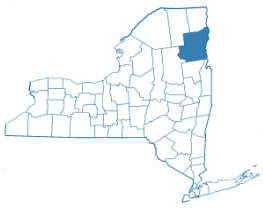
Essex County, NY



Community Health Assessment 2016

Community Health Improvement & Service Plan 2016-2018

Adopted December 2016

Contact Information

The following organizations participated in the development of this Community Health Assessment and Improvement/Service Plan.

Respective Committees and Boards of these organizations reviewed and approved the Assessment & Plan before it was adopted by each participating organization and submitted to the New York State Department of Health (NYSDOH).

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Executive Summary

Community Health [Needs] Assessment Purpose

Community Health [Needs] Assessment (CHA) is the ongoing and systematic process of examining the health of a population. CHA is conducted by compiling and analyzing indicators and statistics from a variety of sources. Data includes demographics, morbidity and mortality (quality and longevity of life outcomes) and contributing health factors including health behaviors, environmental conditions, and the health system available to the population. CHA is used to:

- *determine* the overall health and disease-specific health of the community,
- *assess* underlying causes or conditions detracting from health or contributing to disease,
- *plan* for resource utilization to address health needs, and
- *implement* and *evaluate* targeted initiatives to improve population health.

Data Types and Sources

Much of the data collected was quantitative including rates and percentages. Indicators from numerous data sources including bureaus, divisions and reports of the New York State Department of Health (NYS DOH) along with other national sources such as the Census Bureau and County Health Rankings, a Robert Wood Johnson Foundation project. Most recent data available was compared to NYS for the same time period to provide perspective and previous time periods whenever possible to allow for trend analysis. See **Appendix A** for a summary of data consultants, methodology and sources.

Qualitative data collected was a Community Stakeholder Survey (**Appendix B**). The Survey served to provide input on community health needs and perceived priorities from a diverse group of community stakeholders. It was conducted with healthcare, social service, educational, governmental and others serving a wide variety of populations within the county.

Assessment Partners

This report is the product of a year-long process of collecting and analyzing data and consulting with stakeholders throughout the community and the region facilitated by the Adirondack Rural Health Network (ARHN), a program of the Adirondack Health Institute (AHI). See **Appendix C** for the ARHN Community Health Assessment Committee list and meeting dates. The Center for Health Workforce Studies (CHWS) at the University at Albany School of Public Health was engaged for quantitative and qualitative data collection.

Essex County Health Department, the University of Vermont Health Network -Elizabethtown Community Hospital and Moses Ludington Hospital- and Adirondack Health [hereafter referred to as Essex County Health Partners] participated in this regional health assessment and planning effort and in crafting this Report. The New York State Department of Health (NYS DOH) Prevention Agenda framework[1] was used to categorize and prioritize. See **Appendix D** for more information about the NYS DOH Prevention Agenda.

[1] New York State Department of Health (NYS DOH) Prevention Agenda framework. Available online at https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/

Prioritization Process

A weighted prioritization tool was used to provide a score for each NYS DOH Prevention Agenda Focus Area. The tool was developed locally following guidance from the National Association of County and City Health Officials (NACCHO)[2] and included consideration of ***need*** in categories of *Demonstrated Need* (percent or rate of the population affected); *Variance* (comparison to NY or benchmark); *Trend* (comparison to data for the last assessment) and *Perceived Need* (stakeholder survey results) and ***feasibility*** in categories of *confidence* (perceived ability to engage stakeholders to address the issue), *resources* (availability of evidenced based intervention, staffing & funding) and *capacity* (perceived ability to do more than is currently being done to address the issue). See **Appendix E** for complete prioritization results.

Priorities 2016-2018

Identified priorities for 2016-2018 are a continuation from those last selected in 2013:

Preventing Chronic Disease

Reducing Obesity in Children and Adults &

Increasing Access to Chronic Disease Preventive Care and Management.

Interventions for these common priorities will be both independently and collaboratively conducted by Essex County Health Partners with a broad range of community stakeholders. The scope of interventions span broad through narrow to have both community through individual level impacts.

About Health Disparities

Health disparities may be identified when health-related outcomes are found to a greater or lesser extent within different groups of a population. Disparities in achieving optimal health are often found related to race and ethnicity, gender, sexual identity, disability and geography. Health disparities in Essex County have been identified as related to *rural geography*, *income*, *lack of higher education (Bachelor's or Professional Degree level attainment levels), an aging population, and limited access to health care.*

Disparities of Focus 2016-2018

The first two disparities of focus for 2016-2018 are a continuation from those last selected in 2013; the third is an addition:

Access to care,

Income &

Aging population.

Identifying these issues guides the work of public health (prevention), health care (treatment), and all community stakeholders in an effort to reduce the impact of these disparities on health outcomes.

[2] National Association of County and City Health Officials. Community Health Assessments and Community Health Improvement Plans for Accreditation Preparation Demonstration Project. Tip Sheet: Prioritizing Issues in a Community Health Improvement Process. Available online at http://archived.naccho.org/topics/infrastructure/CHAIP/upload/Final-Issue-Prioritization-Resource-Sheet.pdf

Interventions and Community Engagement

Targeted interventions support the continuation of the work started in 2014 and align with the NYS DOH Prevention Agenda Action Plan[3] of evidence-based strategies and interventions. Refer to **Appendix F** for summaries of previously adopted Improvement/Service Plans of each Essex County Health Partner.

Priority 1. Reduce obesity in children and adults

Strategies
- 1.1 Create **community environments** that promote and support healthy food and beverage choices and physical activity.
- 1.2 Prevent childhood obesity through **early child-care and schools**.
- 1.3 Expand the role of **health care and health service providers and insurers** in obesity prevention.
- 1.4 Expand the role of **public and private employers** in obesity prevention.

Priority 2. Increase access to high quality chronic disease preventive care and management *in clinical & community settings.*

Strategies
- 2.1 Increase **screening rates** for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.
- 2.2 Promote use of **evidence-based care to manage** chronic diseases.
- 2.3 Promote culturally relevant **chronic disease self-management** education.

Lead organizations in these activities include Essex County Health Partners. Community sectors to be engaged in these goals include (and are not limited to) business owners, municipalities, child-care providers, schools, the WIC program, healthcare providers, health and human service providers, employers, Office for the Aging, senior and community centers, trail groups, the media & community members.

Emerging Issues

Other emerging issues identified through the assessment process are important to highlight. Though not identified as priorities for Essex County Health Partners for 2016-2018, they require the attention of Essex County Health Partners and community stakeholders.

Mental, Emotional, Behavioral Health and Substance Abuse

Rates of binge-drinking, alcohol-related injuries and deaths, and death by suicide are identified as higher in Essex County than the 2018 Benchmark or Upstate NY comparisons. Specific data may be found in the Mental, Emotional, Behavioral Health and Substance Abuse section. The 2017 Local Services Plan for Mental Hygiene Services (**Appendix G**) developed by the Essex County Community Services Board (CSB), details nine (9) priority outcomes including ensuring readily accessible care; integrating mental health, substance abuse and primary care health services; improving housing for those with diseases of mental health or addiction; addressing issues of marijuana and opioid use; decreasing deaths by suicide; increasing consumer participation in the service system and reducing tobacco use and its impacts. Essex County Health Partners, though not lead organizations in these priorities, are active partners in collaborative efforts to advance this Plan.

[3] New York State Department of Health. Prevention Agenda 2013-2018: Preventing Chronic Diseases Action Plan. Available online at https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/chronic_diseases/focus_area_1.htm#goals

Climate Change & Human Health

Climate changes has a varied and significant impact on human health. There are numerous health consequences – un-predictable and disastrous weather; changes in drinking water and food security, shift and emergence of infectious diseases and numerous other health consequences that influence both individual and population health. Certain populations such as the elderly, those with pre-existing health conditions and children are more vulnerable and generally less capable of adapting. Following are two climate change issues identified as emerging in Essex County.

Extreme weather events including flooding and winter storms were identified as highly probable for Essex County through the County Emergency Preparedness Assessment last conducted in 2015[4]. Geography, land use, aging population and pre-existing health conditions (chronic diseases) increases the population's vulnerability to negative health outcomes related to these events.

Change in infectious agents are occurring both due to global and local climate change. Infectious agents originating across the globe, such as *Ebola* and *Zika viruses*, are cause for local preparedness and response efforts to prevent local disease spread. Locally, *tick-borne bacterial illnesses* including *Lyme Disease* and recent documentation of *Anaplosmosis* cases have increased; data found in the Zoonoses sub-section of the Communicable Disease section.

Continue Reading

Refer to the ***Community Health Assessment 2016*** section for a comprehensive display of data, comparisons, trends, assets and current activities.

Refer to the ***Community Health Improvement & Service Plan 2016-2018*** for a comprehensive action plan including specific activities, impact targets, partners, and performance measures to evaluate and document progress of intervention.

[4] New York State Division of Homeland Security and Emergency Services. County Emergency Preparedness Assessment, Essex County.

Table of Contents

Community Health Assessment 2016

Community Health Improvement & Service Plan 2016-2018

Appendices*

* Appendices reports were modified from their original format to fit this report. They are available in original format upon request.

Community Health Assessment 2016

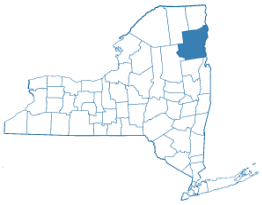
Community Profile

Unless otherwise noted through a footnote, see **Appendix H, Demographics** & **Appendix I, Education System** for additional data indicators & sources.

Geographic & Political Profile

Essex County is in the North Country region of Upstate New York (NY) and situated entirely within the Adirondack Park.

It is the 2nd most geographically large county in NY and 3rd least populated with only 21.56 people per square mile.[5] A large portion of the county is state land (45.82%) with the remainder (47.95%) being private.[6]



The population is estimated to be 39,370 in April 1, 2010 dropping 2.2% to an estimated 38,478 July 1, 2015.[7] There are 18 Towns and 4 Villages. Two (2) Villages are partially situated within Essex County; 1 bordering Franklin County (Lake Placid) on the west and 1 (Keeseville) bordering Clinton county to the north. Two (2) Villages, Port Henry in the Town of Moriah and Keeseville in the Town of Chesterfield, are currently undergoing dissolution processes. The Towns with the largest populations are North Elba, Ticonderoga and Moriah; the smallest are North Hudson, Newcomb & Essex. Essex County is governed by a Board of Supervisors comprised of each Town Supervisor who is provided a weighted vote based on the Town's Population.

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[5] New York State Department of Health. Vital Statistics. Table 2: Population, Land Area, and Population Density by County, New York State-2014. Retrieved from https://www.health.ny.gov/statistics/vital_statistics/2014/table02.htm
[6] Adirondack Park Agency. Adirondack Park Land Use Classification Statistics-May 21, 2014. Retrieved from http://apa.ny.gov/gis/stats/colc201405.htm
[7] United States Census Bureau. Essex County Quick Facts. Retrieved from http://www.census.gov/quickfacts/table/PST120215/36031

Economic Profile

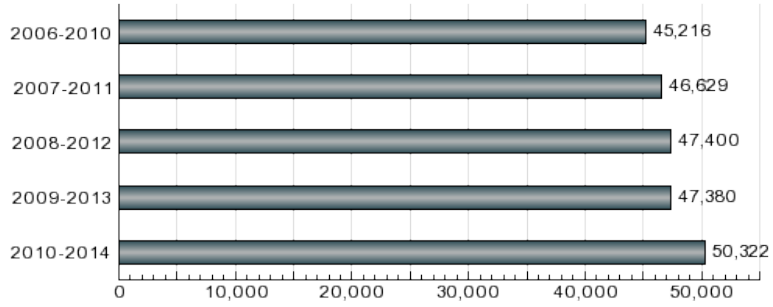
Broadband Access

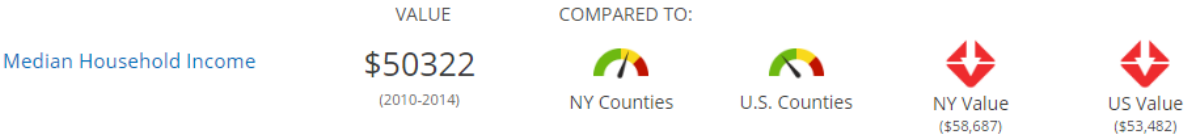
Broadband internet access, through cable or wireless services, has become not a luxury, but a necessity. It is an essential piece of economic development, commerce, education, healthcare and social connectedness. As of August 2016 approximately 30% of Essex County homes & businesses have access at the NYS benchmark speed of at least 100 Mbps. Governor Cuomo has identified broadband access as a key component of New York's infrastructure and launched a new NY Broadband Program in January of 2016 to expand access across NY.[8]

Income

Median household income reflects the relative affluence and prosperity of an area. Areas with higher median household incomes are likely to have more educated residents and lower unemployment rates. Higher employment rates lead to better access to healthcare and better health outcomes, since many families get their health insurance through their employer. Areas with higher median household incomes also have higher home values and their residents enjoy more disposable income. Essex County residents continue to have lower incomes compared to the rest of NYS.

