Essex County, NY

Community Health Assessment, 2022

Community Health Improvement Plan, 2022-2024

Essex County Health Partners

Essex County Health Department

University of Vermont Health Network - Elizabethtown Community Hospital

Adirondack Health

Report Date:

December 23, 2022

Cover photo credit: Mary (Molly) Lawrence
Adirondack Mountains, Essex County, NY

Foreword

Essex County Health Partners are proud to present this report:

Essex County, NY Community Health Assessment (CHA) 2022 and
Community Health Improvement (CHIP) 2022-2024.

Significant attention was given to creating a report that is not only informative to the lead agencies engaged in the assessment, but one that is useful to a wide variety of individuals, groups, and organizations. This is because in order to improve the health of communities, the whole community must engaged.
This report continues a long history of data gathering and analysis from a variety of sources including local, regional, state and national entities. It includes primary and secondary data; as well as quantitative and qualitative data.

Several components of this assessment continue with improvements established in the 2019 assessment. The enhancements include:

• Integration of input from local residents and community stakeholders;
• Consideration of health by sub-population;
• Identification of disparities in health by sub-population;
• Examination of local social determinants of health; and
• Identification of community assets that can be mobilized to improve the health of our community.

Additionally, higher levels of engagement were achieved through intervention planning efforts. This includes:

• Leveraging existing committees and coalitions and convening work groups as needed to review health outcomes and contributing factors;
• Engaging partners to assess social determinants of health as contributing factors to determine true root cause(s) that lead to poor health outcomes and disparate health indicators in certain communities, groups, locations;
• Working to examine the existing assets/programs/initiatives; and
• Collectively selecting the strategies that are most likely to result in measurable health gains; address the disparities identified; and be implemented successfully among partners.

Essex County Health Partners

Essex County Health Department
www.co.essex.ny.us/Health
518-873-3500

Primary Contact:
Andrea Whitmarsh, MPH
Program Coordinator - Community Health Assessment & Planning

Additional Contacts:
Linda Beers, MPH
Director of Public Health

Jessica Darney Buehler, MPH
Director of Health Planning & Promotion

Adirondack Health
Adirondack Medical Center
www.adirondackhealth.org
518-891-4141

Primary Contact:
Matthew G. Scollin
Director of External Affairs

Additional Contacts:
Lisa Tuggle, RHIA
Director of Primary Care and Outpatient Behavioral Health

University of Vermont Health Network- Elizabethtown Community Hospital
www.ech.org
518-873-6377

Primary Contact:
Amanda Whisher
Quality Program Coordinator

Additional Contacts:
Julie Tromblee, MSN, RN
Vice President, Chief Nursing Officer

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Executive Summary

Introduction

The purpose of the **Essex County, NY 2022 Community Health Assessment (CHA) and 2022-2024 Community Health Improvement Plan (CHIP)** is to demonstrate a collective, comprehensive understanding of the significant health needs of Essex County residents and the actions necessary to address these gaps.

Health needs were identified through a systematic analysis of multi-source health indicator data, community and stakeholder feedback, and demographic, socioeconomic, and other factors that influence health and lead to inequities and disparities in health outcomes.

Partnerships

Guiding the development of this assessment and planning effort was the use of a community engagement process model, the **Association for Community Health Improvement's** *Community Health Assessment Toolkit*, supported by the Centers for Disease Control and Prevention in agreement with the Public Health Foundation. The toolkit's nine-step pathway for conducting a Community Health Assessment and developing implementation strategies makes community engagement a central component of the process, maximizing the benefits for hospitals, local health departments, and communities.

The lead partners responsible for the development of the CHA and execution of the CHIP are identified as the **Essex County Health Partners (ECHP)**. They are:

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

These partners participated in a regional collaborative through the Adirondack Health Institute (AHI) Adirondack Regional Health Network (ARHN). The ARHN is a seven (7) county multi-stakeholder coalition tasked with coordinating data collection and analysis, conducting stakeholder surveys, informing prioritization methods and outcomes, and setting regional priorities and initiatives.

Locally, the ECHP maintained a similar effort, focused on Essex County, to engage local partner agencies and organizations, identify the trends, issues, and concerns most important to community members, and craft meaningful and effective solutions with an emphasis on addressing the true root causes of these trends, issues, and concerns.

The ECHP were able to capture broad, multi-sector community and stakeholder participation in this effort by leveraging the following committees and coalitions (and individual member organizations within these groups):

- 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
- AH Board of Directors
- Building Resilience in Essex Families (BRIEF) - System of Care
- Essex County Heroin and Other (Drug) Prevention Coalition (ECHO)
- Essex County Breastfeeding Coalition (since renamed the Bright Futures Coalition)

The longstanding relationships, cross-collaboration and communication, and history of success in advancing shared initiatives helped inform the CHA, define assets and gaps in services, identify partners that best align with the interventions chosen for the CHIP.

Data Sources

The data used to draw health needs conclusions and advise community health improvement planning originated from multiple primary and secondary sources.

Primary Data Source Examples

- 2022 Essex County Community Survey
- 2022 ARHN Stakeholder Survey Analysis & Summary
- Select ECHD Programs & Services Data

Secondary Data Source Examples

- 2022 ARHN Stakeholder Survey
- ARHN Essex County Health Indicator Data Sheets
- ARHN Essex County Community Profile Data Sheets

The ECHP replicated and revamped a previously established deliberative process to compile and review primary data and refine secondary data through distributed community surveys, key informant interviews, an asset mapping initiative, and the assessment and evaluation of reports and studies from various local agencies and groups. The community survey effort garnered 485 responses, key informant interviews recorded responses from 31 individuals across five (5) distinct locations in Essex County, and the asset mapping endeavor categorized over 100 unique organizations, agencies, coalitions, committees, programs or resources that can be called upon to support CHIP interventions and activities.

Prevention Agenda Priorities & Disparities

Narrowing the scope of needs and disparities to address in this CHIP occurred following these iterative steps: reviewing and analyzing data; conducting a prioritization process using a well-established method to characterize need and feasibility; and sharing preliminary findings and requesting feedback/input from local stakeholders and community members.

Working within the 2019-2024 New York State Prevention Agenda framework, which is made up of five Priority Areas, the following three priorities were selected by ECHP:

- **Prevent Chronic Disease**
- **Promote Well Being, Prevent Mental Health and Substance Use Disorders**
- **Promote Healthy Women, Infants, and Children**

Disparities, identified as part of the stakeholder survey summary review process and through the process of in-depth data analysis, included age, geography (rurality), and populations living in poverty and/or those with mental health or substance use disorders.

Access to healthcare was identified as the overarching, cross-cutting disparity for Essex County residents based on the totality of the data review and feedback garnered.

The two remaining priorities not selected for CHIP integration are:

- Promote a Healthy and Safe Environment
- Prevent Communicable Diseases

Although not addressed in the 2022-2024 CHIP, it should be mentioned that programs, services, and initiatives are active and ongoing in these areas.

Evidence-Based Interventions

Selecting evidence-based strategies that address the priority areas and disparities identified above involved leveraging existing committees and coalitions of the ECHP to align future effort with current, ongoing, and/or planned initiatives of partner organizations, maximizing impact and synergy. These committees and internal workgroups were presented with the CHA findings, as well as the Prevention Agenda framework - including focus areas, objectives and strategies for each indicator of concern. Discussions to craft the Community Health Improvement Plan centered on effective and efficient use of current resources and assets to direct work to the areas of highest need, while reducing duplication and redundancy. Collective awareness of the needs in Essex County - and strategies proposed to address them - allowed for better coordination among the agencies engaged in this process.

A summary of the CHIP interventions and partners responsible for advancing the plan are listed in the tables that follow.

CHIP Summary Tables

PRIORITY: CHRONIC DISEASE			
FOCUS AREA	INTERVENTION	LEAD	PARTNER(S)
Healthy Eating & Food Security	Quality nutrition & physical activity in early learning & childcare centers	ECHD	K-12 Schools
	Physical activity and nutrition before, during, and after school	ECHD	K-12 Schools
	Fruit & vegetable incentive programs	UVMHN-ECH	ECHD
Physical Activity	Community physical activity programs	ECHD	Media
Tobacco Prevention	Facilitate tobacco dependence treatment	NCHHN	Providers
	Promote treatment of tobacco dependence	ECHD/AH	Media/CBOs
	Healthcare provider involvement in quit attempts	NCHHN	Providers
	Policy action to reduce tobacco marketing	CVFC	Students
	Decrease availability of flavored tobacco products	CVFC	Businesses
Preventive Care & Management	Systems change for cancer screening reminders	AH	CBOs
	Remove barriers to cancer screening	UVMHN-ECH	
	Increase colorectal cancer screening	ECHD	Media

PRIORITY: WELL-BEING and SUBSTANCE USE & MENTAL HEALTH DISORDERS			
FOCUS AREA	INTERVENTION	LEAD	PARTNER(S)
Promote Well-Being	Evidence-based home visiting programs	ECHD	Providers
	Promote inclusion, integration, and competence	ECMH	CBOs
	Thoughtful messaging on mental illness & substance use	ECHD	Media
Prevent Mental Health & Substance Use Disorders	School-based prevention	The Prevention Team	K-12 Schools
	SBIRT	UVMHN-ECH	
	Trauma informed approaches in prevention programs	ECMH	CBOs
	Access to MAT	UVMHN-ECH	
	Access to overdose reversal	Alliance for Positive Health	Pharmacies
	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

CHIP Summary Tables

PRIORITY: HEALTHY WOMEN, INFANTS & CHILDREN			
FOCUS AREA	INTERVENTION	LEAD	PARTNER(S)
Maternal & Women's Health	Preventive medical visits for women	UVMHN-ECH	
	Depression screening for pregnant & postpartum women	ECHD	
Perinatal & Infant Health	Access to breastfeeding support	ECHD	Providers
	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	CBOs & Providers

Tracking Progress

The Lead Partner for each intervention will assess progress on activities and report status updates as requested to the Essex County Health Partners. The ECHP have committed to ongoing communication and collaboration and will meet quarterly, at a minimum, to:

- assess/measure progress on activities described in the CHIP work plan;
- identify barriers to the implementation of activities;
- develop strategies to overcome barriers and/or determine how activities may be adjusted for success; and
- recommend changes/additions/deletions to the CHIP work plan if new or updated information/data/indicators become available, or as needed based on partner capacity.

Distinct process measures are defined for each intervention and include things like:

- Number of trainings planned/provided
- Number of media campaigns and/or engagement
- Number of policies/plans adopted, revised, or updated
- Number of health practices screening or referring
- Number of coalition/committee meetings held/attended
- Number of programs offered and/or residents served.

Progress will be recorded as a quarterly update to the CHIP work plan.

Annually, or more often if requested, ECHP will submit an updated CHIP to NYSDOH, with progress toward objectives clearly noted.

Community Health Assessment

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 (4). The toolkit offers a nine-step pathway for conducting a CHA and developing implementation strategies documented in the CHIP (Figure 1).

Figure 1: ACHI's Community Health Assessment Toolkit nine-step pathway

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 number in parentheses immediately following a point of reference, within text, tables, charts, or figures, which refer back to the Master Source List (Appendix 7). For the purpose of this report, sources are listed with just two identifiers; a number that refers to a source name. The source may be listed as an agency, report, data set, etc. More detailed information is available upon request. For example:
(1) means NYSDOH Prevention Agenda 2019-2024.

Report Sections

Each major section of this report corresponds to a step in the Community Health Assessment Toolkit process (Figure 1, page 2). 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:

→ Section Title Page Icon

→ Icon denoting additional pages within the section

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 2020 and was 22% in 2014, 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.

Essex County Trends

Trends are identified when comparing current Essex County data with previous Essex County data. Current year data is the most recently available data at the time this report was compiled. Previous data is generally the data that was available and included in the 2019 assessment. Data year or year ranges are included for each indicator.

Trends can be noted with a trend line in a graph or by the following symbols:

▼ ▲ On Track/Improving	Examples: % of population screened for cancer increased & this is good Cancer case rate decreased & this is good
▼ ▲ Off Track/Worsening	Examples: Cancer case rate increased & this is not good % screening decreased and this is not good
■ Stable/No Significant Change	Example: Teen birth rate was 16/1K in 2018; 16/1K in 2019

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.

A Retrospective

Step 1: Reflect & Strategize

A Pandemic Drastically Alters the Public Health & Healthcare Landscape

In late December 2019, a previously unidentified coronavirus, soon named the 2019 novel coronavirus - or COVID-19, emerged from Wuhan, China. We all watched the news reports and press briefings with bated breath, wondering if this new virus would be contained, like the 2009 SARS outbreak more than a decade beforehand. We didn't have to wait long to find out.

Following spread reported in other countries, the U.S. announced its first confirmed case of COVID-19 in February 2020. The Centers for Disease Control and Prevention (CDC), and soon thereafter, NYSDOH, started issuing regular Health Alerts to hospitals, local health departments, and all within the public health and healthcare systems. Planning and response efforts started in earnest in early 2020. Events quickly escalated after that, with the World Health Organization (WHO) declaring a global pandemic on March 11, 2020.

Notable throughout pandemic response was the fact that political affiliations significantly impacted national and state strategies, policies and decisions on how best to deal with the pandemic. Conflicting guidance at national, state and local levels served to erode people's trust in pandemic response approaches. Misinformation and disinformation gained footing and hampered response efforts. The strain of this response contributed to never-before experienced strains in public health and healthcare sectors.

Hospitals and health systems were impacted by swiftly changing guidance, changing workflows and patient management strategies to reduce infections risks, and requirements to delay/postpone elective surgeries to keep beds free for COVID patients. This was especially true in New York State, with the initial COVID-19 epicenter occurring in New York City in early 2020. Healthcare systems faced challenges of addressing delayed patient care, launching more comprehensive telehealth programs, and keeping their services intact amidst public fear of infection.

Yet more than anything, the pandemic directed a glaring spotlight at the underinvestment in the public health system. A look into dollars spent in the US reveals that for every health care dollar spent in the United States, 97 cents is directed toward medical care and 3 cents goes to public health. This, despite the fact that the public health system actually accounted for much of the increases in life expectancy over the last 200 years. Staff who had traded historically lower pay (common to public sector jobs) for good benefits and predictable work schedules found the long hours, stress, and public hostility too much to bear. A perpetually underfunded and resource-strapped public health system would become even more fractured as the pandemic wore on.

The public outcry at health orders and mandates further destabilized a precarious framework for local health departments such as the Essex County Health Department, where virtually all core/mandated services were halted for extended time periods to divert effort towards pandemic response. The Essex County Health Department was not immune to these realities and local hospitals also began to experience impacts - significant staff turnover, burnout, and the loss of historical knowledge through the defection of seasoned staff.

A consequential portion of the public health and health care workforce began careers in pandemic response mode and needed to learn how to operate otherwise when restrictions were lifted.

At the time of this report, and several viral variants of concern later, the world has not yet fully emerged from this pandemic. In fact, at the close of 2022, New York is under three (3) concurrent determinations of Imminent Threats to Public Health including COVID-19, Monkeypox and Polio.

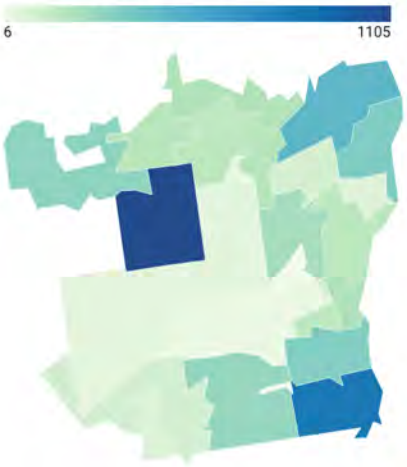
The three (3) following pages demonstrate the concentration of local health department resources toward responding to the COVID-19 Pandemic (from March 2020 - May 2022 for the By the Numbers data). They do not fully capture the sheer magnitude of the effort, or all impacts to the department overall; however, much of this information is available in Essex County Board of Supervisors Human Services Committee meeting minutes (https://www.co.essex.ny.us/BdOfSupervisors/listminutes.aspx) and the Essex County Health Department's reports to this committee (https://www.co.essex.ny.us/Health/about-us/reports/).

COVID-19 Pandemic By the Numbers
Essex County, NY

COVID-19 Cases Reported to ECHD

Case Demographics

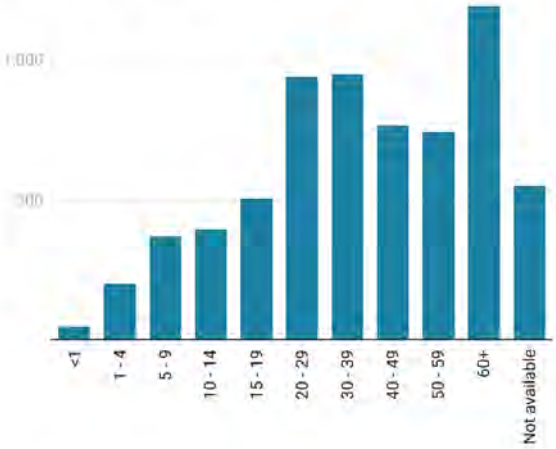
Cases by Zip Code



Lab-confirmed data are for cases reported to the Essex County Health Department from 03/2020 - 05/06/2022.

Source: NYSDOH • Map data: © Esri, TomTom North America, Inc., United States Postal Service • Created with Datawrapper

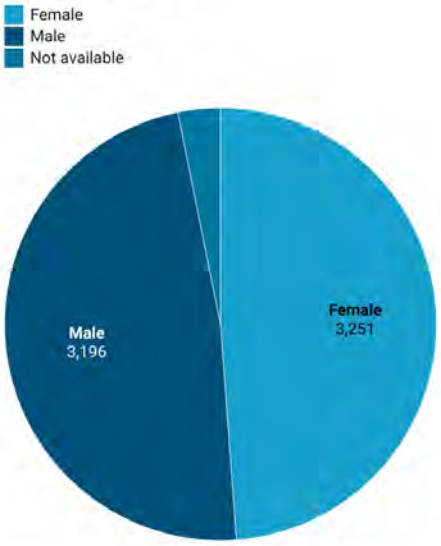
Cases by Age



Data are for lab-confirmed cases reported to the Essex County Health Department from 3/2020 - 05/06/2022

Source: NYSDOH • Created with Datawrapper

Cases by Sex



Data are for lab-confirmed cases reported to the Essex County Health Department from 03/2020 - 05/06/2022

Source: NYSDOH • Created with Datawrapper

COVID-19 Testing

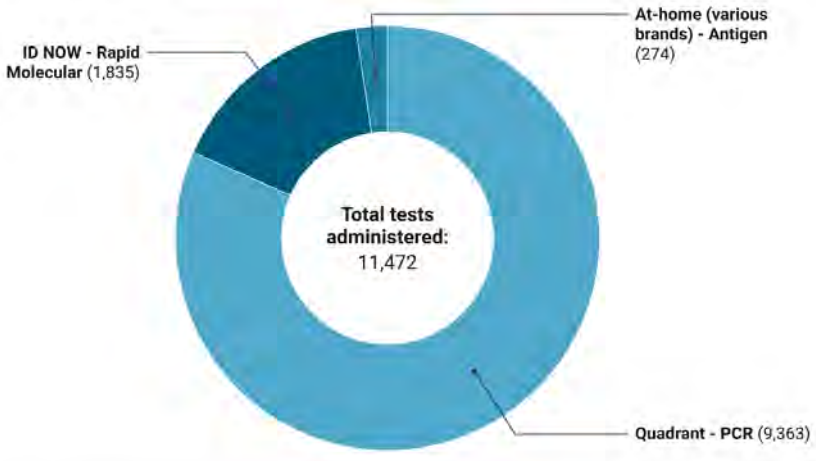
Essex County Schools Participating in School-Based Testing Program

Public School District	Private School
Boquet Valley	Lakeside
Crown Point	North Country
Keene	St. Agnes
Lake Placid	St. Mary's
Minerva	
Mineville - BOCES	
Moriah	
Newcomb	
Schroon Lake	
Ticonderoga	
Willsboro	

Created with Datawrapper

COVID-19 School-Based Testing Facilitated by ECHD

Number of tests administered by test type



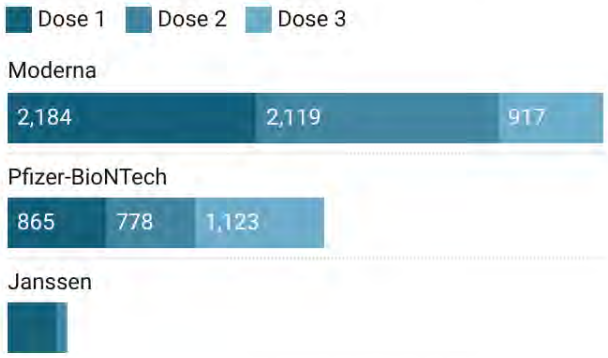
Data are testing facilitated by Essex County Health Department during the Essex County School-Based Testing Program: 09/01/2021 - 05/09/2022.

Source: NYSDOH & app.clarifncovid-19.com • Created with Datawrapper

COVID-19 Pandemic By the Numbers
Essex County, NY

COVID-19 Vaccination

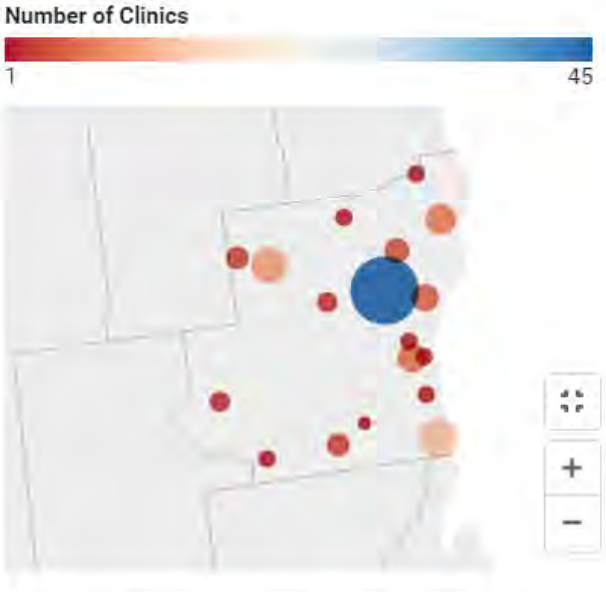
Vaccine Doses Provided by ECHD



Lab-confirmed data are for cases reported to the Essex County Health Department from 03/2020 - 05/06/2022.

Source: NYSDOH • Created with Datawrapper

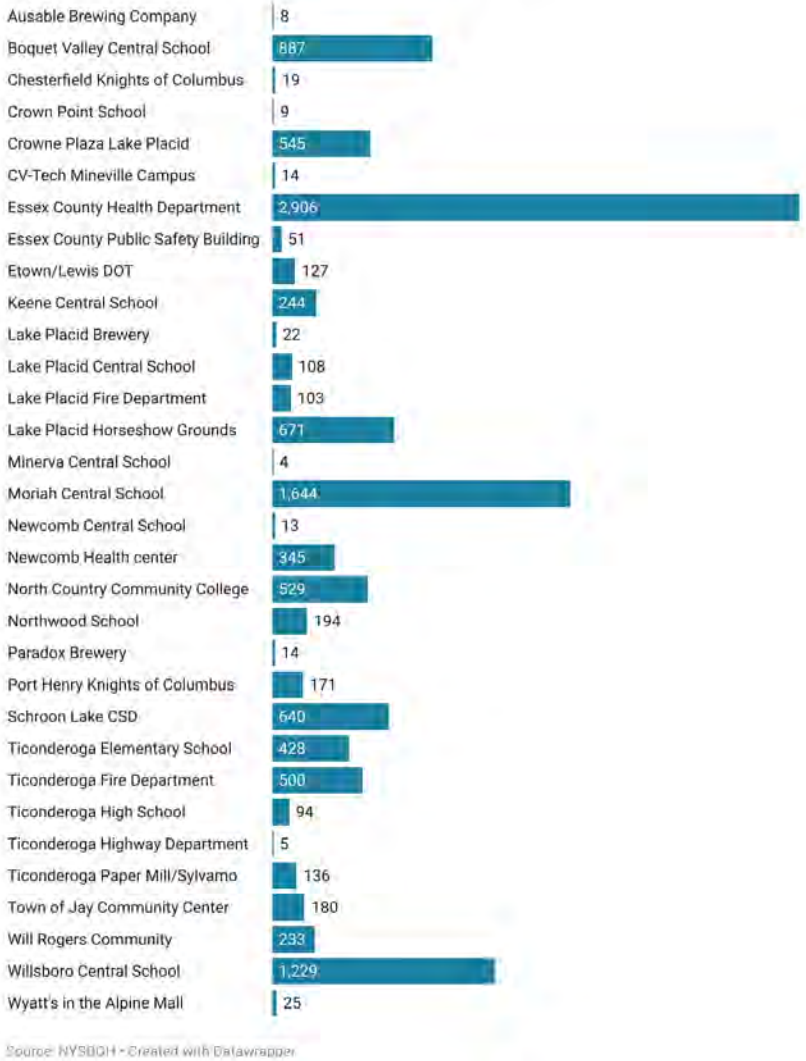
COVID-19 Vaccination Clinics offered by ECHD in Essex County



Data are for COVID-19 Vaccination Clinics conducted in Essex County from 01/2021 - 05/09/2022

Source: NSYDOH • Get the data • Created with Datawrapper

COVID-19 Vaccine Doses Administered By Location



Source: NYSDOH • Created with Datawrapper

HEALTH DEPARTMENT

ELC SCHOOL REOPENING GRANT

NYS Department of Health required all unvaccinated teachers and staff to be tested weekly as well as weekly screening offered to all students

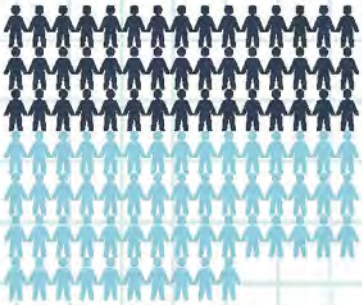
GRANT GOAL

Provide support to schools by establishing covid-19 screening and diagonostic testing in order to reduce virus transmission to maintain in person learning.

Dilemma:

Limited access to covid-19 testing and long turn around time for test results

1,962 unique individuals; 45% of Essex County school population was served with school based testing.



15 Participating Schools

- **Public Schools: 10**
- **Private Schools: 4**
- **BOCES: 1**

Approach:

Expanded access to covid-19 testing from 3 locations to 18 in Essex County

Weekly meetings with superintendents and continuous collaboration with school nurses, administrators, parents, and faculty

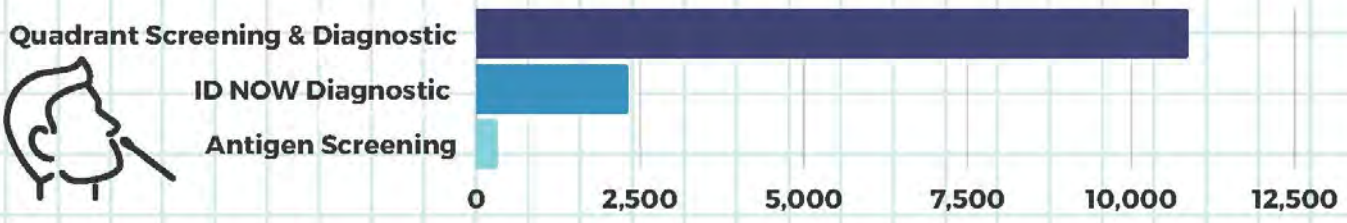
Provided a constant supply of PPE and tesing materials

Provided testing services 162 days out of 180 in session school days

Traveled 10,742 Miles to provide screening services and supplies to schools

Expanded Health Department staffing by 25%

Tests Accessed through School Based Testing



Stakeholder Engagement

Step 2: Identify & Engage Stakeholders

Establishing robust, trusting relationships with community stakeholders fosters a welcoming and inclusive environment, creating a stronger sense of joint ownership of the Community Health Assessment (CHA) process (4). Defining stakeholder engagement in this section will include the ongoing participation of the Essex County Health Partners in local and regional committees/coalitions/networks that serve to inform the CHA and Community Health Improvement Plan (CHIP) - see description of regional and local committees below Table 1. Stakeholder engagement is not a discrete step, however. This work occurs continually during the development and refinement of the assessment and progresses after dissemination of the CHA as work begins on the identified interventions to address community health needs. As such, the list of actions and meetings below includes initial and/or predefined CHA stakeholder engagement, with additional engagement outlined in Step 6: Document and Communicate Results section.

Regional **Local**

Committee/Coalition	Meeting Date(s) and/or Frequency	Participant Organizations*	Lead/Host Organization (if applicable)
Community Health Assessment (CHA) Committee	Quarterly (no meetings held Mar 2020 - Sep 2020; reconvened Oct 2020)	Hospitals and Local Health Departments	Adirondack Health Institute
Adirondack Rural Health Network	Quarterly (no meeting held Mar 2020 - Feb 2021; reconvened Mar 2021)	Hospitals, Local Health Departments, Community Based Organizations	Adirondack Health Institute
CHA Data Subcommittee	July 13, 2021, Aug 25, 2021, Oct 12, 2021, Nov 10, 2021	Hospitals and Local Health Departments	Adirondack Health Institute
Local CHA Committee of the Essex County Health Partners	Monthly reconvened in Mar 2022	UVMHN - Elizabethtown Community Hospital (ECH), Adirondack Health, Essex County Health Department (ECHD), Essex County Mental Health (ECMH)	UVMHN - ECH

Table 1: Regional and Local Stakeholder Engagement

*See Appendix 5 for full Committee membership information

Regional Stakeholder Engagement

Regional collaboration is facilitated by the Adirondack Health Institute (AHI). AHI is an independent, non-profit organization categorized as an Article 28 agency under New York State Department of Health (NYSDOH) regulations.

AHI partners with regional health care providers and community-based organizations to advance three overarching objectives:

- Promote population health best practices and implementation strategies;
- Manage programs that fund health advancement; and
- Ensure individuals have access to care.

AHI works with more than 125 organizations across 9 counties, representing a broad range of health, community, and business sectors, through the administration of multiple programs:

- Adirondack Food System Network
- Adirondack Rural Health Network (ARHN)
- AHI Health Home Care Management
- ADK Wellness Connections
- Clear the Air in the Southern Adirondacks (CASA)
- Community Health Access to Addiction and Mental Healthcare Project (CHAMP)
- Enrollment Assistance Services and Education (EASE)
- North Country Care Coordination Collaborative (NCCCC)
- Practice Innovation Solutions
- Rural Communities Opioid Response Program (RCORP) III
- Telehealth/Telemedicine

Figure 2 below depicts where programs are conducted throughout the AHI region. Essex County is included in 10 of these programs.

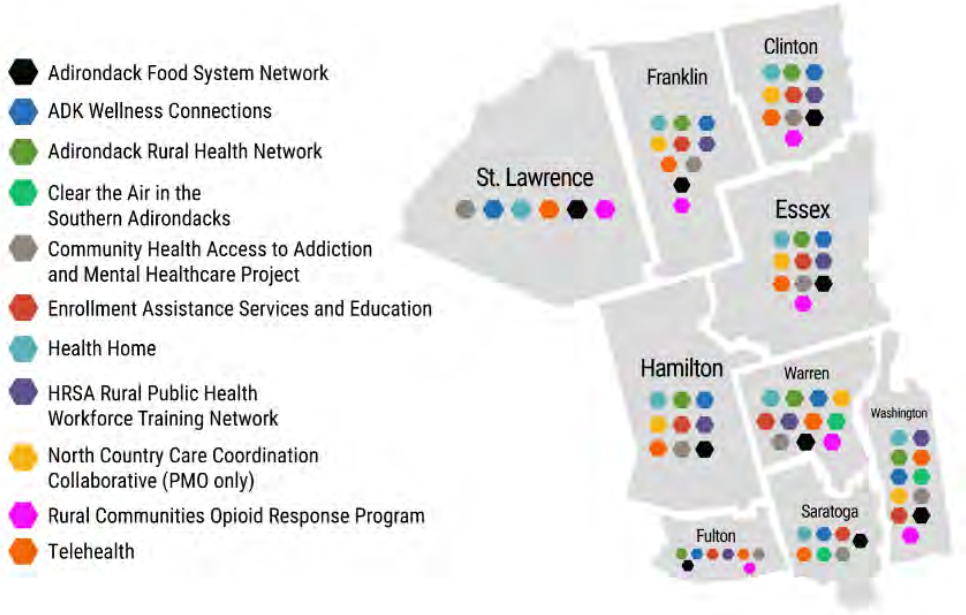


Figure 2: AHI Programs

Adirondack Rural Health Network: As one of the programs listed on the previous page, the Adirondack Rural Health Network (ARHN) facilitates a forum for the assessment of regional population health needs and develops collaborative responses to priorities. ARHN includes organizations from New York's Clinton, **Essex**, Franklin, Fulton, Hamilton, Warren, and Washington counties. The ARHN Forum is conducted through quarterly meetings to:

- Coordinate data collection
- Conduct a regional stakeholder survey
- Inform analysis & prioritization methods
- Determine regional priorities and initiatives

Community Health Assessment (CHA) Committee: The Community Health Assessment (CHA) Committee, facilitated by ARHN, is made up of hospitals and county health departments that have developed and implemented a sophisticated process for community health assessment and planning for the defined region to address identified regional priorities. The CHA Committee is made up of representatives from ***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, and Washington County Public Health.

The CHA Committee, made up of the CHA service contract holders with 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 and the Internal Revenue Service in an effort to advance the New York State Prevention Agenda.

CHA Committee, Ad Hoc Data Sub-Committee: At the June 4, 2021, CHA meeting, it was decided that an Ad Hoc Data Sub-Committee would be re-established to review tools and processes used by CHA Committee members to develop their Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP), as well as identify ways to enhance the CHA/CHIP process. A primary activity of the Ad Hoc Data Sub-Committee was to collaboratively develop a **stakeholder survey**.

Regional Data Gathering and Analyzing

Major components of regional stakeholder engagement for input, data gathering, and analysis resulted in three (3) key components informing this report:

- ARHN Stakeholder Survey Report (Appendix 1)
- ARHN Essex County Community Profile Data Sheets (Appendix 2)
- ARHN Essex County Health Indicator Data Sheets (Appendix 3)

ARHN 2022 Stakeholder Survey

The first component of regional data collection was qualitative data input from stakeholders. The 2022 Stakeholder Survey was conducted to gather information from a variety of fields and perspectives to provide valuable insight into the community's needs. The results help direct the strategic planning process throughout the Adirondack region, for partners who serve individual counties, and those whose footprint covers multiple counties.

ARHN Health Indicator Data Sheets

The second component of regional data collection was quantitative collection of data by ARHN and provided to its regional members in the format of the document identified in this report as the ARHN Essex County Health Indicator Data Sheets. These sheets are a compilation and analysis of hundreds of data indicators from a variety of sources.

The sheets were organized by the following major categories: *Mortality; Injuries, Violence, and Occupational Health; Built Environment and Water; Obesity; Smoke Exposure; Chronic Disease; Maternal and Infant Health; HIV, STD, Immunization and Infectious Diseases; Substance Abuse and Mental Health;* and *Other.*

Each Indicator includes a link to the data source, as well as columns for Essex County, the ARHN region, Upstate New York, New York State, and the NYSDOH Prevention Agenda Target (as available). An analysis of the indicators is included and is based on a comparison of the Essex County data to the Prevention Agenda Target - or Upstate NY (all counties excluding NYC) if there is not an associated target. The comparison uses a traffic light rating system, with green denoting that the target (either Prevention Agenda or Upstate NY benchmark) has been met or exceeded; red denoting that the indicator doesn't meet or is worse than the target; and yellow indicating that the data indicator is statistically unreliable/unstable. To provide further context, quartiles are used to denote how far from the target the indicator lies:

- Quartile 1: within 24% of comparison
- Quartile 2: between 25% and 49% of comparison
- Quartile 3: between 50% and 74% of comparison
- Quartile 4: between 75% and 100% of comparison.

In other words, data indicators closest to the comparison are within Quartile 1; farthest in Quartile 4.

Lastly, these sheets include a severity score, which is the percentage of indicators within a major category area that are either in quartile 3 or 4.

ARHN Community Profile Data Sheets

The third component of regional data collection was the quantitative collection of community profile data by the ARHN.

These sheets are a compilation of data from additional sources and are organized by the following areas: Demographic Profile, Health System Profile, Education System Profile, and ALICE Profile.

Local Stakeholder Engagement

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)
- University of Vermont Health Network - Elizabethtown Community Hospital (ECH)
- Adirondack Health (AH)

These partners participate in the ARHN regional quarterly forum and other committees as noted in Table 1 earlier in this section.

Locally, these partners met throughout 2022, either in person or virtually through the Teams meeting platform and via e-mail to share documents, updates, and information pertinent to the CHA process.

Additionally, the Essex County Health Department led or participated in the following locally based coalitions or committees that informed the health needs assessment and improvement planning:

- Essex County Human Services Sub-Committee of the Board of Supervisors
- Essex County Public Health Advisory Committee
- Essex County Community Services Board facilitated by the Essex County Mental Health Department
- Essex County Breastfeeding Coalition (recently renamed the Essex County Bright Futures Coalition)
- Building Resilience in Essex Families (BRIEF) - System of Care
- Essex County Heroin and Other (Drugs) Prevention Coalition

This collaboration is more fully detailed in the section covering Step 6: Document and Communicate Results.

Local Data Gathering and Analyzing

In addition to participating in regional data collection efforts, the following local data gathering and analysis efforts informed this report:

- 2022 Stakeholder Survey Summary
- 2022 Community Survey
- Key informant interviews at Senior Nutrition Sites
- Review of relevant ECHD Programs & Services Data
- Review of other available local health & human service agency annual reports, plans, and/or data
- Asset Mapping

2022 Stakeholder Survey Summary

Essex County Health Partners utilized the 2022 Stakeholder Survey to develop a Stakeholder Survey Summary (page 17). This summary helped to validate conclusions drawn from data analysis, guide additional data gathering and assessment, and identify themes and disparities based on the answers provided. Stakeholder responses are included throughout the data analysis section (Step 4) of the report.

2022 Community Survey

The community served by the Essex County Health Partners can also be considered a collective stakeholder. Efforts to garner feedback about health needs from community members included a Community Survey, available electronically via Survey Monkey, in paper form at all local libraries, and by request. Surveys were collected for approximately 3 months (from March 2022 to June 2022) and 485 responses were received. A summary of the 2022 Community Survey results is included in the section covering Step 3: Define the Community. Community feedback from the surveys is included throughout the data analysis section (Step 4) of the report.

Key Informant Interviews

Over the summer of 2022, the Essex County Health Department (ECHD) launched an initiative to visit some of the 11 Senior Congregate Meal Sites operated by the Adirondack Community Action Programs (ACAP) Nutrition Program for the Elderly and Essex County Office for the Aging. The Nutrition Program provides area seniors aged 60 and over with healthy, nutritious meals at senior centers or through home delivered meals. Meals are free or donations can be made. Centers provide a warm comfortable atmosphere for seniors to gather to enjoy a meal and activities. The program also provides a link to services and information for seniors.

ECHD staff reached 5 separate meal sites in Keeseville (Chesterfield), Minerva, Schroon Lake, Lake Placid (North Elba), and Mineville/Port Henry (Moriah). A total of 31 seniors, ages ranging from 63 to 88, participated in one-on-one interviews answering the same set of four open-ended questions about the resources that make it easier to age in Essex County and the gaps in services that make it more challenging.

Findings:

Biggest factor making it harder for aging adults to be healthy in Essex County:
!. Issues related to transportation (21/31 responses)
2. Lack of access to grocery stores/healthy food (6/31 responses)

Top reason aging adults remain here in Essex County:
1. Family/friends/community (19/31 responses)
2. Aesthetics - quiet/peaceful/beautiful/clean/private (10/31 responses)

Resources that make it easier to live here:
1. Support services - congregate meal sites/home delivered meals/HEAP (home energy assistance program)/tax break programs (16/31 responses)
2. Pharmacy/stores (8/31 responses)

Resources that are needed:
1. Transportation (11/31 responses)
2. Grocery stores (7/31 responses)

Review of Local Reports and/or Data

A significant component of the final Community Health Assessment was the collection, review, and analysis of local data by the Essex County Health Partners. This information included raw data and plans, reports, and studies conducted or commissioned by local agencies, programs, and groups.

Examples of such information includes:

- **Well Fed Essex County Collaborative - An Evaluation of 5 Food Access Projects, conducted by Leah's Pantry, February 29, 2020**
- **Essex County Housing and Population Study, conducted by Asterhill Research Company, August 15, 2022**
- **The Wellbeing of Infants and Toddlers in the Adirondacks, second edition, 2021; Adirondack Birth to Three Alliance**
- **Overdose data review - Essex County Heroin and Other (Drug) Prevention Coalition**

This assessment, using primary and secondary data sources from local agencies and groups, helped construct a more complete picture of the social and societal factors that contribute to health challenges in Essex County. A complete list of data sources is included as Appendix 7.

Asset Mapping

Another initiative of engaging stakeholders is mapping community assets. The process of mapping assets emphasizes individuals, organizations, and resources in the community that can act as change agents to affect decisions about needed programs or services. The process of identifying assets also supports community health planning because it reveals those assets that are ready to be mobilized. Table 2 that follows on pages 18-20 is a comprehensive list of Essex County Assets.

2022 Stakeholder Survey Summary

The Adirondack Rural Health Network (ARHN) facilitated the release of a survey in its seven-county service area to provide the Community Health Assessment Committee with input on regional health care needs and priorities. For more information about the ARHN and how it supports local health departments and hospitals in Community Health Assessment and planning activities, go to: https://ahihealth.org/arhn/.

Top 3 Stakeholder respondent community sector areas:

Schools K-12

Hospitals

Local Government

ARHN Region

Top Priority Areas

Promote Well Being and Prevent Mental Health & Substance Use Disorders

Promote a Healthy and Safe Environment

Top 5 Health Concerns

- Mental health
- Substance use
- Child/adolescent emotional health
- Overweight/obesity
- Adverse childhood experiences

Top 5 Contributing Factors

- Lack of mental health services
- Poverty
- Addiction to alcohol/illicit drugs
- Age of residents
- Changing family structures

Essex County

Top Priority Areas

Promote Well Being and Prevent Mental Health & Substance Use Disorders

Promote a Healthy and Safe Environment

Top 5 Health Concerns

- Mental health
- Substance use
- Child/adolescent emotional health
- Adverse childhood experiences
- Diabetes

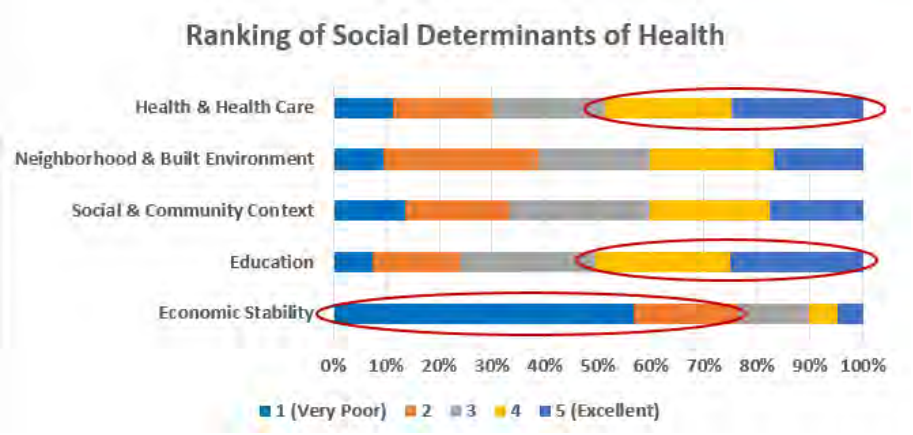
Top 5 Contributing Factors

- Changing family structures
- Poverty
- Addiction to alcohol/illicit drugs
- Lack of mental health services
- Age of residents

For the ARHN Region:

Survey respondents overwhelmingly agreed that Economic Stability is the factor most negatively impacting residents.

Health/Health Care and Education were identified as factors most positively impacting residents in our region.



Identified Disparities in Essex County:

Poverty

Mental Health

Substance Use

Rural Areas

Aging

Asset Mapping

Asset Matrix	KEY: Engaged in the development of the CHA & CHISP.		KEY: Resources available to mobilize in addressing community health.					
			Prevention Agenda Priorities & Cross-Cutting Disparity in Essex County					
Asset Type	Name	Description	Chronic Diseases	Healthy & Safe Environment	Healthy Women, Infants & Children	Well-Bring & Mental/ Behavioral Health	Communicable Diseases	Access to Healthcare
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		■				■
		Car Seat Checks		■				■
		Women's Health Clinic			■			■
		Breast Program: Breast Health Navigator	■					■
		Certified Lactation Consultants			■			■
		Car Seat Checks		■				■
		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)	■					■
	UVHN-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	■		■			■
		Tobacco Cessation Specialists	■		■	■		■
		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				■		■
		Ryan White Grant					■	■
		Antibiotic Stewardship Program					■	■
	Hudson Headwaters Healthcare Network		■	■	■	■	■	■
	Pharmacies					■	■	■
	Essex County Health Department	Public Health Advisory Board	■	■	■	■	■	■
		Public Health Unit Programs	■	■	■	■	■	■
		Children's Services Unit Programs			■			■
		WIC Unit			■			■
		Home Health Unit	■	■	■	■	■	■
	Adirondack Health Institute (AHI)	Adirondack Rural Health Network	■	■	■	■	■	
		Population Health Improvement Program (PHIP)	■	■	■	■	■	
Adult Care Facilities			■	■			■	
Nursing Homes			■	■			■	■
Senior Living Facilities			■	■			■	

Table 2: Essex County Asset Matrix

Asset Mapping (cont'd)

Asset Matrix	KEY: Engaged in the development of the CHA & CHISP.		KEY: Resources available to mobilize in addressing community health.					
			Prevention Agenda Priorities & Cross-Cutting Disparity in Essex County					
Asset Type	Name	Description	Chronic Diseases	Healthy & Safe Environment	Healthy Women, Infants & Children	Well-Bring & Mental/ Behavioral Health	Communicable Diseases	Access to Healthcare
Coalitions/Committees	Adirondack Birth to Three Alliance				■			■
	Essex County Breastfeeding Coalition		■		■			
	BRIEF - System of Care		■	■	■	■		■
	Essex County Drug Court				■	■		■
	Essex County Mental Health Court				■	■		■
	Essex County Heroin & Opioid 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				■		
	Essex, Clinton, Franklin Immunization Action Plan Coalition						■	■
	Essex, Clinton, Franklin Lead Poisoning Prevention Coalition				■			
	Safe Kids Adirondack				■			
	Local Emergency Planning Committee			■	■		■	
	North Country Chronic Disease Prevention Coalition		■					■
	Housing Coalition			■	■	■		■
	Rural Communities Opioid Response Planning (RCORP)				■	■		
County Government Departments	Mental Health				■	■		■
	Department of Social Services				■	■		■
	District Attorney					■		■
	Office for the Aging		■			■		■
	Public Works & Transportation		■	■				
	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 of the North Country				■	■	■	■
	Adirondack Community Action Program (ACAP)	Human Services Coalition	■	■	■	■		
	Families First				■	■		
	North Country Healthy Heart Network (NCHHN)		■	■	■	■		
	Retired Senior Volunteer Program (RSVP)							■
	St. Joseph's Addiction Treatment & Recovery Center		■			■		■
	Behavioral Health Services North					■		■
	Tri-Lakes Center for Independent Living		■					■
	Mountain Lake Services		■					■
	Cornell Cooperative Extension		■		■			
	Industrial Development Association		■	■				
	Housing Assistance Program of Essex County		■	■				
	Literacy Volunteers of Essex & Franklin Counties							■
	Chambers of Commerce	Local & Regional	■	■				
	Businesses		■		■	■		
	United Way of Clinton, Essex, Franklin County							■
	One Work Source							■
	Champlain Valley Family Center		■			■		
Schools		Public, Private, BOCES, Colleges	■	■	■	■	■	

Table 2 (cont'd): Essex County Asset Matrix

Asset Mapping (cont'd)

Asset Matrix	KEY: Engaged in the development of the CHA & CHISP.		KEY: Resources available to mobilize in addressing community health.					
			Prevention Agenda Priorities & Cross-Cutting Disparity in Essex County					
Asset Type	Name	Description	Chronic Diseases	Healthy & Safe Environment	Healthy Women, Infants & Children	Well-Bring & Mental/ Behavioral Health	Communicable Diseases	Access to Healthcare
Religious Groups	Churches, Ecumenical Societies, etc.							
Local Programs/Grants	Cancer Services Program of Northeastern NY							
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)							

Table 2 (cont'd): Essex County Asset Matrix

Community Snapshot

Geography

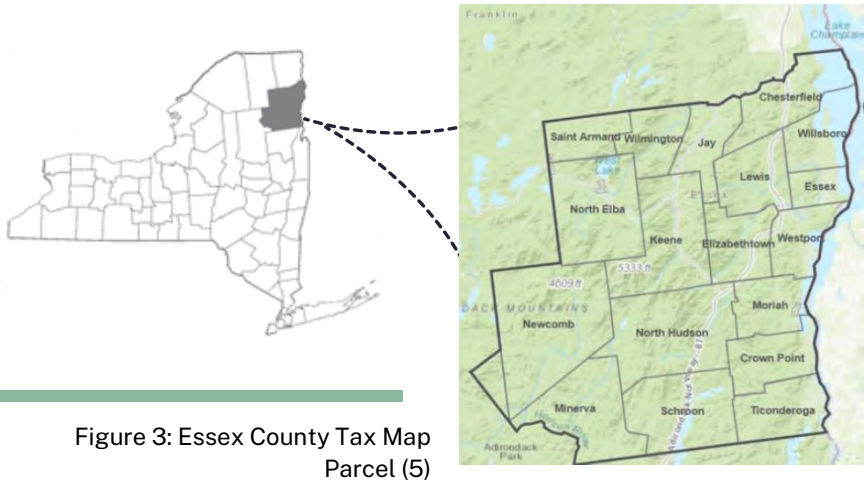


Figure 3: Essex County Tax Map Parcel (5)

Essex County is the 2nd largest county in New York State geographically, and the 3rd least densely populated. 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.

Essex County is the only county in the state situated entirely within the Adirondack Park. The Adirondack Park is 6.1 million acres of public and privately owned land, corresponding with the border of the Adirondack Mountains (the Blue Line boundary). The park use is regulated by the Adirondack Park Agency, ensuring the preservation of more than "3,000 lakes, 30,000 miles of rivers and streams, and a wide variety of habitats, including globally unique wetland types and old growth forests" (7).

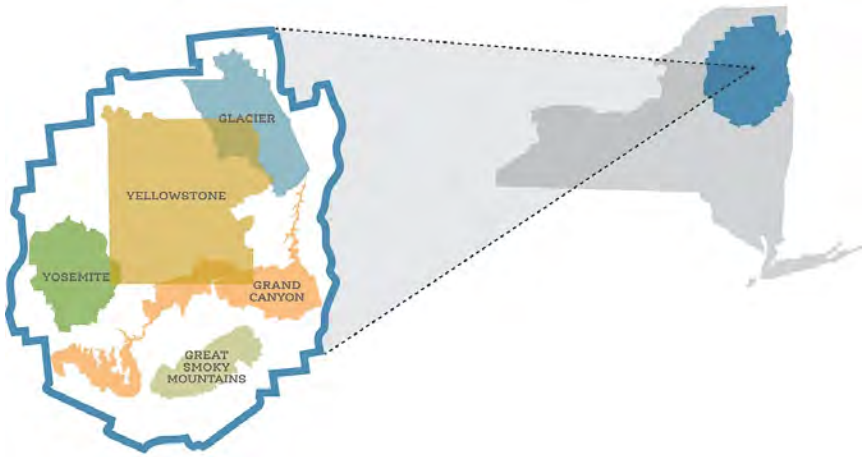


Figure 4: Adirondack Park Boundary (6)

The county boasts a solid agricultural base, ample natural resource amenities, and small-town appeal in the various villages and townships spread throughout its borders.

Located in the north-eastern corner of the state, about an hour from the international border with Canada, the Essex County economy is largely dependent on federal/state government and recreation jobs.

Demographics (8)

An official Decennial Census was conducted by the United States Census Bureau in 2020. Results confirmed previous population estimates, showing that the population of Essex County has declined from 39,370 in 2010 to 37,381 in 2020 - a decrease of 5.1%.

Along with population declines, people in the county are getting older. In 2020, the median age of all people in Essex County was 48.3, up from 48 in 2019. Almost 25% of residents are 65 years or older and this age group has experienced the largest overall increase since 2010 (see Figures 4 and 5).

	Essex County, New York	
Label	**Estimate**	**Percent of Total**
Total:	37,268	
Under 18 years	5,728	15%
18 to 24 years	2,331	6%
25 to 34 years	4,264	11%
35 to 44 years	4,314	12%
45 to 54 years	4,735	13%
55 to 64 years	6,520	17%
65 years and over	9,376	25%

Table 3: Population Estimates by Age Group (8)

Trend Analysis			
	Essex County		% Chg
POPULATION	2010	2020	2010-2020
Under 20 years	8,690	6,687	-23.0%
21 to 24 years	2,223	1,854	-16.6%
25 to 44 years	9,744	8,645	-11.3%
45 to 54 years	6,312	5,087	-19.4%
55 to 59 years	3,246	3,155	-2.8%
60 to 64 years	2,275	3,104	36.4%
65 to 74 years	3,590	5,013	39.6%
75 to 84 years	2,445	2,437	-0.3%
85 years and over	891	1,299	45.8%
Total	39,416	37,281	-5.4%

Table 4: Population Trends by Age Group (9)

The overall racial make-up in Essex County has not changed much over the last 10 years. Non-Hispanic whites make up the largest majority, at about 92% of the total population. This is in contrast with NYS as a whole, where non-Hispanic whites represent about 58% of the total population.

The 4 largest ethnic groups in Essex County, NY are:
White (Non-Hispanic) - 91.7%
Black or African American (Non-Hispanic) - 2.95%
White (Hispanic) - 1.3%
Multiracial - 1.24%

The "All Other" category in Figure 5 includes Asian, American Indian and Native Alaskan, Pacific Islander and Native Hawaiian, and Hispanic Black/African American and Hispanic multiracial populations.

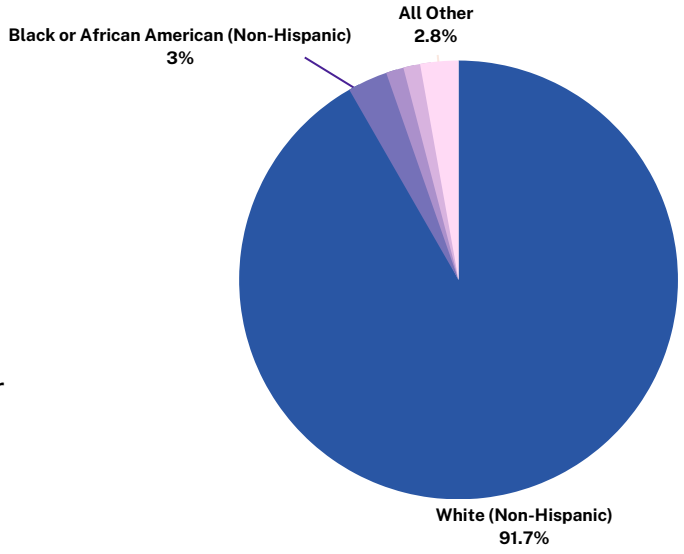


Figure 5: Essex County Diversity (10)

Family Status

In Essex County, almost 25% of households have grandparents that are raising their grandchildren (see Figure 6 below). This is much higher than what is seen in surrounding counties and higher than the NYS average of 18.2% (42).

Grandparents stepping in as parents is termed a kinship family or grandfamily. Kinship families and grandfamilies form in response to a wide range of circumstances including substance use disorders, parental incarceration, economic instability, military deployment, serious mental illness, death, and adverse immigration actions (41).

Grandparents raising grandchildren can come with many benefits, including the support, love, and stability provided to vulnerable children by a trusted family member. However, because of the events that lead to the formation of kinship families and grandfamilies, many of the children involved are at a high risk of emotional disturbance, juvenile justice involvement, and failure to thrive in school. The difference between kinship families and grandfamilies of the past and those emerging today is that the number of children in need of loving kinship or grandparent caregivers is greater than ever before and the systems to support families in need do not recognize or understand the unique needs of these families. Additionally, grandfamilies are not immune to the normal challenges that often come with aging: financial constraints due to being on fixed incomes; food and nutrition challenges from having additional mouths to feed; adequate housing; respite and childcare needs; and health and medical challenges (41).

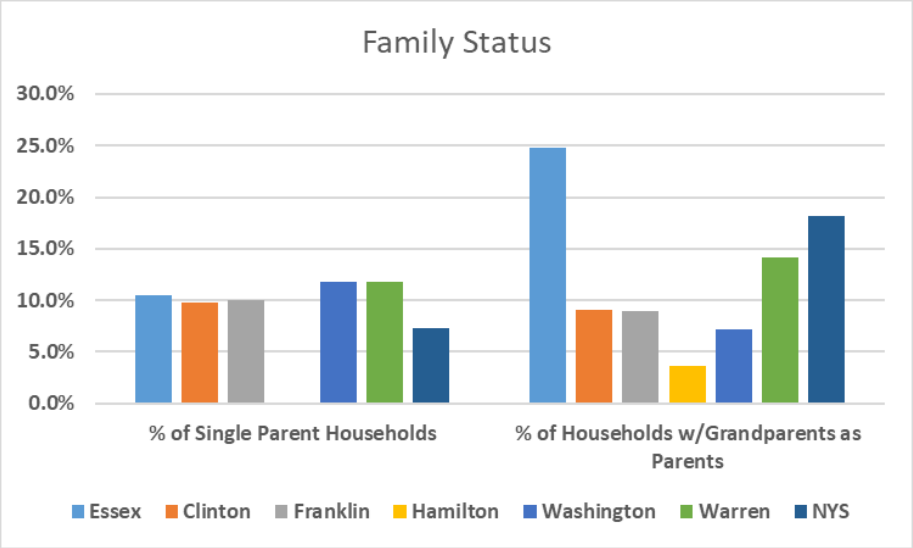


Figure 6: Community Profile Data (42)

Housing

Access to adequate, safe, and affordable housing is a well-known social determinant of health. Essex County residents agreed, identifying affordable housing as a top feature of a healthy community in the 2022 Essex County Community Survey.

A housing data study conducted by the Asterhill Research Company was commissioned by Essex County in 2022. The report "found the county population declining, growing tourism, and seasonal housing increasing" (9). The major conclusion of the report is that there is an unmet demand for affordable housing in Essex County. The number of vacant housing units grew by almost 11% from 2010 to 2020 while the number of seasonal/recreational housing units increased by over 17% in that same time period. Not surprisingly, fewer housing units are occupied in Essex County compared to NYS overall (Figure 7) and *of the units occupied*, more are owner occupied versus renter occupied (Figure 8).

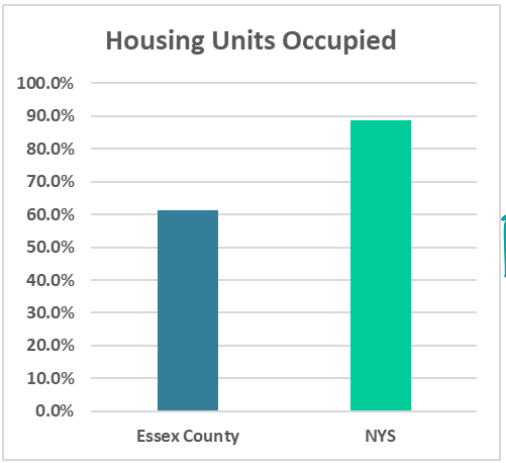


Figure 7: Essex County Housing Units Occupied (9)

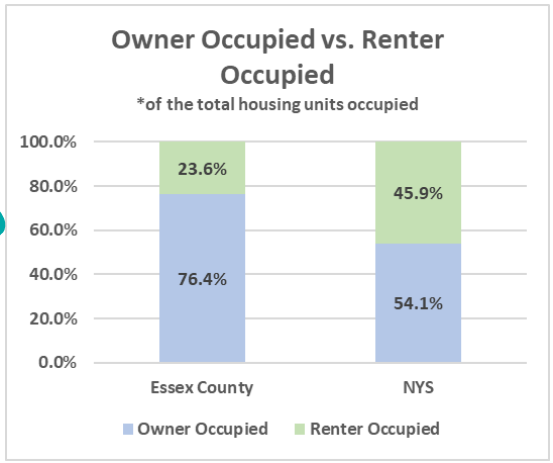


Figure 8: Owner vs. Renter Occupied Housing (9)

In Essex County, 13% of households experienced at least one of the following housing problems: overcrowding, high housing costs, lack of kitchen facilities or lack of plumbing facilities. This is better than the NYS average of 23%. Also, 11% of households in Essex County spent half or more of their income on housing; again, better than 19% overall for NYS (15). A lack of housing availability in general, though has socioeconomic consequences for the county, making it harder to attract businesses and young families to the area.

Rent prices have increased at a more rapid pace than home values in Essex County over the last decade. The cost for larger rental units, able to accommodate a family of 4 or larger, are significantly higher than the median rate.

Essex County - Home Value & Rent Changes			
	2010	2020	Change
Median Home Value	148,100	$160,400	8.3%
Median Rent	$675	$810	20.0%

Table 5: Essex County Housing Costs - Changes Over Time (9)

Transportation

Transportation is closely related to other social determinants of health, including

- access to employment and higher education;
- access to resources to meet daily needs, engage in wellness, and maintain community connections;
- access to health care; and
- costs as a percent of household income.

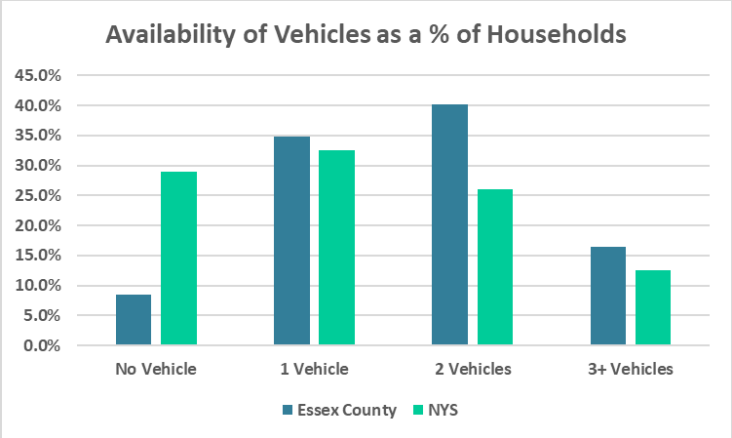


Figure 9: Vehicle Data

The geography of Essex County - rural and sparsely populated - coupled with limited public transportation services, make active transportation and/or foregoing vehicle ownership nearly impossible for most. Essex County households have more personal vehicle access than the average New York household, with far fewer Essex County households not owning any vehicle (Figure 9). An analysis of the total cost of driving in Essex County demonstrates a driving cost budget well above what is considered affordable (Figure 10). This simulation assumes gas at $3.80/gallon, which is on the low end of 2022 prices.

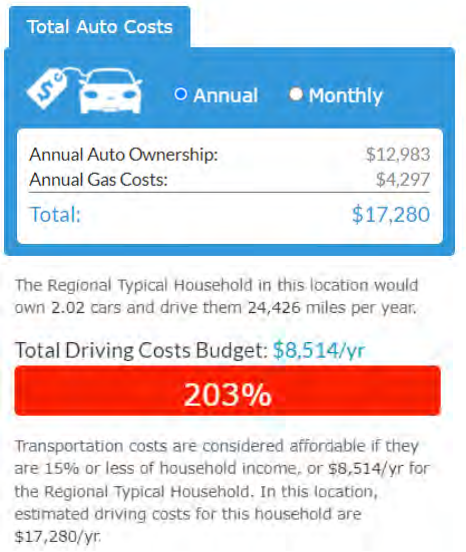


Figure 10: Data from the Housing & Transit Affordability Index (49)

An 2022 initiative to garner feedback from aging residents in Essex County through one-on-one interviews at Senior Nutrition Sites revealed that a lack of transportation is the biggest issue making it harder for aging adults to be healthy here. Over half of interviewees identified transportation as an issue and over a third said that transportation options would help them remain residents of the county.

Public Transit - *Bus and Rail*

The Essex County Transportation Department operates fixed-schedule public transit bus routes within the county and coordinates with inter-county routes to other areas in neighboring counties. With a lack of frequent and fast routes, this service provides limited relief from reliance on personal vehicles to get around. A limited service passenger railway runs North-South along the Lake Champlain corridor; however, service disruptions during the pandemic and the limited number and frequency of routes make this a much less viable option for regular transportation needs.

Poverty and ALICE Households

Residents of impoverished communities often have reduced access to resources that are needed to support a healthy quality of life, such as:

- stable housing
- healthy foods
- safe neighborhoods
- quality education
- employment opportunities

Childhood poverty is associated with:

- developmental delays
- toxic stress
- chronic illness
- nutritional deficits
- cyclical poverty

Adults living in poverty are at a higher risk of:

- obesity,
- smoking
- substance use
- chronic stress
- disability
- mortality (43)

	Two Adults	Two Adults Two Children	Two Adults, Two In Child Care	Two Seniors
Housing	$689	$864	$864	$689
Child Care	$0	$469	$1,292	$0
Food	$554	$924	$807	$472
Transportation	$537	$834	$834	$445
Health Care	$471	$705	$705	$1,078
Technology	$75	$75	$75	$75
Miscellaneous	$278	$442	$537	$322
Taxes	$450	$551	$792	$464
Monthly Total	$3,054	$4,864	$5,906	$3,545
Annual Total	$36,648	$58,368	$70,872	$42,540
Hourly Wage	$18.32	$29.18	$35.44	$21.27

Table 6: Household Survival Budget - Essex County, NY - 2018 (44)

The bare minimum cost of living in the modern economy, as estimated by a Household Survival Budget (Table 6) continues to increase. The Survival Budget does not include savings, making it difficult for families to cover unexpected expenses or contribute to financial investments for the future, such as college or retirement.

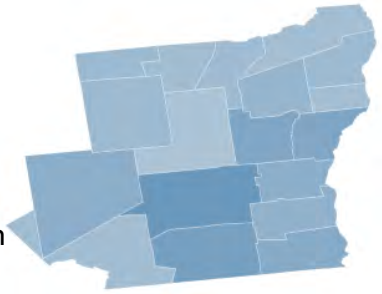
$58,109 Median Household Income - Essex County, 2020 (8)

In 2020, the percentage of individuals living below the Federal Poverty Level was lower in Essex County at 10.1% than NYS at 13.6%. More individuals receive Medicaid in Essex County (27.1%) compared to NYS (25.7%).

ALICE - *Asset Limited, Income Constrained, Employed*

ALICE 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 and ALICE households and are households that are unable to afford the basics (44).

Households in Essex County Living Below ALICE Threshold by Town, 2018



Darkest blue = above 50%

Geographic analysis (map to the right) demonstrates that the greatest percentage of households living BELOW the ALICE threshold are in the towns of North Hudson and Schroon. Further analysis by zip code shows that following percentage of households below ALICE: **Moriah Center** (89%), **Keene Valley** (59%), **North Hudson** (55%), and **Witherbee** (44%). Note: Moriah Center, Keene Valley, and Witherbee are distinct zip codes within larger towns depicted on the map. Moriah Center and Witherbee are within the Town of Moriah. Keene Valley is within the Town of Keene (44).

An analysis of household types by income categories reveals that Essex County residents who are 65 years of age and older are less likely to live in poverty than other Essex County households, but **far more likely** to be an ALICE household (44).

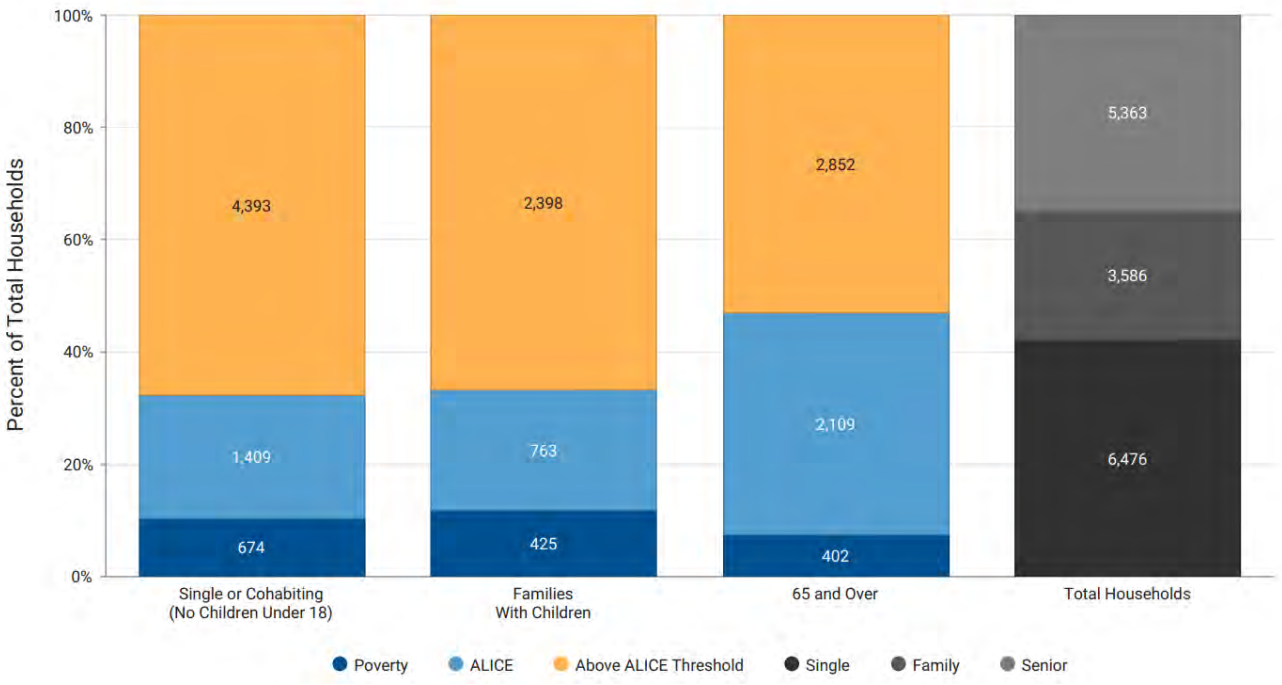


Figure 11: Types of Households That Are Struggling - Essex County, 2018 (44)

Education

Education has been described as the most important modifiable social determinant of health, and has shown to increase healthy behaviors and improve health outcomes across the lifespan.

Adults with higher educational attainment have greater economic resources to support healthy behaviors and those who have attended college report better access to healthcare than those without a college degree. Similarly, early childhood education programs can have profound long-term and far-reaching impacts on health and well-being over a lifespan (46).

Early Education

"While parents remain children's earliest and most important teachers, the significance of early care and education services including center and family-based child care, Early Head Start and Head Start, and Universal Prekindergarten Programs, continues to grow as parents of young children spend more time in the workforce and seek enriching opportunities and care for their children" (47).

	Family Child Care		Group Family Child Care		Center-Based Child Care		Total	
	Programs	Slots	Program	Slots	Programs	Slots	Programs	Slots
2017	29	218	10	154	11	280	46	588
2019	18	144	11	168	11	303	40	615

Table 7: Access to Early Child Care and Education in Essex County (47)

K-12 Education and High School Graduation

Public school enrollment in Essex County has been dropping steadily, from 4,171 in 2010-2011 to 3,423 in the 2020-2021 school year - a decline of almost 18%. Some schools have been more impacted by declining enrollments than others. To address their enrollment challenges, the Elizabethtown-Lewis Central School and Westport Central School Districts merged in 2019, forming the Boquet Valley School District. Currently, the existing school buildings of each former school remain operational, with the school in Elizabethtown named the Mountain View Campus and the school in Westport called Lake View Campus. Each school serves students in grades K-5 in the same manner as before. The Lake View Campus also serves as the middle school for all students grades 6-8 and the Mountain View Campus serves as the high school for all students grades 9-12.

Essex County K-12 Students and Schools

3,423 2020-2021 Enrollment - All Public Schools
10 Total Number of Public School Districts
4 Total Number of Private Schools
3 Total Number of Religious Schools

According to New York State Education Department (NYSED) data (Figure 12), the overall graduation rate for Essex County schools is higher than the NYS graduation rate; however, significant disparities exist. Students who are economically disadvantaged, students with disabilities, and male students all graduate at significantly lower rates in Essex County, following state trends for these sub-populations (48).

