DUTCHESS COUNTY
COMMUNITY HEALTH IMPROVEMENT PLAN
2025 – 2030

Dutchess County Department of Health

LOCAL HEALTH DEPARTMENT

DUTCHESS COUNTY DEPARTMENT OF HEALTH

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This document details an individual Community Health Improvement Plan for Dutchess County, submitted by the Dutchess County Department of Health.

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EXECUTIVE SUMMARY

The Dutchess County Community Health Improvement Plan (CHIP) for 2025–2030 provides a coordinated roadmap to improve health outcomes and reduce disparities across the county. Developed by the Dutchess County Department of Health (DCDOH) in partnership with community organizations, residents, and regional stakeholders, the CHIP is grounded in the New York State Prevention Agenda and informed by extensive quantitative and qualitative data. Together, these sources illustrate the most pressing health challenges facing Dutchess County and guide a focused set of actions through 2030.

Three priorities emerged through the review of over 100 indicators from a variety of sources including, but not limited to, the New York State Behavioral Risk Factor Surveillance System, New York Statewide Planning and Research Cooperative System, and the American Community Survey.[1] Primary data was collected through the Mid-Hudson Region Community Health Survey, the Mid-Hudson Region Community Partner Survey, resident voting at local events and the Dutchess County Community Health Summit. These priorities, **Nutrition Security**, **Preventive Services for Chronic Disease Control and Prevention**, and **Primary Prevention, Substance Misuse, and Overdose Prevention**, reflect both the prevalence of chronic and behavioral health concerns and long-standing inequities between communities.

Selection of the three priority areas was reinforced by strong community input. More than one hundred service providers from Dutchess County contributed through the regional partner survey, emphasizing challenges such as food insecurity, access to mental health care, and limited safe and affordable housing. At community events, over 800 residents identified the most important issues affecting their neighborhoods, with mental health, substance use, access to care, and healthy children emerging as common themes. Subsequently, nearly 70 community partners convened at the countywide Community Health Summit, where discussion and voting helped refine the final focus areas for the CHIP.

To address **Nutrition Security**, the county will embed screening for food insecurity into routine interactions across multiple Department of Health program areas using the Health-Related Social Needs (HRSN) tool. Individuals who screen positive will be connected with local food pantries, nutrition assistance programs, and other supportive services. This approach ensures that low-income residents, especially those living in areas such as the City of Poughkeepsie, are more consistently identified and linked to resources that support long-term health. Process measures to evaluate impact will include number of screenings performed by DCDOH staff.

The second priority, **Preventive Services for Chronic Disease Control and Prevention**, centers on strengthening early detection of hypertension among residents, with a focus on Medicaid enrollees and those facing barriers to healthcare. The Dutchess County Mobile Health Unit (DCMHU) will expand blood pressure screenings in underserved communities, modeled after the successful Dutchess County Medical Reserve Corps (DCMRC) program. Both the DCMHU and DCMRC will refer individuals with elevated readings to their primary care providers or to Sun River Health, a Federally Qualified Health

[1] The complete list of data sources is available in the Mid-Hudson Region Community Health Assessment at www.dutchessny.gov/Departments/DBCH/Docs/MHRCHA2025.pdf

Center, ensuring follow-up care for those most at risk of cardiovascular complications. Process measures being tracked to evaluate impact will include number of blood pressure screenings performed and number of referrals made for those with high blood pressure.

The third priority, **Primary Prevention, Substance Misuse, and Overdose Prevention**, responds to the ongoing overdose crisis. The Dutchess County Department of Mental Health (DCDMH) will continue operating a second-tier syringe exchange program to reduce the spread of infections. Alongside this, DCDOH, DCDMH, EMS agencies, and numerous community partners will conduct Narcan trainings and distribute overdose-reversal kits. EMS personnel will also provide leave-behind kits following overdose-related calls, ensuring that lifesaving resources reach individuals at the highest moment of need. Harm-reduction vending machines placed throughout the county offer Narcan, fentanyl and xylazine test strips, and other safe-use supplies at no cost. These layered strategies are designed to reduce overdose deaths, increase safety, and expand harm-reduction services across all communities. A variety of process measures will be used to evaluate impact, including, but not limited to, number of Narcan kits distributed and number of individuals trained in using Narcan.

