



PUTNAM COUNTY

Community Health Assessment Community Health Improvement Plan

2016-2018

Putnam County Department of Health
One Geneva Road
Brewster, NY 10509
845-808-1390
www.putnamcountyny.gov

Putnam Hospital Center
670 Stoneleigh Avenue
Carmel, NY 10512
845-279-5711
www.healthquest.org/PHC

PARTNERS

Advanced Chiropractic Wellness Care
Akzonobel
American Heart Association
American Lung Association of the NE
Arms Acres-Liberty Management
Boxwood Alliance
Brewster Central School District
Camp Wilbur Herrlich
Carmel Central School District
Center for a Tobacco-Free Hudson Valley
Center for Regional Healthcare Innovation
Child Care Council of Dutchess & Putnam
Cornell Cooperative Extension
Drug Crisis in our Backyard
Dunmore Corporation
Dutchess County Department of Health
Economic Development Corporation
Fishkill Correctional Facility
Four Winds Hospital
Garrison Union Free School District
Green Chimneys
Haldane Central School District
Hannaford
Health Quest
Hudson Valley Cerebral Palsy Association
Hudson Valley Community Services
Hudson Valley Farm to School
HYGEIA Integrated Health LLC
Kidz Country Day Care
Live Healthy Putnam Coalition
Mahopac Central School District

Maternal Infant Services Network (MISN)
Mental Health Association of Putnam
Mental Health Providers Group
National Association of Mental Illness, PC
NCADD, Putnam
New York State Courts
New York State Health Foundation
NYP-Lawrence Hospital
NYS Department of Health
Open Door Family Medical Center
Orange County Department of Health
P & N West. Women's Resource Center
P.A.R.C
Partnership for Success/NCADD/Putnam
PC Board of Health
PC Bureau of Emergency Services
PC Chamber of Commerce
PC Child Advocacy Center
PC Department of DSS, Mental Health
PC Department of Health
PC Disaster Preparedness/Bioterrorism TF
PC Medical Reserve Corps
PC Office for People with Disabilities
PC Office for Senior Resources
PC Parks & Recreation
PC Planning Department
PC Sheriff's Department
PC Veterans Affairs
PC Youth Bureau
PEOPLE, Inc.
Planned Parenthood Hudson Peconic

POW'R Against Tobacco
Public Health Improvement Program
Putnam Communities That Care Coalition
Putnam Community Action Program
Putnam County Courier
Putnam Family & Community Services
Putnam Hospital Center
Putnam Independent Living Service
Putnam Valley Central School District
Putnam/Northern Westchester BOCES
Reality Check
Rockland County Department of Health
Rockland County Office of Mental Health
Rose House (PEOPLE)
Search for Change
St. Christopher's Inn
Suicide Prevention Taskforce
The Freight House Café
Town of Carmel Parks & Recreation
Town of Kent Police Department
Town of Patterson Library
Ulster County Department of Health
Unilock
United Way of Westchester & Putnam
VET2VET Program of Putnam
Veterans Task Force
Visiting Nurse Association of Hudson Valley
Visiting Nurse Service of Putnam
Westchester County Department of Health

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.

To help achieve this mission and vision, in 2013 the Putnam County DOH undertook the challenge of becoming a nationally accredited health department. On March 11, 2016, the Public Health Accreditation Board (PHAB) awarded this coveted distinction to us and our health department became one of only three counties in New York State to attain this recognition.

As an accredited health department, mechanisms have been put in place to ensure ongoing department-wide performance management and workforce development. Additionally, we have chosen to facilitate the best-practice Mobilizing for Action through Planning and Partnerships (MAPP), a “gold standard” community needs assessment and strategic planning process. MAPP uses four unique assessments to determine community priorities and lay the groundwork for future action.

The Putnam County Community Health Improvement Plan (CHIP) is the result of this MAPP work, which brought together a broad representation of Putnam County constituencies and community leaders. This collaborative plan will be used as a guide to improving the health of everyone who

lives in Putnam County, by outlining goals and strategies and identifying areas on which to focus. Community change and health improvement require dedication and commitment from all stakeholders—including all citizen, business, government and community sectors. A special thank you goes to all community partners who have already provided guidance, direction and input to the Putnam County Department of Health.

This report is being posted on our website and we invite all of you to participate in some capacity. Residents can join a coalition, participate in a focus group, or simply respond to our periodic community asset survey. If you are interested, please contact us at (845) 808-1390 or e-mail us at PutnamHealth@putnamcountyny.gov.

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

Sincerely,



Michael Nesheiwat, MD
Interim Commissioner
Putnam County Department of Health

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This report is posted on the Putnam County Department of Health website: www.putnamcountyny.com/health/

EXECUTIVE SUMMARY

Community health improvement planning is most effective when approached through collaborative effort.

Fortunately, the Putnam County Department of Health (DOH) has a long-standing and well-established relationship with the county's only hospital, Putnam Hospital Center. Health assessment activities, public health education campaigns, and emergency and response activities have been worked on jointly for more than a decade.

Since 2012, the New York State DOH has required local health departments to work with local hospitals and community partners on development of the Community Health Assessment and a Community Health Improvement Plan (CHIP). Currently, the basis of these plans is the state's own health improvement plan, the 2013-2018 *Prevention Agenda*.

The Putnam County DOH initiated and continues to facilitate the Mobilizing for Action through Planning and Partnerships (MAPP) strategic planning process with community partners in order to develop these assessments and plans. Established partnerships, including the Live Healthy Putnam Coalition, the Mental Health Provider Group, the Suicide Prevention Task Force and Putnam Hospital Center's Community Health Needs Committee, have been joined by a new alliance with the Communities That

Care Coalition, providing guidance and support in the area of substance abuse prevention. Another alliance supporting and advancing CHIP work is with the Population Health Improvement Program (PHIP), a New York State Department of Health initiative fostering regional collaboration among public and private health organizations in the Hudson Valley. So far PHIP has provided training and data support specifically in the two overlapping areas of concern, Social Determinants of Health and Mental Health Stigma.

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

The MAPP process uses four unique assessments to determine community priorities: Community Themes and Strengths, Community Health Status, Local Public Health System and Forces of Change. These assessments inform the development of the CHIP. More than 85 organiza-

tions participated in these assessments and greater than 600 Putnam County residents responded to the community asset survey. Through the MAPP process two overarching priorities were identified and served as a foundation for developing the Putnam County CHIP: *Promote Mental Health and Prevent Substance Abuse* and *Prevent Chronic Diseases*.

A third priority was recently added to the CHIP: *Promote a Healthy and Safe Environment*. This change came from discussions with Putnam Hospital Center and the Putnam County Office for Senior Resources. Both organizations will be implementing evidenced-based programs to prevent falls in the growing elderly population.

