org/10.1542/peds.2016-0339

Childhood Poverty

Childhood poverty trends in Essex County (Figure 2) follow state and national trends. Increases and decreases in poverty rates over the last two decades are closely linked with major economic events, such as the Great Recession and the COVID-19 Pandemic.

Figure 2: Childhood poverty in Essex County[8]



ALICE Households

Focusing solely on those living below the poverty line does not tell the whole story of economic stability in Essex County, NY. Many households are earning above the Federal Poverty Level (FPL) yet struggling to afford basic expenses. These households are designated as ALICE - **A**sset **L**imited, **I**ncome **C**onstrained, **E**mployed. ALICE households span all races, ages, and ethnicities and include individuals who often work more than one job, yet whose wages cannot keep up with the rising cost of goods and services.[9]

The Household Survival Wage (bottom row of Table 1), reflects the minimum wage needed to live in the current (2023) economy and includes housing, child care, food, transportation, health care, technology, and taxes. It **does not include** savings for emergencies or future goals, like college or retirement.

Household Survival Budget, Essex County, New York, 2023

Monthly Costs	Single Adult	One Adult, One Child	One Adult, One In Child Care	Two Adults	Two Adults Two Children	Two Adults, Two In Child Care	Single Adult 65+	Two Adults 65+
Housing	$867	$904	$904	$904	$1,027	$1,027	$867	$904
Child Care	$0	$391	$1,042	$0	$781	$2,146	$0	$0
Food	$532	$900	$808	$976	$1,637	$1,445	$490	$898
Transportation	$435	$558	$558	$654	$983	$983	$371	$526
Health Care	$196	$452	$452	$452	$775	$775	$528	$1,056
Technology	$86	$86	$86	$116	$116	$116	$86	$116
Miscellaneous	$212	$329	$385	$310	$532	$649	$234	$350
Taxes	$378	$375	$529	$459	$554	$879	$441	$761
Monthly Total	$2,706	$3,995	$4,764	$3,871	$6,405	$8,020	$3,017	$4,611
ANNUAL TOTAL	$32,472	$47,940	$57,168	$46,452	$76,860	$96,240	$36,204	$55,332
Hourly Wage	$16.24	$23.97	$28.58	$23.23	$38.43	$48.12	$18.10	$27.67

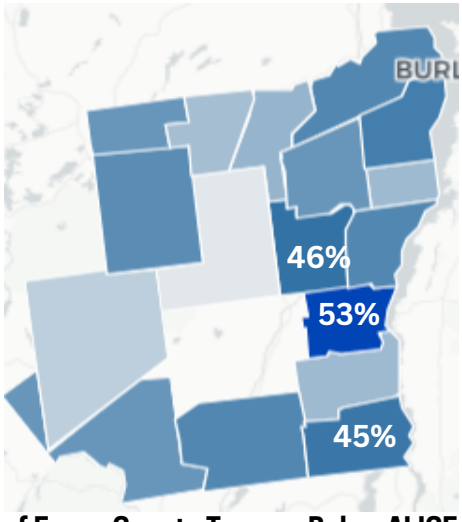
Table 1: Household Survival Budget, Essex County, NY, 2023

[8] University of Wisconsin Population Health Institute. *County Health Rankings & Roadmaps 2025*. Retrieved December 3, 2025 from www.countyhealthrankings.org

[9] UnitedForALICE (2023). *The State of ALICE in New York: ALICE in Essex County*. Retrieved December 4, 2025 from https://unitedforalice.org/county-reports/new-york#9/44.1448/-73.8158

The map to the right is shaded to show the percentage of households that are below the ALICE Threshold (poverty-level and ALICE households combined). The darker the blue, the higher the percentage. In Essex County, 41% of households live below the ALICE threshold. There are areas within the county that experience even higher economic instability - Moriah (53%), Elizabethtown (46%), and Ticonderoga (45%).

Within the town of Moriah, the hamlets of Witherbee and Port Henry have the highest percentages of their populations living below the ALICE threshold, at 66% and 60%, respectively.

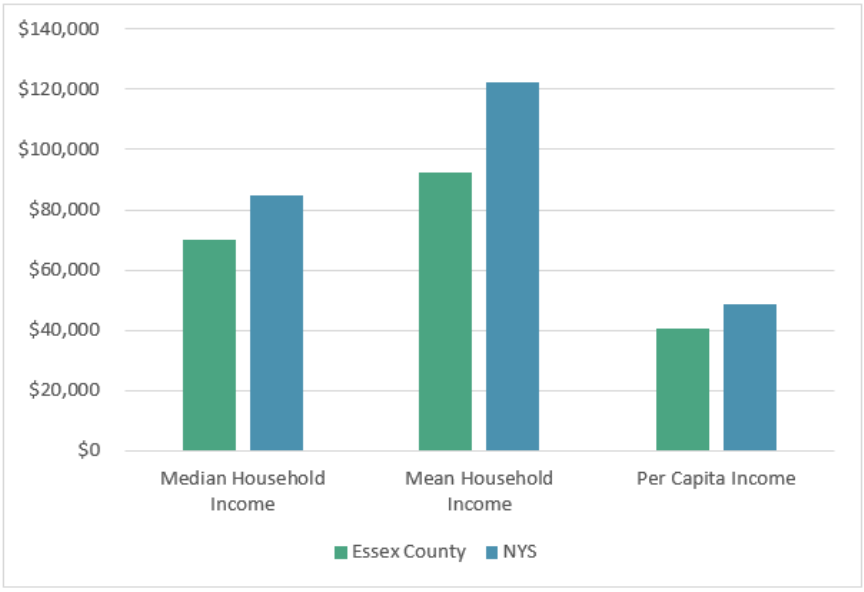


Map of Essex County Towns - Below ALICE

Income

Mean and median household income values are lower in Essex County than New York State, as is the per capita income (Figure 3). The median household income in Essex County grew from $68,090 in 2022 to $70,215 in 2023, a 3.12% increase. However, consumer prices for all items rose 3.4% from December 2022 to December 2023, indicating that wages are not keeping pace with inflation.[10]

Figure 3: Income in Essex County, 2023



Median Household Income

$70,215

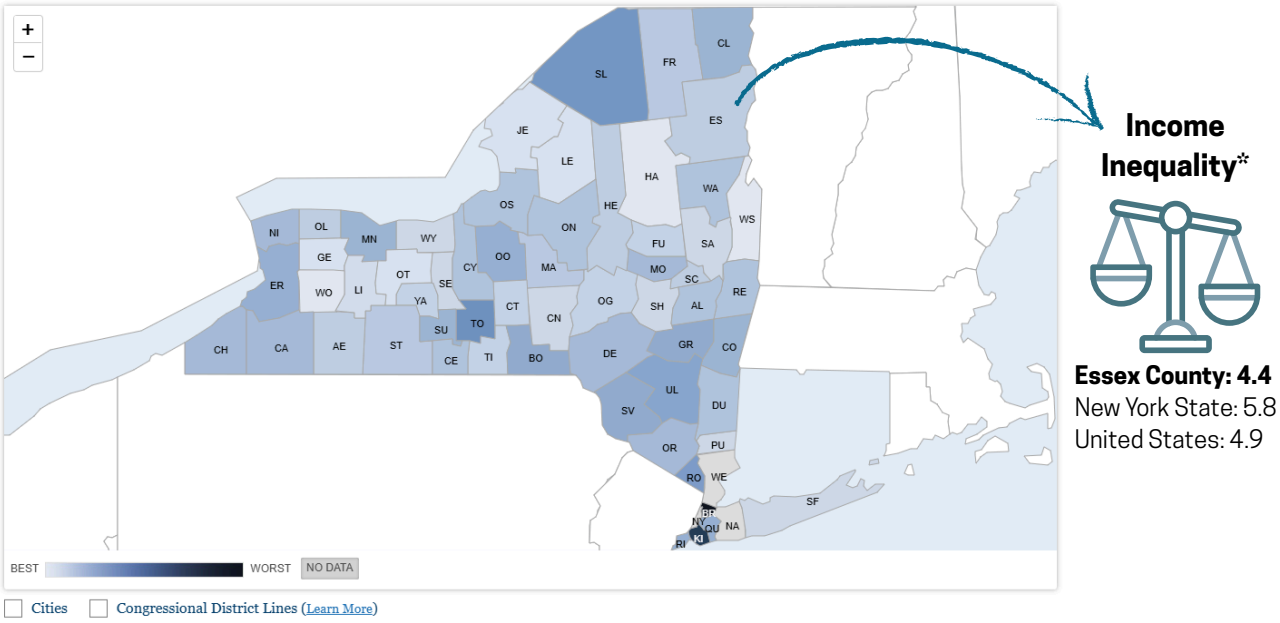
in Essex County

Income Inequality

Income inequality in a society is strongly connected to health, accentuating differences in social class and status and serving as a social stressor. Communities with greater income inequality can experience a loss of social connectedness, decreases in trust and social support, and can suffer far reaching health impacts, including increased risk of mortality, poor health, and cardiovascular disease.[11] Income inequality is not as pronounced in Essex County as in other areas of the state (Figure 4), though recent data suggest income inequality is accelerating (Figure 5).

[10] Bureau of Labor Statistics, U.S. Department of Labor, The Economics Daily, Consumer Price Index: 2023 in review at https://www.bls.gov/opub/ted/2024/consumer-price-index-2023-in-review.htm (visited December 04, 2025).
[11] University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2025. Retrieved December 3, 2025 from www.countyhealthrankings.org

Figure 4: Income Inequality in New York State, 2025

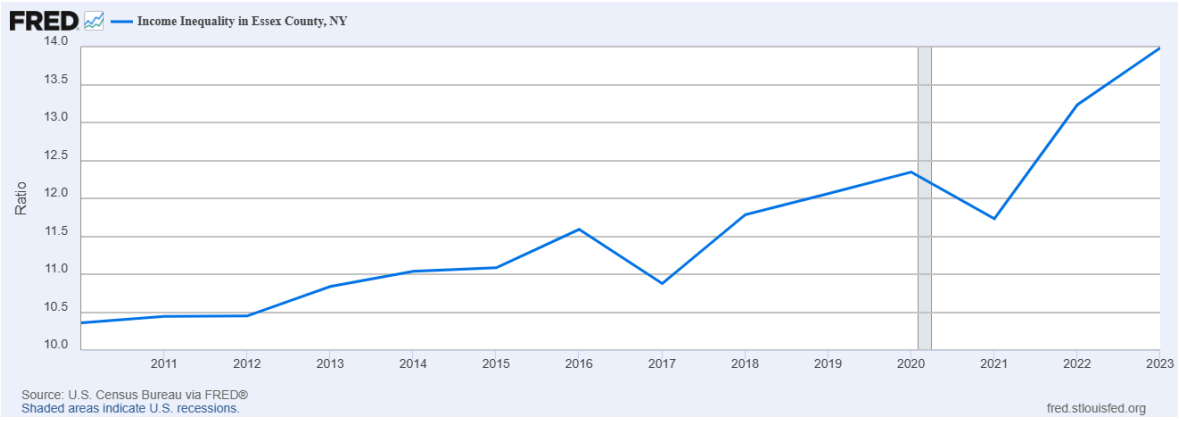


*Income inequality can be calculated/depicted in different ways. County Health Rankings uses the ratio of household income at the upper limit of the 80th percentile (4th quintile) to that at the upper limit of the 20th percentile (lowest quintile). In other words, when the incomes of all households in a county are listed from highest to lowest, the 80th percentile is the level of income at which only 20% of households have higher incomes, and the 20th percentile is the level of income at which only 20% of households have lower incomes. In Essex County, this ratio is 4.4. Meaning the top 20% of households have income that is 4.4 times more than the bottom 20%.

Looking at income inequality trends in Essex County, the Federal Reserve Bank of St. Louis (FRED) uses the ratio of the mean income for the highest quintile (top 20 percent) of earners divided by the mean income of the lowest quintile (bottom 20 percent) of earners in a particular county. In Essex County for 2023 (US Census Bureau ACS 5-Year Estimates), this ratio was 13.98.

Note: Multiyear estimates released in consecutive years consist mostly of overlapping years and shared data. For example, the 2010–2014 ACS 5-year estimates share sample data from 2011 through 2014 with the 2011–2015 ACS 5-year estimates. Because of this overlap, users should use extreme caution in making comparisons with consecutive years of multiyear estimates.

Figure 5: Income Inequality Trends in Essex County, 2010 - 2023

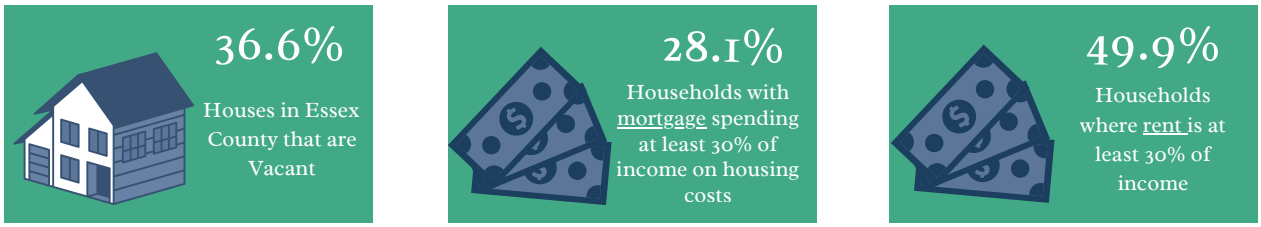


[12] U.S. Census Bureau, Income Inequality in Essex County, NY [2020RATIO036031], retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/2020RATIO036031, December 5, 2025.

Housing Stability & Affordability

Housing as a social determinant of health encompasses several aspects, including affordability, stability, quality and safety, and surrounding neighborhood. A lack of stable housing, including homelessness, is linked to higher rates of chronic illness and shorter life expectancies. Instability can also strain mental health and limit access to regular healthcare and connections to social support systems. High housing costs can burden families, leading to stress, and impossible choices about where to allocate funds, which can cause food insecurity, and delays in seeking medical care. This can also force people into lower-quality or less-safe housing. Substandard housing conditions can directly harm physical health through exposure to lead, mold, pests, poor air quality, and unsafe water. The neighborhood affects health through access to resources like grocery stores, safe spaces for physical activity and community, and job opportunities. Neighborhoods with high crime, violence, or vacant/abandoned/derelict properties contribute to poorer physical and mental health outcomes as well.[13]

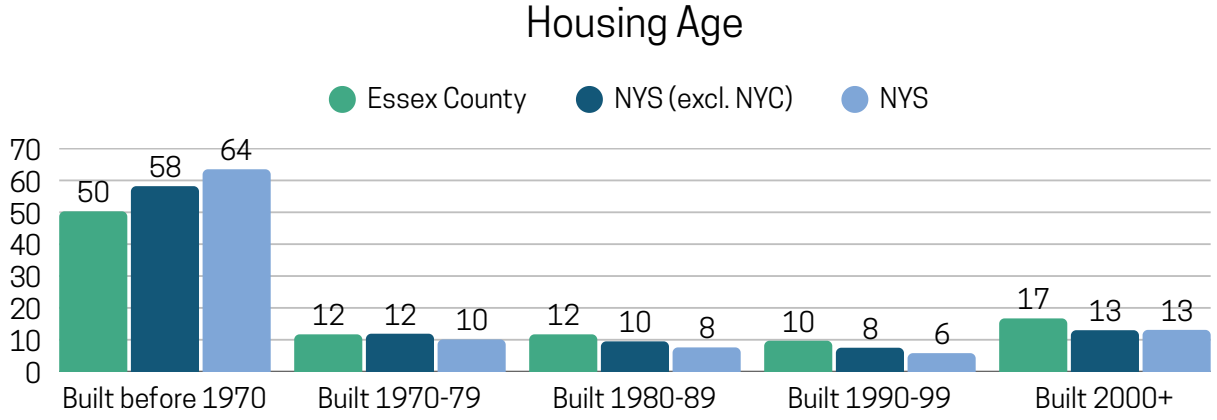
Housing Picture in Essex County

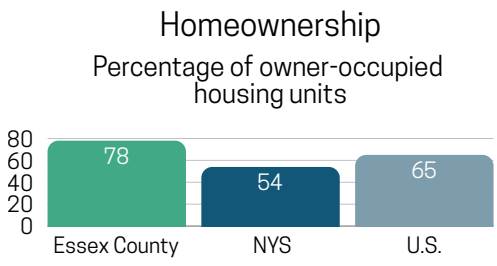


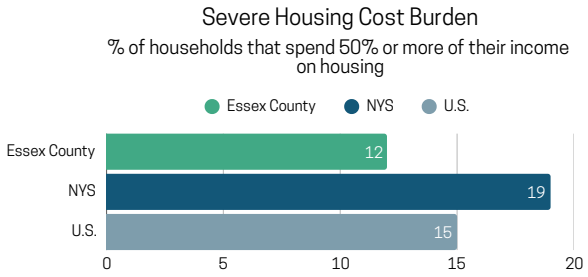
New York State: 15.9%
National Average: 10.4%

New York State: 32.7%
National Average: 27.5%

New York State: 51.5%
National Average: 50.4%







[13] U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. (n.d.). Quality of Housing. Retrieved December 4, 2025 from https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes

Affordable housing was cited as one of the most important features of a healthy community in the 2025 Community Survey of Essex County residents. It was also selected as the top need in that same survey. The issue of housing affordability and availability is not new here. In 2022, Essex County commissioned Asterhill Research Company to compile a Housing Data Report to define the market and identify trends and changes in housing. The report highlighted the following trends in Essex County with respect to housing affordability and availability:

- Declining population
- Growing tourism
- Increasing seasonal-recreation housing

Affordable housing was cited as a **top concern** in the 2025 Community Survey of Essex County Residents

The report concluded that there is an unmet demand for affordable housing in Essex County.[14]

A more recent housing report determined that between 193 and 250 new affordable and market-rate rental and for-sale primary and for-sale second/vacation/weekend units per year could be leased or sold in Essex County, better quantifying the housing need here.

The housing in Essex County is newer overall compared with housing in other parts of the state and homeownership rates are higher here than state or national averages. Essex County residents spend a slightly lower proportion of their incomes on housing - both owners and renters - than the average household in New York State. Renters are significantly more cost burdened (spending 30% or more of household income on rent) than homeowners. This is true in Essex County, New York State, and nationally. About 12% of households are severely cost burdened in Essex County - spending 50% or more of household income on housing - compared to 19% of NYS households and 15% nationally.

Unemployment

According to Healthy People 2030, employment is a social determinant of health because of its broad influence over many other aspects that impact health — including income, social status, health care access, housing, and economic security. Strategies that support educational attainment — such as student support services, financial aid programs for higher education, employment skill building, and job training programs — can help increase employment and positively affect the socioeconomic factors related to work. Additionally, resources and benefits in the workplace, including access to health insurance, paid sick leave, and remote work, can support positive health outcomes.[16]

55.1%

in labor force in Essex County

New York State: 62.8%
National Average: 63.5%

The employment rate in Essex County is lower than the rate at the state or national level. However, the *unemployment rate* is also lower in Essex County when compared to the state and national rates. This could be due to the significant population of older adults in Essex County, many of whom are retired and who are not looking for work. For younger populations, the cost of child care may result in one parent leaving the work force.

5.0%

unemployment rate in Essex County

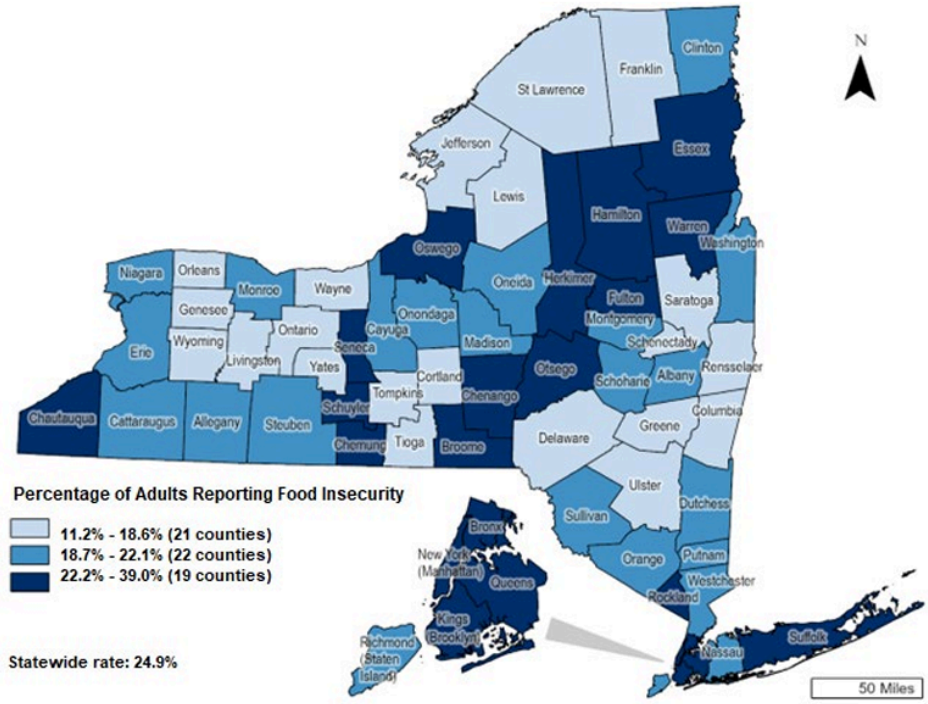
New York State: 6.2%
National Average: 5.2%

[14] Asterhill Research Company. (2022, May 24). *Essex County demographic and housing report with town profiles*. Essex County, NY.
[15] Zimmerman/Volk Associates, Inc. (2025). *An analysis of residential market potential for primary and second/ weekend/ vacation units in Essex County, New York*. Zimmerman/Volk Associates, Inc.
[16] Office of Disease Prevention and Health Promotion. (n.d.). *Social determinants of health*. Healthy People 2030. U.S. Department of Health and Human Services. https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Nutrition Security

Food insecurity is linked to negative health outcomes in children and adults, and it may cause children to have trouble in school.[2] More specifically, food insecurity and the lack of access to affordable, nutritious food is associated with poor dietary quality and an increased risk of diet-related diseases, including cardiovascular disease, diabetes, and certain types of cancer.[17]

Figure 6: *Self-Reported* Food Insecurity Among New York State Adults by County, BRFSS 2021[18]

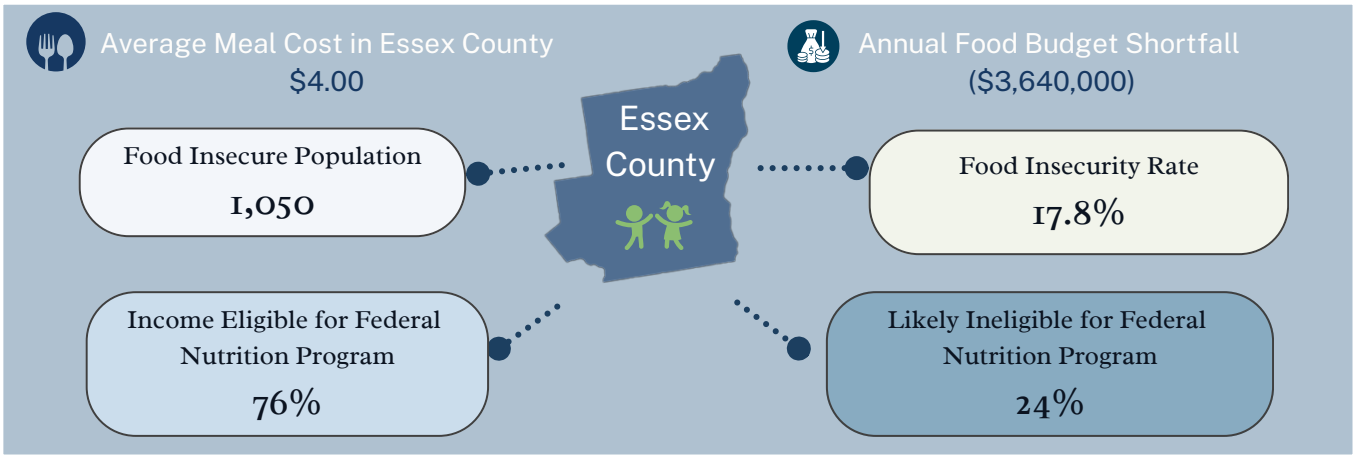


Food Insecurity

Essex County: 22.3%
New York State: 24.9%
Range: 11.2% - 39.0%

Almost one in four adults in Essex County reported that they were always, usually, or sometimes worried or stressed about having enough money to buy nutritious meals.

Figure 7: Food Insecurity among the Child Population in Essex County, NY, 2023[19]



[17] Odoms-Young A, Brown AGM, Agurs-Collins T, Glanz K. *Food Insecurity, Neighborhood Food Environment, and Health Disparities: State of the Science, Research Gaps and Opportunities*. Am J Clin Nutr. 2024 Mar;119(3):850-861. doi: 10.1016/j.ajcnut.2023.12.019. Epub 2023 Dec 30. PMID: 38160801; PMCID: PMC10972712.

[18] New York State Department of Health. (2023). *Self-Reported Food Insecurity Among New York State Adults by County, BRFSS 2021* (IFA 2023-12). https://www.health.ny.gov/statistics/prevention/injury_prevention/information_for_action/docs/2023-12_ifa_report.pdf

[19] Feeding America. (2024). *Map the Meal Gap 2024: Food Insecurity in the U.S.* [Food Insecurity among the Child Population in Essex County]. feedingamerica.org.

Food insecurity is often linked to multiple factors that can be difficult to completely address. In addition to obvious factors, like income and expenses, food insecurity can be the result of other social factors, like access to grocery stores within the surrounding community, availability of transportation, and societal barriers to opportunity.[19] *"People disproportionately impacted by food insecurity include, but are not limited to, children, many communities of color, households with low incomes, immigrant communities, LGBTQ+ individuals, people with disabilities, people in certain geographies (e.g., rural areas, cities, the South), people who are formerly incarcerated, and single-parent households."*[19]

DOMAIN 2: SOCIAL AND COMMUNITY CONTEXT

The Social and Community Context domain encompasses the following priority areas:

- Anxiety & Stress
- Depression
- Alcohol Use
- Suicide
- Tobacco/E-Cigarette Use
- Adverse Childhood Experiences
- Primary Prevention, Substance Misuse, & Overdose Prevention
- Healthy Eating

Anxiety & Stress

Persistent anxiety and chronic stress can profoundly affect overall health, both mentally and physically. According to the *New York State Prevention Agenda 2025–2030*, chronic stress leads to overactivation of the "fight or flight" response, which can negatively affect multiple organ systems and contribute to mental and behavioral health challenges such as depression, anxiety disorders, suicidal thoughts, and substance misuse. The plan highlights that frequent mental distress - often rooted in ongoing stress and anxiety - has been increasing among New Yorkers and is linked with poorer overall health outcomes, underscoring the importance of building resilience and coping skills across populations.[1]

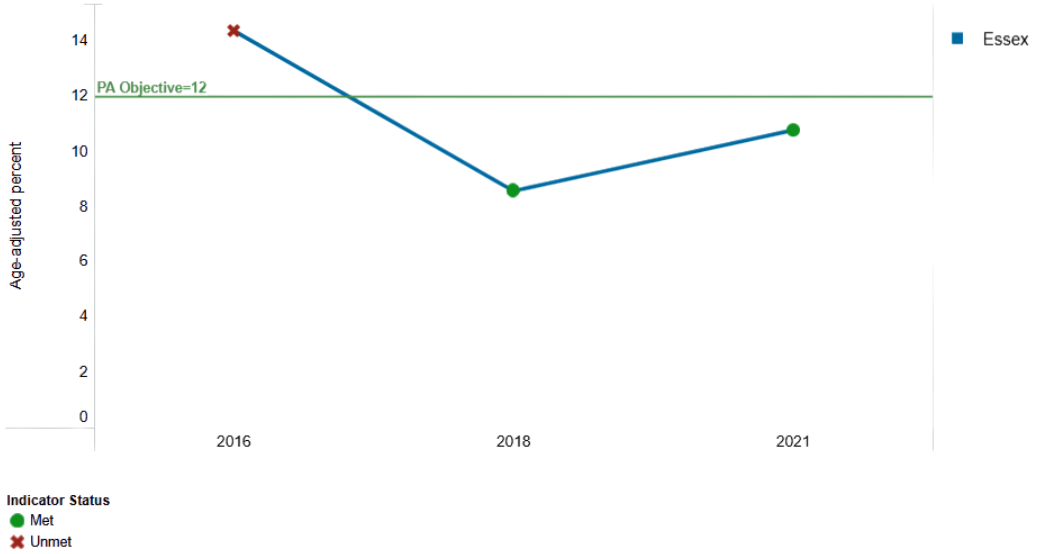
Anxiety and stress are reflected in *County Health Rankings & Roadmaps* measures of mental health because they influence quality of life and are linked with broader health outcomes at the community level. Both the *NYS Prevention Agenda Dashboard* and the *Rankings* include frequent mental distress as an indicator, which captures adults reporting 14 or more days of poor mental health per month. This metric shows how psychological distress, including chronic stress and anxiety, can become a measurable burden on communities and correlate with other health inequities within counties. Poor mental health not only reflects emotional challenges but is associated with reduced ability to work, engage socially, and maintain healthy behaviors, thereby linking stress and anxiety to physical health and quality of life outcomes across populations. The *County Health Rankings* data thus emphasize that higher levels of stress-related distress at the county level are an important component of overall health and help identify where targeted public health actions can improve well-being.[2]

According to the NYS Prevention Agenda Dashboard, the percentage of adults experiencing frequent mental distress during the past month in Essex County is 10.8%, which is below the Prevention Agenda objective of 12.0% (Figure 8). This indicator value is from the 2021 Behavioral Risk Factor Surveillance System BRFSS.

[1] New York State Department of Health. (2024). *Prevention Agenda 2025–2030: New York State's health improvement plan*. New York State Department of Health. Retrieved December 16, 2025 https://health.ny.gov/prevention/prevention_agenda/

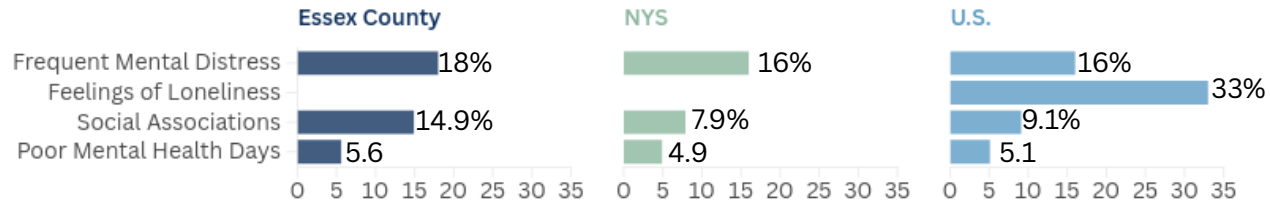
[2] University of Wisconsin Population Health Institute. (2025). *County Health Rankings & Roadmaps 2025: Building power for health and equity*. https://www.countyhealthrankings.org

Figure 8: Percentage of adults experiencing frequent mental distress during the past month, age-adjusted, aged 18 years and older[3]



The *2025 County Health Rankings* report frequent mental distress and several other indicators that provide a more complete picture of mental health, community connections, stress, and anxiety. The indicator data in Figure 9 are all from the 2022 BRFSS, except for the Social Associations data, which is from the 2022 County Business Pattern dataset of the U.S. Census Bureau. According to this data, Essex County residents (adults aged 18 years and older) report feeling frequent mental distress and having poor mental health days more often than their state and national counterparts. Essex County residents report belonging to social groups/associations more often, which can help alleviate social isolation and loneliness.

Figure 9: Percentage of adults experiencing frequent mental distress during the past month, age-adjusted, aged 18 years and older[2]



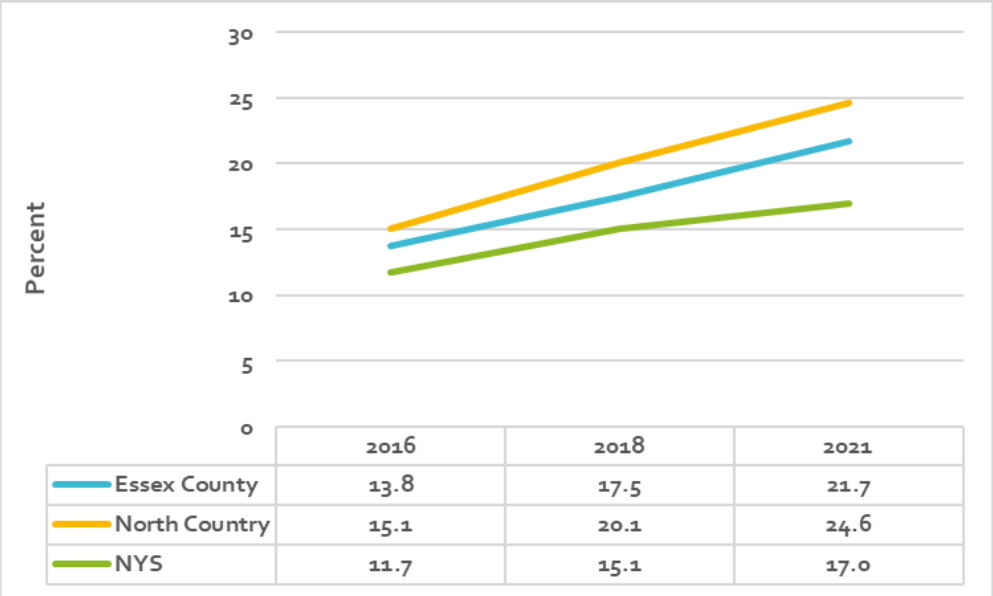
[3] New York State Department of Health. (n.d.). *Prevention Agenda dashboard. New York State Department of Health.* https://apps.health.ny.gov/public/tabvis/PHIG_Public/pa/

Depression

Depression is among the most prevalent mental health conditions in the United States, with symptoms that can vary from mild to severe and significantly interfere with daily functioning. It is associated with higher health care utilization and costs and is commonly linked to chronic conditions such as heart disease and diabetes. In addition, depression increases the risk of suicidal thoughts and behaviors, making it a serious concern for both individual and public health.[4]

The percentage of adults reporting a depressive disorder is increasing in Essex County, with corresponding increases across the North Country region and New York State (Figure 10). Although better awareness, diagnosis, and reporting may account for some of this increase, other factors like social isolation, economic strain, inequality, digital disruptions, etc. are likely also contributing.[5]

Figure 10: Percentage of adults reporting a depressive disorder[6]



	2016	2018	2021
Essex County	13.8	17.5	21.7
North Country	15.1	20.1	24.6
NYS	11.7	15.1	17.0

Mental health was cited as a **top concern** in the 2025 Community Survey of Essex County Residents

[4] National Institute of Mental Health. (n.d.). Depression. Retrieved from https://www.nimh.nih.gov/health/topics/depression/index.shtml

[5] Centers for Disease Control and Prevention. (2025). *Depression prevalence in adolescents and adults: United States, August 2021–August 2023* (NCHS Data Brief No. 527). https://www.cdc.gov/nchs/data/databriefs/db527.pdf

[6] New York State Department of Health. (2023). Behavioral Risk Factor Surveillance System (BRFSS) health indicators by county and region: 2016, 2018, 2021. Retrieved from https://health.data.ny.gov

Alcohol Use

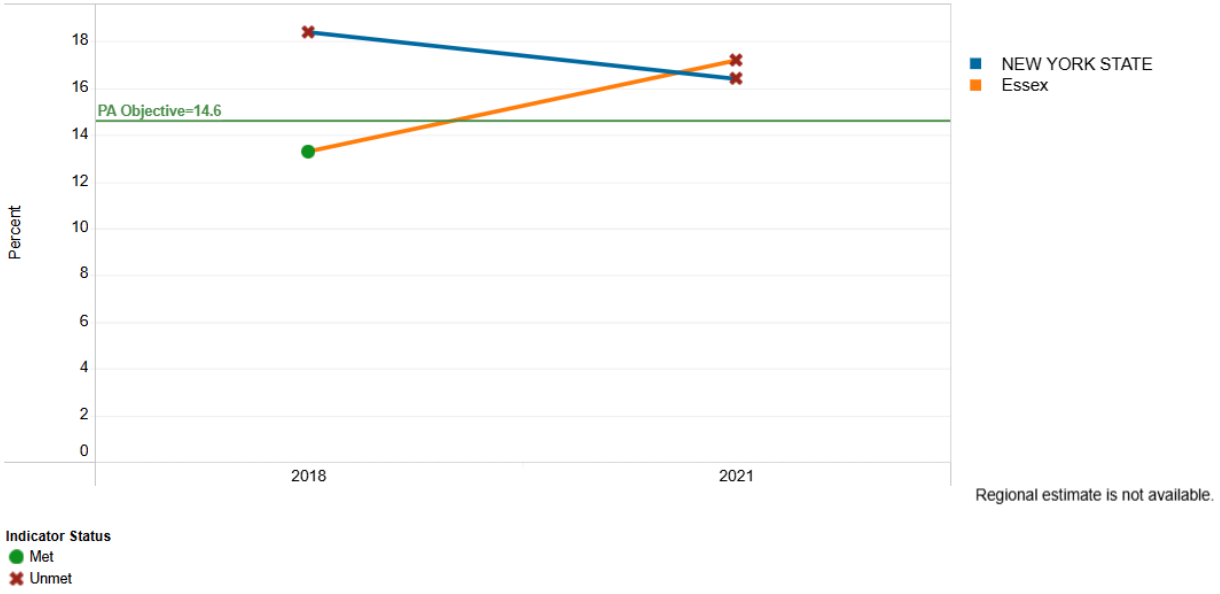
Several key measures are used to monitor alcohol use and related health outcomes. Excessive alcohol use—including binge and heavy drinking, underage drinking, and alcohol use during pregnancy—is linked with significant mortality (about 178,000 deaths annually in the U.S.) and social and health harms.[7] Alcohol consumption raises the risk of developing several different types of cancer, including:

- Mouth
- Throat (pharynx)
- Voice box (larynx)
- Esophagus
- Colon and rectum
- Liver
- Breast (in women)

Some studies show that drinking three or more drinks that contain alcohol per day increases the risk of stomach and pancreatic cancers. Drinking alcohol may also increase prostate cancer risk.[8]

NYS Prevention Agenda data indicate that binge or heavy drinking has increased among Essex County adults from 2018 to 2021, from 13.3% to 17.2%. During the same time frame, binge or heavy drinking decreased in NYS from 18.4% in 2018 to 16.4% in 2021. Prevalence in both Essex County and NYS in 2021 is above the Prevention Agenda Objective of 14.6% (Figure 11).

Figure 11: Prevalence of binge or heavy drinking among adults, aged 18 years of age or older[3]

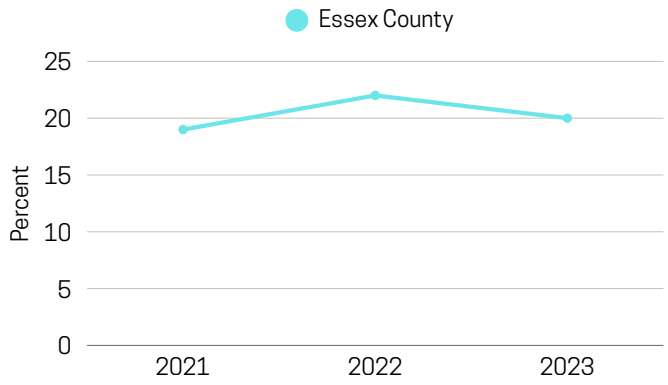


[7]Centers for Disease Control and Prevention. (n.d.). *Chronic Disease Indicators: Alcohol*. https://www.cdc.gov/cdi/indicator-definitions/alcohol.html

[8]Centers for Disease Control and Prevention. (June 11, 2025). *Alcohol use and cancer*. https://www.cdc.gov/cancer/risk-factors/alcohol.html

Looking at more recent data available from County Health Rankings and CDC Places data, the *age-adjusted rates* for binge and heavy drinking are graphed in Figure 12 below. The upward trend continues for Essex County through 2022 and begins to decline in 2023. More data is needed to determine if this change will be sustained, though recent national polls show a marked decrease in drinking for younger generations.[9]

Figure 12: Prevalence of binge or heavy drinking among adults, age adjusted[2, 10]



Student reported alcohol use in trending down in Essex County, though use still remains high when compared to national benchmarks (Monitoring the Future survey).[11] By the time they reach 12th grade, slightly over 50% of Essex County students report ever using alcohol, with 30% reporting use in the past 30 days (Figure 13). For all grades surveyed (7 - 12), a little over 30% report ever using alcohol, with about 1 in 4 reporting use in the past 30 days (Figure 14).

Figure 13: Percentage of student self-reported alcohol use - Essex County 12th Grade

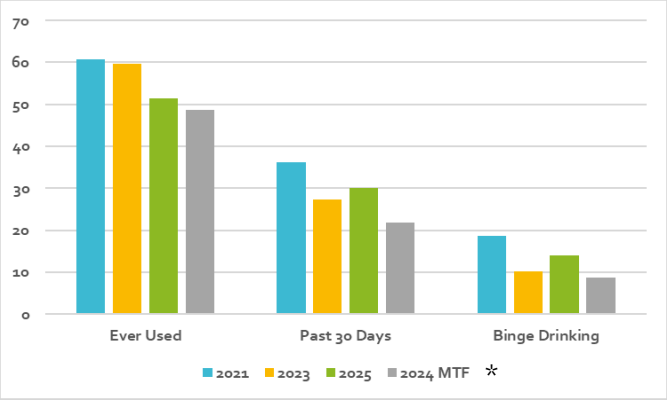
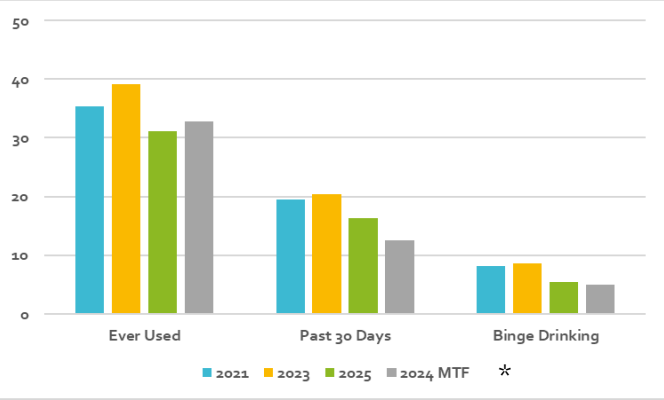


Figure 14: Percentage of student self-reported alcohol use - Essex County All Grades Surveyed



*Monitoring The Future national data

[9] Johns Hopkins Bloomberg School of Public Health. (2025). *The health risks of drinking alcohol*. https://publichealth.jhu.edu/2025/the-health-risks-of-drinking-alcohol
[10] Centers for Disease Control and Prevention. (2023). *PLACES: Local data for better health*. https://www.cdc.gov/places
[11] Essex County Youth Bureau. (2025). *Essex County Prevention Needs Assessment survey*. Essex County [NY] Youth Bureau.

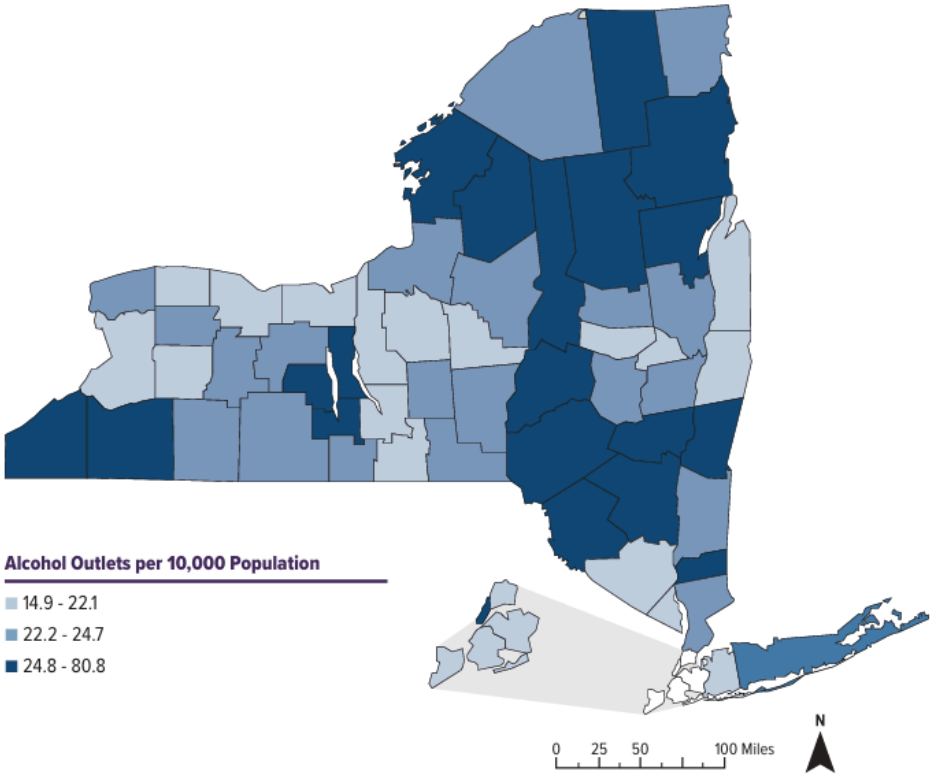
The New York State Department of Health recognizes that health outcomes are strongly shaped by social, economic, and environmental inequalities, often more than by individual behavior alone. Patterns of alcohol use and related harms differ across population groups, with some communities experiencing a disproportionate impact. Although non-Hispanic Black and Hispanic adults historically report lower rates of binge and heavy drinking than non-Hispanic White adults, they frequently suffer higher levels of alcohol-related harm. Factors such as higher concentrations of alcohol retailers, greater access to alcohol, and targeted alcohol marketing—particularly when reinforced by structural racism—contribute to these unequal burdens of excessive alcohol use and its consequences.[12]

Data available for Essex County in this area include alcohol outlet density, with more availability often exacerbating the harmful effects of alcohol, disproportionately experienced in under-resourced communities and communities of color.[13]

Alcohol outlet density can be expressed as the number of outlets in the county relative to the number of people living in the county or the geographic size of county (i.e., number of square miles). In New York counties, alcohol outlet density is positively correlated with binge and heavy drinking when measured relative to the population level, however, outlet density is not correlated with binge and heavy drinking when measured relative to square mile.[13]

Essex County has the 3rd highest on-premises alcohol outlet density and the 2nd highest off-premises alcohol outlet density in the state (per 10,000 population) - Figures 16 and 17.

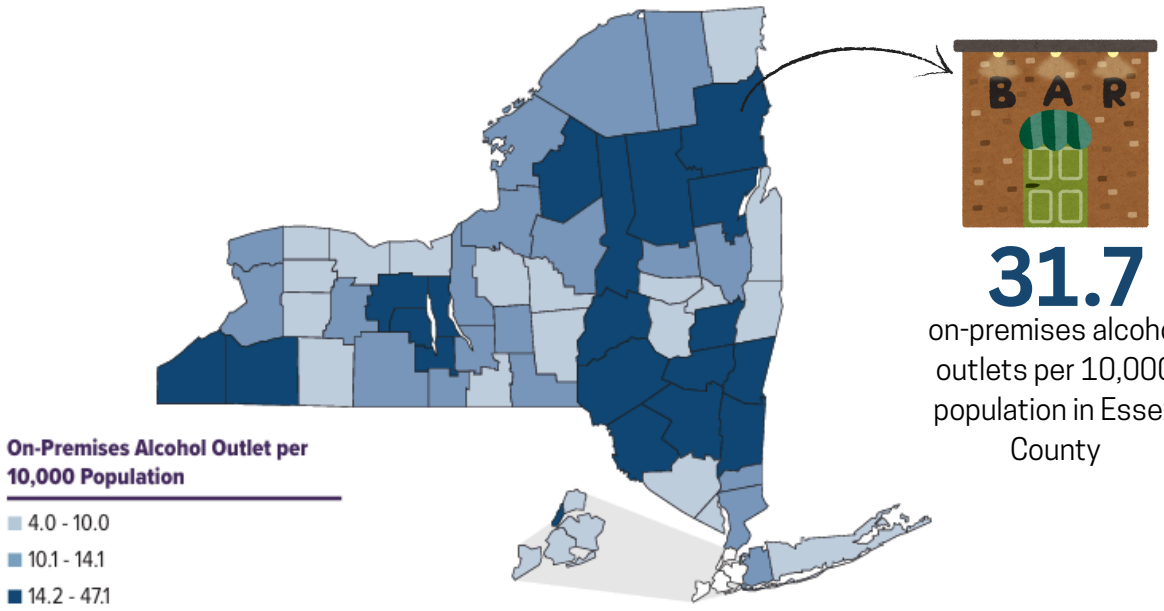
Figure 15: Total Alcohol Outlets per 10,000 Population in New York[13]



[12] Balu, R. K., Lurie, M., Brissette, I., & Battles, H. (2024). *Binge and heavy drinking (New York State BRFSS Brief No. 2025-03).* New York State Department of Health, Division of Chronic Disease Prevention, Bureau of Chronic Disease Evaluation and Research.

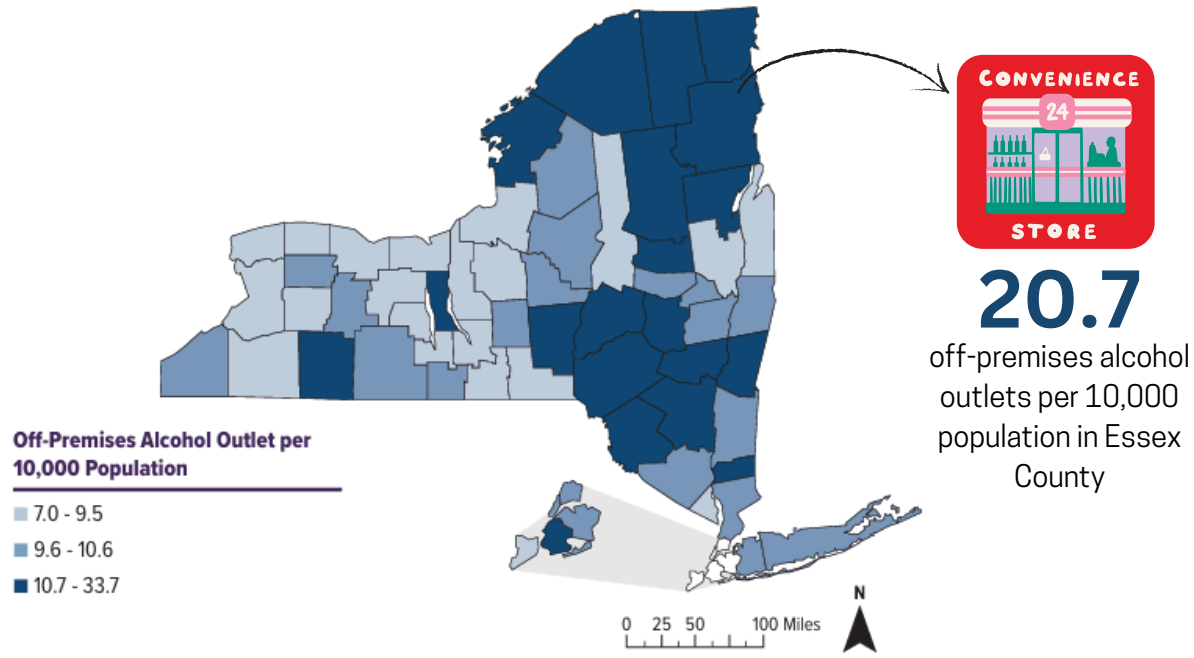
[13] New York State Department of Health, Alcohol Surveillance and Epidemiology Program. (2025). *Alcohol outlet density in New York State* (Information for Action Report No. 2025-15). Albany, NY: New York State Department of Health

Figure 16: On-Premises Alcohol Outlets per 10,000 Population in New York[13]



On-Premises Outlets: Outlets include bars, clubs, producers (wineries, breweries) and restaurants, licensed as of March 2023. Does not include seasonal and other wholesale outlets.

Figure 17: Off-Premises Alcohol Outlets per 10,000 Population in New York[13]

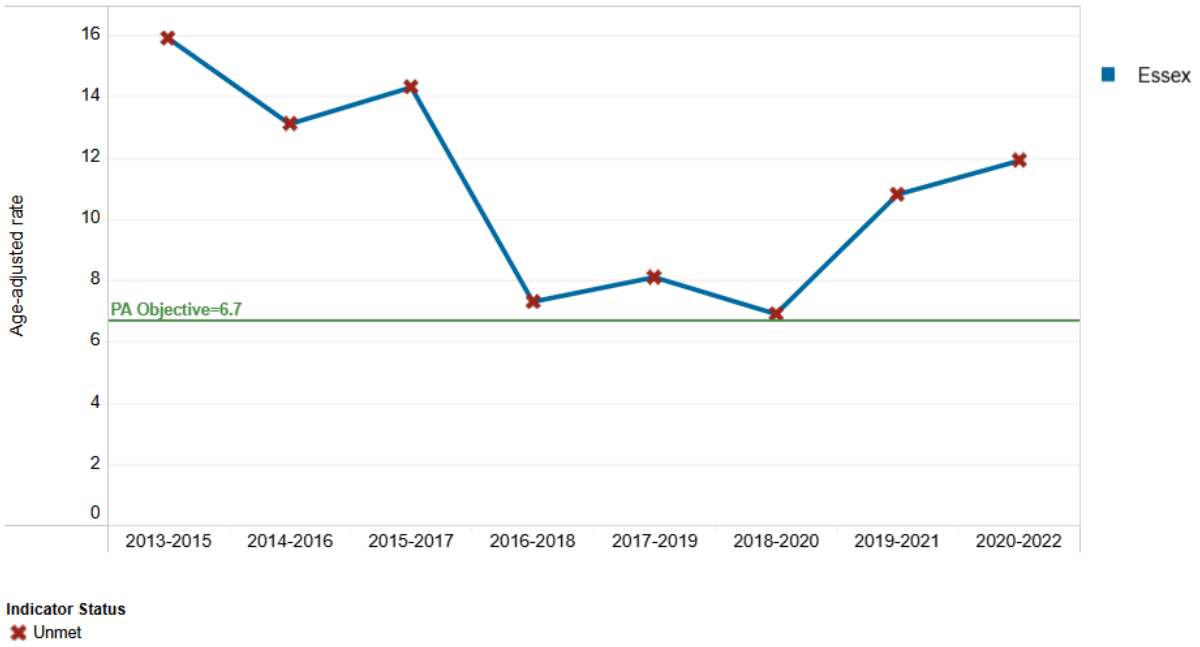


Off-Premises Outlets: Outlets include liquor stores, big-box retailers, grocery stores, small convenience stores, gas stations and pharmacies licensed as of March 2023. Does not include seasonal and other wholesale outlets

Suicide

Suicide is a major public health concern that significantly affects individuals, families, and communities across the United States. The Centers for Disease Control and Prevention (CDC) identifies suicide as a leading cause of death, emphasizing the strong links between suicide risk and factors such as mental health conditions, substance use, social isolation, and economic stressors.[14] Addressing suicide prevention is a priority in the *New York State Prevention Agenda 2025–2030*, which highlights the importance of upstream, community-based strategies that promote mental well-being, reduce health inequities, and improve access to behavioral health services.[1] Similarly, Healthy People 2030 prioritizes reducing suicide rates nationwide by strengthening protective factors, expanding access to mental health care, and improving data-driven prevention efforts.[15]

Figure 18: Suicide mortality, age-adjusted rate per 100,000 population[3]



After experiencing a declining trend in suicide rates from 2013-2020, suicide has been increasing in Essex County since 2020 (Figure 18). Additional indicators for this priority area are covered under Domain 3, Injuries and Violence.

There are many factors that increase suicide risk - ranging from the individual up to the community and societal levels. Suicide has connections to other forms of violence; people who have experienced violence, including child abuse, bullying, or sexual violence, have a higher suicide risk.[14]

[14] Centers for Disease Control and Prevention. (2025, March 26). *About suicide prevention*. U.S. Department of Health and Human Services. Retrieved from https://www.cdc.gov/suicide/about/index.html
[15] U.S. Department of Health and Human Services. (n.d.). *Healthy People 2030: Reduce the suicide rate — MHMD-01*. Office of Disease Prevention and Health Promotion. Retrieved from https://health.gov/healthypeople/objectives-and-data/browse-objectives/mental-health-and-mental-disorders/reduce-suicide-rate-mhmd-01

Tobacco/E-Cigarette Use

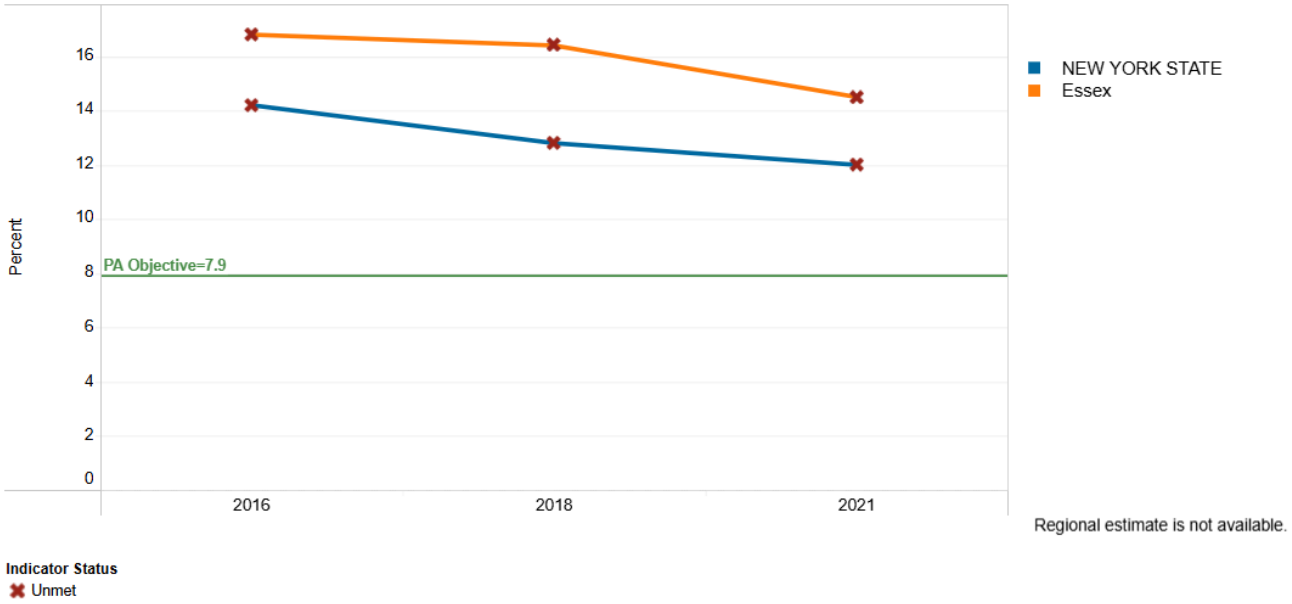
In Essex County, New York, smoking remains a notable public health concern, with about 15% of adult residents reporting that they currently smoke cigarettes, a rate that is higher than NYS prevalence and contributes to preventable disease burden locally (Figure 19).

Cigarette smoking is linked to serious health issues including cardiovascular disease, respiratory illnesses, and cancer, and is one of the leading causes of preventable death in the United States, causing hundreds of thousands of deaths annually and shortening life expectancy by at least a decade for many smokers.[16]

Disparities are observed with higher smoking prevalence among residents with lower income, disabilities, lower educational attainment, and those behavioral health conditions, highlighting ongoing challenges in tobacco control and cessation support.[17]

Addressing smoking through prevention, cessation resources, and policy measures remains crucial to improving health outcomes and reducing chronic disease risk locally and statewide.

