



Community Health Assessment 2013-2017

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Putnam County Department of Health
Mobilizing Action through Planning and Partnerships

Excellence

Professionalism

Services

Compassion

Commitment

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Community Engagement Process

2008 NYS Prevention Agenda

2008 Priorities

2010 Public Health Summit

Priorities: Access to Care
Chronic Disease
Mental Health
Community Preparedness

2011 Public Health Summit

Priorities: Access to Care
Chronic Disease
Mental Health
Community Preparedness

2012 Public Health Summit

Prevention Agenda 2013-2017

Mobilizing for Action through Panning and Partnership (MAPP)

Phase One: Mobilize Partners and Residents

Phase Two: Create a Vision

Phase Three: Assessments

Phase Four: Identify Strategic Issues and Strategies

Phase Five: Action Cycle and Five Year Plan

2013 Public Health Summit

Community Health Improvement Plan Engagement

History

Introduction

2008 Prevention Agenda Toward the Healthiest State

The Putnam County Department of Health (DOH) has developed many partnerships with community-based health organizations, mental health agencies, social services agencies, educational institutions, faith-based organizations, health providers, local industry and emergency service providers. These partners have worked collaboratively with the Putnam County DOH to identify health priorities and needs within the county, and more importantly, to develop the strategies necessary to address these issues.

In April 2008, New York State DOH Commissioner, Dr. Richard Daines launched the Prevention Agenda Toward the Healthiest State. This public health effort supported the goals of health care reform by establishing statewide public health priorities and asking local health departments and their health care and community partners to work together to achieve them. In addition to supporting health care reform, this initiative focused the state and its communities on public health primary and secondary prevention goals. Primary prevention addresses disease prevention on a global level before residents develop a disease. Secondary prevention addresses disease solutions before a resident develops advanced stages of a disease and if possible curtails the detrimental side effects of a disease.

The Prevention Agenda established a set of public health priorities, identified goals for each priority area, and outlined indicators to measure progress toward achieving these goals, including indicators to track progress on eliminating racial, ethnic and socio- economic health disparities where they exist.

The Prevention Agenda focused on the following ten areas of health and wellness:

- Access to Quality Health Care
- Chronic Disease
- Community Preparedness
- Healthy Environment
- Healthy Mothers, Babies, and Children
- Infectious Diseases
- Mental Health and Substance Abuse
- Physical Activity and Nutrition
- Tobacco Use
- Unintentional Injury

Part of the New York State DOH mandate was to have the local DOH collaborate with their community and hospital partners to complete the Community Health Assessment (CHA) and for the hospitals to complete their Community Service Plan (CSP). The Putnam County DOH collaborated closely with the county's only hospital, Putnam Hospital Center, to assess community health needs and identify health priorities. The Putnam County DOH and the Putnam Hospital Center shared data sources in preparation for completion of their respective plans, the Health Department's CHA and the Hospital's CSP.

History

2008 Priorities

Prevention Agenda priorities were reviewed and a committee consisting of high level hospital and health department representatives identified the most significant public health priorities currently facing Putnam County residents. A commitment was made to work together to implement strategies to address established needs.

The Putnam County DOH actively worked with provider and consumer groups throughout the year to focus Department efforts on improving community-wide health status. These groups met regularly to discuss new initiatives as well as to review existing programs and services. The input gathered from these interactions was also included in the health priority setting process.

After this process was completed the following priorities were established:

- Access to Health Care
- Chronic Disease Prevention
- Mental Health and Substance Abuse
- Community Preparedness

HEAL9 Assessment Project

In 2010, the Putnam County DOH participated in a seven-county Hudson Valley Regional Health Assessment including Westchester, Dutchess, Rockland, Orange, Sullivan, Ulster, and Putnam counties. This grant-funded assessment was part of the ninth grant cycle of the Health Care Efficiency and Affordability Law for New Yorkers capital grant program. The goal was to gather current health care information from Putnam County residents so that local priority health areas could be identified. The Putnam County DOH collected 568 consumer surveys from residents. All data were entered on the regional web-based survey site and preliminary data reports were created by the New York Medical College HEAL9 team with input from the regional epidemiologists.

A major requirement of the grant was disseminating the collected survey data and gathering input about local and regional priorities from stakeholders. The Putnam County DOH planned a countywide Summit to disseminate local and HEAL9 data to Putnam County stakeholders. Select stakeholders were also invited to the Hudson Valley Regional Summit. At the regional summit, broader priorities were selected that all seven counties would focus on.

2010 Public Health Summit

The first Public Health Summit was held on May 11, 2010, and provided the Putnam County DOH with an opportunity to interact with over 80 of its partners and discuss the current state of health priorities in the County.

The summit began with a review of current data pertaining to the identified priority areas in Putnam County. After the overview, attendees were directed to break-out sessions for each identified priority area. Attendees were assigned to the break-out groups that most closely fit their area of expertise. Each break-out group was charged with discussing the current gaps in service, solutions for gaps in service, and providing best practices for future use.

History

Access to Care 2010
Priority

Barriers to Access to Care in Putnam County were identified. The most concerning barrier was the absence of a federally-funded qualified health center or other clinic facility where longstanding under and uninsured individuals can access primary health care. The Health Center Task Force had been working with Open Door Family Medical Center to complete the application process to establish a federally-funded health center within the County.

Chronic Disease 2010
Priority

The recommendation from the committee determining local priorities was to select Chronic Disease prevention as the second priority from the Prevention Agenda. Rather than choose more focused priorities, such as physical activity and nutrition, the break-out group recommended the selection of the more general priority of chronic disease. The group identified strategies to combat chronic diseases among the population including: maintaining a healthy lifestyle by eating well, keeping physically active and avoiding tobacco product use. The group also discussed the association of overweight and obesity being strongly linked with several chronic diseases and debilitating conditions.

Mental Health 2010
Priority

The Mental Health break-out group started their session with a discussion about the many gaps in mental health services for Putnam County residents. Specifically, the Putnam County Correctional Facility and the Putnam Hospital Center Emergency Department had been seeing more people being admitted due to unmet mental health needs. The other concern raised was that many of the practitioners were seeing increasing numbers of younger residents in need of mental health services. This initial discussion focused the remainder of the break-out session on how to increase the awareness of: mental illness as a public health issue, the importance of mental health promotion and mental illness prevention.

Community
Preparedness 2010
Priority

Putnam County was at 100 percent for the indicator “percent population living within the jurisdiction with state-approved emergency preparedness plans” for the Community Preparedness priority from the Prevention Agenda. None the less, the committee selecting local priorities felt strongly that Community Preparedness should still be included in the top public health priorities for the county, since there is a significant need for continued partnering and planning. The break-out session focused on areas for training and continued opportunities for exercises.

2011 Public Health
Summit

In June 2011, the Putnam County DOH held a second health summit to bring community partners back together to discuss progress made from the previous year and update plans and strategies for the upcoming year. Data was presented on the four focus areas Access to Health Care, Chronic Disease Prevention, Mental Health and Substance Abuse, and Community Preparedness. Progress on each health priority was reviewed.

2011 Priorities

Breakout sessions were not planned, therefore discussions were held with the entire gathering.

History

Access to Care
2011 Priority

Headway was being made toward achieving the goals set forth for this priority as the Health Center Task force reported the reality of the first federally-qualified health center located in Putnam County was nearing completion. Open Door Family Medical Centers had applied to the New York State DOH for a Certificate of Need to locate a satellite center in Brewster, NY, Putnam County, and this became a reality in 2012.

Chronic Disease
2011 Priority

Chronic disease initiatives were led by the Live Healthy Putnam (LHP) Coalition. Activities during 2011 included initiation of Healthy Meeting Guidelines. Goals for the upcoming year were to involve schools and institute a pilot walking program using pedometers purchased through NYSDOH and HEAL 9 funds.

Mental Health
2011 Priority

Representatives from Mental Health agencies throughout Putnam County meet monthly to discuss issues pertaining to clients and agencies surrounding mental health. The Putnam County Department of Social Services and Mental Health generally leads the discussions. Members of this group have been working on interpreting new rules and regulations set forth by the New York State DOH in the area of Health Homes and Managed Care. Particular focus has been paid to potential problems with implementation of the new regulations. Direction for substance abuse prevention is overseen by the newly formed Putnam Communities That Care Coalition (CTC), funded by the National Office of National Drug Control Policy. The Putnam CTC coalition is composed of many individuals and sectors that work together to reduce underage drinking and substance abuse. The coalition has undertaken a variety of initiatives including Medication Take-Back Days, anti-bullying and anti-drug educational seminars for parents and children, and alcohol and drug awareness programs with school districts among others.

Community
Preparedness
2011 Priority

The Putnam County Bioterrorism/Disaster Preparedness Task Force, under the leadership of the Bureau of Emergency Services and the Health Department, continued to provide oversight for the county's emergency preparedness activities. During the year, many educational programs as well as targeted media education campaigns and events promoting the importance of individual emergency preparedness were conducted. The Putnam County DOH and Bureau of Emergency Services have participated in emergency preparedness drills to test effectiveness of plans and the department's ability to respond to emergencies.

**2012 Public Health
Summit**

Due to several factors, including a change in leadership at the Putnam County DOH, no health summit was held in 2012.

Current Process

Prevention Agenda 2013-2017: New York State's Health Improvement Plan

The New York State Public Health and Health Planning Council's Public Health Committee established an Ad Hoc Committee to lead the development of New York's next five-year state Health Improvement Plan for 2013-2017. The committee assessed progress to date on the Prevention Agenda 2008-12, examined the current health status of New York State's population and proposed a vision, overarching goals and new priorities for the 2013-2017 period. Stakeholder feedback was gathered and used to finalize the priorities. A health improvement plan such as this released by the New York State DOH is a critical prerequisite for public health department accreditation.

In addition, the Prevention Agenda serves as a guide to local health departments as they work with their community partners to develop mandated Community Health Improvement Plans and to hospitals as they develop mandated Community Service Plans and Community Health Needs Assessments required for the coming year by the Affordable Care Act.

The Prevention Agenda features five priority areas:

- Prevent chronic diseases
- Promote healthy and safe environments
- Promote healthy women, infants and children
- Promote mental health and prevent substance abuse
- Prevent HIV, sexually transmitted diseases, vaccine-preventable diseases and healthcare associated infections

The Prevention Agenda establishes goals for each priority area and defines indicators to measure progress toward achieving these goals, including reductions in health disparities among racial, ethnic, and socioeconomic groups and persons with disabilities.

The Agenda also identifies interventions shown to be effective to reach each goal. These interventions are displayed so that each sector can identify evidence-based or promising practices they can adapt for implementation to address the specific health issues in their communities.

The New York State DOH once again asked local health departments and hospitals to work together with community partners to assess the health challenges in communities, identify local priorities and develop and implement plans to address them. The NYSDOH expects that each local health department and hospital will, together with other partners, identify and develop a plan for addressing at least two priorities in the new Prevention Agenda. At least one of these priorities should address a health disparity.

Current Process

Mobilizing for Action through Planning and Partnership Process

Developing a Community Health Improvement Plan (CHIP) is an opportunity for a community to systematically evaluate the health status of the community, to identify and set priorities and to develop actions that will promote the health of the community. This process should involve a wide array of organizations and residents.

The Putnam County DOH utilized the **Mobilizing for Action through Planning and Partnerships (MAPP)** framework for conducting its Community Health Assessment (CHA) and developing its CHIP. MAPP is considered a best practice for conducting a community wide strategic plan that helps the community improve its health and quality of life.

Phase One: Mobilize Partners and Residents

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

Phase Two: Create a Vision

The second phase of the Putnam County MAPP process was to create a vision for the CHIP process. The vision was to have “a healthy and vibrant Putnam County.” The existing motto of “Live Healthy Putnam” was chosen to represent this vision. Working closely with the Putnam Hospital Center Community Needs Committee, the group outlined a framework for completing the CHIP by 2013. This included the creation and implementation of the Community Asset Survey by April 2013; conducting a Public Health Summit by May 2013; establishing priorities by August 2013; completion of the Community Health Assessment, Community Service Plan and Community Health Improvement Plan by October 2013; submission of the CHA, CSP and CHIP to New York State DOH by November 15, 2013, along with dissemination of the documents to the public.

Phase Three: Assessments

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 below.

Community Themes and Strengths Assessment

The Community Themes and Strengths assessment provides a deep understanding of the issues that residents feel are important by answering the questions: "What is important to our community?" "How is quality of life perceived in our community?" and "What assets do we have that can be used to improve community health?"

Current Process

Forces of Change Assessment	The Forces of Change assessment focuses on identifying forces such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operate. This answers the questions: "What is occurring or might occur that affects the health of our community or the local public health system?" and "What specific threats or opportunities are generated by these occurrences?"
Local Public Health System Assessment	The Local Public Health System assessment focuses on all of the organizations and entities that contribute to the public's health. The Local Public Health System assessment answers the questions: "What are the components, activities, competencies, and capacities of our local public health system?" and "How are the Essential Services being provided to our community?" This assessment is conducted utilizing the National Public Health Performance Standards.
Community Health Status Assessment	The Community Health Status assessment identifies priority community health and quality of life issues. Questions include: "How healthy are our residents?" and "What does the health status of our community look like?"
Phase Four: Identify Strategic Issues and Strategies	Identifying strategic issues was initiated during the 2013 Public Health Summit held on May 22, 2013, and continued as each assessment was completed. After identifying the two health priority areas, groups were formed to create specific goals and strategies. Partners and residents were invited to participate in CHIP Health Priority Committees to develop the strategies. Subcommittees were formed and monthly meetings held to ensure specific strategies were crafted for each objective. These meetings will continue with engaged and committed partners.
Phase Five: Action Cycle and Five-Year Plan	Each subcommittee outlined action steps for the plan to achieve the identified goals. These action plans continue to be modified and updated as the process continues. The Putnam County DOH oversees progress in the committees and provides accountability. Progress will be tracked and shared on the Putnam County DOH website @ http://www.putnamcountyny.gov/health The Putnam County 2013-2017 CHIP aims to use best practices and science-based approaches to develop achievable and measurable objectives that can be implemented by the community in a sustainable fashion.

Current Process

2013 Public Health Summit

Prior to the 2013 Health Summit, the Putnam County DOH conducted a number of focus groups, on-line and in-person surveys, and other assessment activities related to the MAPP process. Through this assessment the two leading priorities from the community emerged; prevention of chronic diseases, and promotion of mental health well-being and prevention of substance abuse.

The Public Health Summit held in May, provided the PCDOH with an in-depth opportunity to interact with over 60 of its partners and discuss the current state of health priorities in Putnam County. Together with representatives from the Putnam County DOH, the community partners engaged in a rich and comprehensive conversation about the most pertinent health issues facing the Putnam community.

Before the formal presentation began, community partners engaged in an interactive “Place the Dot” exercise to identify the top two community priorities facing Putnam County. The top two priorities chosen were 1) Preventing Chronic Disease and 2) Promoting Mental Health and Preventing Substance Abuse. These results were consistent with the findings of the focus groups and assessments previously conducted. These two priorities guided the afternoon breakout sessions.

Members of the Health Education Unit at the Putnam County DOH provided an overview of the 2013-2017 New York State Prevention Agenda, and the collaborative process behind the submission of the CHA and CHIP. A representative from Putnam Hospital Center shared information regarding the Community Service Plan priorities that align with the CHA and CHIP. The contract Epidemiologist from the Putnam County DOH gave a thorough presentation on community health indicators and data relevant to Putnam County.

Community partners also engaged in a group exercise called “Forces of Change.” This activity tackled the questions: “What is occurring or might occur that affects the health of our community or the local public health system?” “What specific threats or opportunities are generated by these occurrences?”

After the presentations and Forces of Change exercise, attendees were directed to a breakout session for the identified priority area that most closely fit their area of expertise. Each breakout group was charged with discussing the current gaps in service, solutions for gaps in service, and best practices for future use.

Summit participants interested in fine-tuning goals and objectives were invited to continue to work with partners over the summer to develop the Putnam County Community Health Improvement Plan (CHIP). The Putnam County CHIP represents a collaborative process of identifying health opportunities and strengths as a community and improving the health of the county.

CHIP Engagement

The CHIP outlines the goals and strategies for identified focus areas to assist in attaining a “healthier community” for Putnam County.

Community Themes & Strengths

Introduction

Community Asset Survey Methodology

Community Asset Survey Results

Focus Group Results

Many Voices One Valley

Summary

Introduction

Assessment Approach

The Community Themes and Strengths Assessment (CTSA) is a data-driven report that focuses on identifying residents' perceptions of community strengths, health-related concerns and areas for improvement. Residents completed the Community Asset Survey (CAS) online or participated in focus groups. By utilizing the gathered results, MAPP committees have a better understanding of the community's health status and as a result can prioritize health indicators and select the goals and strategies for the upcoming five-year period. Data were collected by community partners and analyzed by the Putnam County DOH epidemiologist.

Data Sources

Web-based electronic surveys were the primary method of data collection. *Paper surveys* were provided to individuals without computer access and to residents in waiting rooms, at local events and meetings. *Focus groups* were conducted with targeted groups that represented a section of the Putnam population that were identified as high risk.

