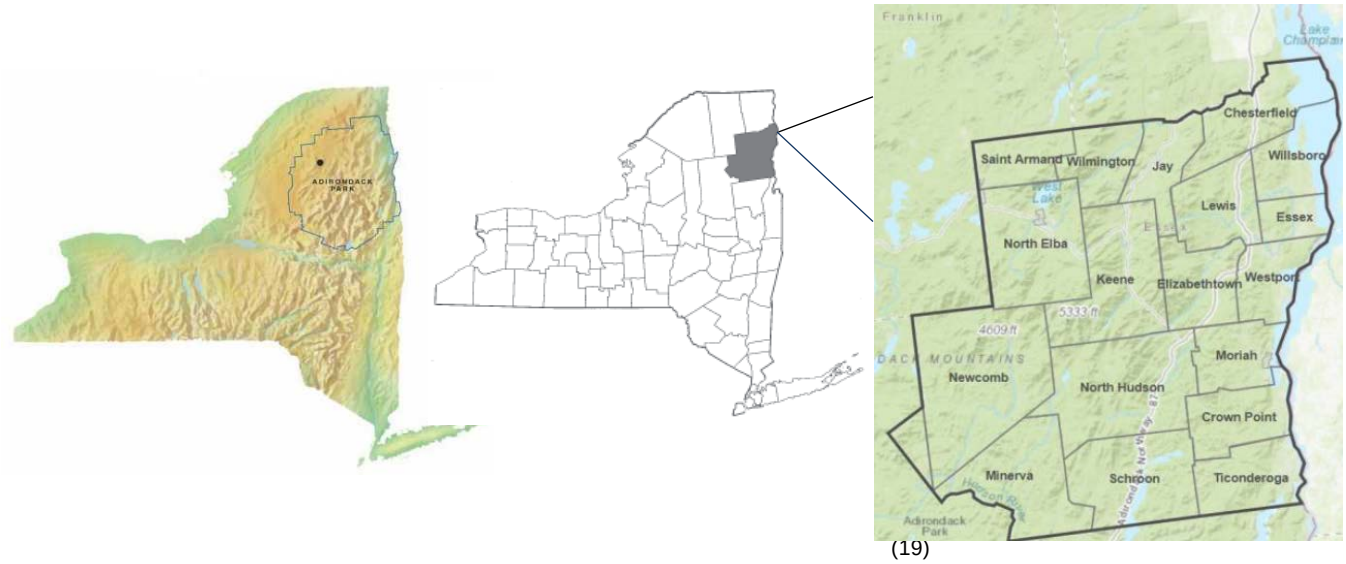
PART I: INTRODUCTION

County Snapshot

Geography (4, 19, 63)

Essex County is the 2nd largest county in New York State geographically, and the 3rd least densely populated. The county includes 18 Towns and two (2) Villages. One of the villages, Saranac Lake, is situated partially in Essex County and partially in Franklin County to the west.



(19)

Essex County is the only county in the state situated entirely within the Adirondack Park – 6.1 million acres of public and privately owned land, corresponding with the border of the Adirondack Mountains. The park use is regulated by the Adirondack Park Agency, "ensuring the preservation of more than 10,000 lakes, 30,000 miles of rivers and streams, and a wide variety of habitats, including wetlands and old-growth forests".

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

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

Demographics (63)

The population has declined about 5% since the last census in 2010, with approximately 37,300 residents calling Essex County home. Of that, 23% are 65 years or older, 27% are disabled, and 10% are veterans. The population is approximately 93% white, although increasingly diverse, with minority populations constituting 7% of the makeup of the county. Additionally, there is a growing Amish community, with approximately six (6) large families settling in the Champlain Valley region.

The median income is about $55,300, with unemployment averaging 3.2%, and 9% living below the poverty line.

Health

The region is challenged by a high incidence of chronic disease, with obesity, diabetes, and smoking-related illnesses being top concerns. Access to health care is a crosscutting priority, as Essex County holds three health professional shortage area (HPSA) designations: Primary Care and Mental Health (related to geography) and Dental Care for the low income population.

According to the 2019 County Health Rankings and Roadmaps, Essex County ranked 10 out of 62 counties in New York State for Health Outcomes and 13 for Health Factors. Refer to Part II of this report for a more in-depth analysis of the social landscape factors in Essex County that contribute to health and well-being.

Political Affiliations and Governance

Politically, Essex County is considered a swing county – voting for George W. Bush in the 2000 and 2004 elections, Barrack Obama in 2008 and 2012, and Donald Trump in 2016 (16). Prior to 1996, Essex County was staunchly Republican, voting for a Democratic Presidential candidate only once since the Civil War (67). Of the 26,307 registered voters in the county, 11,733 are Republican, 7,055 are Democrat, and 2,029 are Independent (56).

Essex County is governed by a Board of Supervisors, with 18 Town Supervisors serving as board members. Currently, the board includes 12 Republicans, 5 Democrats, and 1 Independent. In 2020, this will shift slightly, with 11 Republicans, 4 Democrats, and 3 Independents comprising the board.

Political affiliations and responsibilities to the voting constituency can present challenges for advancing public health priorities at the local level; however, Essex County residents have enjoyed a strong leadership commitment to health initiatives overall. For example, in 2018, Essex County lawmakers approved a bill outlawing the sale of tobacco products to anyone under the age of 21, prior to the state adopting the measure in July 2019.