Implementation of the CHIP is supported by strong partnership networks, including DCDOH, DCDMH, DCMRC, Sun River Health, community-based organizations, local government entities, educational institutions, and public safety agencies. Each group contributes uniquely to screening, education, referral, harm-reduction efforts, and data reporting. To ensure accountability and continuous progress, partners will provide quarterly updates to DCDOH, and the county will submit annual progress reports to the New York State Department of Health. These frequent check-ins allow for mid-cycle adjustments and ensure that the interventions remain responsive to community needs.

Overall, the 2025–2030 CHIP outlines a comprehensive, equity-focused public health strategy tailored to Dutchess County's unique health challenges. Through coordinated action, strengthened partnerships, and ongoing evaluation, the plan aims to ensure that all residents, particularly those historically experiencing the greatest barriers, have improved access to nutritious food, preventive healthcare, and lifesaving harm-reduction services.

MAJOR COMMUNITY HEALTH NEEDS

Based on the findings of the Dutchess County Community Health Assessment, there is a need to focus on factors of chronic disease and mental and behavioral health. Cardiovascular disease is the leading cause of death in Dutchess County and other chronic health conditions, like hypertension, diabetes, and obesity, can contribute to and exacerbate cardiovascular disease. Those with mental health conditions, including but not limited to depression, anxiety, other mood disorders or substance or alcohol use disorder, are also more likely to have chronic health conditions than those without. Due to their interrelatedness, it is important to focus not only on physical health but mental health as well. Within both sectors, there are several disparities that exist between the health of the more urban-suburban western side of the county and the rural eastern side, between White non-Hispanic residents and Black non-Hispanic and Hispanic residents, and between those who have disabilities and those who do not. These disparities can be seen in the rates of preventable hospitalizations, premature death, opioid overdose, participation in primary care, and provision of mental health services. In order to combat these issues, it is important that the residents of Dutchess County have access to and support from sufficient, competent health providers to manage their health.

Community health needs include, but are not limited to:

- Chronic disease, including hypertension, cardiovascular disease, and diabetes
- Childhood immunizations
- Mental health and wellbeing
- Suicide and self-harm
- Opioid overdose
- Behavioral health including diet/exercise, smoking, alcohol and drug use

PRIORITIZATION

DCDOH, in conjunction with input from community partners and Dutchess County residents, selected priorities from the New York State Prevention Agenda (NYSPA) to focus on for the 2025 – 2030 Community Health Improvement Plan (CHIP) cycle. These decisions were made after considering a variety of criteria, which are detailed in the following sections.

HANLON METHOD

After completion of the primary and secondary data analysis detailed in the Community Health Assessment (CHA), the Hanlon Method was used to help prioritize the health problems that should be focused on. The Hanlon Method, a technique created by J.J Hanlon to prioritize health problems, minimizes personal bias and objectively prioritizes health problems based on data. The priority score was calculated using the formula,

Indicator score = size of the health problem + (2 × seriousness of the health problem).

The size of the health problem reflects how widespread the issue is within the population, while the seriousness of the health problem accounts for factors such as financial costs, the burden on disadvantaged groups, impacts on quality of life and mortality rates, and comparisons with surrounding regions. The maximum possible score is 30 points, which represents the highest level of severity for a health issue.

The results from the Hanlon Method are detailed in the Dutchess County Community Health Assessment 2025. The top-rated indicators included physical activity, childhood immunizations, cardiovascular disease, and hypertension.

COMMUNITY ENGAGEMENT IN THE PRIORITIZATION PROCESS

MID-HUDSON REGION COMMUNITY PARTNER SURVEY

As part of the Mid-Hudson Region Community Health Assessment, 109 Dutchess County community providers were surveyed regarding the needs of the clients they serve. The full results of this survey are available in the Mid-Hudson Region Community Health Assessment 2025. Top health issues identified by providers included limited access to affordable, nutritious food, limited access to mental health providers, and limited access to safe, affordable housing. Key social determinants impacting health included economic wellbeing, mental health, and access to care, with poverty, stress, and limited preventive services being especially problematic.

DUTCHESS COUNTY RESIDENT PRIORITY AREA VOTING

To directly engage the community in the prioritization process, informal surveying was completed at community events in summer 2025. DCDOH staff created flowerpots labelled with the NYPSA 2025-2030 priority areas. At six community events in summer 2025, DCDOH staff engaged residents and asked what they thought the most important priorities were to help their community grow. Residents who participated in the activity were given two stones and asked to place them in the flowerpots representing

their top two priority areas. Residents could place both stones in one pot if they felt strongly about that priority area.