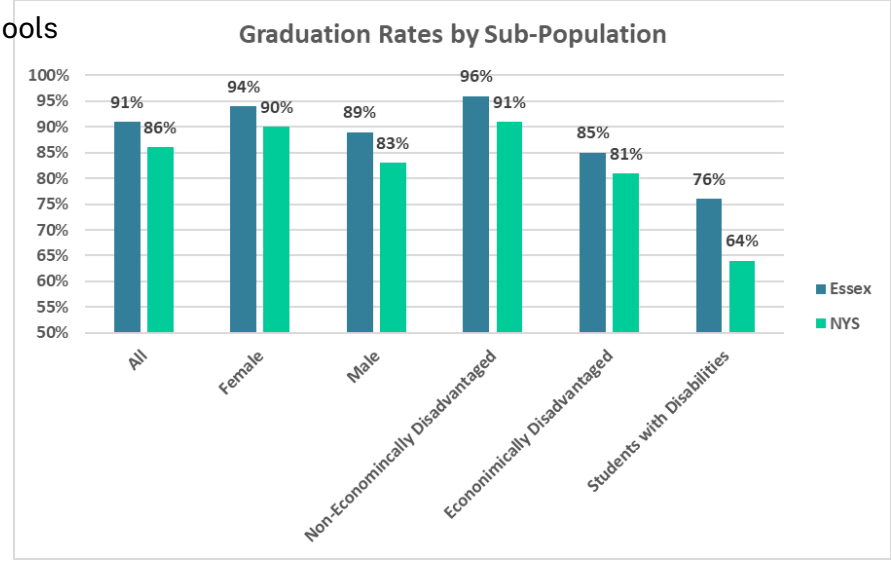


Figure 12: Essex County NYSED Data (48)

2021 Graduation Rates						
Public Districts K-12	**Total # Students**	**All**	**Male**	**Female**	**Non-Economically Disadvantaged**	**Economically Disadvantaged**
Boquet Valley*	414	93%	92%	94%	95%	91%
Crown Point	301	95%	91%	100%	100%	88%
Keene	156	100%	100%	100%	100%	100%
Lake Placid	561	90%	84%	96%	97%	73%
Minerva**	106	89%	-	-	-	-
Moriah	670	84%	76%	90%	94%	67%
Newcomb**	72	100%	-	-	-	-
Schroon Lake	201	100%	100%	100%	100%	100%
Ticondergoa	709	91%	86%	96%	92%	89%
Willsboro**	233	89%	-	-	100%	82%

Table 8: Essex County District Level NYSED Data (48)

Graduation rate disparities also exist from district to district, as highlighted in Table 8.

*Boquet Valley is a merged school district, comprised of two campuses - Mountain View & Lake View.

**Graduation rates unavailable for certain categories based on school size.

Higher Educational Attainment

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 Science and Forestry, located in St. Lawrence County has a campus in southern Essex County.

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 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.

Essex County residents compare better than the state for residents ages 25 years and older with less than a high school education, high school education/GED completion, some college course work, and Associate's Degree attainment. Fewer residents in Essex County complete Bachelor's and graduate or professional level degrees when compared with state attainment levels - see Figure 13.

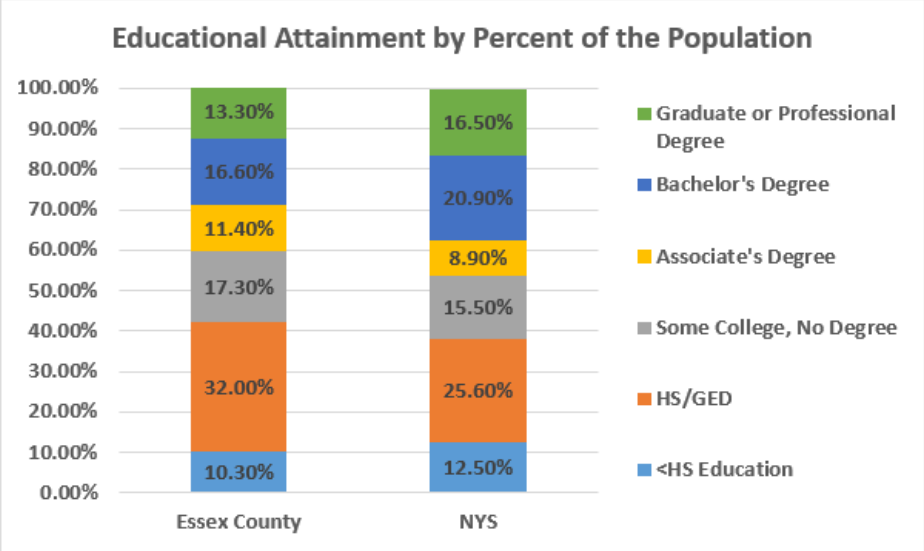


Figure 13: Essex County Educational Attainment Compared with NYS (42).

Political Affiliations and Governance

Politically, Essex County is a swing county. In the 2020 presidential election, the popular vote went to Joseph R. Biden Jr. with 51.1% of the vote. The runner-up was Donald J. Trump, getting 46.1% of the vote (10). The majority vote went to Donald J. Trump in 2016, Barrack Obama in 2012 and 2008, and George W. Bush in 2004 and 2000 (see Figure 14). Prior to 1996 though, Essex County was solidly Republican, voting for a Democratic Presidential candidate only once since the Civil War. Of the 26,501 registered voters in the county, 7,939 are Democrat, 10,969 are Republican, and 7,593 make up all other categories (11).

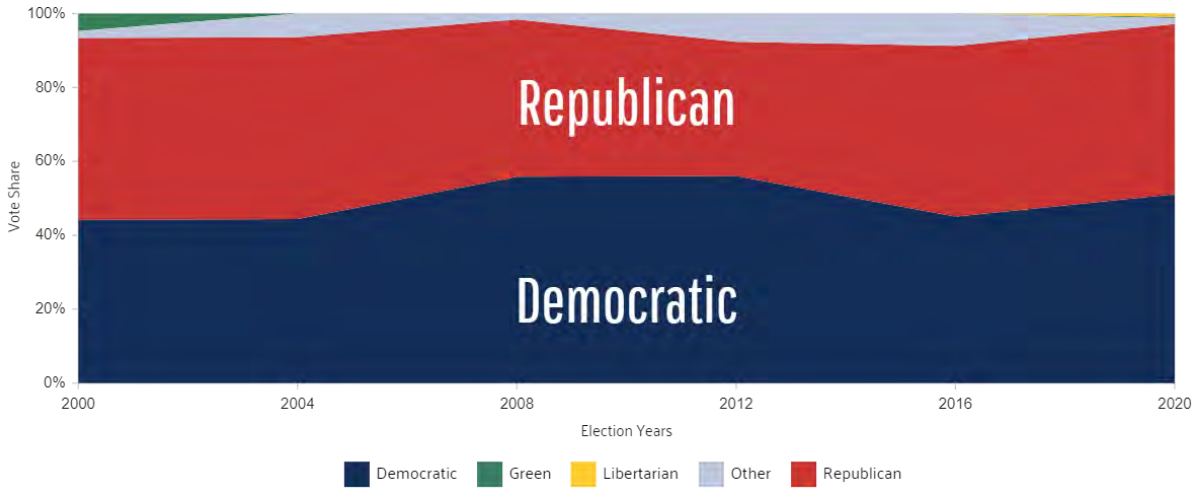


Figure 14: Essex County Vote Share 2000-2020 (10)

Essex County is governed by a Board of Supervisors, with 18 Town Supervisors serving as board members. The current (2022) board is comprised of 10 Republicans, 5 Democrats, 2 unaffiliated members, and 1 Independent (12).

This political profile - Republican majority - is in contrast to the current New York State government, where the governorship, House Assembly and Senate are all controlled by the Democratic Party.

The political climate can have a significant impact on public health and on community sentiment toward advancing public health strategies and interventions at the local level and beyond. Essex County residents have enjoyed a strong leadership commitment to health initiatives overall, demonstrated through lawmaker support of various initiatives and through a balanced and reasoned approach to COVID-19 Pandemic response efforts.

In Essex County, the Board of Supervisors also serves as the Board of Health, with all of the same powers and duties conferred to county boards of health per Article 3, Title 3 of NYS Public Health Law (13).

Impacts of political polarization

"A majority (57%) of U.S. adults say false and misleading information about the coronavirus and vaccines has contributed a lot to problems the country has faced dealing with the outbreak. A similar share of Americans (54%) say disagreement between Democrats and Republicans about how to handle the outbreak has contributed a lot."

Pew Research Center Study

Broadband Access

In terms of economic outcomes, broadband delivers benefits to both individuals and communities. Broadband makes it easier for job seekers to search for jobs, apply for them, and to keep looking for longer. In turn, businesses reap benefits from e-recruiting, which makes it less expensive to access a larger pool of candidates. And having a digitally fluent workforce brings productivity gains to firms, who can then reward employees with higher wages. Taking a macro lens, other researchers have found that higher levels of broadband adoption lead to economic growth, higher incomes, and lower unemployment.

Broadband also plays an important role in improving social outcomes. Broadband democratizes access to education, offering a wide supply of free and open education platforms, courses, and resources. It can also help people foster social supports and stay in contact with a broader social network. For traditionally marginalized groups who are prone to social isolation, access to the internet allows them to connect to others anonymously. Though education and social support both have indirect health benefits, telehealth — the use of telecommunications to deliver health services and education — can directly improve health outcomes, especially for those who otherwise lack access to medical providers. (40)

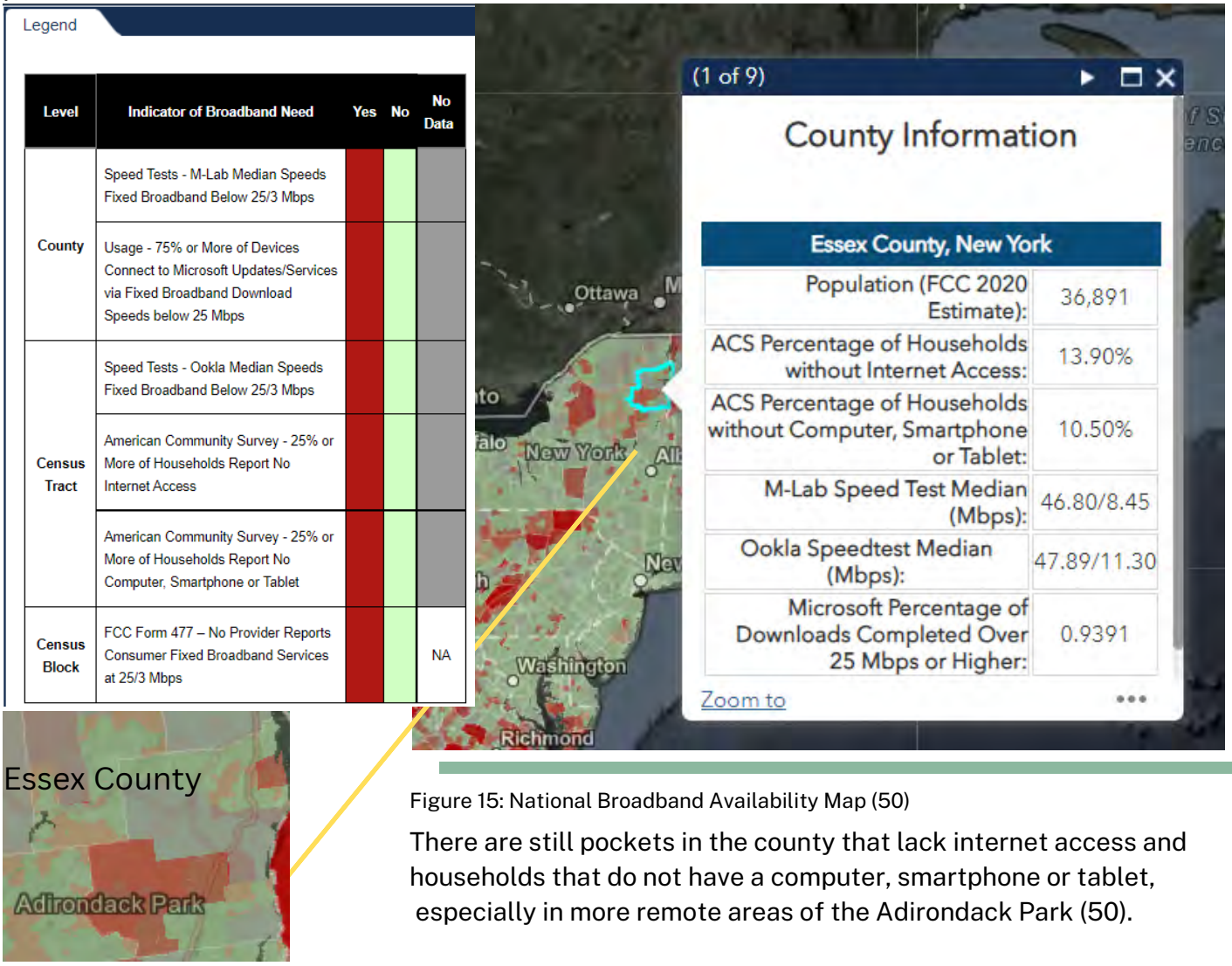


Figure 15: National Broadband Availability Map (50)

There are still pockets in the county that lack internet access and households that do not have a computer, smartphone or tablet, especially in more remote areas of the Adirondack Park (50).

Health

What does the community say about health needs in Essex County?

Essex County Health Partners led a local effort to conduct a Community Survey in 2022. The purpose of the survey was to engage a wide variety of community members in sharing their perspectives about community health and the factors that contribute to the overall health of communities, families, and individuals in Essex County. The survey was launched in the first quarter of 2022 via the platform Survey Monkey and was primarily promoted on the Essex County Health Department Facebook page and website (see examples below); though paper copies were available at every community library in Essex County. The target audience was Essex County residents ages 18 and older. The survey was designed at a 7th grade reading level and took an average of 10 minutes to complete. A total of 485 responses were collected and analyzed by the Essex County Health Department and are included throughout the Community Health Assessment. A survey summary was also made available on the ECHD Facebook and web pages (see next page), allowing residents to review their responses and provide additional feedback, if desired. Refer to Appendix (4) for the full survey results.

What does a healthy community look like to you? Your opinions matter!

What are the top health challenges for you and your family? Your opinions matter!

In our previous Community Survey, residents told us that lack of dental/vision insurance was one of the Top 5 reasons they could not access needed healthcare in the past year.

Have you had trouble getting healthcare in Essex County? Tell us about it!

What factors are most important for a healthy, vibrant community?

This summary was shared publicly on the ECHD Facebook page and website:

2022 Community Survey Summary

HEALTH DEPARTMENT

485 responses received!

YOU TOLD US:

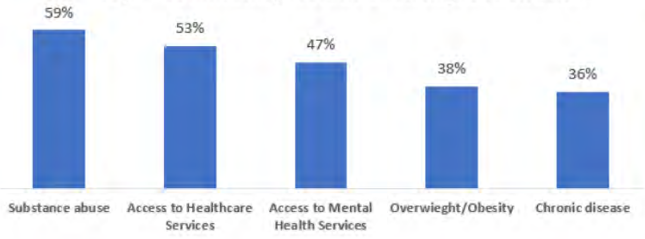
"Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

Residents overwhelmingly (75% of 485 responses) selected this definition of health. Four other definitions of health were each selected by about 5 - 7% of residents.

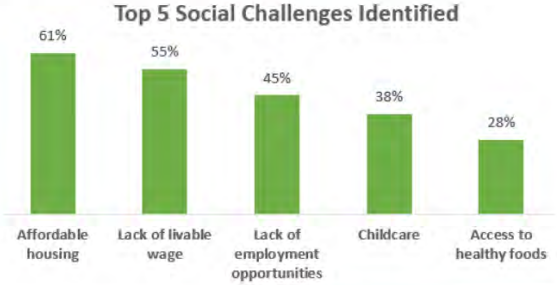
The top 5 features of a healthy community are:

Affordable housing | **Clean Environment** | **Access to Healthcare** | **Good Schools** | **Livable Wages**

Top 5 Community Health Challenges Identified



Top 5 Social Challenges Identified



Health challenges faced by you or family member:

- Issues related to aging
- Chronic disease
- Access to dental care
- Overweight/obesity
- Access to healthcare

Social challenges faced by you or family member:

- Lack of a livable wage
- Affordable housing
- Lack of employment
- Access to healthy food
- Lack of resources for seniors

Reasons you or family member could not get medical care when needed:

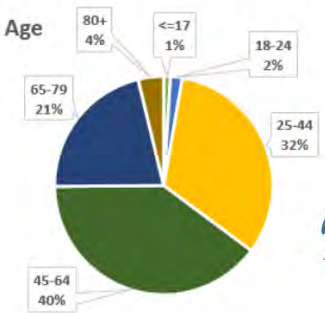
- No specialist locally
- No appointment w/specialist)
- No appointment w/primary
- Did not have insurance
- Copay/deductible too high

Cancer services lacking in Essex County:

- Stress & anxiety resources
- Timely specialty care
- Affordable in-home services
- Access to alternative medicine
- Access to clinical trials

-Answers selected most often by survey respondents-

About our survey respondents:



Gender
Female - 81%
Male - 15%
Non-Binary - 1%
Prefer not to answer/Other - 3%

30% of respondents stated that the COVID-19 pandemic **negatively** impacted their employment status.

% Responses Received by Town (of 485 total)

Chesterfield	5%	Newcomb	1%
Crown Point	4%	North Elba	10%
Elizabethtown	7%	North Hudson	1%
Essex	4%	St. Armand	1%
Jay	12%	Schroon	6%
Keene	7%	Ticonderoga	10%
Lewis	3%	Westport	5%
Minerva	2%	Willsboro	8%
Moriah	8%	Wilmington	6%

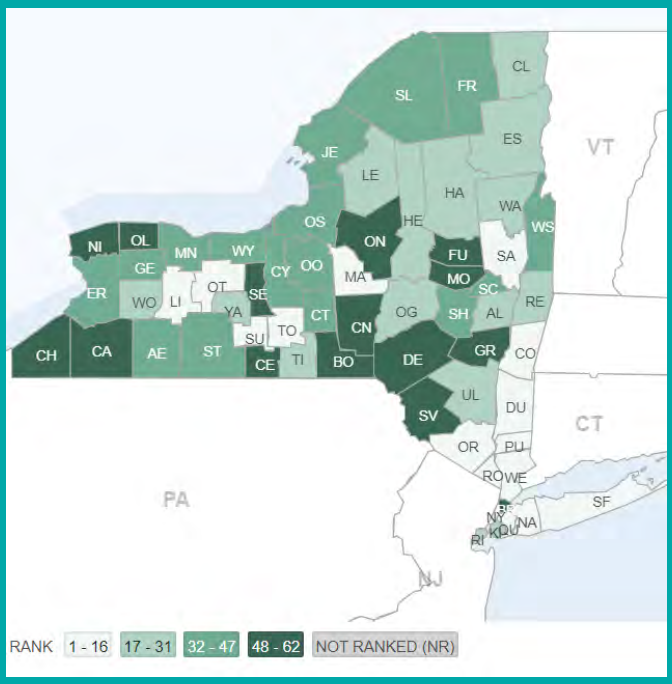


Figure 16: Rankings Map *Note: 1 is best; 62 is worst

2022 County Health Rankings (15)

Essex County ranks:

19th in Health Outcomes

13th in Contributing Factors

Standardized measures based on numerous indicators demonstrate that Essex County residents enjoy better health outcomes than most other peer residents across the state.

Ranking status has trended more negatively since the 2019 Community Health Assessment, where Essex County ranked 10th in overall Health Outcomes and 13th for Contributing Factors.

By ranking the health of nearly every county in the nation, the County Health Rankings (a project of the University of Wisconsin's Population Health Institute and the Robert Wood Johnson Foundation) help communities (1) understand what influences the health of residents and (2) identify challenges and opportunities to improve these outcomes for all. The Rankings are guided by a model of population health that emphasizes the many social, economic, physical, clinical, and other factors that influence both how long and how well we live. They help communities understand the critical influence that education, jobs, income, environment, and more have on individual health and illuminate areas of need for focusing improvement efforts. Following in Table 9 are select indicator comparisons, providing a quick snapshot of overall health and the factors that influence it in Essex County. More in-depth analyses are included later in this report.

HEALTH OUTCOMES

INDICATOR	Essex County Trend	Essex County Previous (2020)	Essex County Previous (2021)	Essex County Current (2022)	Essex County Compared to NYS	NYS Value (2022)
Premature death *(years of potential life lost before age 75 per 100,000 pop.)*	▲	5,300	5,700	6,200	●	6,000
Life expectancy *(age)*	▼	80.8	80.2	79.7	●	80.3
Babies with low birthweight *(%)*	▼	8	8	7	●	8
Frequent physical distress *(%)*	*	10	12	12	●	11
Frequent mental distress *(%)*	*	11	13	14	●	12

**This indicator should not be compared to data from prior years*

Table 9: Population Health Trends in Essex County (15)

CONTRIBUTING FACTORS

INDICATOR	Essex County Trend	Essex County Previous (2020)	Essex County Previous (2021)	Essex County Current (2022)	Essex County Compared to NYS	NYS Value (2022)
BEHAVIORS						
Adult smoking (%)	*	14	19	18	🔴	13
Adult obesity (%)	*	29	30	31	🔴	27
Excessive drinking (%)	*	20	21	24	🔴	19
Teen births *(Number of births per 1,000 female population ages 15-19)*	🟨	18	16	16	🔴	13
CLINICAL CARE						
Uninsured (%)	🟨	5	4	5	🟢	6
Primary Care Providers (ratio)	🔺	2,370:1	2,660:1	2,630:1	🔴	1,180:1
Dentists (ratio)	🟨	3,110:1	3,070:1	3,070:1	🔴	1,190:1
Mental Health Providers (ratio)	🟨	640:1	600:1	600:1	🔴	310:1
SOCIO-ECONOMIC FACTORS						
Unemployment (%)	🔺	4.9	4.7	8.1	🟢	10.0
Children in poverty (%)	🔻	16	17	15	🟢	17
High school completion (%)	🔻	91	91	90	🟢	87
Some college (%) *(% of adults ages 25-44 with some post-secondary education)*	🔻	58	56	56	🔴	70
Violent crime *(Number of reported violent crime offenses per 100,000 population)*	🟨	167	167	167	🟢	379

This indicator should not be compared to data from prior years

Table 9 (cont'd): Population Health Trends in Essex County (15)

Leading Causes of Death in Essex County (16)

The leading causes of death in Essex County are consistently associated with chronic diseases. Four of the five leading causes in 2016, 2017, and 2018 were a result of chronic disease. In 2019 (latest year data is available), all five leading causes of death were due to chronic disease.

	1	2	3	4	5
2019	**Cancer**	**Heart Disease**	**Cerebrovascular Disease**	**Chronic Lower Respiratory Disease**	**Diabetes**
2018	Cancer	Heart Disease	Chronic Lower Respiratory Diseases	Unintentional Injury	Diabetes
2017	Heart Disease	Cancer	Chronic Lower Respiratory Diseases	Unintentional Injury	Alzheimer's Disease
2016	Cancer	Heart Disease	Chronic Lower Respiratory Diseases	Unintentional Injury	Diabetes

Table 10: Leading Causes of Death - Essex County, 2016-2019 (16)

Health Systems Profile

There is one hospital in Essex County - the University of Vermont Health Network-Elizabethtown Community Hospital (UVMHN-ECH). This hospital is considered a critical access facility, with 25 inpatient beds in Elizabethtown and a 24-hour emergency department and outpatient center in Ticonderoga. There is another limited service emergency department located in the county - Adirondack Health's Lake Placid Emergency Department.

Residents have improving access to primary care, with health centers located in many towns throughout the county.

UVMHN-ECH Health Centers
- Ausable Forks
- Crown Point
- Elizabethtown
- Willlsboro
- Wilmington
- Westport

Hudson Headwaters Health Network Health Centers
- Moriah
- Schroon
- Ticonderoga

Adirondack Health Health Centers
- Keene
- Lake Placid

*More health access information is included in the next section.

PRIORITY HEALTH ISSUE

Prevent Chronic Disease

Step 4: Collect & analyze data

What's the issue?

Chronic diseases such as cancer, diabetes, heart disease, stroke, asthma and arthritis are among the leading causes of death, disability and rising health care costs in New York State (NYS). However, chronic diseases are also among the most preventable. Three modifiable risk behaviors - unhealthy eating, lack of physical activity, and tobacco use - are largely responsible for the incidence, severity and adverse outcomes of chronic disease. As such, improving nutrition and food security, increasing physical activity, and preventing tobacco use form the core of the Preventing Chronic Diseases Action Plan from NYSDOH's 2019-2024 Prevention Agenda (1). The first data section below will cover the following Focus Areas:

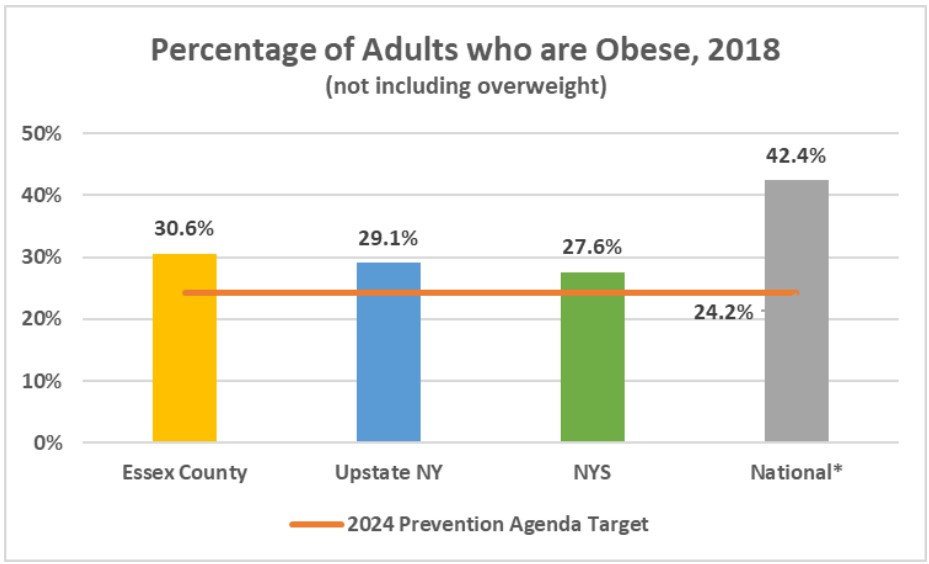
Focus Area 1. Healthy Eating and Food Security
Focus Area 2. Physical Activity

What does the data show in Essex County?

*Note: Health indicator data, unless otherwise specified is sourced from the NYSDOH Prevention Agenda Dashboard/ARHN Essex County Health Indicator Data Sheets (17) and or the Community Health Planning Data source pages at: https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/sources.htm .

Healthy Eating and Food Security

Healthy eating and food security are often measured and discussed in the context of obesity and overweight outcomes. Adult obesity, although lower than the previous assessment, has not significantly decreased in Essex County according to the most recent data available. Still, any decrease is a welcome development, given the complexities of addressing obesity and all of the underlying individual and societal factors that influence weight. The adult obesity rate, at 30.6%, remains higher than upstate and NYS comparisons and is still significantly higher than the 2024 Prevention Agenda target of 24.2%.



14.9% of elementary students are obese in Essex County

By middle and high school, almost 1 out of every 3 students is obese in Essex County

Almost 30% of adults consume at least 1 sugar sweetened beverage daily

1 in 3 adults consume no fruits or vegetables daily

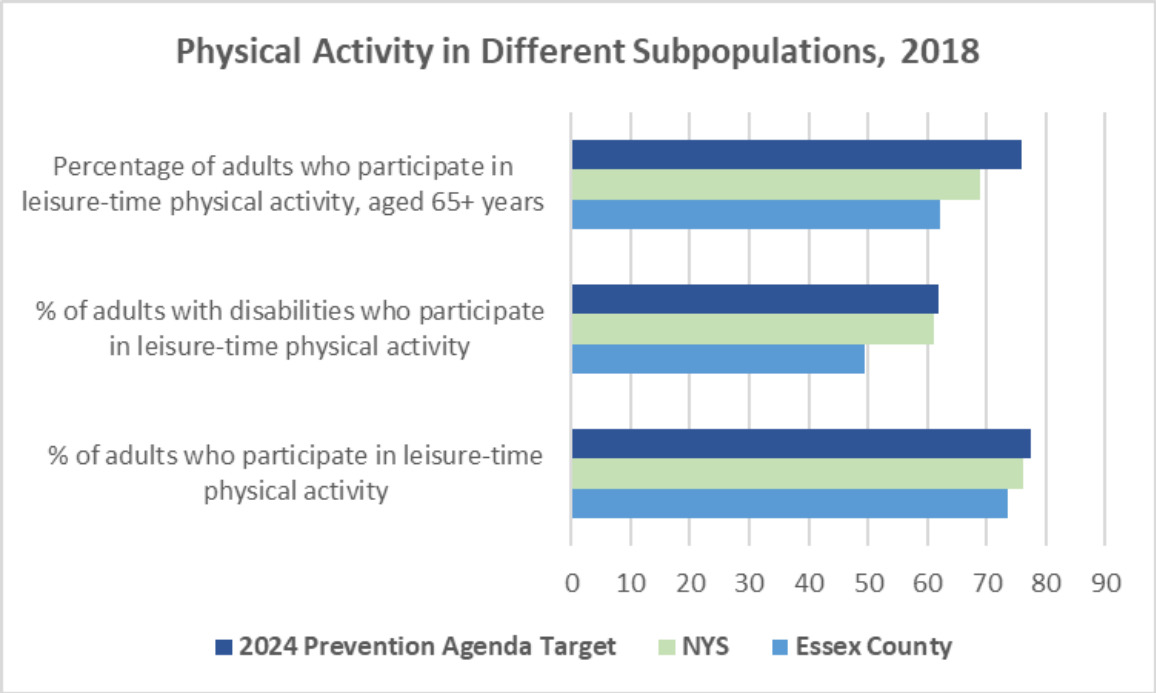
32%

Physical Activity

Decreased physical activity has been related to several disease conditions such as type 2 diabetes, cancer, stroke, hypertension, cardiovascular disease, and premature mortality, independent of obesity. Physical inactivity at the county level is related to health care expenditures for circulatory system diseases (15).

Essex County does not meet 2024 Prevention Agenda Targets for the percentage of adults (overall, age 65+ and those with disabilities) participating in leisure time physical activity (17). Because chronic diseases account for all five of Essex County's top five leading causes of death, the discrepancy in leisure time fitness rates in older adults and/or those with a disability are especially concerning.

Physical activity improves sleep, cognitive ability, and bone and musculoskeletal health, as well as reduces risks of dementia. Physical inactivity is not only associated with individual behavior but also community conditions such as expenditures on recreational activities, access to infrastructure, and poverty (15).



Evidence of Impact in Essex County

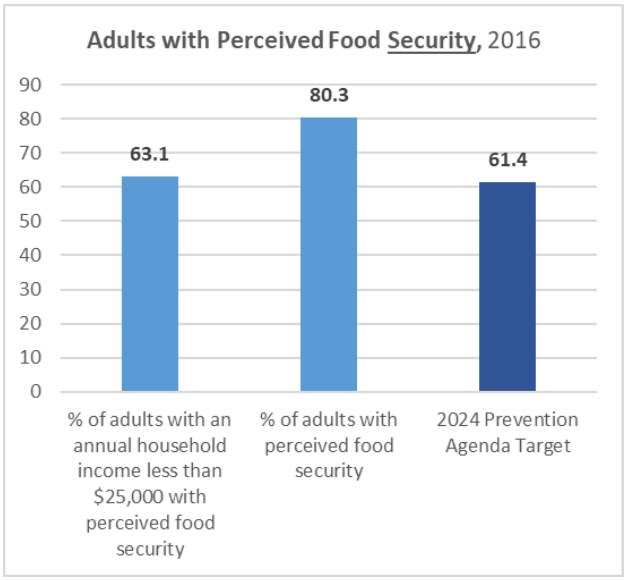
Healthy eating, food security and physical activity are important factors contributing to rates of chronic disease. In Essex County, higher rates of obesity and inactivity correlate closely with our poorer health outcomes for cardiovascular disease, stroke, and diabetes (17).

The **death** rates (2018) for **cardiovascular disease**, **stroke**, and **diabetes** are ALL **higher** in **Essex County** than rates in the North County region or NYS.

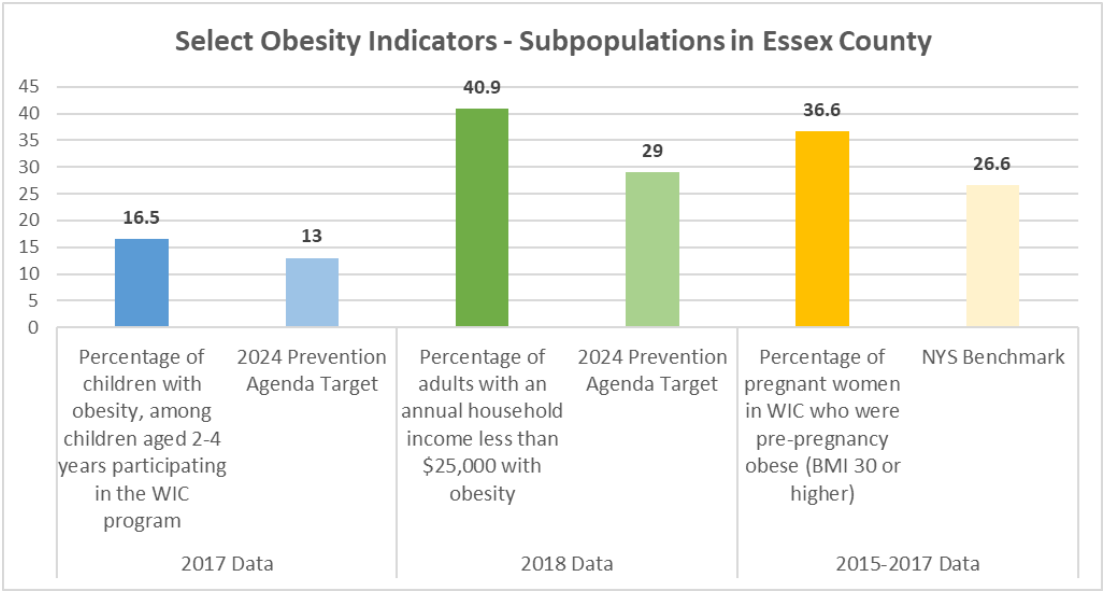
12.6%
of adults have diabetes, 2018

In-depth analysis

Obesity data is available for select subpopulations in Essex County, demonstrating that obesity and related food security and access issues impact populations with lower incomes at a greater rate (17).



Research shows that living in a food desert (an area with limited access to affordable and nutritious food) **or** living in a food swamp (an area where fast food and junk food is more available than healthy food) are both predictors of obesity. Essex County has characteristics of both, with many areas having limited access to larger grocery stores and supermarkets but greater access to convenience stores, dollar stores, and gas station markets - which typically stock mostly processed foods that less healthy (18).



Strategies that focus on improving food environments, early prevention, and addressing the social determinants that make it harder to eat healthfully offer the greatest potential for improvement.

What does the community say?

2022 Stakeholder Survey

Essex County Stakeholders said **diabetes** was a top health concern

Regional Stakeholders said **overweight / obesity** was a top health concern

2022 Community Survey Result Snapshot

Overweight/obesity and **Chronic disease** were identified as **two** of the **top 5 health challenges** in Essex County according to residents.

Substance abuse, access to healthcare, and access to mental health services were also selected.

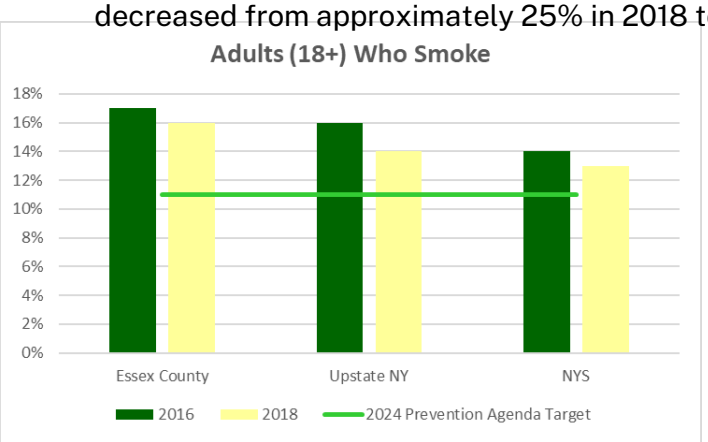
What does the data show in Essex County?

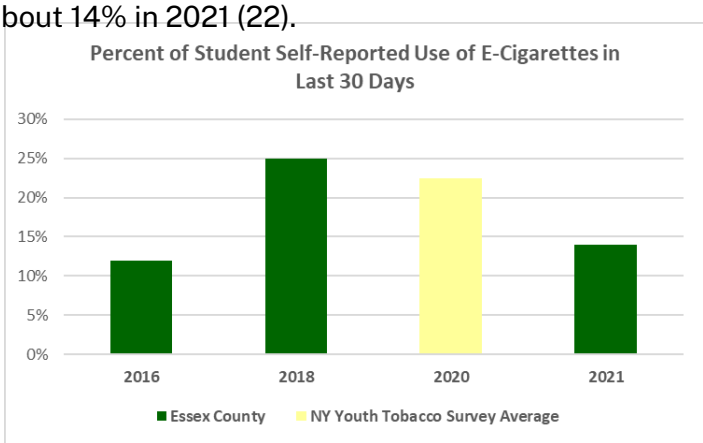
Tobacco Prevention

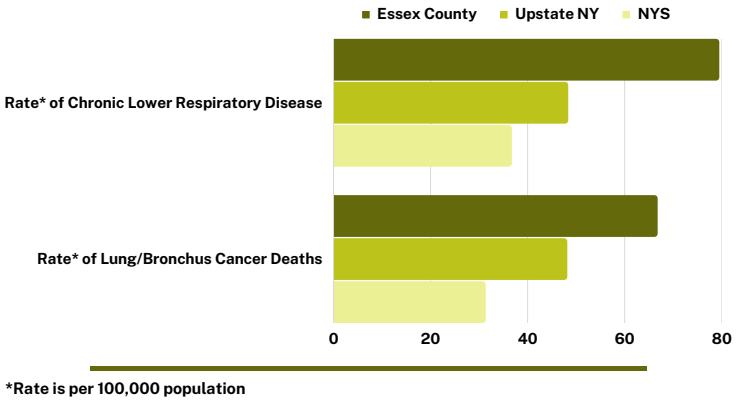
Cigarette smoking is identified as a cause of various cancers, cardiovascular disease, and respiratory conditions, as well as low birthweight and other adverse health outcomes. Measuring the prevalence of tobacco use in the population can alert communities to potential adverse health outcomes and can be valuable for assessing the need for cessation programs and the effectiveness of existing tobacco control programs (15).

Cigarette smoking rates among adults have been trending down throughout NYS over the past several years. The smoking rate in Essex County, though also trending down, is higher than Upstate and NYS averages, and all 3 are higher than the 2024 Prevention Agenda Target of 11% (17).

After staggering increases in youth tobacco use between 2014 and 2018, primarily driven by electronic cigarettes (also referred to as e-cigarettes, Electronic Nicotine Delivery Systems or ENDS), new data from the NY Youth Tobacco Survey (NY-YTS) indicate that tobacco use among high school age youth has declined across all product categories, including e-cigarette use (20). In Essex County, this same trend bore out as evidenced in the local 2021 New York Prevention Needs Assessment Survey. Self-reports of lifetime e-cigarette use in all grades (7-12) decreased from approximately 25% in 2018 to about 14% in 2021 (22).







*Rate is per 100,000 population

Chronic lower respiratory disease (CLRD) is a group of conditions that affect the lungs, such as chronic obstructive pulmonary disease, asthma, pulmonary hypertension, and occupational lung diseases. CLRD is a leading cause of death in Essex County (16).

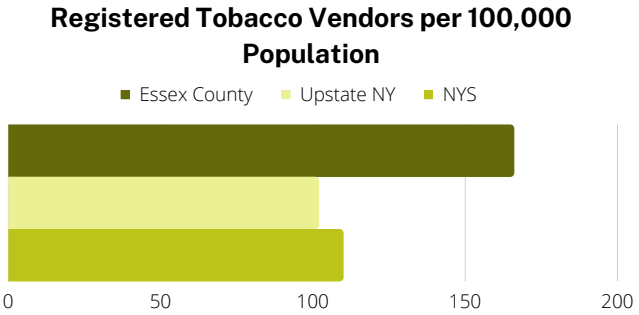
CLRD and lung and bronchus cancer deaths are higher in Essex County than Upstate and NYS rates and correlate with our higher smoking rates (17). Smoking is the greatest risk factor for these types of diseases.

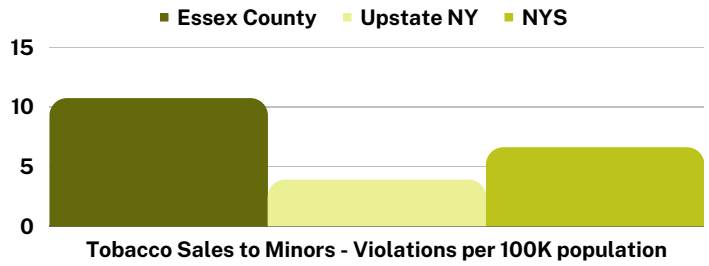
In-depth analysis

Access

In the general population, living in a community with a higher density of tobacco retailers is linked to higher smoking prevalence and a lower likelihood of smoking cessation (19). Higher tobacco retail outlet density is associated with greater levels of youth experimentation with tobacco, youth smoking, and adult smoking, even when controlling for neighborhood factors such as land use, racial composition, and poverty. Tobacco retail outlet density is often highest in neighborhoods with residents with low incomes, neighborhoods with primarily minority residents, particularly black or Hispanic residents, and high poverty, urban areas (15).

Essex County has significantly more tobacco vendors and significantly more tobacco sales violations per 100,000 population than regional or NYS averages.

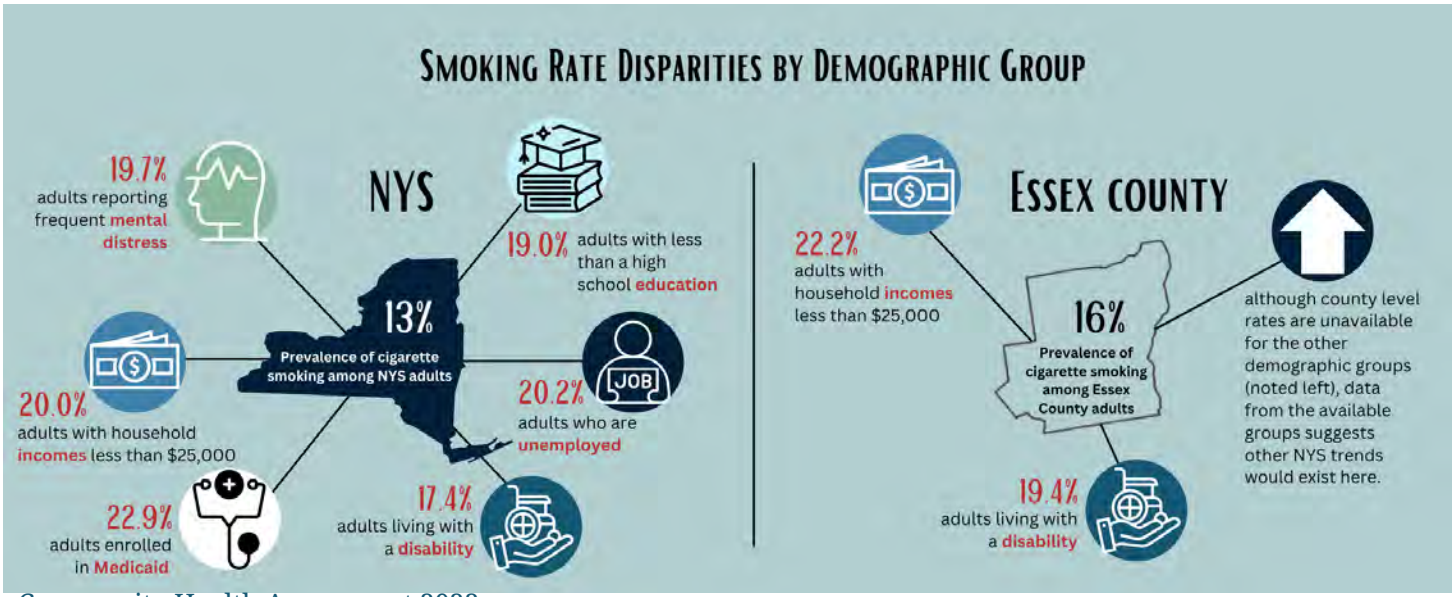




Disparities

Statewide, smoking rates remain highest among adults enrolled in Medicaid; adults who are unemployed; adults with an annual household income of less than $25,000; adults reporting frequent mental distress; adults with less than a high school education; and adults living with disability (20).

Data available for Essex County shows that smoking rates are higher for adults with annual household incomes of less than $25,000 and for adults living with a disability than state rates.

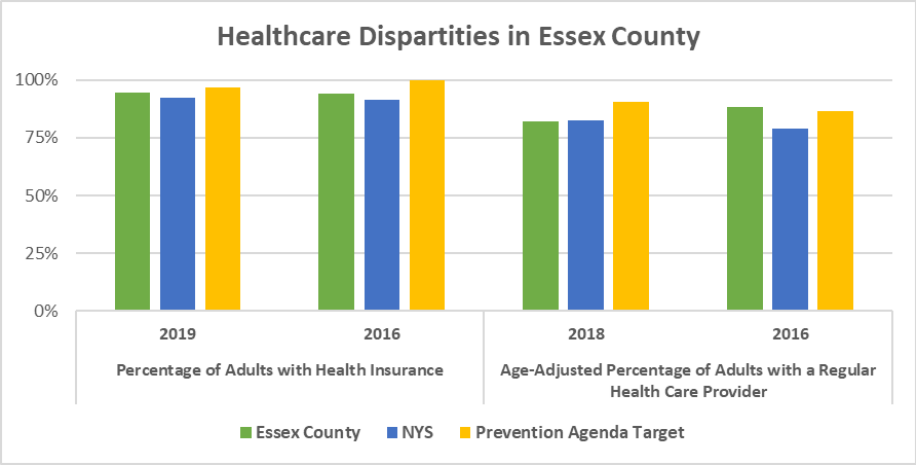


What does the data show in Essex County?

Access to Care

Access to affordable, quality health care is important to physical, social, and mental health. Health insurance helps individuals and families access needed primary care, specialists, and emergency care, but does not ensure access on its own—it is also necessary for providers to offer affordable care, be available to treat patients, and be in relatively close proximity to patients.

The uninsured are much less likely to have primary care providers than the insured; they also receive less preventive care, dental care, chronic disease management, and behavioral health counseling. Those without insurance are often diagnosed at later, less treatable disease stages than those with insurance and, overall, have worse health outcomes, lower quality of life, and higher mortality rates. However, insurance by itself does not remove all barriers in access to care. Out-of-pocket costs (e.g. co-insurance, co-pays, deductibles) for those with insurance can present barriers to accessing care. Language barriers, distance to care, and racial disparities in treatment present further barriers to care (15).



The ratio of population to primary care providers is:

2,630:1 in Essex County **1180:1** in New York State

The ratio of population to dentists is:

3,070:1 in Essex County **1190:1** in New York State

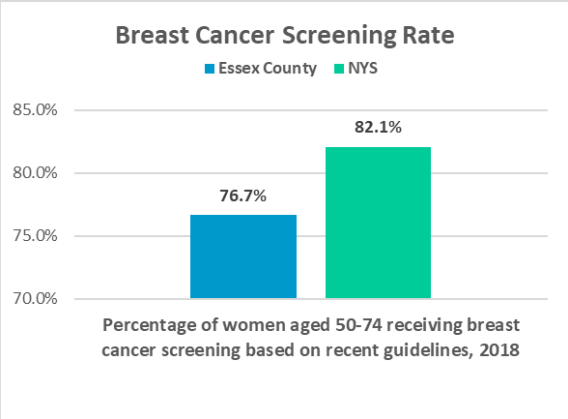
In Essex County, health insurance coverage rates increased slightly, from 94% in 2016 to 94.4% in 2018; however, the percentage of adults with a regular healthcare provider decreased by over 7% in that same time frame, from 88.5% to 82.2%. Both metrics are below 2024 Prevention Agenda Targets.

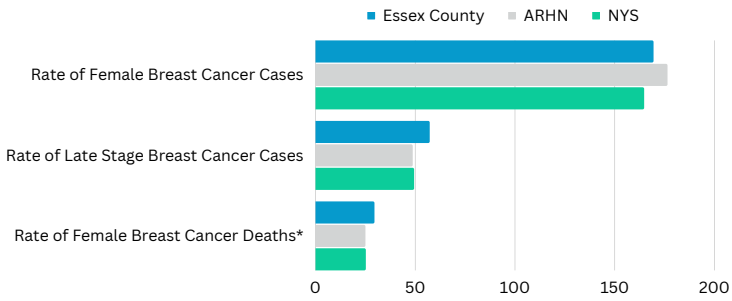
The ratio of population to providers is higher in Essex County than NYS ratios for both primary care and dentists. Sufficient availability of primary care physicians is essential for preventive and primary care, and, when needed, referrals to appropriate specialty care. Untreated dental disease can lead to serious health effects including pain, infection, and tooth loss. Although lack of sufficient providers is only one barrier to accessing oral health care, it is common in many rural areas.

In-depth analysis

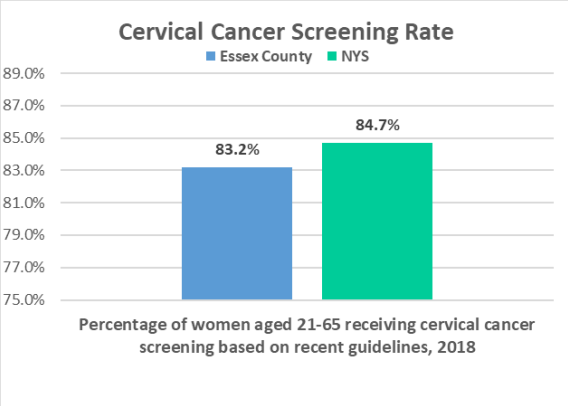
Access Challenges - Impacts & Outcomes

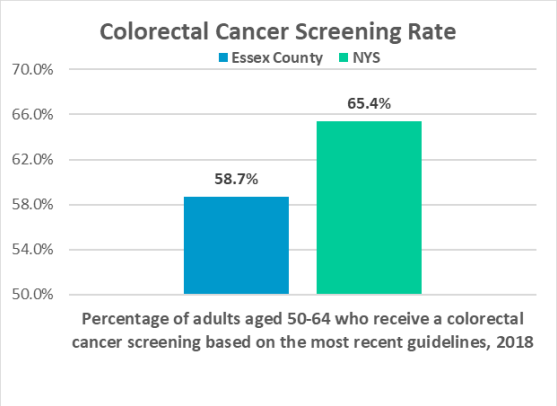
A physician's recommendation or referral – as well as satisfaction with physicians – are major factors facilitating on-time cancer screenings (15). Although the overall rate of female breast cancer cases is lower in Essex County than the rate of the ARHN region, the rate of late stage breast cancer cases and breast cancer deaths are both higher than regional and NYS rates.

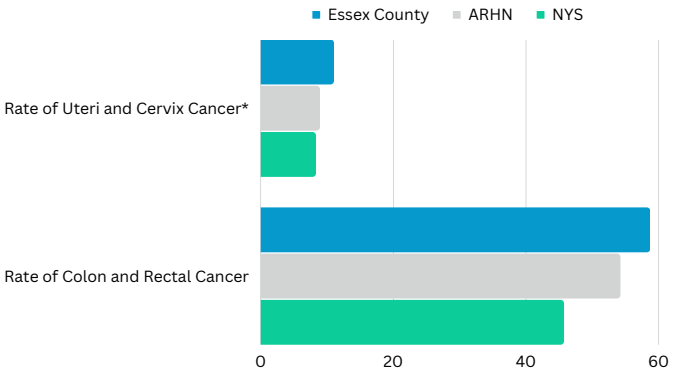




*Rate is unstable; fewer than 10 or 20 incidences in the numerator







*Rate is unstable; fewer than 10 or 20 incidences in the numerator

Screening rates for cervical and colorectal cancer are lower in Essex County when compared to NYS rates. The rates of uterine/cervical cancers and colon/rectal cancers are higher than both regional and state averages. Access to timely and guideline concordant care might be factors influencing these outcomes in Essex County.

Note: All rates expressed as a number rather than a % above are per 100,000 population

What does the community say?

Access to healthcare services is one of the Top 5 most important features of a strong, vibrant, healthy community AND is also one of the Top 5 health challenges in your community.

Access to healthcare and dental services are also top health challenges faced by you or a family member.

2022 Community Survey Results

Reasons you or family member could not get medical care when needed:

- No specialist locally
- No appointment w/specialist)
- No appointment w/primary
- Did not have insurance
- Copay/deductible too high

Cancer services lacking in Essex County:

- Stress & anxiety resources
- Timely specialty care
- Affordable in-home services
- Access to alternative medicine
- Access to clinical trials

Conclusions

Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States. They are also leading drivers of the nation's $4.1 trillion in annual health care costs (19). Essex County mirrors these national trends, with chronic diseases accounting for all five of the top five leading causes of death in the county.

Many chronic diseases are caused by a short list of risk behaviors: poor nutrition, including diets low in fruits and vegetables and high in sodium and saturated fats; physical inactivity; and tobacco use and exposure to secondhand smoke (19). Access to healthcare; more specifically, access to chronic disease preventive care and management, and the varied and diverse factors that impact this access, also contribute to chronic disease health outcomes.

Essex County has made progress in addressing chronic disease. Overweight/obesity rates have ticked down for the first time in years; adult smoking rates continue to decline; and Essex County was at the forefront of the push to move the minimum age to purchase tobacco products from 18 to 21. E-cigarettes and vaping threaten this progress and continued surveillance of all tobacco product use among youth is important, especially to monitor the use of emergent products in this population.

Previous analyses of the healthcare system in Essex County have demonstrated that it is "right-sized" for the population; however, challenges like transportation, distances between providers, and health insurance coverage affect healthcare access and utilization (22).

While Preventing Chronic Disease was not identified as a top priority area in the 2022 Stakeholder Survey, careful review of the data and health indicators available; assets and programs ready for mobilization; and consideration of community input, led the Essex County Health Partners to again prioritize this issue for the 2022-2024 Community Health Improvement Plan. Refer to the section of this report covering Step 5 *Prioritize Community Health Issues* for a more detailed explanation of the prioritization process.

PRIORITY HEALTH ISSUE

Promote Well Being and Prevent Mental Health & Substance Use Disorders

What's the issue?

Mental and emotional well-being is essential to overall health. At any given time, almost one in five young people nationally are affected by mental, emotional and behavioral (MEB) disorders, including conduct disorders, depression and substance abuse. Adverse Childhood Experiences and many MEB disorders, such as substance abuse and depression, have lifelong effects that include high psychosocial and economic costs for people, their families, schools and communities (1). Mental and physical health problems are interwoven. Improvements in mental health help improve individuals and populations' physical health. The data sections below will cover the following Focus Areas:

Focus Area 1. Promote Well-Being
Focus Area 2. Prevent Mental & Substance Use Disorders

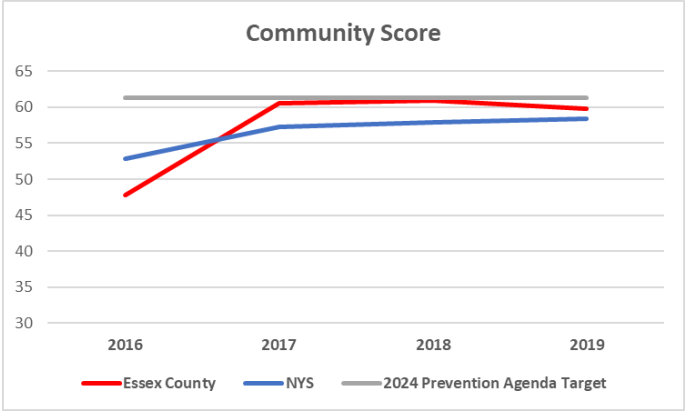
What does the data show in Essex County?

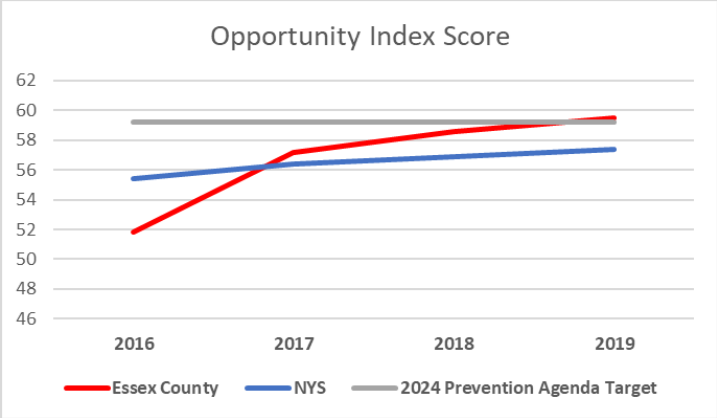
Promote Well Being

Well-being is a relative and dynamic state where one maximizes their physical, mental, and social functioning in the context of supportive environments to live a full, satisfying, and productive life. Well-being is based on the relationship between social determinants of health and person's experiences with quality of life. A person's experience may be influenced by social capital, belief in one's capacity, inclusion, opportunities to engage in meaningful learning, and engagement in actions that influence our lives. Resilience is the capacity to cope with stress, overcome adversity, and thrive despite challenges in life (1).

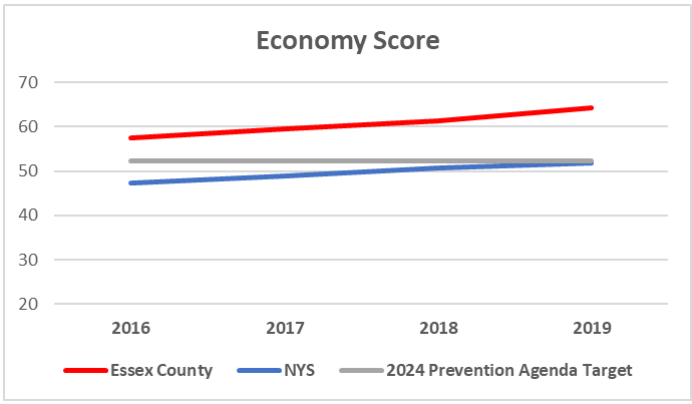
Relevant indicators for this Focus Area include the **Community Score** - an amalgam of seven data sources: volunteering, voter registration, youth disconnection, violent crime, access to primary health care, access to healthy food and incarceration; **Opportunity Index Score** - 17 indicators across four dimensions - Economy, Education, Health, and Community; **Economy Score** - including factors like income inequality, access to banking services, affordable housing, and broadband internet subscriptions; and **mental distress** indicators.

Essex County's Community Score has remained fairly steady over the last 3 years, but has fallen below the 2024 Prevention Agenda Target.

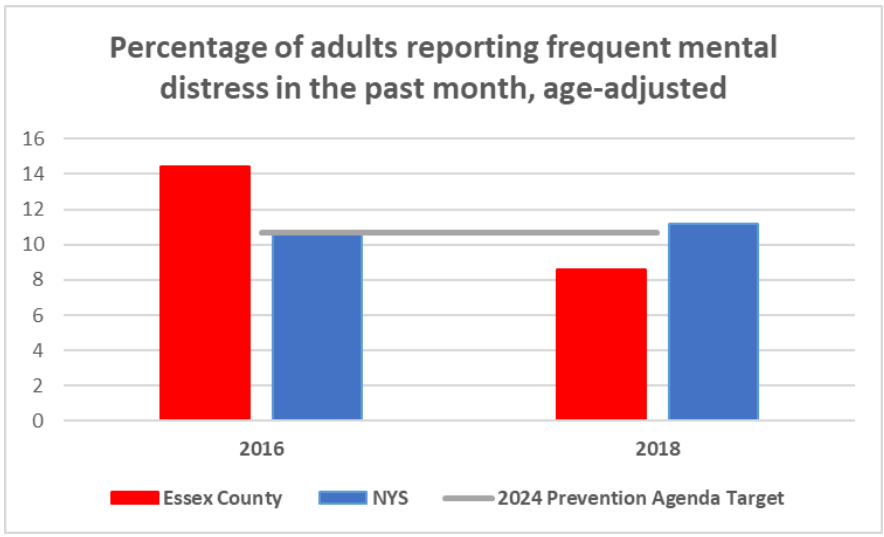




Essex County's Opportunity Index Score has been trending higher since 2016 and exceeded the 2024 Prevention Agenda Target in 2019.



Essex County's Economy Score has also been trending higher since 2016 and has remained above the 2024 Prevention Agenda Target.

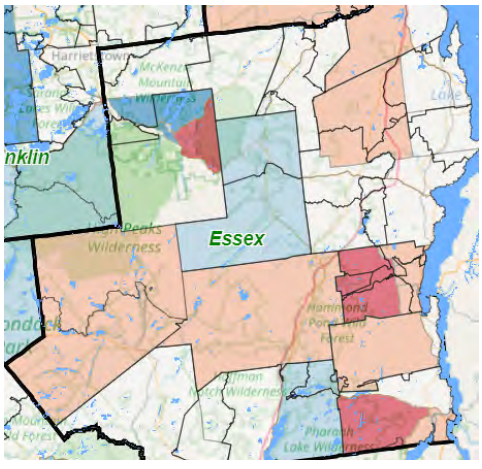


The percentage of adults (aged 18 years and older) in Essex County who reported experiencing frequent mental distress in the last month decreased significantly from 2016 to 2018, falling below the 2024 Prevention Agenda Target. This is in contrast to NYS overall, which experienced a slight increase during the same time period.

In-depth analysis

Even though Essex County's Opportunity and Economy Scores exceed the 2024 Prevention Agenda Targets, there are areas in Essex County facing greater levels of socioeconomic disparity.

The Area Deprivation Index allows for rankings of neighborhoods by socioeconomic disadvantage in a region of interest. It includes factors for the theoretical domains of income, education, employment, and housing quality.

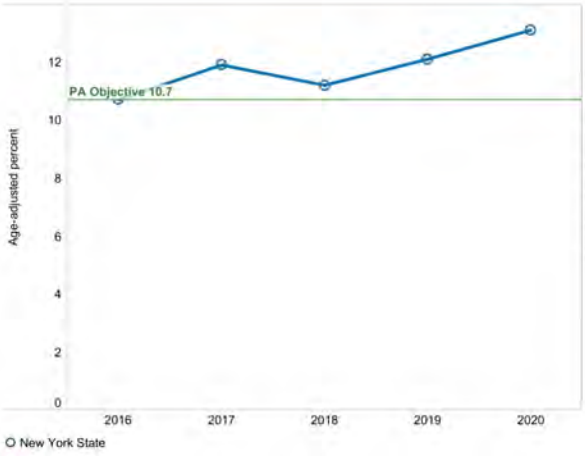


Area Deprivation Index (24)

The map on the previous page reveals that parts of Moriah, Ticonderoga, and North Elba experience the highest levels of deprivation. This is followed by Newcomb, North Hudson, Lewis, Chesterfield, and Crown Point. Living in a disadvantaged neighborhood has been linked to a number of negative healthcare outcomes, including higher rates of diabetes and cardiovascular disease, increased utilization of health services, and earlier death (25).

Another closely linked measure is self-reported frequent mental distress. A study examining the validity of healthy days (mental and physical) as a summary measure for county health status found that counties with more unhealthy days were likely to have higher unemployment, poverty, percentage of adults who did not complete high school, mortality rates, and prevalence of disability than counties with fewer unhealthy days. Self-reported health status is a widely used measure of health-related quality of life that considers an important aspect: how well people live. Further, self-reported days of unwell mental health is a reliable estimate of recent health (15).

More up-to-date data available for New York State shows the percentage of adults reporting frequent mental distress is continuing to increase since 2016. While similar data is unavailable at the county level, there are several factors that suggest Essex County could be mirroring these trends, not least being a global pandemic with far-reaching socio-economic repercussions.



Years	Percent (95% CI) New York State
2016	10.7 (10.0 - 11.4)
2017	11.9 (11.0 - 12.8)
2018	11.2 (10.6 - 11.8)
2019	12.1 (11.2 - 12.9)
2020	13.1 (12.3 - 14.0)

New York State - Frequent mental distress during the past month among adults, age-adjusted percentage (1)

There are distinct disparities across demographic groups for this indicator as well. Females, those with household incomes less than $25,000, and especially those living with a disability report frequent mental distress at higher rates than other groups. Black, non-Hispanic individuals also report more mental distress than other races/ethnicities. Not surprisingly, certain factors that cause stress, such as housing insecurity, food insecurity and insufficient sleep, are also related to frequent mental distress.

Frequent mental distress during the past month among adults, age-adjusted percentage, 2020

Group	Characteristics	Percent (95% CI)
Prevention Agenda	2024 Objective	10.7
Total	New York State	13.1 (12.3 - 14.0)
Gender	Male	10.8 (9.7 - 12.0)
	Female	15.3 (14.1 - 16.6)
Race/Ethnicity	White NH	13.5 (12.4 - 14.7)
	Black NH	14.7 (12.1 - 17.4)
	Other NH	12.2 (9.2 - 15.1)
	Hispanic	13.3 (11.3 - 15.3)
Education	High school non-graduate	15.2 (11.9 - 18.4)
	High school graduate or GED	12.7 (11.1 - 14.4)
	Some post high school	15.3 (13.4 - 17.1)
	College graduate	11.4 (10.3 - 12.5)
Household Income	<$25,000	18.2 (15.9 - 20.4)
	$25,000 - $34,999	17.2 (13.5 - 21.0)
	$35,000 - $49,999	14.9 (12.1 - 17.7)
	$50,000 - $74,999	14.0 (11.1 - 16.9)
	$75,000 and greater	10.4 (9.0 - 11.8)
Regular Health Care Provider	Yes	13.3 (12.3 - 14.3)
	No	13.3 (11.3 - 15.3)
Disability Status	Yes	32.0 (29.0 - 35.1)
	No	9.0 (8.2 - 9.8)
Region	NYC	13.3 (12.0 - 14.6)
	NYS excl NYC	13.1 (12.0 - 14.2)

NYC = New York City. NYS excl NYC = New York State excluding New York City.

White NH = White non-Hispanic. Black NH = Black non-Hispanic. Other NH = Other non-Hispanic.

Data Source: NYS Behavioral Risk Factor Surveillance System, data as of December 2021

What does the community say?

2022 Stakeholder Survey

Essex County & Regional Stakeholders said **mental health** was a top health concern

Essex County & Regional Stakeholders said a **lack of mental health services** was a top contributing factor

2022 Community Survey Result Snapshot

Access to Mental Health Services was identified as one of the **top 5* health challenges** in Essex County according to residents.

**Overweight/obesity, chronic disease, substance abuse, and access to healthcare were also selected.*

47%

Almost half of residents who responded to the survey categorized their mental health as **less than** "good" or "excellent".

Focus Area 2: Prevent Mental Health & Substance Use Disorders

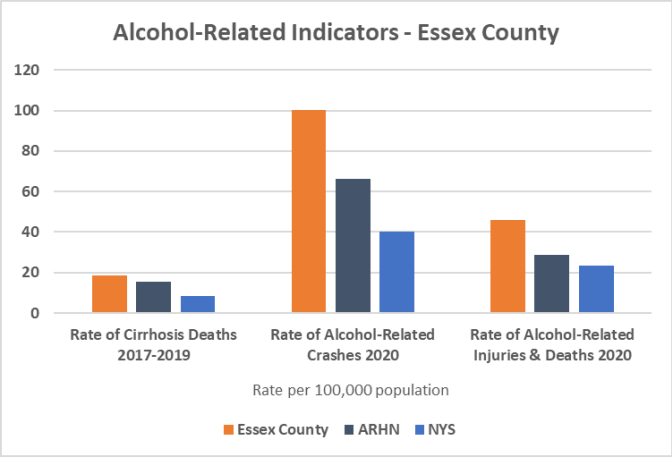
What does the data show in Essex County?

Prevent underage drinking and excessive alcohol consumption by adults

According to the National Institute on Drug Abuse, nearly 90% of addictions begin before age 18 (23). Alcohol is the most-often identified gateway drug by people who misuse other substances such as prescription and illicit drugs. Preventing adolescents from using alcohol and other substances and supporting conditions or attributes that mitigate the risk factors associated with substance use are key strategies that can be used to prevent alcohol misuse (1).

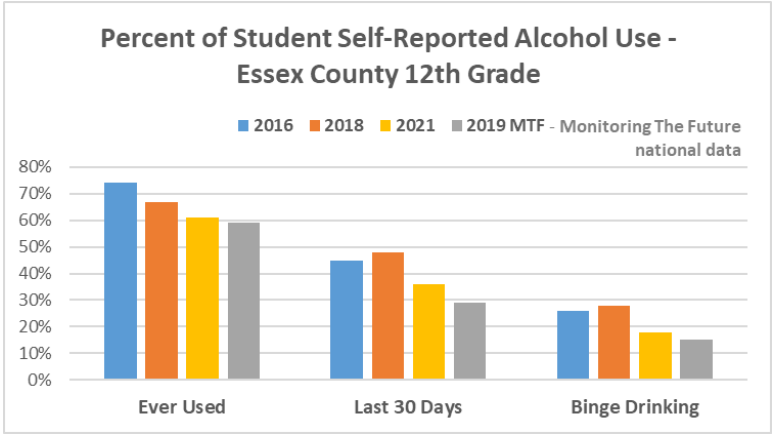
24% - or almost 1 in 4 - adults in Essex County reported binge or heavy drinking in the past 30 days.

Essex County Excessive Drinking (15)



In addition to being a gateway drug, excessive alcohol use is a leading preventable cause of death in the United States, shortening the lives of those who die by an average of 26 years (26). Almost 1 in 4 Essex County residents report binge or heavy drinking in the past 30 days, which is higher than the NYS average of 19%. Rates of cirrhosis and other alcohol-related injuries and deaths are also higher than regional and state averages, and the rate of car crashes involving alcohol is also higher.

By the time they reach 12th grade, the majority of Essex County students have used alcohol, over 30% report use in the last 30 days, and close to 20% report binge drinking.