This political profile – Republican majority - is in contrast to the current New York State government, where the governorship, House Assembly and Senate are all controlled by the Democratic Party. (35)

Several state-wide legislative initiatives have been passed recently that stand to have a significant impact on public health practice and outcomes. These include, but are not limited to:

- Removal of non-medical exemptions from school vaccination;
- Lead Poisoning Prevention Mandate (lowering actionable elevated blood lead level from 10 mcg/dL to 5 mcg/dL);
- Update of the Adolescent Tobacco Use Prevention Act (ATUPA) increasing the minimal legal sale age of tobacco and e-cigarettes from 18 to 21 years;
- Temporary ban on flavored e-cigarette liquids;
- Package of bills to help address the heroin and opioid epidemic, as well as prescription drug abuse. (69)

Understanding the circumstances in which people live in Essex County informs the Community Health Assessment giving more in-depth meaning to the data and health indicators reviewed. The remaining sections in this part of the report describe the rationale, governing documents, and the process that provided the framework for conducting this assessment and devising the improvement plan.

Purpose

The purpose of the Community Health [Needs] Assessment (CHA) is to learn about the community including the:

- health of the population including priority health issues;
- contributing factors to health risks and outcomes; and
- community resources and assets that can be mobilized to improve population health.

This comprehensive CHA is the basis for the Community Health Improvement/Service Plan (CHISP); a later Part of this report.

Guidance, Requirements and Standards

NYSDOH Guidance

This CHA is informed by guidance provided in the New York State Department of Health (NYSDOH) Prevention Agenda (48). The Prevention Agenda is the state's health improvement plan and serves as a blueprint for local action to improve health and well-being for all and promote health equity in populations experiencing disparities. It provides resources for data collection and analysis and includes standards of adhering to evidenced based interventions.

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

Federal Requirements

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

National Accreditation Standards (57)

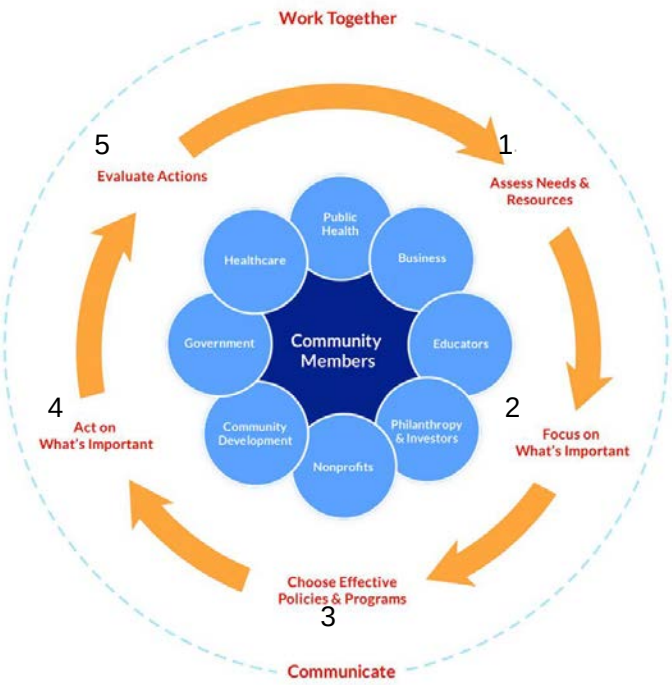
This CHA has been conducted in a manner that meets Public Health Accreditation Board (PHAB) standards; Version 1.5.

Methodology

Collaborative Process Model

The collaborative process used to develop the Community Health Assessment (CHA) and Community Health Improvement/Service Plan (CHISP) is the Take Action Cycle, a model developed by **County Health Rankings and Roadmaps** (58), a collaboration of the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.

Take Action Cycle



The **Take Action Cycle** emphasizes how to create a healthier community (see diagram), wrapped with necessary elements of working together and communication. Each **Take Action Cycle** step includes key steps to undertake in an intentional process of community engagement in examining health issues, analyzing the social determinants of health contributing to health issues and identifying community assets that can be mobilized to address health needs.

Steps 1 - 2 are demonstrated in the CHA.

Steps 3 – 5 are demonstrated in the CHISP.