Formal CHIP Action Plans have been developed to cover work through 2018. All strategies and activities related to these priorities have components focused on reducing health disparities. Understanding how social determinants of health impact health equity is the first step. In addition to identifying the strategies and activities, measurable objectives were set, corresponding timelines developed, and responsible parties named. This labor-intensive work to develop Action Plans was accomplished by five steering committees. The Action Plan for the CHIP priority to *Promote Mental*

Health and Prevent Substance Abuse was worked on by the Mental Health Provider Group, the Suicide Prevention Task Force and the Communities That Care Coalition. The Live Healthy Putnam Coalition worked on the Action Plan for the second CHIP priority—*Prevent Chronic Disease*. In addition to these five steering committees, an extensive number of other community organizations partnered with them to develop these plans. Another steering committee to work on the third CHIP priority to *Promote a Healthy and Safe Environment*, specifically fall prevention activities, is proposed for 2017. Progress on this priority, as well as the two original priorities, will be discussed with Putnam Hospital Center at quarterly Community Health Needs Committee meetings.

Please see the CHIP planning grids starting on page 65 and the Partner Involvement by CHIP Priority list on page 76.

SOCIAL DETERMINANTS OF HEALTH

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

Understanding the relationship between how population groups experience “place” and the impact of “place” on health is fundamental to community health improvement planning.

EXAMPLES OF SOCIAL DETERMINANTS OF HEALTH

- Safe and affordable housing
- Availability of healthy foods
- Educational, economic, and job opportunities
- Access to health care services, both routine and emergency
- Quality of education and job training
- Availability of recreational and leisure-time activities
- Transportation options
- Public safety
- Social support
- Social norms and attitudes (e.g., discrimination, racism, residential segregation, distrust of government)
- Exposure to crime, violence, and social disorder (e.g., presence of trash and lack of cooperation in a community)
- Socioeconomic conditions (e.g., concentrated poverty and the stressful conditions that accompany it)
- Language/Literacy
- Access to mass media and communication technologies (e.g., cell phones, the Internet, and social media)
- Culture

In Putnam County, results from the Community Health Status Assessment show people who live at or below the Federal Poverty Level are more likely to be less educated, have higher rates of unemployment and be uninsured. In general, these factors can lead to poorer health outcomes.

MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS

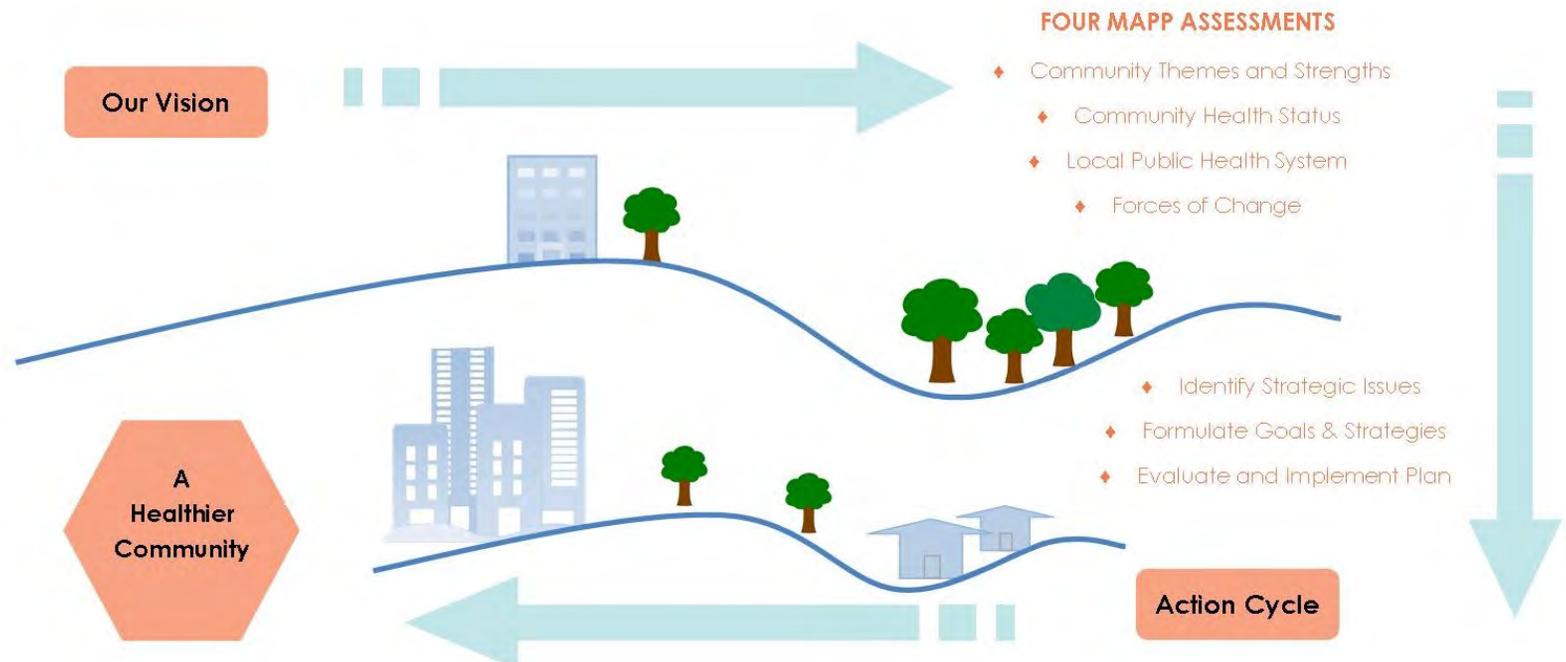
Mobilizing for Action through Planning and Partnerships (MAPP) is a community-driven strategic planning process for improving community health. It provides a framework that helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. MAPP is not an agency-focused assessment process; rather, it is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems. Four MAPP Assessments—Community Themes and Strengths Assessment, Community Health Status Assessment, Local Public Health System Assessment and Forces of Change Assessment—provide a complete picture of health strengths and opportunities in Putnam County.

The use of MAPP signals a shift in how public health is planned. It is a shift from operational to strategic planning: from a focus on the agency to a focus on the public health system, from needs assessment to an emphasis on assets and resources, from a medically or service-oriented model to a model that encompasses a broad definition of

health. In essence it is a move away from an “agency knows all” perspective to the belief that “everyone knows something.” By gathering all of the assets and resources within the community, the community is able to determine how best to use all of the wisdom to create a healthier community.

MAPP:

THE ROADMAP TO COMMUNITY HEALTH



PHASE ONE: ORGANIZING FOR SUCCESS

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 and CHIP process since December 2012 when New York State DOH mandated the CHIP be conducted by each local health department.

The annual Public Health Summit provides the opportunity for the Putnam County DOH, Putnam Hospital Center, community-based organizations, mental health agencies, social service agencies, educational institutions, faith-based organizations, healthcare providers, local industry, emergency services providers, veterans' agencies and residents to convene and review the current state of health in Putnam

County. Local data and planning updates are shared and discussed so that community partners are engaged in the planning process.

The sixth annual Public Health Summit, held on June 7, 2016, provided an opportunity for 78 attendees from 47 different agencies to collaborate, identify, and review health priorities and needs within the county. The half-day format included: a community health assessment data overview; panel discussions from partner agencies working on the 2013-2017 CHIP strategies from the Mental Health, Substance Abuse and Chronic Disease priority areas; and CHIP priority selection for the 2016-2018 CHIP update.