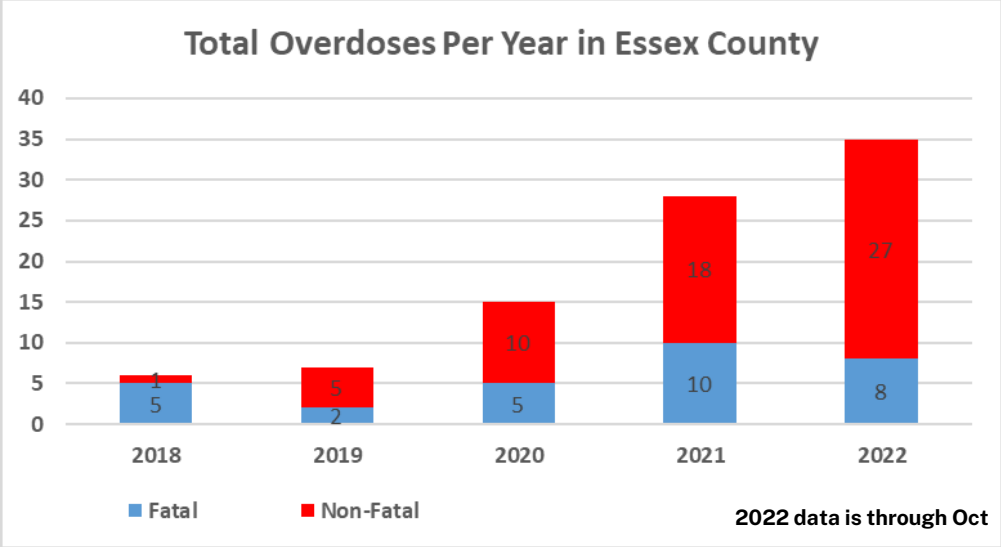


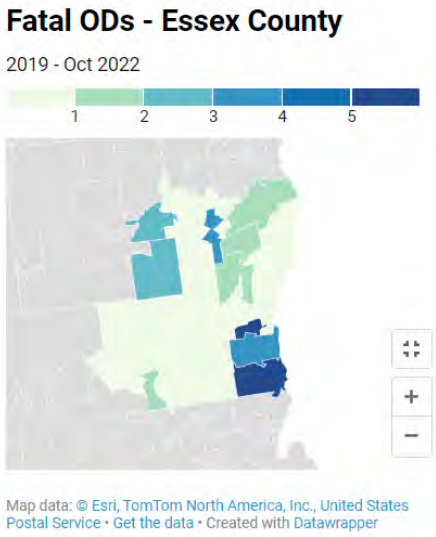
NY Prevention Needs Assessment Survey - Essex County 2021 (22)

Prevent opioid and other substance misuse and deaths

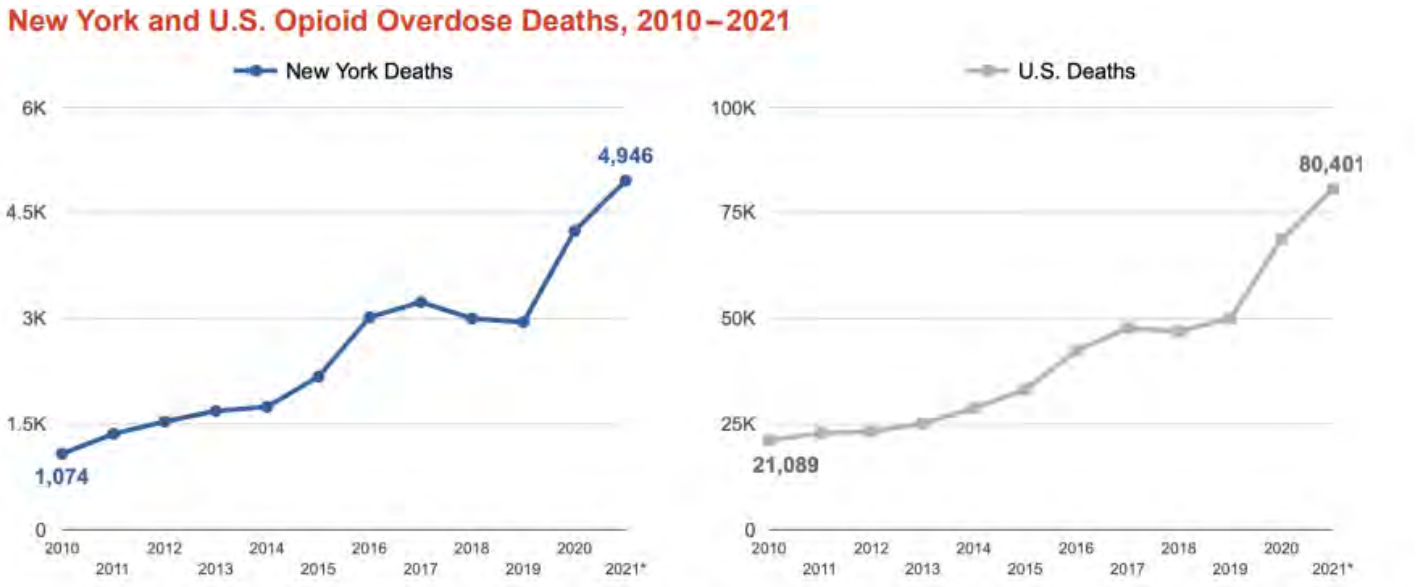
New York, like many states, is experiencing an opioid epidemic (1). Following the federal declaration of a public health emergency in 2017, drug overdose deaths started to decrease. However, mirroring national trends, fatalities surged during the pandemic due to a sharp increase in deaths from opioids, largely from illicit fentanyl and similar synthetic opioids. Federal research on comorbidities involving COVID-19 and substance use cites social isolation and stress, as well as decreased access to treatment and harm reduction services, as pandemic related factors that likely worsened outcomes among vulnerable New Yorkers (27).

Essex County's overdose and fatal overdose trends track closely with NYS and National trends, likely due to similar pandemic stressors and factors.





Essex County Heroin & Other [Opioid] Prevention Coalition Overdose Data (28)



* The 2021 data are provisional counts of drug overdose deaths for the 12-month period ending December 2021, and are subject to change.
Source: Centers for Disease Control and Prevention, National Center for Health Statistics.

NYS Comptroller Report Data (27)

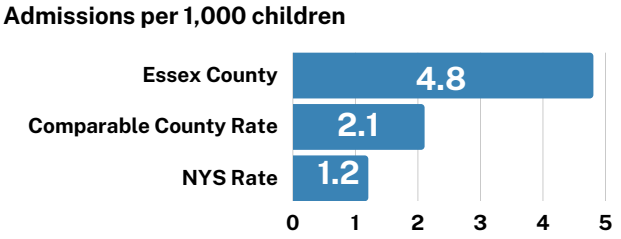
Prevent and address adverse childhood experiences (ACEs)

Adverse childhood experiences (ACEs) are stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse and mental disorders (1). Preventing ACEs, engaging in early identification of people who have experienced them, and helping adults heal from ACEs could have a significant impact on a range of critical health problems.

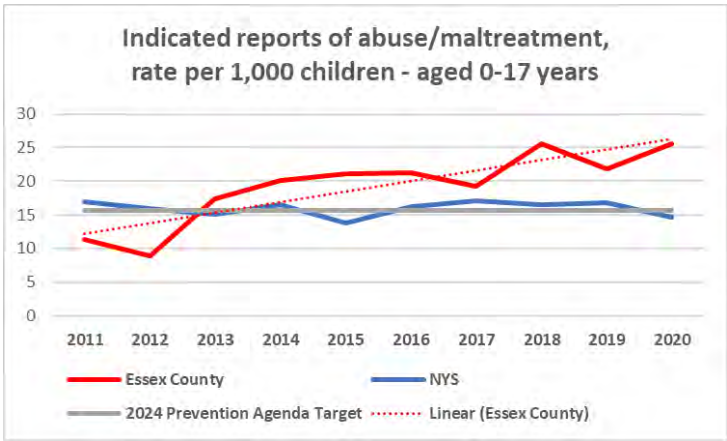
The available indicators that provide information about adverse childhood experiences in Essex County include foster care admission rates, reports of child abuse/maltreatment, the rates of disconnected youth, and the percentage of adults who experienced two or more adverse childhood experiences.

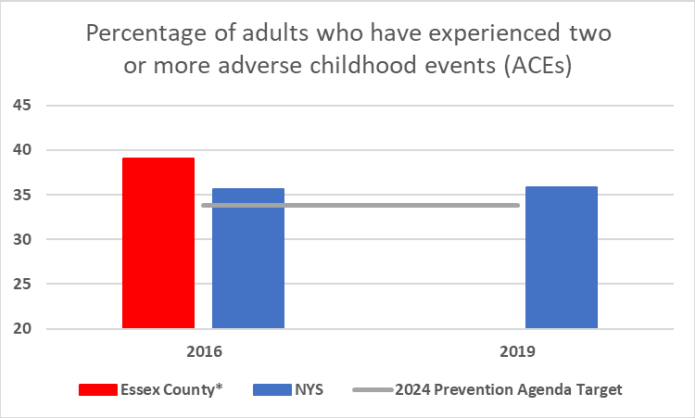
For each of these indicators, Essex County performs worse than state averages and/or 2024 Prevention Agenda targets.

Foster Care Admission Rate



2021 Foster Care Data (29)

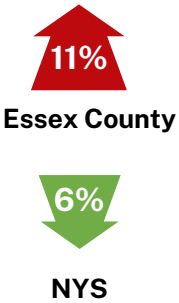




*2019 data not available for Essex County

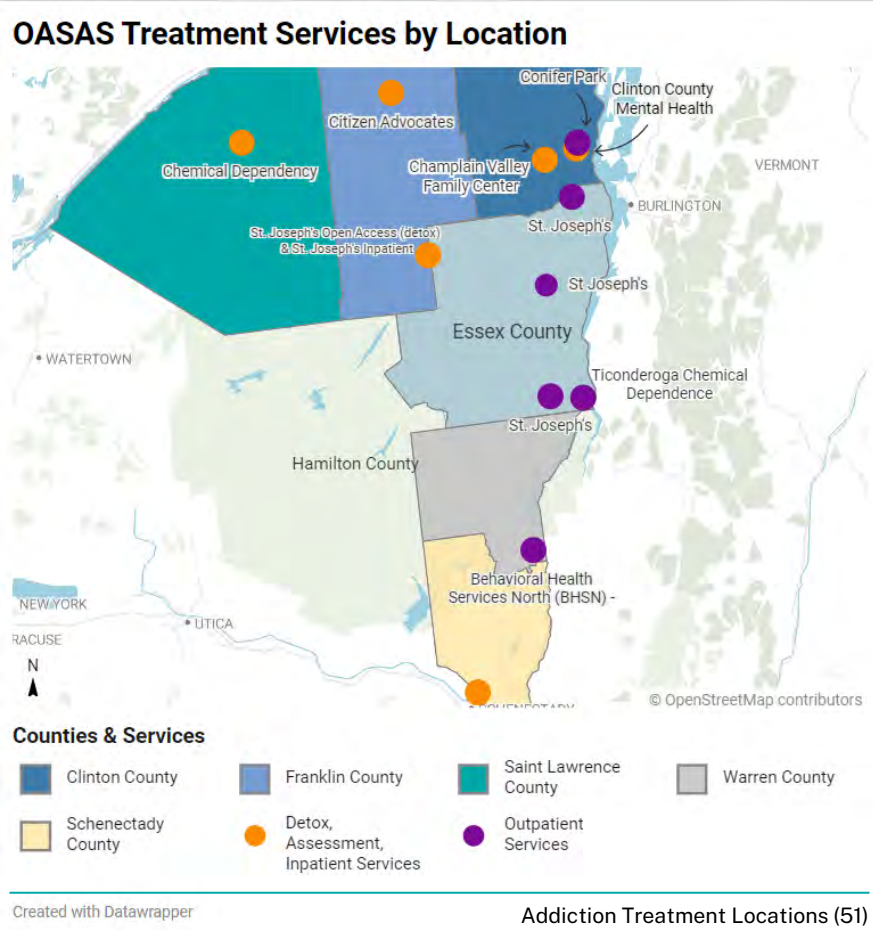
Disconnected Youth

The 2020 % of teens and young adults who are neither working nor in school is higher in Essex County than the NYS average. This rate has increased since 2019 even as the state average has gone down.



In-depth analysis

Access to mental health and addiction treatment services are important components to addressing well-being, mental health and substance use disorders. Essex County residents face disparities in access to services, as noted below.



Addiction Treatment Locations (51)

While there are outpatient services in areas throughout the county, there are no inpatient services/treatment beds located within Essex County.

Additionally, the ratio of population to mental health providers (noted below) is almost twice as high as the ratio across NYS. The ratio represents the number of individuals served by one mental health provider in the county, if the population was equally distributed across providers. When more individuals are served per provider, this could indicate access challenges and gaps in services.

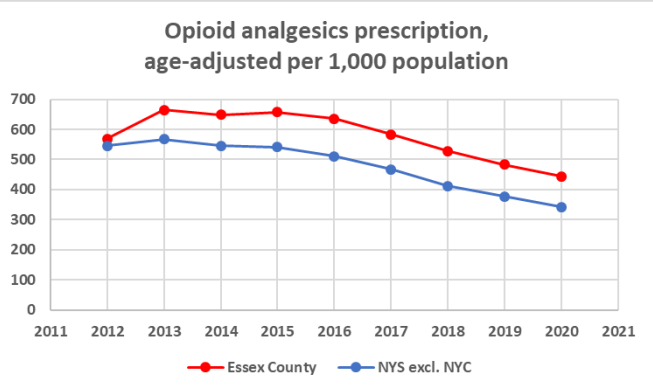
Mental Health

The ratio of population to mental health providers is:

720:1 in Essex County

compared to

370:1 in New York State

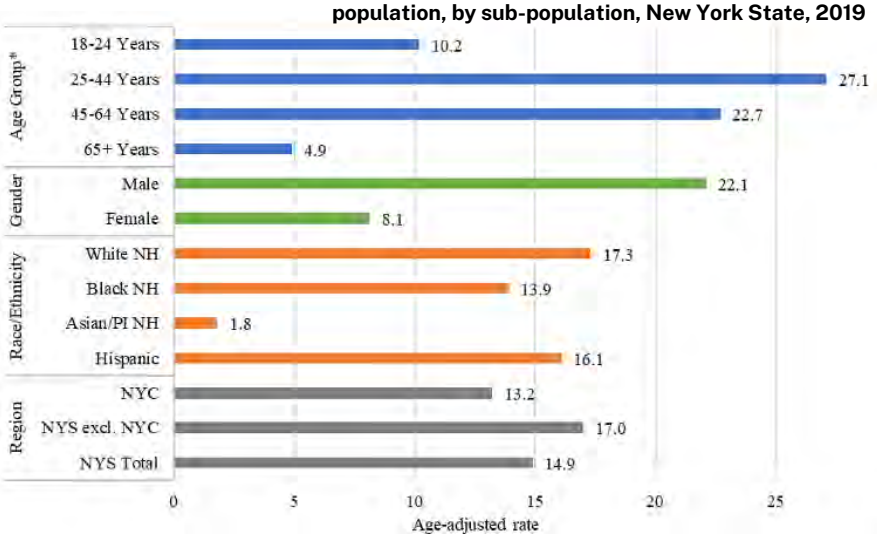


NYS Opioid Dashboard (30)

Another aspect of access, is the access that patients have to prescription opioids. Prescription opioid users and those diagnosed with dependence or abuse of prescription opioids are more likely to switch to heroin; dependence on or abuse of prescription opioids has been associated with a 40-fold increased risk of dependence on or abuse of heroin (32). Although the rate of opioid analgesic prescribing has decreased steadily in Essex County since 2015, prescribing rates are still higher here than NYS averages.

When examining disparities across different demographic groups, those aged 25-44 and 45-64, males, non-Hispanic whites, Hispanics, and non-NYC residents have the highest rates of overdose deaths involving opioids.

Overdose deaths involving any opioid, age-adjusted* rates per 100,000 population, by sub-population, New York State, 2019



NYS Opioid Annual Data Report (31)

What does the community say?

2022 Stakeholder Survey

Essex County & Regional Stakeholders said **substance abuse, adverse childhood experiences,** and **child/adolescent emotional health** were top health concerns.

Essex County & Regional Stakeholders said **addiction to alcohol/illicit drugs** and **changing family structures** were top contributing factors.

2022 Community Survey Result Snapshot

Substance abuse was identified as **one** of the **top 5* health challenges** in Essex County according to residents.

**Overweight/obesity, chronic disease, and access to healthcare, and access to mental health services were also selected.*

Conclusions

There is strong correlation between self-harm behaviors and traumatic experiences, particularly adverse childhood experiences, which in turn are linked to nearly all health and social conditions (1). A coordinated multi-pronged approach that includes policies and programs that support training, education, treatment, strengthening community supports, and data-sharing can prevent opioid and other substance misuse and deaths and promote overall well-being.

Priority Health Issue
Promote Healthy Women, Infants, and Children

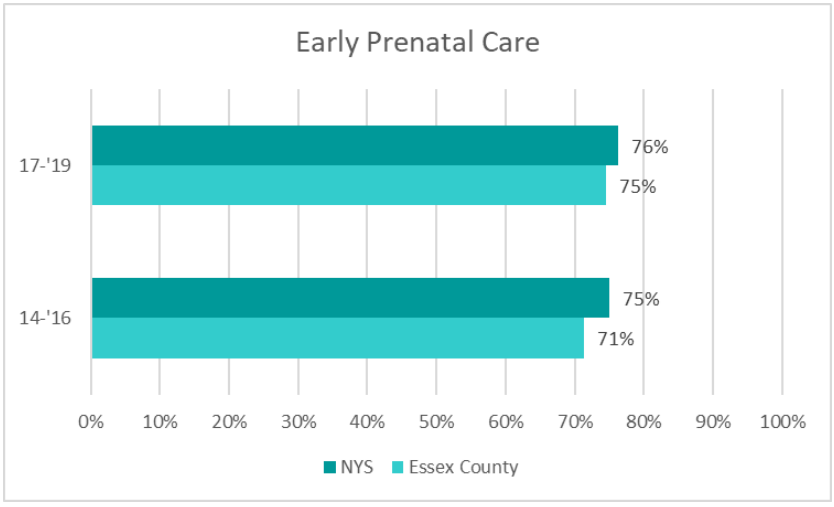
What's the issue?

The health of women, infants, children, and their families is fundamental to population health. Promoting healthy development, behaviors, and relationships early in life and during critical periods lays the groundwork for health promotion and disease prevention throughout the lifespan. Supporting the health and wellness of all women is essential to their current and lifelong well-being, regardless of their age, sexual or gender identity, pregnancy history, or future reproductive plans. Moreover, it requires a deep commitment to promoting health equity and eliminating racial, ethnic, economic, and other disparities, as reflected in the fourth cross-cutting focus area (1). The data sections below will touch on topics in the following Focus Areas, but will not be separated out into distinct sections, as done previously:

Focus Area 1. Maternal & Women's Health
Focus Area 2. Perinatal & Infant Health
Focus Area 3. Child & Adolescent Health
Focus Area 4. Cross Cutting Healthy Women, Infants, & Children

What does the data show in Essex County?

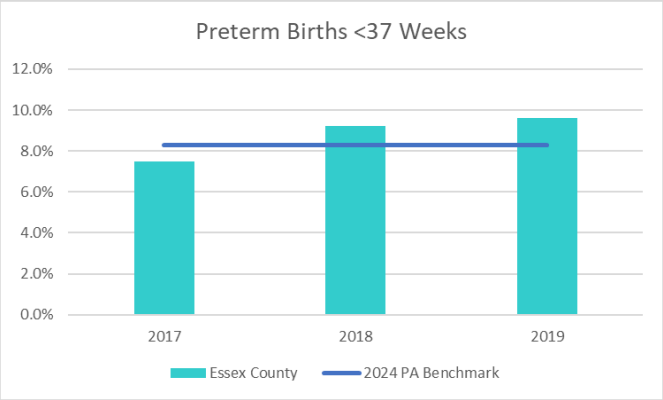
After review of the data for this Priority Area, several sub-categories stood out as factors that impact the health of women, infants, and children in Essex County. Early prenatal care, pre-term births, teen pregnancy, pregnancy spacing, WIC participant pregnancy indicators, breastfeeding rates, infant home-visiting program availability, well-child visits, child blood lead levels, and child dental health were all examined. Other Essex County indicators were better than NYS benchmarks, and many did not meet reporting criteria (17).

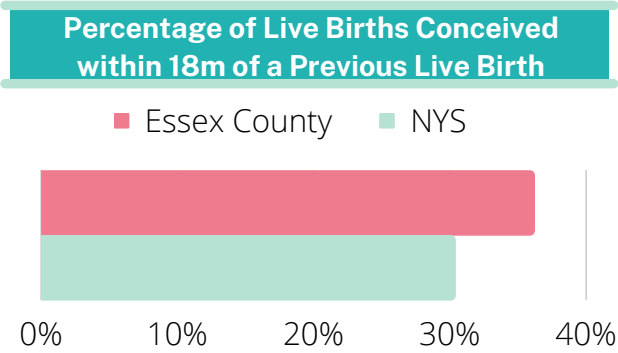


There are ***no full-time obstetrician/ gynecologist practitioners or provider offices located within Essex County***. There are currently OB/GYN providers who rotate to provide clinic hours three days per month in Ticonderoga and one provider offering clinic hours one day per week in Elizabethtown for 6-8 months of the year. Otherwise, residents travel to neighboring counties or to Vermont for reproductive care. That said, the percentage of births with early prenatal care is trending in the right direction, though still slightly lower than the NYS average.

While early prenatal care rates have improved, the percentage of preterm births of total births is on the rise in Essex County. The percentage, now at 9.6%, exceeds the 2024 Prevention Agenda target of 8.3%.

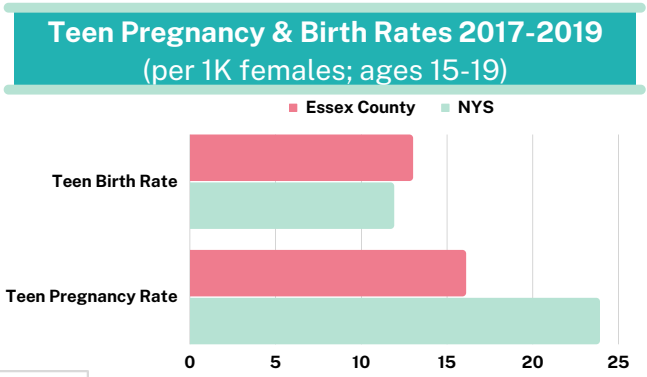
Premature babies are more likely to have acute and chronic health issues requiring hospital care than are full-term infants. Infections, asthma and feeding problems are more likely to develop or persist. Premature infants are also at increased risk of sudden infant death syndrome and developmental delays (33).

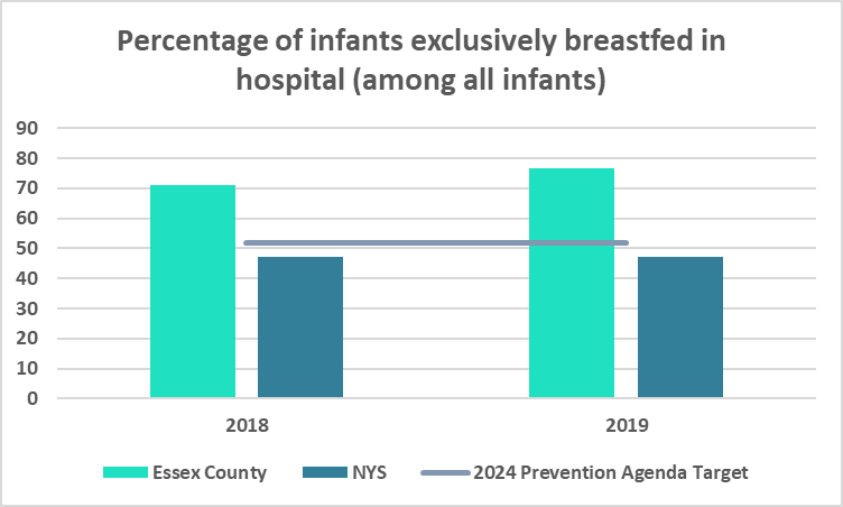




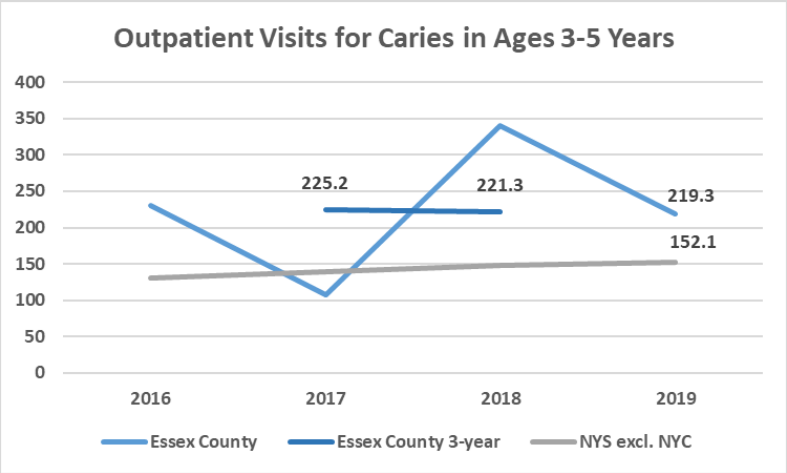
Pregnancy spacing is another important consideration for maternal and infant health. Close proximity of births can be physically, mentally, emotionally, and financially stressful for families. There is also a higher risk for poor birth outcomes when pregnancies occur in close succession. A greater percentage of babies born in Essex County are conceived within 18 months of a previous birth when compared to the NYS average.

Both the teen birth rate and the teen pregnancy rate have significantly improved in Essex County compared to 2014-2016 rates. The teen birth rate is still higher here than the NYS (excluding NYC) average.





The percentage of Essex County infants that are exclusively breastfed in the hospital after birth increased since the last data point and is significantly higher than the NYS average and the 2024 Prevention Agenda Target.



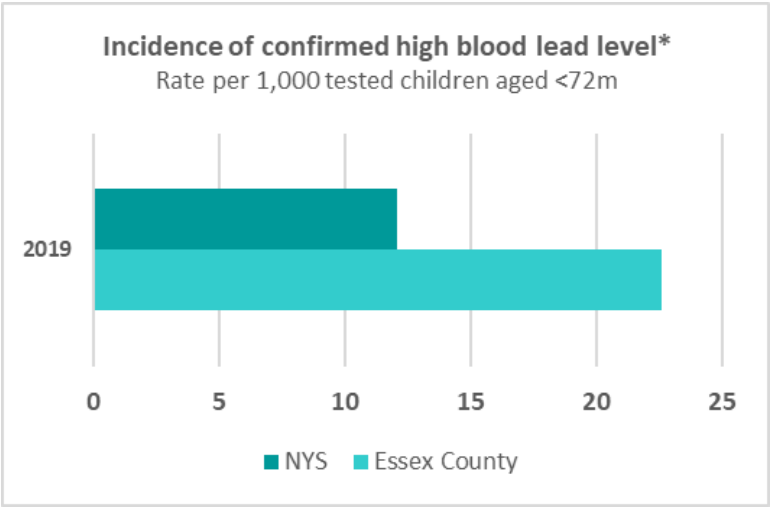
The rate of dental caries (cavities) in Essex County children ages 3-5 is almost 50% higher than the NYS rate (excluding NYC). Tooth decay can cause pain, loss of teeth, impaired growth, and negative quality of life. Preventing tooth decay is an important component of child health programming.

No Essex County residents are served by community water systems that have been optimally fluoridated. By comparison, 71.2% of all NYS residents are served by optimally fluoridated community water systems.

No safe blood lead level in children has been identified. Even low levels of lead in blood have been shown to negatively affect a child's intelligence, ability to pay attention, and academic achievement.

The health effects of exposure are more harmful to children less than six years of age because their bodies are still developing and growing rapidly.

The rate of incidence of high blood lead levels (5 mcg/dL) in young children in Essex County is almost twice the NYS average. Incidence of blood lead levels at 10 mcg/dL or higher is lower - at around 4.4 per 1,000 children tested; however, this is still higher than the NYS average of 3.8.



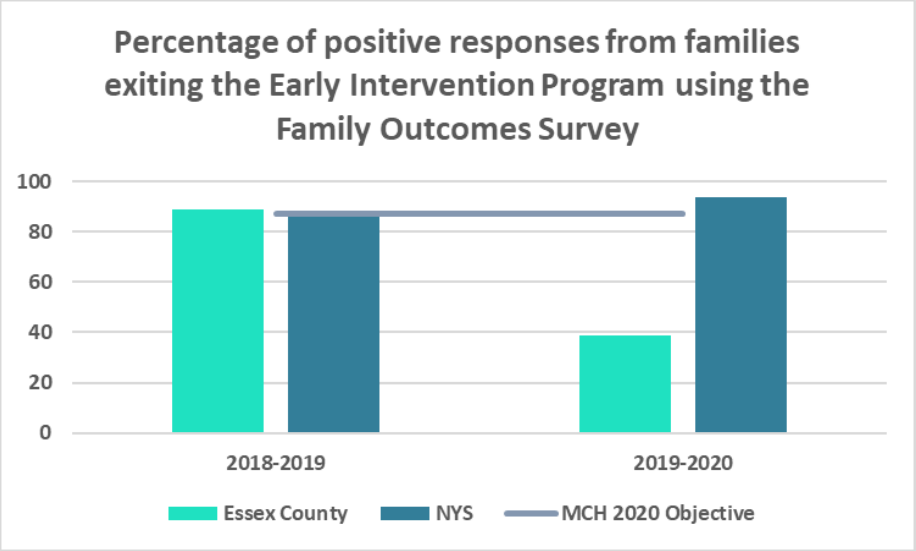
*5 micrograms or higher per deciliter

69%

% of Essex County children with recommended number of well child visits in government sponsored healthcare programs

The NYS average for children in government sponsored healthcare programs getting recommended well child visits is over 8% higher than in Essex County, leaving room for improvement in this area.

Well-child visits are essential for many reasons, including: tracking growth and developmental milestones; discussing any concerns about your child's health; getting scheduled vaccinations to prevent illnesses like measles and whooping cough (pertussis) and other serious diseases; and ensuring that screening tests and procedures are completed (35).



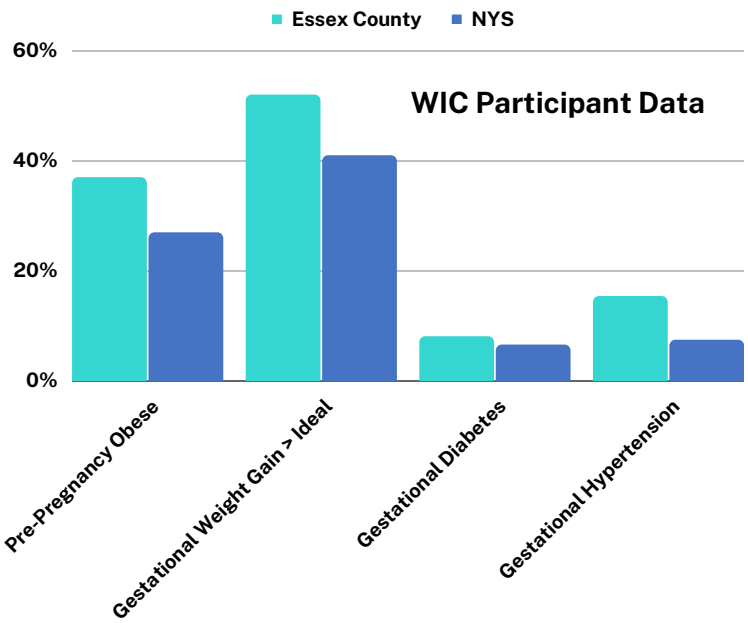
The Early Intervention Program helps young children (birth to 3 years) who are not learning, playing, growing, talking or walking like other children their age. Provided at no cost to families, this program addresses disparities in access and income.

The Family Survey is part of an ongoing federally-required initiative to improve outcomes for children and families who receive early intervention services.

Challenges in program and provider staffing and other pandemic-related changes have impacted the Essex County Children's Services - Early Intervention program that the department will work toward improving over the next Community Health Improvement Plan cycle.

In-depth analysis

Pregnancy and infant health outcomes are significantly impacted by maternal health and well-being. Addressing the disparities that exist among Essex County women of reproductive age is an important consideration of any intervention designed to improve maternal, infant, and child health overall.



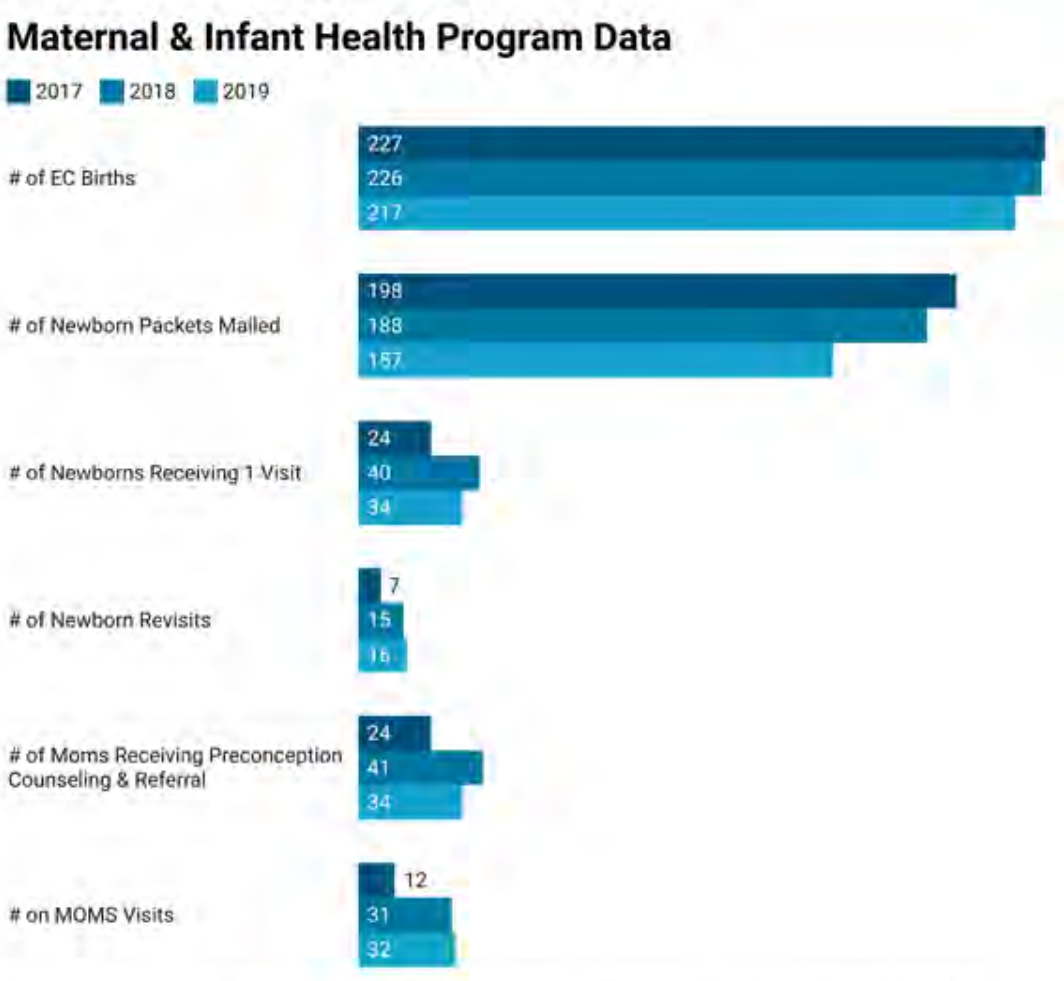
Controlling existing conditions, such as high blood pressure and diabetes, is important to prevent serious pregnancy and birth complications and their effects.

Women enrolled in the Essex County WIC Program experience greater rates of pre-pregnancy obesity, gestational weight gain beyond what is considered ideal, gestational diabetes and gestational hypertension.

With over 44% of all pregnant, post-partum, and children ages 0-4 eligible for WIC in NYS, the potential to impact the overall health of women, infants, and children by focusing on this population is significant (36).

Home visiting programs are a cornerstone of public health efforts to support pregnant and parenting families. An extensive body of research demonstrates that evidence-based home visiting programs improve numerous short- and long-term outcomes for mothers, infants, and families. Local home visiting programs can engage in a variety of efforts to build capacity and improve effectiveness in key areas, including: increasing referrals to needed services, client enrollment, and retention in insurance and service programs; extending the duration of breastfeeding; and increasing home visitors' knowledge and skills related to key topics such as intimate partner violence, substance use, mental health, smoking cessation, self-care, and post-partum/interconception care (1).

Prior to 2020, the Essex County Health Department conducted a home visiting program, with recent year data summarized in the table below. The COVID-19 pandemic severely limited the health department's ability to provide continuity of care and services in most programmatic areas, including within the Family Health core service area. Rebuilding the home visiting program, with a goal of universal reach to Essex County families, is a key objective for the next couple years. Health care providers, community based organizations, and Essex County health and human service agencies are essential partners in this endeavor.



What does the community say?

Although not necessarily specific to women, infants, and children, community and survey stakeholder responses that highlight social and economic determinants of health are included in this section because women with children, especially unmarried women with children, are disproportionately represented among all women living in poverty (37).

Since unmarried women with children are more often living in poverty than other groups, the social and economic determinants related to poverty are likely to impact unmarried women with children at greater levels.

This includes the social challenges identified by residents in the 2022 Community Survey, like affordable housing, lack of livable wages, lack of employment opportunities, childcare, and access to healthy foods.

Conclusions

Excerpt from the NYS Health Assessment Contributing Causes of Health Challenges:

A life course approach to health recognizes that early experiences and exposures during critical periods of development (such as in utero or early childhood) may "program" a person's future health and development, including a woman's reproductive health. Embedded within a life course model is attention to the impact of ACEs. An extensive body of long-term research has demonstrated that adverse experiences during childhood – such as having a parent addicted to alcohol or drugs or in prison, witnessing family or neighborhood violence, and experiencing abuse or neglect – can have significant effects on long-term health and well-being. Early exposure to multiple ACEs is associated with a wide range of chronic health conditions and health risk behaviors later in life, including tobacco and alcohol abuse, high blood pressure, heart disease, cancer, diabetes, depression, and suicide. Studies have demonstrated that adverse experiences during a woman's own childhood are associated with increased risk for unplanned and adolescent pregnancy, fetal death, preterm birth, and low birth weight, as well as perinatal depression later in her life.

Promoting healthy women, infants, and children is a cross-cutting endeavor that is integral to other priorities addressed by the NYSDOH Prevention Agenda. Thus, prioritizing women, infants, and children enhances the work and initiatives for all health issues selected by the Essex County Health Partners and collaborators.

Given this analysis, interventions that focus on access to care, adverse childhood experiences, trauma-informed approaches, resilience, diversity, equity, and inclusion are features of this cycle's Community Health Improvement Plan.

Prioritizing Community Health Issues

The NYS Prevention Agenda 2019-2024 has **five** priorities with priority-specific action plans developed collaboratively with input from community stakeholders. Essex County Health Partners opted to elevate three priority areas as issues deserving of more in-depth and coordinated attention over the next three years. These three areas, as discussed in detail in the previous section are:

Prevent Chronic Diseases
Promote Well-Being and Prevent Mental Health & Substance Use Disorders
Promote Healthy Women, Infants, and Children
Among several identified disparities, a recurring theme that will be addressed is that of access to care.

Several steps were taken to inform the prioritization of health needs by the Essex County Health Partners, including:

1. Reviewing available data and health indicators for each priority area (as summarized in the sections covering Step 4 and Step 6);
2. Considering community input via the 2022 Community Survey (summarized in the Community Snapshot section, Step 3);
3. Considering stakeholder input via the 2022 Stakeholder Survey (summarized in the Stakeholder Engagement section, Step 2);
4. Utilizing a prioritization matrix*;
5. Convening of internal planning groups of Essex County Health Partners, confirming identified priorities
6. Sharing preliminary findings and requesting prioritization input upon review of these findings from the Essex County Board of Supervisors/Board of Health; the Essex County Health Department Public Health Advisory Committee; and Essex County community members;
7. Drawing final conclusions to address 3 Priority Areas in the Community Health Improvement/Service Plan

Note: The prioritization matrix was a locally-modified version of the Hanlon Method (39) that included criteria categories of need and feasibility. The matrix was guided by asking questions regarding the scope and severity (of need) of a health issue and the perceived ability to impact the problem and the community readiness for addressing those health issues.

The final decision to address the 3 Priority Areas listed above does not mean that time and effort will not be devoted to the remaining two areas of **Prevent Communicable Diseases** and **Promote a Healthy & Safe Environment**. These are represented as core service areas with mandated activities for local health departments in NYS. As such, the Essex County Health Department has various programs and initiatives already in place to prevent disease and injury, and advance health and well being in these specific areas.

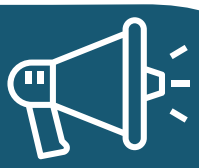
Prioritization Matrix - Essex County Health Partners

PRIORITIZATION WORKSHEET
Final October 2022

SCORE
5 = High Impact/Need
3 = Medium Impact/Need
1 = Low Impact/Need
0 = Not Applicable

				SCOPE		SEVERITY		ABILITY TO IMPACT		COMMUNITY READINESS	
				Breadth	Inequities/ Disparities	Community Cost	Negative Outcomes	Resource Capacity	Confidence	Stakeholder Support	Prevailing Community Attitude
			DESCRIPTION	relatively high % or rate or trending poorly	identifiable sub-population(s) with greater risk	relatively high dollars/time/ social consequences	across other aspects of life & across lifespan	funds, staff, time	evidenced-based practices available; confidence in implementing interventions to produce desired outcomes	leaders, policy makers, community collaborators	Acceptance of the issue and support for interventions
Overall Priority Area Score	PRIORITY AREAS	FOCUS AREAS	SCORE (0-5)								
3.84	Prevent Chronic Diseases	1. Healthy Eating & Food Security	4	4.00	4.00	5.00	3.00	4.00	4.00	4.00	4.00
		2. Physical Activity	4	4.00	3.00	4.00	5.00	3.00	4.00	4.00	3.00
		3. Tobacco Prevention	3	3.00	4.00	4.00	4.00	3.00	3.00	3.00	3.00
		4. Preventive Care & Management	4	4.00	4.00	5.00	5.00	4.00	4.00	4.00	4.00
1.90	Promote a Healthy & Safe Environment	1. Injuries, Violence & Occupational Health	2	1.00	2.00	2.00	3.00	1.00	1.00	2.00	2.00
		2. Outdoor Air Quality	1	1.00	1.00	2.00	2.00	1.00	1.00	1.00	1.00
		3. Built & Indoor Environments	3	2.00	3.00	3.00	3.00	2.00	2.00	3.00	2.00
		4. Water Quality	1	2.00	1.00	1.00	1.00	1.00	1.00	2.00	2.00
		5. Food & Consumer Products	3	3.00	3.00	3.00	3.00	2.00	2.00	3.00	2.00
3.66	Promote Healthy Women, Infants & Children	1. Maternal & Women's Health	4	4.00	5.00	5.00	5.00	4.00	4.00	4.00	4.00
		2. Perinatal & Infants Health	3	3.00	4.00	4.00	4.00	3.00	3.00	3.00	3.00
		3. Child & Adolescent Health	4	4.00	4.00	5.00	5.00	3.00	3.00	3.00	4.00
		4. Cross Cutting Healthy WIC	3	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00
4.00	Promote Well-bring and Prevent MH & SUDs	1. Promote Well-being	4	4.00	4.00	5.00	5.00	3.00	3.00	4.00	5.00
		2. Prevent Mental & Substance Use Disorders	4	4.00	4.00	5.00	5.00	2.00	3.00	4.00	4.00
2.53	Prevent Communicable Diseases	1. Vaccine-Preventable Diseases	4	3.00	3.00	4.00	4.00	4.00	5.00	4.00	4.00
		2. HIV	2	1.00	1.00	1.00	1.00	2.00	2.00	2.00	2.00
		3. STIs	2	2.00	2.00	2.00	2.00	2.00	3.00	3.00	3.00
		4. HepC	2	2.00	2.00	2.00	2.00	2.00	3.00	3.00	3.00
		5. Antibiotic Resistence & Healthcare Associated Infections	3	3.00	2.00	3.00	3.00	3.00	2.00	2.00	2.00

Share Results & Seek Additional Input



Step 6: Document & Communicate Results

Part of conducting a Community Health Assessment includes sharing the results of the assessment with both internal and external audiences. This provides an opportunity for the participating partners and organizations, as well as stakeholders and the community at large to see the conclusions and offer additional feedback.

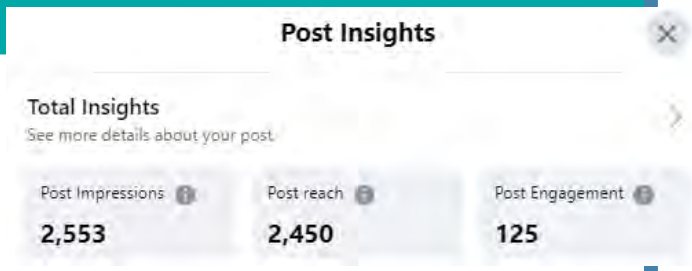
Community Health Assessment presentations, including a process and data overview, were provided to the following audiences:

Audience	Topic	Delivery Method	Date(s)
Community Health Assessment - Essex County Health Partners	All Priority Areas - Data Review	Presentation at monthly partner meeting	08/03/2022
Essex County Heroin & Other (drugs) Coalition [ECHO]	Promote Well-Being and Prevent Mental Health & Substance Use Disorders	Presentation at bimonthly coalition meeting	07/29/2022
System of Care - Essex County Health & Human Service Agencies	Promote Well-Being and Prevent Mental Health & Substance Use Disorders	Presentation at System of Care Summit	08/15/2022
Essex County Breastfeeding Coalition	Promote Healthy Women, Infants, and Children	Presentation at bimonthly coalition meeting	08/19/2022
Essex County Health Department - Public Health and All Unit Head Staff Meeting	All Priority Areas - Data Review, Priority Area Selection, Interventions	Presentation at weekly staff meeting	10/04/2022
Board of Supervisors - Human Services Committee	All Priority Areas - Data Review, Improvement Plan,	Presentation at monthly committee meeting	11/14/2022
Essex County Public Health Advisory Committee	All Priority Areas, Priority Area Selection, Interventions	Presentation at quarterly meeting	12/06/2022

In addition to formal presentations of Community Health Assessment components, portions of the assessment results were shared on the Essex County Health Department website and Facebook page throughout the Fall of 2022. An example post is shared below

Facebook Post
September 2, 2022

Post Reach & Engagement



The following 7 pages represent the Priority Area infographics that were disseminated as part of the process to share the Community Health Assessment results. The Prevent Chronic Disease Priority Area was broken out into 3 separate infographics based on the breadth of the topic. The remaining 4 Priority Areas are covered on one infographic each.

The infographics summarize some of the key data points and indicators that were evaluated during the overall assessment phase. These data points were used to guide the initial prioritization, before additional input was sought.

Community agencies, stakeholders, partners, and the public identified **vaping** and **dental caries** as particular areas of concern that the Essex County Health Partners are working with collaborating providers and organizations to develop additional interventions around. Items that were not included in this version of the Community Health Improvement Plan will be considered for future updates.

NYS PREVENTION AGENDA 2019-2024

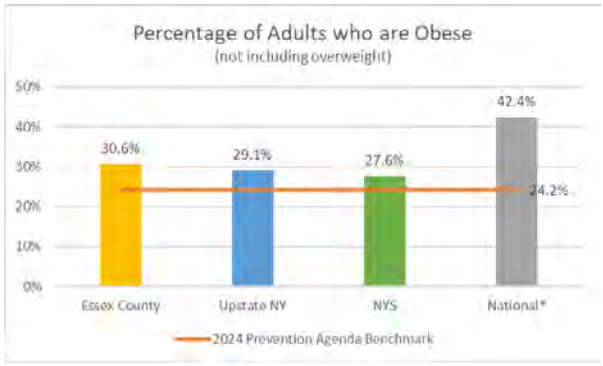
Prevent Chronic Diseases

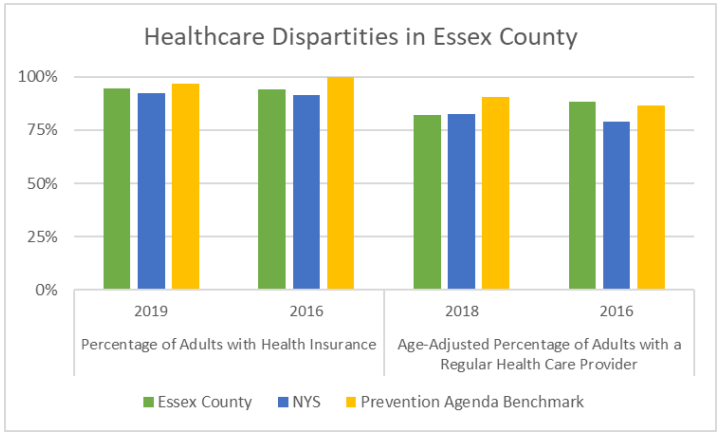
Overarching Goal: Reduce obesity and the risk of chronic diseases

Focus Area 1: Healthy Eating and Food Security
Focus Area 2: Physical Activity

1 out of every 3 students in **middle** and **high school** is **obese** in Essex County

14.9% of **elementary students** are **obese** in Essex County





2022 Community Survey Result Snapshot

The **death** rates for **cardiovascular disease**, **stroke**, and **diabetes** are ALL **higher** in **Essex County** than rates in the North County region or NYS.

Overweight/obesity and **Chronic disease** were identified as **two** of the **top 5 health challenges** in Essex County according to residents.
Substance abuse, access to healthcare, and access to mental health services were also selected.

Other Essex County health behavior & health outcome indicators:

1 in 4 adults get no physical activity daily

26%

1 in 3 adults consume **no** fruits or vegetables daily

32%

Almost 30% of adults consume at least 1 sugar sweetened beverage daily

29%

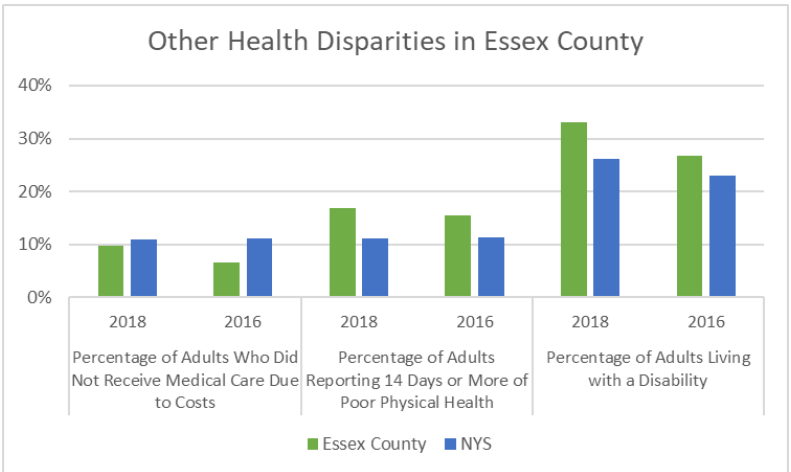
Diabetes

47.7%

of adults have had a test for diabetes in the past **3 years**

12.6%

of adults have diabetes



Available Community Health Improvement Plan Goals - can be selected by health department and/or partner organizations:

Focus Area 1: Healthy Eating and Food Security

- Goal 1.1: Increase access to healthy and affordable foods and beverages
- Goal 1.2: Increase skills and knowledge to support healthy food and beverage choices
- Goal 1.3: Increase food security

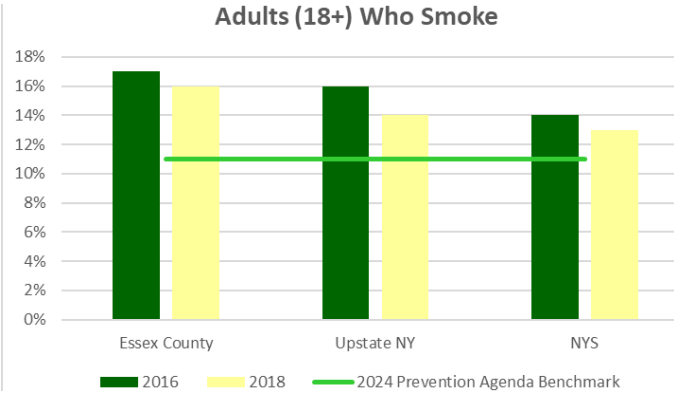
Focus Area 2: Physical Activity

- Goal 2.1: Improve community environments that support active transportation and recreational physical activity for people of all ages and abilities
- Goal 2.2: Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities
- Goal 2.3: Increase access, for people of all ages and abilities, to safe indoor and/or outdoor places for physical activity

Prevent Chronic Diseases

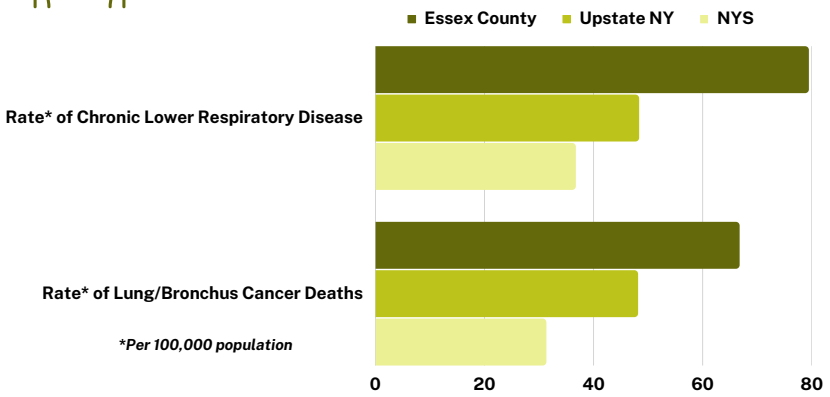
Focus Area 3: Tobacco Prevention

Smoking Rates



Cigarette smoking rates among adults have been trending down throughout NYS over the past several years. The smoking rate in Essex County is **higher** than Upstate and NYS averages, and all 3 are higher than the 2024 Prevention Agenda Benchmark.

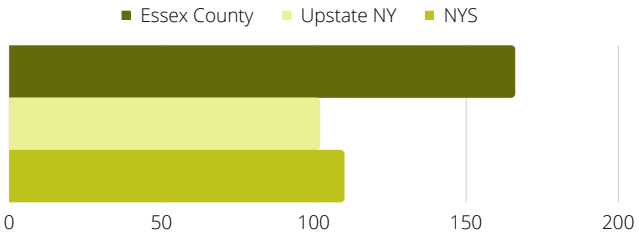
Lung Disease Indicators



Rates of respiratory disease and lung/bronchus cancer deaths - both linked to smoking - are higher in Essex County than regional and state rates.

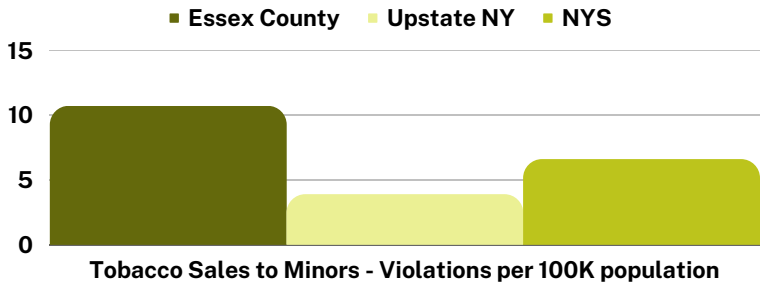
Access to Tobacco

Registered Tobacco Vendors per 100,000 Population



Essex County has significantly more tobacco vendors per 100,000 population than regional or NYS averages.

Essex County has significantly more tobacco sales violations per 100,000 population than regional or NYS averages.



Disparities

Those with disabilities and lower incomes are more likely to smoke. The smoking rate for these populations is higher than the overall smoking rate in Essex County

Essex County Smoking Rates

22%

19%

58% higher

65% higher

New York State data reveals that smoking rates are higher for adults with less education and those who report frequent mental distress.

Available Community Health Improvement Plan Goals - can be selected by health department and/or partner organizations:

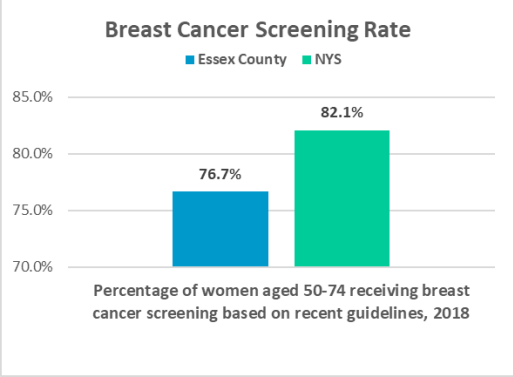
Focus Area 3: Tobacco Prevention

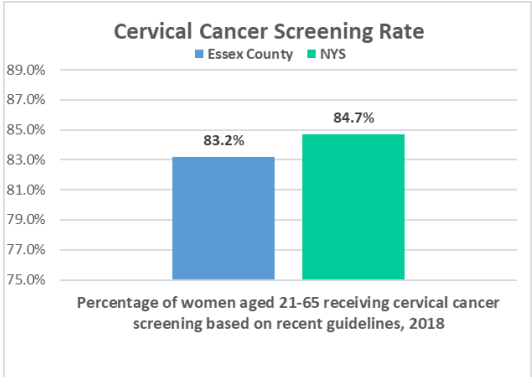
- Goal 3.1: Prevent initiation of tobacco use, including combustible tobacco and electronic vaping products (e-cigarettes and similar devices) by youth and young adults
- Goal 3.2: Promote tobacco use cessation, especially among populations disproportionately affected by tobacco use including: low SES; frequent mental distress/substance use disorder; LGBT; and disability
- Goal 3.3: Eliminate exposure to secondhand smoke and exposure to secondhand aerosol/emissions from electronic vapor products

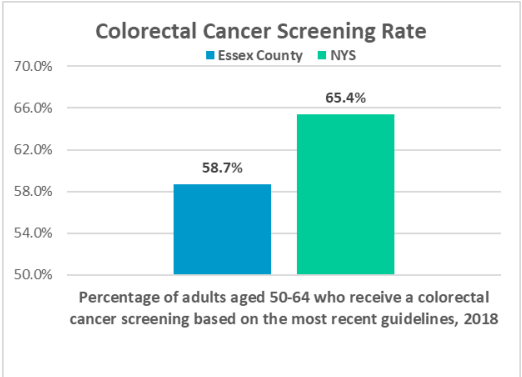
NYS PREVENTION AGENDA 2019-2024: Prevent Chronic Diseases

Screenings

Focus Area 4: Access to Preventive Care and Management

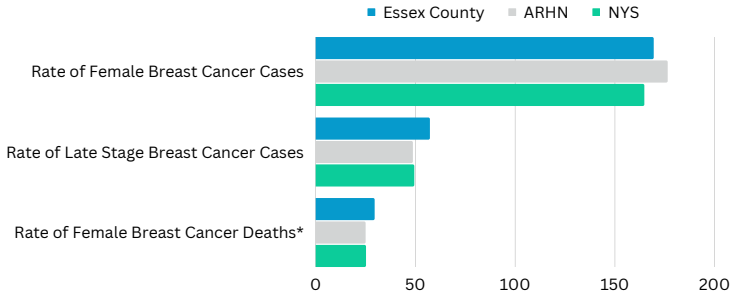


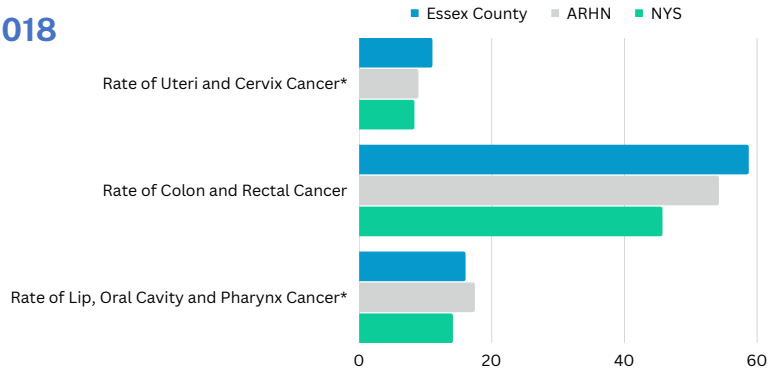




Cancer Outcomes

2016-2018





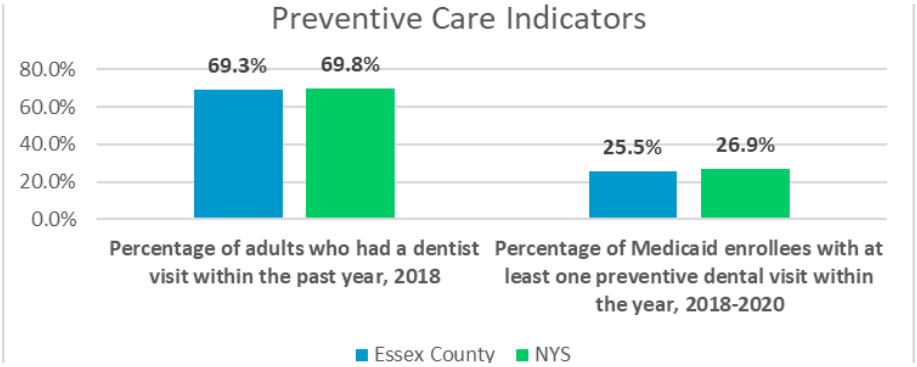
Although the overall rate of female breast cancer cases is lower in Essex County than the rate of the ARHN region, the rate of late stage breast cancer cases and breast cancer deaths are both higher than regional and NYS rates. Access to care might be a contributing factor.

**Fewer than 10 or 20 events in the numerator; therefore, rate is unstable.*

Preventive Care

The ratio of population to primary care providers is: **2,630:1** in Essex County **1180:1** in New York State

The ratio of population to dentists is: **3,070:1** in Essex County **1190:1** in New York State



YOU Told Us:

Access to healthcare services is one of the Top 5 most important features of a strong, vibrant, healthy community AND is also one of the Top 5 health challenges in your community.

Access to healthcare and dental services are also top health challenges faced by you or a family member.

2022 Community Survey Results

Focus Area 4: Preventive Care and Management

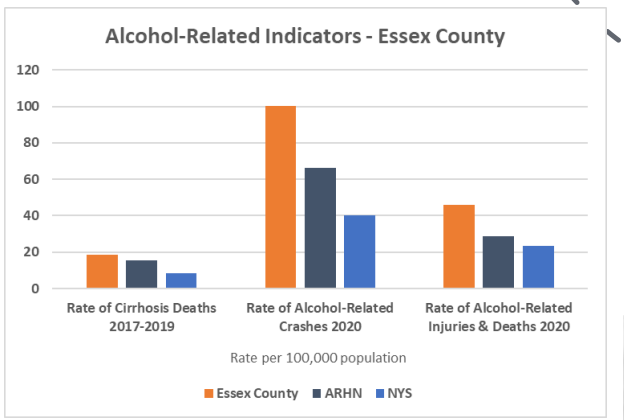
- Goal 4.1: Increase cancer screening rates for breast, cervical, and colorectal cancer
- Goal 4.2: Increase early detection of cardiovascular disease, diabetes, prediabetes, and obesity
- Goal 4.3: Promote the use of evidence-based care to manage chronic disease
- Goal 4.4: Improve self-management skills for individuals with chronic conditions

HEALTH DEPARTMENT
Public Health Unit

NYS PREVENTION AGENDA 2019-2024

Promote Well-Being and Prevent Mental and Substance Abuse Disorders

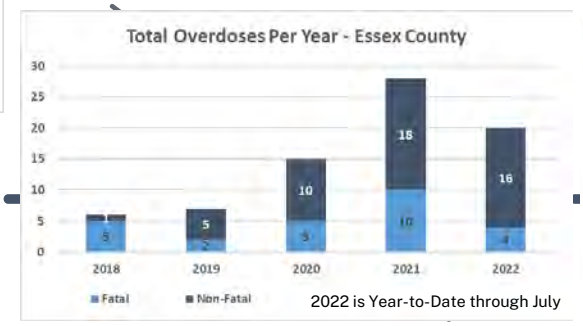
Substance Use Indicators



The rates for select alcohol-related health factors are **significantly worse in Essex County** than state and regional rates.

Focus Area 1: Promote Well-Being
Focus Area 2: Prevent Mental & Substance Use Disorders

24% - or almost 1 in 4 - adults in Essex County reported binge or heavy drinking in the past 30 days.



Jan 2018 - July 2022

Well Being Indicators

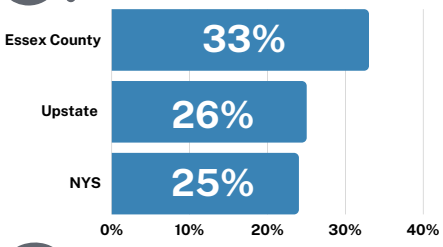
Disconnected Youth

The % of teens and young adults who are neither working nor in school is higher in Essex County than the NYS average. This rate has increased since 2019 even as the state average has gone down.

11% Essex County

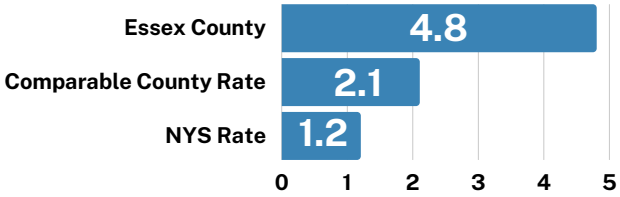
6% NYS

Living with a Disability (adults)



Foster Care Admission Rate

Admissions per 1,000 children



Essex County's rate of foster care admissions is over 2x higher than rates in comparable counties and is 4x higher than the state average.

Mental Health

The ration of population to mental health providers is:

720:1 in Essex County

370:1 in New York State

2022 Community Survey Result Snapshot

Substance abuse and **Access to Mental Health Services** were identified as **two** of the **top 5* health challenges** in Essex County according to residents.

**Overweight/obesity, chronic disease, and access to healthcare were also selected.*

47% Almost half of residents who responded to the survey categorized their mental health as **less than** "good" or "excellent".

Available Community Health Improvement Plan Goals - can be selected by health department and/or partner organizations:

Focus Area 1: Promote Well-Being

- Goal 1.1: Strengthen opportunities to build well-being and resilience across the lifespan
- Goal 1.2: Facilitate supportive environments that promote respect and dignity for people of all ages

Focus Area 2: Prevent Mental & Substance Use Disorders

- Goal 2.1: Prevent underage drinking and excessive alcohol consumption by adults
- Goal 2.2: Prevent opioid and other substance misuse and deaths
- Goal 2.3: Prevent and address adverse childhood experiences (ACEs)
- Goal 2.4: Reduce the prevalence of major depressive disorders
- Goal 2.5: Prevent suicides
- Goal 2.6: Reduce the mortality gap between those living with serious mental illness and the general population

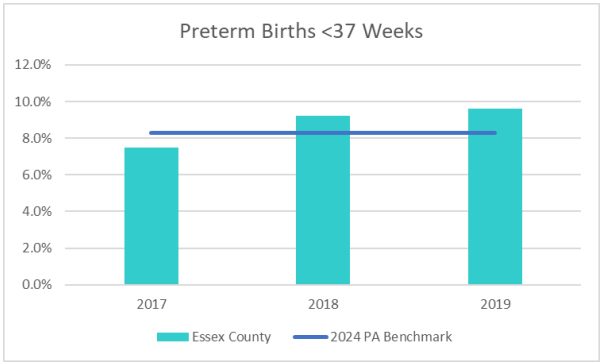
Note: all data on all infographics is from the NYS Prevention Agenda Community Health Planning Data source page, unless otherwise specified. https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/sources.htm

NYS PREVENTION AGENDA 2019-2024

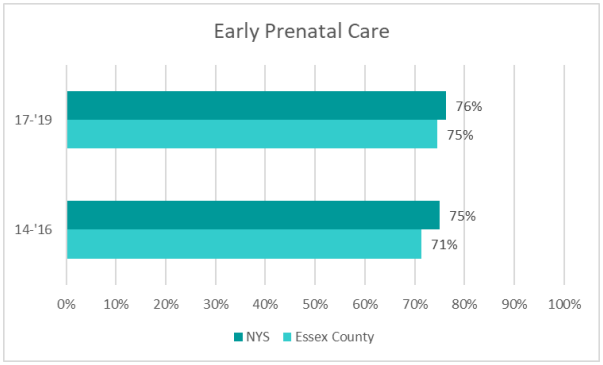
Promote Healthy Women, Infants and Children

Focus Area 1: Maternal & Women's Health
Focus Area 2: Perinatal & Infant Health

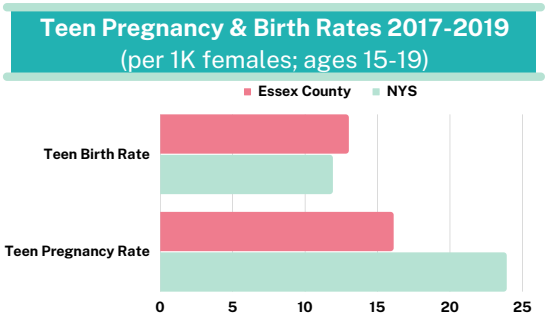
Focus Area 3: Child & Adolescent Health
Focus Area 4: Cross Cutting Healthy Women, Infants, & Children



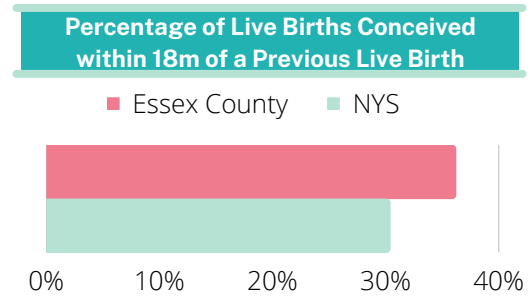
Preterm births are on the rise in Essex County and the latest data points are above the 2024 NYS Prevention Agenda benchmark.



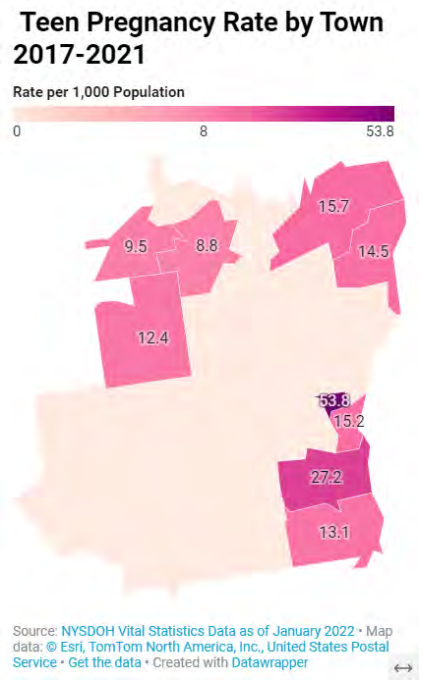
The percentage of births with early prenatal care is trending in the right direction, though still lower than the NYS average.



Both the teen birth rate and the teen pregnancy rate have significantly improved in Essex County compared to 2014-2016 rates.



Pregnancy spacing is an important component of prenatal and post-natal healthcare. Close proximity of births can be physically, mentally, emotionally, and financially stressful for families.

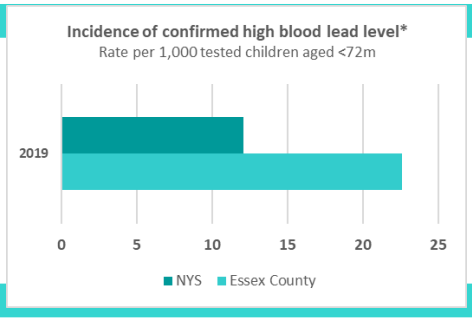


Note: data is suppressed for zip codes with a population fewer than 30 females ages 15-19. These zip codes are displayed as "0".

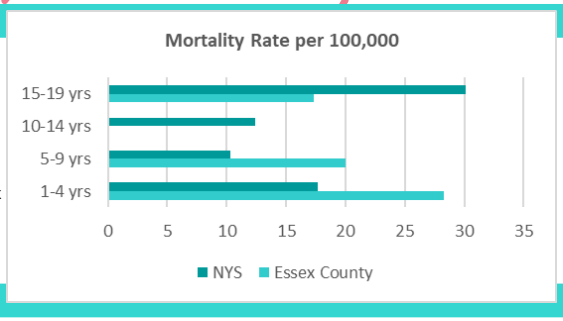
Child Health Indicators

69%

% of Essex County children with recommended number of well child visits in government sponsored healthcare programs

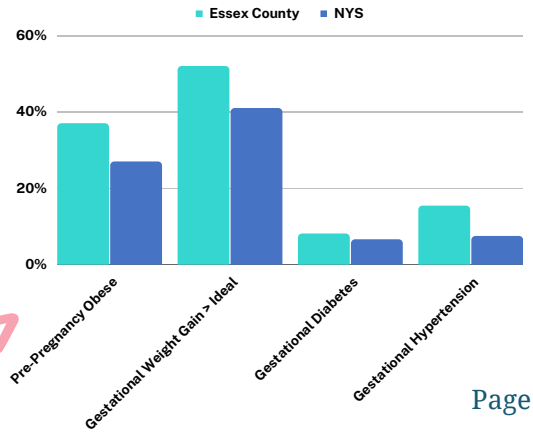


The rate of outpatient visits for dental caries (cavities) for Essex County children ages 3-5 per 10,000 population is over 50% higher than the NYS average.



