



Community Health Improvement Plan 2013-2017

Submitted: November 15, 2013

Putnam County Department of Health
Mobilizing Action through Planning and Partnerships

Excellence

Professionalism

Services

Compassion

Commitment

Inviting you to participate

The mission of the Putnam County Department of Health is to improve and protect the health and well-being of county residents. The vision is to be recognized as bold and innovative leaders, partnering with the community in advocating for public health.

“A community that is continuously creating and improving physical and social environments and expanding community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential” is a healthy community, according to the Centers for Disease Control and Prevention (CDC).

To achieve our vision, the Putnam County DOH facilitated the Mobilizing for Action through Planning and Partnerships (MAPP) community needs assessment and strategic planning process. The MAPP process uses four unique assessments to determine community priorities and was instrumental in the development of our implementation plan.

The Putnam County Community Health Improvement Plan is the result of this community assessment process, which brought together a broad representation of Putnam County constituencies and community leaders. This collaborative plan is meant to be used as a guide in improving the health of everyone who lives in Putnam County, outlining goals and strategies and identifying areas to focus upon. Community change and health improvement require dedication and commitment from all stakeholders—including all citizens, businesses, government and community sectors.

We invite all of you to participate in some capacity towards addressing the focus areas within the plan, so that we can improve the health of all the individuals, families, and communities that make up Putnam County.

A special thank you goes to all community partners who provided guidance, direction and input to the Putnam County Department of Health. Please contact us if you are interested in participating at (845) 808-1390 or e-mail us at PutnamHealth@putnamcountyny.gov.

Sincerely,



Allen Beals, MD, JD
Commissioner
Putnam County Department of Health (PCDOH)

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Executive Summary



Vision for a Healthier Putnam County

The mission of the Putnam County Department of Health is to improve and protect the health of our community. Our vision states, we will be recognized as bold and innovative leaders, partnering with our community in advocating for public health.

The Putnam County Department of Health (DOH) has always partnered with Putnam Hospital Center, the only hospital in the county, on health assessment activities. Even before the 2008 New York State Department of Health (NYSDOH) mandate that local health departments collaborate with hospitals in their county to develop their Community Health Assessments (CHA) that relationship was well-established.

In 2013, the New York State DOH required local health departments again work with local hospitals and this time encouraged collaboration with community partners on development of the CHA and formulate a Community Health Improvement Plan (CHIP). The Putnam County DOH initiated and facilitated the Mobilizing for Action through Planning and Partnerships (MAPP) strategic planning process with our community partners in order to accomplish this. The Putnam County DOH has had a long-standing history of working with the community through its Live Healthy Putnam Coalition and Disaster Preparedness/Bioterrorism Task Force. These coalitions formed the basis to reach out to those individuals both at the organizational and individual level who wanted to participate in the MAPP planning process.

The MAPP process uses four unique assessments to determine community priorities. The four assessments are: Community Health Status, Local Public Health System, Community Themes and Strengths, and Forces of Change. These four assessments inform the development of the Community Health Improvement Plan (CHIP). More than 99 organizations participated in the assessments and greater than 500 Putnam County residents responded to the community survey. Through the MAPP process two overarching priorities were identified and served as a foundation for developing the Putnam County CHIP. As follows:

1. Prevent Chronic Diseases
2. Promote Mental Health and Prevent Substance Abuse

Two Steering Committees, composed of dedicated community partners were formed to address these priorities under the guidance of the Putnam County DOH. Committee members worked to develop a formal CHIP Action Plan to address specific areas within each priority to focus on over the next five years (2013-2017). Strategies and activities were identified with corresponding timelines and responsible parties to achieve specific measurable objectives.

The CHIP Action Plan will be utilized as the roadmap for our vision for a healthier Putnam County. *Live Healthy Putnam* will serve as the umbrella “brand” for both priorities. The CHIP Steering Committee will supervise the implementation of the goals for each of the identified priorities.

MAPP Leadership

CHIP Steering Committee

Allen Beals, M.D., J.D.
Putnam County Department of Health

Kris Boyle
Putnam County Department of Health

Keiren Farquhar
Putnam Hospital Center

Karen Fleming
Putnam Hospital Center

Deb Gesner
Health Quest

Susan Hoffner
Putnam County Department of Health

Barbara Ilardi
Putnam County Department of Health

Erin Ray Pascaretti
Putnam County Department of Health

Michael J. Piazza
Putnam County Department of DSS, Mental Health & Youth Bureau

Maureen Zipparo
Putnam Hospital Center

Putnam County Accreditation Team

Marianne Burdick
Associate Public Health Sanitarian

Barbara Ilardi
Supervising Public Health Educator

Erin Ray Pascaretti
Epidemiologist

Kathy Percacciolo
Supervising Public Health Nurse

MAPP Community Engagement

Thanks to all of the individuals listed below who took time from their busy schedules to participate in the development of the Putnam County Community Health Improvement Plan (CHIP). Special thanks to those individuals who have committed to participate on the various CHIP subcommittees to continue the work we started and must accomplish over the next four years.

2013 Public Health Summit Agencies and Participants

*Chronic Disease Subcommittee

^Mental Health Subcommittee

Advanced Chiropractic Wellness

Anne Brandon, D.C.*

American Dental Health Association

Susan Sloane

American Lung Association in N.Y.

Maureen Kenney*

Didi Raxworthy*

Arms Acres

Naura Slivinsky^

Columbia University Mailman School of Public Health

Joanna Eisman

Grace Lee

Jessica Steele

Cornell University Cooperative Extension-Putnam County

Diane Olsen*

Four Winds Hospital

Valerie Saltz^

Green Chimneys

Roderick MacRae, D.D.S.

Hannaford

Allison Stowell*

Health Quest

Deb Gesner

Hudson Valley Hospital Center

Maryanne Maffei

Hudson Valley Cerebral Palsy

Theresa Burdick^

Lower Hudson Valley Perinatal Network

Marilynn Wolf-Diamond

Mahopac Central School District

Jill Talcovitz

MAPP Community Engagement

2013 Public Health Summit Agencies and Participants, continued

Mental Health Association

Megan Castellano*^
Samantha Macio
Karen Pilner^
John Rock^

Mount Kisco Medical Group

Alan Bernstein, M.D.

National Alliance on Mental Illness – Putnam

Edward Murphy^

National Council on Alcoholism & other Drug Dependency-Putnam

Kristin McConnell^

New York State Department of Health

Lee Norris
Barbara Bright-Motelson

Northern Metropolitan Hospital Association

Lisa Corcoran

Open Door Brewster

Jay Zaslow, M.D.

Open Door Family Medical Center

Grace Beltran*

People, Inc.

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Planned Parenthood

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Putnam ARC

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Putnam County Board of Health

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Putnam County Bureau of Emergency Services

Adam Stiebeling

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Marla Behler^
Michelle Martine*

Putnam County Department of DSS, Mental Health & Youth Bureau

Janeen Cunningham*
Joseph DeMarzo^

MAPP Community Engagement

**2013 Public Health
Summit Agencies
and Participants,
continued**

Putnam County Department of DSS, Mental Health & Youth Bureau

Diane Moore*
Michael J. Piazza^

Putnam County Executive Office

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Putnam County Office for the Aging

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Putnam Family & Community Services

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Doreen Lockwood
Diane Russo^
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Karen Fleming*
Jeffrey Kellogg*
Linda Raffaele^
Maureen Simington
Dennis Ullman^
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Putnam/Northern Westchester Women's Resource Center

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Search for Change

Trish Hollister-Doyle^

Search for Change

Kathy Knox

St. Christopher's Inn

Laurel McCullagh^

St. Christopher's Inn

Marianne Rhoades^

United Way of Westchester & Putnam County

Susan Schefflein

Visiting Nurse Service of Putnam

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MAPP Community Engagement

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American Lung Association in N.Y.
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Wendy Gentile*
Mary Jo Muller*

Catholic Charities
Riki Peterson*

Childcare Council
Mary Schreiber*

Clover Lake
Katherine Devan*

Cornell University Cooperative Extension-Putnam County
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Jen Stengle*

Hannaford
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Kidz Country Day Care
Letitia Brache*
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Mahopac Central School District
Val Nierman*

National Council on Alcoholism & other Drug Dependency-Putnam
Elaine Santos*^

Open Door Family Medical Center
Anita Wilenkin*

Patterson Library
Ellen Clancy*
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Steve Unger*

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Susan Curtiss*
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Chris Ruthven*

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MAPP Community Engagement

***Chronic Disease
Subcommittee,
continued**

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Donna Massero*
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- Town of Patterson Recreation Center**
Matt Chibbaro*
- Visiting Nurse Association of Hudson Valley**
Carol Jaconetti*
Cornelia Schimert*

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Subcommittee**

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Patrice Moore^
- Community Member**
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Alison McGuire^
- Hudson Valley Cerebral Palsy**
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- Mental Health Association**
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- Mental Health Association - Westchester**
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- National Alliance on Mental Illness – Putnam**
Edward Murphy^
Jeanne Toovell^
- National Council on Alcoholism & other Drug Dependency-Putnam**
Elaine Santos*^

MAPP Community Engagement

**^Mental Health
Subcommittee,
continued**

New York State Courts

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New York State Office of Alcohol and Substance Abuse Services

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Open Door Family Medical Center

Lindsay Farrell^

People, Inc.