Figure 19: Prevalence of cigarette smoking among adults, aged 18 years and older[3]

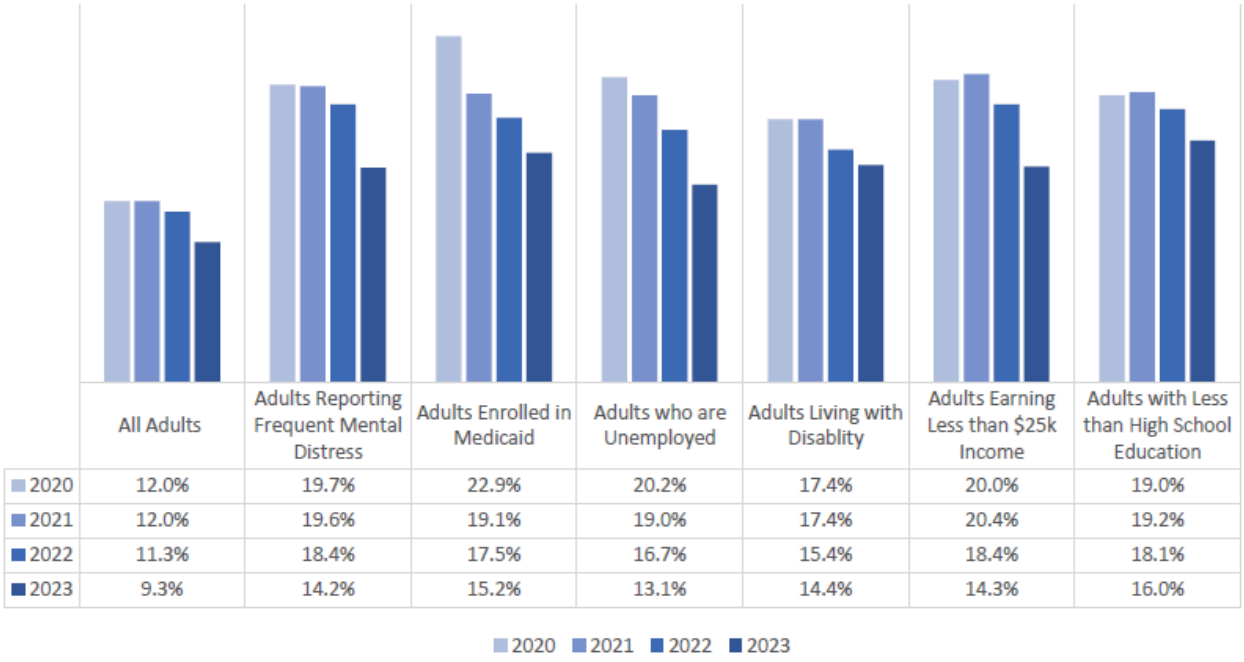


Smoking rate disparity information is available for several demographic categories at the state level (Figure 20 on page 58). The only current disparity data available for Essex County is the rate for for adults living with a disability - 30.1% (Figure 21 on page 58), which is an unreliable estimate. Previously available data (2018 BRFSS) for adults with household incomes below $25,000 and adults living with a disability trended in line with state level data, indicating the likelihood that Essex County would experience the same disparities across other demographic categories (employment, education, levels of mental distress, etc.). The good news - smoking rates are declining across all groups and continue to decline overall in Essex County.

[16] Centers for Disease Control and Prevention. (n.d.). *Smoking & tobacco use*. U.S. Department of Health and Human Services. https://www.cdc.gov/tobacco/

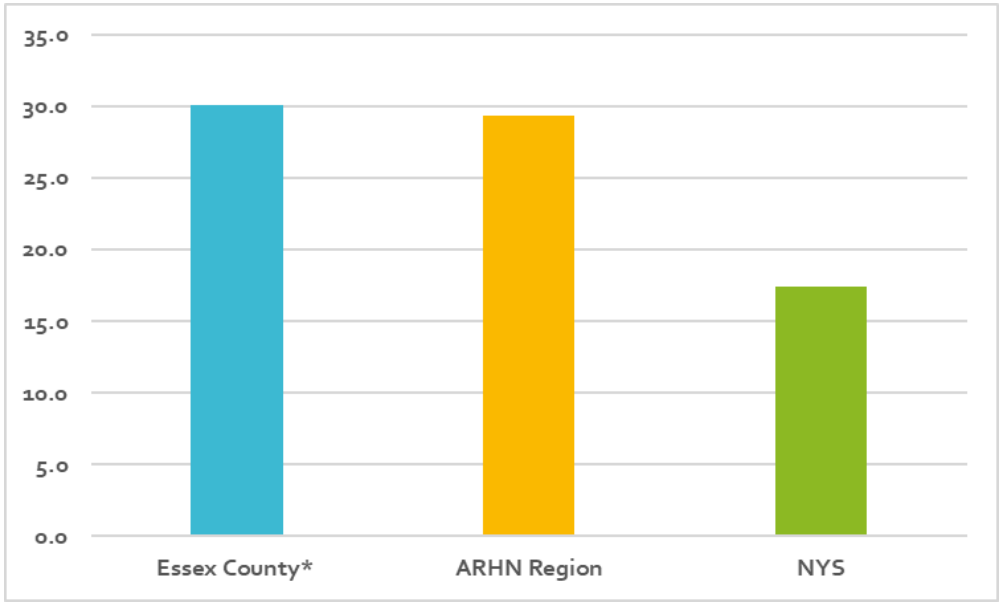
[17] Hunter, L., & Peluso, C. (2025). *Behavioral Risk Factor Surveillance System brief: Cigarette smoking, New York State adults, 2023* (No. 2025-18). New York State Department of Health, Division of Chronic Disease Prevention, Bureau of Chronic Disease Evaluation and Research.

Figure 20: Trends in the prevalence of current smoking among adults and in groups with the highest smoking rates in New York State, Behavioral Risk Factor Surveillance System 2020-2023[17]



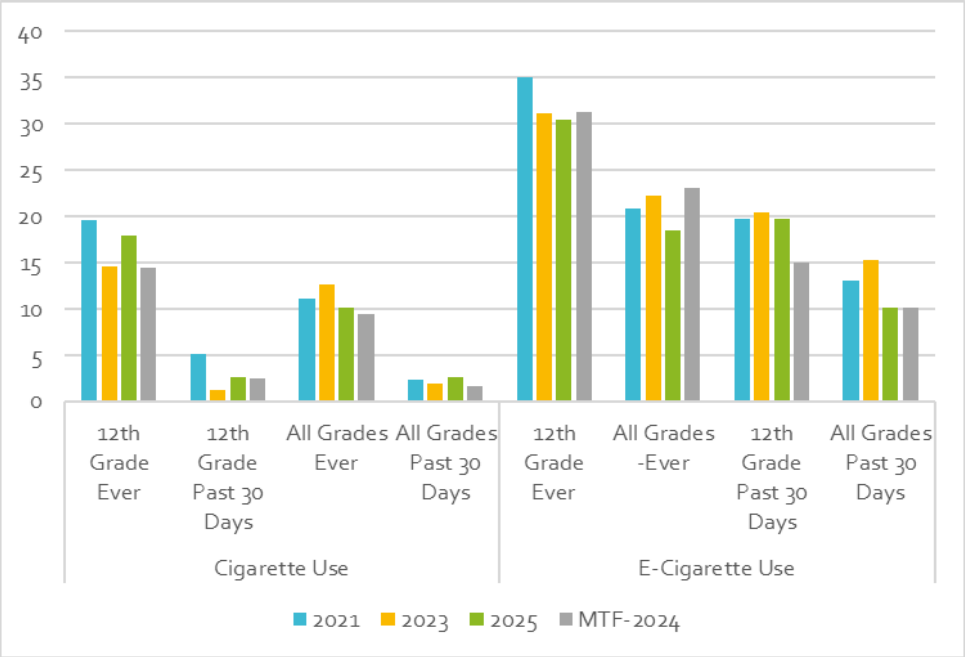
	All Adults	Adults Reporting Frequent Mental Distress	Adults Enrolled in Medicaid	Adults who are Unemployed	Adults Living with Disablity	Adults Earning Less than $25k Income	Adults with Less than High School Education
2020	12.0%	19.7%	22.9%	20.2%	17.4%	20.0%	19.0%
2021	12.0%	19.6%	19.1%	19.0%	17.4%	20.4%	19.2%
2022	11.3%	18.4%	17.5%	16.7%	15.4%	18.4%	18.1%
2023	9.3%	14.2%	15.2%	13.1%	14.4%	14.3%	16.0%

Figure 21: Percentage of adults living with a disability who smoke[6]



*Unreliable estimate

Figure 22: Percentage of student self-reported cigarette and e-cigarette use - Essex County[11]



All Grades = all grades surveyed (grades 7 - 12).

Cigarette smoking among Essex County middle and high school students shows an overall declining trend (Figure 22); however, as cigarette smoking began declining, e-cigarette use began increasing (not shown in above graph but included in previous *Essex County Community Health Assessment* reports). E-cigarette use among U.S. middle and high school students is now a major public health focus, as vaping remains the most commonly used tobacco product in this age group.[18] According to recent data from the National Youth Tobacco Survey, about 5.9% of U.S. middle and high school students (roughly 1.63 million youth) reported current e-cigarette use in 2024, with 7.8% of high school students and 3.5% of middle school students reporting past-30-day use. Among those who currently vape, a substantial majority (87.6%) used flavored products and more than a quarter reported daily use, trends that raise concerns about nicotine dependence and long-term health effects. While youth vaping rates in 2024 represent a significant decline from peaks seen in previous years, ongoing efforts are needed to prevent initiation and support cessation among adolescents, given the addictive nature of nicotine and the appeal of flavored devices.[19]

Living near more tobacco retailers is linked to higher smoking rates and lower quitting success for all ages. These outlets are often concentrated in low-income neighborhoods. This higher density of tobacco outlets also correlates with higher rates of youth tobacco experimentation and smoking.

Tobacco vendor density is high in Essex County and for every one major grocery store in the county, there are six tobacco retailers.[20]

For every **one major grocery store** in Essex County, there are **six tobacco retailers.**

[18] Centers for Disease Control and Prevention. (2024). E-Cigarette use among youth. U.S. Department of Health and Human Services. https://www.cdc.gov/tobacco/e-cigarettes/youth.html

[19] U.S. Food and Drug Administration. (2025). Results from the Annual National Youth Tobacco Survey: E-cigarette use among youth in 2024. FDA. https://www.fda.gov/tobacco-products/youth-and-tobacco/results-annual-national-youth-tobacco-survey

[20] Tobacco-Free Clinton, Franklin, and Essex Counties, & Compass North Consulting, LLC. (2024). *An exploratory landscape analysis of tobacco patterns, prevention, and policy in Essex County, NY: Executive summary* (Essex County Landscape Analysis). https://health.essexcountyny.gov/wp-content/uploads/Essex-Landscape-Analysis_Executive-Summary-4.pdf

Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences (ACEs) are stressful or potentially traumatic events that occur during childhood and can have persistent effects on health and well-being throughout life. According to the *New York State Prevention Agenda 2025-2030* and related health assessments, frequent exposure to ACEs has been directly linked to higher risks of chronic physical and mental health problems, including heart disease, depression, substance misuse, and suicide, as well as increased likelihood of engaging in health-risk behaviors later in life. Preventing ACEs and strengthening protective supports - such as stable relationships and trauma informed services - could significantly reduce the burden of these adverse outcomes; for example, data suggest that reducing ACEs may lower rates of depression, prescription pain medication misuse, and suicide attempts by large margins.[1]

Figure 23: Percentage of adults age 18 years and older who, as a child, experienced three or more ACEs, 2021[3]

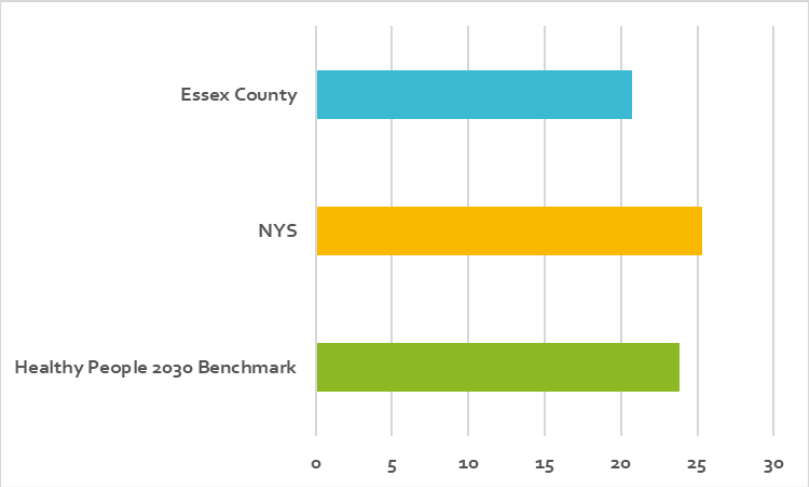
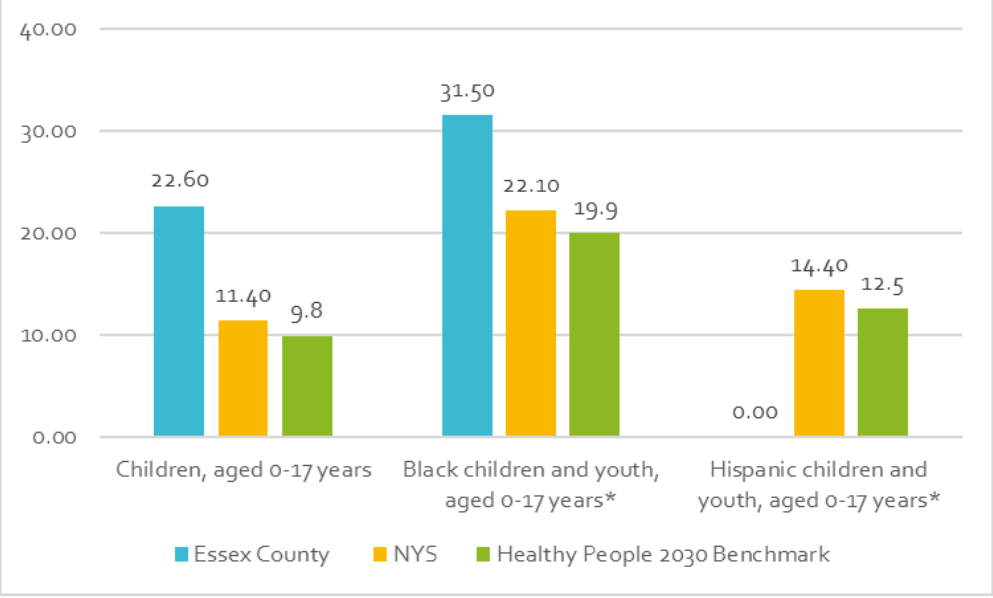


Figure 24: Indicated reports of abuse/maltreatment, rate per 1,000 children, 2024[3]



*Unreliable estimate

Essex County is below the Healthy People 2030 Benchmark for the percentage of adults experiencing three or more ACEs and this is also lower when compared to the New York State rate (Figure 23).

Essex County has almost double the rate of reports for child abuse/maltreatment than the state rate and the Essex County rate is over 75% higher than the Healthy People 2030 Benchmark. While data indicates that black children experience even higher rates of abuse/maltreatment in Essex County (31.5 per 1,000 children), this is an unreliable estimate due to the small sample size (Figure 24).

Primary Prevention, Substance Misuse, & Overdose Prevention

Substance misuse can profoundly worsen health outcomes across physical, mental, and social domains. According to the Centers for Disease Control and Prevention (CDC), drug overdose is a leading cause of preventable death in the United States, with tens of thousands of people dying each year from opioid and other drug overdoses. Overdose deaths frequently involve opioids, particularly synthetic opioids like fentanyl, and these deaths often co-occur with other mental health disorders such as depression and anxiety, underscoring the complex interplay between substance misuse and overall health. People with substance use disorders are also at increased risk for chronic diseases, infectious diseases (e.g., HIV and hepatitis), and complications that reduce life expectancy and quality of life. Substance misuse can contribute to poorer sleep health and increased hospitalizations, and even exacerbate outcomes in conditions such as COVID-19 by raising the likelihood of severe illness and mortality. Preventing these harms often requires an emphasis on addressing social determinants of health and promoting health equity, because inequities can amplify the negative consequences of substance misuse across communities.[21-24]

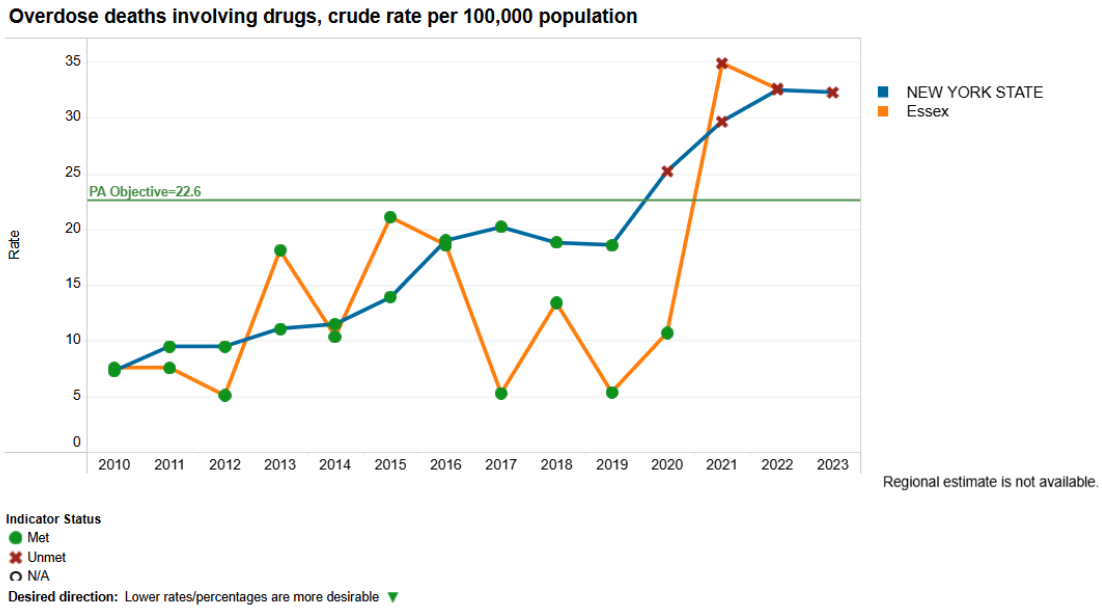
Data from the New York State Department of Health (NYSDOH) show that substance use disorders contribute significantly to overdose deaths in the state, with opioids implicated in the vast majority of cases. These trends illustrate how substance misuse not only leads to immediate harms like overdose but also reflects broader public health challenges that affect families and communities statewide.[25-26]

Available data relevant to this priority area - from both primary and secondary data sources - paint a complicated picture in Essex County. Since at least 2015, county agencies and organizations have dedicated significant resources toward addressing the opioid epidemic, with many notable successes spearheaded by the Essex County Heroin and Other (Drug) Coalition, known as ECHO. Challenges emerged in the form of a global pandemic that exacerbated underlying risk factors for substance misuse - isolation, stress, anxiety, ACEs - to name a few. Overdose death rates reflected this unprecedented time - and mirrored state and national trends, though more recent data suggest a steep decline in deaths due to overdose.

[21] Centers for Disease Control and Prevention. (n.d.). *Substance use among youth*. U.S. Department of Health and Human Services. https://www.cdc.gov/youth-behavior/risk-behaviors/substance-use-among-youth.html CDC
[22] Centers for Disease Control and Prevention. (n.d.). *Drug overdose deaths in the United States, 2002–2022* (Data Brief No. 491). National Center for Health Statistics. https://www.cdc.gov/nchs/products/databriefs/db491.htm CDC
[23] Centers for Disease Control and Prevention. (n.d.). *FastStats: Drug overdoses*. National Center for Health Statistics. https://www.cdc.gov/nchs/fastats/drug-overdoses.htm CDC
[24] Centers for Disease Control and Prevention. (n.d.). *Understanding the opioid overdose epidemic*. U.S. Department of Health and Human Services. https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html
[25] New York State Department of Health. (2023). *New York State opioid annual report 2023*. https://www.health.ny.gov/statistics/opioid/data/pdf/nys_opioid_annual_report_2023.pdf. New York State Department of Health
[26] New York State Office of Addiction Services and Supports. (2023). *Addiction data bulletin: Substance use disorder treatment service system*. https://oasas.ny.gov/addiction-data-bulletin-0

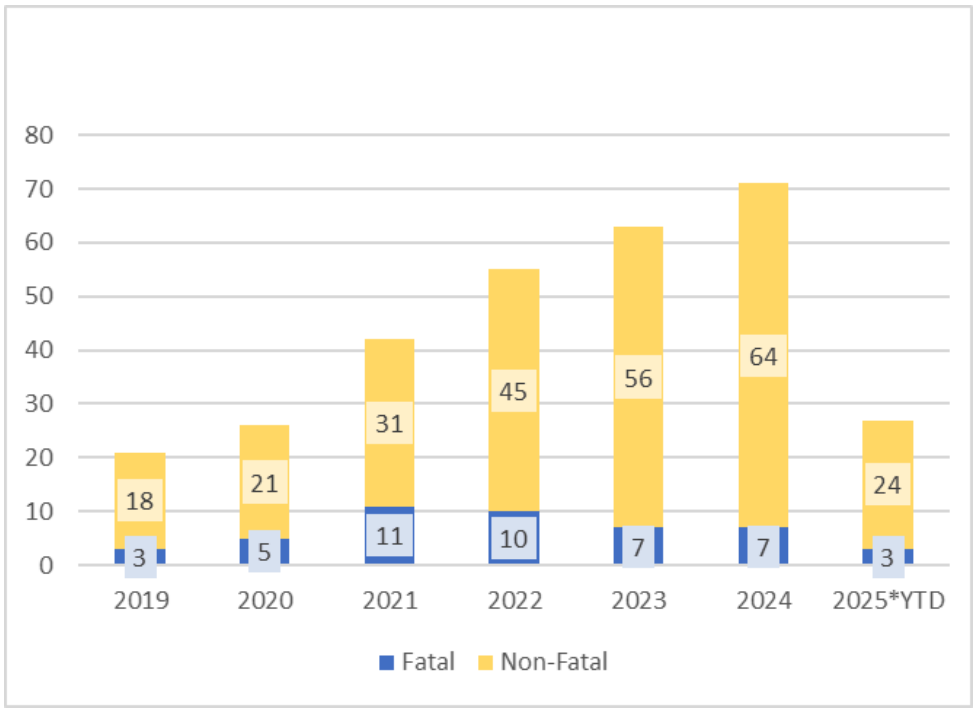
As noted, Essex County experienced a sharp increase in overdose deaths in 2021 and 2022 (Figure 25), though previous estimates (prior to 2021) are unreliable*. Overall incidents of overdose in Essex County - both fatal and non-fatal - were increasing from 2015 through 2024, as depicted in Figure 26. Some of this increase is likely attributable to better reporting, especially for non-fatal overdoses.

Figure 25: Overdose deaths involving drugs, crude rate per 100,000 population[3]



Note: Data points from 2010-2020 for Essex County are unreliable estimates

Figure 26: Essex County Overdose Count By Year, Fatal and Non-Fatal[27]



[27] Essex County Health Department. 2025. Overdose Database.

One of the risk factors for opioid addiction is access to prescription pain medication. The rate that opioid-naive patients receive an initial opioid medication (Figure 27), and the rate for prescriptions lasting more than 7 days in Essex County are both above the respective Prevention Agenda objectives for these indicators. The rate that opioid-naive patients receive prescriptions longer than 7 days has decreased significantly since 2016 however (Figure 28).

Figure 27: Episodes when an opioid-naive patient received an initial opioid prescription, rate per 1,000 population [3]

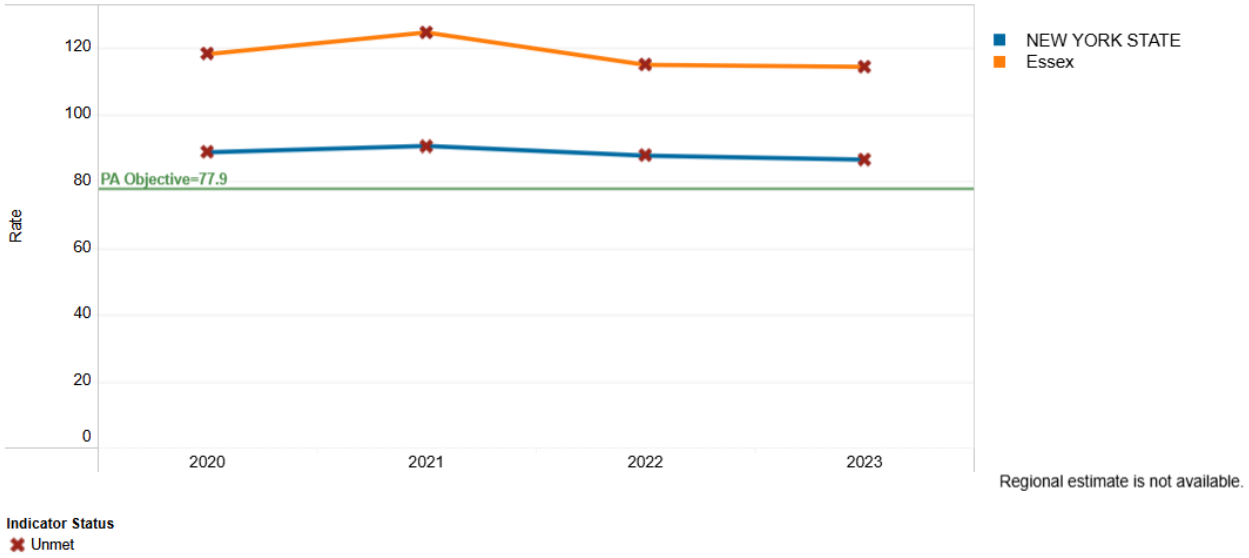
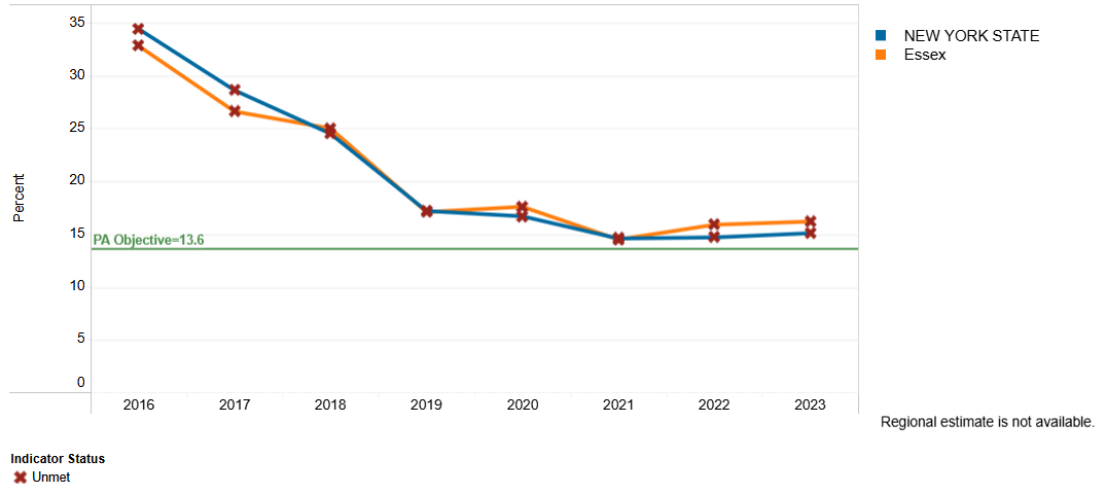
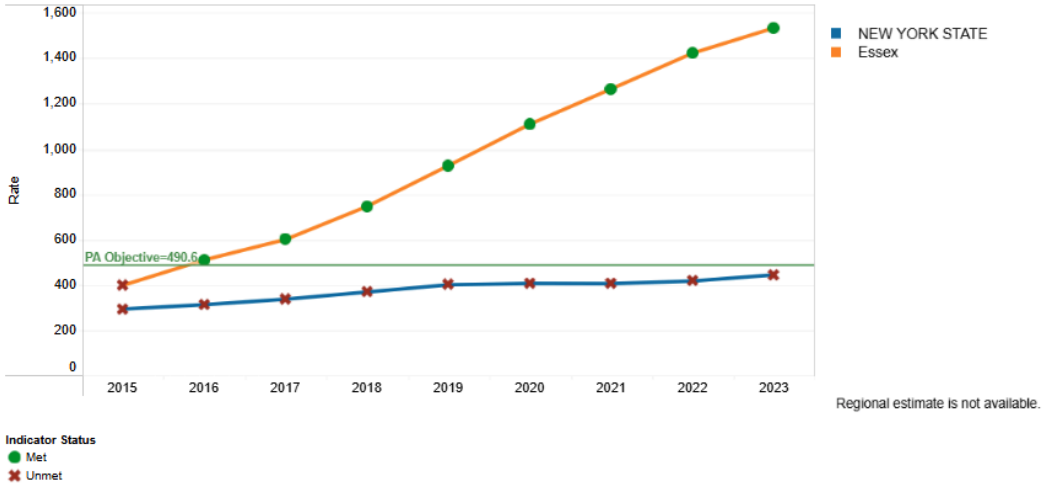


Figure 28: Percentage of episodes when patients were opioid naive and received an opioid prescription of more than seven days[3]



Essex County has also experienced improvements in the number of patients that receive treatment (buprenorphine prescriptions) for their opioid use disorder - far exceeding the state rate and Prevention Agenda objective (Figure 29 on page 64).

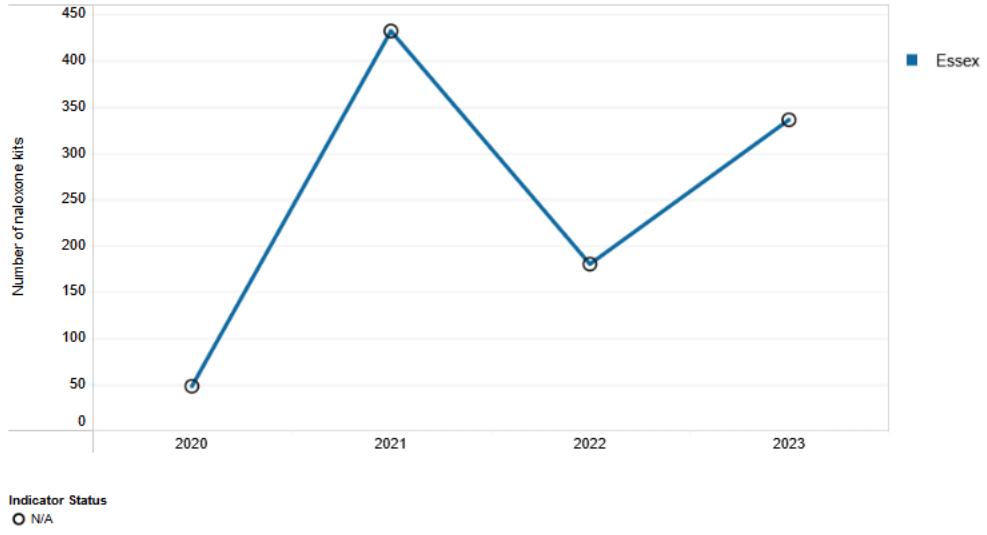
Figure 29: Patients who received at least one buprenorphine prescription for opioid use disorder, crude rate per 100,000 population[3]



Other interventions include improving access to opioid overdose reversal medication, known as naloxone, which can prevent death when overdose is suspected. The Essex County Health Department, hospitals, EMS, and other community based organizations have worked collaboratively to ensure naloxone is readily accessible to the community and kit distribution has increased (Figure 30). The Essex County Health Department is a registered Community Opioid Overdose Prevention Program through the New York State Department of Health and requests and distributes naloxone and conducts training to individuals and groups on its use.

Preliminary data may indicate that overdose deaths have sharply declined, beginning in 2025 in Essex County, but substance misuse was still a top concern noted in both the Community and Stakeholder Surveys conducted in 2025. Consequently, this issue was prioritized in the Community Health Improvement Plan for 2026-2030, ensuring that strides made in this area endure and that new and evolving threats are addressed.

Figure 30: Number of naloxone kits distributed[3]



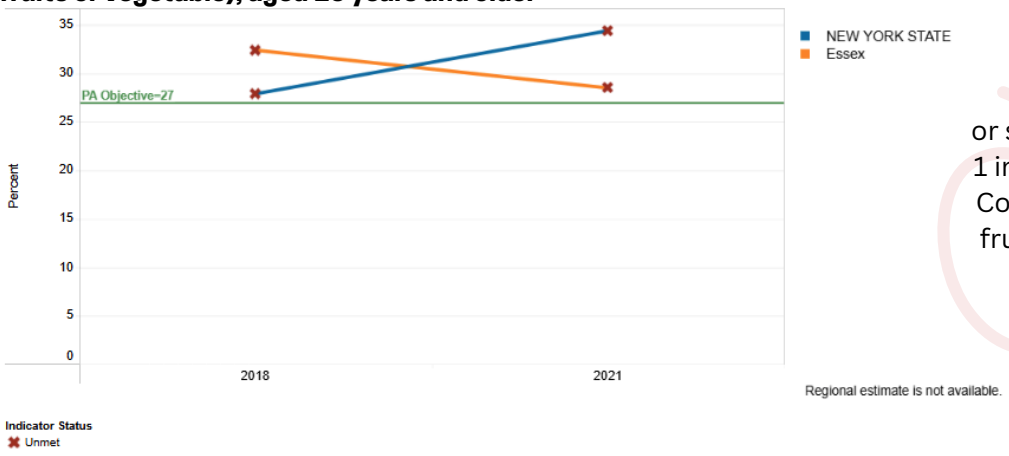
Substance misuse was cited as a **top concern** in the 2025 Community Survey of Essex County Residents

Healthy Eating

The *New York State Prevention Agenda 2025–2030* identifies healthy eating as a core public health priority. A healthy diet has significant benefits for preventing chronic disease and supporting overall health and includes a variety of nutrient-dense foods like fruits and vegetables and limits added sugars. Eating in this manner can reduce the risk of chronic conditions such as cardiovascular disease, type 2 diabetes, osteoporosis, some cancers, and weight-related health issues—outcomes that are key targets of the Prevention Agenda's chronic disease prevention strategies. Many people do not currently meet recommended dietary guidelines, with low daily intake of fruits and vegetables and high consumption of sugar-sweetened beverages, which underscores the need for community and policy efforts to promote healthier dietary patterns. Additionally, their are health inequities related to nutrition - such as disparities in access to healthy foods and breastfeeding support among communities with lower income and communities of color - and improving healthy eating through policy, system, and environmental changes can help advance health equity across the lifespan.[1]

Essex County has seen improvements in fruit and vegetable consumption (Figure 31) and performs well above state and Prevention Agenda targets for infants that are exclusively breastfed in the hospital (Figure 32), and better than other counties in the region (Figure 33).

Figure 31: Percentage of adults who consumed fewer than one fruit and fewer than one vegetable daily (no fruits or vegetable), aged 18 years and older[3]



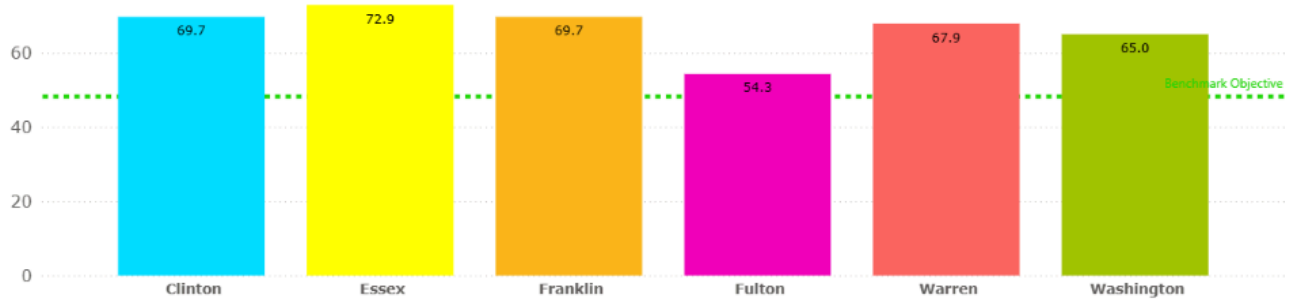
28.5%

or slightly more than 1 in 4 adults in Essex County consume no fruits or vegetables daily

This is down from 32.4% in 2018

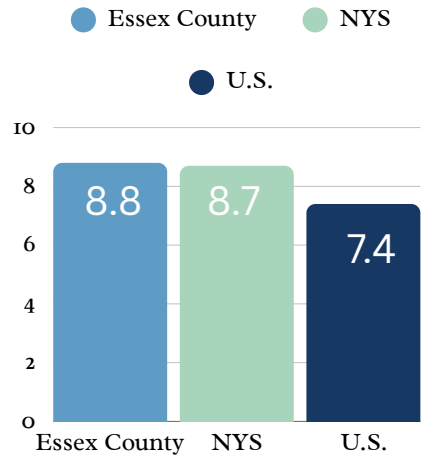
Figure 32: Percentage of infants who are exclusively breastfed in the hospital among all infants[3]

Figure 33: Percentage of infants who are exclusively breastfed in the hospital among all infants - regional comparison



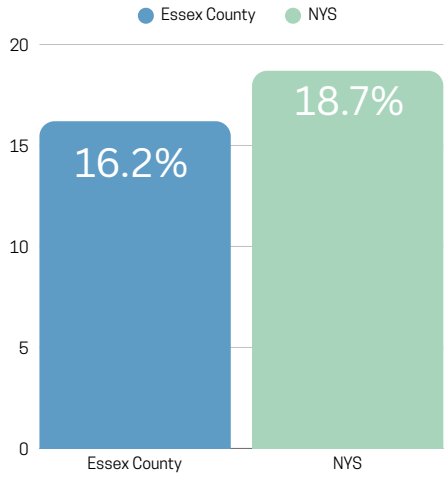
Access to healthy foods can have a considerable impact on whether individuals and families are able to enjoy nutritious foods. The Food Environment Index in Essex County is comparable to NYS as a whole and is better than the U.S. score (Figure 34). Fewer adults in Essex County consume sugar-sweetened beverages each day compared to all NYS adults (Figure 35).

Figure 34: Food Environment Index[2]



Index includes access to healthy foods and food insecurity, with 0 = worst and 10 = best

Figure 35: Daily consumption of soda and sugar-sweetened beverages (SSBs) among adults, 2021*[6]



*Consumed At Least One Regular Soda or SSB Per Day

DOMAIN 3: NEIGHBORHOOD AND BUILT ENVIRONMENT

The Neighborhood and Built Environment domain encompasses the following priority areas:

Opportunities for Active Transportation & Physical Activity

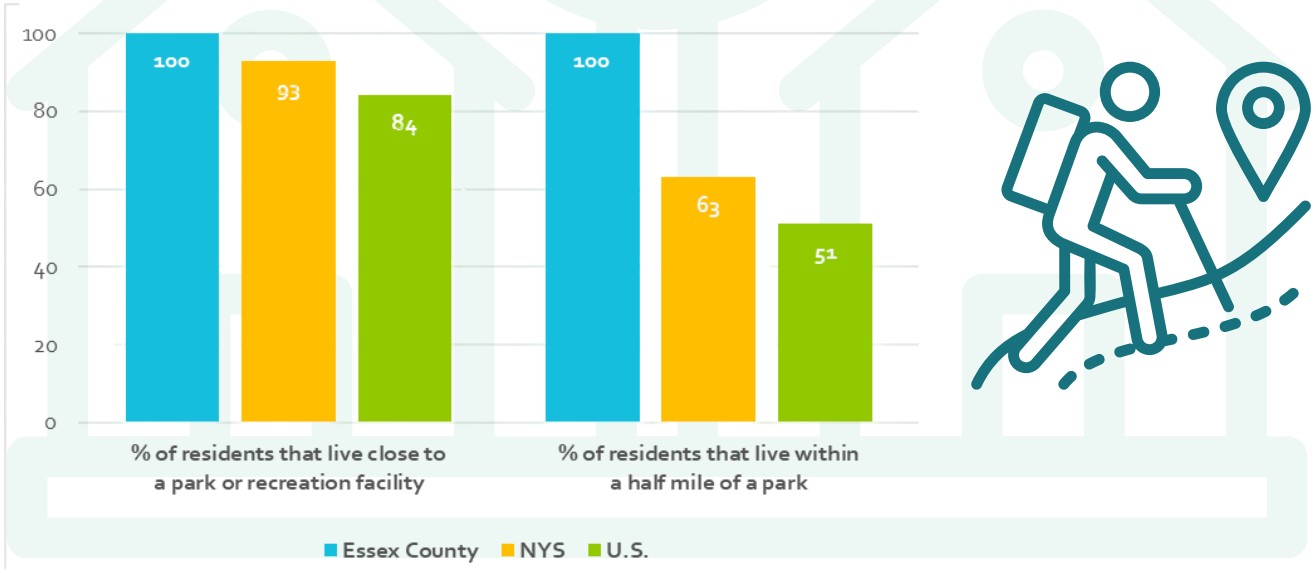
Access to Community Services & Supports

Injuries and Violence

Opportunities for Active Transportation & Physical Activity

Regular physical activity and active transport offer wide-ranging benefits for health and communities. According to the *NYS Prevention Agenda 2025–2030*, engaging in physical activity can reduce the risk of chronic diseases such as heart disease, stroke, type 2 diabetes, and some cancers, while also strengthening muscles and bones, improving mental health and sleep, and increasing life expectancy. The plan emphasizes that incorporating active transportation—like walking or biking as part of daily travel—can make physical activity more accessible and integrated into everyday life, particularly when communities are designed with safe, connected routes and accessible destinations. These changes not only support individual well-being but also contribute to healthier, more activity-friendly environments for all.[1]

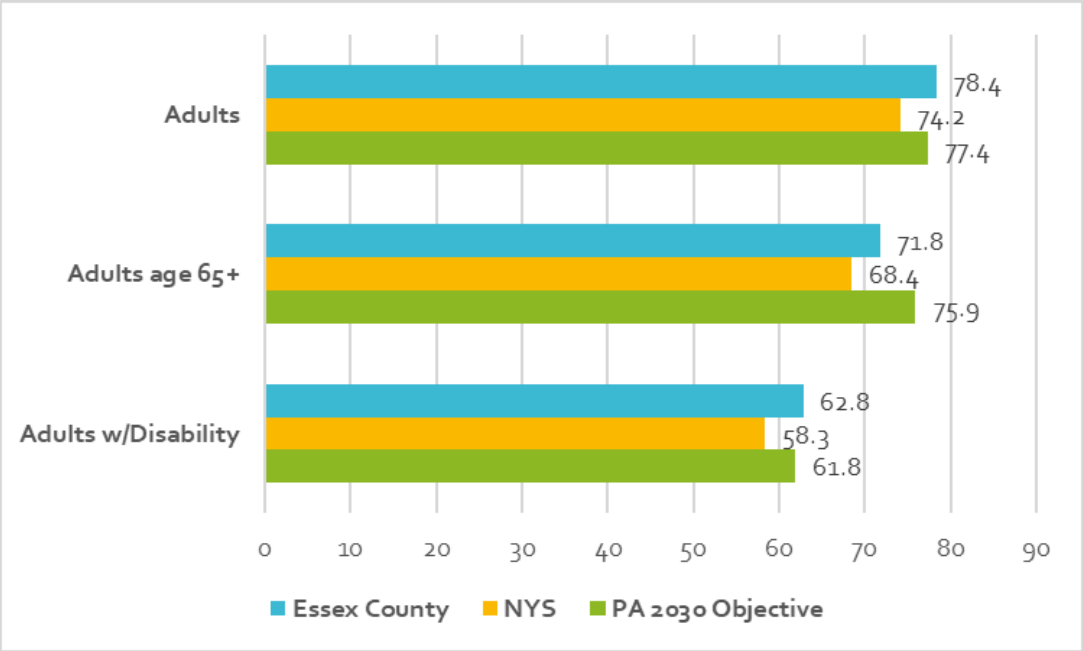
Figure 36: Opportunities to be Physically Active[2]



[1] New York State Department of Health. (2024). *Prevention Agenda 2025–2030: New York State's health improvement plan.* New York State Department of Health. Retrieved December 11, 2025 https://health.ny.gov/prevention/prevention_agenda/

[2] University of Wisconsin Population Health Institute. (2025). *County Health Rankings & Roadmaps 2025*. Retrieved December 11, 2025 from www.countyhealthrankings.org

Figure 37: Prevalence of Leisure Time Physical Activity, 2021[3]



Essex County residents have abundant opportunity for physical activity, as demonstrated by their access to parks and recreation centers (Figure 36 on page 67). Leisure time physical activity indicators (Figure 37 above) reveal that Essex County adults take advantage of these opportunities and are more physically active than the average New Yorker across all categories - meeting the Prevention Agenda 2030 Objective in two out of the three (Adults and Adults with disabilities). However, some of this access is satisfied through outdoor recreation opportunities that may not be as practical or feasible for aging adults or those with other limitations. Physical activity levels in older adults is lower than the Prevention Agenda 2030 target of 75.9%

Access to Community Services & Supports

Healthy People 2030 emphasizes that overall health is deeply influenced by an individual's access to community services and supports, particularly those that address the Social Determinants of Health. According to this framework, access to resources such as safe housing, transportation, nutritious food, mental health services, and social support networks can significantly improve health outcomes by reducing stressors and enabling people to engage in healthy behaviors. When communities provide robust, equitable services, individuals are better able to manage chronic conditions, prevent disease, and participate fully in education and employment—all of which contribute to long-term well-being. Conversely, limited access to these supports can widen health disparities and undermine both physical and mental health, highlighting the importance of community-level investment in health-promoting infrastructure.[4]

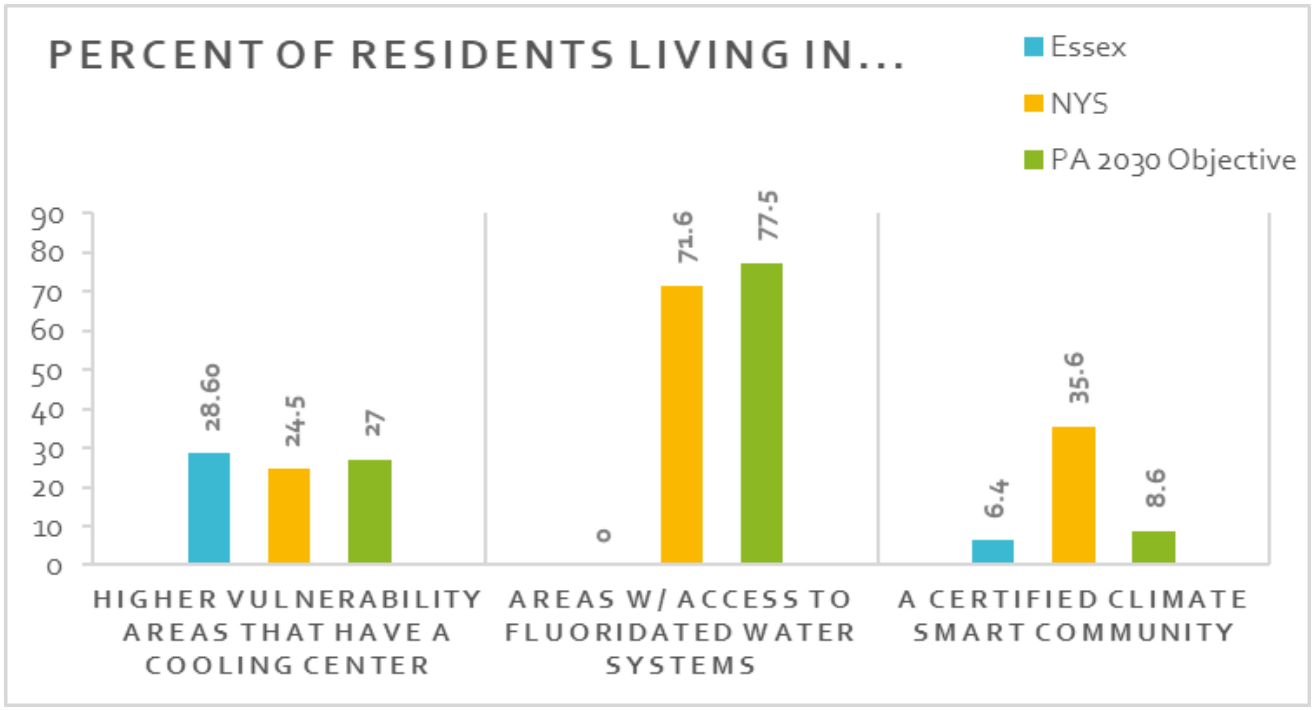
[3] US Department of Health and Human Services, Centers for Disease Control and Prevention (CDC). (2021). *Expanded Behavioral Risk Factor Surveillance System Survey Questionnaire*. Retrieved December 12, 2025 from https://health.data.ny.gov/Health/Behavioral-Risk-Factor-Surveillance-System-BRFSS-H/jsy7-eb4n/about_data

[4] Office of Disease Prevention and Health Promotion. (2020). *Healthy People 2030*. U.S. Department of Health and Human Services. https://health.gov/healthypeople

The New York State Prevention Agenda 2025-2030 identifies Access to Community Services and Supports as a critical factor in improving health and well-being because community services—such as social supports, affordable transportation, safe recreational spaces, and essential programs—enable individuals to meet basic needs, stay connected, and engage in health-promoting activities. Improving awareness, affordability, accessibility, and acceptability of services across diverse neighborhoods helps reduce barriers that disproportionately affect underserved populations and contributes to both preventive health practices and overall quality of life. By prioritizing expanded and equitable access, the plan underscores that when people can readily reach and use supportive community resources, they are better positioned to maintain health, prevent disease, and reduce disparities tied to social and environmental conditions. This emphasis aligns with the broader Prevention Agenda framework, which uses such community-level supports to address social determinants of health and advance health equity throughout the state.[1]

The only NYS Prevention Agenda indicators provided for this priority area relate to climate change, including community level access to cooling centers, fluoridated water systems, and Climate Smart designations.

Figure 38: Access to Community Services & Supports Indicators[5]



Essex County fairs worse in all three Access to Community Services and Support areas where indicator data is available (Figure 38).

[5] New York State Department of Health. (n.d.). Prevention Agenda dashboard. New York State Department of Health. https://apps.health.ny.gov/public/tabvis/PHIG_Public/pa/

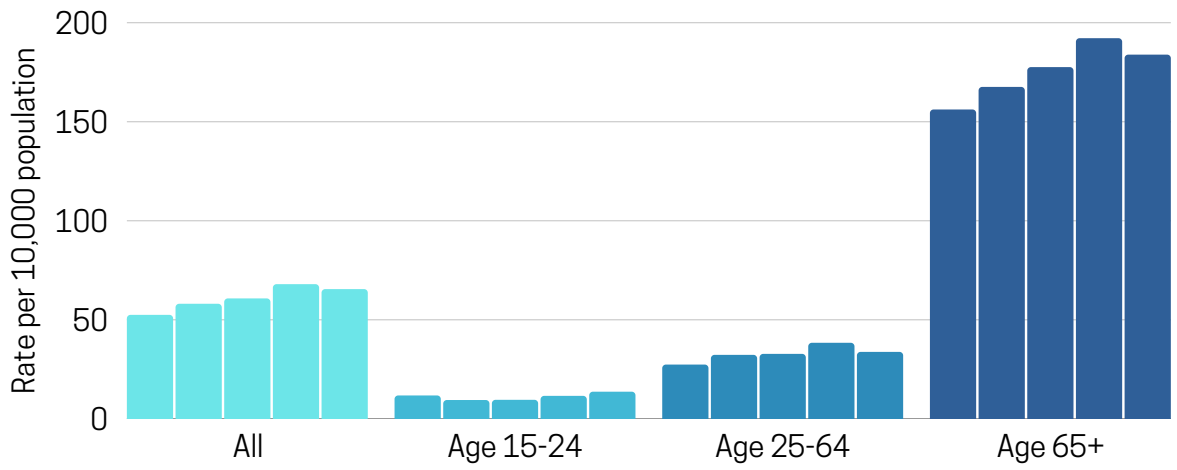
Injuries & Violence

Injuries and violence are significant contributors to poor health outcomes because they result not only in immediate physical harm but also in long-term disability, psychological trauma, and premature death, which collectively undermine individual and community well-being. The New York State Prevention Agenda 2025-2030 highlights that both unintentional and intentional injuries occur across everyday environments—homes, roads, workplaces, and community spaces—and are leading causes of death and disability in New York, particularly among younger age groups, with thousands of deaths, hospitalizations, and emergency visits annually tied to motor vehicle crashes, falls, overdoses, and assaults; structural inequities further exacerbate these impacts among racial and ethnic minority populations.[1]

At the national level, Healthy People 2030 underscores violence prevention as a core objective area, noting that violence like homicide and physical assault not only causes injury and loss of life but also contributes to longer-term behavioral and mental health problems, reinforcing the need for preventive strategies across homes, schools, workplaces, and communities.[4]

Together, these frameworks affirm that addressing injury and violence through prevention and equity-focused interventions is essential for reducing avoidable harm and improving overall population health.

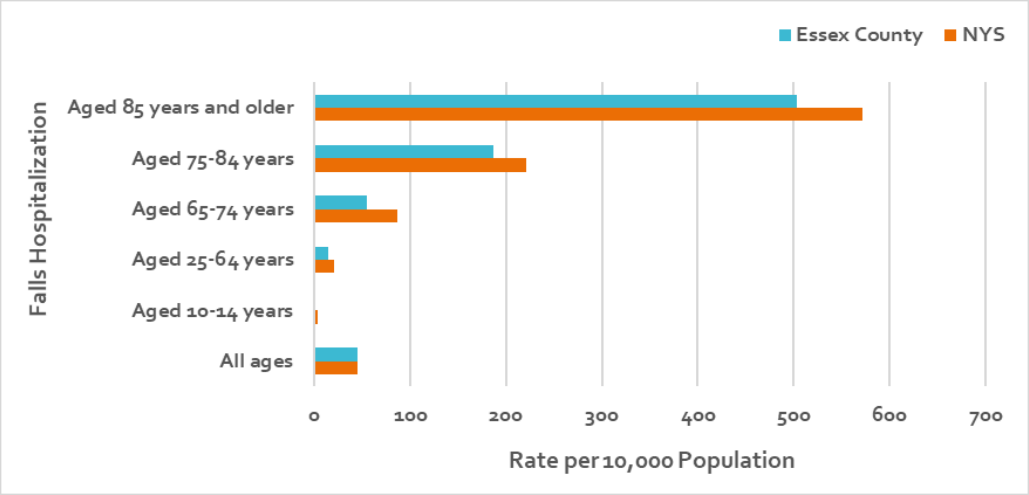
Figure 39: Unintentional injury hospitalization rate - Essex County, Years 2017 - 2021[6]



Unintentional injuries cover a broad category of injuries that often occur due to lapses in attention, lack of safety measures, or unexpected events, affecting all ages but especially younger children and older adults. They include accidents and common mishaps like falls, drowning/near drowning, car crashes, poisoning, fires, accidental overdose, and cuts/burns. The rate of unintentional injuries in Essex County is much higher for older adults, and has remained fairly steady across the five year time frame depicted above, increasing from 2017-2020 for most age ranges before dropping slightly in 2021 (Figure 39).

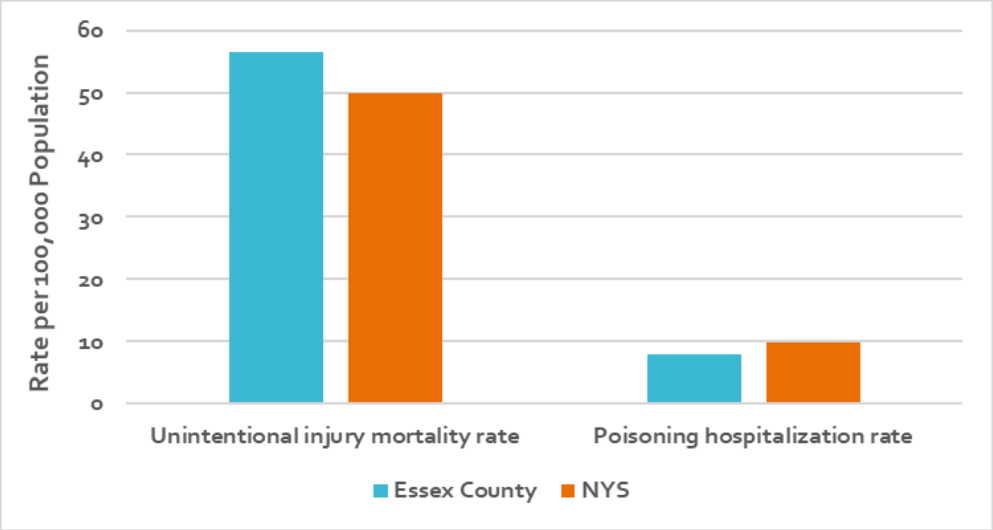
[6] New York State Department of Health. (2025). *New York State Community Health Indicator Reports (CHIRS)*. Retrieved May 27, 2025, from https://www.health.ny.gov/CHIRSDashboard

Figure 40: Falls hospitalization rates by Age, 2020-2022[6]



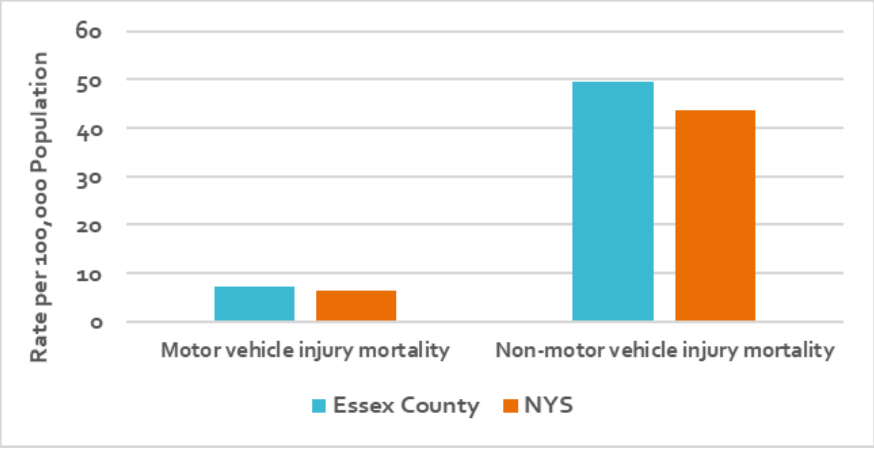
Hospitalizations due to falls occur less frequently than state averages, across all age categories graphed in Figure 40. , though Essex County shows the same trends for increasing hospitalization rates for falls as age increases. The all age falls hospitalization rate is similar to the state rate.

Figure 41: Unintentional injury mortality and poisoning hospitalizations, 2020-2022[6]



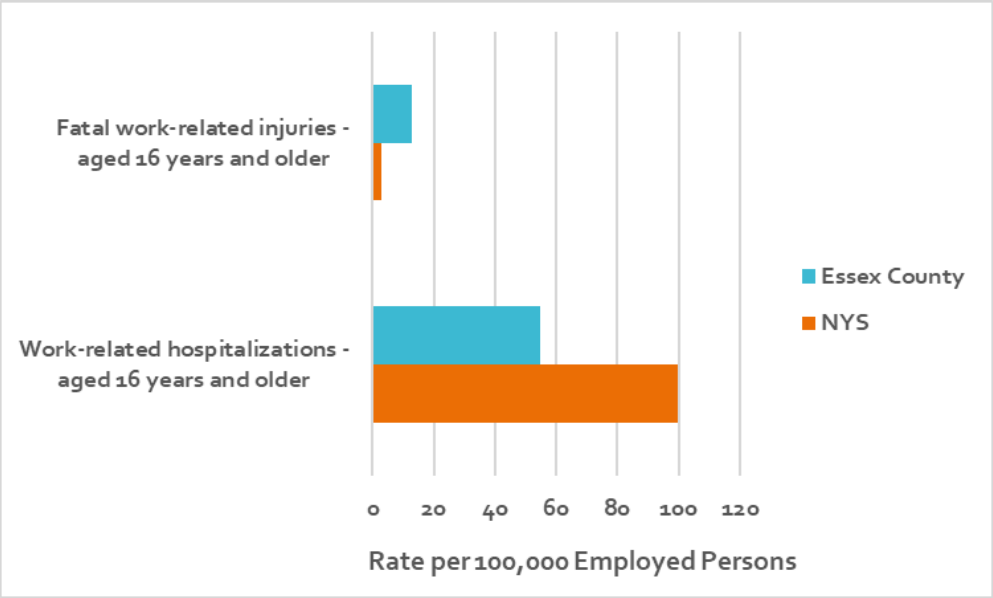
The unintentional injury mortality rate is higher in Essex County than the NYS rate. Hospitalizations due to poisonings (one cause of unintentional injury) are lower in Essex County than the state.

Figure 42: Motor vehicle injury mortality vs. non-motor vehicle injury mortality[6]



Non-motor vehicle injury fatalities occur with a much greater frequency than motor vehicle fatalities in Essex County (similar ratio to NYS). Rate for both indicators are higher than the NYS rate.

Figure 43: Work-related injury hospitalizations and fatalities, 2020-2022[6]



The work-related fatality rate is almost five times higher than the NYS rate. Work related injury hospitalizations occur about half as frequently in Essex County when compared to the state average (Figure 43).