PHASE TWO: VISION FOR A HEALTHIER PUTNAM

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



PHASE THREE: ASSESSING PUTNAM'S HEALTH

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

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

Performance Scores

INSTRUCTIONS: In the shaded yellow box, select your score for the Model Standards under each Essential Service from the drop down menu. Use the following scale: No Activity = 0; Minimal Activity = 25; Moderate Activity = 50; Significant Activity = 75; Optimal Activity = 100.

ESSENTIAL SERVICE 8: Assure a Competent Personal Health Care Workforce

Model Standard: Workforce Assessment, Planning and Development
At what level does the local public health system:

8.1	Set up a process and a schedule to track the number of LPHS jobs and the knowledge, skills, and abilities of those jobs are in the public or private sector?
8.1.1	Review the information from the workforce assessment to find and address gaps in the local public health system?
8.1.2	Provide information from the workforce assessment to community organizations and groups, including public and private agencies, for use in planning?
8.2	Model Standard: Public Health Workforce At what level does the local public health system:
8.2.1	Make sure that all members of the public health workforce have the required certificates, licenses, and meet the law?

Community Asset Survey for Putnam County

This survey is being conducted to get your opinions about our community's strengths and help pinpoint important issues. Questions focus on health and quality of life issues. The Hospital and the Department of Health will use this information to develop the Community Health Improvement Plan in collaboration with the public health partners in Putnam County. Anyone who lives or works in Putnam County is encouraged to respond to this survey. Thank you for helping us to identify our most pressing concerns.

This survey can be taken online at www.putnamcountyny.gov - OR -
Please submit this survey no later than August 31, 2013 by fax: 845-808-1336,
email: karen.yates@putnamcountyny.gov,
or mail: Putnam County Department of Health - Health Education 1 Geneva RD Brewster, NY 10909
For more information, please call 845-808-1390 xt.43125

1. What are the greatest STRENGTHS of our ENTIRE COMMUNITY?
Please select 4 areas by placing an "x" in 4 boxes below:

- Access to affordable, healthy food for everyone
- Access to affordable housing for everyone
- Access to basic health care for everyone
- Access to medical screenings for everyone
- Access to arts and cultural events
- Access to recreation
- Low violence/abuse (domestic, elder, child)
- Meet basic needs of everyone (food, shelter)
- Programs, activities and support for youth and teens during non-school hours

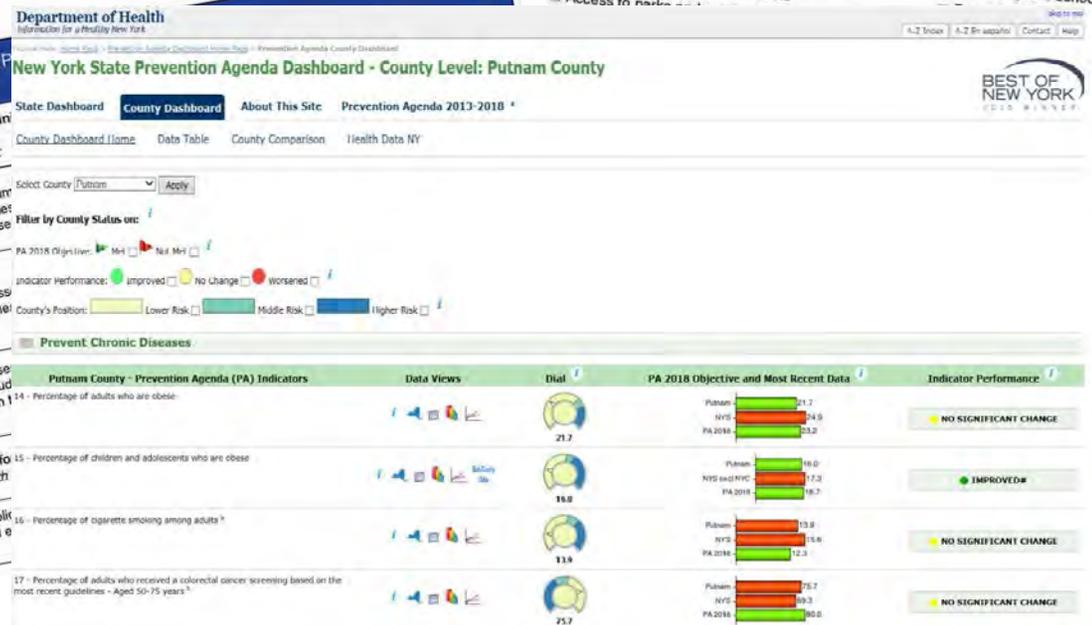
nd support for the senior

if everyone needing and crisis agencies

IMPROVE THE QUALITY OF LIFE
es below:

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COMMUNITY THEMES AND STRENGTHS ASSESSMENT

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

SURVEY METHODOLOGY

The Community Asset Survey (CAS) was developed by the Putnam County DOH with input from Putnam Hospital Center and the Live Healthy Putnam Coalition. 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 Live Healthy Putnam Coalition.

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

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

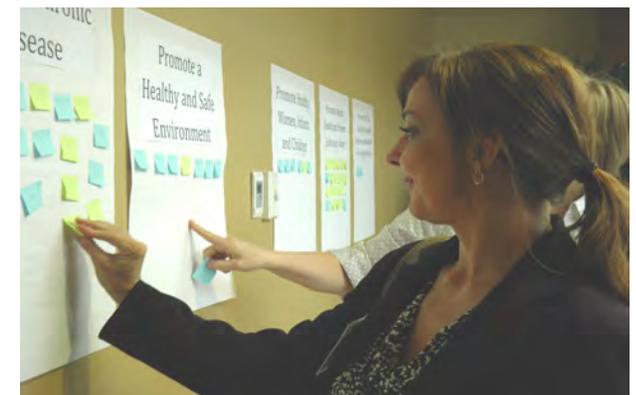
under-represented segments of the population would be focused on in the promotional campaign.

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

The Putnam County Executive and the Putnam Hospital Center CEO sent an email to all of their staff with an online link to the survey (this represented the two largest employers in Putnam County). A media release and campaign were developed and shared in 15 online event calendars, 7 school district newsletters, 2 social media networking sites, 4 print media and 31 community bulletin boards in high traffic areas. The description and link were also shared with agencies participating in the MAPP process, previous Public Health

Summits and other established partnerships. Every agency was then encouraged to share with their members and clients.

Through the efforts of the Putnam County DOH, Putnam Hospital Center, Open Door FQHC and many other agencies, over 600 surveys were received. The survey completion rate (survey fully answered) was nearly 90%.



SURVEY RESPONDENTS

The survey was open to both residents and those who work in Putnam County. If neither the home nor work zip code was in Putnam then the survey response was excluded.

