

ESSEX COUNTY, NY

Community Health Assessment, 2025
Community Health Improvement Plan, 2026-2030



Essex County Health Partners

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

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

County Covered: Essex

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- Appendix 3: ARHN Community Profile Data Sheets
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Executive Summary

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

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

Prevention Agenda Priorities and Disparities

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

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

Economic Stability

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

Social and Community Context

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

Neighborhood and Built Environment

- Access to Community Services and Support

Health Care Access and Quality

- Preventative Services for Chronic Disease Prevention and Control

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

Data Review

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

Primary Data Sources (Examples):

2025 Essex County Community Survey
2025 ARHN Stakeholder Survey Summary
Selected ECHD programs and services data

Secondary Data Sources (Examples):

2025 ARHN Stakeholder Survey and Survey Analysis
ARHN Essex County Community Profile Data Sheets
NYS Prevention Agenda Dashboard

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

Partners and Roles

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

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

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

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

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

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

Essex County Board of Supervisors/Board of Health via the Human Services Committee
Essex County Public Health Advisory Committee
Essex County Community Services Board
Elizabethtown Community Hospital Board of Directors
Adirondack Health Board of Directors

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

Interventions and Strategies

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

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

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

*Note:

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

DOMAIN: Economic Stability

Priority: POVERTY

Interventions

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

Priority: UNEMPLOYMENT

Interventions

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

Priority: NUTRITION SECURITY

Interventions

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

Priority: HOUSING STABILITY & AFFORDABILITY

Interventions

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

DOMAIN: Social and Community Context

Priority: DEPRESSION

Interventions

Implement and promote Mental Health First Aid training.

Priority: PRIMARY PREVENTION, SUBSTANCE MISUSE, AND OVERDOSE PREVENTION

Interventions

Increase community access to naloxone.

Priority: TOBACCO/E-CIGARETTE USE

Interventions

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

Priority: ADVERSE CHILDHOOD EXPERIENCES

Interventions

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

Priority: HEALTHY EATING

Interventions

Expand Food as Medicine program.

DOMAIN: Neighborhood and Built Environment

Priority: ACCESS TO COMMUNITY SERVICES & SUPPORT

Interventions

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

DOMAIN: Health Care Access and Quality

Priority: PREVENTIVE SERVICES FOR CHRONIC DISEASE PREVENTION & CONTROL

Interventions

Increase cancer screenings, and screenings for hypertension and diabetes.

Progress and Evaluation

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

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

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

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

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

Report Overview

Purpose

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

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

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

Guidance, Requirements, and Standards

NYSDOH Guidance

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

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

Federal Requirements

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

National Accreditation Standards

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

Methodology

Collaborative Process Model

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



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



Steps 1 - 6 cover the CHA.

Steps 7 - 9 cover the CHIP.

Reading This Report

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

References to Sources

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

Report Sections

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



Understanding Percent Expressions

A percent is expressed as a portion of 100%.

For example, if 500 people were surveyed and 125 answered a certain way (yes), then 25% of the people said yes to this question.

Data compared to a noted target, benchmark, or previous value is expressed as the percent difference (increase, decrease, more than, less than, etc.).

For example, if the smoking rate in Essex County is 16% in 2022 and was 22% in 2018, the smoking rate decreased by 27% during that time period.

Understanding Rate Expressions

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

Report Terminology

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

Data Discrepancies

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

Trending/Comparing Data

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



Map Development

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

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

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

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

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

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

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

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

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

¹ 2022 Essex County Health Partners included Essex County Health Department, UVMH - Elizabethtown Community Hospital, and Adirondack Health

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



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

Priority Areas & Status in Focus Areas:

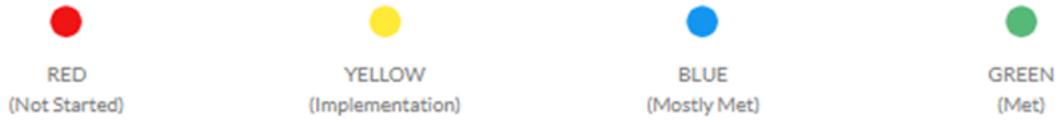


Chronic Diseases

Focus Area	Intervention	Lead	Partner(s)	Status
	Quality nutrition & physical activity in early learning & childcare centers	ECHD	K-12 Schools	<div style="width: 25%; background-color: yellow;"></div>
Health Eating & Food Security	Physical activity & nutrition before, during, & after school	ECHD	K-12 Schools	<div style="width: 25%; background-color: yellow;"></div>
	Fruit & vegetable incentive programs	ECHD	K-12 Schools	<div style="width: 100%; background-color: green;"></div>
Physical Activity	Community physical activity programs	ECHD	Media	<div style="width: 100%; background-color: green;"></div>
	Facilitate tobacco dependence treatment	NCHHN	Providers	<div style="width: 100%; background-color: green;"></div>
	Promote treatment of tobacco dependence	ECHD/AH	Media/CBO's	<div style="width: 10%; background-color: red;"></div>
Tobacco Prevention	Healthcare provider involvement in quit attempts	ECHD	Providers	<div style="width: 100%; background-color: green;"></div>
	Policy action to reduce tobacco marketing	CVFC	Students	<div style="width: 25%; background-color: yellow;"></div>
	Decrease availability of flavored tobacco products	CVFC	Businesses	<div style="width: 25%; background-color: yellow;"></div>
	Systems change for cancer screening reminders	AH	CBO's	<div style="width: 100%; background-color: green;"></div>
Preventative Care & Management	Remove barriers to cancer screening	UVMHN-ECH		<div style="width: 100%; background-color: green;"></div>
	Increase colorectal cancer screening	ECHD	Media	<div style="width: 25%; background-color: blue;"></div>



Priority Areas & Status in Focus Areas:



Well-Being & Substance Use & Mental Health Disorders

Focus Area	Intervention	Lead	Partner(s)	Status
	Evidence-based home visiting programs	ECHD	Media	<div style="width: 100%; height: 10px; background-color: green;"></div>
Promote Well-Being	Promote inclusion, integration, and competence	UVMHN-ECH		<div style="width: 100%; height: 10px; background-color: green;"></div>
	Thoughtful messaging on mental illness & substance use	ECHD	Media	<div style="width: 75%; height: 10px; background-color: blue;"></div>
	School-based prevention	The Prevention Team	K-12 Schools	<div style="width: 75%; height: 10px; background-color: blue;"></div>
	SBIRT	UVMHN-ECH		<div style="width: 25%; height: 10px; background-color: yellow;"></div>
	Trauma informed approaches in prevention programs	ECMH	CBOs	<div style="width: 100%; height: 10px; background-color: green;"></div>
	Access to MOUD	UVMHN-ECH		<div style="width: 25%; height: 10px; background-color: yellow;"></div>
	Access to overdose reversal	Alliance for Positive Health	Pharmacies	<div style="width: 100%; height: 10px; background-color: green;"></div>
Prevent Mental Health & Substance Use Disorders	Opioid Stewardship	UVMHN-ECH		<div style="width: 100%; height: 10px; background-color: green;"></div>
	Safe disposal for Rx drugs	AH	CBOs	<div style="width: 10%; height: 10px; background-color: red;"></div>
	Trauma informed approaches	ECHD	Providers	<div style="width: 100%; height: 10px; background-color: green;"></div>
	ACEs screening in primary care	UVMHN-ECH		<div style="width: 10%; height: 10px; background-color: red;"></div>
	Evidence-based home visiting programs	ECHD	Providers	<div style="width: 100%; height: 10px; background-color: green;"></div>
	Multi-level intervention model	ECMH	CVFC	<div style="width: 75%; height: 10px; background-color: blue;"></div>
	Concurrent therapy for mental illness and nicotine addiction	ECMH	CVFC	<div style="width: 100%; height: 10px; background-color: green;"></div>



Priority Areas & Status in Focus Areas:

RED
(Not Started)

YELLOW
(Implementation)

BLUE
(Mostly Met)

GREEN
(Met)

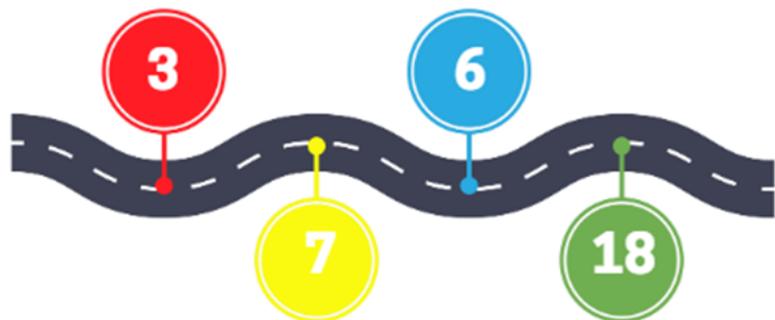
Healthy Women, Infants & Children

Focus Area	Intervention	Lead	Partner(s)	Status
Maternal & Women's Health	Preventive medical visits for women	UVMHN-ECH		<div style="width: 20%; background-color: blue;"></div>
	Depression screening for pregnant & postpartum women	ECHD		<div style="width: 100%; background-color: green;"></div>
	Access to breastfeeding support	ECHD	Providers	<div style="width: 100%; background-color: green;"></div>
Perinatal & Infant Health	Increase breastfeeding support	UVMHN-ECH		<div style="width: 100%; background-color: green;"></div>
	Capacity of home visiting programs	ECHD / Healthy Families North Country		<div style="width: 20%; background-color: blue;"></div>
Child & Adolescent Health	Family-centered services for supporting children with special healthcare needs	ECHD	Providers	<div style="width: 20%; background-color: yellow;"></div>
Cross Cutting Healthy Women, Infants & Children	Collaboration with providers that serve women infants and children	ECHD	CBO & Providers	<div style="width: 100%; background-color: green;"></div>

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

34 Interventions

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





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

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

These 24 priorities are featured across **five domains**, based on *Healthy People 2030's* Social Determinants of Health⁴:

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

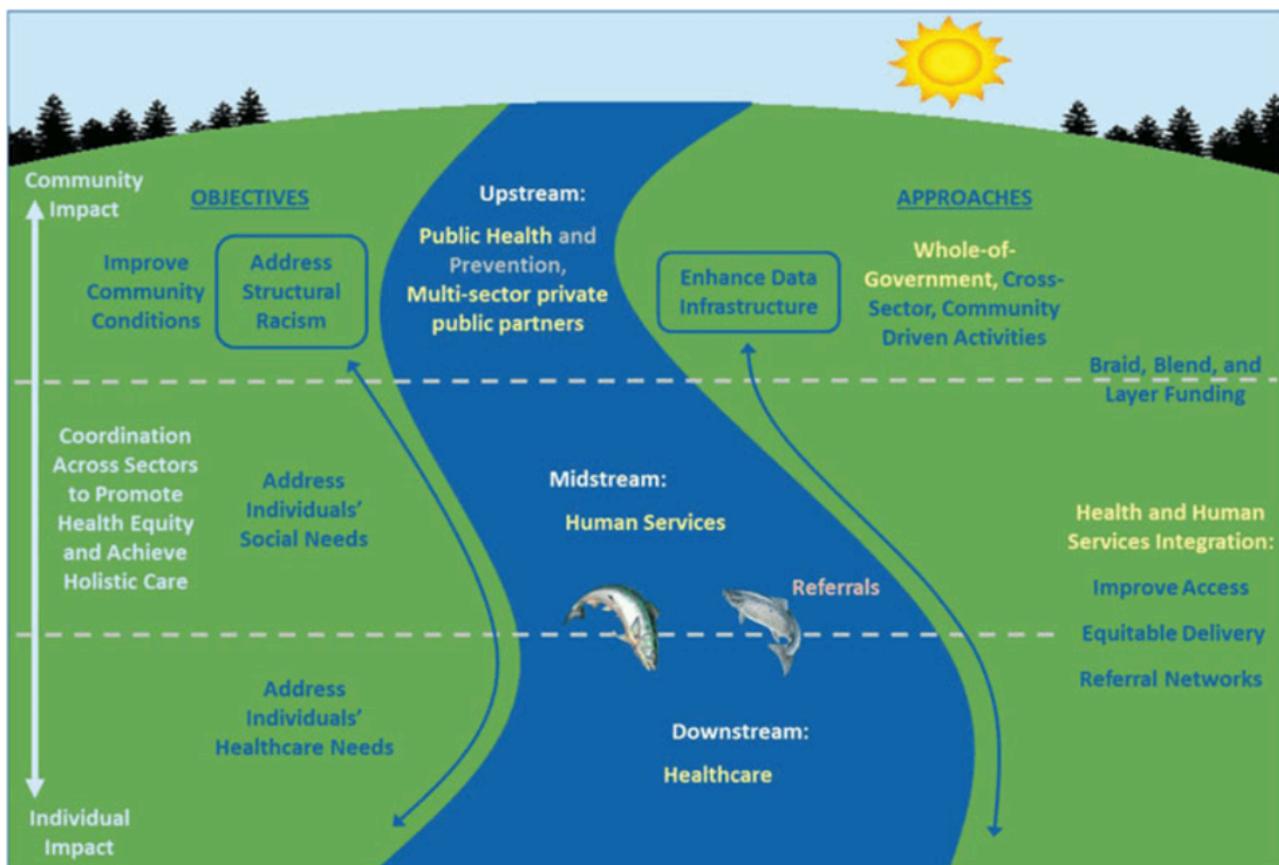
The infographic displays five domains, each with a numbered header and a list of sub-topics:

- 1. Economic Stability**
 - Economic Wellbeing**
 - Poverty
 - Unemployment
 - Nutrition Security
 - Housing Stability and Affordability
- 2. Social & Community Context**
 - Mental Wellbeing and Substance Use**
 - Anxiety and Stress
 - Suicide
 - Depression
 - Primary Prevention, Substance Misuse, and Overdose Prevention
 - Tobacco/E-Cigarette Use
 - Alcohol Use
 - Adverse Childhood Experiences
 - Healthy Eating
- 3. Neighborhood & Built Environment**
 - Safe and Healthy Communities**
 - Opportunities for Active Transportation and Physical Activity
 - Access to Community Services and Support
 - Injuries and Violence
- 4. Health Care Access & Quality**
 - Health Insurance Coverage and Access to Care**
 - Access to and Use of Prenatal Care
 - Prevention of Infant and Maternal Mortality
 - Preventive Services for Chronic Disease
 - Oral Health Care
 - Healthy Children**
 - Preventive Services (Immunization, Hearing Screening and follow up, Lead Screening)
 - Early Intervention
 - Childhood Behavioral Health
- 5. Education Access & Quality**
 - PreK-12 Student Success and Educational Attainment**
 - Health and Wellness Promoting Schools
 - Opportunities for Continued Education

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

³ https://www.health.ny.gov/prevention/prevention_agenda/2025-2030

⁴ <https://odphp.health.gov/healthypeople>



Social Determinants of Health Ecosystem, Adapted from Castrucci and Auerbach, as featured in CDC's Approach to Social Determinants of Health⁵

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

⁵ <https://jphmpdirect.com/cdcs-approach-to-social-determinants-of-health/>



Build Relationships

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

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

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



Local



Regional



State

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

*Meeting frequency based on need

Table continued on next page



Local



Regional



State

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

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

Local Stakeholder Engagement

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

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

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

Local Data Gathering and Analysis

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

- **2025 Stakeholder Survey Summary**

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



- **2024-2025 Community Survey**

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

- **Review of relevant ECHD programs and services data**

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

- **Review of other available local health and human service agency annual reports, plans, and/or data**

- o Community agencies, government organizations, and other groups provide a wealth of information and data in various annual reports, plans, and/or studies either conducted by or commissioned for these entities. Examples of such information includes:

1. *Essex County Prevention Needs Assessment 2025*, sponsored by the Essex County Youth Bureau and prepared by Bach Harrison, L.L.C
2. *From Barriers to Opportunity: Confronting Systemic Barriers to Early Childhood and Poverty-Reduction Programs, October 2024*, prepared by Raising New York
3. *Adirondack Community Action Programs (ACAP) Community Assessment Update, 2023*
4. *Essex County demographic and housing report with town profiles*. Asterhill Research Company. May 24, 2022.
5. *An analysis of residential market potential for primary and second/weekend/vacation units in Essex County, New York*. Zimmerman/Volk Associates, Inc, 2025.

- **Asset Mapping**

- o Related to stakeholder engagement, asset mapping is process of identifying, documenting, and often visualizing the strengths and resources within a community to build upon existing assets. The process of asset mapping supports community health improvement planning because it reveals:

1. Assets that are ready to be mobilized to address needs
2. Gaps in programs and services might be bridged through health planning efforts

The 2025 Asset Matrix is included in this report on pages 26-28.

Regional Stakeholder Engagement

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

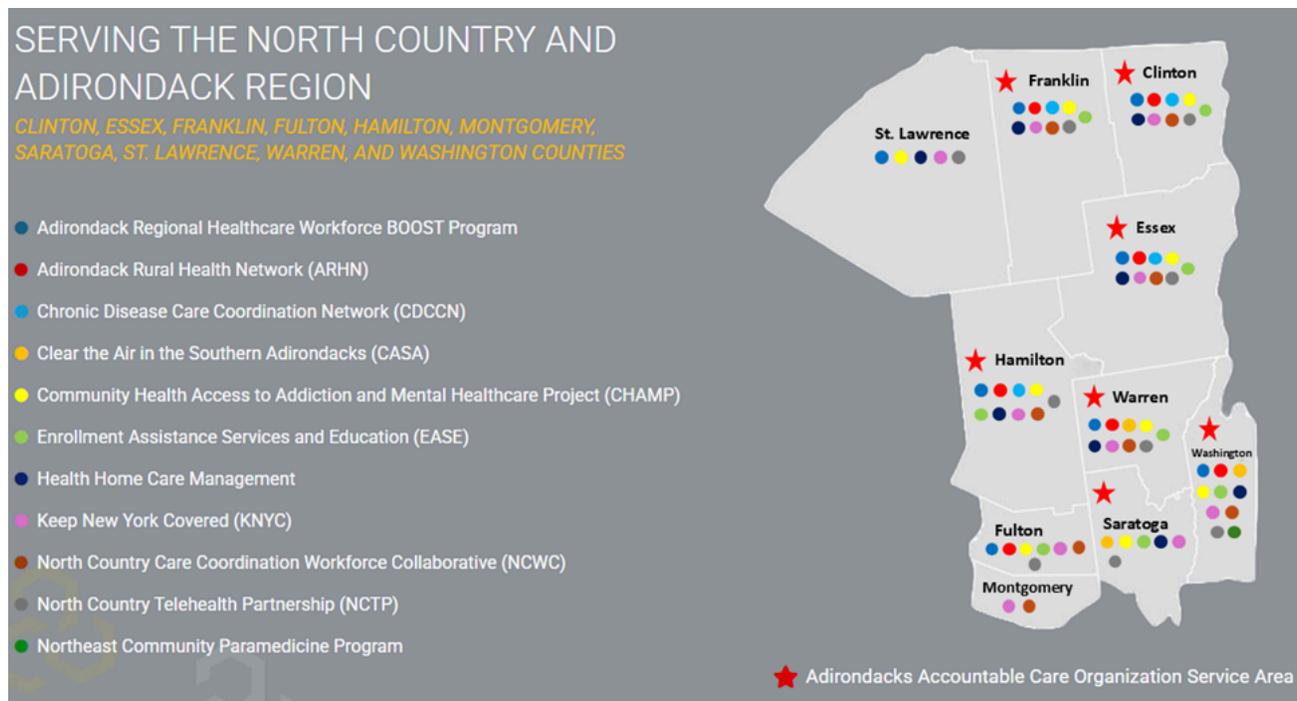
AHI's vision is that every individual in the region reaches their fullest potential and lives their healthiest possible life.

AHI's mission is that their team leads transformative work with clinical and community partners to advance equity, quality, access, and affordability of health and healthcare services.

AHI works to achieve their mission and vision through the administration of various programs and services, as indicated in the image on page 21.



Adirondack Health Institute Programs & Services¹:



Adirondack Rural Health Network

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

Community Health Assessment (CHA) Committee

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

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

¹<https://ahihealth.org/about-us/>



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

CHA Committee: Ad Hoc Data Sub-Committee

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

Regional Data Gathering and Analysis

Major components of regional stakeholder engagement include:

- **ARHN Stakeholder Survey Summary Report** (Appendix 2)

To engage the broad community, the CHA Committee created a list of community stakeholders, including professionals from health care, social services, educational, and governmental institutions as well as community members. A stakeholder survey, developed by the CHA Committee to garner constructive feedback, was sent to the 889 identified stakeholders, and was comprised of 14 community health questions and several demographic questions.

The stakeholder survey was conducted to gather information from a variety of fields and perspectives to provide valuable insight into the community’s needs. The survey summary provided a regional look at the results through a wide-angle lens, focusing on the Adirondack Rural Health Network (ARHN) service area. It provided individual analyses of Clinton, Essex, Franklin, Fulton, Hamilton, Warren, and Washington counties.

The results enable the CHA Committee to guide strategic planning throughout the Adirondack region, for partners who serve individual counties, and those whose footprint covers multiple counties.

- **ARHN County Community Profile Data Sheets** (Appendix 3)

- o **Demographic Profile**

Demographic data was primarily taken from the United States Census Bureau 2023 American Consumer Survey 5-year estimates. Additional sources include the 2020 Census Estimate: Census Quick Stats, and United States Department of Agriculture (USDA) Farm Service Agency (FSA) Crop Acreage Data Reported to FSA. Information included in the demographic profile includes square mileage, population, family status, poverty, immigrant status, housing, vehicle accessibility education, and employment status/sector.

- o **Health System Profile**

The Health System Profile data includes hospital, nursing home, and adult care facilities, bed counts, physician data, and licensure data. Data on facilities is sourced from the NYS Department of Health, NYS Health Profiles, covering profiles for hospitals, nursing homes, and adult care facilities.

Licensure data is pulled from the NYS Education Department (NYSED).

- o **Education Profile**

The Education Profile is comprised of two parts:

- 1) Education System Information

Includes student enrollment, student to teacher ratios, English proficiency rates, free lunch eligibility rates, as well as high school graduate statistics. Data was sourced from the NYSED and the National Center for Education Statistics (NCES).



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

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

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

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

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

The County Health Rankings identifies the two focus areas as:

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

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

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

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

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

State Stakeholder Engagement

NYS Prevention Agenda Workgroup (Domain 1)

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



NYSACHO CHA/CHIP Workgroup

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

Data Sources

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

- U.S. Census Bureau, U.S. Department of Commerce, American Community Survey
 1. Selected Economic Characteristics
 2. Selected Social Characteristics in the United States
 3. Medicaid/Means-Tested Public Coverage by Sex by Age
 4. Poverty Status in the Past 12 Months
- United State Department of Agriculture (USDA) FSA Crop Acreage Data
- NYS Department of Health, NYS Health Profiles
 1. Hospital Profile
 2. Nursing Homes Profile
 3. Adult Care Facilities Profile
- NYS Education Department (NYSED)
 1. Licensed Professions
 2. Enrollment Database Report
 3. Student and Educator Database Report
 4. Enrollment Data by County Report
 5. High School Graduation Rate Report
- National Center for Education Statistics
- United for ALICE
- Community Health Indicator Reports (CHIRs)
- NYS Department of Health, Wadsworth Center
- Division of Criminal Justice Services Index, Property, and Violent Crime Report
- NYS Behavioral Risk Factor Surveillance System (BRFSS)
- Institute for Traffic Safety Report (ITSMR), Traffic Safety Statistical Repository
- Prevention Agenda Dashboard
- Student Weight Status Category Reporting System (SWSCRS)
- USDA Food Environment Atlas
- Essex County Health Department Program Data



Data Collection Methods

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

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

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

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

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



Develop the Community Profile

Service Area: Essex County

Geography

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

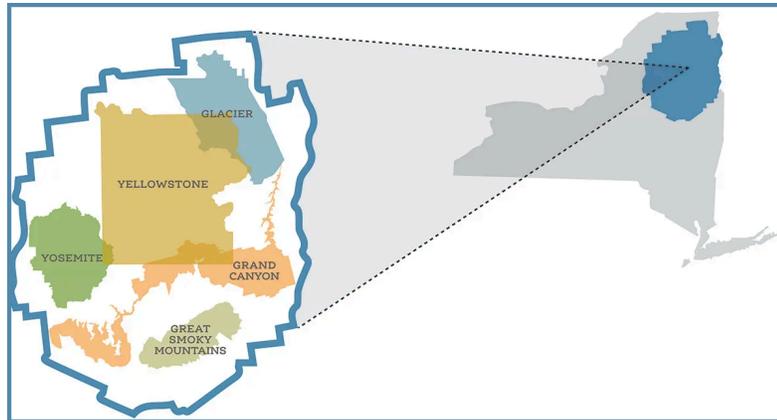
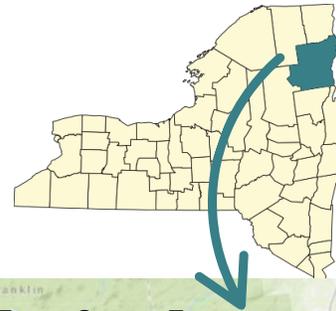
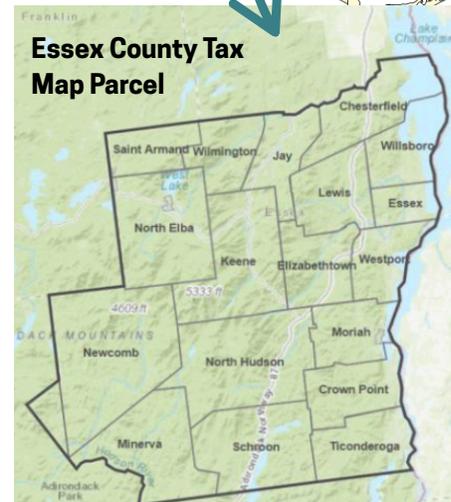


Image Source: Adirondack Land Trust



Source: Essex County Real Property

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

Population

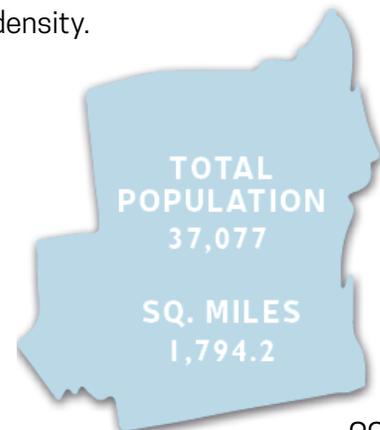
Density

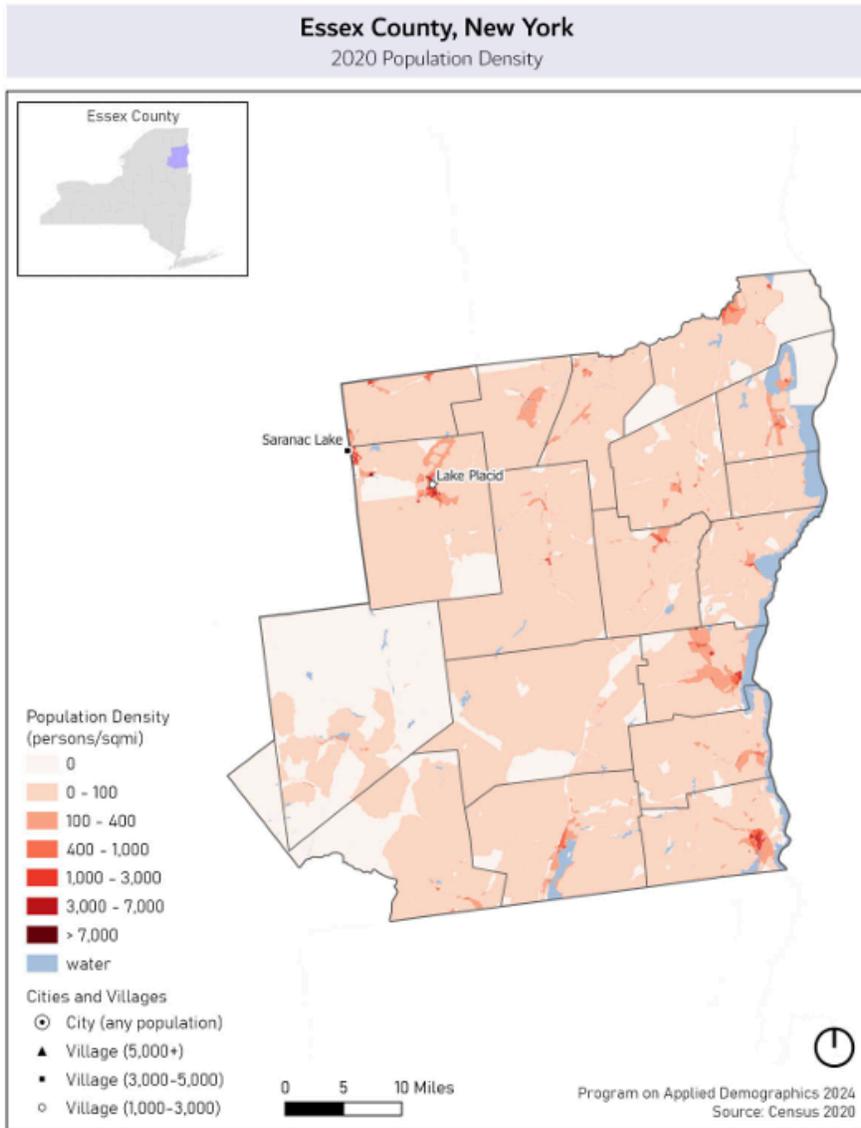
Although Essex County is the 2nd largest county geographically, it is the 2nd least densely populated county in the state, with only Hamilton County having a lower population density.