Anita Schwartz^

Projects to Empower

William Wasserman^

Putnam ARC

Susan Limongello^
Louis Lindenbaum^
Lois Tannenbaum^
Darby Walsh^

Putnam County Department of DSS, Mental Health & Youth Bureau

Grace Balcer^
Medley Broege^

Putnam County Sheriff Department

Donald B. Smith^

Putnam County Veterans Affairs

Arthur Hanley^
Mary Mantilla^
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Maurene Schneider^

Putnam Family & Community Services

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Putnam Independent Living Services

Cynde Stratton^

Rockland County Office of Mental Health

Bob Godley^
Kara Neunzig^

Rockland Psychiatric Center

Robin Crawford^

MAPP Community Engagement

^Mental Health Subcommittee, continued

Search for Change

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Gina Ellis-Simpson^

The National Empowerment Center

Vanessa Turner^

United Way of Westchester & Putnam County

Pat Anderson^

Veterans Task Force

Jessica Mazzuco^

Visiting Nurse Service

Lisa Sioufas^

2011 Public Health Summit Agency Participants

Advanced Chiropractic Wellness

American Cancer Society

American Lung Association in N.Y.

American Red Cross of Greater New York

Arms Acres

Brewster School District

Cancer Services of Putnam County

Carmel School District

Clover Lake

Cornell University Cooperative Extension

Green Chimneys

Haldane Central School District

Hannaford

Health Quest

Hospital Plaza

Hudson River Psychiatric Center

Hudson Valley Cerebral Palsy

Hudson Valley Hospital Center

Lower Hudson Valley Perinatal Network

Mahopac Central School District

Mental Health Association

National Alliance on Mental Illness – Putnam

National Council on Alcoholism & Drug Dependency

New York Medical College, School of Health Sciences and Practice

Open Door Family Medical Center

Private Practice Dentist

Puesto de Salud-Dr. Jay Zaslow

Putnam ARC

MAPP Community Engagement

2011 Public Health Summit Agency Participants, continued

**Putnam County Bureau of Emergency Response
Putnam County Department of DSS, Mental Health & Youth Bureau
Putnam County Department of Health
Putnam County Legislature
Putnam County Office for the Aging
Putnam County Sheriff's Department
Putnam Family & Community Services
Putnam Hospital Center
Putnam Valley School District
Rockland County Office of Mental Health
Search for Change
Town of Carmel
Town of Philipstown
Town of Putnam Valley
Town of Southeast
United Way of Westchester & Putnam County
Village of Brewster
Visiting Nurse Service
Westchester Putnam Access to Care**

2010 Public Health Summit Agency Participants

**American Cancer Society
American Lung Association in N.Y.
American Red Cross of Greater New York
Arms Acres
AVP Business Products, Inc.
Carmel High School
Cornell University Cooperative Extension
Green Chimneys
Hannaford
Health Quest
Hudson Valley Hospital Center
Kent Primary School
Mahopac Library
Mental Health Association
Mother's Club of Putnam Hospital Center
National Alliance on Mental Illness – Putnam
National Council on Alcoholism and Drug Dependency
New York Medical College
Office of Congressman John Hall
Office of Putnam County Executive
Office of Senator Vincent Liebell**

MAPP Community Engagement

**2010 Public Health
Summit Agency
Participants,
continued**

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Putnam County Bureau of Emergency Response
Putnam County Department of Health
Putnam County DSS & Mental Health
Putnam County Legislature
Putnam County Office for the Aging
Putnam County Office for People with Disabilities
Putnam County Youth Bureau
Putnam Family & Community Services
Putnam Hospital Center
Rockland County Department of Health
Search for Change
State Emergency Management Office
Town of Carmel
Westchester Putnam Access to Care**

**PCDOH
Project Staff**

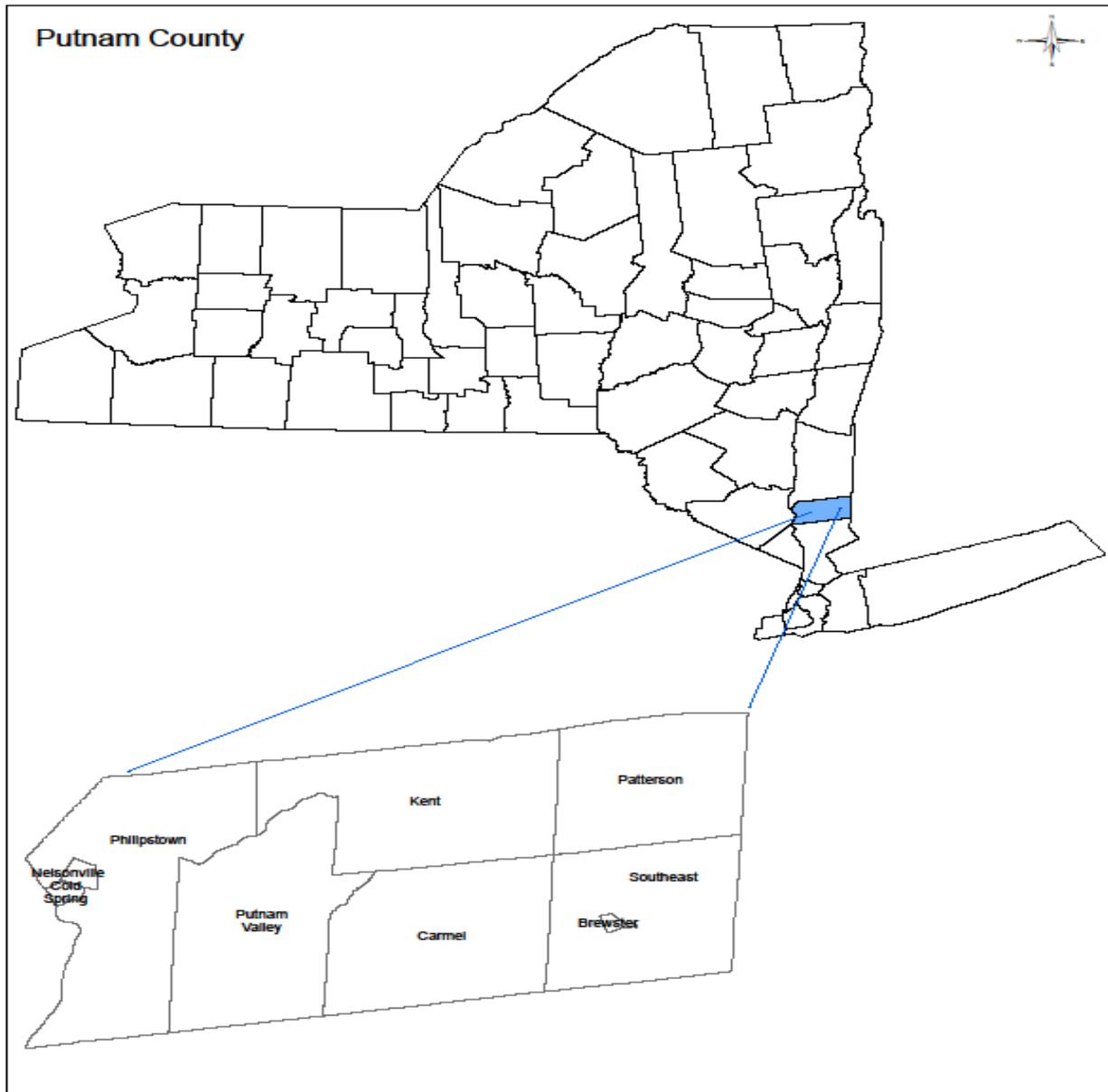
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Columbia University Mailman School of Public Health

Grace Lee
Jessica Steele

*Special thanks to Grace and Jessica for their outstanding
contribution to the development of the CHA & CHIP.*

Putnam County Towns & Villages



The Framework

Why MAPP?