Disparities

Pregnancy Indicators for WIC Women



Focus Area 1: Maternal & Women's Health
- Goal 1.1: Increase use of primary and preventive health care services by women of all ages, with a focus on women of reproductive age
- Goal 1.2: Reduce maternal mortality and morbidity

Focus Area 2: Perinatal & Infant Health
- Goal 2.1: Reduce infant mortality and morbidity
- Goal 2.2: Increase breastfeeding

Focus Area 3: Child & Adolescent Health
- Goal 3.1: Support and enhance children and adolescent's social-emotional development and relationships
- Goal 3.2: Increase supports for children and youth with special health care needs
- Goal 3.3: Reduce dental caries among children

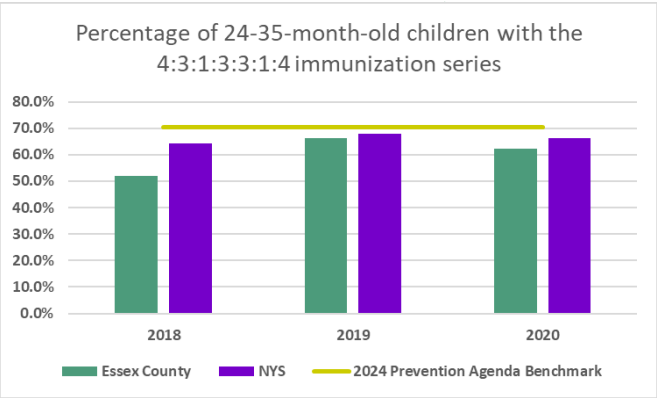
Focus Area 4: Cross Cutting Healthy Women, Infants, & Children
- Goal 4.1: Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations

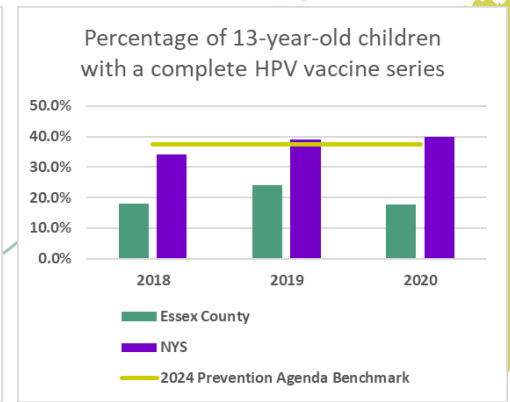
NYS PREVENTION AGENDA 2019-2024: Prevent Communicable Diseases

Focus Area 1: Vaccine-Preventable Diseases
Focus Area 2: Human Immunodeficiency Virus (HIV)

Focus Area 3: Sexually Transmitted Infections (STIs)
Focus Area 4: Hepatitis C Virus (HCV)

Focus Area 5: Antibiotic Resistance and Healthcare-Associated Infections



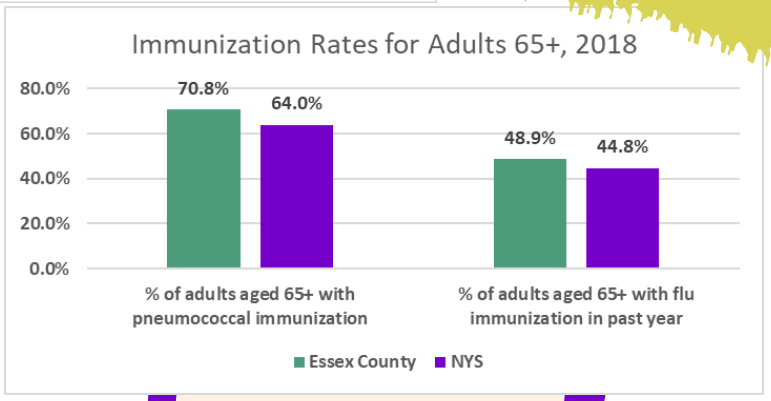


The 4:3:1:3:3:1:4 immunization series includes: 4 DTaP, 3 polio, 1 MMR, 3 hep B, 3 Hib, 1 varicella, 4 PCV13.

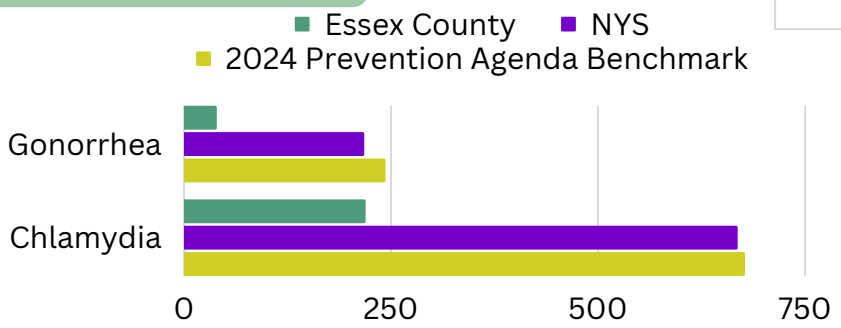
The 2020 immunization rates for this series and for the HPV series are lower in Essex County than the NYS rate, and both rates fall below the 2024 Prevention Agenda benchmarks.

Vaccine Preventable Diseases - Indicators

Select immunization rates for adults 65+ exceed NYS averages.

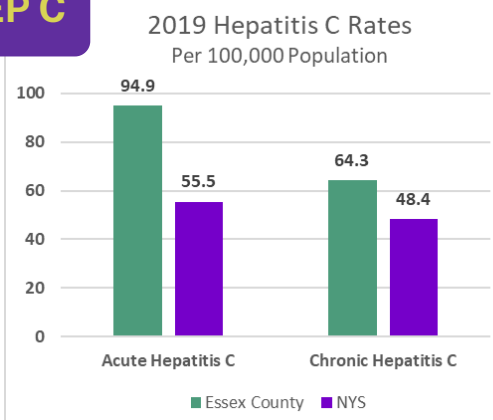


STDs and HIV



The rate of newly diagnosed HIV cases per 100,000 population is suppressed for Essex County for reasons of confidentiality. There are too few events; therefore, the data does not meet reporting criteria.

HEP C



Hepatitis C is a viral infection that affects the liver. It is the most common bloodborne infection and reason for liver transplant, one of the leading causes of liver cancer, and a major cause of infectious disease-related death in the US. Current medications cure over 90% of individuals.

Essex County has the second highest rate of acute Hep C infections in the Northeast region of NY and a rate that is over 70% higher than the state average. Over 50% of acute hep C cases in the Northeast are in individuals younger than 40 years of age, and of those, 85% have a history of injection drug use.

Focus Area 1: Vaccine-Preventable Diseases
- Goal 1.1: Improve vaccination rates
- Goal 1.2: Reduce vaccination coverage disparities

Focus Area 2: Human Immunodeficiency Virus (HIV)
- Goal 2.1: Decrease HIV morbidity (new HIV diagnoses)
- Goal 2.2: Increase viral suppression

Focus Area 3: Sexually Transmitted Infections (STIs)
- Goal 3.1: Reduce the annual rate of growth for STIs

Focus Area 4: Hepatitis C Virus (HCV)
- Goal 4.1: Increase the number of persons treated for HCV
- Goal 4.2: Reduce the number of new HCV cases among people who inject drugs

Focus Area 5: Antibiotic Resistance and Healthcare-Associated Infections
- Goal 5.1: Improve infection control in healthcare facilities
- Goal 5.2: Reduce infections caused by multidrug resistant organisms and C. difficile
- Goal 5.3: Reduce inappropriate antibiotic use

NYS PREVENTION AGENDA 2019-2024

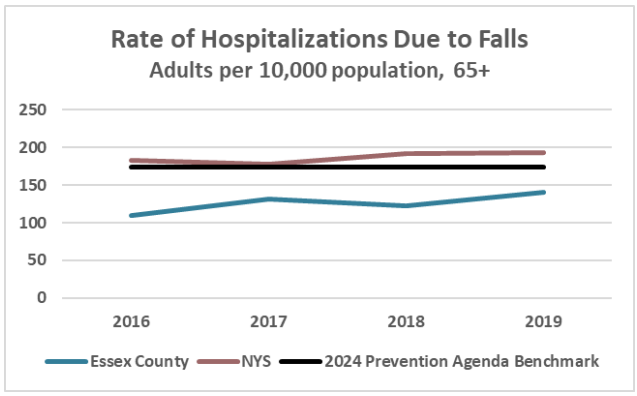
Promote a Healthy and Safe Environment

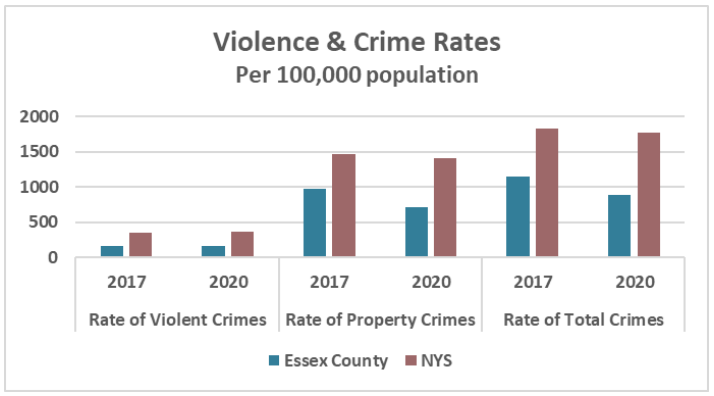
Focus Area 1: Injuries, Violence & Occupational Health
Focus Area 2: Outdoor Air Quality

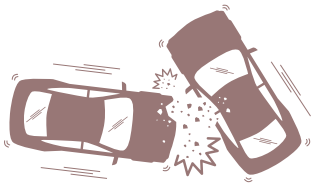
Focus Area 3: Built & Indoor Environments
Focus Area 4: Water Quality

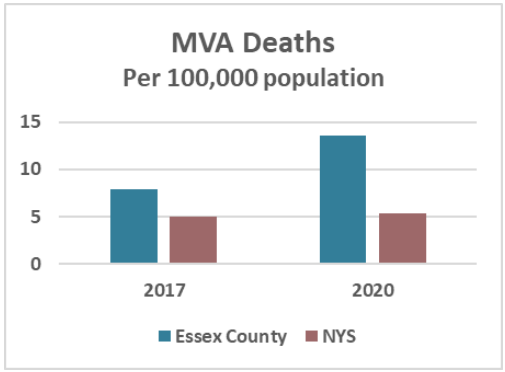
Focus Area 5: Food and Consumer Products

Injuries, Violence & Occupational Health

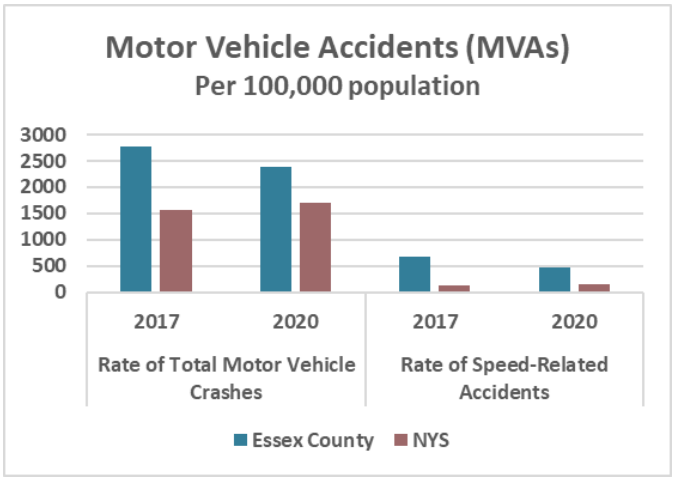








Built & Indoor Environment



21.2% of Essex County residents commute to work using alternate modes of transportation - or they telecommute. This is up from 19.7% (2012-2016 data), but still far below the 2024 Prevention Agenda Benchmark of 47.9%.

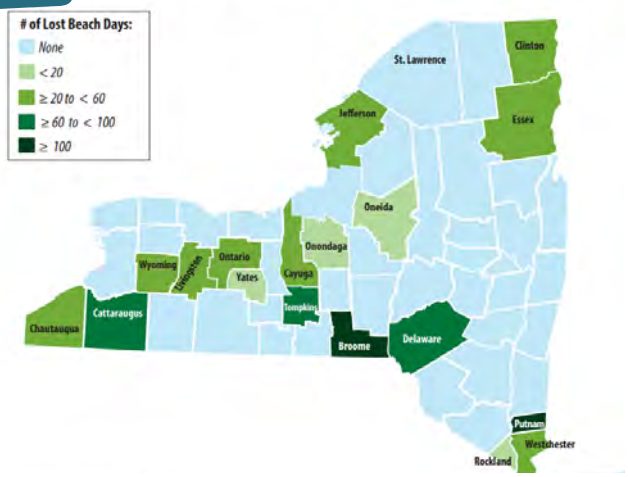
2.1% of the population in Essex County is low-income AND has low access to a supermarket or large grocery store. This is down from 2.2% in 2015.

As of 2021, 0% of the population of Essex County was living in a Certified Climate Smart Community. *Recently, Lake Placid Village received a Bronze level Climate Smart Communities certification. Lake Placid Village has a population of approximately 2,300, accounting for about 6% of the total population of Essex County.*

Water Quality

There are **no** public water systems that are fluoridated in Essex County.

Lost Beach Days due to Harmful Blue-Green Algae Blooms, 2021



Focus Area 1: Injuries, Violence and Occupational Health
- Goal 1.1: Reduce falls among vulnerable populations
- Goal 1.2: Reduce violence by targeting prevention programs particularly to highest risk populations
- Goal 1.3: Reduce occupational injuries and illness
- Goal 1.4: Reduce traffic related injuries for pedestrians and bicyclists

Focus Area 2: Outdoor Air Quality
- Goal 2.1: Reduce exposure to outdoor air pollutants

Focus Area 3: Built and Indoor Environments
- Goal 3.1: Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change

Focus Area 4: Water Quality
- Goal 4.1: Protect water sources and ensure quality drinking water
- Goal 4.2: Protect vulnerable waterbodies to reduce potential public health risks associated with exposure to recreational water

Focus Area 5: Food and Consumer Products
- Goal 5.1: Raise awareness of the potential presence of chemical contaminants and promote strategies to reduce exposure
- Goal 5.2: Improve food safety management

Community Health Planning Process

Selecting evidence-based strategies that address the priority areas and disparities identified in the CHA involved leveraging existing committees and coalitions of the ECHP to align future effort with current, ongoing, and/or planned initiatives of partner organizations, maximizing impact and synergy. These committees and internal workgroups were presented with the CHA findings, as well as the Prevention Agenda framework - including focus areas, objectives and strategies for each indicator of concern. Discussions to craft the Community Health Improvement Plan centered on effective and efficient use of current resources and assets to direct work to the areas of highest need, while reducing duplication and redundancy. Collective awareness of the needs in Essex County - and strategies proposed to address them - allowed for better coordination among the agencies engaged in this process.

Some of the planning work - meetings and presentations - occurred as part of the activities delineated in Step 6: Document & Communicate Results. Additional meetings occurred both internally at each respective ECPH organization - and externally as working groups of the partners. External partner meetings to strategize and draft the CHIP are listed below.

Participants	Priority Area	Interventions Discussed	Meeting/ Communication Date(s)
ECHP, ECMH	Chronic Disease; Well Being and Mental Health/Substance Use Disorders; Healthy Women, Infants, and Children	All interventions included in the NYS Prevention Agenda Action Plans	09/22/2022 11/02/2022
ECHD, ECMH	Well Being and Mental Health/Substance Use Disorders	Trauma informed approaches; DEI; mental health first aid	10/12/2022
ECHD - Public Health, Children's Services, WIC	Healthy Women, Infants, and Children	Home visiting programs; maternal depression screening; breastfeeding support; service linkages for children with special heath care needs	10/19/2022 11/14/2022

Participants	Priority Area	Interventions Discussed	Meeting/ Communication Date(s)
ECHD, Alliance for Positive Health; The Prevention Team; St. Joseph's	Well Being and Mental Health/Substance Use Disorders	Harm reduction; drop boxes; naloxone access; prevention education in schools	09/08/2022 10/03/2022 10/13/2022 10/19/2022
ECHD, North Country Healthy Heart Network, Champlain Valley Family Center	Chronic Disease	Tobacco access; cancer screening services; nutrition and physical activity	10/26/2022 10/28/2022

Taking Action

Step 8: Implement Strategies

One of the final steps of the Association for Community Health Improvement's nine-step pathway for conducting a Community Health Assessment is putting into action the interventions and strategies discussed in Step 7. This is an ongoing process, requiring continued assessment and reassessment of the activities necessary to advance the goals and objectives of the Community Health Improvement Plan. The Plan itself describes in detail the steps that will be taken by lead and partner agencies for each intervention; however, as work begins and progresses, activities, timelines, partner organizations, etc. may need to be modified.

The 2022-2024 Community Health Improvement Plan (CHIP), as developed and agreed upon by all lead and partner agencies, is attached as Appendix 6. The interventions in this CHIP employ an array of strategies to improve population health including:

- Coalitions, committees, and other community planning efforts;
- Policy, systems, and environmental changes;
- Public health marketing 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 6):

NYSDOH Prevention Agenda Identified/Researched

- Priority
- Focus Area
- Goal
- Intervention

Locally Identified

- Objectives
- Disparities
- Family of Measures for Evaluation
- Planned activities
- Partners
- Partner Roles and Resources
- Lead Agency

Examples of process Measures included:

- Number of trainings planned/provided
- Number of media campaigns and/or engagement
- Number of policies/plans adopted, revised, or updated
- Number of health practices screening or referring
- Number of coalition/committee meetings held/attended
- Number of programs offered and/or residents served.

A summary of the CHIP interventions are listed in the following tables. These tables demonstrate the commitment of the Essex County Health Partners and community based organizations in both taking the lead and working collaboratively to improve the health of Essex County.

PRIORITY: CHRONIC DISEASE			
FOCUS AREA	INTERVENTION	LEAD	PARTNER(S)
Healthy Eating & Food Security	Quality nutrition & physical activity in early learning & childcare centers	ECHD	K-12 Schools
	Physical activity and nutrition before, during, and after school	ECHD	K-12 Schools
	Fruit & vegetable incentive programs	UVMHN-ECH	ECHD
Physical Activity	Community physical activity programs	ECHD	Media
Tobacco Prevention	Facilitate tobacco dependence treatment	NCHHN	Providers
	Promote treatment of tobacco dependence	ECHD/AH	Media/CBOs
	Healthcare provider involvement in quit attempts	NCHHN	Providers
	Policy action to reduce tobacco marketing	CVFC	Students
	Decrease availability of flavored tobacco products	CVFC	Businesses
Preventive Care & Management	Systems change for cancer screening reminders	AH	CBOs
	Remove barriers to cancer screening	UVMHN-ECH	
	Increase colorectal cancer screening	ECHD	Media

PRIORITY: WELL-BEING and SUBSTANCE USE & MENTAL HEALTH DISORDERS			
FOCUS AREA	INTERVENTION	LEAD	PARTNER(S)
Promote Well-Being	Evidence-based home visiting programs	ECHD	Providers
	Promote inclusion, integration, and competence	ECMH	CBOs
	Thoughtful messaging on mental illness & substance use	ECHD	Media
Prevent Mental Health & Substance Use Disorders	School-based prevention	The Prevention Team	K-12 Schools
	SBIRT	UVMHN-ECH	
	Trauma informed approaches in prevention programs	ECMH	CBOs
	Access to MAT	UVMHN-ECH	
	Access to overdose reversal	Alliance for Positive Health	Pharmacies
	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: HEALTHY WOMEN, INFANTS & CHILDREN			
FOCUS AREA	INTERVENTION	LEAD	PARTNER(S)
Maternal & Women's Health	Preventive medical visits for women	UVMHN-ECH	
	Depression screening for pregnant & postpartum women	ECHD	
Perinatal & Infant Health	Access to breastfeeding support	ECHD	Providers
	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	CBOs & Providers

Monitor & Evaluate Progress

Step 9: Evaluate Progress

Measuring the extent to which metrics are achieved and progress toward goals is made should be done regularly. The evaluation should point toward the elements of the CHIP work plan interventions that are working and what could be modified. This allows for greater flexibility and more timely corrections if progress is off course. The metrics that will be measured to determine progress are outlined in detail in the CHIP work plan itself; however, in order to keep improvements on track, the Essex County Health Partners will take some additional steps, as outlined below.

Quarterly, at a minimum, the Essex County Health Partners will meet to:

- assess/measure progress on activities described in the CHIP work plan;
- identify barriers to the implementation of activities;
- develop strategies to overcome barriers and/or determine how activities may be adjusted for success; and
- recommend changes/additions/deletions to the CHIP work plan if new or updated information/data/indicators become available, or as needed based on partner capacity.

Quarterly, the Lead Partner for each intervention will reach out to all supporting/contributing partners of that activity to determine the status of identified activities. This information will be documented in the CHIP work plan.

Yearly, a representative of the Essex County Health Partners will submit an update to the NYSDOH.

Dissemination Plan

The 2022 Essex County Community Health Assessment (CHA) and 2022-2024 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 two 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.

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
4. Adirondack Health Board of Directors

Committees / Coalitions Notification

Essex County Health Partners will inform and educate the following local community based committees and coalitions that are engaged with ongoing assessment and planning efforts:

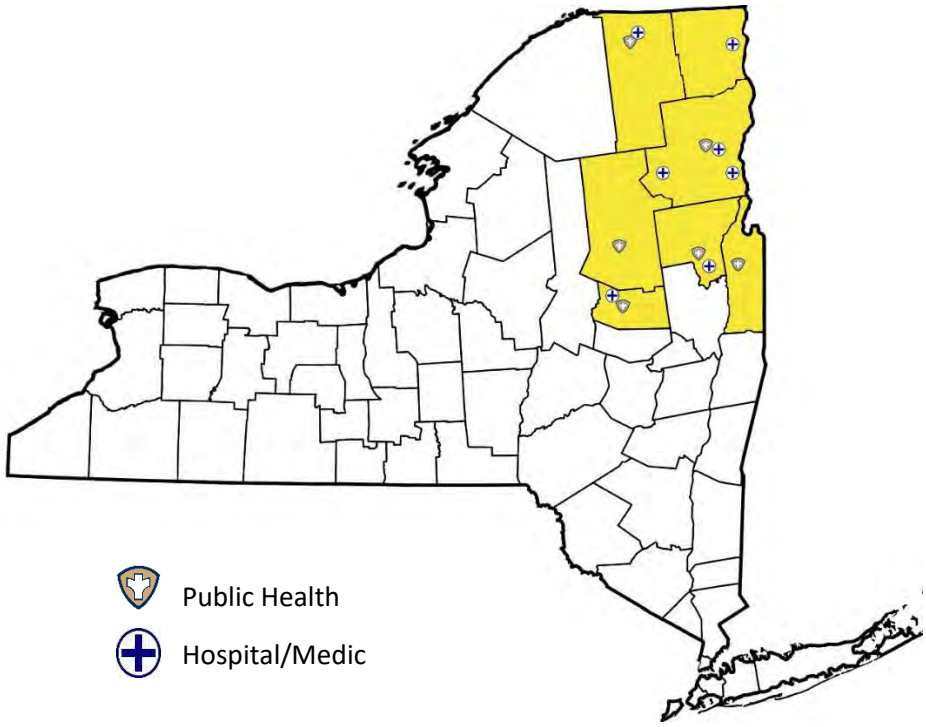
1. Building Resilience in Essex Families (BRIEF) Network
2. Essex County Breastfeeding Coalition
3. Essex County Heroin and Other (ECHO) Prevention Coalition
4. Essex County Community Services Board facilitated by the Essex County Mental Health Department

Additional Public Notification

Further dissemination may be conducted as interest and need arises.

APPENDIX 1

Summary of 2022 Community Stakeholder Survey



Adirondack Rural Health Network Service Area

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

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.

2022

Background:

Adirondack Rural Health Network: The Adirondack Rural Health Network (ARHN) is a program of AHI - Adirondack Health Institute, Inc. Established in 1992 through a New York State Department of Health Rural Health Development Grant, ARHN is a multi-stakeholder, regional coalition that informs planning, assessment, provides education and training to further the implementation of the New York State Department of 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 New York's 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 made up of hospitals and county health departments that have developed and implemented a sophisticated process for community health assessment and planning for the defined region to address identified regional priorities. The CHA Committee is made up of representatives from 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, and Washington County Public Health.

Purpose of the CHA Committee: The CHA Committee, made up of the CHA service contract holders with 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 and the Internal Revenue Service in an effort to advance the New York State Prevention Agenda.

CHA Committee, Ad Hoc Data Sub-Committee: At the June 4, 2021, CHA meeting, it was decided that an Ad Hoc Data Sub-Committee would be created to review tools and processes used by CHA Committee members to develop their Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP), as well as identify ways to enhance the CHA/CHIP process. A primary activity of the Ad Hoc Data Sub-Committee was to collaboratively develop a stakeholder survey.

The data subcommittee met four times from mid-July through mid-November 2021. Meetings were held via Webex/Zoom. Attendance ranged from 6 to 10 subcommittee members per meeting. Meetings were also attended by AHI staff from the Adirondack Rural Health Network.

Survey Methodology:

Survey Creation: The 2022 Community Stakeholder Survey was drafted by the Ad Hoc Data Sub-Committee, with the final version approved by the full CHA Committee at the November 10, 2021, meeting.

Survey Facilitation: ARHN facilitated the release of the stakeholder survey in its seven-county service area, to provide the CHA Committee with input on regional health care needs and priorities. Stakeholders included professionals from health care, social services, educational, and governmental

institutions, as well as community members. The ARHN region is made up of Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington Counties.

Survey Logistics: The survey was developed through SurveyMonkey and included 14 community health questions as well as several demographic questions. The CHA Committee provided a list of health care, social service, education, government, and service providers (hereafter referred to as community stakeholders) by county to be surveyed. The collected distribution list totaled 806 community stakeholders.

An initial email was sent to the community stakeholders in early January 2022 by the CHA Committee partners, introducing and providing a web-based link to the survey. CHA Committee partners released a follow-up email approximately two weeks later after the initial reach out. CHA Committee members were provided the names of all non-respondents for additional follow-up, at partner discretion.

The survey requested that community stakeholders identify the top two priority areas from a list of five which they believe need to be addressed within their county. Community stakeholders also gave insight on what they felt were the top health concerns and what contributing factors were most influential for those specific health concerns. A full list of survey questions can be found under Appendix A.

Survey Responses and Analysis: A total of 263 responses were received through March 1, 2022, for a total response rate of 32.63%. Respondents were asked to indicate in which counties they provided services and could choose coverage of multiple counties, as appropriate. The total response count per county is outlined in the *By County* section. It took respondents an average of 20 minutes to complete the survey, with a median response time of approximately 16 minutes.

Analysis is sorted alphabetically and in order of how the questions were listed in the survey to make the analysis easier to comprehend. Each table is labeled to identify whether the information is by response count or percentage. For tables containing counties, the table below indicates table is color coded to identify counties . All written analysis for each section is provided, with table below, and all written results are done in percentages.

This report provides a regional look at the results thru a wide-angle lens, focusing on the Adirondack Rural Health Network (ARHN) service area. It provides individual analyses of Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties. This stakeholder survey was conducted to gather information from a variety of fields and perspectives to provide valuable insight into the community's needs. The results enable us to guide strategic planning throughout the Adirondack region, for partners who serve individual counties, and those whose footprint covers multiple counties.

Clinton
Essex
Franklin
Fulton
Hamilton
Warren
Washington

Summary Analysis

1. Indicate your job title

Approximately 48.22% of respondents listed themselves as an *Administrator or Director.* There was a significant number of respondents who identified their title as Other (39.13%). Of those responses, the majority included police and fire chiefs, health educators, school nurses, and town supervisors.

It's important to note that based off responses, there did not seem to be enough answer choices. Moving forward, a recommendation would be to broaden answer choices to incorporate more community stakeholders.

Respondent Job Titles		
Job Title	**Responses**	
	Count	**Percentage**
Community Member	9	3.56%
Direct Service Staff	7	2.77%
Program/Project Manager	16	6.32%
Administrator/Director	122	48.22%
Other	99	39.13%

2. Indicate the community sector that best describes your organization

Community stakeholders were asked to indicate one community sector that best described their organization or agency. Over 198 organizations responded to the survey, spanning multiple counties in the ARHN region. Respondents provided a wide range of services, including *Education (22.75%)*, *Health Care (19.22%), Public Health (10.2%), and Local Government (8.63%),* among many others.

Response Counts by Community Sector	
Community Sector	**Total**
Business	1
Civic Association	2
College/University	1
Disability Services	6
Early Childhood	6
Economic Development	2
Employment/Job training	0
Faith-Based	0
Food/Nutrition	4
Foundation/Philanthropy	0
Health Based CBO	1
Health Care Provider	49
Health Insurance Plan	0
Housing	2
Law Enforcement/Corrections	7
Local Government (e.g. elected official, zoning/planning board)	22

Media	1
Mental, Emotional, Behavioral Health Provider	13
Public Health	26
Recreation	3
School (K – 12)	58
Seniors/Aging Services	12
Social Services	12
Transportation	0
Tribal Government	0
Veterans	1
Other (please specify)	26

3. Indicate County/Counties served

Respondents were asked which county their organization/agency serves. Over 64% of respondents were from Essex and Washington counties. Approximately 20% of respondents listed the county they serve as outside of the seven ARHN counties, including Montgomery, Saratoga, and St. Lawrence counties. Twenty-five percent of respondents identified themselves as serving the Adirondack/North Country region as a whole.

It should be noted that the figures below may not add up to 100%, due to organizations with multiple county coverage areas.

Respondents by County		
County/Region	**Total Response Count**	**Total Response Percentage**
Adirondack/North Country Region	67	25.77%
Clinton	51	19.62%
Essex	90	34.62%
Franklin	62	23.85%
Fulton	44	16.92%
Hamilton	44	16.92%
Warren	67	25.77%
Washington	79	30.38%
Other (please specify)	52	20.0%

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

4. NYS Prevention Agenda Priority Areas

Top Priority Area for the ARHN Region:

Survey participants were asked to rank the NYS Prevention Agenda Priority Areas in order of most to least impact. Overall, respondents in the ARHN region identified *Promote Well-Being and Prevent Mental and Substance Use Disorders* (38.05%) as their top priority, followed by *Promote a Healthy and Safe Environment* (29.33%).

NYS Prevention Agenda Top Priority Area for the ARHN Region		
County	**First Choice**	**Second Choice**
ARHN Region	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment

Top Priority Area by County:

To analyze the chosen priority areas, responses were totaled per county and the priority area that received the most responses is listed as the *First Choice*, followed by the second most responses listed as *Second Choice.*

All seven of the ARHN counties identified *Promote Well-Being and Prevent Mental and Substance Use Disorders* as their top priority. Additionally, Clinton, Franklin, Fulton, Hamilton, and Warren counties identified *Prevent Chronic Disease* as their second choice while Essex and Washington counties identified *Promote a Healthy and Safe Environment* as their second choice.

As survey participants were not provided focus areas or goals associated with each priority area, it can be assumed that the answers for these priority areas were slightly swayed due to what partners believe *Promote Well-Being and Prevent Mental and Substance Use Disorders* represents or what they feel would be listed in that category.

NYS Prevention Agenda Top Priority Area by County		
County	**First Choice**	**Second Choice**
Clinton	Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Disease
Essex	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment
Franklin	Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Disease
Fulton	Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Disease
Hamilton	Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Disease
Warren	Promote Well-Being and Prevent Mental and Substance Use Disorders	Prevent Chronic Disease
Washington	Promote Well-Being and Prevent Mental and Substance Use Disorders	Promote a Healthy and Safe Environment

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

Health Concerns for the ARHN Region:

Community stakeholders were asked to choose what they believed to be the top five health concerns affecting the residents in the counties their organization/agency served. The choices were ranked from one, being the highest health concern, to five, indicating the lowest health concern.

Survey respondents felt that the top five health concerns affecting the residents within the ARHN region were *Mental Health (20.96%), Substance Use/Alcoholism/Opioid Use (13.1%), Child/Adolescent emotional health (9.61%), Overweight/Obesity (7.42%),* and *Adverse childhood experiences (6.99%).*

Response Counts for ARHN Region Health Concerns					
ARHN Region Health Concerns	**1 (Highest)**	**2**	**3**	**4**	**5 (Lowest)**
Adverse childhood experiences	16	15	9	11	8
Alzheimer's disease/Dementia	2	9	3	10	5
Arthritis	0	1	0	1	1
Autism	0	3	1	2	2
Cancers	14	12	8	5	5
Child/Adolescent physical health	6	10	7	4	7
Child/Adolescent emotional health	22	23	17	15	9
Diabetes	10	12	10	12	4
Disability	7	4	1	2	7
Dental health	0	5	4	5	12
Domestic abuse/violence	5	3	9	7	11
Exposure to air and water pollutants/hazardous materials	1	1	0	1	4
Falls	0	1	6	3	3
Food safety	3	0	1	1	4
Heart disease	5	6	15	7	5
Hepatitis C	0	1	2	1	0
High blood pressure	0	3	0	5	3
HIV/AIDS	0	0	1	0	2
Hunger	3	3	8	5	10
Infant health	1	1	2	0	1
Infectious disease	7	2	3	3	7
LGBT health	1	1	1	0	1
Maternal health	2	4	1	1	6
Mental health conditions	48	28	32	26	11
Motor vehicle safety (impaired/distracted driving)	0	2	1	2	1
Overweight or obesity	17	8	15	23	17
Pedestrian/bicyclist accidents	0	0	0	0	1
Prescription drug abuse	0	4	4	10	2
Respiratory disease (asthma, COPD, etc.)	1	5	5	2	5
Senior health	16	5	9	8	13
Sexual assault/rape	0	1	0	1	0
Sexually transmitted infections	1	2	0	2	3

Social connectedness	5	8	8	9	9
Stroke	0	0	0	3	2
Substance abuse/Alcoholism/Opioid Use	30	29	30	14	16
Suicide	0	3	2	5	4
Tobacco use/nicotine addiction – smoking/vaping/chewing	6	8	9	17	17
Underage drinking	0	2	1	3	6
Unintended/Teen pregnancy	0	1	2	0	0
Violence (assault, firearm related)	0	1	0	0	2

Health Concerns by County:

Overall, most of the health concerns identified per county 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. Three out of the seven ARHN counties listed *Diabetes* as a top health concern in their county.

Warren and Washington county respondents felt that *Senior Health* was a concern in their area, while Franklin and Hamilton counties included *Disability* as a concern for their counties. Outliers include Fulton County listing *Cancers* as a top concern in their county.

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

6. In your opinion, what are the top five contributing factors to the health concerns you chose in the previous question, affecting the residents of the counties your organization/agency serves?

Respondents were asked to identify what they believed to be the top five contributing factors to the 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.

Contributing Factors for the ARHN Region:

The top five contributing factors identified by survey respondents are *Lack of mental health services (14.2%), Poverty (12.9%), Addiction to alcohol/illicit drugs (12.0%), Age of residents (10.2%), and Changing family structures (9.8%).* Forty-six percent of respondents chose these factors as either the highest or second highest contributing factors for the health concerns that they had previously identified.

Response Counts for Top Contributing Factors in the ARHN Region					
Contributing Factors	**Highest (1)**	**2**	**3**	**4**	**Lowest (5)**
Addiction to alcohol/illicit drugs	27	26	20	12	7
Addiction to nicotine	6	5	7	4	5
Age of residents	23	5	4	9	8
Changing family structures (increased foster care, grandparents as parents, etc.)	22	16	9	9	5
Community blight/Deteriorating infrastructure (roads, bridges, water systems, etc.)	1	1	2	1	1
Crime/violence	0	2	2	1	2
Discrimination/racism	0	1	0	1	1
Domestic violence and abuse	0	4	6	4	8
Environmental quality	4	1	6	1	4
Excessive screen time	2	8	4	5	8
Exposure to tobacco smoke/emissions from electronic vapor products	2	2	2	2	4
Food insecurity	5	8	4	6	4
Health care costs	7	11	7	5	5
Homelessness	0	2	3	3	4
Inadequate physical activity	4	14	11	10	10
Inadequate sleep	0	0	2	2	3
Inadequate/unaffordable housing options	2	3	12	10	1
Lack of chronic disease screening, treatment and self-management services	4	2	7	5	1
Lack of cultural and enrichment programs	2	1	1	0	1
Lack of dental/oral health care services	1	3	5	2	3
Lack of educational, vocational or job-training options for adults	1	4	1	0	3
Lack of employment options	0	3	3	5	4
Lack of health education programs	3	2	3	2	1
Lack of health insurance	1	0	4	1	2
Lack of intergenerational connections within communities	4	2	0	3	2
Lack of mental health services	32	16	17	12	12
Lack of opportunities for health for people with physical limitations or disabilities	1	2	2	1	4

Lack of preventive/primary health care services (screenings, annual check-ups)	1	3	2	3	3
Lack of quality educational opportunities for people of all ages	1	1	1	2	2
Lack of social supports for community residents	1	8	6	12	5
Lack of specialty care and treatment	2	1	5	3	3
Lack of substance use disorder services	1	5	2	2	2
Late or no prenatal care	0	1	0	1	0
Pedestrian safety (roads, sidewalks, buildings, etc.)	0	0	0	1	0
Poor access to healthy food and beverage options	0	4	8	5	6
Poor access to public places for physical activity and recreation	1	2	2	4	4
Poor community engagement and connectivity	2	4	2	6	9
Poor eating/dietary practices	10	9	5	14	13
Poor referrals to health care, specialty care, and community-based support services	6	5	3	4	6
Poverty	29	9	14	12	11
Problems with Internet access (absent, unreliable, unaffordable)	0	1	1	0	3
Religious or spiritual values	0	0	0	0	1
Shortage of childcare options	0	0	2	6	3
Stress (work, family, school, etc.)	14	11	12	12	13
Transportation problems (unreliable, unaffordable)	1	9	12	15	12
Unemployment/low wages	2	7	3	3	7

Contributing Factors by County:

The majority of the ARHN counties identified contributing factors that fell in line with the overall ARHN region's top five. Another contributing factor indicated by Clinton and Franklin counties was *Poor eating/dietary practices.*

Top Five Contributing Factors by County					
County	**1st**	**2nd**	**3rd**	**4th**	**5th**
Clinton	Addiction to alcohol/illicit drugs	Poverty	Poor eating/dietary practices	Age of residents	Poor referrals to health care, specialty care, and community-based support services
Essex	Changing family structures	Poverty	Addiction to alcohol/illicit drugs	Lack of mental health services	Age of residents
Franklin	Addiction to alcohol/illicit drugs	Poverty	Lack of mental health services	Changing family structures	Poor eating/dietary practices
Fulton	Poverty	Addiction to alcohol/illicit drugs	Lack of mental health services	Changing Family Structures	Age of residents
Hamilton	Addiction to alcohol/illicit drugs	Age of residents	Lack of mental health services	Poverty	Addiction to nicotine
Warren	Lack of mental health services	Changing Family Structures	Poverty	Addiction to alcohol/illicit drugs	Lack of chronic disease screening, treatment and self-management services

Washington	Lack of mental health services	Changing Family Structures	Poverty	Age of residents	Addiction to alcohol/illicit drugs

8. Please rank the following Social Determinants of Health impacting the residents of the counties that your organization/agency serves using a scale of (1) "very poor" to (5) "excellent".

This survey question asked respondents to rank the Social Determinants of Health, listed below, in order from one, very poor, to five, excellent. The table below encompasses response counts for the entire survey.

Many respondents chose *Economic Stability (55.7%)* as the social determinant of health that they felt most impacted the residents of the counties that they serve, followed by *Social and Community Context (14.2%).*

Response Counts per Social Determinants of Health Ranking					
Social Determinants of Health	**1 (Very Poor)**	**2**	**3**	**4**	**5 (Excellent)**
Economic Stability (consider poverty, employment, food security, housing stability)	106	37	25	10	9
Education (consider high school graduation, enrollment in higher education, language and literacy, early childhood education and development)	14	31	48	48	47
Social and Community Context (consider social cohesion, civic participation, perceptions of discrimination and equity, incarceration/institutionalization)	27	39	53	45	35
Neighborhood and Built Environment (consider access to healthy foods and beverages, quality of housing, crime and violence, environmental conditions, transportation)	19	59	42	47	34
Health and Health Care (consider access to primary care, access to specialty care, health literacy)	24	40	45	51	53

9. In your opinion, what population in the counties your organization/agency serves experiences the poorest health outcomes?

To help determine who the target audience that has the greatest need is, we asked, in their opinion, what population, in the counties they serve, experiences the poorest health outcomes.

Every county in the ARHN region chose either *Individuals living at or near the federal poverty level* or *Individuals with mental health issues* as the population they felt had the poorest health outcomes. Clinton, Essex, Fulton, and Hamilton counties identified *Individuals living at or near the federal poverty level* or *Individuals with mental health issues*, while Warren and Washington counties identified *Individuals with mental health issues*. Franklin county had a split tie between the two.

Response Counts for Poorest Health Outcomes by County							
Population	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Warren**	**Washington**
Children/adolescents	1	3	2	4	1	4	4
Females of reproductive age	1	1	1	0	0	0	0
Individuals living at or near the federal poverty level	13	28	16	12	11	14	15
Individuals living in rural areas	4	8	5	1	6	8	12
Individuals with disability	0	3	2	1	2	0	0
Individuals with mental health issues	11	17	16	10	10	21	17
Individuals with substance abuse issues	8	11	6	4	7	8	8
Migrant workers	0	0	0	0	0	0	0
Seniors/elderly	9	9	9	4	5	4	7
Specific racial and ethnic groups	0	0	0	0	0	0	0
Other (please specify)	0	0	0	1	0	0	1
Total per county	47	80	57	37	42	59	64

10. New York State Prevention Agenda Goals

Top Three Goals for the ARHN Region:

Respondents were asked to choose three goals that their organization could assist in achieving in their counties. The top three goals for each NYS Prevention Agenda priority area aligned with most of the individual county goals.

Top Three Prevention Agenda Goals for the ARHN Region			
NYS Prevention Agenda Priority Areas	**Goal #1**	**Goal #2**	**Goal #3**
Prevent Chronic Disease	Increase skills and knowledge to support healthy food and beverage choices	Promote school, child-care, and worksite environments that support physical activity for people of all ages and abilities	Promote the use of evidence-based care to manage chronic diseases
Promote Healthy Women, Infants and Children	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Increase supports for children with special health care needs
Promote a Healthy and Safe Environment	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Reduce violence by targeting prevention programs to highest risk populations
Promote Well-Being and Prevent Mental and Substance Use Disorders	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent and address adverse childhood experiences
Prevent Communicable Disease	Improve vaccination rates	Reduce inappropriate antibiotic use	Improve infection control in health care facilities

Top Three Goals by County:

To align with the structure of the survey, county analysis is provided per NYS Prevention Agenda priority area.

Prevent Chronic Disease

Most of the counties contained three specific goals, *Promote the use of evidence-based care to manage chronic diseases, improve self-management skills for individuals with chronic disease, and Increase skills and knowledge to support health food and beverage choices.* Essex County also identified *Promote school, childcare, and worksite environments that support physical activity for people of all ages and disabilities,* while Hamilton County identified *Increase screening rates for breast, cervical, and colorectal cancer.* Lastly, Washington County identified *Increase food security* and *Promote the use of evidence-based care to manage chronic diseases.*

Priority Area: Prevent Chronic Disease			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Improve self-management skills for individuals with chronic disease	Promote the use of evidence-based care to manage chronic diseases	Increase skills and knowledge to support healthy food and beverage choices
Essex	Increase skills and knowledge to support healthy food and beverage choices	Improve self-management skills for individuals with chronic disease	Promote school, child care, and worksite environments that support physical activity for people of all ages and abilities
Franklin	Promote the use of evidence-based care to manage chronic diseases	Improve self-management skills for individuals with chronic disease	Increase skills and knowledge to support healthy food and beverage choices
Fulton	Promote the use of evidence-based care to manage chronic diseases	Increase skills and knowledge to support healthy food and beverage choices	Improve self-management skills for individuals with chronic disease
Hamilton	Promote the use of evidence-based care to manage chronic diseases	Improve self-management skills for individuals with chronic disease	Increase screening rates for breast, cervical, and colorectal cancer
Warren	Increase skills and knowledge to support healthy food and beverage choices	Promote the use of evidence-based care to manage chronic diseases	Improve self-management skills for individuals with chronic disease
Washington	Increase skills and knowledge to support healthy food and beverage choices	Increase food security	Promote the use of evidence-based care to manage chronic diseases

Promote Healthy Women, Infants and Children

All ARHN counties choose *Support and enhance children and adolescents' social-emotional development and relationships* or *Increase use of primary and preventive care services by women of all ages* as their number one goal. Clinton, Essex, Franklin, and Washington counties also listed *Reduce racial, ethnic, economic and geographic disparities in maternal and child health outcomes* as one of their top three goals.

Priority Area: Promote Healthy Women, Infants and Children			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Support and enhance children and adolescents' social-emotional development and relationships	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Essex	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Franklin	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Support and enhance children and adolescents' social-emotional development and relationships	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations
Fulton	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Increase supports for children with special health care needs
Hamilton	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Support and enhance children and adolescents' social-emotional development and relationships	Increase supports for children with special health care needs
Warren	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Increase supports for children with special health care needs
Washington	Support and enhance children and adolescents' social-emotional development and relationships	Increase use of primary and preventive care services by women of all ages, with a focus on women of reproductive age	Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations

Promote a Healthy and Safe Environment

Promote healthy home and schools' environments was chosen as the top goal for six out of seven of the ARHN counties, with *Reduce falls among vulnerable populations* chosen by Hamilton County. *Reduce violence by targeting prevention programs to highest risk populations* was also listed as one of the top three goals for Clinton, Essex, Franklin, Warren, and Washington counties.

Priority Area: Promote a Healthy and Safe Environment			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Reduce violence by targeting prevention programs to highest risk populations
Essex	Promote healthy home and schools' environments	Reduce violence by targeting prevention programs to highest risk populations	Reduce falls among vulnerable populations
Franklin	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Reduce violence by targeting prevention programs to highest risk populations
Fulton	Promote healthy home and schools' environments	Reduce falls among vulnerable populations	Reduce occupational injury and illness
Hamilton	Reduce falls among vulnerable populations	Promote healthy home and schools' environments	Reduce occupational injury and illness
Warren	Promote healthy home and schools' environments	Reduce violence by targeting prevention programs to highest risk populations	Improve design and maintenance of the built environment to promote healthy lifestyles, sustainability, and adaptation to climate change
Washington	Promote healthy home and schools' environments	Reduce violence by targeting prevention programs to highest risk populations	Reduce falls among vulnerable populations

Promote Well-Being and Prevent Mental and Substance Use Disorders

Strengthen opportunities to promote well-being and resilience across the lifespan and *facilitate supportive environments that promote respect and dignity for all ages* were both within the top three goals for every county. Clinton, Franklin, and Fulton counties listed *Prevent opioid and other substance misuse and deaths* in their top three goals, while Essex, Warren, and Washington counties listed *Prevent and address adverse childhood experiences* in their top three goals.

Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Essex	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent and address adverse childhood experiences
Franklin	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Fulton	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent opioid and other substance misuse and deaths
Hamilton	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Reduce the mortality gap between those living with serious mental illness and the general population
Warren	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent and address adverse childhood experiences
Washington	Strengthen opportunities to promote well-being and resilience across the lifespan	Facilitate supportive environments that promote respect and dignity for people of all ages	Prevent and address adverse childhood experiences

Prevent Communicable Diseases

All seven ARHN counties listed *Improve vaccination rates* as their number one goal. *Improve infection control in health care facilities* was identified at the number two goal by Clinton, Essex, Franklin, and Washington counties. Fulton and Hamilton counties listed *Reduce inappropriate antibiotic use* as their number two goal. Five out of seven counties also listed *Reduce vaccination coverage disparities* in their top three goals.

Priority Area: Prevent Communicable Disease			
County/Region	**Goal #1**	**Goal #2**	**Goal #3**
Clinton	Improve vaccination rates	Improve infection control in health care facilities	Reduce vaccination coverage disparities
Essex	Improve vaccination rates	Improve infection control in health care facilities	Reduce vaccination coverage disparities
Franklin	Improve vaccination rates	Improve infection control in health care facilities	Reduce vaccination coverage disparities
Fulton	Improve vaccination rates	Reduce inappropriate antibiotic use	Reduce the annual growth rate for Sexually Transmitted Infections (STIs)
Hamilton	Improve vaccination rates	Reduce inappropriate antibiotic use	Reduce vaccination coverage disparities
Warren	Improve vaccination rates	Reduce vaccination coverage disparities	Improve infection control in health care facilities
Washington	Improve vaccination rates	Improve infection control in health care facilities	Reduce vaccination coverage disparities

12. Based on the goals you selected, please identify the resources your organization/agency can contribute toward achieving these goals.

Respondents were asked to indicate the resources that their organization/agency would be able to contribute toward achieving the goals they listed. The table below encompasses the top ten resources listed.

Approximately 59% of all respondents identified *Participating on committees, workgroups, and coalitions* and *Provide subject-matter knowledge and expertise* as the main resources they can contribute to help achieve the NYS Prevention Agenda goals listed above. Respondents also felt strongly that they can *Share knowledge of community resources* and *Promote health improvement activities through social media* to help achieve the listed goals.

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

Appendix A. 2022 Stakeholder Survey

2022 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 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 any one 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 **<u>one</u>** 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

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

7. Please rank, **by indicating 1 through 5**, the priority areas that, if addressed locally, would have the greatest to the smallest impact on improving the health and well-being of the residents of the counties your organization/agency serves. (#1 ranked priority area would have the most impact; #5 ranked priority area would have the least impact.)

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

8. 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):

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

Social Determinants of Health

10. 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) "very poor" to (5) "excellent".

- ☐ **Economic Stability** (consider poverty, employment, food security, housing stability)

- ☐ **Education** (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 and Health Care** (consider access to primary care, access to specialty care, health literacy)

11. 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 2019-2024 identifies specific goals for improving the health of New Yorkers of all ages. New York State envisions that improving the health of all New Yorkers requires strategies that can be implemented by a diverse set of health and non-health organizations and agencies.

Over the next 5 questions, select the top 3 goals your organization/agency can assist in achieving in the counties it serves.

12. Prevent Chronic Diseases

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

13. Promote Healthy Women, Infants, and Children

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

14. Promote a Healthy and Safe Environment

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

15. Promote Well-Being and Prevent Mental and Substance Use Disorders

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

16. Prevent Communicable Diseases

- ☐ Improve vaccination rates
- ☐ Reduce vaccination coverage disparities
- ☐ Decrease HIV morbidity (new HIV diagnoses)
- ☐ Increase HIV viral suppression
- ☐ Reduce the annual growth rate for Sexually Transmitted Infections (STIs)
- ☐ Increase the number of persons treated for Hepatitis C
- ☐ Reduce the number of new Hepatitis C cases among people who inject drugs
- ☐ Improve infection control in health care facilities

- ☐ Reduce infections caused by multidrug resistant organisms and C. difficile
- ☐ Reduce inappropriate antibiotic use

17. Based on the goals 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):

18. With the overwhelming impact of COVID-19, were operations with your organization put on hold or modified, and if so, for how long? Via the scale below, please measure the impact of COVID-19 on your organization's operations.

- ☐ 1 – Operations were not changed
- ☐ 2 - Minimal operational changes
- ☐ 3 - Moderate operational changes
- ☐ 4 - Significant operational changes
- ☐ 5 - Operations cannot be completed (Limited or no resources available)

Additional Details:

19. Are you interested in being contacted at a later date to discuss the utilization of the resources you identified in Question #17?

- ☐ Yes
- ☐ No

20. 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 2

Adirondack Rural Health Network	County									ARHN Region	Upstate NYS*	New York City	New York State
Summary of Demographic Information	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Montgomery**	**Saratoga**	**Warren**	**Washington**				
Square Miles [1,2]													
Total Square Miles	1,037.9	1,794.2	1,629.1	495.5	1,717.4	403.0	810.0	867.0	831.2	8,372.2	46,823.75	302.65	47,126.4
Total Square Miles for Farms	252.5	90.0	219.9	34.7	1.5	179.7	111.9	15.8	289.5	903.8	10,727.98	0.42	10,728.40
Percent of Total Square Miles Farms	24.3%	5.0%	13.5%	7.0%	0.1%	44.6%	13.8%	1.8%	34.8%	10.8%	0.23	0.1%	22.8%
Population per Square Mile	77.4	20.8	30.9	107.9	2.6	122.3	283.1	74.0	73.4	41.9	237.8	27687.3	414.1
Population [3]													
Total Population	80,320	37,281	50,389	53,452	4,454	49,294	229,313	64,187	61,034	351,117	11,135,297	8,379,552	19,514,849
Percent White, Non-Hispanic	90.4%	93.0%	82.3%	93.0%	94.9%	86.5%	92.1%	95.5%	92.6%	87.9%	79.8%	41.4%	62.3%
Percent Black, Non-Hispanic	4.2%	3.2%	5.6%	1.9%	0.5%	2.8%	1.7%	1.1%	3.0%	3.0%	10.1%	23.8%	15.4%
Percent Hispanic/Latino	2.9%	3.1%	3.6%	3.4%	1.7%	14.7%	3.3%	2.7%	2.8%	2.9%	13.0%	28.8%	19.1%
Percent Asian/Pacific Islander, Non-Hispanic	1.2%	0.4%	1.2%	0.8%	0.0%	0.7%	2.9%	0.9%	0.6%	0.8%	4.9%	14.3%	8.6%
Percent Alaskan Native/American Indian	0.2%	0.2%	6.2%	0.4%	0.0%	0.2%	0.2%	0.2%	0.3%	1.1%	0.4%	0.4%	0.4%
Percent Multi-Race/Other	2.2%	1.9%	2.4%	3.3%	3.9%	3.8%	2.6%	2.0%	2.6%	2.3%	4.3%	5.6%	4.7%
Number Ages 0-4	3,775	1,506	2,405	2,750	135	3,114	11,481	2,829	2,868	16,268	605,910	534,759	1,140,669
Number Ages 5-14	8,142	3,260	5,622	6,104	342	6,147	25,765	6,635	6,625	36,730	1,302,649	934,646	2,237,295
Number Ages 15-17	2,502	1,229	1,721	1,943	123	2,048	8,525	2,176	2,042	11,736	425,114	268,064	693,178
Number Ages 18-64	52,359	22,537	25,071	32,223	2,481	28,798	141,996	38,228	37,864	210,763	6,832,435	5,389,570	12,222,005
Number Ages 65+	13,542	8,749	8,610	10,432	1,373	9,187	41,546	14,319	11,905	68,930	1,969,189	1,252,513	3,221,702
Number Ages 15-44 Female	15,026	5,401	7,825	9,016	526	8,702	40,725	10,485	9,787	58,066	579,669	3,317,146	3,896,815
Family Status [3]													
Number of Households	31,557	16,182	18,880	22,406	1,416	19,621	95,898	29,034	24,054	143,529	4,222,533	3,191,691	7,414,224
Percent Families Single Parent Households	9.8%	10.5%	10.0%	11.9%	N/A	11.4%	8.6%	11.8%	11.8%	11.0%	N/A	6.2%	7.3%
Percent Households with Grandparents as Parents	9.1%	24.8%	9.0%	12.8%	3.6%	8.6%	19.8%	14.1%	7.2%	11.5%	7.2%	18.9%	18.2%
Poverty [3,4]													
Mean Household Income	$ 75,442	$ 77,483	$ 69,689	$ 69,513	$ 71,980	$ 67,109	$ 108,479	$ 85,859	$ 71,922	$ 74,555	$ 97,962	$ 104,788	$ 105,304
Per Capita Income	$ 29,960	$ 33,906	$ 26,886	$ 29,984	$ 28,758	$ 27,346	$ 45,624	$ 38,740	$ 29,014	$ 31,035	$ 33,208	$ 41,907	$ 40,898
Percent of Individuals Under Federal Poverty Level	12.3%	10.1%	17.8%	14.8%	8.6%	17.8%	5.9%	8.5%	10.9%	11.9%	12.5%	16.8%	13.6%
Percent of Individuals Receiving Medicaid	23.3%	27.1%	25.9%	28.5%	24.9%	30.4%	12.9%	19.7%	26.5%	24.2%	20.2%	32.9%	25.7%
Per Capita Medicaid Expenditures	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	9,762
Immigrant Status [3]													
Percent Born in American Territories	95.4%	95.8%	96.8%	98.1%	98.2%	96.5%	94.0%	96.1%	97.5%	96.6%	87.5%	61.3%	76.3%
Percent Born in Other Countries	4.6%	4.2%	3.2%	1.9%	1.8%	3.5%	6.0%	3.9%	2.5%	3.4%	12.5%	38.7%	23.7%
Percent Speak a Language Other Than English at Home	5.9%	6.2%	8.0%	2.5%	3.0%	13.8%	6.8%	4.1%	5.0%	5.2%	17.2%	48.0%	30.3%
Housing [3]													
Total Housing Units	36,723	26,390	25,835	29,148	8,964	23,529	107,192	40,119	29,562	196,741	4,843,376	3,519,595	8,362,971
Percent Housing Units Occupied	85.9%	61.3%	73.1%	76.9%	15.8%	83.4%	89.5%	72.4%	81.4%	73.0%	87.2%	90.7%	88.7%
Percent Housing Units Owner Occupied	67.9%	76.4%	72.1%	69.7%	85.3%	67.5%	72.1%	70.7%	72.7%	71.9%	61.2%	29.8%	54.1%
Percent Housing Units Renter Occupied	32.1%	23.6%	27.9%	30.3%	14.7%	32.5%	27.9%	29.3%	27.3%	28.1%	26.0%	60.9%	45.9%
Percent Built Before 1970	46.2%	53.3%	56.2%	65.0%	52.4%	70.6%	34.1%	45.5%	58.0%	53.2%	60.6%	75.4%	66.8%
Percent Built Between 1970 and 1979	13.5%	12.6%	10.9%	10.8%	13.4%	7.6%	13.5%	11.7%	9.4%	11.7%	12%	7.0%	9.9%
Percent Built Between 1980 and 1989	14.0%	10.5%	12.5%	9.7%	10.2%	8.6%	14.4%	13.9%	10.6%	12.0%	9.6%	4.8%	7.6%
Percent Built Between 1990 and 1999	13.8%	9.2%	11.0%	6.7%	12.7%	7.2%	14.4%	11.1%	9.6%	10.5%	8.1%	3.9%	6.3%
Percent Built 2000 and Later	12.5%	14.4%	9.5%	7.9%	11.2%	6.0%	23.7%	17.9%	12.4%	12.7%	9.7%	8.9%	9.4%
Availability of Vehicles [3]													
Percent of Households with No Vehicles Available	9.4%	8.4%	10.3%	10.2%	3.0%	13.4%	4.4%	8.8%	9.3%	9.3%	9.5%	54.8%	29.0%
Percent of Households with One Vehicle Available	33.1%	34.8%	32.3%	33.0%	32.1%	34.9%	31.7%	33.8%	30.9%	32.9%	33.2%	31.6%	32.5%
Percent of Households with Two Vehicles Available	38.6%	40.2%	41.1%	38.0%	48.0%	33.7%	44.0%	39.7%	38.5%	39.3%	37.9%	10.3%	26.0%
Percent of Households with Three or More Vehicles Available	19.0%	16.5%	16.2%	18.7%	16.9%	18.0%	19.9%	17.8%	21.4%	18.5%	19.4%	3.2%	12.5%
Education [3]													
Total Population Ages 25 and Older	55,208	28,740	35,561	38,599	3,485	34,193	164,817	48,041	44,788	254,422	7,715,731	5,933,426	13,649,157
Percent with Less than High School Education	11.4%	10.3%	12.9%	12.1%	19.8%	13.3%	6.6%	8.4%	12.8%	11.4%	9.4%	16.7%	12.5%
Percent High School Graduate/GED	35.3%	32.0%	37.4%	36.5%	28.7%	34.8%	24.3%	29.1%	39.5%	34.9%	27.1%	23.7%	25.6%
Percent Some College, no degree	16.3%	17.3%	16.6%	18.6%	17.6%	21.1%	15.9%	18.9%	17.5%	17.5%	16.9%	13.6%	15.5%
Percent Associates Degree	11.0%	11.4%	12.9%	15.4%	13.9%	13.0%	11.6%	11.4%	10.8%	12.1%	10.7%	6.4%	8.9%
Percent Bachelor's Degree	13.5%	16.6%	10.6%	9.8%	10.0%	10.6%	23.2%	17.2%	11.6%	13.2%	19.6%	22.6%	20.9%
Percent Graduate or Professional Degree	10.9%	13.3%	10.1%	8.4%	9.9%	8.0%	18.8%	15.1%	8.6%	11.1%	16.5%	16.5%	16.5%

	County									ARHN Region	Upstate NYS*	New York City	New York State
	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington				
Employment Status [3]													
Total Population Ages 16 and Older	67,495	32,128	41,941	43,871	3,922	39,368	189,434	54,190	51,155	294,702	9,087,149	6,821,791	15,908,940
Total Population Ages 16 and Older in Armed Forces	80	7	5	27	3	42	1,342	112	46	280	20,858	2,654	23,512
Total Population Ages 16 and Older in Civilian Workforce	38,029	17,794	21,195	25,913	2,088	23,651	125,915	33,622	29,810	168,451	5,681,725	4,327,484	10,009,209
Percent Unemployed	4.5%	4.7%	7.0%	4.0%	2.1%	6.0%	3.2%	4.1%	5.6%	4.8%	3.0%	4.2%	5.7%
Employment Sector [3]													
Total Employed (Civilian Employed Pop)	36,323	16,952	19,721	24,881	2,044	22,235	121,132	32,257	28,146	160,324	5,398,633	4,040,006	9,438,639
Percent in Agriculture, Forestry, Fishing, Hunting, and Mining	2.0%	2.7%	3.6%	1.5%	5.6%	2.2%	0.8%	0.6%	3.8%	2.3%	0.9%	0.1%	0.6%
Percent in Construction	5.4%	8.4%	6.0%	6.5%	13.7%	6.6%	5.8%	7.2%	7.7%	6.8%	5.9%	5.1%	5.7%
Percent in Manufacturing	12.5%	9.6%	3.8%	11.2%	3.2%	15.1%	10.8%	7.8%	13.7%	10.1%	7.7%	3.1%	6.0%
Percent in Wholesale Trade	1.8%	0.5%	0.9%	1.9%	1.8%	2.2%	2.5%	1.8%	1.4%	1.5%	2.3%	1.9%	2.2%
Percent in Retail Trade	13.4%	9.1%	13.5%	13.3%	6.2%	10.7%	10.2%	12.0%	15.0%	12.8%	10.2%	8.9%	9.9%
Percent in Transportation, Warehousing, Utilities	5.8%	3.2%	4.2%	5.7%	10.0%	7.1%	3.9%	3.7%	4.3%	4.7%	4.6%	6.6%	5.5%
Percent in Information Services	1.4%	2.1%	1.2%	1.5%	1.3%	1.6%	1.5%	0.8%	1.1%	1.3%	2.0%	3.8%	2.8%
Percent in Finance/Insurance/Real Estate	2.4%	4.3%	2.3%	3.9%	6.4%	4.2%	6.8%	5.3%	3.9%	3.7%	6.8%	9.5%	8.1%
Percent in Other Professional Occupations	5.5%	6.7%	6.2%	7.4%	7.3%	6.4%	11.7%	8.4%	8.0%	7.0%	10.4%	14.2%	12.2%
Percent in Education, Health Care and Social Assistance	26.6%	28.2%	31.3%	28.5%	21.4%	25.8%	25.5%	28.3%	23.2%	27.3%	27.6%	27.5%	28.3%
Percent in Arts, Entertainment, Recreation, Hotel & Food Service	9.5%	13.9%	9.3%	6.9%	10.6%	5.8%	9.0%	11.7%	8.1%	9.7%	7.8%	10.2%	9.0%
Percent in Other Services	4.9%	6.0%	4.2%	5.6%	3.7%	6.0%	4.5%	4.9%	3.7%	4.8%	4.3%	5.2%	4.8%
Percent in Public Administration	8.8%	5.3%	13.7%	6.2%	8.8%	6.4%	7.1%	7.6%	6.2%	7.9%	5.2%	3.9%	4.8%

N/A - Data not available

(1) 2010 Census Estimate; Census Quick Stats

(2) USDA Farm Overview; 2017

(3) US Census Bureau, 2020 American Community Survey 5-year Estimates

(4) Centers for Medicaid and Medicare Services; 2019

**Upstate NYS = NYS Total Less NYC; NYC includes NY, Kings, Bronx, Richmond, Queens Counties*

Adirondack Rural Health Network Summary of Health Systems Information	County									ARHN Region	Upstate NYS*	New York State
	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington			
Population, 2020 ACS 5-Year Estimates [1]	80,320	37,281	50,389	53,452	4,454	49,294	229,313	64,187	61,034	351,117	11,135,297	19,514,849
Total Hospital Beds [2]												
Hospital Beds per 100,000 Population	374	67	339	138	0	264	75	609	0	274	N/A	N/A
Medical/Surgical Beds	214	0	129	47	0	70	115	300	0	690	N/A	N/A
Intensive Care Beds	14	0	14	8	0	5	12	12	0	48	N/A	N/A
Coronary Care Beds	7	0	0	0	0	3	7	12	0	19	N/A	N/A
Pediatric Beds	10	0	3	12	0	0	7	14	0	39	N/A	N/A
Maternity Beds	21	0	13	7	0	8	14	23	0	64	N/A	N/A
Physical Medicine and Rehabilitation Beds	0	0	0	0	0	24	0	0	0	0	N/A	N/A
Psychiatric Beds	34	0	12	0	0	20	16	30	0	76	N/A	N/A
Other Beds	0	25	0	0	0	0	0	0	0	25	N/A	N/A
Hospital Beds Per Facility [2]												
Adirondack Medical Center-Lake Placid Site	-	-	-	-	-	-	-	-	-	-	-	-
Adirondack Medical Center-Saranac Lake Site	-	-	95	-	-	-	-	-	-	-	-	-
Alice Hyde Medical Center	-	-	76	-	-	-	-	-	-	-	-	-
Champlain Valley Physicians Hospital Medical Center	300	-	-	-	-	-	-	-	-	-	-	-
Elizabethtown Community Hospital	-	25	-	-	-	-	-	-	-	-	-	-
Glens Falls Hospital	-	-	-	-	-	-	-	391	-	-	-	-
Nathan Littauer Hospital	-	-	-	74	-	-	-	-	-	-	-	-
Saratoga Hospital	-	-	-	-	-	-	171	-	-	-	-	-
St. Mary's Healthcare	-	-	-	-	-	120	-	-	-	-	-	-
St. Mary's Healthcare-Amsterdam Memorial Campus	-	-	-	-	-	10	-	-	-	-	-	-
Total Nursing Home Beds [3]												
Nursing Home Beds per 100,000 Population	640	909	387	715	0	1274	201	637	929	685	672	614
Nursing Home Beds per Facility [3]												
Alice Hyde Medical Center	-	-	135	-	-	-	-	-	-	-	-	-
Capstone Center for Rehabilitation and Nursing	-	-	-	-	-	120	-	-	-	-	-	-
Champlain Valley Physicians Hospital Medical Center SNF	34	-	-	-	-	-	-	-	-	-	-	-
Clinton County Nursing Home	80	-	-	-	-	-	-	-	-	-	-	-
Elderwood at North Creek	-	-	-	-	-	-	-	92	-	-	-	-
Elderwood at Ticonderoga	-	83	-	-	-	-	-	-	-	-	-	-
Elderwood of Uihlein at Lake Placid	-	156	-	-	-	-	-	-	-	-	-	-
Essex Center for Rehabilitation and Healthcare	-	100	-	-	-	-	-	-	-	-	-	-
Fort Hudson Nursing Center, Inc.	-	-	-	-	-	-	-	-	211	-	-	-
Fulton Center for Rehabilitation and Healthcare	-	-	-	176	-	-	-	-	-	-	-	-
Glens Falls Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	117	-	-	-	-
Granville Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	-	122	-	-	-
Meadowbrook Healthcare	287	-	-	-	-	-	-	-	-	-	-	-
Mercy Living Center	-	-	60	-	-	-	-	-	-	-	-	-
Nathan Littauer Hospital Nursing Home	-	-	-	84	-	-	-	-	-	-	-	-
Palatine Nursing Home	-	-	-	-	-	70	-	-	-	-	-	-
Plattsburgh Rehabilitation and Nursing Center	113	-	-	-	-	-	-	-	-	-	-	-
River Ridge Living Center	-	-	-	-	-	120	-	-	-	-	-	-
Seton Health at Schuyler Ridge Residential Healthcare	-	-	-	-	-	-	120	-	-	-	-	-
Slate Valley Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	-	88	-	-	-
St Johnsville Rehabilitation and Nursing Center	-	-	-	-	-	120	-	-	-	-	-	-
The Pines at Glens Falls Center for Nursing & Rehabilitation	-	-	-	-	-	-	-	120	-	-	-	-

	County									ARHN Region	Upstate NYS*	New York State
	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington			
Warren Center for Rehabilitation and Nursing	-	-	-	-	-	-	-	80	-	-	-	-
Washington Center for Rehabilitation and Healthcare	-	-	-	-	-	-	-	-	146	-	-	-
Wells Nursing Home Inc	-	-	-	122	-	-	-	-	-	-	-	-
Wesley Health Care Center Inc	-	-	-	-	-	-	342	-	-	-	-	-
Wilkinson Residential Health Care Facility	-	-	-	-	-	198	-	-	-	-	-	-
Total Adult Care Facility Beds [4]												
Adult Care Facility Beds per 100,000 Population	235	1086	179	311	0	1024	521	633	493	443	735	534
Total Adult Home Beds	150	194	60	114	0	294	483	248	152	918	39921	51893
Total Assisted Living Program Beds	39	30	30	52	0	169	0	54	75	280	8882	14123
Total Assisted Living Residence (ALR) Beds	0	131	0	0	0	21	401	52	50	233	19237	21885
Total Enhanced ALR Beds	0	29	0	0	0	21	252	52	14	95	8787	10520
Special Needs ALR Beds	0	21	0	0	0	0	58	0	10	31	5063	5767
Adult Home Beds by Total Capacity per Facility [4]												
Adirondack Manor HFA D.B.A Adirondack Manor HFA ALP	-	-	-	-	-	-	-	60	-	-	-	-
Adirondack Manor HFA D.B.A Montcalm Manor HFA	-	40	-	-	-	-	-	-	-	-	-	-
Ahana House	-	-	-	-	-	-	17	-	-	-	-	-
Alice Hyde Assisted Living Program	-	-	30	-	-	-	-	-	-	-	-	-
Argyle Center for Independent Living	-	-	-	-	-	-	-	-	35	-	-	-
Arkell Hall	-	-	-	-	-	24	-	-	-	-	-	-
Beacon Pointe Memory Care Community	-	-	-	-	-	-	52	-	-	-	-	-
Champlain Valley Senior Community	-	81	-	-	-	-	-	-	-	-	-	-
Countryside Adult Home	-	-	-	-	-	-	-	48	-	-	-	-
Elderwood Village at Ticonderoga	-	23	-	-	-	-	-	-	-	-	-	-
Hillcrest Spring Residential	-	-	-	-	-	80	-	-	-	-	-	-
Holbrook Adult Home	-	-	-	-	-	-	-	-	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	-	-	-	-	-	-	-	-	-	-
Pine Harbour	66	-	-	-	-	-	-	-	-	-	-	-
Pineview Commons H.F.A.	-	-	-	94	-	-	-	-	-	-	-	-
Samuel F. Vilas Home	44	-	-	-	-	-	-	-	-	-	-	-
Sarah Jane Sanford Home	-	-	-	-	-	40	-	-	-	-	-	-
The Cambridge	-	-	-	-	-	-	-	-	40	-	-	-
The Farrar Home	-	-	30	-	-	-	-	-	-	-	-	-
(3) US Census Bureau, 2020 American Community Survey 5-year Estimates	-	-	-	-	-	-	-	88	-	-	-	-
(4) Centers for Medicaid and Medicare Services; 2019	-	-	-	-	-	-	-	-	44	-	-	-
The Sentinel at Amsterdam, LLC	-	-	-	-	-	150	-	-	-	-	-	-
The Terrace at the Glen at Hiland Meadows	-	-	-	-	-	-	-	52	-	-	-	-
Valehaven Home for Adults	40	-	-	-	-	-	-	-	-	-	-	-
Willing Helpers' Home for Women	-	-	-	20	-	-	-	-	-	-	-	-
Willow Ridge Pointe	-	-	-	-	-	-	13	-	-	-	-	-
Woodlawn Commons	-	-	-	-	-	-	42	-	-	-	-	-
Total Physician [5]												
Total Physician per 100,000 population	273	134	159	112	157	156	259	391	48	198	393	399