Figure 44: Motor vehicle crash rates - all, 2023[7]

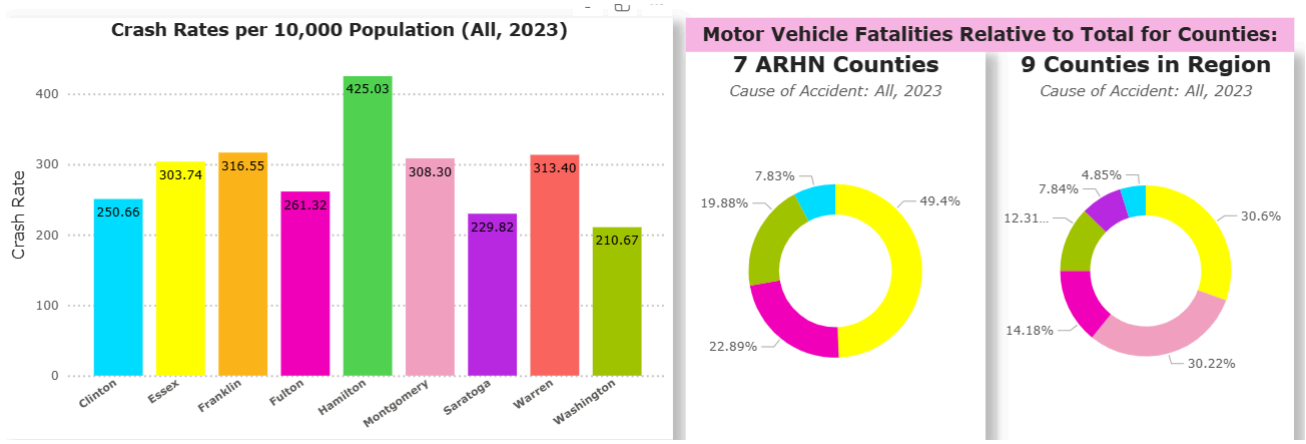
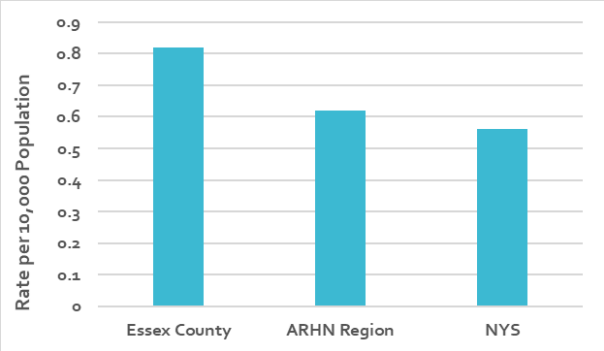


Figure 45: Crash rate, 2023[7]

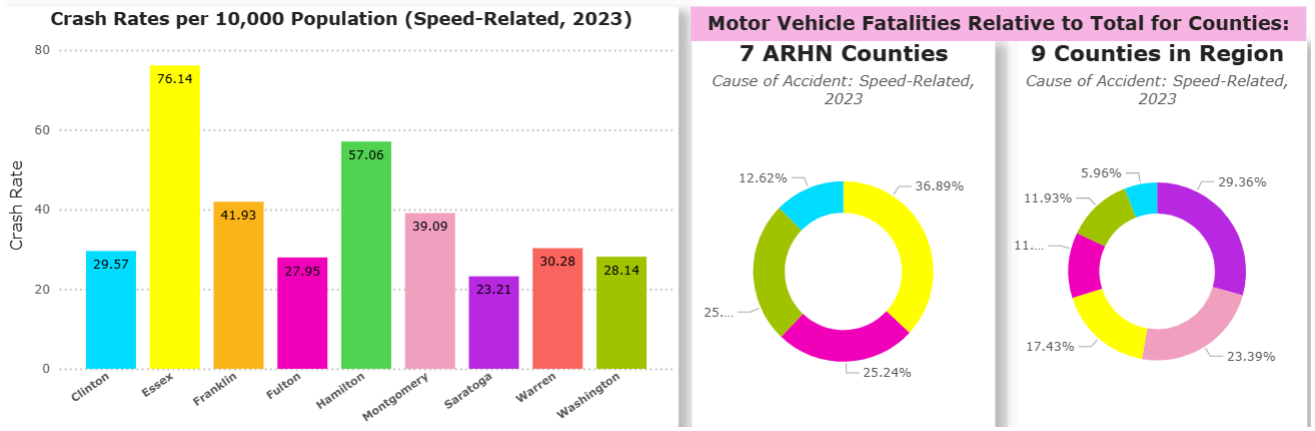
Figure 46: Crash fatality rate, 2023[7]



[7] Institute for Traffic Safety Management & Research. (2025). *Traffic Safety Statistical Repository (TSSR), County Crash Summary Reports, 2023*. Retrieved May 27, 2025, from https://www.itsmr.org/traffic-safety-statistical-repository/

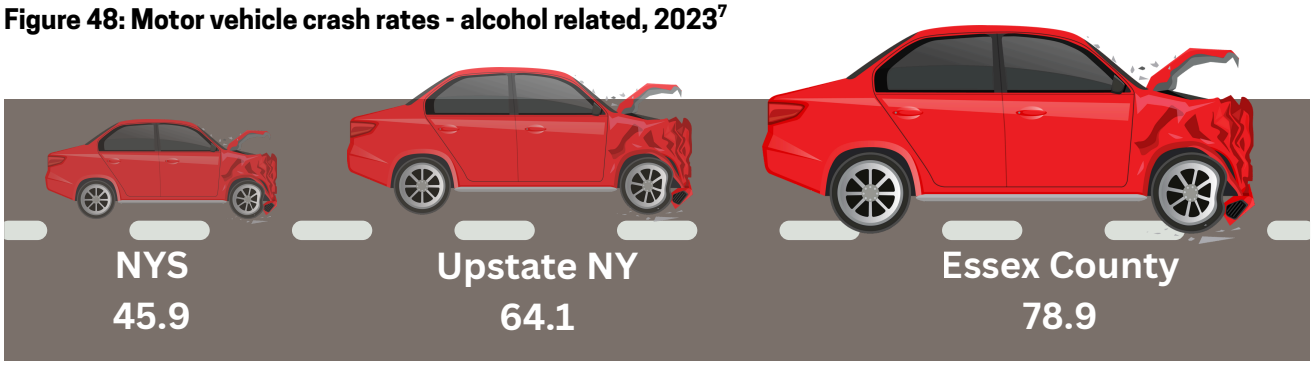
Motor vehicle crash rates in Essex County, while lower than some individual counties in the region (Figure 44), are higher than the overall regional and NYS rates in comparison (Figure 45). The speed related crash rate (Figure 47) in Essex County is about ten times higher than the alcohol related crash rate (Figure 48). The motor vehicle fatality rate is also higher in Essex County than regional or state rates (Figure 46). Essex County speed-related fatalities make up almost 40% of all speed-related fatalities in a 7 county region and almost 20% of the speed-related fatalities in a 9 county region (Figure 47).

Figure 47: Motor vehicle crash rates - speed related, 2023[7]



Alcohol related crashes have steadily decreased in Essex County from 2019 to 2023, though the rate is still almost twice as high as the state rate (Figure 48).

Figure 48: Motor vehicle crash rates - alcohol related, 2023[7]



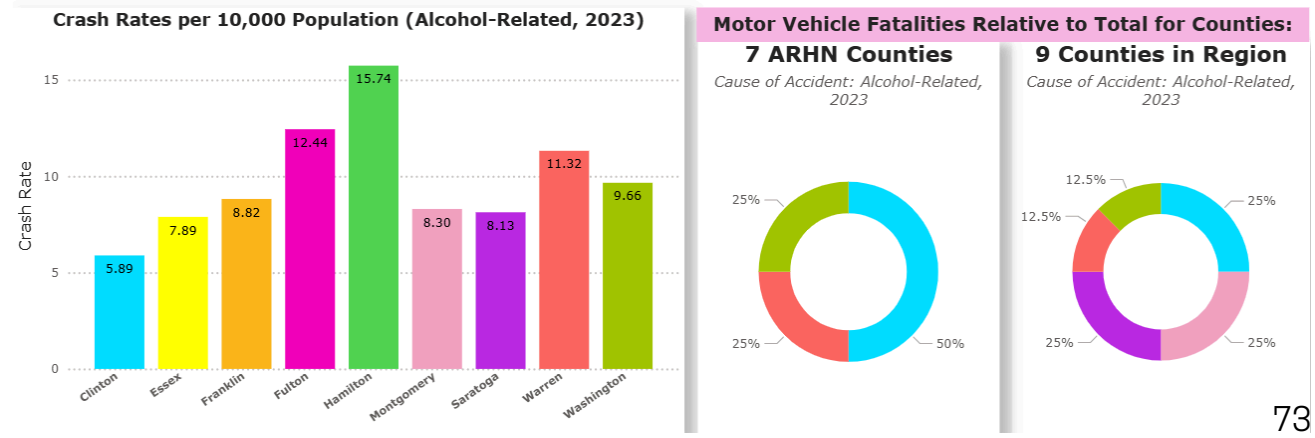


Figure 49: Self-inflicted injury hospitalizations, 2020-2022[6]

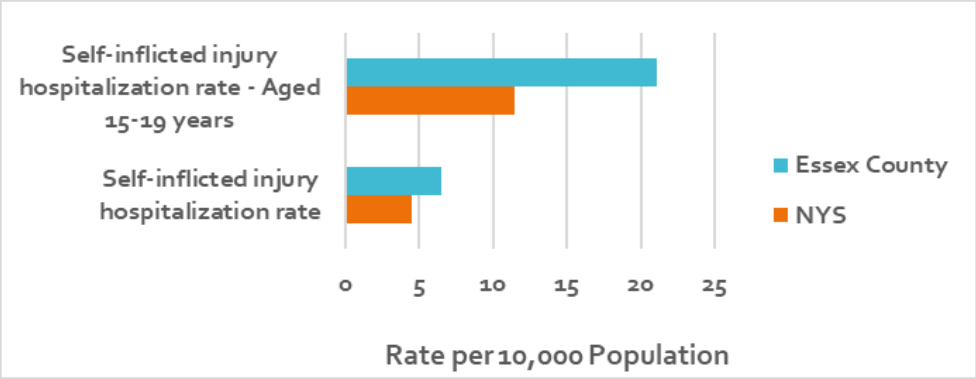
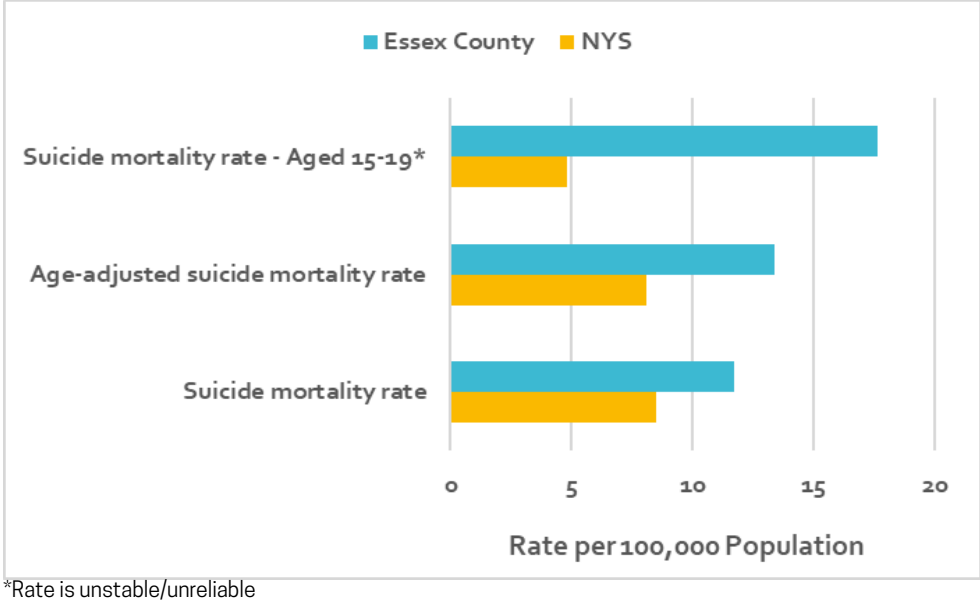


Figure 50: Suicide mortality rates, 2020-2022[6]



*Rate is unstable/unreliable

The rates for self-inflicted injury hospitalizations (Figure 49) and for suicide mortality (Figure 50) are higher in Essex County than for NYS as a whole. The crude suicide mortality rate shows an overall downward trend (Figure 51), though rates appear to be increasing from 2018 forward.

Figure 51: Suicide mortality rate trends, 2013-2022[6]

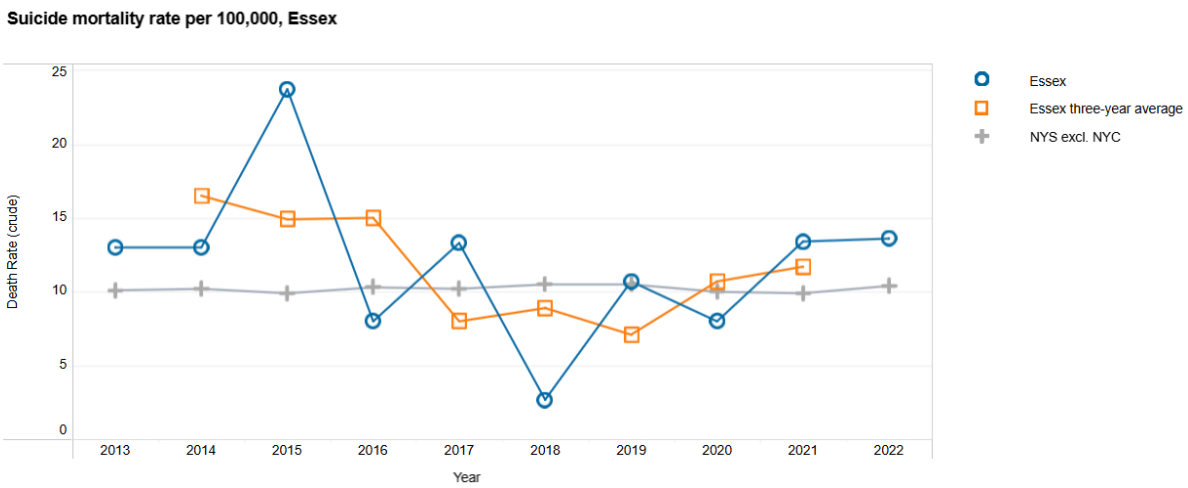


Figure 52: Crime rates, 2020-2022[6]

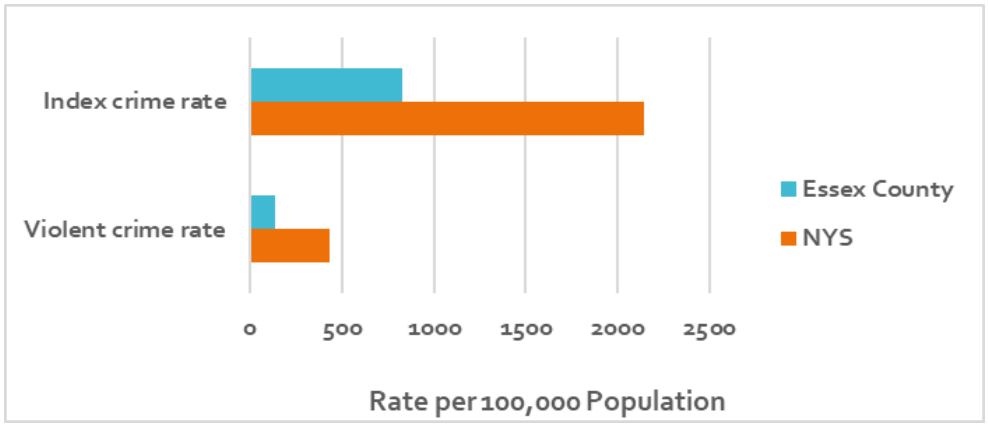
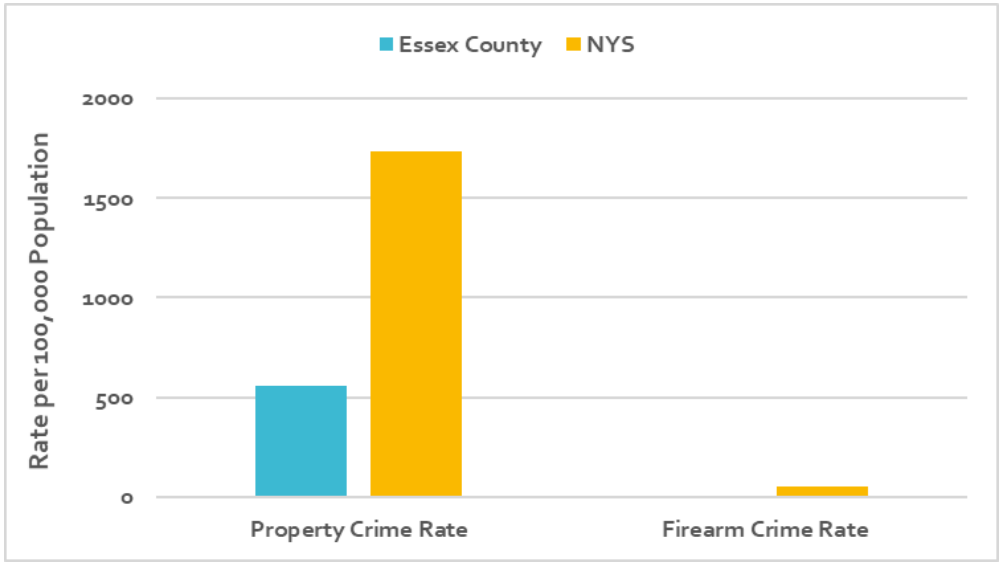


Figure 53: Property and firearm crime rates, 2022[6]



Crime rates are generally low in Essex County when compared to state rates (Figures 52 and 53). This includes the Index Crime rate (murder, rape, robbery, aggravated assault, burglary, larceny, motor vehicle theft), as well as violent, property, and firearm crimes.

DOMAIN 4: HEALTH CARE ACCESS AND QUALITY

The Social and Community Context domain encompasses the following priority areas:

Access to & Use of Prenatal Care* **and** Prevention of Infant & Maternal Mortality*
*These two priority areas are combined for the purposes of this data analysis

Preventive Services for Chronic Disease Prevention & Control

Oral Health Care

Preventive Care
-Immunization
-Hearing Screening & Follow up
-Lead Screening

Early Intervention

Childhood Behavioral Health

Access to & Use of Prenatal Care and Prevention of Infant & Maternal Mortality

Maternal and infant health are foundational to overall community health because healthy beginnings for mothers and babies contribute to long-term well-being across the lifespan. *Healthy People 2030* explicitly prioritizes reducing maternal deaths, improving women's health before, during, and after pregnancy, and increasing access to quality prenatal and postpartum care to prevent complications that can adversely affect both mothers and infants. Pregnant women who receive recommended care and adopt healthy behaviors - such as abstaining from tobacco - are more likely to have healthy pregnancies, which in turn supports infant health during critical early life stages. Furthermore, *Healthy People 2030* includes infant health goals focusing on keeping infants safe and healthy through their first year, emphasizing breastfeeding and developmental screenings as key contributors to better outcomes. These objectives are measured in national Leading Health Indicators like maternal and infant mortality rates, which reflect community conditions such as access to health services and socioeconomic inequities. Improved maternal and infant health leads to lower mortality rates, reduced health disparities, increased economic productivity, and stronger social support systems, ultimately enhancing community resilience and population health.[1]

The NYS Prevention Agenda 2025-2030 tracks indicators like infant mortality, prenatal care, and maternal mortality to measure progress in the areas maternal and infant health.

[1] Office of Disease Prevention and Health Promotion. (n.d.). Pregnancy and childbirth. Healthy People 2030. U.S. Department of Health and Human Services. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth

The current (2022) infant mortality rate in Essex County (7.6) is higher than state and regional comparisons, though the estimates for the county are unstable for each year graphed below (Figures 54 & 55).

Figure 54: Infant mortality rate per 1,000 live births[2]

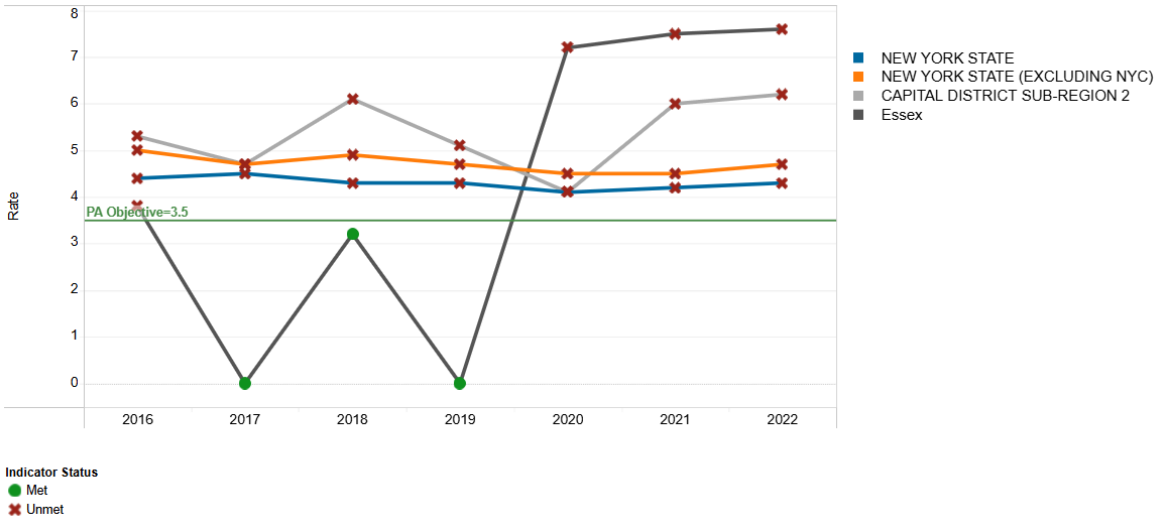
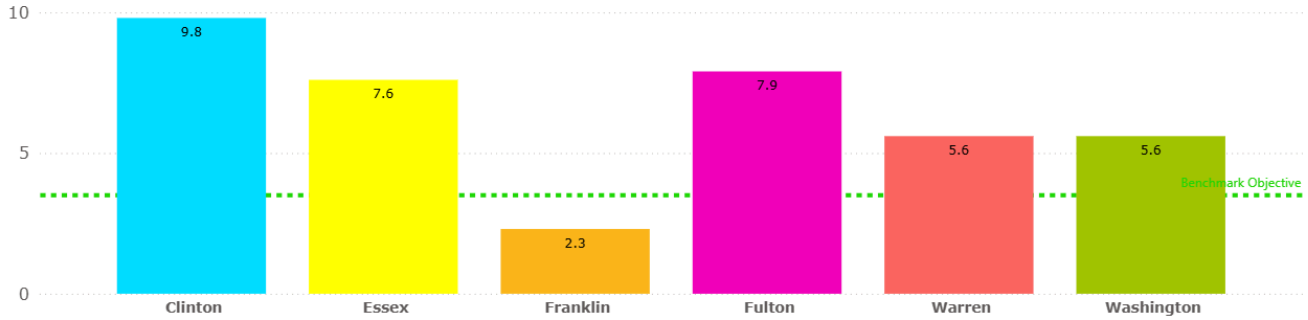


Figure 57: Infant mortality rate per 1,000 live births - regional county comparisons[2]



Pregnant women in Essex County receive early prenatal care more often than women across the state or region (Figure 56 on page 78). This is despite the fact that there are no birthing hospitals in the county and women often have to travel long distances to access obstetrical care.

The maternal mortality rate remains at zero per 100,000 live births, which is lower than regional and state rates and below the Prevention Agenda objective (Figure 57 on page 78). This rate is an unstable estimate.

[2] New York State Department of Health. (n.d.). Prevention Agenda dashboard. New York State Department of Health. https://apps.health.ny.gov/public/tabvis/PHIG_Public/pa/

Figure 56: Percentage of births with early (1st trimester) prenatal care[2]

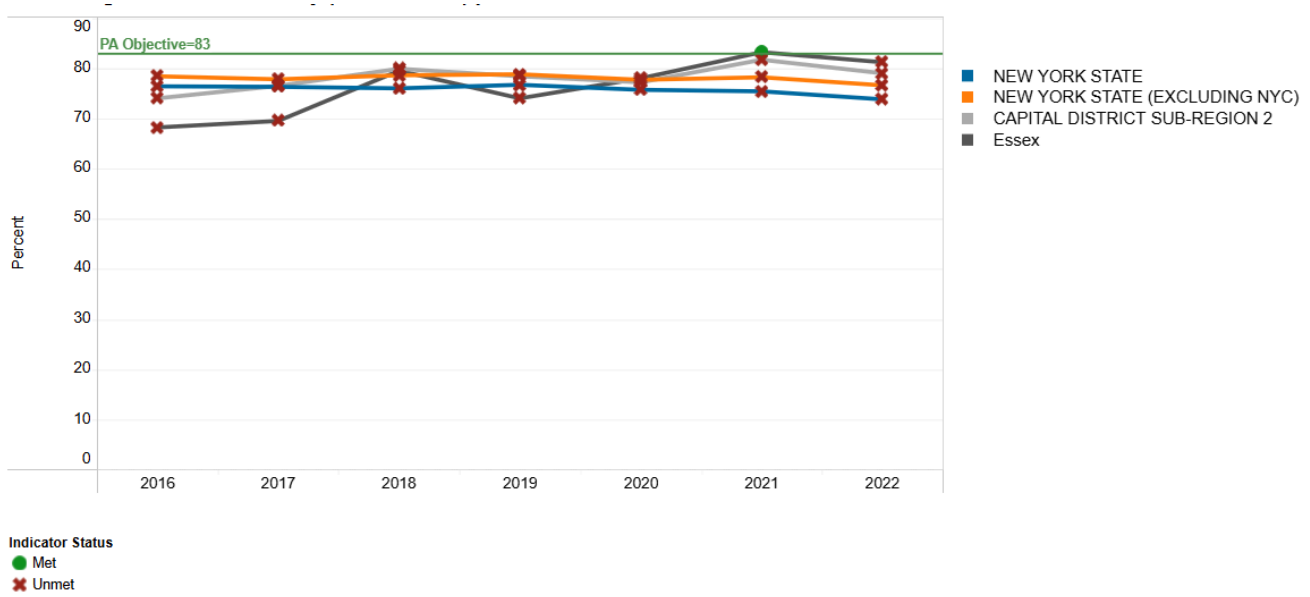
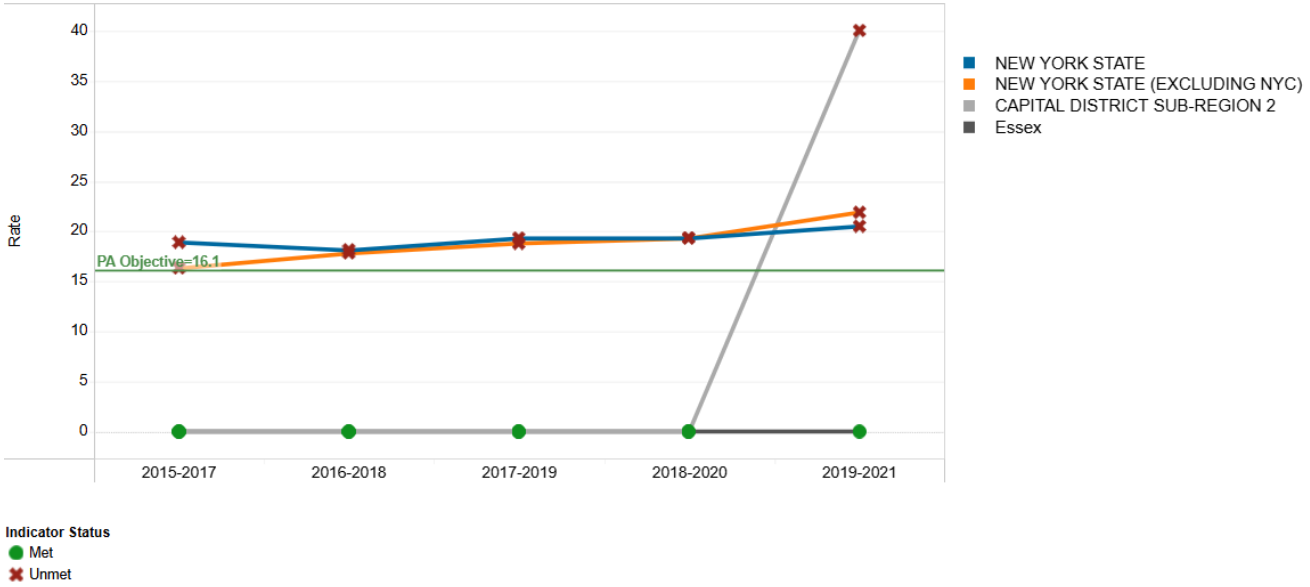


Figure 57: Maternal mortality rate per 100,000 live births[2]



Preventive Services for Chronic Disease Prevention & Control

Chronic diseases, such as heart disease, diabetes, cancer, and asthma, have a significant impact on community health and are a major focus of public health. These conditions are often long-lasting and require ongoing management, placing strain on individuals, families, healthcare systems, and local economies. Chronic diseases are closely linked to social and environmental factors, including access to healthy foods, safe places for physical activity, quality healthcare, education, and income. High rates of chronic illness can lead to increased healthcare costs, reduced workforce productivity, and widened health disparities within communities. By promoting prevention strategies - such as healthy eating, physical activity, tobacco cessation, and early screening - public health and health care can reduce the burden of chronic disease, improve quality of life, and strengthen overall community health outcomes.

Percentage of adults who reported that they:	Essex	NYS (excl. NYC)
Had a diabetes/pre-diabetes test:	49.2%	51.1%
Had a recent check-up:	71.8%	75.1%
Have healthcare coverage, female 18-64:	96.4%	95.2%
Did not get medical care due to cost:	7.7%	6.5%
Ever received a HCV screening test, age adjusted:	33.7%	28.0%
Taken a Chronic disease self management class, age adjusted*:	14.0%	9.6%
Have a regular healthcare provider:	89.3%	88.7%

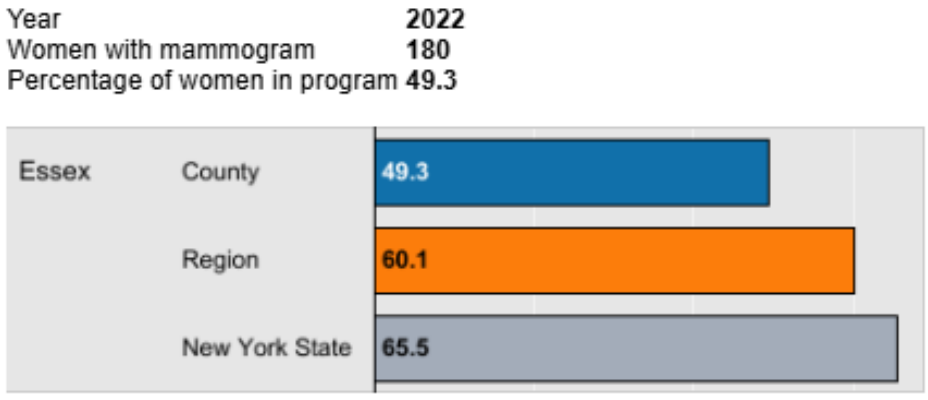
*NOTE: This question is asked of respondents who answer "Yes" to having ever been diagnosed with one of the following chronic conditions: Diabetes, Heart Attack, Angina/ Coronary Heart Disease, Stroke, Asthma, Arthritis, Cancer (other than skin cancer), Chronic Obstructive Pulmonary Disease (COPD), Chronic Kidney Disease.

Table 2: Select Chronic Disease Prevention Indicators, BRFSS 2021[3]

Fewer adults in Essex County report having received a diabetes/pre-diabetes test or a recent check-up with a health care provider than compared with adults across New York State. More adults report not receiving medical care due to cost (7.7%) than the average for New York (6.5%). Essex County adults report better health care coverage, both all adults and females 18-64; greater rates of participation in chronic disease self-management classes, and more screening for hepatitis C than their counterparts in the rest of state (excluding New York City) - Table 2 above.

Screening rates for breast cancer are significantly lower for women in Essex County when compared to the region and New York State (Figure 58).

Figure 58: Percentage of women (aged 50-74 years) who had a mammogram between October 1, 2019 and December 31, 2021, Essex, Medicaid Program[4]



66.1%*

of women aged 50-74 years received breast cancer screening based on current guidelines[3]

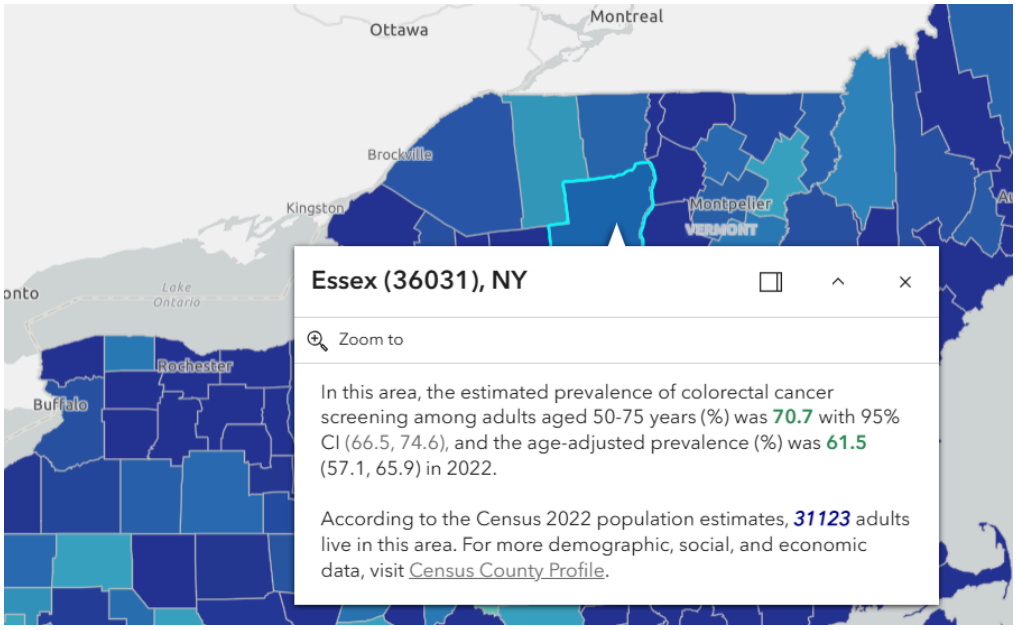
*Unstable/unreliable estimate

[3] New York State Department of Health. (2023). Behavioral Risk Factor Surveillance System (BRFSS) health indicators by county and region: 2016, 2018, 2021. Retrieved December 19, 2025 from https://health.data.ny.gov4

[4] New York State Department of Health. (n.d.). Community Health Indicator Reports (CHIRS) County Dashboard. New York State Department of Health. Retrieved December 20, 2025, from https://apps.health.ny.gov/public/tabvis/PHIG_Public/chirs/

The estimated prevalence of colorectal cancer screening for adults in Essex County is 70.7% and 61.5% when age-adjusted (Figure 59). The age-adjusted rate is below the *Healthy People 2030* goal of 68.3% and both the crude and age-adjusted rates are below the NYS Cancer Consortium and National Colorectal Cancer Roundtable goals of 80.0% screened. The 80% goal was established before the screening guidelines (insurance eligibility) were lowered to those age 45 years and older.[6]

Figure 59: Prevalence of colorectal cancer screening, adults aged 50-75, Essex, 2022[5]



Oral Health Care

Oral health is closely connected to overall health, as conditions such as gum disease and untreated tooth decay are linked to chronic illnesses including heart disease, diabetes, and adverse pregnancy outcomes. Poor oral health can both reflect and worsen underlying health problems, making preventive dental care an important part of overall wellness. However, access to oral health care is not equal across populations. The CDC and *New York State Prevention Agenda* note that low-income individuals, racial and ethnic minority groups, older adults, people with disabilities, and those without dental insurance are significantly less likely to receive regular dental care. Barriers such as cost, lack of providers who accept Medicaid, transportation challenges, language barriers, and limited oral health education contribute to these disparities.[7-8] *Healthy People 2030* identifies improving oral health equity as a national priority, emphasizing that social determinants of health—such as income, education, and neighborhood conditions—play a major role in determining who can access preventive and restorative dental services.[9] Addressing these inequities is essential to improving both oral health outcomes and overall population health.

[5] Centers for Disease Control and Prevention. (n.d.). *PLACES: Local Data for Better Health [Colorectal Cancer Screening]*. CDC. Retrieved December 22, 2025, from https://www.cdc.gov/places

[6] New York State Department of Health. (2024). *The Behavioral Risk Factor Surveillance System (BRFSS) brief: Colorectal cancer screening — New York State adults ages 45–75, 2022* (Report No. 2024-06). https://www.health.ny.gov/statistics/brfss/reports/docs/2024-06_brfss_colorectal_cancer_screening.pdf

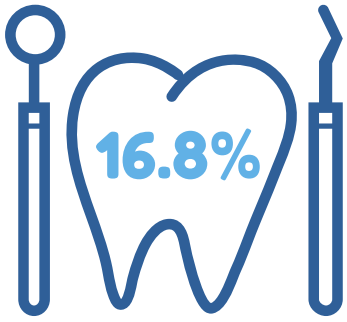
[7] Centers for Disease Control and Prevention. (2024). *Health disparities in oral health*. U.S. Department of Health and Human Services. https://www.cdc.gov/oral-health/health-equity/index.html

[8] New York State Department of Health. (2025). *Prevention Agenda 2025-2030: Priority–Oral health care (pp. D4-4)*. https://www.health.ny.gov/prevention/prevention_agenda/2025-2030/docs/d4-4.pdf

[9] Office of Disease Prevention and Health Promotion. (n.d.). *Healthy People 2030: Oral health*. U.S. Department of Health and Human Services. https://www.cdc.gov/oral-health/php/healthy-people-2030/index.html

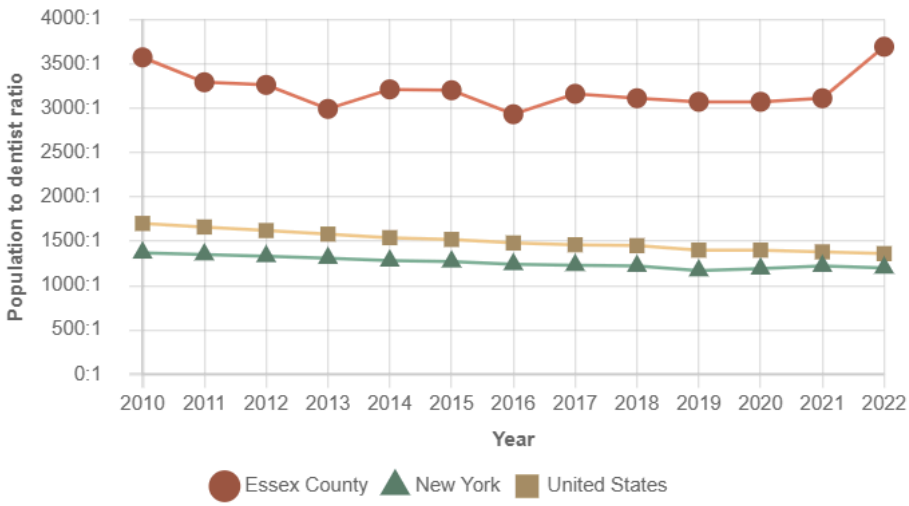
While county level oral health data is not available for all populations that potentially experience disparities, only 16.8% of Medicaid enrollees had at least one preventive dental visit in the last year in Essex County. This is below the Prevention Agenda objective of 21.3% and below New York State and New York State (excluding NYC) comparisons (19.9% and 20.6%, respectively). Younger Medicaid enrollees (children aged 2 - 20) fare better, with 46.2% having at least one preventive dental visit in the last year. This is above the Prevention Agenda objective of 41.1% and above the New York State rates of 39.1% and 42.4% (NYS and NYS excluding NYC, respectively).[2]

Access to dental care is challenging for all residents in Essex County, with a ratio of population to dentists at 3,680:1 (Figure 60). This is well above the New York State ratio of 1,190:1 and the U.S. ratio of 1340:1.[10]



Only **16.8%** of **Medicaid enrollees in Essex County** had at least one **preventive dental visit** in the last year.

Figure 60: Ratio of population to dentists[10]



Access to dental providers was cited as a **top concern** in the 2025 Community Survey of Essex County Residents

Preventive Care

Immunizations, Hearing Screening & Follow-Up, and Lead Screening

Immunizations are a cornerstone of preventive health in New York State, protecting individuals and communities from serious, vaccine-preventable diseases such as measles, polio, and influenza by reducing illness, hospitalization, and death across all ages. Timely vaccination helps maintain high herd immunity and prevents the spread of infectious diseases within schools and the broader community, which is why the New York State Department of Health (NYSDOH) emphasizes the importance of on-schedule immunizations for infants, children, and adults.[11] Regular hearing screening is similarly vital, especially for children, because early detection of hearing loss allows for timely intervention that supports language development, learning, and social engagement; undiagnosed hearing issues can negatively influence academic performance and quality of life.[12]

[10] University of Wisconsin Population Health Institute. (2025). 2025 County Health Rankings & Roadmaps: Essex County, New York [Data profile - 09/24/2025 Update]. County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/health-data/new-york/essex

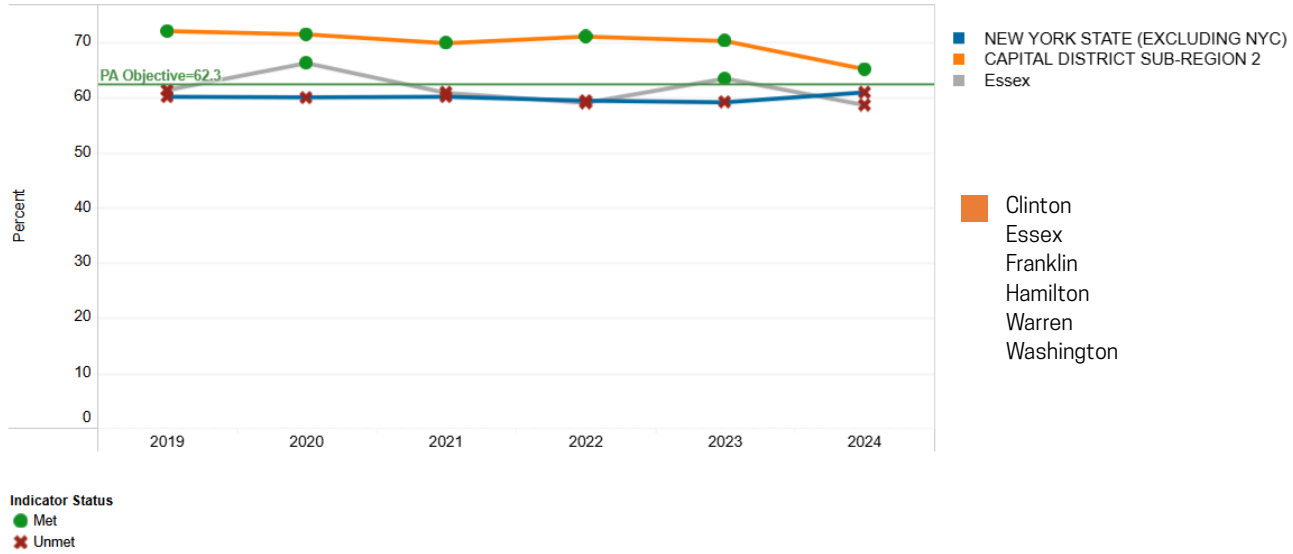
[11] New York State Department of Health. (n.d.). School vaccination requirements. https://www.health.ny.gov/prevention/immunization/schools/school_vaccines/

[12] New York State Education Department. (n.d.). Health screenings (vision, hearing, scoliosis). https://www.nysed.gov/student-support-services/health-screenings

Routine lead screening identifies elevated blood lead levels in young children who may otherwise appear asymptomatic, enabling public health actions to prevent irreversible neurological damage, developmental delays, behavioral problems, and other long-term health effects.[13] Together, these preventive services—immunizations, hearing screening, and lead screening—improve overall health outcomes by enabling early identification and management of conditions that, if left unaddressed, can lead to chronic health issues, developmental setbacks, and increased health care burden later in life.

Immunization rates for young children who have completed their 4:3:1:3:3:1:4 combination series by their 2nd birthday are lower in Essex County 58.6% compared to regional and state values (Figure 61). The Essex County percentage does not meet the Prevention Agenda objective of 62.1%.

Figure 61: Percentage of 24-35-month old children with the 4:3:1:3:3:1:4 combination series by their 2nd birthday[2]



At 11.5%, the number of 13-year-olds in Essex County with a complete HPV vaccine series is less than half the Prevention Agenda target of 26.7% and far below state and regional averages (Figure 62).

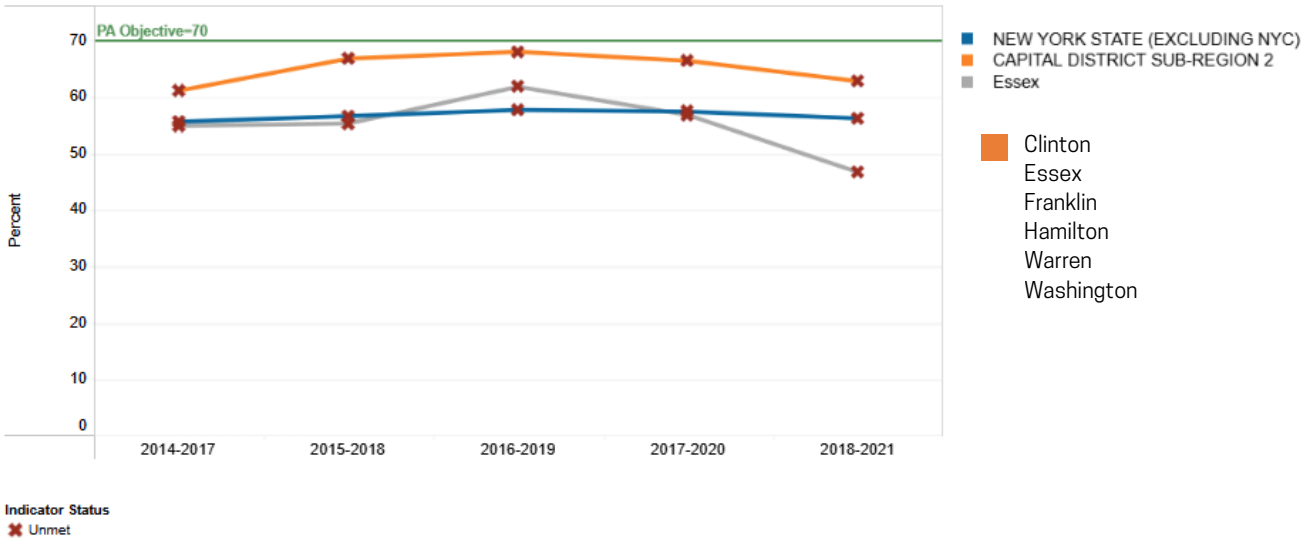
Figure 62: Percentage of 13-year-old adolescents with a complete HPV vaccine series[2]

[13] New York State Department of Health. (n.d.). *Prevention Agenda: Childhood Lead Poisoning Prevention.* https://www.health.ny.gov/prevention/prevention_agenda/healthy_mothers/lead_poisoning_prevention.htm

There are no *NYS Prevention Agenda 2025-2030* data indicators for hearing screening rates in Essex County.

Children in Essex County are tested less often for lead poisoning than children across the region or state (Figure 63), with only 46.8% tested for lead before turning three. This is far below the Prevention Agenda objective of 70.0%, though neither the state nor region have reached this goal either.

Figure 63: Percentage of children in a single birth cohort year tested at least twice for lead before 36 months of age[2]



Early Intervention

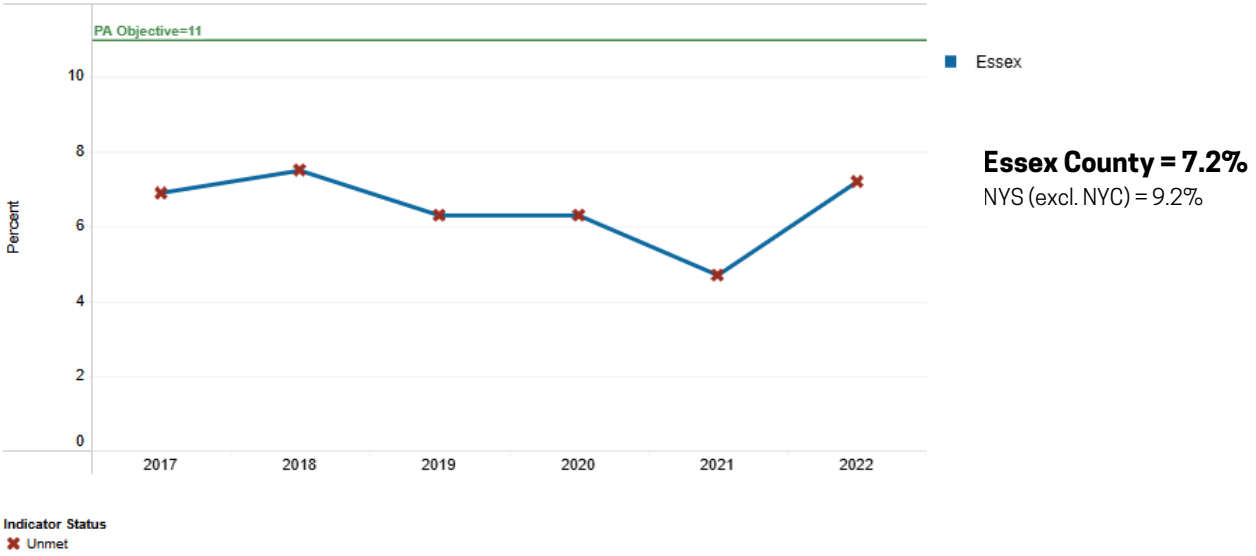
Early intervention is critical to children's health because it addresses developmental delays and health conditions at the earliest stages, when supports are most effective and long-lasting. *The New York State Prevention Agenda 2025-2030* emphasizes that identifying and addressing developmental, behavioral, and health concerns early in life can significantly improve physical health, cognitive development, school readiness, and long-term well-being. Early intervention services—such as developmental screenings, speech and occupational therapy, and family support—can reduce the severity of disabilities, prevent secondary health complications, and decrease the need for more intensive and costly services later in childhood. *The Prevention Agenda* also highlights early intervention as a strategy to reduce health inequities, as children from low-income families and other underserved populations are at higher risk for unmet developmental and health needs.

An Individualized Family Service Plan (IFSP) is a legal document and process for families with infants and toddlers (birth to age 3) who have developmental delays or disabilities, outlining specific early intervention services and supports to help the child reach their potential, with a strong focus on the family's goals and needs within their natural environment. Developed by a team including parents and professionals, the IFSP details the child's present abilities, family concerns, specific services (like therapy or developmental support), where and when they'll happen, and how progress will be measured, transitioning to an IEP at age three.

In Essex County, 7.2% of children under 3 have an IFSP, lower than the target of 11% (Figure 64, page 84).

[14] New York State Department of Health. (2025). *Prevention Agenda 2025–2030: Promote healthy women, infants, and children.* https://www.health.ny.gov/prevention/prevention_agenda/2025-2030/

Figure 64: Percentage of children under 3 with an Individualized Family Service Plan (IFSP)[2]

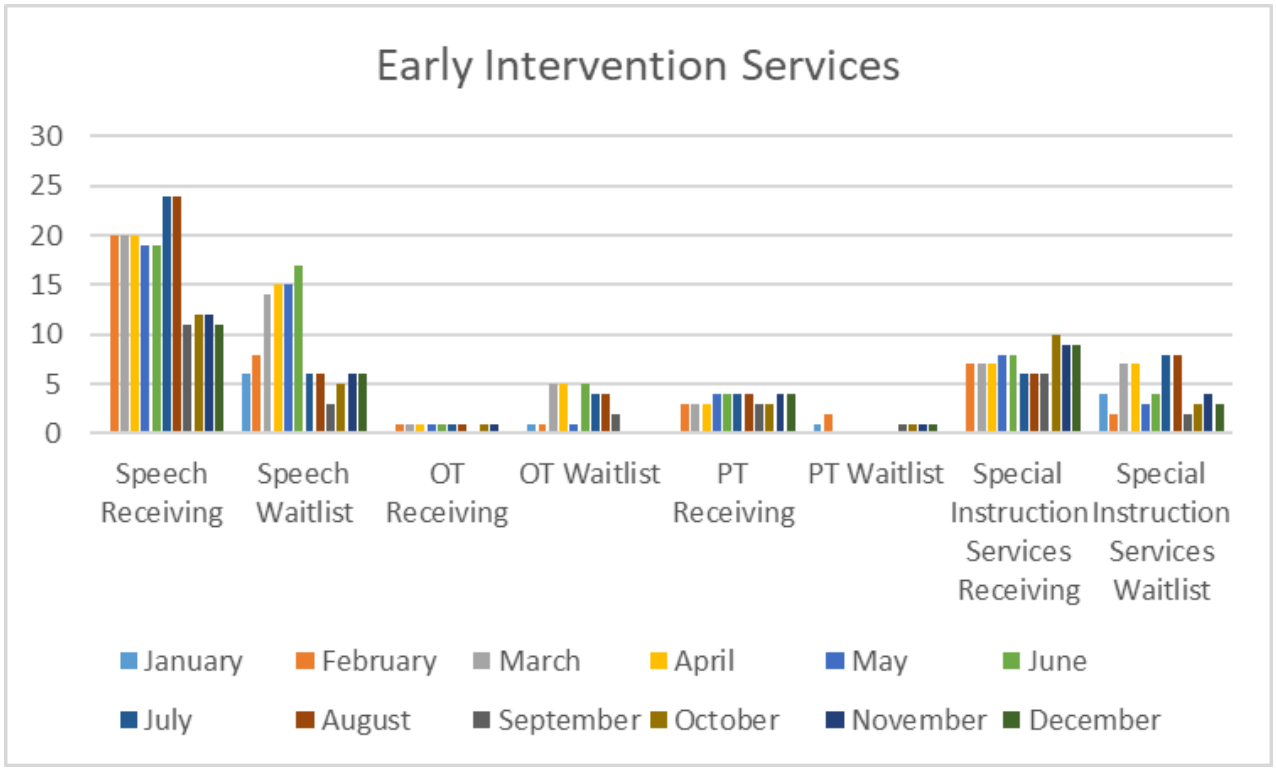


Essex County = 7.2%
NYS (excl. NYC) = 9.2%

Having an IFSP in place is an important step; however, many New York counties - and Essex County is no exception - face major challenges in implementing IFSPs due to a severe shortage of qualified Early Intervention (EI) providers. This is driven by low Medicaid reimbursement rates, leading to long waitlists, especially for in-person therapies, with rural areas and minority families facing greater disparities in access, despite state efforts to increase recruitment and rates.

While Figure 65 is busy, its purpose is to demonstrate the waitlist volumes for Early Intervention services in Essex County - particularly for Speech Therapy, Occupational Therapy and Special Instruction Services. While waitlists have decreased in 2025, the number of children enrolled in the Early Intervention program has also experienced a marked decline from previous years.

Figure 65: Essex County Health Department - Early Intervention Program Data, 2024[15]



[15] Essex County Health Department. January 2025. *Essex County Health Department Report to Human Services Committee of the Essex County Board of Supervisors, January 2025.*

Childhood Behavioral Health

Childhood behavioral health extends beyond the presence of mental health disorders to include prevention and supports that promote overall well-being, such as positive relationships, stress management, safe environments, and opportunities to learn and play. In New York State, challenges remain, with 6% of youth considered disconnected from school or employment in 2022 and only about half of children with a mental health condition receiving treatment in recent years. Behavioral health is a critical component of child development with lifelong health implications and is closely connected to physical health, as individuals with severe mental illness experience significantly shorter life expectancy. Recognized as a national emergency by leading pediatric organizations, improving childhood behavioral health requires a comprehensive approach that includes primary prevention for all children, early screening and identification, and expanded access to treatment, supporting healthier outcomes across the lifespan.

There are no county level indicators for Essex County available of the NYS Prevention Agenda Dashboard. At the state level, the dashboard cites the National Survey of Children's Health (NSCH) data as a metric being tracked for progress in this area. Specifically, the percentage of children reported as flourishing, aged 6 months to 5 years (2022-2023) was 72.2% in New York State. This is below the Prevention Agenda objective of 79.4% and down from 75.0% (2021-2022). Not surprisingly, chidren in households living between 0-99% of the poverty level fair quite a bit worse, with only 58.8% reported as flourishing.[2]

[15] New York State Department of Health. (2025). *Prevention Agenda 2025–2030: Childhood behavioral health*. In Prevention Agenda 2025–2030: New York State's health improvement plan. https://healthweb-back.health.ny.gov/prevention/prevention_agenda/2025-2030/docs/prevention_agenda_plan.pdf

DOMAIN 5: EDUCATION ACCESS & QUALITY

The Education Access and Quality domain encompasses the following priority areas:

Health & Wellness Promoting Schools

Opportunities for Continued Education

Data available for Essex County in this domain are a mix of primary (locally compiled) and secondary data sources.

Health & Wellness Promoting Schools

School environments are a powerful social determinant of health because, as Healthy People 2030 (HP-2030) defines, the conditions in which people "live, learn, work, play, worship, and age" shape a wide range of health, functioning, and quality-of-life outcomes.[1] A well-designed, safe, and supportive school - with policies that ensure a healthy physical environment (e.g., good air quality, safe infrastructure, clean water, adequate lighting) and a positive social and emotional climate - gives students and staff access to better conditions for development, learning, and well-being.[2] Because education settings count as part of the "places where people learn," inequities in school quality, safety, and resources contribute to disparities in long-term health - influencing not just academic outcomes, but also physical health, mental health, and life-course opportunities.[3] This framing underscores that health is shaped not only by medical care or individual behavior, but by the social and structural contexts, including the school environment, that people inhabit.