The Putnam County Department of Health (DOH) utilized the Mobilizing for Action through Planning and Partnerships (MAPP) framework for conducting its Community Health Assessment (CHA) and developing its Community Health Improvement Plan (CHIP). MAPP is considered a best practice for conducting a community-wide strategic planning that helps the community improve its health and quality of life. The MAPP process includes four assessments:

- Community Themes and Strengths
- Local Public Health System
- Community Health Status
- Forces of Change

There are 6 phases to the MAPP process: organizing, visioning, conducting assessments, identifying strategic issues, developing goals/strategies and action cycle.



Early in the MAPP process, the Putnam County DOH, together with community partners discussed how to create a vision for a healthier Putnam County. Through various discussions and exercises a vision was established. Since the phrase “Live Healthy Putnam” already existed, this was chosen to represent the vision and serves as a “brand” for fulfilling the goals and objectives set forth in our CHIP.

The Framework

Why Community Health Assessment and Community Health Improvement Plan?

- The New York State DOH requires local health departments and hospitals to work together with community partners to assess the health challenges in their communities, identify local priorities and develop and implement plans to address them.
- Assessment is a core function of public health. By utilizing the expertise of our community partners and evaluating health data we are able to strategically develop goals and objectives for improving the health of our community.
- A CHIP fosters successful community partnerships in order to have a continuous planning process for identifying and addressing the health needs of Putnam County.

The Framework

Prevention Agenda

The Prevention Agenda serves as a guide to local health departments as they work with their community to develop mandated CHIPs and to hospitals as they develop mandated Community Service Plans (CSP) and Community Health Needs Assessments (CHNA) required by the Affordable Care Act.

The New York State 2013-2017 Prevention Agenda features 5 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

2013-2017 Priorities

After reviewing the results of the four MAPP assessments, data related to the Prevention Agenda priorities, results of various community surveys and focus groups, the Putnam County DOH Steering Committee and community partners identified two priorities and five focus areas for the 2013-2017 CHIP as noted below:

Priority One: Prevent Chronic Diseases

Focus Area One:

Reduce obesity in children and adults.

Focus Area Two:

Increase access to evidence-based Chronic Disease Self-Management Program (CDSMP).

Focus Area Three:

Reduce illness, disability and death related to tobacco use and secondhand smoke exposure.

Priority Two: Promote Mental Health and Prevent Substance Abuse

Focus Area One:

Promote Mental, Emotional and Behavioral (MEB) well-being in communities.

Focus Area Two:

Prevent suicides among youth and adults.

The Framework

How Did We Get Here?

The Putnam County DOH has been working with community partners, particularly the local hospital, for many years on strategies to improve the health of Putnam residents. Since the New York State DOH developed a prevention agenda in 2008, the Putnam County DOH has partnered with many local organizations to work on goals and objectives established to meet identified health priorities.

Accomplishments 2009-2013

The Putnam County DOH along with our community partners, have worked diligently to improve the health and well-being of Putnam County residents. The following is a list of some of the highlights of the last four years:

Priority 1: Access to Health Care

- The first Federally Qualified Health Center (FQHC) located in Putnam County, realized in 2012 with the opening of the Open Door Brewster Family Medical Center, a Putnam County satellite office of the ODFMC.

Priority 2: Chronic Disease Prevention

- Healthy Meeting Guidelines initiated in member organizations
- Outdoor gym equipment purchased for a county park
- Pilot-based walking program using pedometers, established in one school
- Chronic Disease Self-Management Program (CDSMP) provided to Office of Aging Seniors
- Several gardening programs offered to the community through a partnership with Putnam County DOH and Cornell Cooperative Extension

Priority 3: Mental Health/Substance Abuse

- Veterans Task Force established with emphasis on mental health
- A Suicide Prevention Task Force established, a direct result of discussions in the Mental Health CHIP group
- Suicide prevention education mandated by the Commissioner of Health for all Putnam County DOH employees.

Priority 4: Community Preparedness

- Educational programs including COOP planning, emergency preparedness planning geared to special needs populations, provided by Putnam County Bioterrorism Disaster Preparedness Task Force led by both the Bureau of Emergency Services and the Health Department.
- Targeted community education campaigns and events highlighting the importance of individual emergency preparedness.
- Emergency preparedness drills to test effectiveness of plans and the departments' ability to respond to emergencies, performed by the Putnam County DOH and the Bureau of Emergency Services.

The Framework

How Did We Get Here? continued

The Putnam County DOH sponsored a community health summit in 2010, 2011 and again in 2013.

Leading up 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.

The 2013 Public Health Summit, held on May 22, 2013, provided the Putnam County DOH with an 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.

After careful evaluation of all the assessment data, it was clear the two priorities that would form the basis of the CHIP were prevention of chronic diseases and promotion of mental health well-being and prevention of substance abuse.

After the 2013 Summit, the Putnam County DOH worked with two separate formal committees made up of interested community partners. Each worked on one of the two identified priorities, and developed the Putnam County CHIP for 2013-2017.

The first, an existing coalition called Live Healthy Putnam (LHP) is serving as the CHIP Chronic Disease Priority committee. This committee, comprising more than 20 partner agencies, met frequently to decide which focus areas to concentrate on. The committee decided on three:

- Reduce Obesity in Children and Adults
- Increase Access to Evidence Based Chronic Disease Self-Management Program (CDSMP)
- Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure

The LHP coalition membership formed subcommittees to work on each focus areas and goals within each area. The Live Healthy Putnam committee began to formulate a CHIP action plan included measurable objectives, strategies and activities to achieve established goals and objectives. The work has begun in 2013 and will continue through 2017.

The Framework

How Did We Get Here? continued

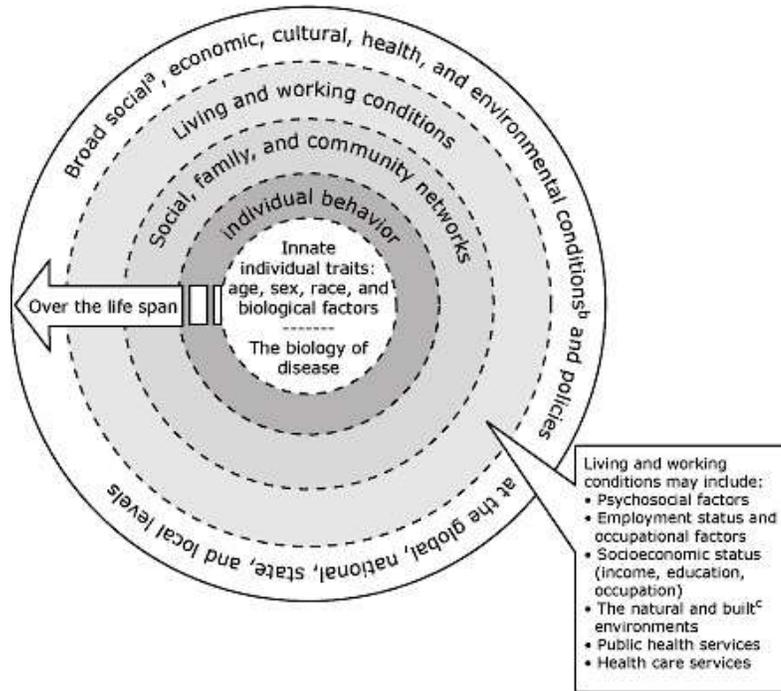
The second formal CHIP priority committee was developed from the existing Mental Health Committee, established by the Putnam County Department of Social Services. This committee, led by the Putnam County Commissioner of Social Services and Mental Health, had been meeting monthly to discuss priorities and issues facing mental health and substance abuse providers in the county.

