PUTNAM COUNTY

Community Health Assessment 2019
Community Health Improvement Plan 2020-2022

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INVITING YOU TO PARTICIPATE

On behalf of the Putnam County Department of Health (DOH), we would like to thank everyone in the community who has assisted in the creation of the Community Health Improvement Plan (CHIP). Community change and health improvement require dedication and commitment from all stakeholders—including the citizen, business, government and community sectors. Without their support, the CHIP would not be possible. This collaborative plan will be used as a guide to improving the health of everyone who lives in Putnam County, by outlining measurable goals and strategies and identifying areas on which to focus.

As an accredited health department, mechanisms have been put in place to ensure that the local public health system is focused on population based health outcomes. Additionally, we have chosen to utilize the best-practice Mobilizing for Action through Planning and Partnerships (MAPP), a "gold standard" community needs assessment and strategic planning process. MAPP uses four unique assessments to determine community priorities and lay the groundwork for future action.

For the next three years, we have a unique opportunity to work together by aligning initiatives, leveraging resources and committing to the implementation of the strategies outlined in the CHIP. Collaborating with our partners will make a long-lasting impact on the conditions, systems and policies to improve health outcomes and overall quality of life for our residents.

As we move forward with the implementation of the CHIP, we are excited to extend an invitation to collaborate with new partners and identify key organizations and individuals that will help us assure the community receives essential public health services. The CHIP is posted on our website and we invite all of you to participate in some capacity. Residents can join a coalition, participate in a focus group, or simply respond to our periodic community asset survey. If you are interested, please call us at (845) 808-1390 or e-mail PutnamHealth@putnamcountyny.gov.

Together we can improve the health of all the individuals, families, and communities that make up Putnam County.

Sincerely,

Michael J. Nesheiwat, MD
Commissioner of Health
Putnam County Department of Health

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EXECUTIVE SUMMARY

For more than a decade, the Putnam County DOH has worked in close alliance with the county's only hospital, Putnam Hospital Center. This well-established relationship serves as the foundation for the partnerships across the entire local public health system (LPHS). Efforts toward health improvement planning have been most effective when approached through cooperative work.

Since 2012, the New York State DOH has required local health departments to work with local hospitals and community partners on development of the Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP). Currently, the basis of these plans is the state's own health improvement plan, the 2019-2024 *Prevention Agenda*.

HOW WERE PRIORITIES CHOSEN?

The Putnam County DOH initiated and continues to facilitate the Mobilizing for Action through Planning and Partnerships (MAPP) strategic planning process with community partners in order to develop these assessments and plans. The MAPP process uses four unique assessments to determine community priorities: Community Themes and Strengths, Community Health Status, Local Public Health System and Forces of Change. This community health assessment also includes a regional collaboration with the six Mid-Hudson local health departments, seventeen local hospitals and HealtheConnections in the creation of a Mid-Hudson Region CHA. These assessments inform the development of the CHIP. During Phase Four of the MAPP process the partners in the local public health system identified the most important issues facing the community based on data gathered from the assessments and discussed during coalition meetings.

WHAT PRIORITIES WERE CHOSEN AND WHAT STRATEGIES ARE BEING IMPLEMENTED TO ADDRESS THE PRIORITY AREAS?

Through the MAPP process two overarching priorities were identified and served as a foundation for developing the Putnam County CHIP. Specific goals and interventions were selected and are listed below.

I - Priority Area: Promote Well-Being and Prevent Mental and Substance Use Disorders

Focus Area 2: Mental and Substance Use Disorders Prevention

Goal 2.2: Prevent opioid and other substance misuse and deaths

Intervention 2.2.1: Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine

Prevention Agenda source: Promote Well-Being and Prevent Mental and Substance Use Disorders Action Plan

Health disparity addressed: Behavioral health equity stems from the notion of health equity and directs specific attention to those impacted by mental health and substance use conditions and disorders

II - Priority Area: Prevent Chronic Diseases

Focus Area 1: Healthy Eating and Food Security

Goal 1.1: Increase access to healthy and affordable foods and beverages

Goal 1.3: Increase food security

Intervention 1.0.6: Screen for food insecurity, facilitate and actively support referral

Prevention Agenda source: Prevent Chronic Diseases Action Plan

Health disparity addressed: Low socio-economic status; food insecure; and asset limited, income constrained, employed individuals

Through discussions with community partners, three additional prevention agenda priorities were also added to the CHIP:

III - Priority Area: Prevent Chronic Diseases

Focus Area 3: Tobacco Prevention

Goal 3.2: Promote tobacco use cessation

Intervention 3.2.1: Assist medical and behavioral health care organizations and provider groups in establishing policies, procedures and workflows to facilitate the delivery of tobacco dependence treatment

Intervention 3.2.3: Use health communications targeting health care providers to encourage their involvement in their patients' quit attempts encouraging use of evidence-based quitting, increasing awareness of available cessation benefits

Local Intervention: School districts, local agencies and coalitions have identified tobacco cessation as a priority, and in addition to expanding existing evidence-based tobacco cessation programs, plans are underway to incorporate vaping prevention and cessation programs

Prevention Agenda source: Prevent Chronic Diseases Action Plan

IV - Promote Healthy Women, Infants and Children

Focus Area 2: Perinatal and Infant Health

Goal 2.2: Increase Breastfeeding

Intervention 2.2.8: Increase access to peer and professional breastfeeding support by creating drop-in centers in faith-based, community-based or health care organizations in communities

Prevention Agenda source: Promote Healthy Women, Infants & Children Action Plan

V - Promote a Healthy and Safe Environment

Focus Area 4: Water Quality

Goal 4.2: Protect vulnerable waterbodies to reduce potential public health risks associated with exposure to recreational water

Intervention 4.2.1: Enhance the public's accessibility to real-time water quality information for recreational waters including beach status (open, closed) and other information

Intervention 4.2.2: Adopt and implement best management practice to reduce nutrient loading through resource conservation, wastewater, and storm water infrastructure improvement

Local Intervention: Putnam County DOH has begun developing partnerships with academia, state and local agencies to address the occurrences of HABs (Harmful Algal Blooms) in local waterbodies in Putnam

Prevention Agenda source: Promote a Healthy and Safe Environment Action Plan

WHO IS INVOLVED AND HOW CAN THE BROADER COMMUNITY BE INVOLVED?

Established partnerships that are integral to community health planning include the: Community Resource Group, Community Health Needs Committee, Live Healthy Putnam Coalition, Mental Health Provider Group, Fall Prevention Task Force, Putnam Communities That Care Coalition, and the Suicide Prevention Task Force.

Each organization or coalition brings a particular agenda and strength to the collective; all work in concert with the ultimate goal of improving the health of the community. These partnerships form the basis for reaching out to individuals both at the organizational and personal level who want to participate in the MAPP planning process. The annual Public Health Summits have also provided an excellent platform to present and discuss data, review existing strategies and select priorities to concentrate on in the upcoming year.

The annual Public Health Summits bring together a broad representation of community health partners and encourage participation in the identification of priorities. Additionally, the broader community is encouraged to participate in public health needs assessments and planning through a variety of forums and surveys.

HOW IS PROGRESS AND IMPROVEMENT BEING TRACKED?

Formal CHIP Action Plans have been developed to cover work through 2022. All strategies and activities related to these priorities are being addressed through the lens of health equity. Throughout the process, progress and improvement are being tracked through collective reporting.

Short-term process indicators and long-term outcome indicators are gathered at the local level by collecting and analyzing primary data, obtaining qualitative feedback from partners, customers and residents and through the use of secondary data generally provided by the New York State DOH.

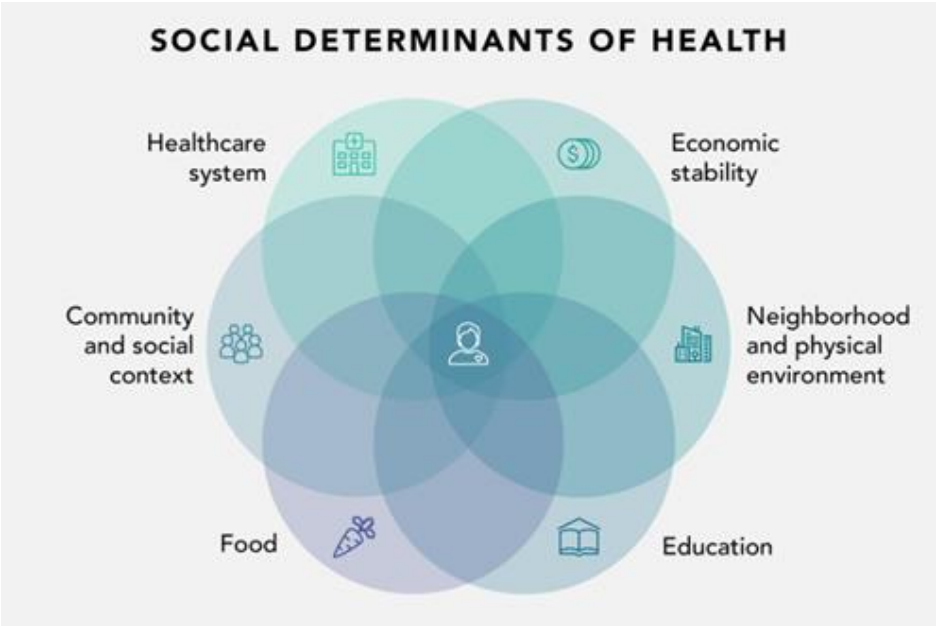
Progress is tracked through quarterly reports composed of information gathered from partners. Partners are identified and tasked with tracking and reporting data to the appropriate coalition. Putnam County DOH staff compiles the data and reports it to the New York State DOH on an annual basis. During coalition meetings, the data are reviewed and adjustments made as needed.

For detailed information on the evidence-based strategies being implemented and how they are being tracked, see the grids located in Phase Five on pages 58 and 59.

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are conditions in the environment where people are born, live, learn, work, play, worship, and finally age, that affect a wide range of health outcomes and quality-of-life issues. Social, economic and physical circumstances play a role in all settings, including the above. Collectively these characteristics are often referred to as "place." Place is not just a sum of material attributes, but also comprises patterns of social engagement, and a sense of security and well-being.

By deliberately addressing SDOH when creating and implementing policies and programs, we can improve individual and population health and advance health equity.



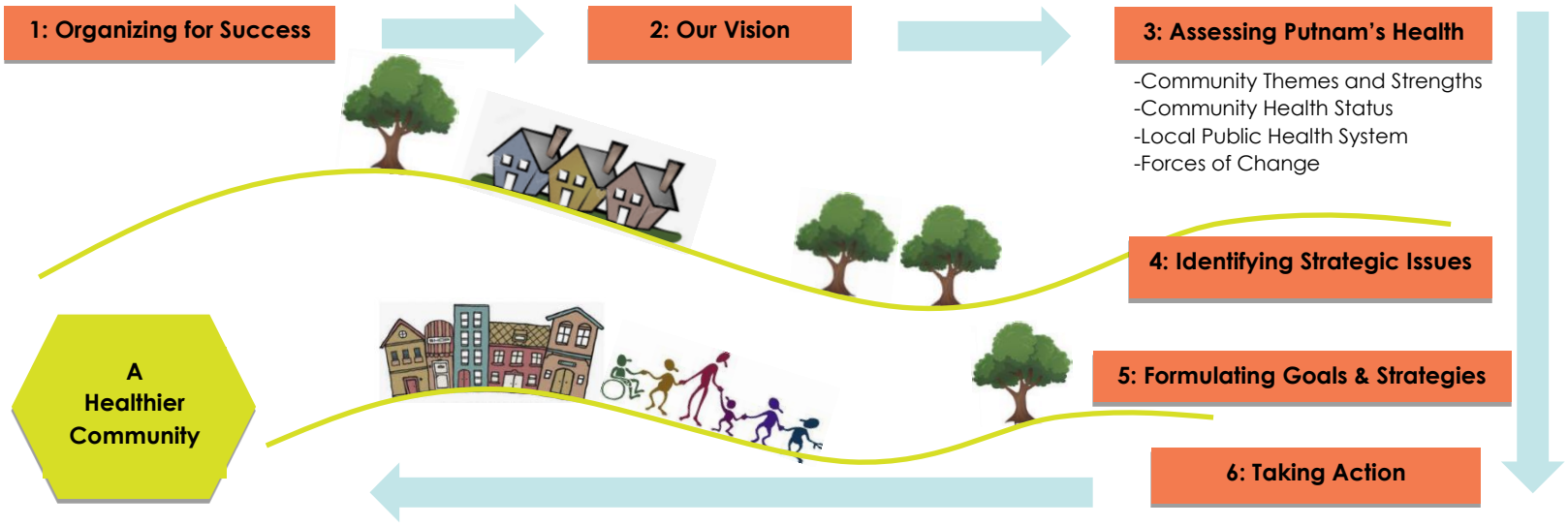
The healthcare system is generally considered the key driver of health outcomes. There is a growing recognition that to achieve better health outcomes and health equity, a broader approach is required. The local public health system in Putnam County aims to address social determinants of health to improve the health of residents and reduce health disparities. Partners are looking to make changes outside of the healthcare system focusing on policy change, encouraging a "Health Across All Policies" view, identifying collaborative approaches and utilizing evidence-based practice. Within the healthcare system partners are identifying opportunities to incorporate social screening tools into their workflow, the delivery system reform incentive payment (DSRIP) initiatives are supporting provider focus on SDOH, and a broader awareness of the link between health and social and environmental factors is being introduced.

This graphic approach for SDOH is based on the Kaiser Family Foundation model and supports what has been identified through the community health assessment process. In Putnam County, transportation, housing, food insecurity and accessing services are barriers faced by many residents. This is particularly true for those who live at or below the Federal Poverty Level. These individuals also face higher rates of unemployment, are more likely to be uninsured and are less educated.

MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS

Mobilizing for Action through Planning and Partnerships (MAPP) is a community-driven strategic planning process for improving community health. It provides a framework that helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is not an agency-focused assessment process; rather, it is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems. The use of MAPP signals a shift in how public health is planned. It is a shift from operational to strategic planning: from a focus on the agency to a focus on the public health system, from needs assessment to an emphasis on assets and resources, from a medically or service-oriented model to a model that encompasses a broad definition of health. In essence it is a movement away from an "agency knows all" perspective to the belief that "everyone knows something." By gathering all of the assets and resources within the community, the community is able to determine how best to use all of the knowledge to create a healthier community.

There are six phases in the MAPP framework. The phases include Organizing for Success, Visioning, Community Health Assessment, Identifying Strategic Issues, Formulating Goals and Strategies, and Taking Action. Phase Three includes four MAPP Assessments—Community Themes and Strengths Assessment, Community Health Status Assessment, Local Public Health System Assessment and Forces of Change Assessment which provide a complete picture of health strengths and opportunities in Putnam County.



PHASE ONE: ORGANIZING FOR SUCCESS

The first phase of the Putnam County MAPP process was to mobilize partners and residents. Putnam County DOH has a robust history of working with healthcare providers, community leaders, organizations and interested residents, to collaborate on health priorities and concerns. The Putnam County DOH has been informing and educating partners about the MAPP and CHIP process since December 2012, when the New York State DOH mandated the CHIP be conducted by each local health department.

The annual Public Health Summit provides the opportunity for the Putnam County DOH, Putnam Hospital Center, community-based organizations, mental health agencies, social service agencies, educational institutions, faith-based organizations, healthcare providers, local industry, emergency services providers, veterans' agencies and residents to convene and review the current state of health in Putnam County (detailed Community Partners list can be found in Phase Six). Local data and planning updates are shared and discussed engaging community partners in the planning process.

Three Summits were held between 2017 and 2019.

Through an Equity Lens was the theme of the September 7, 2017 Summit. The focus was to unite partners and provide an overview of the NYS *Health Across All Policies* collaborative approach highlighting the complexity of health challenges and engaging all segments of the community. Integrating health considerations into policymaking and program selection across all sectors improves health outcomes.

Additionally a viewing of the documentary *UNNATURAL CAUSES…is inequality making us sick?,* prompted a follow-up discussion on health equity issues as they relate to Putnam.

