Jefferson County, NY

2025 Community Health Assessment (CHA), 2025-2030 Community Health Improvement Plan (CHIP), 2025-2030 Community Services Plan (CSP)

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Joint Assessment and Plan
Jefferson County, New York

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Executive Summary

The 2025 Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), and Community Services Plan (CSP) for Jefferson County represent a joint effort to improve health and advance equity across the county. The plan was developed collaboratively by Jefferson County Public Health Service, Carthage Area Hospital, River Hospital, and Samaritan Medical Center. Development was supported by the Fort Drum Regional Health Planning Organization (FDRHPO), which authored the CHA and facilitated the collaborative process that guided creation of the joint plan. Local stakeholders supported the process and will continue to play an active role in implementing the selected interventions and strategies. The CHA uses both primary and secondary quantitative data, along with community feedback, to identify health needs, disparities, and available resources. The CHIP/CSP builds on these findings by implementing measurable, evidence-based interventions designed to improve health and wellness and promote equitable access to care. This work is in alignment with the New York State Prevention Agenda 2025–2030 (NYSDOH, 2025).

The Prevention Agenda is designed to ensure that every person, regardless of background or circumstance, has the opportunity to achieve their highest level of health across the lifespan. The 2025–2030 cycle emphasizes prevention, equity, and the social determinants of health (SDoH), and serves as a resource for health departments, hospitals, community-based organizations, educators, policymakers, and others to align priorities and maximize resources.

The Prevention Agenda 2025–2030 is organized into a hierarchy that includes overarching domains, priorities, and interventions. At the highest level are the domains, which group related factors that influence health. These five domains are Economic Stability, Social and Community Context, Neighborhood and Built Environment, Healthcare Access and Quality, and Education Access and Quality. They reflect the social determinants of health and recognize that health is shaped by much more than clinical care.

Within each domain are priorities, which identify specific health issues or conditions that require focused attention. Each priority is supported by one or more objectives, which set clear, measurable targets to be achieved over the six-year cycle of the Prevention Agenda. Objectives are framed using the SMARTIE approach, ensuring they are Specific, Measurable, Achievable, Relevant, Timely, Inclusive, and Equitable to directly address disparities among populations that experience the greatest health gaps (NYSDOH, 2025).

Progress toward each objective is monitored through one or more indicators, which are specific data points that track change over time. Indicators provide the baseline and target values for each measure, along with the data source. This structure creates a logical framework that connects big-picture health factors to actionable, measurable steps. It ensures that joint efforts remain focused, data-driven, and accountable. Local health departments, hospitals, and community partners will implement selected interventions, adapting these measures to meet the needs of their communities.

By aligning the CHA, CHIP, and CSP with the Prevention Agenda 2025–2030, we ensure that our county's health priorities are grounded in a statewide framework that addresses community needs. This alignment gives us a shared vision, measurable objectives, and evidence-based interventions, while still allowing flexibility to adapt strategies to our unique local needs and challenges.

Our work is not simply about meeting state targets. It is about creating meaningful, equitable improvements in health for every resident. Through cross-sector collaboration, data-driven planning, and targeted action, we are building the systems, partnerships, and community conditions needed to reduce disparities, improve quality of life, and support the health and well-being of our county residents.

The Community Health Assessment (CHA) can be organized in different ways. One possible approach would have been to organize the report by the 2025–2030 New York State Prevention Agenda domains, which are Economic Stability, Education Access and Quality, Healthcare Access and Quality, Neighborhood and Built Environment, and Social and Community Context. This assessment, however, follows the organizational framework outlined in the New York State Department of Health's Community Health Planning Guidance, developed by the Office of Public Health Practice. This guidance specifies the required elements for CHAs, Community Health Improvement Plans (CHIPs), and Community Service Plans (CSPs). For example, the CHA is organized into three major sections listed in the guidance document: Community Description, Health Status Description, and Community Assets and Resources, each with relevant subsections. This approach was chosen to ensure that the county meets state requirements and provides clarity and consistency for readers.

Prevention Agenda Priorities

Based on the Community Health Assessment and partner input, Jefferson County will focus on the following Prevention Agenda priorities and disparities for 2025 – 2030:

1. Poverty

- Individuals and families living in poverty who experience higher rates of unmet social needs, which contribute to poorer health outcomes and reduced access to care.

2. Suicide

- Youth, adolescents, and young adults who are disproportionately affected by mental health challenges and suicide risk.
- Individuals experiencing mental health crises or suicidal thoughts who may not know about or have adequate access to immediate crisis support services.

3. Tobacco / E-Cigarette Use

- Individuals disproportionately impacted by tobacco industry marketing practices and at increased risk of starting tobacco or vaping use.
- Low-income individuals and families who are disproportionately impacted by nicotine marketing practices.

4. Prevention of Infant and Maternal Mortality

- Young mothers, low-income families, and those with limited access to early prenatal care.
- Birthing persons susceptible or at risk of mental illnesses or disorders associated with pregnancy or postpartum.
- Birthing persons experiencing perinatal mood or anxiety disorders who may lack adequate screening and support services.

5. Prevention Services for Chronic Disease Prevention and Control

- Adults with low income or Medicaid coverage with limited awareness of, or access to, preventive services and chronic disease self-management resources.
- Residents experiencing higher rates of hypertension, obesity, and diabetes, along with greater challenges accessing prevention and self-management programs.

6. Oral Healthcare

- Residents with low oral-health literacy and barriers to preventive dental care, including Medicaid-enrolled families, and rural households who are less likely to receive and act on preventive oral-health information.

7. Health and Wellness Promoting Schools

- Young adults and students, particularly those from low-income families or experiencing housing instability, transportation barriers, or mental health challenges, who face higher risk of chronic absenteeism and reduced academic engagement.

Data Review

To identify community health priorities, data from both primary and secondary sources were obtained, analyzed, and reviewed. Primary data included results from the 2025 Community Health Survey (CHS) and a series of key-informant interviews with organizations and stakeholders across Jefferson County. The CHS, conducted annually by FDRHPO since 2016, surveys about 1,500 local residents each year, providing timely data that can be trended over time. Survey results were analyzed in SPSS and cross-tabulated by demographic and social determinant of health variables to identify disparities among specific population groups. Because the CHS surveys only adults, additional information about youth was gathered through interviews with partners who work directly with youth. Data from the Prevention Needs Assessment (PNA), administered regularly by a partnering organization, were also reviewed to complement these discussions and provide further insight into youth-related health challenges.

Additional interviews with community based organizations were conducted to identify the services partners provide, gaps or barriers they observe, populations most in need, and opportunities for collaboration. Presentations at board and committee meetings also allowed partners to review preliminary findings and offer feedback on potential interventions.

Secondary data were obtained from multiple sources, including the New York State Department of Health, U.S. Census Bureau, County Health Rankings & Roadmaps, SPARCS, Vital Statistics, CDC WONDER, and HRSA Area Health Resource Files, among others. A complete list of data sources is available in the main section of the Community Health Assessment (CHA).

By combining these quantitative and qualitative data sources with extensive partner input, Jefferson County developed a comprehensive understanding of community health needs and disparities. This process informed the selection of the county's seven Prevention Agenda priorities: Poverty, Suicide, Tobacco/E-Cigarette Use, Prevention of Infant and Maternal Mortality, Prevention Services for Chronic Disease Prevention and Control, Oral Healthcare, and Health and Wellness Promoting Schools.

Partners and Roles

Jefferson County's CHA and CHIP/CSP were developed through a close partnership of stakeholders: Jefferson County Public Health Service, Samaritan Medical Center, Carthage Area Hospital, River Hospital, and Fort Drum Regional Planning Organization (FDRHPO) as the supporting partner and coordinating entity. These organizations are jointly responsible for submitting the county's CHA/CHIP/CSP and work collaboratively to assess community health needs, identify priorities, and implement interventions that align with the New York State Prevention Agenda.

In addition to the lead agencies, numerous community partners play vital roles in both the assessment and implementation phases. Pivot (formerly the Alcohol and Substance Abuse Council of Jefferson County) contributes to multiple interventions including youth prevention efforts, social-emotional learning, and tobacco control. Pivot conducts the county's Prevention Needs Assessment (PNA) surveys and implements the Second Steps social-emotional learning curriculum in local schools. County school districts collaborate to strengthen social-emotional learning and mental health programming across

grade levels. Pivot also leads community efforts to prevent tobacco and nicotine use, working closely with the Youth Alliance of Jefferson County and area schools to educate youth on the harms of tobacco and vaping, promote cessation resources, and advocate for tobacco-free environments.

The Jefferson County Suicide Prevention Coalition leads local suicide-prevention initiatives and will work closely with the Jefferson County Public Health Service to increase awareness of the 988 Suicide and Crisis Lifeline through targeted outreach and community education. The Children's Home of Jefferson County (CHJC), in collaboration with Jefferson County Community Services (JCCS) and with support from the New York State Office of Mental Health (NYSOMH), recently established a local Mobile Crisis Team (MCT). The Mobile Crisis Team (MCT) and its accompanying hotline complement the 988 Suicide and Crisis Lifeline by providing an in-person response when a situation requires face-to-face intervention. The Suicide Prevention Coalition and local stakeholders will promote this service to raise awareness and improve access to immediate crisis support within the community.

For students experiencing acute mental health needs, the county will also leverage the Community School Liaison Program (CSLP), operated by the Children's Home of Jefferson County (CHJC). CSLP staff work directly with school personnel, students, and families to de-escalate crises, connect youth to appropriate behavioral health services, and prevent unnecessary emergency department referrals. When a higher level of response is required, CSLP staff may coordinate with the CHJC Mobile Crisis Team to provide on-site intervention and follow-up. Both programs collaborate with schools in compliance with all legal and regulatory requirements.

Maternal and child health efforts are led by the North Country Prenatal/Perinatal Council (NCPPC), which administers the Healthy Families Home Visiting Program and provides education and support to expectant and new parents. NCPPC also assists with perinatal and post-partum screenings in coordination with North Country Family Health Center (NCFHC), Jefferson County Public Health Service, and local hospitals. These organizations implement validated screening tools to identify perinatal mental health and anxiety disorders and connect individuals to appropriate follow-up care.

To strengthen suicide prevention and mental health awareness, FDRHPO, NCPPC, Pivot, Jefferson County Community Services, and NCFHC jointly provide Mental Health Awareness Trainings (MHAT) such as Mental Health First Aid (MHFA), QPR, ASIST, and CALM. These trainings help community members, organizations, and educators recognize and respond to individuals who may be at risk of suicide or a mental health crisis.

For chronic disease prevention, Jefferson County Public Health Service collaborates with partners including the Office for the Aging (OFA), The Healthy Heart Network, YMCA, and Northern Regional Center for Independent Living (NRCIL) to promote evidence-based self-management programs and prevention initiatives.

Oral health promotion efforts are supported by Jefferson County Public Health Service through collaboration with the Keep the North Country Smiling (KNCS) Coalition, which assists in developing a dedicated oral-health webpage and related community education resources.

Interventions and Strategies

Several interventions included in this joint plan are supported by comprehensive, collaboratively developed workplans. Family-based prevention efforts are part of a robust workplan designed to address risk factors and strengthen support for families. Education on the harms of tobacco aligns with a CBO workplan focused on reducing commercial tobacco use and improving population health. The oral health resource webpage is included within the regional oral health coalition's workplan, while mental health and emotional well-being programming aligns with the county's prevention workplan. Mental health trainings are also reflected in ongoing strategies coordinated by behavioral health partners.

To address the identified health priorities and disparities, Jefferson County partners selected the following evidence-based interventions from the New York State Prevention Agenda (2025–2030):

Poverty and Economic Barriers

Ongoing challenges were identified related to income, employment, housing, food access, and transportation that affect residents' ability to maintain good health. Many households experience financial strain and difficulty meeting basic needs, which contributes to poorer health outcomes. Similarly, many families in Jefferson County face social and economic stressors that can affect family well-being and maternal and child health. To address the social and economic factors influencing health, hospitals will implement standardized screening for social determinants of health (SDOH) during inpatient encounters to identify needs that include income, employment, housing, food access, and transportation. Results will be used to guide referrals to services and resources.

Community-based partners like NCPPC will support family-based prevention and home-visiting programs, such as Healthy Families, which provide education and early intervention to strengthen parenting skills, improve child development, and connect families to resources that promote long-term stability.

Suicide Prevention and Awareness

Mental health remains a major concern in the county, with residents reporting high levels of stress and emotional distress. Suicide continues to be an increasing issue, and there is a need to increase public awareness, training, and capacity to recognize and respond to individuals who may be at risk. Similarly, while crisis services are available, awareness and understanding of how to access immediate help remain limited.

The recently established Mobile Crisis Team (MCT) and the Community School Liaison Program (CSLP), both operated by the Children's Home of Jefferson County in partnership with Jefferson County Community Services, strengthen the county's ability to provide timely and coordinated crisis response. The MCT delivers local, in-person crisis intervention and complements the 988 Suicide and Crisis Lifeline, while CSLP staff work directly with schools to de-escalate student crises, connect youth and families to

behavioral health services, and prevent unnecessary emergency department referrals. Partners will promote these services alongside the 988 Lifeline to raise awareness and ensure residents know how to access immediate crisis support.

To further strengthen community capacity for suicide prevention, partners will expand the availability of evidence-based trainings for community members, organizations, and schools. These include Adult and Youth Mental Health First Aid (MHFA), QPR (Question, Persuade, Refer), ASIST (Applied Suicide Intervention Skills Training), CALM (Counseling on Access to Lethal Means), and Link to Hope, which equip participants to recognize suicide warning signs and respond appropriately.

Tobacco, E-Cigarette, and Nicotine Use

Tobacco and nicotine use, including vaping among youth, continue to be significant local health issues. These behaviors contribute to chronic disease and addiction. To reduce tobacco and nicotine use, especially among youth, partners will collaborate with Pivot and the Youth Alliance of Jefferson County to provide education on the harms of tobacco and nicotine, share local data from the Prevention Needs Assessment (PNA), and increase community awareness of cessation resources. These efforts will include school-based prevention activities, youth engagement campaigns, and partnerships with healthcare providers to encourage cessation screening and education at well visits.

Perinatal Mental Health and Mortality

Persistent gaps in early prenatal care, postpartum mental health, and preventive care for children continue to affect families in Jefferson County. The county's growing mental health needs, combined with a relatively young population of mothers and higher levels of poverty and financial strain, make maternal and child health a key area of concern. To improve maternal and child health outcomes, Jefferson County Public Health Service, Carthage Area Hospital, Samaritan Medical Center, North Country Family Health Center, and the North Country Prenatal/Perinatal Council (NCPPC) will provide prenatal and post-partum depression screenings using validated tools such as the Edinburgh Postnatal Depression Scale (EPDS) and the PHQ-2/PHQ-9. Screenings will help identify individuals experiencing perinatal mood or anxiety disorders and connect them to follow-up care and community support programs such as Healthy Families.

Chronic Disease Prevention and Program Awareness

Rates of hypertension, obesity, and chronic disease remain above state goals. Partners noted a decline in participation in prevention and self-management programs since the COVID-19 pandemic and the increased use of GLP-1 medications for diabetes and weight management. To address chronic disease disparities, Jefferson County Public Health Service will work with community partners to engage residents in identifying barriers to participation in prevention and self-management programs. This process will help guide the redesign and promotion of evidence-based programs offered through partners such as the Office for the Aging, YMCA, and Northern Regional Center for Independent Living (NRCIL). Efforts will focus on improving access, rebuilding participation, and tailoring programs to populations experiencing the greatest burden of chronic disease.

Oral Healthcare and Prevention Awareness

Preventive dental care utilization remains low among Medicaid-enrolled children and adults, even as oral health problems continue to drive emergency visits. Preventive oral health care is underutilized, and public awareness of early prevention and risk reduction needs to be improved. To improve oral health literacy and access to preventive care, Jefferson County Public Health Service, in collaboration with the Keep the North Country Smiling (KNCS) Coalition, will develop a dedicated oral-health webpage. The page will provide information on oral health during pregnancy, early childhood caries prevention, fluoride varnish in primary care settings, the benefits of fluoridated water, and early detection of oral cancer. This approach promotes consistent public messaging and increases community awareness about preventive oral health practices.

Youth Mental Health and Social-Emotional Learning

Schools are increasingly recognizing the importance of mental health and emotional well-being in student success. High rates of chronic absenteeism and increasing behavioral health concerns among youth highlight the need for school-based interventions. Expansion of age-appropriate mental health and wellness programs with help to strengthen coping skills and emotional support for students. To promote youth mental health and social-emotional development, Pivot, Jefferson County Community Services, the Jefferson County Suicide Prevention Coalition, and local school districts will collaborate to enhance school-based mental health and wellness programming. This includes implementing Second Steps, an evidence-based social-emotional learning curriculum, and Gizmo's Pawesome Guide to Mental Health for younger students. Embedded mental health providers will support classroom delivery and help identify students in need of additional support.

The selection of these interventions was based on local data, stakeholder input, and alignment with state and national evidence-based frameworks. Each strategy addresses a demonstrated community need, builds on existing local capacity, and integrates health equity principles to ensure that interventions reach populations most affected by disparities.

Progress and Evaluation

Progress on the CHIP/CSP will be monitored collaboratively throughout the cycle by the CHIP/CSP Workgroup, which meets quarterly and is facilitated by the Fort Drum Regional Health Planning Organization (FDRHPO). The workgroup includes representatives from the local health department, hospitals, and key community organizations engaged in implementing the selected interventions. During these meetings, partners will review progress toward performance measures, share activity updates, and assess outcomes. FDRHPO will support this process by coordinating meetings, assisting with data collection and analysis, and documenting progress to ensure accountability and alignment with the Prevention Agenda goals.

If data or feedback indicate that goals are not being met, partners will review findings during quarterly CHIP/CSP workgroup meetings using progress updates and performance measures to identify barriers. From there the group will determine if there is a need for mid-course corrections. Adjustments may include modifying interventions, adjusting timelines, or reallocating resources to better achieve intended

outcomes. All decisions will be made collaboratively to ensure the plan remains aligned with the 2025–2030 Prevention Agenda and continues to advance health equity.

Community Health Assessment (CHA)

The 2025 Jefferson County Community Health Assessment (CHA) is a planning document that describes the health status of Jefferson County residents, identifies key health challenges, and supports the selection of local priorities. The CHA is a requirement for local health departments and hospitals as part of New York State's Prevention Agenda 2025–2030, and it directly informs both the Jefferson County Community Health Improvement Plan (CHIP) and partner hospital Community Service Plans (CSPs). This CHA follows the structure and expectations outlined by the New York State Department of Health, aligning with the five domains in the updated Prevention Agenda:

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

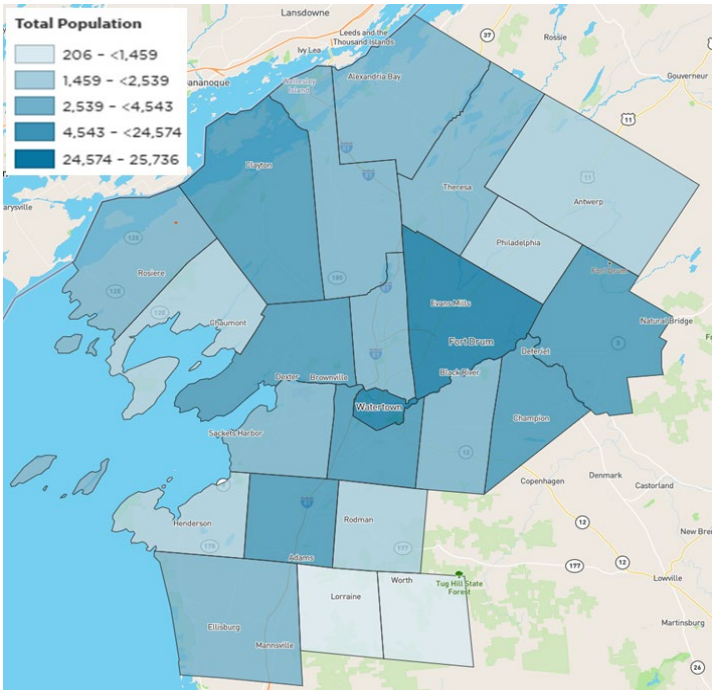
The CHA assesses Jefferson County's performance across the state's 24 priority areas within these domains and provides the evidence base to guide the selection of locally relevant objectives and interventions. The approach ensures consistency with statewide SMARTIE objectives and helps align Jefferson County's public health efforts with New York's health improvement plan.

The CHA is a comprehensive "snapshot" of local health in 2025. It describes current health status, the social and environmental conditions that shape it, and the assets residents can leverage to improve health and wellness. Completing a CHA is an essential public-health service that enables hospitals and public health to identify populations at greatest risk and select interventions that align with the New York State's 2025-2030 Prevention Agenda. The Community Health Improvement Plan (CHIP) and Community Services Plan (CSP) translates those findings into an action plan (NYSDOH, 2025).

Community Description

Service Area Description

Jefferson County, located in northern New York, sits between the eastern edge of Lake Ontario and the St. Lawrence River, just south of the Canadian border and about 60 miles north of Syracuse. Despite its largely rural setting, the population is concentrated in a few key areas. Watertown, the county seat and largest city in the region, is home to more than 24,000 residents. According to the U.S. Census Bureau, the county covers about 1,269 square miles (U.S. Census Bureau, 2023). One of the most important parts of Jefferson County is Fort Drum, a major U.S. Army base and the home of the 10th Mountain Division. The installation covers about 107,000 acres and stretches into neighboring Lewis County. Fort Drum is a major driver of the local economy and community life, with over 15,000 active-duty soldiers, nearly 3,700 civilian workers, and about 15,000 family members, most of whom live, work, and go to school in Jefferson County. Fort Drum is the only division-sized military installation in the United States that does not have its own on-post hospital or school. As a result, soldiers and their families rely on the local healthcare system and public school districts in the surrounding communities. This creates a unique dynamic in Jefferson County, where local providers, hospitals, and schools play a central role in serving the needs of a large and frequently transitioning military population.

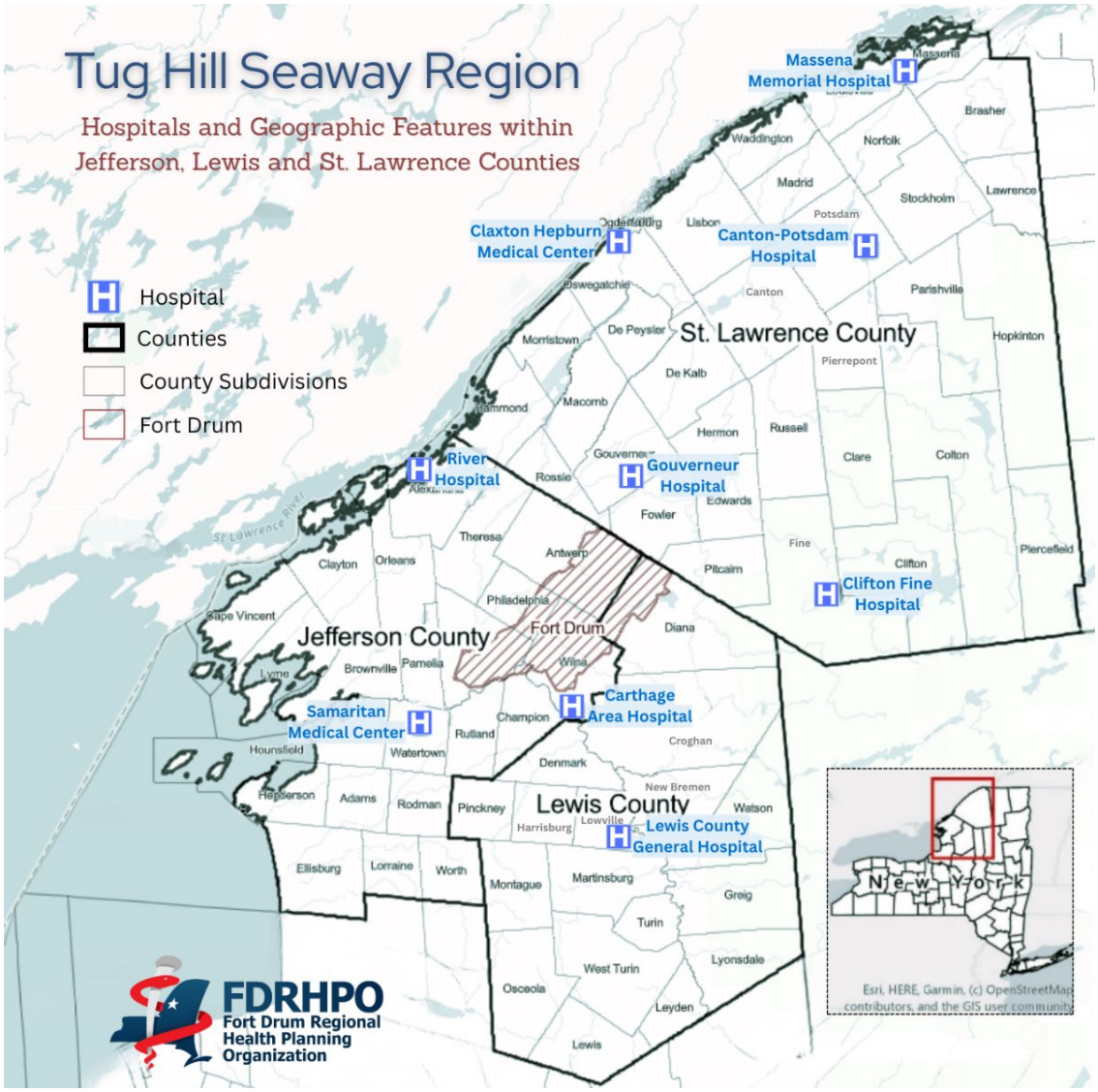


Sources: US Census Bureau ACS 5-year 2019-2023

The county includes a mix of small cities, towns, and rural villages. Watertown is the population center, while riverside and lakeshore communities like Clayton, Cape Vincent, Dexter, and Alexandria Bay are important for tourism and their connection to nearby Canada, just 30 miles away. The area is connected by two major roads: Interstate 81, which runs north to the Canadian border and south to Syracuse, and U.S. Route 11, which also serves many rural communities across the county. Air travel is supported by Watertown International Airport (ART). The airport handles both passenger and cargo flights and plays an important role in local transportation. Jefferson County is served by three hospitals. Samaritan Medical Center is located in Watertown and serves as the main hospital for the county. It offers a wide range of services, including emergency care, surgery, maternity, and specialty care, and acts as the central hub for more complex medical needs in the region. To the southeast, Carthage Area Hospital provides healthcare to residents in and around the Carthage area. It offers emergency services and outpatient care and is especially important to families living in the eastern part of the county and nearby

areas of Lewis County. Up north along the St. Lawrence River, River Hospital in Alexandria Bay serves the river communities and Thousand Islands region. It offers emergency care, inpatient services, behavioral health services, and primary care services, and also plays an important role during the busy tourism season.

As shown in the table below, Jefferson County continues to face shortages across several key healthcare provider types when compared to both the regional and state averages. The supply of physicians, particularly primary care physicians, is lower than the statewide rate, highlighting ongoing challenges in accessing care locally (Health Resources and Services Administration, 2025).



FDRHPO (2025), Regional *Hospitals.* Created using ArcGIS, Esri.

Nurse practitioners represent a growing share of the clinical workforce and help offset some of the physician shortfall, but overall provider availability remains limited. Dental care access is also a concern,

with dentist-to-population ratios well below the state average, contributing to gaps in oral health services, especially for low-income and uninsured residents. These shortages reflect issues that are common to rural areas, including provider recruitment and retention difficulties, and limited access to specialty services. The shortages are also confirmed by federal Health Professional Shortage Area (HPSA) designations from HRSA. Jefferson County is officially designated as having provider shortages for the Medicaid-eligible population in primary care (score=15), mental health (score=17), and dental care (score= 13). These scores indicate a high level of need and correspond with estimated shortfalls in providers. Jefferson County's healthcare workforce is not sufficient to meet the needs of its population, especially for low-income residents (HRSA, 2022).

Source: https://data.hrsa.gov/tools/shortage-area/hpsa-find

Health Resources and Services Administration (HRSA) HPSA Designations for Jefferson				
Discipline	**Designation Type**	**HPSA FTE Short**	**HPSA Score**	**Rural Status**
Primary Care	Medicaid Eligible Population HPSA	7.85	15	Partially Rural
Dental Health		4.40	13	Partially Rural
Mental Health		2.17	17	Partially Rural

Source: HRSA Area Health Resource Files 2022

	Jefferson		Regional		NYS	
Clinician Group	**Count(#)**	**Per 100k pop.**	**Count(#)**	**Per 100k pop.**	**Count(#)**	**Per 100k pop.**
All Physicians (MD and DO)	223	191	440	175	95,370	485
All Physicians (MD)	189	162	385	153	89,249	454
All Physicians (DO)	34	29	55	22	6,121	31
Primary Care Physicians	75	64	164	65	24,365	124
Nurse Practitioners	124	106	249	99	23,438	119
Physician Assistants	143	123	249	99	18,280	93
Dentists	59	51	101	40	14,229	72
Population	**116,130**		**251,069**		**19,677,151**	

Source: https://profiles.health.ny.gov/hospital/view/103027

Hospitals, Services, and Extension Sites			
Jefferson County	**Samaritan Medical Center**	**River Hospital**	**Carthage Area Hospital**
Services			
Ambulatory Surgery - Multi Specialty	x	x	x
Certified Mental Health Services O/P	x	x	
Dental O/P	x		
Emergency Department	x	x	x
Lithotripsy	x		x
Magnetic Resonance Imaging	x		x
Maternity	x		x
Medical Services - Other Medical Specialties	x	x	x
Medical Services - Primary Care	x	x	x

Radiology-Therapeutic	x		
Renal Dialysis - Acute	x		

Hospitals, Services, and Extension Sites			
Jefferson County	**Samaritan Medical Center**	**River Hospital**	**Carthage Area Hospital**
Bed Types			
Coronary Care Beds	4	-	4
Intensive Care Beds	6	-	-
Maternity Beds	29	-	8
Medical / Surgical Beds	166	22	10
Neonatal Intensive Care Beds	7	-	-
Neonatal Intermediate Care Beds	8	-	-
Pediatric Beds	20	-	3
Physical Medicine and Rehabilitation Beds	16	-	-
Psychiatric Beds	39	-	-
TOTAL BEDS	**295**	**22**	**25**

Jefferson County Nursing Home/Long-Term Care/Rehabilitation			
Site	**Total Capacity**	**Available Capacity**	**Location**
Samaritan Keep Nursing Home	272	18	Watertown
Samaritan Senior Village	165	3	Watertown
Carthage Center for Rehabilitation & Nursing	90	3	Carthage

Extension Sites Samaritan Medical Center		
Site Name	**Town/City**	**Services**
Adams Family Health Center	Adams	Certified Mental Health Services O/P; Medical Services - Other Medical Specialties; Medical Services - Primary Care
Samaritan Family Health Center (Clayton)	Clayton	Certified Mental Health Services O/P; Clinical Laboratory Service O/P; Medical Services - Other Medical Specialties; Medical Services - Primary Care
Samaritan Family Health Center (Lacona)	Lacona	Medical Services - Primary Care
Samaritan Family Health Center (Coleman Clinic)	Watertown	Certified Mental Health Services O/P; Medical Services - Other Medical Specialties; Medical Services - Primary Care
Samaritan Family Health Center (Cape Vincent)	Cape Vincent	Medical Services - Primary Care
Samaritan Family Health Center (Sackets Harbor)	Sackets Harbor	Medical Services - Primary Care
Samaritan Family Practice (LeRay)	Le Ray	Clinical Laboratory Service O/P; Medical Services - Other Medical Specialties; Medical Services - Primary Care

Samaritan Lab & X-Ray Services	Watertown	Clinical Laboratory Service O/P; Medical Services - Other Medical Specialties
Samaritan Medical Center Rheumatology Clinic	Watertown	Medical Services - Other Medical Specialties
Samaritan Medical Center Urology, Lab & X-ray	Watertown	Clinical Laboratory Service O/P; Medical Services - Other Medical Specialties; Medical Services - Primary Care
Samaritan Medical Plaza	Watertown	Certified Mental Health Services O/P; Chemical Dependence - Rehabilitation O/P; Medical Services - Other Medical Specialties; Medical Services - Primary Care; Well Child Care O/P
Samaritan Pulmonology	Watertown	Medical Services - Other Medical Specialties

Extension Sites River Hospital		
Site Name	Town/City	Services
River Community Wellness	Alexandria Bay	Certified Mental Health Services O/P
River Hospital – Alexandra Central School-based Mental Health	Alexandria Bay	School-based Mental Health Services
River Hospital – General Brown School-based Mental Health	Brownville, Dexter, Glen Park	School-based Mental Health Services in each school building

Extension Sites Carthage Area Hospital		
Site Name	Town/City	Services
Beaver River Central School	Beaver Falls	Health Education O/P; Immunology; Medical Social Services O/P; Multiphasic Screening O/P; Nursing; Primary Medical Care O/P; Psychology O/P; Venereal Disease Prevention; Well Child Care O/P
CAH Medical Building	Carthage	Primary Care; Pediatric O/P; Podiatry O/P; Prenatal O/P
CAH Medical Center	Carthage	Other Medical Specialties; Medical Services - Primary Care; Therapy - Physical O/P
CHMC Ravindar Agarwal Renal Center	Ogdensburg	Home Hemodialysis Training and Support; Home Peritoneal Dialysis Training and Support; Renal Dialysis - Chronic O/P
Carthage Area Hospital Walk-In Clinic	Carthage	Medical Services - Other Medical Specialties; Medical Services - Primary Care
Carthage High School	Carthage	Health Education O/P; Immunology; Medical Social Services O/P; Multiphasic Screening O/P; Nursing; Primary Medical Care O/P; Psychology O/P; Venereal Disease Prevention; Well Child Care O/P
Carthage Middle School	Carthage	Health Education O/P; Immunology; Medical Social Services O/P; Multiphasic Screening O/P; Nursing; Primary Medical Care O/P; Psychology O/P; Venereal Disease Prevention; Well Child Care O/P
Heuvelton Health Center	Heuvelton	Certified Mental Health Services O/P; Medical Services - Primary Care
La Fargeville Central School	LaFargeville	Health Education O/P; Immunology; Medical Social Services O/P; Multiphasic Screening O/P; Nursing; Primary Medical Care O/P;

		Psychology O/P; Venereal Disease Prevention; Well Child Care O/P
Philadelphia Medical Center	Philadelphia	Medical Services - Other Medical Specialties; Medical Services - Primary Care; Therapy - Physical O/P

Healthcare Resources

Jefferson County is served by three hospitals:

- Carthage Area Hospital, a 25-bed not-for-profit critical access hospital in Carthage
- River Hospital, a 22-bed not-for-profit critical access hospital in Alexandria Bay
- Samaritan Medical Center, a 290-bed not-for-profit hospital in Watertown

Carthage Area Hospital

History

Carthage Area Hospital (CAH) has been a cornerstone of community healthcare since its inception as a not-for-profit rural hospital in 1965. Today, CAH operates as a fully accredited 25-bed Critical Access Hospital, proudly serving approximately 83,000 residents across Jefferson, northern Lewis, and southern St. Lawrence counties. With a network of 13 regional healthcare centers, to include our Rural Health Clinics, Walk-in Clinic and School-Based Clinics, we ensure that quality healthcare is never far from home.