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

Data Source: 2020 Census

Density = people/sq. mile





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

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

Total Population

The total population in Essex County is 37,077, according to the US Census Bureau, American Community Survey (ACS) 5-Year Estimates, 2023. This represents an almost 6% decline since the 2010 census. The population declined 5% between the 2010 and 2020 census and declined another 1% from 2020 to 2023.

Age

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

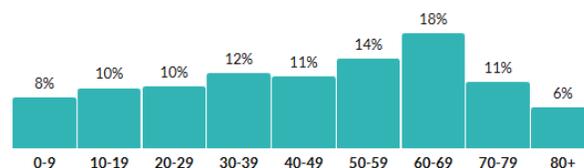
49.5

Median age

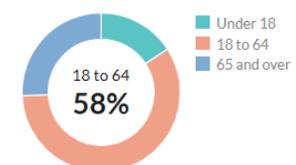
about 25 percent higher than the figure in New York: 39.6

about 1.3 times the figure in United States: 38.7

Population by age range



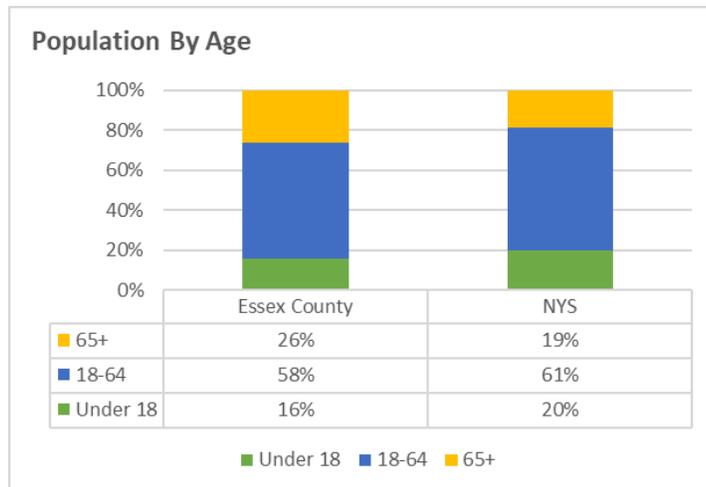
Population by age category



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



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



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

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

Race and Ethnicity

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

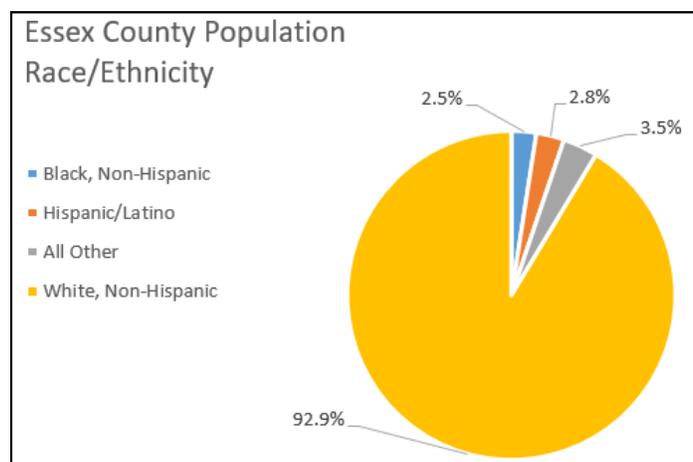
New York State (excluding New York City), in comparison, has the following racial/ethnic make-up:

White, non-Hispanic: 70.7%

Black, non-Hispanic: 8.7%

Hispanic/Latino: 13.5%

All Other: 14.1%



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

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

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



Family Status

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

Households

16,039

Number of households

New York: 7,668,956

United States: 127,482,864

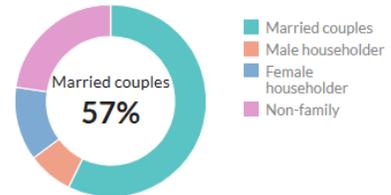
2.2

Persons per household

about 90 percent of the figure in New York: 2.5

about 90 percent of the figure in United States: 2.5

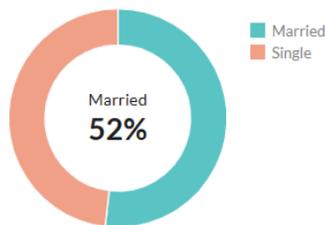
Population by household type



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

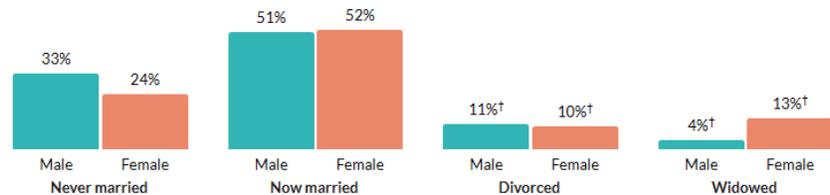
Essex County has more married couples (52%) and fewer single individuals (48%) than NYS (47% and 53%, respectively), with the rates almost exactly reversed.

Marital status



* Universe: Population 15 years and over

Marital status, by sex

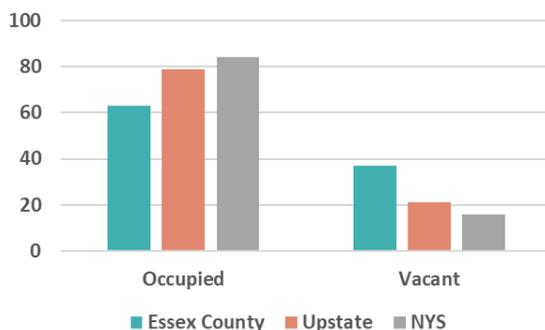


Source: U.S. Census Bureau (2023). American Community Survey 5-year estimates. Retrieved from Census Reporter Profile page for Essex County, NY <<http://censusreporter.org/profiles/05000US36031-essex-county-ny/>>

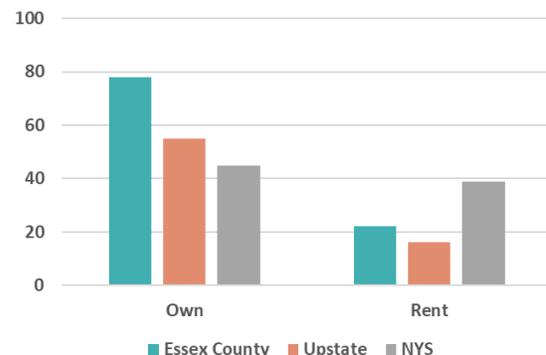
Housing

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

Occupied vs. Vacant



Own vs. Rent



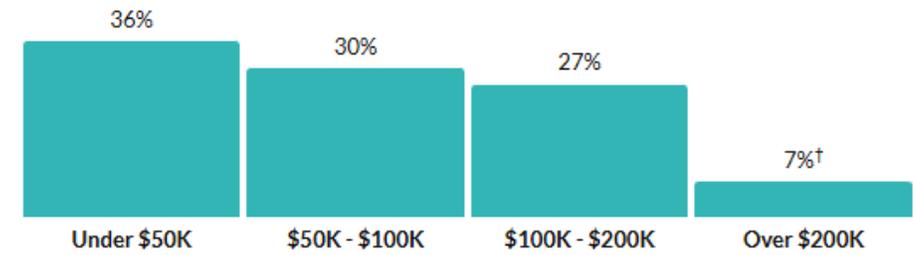
Source: US Census Bureau, ACS 5-Year Estimates, 2023



Income & Poverty

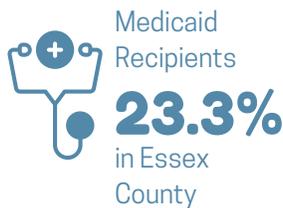
The median household income in Essex County is \$70,215. The median household income for NYS is \$84,578. The per capita income for Essex County residents is \$40,807 compared to NY's \$48,847.

Household income



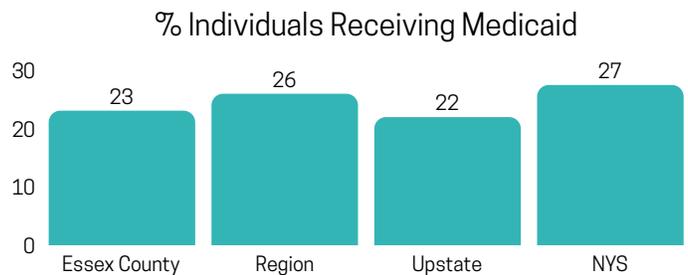
Source: U.S. Census Bureau (2023). American Community Survey 5-year estimates. Retrieved from Census Reporter Profile page for Essex County, NY <<http://censusreporter.org/profiles/05000US36031-essex-county-ny/>>

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



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

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

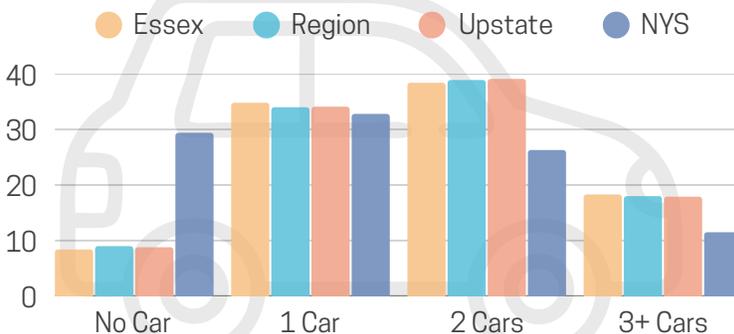


Source: US Census Bureau, ACS 5-Year Estimates, 2023

Transportation

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

Availability of Vehicles



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

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



Education

K-12 Schools

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

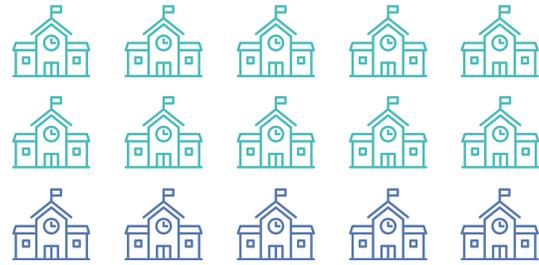


During the 2023-2024 school year, there was a total of 3,352 students across the 10 public school districts, approximately 480 students enrolled at the 5 private schools.



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

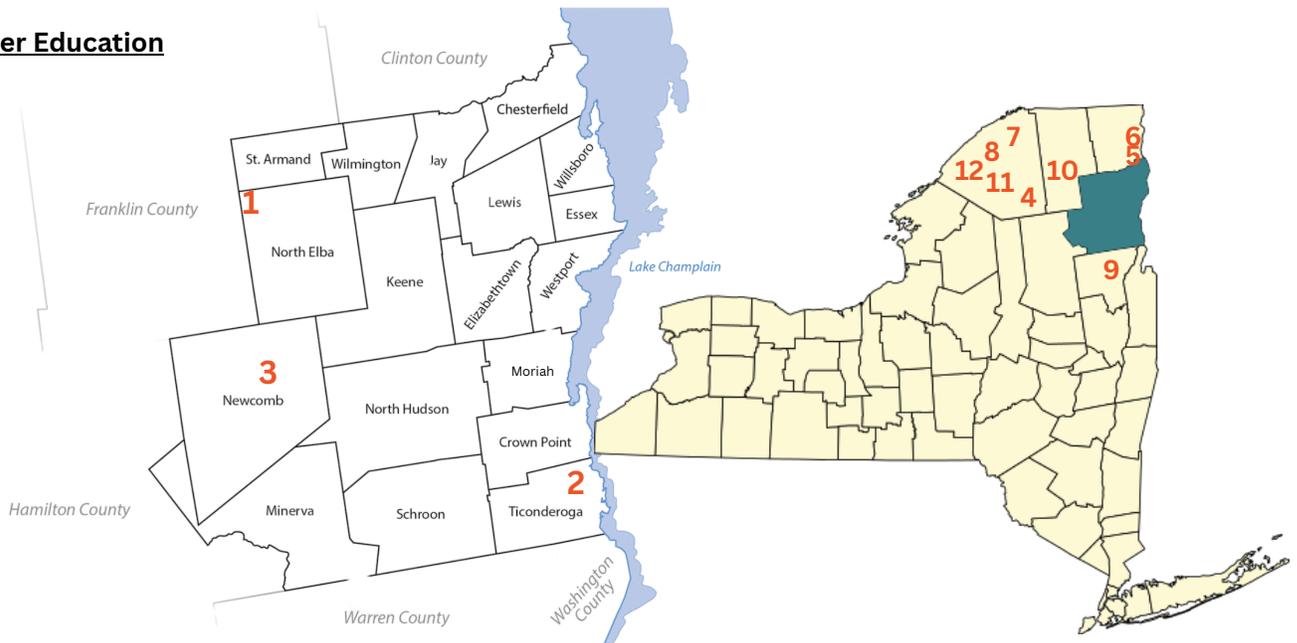
Schools in Essex County



Public

Private

Higher Education



SUNY Colleges/Universities

North Country Community College

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

College of Environmental Science & Forestry

- 3 • Newcomb Campus
- 4 • Ranger School at Wanakena

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

Private Colleges/Universities

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

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

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



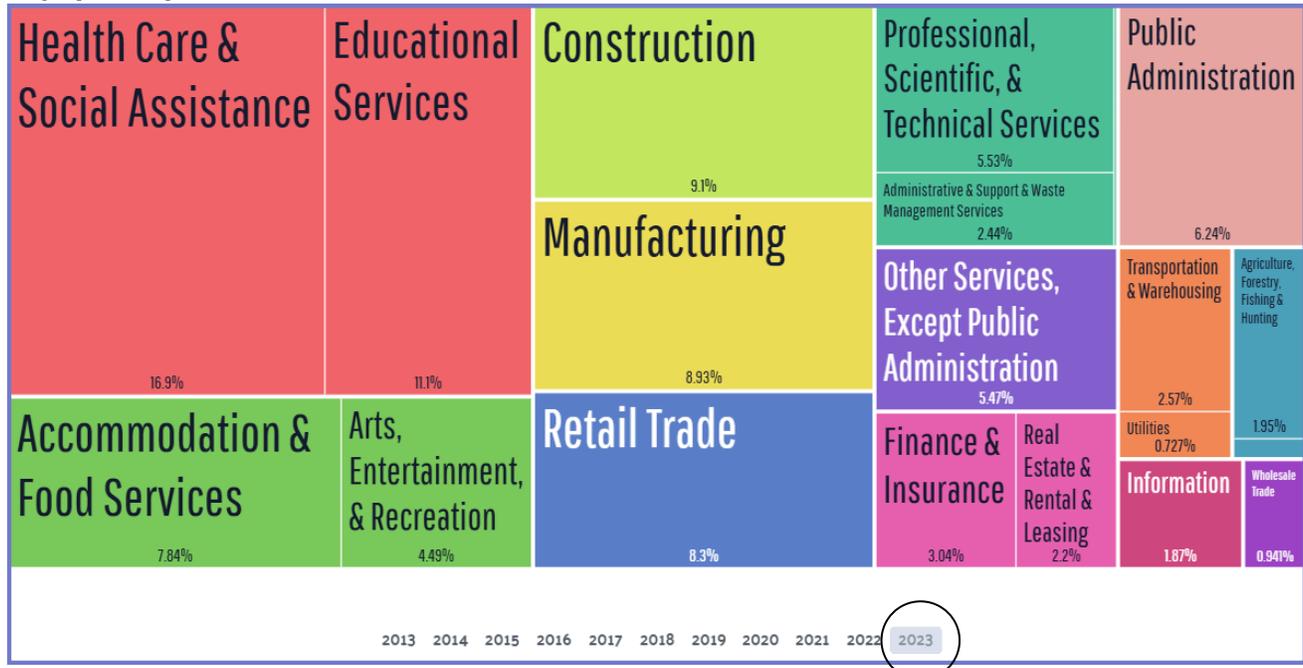
Employment



% Unemployed
2.8

After briefly reaching a high of 19.2% during the COVID-19 pandemic, the unemployment rate in Essex County has steadily declined to 30-year lows - fluctuating between 2.5-5.0% since 2021.²⁻³ The labor force participation rate for individuals 16 years of age and older is 55.1%.³ This is lower than the NYS rate of 61.1%, but is not unexpected due to the higher proportion of older adults that live here.

Employment by Sector



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

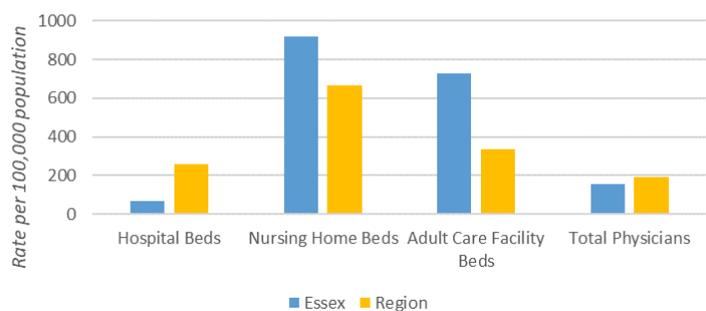
Image Source: [Data USA](#)

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

Health Care

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

Health System Data



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

² <https://fred.stlouisfed.org/series/NYESSE1URN>

³ US Census Bureau, ACS 5-Year Estimates, 2023



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

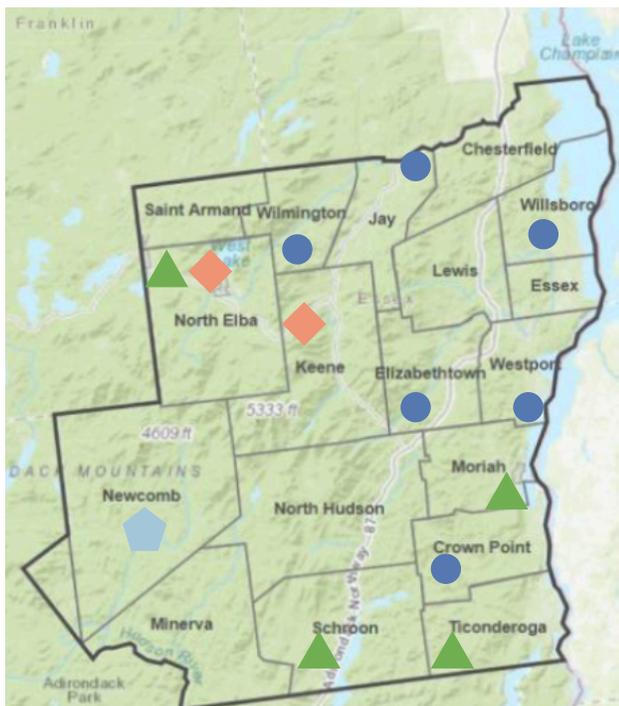


Image Source: Essex County Real Property; icons added

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

Population Health Status Overview

2025 County Health Rankings⁴

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

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

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

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

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

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



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

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



Essex County Population Health and Well-being - 2025



Diagram summarizes data released on 03/19/2025

Essex County is faring about the same as the average county in New York for Population Health and Well-being, and better than the average county in the nation.



Essex County Community Conditions - 2025

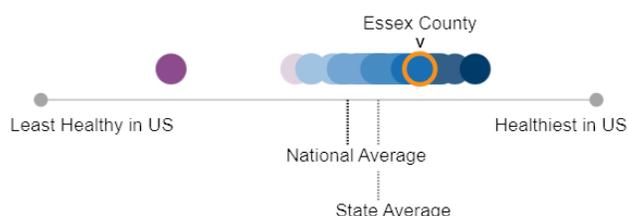


Diagram summarizes data released on 03/19/2025

Essex County is faring slightly better than the average county in New York for Community Conditions, and better than the average county in the nation.

Image Source: www.countyhealthrankings.org

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

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

Legend:

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

Data Source: www.countyhealthrankings.org

Table cont'd on next page



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

Legend:

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

Data Source: www.countyhealthrankings.org



Leading Causes of Death

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

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

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



Increase Equity with Data

A Community Health Assessment integrates a combination of data that reflects and describes the characteristics, experiences, priorities and culture of the communities we serve¹. A comprehensive CHA includes a combination of internal data from the health department and hospital systems, as well as external or community data from a variety of sources at the local, state and national levels.

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

Social Determinants of Health



Social Determinants of Health
Copyright-free Healthy People 2030

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

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

SDOH also contribute to wide health disparities and inequities.

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

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

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



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

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

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



DOMAIN 1: ECONOMIC STABILITY

The Economic Stability domain encompasses the following priority areas:

 Poverty

 Housing Stability & Affordability

 Unemployment

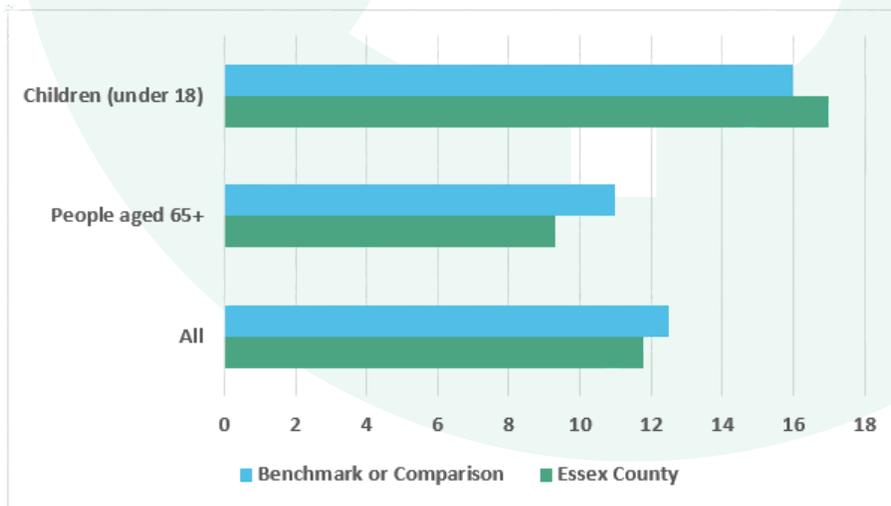
 Nutrition Security

Poverty

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

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

Figure 1: Percent of persons living below the poverty line



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

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

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

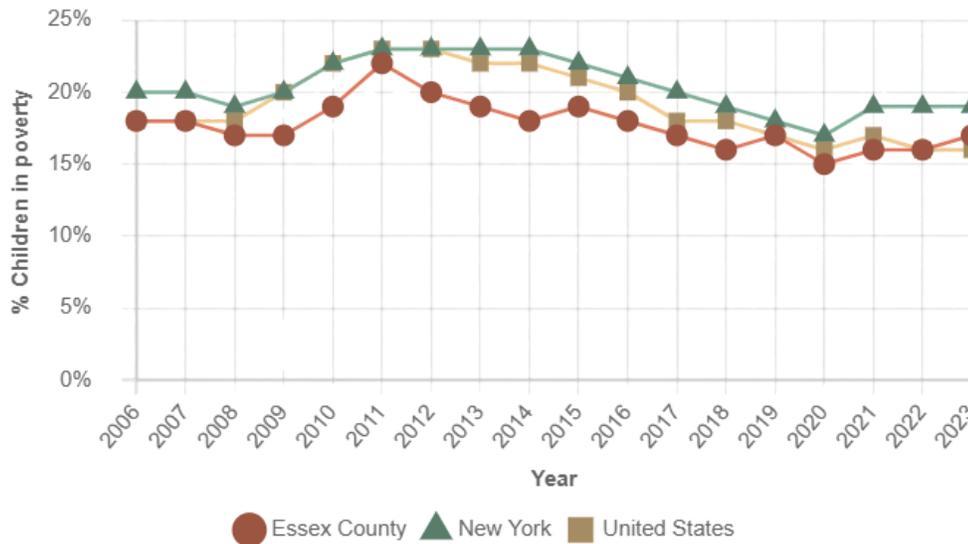
⁷ Council on Community Pediatrics, Gitterman, B. A., Flanagan, P. J., Cotton, W. H., Dille, K. J., Duffee, J. H., Green, A. E., Keane, V. A., Krugman, S. D., Linton, J. M., McKelvey, C. D., & Nelson, J. L. (2016). Poverty and child health in the United States. *Pediatrics*, 137(4), e20160339. <https://doi.org/10.1542/peds.2016-0339>



Childhood Poverty

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

Figure 2: Childhood poverty in Essex County⁸



ALICE Households

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

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

Household Survival Budget, Essex County, New York, 2023								
Monthly Costs	Single Adult	One Adult, One Child	One Adult, One In Child Care	Two Adults	Two Adults Two Children	Two Adults, Two In Child Care	Single Adult 65+	Two Adults 65+
Housing	\$867	\$904	\$904	\$904	\$1,027	\$1,027	\$867	\$904
Child Care	\$0	\$391	\$1,042	\$0	\$781	\$2,146	\$0	\$0
Food	\$532	\$900	\$808	\$976	\$1,637	\$1,445	\$490	\$898
Transportation	\$435	\$558	\$558	\$654	\$983	\$983	\$371	\$526
Health Care	\$196	\$452	\$452	\$452	\$775	\$775	\$528	\$1,056
Technology	\$86	\$86	\$86	\$116	\$116	\$116	\$86	\$116
Miscellaneous	\$212	\$329	\$385	\$310	\$532	\$649	\$234	\$350
Taxes	\$378	\$375	\$529	\$459	\$554	\$879	\$441	\$761
Monthly Total	\$2,706	\$3,995	\$4,764	\$3,871	\$6,405	\$8,020	\$3,017	\$4,611
ANNUAL TOTAL	\$32,472	\$47,940	\$57,168	\$46,452	\$76,860	\$96,240	\$36,204	\$55,332
Hourly Wage	\$16.24	\$23.97	\$28.58	\$23.23	\$38.43	\$48.12	\$18.10	\$27.67

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

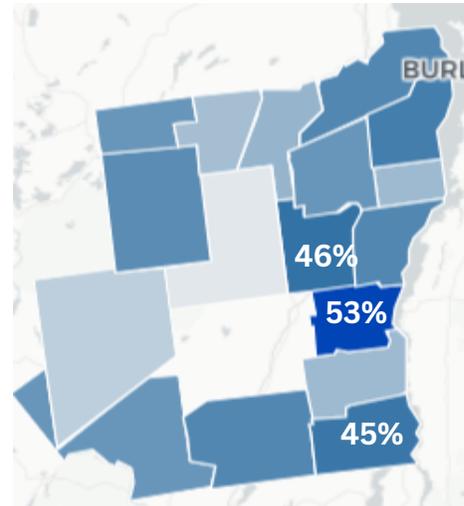
⁸ University of Wisconsin Population Health Institute. *County Health Rankings & Roadmaps 2025*. Retrieved December 3, 2025 from www.countyhealthrankings.org