Healthy People 2030 recommends that schools consider the following features to promote physical and mental health and well-being for children and adolescents:

- safe and supportive environments
- healthy foods
- health education
- physical education
- access to health care and mental health services
- help for students who manage chronic conditions
- trauma-informed practices
- counseling and mental health interventions
- steps/programs to reduce bullying

[1] Office of Disease Prevention and Health Promotion. (n.d.). Social determinants of health (SDOH). Healthy People 2030. U.S. Department of Health and Human Services. Retrieved December 9, 2025, from https://health.gov/healthypeople/priority-areas/social-determinants-health

[2] Office of Disease Prevention and Health Promotion. (n.d.). Increase the proportion of schools with policies and practices that promote health and safety — EH-D01. Healthy People 2030. U.S. Department of Health and Human Services. Retrieved December 9, 2025, from https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/neighborhood-and-built-environment/increase-proportion-schools-policies-and-practices-promote-health-and-safety-eh-d01

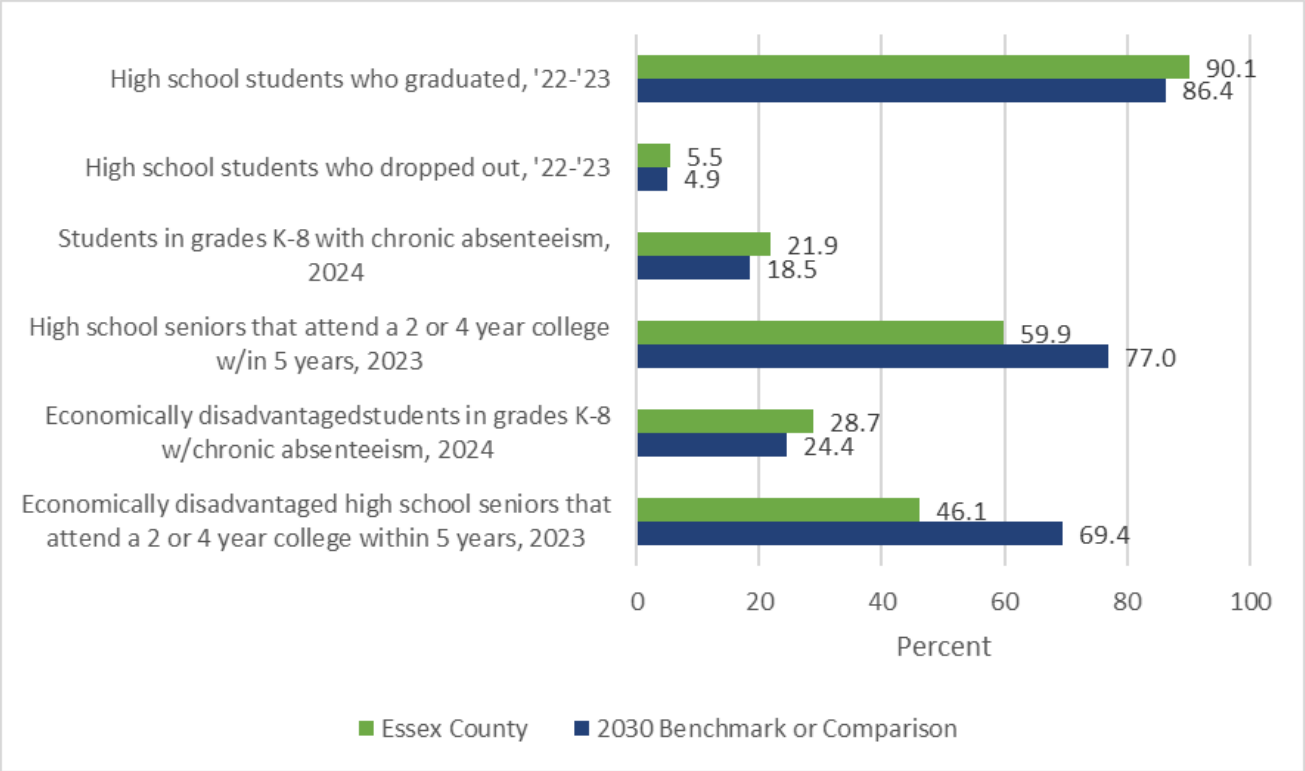
[3] Centers for Disease Control and Prevention. (2024, May 15). Social determinants of health. Public Health Gateway. https://www.cdc.gov/public-health-gateway/php/about/social-determinants-of-health.html

Key Education Quality Metrics

2023 - 2024 School Year										
	Graduation Rate						Chronic Absenteeism Rate			
	All	Female	Male	Students with Disabilities	Economically Disadvantaged	Not Economically Disadvantaged	Elementary	Elementary Economically Disadvantaged	Secondary	Secondary Economically Disadvantaged
BVCS	91%	89%	93%		100%	83%	17.3%	24.5%	24.5%	33.9%
Crown Point	89%	86%	92%	60%	88%	89%	14.9%	21.6%	6.5%	10.0%
Keene	100%						23.8%	25.0%	23.0%	
Lake Placid	92%	93%	92%	83%	78%	97%	13.0%	25.4%	16.8%	27.1%
Minerva	86%						14.8%	16.3%	45.7%	
Moriah	89%	93%	86%	68%	83%	93%	35.4%	41.0%	29.9%	38.6%
Newcomb	100%									
Schroon Lake	85%	83%	86%		100%	67%	31.5%	33.7%	27.7%	33.3%
Ticonderoga	83%	86%	81%	56%	82%	85%	21.6%	26.4%	7.2%	8.6%
Willsboro	91%	93%	88%	80%	85%	100%	17.1%	22.4%	30.1%	39.5%
	Data not available due to small class/cohort size									

Table 3: Graduation and Chronic Absenteeism Rates by Essex County Public School, 2023-2024[4]

Figure 66: Education Access & Quality Indicators[5]

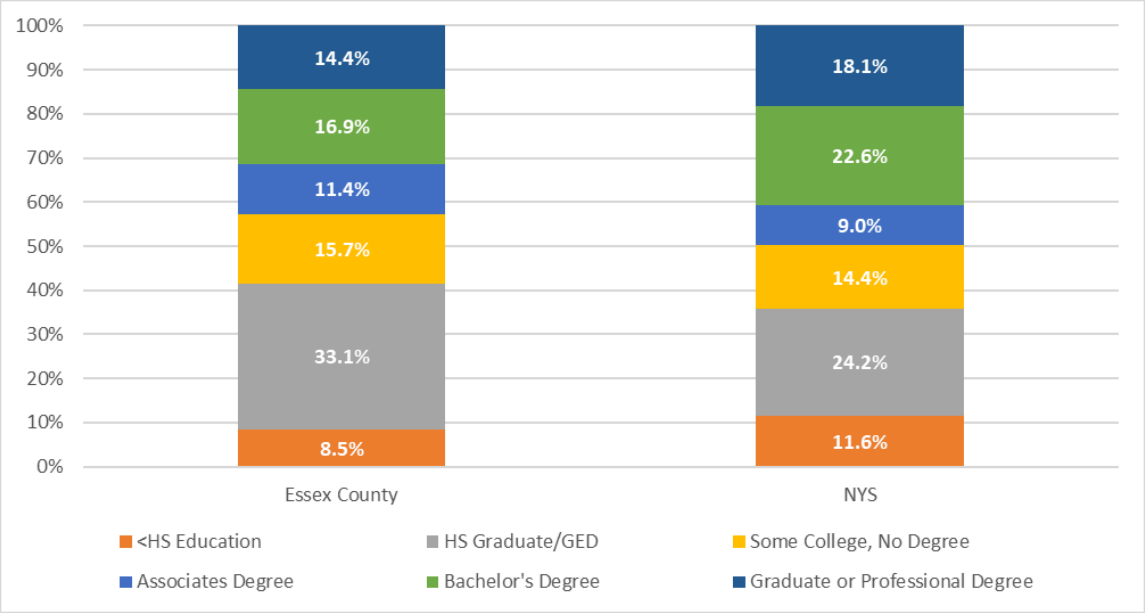


The overall graduation rate in Essex County (90.1%) is higher than the New York State comparison (86.4%) but the drop-out rate in Essex County is also higher. Graduation rates vary by school district and vary even more widely by different subpopulations (gender, ability, socioeconomics) within school districts. Almost all schools have chronic absenteeism rates that are higher than the Healthy People 2030 Benchmarks, and the rate of high school seniors attending college within 5 years is significantly lower than the Healthy People 2030 Benchmarks.

[4] New York State Education Department. (2023-2024). School Report Card and High School Graduation Rate. Retrieved June 13, 2025 from https://data.nysed.gov/

[5] New York State Department of Health. (2025). Prevention Agenda Tracking Dashboard. Retrieved June 20, 2025, from https://apps.health.ny.gov/public/tabvis/PHIG_Public/pa/.

Figure 67: Educational Attainment[6]

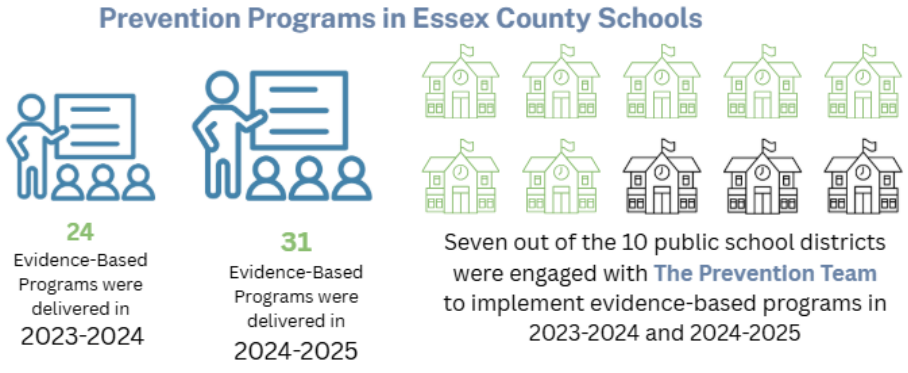


Fewer residents in Essex County complete a college degree program when compared with state attainment levels; however, degree attainment increased in Essex County by 3.4% since 2020 (Figure 67). Essex County residents compared better than the state for residents aged 25 and older with less than a high school education.

Positive School Environments

New York State Education Department (NYSED) curriculum standards require the integration of Social-Emotional Learning (SEL), Mental Health Literacy, and Substance Use Prevention through required health education, focusing on core competencies (self-awareness, management, social awareness, relationship skills, responsible decisions) and linking them to overall well-being, resilience, and positive behaviors, supported by specific guidance documents for evidence-based programs and school-wide practices.[7]

Standards can be achieved in various ways. The Prevention Team delivers evidence-based programming across a wide array of topics, like healthy choices, peer pressure, substance use prevention, media use, etc. As of 2023-2024, they were providing programs at 7 out of the 10 public schools in Essex County.



The Prevention Team :

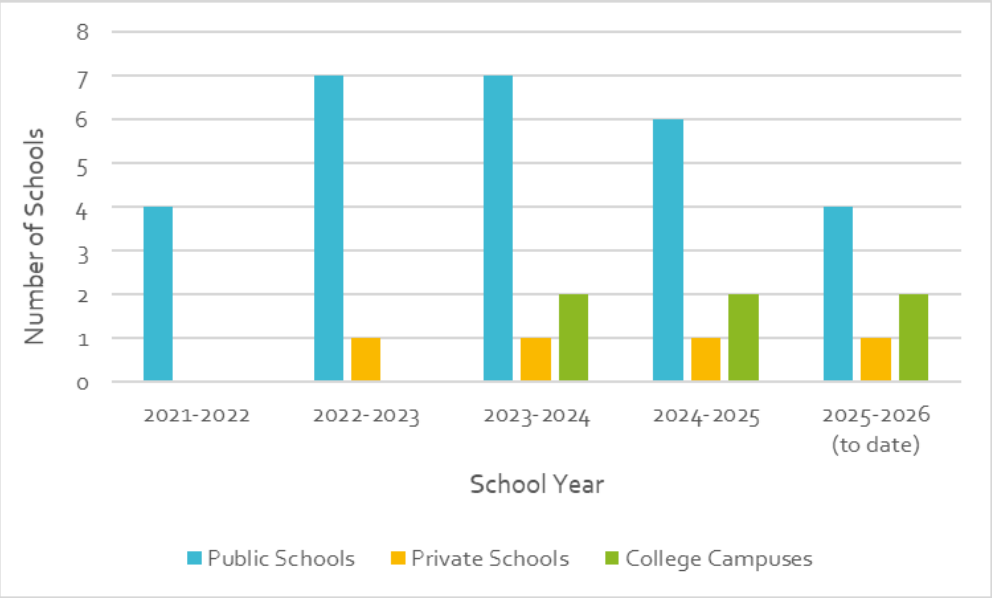
- Facilitates skills to Help Kids be safe, confident, and have happy, strong relationships;
- Prepares teens with safety strategies/refusal skills to address the pressures they face in today's society; and
- Empowering Adults with resiliency tools to strengthen their relationships personally and professionally using protective factors

[6] US Census Bureau, ACS 5-Year Estimates, 2023

[7] New York State Education Department. (n.d.) *New York State P-12 Common Core Learning Standards for Health Education*. Retrieved December 10, 2025 from nysed.gov

Since 2021, the Essex County Health Department (ECHD) has partnered with 8 of the 10 public schools and two of the five private schools in Essex County, as well as both community college campus locations to provide tailored, age appropriate comprehensive reproductive and relationship health education (Figure 68). *One additional public school received programming during the time frame noted; however, the school is located in an adjacent county, with students from Essex County attending.

Figure 68: ECHD School Health Curriculum Outreach Metrics[8]



70%

of the public school districts in Essex County participated in the **National Free Lunch Program (NFLP)** in 2023[9]. **Program requirements:**

- create menus that meet Federal nutrition standards to ensure students receive balanced & healthy meals
- ensure school nutrition staff meet specific training requirements
- ensure foods sold outside the school meal program comply with Smart Snacks Standards
- develop & implement Wellness Policies that promote student health & well-being

Research shows that school meals alleviate food insecurity and poverty, support good nutrition, improve health outcomes, and boost learning.[11] Starting in 2025, New York State now offers ***Universal Free School Meals***, providing free breakfast and lunch to every student in participating schools for the 2025-2026 school year and beyond, regardless of family income.[10]

[8] Essex County Health Department. (2025). *Family Health Program Data*. Compiled December 11, 2025. Available upon request.
[9] USDA. (2025). National Free Lunch Program. Retrieved May 27, 2025 from usda.gov
[10] NYSED. (May 13, 2025). *New York State Universal Free Meals [Policy Memo].* Retrieved December 11, 2025 from https://www.cn.nysed.gov/content/new-york-state-universal-free-meals
11 Food Research and Action Center. (May 2021). *School Meals are Essential for Student Health and Learning* [Research Brief]. Retrieved December 11, 2025 from https://frac.org/programs/national-school-lunch-program/benefits-school-lunch

Opportunities for Continued Education

As noted in Step 3, Develop a Community Profile, North Country Community College is the only institution of higher learning based in Essex County. Proximity to population centers within the county is satisfied through the main campus in Saranac Lake (a shared village of Essex and Franklin counties) and an extension campus in Ticonderoga. The State University of New York (SUNY) College of Environmental Sciences and Forestry, has an extension campus in Newcomb.

The SUNY system offers many options throughout New York for students pursuing an in-state higher education. Other nearby SUNY schools include Clinton Community College, Adirondack Community College, Plattsburgh, Canton, and Potsdam.

Private colleges and universities in the region include Paul Smith's College of Arts & Sciences, St. Lawrence University and Clarkson University in New York and several in Vermont, though cost, especially out-of-state tuition, can be prohibitive for many without significant assistance.

College / University	Type	General Location
North Country Community College	SUNY CC	Saranac Lake, NY
Paul Smith's College	Private	Paul Smiths, NY
SUNY Plattsburgh	Public	Plattsburgh, NY
Clinton Community College	SUNY CC	Plattsburgh, NY
SUNY Potsdam	Public	Potsdam, NY
Clarkson University	Private	Potsdam, NY
Middlebury College	Private	Middlebury, VT
University of Vermont (UVM)	Public	Burlington, VT
Champlain College	Private	Burlington, VT
Saint Michael's College	Private	Colchester, VT
SUNY Adirondack	SUNY CC	Queensbury, NY
SUNY Albany	Public	Albany, NY
RPI	Private	Troy, NY

Table 4: Colleges and Universities In or Near Essex County, NY

Opportunities for continued education as an alternative to college/university enrollment are available in Essex County, including adult education, workforce training, personal enrichment, and GED/skills programs, as noted in Table 5.

Provider / Program	Services Offered / Notes
Champlain Valley Educational Services (CVES / CV-TEC)	Career & Technical Education (CTE) for adults, adult literacy, job skills training, online courses, GED/HSE prep, continuing education for community members
CV-TEC – OneWorkSource Campus	Adult High School Equivalency (HSE / GED) preparation, adult literacy, job-skills training
Literacy Volunteers of Clinton, Essex and Franklin Counties (LVCEF)	Free one-on-one adult tutoring: basic literacy, reading, writing, math, English for non-native speakers (ESOL), GED support
Literacy Volunteers of Essex/Franklin Counties (Port Henry / Essex-area branch)	HSE preparation, adult literacy, basic education services

Table 5: Continuing Education Programs and Services Available to Essex County Residents

Essex County continues to experience workforce shortages in critical health, human services, and infrastructure roles—including Advanced Emergency Medical Technician and EMS training, nursing, Child Development Associate preparation, wastewater operator certification, crisis intervention, and high-demand micro-credentials such as Direct Support Professional and Crisis Intervention—which directly affect access to care, emergency response capacity, and overall community well-being. These challenges are intensified by the county's rural geography, limited transportation, and restricted access to education and training, creating barriers across multiple social determinants of health. In alignment with Community Health Assessment and Community Health Improvement Plan priorities, North Country Community College collaborates with healthcare systems, local and county government agencies, businesses, and community organizations to develop accessible, regionally responsive workforce pipeline programs. Through flexible delivery models, stackable credentials, employer-aligned training, and community-based education, the College reduces structural barriers, strengthens workforce readiness, and supports economic stability.

In addition, while not a branch campus, North Country Community College maintains strong, formal transfer pathways within the SUNY system - most notably through programs such as Gateway to Plattsburgh - enabling seamless degree completion for students, including registered nurses pursuing RN-to-BS pathways. These coordinated efforts expand rural access to education, support career advancement, and strengthen the long-term capacity of the local healthcare and public service workforce, contributing to improved health equity across Adirondack communities.

Conclusion

Health Challenges and Associated Risk Factors

This current Community Health Assessment identified several health challenges faced by residents of Essex County. Physical health challenges include high rates of obesity, chronic conditions, and dental caries and lower immunization rates for common childhood immunizations. Mental and behavioral health challenges include higher rates of depression, suicide, alcohol and tobacco use, along with increasing numbers of overdoses in the county - fatal and non-fatal combined - (though more recent data reveal are marked decrease in overdose deaths at the local, state and national levels), and high rates of chronic absenteeism in schools.

The contributing causes are multifaceted and include poverty (higher childhood poverty rates and pockets of the county that have many ALICE families); housing availability and affordability challenges; food insecurity; lower access to health, mental health, oral health care, Early Intervention services, and other community services and supports; higher access to alcohol, tobacco, and prescription opioid medications due to high vendor/outlet densities and high rates of prescribing and higher rates of child abuse/maltreatment. Additionally, while violence and crime rates are low, unintentional injuries and motor vehicle crash rates are high.

Disparities

There is limited race/ethnicity data for Essex County. Indicators where this information exists often have values suppressed or the data is unreliable/unstable. Key disparities in the county include **age** (high proportion of older adults living in the county), **income** (increasing income inequality), **access to care** (higher population to provider ratios for all areas of care), and **geography** (rural area where distance and transportation can impact health outcomes).

Prioritize Community Health Issues

Prioritizing community health issues is a process that involves collecting and analyzing data, then using it to build consensus with stakeholders, partners, and community members. This consensus is used to select priorities based on criteria such as problem magnitude, available interventions, and community concern.

The health issues presented to and discussed with stakeholders, partners, and community members were framed in the context of the *NYS Prevention Agenda 2025-2030*. As previously noted, identifies five Domains comprised of 24 priority areas, with priority-specific action plans that were developed following extensive cross-sector collaboration.

Following a highly collaborative local process, the Essex County Health Partners (ECHP) settled on four domains and eleven corresponding priority areas that would benefit from coordinated initiatives over the next five years. These four domains and eleven priority areas are:

Domain	Priority Areas
Economic Stability	• Poverty • Housing stability and affordability • Unemployment • Nutrition security
Neighborhood & Built Environment	• Access to community services and support
Social & Community Context	• Adverse Childhood Experiences (ACEs) • Depression • Healthy Eating • Primary Prevention, Substance Misuse, & Overdose Prevention • Tobacco/E-Cigarette use
Health Care Access & Quality	• Preventative Services for Chronic Disease Prevention and Control

Key disparities in the county include **age** (high proportion of older adults living in the county), **income** (increasing income inequality), **access to care** (higher population to provider ratios for all areas of care), and **geography** (rural area where distance and transportation can impact health outcomes).

Prioritization Methods

Several steps were taken to inform the prioritization of health needs by ECHP, including:

- Reviewing available demographic data (Step 3) and the data and health indicators for each domain, as summarized in the sections covering Step 4 and Step 6.
- Considering community input via the 2025 Community Survey, attached in Step 6.
- Considering stakeholder input via the 2025 Stakeholder Survey, attached in Step 6.
- Convening internal planning groups and external partners to share preliminary findings and request prioritization input. This engagement was outlined in the section covering Step 2.
- Utilizing a prioritization matrix* (see page 95).
- Presenting draft prioritization and requesting feedback from the Essex County Board of Supervisors/Board of Health, Essex County Health Department Public Health Advisory Committee, hospital boards, and Essex County community members.
- Drawing final conclusions based on feedback.

*Note: The prioritization matrix is a locally-modified version of a matrix from MAPP 2.0, which included criteria based on data comparisons, trends, problem magnitude, problem severity, and disparities. ECPH modified this matrix to include considerations in the areas of local feedback and community readiness to address problems. In other words, are there assets that can be mobilized now or in the near future to begin CHIP work plan implementation?

Justification for Unaddressed Health Needs

Ultimately, the final decision to collectively elevate the three Domains and corresponding Priority Areas noted above (plus the additional Health Care Access and Quality Domain for hospitals) should not be taken to assume that effort and resources will not be directed at the remaining Domains and Priority Areas. First, many of the interventions that are featured in the Essex County 2026-2030 CHIP are cross-cutting strategies that will have an impact across multiple domains/priority areas. For example, addressing access to food programs to alleviate poverty will not only improve poverty indicators, but will improve access to health care and to social and community supports. Second, the Essex County Health Department and hospital partners conduct programs and services in number of core areas that address many of the priority areas not selected during this cycle.

These programs and services will continue, ensuring ongoing efforts to target the other health needs identified in Essex County. For example, the Essex County Suicide Prevention Coalition is a long-standing, multi-sector collaboration whose mission is *to work together as a community to increase suicide awareness and prevention;* and vision is *that Essex County will have the necessary information and tools to raise awareness, promote education, and increase action to reduce suicides*. Another example is ECHD's Immunization Action Plan grant, which is administered with the purpose of increasing immunization rates in the county through several evidence-based strategies and specific actions that support community and health care provider outreach. Many other programs, services, and activities exist through health department, hospital, and community partner deployment. More information about these programs, services, and activities is available upon request or by visiting agency websites.

Document & Communicate Results

Sharing the outcomes of the CHA process with various stakeholders - both internal and external - is a critical component of the community health assessment cycle. Communicating with interested and impacted parties provides an opportunity for those parties to offer feedback and helps ensure a diversity of voices and ideas.

Community Health Assessment presentations, formal and informal, were provided to the following audiences:

Audience	Delivery Method	Dates
Essex County Board of Supervisors (Board of Health)	1. Written updates in BOS Report	Monthly throughout 2025
	2. Presentation at Human Services Committee Meeting	October 14, 2025
Public Health Advisory Committee	1. Written updates in PHAC Report	Quarterly throughout 2025
	2. Presentation at PHAC Meeting	September 9, 2025
Internal Staff Meetings	1. Informal updates	Weekly throughout 2025
	2. Presentation of data & priority areas selected	September 25, 2025
Community Health Coalition of Essex County	In-person and virtual meetings	Quarterly: June 23, 2025 September 8, 2025 December 8, 2025
Essex County Health Partners	In-person and virtual meetings	Ad Hoc - as needed (quarterly, monthly, and bi-monthly depending on work load)
UVM Health - Elizabethtown Community Hospital Senior Leadership Team and Board of Trustees	Presentation at a Regular Board Meeting	November 6, 2025
ECHD Internal Staff	In-person meetings and e-mail communications	Ad Hoc - as needed
External Partners	Virtual meetings and e-mail communications	Ad-Hoc - as needed
General Public	Press Releases and Social Media communications	Various (multiple)

Much of the initial sharing and communicating results centered on the following two aspects of the CHA:

1. The early cycle effort to garner community, partner, and stakeholder feedback that would help ECHP plan and prioritize our work; and
2. The preliminary data analysis conducted by ECPH. Data indicators and the overall analyses were categorized into the five 2025-2030 Prevention Agenda Domains, allowing for a more holistic view of each.

The following pages (97 - 103) contain the Community and Stakeholder Survey Summaries, as well as Domain posters that were created to to disseminate the information*. These materials were generally accompanied by a presentation/description of the purpose, goals, and objectives of the discrete steps of the process, as well as an invitation to submit feedback.

Later sharing centered on the results of the CHA and introduction of the CHIP, including the prioritization and selection of domains and priority areas, as well as the interventions identifies to advance action in those areas.

*Note: Information on the Domain Posters may appear illegible due to sizing. Data from the posters is covered in Step 4: Collect and Analyze Data.

COMMUNITY SURVEY SUMMARY 2025 - WHAT **YOU** TOLD US:

562 Survey Participants!

Most important features of a strong, vibrant, healthy community:

- **Affordable housing**
- **Livable wages**
- **Access to healthcare**
- **Safe neighborhoods**
- **Good schools**

Essex County residents said affordable housing, livable wages, access to healthcare, safe neighborhoods, and good schools were most important for a strong, vibrant, healthy community. These were followed by: a **clean environment** and **resources for older adults**.

What are the **main health concerns** in the community where you live?

- **Access to healthcare and/or dental providers**
- **Substance misuse**
- **Mental health** (including access to mental health services)
- **Nutrition/eating habits** (including access to healthy food)
- **Issues related to aging** (arthritis, falls, hearing/vision loss, cognitive impairment)

Your Most Trusted Sources of Health Information (top 3):

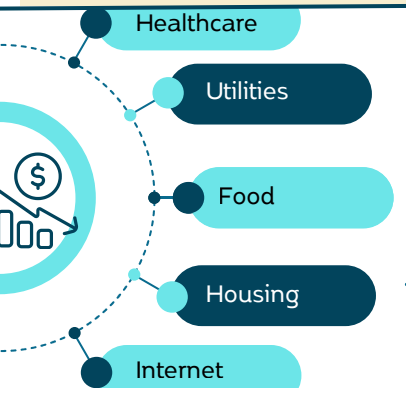
- **Healthcare providers**
- **Health departments**
- **Hospitals**

How do you think your community will be doing in 5 years?

- **Access to transportation**
- **Affordable housing**
- **Employment opportunities**
- **Access to healthy food**
- **Access to childcare**
- **Safety**

The majority of survey respondents said that their communities would be doing about the **same** or **worse** in 5 years, in all of the above categories.

What would help most in the community where you live?

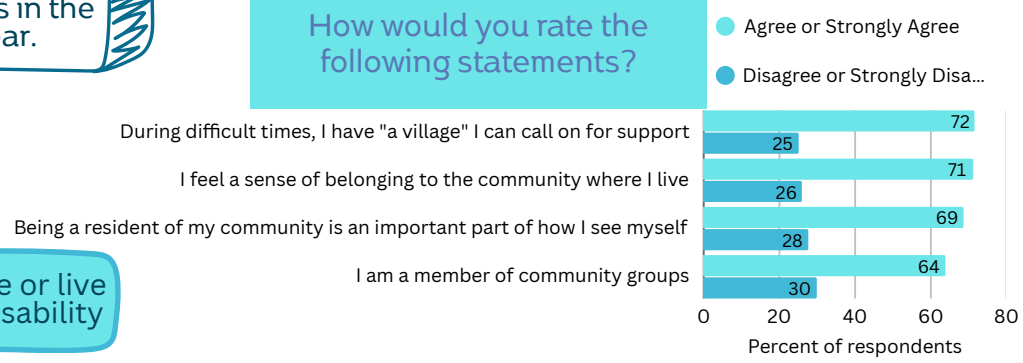


Areas where you have had the **most** financial trouble meeting your needs in the last year.

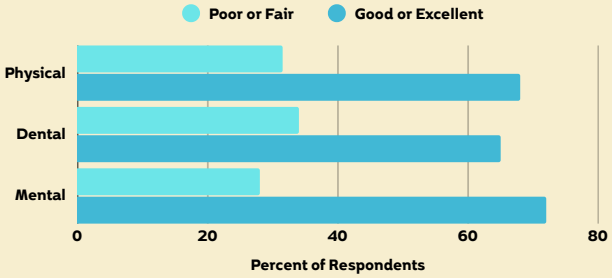
Affordable housing
Stable & gainful employment
Healthcare access
Resources and support for aging adults
Access to affordable, high quality child care

24% of survey respondents have or live with someone who has a disability

How would you rate the following statements?



How You Rated Your Health:



Of the respondents who said they had children under 18 living in their household:

18% rated their child's mental health as fair or poor

STAKEHOLDER SURVEY SUMMARY 2025

118
Stakeholder Respondents (highest participation of 7 county region!)

Top 5 health concerns in Essex County:

1. Mental Health
2. Substance use/alcoholism/opioid use
3. Child/adolescent emotional health
4. Adverse childhood experiences
5. Overweight or obesity

Top 5 contributing factors in Essex County:

1. Poverty
2. Lack of mental health services
3. Addiction to alcohol/illicit drugs
4. Changing family structures
5. Age of residents

Rank the social determinants of health that impact residents the most:

- **Economic stability**
- **Health access**
- **Education access and quality**
- **Neighborhood and built environment**
- **Social and community context**

What population experiences the poorest health outcomes in Essex County?

1. Individuals living at or near Federal Poverty Limit
2. Individuals with mental health issues
3. Seniors/elderly
4. Individuals with substance use issues tied with individuals living in rural areas
5. Children/adolescents

TOP PRIORITY AREAS IN EACH DOMAIN

that organizations serving Essex County said they are best positioned to support:

DOMAIN
Economic Stability

- Nutrition Security
- Poverty
- Unemployment **tied** with Housing Stability & Affordability

DOMAIN
Social & Community Context

- Primary Prevention, Substance Misuse, & Overdose Prevention **tied** with Healthy Eating
- Anxiety & Stress
- Adverse Childhood Experiences

DOMAIN
Neighborhood & Built Environment

- Access to Community Services & Support
- Opportunities for Active Transportation & Physical Activity
- Injuries & Violence

DOMAIN
Health Care Access & Quality

- Childhood Behavioral Health
- Preventive Services for Chronic Disease Prevention & Control **tied** with Preventive Services
- Early Intervention

DOMAIN
Education Access & Quality

- Health & Wellness Promoting Schools
- Opportunities for Continued Education

Assets/resources your organizations said you could contribute toward achieving goals in the above priority areas:

- Participate on committees, work groups, and coalitions
- Provide subject matter knowledge & expertise
- Share knowledge of community resources
- Promote health improvement activities/events through social media & other channels your agency/organization operates

Domain 1
Economic Stability
Priority Areas

- Poverty
- Income
- Employment
- Housing
- Food Security

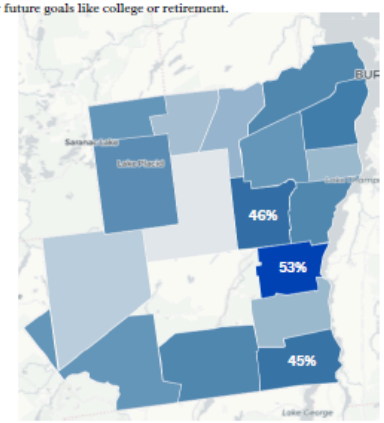
ALICE - Asset Limited, Income Constrained, Employed households are those with incomes above the Federal Poverty Limit, but below the basic cost of living.
Households below the ALICE Threshold include both poverty-level & ALICE households and are unable to afford the basics.

Household Survival Wages, Essex County, NY, 2023

	Single Adult	One Adult One Childcare	Two Adults	Two Adults Two Childcare	Single Senior	Two Seniors
Hourly Wage	$16.24	$28.58	$23.23	$48.12	$18.10	$27.67

The Household Survival Wage reflects the minimum wage needed to live in the current economy and includes housing, child care, food, transportation, health care, technology, and taxes. It does not include savings for emergencies or future goals like college or retirement.

Areas of Essex County with the highest percent of their population living below the ALICE Threshold



Moriah 53%
Elizabethtown 46%
Ticonderoga 45%

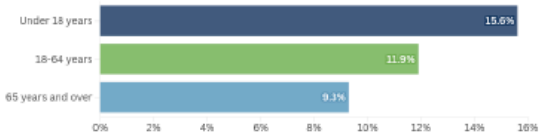
Within the town of Moriah, the hamlets of Port Henry and Witherbee have the highest percent of their population living below the ALICE Threshold, at 66% and 60%, respectively.

Source: UnitedForALICE.org

Poverty

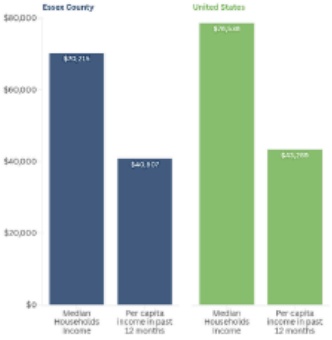
13% In 2023, the percentage of individuals living below the Federal Poverty Level was higher in Essex County at 13% than U.S. at 11.1%.

Poverty by Age
Essex County



Income

Household Income (in 2023 dollars)
2019-2023



Source: US Census Bureau, 2019-2023 ACS 5 year estimates

Housing

Housing quality in Essex County is comparable to housing quality across NYS

Residents spend a smaller portion of their incomes on housing than the average state resident

Essex County has an affordable housing shortfall

37.6% Houses in Essex County that are Vacant
National Average 17.6%

25.1% Households spending at least 30% of income on housing
National Average 23.5%

47.6 Work hours needed to pay for affordable housing
National Average 40.2

Housing Data Source: 2018-2022; American Community Survey 5-year estimates, U.S. Census Bureau

Food Security

Average Meal Cost in Essex County
$4.00

Annual Food Budget Shortfall
($3,640,000)

Essex County

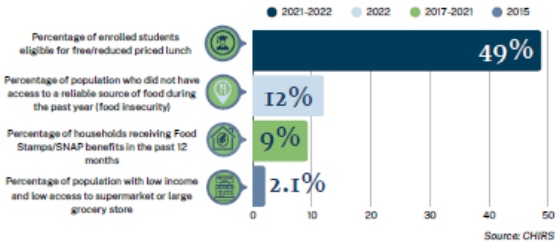
Food Insecure Population (child)
1,050

Food Insecurity Rate in Essex County (child)
17.8%

Income Eligible for Federal Nutrition Program
76%

Likely Ineligible for Federal Nutrition Program
24%

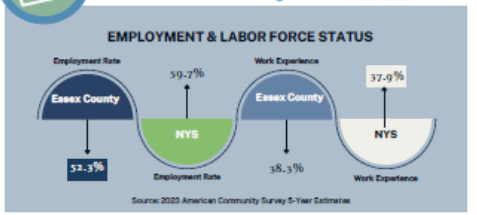
Source: Feeding America, 2023



Source: CHIRS

Employment

Essex County had an unemployment rate of 4.4% in March 2025*



*Source: https://fred.stlouisfed.org/series/NYESSETURN

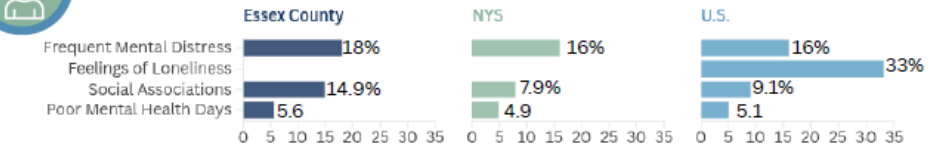
Domain 2

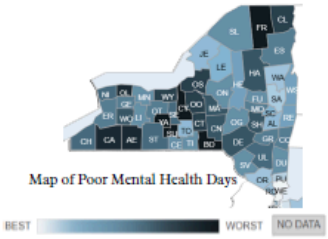
Social & Community Context

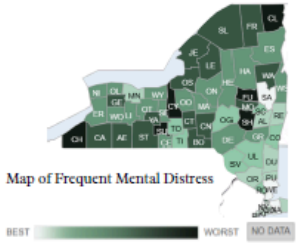
Priority Areas

- Anxiety & Stress
- Primary Prevention: Substance Misuse, Overdose, Tobacco/E-cig/Alcohol Use
- Adverse Childhood Experiences
- Suicide/Depression
- Healthy Eating

Anxiety & Stress





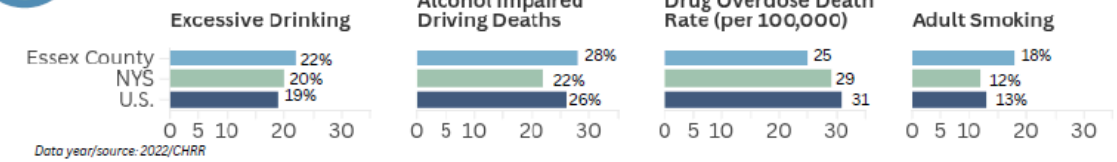


Mental Health Providers

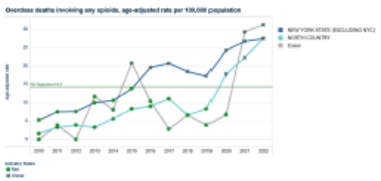
Essex County - 490:1
NYS - 260:1
U.S. - 300:1

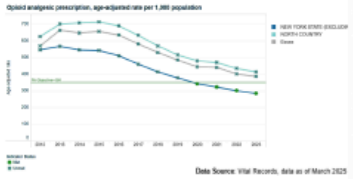
Data year/source: 2022/CHRR

Primary Prevention: Substance Misuse, Overdose, Tobacco/E-cig/Alcohol Use



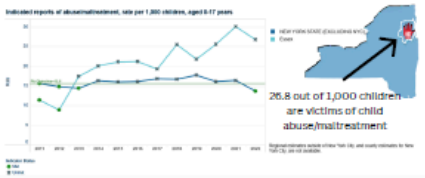
Data year/source: 2022/CHRR



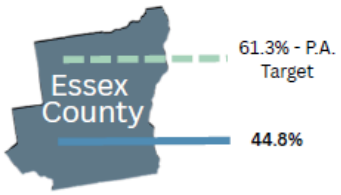


Data Source: Vital Records, data as of March 2025

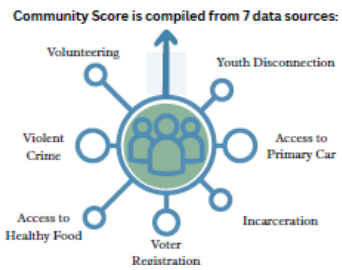
Adverse Childhood Experiences



Community Score

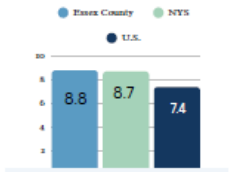


Community Score is compiled from 7 data sources:



Healthy Eating

Food Environment Index



Index includes access to healthy foods and food insecurity, with 0 = worst and 10 = best

Data year/source: 2022/CHRR

Suicide/Depression

Domain 3

Neighborhood & Built Environment

Priority Areas

- Opportunities for Active Transportation and Physical Activity
- Access to Community Services & Support
- Injuries & Violence

Community Service & Support

Health & Human Services Agencies & Organizations

High level of awareness and collaboration among these agencies; many/most link or refer to multiple other agencies and programs on this list and beyond.

- **Essex County Health Department -**
Children's Services, Home Health, Public Health, WIC
Bright Futures Coalition
Little Feeders Circle of Support (lactation support groups)
ECHO (Essex County Heroin & Other) Coalition
- **Primary Care - Adirondack Health, UVMHN, HHHN**
Ausable Forks, Crown Point, Elizabethtown, Keene, Moriah, Newcomb, Schroon Lake, Ticonderoga, Westport, Willsboro, Wilmington
- **Hospitals -**
UVMHN - Elizabethtown Community Hospital and Ticonderoga Campus
- **Specialty Clinics -**
Available at both UVMHN-ECH locations
- **Department of Social Services -**
Adult Services, Day Care, HEAP, Medicaid, SNAP, Temporary Assistance, Youth Bureau, etc.
- **Adirondack Community Action Programs -**
Meals on Wheels, food pantries, emergency assistance, medical transport, daycare/child care/Early Head Start/Head Start, etc.

- The Heart Network
- North Country Center for Independent Living
- Southern Adirondack Independent Living
- Mercy Care for the Adirondacks
- RSVP - Retired and Senior Volunteer Program
- Citizen's Advocates
- Families First
- Schools
- Colleges/Universities
- Libraries
- Office for the Aging - NY Connects
- Essex County Mental Health
- Mental Health Association in Essex County
- BRIEF - Building Resilience in Essex Families
- Community Services Board
- Essex County Suicide Coalition
- Cornell Cooperative Extension
- Adirondack Roots
- Mountain Lake Services
- Adirondack Foundation
- 2-1-1
- Where to Turn Directory

Physical Activity & Active Transport

100%
of Essex County residents live close to a **park** or **recreation facility**

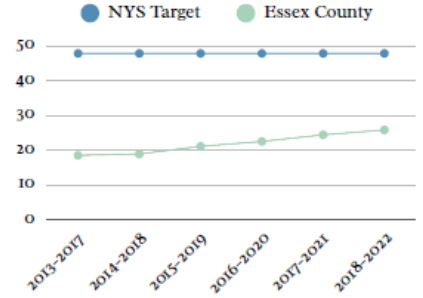
NYS: 93%
US: 84%

100%
of Essex County residents live within a half mile of a **park**

NYS: 63%
US: 51%

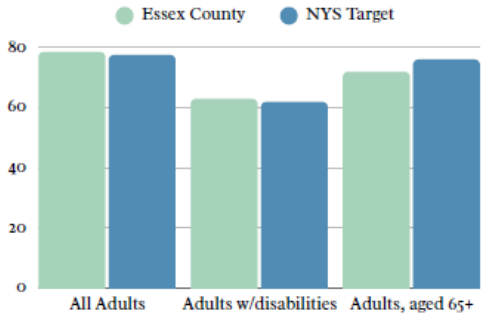
Source: 2025 County Health Rankings and Roadmaps

Percentage of people who commute using alternate modes of transportation (e.g. public transportation, carpool, bike/walk) or who telecommute



Source: NYS Prevention Agenda Dashboard

Percentage of adults who participate in leisure time physical activity



Source: NYS Prevention Agenda Dashboard

Injuries & Violence

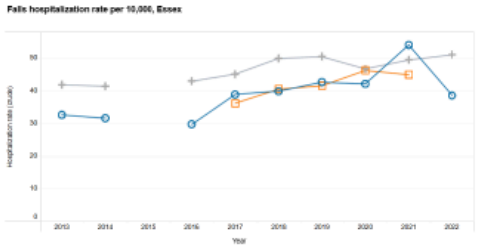
Unintentional Injury was the **4th leading cause of death** in Essex County in 2022, behind only heart disease, cancer, and chronic lower respiratory diseases.

Unintentional injuries include: drowning, falls, motor vehicle accidents, poisonings, etc.

Source: NYS Vital Statistics

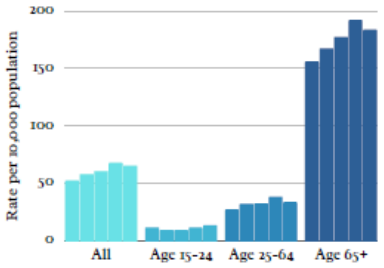
Assault-related and firearm-related hospitalization rates, work-related emergency department visit rates, and crash-related pedestrian fatality rates are all suppressed* or zero for Essex County.

Source: CHIRS



Source: CHIRS

Unintentional injury hospitalization rate - Essex



Source: CHIRS

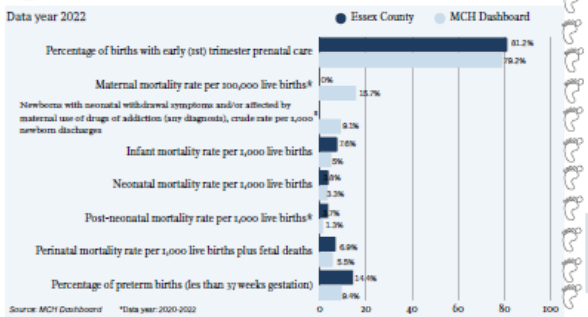
Domain 4

Health Care Access and Quality

Priority Areas

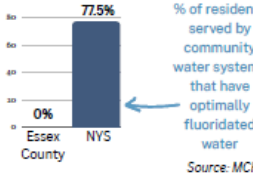
- Access to and Use of Prenatal Care & Prevention of Infant and Maternal Mortality
- Preventive Services for Chronic Disease
- Oral Health Care
- Preventive Services - Immunization, Hearing Screening, Lead Screening
- Early Intervention
- Childhood Behavioral Health

Access to and Use of Prenatal Care & Prevention of Infant & Maternal Mortality



Oral Health Care

The ratio of population to dentists is: **3,106:1**



% of residents served by community water systems that have optimally fluoridated water

Source: MCH Dashboard

Childhood Behavioral Health

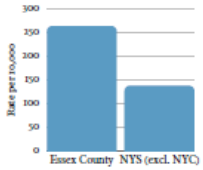
	Total # of Referrals from Pediatrician/PCP*	# of No Follow Throughs	Total # Served
2023 (6/1/23-12/31/23)	75	44	31
2024	130	98	32
2025 (YTD)	36	9	27

*Includes children & adults

Does not include self-referrals or referrals from other sources like DSS, Courts, Probation, Parole, etc.

Source: Essex County Mental Health

Dental Caries Outpatient Visit Rate 2019-2022



Source: CHIRS

Only 22.8% of Medicaid enrollees in Essex County had at least one preventive dental visit in the last year.

2021-2023
Source: CHIRS

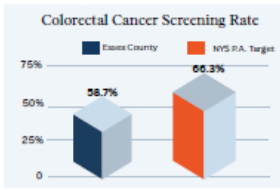
Preventive Services for Chronic Disease

Percentage of adults who have:

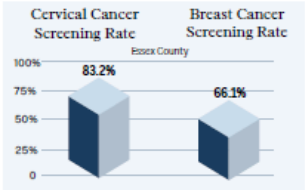
Had a diabetes/pre-diabetes test (self reported): **49.2%**
Had a recent check-up: **71.8%**
Has healthcare coverage female 18-64: **96.4%**
No medical care due to cost: **7.7%**
HCV ever tested, age adjusted: **33.7%**
Chronic disease self management, age adjusted: **14%**
Has a healthcare provider: **89.3%**

Source:BRFSS: 2021

P.A. - Prevention Agenda

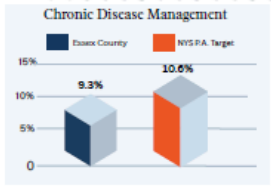


% of adults who receive a colorectal cancer screening based on most recent guidelines, aged 50-64, 2018

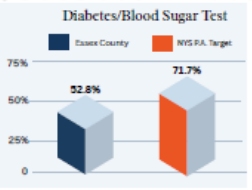


% of women aged 21-65 years receiving cervical cancer screening based on most recent guidelines, 2018

% of women aged 50-74 years receiving breast cancer screening based on recent guidelines, 2022



% of adults with chronic conditions (arthritis, asthma, CVD, diabetes, CKD, caner) who have taken a course or class to learn how to manage their condition, 2021

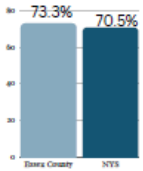


% of adults who had a test for high blood sugar or diabetes within the past three years, aged 45+years, 2021

Source: NYS Prevention Agenda Dashboard

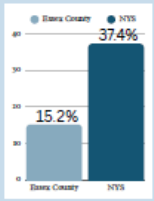
Preventive Services Immunizations, Hearing Screening, Lead Screening

% of 24-35 month old children with the 4:3:1:3:3:1:4 immunization series - 2023

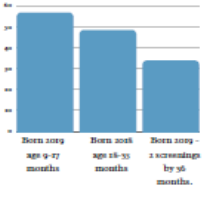


Source: NYS Prevention Agenda Dashboard

% of 13-year-olds with a complete HPV Vaccine Series - 2023

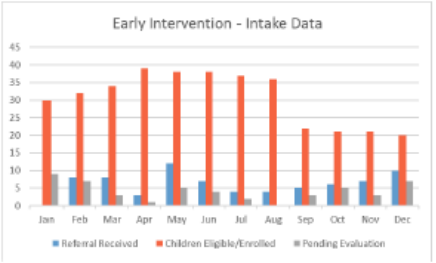


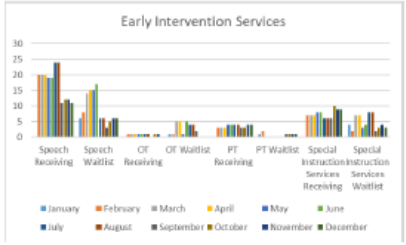
% of Children with a Lead Screening Essex County



Source: CHIRS

Early Intervention





Early Intervention Data Source: Essex County Health Department
Data year: 2024

Domain 5

Education Access & Quality

Priority Areas

Health & Wellness Promoting Schools

Opportunities for Continued Education

Health & Wellness Promoting Schools

	2023 - 2024 School Year									
	Graduation Rate						Chronic Absenteeism Rate*			
	All	Female	Male	Students with Disabilities	Economically Disadvantaged	Not Economically Disadvantaged	Elementary	Elementary Economically Disadvantaged	Secondary	Secondary Economically Disadvantaged
BVCS	91%	89%	93%		100%	83%	17.3%	24.5%	24.5%	33.9%
Crown Point	89%	86%	92%	60%	88%	89%	14.9%	21.6%	6.5%	10.0%
Keene	100%						23.8%	25.0%	23.0%	
Lake Placid	92%	93%	92%	83%	78%	97%	13.0%	25.4%	16.8%	27.1%
Minerva	86%						14.8%	16.3%	45.7%	
Moriah	89%	93%	86%	68%	83%	93%	35.4%	41.0%	29.9%	38.6%
Newcomb	100%									
Schroon Lake	85%	83%	86%		100%	67%	31.5%	33.7%	27.7%	33.3%
Ticonderoga	83%	86%	81%	56%	82%	85%	21.6%	26.4%	7.2%	8.6%
Willsboro	91%	93%	88%	80%	85%	100%	17.1%	22.4%	30.1%	39.5%

Data not available due to small class/cohort size

*Percentage of students who were absent (excused or unexcused) for at least 10% of enrolled instructional days.

Source: NYSED Report Cards

70%

of the public school districts in Essex County participated in the **National Free Lunch Program (NFLP)** in 2023.

Key requirements to participate in the NFLP:

- create menus that meet Federal nutrition standards to ensure students receive balanced & healthy meals
- ensure school nutrition staff meet specific training requirements
- ensure foods sold outside the school meal program comply with Smart Snacks Standards
- develop & implement Wellness Policies that promote student health & well-being

Source: USDA

Prevention Programs in Essex County Schools

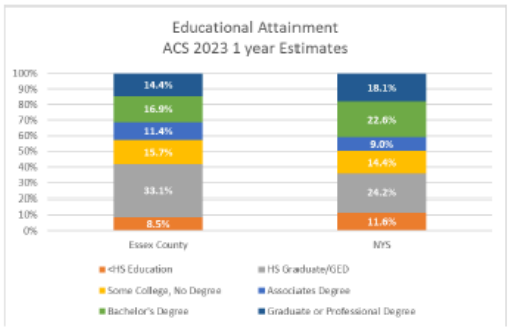
Programs cover healthy choices, peer pressure, substance use prevention, media use, etc.

24 Evidence-Based Programs were delivered in 2023-2024

31 Evidence-Based Programs were delivered in 2024-2025

Seven out of the 10 public school districts were engaged with **The Prevention Team** to implement evidence-based programs in 2023-2024 and 2024-2025

Opportunities for Continued Education



Source: 2019-2023; American Community Survey 5-year estimates, U.S. Census Bureau

Fewer residents in Essex County complete a college degree program when compared with state attainment levels; however, degree attainment increased in Essex County by **3.4%** since 2020.

CFES Brilliant Pathways 2023-2024 Schools of Distinction* in Essex County:

- Boquet Valley
- Crown Point
- Moriah
- Ticonderoga

*Recognized for exemplary efforts in helping students become college and career ready, executing highly effective, year-long plans encompassing their entire student bodies. CFES 10-Point College and Career Readiness Plan is built around mentoring, career-building skills and on-site involvement with schools and businesses.

Higher Education in the Region

SUNY Colleges/Universities

North Country Community College
1 • Saranac Lake - Main Campus
2 • Ticonderoga - Extension
College of Environmental Science & Forestry
3 • Newcomb Campus
4 • Ranger School at Wanakena
5 Clinton Community College
6 Plattsburgh
7 Canton
8 Potsdam
9 Adirondack

Private Colleges/Universities

10 Paul Smith's College
11 St. Lawrence University
12 Clarkson University

Plan Health Strategy

The selection of evidence-based strategies to address the priority areas and disparities identified through the CHA was guided by the establishment of the Community Health Coalition of Essex County and through leveraging other existing committees and coalitions. This approach aligned future efforts with the current, ongoing, and planned initiatives of partner organizations, maximizing impact and fostering synergy. The Community Health Coalition was presented with the CHA findings and the Prevention Agenda framework, including domains, priority areas, objectives, and strategies for each priority indicator. Development of the Community Health Improvement Plan emphasized the effective and efficient use of existing resources and assets to target areas of greatest need while minimizing duplication and redundancy. A shared understanding of Essex County's health needs and the proposed strategies to address them strengthened coordination among participating agencies.

Portions of the planning process - including meetings and presentations - were conducted as part of activities outlined in Step 6: Document & Communicate Results. Additional meetings took place both internally within individual ECHP organizations and externally through the Community Health Coalition and other ad hoc meetings, as needed. The meetings to develop the CHIP are listed below.

Participants	Domains	Interventions Discussed	Meeting/ Communication Date(s)
Community Health Coalition of Essex County (incl. individual partners as needed)	All	All interventions included in the NYS Prevention Agenda Action Plans	09/08/2025 12/08/2025 12/22/2025
ECHD - Public Health (Internal)	Economic Stability; Social and Community Context	Access to WIC/SNAP; naloxone distribution; education; referrals to home visiting programs	11/24/2025 12/19/2025
ECHD and Hospitals	Economic Stability; Social and Community Context; Neighborhood & Built Environment; Health Care Access & Quality	Promoting nutrition programs; naloxone distribution; tobacco use prevention; cancer screening; age-friendly education for health care providers/community	11/17/2025 12/01/2025 12/17/2025

Develop Action Plan

Following the Community Health Improvement Planning effort, an action plan was developed to address the prioritized community health needs that were selected. The Action Plan (a summary of the CHIP Work Plan) represents ongoing processes that evolve as the engaged partners work to improve health and turn strategies into concrete actions that are effective for all community members.

The 2026-2030 Community Health Improvement Plan (CHIP) Work Plan is attached as Appendix 5. The interventions in this CHIP employ an array of strategies to improve population health including:

- Participation in coalitions, working groups and other partner engagement strategies;
- Policy, systems, and environmental changes;
- Public health promotion and communication campaigns;
- Outreach, education, training, and technical assistance;
- Delivery of early detection and guideline-concordant care; and
- Utilization of harm reduction and other evidence-based practices.

The following elements are included in the CHIP Work Plan (Appendix 5):

NYSDOH Prevention Agenda Identified/Researched

- Domain
- Priority Area
- Objective
- Intervention (recommended)

Locally Identified

- Interventions (selected)
- Disparities
- Family of Measures for Evaluation
- Time frame
- Implementation Partner(s)
- Partner Roles and Resources

Examples of activities that make up the Family of Measures include:

- number of trainings planned or delivered;
- percent increase in number of individuals or groups reached;
- number of media campaigns conducted and/or engagement activities completed;
- number of policies or plans adopted, revised, or updated;
- number of healthcare practices conducting screening or making referrals;
- number of coalition or committee meetings held or attended; and
- percent increase or number of programs offered and/or residents served.

The Essex County CHIP Action Plans are included on the following pages (106 - 112). These Action Plans are separated by Domain.

Partners for all Domain Action Plans Can Include*: Essex County Department of Social Services (DSS), Essex County Mental Health, Mental Health Association in Essex County, Heart Network, Well Fed Collaborative, The Prevention Team, Healthy Families NY, ACAP - Head Start/Early Head Start, Schools, Cancer Services Program of the North Country

**In addition to health department and hospitals. Refer to the CHIP Work Plan for complete details regarding partner activities.*

CHIP Action Plan
Domain: Economic Stability

Priority

Poverty

Actions & Impact

ECHD, UVMH-ECH and partners will:

1. Increase access to supplental nutrition programs; and
2. Conduct regular/standardized SDOH screenings for patients

Geographic Focus

Essex County

Resource Commitment

ECHD will commit staff and resources to ensure health department programs and services provide education about and referrals to WIC and SNAP. UVMH-ECH will maintain EMR and embedded workflows to ensure SDOH screening occurs.

Participant Roles

ECHD will track progress on all partner activities to increase access to nutritional programs for eligible participants and create universal approach to providing WIC & SNAP information and referrals. UVMH-ECH will implement/update/maintain SDOH screening, provide staff training, and monitor quality metrics to confirm screening completion.

Health Equity

Health equity will be addressed through focus on low income populations, particularly those with access barriers.

Priority

Unemployment

Actions & Impact

ECHD, UVMH-ECH and partners will:

1. Engage in multi-sector collaborations to highlight the health burden of unemployment/underemployment.
2. Strengthen partnerships with BOCES and area schools to expand training programs and employment opportunities.

Geographic Focus

Essex County

Resource Commitment

ECHD will devote staff/program time to developing data summaries for partners engaged in employment programs and services. UVMH-ECH will build on existing health care and educational partnerships, like New Visions, to increase exposure to health care careers.

Participant Roles

ECHD will concentrate on promoting a health in all policies approach through SDOH awareness building among non-traditional partnerships. UVMH-ECH will direct the alignment of training programs to career fields and open pathways to employment.

Health Equity

Health equity will be addressed by increasing career exposure, educational offerings, and employment opportunities for rural communities (geography disparities).

Priority

Nutrition Security

Actions & Impact

ECHD, UVMH-ECH and partners will:
Promote and expand the availability of fruit and vegetable incentive programs.

Geographic Focus

Essex County

Resource Commitment

ECHD, UVMH-ECH, and partners will participate in local Well Fed Coalition, research grant opportunities, and secure funding for expansion of fruit and vegetable incentive programs.

Participant Roles

ECHD will facilitate collaborative (staff time and effort) and support grant application and administration. Collaborative partners will assist in various capacities with completing grant deliverables.

Health Equity

Health equity will be addressed by increasing access to nutritious foods, helping populations disproportionately burdened by chronic disease (individuals with lower incomes, disabilities, lower educational attainment, and aging adults.

Priority

Housing Stability & Affordability

Actions & Impact

ECHD and partners will:
1. Collaborate with new and current partners to increase access to safe and affordable housing.
2. Provide Supported Housing Program to individuals with serious or persistent mental illness.

Geographic Focus

Essex County

Resource Commitment

ECHD and partners will participate in Essex County Housing Task Force meetings to promote multi-agency collaboration; complete training to screen for housing instability; and provide relevant data regarding housing stability and affordability as these issues relate to health outcomes in Essex County.

Participant Roles

ECHD will develop data sharing and outreach plans for engagement with housing sector. Partners will engage in Task Force meetings and will prioritize housing as health determinant that requires assessment and intervention.

Health Equity

These activities will improve health equity for individuals with lower incomes and families burdened by childcare costs or other financial constraints (e.g. ALICE households)

CHIP Action Plan

Domain: Social and Community Context

Priority

Depression

Actions & Impact

UVMH-ECH will implement and promote Mental Health First Aid training.

Geographic Focus

Essex County

Resource Commitment

UVMH-ECH will allocate staff/resources to offer MHFA program in communities and health care settings.

Participant Roles

skills.

Health Equity

This program with improve health equity by addressing mental health disparities.

Priority

Primary Prevention, Substance Misuse, and Overdose Prevention

Actions & Impact

Adirondack Health, UVMH-ECH, and ECHD will increase community access to naloxone.

Geographic Focus

Essex County

Resource Commitment

Adirondack Health will implement a program to distribute take-home doses of naloxone to patients in the emergency care setting. UVMH-Elizabethtown Community Hospital will increase the availability of naloxone by maintaining supply in emergency department and health clinic settings. ECHD will expand Community Care Kiosk program (which includes naloxone kit distribution) to offer online requests for resources.

Participant Roles

Adirondack Health and UVMH-ECH will provide the care settings for distribution of naloxone. ECHD will maintain Community Opioid Overdose registration and maintain/stock Community Care Kiosks, both physical and online inventory.

Health Equity

These efforts improve health equity by removing transportation and income barriers to accessing naloxone.

Priority

Tobacco/E-Cigarette Use

Actions & Impact

ECHD, Adirondack Health, and partners will:
1. Provide access to tobacco cessation treatments.
2. Implement screening for tobacco use.
3. Advance community-wide support for restricting minors' access to tobacco products.

Geographic Focus

Essex County

Resource Commitment

Adirondack Health and UVMH-ECH will maintain prompts in the EMR work flows to screen patients 18+ for tobacco use, maintain EMR functionality, and employ clinicians performing the screening. The Heart Network will employ staff to advance the health system tobacco-free initiatives. ECHD will provide funding/support to The Prevention Team to work in schools and communities.

Participant Roles

Adirondack Health will increase tobacco use assessments for all health-center-based primary care patients 18+ by five percent. UVMH-ECH will increase screenings and referrals to treatment. ECHD will facilitate health care, CBO, school collaborations. The Prevention Team will train staff and deliver evidence-based curriculum.

Health Equity

Implmenting these strategies to reduce tobacco access and use will improve health equity in Essex County where tobacco vendor density is high.

Priority

Adverse Childhood Experiences (ACEs)

Actions & Impact

1. ECHD will strengthen community partnerships to support education, case coordination, and referrals of at-risk families to local health departments, hospitals, and other community-based organizations to increase participation in home visiting programs.
2. Essex County Mental Health (ECMH) will perform ACEs screening during new client intake.

Geographic Focus

Essex County

Resource Commitment

ECHD will maintain the Baby Steps to Bright Futures universal maternal/infant home visiting program and employ staff to administer program services. ECMH will train and employ the clinical staff that will perform ACEs screening.

Participant Roles

ECHD will work with partners such as Healthy Families NY, Early Head Start/Head Start (ACAP), and Essex County DSS to ensure families receive in-home education and supports. ECMH will perform ACEs screening on at least 50% of new clients and refer to home visiting programs as applicable.

Health Equity

These actions address healthy equity by focusing on at-risk families and individuals with mental health diagnoses.