Our commitment to healthcare excellence and equitable, value-based personal care remains steadfast. We are dedicated to delivering comfort and healing to every individual, ensuring that all residents have convenient access to necessary services without the burden of unnecessary travel. CAH is honored to serve our North Country communities—especially the men and women of Fort Drum and the 10th Mountain Division (Light) and their families. As one of the few U.S. military installations without an on-post hospital, Fort Drum relies on our facility to fulfill its healthcare needs. In keeping with our mission to support overall health and well-being, we continually evaluate and enhance the services and technologies we offer. We are committed patriots, grateful for the sacrifices of our military members and their families and strive to integrate them fully into our community's care network.

CAH is a proud member of the North Star Health Alliance (NSHA). NSHA is a collaborative system of healthcare organizations in Northern New York, committed to elevating community health and well-being. Members of the NSHA include Carthage Area Hospital (CAH), Claxton-Hepburn Medical Center (CHMC), Claxton-Hepburn Medical Campus (Claxton Campus), North Country Orthopedic Group (NCOG), and Meadowbrook Terrace Assisted Living Facility (MBT). By working together, we aim to enhance accessibility and affordability of care, deliver exceptional medical services, and strengthen our local health infrastructure. United in our efforts, we are committed to keeping healthcare local, to ensure sustainable patient centered healthcare solutions for our communities.

Through unwavering commitment to value-based, patient-centered care—and in partnership with Fort Drum, the North Star Health Alliance, and community organizations—CAH remains dedicated to keeping quality healthcare close to home and building a healthier future for all we serve.

Mission

Carthage Area Hospital commits to healthcare excellence and equitable value-based personal care to all those who seek comfort and healing.

Vision

Carthage Area Hospital improves the quality of life, achieving the highest level of wellness to the diverse communities we serve. Carthage Area Hospital will foster a patient-centered, employee-centered culture that values diversity and inclusion while providing high quality, equitable healthcare services to the populations we serve.

Our Values

Carthage Area Hospital values professionalism, accountability, compassion, customer service, and teamwork.

Service Area

Carthage Area Hospital is located in Carthage, NY. Defined by zip code area, its service area includes Fort Drum, Black River, and Carthage in Jefferson County; Natural Bridge, split between Jefferson and Lewis counties; and Harrisville, split between Lewis and St. Lawrence counties.

River Hospital

History

River Hospital is a private not-for-profit Critical Access Hospital located in a rural area of Northern New York, with 22 licensed beds. This area is a federally designated Health Provider Shortage Area (HPSA). Under the Hospital licensure, River Hospital operates inpatient, outpatient, and emergency services. In addition to the full-time residents of these communities, River Hospital serves a large population of seasonal residents and visitors from the United States and other countries of the world, due in part to the tourism industry. The seasonal residents are typically in this area for up to six months of the calendar year, and rely on the primary care and ancillary services for their routine healthcare needs. River Hospital is the one of the two largest year-round employers in the Town of Alexandria, contributing resources to the surrounding communities beyond health care.

Scope of Services include acute care admissions with the 96 hour rule as governed by the Critical Access Hospital designation; Swing Bed services for individuals requiring ‘short term’ inpatient rehabilitation and providing medical services for patients needing longer recuperation period following an acute illness or surgical procedure; Non-emergent Ambulatory Surgery; Emergency Services with an Observation Unit for patients requiring longer term monitoring and assessment; Laboratory Services; Radiology Services; Cardiopulmonary Services; Physical Therapy Services; Primary Care Family Health Services; Convenient Care Services for patients needing non-emergent acute services who are unable to get an appointment

with their primary care provider or who do not have a primary care provider; Behavioral Health Services for adult, children and adolescent community members; Specialty providers with limited schedules for access to cardiology, gynecology, colorectal, general surgery, nephrology, orthopedic, vascular dermatology, and pulmonology. Behavioral Health Services for specialized intense outpatient (IOP) treatment program for active duty soldiers and Veterans suffering from Post-Traumatic Stress; and Patient Financial Services. River Hospital's outpatient primary care is a Patient Centered Medical Home model, and PCMH Level 3. River Hospital strives to maintain population health to engage patients in their own care.

Mission

It is the mission of River Hospital to deliver vital patient centered healthcare, which ensures access to compassionate, comprehensive health and wellness for our Northern New York Community.

Vision

It is the vision of River Hospital to lead the advancement of rural healthcare, creating a healthier future for our community.

Service Area

River Hospital is located in Alexandria Bay, New York. Defined by zip code area, this facility provides healthcare services to several surrounding communities, which primarily include but not limited to Alexandria Bay, Clayton, La Fargeville, Wellesley Island, Theresa, Fort Drum, Cape Vincent, Plessis, and Redwood in Jefferson County, as well as Hammond and Morristown in St. Lawrence County.
Given the void of any public transportation systems in this area and the frequently difficult winter travel conditions, some situations would result in unfavorable and even fatal consequences if River Hospital was not able to provide needed services in this area. Without the delivery of healthcare services at River Hospital, there would be a 60 mile stretch between healthcare facilities, making such services unavailable to the surrounding communities, residents, and visitors without the required traveling.

Samaritan Medical Center

History

Samaritan Medical Center, founded in 1881 as House of the Good Samaritan, is a 290-bed not-for-profit community hospital. Located in Watertown, Samaritan offers a full spectrum of inpatient and outpatient services. From primary and emergency care to highly specialized medical and surgical services, including cancer treatment, neonatal intensive care, behavioral health and addiction services, and imaging, the Samaritan Health System serves the medical needs of the region's civilian and military community. Samaritan's medical staff includes more than 180 physicians representing 45 specialties. The Samaritan Health System employs 2,200 full-time equivalent employees. It is both the largest provider of healthcare services and the largest private employer in Jefferson County.

In addition to the inpatient and outpatient services available at the main hospital and at more than 25 community-based clinics, specialty offices, and satellite testing centers, Samaritan serves the community's post-acute care needs with Samaritan Keep Home, a 272-bed nursing home; Samaritan Summit Village, a 288-bed long-term care facility with skilled nursing and assisted living programs, and

Samaritan Home Health, which provides short-term, in-home nursing and therapeutic services. Samaritan also operates a Graduate Medical Education program, training residents, interns, and medical students.

Mission

Samaritan shall provide high quality, comprehensive, safe, and compassionate healthcare services to meet the needs of our civilian and military community.

Vision

Samaritan will be recognized, foremost, as the preferred provider of inpatient, outpatient, emergency, and long-term care services in Jefferson County. Additionally, our health system will enhance selected specialty services to meet the needs of the North Country

Our Values

In order to succeed as a team in meeting the healthcare needs of those we serve, Samaritan is committed to honesty, empathy, accountability, respect, and trust.

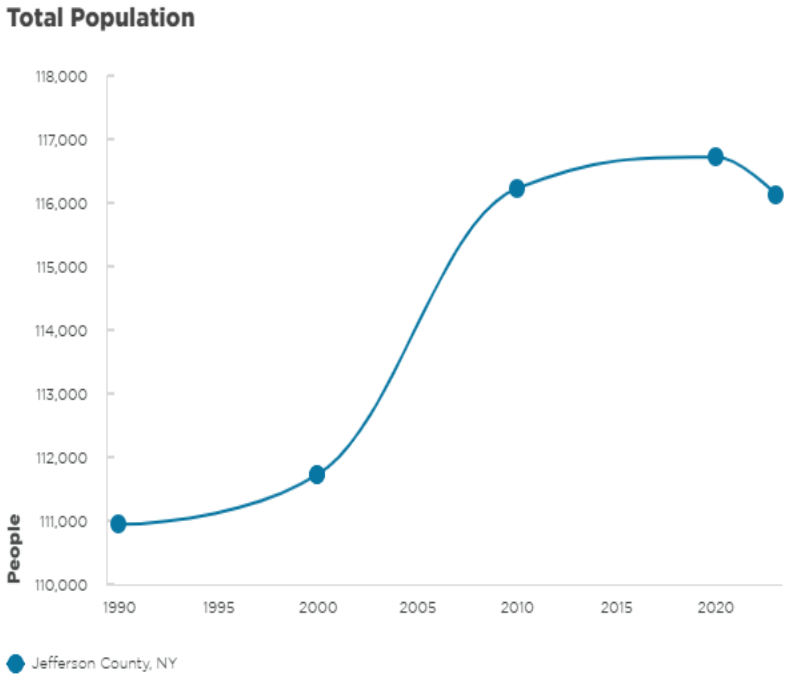
Service Area

Samaritan Medical Center is located in Watertown, NY. Defined by zip codes, its primary service area includes all of Jefferson County, including Watertown, Fort Drum, Carthage, and nearly three dozen smaller villages and hamlets, in addition to adjacent rural areas. The primary service area extends beyond Jefferson County's borders to include Sandy Creek and Lacona in Oswego County, Copenhagen in Lewis County, and Harrisville, split between Lewis and St. Lawrence counties.
The largest populated places in Samaritan Medical Center's primary service area are Watertown, which is the only city in the county, and Fort Drum, home of the U.S. Army's 10th Mountain Division.

Demographic Profile

Population

The U.S. Census Bureau provides several different population figures for Jefferson County, and it's important to understand what each one means. The official 2020 Census count recorded a population of 116,721 (U.S. Census Bureau, 2021). This is an official fixed number collected during the nationwide decennial census on April 1, 2020. The Bureau's Population Estimates Program (PEP) provides updated annual estimates. The most recent PEP estimate, for July 1, 2024, puts Jefferson County's population at 113,140, which reflects a 3.1% decrease from the 2020 Census base of 116,721 (U.S. Census Bureau, 2025). A third number, 116,130, comes from the American Community Survey (ACS) 5-year estimates for the period 2019–2023 (U.S. Census Bureau, 2024). The ACS is a rolling survey that averages responses collected over five years and is commonly used for demographic and socioeconomic data in public reports. While each of these estimates is valid, they serve different purposes. While the PEP estimate is the most current and the decennial census provides an official fixed baseline, the ACS gives a range of detailed demographic characteristics that are important for an assessment such as this one. To maintain consistency throughout this report, and because the ACS 5-year dataset is the source for many demographic and health indicators, the ACS 5-year estimate of 116,130 will be used throughout most of this Community Health Assessment. Like the population estimates, other data points, such as household income, poverty levels, and housing characteristics, may also vary slightly depending on how and when the data were collected. For example, median household income figures from County Health Rankings may differ from those reported by the U.S. Census Bureau due to differences in methodology, data sources, or reference years. Even within Census data numbers, variations can occur depending on whether the estimates are based on 1-year or 5-year averages. These differences are expected and do

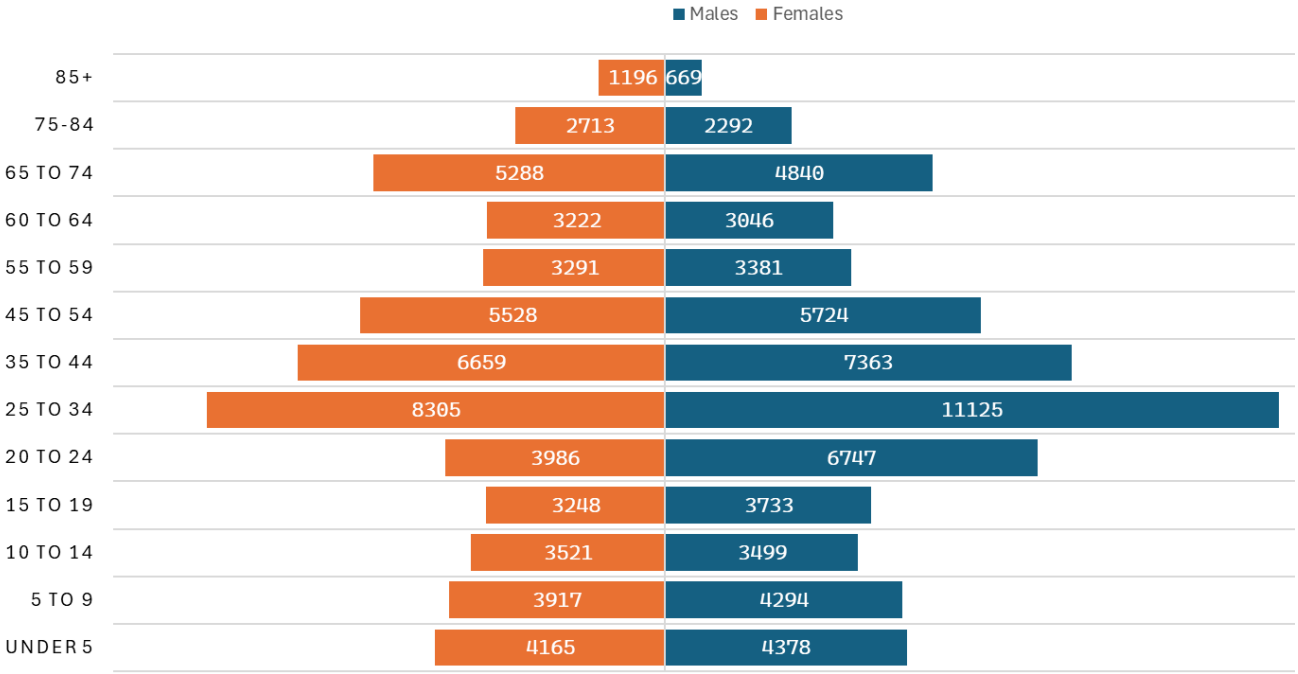


Sources: US Census Bureau; US Census Bureau ACS 5-year

not indicate inaccuracies, but rather reflect the use of multiple valid data sources tailored to specific indicators.

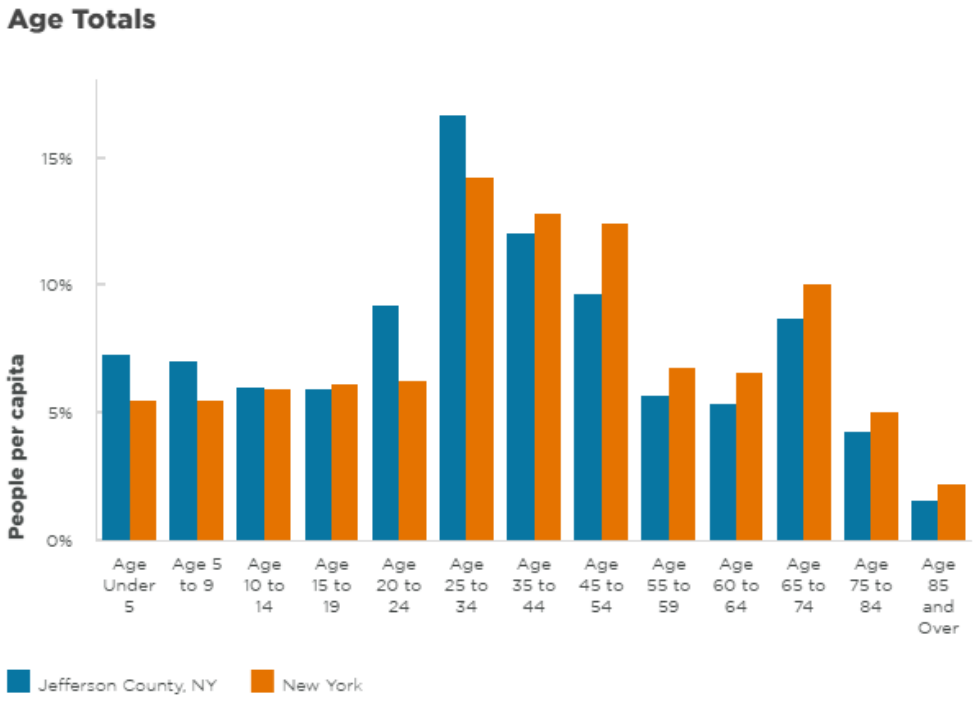
The population breakdown by age reflects a young demographic overall, with a concentration of residents in the 25-44 age range, particularly among males. This difference is largely influenced by the presence of Fort Drum, which brings in a sizable number of active-duty soldiers and younger workers. Males outnumber females in most age groups under 55, with the greatest disparity seen between ages 25 and 34. Children under age 15 represent a stable portion of the population, indicating continued need for pediatric and family services. In contrast, the population ages 65 and older shifts toward females, consistent with longer female life expectancy. These older cohorts are growing and will require support for aging-in-place, chronic disease self-management, and long-term care. Overall, Jefferson County's population profile highlights the need to support a young workforce while also preparing for an aging population.

Population by Age and Gender. Source: Census ACS 2019-2023



Jefferson County has one of the youngest populations in the state, with a median age of 34.1 years, compared to a statewide median of approximately 40. The strong military presence contributes to this younger demographic and tilts the gender balance slightly male. Adults between the ages of 25 and 34 make up the largest single age group in the county, accounting for over 17% of residents, above the statewide average. This is likely influenced by the presence of Fort Drum, which draws a significant number of active-duty service members and young families to the region (U.S. Census Bureau, 2024).

Jefferson County has a smaller proportion of residents aged 55 and older than the state as a whole. This is especially evident in the 65 to 74 and 75 to 84 age brackets, suggesting a lower concentration of retirees or aging populations compared to other parts of New York. A higher concentration of young adults and families may increase the need for services related to maternal and child health, mental health support for young adults, workforce development programs, and access to affordable child care. However, it remains important to monitor aging trends over time. While Jefferson County currently has a smaller proportion of older adults than the state overall, planning for older adult services is important, especially as the population shifts and as communities work to support long-term residents and attract or retain retirees.



Sources: US Census Bureau ACS 5-year 2019-2023

Race/Ethnicity

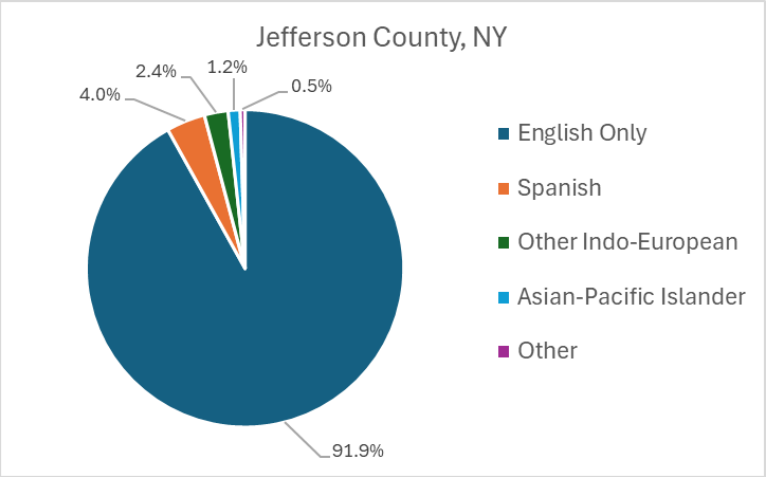
Jefferson County's population is predominantly White (Non-Hispanic), making up approximately 80.8% of residents. The next largest group is individuals who identify as Hispanic or Latino, accounting for 7.3%, followed by people of two or more races (4.9%) and Black or African American (Non-Hispanic) residents (4.6%). Other racial and ethnic groups make up smaller portions of the population, including Asian (1.8%), Native Hawaiian or Other Pacific Islander (0.2%), and American Indian (0.1%), (U.S. Census Bureau, 2024). While Jefferson County is less racially and ethnically diverse than New York State overall, the presence of various racial and ethnic groups contributes to the county's cultural and demographic makeup. National, state, and local data indicate that some smaller groups may experience healthcare disparities. These findings are important when examining local health outcomes and when assessing needs across different population groups.

Sources: US Census Bureau ACS 5-year (via mySidewalk)

Race/Ethnicity	Population
White (Not Hispanic or Latino)	80.8%
Hispanic or Latino	7.3%
Two or More Races Other (Not Hispanic or Latino)	4.9%
Black (Not Hispanic or Latino)	4.6%
Asian (Not Hispanic or Latino)	1.8%
Single Race Other (Not Hispanic or Latino)	0.3%
Native Hawaiian and Other Pacific Islander (Not Hispanic or Latino)	0.2%
American Indian (Not Hispanic or Latino)	0.1%

Language

Jefferson County is primarily English-speaking, with 91.9% of residents ages 5 and older speaking only English at home. However, nearly 1 in 12 residents (8.1%) speak a language other than English at home. Spanish is the most common non-English language, spoken by 4.0% of residents. Other Indo-European languages such as German, French, and Russian account for 2.4%, while 1.2% speak Asian or Pacific Island languages, and 0.5% report speaking other languages (U.S. Census Bureau, 2024). While the county is not highly linguistically diverse compared to New York State overall, the presence of Fort Drum likely contributes to a wider array of languages than typical for rural counties. Spanish and Indo-European language speakers each exceed 1,000 residents, which suggests a need for language access planning. Public health and healthcare providers may want to maintain Spanish-language materials and interpretation resources, while monitoring language shifts over time, particularly among military, immigrant, and refugee populations.

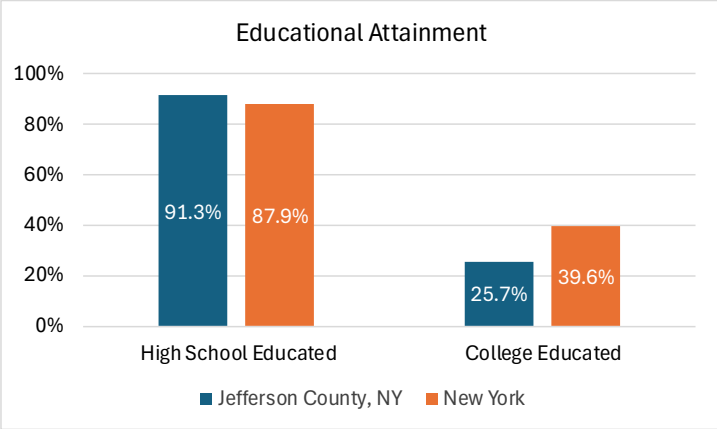


Sources: US Census Bureau ACS 5-year 2019-2023

Education

Approximately 91.3% of Jefferson County residents have completed high school or obtained a high school equivalency diploma. This is slightly above the statewide average of 87.9%, indicating relatively strong high school-level attainment in the county. However, college attainment in Jefferson County is notably lower than the state average. Just 25.7% of residents hold a bachelor's degree or higher, compared to 39.6% across New York State (U.S. Census Bureau, 2024). This gap in higher education may have implications for workforce development, income potential, and access to jobs that require advanced training or credentials. As workforce needs evolve, particularly with the rise of artificial

intelligence and a growing demand for skilled trades and technical occupations, addressing educational attainment beyond high school, whether through college or alternative training pathways, will be increasingly important for regional economic resilience and opportunity. When it comes to healthcare, it's important for the county to ensure that the right educational pathways are in place, not just for advanced degrees, but also for mid-level and entry-level roles that are critical to keeping healthcare systems running.



Sources: US Census Bureau ACS 5-year 2019-2023 (via mySidewalk)

The county is home to 12 public school districts, one regional BOCES, a handful of private and parochial schools, and a centrally located community college. The majority of Jefferson County students attend one of 12 public districts that vary in size and geography. The largest, Watertown City School District, serves the county's main urban city, while Indian River and Carthage districts span areas with strong military connections due to their proximity to Fort Drum. Smaller districts like Lyme, La Fargeville, and Sackets Harbor operate single campuses and serve tight-knit rural communities (NCES, 2024). Most districts offer comprehensive K–12 education, though the availability of universal pre-K, specialized services, and college or career pathway programs varies . Participation in Jefferson-Lewis BOCES supplements this gap by offering regional access to career and technical education (CTE), special education, and adult-learning services, especially for smaller districts that lack capacity in-house. Indian River and Carthage have strong connections to Fort Drum and are accustomed to serving highly mobile military families. BOCES expands access to specialized programs that would otherwise be unavailable in small districts. KIIs and CHS data indicate increasing behavioral and emotional challenges among students, with many districts struggling to recruit enough school counselors, social workers, or behavioral support staff. Stakeholders noted that many students lack clear, supported pathways from high school to college or the workforce, particularly in more rural areas.

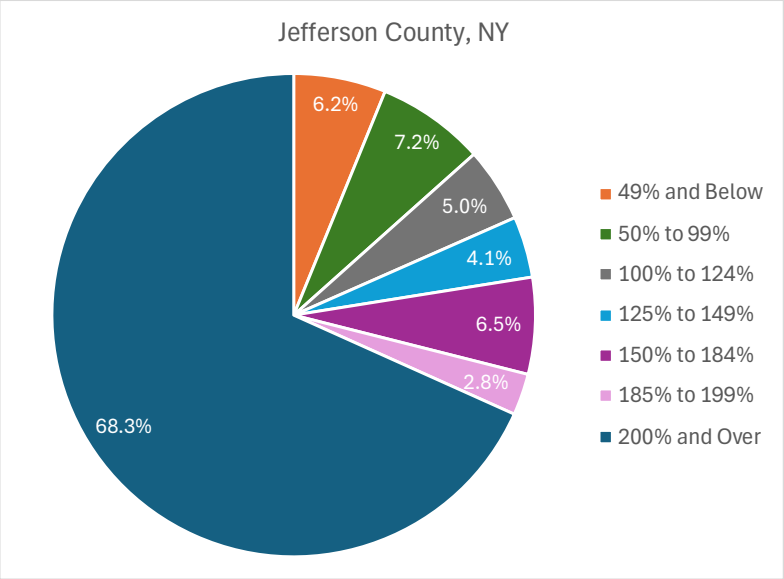
Jefferson Community College (JCC) is the county's primary local institution of higher education. As part of the SUNY system, JCC provides over 30 associate-degree pathways, transfer programs, and targeted workforce credentials. It also hosts satellite bachelor's programs in collaboration with several institutions, including SUNY Canton. JCC plays a crucial role in career pipeline development.

Source: NCES *CCD public school district data for the 2023-2024 school year*

School District	City	Students	Teachers	Schools	Locale	Student Teacher Ratio
Alexandria	Alexandria Bay	471	48.67	1	Rural, Distant	9.68
Belleville-Henderson	Adams	512	43.83	1	Rural, Distant	11.68
Carthage	Carthage	3127	295.64	5	Rural, Fringe	10.58
General Brown	Dexter	1369	94.99	3	Rural, Fringe	14.41
Indian River	Philadelphia	3494	310.84	8	Rural, Fringe	11.24
Jefferson-Lewis BOCES	Watertown	N/A	38.99	1	Rural, Fringe	N/A
La Fargeville	La Fargeville	477	41.01	1	Rural, Distant	11.63
Lyme	Chaumont	353	29.92	1	Rural, Distant	11.80
Sackets Harbor	Sackets Harbor	408	34.50	1	Rural, Distant	11.83
South Jefferson	Adams	1824	140.00	4	Rural, Distant	13.03
Thousand Islands	Clayton	841	69.70	4	Rural, Distant	12.07
Watertown City	Watertown	3993	294.72	8	City, Small	13.55

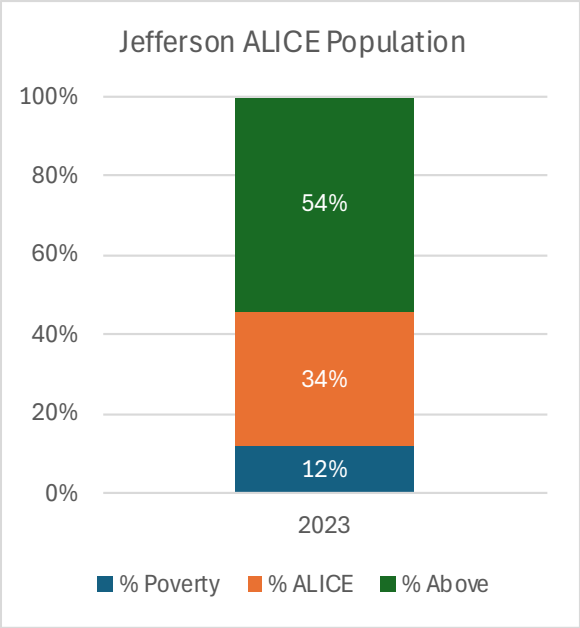
Household Income

The median household income in Jefferson County is approximately $64,978, below the New York State median of $82,095 (U.S Census Bureau, 2024). Roughly 13% of residents live below the federal poverty level. The income-to-poverty ratio chart represents the share of Jefferson County residents whose household income falls within specific ranges compared to the federal poverty level (FPL). The FPL is a national standard set each year based on household size, and it is used to determine eligibility for many public assistance programs. Each category in the chart reflects how close or far a household's income is from that poverty line. For example, a ratio of 49% or below means the household earns less than half of the poverty threshold, while a ratio of 100% to 124% means the household earns just above the poverty line, still often qualifying for programs like Medicaid or food assistance. As the percentages increase, they reflect higher income levels relative to the poverty threshold. A ratio of 200% or more means the household earns at least twice the poverty level and is less likely to qualify for income-based services. In short, the chart shows how income is distributed across the population in relation to the poverty line.



Sources: US Census Bureau ACS 5-year 2019-2023

The ALICE population (Asset Limited, Income Constrained, Employed), represent households that earn above the FPL but still struggle to afford basic necessities such as housing, child care, food, transportation, healthcare, and technology. These households fall into the gap between poverty and financial stability: they are not poor enough to qualify for many assistance programs, but they are far from economically secure. Because the ALICE Threshold is based on actual local expenses rather than a fixed multiple of the FPL, it may be lower or higher than 200% of FPL. Households can move above or below the threshold over time as wages, prices, and family circumstances change (United For ALICE, 2024). In Jefferson County, 12% of households were in poverty and 34% were in the ALICE population, meaning about 46% of households are below the ALICE Threshold. While these proportions fluctuate from year to year, the shifts are generally modest. The overall pattern, roughly half of households above the threshold and the remainder split between ALICE and poverty, has remained consistent over the past decade. Based on this stable trend, it is reasonable to assume that current figures are similar to those shown for 2023. The combination of the county's poverty rate and large ALICE population places pressure on families, health systems, schools, and social services, and highlights the need for strategies that address both immediate needs and long-term economic stability. Efforts to improve population health will need to prioritize affordable care access, transportation solutions, workforce development, and programs that support food security and stable housing.