Step 1: Assess Needs and Resources

Framework for Conducting the Assessment

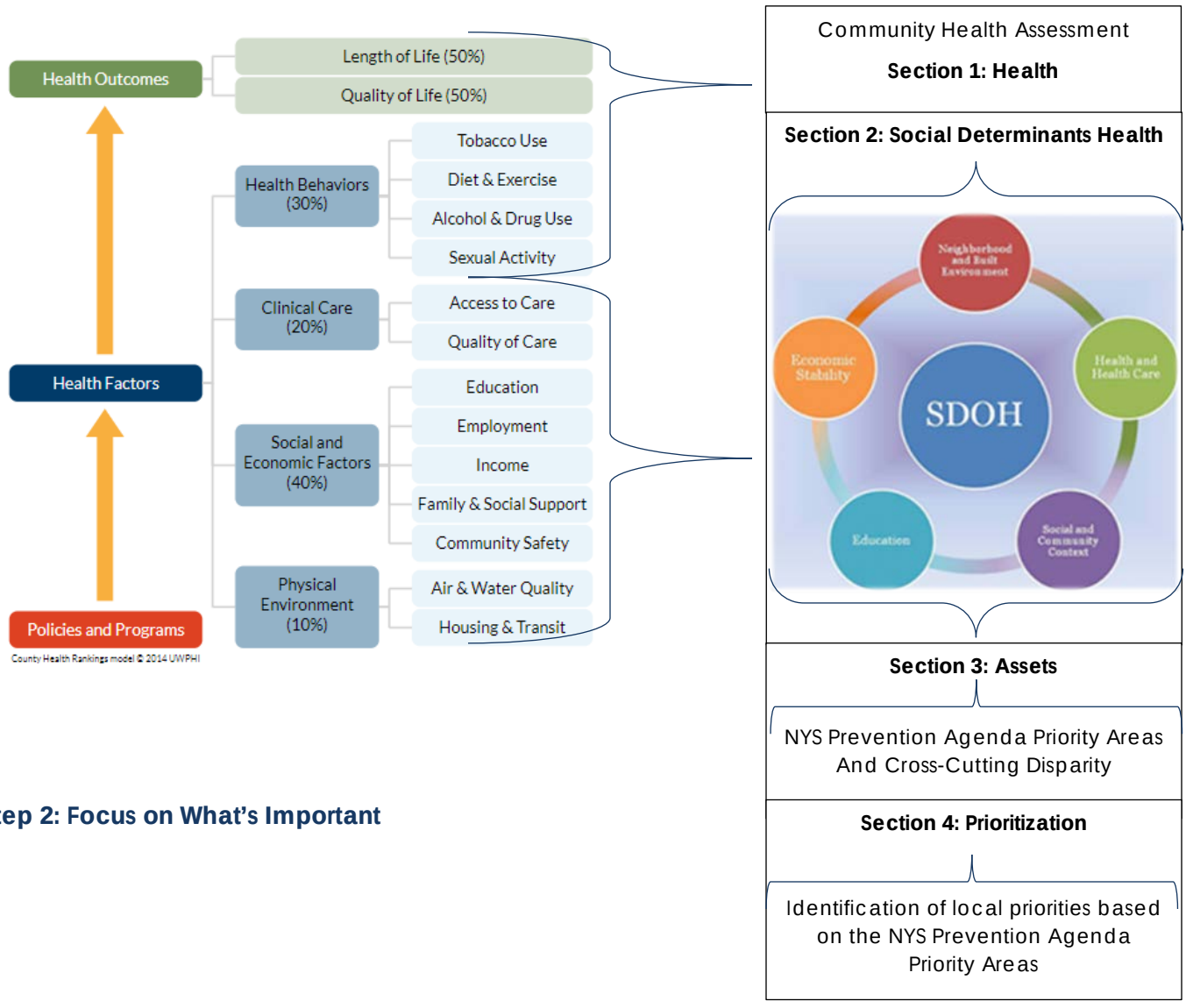
The Framework for conducting the assessment follows the **NYSDOH Prevention Agenda** (48) and the following two models it references:

- **County Health Rankings and Roadmaps Model** (58) and the
- **Healthy People Social Determinants of Health** (27).

The County Health Rankings and Roadmaps Model (58) emphasizes the many factors that influence health outcomes. Healthy People Social Determinants of Health Domains (27) reveal how factors of economic stability, education, health care access, neighborhood and the environment and social and community context impact health behaviors and outcomes. Exploration of these domains make evident the need to engage the broader (beyond health partners) community in working collaboratively across domains to address the unique needs of our communities and residents.

The diagram below depicts how this CHA integrates these three models as a single Framework.

Step 1: Assess Needs and Resources



Step 2: Focus on What's Important

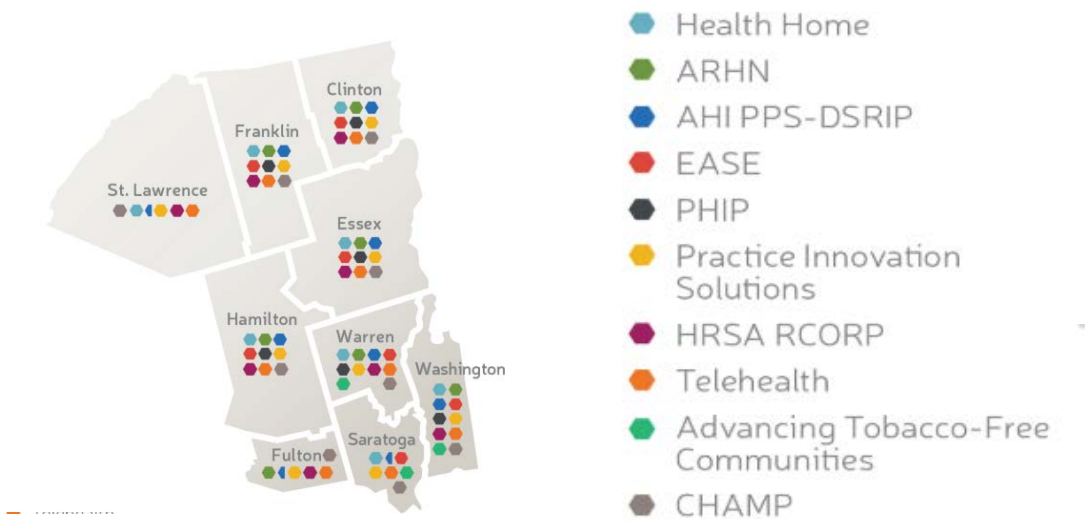
Regional Collaboration

Regional collaboration is facilitated by Adirondack Health Institute (AHI). AHI is an independent, non-profit organization categorized as an Article 28 agency under New York State Department of Health (NYSDOH) Regulations. AHI operates as a regional population health improvement network. (3)