The newly formed CHIP Mental Health Priority Committee decided to focus only on the mental health piece of this priority since there was a well-established county-wide coalition working on preventing substance abuse in the county. The Putnam Communities That Care Coalition (CTC), funded by the National Office of National Drug Control Policy four years ago is composed of many individuals and sectors that work together to reduce underage drinking and substance abuse. This coalition just received funding for the next five years, and will continue to work on substance abuse prevention goals and objectives established by their grantor. The CHIP Mental Health Priority Committee will concentrate on two focus areas:

- Promote Mental, Emotional and Behavioral (MEB) well-being in communities
- Prevent suicides among youth and adults

This committee also began to formulate a CHIP action plan, with measurable objectives, strategies and activities to achieve established goals and objectives. The work has begun in 2013 and will continue through 2017.

Socio-Ecological Model



The Putnam County DOH CHIP is based on the Socio-Ecological model. This model provides a contextual framework that takes into account the varying levels of influence on health. Using this approach which embodies MAPP process principles, the CHIP can be formulated to assess and affect the social determinants of health and move toward health equity.

Many factors influence health; how we address these factors determines health outcomes. Health problems are often addressed with medical treatment and/or behavior change. However, there is mounting evidence indicating the root causes of poor health go beyond the choices made by an individual and that environmental factors play a much more significant role than previously thought. Tackling the problem on all levels provides a better opportunity for influencing someone's health.

Individual health status is the result of the interaction between factors related to the physical and social environment, the individual's behavior, and to a lesser extent, inherited health characteristics. Such factors are called determinants of health. Social determinants of health are a subset of these factors and include income and social status, employment, education, housing, the built environment and social support networks.

The Vision

Live Healthy Putnam

The CHIP Committee of Putnam County embraces the following visions for our Priority Health Issues:

Priority One: Prevent Chronic Disease

All residents of Putnam County will live in a community that promotes and supports residents in achieving a healthy lifestyle across the lifespan.

Priority Two: Promote Mental Health

Putnam County residents will live in a community that promotes and supports mental and emotional well-being across the lifespan



Putnam County CHIP Priorities

Priority One: Prevent Chronic Diseases

Focus Area One: Reduce Obesity in Children and Adults.

- Goal One: Expand the role of public and private employers in obesity prevention.
- Goal Two: Prevent childhood obesity through early child-care centers and schools.

Focus Area Two: Increase Access to Evidence Based Chronic Disease Self-Management Program (CDSMP).

- Goal: Promote chronic disease self-management education.

Focus Area Three: Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure.

- Goal One: Prevent initiation of tobacco use in New York youth and young adults.
- Goal Two: Promote tobacco use cessation, especially among low-income populations* and those with poor mental health.*

Priority Two: Promote Mental Health

Focus Area One: Promote Mental, Emotional and Behavioral (MEB) well-being in communities.

- Goal: Promote mental, emotional and behavioral well-being.

Focus Area Two: Prevent Suicides Among Youth and Adults.

- Goal: Prevent suicides among youth and adults, with emphasis on veterans*.

*addresses a health disparity



Public Health Priority One: Chronic Disease

Health Issue

Chronic diseases—such as heart disease, stroke, cancer, diabetes, asthma, and arthritis—are among the most common and costly health issues in the United States. The prevalence of child and adult obesity are high in Putnam County. According to the County Health Rankings, 29% adults in Putnam County are obese, 17.2% children are obese, and 23% of county residents are physically inactive. Smoking (11%) and excessive drinking (22%) are other risk factors that contribute to chronic disease in Putnam County.

Although some genetic and biological factors can lead to chronic disease, personal lifestyles and risk behaviors such as diet, tobacco use, physical inactivity, and alcohol abuse should be addressed early on. Furthermore, improper management of chronic disease accelerates disease progression, increasing levels of morbidity and mortality. The CHIP will tackle obesity, smoking and chronic disease management in an effort to prevent the incidence of chronic disease in Putnam County residents.

Focus Area I



Reduce obesity in children and adults

Obesity is a major risk factor for many chronic diseases, and has reached epidemic proportions in New York and across the nation. In the past decade, the percentage of obese adults in New York more than doubled. New York ranks second among states in adult obesity-related medical expenditures, with total spending estimated at nearly \$7.6 billion. In addition to increased morbidity, mortality and high health care costs, obesity is among the most preventable diseases. Physical inactivity, poor nutrition, consumption of sugar-sweetened beverages, and television viewing all contribute to weight gain in children and adults.

**Focus Area I,
continued**

Goal 1: Expand the role of public and private employers in obesity prevention.

Objective: Increase the number of worksites that offer employee wellness programs for all employees by 10%.

STRATEGIES	ACTIVITIES
Determine the status of worksite wellness programs in Putnam County (PC).	<ul style="list-style-type: none"> - Develop a worksite assessment survey. - Create a list of available worksite wellness options.
Promote value of worksite wellness.	<ul style="list-style-type: none"> - Educate PC employers about the benefits of implementing worksite wellness.
Provide access to a comprehensive worksite wellness website.	<ul style="list-style-type: none"> - Create a user-friendly website that shares worksite wellness activities and best practices available from the Putnam County DOH. - Advertise website to PC employers.
Provide access to worksite wellness best practices resources.	<ul style="list-style-type: none"> - Develop worksite wellness toolkit utilizing best practices. - Pilot the toolkit with at least 3 interested worksites.

Goal 2: Prevent childhood obesity through early child-care centers and schools.

Objective: Increase the percentage of early child-care and after school centers that incorporate a garden to support healthy eating and active living.

STRATEGIES	ACTIVITIES
Determine the status of early child-care centers that have a garden activity incorporated into their curriculum.	<ul style="list-style-type: none"> - Develop a phone survey for all PC child-care centers. - Compile and analyze survey findings.
Provide access to comprehensive school garden resources.	<ul style="list-style-type: none"> - Explore best practices for school gardening. - Share available facilities and garden resources. - Develop a system for measuring utilization of available resources. - Define, describe and provide training program to childcare providers.
Provide access to comprehensive school garden toolkit.	<ul style="list-style-type: none"> - Using best practices, develop child-care center garden start-up and maintenance toolkit. - Pilot toolkit with at least 3 centers. - Provide on-site support.

**Focus Area I,
continued**

Objective 2: Increase the percentage of elementary schools that incorporate physical activity into the classroom.	
STRATEGIES	ACTIVITIES
Determine the status: number of PC elementary schools that incorporate physical activity.	<ul style="list-style-type: none"> - Develop survey for PC elementary schools. - Compile and analyze survey findings.
Provide access to comprehensive physical activity classroom resources.	<ul style="list-style-type: none"> - Investigate best practices for physical activity in the classroom. - Share available physical activity classroom sources. - Develop a system for measuring utilization of available resources.
Provide access to comprehensive physical activity classroom toolkit.	<ul style="list-style-type: none"> - Using best practices, develop physical activity classroom curriculum start-up and maintenance toolkit. - Pilot toolkit with at least one interested classroom.

Focus Area II



Increase access to evidence-based chronic disease self-management program (CDSMP)

Chronic diseases such as asthma, cancer, diabetes, heart disease and stroke, are the leading causes of disability and death in the United States. These diseases account for seven out of every ten deaths each year and affect the quality of life of 90 million Americans. In 2001, over 70% of all deaths that occurred in New York State are due to chronic diseases. Addressing chronic disease is rooted in prevention, detecting diseases early, treatment and attention to disease management and self-management in order to prevent debilitating and costly complications.

Goal: Promote chronic disease self-management education.

Objective 1: Increase (by at least 5%) the number of adults with chronic disease (arthritis, diabetes, asthma, cardiovascular disease) who have taken a class on managing their condition.

Objective 2: Increase the percentage of mental health and substance abuse partner organizations that utilize the CDSMP model with their clients.

Objective 3: Identify one community partner working with minority residents to become trained in and provide CDSMP to the minority population in Putnam.

**Focus Area II,
continued**

STRATEGIES	ACTIVITIES
Determine the status and interest in CDSMP.	<ul style="list-style-type: none"> - Develop a survey for community partners. - Compile and analyze survey findings.
Provide access to CDSMP training for interested partners.	<ul style="list-style-type: none"> - Identify Master Trainers. - Identify partners that work with targeted populations, and want CDSMP training. - Investigate avenues to develop a suitable training system.
Provide Putnam County residents with access to CDSMP.	<ul style="list-style-type: none"> - Educate clinicians, partners, and residents about CDSMP opportunities. - Identify partners that work with targeted populations (e.g. minority) and would like to offer CDSMP opportunities to their clients.