Overall, 830 Dutchess County residents participated. Mental Wellbeing and Substance Use was the most common response, followed by Health Insurance Coverage and Access to Care and Healthy Children.

DUTCHESS COUNTY COMMUNITY HEALTH SUMMIT

Nearly 70 community partners and stakeholders attended the Dutchess County Community Health Summit in the fall of 2025. Attendees engaged with presentations on food security in Dutchess County and the DCDOH's Mobile Health Unit, as well as a CHA specific presentation which covered data from each priority area. After the presentations, attendees voted to select the top NYSPA priority areas. Participants then formed breakout groups to discuss the two winning topics. These were Health Insurance Coverage and Access to Care, along with Mental Wellbeing and Substance Use.

SELECTION OF PRIORITIES

To make final decisions regarding priorities for the CHIP, DCDOH staff covering all divisions/program areas within the department convened to review the CHA findings and give input on possible current and future activities that would help address priorities within the top selected NYSPA priority areas. These decisions were made considering the Hanlon Method results, current performance on NYSPA, input from community partners and the public, and the feasibility of developing programs in these areas.

Based on the feasibility of activities and their alignment with NYSPA, DCDOH leadership and the Epidemiology and Biostatistics unit ultimately met to select the following three priorities for the 2025-2030 cycle:

- **Nutrition Security**
- **Preventive Services for Chronic Disease Control and Prevention**
- **Primary Prevention, Substance Misuse, and Overdose Prevention.**

JUSTIFICATION FOR UNADDRESSED HEALTH NEEDS

Not all health needs can be addressed in one Community Health Improvement Plan. Priorities and health needs that were not selected for this CHIP include preventive services for children, education, physical activity, and mental health related needs including suicide. In many of these cases, county or partner programs already exist to target and improve these health needs. Interventions were selected to maximize impact on stakeholder and community partner selected priorities within the available resources.

PRIORITY 1: NUTRITION SECURITY

Goal: Improve consistent and equitable access to healthy, affordable, safe, and culturally appropriate foods.

NYS Objective: Increase food security in households with an annual total income of less than $25,000.

Intervention

1. Screen individuals interacting with Dutchess County Department of Health staff and services for food insecurity using the Health-Related Social Needs (HRSN) screening tool. Individuals who screen positive for food insecurity will be referred to community-based organizations and other local resources.

Actions and Impact

DCDOH is implementing routine screening for food insecurity among individuals interacting with its services, using the standardized Health-Related Social Needs (HRSN) screening tool. Medicaid enrolled individuals who interact with clinical, communicable disease, and environmental health/lead services are eligible to be screened. Additionally, diverse roles within DCDOH have been or will be trained as screeners to help maximize impact. This approach allows DCDOH to proactively identify residents experiencing or at risk for food insecurity, a key social determinant of health that influences chronic disease outcomes, developmental health, and overall well-being.

Individuals who screen positive for food insecurity are referred to community-based organizations and local resource networks that can provide direct support. Referrals will be made through Hudson Valley Care Coalition (HVCC) and their network of partner organizations. These referrals may include food pantries, nutrition assistance programs, meal delivery services, and other supportive agencies across the county.

This coordinated action is anticipated to have several positive impacts. It increases early identification of unmet basic needs among residents who may otherwise remain unseen in traditional clinical or service settings. It strengthens linkage to community resources, improving access to healthy foods and reducing the duration and severity of food insecurity. It enhances care coordination between DCDOH and community organizations, promoting a more integrated public health response. And over time, it may contribute to improved health outcomes by reducing stress, improving nutrition, and mitigating downstream health complications associated with food insecurity.

Geographic Focus

Although screenings will be conducted through multiple program services that serve the whole of the county, they will mainly occur in the DCDOH health clinic in the City of Poughkeepsie. When compared to the county as a whole, the City of Poughkeepsie has a higher proportion of low-income households.

Partner Roles

HVCC is the Social Care Network in the Hudson Valley which has connected a network of providers to the Unite Us platform. Unite Us is a referral technology that allows for the tracking of referrals and their outcomes through multiple agencies. By utilizing this technology for social needs screenings, the DCDOH leverages partnerships with both HVCC and a robust network of area providers to connect residents with vital resources. It will also allow HVCC to follow-up with and further assist Medicaid enrollees who have further social care needs.