Evaluation

The CTSA is a main component of the comprehensive MAPP assessment and planning process. The philosophy of the MAPP steering committee was to use a variety of approaches to gather input from broad segments of Putnam County. By using a multipronged approach the information collected would provide a solid foundation for identifying the PC CHIP public health priorities. Combined with the Community Health Status Assessment, Forces of Change Assessment and the Public Health System Assessment, a broad picture of the health status of PC could be described.

Community Asset Survey - Methodology

Overview	Community members' first exposure to the MAPP process and Community Health CHIP process was through the Community Asset Survey. The CAS was determined to be the most efficient way the community could participate in the assessment process. A copy of the survey tool is located on the Putnam County website, www.putnamcountyny.gov/health .
Survey Design	<p>The CAS was developed by the Putnam County DOH with input from Putnam Hospital Center. Survey samples from agencies previously conducting the MAPP process were reviewed and modified to create the Putnam CAS.</p> <p>It was decided that three key questions, eight demographic questions and an open ended comment section would be used. The survey was piloted with members of the PCDOH staff and WIC clients.</p> <p>Three versions of the survey were created; two in English and one in Spanish. The online English survey was the version that was most heavily promoted. English and Spanish paper versions were used as well. All surveys were anonymous.</p>
Sampling	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 historically over represent female residents and under represent minority groups and lower SES residents. With this knowledge it was determined that under-represented segments of the population would be focused on in the promotional campaign.
Promotional Campaign	<p>A promotional campaign was developed to advertise the importance of residents' input in the CAS. Since no fiscal resources were available for the MAPP process, free opportunities based on existing community relationships and the local public health system were used (Appendix 2).</p> <p>The Putnam County Executive and the Putnam Hospital Center CEO sent an email to all of their staff with an online link to the survey (this represents the two largest employers in Putnam County). A media release and campaign yielded coverage in 4 outlets, 1 radio market and 2 television markets. A description of the survey, complete with link, was also shared in the following venues: 31 bulletin boards in high traffic venues, 7 online calendars, 2 social networking sites and 7 school district newsletters. The description and link were also shared with agencies participating in: the MAPP process, previous PH Summits and other established partnerships. Every agency was then encouraged to share with their members and clients.</p> <p>Agencies identified as serving lower SES and minority populations were asked to provide paper surveys to clients. PHC proctored the survey to 16 support groups. PCDOH proctored the survey at all meetings involving outside agencies.</p>
Data Entry	Any paper surveys were forwarded to the Putnam County DOH and were entered online by support staff. Surveys were excluded if the respondent did not answer at least one of the three key questions.

Community Asset Survey – Methodology

Focus Groups

Focus groups were identified as a method to gather data from groups identified as possibly being under represented in the online survey and groups specifically identified as key stakeholders.

Goal

The survey was available from April 11 – August 31, 2013, and focus groups were to follow. A benchmark was set to gather input from at least 500 residents, including under-represented populations as much as possible.

Community Asset Survey - Results

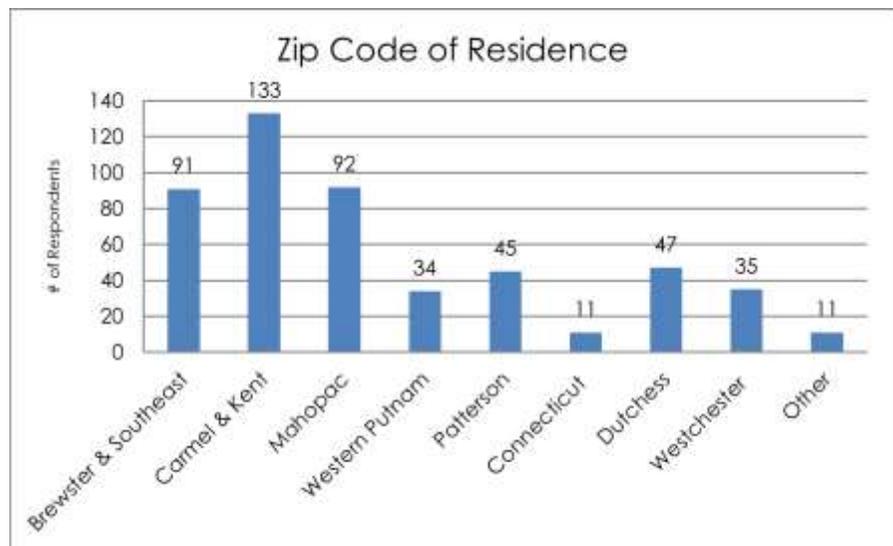
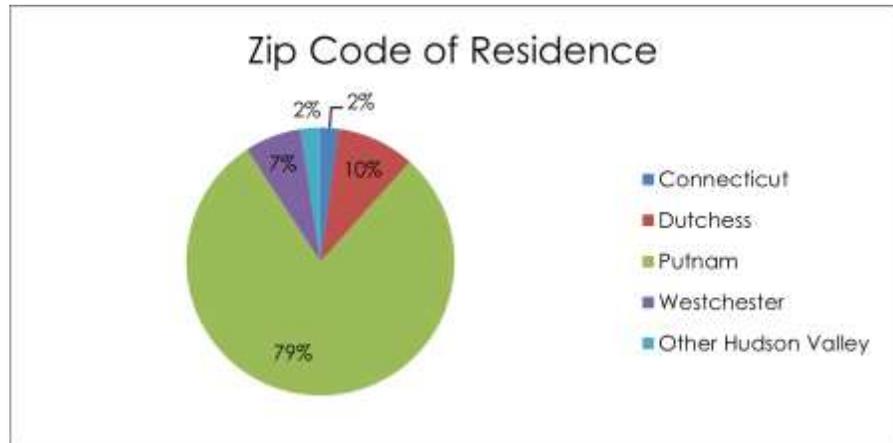
Overall Response

Through the efforts of the Putnam County DOH, Putnam Hospital Center and many other agencies, over 500 surveys were returned and over 200 residents participated in focus group activities.

The survey completion rate was excellent with nearly 90% of the surveys fully answered. Two-thirds of the surveys were completed by residents using the web-based portal and the other third were completed on paper and then entered online.

Zip Code of Residence

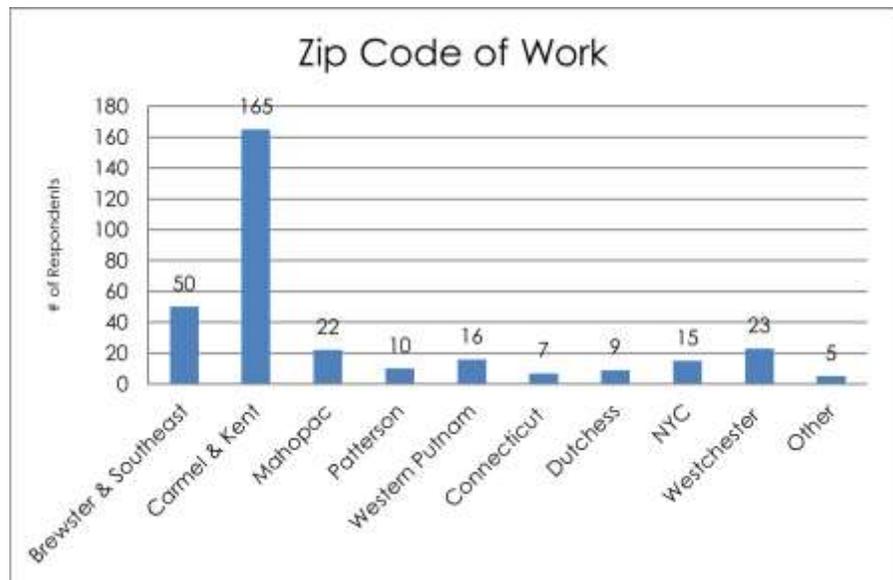
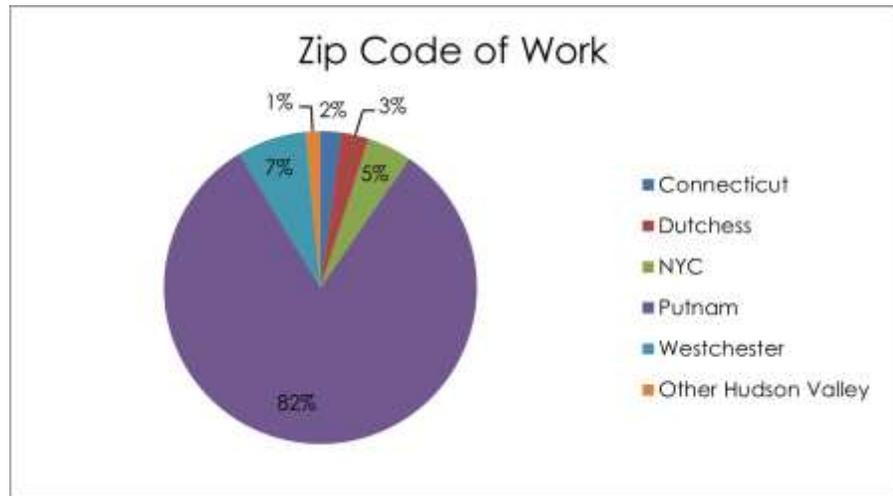
Nearly three-quarters of the respondents live in Putnam County and nearly a quarter live in neighboring Westchester and Dutchess Counties. The eastern side of Putnam was better represented than the western side. Brewster, Carmel and Mahopac accounted for 63% of the respondent's home zip codes.



Community Asset Survey – Results

Zip Code of Work

The majority of respondents work in Putnam County. Outside of Putnam, Westchester County and New York City were the two largest areas where respondents reported working. Overall, respondents mostly work in Putnam or a surrounding county/state.



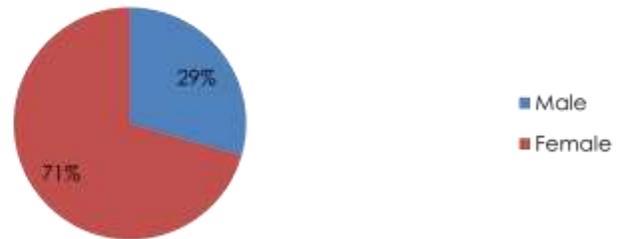
Community Asset Survey – Results

Gender

	CAS Sample	2010 Census
Size	505	99,710
Male	29%	49.90%
Female	71%	50.10%

Nearly three-quarters of the respondents were female. This exceeds the actual gender distribution of the county, which according to the 2010 Census is closer to a fifty-fifty ratio for the population.

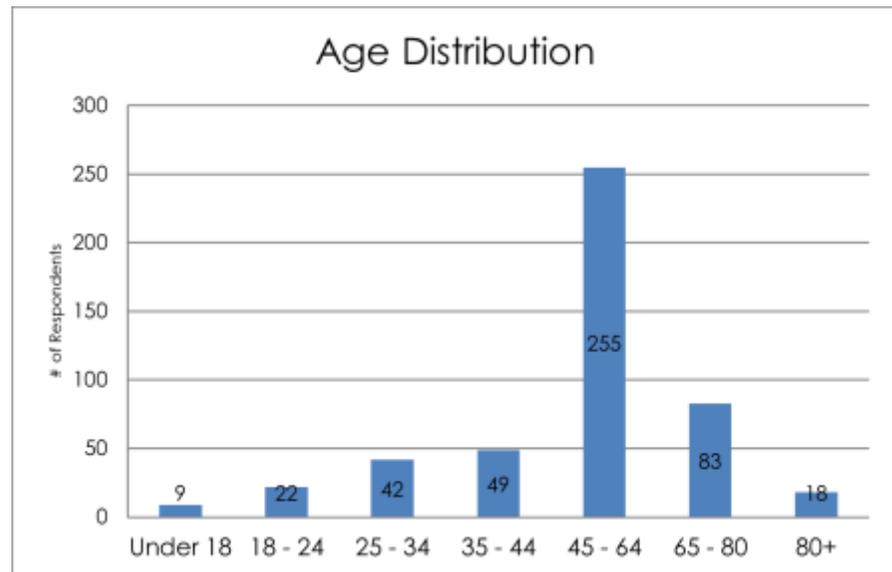
Gender Distribution



Age

Over half of the respondents were between 45 and 65 and nearly a quarter were over 65. These groups were over sampled. Although all age groups were included the survey was not promoted for children under the age of 18.

Age Distribution

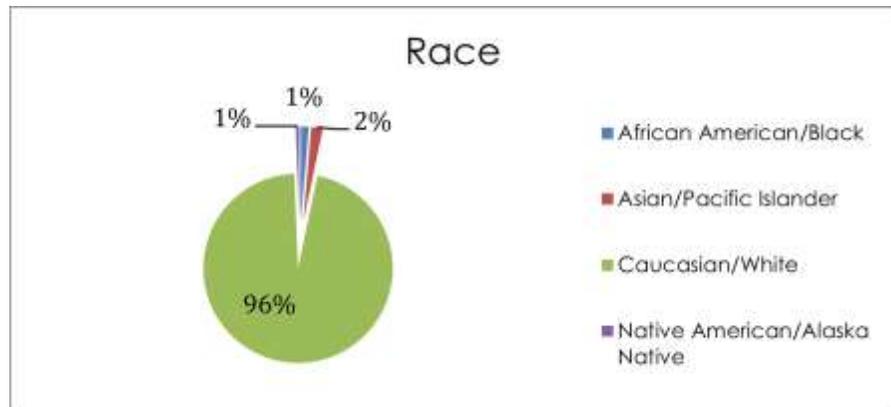


Community Asset Survey – Results

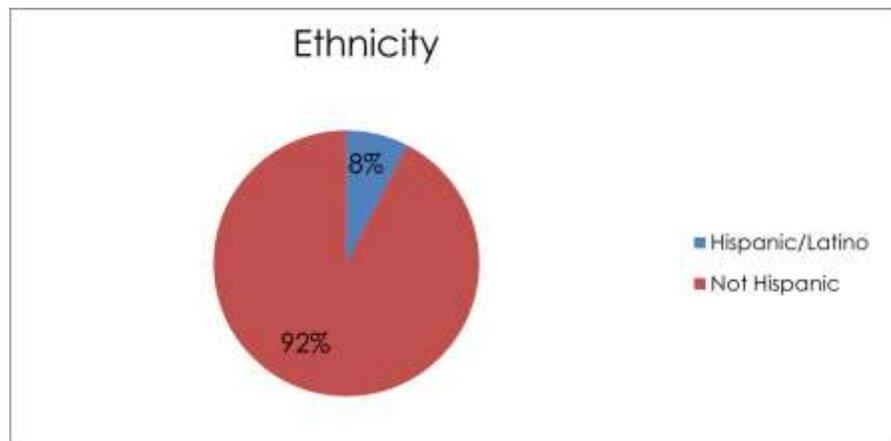
Race & Ethnicity

RACE	CAS Sample	2010 Census
White	95.60%	90.70%
Black	1.30%	2.40%
Asian & Pacific Islander	2.00%	1.90%
Native American & Alaskan	0.70%	0.20%
ETHNICITY		
Hispanic or Latino	7.60%	11.70%

The majority of respondents were Caucasian/White which is similar to Census data. In Spast surveys, minority populations were generally underrepresented in comparison to Census data and this was true with the African American/Black respondents in this survey. However, the Asian/Pacific Islander group was accurately represented and the Native American/Alaska Native group was overrepresented.



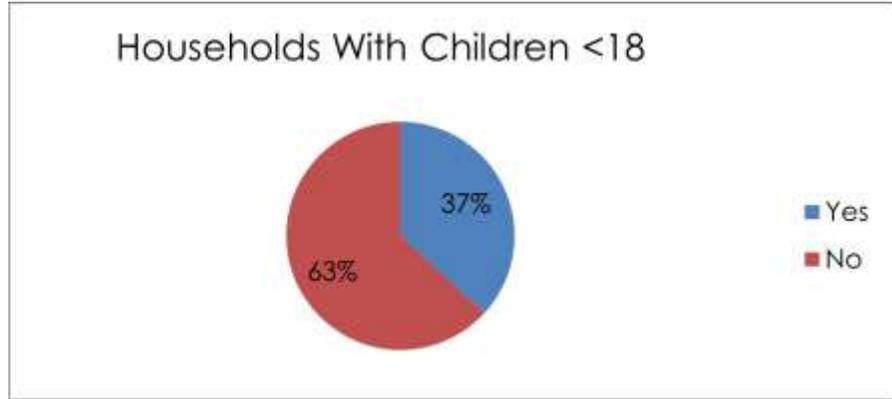
Ethnicity is a separate measure from race asking whether a respondent is of Hispanic or Latino origin. The majority of respondents were not Hispanic or Latino which is similar to Census data.



Community Asset Survey – Results

Households with Children

A third of the respondents reported having children under the age of 18 which is similar to Census data.