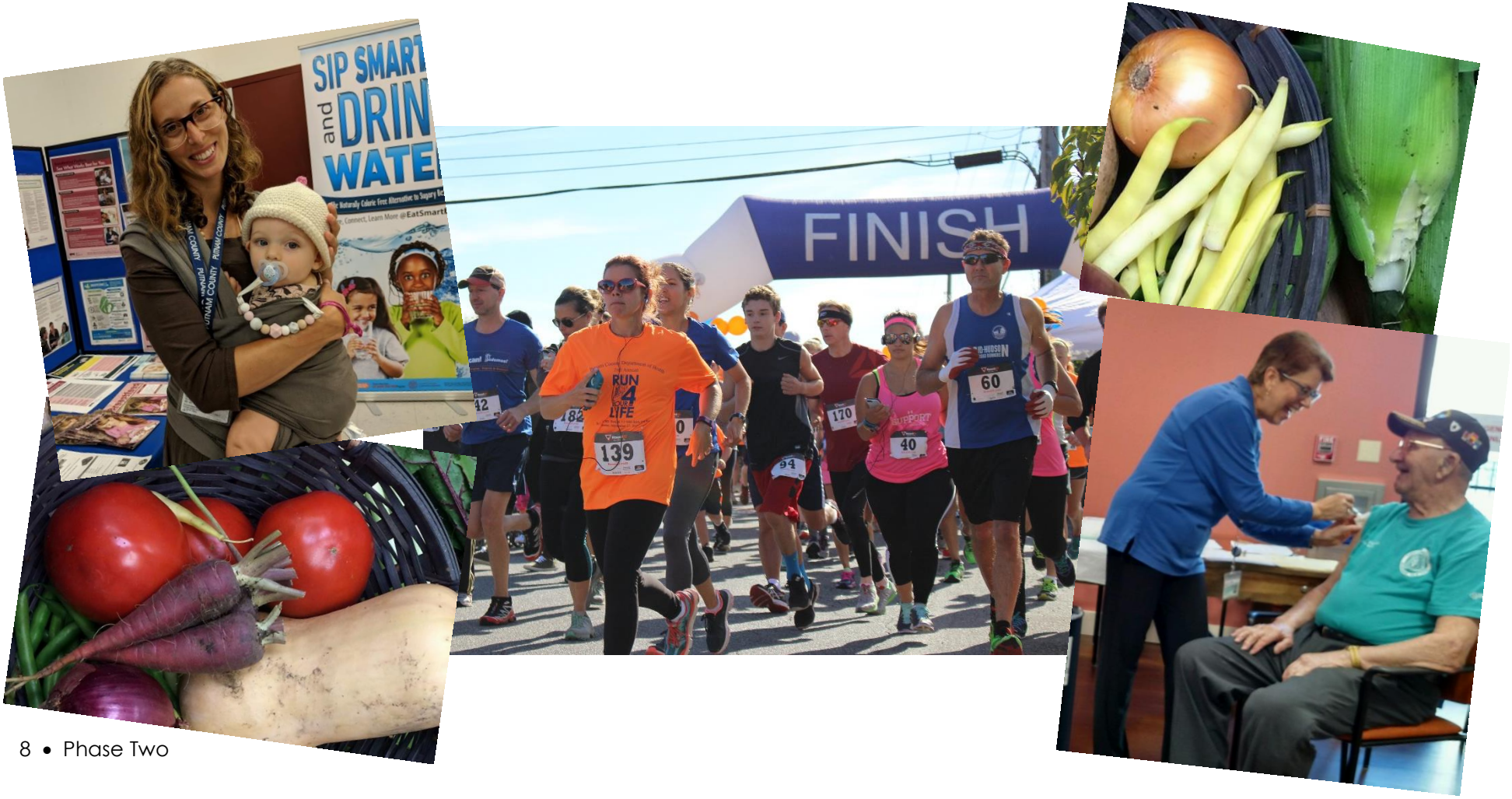
Moving Forward…Together: A collaborative approach to community health planning was the theme of both the October 18, 2018 and the June 19, 2019 summits. These meetings paved the way for moving through the six MAPP phases and creating the 2020-2022 CHIP.

The 2018 Summit focused on the community health assessment data overview. Presentations by community partners included: community health planning in Putnam, transformation to an integrated co-occurring system of care, Fall Prevention Task Force successes in Putnam, and a review of the Tobacco 21 "T21" history, implications and legislative updates. A Forces of Change assessment was also performed by the 80+ attendees (for an overview of the Forces of Change Assessment see the summary in Phase Three).

The 2019 Summit provided an overview of the four MAPP assessments leading to priority selection and initial CHIP planning. Population-specific break-out groups consisting of community partners discussed the existing community services and identified gaps. At the end of the Summit the group selected potential areas for evidence-based intervention selection to work on moving forward.

PHASE TWO:
VISION FOR A HEALTHIER PUTNAM

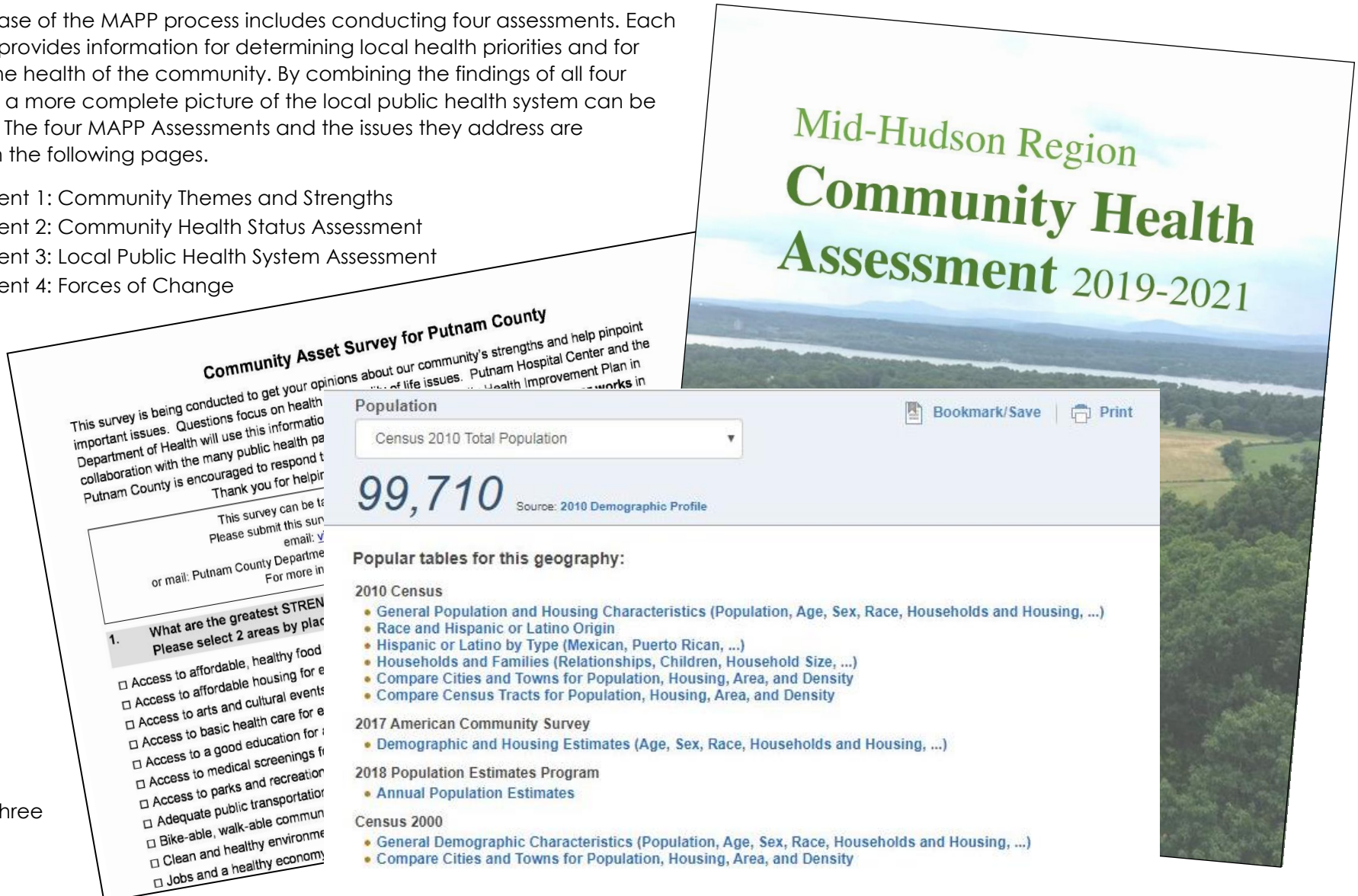
The vision to create a healthy community by actively collaborating with our partners to identify gaps and leverage resources is a common theme among all involved. The many partnerships, committees and coalitions are dedicated to improving the overall health of our community without stigma or judgment.



PHASE THREE: OVERVIEW

The third phase of the MAPP process includes conducting four assessments. Each assessment provides information for determining local health priorities and for improving the health of the community. By combining the findings of all four assessments a more complete picture of the local public health system can be established. The four MAPP Assessments and the issues they address are described in the following pages.

- Assessment 1: Community Themes and Strengths
- Assessment 2: Community Health Status Assessment
- Assessment 3: Local Public Health System Assessment
- Assessment 4: Forces of Change



COMMUNITY THEMES AND STRENGTHS ASSESSMENT

The Community Themes and Strengths Assessment is a data-driven report that focuses on identifying residents' perceptions of community strengths, health-related concerns and areas for improvement. By utilizing results from the Community Asset Survey and the Mid-Hudson Region Community Survey, along with focus group input, MAPP committees have a better understanding of the community's health status. Combined with the Community Health Status Assessment, Local Public Health System Assessment and Forces of Change Assessment, a broad picture of the health status of Putnam County can be formulated.

COMMUNITY ASSET SURVEY

The Community Asset Survey (CAS) was developed by the Putnam County DOH with input from Putnam Hospital Center and MAPP Committees. It was decided that a total of 13 questions would be asked: three primary questions, two health care questions, and eight demographic questions. The survey was piloted with members of the Putnam County DOH, the Special Supplemental Nutrition Program for Women, Infants (WIC) and the Live Healthy Putnam Coalition.

Online and paper surveys were created in both English and Spanish. The most frequently used survey was the online English survey. All surveys were anonymous.

It was determined that a convenience sample would be utilized to gather survey responses. The Putnam County DOH has a history of conducting online surveys which often over represent female residents and under represent minority groups and lower socio-economic status (SES) residents. With this knowledge it was determined that under-represented segments of the county would have specific outreach efforts planned to reach these groups.

Since no fiscal resources were available to conduct the MAPP process, no-cost opportunities based on existing community relationships and the local public health system were used and a promotional campaign was developed.

The Putnam County Executive and Putnam Hospital Center CEO each sent an email to all of their staff with an online link to the survey (this represented the two largest employers in Putnam County). A media release and campaign yielded coverage in 4 media outlets. Information and a an email link were also shared with agencies participating in the MAPP process, previous Public Health Summits and other established partnerships. Every agency was then encouraged to share with their members and clients.

SUMMARY OF RESULTS

Through the efforts of the Putnam County DOH, Putnam Hospital Center, and many other agencies, 556 surveys were received. All attempts were made for the CAS sample to mirror census data. For more details, see the full report at putnamcountyny.com/health/data/.

- The survey completion rate (survey fully answered) was nearly 97%.
- 82% of the respondents live in Putnam County. Nearly half of the remaining residences were in Dutchess County. Of those that reside in Putnam County, Brewster, Carmel and Mahopac accounted for 92% of the respondent's home zip codes.
- Of those that reported their place of employment, 91% of respondents work in Putnam County. Outside of Putnam, Westchester County was the largest location where respondents reported working.
- Over half of respondents (55%) were age 45 or older. Those aged 18-24 accounted for 8% of respondents and those 25-44 accounted for 37% of respondents.
- Regarding race, the majority of respondents were Caucasian/White, accounting for 87% of respondents. A total of 2% of respondents reported themselves as African American/Black, 1% reported themselves as Asian/Pacific Islander, and another 1% reported themselves as Native American/Alaskan. The remaining 9% of respondents were other races, not specified.
- Ethnicity is a separate measure from race asking whether a respondent is of Hispanic or Latino origin. Of those that reported their ethnicity, 38% reported being of Hispanic/Latino origin.
- The majority of respondents (71%) reporting living in a household with children under the age of 18.
- More than half of respondents (64%) reported having health insurance. A total of 3% of respondents have health insurance with high deductibles that limits their ability to see a doctor. Most of the remaining respondents reported not having health insurance due to issues with the Health Exchange, employment not offering it, or not being able to afford it.
- When the respondents were asked about how they access healthcare services, 4% reported that they do not receive any healthcare.

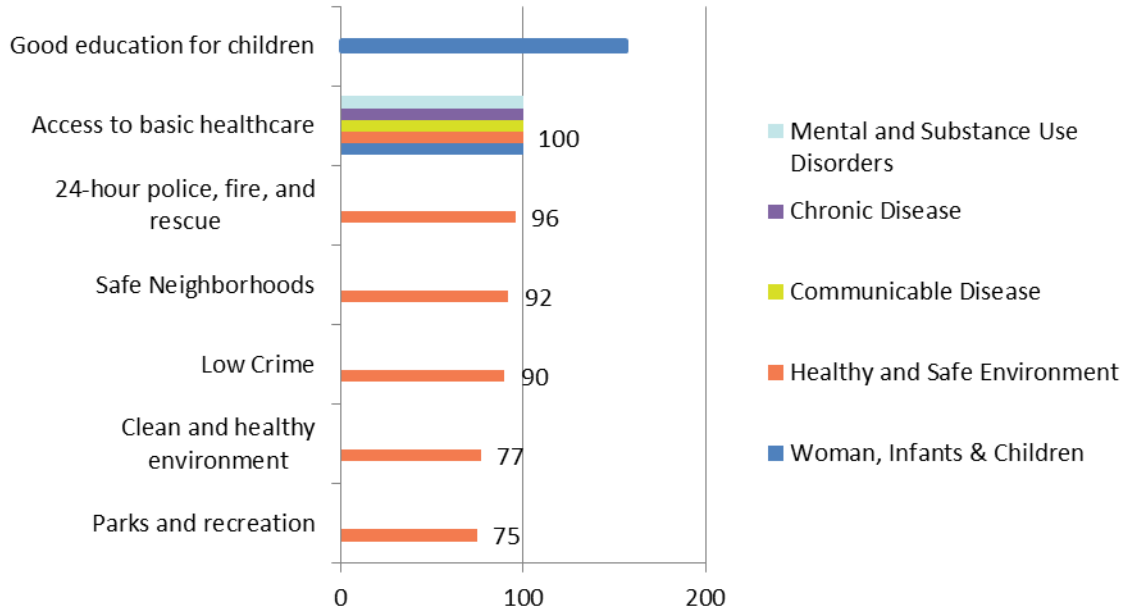
OVERARCHING RESULTS: GREATEST COMMUNITY STRENGTHS

The first question asked on the CAS was, "What are the greatest strengths of our entire community?"

The highest ranked community strengths are displayed in the chart below. Each of the top rankings is color coordinated to represent the Prevention Agenda priority that each social determinant of health corresponds with.

Good education for children was considered the greatest strength of the community, which corresponds with the *Promote Women, Infants, and Children* priority area. Access to basic health care was considered the second greatest community strength. Access to basic healthcare is a social determinant that impacts all 5 areas in the Prevention Agenda.

The following highest ranked community strengths include 24-hour police fire and rescue, Safe neighborhoods, Low crime, Clean and healthy environment, and Parks and recreation. These five social determinants of health all fall under the Prevention Agenda priority *Promote a Healthy and Safe Environment*. The sum of the number of responses for this priority area indicates that promoting a healthy and safe environment is the community's greatest strength.