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



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

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

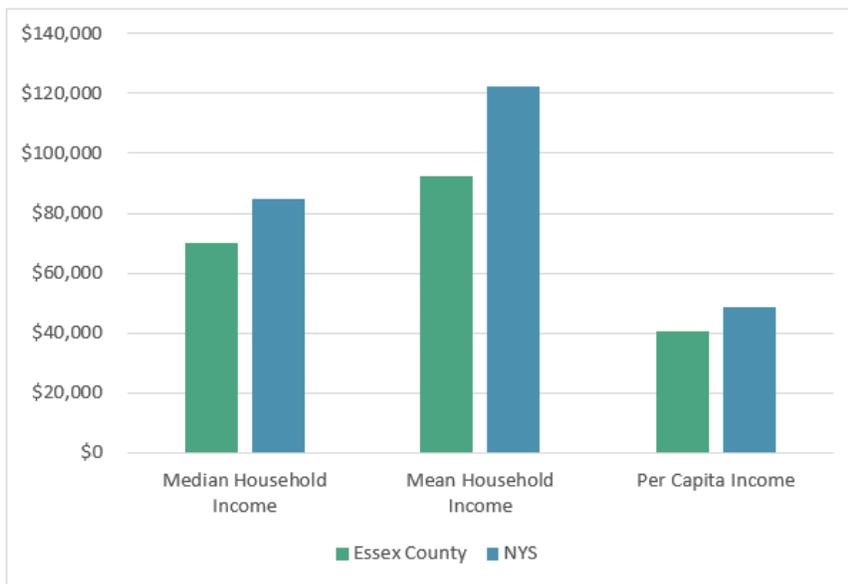


Map of Essex County Towns - Below ALICE

Income

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

Figure 3: Income in Essex County, 2023



Income Inequality

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

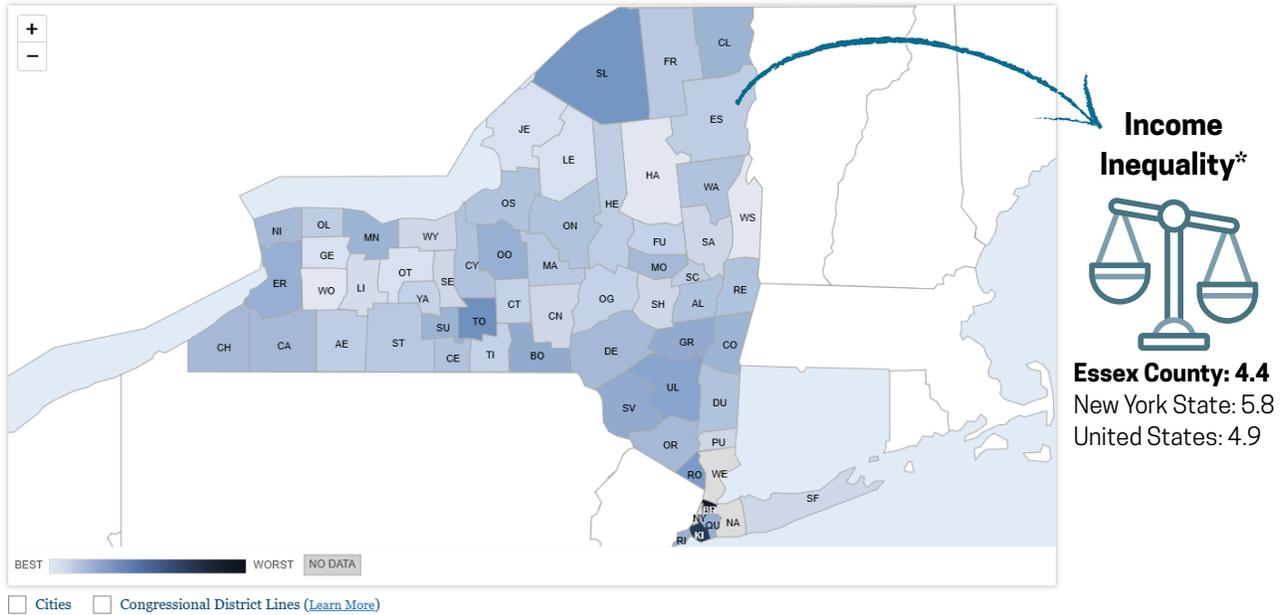
¹⁰ Bureau of Labor Statistics, U.S. Department of Labor, The Economics Daily, Consumer Price Index: 2023 in review at <https://www.bls.gov/opub/ted/2024/consumer-price-index-2023-in-review.htm> (visited December 04, 2025).

¹¹ University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2025. Retrieved December 3, 2025 from www.countyhealthrankings.org



Figure 4: Income Inequality in New York State, 2025

County Health Rankings & Roadmaps 2025 Income Inequality - New York

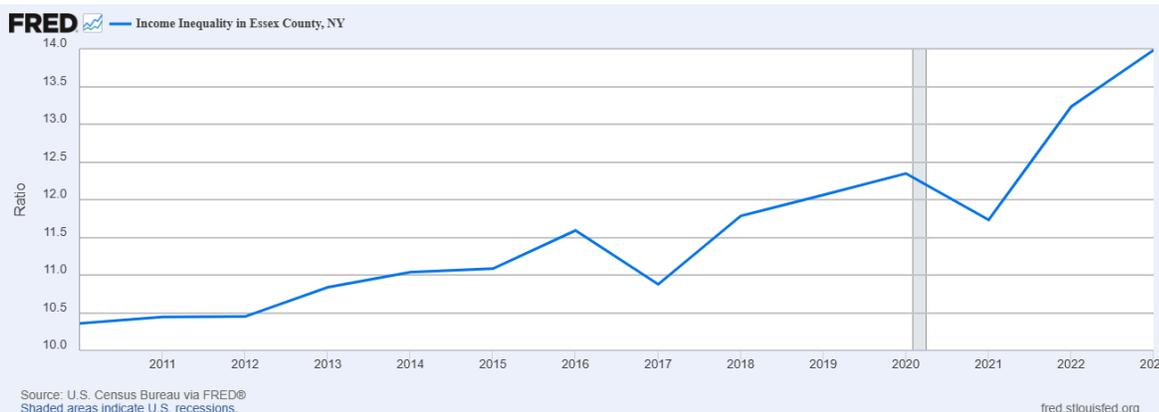


*Income inequality can be calculated/depicted in different ways. County Health Rankings uses the ratio of household income at the upper limit of the 80th percentile (4th quintile) to that at the upper limit of the 20th percentile (lowest quintile). In other words, when the incomes of all households in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

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

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

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



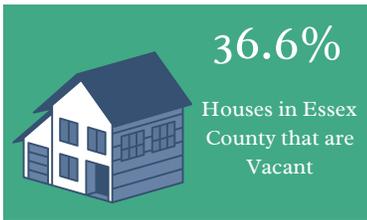
¹² U.S. Census Bureau, Income Inequality in Essex County, NY [2020RATIO036031], retrieved from FRED, Federal Reserve Bank of St. Louis; <https://fred.stlouisfed.org/series/2020RATIO036031>, December 5, 2025.



Housing Stability & Affordability

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

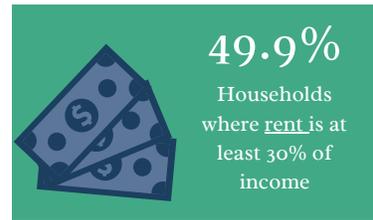
Housing Picture in Essex County



New York State: 15.9%
National Average: 10.4%

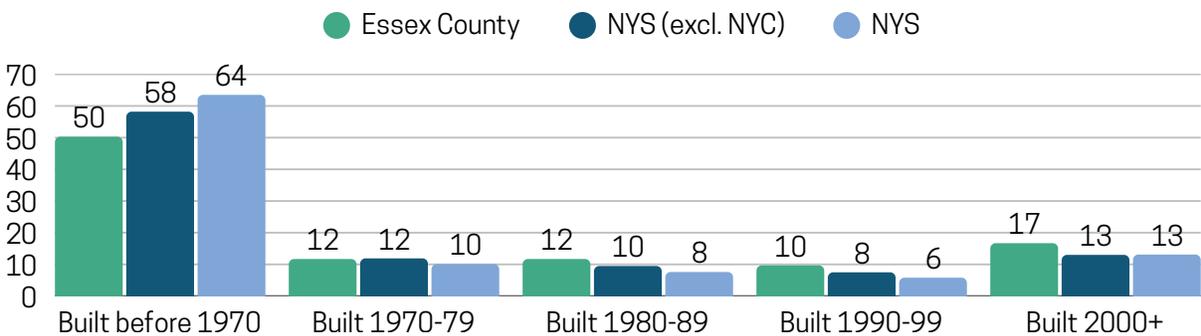


New York State: 32.7%
National Average: 27.5%



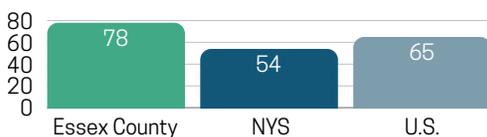
New York State: 51.5%
National Average: 50.4%

Housing Age



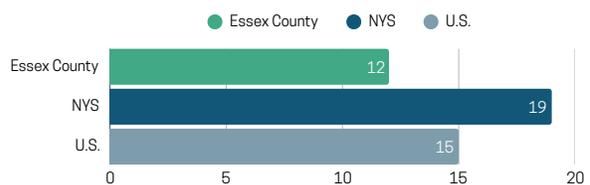
Homeownership

Percentage of owner-occupied housing units



Severe Housing Cost Burden

% of households that spend 50% or more of their income on housing



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



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

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



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

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

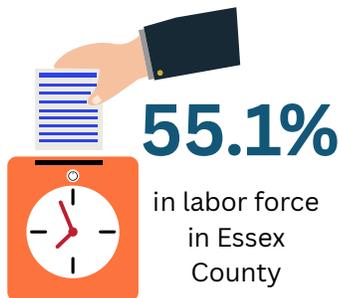
A more recent housing report determined that between 193 and 250 new affordable and market-rate rental and for-sale primary and for-sale second/vacation/weekend units per year could be leased or sold in Essex County, better quantifying the housing need here.

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



Unemployment

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



New York State: 62.8%
National Average: 63.5%

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



New York State: 6.2%
National Average: 5.2%

¹⁴ Asterhill Research Company. (2022, May 24). *Essex County demographic and housing report with town profiles*. Essex County, NY.

¹⁵ Zimmerman/Volk Associates, Inc. (2025). *An analysis of residential market potential for primary and second/ weekend/ vacation units in Essex County, New York*. Zimmerman/Volk Associates, Inc.

¹⁶ Office of Disease Prevention and Health Promotion. (n.d.). *Social determinants of health*. Healthy People 2030. U.S. Department of Health and Human Services. <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>

Nutrition Security



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

Figure 6: Self-Reported Food Insecurity Among New York State Adults by County, BRFSS 2021¹⁸

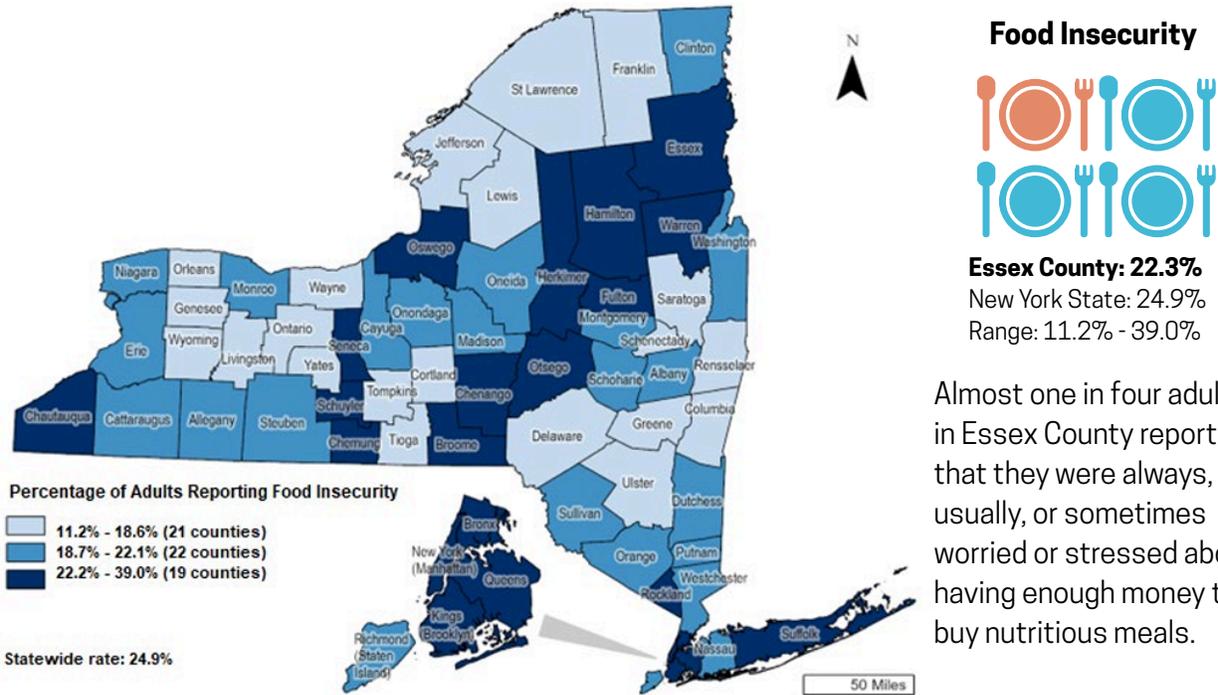
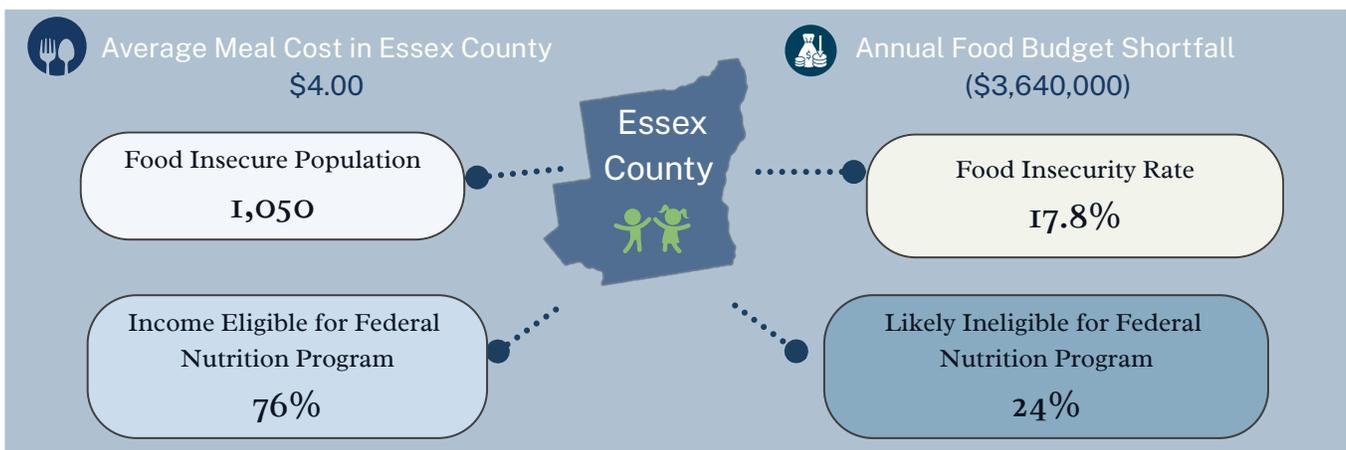


Figure 7: Food Insecurity among the Child Population in Essex County, NY, 2023¹⁹



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

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

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



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



DOMAIN 2: SOCIAL AND COMMUNITY CONTEXT

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

 Anxiety & Stress

 Depression

 Alcohol Use

 Suicide

 Tobacco/E-Cigarette Use

 Adverse Childhood Experiences

 Primary Prevention, Substance Misuse, & Overdose Prevention

 Healthy Eating

Anxiety & Stress

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

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

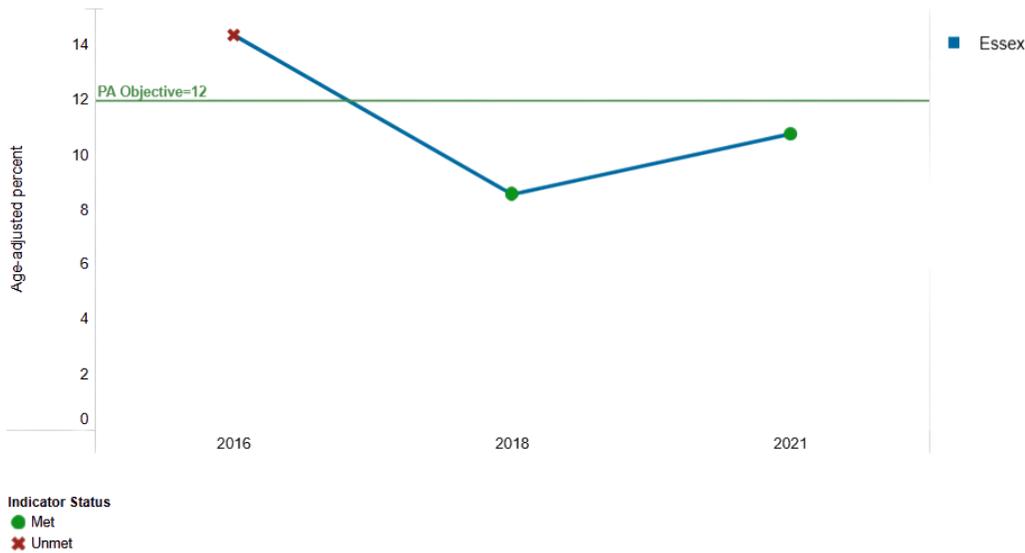
According to the NYS Prevention Agenda Dashboard, the percentage of adults experiencing frequent mental distress during the past month in Essex County is 10.8%, which is below the Prevention Agenda objective of 12.0% (Figure 8). This indicator value is from the 2021 Behavioral Risk Factor Surveillance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

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

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

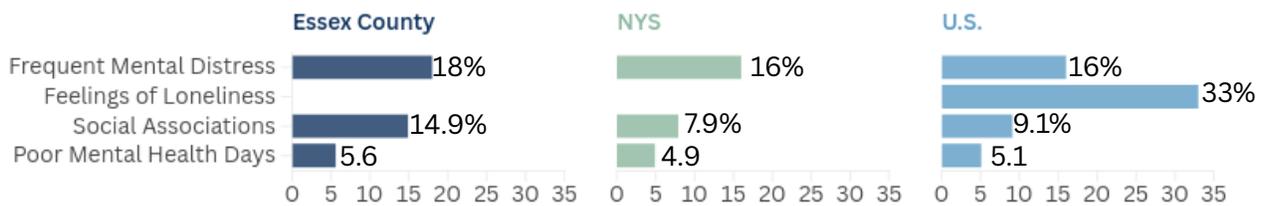


Figure 8: Percentage of adults experiencing frequent mental distress during the past month, age-adjusted, aged 18 years and older³



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

Figure 9: Percentage of adults experiencing frequent mental distress during the past month, age-adjusted, aged 18 years and older²



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

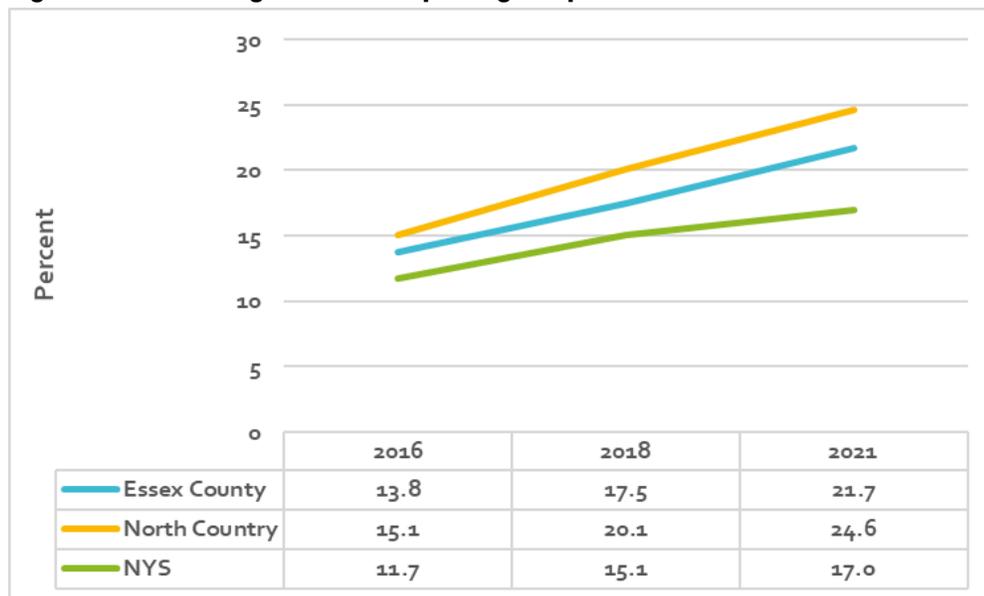


Depression

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

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

Figure 10: Percentage of adults reporting a depressive disorder⁶



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

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

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

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



Alcohol Use

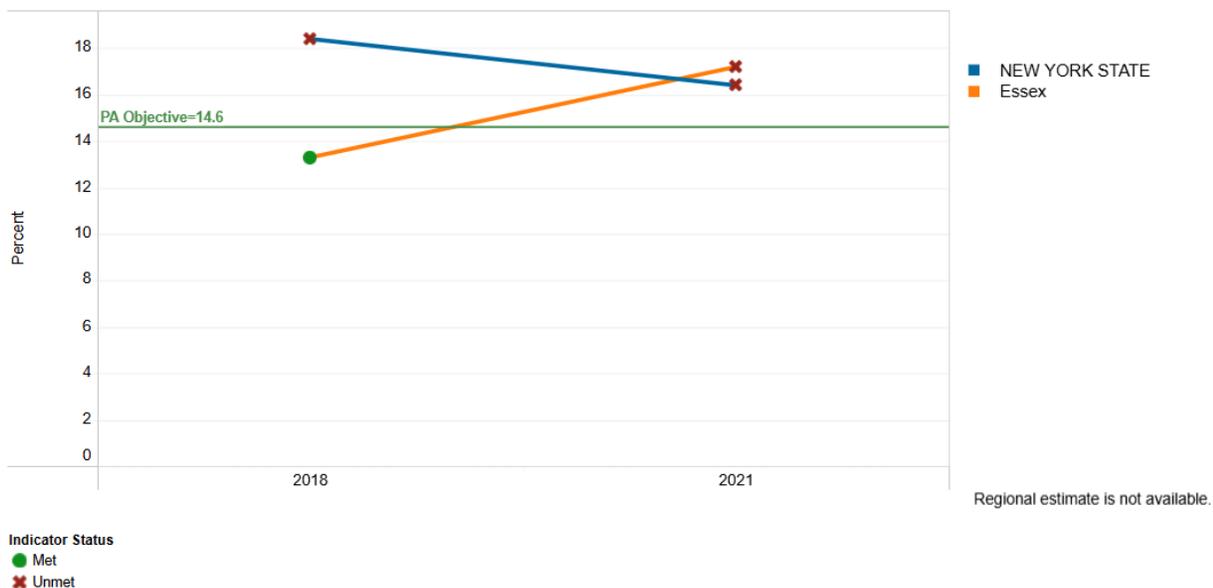
Several key measures are used to monitor alcohol use and related health outcomes. Excessive alcohol use—including binge and heavy drinking, underage drinking, and alcohol use during pregnancy—is linked with significant mortality (about 178,000 deaths annually in the U.S.) and social and health harms.⁷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

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

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

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

Figure 11: Prevalence of binge or heavy drinking among adults, aged 18 years of age or older³



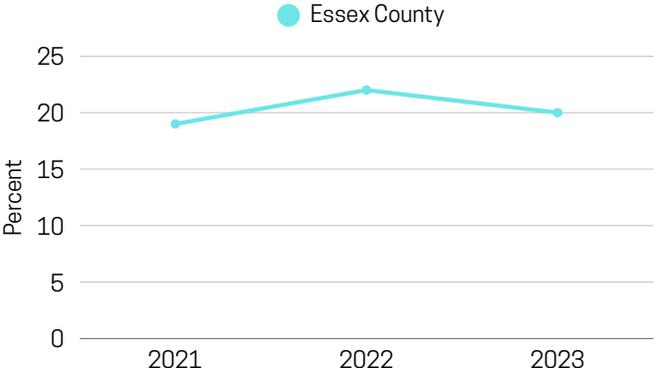
⁷Centers for Disease Control and Prevention. (n.d.). *Chronic Disease Indicators: Alcohol*. <https://www.cdc.gov/cdi/indicator-definitions/alcohol.html>

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



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

Figure 12: Prevalence of binge or heavy drinking among adults, age adjusted^{2,10}



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

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

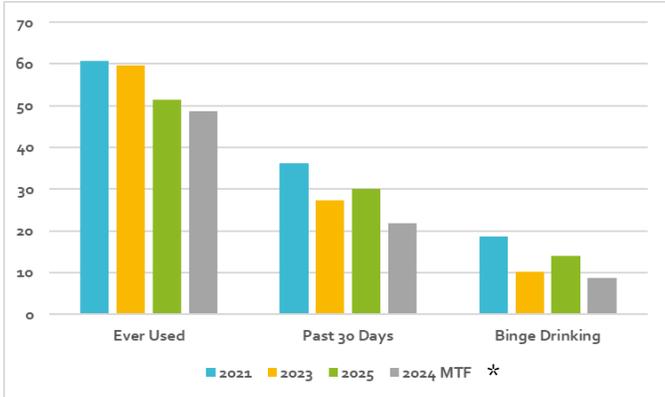
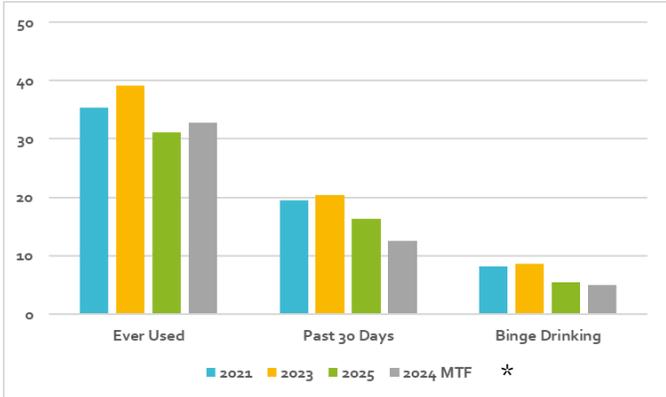


Figure 14: Percentage of student self-reported alcohol use - Essex County All Grades Surveyed