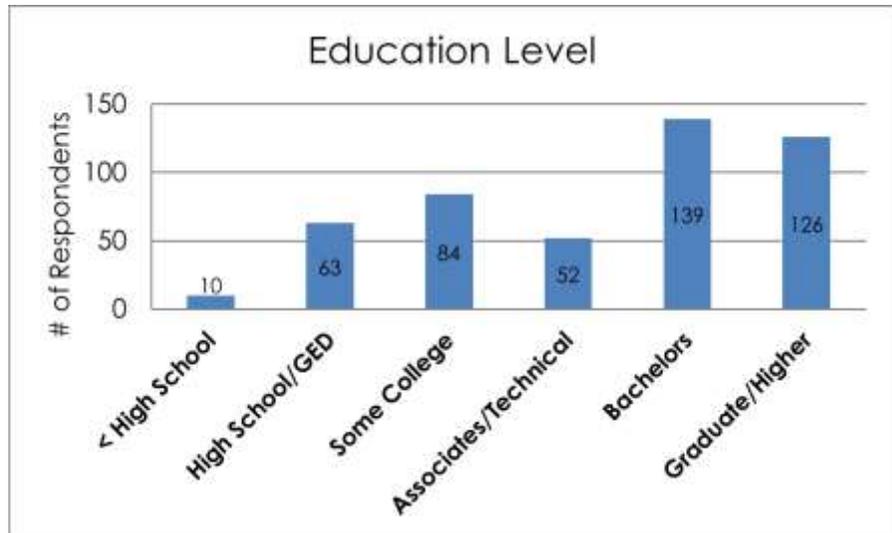
Education Level

Respondents were well-educated with over two-thirds having completed an Associates/Technical degree or higher degree. In comparison Census data shows this population represents just under half of the residents, indicating this group was overrepresented in the sample.

Residents with a High School Diploma/GED were underrepresented in the sample. Only one-third of survey respondents earned a High School Diploma or attended some college, compared to census data which shows approximately half of residents earning up to a high school degree or having some college.

Overall, survey respondents skew to a higher education level than census data indicates, due in part to low representation among youth.

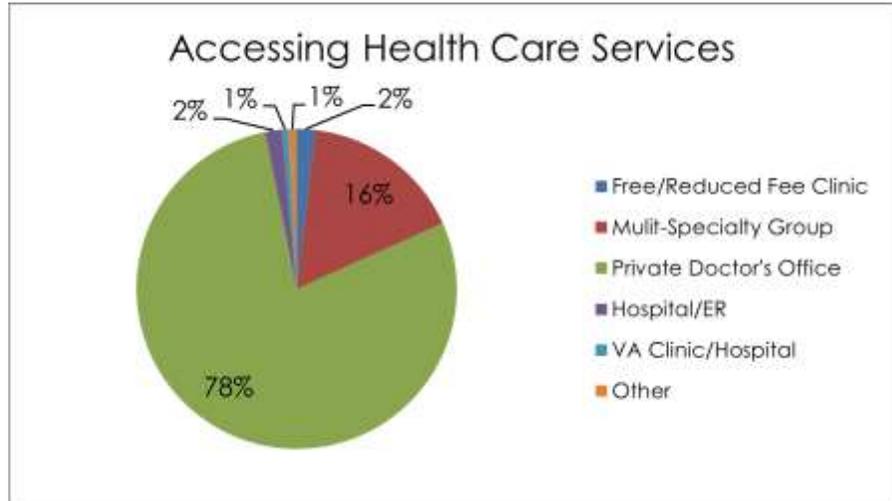
	CAS Sample	2010 Census
No HS Diploma	2.10%	7.00%
HS Diploma	13.30%	28.20%
Some College	17.70%	18.70%
Associate's Degree	11.00%	8.00%
Bachelor's Degree	29.30%	21.30%
Graduate or Higher	26.60%	16.80%



Community Asset Survey – Results

Accessing Health Care Services

The majority of respondents report accessing health care at their private doctor's office. Multi-specialty groups account for the next largest provider of health care services.



Community Asset Survey – Results

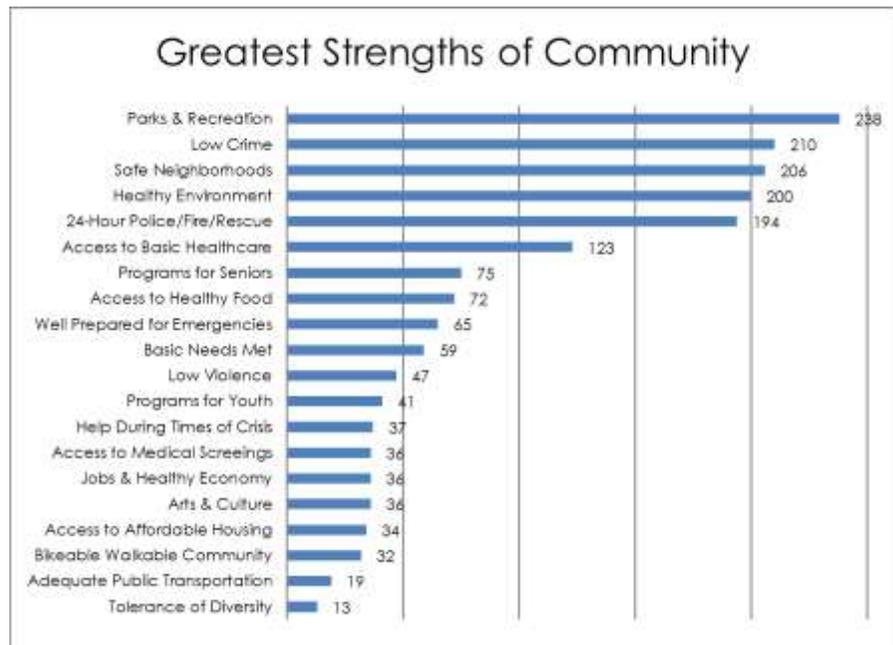
Greatest Strengths of Community

Key Question #1:
 “What are the greatest STRENGTHS of our ENTIRE COMMUNITY?”

The top five strengths of the community include safety and environmental issues. The majority of respondents reported access to Parks and Recreation and the Clean and Healthy Environment as an asset of Putnam. Safety issues were also rated highly including, Low Crime, Safe Neighborhoods and 24-Hour Police/Fire/Rescue.

When grouped, safety (low crime, safe neighborhoods, 24-hour services, emergency preparedness and low violence) was overwhelming the greatest strength of the community. Healthy and active environment (access to park and recreation, healthy environment and bike-able & walk-able community) was the second greatest asset.

The two strengths with the least number of selections were Tolerance of Diversity and Adequate Public Transportation.



The total number of responses exceeds the total (504) number of surveys collected because respondents were able to select up to four priority areas.

Community Asset Survey – Results

Focus to Improve Quality of Life of Community

Key Question #2:
 “Where should the community focus its resources and attention to IMPROVE THE QUALITY OF LIFE for our community?”

The majority of respondents selected Jobs & Healthy Economy and Programs for Youth equally as the main areas to focus community efforts. More Adequate Public Transportation was the third highest focus area selected.

When Access to Basic Healthcare was coupled with Access to Medical Screenings it ranked equally with More Adequate Public Transportation. Of note is that Access to Basic Healthcare was not ranked as a top three strength of our community nor a focus area for improvement, but was ranked in the top five for both.

Even when grouped safety (low crime, safe neighborhoods, 24-hour services, emergency preparedness and low violence) and healthy and active environment (access to park and recreation, healthy environment and bike-able & walk-able community) were not among the top areas of concern.



The total number of responses exceeds the total (504) number of surveys collected because respondents were able to select up to four priority areas.

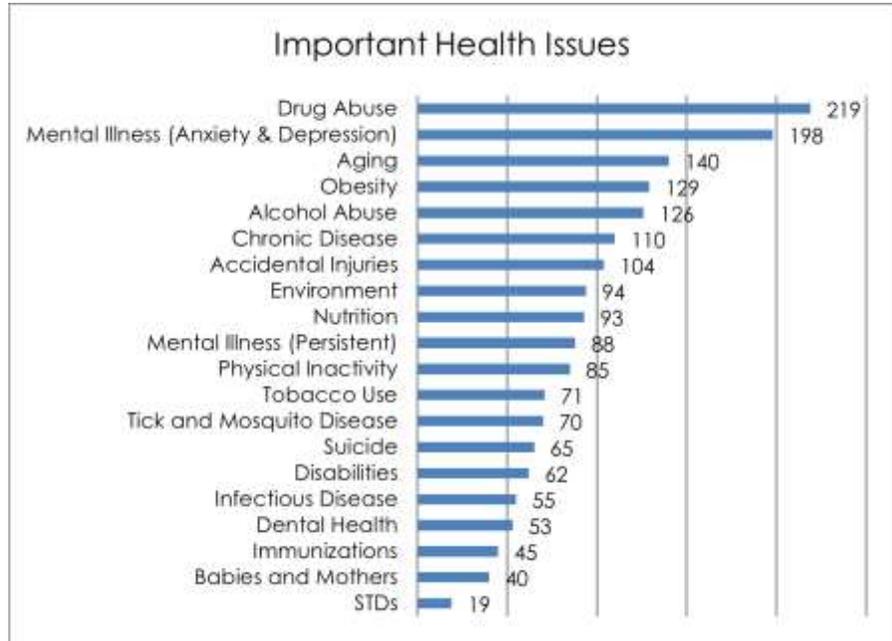
Community Asset Survey – Results

Important Health Issues

Key Question 3:
“What are the most important HEALTH ISSUES that our community should focus on?”

The most important health issue for the respondents was Drug Abuse (prescription and illegal). A close second was Mental Illness (depression, anxiety, stress).

When grouped, Chronic Disease (nutrition, obesity, physical inactivity, chronic disease and tobacco use) was the most important health issue. Drug and Alcohol Abuse and Mental Illness (serious & persistent and depression, anxiety, stress) were similarly ranked as the second most important health issues.



The total number of responses exceeds the total (504) number of surveys collected because respondents were able to select up to four priority areas.

Community Asset Survey - Comments

Comments

All respondents were offered the opportunity to provide additional comments and listed below are a few quotes from this section.

“The country is facing an obesity epidemic that will cripple our children; our future economy; and the nation as a whole if we do not do something about it. The small changes we begin to implement in Putnam County will spread beyond our county borders and together we can make a difference!”

“Lack of adequate county wide communication system reaching all segments of population.”

“Free screenings and universal health care eviscerating the value of corporation given health care.”

“A great benefit to the community would be an indoor community center for indoor activities during bad weather and winter months. Example...indoor walking track.”

“Putnam is a wonderful place to live but with increasing taxes; housing for seniors must be focused on.”

“We have a beautiful; scenic community here in Putnam County. We should really try to keep it that way.”

“Consistent code enforcement sends signals to all that the community is being safeguarded against illegal housing; unlawful rentals; unregistered vehicles; wayward parking near train stations. WE NEED CODE ENFORCEMENT!!!”

“Putnam County is becoming Nextchestertaxes outweigh services provided. Tighten the belt like we have had to do.”

“Transportation continues to be a problem.”

“Access to dental and medical care without ability to pay.”

“Transportation is practically non-existent which means it's very difficult for people to get jobs; go to jobs and do things such as shop independently. Instead I see many clients using Medicaid transportation to go to their doctor appointment and after the appointment they go grocery shopping before they get back in their cab. This leaves them shopping only once or twice a month; and does not allow them to buy healthier foods.”

“Thank you for doing this.”

“One of the most devastating spectrums for most seniors is abandonment and/or depression. Need counseling.”

“Good snow removal!”

“I believe that racism issues of diversity and stereotypes are important issues to focus on. The diverse Putnam Community is very positive on one hand; yet creates very obvious inequities that cause problems with bullying especially towards marginalized groups.”

Focus Groups

Focus Groups

Focus groups were identified as a method to gather data from groups identified as possibly being under represented in the online survey and groups specifically identified as key stakeholders.

Putnam County DOH staff worked with the New York City Long Island Lower Tri-County Hudson Valley Public Health Training Center to develop training for staff on how to conduct a focus group. Six staff were trained, including one bilingual (Spanish/English).

Four focus groups were planned. Lower socioeconomic residents and Spanish speaking residents were targeted along with key-stakeholders including chronic disease, mental health and substance abuse partners. Due to time constraints with the Summit and the deadline for submission, only three focus groups were conducted.

Focus Group Guide

After the focus group training was conducted, a facilitator’s guide was created to promote consistency in data collection. Guidance was also given for the person recording the interactions and responses of the focus group participants. All sessions were recorded to ensure accurate documentation of participants comments and input.

Live Healthy Putnam Coalition

The Live Healthy Putnam (LHP) Coalition is comprised of representatives from a variety of organizations throughout Putnam County dedicated to improving the health of Putnam County residents. The focus of the coalition is on chronic disease prevention.

The LHP coalition was used to pilot the CAS. Each member was asked to complete the survey and then answer a series of guided group questions. Input from coalition members was used to create a final CAS.

After the final survey was completed a focus group with nine LHP members was conducted. The findings from this focus group were consistent with the overall CAS findings. Below are a few quotes from participants specific to their expertise as chronic disease partners.

“Healthy Food = Expensive”

“Parents not being more strict in the foods their children eat”

“Poor choices and education = inactivity”

“Overly reliant on cars”

“No sidewalks so can’t walk anywhere”

“More opportunities for outdoor time and exercise”

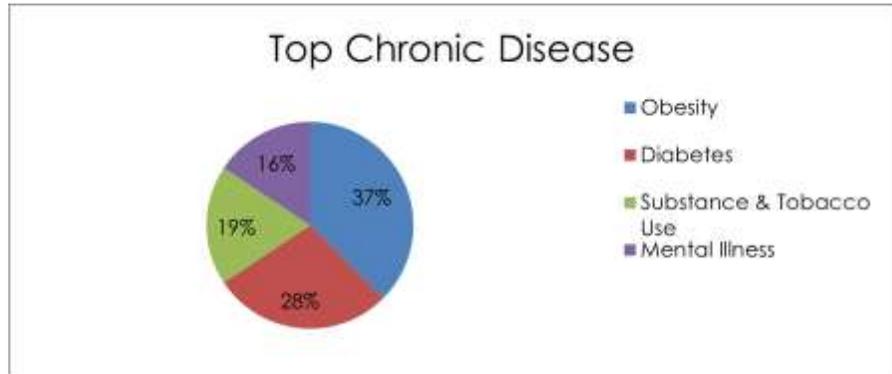
“Most pressing need is to address childhood obesity”

“Lack of exercise and outdoor time among children; especially the Hispanic minority”

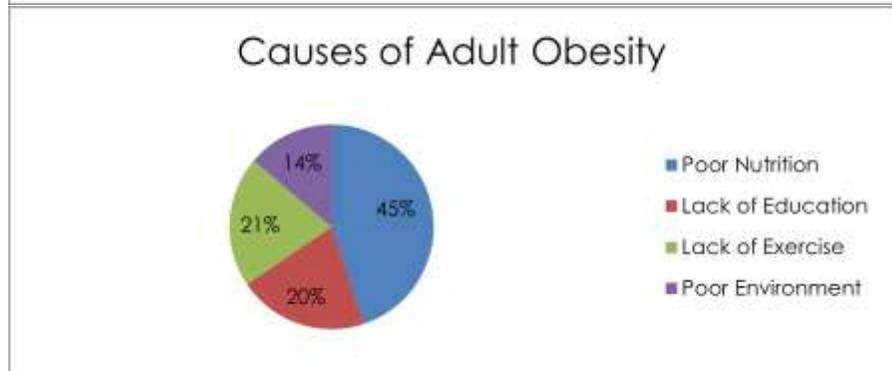
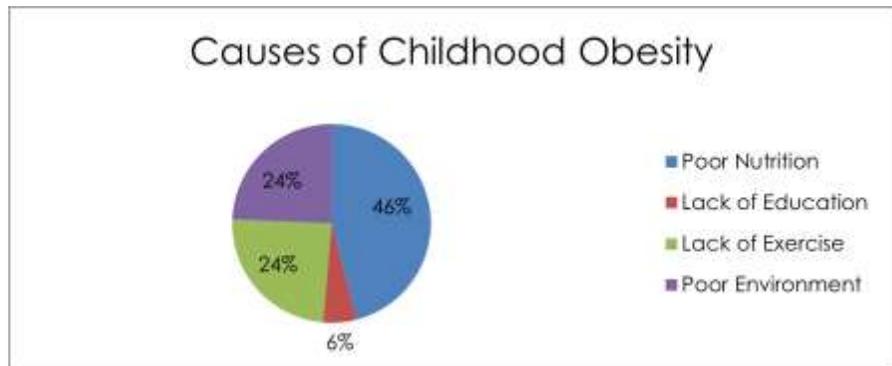
Focus Groups

Live Healthy Putnam Coalition Summary

The respondents selected obesity and diabetes as the top chronic diseases. Similar to the CAS results, mental illness and substance abuse were also top health concerns.



Nearly half of the participants reported that poor nutrition was the leading cause of adult and childhood obesity. Lack of education, lack of exercise and poor environment were also factors in obesity. Lack of education was considered a bigger issue with adults than with children.



Focus Groups

Mental Health and Substance Abuse Provider Group

The Mental Health and Substance Abuse Providers (MHSAP) Group is comprised of representatives from a variety of organizations throughout Putnam County and surrounding counties dedicated to providing services to Putnam residents.

Eleven members of the MHSAP group participated in a focus group. The majority of responses pertained to mental health and substance abuse issues within Putnam. Below are a few quotes from participants specific to their expertise as mental health and substance abuse professionals.