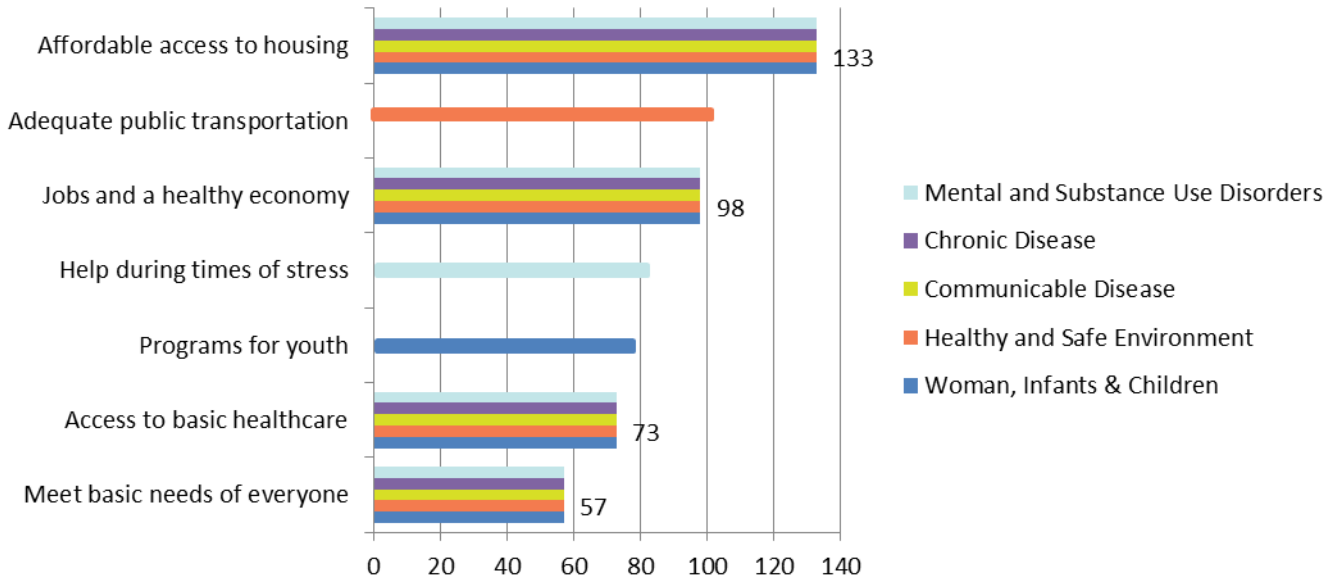
OVERARCHING RESULTS: AREAS TO IMPROVE QUALITY OF LIFE

In the next question regarding the community, respondents were asked, "Where should the community focus its resources and attention to improve the quality of life for our community?"

The highest ranked areas to improve quality of life are displayed in the chart below. Each of the top rankings is color coordinated to represent the Prevention Agenda priority that each social determinant of health corresponds with.

The area that was ranked highest by the community to improve quality of life was Affordable access to housing, followed by Adequate public transportation, Jobs and a healthy economy, Help during time of stress, Programs for youth, Access to basic healthcare and Meet basic needs of everyone.

The majority of the highest ranked areas to improve quality of life are overarching social determinants that impact all 5 areas in the Prevention Agenda. In other words, if the areas that were highlighted by community were focused on, overall quality of life would improve by promoting a healthy and safe environment, promoting well-being, promoting women, infants and children, preventing chronic disease and preventing communicable disease.



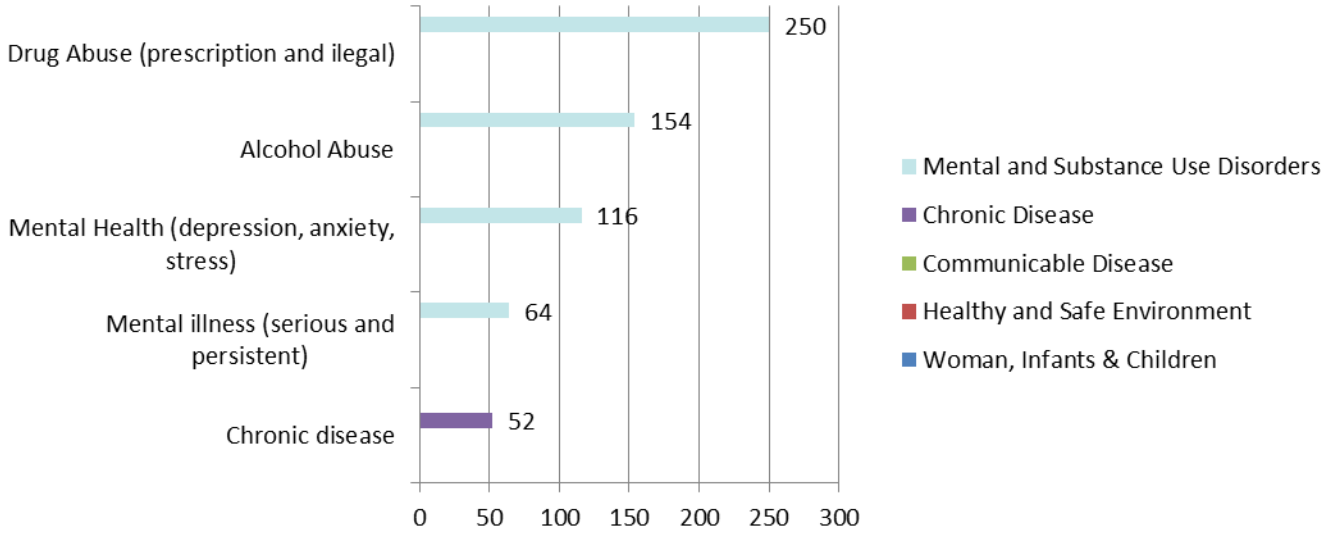
OVERARCHING RESULTS: IMPORTANT HEALTH ISSUES

The third question regarding the community, respondents were asked, "What are the most important health issues that our community should focus on?"

The highest ranked important health issues are displayed in the chart below. Each of the top rankings is color coordinated to represent the Prevention Agenda priority that each social determinant of health corresponds with.

The important health issues that were ranked highest by the community include Drug abuse (prescription and illegal), Alcohol abuse, Mental health (depression and anxiety), and Mental illness (serious and persistent). These top four health issues are all part of the *Promote Well-Being and Prevent Mental and Substance Use Disorders* priority area in the Prevention Agenda, indicating that mental health and substance use are the most overwhelming concerns of community members.

Chronic disease was the next most pressing health concern. However it should be noted, chronic disease can often result from obesity, tobacco use, physical inactivity, and/or poor nutrition; none of which were highly ranked health issues. This suggests that there is a need for education in our community regarding prevention of chronic diseases.



PREVENTION AGENDA PRIORITIES

After completing the Community Asset Survey, gathering input from local coalitions and through discussions at the annual Public Health Summit, common themes were identified. Overall, Putnam County is considered an asset rich place to live and work.

The main theme identified by respondents is that Putnam has an active and healthy environment. The availability of parks, recreation facilities, rail trails and the opportunity to fish, canoe and kayak on the abundant lakes, streams, and reservoirs provides many opportunities for physical activity and recreation. The other main theme is that Putnam is considered a safe place to live, work and raise a family. The availability of 24-hour police, fire and rescue, and low crime rates led residents to feel that they live in safe neighborhoods.

Availability of affordable access to housing and opportunities for jobs and a healthy economy were focus areas to further address. By doing so, the overall quality of life of the community would improve by impacting all 5 areas of the Prevention Agenda.

The overarching health concerns in Putnam County are mental health, substance abuse (drug and alcohol), and chronic disease. The data suggests that the community is in need of prevention messages and education regarding these topics.

One of the main purposes of this Community Themes and Strengths Assessment is to identify the New York State DOH Prevention Agenda priorities that the Putnam County community will focus future efforts on. Promoting Mental Health and Preventing Substance Abuse was the overwhelming priority followed next by Preventing Chronic Disease.

MID-HUDSON REGION COMMUNITY HEALTH SURVEY

In partnership, the seven Mid-Hudson Valley health departments, seventeen local hospitals and HealtheConnections created a regional survey. The survey was designed to include questions focusing on the Prevention Agenda and the eight Domains of Livability. Siena College Research Institute was hired to administer the random digit dial survey by phone. Below is an overview of selected highlights.

PUTNAM SAMPLE

For a statistically valid sample size, 500 surveys needed to be collected. When looking at the County regionally, the goal was to have two-thirds of the sample come from the more populous eastern region and one-third from the western region. All respondents were 18 years or older.

521 Total Putnam Residents
- Eastern side: 343 (66%)
- Western side: 178 (34%)

IDENTIFIED THEMES

Transportation - has been a recurring theme identified during focus groups and coalition meetings and was also found to be an issue in this survey.

QUESTION: People can get to where they need using public transportation?

Not Very True and Not At All True responses

- 55% Putnam versus Hudson Valley 52%
- 68% Western versus Eastern 50%
- For those Unemployed 61%
- With a Disabled Household member 58%
- With a Veteran Household member 63%

Stress - has been linked to health problems and wellbeing; therefore is a primary concern. In this survey over half of the respondents reported being stressed.

QUESTION: On an average day, how stressed do you feel?

Somewhat Stressed and Very Stressed responses

- 59% Putnam versus Hudson Valley 59%
- 60% Western versus Eastern 59%
- For those Unemployed 45%
- With a Disabled HH member 59%
- With a Veteran HH member 52%

Physical activity - can improve your quality of life, health, and mood and should be part of every individual routine. In this survey over half of the respondents did not incorporate physical activity into their lifestyle.

QUESTION: Over the past 12 months how many days in an average week did you exercise for 30 minutes or more a day?

0 days and 1-3 days responses

- 57% Putnam versus Hudson Valley 59%
- 54% Western versus Eastern 58%
- For those Unemployed 64%
- With a Disabled HH member 55%
- With a Veteran HH member 55%

Smoking - can lead to long-term health conditions as does secondhand smoke. This has been identified as a health issue in Putnam from other data sources as well as this survey.

QUESTION: Have you ever smoked at least 100 cigarettes in your entire life?

- 42% Yes versus Hudson Valley 37%

QUESTION: If you did smoke 100 do you now smoke?

Every Day or Some Days responses

- 30% Putnam versus Hudson Valley 33%
- 16% Western versus Eastern 39%
- With a Disabled HH member 38%
- With a Veteran HH member 27%

Alcohol and Binge Drinking - have been identified as ongoing health issues. In this survey, a small segment binge drink and nearly two-thirds reported drinking alcohol.

QUESTION: During the last 30 days, on the days when you drank, about how many drinks did you drink on average?

- 9% 1 – 5+ versus Hudson Valley 57%

QUESTION: If you did drink, how many times did you have more than 4 drinks for females and 5 drinks for males?

More than 4 Drinks for Females and More than 5 Drinks for Males responses

- 20% Putnam versus Hudson Valley 16%
- 24% Western versus Eastern 19%
- 29% Males and Females 11%
- With a Disabled HH member 29%
- With a Veteran HH member 15%

For complete results see the Mid-Hudson Region Community Health Assessment 2019-2021 located at putnamcountyny.com/health/data/.

COMMUNITY BASED ORGANIZATION FOCUS GROUPS

After the regional community health survey was conducted, it was clear that various segments of the community were not accounted for. It was decided that focus groups would be held with providers in an effort to gain insight into the underrepresented populations including residents experiencing homelessness, LGBTQ individuals, veterans and those with low-income. Two focus groups were held with providers to gather information about these groups.

The top three issues were identified as:

- Access to affordable, decent and safe housing
- Access to mental health providers
- Access to affordable, reliable public and personal transportation & Access to affordable health insurance (tied for third)

The top three barriers were identified as:

- Knowledge of existing resources
- Geographic location – living in a rural area
- Drug and/or alcohol use

IDENTIFIED THEMES

- Collaborative Partnerships within County: A strength of the local public health system in Putnam County is the willingness of agencies to work collaboratively. This strength needs to continue being leveraged to identify solutions to lessen gaps in service.

- Co-Occurring Disorder Treatment: There are challenges for residents with co-occurring disorders. Treatment is frequently not delivered in an integrated and comprehensive way. The best method is for both diagnostic areas to be addressed without compromising the ideal treatment for either. The County has formed a Co-Occurring System of Care work group to transform the system.

- Food security: Many residents contribute a large portion of their income to housing. This can led to high levels of stress and forces them to make decisions about how to pay for transportation, childcare, technology and food. This impacts the kind and quality of food residents can or cannot afford. In this situation, health is not a priority when the focus is on how to live.

- Knowledge of Resources: It is difficult for providers and residents to know what resources are available and for what populations. The 2-1-1 system needs to be advertised better.

IDENTIFIED THEMES, CONTINUED

- Mental Health Providers for Adolescent: There are insufficient mental health providers, particularly for adolescents. For those who are required to have an evaluation before they can return to school, this impacts their well-being, as well as their education.

- School-based Services for Behavioral Health: Schools are being required to develop additional strategies to ensure safe school settings, suicide prevention and ways to deal with behavioral health situations that can lead to crisis. To focus on strategies and solutions, Putnam County providers, Putnam/Northern Westchester BOCES and local school districts need to continue to partner.

- Transportation: Transportation issues impact may segments of the community. It can impact opportunities for employment, daycare service, socialization, education and healthcare.

COMMUNITY HEALTH STATUS ASSESSMENT

The Community Health Status Assessment is a data-driven report that focuses on identifying, collecting and analyzing information to describe the health status of Putnam County residents and identify key indicators of health. By utilizing the results of this assessment, MAPP committees have a better understanding of the community's health status, can prioritize various health indicators and ultimately select and monitor the goals and strategies contained in the CHIP. This report also allows for comparison to bench-mark data at the state and national levels. The New York State Prevention Agenda 2019-2024 is the blueprint for state and local action to improve the health of New Yorkers and provides objectives and indicator performance data. The Healthy People 2020 and National Prevention Strategy are national objectives for improving the health of all Americans and used to set and monitor goals.

Multiple sources of data have been gathered and analyzed.

Unique to this CHA cycle was the collaboration with HealtheConnections and the Hudson Valley local health departments in the creation of a regional CHA. The Mid-Hudson Region Community Health Assessment 2019-2021 was created as a comprehensive review of the current data as well as identifying opportunities for new data like the Mid-Hudson Region Community Health Survey (previously discussed).

Another unique addition was the review of data using the Hanlon method. Epidemiologists from Dutchess, Orange, Putnam and Rockland worked to identify the leading health indicators utilizing this method.

MID-HUDSON REGION COMMUNITY HEALTH ASSESSMENT 2019-2021

DATA SOURCES

By using multiple data sources, a more comprehensive snapshot of health in Putnam County can be created. Sources include: the *Behavioral Risk Factor Surveillance System Report (BRFSS)* designed by the Centers for Disease Control and Prevention; the *Community Health Status Report Card* from the U.S. Department of Health and Human Services; *County Health Assessment Indicators* compiled by the New York State DOH; the *County Health Rankings* conducted by the Robert Wood Johnson Foundation and the University of Wisconsin; *Healthy People 2020* compiled by the U.S. Department of Health and Human Services; *Local Data* including reports and data provided by local agencies; *Prevention Agenda 2019-2024 Dashboard* gathered by the New York State DOH; *Statewide Planning and Research Cooperative System (SPARCS)* hospital based data compiled by the New York State DOH; and *Vital Statistics of New York State* compiled by the New York State DOH.

See specific list of resources at the end of this document and in the Mid-Hudson Region Community Health Assessment 2019-2021.

COMMUNITY HEALTH STATUS

Putnam County, with a population approaching 100,000 residents, has historically ranked high in health status due in part to the high per capita income and numerous community resources. These assets, along with high education levels and high socio-economic status, generally translate to a population that also enjoys low unemployment and high rates of insurance coverage, leading to good life expectancy.

The past twenty years have seen a shift in the Putnam County population leading to increased racial diversity, advancing age of the residents and changes in socioeconomic status. The result is a greater contrast in population characteristics and more challenges in the health planning process.

Although these subgroups are growing, they remain small in comparison to the total population. Poor health outcomes are more common among racial minorities, in groups at or near the poverty level, and among those without access to health care. Health disparities must be recognized and addressed, while balancing the health needs of the entire community.

The Community Health Status Assessment attempts to identify these health disparities, as well as other priority areas that can lead to identification of CHIP goals, opportunities for collaboration among community partners and strategies for measuring progress.

COMMUNITY CHARACTERISTICS

A community's population size, age and racial composition are important determinants of health status and healthcare needs. The following table shows Putnam County and New York State demographic information.