Priority

Healthy Eating

Actions & Impact

UVMH-ECH will expand Food as Medicine program.

Geographic Focus

Essex County

Resource Commitment

Allocate staff and resources to administer and expand the Wellness Rx program.

Participant Roles

UCMH-ECH will increase the number of participants in the Wellness Rx Program, increase the redemption rate of Wellness Rx coupons, and work with vendors to increase the number of sites participating in the program.

Health Equity

Implementing Food as Medicine program will reduce health inequities by addressing income barriers to healthy eating through the provision of coupons for purchasing nutritious foods. Other barriers addressed include transportation (increasing vendors) and education (health literacy) through an educational component.

CHIP Action Plan
Domain: Neighborhood and Built Environment

Priority

Access to Community Services & Support

Actions & Impact

ECHD, UVMH-ECH, and partners will:

1. Educate policymakers and healthcare leaders on promoting age-friendly practices in health care and community infrastructures.
2. Promote and prioritize age-friendly initiatives by educating primary care providers

Geographic Focus

Essex County

Resource Commitment

ECHD, UVMH-ECH, Mercy Care, ECMH, and the Heart Network will maintain the programs, staff, and leadership/participation on task force/coalitions that advance age-friendly approaches.

Participant Roles

ECHD and Heart Network will provide educational outreach; ECMH will participate in Aging Working Group meetings; Mercy Care will lead Caregiving Work Group and develop a Health Care Companion Volunteer Advocate Program and train volunteers.

Health Equity

These interventions improve health equity by addressing disparities due to age.

CHIP Action Plan
Domain: Health Care Access & Quality

Priority

Preventive Services for Chronic Disease Prevention and Control

Actions & Impact

Adirondack Health and UVMH-ECH will increase cancer screenings, and screenings for hypertension and diabetes.

Geographic Focus

Essex County

Resource Commitment

Adirondack Health will employ staff and send annual communications to clinicians, ensuring awareness of current screening guidelines. UVMH-ECH will allocate staff and space for free community screening events and will partner with NYS Cancer Services

Participant Roles

Adirondack Health will continuously review practices for reliability and timeliness and will track metrics through the use of quality dashboards. UVMH-ECH will conduct free community screening events quarterly (at a minimum) at the Elizabethtown and Ticonderoga campus locations.

Health Equity

These interventions will improve health equity by reducing barriers to care like access and transportation.

Evaluate Progress

Evaluation occurs throughout the community health assessment process to assess the impact of strategies and progress toward goals. Regular measurement of performance metrics and progress toward goals is essential to effective evaluation. This process should identify which CHIP work plan interventions are achieving desired results and which may require adjustment. Ongoing evaluation allows for greater flexibility and timely course corrections when progress does not align with expectations.

While the specific metrics used to assess progress are detailed within the CHIP Work Plan, the Essex County Health Partners (ECHP) will also implement additional actions to ensure continuous improvement and sustained momentum, as outlined below.

Quarterly

Lead partners for each intervention will be identified to monitor implementation progress and provide status updates to the ECHP, as requested. The ECHP have committed to ongoing communication and collaboration and will convene at least quarterly (via pre-established mechanims, such as ARHN and/or CHA Committee meetings) to:

- assess and measure progress on activities outlined in the CHIP work plan;
- identify barriers to implementation;
- develop strategies to address barriers and/or modify activities to improve effectiveness; and
- recommend revisions, additions, or deletions to the CHIP work plan as new or updated data, indicators, or information become available, or as partner capacity changes.

Annually

Progress will be documented through annual updates (at a minimum) to the CHIP Work Plan.

Dissemination Plan

The 2025 Essex County Community Health Assessment (CHA) and 2026-2030 Community Health Improvement Plan (CHIP) is one report with multiple parts that will be shared broadly in its entirety, or in parts and summaries.

Public Notification

Public notification will occur in the following ways:

1. Essex County Health Partners will post this report on their respective websites/social media; and
2. A joint press release of the Partners will be issued to local media outlets.
3. Copies of the report will be distributed to local libraries throughout Essex County

Stakeholder Notification

Essex County Health Partners will summarize findings, share information, and educate their committees as to the contents and availability of the report and how it may be used to improve future health outcomes. This includes, but is not limited to, the stakeholder committees engaged with the assessment and planning process:

1. Public Health Advisory Committee of the Essex County Health Department
2. Essex County Human Services Sub-Committee of the Essex County Board of Supervisors/Board of Health
3. UVMHN - Elizabethtown Community Hospital Board of Directors and/or Population Health Committee
4. Adirondack Health Board of Directors and/or Population Health Committee

Committees / Coalitions Notification

Essex County Health Partners will inform and educate local community based committees and coalitions that are engaged with ongoing assessment and planning efforts, including but not limited to:

1. Building Resilience in Essex Families (BRIEF) Network
2. Essex County Bright Futures Coalition
3. Essex County Heroin and Other (ECHO) Prevention Coalition
4. Essex County Community Services Board facilitated by the Essex County Mental Health Department
5. Well Fed Collaborative
6. Community Health Coalition of Essex County

Additional Public Notification

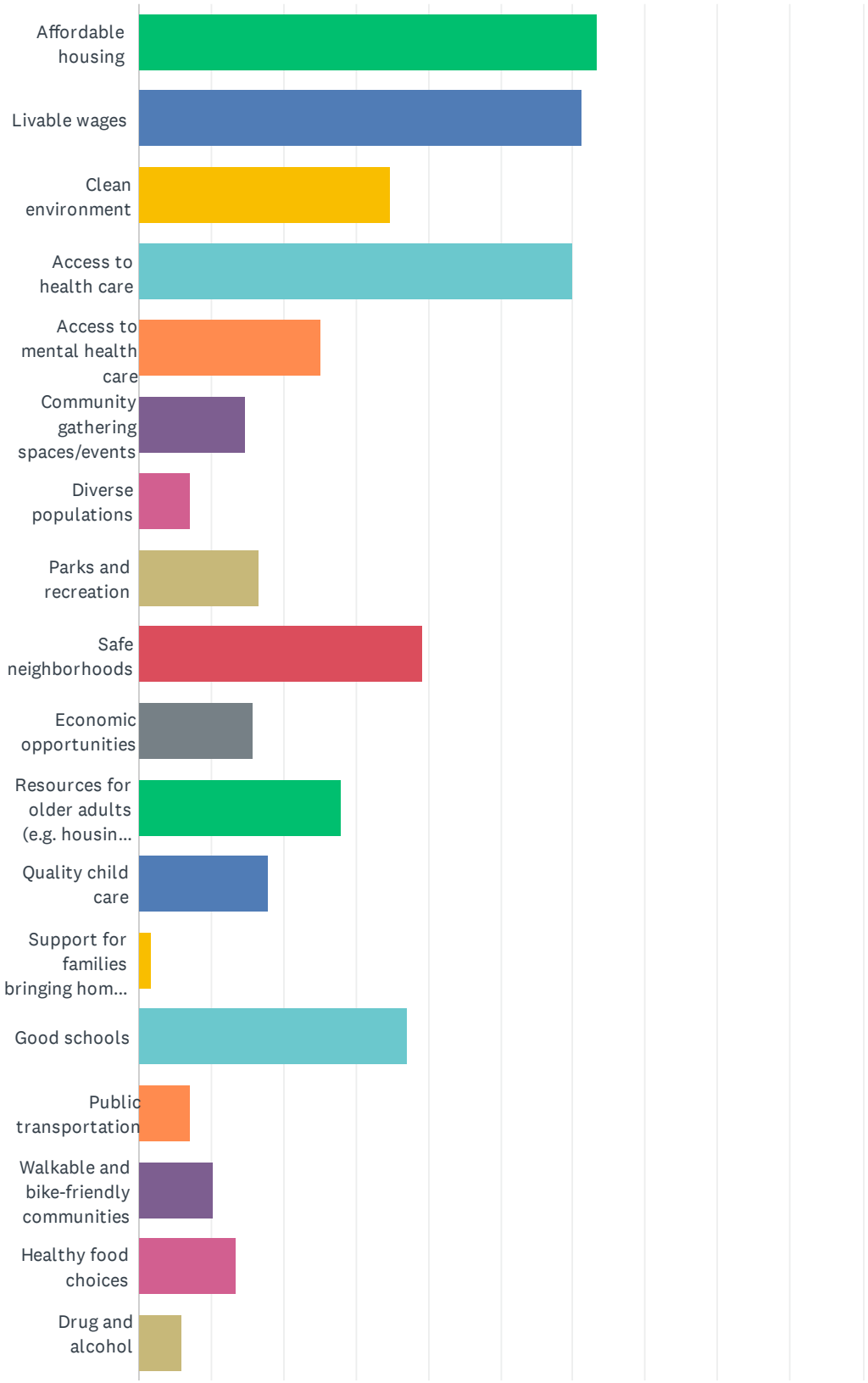
Further dissemination may be conducted as interest and need arises.

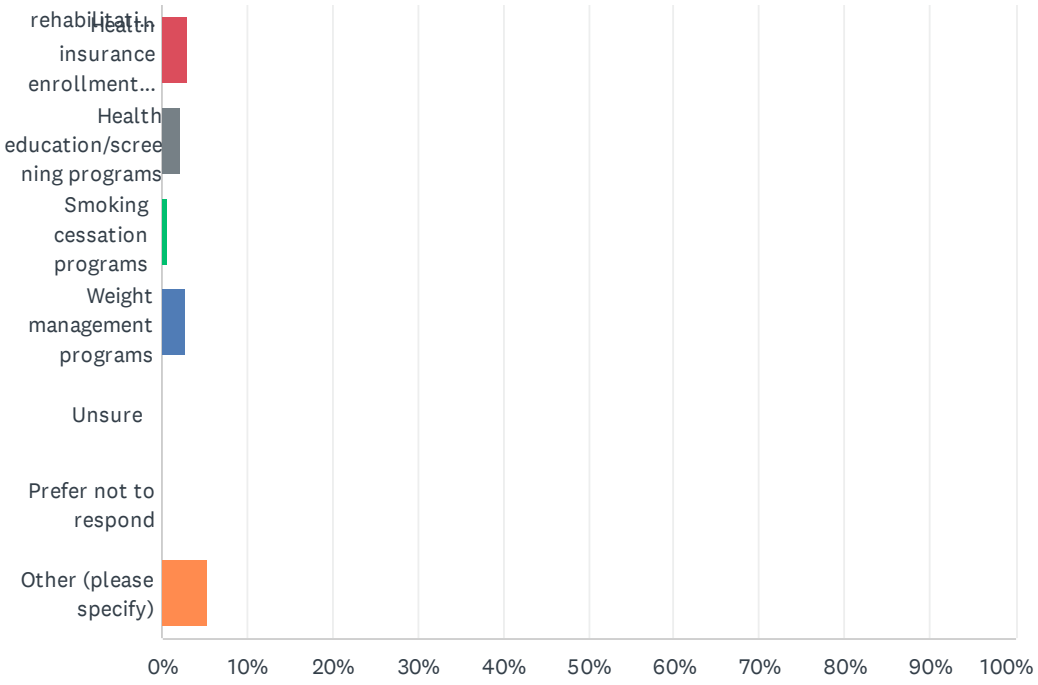
APPENDICES

2025 Communitv Survev Results

Q1 When you imagine a strong, vibrant, healthy community, what are the most important features that come to mind? Choose up to 5.

Answered: 562 Skipped: 0

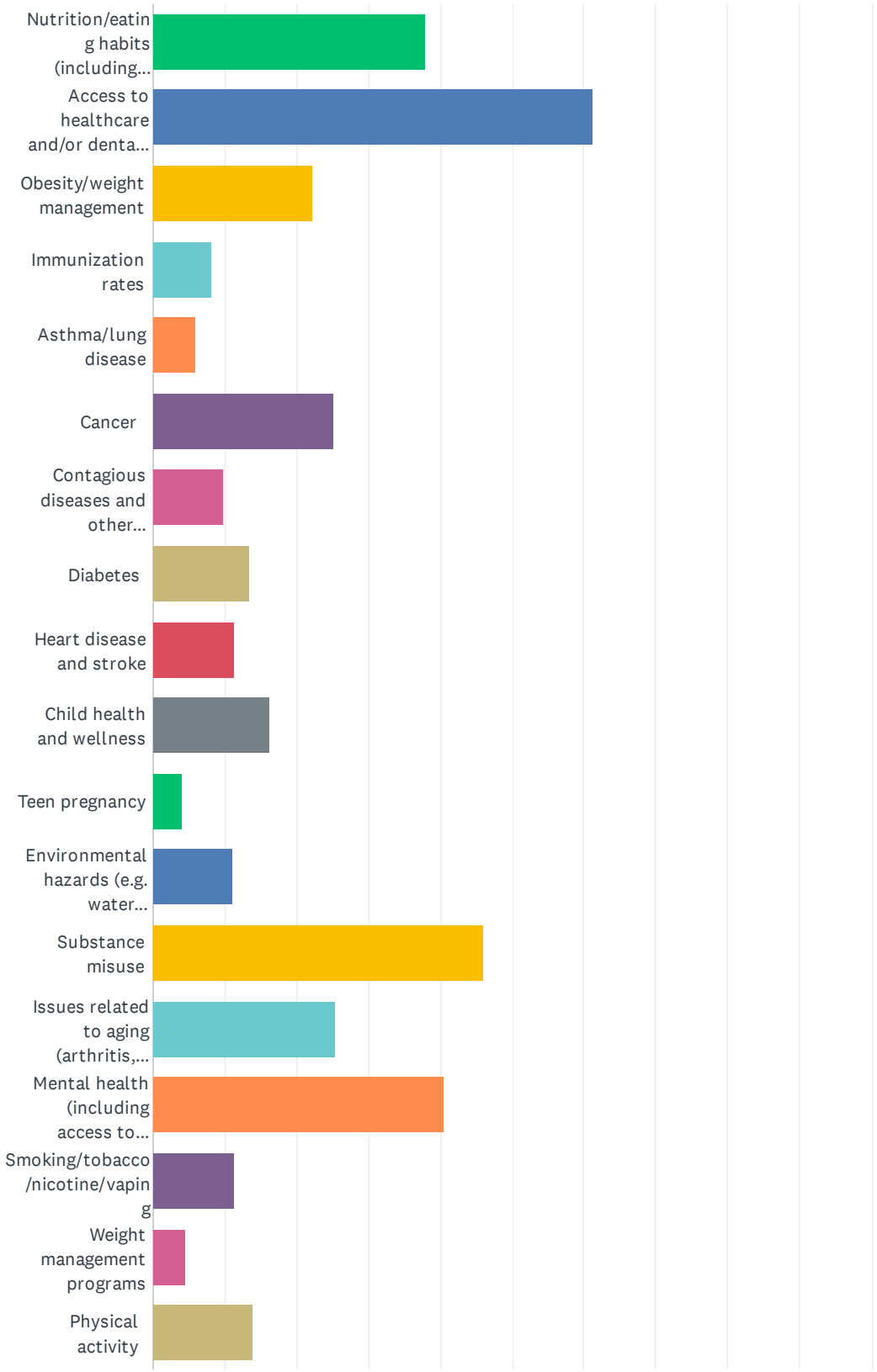


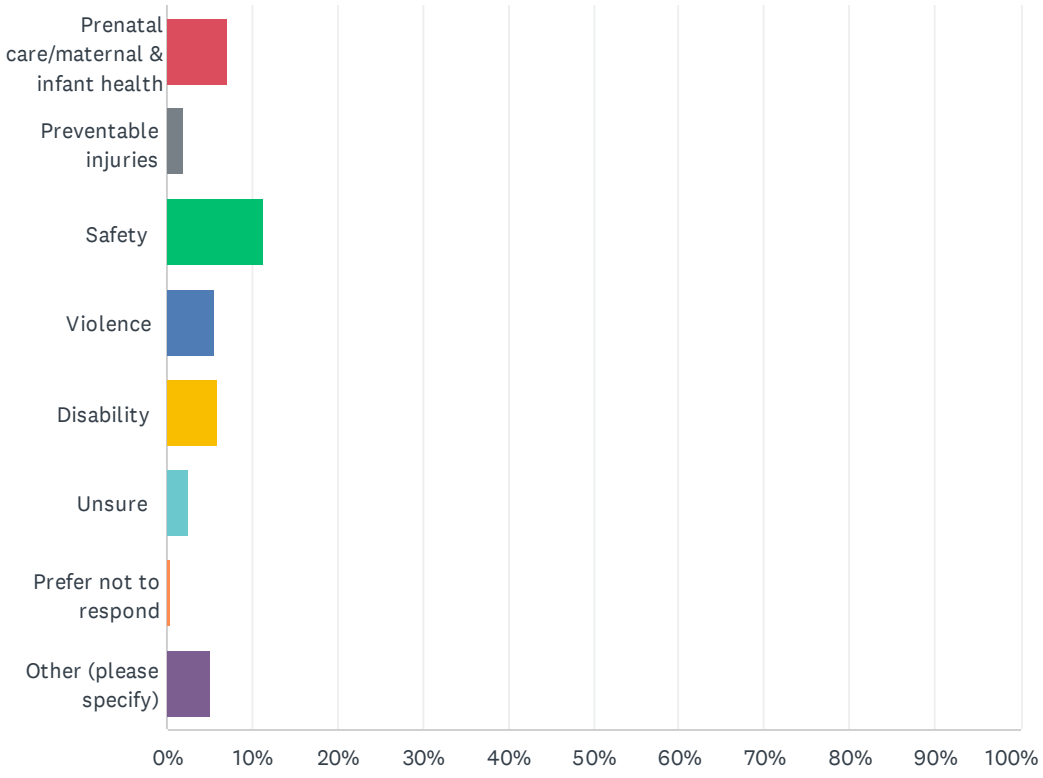

rehabilitati...
Health insurance enrollment...
Health education/screening programs
Smoking cessation programs
Weight management programs
Unsure
Prefer not to respond
Other (please specify)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

ANSWER CHOICES	RESPONSES	
Affordable housing	63.35%	356
Livable wages	61.21%	344
Clean environment	34.70%	195
Access to health care	59.96%	337
Access to mental health care	25.09%	141
Community gathering spaces/events	14.77%	83
Diverse populations	7.12%	40
Parks and recreation	16.55%	93
Safe neighborhoods	39.32%	221
Economic opportunities	15.84%	89
Resources for older adults (e.g. housing, home health, Meals on Wheels, community centers)	27.94%	157
Quality child care	17.97%	101
Support for families bringing home new babies	1.78%	10
Good schools	37.19%	209
Public transportation	7.12%	40
Walkable and bike-friendly communities	10.32%	58
Healthy food choices	13.52%	76
Drug and alcohol rehabilitation services	5.87%	33
Health insurance enrollment programs	3.02%	17
Health education/screening programs	2.14%	12
Smoking cessation programs	0.71%	4
Weight management programs	2.85%	16
Unsure	0.00%	0
Prefer not to respond	0.00%	0
Other (please specify)	5.34%	30
Total Respondents: 562		

Q2 What are the main health concerns in the community where you live? Choose up to 5.

Answered: 562 Skipped: 0

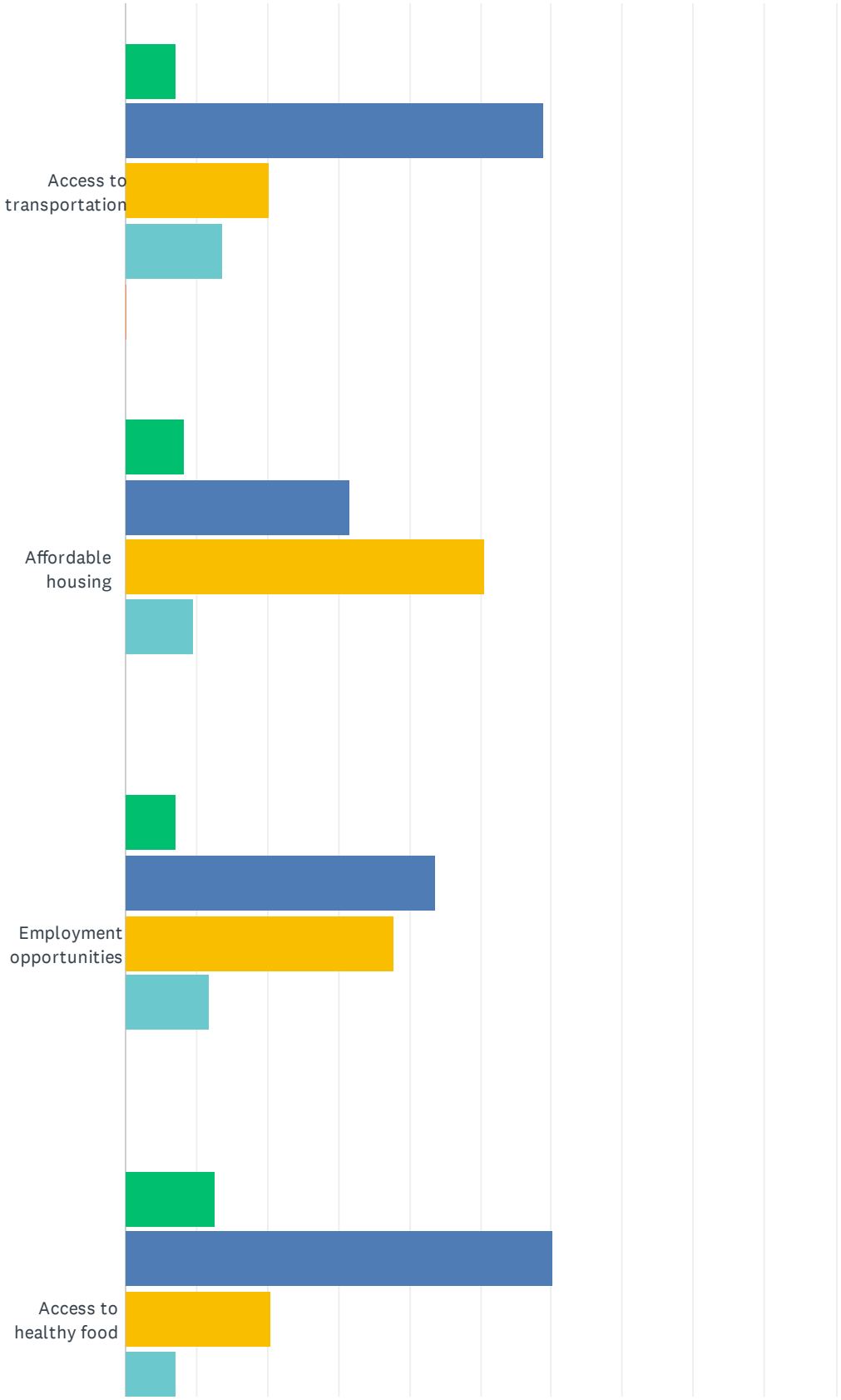


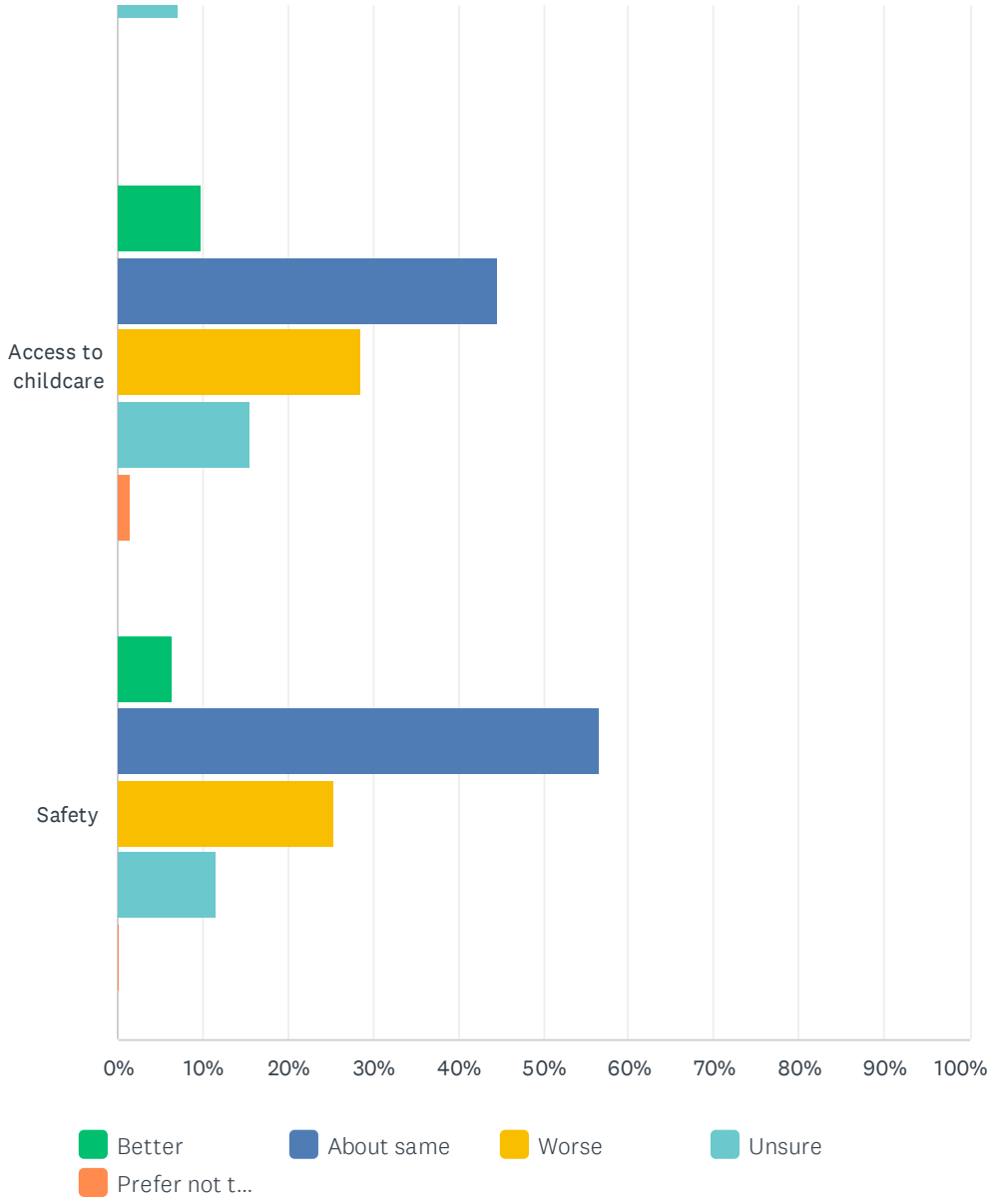

Prenatal care/maternal & infant health
Preventable injuries
Safety
Violence
Disability
Unsure
Prefer not to respond
Other (please specify)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

ANSWER CHOICES	RESPONSES	
Nutrition/eating habits (including access to healthy food)	37.90%	213
Access to healthcare and/or dental providers	61.21%	344
Obesity/weight management	22.24%	125
Immunization rates	8.01%	45
Asthma/lung disease	5.87%	33
Cancer	25.09%	141
Contagious diseases and other infections	9.79%	55
Diabetes	13.52%	76
Heart disease and stroke	11.39%	64
Child health and wellness	16.19%	91
Teen pregnancy	4.09%	23
Environmental hazards (e.g. water pollution, air quality, etc.)	11.03%	62
Substance misuse	46.09%	259
Issues related to aging (arthritis, falls, hearing/vision loss, cognitive impairment)	25.44%	143
Mental health (including access to mental health services)	40.57%	228
Smoking/tobacco/nicotine/vaping	11.21%	63
Weight management programs	4.45%	25
Physical activity	13.88%	78
Prenatal care/maternal & infant health	7.12%	40
Preventable injuries	1.96%	11
Safety	11.21%	63
Violence	5.52%	31
Disability	5.87%	33
Unsure	2.49%	14
Prefer not to respond	0.36%	2
Other (please specify)	5.16%	29
Total Respondents: 562		

Q3 How do you think your community will be doing in 5 years?

Answered: 561 Skipped: 1

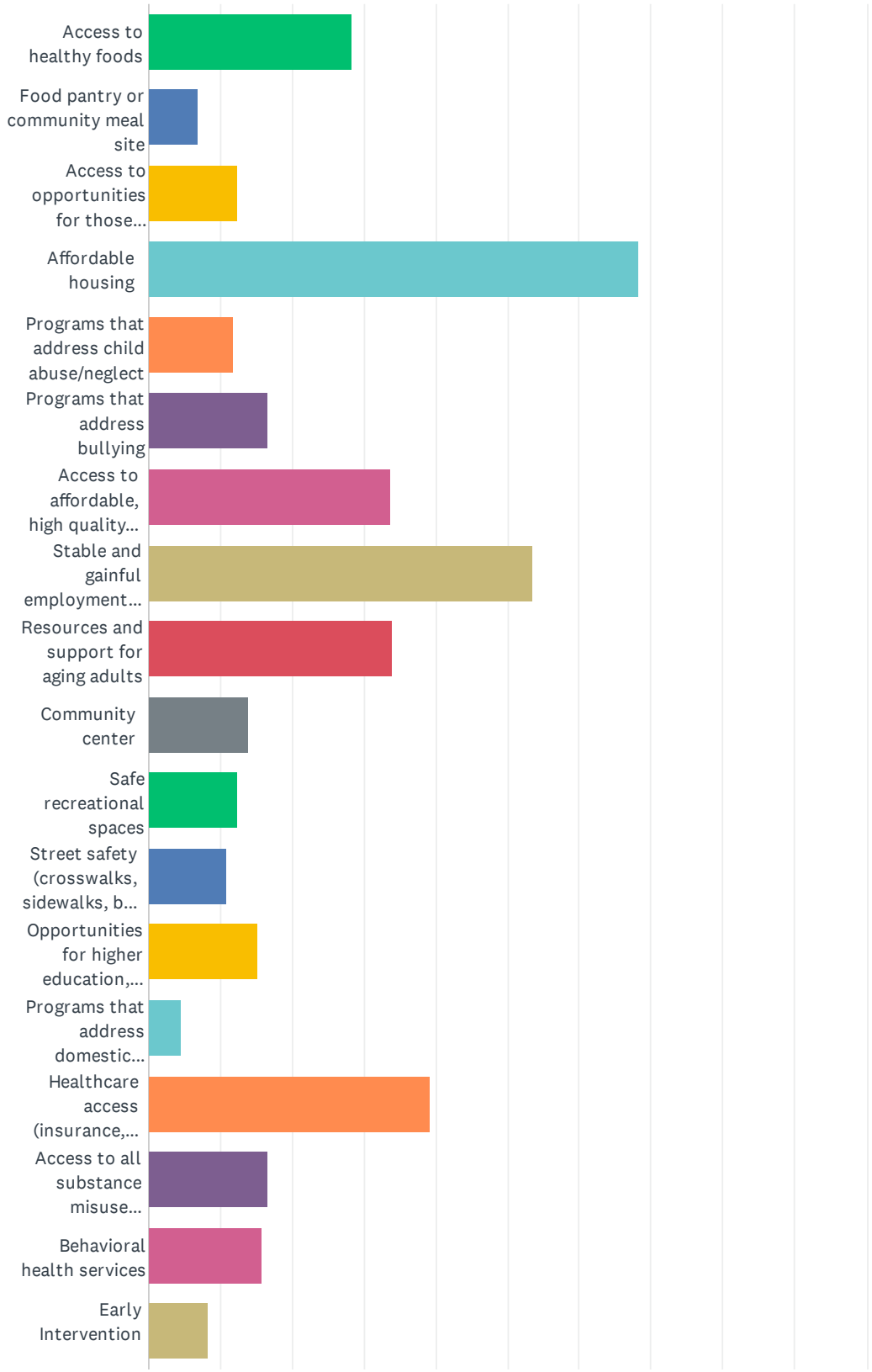


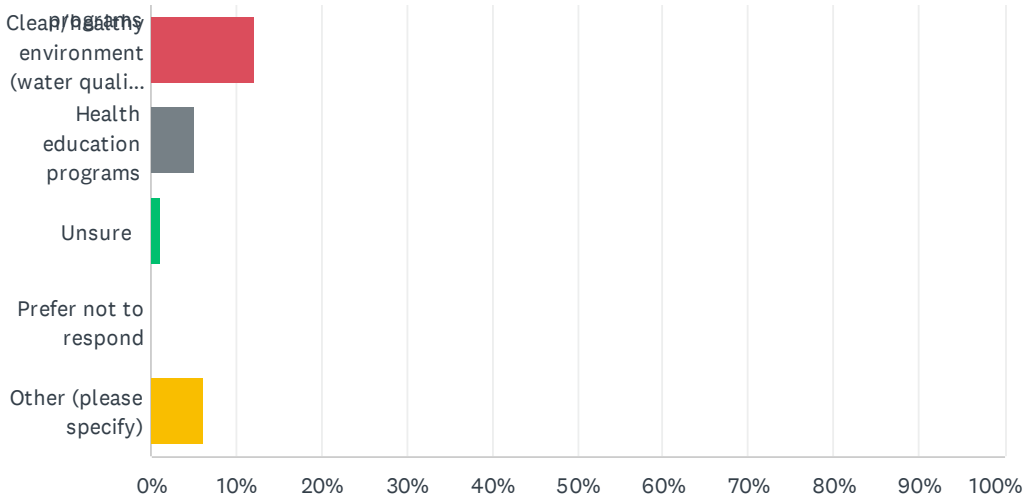


	BETTER	ABOUT SAME	WORSE	UNSURE	PREFER NOT TO RESPOND	TOTAL
Access to transportation	6.95% 39	58.82% 330	20.32% 114	13.73% 77	0.18% 1	561
Affordable housing	8.30% 46	31.59% 175	50.54% 280	9.57% 53	0.00% 0	554
Employment opportunities	7.00% 39	43.63% 243	37.70% 210	11.67% 65	0.00% 0	557
Access to healthy food	12.52% 70	60.11% 336	20.39% 114	6.98% 39	0.00% 0	559
Access to childcare	9.91% 55	44.50% 247	28.65% 159	15.50% 86	1.44% 8	555
Safety	6.47% 36	56.47% 314	25.36% 141	11.51% 64	0.18% 1	556

Q4 What would help most in the community where you live? Choose up to 5.

Answered: 562 Skipped: 0

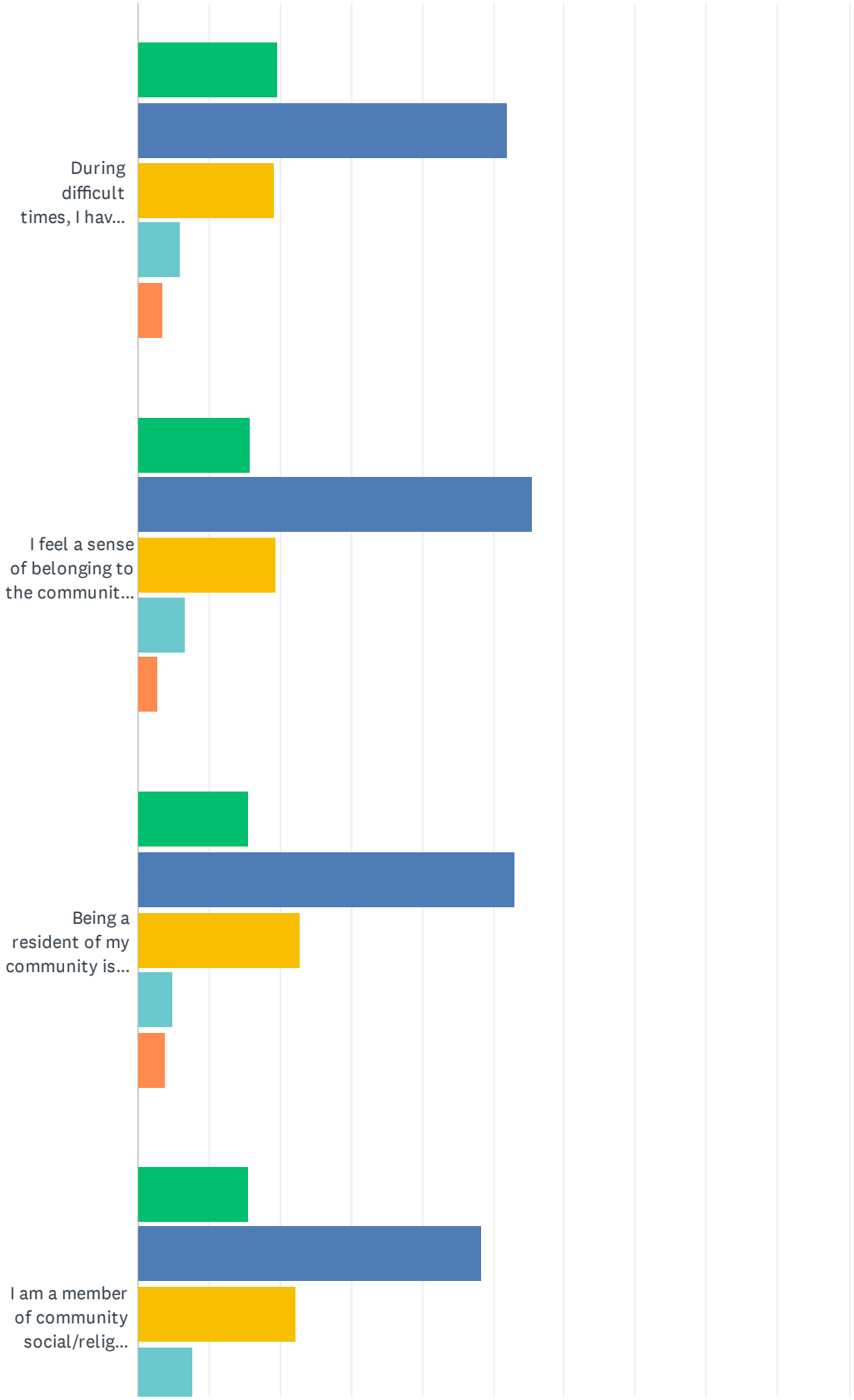


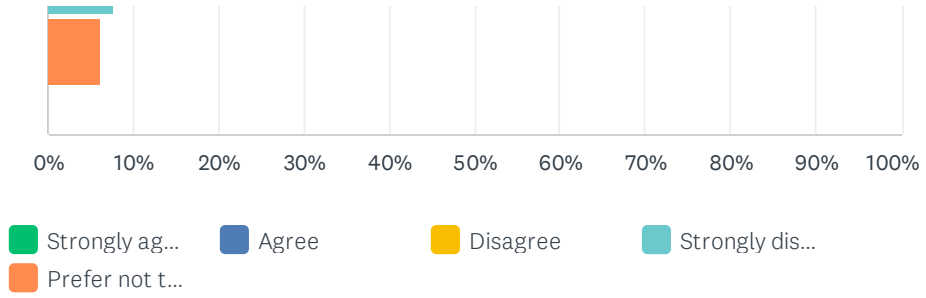

Clean/ healthy environment (water quali...
Health education programs
Unsure
Prefer not to respond
Other (please specify)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

ANSWER CHOICES	RESPONSES	
Access to healthy foods	28.29%	159
Food pantry or community meal site	6.76%	38
Access to opportunities for those living with a disability	12.46%	70
Affordable housing	68.33%	384
Programs that address child abuse/neglect	11.74%	66
Programs that address bullying	16.55%	93
Access to affordable, high quality child care	33.63%	189
Stable and gainful employment opportunities	53.56%	301
Resources and support for aging adults	33.81%	190
Community center	13.88%	78
Safe recreational spaces	12.28%	69
Street safety (crosswalks, sidewalks, bike lanes)	10.85%	61
Opportunities for higher education, continuing education, and trades	15.12%	85
Programs that address domestic violence	4.45%	25
Healthcare access (insurance, affordability, proximity, availability of appointments, specialty care, screening, etc.)	39.32%	221
Access to all substance misuse treatments available	16.55%	93
Behavioral health services	15.84%	89
Early Intervention programs	8.36%	47
Clean/healthy environment (water quality, air pollution, climate change, etc.)	12.10%	68
Health education programs	5.16%	29
Unsure	1.07%	6
Prefer not to respond	0.00%	0
Other (please specify)	6.23%	35
Total Respondents: 562		

Q5 How would you rate the following statements?

Answered: 562 Skipped: 0

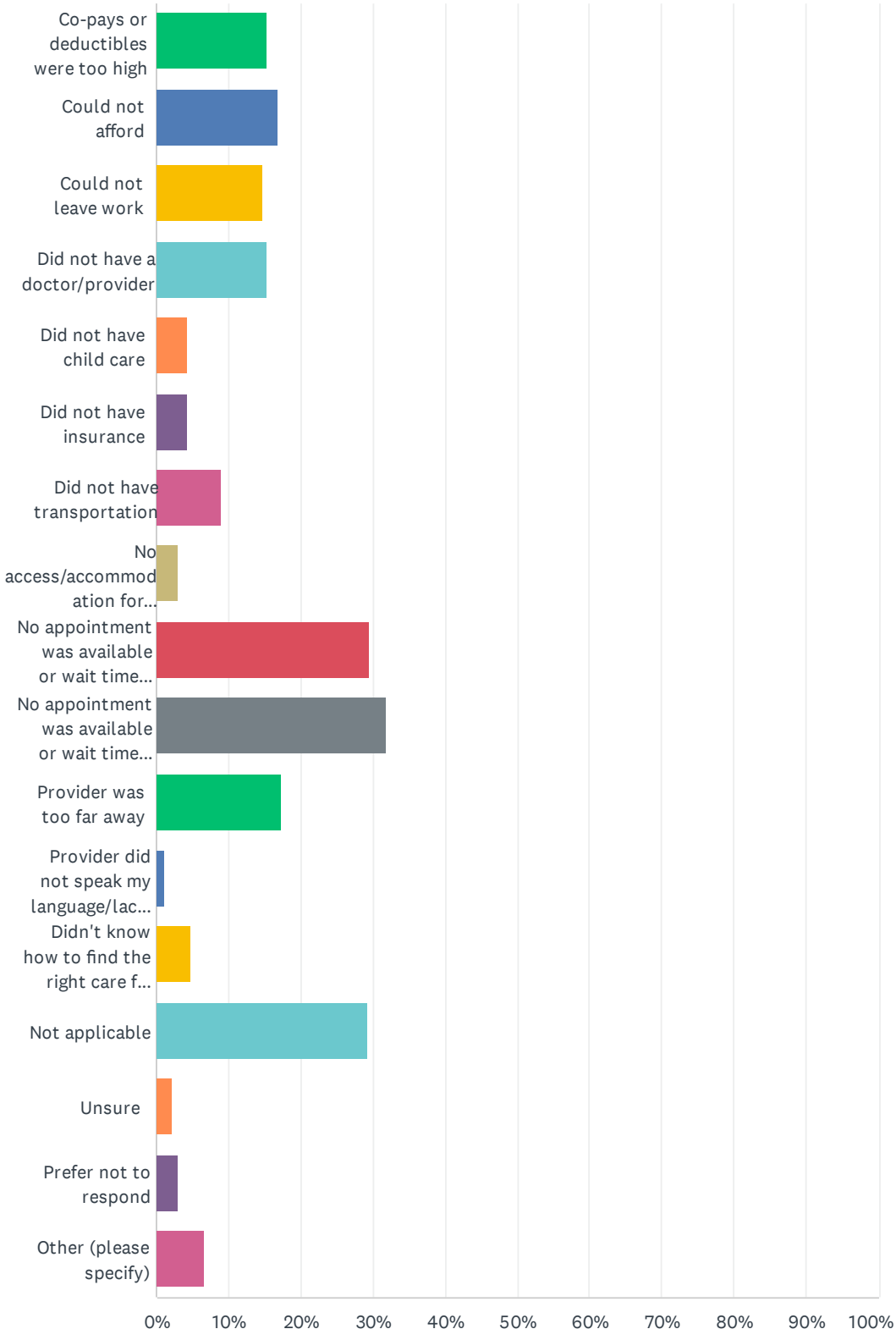




	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	PREFER NOT TO RESPOND	TOTAL
During difficult times, I have "a village" I can call on for support.	19.57% 110	51.96% 292	19.22% 108	5.87% 33	3.38% 19	562
I feel a sense of belonging to the community where I live.	15.74% 88	55.46% 310	19.32% 108	6.62% 37	2.86% 16	559
Being a resident of my community is an important part of how I see myself.	15.51% 87	53.12% 298	22.82% 128	4.81% 27	3.74% 21	561
I am a member of community social/religious/other groups and/or I participate in community events.	15.56% 87	48.30% 270	22.18% 124	7.69% 43	6.26% 35	559

Q6 If there was a time in the past year that you or a family member needed medical care but could not get it, why did you not get care? Select all that apply.

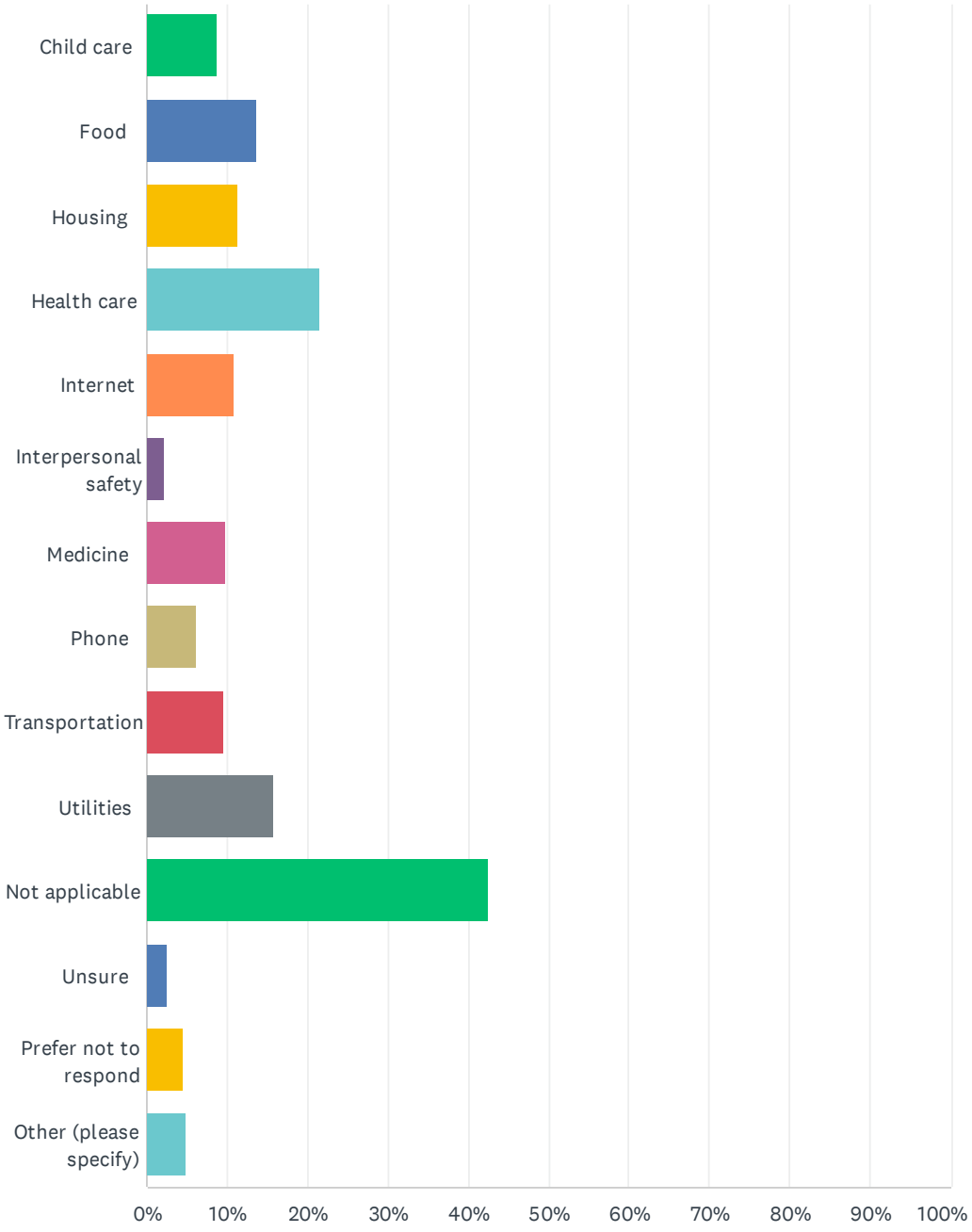
Answered: 553 Skipped: 9


Co-pays or deductibles were too high
Could not afford
Could not leave work
Did not have a doctor/provider
Did not have child care
Did not have insurance
Did not have transportation
No access/accommodation for...
No appointment was available or wait time...
No appointment was available or wait time...
Provider was too far away
Provider did not speak my language/lac...
Didn't know how to find the right care f...
Not applicable
Unsure
Prefer not to respond
Other (please specify)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

ANSWER CHOICES	RESPONSES	
Co-pays or deductibles were too high	15.37%	85
Could not afford	16.82%	93
Could not leave work	14.65%	81
Did not have a doctor/provider	15.37%	85
Did not have child care	4.34%	24
Did not have insurance	4.34%	24
Did not have transportation	8.86%	49
No access/accommodation for people with disabilities	2.89%	16
No appointment was available or wait time too long (primary care)	29.48%	163
No appointment was available or wait time too long (specialist)	31.83%	176
Provider was too far away	17.18%	95
Provider did not speak my language/lack of culturally appropriate care	1.08%	6
Didn't know how to find the right care for my medical need	4.70%	26
Not applicable	29.11%	161
Unsure	2.17%	12
Prefer not to respond	3.07%	17
Other (please specify)	6.69%	37
Total Respondents: 553		

Q7 In the last year, have you had trouble meeting your needs or the needs of those in your household in any of the following areas? Check all that apply.

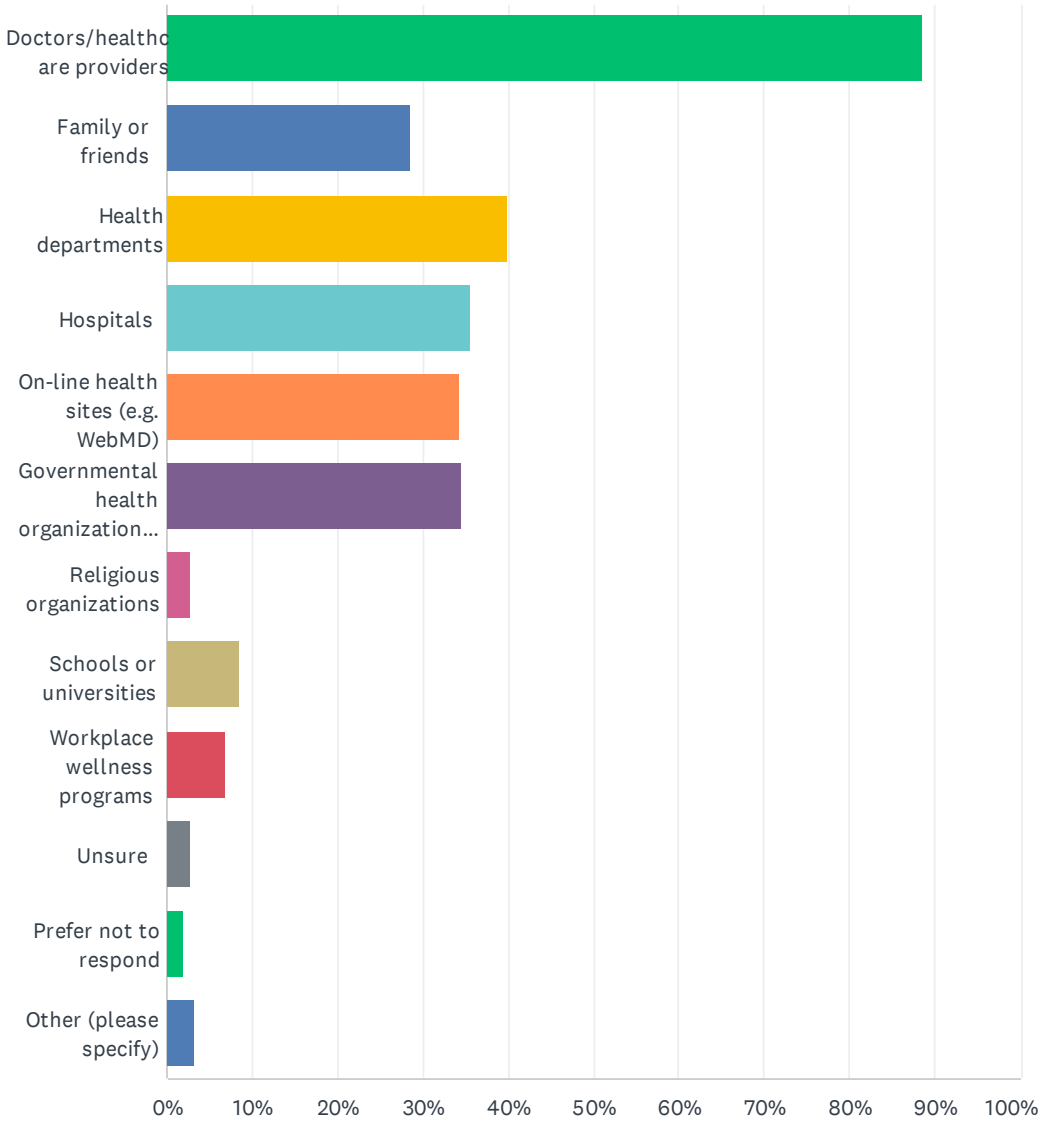
Answered: 526 Skipped: 36



ANSWER CHOICES	RESPONSES	
Child care	8.75%	46
Food	13.69%	72
Housing	11.41%	60
Health care	21.48%	113
Internet	10.84%	57
Interpersonal safety	2.09%	11
Medicine	9.89%	52
Phone	6.27%	33
Transportation	9.70%	51
Utilities	15.78%	83
Not applicable	42.40%	223
Unsure	2.47%	13
Prefer not to respond	4.56%	24
Other (please specify)	4.94%	26
Total Respondents: 526		

Q8 What are the trusted sources of health information for you and your family? Please check all that apply.

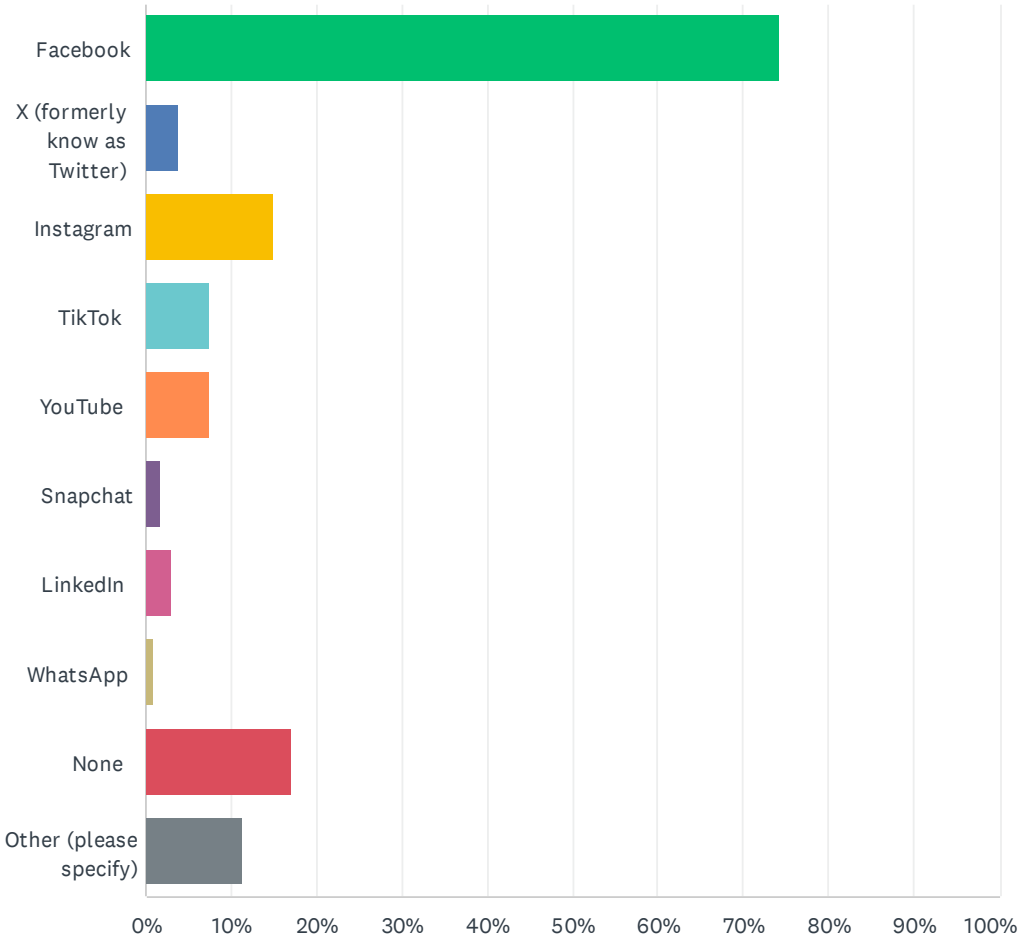
Answered: 559 Skipped: 3



ANSWER CHOICES	RESPONSES	
Doctors/healthcare providers	88.55%	495
Family or friends	28.62%	160
Health departments	39.89%	223
Hospitals	35.60%	199
On-line health sites (e.g. WebMD)	34.35%	192
Governmental health organizations (CDC, Department of Health & Human Services, World Health Organization, etc.)	34.53%	193
Religious organizations	2.86%	16
Schools or universities	8.59%	48
Workplace wellness programs	6.80%	38
Unsure	2.68%	15
Prefer not to respond	1.97%	11
Other (please specify)	3.22%	18
Total Respondents: 559		

Q9 Which of the following social media platforms/pages do you use to learn about local health or community-related events and programs? Check all that apply.