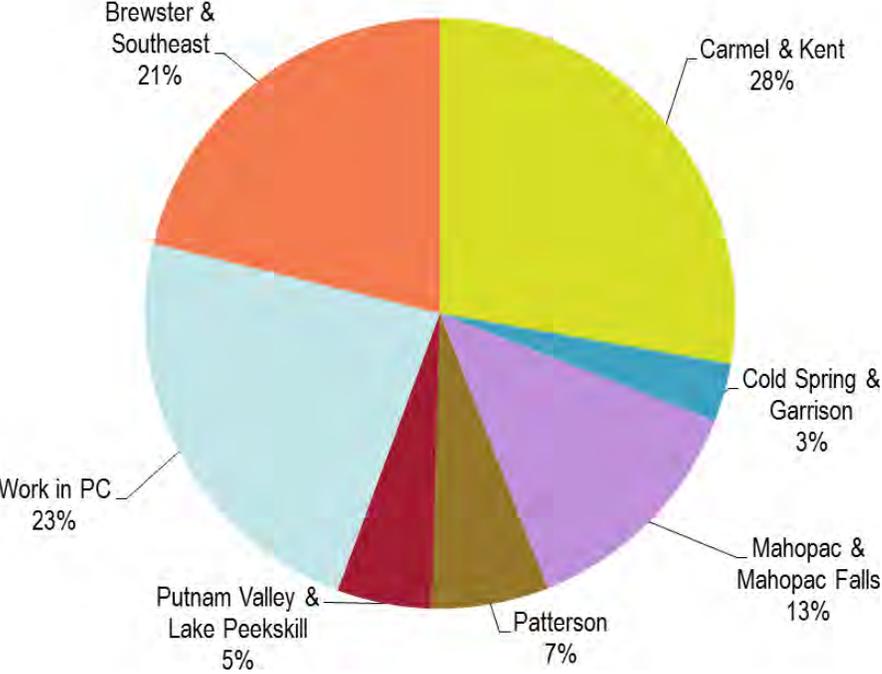
- Three quarters of the respondents live in Putnam County.
- Nearly half of the respondents live in Brewster, Southeast, Carmel or Kent.
- Less than a quarter of respondents live or work on the western side of Putnam.

RACE OR ETHNICITY

RACE	CAS Sample	2015 Census
White	83.8%	89.6%
Black	1.5%	2.0%
Asian and Pacific Islander	1.0%	2.3%
Native American and Alaskan	0.5%	0.4%
ETHNICITY		
Hispanic or Latino	18.9%	12.3%

- White, Asian and Pacific Islander significantly under sampled
- Hispanic or Latino oversampled

LIVE OR WORK IN PUTNAM COUNTY



OVERARCHING CAS RESULTS

Survey participants were asked “What are the greatest STRENGTHS of our ENTIRE COMMUNITY?” 19 choices were provided, along with an opportunity to write in a response. The table below summarizes what residents deemed the Strengths of Putnam County. These aspects of the community are assets relating to safety and the local environment and have a direct impact on the health of residents.

- A Clean and Healthy Environment – ranked 1st by most respondents
- Safe Neighborhoods – ranked 1st by Mahopac residents

RESULTS RANKING – TOP 5 GREATEST STRENGTHS OF OUR ENTIRE COMMUNITY

POPULATION AREA	CLEAN AND HEALTHY ENVIRONMENT [1]	LOCAL 24/7 POLICE, FIRE AND RESCUE SERVICES [2]	LOW CRIME (THEFT, DWI, HOMICIDE) [3]	ACCESS TO PARKS AND RECREATION [4]	SAFE NEIGHBORHOODS [5]
Brewster and Southeast	1	3	2	4	5
Carmel and Kent	1	1	3	4	2
Cold Spring and Garrison	1	3	2	5	4
Mahopac	3	4	2	5	1
Putnam Valley	1	3	3	2	3
Patterson	1	2	3	2	3
Live in PC (Total)	1	2	3	5	4
Work in Putnam	1	2	5	2	3

Respondents were asked “Where should the community focus its resources and attention to IMPROVE THE QUALITY OF LIFE for our community?” 19 choices were provided, along with a write-in option. The table below summarizes where residents feel resources and attention should be focused to improve the quality of life in Putnam County. Many of the areas identified in this assessment are common challenges that have been identified in other assessments and by partners. Unlike the unified response in the previous table four priority areas were identified.

- More Programs for Youth – ranked 1st by Mahopac and all respondents that Live in Putnam County
- Housing – ranked 1st by Cold Spring, Garrison, Patterson and all respondents that Work in Putnam County
- More Jobs – ranked 1st by Brewster, Southeast, Carmel and Kent
- Transportation – ranked 1st by Putnam Valley

RESULTS RANKING – TOP 5 AREAS TO FOCUS RESOURCES AND ATTENTION TO IMPROVE QUALITY OF LIFE

POPULATION AREA	MORE PROGRAMS FOR YOUTH [1]	HOUSING [2]	MORE JOBS [3]	TRANSPORTATION [4]	MORE AFFORDABLE FOOD [5]
Brewster and Southeast	2	3	1	5	4
Carmel and Kent	3	2	1	4	5
Cold Spring and Garrison	2	1	2	3	4
Mahopac	1	3	4	2	5
Putnam Valley	3	2	4	1	5
Patterson	2	1	3	2	5
Live in PC (Total)	1	3	2	4	5
Work in Putnam	3	1	2	4	6

Respondents were asked “What are the most important HEALTH ISSUES that our community should focus on?” 20 choices were provided, along with a write-in option. The table below shows how respondents answered when asked to identify the most important health issues that our community should focus on. Many of these health issues are well known to Putnam County and are major priorities for the local public health system.

- Drug Abuse – ranked 1st by Carmel, Kent, Cold Spring, Garrison, Mahopac, Patterson, all respondents that Live in Putnam County and all respondents that Work in Putnam County
- Mental Health – ranked 1st by Brewster, Southeast and Putnam Valley
- Alcohol Abuse – most commonly ranked 3rd

RESULTS RANKING - TOP 5 MOST IMPORTANT HEALTH ISSUES

POPULATION AREA	DRUG ABUSE (PRESCRIPTION AND ILLEGAL) [1]	MENTAL HEALTH (DEPRESSION, ANXIETY, STRESS) [2]	ALCOHOL ABUSE [3]	MENTAL ILLNESS (SERIOUS AND PERSISTENT) [4]	OBESITY [5]
Brewster and Southeast	2	1	3	6	6
Carmel and Kent	1	2	5	3	4
Cold Spring and Garrison	1	2	3	5	6
Mahopac	1	2	3	7	6
Putnam Valley	2	1	5	6	5
Patterson	1	2	7	4	3
Live in PC (Total)	1	2	3	4	6
Work in Putnam	1	2	5	3	4

PREVENTION AGENDA PRIORITIES

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

The main theme identified by respondents is that Putnam has an active and healthy environment. The availability of parks, recreation facilities, rail trails and the opportunity to fish, canoe and kayak on the abundant lakes, streams, and reservoirs provides many opportunities for physical activity and recreation.

The other main theme is that Putnam is considered a safe place to live, work and raise a family. The availability of 24-hour police, fire and rescue, low crime and violence rates led residents to feeling that they live in safe neighborhoods. Generally, the police, fire, rescue and health department are well prepared to handle emergency events as evidenced by the response during Hurricane Irene.