Median Household Income Time Series[9]





Income Indicator	Essex County 2011	Essex County 2014	NY 2014
Mean Household Income	$60,171	$64,341	$85,736
Per Capita Income	$24,915	$26,755	$32,829

[8] New York State. Empire State Development Agency. Broadband Program Office. Available online at http://nysbroadband.ny.gov/
[9] Healthy ADK. Community Dashboard/American Community Survey Data. Available Online at http://www.healthyadk.org/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=20326145

Poverty

Households receiving general assistance or temporary assistance to Needy Families (TANF) is 2.7%.[10]

A time series review of poverty indicators for all sub-populations demonstrate a decreasing percent from the time period 2006-2010 and 2010-2014. A smaller percentages of individuals are living under the federal poverty and receiving Medicaid compared to percentages in 2011 and 2014 as detailed in the table below.

Poverty Indicator	Essex County 2011	Essex County 2014	NY 2014
% Individuals Under Federal Poverty Level	12.2%	11.4%	15.6%
% Individuals Receiving Medicaid	16.4%	15.2%	24.7%

Sub-population examination for the time period of 2010-2014 demonstrate the sub-population with the highest percent living in poverty is children as demonstrated in the table below.[11]

Sub-Population Living Below Poverty	Essex County 2006-2010	Essex County 2010-2014
People	12.9%	11.4%
Families	8.1%	7.2%
Children	19.2%	16.1%
People 65+	7.7%	5.8%

Public School District Free & Reduced Lunch Program Percent Eligibility to Enrollment (all January of the year) demonstrate a general increase from 2005 through 2016 as shown in the table below.[12]

School District	2005	2010	2014	2015	2016
Crown Point	46.5	49.4	51.7	53.1	54.6
Elizabethtown-Lewis	30.8	41.5	45.4	48.6	55.7
Keene	18.1	31.0	39.6	43.0	37.4
Lake Placid	22.5	25.7	33.1	33.9	37.6
Minerva	38.2	40.0	41.7	42.2	47.3
Moriah	60.6	62.9	55.4	52.9	53.8
Newcomb	30.9	24.7	23.9	40.6	40.2
Schroon Lake	45.2	46.9	50.7	60.9	89.8
Ticonderoga	48.6	45.4	53.6	55.6	66.1
Westport	34.9	33.1	36.6	41.8	44.7
Willsboro	37.9	44.1	45.5	49.4	52.6
COUNTY TOTAL	40.8	43.1	46.1	48.1	53.5

[10] Healthy ADK. Custom Report of Economic Indicators/Bureau of Labor Statistics. Available Online at http://www.healthyadk.org/
[11] Healthy ADK. Custom Report of Poverty Indicators for Sub-populations/American Community Survey Data. Available Online at http://www.healthyadk.org
[12] New York State Education Department. Child Nutrition Management System. Child Nutrition Knowledge Center. Eligibles to Enrollment Report. Available Online at http://portal.nysed.gov/pls/cn_port/mel3_pkg.elig_enroll_query

Childcare, Education & Employment Profile

Early Childhood/Preschool

Adirondack Community Action Program (ACAP) operates Early Head Start and Head Start Programs in Essex County with 72 slots available for Early Head Start; 125 for Head Start. These programs function at 100% capacity and are unable to meet community demand. ACAP is also the local Child Care Resource and Referral Agency. They have 38child Registered/Licensed Child Care Providers and 16 Legally exempt Child Care providers in the county and continue to note insufficient providers and slots to meet community demand.[13]

Schools

There are 11 public school districts entirely within the county and 2 bordering districts, Saranac Lake to the north-west and Ausable Valley to the North that serve Essex County student populations. Student to teacher ratio is lower than NY (9.0 in Essex County; 13.8 in NY) and the percent of students that dropped out of high school (8.6%) is also lower than the region (12.7%) and the state (12.8%). There are 3 private boarding schools: Mountain Lake Academy, North Country School and North Woods School located in Lake Placid; and two Christian schools: St. Agnes in Lake Placid and St. Mary's in Ticonderoga.

There is 1 community College, North Country Community College, located just inside the county in Saranac Lake (North-West corner of the county) and 1 satellite campus of that college in Ticonderoga.

Educational Attainment

Educational attainment indicators remain similar to the previous assessment as demonstrated in the table below.

Education Indicators (as Percent)	Essex County 2007-2011	Essex County 2010-2014	NY 2010-2014
Less than High School Diploma/GED	12.1	12.0	14.6
HS Graduate/GED	34.1	33.6	26.9
Some College, No Degree	18.1	20.7	16.3
Associate Degree	10.8	9.9	8.5
Bachelor's Degree	14.6	13.4	19.1
Professional Degree	10.3	10.4	14.6

Employment

Education, Healthcare and Social Assistance is the largest employment sector (30.3%); Higher than upstate NY (28.3%) and NYS (27.5%). Other large sectors include Arts, Entertainment, Recreation, Hotel & Food Service at 12.7% and Retail Trade at12.0%.

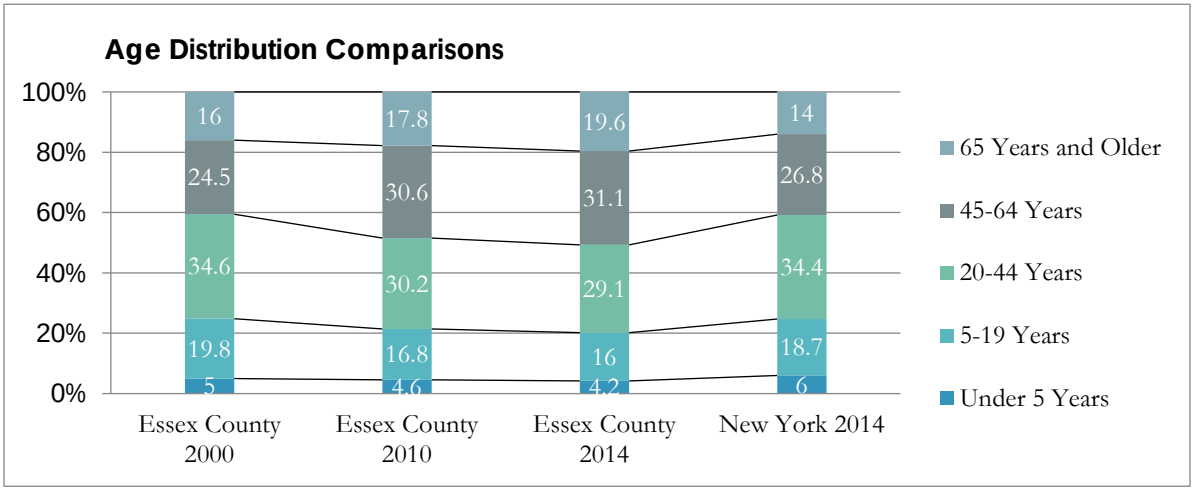
The most recent percent of unemployed, 2014, is 6.9%, lower than the 2011 percent of 7.2%. This percent is slightly higher than Upstate NY (5.6%) and NY (6.3%).

[13] Adirondack Community Action Program. Child Care Annual Report. Available Online at http://www.acapinc.org/wp-content/uploads/2012/02/Child-Care-Annual-Report-2014-2015.pdf

Family & Social Profile

Age

The median age in Essex County is 45.6 compared to that of NY at 38.1. Essex County continues to experience a shrinking percent of younger citizens and growing percent of aged citizens compared to the relatively stable age



distribution of NY as demonstrated in the chart below.[14]

Race, Language & Family

The racial distribution in Essex County continues to be limited with the majority (92.5%) being white compared to NY (57.3%). There are 2.8% each Black and Hispanic/Latino population compared to NY with 14.4% Black; 18.2% Hispanic/Latino. A small percent, 6.3% of residents speak a language other than English at home; much smaller than the 30.2% in NY. Average household size is approximately 2.5 people, slightly smaller than the 2.7 of NY. Single parent households account for 13.2% of families (compared to 19.8% in NY) and a small, 1.3% of households are comprised of grandparents as parents, similar to the 1.8% in NY. A fair amount of those ages 65+ live alone (28.8%).[15]

Disabilities

The percent of adults with disabilities is 21.1%, a decrease from the 24.7% noted in the previous assessment and less than comparisons for the region (25.2%) and Upstate NY (22.4%).

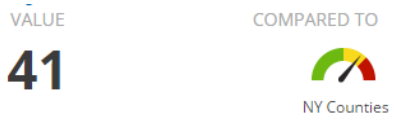
[14] US Census Bureau. American Fact Finder. Available Online at http://factfinder.census.gov/
[15] Healthy ADK. Community Dashboard/American Community Survey. Available Online at http://www.healthyadk.org/

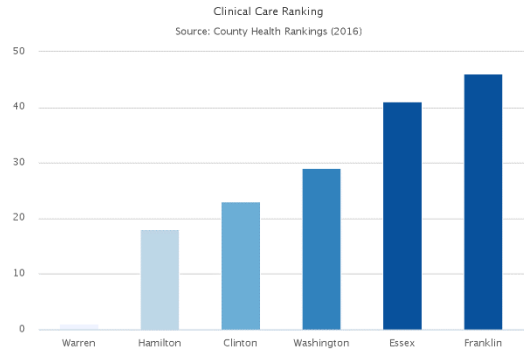
Health System Profile

Unless otherwise noted, complete data and sources for the Health Systems Profile section may be found in **Appendix J**.

Clinical Care Ranking[16]

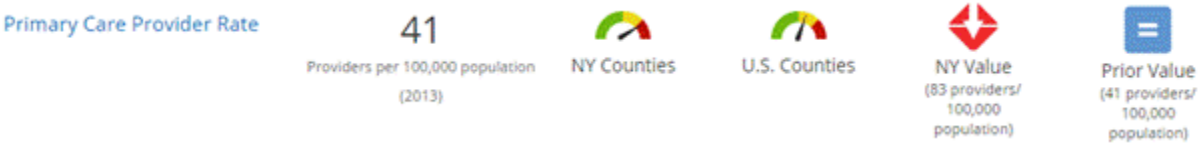
This indicator shows the ranking of the county in clinical care according to the County Health Rankings. The ranking is based on a summary composite score calculated from the following measures: uninsured, primary care physicians, mental health providers, dentists, preventable hospital stays, diabetic monitoring, and mammography screening.





Licensed Provider Rates

Essex County has a significantly lower Total Physician per 100,000 population (93.5) compared to the region (214.2) and NY (307.0). Rates of all subspecialty licensed providers are much lower in Essex County compared to the region and NY. Of particular note are rates of Primary Care Providers (54.5/100,000) compared to the region (81.5) and NY (94.5). There is 1 full time Pediatric provider, no (0) Obstetrics/Gynecology providers and no (0) Psychiatry providers.