AHI supports health care systems, practices, medical and healthcare providers, local health departments and community based organizations in transforming health care and improving population health through multiple programs. They are:

- Health Home Care Management
- Adirondack Rural Health Network (ARHN)
- AHI PPS (Performing Provider System): Delivery System Reform Incentive Payment (DSRIP) Program
- Enrollment Assistance Services and Education (EASE)
- Population Health Improvement Program (PHIP)
- Practice Innovation Solutions
- HRSA Rural Communities Opioid Response Program (HRSA RCORP)
- Telehealth/Telemedicine
- Advancing Tobacco-Free Communities
- Community Health Access to Addiction and Mental Healthcare Project (CHAMP). (3)

The figure below depicts which program are conducted throughout the AHI region.
Essex County is included in 9 of these programs. (3)

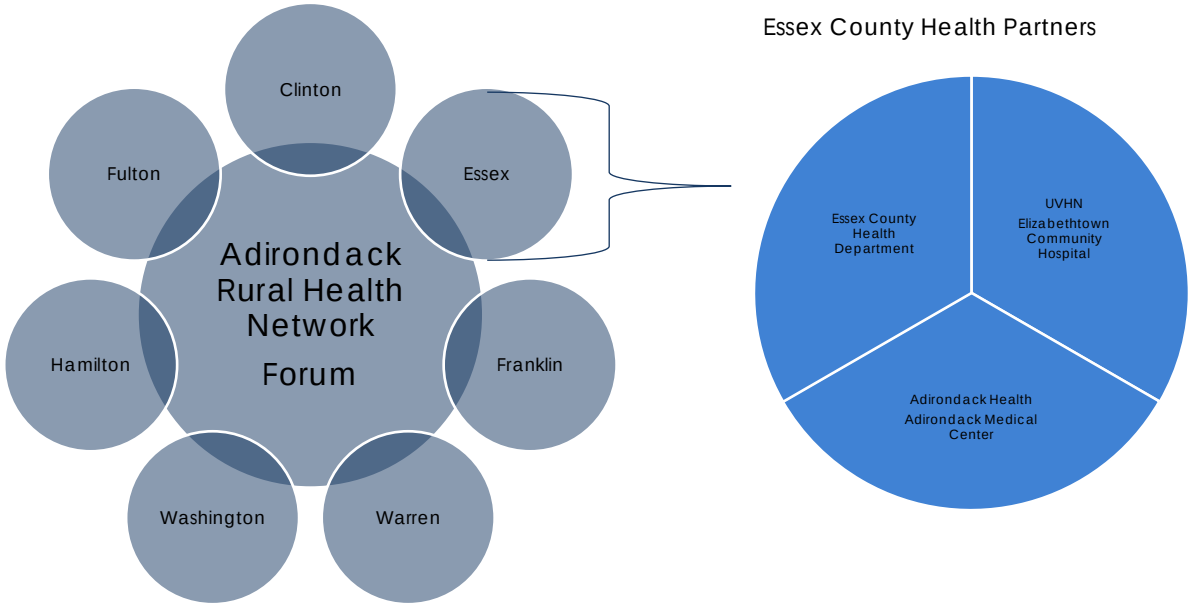


One of these programs, Adirondack Rural Health Network (ARHN), facilitates a Forum to assess regional health needs and develop collaborative responses to priority health issues. It does so through a seven-county multi-stakeholder coalition including Clinton, Essex, Franklin, Hamilton, Fulton, Warren & Washington counties of NY. (3)

The ARHN Forum is conducted through quarterly meetings to:

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

As displayed below, local partners from each of these counties contribute to the regional Forum. Representing Essex County are ***Essex County Health Partners***.



Regional Data Gathering and Analyzing

Intentional data gathering occurred in 2018 and 2019 through guidance of the ARHN partner forum; quarterly meetings. It was guided by a Data Sub-Committee that strategized on recommendations for quantitative and qualitative data needs assessment. The ARHN Ad Hoc Data Subcommittee included participation by ***Essex County Health Partners*** members.

There are three (3) components [and resulting documentation] of the regional data gathering and analysis:

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

ARHN Stakeholder Survey

The first component of regional data collection was qualitative input from stakeholders. The data sub-committee met seven (7) times in 2018 and proposed a survey that was approved at the December 2018 quarterly meeting of the regional forum to be used early in 2019.

The purpose of the survey was to gain valuable insight from key informants into factors impacting the health and well-being of the people their organization/agency serves with NYSDOH Prevention Agenda priorities. This survey also included asset information by asking about resources the respondents could provide to help address community needs. The target audience was local stakeholders as provided by ARHN members including ***Essex County Health Partners***. The survey was launched in January of 2019 using the electronic Survey Monkey platform; a paper version was not available.

Essex County Health Partners used internal contact lists based on existing committees, coalitions, networks, partnerships and contacts to identify the local target audience. The target audience was 170 key informants from a wide cross section of 18 different community based organization types. There were 129 responses from Essex County stakeholders.

Data from this regionally-launched survey was analyzed by ARHN staff who also provided a report to forum partners in April 2019.

ARHN Health Indicator Data Sheets

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

These sheets were organized across ten tabs: *Mortality; Injuries, Violence and Occupational Health; Built Environment and Water; Obesity; Smoke Exposure; Chronic Disease; Maternal and Infant Health; HIV, STD, Immunization and Infections Diseases; Substance Abuse and Mental Health;* and *Other.*

Each indicator includes a link to the data source and columns for Essex County, the ARHN region, Upstate New York, New York State and the NYSDOH Prevention Agenda Benchmark (as available). An analysis of indicators is included and based on a comparison of the Essex County data to the NYSDOH Prevention Agenda Benchmark or Upstate NY (all counties in NYS excluding the 5 boroughs of New York City) if there was not an associated Benchmark.