*Monitoring The Future national data

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



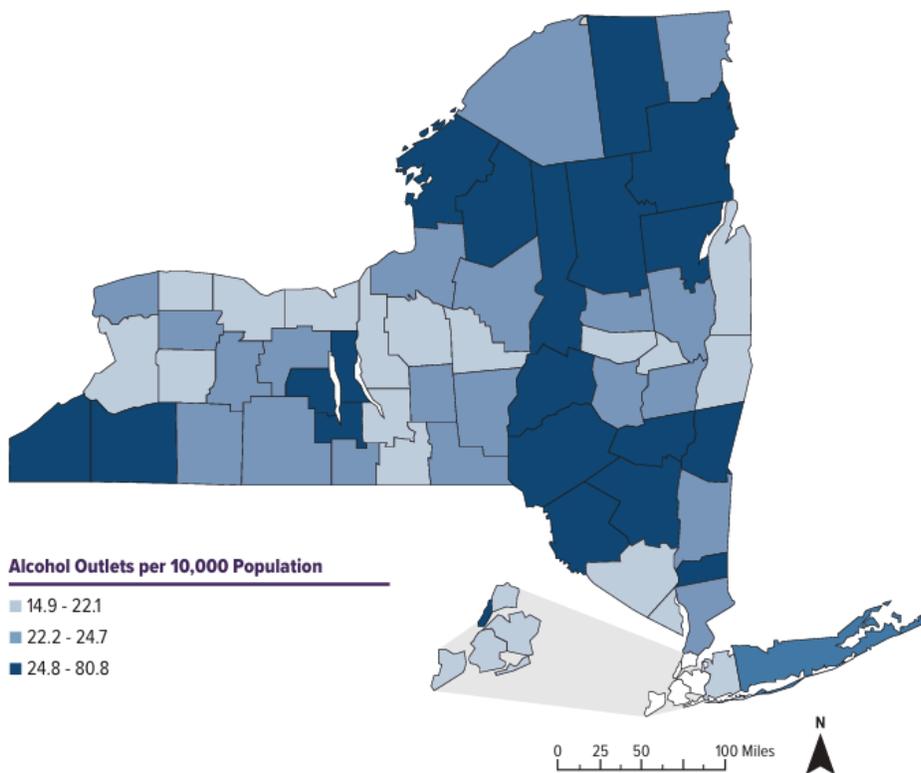
The New York State Department of Health recognizes that health outcomes are strongly shaped by social, economic, and environmental inequalities, often more than by individual behavior alone. Patterns of alcohol use and related harms differ across population groups, with some communities experiencing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

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

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

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

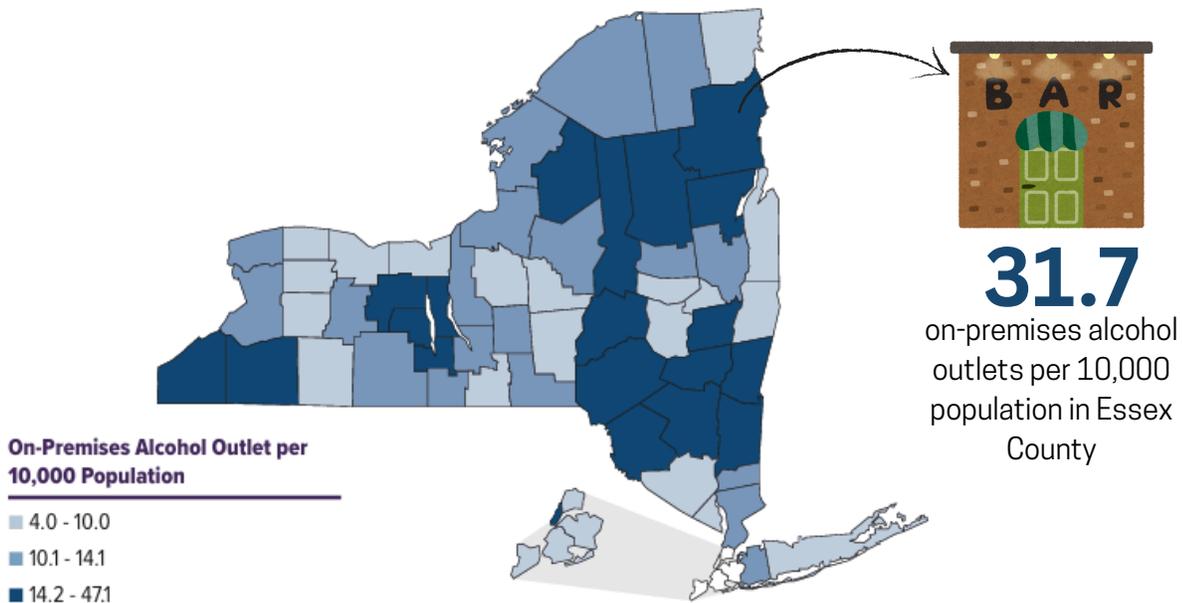
Figure 15: Total Alcohol Outlets per 10,000 Population in New York¹³



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

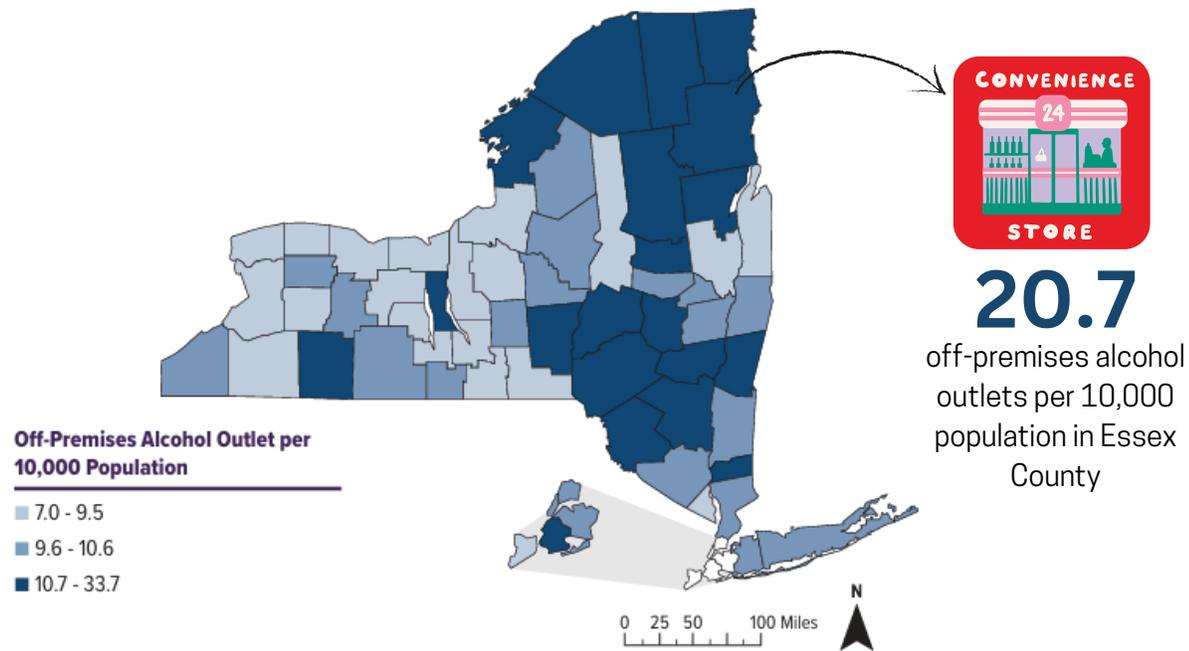
¹³ New York State Department of Health, Alcohol Surveillance and Epidemiology Program. (2025). *Alcohol outlet density in New York State* (Information for Action Report No. 2025-15). Albany, NY: New York State Department of Health

Figure 16: On-Premises Alcohol Outlets per 10,000 Population in New York¹³



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

Figure 17: Off-Premises Alcohol Outlets per 10,000 Population in New York¹³



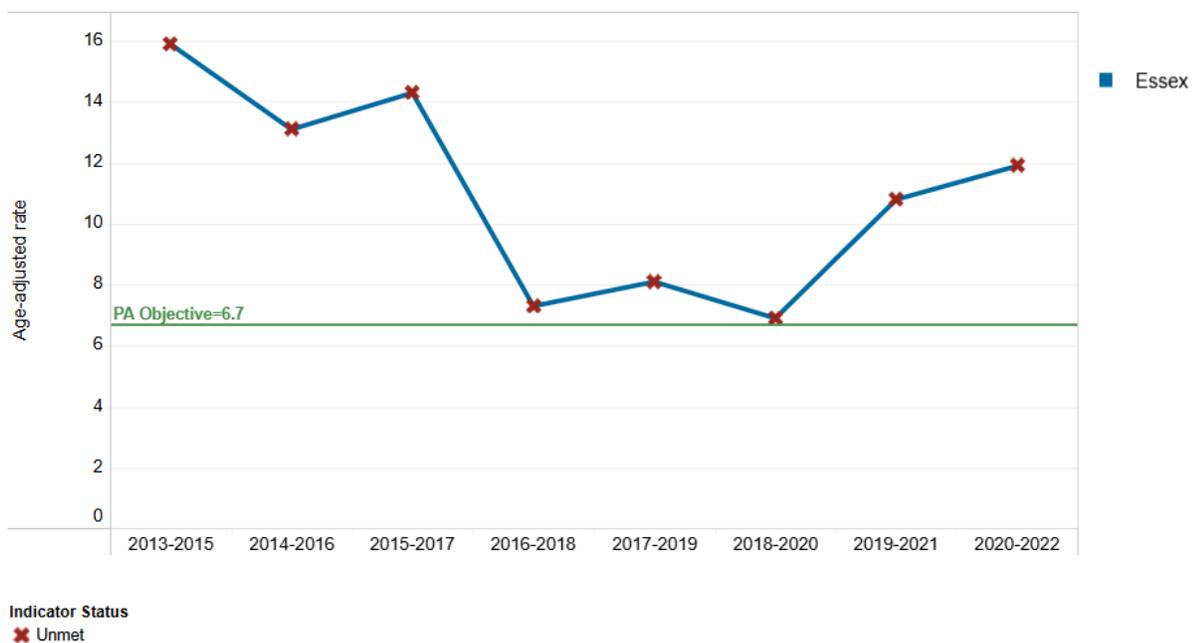
Off-Premises Outlets: Outlets include liquor stores, big-box retailers, grocery stores, small convenience stores, gas stations and pharmacies licensed as of March 2023. Does not include seasonal and other wholesale outlets

Suicide



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

Figure 18: Suicide mortality, age-adjusted rate per 100,000 population³



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

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

¹⁴Centers for Disease Control and Prevention. (2025, March 26). *About suicide prevention*. U.S. Department of Health and Human Services. Retrieved from <https://www.cdc.gov/suicide/about/index.html>

¹⁵U.S. Department of Health and Human Services. (n.d.). *Healthy People 2030: Reduce the suicide rate — MHMD-01*. Office of Disease Prevention and Health Promotion. Retrieved from <https://health.gov/healthypeople/objectives-and-data/browse-objectives/mental-health-and-mental-disorders/reduce-suicide-rate-mhmd-01>



Tobacco/E-Cigarette Use



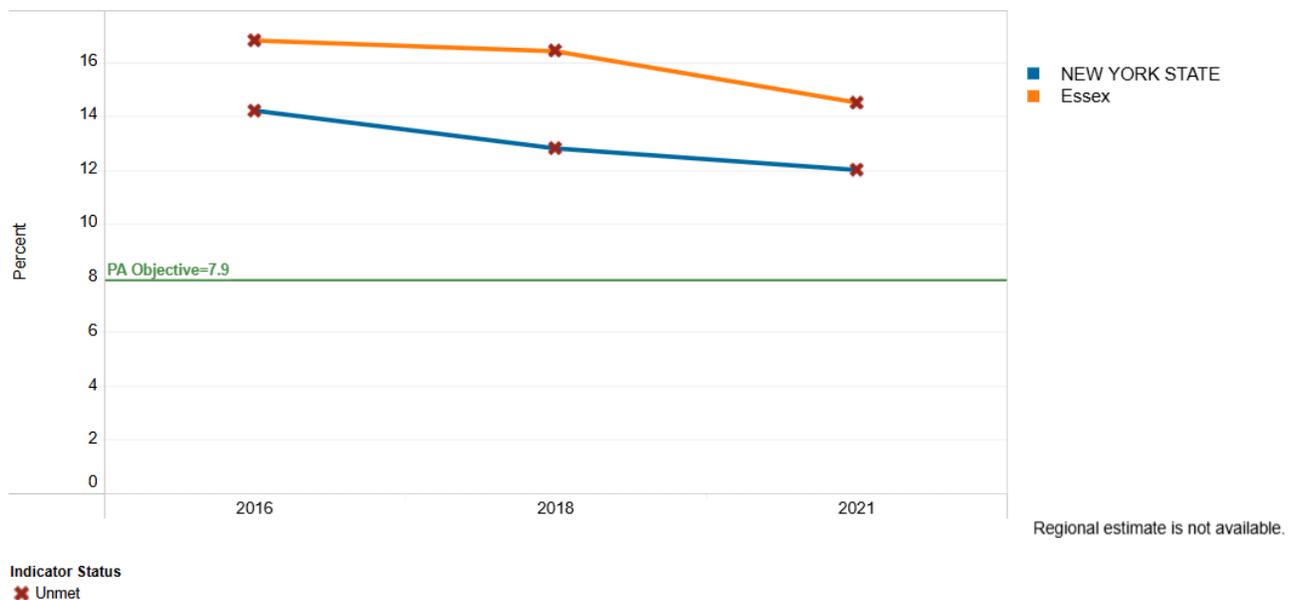
In Essex County, New York, smoking remains a notable public health concern, with about 15% of adult residents reporting that they currently smoke cigarettes, a rate that is higher than NYS prevalence and contributes to preventable disease burden locally (Figure 19).

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

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

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

Figure 19: Prevalence of cigarette smoking among adults, aged 18 years and older³



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

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

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



Figure 20: Trends in the prevalence of current smoking among adults and in groups with the highest smoking rates in New York State, Behavioral Risk Factor Surveillance System 2020-2023¹⁷

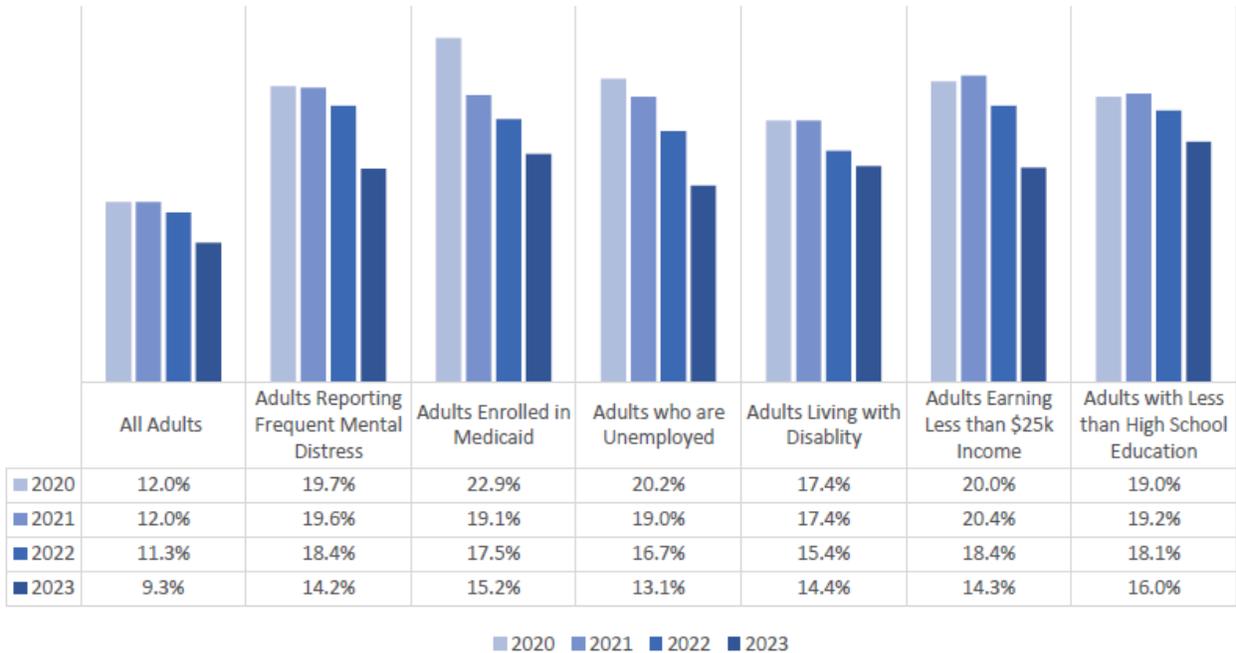
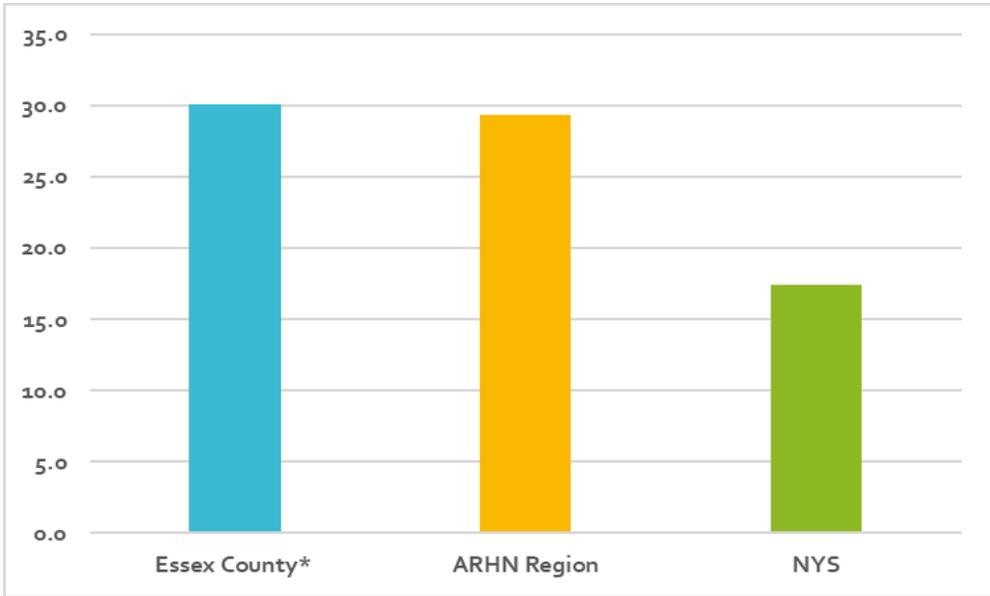


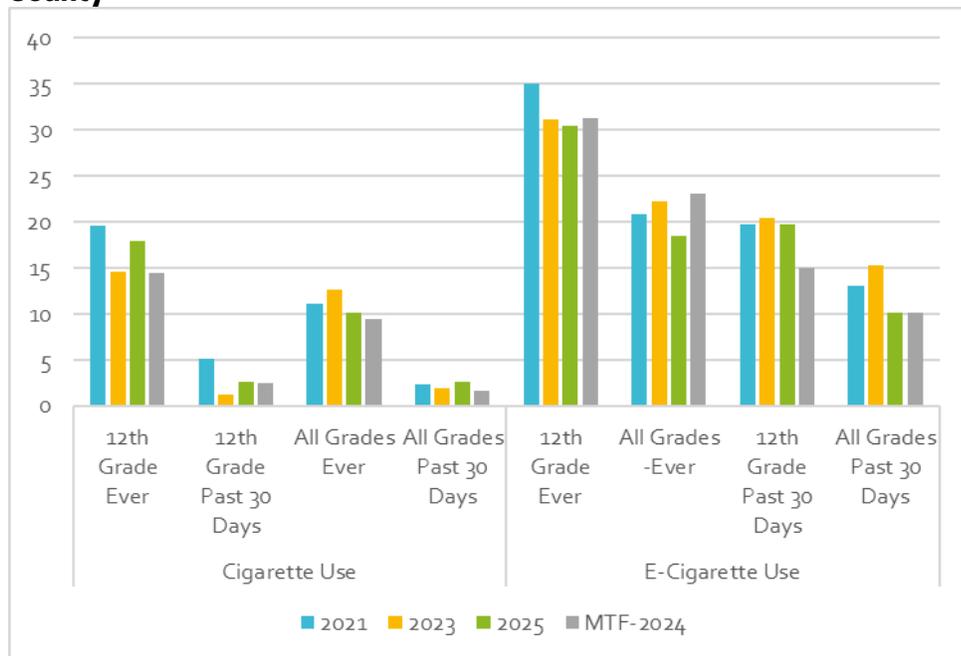
Figure 21: Percentage of adults living with a disability who smoke⁶



*Unreliable estimate



Figure 22: Percentage of student self-reported cigarette and e-cigarette use - Essex County¹¹



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

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

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

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

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

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

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

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



Adverse Childhood Experiences (ACEs)

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

Figure 23: Percentage of adults age 18 years and older who, as a child, experienced three or more ACEs, 2021³

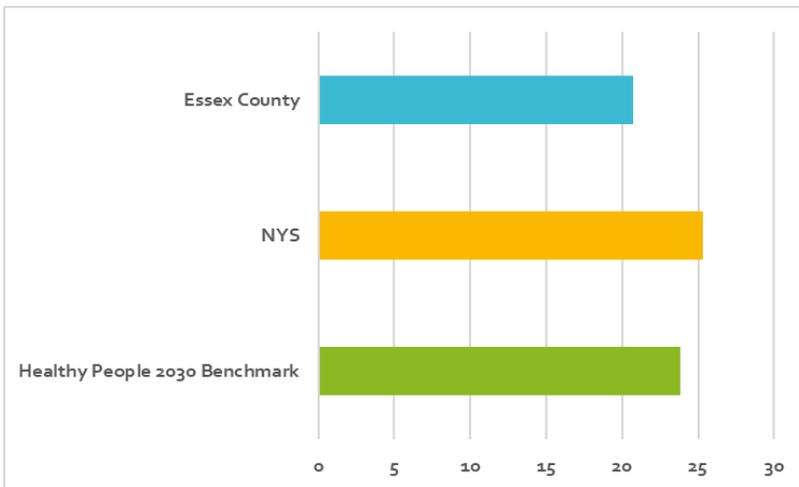
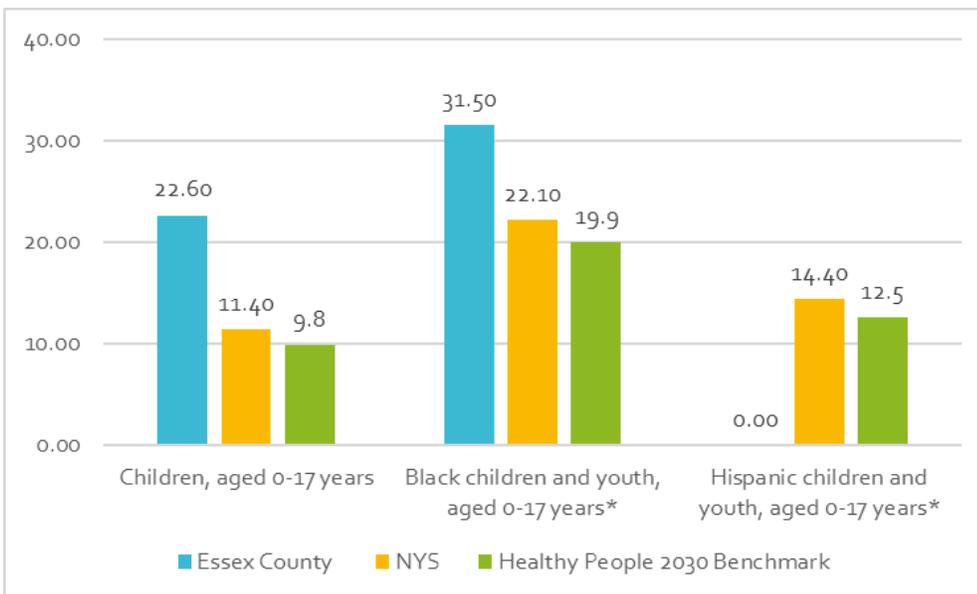


Figure 24: Indicated reports of abuse/maltreatment, rate per 1,000 children, 2024³



*Unreliable estimate



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

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



Primary Prevention, Substance Misuse, & Overdose Prevention

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

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

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

²¹ Centers for Disease Control and Prevention. (n.d.). *Substance use among youth*. U.S. Department of Health and Human Services. <https://www.cdc.gov/youth-behavior/risk-behaviors/substance-use-among-youth.html> CDC

²² Centers for Disease Control and Prevention. (n.d.). *Drug overdose deaths in the United States, 2002-2022* (Data Brief No. 491). National Center for Health Statistics. <https://www.cdc.gov/nchs/products/databriefs/db491.htm> CDC

²³ Centers for Disease Control and Prevention. (n.d.). *FastStats: Drug overdoses*. National Center for Health Statistics. <https://www.cdc.gov/nchs/fastats/drug-overdoses.htm> CDC

²⁴ Centers for Disease Control and Prevention. (n.d.). *Understanding the opioid overdose epidemic*. U.S. Department of Health and Human Services. <https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html>

²⁵ New York State Department of Health. (2023). *New York State opioid annual report 2023*.

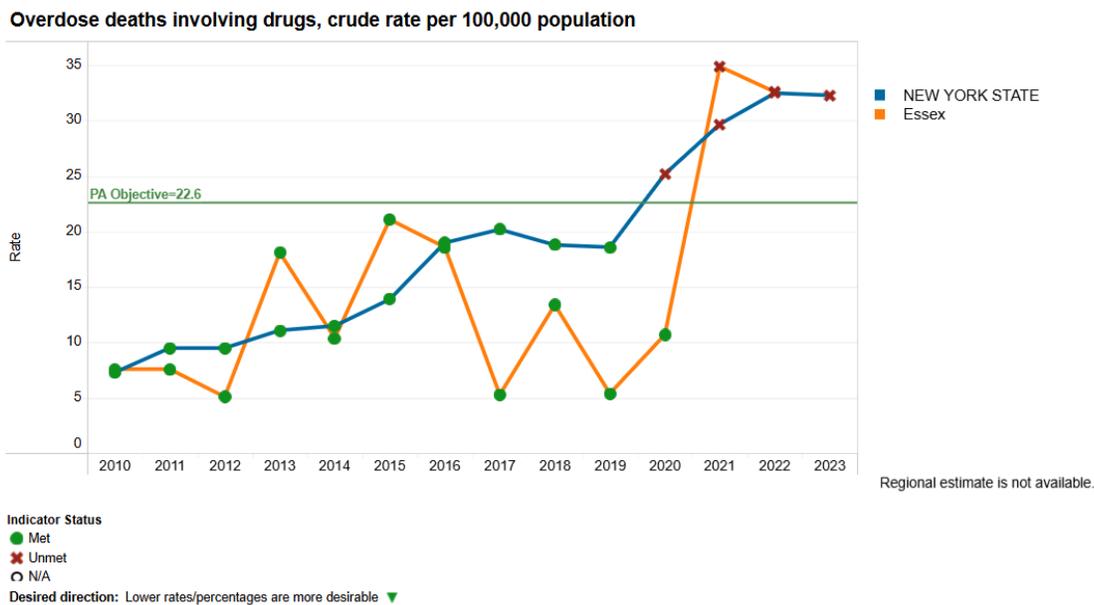
https://www.health.ny.gov/statistics/opioid/data/pdf/nys_opioid_annual_report_2023.pdf. New York State Department of Health

²⁶ New York State Office of Addiction Services and Supports. (2023). *Addiction data bulletin: Substance use disorder treatment service system*. <https://oasas.ny.gov/addiction-data-bulletin-0>



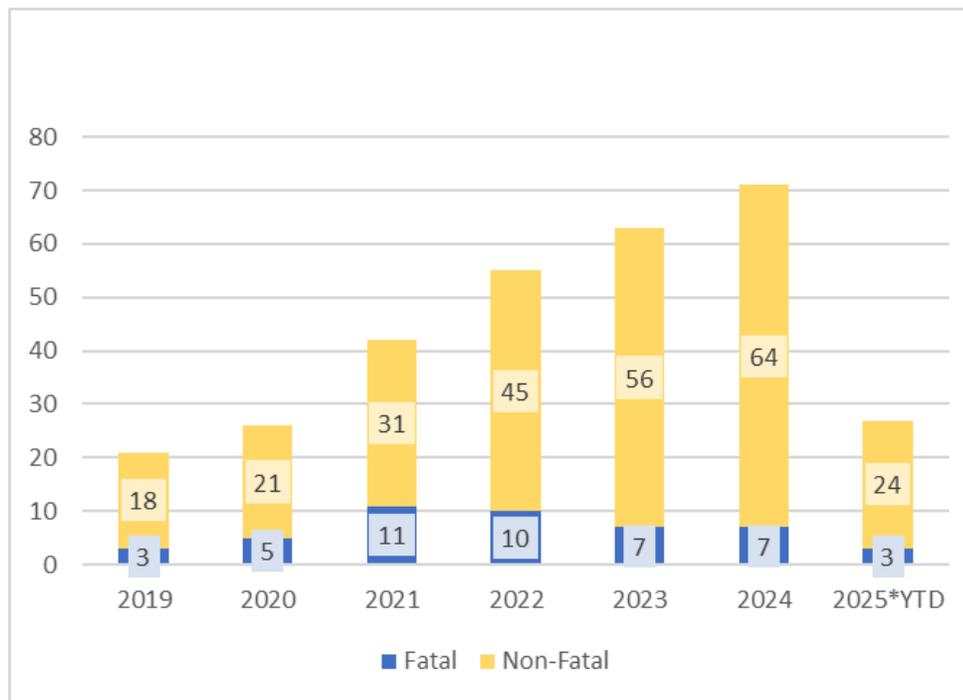
As noted, Essex County experienced a sharp increase in overdose deaths in 2021 and 2022 (Figure 25), though previous estimates (prior to 2021) are unreliable*. Overall incidents of overdose in Essex County - both fatal and non-fatal - were increasing from 2015 through 2024, as depicted in Figure 26.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

Figure 25: Overdose deaths involving drugs, crude rate per 100,000 population³



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

Figure 26: Essex County Overdose Count By Year, Fatal and Non-Fatal²⁷



²⁷ Essex County Health Department. 2025. Overdose Database.