Health Professional Shortage Areas (HPSAs)

There are 5 Primary Care HPSAs in Essex County (covering 8,080 people); 1 Dental Care HPSA (covering 6,395 people); and 1 Mental Health HPSA (covering 35,299 people).

Hospitals

There are a total of 40 hospital beds in Essex County. Hospital Beds by facility are Elizabethtown Community Hospital (25); Inter-lakes Health (ILH)/Moses Ludington Hospital (MLH) (15).

[16] Healthy Communities Inc. Community Dashboard. Clinical Care Ranking. Available online at http://www.healthyadk.org/index.php?module=indicators&controller=index&action=view&indicatorId=213&localeId=1895

Healthcare Transformation

Adirondack Health, Adirondack Medical Center

Adirondack Health has embarked on a healthcare transformation project called the Future of Care Campaign. The campaign has two major projects: 1) a new surgical services department for Adirondack Medical Center, and 2) the construction of Lake Placid Health and Medical Fitness Center. The surgical services upgrade of an existing suite [that is over 50 years in service] allows for the continuation and growth of vital surgical services to patients in the region accommodating an increasing number of seniors and ensuring faster, more comfortable and convenient care. The Lake Placid Health and Medical Fitness Center embraces healthy lifestyle promotion and the philosophy of exercise as medicine. These projects are also projected to support the recruitment and retention of qualified health care professionals to the region.

Inter Lakes Health, Moses Ludington Hospital AND University of Vermont Health Network, Elizabethtown Community Hospital

Since 2014, Moses Ludington Hospital has been an organization in transition. The organization is complex; and the challenges it faces are even more so. ILH (its parent organization) has had a number of issues plaguing it over the years. As a result, it must enact changes that will impact its structure, the services it offers and the manner in which it does so.

Along with providing essential healthcare to the people within the Moses Ludington service area, the primary focus of Moses Ludington has been a transition plan. There are two organizational transformations that are taking take place in relative unison: the Inter Lakes Health (ILH) organization will be restructured, along with Moses-Ludington Hospital, one of ILH's member organizations. Inter Lakes Health will be reconfigured; and will become a part of a medical village campus in Ticonderoga. Almost simultaneously, Moses-Ludington Hospital is also being reorganized; and will become part of the same medical village campus. There are 4 main parts that compose the medical village:

- Transformed hospital services operated by University of Vermont Health Network - Elizabethtown Community Hospital
- Long term care (operated by Post Acute Partners under its Elderwood brand of nursing homes)
- Primary care (working with Hudson Headwaters Health Network to develop primary care on-site.) and
- Senior housing (Lord Howe Estates and Moses Circle Senior Housing) already in place.

Central to the changes, transformations and plans for the future of health care in the Ticonderoga region is the commitment to the community by board members, management and staff at ILH – driven by the desire to provide health care to residents of, and visitors to, the entire region.

Community Health Centers

A greater percent of the Essex County population (19.0%) receive medical care at a Community Health Center compared with the region (16.84%) and NY (8.69%).

UVHN Elizabethtown Community Hospital (ECH) is working to improve Community Health Center based access to primary care by recruiting physicians and establishing primary care centers within Essex County. ECH owns a network of community-based health centers throughout Essex County including Ausable Forks, Elizabethtown, Westport, Willsboro and Wilmington. This year (2016) Elizabethtown Community Hospital expanded its network of health centers within the county by welcoming into its network the practice of Dr. Peter Sayers in Crown Point; formerly a single-provider private practice, Mountain Family Care. The health centers are supported by the hospital and its services,

assuring residents have easy access to primary care services with physicians and physician assistants and additional health services as necessary through the hospital.

Adirondack Health continues to provide primary care through health centers located in Keene and Lake Placid. Hudson Headwaters Health Centers continue to provider primary care through centers located in Moriah, Schroon Lake and Ticonderoga. Residents may also access primary care at Mountain Medical Services in Lake Placid and a limited number of single-provider practices.

Birthing Care

There are no prenatal classes, birthing facilities or beds in Essex County. As described above under Licensed Providers there are no OB/GYN providers in the county. Essex County Health Department provides at least 1 prenatal home visit for families, regardless of income, to provide birthing and breastfeeding education.

Emergency Care

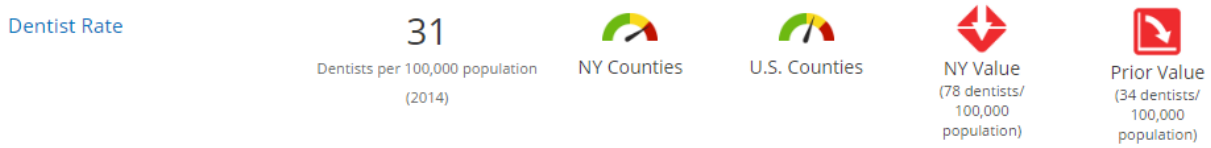
Essex County residents and visitors may access emergency care through Adirondack Health Emergency Department in Lake Placid, Elizabethtown Community Hospital Emergency Department in Elizabethtown, Interlakes Health/Moses Ludington Hospital Emergency Department in Ticonderoga. Urgent care is also provided by mountain Medical Services in Lake Placid.

EMS

EMS agencies in Essex County include 2 privately owned (Elizabethtown Community Hospital Transport and International Paper) and 13 publicly owned (located in Ausable Forks, Elizabethtown, Keene, Keene Valley, Lake Placid, Minerva, Moriah, Newcomb, Schroon Lake, Ticonderoga, Westport, Willsboro and Wilmington).[17] Most of these rely solely on volunteers. Areas of coverage for certified services vary and are determined by a Certificate of Need (CON) process. Essex County appointed an EMS Coordinator in 2016.

Dental Care

There are 9 Dental Health Centers in Essex County; only 1 of these providers accepts Medicaid and 3 of these providers accept Child Health Plus. Seven (7) are known to accept private insurance. Essex County Health Department maintains a listing of Dentists in Essex County and the surrounding region to provide to the public.



[17] New York State Department of Health. Bureau of EMS. EMS Agency Information by County. Available online at http://www.health.ny.gov/professionals/ems/counties/map.htm

Adult Care Centers

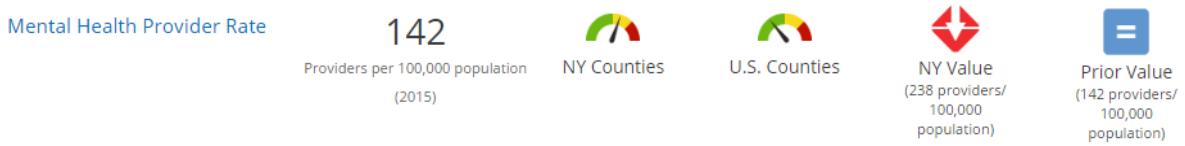
There are a total of 194 Adult Care Facility beds in Essex County. This is a per 100,000 population rate of 497; higher than the region (252) and NY (239) though necessary given the aging population. There are 20 Assisted Living Program beds and 131 assisted living residence beds. Adult home beds by facility are 40 at Adirondack Manor (DBA Montcalm Manor) and 23 at Moses Ludington Adult Care Facility [both in Ticonderoga] and 50 at Keene Valley Neighborhood House.

Nursing Homes

There are a total of 340 Nursing Home beds in Essex County. This is a per 100,000 population rate of 870; higher than the region (775) and NY (580) though justified given the aging population. Nursing Home Beds by facility are the Essex Center for Rehabilitation and Healthcare (100) in Elizabethtown, Heritage Commons Residential Health Care facility (84) in Ticonderoga and Uihlein Living Center (156) in Lake Placid.

Mental Health

Essex County Mental Health Services serves residents through its clinic for a range of diagnoses. The Clinic provides case management as well as individual, group, school, and crisis services on an out-patient basis to Essex County residents of all ages. The Mental Health Association provides a crisis hotline and support, case management and classes. There are a limited number of private clinical psychologists and social workers. Families First in Essex County raises awareness of issues for children with mental illness, provides case management and helps families become more connected in their communities and access resources.



Substance Abuse

The Prevention Team is an Office of Alcohol and Substance Abuse Services (OASAS) OASAS funded, prevention focused program serving Essex County whose mission is to build relationships to promote healthy social environments for families, schools and communities leading to healthy choices by individuals. St. Joseph's Addiction & Treatment and Recovery Centers provide out-patient alcohol and substance abuse services at 2 locations in Essex County-Ticonderoga, Elizabethtown- and nearby out of county – Keeseville and Saranac Lake. Inpatient services are available in Saranac Lake, Franklin County. There are currently no detox programs in Essex County.

Community Services Board

The Community Service Board (CSB) is a coalition of mental health, substance abuse and developmental disability providers governed by NYS Mental Hygiene Law designated to assure joint planning and financing of mental health services. Responsibilities include assuring the population is adequately covered by services, that there is coordination and cooperation of providers and other community support services and that there is continuity of care among providers. The CSB Local Service Plan, with a focus on issues related to mental health and substance abuse, is similar to the Community Health Improvement Plan, the responsibility of the local health department, and the Community Services Plan, the responsibility of hospitals. Essex County's Local Service Plan in available in **Appendix G**.

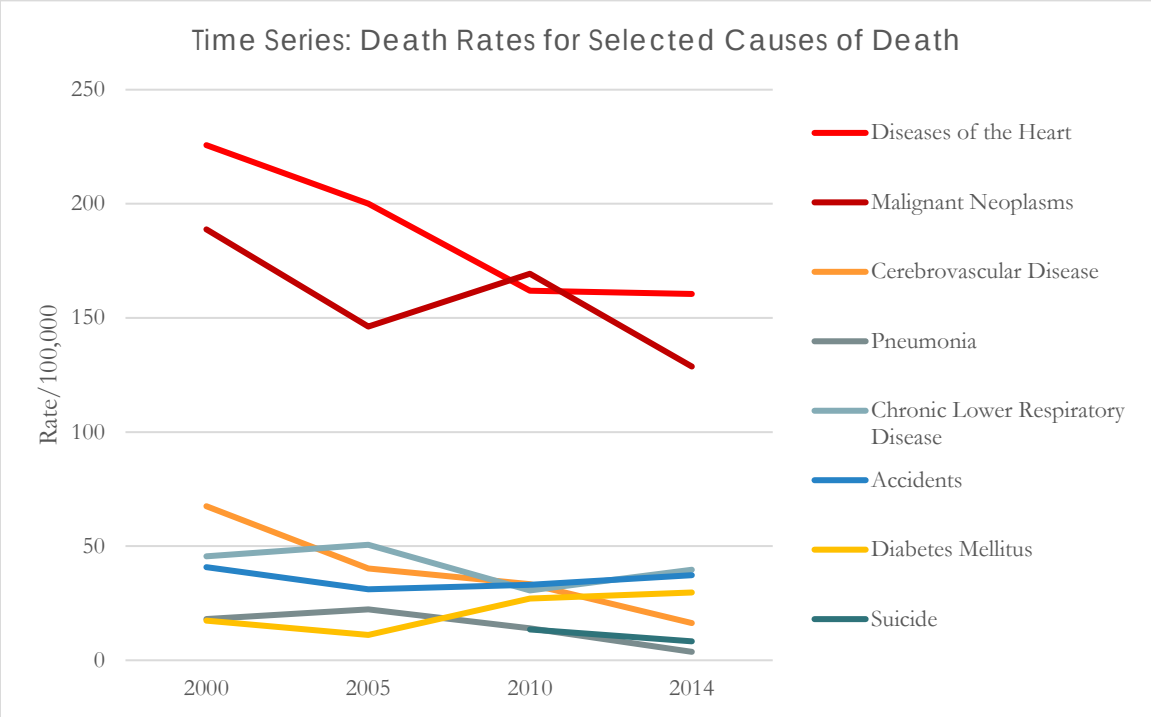
NYS Prevention Agenda Priority Area Indicators

Unless otherwise noted, complete health indicator data and sources for the NYS Prevention Agenda Priority Area Indicators section may be found in **Appendix K**.