R**esource Commitment**

DCDOH staff time will be dedicated to completing the HRSN screening tool with eligible patients at the clinic, and through other DOH interactions. To ensure no gaps in care, HVCC will provide dedicated follow-up support to complete any remaining referrals for these individuals.

Health Equity

The planned screening and referral process is expected to reduce health disparities within Dutchess County. Food insecurity disproportionately affects low-income households, racial and ethnic minority groups, and individuals with limited access to healthcare and social resources. By embedding the Health-Related Social Needs (HRSN) screening tool into existing interactions with DCDOH, the approach ensures that these higher-risk populations are systematically identified rather than relying on self-disclosure or chance encounters.

Linking individuals who screen positive to community-based organizations helps close gaps in access to nutritious food, one of the core drivers of unequal health outcomes. Strengthened referral pathways ensure that residents facing the greatest barriers receive timely, concrete support, which can reduce downstream disparities in chronic disease burden, mental health stressors, and overall quality of life.

In essence, this strategy shifts food insecurity from an invisible barrier to a routinely detected and addressed health determinant, helping to narrow inequities across the populations most affected.

PRIORITY 2: PREVENTIVE SERVICES FOR CHRONIC DISEASE CONTROL AND PREVENTION

Goal: Reduce disparities in access and quality of evidence-based preventive and diagnostic services for chronic diseases

NYS Objective: Increase the percentage of adult Medicaid members aged 18 years and older with hypertension who are currently taking medication to manage their high blood pressure.

Interventions:

1. Development of a blood pressure screening program through the Dutchess County Mobile Health Unit (DCMHU) that uses the existing Dutchess County Medical Reserve Corps (DCMRC) screening program as a model
2. Continuation of the DCMRC blood pressure screening program

Actions and Impact

DCDOH is implementing two coordinated actions to address elevated blood pressure and reduce cardiovascular disease burden within Dutchess County. Particular emphasis is placed on improving access for Medicaid recipients, who face disproportionate barriers to preventive services.

DCDOH is developing a blood pressure screening program operated through DCMHU. Modeled after the established DCMRC screening program, this initiative expands access to preventive screenings in underserved neighborhoods with high concentrations of Medicaid beneficiaries. Participants who are determined to have high blood pressure will either be referred to their own primary care provider (PCP) or to Federally Qualified Health Center (FQHC) Sun River Health. By bringing screening, education, and referral resources directly into these communities, the program is expected to improve early identification of hypertension and strengthen linkage to appropriate follow-up care for Medicaid recipients and other residents with limited access to traditional healthcare settings. DCDOH collaborates with community organizations, health insurance agencies, food pantries, and healthcare providers for DCMHU events.

In addition, DCMRC will maintain its established schedule of blood pressure screening activities. Blood pressure screening is offered at community events, creating a low barrier to entry for individuals. Participants determined to have high blood pressure will follow the same referral process as the DCMHU portion of the intervention, to their own PCP or Sun River Health.

Together, these actions are anticipated to increase hypertension awareness, enhance early detection efforts, and facilitate timely management across the county, contributing to long-term reductions in cardiovascular morbidity and reducing disparities in preventive care access.

Geographic Focus

DCMHU events typically take place in parts of Dutchess County that are either 1) rural or 2) have populations that generally experience more health disparities. This is typically in the City of Poughkeepsie and rural eastern part of the county. These areas generally have higher rates of Medicaid enrollment when compared to Dutchess County as a whole. Events that DCMRC participate in take place all through the county, with no specific geographic focus.

Partner Roles

As the main partner for this intervention, DCMRC will continue their successful blood pressure screening program at community events. There is not one specific partner to highlight for the DCMHU portion of this intervention. DCMHU events bring together a variety of community based, governmental, and other health and human service providers. This includes, but is not limited to, food pantries, health insurance agencies, mental health organizations, and health care providers. By bringing these types of organizations together, these events can help connect attendees to services they might need to help support maintaining healthy blood pressure.

Sun River Health will play a particularly essential role connecting participants who lack a primary care provider to clinicians for formal diagnosis and management of their high blood pressure.

Resource Commitment

The main resource that both DCDOH and DCMRC will commit is time. DCDOH education and clinical staff and DCMRC volunteers will spend time completing blood pressure screenings and providing education and educational materials regarding high blood pressure. Various partners may also join DCDOH events to offer extra resources addressing needs related to health care access and the social determinants of health.