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

Figure 27: Episodes when an opioid-naive patient received an initial opioid prescription, rate per 1,000 population³

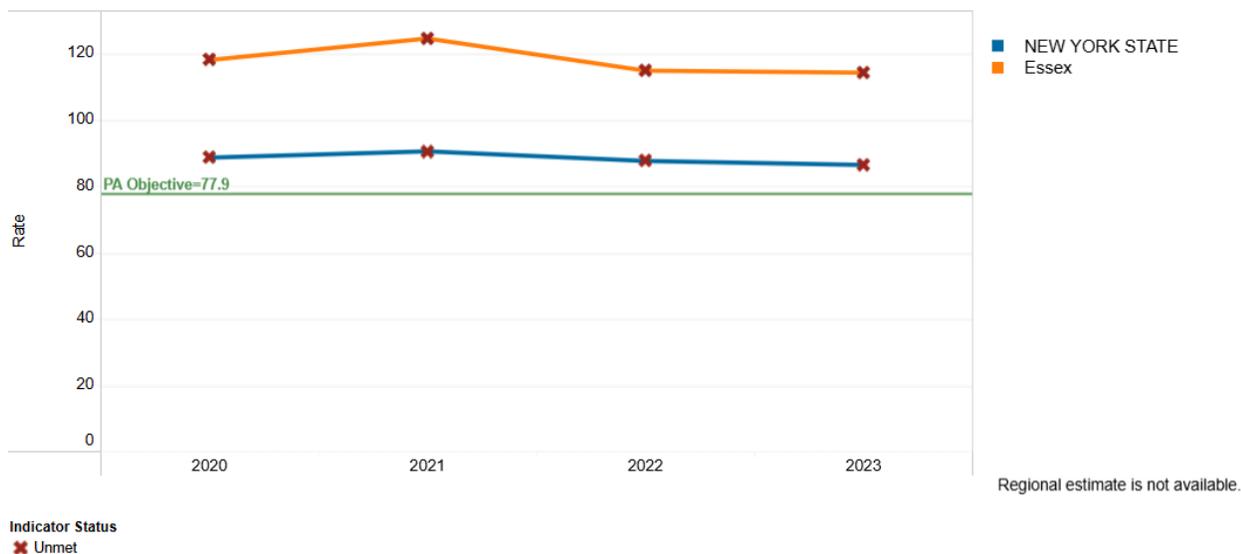
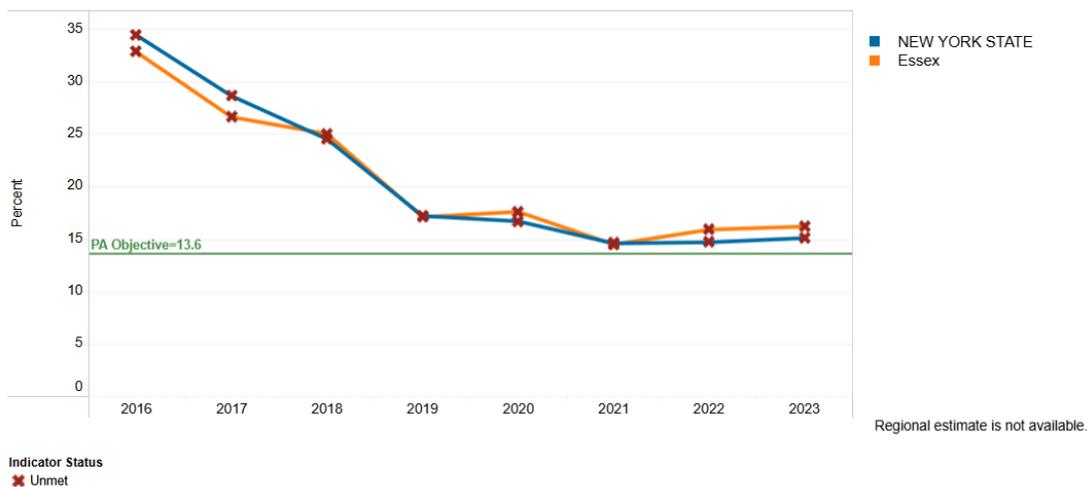


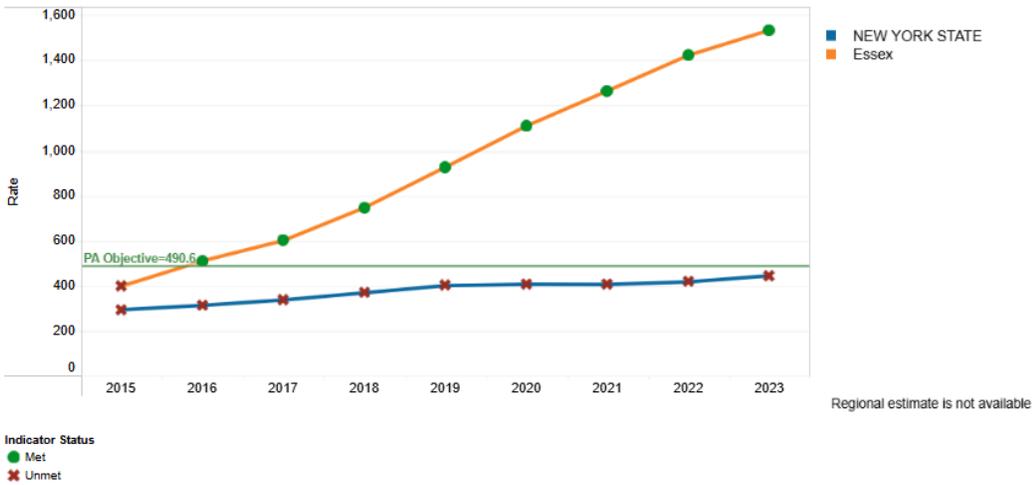
Figure 28: Percentage of episodes when patients were opioid naive and received an opioid prescription of more than seven days³



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



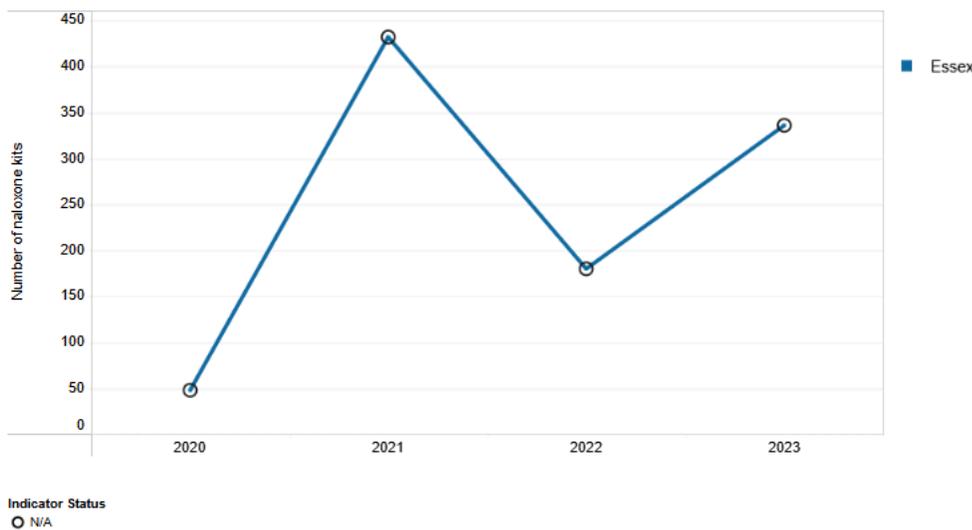
Figure 29: Patients who received at least one buprenorphine prescription for opioid use disorder, crude rate per 100,000 population³



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

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

Figure 30: Number of naloxone kits distributed³



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

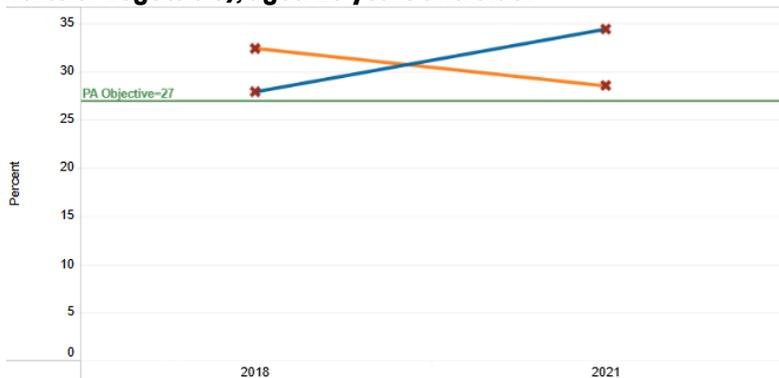


Healthy Eating

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

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

Figure 31: Percentage of adults who consumed fewer than one fruit and fewer than one vegetable daily (no fruits or vegetable), aged 18 years and older³

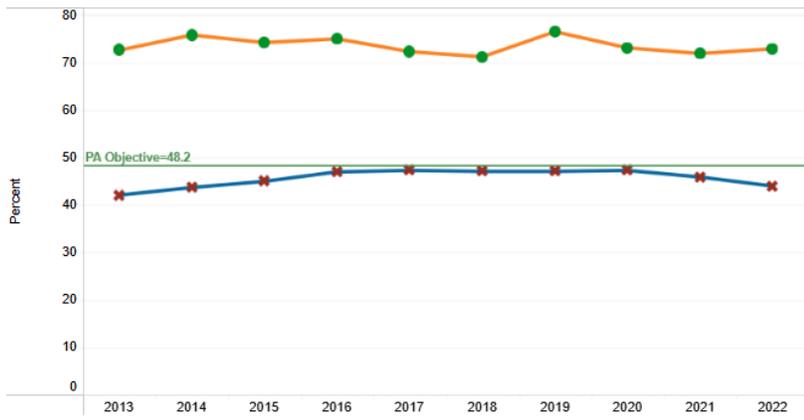


28.5%
 or slightly more than
 1 in 4 adults in Essex
 County consume no
 fruits or vegetables
 daily
*This is down from
 32.4% in 2018*

Regional estimate is not available.

Indicator Status
 ✖ Unmet

Figure 32: Percentage of infants who are exclusively breastfed in the hospital among all infants³

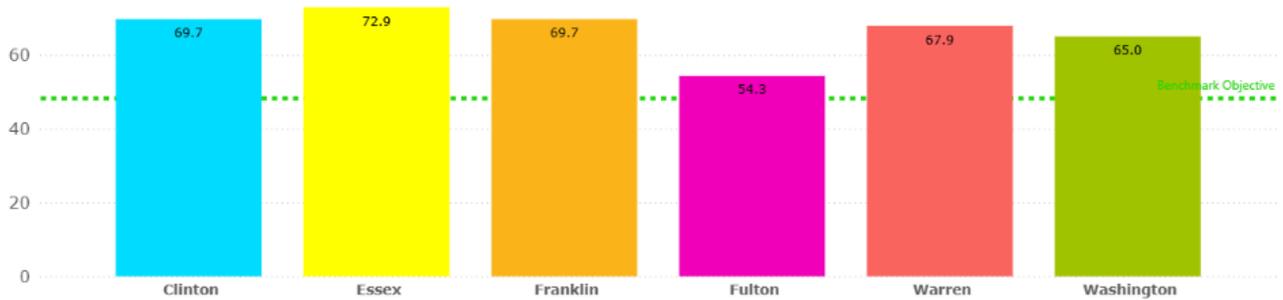


Regional estimate is not available.

Indicator Status
 ● Met
 ✖ Unmet

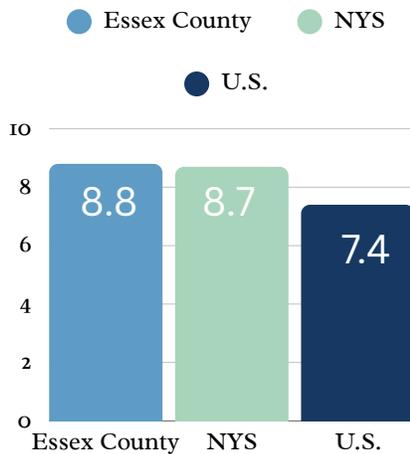


Figure 33: Percentage of infants who are exclusively breastfed in the hospital among all infants - regional comparison



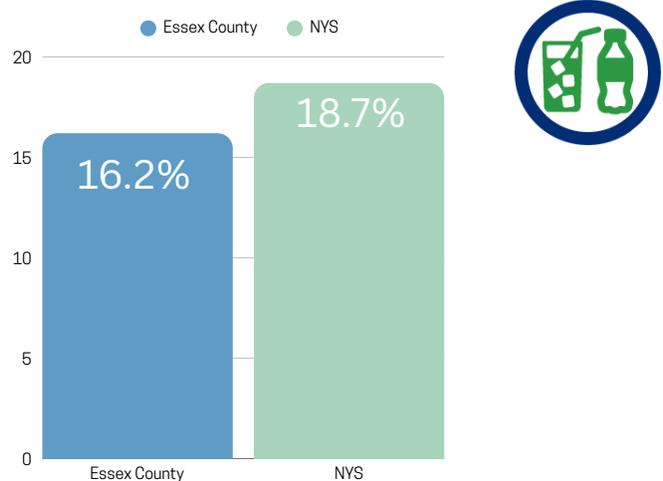
Access to healthy foods can have a considerable impact on whether individuals and families are able to enjoy nutritious foods. The Food Environment Index in Essex County is comparable to NYS as a whole and is better than the U.S. score (Figure 34). Fewer adults in Essex County consume sugar-sweetened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

Figure 34: Food Environment Index²



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

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



*Consumed At Least One Regular Soda or SSB Per Day



DOMAIN 3: NEIGHBORHOOD AND BUILT ENVIRONMENT

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

 Opportunities for Active Transportation & Physical Activity

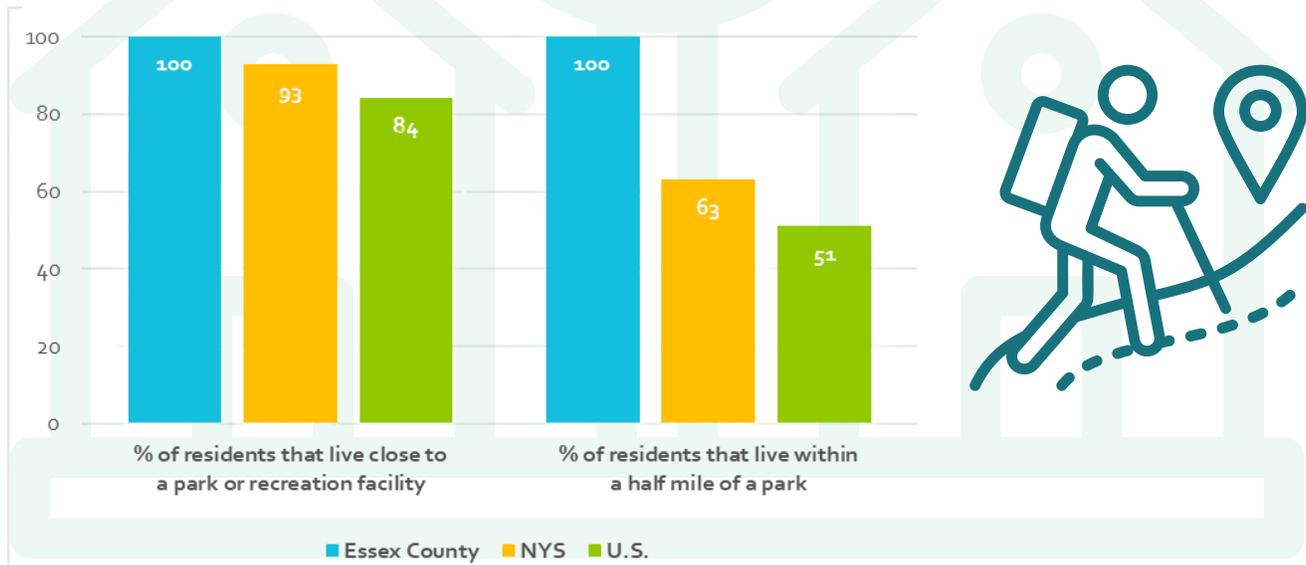
 Access to Community Services & Supports

 Injuries and Violence

Opportunities for Active Transportation & Physical Activity

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

Figure 36: Opportunities to be Physically Active²

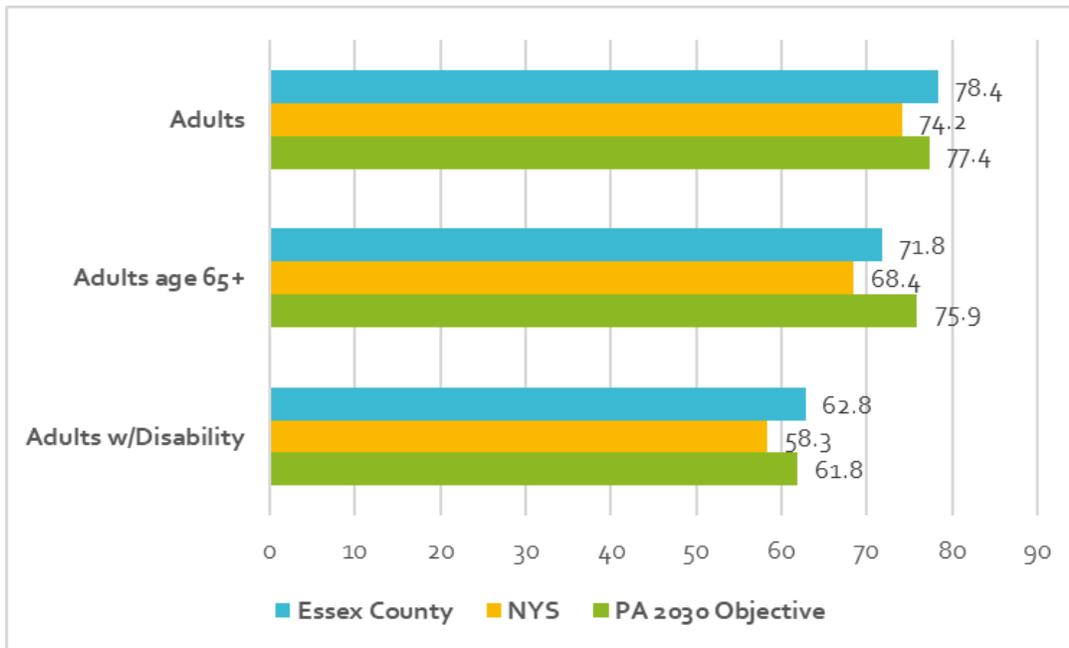


¹ New York State Department of Health. (2024). *Prevention Agenda 2025–2030: New York State’s health improvement plan*. New York State Department of Health. Retrieved December 11, 2025 https://health.ny.gov/prevention/prevention_agenda/

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



Figure 37: Prevalence of Leisure Time Physical Activity, 2021³



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



Access to Community Services & Supports

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

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

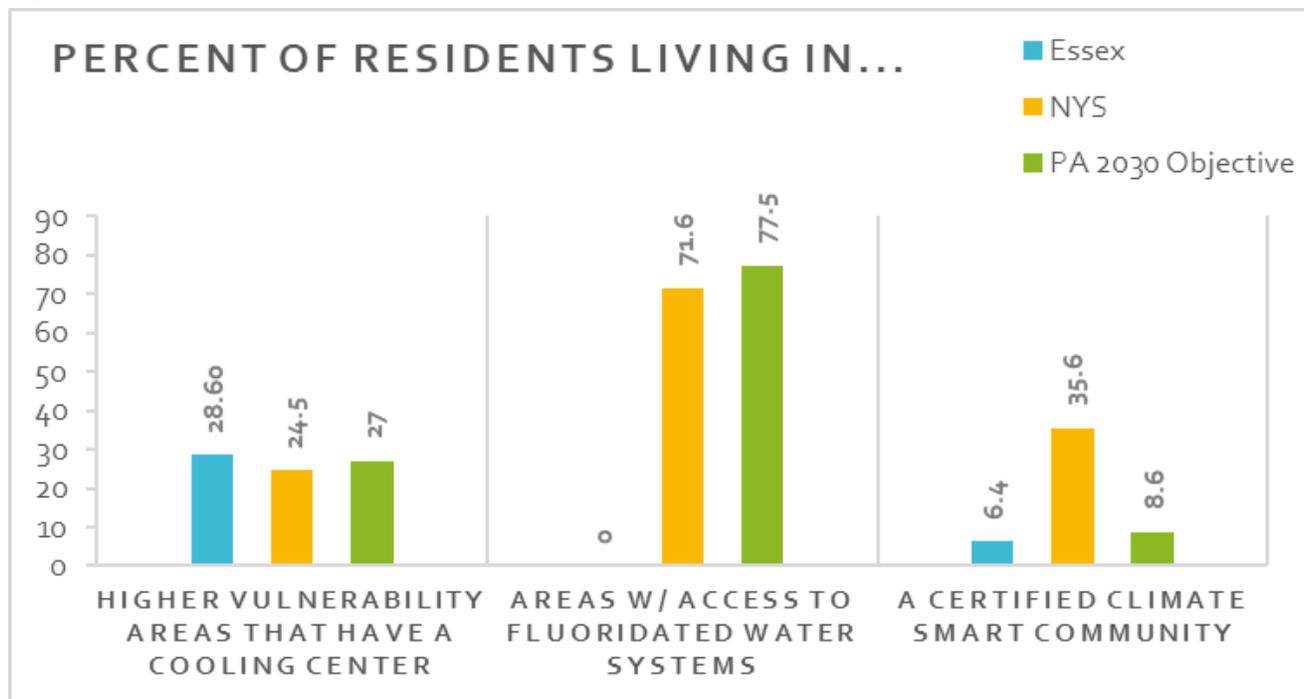
⁴ Office of Disease Prevention and Health Promotion. (2020). *Healthy People 2030*. U.S. Department of Health and Human Services. <https://health.gov/healthypeople>



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

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

Figure 38: Access to Community Services & Supports Indicators⁵



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

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



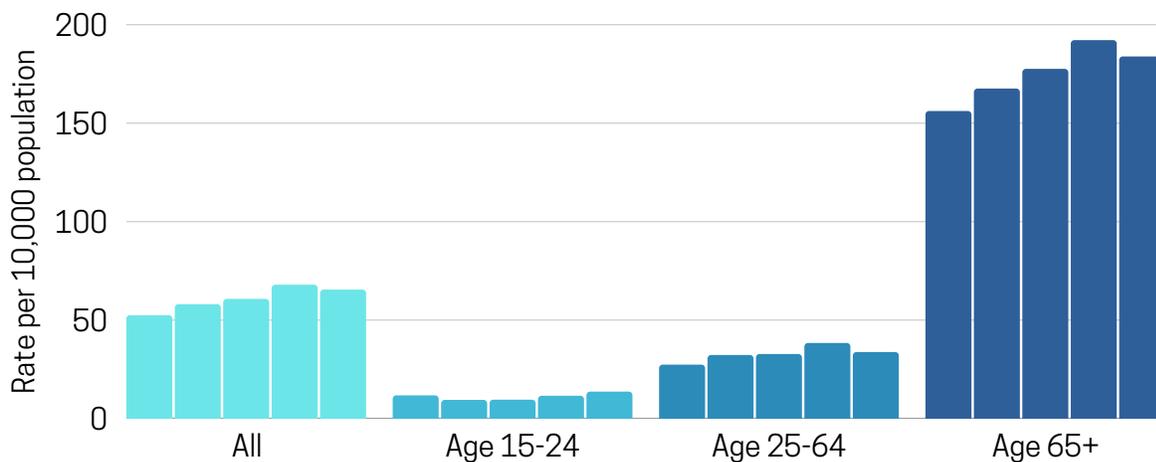
Injuries & Violence

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

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

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

Figure 39: Unintentional injury hospitalization rate - Essex County, Years 2017 - 2021⁶

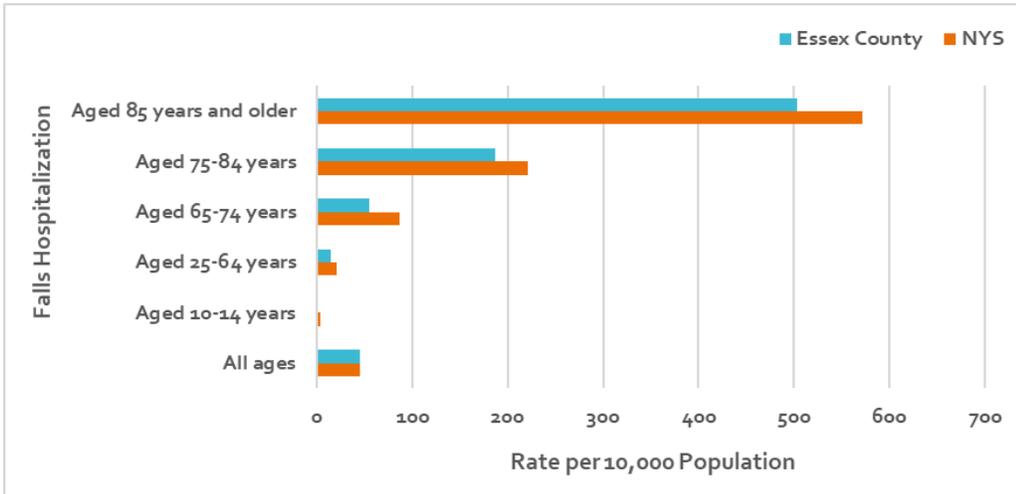


Unintentional injuries cover a broad category of injuries that often occur due to lapses in attention, lack of safety measures, or unexpected events, affecting all ages but especially younger children and older adults. They include accidents and common mishaps like falls, drowning/near drowning, car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

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

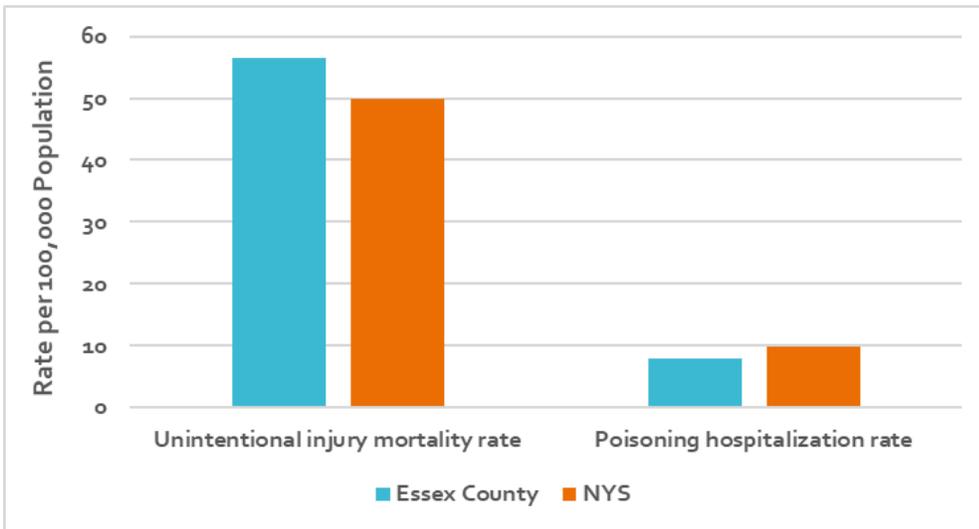


Figure 40: Falls hospitalization rates by Age, 2020-2022⁶



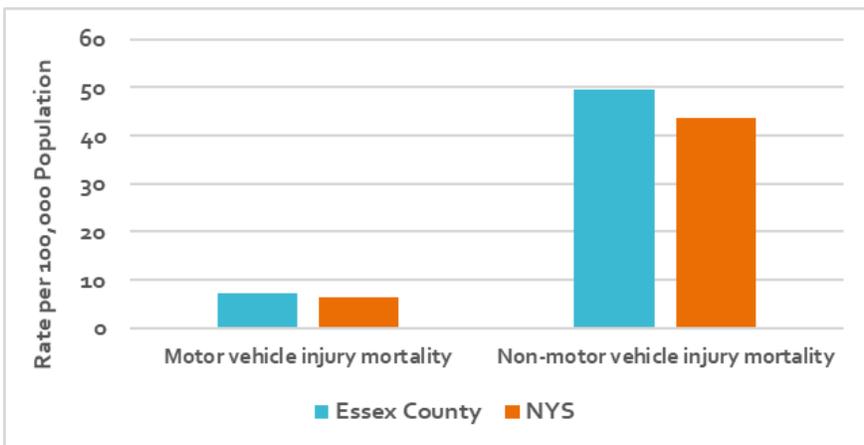
Hospitalizations due to falls occur less frequently than state averages, across all age categories graphed in Figure 40. , though Essex County shows the same trends for increasing hospitalization rates for falls as age increases. The all age falls hospitalization rate is similar to the state rate.