Health Status & Disparities

Death Rates for Selected Causes of Death[18]

The age-sex adjusted death rates for selected causes of death has remained fairly consistent from 2000-2014 with Diseases of the Heart and Malignant Neoplasms (Cancer) being leading causes of death. Cerebrovascular Disease rates demonstrate a general decline over this time period; Diabetes an increase.



Chronic conditions remain a priority in Essex County. Diseases of the heart and cancer remain predominant causes of morbidity and mortality. And while these align with an aging population (20% of residents are 65 years and older), indicators for overweight, obesity and diabetes also continue to rise, including those for children. For more complete information, see the Chronic Diseases section.

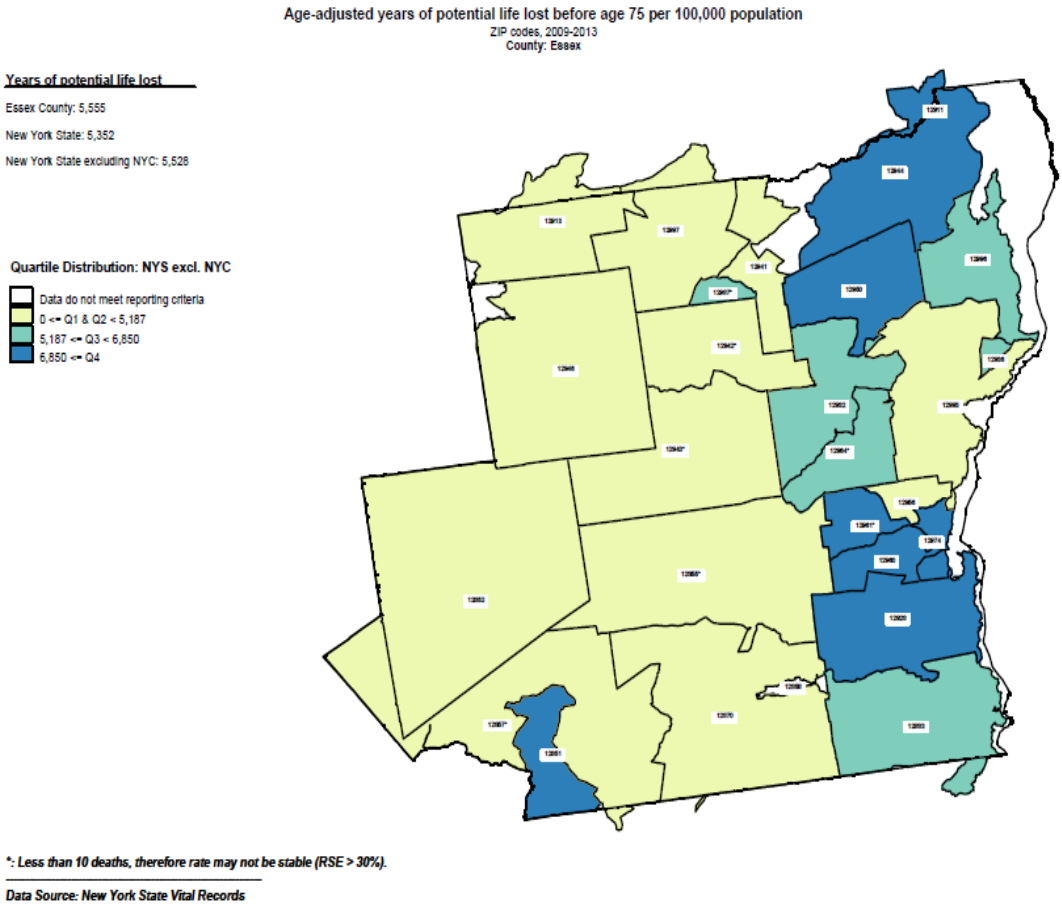
[18] New York State Department of Health. Vital Statistics. Available online at https://www.health.ny.gov/statistics/vital_statistics/

Healthcare Utilization & Death

Indicator	Essex (Previous)	Essex (Current)	NY (Same as (Essex Current))	2018 Benchmark
Emergency Department Visits/10,000	4,611.8 ('08-'10)	4,484.8 ('11-'13)	4,086.4	NA
Adult Preventable Hospitalizations/100,000	134.9% ('08-'10)	88.9 (2014)	119	122
Premature (Ages 35-64) Death Percent	19.9% ('08-'09)	23.7% (2013)	23.7%	21.8%

Premature Death by Zip Code[19]

A zip code view of age-adjusted premature death demonstrates a correlation of socioeconomic status with years of potential life lost (figure below).



[19] NYS DOH. Office of Public Health Practice. Bureau of Chronic Disease Evaluation and Research. Sub-County Health Data Report. Available online at http://www.nysachoinfo.org/Sub-County-Health-Data-Report/Essex.pdf

Access to Healthcare

People who lack a regular source of health care may not receive the proper medical services, including routine check-ups and screenings, when they need them. When they become ill, they generally delay seeking treatment until the condition is more advanced and therefore more difficult and costly to treat. Maintaining regular contact with a health care provider is especially difficult for low-income people, who are less likely to have health insurance. This often results in emergency room visits, which raises overall costs and lessens the continuity of care.

The percent of children, women and adults with health insurance have all increased since the last assessment though they do not yet meet the NYS 2018 Prevention Agenda benchmark of 100%. The percent of adults with a regular healthcare provider has decreased since the last assessment, though so has the percent of adults unable to receive care due to costs.

Indicator	Essex (Previous)	Essex (Current)	NY (Same as (Essex Current))	2018 Benchmark
Adults (18-64) with Health Insurance	84.0% ('08/'09)	89.8% (2013)	87.6%	100.0%
Women (18-64) with Health Insurance	85.7% ('08/'09)	91.7% (2014)	89.7%	100.0%
Children (0-19) with Health Insurance	93.6% (2010)	95.8% (2014)	96.6%	100.0%
Adults with a regular health care provider	83.7% ('08/'09)	77.8% ('13-'14)	84.4%	90.8%
Adults who did not receive care due to costs	11.1% ('08/'09)	10.0% ('13/'14)	13.1%	NA

Disparities

Healthcare Providers/Professional Access

While the percent of residents with health insurance has been increasing, residents continue to be at a healthcare provider access disadvantage as described in detail in the Health System Profile section. Of particular note are that there remains no OB/GYN or Psychiatry providers in county, primary care providers are considerable less than the region and NY and that there are Health Professional Shortage Areas (HPSAs) for Primary Care, Dental Care and Mental Health.

Income

Data available supports additional health risks for lower income populations such as those eligible for Medicaid or WIC. Residents continue to experience lower mean household incomes and per-capital incomes than NY. The higher percent of sub-populations living in poverty are children at 16.1%. An increasing percent of children are eligible for free and reduced lunches (40.8% in 2005 to 53.5% in 2016). Refer to the Economic Profile section for more detailed information.

Age

The age distribution in Essex County continues to display an aging population with almost 20% aged 65+; higher than the 14% in NYS; those 45-64 about 31% compared to the approximate 27% of NYS. Refer to the Family & Social Profile section for more detailed information.

Healthy & Safe Environment

Air and Water Quality

Data for the number of days with unhealthy ozone or particulate matter is unavailable.

Public Water

Of Essex County's 18 Towns, all but 1, North Hudson, have municipal water supplies. There are a total of 25 water districts. Most (10) Towns have 1 water district; 6 have 2 districts; 1 has 3 districts. None of the public water supplies are fluoridated.

Accidents/Injuries

The rates of falls for both children and aged adults continues to be lower than Upstate NY and the benchmark. Occupational injuries for those 15-19 has increased since the last assessment and is higher than Update NY & Benchmark levels.

Total Motor Vehicle Crashes, speed-related accidents and alcohol-related crashes and deaths have all continued to increase and exceed Upstate NY levels.

Select Indicators	Essex	Essex (Current)	Upstate NY (Same as Essex Current)	2018 Prevention Agenda Benchmark
ED Visits Due to Falls, Children Ages 1-4/10,000	537.9 ('08-'10)	392.6 ('14)	442.7	429.1
ED Occupational Injuries, Ages 15-19/10,000	98.4 ('08-'10)	101.7 ('13)	28.2	33.0
Hospitalizations Due to Falls, Ages 65+/10,000	205.0 ('08-'10)	110.9 ('13)	188.7	204.6
Total Motor Vehicle Crashes/100,000	2,550.2 ('09-'11)	2,661.2 ('09-'11)	2,061.9	NA
Speed-Related Accidents/100,000	588.4 ('09-'11)	635.6 ('11-'13)	217.1	NA
Alcohol-Related Crashes	Change in data reporting	102.6 ('11-'13)	43.4 (NY; not Upstate)	NA
Motor Vehicle Accident Deaths/100,000	7.0 ('08-'10)	12.8 ('11-'13)	7.4	NA

Crime

Crime data, including total crimes, property crimes & violent crimes are all less than those of the compared region, Upstate NY and NY State.

Grocery/Food Access[20]

The grocery store (including grocery & supermarkets; excluding convenience stores or supercenters) density in Essex County is .62/1000; this rate fairs well compared to other counties in the US. Households with no car and low access to a grocery store account for only 3.7% of the population. Those with low income and limited access to a grocery store is 2.0%. Subpopulation with limited access to a grocery store include 1.4% of children and 1.2% of people ages 65+.

The farmer's market density is .18/1,000 population which is also considered to fair well when measured against other counties in the US.

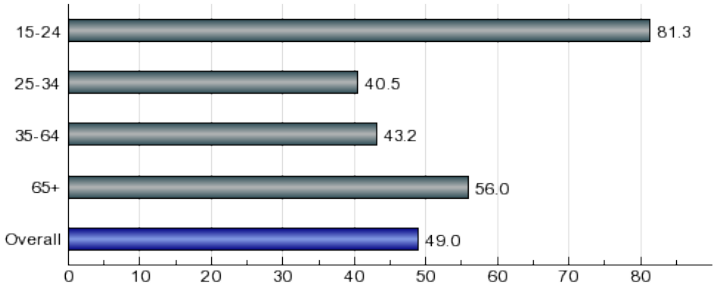
Recreation & Fitness Access

All of Essex County is within the Adirondack Park so access to exercise opportunities are often documented as highly accessible. However communities are comprised on public and private lands and access to park lands that provide opportunities for physical activity to most are not well documented. Efforts are underway to better assess local opportunities for physical activity and market these to the public. Fitness facility availability has decreased over time from .21/1,000 in 2007 to .08/1,000 in 2012.[21]

Housing

There is a higher percent of owner-occupied housing, 73.5% compared to that of NY, 53.8%. However the percent of renters that spend more than 30% of their income on housing is high, 49% overall with a significant burden exhibited for young adults (81.3%) and those aged 65+ (56%), as demonstrated by the chart to the right.

Percent of Renters Spending Over 30% on Housing



Transportation

Residents rely heavily on personal vehicles for transportation though an increasing percent of households, 8.5% in 2016, report having no vehicle available. Public transportation is limited to the county transportation system that offers limited routes throughout the county and a trolley in the Village of Lake Placid primarily geared towards visitors. The percent of commuters who use alternate modes of transportation to work is 20.7% compared with 22.6% for Upstate NY and less than the 2018 benchmark of 49.2%.

Vehicle ownership is directly related to the ability to travel. In general, people living in a household without a car make fewer than half the number of journeys compared to those with a car. This limits their access to essential local services such as supermarkets, post offices, doctors' offices and hospitals. Most households with above-average incomes have a car while only half of low-income households do.