DEMOGRAPHICS – 2017 U.S. CENSUS BUREAU	PUTNAM	NEW YORK
Population	99,464	19,798,228
Persons under 5 years	4.5%	5.9%
Persons under 18 years	20.9%	21.2%
Persons 65 years and over	15.6%	15.2%
Race – White Alone (reporting only one race)	90.7%	65.7%
Black or African American Alone	2.4%	15.9%
American Indian and Alaska Native Alone	0.2%	0.6%
Asian Alone	1.9%	7.3%
Native Hawaiian and Other Pacific Islander Alone	0.0%	0.0%
Other	2.8%	7.4%
Ethnicity* - Hispanic or Latino (of any race)	11.7%	17.6%
Not Hispanic or Latino	88.3%	82.4%
Foreign born persons	13.3%	22.7%
Language other than English spoken at home age 5+	9.7%	16.3%
Housing - Homeownership	81.9%	54.0%
Multi-unit structures	13.1%	50.7%
30% or + of Rent as percentage of household income	51.7%	50.4%
Veterans	5.3%	4.9%

*Hispanics may be of any race, so are also included in race applicable categories.

Community Characteristic Summary

Population:

- Under 100,000 residents
- Representing only 0.5% of the New York State population
- Percentage of males and females is equal at 50%

The population has remained constant.

Age:

- Population is aging
- Median age rose from 40.2 to 43.8 in the past 9 years
- A quarter of the residents are over 55 years
- Senior residents (60+) now account for 16.4% of the population

Lack of transportation, social isolation, financial decline and increased incidence of chronic diseases are all factors that affect the health outcomes of seniors and leads them to be considered a vulnerable population.

Race:

- Racially homogenous
- Majority of residents are White
- Hispanics (of any race) are 11.7% of the population
- Residents are predominantly American born and speak English in the home

Race is linked to poorer health outcomes. Regardless of economic status, Blacks, Asians and Native Americans have greater health disparities than Whites.

Housing:

- Majority of Putnam residents own and live in their own home
- Homeownership rate in Putnam exceeds the State
- 13% of the units available in Putnam are multi-unit causing shortages for those renting
- Of those paying rent, nearly 50% spend 30% or more of their household income on rent

Families paying a large portion of their income on rent potentially limits their ability to make choices between rent, healthy food, transportation, health care and other expenses. Lack of affordable housing can lead to instability and poor health outcomes for most residents, but for those residents with persistent and severe mental illness and disabilities, housing is of particular concern.

Veterans:

- 5.3% of Putnam residents are veterans
- Similar to that of New York State

Mental health issues, high rates of traumatic brain injuries and housing issues make veterans a vulnerable population with disparate health outcomes.

SOCIAL DETERMINANTS OF HEALTH

SOCIAL AND ECONOMIC FACTORS - 2013-2017 U.S. CENSUS DATA	PUTNAM ALL RESIDENTS	PUTNAM/ NYS BELOW POVERTY LEVEL	NEW YORK
Highest Education - High school graduate or equivalency	27.8%	6.8%/15.0%	26.0%
Some college with no degree	17.1%	4.7%/10.7%	27.2%
Associate's degree	9.4%		
Bachelor's degree or higher	38.6%	2.2%/5.2%	35.3%
High School graduation rate (2018 NYS Education Dept.)	90.0%	76.0%/73.0%	80.0%
Unemployment	5.3%	5.7%/30.8%	6.8%
Poverty	4.8%	N/A	15.1%
Children in Poverty	4.0%		21.3%
Single parent households	13.2%		19.9%
Single household 65 years and older	8.0%		10.5%
Mean travel time to work	39.2 min.		33.0 min.
Commute to work - drove alone - car, truck or van	75.4%		52.9%
Commute to work - public transportation	8.5%		28.2%
Homicide mortality rate (age-adjusted)/100,000 (NYSDOH 2011-2013)	0.3		3.5
Assault hospitalization rate (age-adjusted)/100,000 (NYSDOH 2011-2013)	1.3		3.2

Community Characteristic Summary

Education:

- Well educated, 93% having a high school diploma or higher
- Nearly half have an Associate's or college degree
- Compared to New York State, more Putnam residents have some college with or without a degree
- High school graduation rates exceed the New York State rate
    - 90% of students graduating within four years
- Putnam County, second highest rate in New York State (after Lewis and Wyoming at 91%)

Residents living in poverty have lower rates of graduation and attaining all levels of education. Education, particularly a college degree, is associated with higher paying jobs and improved health throughout the life cycle. Adults with limited education are more likely to be unemployed and involved in crime.

Employment & Income:

- Nearly 5% of Putnam children and adults live in poverty
- Putnam residents have a higher level of employment than New York State
    - One of the lowest unemployment rates within the State
    - Constant since 2012
    - Level of unemployment for those in poverty was a third of the New York State level

Employment impacts health through the income that it provides and the potential of health benefits provided by employers. Income and health have a reciprocal relationship; higher income leads to improved health and improved health leads to more opportunity for attaining higher income. Access to safe housing, healthy food and quality child care are also associated with higher income.

Family & Social Support:

- Putnam County has less single parent households than New York State
- Single households with individuals 65 years and older has remained constant since 2010

Individuals with more social support, less isolation and greater interpersonal relationships have healthier lives. Levels of anxiety, depression and stress-related behaviors are lower in those with social connectedness.

Transportation:

- Putnam workers have a longer commute than New York State by six minutes
- More Putnam workers commute alone than New York State workers
- Putnam workers use public transportation less than New York State workers

Longer commute times are associated with less free time, can contribute to poor health outcomes and can be associated with increased stress levels. There are also increased costs associated with owning a vehicle as well as the impact on traffic congestion and air pollution.

Community Safety:

- Putnam has low levels of homicide and assault
- Considered a safe county to live in

Lower levels of violence and higher levels of community safety are associated with improved health outcomes.

MORTALITY

A mortality rate is a measure of the number of specified deaths in a defined population during a certain time frame. Monitoring the total number of deaths in a population is an important public health function and is useful in determining the magnitude of deaths due to specific diseases. Disease mortality generally occurs more in older residents, but does occur across all age groups. To appropriately compare different populations (Putnam County versus the Mid-Hudson Valley versus New York State), it is best to use age-adjusted rates to ensure that the differences being observed are not due to differences in the age of a population. All mortality rates are age-adjusted and per 100,000 residents.

LEADING CAUSES OF DEATH 2016		
RANK	CAUSE OF DEATH	AGE-ADJUSTED RATE
1	Cancer	167.9
2	Heart Disease	148.8
3	Unintentional Injury	41.9
4	Chronic Lower Respiratory Disease	26.7
5	Septicemia	21.7
6	Stroke	19.1
7	Pneumonia and Influenza	20.6

LEADING CAUSES OF PREMATURE (<75 YEARS) DEATH 2016		
RANK	CAUSE OF PREMATURE DEATH	AGE-ADJUSTED RATE
1	Cancer	94.5
2	Heart Disease	42.4
3	Unintentional Injury	37.8
4	Septicemia	10.5
5	Chronic Lower Respiratory Disease	9.4
6	Suicide	10.5
7	Diabetes	6.8

Focusing on both overall mortality and premature mortality provides an opportunity to identify diseases that cause death in general as well as prematurely.

- Premature death rate – 5,070.8 years of potential life lost
  - 7th lowest rate in New York State
- Mortality rate – 594.0 per 100,000
  - 6th lowest rate in New York State
- Cancer is the leading cause of death and premature death.

COMPLETE DATA OVERVIEW

For a more complete overview of health in Putnam County review the Mid-Hudson Region Community Health Assessment 2019-2021. This contains the following data reviews: health care access and usage; neighborhood and built environment; domains of livability; health behavior indicators; and health indicators. The complete document is located at https://www.putnamcountyny.com/health/data/.

HANLON METHOD

The Hanlon Method is a technique created by J.J Hanlon to prioritize health problems. The trusted Hanlon Method minimizes personal bias and objectively prioritizes health problems based on baseline data and numerical values. This method guides the decision-making process for selecting health priorities and focuses on four criteria of individual health problems: size of the problem, seriousness of the problem, estimated effectiveness of the solution, and PEARL factors (propriety, economics, acceptability, resources, and legality).

For the Community Health Assessment, a modified Hanlon Method was used to determine health priorities in Putnam County. A total of 28 Health indicators from the five Prevention Agenda areas were analyzed. The size and seriousness of the problem were utilized to select the top eight health priorities in Putnam County, while the effectiveness of the solution and PEARL were addressed in the planning process. The highest possible score was 30 representing the most pressing concern. Final scores ranged from 11-26 and the top eight ranged from 26-23.

Score	Health Indicator
26	Cardiovascular Disease
25	Breast Cancer
24	Binge Drinking
24	Physical Inactivity
23	Chronic Lower Respiratory Disease
23	Childhood Immunization Series Completion
23	Opioid Burden
23	Smoking

The following pages include snapshots of each of the top eight Health Priority Profiles.

2019 COMMUNITY HEALTH ASSESSMENT
PUTNAM COUNTY, NY

#1 HEALTH PRIORITY

CARDIOVASCULAR DISEASE

Prevent chronic disease

WHAT IS CARDIOVASCULAR DISEASE?

Cardiovascular disease describes numerous conditions that affect the structures or function of the heart and/or blood vessels. These conditions typically involve narrowed or blocked blood vessels, often resulting in chest pain, a heart attack or stroke. Other forms of heart disease affect the heart's muscle, valves, or rhythm. Heart disease is the leading cause of death in the United States.[1]

PREVENTION[1]

- Don't smoke
- Exercise at least 30 minutes/day, 5x/week
- Reduce salt and saturated fat intake
- Maintain a healthy weight
- Reduce and manage stress in a healthy way

3 KEY RISK FACTORS FOR CVD[1]

- High blood pressure
- High HDL cholesterol
- Smoking

49%
of Americans have at least one of these 3 risk factors[2]

97.5
hospitalizations per 10,000 people in Putnam County[3]

37%
non-communicable, premature deaths that are CVD related in the United States[4]

$23 billion
estimated economic burden of CVD in New York State[5]

1 Mayo Clinic, 2018. https://www.mayoclinic.org/diseases-conditions/heart-disease/symptoms-causes/syc-20353118
2 Center for Disease Control and Prevention, 2011. https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6036a4.htm?s_cid=mm6036a4_w
3 New York State Community Health Indicator Reports, 2014-2016. https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/chir_dashboard/chir_dashboard&p=it&ind_id=Hd24a
4 World Health Orginization, 2017. https://www.who.int/news-room/fact-sheets/detail/cardiovascular-diseases-(cvds)
5 The Burden of Cardiovascular Disease in New York: Mortality, Prevalence, Risk Factors, Costs, and Selected Populations

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#2 HEALTH PRIORITY

BREAST CANCER

Prevent chronic disease

WHAT IS BREAST CANCER?

Breast cancer is a disease in which abnormal cells in the breast multiply uncontrollably. These abnormal cells typically form a tumor that can often be felt as a lump in the breast or seen on an x-ray. Unless detected early, the cancerous cells can invade other areas of the body. Breast cancer can affect anyone, regardless of gender. [1]

PREVENTION

- Maintain a healthy weight and exercise regularly [2]
- Do not drink alcohol or limit alcohol intake [2]
- Talk to your doctor about the risks of birth control [2]
- Talk to your doctor if you have a family history of breast cancer [3]
- Conduct regular breast self-exams and inform your doctor if you feel any unusual lumps [3]

145
breast cancer cases per 100,000 people in Putnam County [4]

30%
Putnam women aged 50-74 who did not get a mammogram in the past 2 years [5]

340
new cases of breast cancer in Putnam County over the past 5 years [6]

13
Putnam women die from breast cancer each year (on average) [7]

1 American Cancer Society, 2017. https://www.cancer.org/cancer/breast-cancer/about/what-is-breast-cancer.html
2 American Cancer Society, 2017. https://www.cancer.org/cancer/breast-cancer/risk-and-prevention/lifestyle-related-breast-cancer-risk-factors.html
3 American Cancer Society, 2017. https://www.cancer.org/cancer/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html
4 New York State Community Health Indicator Reports, 2013-2015. https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fchir_dashboard%2Fchir_dashboard&p=cct&cos1=13&cos2=33&cos3=37&cos4=3
5 Behavioral Risk Factor Surveillance System Brief, 2017. https://www.health.ny.gov/statistics/brfss/reports/docs/1811_breast_cancer_screening.pdf
6 New York State Cancer Registry, 2016. https://www.health.ny.gov/statistics/cancer/registry/table8/table8cnty.htm
7 New York State Cancer Registry, 2012-2016. https://www.health.ny.gov/statistics/cancer/registry/vol1/v1cputnam.htm

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#3 HEALTH PRIORITY

BINGE DRINKING

Promote well-being and prevent mental and substance use disorders

WHAT IS BINGE DRINKING?

Binge drinking is when large quantities of alcohol are consumed during a single session.[1] For men, 5 drinks or more over a 2 hour period is considered binge drinking.[2] For women, 4 drinks or more over a two hour period is considered binge drinking. Binge drinking is considered to be the most common, expensive, and dangerous pattern of excessive alcohol use in the United States.[2]

PREVENTION[3]

- Discontinue or limit alcohol use
- Do not supply alcohol to individuals under the age of 21
- Do not encourage drunk individuals to continue drinking
- Find healthy alternatives to cope with stress and other emotions
- Consult a healthcare professional if you're worried about your drinking habits leading to alcohol addiction

21.7%
adults in Putnam County binge drank in the past month[4]

88,000
lives lost in the United States each year due to excessive drinking[5]

42.5%
students age 13-18 in Putnam County who have used alcohol in their lifetime[6]

90%
or more of the alcohol that youth drink is while binge drinking[7]

Foundation for a Drug-Free World, n.d. https://www.drugfreeworld.org/drugfacts/alcohol/what-is-binge-drinking.html
Center for Disease Control and Prevention https://www.cdc.gov/alcohol/fact-sheets/binge-drinking.htm
American Addiction Center, 2018. https://www.recovery.org/alcohol-treatment/binge-drinking/
Behavioral Risk Factor Surveillance System, 2016. https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard&p=it&ind_id=pa55_0
Center for Disease Control and Prevention, 2018. https://www.cdc.gov/features/costsofdrinking/index.html
Prevention Council of Putnam, 2018. https://preventioncouncilputnam.org/wp-content/uploads/2018/09/Putnam-County-Profile-Report.pdf
Center for Disease Control and Prevention, 2012. https://www.cdc.gov/vitalsigns/bingedrinking/index.html

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#4 HEALTH PRIORITY

PHYSICAL INACTIVITY

Prevent chronic disease

WHAT IS PHYSICAL INACTIVITY?

Physical inactivity refers to people that don't get the recommended amount of regular physical activity.[1] Physical activity can include anything from taking a brisk walk, to lifting weights at the gym. Regular physical activity is one of the most significant things people can do to enhance their health.[2] Physically active individuals have a decreased risk for chronic disease and premature death.[2]

RECOMMENDATIONS [3]

- Children and adolescents should participate in at least 1 hour of physical activity per day
- Children and adolescents should participate in activity that is enjoyable, appropriate for their age, and includes muscle-strengthening and bone-strengthening activities
- Adults should partake in moderate intensity physical activity 150-300 minutes/week or 75-150 minutes/week of vigorous-intensity physical activity
- Adults should include muscle-strengthening activities at least 2x per week

75%
Putnam County residents who do not participate in leisure time physical activity on a regular basis[4]

80%
adolescents worldwide who are insufficiently physically active[5]

20-30%
increased risk of premature death for those that are physically inactive[5]

52.2%
Putnam County residents are obese or overweight [6]

New York State Department of Health, 1999. https://www.health.ny.gov/diseases/chronic/cvd.htm
Center for Disease Control and Prevention, 2019. https://www.cdc.gov/physicalactivity/about-physical-activity/index.html
Office of Disease Prevention and Health Promotion, 2015. https://health.gov/dietaryguidelines/2015/guidelines/appendix-1/
New York State Community Health Indicator Reports, 2013-2016. https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fchir_dashboard%2Fchir_dashboard&p=cct&cos1=13&cos2=55&cos3=48&cos4=51
World Health Organization, 2018. https://www.who.int/news-room/fact-sheets/detail/physical-activity
Behavioral Risk Factor Surveillance System, 2016. https://health.data.ny.gov/Health/Behavioral-Risk-Factor-Surveillance-System-BRFSS-H/jsy7-eb4n/data

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#5 HEALTH PRIORITY

CHRONIC LOWER RESPIRATORY DISEASE

Prevent chronic disease

WHAT IS CHRONIC LOWER RESPIRATORY DISEASE (CLRD)?