Focus Area III



Reduce illness, disability and death related to tobacco use and secondhand smoke exposure

Tobacco addiction is the leading preventable cause of morbidity and mortality in New York State. The list of illnesses caused by tobacco use is long—including heart disease, stroke, lung and vascular disease, as well as many forms of cancer. Cigarette use alone results in an estimated 440,000 deaths each year in the U.S. and 25,000 in New York State. More than half a million New Yorkers currently suffer from serious smoking-caused disease, at a cost of \$8.17 billion in health care expenditures annually. According to Putnam County statistics, 13.1% of adults in Putnam County smoke cigarettes.

Goal 1: Prevent initiation of tobacco use in New York youth and young adults.

Objective 1: Increase the number of Putnam County legislative policies that restrict the sale and marketing of tobacco products.

Objective 2: Decrease the percentage of youth using e-cigarettes.

STRATEGIES	ACTIVITIES
Pursue policy action to reduce the impact of tobacco marketing.	<ul style="list-style-type: none"> - Advocate for tobacco sale in pharmacy ban. - Advocate against point-of-sale advertising for tobacco products. - Use media and health communications to support advocacy initiatives.

**Focus Area III,
continued**

Goal 2: Promote tobacco use cessation, especially among low-income populations and those with poor mental health.

Objective 1: Increase the number of providers who complete the “5A” screening through use of the electronic medical record.

Objective 2: Increase (by at least 10%) the number of referrals to the NYS Quitline.

STRATEGIES	ACTIVITIES
Determine the baseline average number of calls and referrals to the NYS Quitline.	<ul style="list-style-type: none"> - Compile reports from the NYS Quitline (e.g. monthly, quarterly).
Conduct a symposium for providers regarding Opt-to-Quit and 5A’s Screening.	<ul style="list-style-type: none"> - Secure venue, speakers and agenda. - Communicate, market and promote the event to providers.
Partner with the Office of Mental Health to communicate training opportunities.	<ul style="list-style-type: none"> - Identify Medicaid providers. - Connect providers to cessation training, including Learning about Healthy Living.

What can I do to impact Chronic Disease in Putnam County?



Successful implementation of the Putnam County Health Improvement Plan requires a collaboration of individuals, organizations, and partnerships within the community. You can make a difference in Putnam County by altering lifestyle behaviors that contribute to the risk of developing heart disease, cancer, stroke, and diabetes.

Individuals & Families

- Limit family “screen time.”
- Utilize local resources that promote physical activity (www.putnamcountyny.com/health).
- Become informed and educated about healthy nutrition and get needed annual preventive care.
- Support breastfeeding.
- Create a family garden.
- Encourage family lifelong sports such as walking, biking, hiking, etc.
- Develop and promote personal and family nutrition challenges related to sweetened beverages, consumption of fruit and vegetables, and family meal time without the TV.
- Participate in the Live Healthy Putnam coalition and support partnerships with the coalition.

Organizations & Institutions

- Implement worksite wellness programs and physical activity challenges in your worksite.
- Partner with the Live Health Putnam Coalition.
- Encourage schools and worksites to utilize resources to increase physical activity opportunities and nutrition policies.
- Encourage schools and licensed day cares to adopt policies that exceed state and national standards related to nutrition and physical activity.
- Encourage schools and licensed day cares to plant a garden.
- Implement policies to encourage breastfeeding.
- Increase access to healthy food by implementing healthy vending machine policies and healthy meeting guidelines.
- Participate in community coalitions and support partnerships within the coalition.

Community & Systems

- Increase physical activity programs within the school setting that exceed state and national standards.
- Continue to support statewide smoke-free air laws.
- Conduct a community-wide campaign to raise physical activity awareness.
- Establish safe biking and walking routes within communities that increase opportunities for physical activity.
- Support and enact zoning regulations that require all new subdivisions to include pedestrian/bicycle friendly facilities.
- Increase access to healthy foods and support breastfeeding.
- Participate and support community coalitions.



Public Health Priority Two: Mental Health

Health Issue

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.

Focus Area I

Promote Mental, Emotional and Behavioral (MEB) well-being in communities



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 each year, serious enough to affect functioning in work, family and school life. A 2009 Institute of Medicine report concluded that increasing evidence shows promotion of positive aspects of mental health is an important approach to reducing Mental, Emotional and Behavioral (MEB) disorders and related problems. This approach, focusing on the positive aspects, will serve as a foundation for both prevention and treatment of MEB disorders.

Goal: Promote Mental, Emotional & Behavioral well-being.

Objective 1: Reduce the number of adults with poor mental health for 14 or more days (age-adjusted, compared to 2008-2009 data).

Objective 2: Reduce the number of students with depressive symptoms (grade-specific, compared to 2012 data).

STRATEGIES	ACTIVITIES
Determine the prevalence of depression in Putnam County adults and children.	<ul style="list-style-type: none"> - Gather available data to measure the level of depression. - Develop a specific survey tool to measure the level of depression in Putnam County adults. - Determine in Veterans Affairs health data is available to measure depression prevalence in Putnam County veterans.
Assess MEB well-being programs.	<ul style="list-style-type: none"> - Develop survey for agencies. - Create an inventory of MEB well-being resources.

**Focus Area I,
continued**

Provide youth and adult access to MEB well-being resources.	<ul style="list-style-type: none"> - Develop a system for educating residents, schools and community partners about MEB well-being resources. - Promote programs that support protective factors.
Change individual and social norms around MEB well-being.	<ul style="list-style-type: none"> - Investigate best practices to decrease stigma against mental health illnesses. - Implement a best practice media campaign targeted at decreasing the stigma associated with mental health illness.
Create a Mental Health coalition to improve MEB programming.	<ul style="list-style-type: none"> - Develop a coalition of government, non-profits, business and educational institutions around MEB well-being. - Assess and improve MEB program effectiveness and sustainability.

Focus Area II



Prevent suicides among youth and adults.

Suicidal behavior can result in loss of life, as well as a significant burden on families and the community. Populations with high rates of suicide include youth, veterans and seniors. An engaged community can address suicide by defining the burden of suicide, identifying risk factors, and then implementing evidence-based strategies to promote MEB well-being.

Goal: Prevent suicides among youth and adults.

Objective 1: Reduce adult suicide death rates in Putnam County (age-adjusted; compared to 2008-2009 data).

Objective 2: Reduce adolescent/young adult suicide death rates in Putnam County (ages 15-19; compared to 2008-2009 data).

Objective 3: Reduce adolescent/young adult self-inflicted injury hospitalization rates in Putnam County (ages 15-19; compared to 2008-2009 data).

STRATEGIES	ACTIVITIES
Determine the prevalence of suicide attempts and suicide completions.	<ul style="list-style-type: none"> - Gather available data that measures suicide attempts and completions. - Determine in Veterans Affairs data is available to measure suicide prevalence in PC veterans.
Increase community awareness of suicidal warning signs and available resources.	<ul style="list-style-type: none"> - Investigate best practices for community education on suicide awareness, prevention and coping. - Promote <i>Safe TALK</i>, <i>Assist</i>, and <i>Project Connect</i> trainings to partners and the community. - Promote <i>Means Matter</i> to community partners. - Increase use of community- and school-based peer mentoring programs. - Increase community awareness to available resources.

What can I do to impact Mental Health in Putnam County?



Successful implementation of the Putnam County Community Health Improvement Plan requires a collaboration of individuals, organizations, and partnerships within the community. You can make a difference in Putnam County.

Individuals & Families

- Become informed about mental health issues and its association with mental health illness.
- Prevent bullying behavior.
- Promote healthy behaviors by including physical activity and healthy foods in your lifestyle.
- Access screening and early interventions for mental health disorders.
- Encourage youth in grades 6-12 to participate in the risk assessment screening tool.

Organizations & Institutions

- Implement comprehensive care coordination to support patient centered medical homes.
- Partner with the CHIP Mental Health Priority Committee.
- Promote the use of screening tools for depression, anxiety, and suicide risk across all medical settings, community and schools.
- Provide intensive training, support, and consultation for primary care providers in the treatment of children's mental health problems.
- Implement *SAFETALK*'s Suicide Prevention Strategy.
- Promote stigma reduction.
- Support legislation that brings about equity and parity for mental health services.

Community & Systems

- Implement comprehensive care coordination to support patient centered medical homes.
- Partner with the Mental Health Coalition.
- Target stigma reduction.
- Support legislation that brings about equity and parity for mental health services.