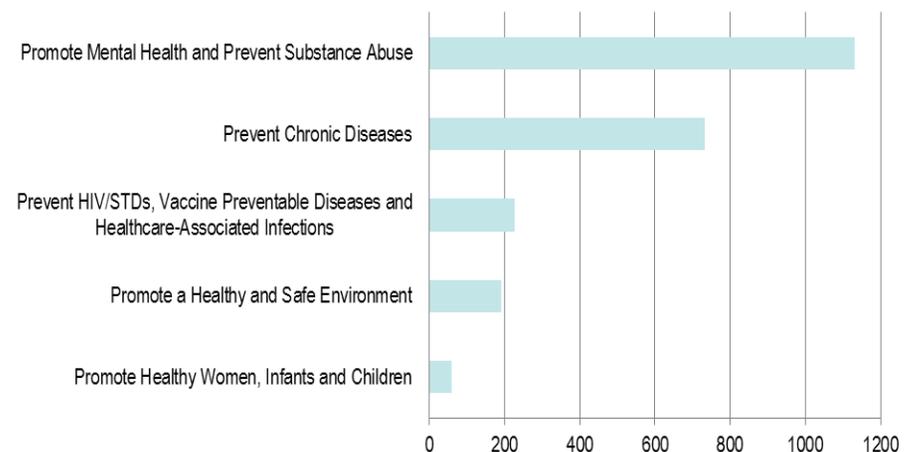
Availability of programs for youth, particularly after school, was considered a focus area to address. With more dual working and single parent households, the need for pro-social involvement is very important. When youth are given opportunities to participate in meaningfully important activities at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

There was a 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.

The overarching health concerns in Putnam County are the opioid epidemic, mental health and chronic disease.

One of the main purposes of this CTS Assessment is to identify the New York State DOH Prevention Agenda priorities that the Putnam County community will focus collective efforts on. Promoting Mental Health and Preventing Substance Abuse was the overwhelming priority.

COMMUNITY THEMES AND STRENGTHS ASSESSMENT SUMMARY BY PREVENTION AGENDA CATEGORY



COMMUNITY HEALTH STATUS ASSESSMENT

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 of health. By utilizing the results of this assessment, MAPP committees have a better understanding of the community's health status, can prioritize various health indicators and ultimately select and monitor the goals and strategies contained in the CHIP. This report also allows for comparison to benchmark data at the state and national levels. The New York State Prevention Agenda 2103-2018 is the blueprint for state and local action to improve the health of New Yorkers and provides objectives and indicator performance data. The Healthy People 2020 and National Prevention Strategy are sets of national objectives for improving the health of all Americans and are used to set and monitor goals.

Report (BRFSS) designed by the Centers for Disease Control and Prevention; the *Community Health Status Report Card* from the U.S. Department of Health and Human Services; *County Health Assessment Indicators* compiled by the New York State DOH; the *County Health Rankings* conducted by the Robert Wood Johnson Foundation and the University of Wisconsin; *Healthy People 2020* compiled by the U.S. Department of Health and Human Services; *Local Data* including reports and data provided by local agencies; *Prevention Agenda 2013-2018 Dashboard* gathered by the New York State DOH; *Statewide Planning and Research Cooperative System (SPARCS)* hospital based data compiled by the New York State DOH; and *Vital Statistics of New York State* compiled by the New York State DOH.

See specific list of resources at the end of this document.

DATA SOURCES

Multiple sources of data have been gathered and analyzed by the Putnam County DOH Epidemiologist and MAPP committees in creating this assessment. By using multiple data sources a more comprehensive snapshot of health in Putnam County can be created. Sources include: the *Behavioral Risk Factor Surveillance System*

COMMUNITY HEALTH STATUS

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

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

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

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

* Alone = reporting only one race

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

COMMUNITY CHARACTERISTICS

A community's population size, age and racial composition are important determinants of health status and health care needs. The following table and summaries provide a snap shot of Putnam County residents.

Demographics - 2015 U.S. Census Data	Putnam	New York
Population	99,042	19,795,791
Persons under 5 years	4.5%	6.0%
Persons under 18 years	20.9%	21.3%
Persons 65 years and over	15.2%	15.0%
Race - White Alone* (reporting only one race)	92.0%	70.1%
Black or African American Alone	3.3%	17.6%
American Indian and Alaska Native Alone	0.4%	1.0%
Asian Alone	2.5%	8.8%
Native Hawaiian and Other Pacific Islander Alone	0.1%	0.1%
Two or more races	1.8%	2.4%
Ethnicity - Hispanic** of Latino	13.5%	18.8%
White Alone, not Hispanic or Latino	80.2%	56.0%
Other not Hispanic or Latino	6.3%	25.2%
2010-2014 U.S. Census Data		
Foreign born persons	12.9%	22.3%
Language other than English spoken at home age 5+	18.8%	30.2%
Veterans	5.03%	4.4%
Housing - Homeownership rate	82.7%	53.8%
Housing multi-unit structures	15.2%	50.7%
35% or + Rent as percentage of household income	48.7%	44.8%

POPULATION

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

AGE

- Population is aging
- Median age rose from 37.4 years to 42.6 years in the past 5 years
- A quarter of the residents are over 55 years
- Senior residents now account for 15.2% of the population

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

RACE

- Racially homogenous
- Majority of residents are White
- Hispanics (of any race) 13.5% of the population
 - ◊ The largest increase in any race or ethnicity group
- Asians and Blacks also continue to increase but at smaller rates than Hispanics
- Residents are predominantly American born and speak English in the home, but these rates are also rising

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

VETERANS

- 5% of Putnam residents are veterans
- Similar to New York State

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

HOUSING

- Majority of Putnam residents own and live in their own home
- Homeownership rate in Putnam exceeds the State
- 15% of the units available in Putnam are multi-unit causing shortages for those renting
- Of those paying rent, nearly 50% spend 35% or more of their household income on rent

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

SOCIAL DETERMINANTS OF HEALTH

Many factors can influence the health of an individual. The resources a person has access to and the environment a person lives, 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 and well-being.

Social and Economic Factors - 2010-2014 U.S. Census Data	Putnam All Residents	Putnam/NYS Below Poverty Level	New York/All residents
Highest Education - High school graduate or equivalency	26.5%	8.4%/16.8%	26.9%
Some college with no degree	18.7%	4.8%/12.3%	16.3%
Associate's degree	8.8%		8.5%
Bachelor's degree or higher	38.3%		2.3%/5.7%
High School graduation rate (2015 NYS Education Dept.)	90.0%	77.0%/70.0%	78.0%
Unemployment	7.8%	11.6%/29.6	8.9%
Poverty	5.6%	N/A	15.6%
Children in Poverty	5.7%		22.1%
Single parent households	13.3%		19.8%
Single household 65 years and older	8.1%		10.9%
Mean travel time to work	39.1 min.		31.9 min
Commute to work - drove alone - car, truck or van	76.0%		53.6%
Commute to work - public transportation	8.6%		27.4%
Homicide mortality rate/100,000 (NYSDOH 2011-2013)	0.0		3.0
Assault hospitalization rate/100,000 (NYSDOH 2011-2013)	1.1		2.6

EDUCATION

- Well educated, nearly 95% having a high school diploma or higher
- Nearly half have an Associate's or college degree
- Compared to NYS, more Putnam residents have some college with or without a degree
- High school graduation rates exceed the New York State rate
 - ◇ 90% of students graduating within four years
- Putnam County, along with Nassau County, has the highest graduation rate in NYS

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

EMPLOYMENT & INCOME

- Nearly 6% of Putnam children and adults live in poverty
- Putnam residents have a higher level of employment than NYS
 - ◇ One of the lowest unemployment rates within the State
 - ◇ Constant since 2012
 - ◇ Level of unemployment for those in poverty was half of the NYS level

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

FAMILY & SOCIAL SUPPORT

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

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

TRANSPORTATION

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

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

COMMUNITY SAFETY

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

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

HEALTH INDICATORS

Health indicators are a summary of measures that describe the population health status, the health care system and the factors that have the potential to influence health outcomes. These indicators provide comparable information, an opportunity to track progress over time, and identify areas for improvement within the health care system. In order to make the data included in this report comparable, the indicators have been developed in context of the Prevention Agenda (PA) framework first and then with Healthy People (HP) 2020 second.