Source: ALICE Threshold 2010-2022; American Community Survey 2010-2022 via unitedforalice.org/county-reports

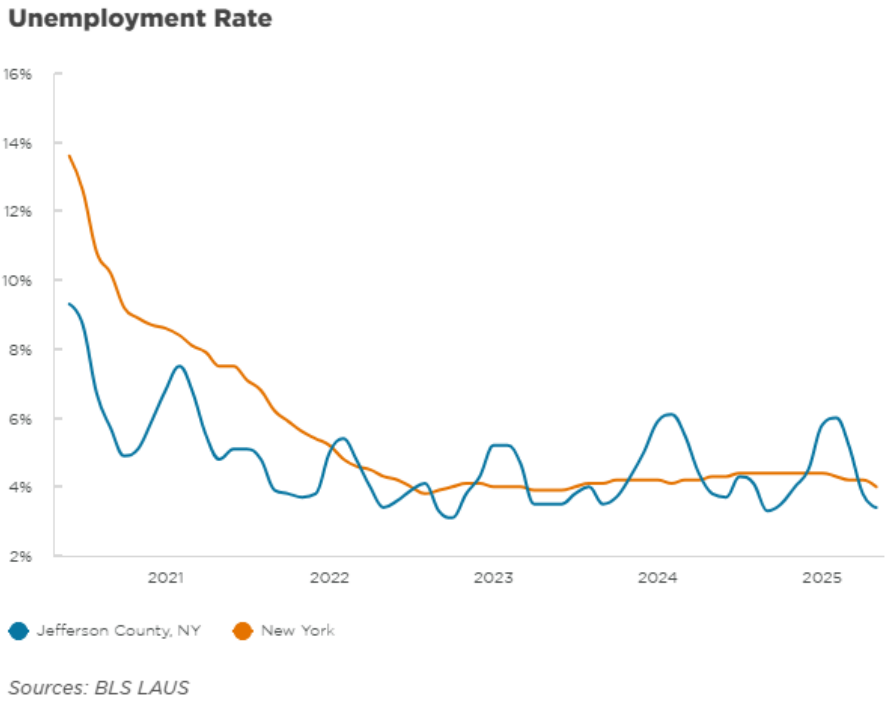
The Fort Drum military continues to shape the local economy and culture. Approximately 9,485 veterans live in Jefferson County, higher than the statewide average, indicative of the area's ongoing connection to military service. Fort Drum, home to the U.S. Army's 10th Mountain Division, is located in northern New York. While some military families reside in Lewis or St. Lawrence counties, the majority live in Jefferson County, given its proximity to the base.

About 54% of occupied housing units in the county are owner-occupied, and the median home value is $181,000, which is significantly lower than the New York State median (U.S. Census Bureau, 2024). Transportation and access issues are common in more isolated areas of the county. An estimated 11.0% of residents under age 65 report having a disability, which may impact their ability to access health services, employment, and transportation. About 80.5% of residents age 1 and older lived in the same house one year ago, which may suggest relative residential stability.

As stated previously, roughly 8.1% of residents age 5 and older speak a language other than English at home, and 4.7% of the population is foreign-born. While Jefferson County is not highly linguistically or

culturally diverse compared to the state, these populations still represent meaningful subgroups with potential language access and cultural care needs.

Jefferson County's unemployment rate has generally followed statewide trends, though with greater seasonal fluctuation. According to data from the Bureau of Labor Statistics Local Area Unemployment Statistics, Jefferson County experienced a pandemic-related spike in unemployment in early 2020. While this was significant, it was lower than the statewide peak during the same period. Since then, the county's unemployment rate has declined overall, with a noticeable pattern of seasonal variation, typically ranging from 3.5% to 6.5%. These swings are likely influenced by factors such as seasonal work, tourism, construction, and the existence of Fort Drum Army Base, one of the region's largest employers. The New York State unemployment rate has remained relatively stable since mid-2022, hovering around 4% with minimal fluctuation (Bureau of Labor Statistics, 2025). Jefferson County's unemployment rate sometimes dips below the state average during low seasons and exceeds it during seasonal highs. The seasonal nature of work and the high proportion of low-wage jobs in the region contribute to financial instability for some households, particularly those within the ALICE population.

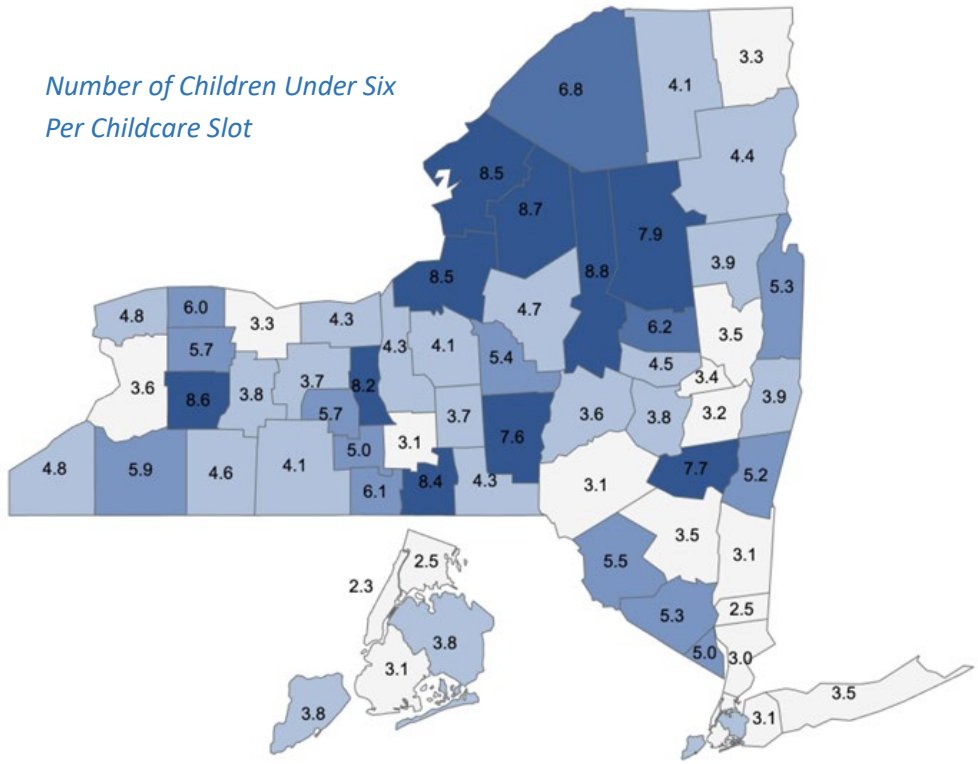


Sources: BLS LAUS

Childcare

Access to affordable child care in Jefferson County continues to be a challenge. According to the 2025 MIT Living Wage Calculator, full-time care averages about $13,100 per year, per child. This figure is comparable to the national average of $13,128, but below New York State's average of $21,826. Despite the lower cost relative to the state, care remains financially out of reach for many families, especially single parents, for whom costs can consume over 60% of income **(Massachusetts Institute of Technology, 2025)**. Licensed childcare capacity in the North Country is limited, with all three counties in the North Country falling well above the statewide averages for the number of young children per available slot. In Jefferson County, there are 8.5 children under age six for every licensed childcare space, meaning only a fraction of children can be served in regulated care at any given time. Lewis County faces a similar challenge at 8.7 children per slot, one of the highest ratios in the state. St. Lawrence County,

while somewhat lower, still has 6.8 children per slot, indicating a shortage that leaves many families reliant on informal or unlicensed care. These shortages have implications beyond early childhood development. Limited childcare access can affect parental workforce participation, contribute to economic instability, and place additional strain on family and social support systems. For employers, the lack of childcare can hinder recruitment and retention, particularly in sectors with nontraditional work hours like healthcare. From a public health perspective, reliable and high-quality childcare is linked to improved school readiness, early detection of developmental delays, and better long-term health outcomes (NYS Childcare in NYS Report, 2023).



Source: NYSDOL 2023 Childcare Report (2021 ACS 5-Year Estimates Table B09001).
Childcare Capacity by Age Group.

Health Insurance

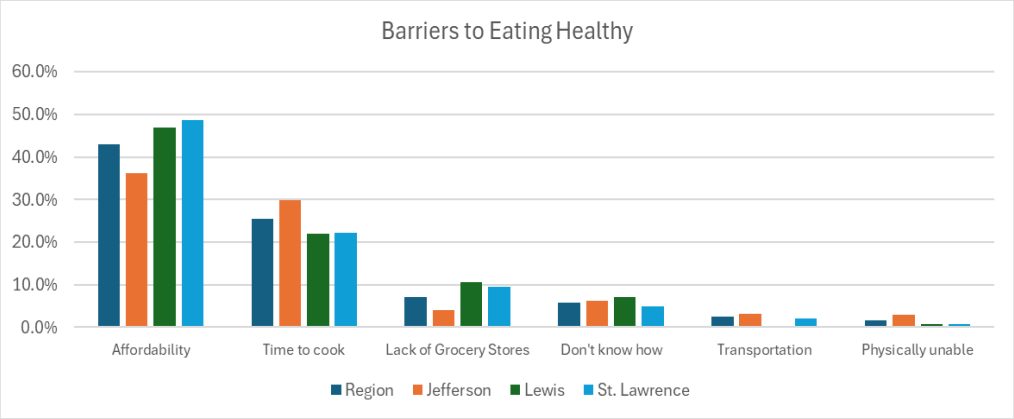
Approximately 94.2% of Jefferson County residents have health insurance, leaving only 5.8% without coverage. Roughly 18% is enrolled in Medicare, reflecting the county's growing aging population, while 26% rely on Medicaid, which is in line with the statewide rate. About 4.5% of residents receive care through the Veterans Health Administration. This rate is nearly four times higher than New York State overall (1.2%) (U.S. Census Bureau, 2024). This is likely driven by Fort Drum's presence in the county.

Source: U.S. Census Bureau 2019-2023 ACS 5-Year

	Insured	Uninsured	Medicare	Medicaid	VA Healthcare
Jefferson	**94.2%**	**5.8%**	**18.0%**	**26.1%**	**4.5%**
Lewis	95.1%	4.9%	22.6%	28.4%	3.1%
St. Lawrence	94.1%	5.9%	21.9%	26.6%	2.7%
NYS	94.9%	5.1%	18.4%	27.4%	1.2%

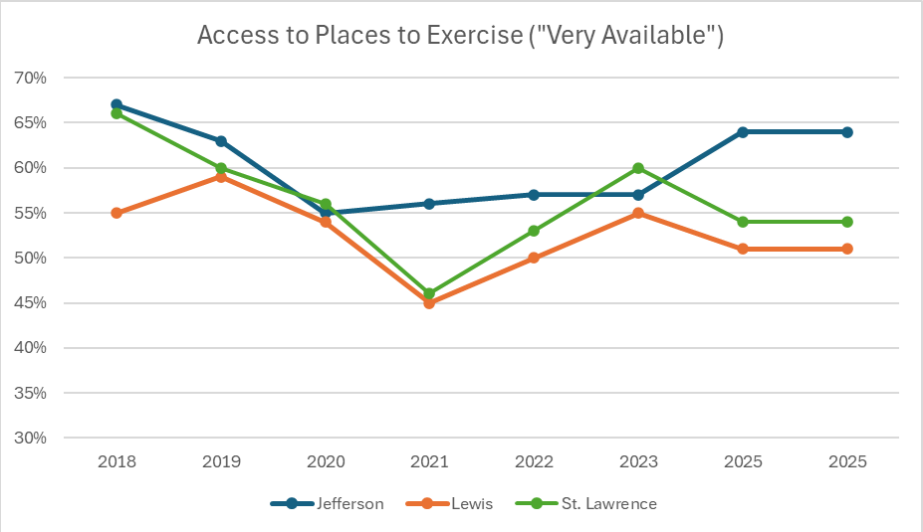
Environmental Conditions and Policies

In the City of Watertown, public recreation spaces are protected by tobacco-free ordinances, and efforts to enhance walkability are supported through a Complete Streets policy that prioritizes accessibility for all users. While air quality in the county generally meets federal standards, seasonal events, such as wildfire smoke, have contributed to short-term air quality concerns. Most public water systems operate within regulatory limits, though smaller systems occasionally face compliance issues related to monitoring and reporting. The county has also experienced the growing effects of severe weather, with recent storm events resulting in infrastructure damage and signaling a need for continued investment in climate resilience.



Source: FDRHPO, Community Health Survey, 2025

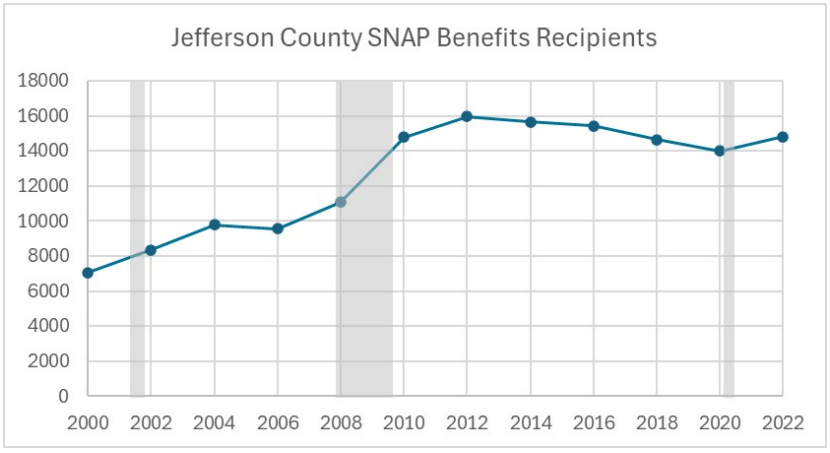
In Jefferson County, most residents report relatively fewer barriers to healthy eating compared to neighboring counties. While affordability remains the most common challenge, it is cited less often in Jefferson than it is regionally. Jefferson does stand out for having a higher percentage of respondents who say they simply don't have time to cook healthy meals. This suggests that convenience and time constraints, rather than cost or access, may be the more prominent day-to-day barriers for many households. Few respondents identified a lack of grocery stores, physical limitations, or transportation as obstacles. Nearly half of those surveyed indicated no barriers at all, which is slightly above the regional average.



Source: FDRHPO, Community Health Survey, 2025

Benefits

Supplemental Nutrition Assistance Program (SNAP) participation in Jefferson County has grown over the past two decades. While spikes in enrollment align with national recessions, particularly the Great Recession in 2008 and the COVID-19 pandemic in 2020, SNAP caseloads have remained elevated even during periods of recovery (U.S. Department of Agriculture, Food and Nutrition Service, 2025; Federal Reserve Bank of St. Louis, 2025). This suggests that many households continue to face challenges affording basic needs, including food, even when overall unemployment is low. The sustained reliance on SNAP may indicate economic vulnerability in the county.



Source: U.S. Census Bureau via FRED®

Social Vulnerability Index

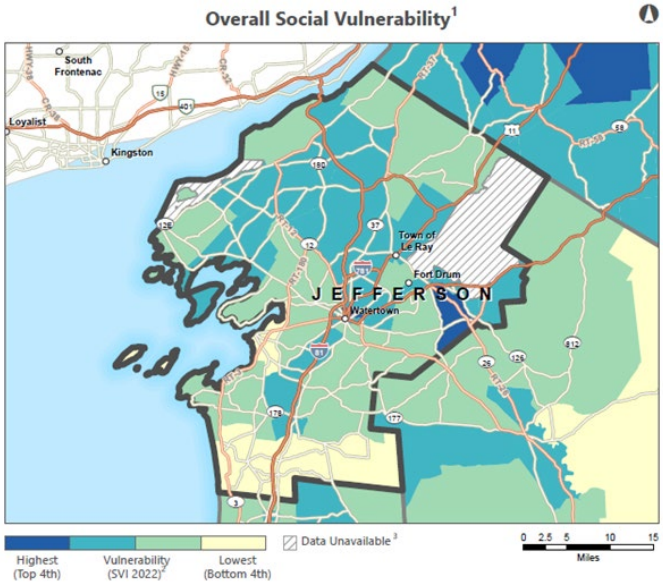
Social Vulnerability Index (CDC/ATSDR SVI 2022)		
Overall Vulnerability	Socioeconomic Status	Below 150% Poverty
		Unemployed
		Housing Cost Burden
		No High School Diploma
		No Health Insurance
	Household Characteristics	Aged 65 and Older
		Aged 17 and Younger
		Civilian with a Disability
		Single-Parent Households
		English Language Proficiency
	Racial and Ethnic Minority Status	Hispanic or Latino (of any race) Black and African American, Not Hispanic, or Latino American Indian and Alaska Native, Not Hispanic or Latino Asian, Not Hispanic, or Latino Native Hawaiian and Other Pacific Islander, Not Hispanic or Latino Two or More Races, Not Hispanic or Latino Other Races, Not Hispanic or Latino
	Housing Type & Transportation	Multi-Unit Structures
		Mobile Homes
		Crowding
		No Vehicle
		Group Quarters

The Social Vulnerability Index (SVI), developed by the CDC's Agency for Toxic Substances and Disease Registry (ATSDR), is a tool used to identify communities that may be more vulnerable to negative health outcomes, when faced with certain factors like natural disasters, disease outbreaks, or economic instability. This index ranks counties based on 15 social factors grouped into four themes: Socioeconomic Status, Household Characteristics, Minority Status and Language, and Housing Type and Transportation. Each area is assigned a percentile rank between 0 and 1, with higher values indicating greater vulnerability.

According to the most recent data (2022), the overall SVI score in Jefferson County is 0.80, placing it in the higher range of vulnerability nationally. The theme scores are as follows:

- Socioeconomic Status: 0.77
- Household Characteristics: 0.56
- Minority Status and Language: 0.64
- Housing Type and Transportation: 0.79

This suggests that relative to other counties across New York, Jefferson County faces more structural and social challenges that may affect the population's ability to prevent illness, recover from crises, or access timely health services (Centers for Disease Control and Prevention/ATSDR, 2023).



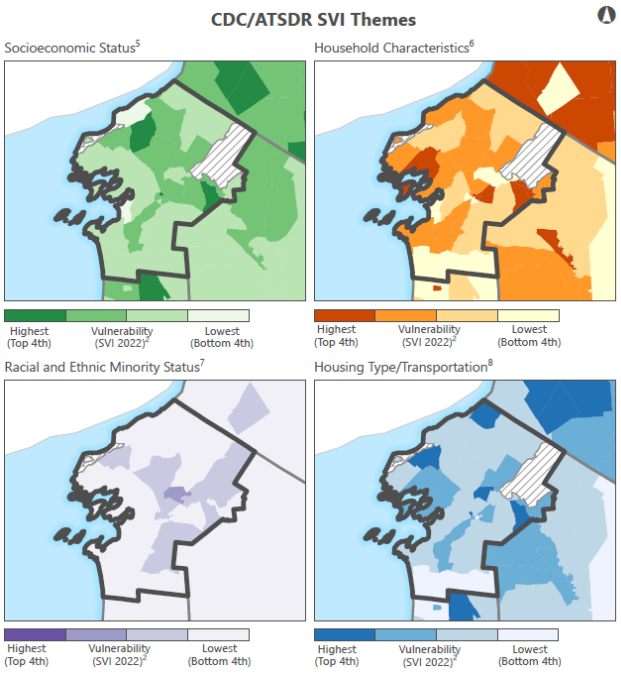
Source: CDC/ATSDR SVI 2022

Socioeconomic Status: Jefferson scored 0.77 within the state, reflecting above-average vulnerability due to factors such as poverty, unemployment, and lower educational attainment. These socioeconomic pressures are closely tied to poor health outcomes and often limit access to care, healthy food, and stable housing.

Household Characteristics: With a score of 0.56, Jefferson again ranks higher than the state median. This theme includes the proportion of older adults, children, people with disabilities, and single-parent households. These are groups who may need additional support or targeted services.

Minority Status and Language: Jefferson's score of 0.64 indicates moderate vulnerability in this domain. While the county has a smaller proportion of racial and ethnic minorities compared to other parts of the state, language access and cultural considerations may still be barriers for specific populations, including military families and recent immigrants.

Housing Type and Transportation: This is another area of vulnerability with a state ranking of 0.79. This reflects a high prevalence of factors like mobile homes, crowded housing, lack of personal vehicles, and reliance on group housing settings. This can create barriers to accessing healthcare, employment, and emergency response services.



Health Status Description

Data Sources

To assess the health status of Jefferson County and identify disparities, we utilized a mixed-methods approach that combined secondary data sources with primary data from the 2016–2025 Community Health Surveys (CHS). A major component of our work involved cross-tabulating CHS data against key demographic and social determinants of health (SDoH) variables such as income, disability status, housing stability, sexual orientation, veteran status, and more. Additionally, we used the mySidewalk data platform, which integrates billions of data points from trusted federal and academic sources to support localized analysis and visualization. The mySidewalk datasets draw from federal agencies including the Census Bureau, Department of Housing and Urban Development (HUD), Bureau of Labor Statistics (BLS), Centers for Disease Control and Prevention (CDC), Environmental Protection Agency (EPA), Department of Agriculture (USDA), and others. It also incorporates data from academic and nonprofit institutions such as Emory University's Rollins School of Public Health, the University of South Carolina, and the National Housing Preservation Database (NHPD).

Secondary data used in this report reflect the most recent data available at the time of analysis, whenever possible, and included sources such as the New York State Department of Health (NYSDOH) dashboards and the U.S. Census Bureau. For most Census-related indicators, we used the most current 5-year ACS rolling averages. Timeframes for each data source are noted throughout the report. For small-population indicators or unstable estimates, values were either pooled across years, flagged, or suppressed.

Primary data from the 2025 Community Health Survey were analyzed using SPSS, with weighting applied to reflect the county's age and gender distribution. Survey responses were cross-tabulated by more than a dozen demographic and social variables to identify disparities. To assess geographic disparities, we used both HRSA mapping and the mySidewalk mapping interface to visualize data by ZIP code, census tract, and the Social Vulnerability Index (SVI). Throughout the development of this assessment, we obtained and incorporated feedback from key community partners and stakeholders. Findings were presented to the Health Compass Partners and the CHA/CHIP Workgroups.

Data Collection Methods

Primary Data Collection

- 2025 Regional Community Health Survey - a regional survey of approximately 1500 adult residents, using mixed-method outreach (random-digit-dial and online panel sampling) to collect information on health behaviors, service access, healthcare and social needs, and experiences with care. The sampling modes were intercept-surveys, MMS text message push-to-web online participants, and random nonprobability panel email invitation responses. All interviews were completed between June 2 and June 9, 2025.
- Key-Informant Interviews (KIIs) - structured interviews with stakeholders from school districts, youth-serving organizations, community health agencies, and government partners. These

provided qualitative insight into youth health, behavioral risk factors, health equity barriers, and systems-level challenges.
- Ongoing engagement with the North Country Health Compass Partners and relevant stakeholders.

Secondary Data Collection

- U.S. Census Bureau (Decennial Census, PEP, & American Community Survey)
- County Health Rankings & Roadmaps (University of Wisconsin)
- New York State Department of Health
  - Vital Statistics
  - Statewide Planning and Research Cooperative System (SPARCS)
  - Immunization Information System (NYSIIS)
  - Prevention Agenda Dashboard
  - Opioid Surveillance Dashboard
  - Community Health Indicator Reports (CHIRS)
  - Health Equity Report (2023)
- CDC WONDER
- Behavioral Risk Factor Surveillance System (BRFSS)
- HRSA Area Health Resource Files and HPSA Designations
- Office of Addiction Services and Supports (OASAS)
- Office of Mental Health (OMH)
- mySidewalk
- Local and County services and resources - including school districts, regional health-related coalitions, broadband providers, community-based organizations, and regional healthcare providers.

Community Engagement

This CHA was developed through collaborative planning and stakeholder engagement consistent with NYSDOH expectations. Partners involved include Jefferson County Public Health Service, local hospitals, school leaders, behavioral health providers, social service agencies, and nonprofit organizations across multiple sectors.

Engagement efforts included:

- Resident participation through the Community Health Survey.
- Sector-specific insight through key-informant interviews.
- Data-sharing partnerships through CHA/CHIP workgroups and the North Country Health Compass Partners committee.
- Ongoing feedback loops with local coalitions and working groups to review findings and shape intervention plans.

Community engagement will continue throughout CHIP/CSP development, implementation, and monitoring. Preliminary findings were reviewed with stakeholders and will be disseminated publicly as part of the CHA/CHIP/CSP rollout. The report will be made available on the public health department's website, with printed copies available upon request.

Relevant Health Indicators

2025 Prevention Agenda Indicators

The 2025–2030 New York State Prevention Agenda represents a shift from previous cycles. The new framework focuses more on Social Determinants of Health (SDOH) and the following domains: Economic Stability, Education Access and Quality, Healthcare Access and Quality, Neighborhood and Built Environment, and Social and Community Context. This cycle has a new set of statewide objectives for 2030, and a revised set of indicators that align with the new framework. For Jefferson County, the current data represent baseline measures or a starting point from which to assess progress and set local priorities over time.

Based on Jefferson County's 2025 Prevention Agenda data, the county is currently meeting or exceeding several of the newly established 2030 objectives, while others remain below target. Areas where the county is already performing well include access to medication-assisted treatment for opioid use disorder, with buprenorphine prescribing rates above the state benchmark. Rates of childhood asthma-related emergency department visits are also below the 2030 threshold, and the county is performing better than the target in the percentage of infants who are exclusively breastfed in the hospital among all infants. Some indicators have not yet met the 2030 targets. These include the rate of indicated child abuse and maltreatment, which is currently higher than the benchmark. Adult smoking and binge drinking rates are also above target levels, as is the rate of opioid prescriptions issued to opioid-naïve patients. These data provide a baseline of Jefferson County's progress toward the state's 2030 objectives and will help guide priority setting and planning throughout the current Prevention Agenda cycle (New York State Department of Health, 2025).

In the tables below, the "Status" column is designed to help readers interpret whether each health indicator is currently aligned with the New York State 2030 Objective. Arrows indicate whether the county value is higher or lower than the state's 2030 target, while color is used to reflect whether the current performance is favorable or unfavorable. An upward arrow (↑) means the county value is greater than the NYS 2030 objective, while a downward arrow (↓) means the value is less than the objective. Whether that is considered positive or negative depends on the color. A green arrow indicates that the county is meeting or exceeding the 2030 objective. A red arrow indicates the county is not currently meeting the objective.

- A green upward arrow (↑) would be used if the percentage of adults receiving preventive screenings exceeds the state objective.
- A red upward arrow (↑) would appear if the adult obesity rate is above the desired level.
- A green downward arrow (↓) would be used if preventable hospitalizations are lower than the state target.
- Red downward arrow (↓) would indicate a decrease in access to routine care below the goal.

Source: Prevention Agenda Indicators 2025-2030 from Prevention Agenda Team at prevention@health.ny.gov

General Health Indicators							
Indicator ID	**Indicator**	**Priority Area**	**Data Years**	**Jefferson Rate**	**NYS Rate**	**NYS 2030 Objective**	**Jefferson vs. Objective**
paA1	Percentage of deaths that are premature (before age 65 years)	Improve Health Status and Reduce Disparities	2022	23.8	23.6	22.4	↑
paA1.1	Premature deaths (before age 65 years), difference in percentages between Black non-Hispanics and White non-Hispanics		2022	36.9*	19.4	18.4	↑
paA1.2	Premature deaths (before age 65 years), difference in percentages between Hispanics and White non-Hispanics		2022	4.2*	17.9	17	↓
paA2	Potentially preventable hospitalizations among adults, age-adjusted rate per 10,000		2023	95.7	93.9	89.2	↑
paA2.1	Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Black non-Hispanics and White non-Hispanics		2023	66.1	101.8	96.7	↓
paA2.2	Potentially preventable hospitalizations among adults, difference in age-adjusted rates per 10,000 between Hispanics and White non-Hispanics		2023	-43.5*	32.6	31	N/A
paA3	Percentage of adults with health insurance, aged 18-64 years		2022	94.3	93.2	95	↓
paA4	Adults 18 years of age and older who have a regular healthcare provider, age-adjusted percentage		2021	86.5	85.8	87.5	↓

Economic Stability							
Indicator ID	**Indicator**	**Priority Area**	**Data Years**	**Jefferson Rate**	**NYS Rate**	**NYS 2030 Objective**	**Jefferson vs. Objective**
pa1.0	Percentage of people living in poverty	Poverty	2019-2023	13.4	13.6	12.5	↑
pa1.1	Percentage of people, aged 65+, living in poverty		2019-2023	10.6	12.2	11	↓
pa2.0	Percentage unemployed	Unemployment	2019-2023	6.4	6.2	5.5	↑
pa2.1	Percentage unemployed, Black residents, aged 16+		2019-2023	7.8	9.3	7.9	↓
pa3.0	Percentage of adults 18 years of age and older that were food secure in the past 12 months	Nutrition Security	2021	82.2	71.1	75.9	↑
pa4.0	Number of people living in HUD subsidized housing in the past 12 months	Housing and Affordability	2024	4439**	987957**	1092000**	N/A

Education Access and Quality							
Indicator ID	**Indicator**	**Priority Area**	**Data Years**	**Jefferson Rate**	**NYS Rate**	**NYS 2030 Objective**	**Jefferson vs. Objective**
pa41.0	Percentage of public-school students in grades K-8 with >10% absenteeism (chronic absenteeism)	Health and Wellness Promoting Schools	2024	30.5	26.4	18.5	↑
pa41.1	Percentage of economically disadvantaged public-school students in grades K-8 with >10% absenteeism (chronic absenteeism)		2024	38.2	34.9	24.4	↑
pa42.0	Percentage of high school seniors that attend a 2 or 4 year college within 5 years	Opportunities for Continued Education	2023	57.6	70.2	77	↓
pa42.1	Percentage of economically disadvantaged high school seniors that		2023	43.7	63.1	69.4	↓

	attend a 2 or 4 year college within 5 years						

Healthcare Access and Quality							
Indicator ID	**Indicator**	**Priority Area**	**Data Years**	**Jefferson Rate**	**NYS Rate**	**NYS 2030 Objective**	**Jefferson vs. Objective**
pa25.0	Percentage of births with early (1st trimester) prenatal care	Access and Use of Prenatal Care	2022	71	80.7	83	↓
pa26.0	Infant mortality rate per 1,000 live births	Prevention of Infant and Maternal Mortality	2022	3.4*	4.3	3.5	↓
pa27.0	Maternal mortality rate per 100,000 live births		2019-2021	18.5*	19.8	16.1	↑
pa31.0	Asthma emergency department visit rate per 10,000, aged 0-17	Preventive Services for Chronic Disease Prevention and Control	2023	37.8	93.8	89.1	↓
pa32.0	Hypertension management (percentage of adults 18 years of age and older reporting medication use to manage their hypertension)		2021	74.3	77	81.7	↓
pa34.0	Percentage of Medicaid enrollees with at least one preventive dental visit within the last year	Oral Health Care	2023	18.2	20.3	21.3	↓
pa34.1	Percentage of Medicaid enrollees, aged 2-20 years, with at least one preventive dental visit within the last year		2023	35.6	39.1	41.1	↓
pa36.0	Percentage of 24–35-month old children with the 4:3:1:3:3:1:4 combination series by their 2nd birthday	Preventive Services (Immunization)	2024	46	59.3	62.3	↓
pa37.0	Percentage of 13-year-old adolescents with a complete HPV vaccine series		2024	7.6	25.7	28.7	↓
pa38.0	Percentage of children in a single birth cohort year tested at least twice for lead before 36 months of age	Preventive Services (Lead Screening)	2018-2021	31.9	61	70	↓

pa39.0	Percentage of children under 3 with an IFSP	Early Intervention	2022	3.3	8.3	11	↓
pa39.1	Percentage of Black children under 3 with an IFSP		2022	6.1	7	10	↓

Neighborhood and Built Environment							
Indicator ID	**Indicator**	**Priority Area**	**Data Years**	**Jefferson Rate**	**NYS Rate**	**NYS 2030 Objective**	**Jefferson vs. Objective**
pa21.0	Percentage of adults 18 years of age and older who are physically active	Opportunities for Active Transportation and Physical Activity	2021	78.2	73.9	77.6	↑
pa22.0	Count of Climate Smart Community Actions related to community resilience	Access to Community Services and Support	2024	0	363	382	↓
pa22.1	Percentage of higher vulnerability areas that have a cooling center		2024	33.3*	24.5	27	↑

Social and Community Context							
Indicator ID	**Indicator**	**Priority Area**	**Data Years**	**Jefferson Rate**	**NYS Rate**	**NYS 2030 Objective**	**Jefferson vs. Objective**
pa5.0	Percentage of adults 18 years and older experiencing frequent mental distress during the past month, age-adjusted percentage	Anxiety and Stress	2021	14.1	13.4	12	↑
pa6.0	Suicide mortality, age-adjusted rate per 100,000 population	Suicide	2020-2022	11.5	7.9	6.7	↑
pa9.0	Episodes when an opioid-naive patient received an initial opioid prescription, rate per 1,000 population	Primary Prevention Substance Misuse and Overdose Prevention	2023	102.9	86.5	77.9	↑
pa9.1	Percentage of episodes when patients were opioid naïve and received an opioid prescription of more than seven days		2023	15.8	15.1	13.6	↑

pa10.1	Unique individuals enrolled in OASAS treatment programs - rate per 100,000 population - who reported any opioid as the primary substance		2023	890.7	465.2	511.7	↑
pa11.0	Patients who received at least one buprenorphine prescription for opioid use disorder - crude rate per 100,000 population		2023	641.2	446	490.6	↑
pa12.0	Overdose deaths involving drugs - crude rate per 100,000 population		2023	25.3	32.3	22.6	↑
pa12.1	Overdose deaths involving drugs - crude rate per 100,000 population - for Black, non-Hispanic residents		2023	s	59.2	35.5	N/A
pa13.0	Number of naloxone kits distributed		2023	7092**	397620**	596430**	N/A
pa14.0	Prevalence of cigarette smoking among adults 18 years of age and older	Tobacco and e-Cigarettes	2021	19.9	9.3	7.9	↑
pa15.0	Prevalence of binge or heavy drinking among adults 18 years of age and older	Alcohol	2021	21.3	16.2	14.6	↑
pa17.0	Percentage of adults age 18 years and older who, as a child, experienced three or more adverse childhood experiences (ACEs)	Adverse Childhood Experiences	2021	24.6	25.3	23.8	↑
pa18.0	Indicated reports of abuse/maltreatment, rate per 1,000 children, aged 0-17 years		2024	23.4	11.3	9.8	↑
pa18.1	Indicated reports of abuse/maltreatment, rate per 1,000 Black children and youth, aged 0-17 years		2024	47.4	21.8	19.9	↑
pa18.2	Indicated reports of abuse/maltreatment, rate per 1,000 Hispanic children and youth, aged 0-17 years		2024	20.3	13.9	12.5	↑

pa19.0	Percentage of adults 18 years of age and older who consumed fewer than one fruit and fewer than one vegetable daily (no fruits or vegetables)	Healthy Eating	2021	35.6	28.4	27	↑
pa20.0	Percentage of infants who are exclusively breastfed in the hospital among all infants		2022	51	45.9	48.2	↑
pa20.1	Percentage of infants who are exclusively breastfed in the hospital among Black non-Hispanic infants		2022	44.4	34.1	35.8	↑

KEY:

"s = Data do not meet reporting criteria.