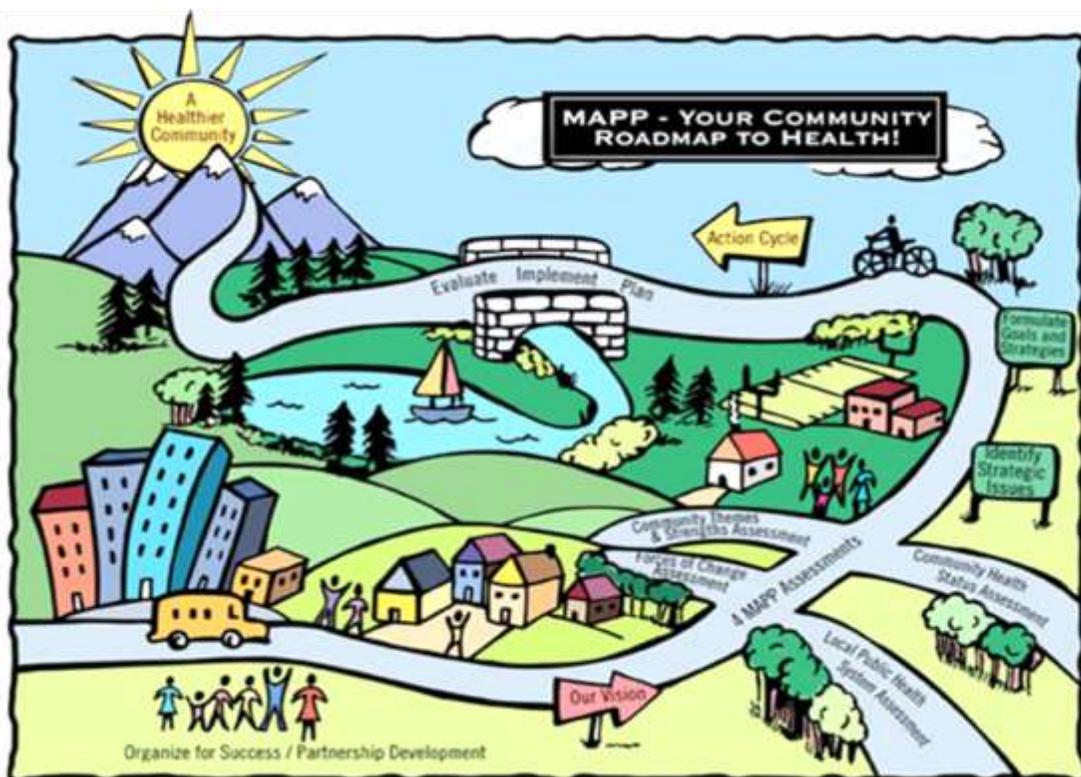
THE PLAN AHEAD

Next Steps

The MAPP process is a roadmap for community health improvement. It guides community partners and coalitions in implementing strategies to produce better health outcomes. Our next steps for the Chronic Disease and Mental Health subcommittees are to begin evaluating and implementing evidence-based practices in order to reach our goals.

The following CHIP Action Plan is the working document partners will use over the next five years with Putnam County DOH oversight. It describes in detail our selected priorities and focus areas, along with specific strategies, activities, responsible parties, timeframe, evaluation measures and outcomes. Some activities have begun; others are still being developed. In each case, specific, measurable objectives, both process and outcome, will be defined, assessments made and progress tracked.

We have a long, strong history of collaboration with some of our partners. Many of these loyal colleagues are already heavily engaged in this process, supporting public health goals and objectives. Other partners are new to us. These budding relationships began through the MAPP process and development of the CHIP. This is particularly true in the area of mental health services. These agencies and organizations have not been traditional partners to public health. With the growing realization and acceptance that mental health and well-being are intricately related to physical health, the fields of public health and mental health services are converging and we need to work together. It is only by bringing *all* partners in health to the table together that we can make great strides to strengthen our community health, and reduce disparities among racial, ethnic, and socioeconomic groups and persons with disabilities.





COMMUNITY HEALTH IMPROVEMENT PLAN

Prevent Chronic Diseases Action Plan

INTRODUCTION: Obesity is a major risk factor for many chronic diseases, and has reached epidemic proportions in New York and across the nation. In the past decade, the percentage of obese adults in New York more than doubled. New York ranks second among states in adult obesity-related medical expenditures, with total spending estimated at nearly \$7.6 billion. In addition to increased morbidity, mortality and high health care costs, obesity is among the most preventable disease(s). 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 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.

FOCUS AREA ONE: Reduce Obesity in Children and Adults.

GOAL1-1: Expand the role of public and private employers in obesity prevention.

OBJECTIVE 1-1: By December 31, 2017, increase by 10% the percentage of small to medium worksites that offer a worksite wellness program for all employees. (Behavioral Risk Factor Surveillance System data)

Strategy	Activity	Responsible Partners	Timeframe	Evaluation Measure	Outcomes
Determine the status of worksite wellness programs in PC.	Develop an assessment survey for small to medium worksites.	PCDOH LHP partners Columbia MPH	Year-1 2014	Survey Tool	The prevalence of current worksites that have a worksite wellness program.
	Create a list of available worksite wellness options.	PCDOH LHP partners	Year-1 2014		Develop a brochure; dedicated website
Promote value of worksite wellness.	Educate PC employers about the benefits of implementing worksite wellness.	PCDOH Economic Develop. Corp (EDC) Director Chambers of Commerce President	Year-1 2014	Sign-in sheets from meetings.	Support of EDC, Chambers and worksites.
Provide access to a comprehensive worksite wellness website.	Create website that shares worksite wellness activities available from the PCDOH. Incorporate best practice worksite wellness programs into a user-friendly website.	PCDOH LHP Partners IT Dept.	End of Year-1 2014	Usability of website.	Live website.
	Advertise PC worksite wellness website to PC employers.	PCDOH LHP Partners Columbia MPH		Develop system for measuring utilization and success of worksite wellness website.	Number of worksites utilizing website.
Provide access to worksite wellness best practice resources.	Develop worksite wellness toolkit utilizing best practices.	PCDOH LHP Partners			Toolkit
	Pilot worksite wellness toolkit with at least three interested worksites.	PCDOH LHP Partners		Survey pilot worksites.	Use of Toolkit

PCDOH – Putnam County Department of Health LHP – Live Healthy Putnam Coalition MPH - Masters of Public Health Student

FOCUS AREA ONE: Reduce Obesity in Children and Adults.

GOAL 1-2: Prevent childhood obesity through early child-care centers and schools.

OBJECTIVE 1-2: By December 31, 2017, increase (after prevalence survey quantifies this) the percentage of early child-care centers, home based child-care centers and after school care that incorporate a garden as an environmental change that promotes and supports healthful eating and active living.

Strategy	Activity	Responsible Partners	Timeframe	Evaluation Measure	Outcome
Determine the status of early child-care centers that have a school garden incorporated into their curriculum.	Develop survey for PC early child-care centers that includes representation from all modalities.	PCDOH, Westchester/Putnam Child Care Council, Catholic Charities, CCE	January 2014	Phone Survey	Survey results
	Compile and analyze survey findings.		January 2014	TBD	Inventory of childcare w/o gardens. Re: survey prior to proceeding.
Provide access to comprehensive school garden resources.	Investigate best practices for school garden.	CCE	June 2014	TBD	Best practices
	Share available early child-care facilities garden resources.	PCDOH, CCE, Childcare & Catholic Charities		TBD	More pre-schools, daycares with gardens.
	Develop system for measuring utilization of available resources.	All Participants		f/u survey call	TBD
	Define and describe training program.	CCE		TBD	TBD
	Provide training event to childcare providers.			TBD	TBD
Provide access to comprehensive school garden toolkit.	Develop early child-care center garden start-up and maintenance toolkit utilizing best practices.	CCE	Spring/ Summer 2015		
	Pilot toolkit with at least three interested early child-care centers.		Spring/ Summer 2015		
	Provide Onsite Support.	Mastergardeners			

PCDOH – Putnam County Department of Health CCE – Cornell Cooperative Extension

FOCUS AREA ONE: Reduce Obesity in Children and Adults.

GOAL 1-2: Prevent childhood obesity through early child-care centers and schools.

OBJECTIVE 1-3: By December 31, 2017, increase (after prevalence survey quantifies this) the percentage of elementary schools that incorporate physical activity into the classroom.