Chronic lower respiratory diseases are diseases that are characterized as shortness of breath caused by airway obstruction.[1] The four major diseases that CLRD refers to are chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, and asthma.[2] CLRD is the fourth leading cause of death in the United States.[3]

PREVENTION [4]

- Do not smoke cigarettes or electronic cigarettes such as vape pens, hookah pens, vaporizers and e-pipes[5]
- Avoid secondhand smoke
- Maintain proper nutrition
- Exercise regularly to build healthy lung capacity
- Avoid indoor, outdoor, and occupational air pollution; protect yourself by wearing a face mask in environments with significant air pollution

4.2%
adults in Putnam County with Chronic Obstructive Pulmonary Disease [6]

18
CLRD related hospitalizations per 10,000 people in Putnam County[6]

51%
COPD patients state that their disease disrupts their ability to work[7]

30
CLRD related deaths per 100,000 people in Putnam County [8]

1 West Virginia Health Statistics Center, 2006. http://www.wvdhhr.org/bph/hsc/pubs/other/clrd/national.htm
2 Oelsner, et.al., 2016. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5015752/
3 Center for Disease Control and Prevention, 2017. http://www.wvdhhr.org/bph/hsc/pubs/other/clrd/national.htm
4 World Health Organization, 2019. https://www.who.int/respiratory/publications/strategy/en/index5.html
5 New York Presbyterian, n.d. https://healthmatters.nyp.org/can-vaping-lead-to-lung-disease/
6 Behavioral Risk Factor Surveillance System, 2013-2014. https://health.data.ny.gov/Health/Behavioral-Risk-Factor-Surveillance-System-BRFSS-H/jsy7-eb4n
7 Guarascio, Ray, Finch & Self, 2013. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3694800/
8 New York State Community Health Indicator Reports, 2016. https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/chir_dashboard/chir_dashboard&p=it&ind_id=Md30

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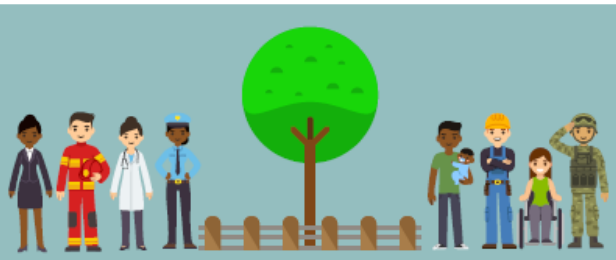

#6 HEALTH PRIORITY

IMMUNIZATION

Prevent communicable disease

WHAT ARE IMMUNIZATIONS?

Immunization is when a person becomes protected against a disease through vaccination.[1] Immunization throughout childhood is critical because it gives children protection from potentially life-threatening diseases before being exposed.[2] It is important to abide by the recommended immunization schedule because the body will not develop immunity against a disease unless the full immunization series is completed. Vaccines have been proven to be one of the most significant ways to put a stop to the serious consequences of vaccine-preventable diseases.[3]

RECOMMENDATONS [4]

- Be sure your children complete the 4:3:1:3:3:1:4 series by 18 months old
- After the age of 3, individuals should be vaccinated against the flu every year before the end of October
- Adults should get a Td vaccine every 10 years
- Adults over the age of 50 should get a shingles vaccine
- Consult your doctor regarding recommended vaccines based on your specific lifestyle

3 million
people die from vaccine-preventable deaths every year [5]

1.5 million
of these deaths are in children less than 5 years of age [5]

35.7%
children in Putnam have not completed the 4:3:1:3:3:1:4 series [6]

11
serious diseases can be prevented by completing the 4:3:1:3:3:1:4 series

Center for Disease Control and Prevention, 2018. https://www.cdc.gov/vaccines/vac-gen/imz-basics.htm
Center for Disease Control and Prevention, n.d. https://www.cdc.gov/vaccines/growing/index.html
Center for Disease Control and Prevention, 2018. https://www.cdc.gov/vaccines/vac-gen/why.htm
Center for Disease Control and Prevention, 2018. https://www.cdc.gov/vaccines/growing/images/global/CDC-Growing-Up-with-Vaccines.pdf
Children's Hospital of Philidelphia, 2018. https://www.chop.edu/centers-programs/vaccine-education-center/global-immunization/diseases-and-vaccines-world-view
New York State Department of Health Prevention Agenda, 2013-2018. https://www.health.ny.gov/prevention/prevention_agenda/2013-2017/tracking_indicators.htm

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2019 COMMUNITY HEALTH ASSESSMENT
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#7 HEALTH PRIORITY

OPIOID BURDEN

Promote well-being and prevent mental and substance use disorders

WHAT IS OPIOID BURDEN?

The opioid burden refers to deaths, non-fatal emergency room visits, and hospital discharges as a result of opioid use. Opioids are a class of drugs that include legal prescription pain relievers, as well as illegal drugs such as heroin and fentanyl.[1] Opioids block pain signals that the brain sends to the body, and release substantial amounts of dopamine, producing a euphoric effect.[1] This results in the misuse and abuse of opioids, which can lead to addiction, overdose, and death.[2]

COMBATTING THE CRISIS

- Understand the risks of taking opioids and consult your doctor about alternative pain management methods
- Attend a naloxone administration training session (naloxone is a medication that rapidly reverses the effects of other opioids and can save a life if someone around you is having an opioid overdose)[3]
- If you are seeking recovery, call the Substance Abuse and Mental Health Services Administration's (SAMHSA) hotline for drug abuse and addiction 1-800-662-HELP (1-800-662-4357)

250
opioid burden per 100,000 people in Putnam County[4]

116
opioid related hospitalizations per 100,000 people in Putnam County[5]

130
people die of an opioid overdose every day in the United States[6]

22
opioid overdoses per 100,000 people in Putnam County[7]

National Institute on Drug Abuse, n.d. https://www.drugabuse.gov/drugs-abuse/opioids
Center for Disease Control and Prevention, 2018. https://www.cdc.gov/drugoverdose/epidemic/index.html
National Institute on Drug Abuse, 2018. https://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio
NYSDOH Opioid Annual Report, 2018. https://www.health.ny.gov/statistics/opioid/data/pdf/nys_opioid_annual_report_2018.pdf
New York State Opioid Data Dashboard, 2016. https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/opioid_dashboard/op_dashboard&p=it&ind_id=op56
National Institute on Drug Abuse, 2019. https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis
NYSDOH County Opioid Quarterly Report, 2019. https://www.health.ny.gov/statistics/opioid/data/pdf/nys_apr19.pdf

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#8 HEALTH PRIORITY

SMOKING

Prevent chronic disease

WHAT IS SMOKING?

Smoking cigarettes is highly addictive, harms almost every organ in the body, and significantly disrupts overall health.[1] Cigarette smoking is the most significant preventable cause of death. Smokers are more likely than non-smokers to develop heart diseases, respiratory diseases, and cancer. In addition, smoking affects reproductive health, bone health, optical health, and health of the teeth and gums.[1]

FOR HELP QUITTING:[2]

- Discuss quitting with your healthcare provider
- Call the NYS Smokers Quitline at 1-866-NY-QUITS (1-866-697-8487)
- Try smoke free text: text QUIT to 47848
- Chat with a specialist online at LiveHelp.cancer.gov/
- Quitting smoking reduces the risk of disease, and can add years to your life.[1]

18.3%
Putnam residents are smokers
NYS: 14.5%[3]

30%
cancer deaths related to smoking[4]

1 in 5
deaths in the United States are caused by smoking[5]

9.6%
students age 13-18 in Putnam who report smoking in their lifetime[6]

Center for Disease Control and Prevention, 2018. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/index.htm
https://smokefree.gov/quit-smoking
Behavioral Risk Factor Surveillance System, 2016. https://webbi1.health.ny.gov/SASStoredProcess/guest?program=%2FEBI%2FPHIG%2Fapps%2Fchir_dashboard%2Fchir_dashboard&p=cct&cos1=13&cos2=55&cos3=48&cos4=51
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U.S. Department of Health and Human Services, 2014. U.S. Department of Health and Human Services. The Health Consequences of Smoking—50 Years of Progress: A Report of the Surgeon General.
Prevention Council of Putnam, 2018. https://preventioncouncilputnam.org/wp-content/uploads/2018/09/Putnam-County-Profile-Report.pdf

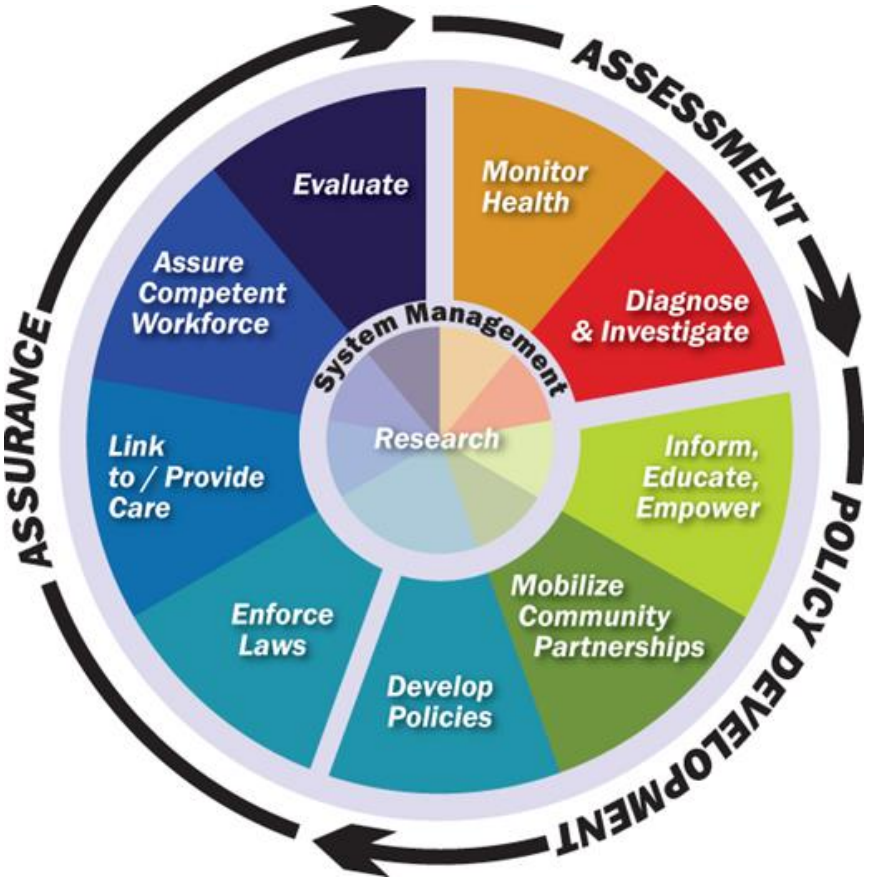
putnamcountyny.com/health

LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

The Local Public Health System (LPHS) Assessment measures the capacity of the public health system to provide the ten Essential Public Health Services. These services provide the fundamental framework for all local public health system activities that contribute to the health and well-being of communities.

THE TEN ESSENTIAL PUBLIC HEALTH SERVICES

1. Monitor health status to identify community health problems
2. Diagnose and investigate health problems and health hazards
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provisions of health
8. Assure a competent public and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population health services
10. Research for new insights and Innovative solutions to health



THE LOCAL PUBLIC HEALTH SYSTEM

The LPHS includes all of the organizations and entities that contribute to public health in a community, including the local health department and public, private and voluntary organizations.

In Putnam County, the LPHS is composed of many organizations (public, private and voluntary entities) and individuals that engage in activities that contribute to the delivery of the ten essential public health services.

The following is a list of the groups, committees, coalitions and task forces that are part of the LPHS:

Community Resource Group
Community Health Needs Committee
Live Healthy Putnam Coalition
Mental Health Provider Group
PC Disaster Preparedness/Bioterrorism Task Force
PC Fall Prevention Task Force
Putnam Communities That Care Coalition
Putnam Community Resilience Coalition
Putnam Reproductive Health Coalition
Regional Planning Consortium
Suicide Prevention Task Force
Tri-County Steering Committee

ASSESSMENT

This assessment aids in identifying paths for improvement, ensuring the provisions of quality services and the means for implementing more efficient responses to public health challenges. The Local Public Health System Assessment helps to answer these questions:

- What are the activities and capacities of our public health system?
- How well are we providing the Essential Public Health Services in our County?

METHODOLOGY

Putnam County utilized the National Public Health Performance Standards, a local public health system assessment, which is framed around the 10 Essential Public Health Services (EPHS). This tool is used throughout the United States to evaluate the performance of local public health systems. It was developed in 2001 as a collaboration of the Centers for Disease Control and Prevention and the National Association of County and City Officials. The assessment included model standards for each EPHS that describe the key aspects of an optimally performing public health system. Each model standard is followed by assessment questions that serve as measures of performance. Responses to these questions indicate how well the model standard, which portrays the highest level of performance, is being met. Participants responded to assessment questions using the response options beside. These same categories are used in this report to characterize levels of activity for each Essential Service.

LPHSA PERFORMANCE SCORING SCALE	
Optimal Activity	75% - 100% of the activity is met
Significant Activity	50% but no more than 74% of the activity is met
Moderate Activity	25% but no more than 49% of the activity is met
Minimal Activity	Greater than 0% but no more than 24% of the activity is met
No Activity	0% or absolutely no activity

PROCESS

The assessment was conducted during multiple sessions with key community partners representing the public health system. Sessions were organized by EPHS. Scoring is based on the knowledge and perception of participants in each EPHS group. This perception may not always be a true reflection of activity that is or is not taking place in the county. Results from the current 2019 assessment and the original 2016 assessment are shown beside.

SUMMARY OF ESSENTIAL PUBLIC HEALTH SERVICES SCORES		2016	2019
EPSH1	Monitor health status to identify community health problems	91	61
EPSH2	Diagnose and investigate health problems and health hazards	73	94
EPSH3	Inform, educate, and empower people about health issues	72	61
EPSH4	Mobilize community partnerships to identify and solve health problems	96	68
EPSH5	Develop policies and plans that support individual and community health efforts	83	56
EPSH6	Enforce laws and regulations that protect health and ensure safety	78	68
EPSH7	Link people to needed personal health services and assure the provision of health	78	59
EPSH8	Assure a competent public and personal health care workforce	58	34
EPSH9	Evaluate effectiveness, accessibility, and quality of personal and population health services	44	62
EPSH10	Research for new insights and innovative solutions to health problems	46	44
Overall Score		72	61

STRENGTHS

Based on the 2019 results from the assessment, the following areas have been identified as the top three strengths of the local public health system:

Number One Strength: ESSENTIAL SERVICE 2—Diagnose and investigate health problems and hazards.

- Reporting of suspected or confirmed communicable diseases is mandated under the NYS Sanitary Code. The PCDOH works with healthcare providers to ensure that reporting is done promptly and that the appropriate information is shared. PCDOH staff have worked to ensure that the current surveillance system is comprehensive. Also f importance is that providers recognize the PCDOH as a resource for testing and reporting questions.
- The PCDOH has continual access to the NYS testing laboratory at Wadsworth during emergencies, threats and other hazards. Written protocols are followed that relate to laboratory procedures and chain of command. Staff attend specific trainings to properly handle these protocols. PCDOH staff work to ensure that providers understand what specimens need to be collected and how they must be transported to Wadsworth.

Number Two Strength: ESSENTIAL SERVICE 6— Enforce laws and regulations that protect health and ensure safety.

- The NYS Association of City and County Health Officials and the National Association of City and County Health Officials provide updates on pending legislation allowing for local input into crafting new legislation.
- As part of general practice, staff receive information from partner agencies (NYSDOH, NYS Department of Environmental Conservation (DEC)) on changing laws, regulations and ordinances.
- Local coalitions monitor state and federal agencies for potential changes to laws and regulations impacting local services.
- There are several Public Health Law enforcement agencies in Putnam (PCDOH, PC Sheriff, NYSDEC, NYCDEP) and partners are aware of contacts so that questions are answered and potential issues resolved.
- In the event of a public health emergency or disaster the emergency preparedness partners work together to ensure appropriate legal agreements are prepared ahead of time, so that in the event of an emergency, MOUs and other agreements are already in place. In cases of public health emergencies, Isolation and Quarantine orders are necessary, and protocols are written so that they can be activated.