“Getting Schools and Medical Health Professionals to unite with Mental Health and Chemical Dependency Professionals so that we all recognize and support each person as a whole”

“Total wellness of an individual regardless of mental health, alcohol abuse, substance use or physical health”

“Community education on wellness”

“Integrated treatment – mental health, addiction, primary health care, intervention”

“Improving community involvement to decrease stigma”

“Reducing youth drug and alcohol use through education & awareness campaigns”

“Prevention and education to reduce premature death whether suicide or drug od”

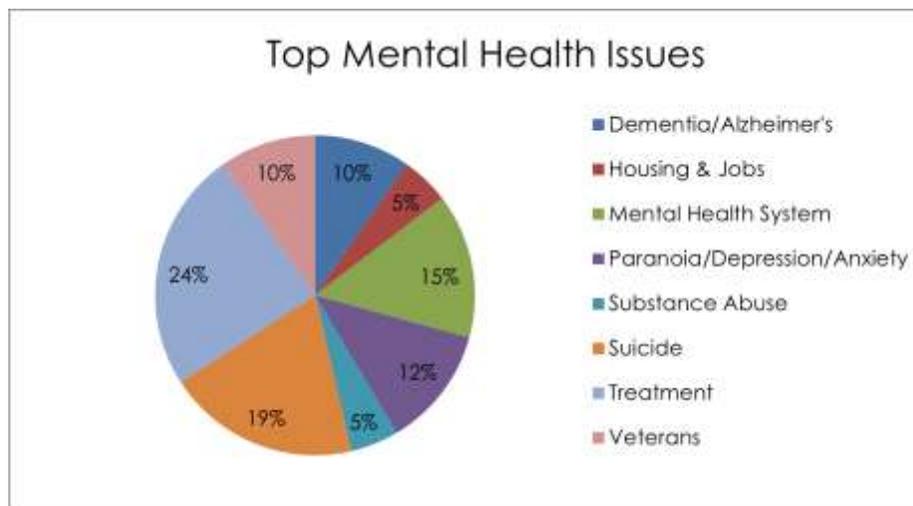
“Family and child mental health services”

“Prevention and assessment”

“Enhanced service delivery in schools of MEB services”

Mental Health and Substance Abuse Provider Group Summary

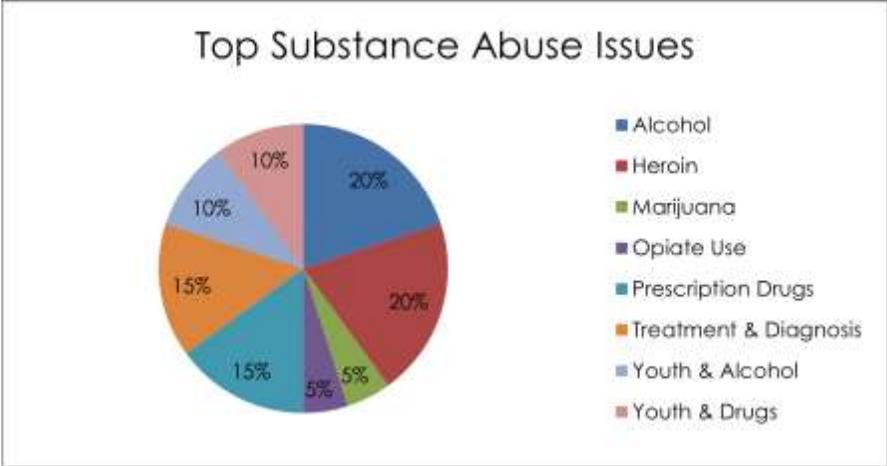
The top mental health issues mentioned were treatment and suicide.



Focus Groups

Mental Health and Substance Abuse Provider Group Summary

The top substance abuse issues were alcohol and heroin abuse. Overall drug use, including heroin, marijuana, opiate use and prescription drug use was the leading substance abuse issues.

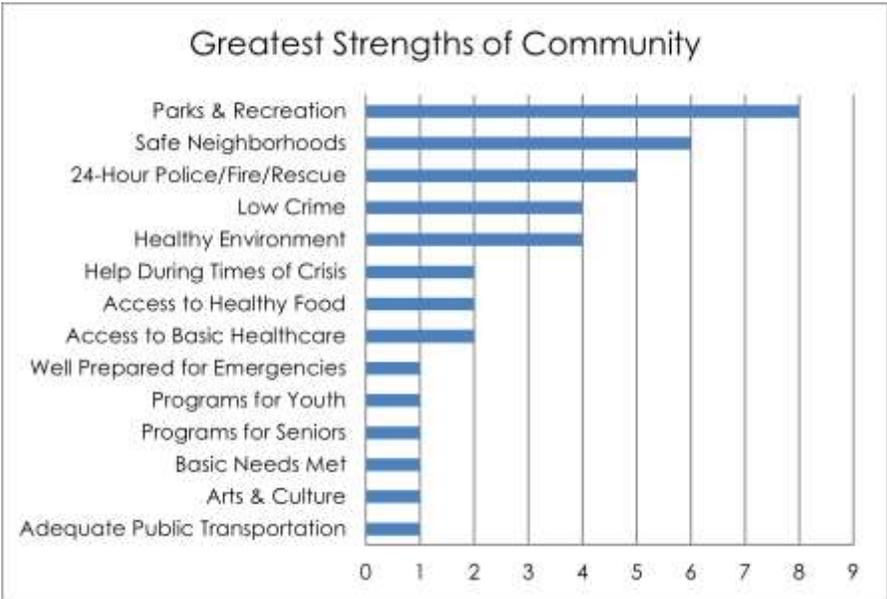


When discussing Mental Health and Substance Abuse as a whole, the group determined that by focusing on anxiety, depression and stress, Putnam residents would see improvement in mental health and reductions in suicide and substance abuse.

Mahopac Central School District

Key Question #1:
 "What are the greatest STRENGTHS of our ENTIRE COMMUNITY?"

A focus group was held at the Mahopac High School with eight students and one teacher. Similar to CAS findings, this group selected parks and recreation and safety as top assets of the Putnam community.

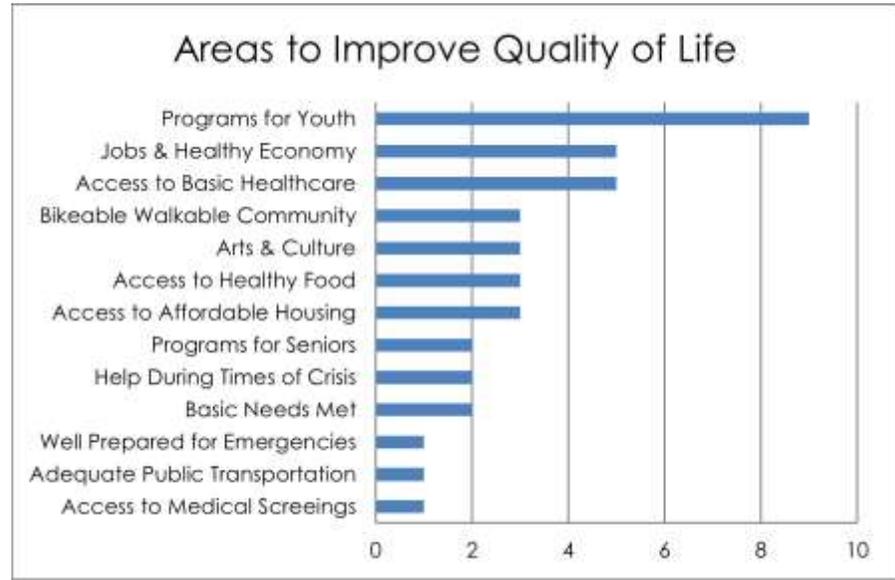


Focus Groups

Mahopac Central School District Summary

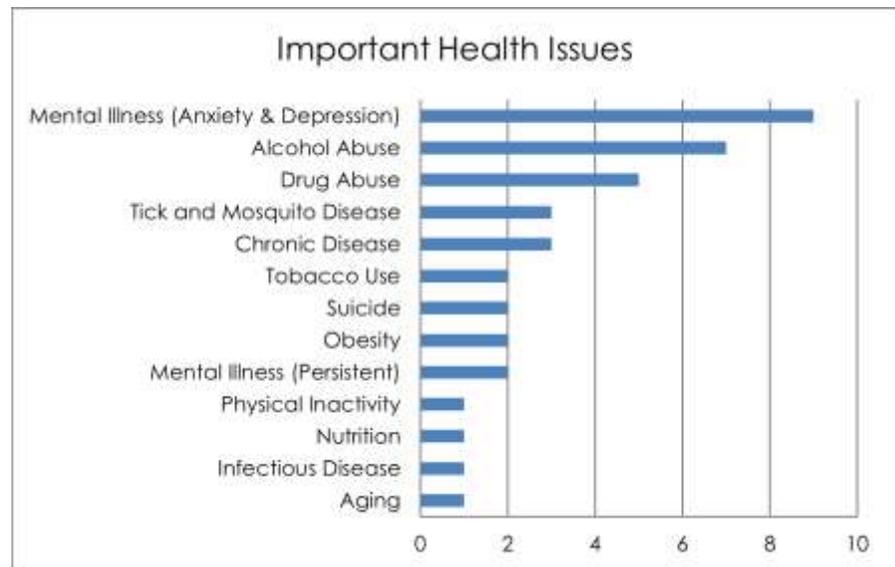
Key Question #2: "Where should the community focus its resources and attention to IMPROVE THE QUALITY OF LIFE for our community?"

Similar to CAS findings, programs for youth and jobs and a healthy economy were the top two areas to improve quality of life. The only difference with CAS findings was that the top two areas were not equally ranked, in this case the program for youth ranked higher than the jobs and healthy economy.



Key Question #3: "What are the most important HEALTH ISSUES that our community should focus on?"

General mental health was selected as the top health issue. Substance abuse (both drugs and alcohol) was selected as the second top health issue. This was similar to CAS findings in that these were the same top areas of concern.



Focus Groups

Mahopac Central School District

“How do you get health information?”

The Putnam County DOH has been attempting to reach younger residents so additional targeted questions were added to the focus group script.

In general the participants used social media for gathering health information. If they did ask a health question it would be to their mother, a health teacher or the school psychologist. Responses included:

“Facebook” “Twitter” “Instagram” “Snap Chat” “Tumblr”
“Would ask Mom, health teacher or school psychologist”

“Are you more comfortable speaking with a peer or an adult?”

In general the participants were more likely to discuss health concerns with peers. In particular they would speak with peers who have the same experiences.

“Would feel more comfortable asking a peer”

“Would ask people who had same experience because they can relate”

“People who experienced it too”

Where would you be comfortable going if there was a support group?

The participants were open to support groups being held at schools or libraries. They would not participate if the support groups were held at churches or other unfamiliar places. In general the group felt that they would prefer to attend peer led support groups with those that have experienced the same issues.

Putnam County 4-H Fair

The Putnam County 4-H Fair is a countywide summer event led by the Cornell Cooperative Extension. The Putnam County DOH has a presence at the fair providing opportunities for youth and community education. This year the Putnam County DOH staff interacted with nearly 200 residents explaining the CHIP process. These residents were provided an opportunity to vote on the top health priorities within the county. Mental Health was the leading priority area with Healthy Environment being the second. The bottom three areas were Women, Infants & Children, Chronic Disease and then HIV/STD.

Many Voices, One Valley

Overview

Many Voices One Valley is a study conducted by the Marist College Institute for Public Opinion and funded by the Dyson Foundation. The study was initially conducted in 2002 with updates in 2007 and 2012. Residents from seven counties (Columbia, Dutchess, Greene, Orange, Putnam Sullivan and Ulster) were asked their perceptions of life and work in the region.

Top Priorities in Putnam County

Economic concerns continue to be the main priority for respondents in Putnam County. The top issue for 2012 was “keeping businesses in the area.” Residents also selected this as a number one priority in 2002 and number two priority in 2007.

The second highest priority for residents in 2012 was “creating more jobs.” In previous surveys it was ranked among the top ten priorities.

The third most important issue in 2012 was “reducing taxes.” This issue was ranked second in 2002 and first in 2007.

Children and Youth

Overall, respondents had a good outlook on the activities available for children and teens and felt that childcare costs were not causing a strain on finances.

“Recreational activities for children and teens” was considered a good to excellent resource by 59% of respondents. Residents also considered this a good to excellent resource in 2007 (61%) and 2002 (24%).

In 2012 the majority of respondents felt that “community spending on recreational activities for children and teens” was just right (51%) or too little (41%). In previous surveys it was ranked similarly.

The survey also included questions about the “financial strain of child care” and in 2012, 64% of respondents reported the strain as “none at all.” Nearly 20% reported the financial strain of child care as “a great deal” or “a good amount.”

Community Engagement

The majority of respondents (92%) felt that Putnam was an excellent to good “place to live.” This is similar to results in 2007 and 2002.

Respondents felt that they could have a personal impact on “making your community a better place to live.” Three-quarters felt that they could make a big impact or moderate impact on their community which is similar to responses in 2007 and 2002.

Many Voices, One Valley

Economy

The “quality of jobs” in Putnam were considered good to excellent by only 38% of respondents. The percentage of respondents listing the “quality of jobs” as fair to poor rose to 59% from 48% in 2007.

Nearly half of the respondents felt that “community spending on the quality of jobs” was “too little.” This is a 10% increase from 2007 and 2002.

Unemployment is a great concern among respondents. Fifty-three percent of respondents are “somewhat” or “very” concerned “that in the next 12 months they or someone else in their household might be out of work and looking for a job.”

The majority of respondents felt that “jobs are difficult to find” (90%) and that if they “were to lose their job” it would be difficult (40%) or very difficult (38%) to “find another similar position about the same distance from home.” This is nearly a 25% increase from the 2007 survey.

The “financial strain of property taxes” remains a concern with 77% of respondents. Of the 30% of respondents who report “plans to move five years from now, 54% report “economic reasons” for their plans to move.

Health

Health care availability and costs continue to be a concern for respondents.

“Household members not insured now or in past year” rose from 14% in 2007 to 20% in 2012. “Children not insured now or in past year” had a slight increase from 9% in 2007 to 12% in 2012.

The “financial strain of health care costs or medical expenses NOT including health insurance” rose from 38% in 2007 to 43% in 2012. The “financial strain of health insurance” rose from 41% in 2007 to 49% in 2012.

Safety

Most respondents (60%) felt that “in the event of a major disaster where there was no warning the community has an adequate emergency response plan in place.”

The rating of good to excellent for “protecting residents from crime” was also high at 89%. Similarly 83% of respondents felt that “community spending on protecting residents from crime” was “about the right amount.”

Transportation

The majority (64%) of respondents felt that “public transportation” was fair to poor and that “community spending” (52%) was too little.

“On most workdays” 81% of respondents “commute to work by car by self.” The “financial strain of the cost of gasoline” is a concern for 80% of the respondents.

Summary

After completing the community asset survey, local focus groups and looking at the Many Voices One Valley data, common themes were identified. Overall, Putnam County is considered an asset rich place to live and work.

Assets

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 leads to low crime and violence rates. Generally, the police, fire, rescue and health department are well prepared to handle emergency events as evidenced by the response during H1N1 and Hurricane Sandy. All of this led to residents feeling that they live in safe neighborhoods.

Opportunities for Improvement

There was an overwhelming perception that the current state of the economy and jobless rate are areas for focus and improvement. The lack of job stability and rising cost of living caused many residents concern.

Availability of programs for youth, particularly after school, was considered a focus area by youth and adults. With more dual working households and single parent households, the need for prosocial involvement are very important. When youth are given opportunities to participate in meaningfully important activities at school and in the community, they are less likely to engage in drug use and other problem behaviors.

Health Concerns

The leading health concerns are chronic disease and mental health. The new trend is for mental health to be provided jointly with medical health leading to a better model of well-being.

In Putnam County, mental health, with suicide in particular, has been a leading health priority since the HEAL9 assessment project. The County is now establishing a Veterans Suicide Task Force and a Suicide Task Force. These task forces coupled with the efforts of the Mental Health and Substance Abuse Providers Group, will focus on improving the general mental, emotional and behavioral (MEB) well-being of all Putnam residents. The expectation is that by focusing on MEB, well-being improvement will also be seen in suicide and substance abuse rates.

Chronic disease has always been a health priority for the Putnam County DOH. The Live Healthy Putnam Coalition is the leader in Putnam for establishing goals and priorities for agencies to work on in collaboration with the Putnam County DOH. It will continue to shape the Putnam vision for giving all the residents an opportunity to live a healthy and productive life.

Forces of Change

Introduction

Social Forces

Economic Forces

Political Legal Forces

Technological and Scientific Forces

Environmental Forces

Ethical Forces

Summary

Forces of Change

Introduction

The Forces of Change assessment is a group exercise that looks at the current social, economic, and political and legal trends in the community supporting or hindering the health of the Putnam County community. Participants answered the following questions:

- What is occurring or might occur that affects the health of our community or the local public health system?
- What specific threats or opportunities are generated by these occurrences?

The Forces of Change assessment leads to a comprehensive, detailed list of key forces and describes their impacts.

During the 2013 Public Health Summit the attendees were invited to participate in the Forces of Change assessment. The group activity was conducted with three scribes. The highlights of each force of change are discussed below. Following the highlights are complete grids with the specific force, the threats it poses and the opportunities that are created.