[20] Healthy ADK. Community Dashboard/US Department of Agriculture. Available Online at http://www.healthyadk.org/
[21] Healthy ADK. Community Dashboard/ US Department of Agriculture. Available Online at http://www.healthyadk.org/

Chronic Diseases

Chronic diseases- diseases of the heart & circulatory system, cancer, diabetes, arthritis and asthma – are the leading causes of reduced quality and length of life in Essex County and New York State. Yet these conditions are among the most preventable and can be largely delayed, reduced or eliminated by living healthfully. This section will examine chronic disease **outcomes** (quality & length of life) along with contributing health factors including personal health **behaviors** and **environmental conditions** that lead to these outcomes.

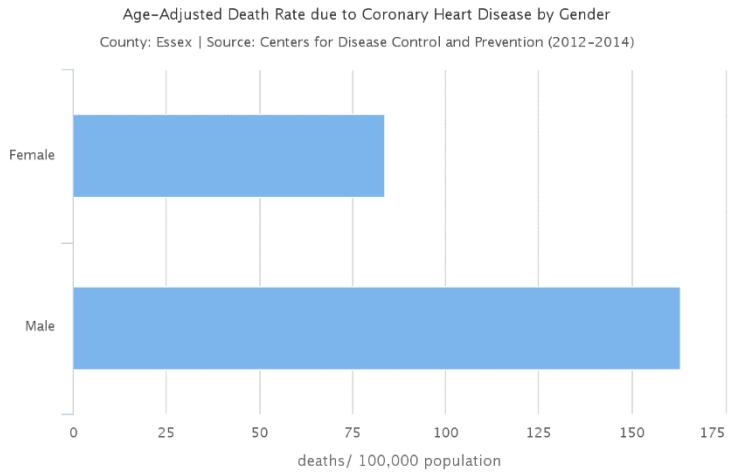
Heart Disease and Cancer continue to be leading causes of death in Essex County. Respiratory Disease and Diabetes also remain notable causes of death.

Heart & Circulatory System

Outcomes

Rates of premature death due to heart & circulatory conditions has increased since the last assessment and is higher than comparison rates for NY as demonstrated in the table below. Males experience a higher death rate than females.

Heart & Circulatory System Indicators/100,000	Essex ('08-'10)	Essex ('11-'13)	Upstate NY ('11-'13)	NY ('11-'13)
Cardiovascular Disease Premature (Ages 35-64) Deaths	50.5	127.2	96.8	99.0
Diseases of the Heart Premature (Ages 35-64) Deaths	45.3	115.3	79.9	80.6
Coronary Heart Disease Premature (Ages 35-64) Deaths	33.1	75.5	60.7	65.5
Cerebrovascular (Stroke) Deaths/100,000	53.1	36.8	38.5	30.9



Coronary heart disease (also called coronary artery disease) is the most common type of heart disease. It occurs when the coronary arteries become narrowed or clogged by fat and cholesterol deposits (plaques) and cannot supply enough blood to the heart. As the arteries narrow, or as the plaques rupture, the flow of blood to the heart can slow or stop.

Screening Behaviors/Diagnosis

Screenings based on the most recent clinical guidelines has improved since the last assessment

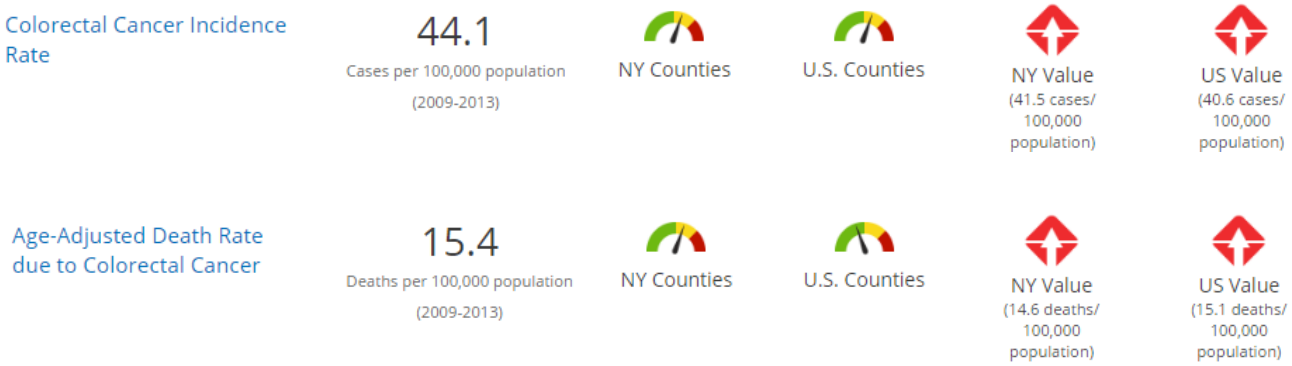
Screening/Diagnosis Indicators	Essex ('08/'09)	Essex ('13/'14)	Upstate NY ('13/'14)	NY ('13/'14)
Adults with Cholesterol Check	71.3%	78.2%	79.7%	84.2%
Adults with Diagnosed High Blood Pressure	28.2%	30.8%	30.2%	28.3%

Cancer

Outcomes

Cancer remains one of the leading causes of death in Essex County. Since the last assessment, most cancer death rates have increased (all but colon & rectum) and compared to NY most (all but Prostate) most rates are higher.

Cancer Outcome Indicators	Essex ('07-'09)	Essex ('10-'12)	Upstate NY ('10-'12)	NY ('10-'12)
Cancer Cases/100,000	689.4	664.8	610.5	550.9
Cancer Deaths 100,000	263.9	244.0	202.4	180.7
Breast Cancer Deaths/100,000 female pop.	9.7 ('07)	31.8	28.1	26.3
Ovarian Cancer Deaths/100,000 female pop.	5.3	12.3	10.4	9.5
Colon & Rectum Cancer Deaths/100,000	27.4	20.4	17.2	16.6
Prostate Cancer Deaths/100,000 male pop.	6.2	14.8	21.2	18.6
Melanoma Cancer Deaths/100,000	5.3	6.0	3.3	2.5
Oral Cavity & Pharynx Cases/100,000	14.1	17.9	13.5	12.1
Lung & Bronchus Cancer Deaths/100,000	72.4	75.7	55.9	46.4



Screening Behaviors

The percent of women having received breast cancer screening is better than NY comparisons. The percent of adults having received colorectal screening is similar to that of NY though does not meet the NYS Prevention Agenda Benchmark set at 80%.

Cancer Screening	Essex ('07-'09)	Essex ('13/'14)	Upstate NY ('13/'14)	NY ('13/'14)
Breast Cancer Screening, Women 50-74	689.4 ('07-'09)	83.0%	80.5%	80.9%
Colorectal, Adults 50-75	263.9 ('07-'09)	68.3%	70.0%	69.3%

Diabetes

Outcomes

Diabetes can have a harmful effect on most of the organ systems in the human body; it is a frequent cause of end-stage renal disease, non-traumatic lower-extremity amputation, and a leading cause of blindness among working age adults. Persons with diabetes are also at increased risk for ischemic heart disease, neuropathy, and stroke. Diabetes disproportionately affects the elderly and its incidence is likely to increase as the population ages.

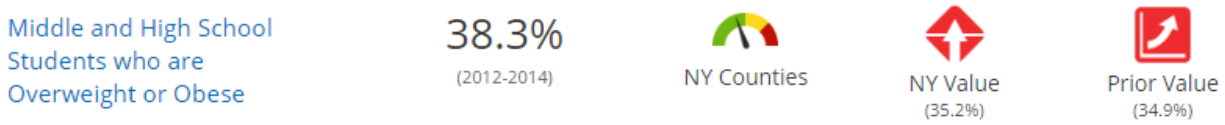
The rate of Diabetes deaths has increased since the last assessment and remains higher than Upstate and NY rates.

Diabetes Indicators (per 100,000)	Essex ('08-'10)	Essex ('11-'13)	Upstate NY ('11-'13)	NY ('11-'13)
Deaths	28.7	31.6	19.6	20.3
Hospitalization, Primary Diagnosis	12.4	11.0	15.6	19.3

Overweight & Obesity

Outcomes

Obese and overweight children and adolescents are at risk for multiple health problems during their youth and are likely to be more severe as adults. Obese and overweight youth are more likely to have risk factors associated with cardiovascular diseases, such as high blood pressure, high cholesterol, and Type 2 diabetes. The percent of children and adults who are obese continue to increase as demonstrated below.



Obesity Indicator	Essex ('08-'09)	Essex ('13-'14)	Upstate NY ('13-'14)	2018 NYS Prevention Agenda Benchmark
Adults, Obese	24.8%	32.2%	27.0%	23.2%
Adults, Overweight or Obese	64.3%	68.6%	62.2%	60.9%
School-Age Children, Obese	18.8% ('10-'12)	19.2% ('12-'14)	17.3% ('12-'14)	16.7%

Behaviors/Environmental Conditions

Obesity is a complex health condition both physiologically and socially. Certain behaviors including dietary and physical activity practices of individuals contribute to weight. However there are many environmental circumstances that either contribute or detract from an individual's behaviors and ability to maintain a healthy weight such as access to fruits, vegetables and other naturally whole foods; access to nutritionally limited/void food products; marketing and social norms related to food and eating; and access to and opportunities for a variety of physical activities. These circumstances are much more difficult to assess and measure, though limited pieces of local data are available such as those detailed already under the Prevention Agenda >Healthy & Safe Environment>Grocery/Food Access and the Recreation/Fitness Access sections .

Tobacco Use

Outcomes

Rates of Lung and Bronchus cancer cases and deaths (both per 100,000 population) have increased since the last assessment and are worse than NY comparisons. The rate of chronic lower respiratory disease deaths has decreased since the last assessment though remains higher than NY comparisons.

Tobacco Use Related Indicators (Rate/100,000)	Essex ('07-'09)	Essex ('10-'12)	Upstate NY ('10-'12)	NYS ('10-'12)
Lung & Bronchus Cancer Cases	102.4	112.2	83.0	69.6
Lung & Bronchus Cancer Deaths	72.4	75.7	55.9	46.4
Chronic Lower Respiratory Deaths	68.8 ('08-'10)	56.5 ('11-'13)	46.2 ('11-'13)	35.6 ('11-'13)

Behaviors/Environmental Conditions

Smoking tobacco is linked to asthma and breathing complications including lung and bronchus cases along with diseases of the heart. Adult smoking and access indicators are described in the table below and demonstrate a decrease in adult smoking and vendors. The percent of adult smokers does not reach the NYS Prevention Agenda Benchmark for 2018 of 12.3%. The percent of vendors with sales to minors is 3.8%; an increase from the previous assessment. A continued decrease in access to and use of tobacco products are predicted to lead to reduced rates of lung & bronchus cancer cases in the future.

Tobacco Access & Use Indicators	Essex ('09-'10)	Essex ('10-'12)	Upstate NY ('10-'12)	NYS ('10-'12)
Tobacco Vendors (rate/100,000)	135.8	54.4	22.7	41.4
Vendor Sales to Minors	1.9%	3.8%	5.5%	8.9%
Adults who Smoke	23.0% ('08-'09)	16.6% ('13-'14)	22.5% ('13-'14)	17.3% ('13-'14)

Asthma

Asthma ED visits hospitalization and death rate indicators are better in Essex County than Upstate NY and NY.

Women, Infants and Children

Health Insurance

The percent of women ages 18-64 with health insurance is 91.7% (2014).

Pregnancy, Birth

The rate of pregnancies for women ages 15-17 decreased from the last assessment (21.2 to 10.3); the rate of pregnancies for women ages 18-19 decreased from the last assessment (from 79.8 to 58.2). The percent of women receiving early prenatal care has remained fairly consistent from the previous to current assessment.