** = Unstable estimate.*

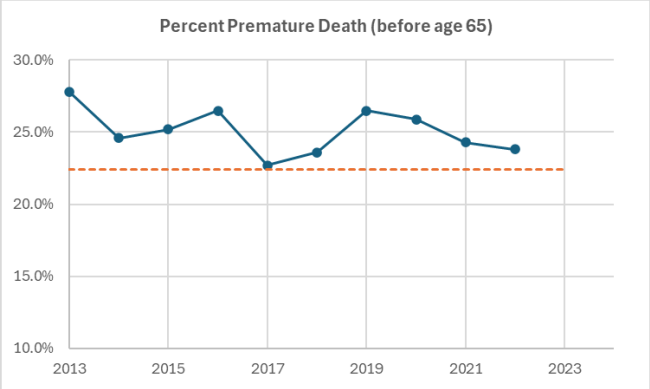
***= Number (not rate)."*

Summary of Indicators

Health Area	Pros	Cons
Maternal & Child Health	Higher-than-average breastfeeding rates.	Prenatal care below target. Maternal mortality above state objective. Childhood immunization and early intervention rates below target.
Chronic Disease & Prevention	Physical activity exceeds NYS 2030 objective. Low childhood asthma emergency visits.	Premature deaths (under age 65) exceeds state target. Elevated avoidable hospitalizations. Preventive dental visits among Medicaid enrollees below objective.
Mental Health & Substance Use	None identified.	High prevalence of frequent mental distress. Elevated suicide rates. High rates of smoking, binge drinking, opioid prescribing, and overdose deaths.
Economic & Social Factors	82% of adults report consistent food access (above NYS benchmark)	Poverty and unemployment above state goals. Chronic absenteeism in K–8. Lower college attendance rates among economically disadvantaged students.
Health Equity & Disparities	Breast feeding rates are strong across racial groups.	Disparity in preventable hospitalizations (Hispanic vs. White). Indicated child maltreatment rates are higher than state target.

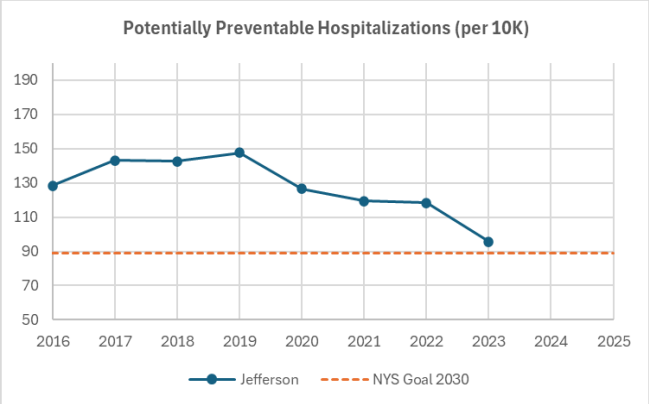
The indicators show that Jefferson County performs well in several foundational areas and has opportunities for improvements in others.

While some trending data is available for selected New York State Prevention Agenda indicators, it is important to note that not all new NYS Prevention Agenda indicators align with those from previous reporting cycles. Several indicators are newly introduced or have been revised, limiting the ability to assess long-term trends. Trends are included for some indicators where relevant and consistent data exist.



Source: NYS Prevention Agenda Indicators 2025-2030

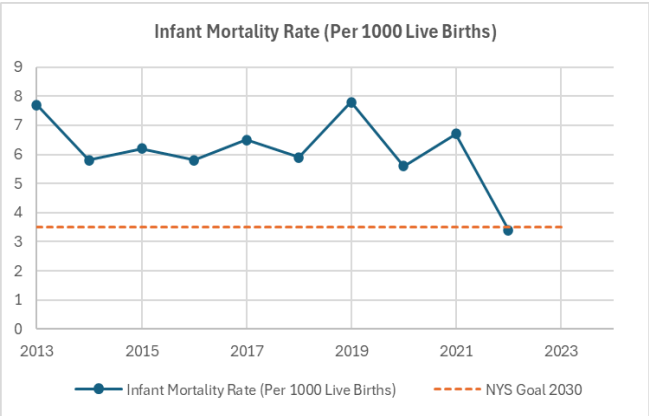
Jefferson County has made steady progress in reducing premature deaths among residents under age 65. The percentage has declined from 27.8% in 2013 to 23.8% in 2022, reflecting a 14% improvement over the past decade. While there were some fluctuations, particularly in 2016 and 2019, the overall trend has moved closer to the NYS Prevention Agenda 2030 goal of 22.4%.



Source: NYS Prevention Agenda Indicators 2025-2030

Avoidable hospitalizations are higher than the NYS goal, with an estimated disparity between Hispanic and White residents, although that estimate is labeled as 'unstable.' Overall, Jefferson County has made steady progress in reducing potentially preventable hospitalizations among all adults. After reaching a high of 147.6 per 10K in 2019, the rate declined each year to 95.7 by 2023, a 35% reduction over four years. The county is closer to achieving the NYS Prevention Agenda 2030 Objective (89.2).

Jefferson County's infant mortality rate has fluctuated over the past decade, ranging from a high of 7.8 deaths per 1,000 live births in 2019 to a low of 3.4 in 2022. The most recent figure represents a 56% reduction since 2019 meeting the New York State Prevention Agenda 2030 target, although the estimate is considered 'unstable'. Overall, the trend suggests these rates are improving. Jefferson County has more births than other counties with



Source: NYS Prevention Agenda Indicators 2025-2030

similar population sizes. Between 2020 and 2022, there were 5,460 births in Jefferson County, which is higher than counties like St. Lawrence, Ontario, Oswego, and Chautauqua. This may explain why Jefferson County faces some challenges related to maternal and child health. With more births, there is a greater need for services like childcare and support for young families in need who may be experiencing challenges. This data shows that Jefferson County may require additional services and resources compared to other counties of similar size.

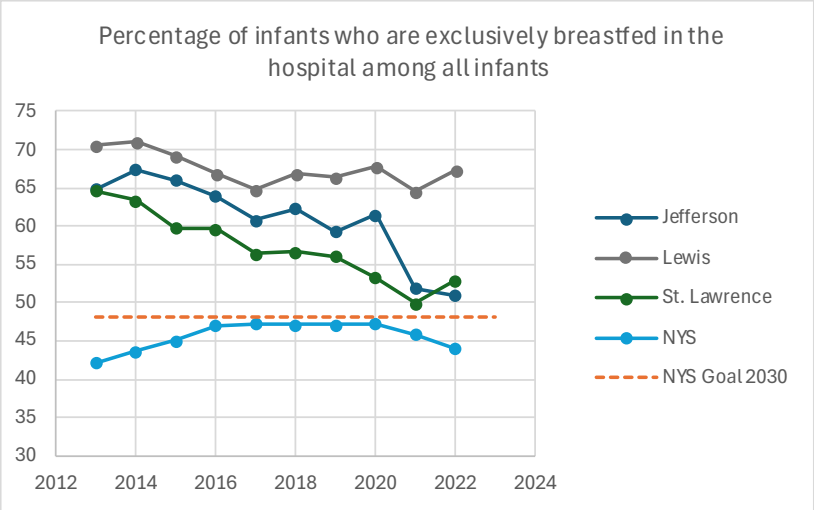
	2022 Population	3-Year Birth Totals	Late or No Prenatal Care	Low Birth Weight	Teen Pregnancy Rate	Teen Birth Rate
Jefferson	**117,680**	**5,460**	**3.3**	**7.7**	**38.2**	**28.5**
St. Lawrence	108,410	2,975	7.3	7.3	14.6	10.0
Ontario	112,707	2,903	7	3.1	11.1	7.3
Oswego	118,287	3,601	4.4	7	13.3	18.5
Chautauqua	126,027	3,776	7.8	8.2	19.4	23.4

Source: 2020-2022 New York State Vital Statistics Data (October 2024).

Jefferson shows promising results in food security, with 82% of adults reporting consistent access to food, well above the state benchmark. Childhood asthma emergency visits are low, and adult physical activity levels exceed the NYS 2030 objective, suggesting some success in preventive health behaviors.

Economic indicators reflect vulnerability, with poverty and unemployment rates above state targets, which may contribute to poorer health outcomes and long-term instability. Education-related metrics show some gaps, including an elevated number of public school students in grades K–8 who experience chronic absenteeism. College attendance rates among all students, especially those who are economically disadvantaged, also fall below state goals. Preventive care and maternal health also lag in prenatal care of pregnant individuals, and the maternal mortality rate exceeds the state target. Preventive dental visits among Medicaid enrollees, childhood immunization rates, and early intervention enrollment for young children are below benchmarks. The prevalence of frequent mental distress, high rates of suicide, smoking, binge drinking, and opioid-related prescribing and overdose deaths all point to a community in need of enhanced mental health and substance use support systems. Child abuse and trauma-related indicators are not yet meeting benchmarks. Rates of indicated child maltreatment are more than double the state target, with even higher rates among the BIPOC community.

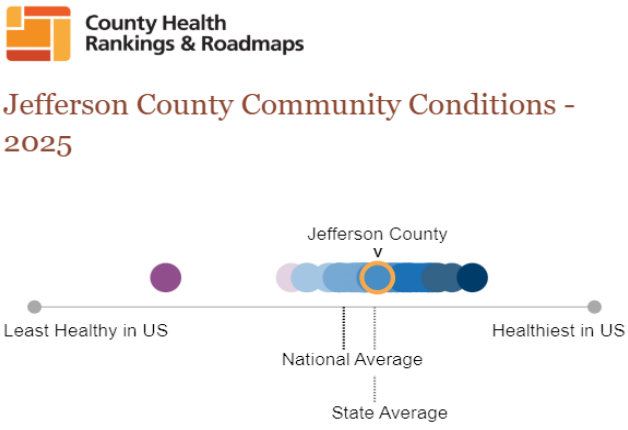
Exclusive breastfeeding in the hospital is a key early indicator of infant health and maternal support. In-hospital practices, prenatal education, and access to postnatal lactation support all play a role in shaping these outcomes. Over the past decade, breastfeeding trends across the North Country have somewhat diverged, with some counties maintaining stronger performance while others have experienced consistent declines. In 2012, Jefferson, Lewis, and St. Lawrence counties all reported breastfeeding rates well above the NYS average and the state's 2030 Prevention Agenda objective of 48.2%. Lewis County has consistently remained the regional leader, with rates staying between 65% and 70% through nearly a decade. Jefferson and St. Lawrence counties have seen gradual but steady declines, especially after 2019. By 2022, both counties had dipped to the low-fifties, yet still above the state 2030 goal. The COVID-19 pandemic likely played a role in the more recent declines, as it disrupted access to maternity care, lactation services, and postpartum support networks.



Source: NYS Prevention Agenda Indicators 2025-2030

County Health Rankings

The County Health Rankings & Roadmaps (CHR&R) is an annual program developed by the University of Wisconsin Population Health Institute with support from the Robert Wood Johnson Foundation. It provides a snapshot of community health across the nation by ranking counties within each state on a range of health outcomes and health factors. The rankings draw on national data sources to measure key drivers of health, including clinical care, social and economic factors, physical environment, and health behaviors. These rankings are widely used by public health officials, policymakers, and community leaders to identify local health challenges, prioritize interventions, and track progress toward health improvement over time.

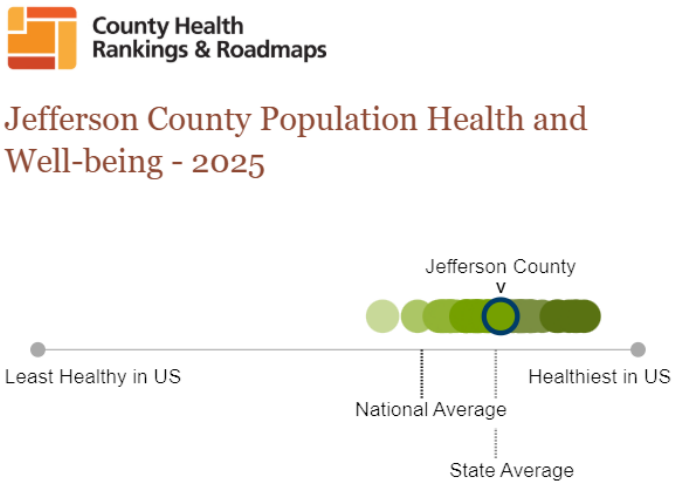


Jefferson County is faring about the same as the average county in New York for Community Conditions, and slightly better than the average county in the nation.

Source: https://www.countyhealthrankings.org/health-data/new-york/jefferson?year=2025

Jefferson County presents a complex health profile shaped by its unique geography, demographic composition, and social and economic conditions. Although designated as a metropolitan county, nearly half of Jefferson residents live in low-density rural areas. This influences both the strengths and the challenges reflected in the County Health Ranking indicators. Overall, Jefferson performs similarly to the New York State average in many areas, outperforms the national average in some areas, and lags behind in others.

Jefferson County continues to face several persistent health and socioeconomic challenges. The premature death rate is 7,400 years of potential life lost (YPLL) per 100,000, higher than the state average of 6,600, and trending worse in recent years. Life expectancy in the county is 77.3 years, nearly two years shorter than the state average. Disparities are evident in many areas. Non-Hispanic Black residents experience higher rates of premature mortality (8,000 YPLL) and child mortality (150 per 100,000) compared to White residents (7,800 YPLL; 60 per 100,000). Similarly, maternal and child health indicators show gaps. While the overall rate of low birth weight aligns with state and national averages, the rate for Black infants is much greater compared to White infants. Jefferson's teen birth rate is nearly triple the state average (29 per 1,000 vs. 10 per 1,000), with especially high rates among Hispanic teens (40 per 1,000), followed by both Black and White teens at 28 per 1,000 (County Health Rankings & Roadmaps, 2025).



Jefferson 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.

Source: https://www.countyhealthrankings.org/health-data/new-york/jefferson?year=2025

Mental health remains an area of concern. Adults in Jefferson report an average of 5.2 poor mental health days per month, and 19% experience frequent mental distress, both slightly worse than state averages. The suicide rate is also elevated at 13 per 100,000, compared to 8 per 100,000 statewide. Behavioral health risk factors persist as well, including high rates of smoking (18%), obesity (37%), physical inactivity (29%), and excessive drinking (21%).

Healthcare workforce shortages compound these issues. Jefferson has one primary care provider for every 1,970 residents, compared to the state ratio of 1,240:1. The mental health provider ratio is 400:1, also worse than the state's 260:1. These gaps likely contribute to the county's high rate of preventable hospital stays (2,977 per 100,000 Medicare enrollees).

Nineteen percent of children in Jefferson live in poverty, but this rises to 41% among Black children and 24% among Hispanic children. The median household income is $61,700, well below the state median of $82,100. Among communities of color, incomes are even lower: $59,400 for Black households and

$58,500 for Hispanic households, compared to $66,200 for White households. The gender pay gap remains, with women earning $0.88 for every dollar earned by men. Families also face a heavy child care burden, with costs consuming 40% of income for a household with two children, and only four licensed child care centers exist per 1,000 children under age five (County Health Rankings & Roadmaps, 2025).

The uninsured rate is just 5%, better than both state and national averages. The dentist-to-population ratio, while still strained, is better than the state and national average (1,070:1). Mammography screening rates among Medicare enrollees (52%) exceed both state and national levels. Air quality is relatively strong (PM2.5 at 6.5 μg/m³), and the county has a high level of social association density (9.8 associations per 10,000 population), which supports social cohesion.

However, other indicators point to infrastructure and civic engagement gaps. Just 30% of the population has access to parks, compared to 63% statewide. A 2023 drinking water violation further highlights infrastructure concerns. Civic engagement also appears to lag, where the Census self-response in 2020 was only 48.1%, and voter turnout in the last presidential election was 53.3%, both well below state and national benchmarks.

Potential future improvement efforts:

- Increasing the local healthcare workforce through enhanced workforce pipelines, and increased local healthcare educational programs.
- Investing in the built-environment, including parks and walkable spaces.
- Targeting maternal and child health disparities.
- Addressing child poverty, housing, food access, and transportation needs.
- Increasing health literacy, mental health awareness, and cultural competency through community training.
- Enhancing civic and youth engagement.
- Supporting economic stability through childcare affordability and workforce development.
- Expanding access to dental, primary, and mental health services through telemedicine, particularly in rural areas.

Source: https://www.countyhealthrankings.org/health-data/new-york/jefferson?year=2025

Jefferson County Population Health and Well-Being			
Length of Life			
	Jefferson County	**New York State**	**United States**
Premature Death	7400	6600	8400
Additional Length of Life (not included in summary)			
Life Expectancy	77.3	79.4	77.1
Premature Age-Adjusted Mortality	380	340	410
Child Mortality	60	40	50
Infant Mortality	6	4	6
Quality of Life			
Poor Physical Health Days	4	3.9	3.9
Low Birth Weight	8%	8%	8%
Poor Mental Health Days	5.2	4.9	5.1
Poor or Fair Health	17%	16%	17%

Additional Quality of Life (not included in summary)			
Frequent Physical Distress	13%	12%	12%
Diabetes Prevalence	10%	10%	10%
HIV Prevalence	168	742	387
Adult Obesity	37%	30%	34%
Frequent Mental Distress	19%	16%	16%
Suicides	13	8	14
Feelings of Loneliness	Not Available	Not Available	33%

Jefferson County Community Conditions			
Health Infrastructure			
	Jefferson County	**New York State**	**United States**
Flu Vaccinations	50%	51%	48%
Access to Exercise Opportunities	63%	93%	84%
Food Environment Index	7.9	8.7	7.4
Primary Care Physicians	1,970:1	1,240:1	1,330:1
Mental Health Providers	400:1	260:1	300:1
Dentists	1,070:1	1200:1	1,360:1
Preventable Hospital Stays	2,977	2,595	2,666
Mammography Screening	52%	44%	44%
Uninsured	5%	6%	10%
Additional Health Infrastructure (not included in summary)			
Limited Access to Healthy Foods	6%	2%	6%
Food Insecurity	14%	13%	14%
Insufficient Sleep	43%	39%	37%
Teen Births	29	10	16
Sexually Transmitted Infections	587.3	526.9	495
Excessive Drinking	21%	20%	19%
Alcohol-Impaired Driving Deaths	39%	22%	26%
Drug Overdose Deaths	25	29	31
Adult Smoking	18%	12%	13%
Physical Inactivity	29%	25%	23%
Uninsured Adults	6%	7%	11%
Uninsured Children	3%	3%	5%
Other Primary Care Providers	480:1	610:1	710:1
Physical Environment			
Severe Housing Problems	13%	23%	17%
Driving Alone to Work	77%	50%	70%
Long Commute - Driving Alone	21%	39%	37%
Air Pollution: Particulate Matter	6.5	6.9	7.3
Drinking Water Violations	Yes	N/A	N/A
Broadband Access	89%	90%	90%
Library Access	2	3	2
Additional Physical Environment (not included in summary)			
Traffic Volume	38	438	108
Homeownership	54%	54%	65%
Severe Housing Cost Burden	13%	19%	15%
Access to Parks	30%	63%	51%
Adverse Climate Events	1	N/A	N/A
Census Participation	48.10%	N/A	65.20%

Voter Turnout	53.30%	62.90%	67.90%
Social and Economic Factors			
Some College	67%	71%	68%
High School Completion	91%	88%	89%
Unemployment	4.40%	4.20%	3.60%
Income Inequality	4	5.8	4.9
Children in Poverty	19%	19%	16%
Injury Deaths	66	60	84
Social Associations	9.8	7.9	9.1
Child Care Cost Burden	40%	38%	28%
Additional Social and Economic Factors (not included in summary)			
High School Graduation	88%	87%	87%
Reading Scores	Not Available	Not Available	3.1
Math Scores	Not Available	Not Available	3
School Segregation	0.08	0.33	0.24
School Funding Adequacy	$8,920	$12,745	$1,411
Children Eligible for Free or Reduced Lunch	54%	57%	55%
Gender Pay Gap	0.88	0.88	0.81
Median Household Income	$61,700	$82,100	$77,700
Living Wage	$50.72	$61.75	
Child Care Centers	4	6	7
Residential Segregation - Black/White	59	75	63
Homicides	2	4	7
Motor Vehicle Crash Deaths	11	6	12
Firearm Fatalities	6	5	13
Disconnected Youth	7%	7%	7%
Lack of Social and Emotional Support	Not Available	Not Available	25%

The County Health Rankings data used in this assessment provide valuable insights into health outcomes and social determinants at the county level. However, these data are modeled estimates and often reflect multi-year averages, which may limit their timeliness and sensitivity to recent local changes. In addition, some measures, such as the disaggregated by race or subpopulation measures, may have wide margin error due to small sample sizes or suppressed data.

2025 Community Health Survey

This summary presents key findings from the 2025 North Country Community Health Survey of adult residents in Jefferson County. Conducted annually since 2016 by the Fort Drum Regional Health Planning Organization (FDRHPO) in collaboration with the North Country Health Compass Partners, the survey aims to monitor real-time health-related behaviors, attitudes, and perceptions across Jefferson, Lewis, and St. Lawrence counties in Northern New York. The 2025 survey was conducted in June and included a total of 1,497 adult participants, with 637 respondents from Jefferson County. Data were collected using a multi-mode approach, including push-to-web MMS text invitations, email-based online panels, and targeted intercept surveys to reach Fort Drum's military population. The survey sample was weighted and calibrated to reflect each county's demographic composition, including age, gender, education, race/ethnicity, household structure, and military affiliation. The final weighted dataset yields an approximate margin of error of ±2.9% regionally, with Jefferson County-specific results carrying an estimated ±4.5% margin of error, assuming a simple random sample.

The 2025 Community Health Survey focused on three primary research goals:

- Planning: to gather current information about local residents' health status, behaviors, and experiences in order to inform future initiatives, interventions, and services.
- Education: to help healthcare professionals and decision-makers understand public opinion regarding health issues.
- Evaluation: to assess the impact of past and ongoing initiatives by comparing current results to survey data from previous years (2016–2024), identifying significant trends.

This overview includes a demographic overview of survey respondents, county-specific and regional findings, trend comparisons, and cross-tabulations by social determinants and demographic factors. The survey instrument included approximately 40 health-related questions and 10 demographic questions. Results are grouped into three thematic areas: healthcare experiences, personal health status, and lifestyle behaviors.

2025 Community Health Survey Demographic Breakdown

Source: Fort Drum Regional Health Planning Organization (FDRHPO) Community Health Survey 2025

Nature of the County-Specific Samples (after weighting)			
Sample Size (raw)	**Jefferson County n=637**	**Lewis County n=374**	**St. Lawrence County n=486**
Gender			
Male	51%	50%	50%
Female	49%	50%	50%
Other	0%	0%	0%
Age			
18-44	53%	37%	40%
45-64	29%	38%	36%
75 or older	18%	25%	24%
Educational Attainment			
Less than a 4-Year Degree	74%	74%	68%
Bachelor's Degree or Higher	26%	26%	32%
Annual Household Income			
Less than $25,000	8%	9%	11%
$25,000-$49,999	24%	20%	23%
$50,000-$74,999	22%	24%	23%
$75,000-$99,999	21%	18%	17%
$100,000 or more	25%	29%	26%
Military Affiliation			
Active Military in the Household	25%	3%	2%
Veteran in the Household	22%	21%	22%
No Military Affiliation or Not Sure	53%	76%	76%
Household Composition - # Minors			
No household members Under Age 18	70%	71%	74%
One or more household members < 18	30%	29%	26%
Disability Status			
Disabled	18%	16%	19%
Not disabled/Not sure	82%	84%	81%
Sexual Orientation			
Identify as LGBTQ+	6%	4%	9%
Do not identify as LGBTQ+	93%	95%	91%
Not sure	1%	2%	1%
Racial Background			
American Indian or Alaskan Native	0%	0%	3%
Asian/Pacific Islander	1%	0%	1%
Black or African American	4%	1%	0%
Hispanic/Latino	6%	1%	2%
White/Caucasian	83%	96%	92%
Multi-racial	6%	2%	3%

2025 Community Health Survey Questions

The following section outlines the questions included in our 2025 Community Health Survey. While we've listed all survey questions here for reference, not every survey data point is included in this Community Health Assessment (CHA). Instead, we've focused on highlighting the responses most relevant to the goals of this CHA and the health needs of our region. Where appropriate, we have also included trending data to compare 2025 results to previous survey years. This helps identify shifts in perception, behavior, and community need over time. While not every question has trend data available, we've included it whenever it makes sense, especially where the changes reveal emerging needs, continued concerns, or progress on specific health issues.

In addition, we've provided cross-tabulated data where possible. Cross-tabs allow us to explore how different demographic or socioeconomic groups respond to the same question. This is an important step in understanding disparities and uncovering key insights that could be missed in aggregate data alone. For example, knowing that 25% of respondents report difficulty accessing care is helpful, but knowing that the rate jumps to 45% among those without stable housing gives us actionable direction. Cross-tabs help us move beyond the surface to better identify which populations are most affected and where equity gaps may exist.

While this report focuses on Jefferson County, many of the more nuanced results, such as trends and cross-tabulated data, are discussed at the regional level when the county's results aligned with those of the greater North Country region. Presenting these findings regionally allows for a cohesive summary of shared patterns, while still acknowledging Jefferson-specific data where meaningful differences exist.

Section A: Your Experiences with Healthcare in the North Country

Q: 1 – How long has it been since you last had a primary care visit at a healthcare provider?
Q: 2 – Who do you trust most for guidance with regard to your health and wellbeing?
Q: 3 – How long has it been since you last visited a dentist or a dental clinic for a routine cleaning?
Q: 4 – Have you had a colorectal cancer screening within the past 10 years? (all participants)
Q: 5 – Have you had a colorectal cancer screening within the past 10 years? (ages 45 75)
Q: 6 – Have you had a mammogram within the past 2 years? (among all participants)
Q: 7 – Have you had a mammogram within the past 2 years? (females, age 18+)
Q: 8 – Have you had a mammogram within the past 2 years? (females, age 40-75)
Q: 9 – Which of the following describes your health insurance?
Q: 10 – In the last 12 months, have you experienced challenges or difficulties accessing any of the following types of healthcare services? (choose all)
Q: 11 – If yes, what was the one largest challenge you experienced in receiving services locally?
Q: 12 – How confident are you in your ability to recognize the signs and symptoms that someone may be experiencing a mental health crisis?
Q: 13 – How confident are you in your ability to seek resources for yourself or someone else experiencing a mental health crisis?

Section B: Your Health

Q: 14 – How would you rate your physical health?

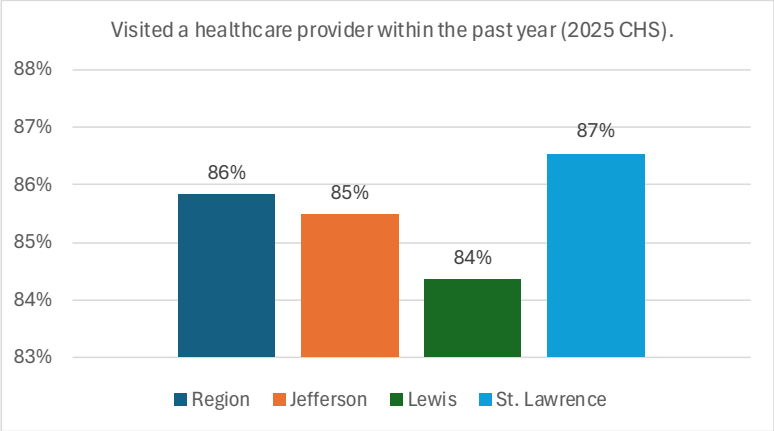
Q: 15 – How would you rate your mental health?
Q: 16 – How would you rate your dental health?
Q: 17 – Have you ever been diagnosed with any of the following eight chronic health conditions or illnesses? (choose all)
Q: 18 – Would you be willing to take a class to teach you how to manage your chronic health condition(s) that you cited earlier?

Section C: Social Determinant Factors that May Impact Your Health
Q: 19 – In the past 12 months, have you regularly used any of the following nicotine products? (choose all)
Q: 20 – In the past week, how many times did you have 5 or more alcoholic beverages on one occasion?
Q: 21 – Within the past year, has anyone in your household been personally affected by opiate use or addiction?
Q: 22 – Are you aware of locations where you can obtain Narcan, a medication that can help reverse an opioid overdose?
Q: 23 – How would you rate your family's access to places where you can walk and exercise, either indoors or outdoors?
Q: 24 – What barriers, if any, are preventing you from eating healthier foods and maintaining a healthier diet?
Q: 25 – In the past 12 months, how many hours per week do you regularly provide unpaid care for an aging or disabled family member or friend?
Q: 26 – What are the biggest challenges you face as a caregiver, or would expect to face if you were to begin being a caregiver?
Q: 27 – What concerns you the most about aging?
Q: 28 – Which of the following best describes your living situation today?
Q: 29 – How confident are you that you could cover an unexpected $500 expense (e.g., medical bill) without using a credit card or borrowing?
Q: 30 – Before the age of 18, did you experience at least three ACE's?
Q: 31 – In the past year, on average, how many hours per day do you spend on social media platforms like Facebook, X (Twitter), Instagram, Snapchat, TikTok, etc.)?
Q: 32 – In the past year, how do you think your use of social media has affected your overall mood, mental health, or self-esteem?
Q: 33 – Based on your observation, how often does social media or smartphone use interfere with individuals' quality time, and daily responsibilities or priorities?
Q: 34 – How often do you feel supported, accepted, and connected to people who understand you?

2025 Community Health Survey Key Findings

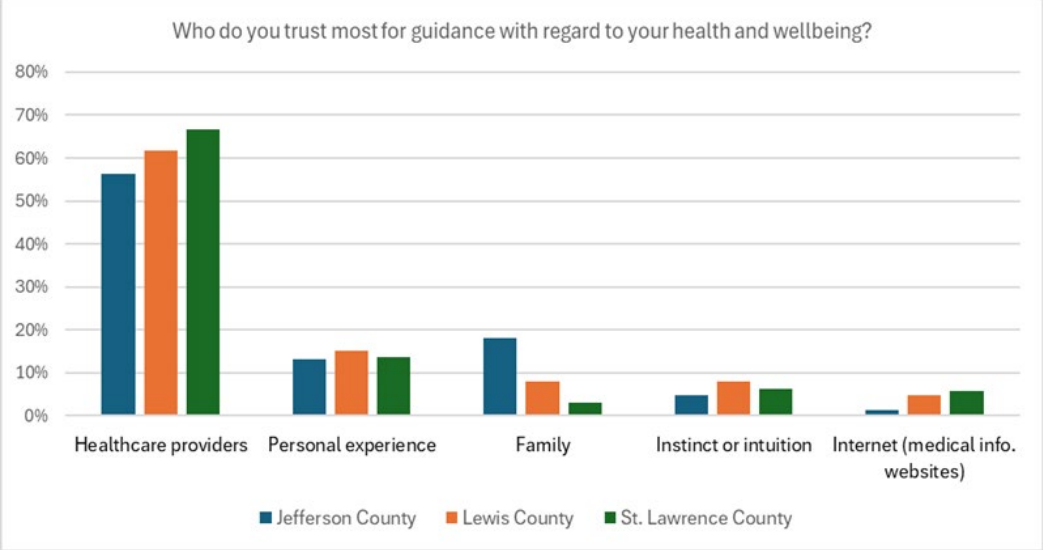
Q: 1 – How long has it been since you last had a primary care visit at a healthcare provider?