Strategy	Activity	Responsible Partners	Timeframe	Evaluation Measure	Outcome
Determine the status of physical activity incorporated into PC elementary classrooms.	Develop survey for PC elementary schools.	PCDOH	2014		Survey Results
	Compile and analyze survey findings.	PCDOH	2014-2105		
Provide access to comprehensive physical activity classroom resources.	Investigate best practices for physical activity in the classroom.	PCDOH	2014		Best Practices for phys. activity in classroom.
	Share available physical activity classroom resources.	PCDOH Pilot School	2014-2015		
	Develop system for measuring utilization of available resources.	PCDOH	2104-2015		TBD
Provide access to comprehensive physical activity classroom toolkit.	Develop physical activity classroom curriculum start-up and maintenance toolkit utilizing best practices.	PCDOH MPH Intern	2104-2015		Comprehensive Toolkit
	Pilot toolkit with at least one interested elementary classroom.	Pilot School	2104-2015		
PCDOH – Putnam County Department of Health MPH - Masters of Public Health Student					

INTRODUCTION: Chronic diseases such as asthma, cancer, diabetes, heart disease and stroke, are the leading causes of disability and death in the United States. These diseases account for seven out of every ten deaths and affect the quality of life of 90 million Americans. In 2001, over 70% of all deaths that occurred in New York State were due to chronic diseases. Addressing chronic disease is rooted in prevention, detecting diseases early, treatment and attention to disease management and self-management in order to prevent debilitating and costly complications. According to Putnam County statistics, the leading cause of death is from diseases from the heart and the second leading cause is from malignant neoplasms. (NYSDOH Vital Statistics)

FOCUS AREA TWO: Increase Access to Evidence Based Chronic Disease Self-Management Program (CDSMP).

GOAL 2-1: Promote chronic disease self-management education, including disparate populations.

OBJECTIVE 2-1.1: By December 31, 2017, increase by at least 5% the percentage of adults with arthritis, asthma, cardiovascular disease, or diabetes who have taken a course or class to learn how to manage their condition. (Behavioral Risk Factor Surveillance System data)

OBJECTIVE 2-1.2: By December 31, 2017, increase (after prevalence survey quantify this) the percentage of Putnam County mental health and substance abuse partner organizations that utilize the CDSMP model with their clients.

OBJECTIVE 2-1.3: By December 31, 2017, identify one community partner working with minority residents to become trained in CDSMP and partner with the PCDOH to provide a CDSMP for the PC minority population.

Strategy	Activity	Responsible Partners	Timeframe	Evaluation Measure	Outcome
Determine the status and interest of CDSMP in Putnam County.	Develop a survey for community partners.	PCDOH, OFA, VNA	2014	Baseline data	Survey Results
	Compile and analyze survey findings.	PCDOH	2014	Survey Results	# of agencies engaged & interested in CDSMPs
Provide access to CDSMP training for interested partners.	Identify Master Trainers.	OFA, VNA	2014-2015	# of Master Trainers	I.D. of Master Trainers
	Identify partners that work with targeted populations and want to have CDSMP training.	OFA, PCDOH	2014-2015	TBD	# of partners with trained staff.
	Investigate avenues for developing a sustainable training system.	OFA, PCDOH		TBD	Training schedule
Provide PC residents access to CDSMP.	Educate clinicians, partners & residents about CDSMP opportunities.	PCDOH	2014-2015	TBD	# of providers who will refer pts. To CDMSPs
	Identify partners that work with targeted populations (i.e. minority population) & would like to offer CDSMP opportunities to their clients.	PCDOH, Open Door FMC	2015-2016	TBD	Increased # of PC residents participating in a CDSMP course including disparate populations.

OFA – Office for Aging VNA – Visiting Nurse Association of Hudson Valley FMC – Family Medical Center

INTRODUCTION: Tobacco addiction is the leading preventable cause of morbidity and mortality in New York State. The list of illnesses caused by tobacco use is extensive—including heart disease, stroke, lung and vascular disease, as well as many forms of cancer. Cigarette use alone results in an estimated 440,000 deaths each year in the U.S. and 25,000 in New York State. More than half a million New Yorkers currently suffer from serious smoking-caused disease, at a cost of \$8.17 billion in health care expenditures annually. According to Putnam County statistics, 13.1% of adults in Putnam County smoke cigarettes.

Source [440,000 deaths in U.S.]: http://www.health.ny.gov/prevention/prevention_agenda/tobacco_use/

Source [13.1% smokers]: http://www.health.ny.gov/prevention/prevention_agenda/indicators/county/putnam.htm

FOCUS AREA THREE: Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure.

GOAL 3-1: Prevent initiation of tobacco use by New York youth and young adults, including low SES populations.

OBJECTIVE 3-1: Increase the number of PC legislative policies that restrict the sale and marketing of tobacco products.

OBJECTIVE 3-2: Decrease the percentage (after prevalence data is established) of youth using e-cigarettes.

Strategy	Activity	Responsible Partners	Timeframe	Evaluation Measure	Outcome
Promote effective tobacco control policies through media	Conduct survey of residents to determine support of legislative policies to restrict the sale of tobacco; publish survey results.	Realty Check, POW'R Against Tobacco, PCDOH	2014-2015	TBD	Tobacco Sale in Pharmacy Ban
Increase awareness of the impact of tobacco marketing on youth smoking.	Educate policymakers about the impact of tobacco marketing on youth smoking. Use earned media to promote education on youth smoking and the impact of tobacco marketing.	Realty Check, POW'R Against Tobacco, PCDOH	2014-2015	TBD	Eliminate POS advertising close to schools
Discourage use of e-cigarettes especially among youth.	Educate public on the dangers of e-cigarette use especially among youth.	Realty Check, POW'R Against Tobacco, PCDOH	2014-2017	TBD	Decrease in e-cigarette use among youth.

PCDOH – Putnam County Department of Health POW'R – Putnam Orange Westchester Rockland

FOCUS AREA THREE: Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure.

GOAL 3-2: Promote tobacco use cessation, especially among low socioeconomic status (SES) populations and those with poor mental health.

OBJECTIVE 3-2.1: Increase the number of providers who complete the “5 A” screening through the use of the Electronic Medical Record.

OBJECTIVE 3-2.2: Increase referrals to the NYS Quitline by 10% (determine baseline first).

Strategy	Activity	Responsible Partners	Timeframe	Evaluation Measure	Outcome
Determine Baseline data to NYS Quitline.	Compile Reports from the NYS Quitline, monthly, quarterly, etc.	PCDOH, POW’R Cessation Ctr.	December 2013	Average calls and referrals to the NYS Quitline.	Increase calls to the NYS Quitline.
Half-day Symposium for Putnam Providers regarding Opt-to-Quit and 5 A’s Screening.	Secure venue, speakers, and agenda.	PCDOH, POW’R Cessation Ctr., NYS Quitline Staff Open Door FMC	March 2014	Pre-post test results of attendees.	Increase # of providers utilizing 5A’s Screening.
	Communication/Marketing to Providers.			# of attendees	
Partner with the OMH to communicate training opportunities; Identity Medicaid providers.	Cessation Training, Including “Learning About Healthy Living” to Medicaid Providers and PROS and other Mental Health Providers.	PCDOH, POW’R Cessation Ctr. PF & CS, NYS Bureau of Tobacco Control, and NYS Medicaid Office	June 2014	# of clients of MH providers who quit smoking.	Increase number of PC residents with poor mental health who quit smoking.

PCDOH – Putnam County Department of Health POW’R – Putnam Orange Westchester Rockland FMC – Family Medical Center
 OMH- Office of Mental Health PF&CS – Putnam Family & Community Services PROS - Personalized Recovery Oriented Services



COMMUNITY HEALTH IMPROVEMENT PLAN

Promote Mental Health Action Plan

INTRODUCTION: 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 each year 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)

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. Youth reporting depressive symptoms in the Prevention Needs Assessment has been rising with an increase from 33% in 2008 to 36% in 2012. Suicide has been a priority issue since the 2010 Public Health Summit. In particular, suicides and drug heroin overdoses have seen a recent increase in the past year with more than 11 deaths.

Source: http://www.health.ny.gov/prevention/prevention_agenda/mental_health_and_substance_abuse/index.htm

Source: http://www.health.ny.gov/prevention/prevention_agenda/mental_health_and_substance_abuse/mental_health.htm

FOCUS AREA ONE: Promote Mental, Emotional and Behavioral (MEB) Well-Being in Communities.