The rate of abortions for Ages 15-19 and All Ages is less than those of Upstate NY comparisons. The percent of unintended births (31.7%) has remained consistent from the last assessment and exceeds Upstate NY (26.5%) and the 2018 benchmark comparison (23.8%). The ratio of unintended births Medicaid to Non-Medicaid populations increased from the last assessment and exceeds the 2018 benchmark. The ratio of pre-term birth data for the Medicaid to Non-Medicaid population is 1.23, slightly worse than the Upstate NY (1.12) and 2018 (1.00) benchmarks.

The rate of newborn drug related hospitalizations increased from 37.6 at the last assessment to 101.9 though the total patient number is less than 10.

Select Indicators	Essex ('08-'10)	Essex ('11-'13)	Upstate NY	2018 Benchmark
Rate of Pregnancies Ages 15-17/1,000	21.2	10.3	11.7	25.6
Rate of Pregnancies Ages 18-19/1,000	79.8	58.2	47.6	NA
Early Prenatal Care	74.2%	73.3%	75.4%	NA
Unintended Births to Total Births	31.5% (2011)	31.7% (2013)	26.5%	23.8%
Ratio of Unintended Births Medicaid to Non-Medicaid	1.26	1.82	1.97	1.54
Births Within 24 Months of Previous Pregnancy	24.5%	19.5%	21.1%	17.0%
Rate of Newborn Drug Related Hospitalizations/10,000 Births	37.6 (less than 10)	101.9 (less than 10)	12.2	

WIC Pregnancy Spotlight

Examination of select indicators identifies increased risk for pregnant women and their babies. Of note is the increase of gestational diabetes for WIC Women that has continued to increase since the last assessment (from 7.9% to 9.6%) and is higher than the Upstate NY comparison (5.7%).

Select WIC Women Indicators	Essex ('08-'10)	Essex (Current)	Upstate NY (Essex Current)
Pre-Pregnancy Underweight	5.9%	5.4% ('10-'12)	4.1%
Pre-Pregnancy Obese	32.5%	29.1% ('10-'12)	28.0%
Gestational Weight Gain Greater Than Ideal	54.3%	52.9% ('09-'11)	47.1%
Gestational Diabetes	7.9%	9.6% ('09-'11)	5.7%
Gestational Hypertension	15.5%	14.5% ('09-'11)	9.1%

Breastfeeding

Indicators for breastfeeding have generally improved since the last assessment and meet or exceed Upstate NY and 2018 benchmark comparisons with the exception of WIC Women Breastfeeding at 6 Months which demonstrates a slightly lower local percent compared to Upstate NY.

Select Indicators	Essex ('08-'10)	Essex ('11-'13)	Upstate NY (Essex Current)	2018 Benchmark
Infants Exclusively Breastfed in Delivery Hospital	66.8%	75.0%	51.1%	48.1%
Ratio Infants Exclusively Breastfed in Delivery Hospital Medicaid to Non-Medicaid	.80	.86	.69	.66
Infants Receiving Any Breastmilk in Delivery Hospital	69.3%	80.1%	78.0%	NA
WIC Women Breastfeeding at 6 Months	20.0%	19.9%	27.8%	NA

Child Health

Indicators for children including having health insurance and receiving recommended well child visits has improved from 2010-2014 as demonstrated in the data below though some do not yet meet the 2018 benchmark comparison.

Select Indicators	Essex (2010)	Essex (2014)	Upstate NY (Same as Essex Current)	2018 Benchmark
Children with Health Insurance	93.6%	95.8%	96.6%	100%
Children with Recommended Child Health Visits, Ages 0-15 Months, Government Months, Health Insurance	62.5%	92.2%	84.3%	91.3%
Children with Recommended Child Health Visits, Ages 3-6 Years, Government Months, Health Insurance	77.1%	86.2%	81.4%	91.3%
Children with Recommended Child Health Visits, Ages 12-21 Years, Government Months, Health Insurance	46.3%	53.1%	62.0%	67.1%

Lead Screening

The percent of children screened for lead levels has decreased, at both By 18 months at By 36 months, and is less than the Upstate NY comparison.

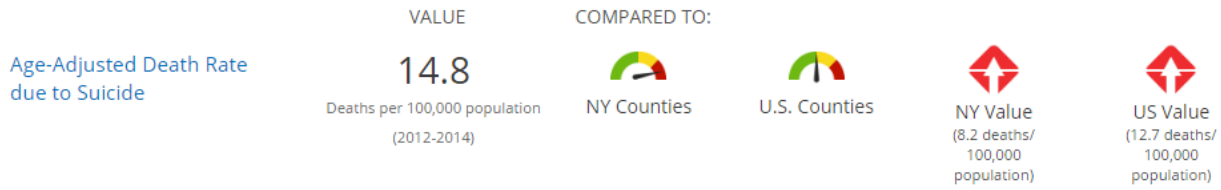
Oral Health

The percent of Medicaid Enrollees Ages 2-20 with at least One Dental Visit increased from the previous to current assessment. The percent of 3rd Graders with dental sealants is 34.5% ('09-'11). The rate of Caries ED visits for children ages 3-5 increased from 48.9 ('08-'10) to 85.5 ('11-'13).

Mental, Emotional, Behavioral Health and Substance Abuse

Mental Health

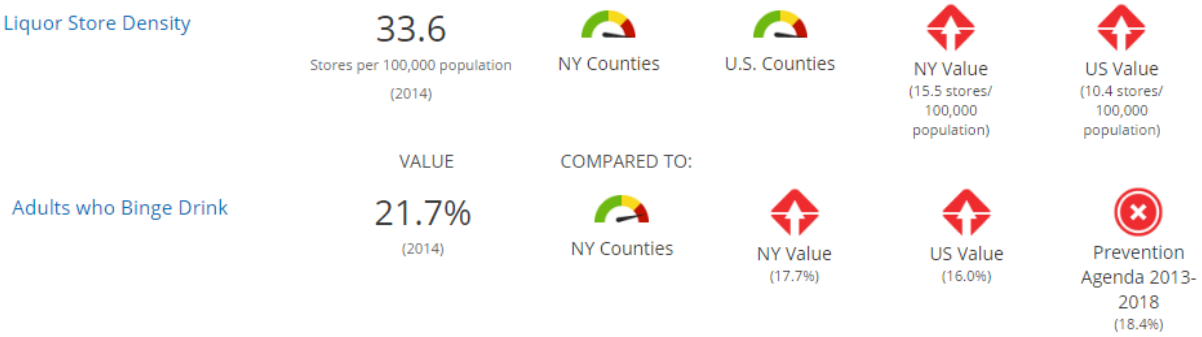
Psychological distress can affect all aspects of our lives. Men are more likely than women to suffer death by suicide. Repercussions of suicide include the emotional toll on family and friends and combined medical and lost work costs on the community.



Outcome Indicators	Essex (Previous)	Essex (Current)	Upstate NY (Same as Essex Current)	2018 Benchmark
Age-Adjusted Suicides/100,000	6.8 ('08-'10)	14.8 ('11-'13)	9.5	5.9
Self-Inflicted Hospitalizations/10,000	8.4 ('08-'10)	6.8 ('11-'13)	6.8	NA
Adults with Poor Mental Health (14+ days) in the Last Month	8.8% ('08/'09)	11.3% ('13-'14)	11.8%	10.1%

Alcohol

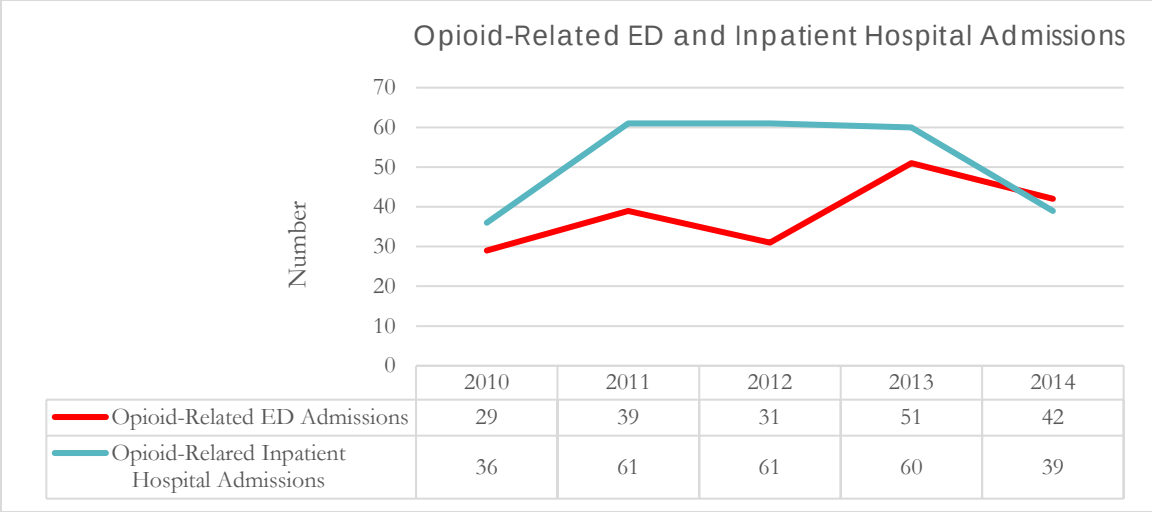
High alcohol outlet density has been shown to be related to increased rates of drinking and driving, motor vehicle-related pedestrian injuries, and child abuse and neglect. In addition, liquor stores frequently sell food and other goods that are unhealthy and expensive. Setting rules that mandate minimum distances between alcohol outlets, limiting the number of new licenses in areas that already have a high number of outlets, and closing down outlets that repeatedly violate liquor laws can all help control and reduce liquor store density.



Select Indicators	Essex ('08-'10)	Essex ('11-'13)	Upstate NY	2018 Benchmark
Cirrhosis Deaths/100,000	13.9	12.0	8.7	NA
Alcohol-Related Injuries & Deaths/100,000	67.9	54.7	44.4	NA
Alcohol-Related Crashes	Change in data reporting	102.6	43.4 (NY)	NA

Opioids/Drugs

Opioids and all drugs, having devastating health and social consequences on the population, is a public health and health care issue. Prescription opioid misuse and heroin related morbidity and mortality (overdose/drug poisoning and death) has been increasing across the US, NY and Essex County. NYS DOH and the AIDS Institute, *Opioid Poisoning, Overdose and Prevention; 2015 Report to the Governor and NYS Legislature*[22](used for all data in this section), describes over 47,ooo lives lost in 2014; 61% attributed to prescription opioids and heroin and that heroin-related overdoses have tripled in the US from 2011-2014. Essex County opioid-related ED Admission have increased by 44.8% from 2010-2014 compared to NY state-wide increase of 73.1%. The inpatient hospital admission decreased by 37.1% for this same time period.



	2010	2011	2012	2013	2014
Opioid-Related ED Admissions	29	39	31	51	42
Opioid-Relared Inpatient Hospital Admissions	36	61	61	60	39

Overdose/Death Data

From 2009 to 2013, the percent of heroin-related deaths increased by 163% in NY; opioid-related deaths by 30%. NY data available for 2013 demonstrate four-times as many men died to heroin-related overdoses than women, and whites at twice the rate of blacks. For the same year the data demonstrates twice as many men compared to women died of opioid-related overdose; whites at a rate twice that of blacks and Hispanics.

Select Indicators	Essex	Essex	Upstate NY	NY
Drug-Related Hospitalizations/10,000	13.9 ('08-'10)	10.5 ('11-'13)	20.4	23.9
Deaths Due to Overdose (2009-2013) Mean Annual Frequency	Unknown	3	1,099	1,755
Deaths Due to Drug Overdose: Heroin (2009-2013) Mean Annual Frequency 5-Year Total	Unknown	less than 6 – not reported	223	368
Deaths Due to Drug Overdose: Opioids (2009-2013) Mean Annual Frequency 5-Year Total	Unknown	less than 6 – not reported	543	844

The reported number of law-enforcement Naloxone administrations through the end of 2015 is 3 for Essex County. For all Naloxone administered by Law Enforcement in NY, the greatest percent (42.4%) was administered to 25-34 year olds, followed by 30.9% to 15-24 year olds.