The comparison is displayed as follows:

- Green: meets/exceeds/is better than the comparison
- Red: doesn't meet/falls below/ worse than the comparison.
- Yellow: Less than 10 incidence making the data indicator statistically unstable/unreliable

To provide context for the distance of the given indicator data [rate or percent], from the comparison data (Benchmark or Upstate NY) a quartile ranking was used as follows:

- Quartile 1: within 24.9% of comparison
- Quartile 2: between 25% and 49.9%
- Quartile 3: between 50% and 74.9%
- Quartile 4: 75% to 100% from the comparison

In other words, data indicators closest to the comparison are within Quartile 1; farthest in Quartile 4. A Quartile score is included and based on the percent of indicators that were worse than the comparison of total indicators.

Finally, these sheets include a severity score, the percentage of indicators that were either in quartile 3 or 4.

ARHN Community Profile Data Sheets

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

These sheets are a compilation of data from additional sources and are organized by these tabs: *Demographic Profile, Health System Profile, Education Profile, and Asset Limited Income Constrained Employed (ALICE) Profile.*

Local Collaboration

Primary partners/lead agencies engaged in the development of the CHA and CHISP identify as ***Essex County Health Partners*** and include:

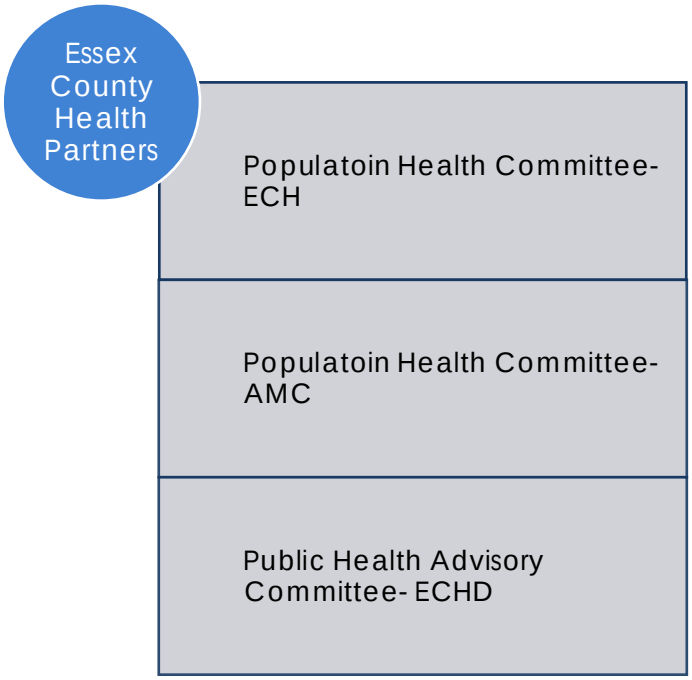
- Essex County Health Department (ECHD),
- University of Vermont Health Network-Elizabethtown Community Hospital (UVHN-ECH) and
- Adirondack Health-Adirondack Medical Center (AMC).

These partners participate in the ARHN regional forum quarterly and ad-hoc sub-committees described above.

ECHD, UVHN-ECH and AMC met more than a dozen times during 2019 to collaborate on the development of this assessment. Meetings were conducted in person, through the virtual Zoom meeting platform and phone calls. Partners also collaborated using email, meetings and sharing information using the internet based platform, Drop Box.

Essex County Health Partners lead three (3) key committees responsible for sharing and analyzing data related to population health, health challenges and community resources. These committees each meet quarterly (at a minimum), and more as necessary. They are:

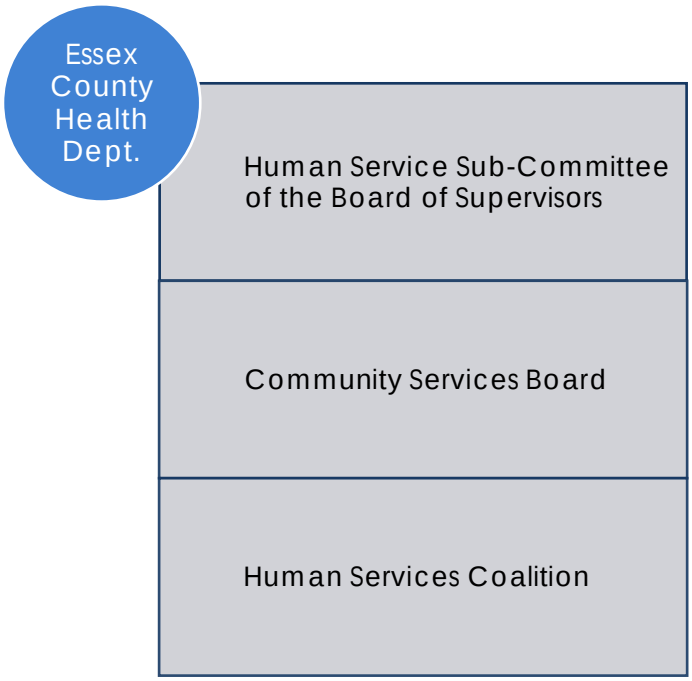
- Public Health Advisory Committee of the Essex County Health Department
- Population Health Committee of Adirondack Health
- Population Health Committee of UVHN-Elizabethtown Community Hospital



Additionally, Essex County Health Department led or participated in local community based committees, coalitions and workgroups that informed health needs assessment and improvement planning.