Social Forces

The two leading social forces of change identified by the group are:

The **culture of productivity in the workplace** leads to increased stress and decreased health among the workforce. Policy revisions are needed to protect individuals from working overtime.

The **stigma against mental illness** marginalizes an already at-risk group, and prevents individuals and families from seeking help and mental health treatment. This stigma is further perpetuated by the media. Anti-stigma campaigns can work to change knowledge levels leading to social acceptance.

Economic Forces

The leading economic force of change was the **declining economic conditions and decreased funding** leading to fewer medically insured individuals, as well as decreased health services and education. The presence of the new Federal Qualified Health Center should address some of these issues.

Political and Legal Forces

Two recent pieces of legislation were identified as potential change agents for the improvement of the local public health system:

Healthcare reform (Affordable Care Act), while creating an atmosphere of uncertainty, also stimulates opportunities for expanded healthcare coverage, re-investment of health care dollars, and shifts the focus from acute care to community-focused care.

The **New York Safe Act**, the gun control legislation enacted last spring, may keep individual gun owners from seeking mental health treatment even if they need it. An unintended consequence of the new law tends to increase the stigma of mental illness. An opportunity is created for further education, awareness and collaboration.

Forces of Change

Technological and Scientific Forces

Technological advances continue to pose opportunities and threats. The transition to **Electronic Medical Records (EMR)** initially puts additional burden on personnel and finances and but ultimately produces better reporting and increased standardization. **Evolving communication technologies** increase the availability of a plethora of misinformation. **Social media expansion and its high utilization** among youth are increasing the vulnerability of this population. Mental health implications include bullying, anxiety and depression and suicide. These new communication platforms can be used to convey important public health messages and engage the public on health issues.

Environmental Forces

Environmental forces continue to present areas of concern: **Climate change** (e.g. increased snowstorms, hurricane) risks injury and other negative health effects on the community. A backup, continuity of operations plan is needed to prepare the community during emergency disasters.

Corporate Marketing Practices shape public perception about social norms, increasing consumption of unhealthy products (food, alcohol, drugs, etc.) leading to obesity and addiction. Public policy and education needs to be crafted to reverse this trend.

Ethical Forces

Family planning opposition leads to lower human papillomavirus vaccinations, HIV testing among youth, and diminished condom distribution in schools. The opening of the Federally Qualified Health Center and the opening of the PCDOH STD/HIV testing clinic are potential opportunities for no- and low-cost vaccination and immunization. **New needs of the aging population** are increasing, including unemployment, housing, health care, and end-of-life issues.

Complete Tables

The following section of complete tables was written up from the Forces of Change flip charts, on which the scribes recorded comments of the participants. The identified forces have been organized into common themes to help frame the discussion. Many forces fell into more than one theme, and therefore are found in more than one table.

Social Forces of Change

Complete Tables

FORCE	THREATS POSED	OPPORTUNITIES CREATED
Social climate	- Increased use of drugs and alcohol	+ Treatment versus punishment + Prevention education
Social media (expansion and increased utilization)	- Increased vulnerability for children - Mental health implications (e.g. suicide, youth safety)	+ Improved engagement and productivity in certain situations + Advertising public health services and programs through use of social media
Political polarization on issues	- Don't get together to solve a problem	+ Coalitions and forums to bring different groups together to cover the middle ground
Use of school suspensions (zero tolerance policies)	- Create disharmony in the community - Negative perceptions in schools	+ Re-education in schools + Re-empowerment of students + Utilizing community partners to those in need
Culture of productivity over health in the workplace (e.g. working overtime)	- Increased stress, decreased health for the workforce - Unavailability to families and self - Increased rise of pharmaceuticals	+ Policy revisions protecting individuals from working overtime
Family planning opposition	- Low HPV vaccinations among youth - Lack of condom distribution in schools - Low HIV tests among youth	+ Increased education for parents and community
Mental illness stigma, perpetuated by the media	- Further marginalizing an already at-risk group - Prevents individuals and families from seeking help and mental health treatment	+ Program and policies countering mental illness stigma
Obesity stigma, targeting behavioral factors for chronic	- Further marginalizing an already at-risk group	+ Education opportunities + Voluntary opportunities

Economic Forces of Change

Complete Tables

FORCE	THREATS POSED	OPPORTUNITIES CREATED
Declining economic conditions; Decreased funding	- Lack of medically insured individuals - Decreased services and education	+ Increase acceptance of Federally Qualified Health Center + Look for other funding sources + Increased partnerships
Affordable Care Act	- Uncertainty - Changes in funding	+ Increased coverage + Increased preventable care of all ages
Managed Care (aka Medicaid redesign)	- Changes in funding - Changes in how disabled get care or receive services in a different way - Uncertainty - Hospital closures - Decreased acute care, pressure on the community	+ Coordinated care + More efficient care + Savings on hospital expenses, reinvestment in the community + Emphasis on peer resources and counseling
Rising healthcare costs; Reimbursement decrease	- Decreased services provided - Optional programs cut	+ Refocus on primary care + Potential savings + Increase cost effectiveness (e.g. peer counseling) + Do more with less

Political & Legal Forces of Change

Complete Tables

FORCE	THREATS POSED	OPPORTUNITIES CREATED
Healthcare reform	<ul style="list-style-type: none"> - Uncertain impact on health care programs - Changes in funding 	<ul style="list-style-type: none"> + Expanded healthcare coverage for certain individuals + Reinvest cost savings + From acute care into community-focused care
Immigration reform	<ul style="list-style-type: none"> - Limited resources further reduced - Undocumented immigrants afraid to access services because they are afraid they will be reported - Unreported STDs, etc. 	<ul style="list-style-type: none"> + Empowerment + Increased unity within the community
Legalization of marijuana; Decriminalization of marijuana and drug use	<ul style="list-style-type: none"> - Increased access to the substance - Increased use and misuse - Decreased well-being 	<ul style="list-style-type: none"> + Taxes
NY Safe Act (2013 legislation on gun ownership and mental health)	<ul style="list-style-type: none"> - People will not be forthcoming with mental health treatment if they own guns - Increased stigma on mental health 	<ul style="list-style-type: none"> + Education, awareness + Increased collaboration + Partnership with the police
Veteran's Re-patriot	<ul style="list-style-type: none"> - Not being able to provide certain services that could overwhelm the system (e.g. TBI, social/emotional support) 	<ul style="list-style-type: none"> + Community can come together to provide support (e.g., task force)
Use of school suspensions (zero tolerance policies)	<ul style="list-style-type: none"> - Create disharmony in the community - Negative perceptions in schools 	<ul style="list-style-type: none"> + Re-education in schools + Re-empowerment of students + Utilizing community partners to those in need
Political polarization on issues	<ul style="list-style-type: none"> - Don't get together to solve a problem 	<ul style="list-style-type: none"> + Coalitions and forums to bring different groups together to cover the middle ground
Insurance companies are unregulated, transition to managed care	<ul style="list-style-type: none"> - Inconsistency in service provision (e.g. behavioral health must 'fight for every visit') - Increased spending without treating those who need it 	<ul style="list-style-type: none"> + Government regulation of insurance companies to ensure consistent treatment + Increased infrastructure, hiring more staff

Technologic & Scientific Forces

Complete Tables

FORCE	THREATS POSED	OPPORTUNITIES CREATED
Evolving communication technologies	- Readily available misinformation	+ New technologies to convey important public health messages
Increased use of evidence-based strategies (or limited funding)	- Lose some programs that may not fall into certain categories - Need for staff training - Takes a lot of time	+ More effective programming + Push to obtain funding for more research to use evidence-based programs
Electronic medical records	- Funding issues - Increased staff burden, need for staff training - Takes a lot of time - Difficult to implement - Technical lang. barriers	+ Increased reporting & communication records + Increased standardization
Increased information collected in databases	- Misuse of the information, mishandling (who's responsible?) - Perceived threat	+ Increased data availability = funding & opportunities for + things + Better health outcomes + Re-training existing staff to use electronic programs
New ways to diagnose and treat illness	- Easy to resort to the most expensive treatment - Decreased focus on primary care and healthy lifestyles (prevention) - Healthcare costs increase	+ More options for treatment + Better diagnoses + Push to examine patient lifestyle
Lack of technology to document community interventions & outcomes	- Community initiative effects are not being captured - Decreased funding towards community-focused interventions	+ Community service coupled with treatment modality + Participate in the system to increase community initiatives
Telemedicine	- Unreliable practitioners take advantage of telemedicine to make a profit - Deceit & decreased health	+ More rural areas have access very highly specialized care
Probiotics	- Unreliable individuals and corporations take advantage of probiotics to make a profit - Deceit & decreased health	+ Scientific advancements + Increased health
Social media (expansion and increased utilization)	- Increased vulnerability for children - Mental health implications (e.g. suicide, youth safety, bullying, anxiety & depression)	+ Improved engagement & productivity in certain situations + Advertising PH services and programs through use of social media

Environmental Forces of Change

Complete Tables

FORCE	THREATS POSED	OPPORTUNITIES CREATED
Projected increase in flooding & rainfall	<ul style="list-style-type: none"> - Physical and health threat - Water treatment systems contaminated - Resident displacement 	<ul style="list-style-type: none"> + Increased preparedness for emergencies + Grants and funding availability to upgrade waste/water facilities + Education about preparing to maintain health in emergency cases
Transportation limitations (esp. in suburb/rural community)	<ul style="list-style-type: none"> - Difficult to relocate in emergency situations - Difficult to access healthcare 	<ul style="list-style-type: none"> + Create a loop bus, or small bus to go to the hospitals
Corporate Marketing Practices	<ul style="list-style-type: none"> - Marketing for profit - Increased substance abuse - Unhealthy products as social norm 	<ul style="list-style-type: none"> + Adopt policies to protect healthy environments
Air quality	<ul style="list-style-type: none"> - Lung health and overall well-being 	<ul style="list-style-type: none"> + Alerts + Technological improvements (e.g. electric cars, hybrids, wind & solar energy)
Access to healthy foods	<ul style="list-style-type: none"> - Increased obesity - Decreased health outcomes 	<ul style="list-style-type: none"> + Vegetable garden in every home + Programs to have people grow & cook their own + Community recreation for youth
Climate Change (e.g. snowstorms, hurricane)	<ul style="list-style-type: none"> - Injury and negative health effects 	<ul style="list-style-type: none"> + Continuity of Operations Plan ("COOP planning," or the backup plan to an operation when staff are unavailable)

Ethical Forces of Change

Complete Tables

FORCE	THREATS POSED	OPPORTUNITIES CREATED
Social determinants of health	- Potential disparity in health outcomes due to differences in socioeconomic status	+ Support for population-based public health
Immigration reform (healthcare as a human right)	- Threats to public health and community health	+ Help people understand health as a human right
Commercial marketing targets certain, vulnerable populations	- Decreased health outcomes among specific populations (e.g. obesity and junk food)	+ Protect vulnerable populations in the community
Culture of productivity over health in the workplace (e.g. working overtime)	- Increased stress, decreased health for the workforce - Unavailability to families and self - Increased rise of pharmaceuticals	+ Policy revisions protecting individuals from working overtime
Family planning opposition	- Low HPV vaccinations among youth - Lack of condom distribution in schools - Low HIV tests among youth	+ Increased education for parents and community
Mental illness stigma, perpetuated by the media	- Further marginalizing an already at-risk group - Prevents individuals and families from seeking help and mental health treatment	+ Program and policies countering mental illness stigma
Aging community	- Increased elderly population - increased disease prevalence - End of life issues, lack of education in end of life choices	+ Education opportunities, informing people what options they have
Obesity stigma, targeting behavioral factors for chronic diseases	- Further marginalizing an already at-risk group	+ Education opportunities + Voluntary opportunities

Local Public Health System

Introduction

Essential Service #1 - Monitor health status to identify health problems

Essential Service #2 - Diagnose and investigate health problems and health hazards

Essential Service #3 - Inform, educate and empower people about health issues

Essential Service #4 - Mobilize community partnerships to identify and solve health problems

Essential Service #5 - Develop policies and plans that support individual and community health efforts

Essential Service #6 - Enforce laws and regulations that protect health and ensure safety

Essential Service #7 - Link people to needed personal health services and assure the provision of health care when otherwise unavailable

Essential Service #8 - Assure a competent public health and personal health care workforce

Essential Service #9 - Evaluate effectiveness, accessibility, and quality of personal and population-based health services

Essential Service #10 - Research for new insights and innovative solutions to health problems

Local Public Health System

Introduction

The National Public Health Performance Standards assessment was employed to assess the services provided by the community public health system. Developed by the Centers for Disease Control and Prevention, the assessment answers the questions: “What are the components, activities, competencies and capacities of our local public health system?” and “How are the essential services being provided to our community?”

The Local Public Health System (LPHS) assessment focuses on all organizations and entities within the community that contribute to the public’s health.

The 10 Essential Public Health Services describe public health activities that should be undertaken in all communities. The essential services provide a guiding framework for the responsibilities of local public health systems. The level of service provided in the community for each essential service was assessed and each indicator was rated as none, minimal, moderate, significant and optimal.

The 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 services and assure the provision of healthcare when otherwise unavailable
8	Assure competent public and personal healthcare workforce
9	Evaluate effectiveness, accessibility and quality of personal and population-based health services
10	Research for new insights and innovative solutions to health problems

Essential Service #1

Monitor health status to identify community health problems

In 2013, the Mobilizing for Action through Planning and Partnerships (MAPP) assessment process was utilized-involving over 60 community partners. Numerous surveys were distributed, focus groups conducted and results collected. Data was analyzed by the Putnam County DOH epidemiologist and was used to identify health problems within the county and informed the 2013-2017 Community Health Assessment (CHA). The Putnam County DOH is responsible for the development of the county CHA that is submitted to the New York State Department of Health every four years and updated annually.

Local Public Health System

Essential Service #2

Diagnose and investigate health problems and health hazards

The local status of the community through its communicable disease surveillance system, comprising sentinel health care providers such as physician practices, schools, nursing homes, and the local hospital and Putnam County DOH disease control and environmental staff, monitor and investigate disease outbreaks and other trends. This process is expanded to include additional sentinel providers during influenza season. For an all hazards emergency response, these system players work in conjunction with Putnam County Emergency Services providers.

Essential Service #3

Inform, educate and empower people about health issues

Health education and communication takes many forms. Presentations, newspaper articles, online resources and informational brochures are just a sample. The health education unit at the Putnam County DOH works with local media, schools and other community health providers and advocacy groups to provide the public with the most accurate information. The Health Department works closely with the health educator at the Child Advocacy Center of Putnam County to educate the public about the prevention of serious injuries and abuse of children. Health alerts are disseminated to area physicians and other health professionals. Emerging health issues, disease outbreaks and community events are publicized through a variety of free and paid media. Online sites and social media platforms are also used to augment traditional release venues, and provide “real-time” dissemination at low-cost in a suburban area without a true daily paper or local television station.

Essential Service #4

Mobilize community partnerships to identify and solve health problems

Mobilizing community partners took another step forward in spring 2013 when the Putnam County DOH kicked off Public Health Summit III, launching the MAPP process in Putnam County. The process was not embarked upon without a foundation of collaboration and mobilization behind it. Chronic disease prevention partners mobilized around a trans-fat ban in 2007 and in doing so launched the Live Healthy Putnam coalition which has expanded and taken a leadership role in crafting goals and objectives for the 2013 Community Health Improvement Plan (CHIP). Mental health providers in the county have additionally mobilized to form the Mental Health Provider Group, and taken up the challenge of formulating their own strategies, goals and objectives for the 2013 CHIP. Other major community partnerships and coalitions include: POW’R Against Tobacco, Communities That Care (Anti-Drug) Coalition, Lower Hudson Valley Perinatal Network, and the newly formed Suicide Prevention Task Force.

Local Public Health System

Essential Service #5

Develop policies and plans that support individual and community health efforts

Working with the New York State DOH, local policy and law makers, advocacy groups and community leaders and other key Putnam County agencies and departments, the Putnam County DOH reviews and provides input to improve public health policies. The public health impact of current or proposed policies is discussed with policymakers and community members at meetings and education is provided to appropriate personnel via various methods including media relations efforts, such as direct contact, email and media releases; online information on the County website, and social media platforms. Past and ongoing policy and planning efforts include improving healthy food choices, reducing access to tobacco and alcohol, establishing a community health improvement process and enhancing public health preparedness. The Bioterrorism/Disaster Preparedness Task Force, developed in 2002, brings together the County's Bureau of Emergency Services and the Health Department, with multiple community partners, for meetings on a monthly basis to address key issues in emergency preparedness.

Essential Service #6

Enforce Laws and Regulations that Protect Health and Ensure Safety

Smooth enforcement and just application of laws demands collaboration from a number of partners supporting the Local Public Health System. These partners include not only the New York State DOH and the Putnam County Bureau of Emergency Services (BES), but also local law enforcement, law makers and judges, the New York State Department of Environmental Protection, New York State Department of Environmental Conservation, Environmental Protection Agency and Building/Code Enforcement Officers as well. Under mandate of Public Health Law, New York State and Putnam County Sanitary Codes, the Putnam County DOH enforces laws and regulations that pertain to public health and safety. The New York State DOH notifies the Putnam County DOH of amendments to current laws, regulations and ordinances that affect local enforcement. With other public health authorities as noted above and local law enforcement, the Putnam County DOH ensures all enforcement activities related to public health codes are executed in accordance with the law. Together with the BES, law enforcement, local law makers and judges, plans and protocol are developed to ensure the Putnam County DOH has the authority to act in public health emergencies.