A large majority of Jefferson County adult residents in 2025 (86%) continue to report having visited a healthcare provider for a primary care visit within the past year. This is similar to the overall North Country rate (86%) and close to Lewis (84%) and St. Lawrence (87%) counties. This survey item was last asked three years ago, and in 2022, during the closing stages of the COVID-19 pandemic, this rate was significantly lower at 74%. Similarly, the rate of responding that "it has been five or more years since having a primary care visit" has decreased between 2022 and 2025, from 5% in 2022 to only 3% in 2025. Females reported higher rates of recent primary care use (90%) compared to males (82%). Among uninsured respondents, only 45% had seen a primary care provider in the past year, a much lower rate compared to the overall population.



Q: 2 – Who do you trust most for guidance with regard to your health and wellbeing?

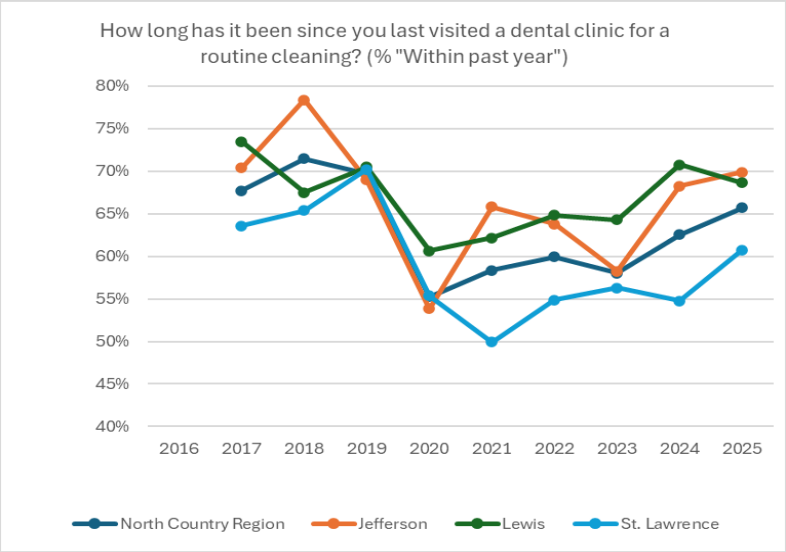
Local healthcare providers were the most frequently cited trusted source of health information across all respondent groups. In Jefferson County, 56% of respondents reported relying on healthcare providers for health-related information, slightly lower than the regional average of 62%, but still the leading source in the county. Respondents in Jefferson County were more likely to rely on family for health information than those in other areas, with 18% identifying it as a primary source, nearly twice the regional average of 10%. This may reflect the unique dynamics of the county's population, including the presence of the Fort Drum military community, where individuals and families may rely more heavily on close personal



networks for support due to frequent relocation and limited long-term connections to local providers. Other sources such as instinct or intuition (5%) and the internet (1%) were used far less frequently in Jefferson County.

Q: 3 – How long has it been since you last visited a dental clinic for a routine cleaning?

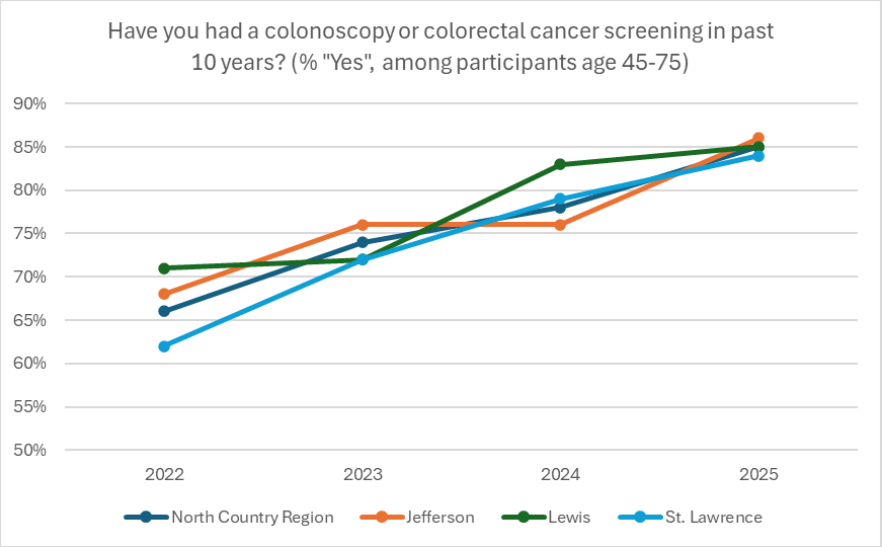
In the North Country region, 66% of adults reported having a routine dental cleaning within the past year. Jefferson County reported a slightly higher rate at 70%. All counties in the region experienced a peak in routine dental visits around 2018, followed by a sharp decline in 2020, likely due to the COVID-19 pandemic. Since that decline, rates have shown a steady recovery, with counties gradually returning toward pre pandemic levels.



Despite this overall progress, several populations across the region continue to report lower rates of preventive dental care. Among adults facing financial insecurity, specifically those who did not feel confident in their ability to cover an unexpected 500 dollar expense, only 44% had visited a dentist in the past year. Similarly, just 45% of individuals identifying as LGBTQ+ and 42% of adults who were unemployed reported having a recent dental visit. Those with a history of three or more adverse childhood experiences also reported lower utilization, with only 47% having accessed routine dental care within the past year. Educational attainment was also closely linked to dental care utilization. Among adults with no college education, only 58% received a routine dental cleaning in the past year. In contrast, 79% of adults with a four year college degree or higher reported doing so.

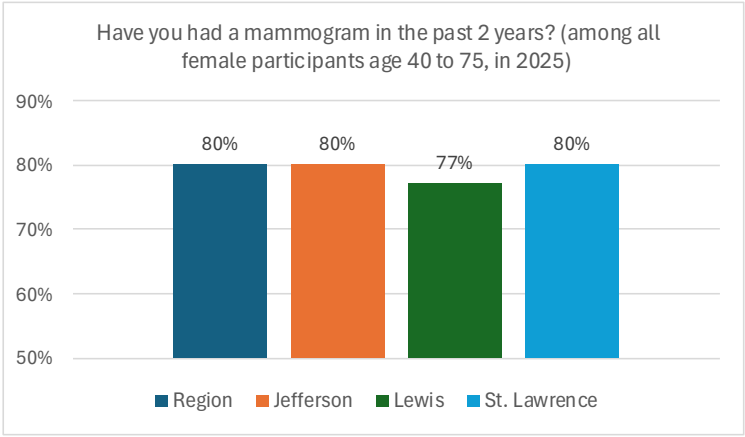
Q: 5 – Have you had a colorectal cancer screening within the past 10 years? (ages 45-75)

Among adults aged 45-75, more than five-in-six in the North Country in 2025 (85%) report to have had a colonoscopy or other colorectal cancer screening in the past 10 years, which is significantly increased from 66% in the North Country when first measured for this age group in 2022. From 2022 to 2025, Jefferson County saw a strong and consistent increase in colorectal cancer screening rates among adults aged 45 to 75. The percentage of residents reporting a screening rose from 68% in 2022 to 86% in 2025. While screening rates held steady between 2023 and 2024 in Jefferson, the county rebounded in 2025.



Q: 8 – Have you had a mammogram within the past 2 years? (females, age 40-75)

In 2025, 80% of female adult participants aged 40 to 75 in the North Country reported having had a mammogram within the past two years. This rate is consistent with 2024, the first year after national screening guidelines were updated to recommend mammography beginning at age 40. In Jefferson County, the rate was identical, with 80% of eligible women reporting recent screening. However, across the region, screening rates varied by population subgroup. Only 31% of uninsured women reported receiving a mammogram. In contrast, screening rates were considerably higher among those with Medicare (85%) and employer-sponsored insurance (83%).

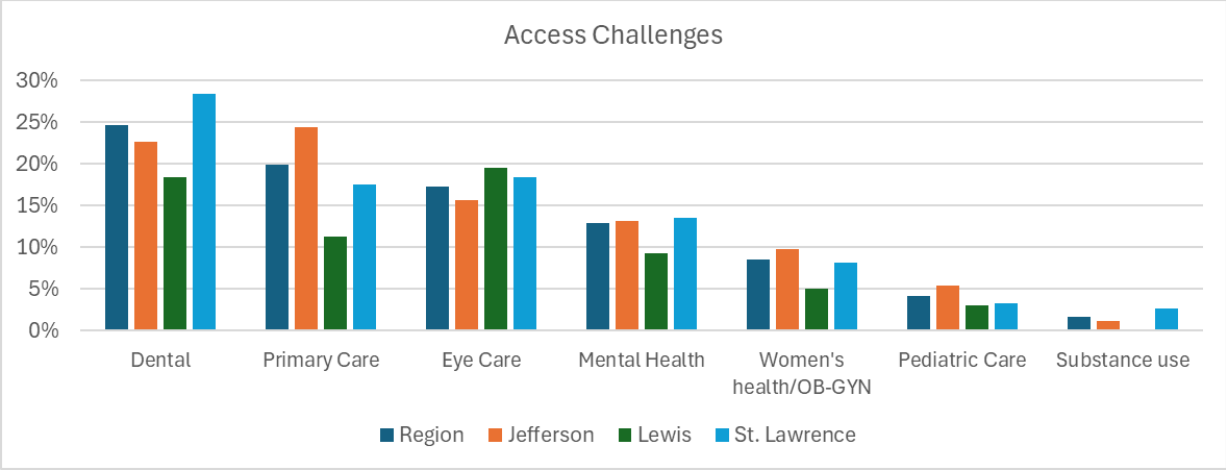


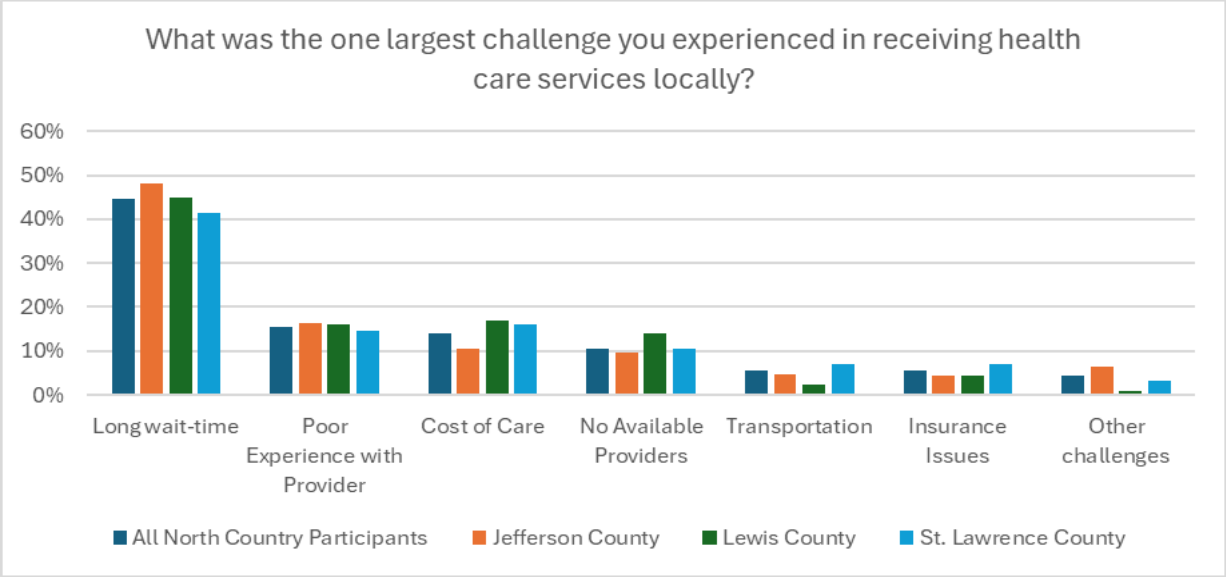
Q: 10 – In the last 12 months, have you experienced challenges or difficulties accessing any of the following types of healthcare services?
Q: 11 – What was the one largest challenge you experienced in receiving healthcare services locally?

In 2025, approximately half of the respondents in the region reported experiencing at least one challenge accessing healthcare services locally. This rate has remained fairly consistent over the past several years. Dental care was the most commonly reported service that residents had difficulty accessing, with 25% of adults citing challenges in accessing these services. In Jefferson County specifically, 48% of adults reported experiencing difficulty accessing at least one type of healthcare service in the past year, slightly below the North Country regional average of 50%. The most frequently

cited type of challenge in Jefferson County was long wait times to get an appointment, reported by 48% of those who had experienced access issues. Access was particularly challenging among uninsured residents in the county.

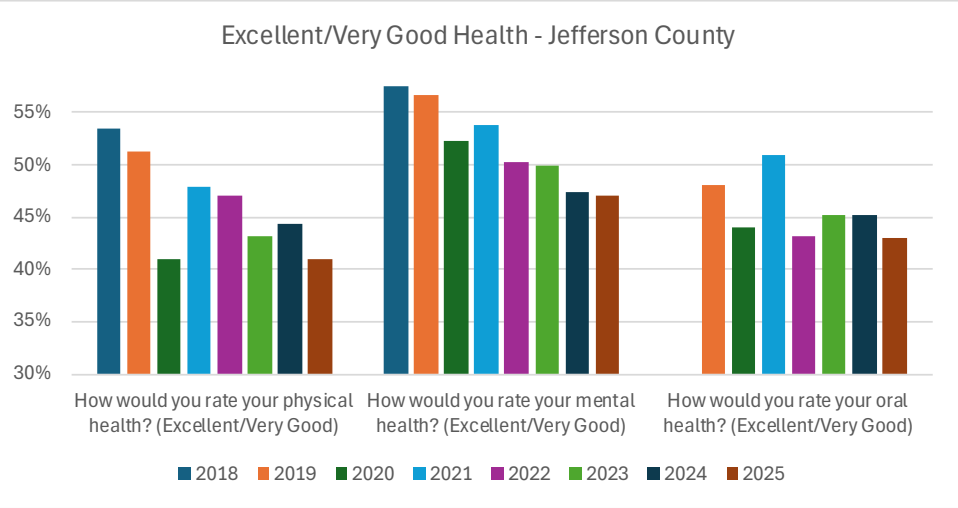
Primary care was the second most frequently cited service that residents had difficulty accessing. Regionally, access challenges were even more pronounced among Medicaid-insured individuals, those not confident they could cover a $500 emergency, and those experiencing unstable housing.





Q: 14 – How would you rate your physical health?
Q: 15 – How would you rate your mental health?
Q: 16 – How would you rate your dental health?

In 2018 and 2019, a majority of Jefferson County residents rated their physical health as "Excellent" or "Very Good." However, beginning in 2020, there was a sharp and consistent decline, with ratings dropping during the pandemic years and continuing to fall through 2025, reaching a low of approximately 41%. This marks the largest drop among the three health categories. Mental health began at the highest rating among the three categories, with 58% of residents reporting "Excellent" or "Very Good" mental health in 2018. These ratings steadily declined, reaching approximately 47% by 2025. While the decline has been less sharp than for physical health, the downward trend is still significant and consistent. Ratings of dental health have remained the most stable across the years. While they too show a gradual decline, from about 48% in 2019 to roughly 43% in the current year, the changes have been less dramatic. It's important to note that oral health access issues remain county-wide, particularly for the uninsured. Together, these trends suggest a general decline in self-perceived health among county adults over the past seven years, with physical health seeing the steepest drop, mental health showing a consistent downward trend, and dental health holding steady but still reflecting modest decline.

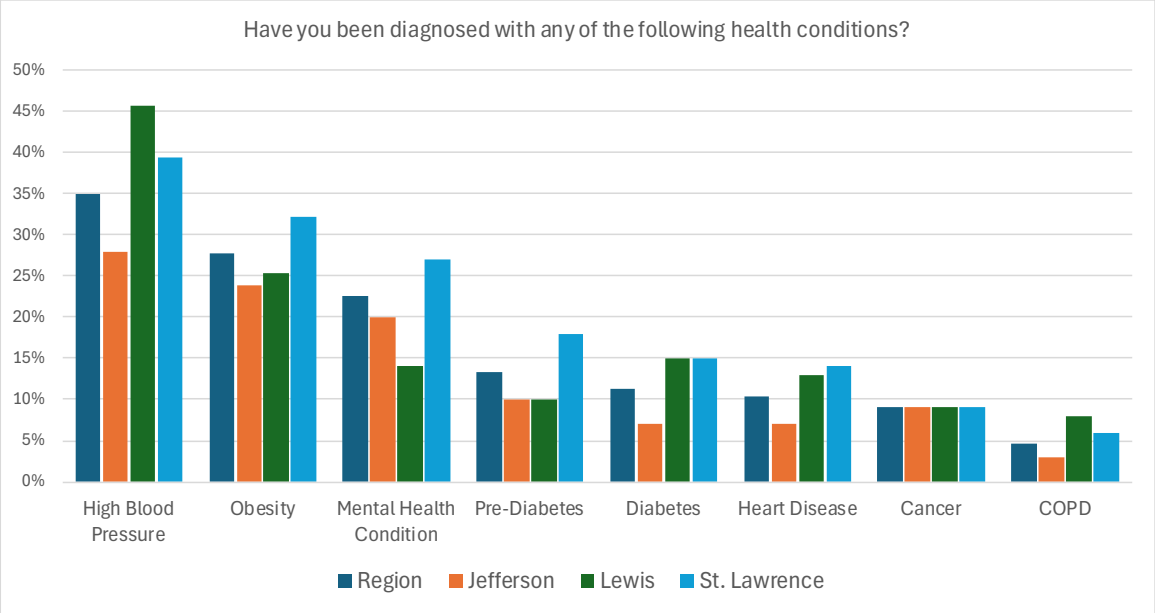


Q: 17 – Have you ever been diagnosed with any of the following eight chronic health conditions or illnesses? (choose all)

Roughly 57% of adults in Jefferson County report having been diagnosed with at least one chronic health condition, while 43% report no chronic conditions. Key findings include:

- Chronic conditions increase steadily with age, affecting 38% of adults ages 18–34, but rising to 53% in those 35–54, 76% among 55–74 year-olds, and 84% in those 75 and older.
    - Pre-diabetes (10%) and diabetes (7%) are more prevalent among older adults, veterans, and those with low income or financial insecurity.
    - High blood pressure affects 28% of Jefferson County residents and rises sharply with age, impacting nearly 60% of adults 75+. It is also slightly elevated among veterans (32%), those with disabilities (32%), and financially insecure individuals (30%).

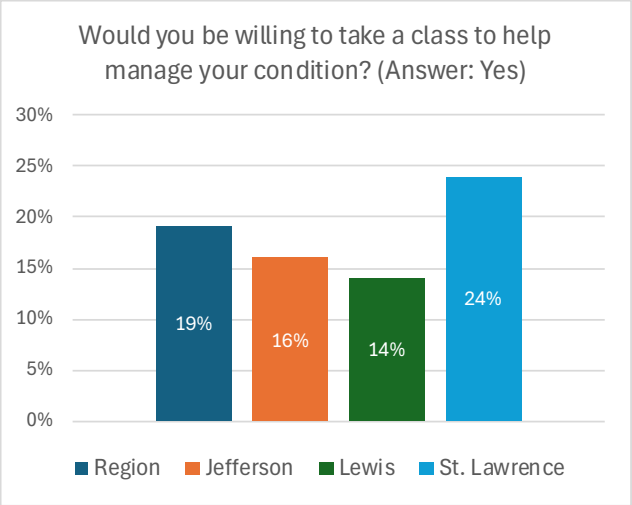
- Gender disparities exist, with 65% of women reporting at least one chronic condition compared to 50% of men.
- Obesity is reported by 24% of county residents, but is higher among women, LGBTQ+ residents, and people with a history of three or more ACEs.
- Mental health diagnoses are reported by 20%, but rise to 47% among disabled adults, 33% among LGBTQ+ residents, and 48% of those who rarely or never feel supported.
- COPD remains relatively low at 3%, but is elevated among adults 55+ and those with lower income.
- 63% of those facing housing instability (worried about or experiencing homelessness) report at least one condition compared to 57% of county residents.
- 77% of those who cannot cover a $500 emergency expense report a chronic condition, compared to 57% of all county residents.
- Residents in active-duty military households report significantly lower rates of chronic illness, likely due to younger age and fitness requirements. In contrast, veterans show higher rates of high blood, diabetes, and heart disease compared to the county population.



Q: 18 – Would you be willing to take a class to teach you how to manage your chronic health condition(s) that you cited earlier?

Across the North Country region, a small portion of adults with chronic conditions express a willingness to participate in self-management classes. When asked if they would be willing to take a class to help manage their condition, responses varied by county. In Jefferson County, about 16% of adults responded affirmatively. While not as high as in St. Lawrence, this still represents a meaningful segment of the population that could be reached with targeted promotion. Overall, these findings support the idea that

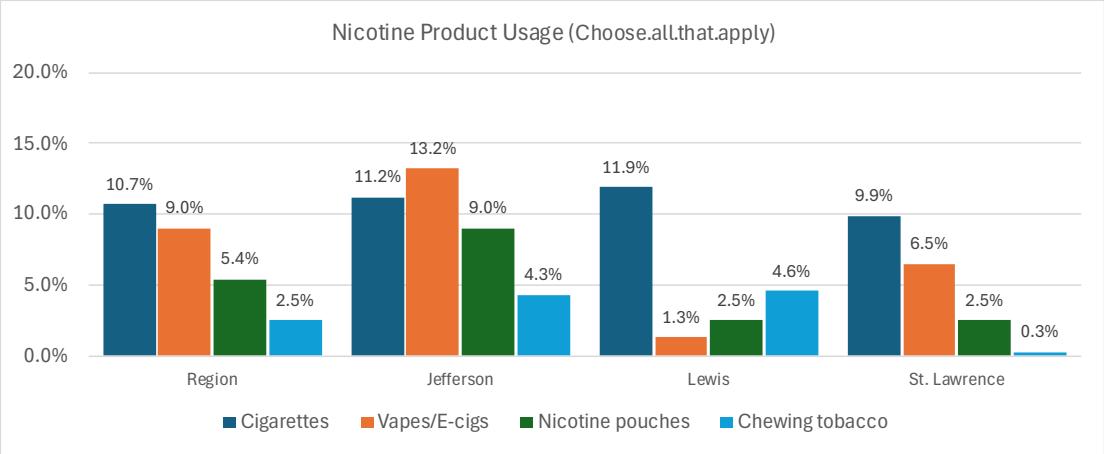
a regional chronic disease self-management initiative may be viable, particularly if it incorporates flexible delivery methods and tailors outreach strategies to the varying levels of interest seen across the counties.



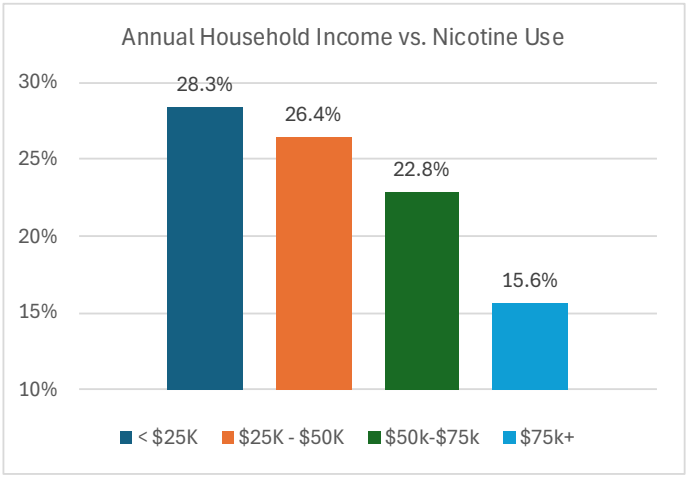
Q: 19 – In the past 12 months, have you regularly used any of the following nicotine products? (choose all that apply)

Because respondents could select more than one nicotine product, the bar graph exceeds the total share of adults who reported using any nicotine product in each county. This overlap is important to acknowledge when interpreting the chart. Across the region, roughly 21% of adults report using at least one nicotine product in the past year. Traditional tobacco cigarettes (11%) and vapes or e-cigarettes (9%) account for the majority of use, while nicotine pouches (5%) and chewing tobacco (3%) represent smaller but relevant segments of consumption. Jefferson County stands out with nearly 27% of adults reporting nicotine use, exceeding the regional average of 21%. Vaping and nicotine pouch use are especially elevated in Jefferson, with 13% using vapes (vs. 9% regionally) and 9% using nicotine pouches (vs. 5% regionally). Cigarette use in Jefferson aligns closely with the regional average at 11%.

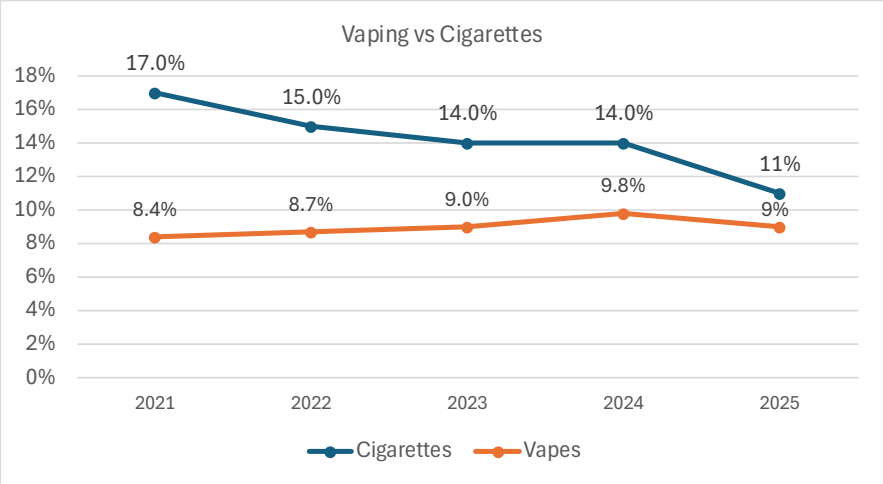
Several factors likely contribute to Jefferson's higher nicotine use. Jefferson is home to Fort Drum, New York's largest active-duty military installation. Survey data shows that nearly half (46%) of households with an active-duty service member report nicotine use, and over one in four (27%) report vaping. Also, the presence of military personnel contributes to a larger percentage of younger adults, the age group with the highest rates of nicotine use.



Regionally, nicotine use varies across demographic and socioeconomic subgroups. Nicotine use decreases with income, ranging from 28% among those earning less than $25,000 annually to 16% among those earning $75,000 or more. Cigarette use is most concentrated in the lowest income bracket. Use of any nicotine product is slightly higher among men (23%) than women (19%). While cigarette use is similar across genders (11%), women report higher vaping rates (10%) than men (7%). Nicotine use is highest among younger adults, with 41% of those aged 18–34 reporting use. This is nearly triple the rate of those 55–74 (14%) and substantially higher than those 75+ (5%). Vaping (26%) and nicotine pouches (22%) are especially common in the youngest group. BIPOC respondents report higher overall nicotine use (33%) compared to white respondents (19%), with higher rates of both cigarette smoking (16% vs. 10%) and vaping (22% vs. 7%). Adults who report experiencing three or more ACEs are more likely to use nicotine (26%) compared to those with none (18%). Individuals who are not confident they could cover a $500 emergency expense report nearly twice the rate of nicotine use (29%) as those who are very confident (16%).

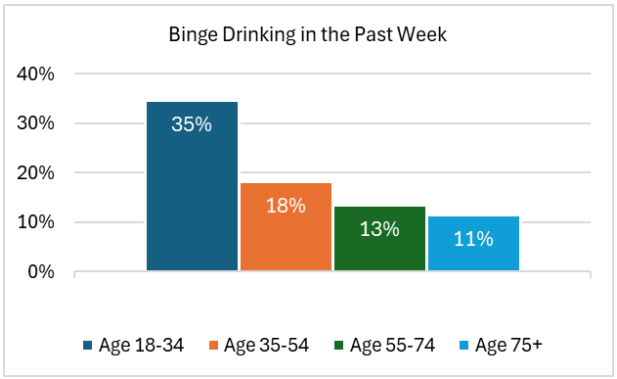


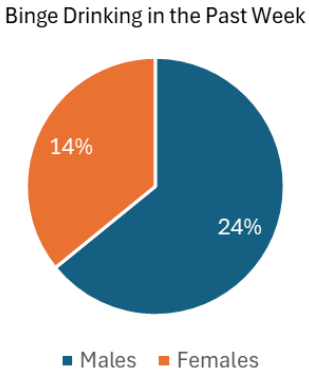
Over the past five years, cigarette use in the North Country region has declined steadily, dropping from 17% in 2021 to 11% in 2025. Meanwhile, vaping rates have gradually increased, rising from 8.4% in 2021 to a peak of 9.8% in 2024 before dipping slightly to 9% in 2025. The gap between cigarette and vape use has narrowed significantly, from 8.6 percentage points in 2021 to just 2 points in 2025. This convergence suggests a potential shift in nicotine use patterns, where vaping may soon match or exceed smoking prevalence if current trends continue.

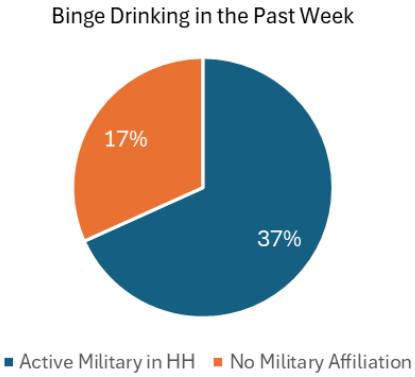


Q: 20 – In the past week, how many times did you have 5 or more alcoholic beverages on one occasion?

Regionally, 19% of respondents reported at least one binge drinking episode in the past week, defined as consuming five or more alcoholic drinks on one occasion. Jefferson County reported the highest prevalence of binge drinking compared to the other two counties, with 22% of adults indicating at least one episode in the past week. Regional rates of binge drinking were particularly elevated among men (24%), young adults ages 18-34 (35%), and households with an active-duty service member (37%). BIPOC residents were also more likely to report binge drinking episodes compared to white residents. Residents experiencing low income, and those with a history of three or more ACEs were more likely to report binge drinking compared to the overall population.



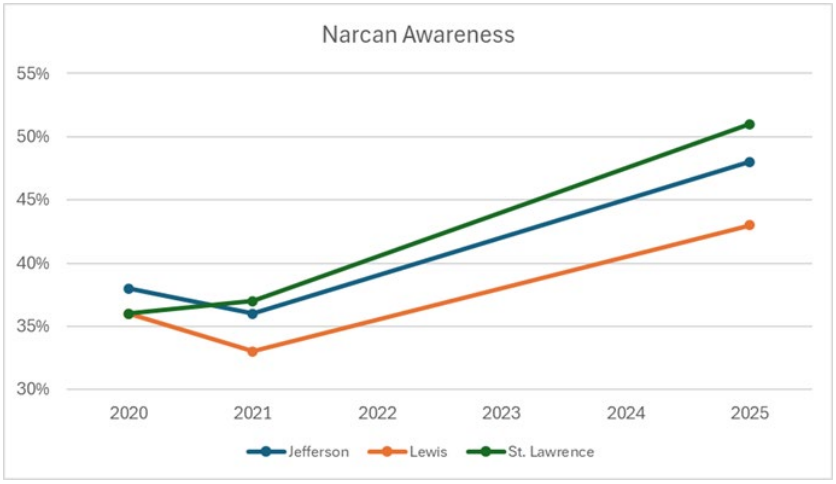




Q: 21 – Within the past year, has anyone in your household been personally affected by opiate use or addiction?

Q: 22 – Are you aware of locations where you can obtain Narcan, a medication that can help reverse an opioid overdose?

Residents were asked whether anyone in their household had been personally affected by opiate use or addiction in the past year. In the region, reported household impact from opioid use has steadily declined since reaching a regional high of 5.6% in 2022. In 2025, only 2.7% of households reported being affected. This downward trend suggests some meaningful progress. Jefferson County experienced the most significant decrease among the three counties. In 2022, 5.6% of households reported being affected, the highest rate in the county's trend. By 2025, that number had dropped to just 1.5%. This was a 73% decline in a three-year period.