	County									ARHN Region	Upstate NYS*	New York State
	Clinton	Essex	Franklin	Fulton	Hamilton	Montgomery	Saratoga	Warren	Washington			
Licensure Data [5]												
Clinical Laboratory Technician	14	6	6	1	0	3	19	8	4	39	1,211	1,631
Clinical Laboratory Technologist	49	20	30	29	0	34	148	49	26	203	7,421	11,418
Dental Assistant	12	3	10	3	0	7	40	11	14	53	1,372	1,521
Dental Hygienist	45	17	13	23	2	23	260	46	40	186	7,969	10,459
Dentist	44	12	20	16	0	24	180	44	17	153	8,695	14,893
Dietitian/Nutritionist, Certified	23	9	10	4	1	11	127	22	6	75	3,767	5,678
Licensed Clinical Social Worker (LCSW)	43	27	28	21	2	18	292	81	34	236	15,553	26,630
Licensed Master Social Worker (LMSW)	44	20	28	22	3	30	294	49	36	202	16,001	28,452
Licensed Practical Nurse	376	195	397	291	7	340	885	321	418	2005	47,600	61,550
Physician	219	50	80	60	7	77	595	251	29	696	43,720	77,825
Mental Health Counselor	63	21	33	10	1	15	184	41	16	185	5,573	8,306
Midwife	5	1	2	4	0	4	17	15	4	31	640	1,080
Nurse Practitioner	85	20	43	46	3	39	346	99	30	326	18,074	26,172
Pharmacist	102	27	36	40	2	36	505	78	42	327	14,089	21,930
Physical Therapist	73	45	48	31	4	43	414	71	30	302	14,245	20,265
Physical Therapy Assistant	19	5	21	20	0	23	62	26	15	106	4,080	5,619
Psychologist	12	12	5	10	1	5	115	26	5	71	6,227	11,730
Registered Physician Assistant	46	30	35	11	3	27	248	82	19	226	10,459	15,282
Registered Professional Nurse	1320	512	742	644	57	751	4029	1166	778	5219	181,132	255,088
Respiratory Therapist	21	2	6	19	0	17	113	20	14	82	4,161	5,806
Respiratory Therapy Technician	6	0	3	2	0	1	14	4	1	16	524	678

N/A - Data not available
(1) US Census Bureau, 2020 American Community Survey 5-year Estimates
(2) NYS Department of Health; NYS Health Profiles
(3) NYS Department of Health; Nursing Home Weekly Bed Census, 2022
(4) NYS Department of Health; Adult Care Facility Directory,2022
(5) NYS Education Department; License Statistics, 2021
**Upstate NYS = NYS Total Less NYC; NYC includes NY, Kings, Bronx, Richmond, Queens Counties*

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			
School System Information [1,2,3,4]												
Total Number of Public School Districts	8	10	7	6	4	5	12	9	11	55	439	731
Total Pre-K Enrollment	367	164	269	220	18	145	319	44	217	1,299	41,126	112,797
Total K-12 Enrollment	10,314	3,423	6,717	6,802	379	6,985	31,780	8,058	7,708	43,401	1,531,010	2,512,973
Number of Students Eligible for Free Lunch	4,113	1,433	3,506	3,398	137	4,055	7,313	3,092	3,177	18,856	625,885	1,343,837
Number of Students Eligible for Reduced Lunch	393	216	397	273	24	191	724	223	188	1,714	53,943	87,949
Percent Free and Reduced Lunch	44%	48%	58%	54%	42%	61%	25%	41%	44%	47%	44%	57%
Number English Proficiency	1,317	608	596	1,041	76	900	7,063	1,616	1,284	6,538	228,804	447,858
Percent with English Proficiency	37.0%	41.0%	25.0%	34.0%	44.0%	30.0%	56.0%	47.0%	39.0%	37.5%	42.6%	45.0%
Total Number of Graduates	724	263	435	490	30	533	2,510	603	540	3,085	114,153	179,195
Number Went to GED Transfer Program	0	0	0	0	0	0	7	17	6	23	584	1,187
Number Dropped Out of High School	60	12	21	57	0	34	101	38	44	232	4,969	8,699
Percent Dropped Out of High School	7.0%	4.0%	4.0%	10.0%	0.0%	6.0%	4.0%	5.0%	7.0%	5.3%	7.3%	4.0%
Total Number of Public School Teachers	963.5	393.8	687.1	593.9	78.0	553.4	2,631.7	781.9	736.9	4,235.1	136,911	212,296
Student to Teacher Ratio	9.3	11.5	10.2	8.7	20.6	7.9	8.3	9.7	9.6	9.8	8.9	8.4

(1) National Center for Education Statistics, 2020-2021

(2) NYS Education Department; Report Card Database 2019-2020

(3) NYS Education Department; Report Card Database 2020-2021

(4) NYS Education Department; 3-8 ELA Assessment Database 2019-2020

**Upstate NYS = NYS Total Less NYC; NYC includes NY, Kings, Bronx, Richmond, Queens Counties*

Adirondack Rural Health Network

Summary of Education System Information

School Districts by County [1]

Clinton	Essex	Franklin	Fulton	Hamilton
AUSABLE VALLEY CENTRAL SCHOOL DISTRICT	BOQUET VALLEY CSD*	BRUSHTON-MOIRA CENTRAL SCHOOL DISTRICT	BROADALBIN-PERTH CENTRAL SCHOOL DISTRICT	INDIAN LAKE CENTRAL SCHOOL DISTRICT
BEEKMANTOWN CENTRAL SCHOOL DISTRICT	CROWN POINT CENTRAL SCHOOL DISTRICT	CHATEAUGAY CENTRAL SCHOOL DISTRICT	GLOVERSVILLE CITY SCHOOL DISTRICT	LAKE PLEASANT CENTRAL SCHOOL DISTRICT
CHAZY UNION FREE SCHOOL DISTRICT	KEENE CENTRAL SCHOOL DISTRICT	MALONE CENTRAL SCHOOL DISTRICT	JOHNSTOWN CITY SCHOOL DISTRICT	LONG LAKE CENTRAL SCHOOL DISTRICT
NORTHEASTERN CLINTON CENTRAL SCHOOL DISTRICT	LAKE PLACID CENTRAL SCHOOL DISTRICT	SAINT REGIS FALLS CENTRAL SCHOOL DISTRICT	MAYFIELD CENTRAL SCHOOL DISTRICT	WELLS CENTRAL SCHOOL DISTRICT
NORTHERN ADIRONDACK CENTRAL SCHOOL DISTRICT	MINERVA CENTRAL SCHOOL DISTRICT	SALMON RIVER CENTRAL SCHOOL DISTRICT	NORTHVILLE CENTRAL SCHOOL DISTRICT	
PERU CENTRAL SCHOOL DISTRICT	MORIAH CENTRAL SCHOOL DISTRICT	SARANAC LAKE CENTRAL SCHOOL DISTRICT	WHEELERVILLE UNION FREE SCHOOL DISTRICT	
PLATTSBURGH CITY SCHOOL DISTRICT	NEWCOMB CENTRAL SCHOOL DISTRICT	TUPPER LAKE CENTRAL SCHOOL DISTRICT		
SARANAC CENTRAL SCHOOL DISTRICT	SCHROON LAKE CENTRAL SCHOOL DISTRICT			
	TICONDEROGA CENTRAL SCHOOL DISTRICT			
	WILLSBORO CENTRAL SCHOOL DISTRICT			

Montgomery	Saratoga	Warren	Washington
AMSTERDAM CITY SCHOOL DISTRICT	BALLSTON SPA CENTRAL SCHOOL DISTRICT	BOLTON CENTRAL SCHOOL DISTRICT	ARGYLE CENTRAL SCHOOL DISTRICT
CANAJOHARIE CENTRAL SCHOOL DISTRICT	BURNT HILLS-BALLSTON LAKE CENTRAL SCHOOL DISTRICT	GLENS FALLS CITY SCHOOL DISTRICT	CAMBRIDGE CENTRAL SCHOOL DISTRICT
FONDA-FULTONVILLE CENTRAL SCHOOL DISTRICT	CORINTH CENTRAL SCHOOL DISTRICT	GLENS FALLS COMMON SCHOOL DISTRICT	FORT ANN CENTRAL SCHOOL DISTRICT
FORT PLAIN CENTRAL SCHOOL DISTRICT	EDINBURG COMMON SCHOOL DISTRICT	HADLEY-LUZERNE CENTRAL SCHOOL DISTRICT	FORT EDWARD UNION FREE SCHOOL DISTRICT
OPPENHEIM-EPHRATAH-ST. JOHNSVILLE CSD	GALWAY CENTRAL SCHOOL DISTRICT	JOHNSBURG CENTRAL SCHOOL DISTRICT	GRANVILLE CENTRAL SCHOOL DISTRICT
	MECHANICVILLE CITY SCHOOL DISTRICT	LAKE GEORGE CENTRAL SCHOOL DISTRICT	GREENWICH CENTRAL SCHOOL DISTRICT
	SARATOGA SPRINGS CITY SCHOOL DISTRICT	NORTH WARREN CENTRAL SCHOOL DISTRICT	HARTFORD CENTRAL SCHOOL DISTRICT
	SCHUYLERVILLE CENTRAL SCHOOL DISTRICT	QUEENSBURY UNION FREE SCHOOL DISTRICT	HUDSON FALLS CENTRAL SCHOOL DISTRICT
	SHENENDEHOWA CENTRAL SCHOOL DISTRICT	WARRENSBURG CENTRAL SCHOOL DISTRICT	PUTNAM CENTRAL SCHOOL DISTRICT
	SOUTH GLENS FALLS CENTRAL SCHOOL DISTRICT		SALEM CENTRAL SCHOOL DISTRICT
	STILLWATER CENTRAL SCHOOL DISTRICT		WHITEHALL CENTRAL SCHOOL DISTRICT
	WATERFORD-HALFMOON UNION FREE SCHOOL DISTRICT		

(1) National Center for Education Statistics, public school district data for the 2020-2021 school years

* BOQUET VALLEY CSD was formed when Elizabethtown-Lewis CSD and Westport CSD merged in December 2018

Hamilton County Inlet School- no longer a public school, tuition only

ALICE is a United Way acronym that stands for Asset Limited, Income Constrained, Employed.												
Adirondack Rural Health Network	**County**									**ARHN****	**Upstate NYS***	**New York State**
Summary of ALICE Information	**Clinton**	**Essex**	**Franklin**	**Fulton**	**Hamilton**	**Montgomery**	**Saratoga**	**Warren**	**Washington**			
Total Households	31,392	15,425	19,088	22,439	1,124	19,665	94,156	28,007	24,009	141,484	4,185,726	7,370,222
ALICE Households over 65 years of age	3,209	2,109	2,055	2,911	158	2,792	10,254	3,613	2,871	16,926	476,148	816,702
ALICE Households by Race/Ethnicity												
Asian	102	0	0	5	0	59	326	76	0	183	29,940	192,069
Black	63	0	19	41	0	166	397	119	37	279	125,803	456,100
Hispanic	67	33	42	185	0	711	454	196	89	612	130,972	513,372
American Indian/ Alaska Native	29	0	298	0	0	0	17	0	0	327	5,051	11,770
White	7,753	4,187	4,768	6,047	520	5,647	24,511	8,312	7,738	39,325	886,364	1,251,617
2+ races	61	43	43	52	0	65	256	70	57	326	21,622	62,524
Poverty %	12.3%	9.7%	17.7%	14.0%	9.9%	17.2%	6.4%	9.5%	12.0%	12.4%	11.0%	13.7%
ALICE %	24.6%	27.8%	25.4%	26.0%	46.2%	30.4%	26.8%	29.7%	31.6%	27.6%	27.1%	31.0%
Above ALICE %	63.1%	62.5%	57.0%	59.9%	44.0%	52.4%	66.9%	60.8%	56.4%	60.0%	61.9%	55.3%
# of ALICE and Poverty Households	11,568	5,782	8,214	8,988	630	9,357	31,199	10,984	10,469	56,635	1,593,472	3,291,828
Unemployment Rate	3.8%	5.8%	7.1%	6.1%	8.0%	7.7%	3.6%	4.7%	5.7%	5.9%	N/A	5%
Percent of Residents with Health Insurance	95%	96%	93%	95%	94%	95%	96%	95%	95%	94.7%	N/A	6%
Median Household Income	$56,704	$56,196	$51,696	$50,248	$57,552	$45,837	$83,765	$56,482	$54,114	$54,713	N/A	$67,844

(1) American Community Survey, 2018
(2) ALICE Threshold, 2018
(3) United for Alice, 2018
(4) NYS County Health Rankings, 2018
**Upstate NYS = NYS Total Less NYC; NYC includes NY, Kings, Bronx, Richmond, Queens Counties*
***ARHN region reflects an average of ARHN counties*

APPENDIX 3

Essex County Revised: August 2022

	Number Per Year (If Available)			Essex County Average, Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score			
	One	Two	Three		ARHN[1]	Upstate NY	New York State	2024 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4				Source	Updated	Notes
Focus Area: Disparities																			
Prevention Agenda Indicators																			
Percentage of Overall Premature Deaths (before age 65 years), 2019				19.3%	22.1%	21.0%	22.7%	**22.8%**	Meets/Better							0.00	Prevention Agenda Dashboard	Feb-22	
Premature Deaths (before age 65 years), difference in percentages between Black, non-hispanics and White, non-hispanics, 2019				-19.2+	N/A	20.2	17.7	**17.3**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	
Premature deaths (before age 65 years), difference in percentages between Hispanics and White, non-hispanics, 2019				30.8+	N/A	21.1	16.4	**16.2**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	
Rate of Potentially preventable hospitalizations among adults, age-adjusted, per 10,000, 2019				67.0	142.52	120.4	125.9	**115.0**	Meets/Better							0.00	Prevention Agenda Dashboard	Feb-22	
Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Black, non-hispanics and White, non-hispanics, 2019				-66.8+	N/A	128.4	115.8	**94**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	
Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Hispanics and White, non-hispanics, 2019				-66.8+	N/A	1.0	34.6	**23.9**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	
Percentage of Adults (Ages 18 - 64) with Health Insurance, 2019				94.4%	93.6%	94.00	92.5%	**97.0%**	Worse	X						0.03	Prevention Agenda Dashboard	Feb-22	Upstate NY calculated using county data.
Age-Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2018				82.2%	82.3%	82.0%	79.1%	**86.7%**	Worse	X						0.05	Prevention Agenda Dashboard	Feb-22	
Quartile Summary for Prevention Agenda Indicators										2	0	0	0	25.0%	0.0%				
Other Disparity Indicators																			
Rate of Total Deaths per 100,000 Population, 2017-2019	429	407	487	1,179.8	1,069.7	**916.2**	798.8	N/A	Worse		X					0.29	Community Health Indicator Reports	Feb-22	
Rate of Emergency Department Visits per 10,000 Population, 2017-2019	19,386	18,291	18,291	4,990.9	4,694.3	**3,843.0**	4,134.7	N/A	Worse		X					0.30	Community Health Indicator Reports	Feb-22	
Rate of Total Hospitalizations per 10,000 Population, 2017-2019	2,897	2,359	2,499	691.5	981.2	**1,144.2**	1,154.8	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Percentage of Adults Who Did Not Receive Medical Care Due to Costs, 2018				9.7%	9.6%	**9.2%**	11.0%	N/A	Worse	X						0.06	NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22	
Percentage of adults reporting 14 or more days of poor physical health, 2018				16.8%	13.0%	**11.1%**	11.2%	N/A	Worse			X				0.51	NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22	
Percentage of adults living with a disability (based on 6 ACA disability questions), 2018				33.0%	29.2%	**24.6%**	26.2%	N/A	Worse		X					0.34	NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22	
Quartile Summary for Other Indicators										1	3	1	0	83.3%	20.0%				
Quartile Summary for Mortality										3	3	1	0	50.0%	14.3%				

N/A: Data does not meet reporting criteria

*: Fewer than 10 or 20 events in the numerator, therefore the rate/percentage is unstable

+: Fewer than 10 events in at least one of the numerators of the rates/percentages, therefore the ratio or rate difference is unstable.

1: ARHN data not available when two or more counties do not have reported data

	Number Per Year (If Available)			Comparison Regions/Data					Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score			
	One	Two	Three	Essex County Average, Rate, Ratio or Percentage for the Listed Years	ARHN[1]	Upstate NY	New York State	2024 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4			Source	Updated	Notes
Focus Area: Injuries, Violence, and Occupational Health																		
Prevention Agenda Indicators																		
Rate of Hospitalizations due to falls among adults per 10,000 population, aged 65+, 2019				140.8	165.2	210.4	193.9	**173.7**	Meets/Better							0.00 Prevention Agenda Dashboard	Feb-22	
Rate of Assault-Related Hospitalizations per 10,000 Population, 2019				0*	1.00	2.2	3.1	**3.0**	Less than 10							0.00 Prevention Agenda Dashboard	Feb-22	
Ratio of Rates of Assault-related hospitalizations between Black non-Hispanics and White non-Hispanics, 2019				N/A	N/A	5.6	5.1	**5.5**	Less than 10							0.00 Prevention Agenda Dashboard	Feb-22	
Ratio of Rates of Assault-related hospitalizations, between Hispanics and White non-Hispanics, 2019				0.00+	N/A	1.8	2.4	**2.5**	Less than 10							0.00 Prevention Agenda Dashboard	Feb-22	
Ratio of Rates of Assault-Related Hospitalizations for Low-Income ZIP codes and Non-Low Income Zip Codes, 2019				N/A	N/A	3.0	2.8	**2.7**	Less than 10							0.00 Prevention Agenda Dashboard	Feb-22	
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%			
Other Indicators																		
Falls hospitalization rate per 10,000 - Aged <10 years, 2017-2019				N/A	5.5	**6.2**	6.8	N/A	Less than 10							0.00 Community Health Indicator Reports	Feb-22	
Falls hospitalization rate per 10,000 - Aged 10-14 years, 2017-2019				N/A	2.6*	**3.4**	4.0	N/A	Less than 10							0.00 Community Health Indicator Reports	Feb-22	ARHN rate is not inclusive of Fulton County as there is no data available. ARHN calculation not included due to unstable rate.
Falls hospitalization rate per 10,000 - Aged 15-24 years, 2017-2019				N/A	2.9	**4.0**	4.4	N/A	Less than 10							0.00 Community Health Indicator Reports	Feb-22	
Falls hospitalization rate per 10,000 - Aged 25-64 years, 2017-2019	33	21	26	13.4	18.5	**19.7**	18.8	N/A	Meets/Better							0.00 Community Health Indicator Reports	Feb-22	
Rate of Violent Crimes per 100,000 Population, 2020				172.0	157.0	**204.7**	364.9	N/A	Meets/Better							0.00 Division of Criminal Justice Services Index, Property, and Firearm Rates	Oct-21	
Rate of Property Crimes per 100,000 Population, 2020				722.5	1,056.8	**1,292.1**	1,406.5	N/A	Meets/Better							0.00 Division of Criminal Justice Services Index, Property, and Firearm Rates	Oct-21	
Rate of Total Crimes per 100,000 Population, 2020				894.5	1,213.9	**1,496.8**	1,771.4	N/A	Meets/Better							0.00 Division of Criminal Justice Services Index, Property, and Firearm Rates	Oct-21	
Incidence Rate of Malignant Mesothelioma Cases, Ages 15 Plus, per 100,000 Population, 2016-2018				N/A	1.2*	**1.4**	1.1	N/A	Less than 20							0.00 Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Rate of Pneumoconiosis Hospitalizations, Ages 15 and older, per 100,000 Population, 2017-2019				N/A	9.4	**9.0**	6.6	N/A	Less than 10							0.00 Community Health Indicator Reports	Feb-22	
Rate of Asbestosis Hospitalizations, Ages 15 Plus, per 10,000 Population, 2017-2019				0.0*	0.8	**0.8**	5.7	N/A	Less than 10							0.00 Community Health Indicator Reports	Feb-22	
Rate of Work-Related Hospitalizations, Employed Ages 16 Plus per 100,000 Individuals Employed, 2017-2019	13	13	15	84.4	138.1	**175.8**	145.9	N/A	Meets/Better							0.00 Community Health Indicator Reports	Feb-22	
Rate of Total Motor Vehicle Crashes per 100,000, 2020				2,382.7	2,298.7	**2,157.0**	1,693.1	N/A	Worse	X						0.10 NYS Traffic Safety Statistical Repository	Feb-22	
Rate of Speed-Related Accidents per 100,000 Population, 2020				482.5	260.2	**205.7**	146.0	N/A	Worse				X			1.35 NYS Traffic Safety Statistical Repository	Feb-22	
Rate of Motor Vehicle Accident Deaths per 100,000 Population, 2020				13.6	7.2	**6.6**	5.3	N/A	Worse				X			1.05 NYS Traffic Safety Statistical Repository	Feb-22	
Rate of Traumatic Brain Injury Hospitalizations per 10,000 Population, 2017-2019	9	10	11	2.7	6.4	**9.0**	8.5	N/A	Meets/Better							0.00 Community Health Indicator Reports	Feb-22	
Rate of Unintentional Injury Hospitalizations Ages 65 Plus per 10,000 Population, 2017-2019	127	123	152	154.6	210.3	**275.1**	249.9	N/A	Meets/Better							0.00 Community Health Indicator Reports	Feb-22	
Rate of Poisoning Hospitalizations per 10,000 Population, 2017-2019	10	10	11	2.8	6.7	**7.6**	8.0	N/A	Meets/Better							0.00 Community Health Indicator Reports	Feb-22	
Quartile Summary for Other Indicators										1	0	0	2	17.6%	66.7%			
Quartile Summary for Focus Area Injuries, Violence, and Occupational Health										1	0	0	2	13.6%	66.7%			

N/A: Data does not meet reporting criteria
*: Fewer than 10 or 20 events in the numerator, therefore the rate/percentage is unstable
+: Fewer than 10 events in at least one of the numerators of the rates/percentages, therefore the ratio or rate difference is unstable.
1: ARHN data not available when two or more counties do not have reported data

	Number Per Year (If Available)			Essex County Average, Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score			
	One	Two	Three		ARHN[1]	Upstate NY	New York State	2024 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4				Source	Updated	Notes
Focus Area: Outdoor Air Quality																			
Prevention Agenda Indicators																			
Annual number of days with air quality index >100 (unhealthy levels of ozone or particulate matter), 2021				N/A	N/A	N/A	20	**3**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	
Quartile Summary for Focus Area Outdoor Air Quality										0	0	0	0	0.0%	0.0%				
Focus Area: Built Environment																			
Prevention Agenda Indicators																			
Percentage of population living in a certified Climate Smart Community, 2021				0.0%*	20	54.2%	31.3%	**8.6%**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	
Percentage of people who commute to work using alternate modes of transportation or who telecommute, 2015-2019				21.2%	17.4%	22.9%	45.6%	**47.9%**	Worse			X				0.56	Prevention Agenda Dashboard	Feb-22	
Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 2015				2.1%	6.0%	**3.9%**	2.2%	N/A	Meets/Better							0.00	USDA Food Environment Atlas	Dec-20	
Quartile Summary for Focus Area Built Environment										0	0	1	0	33.3%	100.0%				
Focus Area: Water Quality																			
Prevention Agenda Indicators																			
Percentage of residents served by community water systems that have optimally fluoridated water, 2019				0.0%*	26.8%	46.9%	71.1%	**77.5%**	Less than 10							0.00	Prevention Agenda Dashboard	Aug-21	
Quartile Summary for Focus Area Water Quality										0	0	0	0	0.0%	0.0%				
Quartile Summary for Focus Area Air Quality, Built Enviroment, Water Qaulity										0	0	1	0	20.0%	100.0%				

N/A: Data does not meet reporting criteria

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+: Fewer than 10 events in at least one of the numerators of the rates/percentages, therefore the ratio or rate difference is unstable.

1: ARHN data not available when two or more counties do not have reported data

	Number Per Year (If Available)			Essex County Average, Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score		Source	Updated	Notes
	One	Two	Three		ARHN[1]	Upstate NY	New York State	2024 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4						
Focus Area: Reduce Obesity in Children and Adults																			
Prevention Agenda Indicators																			
Percentage of Adults Ages 18 Plus Who are Obese, 2018				30.6%	34%	29.1%	27.6%	**24.2%**	Worse		X					0.26	Prevention Agenda Dashboard	Feb-22	
Quartile Summary for Prevention Agenda Indicators										0	1	0	0	100.0%	0.0%				
Other Indicators																			
Percentage of Total Students Overweight, 2018-2019				15.3%	17.5%	**16.9%**	N/A	N/A	Meets/Better							0.00	Student Weight Status Category Reporting System (SWSCRS) Data	Jul-20	Total Population is the number of overweight/obese and total healthy weight
Percentage of Elementary Students Overweight, Not Obese, 2018-2019				15.3%	17.2%	**16.1%**	N/A	N/A	Meets/Better							0.00	Student Weight Status Category Reporting System (SWSCRS) Data	Jul-20	Total Population is the number of overweight/obese and total healthy weight
Percentage of Elementary Student Obese, 2018-2019				14.9%	19.4%	**16.6%**	N/A	N/A	Meets/Better							0.00	Student Weight Status Category Reporting System (SWSCRS) Data	Jul-20	Total Population is the number of overweight/obese and total healthy weight
Percentage of Middle and High School Students Overweight, Not Obese, 2018-2019				0.0%	17.4%	**17.8%**	N/A	N/A	Meets/Better							0.00	Student Weight Status Category Reporting System (SWSCRS) Data	Jul-20	Total Population is the number of overweight/obese and total healthy weight
Percentage of Middle and High School Students Obese, 2018-2019				32.9%	25.3%	**19.5%**	N/A	N/A	Worse			X				0.69	Student Weight Status Category Reporting System (SWSCRS) Data	Jul-20	Total Population is the number of overweight/obese and total healthy weight
Percentage obese (95th percentile or higher) children (aged 2-4 years) in WIC, 2015-2017				16.5%	16.1%	**15.5%**	13.8%	N/A	Worse	X						0.06	Community Health Indicator Reports	Feb-22	
Percentage of adults overweight or obese, 2018				67.2%	69.1%	**64.2%**	62.7%	N/A	Worse	X						0.05	NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22	
Percentage of adults who participated in leisure time physical activity in the past 30 days, 2018				73.7%	73.3%	**77.6%**	76.2%	N/A	Worse	X						0.05	NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22	
Number of Recreational and Fitness Facilities per 100,000 Population, 2016				10.5	8.8	**13.2**	12.3	N/A	Worse	X						0.20	USDA Food Environment Atlas	Dec-20	
Percentage of adults who had a test for high blood sugar or diabetes within the past three years, 2018				47.7%	49.1%	**48.6%**	51.1%	N/A	Worse	X						0.02	NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22	
Rate of Cardiovascular Disease Deaths per 100,000 Population, 2017-2019	141	100	120	321.9	309.6	**295.9**	278.3	N/A	Worse	X						0.09	Community Health Indicator Reports	Feb-22	
Rate of Cardiovascular Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019	20	15	18	114.0	123.3	**102.4**	104.2	N/A	Worse	X						0.11	Community Health Indicator Reports	Feb-22	
Rate of Cardiovascular Disease Pretransport Deaths per 100,000 Population, 2017-2019	92	58	66	192.6	184.7	**179.5**	163.6	N/A	Worse	X						0.07	Community Health Indicator Reports	Feb-22	
Rate of Cardiovascular Hospitalizations per 10,000 Population, 2017-2019	439	310	352	98.2	141.4	**161.7**	155.2	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Diseases of the Heart Deaths per 100,000 Population, 2017-2019	115	83	86	253.3	240.1	**234.0**	169.4	N/A	Worse	X						0.08	Community Health Indicator Reports	Feb-22	
Rate of Diseases of the Heart Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019	16	13	12	88.2	100.9	**82.4**	83.9	N/A	Worse	X						0.07	Community Health Indicator Reports	Feb-22	
Rate of Disease of the Heart Pretransport Deaths per 100,000 Population, 2017-2019	77	49	51	157.8	149.1	**147.2**	138.7	N/A	Worse	X						0.07	Community Health Indicator Reports	Feb-22	
Rate of Disease of the Heart Hospitalizations per 10,000 Population, 2017-2019	290	216	258	68.1	97.5	**111.2**	84.2	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Coronary Heart Diseases Deaths per 100,000 Population, 2017-2019	71	56	62	168.5	155.2	**162.4**	173.4	N/A	Worse	X						0.04	Community Health Indicator Reports	Feb-22	

Rate of Coronary Heart Diseases Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019	12	10	9	66.7	69.6	**59.7**	66.4	N/A	Worse	X						0.12	Community Health Indicator Reports	Feb-22	
Rate of Coronary Heart Disease Pretransport Deaths per 100,000 Population, 2017-2019	46	39	37	108.8	100.8	**106.6**	112.4	N/A	Worse	X						0.02	Community Health Indicator Reports	Feb-22	
Rate of Coronary Heart Disease Hospitalizations per 10,000 Population, 2017-2019	83	52	59	17.3	29.1	**32.9**	31.5	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Congestive Heart Failure Deaths per 100,000, 2017-2019	12	3	4	16.9	19.1	**22.3**	15.1	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Congestive Heart Failure Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019	2	0	1	6.5*	4.2*	**3.2**	2.4	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Rate of Congestive Heart Failure Pretransport Deaths per 100,000 Population, 2017-2019	9	2	3	12.5	12.2	**13.7**	8.7	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Potentially preventable heart failure hospitalization rate per 10,000 - Aged 18 years and older, 2017-2019	72	68	85	24.0	38.8	**69.4**	41.3	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Cerebrovascular (Stroke) Deaths per 100,000 Population, 2017-2019	10	10	24	39.2	41.5	**38.2**	31.5	N/A	Worse	X						0.03	Community Health Indicator Reports	Feb-22	
Rate of Cerebrovascular (Stroke) Hospitalizations per 10,000 Population, 2017-2019	78	44	59	16.1	23.7	**28.2**	26.6	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Potentially preventable hypertension hospitalization rate per 10,000 - Aged 18 years and older, 2017-2019				1.4	2.7	**5.9**	7.3	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Diabetes Deaths per 100,000 Population, 2017-2019	10	15	22	41.9	33.0	**22.5**	22.5	N/A	Worse				X			0.86	Community Health Indicator Reports	Feb-22	
Rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 Population, 2017-2019	34	47	38	10.6	18.9	**18.9**	21.4	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Diabetes Hospitalizations (Any Diagnosis) per 10,000 Population, 2017-2019	613	486	591	150.7	238.0	**252.0**	262.7	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Quartile Summary for Other Indicators										15	0	1	1	53.1%	11.8%				
Quartile Summary for Focus Area Reduce Obesity in Children and Adults										15	1	1	1	54.5%	11.1%				

N/A: Data does not meet reporting criteria

*: Fewer than 10 or 20 events in the numerator, therefore the rate/percentage is unstable

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	Number Per Year (If Available)			Essex County Average, Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score		Source	Updated	Notes
	One	Two	Three		ARHN[1]	Upstate NY	New York State	2024 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4						
Focus Area: Reduce Illness, Disability, and Death Related to Tobacco Use and Secondhand Smoke Exposure																			
Prevention Agenda Indicators																			
Percentage of Adults Ages 18 Plus Who Smoke, 2018				16.4%	19.5%	13.9%	12.8%	**11.0%**	Worse		X					0.49	Prevention Agenda Dashboard	Feb-22	
Quartile Summary for Prevention Agenda Indicators										0	1	0	0	100.0%	0.0%				
Other Indicators																			
Rate of Chronic Lower Respiratory Disease Deaths per 100,000 Population, 2017-2019	36	29	24	79.4	76.6	**48.3**	36.7	N/A	Worse			X				0.64	Community Health Indicator Reports	Feb-22	
Rate of Chronic Lower Respiratory Disease Hospitalizations per 10,000, Population, 2017-2019	143	59	60	23.4	32.5	**28.7**	29.7	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Asthma Deaths per 100,000 Population, 2017-2019	0	0	0	0.0*	0.7*	**0.9**	1.4	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Rate of Asthma Hospitalizations per 10,000 Population, 2017-2019				0.9	3.1	**6.2**	9.8	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Asthma Hospitalizations, Ages 25 - 44, per 10,000 Population, 2017-2019				0.0*	2.4	**4.2**	5.0	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Asthma Hospitalizations, Ages 45 - 64, per 10,000 Population, 2017-2019				N/A	2.9	**5.2**	8.8	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Asthma Hospitalizations, Ages 65 Plus, per 10,000 Population, 2017-2019				N/A	3.9	**4.9**	9.3	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN rate is not inclusive of Fulton County as there is no data available.
Percentage of adults with current asthma, 2018				15.4%	13.5%	**10.6%**	10.1%	N/A	Worse		X					0.45	NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22	
Rate of Lung and Bronchus Cancer Deaths per 100,000 Population, 2016-2018	32	19	24	66.7	65.0	**48.1**	39.6	N/A	Worse		X					0.39	Community Health Indicator Reports	Feb-22	
Rate of Lung and Bronchus Cancer Cases per 100,000 Population, 2016-2018	41	40	33	101.4	119.0	**87.6**	72.6	N/A	Worse	X						0.16	Community Health Indicator Reports	Feb-22	
Number of Registered Tobacco Vendors per 100,000 Population, 2016-2017				166.3	132.7	**104.4**	110	N/A	Worse			X				0.59	NYS Department of Health Tobacco Enforcement Compliance Results	Oct-19	Population is 5-year Census data 2015-2020
Tobacco Sales to Minors Violations per 100,000 Population, 2016-2017				10.7	4.0*	**4.0**	6.6	N/A	Worse				X			1.68	NYS Department of Health Tobacco Enforcement Compliance Results	Oct-19	Population is 5-year Census data 2015-2020 ARHN calculation not included due to unstable rate.
Percentage of Vendors with Complaints per 100,000 Population, 2016-2017				0.0	0.0*	**0.0***	1.1	N/A	Meets/Better							0.00	NYS Department of Health Tobacco Enforcement Compliance Results	Oct-19	Population is 5-year Census data 2015-2020 ARHN calculation not included due to unstable rate.
Quartile Summary for Other Indicators										1	2	2	1	46.2%	50.0%				
Quartile Summary for Focus Area Reduce Illness, Disability, and Death Related to Tobacco Use & Secondhand Smoke Exposure										1	3	2	1	50.0%	42.9%				

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	Number Per Year (If Available)			Essex County Average, Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score				
	One	Two	Three		ARHN[1]	Upstate NY	New York State	2024 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4				Source	Updated	Notes
Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings																			
Prevention Agenda Indicators																			
Asthma emergency department visits, rate per 10,000, aged 0-17 years, 2019				55.7	42.3	57.5	99.9	**131.1**	Meets/Better							0.00	Prevention Agenda Dashboard	Feb-22	
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%				
Other Indicators																			
Asthma emergency department visit rate per 10,000 - aged 18-64 years, 2017-2019				32.7	41.4	**39.0**	63.3	N/A	Meets/Better							0.00	Asthma Summary Report	Feb-22	
Asthma emergency department visit rate per 10,000 - aged 65+ years, 2017-2019				20.0	16.0	**14.8**	28.2	N/A	Worse		X					0.35	Asthma Dashboard-County Level	Feb-22	
Rate of All Cancer Cases per 100,000 Population, 2016-2018	260	275	235	684.8	710.8	**657.0**	587.7	N/A	Worse	X						0.04	Community Health Indicator Reports	Feb-22	
Rate of all Cancer Deaths per 100,000 Population, 2016-2018	115	92	86	260.6	232.6	**194.7**	175.5	N/A	Worse		X					0.34	Community Health Indicator Reports	Feb-22	
Rate of Female Breast Cancer Cases per 100,000 Female Population, 2016-2018	38	33	21	169.3	176.3	**180.1**	164.6	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Female Late Stage Breast Cancer Cases per 100,000 Female Population, 2016-2018	13	9	9	57.1	48.6	**50.9**	49.3	N/A	Worse	X						0.12	Community Health Indicator Reports	Feb-22	
Rate of Female Breast Cancer Deaths per 100,000 Female Population, 2016-2018				29.4*	24.9	**26.3**	25.1	N/A	Less than 20							0.00	Community Health Indicator Reports	Feb-22	
Percentage of women aged 50-74 years receiving breast cancer screening based on recent guidelines, 2018				76.7%	80.4%	**80.9%**	82.1%	N/A	Worse	X						0.05	NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22	
Rate of Cervix Uteri Cancer Incidence per 100,000, 2016-2018				11.0*	8.9	**7.1**	8.3	N/A	Less than 20							0.00	Community Health Indicator Reports	Feb-22	
Rate of Cervix and Uteri Cancer Deaths per 100,000 Female Population, 2016-2018				N/A	6.2*	**2.2**	2.5	N/A	Less than 20							0.00	Community Health Indicator Reports	Feb-22	ARHN rate is not inclusive of Fulton County as there is no data available. ARHN calculation not included due to unstable rate.
Percentage of women aged 21-65 years receiving cervical cancer screening based on recent guidelines, 2018				83.2%	87.2%	**86.1%**	84.7%	N/A	Worse	X						0.03	NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22	
Rate of Ovarian Cancer Cases per 100,000 Female Population, 2016-2018				12.9*	14.8	**15.2**	14.2	N/A	Less than 20							0.00	Community Health Indicator Reports	Feb-22	
Rate of Ovarian Cancer Deaths per 100,000 Female Population, 2016-2018				11.0*	8.8	**9.3**	8.7	N/A	Less than 20							0.00	Community Health Indicator Reports	Feb-22	ARHN rate is not inclusive of Fulton County as there is no data available.
Rate of Colon and Rectal Cancer incidence per 100,000 Population, 2016-2018	20	23	23	58.7	54.2	**48.8**	45.7	N/A	Worse	X						0.20	Community Health Indicator Reports	Feb-22	
Rate of Colon and Rectal Cancer Deaths per 100,000 Population, 2016-2018	13	8	7	24.9	19.8	**15.7**	15.1	N/A	Worse			X				0.58	Community Health Indicator Reports	Feb-22	
Rate of Prostate Cancer Deaths per 100,000 Male Population, 2016-2018				25.8*	22.1	**18.9**	18.5	N/A	Less than 20							0.00	Community Health Indicator Reports	Feb-22	
Rate of Prostate Cancer Incidence per 100,000 Male Population, 2016-2018	26	35	33	161.8	166.2	**174.9**	158.7	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Prostate Cancer Late Stage Cancer Cases per 100,000 Male Population, 2016-2018				31.0*	38.3	**33.3**	30.5	N/A	Less than 20							0.00	Community Health Indicator Reports	Feb-22	
Rate of Melanoma Cancer Deaths per 100,000 Population, 2016-2018				5.3*	3.6	**2.7**	2.1	N/A	Less than 20							0.00	Community Health Indicator Reports	Feb-22	
Percentage of Medicaid Enrollees with at Least One Preventive Dental Visit within the Year, 2018-2020	2,499	2,398	1,816	25.5%	26.0%	**27.7%**	26.9%	N/A	Worse	X						0.08	Community Health Indicator Reports	Feb-22	
Percentage of adults who had a dentist visit within the past year, 2018				69.3%	63.8%	**71.6%**	69.8%	N/A	Worse	X						0.03	NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22	

Oral Cancer Deaths per 100,000 Population, Aged 45-74 years, 2016-2018				0.0*	5.0*	**4.7**	4.6	N/A	Less than 20							0.00	Community Health Indicator Reports	Feb-22	ARHN rate is not inclusive of Fulton County as there is no data available. ARHN calculation not included due to unstable rate.
Lip, Oral Cavity and Pharynx Cancer Cases per 100,000 Population, 2016-2018	6	6	6	16.0*	17.4	**16.3**	14.1	N/A	Less than 20							0.00	Community Health Indicator Reports	Feb-22	
Quartile Summary for Other Indicators										7	2	1	0	43.5%	10.0%				
Quartile Summary for Focus Area Increase Access to High Quality Chronic Disease Preventive Care & Management										7	2	1	0	41.7%	10.0%				

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	One	Two	Three		ARHN[1]	Upstate NY	New York State	2024 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4						
Focus Area: Maternal and Infant Health																			
Prevention Agenda Indicators																			
Percentage of births that are preterm, 2019				9.6%	9.4%	9.3%	9.2%	**8.3%**	Worse	X						0.16	Prevention Agenda Dashboard	Feb-22	
Percentage of Black, non-hispanic births that are pre-term, 2019				N/A	N/A	N/A	13.2%	**8.30**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	
Percentage of Hispanic births that are pre-term, 2019				N/A	N/A	N/A	10.1%	**8.30**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	
Percentage of births that are pre-term on Medicaid, 2019				N/A	N/A	N/A	9.6%	**8.30**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	
Rate of Maternal Mortality per 100,000 Births, 2017-2019				0.0*	0.0*%	18.8	19.3	**16.0**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	ARHN calculation not included due to unstable rate
Percentage of infants who are exclusively breastfed in the hospital among all infants, 2019				76.5%	65.8%	49.6%	47.1%	**51.7%**	Meets/Better							0.00	Prevention Agenda Dashboard	Feb-22	
Percentage of Black, non-hispanic infants who are exclusively breastfed in delivery hospital, 2019				N/A	N/A	N/A	34.9%	**51.7**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	
Percentage of Hispanic infants who are exclusively breastfed in delivery hospital, 2019				N/A	N/A	N/A	35.7%	**51.7**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	
Percentage of Infants Exclusively Breastfed in Delivery Hospital on Medicaid Insurance, 2019				N/A	N/A	N/A	34.9%	**51.7**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	
Quartile Summary for Prevention Agenda Indicators										1	0	0	0	11.1%	0.0%				
Other Indicators																			
Percentage Preterm Births < 32 weeks of Total Births, 2017-2019	4	7	4	1.7%	1.3%	**1.5%**	1.5%	N/A	Worse	X						0.16	Community Health Indicator Reports	Oct-21	
Percentage Preterm Births 32 to < 37 Weeks of Total Births, 2017-2019	17	21	26	7.1%	7.8%	**7.6%**	7.6%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Oct-21	
Percentage of very low birthweight Less Than 1,500 grams, 2017-2019	3	5	2	1.1%	1.1%	**1.3%**	1.4%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Oct-21	
Percentage of Singleton Births with Weights Less Than 1,500 grams, 2017-2019	2	5	2	1%*	0.9%	**1.0%**	1.0%	N/A	Less than 10							0.00	Community Health Indicator Reports	Oct-21	
Percentage of Total Births with Weights Less Than 2,500 grams, 2017-2019	26	26	25	8.5%	7.7%	**7.7%**	8.1%	N/A	Worse	X						0.10	Community Health Indicator Reports	Oct-21	
Percentage of Singleton Births with weight less than 2,500 grams, 2017-2019	21	21	19	7.0%	6.0%	**5.9%**	6.3%	N/A	Worse	X						0.18	Community Health Indicator Reports	Oct-21	
Percentage of low birthweight births (< 2.5 kg) for Black, Non-Hispanic, 2016-2018				N/A	N/A	**13.2%**	12.6%	N/A	Less than 10							0.00	State and County Indicators for Tracking Public Health Priority Areas	Jul-21	
Percentage of low birthweight births (< 2.5 kg) for Hispanic/Latino, 2016-2018				N/A	N/A	**7.9%**	8.1%	N/A	Less than 10							0.00	State and County Indicators for Tracking Public Health Priority Areas	Jul-21	
Infant Mortality Rate per 1,000 Live Births- Infant (<1 year), 2017-2019	0	1	0	1.1*	5.1	**4.8**	4.4	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Deaths (28 Weeks Gestation to < Seven Days) per 1,000 Live Births and Perinatal Deaths, 2017-2019	0	1	0	1.0*	4.9	**5.1**	5.1	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Percentage of births with early (1st trimester) prenatal care, 2017-2019	194	244	231	74.5%	77.8%	**78.4%**	76.3%	N/A	Worse	X						0.05	Community Health Indicator Reports	Oct-21	
Percentage of births with adequate prenatal care (APNCU) for Black, Non-Hispanic, 2016-2018				N/A	N/A	**68.4%**	66.1%	N/A	Less than 10							0.00	State and County Indicators for Tracking Public Health Priority Areas	Jul-21	
Percentage of births with adequate prenatal care (APNCU) for Hispanic/Latino, 2016-2018				N/A	N/A	**70.9%**	71.1%	N/A	Less than 10							0.00	State and County Indicators for Tracking Public Health Priority Areas	Jul-21	
Percentage of births with a 5 minute APGAR <6, 2017-2019	1	4	5	1.1%	1.4%	**0.8%**	0.7%	N/A	Worse		X					0.32	Community Health Indicator Reports	Oct-21	
Percentage WIC Women Breastfeeding for at least 6 months, 2015-2017				27.9%	24.6%	**30.6%**	41.0%	N/A	Worse	X						0.09	Community Health Indicator Reports	Jun-18	

Percentage Infants Fed Any Breast Milk in Delivery Hospital, 2017-2019	186	168	175	84.6%	79.8%	**84.2%**	88.5%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Oct-21	
Quartile Summary for Other Indicators										5	1	0	0	37.5%	0.0%				
Quartile Summary for Focus Area Maternal and Infant Health										6	1	0	0	28.0%	0.0%				
Focus Area: Preconception and Reproductive Health																			
Prevention Agenda Indicators																			
Percentage of Women Ages 18- 64 with Health Insurance, 2019				N/A	N/A	N/A	94.0%	**97.0%**	Less than 10							0.00	Prevention Agenda Dashboard	Jul-21	
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%				
Other Indicators																			
Rate of Total Births per 1,000 Females Ages 15-44, 2017-2019	283	308	314	54.6	53.1	**57.1**	57.5	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Percent Multiple Births of Total Births, 2017-2019	10	10	10	3.3%	3.4%	**3.7%**	3.5%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Oct-21	
Percent C-Sections to Total Births, 2017-2019	83	97	104	31.4%	32.2%	**34.2%**	33.6%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Oct-21	
Rate of Total Pregnancies per 1,000 Females Ages 15-44, 2017-2019	362	364	371	60.3	64.0	**72.3**	79.7	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Births Ages 10 - 14 per 1,000 Females Ages 10-14, 2017-2019	0	0	0	0.0*	0.1*	**0.1**	0.1	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Rate of Births Ages 15 - 17 per 1,000 Females Ages 15-17, 2017-2019	3	2	0	3.0*	5.7	**4.7**	4.9	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Births Ages 18 - 19 per 1,000 Females Ages 18-19, 2017-2019	13	12	5	29.1	30.2	**20.1**	21.5	N/A	Worse		X					0.45	Community Health Indicator Reports	Feb-22	
Rate of Teen pregnancy per 1,000 females aged <18 years, 2017-2019	3	2	0	1.1*	3.7	**3.7**	4.7	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Pregnancies Ages 18 - 19 per 1,000 Females Ages 18-19, 2017-2019	21	14	8	38.4	42.4	**32.8**	41.1	N/A	Worse	X						0.17	Community Health Indicator Reports	Feb-22	
Percent Total Births to Women Ages 35 Plus, 2017-2019	45	53	56	17.0%	13.9%	**22.3%**	24.5%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Ratio+ of Abortions All Ages per 1000 Live Births to All Mothers, 2017-2019	38	27	19	85.5	N/A	N/A	**333.1**	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Percentage of WIC Women Pre-pregnancy Underweight (BMI less than 18.5), 2015-2017	6	10	6	4.3%	4.7%	**3.9%**	4.6%	N/A	Worse	X						0.10	Community Health Indicator Reports	Feb-22	
Percentage of WIC Women Pre-pregnancy Overweight but not Obese (BMI 25 >30), 2015-2017	37	37	33	20.9%	23.1%	**27.1%**	27.6%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Percentage of WIC Women Pre-pregnancy Obese (BMI > 30),2015-2017	65	47	76	36.6%	35.8%	**31.1%**	26.6%	N/A	Worse	X						0.18	Community Health Indicator Reports	Feb-22	
Percentage of WIC Women with Gestational Weight Gain Greater than Ideal, 2015-2019	86	71	88	52.1%	51.9%	**45.7%**	41.0%	N/A	Worse	X						0.14	Community Health Indicator Reports	Feb-22	
Percentage of WIC Women with Gestational Diabetes, 2015-2017	15	8	16	8.1%	8.2%	**6.6%**	6.6%	N/A	Worse	X						0.22	Community Health Indicator Reports	Feb-22	
Percentage of WIC Women with Gestational Hypertension, 2015-2017	29	23	22	15.4%	13.1%	**9.0%**	7.5%	N/A	Worse			X				0.72	Community Health Indicator Reports	Feb-22	
Quartile Summary for Other Indicators										5	1	1	0	41.2%	14.3%				
Quartile Summary for Focus Area Preconception and Reproductive Health										5	1	1	0	38.9%	14.3%				
Focus Area: Child Health																			
Other Indicators																			
Percentage of children with recommended number of well child visits in government sponsored insurance programs, 2019				69.1%	74.1%	**73.3%**	75.2%	N/A	Worse	X						0.00	Community Health Indicator Reports	Nov-21	
Rate of Children Deaths Ages 1 - 4 per 100,000 Population Children, 2017-2019	1	0	0	28.3*	25.1*	**18.9**	17.7	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate

Rate of Adolescent Deaths Ages 15 - 19 per 100,000 Population Children, 2017-2019	0	1	0	17.3*	32.5	**31.3**	30.1	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Asthma Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019				N/A	10.8	**24.9**	35.6	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Asthma Hospitalizations Children Ages 5 - 14 per 10,000 Population Children, 2017-2019				0.0*	3.4	**9.4**	16.6	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Asthma Hospitalizations Children Ages 0 - 17 per 10,000 Population Children, 2017-2019				N/A	4.9	**12.4**	20.3	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Gastroenteritis Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019				0.0*	4.3	**7.5**	10.4	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Otitis Media Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019				0.0*	1.6*	**1.5**	1.8	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Rate of Pneumonia Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019				N/A	18.3	**20.3**	25.2	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of ED Asthma Visits Children Ages 0 - 4 per 10,000 Population Children, 2016				60.4*	65.5	**105.9**	186.4	N/A	Less than 10							0.00	Asthma Dashboard-County Level	Feb-22	
Percentage of Children born in 2016 Screened for Lead by Age 0-8 months, 2016				.8%*	2.4%	**1.2%**	1.7%	N/A	Less than 10							0.00	Community Health Indicator Reports	Sep-21	
Percentage of Children Born in 2016 Screened for Lead by Age 9-17 months, 2016				83.0%	81.7%	**73.0%**	75.6%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Sep-21	
Percentage of Children Born 2016 Screened for Lead by Age 36 months (at least two screenings), 2016				61.9%	63.7%	**57.8%**	63.3%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Sep-21	
Rate of Incidence of confirmed high blood lead level (10 micrograms or higher per deciliter) Per 1,000 tested children aged <72 months, 2017-2019	3	3	0	4.4*	8.5	**6.6**	3.8	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Unintentional Injury Hospitalizations for Children Under Age 10 per 10,000 Population Children, 2017-2019				8.5*	12.9	**17.7**	18.4	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Unintentional Injury Hospitalizations for Children Ages 10 - 14 per 10,000 Population Children, 2017-2019				N/A	8.9	**12.7**	13.2	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Unintentional Injury Hospitalizations for Children/Young Adults Ages 15 - 24 per 10,000 Population, 2017-2019				8.6	17.7	**23.1**	22.6	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Asthma ED Visits for Children Ages 0 - 17 per 10,000 Population Children, 2016				55.7	51.3	**68.1**	137.1	N/A	Meets/Better							0.00	Asthma Summary Report	Feb-22	
Percentage of Medicaid Enrollees Ages 2 - 20 with at Least One Dental Visit within the last year, 2018-2020	1,437	1,409	1,212	48.3%	49.3%	**47.9%**	46.9%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Sep-21	
Percentage of 3rd Graders with Dental Caries Experience, 2009-2011				50.4%	N/A	N/A	N/A	N/A	No comparison data available							0.00	Community Health Indicator Reports	Aug-12	
Percentage of 3rd Graders with Dental Sealants, 2009-2011				34.5%	N/A	N/A	N/A	N/A	No comparison data available							0.00	Community Health Indicator Reports	Aug-12	
Percentage of 3rd Graders with Dental Insurance, 2009-2011				86.6%	85.2%	N/A	N/A	N/A	Meets/Better							0.00	Community Health Indicator Reports	Aug-12	
Percentage of 3rd Graders with at Least One Dental Visit, 2009-2011				76.8%	**81.0%**	N/A	N/A	N/A	Worse	X						0.05	Community Health Indicator Reports	Aug-12	
Percentage of 3rd Graders Taking Fluoride Tablets Regularly, 2009-2011				85.4%	N/A	N/A	N/A	N/A	No comparison data available							0.00	Community Health Indicator Reports	Aug-12	
Rate of Caries Outpatient Visits for Children Ages 3 - 5 per 10,000 Population, 2017-2019	10	31	20	221.3	228.2	**146.7**	146.4	N/A	Worse			X				0.51	Community Health Indicator Reports	Nov-21	
Percentage of WIC Children Ages 2 - 4 Viewing Two Hours TV or Less Per Day, 2015-2017				88.4%	85.4%	**84.9%**	86.6%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Jun-18	
Quartile Summary for Other Indicators										2	0	1	0	11.5%	33.3%				
Quartile Summary for Focus Area Child Health										2	0	1	0	11.5%	33.3%				

N/A: Data does not meet reporting criteria

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	Number Per Year (If Available)			Comparison Regions/Data					Quartile Ranking								
	One	Two	Three	Essex County Average, Rate, Ratio or Percentage for the Listed Years	ARHN[1]	Upstate NY	New York State	2024 Prevention Agenda Benchmark	Comparison to Benchmark	Q1	Q2	Q3	Q4	Quartile Score	Severity Score		Source	Updated	Notes
Focus Area: Human Immunodeficiency Virus (HIV)																			
Prevention Agenda Indicators																			
Rate of Newly Diagnosed HIV Cases per 100,000 Population, 2017-2019				N/A	4.3*	5.7	13.1	**5.2**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	ARHN calculation not included due to unstable rate
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%				
Other Indicators																			
AIDS Deaths per 100,000, 2017-2019	0	0	0	0.0*	0.4*	**0.9**	2.2	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%				
Quartile Summary for Focus Area Human Immunodeficiency Virus (HIV)										0	0	0	0	0.0%	0.0%				
Focus Area: Sexually Transmitted Disease (STDs)																			
Prevention Agenda Indicators																			
Early syphilis diagnoses, age-adjusted rate per 100,000 population, 2019				0.0*	3.71*	15.3	38.6	**79.6**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	ARHN calculation not included due to unstable rate
Gonorrhea diagnoses, age-adjusted rate per 100,000 population, 2019				39.5	33.40	114.9	217	**242.6**	Meets/Better							0.00	Prevention Agenda Dashboard	Feb-22	
Chlamydia diagnoses, age-adjusted rate per 100,000 population, 2019				219.1	244.33	457.5	667.9	**676.9**	Meets/Better							0.00	Prevention Agenda Dashboard	Feb-22	
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%				
Other Indicators																			
Rate of Gonorrhea case rate per 100,000 males - Aged 15-44 years, 2017-2019	2	6	4	57.7	54.45	**267.8**	614.9	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Gonorrhea case rate per 100,000 females - Aged 15-44 years, 2017-2019				N/A	88.72	**218.3**	252.5	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Gonorrhea case rate per 100,000 - Aged 15-19 years, 2017-2019	1	0	0	17.3*	73.15	**246.4**	401.5	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	10
Rate of Chlamydia Cases All Males Aged 15-44 years per 100,000 Male Population, 2017-2019				N/A	406.45	**41.2**	1,175.1	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Chlamydia Cases Males Ages 15 - 19 Cases per 100,000 Male Population Ages 15-19, 2017-2019	2	8	5	485.4	466.03	**766.4**	1,142.6	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Chlamydia Cases Males Ages 20 - 24 per 100,000 Male Population Ages 20-24, 2017-2019				N/A	945.09	**1,513.3**	2,107.1	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Chlamydia Cases All Females Aged 15-44 years per 100,000 Female Population, 2017-2019				N/A	1118.40	**1,455.2**	1,741.1	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Chlamydia Cases Females Ages 15- 19 per 100,000 Female Population, 2017-2019				N/A	2006.20	**2,623.6**	3,535.7	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Chlamydia Cases Females Ages 20 - 24 per 100,000 Female Population, 2017-2019				N/A	2740.07	**3,203.9**	3,912.5	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of PID Hospitalizations Females Ages 15 - 44 per 10,000 Female Population, 2017-2019				0.0*	0.95*	**1.9**	2.5	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%				
Quartile Summary for Sexually Transmitted Diseases										0	0	0	0	0.0%	0.0%				
Focus Area: Vaccine Preventable Disease																			
Prevention Agenda Indicators																			
Percentage of 24-35-month old children with the 4:3:1:3:3:1:4 immunization series, 2020				62.4%	68.2%	66.3%	66.1%	**70.5%**	Worse	X						0.13	Prevention Agenda Dashboard	Oct-21	Age range adjusted to 24-35 months

Percentage of 13-year-old adolescents with a complete HPV vaccine series, 2020				17.7%	25.8%	32.8%	39.8%	**37.4%**	Worse				X			1.11	Prevention Agenda Dashboard	Oct-21	
Quartile Summary for Prevention Agenda Indicators										1	0	0	1	100.0%	50.0%				
Other Indicators																			
Rate of Pertussis Cases per 100,000 Population, 2017-2019	3	17	1	18.7	12.3	**5.0**	3.8	N/A	Worse				X			2.74	Community Health Indicator Reports	Feb-22	
Rate of Pneumonia/Flu Hospitalizations Ages 65 Plus per 10,000 Population, 2017-2019	82	77	64	85.7	87.7	**95.2**	85.5	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Percentage of adults aged 65+ years with pneumococcal immunization, 2018				70.8%	70.0%	**69.4%**	64.0%	N/A	Meets/Better							0.00	NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22	
Rate of Mumps Cases per 100,000 Population, 2017-2019	3	0	1	3.6*	1.4*	**1.3**	1.7	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Rate of Meningococcal Cases per 100,000 Population, 2017-2019	0	0	0	0.0*	0.0*	**0.1**	0.1	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Rate of H Influenza Cases per 100,000 Population, 2017-2019	0	0	1	0.9*	2.1	**2.3**	2.0	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Quartile Summary for Other Indicators										0	0	0	1	16.7%	100.0%				
Quartile Summary for Focus Area Vaccine Preventable Diseases										1	0	0	2	37.5%	66.7%				
Focus Area: Healthcare Associated Infections																			
Prevention Agenda Indicators																			
Rate of Hospital Onset Clostridium difficile infections (CDIs) per 10,000 Patient Days (Risk-adjusted), 2019				N/A	N/A	N/A	**4.0**	N/A	Worse	#VALUE!	#VALUE!	#VALUE!	#VALUE!			#VALUE!	NYS Department of Health Hospital Report on Hospital Acquired Infections	May-21	CDI Hospital Onset; No data for Essex County; Elizabethtown Hospital
Rate of Community Onset, Healthcare Facility Associated CDIs per 100 Admissions, not risk-adjusted, 2019				N/A	N/A	N/A	**0.2**	N/A	Worse	#VALUE!	#VALUE!	#VALUE!	#VALUE!			#VALUE!	NYS Department of Health Hospital Report on Hospital Acquired Infections	May-21	CDI Community Onset Not-My-Hospita; No data for Essex County; Elizabethtown Hospital
Quartile Summary for Healthcare Associated Infections										0	0	0	0	0.0%	0.0%				

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	Number Per Year (If Available)			Essex County Average, Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score			
	One	Two	Three		ARHN[1]	Upstate NY	New York State	2024 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4				Source	Updated	Notes
Focus Area: Prevent Substance Abuse and Other Mental, Emtional, and Behavorial Disorders																			
Prevention Agenda Indicators																			
Age-adjusted Percent of Adults Binge Drinking within the Last Month, 2018				13.2%	16.6%	18.4%	17.5%	**16.4%**	Meets/Better							0.00	Prevention Agenda Dashboard	Feb-22	
Age Adjusted Rate of Suicides per 100,000 Adjusted Population, 2017-2019				8.1	N/A	9.9	8.2	**7.0**	Worse	X						0.16	Prevention Agenda Dashboard	Feb-22	Not enough information to calculate ARHN region rate.
Quartile Summary for Prevention Agenda Indicators										1	0	0	0	50.0%	0.0%				
Other Indicators																			
Rate of Suicides for Ages 15 - 19 per 100,000 Population Ages 15 - 19, 2017-2019	0	0	0	0.0*	8.1*	**7.3**	6.0	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Rate of Self-inflicted injury Hospitalizations 10,000 Population, 2017-2019	11	13	7	2.8	6.1	**4.4**	3.7	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Self-inflicted injury Hospitalizations for Ages 15 - 19 per 10,000 Population, 2017-2019				15.6*	17.0	**10.3**	9.0	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Cirrhosis Deaths per 100,000 Population, 2017-2019	9	2	10	18.7	15.3	**10.1**	8.4	N/A	Worse				X			0.84	Community Health Indicator Reports	Feb-22	
Rate of Alcohol-Related Crashes per 100,000, 2020				100.3	66.4	**52.0**	40.1	N/A	Worse				X			0.93	NYS Traffic Safety Statistical Repository	Jan-22	
Rate of Alcohol-Related Injuries and Deaths per 100,000 Population, 2020				46.1	28.7	**28.8**	23.3	N/A	Worse			X				0.60	NYS Traffic Safety Statistical Repository	Jan-22	
Quartile Summary for Other Indicators										0	0	1	2	50.0%	100.0%				
Quartile Summary for Focus Area: Prevent Substance Abuse and Other Mental, Emotional, and Behavorial Disorders										1	0	1	2	50.0%	75.0%				

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	Number Per Year (If Available)			Essex County Average, Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score				
	One	Two	Three		ARHN[1]	Upstate NY	New York State	2024 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4				Source	Updated	Notes
Other Non-Prevention Agenda Indicators																			
Rate of Hepatitis A Cases per 100,000 Population, 2017-2019	0	0	0	0.0*	0.4*	**1.4**	1.3	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Rate of Acute Hepatitis B Cases per 100,000 Population, 2017-2019	0	0	0	0.0*	0.3*	**0.4**	0.4	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Rate of TB Cases per 100,000 Population, 2017-2019	0	0	1	0.9*	0.6*	**1.7**	3.9	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Rate of E. Coli Shiga Toxin Cases per 100,000 Population, 2017-2019	1	2	0	2.7*	3.0	**3.1**	4.1	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Salmonella Cases per 100,000 Population, 2017-2019	6	4	2	10.7	11.1	**12.9**	14.0	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Shigella Cases per 100,000 Population, 2017-2019	1	0	1	1.8*	0.5*	**3.4**	6.3	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Rate of Lyme Disease Cases per 100,000 Population, 2017-2019	121	37	107	236.3	118.1	**70.7**	44.7	N/A	Worse				X			1.00	Community Health Indicator Reports	Feb-22	Upstate NY rate calculated using county data.
Rate of Confirmed Rabies Cases per 100,000 Population, 2020				5.4	3.4*	**3.1**	1.8	N/A	Worse			X				0.73	Department of Health, Wadsworth Center	Dec-20	Used 2020 Profile Population data (U.S. Census Bureau) ARHN calculation not included due to unstable rate
Quartile Summary for Non-Prevention Agenda Issues										0	0	1	1	25.0%	100.0%				

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Essex County Revised: August 2022

	Number Per Year (If Available)			Essex County Average, Rate, Ratio or Percentage for the Listed Years	Comparison Regions/Data				Comparison to Benchmark	Quartile Ranking				Quartile Score	Severity Score	Source	Updated	Notes
	One	Two	Three		ARHN[1]	Upstate NY	New York State	2024 Prevention Agenda Benchmark		Q1	Q2	Q3	Q4					
Focus Area: Disparities																		
Prevention Agenda Indicators																		
Percentage of Overall Premature Deaths (before age 65 years), 2019				19.3%	22.1%	21.0%	22.7%	**22.8%**	Meets/Better							0.00 Prevention Agenda Dashboard	Feb-22	
Premature Deaths (before age 65 years), difference in percentages between Black, non-hispanics and White, non-hispanics, 2019				-19.2+	N/A	20.2	17.7	**17.3**	Less than 10							0.00 Prevention Agenda Dashboard	Feb-22	
Premature deaths (before age 65 years), difference in percentages between Hispanics and White, non-hispanics, 2019				30.8+	N/A	21.1	16.4	**16.2**	Less than 10							0.00 Prevention Agenda Dashboard	Feb-22	
Rate of Potentially preventable hospitalizations among adults, age-adjusted, per 10,000, 2019				67.0	142.52	120.4	125.9	**115.0**	Meets/Better							0.00 Prevention Agenda Dashboard	Feb-22	
Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Black, non-hispanics and White, non-hispanics, 2019				-66.8+	N/A	128.4	115.8	**94**	Less than 10							0.00 Prevention Agenda Dashboard	Feb-22	
Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Hispanics and White, non-hispanics, 2019				-66.8+	N/A	1.0	34.6	**23.9**	Less than 10							0.00 Prevention Agenda Dashboard	Feb-22	
Percentage of Adults (Ages 18 - 64) with Health Insurance, 2019				94.4%	93.6%	94.00	92.5%	**97.0%**	Worse	X						0.03 Prevention Agenda Dashboard	Feb-22	Upstate NY calculated using county data.
Age-Adjusted Percentage of Adults with Regular Health Care Provider - Over 18 Years, 2018				82.2%	82.3%	82.0%	79.1%	**86.7%**	Worse	X						0.05 Prevention Agenda Dashboard	Feb-22	
Quartile Summary for Prevention Agenda Indicators										2	0	0	0	25.0%	0.0%			
Other Disparity Indicators																		
Rate of Total Deaths per 100,000 Population, 2017-2019	429	407	487	1,179.8	1,069.7	**916.2**	798.8	N/A	Worse		X					0.29 Community Health Indicator Reports	Feb-22	
Rate of Emergency Department Visits per 10,000 Population, 2017-2019	19,386	18,291	18,291	4,990.9	4,694.3	**3,843.0**	4,134.7	N/A	Worse		X					0.30 Community Health Indicator Reports	Feb-22	
Rate of Total Hospitalizations per 10,000 Population, 2017-2019	2,897	2,359	2,499	691.5	981.2	**1,144.2**	1,154.8	N/A	Meets/Better							0.00 Community Health Indicator Reports	Feb-22	
Percentage of Adults Who Did Not Receive Medical Care Due to Costs, 2018				9.7%	9.6%	**9.2%**	11.0%	N/A	Worse	X						0.06 NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22	
Percentage of adults reporting 14 or more days of poor physical health, 2018				16.8%	13.0%	**11.1%**	11.2%	N/A	Worse			X				0.51 NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22	
Percentage of adults living with a disability (based on 6 ACA disability questions), 2018				33.0%	29.2%	**24.6%**	26.2%	N/A	Worse		X					0.34 NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22	
Quartile Summary for Other Indicators										1	3	1	0	83.3%	20.0%			
Quartile Summary for Mortality										3	3	1	0	50.0%	14.3%			
Focus Area: Injuries, Violence, and Occupational Health																		
Prevention Agenda Indicators																		
Rate of Hospitalizations due to falls among adults per 10,000 population, aged 65+, 2019				140.8	165.2	210.4	193.9	**173.7**	Meets/Better							0.00 Prevention Agenda Dashboard	Feb-22	
Rate of Assault-Related Hospitalizations per 10,000 Population, 2019				0*	1.00	2.2	3.1	**3.0**	Less than 10							0.00 Prevention Agenda Dashboard	Feb-22	
Ratio of Rates of Assault-related hospitalizations between Black non-Hispanics and White non-Hispanics, 2019				N/A	N/A	5.6	5.1	**5.5**	Less than 10							0.00 Prevention Agenda Dashboard	Feb-22	
Ratio of Rates of Assault-related hospitalizations, between Hispanics and White non-Hispanics, 2019				0.00+	N/A	1.8	2.4	**2.5**	Less than 10							0.00 Prevention Agenda Dashboard	Feb-22	
Ratio of Rates of Assault-Related Hospitalizations for Low-Income ZIP codes and Non-Low Income Zip Codes, 2019				N/A	N/A	3.0	2.8	**2.7**	Less than 10							0.00 Prevention Agenda Dashboard	Feb-22	
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%			
Other Indicators																		
Falls hospitalization rate per 10,000 - Aged <10 years, 2017-2019				N/A	5.5	**6.2**	6.8	N/A	Less than 10							0.00 Community Health Indicator Reports	Feb-22	

Falls hospitalization rate per 10,000 - Aged 10-14 years, 2017-2019				N/A	2.6*	**3.4**	4.0	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN rate is not inclusive of Fulton County as there is no data available. ARHN calculation not
Falls hospitalization rate per 10,000 - Aged 15-24 years, 2017-2019				N/A	2.9	**4.0**	4.4	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Falls hospitalization rate per 10,000 - Aged 25-64 years, 2017-2019	33	21	26	13.4	18.5	**19.7**	18.8	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Violent Crimes per 100,000 Population, 2020				172.0	157.0	**204.7**	364.9	N/A	Meets/Better							0.00	Division of Criminal Justice Services Index, Property, and Firearm Rates	Oct-21	
Rate of Property Crimes per 100,000 Population, 2020				722.5	1,056.8	**1,292.1**	1,406.5	N/A	Meets/Better							0.00	Division of Criminal Justice Services Index, Property, and Firearm Rates	Oct-21	
Rate of Total Crimes per 100,000 Population, 2020				894.5	1,213.9	**1,496.8**	1,771.4	N/A	Meets/Better							0.00	Division of Criminal Justice Services Index, Property, and Firearm Rates	Oct-21	
Incidence Rate of Malignant Mesothelioma Cases, Ages 15 Plus, per 100,000 Population, 2016-2018				N/A	1.2*	**1.4**	1.1	N/A	Less than 20							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Rate of Pneumoconiosis Hospitalizations, Ages 15 and older, per 100,000 Population, 2017-2019				N/A	9.4	**9.0**	6.6	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Asbestosis Hospitalizations, Ages 15 Plus, per 10,000 Population, 2017-2019				0.0*	0.8	**0.8**	5.7	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Work-Related Hospitalizations, Employed Ages 16 Plus per 100,000 Individuals Employed, 2017-2019	13	13	15	84.4	138.1	**175.8**	145.9	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Total Motor Vehicle Crashes per 100,000, 2020				2,382.7	2,298.7	**2,157.0**	1,693.1	N/A	Worse	X						0.10	NYS Traffic Safety Statistical Repository	Feb-22	
Rate of Speed-Related Accidents per 100,000 Population, 2020				482.5	260.2	**205.7**	146.0	N/A	Worse				X			1.35	NYS Traffic Safety Statistical Repository	Feb-22	
Rate of Motor Vehicle Accident Deaths per 100,000 Population, 2020				13.6	7.2	**6.6**	5.3	N/A	Worse				X			1.05	NYS Traffic Safety Statistical Repository	Feb-22	
Rate of Traumatic Brain Injury Hospitalizations per 10,000 Population, 2017-2019	9	10	11	2.7	6.4	**9.0**	8.5	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Unintentional Injury Hospitalizations Ages 65 Plus per 10,000 Population, 2017-2019	127	123	152	154.6	210.3	**275.1**	249.9	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Poisoning Hospitalizations per 10,000 Population, 2017-2019	10	10	11	2.8	6.7	**7.6**	8.0	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Quartile Summary for Other Indicators										1	0	0	2	17.6%	66.7%				
Quartile Summary for Focus Area Injuries, Violence, and Occupational Health										1	0	0	2	13.6%	66.7%				
Focus Area: Outdoor Air Quality																			
Prevention Agenda Indicators																			
Annual number of days with air quality index >100 (unhealthy levels of ozone or particulate matter), 2021				N/A	N/A	N/A	20	**3**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	
Quartile Summary for Focus Area Outdoor Air Quality										0	0	0	0	0.0%	0.0%				
Focus Area: Built Environment																			
Prevention Agenda Indicators																			
Percentage of population living in a certified Climate Smart Community, 2021				0.0%*	20	54.2%	31.3%	**8.6%**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	
Percentage of people who commute to work using alternate modes of transportation or who telecommute, 2015-2019				21.2%	17.4%	22.9%	45.6%	**47.9%**	Worse			X				0.56	Prevention Agenda Dashboard	Feb-22	
Percentage of Population with Low-Income and Low-Access to a Supermarket or Large Grocery Store, 2015				2.1%	6.0%	**3.9%**	2.2%	N/A	Meets/Better							0.00	USDA Food Environment Atlas	Dec-20	
Quartile Summary for Focus Area Built Environment										0	0	1	0	33.3%	100.0%				
Focus Area: Water Quality																			
Prevention Agenda Indicators																			
Percentage of residents served by community water systems that have optimally fluoridated water, 2019				0.0%*	26.8%	46.9%	71.1%	**77.5%**	Less than 10							0.00	Prevention Agenda Dashboard	Aug-21	
Quartile Summary for Focus Area Water Quality										0	0	0	0	0.0%	0.0%				