Essential Service #7

Link people to needed personal health services and assure the provision of health care when otherwise unavailable

Residents needing home health and dental care services, mental health services and substance abuse counseling, as well as Women, Infants and Children (WIC) clients in need of prenatal care, are routinely referred to Health Department staff or linked with outside agencies when the care is not available through the Putnam County DOH. Making many of these outside referrals became easier with the 2012 establishment of the first Federally Qualified Health Center in Putnam. However even with the addition of this new service, mental health services remain limited in the county and residents without insurance are still at a distinct disadvantage when it comes to health care access.

Local Public Health System

Essential Service #8

Assure a competent public health and personal health care workforce

Education and training build a better workforce. The New York State DOH Learning Management System, other LHDs and our partners at the Columbia University Mailman School of Public Health's NYC-Long Island-Lower Tri-County Public Health Training Center offer numerous educational opportunities on a continual basis. Additionally Putnam County offers employees a tuition reimbursement program for courses at accredited institutions.

Two issues currently being addressed are cultural competence of staff members and leadership development throughout the local public health system. Formal leadership development opportunities, while currently available, are primarily accessed through academic institutions for substantial fees. Building leadership skills in the workplace is lacking and remedies are being pursued. The Putnam County DOH is in the process of developing a formal workforce development plan and an initial assessment has been completed with the assistance of the Columbia University's Public Health Training Center.

Essential Service #9

Evaluate effectiveness, accessibility, and quality of personal and population-based health services

Quality improvement, or QI, is the basis for ensuring service quality. It is the ultimate goal of any health department. This process, as a public health function, has been evolving, and health department accreditation takes QI to the next level. The Putnam County DOH is in the process of applying for national public health accreditation, through the Public Health Accreditation Board (PHAB). A recent gap analysis, conducted as part of the pre-accreditation process, found that while some programs are currently evaluated on a program-by-program basis, each department needs a QI program, and a broad-based culture of QI/QA (quality assurance) needs to be established. Presently the Maternal Child Health, Immunization, Communicable Disease and Child Lead Prevention programs have robust QI policies and procedures. This area has been identified as needing further development and department-wide implementation.

Essential Service #10

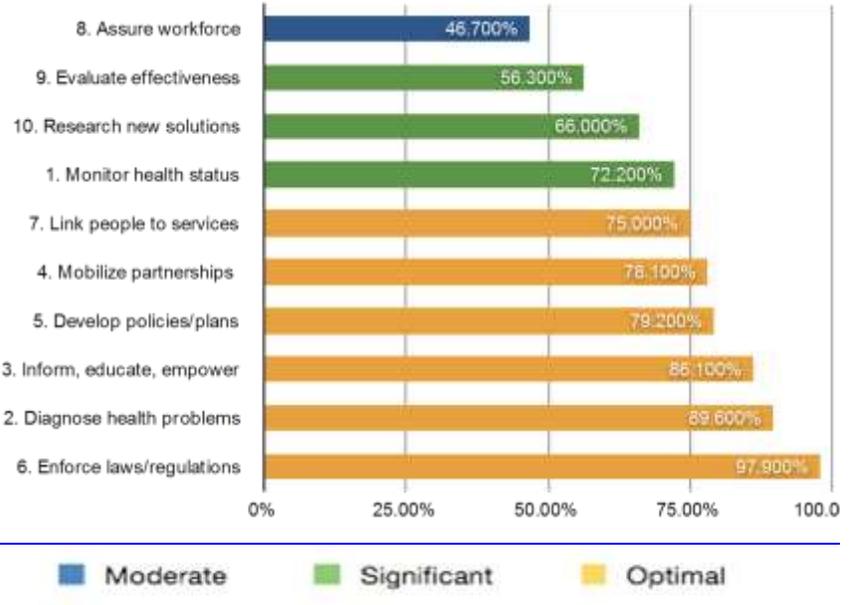
Research for new insights and innovative solutions to health problems.

Bringing evidenced-based solutions and other research insights into public health practice requires partnering with institutions of higher learning. In public health this generally means both academic institutions and teaching hospitals. Putnam County has neither, so to remedy this, the Putnam County DOH partners with local high schools, regional colleges and graduate programs that provide field learning experiences for students. Partnerships with Columbia University Mailman School of Public Health, State University of New York Albany School of Public Health and New York Medical College School of Health Sciences and Practice have enhanced the Putnam County DOH's ability to apply research to practical work. When research is conducted, scientific procedures are followed to ensure patient safety, according to Institutional Review Board protocol.

Overall Results

Overall Results

Figure 3. Scores for the Essential Public Health Services



Strengths

The strengths of the local public health system are enforcing laws (Essential Service #6), diagnosing health problems (Essential Service #2), and informing/educating the public about health issues (Essential Service #3). Developing policies (Essential Service #5), mobilizing community partnerships (Essential Service #4), and linking people with services received high marks as well (Essential Service #7).

Weaknesses

The weaknesses of the local public health system were also identified and prioritized. The top priorities were assuring a competent public and personal healthcare workforce (Essential Service #8) and evaluating the effectiveness of population-based health services (Essential Service #9). Other areas for improvement include researching new innovative solutions (Essential Service #10), and monitoring the health status (Essential Service #1).

In identifying and reviewing limitations, the assessment team also reasoned and formulated the following solutions: to gather and disseminate data in a more timely manner, to regularly complete an annual review, to compile and document all health-related protocol and regulations, to establish regular review of health-related policy, to extend communication efforts to non-English speaking populations, and to create a routine and periodic workforce assessment.

Community Health Status

Introduction

Community Health Status

Community Characteristics

Social Determinants of Health

Mortality

Causes of Chronic Disease

Overweight & Obesity

Nutrition & Physical Activity

Tobacco Use

Depression & Suicide

Next Steps

Introduction

Assessment Approach

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. 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 the goals and strategies for the upcoming five-year period. Multiple sources of data, described below, have been gathered and analyzed by the Putnam County DOH epidemiologist.

Data Sources

Community Health Status Report Card provides an overview of key health indicators for local communities (reported by the US Department of Health and Human Services).

County Health Rankings indicates the overall health of a county and the health outcomes and health factors that influence the rank of a county (conducted by the University of Wisconsin and the Robert Wood Johnson Foundation).

Health People 2010 & 2020 provide national objectives for improving the health of Americans (compiled by the US Department of Health and Human Services).

Live Health Putnam Survey – captures data about residents' nutrition and physical activity habits. Two versions were utilized, the second included more in-depth nutrition and physical activity questions plus a mental health component (both conducted by the PCDOH).

Local Data includes annual reports and data provided by local agencies.

Prevention Agenda (PA) 2013-2017 provides overarching guidance through a New York State Improvement Plan (from New York State DOH)

A wide variety of sources were included so that a more comprehensive health status assessment could be conducted.

Community Health Status

Health Indicators:

- Community Characteristics
- Social Determinants of Health
- Access to Healthcare
- Health Outcomes
- Overweight & Obesity
- Nutrition & Physical Activity
- Tobacco Use
- Depression & Suicide

These indicator categories most closely align with the objectives selected in the CHIP.

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 socioeconomic 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

Demographics (2012 US Census Data)	Putnam	New York
Population	99,607	19,570,261
Persons under 5 years	4.70%	6.00%
Persons under 18 years	22.30%	21.80%
Persons 65 years and over	13.70%	14.10%
White alone (reporting only one race)	93.20%	71.20%
Black or African American (reporting only one race)	2.80%	17.50%
American Indian and Alaska Native (reporting one race)	0.30%	1.00%
Asian (reporting only one race)	2.10%	8.00%
Native Hawaiian and Other Pacific Islander (reporting one race)	0.10%	0.10%
Two or more races present	1.60%	2.20%
Hispanic or Latino (may be of any race so included in race categories)	12.20%	18.20%
White alone , not Hispanic or Latino	82.30%	57.60%
Foreign born person	11.10%	21.80%
Language other than English spoken at home (age 5+)	16.30%	29.50%
Veterans (2007-2011)	5.53%	5.04%
Homeownership rate (2007-2011)	83.40%	54.80%
Housing units in multi-unit structures	15.20%	50.50%

Population

Between 2000 and 2010 the population of Putnam County increased by 4.14%. Putnam Valley had the largest growth (10.5%) of any town. The villages of Brewster (10.5%) and Nelsonville (11.2%) had similar growth rates as Putnam Valley. Kent was the only town or village to lose population.

Age

The Putnam population is aging. The median age rose from 39.9 to 41.9 years. A quarter of the residents are now over 55 years. Senior residents over 65 years now account for 13.7% of the population which is a 5% rise since 2007.

Race

The majority of residents remain White. Blacks and Hispanics (of any race) both had a 20% population growth from the 2000 census. Hispanics (of any race), now make up 12.2% of the population, which is moving toward the State percentage. Residents are predominantly American born and speak English in the home.

Housing

The majority of Putnam residents own and live in their own home. The homeownership rate in Putnam exceeds the State. Only 15% of the units available are multi-unit causing shortages for those renting. Housing has been identified as an emerging issue for those residents with persistent and severe mental illness, disabilities and minorities.

Veterans

Veterans only make up 5% of the community. However, these individuals are identified as a disparate mental health population.

Social Determinants of Health

Overview

Many factors can influence the health of an individual. The resources a person has access to and the environment a person lives in, works and plays in impact health outcomes. Quality of jobs, family income, level of education, community safety, access to quality health care, transportation, and family and social support are all resources that can affect health.

Social and Economic Factors	Putnam	New York
High school graduate or equivalency (2007-2011)	28.20%	27.80%
Some college with no degree (2007-2011)	18.70%	16.10%
Associate's degree (2007-2001)	8.20%	8.00%
Bachelors' degree or higher (2007-2011)	38.10%	32.50%
Unemployment (2012)	6.70%	8.50%
Poverty (2011)	5.90%	16.10%
Children in poverty (2011)	6.50%	22.80%
Single parent households (2007-2011)	6.00%	9.60%
Single Household 65 years and older (2007-2011)	7.50%	10.40%
Homicide rate per 100,000 (2009-2011) [less than 10 cases]	1.00	4.30
Mean travel time to work in minutes (2007-2011)	37.3	31.4

Education

Putnam residents are well educated with nearly 95% having a high school diploma or higher. Nearly half of the residents have an associates or college degree. Education is associated with improved health throughout the life cycle. Particularly, early education in the preschool years is vital to developing a foundation of good health habits.

Employment & Income

Putnam residents have a higher level of employment than New York State with the second lowest rate within the State. The unemployment rate for Putnam has remained constant since 2009 with a 2.4% increase this year. Nearly 7% of children and 6% of adults live in poverty. 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 leaders 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

There are less single parent households in Putnam than in New York State. The number of single households with individual 65 years or older is rising with a 1.7% rise since 2000. 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.

Community Safety

Putnam has a very low homicide rate and is considered a safe county to live in. Lower levels of violence and higher levels of community safety are associated with improved health outcomes.

Social Determinants of Health

Access to Care	Putnam	New York
Population to primary care physician ratios (2013)	1,749:1	1,222:1
Population dentist ratio (2013)	1,968:1	1,414:1
Adult health care coverage (2013)	86.80%	83.30%
Adults who have a regular health care provider (2013)	89.60%	84.90%
14 or more days of poor mental health in last month (2013)	22.20%	10.30%
School students reporting depressive symptom (2012)	36.00%	40.50% (Not NYS comparison)
Median household income (2007-2011)	\$92,711	\$56,951

Access to Care

Access to health care refers to a resident’s ability to seek services including: primary, secondary and tertiary care, and is considered a key social determinant of health. Inequities clearly exist for those who are under- or un-insured. Cultural and language barriers also lead to inequities that can result in poorer health outcomes. Transportation issues also directly impact resident’s ability to access care, as well as healthy food, education and other life opportunities.

Putnam residents have long had higher rates of health coverage than New York State and the United States and this gap still remains at about 5%. Ratios of physician and dentist to residents have always been lower in comparison to New York State being that Putnam is a rural county. Although the ratio within the county is lower than the State ratio, residents do utilize services in Westchester County and New York City. For residents without transportation, utilizing out of county resources is generally difficult.

Access to mental health services has been a concern of the agencies participating in the Mental Health Providers Group. Changes in insurance reimbursement, closing of regional mental health facilities and increasing need for services from adults and youth are straining the already limited providers currently available. Limited data is available to quantify these gaps but the group is determining ways to measure this. Data that is available suggests that adults in Putnam are reporting more poor mental health days than New York State residents. One third of Putnam students (8th- 12th grade) are reporting depressive symptoms is below the Bach Norman comparison group but has risen 3% since 2008.

Sources:

(2007-2011) US Census Bureau American Community Survey

<http://factfinder2.census.gov>

(2009-2011) New York State Department of Health Vital Statistics

<http://www.health.ny.gov/statistics/chac/mortality/d26.htm>

(2011) US Census Bureau Summary File

(2012) Prevention Needs Assessment

<http://www.putnamcadd.org/html/ctc.html>

(2013) County Health Rankings

<http://www.countyhealthrankings.org/app/#/new-york/2013/putnam/county/outcomes/overall/snapshot/by-rank>

Mortality

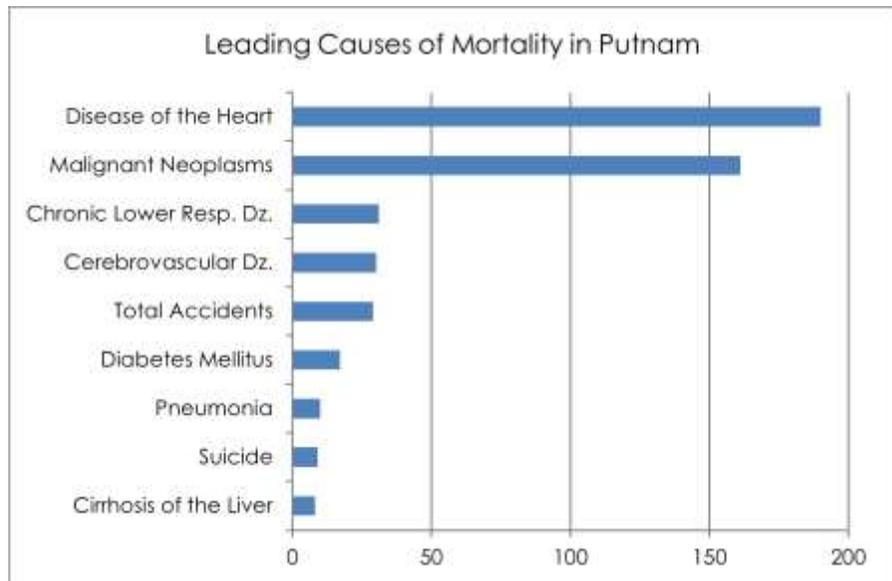
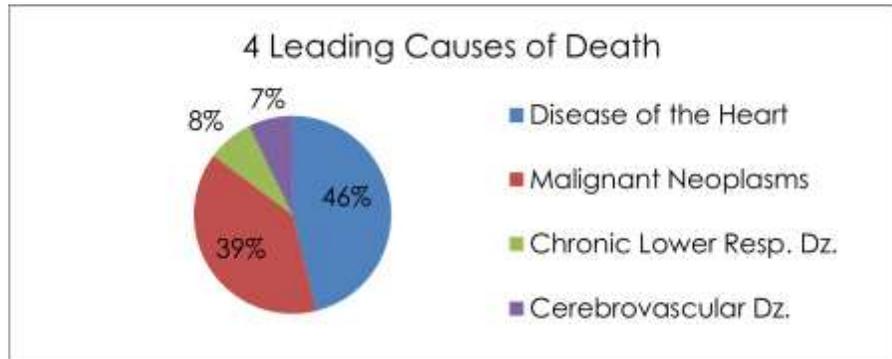
Leading Causes of Death

In 2011, there were 619 deaths. Deaths due to diseases of the heart were the leading cause of death, followed by malignant neoplasms. These two causes account for over half of the deaths in Putnam residents.

The third and fourth leading mortality causes of death remain chronic lower respiratory disease and cerebrovascular disease. Over the years, these causes have shifted back and forth.

Deaths due to total accidents, diabetes mellitus and pneumonia ranked fifth, sixth and seventh. These causes have consistently fallen among these spots although the order has varied.

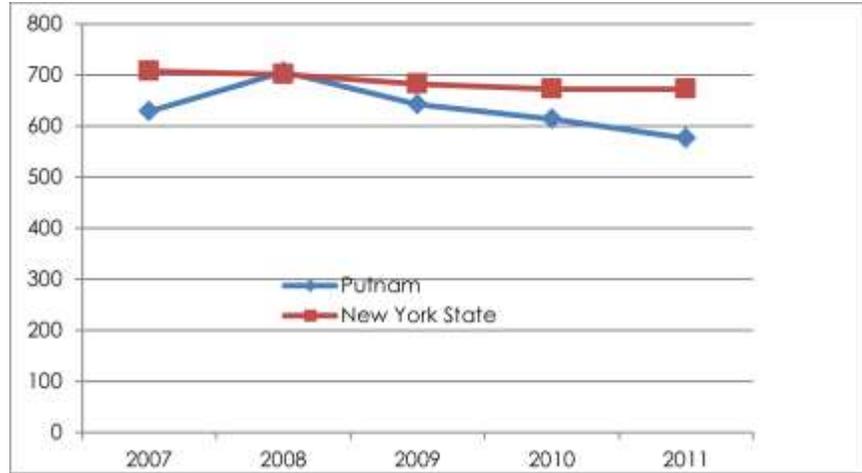
The top four causes of death in Putnam are similar to the leading causes of death in New York State and the United States. These top four causes of Putnam deaths remained the same as in past years.