Health Equity

The planned actions are expected to address health disparities by improving access to timely blood pressure screening and follow-up among populations that experience disproportionate barriers to preventive care. The scheduled screening events conducted through the DCMHU will be strategically located in areas with high concentrations of Medicaid recipients and other residents with limited access to traditional healthcare settings. By bringing screening, education, and referral services directly to these locations, the initiative reduces transportation, financial, and logistical barriers that contribute to delayed diagnosis and poorer cardiovascular outcomes.

PRIORITY 3: PRIMARY PREVENTION, SUBSTANCE MISUSE, AND OVERDOSE PREVENTION

Goal: Reduce substance use, misuse, overdose, and/or associated harms.

NYS Objective: Reduce the crude rate of overdose deaths involving drugs, per 100,000 population.

Interventions

1. Second tier syringe exchange program, providing sterile syringes and other harm reduction/safe use supplies
2. Narcan training and distribution by DCDOH and partner organization staff
3. Harm reduction vending machines containing harm reduction supplies, including Narcan and fentanyl test strips

Actions and Impact

Partner organization Dutchess County Department of Mental Health (DCDMH) operates a second-tier syringe exchange program that provides sterile syringes and safe-use supplies, reducing transmission of blood-borne infections. Both DCDOH, DCDMH, and partner organization staff conduct Narcan training and distribution to increase community capacity to reverse opioid overdoses. Additionally, EMS teams distribute leave-behind kits with Narcan and educational materials during overdose-related calls, ensuring immediate support for individuals at high risk. Harm-reduction vending machines stocked with Narcan, fentanyl test strips, and other supplies expand access to lifesaving tools. Together, these actions are anticipated to reduce overdose fatalities, limit infectious disease spread, and improve community engagement with harm-reduction services.

Geographic Focus

In general, these interventions and activities don't have a specific geographic focus and will benefit residents countywide. Harm reduction vending machines are located in six locations across Dutchess County in the cities of Beacon (1) and Poughkeepsie (2), the town of Amenia (1), and the villages of Red Hook (1) and Millbrook (1). While these vending machines are geographically located in these municipalities, they are free for anyone to use regardless of residence.

Partner Roles

DCDMH is the main partner for all interventions related to overdose prevention. Their roles include spearheading the EMS Narcan leave behind program, provision of the second-tier syringe exchange program, and management of harm reduction vending machines. DCDOH manages Narcan training and distribution as part of the ongoing Opioid Overdose Prevention Program. Other community partners, including EMS providers, police and fire departments, local government agencies, institutions of higher learning, and community-based organizations provide Narcan trainings and distribute kits to community members. All participating organizations report Narcan training and distribution data back to DCDOH.

Resource Commitment

Harm reduction supplies (Narcan, fentanyl and xylazine test strips, sterile syringes) are provided to DCDOH and DCDMH from New York State Department of Health (NYSDOH) and New York State Office of Addiction Services and Supports (OASAS). Both DCDOH and DCDMH will commit staff time to managing distribution of these harm reduction supplies, providing Narcan trainings, management of the harm reduction vending machines, and the second-tier syringe exchange program.

Health Equity

These interventions directly address health disparities. People who experience unstable housing, limited transportation, low income, or stigmatization often face barriers to traditional healthcare and harm-reduction services. By providing low-threshold, widely accessible resources through mobile services, vending machines, and EMS interactions, the initiatives reach individuals who are disproportionately impacted by overdose and infectious disease. As a result, the actions are expected to reduce inequities in overdose mortality, disease burden, and improve access to overdose prevention services.

PARTNER ENGAGEMENT

DCDOH CHA/CHIP staff will be in frequent communication with partners regarding CHIP activities. Partners will be asked to report on progress being made on a quarterly basis, allowing ample time for mid-cycle changes to be made. Changes to the plan will be communicated to NYSDOH through submission of annual workplan progress reports.

DISSEMINATION TO THE COMMUNITY

The Dutchess County Community Health Improvement Plan Executive Summary and plan will be shared with partners and the community. An email blast will be sent to community partners indicating that the plan is available. The plan will also be available on the Dutchess County website at www.dutchessny.gov/healthydutchess.

“The test of our progress is not whether we add more to the abundance of those who have much; it is whether we provide enough for those who have too little.”
— Franklin D. Roosevelt