Quartile Summary for Focus Area Air Quality, Built Enviroment, Water Qaulity										0	0	1	0	20.0%	100.0%					
Focus Area: Reduce Obesity in Children and Adults																				
Prevention Agenda Indicators																				
Percentage of Adults Ages 18 Plus Who are Obese, 2018				30.6%	34%	29.1%	27.6%	**24.2%**	Worse		X					0.26	Prevention Agenda Dashboard	Feb-22		
Quartile Summary for Prevention Agenda Indicators										0	1	0	0	100.0%	0.0%					
Other Indicators																				
Percentage of Total Students Overweight, 2018-2019				15.3%	17.5%	**16.9%**	N/A	N/A	Meets/Better							0.00	Student Weight Status Category Reporting System (SWSCRS) Data	Jul-20	Total Population is the number of overweight/obese and total healthy weight	
Percentage of Elementary Students Overweight, Not Obese, 2018-2019				15.3%	17.2%	**16.1%**	N/A	N/A	Meets/Better							0.00	Student Weight Status Category Reporting System (SWSCRS) Data	Jul-20	Total Population is the number of overweight/obese and total healthy weight	
Percentage of Elementary Student Obese, 2018-2019				14.9%	19.4%	**16.6%**	N/A	N/A	Meets/Better							0.00	Student Weight Status Category Reporting System (SWSCRS) Data	Jul-20	Total Population is the number of overweight/obese and total healthy weight	
Percentage of Middle and High School Students Overweight, Not Obese, 2018-2019				0.0%	17.4%	**17.8%**	N/A	N/A	Meets/Better							0.00	Student Weight Status Category Reporting System (SWSCRS) Data	Jul-20	Total Population is the number of overweight/obese and total healthy weight	
Percentage of Middle and High School Students Obese, 2018-2019				32.9%	25.3%	**19.5%**	N/A	N/A	Worse			X				0.69	Student Weight Status Category Reporting System (SWSCRS) Data	Jul-20	Total Population is the number of overweight/obese and total healthy weight	
Percentage obese (95th percentile or higher) children (aged 2-4 years) in WIC, 2015-2017				16.5%	16.1%	**15.5%**	13.8%	N/A	Worse	X						0.06	Community Health Indicator Reports	Feb-22		
Percentage of adults overweight or obese, 2018				67.2%	69.1%	**64.2%**	62.7%	N/A	Worse	X						0.05	NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22		
Percentage of adults who participated in leisure time physical activity in the past 30 days, 2018				73.7%	73.3%	**77.6%**	76.2%	N/A	Worse	X						0.05	NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22		
Number of Recreational and Fitness Facilities per 100,000 Population, 2016				10.5	8.8	**13.2**	12.3	N/A	Worse	X						0.20	USDA Food Environment Atlas	Dec-20		
Percentage of adults who had a test for high blood sugar or diabetes within the past three years, 2018				47.7%	49.1%	**48.6%**	51.1%	N/A	Worse	X						0.02	NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22		
Rate of Cardiovascular Disease Deaths per 100,000 Population, 2017-2019	141	100	120	321.9	309.6	**295.9**	278.3	N/A	Worse	X						0.09	Community Health Indicator Reports	Feb-22		
Rate of Cardiovascular Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019	20	15	18	114.0	123.3	**102.4**	104.2	N/A	Worse	X						0.11	Community Health Indicator Reports	Feb-22		
Rate of Cardiovascular Disease Pretransport Deaths per 100,000 Population, 2017-2019	92	58	66	192.6	184.7	**179.5**	163.6	N/A	Worse	X						0.07	Community Health Indicator Reports	Feb-22		
Rate of Cardiovascular Hospitalizations per 10,000 Population, 2017-2019	439	310	352	98.2	141.4	**161.7**	155.2	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22		
Rate of Diseases of the Heart Deaths per 100,000 Population, 2017-2019	115	83	86	253.3	240.1	**234.0**	169.4	N/A	Worse	X						0.08	Community Health Indicator Reports	Feb-22		
Rate of Diseases of the Heart Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019	16	13	12	88.2	100.9	**82.4**	83.9	N/A	Worse	X						0.07	Community Health Indicator Reports	Feb-22		
Rate of Disease of the Heart Pretransport Deaths per 100,000 Population, 2017-2019	77	49	51	157.8	149.1	**147.2**	138.7	N/A	Worse	X						0.07	Community Health Indicator Reports	Feb-22		
Rate of Disease of the Heart Hospitalizations per 10,000 Population, 2017-2019	290	216	258	68.1	97.5	**111.2**	84.2	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22		
Rate of Coronary Heart Diseases Deaths per 100,000 Population, 2017-2019	71	56	62	168.5	155.2	**162.4**	173.4	N/A	Worse	X						0.04	Community Health Indicator Reports	Feb-22		
Rate of Coronary Heart Diseases Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019	12	10	9	66.7	69.6	**59.7**	66.4	N/A	Worse	X						0.12	Community Health Indicator Reports	Feb-22		
Rate of Coronary Heart Disease Pretransport Deaths per 100,000 Population, 2017-2019	46	39	37	108.8	100.8	**106.6**	112.4	N/A	Worse	X						0.02	Community Health Indicator Reports	Feb-22		
Rate of Coronary Heart Disease Hospitalizations per 10,000 Population, 2017-2019	83	52	59	17.3	29.1	**32.9**	31.5	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22		
Rate of Congestive Heart Failure Deaths per 100,000, 2017-2019	12	3	4	16.9	19.1	**22.3**	15.1	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22		
Rate of Congestive Heart Failure Premature Deaths (Ages 35 - 64) per 100,000 Population, 2017-2019	2	0	1	6.5*	4.2*	**3.2**	2.4	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate	

Rate of Congestive Heart Failure Pretransport Deaths per 100,000 Population, 2017-2019	9	2	3	12.5	12.2	**13.7**	8.7	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Potentially preventable heart failure hospitalization rate per 10,000 - Aged 18 years and older, 2017-2019	72	68	85	24.0	38.8	**69.4**	41.3	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Cerebrovascular (Stroke) Deaths per 100,000 Population, 2017-2019	10	10	24	39.2	41.5	**38.2**	31.5	N/A	Worse	X						0.03	Community Health Indicator Reports	Feb-22	
Rate of Cerebrovascular (Stroke) Hospitalizations per 10,000 Population, 2017-2019	78	44	59	16.1	23.7	**28.2**	26.6	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Potentially preventable hypertension hospitalization rate per 10,000 - Aged 18 years and older, 2017-2019				1.4	2.7	**5.9**	7.3	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Diabetes Deaths per 100,000 Population, 2017-2019	10	15	22	41.9	33.0	**22.5**	22.5	N/A	Worse				X			0.86	Community Health Indicator Reports	Feb-22	
Rate of Diabetes Hospitalizations (Primary Diagnosis) per 10,000 Population, 2017-2019	34	47	38	10.6	18.9	**18.9**	21.4	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Diabetes Hospitalizations (Any Diagnosis) per 10,000 Population, 2017-2019	613	486	591	150.7	238.0	**252.0**	262.7	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Quartile Summary for Other Indicators										15	0	1	1	53.1%	11.8%				
Quartile Summary for Focus Area Reduce Obesity in Children and Adults										15	1	1	1	54.5%	11.1%				
Prevention Agenda Indicators																			
Percentage of Adults Ages 18 Plus Who Smoke, 2018				16.4%	19.5%	13.9%	12.8%	**11.0%**	Worse		X					0.49	Prevention Agenda Dashboard	Feb-22	
Quartile Summary for Prevention Agenda Indicators										0	1	0	0	100.0%	0.0%				
Other Indicators																			
Rate of Chronic Lower Respiratory Disease Deaths per 100,000 Population, 2017-2019	36	29	24	79.4	76.6	**48.3**	36.7	N/A	Worse			X				0.64	Community Health Indicator Reports	Feb-22	
Rate of Chronic Lower Respiratory Disease Hospitalizations per 10,000, Population, 2017-2019	143	59	60	23.4	32.5	**28.7**	29.7	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Asthma Deaths per 100,000 Population, 2017-2019	0	0	0	0.0*	0.7*	**0.9**	1.4	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Rate of Asthma Hospitalizations per 10,000 Population, 2017-2019				0.9	3.1	**6.2**	9.8	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Asthma Hospitalizations, Ages 25 - 44, per 10,000 Population, 2017-2019				0.0*	2.4	**4.2**	5.0	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Asthma Hospitalizations, Ages 45 - 64, per 10,000 Population, 2017-2019				N/A	2.9	**5.2**	8.8	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Asthma Hospitalizations, Ages 65 Plus, per 10,000 Population, 2017-2019				N/A	3.9	**4.9**	9.3	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN rate is not inclusive of Fulton County as there is no data available.
Percentage of adults with current asthma, 2018				15.4%	13.5%	**10.6%**	10.1%	N/A	Worse		X					0.45	NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22	
Rate of Lung and Bronchus Cancer Deaths per 100,000 Population, 2016-2018	32	19	24	66.7	65.0	**48.1**	39.6	N/A	Worse		X					0.39	Community Health Indicator Reports	Feb-22	
Rate of Lung and Bronchus Cancer Cases per 100,000 Population, 2016-2018	41	40	33	101.4	119.0	**87.6**	72.6	N/A	Worse	X						0.16	Community Health Indicator Reports	Feb-22	
Number of Registered Tobacco Vendors per 100,000 Population, 2016-2017				166.3	132.7	**104.4**	110	N/A	Worse			X				0.59	NYS Department of Health Tobacco Enforcement Compliance Results	Oct-19	Population is 5-year Census data 2015-2020
Tobacco Sales to Minors Violations per 100,000 Population, 2016-2017				10.7	4.0*	**4.0**	6.6	N/A	Worse				X			1.68	NYS Department of Health Tobacco Enforcement Compliance Results	Oct-19	Population is 5-year Census data 2015-2020 ARHN calculation not included due to unstable
Percentage of Vendors with Complaints per 100,000 Population, 2016-2017				0.0	0.0*	**0.0***	1.1	N/A	Meets/Better							0.00	NYS Department of Health Tobacco Enforcement Compliance Results	Oct-19	Population is 5-year Census data 2015-2020 ARHN calculation not included due to unstable
Quartile Summary for Other Indicators										1	2	2	1	46.2%	50.0%				
Quartile Summary for Focus Area Reduce Illness, Disability, and Death Related to Tobacco Use & Secondhand Smoke Exposure										1	3	2	1	50.0%	42.9%				
Focus Area: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings																			
Prevention Agenda Indicators																			
Asthma emergency department visits, rate per 10,000, aged 0-17 years, 2019				55.7	42.3	57.5	99.9	**131.1**	Meets/Better							0.00	Prevention Agenda Dashboard	Feb-22	

Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%				
Other Indicators																			
Asthma emergency department visit rate per 10,000 - aged 18-64 years, 2017-2019				32.7	41.4	**39.0**	63.3	N/A	Meets/Better							0.00	Asthma Summary Report	Feb-22	
Asthma emergency department visit rate per 10,000 - aged 65+ years, 2017-2019				20.0	16.0	**14.8**	28.2	N/A	Worse		X					0.35	Asthma Dashboard-County Level	Feb-22	
Rate of All Cancer Cases per 100,000 Population, 2016-2018	260	275	235	684.8	710.8	**657.0**	587.7	N/A	Worse	X						0.04	Community Health Indicator Reports	Feb-22	
Rate of all Cancer Deaths per 100,000 Population, 2016-2018	115	92	86	260.6	232.6	**194.7**	175.5	N/A	Worse		X					0.34	Community Health Indicator Reports	Feb-22	
Rate of Female Breast Cancer Cases per 100,000 Female Population, 2016-2018	38	33	21	169.3	176.3	**180.1**	164.6	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Female Late Stage Breast Cancer Cases per 100,000 Female Population, 2016-2018	13	9	9	57.1	48.6	**50.9**	49.3	N/A	Worse	X						0.12	Community Health Indicator Reports	Feb-22	
Rate of Female Breast Cancer Deaths per 100,000 Female Population, 2016-2018				29.4*	24.9	**26.3**	25.1	N/A	Less than 20							0.00	Community Health Indicator Reports	Feb-22	
Percentage of women aged 50-74 years receiving breast cancer screening based on recent guidelines, 2018				76.7%	80.4%	**80.9%**	82.1%	N/A	Worse	X						0.05	NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22	
Rate of Cervix Uteri Cancer Incidence per 100,000, 2016-2018				11.0*	8.9	**7.1**	8.3	N/A	Less than 20							0.00	Community Health Indicator Reports	Feb-22	
Rate of Cervix and Uteri Cancer Deaths per 100,000 Female Population, 2016-2018				N/A	6.2*	**2.2**	2.5	N/A	Less than 20							0.00	Community Health Indicator Reports	Feb-22	ARHN rate is not inclusive of Fulton County as there is no data available. ARHN calculation not
Percentage of women aged 21-65 years receiving cervical cancer screening based on recent guidelines, 2018				83.2%	87.2%	**86.1%**	84.7%	N/A	Worse	X						0.03	NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22	
Rate of Ovarian Cancer Cases per 100,000 Female Population, 2016-2018				12.9*	14.8	**15.2**	14.2	N/A	Less than 20							0.00	Community Health Indicator Reports	Feb-22	
Rate of Ovarian Cancer Deaths per 100,000 Female Population, 2016-2018				11.0*	8.8	**9.3**	8.7	N/A	Less than 20							0.00	Community Health Indicator Reports	Feb-22	ARHN rate is not inclusive of Fulton County as there is no data available.
Rate of Colon and Rectal Cancer incidence per 100,000 Population, 2016-2018	20	23	23	58.7	54.2	**48.8**	45.7	N/A	Worse	X						0.20	Community Health Indicator Reports	Feb-22	
Rate of Colon and Rectal Cancer Deaths per 100,000 Population, 2016-2018	13	8	7	24.9	19.8	**15.7**	15.1	N/A	Worse			X				0.58	Community Health Indicator Reports	Feb-22	
Rate of Prostate Cancer Deaths per 100,000 Male Population, 2016-2018				25.8*	22.1	**18.9**	18.5	N/A	Less than 20							0.00	Community Health Indicator Reports	Feb-22	
Rate of Prostate Cancer Incidence per 100,000 Male Population, 2016-2018	26	35	33	161.8	166.2	**174.9**	158.7	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Prostate Cancer Late Stage Cancer Cases per 100,000 Male Population, 2016-2018				31.0*	38.3	**33.3**	30.5	N/A	Less than 20							0.00	Community Health Indicator Reports	Feb-22	
Rate of Melanoma Cancer Deaths per 100,000 Population, 2016-2018				5.3*	3.6	**2.7**	2.1	N/A	Less than 20							0.00	Community Health Indicator Reports	Feb-22	
Percentage of Medicaid Enrollees with at Least One Preventive Dental Visit within the Year, 2018-2020	2,499	2,398	1,816	25.5%	26.0%	**27.7%**	26.9%	N/A	Worse	X						0.08	Community Health Indicator Reports	Feb-22	
Percentage of adults who had a dentist visit within the past year, 2018				69.3%	63.8%	**71.6%**	69.8%	N/A	Worse	X						0.03	NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22	
Oral Cancer Deaths per 100,000 Population, Aged 45-74 years, 2016-2018				0.0*	5.0*	**4.7**	4.6	N/A	Less than 20							0.00	Community Health Indicator Reports	Feb-22	ARHN rate is not inclusive of Fulton County as there is no data available. ARHN calculation not
Lip, Oral Cavity and Pharynx Cancer Cases per 100,000 Population, 2016-2018	6	6	6	16.0*	17.4	**16.3**	14.1	N/A	Less than 20							0.00	Community Health Indicator Reports	Feb-22	
Quartile Summary for Other Indicators										7	2	1	0	43.5%	10.0%				
Quartile Summary for Focus Area Increase Access to High Quality Chronic Disease Preventive Care & Management										7	2	1	0	41.7%	10.0%				
Focus Area: Maternal and Infant Health																			
Prevention Agenda Indicators																			
Percentage of births that are preterm, 2019				9.6%	9.4%	9.3%	9.2%	**8.3%**	Worse	X						0.16	Prevention Agenda Dashboard	Feb-22	
Percentage of Black, non-hispanic births that are pre-term, 2019				N/A	N/A	N/A	13.2%	**8.30**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	

Percentage of Hispanic births that are pre-term, 2019				N/A	N/A	N/A	10.1%	**8.30**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	
Percentage of births that are pre-term on Medicaid, 2019				N/A	N/A	N/A	9.6%	**8.30**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	
Rate of Maternal Mortality per 100,000 Births, 2017-2019				0.0*	0.0**	18.8	19.3	**16.0**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	ARHN calculation not included due to unstable rate
Percentage of infants who are exclusively breastfed in the hospital among all infants, 2019				76.5%	65.8%	49.6%	47.1%	**51.7%**	Meets/Better							0.00	Prevention Agenda Dashboard	Feb-22	
Percentage of Black, non-hispanic infants who are exclusively breastfed in delivery hospital, 2019				N/A	N/A	N/A	34.9%	**51.7**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	
Percentage of Hispanic infants who are exclusively breastfed in delivery hospital, 2019				N/A	N/A	N/A	35.7%	**51.7**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	
Percentage of Infants Exclusively Breastfed in Delivery Hospital on Medicaid Insurance, 2019				N/A	N/A	N/A	34.9%	**51.7**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	
Quartile Summary for Prevention Agenda Indicators										1	0	0	0	11.1%	0.0%				
Other Indicators																			
Percentage Preterm Births < 32 weeks of Total Births, 2017-2019	4	7	4	1.7%	1.3%	**1.5%**	1.5%	N/A	Worse	X						0.16	Community Health Indicator Reports	Oct-21	
Percentage Preterm Births 32 to < 37 Weeks of Total Births, 2017-2019	17	21	26	7.1%	7.8%	**7.6%**	7.6%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Oct-21	
Percentage of very low birthweight Less Than 1,500 grams, 2017-2019	3	5	2	1.1%	1.1%	**1.3%**	1.4%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Oct-21	
Percentage of Singleton Births with Weights Less Than 1,500 grams, 2017-2019	2	5	2	1%*	0.9%	**1.0%**	1.0%	N/A	Less than 10							0.00	Community Health Indicator Reports	Oct-21	
Percentage of Total Births with Weights Less Than 2,500 grams, 2017-2019	26	26	25	8.5%	7.7%	**7.7%**	8.1%	N/A	Worse	X						0.10	Community Health Indicator Reports	Oct-21	
Percentage of Singleton Births with weight less than 2,500 grams, 2017-2019	21	21	19	7.0%	6.0%	**5.9%**	6.3%	N/A	Worse	X						0.18	Community Health Indicator Reports	Oct-21	
Percentage of low birthweight births (< 2.5 kg) for Black, Non-Hispanic, 2016-2018				N/A	N/A	**13.2%**	12.6%	N/A	Less than 10							0.00	State and County Indicators for Tracking Public Health Priority Areas	Jul-21	
Percentage of low birthweight births (< 2.5 kg) for Hispanic/Latino, 2016-2018				N/A	N/A	**7.9%**	8.1%	N/A	Less than 10							0.00	State and County Indicators for Tracking Public Health Priority Areas	Jul-21	
Infant Mortality Rate per 1,000 Live Births- Infant (<1 year), 2017-2019	0	1	0	1.1*	5.1	**4.8**	4.4	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Deaths (28 Weeks Gestation to < Seven Days) per 1,000 Live Births and Perinatal Deaths, 2017-2019	0	1	0	1.0*	4.9	**5.1**	5.1	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Percentage of births with early (1st trimester) prenatal care, 2017-2019	194	244	231	74.5%	77.8%	**78.4%**	76.3%	N/A	Worse	X						0.05	Community Health Indicator Reports	Oct-21	
Percentage of births with adequate prenatal care (APNCU) for Black, Non-Hispanic, 2016-2018				N/A	N/A	**68.4%**	66.1%	N/A	Less than 10							0.00	State and County Indicators for Tracking Public Health Priority Areas	Jul-21	
Percentage of births with adequate prenatal care (APNCU) for Hispanic/Latino, 2016-2018				N/A	N/A	**70.9%**	71.1%	N/A	Less than 10							0.00	State and County Indicators for Tracking Public Health Priority Areas	Jul-21	
Percentage of births with a 5 minute APGAR <6, 2017-2019	1	4	5	1.1%	1.4%	**0.8%**	0.7%	N/A	Worse		X					0.32	Community Health Indicator Reports	Oct-21	
Percentage WIC Women Breastfeeding for at least 6 months, 2015-2017				27.9%	24.6%	**30.6%**	41.0%	N/A	Worse	X						0.09	Community Health Indicator Reports	Jun-18	
Percentage Infants Fed Any Breast Milk in Delivery Hospital, 2017-2019	186	168	175	84.6%	79.8%	**84.2%**	88.5%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Oct-21	
Quartile Summary for Other Indicators										5	1	0	0	37.5%	0.0%				
Quartile Summary for Focus Area Maternal and Infant Health										6	1	0	0	28.0%	0.0%				
Focus Area: Preconception and Reproductive Health																			
Prevention Agenda Indicators																			
Percentage of Women Ages 18- 64 with Health Insurance, 2019				N/A	N/A	N/A	94.0%	**97.0%**	Less than 10							0.00	Prevention Agenda Dashboard	Jul-21	
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%				

Other Indicators																		
Rate of Total Births per 1,000 Females Ages 15-44, 2017-2019	283	308	314	54.6	53.1	**57.1**	57.5	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22
Percent Multiple Births of Total Births, 2017-2019	10	10	10	3.3%	3.4%	**3.7%**	3.5%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Oct-21
Percent C-Sections to Total Births, 2017-2019	83	97	104	31.4%	32.2%	**34.2%**	33.6%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Oct-21
Rate of Total Pregnancies per 1,000 Females Ages 15-44, 2017-2019	362	364	371	60.3	64.0	**72.3**	79.7	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22
Rate of Births Ages 10 - 14 per 1,000 Females Ages 10-14, 2017-2019	0	0	0	0.0*	0.1*	**0.1**	0.1	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22 ARHN calculation not included due to unstable rate
Rate of Births Ages 15 - 17 per 1,000 Females Ages 15-17, 2017-2019	3	2	0	3.0*	5.7	**4.7**	4.9	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22
Rate of Births Ages 18 - 19 per 1,000 Females Ages 18-19, 2017-2019	13	12	5	29.1	30.2	**20.1**	21.5	N/A	Worse		X					0.45	Community Health Indicator Reports	Feb-22
Rate of Teen pregnancy per 1,000 females aged <18 years, 2017-2019	3	2	0	1.1*	3.7	**3.7**	4.7	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22
Rate of Pregnancies Ages 18 - 19 per 1,000 Females Ages 18-19, 2017-2019	21	14	8	38.4	42.4	**32.8**	41.1	N/A	Worse	X						0.17	Community Health Indicator Reports	Feb-22
Percent Total Births to Women Ages 35 Plus, 2017-2019	45	53	56	17.0%	13.9%	**22.3%**	24.5%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22
Ratio+ of Abortions All Ages per 1000 Live Births to All Mothers, 2017-2019	38	27	19	85.5	N/A	N/A	**333.1**	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22
Percentage of WIC Women Pre-pregnancy Underweight (BMI less than 18.5), 2015-2017	6	10	6	4.3%	4.7%	**3.9%**	4.6%	N/A	Worse	X						0.10	Community Health Indicator Reports	Feb-22
Percentage of WIC Women Pre-pregnancy Overweight but not Obese (BMI 25 >30), 2015-2017	37	37	33	20.9%	23.1%	**27.1%**	27.6%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22
Percentage of WIC Women Pre-pregnancy Obese (BMI > 30),2015-2017	65	47	76	36.6%	35.8%	**31.1%**	26.6%	N/A	Worse	X						0.18	Community Health Indicator Reports	Feb-22
Percentage of WIC Women with Gestational Weight Gain Greater than Ideal, 2015-2019	86	71	88	52.1%	51.9%	**45.7%**	41.0%	N/A	Worse	X						0.14	Community Health Indicator Reports	Feb-22
Percentage of WIC Women with Gestational Diabetes, 2015-2017	15	8	16	8.1%	8.2%	**6.6%**	6.6%	N/A	Worse	X						0.22	Community Health Indicator Reports	Feb-22
Percentage of WIC Women with Gestational Hypertension, 2015-2017	29	23	22	15.4%	13.1%	**9.0%**	7.5%	N/A	Worse			X				0.72	Community Health Indicator Reports	Feb-22
Quartile Summary for Other Indicators										5	1	1	0	41.2%	14.3%			
Quartile Summary for Focus Area Preconception and Reproductive Health										5	1	1	0	38.9%	14.3%			

Focus Area: Child Health																		
Other Indicators																		
Percentage of children with recommended number of well child visits in government sponsored insurance programs, 2019				69.1%	74.1%	**73.3%**	75.2%	N/A	Worse	X						0.00	Community Health Indicator Reports	Nov-21
Rate of Children Deaths Ages 1 - 4 per 100,000 Population Children, 2017-2019	1	0	0	28.3*	25.1*	**18.9**	17.7	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22 ARHN calculation not included due to unstable rate
Rate of Adolescent Deaths Ages 15 - 19 per 100,000 Population Children, 2017-2019	0	1	0	17.3*	32.5	**31.3**	30.1	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22
Rate of Asthma Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019				N/A	10.8	**24.9**	35.6	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22
Rate of Asthma Hospitalizations Children Ages 5 - 14 per 10,000 Population Children, 2017-2019				0.0*	3.4	**9.4**	16.6	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22
Rate of Asthma Hospitalizations Children Ages 0 - 17 per 10,000 Population Children, 2017-2019				N/A	4.9	**12.4**	20.3	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22
Rate of Gastroenteritis Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019				0.0*	4.3	**7.5**	10.4	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22
Rate of Otitis Media Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019				0.0*	1.6*	**1.5**	1.8	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22 ARHN calculation not included due to unstable rate

Rate of Pneumonia Hospitalizations Children Ages 0 - 4 per 10,000 Population Children, 2017-2019				N/A	18.3	**20.3**	25.2	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of ED Asthma Visits Children Ages 0 - 4 per 10,000 Population Children, 2016				60.4*	65.5	**105.9**	186.4	N/A	Less than 10							0.00	Asthma Dashboard-County Level	Feb-22	
Percentage of Children born in 2016 Screened for Lead by Age 0-8 months, 2016				.8%*	2.4%	**1.2%**	1.7%	N/A	Less than 10							0.00	Community Health Indicator Reports	Sep-21	
Percentage of Children Born in 2016 Screened for Lead by Age 9-17 months, 2016				83.0%	81.7%	**73.0%**	75.6%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Sep-21	
Percentage of Children Born 2016 Screened for Lead by Age 36 months (at least two screenings), 2016				61.9%	63.7%	**57.8%**	63.3%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Sep-21	
Rate of Incidence of confirmed high blood lead level (10 micrograms or higher per deciliter) Per 1,000 tested children aged <72 months, 2017-2019	3	3	0	4.4*	8.5	**6.6**	3.8	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Unintentional Injury Hospitalizations for Children Under Age 10 per 10,000 Population Children, 2017-2019				8.5*	12.9	**17.7**	18.4	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Unintentional Injury Hospitalizations for Children Ages 10 - 14 per 10,000 Population Children, 2017-2019				N/A	8.9	**12.7**	13.2	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Unintentional Injury Hospitalizations for Children/Young Adults Ages 15 - 24 per 10,000 Population, 2017-2019				8.6	17.7	**23.1**	22.6	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Asthma ED Visits for Children Ages 0 - 17 per 10,000 Population Children, 2016				55.7	51.3	**68.1**	137.1	N/A	Meets/Better							0.00	Asthma Summary Report	Feb-22	
Percentage of Medicaid Enrollees Ages 2 - 20 with at Least One Dental Visit within the last year, 2018-2020	1,437	1,409	1,212	48.3%	49.3%	**47.9%**	46.9%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Sep-21	
Percentage of 3rd Graders with Dental Caries Experience, 2009-2011				50.4%	N/A	N/A	N/A	N/A	No comparison data available							0.00	Community Health Indicator Reports	Aug-12	
Percentage of 3rd Graders with Dental Sealants, 2009-2011				34.5%	N/A	N/A	N/A	N/A	No comparison data available							0.00	Community Health Indicator Reports	Aug-12	
Percentage of 3rd Graders with Dental Insurance, 2009-2011				86.6%	85.2%	N/A	N/A	N/A	Meets/Better							0.00	Community Health Indicator Reports	Aug-12	
Percentage of 3rd Graders with at Least One Dental Visit, 2009-2011				76.8%	**81.0%**	N/A	N/A	N/A	Worse	X						0.05	Community Health Indicator Reports	Aug-12	
Percentage of 3rd Graders Taking Fluoride Tablets Regularly, 2009-2011				85.4%	N/A	N/A	N/A	N/A	No comparison data available							0.00	Community Health Indicator Reports	Aug-12	
Rate of Caries Outpatient Visits for Children Ages 3 - 5 per 10,000 Population, 2017-2019	10	31	20	221.3	228.2	**146.7**	146.4	N/A	Worse			X				0.51	Community Health Indicator Reports	Nov-21	
Percentage of WIC Children Ages 2 - 4 Viewing Two Hours TV or Less Per Day, 2015-2017				88.4%	85.4%	**84.9%**	86.6%	N/A	Meets/Better							0.00	Community Health Indicator Reports	Jun-18	
Quartile Summary for Other Indicators										2	0	1	0	11.5%	33.3%				
Quartile Summary for Focus Area Child Health										2	0	1	0	11.5%	33.3%				
Focus Area: Human Immunodeficiency Virus (HIV)																			
Prevention Agenda Indicators																			
Rate of Newly Diagnosed HIV Cases per 100,000 Population, 2017-2019				N/A	4.3*	5.7	13.1	**5.2**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	ARHN calculation not included due to unstable rate
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%				
Other Indicators																			
AIDS Deaths per 100,000, 2017-2019	0	0	0	0.0*	0.4*	**0.9**	2.2	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%				
Quartile Summary for Focus Area Human Immunodeficiency Virus (HIV)										0	0	0	0	0.0%	0.0%				
Focus Area: Sexually Transmitted Disease (STDs)																			
Prevention Agenda Indicators																			
Early syphilis diagnoses, age-adjusted rate per 100,000 population, 2019				0.0*	3.71*	15.3	38.6	**79.6**	Less than 10							0.00	Prevention Agenda Dashboard	Feb-22	ARHN calculation not included due to unstable rate
Gonorrhea diagnoses, age-adjusted rate per 100,000 population, 2019				39.5	33.40	114.9	217	**242.6**	Meets/Better							0.00	Prevention Agenda Dashboard	Feb-22	

Chlamydia diagnoses, age-adjusted rate per 100,000 population, 2019				219.1	244.33	457.5	667.9	**676.9**	Meets/Better							0.00	Prevention Agenda Dashboard	Feb-22	
Quartile Summary for Prevention Agenda Indicators										0	0	0	0	0.0%	0.0%				
Other Indicators																			
Rate of Gonorrhea case rate per 100,000 males - Aged 15-44 years, 2017-2019	2	6	4	57.7	54.45	**267.8**	614.9	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Gonorrhea case rate per 100,000 females - Aged 15-44 years, 2017-2019				N/A	88.72	**218.3**	252.5	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Gonorrhea case rate per 100,000 - Aged 15-19 years, 2017-2019	1	0	0	17.3*	73.15	**246.4**	401.5	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	10
Rate of Chlamydia Cases All Males Aged 15-44 years per 100,000 Male Population, 2017-2019				N/A	406.45	**41.2**	1,175.1	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Chlamydia Cases Males Ages 15 - 19 Cases per 100,000 Male Population Ages 15-19, 2017-2019	2	8	5	485.4	466.03	**766.4**	1,142.6	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Chlamydia Cases Males Ages 20 - 24 per 100,000 Male Population Ages 20-24, 2017-2019				N/A	945.09	**1,513.3**	2,107.1	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Chlamydia Cases All Females Aged 15-44 years per 100,000 Female Population, 2017-2019				N/A	1118.40	**1,455.2**	1,741.1	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Chlamydia Cases Females Ages 15- 19 per 100,000 Female Population, 2017-2019				N/A	2006.20	**2,623.6**	3,535.7	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Chlamydia Cases Females Ages 20 - 24 per 100,000 Female Population, 2017-2019				N/A	2740.07	**3,203.9**	3,912.5	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of PID Hospitalizations Females Ages 15 - 44 per 10,000 Female Population, 2017-2019				0.0*	0.95*	**1.9**	2.5	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Quartile Summary for Other Indicators										0	0	0	0	0.0%	0.0%				
Quartile Summary for Sexually Transmitted Diseases										0	0	0	0	0.0%	0.0%				
Focus Area: Vaccine Preventable Disease																			
Prevention Agenda Indicators																			
Percentage of 24-35-month old children with the 4:3:1:3:3:1:4 immunization series, 2020				62.4%	68.2%	66.3%	66.1%	**70.5%**	Worse	X						0.13	Prevention Agenda Dashboard	Oct-21	Age range adjusted to 24-35 months
Percentage of 13-year-old adolescents with a complete HPV vaccine series, 2020				17.7%	25.8%	32.8%	39.8%	**37.4%**	Worse				X			1.11	Prevention Agenda Dashboard	Oct-21	
Quartile Summary for Prevention Agenda Indicators										1	0	0	1	100.0%	50.0%				
Other Indicators																			
Rate of Pertussis Cases per 100,000 Population, 2017-2019	3	17	1	18.7	12.3	**5.0**	3.8	N/A	Worse				X			2.74	Community Health Indicator Reports	Feb-22	
Rate of Pneumonia/Flu Hospitalizations Ages 65 Plus per 10,000 Population, 2017-2019	82	77	64	85.7	87.7	**95.2**	85.5	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Percentage of adults aged 65+ years with pneumococcal immunization, 2018				70.8%	70.0%	**69.4%**	64.0%	N/A	Meets/Better							0.00	NYS Expanded Behavioral Risk Factor Surveillance System	Mar-22	
Rate of Mumps Cases per 100,000 Population, 2017-2019	3	0	1	3.6*	1.4*	**1.3**	1.7	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Rate of Meningococcal Cases per 100,000 Population, 2017-2019	0	0	0	0.0*	0.0*	**0.1**	0.1	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Rate of H Influenza Cases per 100,000 Population, 2017-2019	0	0	1	0.9*	2.1	**2.3**	2.0	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Quartile Summary for Other Indicators										0	0	0	1	16.7%	100.0%				
Quartile Summary for Focus Area Vaccine Preventable Diseases										1	0	0	2	37.5%	66.7%				
Focus Area: Healthcare Associated Infections																			
Prevention Agenda Indicators																			
Rate of Hospital Onset Clostridium difficile infections (CDIs) per 10,000 Patient Days (Risk-adjusted), 2019				N/A	N/A	N/A	**4.0**	N/A	Worse	#VALUE!	#VALUE!	#VALUE!	#VALUE!			#####	NYS Department of Health Hospital Report on Hospital Acquired Infections	May-21	CDI Hospital Onset; No data for Essex County; Elizabethtown Hospital
Rate of Community Onset, Healthcare Facility Associated CDIs per 100 Admissions, not risk-adjusted, 2019				N/A	N/A	N/A	**0.2**	N/A	Worse	#VALUE!	#VALUE!	#VALUE!	#VALUE!			#####	NYS Department of Health Hospital Report on Hospital Acquired Infections	May-21	CDI Community Onset Not-My-Hospita; No data for Essex County; Elizabethtown Hospital

Quartile Summary for Healthcare Associated Infections										0	0	0	0	0.0%	0.0%				
Focus Area: Prevent Substance Abuse and Other Mental, Emtional, and Behavorial Disorders																			
Prevention Agenda Indicators																			
Age-adjusted Percent of Adults Binge Drinking within the Last Month, 2018				13.2%	16.6%	18.4%	17.5%	**16.4%**	Meets/Better							0.00	Prevention Agenda Dashboard	Feb-22	
Age Adjusted Rate of Suicides per 100,000 Adjusted Population, 2017-2019				8.1	N/A	9.9	8.2	**7.0**	Worse	X						0.16	Prevention Agenda Dashboard	Feb-22	Not enough information to calculate ARHN region rate.
Quartile Summary for Prevention Agenda Indicators										1	0	0	0	50.0%	0.0%				
Other Indicators																			
Rate of Suicides for Ages 15 - 19 per 100,000 Population Ages 15 - 19, 2017-2019	0	0	0	0.0*	8.1*	**7.3**	6.0	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Rate of Self-inflicted injury Hospitalizations 10,000 Population, 2017-2019	11	13	7	2.8	6.1	**4.4**	3.7	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Self-inflicted injury Hospitalizations for Ages 15 - 19 per 10,000 Population, 2017-2019				15.6*	17.0	**10.3**	9.0	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Cirrhosis Deaths per 100,000 Population, 2017-2019	9	2	10	18.7	15.3	**10.1**	8.4	N/A	Worse				X			0.84	Community Health Indicator Reports	Feb-22	
Rate of Alcohol-Related Crashes per 100,000, 2020				100.3	66.4	**52.0**	40.1	N/A	Worse				X			0.93	NYS Traffic Safety Statistical Repository	Jan-22	
Rate of Alcohol-Related Injuries and Deaths per 100,000 Population, 2020				46.1	28.7	**28.8**	23.3	N/A	Worse			X				0.60	NYS Traffic Safety Statistical Repository	Jan-22	
Quartile Summary for Other Indicators										0	0	1	2	50.0%	100.0%				
Quartile Summary for Focus Area: Prevent Substance Abuse and Other Mental, Emotional, and Behavorial Disorders										1	0	1	2	50.0%	75.0%				
Other Non-Prevention Agenda Indicators																			
Rate of Hepatitis A Cases per 100,000 Population, 2017-2019	0	0	0	0.0*	0.4*	**1.4**	1.3	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Rate of Acute Hepatitis B Cases per 100,000 Population, 2017-2019	0	0	0	0.0*	0.3*	**0.4**	0.4	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Rate of TB Cases per 100,000 Population, 2017-2019	0	0	1	0.9*	0.6*	**1.7**	3.9	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Rate of E. Coli Shiga Toxin Cases per 100,000 Population, 2017-2019	1	2	0	2.7*	3.0	**3.1**	4.1	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	
Rate of Salmonella Cases per 100,000 Population, 2017-2019	6	4	2	10.7	11.1	**12.9**	14.0	N/A	Meets/Better							0.00	Community Health Indicator Reports	Feb-22	
Rate of Shigella Cases per 100,000 Population, 2017-2019	1	0	1	1.8*	0.5*	**3.4**	6.3	N/A	Less than 10							0.00	Community Health Indicator Reports	Feb-22	ARHN calculation not included due to unstable rate
Rate of Lyme Disease Cases per 100,000 Population, 2017-2019	121	37	107	236.3	118.1	**70.7**	44.7	N/A	Worse				X			1.00	Community Health Indicator Reports	Feb-22	Upstate NY rate calculated using county data.
Rate of Confirmed Rabies Cases per 100,000 Population, 2020				5.4	3.4*	**3.1**	1.8	N/A	Worse			X				0.73	Department of Health, Wadsworth Center	Dec-20	Used 2020 Profile Population data (U.S. Census Bureau) ARHN calculation not
Quartile Summary for Non-Prevention Agenda Issues										0	0	1	1	25.0%	100.0%				

N/A: Data does not meet reporting criteria

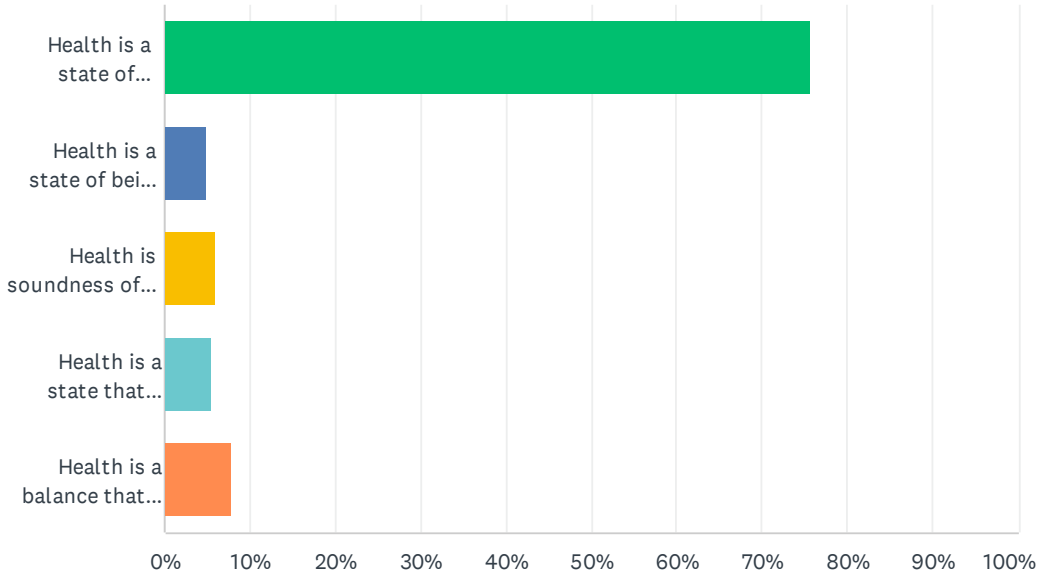
*: Fewer than 10 or 20 events in the numerator, therefore the rate/percentage is unstable

+: Fewer than 10 events in at least one of the numerators of the rates/percentages, therefore the ratio or rate difference is unstable.

1: ARHN data not available when two or more counties do not have reported data

Q1 Which one definition below best describes what you think of as "health"? Select one.

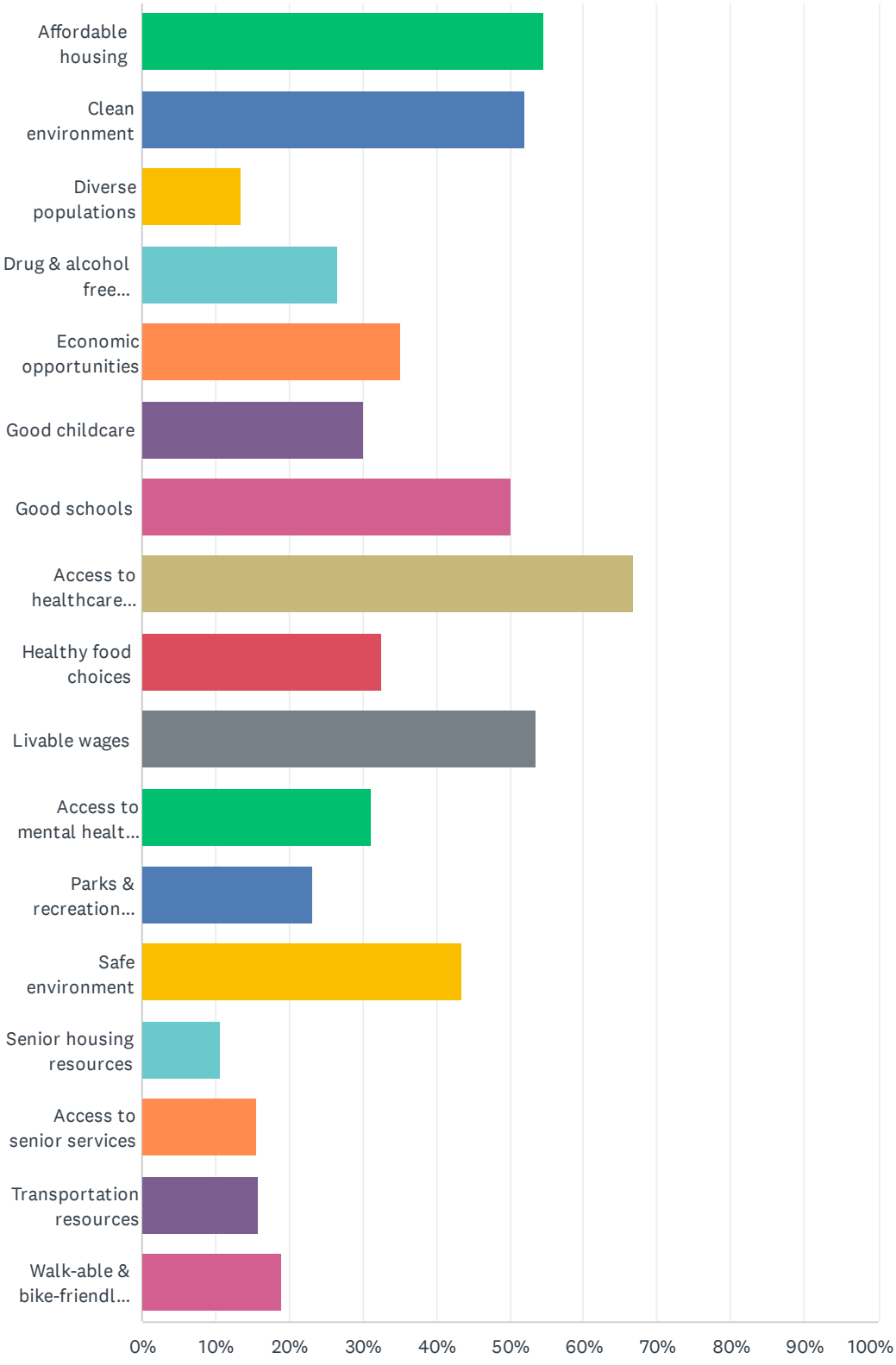
Answered: 485 Skipped: 0



ANSWER CHOICES	RESPONSES	
Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.	75.67%	367
Health is a state of being free from illness or injury.	4.95%	24
Health is soundness of mind and body	5.98%	29
Health is a state that allows an individual to cope with all demands of daily life.	5.57%	27
Health is a balance that an individual has between him/herself and his/her social and physical environment.	7.84%	38
TOTAL		485

Q2 When you imagine a strong, vibrant, healthy community, what are the most important features you think of? Choose up to 5.

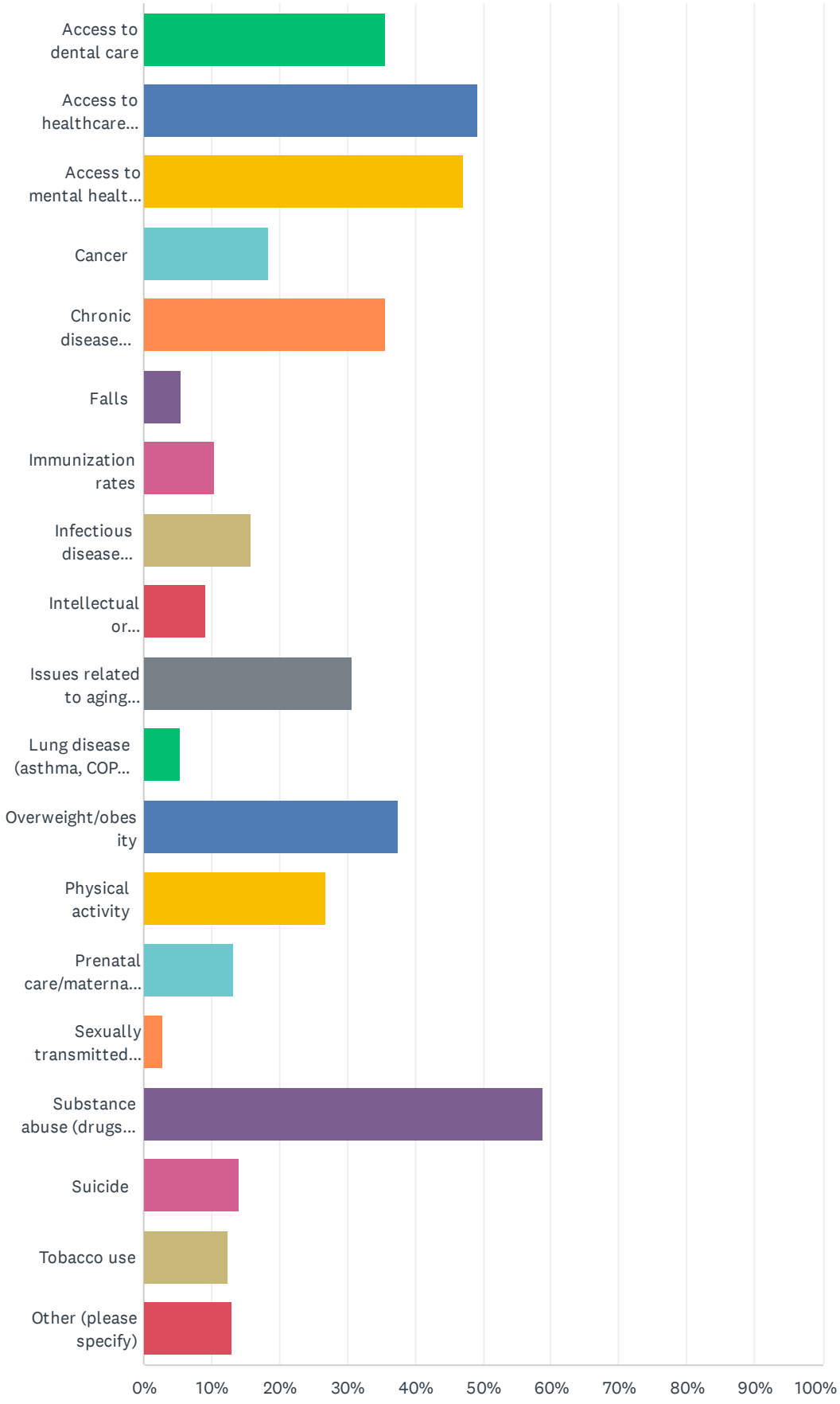
Answered: 485 Skipped: 0


Affordable housing
Clean environment
Diverse populations
Drug & alcohol free...
Economic opportunities
Good childcare
Good schools
Access to healthcare...
Healthy food choices
Livable wages
Access to mental healt...
Parks & recreation...
Safe environment
Senior housing resources
Access to senior services
Transportation resources
Walk-able & bike-friendl...
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

ANSWER CHOICES	RESPONSES	
Affordable housing	54.64%	265
Clean environment	51.96%	252
Diverse populations	13.40%	65
Drug & alcohol free communities	26.60%	129
Economic opportunities	35.26%	171
Good childcare	30.10%	146
Good schools	50.10%	243
Access to healthcare services	66.80%	324
Healthy food choices	32.58%	158
Livable wages	53.61%	260
Access to mental health services	31.13%	151
Parks & recreation resources	23.30%	113
Safe environment	43.51%	211
Senior housing resources	10.72%	52
Access to senior services	15.67%	76
Transportation resources	15.88%	77
Walk-able & bike-friendly communities	18.97%	92
Total Respondents: 485		

Q3 When you think about health challenges in the community where you live, what are you most concerned about? Choose up to 5.

Answered: 440 Skipped: 45


Access to dental care
Access to healthcare...
Access to mental healt...
Cancer
Chronic disease...
Falls
Immunization rates
Infectious disease...
Intellectual or...
Issues related to aging...
Lung disease (asthma, COP...
Overweight/obesity
Physical activity
Prenatal care/materna...
Sexually transmitted...
Substance abuse (drugs...
Suicide
Tobacco use
Other (please specify)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

ANSWER CHOICES	RESPONSES	
Access to dental care	35.68%	157
Access to healthcare services	49.32%	217
Access to mental health services	47.05%	207
Cancer	18.41%	81
Chronic disease (diabetes, heart disease, high blood pressure, high cholesterol, stroke, etc.)	35.68%	157
Falls	5.45%	24
Immunization rates	10.45%	46
Infectious disease (COVID-19, Hepatitis A, B or C, flu, etc.)	15.68%	69
Intellectual or developmental disabilities	9.09%	40
Issues related to aging (arthritis, hearing/vision loss, etc.)	30.68%	135
Lung disease (asthma, COPD, etc.)	5.23%	23
Overweight/obesity	37.50%	165
Physical activity	26.82%	118
Prenatal care/maternal & infant health	13.18%	58
Sexually transmitted infections (including HIV)	2.73%	12
Substance abuse (drugs, alcohol, etc.)	58.86%	259
Suicide	14.09%	62
Tobacco use	12.27%	54
Other (please specify)	12.95%	57
Total Respondents: 440		

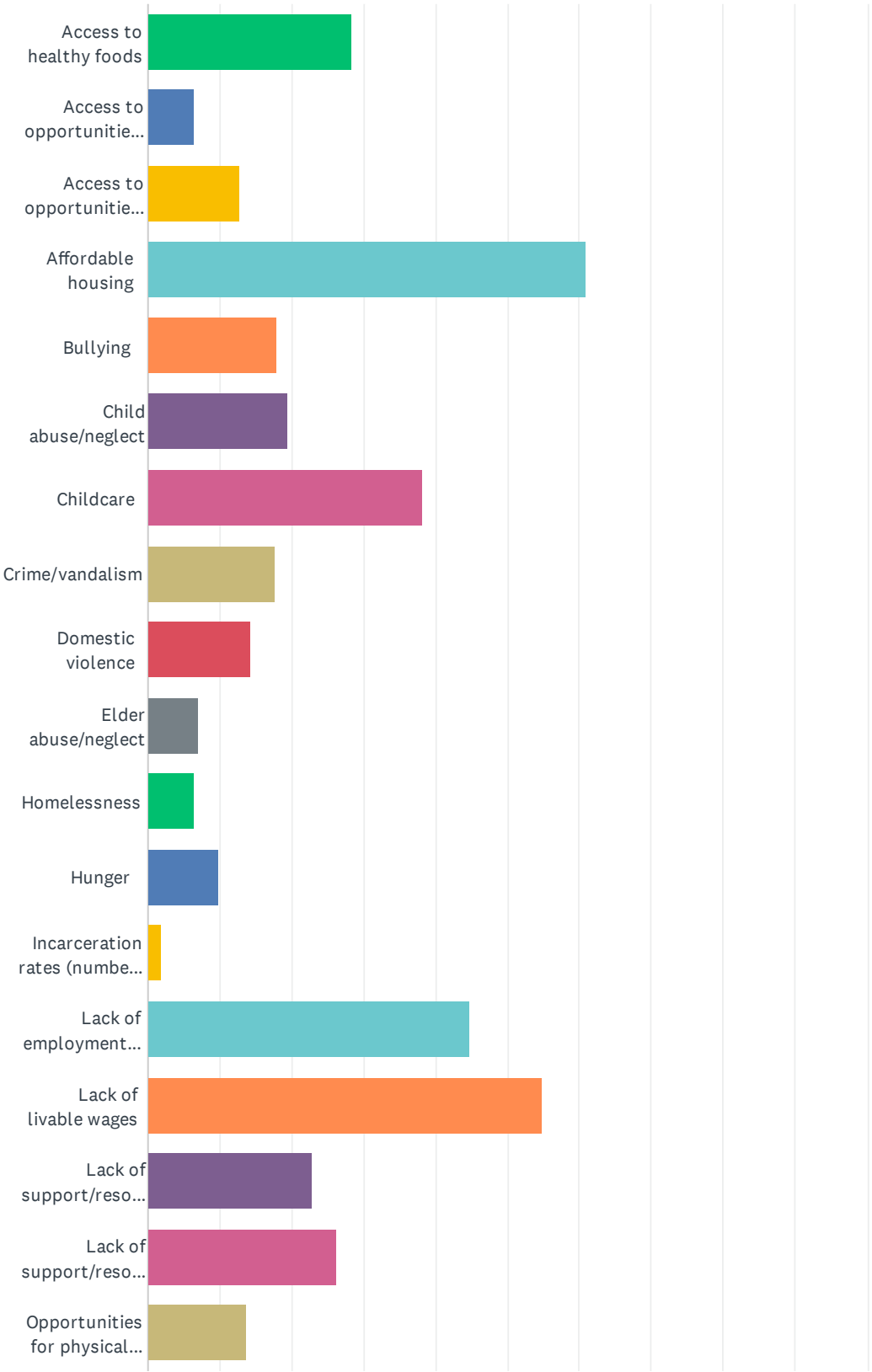
#	OTHER (PLEASE SPECIFY)	DATE
1	Transportation, owning a car, low & middle income housing	6/21/2022 2:56 PM
2	distance to healthcare providers	6/21/2022 2:46 PM
3	Have access to healthcare, dental, and mental health services, but can't afford to pay health insurance and dr. bills	6/21/2022 2:43 PM
4	Isolation - especially in winter months	6/21/2022 2:24 PM
5	Chronic pain	5/19/2022 1:49 PM
6	High # of people relying on public assistance to live.	5/19/2022 4:14 AM
7	Air and noise pollution. Traffic.	5/19/2022 3:29 AM
8	rodent, nuisance animal and stray cat infestation	5/16/2022 2:51 PM
9	A community (especially health care services) that can better communicate with those who are hearing impaired or deaf.	5/16/2022 10:57 AM
10	political disinformation and polarization	5/11/2022 1:35 AM
11	Tickborne disease	5/10/2022 8:51 PM
12	Government intrusion	5/10/2022 3:35 PM

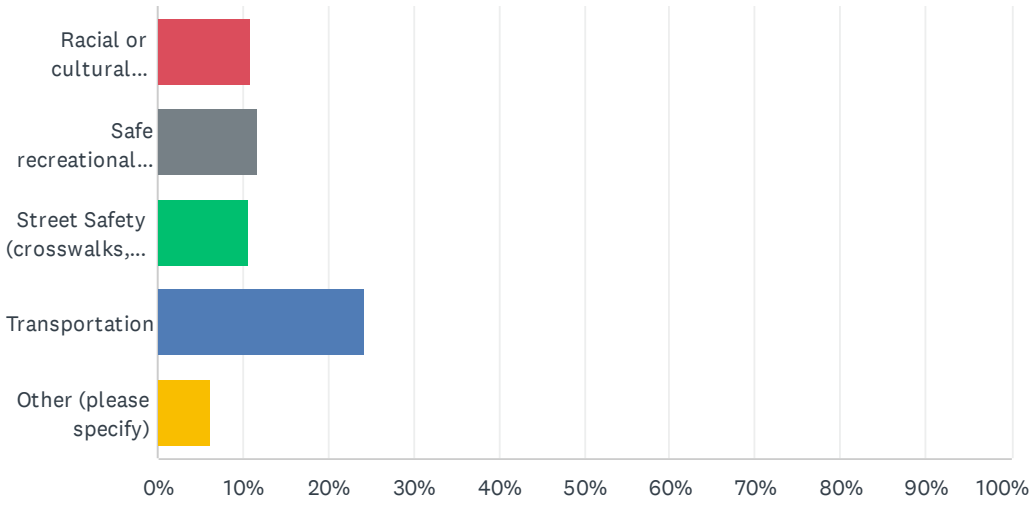
13	The idea that health is found in prescriptions and vaccines is false and yet widely propagated	4/26/2022 12:23 PM
14	Opportunities for relationship building especially in winter	4/26/2022 8:39 AM
15	Tick born Illnesses	4/26/2022 8:23 AM
16	Faulty education	4/19/2022 8:52 PM
17	going to a doc for ANYTHING and having it NOT be covered by Medicare OR my supplemental so called insurance	4/9/2022 7:26 AM
18	I don't think my community has a lack of any of these listed as access, and have no idea about the other conditions listed.	4/8/2022 11:19 AM
19	Health literacy	4/8/2022 8:07 AM
20	Access to healthy food	4/8/2022 8:00 AM
21	Distance to diagnostic services	4/8/2022 6:30 AM
22	There is no hospital in the community.	4/7/2022 11:25 PM
23	Not being able to afford it and/or meds….I am on the market place and had an asthma attack. I had to pay almost $400 for two inhalers because my deductible is so high.	4/7/2022 9:08 PM
24	Access to home health care; access to transportation	4/7/2022 6:47 PM
25	Safe family life.	4/7/2022 12:05 PM
26	access to health care specialists	4/1/2022 2:57 PM
27	Sex Education for Youths	3/29/2022 2:40 PM
28	lack of accessing help due to lack of affordable insurance	3/28/2022 1:19 PM
29	Mental Health Challenges	3/27/2022 1:34 PM
30	Challenging getting therapy appointments OT PT ST Pysch	3/27/2022 8:32 AM
31	Access to home care for elderly	3/26/2022 11:55 AM
32	Bullying and suicidal ideation in teens	3/25/2022 7:52 PM
33	Healthcare is poor here, lack of interest in patient services.	3/25/2022 12:31 PM
34	Access to child care	3/25/2022 11:01 AM
35	Knowledge of specific health issues within the community.	3/25/2022 10:26 AM
36	Woke, progressive, neo-marxist communistic authoritarianism and bullying are eroding healthy political and social discourse and driving people insane	3/25/2022 10:10 AM
37	i moved out of the Town i lived in because it was not a safe place to be a pedestrian.	3/25/2022 9:19 AM
38	a local government that cares about the people not the dollar	3/25/2022 9:04 AM
39	maintaining the excellent level of available resources we currently have.	3/25/2022 8:53 AM
40	Access to resources such as groceries, recreation, transportation	3/25/2022 8:29 AM
41	affordable and adequate housing for all age groups	3/25/2022 8:25 AM
42	Lack of gluten free food options	3/24/2022 9:32 PM
43	elderly people who live alone and refuse services, fear of change	3/24/2022 8:26 PM
44	Access to QUALITY healthcare	3/24/2022 7:37 PM
45	Understanding that food is medicine and that stress causes disease. These are 2 most important factors to create health. Need more education and public policy based on this vs. Medication and vaccines.	3/24/2022 6:37 PM
46	Home health care for elderly	3/24/2022 6:34 PM

47	Childcare	3/24/2022 4:44 PM
48	Drug use	3/24/2022 1:33 PM
49	Accessibility and resources for individuals with physical impairments	3/24/2022 1:16 PM
50	Senior housing	3/24/2022 12:24 PM
51	The very poor communication, accountability & analytical ability of the county health dept.	3/24/2022 8:42 AM
52	Access to a good Doctor	3/24/2022 6:45 AM
53	Housing also affects health as does fixed and low income	3/24/2022 6:06 AM
54	Access to quality doctors	3/23/2022 8:49 PM
55	Understanding what services are available where and access to specialists, notably in endocrinology, dermatology and neurology.	3/23/2022 8:04 PM
56	Difficulty getting medical appointments with specialists	3/23/2022 6:28 PM
57	Socialization and diversity. Good supply of organic fruit and veggies	3/21/2022 3:48 PM

Q4 When you think about social challenges in the community where you live, what are you most concerned about? Choose up to 5.

Answered: 440 Skipped: 45




Racial or cultural...
Safe recreational...
Street Safety (crosswalks,...
Transportation
Other (please specify)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

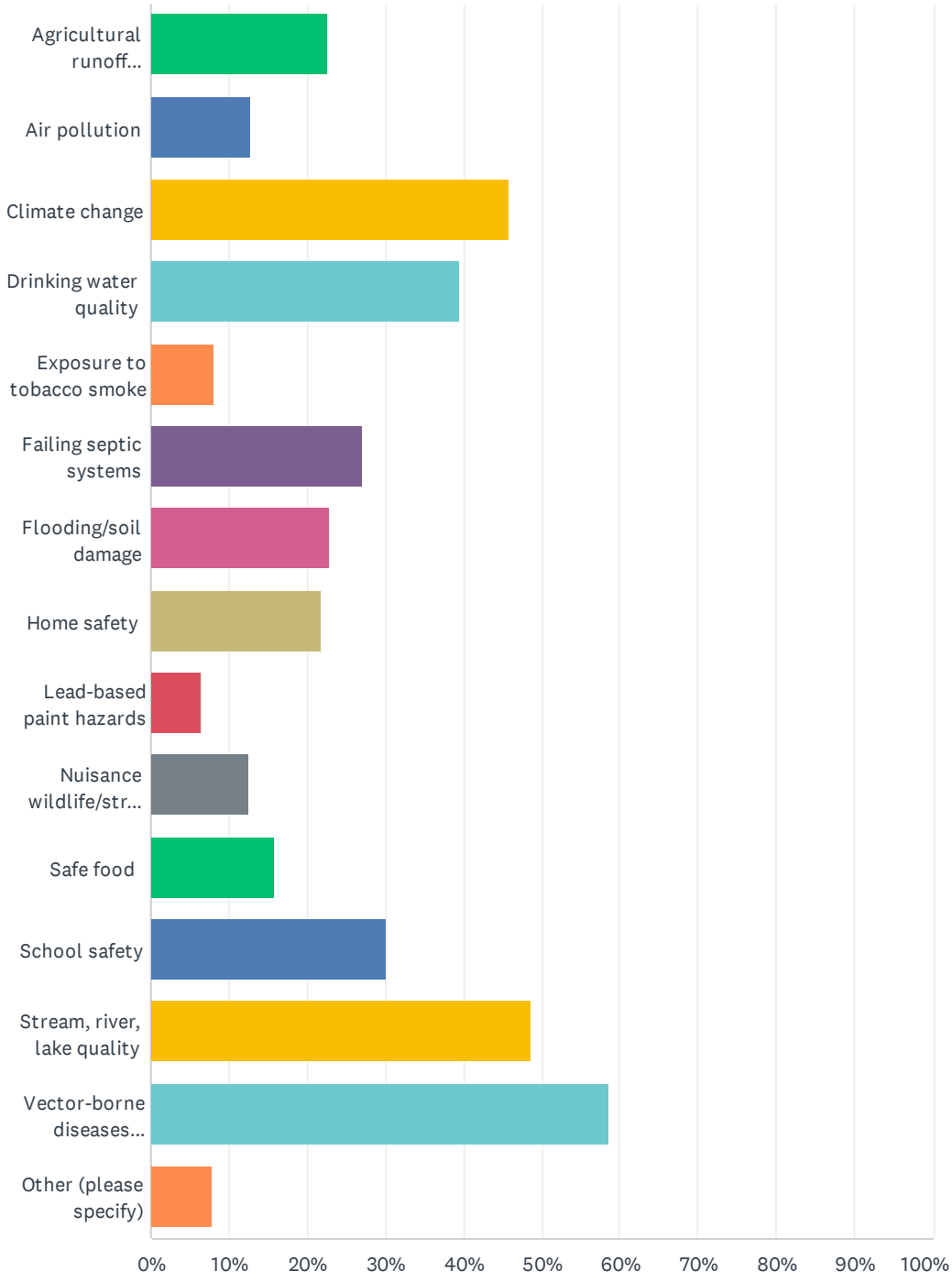
ANSWER CHOICES	RESPONSES	
Access to healthy foods	28.41%	125
Access to opportunities for health for people with intellectual or developmental disabilities	6.36%	28
Access to opportunities for people with physical limitations or disabilities	12.73%	56
Affordable housing	60.91%	268
Bullying	17.95%	79
Child abuse/neglect	19.32%	85
Childcare	38.18%	168
Crime/vandalism	17.73%	78
Domestic violence	14.32%	63
Elder abuse/neglect	7.05%	31
Homelessness	6.36%	28
Hunger	9.77%	43
Incarceration rates (number of people in jail)	1.82%	8
Lack of employment opportunities	44.77%	197
Lack of livable wages	54.77%	241
Lack of support/resources for seniors	22.73%	100
Lack of support/resources for youth	26.14%	115
Opportunities for physical activity	13.64%	60
Racial or cultural discrimination	10.91%	48
Safe recreational areas	11.82%	52
Street Safety (crosswalks, shoulders, bike lanes, traffic)	10.68%	47
Transportation	24.32%	107
Other (please specify)	6.14%	27
Total Respondents: 440		

#	OTHER (PLEASE SPECIFY)	DATE
1	Affordable health insurance	6/21/2022 3:14 PM
2	Speed limit on Water St. is too high.	5/21/2022 10:54 PM
3	Elise Stefanic	5/21/2022 10:45 PM
4	politics, right-wing agenda, MAGA-followers	5/11/2022 1:35 AM
5	Censorship, inflation, democrats	5/10/2022 3:35 PM
6	Substance and alcohol abuse/addiction, lack of sober supports	4/28/2022 3:34 AM
7	that many people are choosing welfare instead of working	4/26/2022 12:23 PM
8	Faulty education	4/19/2022 8:52 PM

9	Lack of enough services locally	4/6/2022 7:03 PM
10	Animal abuse	4/5/2022 8:09 PM
11	Lack of affordable houses comparable the salaries	4/2/2022 9:46 PM
12	Lack of anything for deaf children	3/31/2022 10:54 AM
13	clean/affordable water source	3/30/2022 11:05 AM
14	Addiction	3/29/2022 8:58 PM
15	Drugs related	3/28/2022 11:47 AM
16	How is substance abuse not a listed option here? Years of progressive enabling, victimhood ideology, open borders, and soft-on-crime policies are driving substance abuse through the roof. It is here and will only get worse without a move away from progressivism	3/25/2022 10:10 AM
17	a local government that cares	3/25/2022 9:04 AM
18	Maintaining the excellent level we currently enjoy.	3/25/2022 8:53 AM
19	Lack of laundry facilities in towns and rural areas where people can not clean their clothes	3/24/2022 8:26 PM
20	The municipalities continually put the comfort of visitors over the needs of locals	3/24/2022 6:36 PM
21	The Changing demographic: all the new people to the area bring their failed systems from which they came and pushing them here.	3/24/2022 1:48 PM
22	No leadership or sense of direction and improvement. No priorities, no accountability, no communication and no value for money. The County is more of a non-accountable employment mechanism than a value-adding service mechanism. Although, the snow management is quite good.	3/24/2022 8:42 AM
23	Their are jobs, but a lack of pay scale to meet housing costs	3/24/2022 6:06 AM
24	Understanding of quality food preparation	3/23/2022 8:49 PM
25	Availability of simple supportive services for the elderly and disabled, such as snow shoveling, changing batteries in smoke/CO detectors, installing grab bars, etc.	3/23/2022 8:04 PM
26	Political divisiveness	3/23/2022 6:56 PM
27	Willsboro CS often times does not have enough bus drivers and cancels route for the day	3/23/2022 3:02 PM

Q5 When you think about environmental challenges in the community where you live, what are you most concerned about? Choose up to 5.