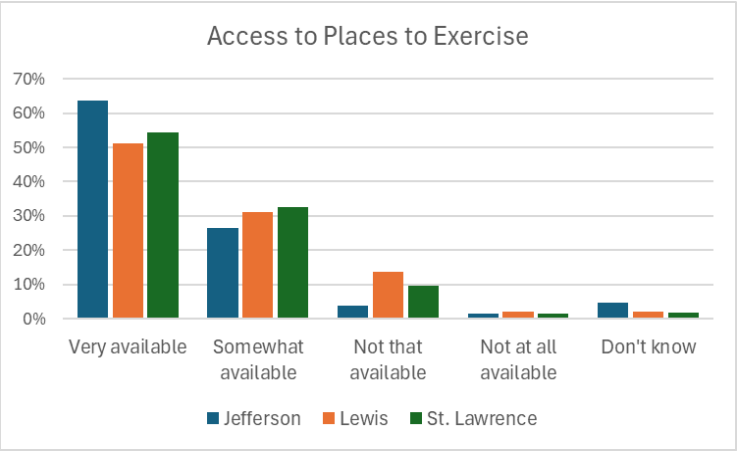
In the 2025 Community Health Survey, residents were asked whether they were aware of locations where they could obtain Narcan, the opioid overdose reversal medication. Awareness of Narcan availability is a key indicator of community readiness to respond to opioid-related emergencies. It also reflects positive, proactive efforts among community members and stakeholders. Across all three counties, awareness has risen consistently since 2021, showing the success of ongoing community education campaigns and increased access points. In Jefferson County, awareness increased from 36% in 2021 to 48% in 2025, a 12-point gain. Lewis County started with the lowest awareness in 2021 at just under 33%, but saw steady improvement year over year, reaching 43% in 2025. St. Lawrence County showed the most significant increase, from 37% in 2021 to 51% in 2025. These trends suggest that Narcan education and access initiatives are working across the North Country.

Q: 23 – How would you rate your family's access to places where you can walk and exercise, either indoors or outdoors?

Q: 24 – What barriers, if any, are preventing you from eating healthier foods and maintaining a healthier diet?

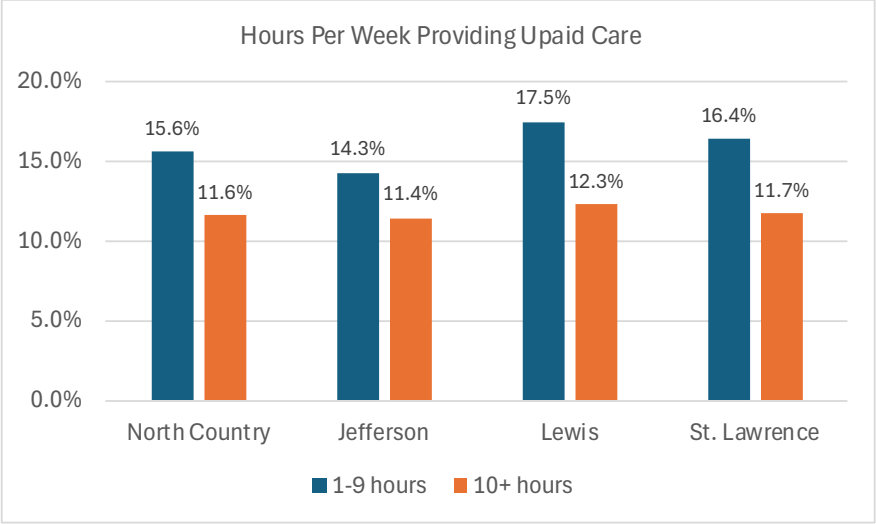
When asked "How would you rate your family's access to places where you can walk and exercise, either indoors or outdoors?," a majority of North Country residents reported having good access. In 2025, 58% of respondents across the region said access was "very available." Jefferson County stood out with the

highest level of reported access (64%), while Lewis County had the lowest (51%) and the highest percentage reporting limited or no access. These patterns have remained relatively stable since the question was first asked in 2018.



In response to "What barriers, if any, are preventing you from eating healthier foods and maintaining a healthier diet?," affordability was the most common barrier across the region, cited by 43% of residents. This concern was most frequently reported in St. Lawrence County (49%) and least in Jefferson (36%). Lack of time to cook was the second most cited barrier, while structural challenges such as store proximity or transportation were mentioned less often. About 43% of respondents reported facing no barriers at all.

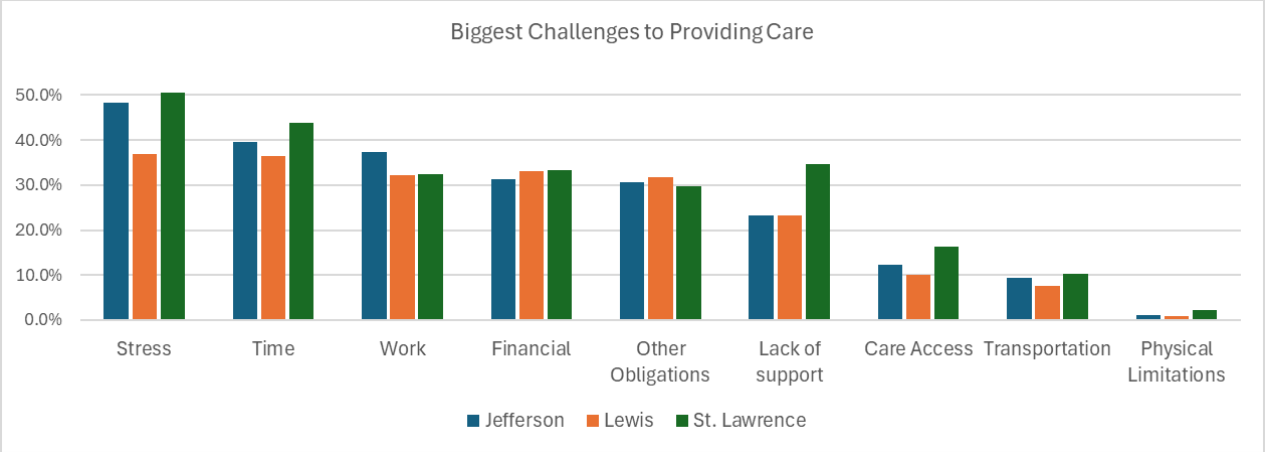
Q: 25 – In the past 12 months, how many hours per week do you regularly provide unpaid care for an aging or disabled family member or friend?



Across the North Country region, more than one in four adults (27%) report providing some level of unpaid care to an aging or disabled family member, friend, or neighbor. Nearly 12% offer 10 or more hours weekly. Jefferson County shows that approximately 26% of adults are engaged in caregiving responsibilities, with rates of substantial caregiving (10+ hours) closely mirroring the regional pattern. Women are more likely than men to provide unpaid care, especially at longer hours. Adults aged 55 to 74 stand out as the region's primary caregiving group, with more than one in three reporting that they provide unpaid care to an aging or disabled loved one. Adults not in the labor force and those earning less than $25,000 annually are among the most likely to report providing substantial care.

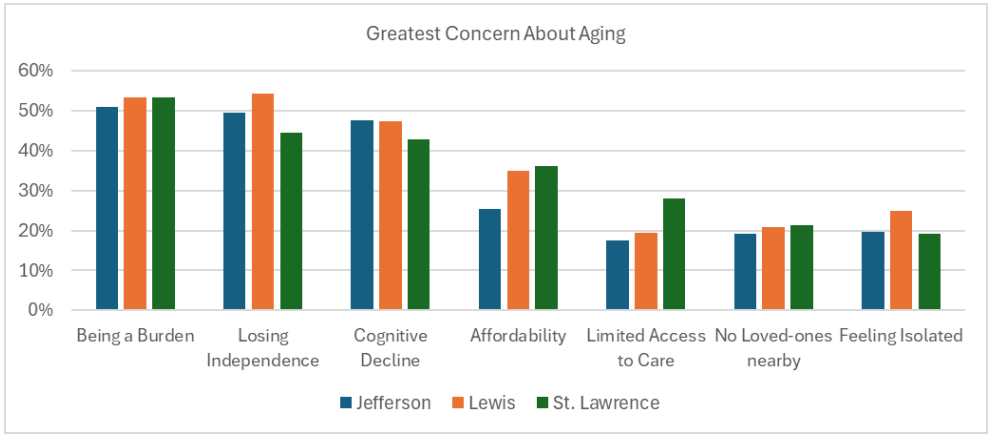
Q: 26 – What are the biggest challenges you face as a caregiver, or would expect to face if you were to begin being a caregiver?

Across the North Country, caregiving presents a challenge for many adults. Roughly 75% of respondents across the three-county region identified at least one difficulty they either face now or would expect to face as an unpaid caregiver for an aging or disabled loved one. While the pattern of challenges is generally consistent across counties, there are some variations. Stress is the most common concern regionwide, reported by 48% of adults. Following closely are struggles with balancing time (41%) and work (35%). In Jefferson County, balancing work and caregiving stood out more than in any other county (37%).

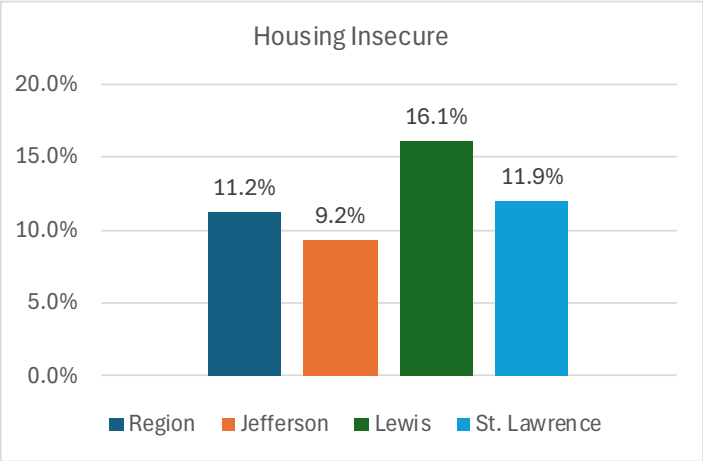


Q: 27 – What concerns you the most about aging?

In Jefferson County, aging-related concerns largely align with regional trends, but a few distinctions stand out. Just over half of Jefferson County respondents (51%) cited “being a burden” as their greatest concern, closely aligned with neighboring counties. Nearly half also worry about losing their independence (49.6%) and cognitive decline (47.7%). Roughly 25.4% identified affordability as a top concern, lower than the 34.9% in Lewis and 36.2% in St. Lawrence. Roughly one in five Jefferson respondents worried about not having loved ones nearby (19.1%) or feeling isolated (19.7%).



Q: 28 – Which of the following best describes your living situation today?



Participants were asked to describe their current living situation. Those who indicated that they either do not have a steady place to live or are worried about losing their housing were considered to be experiencing housing instability. Jefferson County reported the lowest rate of housing instability among the three counties, at 9.2%. While this is lower than the regional average, it still represents nearly 1 in 11 adults. Across the North Country region, 11.2% of adults fell into this category. Adults in the region who are unemployed report the highest rate, with 32.8% experiencing housing instability. Similarly, nearly 1 in 3 uninsured residents (29.4%) and over one-quarter of those not confident they could cover a $500 expense (26.5%) face unstable housing. Emotional and social factors also play a role: 25.7% of those who rarely or never feel supported report housing concerns, as do 22.8% of people living with a disability and 23.1% of Medicaid recipients. Those with 3 or more ACEs (20.6%) report greater instability. Disparities are also evident among young adults aged 18–34 (13.3%) and those who identify as LGBTQ+ (14.1%), as well as among BIPOC respondents (12.8%).

Source: FDRHPO Community Health Survey 2025

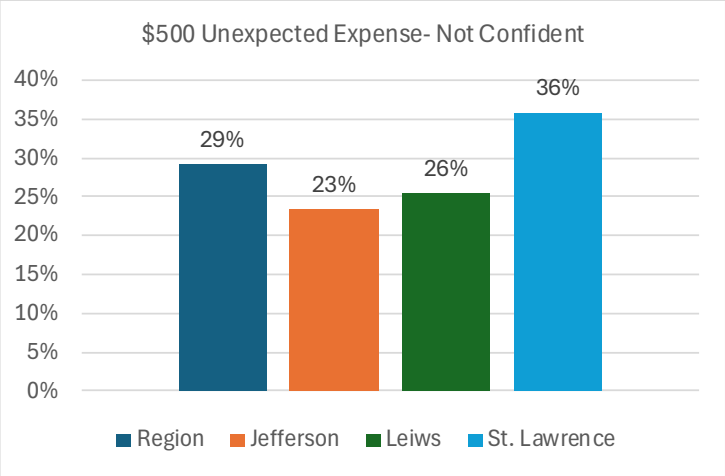
Demographic	Housing Insecure
Not employed (not retired)	32.8%
Uninsured	29.4%
Not confident about covering a $500 expense	26.5%
Rarely/Never feel supported	25.7%
Medicaid insured	23.1%
Disabled	22.8%
Experienced 3+ ACEs	20.6%
Identify as LGBTQ+	14.1%
Young adults (18–34)	13.3%
BIPOC	12.8%

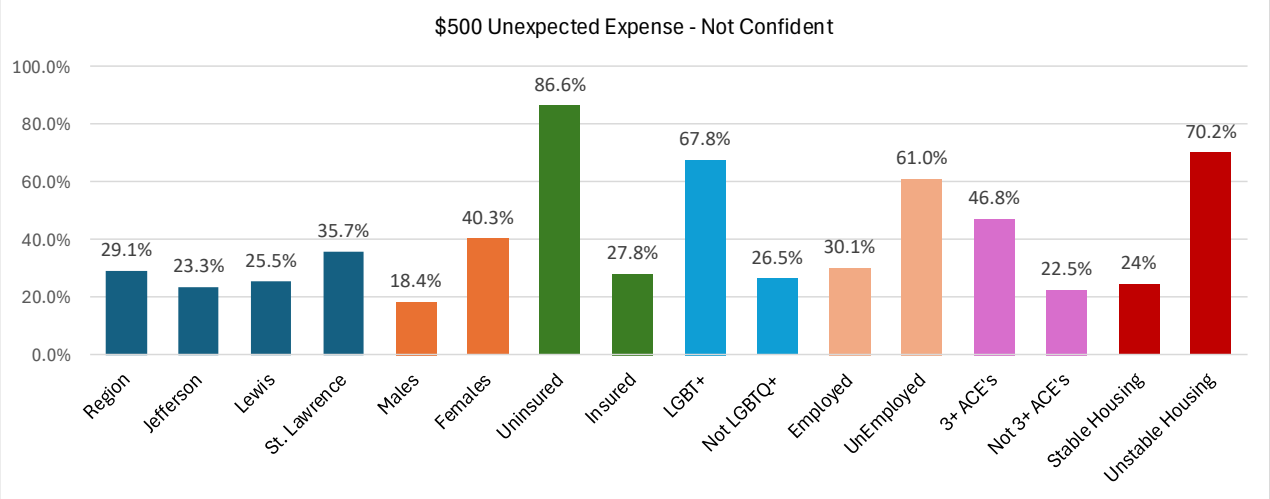
Q: 29 – How confident are you that you could cover an unexpected $500 expense (e.g., medical bill) without using a credit card or borrowing?

This survey question was included to explore not just income levels, but financial resilience and economic vulnerability, serving as a practical indicator of how well residents can manage unforeseen expenses. By cross-tabulating responses with key demographics and social determinants of health, we

aim to better understand which populations are most at risk and identify potential gaps that may otherwise be overlooked.

While Jefferson (23%) fares better than the regional average, nearly a quarter of its residents reported "not confident". Overall, those ages 55+ reported more confidence. Regionally, 29.1% of North Country adults reported that they are not confident they could cover a $500 emergency expense. St. Lawrence County reported the highest level of financial vulnerability, with 35.7% of adults not confident, followed by Lewis County at 25.5%, and Jefferson County at 23.3%.

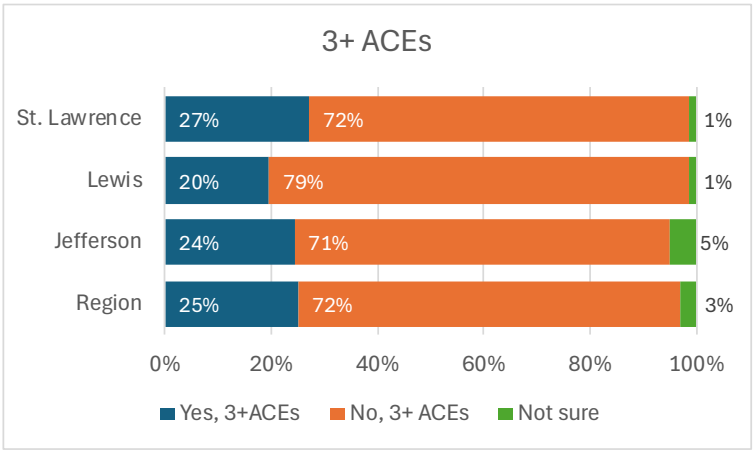




Regional demographic breakdowns reveal deeper disparities. Females (40.3%) were more than twice as likely as males (18.4%) to report low financial confidence. Among those with no health insurance, the problem is also high. Roughly 86.6% of uninsured respondents said they could not cover a $500 emergency without borrowing, compared to just 27.8% of those with insurance. LGBTQ+ adults (67.8%) also reported significantly higher financial insecurity compared to those who do not identify as LGBTQ+ (26.5%). Other at-risk groups include the unemployed (61.0%), individuals with unstable housing (70.2%), and those who have experienced three or more adverse childhood experiences (46.8%).

Q: 30 – Before the age of 18, did you experience at least three ACE's?

ACEs, or Adverse Childhood Experiences, refer to traumatic or stressful events that occur before the age of 18 (e.g., abuse, neglect, or growing up in a household with substance use, mental illness, or domestic violence). Research shows that experiencing multiple ACEs can have long-term effects on a person's health, behavior, and economic stability throughout life (Centers for Disease Control and Prevention, 2025). To better understand the impact of early life experiences on adult health and stability, the 2025 Community Health Survey asked participants whether they had experienced three or more ACEs. In Jefferson County, 24% of adults reported experiencing three or more Adverse Childhood Experiences (ACEs). Understanding ACE prevalence helps public health partners target resources and develop trauma-informed services. Those with 3+ ACEs in our region are also more likely to face challenges such as housing instability, poor financial resilience, and worse health outcomes. Disparities emerged across regional demographic groups. Young adults ages 18–34 were the most affected, with 45% reporting 3+ ACEs, nearly double the regional average. Similarly, LGBTQ+ individuals (46%), those with unstable housing (46%), the uninsured (32%), and those not employed and not retired (39%) were far more likely to report a history of early trauma. Other groups with elevated ACE exposure include Medicaid-insured adults (44%), BIPOC respondents (41%), and individuals who said they were not confident they could cover a $500 emergency expense (40%). In contrast, those who feel socially supported most days (20%) and those who are very confident in their financial stability (16%) reported lower ACE exposure, suggesting that both community connection and financial resilience can serve as protective factors.

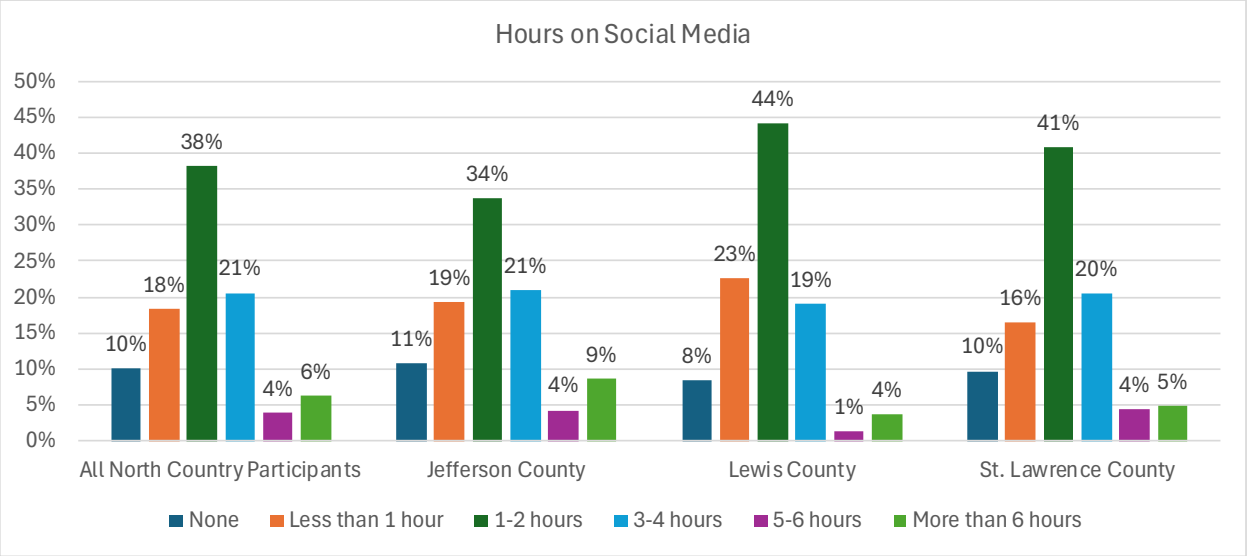


Q: 31 – In the past year, on average, how many hours per day do you spend on social media platforms like Facebook, X (Twitter), Instagram, Snapchat, TikTok, etc.)?

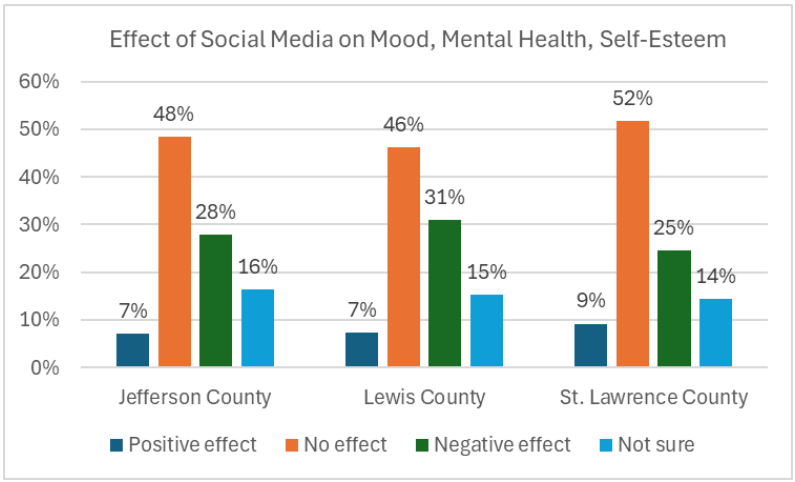
Residents were asked how much time they typically spend on social media each day. In Jefferson County, most adults reported moderate use, with 34% saying they spend 1–2 hours per day and 21% reporting 3–4 hours. Only 11% of respondents said they do not use social media at all. Jefferson County had the highest percentage of heavy users, with 9% reporting more than 6 hours per day. Young adults ages 18–34 are the most likely to engage heavily, with 17% using social media more than six hours daily, and another 11% using it for 5–6 hours. This is nearly five times the heavy-use rate of older adults. Similarly, individuals from active-duty military households (16%), Medicaid recipients (15%), and those with unstable housing (14%) report significantly higher daily use. BIPOC residents (15%), LGBTQ+ individuals (10%), and those who are not employed and not retired (13%) also demonstrate elevated usage

patterns. Those who are not confident in their ability to cover a $500 expense and individuals with three or more ACEs each show higher rates of extended use (10%).

Q: 32 – In the past year, how do you think your use of social media has affected your overall mood, mental health, or self-esteem?



When asked about the overall impact of social media on their lives, about half of all respondents (50%) said social media has had no effect, while just 8% described it as having a positive effect. In contrast, more than one in four adults (27%) believe social media has had a negative effect on their mood, mental health or self-esteem, and 15% were unsure. Jefferson County closely mirrored the regional average across all response categories.



Perceptions differed by some demographic groups. Adults ages 35–54 were the most likely to report negative effects, while younger adults ages 18–34 were more likely to view social media positively. Parents and caregivers reported higher rates of negativity (37%) than those without children at home (23%), suggesting added concerns around social media's influence on families.

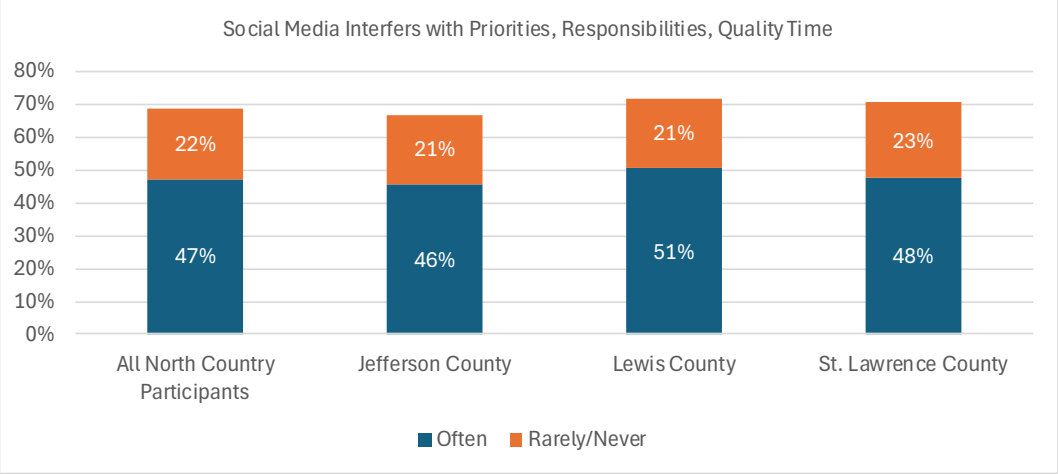
Individuals with unstable housing (40%), those who rarely or never feel supported (36%), and those not confident in their ability to cover a $500 expense (30%) were among the most likely to view social media

negatively. More positive views were found among LGBTQ+ individuals (28%), BIPOC respondents (23%), and the uninsured (30%), suggesting that for some groups, social media may serve as a valuable tool for connection, identity affirmation, or access to support.

Q: 33 – Based on your observation, how often does social media or smartphone use interfere with individuals' quality time, and daily responsibilities or priorities?

Residents were asked, "Based on your observation, how often does social media or smartphone use interfere with individuals' quality time, and daily responsibilities or priorities?." This question was designed to capture community perceptions, not personal behavior, regarding how digital technology affects everyday life. Across all three counties, a majority of respondents said they often observe social media interfering with people's responsibilities, priorities, or quality time. Jefferson County had the lowest share of respondents reporting frequent interference (46%) compared to the other two counties. In all three counties fewer than 1 out of 4 said they "rarely or never" observe this kind of interference. These responses suggest that most residents perceive social media and smartphone use as a behavior that regularly interferes in daily life.

Regionally, this perception was especially common among younger adults (55%), LGBTQ+ individuals (47%), parents, or caregivers (50%), and those experiencing economic or social hardship, including the uninsured (53%), those not confident covering a $500 expense (55%), and individuals with unstable housing (55%).

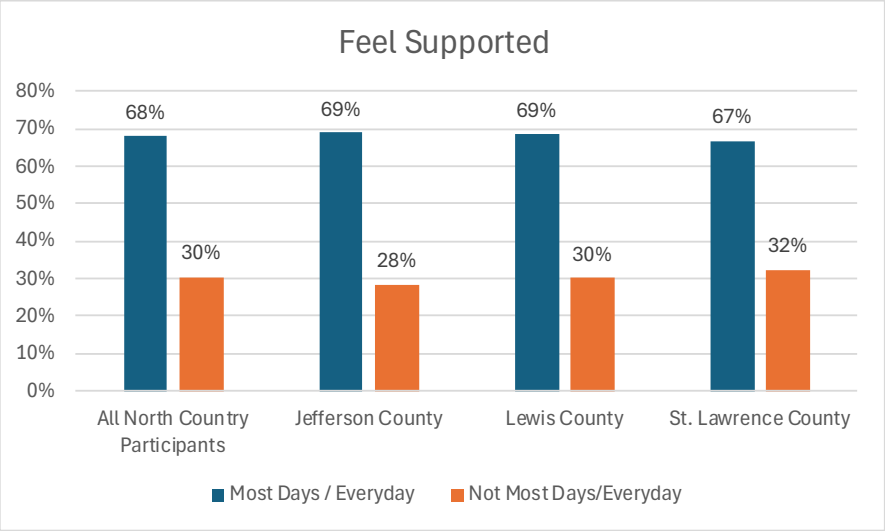


Q: 34 – How often do you feel supported, accepted, and connected to people who understand you?

Residents were asked how often they feel supported, accepted, and connected to people who understand them. Regionally, 68% of North Country adults said they feel this way most days or every day, while 30% said they do not. At the county level, responses were fairly consistent, with Jefferson and

Lewis Counties each at 69%, and St. Lawrence County slightly lower at 67%. This suggests a relatively uniform sense of support across the region.

Across the counties, younger adults reported lower levels of support. Just 56% of 18–34-year-olds feel supported most days, compared to 78% of those ages 55–74 and 81% of those 75 and older. Retirees (81%) were among the most likely to report feeling supported, while adults who are not employed and not retired (57%) were among the least. Housing and financial security were strongly linked to perceived support. Only 32% of those experiencing unstable housing said they feel supported most days, compared to 73% of those with stable housing. Similarly, 81% of people who were very confident in their ability to cover a $500 emergency felt supported regularly, while only 61% of those who were not confident said the same.



Differences also emerged across identity groups. Roughly 41% of LGBTQ+ respondents and 57% of disabled adults reported feeling supported most days, compared to 70% and 71% of their non-LGBTQ+ and non-disabled peers, respectively. Experiences of childhood trauma also appeared to impact feelings of being supported. Only 55% of people with three or more ACEs felt supported, compared to 74% of those with fewer ACEs.

Key Informant Interviews: Youth Priorities

As part of the 2025 Community Health Assessment (CHA), eight key informant interviews were conducted with professionals who work closely with youth across Jefferson, Lewis, and St. Lawrence Counties. Participants represented a cross-section of subject matter experts from K–12 schools, county youth bureaus, and community-based organizations that support young people and their families. The primary goal of these interviews was to better understand the needs, challenges, and opportunities related to youth health and wellness. Discussions focused on topics such as educational engagement, mental and physical health, social-emotional development, and access to supportive services. Particular attention was given to the concept of building "health and wellness promoting schools" and expanding pathways to postsecondary education, consistent with the 2025–2030 New York State Prevention Agenda. Interviewees brought perspectives from a range of youth-focused roles, including mental health counseling, guidance and academic support, STEM education, and youth empowerment. Interviews were conducted in all three counties. Responses were largely consistent across counties. These conversations provided meaningful qualitative insight into youth-related gaps and strengths, helping to inform this assessment and guide future efforts to promote healthy, supportive environments for young people.

Key Informants	Stakeholder Type	Location	Date
Key Informant #1	K-12 Schools	Jefferson and Lewis	5/7/2025
Key Informant #2	Community-based Organization	Jefferson and Lewis	5/16/2025
Key Informant #3	Community-based Organization	Jefferson	5/16/2025
Key Informant #4	Community-based Organization	Jefferson	5/16/2025
Key Informant #5	Local Government Agency	Lewis	5/21/2025
Key Informant #6	Local Government Agency	St. Lawrence	5/19/2025
Key Informant #7	K-12 Schools	St. Lawrence	5/15/2025
Key Informant #8	K-12 Schools	Jefferson	6/2/2025

Key Themes and Findings

Youth Mental and Emotional Well-being

Stakeholders consistently identified mental health challenges as some of the most pressing concerns for youth in the region. Students in grades 7–9 were cited as particularly vulnerable. Participants noted that while stigma surrounding mental health has decreased in recent years, many families still do not recognize or address issues until they have escalated to a crisis point. Limited availability of in-school mental health services and long waitlists for counseling were cited as barriers to intervention.

> *Students in grades 7–9 were cited as particularly vulnerable.*

Impact of Technology and Social Media

The influence of screen time and social media on youth well-being was repeatedly emphasized. Stakeholders reported that overuse of digital platforms contributes to social isolation, sleep disruptions, cyberbullying, and negative self-comparisons among students. Respondents observed shorter attention

spans, increased classroom conflicts, and increased stress that they attributed to excessive online interactions. Recommendations included digital wellness initiatives and education designed to promote healthy technology use.

Risky Behaviors and Substance Use

Vaping was identified as one of the most concerning behaviors among adolescents, along with alcohol, marijuana use. Sharing of prescription medications was also noted. Stakeholders linked these behaviors to peer influence, stress, and normalization of substance use. Some also expressed concern over the growing prevalence of teen dating violence and early sexual activity, which they attributed, in part, to exposure through social media and online content.

Vaping was identified as one of the most concerning behaviors among adolescents, along with alcohol, marijuana use.

Trauma and Adverse Childhood Experiences (ACEs)

Stakeholders cited the ongoing impact of poverty, family instability, and other ACE-related trauma on youth mental health. The isolation experienced during the COVID-19 pandemic was reported to have exacerbated stress and behavioral health issues. Schools often serve as the primary source of structure and support for students facing these challenges. However, stakeholders stated that schools lack the capacity to provide the necessary type and level of trauma-informed care that some students need. Teachers and staff also need training and support to respond effectively to student needs.