The three (3) multi-sector committees that are engaged with ongoing assessment and planning efforts are:

- Essex County Human Service Sub-Committee of the Board of Supervisors,
- Essex County Community Services Board facilitated by the Essex County Mental Health Department and the
- Human Services Coalition facilitated by the Adirondack Community Action Program.



Appendix 4 is a list of these six (6) committees including participating members, and the agency/organization they represent with the meeting dates for 2018-2019.

Local Data Gathering and Analyzing

Beyond participation in regional data collection efforts, intentional local data gathering and analyzing efforts were conducted during 2018-2019, led by ***Essex County Health Partners*** and through multiple committees and work groups as described previously in the Local Collaboration section.

Efforts to include new primary and secondary data, and qualitative and quantitative data, may be categorized into four initiatives described further below. These efforts helped ensure input from local organizations, stakeholder and community members and included gathering of additional new information about the social determinants of health [as they exist for Essex County].

There are three (3) components of the local data gathering and analysis resulting in stand-alone documents:

- Distributed Focus Group Analysis Report (Appendix 5);
- Community Survey Analysis Report (Appendix 6); and
- Stakeholder Survey Analysis Report (Appendix 7).

Distributed Focus Group Initiative

The first local component was called a Distributed Focus Group Initiative. The purpose was to ask a single broad question across multiple stakeholder groups: *If you could change one thing about your community to make it better what would it be?* From January-March 2019 Essex County Health Department staff asked the question and facilitated discussions at existing community coalitions/networks/committee stakeholder meetings; the target audience of the initiative.

Staff documented the names of groups, number of participants and responses. In total, 5 groups of stakeholders, facilitated by three different staff and including 49 stakeholders were surveyed. This process was trialed as a strategy to provide latitude in interpreting the question being asked, leading to a wide range of responses what were likely to tap into social determinants of health areas. Results were analyzed by Essex County Health Department staff and the results are included in Section 2 of the Community Health Assessment.

Community Survey Initiative

The second local component was a Community Survey. The purpose of the survey was to engage a wide variety of community members to collect their perspectives about community health including their definition of health, challenges within the community including health, social and environmental and challenges experienced by respondents and their families including social and access to healthcare. The target audience was Essex County residents ages 18 and older. The survey was designed at a 7th grade reading level and took approximately 10 minutes to complete. It was primarily launched on the electronic Survey Monkey platform though paper versions were also distributed. Efforts were made to reach a wide variety of residents including ages, genders and social connections. Three hundred and fifty four (354) residents participated in the survey. Results were analyzed by the Essex County Health Department staff and included throughout the Community Health Assessment

Stakeholder Survey Initiative

The third local component was further analysis of the ARHN Stakeholder Survey Report with a focus on just Essex County conducted by Essex County Health Department staff.

Local Data, Surveys and Reports Initiative

A final local component was the collection, review and analysis of local data by ***Essex County Health Partners*** including needs and contributing factors. This information included raw data, survey results, reports and plans from local agencies, programs and groups.

Examples of such information includes the:

- Adirondack Community Action Programs Community Assessment Report 2019;
- Area Agency on Aging/Essex County Office for the Aging County Plan for 2020-2024; and
- Essex County Local Service Plan 2020.

This assessment, more than any previously conducted local Community Health Assessment, provides an examination of factors that contribute to health challenges – otherwise described as Social Determinants of Health. Research to find this type of information yielded the collection, review and analysis of information from numerous new sources and is included in Section 2 of the Community Health Assessment. A complete list of Data Sources is included as Appendix 8.

Sharing Preliminary Information & Using Feedback

Preliminary data and reports were shared with stakeholders and the community at large to gather additional input and feedback before the completion of this assessment. This includes sharing, posting and presenting with requests and opportunities for feedback through these methods:

- Stakeholder Survey Report – emailed to Stakeholders that had been invited to participate in the survey
- Community Survey Report - posted on the Essex County Health Department Facebook page and website
- Preliminary Findings – posted on the Essex County Health Department Facebook page and website
- Preliminary Findings – presented to:
    - Public Health Advisory Committee (PHAC) of Essex County Health Department
    - Essex County Board of Supervisors (BOS)
    - University of Vermont Health Network-Elizabethtown Community Hospital (UVHN-ECH) Internal Planning Team
    - Adirondack Health-Adirondack Medical Center (AH-AMC) Population Health Committee

These opportunities yielded additional information including but not limited to:

- Prioritization input;
- Themes to include in the final report:
    - Alzheimer's Disease, elder care and care-giver care;
    - Climate Change;
    - Travel barriers, telehealth and telemedicine;
    - Food access and physical fitness; and
- Request for more overlaying of data.

This information was captured, considered and integrated as possible in the final assessment report.