Answered: 440 Skipped: 45



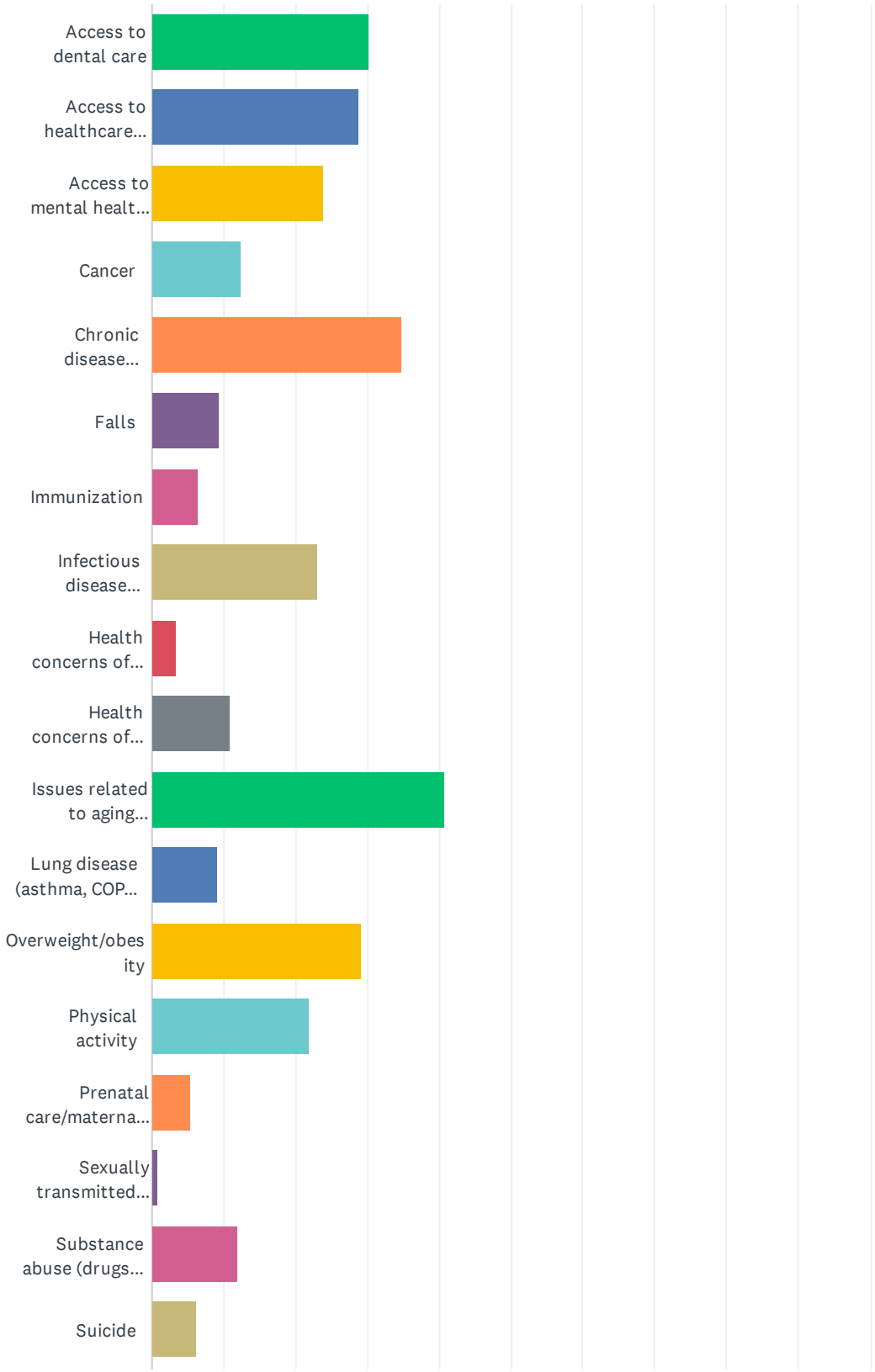
ANSWER CHOICES	RESPONSES	
Agricultural runoff (manure, pesticides, etc.)	22.50%	99
Air pollution	12.73%	56
Climate change	45.91%	202
Drinking water quality	39.55%	174
Exposure to tobacco smoke	8.18%	36
Failing septic systems	27.05%	119
Flooding/soil damage	22.73%	100
Home safety	21.82%	96
Lead-based paint hazards	6.36%	28
Nuisance wildlife/stray animals	12.50%	55
Safe food	15.68%	69
School safety	30.00%	132
Stream, river, lake quality	48.64%	214
Vector-borne diseases (mosquitoes, ticks, etc.)	58.64%	258
Other (please specify)	7.95%	35
Total Respondents: 440		

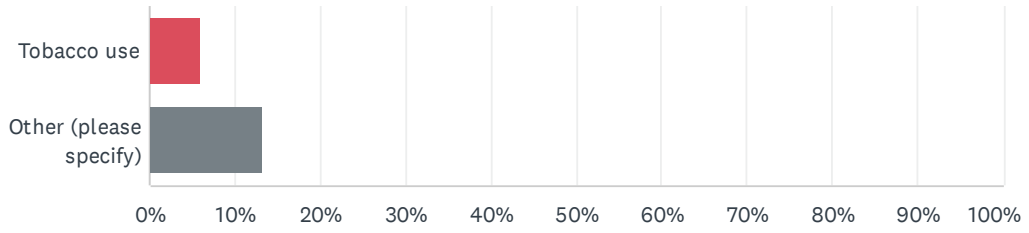
#	OTHER (PLEASE SPECIFY)	DATE
1	Illegal disposal of toxic waste such as chemicals, oil, paint, etc.	6/21/2022 2:24 PM
2	People burning garbage is a concern. I'm also concerned with how our drinking water source is being protected, managed and tested.	5/21/2022 10:54 PM
3	Programs for very low income	5/19/2022 1:49 PM
4	when i worked at Uihlein 10 years ago they flushed medication down the toilets to “properly” dispose of them	5/18/2022 9:33 PM
5	unkempt properties; trash, discarded appliances, vehicles	5/16/2022 2:51 PM
6	Government propaganda	5/10/2022 3:35 PM
7	Pesticides where children play, and salt runoff from the roads, chlorine and other supposedly safe chemicals added to our town water.	4/26/2022 8:39 AM
8	Energy rates for heating and cooling homes affordabley	4/26/2022 8:23 AM
9	limited education	4/19/2022 8:52 PM
10	Poor infrastructure, aging sewers and municipal water systems, lack of affordable waste removal options	4/6/2022 7:03 PM
11	Negative Impact of so many junk cars/appliances on properties	4/2/2022 9:46 PM
12	Asbestos	3/31/2022 10:55 AM
13	recycling not being processed	3/30/2022 5:58 PM
14	The amount of salt put down on the roads seems excessive and worrisome for water quality. If drivers could slow down and the DOT put more dirt we could potentially reduce salt on	3/28/2022 2:58 PM

	roadways. I'm concerned about the effect in our streams, lakes and drinking water. The environmental impact on vehicles, home appliances and water quality seems unnecessary.	
15	Smoke from outdoor boilers, trash burning	3/27/2022 9:15 PM
16	Road salt	3/27/2022 1:35 PM
17	Road salt contamination and ecological damage.	3/26/2022 8:54 AM
18	Local Public transportation at any level for other than seniors	3/25/2022 7:52 PM
19	Law enforcement at all levels have neglected to enforce vehicle emissions laws. Obnoxious, illegally modified exhaust systems on trucks and motorcycles have become a public menace.	3/25/2022 10:10 AM
20	light pollution	3/25/2022 9:53 AM
21	Roadway Runoff / Salt/Sand /	3/25/2022 9:19 AM
22	a local government that cares	3/25/2022 9:04 AM
23	maintaining the excellent level of these we currently have.	3/25/2022 8:53 AM
24	challenges related to living in an adverse climate such as heating costs in the winter, un safe road conditions	3/25/2022 8:29 AM
25	Dogs which are unleashed	3/25/2022 12:03 AM
26	Excess cows	3/24/2022 10:30 PM
27	Noise	3/24/2022 9:32 PM
28	Homes that are unfit to live in, leaking roof, failed septic, lack of heat and clean water	3/24/2022 8:26 PM
29	finding ways that include multiple methods of creating power for our homes cars and equipment	3/24/2022 6:45 PM
30	Mold in environment exploding because of pesticides	3/24/2022 6:37 PM
31	out of control motorcycle noise pollution	3/23/2022 8:49 PM
32	Fires from chimneys not being inspected annually.	3/23/2022 6:45 PM
33	Road salt	3/21/2022 9:41 PM
34	None	3/21/2022 7:23 PM
35	mold- we are in an area with water	3/21/2022 3:48 PM

Q6 What health challenges have you or a family member had in the past year? Select all that apply.

Answered: 417 Skipped: 68





ANSWER CHOICES	RESPONSES	
Access to dental care	30.22%	126
Access to healthcare services	28.78%	120
Access to mental health services	23.98%	100
Cancer	12.47%	52
Chronic disease (diabetes, heart disease, high blood pressure, high cholesterol, stroke, etc.)	34.77%	145
Falls	9.35%	39
Immunization	6.47%	27
Infectious disease (hepatitis A, B, C, flu, COVID-19 etc.)	23.02%	96
Health concerns of intellectual or developmental disability	3.36%	14
Health concerns of physical disability	10.79%	45
Issues related to aging (arthritis, hearing/vision loss, etc.)	40.77%	170
Lung disease (asthma, COPD, etc.)	9.11%	38
Overweight/obesity	29.26%	122
Physical activity	22.06%	92
Prenatal care/maternal & infant health	5.28%	22
Sexually transmitted infections (including HIV)	0.96%	4
Substance abuse (drugs, alcohol, etc.)	11.99%	50
Suicide	6.24%	26
Tobacco use	6.00%	25
Other (please specify)	13.19%	55
Total Respondents: 417		

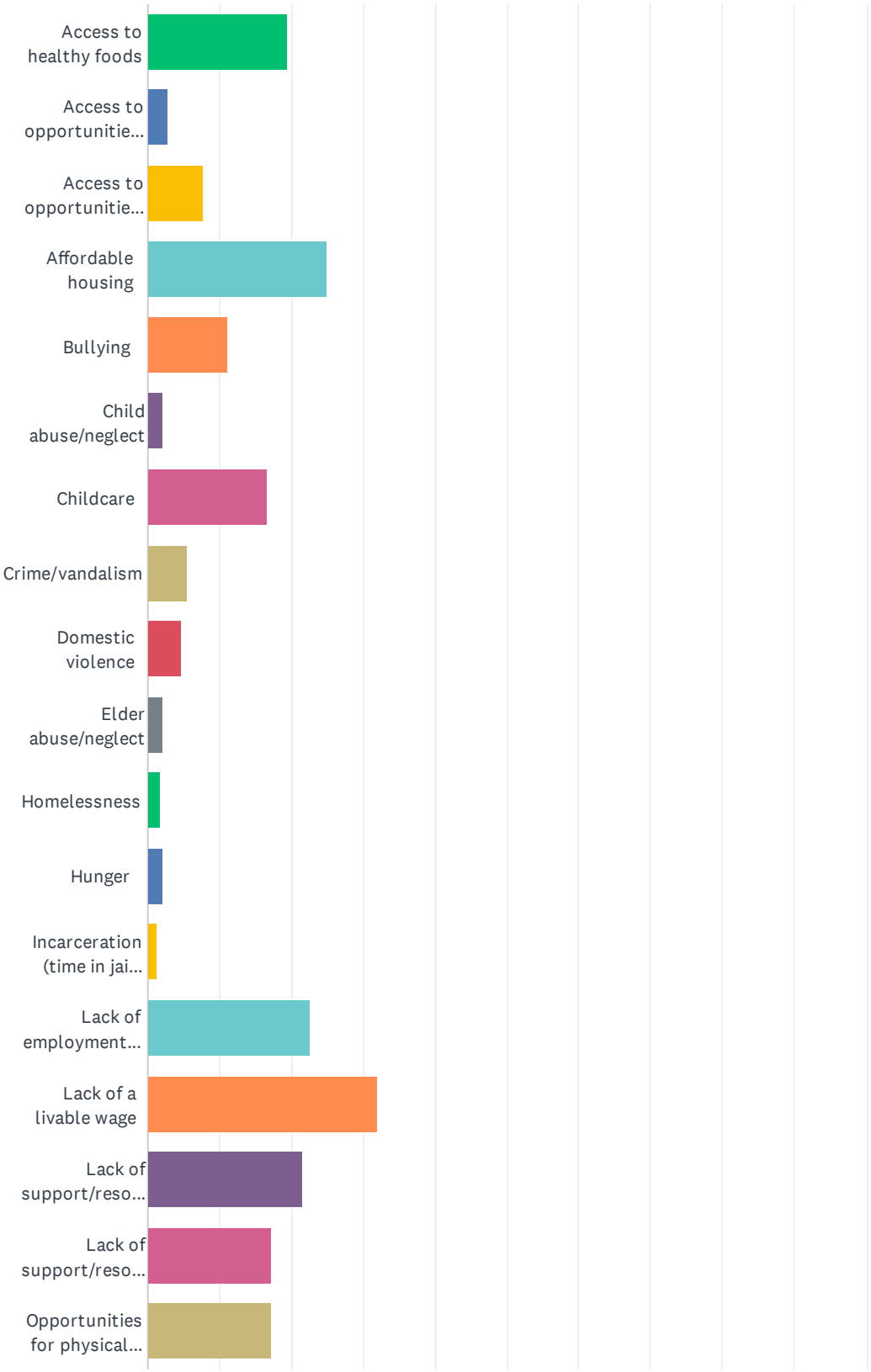
#	OTHER (PLEASE SPECIFY)	DATE
1	Access to affordable health insurance	6/21/2022 3:15 PM
2	Urinary problem - I had to go to Syracuse for adequate treatment	6/21/2022 3:02 PM
3	All health concerns are important	6/21/2022 2:57 PM
4	N/A	6/21/2022 2:44 PM
5	No answer	6/21/2022 2:39 PM

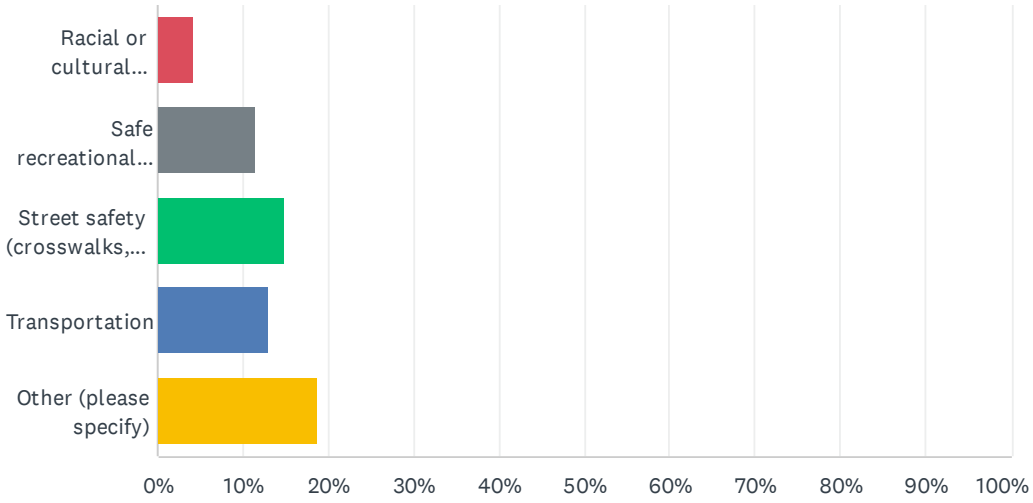
6	I have been lucky that I have relatively good health and economically can afford good health and dental care. I am concerned that there is such inequality in my town...and state...that too many people are in need.	6/21/2022 2:34 PM
7	Chronic pain	5/19/2022 1:51 PM
8	None	5/19/2022 4:17 AM
9	Lyme disease	5/19/2022 3:33 AM
10	Lack of understanding how to communicate with a person with hearing impairment.	5/16/2022 11:01 AM
11	Lyme's disease 2x	5/11/2022 1:39 AM
12	No Dental provider in the area that accepts state medicaid and or fidelis	5/10/2022 7:05 PM
13	Bullying due to vaxx rules	5/10/2022 3:38 PM
14	Help with aging parents	5/10/2022 11:46 AM
15	none	4/26/2022 12:25 PM
16	health concerns / undiagnosed	4/19/2022 8:59 AM
17	regular Preventive Anything(s) that are NOT covered if YOU pay for your insurance.	4/9/2022 7:29 AM
18	Respite services for caregivers	4/8/2022 8:10 AM
19	tic bites	4/7/2022 11:27 PM
20	Stress	4/7/2022 8:02 PM
21	Lack of school awareness about mental health	4/7/2022 6:25 PM
22	VA Medical Support	4/7/2022 8:52 AM
23	Shortage of physicians, inability to schedule an appointment with a medical professional in a timely manor	4/6/2022 7:08 PM
24	access to primary care physicians....I've been on a waitlist...dr's not taking new patients	3/30/2022 4:31 PM
25	none	3/29/2022 3:22 PM
26	When we moved to the area it took almost a year to get a new patient appointment to establish care with a primary provider.	3/28/2022 3:05 PM
27	Lyme disease	3/28/2022 1:21 PM
28	None	3/27/2022 1:45 PM
29	None	3/27/2022 1:37 PM
30	Na	3/27/2022 1:13 PM
31	A lack of even online mental health services. Very challenging to find, maintain and afford	3/25/2022 8:01 PM
32	affordable health insurance	3/25/2022 1:09 PM
33	Stress and anxiety due to constant socio-political issues constantly pushed into every aspect of daily life, including sports, work, and entertainment. The mainstreaming of anti-American neo-marxist/communist ideology in the Democrat Party is of huge concern to the stability of my family's future and for the Country.	3/25/2022 10:20 AM
34	Autoimmune issues	3/25/2022 9:53 AM
35	a local government that cares	3/25/2022 9:06 AM
36	cost of healthcare and insurance	3/25/2022 8:33 AM
37	Lack of gluten free food options	3/24/2022 9:37 PM
38	I go to Vermont for medical services	3/24/2022 8:29 PM
39	coping with constantly changing Covid rules and the oppressive Federal response especially which continues via mandates to this day.	3/24/2022 6:52 PM

40	Lyme/mold	3/24/2022 6:40 PM
41	Nutritious food for youth	3/24/2022 6:26 PM
42	None	3/24/2022 4:46 PM
43	NA	3/24/2022 3:04 PM
44	Livable Wage	3/24/2022 1:58 PM
45	The forcing of vaccines. And quarantining	3/24/2022 12:55 PM
46	none	3/24/2022 12:39 PM
47	bullying	3/24/2022 12:16 PM
48	Being on the NY marketplace insurance has severely limited health issues I should have checked by a specialist because I cannot afford the medical care/doctor, etc. - that does not mean the health problem dissapated.	3/24/2022 6:15 AM
49	Quality doctors- having to travel to UVM	3/23/2022 8:52 PM
50	none	3/23/2022 8:06 PM
51	late stage dementia	3/23/2022 6:50 PM
52	Tick born disease	3/22/2022 7:12 AM
53	immunocompromised	3/21/2022 7:16 PM
54	Grief—lost a parent	3/21/2022 7:10 PM
55	Availability of diverse organic veggies and fruit	3/21/2022 3:53 PM

Q7 What social challenges have you or a family member had in the past year? Select all that apply.

Answered: 417 Skipped: 68




Racial or cultural...
Safe recreational...
Street safety (crosswalks,...
Transportation
Other (please specify)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

ANSWER CHOICES	RESPONSES	
Access to healthy foods	19.42%	81
Access to opportunities for health for those with intellectual or developmental disabilities	2.88%	12
Access to opportunities for health for those with physical limitations or disabilities	7.67%	32
Affordable housing	24.94%	104
Bullying	11.03%	46
Child abuse/neglect	2.16%	9
Childcare	16.55%	69
Crime/vandalism	5.52%	23
Domestic violence	4.80%	20
Elder abuse/neglect	2.16%	9
Homelessness	1.68%	7
Hunger	2.16%	9
Incarceration (time in jail or prison)	1.20%	5
Lack of employment opportunities	22.54%	94
Lack of a livable wage	31.89%	133
Lack of support/resources for seniors	21.58%	90
Lack of support/resources for youth	17.27%	72
Opportunities for physical activity	17.27%	72
Racial or cultural discrimination	4.32%	18
Safe recreational areas	11.51%	48
Street safety (crosswalks, shoulders, bike lanes, traffic, etc.)	14.87%	62
Transportation	12.95%	54
Other (please specify)	18.71%	78
Total Respondents: 417		

#	OTHER (PLEASE SPECIFY)	DATE
1	Access to affordable health insurance	6/21/2022 3:15 PM
2	None	6/21/2022 3:02 PM
3	Many people are finding cost of food and utilities a challenge	6/21/2022 2:57 PM
4	Isolation due to COVID	6/21/2022 2:53 PM
5	N/A	6/21/2022 2:50 PM
6	N/A	6/21/2022 2:47 PM
7	N/A	6/21/2022 2:44 PM
8	N/A	6/21/2022 2:39 PM

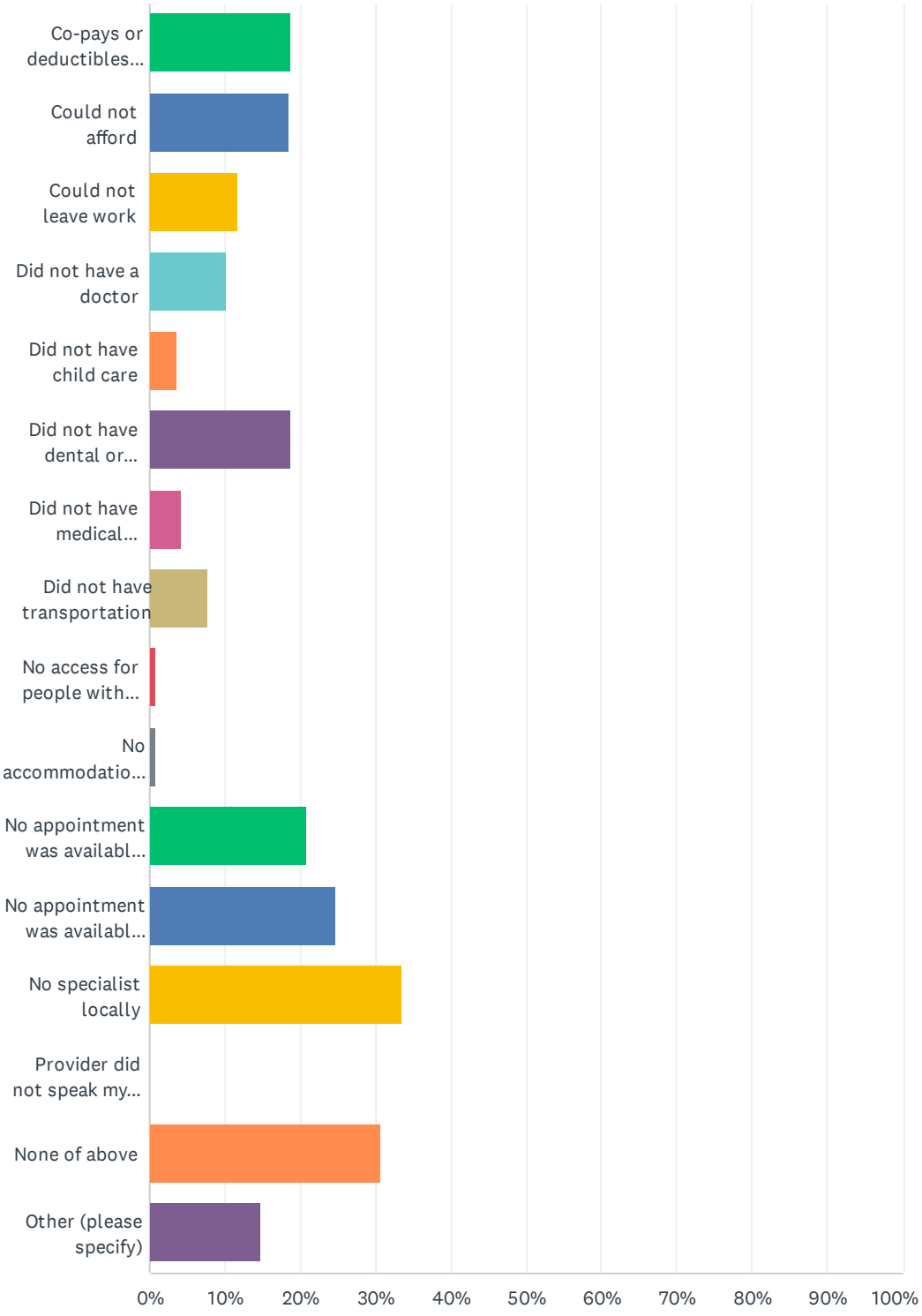
9	Again, I worry for my fellows in my county.	6/21/2022 2:34 PM
10	Excessive speed limits in residential area.	5/21/2022 10:54 PM
11	Phone scams	5/19/2022 7:01 PM
12	Programs for chronic pain	5/19/2022 1:51 PM
13	None personally	5/19/2022 5:47 AM
14	Having to drive 45+ minutes for quality, healthy foods is inconvenient	5/19/2022 4:17 AM
15	Noise and air pollution	5/19/2022 3:33 AM
16	Lack of help for mental illness	5/18/2022 9:08 PM
17	None of the above	5/18/2022 9:07 PM
18	unease because of pressure from outspoken political MAGA supporters	5/11/2022 1:39 AM
19	Conmection with people during Covid and non-compliance by others with Covid precautions and preventive measures	5/11/2022 12:39 AM
20	None of these apply to ME	5/10/2022 5:49 PM
21	Covid shutdown fallout!!!! Constant fear mongering	5/10/2022 3:38 PM
22	Lack of opportunities for sober supports for family member with addiction	4/28/2022 3:39 AM
23	none	4/27/2022 3:03 AM
24	2nd home owners taking over town	4/26/2022 5:29 PM
25	Access to doctor, rather than PA, in local ER on a Sunday am	4/26/2022 3:28 PM
26	inflation	4/26/2022 12:25 PM
27	Nowhere to exercise indoors when weather is bad	4/26/2022 8:30 AM
28	Opportunities for social activity	4/19/2022 8:55 PM
29	Had to go to VT for a basic food allergy test	4/9/2022 1:38 PM
30	none i guess...	4/9/2022 7:29 AM
31	None of the above	4/8/2022 4:45 PM
32	None of these	4/8/2022 9:53 AM
33	Respite care for caregivers	4/8/2022 8:10 AM
34	N/A	4/8/2022 6:32 AM
35	No social challenges.	4/7/2022 11:27 PM
36	None	4/7/2022 10:16 PM
37	None	4/7/2022 9:05 PM
38	Lack of in person social activities	4/7/2022 8:02 PM
39	Non we	4/5/2022 6:46 PM
40	None	4/1/2022 2:11 PM
41	Airbnb	3/31/2022 4:30 PM
42	None	3/31/2022 10:40 AM
43	Access to affordable counseling for seniors	3/31/2022 7:59 AM
44	none	3/29/2022 3:22 PM
45	none	3/28/2022 10:25 PM
46	Our previous community had many bike lanes and we, as a family, rode bicycles to parks, out	3/28/2022 3:05 PM

	for dinner or errands. In Lake Placid, with the traffic it isn't safe for us to bike as a family. We only live 1.5 mile from Main Street and rarely go there to shop because we can't bike nor find free parking. Bike lanes and bike racks would be amazing!	
47	N/A	3/28/2022 11:48 AM
48	rising costs for everything making it difficult to live on one income	3/28/2022 8:33 AM
49	none	3/27/2022 1:45 PM
50	None	3/27/2022 1:37 PM
51	None	3/27/2022 1:35 PM
52	none	3/27/2022 12:57 PM
53	Isolation due. To covid	3/26/2022 2:11 PM
54	Need indoor recreation during the long winter months for all ages	3/25/2022 8:01 PM
55	Coping with tyrannical lockdowns and being forced to wear masks against my will- mostly driven by Democrats and unelected officials. Recent studies by major Universities have proven these tactics to have done more harm than good, and were ineffective. No main stream attention on physical fitness and weight loss to combat COVID though... curious. We know obesity and diabetes are at the top of the list for many health problems, especially COVID complications and mortality.	3/25/2022 10:20 AM
56	a local government that cares	3/25/2022 9:06 AM
57	none - we live in a great community.	3/25/2022 8:56 AM
58	lack of recreational opportunities, lack of access to affordable groceries, lack of employers that care about employees, not the bottom line	3/25/2022 8:33 AM
59	No where to run safely	3/25/2022 8:09 AM
60	None of these, I am very fortunate but I know others who are not	3/24/2022 8:29 PM
61	none	3/24/2022 6:52 PM
62	NA	3/24/2022 3:04 PM
63	NO HELP FOR DRUG ADDICTS	3/24/2022 2:35 PM
64	none	3/24/2022 2:17 PM
65	None of the above	3/24/2022 2:15 PM
66	none, though we have watched many people in the community suffer from the challenges above.	3/24/2022 1:35 PM
67	none	3/24/2022 12:11 PM
68	Political hatred	3/24/2022 8:47 AM
69	none	3/24/2022 8:27 AM
70	Living on a lower fixed income automatically limits you to joining a gym, etc. - as it is preventable medicine in the bank! Frustrating when your income is not low enough for assistance of any kind, not high enough to break the glass ceiling of opportunity-	3/24/2022 6:15 AM
71	Quality food	3/23/2022 8:52 PM
72	social isolation of COVID	3/23/2022 8:06 PM
73	None personally	3/23/2022 7:14 PM
74	Participating in a community during a pandemic	3/23/2022 7:00 PM
75	Retired with reasonable income, and currently not challenged	3/23/2022 6:29 PM
76	Tick born disease not understood	3/22/2022 7:12 AM
77	Overwork	3/21/2022 7:10 PM

78	Furthering education for seniors at the college would be nice, subjects including mentally stimulating opportunities, employment, how to do this, that...	3/21/2022 3:53 PM

Q8 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: 417 Skipped: 68



ANSWER CHOICES	RESPONSES	
Co-pays or deductibles were too high	18.71%	78
Could not afford	18.47%	77
Could not leave work	11.75%	49
Did not have a doctor	10.31%	43
Did not have child care	3.60%	15
Did not have dental or vision insurance	18.71%	78
Did not have medical insurance	4.32%	18
Did not have transportation	7.67%	32
No access for people with physical disabilities	0.96%	4
No accommodations for people with intellectual or developmental disabilities	0.96%	4
No appointment was available (primary care)	20.86%	87
No appointment was available (specialist)	24.70%	103
No specialist locally	33.57%	140
Provider did not speak my language	0.00%	0
None of above	30.70%	128
Other (please specify)	14.63%	61
Total Respondents: 417		

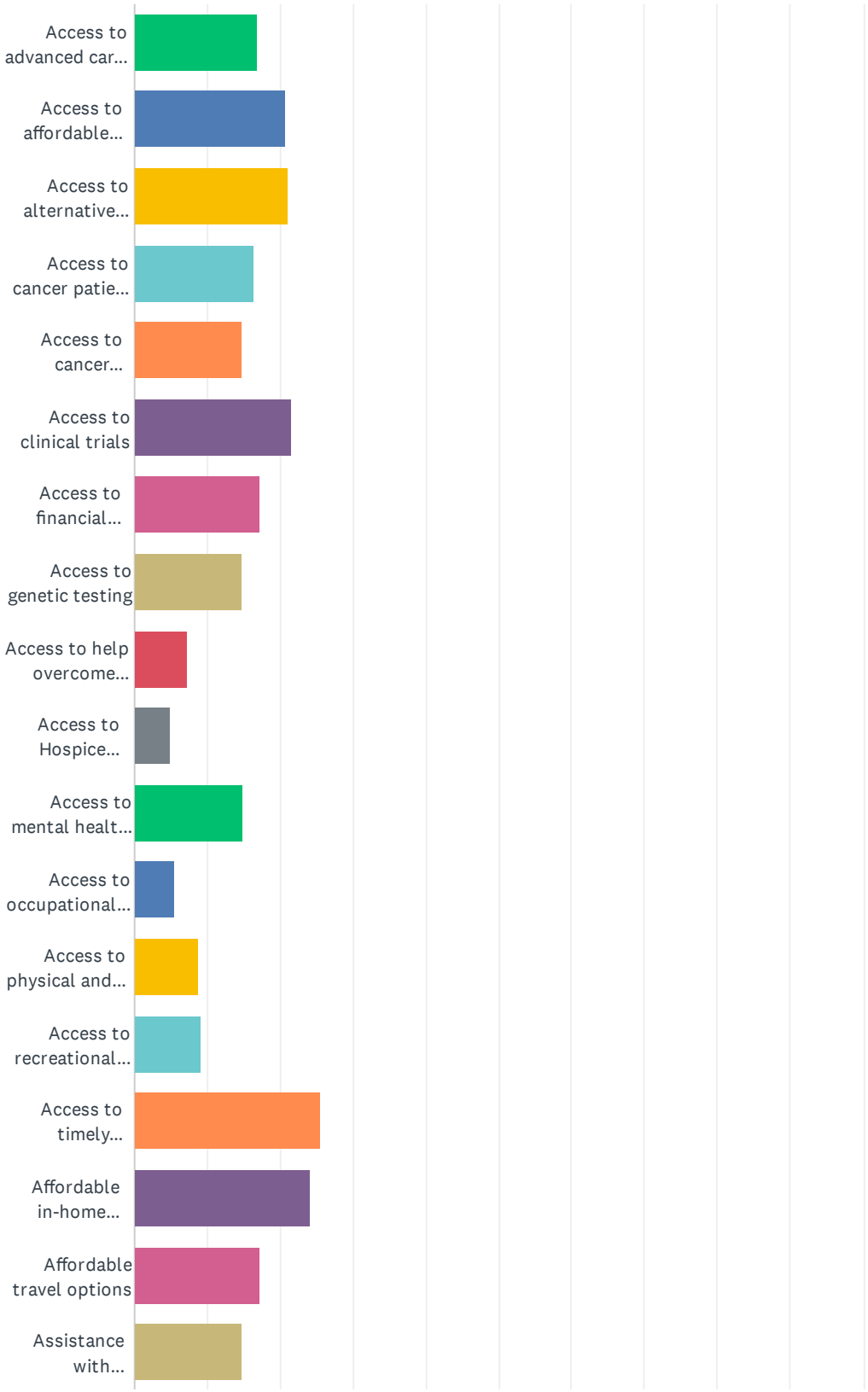
#	OTHER (PLEASE SPECIFY)	DATE
1	wait for COVID vaccines to arrive	6/21/2022 2:53 PM
2	N/A	6/21/2022 2:50 PM
3	N/A	6/21/2022 2:47 PM
4	The cost of insurance is so high. Doesn't leave much leftover to pay cost of co-pays or deductibles.	6/21/2022 2:44 PM
5	Dental - stopped taking people	6/21/2022 2:29 PM
6	Covid	5/21/2022 10:54 PM
7	No dental care nearby for medicaid folks	5/20/2022 11:43 AM
8	Health center refusal to see patients in an exam room. Granddaughter was having issues with her belly and was refused exam room visit because of Covid. Apparently weeks of belly pain could result in a positive Covid diagnosis. Had to take her to the emergency room to be evaluated properly	5/19/2022 2:41 PM
9	Transportation and insurance won’t pay fir tests	5/19/2022 1:51 PM
10	Covid Fears	5/19/2022 10:42 AM
11	Covid-19 protocols limited ability to see a doctor without having to quarantine every visit	5/18/2022 9:41 PM
12	There was NO time in the past year we did not get the medical help we needed	5/10/2022 5:49 PM
13	Covid and masking restrictions	5/10/2022 3:38 PM
14	Needed someone to come into our home to assist elderly parent and no one who could accept	5/10/2022 11:46 AM

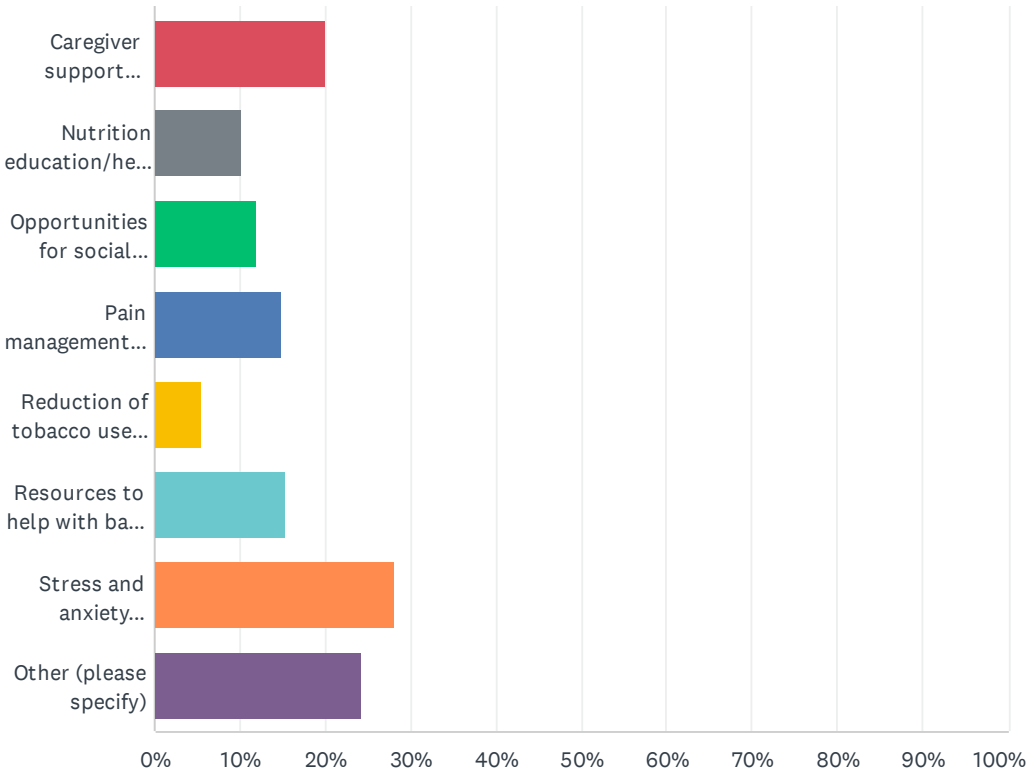
	mom's insurance was available	
15	Distance required to travel for appointments conflicted with work. Medical care delayed due to Covid restrictions in senior living community for a family member.	4/28/2022 3:39 AM
16	Lack of physical therapists. Doctor would not treat for tick bite	4/26/2022 8:30 AM
17	braces for my son in local area with work its hard to travel 2 hours away and add on gas prices now	4/8/2022 11:54 AM
18	No provider would see new patients or there was at least a six month wait for an appointment. Some instances a provider would not even return our calls. We have lived here for three years and have had to drive back to NYC for healthcare services because we have zero access to care here. We are moving out of the area because this is unsustainable for our life	4/8/2022 8:03 AM
19	prescription med not dispensed in timely manner	4/8/2022 7:37 AM
20	Does not apply	4/7/2022 8:19 PM
21	Not applicable	4/7/2022 6:50 PM
22	Lack of mental health providers	4/7/2022 6:25 PM
23	no medicaid doctors in our area	4/7/2022 8:52 AM
24	pandemic	4/4/2022 7:42 PM
25	N/A	4/1/2022 2:11 PM
26	This question does not apply to me	4/1/2022 1:11 PM
27	Providers did not take insurance	3/31/2022 9:17 AM
28	Lack of mental health options/counseling	3/30/2022 6:00 PM
29	Providers didn’t accept the kind of insurance we have	3/29/2022 7:21 AM
30	None	3/28/2022 7:13 PM
31	Particularly hard to find dentist that accepts medicaid	3/27/2022 9:17 PM
32	Concern about exposure to COVID-19	3/27/2022 1:23 PM
33	Covid prevented access to Dr office	3/26/2022 12:35 AM
34	More that I had the care then months and months later get slammed with a large bill	3/25/2022 8:56 PM
35	The county did not even have the capability to provide enough mental health appointments. They knew my child needed services 3x a week and knowing that they couldn’t offer that they insisted I get and pay for an evaluation. Waste of time and money for us but the county pushed paper and made money off if my family. So sad so wrong	3/25/2022 8:01 PM
36	Specialist in my area did not take insurance	3/25/2022 4:57 PM
37	NO dental	3/25/2022 1:20 PM
38	Our medical insurance wasn't accepted by our previous providers.	3/25/2022 11:06 AM
39	No local dentist or vision provider would take the insurance when we had it.	3/25/2022 11:06 AM
40	Insurance doesn't cover certain preventable health measures	3/25/2022 9:21 AM
41	a local government that cares	3/25/2022 9:06 AM
42	Needed bandages changed after surgery, could not get local help with that.	3/25/2022 12:06 AM
43	Concerns relating to Covid-19	3/24/2022 9:37 PM
44	I have what I need	3/24/2022 8:29 PM
45	Covid 19 rextrictions	3/24/2022 7:30 PM
46	none, we managed as a family	3/24/2022 6:52 PM
47	Dna	3/24/2022 6:32 PM

48	Covid restrictions limited care	3/24/2022 4:47 PM
49	NO HELP FOR DRUG ADDICTS	3/24/2022 2:35 PM
50	Having to wait several months for an appointment.	3/24/2022 12:43 PM
51	Medical insurance will not cover a lot of things.	3/24/2022 12:21 PM
52	Go ahead… get the flu or have a sudden issue try and see a doctor in this community.	3/24/2022 8:47 AM
53	I have sold x-c skis to see a dr to have a cyst drained several times so it would not become sepsis- what is not right about that picture?!	3/24/2022 6:15 AM
54	Maintain doctors 2, and 5 hours away from home	3/23/2022 8:52 PM
55	NA	3/23/2022 8:06 PM
56	Had no issues.	3/23/2022 7:58 PM
57	Did not have a dentist	3/23/2022 7:00 PM
58	No home health care nurse available for evaluating a patient.	3/23/2022 6:50 PM
59	excessively long wait times for appointments	3/23/2022 2:16 PM
60	gender affirming healthcare	3/21/2022 7:16 PM
61	PT isn't covered at the hospital because it is called a post op care out patient facility, blue cross won't cover unless I have surgery. CRAZY	3/21/2022 3:53 PM

Q9 Select the cancer services you feel are missing or lacking in the community based on your experience. Select all that apply.

Answered: 403 Skipped: 82




Caregiver support...
Nutrition education/he...
Opportunities for social...
Pain management...
Reduction of tobacco use...
Resources to help with ba...
Stress and anxiety...
Other (please specify)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

ANSWER CHOICES	RESPONSES	
Access to advanced care planning	16.87%	68
Access to affordable prescription/medication coverage	20.60%	83
Access to alternative healthcare providers (acupuncture, chiropractors, etc.)	21.09%	85
Access to cancer patient support groups	16.38%	66
Access to cancer screenings/resources/information	14.64%	59
Access to clinical trials	21.59%	87
Access to financial assistance programs for co-pays and bills	17.37%	70
Access to genetic testing	14.64%	59
Access to help overcome drug/alcohol dependence	7.20%	29
Access to Hospice services	4.96%	20
Access to mental health services	14.89%	60
Access to occupational therapy	5.46%	22
Access to physical and exercise therapy	8.68%	35
Access to recreational/exercise facilities and services for individuals with physical impairments and disabilities	9.18%	37
Access to timely specialty care	25.56%	103
Affordable in-home services	24.07%	97
Affordable travel options	17.37%	70
Assistance with understanding health insurance benefits and coverage	14.64%	59
Caregiver support (respite)	20.10%	81
Nutrition education/healthy meal planning	10.17%	41
Opportunities for social connections	11.91%	48
Pain management services	14.89%	60
Reduction of tobacco use including e-cigarettes	5.46%	22
Resources to help with basic needs (food, housing, paying bills, etc.)	15.38%	62
Stress and anxiety resources and treatment	28.04%	113
Other (please specify)	24.32%	98
Total Respondents: 403		

#	OTHER (PLEASE SPECIFY)	DATE
1	N/A	6/21/2022 3:15 PM
2	N/A	6/21/2022 3:02 PM
3	Cost of medications, access to timely care and support groups would all be essential	6/21/2022 2:58 PM
4	N/A	6/21/2022 2:50 PM
5	N/A	6/21/2022 2:47 PM

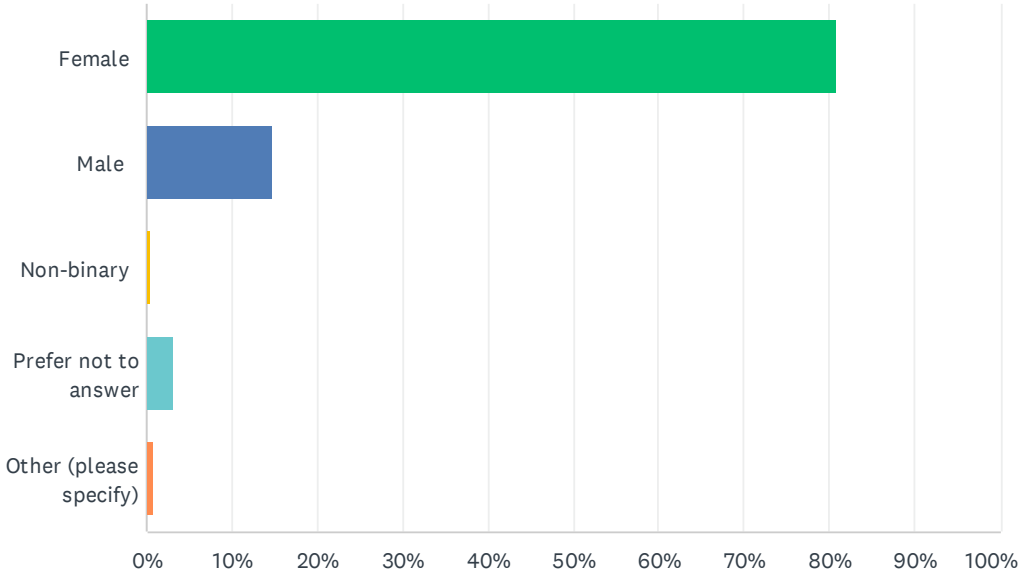
6	N/A	6/21/2022 2:44 PM
7	N/A	6/21/2022 2:39 PM
8	I was living in a very different community when I was diagnosed with breast cancer and had access to excellent care (within an hour's drive)	6/21/2022 2:35 PM
9	N/A	6/21/2022 2:29 PM
10	Not applicable	5/20/2022 5:00 AM
11	Whoever designed this survey needed to add a “n/a”option	5/19/2022 7:02 PM
12	Transportation	5/19/2022 1:52 PM
13	none	5/19/2022 10:42 AM
14	No	5/19/2022 5:48 AM
15	No personal experience with this. Obviously the fact that people have to travel at least an hour for quality treatment for any medical appointments could be hard for some people.	5/19/2022 4:18 AM
16	it’s always a concern but not had to deal with it yet	5/18/2022 9:36 PM
17	Does not apply.	5/16/2022 11:02 AM
18	Unknown	5/11/2022 12:40 AM
19	Transportation to treatments	5/10/2022 8:53 PM
20	When I had cancer 15 years ago I had all the services needed. Many of the above services did not apply to me at that time.	5/10/2022 5:51 PM
21	N/A	5/10/2022 4:23 PM
22	Have not experienced cancer	5/10/2022 2:50 PM
23	n/a	4/27/2022 3:03 AM
24	N/A	4/26/2022 11:13 AM
25	NA-No experience with cancer treatments	4/25/2022 5:42 PM
26	I have no experience in this area.	4/19/2022 8:57 PM
27	My daughter was living outside the US.	4/8/2022 4:46 PM
28	NA	4/8/2022 11:22 AM
29	no experience in this community	4/8/2022 9:54 AM
30	Transportation costs to Vermont	4/8/2022 9:42 AM
31	While I have not been diagnosed with cancer based on my experience in being able to get access to primary care and specialty care for other health concerns there is zero access to cancer care in Essex county.	4/8/2022 8:05 AM
32	Not applicable	4/8/2022 7:24 AM
33	N/A	4/7/2022 10:17 PM
34	D/n apply	4/7/2022 9:11 PM
35	N/A	4/7/2022 9:05 PM
36	Does not apply	4/7/2022 8:20 PM
37	Not applicable	4/7/2022 6:34 PM
38	NA	4/7/2022 6:26 PM
39	Not pertinent	4/7/2022 9:32 AM
40	N/A	4/6/2022 7:09 PM

41	None	4/5/2022 8:12 PM
42	Social services and mental health in hospital setting	4/4/2022 7:29 PM
43	N/A	4/1/2022 2:59 PM
44	#9 above does not apply to me	4/1/2022 1:13 PM
45	n/a	4/1/2022 10:13 AM
46	None. Community too small and access is within 2 hrs	4/1/2022 9:56 AM
47	No dermatologist within 2 hour drive	3/31/2022 4:33 PM
48	Does not apply to me	3/31/2022 10:45 AM
49	None	3/31/2022 10:42 AM
50	Na	3/31/2022 9:17 AM
51	n/a	3/30/2022 9:22 AM
52	NA	3/29/2022 9:05 PM
53	none	3/29/2022 3:22 PM
54	None	3/28/2022 7:14 PM
55	Access to higher levels of care than Albany or Burlington can provide for complicated cases.	3/28/2022 3:50 PM
56	N/A	3/28/2022 3:06 PM
57	N/A (no experience here)	3/27/2022 1:37 PM
58	Support for patient whose services were on the other side of the lake	3/27/2022 1:25 PM
59	Ccx	3/26/2022 10:12 PM
60	NA	3/25/2022 12:27 PM
61	Multiple cancer dx in family, but don't live in this community.	3/25/2022 11:08 AM
62	n/a	3/25/2022 9:53 AM
63	unknown	3/25/2022 9:22 AM
64	no local specialists	3/25/2022 9:07 AM
65	we've received excellent care / support as caregiver and patient.	3/25/2022 8:57 AM
66	Essex county healthcare is severely lacking. I go to VT for better services that I feel confident in	3/25/2022 8:35 AM
67	Na	3/25/2022 8:09 AM
68	Complacent medical staff	3/24/2022 10:34 PM
69	I have not had cancer	3/24/2022 8:29 PM
70	NA	3/24/2022 8:03 PM
71	None	3/24/2022 7:31 PM
72	none, but this is confusing as to your goal in collecting information	3/24/2022 6:53 PM
73	N/A	3/24/2022 6:47 PM
74	No cancer	3/24/2022 6:37 PM
75	Na	3/24/2022 6:16 PM
76	NA	3/24/2022 4:46 PM
77	OUR COMMUNITY HAS NONE OF THIS	3/24/2022 2:36 PM
78	none	3/24/2022 2:18 PM

79	Not applicable	3/24/2022 2:16 PM
80	NA	3/24/2022 1:52 PM
81	N/A	3/24/2022 1:07 PM
82	n/a	3/24/2022 12:17 PM
83	ALL OPTIONS AVAILABLE	3/24/2022 12:17 PM
84	Assistance to family members going through this	3/24/2022 12:11 PM
85	n/a	3/24/2022 10:27 AM
86	The crackdown on narcotic abuse has made prescriber too frightened or overburdened with paperwork to consider the whole patient	3/24/2022 8:54 AM
87	Timely cancer services and expertise is a complete void. If you think access to a general oncologist once a month is a sufficient care plan for an acute case, you simply do not understand some types of cancer.	3/24/2022 8:51 AM
88	N/A	3/24/2022 8:28 AM
89	While this has not been a disease I / we have dealt with (their are other issues though), we have an exceedingly number of fund raisers for folks in the area for treatment costs, etc.-the health insurance is inadequate for the majority of the people.	3/24/2022 6:19 AM
90	Access to quality surgeon, oncologist and radiologist	3/23/2022 8:54 PM
91	Not applicable	3/23/2022 8:41 PM
92	NA	3/23/2022 8:06 PM
93	N/A	3/23/2022 2:24 PM
94	N/A	3/23/2022 2:17 PM
95	Don’t know	3/22/2022 7:13 AM
96	Doesn't apply	3/21/2022 7:25 PM
97	My family members with cancer lived in other states	3/21/2022 7:11 PM
98	I don't have this issue	3/21/2022 3:54 PM

Q10 What gender do you identify with?

Answered: 396 Skipped: 89

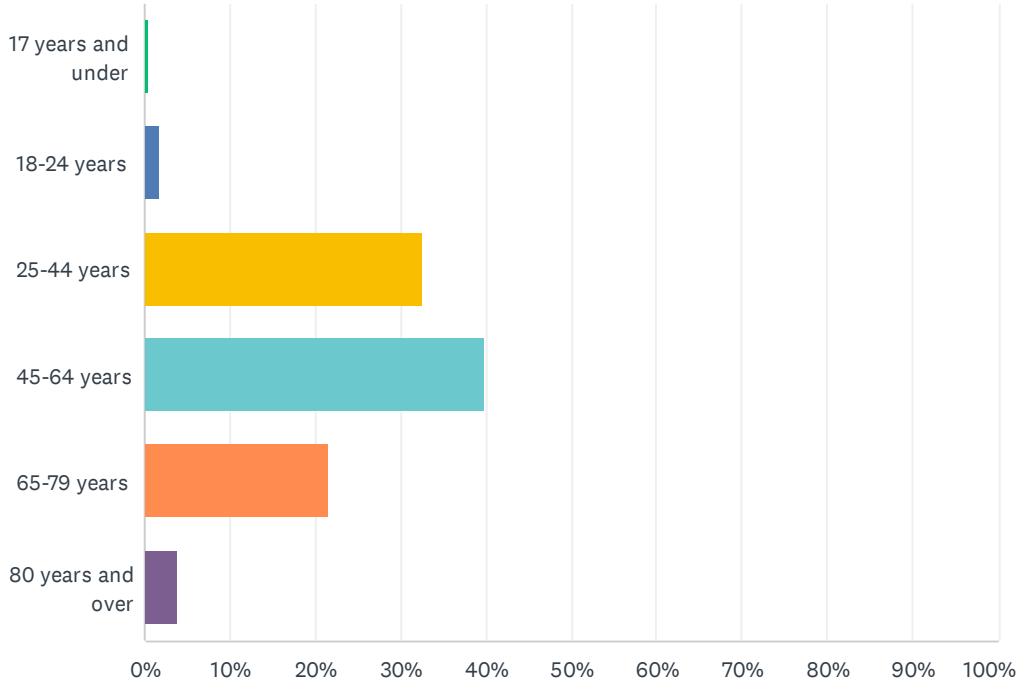


ANSWER CHOICES	RESPONSES	
Female	80.81%	320
Male	14.65%	58
Non-binary	0.51%	2
Prefer not to answer	3.28%	13
Other (please specify)	0.76%	3
TOTAL		396

#	OTHER (PLEASE SPECIFY)	DATE
1	Agender	4/8/2022 4:08 PM
2	The three of us are two males and a female	3/24/2022 6:56 PM
3	I no more trust your data collection process than I trust your communication skills.	3/24/2022 8:55 AM

Q11 What is your age?

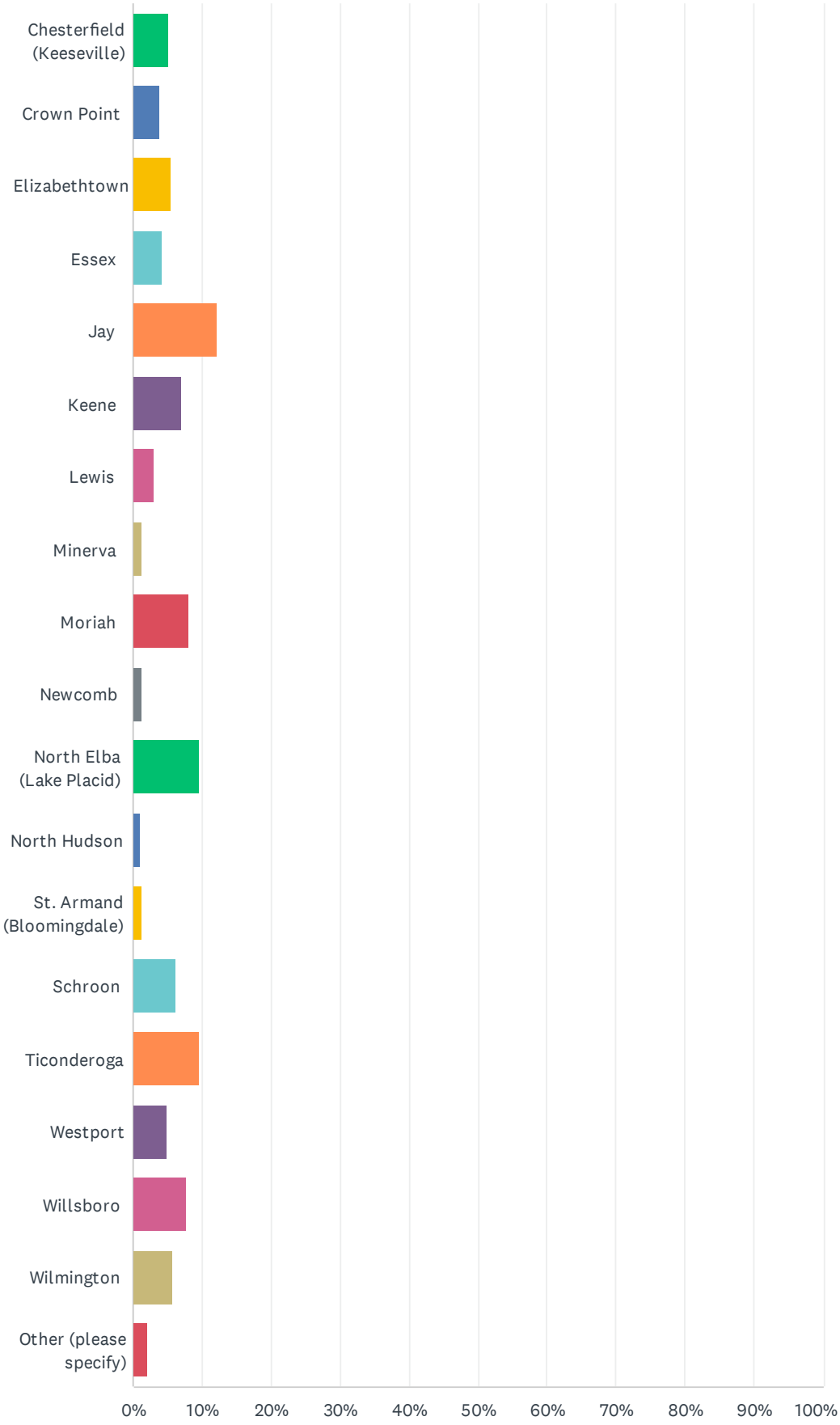
Answered: 396 Skipped: 89



ANSWER CHOICES	RESPONSES	
17 years and under	0.51%	2
18-24 years	1.77%	7
25-44 years	32.58%	129
45-64 years	39.90%	158
65-79 years	21.46%	85
80 years and over	3.79%	15
TOTAL		396

Q12 What city/town do you live in? Select only one based on your primary residence.

Answered: 393 Skipped: 92

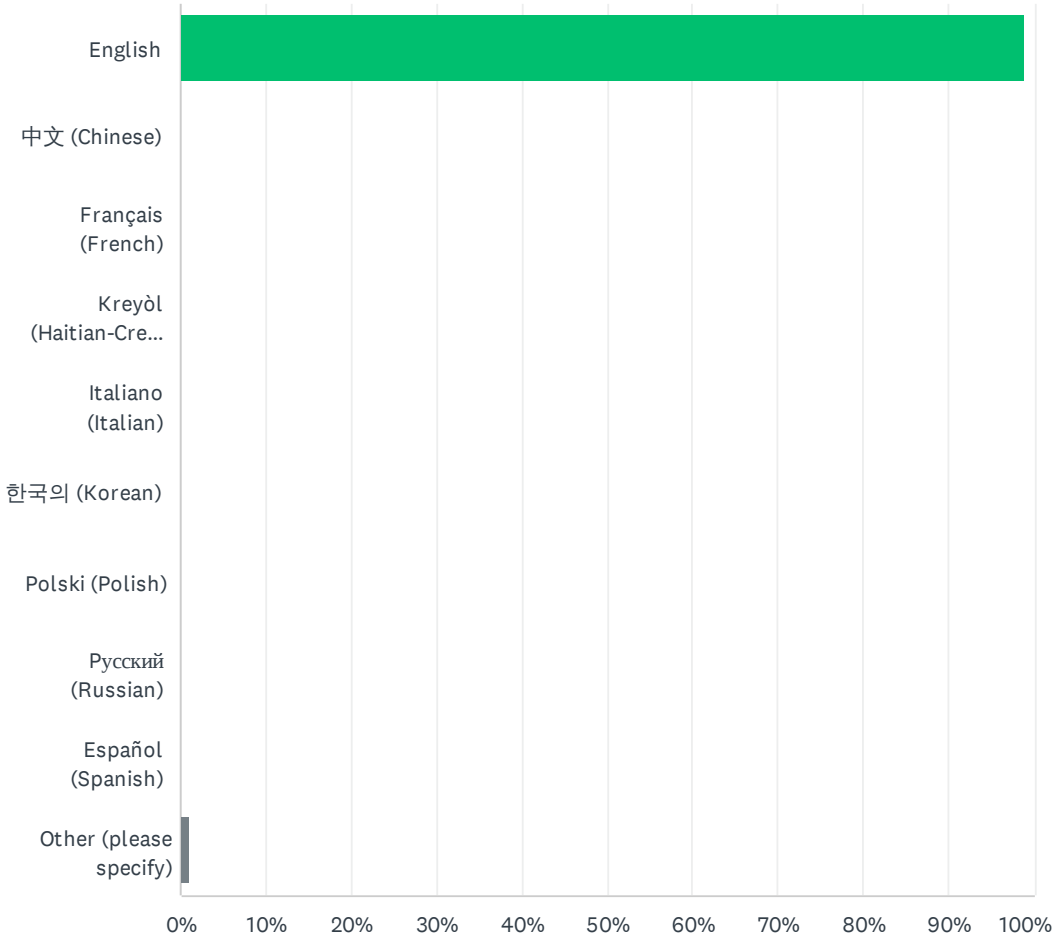

Chesterfield (Keeseville)
Crown Point
Elizabethtown
Essex
Jay
Keene
Lewis
Minerva
Moriah
Newcomb
North Elba (Lake Placid)
North Hudson
St. Armand (Bloomingdale)
Schroon
Ticonderoga
Westport
Willsboro
Wilmington
Other (please specify)
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

ANSWER CHOICES	RESPONSES	
Chesterfield (Keeseville)	5.09%	20
Crown Point	3.82%	15
Elizabethtown	5.60%	22
Essex	4.33%	17
Jay	12.21%	48
Keene	7.12%	28
Lewis	3.05%	12
Minerva	1.27%	5
Moriah	8.14%	32
Newcomb	1.27%	5
North Elba (Lake Placid)	9.67%	38
North Hudson	1.02%	4
St. Armand (Bloomingdale)	1.27%	5
Schroon	6.11%	24
Ticonderoga	9.67%	38
Westport	4.83%	19
Willsboro	7.63%	30
Wilmington	5.85%	23
Other (please specify)	2.04%	8
TOTAL		393

#	OTHER (PLEASE SPECIFY)	DATE
1	New Russia	4/4/2022 7:45 PM
2	Olmstedville	3/31/2022 8:01 AM
3	saranac lake	3/30/2022 4:34 PM
4	Putnam Station NY	3/25/2022 1:27 PM
5	Cadyville	3/25/2022 8:55 AM
6	Port Henry	3/24/2022 7:59 PM
7	CITY OF ELIZABETHTOWN/TOWN OF LEWIS	3/24/2022 12:18 PM
8	Essex County	3/24/2022 8:55 AM

Q13 What is the primary language spoken in your household?

Answered: 396 Skipped: 89

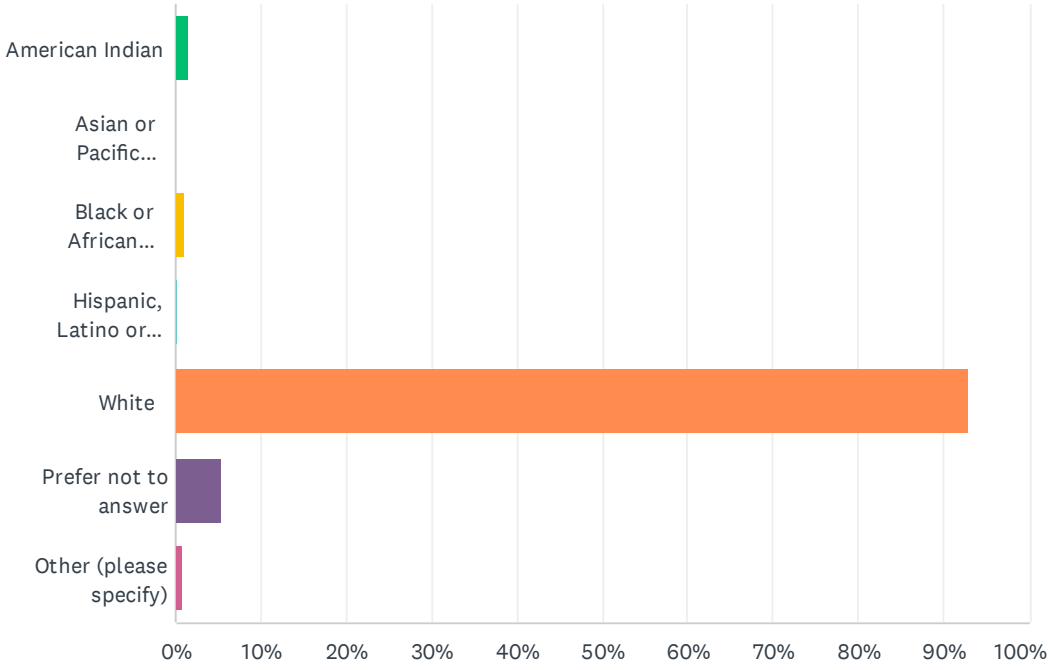


ANSWER CHOICES	RESPONSES	
English	98.99%	392
中文 (Chinese)	0.00%	0
Français (French)	0.00%	0
Kreyòl (Haitian-Creole)	0.00%	0
Italiano (Italian)	0.00%	0
한국의 (Korean)	0.00%	0
Polski (Polish)	0.00%	0
Русский (Russian)	0.00%	0
Español (Spanish)	0.00%	0
Other (please specify)	1.01%	4
TOTAL		396

#	OTHER (PLEASE SPECIFY)	DATE
1	no answer provided	6/21/2022 3:13 PM
2	Macedonian	5/18/2022 7:42 PM
3	cat	4/9/2022 7:33 AM
4	American Sign Language	4/8/2022 4:08 PM

Q14 What is your race/ethnicity? Select all that apply.

Answered: 396 Skipped: 89

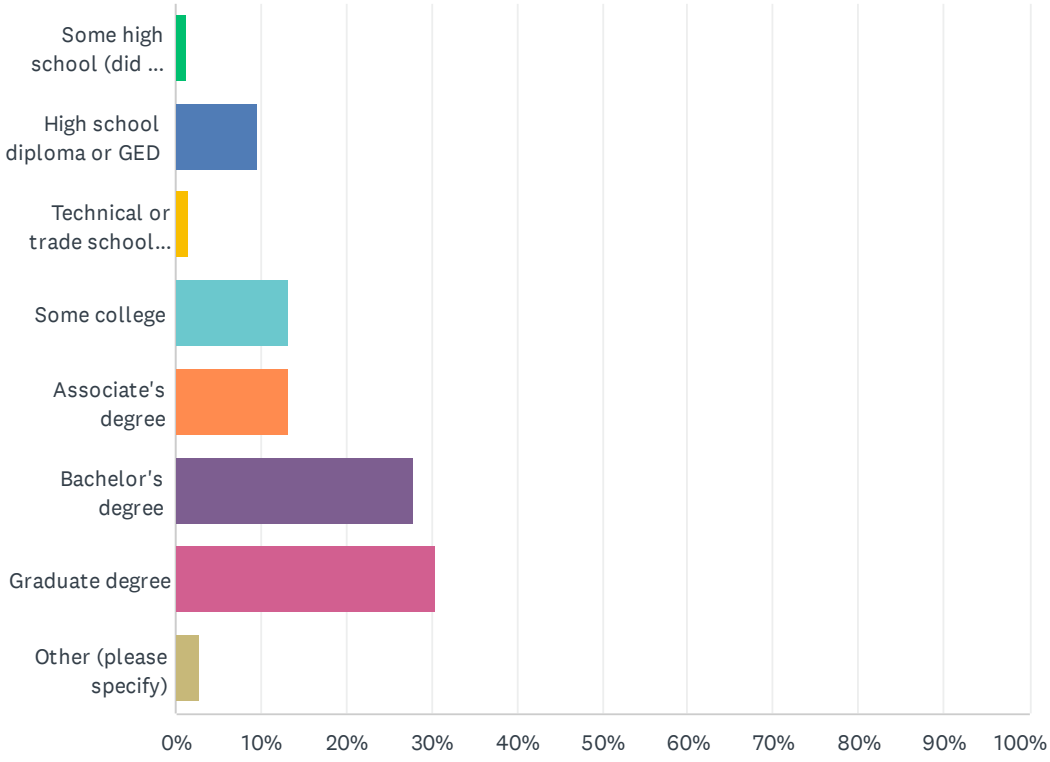


ANSWER CHOICES	RESPONSES	
American Indian	1.52%	6
Asian or Pacific Islander	0.00%	0
Black or African American	1.01%	4
Hispanic, Latino or Spanish origin	0.25%	1
White	92.93%	368
Prefer not to answer	5.30%	21
Other (please specify)	0.76%	3
Total Respondents: 396		

#	OTHER (PLEASE SPECIFY)	DATE
1	local / Adirondack	4/9/2022 7:33 AM
2	MENA	3/31/2022 9:19 AM
3	XYZ	3/24/2022 8:55 AM

Q15 What is your highest level of education?

Answered: 396 Skipped: 89



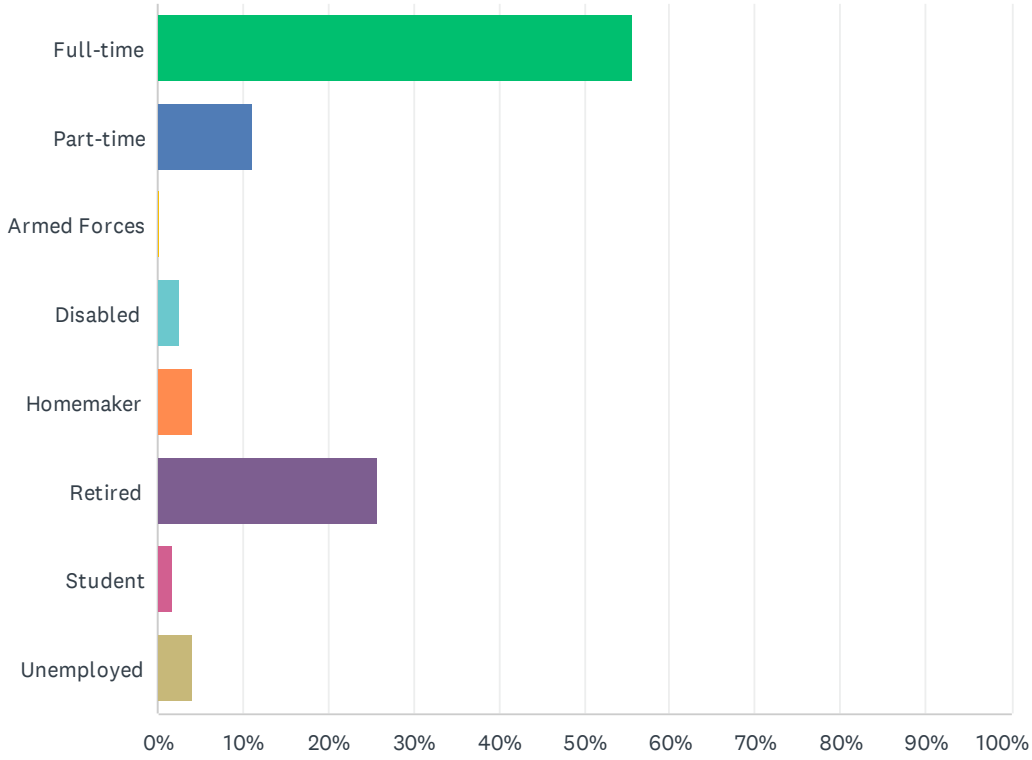
ANSWER CHOICES	RESPONSES	
Some high school (did not finish)	1.26%	5
High school diploma or GED	9.60%	38
Technical or trade school certificate	1.52%	6
Some college	13.13%	52
Associate's degree	13.13%	52
Bachelor's degree	28.03%	111
Graduate degree	30.56%	121
Other (please specify)	2.78%	11
TOTAL		396

#	OTHER (PLEASE SPECIFY)	DATE
1	Post graduate studies	5/23/2022 5:04 PM
2	Masters	4/7/2022 9:12 PM
3	Currently in high school	3/31/2022 6:27 PM
4	Graduate degree + EDD	3/27/2022 8:41 AM

5	Masters	3/25/2022 12:28 PM
6	Doctorate	3/25/2022 8:11 AM
7	Doctorate	3/24/2022 10:36 PM
8	Doctorate	3/24/2022 9:42 PM
9	BA in history AAS in nursing	3/24/2022 8:56 AM
10	XYZ	3/24/2022 8:55 AM
11	Masters	3/24/2022 6:21 AM

Q16 What is your current employment status?

Answered: 396 Skipped: 89



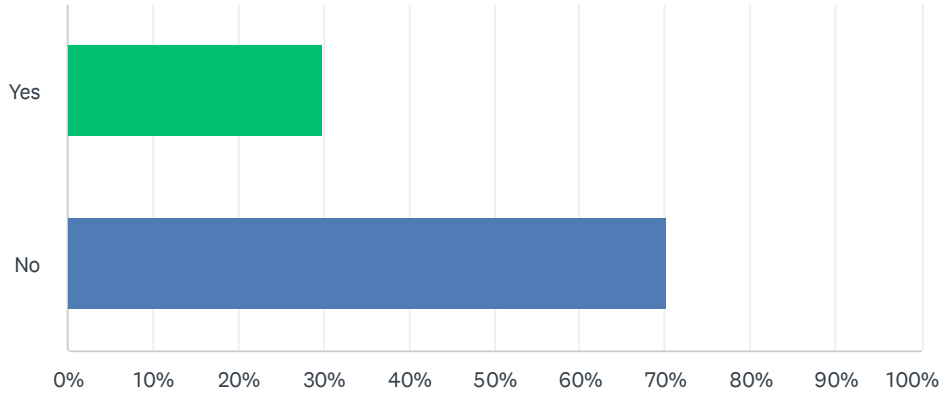
ANSWER CHOICES	RESPONSES	
Full-time	55.56%	220
Part-time	11.11%	44
Armed Forces	0.25%	1
Disabled	2.53%	10
Homemaker	4.04%	16
Retired	25.76%	102
Student	1.77%	7
Unemployed	4.04%	16
Total Respondents: 396		

#	OTHER (PLEASE SPECIFY)	DATE
1	Medical Leave	5/18/2022 7:37 PM
2	just laid off	4/9/2022 7:33 AM
3	Self Employed	4/7/2022 9:42 PM
4	Semi-retired	4/4/2022 6:20 PM

5	I have both a full time and part time job- cost of living doesn't equal wages	3/30/2022 6:03 PM
6	N/A	3/28/2022 7:13 PM
7	Full time as well as another part time job	3/27/2022 8:41 AM
8	seasonal employee / semi-retired	3/26/2022 8:54 AM
9	Haven't been able to work because of a high needs mentally ill child	3/25/2022 8:06 PM
10	self employed	3/25/2022 10:00 AM
11	RETIRED, STILL WORK FULL TIME	3/24/2022 1:09 PM
12	and 2 part time jobs	3/24/2022 12:18 PM
13	Per diem	3/24/2022 8:56 AM
14	XYZ	3/24/2022 8:55 AM
15	Volunteer	3/21/2022 3:59 PM

Q17 Did the COVID-19 pandemic negatively impact your employment status (i.e. lay-off, reduction is hours/wages, left job due to childcare issues, etc.)?