[22] NYS DOH and the AIDS Institute. Opioid Poisoning, Overdose and Prevention; 2015 Report to the Governor and NYS Legislature. Available online at http://www.health.ny.gov/diseases/aids/general/opioid_overdose_prevention/docs/annual_report2015.pdf

Communicable Diseases

Zoonoses

Communicable diseases of concern in Essex County include tick-borne diseases (Lyme Disease and Anaplasmosis) and rabies. Lyme Disease case rates increased from 79.2(/100,000) from the last assessment ('08-'10) to 103.5 in the current assessment ('11-'13); higher than Upstate and NY comparisons. Anaplasmosis has recently been documented in Essex County and is considered an emerging concern with 2 confirmed and 3 probable cases in 2015. The rabies rate is 28.2 (per 100,000 for '11-'13); significantly higher than the upstate rate of 1.9 and an increase from the previously assessed rate of 7.8 (per 100,000 for '08-'10).

Vaccine-Preventable Diseases

The percent of children ages 19-35 months with recommended immunizations increased from the previous to current assessment though this percent (61.5%) does not yet meet the 2018 benchmark of 70.7%. However the percent of females ages 13-17 with 3 doses of HPV increased from 15.7% to 24.7%. The percent of adults ages 65+ with flu and pneumonia vaccines decreased since the last assessment, though so did hospitalizations for those illnesses.

Select Indicators	Essex (Previous)	Essex (Current)	Upstate NY (Same as Essex Current)	2018 Benchmark
Children Ages 19-35 months with 4:3:1:3:3:1:4	46.0% (2011)	61.5% (2014)	59.4%	70.7%
Pertussis Cases/100,000	5.2 ('08-'10)	16.3 ('11-'13)	12.9	NA
Females Ages 13-17 with 3 Dose HPV	15.7% (2011)	24.7% (2014)	30.3%	50.0%
Adults Ages 65+ with Flu Shot in the Last Year	72.6% ('08/'09)	68.3% ('13-'14)	77.1%	70.0%
Adults Ages 65+ Ever Received Pneumonia Shot	76.2% ('08/'09)	59.3%	70.7%	NA
Pneumonia/Flu Hospitalizations Ages 65+/100,000 Ages 65+	188.5 ('08-'10)	133.7 ('11-'13)	121.9	NA

Healthcare Associated Infections

Healthcare-associated infections including both hospital onset and community onset indicators demonstrate values less than 10.

HIV/AIDS

Essex County data continues to demonstrate less than 10 cases of newly diagnosed HIV and AIDS cases.

STDs

Essex County data demonstrates rates of selected sexually transmitted diseases (Syphilis, Gonorrhea and Chlamydia) that are considerably less than comparison Upstate and NY state rates.

Community Health Improvement & Service Plan 2016-2018

The Improvement & Service Plan describes interventions based on evidence based programs, policies and practices as described in the NYS DOH Prevention Agenda Prevention Agenda 2013-2018: Preventing Chronic Diseases Action Plan.[23] Goals are set based on indicators from the Community Health Assessment. Ongoing analysis of these indicators will be used to evaluate the long-term outcomes of these plans. Interim performance measures will capture progress of activities related to each strategy. The tables in this section detail how priority health issues will be addressed by Lead organizations and through Partner (broader community) engagement. Lead organizations assume responsibility for facilitating, coordinating and evaluating (using performance measures) each activity as described in the Plan. Lead organizations will ensure Partner engagement through established and ad-hoc groups; formal and informal meetings and communications.

Summary of Priorities, Strategies & Lead Organizations 2016-2018

1. Reduce obesity in children and adults	Public Health	Hospitals
Strategy 1.1: Create **community environments** that promote and support healthy food and beverage choices and physical activity.	x	
Strategy 1.2: Prevent childhood obesity through **early child-care and schools**.	x	
Strategy 1.3: Expand the role of **health care and health service providers** and insurers in obesity prevention.	x	x
Strategy 1.4: Expand the role of **public and private employers** in obesity prevention.	x	x
2. Increase access to high quality chronic disease preventive care and management in clinical & community settings	**Public Health**	**Hospitals**
Strategy 2.1: Increase **screening rates** for cardiovascular disease, diabetes and breast, cervical and colorectal cancers, especially among disparate populations.	x	x
Strategy 2.2: Promote **evidence-based care** to manage chronic diseases.		x
Strategy 2.3: Promote culturally relevant **chronic disease self-management education**.	x	x

Summary of Disparities of Focus 2016-2018

For each priority, interventions and activities are designed to reduce disparities and improve social justice. This is accomplished by:

- determining individuals and communities at increased risk;
- targeting these populations for interventions;
- partnering with community-based stakeholders;
- assuring culturally-relevant interventions that consider **priority disparities** including **income (socioeconomic status)**, **an aging population** and **access to care**.

[23] NYS DOH. Prevention Agenda 2013-2018: Preventing Chronic Diseases Action Plan. Available online at https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/chronic_diseases/

Reduce Obesity in Children and Adults

Goal: Reduce the percent of school-age children and adults who are obese to meet 2018 NYS Prevention Agenda Benchmarks:

School age children: **19.2%** to **16.7%**
Adults: **32.2%** to **23.2%.**

Strategy 1.1: Create community environments that promote and support healthy food and beverage choices and physical activity.			
Intervention: Improve retail availability of nutritious foods and beverages & educate consumers on how to select the healthiest options.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Improve offerings at small stores; improve visibility and access through store layout & displays by implementing *Better Choice Retailer* or other similar on-site marketing/cues for healthier choices.	Income Target communities that met socioeconomic indicators making them eligible for the Creating Health Schools & Communities (CHSC) grant program.	Public Health with- Creating Health Schools & Communities (CHSC) grant program small store operators grocery stores Community Action Program (CAP) participants Office for the Aging (OFA) existing social groups (faith, parent, senior)	Number of stores that have improved offerings. Number of stores that improve visibility & access
Educate consumers about food shopping assistance systems (such as NuVal or the Stars Program) to encourage purchase of healthier options when shopping in grocery stores.	Income & Aging Population Target education to income-eligible Community Action Program (CAP) participants and OFA senior clients.		Number of education sessions offered. Number of participants reached.
Intervention: Adopt, strengthen & implement local policies & guidelines that facilitate increased physical activity for residents of all ages & abilities.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Adopt, improve or implement *Complete Streets* principles through: • policies or resolutions • land use planning (comprehensive; local use local law) • projects • education & encouragement activities.	Income Target low-income communities for policy adoption, land use planning and projects to ensure residents of these neighborhoods are afforded living conditions that follow complete streets principles. Income & Aging Ensure housing developments/units that serve low-income and aging populations are well-served through complete streets projects.	Public Health • CHCS Grant program • Local Government • Office for the Aging (OFA) • Trail Groups	Number of policies or resolutions adopted. Number of land use planning documents impacted.

Strategy 1.2: Prevent childhood obesity through early child care and schools.			
Intervention: Increase the number of schools that establish strong nutritional standards for all foods & beverages sold and provided through the school.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Partner with public schools to update school wellness policies and practices to include: • School meals • Concessions • Fundraising.	Income Target schools that met socioeconomic indicators making them eligible for the Creating Health Schools & Communities (CHSC) grant program. Target additional schools that meet similar socio-economic standards such as the percent of students eligible for free & reduced lunches.	Public Health with- • Creating Health Schools & Communities (CHSC) grant program • Public schools • Farmers and farm groups • Parent groups	Number of districts with updated wellness policies that meet target criteria.
Intervention: Increase the number of schools that meet NYSED regulations to increase activity before, during & after the school day.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Partner with public schools to update school wellness policies and practices to include: • active recess • classroom activity breaks.	Income Target low-income communities for policy adoption, land use planning and projects to ensure residents of these neighborhoods are afforded living conditions that follow complete streets principles. Income & Aging Ensure housing developments/units that serve low-income and aging populations are well-served through complete streets projects.	Public Health with- • CHCS Grant program • Local Government • Office for the Aging (OFA) • Trail Groups	Number of districts with updated wellness policies that meet target criteria.

Intervention: Increase the number of and awareness of day breastfeeding friendly child care providers.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Partner with the CAP to: • encourage breastfeeding friendly child care providers • update breastfeeding friendly provider lists.	Access & Income Target child care providers to ensure breastfeeding friendly providers are available across geographic areas & provider fee ranges.	Public Health with- • Adirondack CAP • WIC	Number and location of breastfeeding friendly child care providers is made available through Adirondack Community Action Program, WIC & websites.

Strategy 1.3: Expand the role of health care and health service providers and insurers in obesity prevention.			
Intervention: Link health care with community-based programs and services for breastfeeding counseling and support.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Partner with health care providers on the adoption of breastfeeding friendly clinic practices & environmental supports.	Access Target provider practices across the geographic region.	Public Health with – • Hospitals (All) • Hospital-owned health centers • FQHCs • Other health care outpatient facilities/centers	Number of provider practices that have adopted breastfeeding friendly policies and implemented environmental supports.
Conduct Public Health Detailing with primary care providers regarding locally available breastfeeding counseling and support resources including the Certified Lactation Consultant (CLC) available to WIC participants and Internationally Certified Lactation Consultant (IBCLC) available through the LHD to anyone in the county.	Income Assure providers are aware of resources available to WIC-eligible families and all families in Essex County.		Number of public health detailing sessions with providers. Number of women who use locally available breastfeeding support resources.
Provide a Women's Health Navigator, reprint Women's Guidebook and operate the associated phone line.	Access Target women and provide necessary information for any and all health needs for her and her family.	Hospital Adirondack Health • Hospital-owned health centers	Number of referrals
Intervention: Increase the capacity of primary care providers to implement screening, prevention and treatment measures for obesity in children and adults.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Expand access to and consistency of primary patient care to implement screening prevention & treatment for obesity.	Access Construct a new primary care center in an underserved area and add a mid-level provider.	Hospital UVHN Elizabethtown Community Hospital	Complete the move of the health center into new building. Number of new patients served.
Conduct Public Health detailing with primary care providers regarding locally available chronic disease self-management and other community-based prevention programs and opportunities to assist with patient measure to reduce weight.	Access & Age Ensure community opportunities are geographically accessible. Ensure age-appropriate opportunities are available & promoted.	Public Health and Hospitals (All) with – • Hospital-owned health centers • FQHCs • Other health care outpatient facilities/centers	Number of sessions & providers reached through public health detailing sessions.
Providers at primary care clinics will document patient BMI, develop a plan with the patient & document in the patient EMR.	Access Target population will have discussion with provider and referral to community-based opportunities.	Hospital UVHN Elizabethtown Community Hospital	Number of patients with BMI >25 with documented discussion with provider twice yearly regarding plan for overweight/obesity.

Strategy 1.4: Expand the role of public and private employers in obesity prevention.			
Intervention: Strengthen business practices that align with the NYS Labor Law to support breastfeeding at work.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Increase the number of employer sites that have policies and practices to support breastfeeding friendly work environments.	Income Target lower-wage employers.	Public Health with- • WIC • Small business owners • Franchise owners	Number of worksites that have adopted breastfeeding friendly policies and practices.
Intervention: Increase adoption of food procurement and vending policies based on the Dietary Guidelines for Americans.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Partner with local farmers on a farm to employer initiative to allow employees to pre-order goods to be delivered to worksites for pick-up.	Access Target large employers to increase access to farm-fresh produce and goods.	Hospital UVHN Elizabethtown Community Hospital and MLH with- • Farmers • Farmer organizations/representatives • Employers (potential employers include schools, Mountain Lakes Services, Ticonderoga Mill)	Number of employers that have implemented a farm to employer initiative. 2018 goal is to extend this to MLH campus as well.
Improve vending options at hospitals, health centers & employers to support employee health & wellness and role modeling for patients and visitors.	Aging Provide consistent messaging for aging patients.	Public Health and Hospitals (All) with- • Health care systems (FQHCs; others) • Local vending company • Employers (potential employers include schools, Mountain Lakes Services, Ticonderoga Mill)	Number of hospitals/health care systems that have improved vending options. 2018 goal to improve vending choices as MLH cafeteria closes.
Offer lifestyle modification workshops to local employers to prevent obesity.	Partner with community employers to offer on-site lifestyle modification workshops.	Hospital UVHN Elizabethtown Community Hospital and MLH	Number of worksites which have taken part in program. Extend to MLH campus as it comes under ECH (projected for 2017).