Step 2: Focus on What's Important (Prioritization)

Numerous steps were taken to inform the prioritization of health needs by ***Essex County Health Partners***:

1. Analyzing 3 Regional Data components [as described in Regional Data Gathering and Analysis];

2. Analyzing 4 Local Data components [as described in Local Data Gathering and Analysis];

3. Using a prioritization matrix with internal planning groups of:

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

Internal planning groups of the ***Essex County Health Partners*** included:

- Essex County Health Department team was comprised of the Director of Public Health, Director of Preventive Services, Community Health Assessment and Planning Coordinator and Senior Health Educator. This group met over a dozen times during 2019.
- UVHN-ECH Internal Planning Team was comprised of the Chief Nursing Officer/Vice President; Medical Director, Director of Quality, Primary Care Quality Support Specialist and Director of Communications and met once during 2019.
- Adirondack Health Population Health Steering Committee was comprised of the Chief Medical Officer, Chief Nursing Officer, Chief Financial Officer, Chief Operating Officer, and Chief Financial Officer and representation from Program Managers to Care Coordinators from both in-Patient and Outpatient programs and services met eight (8) times during the 2019 year.

The prioritization matrix (Appendix 9) was a locally-modified version of the Hanlon Method[1] that included criteria categories of need and feasibility. The matrix was guided by asking questions regarding the scope and severity (need) of health issue and the perceived ability to impact and community readiness (feasibility) regarding addressing those health issues.

Health issues were categorized and scored following the five (5) NYSDOH Prevention Agenda[2] areas:

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

[1] https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf
[2] https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/index.htm

Internal planning groups of ***Essex County Health Partners*** identified priorities as:

- Prevent Chronic Disease (3 of 3 groups)
- Promote Healthy Women, Infants & Children (2 of 3 groups)
- Promote Well-Being and Prevent Mental Health & Substance Use Disorders (3 of 3 groups)

4. Sharing preliminary findings and requesting prioritization input upon review of these findings from:

- Essex County Health Department Public Health Advisory Committee (PHAC)
- Essex County Board of Supervisors (BOS)
- Essex County Community Members

5. Drawing a conclusion to address 3 priorities in the Community Health Improvement/Service Plan:

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

Identification of Disparities

Essex County Health Partners identified disparities during the data analysis process.

Within Section 1: Health, disparities were identified within each priority area specific to indicators including:

- Age
- Gender
- Geography/Communities within the county
- Socio-economics as Medicaid/Non-Medicaid

Disparities were identified within the Community Health Assessment report for specific health indicators in Section 1: Health, and within Section 2: Social determinants of Health within sub-areas of each domain.

Within Section 2: Social Determinants of Health, Access to Healthcare was identified as a cross-cutting disparity for Essex County residents and include barriers of Geography, Transportation and Provider Shortages. Additionally, the changing healthcare environment is addressed in the Community Health Assessment as an evolving issue. Themes identified in this section of the report underscore how the system continues to evolve to improve healthcare experiences of residents and address this cross-cutting disparity.

Asset Identification

Essex County Health Partners also considered local assets that may be mobilized to address community health. Existing resources data was gathered and assembled into a matrix including the locally identified priority areas of the NYSDOH Prevention Agenda Priority Areas and the locally identified cross-cutting Social Determinant of Health: Access to Health Care.

Categories include Healthcare System; Coalitions and Committees; County Government Departments; Community Based Organizations; Media, Law Enforcement, Education Systems, Religious Groups, Local Programs and Grants, and New York State Health Department and Associations.

Section 3 of the Community Health Assessment is the Asset Matrix.

Essex County Health Partners recognize the benefit of additional asset mapping including broader considerations such as programs and policies directly or indirectly influencing health and as related to additional Social Determinants of Health.

This activity informed prioritization and is an essential piece of the Take Action Cycle as work progresses into identifying effective programs and policies.

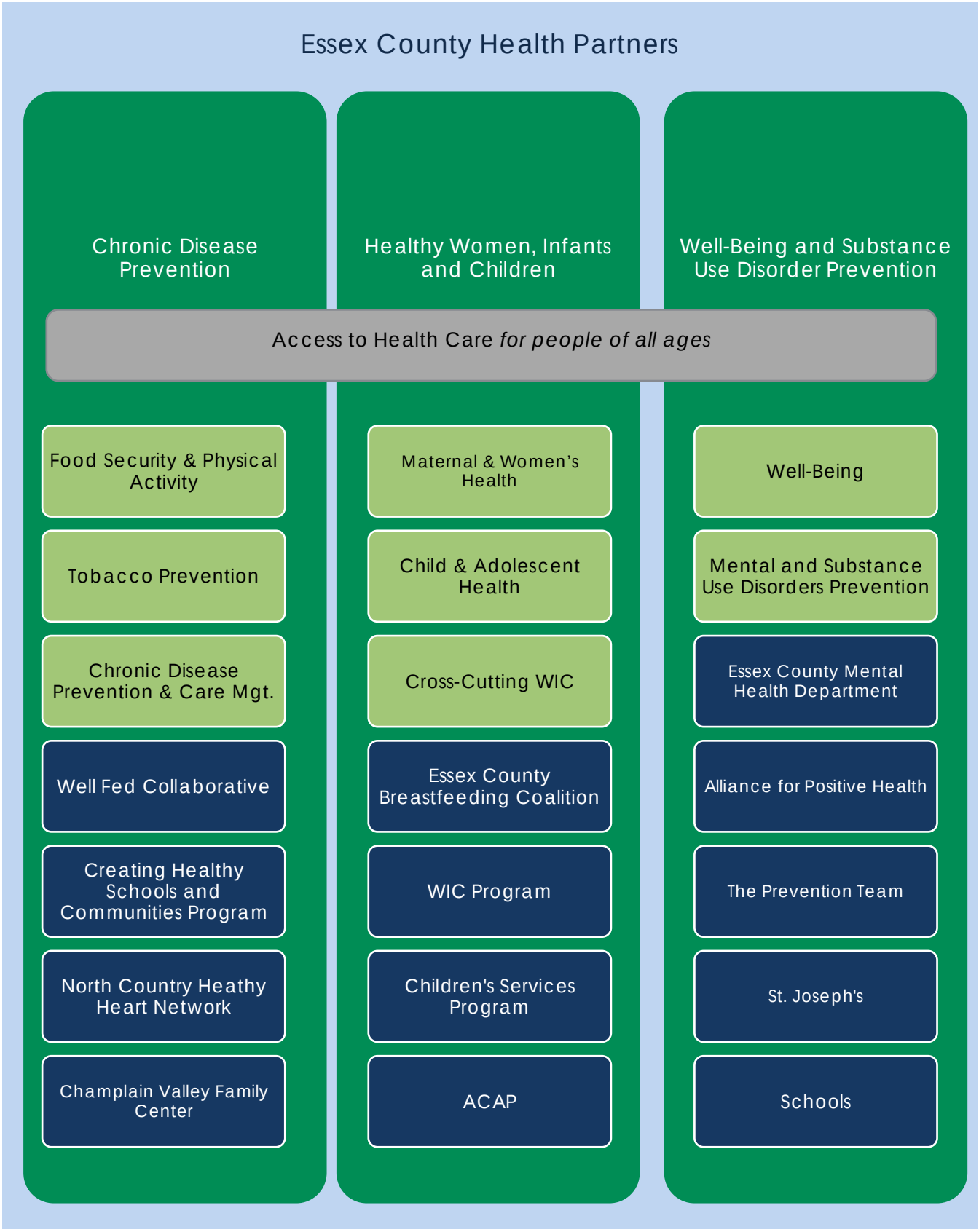
Step 3: Choosing Effective Policies & Programs