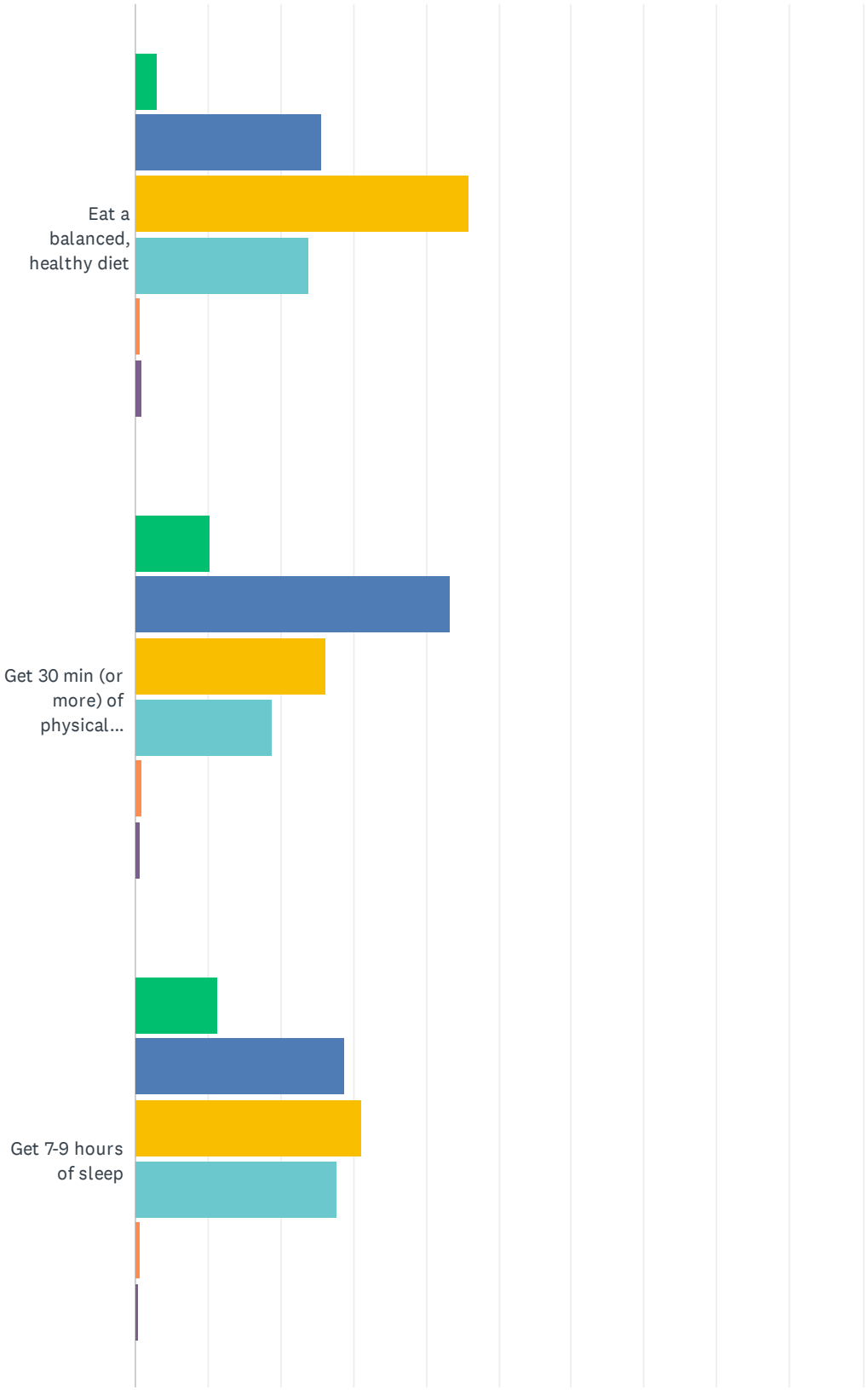
Answered: 560 Skipped: 2

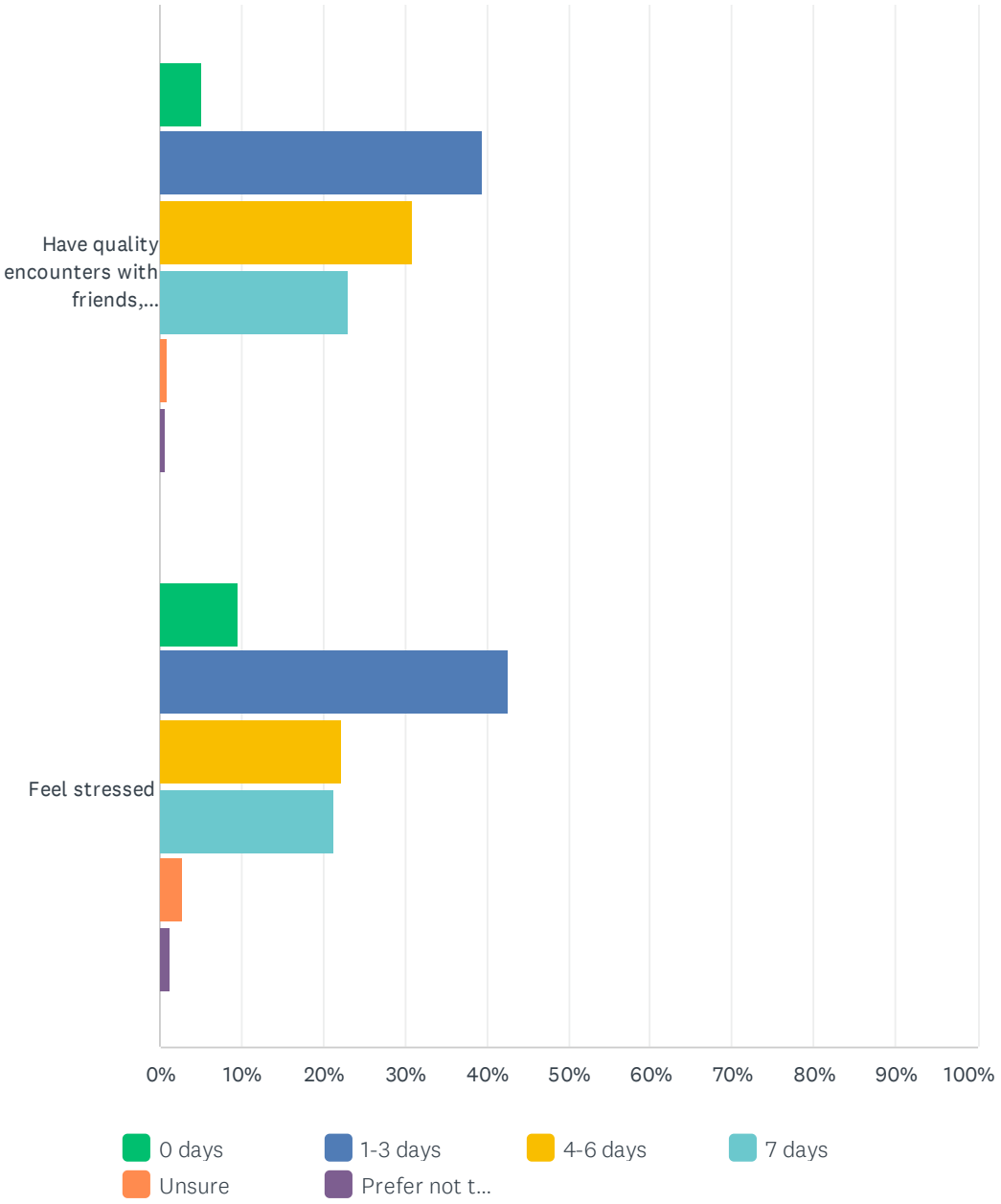


ANSWER CHOICES	RESPONSES	
Facebook	74.29%	416
X (formerly know as Twitter)	3.75%	21
Instagram	15.00%	84
TikTok	7.50%	42
YouTube	7.50%	42
Snapchat	1.61%	9
LinkedIn	3.04%	17
WhatsApp	0.89%	5
None	16.96%	95
Other (please specify)	11.25%	63
Total Respondents: 560		

Q10 In the last year, in an average week, how often did you (please check one response per row):

Answered: 561 Skipped: 1

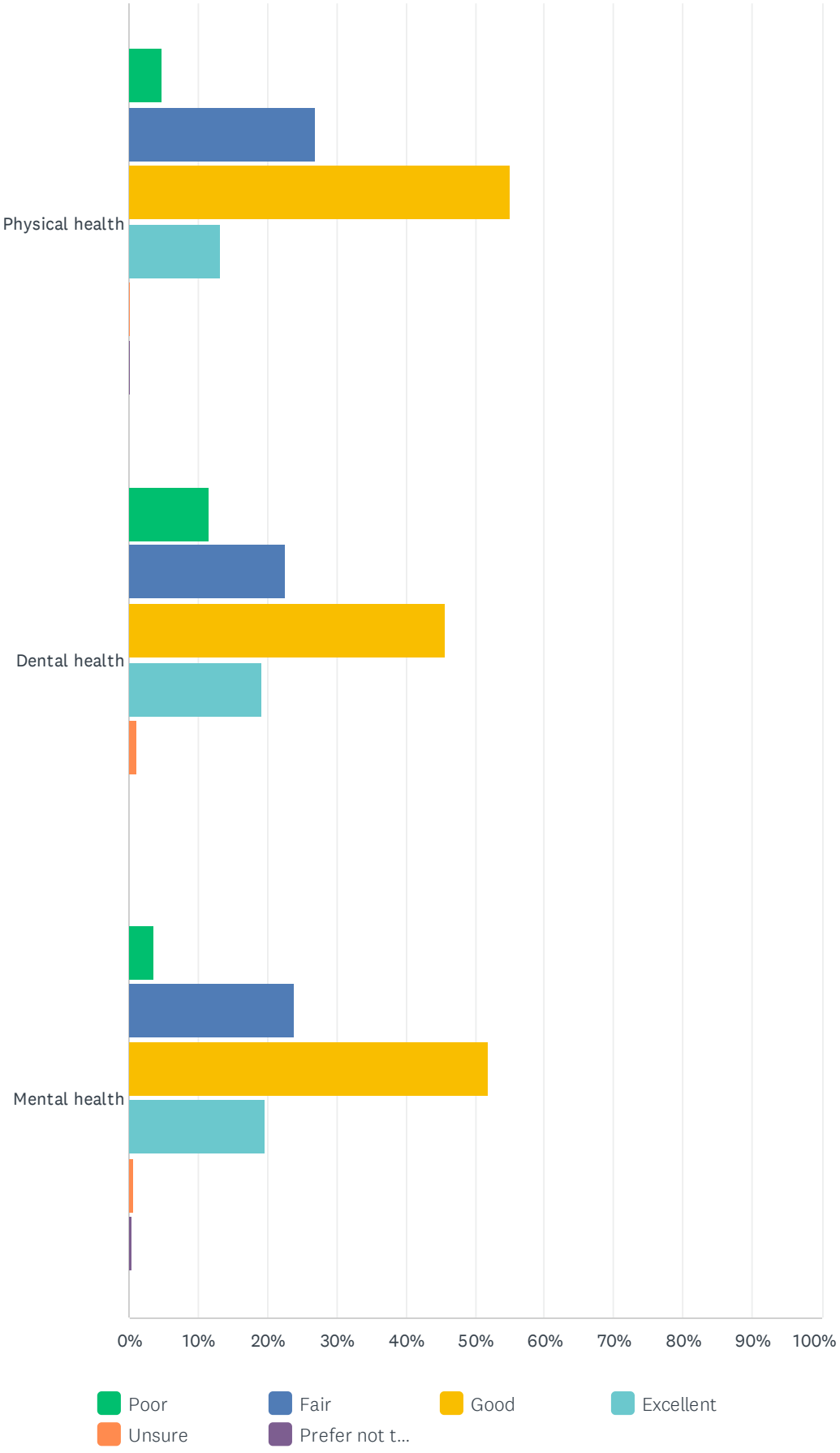




	0 DAYS	1-3 DAYS	4-6 DAYS	7 DAYS	UNSURE	PREFER NOT TO RESPOND	TOTAL
Eat a balanced, healthy diet	3.03% 17	25.67% 144	45.81% 257	23.89% 134	0.71% 4	0.89% 5	561
Get 30 min (or more) of physical activity	10.20% 57	43.29% 242	26.30% 147	18.78% 105	0.89% 5	0.54% 3	559
Get 7-9 hours of sleep	11.23% 63	28.88% 162	31.19% 175	27.81% 156	0.53% 3	0.36% 2	561
Have quality encounters with friends, family, or community members	5.20% 29	39.43% 220	30.82% 172	23.12% 129	0.90% 5	0.54% 3	558
Feel stressed	9.69% 54	42.73% 238	22.08% 123	21.36% 119	2.87% 16	1.26% 7	557

Q11 How would you rate your health in each area below? Please check one response per row.

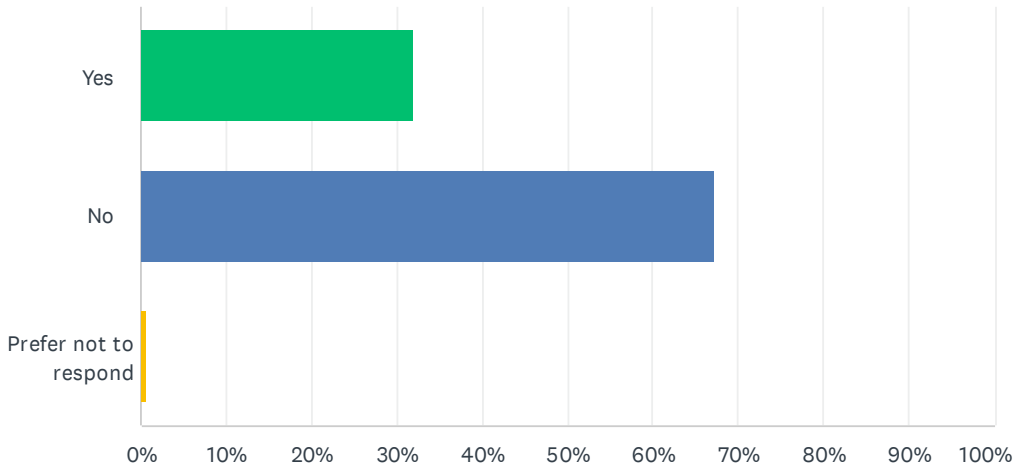
Answered: 562 Skipped: 0


Physical health
Dental health
Mental health
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Poor
Fair
Good
Excellent
Unsure
Prefer not t...

	POOR	FAIR	GOOD	EXCELLENT	UNSURE	PREFER NOT TO RESPOND	TOTAL
Physical health	4.63% 26	26.87% 151	54.98% 309	13.17% 74	0.18% 1	0.18% 1	562
Dental health	11.43% 64	22.68% 127	45.54% 255	19.29% 108	1.07% 6	0.00% 0	560
Mental health	3.58% 20	23.97% 134	51.88% 290	19.68% 110	0.54% 3	0.36% 2	559

Q12 Are there children under the age of 18 living in your household?

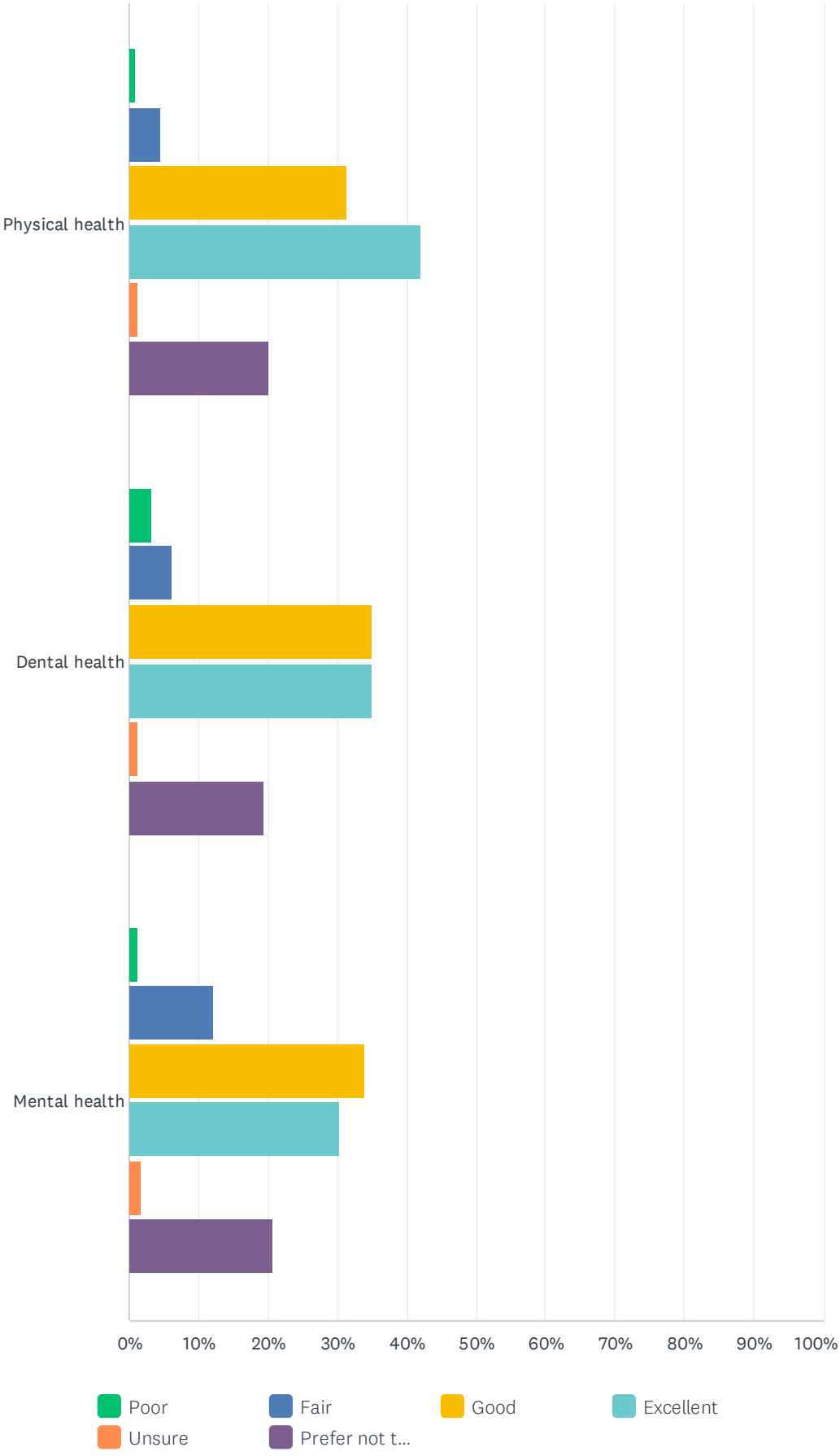
Answered: 562 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	32.03%	180
No	67.26%	378
Prefer not to respond	0.71%	4
TOTAL		562

Q13 If you answered yes to question #12, how would you rate the health of the children in your household (please check one response per row):

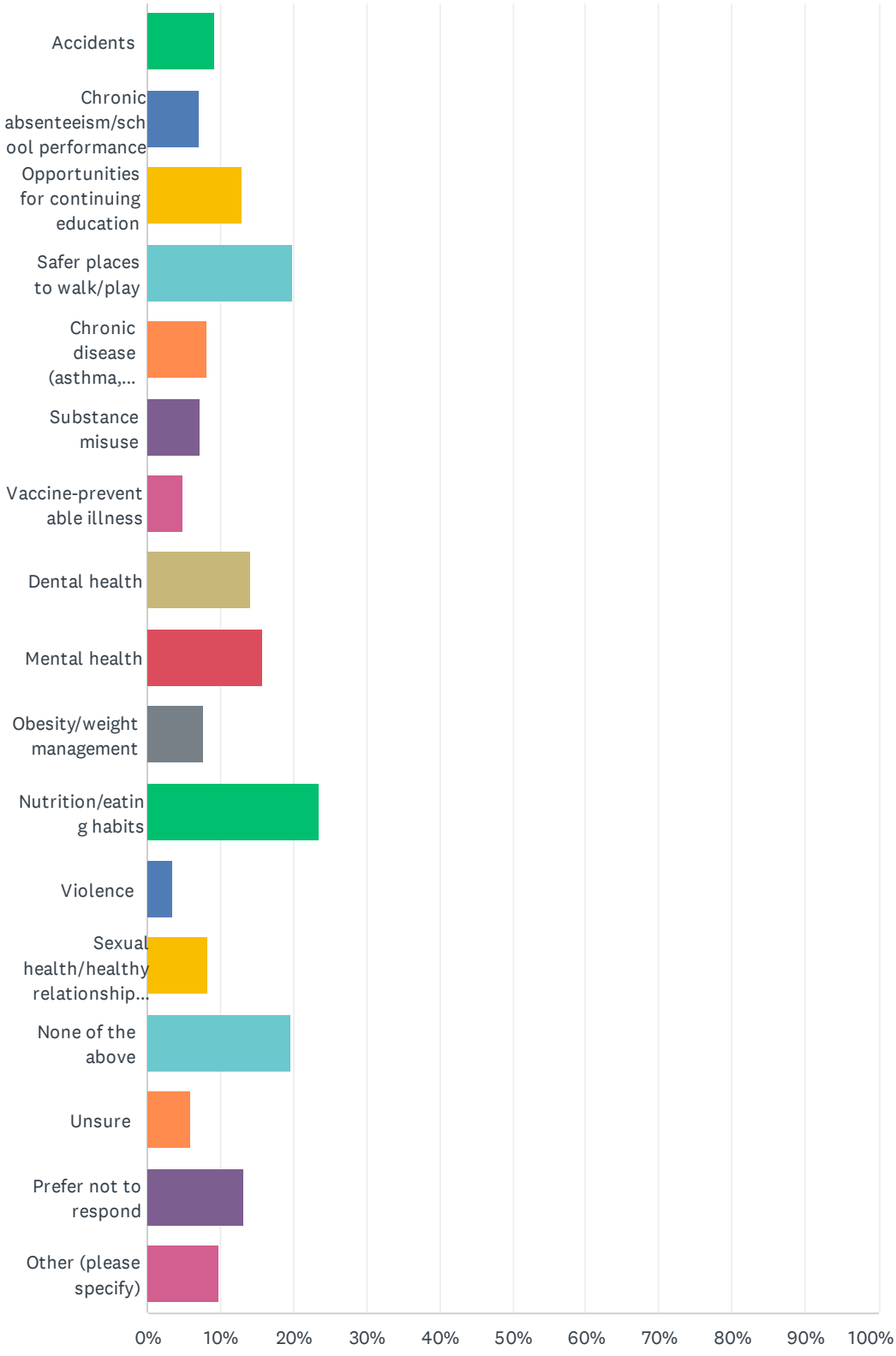
Answered: 248 Skipped: 314


Physical health
Dental health
Mental health
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Poor
Fair
Good
Excellent
Unsure
Prefer not t...

	POOR	FAIR	GOOD	EXCELLENT	UNSURE	PREFER NOT TO RESPOND	TOTAL
Physical health	0.83% 2	4.58% 11	31.25% 75	42.08% 101	1.25% 3	20.00% 48	240
Dental health	3.29% 8	6.17% 15	34.98% 85	34.98% 85	1.23% 3	19.34% 47	243
Mental health	1.21% 3	12.15% 30	34.01% 84	30.36% 75	1.62% 4	20.65% 51	247

Q14 If you answered yes to question #12, what are the biggest concerns for the children in your household? Please check up to 3 major categories.

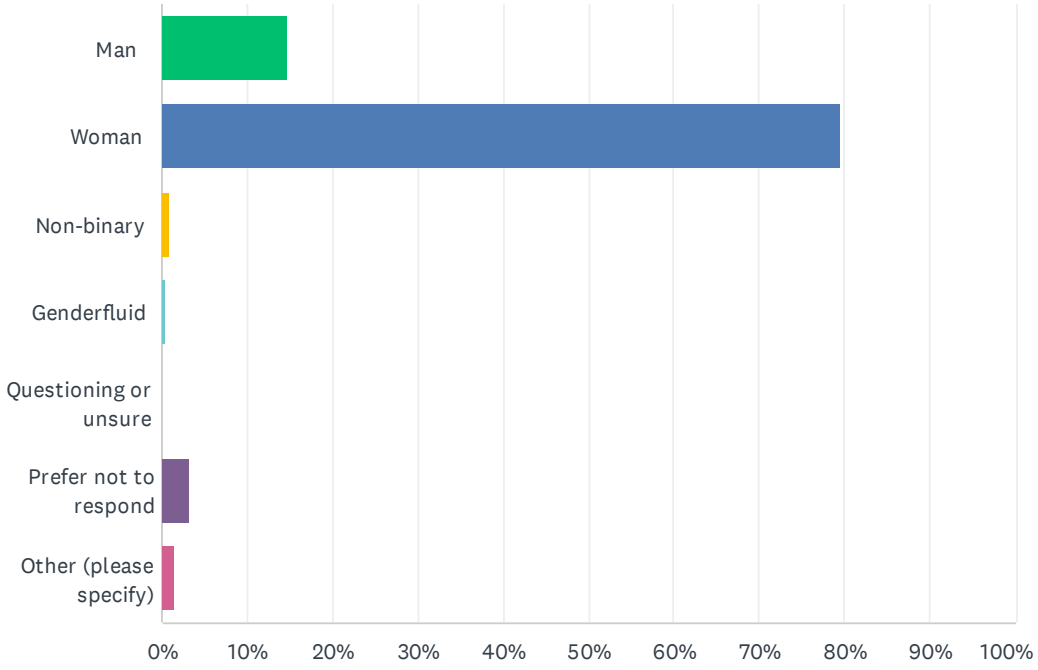
Answered: 286 Skipped: 276


Accidents
Chronic absenteeism/school performance
Opportunities for continuing education
Safer places to walk/play
Chronic disease (asthma,...
Substance misuse
Vaccine-preventable illness
Dental health
Mental health
Obesity/weight management
Nutrition/eating habits
Violence
Sexual health/healthy relationship...
None of the above
Unsure
Prefer not to respond
Other (please specify)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

ANSWER CHOICES	RESPONSES	
Accidents	9.09%	26
Chronic absenteeism/school performance	6.99%	20
Opportunities for continuing education	12.94%	37
Safer places to walk/play	19.93%	57
Chronic disease (asthma, diabetes, etc.)	8.04%	23
Substance misuse	7.34%	21
Vaccine-preventable illness	4.90%	14
Dental health	13.99%	40
Mental health	15.73%	45
Obesity/weight management	7.69%	22
Nutrition/eating habits	23.43%	67
Violence	3.50%	10
Sexual health/healthy relationships/pregnancy prevention	8.39%	24
None of the above	19.58%	56
Unsure	5.94%	17
Prefer not to respond	13.29%	38
Other (please specify)	9.79%	28
Total Respondents: 286		

Q15 What gender do you identify with?

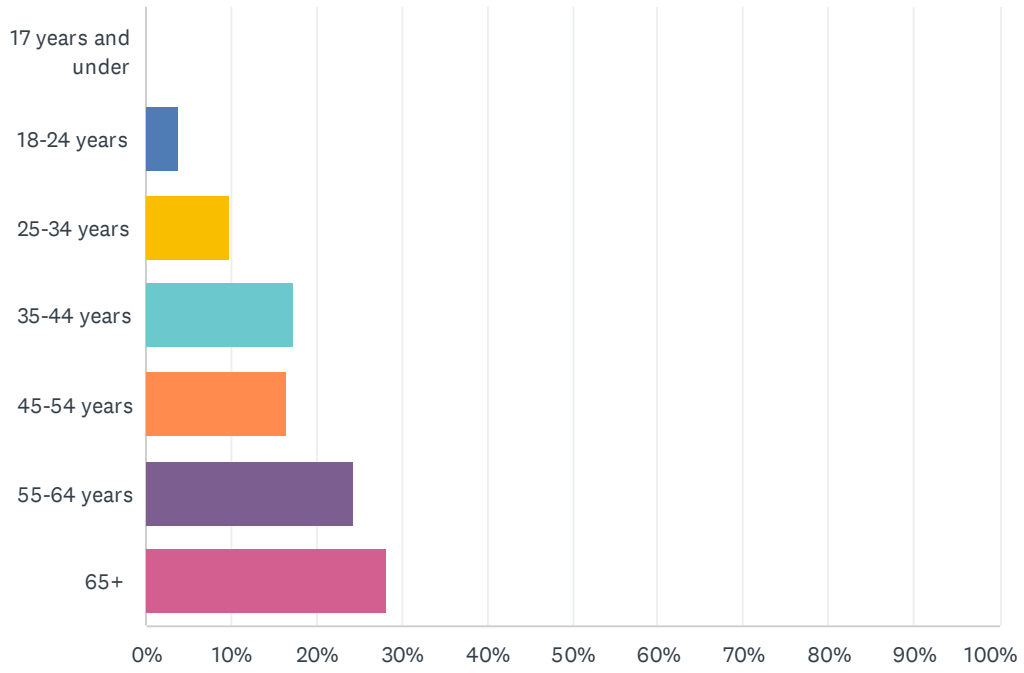
Answered: 561 Skipped: 1



ANSWER CHOICES	RESPONSES	
Man	14.62%	82
Woman	79.50%	446
Non-binary	0.89%	5
Genderfluid	0.36%	2
Questioning or unsure	0.00%	0
Prefer not to respond	3.21%	18
Other (please specify)	1.43%	8
TOTAL		561

Q16 What is your age?

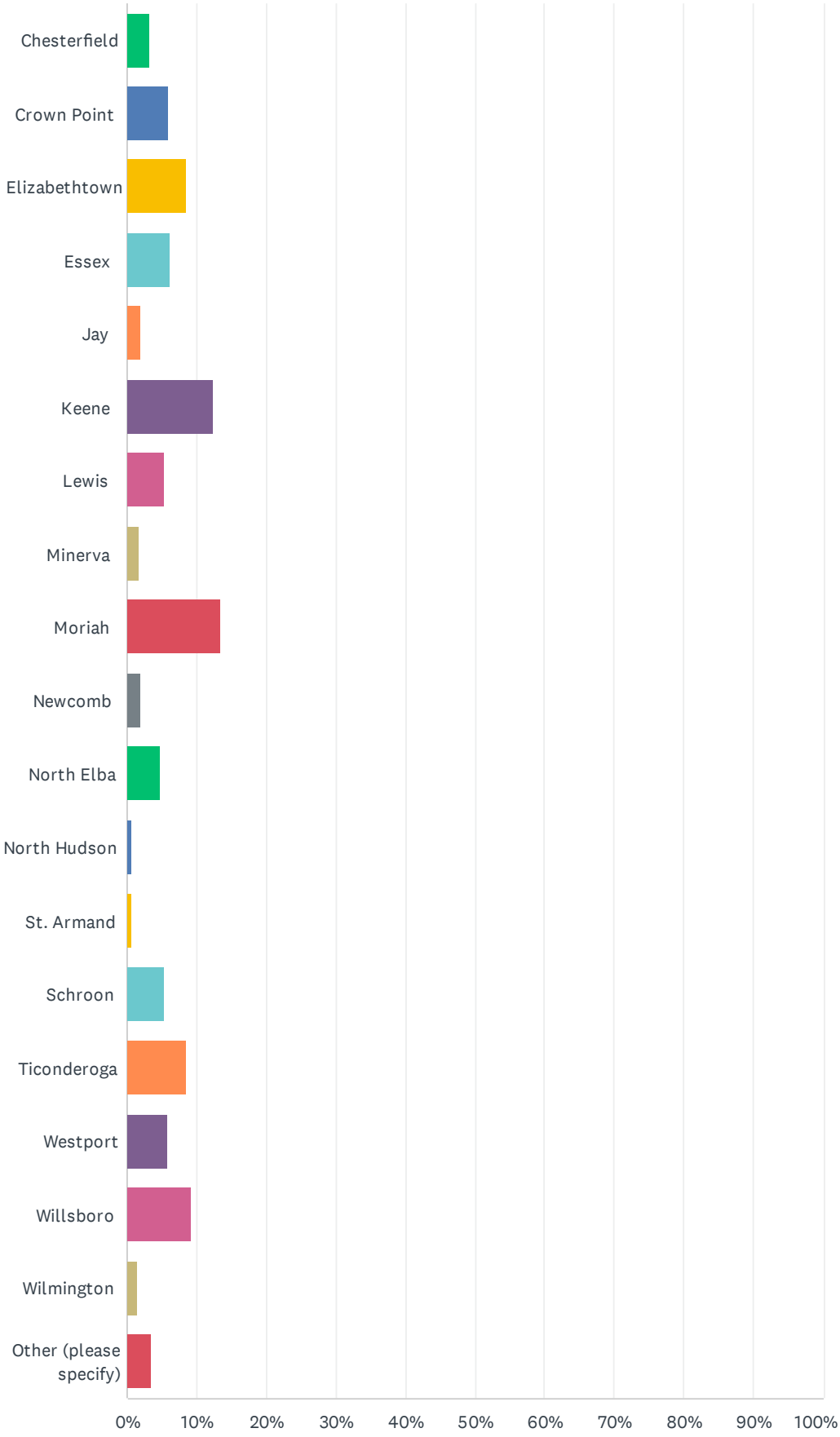
Answered: 560 Skipped: 2



ANSWER CHOICES	RESPONSES	
17 years and under	0.00%	0
18-24 years	3.93%	22
25-34 years	9.82%	55
35-44 years	17.32%	97
45-54 years	16.43%	92
55-64 years	24.29%	136
65+	28.21%	158
TOTAL		560

Q17 In which town of Essex County do you reside? Select only one based on your primary residence

Answered: 562 Skipped: 0


Chesterfield
Crown Point
Elizabethtown
Essex
Jay
Keene
Lewis
Minerva
Moriah
Newcomb
North Elba
North Hudson
St. Armand
Schroon
Ticonderoga
Westport
Willsboro
Wilmington
Other (please specify)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

ANSWER CHOICES	RESPONSES	
Chesterfield	3.20%	18
Crown Point	6.05%	34
Elizabethtown	8.54%	48
Essex	6.23%	35
Jay	1.96%	11
Keene	12.46%	70
Lewis	5.34%	30
Minerva	1.60%	9
Moriah	13.52%	76
Newcomb	1.96%	11
North Elba	4.63%	26
North Hudson	0.53%	3
St. Armand	0.53%	3
Schroon	5.34%	30
Ticonderoga	8.54%	48
Westport	5.69%	32
Willsboro	9.07%	51
Wilmington	1.42%	8
Other (please specify)	3.38%	19
Total Respondents: 562		

Q18 What is the primary language spoken in your household?

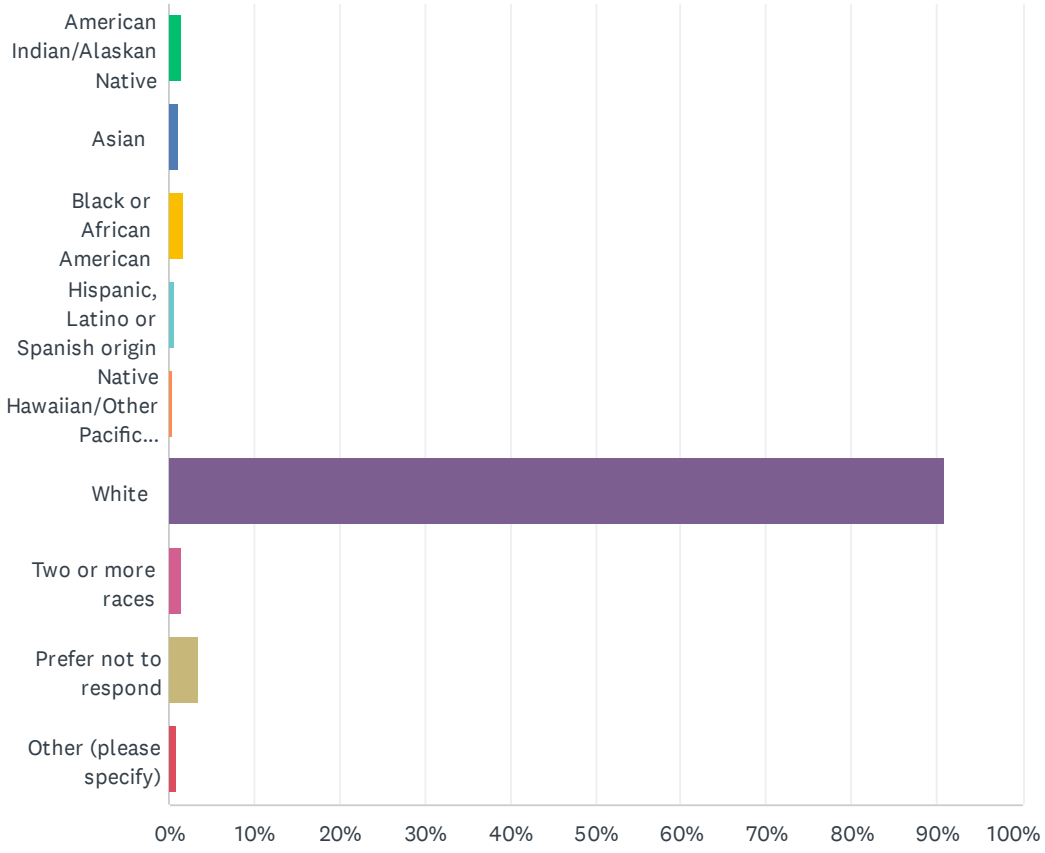
Answered: 560 Skipped: 2


English
French
Spanish
French-Creole
Haitian-Creole
Polish
Portuguese
Chinese
Korean
Russian
Italian
Arabic
Albanian
Farsi
Samoan
Yiddish
Hindi
Other (please specify)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

ANSWER CHOICES	RESPONSES	
English	98.93%	554
French	0.00%	0
Spanish	0.36%	2
French-Creole	0.00%	0
Haitian-Creole	0.00%	0
Polish	0.36%	2
Portuguese	0.00%	0
Chinese	0.00%	0
Korean	0.00%	0
Russian	0.00%	0
Italian	0.00%	0
Arabic	0.00%	0
Albanian	0.00%	0
Farsi	0.00%	0
Samoan	0.00%	0
Yiddish	0.00%	0
Hindi	0.00%	0
Other (please specify)	0.36%	2
TOTAL		560

Q19 What is your race/ethnicity?

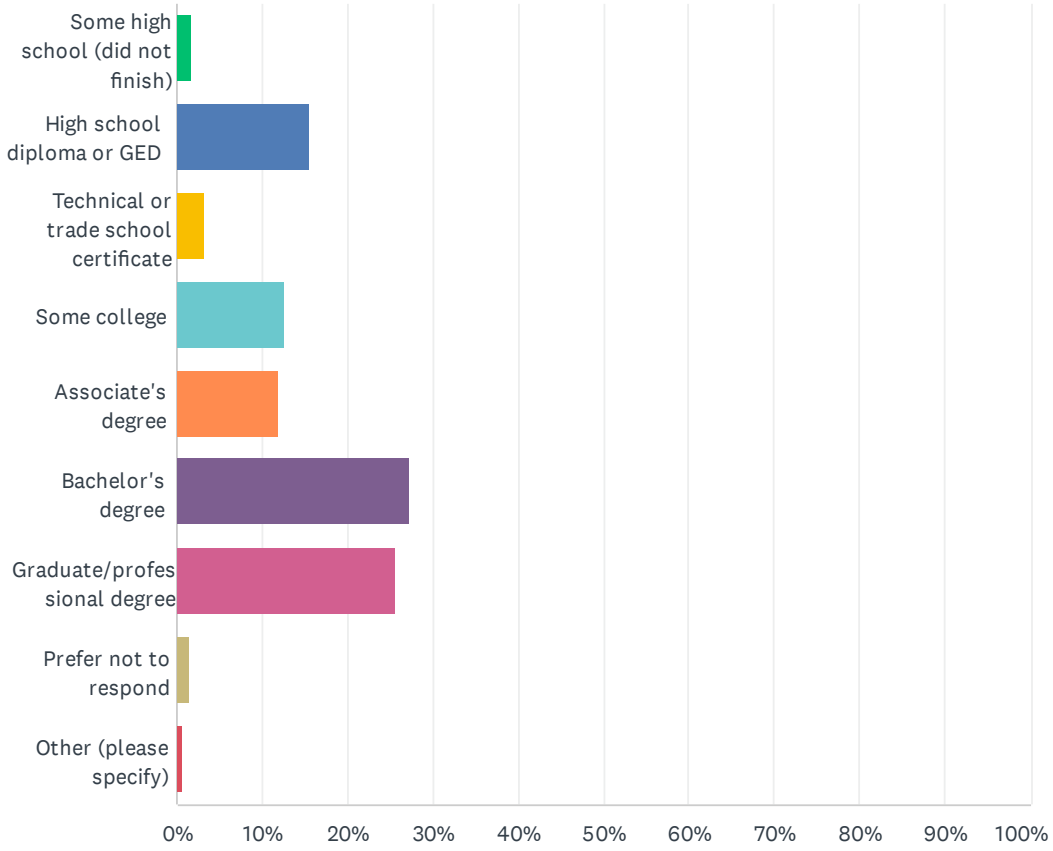
Answered: 556 Skipped: 6



ANSWER CHOICES	RESPONSES	
American Indian/Alaskan Native	1.44%	8
Asian	1.08%	6
Black or African American	1.80%	10
Hispanic, Latino or Spanish origin	0.54%	3
Native Hawaiian/Other Pacific Islander	0.36%	2
White	90.83%	505
Two or more races	1.44%	8
Prefer not to respond	3.42%	19
Other (please specify)	0.90%	5
Total Respondents: 556		

Q20 What is your highest level of education?

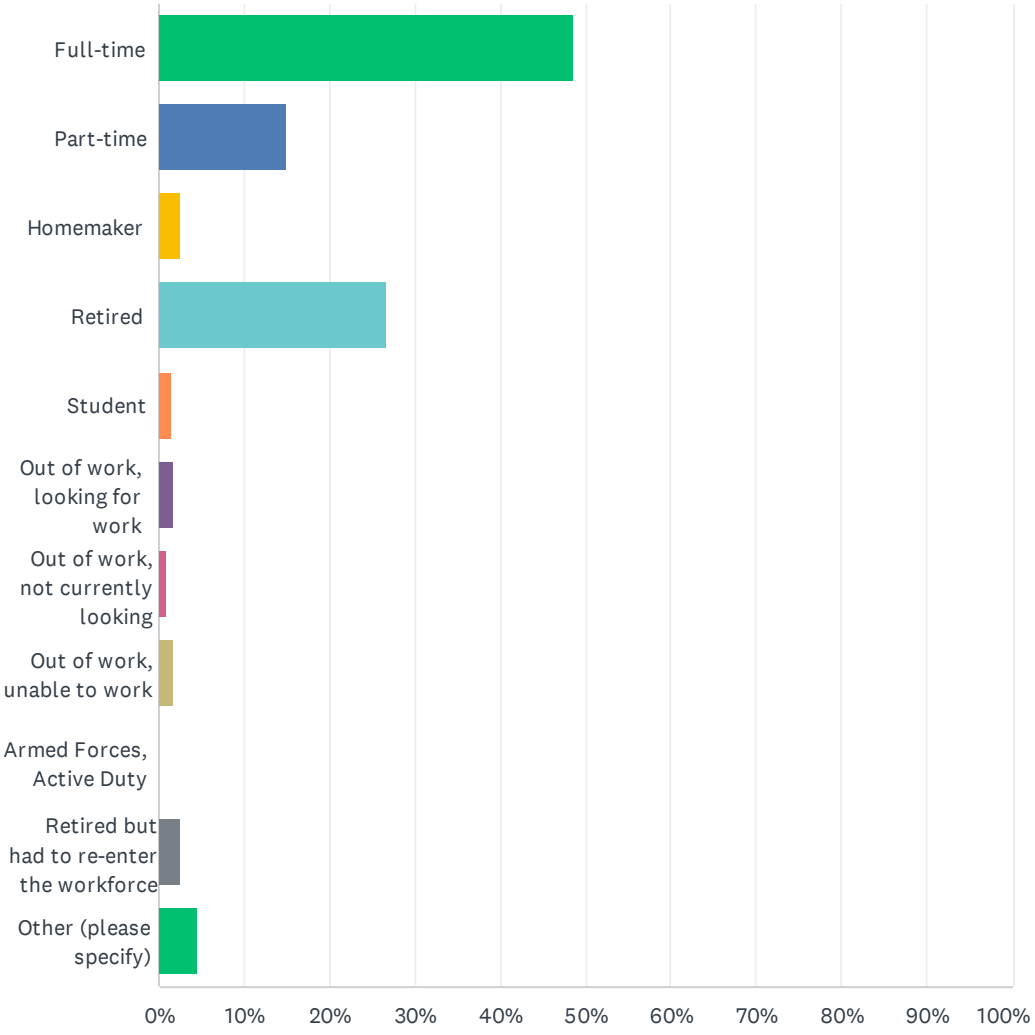
Answered: 559 Skipped: 3



ANSWER CHOICES	RESPONSES	
Some high school (did not finish)	1.79%	10
High school diploma or GED	15.56%	87
Technical or trade school certificate	3.22%	18
Some college	12.52%	70
Associate's degree	11.99%	67
Bachelor's degree	27.37%	153
Graduate/professional degree	25.58%	143
Prefer not to respond	1.43%	8
Other (please specify)	0.54%	3
TOTAL		559

Q21 What is your current employment status?

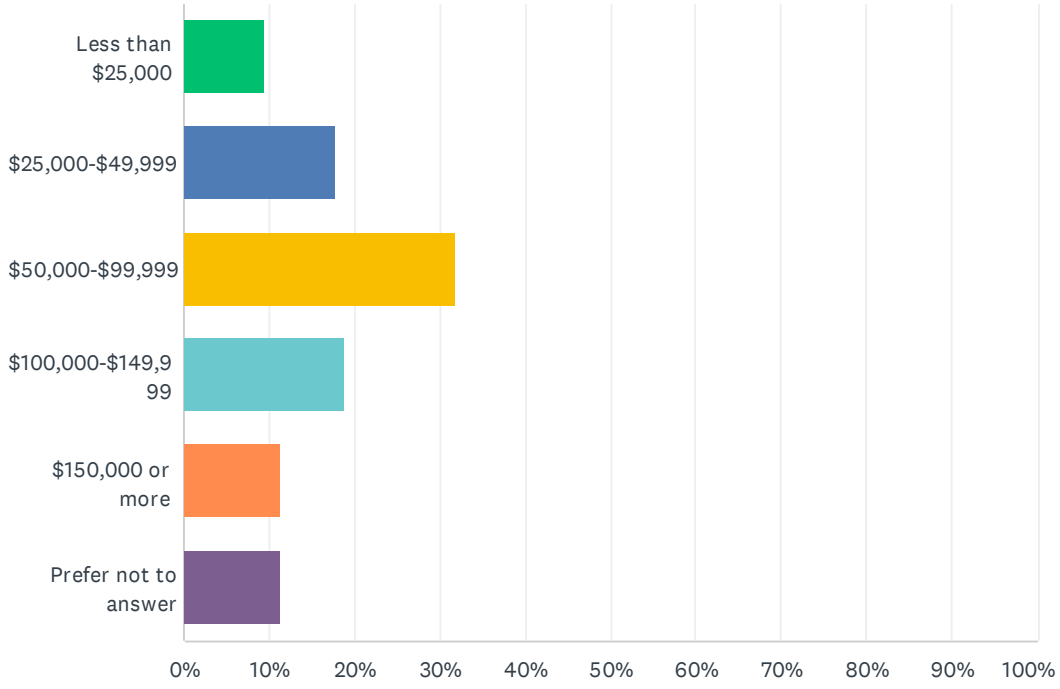
Answered: 561 Skipped: 1



ANSWER CHOICES	RESPONSES	
Full-time	48.66%	273
Part-time	14.97%	84
Homemaker	2.50%	14
Retired	26.74%	150
Student	1.43%	8
Out of work, looking for work	1.60%	9
Out of work, not currently looking	0.89%	5
Out of work, unable to work	1.78%	10
Armed Forces, Active Duty	0.00%	0
Retired but had to re-enter the workforce	2.50%	14
Other (please specify)	4.46%	25
Total Respondents: 561		

Q22 What is your annual household income?

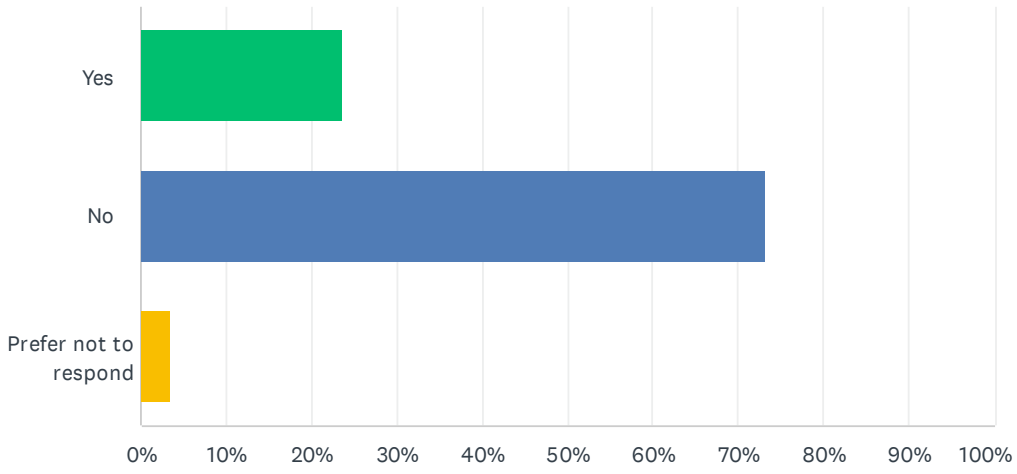
Answered: 560 Skipped: 2



ANSWER CHOICES	RESPONSES	
Less than $25,000	9.29%	52
$25,000-$49,999	17.68%	99
$50,000-$99,999	31.79%	178
$100,000-$149,999	18.75%	105
$150,000 or more	11.25%	63
Prefer not to answer	11.25%	63
TOTAL		560

Q23 Do you or does anyone in your household have a disability?

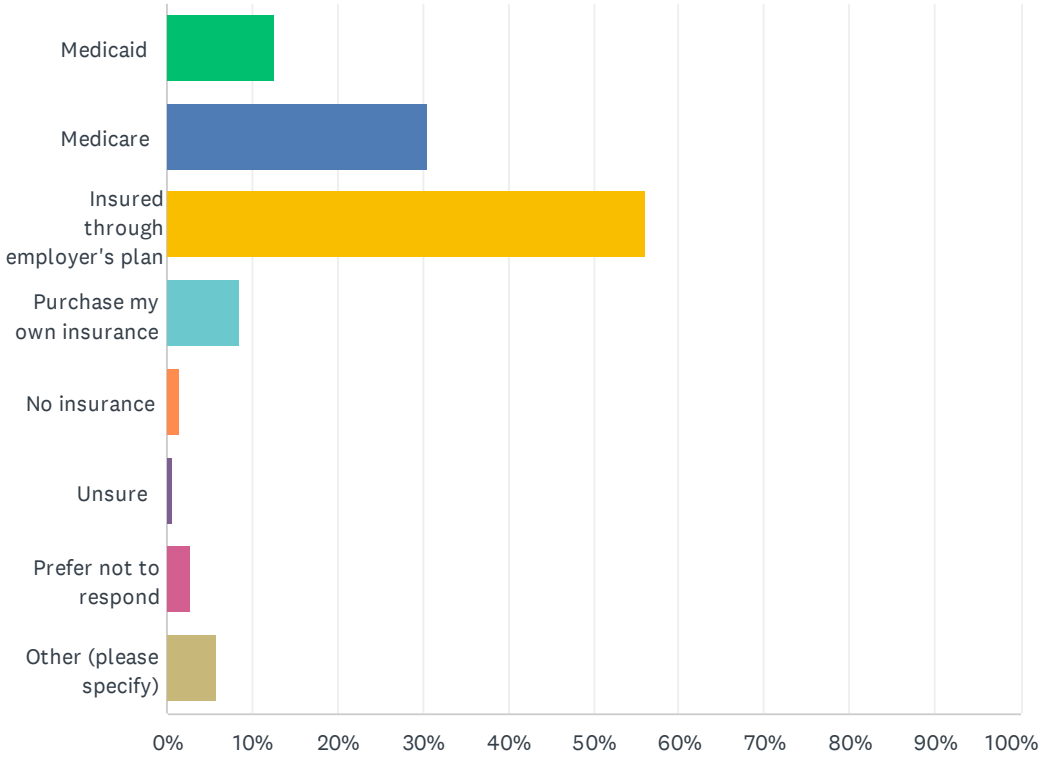
Answered: 560 Skipped: 2



ANSWER CHOICES	RESPONSES	
Yes	23.57%	132
No	73.04%	409
Prefer not to respond	3.39%	19
TOTAL		560

Q24 What type of health insurance do you currently have?

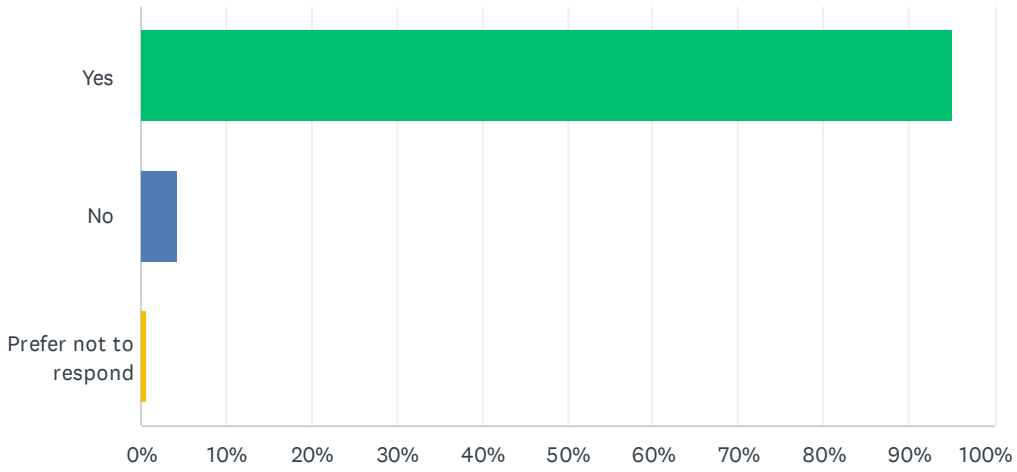
Answered: 560 Skipped: 2



ANSWER CHOICES	RESPONSES	
Medicaid	12.68%	71
Medicare	30.54%	171
Insured through employer's plan	56.07%	314
Purchase my own insurance	8.57%	48
No insurance	1.43%	8
Unsure	0.71%	4
Prefer not to respond	2.68%	15
Other (please specify)	5.71%	32
Total Respondents: 560		

Q25 Do you have reliable access to the internet in your home?

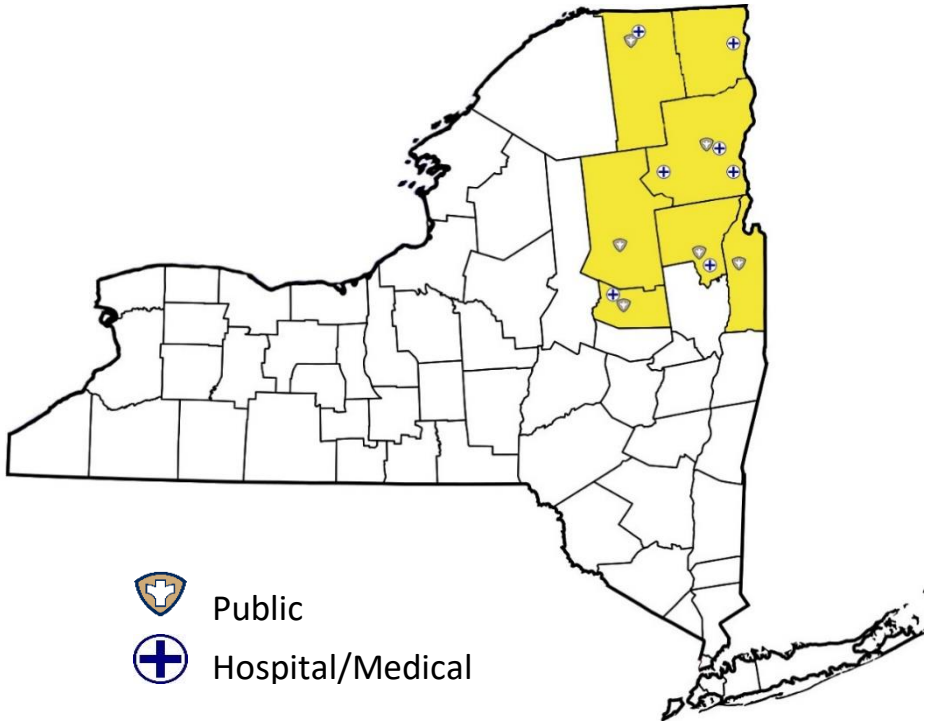
Answered: 560 Skipped: 2



ANSWER CHOICES	RESPONSES	
Yes	95.18%	533
No	4.29%	24
Prefer not to respond	0.54%	3
TOTAL		560

Appendix 2

2025 STAKEHOLDER SURVEY REPORT



Adirondack Rural Health Network Area

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

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

2025

BACKGROUND INFORMATION:

Adirondack Rural Health Network:

The Adirondack Rural Health Network (ARHN) is a program of Adirondack Health Institute, Inc. (AHI), a 501c3 not-for-profit organization. ARHN is the longest-running program of AHI, established in 1987 through a New York State Department of Health (NYS DOH) Rural Health Network Development Grant. ARHN is a multi-stakeholder, regional coalition that informs planning and assessment, provides education and training to further the implementation of the NYS DOH Health Prevention Agenda, and offers other resources that support the development of the regional health care system. Since its inception, ARHN has provided a forum to assess regional population health needs and develop collaborative responses to priorities. ARHN includes organizations from Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.

Description of the Community Health Assessment Committee:

Since 2002, ARHN has been recognized as the leading sponsor of formal community health planning throughout the region. The Community Health Assessment (CHA) Committee, facilitated by ARHN, is a multi-county, regional stakeholder group consisting of hospitals and local county health departments that convenes to develop and support sophisticated process for ongoing community health planning and assessment and planning for the defined region to address identified regional priorities. The CHA Committee is made up of representatives from the following organizations:

- Adirondack Health
- Clinton County Health Department
- University of Vermont Health Network - Alice Hyde Medical Center
- University of Vermont Health Network - Elizabethtown Community Hospital
- Essex County Health Department
- Franklin County Public Health
- Fulton County Public Health
- Glens Falls Hospital
- Hamilton County Public Health and Nursing Services
- Nathan Littauer Hospital
- University of Vermont Health Network – Champlain Valley Physicians Hospital
- Warren County Health Services
- Washington County Public Health.

The purpose of the CHA Committee is to address regional priorities, identify interventions, and develop the planning documents required by NYS DOH and the Internal Revenue Service (IRS) in an effort to advance the New York State Prevention Agenda.

CHA Data Sub-Committee:

The Data Sub-Committee (DSC) is a subset of CHA partners that meet regularly to review the tools and processes used by CHA Committee members to develop their Community Health Assessments (CHAs) and Community Health Needs Assessments (CHNAs), as well as their Community Health Improvement Plans (CHIPs) and Community Service Plans (CSPs). The DSC also works to identify opportunities to strengthen the CHA/CHNA/CHIP/CSP process. One of the primary activities of the DSC was to collaboratively develop a stakeholder survey.

The DSC met nine times from January 2024 through January 2025. Meetings were held via Webex. Attendance ranged from 6 to 11 subcommittee members per meeting. Meetings were facilitated by AHI staff from ARHN and attended by members of the AHI Data and Analytics team.

SURVEY METHODOLOGY:

Survey Creation:

The 2025 CHA Stakeholder Survey was updated by the DSC, with the definitive version incorporating additional questions and information related to Social Determinants of Health (SDOH), aligning with the priorities of the 2025-2030 NYS Prevention Agenda.

Survey Facilitation:

ARHN facilitated the release of the stakeholder survey across its seven-county service area to gather input on regional health care needs and priorities for the CHA Committee. Survey participants included professionals from health care, social services, education, and government, as well as community members. The ARHN region comprises Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington Counties.

Survey Logistics:

The survey was developed through SurveyMonkey and included 14 community health questions along with several demographic questions. The CHA Committee compiled a county level list of health care, social service, education, government, and service providers (hereafter referred to as community stakeholders) to receive the survey. In total, 889 community stakeholders were identified for distribution.

In early February 2025, CHA Committee partners sent an initial email to community stakeholders introducing the survey and providing a web-based link. ARHN followed up with several reminder emails to stakeholders who had not completed the survey. Additionally, CHA Committee members were provided with the names of all non-respondents for additional follow-up, at partner discretion.

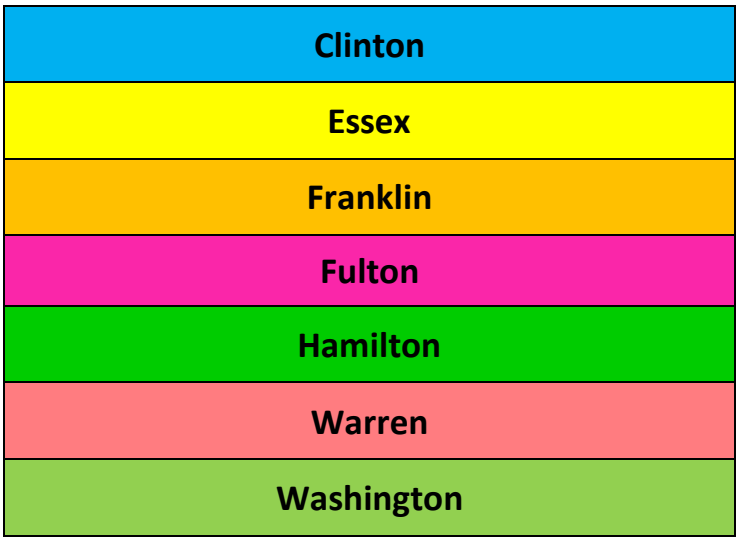
The survey requested that community stakeholders rank the five domains of SDOH based on their impact within their communities and identify key priority areas addressed by their organizations. Respondents also provided insight into what they viewed as the top health concerns in their communities and the most influential contributing factors. A full list of survey questions can be found under Appendix A.

Survey Responses and Analysis:

A total of 307 responses were received through March 14, 2025, resulting in a response rate of 34.5%. Respondents were asked to indicate the counties in which they provide services and were able to select multiple counties, as appropriate. County specific response totals are outlined in the "*By County"* section.

Analysis is organized both alphabetically and in the order of which questions appeared on the survey to support easier comprehension. Each table is clearly labeled to indicate whether the data is presented as response counts or percentages. For tables involving county data, color coding is used to differentiate counties. Written analysis accompanies each section and present findings are in percentages.

This report provides a regional overview of the results, focusing on the ARHN service area. It provides individual analyses of Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties. The stakeholder survey aimed to collect insights from diverse sectors and perspectives to inform our understanding of community needs. These findings will guide strategic planning across the Adirondack region, benefiting partners who serve individual counties, and those whose footprint covers multiple counties.