Number Three Strength: ESSENTIAL SERVICE 4— Mobilize community partnerships to identify and solve health problems

- Partnerships and alliances are strong within the community. The local public health system has strong connections and partners are familiar with community agencies.
- Many coalitions and task forces have been formed to address a broad variety of health topics.
- NYConnects and 2-1-1 provide current directories of resources for residents in need.

CHALLENGES

While much strength exists within Putnam's public health system, there are also always areas in which the County can improve.

Number One Challenge: ESSENTIAL SERVICE 8: Assure competent and personal health care workforce.

- There is limited funding available for workforce training incentives.
- Many agencies have a process for evaluating the need for training. Some discussions occur in coalition meetings so that agencies can share resources and optimize cost.
- The PCDOH includes education about the 10 essential services in public health summit presentations.

Number Two Challenge: ESSENTIAL SERVICE 10: Research for New Insights and Innovative Solutions to Health Problems.

- An understanding and intention exist that best practices in public health should be identified and used whenever possible; however, this does not always happen.
- There are no college or universities within Putnam County. When possible, partnerships are made with other institutions to further research and to expose students to the field of public health.

Number Three Challenge: ESSENTIAL SERVICE 5: Develop policies and plans that support individual and community health efforts.

- Many local partnerships exist within the emergency preparedness community. Ensuring the right partners attend meetings and participate in exercises is a challenge.
- The Bioterrorism/Disaster Preparedness Task Force does not always include a discussion of plan development. Most plan discussions focus on the health department's Public Health Emergency Preparedness and Response Plan (PHEPR); especially after an exercise is conducted and needs are identified through the after action process. The County Emergency Management Plan is not updated and discussed as regularly as the PHEPR.
- Plans exist but lack specific steps and the necessary details to respond in an emergency situation.

TRENDS

2019 was the second time the LPHSA was conducted. Comparisons to the initial 2016 LPHSA can be made, but it is difficult to pinpoint the cause of the changes over time. Some possible reasons include: overall development of the local public health system; participants' greater understanding of the issues; enhanced familiarity with the MAPP process; and even an economic or political climate that produces a different mental framework from which participants are making judgements. There is also always fluidity in these focus-group type assessments in which different respondents are participants to a greater and lesser degree.

Overall the number-one strength identified in 2019 was Essential Service 2—Diagnose and investigate health problems and hazards. In the previous 2016 assessment, this EPHS was not identified as a strength, nor as a challenge. In 2016 Essential Service 4—Mobilize community partnerships to identify and solve health problems was the leading EPHS.

For the challenges, more consistency seems apparent between the earlier 2016 assessment and the current one. The number-one challenge identified in 2019 and 2016 was Essential Service 8—Assure competent and personal health care workforce.

FORCES OF CHANGE ASSESSMENT

The most recent Forces of Change assessment (FOCA) was completed at the 2018 Public Health Summit. It was conducted as a brainstorming session with significant community partner discussion, looking for possible threats and opportunities. It identified forces—trends, factors or events—which will affect the health and quality of life of residents and the local public health system. These forces may be social and economic, political and legal, technological and scientific, environmental or ethical in nature. Although this assessment was formally conducted at the summit, these discussions are ongoing at committee and coalition meetings held throughout the year. This FOCA also included input from residents attending the Local Government Plan public forum.

OVERARCHING THEMES

ACCESSING SERVICES

Health outcomes can be directly impacted by the ability of residents to access services. Factors that impact access to services include: housing, transportation, availability of specialists (including mental health professionals), and referral along the continuum of care. To achieve the best possible health outcomes, partners have determined that publicity efforts will be increased in order to ensure residents are better informed regarding availability of services.

DISCUSSION DETAILS

SOCIAL AND ECONOMIC FORCES	THREATS POSED	OPPORTUNITIES CREATED
Demographic shift to an aging population	• Increased need for long-term care support and services • Increased need for caregiver support • Financial strain of home ownership • Lack of medical specialists to serve the changing population	• Office for Senior Resources was awarded a grant focusing on case management, home health aide support and connection to services
Domestic violence and sexual harassment	• Public health impact of trauma • Misconceptions of what is considered sexual violence and harassment, as well as lack of understanding of consent • Stigma and victim blame prevent victims from seeking help	• Create partnerships and coalitions to educate across all populations including age-appropriate education within schools to training law enforcement • Address trauma as a public health issue by promoting research and programs associated with Adverse Childhood Experiences and resilient and trauma informed communities • Formation of the Putnam County Domestic Violence and Sexual Violence Task Force

SHIFTING DEMOGRAPHIC TO AGING POPULATION

Putnam County is home to an aging population, which includes a significant Veteran population. While there are noteworthy services for older residents, still there remains a disparity in health care access, specifically integration of care and seamless referrals for services along the continuum of care. Much of this demand often falls on the shoulders of family caregivers, and the financial, emotional, and physical impacts of this can further burden families.

PREVENTION

Local agencies band together to address social determinants of health from both prevention and treatment perspectives. Through this work, the goal remains to create and support policy and a culture of care that identifies prevention (primary, secondary, and tertiary) as the key to improving population health. Employing health promotion as an integral component of prevention decreases the strain on the medical system and providers and integrates the community service agencies that address behavioral risk factors. Putnam County partners address behavioral risk factors such as tobacco use, diet and physical inactivity, mental health, injury prevention, drug and alcohol use, and behaviors related to sexual health.

DISCUSSION DETAILS

SOCIAL AND ECONOMIC FORCES	THREATS POSED	OPPORTUNITIES CREATED
Health insurance and marketplace	• Insurance company stock rises • Unknown future • Increased cost for some	• Insurance company structure may shift • Federally qualified health center (FQHC) may provide care • Benefit awareness • Shift to early intervention and prevention
Increased rates of STIs locally and nationally	• Infertility • Communicable disease spread • Overuse of antibiotics, antibiotics resistant strains	• Provider education to increase screening • Increase age-appropriate education through partnership with schools, community settings and physician offices • Research opportunities focused on prevention
Socialization	• Social isolation and loneliness is present is some segments of the senior population • Due to the closing of the Rockland Psychiatric Clinic satellite office in Brewster, many consumers do not have a place to socialize and make connections	• Connect seniors to services and programs available from Office for Senior Resources • Pursue opportunities for a Consumer Drop-In Center
State and Federal Regulations	• Medicaid challenges • Challenges acquiring services for non-Medicaid families • Lack of providers • Providers required to keep abreast of changing insurance regulations in order to provide services	• Delivery system redesign incentive program (DSRIP) working on addressing some gaps • Some regulations created to address health inequities • More children insured via affordable care act (ACA)
Veteran's Issues	• Housing issues • Mental health and PTSD issues • Aging veteran population	• Model Veteran support programs • Connect veterans to treatment services • Expand peer support

DISCUSSION DETAILS

POLITICAL AND LEGAL FORCES	THREATS POSED	OPPORTUNITIES CREATED
Uncertain Future of the ACA	• People may lose health coverage • Patients who do not utilize services appropriately will have preventable hospital admissions • Substance abuse and mental health clients difficult to insure appropriate access	• Increased number of residents with coverage • Value based payment system • Possibility for more collaborative discharge planning with all agencies
Legislation is not designed with prevention in mind	• Increased health care costs • Lack of support and investment in prevention • No mechanism in many health insurance plans and ACA to direct funds to prevention agencies. • Marijuana legalization	• Advocacy • DSRIP reinvestment of cost savings into prevention programs
Legalization of Recreational Marijuana	• Increase in marijuana usage, addiction, and likelihood of using other drugs • Law enforcement challenges with testing for impairment creates public safety concern	• Regulation of marijuana creates opportunities for business and research • Implementation of treatment programs over incarceration
TECHNOLOGICAL AND SCIENTIFIC FORCES	**THREATS POSED**	**OPPORTUNITIES CREATED**
Opioid Epidemic	• Pain needs to be managed and opioid based pain relievers provide the best pain management	• Create opportunities and education about non-physician pain management assistance • Less addictive alternative pain relievers are being administered
Addressing Addiction in Putnam County	• Narcan funding may not be sustained • Addiction and abuse continue in prisons even after the user is incarcerated	• Narcan training is widely available • Harm reduction strategies relieve the immediate overdose issue

DISCUSSION DETAILS

TECHNOLOGICAL AND SCIENTIFIC FORCES	THREATS POSED	OPPORTUNITIES CREATED
Emerging science of building resilient and trauma-informed communities	• Fear of violence • Looking at individual effect versus community impact	• Cross-sector and agency collaboration • Combine education regarding trauma and resilience with prevention and support • Apply a trauma informed framework • Provide peer support
Co-occurring Disorder Treatment	• Individuals with COD do not receive integrated care • Mental health agencies and substance use agencies are provided oversight and reimbursement from separate NYS offices, limiting services to those with COD	• Transform system of care to provide integrated and co-occurring capable treatment • Integrate the developmentally disabled population into mental health and substance use COD
On-line education	• No higher learning opportunities within Putnam County • Decreased personal interaction	• Increase opportunities for education without travel • Increase pathways to high school and college graduation
ETHICAL FORCES	**THREATS POSED**	**OPPORTUNITIES CREATED**
Affordable Housing Access challenges for marginalized populations	• Availability of affordable housing in general • People with mental illness often have co-morbidities such as substance abuse and chronic diseases • Social determinants of health impact diverse populations in need of housing • Funding is available for mixed-use housing however, there is a Not In My Backyard (NIMB) mentality blocking implementation	• Search For Change offers supportive housing opportunities for those in recovery

DISCUSSION DETAILS

ENVIRONMENTAL FORCES	THREATS POSED	OPPORTUNITIES CREATED
Transportation Limitations of Suburban/ Rural Community	• An aging population is unable to access healthcare due to lack of transportation • Youth have limited opportunities for after-school work • Working parents have limited options for youth involvement in after-school opportunities • Residents are unable to access services, food, and employment	• Use of technology and tele-help to reach patients who cannot access healthcare due to lack of transportation • Transportation Consortium created
Fossil Fuel Reliance	• Health impacts due to pollution-related diseases	• Use of mitigation control technologies that can reduce amount of pollution • Potential for education and regulation
Healthy Food Challenges	• Increasing costs of fresh fruits and vegetables • Access issues • Food deserts	• Farmer's markets • Implementation of nutrition policy • Formation of Food Security Task Force • Diversion of food waste

DATA SUMMARY

The following is a summary of data findings across all assessments. The table has been color coded by Prevention Agenda area. The leading priority areas identified were: Promote Well-Being and Prevent Mental and Substance Use Disorders and Prevent Chronic Diseases. Recurring Social Determinants of Health themes were also identified across the various assessments.

Overall the data from the Phase Three assessments supports the selection of the Priority Areas in Phase Four.

SUMMARY OF ASSESSMENT FINDINGS

COMMUNITY ASSET SURVEY	SIENA SURVEY	FOCUS GROUPS	HANLON	FORCES OF CHANGE	SUMMIT PRIORITY SELECTION	ONGOING COALITION DISCUSSIONS
Drug Abuse	Smoking	Access to Affordable Housing	Cardiovascular Disease	Aging Population and Associated Issues	Promote Mental Health and Prevent Substance Use	Food Security
Alcohol Abuse	Lack of Physical Activity	Knowledge of Existing Resources	Breast Cancer	Domestic Violence and Sexual Harassment	Prevent Chronic Disease	Fall Prevention
Mental Health	Stress	Drug and Alcohol Use	Binge Drinking	Rising Rates of STI		Smoking and Vaping
Mental Illness	Alcohol and Binge Drinking	Access to MH Providers	Physical Inactivity	Health Insurance and Marketplace		Co-Occurring Disorder Treatment
Chronic Disease	Knowledge of Services	Access to Health Insurance	Chronic Lower Respiratory Disease	Veteran's Issues		Trauma Informed Approach
	Transportation	Transportation		Food Security		STIs
	Use of ER for non-emergencies			Transportation		Harmful Algal Blooms

Promote Mental Health and Prevent Substance Use
Prevent Chronic Disease
Promote a Healthy and Safe Environment
Prevent Communicable Diseases
Social Determinants of Health

PHASE FOUR: STRATEGIC ISSUES

During this phase of the MAPP process the partners in the local public health system identified the most important issues facing the community. Priorities were selected by exploring the convergence of the results of the four MAPP assessments, partner input and review of priorities selected during the previous CHIP process, all through the lens of the Prevention Agenda. Below is an overview of the health issues that were identified as a new or ongoing priority in the community.

IDENTIFIED HEALTH PRIORITIES	
Promote Well-Being and Prevent Mental and Substance Use Disorders	Binge drinking
	Co-occurring disorder treatment
	Drug use (prescription and illegal)
	Trauma informed approach
Prevent Chronic Disease	Food security
	Physical Inactivity
	Smoking
	Vaping
Promote a Healthy and Safe Environment	Fall prevention
	Harmful algal blooms (HAB)
Promote Healthy Women, Infants, and Children	Breastfeeding
	Mental health support
Prevent Communicable Diseases	Sexually transmitted infections
	Vaccine preventable diseases

Partners are engaged in providing evidence-based programs and services. The following is an overview of some of the efforts currently being addressed within Putnam County.

FRAMEWORK FOR PRIORITY SELECTION

The Prevention Agenda (PA) is New York State's health improvement plan and is the guide for state and local action. The goal is to improve the health and well-being of all New Yorkers and promote health equity across populations. The PA is based on a statewide health assessment using the County Health Rankings model and Health Across All Policies approach. In the current 2019-2024 cycle, the Prevention Agenda has five priority areas:

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

These priority areas are the foundation for the Putnam County CHA and CHIP as well as the previously discussed SDOH focus. During the past year and through regular coalition meetings, the following strategic issues have been identified and are the focus for the 2020-2022 CHIP.

PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS

Behavioral Health is the intersection of mental and emotional well-being and is essential to overall health and quality of life. Mental health and well-being can drive physical health issues, substance use and chronic diseases. Because mental and physical health are interwoven, opportunities exist within routine healthcare visits to improve mental health.

Locally, residents identified drug use, alcohol use and mental health as the top health concerns within the County. Provider and resident feedback suggest that accessing mental health services in a timely manner continues to be a significant challenge. According to the 2018 Prevention Needs Assessment school survey, 42% of eighth through twelfth grade students in Putnam have experienced depressive symptoms (an increase of 14% since 2014). While awareness of mental health issues grows, and stigma surrounding mental health dissipates, services must become more accessible. By addressing this priority area residents can achieve more at school, be more productive at work and have a better quality of life.

Social Determinants of Health: In order to improve mental health and well-being, the Putnam community recognizes the importance of having a resilient and trauma-informed community. When agencies understand the impact of trauma on individuals and the community, they can change their philosophy and approach. This includes: realizing the prevalence of trauma, recognizing the signs and symptoms, responding in an understanding and supportive manner and resist doing further harm.

Adverse Childhood Experiences have lifelong effects that include enormous psychosocial and economic costs for individuals, their families, schools and communities. Locally, agencies are committed to building resilience across the lifespan for people of all ethnicities, education level, income and employment status and especially for those facing barriers to treatment and recovery.