Figure 41: Unintentional injury mortality and poisoning hospitalizations, 2020-2022⁶



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

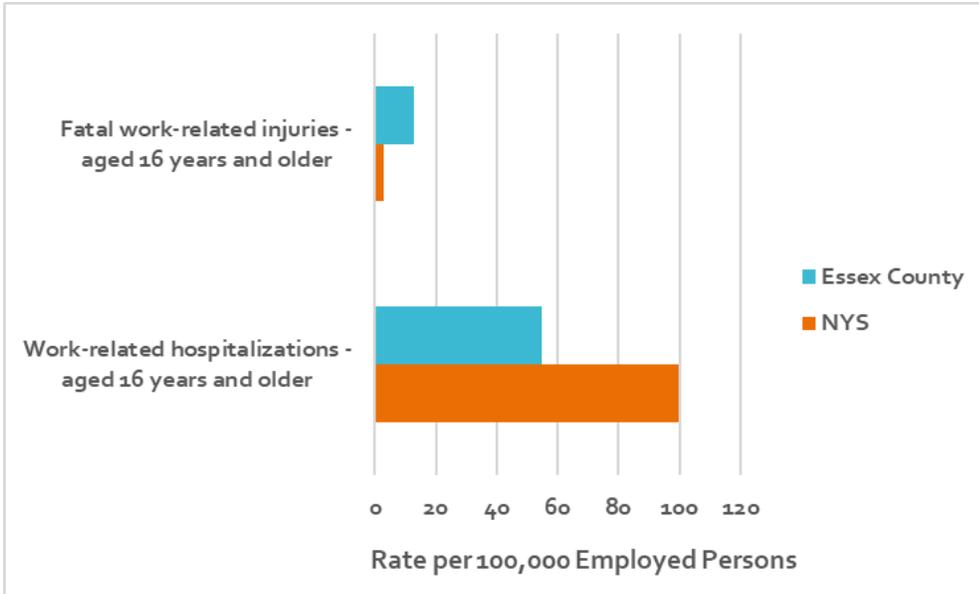
Figure 42: Motor vehicle injury mortality vs. non-motor vehicle injury mortality⁶



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



Figure 43: Work-related injury hospitalizations and fatalities, 2020-2022⁶



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

Figure 44: Motor vehicle crash rates - all, 2023⁷

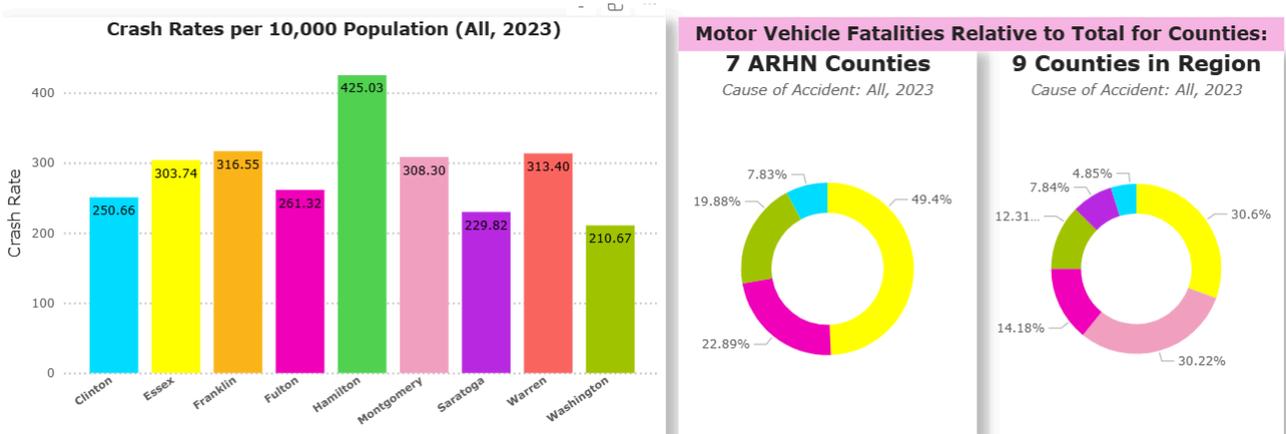


Figure 45: Crash rate, 2023⁷

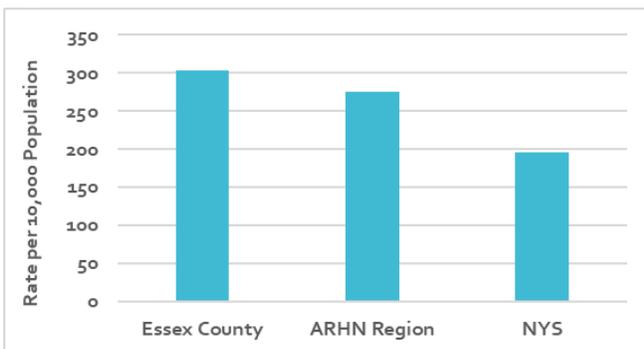
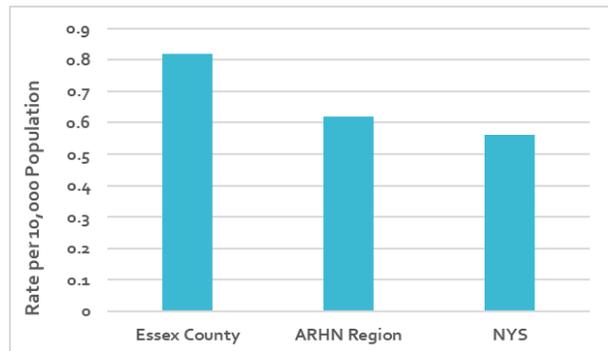


Figure 46: Crash fatality rate, 2023⁷

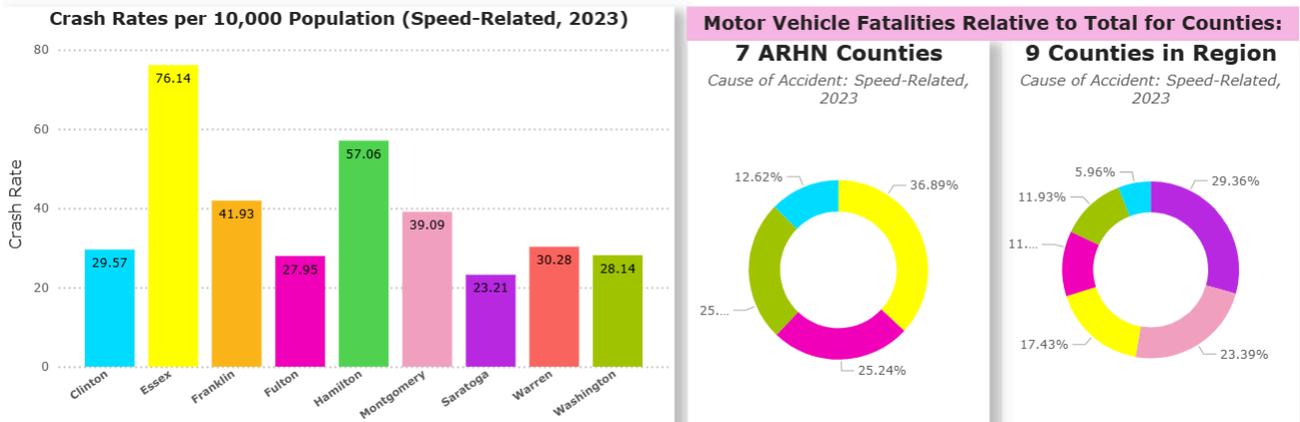


⁷ Institute for Traffic Safety Management & Research. (2025). *Traffic Safety Statistical Repository (TSSR), County Crash Summary Reports, 2023*. Retrieved May 27, 2025, from <https://www.itsmr.org/traffic-safety-statistical-repository/>



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

Figure 47: Motor vehicle crash rates - speed related, 2023⁷



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

Figure 48: Motor vehicle crash rates - alcohol related, 2023⁷

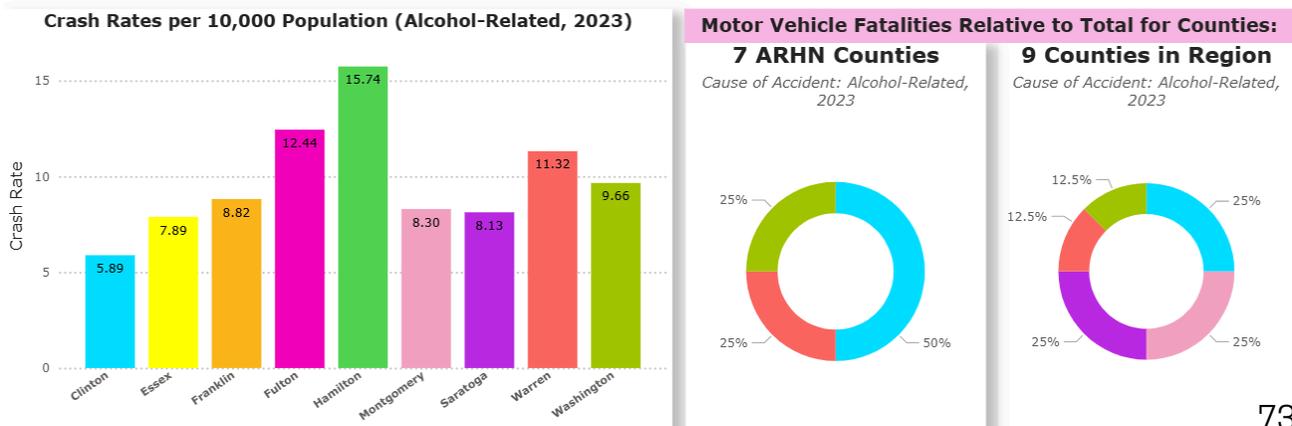
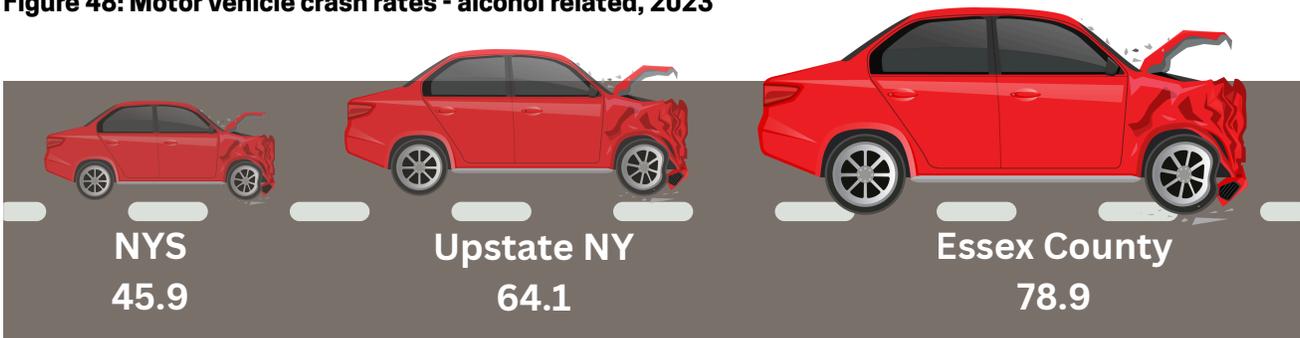




Figure 49: Self-inflicted injury hospitalizations, 2020-2022⁶

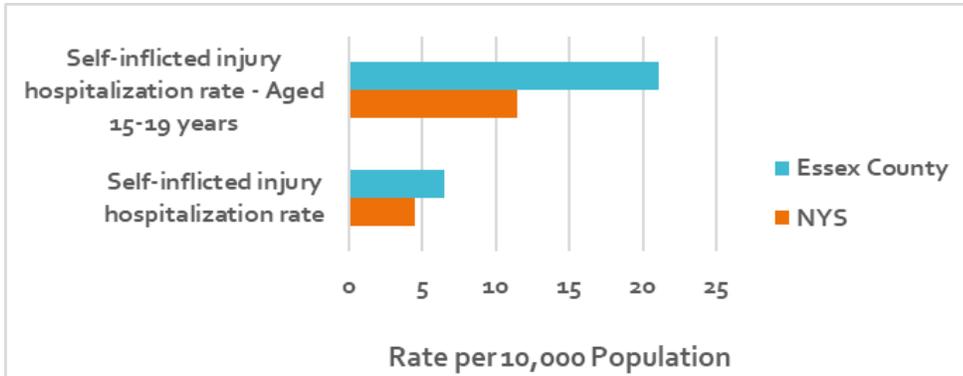
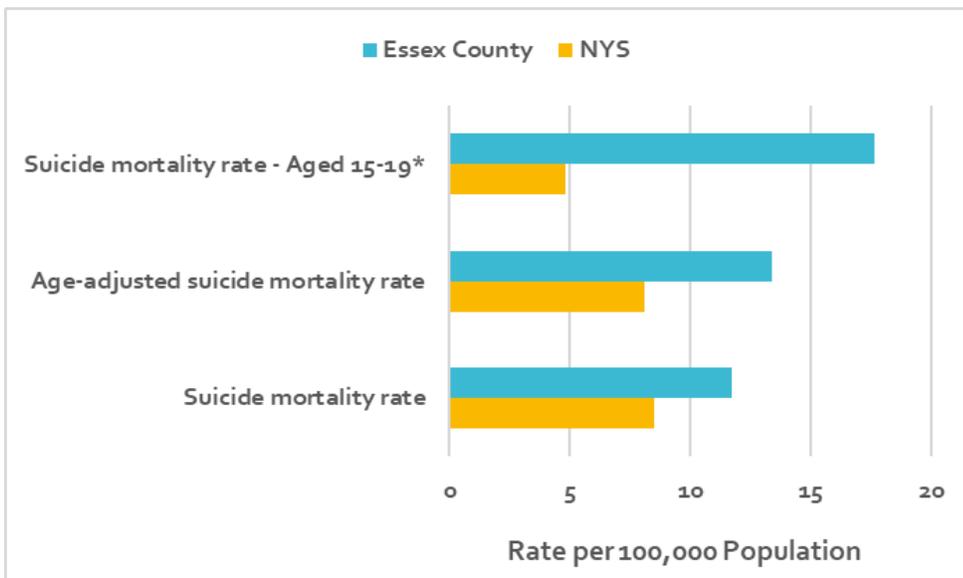


Figure 50: Suicide mortality rates, 2020-2022⁶



*Rate is unstable/unreliable

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

Figure 51: Suicide mortality rate trends, 2013-2022⁶

Suicide mortality rate per 100,000, Essex

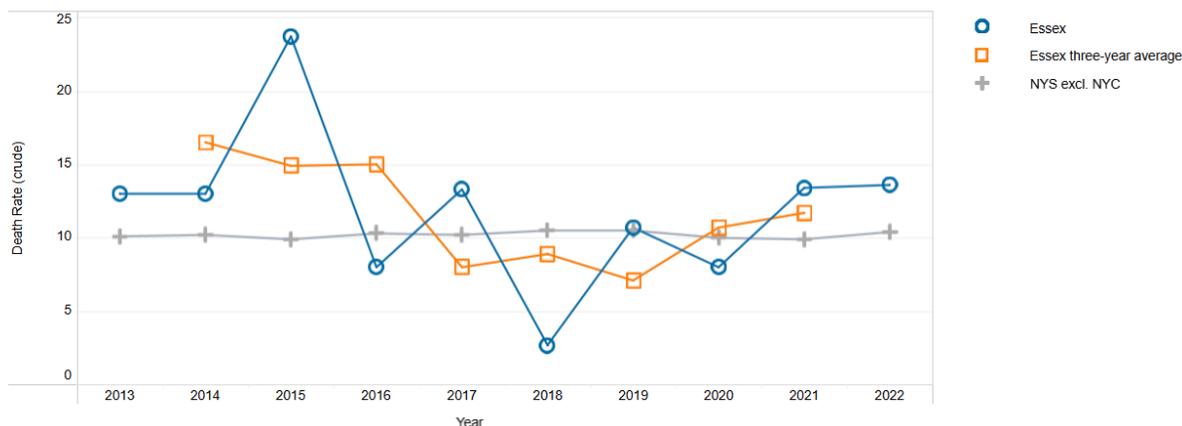




Figure 52: Crime rates, 2020-2022⁶

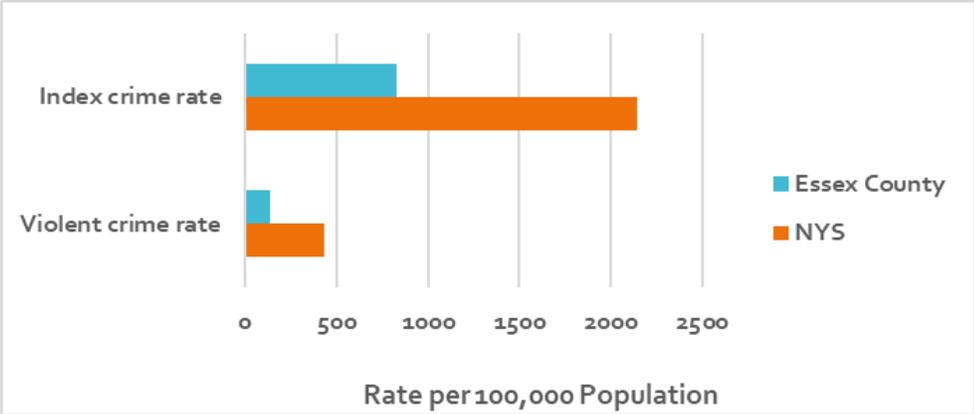
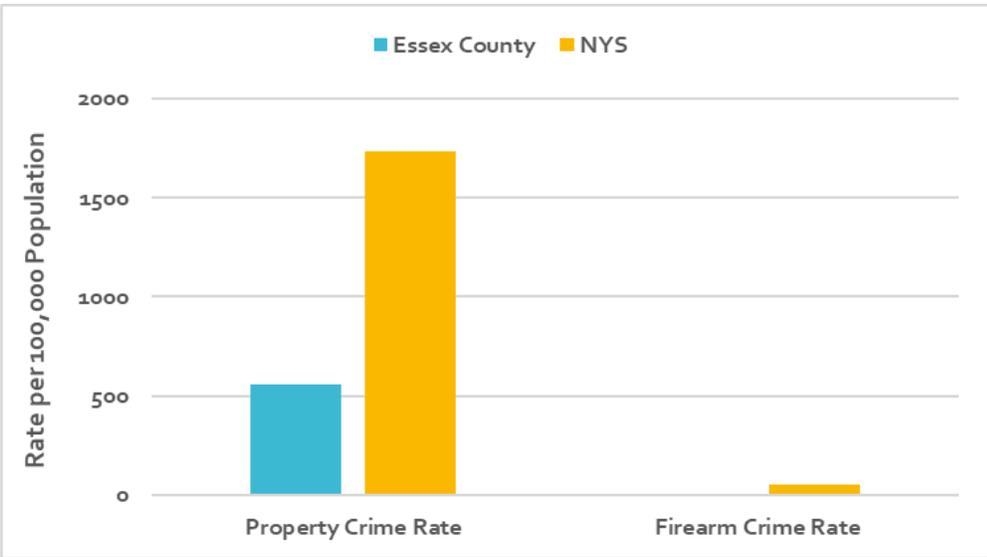


Figure 53: Property and firearm crime rates, 2022⁶



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



DOMAIN 4: HEALTH CARE ACCESS AND QUALITY

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

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

 Preventive Services for Chronic Disease Prevention & Control

 Oral Health Care

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

 Early Intervention

 Childhood Behavioral Health

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

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

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

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



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

Figure 54: Infant mortality rate per 1,000 live births²

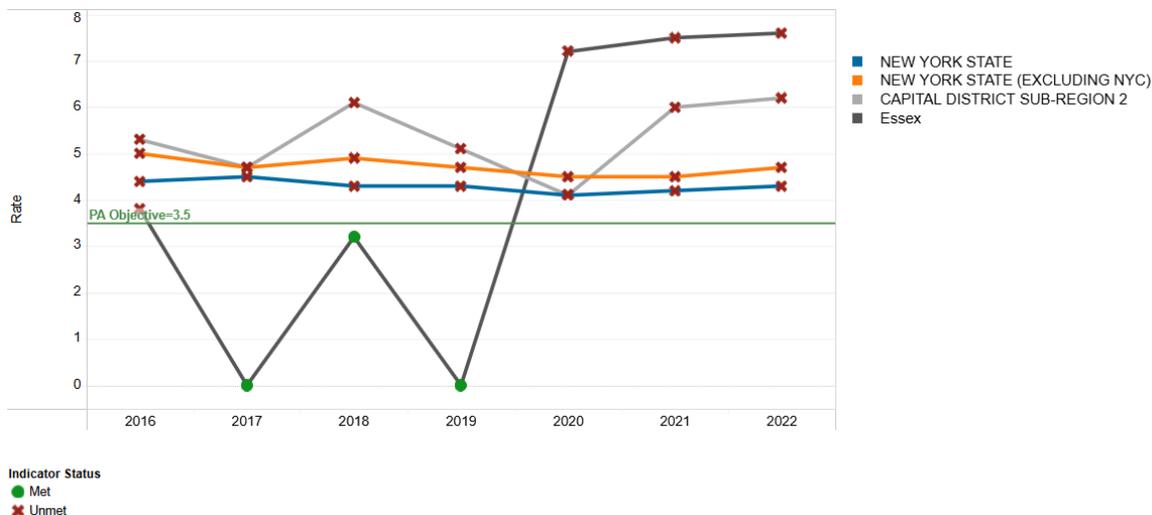
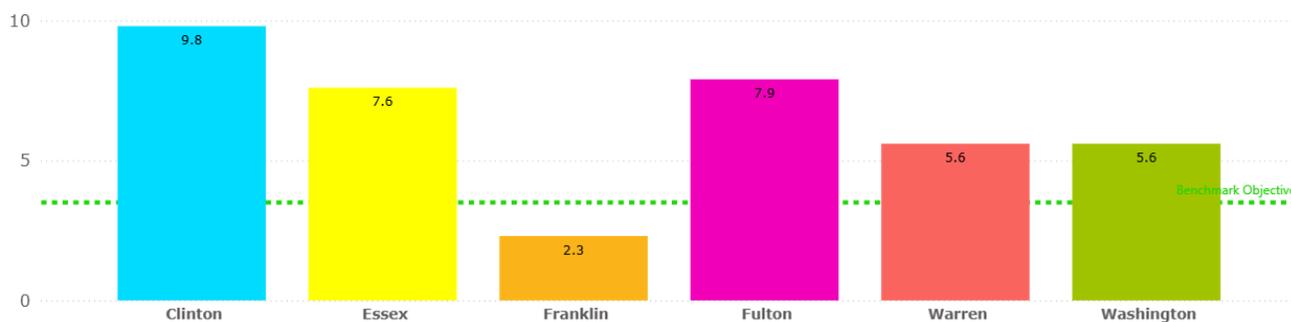


Figure 57: Infant mortality rate per 1,000 live births - regional county comparisons²



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

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

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



Figure 56: Percentage of births with early (1st trimester) prenatal care²

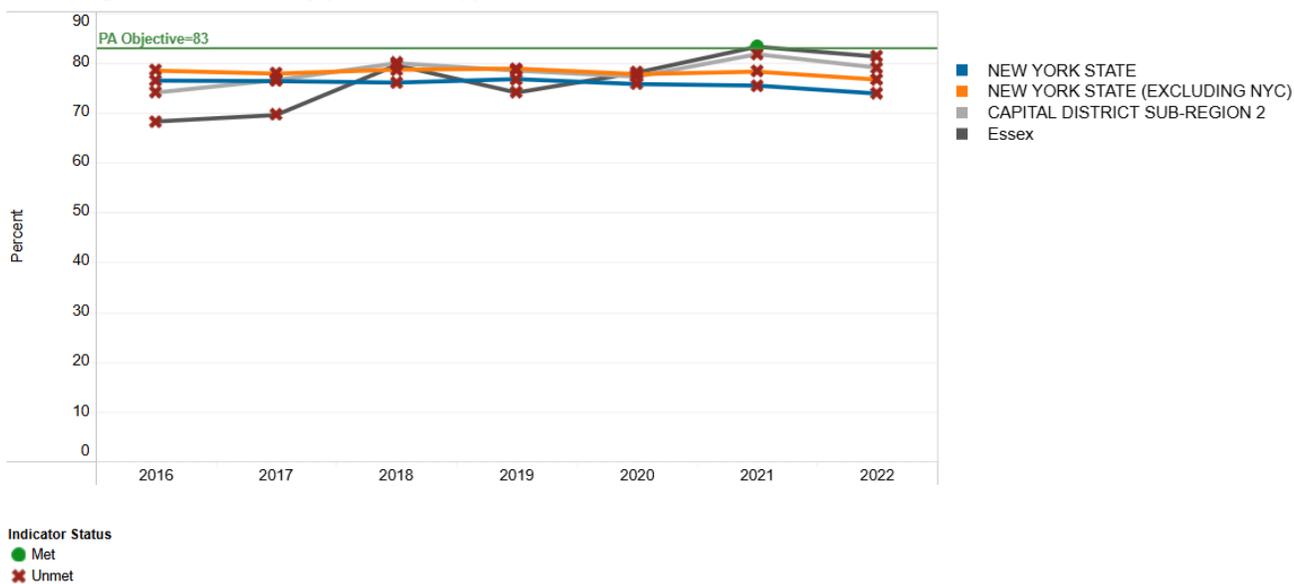
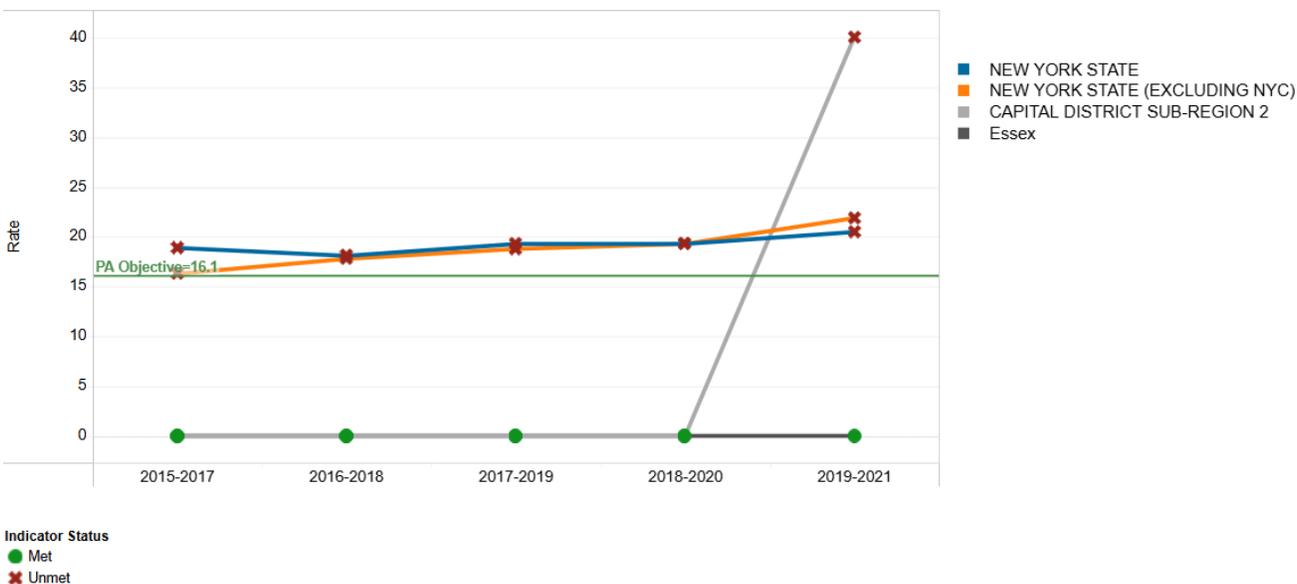