Planning was informed through long-standing relationships between ECHD, hospitals, community based organizations and stakeholders. Collaboration and communication occurs directly between and among community based partners and stakeholders. Specific to the Improvement/Service Plan Part of this report, work was convened by priority area as depicted in the visual aid on the following page.

Workgroups for each priority area were convened and considered:

- Data leading to these priority areas
- Disparities experienced by sub-categories of populations within these priority areas
- Social Determinants of Health contributing to priority outcomes and disparities
- Evidenced-based interventions as directed by NYSDOH
- Assets that may be mobilized to address health needs
- Lead organizations for specific interventions and community based partners essential to intervention success

The graphic below depicts Essex County Health Partners (in light blue) overseeing the identification of three (3) health priorities (in green) and focus areas (in light green) with the cross-cutting disparity of Access to Healthcare (in grey). It also demonstrates the engagement of community based organizations, programs and partners (in dark blue) in the development of interventions.


Essex County Health Partners
Chronic Disease Prevention
Healthy Women, Infants and Children
Well-Being and Substance Use Disorder Prevention
Access to Health Care for people of all ages
Food Security & Physical Activity
Tobacco Prevention
Chronic Disease Prevention & Care Mgt.
Well Fed Collaborative
Creating Healthy Schools and Communities Program
North Country Heathy Heart Network
Champlain Valley Family Center
Maternal & Women's Health
Child & Adolescent Health
Cross-Cutting WIC
Essex County Breastfeeding Coalition
WIC Program
Children's Services Program
ACAP
Well-Being
Mental and Substance Use Disorders Prevention
Essex County Mental Health Department
Alliance for Positive Health
The Prevention Team
St. Joseph's
Schools

Step 4: Acting on What's Important

The Lead Partner for these workgroup activities established work plans for each of the three priority areas. A summary of these interventions is described in Part III: Community Health Improvement/Service Plan.

Interventions in the CHISP include an array of strategies to improve population health including:

- Coalitions and other community planning efforts;
- Policy, systems and environmental changes;
- Public health marketing and campaigns;
- Outreach, education, training and technical assistance;
- Delivery of early detection and guideline-concordant health care; and
- Application of new technologies in healthcare and improved care coordination.

A detailed description of these interventions (Appendix 10; CHISP Work Plan) includes:

NYSDOH Prevention Agenda Identified:

- Priority
- Focus Area
- Goal

Locally Identified:

- Objectives
- Disparities
- Interventions
- Family of Measure for Evaluation
- 3 Years of Planned Activities
- Partners
- Partner Roles and Resources.

Examples of Process measures included:

- Number of trainings provided
- Number of media campaigns and engagement
- Number of policies revised and updated
- Number of health practices screening and referring
- Number of smoke-free housing unit, parks and playgrounds
- Implementation of updated guidance related to priority areas
- Number of programs offered and residents served

Essex County Health Partners will share the CHISP with the ARHN Forum to facilitate regional planning and identification of additional regionally-based activities.

Step 5: Evaluating Actions

Essex County Health Partners and the community based organization partners engaged in the planning of the CHISP have pledged on-going commitment to the health and well-being of Essex County residents.

Minimally, ***Essex County Health Partners*** will meet quarterly to:

- assess progress on activities,
- identify barriers to the implementation of activities, and
- develop strategies to overcome barriers and/or determine how activities may be adjusted for success.

The Lead Partner for each activity will document activities through quarterly work plan updates.

A representative of ***Essex County Health Partners*** will submit this update to NYSDOH quarterly.

The Take Action Cycle was the foundational basis for conducting the Community Health [Needs] Assessment and for developing the Community Health Improvement/Service Plan. The following Part includes these two major components, as well as an analysis of various other supporting data, documents, and information that helped to shape conclusions and direction.