… schools lack the capacity to provide the necessary type and level of trauma-informed care that some students need.

Social Determinants of Health (SDoH)

Economic disadvantage was a recurring theme, with some stakeholders noting that most of their students are economically disadvantaged. Food insecurity remains a concern, particularly with limited access to healthy, affordable options both at school and in the community. Transportation and broadband access were identified as barriers for some rural students.

Access to Services and System Capacity

Gaps in healthcare and behavioral health access were a consistent finding. Mental health waitlists are too long, according to most of the respondents. They also reported challenges with emergency response times for behavioral crises, which they described as incompatible with the urgent needs of students in crisis situations.

Youth Voice and Empowerment

Several stakeholders highlighted the importance of involving youth directly in program design and decision-making. While some youth advisory roles exist, participants noted that these roles often attract high-achieving students and do not always reflect the perspectives of marginalized or less vocal students.

The concept of “nothing about us without us” was emphasized as a way to ensure that interventions are relevant and resonate with youth.

Respondent Recommendations

Respondents offered the following recommendations:

- Expand mobile mental health teams and school-based behavioral health services.
- Increase trauma-informed training for teachers and staff.
- Create after-school mentorship and recreation programs to strengthen protective factors.
- Develop coordinated strategies based on the Strategic Prevention Framework to bring together community resources and services and improve collaboration.
    - The SAMHSA Strategic Prevention Framework (SPF) is a five-step, data-driven planning process that helps organizations and communities prevent and reduce substance use and related mental health problems. It provides a structured approach to guide prevention efforts, from identifying needs to evaluating outcomes.
- Promote youth-led initiatives and leadership opportunities to encourage engagement, resilience, and a sense of purpose.

The key-informant interviews reinforce the data highlighted in the CHA, including high rates of mental health crises, substance use, chronic absenteeism, and ongoing gaps in healthcare access.

Leading Causes of Death

The New York State Department of Health tracks the leading causes of death in each county using standardized ICD-10 classifications. The most recent mortality data show that Jefferson County's leading causes of death generally follow state-level patterns, with some variations in rate. Heart disease remains the top cause of death in the county, followed closely by cancer (malignant neoplasms). While heart disease occurs at a lower rate than the state average, cancer deaths in Jefferson County are higher.

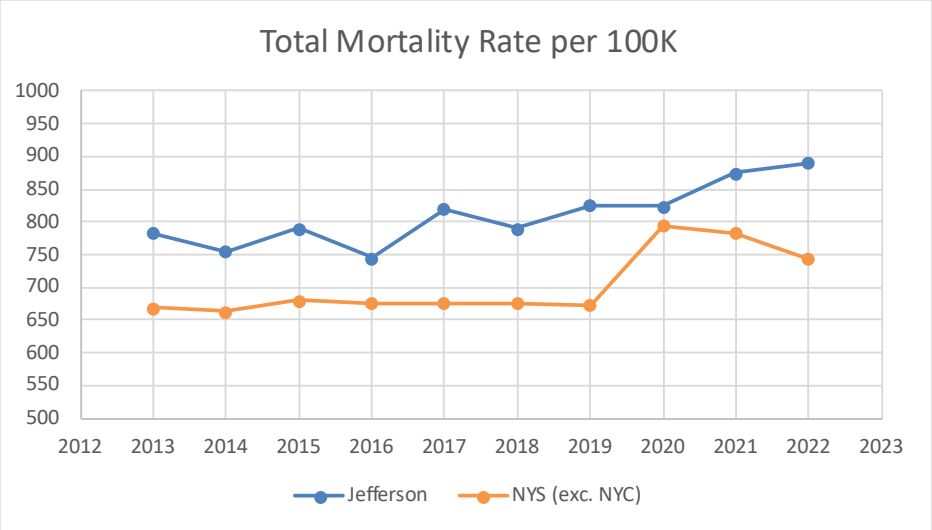
Source: CDC Wonder Online Database, National Center for Health Statistics, Multiple Causes of Death

15 Leading Causes of Death, 2018 – 2023 Average	Jefferson County	New York State
Diseases of heart (I00-I09,I11,I13,I20-I51)	195.6	224.6
Malignant neoplasms (C00-C97)	188.4	169.2
COVID-19 (U07.1)	24.9	61.0
Accidents (unintentional injuries) (V01-X59,Y85-Y86)	50.6	47.1
Chronic lower respiratory diseases (J40-J47)	49.2	33.4
Cerebrovascular diseases (I60-I69)	38.2	32.9
Diabetes mellitus (E10-E14)	29.7	24.4
Influenza and pneumonia (J09-J18)	13.7	21.8
Alzheimer disease (G30)	22.9	18.1
Essential hypertension and hypertensive renal disease (I10,I12,I15)	10.3	14.8
Nephritis, nephrotic syndrome, and nephrosis (N00-N07,N17-N19,N25-N27)	14.9	13.2
Septicemia (A40-A41)	9.9	10.8
Chronic liver disease and cirrhosis (K70,K73-K74)	17.4	9.3
Parkinson disease (G20-G21)	9.9	8.7
Intentional self-harm (suicide) (*U03,X60-X84,Y87.0)	15.1	8.7

Chronic lower respiratory diseases and unintentional injuries rank third and fourth, respectively. Jefferson's rate of death from unintentional injuries slightly exceeds the state rate, while chronic lower respiratory disease is lower than the state average. COVID-19 appears as the fifth leading cause of death and is also somewhat higher than the statewide figure for the same period. Several other causes, such as cerebrovascular disease, kidney disease (nephritis and related conditions), chronic liver disease, influenza and pneumonia, and hypertensive disease, occur at rates comparable to or slightly above those seen across New York State. Suicide (intentional self-harm) remains among the top 15 causes of death in Jefferson County and occurs at a higher rate than the state overall. While diabetes, septicemia, Alzheimer's disease, and Parkinson's disease also contribute to the county's mortality profile, their rates are relatively close to state averages **(Centers for Disease Control and Prevention, 2025)** .

Total mortality rate reflects all deaths from all causes and provides context for understanding how each leading cause contributes to overall mortality.

From 2013 to 2022, Jefferson County's total mortality rate has consistently exceeded the New York State average (excluding New York City). From 2013 to 2019, Jefferson's rate remained fairly steady but higher than the state rate. Both experienced an increase during the COVID-19 pandemic, but while the state's rate peaked and then declined, Jefferson's mortality rate continued to rise and plateaued at a higher level through 2022 **(New York State Department of Health, 2025).**



Source: Vital Statistics Data at apps.health.ny.gov/public/tabvis/PHIG_Public/lcd/

Health Challenges and Associated Risk Factors

The following section provides a summary of key health challenges and risk factors in Jefferson County, based on the data presented throughout this Community Health Assessment.

Jefferson County faces a range of health challenges. Chronic conditions such as hypertension, obesity, diabetes, and COPD remain common among adults, and illnesses like cancer and heart disease continue to account for a large share of local mortality. Mental health concerns are also prevalent, with some residents reporting frequent psychological distress and elevated suicide risk. Substance use, particularly nicotine and alcohol, continues to be a concern, especially among younger residents and those affiliated with the military. Maternal and child health indicators show some areas of concern, including a higher teen birth rate. The elevated teen birth rate may be influenced by the county's younger population and the presence of Fort Drum, which brings a large number of young families. Rates of unintentional injury and drug-related deaths also exceed desired benchmarks. Health risk behaviors such as smoking, vaping, excessive alcohol use, and physical inactivity are more common in certain demographic groups within the county. Access to parks and walkable communities falls below statewide averages.

Many Jefferson County residents experience financial strain, with a large share living paycheck to paycheck and struggling to manage unexpected expenses. Economic challenges exist among those in the ALICE population. At the same time, access to healthcare is impacted by shortages in primary care, dental, and mental health providers, along with long wait times and limited availability of some specialists.

The presence of Fort Drum brings both opportunities and complexities. Military-connected populations often have unique health needs and may face challenges accessing timely care, especially family members in need of OB/GYN, pediatric, or dental services. The county's seasonal economy also contributes to instability in housing and employment, particularly in areas dependent on tourism.

Some of these challenges pose heavier burdens for specific populations, including BIPOC residents, military families, ALICE households, individuals with disabilities, LGBTQ+ individuals, and young adults. These groups are more likely to experience social isolation, financial hardship, housing insecurity, and limited preventive care.

Integrating strategies that connect clinical services with social supports may help mitigate some of these challenges. Providing mental health awareness training and trauma-informed care training can help address community needs. Reducing nicotine use, alcohol misuse, and ACE-related trauma, especially among youth, military families, and underserved populations, should be a priority. Policy and environmental changes, such as expanding smoke-free spaces, empowering youth, improving walkability, and increasing access to healthy foods and child care, can support long-term prevention.

The North Country region continues to experience persistent workforce shortages across key areas of healthcare, including primary care, mental health, and dental services. Jefferson County, like its neighboring counties, faces challenges in maintaining an adequate supply of providers to meet community needs. These shortages impact access to timely and preventive care, particularly for vulnerable populations. The county is federally designated as a Health Professional Shortage Area (HPSA) across all major sectors. This designation also points to the workforce strains and underscores the importance of continued investment in recruitment, workforce pipelines, and retention strategies to build and sustain the local healthcare workforce.

According to The Healthcare Workforce in New York State: Trends in the Supply of and Demand for Healthcare Workers, released by the Center for Health Workforce Studies in 2024, the North Country had the second-lowest physician-per-capita rate of any New York region as of 2021. The report further notes that over 40% of active physicians in the region are age 55 or older, raising serious concerns about future retirements and the risk of worsening provider shortages.

Local employers across the region report difficulty recruiting and retaining workers in nearly every major discipline, particularly in behavioral health, nursing, and oral health. These shortages affect not only hospitals and clinics, but also community-based organizations, schools, and long-term care settings.

A separate August 2025 analysis, by New York State Comptroller Thomas DiNapoli, examined healthcare professional shortages in 16 rural New York counties. It found provider gaps in primary care, pediatrics, obstetrics/gynecology, dentistry, and mental health. DiNapoli's report noted that these rural counties, on average, have half the number of primary care physicians and dentists per capita as the state overall and only 0.5 pediatricians per 10,000 people, compared to 2.8 statewide.

Although Jefferson County was not specifically included in the Comptroller's study, some neighboring counties were, and their workforce shortages may place additional pressure on Jefferson's healthcare system. Jefferson is also home to Fort Drum, the only division-sized Army installation in the United States

without its own on-base hospital, making it especially important for the county to maintain adequate provider capacity to serve both military personnel and their families.

Jefferson County shares many of the same characteristics and barriers as the counties included in the Comptroller's study, including a largely rural geography, high reliance on Medicaid, and an aging provider population.

Community Assets and Resources

The list of assets is categorized by asset type. The county is supported by a network of organizations, services, resources, which work to address the health challenges identified in this Community Health Assessment. These assets encompass the healthcare, behavioral health, social service, housing, transportation, and education sectors.

The county's clinical care infrastructure includes three hospitals, Samaritan Medical Center in Watertown, Carthage Area Hospital, and River Hospital in Alexandria Bay, which offer a range of acute, primary, and specialty services. These are complemented by the North Country Family Health Center, a federally qualified health center (FQHC) providing integrated primary, dental, and school-based care, and by numerous private practices and outpatient providers.

Behavioral health and substance-use needs are supported by a county-wide network of counseling centers, treatment programs, peer-support groups, harm-reduction providers, and recovery programs that deliver a continuum of services from prevention through long-term treatment. Nutrition education, WIC services, and school-based wellness programs are available throughout the county to promote healthier eating among families and children. Physical activity is supported through a mix of local fitness facilities, recreation programs, parks, and public trail systems. Maternal and child health needs are supported by public health agencies and community partners that offer home visiting, early intervention, parenting support, and specialized services for children with developmental or medical needs.

To address economic instability and housing challenges, a variety of organizations provide affordable housing development, emergency shelter, utility assistance, and case management services. Transportation is supported by both public transit and volunteer-based programs.

Workforce development efforts led by school districts, career and technical education providers, health planning organizations, postsecondary institutions, and military-connected partners are helping to build a stronger healthcare pipeline.

These assets form a solid foundation for coordinated community-driven strategies that align with New York State's Prevention Agenda.

List of Community Resources

Food and Nutrition	
Alexandria Bay Food Pantry 42975 State Rt 12, Alexandra Bay, NY 315-686-3398	Antwerp Food Pantry 45 Main St., Antwerp, NY 315-783-7527
Cape Vincent Food Pantry 159 Esselstyne St., Cape Vincent, NY 315-775-4117	Community Action Planning Council 518 Davidson St., Watertown, NY 315-782-4900
Cornell Cooperative Extension of Jeff Co. 203 North Hamilton St., Watertown NY 315-788-8450 [nutrition]	Evans Mills Food Pantry 8412 Main St., Evans Mills, NY 315-629-4458
Food Bank of Central New York 131 Washington St., Watertown, NY 315-782-8440	Gwen's Food Pantry 35923 NY State Rt 180., LaFargeville, NY 315-658-4796
Jefferson County Office for the Aging 175 Arsenal St., Watertown, NY 315-785-3191	Jefferson County Public Health Service 531 Meade St, Watertown, NY 315-786-3720
NRCIL 210 Court St. #30, Watertown, NY 315-785-8703	Philadelphia Pantry 42 Main Street, Philadelphia, NY 315-921-7925
PIVOT 167 Polk St. #320, Watertown, NY 315-788-4660	Rhode Center 2 East Church Street, Adams NY 315-232-2621
Salvation Army 723 State St, Watertown NY 315-782-4470	SNAP Outreach Coordinator Kristine Kriwax 315-437-1899 x251
St. Cecilia's Church 17 Gove St., Adams NY 315-232-2392	Vem-Food Pantry 495 S. Washington St., Carthage, NY 13619 315-493-1341
Watertown Family YMCA 146 Arsenal Street, NY 315-782-3100	Watertown Urban Mission 247 Factory St., Watertown, NY 315-782-8440

Housing	
ACR Health 210 Court Street #20, Watertown NY 315-475-2430	American Red Cross 203 N. Hamilton St., Watertown NY 315-782-4410
Army Community Services P4330 Conway Rd., Fort Drum, NY 315-772-2271	Catholic Charities 44 Public Sq., Watertown NY 315-788-4330
Central Assc. for Blind & Visually Impaired 507 Kent St., Utica NY 315-797-2233	Citi Bus 544 Newell Street., Watertown, NY 315-788-0422
Jefferson County Office for the Aging	

175 Arsenal St., Watertown NY 315-785-3191	

Clothing	
Community Action Planning Council 518 Davidson St., Watertown, NY 315-782-4900	Jefferson County DSS 250 Arsenal St., Watertown, NY 315-782-9030
Lewis County Opportunities 8265 NY-812 Lowville NY 315-376-8202	MAS Transportation (Medicaid) 1-800-932-7740
Maximizing Independent Living Choices 120 Washington Street, Watertown, NY 315-764-9442	National Grid Advocate - Aurora Navarro Aurora.Navarro@nationalgrid.com 315-263-6538
Neighbors of Watertown 112 Franklin St., Watertown, NY 315-782-8497	North Country Affordable Housing 118 Franklin St., Watertown, NY 315-785-8684
North Country Family Health Center 238 Arsenal St., Watertown NY 315-782-9450	NRCIL 210 Court St. #30, Watertown, NY 315-785-8703
Salvation Army 723 State St., Watertown NY 315-782-4470	The ARC - Jefferson site 380 Gaffney Dr., Watertown NY 315-788-2730
The Mental Health Association (Jeff County) 425 Washington, St., Watertown, NY 315-788-0970	The Spare Closet 403 Washington St., Watertown, NY 315-782-2360
Thrive Wellness and Recovery 482 Black River Parkway, Watertown, NY 315-782-1777	Town of Wilna Housing Authority 600 S. Washington Street, Carthage, NY 315-783-9192

Transportation / Utilities and Emergency Needs (Water, Gas, Electricity, Oil)	
Victims Assistance Center of Jeff Co. 418 Washington St, Watertown, NY 315-782-1823	Volunteer Transportation Center of Jeff Co. 203 N. Hamilton St., Watertown NY 315-788-0422
Watertown Housing Authority 142 Mechanic St., Watertown, NY 315-782-1251	Watertown Vet Center 1511 Washington St., Suite A Watertown NY 315-782-5479

Child Care	
Army Community Services P4330 Conway Rd., Fort Drum 315-772-6557	Benchmark Family Services 1635 Ohio Street, Watertown, NY 315-786-7285
Community Action Planning Council 518 Davidson Street, Watertown, NY	Cornell Cooperative Extension of Jeff. Co 203 Hamilton St., Watertown, NY

315-782-4900	315-788-8450
Disabled Persons Action Organization 617 Davidson St., Watertown, NY 315-782-3577	Exceptional Kidz Rehabilitation 26121 US-11, Evans Mills, NY 315-221-5101
Jefferson County DSS 250 Arsenal St., Watertown, NY 315-782-9030	The Arc of Jeff Co. 420 Gaffney Dr., Watertown, NY 315-788-2730
YMCA 146 Arsenal Street, Watertown, NY 315-782-3100	

Personal Safety	
ACR Health 120 Washington St., Watertown, NY 315-785-8222	CHJC Community Clinic of Jefferson County 211 JB Wise, Watertown, NY 315-782-7445
DPAO 617 Davidson St., Watertown, NY 315-782-3577	Family Counseling Service of NNY, Inc. 531 Washington St., Watertown NY 315-782-4483
North Country Family Health Center 238 Arsenal St., Watertown NY 315-782-9450	NRCIL 210 Court St. #30, Watertown, NY 315-785-8703
Thrive Wellness and Recovery 482 Black River Parkway, Watertown, NY 315-782-1777	UP! Coalition 7714 Number Three Rd., Lowville, NY 315-376-2321
Victims Assistance Center of Jeff Co. 418 Washington St, Watertown, NY 315-782-1823	

Finances	
ACR Health 120 Washington St., Watertown, NY 315-785-8222	Army Community Services P4330 Conway Rd., Fort Drum NY 315-772-6557
Catholic Charities 44 Public Sq., Watertown NY 315-788-4330	Community Action Planning Council 518 Davidson St., Watertown NY 315-782-4900
Fidelis Care 101 East Main Street, Gouverneur, NY 315-350-0696	Jefferson County DSS 250 Arsenal St., Watertown, NY 315-782-9030
North Country Prenatal Perinatal Council 200 Washington St., Watertown, NY 315-788-8533	NRCIL 210 Court St. #30, Watertown, NY 315-785-8703
Salvation Army 723 State St., Watertown NY 315-782-4470	Watertown Urban Mission 247 Factory St., Watertown, NY 315-782-8440

Other (Literacy, Self-Care, Family Services)	
Benchmark Family Services 1635 Ohio Street, Watertown, NY 315-786-7285	Central New York Health Home Network (HEALTH HOMES) call 1-855-784-1262 to enroll
CHJC Community Clinic of Jefferson County 211 JB Wise, Watertown, NY 315-782-7445	Family Counseling Service of NNY, Inc. 531 Washington St., Ste. 4124, Watertown NY 315-782- 4483
For members: Fidelis Care 101 East Main Street, Gouverneur, NY 315-350-0696	HCR Home Care 6007 Fair Lakes Rd., E. Syracuse, NY 315-280-0681
Hospice of Jefferson County 1398 Gotham St., Watertown NY 315-788-7323	Lewis County Public Health 7785 N. State St., Lowville, NY 315-376-5433
Literacy of NNY – Jefferson Co. 200 Washington St., Ste. 303, Watertown, NY 315-782-4270	Mental Health Associates 425 Washington Street, Watertown, NY 315-788-8092
North Country Family Health Center 238 Arsenal St., Watertown NY 315-782-9450	North Country Prenatal Perinatal Council 200 Washington St., Watertown, NY 315-788-8533
Northern NY Cerebral Palsy Association 714 Washington Street, Watertown, NY 315-788-9186	NRCIL 210 Court St. #30, Watertown, NY 315-785-8703
PIVOT 167 Polk St. #320, Watertown, NY 315-788-4660	Salvation Army 723 State St., Watertown NY 315-782-4470
Thrive Wellness and Recovery 482 Black River Parkway, Watertown, NY 315-782-1777	UP! Coalition 7714 Number Three Rd., Lowville, NY 315-376-2321

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Community CHIP/CSP

Major Community Health Needs

Social and Economic Barriers

Ongoing challenges were identified related to income, employment, housing, food access, and transportation that affect residents' ability to maintain good health. Many households experience financial strain and difficulty meeting basic needs, which contributes to poorer health outcomes. There is a need to implement more consistent screening and referral processes to better identify and address these underlying social and economic factors that influence health.

Similarly, many families in Jefferson County face social and economic stressors that can affect family well-being and maternal and child health. There is a need to enhance early, evidence-based home-based supports to strengthen parenting skills, promote healthy child development, and connect families to community resources that improve long-term outcomes.

Suicide Prevention and Community Readiness

Mental health remains a major concern in the county, with residents reporting high levels of stress and emotional distress. Suicide continues to be an increasing issue, and there is a need to increase public awareness, training, and capacity to recognize and respond to individuals who may be at risk.

Similarly, while crisis services are available, awareness and understanding of how to access immediate help remain limited. There is a need to increase visibility and understanding of the 988 Suicide and Crisis Lifeline, and local crisis hotline. There is also a need to better leverage the Community School Liaison Program and the newly established Mobile Crisis Team to strengthen early identification, intervention, and coordinated response to youth experiencing mental health challenges.

Tobacco and Nicotine Use

Tobacco and nicotine use, including vaping among youth, continue to be significant local health issues. These behaviors contribute to chronic disease and addiction. Community education and cessation promotion remain important to reduce use and prevent initiation, especially among young people.

Perinatal Mental Health

Persistent gaps in early prenatal care, postpartum mental health, and preventive care for children continue to affect families in Jefferson County. The county's growing mental health needs, combined with a relatively young population of mothers and higher levels of poverty and financial strain, make maternal and child health a key area of concern. There is a need to strengthen perinatal depression screening during pregnancy and after birth and to expand outreach and connection to support services for families.

Chronic Disease Disparities and Community Input

Rates of hypertension, obesity, and chronic disease remain above state goals. Partners noted a decline in participation in prevention and self-management programs since the COVID-19 pandemic and the increased use of GLP-1 medications for diabetes and weight management. A coordinated effort to

identify underlying causes of this decline will help to reboot community engagement by elevating resident voices to better understand participation barriers and ensure programs are accessible to those who need them most.

Oral Health Education and Prevention

Preventive dental care utilization remains low among Medicaid-enrolled children and adults, even as oral health problems continue to drive emergency visits. Preventive oral health care is underutilized, and public awareness of early prevention and risk reduction needs to be improved. Increasing access to information about oral health can promote better oral health outcomes.

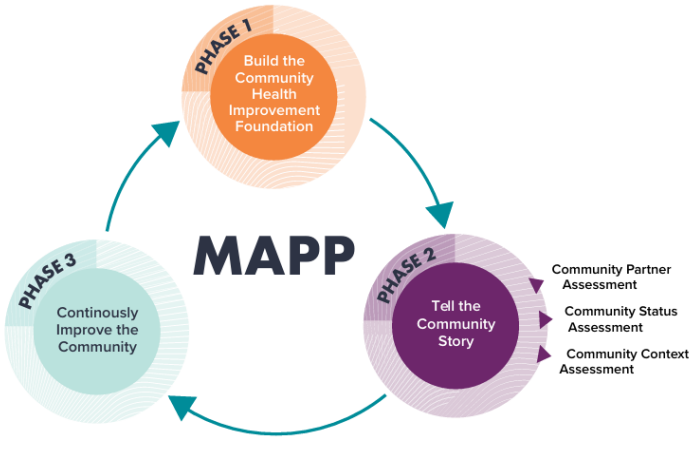
School Mental Health and Social-Emotional Learning

Schools are increasingly recognizing the importance of mental health and emotional well-being in student success. High rates of chronic absenteeism and increasing behavioral health concerns among youth highlight the need for school-based interventions. Expansion of age-appropriate mental health and wellness programs with help to strengthen coping skills and emotional support for students. There is a need to expand access to social-emotional learning programs and ensure that students have consistent, age-appropriate mental health support.

Prioritization Methods

Description of Prioritization Process

The Jefferson County Community Health Assessment (CHA), Community Health Improvement Plan (CHIP), and Community Service Plan (CSP) are guided by the principles of the MAPP 2.0 framework, which stands for Mobilizing for Action through Planning and Partnerships. MAPP 2.0 is a community health improvement framework developed by the National Association of County and City Health Officials (NACCHO) and produced with funding support from the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). This collaborative approach helps stakeholders improve health and advance equity by bringing together public health agencies, hospitals, and other partners to identify local needs, set priorities, and implement evidence-based strategies. MAPP 2.0 is flexible and adaptable, allowing each community to tailor the process based on existing partnerships, capacity, and readiness.



Jefferson County entered this planning cycle with a strong collaborative foundation already in place. Long-standing partnerships among local health departments, hospitals, and regional organizations provided an established foundation for county stakeholders to collaborate. The county continues to leverage both regional and local partnerships to support ongoing community health improvement. The regional Population Health Committee, which has been in existence since 2013, serves as the collaborative body for Jefferson, Lewis, and St. Lawrence Counties. This committee includes the directors of all three county health departments along with representatives from hospitals, clinics, schools, community-based organizations, behavioral health providers, Fort Drum military installation, and other relevant partners. Facilitated by FDRHPO, the group meets monthly and provides a consistent venue for stakeholders to share data and resources, discuss emerging issues, and coordinate strategies to address both county and regional health priorities. The committee also supports the development of the annual Community Health Survey, assists with qualitative research efforts, and helps align the CHA, CHIP, and CSP processes across counties.

A Jefferson County sub-committee of the regional Population Health Committee meets monthly, and more frequently during the CHA/CHIP/CSP planning cycle, to develop and implement the Jefferson County plan. County partners analyzed the Community Health Assessment (CHA) and identified community health needs, service gaps, and areas for improvement. Using this information, the group engaged in a prioritization process to determine which health needs warranted the greatest attention. Partners participated in a series of facilitated discussions to examine each identified issue in relation to the nature and extent of the need, existing disparities, feasibility, and potential for meaningful impact. Members discussed each factor and used a consensus-based approach to narrow the list to those priorities that offered the greatest opportunity for improvement. To support this process, partners used a shared Excel worksheet that lists potential priorities and interventions. This living document is updated collaboratively, allowing partners to document whether an intervention is already being implemented, could potentially be implemented, or is currently in place but could be enhanced. The worksheet also tracks whether relevant data are available to measure progress and report performance outcomes. Maintaining this shared tool helps ensure transparency, alignment across organizations, and consistent monitoring of progress toward CHIP/CSP goals.

This process served as the transition between assessment and planning. It allowed partners to move from data interpretation to action planning by focusing on the most pressing issues and aligning available resources and services to address them.

Additionally, the three county CHA/CHIP/CSP groups that make up the North Country region (Jefferson, Lewis, and St. Lawrence Counties), participated in a sharing session at one of our monthly Population Health Committee meetings. During this session, each county group shared the priorities and interventions being planned for their respective CHIP/ CSP. This regional discussion provided an opportunity for partners to exchange information, identify common themes, and explore ways to share resources and expertise to support coordinated implementation across the region. After the Jefferson County planning group identified and refined its proposed priorities, the findings were presented to public health and hospital leadership for review and feedback. This provided an opportunity for

additional input and helped ensure that the final priorities and strategies aligned with both community needs and organizational capacity.

The final priorities and interventions emerged from this process and formed the foundation of the Jefferson County CHIP/CSP.

Community Engagement

The CHIP/CSP process was conducted collaboratively by the local health department, and county hospitals, with support from local schools, partnering CBOs, and FDRHPO. Collaboratives were facilitated by FDRHPO through our regional population health committee (North Country Health Compass Partners). Partners were engaged throughout the process to ensure that diverse perspectives and populations were consistently represented.

Community engagement occurred through several strategies:

- Community Health Survey: Facilitated by FDRHPO and distributed to nearly 1,500 residents to gather input on health behaviors, access to care, and perceived community needs. Responses were analyzed and cross-tabulated to identify disparities and were shared with regional partners to inform discussions and planning.
- Key Informant Interviews: Conducted with community leaders, healthcare providers, school officials, behavioral health professionals, and social service agencies to gain deeper insight into local challenges, resource gaps, and opportunities for improvement.
- Standing Committees and Workgroups: Existing committees and workgroups, including the Population Health Committee, Behavioral Health Committee, Healthcare Workforce Committee, and the Jefferson County CHA/CHIP/CSP Workgroup, reviewed data and findings, provided feedback, and helped ensure that priorities reflected the needs of the community and the capabilities of stakeholders to implement potential interventions.
- Partner Collaboration: Preliminary findings and potential priorities were presented to public health, hospital, and community-based organization partners for review and feedback, ensuring that the final assessment reflected the needs of all county residents, with particular attention to populations experiencing disparities.

CHA findings were shared with community partners through presentations at committee meetings, workgroup sessions, and stakeholder board meetings. Partners were asked to review findings, and provide feedback. Relevant feedback from these discussions was incorporated into the final CHA narrative.

The CHIP/CSP priorities were selected through a collaborative, data-informed, and transparent process involving all CHIP/CSP Workgroup partners. The CHIP/CSP Workgroup then reviewed CHA findings against the 2025–2030 NYS Prevention Agenda framework. Partners evaluated potential priorities and interventions using the following criteria:

- Identified need and disparities
- Feasibility of implementation and available resources

- Alignment with existing initiatives
- Ability to measure progress and impact

Through facilitated workgroup sessions, and follow-up discussions, members narrowed down the list of potential interventions to those that best reflect community need and stakeholder capacity. Community perspectives gathered through the community health survey and focus groups helped guide which populations and issues were targeted, ensuring the final plan addressed both the most pressing health issues and the underlying social determinants of health affecting local residents.

Justification for Unaddressed Health Needs

While many health needs were identified through the Community Health Assessment, not all could be included as formal CHIP/CSP priorities. The selected priorities and interventions represent areas where partners determined there was both significant community need and sufficient capacity to make measurable progress during this cycle. Additional work continues across multiple areas of community health through public health, hospital, and community-based organization efforts. The decision not to include certain needs in the CHIP/CSP does not indicate that these issues are unimportant, but rather that they are being addressed through other ongoing programs, partnerships, and initiatives outside the formal plan.

Developing Objectives, Interventions, and an Action Plan

Alignment with Prevention Agenda

The CHIP/CSP was developed in alignment with the 2025–2030 New York State Prevention Agenda. In accordance with state guidance, partners selected seven Prevention Agenda priorities, including two addressing the Social Determinants of Health. Each selected priority includes one or more objectives from the official Prevention Agenda framework, with at least two identified as SMARTIE objectives to ensure that they are specific, measurable, achievable, realistic, time-bound, inclusive, and equitable.

The selection process emphasized reducing health disparities and inequities by identifying where needs are greatest and tailoring interventions and resources to those communities. This approach ensures that the CHIP/CSP aligns with statewide goals while remaining responsive to the unique needs, capacities, and opportunities within the county. All interventions were chosen directly from the Prevention Agenda's recommended list of interventions with the exception of the following:

Local Intervention: Promote Awareness and Utilization of a County Mobile Crisis Team (MCT) and Hotline

NYS OMH, Jefferson County Community Services, and Lewis County Community Services identified a need for enhanced, coordinated crisis response services to improve timely access to behavioral health care and reduce reliance on law enforcement or emergency departments during behavioral health emergencies. To address this need, Jefferson and Lewis Counties jointly contracted with the Children's Home of Jefferson County (CHJC) to operate a Mobile Crisis Team (MCT) and Hotline providing 24/7 response to community members in both counties. This locally developed intervention was added because no comparable intervention exists within the Prevention Agenda. Promoting awareness and appropriate use of the Mobile Crisis Team and Hotline will ensure residents and providers understand

how to access behavioral health crisis services and will strengthen coordination across local systems of care.

This intervention was developed in response to needs identified by NYS OMH, Jefferson County Community Services, and Lewis County Community Services. Both counties continue to experience suicide rates above state benchmarks and increasing reports of mental health concerns, as documented in the Community Health Assessment. Unlike most New York counties, Jefferson and Lewis did not previously have a dedicated mobile crisis team, and OMH has emphasized expanding this resource statewide. The rural geography and transportation barriers across the region further limit timely access to behavioral health care, reinforcing the need for a coordinated, local crisis response system.

The Mobile Crisis Team complements the 988 Suicide and Crisis Lifeline by serving as the local in-person response when a situation requires face-to-face intervention. While 988 functions as a state-managed communication hub, calls that require an in-person response are routed to CHJC's team, ensuring one coordinated system. This integrated structure strengthens local capacity, and ensures residents receive timely, on-site behavioral health support from trained professionals.