HEALTH OUTCOMES		
INDICATOR	MEASURE	SOURCE
Deaths (Mortality)		
Chronic Disease	All Cancer — Age-Adjusted Death Rate	HP2020 C-1; NYSDOH
	Cerebrovascular Disease — Age-Adjusted Death Rate	HP2020 HDS-3; NYSDOH
	Coronary Heart Disease — Age-Adjusted Death Rate	HP2020 HDS-2; NYSDOH
	Diabetes Mellitus — Age-Adjusted Death Rate	HP2020 D-3; NYSDOH
Injury & Violence	Homicide — Age-Adjusted Death Rate	HP2020 IVP-29; NYSDOH
	Motor Vehicle Related — Age-Adjusted Death Rate	HP2020 IVP-11; NYSDOH
	Unintentional Injury — Age-Adjusted Death Rate	HP2020 IVP-13; NYSDOH
Maternal & Infant Health	Infant Mortality Rate	HP2020 MICH-1.3; NYSDOH
	Maternal Mortality Rate	PA-50; HP2020 MICH-5; NYSDOH
Mental Health	Suicide — Age-Sex-Adjusted Death Rate	PA-64; HP2020 MHMD-1; NYSDOH
Premature Death	% Premature Deaths (before age 75 YO)	PA-1; NYSDOH
Quality of Life		
Mental Health	% Adults with Good or Better Mental Health	PA-60; HP2020 HRQOL-1.2; BRFSS
Physical Health	% Adults with Good or Better Physical Health	HP2020 HRQOL-1.1; BRFSS

HEALTH OUTCOMES

Health outcomes include disease mortality and how healthy people feel. By looking at these measures an assessment of health status can be measured and monitored over time. Focusing on both overall mortality and premature mortality provides an opportunity to identify diseases that cause death in general as well as prematurely.

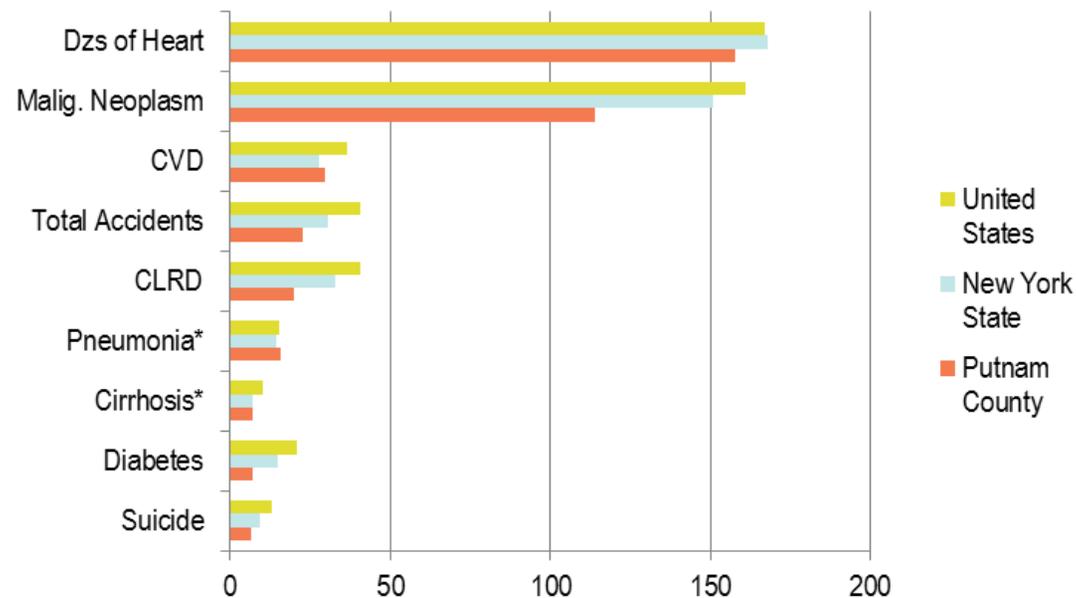
- Premature death rate - 4,715 years of potential life lost
- 6th lowest rate in New York State
- Mortality rate – 532 per 100,000
- 5th lowest rate in New York State

MORTALITY

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

All mortality rates are age-adjusted. When possible, data are 3-Year combined rates with the year shown being the mid-point (2004 represents 2003-2005).

ALL DISEASES 2014 MORTALITY—TOP 9 CAUSES

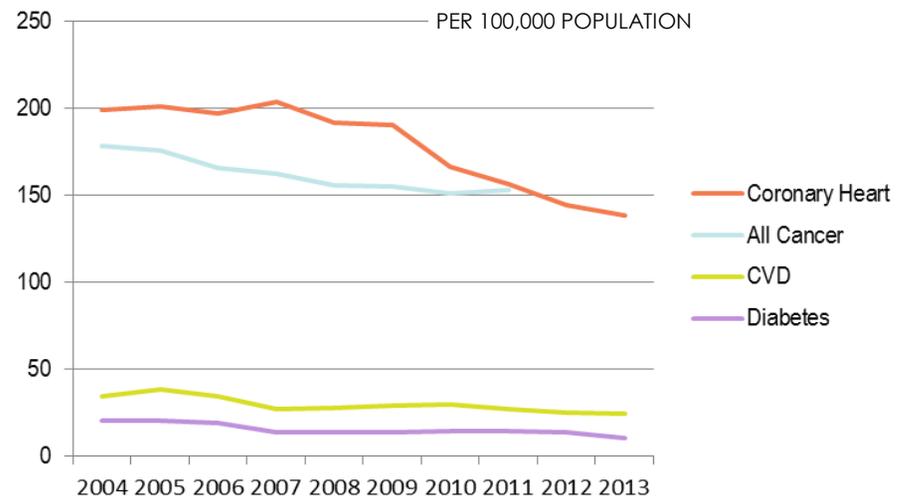


The top two causes of death in Putnam County, Diseases of the Heart and Malignant Neoplasms, are the same as the State and Country. These have been the leading causes of death for the past ten years. Cerebrovascular Diseases, Total Accidents, and Chronic Lower Respiratory Diseases (CLRD), although in different rank order, are the third –fifth most common causes of mortality. Of note is that for the United States, Cirrhosis also includes deaths from liver disease and Pneumonia also includes Influenza deaths.