GOAL: Promote Mental, Emotional and Behavioral (MEB) Well-Being in Communities.

OBJECTIVE 1: By December 31, 2017, the age-adjusted percentage of adults with poor mental health for 14 or more days in Putnam County will show a 5% improvement from the 2013 Behavioral Risk Factor Surveillance System data by

OBJECTIVE 2: By December 31, 2017, the total percentage of students reporting depressive symptoms will show a 3% improvement from the 2012 Prevention Needs Assessment Survey data.

Activity	Indicator	Responsible Partners	Timeframe	Evaluation Measure	Outcome
Determine the prevalence of depression in PC adults and children.	Gather available PC data that measures the level of depression in PC adults and youth.	PCDSS, PCDOH, PHC, Partners	Yearly	Available data updated yearly and shared with partners.	Use data to track changes in prevalence of depression.
	Develop Putnam County specific survey tool to measure level of depression in PC adults.	PCDOH, PCDSS, PHC, Partners	Fall 2014	Survey conducted every two years and shared with partners.	
	Determine if Veterans Affairs health data is available to measure prevalence in PC veterans.	PC VTF, PCDOH	Yearly	Available Veterans data updated yearly and shared with partners.	
Create a MH/SA coalition that improves effectiveness and	Develop a coalition of government, non-profits, businesses and educational institutions surrounding MEB well-being.	PCDOH, PCVTF, MHA, SPTF	Ongoing	Engage expansive group of agencies to actively participate in the	Majority of agencies will actively

Activity	Indicator	Responsible Partners	Timeframe	Evaluation Measure	Outcome
sustainability of programmatic efforts.	Collaborate with PC Veteran’s Suicide Task Force.		Ongoing	MH CHIP process.	support MH CHIP activities.
	Collaborate with PC Suicide Prevention Task Force.		Ongoing		
Determine the status of MEB well-being programs in PC.	Develop survey for agencies to complete.	PCMHA, PCDOH, PCDSS	Spring 2014 Spring 2016	Survey and dissemination plan developed.	Develop plan for assessing gaps in MEB well-being programs.
	Inventory PC MEB well-being resources.	Partners	Spring 2015 Spring 2017	Survey deployed.	
Provide access to PC MEB well-being resources in PC for youth and adults.	Develop a system for educating residents, schools and community partners about available MEB well-being resources.	MH Partners Group, Veterans Task Force and Suicide Task Force	Fall 2015	Update PC Resource Book every other year.	Develop a system for measuring MEB well-being program utilization.
	Promote programs that support protective factors.	MH Partners Group, PC Veterans Task Force and PC Suicide Task Force	Fall 2015		
Change family, individual and community norms regarding perception of MEB well-being.	Investigate best practices for decreasing stigma associated with MH illness.	PCDOH, PCDSS, PHC, MHA	TBD		Decrease stigma associated with mental illness.
	Implement a best practice media campaign targeted at decreasing the stigma associated with MH illness.	PCDOH, MHA	TBD	# of press releases published, # of news articles printed, social media analytics.	
PCDOH – Putnam County Department of Health PHC – Putnam Hospital Center MHA- Mental Health Association PCDSS – Putnam County Department of Social Services SPTF – Special Populations Task Force PCVTF – Putnam County Veterans Task Force					

INTRODUCTION: Someone dies by suicide every 15 minutes in the United States, although the number of deaths from suicide reflect only a small portion of suicidal behavior impact. Suicidal behavior can result in loss of life as well as placing a significant burden on families and the community. In 2007, 165,997 people were hospitalized following suicidal attempts, and more than 395,320 were treated in hospital emergency departments for self-inflicted injuries. Populations with high rates of suicide include youth, veterans, and seniors. An engaged community can address suicide by defining the burden of suicide, identifying risk factors, and then implementing evidence based strategies to promote MEB well-being in residents. Suicide has been a major public health concern for the local public health system. The PC mental health partners have now developed the PC Veterans Task Force and the Suicide Task Force to address the current suicide problem in PC. The MH CHIP process will be a key partner in these Task Forces.
Source: <http://www.cdc.gov/violenceprevention/pdf/preventingsuicide-a.pdf>

FOCUS AREA TWO: Prevent Suicides Among Youth and Adults.

GOAL: Prevent suicides among youth and adults, with emphasis on veterans.

OBJECTIVE 1: By December 31, 2017, the age-adjusted suicide death rate of adults in Putnam County will show a 1% improvement from the 2008-2009 data. (NYSDOH)

OBJECTIVE 2: By December 31, 2017, the adolescent/young adult (Age 15-19) suicide death rate in Putnam County will show a 1% improvement from the 2008-2009 data. (NYSDOH)

Activity	Indicator	Responsible Partners	Timeframe	Evaluation Measure	Outcome
Determine the prevalence of suicide attempts and suicide completions in PC.	Gather available PC data that measures suicide attempts and suicide completions.	PCDOH, PCDSS, PHC, MHA, PC Coroner's Office	December 2013 and ongoing	Review available suicide data on a yearly basis.	Use data to track changes in prevalence of suicide attempts and completion.
	Determine if Veterans Affairs data is available to measure prevalence in PC veterans.			Develop a system for gathering timely and relevant suicide data.	
Increase community awareness of the warning signs of suicide and available resources.	Investigate best practices regarding community education of suicide awareness, prevention and coping.	PC Mental Health Providers Group	Spring 2014	Selection of a best practice model.	MH partners will utilize best practices for community education of suicide awareness.
	Promote <i>safe TALK, Assist</i> and <i>Project Connect</i> trainings among partners and community.	PCDSS, MHA, PCDOH, MH Partners	Winter 2013-14	# of trainings provided TBD	Increase number of PC providers and residents who are trained.
	Promote <i>Means Matters</i> among partners and community.	PC Child Advocacy Center			
	Increase use of community and school-based peer mentoring programs.	PCDOH, MH partners, School districts	Fall 2015	TBD	# of individuals participating.
	Increase awareness of available resources.	TBD	TBD	TBD	TBD
Increase use of Columbia Suicide Severity Rating Scale in Electronic Medical Records.	Putnam Hospital Center will educate ER and inpatient staff in use of Columbia Scale.	Putnam Hospital Center	Fall 2013	# of PHC staff trained	Increase PHC staff utilizing Columbia scale
	Putnam Hospital Center will implement the use of the EMR Columbia Scale.	Putnam Hospital Center	Winter 2013/2014	# of PHC staff utilizing Columbia Scale	
	Identify other medical offices with EMR technology use of Columbia Scale.	PCDOH, PHC, Open Door Family Medical Center	TBD	# of healthcare providers utilizing Columbia Scale	Increase healthcare providers utilizing Columbia scale.

PCDSS – Putnam County Dept. of Social Services PHC – Putnam Hospital Center MHA – Mental Health Association

References

Community Health Assessments

Fairfax County Health Department (2011)
www.fairfaxcounty.gov/hd/mapp/pdf/comm-health-assessment.pdf

Humboldt County Health Department (2013)
<https://co.humboldt.ca.us/hhs/phb/documents/cha%201.11.13.pdf>

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www.lickingcohealth.org/documents/2010%20LCHD%20CHA.pdf

Oneida County Health Department (2010-2013)
www.ocgov.net/health/CommunityHealthAssess2010-2013

Community Health Improvement Plans

Madison County Health Department (2009)
<http://www.healthymadisoncounty.org/data/cha/assessment-09.htm>

Northern Kentucky Health Department (2009)
www.nkyhealth.org/Services/Healthandsocneeds.aspx

Healthy People 2020

Centers for Disease Control and Prevention
<http://www.healthypeople.gov/2020/topicsobjectives2020/>

Mobilizing for Action through Planning and Partnerships

National Association of County and City Health Officials
www.naccho.org/topics/infrastructure/mapp

National Prevention Strategy

National Prevention Council, *National Prevention Strategy*, Washington, DC:
<http://www.healthcare.gov/center/councils/nphpphc>.

National Public Health Performance Standards Program

Centers for Disease Control and Prevention
www.cdc.gov/od/ocphp/nphsps/

Prevention Agenda 2013-2017

New York State Department of Health
http://www.health.ny.gov/prevention/prevention_agenda/

Socio-Ecological Model

Centers for Disease Control and Prevention
http://www.cdc.gov/violenceprevention/pdf/sem_framework-a.pdf

For More Information

Contact

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