Increase access to high quality chronic disease preventive care and management in clinical and community settings.

Goal: Reduce morbidity & mortality due to chronic conditions including cardiovascular disease, diabetes and cancers to meet or be less than Upstate NY comparisons:

Cardiovascular Disease, Premature (Ages 35-64) Deaths/100,000	**127.2 to**	**<=96.8**
Diseases of the Heart, Premature (Ages 35-64) Deaths/100,000	**115.3 to**	**<=79.9**
Diabetes Deaths/100,000	**31.6 to**	**<=19.6**
Cancer Cases/100,000	**664.8 to**	**<=610.5**

Strategy 2.1: Increase screening rates for chronic conditions, especially among disparate populations.			
Intervention: Use media and health communications to build public awareness and demand.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Use paid and earned print media, social media and community outreach to raise awareness of need and demand for screening for chronic conditions.	Income Target those without health insurance/eligible for the Cancer Services Program.	Public Health & Hospitals (All) with- • Franklin & Essex Cancer Screening Program (CSP) • Media • OFA/NY Connects • Food pantries	Number of media and outreach activities conducted. Number of individuals served through the CSP.
Intervention: Ensure consumer access to screening, intervention and coverage for chronic disease.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Offer cancer screening events at least twice per year at different locations in the county.	Income, Access & Aging Target people eligible for the CSP to ensure screening is available to those ages 50+ without health insurance.	Public Health & Hospitals (All) with- • Franklin & Essex Cancer Screening Program • Media • OFA/NY Connects • Food pantries	Number of events offered. Number of individuals served through screening events.
Offer diabetes screenings at community health events	Access Target those without health insurance and increase ability of diabetes screening	Hospital UVHN Elizabethtown Community Hospital and MLH	Number of screenings completed. Extend to MLH campus in 2017/2018.
Screen all adult patients with a history of tobacco use for COPD.	Patients will complete tobacco use survey. Spirometry testing will be available at each health center for those identified as 'at risk' by survey.	Hospital UVHN Elizabethtown Community Hospital	Number of new patients and current patients screened.

Intervention: Expand the use of health information technology to remind clinicians to screen for pre-diabetes and diabetes.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Use public health detailing to increase the number of health care practices that adopt policies and a system for identifying & referring patients with pre-diabetes & diabetes.	Access & Income Adoption of policies and systems ensures universal screening and referral.	Public Health & Hospital UVHN Elizabethtown Community Hospital Diabetes Educator at ECH	Number of practices that adopt a policy for identification and referral system for care.

Strategy 2.2 Promote evidence-based care to manage chronic diseases.			
Intervention: Establish clinical-community linkages that connect patients to self-management education and community resources.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Establish an Outreach Coordinator position & a Chronic Disease Care Coordinator position to facilitate care & link of patients to care & community resources.	Access Facilitate access to care & community resources for patients.	Hospital UVHN Elizabethtown Community Hospital & Public Health	Positions established & filled.
Offer at least two (2) Better Breathers program to community annually.	Access ALA sponsored pulmonary exercise and education program.	Hospital UVHN Elizabethtown Community Hospital	Number of programs provided each year.
Establish a system for identifying & referring patients for Smoking Cessation.	Access, Income Universal screening likely to identify income-limited patients eligible for smoking cessation services.	Hospital UVHN Elizabethtown Community Hospital	Referral built into GE (EMR).
Offer cardiac or pulmonary rehab to any patient who qualifies.	Access, Income Universal screening likely to identify income-limited patients eligible for smoking cessation services.	Hospital UVHN Elizabethtown Community Hospital	Number of patients served through these programs.

Strategy 2.3 Promote culturally relevant chronic disease self-management education.			
Intervention: Develop infrastructure for widely accessible, readily available lifestyle intervention professionals and opportunities.			
Activity	Disparity & how it is being addressed	Lead & Partners	Performance Measure
Assure instructors for chronic disease self-management (CDSM) classes are trained.	Access, Aging, Income Provide classes at no or low cost	Hospital UVHN Elizabethtown Community Hospital, MLH, & Public Health with- • Eastern Adirondack Health Care Network • Office for the Aging/NY Connects Low-income housing facilities	At least 3 instructors trained. Extend to MLH campus in 2018.
Provide CDSM classes at least twice per year in Essex County.	Access, Aging, Income Provide classes at no or low cost. Target low-income/high risk communities. Target seniors.	Hospitals (All) & Public Health • Hospital-owned health centers • FQHCs • Other health care outpatient facilities/centers • OFA/Senior Nutrition Sites • Community Centers	Number of classes conducted and participants completed in CDSM.
Assure trained lifestyle intervention professionals are available in clinical and community settings.	Access, Aging, Income Provide classes at no or low cost. Target low-income/high risk communities. Target seniors.	Hospitals (All) & Public Health • Hospital-owned health centers • FQHCs • Other health care outpatient facilities/centers • OFA/Senior Nutrition Sites • Community Centers	Professional resource list of Chronic Disease Self-Management (CDSM) professionals is developed.

Intervention: Establish clinical-community linkages that connect patients to self-management education and community resources.			
Activity	**Disparity & how it is being addressed**	**Lead & Partners**	**Performance Measure**
Maintain a community resource list of Chronic Disease Self-Management (CDSM) opportunities including multi-session education series, support groups, etc.	Income Assure there are no or low cost options available. Access, Income Assure opportunities are easily accessible to those with limited income & transportation. Aging Assure opportunities are offered at times and locations and content is targeted for the aging population.	Public Health with- • Eastern Adirondack Health Care Network • Office for the Aging/NY Connects • Low-income housing facilities	Create and make available to clinicians & the public community based CDSM opportunities.
Use public health marketing & communication to share opportunities for CDSM in the community setting.	Income Target community outreach efforts to those with limited income or transportation.	Public Health with- • Franklin & Essex Cancer Screening Program (CSP) • Media • OFA/NY Connects • Food pantries • Low-income housing facilities	Number of marketing/communications promoting CDSM in the community.
Use public health detailing to increase the number of health care practices that adopt policies and a system for identifying & referring patients to chronic disease self-management opportunities in the community setting.	Access & Income Adoption of policies and systems ensures universal screening and referral.	Public Health and Hospitals (All)	Number of hospital healthcare systems that have an established system in place.

Crosswalk of Other Initiatives of Essex County Health Partners with CHIP/CSP Priorities, Emerging Issues & Disparities

This section serves to identify how other initiatives of Essex County Health Partners align with Priorities & Disparities identified in the CHIP/CSP. These initiatives support, not supplant, efforts to achieve shared community health improvement goals.

Initiatives

		CHIP/CSP Priorities		Emerging	Disparities			Essex County Health Partners			
TYPE	DESCRIPTION	Obesity	Chronic Disease	MEB/SA	Income	Aging	Access	AH	ECH	MLH	ECHD
DSRIP	2ai Integrated Delivery System	X	X		X		X	X	X	X	
	2aii Advancing Primary Care	X	X		X		X	X	X		
	2aiv Medical Village		X		X	X	X			X	
	2bviii Hospital-Home Collaboration Solutions	X	X		X	X		X			
	2di Patient Activation	X	X	X	X	X	X	X			X
	3ai Integrate Behavioral Health with Primary Care		X	X	X		X	X	X		
	3aii Crisis Stabilization				X		X				
	3aiv Withdrawal Management				X		X				
	3gi Integrate Palliative Care into the PCMH Model			X	X	X		X			
	4aiii Mental Health & Substance Abuse Infrastruct.			X	X		X				X
	4bii Chronic Care: COPD		X		X	X	X	X	X		X
Grants	Vital Access Providers (VAP) Program						X	X	X	X	
	MAX Program: Medicaid Accelerated eXchange Series				X		X	X			
	Essential Provider Medical Village Grant		X			X	X		X	X	
	Creating Healthy Schools & Communities Grant										X
	Linking **I**nterventions **F**or **T**otal (LIFT) Population Health grant (pending approval/funding)	X	X		X		X		X	X	X
Community Benefit	Diabetes Self-Management Program	X	X				X	X	X		
	Diabetes Support Group	X	X		X		X		X		
	Integrative Healthcare (Yoga, meditation, etc.)		X	X				X			
	Walk/Run Health Events	X		X				X	X		
	Chronic Disease Self-Management Resources List		X		X	X	X	X	X	X	X
	Health Symposiums, Monthly Community Health Outreach Series, Screening & Other Health Events	X	X	X	X	X	X	X	X	X	X
	Women's Guidebook & Navigator						X	X			
	Respecting Choices Palliative Care			X				X			
	Employee Wellness Programs/Open Enrollment Ed.	X	X				X	X	X	X	X

Regional Priority

The Community Health Assessment (CHA) Committee identified and selected **Chronic Disease Prevention and Management** as a regional priority in support of the NYS Prevention Agenda 2013-2018. Essex County Health Partners, through active participation in the ARHN and with all the regional CHA partners, will work to identify interventions that have the potential for a regional impact on Chronic Disease Prevention and Management. The Committee's initial discussions about how best to support the regional priority included:

- Identifying a subject matter expert speaker(s) for the region;
- Implementing a media campaign;
- Creating Prevention Agenda projects;
- Using social media outlets and websites to raise awareness of initiatives and programs currently in place from partners and others in the region; and
- Creating a new page on the ARHN website to house resources and links to evidence-based strategies.

The Committee will continue to explore strategies on how to best support a regional priority through its regular meetings.

Resource Allocation to Achieve Goals

Essex County Health Partners will work collaboratively to allocate staff and resources (data, meeting rooms, educational materials & more) to implement these identified strategies and achieve established goals. Additional resources available through other initiatives and grant-funded projects including those described in the above chart may be used to support these goals.

Essex County Health Partners are involved in regional initiatives that support these priorities, address disparities, and engage a broad range of community stakeholders to improve health. The independent not-for-profit, Adirondack Health Institute, plays a large role in regional health through its Community Health and Health System Transformation projects.

Community Health

- Adirondack Rural Health Network (ARHN) - regional health assessment & planning facilitation;,
- Enrollment Assistance Services and Education (EASE) - health insurance navigation & enrollment services; and
- Population Health Improvement Program (PHIP) stakeholder engagement to advance the NYS Triple Aim of improving health, enhancing quality & reducing costs

Health System Transformation

- Adirondack Health Home - care coordination for high-risk Medicaid individuals;
- Adirondack Medical Home Initiative (AMHI) -provider and insurer partnership to assure quality, effective care while reducing costs, enhanced management of chronic conditions and assurance of close provider-patient relationships; and
- Performing Provider System (PPS)/Delivery System Reform Incentive Payment Program (DSRIP) - restructure the health care delivery system by reinvesting in the Medicaid program & addressing social factors that impact health. See **Appendix L** for details of AHI PPS DSRIP Projects.

Dissemination of this Plan

The engagement of community partners is essential to positively influencing the entire health system. The dissemination of this document is one piece of community awareness of health issues and engagement in addressing health priorities. Essex County Health Partners will each make this document available on their respective websites by March 31, 2017. This document will be made available to Adirondack Rural Health Network for posting on that website for regional access.