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.

[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

Essex County Health Partners, though not lead organizations in these priorities, are active partners in collaborative efforts to advance this Plan.

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.