Education and Prevention Efforts	Co-Occurring Disorders	The COMPASS-EZ self-assessment tool being used by agencies
		Co-Occurring Systems of Care committee created
		National expert provided training
		Regional Planning Consortium (RPC) statewide priority
	HEALing (Helping to End Addiction) Communities Study	Putnam County selected as a first phase community in the National Institutes of Health long-term study
		Communities That Care model
	Suicide Prevention Gatekeeper Trainings	ASIST (Applied Suicide Intervention Skills Training)
		CIT (Crisis Intervention Team)
		Lifelines Intervention
		Mental Health First Aid
		QPR (Question, Persuade, Refer)
		safeTALK (Suicide Alertness for Everyone)

Education and Prevention Efforts, continued	Co-Occurring Disorders	Naloxone training
		Peer support services
		Physician education with CDC *Guidelines for Prescribing Opioids for Chronic Pain*
		Two annual medication take back days and six permanent medication drop boxes
	Senior Social Isolation	Adult day services
		Chronic disease self-management program
		Fall prevention classes
		Four Senior Centers within in Putnam County
		Senior Center nutrition program
		Transportation services
	Trauma-Informed Community	GlaxoSmithKline grant establishing the Community Resilience Coalition
		Hudson Valley Trauma-Informed Committee
		Mental Health and Regional Youth Justice grant – use of self-ARTIC (Attitudes Related to Trauma-Informed Care) scale assessment tool; and use of Risking Connection framework for trauma-informed system change
		Provider education on ACEs (Adverse Childhood Experiences)
		RESILIENCE screenings
		Resilient Children/Resilient Communities Toolbox created
		State University at Buffalo trauma-informed organization change collaborative
Policy Efforts	Drug Treatment Court	Combines judicial oversight as well as treatment, case management, drug testing and support of a multidisciplinary team to strengthen recovery from substance use and mental illness
	Hope not Handcuffs	Initiative brings law enforcement and community organizations together to find treatment options for individuals seeking help to reduce drug dependency
Healthcare	Electronic Medical Records	Embedding screenings for suicide, mental health, trauma and referral to community programs into the EMR (electronic medical record)
	Controlled Substance Registry	Use of I-STOP/PMP (Internet System for Tracking Over-Prescribing/Prescription Monitoring Program) registry for schedule II, III, and IV controlled substance prescriptions

Community Partners:

CoveCare Center, Drug Crisis in Our Backyard, Faith-based agencies, Fidelis Care, Green Chimneys, the harris project, Mental Health Association of Putnam, PC Departments of Mental Health, Social Services, & the Youth Bureau, PC Office for Senior Resources, PC Probation Department, PC Public School Districts (Brewster Central School District, Carmel Central School District, Garrison Union Free School District, Haldane Central School District, Mahopac Central School District, Putnam Valley Central District), PC Sheriff's Department, Putnam Communities That Care Coalition, Putnam Hospital Center, Putnam-Northern Westchester BOCES, Prevention Council of Putnam, Suicide Prevention Task Force

PREVENT CHRONIC DISEASE

Cancer, heart disease and stroke, type 2 diabetes and chronic lung diseases account for over 50 percent of all deaths worldwide. Unhealthy eating, lack of physical activity and tobacco use are all health behaviors that if improved could directly decrease the leading causes of mortality. Environments that support physical activity and healthy food access can promote health and prevent chronic diseases.

Locally, cardiovascular disease, breast cancer and physical inactivity are leading health indicators identified in the Hanlon assessment. The Community Asset Survey revealed that Putnam has opportunities for physical activity. However, census data reveal a large portion of residents commuting far distances reducing their availability to take advantage of those opportunities. By addressing this priority area, residents can have better health outcomes, improved mental health and social cohesion.

Social Determinants of Health: Countywide, agencies work to address the modifiable factors that contribute to chronic diseases, including but not limited to preventative measures in medicine. Through availability of healthy foods, keeping residents active, increasing access to health care services, including transportation, and addressing the unique needs of vulnerable populations, organizations in Putnam address the causes and implications of chronic disease.

Education and Prevention Efforts	Food Security	Electronic listing of food resources; Various agencies are conducting food security screenings as part of the intake process; Referral system in place for some agencies; Nutrition education services; Meal delivery services for the elderly; Food banks; Food rescue organization and system; and Farmers markets.
	Chronic Disease Management	CDSMP (Chronic Disease Self-Management Program) offered in collaboration with the visiting nurse agencies, hospital and senior centers.
	Early Childhood Gardening	Establishing healthy eating patterns begins at a young age. Partnerships with daycares, schools and libraries have been established to encourage gardening as a way to introduce fruits and vegetables to children.
	School District Wellness Committees	Each school district has formed a wellness committee. These groups identify ways to implement policies and programs that support health eating, increased physical activity and decrease consumption of sugar-sweetened beverages.
	Vaping and Smoking Cessation	Encourage and promote use of vaping and smoking education and cessation programs like Freedom From Smoking (FFS), In Depth, Fresh Start and Not On Tobacco (N-O-T).
	Vaping and Smoking Education	Prevention Council, POW'R Against Tobacco and the schools work closely to identify trends based on data and then implement evidence-based programs to increase awareness and prevent initiation of tobacco use and vaping. The CTC (Communities That Care) prevention system is currently focusing on the vaping epidemic.

Policy Efforts	Flavor Ban	Support of New York State executive action for flavored vape ban that is currently undergoing legal challenges in court.
	Point of Sale	Continue to educate and enforce limits on point-of-sale tobacco marketing and advertising.
	T21 (Tobacco)	Continue education efforts and enforcement actions around the T21 legislation.
	Tobacco-Free Grounds	Department of Veterans Affairs implemented tobacco-free grounds for VA hospitals.
Healthcare	EMR	Embedding screenings for smoking and vaping and referral to community programs into the EMR (electronic medical record).
	HIE	Work with medical providers to utilize the community referral platform in the HIE (health information exchange) to seamlessly refer patients to evidence-based education resources (CDSMP, NDPP, FFS).

Community Partners:

American Lung Association, CareMount Medical, Catholic Charities Community Services, Center for a Tobacco-Free Hudson Valley, Childcare Council of Putnam and Dutchess, Cornell Cooperative Extension, Drug Crisis in Our Backyard, HealtheConnections, Health Quest Medical Practice, Local Child Care Providers, Local Food Pantries, Local Healthcare Providers, Master Gardeners, MiSN, Northwell Health at Home, NYS Police Department, One Army in the War Against Addiction, Open Door Family Medical Center, PC Department of Health, PC Legislature, PC Office for Senior Resources, PC Libraries (Brewster Public Library, Kent Public Library, Reed Memorial Library, Butterfield Memorial Library, Desmond-Fish Library, Mahopac Public Library, Patterson Library, Putnam Valley Free Library), PC Public School Districts (Brewster Central School District, Carmel Central School District, Garrison Union Free School District, Haldane Central School District, Mahopac Central School District, Putnam Valley Central District), PC Sheriff's Department, Prevention Council of Putnam, Putnam Communities That Care Coalition, Putnam Community Action Partnership, Putnam Hospital Center, Putnam Independent Living Services, Putnam Northern-Westchester BOCES, Second Chance Foods, The Plaza at Clover Lake Assisted Living, POW'R Against Tobacco, Visiting Nurse Services in Westchester.

PROMOTE A HEALTHY AND SAFE ENVIRONMENT

While this priority area is wide ranging, it includes focus areas that are integral to public health and wellbeing such as: injuries, violence, occupational health, air and water quality, environmental safety, and food and consumer products. Focusing on intentional and unintentional injuries has much overlap with the promotion of mental health and well-being particularly the trauma-informed community approach.

Locally, unintentional injury is the third leading cause of death. Falls remain a concern in residents over age 65 with the rate in Putnam being higher than the Hudson Valley. Also higher in Putnam is the presence of HABs (Harmful Algal Blooms) in local waterbodies.

Social Determinants of Health: A key factor in reducing falls is the home environment, and recommended changed depend upon an individual's control of and financial ability to accomplish this. In addition, many of the same social factors that shape health are also linked to violence. Therefore understanding these links can contribute to understanding those more affected by violence. Globally, community organizations are addressing the role of environment on public health by working to ensure the environment where we live, work, learn and play are healthy and safe for everyone.

Education and Prevention Efforts	Domestic Violence and Sexual Violence Task Force	A Task Force created to coordinate efforts for education and prevention focused on domestic violence, sexual violence and human trafficking.
	Fall Prevention	Use of evidence-based classes that prevent falls (Tai Chi for Arthritis, A Matter of Balance); General education about fall risks through events and classes; and Coordination of fall prevention efforts through the Fall Prevention Task Force.
	Food Safety	Continue to identify opportunities to bring food operators and public health experts together for better food safety management.
	Water Quality - HAB (Harmful Algal Blooms)	Work with partners to provide technical assistance to ensure clean drinking water and safe recreational areas; Continue public outreach and educational events to ensure that residents understand health implications; Partner with academia, state and local agencies to develop strategies for prevention and mitigation; and Educate the community about state laws and programs to control pollution and reduce excess nutrients from entering waterbodies.
Policy Efforts	Cooling Centers	Work with local governments to identify locations for cooling centers during extreme heat events and have memorandum of understanding in place to ensure availability and accessibility when centers are needed.
	Housing	Continue to collaborate on identifying grants to expand affordable and accessible housing; and Continue to collaborate on locating a permanent homeless shelter.
	Nutrient Loading Reduction	Work with state and local agencies to identify possible environmental nutrient (nitrogen, phosphorus and sulfur) loading reduction strategies in agricultural, industrial and urban activities.

Community Partners:

Catholic Charities Community Services, Cornell Cooperative Extension, Hudson Valley Regional Community Health Centers, Local Food Operators, Northwell Health at Home, NY Presbyterian Hudson Valley Hospital, NYC Department of Environmental Protection, NYS Department of Environmental Conservation, NYS Department of Health, PC Bureau of Emergency Services, PC Department of Health, PC Departments of Mental Health, Social Services, & the Youth Bureau, PC Disaster Preparedness/Bioterrorism Task Force, PC District Attorney's Office, PC Domestic Violence & Sexual Violence Task Force, PC Fall Prevention Task Force, PC Office for Senior Resources, PC Probation Department, PC Public School Districts (Brewster Central School District, Carmel Central School District, Garrison Union Free School District, Haldane Central School District, Mahopac Central School District, Putnam Valley Central District), PC Sheriff's Department, PC Town Supervisors, PC Veterans Service Agency, PFC Joseph P. Dwyer Vet 2 Vet Program of Putnam County, Putnam Hospital Center, Putnam Independent Living Services, Putnam Northern-Westchester BOCES, Putnam Nursing and Rehabilitation Center, Putnam Ridge, Putnam/Northern Westchester Women's Resource Center, Search for Change, Second Chance Foods, The Plaza at Clover Lake Assisted Living, United States Senate, Visiting Nurse Services in Westchester.

PROMOTE HEALTHY WOMEN, INFANTS, AND CHILDREN

When it comes to evaluating a healthy community, the health of its children is of utmost importance. Fostering healthy children includes educating parents about developmental milestones, immunizations, and community services. When a community prioritizes maternal health, it also commits to ensuring healthy babies and healthy children. Focusing on these critical developmental periods – pregnancy, early childhood and adolescent, improves quality of life across the lifespan.

Social Determinants of Health: Across sectors, local agencies are working toward a goal of creating physically, mentally and emotionally healthy and resilient children, who will continue to grow into healthy adults. Providers pay particular attention to the healthy development, behaviors and relationships throughout childhood and adolescence. Particular attention is also given to the needs of women, regardless of their age, sexual or gender identity, pregnancy history or future reproductive plans. By addressing the social factors that impact these vulnerable groups, improved birth outcomes and long-term health outcomes can be impacted.

Education and Prevention Efforts	Breastfeeding Support	Collaborate with local hospitals to increase access to professional breastfeeding support (RN and lactation consultants); Expand peer support opportunities; and Expand support groups and drop-in center model.
	Co-Occurring Disorders	Expand the co-occurring disorder model of treatment to include populations with developmental disabilities.
	Coordinated Care	Continue a collaborative care model that ensures opioid and drug addicted pregnant women receive treatment to lessen impact on infants.
	Home Visits	Continue access to home visits for those parents that are unable to attend support groups.
	Trauma-Informed Care	Increase awareness and knowledge of social-emotional development and wellness, ACEs (adverse childhood experiences) and trauma-informed care; Support those families impacted by violence and trauma.
	Well Visits	Promote resources that assist with health insurance enrollment and access to well visits.
Policy Efforts	Breastfeeding in Public Places	Educate mothers about the law permitting breastfeeding in public and private locations.
	Breastfeeding in the Workplace	Educate mothers about the law permitting a mothers right to pump milk at work and the requirement that employers must attempt to accommodate an employees' request for a private place.
	Developmental Screenings	Ensure access to developmental screenings and evaluation of need for Early Intervention services.

Community Partners:

CareMount Medical, Catholic Charities Community Services, Childcare Council of Dutchess and Putnam, Cornell Cooperative Extension, CoveCare Center, Eat Smart NY, Fidelis Care, Green Chimneys, MiSN, MVP Heath Care, New York Presbyterian Hudson Valley Hospital, Open Door Family Medical Center, PC Bureau of Emergency Services, PC Child Advocacy Center, PC Department of Health, PC Head Start, PC Libraries (Brewster Public Library, Kent Public Library, Reed Memorial Library, Butterfield Memorial Library, Desmond-Fish Library, Mahopac Public Library, Patterson Library, Putnam Valley Free Library), PC Public School Districts (Brewster Central School District, Carmel Central School District, Garrison Union Free School District, Haldane Central School District, Mahopac Central School District, Putnam Valley Central District), Putnam Community Action Partnership, Putnam Hospital Center, Putnam Independent Living Services, Putnam Northern-Westchester BOCES.

PREVENT COMMUNICABLE DISEASES

At the state level, there are several focus areas regarding communicable disease prevention: immunization for vaccine-preventable diseases, HIV, STIs (sexually transmitted infections), hepatitis C virus, antibiotic resistance and healthcare-associated infections. Presently, with measles in the spotlight, public education regarding the importance of vaccination has reemerged as a priority.

Locally rising rates of STIs are a growing concern especially with reports of difficulties for young adults accessing testing and treatment resources. Changes in vaccine requirements for school-aged children continue to require education for both parents and schools.

Social Determinants of Health: By offering free and reduced cost vaccinations, partners are addressing the disparities that lead to lower vaccination coverage among certain populations. Putnam county agencies employ a collaborative approach to antibiotic, immunization and communicable disease education.

Education and Prevention Efforts	Hepatitis C and HIV clinics	Free Hepatitis C and HIV testing available for those unable to access testing from providers or other clinics.
	Influenza Clinics	Residents are encouraged to get vaccinated for influenza annually and can obtain this vaccine from their provider or at local pharmacies. School-based and public influenza clinics are also held to ensure that residents have various options.
	Travel Vaccine Clinic	Vaccines are recommended in general and when traveling abroad. Residents who attend this clinic are provided with assistance in determining what vaccines are required or recommended for their destination. It is also an opportunity to discuss other health risks and where to stay up to date on travel notices and alerts.
	Teen Reproductive Health	Expand education provided to adolescents about reproductive health issues, HIV and STI testing and legal rights.
	Vaccine for Children (VFC)	VFC is a federally-funded program that provides vaccines at no cost to eligible children.
Policy Efforts	Expedited Partner Therapy (EPT)	Legislation enacted allowing for the treatment of sex partners of persons diagnosed with Chlamydia trachomatis (Ct). EPT allows health care providers to provide patients with medication or a prescription to deliver to his/her sex partner(s) without a medical evaluation or clinical assessment of those partners.
	Immunization Requirements	NYS changed the legislation eliminating the non-medical exemptions from school vaccination requirements in child day care programs and public, private or parochial schools.
	Minors' Rights Law	Educating adolescents about the minors' rights law allowing for STI testing without parental consent.
	Tracking System for Vaccine Administration	Expansion of the use of the New York State Immunization Information System to include adult vaccine information as well as children under age 18.

Community Partners:

CareMount Medical, Green Chimneys, Health Quest Medical Practice, Local Healthcare Providers, Local Pharmacists, NYS Department of Health, Open Door Family Medical Center, PC Department of Health, PC Office for Senior Resources, PC Public Schools (Brewster Central School District, Carmel Central School District, Garrison Union Free School District, Haldane Central School District, Mahopac Central School District, Putnam Valley Central District), Planned Parenthood, Putnam Hospital Center, Putnam Northern-Westchester BOCES, PC Youth Bureau, Putnam Reproductive Health Coalition.

PHASE FIVE:
FORMULATE GOALS AND STRATEGIES

During this phase of the MAPP process, strategic issues identified in the previous phase are formulated into goal statements. Then, broad strategies are identified for addressing issues and achieving goals related to the community's vision. The result is the development of the following CHIP grids which include goals, objectives, interventions, activities, partner roles, timelines and process measures for each selected priority and focus area.