21% of deaths are from other causes not compared in this list.

Mortality

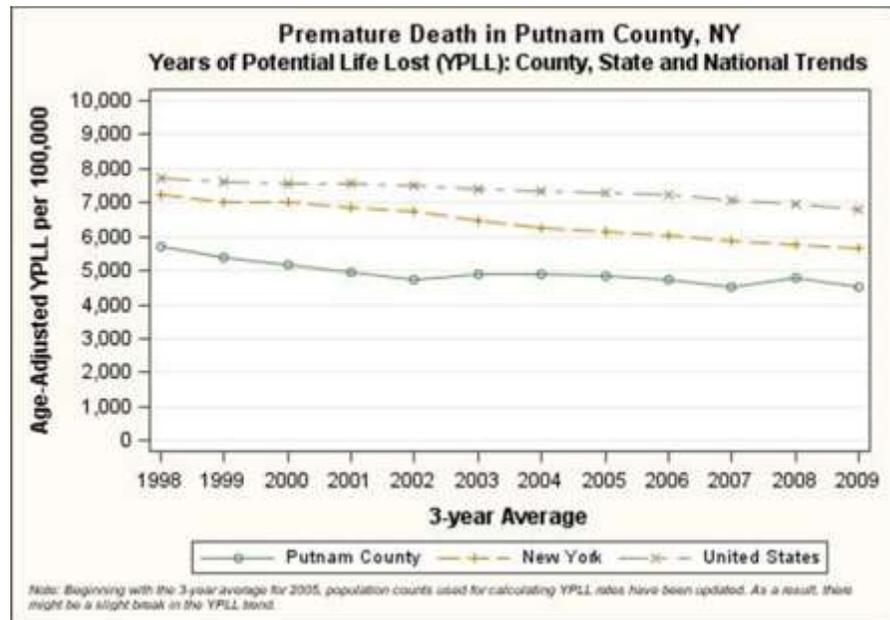
Death Rate



Premature Death

In general, Putnam County has a lower overall age-sex adjusted death rate in comparison to New York State. In 2011, it was 15% lower in Putnam compared to New York State (without New York City). Additionally, the death rate in Putnam has been falling over the past four years.

If a resident dies before the age of 75, this is described as premature death. Years of Potential Life Lost can be calculated by subtracting a person's age at death from 75 years to get a measure of premature death. Putnam County has a lower level of premature death than New York State and the United States. In general, Putnam residents are living longer.

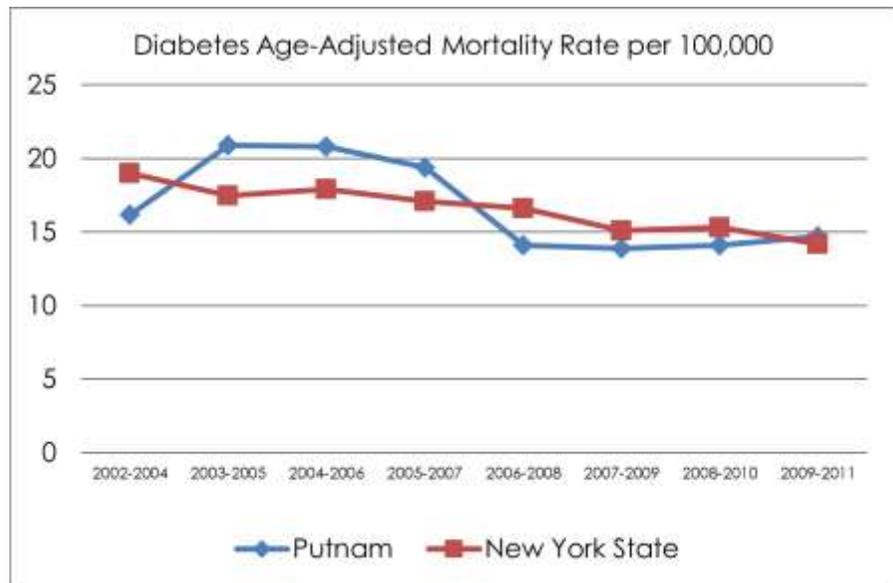


Causes of Chronic Disease

According to the Centers for Disease Control and Prevention, chronic diseases are among the most common, costly, and preventable of all health problems in the U.S. Health behavior choices play a part in developing disease and leading to premature death. Lack of physical activity, poor nutrition and tobacco use are the leading health risk behaviors that individuals can change to lead to a healthier lifestyle and less chronic disease.

Diabetes

Diabetes is a chronic disease in which a person does not make enough insulin, the body is not able to utilize it properly, or both. Physical activity, proper nutrition, medication, communication and support from health care providers are all self-management tools that can lead to improved health outcomes for those with diabetes.



The mortality rate from diabetes has been consistent over the past four years and is similar to the New York State (excluding New York City) rate. Data is not available by race due to Putnam's low number of cases in minority populations.

Causes of Chronic Disease

Diabetes

Diabetes Hospitalization Age-Adjusted Rate per 10,000				
Year	Primary Diagnosis Putnam	Primary Diagnosis New York State	Any Diagnosis Putnam	Any Diagnosis New York State
2002-2004	10.4	14.2	145	181.3
2003-2005	10.2	13.8	148	188
2004-2006	10.1	13.9	146.7	191.6
2005-2007	10	14.1	148.1	196.1
2006-2008	9.2	14.7	152.2	198.8
2007-2009	8.5	14.4	155.4	198.2
2008-2010	9.2	14.2	155.8	198.4
2009-2011	9.3	14.4	149.7	198.1

Hospitalizations rates vary by level of diabetes diagnosis. There are considerably more hospitalizations for residents with any diagnosis of diabetes versus those with a primary diagnosis of diabetes. Both rates of hospitalizations for Putnam residents are lower than the New Yorks State (without New York City) rate.

Race data is available for hospitalizations with any diagnosis of diabetes. Black non-Hispanic residents have the highest rate of hospitalization (221.6) as compared to Hispanic residents (149.7) and White non-Hispanic residents (125.3). These minority populations will be targeted for inclusion in the chronic disease self-management programs.

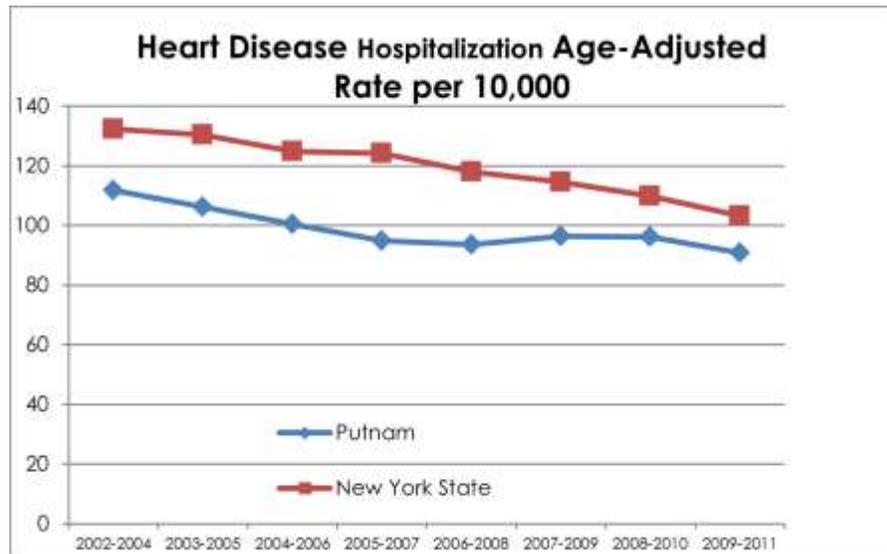
Heart Disease

Heart disease is the leading cause of death in the United States. Diseases of the heart is a generic term that can include issues with the coronary arteries, heart valves, or heart muscle that can affect the heart rate and rhythm. Physical activity, proper nutrition, medication, communication and support from health care providers are all self-management tools that can lead to improved health outcomes for those with heart disease.

Causes of Chronic Disease

Heart Disease

The hospitalization rate for Putnam residents with heart disease is lower than the New York State (without New York City) rate. Data by race was available for this measure and White non-Hispanic residents have the highest rate (80.3), Black non-Hispanics have the next highest rate (74.0) and Hispanic residents had a lower rate (42.0). As with all chronic diseases, the promotion of the chronic disease self-management model is being encouraged through the Community Health Improvement Plan.



The mortality rates for Putnam County residents are higher than the New York State (without New York City) rates for both heart disease and coronary heart disease. Of note is the 12% drop in both coronary heart and heart disease deaths for Putnam during the last time period.

Age-Adjusted Heart Disease Mortality Rate per 100,000				
	Coronary Heart DZ PC	Coronary Heart DZ NYS	Heart DZ PC	Heart DZ NYS
2002-2004	206.5	195.5	257.3	248.4
2003-2005	200.5	178.9	249	230.6
2004-2006	205.2	174.5	249.5	226.1
2005-2007	197.1	165	237.8	217.4
2006-2008	203.6	157.2	245.6	212
2007-2009	192.1	153	230.2	207
2008-2010	190.8	142.7	226	192.4
2009-2011	166.3	139.7	198.4	190.4

Overweight & Obesity

Adult Overweight and Obesity

Overweight and obesity are major risk factors for many chronic diseases, and have reached epidemic proportions in New York and across the nation. Physical inactivity, poor nutrition, consumption of sugar-sweetened beverages, and television viewing can contribute to excess weight gain in children and adults. The causes of overweight and obesity are complex, and there is no single solution. Successful prevention efforts will require multiple strategies that must be supported and implemented in multiple sectors including government agencies, businesses, communities, schools, child care, health care and worksites.

Adult Overweight & Obesity Indicators	Putnam	NYS
% Overweight & Obese Adults (NYSDOH BRFSS Data 2008-2009)	58.3	60.6
% Obese Adults (NYSDOH BRFSS Data 2008-2009)	25.2	24.5
% Obese Adults (HEAL9 Data 2009)	38.9	N/A
% Pregnant Women in WIC Pre-Pregnancy Overweight not Obese (NYSDOH CHAI Data 2009)	30.7	26.3
% Pregnant Women in WIC Pre-Pregnancy Obese (NYSDOH CHAI Data 2009)	19.7	26.2
Healthy People 2020 Obesity Objective	30.5%	
Healthy People 2010 Obesity Objective	15.0%	

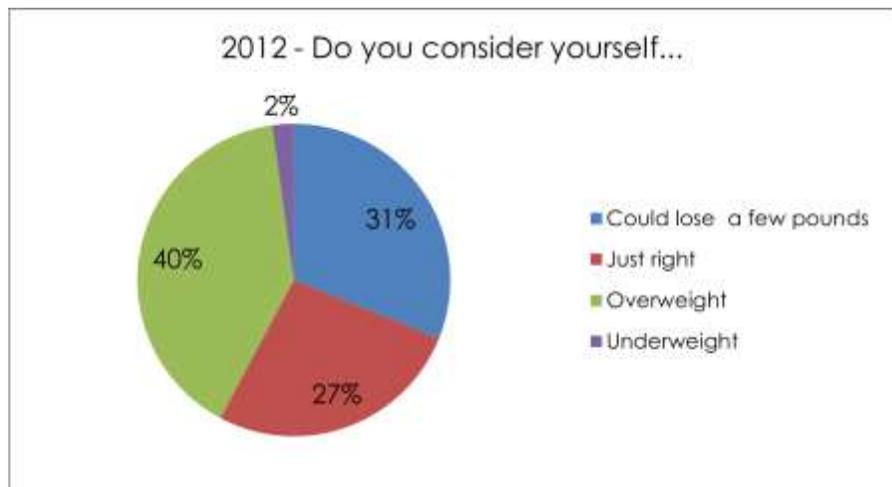
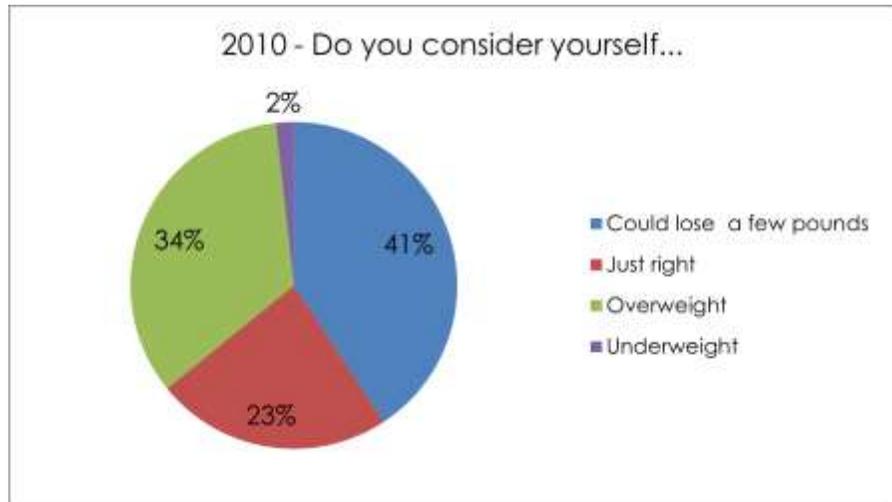
The most recent data for obesity and overweight is from 2009. In general Putnam County rates of obesity are similar to the NYS rate. Locally gathered data from the HEAL9 survey suggested a higher rate of obesity in Putnam County adults as compared to the BRFSS data. This could be in part due to different sampling methods.

A dramatic increase in population rates of obesity has led to a significant change in the Healthy People Objectives – from a target of only 15% to 30.5%.

Overweight & Obesity

Adult Perception of Overweight

Many residents struggle with weight issues as evidenced by the current obesity trends. Perception of weight status, if accurate, can lead to improved or changes in health behaviors. The first Nutrition and Physical Activity Survey did not ask respondents their actual height and weight to compare perceptions to actual body mass index. In the second survey, height and weight data were collected. Although there were many discrepancies between a respondents perception of their body weight and their actual body mass index, there were no global trends. The only noted trend was that more women reported the perception of being overweight when their BMI was actually normal. Those reporting “underweight” and “just right” were similar in both groups with about a quarter of the respondents falling within these groups. More respondents reported “could lose a few pounds” in the initial survey than the follow-up survey. Three quarters of respondents fell within a category suggesting a need for weight loss.



Overweight & Obesity

Overweight and Obesity in Children

% Obese Children Age 2 – 4, Putnam County								
	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	Hudson Valley	NYS
% Obese Children 2-4 Years Old	17.9	20.0	22.2	23.7	22.7	22.7	14.8	14.4

This data is obtained from children age 2 – 4 participating in the Women, Infants and Children Program. The percent of obese children in the Putnam County WIC program remains higher than the Hudson Valley and New York State (with and without New York City). As part of the services of the WIC program, clients receive nutrition counseling.

School Based Overweight & Obesity Indicators				
Putnam County	%Underweight (less than 5 th percentile)	%Healthy Weight (5 th to 84 th percentile)	%Overweight (85 th to 94 th percentile)	%Obese (95 th percentile)
Elementary (PK, K, 2 nd , 4 th)	2.8	78.1	9.4	9.7
Middle/High (7 th , 10 th)	1.6	71.6	13.1	13.7
Total	2.2	75.1	11.1	11.5
New York State (without NYC)	2.0	66.0	15.0	17.0

This data was gathered by the New York State DOH from data supplied from the local school districts, during the 2008-2009 and 2009-2010 school years. Not all of the school districts participated so the data is not complete. Only 55.1% of available student information was reported in Putnam County. The available data shows that of the sampled students, the Putnam County rates of overweight and obesity are lower than the New York State rate.

Nutrition & Physical Activity

Good nutrition, physical activity and a healthy body weight are essential parts of a person's overall health and well-being. Together, these can help decrease a person's risk of developing serious health conditions, such as high blood pressure, high cholesterol, diabetes, heart disease, stroke and cancer. A healthful diet, regular physical activity and achieving and maintaining healthy weight also are paramount to managing health conditions so they do not worsen over time.