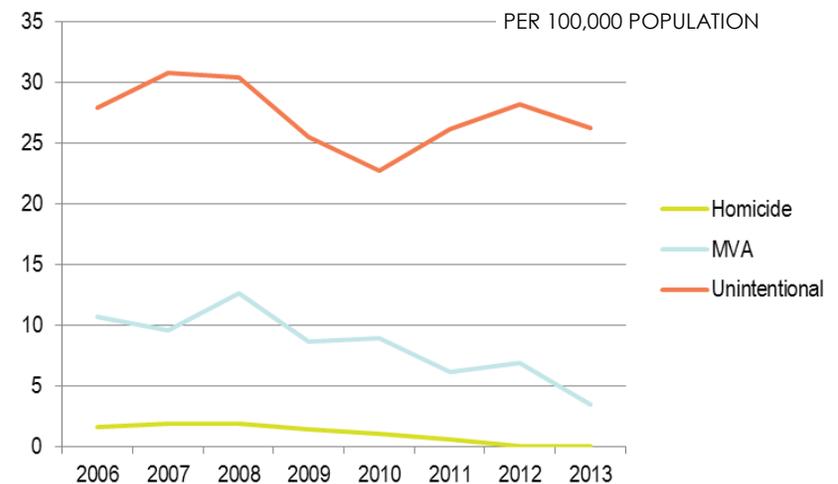
Mortality rates for Coronary Heart Disease, All Cancers, Cerebrovascular Disease and Diabetes, four diseases associated with health behaviors and chronic conditions are shown. Coronary Heart Disease mortality has been decreasing over the past seven years. All Cancer mortality has also been on the decline but over the past ten years. Cerebrovascular Disease and Diabetes have remained constant. Data for All Cancer deaths were not yet available after 2011-2013.

Homicides in Putnam County are rare, ranging from zero to a high of three in 2007. Motor Vehicle Accidents (MVA) have been on the decline over the past eight years, with a high of 13 deaths in 2009 to a low of 2 in 2010 and 2014. Deaths due to unintentional injury exceed both homicide and MVA. These rates have fluctuated over the past eight years.

CHRONIC DISEASE 3-YEAR MORTALITY RATES



INJURY AND VIOLENCE 3-YEAR MORTALITY RATES



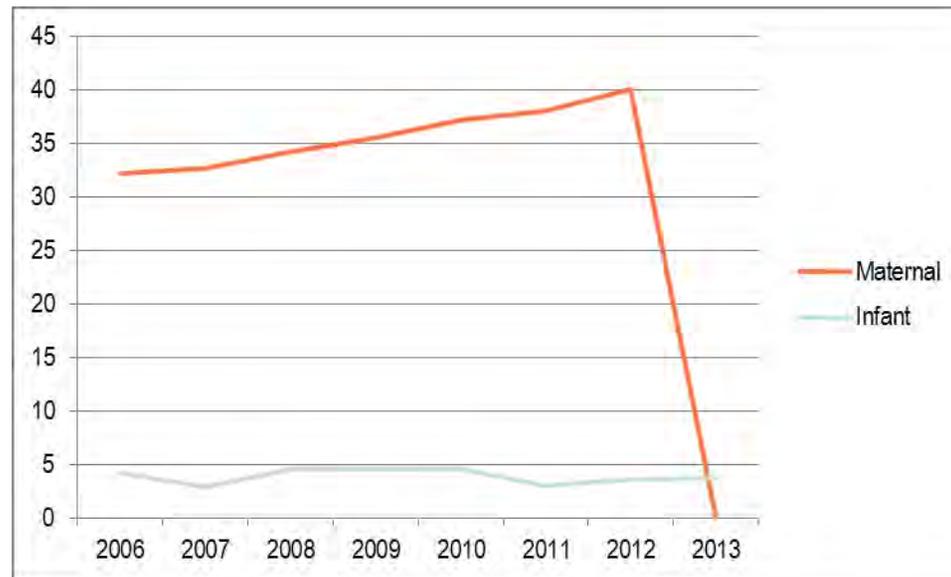
MATERNAL AND INFANT 3-YEAR MORTALITY RATES

Live Births in Putnam have been on the decline over the past ten years with highs of 1,034 in 2005 and 1,036 in 2007 to the low of 802 in 2013. Over the past four years the number of live births has been between 802 and 866.

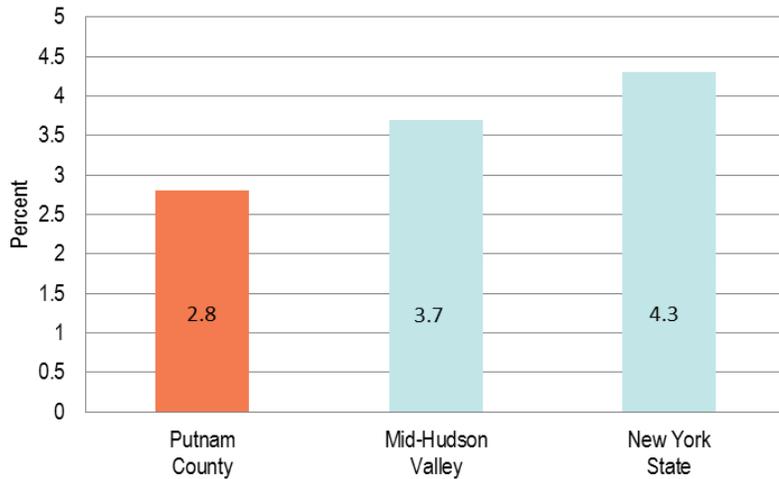
Maternal mortality (per 100,000 live births) is rare in Putnam County. There have been three deaths, one each in 2011, 2008 and 2005. Interpreting the rates is difficult due to the low number of deaths.

Infant deaths (per 1,000 live births) are also rare in Putnam

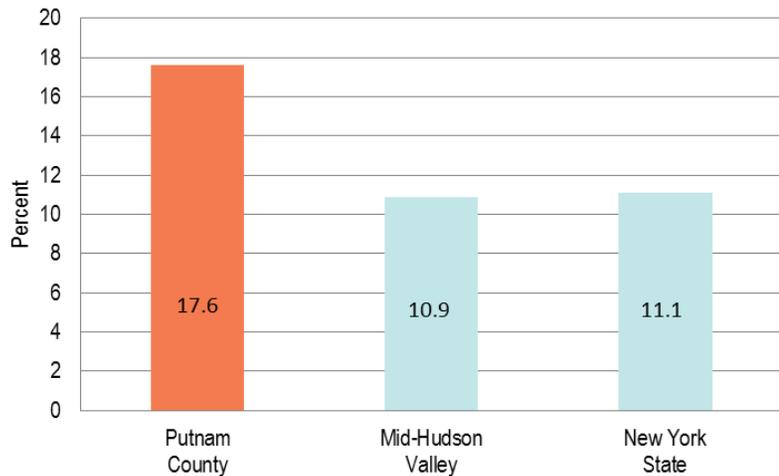
County. The most deaths occurred in 2008 (eight) and the least occurred in 2012 and 2006 (one each). Like maternal mortality it is difficult to interpret these rates due to the low number of deaths.