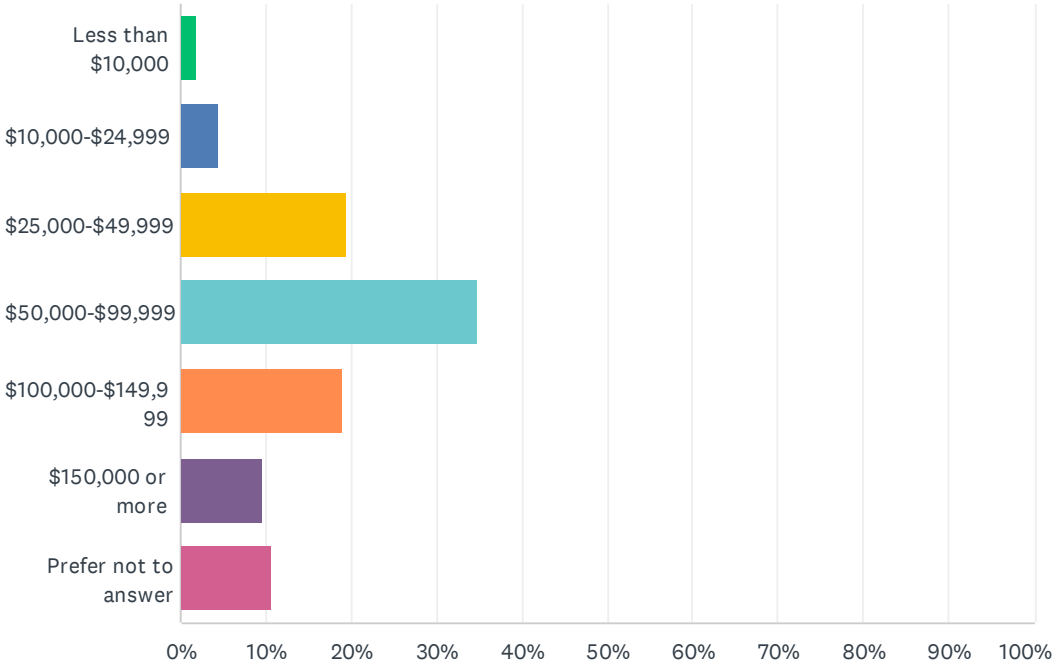
Answered: 396 Skipped: 89



ANSWER CHOICES	RESPONSES	
Yes	29.80%	118
No	70.20%	278
TOTAL		396

Q18 What is your household's annual income?

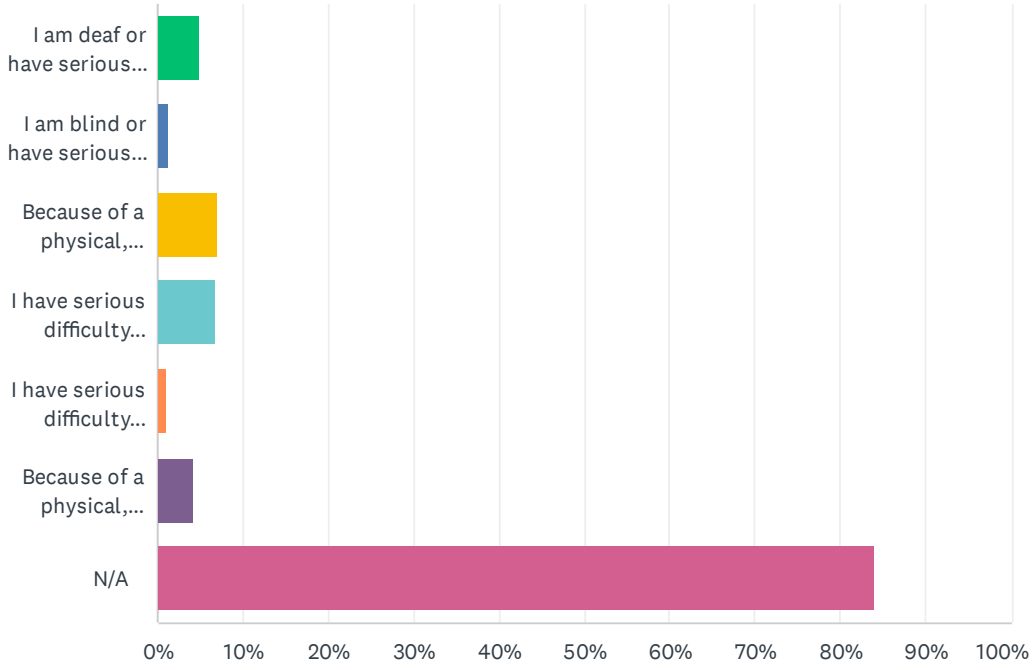
Answered: 396 Skipped: 89



ANSWER CHOICES	RESPONSES	
Less than $10,000	2.02%	8
$10,000-$24,999	4.55%	18
$25,000-$49,999	19.44%	77
$50,000-$99,999	34.85%	138
$100,000-$149,999	18.94%	75
$150,000 or more	9.60%	38
Prefer not to answer	10.61%	42
TOTAL		396

Q19 Do any of the following apply to you? Select all that apply.

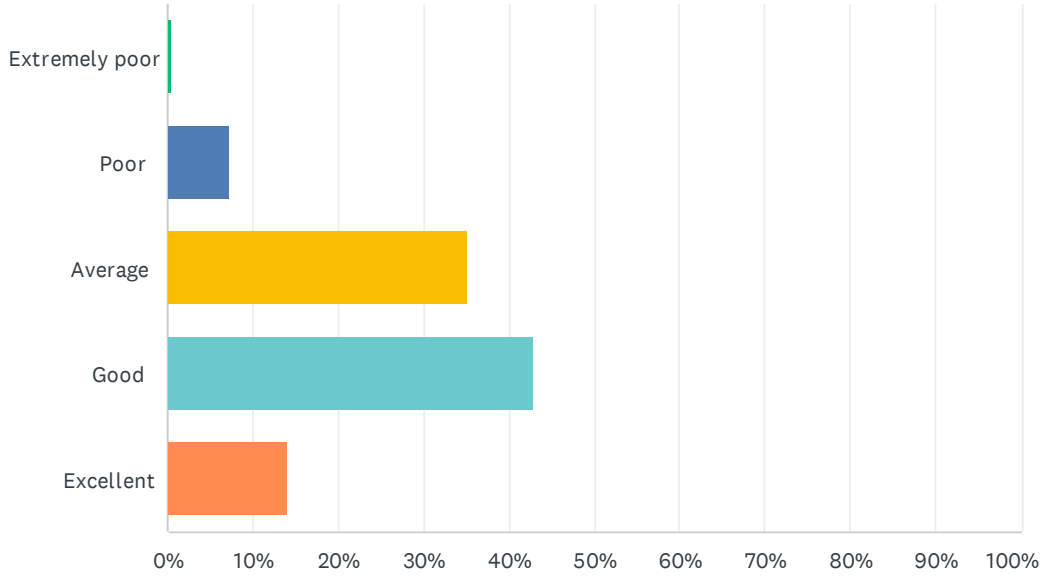
Answered: 396 Skipped: 89



ANSWER CHOICES	RESPONSES	
I am deaf or have serious difficulty hearing	4.80%	19
I am blind or have serious difficulty seeing, even when wearing glasses	1.26%	5
Because of a physical, mental, or emotional condition, I have serious difficulty concentrating, remembering, or making decisions.	7.07%	28
I have serious difficulty walking or climbing stairs	6.82%	27
I have serious difficulty dressing or bathing	1.01%	4
Because of a physical, mental, or emotional condition, I have difficulty doing errands alone, such as visiting a doctor's office or shopping.	4.29%	17
N/A	84.09%	333
Total Respondents: 396		

Q20 My physical health is:

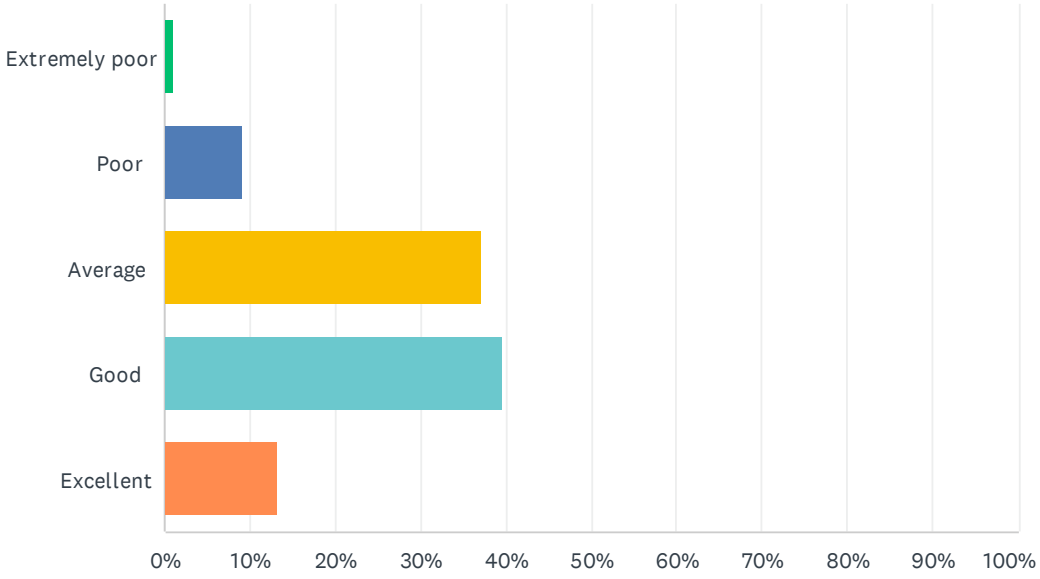
Answered: 395 Skipped: 90



ANSWER CHOICES	RESPONSES	
Extremely poor	0.51%	2
Poor	7.34%	29
Average	35.19%	139
Good	42.78%	169
Excellent	14.18%	56
TOTAL		395

Q21 My mental health is:

Answered: 396 Skipped: 89



ANSWER CHOICES	RESPONSES	
Extremely poor	1.01%	4
Poor	9.09%	36
Average	37.12%	147
Good	39.65%	157
Excellent	13.13%	52
TOTAL		396

APPENDIX 5

Collaborative Committee Lists

REGIONAL COLLABORATIVE COMMITTEE

Adirondack Health Institute; Adirondack Rural Health Network

Communinty Health Assessment Committee

County Health Departments	Primary Representative	Additonal Representatives
Clinton County Health Department	Mandy Snay	
		Jessica Darney Buehler
Essex County Health Department	Linda Beers	Andrea Whitmarsh
Franklin County Public Health	Katie Strack	Sarah Granquist
Fulton County Public Health	Laurel Headwell	Angela Stuart Palmer
Hamilton County Public Health	Dr. Erica Mahoney	Victoria Fish
		Dan Durkee
		Olivia Cohens
Warren County Health Services	Ginelle Jones	Drew Crawford
Washington County Public Health	Tina McDougall	Elizabeth St. John
Hospitals		
Adirondack Medical Center	Dan Hill	Rachelle Waters
Glens Falls Hospital	Cathleen Traver *CHA Co-Chair	
Nathan Littauer Hospital	Geoff Peck	
UVMHN - Alice Hyde Medical Center	Annette Marshall	
UVMHN - CVPH	Kaitlyn Tentis	Gregory E. Freeman
UVMHN - Elizabethtown Community Hospital	Amanda Whisher	Julie Tromblee
AHI		
	Sara Deukmejian	Andrea Bonacci

Data Subcommittee Members

Member	Affiliation
Dan Hill	Adirondack Health
Mandy Snay	Clinton County Health Department
Angela Stuart Palmer	Fulton County Public Health
Amanda Whisher	UVMHN- Elizabethtown Hospital
Sarah Granquist	Franklin County Public Health
Andrea Whitmarsh	Essex County Health Department
Cathleen Traver	Glens Falls Hospital
Dan Durkee	Warren County Health Services
AHI Staff	
Sara Deukmejian	ARHN Manager
Andrea Bonacci	Director of Population Health Programs

LOCAL COLLABORATIVE COMMITTEES

2022 Essex County Board of Supervisors/Board of Health

Member	Town/Role
Clayton J. Barber	Chesterfield
Charles Harrington	Crown Point
Noel Merrihew	Elizabethtown
Ken Hughes	Essex
Matthew Stanley	Jay
Joe Pete Wilson	Keene
James W. Monty	Lewis, Vice-Chairman
Stephen McNally	Minerva
Thomas Scozzafava	Moriah
Robin DeLoria	Newcomb
Derek Doty	North Elba
Stephanie DeZalia	North Hudson
Davina Winemiller	St. Armand
Margaret Wood	Schroon
Mark Wright	Ticonderoga
Michael K. Tyler	Westport
Shaun Gillilland	Willsboro, Chairman
Roy Holzer	Wilmington
Daniel T. Manning, III	County Attorney
Daniel L. Palmer	County Manager

2022 Human Services Subcommittee

Member	Role
Joe Pete Wilson	Chairman
Charles Harrington	
Stephen McNally	
Thomas R. Scozzafava	
Ken Hughes	
Matthew Stanley	
Derek Doty	
Margaret Wood	
Mark Wright	

County Agency Representation

Social Services
Mental Health
Public Health Aging

Essex County Health Department

Professional Advisory Committee/Public Health Advisory Committee

Member	Organization
Kristen Sayers	NYSDOH - Saranac Lake District Office of Environmental Health
Jennifer Newberry, RN, BSN	Essex County Health Department - Home Health Unit
Jessica Darney Buehler	Essex County Health Department - Public Health Unit
Diana Dodd, DVM	Community Member
Michael Celotti, MD	Hudson Headwaters Health Network
Julie Tromblee	UVMHN-ECH
Hannah Smith, PT	Essex County Health Department - Home Health Unit
Linda Beers	Essex County Health Department
Mary Halloran, MD	UVMHN-ECH
Kathy Dagget	Community Member
Krissy Leerkes	Essex County Office of the Aging
Terri Morse	Essex County Mental Health
Derek Doty	Town Supervisor
Katie Alexander, DVM	Ticonderoga Animal Hospital
Matthew Watts	Essex County Emergency Services
Danielle Van Ness	Keene Central School
Morgan Conley	ACAP Headstart
Megan Murphy	Housing Assistance Program of Essex County
Jessica Duhaime	Adirondack Health

Essex County Breastfeeding Coalition

Member	Organization
Elizabeth Terry	ECHD - Public Health Unit
Krista Berger	ECHD - WIC Unit
Morgan Conley	ACAP - Head Start
Ginger Phinney	ACAP - Daycare
Lindsay Marcotte-Hamel	ACAP - Health Programs
KayLeigh Raville	Clinton County Health Department
Alexandra Mesick	Clinton County Health Department
Lucianna Celotti	ECHD - Children's Services
Amanda Whisher	UVMHN-ECH
Esther Piper	Behavioral Health Services North - Healthy Families
Meghan Lovering	Hudson Headwaters Health Network
Cassandra Jones	Hudson Headwaters Health Network

Building Resilience in Essex Families - Member Organizations

Adirondack Birth to Three Alliance
Adirondack Community Action Program, Inc
Adirondack Foundation
Adirondack North Country Gender Alliance
Bridges to Empowerment Mentorship Program
Champlain Valley Educational Services
Champlain Valley Physicians Hospital
Child Advocacy Center
Child Care Coordinating Council of the North Country
Cloudsplitter Foundation
Community, Family, and Youth Member Representatives
Cornell Cooperative Extension of Clinton County
Cornell Cooperative Extension of Essex County
Elizabethtown Community Hospital and Health Center
Essex County Community Services Board
Essex County Department of Social Services
Essex County Health Department, Childrens Services Unit
Essex County Health Department, Public Health Unit
Essex County Health Department, WIC Unit
Essex County Jail
Essex County Mental Health Services
Essex County Office for the Aging
Essex County Probation Department
Essex County School Districts
Essex County Youth Advocate Program
Essex County Youth Bureau
Families First of Essex County
Family Forever
Housing Assistance Program of Essex County
Hudson Headwaters Health Network
Mental Health Association in Essex County
Mountain Lake Services
New York State Office of Mental Health
North Country Early Childhood Family & Community Engagement Center
North Country School-Age Family & Community Engagement Center
Plattsburgh Primary Care Pediatrics
Sameritan House
St. Johns Episcopal Church, Essex NY
St. Joseph's Addiction Treatment & Recovery Centers
Steppingstone Psychological Services
Stop DV
Substance Abuse Prevention Team of Essex County, Inc
United Way - ADK 211

Essex County Heroin & Other (Drug) Prevention Coalition - Member Organizations

ACAP
Adirondack Health
Adirondack Health Institute
Alliance for Positive Health
Americorps Vista - United Way
NYS Assembly
Board of Superviors - Town Supervisor
Champlain Valley Family Center
Conifer Park
UVMHN-Champlain Valley Physician's Hospital
DEA - HIDTA
Deputy County Manager - Essex County
Essex County Health Department
Essex County Community Services/Mental Health
Essex County Department of Social Services
Essex County District Attorney
Essex County Emergency Services
Essex County Probation Department/Governmental Agency
Essex County Sheriff's Department
Families First
Hudson Mohawk AHEC
Husdon Headwaters Health Network
Lake Placid Central School
Lake Placid Police Department
Liberty Behavioral Management
Mental Health Association in Essex County
New York State Assembly
Northwinds Integrated Health Network
NY Courts
NYS Troopers
OASAS
Prevention team
St. Joseph's Addiction Treatment & Recovery
The Northeast Group
The Prevention Team
UVMHN-Elizabethtown Community Hospital

APPENDIX 6

Note: Enlarged copies available upon request

Name of County - Organization(s) 2023 Workplan	Essex County Health Department (ECHD)	North Country Healthy Heart Network	Champlain Valley Family Center	Cancer Services Program of Northeastern NY	UVMHN Elizabethtown Community Hospital
Planning Report Liaison	Molly Lawrence	Ann Morgan	Dana Bushy Isabella	Didi Remchuk	Amanda Whisher
E-mail:	Mary.lawrence@essexcounty.gov	amorgan@heartnetwork.org	tobaccofree@cvfamilycenter.org	dremchuk@cvph.org	awhisher@ech.org

Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Objectives through 2024	Disparities	Interventions	Family of Measures	By December 2023, we will have completed . . .	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources	Lead Agency
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.0 Reduce obesity and the risk of chronic disease	Increase the number of schools offering preschool programs that reinvigorate and improve nutrition policies and practices in at least 3 of 11 school districts in Essex County in an effort to reduce the percentage of early childhood obesity (among children ages 2 - 4 years participating in SNAP for WIC) rates from 16.5% to the NYS Prevention Agenda benchmark of 13.0% by December 2024.	Socioeconomic, Neighborhood and Built Environment (Limited access to healthy foods and physical activity. Examples: sidewalks and grocery stores).	1.0.2 - Quality nutrition (and physical activity) in early learning and child care settings.	*Input measures: provide assessment, targeted technical assistance to school wellness committees to support their efforts to improve, communicate and implement their school wellness policies. *Output measures: Three school districts will demonstrate improved implementation of policies and practices in three areas: 1) Nutrition Standards for Competitive Foods and Other Foods and Beverages; 2) Physical Education and Physical Activity; 3) School Wellness Promotion and Marketing *Short-term Outcome: Number of school districts with Wellness Committees meeting 2 x per year with goals related to implementation and having complete pre-assessments. *Intermediate Outcome: Number of school districts with improved implementation of policies and practices related to PA&N *Long-term Outcome: reduction in overweight and obese school-aged children in the three targeted school districts.	ECHD will collaborate with local school districts to reinvigorate existing/implement multi-component school-based obesity prevention interventions to include policy and environmental changes that target physical activity and nutrition (PA&N) for pre-school before, during and/or after school. ECHD will provide pre/post assessment and targeted technical assistance to three of the highest risk Essex County School Districts, to support their implementation of implement policies and practices to increase PA&N.	K-12 School	School districts with onsite preschool programs, Wellness Committees, and administrative leaders meet regularly with ECPH specialists to review and enact recommendations (provided through assessment) to improve implementation of school wellness policies.	Essex County Health Department
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.0 Reduce obesity and the risk of chronic disease	Increase the number of schools that reinvigorate and improve nutrition policies and practices in at least 3 of 11 school districts in Essex County in an effort to reduce the percentage of school children obesity rates from 21.7% to the NYS Prevention Agenda benchmark of 16.4% by December 2024.	Socioeconomic, Neighborhood and Built Environment (Limited access to healthy foods and physical activity. Examples: sidewalks and grocery stores).	1.0.4 - Local health departments, hospitals, health centers, insurers, businesses, CBOs and other stakeholders can collaborate to work with local school districts and parent-teacher organizations (PTOs) to support policy, and environmental changes that target physical activity and nutrition before, during or after school.	*Input measures: provide assessment, targeted technical assistance to school wellness committees to support their efforts to improve, communicate and implement their school wellness policies. *Output measures: Three school districts will demonstrate improved implementation of policies and practices in three areas: 1) Nutrition Standards for Competitive Foods and Other Foods and Beverages; 2) Physical Education and Physical Activity; 3) School Wellness Promotion and Marketing *Short-term Outcome: Number of school districts with Wellness Committees meeting 2 x per year with goals related to implementation and having complete pre-assessments. *Intermediate Outcome: Number of school districts with improved implementation of policies and practices related to PA&N *Long-term Outcome: reduction in overweight and obese school-aged children in the three targeted school districts.	ECHD will provide pre/post assessment and targeted technical assistance to three of the highest risk Essex County School Districts, to support their implementation of implement policies and practices to increase PA&N.	K-12 School	School district Wellness Committees and administrative leaders meet regularly with ECPH specialists to review and enact recommendations (provided through assessment) to improve implementation of school wellness policies.	Essex County Health Department
Prevent Chronic Diseases	Focus Area 1: Healthy eating and food security	Goal 1.1 Increase access to healthy and affordable foods and beverages	1.12 Increase the percentage of adults who buy fresh fruit and vegetables in their neighborhood	Socioeconomic, Neighborhood and Built Environment (Limited access to healthy foods and physical activity. Examples: sidewalks and grocery stores).	1.0.5 Increase the availability fruit and vegetable incentive programs Systematic evidence reviews find that financial incentive programs can increase affordability, access, purchases, and consumption of fruits and vegetables. Incentive programs for the purchase of fruits and vegetables have also been shown to increase sales and use of food assistance benefits (e.g., SNAP or WIC) at farmers' markets. Financial incentives can be a dollar-for-dollar match or a set amount per dollar spent (i.e., $2 for every $5 spent). Local health departments, hospitals, health centers, insurers, businesses, CBOs, hunger prevention advocates and other stakeholders can collaborate	Input Measures: Total number of participants in the program WIlness RX. Output Measures: Output measures will included looking at increased consumption of fruits and vegetables, reduction in A1c and/or weight. Long-term Outcome: Increased access to fruits and vegetable aiding in improved health outcomes.	UVMHN ECH will continue to support the Wellness RX program looking at opportunities for improvement such as additional locations, redemption sites, and expansion of program objectives. The hospital will continue to build upon relationships with community partners and remain active in the Well Fed Collabortive sponsored by Essex County Health Department. By the end of 2023 Wellness Rx will increase redemption sites from 11 to 13 and increase consumption of fruits and vegetables by 5% of participants.	Hospital	Well Fed Collaborative (Essex County Health Depart	UVMHN Elizabethtown Community Hospital
Prevent Chronic Diseases	Focus Area 2: Physical activity	Goal 2.3 Increase access, for people of all ages and abilities, to indoor and/or outdoor places for physical activity.	Increase access and awareness for outdoor and indoor activity through collaboration with libraries and media promotion to encourage adult exercise, and exercise as a family, to reduce adult obesity rates from 29.2% to the NYS Prevention Agenda Benchmark of 24.2% by December 2024.	Natural and Buld Environment	2.3.1 Implement and/or promote a combination of community walking, wheeling, or biking programs, Open Streets programs, joint use agreements with schools and community facilities, Safe Routes to School programs, increased park and recreation facility safety and decreased incivilities, new or upgraded park or facility amenities or universal design features; supervised activities or programs combined with onsite marketing, community outreach, and safety education.	Input Measures: # of participating libraries, # of times snowshoes are checked out of each library Output Measures: # of indoor fitness and outdoor recreational activity ideas (snowshoe trails, hiking trails, playgounds, etc..) media posts, ads, and campaigns posted/printed/promoted Short-term Outcome: increased exercise and health communications via social media. Increased publications, distribution and promotion of no cost outdoor recreation opportunities. Intermediate Outcome: Increase in access to physical activities for adults. Long-term Outcome: Increase the number of adults participating in regular exercise.	ECHD will collaborate with at least four local libraries to promote outside winter recreation opportunities, and promote local trails, outdoor recreation opportunities year round, and home exercises for all fitness levels through media posts and community outreach. ECHD will distribute snowshoes to four libraries and have checkout data for one winter season to review. ECHD will review and update existing ECHD created information regarding local trails and outdoor recreational activities. ECHD will create a guide for family friendly outside hikes and recreational activities, if the review of existing materials warrants. ECHD will post at least one in-home fitness activity per month for all fitness levels.	Media	Media - publish content and disseminate information to Essex County residents. Libaries - lend out snowshoes and track use data. ECHD - develop and review recreational informaiton, review data.	Essex County Health Department
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.2 Promote tobacco use cessation	Increase (or maintain) % of medical and behavioral health provider systems serving Essex County residents that have adopted Public Health Service (PHS) guideline concordant policies for treatment of tobacco addiction to at least 75% (Medical Baseline: 100%; Behavioral Baseline: 33%) by December 2024.	Health Care Access	3.2.1 - Assist medical and behavioral health care organizations (defined as those organizations focusing on mental health and substance use disorders) and provider groups in establishing policies, procedures and workflows to facilitate the delivery of tobacco dependence treatment, consistent with the Public Health Service Clinical Practice Guidelines, with a focus on Federally Qualified Health Centers, Community Health Centers and behavioral health providers. Evidenced Based Intervention - Treating Tobacco Use and Dependence - Public Health Services Guideline (2008 edition)https://www.ahrq.gov/prevention/guidelines/tobacco/index.html	Input Measures: Administrative presentations offered; Improvement process trainings offered; Planning meetings held; Model policies shared Output Measures: # presentations/trainings offered; # Memorandum of understanding (MOU); # planning meetings held Short-term Outcome: # policy development, implementation or improvement plans created; # new policies/standards of care adopted Intermediate Outcome: Tobacco using patients report received assistance from their health care provider to quit smoking; increased utilization of cessation benefits (counseling and/or medication) Long-term Outcome: Decrease in prevalence of adult tobacco use	The North Country Healthy Heart Network will provide technical assistance for adoption of PHS guideline concordant policy to remaining medical and behavioral health systems where policies have not yet been adopted. Provide ongoing support to medical and behavioral health systems with PHS guideline concordant policies to ensure ongoing improvement of tobacco treatment policy implementation.	Providers	Providers adopt and implement PHS guideline concordant policies. Health Systems for a Tobacco Free NY contractor (North Country Healthy Heart Network) provides technical assistance and patient and/or provider education materials to all health system providers in the county.	North Country Healthy Heart Network
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.2 Promote tobacco use cessation	3.2.1 Increase the percentage of smokers who received assistance from their health care provider to quit smoking by 13.1% from 53.1% (2017) to 60.1%.	Health Care Access	3.2.1 Assist medical and behavioral health care organizations (defined as those organizations focusing on mental health and substance use disorders) and provider groups in establishing policies, procedures and workflows to facilitate the delivery of tobacco dependence treatment, consistent with the Public Health Service Clinical Practice Guidelines, with a focus on Federally Qualified Health Centers, Community Health Centers and behavioral health	Number of patients who quit and sustained smoking cessation. Input Measures: Administrative presentations offered; Improvement process trainings offered; Planning meetings held; Model policies shared Output Measures: # presentations/trainings offered; # Memorandum of understanding (MOU); # planning meetings held Short-term Outcome: # policy development, implementation or improvement plans created; # new policies/standards of care adopted Intermediate Outcome: Tobacco using patients report received assistance from their health care provider to quit smoking; increased utilization of cessation	Provide technical assistance for adoption of PHS guideline concordant policy to at least one behavioral health system. Provide ongoing support to medical and behavioral health systems with PHS guideline concordant policies to ensure ongoing improvement of tobacco treatment policy implementation. Standing orders followed and administered by health center clinical staff.	Hospital	Providers adopt and implement PHS guideline concordant policies. Health Systems for a Tobacco Free NY contractor (North Country Healthy Heart Network) provides technical assistance and patient and/or provider education materials to all health system providers in the county.	UVMHN Elizabethtown Community Hospital
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.2 Promote tobacco use cessation	Increase/maintain the use of health communications and social media opportunities to promote tobacco dependence treatment by at least 12 messages (once monthly) by December 2024.	Health Care Access	3.2.2 - Use health communications and media opportunities to promote the treatment of tobacco dependence by targeting smokers with emotionally evocative and graphic messages to encourage evidence-based quit attempts, to increase awareness of available cessation benefits (especially Medicaid), and to encourage health care provider involvement with additional assistance from the NYS Smokers' Quitline. Evidenced Based Intervention - https://talktoyourpatients.health.ny.gov/ https://www.nysmokefree.com/	Input Measures: # of tobacco cessation social media posts, ads, and campaigns created Output Measures: # of tobacco cessation social media posts, ads, and campaigns posted/printed/promoted Short-term Outcome: increased tobacco cessation health communications Intermediate Outcome: increased # of residents who engage in tobacco cessation campaign/communications Long-term Outcome: increase in tobacco cessation referrals and quit attempts	Post monthly tobacco dependence treatment health messaging on the Essex County Health Department Facebook page promoting local evidence-based tobacco cessation services and the NY Quits line. Create and print newspaper ads promoting cessation services available during targeted tobacco public health observances (E.g. November - Great American Smoke Out, December - New Years Eve, March - Kick Butts Day).	Media	ECHD - Will create educational materials using evidence-based interventions and will distribute though various media outlets. Media - Will publish ads and disseminate information to Essex County residents.	Essex County Health Department

Name of County - Organization(s) 2023 Workplan	Essex County Health Department (ECHD)	North Country Healthy Heart Network	Champlain Valley Family Center	Cancer Services Program of Northeastern NY	UVMHN Elizabethtown Community Hospital
Planning Report Liaison	Molly Lawrence	Ann Morgan	Dana Bushy Isabella	Didi Remchuk	Amanda Whisher
E-mail:	Mary.lawrence@essexcounty.gov	amorgan@heartnetwork.org	tobaccofree@cvfamilycenter.org	dremchuk@cvph.org	awhisher@ech.org

Priority	Focus Area (select one from drop down list)	Goal Focus Area (select one from drop down list)	Objectives through 2024	Disparities	Interventions	Family of Measures	By December 2023, we will have completed . . .	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources	Lead Agency
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.2 Promote tobacco use cessation	Increase the percentage of smokers who received assistance from their healthcare providers to quit smoking by 5%.	Income, Access, Disability	3.2.2 Use health communications and media opportunities to promote the treatment of tobacco dependence by targeting smokers with emotionally evocative and graphic messages to encourage evidence-based quit attempts, to increase awareness of available cessation benefits (especially Medicaid), and to encourage health care provider involvement with additional assistance from the NYS Smokers' Quitline.	Number of media and marketing outreach encounters. Number of providers participating in smoking cessation campaigns.	**1.** Provide guidance and education to health center-based primary care providers. **2.** Participate in marketing outreach. **3.** Monitor patients via quality dashboard.	Community-based organizations	Health system grantee will provide support on policy implementation and the development of standards of care as the lead for this intervention. Franklin and Essex county health departments will assist by communicating and promoting hospital resources to reach a larger group, provide subject matter expertise to keep hospital attuned to health disparities in the counties, and connect to healthcare resources.	Adirondack Health
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.2 Promote tobacco use cessation	Engage at least 3 health providers (medical and behavioral health) in Essex County in a communications campaign.	Economic Stability, Health & Health Care	3.2.3 - Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts encouraging use of evidence-based quitting, increasing awareness of available cessation benefits (especially Medicaid), and removing barriers to treatment.	Input Measures: Planning meeting structure Output Measures: # Meetings held; Implementation Plans created; campaign materials distributed Short-term Outcome: % tobacco using patients "advised" to quit tobacco increases Intermediate Outcome: Tobacco using patients report received assistance from their health care provider to quit smoking; increased utilization of cessation benefits (counseling and/or medication) Long-term Outcome: Decrease in prevalence of adult tobacco use	Provide technical assistance for implementation of the campaign. Provide ongoing support for continued implementation of the campaign.	Providers	Providers participate in campaign implementation planning process; then monitor implementation. Health Systems for a Tobacco Free NY contractor (Year 1 - North Country Healthy Heart Network) provides technical assistance and campaign materials to participating provider systems.	North Country Healthy Heart Network
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.3 Eliminate exposure to secondhand smoke	Utilize the It's Not Just campaign to raise awareness of the impact of mentol products on youth, LGBTQ+ and BIPOC communities.	Economic Stability, Neighborhood & Built Environment, Education	3.1.3 - Pursue policy action to reduce the impact of tobacco marketing in lower-income and racial/ethnic minority communities, disadvantaged urban neighborhoods and rural areas.	Input Measures: target communities, schools, areas identified for campaign launch Output Measures: Develop communications/campaign materials. Short-term Outcome: # of materials distributed/ads placed/articles and letters to the editor written. Intermediate Outcome: # of communities, schools, areas that have received campaign materials/information. Long-term Outcome: decrease in youth/target community smoking rates.	Conduct a community education campaign (presentations, print materials, newsletter articles, letters to the editor) to raise awareness of tobacco marketing and the impact of flavored products on tobacco use.	Students	CVFC ATFC - will work with youth and student groups to advance educational campaigns.	Champlain Valley Family Center
Prevent Chronic Diseases	Focus Area 3: Tobacco prevention	Goal 3.3 Eliminate exposure to secondhand smoke	Present findings from all retail observations to the Essex County Health Committee and Essex County Board of Supervisors. Provide community support for any policy action developed by any interested local municipality to reduce the impact of tobacco marketing and flavored tobacco products.	Neighborhood & Built Environment	3.1.5 - Decrease the availability of flavored tobacco products including menthol flavors used in combustible and non-combustible tobacco products and flavored liquids including menthol used in electronic vapor products. Evidence-based intervention: Public Health Law Center - http://www.publichealthlawcenter.org/sites/default/files/resources/Regulating-Flavored-Tobacco-Products-2017.PDF	Input Measures: # of retail observations conducted. Output Measures: summary of retail observations Short-term Outcome: increase the # of municipal leaders/organizational decision makers engaged in conversations about the availability of flavored tobacco products. Intermediate Outcome: Increase the # of municipal/organizational decision makers that are in support of policies that limit the amount of flavored tobacco products available for purchase at retail locations. Long-term Outcome: decrease the % of youth and minority groups that have access to flavored tobacco products.	Conduct retail observation of all licensed tobacco retailers (including vape shops) in Essex County.	Business	CVFC ATFC - Facilitate and conduct retail observation and presentations to Essex County leaders and policy makers.	Champlain Valley Family Center
Prevent Chronic Diseases	Focus Area 4: Preventative care and management	Goal 4.1 Increase cancer screening rates	Increase the percentage of adults who receive a colorectal cancer screening based on the most recent guidelines (ages 50-75 years old) by 5%.	Income, Access, Disability	4.1.1 Systems change for cancer screening reminders	Number of patients reached through patient reminder system and compliance with cancer screening guidelines.	**1.** Review current practice for reliability and timeliness to ensure reminders are being sent by all providers. **2.** Continue to track patient reminders. **3.** Monitor patients via quality dashboard.	Community-based organizations	Health system grantee will partner and support this intervention. Franklin and Essex county health departments will assist by communicating and promoting hospital resources to reach a larger group, provide subject matter expertise to keep hospital staff attuned to health disparities in the county, and connect to healthcare resources.	Adirondack Health
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	4.1.1 Increase the percentage of women with an annual household income less than $25,000 who receive a breast cancer screening based on most recent guidelines. 4.1.2 Increase the percentage of women with an annual household income less than $25,000 who receive a cervical cancer screening based on the most recent guidelines	Health Access, Economic Stability	4.1.5 Remove structural barriers to cancer screening such as providing flexible clinic hours, offering cancer screening in non-clinical settings (mobile mammography vans, flu clinics), offering on-site translation, transportation, patient navigation and other administrative services and working with employers to provide employees with paid leave or the option to use flex time for cancer screenings.	ECH will offer an increased number and locations of screening events throughout the year. Continued collaboration with the Cancer Screening Program and joint patient engagement will allow for positive patient outcomes. At least four events per year will hightlight cancer screening education. The hospital will continue to build screening events that are open and free to the public to address economic and access barriers.	Cancer screening events will be expanded to include additional services to aid with transportation barriers. The hospital will coordinate	Hospital	Cancer Services Program of Northeastern NY	UVMHN Elizabethtown Community Hospital
Prevent Chronic Diseases	Focus Area 4: Preventive care and management	Goal 4.1 Increase cancer screening rates	Increase colorectal cancer screening rates in Essex County from 66.9% to at least 68.5% to meet upstate NY colorectal cancer screening rate by December 2024.	Health Access, Education, Economic Stability	4.1.3 - Use small media such as videos, printed materials (letters, brochures, newsletters) and health communications to build public awareness and demand of the importance of colorectal cancer screening. Evidence Based Intervention - The Community Guide - https://www.thecommunityguide.org/topic/cancer	Input Measures: # of cancer screening social media posts, ads, and campaigns created Output Measures: # of cancer screening social media posts, ads, and campaigns posted/printed/promoted Short-term Outcome: increased cancer screening health communications Intermediate Outcome: increased # of residents who engage in cancer screening campaign/communications and # of locations materials were distributed. Long-term Outcome: increase in cancer screening referrals and screening events	Post cancer screening health messaging on the Essex County Health Department Facebook page to remind people of the importance of prevention and early detection. Create and print newspaper ads promoting the importance of cancer screening including targeted cancer screening public health observances (E.g. March - Colorectal Cancer Awareness). Collaborate with the CSP of Northeastern NY on awareness campaigns and assist in promoting scheduled screening events.	Media	ECHD - collaborate with CSP Northeastern NY on creating educational materials using evidence-based interventions assist in distributing though various media outlets. CSP Northeastern NY - collaborate with ECHD on creating educational materials using evidence-based interventions and assist in distribution, collaborate with health networks to schedule and offer screening events Media - publish ads and disseminate information to Essex County residents.	Cancer Services Program of Northeastern NY

Name of County - Organization(s) 2023 Workplan	Essex County Health Department (ECHD)	Essex County Mental Health	The Prevention Team	Alliance for Positive Health	UVMHN Elizabethtown Community Hospital	Adirondack Health
Planning Report Liaison	Andrea Whitmarsh	Stefanie Miller	Traci Ploufe	Meagan Strack	Amanda Whisher	Matthew Scollin
E-mail:	andrea.whitmarsh@essexcountyny.gov	stefanie.v.miller@essexcountyny.gov	traci@preventionteam.org	mstrack@alliancefph.org	awhisher@ech.org	mgscollin@adirondackhealth.org

Priority	Focus Area	Goal	Objectives through 2024	Disparities	Interventions	Family of Measures	By December 2023, we will have completed . . .	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources	Lead Agency
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages	Home-visiting program staff will make a connection with 75% of the Essex County families with newborns in 2024 to offer home visits or a newborn welcome packet.	Income Access to healthcare Transportation	1.2.1 Implement evidence-based home visiting programs	Input measures: engage in technical assistance sessions with home visiting program models to determine which is the best fit for Essex County. Output Measures: Launch a universal home visiting program in Essex County. Short-Term Outcome: train at least 2 ECHD staff members in program delivery components. Intermediate Outcomes: Conduct targeted outreach with area OB providers, pediatricians and hospitals to raise awareness of the program. Long-Term Measures: Home-visiting program staff will make a connection with 90% of Essex County families with newborns to either receive home visits or a newborn welcome packet.	Launch a universal newborn home-visiting program in Essex County, partnering with ECHD WIC and Children's Services Units, as well as community-based partners and healthcare providers to ensure early supports and wrap-around care.	Local governmental unit	ECHD Public Health Unit will collaborate with the WIC, Home Health, and Children's Services Units to develop, launch, and maintain a universal newborn home visiting program in Essex County.	Essex County Health Department
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages	1. Develop and administer Equity Assessment for Essex County Health & Human Services organizations that can be used to inform the future development of DEI strategic plans. 2. Increase from 0 to 2 the number of Essex County Health & Human Services agencies that have a DEI Strategic Plan (or an existing stategic plan updated to include DEI concepts) in place at the organizational level.	All	1.2.3 Implement policy and program interventions that promote inclusion, integration, and competence	Input measures: DEI survey development, dissemination and analysis Output measures: presentation of survey results and additional training for participating organizations Short term outcomes: increase in the number of organizations in Essex County that have a shared understanding of DEI (including language, standards, etc.) Intermediate Outcomes: increase in the the number of organizations in Essex County that have adopted DEI plans. Long-term Outcomes: increase in employee recruitment and retention rates for Essex County Health & Human Services organizations, translating to an increase in the ability to provide critical and timely services to residents.	1. DEI Survey development 2. DEI Survey dissemination 3. DEI Survey analysis 4. Presentation of survey results 5. DEI Strategic Planning walk through training	Other (please describe partner and role(s) in column D)	Essex County Community Services Board; BRIEF Program Coordinator; CCSI will work with Essex County Health & Human Services agencies to increase DEI practices and policies within their organizations.	Essex County Community Services

Name of County - Organization(s) 2023 Workplan	Essex County Health Department (ECHD)	Essex County Mental Health	The Prevention Team	Alliance for Positive Health	UVMHN Elizabethtown Community Hospital	Adirondack Health	
Planning Report Liaison	Andrea Whitmarsh	Stefanie Miller	Traci Ploufe	Meagan Strack	Amanda Whisher	Matthew Scollin	
E-mail:	andrea.whitmarsh@essexcountyny.gov	stefanie.v.miller@essexcountyny.gov	traci@preventionteam.org	mstrack@alliancefph.org	awhisher@ech.org	mgscollin@adirondackhealth.org	

Priority	Focus Area	Goal	Objectives through 2024	Disparities	Interventions	Family of Measures	By December 2023, we will have completed . . .	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources	Lead Agency
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 1: Promote Well-Being	Goal 1.2 Facilitate supportive environments that promote respect and dignity for people of all ages	1. Implement evidence-based communications practices for messaging around mental illness and substance use. 2. Share best practices and resources with CBOs, human service agencies, mental, emotional and behavioral health agencies in Essex County through existing networks and coalitions (e.g. ECHO, BRIEF).	Mental health Substance Use Disorder	1.2.4 Use thoughtful messaging on mental illness and substance use	Input measures: Train Communications staff on materials related to cultural competance around communications that address mental health and substance use disorder. Output measures: Update the ECHD Communications Plan to include references to the National Academy of Sciences *Ending Discrimination Against People with Mental and Substance Use Disorders.* Short Term Outcomes: update the ECHD Communications Plan Intermediate Outcomes: create a social media messaging and content plan utilizing the concepts outlined in the National Academy of Sciences article. Long Term Outcomes: share information and best practices with other MH/SUD organizations in order to increase use of shared communication concepts	1. Develop a Mental Health and Substance Use Disorder communications plan using the National Academcy of Sciences *Ending Discrimination Against People with Mental and Substance Use Disorders* as a guide. 2. Create messages and content for ECHD social media pages utilizing the communications plan developed.	Community-based organizations	ECHD will work with Community Based Organizations to share best practices in communication strategies for outreach to populations living with mental health and substance use disorders.	Essex County Health Department
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.1: Prevent underage drinking and excessive alcohol consumption by adults	1. Increase by 50% the number of school districts participating in the evidence-based program Mind-Up. 2. Increase by 20% the number of evidence-based prevention programs conducted in Essex County schools.	Mental health Access (to Mental Health Care)	2.1.2 Implement School based prevention	Input measures: outreach to schools in Essex County to increase awareness of programs and services offered by The Prevention Team. Output measures: program dissemination plan for Essex County. Short Term Outcomes: increase in the number of school districts participating in evidence-based programs Intermediate Outcomes: increase in the number of programs conducted and students reached by programs. Long Term Outcomes: Decrease in the number of behavioral issues/referrals in schools participating.	1. Mind-Up implmentation in 3 additional Essex County school districts 2. Administration of the Prevention Needs Assessment which will be utilized to determine	K-12 School	The Prevention Team; Essex County Youth Bureau will collaborate with schools to deliver evidence-based prevention education in Essex County schools.	The Prevention Team
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.1: Prevent underage drinking and excessive alcohol consumption by adults	1. Increase the number of individual screened for alcohol use in patient 18 years and older by 20% by December 31, 2024.	Substance Use Disorders Access to care	2.1.4 Implement routine screening and brief behavioral counseling in primary care settings to reduce unhealthy alcohol use for adults 18 years or older, including pregnant women	Input measure: number of patients 18 years and older who have had a visit within the measurement year. Output Measure: number of patients 18 years and older who have had a visit within the measurment year and who have been screened for alcohol use. Intermediate outcome: Increase screening for alcohol use. Longterm Outcomes: See intervention 2.1.5.	By December 2023 staff education will be completed regarding alcohol and substance use screenigs. A list of referral resources will be maintained and quarterly care team meeting will address any barriers or concerns related to social determinants within the population served.	Hospital		UVMHN Elizabethtown Community Hospital

Name of County - Organization(s) 2023 Workplan	Essex County Health Department (ECHD)	Essex County Mental Health	The Prevention Team	Alliance for Positive Health	UVMHN Elizabethtown Community Hospital	Adirondack Health			
Planning Report Liaison	Andrea Whitmarsh	Stefanie Miller	Traci Ploufe	Meagan Strack	Amanda Whisher	Matthew Scollin			
E-mail:	andrea.whitmarsh@essexcountyny.gov	stefanie.v.miller@essexcountyny.gov	traci@preventionteam.org	mstrack@alliancefph.org	awhisher@ech.org	mgscollin@adirondackhealth.org			

Priority	Focus Area	Goal	Objectives through 2024	Disparities	Interventions	Family of Measures	By December 2023, we will have completed . . .	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources	Lead Agency
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.1: Prevent underage drinking and excessive alcohol consumption by adults	1. Increase the Trauma Responsive Understanding Self-Assessment Tool (TRUST) Survey scores of participating Essex County Health & Human Services organizations by 25% 2. Offer a TRUST feedback session for Essex County Health & Human Services organizational Leaders	Mental Health Substance Use Disorders	2.1.6 Integrate trauma-informed approaches and responses into prevention programs by training staff, developing protocols and engaging in cross-system collaboration	Input Measures: Conduct learning sessions, offer consultation hours and re-administer the TRUST survey. Output Measures: Analyze & disseminate results and offer a feedback session for participants. Short-term Outcomes: increase in number of Essex County Health & Human Services agencies that have trauma-informed leadership. Intermediate Outcomes: increase in number of Essex County Health & Human Service agencies that have trauma-informed staff. Long-term Outcomes: Increase in number of Essex County Health & Human Service agencies that have implemented plans/policies/procedures that include trauma-informed approaches and strategies.	**1.** Conduct (3) Trauma Responsive Practice Learning Community training sessions with Essex County Health & Human Services organizations: (1) Equity Focused, Trauma Responsive Practice to support staff resilience (2) Trauma Responsive Supervision (3) Trauma Responsive Policies and Practices **2.** Conduct (4) quarterly calls for the Learning Community teams to support implmentation of trauma responsive work plans **3.** Offer consultation hours for Learning Community teams **4.** Re-administer the TRUST survey to measure level of implementation of SAMSHA's 10 Implementation Domains for implementation of Trauma-Informed Approach	Other (please describe partner and role(s) in column D)	Essex County Community Services Board; BRIEF Program Coordinator; CCSI will work with Essex County Health & Human Services agencies to increase trauma-informed training and practices and policies within their organizations.	Essex County Community Services
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	1. Increase the number of MAT prescribers	Substance Use Disorders Access to care	2.2.1 Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine	Number of MAT prescribers	ECH will increase the number of providers who are x-waivered to be able to prescribe MAT.	Hospital		UVMHN Elizabethtown Community Hospital
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	1. Continue to increase overdose prevention and response training opportunities for pharmacists, prescribers, and consumers. 2. Increase distribution of narcan kits to healthcare establishments, community members, and participants.	Substance Use Disorders Access to care	2.2.2 Increase availability of/access to overdose reversal (Naloxone) trainings to prescribers, pharmacists, and consumers	Input Measures: Offer and execute trainings. Output Measures: Distribute Narcan kits to community members and locations. Short-Term Outcomes: Increased community access and awareness to opioid overdose reversal materials. Intermediate Outcomes: Increased availability and use of opioid overdose reversal medication. Long-Term Outcomes: decreased stigma around and increased utilization of harm reduction strategies for substance use disorders.	1. Offer and execute 30+ trainings. 2. Distribute 250 kits to community members and healthcare facilities such as outpatient and or inpatient locations. 3. Conduct quarterly reporting of data measurements.	Pharmacies	Alliance for Positive Health will work with pharmacists, prescribers, and consumers to increase overdose prevention strategies.	Alliance for Positive Health
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	1. Increase awareness to prescribing practices and education on best practices will be provided.	Substance Use Disorders	2.2.3 Promote and encourage prescriber education and familiarity with opioid prescribing guidelines and limits as imposed by NYS statutes and regulations	Input Measure: Quarterly meetings Output Measures: The number of controlled prescriptions provided (provider specific) Long-Term Outcomes: decreased prescribing of opioids.	The pharmacy team at the hospital will host Opioid stewardship meetings on a quarterly basis. The Stewardship will focus on prescribing paterns and education for providers on best practices associated with prescribing of controlled medications.	Hospital	The hospital pharmacy team will provide education and host quarterly Opioid Stewardship meetings	UVMHN Elizabethtown Community Hospital
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Mental and Substance Use Disorders Prevention	Goal 2.2 Prevent opioid and other substance misuse and deaths	**1.** Safe disposal receptacles located in Adirondack Health's primary care health centers in St. Regis Falls, Lake Placid, Tupper Lake, and Keene. There is already a safe disposal receptacle located in the main lobby of Adirondack Medical Center.	All	2.2.5 Establish additional permanent safe disposal sites for prescription drugs and organized take-back days	Number of prescription drugs deposited in safe disposal receptacles	**1.** Installation of safe disposal receptacles in at least two of four Adirondack Health primary care health centers	Community-based organizations	Health system grantee will provide support on policy implementation as the lead for this intervention. Franklin and Essex county health departments will assist by communicating and promoting hospital resources to reach a larger group, provide subject matter expertise to keep hospital attuned to health disparities in the counties, and connect to healthcare resources.	Adirondack Health

Name of County - Organization(s) 2023 Workplan	Essex County Health Department (ECHD)	Essex County Mental Health	The Prevention Team	Alliance for Positive Health	UVMHN Elizabethtown Community Hospital	Adirondack Health
Planning Report Liaison	Andrea Whitmarsh	Stefanie Miller	Traci Ploufe	Meagan Strack	Amanda Whisher	Matthew Scollin
E-mail:	andrea.whitmarsh@essexcountyny.gov	stefanie.v.miller@essexcountyny.gov	traci@preventionteam.org	mstrack@alliancefph.org	awhisher@ech.org	mgscollin@adirondackhealth.org

Priority	Focus Area	Goal	Objectives through 2024	Disparities	Interventions	Family of Measures	By December 2023, we will have completed . . .	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources	Lead Agency
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.2 Prevent opioid overdose deaths	1. By the end of 2024, 75% of ECHD leaders and staff will have completed at least 2 instructor-led/evidence-based training on trauma-informed approaches. 2. By the end of 2024, ECHD will have adopted a department-wide plan/policy that requires trauma-informed approaches be embedded in program and service delivery.	All	2.2.6 Integrate trauma informed approaches in training staff and implementing program and policy.	Input Measures: Train ECHD leaders and staff in trauma-informed concepts and approaches. Output Measures: Adopt a department-wide plan/policy that incorporates trauma-informed care concepts. Short-Term Outcomes: Increase in the number of ECHD leaders who are familiar with trauma-informed approaches, concepts, and language. Intermediate Outcomes: Increase in the number of ECHD staff who are familiar with trauma-informed approaches, concepts, and language. Long-Term Outcomes: Increase in the number of ECHD programs that are developed/delivered considering trauma informed care approaches.	ECHD will pursue trauma-informed training opportunities that are geared appropriately toward service sector target populations (e.g. children, young adults, older adults, etc.). By the end of 2023, 75% of ECHD Unit leaders and staff will have completed at least 1 instructor-led/evidence-based training on trauma-informed approaches.	Local governmental unit	ECHD will work with Essex County Community Services Board/BRIEF Coordinator/CCSI to coordinate and implement trauma-informed training for organizational leaders and staff.	Essex County Health Department
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.3 Prevent and address adverse childhood experiences	2.3.3 Increase communities reached by opportunities to build resilience by at least 10 percent.	All	2.3.2 Address Adverse Childhood Experiences and other types of trauma in the primary care setting	Input Measure: Health Center staff training of ACEs. Output Measure: Children who screen positive will be referred to additional resources/services. Long-Term Measure: The affects of childhood trauma will be addressed once identified to reduce the impact on the child's long term healthcare needs.	The hospital's pediatrician will implement an ACEs screen within the primary care setting.	Hospital	The hospital's pediatrician will work with staff on the importance of screening. Referrals to social work/community resources will occur when appropriate.	UVMHN Elizabethtown Community Hospital
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.3 Prevent and address adverse childhood experiences	Home-visiting program staff will make a connection with 75% of the Essex County families with newborns in 2024 to offer home visits or a newborn welcome packet.	Income Access	2.3.4 Implement evidence-based home visiting programs	Input measures: engage in technical assistance sessions with home visiting program models to determine which is the best fit for Essex County. Output Measures: Launch a universal home visiting program in Essex County. Short-Term Outcome: train at least 2 ECHD staff members in program delivery components. Intermediate Outcomes: Conduct targeted outreach with area OB providers, pediatricians and hospitals to raise awareness of the program. Long-Term Measures: Home-visiting program staff will make a connection with 90% of Essex County families with newborns to either receive home visits or a newborn welcome packet.	Launch a universal newborn home-visiting program in Essex County, partnering with ECHD WIC and Children's Services Units, as well as community-based partners and healthcare providers to ensure early supports and wrap-around care.	Local governmental unit	ECHD Public Health Unit will collaborate with the WIC, Home Health, and Children's Services Units to develop, launch, and maintain a universal newborn home visiting program in Essex County.	Essex County Health Department

Name of County - Organization(s) 2023 Workplan	Essex County Health Department (ECHD)	Essex County Mental Health	The Prevention Team	Alliance for Positive Health	UVMHN Elizabethtown Community Hospital	Adirondack Health
Planning Report Liaison	Andrea Whitmarsh	Stefanie Miller	Traci Ploufe	Meagan Strack	Amanda Whisher	Matthew Scollin
E-mail:	andrea.whitmarsh@essexcountyny.gov	stefanie.v.miller@essexcountyny.gov	traci@preventionteam.org	mstrack@alliancefph.org	awhisher@ech.org	mgscollin@adirondackhealth.org

Priority	Focus Area	Goal	Objectives through 2024	Disparities	Interventions	Family of Measures	By December 2023, we will have completed . . .	Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources	Lead Agency
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.6 Reduce the mortality gap between those living with serious mental illnesses and the general population	Increase by 2 clients per quarter with documented NYS Quitline active referrals; Decrease by 20% the prevalence of cigarette smoking among adults who are diagnosed with serious mental illness to 27.4%	An identified barrier/disparity is obtaining client consent for NYS Quitline referral.	2.6.1 Implement a multilevel intervention model that focused at the individual, health systems, community and policy-levels	Input measures: number of quarterly meetings held, number of data reports reviewed Output measures: Number of staff receiving feedback and support with delivering quit assistance to clients Outcome measures: Number of clients receiving active referrals to NYS Quitline; prevalence of cigarette smoking in individuals diagnosed with serious mental illness	The ECMH Tobacco Dependance Treatment Team (TDTT) will continue to meet quarterly in collaboration with the NC Heart Network. Quarterly Utilization Review (UR) meetings with ECMH administration and clinical staff highlight documentation consistency, which includes presence of a Tobacco diagnosis and 5 As assessments. RN will run quarterly data reports in the Electronic Clinical Record (ECR) on clients with Tobacco diagnosis and cross references these clients with presence of ECR documented 5 As assessment. The RN will meet quarterly with Champlain Valley Family Center (CVFC) for Drug Treatment & Youth Services Tobacco-Free CFE & Reality Check staff and the Essex County Prevention Team. Agenda items include CVFC environment and policy strategies, school initiatives and vaping strategies. RN will meet quarterly with the NCHHN Tobacco Treatment Network to discuss and problem solve area wide strategies. The ECMH D/DCS will provide outreach to customers and stakeholders via the Community Service Board and Essex County Board of Supervisors meetings and reports of ECMH Tobacco Dependence Treatment progress.			
Promote Well-Being and Prevent Mental and Substance Use Disorders	Focus Area 2: Prevent Mental and Substance User Disorders	Goal 2.6 Reduce the mortality gap between those living with serious mental illnesses and the general population	Maintain an average of 80% ECMH clients with tobacco diagnosis that have documented 5As. Maintain 100% of clinician offices displaying tobacco and nicotine cessation messages	Access to care, income	2.6.2 Integrated treatment: Concurrent therapy for mental illness and nicotine addiction have the best outcomes. Smokers who receive mental health treatment have higher quit rates than those who do not. For example, people with schizophrenia showed better quit rates with the medication bupropion, compared with placebo, and showed no worsening of psychiatric symptoms. A combination of the medication varenicline and behavioral support has shown promise for helping people with bipolar and major depressive disorders quit, with no worsening of psychiatric symptoms. A clinical trial found that a combination of varenicline and cognitive behavioral therapy (CBT) was more effective than CBT alone for helping people with serious mental illness stop smoking for a prolonged period—after 1 year of treatment and at 6 months after treatment ended.	Input measures: number of therapists receiving feedback and support with offering quit assistance Output measures: number of clients reached with information and/or prescriptions for quit support Outcome measures: % of clients with tobacco diagnosis that have quit support documents in EMR; % of clinician offices with cessation messaging displayed	ECR will document oral consent for the NYS Quit Line and provide electronic Quitline referral. Many mental health clients remain reluctant to connect with the NYS Quitline, so ECMH clinicians will provide behavioral counseling and refer clients to the RN and NPP for NRT and resources such as Quit Kits and other tobacco dependance treatment incentives. The RN will offer clients Smokerlyzer CO2 Monitor breath test (on hold during the pandemic) and advocate for applying a trauma-informed framework across multiple levels to address tobacco-related disparities among individuals with mental health/substance use challenges with trauma histories. The RN will provide quarterly emails to therapists with a list of their tobacco clients missing 5 As assessments and add these to their schedules as indicated. The ECR will alert clinicians when their client 5 As assessments are due. ECMH clients will be prescribed bupropion and/or varenicline as indicated. Communication will be bi-directional with ECMH clinicians, prescribers and client health care providers.The ECMH Wait Room video loop will contain tobacco dependance messages, including NYS Quitline access. A Nicotine Dependance resource page will be updated quarterly on the ECMH website with a variety of evidence-based links, apps and resources			

Name of County - Organization(s)	Essex County Health Dept.	Essex County Health Dept. (WIC)	Essex County Health Dept. (Early Intervention)	Healthy Families North Country	UVMHN Elizabethtown Community Hospital
2023 Workplan					
Planning Report Liaison	Elizabeth Terry	Krista Berger	Lucianna Celotti	Esther Piper	Amanda Whisher
E-mail:	elizabeth.terry@essexcountyny.gov	krista.berger@essexcountyny.gov	lucianna.celotti@essexcountyny.gov	epiper@bhsn.org	awhisher@ech.org

Priority	Focus Area	Goal	Objectives through 2024	Disparities	Interventions	Family of Measures	By December 2023, we will have completed . . .	Implementation Partner (Please select one partner from the dropdown list per row)	Partner Role(s) and Resources	Lead Agency
Promote Healthy Women, Infants and Children	Focus Area 1: Maternal & Women's Health	Goal 1.1: Increase use of primary and preventive health care services by women, with a focus on women of reproductive age	By December 31, 2024, UVMHN ECH will increase the percentage of women who have had an annual exam by at least 2%.	Access to healthcare	Intervention 1.1.2: Increase the percentage of women ages 45 years and older with a past year preventive medical visit by 2%.	Input Measures: # of women aged 45 years and older who are established with Primary Care (UVMHN ECH PCP) Output Measures: # of established women aged 45 years and older who have had an annual preventive exam Short-term Outcome: Additional GYN providers offering services at both the Elizabethtown and Ticonderoga Campus. Long-term Outcome: An increase in women who have preventive exams.	1. GYN clinics began at the Ticonderoga campus in 2022. By December of 2023 UVMHN ECH will have increased the number of days per month GYN services will be available at the Ticonderoga campus.	Hospital	The hospital will continue to work on recruitment and retention strategies and identify innovative, evidence-based practices to providing preventive care in a rural setting.	UVMHN - Elizabethtown Community Hospital
Promote Healthy Women, Infants and Children	Focus Area 1: Maternal and Women's Health	Goal 1.2: Reduce maternal mortality & morbidity	By December 31, 2024, ECHD will screen 90% of postpartum women that accepts a home visit through the Baby Steps to Bright Futures Home Visiting Program.	Access to healthcare	Intervention 1.2.4: Screen all pregnant and postpartum women for depression, with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.	Input Measures: Screening tool identified Output Measures: # of screening tools completed. women/families engaged. Short-term Outcome: Referral created to mental health supports.	1. Implement maternal depression screening into Baby Steps to Bright Futures Home Visiting Program.	Local governmental unit	Essex County Community Service Board will provide the mental health and substance use services.	Essex County Health Department
Promote Healthy Women, Infants and Children	Focus Area 2: Perinatal and Infant Health	Goal 2.2: Increase breastfeeding	By December 31, 2024, ECHD WIC Unit will increase the Breastfeeding Initiation Rate of Infants and Children from 75% to 77%.	Access to healthcare	Intervention 2.2.1: Increase access to professional support, peer support, and formal education to change behavior and outcomes.	Input Measures: Update information on local breastfeeding support services. Output Measures: Breastfeeding Resource Guide is shared publicly and with providers/CBO's. Short-term Outcome: # of social media engagements, # of providers reached	1. WIC staff will visit local Health Care Provider offices 2 times per month to provide education on how ECHD staff can support breastfeeding women. 2. Staff will conduct visits to birthing hospitals 1 x per year to provide information on ECHD programs and local Essex County breastfeeding supports. 3. WIC Staff will contact every prenatal woman based on NYS PC Program Frequency of Contacts Guidance and will be trained on the BAPT tool and start	Providers	Health care providers will make breastfeeding support referrals to local programs and services or provide information to families on how to refer.	Essex County Health Department
Promote Healthy Women, Infants and Children	Focus Area 2: Perinatal and Infant Health	Goal: 2.2 Increase breastfeeding	By December 31, 2024, ECHD Public Health Unit will work with local health care provider offices to offer lactation support groups once a month at two Essex County health care provider locations.	Access to healthcare Transportation	Intervention 2.2.8: Increase access to peer and professional breastfeeding support by creating drop-in centers (e.g., Baby Cafés) in faith-based, community-based or health care organizations in communities.	Input Measures: # of lactation support groups offered. Output Measures: # of breastfeeding women/families engaged. Short-term Outcome: # lactation support groups offered. Intermediate Outcome: # of mothers/families that receive	1. Meet monthly with Elizabethtown Community Hospital and the Creating Breastfeeding Friendly Communities grant to discuss collaboration and logestics to starting a lactation support group. 2. Launch a lactation support group by March 2023 at the Elizabethtown Community Hospital with meetings to be held once a month. 3. Launch a second lactation support group by June 2023 at the UVM Ticonderoga Campus with meetings to be held once a month to serve those in the southern region of Essex County.	Hospital	Elizabethtown Community Hospital and Creating Breastfeeding Friendly Communities grant will collaborate to provide support and TA for lactation support group.	UVMHN - Elizabethtown Community Hospital
Promote Healthy Women, Infants and Children	Focus Area 2. Perinatal & Infant Health	Goal 2.1 Reduce infant mortality & morbidity	ECHD will launch a Universal Home Visiting Program and program staff will make a connection with 75% of the Essex County families with newborns in 2024 to offer home visits or a newborn welcome packet.	Transportation	Intervention 2.1.2: Increase capacity and competencies of local maternal and infant home visiting programs	Input measures: engage in technical assistance sessions with home visiting program models to determine which is the best fit for Essex County. Output Measures: Launch a universal home visiting program in Essex County. Short-Term Outcome: train at least 2 ECHD staff members in program delivery components. Intermediate Outcomes: Conduct targeted outreach with area OB providers, pediatricians and hospitals to raise awareness of the program. Long-Term Measures: Home-visiting program staff will make a connection with 90% of Essex County families with newborns to either receive home visits or a newborn welcome packet.	Launch a universal newborn home-visiting program in Essex County, partnering with ECHD WIC and Children's Services Units, as well as community-based partners and healthcare providers to ensure early supports and wrap-around care.	Local governmental unit	ECHD Public Health Unit will collaborate with the WIC, Home Health, and Children's Services Units to develop, launch, and maintain a universal newborn home visiting program in Essex County.	Essex County Health Department
Promote Healthy Women, Infants and Children	Focus Area 2. Perinatal & Infant Health	Goal 2.1 Reduce infant mortality & morbidity	Healthy Families North County will launch a new program in Essex County and will serve at least 12 families by December 31, 2024.	Income, Educational Attainment, Mental Health	Intervention 2.1.2: Increase capacity and competencies of local maternal and infant home visiting programs	Input Measures: # of families referred to Healthy Families Essex Program. Output Measures: # of of Essex Families that accept the program. Short-term Outcome: Number of families that accept the referral. Intermediate Outcome: # of people that complete the entire program. Long-term Outcome: Increased number of children receive EIP s families are served by the Healthy Families Essex Program.	Healthy Families North County will launch a new program in Essex County and will serve at least 12 families by December 31, 2024.	Community-based organizations	Community based organizations, health care providers and local government will provide referrals to the Healthy Families Program.	Healthy Families North Country
Promote Healthy Women, Infants and Children	Focus Area 3. Child & Adolescent Health	Goal 3.2: Increase supports for children and youth with special health care needs	Increase the number of children enrolled in the EIP by 20% by December 31, 2024.	Educational attainment	Intervention 3.2.1: Engage families in planning and systems work to improve family centered services and effective practices for supporting CSHCN and their families.	Input Measures: # Create system to improve referral follow-up with primary referral sources. Output Measures: New referral follow up process implemented on January 1, 2023. Short-term Outcome: Increased number of referrals accepted. Intermediate Outcome: Increased number of children enrolled in EIP after successfully completing evaluation. Long-term Outcome: Increased number of children receive EIP services based of their individualized service plan.	1. Increase outreach to primary referral sources (health care providers and community based organizations) and follow up with those referral sources when the program is declined for re-referral and family education/support. 2. Include a follow up call to referred family approximately one month after initial EI referral or services are declined to provide support and education on program benefits for child suspected of delay. 3. Provide outreach, educational and marketing materials to the Baby Steps to Bright Futures Universal Home Visiting program to increase referrals and resources to families to support their child's development. 4. Survey families with children participating in the Children with Special Healthcare Needs Program to identify strengths and barriers of local resources.	Providers	Health care providers will reach out to parents to re-refer to EIP.	Essex County Health Department
Promote Healthy Women, Infants and Children	Cross Cutting Healthy Women, Infants, & Children	Goal 4.1 : Reduce racial, ethnic, economic, and geographic disparities in maternal and child health outcomes, and promote health equity for maternal and child health populations	4.1 - Increase and enhance collaboration with other programs, providers, agencies, and community members to address key social determinants of health that impact the health of women, infants, children, and families through bi-monthly coalition meetings through December 2024.	Access to healthcare	Intervention 4.1: Enhance collaboration with other programs, providers, agencies, and community members to address key social determinants of health that impact the health of women, infants, children, and families across the life course.	Input Measures: # of community based partners invited Output Measures: # of community based partners engaged Short-term Outcome: # of coalition meetings scheduled Intermediate Outcome: # of collaborations with partners that address social determinants of health impacting women, infants, children, and families. Long-term Outcome: Identify racial, ethnic, economic, and geographic disparities in maternal and child health outcomes and promote health equity for maternal and child health populations	1. ECHD will schedule and facilitate coalition meetings bi-monthly starting in November 2022 to address strengths, challenges, and collaboration opportunities for all agencies and providers serving children, youth, and families.	Other (please describe partner and role(s) in column D)	Community based Organizations and Health Care Providers will participate and collaborate with the Bright Futures Coalition.	Essex County Health Department

APPENDIX 7

Master Source List	
1	New York State Department of Health Prevention Agenda
2	IRS - Requirements for 501(c)(3) Hospitals Under the Affordable Care Act - Section 501 (r)
3	Public Health Accreditation Board Standards & Measures
4	Association for Community Health Improvement (2017) Community Health Assessment Toolkit
5	Essex County Real Property Tax Services Department
6	Adirodack Land Trust
7	Adirondack Park Agency
8	United States Census Bureau
9	Asterhill Research Company - Essex County Housing and Population Study, 2022
10	Data USA; Essex County, NY
11	NYS Board of Elections, Enrollment by County
12	NYS Legislature - Laws of NY
13	Pew Research Center
14	County Health Rankings
15	NYS Leading Causes of Death Reports
16	NYS Physical Activity Dashboard - Essex County
17	Well Fed Essex County Collaborative - An Evaluation of 5 Food Projects Report
18	CDC - Preventing Chronic Disease
19	NYS BRFSS Brief - Cigarette Smoking 2022; 2022-12
20	NYS Youth Tobacco Data Sheet
21	NY Prevention Needs Assessment Survey - Essex County, 2021
22	2019 Essex County Community Health Assessment; 2019-2022 Community Health Improvement Plan
23	National Institute on Drug Abuse
24	Adirondacks ACO - North Country COVID-19 Vaccine Dashboard
25	Neighborhood Atlas
26	CDC - Excessive Alcohol Use
27	NYS Comptroller Report: Continuing Crisis - Drug Overdose Deaths in New York, November 2022
28	Essex County Heroin & Other (Drug) Coalition - HIDTA ODMAP
29	2021 Monitoring and Analysis Profiles with Selected Trend Data: 2017-2021; Child Protective Services, Foster Care, Adoption. Essex County
30	New York State Opioid Dashboard
31	NYSDOH: NYS Opioid Annual Data Report 2021
32	Prescription Opioids and Heroin Research Report, 2018
33	Mayo Clinic - Preterm Birth
34	NYS Community Health Indicator Reports
35	CDC Well Child Visits and Recommended Vaccinations
36	USDA WIC Eligibility and Coverage Rates 2018
37	Center for American Progress - The Basic Facts About Women in Poverty
38	NYS Health Assessment - Contributing Causes of Health Challenges
39	NACCHO - Guide to Prioritization Techniques
40	Digital Prosperity: How broadband can deliver health and equity to all communities, Brookings Institute. February 27, 2020
41	for Community Living, November 16, 2021

Master Source List (cont'd)	
42	ARHN Community Profile Data Sheets
43	Healthy People 2030 - Poverty
44	United for ALICE - NY, 2018 County Profiles
45	Poverty USA
46	Rural Health Information Hub - Federal Office of Rural Health Policy
47	The Wellbeing of Infants and Toddlers in the Adirondacks, second edition, 2021. Adirondack Birth to Three Alliance
48	NYS Education Department
49	Center for Neighborhood Technology
50	United States Department of Commerce - Broadband USA
51	Office of Addiction Services and Supports - Find Addiction Treatment