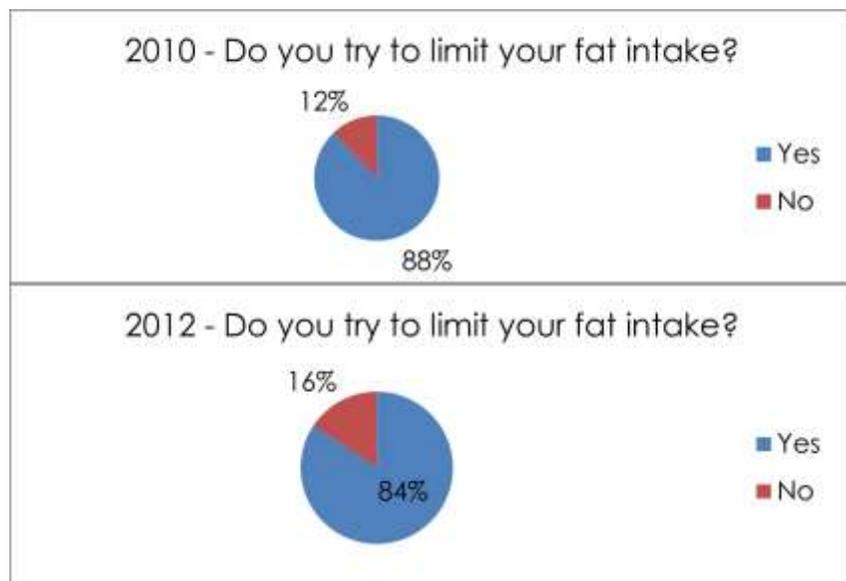
Access to Healthy Food

According to County Health Rankings data, more low income residents in Putnam (5%) do not live within close distance to a grocery store as compared to the New York State rate (2%) and the national benchmark (1%). With limited public transportation in a rural community, access to healthy foods can be a struggle. Nearly half (44%) of Putnam restaurants are considered fast food, which is similar to the New York State (45%) fast food restaurant density, but well above the national benchmark (27%).

Nutrition and Physical Activity Surveys

The Putnam County DOH has conducted two online nutrition and physical activity surveys. The first survey was conducted in spring 2010 and was a simple prevalence survey. The purpose of the survey was to identify health trends in the adult residents of Putnam County. The second survey was conducted in the winter of 2012 and was also conducted online. The new survey, like the earlier one in 2010, included questions about dietary and physical activity habits; particularly important given the growing obesity epidemic in the U.S. Unfortunately, Putnam County has not been immune to these trends. Other topics covered that were important to overall health are mood, depression, and substance use and abuse. Over 600 surveys were completed in the 2010 survey and over 200 were completed in the 2012 survey. Both surveys utilized convenience sampling. Below is a sampling of results from each survey.

Fat Intake

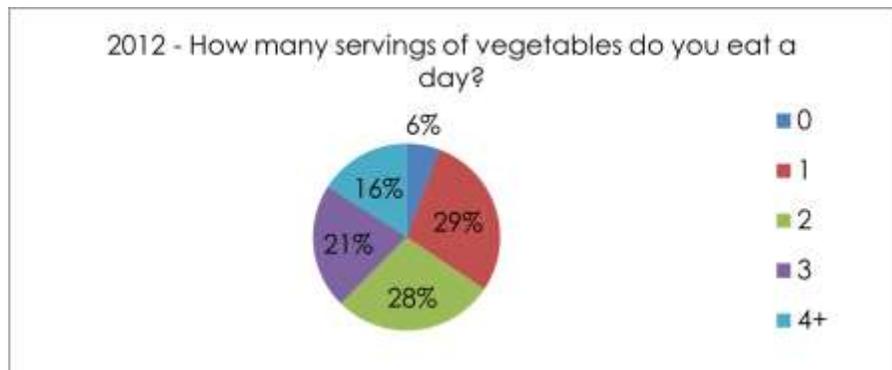
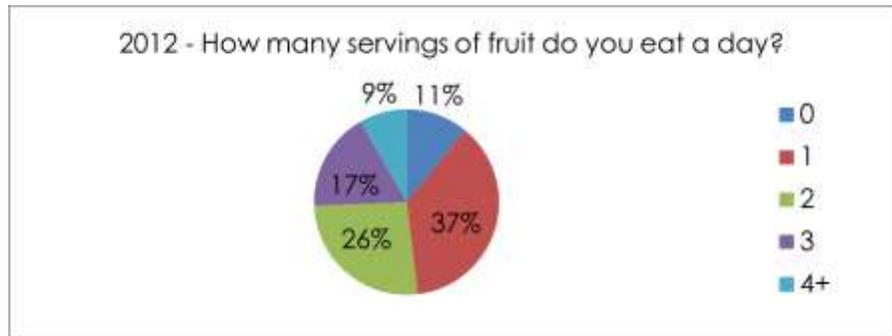
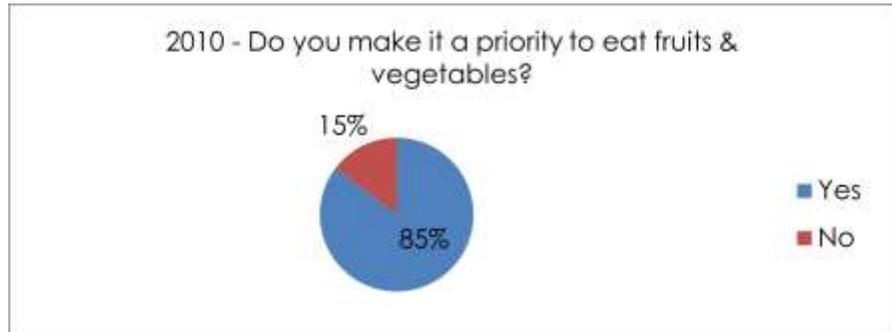


For both surveys the majority of respondents reported trying to limit their fat intake.

Nutrition & Physical Activity

Fruit and Vegetable Consumption

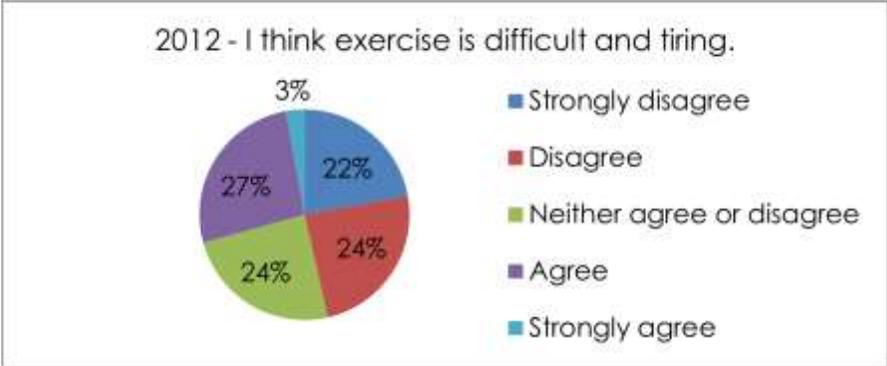
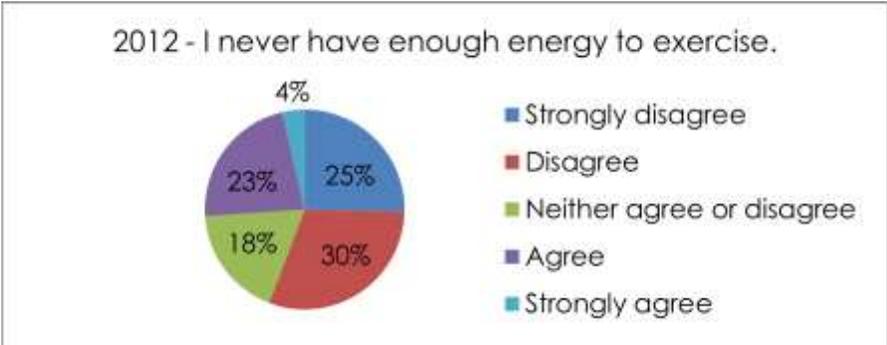
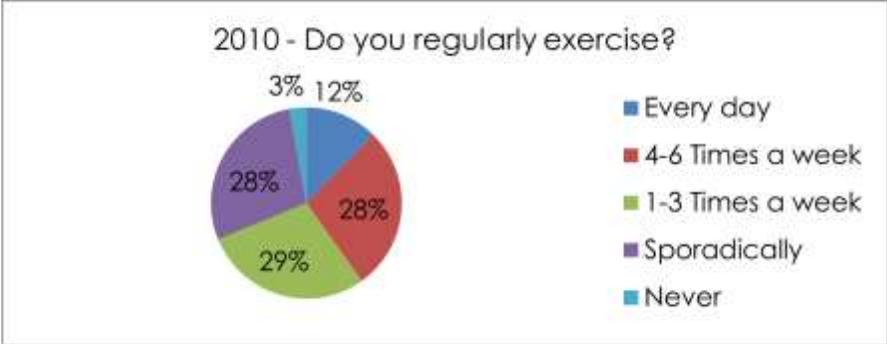
A diet that contains varied fruits and vegetables may help reduce the risk of cancer, heart disease, diabetes and stroke. In the 2010 survey, the majority of respondents reported making it a priority to eat fruits and vegetables. In the follow-up survey, this was a similar finding. To quantify, levels of consumption questions were asked about the number of servings of fruit and vegetable consumed in a day. The 2012 survey findings suggest that although respondents try to make consuming fruits and vegetables a priority, not all meet the recommended goals. Nearly half (52%) of the respondents consumed at least 2 servings a day of fruit and a third (37%) consumed at least 3 servings of vegetables a day.



Nutrition & Physical Activity

Physical Activity

Keeping an active life style and being physical fit play an important role in reducing the risk of chronic diseases. In both surveys, less than half of the respondents reported regularly exercising. In the 2012 survey, questions were asked about “why” respondents don’t exercise. Nearly a quarter of respondents reported “not having enough energy to exercise” and that “it is tiring and difficult.” According to 2009 Behavioral Risk Factor Surveillance Survey data, nearly a quarter of residents surveyed reported being physically inactive.



Tobacco Use

Smoking History

Smoking is a leading cause of preventable death and also can cause many illnesses, including heart disease, stroke, emphysema and lung cancer.

The Putnam County DOH partner POW'R Against Tobacco conducts a regional survey measuring attitudes and prevalence of smoking. Nearly half of Putnam respondents have smoked at least 100 cigarettes in their entire life. Although similar to some Hudson Valley counties, Putnam has one of the highest levels of respondents that have smoked.

% Have Smoked 100 Cigarettes in Entire Life?			
	2009	2010	2011
Putnam	46	45	44
Dutchess	45	45	44
Ulster	49	55	40
Westchester	39	40	38

SOURCE: POW'R

Current Smoking

According to Behavioral Risk Factor Surveillance System data, 13.9% of Putnam respondents report currently smoking. This is higher than the County Health Ranking report of 11% but similar to the previous Behavioral Risk Factor Surveillance System survey of 13.1%. The POW'R survey is similar with 12% reporting smoking everyday or some days.

2011 - % Do you now smoke cigarettes?			
	Everyday	Some Days	Or Not at All
Putnam	8	4	88
Dutchess	7	6	87
Ulster	13	6	81
Westchester	7	4	90

SOURCE: POW'R

Lung and Bronchus Cancer

Putnam County has a higher age-adjusted rate of lung and bronchus cancer incidence than the Hudson Valley region and a similar rate to New York State (without New York City). Overall the Putnam County rate has been declining since 2001-2003. An increase was noted between 2007-2009 and 2008-2010.

Lung and Bronchus Age-Adjusted Cancer Incidence Rates per 100,000 Residents							
Region	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010
Putnam	83.3	79.6	77.9	75.2	68.2	64.2	70.6
HV Region	N/A						62.7
NYS (w/out NYC)	73.0	72.5	72.1	73.5	72.0	73.3	71.2

SOURCE: NYS Cancer Registry

Tobacco Use

Lung and Bronchus Cancer Mortality

Putnam County has a higher age-adjusted rate of lung and bronchus cancer mortality than the Hudson Valley region and a lower rate than New York State (without New York City). Overall the Putnam County rate has been declining since 2001-2003. An increase was noted between 2007-2009 and 2008-2010.

Region	2002-2004	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010
Putnam	63.8	58.5	57.6	50.1	45.8	40.6	43.8
HV Region	N/A						41.1
NYS (w/out NYC)	52.5	52.3	51.4	50.8	50.5	48.9	47.4

SOURCE: NYS Cancer Registry

Lung and Bronchus Cancer Incidence by ZIP Code

Four ZIP codes cross Putnam County boundaries and therefore include residents from adjacent counties. These include Mahopac, Holmes, Hopewell Junction and Stormville.

In general, there was a greater percentage of observed cases of lung and bronchus cancer than expected cases in female residents. Five ZIP codes were 15-49% above the expected rate, including: Brewster, Mahopac, Putnam Valley, Holmes and Hopewell Junction. Females in Cold Spring had the greatest difference between observed and expected cases exceeding the expected by more than 50%.

Male residents in Hopewell Junction and Stormville both had 15-49% more observed cases than expected. In general male residents were more likely to have observed cases of lung and bronchus cancer within 15% of the expected cases.

Lip, Oral Cavity and Pharynx Cancer

The use of tobacco products is also associated with the development of oral cancers. The incidence and mortality rates for lip, oral cavity and pharynx cancer in Putnam County remain lower than the Hudson Valley Region and New York State (without New York City). The incidence rate is currently 7.6 per 100,000 compared to 11.0 per 100,000 for New York State (without New York City). There have been fewer than 10 deaths each year since 1996, so the mortality rate is considered unstable.

Depression & Suicide

Overview

Mental health conditions, such as depression and anxiety, affect people’s ability to engage in health promoting behaviors. In turn, problems with physical health, such as chronic disease and risky behaviors, can have a serious impact on mental health and decrease a person’s ability to participate in treatment and recovery. Every year, more than 1 in 5 New Yorkers have symptoms of a mental disorder. One in ten adults and children experience mental health challenges serious enough to affect functioning in work, family and school life. The 2009 Institute of Medicine report concluded there is increasing evidence that promotion of positive aspects of mental health is an important approach to reducing Mental, Emotional and Behavioral (MEB) disorders and related problems. It will serve as a foundation for both prevention and treatment of MEB disorders. (NYS Prevention Agenda)

Poor Mental Health

Putnam County mirrors national trends with increasing numbers of residents reporting poor mental health. The percentage of adults reporting poor mental health for 14 or more days has risen from 9.5% in 2008 to 22% in 2013.

According to data gathered in the Prevention Needs Assessment, more youth have been reporting depressive symptoms. The combined eighth to twelfth grade rate has been rising with an increase from 33% in 2008 to 36% in 2012. In 2010 and 2011, ninth and eleventh grade students reported higher levels of depressive symptoms. All grade specific and combined rates were lower than the comparison group.

Students Reporting Depressive Symptoms						
	Eighth Grade	Ninth Grade	Tenth Grade	Eleventh Grade	Twelfth Grade	Putnam Total
2008	29.1	33.7	35.6	34.8	31.1	33.0
2010	33.7	38.6	34.6	37.4	30.2	35.3
2012	32.4	38.6	37.4	38.6	32.2	36.0
Comparison Group	40.4	41.5	41.6	41.0	37.7	40.5

SOURCE: Prevention Needs Assessment

Depression & Suicide

Suicide Mortality

Suicide has been a priority issue since the 2010 Public Health Summit. In particular, suicides and heroin overdoses have seen a recent increase in the past six months with more than 10 deaths.

The suicide rate for Putnam has been increasing over the past three time periods. In comparison to the New York State rate (without New York City) and the United States, Putnam has a lower rate of suicide.

Suicide Mortality Rate per 100,000 Age- Adjusted		
	Putnam	New York State
2002-2004	6.4	6.5
2003-2005	5.5	6.4
2004-2006	6	7.4
2005-2007	5	7.7
2006-2008	5.7	8
2007-2009	5.1	8.1
2008-2010	6.4	7.1
2009-2011	7.5	9.1
United States - 11.3(2007)		

SOURCE: NYS Vital Statistics

Adolescent Suicide Mortality

The adolescent suicide rate has been on the decline, and in the past five years there have been no adolescent suicides in Putnam County.

Suicide Mortality Rate per 100,000 Age- Adjusted		
	Putnam	New York State
2002-2004	10.3	6.3
2003-2005	10.1	4.7
2004-2006	9.8	5.3
2005-2007	0.0	5.1
2006-2008	0.0	4.6
2007-2009	0.0	4.5
2008-2010	0.0	3.6
2009-2011	0.0	4.9

SOURCE: NYS Vital Statistics

Next Steps

CHIP Process

The Putnam County CHIP process is an ongoing effort to improve the health of all residents. Work groups have already identified gathering local data as a priority area, with the expectation that new data streams will be identified and shared. As part of this CHIP process, the Putnam County website will be utilized to share continuously updated assessments and health data. Partners and the community will be notified of updates using the established media protocol.

A key part of the CHIP is to measure progress towards achieving the established goals. Work groups for both the chronic disease priority and the mental health priority have begun the initial process of developing SMART objectives (specific, measurable, achievable, realistic and time scaled). Over the coming months these measures will be refined.

Health Data Resources

Putnam County DOH
www.putnamcountyny.gov/health

Centers for Disease Control and Prevention
<http://www.cdc.gov/DataStatistics/>

County Health Rankings
<http://www.countyhealthrankings.org>

Healthy People 2020
<http://www.healthypeople.gov/2020/default.aspx>

New York State DOH - Data & Reports
<http://www.health.ny.gov/statistics/>

New York State DOH - Prevention Agenda
http://www.health.ny.gov/prevention/prevention_agenda/



If you would like participate in the Putnam Community Health Improvement Process, please contact: PutnamHealth@putnamcountyny.gov.