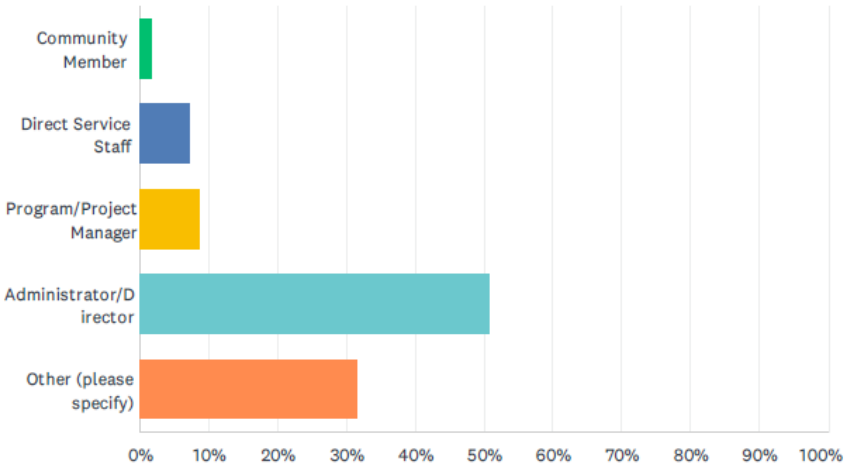


ANALYSIS:

Q3. Job Title/Role

Approximately 50.83% of respondents identified themselves as *Administrator or Director,* making it the most common selection. The second most frequent response was the "*Other"* category, accounting for 31.56% of responses. Among those who selected "Other," common roles included *President, Nurse and Purse Practitioner, School Nurse, Town Supervisors, or other county-level roles.*

It is important to note that based on responses indicated their roles did not fit the available options. To improve future surveys, it is recommended to expand the list of job titles to better capture the range of positions held by stakeholders



Respondent Job Titles		
Job Title	**Responses**	
	Count	**Percentage**
Community Member	5	1.66%
Direct Service Staff	22	7.31%
Program/Project Manager	26	8.64%
Administrator/Director	153	50.83%
Other	95	31.56%

Q5. Indicate the one community sector that best describes your organization/agency:

Community stakeholders were asked to identify one community sector that best described their organization or agency. Respondents represented a diverse range of services, with the most frequently selected sectors being *Education (27.09%),* which includes both K-12 and College/Universities, followed by *Health Care Provider (12.04%), Local Government (11.04%),* and *Other (10.70%)*.

Among those who selected "*Other,"* most listed roles could have fit into one of the defined sectors. To improve clarity in future surveys, it is recommended to refine sector definitions or offer clarifying examples to help respondents accurately categorize their roles.

Community Sector	1-25	25-50	50-75	75-100
College/University	2 (0.67%)			
Disability Services	5 (1.67%)			
Early Childhood	7 (2.34%)			
Economic Development	2 (0.67%)			
Employment/Job Training	3 (1.00%)			
Food/Nutrition	8 (2.68%)			
Foundation/Philanthropy	1 (0.33%)			
Health Based CBO	7 (2.34%)			
Health Care Provider		36 (12.04%)		
Housing	3 (1.00%)			
Law Enforcement/Corrections	11 (3.68%)			
Local Government (e.g., elected official, zoning/planning board)		33 (11.04%)		
Media	1 (0.33%)			
Mental, Emotional, Behavioral Health Provider	15 (5.02%)			
Other		32 (10.70%)		
Public Health	23 (7.69%)			
Recreation	3 (1.00%)			
School (K-12)				79 (26.42%)
Seniors/Aging Services	10 (3.34%)			
Social Services	15 (5.02%)			
Transportation	3 (1.00%)			

Q6. Indicate the region/counties your organization/agency serves:

Respondents were asked to indicate which county or counties their organization or agency serves. Over 93% of responses (285 total) were from Clinton, Essex, and Washington counties. Approximately 28.5% of respondents reported serving counties outside the seven ARHN counties, including Montgomery and Saratoga counties. In addition,22% of respondents identified themselves as serving the entirety of the Adirondack/North Country region.
It should be noted that the figures below exceed 100%, as many organizations serve multiple counties.

Respondents by County		
County	**Count**	**Percentage**
Adirondack/North Country Region	68	22.30%
Clinton	78	25.57%
Essex	118	38.68%
Franklin	70	22.95%
Fulton	52	17.05%
Hamilton	46	15.08%
Montgomery	30	9.84%
Saratoga	39	12.79%
Warren	65	21.31%
Washington	89	29.18%
Other (please specify)	18	5.90%

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

Respondents in the *Other* column identified a variety of counties outside the region, including St. Lawrence (6), Schenectady (4), Albany (3), Rensselaer (3), Jefferson (3), Schoharie (3), Herkimer (2), Vermont (2), and Herkimer (2).

Q7. What are the top five health concerns affecting the residents of the counties your organization/agency serves?

Community stakeholders were asked to identify what they believed to be the top five health concerns affecting residents in the counties their organization or agency serves. Respondents ranked their selections from one, the highest health concern, to five, indicating the lowest health concern.

According to the survey results, the top five health concerns affecting the residents within the ARHN region were *Mental Health (22.83%), Substance Use/Alcoholism/Opioid Use (11.59%), Child/Adolescent emotional health (10.14%), Adverse Childhood Experiences (8.33%), with a tie for fifth between Overweight/Obesity (6.88%)* and *Cancers (6.88%).*

Health Concern	Highest (1)	2	3	4	Lowest (5)
Mental Health Conditions	63	43	37	15	12
Substance Abuse/Alcoholism/Opioid Use	32	37	28	33	13
Child/Adolescent Emotional Health	28	28	18	20	17
Adverse Childhood Experiences	23	16	13	15	14
Overweight or Obesity	19	19	19	19	10
Cancers	19	12	8	8	6
Senior Health	16	7	16	7	9
Heart Disease	12	11	9	7	7

Maternal Health	10	3	4	2	4
Diabetes	9	15	14	8	7
Hunger	7	3	5	16	8
Dental Health	5	4	6	4	10
Child/Adolescent Physical Health	4	13	6	8	14
Alzheimer's Disease/Dementia	4	9	7	5	5
Respiratory Disease (Asthma, COPD, etc.)	4	3	3	10	13
Disability	4	2	5	12	11
Tobacco Use/Nicotine Addiction-Smoking/Vaping/Chewing	3	12	18	9	15
Domestic Abuse/Violence	3	6	9	8	7
Social Connectedness	2	5	17	21	24
Infant Health	2	5	0	1	3
Prescription Drug Abuse	2	0	6	2	8
Falls	1	3	3	2	3
High Blood Pressure	1	2	3	4	10
Food Safety	1	1	1	2	3
Motor Vehicle Safety (Impaired/Distracted Driving)	1	0	1	5	0
Unintended/Teen Pregnancy	1	0	0	1	5
Autism	0	5	5	3	7
Exposure to Air and Water Pollutants/Hazardous Materials	0	2	1	1	3
Infectious Disease	0	2	0	3	1
Pedestrian/Bicyclist Accidents	0	2	0	0	0
Underage Drinking	0	1	3	1	1
Sexually Transmitted Infections	0	1	2	1	2
Violence (Assault, Firearm Related)	0	1	1	3	3
LGBT Health	0	1	1	2	4
Sexual Assault/Rape	0	1	0	1	0
Suicide	0	0	7	7	5
Stroke	0	0	0	3	3
HIV/AIDS	0	0	0	2	1
Hepatitis C	0	0	0	1	0
Arthritis	0	0	0	0	1

Overall, the majority of health concerns identified at the individual county level aligned with the top five health concerns identified for the ARHN region. Several counties recognized health concerns outside the top five for the ARHN region. Five out of the seven ARHN counties listed *Cancers* as a top health concern in their county.

Franklin and Hamilton County respondents identified *Diabetes* as a concern in their area, while Fulton County identified Maternal Health, and Hamilton County identified Senior Health. Outliers include Franklin County listing *Heart Disease* as a top concern in their county.

Top Five Health Concerns Identified by County					
County	**1st**	**2nd**	**3rd**	**4th**	**5th**
Clinton	Mental Health Conditions	Substance Use/Alcoholism/Opioid Use	Cancers	Adverse Childhood Experiences	Overweight or Obesity
Essex	Mental Health Conditions	Substance Use/Alcoholism/Opioid Use	Child/Adolescent Emotional Health	Adverse Childhood Experiences	Overweight or Obesity
Franklin	Mental Health Conditions	Substance Use/Alcoholism/Opioid Use	Diabetes	Heart Disease	Overweight or Obesity
Fulton	Mental Health Conditions	Substance Use/Alcoholism/Opioid Use	Cancers	Child/Adolescent Emotional Health	Maternal Health
Hamilton	Mental Health Conditions	Substance Use/Alcoholism/Opioid Use	Cancers	Diabetes	Senior Health
Warren	Mental Health Conditions	Substance Use/Alcoholism/Opioid Use	Child/Adolescent Emotional Health	Adverse Childhood Experiences	Cancers
Washington	Mental Health Conditions	Substance Use/Alcoholism/Opioid Use	Child/Adolescent Emotional Health	Adverse Childhood Experiences	Cancers

Q8. What are the top five contributing factors to the health concerns you identified in Question 7?

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

The top five contributing factors identified by survey respondents were *Lack of Mental Health Services (13.28%), Addiction to Alcohol/Illicit Drugs (13.28%), Poverty (11.07%), Age of Residents (8.49%), and Changing Family Structures (5.90%).*

Contributing Factors	Highest (1)	2	3	4	Lowest (5)
Addiction to Alcohol/Illicit Drugs	36	17	18	9	10
Addiction to Nicotine	6	9	7	7	6
Age of Residents	23	9	3	6	8
Changing Family Structures (Increased Foster Care, Grandparents as Parents, etc.)	16	24	9	10	9
Crime/Violence	1	2	2	3	4
Community Blight/Deteriorating Infrastructure (Roads, Bridges, Water Systems, etc.)	0	1	1	1	0
Discrimination/Racism	0	2	1	3	0
Domestic Violence and Abuse	3	8	4	6	7
Environmental Quality	4	3	4	6	1
Excessive Screen Time	9	8	14	13	3
Exposure to Tobacco Smoke/Emissions from Electronic Vapor Products	1	2	4	2	3
Food Insecurity	8	10	15	11	8
Health Care Costs	10	15	17	7	10
Homelessness	5	10	7	6	6
Inadequate Physical Activity	6	15	10	15	7
Inadequate Sleep	0	4	3	1	4
Inadequate/Unaffordable Housing Options	4	13	12	12	7
Lack of Chronic Disease Screening Treatment and Self-Management Services	6	5	8	7	4
Lack of Cultural and Enrichment Programs	1	2	2	1	1
Lack of Dental/Oral Health Care Services	3	2	8	5	4
Lack of Quality Educational Opportunities for People of All Ages	2	1	0	1	2
Lack of Educational, Vocational, or Job-Training Options for Adults	0	0	1	0	3
Lack of Employment Options	3	1	2	1	4
Lack of Health Education Programs	2	0	2	2	2
Lack of Health Insurance	1	3	2	9	2
Lack of Intergenerational Connections within Communities	2	2	1	6	7
Lack of Mental Health Services	36	22	23	16	8
Lack of Opportunities for Health for People with Physical Limitations or Disabilities	2	1	1	2	1
Lack of Preventive/Primary Health Care Services (Screenings, Annual Check-Ups)	6	5	4	5	1
Lack of Social Supports for Community Residents	1	6	3	8	10
Lack of Specialty Care and Treatment	3	4	3	3	6
Lack of Substance Use Disorder Services	1	6	7	5	4
Late or No Prenatal Care	0	2	0	2	0

Pedestrian Safety (Roads, Sidewalks, Buildings, etc.)	0	0	0	0	1
Poor Access to Healthy Food and Beverage Options	3	5	7	4	7
Poor Access to Public Places for Physical Activity and Recreation	0	0	1	5	4
Poor Community Engagement and Connectivity	4	2	4	5	10
Poor Eating/Dietary Practices	11	9	12	5	7
Poor Referrals to Health Care, Specialty Care, and Community-Based Support Services	4	3	4	5	4
Poverty	30	12	14	19	20
Problems with Internet Access (Absent, Unreliable, Unaffordable)	0	0	0	0	1
Religious or Spiritual Values	0	0	1	1	1
Shortage of Child Care Options	2	2	2	4	8
Stress (Work, Family, School, etc.)	6	16	12	15	15
Transportation Problems (Unreliable, Unaffordable)	4	8	9	13	15
Unemployment/Low Wages	6	0	5	2	19

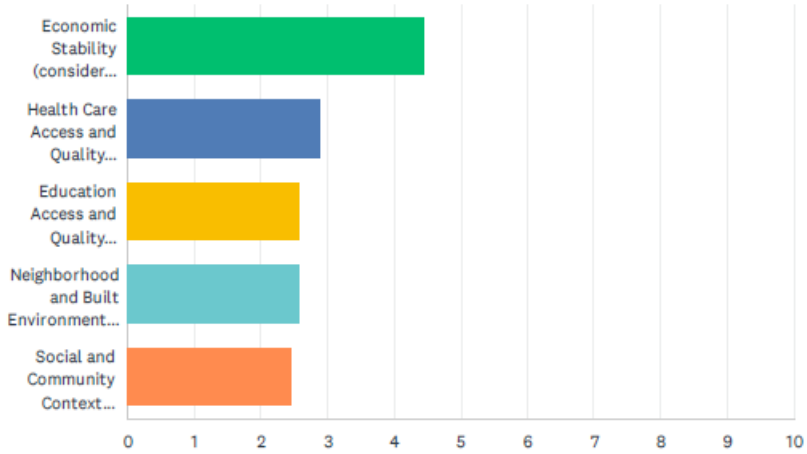
The majority of ARHN counties identified contributing factors that closely aligned with the overall top five for the region. However, several counties also highlighted unique concerns specific to their populations. Clinton County identified food insecurity as a significant contributing factor, while Franklin County emphasized poor eating and dietary practices. Warren County respondents pointed to both transportation and health care costs as key issues. Additionally, Fulton, Hamilton, and Warren counties all included health care costs among their top five contributing factors. Notably, in Warren County, health care costs and homelessness were tied as the fifth most significant contributing factor. These variations underscore the importance of addressing both regional and county-level priorities when planning public health strategies.

Top Five Contributing Factors by County					
County	**1st**	**2nd**	**3rd**	**4th**	**5th**
Clinton	Poverty	Addiction to alcohol/illicit drugs	Lack of Mental Health Services	Age of Residents	Food Insecurity
Essex	Poverty	Lack of Mental Health Services	Addiction to alcohol/illicit drugs	Changing Family Structures	Age of Residents
Franklin	Addiction to alcohol/illicit drugs	Lack of Mental Health Services	Poor eating/dietary practices	Age of Residents	Poverty
Fulton	Lack of Mental Health Services	Poverty	Addiction to alcohol/illicit drugs	Changing Family Structures	Health Care Costs
Hamilton	Age of Residents	Lack of Mental Health Services	Poverty	Addiction to alcohol/illicit drugs	Health Care Costs

Warren	Poverty	Lack of Mental Health Services	Addiction to alcohol/illicit drugs	Transportation problems	Health Care Costs & Homelessness
Washington	Poverty	Lack of Mental Health Services	Addiction to alcohol/illicit drugs	Changing Family Structures	Age of Residents

Q9. Social Determinants of Health are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. Please rate the following Social Determinants of Health impacting the residents of the counties that your organization/agency serves using a scale of (1) "most impact" to (5) "least impact".

Respondents were asked to rank SDOH, listed below, on a scale from one (excellent) to five (very poor). The table below presents the response counts for each determinant across all survey participants.



Sixty-six percent of respondents identified *Economic Stability* as the SDOH that most impacts residents of the counties they serve, followed by *Health Care Access and Quality (14.79%)*.

SDOH Domain	1 Most Impact	2	3	4	5 Least Impact	Score
Economic Stability	170 (66.15%)	56 (21.79%)	16 (6.23%)	10 (3.89%)	5 (1.95%)	4.46
Health Care Access and Quality	38 (14.79%)	64 (24.90%)	51 (19.84%)	41 (15.95%)	63 (24.51%)	2.89
Education Access and Quality	25 (9.73%)	46 (17.90%)	50 (19.46%)	71 (27.63%)	65 (25.29%)	2.59

Neighborhood and Built Environment	15 (5.84%)	50 (19.46%)	65 (25.29%)	66 (25.68%)	61 (23.74%)	2.58
Social and Community Context	9 (3.50%)	41 (15.95%)	75 (29.18%)	69 (26.85%)	63 (24.51%)	2.47

Q10. What population in the counties your organization/agency serves experiences the poorest health outcomes?

To help identify the population with the greatest need, respondents were asked to indicate which group, in their opinion, experiences the poorest health outcomes in the counties they serve.

Population	Count	Percentage
Children/Adolescents	17	6.32%
Females of Reproductive Age	2	0.74%
Individuals living at or near the federal poverty level	88	32.71%
Individuals living in rural areas	26	9.67%
Individuals with Disability	11	4.09%
Individuals with Mental Health issues	58	21.56%
Individuals with Substance Abuse Issues	26	9.67%
Migrant Workers	1	0.37%
Other (please specify)	2	0.74%
Seniors/Elderly	37	13.75%
Specific racial and ethnic groups	1	0.37%

Across all counties in the ARHN, *Individuals living at or near the federal poverty level (66.21%)* were identified as the population experiencing the poorest health outcomes. In six of the seven ARHN counties, excluding Franklin County, the second most commonly identified population was *Individuals with mental health issues (39.72%).* In contrast, Franklin County respondents identified *Seniors or Elderly (4.11%)* as the population with the second poorest health outcomes.

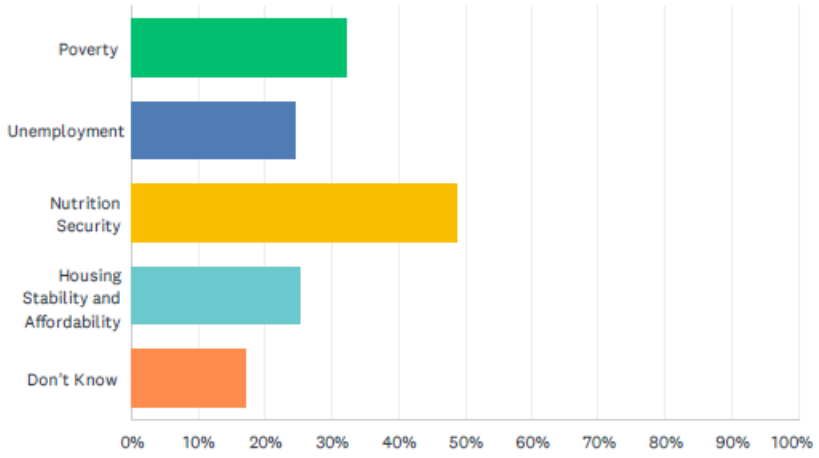
Response Counts for Poorest Health Outcomes by County							
Population	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Warren**	**Washington**
Children/Adolescents	2	7	3	1	1	2	5
Females of reproductive age	1	0	0	1	0	0	0
Individuals living at or near the federal poverty level	20	32	22	15	12	17	27
Individuals living in rural areas	10	10	7	3	4	8	10
Individuals with disability	5	6	3	0	3	6	4
Individuals with mental health issues	12	19	7	13	9	14	13

Individuals with substance abuse issues	9	10	9	5	6	4	6
Migrant workers	0	0	0	0	0	0	1
Seniors/Elderly	10	14	9	7	5	3	7
Specific racial or ethnic groups	0	1	0	0	1	1	1
Other (please specify)	1	1	1	2	1	2	1
Total per county	**76**	**116**	**69**	**52**	**46**	**64**	**89**

2025 New York State Prevention Agenda:

The NYS Prevention Agenda is an initiative focused on improving the health and well-being of all New Yorkers. The 2025-2030 Prevention Agenda outlines 24 key priorities to address health conditions, behaviors, and systemic issues such as poverty, education, housing, and access to quality healthcare. Addressing these issues is crucial for reducing health disparities.
The next five questions of the survey asked respondents to select the top three goals their organization or agency can assist in achieving in the counties it serves.

Q11. Economic Stability (Economic Well-Being)



Domain: Economic Stability		
Priority Area	**Count**	**Percentage**
Poverty	74	32.31%
Unemployment	56	24.45%
Nutrition Security	112	48.91%
Housing Stability and Affordability	58	25.33%
Don't Know	39	17.03%

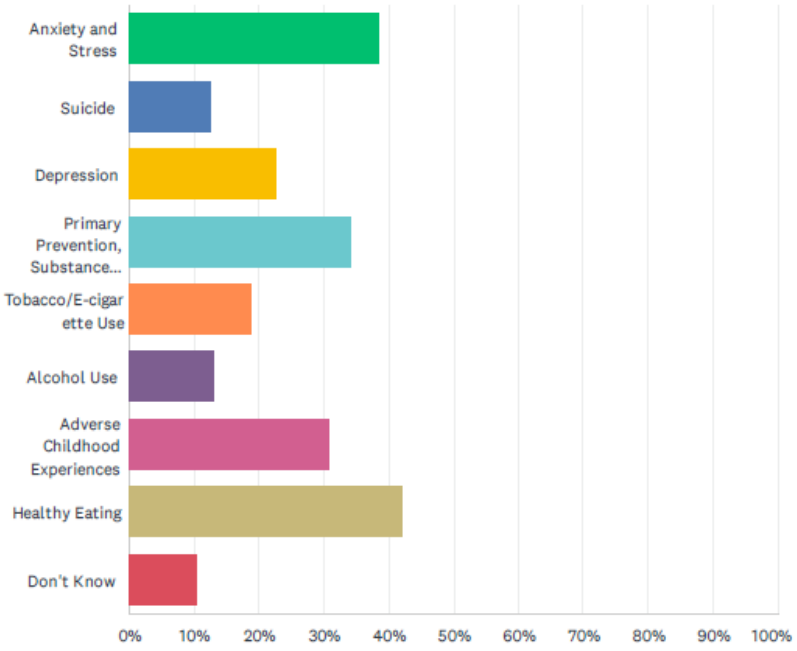
Respondents identified *Nutrition Security* (48.91%), *Poverty* (32.31%), and *Housing Stability and Affordability* (25.33%) as the top three priority areas that their organization are best positioned to support achieving in the region. Six out of seven ARHN counties identified

Nutrition Security as the top priority, with the exception of Franklin County which identified *Poverty*.

Domain: Economic Stability			
County/Region	**Priority #1**	**Priority #2**	**Priority #3**
Clinton	Nutrition Security	Poverty	Tied: Unemployment & Housing Stability and Affordability
Essex	Nutrition Security	Poverty	Tied: Unemployment & Housing Stability and Affordability
Franklin	Poverty	Nutrition Security	Unemployment
Fulton	Nutrition Security	Poverty	Tied: Unemployment & Housing Stability and Affordability
Hamilton	Nutrition Security	Poverty	Tied: Unemployment & Housing Stability and Affordability
Warren	Nutrition Security	Housing Stability and Affordability	Poverty
Washington	Nutrition Security	Tied: Poverty and Housing Stability and Affordability	Unemployment

Domain: Economic Stability							
Priority Area	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Warren**	**Washington**
Poverty	23	26	24	13	9	14	18
Housing Stability and Affordability	17	21	14	9	7	15	18
Nutrition Security	31	38	20	20	13	21	31
Unemployment	16	21	17	8	7	12	14
Don't Know	8	12	5	10	8	9	10

Q12. Social and Community Context (Mental Well-Being and Substance Use)



Respondents identified *Healthy Eating* (42.26%) as the top priority area that their organization could assist with achieving, followed by *Anxiety* and *Stress* (38.49%) and *Primary Prevention, Substance Misuse, and Overdose prevention* (34.31%) as the third highest priority areas.

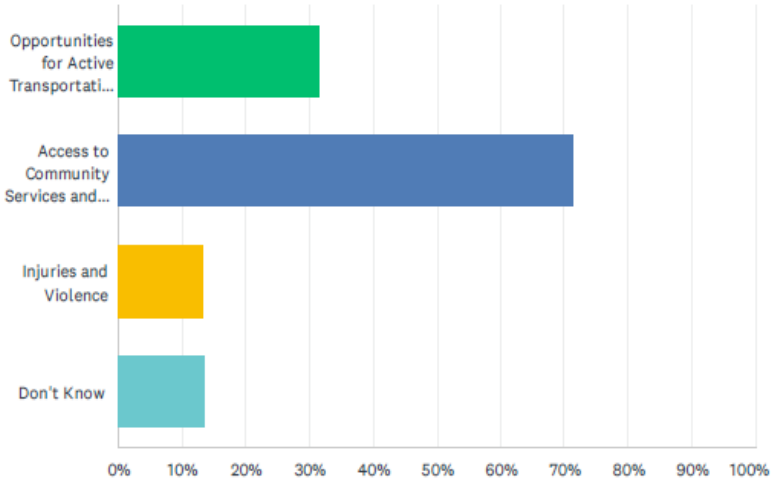
Domain: Social and Community Context		
Priority Area	**Count**	**Percentage**
Adverse Childhood Experiences	74	30.96%
Alcohol Use	31	12.97%
Anxiety and Stress	92	38.49%
Depression	54	22.59%
Healthy Eating	101	42.26%
Primary Prevention, Substance Misuse, and Overdose Prevention	82	34.31%
Suicide	30	12.55%
Tobacco/E-cigarette Use	45	18.83%
Don't Know	25	10.46%

All seven counties identified the same top three regional priorities, apart from Franklin County, which included Depression among its top three. Additionally, four of the seven counties identified *Adverse Childhood Experiences* in their top three priority areas.

Domain: Social and Community Context			
County/Region	**Priority #1**	**Priority #2**	**Priority #3**
Clinton	Healthy Eating	Anxiety and Stress	Primary Prevention, Substance Misuse, and Overdose Prevention
Essex	Tied: Primary Prevention, Substance Misuse, and Overdose Prevention & Healthy Eating	Anxiety and Stress	Adverse Childhood Experiences
Franklin	Primary Prevention, Substance Misuse, and Overdose Prevention	Anxiety and Stress	Depression
Fulton	Anxiety and Stress	Tied: Primary Prevention, Substance Misuse, and Overdose Prevention & Healthy Eating	Adverse Childhood Experiences
Hamilton	Primary Prevention, Substance Misuse, and Overdose Prevention	Anxiety and Stress	Tied: Depression & Healthy Eating
Warren	Anxiety and Stress	Healthy Eating	Tied: Primary Prevention, Substance Misuse, and Overdose Prevention & Adverse Childhood Experiences
Washington	Anxiety and Stress	Tied: Adverse Childhood Experiences & Healthy Eating	Primary Prevention, Substance Misuse, and Overdose Prevention

Domain: Social and Community Context							
Priority Area	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Warren**	**Washington**
Adverse Childhood Experiences	16	29	12	12	8	16	23
Alcohol Use	8	16	11	6	6	6	7
Anxiety and Stress	26	32	19	17	12	20	26
Depression	17	22	18	8	9	10	12
Healthy Eating	29	34	17	15	10	18	23
Primary Prevention, Substance Misuse, and Overdose Prevention	22	34	22	15	12	16	22
Suicide	10	16	12	4	6	4	5
Tobacco/E-cigarette Use	15	17	15	6	8	9	13
Don't Know	4	10	3	5	4	5	6

Q13. Neighborhood and Built Environment (Safe and Healthy Communities)

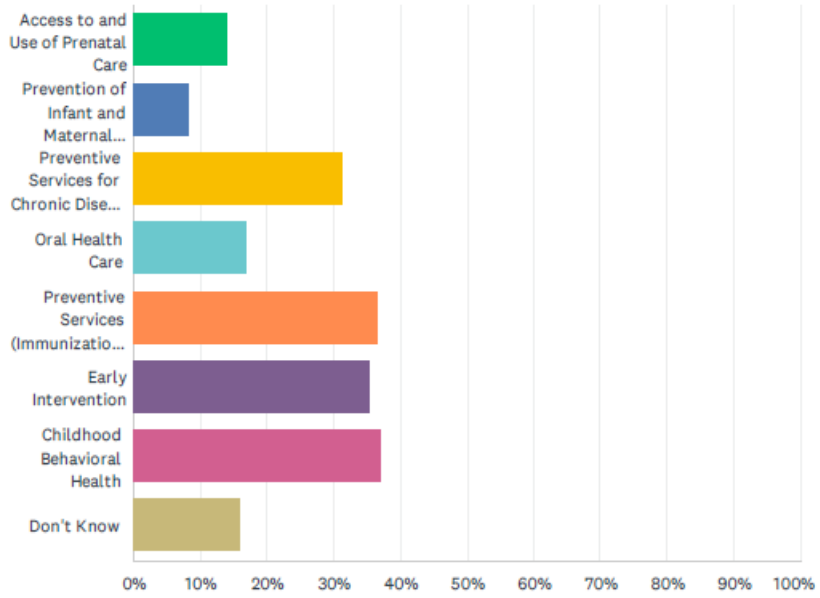


Domain: Neighborhood and Built Environment		
Priority Area	**Count**	**Percentage**
Access to Community Services and Support	167	71.37%
Injuries and Violence	31	13.25%
Opportunities for Active Transportation and Physical Activity	74	31.62%
Don't Know	32	13.68%

Domain: Neighborhood and Built Environment			
County/Region	**Priority #1**	**Priority #2**	**Priority #3**
Clinton	Access to Community Services and Support	Opportunities for Active Transportation and Physical Activity	Injuries and Violence
Essex	Access to Community Services and Support	Opportunities for Active Transportation and Physical Activity	Injuries and Violence
Franklin	Access to Community Services and Support	Opportunities for Active Transportation and Physical Activity	Injuries and Violence
Fulton	Access to Community Services and Support	Opportunities for Active Transportation and Physical Activity	Injuries and Violence
Hamilton	Access to Community Services and Support	Tied: Opportunities for Active Transportation and Physical Activity & Injuries and Violence	
Warren	Access to Community Services and Support	Opportunities for Active Transportation and Physical Activity	Injuries and Violence
Washington	Access to Community Services and Support	Opportunities for Active Transportation and Physical Activity	Injuries and Violence

Domain: Neighborhood and Built Environment							
Priority Area	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Warren**	**Washington**
Access to Community Services and Support	44	62	36	28	21	21	42
Injuries and Violence	11	10	12	4	6	6	10
Opportunities for Active Transportation and Physical Activity	22	25	18	8	6	14	23
Don't Know	7	13	5	5	8	7	7

Q14. Health Care Access and Quality (Health Insurance Coverage and Access to Care and Healthy Children)

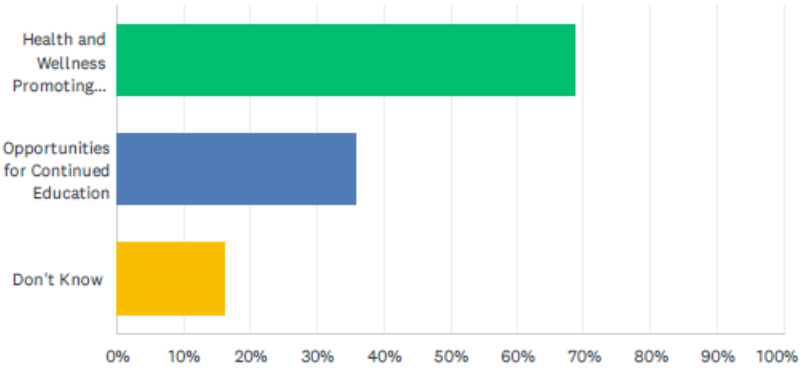


Domain: Health Care Access and Quality		
Priority Area	**Count**	**Percentage**
Access to and Use of Prenatal Care	32	14.16%
Childhood Behavioral Health	84	37.17%
Early Intervention	80	35.40%
Oral Health Care	38	16.81%
Prevention of Infant and Maternal Mortality	19	8.41%
Prevention Services for Chronic Disease Prevention and Control	71	31.42%
Preventive Services (Immunization, Hearing Screening, and follow up, Lead Screening)	83	36.73%
Don't Know	36	15.93%

Domain: Health Care Access and Quality			
County/Region	**Priority #1**	**Priority #2**	**Priority #3**
Clinton	Prevention Services for Chronic Disease Prevention and Control	Preventive Services	Early Intervention
Essex	Childhood Behavioral Health	Tied: Prevention Services for Chronic Disease Prevention and Control & Preventive Services	Early Intervention
Franklin	Prevention Services for Chronic Disease Prevention and Control	Early Intervention	Childhood Behavioral Health
Fulton	Preventive Services	Childhood Behavioral Health	Prevention Services for Chronic Disease Prevention and Control
Hamilton	Prevention Services for Chronic Disease Prevention and Control	Preventive Services	Childhood Behavioral Health
Warren	Childhood Behavioral Health	Prevention Services for Chronic Disease Prevention and Control	Preventive Services
Washington	Childhood Behavioral Health	Early Intervention	Preventive Services

Domain: Health Care Access and Quality							
Priority Area	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Warren**	**Washington**
Access to and Use of Prenatal Care	13	15	8	8	10	5	7
Childhood Behavioral Health	18	38	16	16	12	20	27
Early Intervention	20	26	17	13	8	11	24
Oral Health Care	6	15	9	9	4	5	12
Prevention of Infant and Maternal Mortality	6	10	6	7	8	7	8
Prevention Services for Chronic Disease Prevention and Control	27	27	23	15	19	16	20
Preventive Services (Immunization, Hearing Screening, and follow up, Lead Screening)	25	27	15	21	13	12	23
Don't Know	5	13	7	7	5	5	6

Q15. Education Access and Quality (PreK-12 Student Success and Educational Attainment)



Domain: Education Access and Quality		
Priority Area	**Count**	**Percentage**
Health and Wellness Promoting Schools	152	68.78%
Opportunities for Continued Education	79	35.74%
Don't Know	36	16.29%

Domain: Education Access and Quality		
County/Region	**Priority #1**	**Priority #2**
Clinton	Health and Wellness Promoting Schools	Opportunities for Continued Education
Essex	Health and Wellness Promoting Schools	Opportunities for Continued Education
Franklin	Health and Wellness Promoting Schools	Opportunities for Continued Education
Fulton	Health and Wellness Promoting Schools	Opportunities for Continued Education
Hamilton	Health and Wellness Promoting Schools	Opportunities for Continued Education
Warren	Health and Wellness Promoting Schools	Opportunities for Continued Education
Washington	Health and Wellness Promoting Schools	Opportunities for Continued Education

Domain: Education Access and Quality							
Priority Area	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Warren**	**Washington**
Health and Wellness Promoting Schools	39	21	36	26	22	32	41
Opportunities for Continued Education	18	10	15	15	11	9	13
Don't Know	7	3	6	9	8	6	10

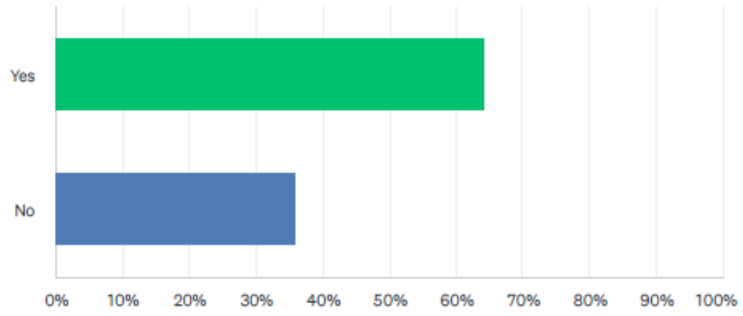
Q16. Please identify the primary assets/resources your organization/agency can contribute toward achieving the goals you have selected.

Respondents were asked to indicate the resources that their organization or agency could contribute toward achieving the goals they identified.

Approximately 59% of all respondents indicated that providing expertise and knowledge, as well as participating in committees, workgroups, and coalitions were key ways they could support progress towards the NYS Prevention Agenda goals listed above. Additionally, respondents noted that they could contribute sharing resources and promoting initiatives via social media to help advance the listed goals.

Response Counts and Percentages for Resources Organizations Can Contribute		
Resources	**Count**	**Percentage**
Participate on committees, work groups, and coalitions to help achieve the selected goals	124	59.33%
Provide subject-matter knowledge and expertise	121	57.89%
Share knowledge of community resources (e.g. food, clothing, housing, transportation, etc.)	104	49.76%
Promote health improvement activities/events through social media and other communication channels your organization/agency operates	99	47.37%
Offer health-related educational materials	71	33.97%
Facilitate access to populations your organization/agency serves (to encourage participation in programs, provide feedback about health improvement efforts, etc.)	66	31.58%
Facilitate access to committees, work groups, coalitions currently working to achieve the selected goals	61	29.19%
Provide letters of support for planned health improvement activities	61	29.19%
Sign partnership agreements related to community level health improvement efforts	48	22.97%
Offer periodic organizational/program updates to community stakeholders	46	22.01%
Provide in-kind space for health improvement meetings/events	45	21.53%
Provide knowledge of and/or access to potential sources of funding (grants, philanthropy)	37	17.7%
Share program-level data to help track progress in achieving goals	36	17.22%
Assist with data analysis	24	11.48%

Q17. Are you interested in being contacted at a later date?



Over 64% of respondents indicated they would be open to being contacted at a later date. Depending on the content and priorities outlined in the official 2025-2030 NYS Prevention Agenda official release, it may be beneficial to follow-up with partners to gather more targeted input or ask specific questions aligned with the finalized goals.

Appendix: The 2025 Stakeholder Survey

2025 CHA Stakeholders Survey

Introduction

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

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

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

Your Organization/Agency

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

1. Organization/Agency name: _____

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

3. Your job title/role: _____

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

4. Your email address: _____

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

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

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

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

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

Health Priorities, Concerns and Factors

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

- ☐ Adverse childhood experiences
- ☐ Alzheimer's disease/Dementia
- ☐ Arthritis
- ☐ Autism
- ☐ Cancers
- ☐ Child/Adolescent physical health
- ☐ Child/Adolescent emotional health
- ☐ Diabetes
- ☐ Disability
- ☐ Dental health
- ☐ Domestic abuse/violence
- ☐ 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)
- ☐ Overweight or obesity
- ☐ Pedestrian/bicyclist accidents
- ☐ Prescription drug abuse
- ☐ Respiratory disease (asthma, COPD, etc.)
- ☐ Senior health
- ☐ Sexual assault/rape
- ☐ Sexually transmitted infections
- ☐ Social connectedness

- ☐ Stroke
- ☐ Substance abuse/Alcoholism/Opioid Use
- ☐ Suicide
- ☐ Tobacco use/nicotine addiction – smoking/vaping/chewing
- ☐ Underage 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 question #7? Please rank the contributing factors from 1 (highest) to 5 (lowest).

- ☐ Addiction to alcohol/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 quality 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 specialty care and treatment
- ☐ Lack of substance use disorder services.
- ☐ Late or no prenatal care
- ☐ Pedestrian safety (roads, sidewalks, buildings, etc.)
- ☐ Poor access to healthy food and beverage options
- ☐ Poor access to public places for physical activity and recreation
- ☐ Poor community engagement and connectivity
- ☐ Poor eating/dietary practices
- ☐ Poor referrals to health care, specialty care, and community-based support services
- ☐ Poverty
- ☐ Problems with Internet access (absent, unreliable, unaffordable)
- ☐ Religious or spiritual values
- ☐ Shortage of childcare options
- ☐ Stress (work, family, school, etc.)
- ☐ Transportation problems (unreliable, unaffordable)
- ☐ Unemployment/low wages
- ☐ Other (please specify)

Prevention Agenda 2025 -2030: New York State's Health Improvement Plan

The NYS Prevention Agenda is a six-year initiative aimed at improving the health and well-being of all New Yorkers. By outlining the key health priority areas, the prevention agenda is a tool for agencies to collaborate and prioritize strategies that advance health.

Although not officially released, NYS DOH recognizes that the 2025-2030 Prevention Agenda will "adopt a broader perspective, emphasizing factors that influence health beyond traditional health outcomes, prevention strategies, medical care, and public health systems".

Twenty-four priorities have been identified based on Healthy People's 2030 Social Determinants of Health domains, listed below:

1. Economic Stability
2. Social and Community Context
3. Neighborhood and Built Environment
4. Health Care Access and Quality
5. Education Access and Quality

For more information on the upcoming 2025-2030 NYS Prevention Agenda, please visit: Prevention Agenda 2025-2030: New York State's Health Improvement Plan.

For more information on Healthy People's 2030 Social Determinants of Health, please visit: Social Determinants of Health - Healthy People 2030 | odphp.health.gov.

Social Determinants of Health

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

- ☐ Economic Stability (consider poverty, employment, food security, housing stability)
- ☐ Education Access and Quality (consider high school graduation, enrollment in higher education, language and literacy, early childhood education and development)
- ☐ Social and Community Context (consider social cohesion, civic participation, perceptions of discrimination and equity, incarceration/institutionalization)
- ☐ Neighborhood and Built Environment (consider access to healthy foods and beverages, quality of housing, crime and violence, environmental conditions, transportation)
- ☐ Health Care Access and Quality (consider access to primary care, access to specialty care, health literacy)

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

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

Improving Health and Well-Being

The NYS Prevention Agenda is an initiative focused on improving the health and well-being of all New Yorkers. The 2025-2030 Prevention Agenda outlines 24 key priorities to address health conditions, behaviors, and systemic issues such as poverty, education, housing, and access to quality healthcare. Addressing these issues is crucial for reducing health disparities.

Over the next 5 questions, please check all the priority areas that your organization serves.

11. Economic Stability (Economic Well-being)

□ Poverty

□ Unemployment

□ Nutrition Security

□ Housing Stability and Affordability

12. Social and Community Context (Mental Well-being and Substance Use)

□ Anxiety and Stress

□ Suicide

□ Depression

□ Primary Prevention, Substance Misuse, and Overdose Prevention

□ Tobacco/E-cigarette Use

□ Alcohol Use

□ Adverse Childhood Experiences

□ Healthy Eating

13. Neighborhood and Built Environment (Safe and Healthy Communities)

□ Opportunities for Active Transportation and Physical Activity

□ Access to Community Services and Support

□ Injuries and Violence

14. Health Care Access and Quality (Health Insurance Coverage and Access to Care and Healthy Children)

□ Access to and Use of Prenatal Care

□ Prevention of Infant and Maternal Mortality

□ Preventive Services for Chronic Disease Prevention and Control

□ Oral Health Care

□ Preventive Services (Immunization, Hearing Screening and follow up, Lead screening)

□ Early Intervention

□ Childhood Behavioral Health

15. Education Access and Quality (PreK-12 Student Success and Educational Attainment)

□ Health and Wellness Promoting Schools

□ Opportunities for Continued Education

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

- Provide subject-matter knowledge and expertise
- Provide knowledge of and/or access to potential sources of funding (grants, philanthropy)
- Facilitate access to committees, work groups, coalitions currently working to achieve the selected goals
- Participate on committees, work groups, coalitions to help achieve the selected goals
- Share knowledge of community resources (e.g. food, clothing, housing, transportation, etc.)
- Facilitate access to populations your organization/agency serves (to encourage participation in programs, provide feedback about health improvement efforts, etc.)
- Promote health improvement activities/events through social media and other communication channels your organization/agency operates
- Share program-level data to help track progress in achieving goals
- Provide in-kind space for health improvement meetings/events
- Offer periodic organizational/program updates to community stakeholders
- Provide 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. Are you interested in being contacted at a later date to discuss the utilization of the resources you identified in Question #16?

- ☐ Yes
- ☐ No

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

Appendix 3

ARHN Community Profile Data Sheets

Demographic Profile

Adirondack Rural Health Network	County									ARHN	Upstate	New York State
Summary of Demographic Information	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Montgomery**	**Saratoga**	**Warren**	**Washington**			
Square Miles												
Total Square Miles	1037.8	1794.1	1629.3	495.5	1717.4	403.11	810	867.2	831.2	8372.4	300.5	47123.6
Total Square Miles for Farms	268.79	12.5	79.3	52.9	N/A	130.9	39.5	0.79	121.7	N/A	N/A	4947.9
Percent of Total Square Miles Farms	25.90%	0.70%	4.90%	10.70%	N/A	32.50%	4.90%	0.10%	14.60%	N/A	N/A	10.50%
Population per Square Mile	76.9	20.8	29.2	107.6	3	122.9	290.8	75.8	73.8	387.1	N/A	428.7
Population												
Total Population	78961	37077	47066	52787	5102	49461	237075	65560	60883	347436	11313181	19571216
Percent White, Non-Hispanic	90.00%	92.90%	84.30%	89.90%	92.00%	83.00%	89.30%	93.30%	90.60%	90.30%	70.70%	55.10%
Percent Black, Non-Hispanic	3.10%	2.50%	3.40%	1.50%	1.00%	3.10%	1.60%	1.30%	2.50%	2.40%	8.70%	14.30%
Percent Hispanic/Latino	3.40%	2.80%	2.80%	4.10%	2.00%	15.20%	3.80%	2.80%	2.90%	3.10%	13.50%	19.80%
Percent Asian, Native Hawaiian,Pacific Islander	1.50%	0.30%	0.70%	1.00%	0.40%	0.70%	3.00%	0.80%	0.60%	0.90%	4.60%	9.10%
Percent Alaskan Native/American Indian	0.30%	0.20%	6.90%	0.00%	0.00%	0.30%	0.20%	0.00%	0.10%	1.00%	0.50%	0.70%
Percent Two or more races	3.70%	3.00%	2.70%	6.20%	5.60%	6.90%	4.80%	4.10%	4.20%	4.10%	9.00%	10.50%
Population by Age												
Under 5 years	3545	1399	2291	2460	159	3049	11066	2769	2771	15394	590144	1035708
5 to 14 years	8341	3278	5409	6233	366	6301	26398	6774	6464	36865	1417466	2214151
15 to 17 years	2494	1200	1856	1942	141	2073	8443	2063	2068	11764	427466	700890
Under 18 years	14380	5877	9556	10635	666	11423	45907	11606	11303	64023	2316783	3950749
18 years and over	64581	31200	37510	42152	4436	38038	191168	53954	49580	283413	8996398	15620467
65 years plus	14447	9525	8902	10746	1671	9376	45947	15454	12718	73463	2205779	3635501
Family Status												
Number of Households	33276	16039	19234	22607	2111	19234	99835	30041	24254	147562	4355640	7668956
Percent Families Single Parent Households	4.80%	4.80%	4.40%	4.60%	3.60%	6.60%	4.40%	3.60%	4.60%	4.40%	229769	462170
Percent Households with Grandparents as Parents	1.70%	1.10%	2.30%	1.90%	1.50%	1.60%	1.10%	1.50%	2.70%	1.90%	55271	101510
Poverty												
Mean Household Income	$91,067	$92,245	$78,937	$80,448	$90,814	$79,106	$123,673	$94,235	$86,922	$87,810	N/A	$122,227
Per Capita Income	$39,384	$40,807	$31,801	$34,843	$41,820	$31,975	$53,782	$43,718	$35,496	N/A	N/A	$48,847
Percent of Individuals Under Federal Poverty Level	13.80%	11.80%	16.50%	14.50%	10.00%	14.70%	6.70%	9.10%	10.80%	12.60%	11.10%	13.70%
Percent of Individuals Receiving Medicaid	23.80%	23.30%	28.10%	31.30%	23.70%	30.60%	15.00%	22.50%	27.60%	25.90%	21.9	27.4
Immigrant Status												
Percent Born in American Territories	90.80%	92.10%	91.90%	93.20%	95.60%	90.70%	89.70%	92.50%	92.40%	92.10%	82.80%	73.00%
Percent Born in Other Countries	4.70%	4.10%	3.20%	2.10%	1.20%	3.10%	5.70%	3.30%	3.10%	3.40%	12.20%	22.90%
Percent Speak a Language Other Than English at Home	2.50%	3.00%	4.30%	1.80%	1.30%	9.10%	2.80%	1.70%	2.40%	2.50%	16.90%	17.30%
Housing												
Total Housing Units	37461	25318	25442	28169	7893	22944	111127	40177	29111	193571	4924670	8631232
Percent Housing Units Occupied	88.83%	63.35%	75.60%	80.25%	26.75%	83.83%	89.84%	74.77%	83.32%	76.23%	78.50%	84.10%
Percent Housing Units Owner Occupied	68.90%	78.10%	71.20%	69.20%	82.50%	69.30%	72.20%	71.50%	76.60%	72.20%	54.70%	45.10%

Demographic Profile

Adirondack Rural Health Network	County									ARHN	Upstate	New York State
Summary of Demographic Information	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Montgomery**	**Saratoga**	**Warren**	**Washington**			
Percent Housing Units Renter Occupied	31.10%	21.90%	28.80%	30.80%	17.50%	30.70%	27.80%	28.50%	23.40%	27.80%	17.50%	39.00%
Percent Built Before 1970	45.40%	50.30%	52.70%	65.10%	52.70%	70.70%	32.60%	46.80%	55.60%	52.00%	58.20%	63.5
Percent Built Between 1970 and 1979	12.30%	11.70%	12.00%	9.50%	11.90%	8.10%	12.20%	12.30%	9.90%	11.40%	11.90%	10.1
Percent Built Between 1980 and 1989	13.10%	11.70%	12.10%	9.60%	10.30%	7.20%	13.90%	14.10%	11.40%	12.10%	9.50%	7.6
Percent Built Between 1990 and 1999	12.70%	9.70%	10.40%	7.50%	10.00%	6.90%	13.80%	10.70%	9.20%	10.20%	7.50%	5.8
Percent Built 2000 and Later	16.50%	16.70%	12.70%	8.50%	15.10%	7.20%	27.30%	15.90%	13.90%	14.30%	13.00%	13.1
Availability of Vehicles												
Percent of Households with No Vehicles Available	10.20%	8.40%	11.30%	9.70%	3.30%	12.50%	4.80%	8.00%	8.40%	9.00%	8.80%	29.40%
Percent of Households with One Vehicle Available	32.30%	34.80%	32.90%	35.50%	36.30%	35.60%	33.60%	35.10%	32.80%	34.00%	34.10%	32.80%
Percent of Households with Two Vehicles Available	40.20%	38.40%	37.30%	36.60%	43.20%	34.00%	42.40%	40.40%	38.20%	38.90%	39.10%	26.30%
Percent of Households with Three or More Vehicles Available	17.30%	18.30%	18.50%	18.20%	17.20%	17.90%	19.20%	16.50%	20.60%	18.00%	17.90%	11.50%
Education												
Total Population Ages 25 and Older	54905	28918	33482	38160	4135	34228	172398	49426	45248	254274	8040086	13996138
Percent with Less than High School Education	11.80%	8.50%	12.70%	11.50%	10.70%	11.50%	5.80%	8.20%	9.70%	10.40%	45.00%	12.20%
Percent High School Graduate/GED	32.50%	33.10%	33.90%	35.90%	31.00%	35.40%	24.40%	28.00%	39.90%	33.70%	61.70%	24.60%
Percent Some College, no degree	17.00%	15.70%	15.70%	16.30%	15.90%	18.70%	14.90%	16.80%	17.60%	16.60%	62.60%	14.90%
Percent Associates Degree	11.90%	11.40%	14.00%	15.20%	15.60%	13.90%	11.20%	12.50%	11.60%	12.70%	69.10%	8.90%
Percent Bachelor's Degree	15.30%	16.90%	13.10%	13.20%	14.20%	11.40%	24.40%	18.70%	12.50%	15.00%	52.70%	22.00%
Percent Graduate or Professional Degree	11.50%	14.40%	10.70%	7.80%	12.70%	9.20%	19.40%	15.90%	8.70%	11.50%	56.00%	17.50%
Employment Status												
Total Population Ages 16 and Older	65,792	32078	38628	43403	4524	39216	199085	55611	51012	291048	9284447	16,085,030
Total Population Ages 16 and Older in Armed Forces	185	2	0	44	0	52	615	0	30	261	19215	23559
Total Population Ages 16 and Older in Civilian labor force	37,356	17679	20,256	25451	2357	23929	127,599	35,223	29998	168320	5736756	10083719
Percent Unemployed	1.00%	2.80%	2.50%	2.20%	2.80%	2.90%	1.60%	1.60%	3.20%	2.10%	4.40%	5.20%
Employment Sector												
Total Employed (Civillian Employed Pop)	36687	16,792	19,302	24,495	2,230	22,798	124,500	34,333	28,381	162220	5181251	9254578
Percent in Agriculture, Forestry, Fishing, Hunting, and Mining	1.40%	2.20%	3.40%	1.20%	4.30%	2.50%	0.30%	1.30%	3.40%	2.00%	0.10%	0.60%
Percent in Construction	6.60%	9.10%	6.70%	7.50%	16.50%	7.80%	6.00%	6.50%	8.30%	7.40%	2.10%	5.60%
Percent in Manufacturing	11.60%	8.90%	3.90%	10.70%	2.60%	12.20%	11.00%	7.60%	13.10%	9.50%	1.30%	6.50%
Percent in Wholesale Trade	0.50%	0.90%	1.10%	2.30%	1.30%	1.60%	2.30%	1.30%	1.60%	1.30%	0.60%	2.50%
Percent in Retail Trade	9.20%	8.30%	13.90%	14.90%	8.70%	13.00%	9.50%	10.90%	13.40%	11.60%	3.60%	10.80%
Percent in Transportation, Warehousing, Utilities	5.20%	3.30%	3.90%	5.70%	4.90%	7.20%	3.60%	4.90%	3.90%	4.60%	2.90%	5.10%
Percent in Information Services	1.00%	1.90%	1.70%	1.20%	2.10%	1.10%	2.80%	1.70%	1.20%	1.40%	1.60%	2.90%

Demographic Profile

Adirondack Rural Health Network	County									ARHN	Upstate	New York State
Summary of Demographic Information	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington			
Percent in Finance/Insurance/Real Estate	1.90%	5.20%	2.60%	3.30%	4.80%	4.40%	9.70%	5.50%	4.10%	3.70%	4.10%	8.00%
Percent in Other Professional Occupations	5.70%	8.10%	5.60%	6.30%	6.00%	5.60%	12.60%	12.00%	9.10%	7.90%	7.10%	11.40%
Percent in Education, Health Care and Social Assistance	32.70%	28.10%	33.00%	27.20%	22.20%	27.00%	24.60%	25.30%	22.60%	28.00%	12.50%	27.50%
Percent in Arts, Entertainment, Recreation, Hotel & Food Service	10.10%	12.30%	7.80%	7.50%	10.60%	5.70%	7.20%	11.20%	8.00%	9.60%	4.10%	9.50%
Percent in Other Services	5.60%	5.50%	4.20%	6.00%	3.50%	6.10%	4.00%	5.40%	4.60%	5.30%	2.30%	5.00%
Percent in Public Administration	8.40%	6.20%	12.30%	6.10%	12.30%	5.80%	6.20%	6.50%	6.60%	7.60%	1.70%	4.60%

**Upstate NYS = NYS Total Less NYC; NYC includes NY, Kings, Bronx, Richmond, Queens Counties*

U.S. Census Bureau, U.S. Department of Commerce. "Selected Economic Characteristics." American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP03, 2023

U.S. Census Bureau, U.S. Department of Commerce. "Selected Social Characteristics in the United States." American Community Survey, ACS 5-Year Estimates Data Profiles, Table DP02, 2023

U.S. Census Bureau, U.S. Department of Commerce. "Medicaid/Means-Tested Public Coverage by Sex by Age." American Community Survey, ACS 5-Year Estimates Detailed Tables, Table C27007, 2023

U.S. Census Bureau, U.S. Department of Commerce. "Poverty Status in the Past 12 Months." American Community Survey, ACS 5-Year Estimates Subject Tables, Table S1701, 2023

Health Systems Profile

Adirondack Rural Health Network	County									ARHN Region	Upstate NYS*	New York State
Summary of Health Systems Information	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Montgomery**	**Saratoga**	**Warren**	**Washington**			
Population, 2023 ACS 1-Year Estimates	78,115	37,077	47,066	52,787	5,102	49,461	238,711	65,380	60,883	346,410	8,258,035	19,571,216
Total Hospital Beds												
Hospital Beds per 100,000 Population	366.1	67.4	255	140.2	N/A	262.8	71.6	598	N/A	258.7	-	-
Medical/Surgical Beds	204	0	90	47	N/A	70	115	300	N/A	641	-	-
Intensive Care Beds	14	0	8	8	N/A	5	12	12	N/A	42	-	-
Coronary Care Beds	7	0	0	0	N/A	3	7	12	N/A	19	-	-
Pediatric Beds	10	0	3	12	N/A	0	7	14	N/A	39	-	-
Maternity Beds	21	0	7	7	N/A	8	14	23	N/A	58	-	-
Physical Medicine and Rehabilitation Beds	0	0	0	0	N/A	10	0	0	N/A	0	-	-
Psychiatric Beds	30	0	12	0	N/A	20	16	30	N/A	72	-	-
Other Beds	0	25	0	0	N/A	14	0	0	N/A	25	-	-
Hospital Beds Per Facility												
Adirondack Medical Center-Lake Placid Site	-	-	-	-	-	-	-	-	-	-	-	-
Adirondack Medical Center-Saranac Lake Site	-	-	95	-	-	-	-	-	-	95	-	-
UVMHN - Alice Hyde Medical Center	-	-	25	-	-	-	-	-	-	25	-	-
Champlain Valley Physicians Hospital Medical Center	286	-	-	-	-	-	-	-	-	286	-	-
Elizabethtown Community Hospital	-	25	-	-	-	-	-	-	-	25	-	-
Glens Falls Hospital	-	-	-	-	-	-	-	391	-	391	-	-
Nathan Littauer Hospital	-	-	-	74	-	-	-	-	-	74	-	-
Saratoga Hospital	-	-	-	-	-	-	171	-	-	-	-	-
St. Mary's Healthcare	-	-	-	-	-	106	-	-	-	-	-	-
St. Mary's Healthcare-Amsterdam Memorial Campus	-	-	-	-	-	24	-	-	-	-	-	-
Total Nursing Home Beds												
Nursing Home Beds per 100,000 Population	627.3	917	414.3	682	0	1192.9	193.5	610.3	867.2	667.4	N/A	N/A
Nursing Home Beds per Facility												
Alice Hyde Medical Center	-	-	135	-	-	-	-	-	-	135	-	-
Capstone Center for Rehabilitation and Nursing	-	-	-	-	-	120	-	-	-	-	-	-
Champlain Valley Physicians Hospital Medical Center SNF	34	-	-	-	-	-	-	-	-	34	-	-
Clinton County Nursing Home	80	-	-	-	-	-	-	-	-	80	-	-
Elderwood at North Creek	-	-	-	-	-	-	-	82	-	82	-	-
Elderwood at Ticonderoga	-	84	-	-	-	-	-	-	-	84	-	-
Elderwood of Uihlein at Lake Placid	-	156	-	-	-	-	-	-	-	156	-	-
Essex Center for Rehabilitation and Healthcare	-	100	-	-	-	-	-	-	-	100	-	-
Fort Hudson Nursing Center, Inc.	-	-	-	-	-	-	-	-	196	196	-	-
Fulton Center for Rehabilitation and Healthcare	-	-	-	176	-	-	-	-	-	176	-	-
Glens Falls Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	117	-	117	-	-
Granville Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	-	122	122	-	-
Meadowbrook Healthcare	287	-	-	-	-	-	-	-	-	287	-	-
Mercy Living Center	-	-		-	-	-	-	-	-	-	-	-
Nathan Littauer Hospital Nursing Home	-	-	-	84	-	-	-	-	-	84	-	-
Palatine Nursing Home	-	-	-	-	-	70	-	-	-	-	-	-
Plattsburgh Rehabilitation and Nursing Center	89	-	-	-	-	-	-	-	-	89	-	-
River Ridge Living Center	-	-	-	-	-	120	-	-	-	-	-	-
Seton Health at Schuyler Ridge Residential Healthcare	-	-	-	-	-	-	120	-	-	-	-	-
Slate Valley Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	-	88	88	-	-