This intervention aligns with the Social and Community Context domain within the Suicide Prevention priority, as it strengthens community response networks, promotes connection to care during behavioral health crises, and enhances coordination among crisis services, law enforcement, and local providers to prevent suicide and improve timely access to services. The overall objective is to improve access to and utilization of the Jefferson/Lewis Mobile Crisis Team by increasing timely crisis responses and ensuring consistent follow-up and linkage to behavioral health services for individuals experiencing a behavioral health crisis. The desired outcome is improved access to behavioral health crisis services and consistent, timely response for residents.

The intervention serves individuals of all ages in Jefferson and Lewis Counties experiencing behavioral health crises, with particular attention to youth, adults with co-occurring substance use disorders, and residents in rural areas with limited access to behavioral health care. Progress will be measured by the number of crisis calls received and responded to and the number of individuals receiving follow-up services. Data will come from CHJC program records reported to Jefferson and Lewis County Community Services and FDRHPO, including telephonic triage logs, mobile response records, and follow-up documentation. Baseline data will be established from CHJC reports following implementation in 2026, and 2030 targets will be determined once the baseline is available, with the goal of achieving consistent, timely crisis response and follow-up for all residents.

Action Plan

Priority: Poverty	
Entities Action and Impact:	There are two interventions for this priority. For the first intervention, Samaritan Medical Center, Carthage Area Hospital, and River Hospital will implement a standardized Social Determinants of Health (SDOH) screening process within their inpatient settings to identify patients experiencing challenges such as low income, unemployment, housing instability, and more. The hospitals will incorporate the screening into admission or discharge workflows, train staff to administer it, and connect patients with unmet social needs to appropriate community resources and support services. This work will be supported by Jefferson County Public Health Service and local CBOs that can assist with follow-up and navigation. The goal is to improve the identification of social needs, strengthen stakeholder collaboration, and reduce health disparities. For the second intervention, the North Country Prenatal Perinatal Council (NCPPC) will lead efforts to promote and strengthen participation in family-based prevention and home-visiting programs such as Healthy Families (OCFS). The goal of this intervention is to connect more families, especially those living in poverty, to evidence-based home-visiting programs that provide parenting education, early child-development support, and linkage to health and social services. Jefferson County has a young population of mothers, high rates of poverty and ALICE households, and lower participation in home-visiting programs. Increasing enrollment will help connect more families to early support, parenting education, and community resources that promote healthy child development and family stability.
Geographic Focus:	The priority focuses on Jefferson County residents, particularly individuals and families living in poverty or part of the ALICE population.
Resource Commitment:	For the first intervention, resources committed include staff time and data collection, integration of screening tools into hospital information systems, and coordination with local partners to ensure appropriate referrals and outcome tracking. Each hospital will contribute in-kind staff and infrastructure support. For the second intervention, the North Country Prenatal Perinatal Council (NCPPC) will provide program staff, supervision, and administrative support needed to operate and expand participation in the Healthy Families program. Resources include staff time for outreach, enrollment, home visits, and data tracking, as well as program materials and coordination with referral sources.
Participant Roles:	For the first intervention, Jefferson County Public Health Service and FDRHPO will assist hospitals with coordination, data review, and quality improvement to strengthen referral and follow-up systems. Hospital staff will identify patient needs and initiate referrals to community resources. Community-based organization, including human service

	agencies, food assistance programs, housing and employment services, and behavioral health providers, will receive referrals and provide direct support to address identified social needs. For the second intervention CHIP/CSP partners and relevant stakeholders will provide support for referrals and promotion to help NCPPC reach more families.
Health Equity:	By prioritizing patients with the greatest economic barriers, the first intervention directly advances health equity, ensuring that residents facing poverty are systematically identified, supported, and connected to the resources necessary for better health and overall stability. The second intervention will help address health disparities by expanding access to proven, evidence-based programs for families who face the greatest economic and social challenges.

Priority: Suicide	
Entities Action and Impact:	Jefferson County Community Services, the County Suicide Prevention Coalition, the Fort Drum Regional Health Planning Organization (FDRHPO), the North Country Prenatal Perinatal Council (NCPPC), Pivot, and the North Country Family Health Center (NCFHC) will collaborate to expand access to Mental Health Awareness Training throughout Jefferson County. The goal is to increase the number of community members and professionals who are trained to recognize and respond to individuals who may be at risk for suicide, with a particular focus on youth and young adults. Stakeholders will offer evidence-based trainings that include Adult Mental Health First Aid (AMHFA), Youth Mental Health First Aid (YMHFA), QPR (Question, Persuade, Refer), Link to Hope, ASIST (Applied Suicide Intervention Skills Training), and CALM (Counseling on Access to Lethal Means). Trainings will be offered throughout the community prioritizing schools, youth-serving organizations, community groups, health care providers, and other partners who regularly interact with adolescents and young adults. In addition, partners will work collectively to increase awareness and utilization of the 988 Suicide and Crisis Lifeline and the newly established Mobile Crisis Team (MCT) operated by the Children's Home of Jefferson County (CHJC) in collaboration with Jefferson County Community Services and county law enforcement. Through coordinated outreach, social media, and distribution of informational materials in community and healthcare settings, these efforts aim to ensure residents know how to access immediate crisis support and strengthen the county's overall response to behavioral health emergencies.
Geographic Focus:	The geographic focus will include all of Jefferson County, with priority given to areas where access to behavioral health services is limited.
Resource Commitment:	Resource commitments include staff time from each participating organization to deliver, promote, and coordinate services and resources. FDRHPO will dedicate resources to facilitate coordination, scheduling,

	and data tracking across all partners sites to ensure consistent reporting.
Participant Roles:	Jefferson County Community Services and the Suicide Prevention Coalition will lead overall planning and alignment with the county's suicide prevention strategy. The Suicide Prevention Coalition, FDRHPO, NCPPC, Pivot, and NCFHC will coordinate and deliver evidence-based trainings throughout the community. The Children's Home of Jefferson County (CHJC) will oversee operation and promotion of the Mobile Crisis Team (MCT) in coordination with Jefferson County Community Services. All partners, including law enforcement, will collaborate to promote awareness and utilization of the 988 Suicide and Crisis Lifeline and the Mobile Crisis Team Hotline through coordinated outreach and community education efforts.
Health Equity:	This priority addresses health equity by targeting populations disproportionately affected by suicide risk, particularly adolescents and young adults. Interventions under this priority will equip more community members with skills to recognize warning signs and connect individuals to help. These initiatives help overcome stigma, promote early identification of risk, and strengthen the community's overall capacity to prevent suicide and respond to mental health crises. By promoting awareness of both the 988 Suicide and Crisis Lifeline and the local Mobile Crisis Team Hotline, the intervention also improves equitable access to timely crisis response services, especially for individuals who may face barriers to traditional care or lack knowledge of available supports.

Priority: Tobacco/E-Cigarette Use	
Entities Action and Impact:	Pivot and the Youth Alliance of Jefferson County will lead this community-based intervention to increase awareness of the harms of tobacco and vaping and to promote cessation supports among both youth and young adults. Using Prevention Needs Assessment (PNA) survey data, partners will identify local patterns of youth nicotine and vape use and share findings with schools, stakeholders, and community members to drive data-informed action. Activities will include holding an annual summit that engages stakeholder, including youth, to share information, gather input, and strengthen community awareness. Outreach efforts will feature school-based education, poster and banner campaigns, social media promotions, a countywide youth video competition focused on vaping prevention, and a nicotine- and vape-free pledge initiative. Pivot will also develop a GIS map of tobacco retail outlets to visualize their proximity to alcohol outlets and youth-centered spaces, and collaborate with pediatric providers to encourage routine screening for tobacco and vaping use during sports physicals and other visits. Clinics will be encouraged to promote cessation services and connect patients to treatment resources.
Geographic Focus:	The geographic focus will include all Jefferson County residents with a focus on youth and young adults.

Resource Commitment:	Resource commitments include staff time and materials from Pivot and the Youth Alliance for program coordination, education campaigns, and community engagement. FDRHPO and Jefferson County Public Health Service will assist with data analysis, promotion, and distribution of educational materials. Partners will provide in-kind support such as meeting space, printing, and technical assistance for outreach and mapping activities. Participating hospitals and clinics will review their existing tobacco cessation policies and workflows to assess how consistently screening, counseling, and referral practices are being implemented.
Participant Roles:	Pivot and the Youth Alliance will lead program implementation, youth engagement, and education campaigns. Jefferson County Public Health Service and FDRHPO will support coordination and data sharing, and facilitate connections with clinical partners. Hospitals, pediatric practices, and community health centers will review and enhance cessation workflows, incorporate screening for tobacco and vaping use, and connect patients to cessation resources. Schools and youth-serving organizations will host prevention activities and encourage youth participation in awareness campaigns.
Health Equity:	The intervention addresses nicotine addiction and exposure among youth and residents with limited access to prevention and cessation resources. This reduces early nicotine use, particularly among youth and those living in poverty.

Priority: Prevention of Infant and Maternal Mortality	
Entities Action and Impact:	Multiple Jefferson County partners, including hospitals, hospital clinics, public health, and community-based organizations, will implement standardized screening for depression among perinatal and postpartum individuals using validated tools such as the Edinburgh Postnatal Depression Scale (EPDS) and PHQ-2 or PHQ-9. Screenings will occur at key points during the perinatal period to identify depressive symptoms early and connect individuals to appropriate follow-up care and support. Participating organizations will track the number of people screened and, when possible, the number referred for further evaluation or services. The objective focuses on reducing depressive symptoms before and after birth by strengthening early identification and referral systems across clinical and community settings.
Geographic Focus:	Birthing persons in Jefferson County.
Resource Commitment:	Participating hospitals, clinics and community-based organizations will commit staff time for screening, documentation, and referral follow-up. The CHIP/CSP Workgroup will provide assistance with data collection. Resources include staff time to administer and record screening results, staff training on tool use, and data tracking for performance monitoring.
Participant Roles:	Screenings will take place at key points during the perinatal period, including intake and postpartum visits, across participating healthcare locations. The North Country Family Health Center will incorporate screening into primary care encounters, while the North Country

	Prenatal Perinatal Council will conduct screenings within its family-support and home-visiting programs. Jefferson County Public Health Service will screen live births using the 1115 waiver questions, and mothers referred to Certified Home Health Agencies will complete the Edinburgh screening. Behavioral health providers and community organizations will serve as referral destinations for individuals identified as needing further evaluation or support.
Health Equity:	This intervention promotes health equity by increasing early identification of depression during pregnancy and postpartum among young adults who may face barriers to mental healthcare services.

Priority: Prevention Services for Chronic Disease Prevention and Control	
Entities Action and Impact:	Jefferson County Public Health Service will lead a coordinated effort to re-engage residents in chronic disease prevention and management programs by leveraging community feedback to identify barriers, solutions, and innovations that can help reduce disparities. This initiative will explore the underlying causes of declining participation and develop strategies to ensure that those who most need these programs are able to access and benefit from them. The effort will leverage existing infrastructure by identifying and mapping chronic disease programs already underway. Community input will be gathered through listening sessions, focus groups, and informal discussions held in partnership with hospitals, faith-based organizations, and community groups where residents already meet. Efforts will prioritize hearing from individuals living with or at risk for chronic conditions, especially those who have faced barriers to participating in local programs. Insights gathered from these conversations will guide efforts to increase participation and strengthen program delivery. The overall goal is to move beyond the current status quo by improving access and implementation of chronic disease programs using community feedback as the foundation for change.
Geographic Focus:	This initiative will focus on reaching residents in Jefferson County who are affected by chronic disease and who may face barriers to participation in prevention and management programs.
Resource Commitment:	Jefferson County Public Health Service will commit staff time to coordinate engagement sessions, analyze community feedback, and communicate findings to partners. Partner organizations will contribute in-kind support such as meeting space, facilitation, and outreach through their existing networks.
Participant Roles:	Jefferson County Public Health Service will coordinate and facilitate the initiative. Hospitals, community-based organizations, and wellness coalitions will help identify participants, host engagement activities, and apply feedback to strengthen their chronic disease programs. Community members will contribute their experiences and perspectives to help identify practical, equitable solutions to improve participation.
Health Equity:	By directly engaging those most affected by chronic conditions and the barriers that limit participation, this intervention advances health equity

	by ensuring that programs are accessible, inclusive, and responsive to community needs, particularly for populations disproportionately impacted by these diseases.

Priority: Oral Health Care	
Entities Action and Impact:	Jefferson County Public Health Service will lead the development and maintenance of a comprehensive oral health education page on its website, in collaboration with the Keep the North Country Smiling (KNCS) coalition. The webpage will provide evidence-based information on the importance of oral health beginning during pregnancy, early caries prevention through nutrition, the benefits of fluoride varnish application in primary care settings, the benefits of fluoridated water, and the risks and early detection of oral cancer. The page will serve as a central hub for educational materials, local resources, and preventive care messaging. The coalition will guide content updates and promote the page through partner networks to ensure that accurate and consistent information reaches residents, providers, and community organizations. The anticipated impact is increased public awareness and improved understanding of preventive oral health practices across all ages.
Geographic Focus:	This intervention will reach all residents of Jefferson County, with particular outreach to young Medicaid enrollees.
Resource Commitment:	Public Health will provide staff time to develop, publish, and update the webpage and coordinate KNCS input. KNCS will contribute time to conduct regular coalition meetings and review and update content.
Participant Roles:	Public Health is the lead agency for webpage development, publishing, and coordination. The KNCS coalition will support implementation by reviewing content, guiding promotional efforts, and assisting with updates.
Health Equity:	This intervention promotes health equity by making oral health information easily accessible and relevant to all residents, including those with limited access to dental care. By emphasizing prevention and early detection, the initiative supports better outcomes for populations at higher risk. This helps reduce disparities in oral health across Jefferson County.

Priority: Health and Wellness Promoting Schools	
Entities Action and Impact:	Pivot will lead implementation of Second Steps, a social emotional learning (SEL) curriculum, in select Jefferson County schools. In addition, the Gizmo Project, a mental health awareness and emotional wellness program for young students, will be introduced in several schools. To assess the reach and consistency of SEL programming countywide, all districts will be asked to complete a brief SEL program survey to identify existing program offerings, program challenges, and opportunities for improvement. A new Behavioral Health Collaborative will be formed to include school representatives, the Community School Liaison Team (CSLP), and the Mobile Crisis Team (MCT). CSLP staff work directly with

	school personnel, students, and families to address emerging behavioral health needs, while the MCT provides in person crisis response when more acute intervention is required. Together, these coordinated initiatives strengthen prevention, intervention, and system level collaboration to support student well-being, build coping and communication skills, and ensure timely access to care.
Geographic Focus:	Jefferson County schools, focusing on ask-risk students, including those who are economically disadvantaged.
Resource Commitment:	Pivot will provide program coordination, staff time, and curriculum materials to support delivery of Second Steps. Gizmo activities will be led by Jefferson County Community Services and the Suicide Prevention Coalition. The Children's Home of Jefferson County (CHJC) will contribute staff time and resources through the School Community Liaison Program and the Mobile Crisis Team (MCT). BOCES will coordinate SEL survey distribution and allocate staff time to this project. Participating schools and school based health centers will dedicate staff time for planning, implementation, and integration with existing student support structures.
Participant Roles:	Pivot will coordinate overall implementation and delivery of the Second Steps curriculum in participating schools. Jefferson County Community Services and the Suicide Prevention Coalition will lead Gizmo Project activities and provide technical assistance on mental health promotion. The Children's Home of Jefferson County (CHJC) will engage through the School Community Liaison Program and Mobile Crisis Team (MCT) to support early intervention and crisis response within schools. BOCES will oversee SEL survey distribution, data collection, and coordination with participating districts. Schools and school based health centers will host program activities, provide staff participation, and integrate SEL and mental health initiatives into existing student support systems.
Health Equity:	This intervention promotes health equity by expanding access to age-appropriate mental health education and early support for students who may otherwise have limited exposure to prevention and coping resources. By integrating these programs into schools across Jefferson County, the initiative ensures consistent mental health messaging, reduces stigma, and supports equitable access to emotional wellness education for students of all backgrounds. The inclusion of the School Community Liaison Program (SCLP) and the Mobile Crisis Team (MCT), both operated by the Children's Home of Jefferson County, strengthens early identification and response for students experiencing behavioral health challenges. The SEL survey further supports equity by identifying gaps in programming and helping ensure that all districts, regardless of size or resources, have access to tools and support that promote student well-being.

Partner Engagement

Progress on the CHIP/CSP will be monitored collaboratively throughout the cycle by the CHIP/CSP Workgroup, which meets quarterly and is facilitated by the Fort Drum Regional Health Planning Organization (FDRHPO). The workgroup includes representatives from the local health department, hospitals, and key community organizations engaged in implementing the selected interventions. During these meetings, partners will review progress toward performance measures, share activity updates, and assess outcomes. FDRHPO will support this process by coordinating meetings, assisting with data collection and analysis, and documenting progress to ensure accountability and alignment with the Prevention Agenda goals.

If data or feedback indicate that goals are not being met, partners will review findings during quarterly CHIP/CSP workgroup meetings using progress updates and performance measures to identify barriers. From there the group will determine if there is a need for mid-course corrections. Adjustments may include modifying interventions, adjusting timelines, or reallocating resources to better achieve intended outcomes. All decisions will be made collaboratively to ensure the plan remains aligned with the 2025–2030 Prevention Agenda and continues to advance health equity.

Sharing Findings with Community

The Executive Summary of the CHA/CHIP/CSP will be made publicly available to ensure transparency and community awareness. Upon completion, the final plan and Executive Summary will be posted on both the Local Health Department and hospital websites, as well as the Fort Drum Regional Health Planning Organization (FDRHPO). The plan will also be shared to stakeholders at regional committee meetings. Partner organizations will be encouraged to share the report through their own communication platforms and community networks.

Printed copies will be available upon request. Updates on progress and outcomes will be shared periodically through partner meetings ensuring that community members remain informed and engaged throughout the 2025–2030 Prevention Agenda cycle.

2025-2030 Prevention Agenda Workplan

The Workplan is in Excel format. Please refer to the Excel document.

Submitting Organization			
Organization Name	**County(ies) of Service**	**Liaison Name**	**Liaison Email**
Jefferson County Public Health	Jefferson County	Steve Jennings	stevej@jeffersoncountyny.gov
Is this a joint plan? Yes/No	Yes		
Note: a joint plan is defined as submitting one Community Health Assessment and Community Health Improvement Plan for both the LHD(s) and hospital(s) within the same county.			

Participating Organization(s)			
Organization Name	**County(ies) of Service**	**Liaison Name**	**Liaison Email**
Carthage Area Hospital	Jefferson County	Bethanie Clarke	bclarke@nshany.org
River Hospital	Jefferson County	Cindy Nelson	cindynelson@riverhospital.org
Samaritan Medical Center	Jefferson County	Leslie Distefano	ldistefano@shsny.com

Economic Stability	**Instructions:** Please review the Community Health Improvement Planning Guidance for the required elements of the Community Health Improvement Plan (CHIP) and Community Service Plan (CSP): https://www.health.ny.gov/prevention/prevention_agenda/2025-2030/docs/letter_and_guidence.pdf. **Column B:** Select a priority from the dropdown menu. For new priorities NOT listed in the Prevention Agenda, first identify the appropriate SDOH domain tab, then manually enter the priority name. See page 9 of the guidance for details about adding additional priorities. **Column C:** Select an objective from the dropdown menu. To add an additional objective not in the dropdown, type it in the blank cell. See page 9 of the guidance for details about adding additional objectives not included in the Prevention Agenda. **Column D:** Enter and cite the intervention. List each intervention on a separate row; use evidence-based interventions; if not available, best or promising practices. **Column E:** List disparities the intervention addresses. **Column F:** Identify the specific metric or measure used to evaluate the intervention's implementation progress.

Domain	Priority (select one from drop down list)	Objective (select one from drop down list)	Intervention	Disparities Being Addressed	Family of Measures	Timeframe		Implementation Partner *(Please select one partner from the dropdown list per row)*	Partner Role(s) and Resources
						Start Date (mm/dd/yyyy)	Completion Date (mm/dd/yyyy)		
Economic Stability	Poverty	1.0 Reduce the percentage of people living in poverty from 13.6% to 12.5%.	Conduct regular screening of patients at the hospital for SDOH factors like income and unemployment.	Low-income individuals and families who experience higher rates of unmet social needs, which contribute to poorer health outcomes and reduced access to care.	# of patients screened for SDOH at the hospital (inpatient). # of hospitals implementing SDOH screening.	1/1/2026	12/31/2028	Hospital	Carthage Area Hospital, River Hospital, Samaritan Medical Center will provide screenings and referrals. County CBOs and Providers will provide services and resources based on screenings and referrals.
Economic Stability	Poverty	1.0 Reduce the percentage of people living in poverty from 13.6% to 12.5%.	Promote and partner with family-based prevention programs such as Healthy Families Home Visiting Programs (HFNY) offered by OCFS, Perinatal and Infant Community Health Collaborative (PICHC), and Jefferson County MCH Coordinated Intake and Referral.	Families living in poverty with limited social supports.	# familes screened for home visiting services. % referrals made for home visiting services. # of families/individuals enrolled in home visiting services	1/1/2025	12/31/2028	Community-based organizations	North Country Prenatal/Perinatal Council will screen and lead the Healthy Families Home Visiting Program, and PICHC. Jeferson County Public Health Service will promote family-based prevention programs by facilitating referrals to NCPPC home visiting programs through implementing the associated Maternal Child Health Work Plan.

Social & Community Context	**Instructions:** Please review the Community Health Improvement Planning Guidance for the required elements of the Community Health Improvement Plan (CHIP) and Community Service Plan (CSP): https://www.health.ny.gov/prevention/prevention_agenda/2025-2030/docs/letter_and_guidence.pdf. **Column B:** Select a priority from the dropdown menu. For new priorities NOT listed in the Prevention Agenda, first identify the appropriate SDOH domain tab, then manually enter the priority name. See page 9 of the guidance for details about adding additional priorities. **Column C:** Select an objective from the dropdown menu. To add an additional objective not in the dropdown, type it in the blank cell. See page 9 of the guidance for details about adding additional objectives not included in the Prevention Agenda. **Column D:** Enter and cite the intervention. List each intervention on a separate row; use evidence-based interventions; if not available, best or promising practices. **Column E:** List disparities the intervention addresses. **Column F:** Identify the specific metric or measure used to evaluate the intervention's implementation progress.

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Social & Community Context	Suicide	6.2 Reduce adolescent suicide attempts from 9.4% to 8.5% (New York State outside New York City).	Provide training for community members, organizations, and other groups to identify and respond to people who may be at risk of suicide prevention.	Adults, adolescents, and youth disproportionately affected by mental health challenges and suicide risk.	# trainings provided (YMHFA, AMHFA, QPR, ASIST, CALM, Link to Hope, Trauma-Informed). # total individuals trained. # youth-serving individuals trained (e.g. school staff). # healthcare-related stakeholders trained. # schools with a coalition. # Schools participating in Prevention Needs Assessment (PNA) Youth survey. # PNA survey reponses.	1/1/2026	12/31/2028	Community-based organizations	CBOs and Providers including Fort Drum Regional Health Planning Organization, North Country Prenatal Perinatal Council, North Country Family Health Center, and Jefferson County Community Services will provide trainings. Local schools, CBOs, Providers, Law Enforcement, Local Government, and Community Coalitions will promote and host trainings. JCPHS and Pivot will implement the Youth Substance Use and Mental Health Work Plan which includes conducting county-wide PNA surveys to students. Participating School Districts: Support and host Youth Alliance Coalition events and activities. Support youth-led mental health education, awareness, and prevention activities within their schools.
Social & Community Context	Suicide	6.0 Reduce the suicide mortality rate from 7.9% to 6.7%.	Promote calling or texting 988 through social media, digital marketing campaigns, and other utilized marketing strategies.	Individuals experiencing mental health crises or suicidal thoughts who may not know about or have access to immediate crisis support services.	# campaigns. # views. # impressions (views). # conversions (clicks). # website visits.	1/1/2026	12/31/2028	Local health department	JCPHS will lead and implement 988 promotional campaigns. Samaritan Medical Center, River Hospital, and Carthage Area Hospital will promote 988. Jefferson County Suicide Prevention Coalition, JC Community Services, Fort Drum Regional Health Planning Organization, and county CBOs will promote 988 in alignment with JCPHS campaigns.
Social & Community Context	Suicide	6.0 Reduce the suicide mortality rate from 7.9% to 6.7%.	Increase awareness and utilization of the Jefferson/Lewis Mobile Crisis Team (MCT) and Hotline through coordinated outreach, social media messaging, and distribution of informational materials across community and healthcare settings.	Individuals experiencing mental health crises or suicidal thoughts who may not know about or have access to immediate crisis support services, particularly those in rural areas or with limited transportation or behavioral health resources.	# promotional campaigns. # views, clicks. # calls received by MCT. # MCT responses. # receiving follow-up services.	1/1/2026	12/31/2028	Providers	Children's Home of Jefferson County (CHJC) will provide Mobile Crisis Team and Hotline services, along with promotion of MCT services. Law Enforcement (911 Dispatch, Sheriff's Department) will partner with CHJC and support MCT. CBOs, JCPHS, and Hospitals (including Victims Assistance Center, NRCIL, MHA, FDRHPO, Thrive, JCPH, JCCS, SMC, CAH, River) will raise awareness and promote MCT services.
Social & Community Context	Tobacco/E-Cigarette Use	14.1 Reduce the percentage of high school students who use tobacco products from 17.0% to 14.5%.	Educate residents, including school-aged youth, on the harms of tobacco and the benefits of tobacco-free treatment.	Individuals, including youth and individuals in poverty, who are disproportionately impacted by tobacco industry marketing practices and at increased risk of initiating tobacco or vaping use.	# PNA survey responses. # participating schools. # presentations. # schools with a coalition. # youth trained in coalition bldg. # coalition members. # educational media campaigns. # public awareness events.	1/1/2026	12/31/2028	Community-based organizations	CBOs (Pivot, Youth Alliance of Jefferson County): Surveying, coalition building, outreach events and marketing, and implementation of the associated JUUL Work Plan. JCPHS: tobacco/nicotine cessation marketing and promotions. School Districts: support and host Youth Alliance Coalition events and activities. Support youth-led nicotine education, awareness, and prevention activities within their schools.

Neighborhood & Built Environment	**Instructions:** Please review the Community Health Improvement Planning Guidance for the required elements of the Community Health Improvement Plan (CHIP) and Community Service Plan (CSP): https://www.health.ny.gov/prevention/prevention_agenda/2025-2030/docs/letter_and_guidence.pdf. **Column B:** Select a priority from the dropdown menu. For new priorities NOT listed in the Prevention Agenda, first identify the appropriate SDOH domain tab, then manually enter the priority name. See page 9 of the guidance for details about adding additional priorities. **Column C:** Select an objective from the dropdown menu. To add an additional objective not in the dropdown, type it in the blank cell. See page 9 of the guidance for details about adding additional objectives not included in the Prevention Agenda. **Column D:** Enter and cite the intervention. List each intervention on a separate row; use evidence-based interventions; if not available, best or promising practices. **Column E:** List disparities the intervention addresses. **Column F:** Identify the specific metric or measure used to evaluate the intervention's implementation progress.

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Healthcare Access & Quality	**Instructions:** Please review the Community Health Improvement Planning Guidance for the required elements of the Community Health Improvement Plan (CHIP) and Community Service Plan (CSP): https://www.health.ny.gov/prevention/prevention_agenda/2025-2030/docs/letter_and_guidence.pdf. **Column B:** Select a priority from the dropdown menu. For new priorities NOT listed in the Prevention Agenda, first identify the appropriate SDOH domain tab, then manually enter the priority name. See page 9 of the guidance for details about adding additional priorities. **Column C:** Select an objective from the dropdown menu. To add an additional objective not in the dropdown, type it in the blank cell. See page 9 of the guidance for details about adding additional objectives not included in the Prevention Agenda. **Column D:** Enter and cite the intervention. List each intervention on a separate row; use evidence-based interventions; if not available, best or promising practices. **Column E:** List disparities the intervention addresses. **Column F:** Identify the specific metric or measure used to evaluate the intervention's implementation progress.

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Healthcare Access & Quality	Prevention of Infant and Maternal Mortality	29.0 Decrease percentage of birthing persons who experience depressive symptoms after birth from 11.9% to 9.9%.	Provide mental health screenings to prenatal and post-partum patients using validated tools: - Edinburgh Postnatal Deppresion Scale screening (EPDS) - PHQ-2 / PHQ-9 Depression Screenings	Birthing persons, especially those more susceptible or at risk of mental illnesses or disorders associated with pregnancy or postpartum.	# people screened (EPDS). # people screened (PHQ). # referrals made.	1/1/2026	12/31/2028	Hospital	Samaritan Medical Center, and Carthage Area Hospital will conduct screenings and provide referrals. JCPHS and North Country Prenatal/Perinatal Council will conduct screenings and provide referrals.
Healthcare Access & Quality	Preventative Services for Chronic Disease Prevention and Control	32.0 Increase the percentage of adults aged 18 years and older with hypertension who are currently taking medication to manage their high blood pressure from 77.0% to 81.7%.	Include community voices in identifying changes, solutions, and innovations needed to address disparities.	Adults who are candidates for self-management and prevention programs, with limited knowledge of, or access to, services and resources.	# Focus groups. # Key-informant interviews (KIIs). # Survey responses. Key findings/barriers identified. List of existing services created.	1/1/2026	12/31/2028	Local health department	JCPHS will conduct key-informant interviews, info sessions, focus group sessions, and surveys. They will also identify existing prevention and self-management programs in the county. FDRHPO: support JCPHS with qualitative research analysis and identification and promotion of existing programs.
Healthcare Access & Quality	Oral Health Care	34.1 Increase the percentage of Medicaid enrollees aged 2-20 years with at least one preventive dental visit within the last year from 39.1% to 41.1%.	Develop page dedicated to oral health on LHD websites which provides education on: - The importance of oral health beginning during pregnancy. - The benefits of fluoride varnish application in the primary care physician (PCP) office at well childcare visits. - The benefits of fluoridated water.	County residents with low oral-health literacy and barriers to preventive dental care, including Medicaid-enrolled families, rural households, and those who are less likely to receive and act on preventive oral-health information.	Existence of Oral Health Coalition to inform oral health initiatives. An Oral Health Coalition Active Workplan. # Coalition meetings per year. # workplan deliverables met. Existence of local health department oral health webpage. # website visits, views.	1/1/2026	12/31/2028	Local health department	JCPHS will develop, host and maintain an oral health website, as part of the implementation of the the associated Keep the North Country Smiling Coalition Work Plan. Keep the North Country Smiling Oral Health Coalition will promote the website, and inform website content.

Education Access & Quality	**Instructions:** Please review the Community Health Improvement Planning Guidance for the required elements of the Community Health Improvement Plan (CHIP) and Community Service Plan (CSP): https://www.health.ny.gov/prevention/prevention_agenda/2025-2030/docs/letter_and_guidence.pdf. **Column B:** Select a priority from the dropdown menu. For new priorities NOT listed in the Prevention Agenda, first identify the appropriate SDOH domain tab, then manually enter the priority name. See page 9 of the guidance for details about adding additional priorities. **Column C:** Select an objective from the dropdown menu. To add an additional objective not in the dropdown, type it in the blank cell. See page 9 of the guidance for details about adding additional objectives not included in the Prevention Agenda. **Column D:** Enter and cite the intervention. List each intervention on a separate row; use evidence-based interventions; if not available, best or promising practices. **Column E:** List disparities the intervention addresses. **Column F:** Identify the specific metric or measure used to evaluate the intervention's implementation progress.

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Education Access & Quality	Health and Wellness Promoting Schools	41.1 Decrease the percentage of chronic absenteeism (defined as missing more than 18 days (>10%) per academic year) among public school students in grades K-8 who are economically disadvantaged from 34.9% to 24.4%.	Improve the utilization and availability of age-appropriate mental health well-being programs throughout Pre-K to 12th grade through partnerships with mental health service providers.	Students experiencing social, economic, or mental-health challenges that place them at higher risk for chronic absenteeism and lower academic engagement.	# schools offering Second Steps (SEL curriculum). # children served by Second Steps program. # schools offering Gizmo mental wellness curriculum. # children served by Gizmo curriculum. # schools completing SEL survey. # Community School Liaison Program (CSLP) and Mobile Crisis Team (MCT) school-linked responses. Formation of Mental Health Collaborative. # Mental Health Collaborative meetings held.	1/1/2026	12/31/2028	Providers	Children's Home of Jefferson County (CHJC) will provide School Community Liaisons and MCT Services. County schools will host SEL programs, and collaborate with CHJC and the Mental Health Collaborative. Pivot and the Jefferson County Suicide Prevention Coalition will deliver SEL program instruction, supporting the implementation of Pivot's mental health and substance use workplan.