PROMOTE WELL-BEING AND PREVENT MENTAL AND SUBSTANCE USE DISORDERS					
Focus Area	Mental and Substance Use Disorders Prevention				
Overarching Goal	2.2 Prevent opioid and other substance misuse and deaths				
Objectives	Reduce the age-adjusted overdose deaths involving any opioid by 7% to 22.9 per 100,000 population. 2016 Baseline 24.3 per 100,000				
	Increase the age-adjusted Buprenorphine prescribing rate for substance use disorder (SUD) by 20% to 67.2 per 1,000 population. 2017 Baseline: 56.0 per 1,000				
	Reduce the age-adjusted all emergency department visits (including outpatients and admitted patients) involving any opioid overdose rate by 5% to 59.4 per 100,000 population. 2016 Baseline: 62.5 per 100,000				
	Data Sources: NYS Vital Statistics; NYS Prescription Monitoring Program; and NYS Statewide Planning and Research Cooperative System				
Timeframe	By December 31, 2022				
EVIDENCE-BASED (EB) STRATEGY	ACTIVITIES	LEAD PARTNERS	TIMEFRAME	EVALUATION MEASURE	OUTCOME
Increase availability of/access and linkages to medication-assisted treatment (MAT) including Buprenorphine	Identify potential trainers for training that complies with the Drug Addiction Treatment Act of 2000 requirement for eight-hour training	PCDOMH Putnam Hospital	Q1 2020	Number of trainers identified	Increased access to EB MAT Waiver Training
	Identify potential community partners to provide overview of local resources and support	PCDOMH Putnam Hospital MH Provider Group	Q1 2020	Number of community partners identified to educate providers	Increased provider awareness of local resources within Putnam County
	Identify time and place for training	PCDOMH Putnam Hospital MH Provider Group	Q1 2020	Number of EB trainings set	Increased access to EB MAT Waiver Training
	Identify providers to include in initial MAT training	PCDOMH Putnam Hospital MH Provider Group	Q2 2020	Number of providers identified	Increased pool of providers invited to EB MAT Waiver Training
	Conduct an evaluation of the initial MAT training process	Local providers PCDOMH Putnam Hospital MH Provider Group	Q3-Q4 2020	Number of completed evaluations	Increased attendance to EB MAT Waiver Training
	Develop system for ongoing MAT training	PCDOMH Putnam Hospital MH Provider Group	Q1 2021	Number of EB trainings set	Increased number of providers that can prescribe Buprenorphine
MAT Measures	% Initiation of pharmacotherapy upon new episode of opioid dependence				Decreased opioid related deaths and hospitalizations
	# Providers trained in MAT				
Evidence-Base	Implementing Transmucosal Buprenorphine for Treatment of Opioid Use Disorder Best Practices from New York State Department of Health and Office of Alcoholism and Substance Abuse Services https://www.health.ny.gov/diseases/aids/consumers/prevention/buprenorphine/docs/bupe_best_practices_2019.pdf				

PREVENT CHRONIC DISEASES					
Focus Area 1	**Healthy Eating and Food Security**				
Overarching Goal	1.3 Increase Food Security				
Objectives	Increase the age-adjusted percentage of adults with perceived food security (among all adults) by 5%. 2016 Baseline 79.6%				
	Increase the percentage of adults with perceived food security (among adults with an annual household income of <$25,000) by 10%. Baseline TBD				
	Data Sources: NYS Behavioral Risk Factor Surveillance System				
Timeframe	By December 31, 2022				
EVIDENCE-BASED (EB) STRATEGY	ACTIVITIES	LEAD PARTNERS	TIMEFRAME	EVALUATION MEASURE	OUTCOME
Screen for food insecurity, facilitate and actively support referral	Create Putnam County Food Security Coalition	Cornell Cooperative Ext PCDOH Putnam Hospital Second Chance Foods	Q1 2020	Coalition created	Group dedicated to increasing food security
	Investigate use of American Academy of Pediatrics Promoting Food Security for All Children EB intervention	Food Security Coalition	Q2 2020	Number of EB models reviewed	EB model used as foundation
	Develop standardized definition and screening questions for food insecurity	PCDOH Putnam Hospital	Q3 2020	Number of standardized screening questions identified	Standardized screening questions utilized
	Develop system for embedding questions into provider EMRs	PCDOH Putnam Hospital	Q4 2020 – Q1 2021	System created for EMR	Food security screening embedded in EMR
	Develop system for referral of food insecure patients to community services via Health Information Exchange	HealtheConnections PCDOH Food Security Coalition	Q1-Q2 2021	System created for HIE	Food security referrals embedded in HIE
Refer food insecure clients to local resources	Conduct data review and inventory current food system resources	Cornell Cooperative Ext PCDOH Second Chance Foods	Q1 2020	Number of resources available	Systematic review of data and resources conducted
	Develop interactive website of local resources	PCDOH PC Information Technology	Q2-Q4 2020	Online tool created	Providers and residents aware of resources
Food Security Measures	# Providers incorporating food security screening into EMR				Increased food security
	# Providers that facilitate referrals to supportive services				
Evidence-Base	Promoting Food Security for All Children https://pediatrics.aappublications.org/content/136/5/e1431#sec-3				

PHASE SIX: TAKING ACTION

The Taking Action phase links three activities—Planning, Implementation, and Evaluation. Each of these activities builds upon the other in a continuous and interactive manner. The action cycle is the final phase of MAPP, but it is by no means the "end" of the process. During this phase, the efforts of the previous phases begin to produce results. The local public health system develops and implements an action plan, and evaluates performance for addressing priority goals and objectives.

The Community Resource Group, Communities That Care Coalitions, Fall Prevention Task Force, Hudson Valley Regional Health Official Network, Live Healthy Putnam Coalition, Mental Health Provider Group, Putnam Hospital Center Community Health Needs Committee, and Suicide Prevention Task Force will plan, implement and monitor the progress toward meeting the goals set forth in the following grids. As part of the evaluation process quarterly updates will be provided whereby process measures will be tracked and interventions adjusted accordingly.

The MAPP process and CHIP planning activities are a roadmap to improving the health status of Putnam County. This process guides the actions of our local public health system to implement evidenced-based initiatives and strategies to improve health outcomes.

Successful achievement of the plan depends upon the continued commitment of all of our community partners and residents. The following list shows the partners dedicated to improving the health of residents by Prevention Agenda priority area.

PARTNER INVOLVEMENT BY CHIP PRIORITY

Advanced Chiropractic Wellness Care
American Heart Association
American Lung Association
Anthem, Inc.
The Arc. Mid-Hudson
Arms Acres-Liberty Management
Brewster Central School District
Brewster Emergency Center Partnership
Brewster Public Library
Butterfield Memorial Library
Camp Wilbur Herrlich
CareMount Medical
Carmel Central School District
Catholic Charities Community Services
Catskill Hudson Area Health Education Center
Center for a Tobacco-Free Hudson Valley
Child Care Council of Dutchess & Putnam
Community Health Needs Committee
Community Resource Group
Cornell Cooperative Extension
CoveCare Center
Desmond-Fish Library
Drug Crisis in our Backyard
Dutchess County Department of Health
Eat Smart NY
Fidelis Care
Four Winds Hospital
Garrison Union Free School District
Green Chimneys
Haldane Central School District
the harris project
HealtheConnections
Hudson Valley Community Services, Brewster
Hudson Valley Regional Community Health Center
HYGEIA Integrated Health LLC
Kent Police Department
Kent Public Library
Live Healthy Putnam Coalition

Lower Hudson Valley Perinatal Network 
Mahopac Central School District 
Mahopac Public Library 
Mental Health Association of Putnam 
Mental Health Providers Group 
MiSN (Maternal Infant Services Network) 
MVP Healthcare 
National Association of Mental Illness 
Northwell Health at Home 
Nuvance Health 
NY Presbyterian Hudson Valley Hospital 
NY Presbyterian Hudson Valley Physical Therapy 
NYS Department of Health 
NYS Office of Children and Family Services 
NYS Office of Emergency Management 
NYS Police Department 
Open Door Family Medical Center 
Orange County Department of Health 
Patterson Library 
PC Board of Health 
PC Bureau of Emergency Services 
PC Child Advocacy Center 

PC Department of DSS, Mental Health 
PC Department of Health 
PC Disaster Preparedness/Bioterrorism TF 
PC District Attorney's Office 
PC Fall Prevention Task Force 
PC Legislature 
PC Medical Reserve Corps 
PC Office for People with Disabilities 
PC Office for Senior Resources 
PC Probation Department 
PC Sheriff's Department 
PC Veterans Service Agency 
PC Youth Bureau 
PEOPLE, Inc. 
Planned Parenthood Hudson Peconic 
The Plaza at Clover Lake Assisted Living 
POW'R Against Tobacco 
Prevention Council of Putnam 
Putnam Communities That Care Coalition
Putnam Community Action Partnership
Putnam Community Resilience Coalition
Putnam Hospital Center

Putnam Independent Living Services
Putnam & N. Westchester BOCES
Putnam & N. Westchester Women's Resource Center
Putnam Nursing and Rehabilitation Center
Putnam Reproductive Health Coalition
Putnam Ridge
Putnam Valley Central School District
Putnam Valley CTC
Putnam Valley Free Library
Reed Memorial Library
Regional Planning Consortium
Rockland County Department of Health
Rockland County Office of Mental Health
Rose House (PEOPLE)
Search for Change
Second Chance Foods
St. Christopher's Inn
Suicide Prevention Task Force
Sullivan County Department of Health
Town of Carmel Parks & Recreation
Tri-County Steering Committee
Ulster County Department of Health
United Way of Westchester & Putnam
VET2VET Program of Putnam
Veterans Task Force
Visiting Nurse Service Westchester
Westchester County Department of Health

Prevent Chronic Disease
Promote Mental Health and Prevent Substance Abuse
Promote a Healthy and Safe Environment
Prevent Communicable Diseases
Promote Healthy Women, Infants, and Children

RESOURCES

*Topic and Sources are arranged in order of the documents utilized

TOPIC	SOURCE
Mobilizing for Action through Planning and Partnerships (MAPP)	National Association of County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC) https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp
2019-2024 Prevention Agenda	New York State Department of Health (NYSDOH) https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/
Social Determinants of Health	Kaiser Family Foundation https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/
	Office of Disease Prevention and Health Promotion (ODPHP) https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
Health Across All Policies	New York State Department of Health (NYSDOH) https://www.health.ny.gov/prevention/prevention_agenda/health_across_all_policies/
Community Asset Survey	Putnam County Department of Health (DOH) – 2019
Mid-Hudson Region Community Health Survey 2019	HealtheConnections and Mid-Hudson Health Departments
Community Based Organization Focus Groups 2019	HealtheConnections and Mid-Hudson Health Departments
Mid-Hudson Region Community Health Assessment 2019-2021	HealtheConnections and Mid-Hudson Health Departments
Community Characteristics	US Census Bureau – 2013-2017 American Community Survey 5-Year Estimates

Social Determinants of Health	US Census Bureau – 2013-2017 American Community Survey 5-Year Estimates
	New York State Education Department – 2018
	New York State Vital Statistics – 2018
	New York State Statewide Planning and Research Cooperative System – 2016
	New York State DOH – 2010-2013 Statewide Planning and Research Cooperative System
Leading Causes of Death	New York State Vital Statistics – 2014-2016
Hanlon Method	NACCHO *Guide to Prioritization Techniques* https://www.naccho.org/uploads/downloadable-resources/Gudie-to-Prioritization-Techniques.pdf
Ten Essential Public Health Services	CDC https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html
National Public Health Performance Standards Program	CDC https://www.cdc.gov/publichealthgateway/nphps/index.html
	NACCHO https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/local-assessment-and-governance-tools
	Putnam County Local Public Health System
Forces of Change	NACCHO https://www.naccho.org/resources/lhd-research/forces-of-change
	Putnam County Local Public Health System
Fall Evidence-Based Strategic Issues	COMPASS-EZ http://www.aamentalhealth.org/aaco/docs/COMPASS-EZ-v1.pdf
	Co-Occurring System of Care https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4366
	NIH HEAL grant https://heal.nih.gov/funding
	Communities That Care https://www.communitiesthatcare.net/
	ASIST (Applied Suicide Intervention Skills Training) https://www.livingworks.net/asist
	CIT (Crisis Intervention Training) https://www.nami.org/get-involved/law-enforcement-and-mental-health
	Lifelines Curriculum https://www.hazelden.org/web/public/lifelines.page

Fall Evidence-Based Strategic Issues, continued	Mental Health First Aid https://www.mentalhealthfirstaid.org/
	QPR (Question. Persuade. Refer) https://qprinstitute.com/
	safeTALK https://www.livingworks.net/safetalk
	Naloxone Training https://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone
	Peer Support Services https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers
	CDC *Guideline for Prescribing Opioids for Chronic Pain* https://www.cdc.gov/drugoverdose/prescribing/guideline.html
	Medication Take Back Day https://www.deadiversion.usdoj.gov/drug_disposal/takeback/
	Chronic Disease Self-Management https://www.selfmanagementresource.com/programs/small-group/chronic-disease-self-management/
	Fall Prevention Programs https://www.cdc.gov/homeandrecreationalsafety/pdf/falls/fallpreventionguide-2015-a.pdf
	Senior Center Nutrition Programs and Transportation Services https://www.cdc.gov/aging/pdf/healthy-aging-in-action508.pdf
	Community Resilience Coalition https://ncdp.columbia.edu/microsite-page/resilient-children-resilient-communities/rcrc-home/
	self-ARTIC Scale Assessment Tool https://traumaticstressinstitute.org/the-artic-scale/
	Adverse Childhood Experiences Training https://www.cdc.gov/violenceprevention/pdf/preventingACES-508.pdf
	Drug Treatment Court https://www.ncjrs.gov/pdffiles1/nij/238527.pdf
	Hope not Handcuffs https://www.familiesagainstnarcotics.org/hopenothandcuffs
	Electronic Medical Record Screenings https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/improved-diagnostics-patient-outcomes
	Controlled Substance Registry https://www.health.ny.gov/professionals/narcotic/prescription_monitoring/
	Food Insecurity http://www.frac.org/wp-content/uploads/frac-aap-toolkit.pdf
	Early Childhood Gardening https://www.cdc.gov/obesity/downloads/obesity_program_highlights.pdf
	School Wellness Committees https://www.healthiergeneration.org/take-action/schools/wellness-topics/policy-environment/school-wellness-committees

Fall Evidence-Based Strategic Issues, continued	Freedom From Smoking https://www.freedomfromsmoking.org/
	INDEPTH https://www.lung.org/stop-smoking/helping-teens-quit/indepth.html
	Fresh Start https://www.acsworkplacesolutions.com/freshstart.asp
	N-O-T (Not on Tobacco) https://www.lung.org/stop-smoking/helping-teens-quit/not-on-tobacco.html
	Breastfeeding Support https://www.cdc.gov/breastfeeding/pdf/breastfeeding_interventions.pdf
	Trauma-Informed Approach https://store.samhsa.gov/system/files/sma14-4884.pdf
	Access to Vaccines https://www.thecommunityguide.org/findings/vaccination-programs-community-based-interventions-implemented-combination
	Access to Testing https://www.cdc.gov/std/prevention/screeningreccs.htm
	Expedited Partner Therapy https://www.health.ny.gov/diseases/communicable/std/ept/
	Minor's Rights Law https://statelaws.findlaw.com/new-york-law/new-york-legal-ages-laws.html
	Medication Assisted Therapy https://www.samhsa.gov/medication-assisted-treatment
Other General Sources Utilized	BRFSS (Behavioral Risk Factor Surveillance System) https://www.health.ny.gov/statistics/brfss/
	County Health Rankings & Roadmaps https://www.countyhealthrankings.org/app/new-york/2019/rankings/putnam/county/outcomes/overall/snapshot
	Public Health Accreditation Board https://phaboard.org/reaccreditation/
	US Department of Health and Human Services National Prevention Strategy https://www.hhs.gov/sites/default/files/disease-prevention-wellness-report.pdf

CHANGES MADE

*in order of date changed

DATE	PAGE NUMBER	DESCRIPTION
7/7/2020	16	Percentages have been arranged to a consistent format
7/7/2020	17	Dashes have been added between 211 and sentence has been revised
7/72020	64	Note has been added below resources stating how the topics/sources are arranged