Figure 57: Maternal mortality rate per 100,000 live births²



Preventive Services for Chronic Disease Prevention & Control

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



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

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

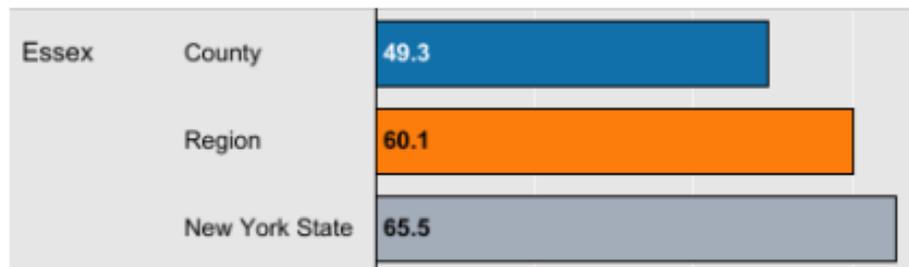
Table 2: Select Chronic Disease Prevention Indicators, BRFSS 2021³

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

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

Figure 58: Percentage of women (aged 50-74 years) who had a mammogram between October 1, 2019 and December 31, 2021, Essex, Medicaid Program⁴

Year **2022**
 Women with mammogram **180**
 Percentage of women in program **49.3**



66.1%*

of women aged 50-74 years received breast cancer screening based on current guidelines³

*Unstable/unreliable estimate

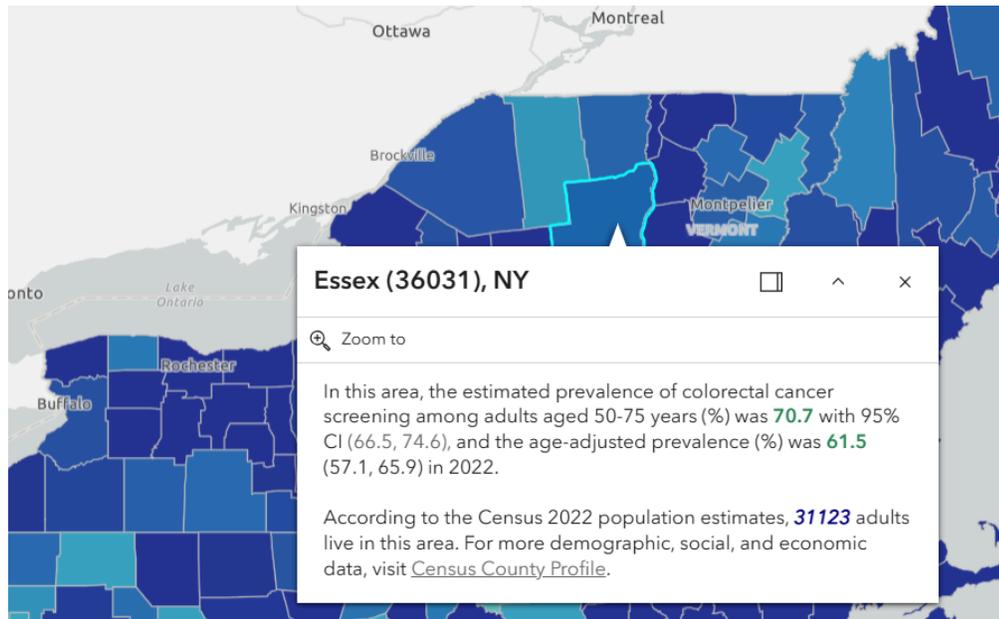
³ New York State Department of Health. (2023). Behavioral Risk Factor Surveillance System (BRFSS) health indicators by county and region: 2016, 2018, 2021. Retrieved December 19, 2025 from <https://health.data.ny.gov>

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



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

Figure 59: Prevalence of colorectal cancer screening, adults aged 50-75, Essex, 2022⁵



Oral Health Care

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

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

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

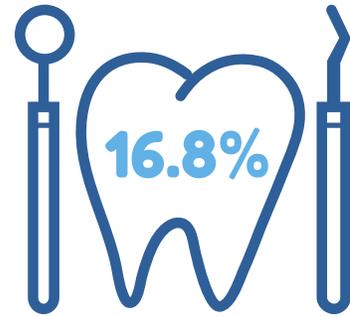
⁷ Centers for Disease Control and Prevention. (2024). *Health disparities in oral health*. U.S. Department of Health and Human Services. <https://www.cdc.gov/oral-health/health-equity/index.html>

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

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



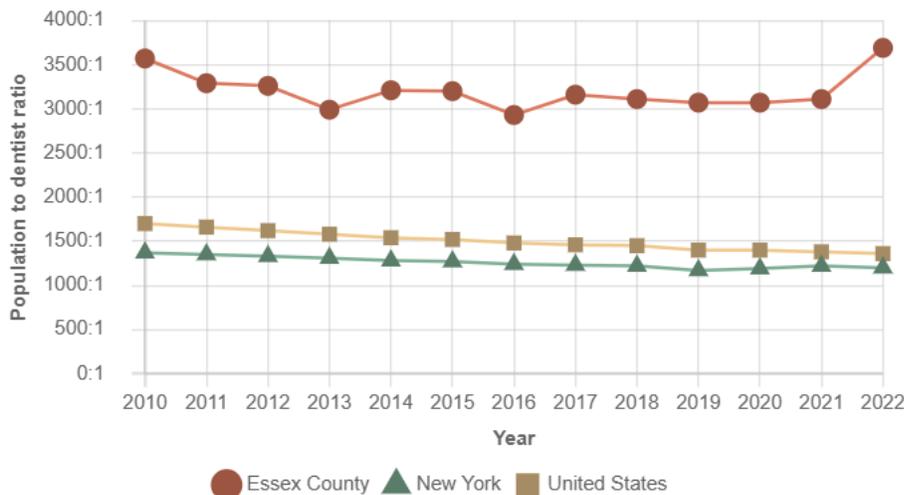
While county level oral health data is not available for all populations that potentially experience disparities, only 16.8% of Medicaid enrollees had at least one preventive dental visit in the last year in Essex County. This is below the Prevention Agenda objective of 21.3% and below New York State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



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

Access to dental care is challenging for all residents in Essex County, with a ratio of population to dentists at 3,680:1 (Figure 60). This is well above the New York State ratio of 1,190:1 and the U.S. ratio of 1340:1.¹⁰

Figure 60: Ratio of population to dentists¹⁰



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



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

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

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

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

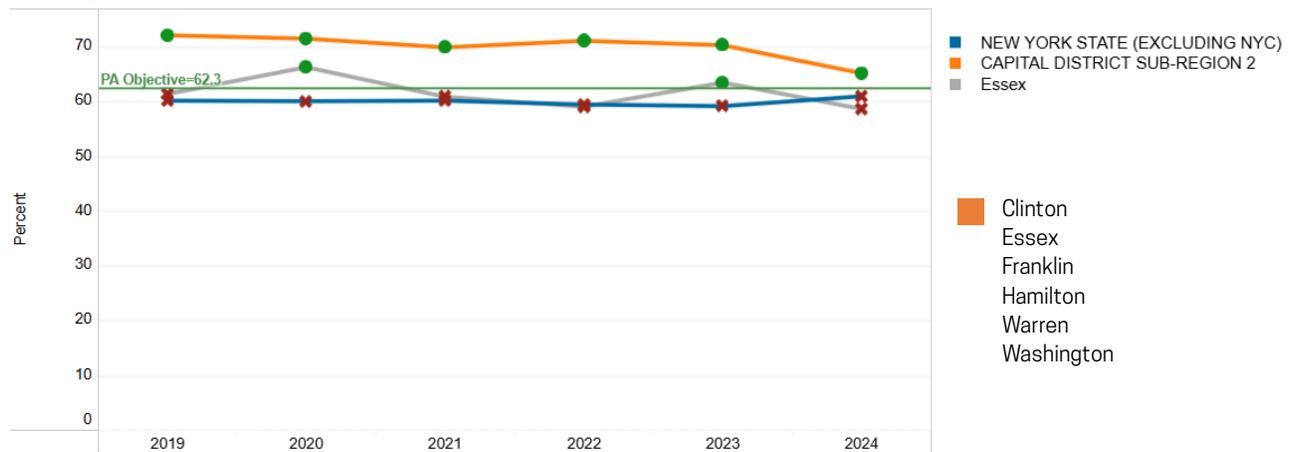
¹² New York State Education Department. (n.d.). Health screenings (vision, hearing, scoliosis). <https://www.nysed.gov/student-support-services/health-screenings>



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

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

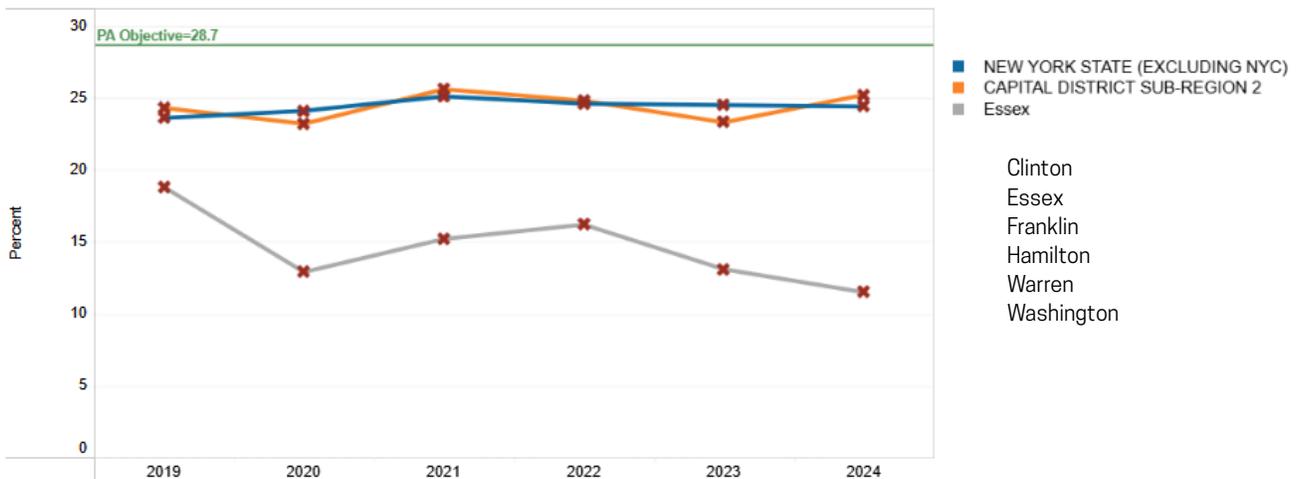
Figure 61: Percentage of 24-35-month old children with the 4:3:1:3:3:1:4 combination series by their 2nd birthday²



Indicator Status
 ● Met
 ✖ Unmet

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

Figure 62: Percentage of 13-year-old adolescents with a complete HPV vaccine series²



Indicator Status
 ✖ Unmet

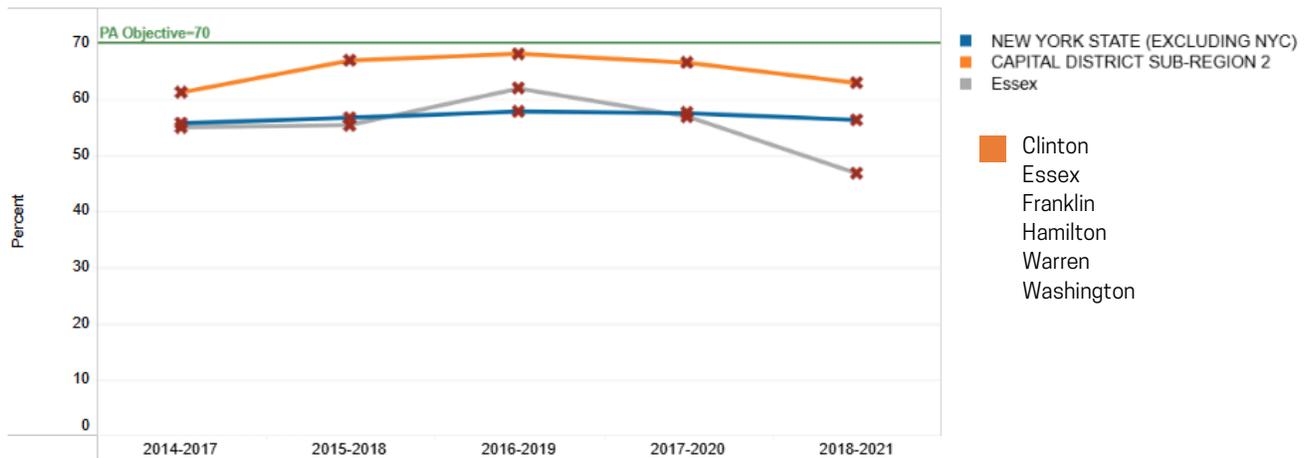
¹³ New York State Department of Health. (n.d.). *Prevention Agenda: Childhood Lead Poisoning Prevention*. https://www.health.ny.gov/prevention/prevention_agenda/healthy_mothers/lead_poisoning_prevention.htm



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

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

Figure 63: Percentage of children in a single birth cohort year tested at least twice for lead before 36 months of age²



Indicator Status
 ✖ Unmet

Early Intervention

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

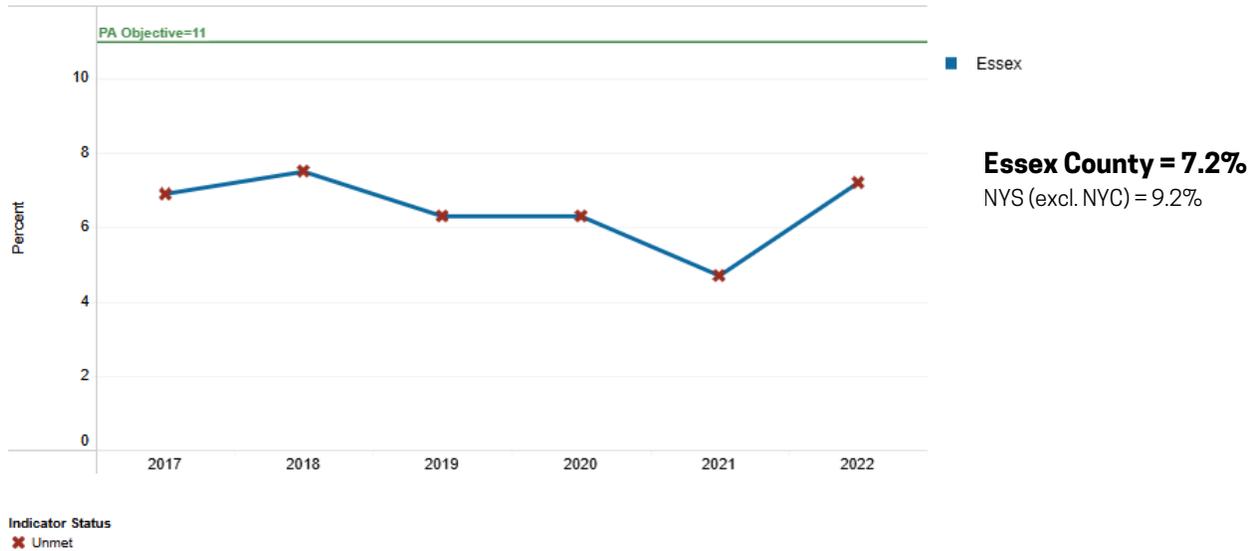
An Individualized Family Service Plan (IFSP) is a legal document and process for families with infants and toddlers (birth to age 3) who have developmental delays or disabilities, outlining specific early intervention services and supports to help the child reach their potential, with a strong focus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

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

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



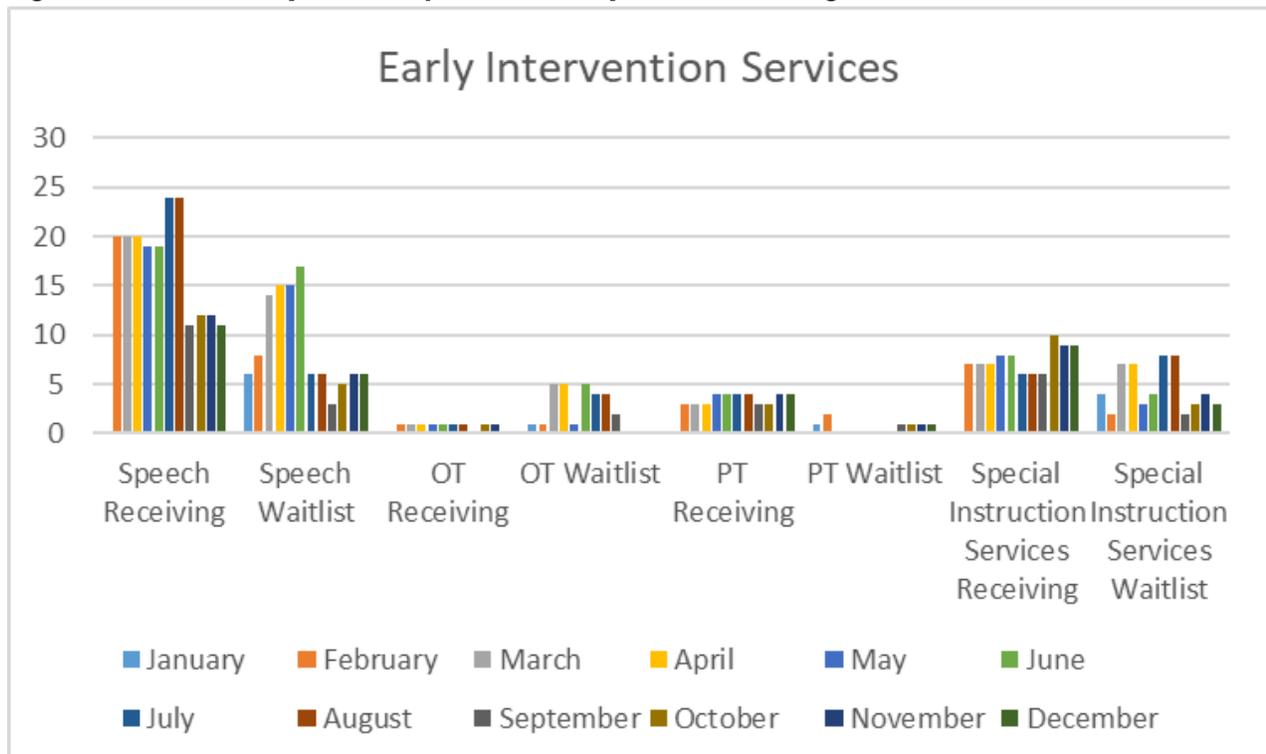
Figure 64: Percentage of children under 3 with an Individualized Family Service Plan (IFSP)²



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

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

Figure 65: Essex County Health Department - Early Intervention Program Data, 2024¹⁵



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



Childhood Behavioral Health

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

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

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



DOMAIN 5: EDUCATION ACCESS & QUALITY

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



Health & Wellness Promoting Schools



Opportunities for Continued Education

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



Health & Wellness Promoting Schools

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

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

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

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

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

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



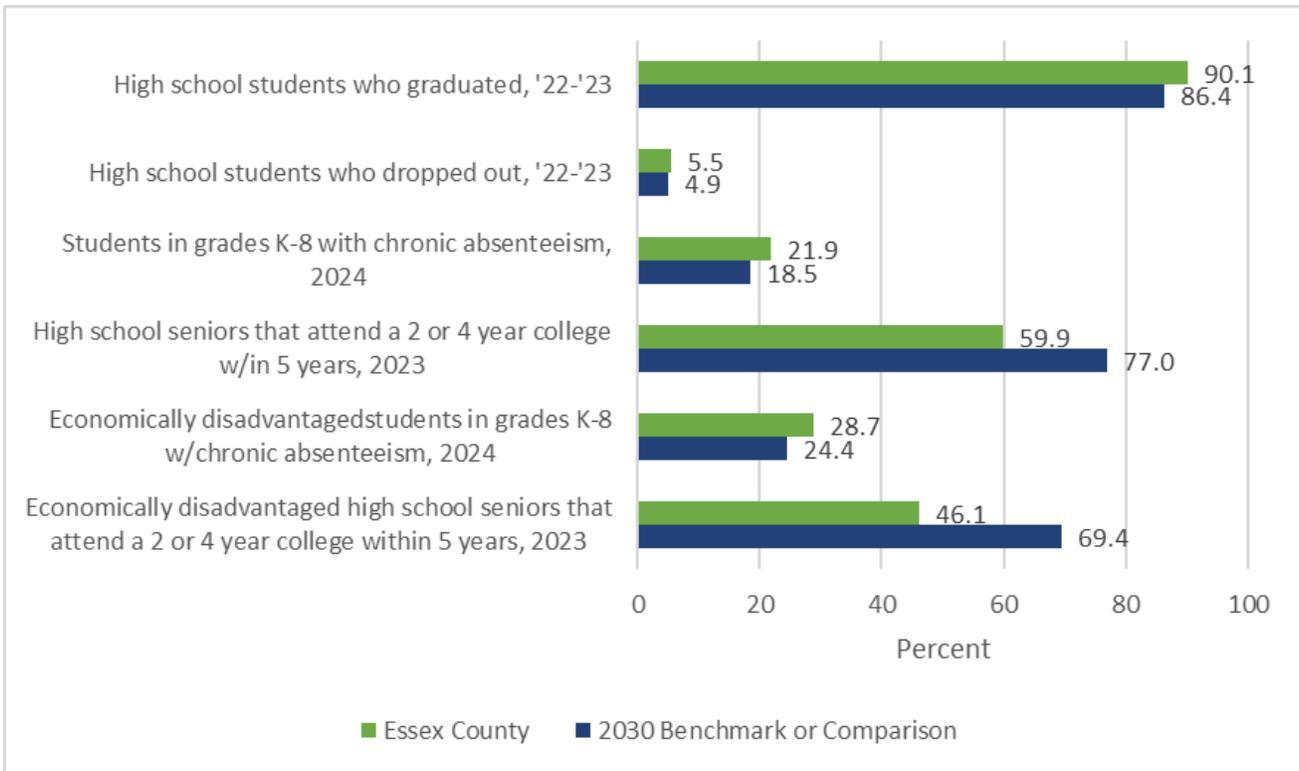
Key Education Quality Metrics

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

Data not available due to small class/cohort size

Table 3: Graduation and Chronic Absenteeism Rates by Essex County Public School, 2023-2024⁴

Figure 66: Education Access & Quality Indicators⁵



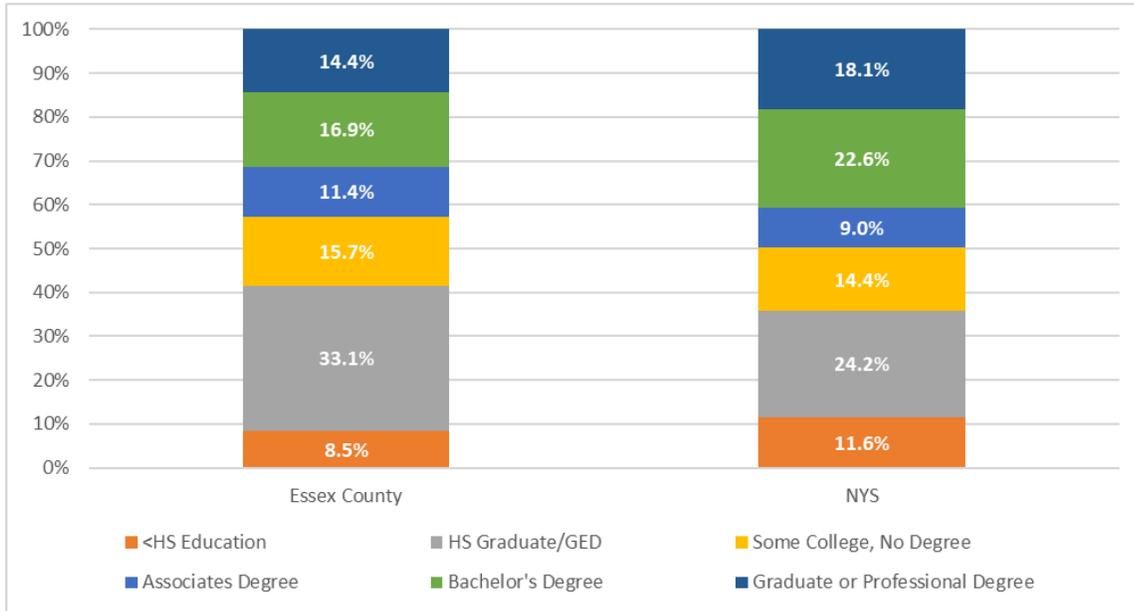
The overall graduation rate in Essex County (90.1%) is higher than the New York State comparison (86.4%) but the drop-out rate in Essex County is also higher. Graduation rates vary by school district and vary even more widely by different subpopulations (gender, ability, socioeconomic) within school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

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

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



Figure 67: Educational Attainment⁶



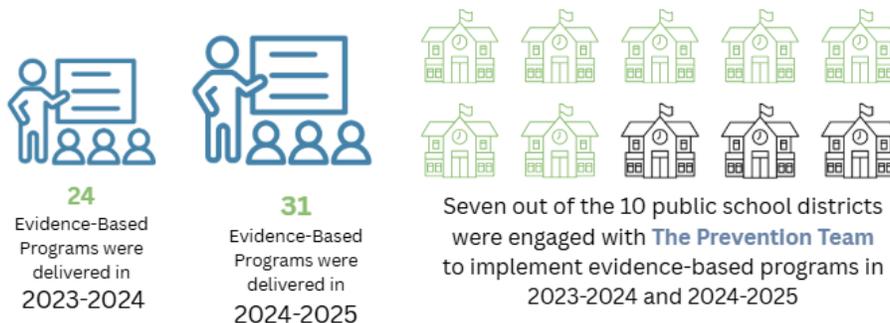
Fewer residents in Essex County complete a college degree program when compared with state attainment levels; however, degree attainment increased in Essex County by 3.4% since 2020 (Figure 67). Essex County residents compared better than the state for residents aged 25 and older with less than a high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

Positive School Environments

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

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

Prevention Programs in Essex County Schools



The Prevention Team :

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

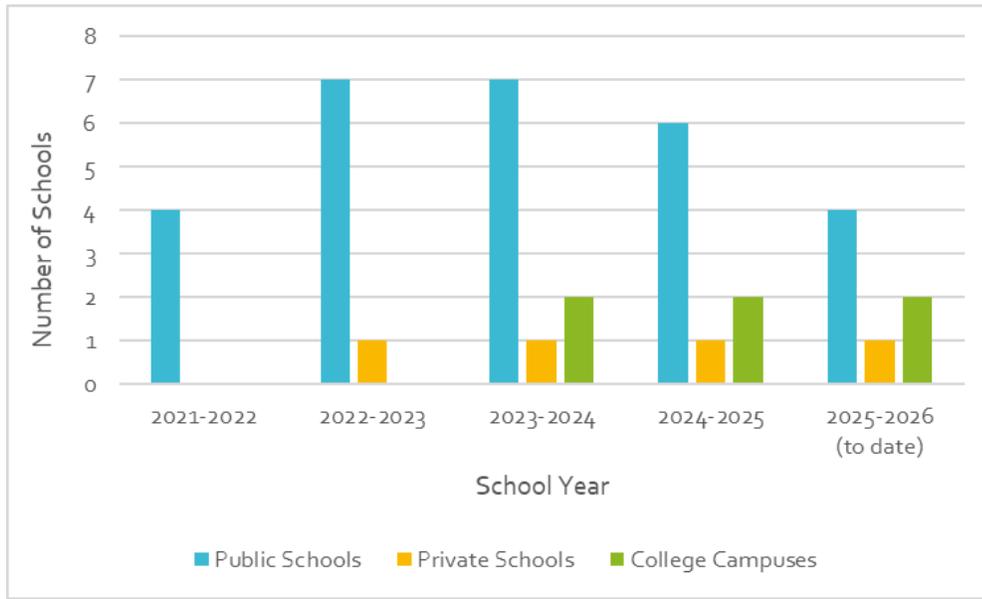
⁶ US Census Bureau, ACS 5-Year Estimates, 2023

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



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

Figure 68: ECHD School Health Curriculum Outreach Metrics⁸



70%

of the public school districts in Essex County participated in the **National Free Lunch Program (NFLP)** in 2023⁹. **Program requirements:**

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

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

⁸ Essex County Health Department. (2025). *Family Health Program Data*. Compiled December 11, 2025. Available upon request.