Adirondack Rural Health Network	County									ARHN Region	Upstate NYS*	New York State
Summary of Health Systems Information	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Montgomery**	**Saratoga**	**Warren**	**Washington**			
St Johnsville Rehabilitation and Nursing Center	-	-	-	-	-	120	-	-	-		-	-
The Pines at Glens Falls Center for Nursing & Rehabilitation	-	-	-	-	-	-	-	120	-	120	-	-
Tupper Lake Center for Nursing and Rehabilitation			60							60		
Warren Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	80	-	80	-	-
Washington Center for Rehabilitation and Healthcare	-	-	-	-	-	-	-	-	122	122	-	-
Wells Nursing Home Inc	-	-	-	100	-	-	-	-	-	100	-	-
Wesley Health Care Center Inc	-	-	-	-	-	-	342	-	-	-	-	-
Wilkinson Residential Health Care Facility	-	-	-	-	-	160	-	-	-	-	-	-
Total Adult Care Facility Beds												
Adult Care Facility Beds per 100,000 Population	294.4	728.2	127.5	98.5	0	628.8	293.2	648.5	221.7	338	483.4	265.1
Total Adult Home Beds	230	270	60	52	0	311	700	424	135	1,171	39,921	51,893
Total Assisted Living Program Beds	185	39	30	52	0	209	0	54	75	435	8,882	14,123
Total Assisted Living Residence (ALR) Beds	0	181	0	0	0	61	315	170	50	401	19,237	21,885
Total Enhanced ALR Beds	25	29	0	0	0	41	279	149	0	203	8,787	10,520
Special Needs ALR Beds	20	21	0	0	0	0	106	51	10	102	5,063	5,767
Adult Home Beds by Total Capacity per Facility												
Adirondack Manor HFA D.B.A Adirondack Manor HFA ALP	-	-	-	-	-	-	-	60	-	60	-	-
Adirondack Manor HFA D.B.A Montcalm Manor HFA	-	40	-	-	-	-	-	-	-	40	-	-
Ahana House	-	-	-	-	-	-	17	-	-	-	-	-
Alice Hyde Assisted Living Program	-	-	30	-	-	-	-	-	-	30	-	-
Argyle Center for Independent Living	-	-	-	-	-	-	-	-	35	35	-	-
Arkell Hall	-	-	-	-	-	24	-	-	-	-	-	-
Champlain Valley Senior Community	-	81	-	-	-	-	-	-	-	81	-	-
Countryside Adult Home	-	-	-	-	-	-	-	48	-	48	-	-
Elderwood Village at Ticonderoga	-	23	-	-	-	-	-	-	-	23	-	-
Hillcrest Spring Residential	-	-	-	-	-	80	-	-	-	-	-	-
Holbrook Adult Home	-	-	-	-	-	-	-	-	33	33	-	-
Home of the Good Shepherd at Highpointe	-	-	-	-	-	-	86	-	-	-	-	-
Home of the Good Shepherd	-	-	-	-	-	-	42	-	-	-	-	-
Home of the Good Shepherd Moreau	-	-	-	-	-	-	72	-	-	-	-	-
Home of the Good Shepherd Saratoga	-	-	-	-	-	-	105	-	-	-	-	-
Home of the Good Shepherd Wilton	-	-	-	-	-	-	54	-	-	-	-	-
Keene Valley Neighborhood House	-	50	-	-	-	-	-	-	-	50	-	-
Peregrine Senior Living at Clifton Park							64					
Pine Harbour	66	-	-	-	-	-	-	-	-	66	-	-
Pineview Commons H.F.A.	-	-	-	94	-	-	-	-	-	94	-	-
Samuel F. Vilas Home	80	-	-	-	-	-	-	-	-	80	-	-
Sarah Jane Sanford Home	-	-	-	-	-	40	-	-	-	-	-	-
The Cambridge	-	-	-	-	-	-	-	-	40	40	-	-
The Farrar Home	-	-	30	-	-	-	-	-	-	30	-	-
The Landing at Queensbury	-	-	-	-	-	-	-	88	-	88	-	-
The Mansion at South Union	-	-	-	-	-	-	-	-	44	44	-	-
The Sentinel at Amsterdam, LLC	-	-	-	-	-	150	-	-	-	-	-	-
The Terrace at the Glen at Hiland Meadows	-	-	-	-	-	-	-	52	-	52	-	-
Memory Care at The Glen at Hiland Meadows								30		30		
Valehaven Home for Adults	40	-	-	-	-	-	-	-	-	40	-	-

Adirondack Rural Health Network	County									ARHN Region	Upstate NYS*	New York State
Summary of Health Systems Information	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Montgomery**	**Saratoga**	**Warren**	**Washington**			
Willow Ridge Pointe	-	-	-	-	-	-	13	-	-	-	-	-
Woodlawn Commons	-	-	-	-	-	-	42	-	-	-	-	-
Total Physician												
Total Physician per 100,000 population	272.7	153.7	167.8	89.0	137.2	127.4	270.6	347.2	47.6	190.2	N/A	410.0
Licensure Data												
Clinical Laboratory Technician	11	5	6	1	0	3	12	6	5	34	1,223	1,623
Clinical Laboratory Technologist	49	21	26	34	0	27	154	40	22	192	7,181	11,084
Dental Hygienist	42	15	13	20	2	24	280	46	32	170	7,938	10,594
Dentist	45	11	14	14	0	19	182	46	12	142	8,504	14,677
Dietition/Nutritionist, Certified	17	10	9	6	3	10	133	22	6	73	3,926	5,923
Licensed Clinical Social Worker (LCSW)	48	25	33	24	5	22	342	85	41	261	17,670	29,479
Licensed Master Social Worker (LMSW)	59	27	29	25	4	41	318	50	37	231	17,990	31,810
Licensed Practical Nurse	362	162	287	266	11	330	841	308	399	1,795	45,788	58,010
Physicians	213	57	79	47	7	63	646	227	29	659	45,066	80,239
Mental Health Counselor	86	23	29	15	1	23	230	56	24	234	7,276	10,865
Midwife	4	2	3	4	0	2	15	15	5	33	674	1,125
Nurse Practitioner	113	30	60	57	3	53	239	128	43	434	22,543	32,589
Pharmacists	113	26	33	32	1	31	522	71	47	323	14,795	23,018
Physical Therapist	69	43	51	33	4	43	480	83	32	315	15,677	22,343
Physical Therapy Assistant	16	8	24	17	0	17	55	24	9	98	1,086	2,697
Psychologist	8	13	5	7	1	3	121	26	5	65	6,073	11,394
Physician Assistant	59	30	31	23	2	25	313	84	22	251	12,537	18,146
Registered Professional Nurse	1,316	552	769	656	55	753	4,318	1,237	805	5,390	192,584	272,352
Respiratory Therapist	20	2	5	15	0	17	101	30	13	85	4,263	5,886
Respiratory Therapy Technician	1	0	2	1	0	2	12	3	5	12	481	652

**Upstate NYS = NYS Total Less NYC; NYC includes NY, Kings, Bronx, Richmond, Queens Counties*

New York State Licensed Professions, NYS Education Department, Office of the Professions, January 2025

U.S. Census Data 2023 American Community Survey 1-Year Estimates

NYS Department of Health, NYS Health Profiles, May 2025

Education System Profile												
Adirondack Rural Health Network	**County**									**ARHN Region**	**Upstate NYS***	**New York State**
Summary of Education System Information	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Montgomery**	**Saratoga**	**Warren**	**Washington**			
Total Number of Public School Districts	9	10	8	6	4	6	12	9	12	58	796	1,104
Total Pre-K Enrollment	450	135	344	291	0	419	670	180	203	1,603.00	56,808	157,128
Total K-12 Enrollment	10,418	3,352	6,592	6,638	352	6,866	31,049	7,739	7,438	42,529	1,504,729	2,418,513
Number of Students Eligible for Free Lunch	4,678	1,453	3,427	3,602	133	4,094	8,443	3,147	3,269	19,709	638,721	1,329,551
Number of Students Eligible for Reduced Lunch	199	126	264	154	8	92	581	105	141	997	35,463	60,287
Percent Free and Reduced Lunch	47.0%	47.0%	56.0%	56.0%	40.0%	61.0%	29.0%	42.0%	46.0%	48.0%	N/A	57.0%
Number of English as a New Language	87	14	N/A	42	N/A	273	435	52	27	222	147,210	259,829
Percent Students with Disabilities	12.0%	22.0%	19.0%	14.0%	14.0%	15.0%	14.0%	17.0%	20.0%	16.5%	17.8%	19.0%
Total Number of Graduates	664	245	462	494	34	617	2,539	667	638	3,204	123,135	199,694
Number Went to GED Transfer Program	0	0	0	1	0	0	9	4	11	16	527	1,130
Number Dropped Out of High School	57	15	31	48	1	56	113	60	45	257	5,834	9,751
Percent Dropped Out of High School	7.0%	6.0%	6.0%	8.0%	3.0%	9.0%	4.0%	9.0%	7.0%	6.6%	N/A	5.0%
Percent Economically Disadvantaged	50.0%	52.0%	58.0%	58.0%	42.0%	66.0%	31.0%	44.0%	49.0%	51.3%	N/A	59.0%
Turnover Rate of Teachers	99	123	129	77	28	55	126	122	132	101.4	N/A	N/A
Total Number of Teachers	1029	398	753	642	79	711	2645	790	726	4,417	N/A	215,701
Student to Teacher Ratio	10.1	8.4	8.8	10.3	4.5	9.7	11.7	9.8	10.2	9.6	N/A	11.2

**Upstate NYS = NYS Total Less NYC; NYC includes NY, Kings, Bronx, Richmond, Queens Counties*

1: CCD Public School District Data for the 2023-2024 school year

Education System Profile - School Districts by County

Clinton	Number of Schools
AUSABLE VALLEY CENTRAL SCHOOL DISTRICT	4
BEEKMANTOWN CENTRAL SCHOOL DISTRICT	4
CHAZY UNION FREE SCHOOL DISTRICT	2
CLINTON-ESSEX-WARREN-WASHINGTON BOCES	1
NORTHEASTERN CLINTON CENTRAL SCHOOL DISTRICT	4
NORTHERN ADIRONDACK CENTRAL SCHOOL DISTRICT	2
PERU CENTRAL SCHOOL DISTRICT	3
PLATTSBURGH CITY SCHOOL DISTRICT	5
SARANAC CENTRAL SCHOOL DISTRICT	4
Total Number of Schools in the County	29

Essex	Number of Schools
BOQUET VALLEY CSD	2
CROWN POINT CENTRAL SCHOOL DISTRICT	1
KEENE CENTRAL SCHOOL DISTRICT	1
LAKE PLACID CENTRAL SCHOOL DISTRICT	2
MINERVA CENTRAL SCHOOL DISTRICT	1
MORIAH CENTRAL SCHOOL DISTRICT	2
NEWCOMB CENTRAL SCHOOL DISTRICT	1
SCHROON LAKE CENTRAL SCHOOL DISTRICT	1
TICONDEROGA CENTRAL SCHOOL DISTRICT	2
WILLSBORO CENTRAL SCHOOL DISTRICT	1
Total Number of Schools in the County	14

Franklin	Number of Schools
BRUSHTON-MOIRA CENTRAL SCHOOL DISTRICT	2
CHATEAUGAY CENTRAL SCHOOL DISTRICT	2
FRANKLIN-ESSEX-HAMILTON BOCES	1
MALONE CENTRAL SCHOOL DISTRICT	5
SAINT REGIS FALLS CENTRAL SCHOOL DISTRICT	1
SALMON RIVER CENTRAL SCHOOL DISTRICT	4
SARANAC LAKE CENTRAL SCHOOL DISTRICT	4
TUPPER LAKE CENTRAL SCHOOL DISTRICT	2
Total Number of Schools in the County	21

Fulton	Number of Schools
BROADALBIN-PERTH CENTRAL SCHOOL DISTRICT	2
GLOVERSVILLE CITY SCHOOL DISTRICT	5
JOHNSTOWN CITY SCHOOL DISTRICT	4
MAYFIELD CENTRAL SCHOOL DISTRICT	2
NORTHVILLE CENTRAL SCHOOL DISTRICT	2
WHEELERVILLE UNION FREE SCHOOL DISTRICT	1
Total Number of Schools in the County	16

Hamilton	Number of Schools
INDIAN LAKE CENTRAL SCHOOL DISTRICT	1
LAKE PLEASANT CENTRAL SCHOOL DISTRICT	1
LONG LAKE CENTRAL SCHOOL DISTRICT	1
WELLS CENTRAL SCHOOL DISTRICT	1
Total Number of Schools in the County	4

Montgomery	Number of Schools
AMSTERDAM CITY SCHOOL DISTRICT	6
CANAJOHARIE CENTRAL SCHOOL DISTRICT	3
FONDA-FULTONVILLE CENTRAL SCHOOL DISTRICT	3
FORT PLAIN CENTRAL SCHOOL DISTRICT	2
HAMILTON-FULTON-MONTGOMERY BOCES	1
OPPENHEIM-EPHRATAH-ST. JOHNSVILLE CSD	2
Total Number of Schools in the County	17

Saratoga	Number of Schools
BALLSTON SPA CENTRAL SCHOOL DISTRICT	6
BURNT HILLS-BALLSTON LAKE CENTRAL SCHOOL DISTRICT	5
CORINTH CENTRAL SCHOOL DISTRICT	3
EDINBURG COMMON SCHOOL DISTRICT	1
GALWAY CENTRAL SCHOOL DISTRICT	2
MECHANICVILLE CITY SCHOOL DISTRICT	2
SARATOGA SPRINGS CITY SCHOOL DISTRICT	8
SCHUYLERVILLE CENTRAL SCHOOL DISTRICT	3
SHENENDEHOWA CENTRAL SCHOOL DISTRICT	12
SOUTH GLENS FALLS CENTRAL SCHOOL DISTRICT	6
STILLWATER CENTRAL SCHOOL DISTRICT	2
WATERFORD-HALFMOON UNION FREE SCHOOL DISTRICT	2
Total Number of Schools in the County	52

Warren	Number of Schools
BOLTON CENTRAL SCHOOL DISTRICT	1
GLENS FALLS CITY SCHOOL DISTRICT	5
GLENS FALLS COMMON SCHOOL DISTRICT	1
HADLEY-LUZERNE CENTRAL SCHOOL DISTRICT	2
JOHNSBURG CENTRAL SCHOOL DISTRICT	1
LAKE GEORGE CENTRAL SCHOOL DISTRICT	2
NORTH WARREN CENTRAL SCHOOL DISTRICT	1
QUEENSBURY UNION FREE SCHOOL DISTRICT	4
WARRENSBURG CENTRAL SCHOOL DISTRICT	2
Total Number of Schools in the County	19

Washington	Number of Schools
ARGYLE CENTRAL SCHOOL DISTRICT	2
CAMBRIDGE CENTRAL SCHOOL DISTRICT	2
FORT ANN CENTRAL SCHOOL DISTRICT	2
FORT EDWARD UNION FREE SCHOOL DISTRICT	1
GRANVILLE CENTRAL SCHOOL DISTRICT	3
GREENWICH CENTRAL SCHOOL DISTRICT	2
HARTFORD CENTRAL SCHOOL DISTRICT	2
HUDSON FALLS CENTRAL SCHOOL DISTRICT	5
PUTNAM CENTRAL SCHOOL DISTRICT	1
SALEM CENTRAL SCHOOL DISTRICT	2
WASHINGTON-SARATOGA-WARREN-HAMILTON-ESSEX BOCES	1
WHITEHALL CENTRAL SCHOOL DISTRICT	2
Total Number of Schools in the County	25

https://nces.ed.gov/ccd/districtsearch/index.asp
Source: CCD public school district data for the 2023-2024 school year

County Health Rankings Community Conditions Profile

Indicator	County									NYS
	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington	
Health Infrastructure										
Percentage of fee-for-service (FFS) Medicare enrollees who had an annual flu vaccination	49%	51%	46%	48%	50%	47%	57%	51%	47%	51%
Percentage of population with adequate access to locations for physical activity.	72%	100%	57%	90%	100%	54%	86%	99%	71%	93%
Index of factors that contribute to a healthy food environment, from 0 (worst) to 10 (best).	8.3	8.8	7.5	8	7.5	6.4	9.1	8.4	8.6	8.7
Ratio of population to primary care physicians.	1240:1	1960:1	1900:1	3120:1	2560:1	1910:1	1440:1	900:1	2770:1	1240:1
Ratio of population to mental health providers.	280:1	490:1	280:1	380:1	1690:1	970:1	420:1	210:1	550:1	260:1
Ratio of population to dentists	1540:1	3690:1	1780:1	4050:1	N/A	1650:1	1470:1	1130:1	4680:1	1200:1
Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees.	2,808	2,018	2,991	3,231	1,600	2,689	2,389	2,631	2,487	2,595
Percentage of female Medicare enrollees ages 65-74 who received an annual mammography screening	54%	43%	49%	44%	45%	44%	52%	52%	43%	44%
Percentage of population under age 65 without health insurance	5%	5%	6%	6%	9%	5%	4%	5%	5%	6%
Physical Environment										
Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.	12%	11%	14%	12%	9%	15%	11%	11%	13%	23%
Percentage of the workforce that drives alone to work.	77%	73%	76%	81%	74%	77%	75%	79%	81%	50%
Among workers who commute in their car alone, the percentage that commute more than 30 minutes.	22%	31%	21%	32%	38%	37%	37%	28%	40%	39%
Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	6.2	3.2	6.5	7	5.7	7.3	8.2	7.3	7.6	6.9
Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation.	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	N/A
Percentage of households with broadband internet connection	87%	89%	85%	87%	88%	82%	92%	89%	86%	90%
Library visits per person living within the library service area per year.	<1	2	2	4	13	2	3	2	1	3
Social and Economic Factors										
Percentage of adults ages 25-44 with some post-secondary education.	63%	58%	52%	62%	63%	58%	78%	68%	53%	71%
Percentage of adults ages 25 and over with a high school diploma or equivalent.	88%	92%	87%	88%	89%	89%	94%	92%	90%	88%
Percentage of population ages 16 and older unemployed but seeking work.	3.5%	3.8%	3.8%	4.4%	5.0%	4.6%	2.9%	3.7%	3.4%	4.2%
Ratio of household income at the 80th percentile to income at the 20th percentile.	4.9	4.4	4.5	4.3	3.9	4.8	4.2	4.6	3.9	5.8
Percentage of people under age 18 in poverty.	16%	17%	19%	20%	14%	23%	8%	15%	16%	19%
Number of deaths due to injury per 100,000 population.	64	71	61	71	81	67	47	55	71	60
Number of membership associations per 10,000 population.	6.1	14.9	10.1	9.1	13.7	6.2	7.3	12	870%	7.9
Child care costs for a household with two children as a percent of median household income.	38%	35%	39%	39%	36%	40%	32%	41%	34%	38%

Key (according to County Health Rankings)

**Purple highlight indicates areas of strength*

**Orange highlight indicates areas to explore*

County Health Rankings Population Health and Well-being Profile										
Indicator	**County**									**NYS**
	Clinton	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Montgomery**	**Saratoga**	**Warren**	**Washington**	
Length of Life										
Deaths of individuals under age 75, per 100,000 people	7,300	7,200	8,000	9,900	N/A	9,200	5,500	7,400	8,500	6,600
Quality of Life										
Average number of physicially unhealthy days reported in the past 30 days	4	4.1	4.6	4.2	4.2	4.6	3.4	3.8	4	3.9
Percentage of live births with low birth weight (<2500 grams)	8%	8%	7%	8%	6%	8%	7%	8%	8%	8%
Average number of mentally unhealthy days reported in the past 30 days (age-adjusted)	5.9	5.6	6.1	5.5	5.8	5.6	5	5.1	5.4	4.9
Percentage of adults reporting fair or poor health (age-adjusted)	17%	15%	18%	19%	17%	19%	10%	16%	15%	16%

2025 Annual Data Release, County Health Rankings and Roadmaps

For a full list of data sources, visit: https://www.countyhealthrankings.org/health-data/county-health-rankings-measures

Asset Limited, Income Constrained, Employed (ALICE) Profile												
ALICE is a United Way acronym that stands for Asset Limited, Income Constrained, Employed.												
County	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Montgomery**	**Saratoga**	**Warren**	**Washington**	**ARHN**	**Upstate NY***	**NYS**
Total Households	33,231	15,750	18,933	22,103	1,725	18,918	101,315	29,782	24,235	145,759	4,385,605	7,758,644
Total Alice Households	7,695	4,657	5,028	6,514	603	6,443	27,077	7,985	7,721	40,203	1,191,265	2,416,106
Total Poverty Households	5,763	1,701	2,999	3,099	149	2,836	7,426	2,579	2,859	19,149	510,829	1,131,514
Total Above Alice Households	19,773	9,392	10,906	12,490	973	9,639	66,812	19,218	13,655	86,407	2,662,155	4,189,668
ALICE Households over 65 years of age	3,848	2,282	2,564	3,648	259	3,866	12,997	3,833	3,938	20,371	1,378,457	2,204,582
ALICE Households by Race/Ethnicity												
Asian	365	28	58	147	N/A	178	2,533	217	108	776	159,350	606,443
Black	430	18	72	208	3	495	1,257	277	39	1,047	346,078	1,071,085
Hawaiian	N/A	N/A	N/A	N/A	N/A	6	N/A	N/A	2	N/A	1,366	2,944
Hispanic	296	148	166	645	5	2,183	2,412	486	422	2,168	379,928	1,258,451
American Indian/ Alaska Native	29	34	1,143	N/A	N/A	88	89	3	32	1,241	13,089	30,225
White	30,763	15,146	17,069	20,499	1652	15,666	91,265	28,593	23,163	136,885	3,345,930	4,544,209
2+ races	721	293	416	752	69	836	2,438	880	467	3,598	195,798	580,422
Households in Poverty %	17.0%	11.0%	16.0%	14.0%	9.0%	15.0%	7.0%	9.0%	12.0%	13.1%	11.6%	15.0%
Households in ALICE %	23.0%	30.0%	27.0%	29.0%	35.0%	34.0%	27.0%	27.0%	32.0%	27.6%	27.2%	31.0%
Above ALICE %	60.0%	60.0%	58.0%	57.0%	56.0%	51.0%	66.0%	65.0%	56.0%	59.3%	60.7%	54.0%
# of ALICE and Poverty Households	13,458	6,358	8,027	9,613	752	9,279	34,503	10,564	10,580	59,352	1,702,094	3,547,620
Unemployment Rate	2.6%	2.9%	2.7%	2.5%	2.5%	3.5%	2.3%	2.5%	3.0%	2.7%	N/A	3.4%
Median Household Income	$66,152	$68,090	$60,270	$60,557	$66,891	$58,033	$93,301	$69,865	$68,703	$65,790	N/A	N/A

Home | UnitedForALICE

Data included in the ALICE profile is reflective of the most recent update provided by UnitedforAlice.org in May 2025. Sourcing information below:

**Upstate NYS = NYS Total Less NYC; NYC includes NY, Kings, Bronx, Richmond, Queens Counties*

ARHN region reflects an average of ARHN counties

ALICE Threshold, 2010-2022; American Community Survey, 2010-2022

ALICE Threshold, 2022; American Community Survey, 2022

American Community Survey, 2022; ALICE Threshold, 2022

American Community Survey, 2022; Federal Reserve Bank of St. Lewis, 2022

Appendix 4

2025 Data Methodology

Background:

The Community Health Assessment (CHA) Committee, facilitated by the Adirondack Rural Health Network (ARHN), a program of Adirondack Health Institute (AHI), is a multi-county, regional stakeholder group, that convenes to support ongoing health planning and assessment by working collaboratively on interventions, and developing the planning documents required by the New York State Department of Health (NYS DOH) and the Internal Revenue Service (IRS) to advance the New York State Prevention Agenda.

The overarching goal of collecting and providing this data to the CHA Committee is to provide a comprehensive picture of individual counties as well as an overview of population health within the ARHN region, as well as Montgomery and Saratoga counties. The ARHN region is comprised of Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.

When available, Upstate New York (NY) data is provided as a benchmark statistic. Upstate NY is calculated as the NYS total minus New York City (NYC), which includes New York, Kings, Bronx, Richmond, and Queens counties.

Demographic Profile:

Demographic data was primarily taken from the United States Census Bureau 2023 American Consumer Survey 5-year estimates. Additional sources include: 2020 Census Estimate: Census Quick Stats, and United States Department of Agriculture (USDA) Farm Service Agency (FSA) Crop Acreage Data Reported to FSA. Information included in the demographic profile includes square mileage, population, family status, poverty, immigrant status, housing, vehicle accessibility education, and employment status/sector.

Health System Profile:

The Health System Profile data includes hospital, nursing home, and adult care facilities, bed counts, physician data, and licensure data. Data on facilities is sourced from the NYS Department of Health, NYS Health Profiles, covering profiles for hospitals, nursing homes, and adult care facilities. Licensure data is pulled from the NYS Education Department (NYSED).

Education Profile:

The Education Profile is separated into two parts: 1) Education System Information and 2) School Districts by County.

1) The Education System Profile includes student enrollment, student to teacher ratios, English proficiency rates, free lunch eligibility rates, as well as high school graduate

statistics. Data was sourced from the NYSED and the National Center for Education Statistics (NCES).

2) The Education System Profiles by School District identifies all the school districts in each county, sourced from the National Center for Education Statistics (NCES).

Asset Limited, Income Constrained, Employed (ALICE) Profile:

ALICE profile data includes total households, ALICE households over 65 years, ALICE households by race/ethnicity, poverty/ALICE percentages within each county, unemployment rates, percent of residents with health insurance, and median household income. All ALICE data is reflective of data presented in the ALICE profile originated from the 2024 ALICE report (www.unitedforalice.org/new-york). Within the ALICE report, data was pulled from the 2022 American Community Survey, 2022 ALICE Threshold and ALICE county demographics.

County Health Rankings (CHR) Profile:

The County Health Rankings profile includes indicators from the 2025 CHR release, with focuses on Population Health and Well-Being and Community Conditions. The population health and well-being section focuses on length of life and quality of life indicators. The community conditions section focuses on health infrastructure, physical environment, and social and economic factors.

The County Health Rankings identifies the two focus areas as:

- **Population health and well-being** is something we create as a society, not something an individual can attain in a clinic or be responsible for alone. Health is more than being free from disease and pain; health is the ability to thrive. Well-being covers both quality of life and the ability of people and communities to contribute to the world. Population health involves optimal physical, mental, spiritual and social well-being.
- **Community conditions** include the social and economic factors, physical environment and health infrastructure in which people are born, live, learn, work, play, worship and age. Community conditions are also referred to as the social determinants of health.

**All data included in the writing analysis relating to the County Health Rankings section is pulled from the website directly and does not reflect analysis completed by ARHN. Strengths and areas for improvement are identified by County Health Rankings.*

Data Dashboard:

The Data Dashboard, compiled of 355 data indicators, provides an overview of population health as compared to the ARHN region, Upstate New York region, Prevention Agenda Benchmark and/or NYS.

Each source file has visualization aspects to better depict data, as well as a deep dive tab that provides a table with a benchmark comparison, color-coded to identify where the county rate falls in comparison.

The Data Dashboard is composed of 10 sources, each with their own overview and deep dive tab.
Data and statistics for all indicators come from a variety of sources, including:

- Prevention Agenda Dashboard (PA) – 65 indicators
- Community Health Indicator Reports (CHIRs) – 204 indicators
- NYS Behavioral Risk Factor Surveillance System (BRFSS) Health Indicators – 45 indicators
- Division of Criminal Justice Services Index, Property, and Firearm Rates (DCJS) – 3 indicators
- NYS Traffic Safety Statistical Repository (ITSMR) – 6 indicators
- Student Weight Status Category Reporting System (SWSCRS) Data – 8 indicators
- US Department of Agriculture (USDA) Food Atlas – 2 indicators
- NYS Department of Health Tobacco Enforcement Compliance Results (Tobacco) – 4 indicators
- NYS Department of Health Maternal and Child Health (MCH) – 15 indicators
- Department of Health, Wadsworth Center (Wadsworth) – 3 indicators

<u>ARHN Region Calculations:</u>
The ARHN region includes Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington Counties.

- For percentages, formula is [sum all numerators/sum of all denominators) *100].
- For rates per 100,000, formula is [(sum all numerators/sum of all denominators) *100000)]
- For rates per 10,000, formula is [(sum all numerators/sum of all denominators) *10000)]
- For rates per 1000, formula is [sum all numerators/sum of all denominators) *1000)]

** For ratio of rates, differences in rates, and indicators that include 3 or more ARHN counties as unstable/unavailable/suppressed, ARHN rates/percentages are unable to be calculated.*

<u>UPSTATE Calculations:</u>
Upstate NY includes all counties in NYS counties except for the five boroughs of NYC: Kings, Queens, New York, Richmond, and Bronx counties.

- For percentages, formula is [(**A**) *100]
- For rates per 100,000, formula is [(**A**) *100000)]
- For rates per 10,000, formula is [(**A**) *10000)]

- For rates per 1000, formula is [(**A**) *1000)]

For all data sources, the information under a. identifies **A.**

1. PA
    a. The NYS Prevention Agenda Dashboard provides a New York State (excluding NYC) region.
2. CHIRs
    a. A NYS (excluding NYC) region is provided for some indicators. For indicators without a NYS (excluding NYC) measure, calculations were provided (using the methodology above) when data was available.

3. BRFSS
    a. A NYS exclusive of NYC region is available for some indicators. For indicators without a NYS Exclusive of NYC region, calculations were provided (using the methodology above) when data was available.
4. MCH
    a. The NYS Maternal-Child Health Dashboard provides a New York State (excluding NYC) measure.
5. SWSCRS
    a. The Student Weight Status Category Reporting System features a Statewide (Excluding NYC) region.
6. For Wadsworth, DCJS, ITSMR, USDA, and Tobacco data sources, upstate rates were calculated using the calculation below:

$$\left[\frac{\text{Total numerator for NYS - Total numerator for NYC}}{\text{Total denominator for NYS – Total denominator for NYC}}\right] \text{ x Specific Rate}$$

**NYS totals are either provided by the source or computer incorporating all the counties within NYS.*
**NYC totals include the five NYC boroughs: Bronx, Kings, New York, Queens, and Richmond counties.*
**Specific rate multiplier depends on the indicator (i.e. rate per 100,000, rate per 10,000, or rate per 1,000).*

All rates in the ARHN region and Upstate NY (where not provided by the data source) are calculated (unless data is not available for calculations).

Unstable Estimates:

Due to limitations in the PowerBI software, all unstable estimates are identified in a column of each data sources deep dive or data compilation table. For further information on what

quantifies the indicator as unstable, please see below for explanations (provided by each data source) or visit the data source website for more information.

Prevention Agenda Dashboard

- Multiple years of data were combined to generate more stable estimates when the number of events for an indicator was small (i.e., rare conditions).
  The relative standard error (RSE) is a tool for assessing reliability of an estimate. A large RSE is produced when estimates are calculated based on a small number of cases.[2] Estimates with large RSEs are considered less reliable than estimates with small RSEs. The **National Center for Health Statistics** recommends that estimates with RSEs greater than 30% should be considered unreliable/unstable.[3]
- The RSE is calculated by dividing the standard error of the estimate by the estimate itself, then multiplying that result by 100. The RSE is expressed as a percentage of the estimate.
- For the Prevention Agenda dashboard, an asterisk (*) or plus (+) symbol is used to indicate that a percentage, rate, or ratio is unreliable/unstable. This usually occurs when there are less than 10 events in the numerator (RSE is greater than 30%).

Data Suppression for Confidentiality

Results are not shown (i.e., suppressed) when issues of confidentiality exist. Suppression rules vary depending on the data source and the indicator.

Table 1. Summary of data suppression and statistical evaluation significance for the Prevention Agenda Indicators by data source

Data Sources	Suppression Criteria	Statistical Significance Techniques
Sample Surveys		
Pregnancy Risk Assessment Monitoring System	Denominator <30	95% CI comparison
BRFSS and Expanded BRFSS	Numerator <6 or Denominator <50	95% CI comparison
US Census		90% CI comparison
National Survey on Drug Use and Health		95% CI comparison
Youth Risk Behavior Surveillance System	Denominator <100	95% CI comparison
Youth Tobacco Survey		95% CI comparison
Population Count Data		

Death	Single Year: Denominator population <50; Three-Year Combined: Denominator population <30	Rate/percentage: one sided chi-square test with p-value <0.05 Rate difference: one sided 95% CI comparison
Birth	Single Year: Denominator total Births <50	One sided chi-square test with p-value <0.05
Sexually Transmitted Infection (STI) Surveillance		One sided chi-square test with p-value <0.05
HIV Surveillance	Numerator 1-2 cases	County level (rate): one sided 95% CI comparison; State level (rate): one sided chi-square test with p-value <0.05
SPARCS	Numerator between 1 - 5 cases	Rate/percentage: one sided chi-square test with p-value <0.05; Ratio/Rate difference: one sided 95% CI comparison
Prescription Monitoring Program (PMP) Registry	Numerator between 1 - 5 cases	One sided chi-square test with p-value <0.05

CI: Confidence Interval
BRFSS: Behavioral Risk Factor Surveillance System
SPARCS: Statewide Planning and Research Cooperative System

Community Health Indicator Reports (CHIRs)

- Multiple years of data were combined to generate more stable estimates when the number of events for an indicator was small (i.e., rare conditions).
  The relative standard error (RSE) is a tool for assessing reliability of an estimate. A large RSE is produced when estimates are calculated based on a small number of cases.[2] Estimates with large RSEs are considered less reliable than estimates with small RSEs. The **National Center for Health Statistics** recommends that estimates with RSEs greater than 30% should be considered unreliable/unstable.[3]
- The RSE is calculated by dividing the standard error of the estimate by the estimate itself, then multiplying that result by 100. The RSE is expressed as a percent of the estimate.

- For notation purposes, an asterisk (*) symbol is used to indicate that a percentage, rate, or ratio is unreliable/unstable. This usually occurs when there are less than 10 events in the numerator (RSE is greater than 30%).

Data Suppression Rules for Confidentiality

Results are not shown (i.e., suppressed) when issues of confidentiality exist. Suppression rules vary depending on the data source and the indicator. An '*s*' notation indicates that the data did not meet reporting criteria.

Table 1. Summary of Data Suppression Rules

Data Sources	Suppression Criteria
Bureau of Dental Health (BDH)	Margin of error>20% or Denominator <50
Behavioral Risk Factor Surveillance System (BRFSS) and Expanded BRFSS	Denominator <50 or Numerator < 10
Vital Statistics - Death Records	Denominator population <30
Statewide Perinatal Data System (SPDS) - birth records	Denominator population/births <30
AIDS/HIV	Numerator 1-2 cases
Statewide Planning and Research Cooperative System (SPARCS) - ED and hospital records	Numerator 1-5 cases
Office of Quality and Patient Safety (QARR and eQARR)	Denominator <30 and Numerator >0 cases
Cancer Registry	Numerator 1 - 15 cases
Sexually Transmitted Disease Surveillance System	Annual population less than 1,000 and secondary suppression
NYS Pregnancy Nutrition Surveillance System (PNSS) - WIC Program	Denominator <100

NYS Behavioral Risk Factor Surveillance System (BRFSS) Health Indicators

Limitations of Use:

- Data are sample based and therefore subject to sampling variability. The sampling variability for each indicator is highlighted by including the 95% confidence interval.
- Data are based on respondents' answers to a telephone survey, so data are self-reported and therefore potentially subject to response bias, recall bias, social desirability bias, and other limitations associated with self-report. Great effort is undertaken when administering the BRFSS to mitigate or minimize the risk of such biases, but they cannot be eliminated altogether.
- Indicator estimates are sometimes based on small samples, resulting in low precision of the estimates. If the eBRFSS or BRFSS sample has less than 10 respondents with the condition measured by the health indicator or less than 50 respondents at risk for the health condition, the crude and age-adjusted rates are suppressed. The suppression is noted in the "Notes" field.
- Some crude/age-adjusted rates that meet this requirement may still be estimated but with high variability. Highly variable rates are defined as having confidence limits greater than ±10%.
- These highly variable rates are flagged as being unreliable in the "Notes" section. In addition, the age-adjustment process may generate rates that are suspect, due to small (three or fewer observations) age-adjustment cells. The age-adjusted rates with which there are concerns are identified in the "Notes" field. Age-adjusted rates are not calculated for indicators that apply to a specific age-group (e.g., adults 50 to 75 years of age). The indicators with an age-restriction are identified in the "Notes" field.

Division of Criminal Justice Services Index, Property, and Firearm Rates

Limitations of Data Use:

- Although crime reports are collected from more than 500 NYS police and sheriffs' departments, this data set is limited to the crimes reported to the police agencies but not the total crimes that occurred.

- Requests for additional information, missing data or actual copies of the crime reports should be directed to DCJS or the local submitting police agency.
- Public access to this crime data is intended solely to allow the public convenient and immediate access to public information. While all attempts are made to provide accurate, current and reliable information, the Division of Criminal Justice Services recognizes the possibility of human and/or mechanical error and that information captured at a point in time may change over time

NYS Traffic Safety Statistical Repository (TSSR)

- ITSMR provides data on police-reported fatal and personal injury crashes and select tickets issued by law enforcement agency via our PTS Data Form. These data include numbers of crashes submitted to the DMV that were "reportable," meaning a motor vehicle crash reported by a police officer or a motorist, in which there was a fatality, a person injured, and/or property damage of more than $1,000 to the vehicle of one person. Crashes that occurred in parking lots or on private property are excluded. The ticket counts include only those tickets issued by the police agency and submitted to the DMV.
- In the TSSR ITSMR also provides Crash Data by County and Municipality and Ticket Data by County and Municipality. The crash data here include reportable crashes that occurred within the municipality, regardless of the agency that submitted the crash reports. The ticket data here include the municipality where the tickets were issued, regardless of the agency that submitted the tickets. In the TSSR report County Traffic Tickets — Select Violations by Enforcement Agency, tables show TSLED tickets issued by enforcement agency and submitted to the DMV.
- Tickets submitted to the DMV after DMV has given ITSMR the okay to finalize the ticket data for a calendar year will not appear in that year's totals.

Student Weight Status Category Reporting System (SWSCRS) Data

Limitations of Data:

- Because of restrictions in reporting due to the FERPA there was variation in how much of the student population was represented in the data school districts submitted, especially among smaller school districts. Therefore, the percentage of the student population represented in the county and regional level estimates may vary. This limits researchers' ability to draw absolute conclusions about observed differences in student weight status among counties and regions.
- Because school district boundaries do not align with county or regional boundaries, the county and regional-level estimates reflect data from students attending school within districts assigned a particular county or regional-code. County/regional assignment is not based on county or region of residence. The Page 3 of 3 county and regional-level

estimates represent the percentage of students within a weight status category reported to the Student Weight Status Category Reporting System.
- These data should not be considered to represent all school aged-children attending school in that county or region because of: restrictions in reporting due to FERPA, parents/guardians' ability to request that their child's weight status data be excluded from reporting, and other sources of missing data.

US Department of Agriculture (USDA) Food Atlas

The current version of the Food Environment Atlas has more than 280 variables, including new indicators on food banks and nutrition assistance program participation rates. All of the data included in the Atlas are aggregated into an Excel spreadsheet for easy download. These data come from a variety of sources and cover varying years and geographic levels. The documentation for each version of the data provides complete information on definitions and data sources.

In the downloadable Excel spreadsheets:

- State and county Federal information processing standards (FIPS) codes are provided.
- The variable lookup file links the short field descriptions (indicator names) used in the data file with the longer indicator names used in the Atlas.
- Unless otherwise noted with asterisks on the longer indicator names (in the variable lookup file), indicators are county-level measures. A single asterisk * denotes a State-level indicator, while a double asterisk ** denotes a regional-level indicator.
- "No data" fields are empty or referenced with "-9999".
- Supplemental data are provided in additional tabs (State- and county-level data are provided separately).

NYS Department of Health Tobacco Enforcement Compliance Results

Limitations of Use:

- County health departments and the New York City Department of Consumer Affairs may provide this information on their own websites. These websites and the data on them may be updated more frequently. More detailed information may be obtained directly from these partner agencies or DOH through the Freedom of Information Law (FOIL) process. The FOIL process for DOH can be found on its website, for other agencies' FOIL process please contact them directly.
- Enforcement data reflects information that was gathered during an inspection, and confirmed through official enforcement action. There may be a significant delay between the date of an inspection and the date that a violation is confirmed through

enforcement action. Accordingly, enforcement data included in a certain measurement period may actually reflect violations that occurred in a previous measurement period.

- As previously stated, the data in Health Data NY maps, data lists, and data tables is updated annually. Requests for data pertaining to more recent inspections, or requests for more detailed information or copies of individual inspection reports should be directed to the individual county health department, New York City Department of Consumer Affairs, or State District Office which conducted the inspection or inspections in question.

NYS Department of Health Maternal and Child Health

Unstable Estimates:

- Multiple years of data were combined to generate more stable estimates when the number of events for an indicator was small (i.e., rare conditions).
  The relative standard error (RSE) is a tool for assessing reliability of an estimate. A large RSE is produced when estimates are calculated based on a small number of cases.[1] Estimates with large RSEs are considered less reliable than estimates with small RSEs. The **National Center for Health Statistics** recommends that estimates with RSEs greater than 30% should be considered unreliable/unstable.[2]
- The RSE is calculated by dividing the standard error of the estimate by the estimate itself, then multiplying that result by 100. The RSE is expressed as a percent of the estimate.
- For the Maternal and Child Health dashboard, an asterisk (*) symbol is used to indicate that a percentage or rate is unreliable/unstable. This usually occurs when there are fewer than 10 events in the numerator (RSE is greater than 30%).

Data Suppression for Confidentiality
Results are not shown (i.e., suppressed) when issues of confidentiality exist. Suppression rules vary depending on the data source and the indicator.

Table 1. Summary of data suppression and statistical evaluation significance for the Maternal and Child Health Indicators by data source

Data Sources	Suppression Criteria	Statistical Significance Techniques
Sample Surveys		
BRFSS (NYS)	Unweighted numerator <6 or Unweighted denominator <50	95% CI comparison
BRFSS (CDC)	Unweighted denominator <30	95% CI comparison

NSCH	Unweighted denominator <30	95% CI comparison
YRBSS	Unweighted denominator < 100	95% CI comparison
NYS PRAMS	Unweighted denominator < 30	95% CI comparison
Population Count Data		
NYS VS	Denominator population or event <30	Rate/percentage: one sided chi-square test with p-value <0.05
NYS SPARCS	Numerator between 1 - 5 cases	Rate/percentage: one sided chi-square test with p-value <0.05
HCUP-SID	Numerator <=10	Rate/percentage: one sided chi-square test with p-value <0.05
NVSS	Numerator <10	Rate/percentage: one sided chi-square test with p-value <0.05
Special Supplemental Nutrition Program for WIC	Indicator has a denominator <50	Rate/percentage: one sided chi-square test with p-value <0.05

- CI: Confidence Interval
- **BRFSS:** Behavioral Risk Factor Surveillance System
  SPARCS: Statewide Planning and Research Cooperative System
  Vital Statistics: New York State Vital Statistics (NYS VS Event Registry)
  YRBSS: Youth Risk Behavioral Surveillance System
  PRAMS: Pregnancy Risk Assessment Monitoring System
- HRSA provided data[6] are from the following sources:
  - BRFSS (CDC): Behavioral Risk Factor Surveillance System
    HCUP-SID: Healthcare Cost and Utilization Project-State Inpatient Database
    NSCH: National Survey of Children's Health
    NVSS: National Vital Statistics System (Natality and Death)
    WIC: Women, Infants, and Children (Special Supplemental Nutrition Program)
    CMS: Centers for Medicare and Medicaid Services

Department of Health, Wadsworth Center

Limitations of Use:

- Address accuracy is dependent on the information provided by the individual submitting the rabies specimen. Additionally, not all submissions are included in the monthly

reports; samples received from out of state and samples that are unsatisfactory for testing are not listed. However, all samples, regardless of the testing outcome, are included in the annual report (https://www.wadsworth.org/programs/id/rabies/reports).

- The data does not describe why the animal was tested. The most common reason to request rabies testing is due to human exposure. However, because rabies has a 99.9% fatality rate, the laboratory often receives samples from animals with neurological illness to rule out rabies before additional tests are performed. For example, the laboratory receives exotic animals with neurological illnesses from zoological settings for rabies testing. If these animals test negative for rabies, additional post- mortem tests can be completed to determine the cause of illness without the risk of exposing multiple people or testing facilities to rabies. The data is not necessarily representative of rabies in wild populations. The data may be biased, since a greater number of sick animals are submitted for testing, as opposed to healthy animals randomly chosen from the wild population.

Appendix 5

Community Health Improvement Plan 2026-2030
Work Plan

Submitting Organization			
Organization Name	**County(ies) of Service**	**Liaison Name**	**Liaison Email**
Essex County Health Department	Essex	Andrea Whitmarsh	andrea.whitmarsh@essexcountyny.gov
Is this a joint plan? Yes/No	Yes		
Note: a joint plan is defined as submitting one Community Health Assessment and Community Health Improvement Plan for both the LHD(s) and hospital(s) within the same county.			

Participating Organization(s)			
Organization Name	**County(ies) of Service**	**Liaison Name**	**Liaison Email**
University of Vermont Health - Elizabethtown Community Hospital	Essex	Amanda Bola	abola@ech.org
Adirondack Health	Essex and Franklin	Matthew G. Scollin	mgscollin@adirondackhealth.org
Org D:			

Economic Stability	**Instructions:** Please review the Community Health Improvement Planning Guidance for the required elements of the Community Health Improvement Plan (CHIP) and Community Service Plan (CSP): *https://www.health.ny.gov/prevention/prevention_agenda/2025-2030/docs/letter_and_guidence.pdf* . - **Columns B & C:** Priorities and Objectives can be selected from the dropdown menus. *Please note: These objectives include statewide baseline and target measures and those selected should align with your local plan.* - **Column D:** Enter and cite the intervention you organization plans to implement to address the selected objective. Each intervention must be listed in a separate row. Use evidence-based interventions; if not available, best or promising practices. - **Column E:** List any disparities the intervention addresses. - **Column F:** Identify the specific metric or measure used to evaluate the intervention's implementation progress.

Domain	Priority (select one from drop down list)	Objective (select one from drop down list)	Intervention	Disparities Being Addressed	Family of Measures	Timeframe		Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
						Start Date (mm/dd/yyyy)	Completion Date (mm/dd/yyyy)		
Economic Stability	Priority 1: Poverty	1.0 Reduce the percentage of people living in poverty from 13.6% to 12.5%.	Partner with, promote, and refer to supplental nutrition programs including Women, Infants, and Children (WC) and Supplmental Nutrition Assistance (SNAP) and the NYS Agency Nutrition programs.	Low-income individuals and families Other populations experiencing barriers to accessing programs: *lower educational attainment levels; *working multiple jobs; *language barriers; *involvement with multiple agencies; *expressed barrier of any sort with enrollment	1. Essex County Department of Social Services will participate in 6 community meetings to educate agency partners about SNAP program by 12/31/2026. 2. Mental Health Association will host 1 SNAP education class in 2026 and 1 class in 2027. 3. Essex County Mental Health will facilitate 100% if Medicaid and Managed Care clients to 1115 Waiver Screening by 12/31/2026. 3. Essex County Health Department will embed nuritional program informational prompts into 100% of direct outreach services by 12/31/2027. 4. Get Healthy North Country (GHNC) Network will coordinate with Essex County Health Department to provide education about GHNC programs to WIC and SNAP staff annually beginning in 2026.	1/1/2026	12/31/2027	Social Services	Full partner roles and resources are listed under the Family of Measures column.
Economic Stability	Priority 1: Poverty	1.0 Reduce the percentage of people living in poverty from 13.6% to 12.5%.	Conduct regular screening of patients at the hospital or community members accessing programs for SDOH factors like income and unemployment	Low income individuals and families Justice-involved individuals	1. UVMH-Elizabethtown Community Hospital will conduct standardized screening for SDOH. 2. Mental Health Association will aim to screen 80% of referrals for health care needs and refer 60% for 2026.	1/1/2026	12/31/2026	Hospital	
Economic Stability	Priority 2: Unemployment	2.0 Reduce unemployment among individuals aged 16 and older from 6.2% to 5.5%.	Engage in multi-sector collaborations that highlight the health burden of unemployment and underemployment and leverage these collaborations to create local pathways to meaningful employment. Strategies include identifying the partners and resources to develop job training programs and job opportunities that align with local labor market demands.	Low income individuals and families Education	1. By 06/30/2026, work with ECHD- Home Health create/promote paid Home Health Summer Internship program for college bound or high school students interested in health careers 2. By 12/31/2026, ECHD will develop a list of agencies/coalitions/networks that address employment/unemployment for Essex County Residents. 3. By 13/31/2027, ECHD will share timely health data relevant to employment with 75% of these agencies/coalitions/networks.	1/1/2026	12/31/2027	Local health department	Partners will invite/include ECHD in collaborations and allow data sharing and engagement.
Economic Stability	Priority 2: Unemployment	2.0 Reduce unemployment among individuals aged 16 and older from 6.2% to 5.5%.	Strengthen partnerships among health care employers, Boards of Cooperational Services (BOCES) programs, high schools, and community colleges to expand training, apprenticeships, and employment opportunities for entry-level careers.	Education	1. Participation rates among number of graduates from high school and community college that complete hospital-based learning programs 2. Percentage of new hires that completed programs	1/1/2026	12/31/2028	Educational institution	Full partner roles and resources are listed under the Family of Measures column.
Economic Stability	Priority 3: Nutrition Security	3.1 Increase food security in households with an annual total income of less than $25,000 from 46.6% to 56.7%.	Promote and expand the availability of fruit and vegetable incentive programs	Low income individuals and families	1. By 12/31/2027, the Well Fed Collaborative will identify and secure funding from at least one (1) source for the enhancement and expansion of fruit and vegetable incentive programs. 2. By 12/31/2030, ECHD will share updated (timely) health data relevant to nutritional security with Well Fed Collaborative, at least annually (for a total of 5 updates if new data available).	1/1/2026	12/31/2030	Community-based organizations	Well Fed Collaborative partners: Essex County Health Department -Public Health -WIC UVMH-Elizabethtown Community Hospital Cornell Cooperative Extension - Essex County ADK Action North Country Ministries Essex County Office for the Aging Essex County Food Hub
Economic Stability	Priority 4: Housing Stability and Affordability	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 65.1% to 75.1%.	Provide Supported Housing Program to individuals with serious or persistent mental illness.	Mental health/frequent mental distress	1. By 12/31/2026, the Mental Health Association will provide 30 rental stipends to individuals in Essex County who have serious or persistent mental illness. 2. By 12/31/2026, MHA will devise a process to formally track the number of people monthly on the waitlist for these stipends/services in order to show need for increased funding.	1/1/2026	12/31/2026	Community-based organizations	
Economic Stability	Priority 4: Housing Stability and Affordability	4.0 Increase the number of people living in HUD-subsidized housing from 987,957 to 1,092,000.	Collaborate with new and current partners to increase access to safe and affordable housing.	Low income individuals and families	1. Essex County Director of Community Services will participate in 100% of Essex County Housing Task Force meetings in 2026 to promote multi-agency collaboration 2. MHA will complete training to screen individuals for 1115 waiver services by 03/01/2026. 3. By 12/31/2030, ECHD will share updated (timely) health data relevant to housing with the Essex County Housing Task Force, at least annually (for a total of 5 updates if new data available).	1/1/2026	12/31/2026	Local government	

Social & Community Context	**Instructions:** Please review the Community Health Improvement Planning Guidance for the required elements of the Community Health Improvement Plan (CHIP) and Community Service Plan (CSP): *https://www.health.ny.gov/prevention/prevention_agenda/2025-2030/docs/letter_and_guidence.pdf* . **- Columns B & C:** Priorities and Objectives can be selected from the dropdown menus. *Please note: These objectives include statewide baseline and target measures and those selected should align with your local plan.* **- Column D:** Enter and cite the intervention you organization plans to implement to address the selected objective. Each intervention must be listed in a separate row. Use evidence-based interventions; if not available, best or promising practices. **- Column E:** List any disparities the intervention addresses. **- Column F:** Identify the specific metric or measure used to evaluate the intervention's implementation progress.

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Social & Community Context	Priority 3: Depression	3.0 Reduce the percentage of adults with a major depressive episode during the past year from 6.7% to 5.7%.	Implement and promote Mental Health First Aid (MHFA) and Teen Mental Health First Aid training in communities and health care settings.	Mental health/frequent mental distress	1. UVMH-Elizabethtown Community Hospital will increase the number of MHFA trainers and the number of organizations participating in training. 2. Essex County Mental Health will implement and promote Teen Mental Health First Aid to all 9th grade classes of local schools who agree to this initiative, with the target being 60% of 9th grade classes in Essex County (or 6 out of 10 public school districts) in 2026.	1/1/2026		Hospital	
Social & Community Context	Priority 4: Primary Prevention, Substance Misuse, and Overdose Prevention	4.8 Reduce the rate of overdose deaths involving drugs per 100,000 people from 32.3 to 22.6.	Provide or expand access to naloxone to reduce overdose fatalities.	Substance misuse Rural communities Access to care Low income individuals	1. Adirondack Health will implement a program to distribute take-home doses of naloxone to patients in the emergency care setting by the end of 2026. 2. UVMH-Elizabethtown Community Hospital will increase the availability of naloxone. 3. ECHD will expand Community Care Kiosk program (which includes naloxone kit distribution) to offer online requests for resources by 12/31/2028.	1/1/2026	12/31/2028	Hospital	Full partner roles and resources are listed under the Family of Measures column.
Social & Community Context	Priority 5: Tobacco/E-Cigarette Use	5.0 Reduce the percentage of adults who use tobacco products from 9.3% to 7.9%.	Provide access to tobacco cessation treatments, including individual, group, telephone counseling, and FDA approved cessation medications.	Access to care	Percentage of patients screened and number of referrals for positive screenings.	1/1/2026	12/21/2030	Hospital	UVMH-Elizabethtown Community Hospital
Social & Community Context	Priority 5: Tobacco/E-Cigarette Use	5.0 Reduce the percentage of adults who use tobacco products from 9.3% to 7.9%.	Implement screening for tobacco use and navigate to appropriate services in all health care practice settings.	Access to care	1. The Heart Network will increase the percent of Essex County healthcare provider systems that have adopted evidence-based nicotine treatment protocols in clinical settings to at least 80% by 12/31/2030. 2. Adirondack Health will increase tobacco use assessments for all health-center-based primary care patients 18+ by five percent.	1/1/2026	12/31/2030	Community-based organizations	Heart Network - facilitate nicotine treatment protocols UVMH-Elizabethtown Community Hospital, Adirondack Health, Mental Health Association and FQHCs will adopt protocols
Social & Community Context	Priority 5: Tobacco/E-Cigarette Use	5.1 Reduce the percentage of high school students who use tobacco products from 14.8% to 12.6%.	Advance community-wide support for restricting minors' access to tobacco products. Examples include: • Promotion of community-wide education on tobacco issues • Education to retailers about restricting the sale of tobacco to minors		# of School engaged in evidenced -based prevention programming & # Sessions provided by year	1/1/2026	12/31/2026	Educational institution	Prevention Team is contract with by the Essex County Health Department to offer evidenced-based programs: Standford Medicine's "You and Me Vape Free" Curriculum.
Social & Community Context	Priority 7: Adverse Childhood Experiences	7.5 Reduce the rate of indicated reports of abuse/maltreatment among children and youth aged 0-17 years from 11.5 to 10.0.	Strengthen community partnerships to support education, case coordination, and referrals of at-risk families to local health departments, hospitals, and other community-based organizations to increase participation in home visiting programs (e.g., Healthy Families, Community Health Worker (CHW), Nurse Family Partnership (NFP)).	Families referred through perinatal database system as high risk or recevied as a referral from healthcare provider to accept services. Mental health/frequent mental distress	1. # of families that accept Baby Steps to Bright Futures Program; # Referrals to Healthy Families, NY; 2. # Referrals to Early Head Start/Head Start # Families Baby Steps DSS Preventive Services collaborative families 3. Essex County Mental Health clinical staff will utilize the 10 ACEs questionnaires with at least 50% of all new clients and will refer positive screens to home visiting programs as applicable.	1/1/2026	12/31/2030	Community-based organizations	Healthy Families NY provides ongoing in-homes supports. Early Head Start/Head Start provides ongoing parenting education & support. DSS Prevent Collaborative Families are high risk families access additional supports from the Health Dept & DSS.
Social & Community Context	Priority 8: Healthy Eating	8.1 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%.	Establish, enhance, or expand Food as Medicine programs and connect these programs with disease prevention and management programs.	Income	1. Increase the number of participants in the Wellness Rx Program. 2. Increase the redemption rate of Wellness Rx coupons 3. Expand the number of vendor sites accepting Wellness Rx coupons 4. Increase community education sessions for the Wellness Rx Program	1/1/2026	12/31/2030	Hospital	UVMH-Elizabethtown Community Hospital is administering the Wellness Rx Program

Neighborhood & Built Environment	**Instructions:** Please review the Community Health Improvement Planning Guidance for the required elements of the Community Health Improvement Plan (CHIP) and Community Service Plan (CSP): *https://www.health.ny.gov/prevention/prevention_agenda/2025-2030/docs/letter_and_guidence.pdf* . - **Columns B & C:** Priorities and Objectives can be selected from the dropdown menus. *Please note: These objectives include statewide baseline and target measures and those selected should align with your local plan.* - **Column D:** Enter and cite the intervention you organization plans to implement to address the selected objective. Each intervention must be listed in a separate row. Use evidence-based interventions; if not available, best or promising practices. - **Column E:** List any disparities the intervention addresses. - **Column F:** Identify the specific metric or measure used to evaluate the intervention's implementation progress.

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Neighborhood & Built Environment	Priority 2: Access to Community Services and Support	2.1 Increase the number of cooling centers on the Cooling Center Finder, accessible to individuals living in high heat-vulnerable areas and disadvantaged communities from 698 to 768.	Educate policymakers and healthcare leaders on promoting age-friendly practices in health care and community infrastructures, focusing on integrating aging into core health care practices.	Aging	1. Essex County Health Department - Home Health will provide one educational offering with health care leaders regarding access to community services by 12/31/2026. 2. Essex County Mental Health/Community Service Board will participate in 100% of bi-monthly meetings with the Aging Working Group in 2026 to promote collaboration with other human services partners on the high-needs/high-risk adult populations. 3. Mercy Care for the Adirondacks will develop a Health Care Companion Volunteer Advocate Program in 2026, training 10 new volunteers by end of year. 4. Mercy Care of the Adirondacks will host quarterly Caregiving Work Group of the North Country meetings throughout 2026. 5. Heart Network will provide annual education sessions to healthcare leaders and policy makers that emphasize the importance of access to prevention/chronic disease self-management services as part of healthy aging strategies.	1/1/2026	12/31/2030	Community-based organizations	Full partner roles and resources listed in Family of Measures column
Neighborhood & Built Environment	Priority 2: Access to Community Services and Support	2.1 Increase the number of cooling centers on the Cooling Center Finder, accessible to individuals living in high heat-vulnerable areas and disadvantaged communities from 698 to 768.	Promote and prioritize age-friendly initiatives by educating primary care providers during annual wellness visits, ensuring they are equipped to discuss and implement these practices.	Aging	1. Number of older adults who participate in screenings 2. Assess knowledge/awareness in preventive care options 3. Assess engagement with health resources	1/1/2026	12/31/2025	Hospital	

Healthcare Access & Quality	**Instructions:** Please review the Community Health Improvement Planning Guidance for the required elements of the Community Health Improvement Plan (CHIP) and Community Service Plan (CSP): *https://www.health.ny.gov/prevention/prevention_agenda/2025-2030/docs/letter_and_guidence.pdf* . **- Columns B & C:** Priorities and Objectives can be selected from the dropdown menus. *Please note: These objectives include statewide baseline and target measures and those selected should align with your local plan.* **- Column D:** Enter and cite the intervention you organization plans to implement to address the selected objective. Each intervention must be listed in a separate row. Use evidence-based interventions; if not available, best or promising practices. **- Column E:** List any disparities the intervention addresses. **- Column F:** Identify the specific metric or measure used to evaluate the intervention's implementation progress.

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Healthcare Access & Quality	Priority 3: Preventative Services for Chronic Disease Prevention and Control	3.6 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 71.6% to 80.0%.	Encourage the use of client reminders by providers to increase cancer screening per the Community Guide national guidelines.	Access to health care Income Disability	1. Adirondack Health will send annual e-mail reminders to the full medical staff, highlighting the most recent colorectal cancer screening guidelines. 2. Adirondack Health will continuously review current practices for reliability and timeliness to ensure reminders are being sent by all providers. 3. Adirondack Health will continue to track patient reminders and monitor patients via quality dashboard and HEDIS dashboard.	1/1/2026	12/31/2027	Hospital	Adirondack Health
Healthcare Access & Quality	Priority 3: Preventative Services for Chronic Disease Prevention and Control	3.0 Increase the percentage of adults aged 35+ who had a test for high blood sugar in the past year from 78.1% to 82.4%.	Implement community screenings to detect and address diabetes	Access to health care Income Disability	Number of events within the community setting where hospital provides screening and education for diabetes.	1/1/2026	12/31/2030	Hospital	UVMH-Elizabethtown Community Hospital
Healthcare Access & Quality	Priority 3: Preventative Services for Chronic Disease Prevention and Control	3.5 Increase the percentage of adult Medicaid members aged 18+ with hypertension who are currently taking medication to manage their high blood pressure from 66.9% to 75.5%.	Implement community screenings to detect and address hypertension.	Access to health care Income Disability	Number of events within the community setting where hospital provides screening and education for hypertension.	1/1/2026	12/31/2030	Hospital	UVMH-Elizabethtown Community Hospital
Healthcare Access & Quality	Priority 3: Preventative Services for Chronic Disease Prevention and Control	3.6 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 71.6% to 80.0%.	Work with local cancer screening programs such as the NYS Cancer Services Program to improve access to cancer screening and diagnostic testing for individuals without health insurance.	Access to health care Income Disability	1. Increase percentage of individuals meeting current cancer creening guidelines	1/1/2026	12/31/2030	Hospital	UVMH-Elizabethtown Community Hospital