⁹ USDA. (2025). National Free Lunch Program. Retrieved May 27, 2025 from [usda.gov](https://www.usda.gov)

¹⁰ NYSED. (May 13, 2025). *New York State Universal Free Meals [Policy Memo]*. Retrieved December 11, 2025 from <https://www.cn.nysed.gov/content/new-york-state-universal-free-meals>

¹¹ Food Research and Action Center. (May 2021). *School Meals are Essential for Student Health and Learning [Research Brief]*. Retrieved December 11, 2025 from <https://frac.org/programs/national-school-lunch-program/benefits-school-lunch>



Opportunities for Continued Education

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

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

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

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

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



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

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

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

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

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



Conclusion

Health Challenges and Associated Risk Factors

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

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

Disparities

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



Prioritize Community Health Issues

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

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

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

Domain	Priority Areas
Economic Stability	<ul style="list-style-type: none"> • Poverty • Housing stability and affordability • Unemployment • Nutrition security
Neighborhood & Built Environment	<ul style="list-style-type: none"> • Access to community services and support
Social & Community Context	<ul style="list-style-type: none"> • Adverse Childhood Experiences (ACEs) • Depression • Healthy Eating • Primary Prevention, Substance Misuse, & Overdose Prevention • Tobacco/E-Cigarette use
Health Care Access & Quality	<ul style="list-style-type: none"> • Preventative Services for Chronic Disease Prevention and Control

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



Prioritization Methods

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

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

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

Justification for Unaddressed Health Needs

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

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



Prioritization Matrix Tool

Domain	Priority Name	Priority Areas	Comparison	Trend	Disparities	Magnitude	Severity	Data Quality	Partner / Stakeholder/ Community Priority	Total Score (of 1st six criteria)	Domain Score
Economic Stability	Economic Well-being	Poverty	2	3	2	2	3	1	3	2.50	2.21
		Unemployment	1	1	1	1	2	2	3	1.50	
		Nutrition Security	1	2	3	3	2	2	3	2.33	
		Housing Stability & Affordability	2	2	3	3	2	2	3	2.50	
Social & Community Context	Mental Well-being & Substance Use	Anxiety & Stress	3	3	2	2	2	2	2	2.33	2.16
		Suicide	3	1	2	1	3	1	1	1.83	
		Depression	2	2	2	2	2	2	2	2.00	
		Primary Prevention, Substance Misuse, and Overdose Prevention	1	1	1	2	3	1	2	1.67	
		Tobacco/E-Cigarette Use	2	2	3	3	3	1	3	2.67	
		Alcohol Use	3	1	2	2	2	2	1	1.83	
		Adverse Childhood Experiences			2	3	3	3	3	2.75	
		Healthy Eating	2	2	2	2	2	2	3	2.17	
Neighborhood & Built Environment	Safe & Healthy Communities	Opportunities for Active Transportation & Physical Activity	2	1	2	1	2	2	1	1.50	1.67
		Access to Community Services & Support	3	2	2	3	2	2	3	2.50	
		Injuries & Violence	1	1	1	1	1	1	1	1.00	
Health Care Access & Quality	Health Insurance Coverage & Access to Care	Access to & Use of Prenatal Care	1	2	2	1	2	1	1	1.50	1.65
		Prevention of Infant & Maternal Mortality	1	1	1	1	2	1	1	1.17	
		Preventive Services for Chronic Disease Prevention & Control	2	2	3	3	3	1	1	2.33	
		Oral Health Care	2	1	2	2	2	2	1	1.67	
	Healthy Children	Preventive Services (Immunization, Hearing Screening, Lead Screening)			2		2	3	1	1.67	
		Early Intervention	1	2	2	1	2	3	1	1.5	
Education Access & Quality	PreK-12 Student Success & Educational Attainment	Health & Wellness Promoting Schools	2	2	1	2	1	2	1	1.50	1.58
		Opportunities for Continued Education	2	1	2	2	2	2	1	1.67	

Coding Scheme

Comparison (region, state, benchmark, target)	Better than comparison	Comparable/no difference	Worse than comparison
Trend	Moving in right direction	Stable	Moving in wrong direction
Disparities	No discernable disparities	Disparities in at least 1 group	Disparities in multiple groups
Magnitude	Few affected	Moderate number affected	Large number affected
Severity	Not life threatening/causes little chronic disease/disability	Causes moderate amount of morbidity/disability and/or mortality	Causes many deaths and/or many years of chronic disease/disability/years of life lost
Data	Good quality and availability	Improvements needed in availability and/or quality	No data/poor quality data/poor timeliness/lack of subpopulation data
Partner/Stakeholder/Community Priority	Low ranking priority	Moderately ranking priority	High ranking priority
Score	1	2	3
Unable to Score/Not applicable			



Document & Communicate Results

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

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

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

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

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

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

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

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

COMMUNITY SURVEY SUMMARY 2025 - WHAT YOU TOLD US:

562 Survey Participants!

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



Affordable housing



Livable wages



Access to healthcare



Safe neighborhoods



Good schools

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

.....> a **clean environment** and **resources for older adults**. <.....

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

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



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



- Healthcare providers
- Health departments
- Hospitals

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



Access to transportation



Affordable housing



Employment opportunities



Access to healthy food



Access to childcare

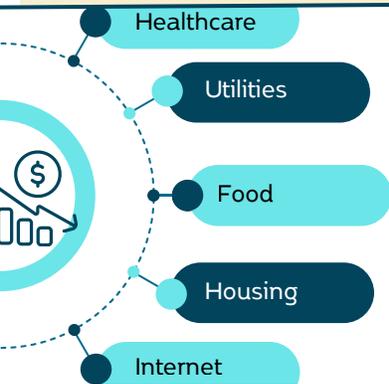


Safety



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

What would help most in the community where you live?



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

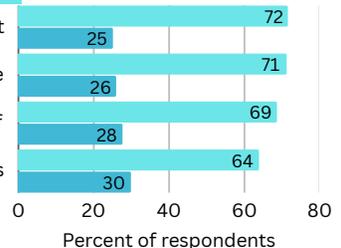
Affordable housing
Stable & gainful employment
Healthcare access

Resources and support for aging adults
Access to affordable, high quality child care

How would you rate the following statements?

- Agree or Strongly Agree
- Disagree or Strongly Disagree

During difficult times, I have "a village" I can call on for support



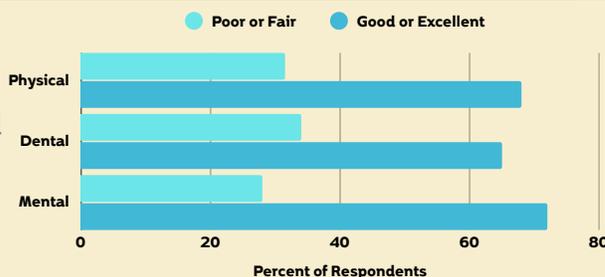
I feel a sense of belonging to the community where I live

Being a resident of my community is an important part of how I see myself

I am a member of community groups

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

How You Rated Your Health:



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



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

STAKEHOLDER SURVEY SUMMARY 2025

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

Top 5 health concerns in Essex County:

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

Top 5 contributing factors in Essex County:

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

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



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

What population experiences the poorest health outcomes in Essex County?

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

TOP PRIORITY AREAS IN EACH DOMAIN

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

DOMAIN

Economic Stability



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

DOMAIN

Social & Community Context



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

DOMAIN

Neighborhood & Built Environment



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

DOMAIN

Health Care Access & Quality



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

DOMAIN

Education Access & Quality



- Health & Wellness Promoting Schools
- Opportunities for Continued Education

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

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

Domain 1 Economic Stability Priority Areas

- Poverty
- Income
- Employment
- Housing
- Food Security

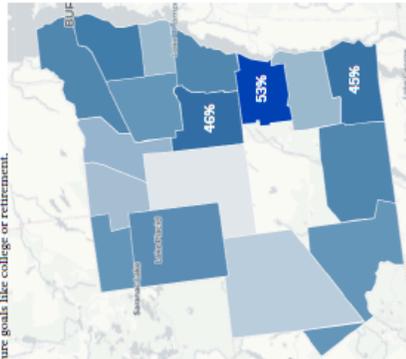
ALICE - Asset Limited, Income Constrained, Employed households are those with incomes above the Federal Poverty Limit, but below the basic cost of living. Households below the ALICE Threshold include both poverty-level & ALICE households and are unable to afford the basics.

Household Survival Wages, Essex County, NY, 2023

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

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

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



Morriah 53%
Elizabethtown 46%
Ticonderoga 45%

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

Source: UnitedForALICE.org

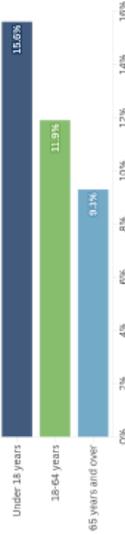
Poverty

13%

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

Poverty by Age

Essex County



Housing

Housing quality in Essex County is comparable to housing quality across NYS. Residents spend a smaller portion of their incomes on housing than the average state resident.

37.6%

Houses in Essex County that are vacant

National Average 17.6%

25.1%

Households spending at least 30% of income on housing

National Average 23.5%

47.6

Work hours needed to pay for affordable housing

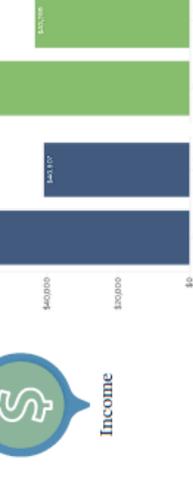
National Average 40.2

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

Household Income (in 2023 dollars)

2019-2023

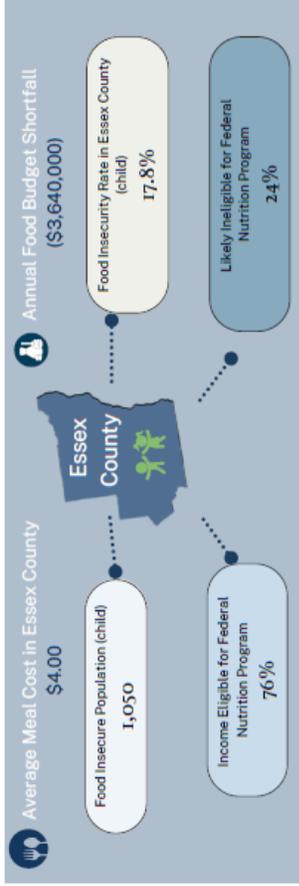
Income



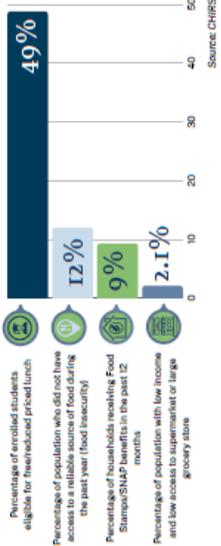
Source: U.S. Census Bureau, 2019-2023 ACS

Essex County has an affordable housing shortfall

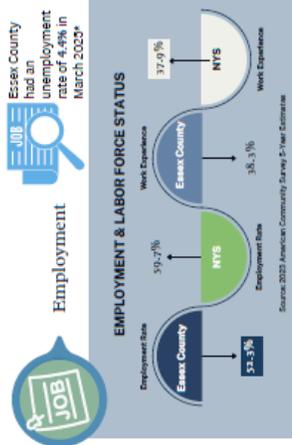
Food Security



Source: Feeding America, 2023



Source: CHRS



Source: https://fred.stlouisfed.org/series/NYSESELEUR

Domain 2 Social & Community Context Priority Areas

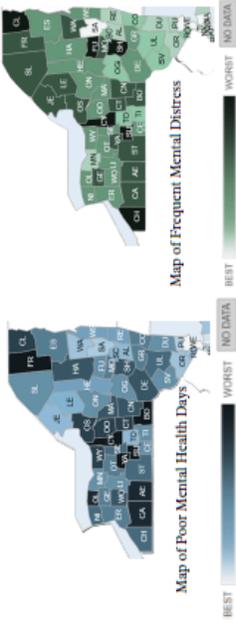
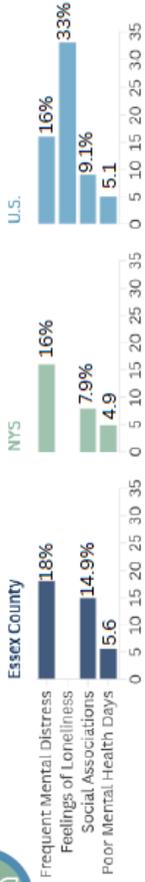


Anxiety & Stress
Primary Prevention: Substance Misuse,
Overdose, Tobacco/E-cig/Alcohol Use

Adverse Childhood Experiences
Suicide/Depression

Healthy Eating

Anxiety & Stress

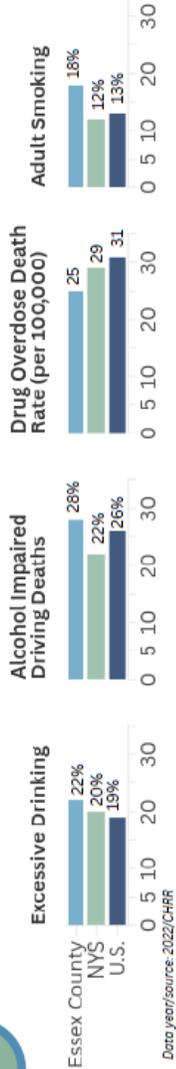


Mental Health Providers

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



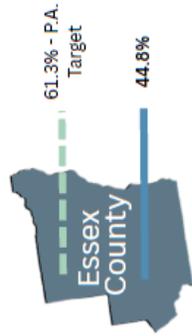
Primary Prevention: Substance Misuse, Overdose, Tobacco/E-cig/Alcohol Use



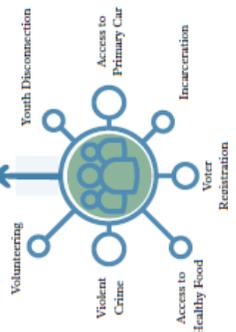
Adverse Childhood Experiences



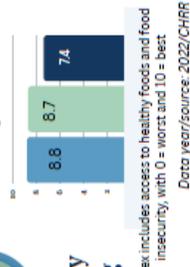
Community Score



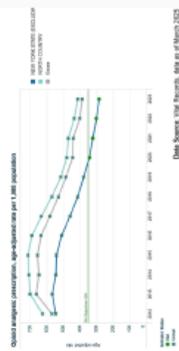
Community Score is compiled from 7 data sources:



Healthy Eating



Food Environment Index



Domain 3 Neighborhood & Built Environment Priority Areas

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



Physical Activity & Active Transport



100% of Essex County residents live close to a park or recreation facility
NYS: 93%
US: 84%



100% of Essex County residents live within a half mile of a park
NYS: 63%
US: 51%

Source: 2025 County Health Rankings and Roadmaps



Injuries & Violence



Unintentional Injury was the 4th leading cause of death in Essex County in 2022, behind only heart disease, cancer, and chronic lower respiratory diseases.
Unintentional injuries include drowning, falls, motor vehicle accidents, poisonings, etc.

Source: NYS Vital Statistics



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

Source: CHIRS



Community Service & Support

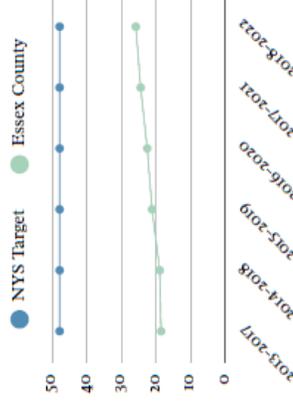
High level of awareness and collaboration among these agencies; many/most link or refer to multiple other agencies and programs on this list and beyond.

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

Health & Human Services Agencies & Organizations

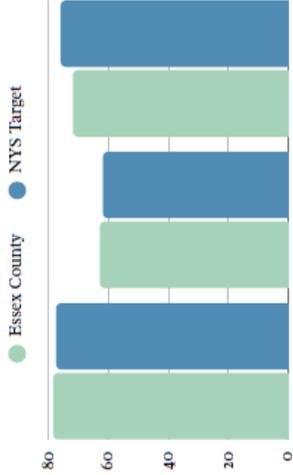
- The Heart Network
- North Country Center for Independent Living
- Southern Adirondack Independent Living
- Mercy Care for the Adirondacks
- RSVP - Retired and Senior Volunteer Program
- Citizen's Advocates
- Families First
- Schools
- Colleges/Universities
- Libraries
- Office for the Aging - NY Connects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

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



Source: NYS Prevention Agenda Dashboard

Percentage of adults who participate in leisure time physical activity



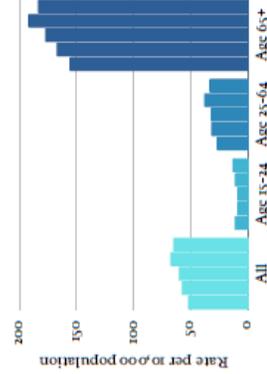
Source: NYS Prevention Agenda Dashboard

Falls hospitalization rate per 10,000, Essex



Source: CHIRS

Unintentional injury hospitalization rate - Essex



Source: CHIRS

Domain 4 Health Care Access and Quality Priority Areas

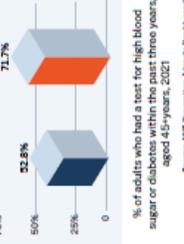
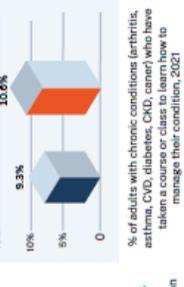
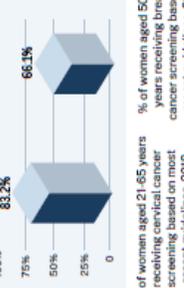
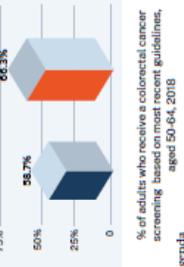
- Access to and Use of Prenatal Care & Prevention of Infant and Maternal Mortality
- Preventive Services for Chronic Disease Oral Health Care
- Preventive Services - Immunization, Hearing Screening, Lead Screening
- Early Intervention
- Childhood Behavioral Health

Preventive Services for Chronic Disease

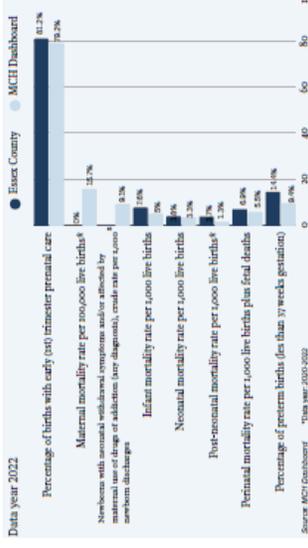
Percentage of adults who have:

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

Source: BRSS, 2021



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



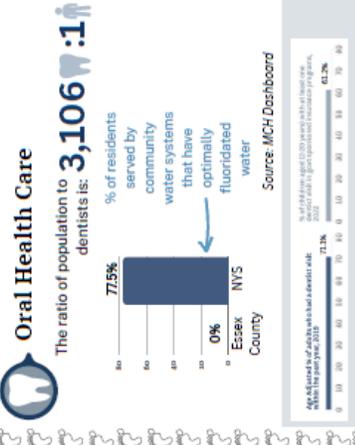
Oral Health Care

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

77.5% of residents served by community water systems that have optimally fluoridated water

0% Essex County NYS

Source: MCH Dashboard



Childhood Behavioral Health

Total of children (N=20,207,076)	Total of children (N=20,207,076)	Total of children (N=20,207,076)
75	44	31
130	98	32
36	9	27

Includes children & adults

Source: Essex County Mental Health

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

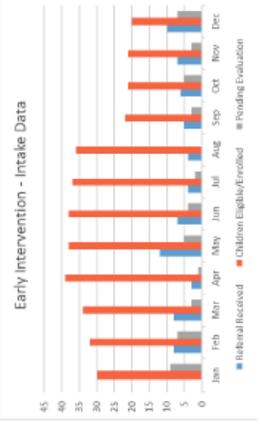
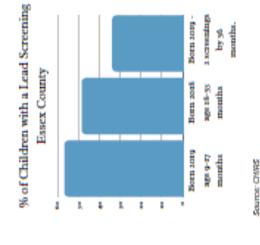
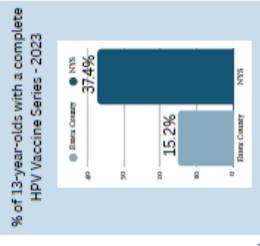
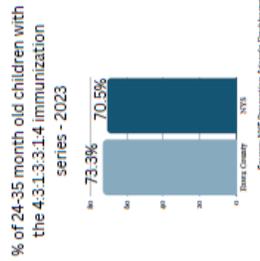


Oral Health Care

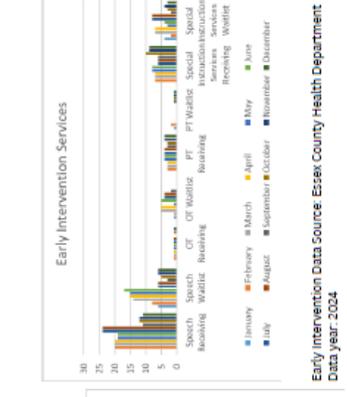
22.8%



Preventive Services Immunizations, Hearing Screening, Lead Screening



Early Intervention



Domain 5 Education Access & Quality Priority Areas

Health & Wellness Promoting Schools
Opportunities for Continued Education



70% of the public school districts in Essex County participated in the National Free Lunch Program (NFLP) in 2023.

KEY requirements to participate in the NFLP:

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

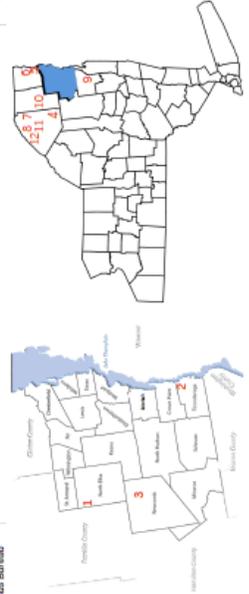
Source: USDA



Opportunities for Continued Education



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



Health & Wellness Promoting Schools

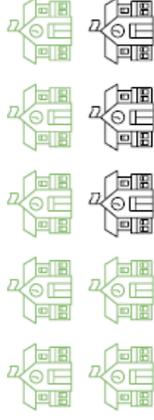
Prevention Programs in Essex County Schools



24 Evidence-Based Programs were delivered in 2023-2024



31 Evidence-Based Programs were delivered in 2024-2025



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

Source: NYSED Report Cards

District	2023 - 2024 School Year				2024 - 2025 School Year			
	All	Female	Male	Students with Disabilities	Economically Disadvantaged	Not Economically Disadvantaged	Elementary Economically Disadvantaged	Secondary Economically Disadvantaged
BVCS	91%	89%	93%	100%	100%	83%	17.3%	24.5%
Crown Point	89%	86%	92%	60%	88%	89%	14.9%	21.6%
Keene	100%	92%	92%	83%	78%	97%	23.8%	25.0%
Lake Placid	86%	93%	92%	83%	78%	97%	13.0%	16.8%
Minerva	89%	93%	86%	68%	83%	93%	14.8%	16.3%
Moriah	100%	83%	86%	100%	100%	67%	31.5%	33.7%
Newcomb	85%	86%	81%	56%	82%	85%	21.6%	26.4%
Schroon Lake	91%	93%	88%	80%	85%	100%	17.1%	22.4%
Ticonderoga	91%	93%	88%	80%	85%	100%	17.1%	22.4%
Willisboro	91%	93%	88%	80%	85%	100%	17.1%	22.4%

Data not available due to small class/cohort size

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



Plan Health Strategy

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

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

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



Develop Action Plan

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

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

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

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

NYSDOH Prevention Agenda Identified/Researched

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

Locally Identified

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

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

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

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

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

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

CHIP Action Plan Domain: Economic Stability

Priority

Poverty

Actions & Impact

ECHD, UVMH-ECH and partners will:

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

Geographic Focus

Essex County

Resource Commitment

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

Participant Roles

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

Health Equity

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

Priority

Unemployment

Actions & Impact

ECHD, UVMH-ECH and partners will:

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

Geographic Focus

Essex County

Resource Commitment

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

Participant Roles

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

Health Equity

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

Priority

Nutrition Security

Actions & Impact

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

Geographic Focus

Essex County

Resource Commitment

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

Participant Roles

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

Health Equity

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

Priority

Housing Stability & Affordability

Actions & Impact

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

Geographic Focus

Essex County

Resource Commitment

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

Participant Roles

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

Health Equity

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

CHIP Action Plan
Domain: Social and Community Context

Priority

Depression

Actions & Impact

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

Geographic Focus

Essex County

Resource Commitment

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

Participant Roles

skills.

Health Equity

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

Priority

Primary Prevention, Substance Misuse, and Overdose Prevention

Actions & Impact

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

Geographic Focus

Essex County

Resource Commitment

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

Participant Roles

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

Health Equity

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

Priority

Tobacco/E-Cigarette Use

Actions & Impact

ECHD, Adirondack Health, and partners will:

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

Geographic Focus

Essex County

Resource Commitment

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

Participant Roles

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

Health Equity

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

Priority

Adverse Childhood Experiences (ACEs)

Actions & Impact

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

Geographic Focus

Essex County

Resource Commitment

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

Participant Roles

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

Health Equity

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

Priority

Healthy Eating

Actions & Impact

UVMH-ECH will expand Food as Medicine program.

Geographic Focus

Essex County

Resource Commitment

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

Participant Roles

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

Health Equity

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

CHIP Action Plan
Domain: Neighborhood and Built Environment

Priority

Access to Community Services & Support

Actions & Impact

ECHD, UVMH-ECH, and partners will:

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

Geographic Focus

Essex County

Resource Commitment

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

Participant Roles

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

Health Equity

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

CHIP Action Plan
Domain: Health Care Access & Quality

Priority

Preventive Services for Chronic Disease Prevention and Control

Actions & Impact

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

Geographic Focus

Essex County

Resource Commitment

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

Participant Roles

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

Health Equity

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



Evaluate Progress

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

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

Quarterly

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

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

Annually

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

Dissemination Plan

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



Public Notification

Public notification will occur in the following ways:

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



Stakeholder Notification

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

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



Committees / Coalitions Notification

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

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



Additional Public Notification

Further dissemination may be conducted as interest and need arises.

APPENDICES