ADULTS REPORTING POOR PHYSICAL HEALTH (past 30 days)



ADULTS REPORTING POOR MENTAL HEALTH (≥14 days)



QUALITY OF LIFE

Quality of life (QOL) is the perception that an individual has about their well-being. It can include emotional, social and physical components of one's life. A person's health status can have a direct impact on their QOL and satisfaction with life.

Putnam has less residents reporting that they are generally in poor health. This level rises to 10% when you include residents who report generally being in poor or fair health. Both levels are below the Regional and State. The average number of physically unhealthy days for all residents is 2.9 days, compared to 3.6 days for the State. People who feel healthy are more productive and engaged in their community. This level meets the Healthy People 2020 goal of 79.8% of residents reporting good or better health.

Putnam has more residents reporting poor mental health for 14 or more days in the last month. This level is significantly higher than the Region and State. The average number of mentally unhealthy days for all residents is 3.1 days, compared to 3.7 for the State. Like physical health, people who feel mentally healthy are more productive and engaged in their community. This level meets the Healthy People 2020 goal of 79.1% of residents reporting good or better mental health but does not meet the Prevention Agenda goal of 89.9%.

HEALTH FACTORS

Health Factors are characteristics and exposures that influence a person developing a disease. Health behaviors, access to care, the physical environment and social and economic factors are some examples. Due to the high socioeconomic status and low unemployment rates, Putnam residents generally have better health outcomes. Despite these benefits, some residents do not have the same advantages since social determinants of health do not afford them the same health outcomes.

- High School Graduation
 - ◊ 90% All residents versus only 77% of residents below the poverty level
- Unemployment
 - ◊ 7.8% All residents versus 11.6% of residents who are below the poverty level

HEALTH FACTORS		
INDICATOR	MEASURE	SOURCE
Health Behaviors		
Diet and Exercise	% Adults Who Are Obese	PA-14; HP2020 NWS-8; BRFSS
	% Adults Reporting No Leisure-Time Physical Activity	HP2020 PA-1; BRFSS
	% Adults Stressed About Money for Nutritious Meals	HP2020 NWS-13; BRFSS
	Food Environment Index	USDA Food Environment Atlas
Sexual Health	Chlamydia Case Rate	PA-29; HP2020 STD-2; NYSDOH
	Syphilis Case Rate	PA-30; HP2020 STD-7; NYSDOH
Substance Abuse	% Adults Binge Drinking	PA-42; HP 2020 SA-14.3; BRFSS
	% High School Seniors Never Using Illicit Drugs	HP2020 SA-2.4; Prevention Needs Assessment
Tobacco Use	% Adults Currently Smoking	PA-16; HP2020 TU-1.1; BRFSS
Clinical and Access to Care		
Immunizations	% Children with 4:3:1:3:3:1:4 Series 19-35 Month Old	PA-23; HP2020 IID-8
Insurance	% Adults and Children with Health Insurance	PA-3; HP2020 AHS-1.1; US Census
Regular Provider	% Adults with Regular Health Care Provider	PA-4; AHS-3; EBRFSS
Social and Economic Factors		
Assault	Assault-Related Hospitalization Rate	PA-7; NYSDOH
Poverty	% Children Living in Poverty	HP2020 SDOH-3.2; US Census
Education	% 9 th Graders Graduating within 4 Years	HP2020 AH-5.1; BRFSS; US Census
Employment	% Population Employed	US Census
Housing Insecurity	% Adults Stressed About Having Money for Housing	BRFSS
Physical Environment		
Commute Time	% Adults with Long Commute-Driving Alone	US Census
Food Environment	% Low-Income and Access to Supermarket	PA-11; US Department of Agriculture

HEALTH BEHAVIORS

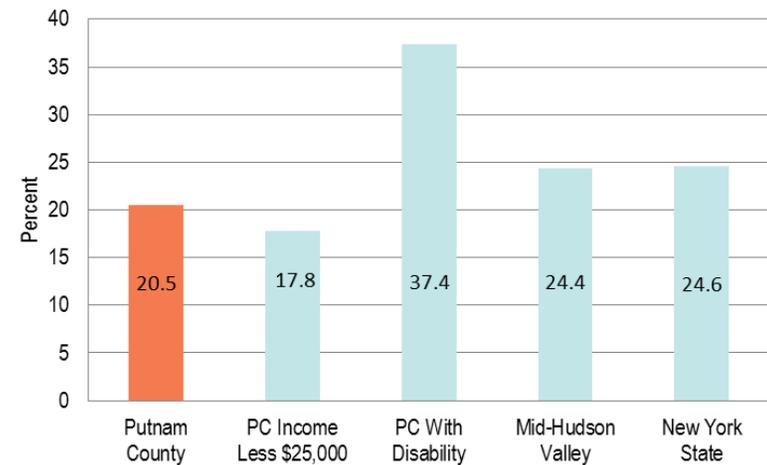
DIET AND EXERCISE

Consuming a healthy, well-balanced diet and being physically active have direct links to maintaining a healthy weight, preventing chronic diseases and improving quality of life. Changing diet and increasing physical activity should include efforts at the individual level as well as at the policy level.

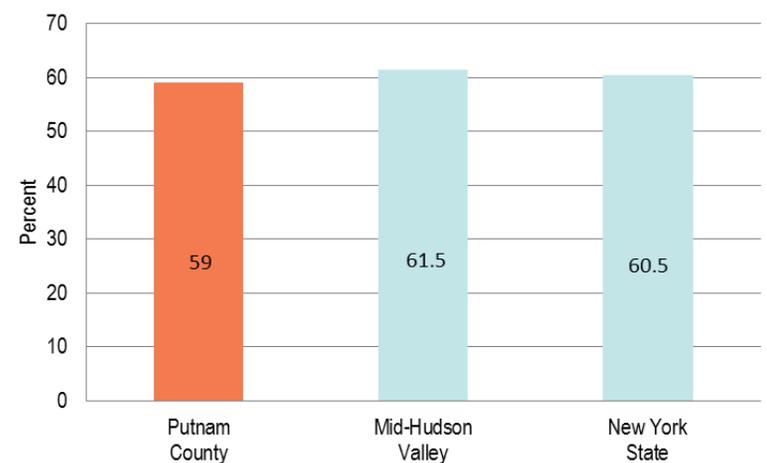
Putnam County has shown declines in the obesity (body mass index ≥ 30) level and is currently lower than the State and Regional levels. Generally those living in poverty are more likely to be obese; however, Putnam households with an income less than \$25,000 have lower levels of obesity than the County as a whole and in comparison to the Mid-Hudson Valley and New York State. The highest levels of obesity were found in residents who are disabled and can find it more difficult to eat healthy, be physically active and control their weight. Overall obesity rates are below the Prevention Agenda goal of 23.2% and the Healthy People 2020 goal of 30.5%.

Being overweight (BMI 25 - <30), as well as obese, raises the risk of acquiring health problems like Type 2 Diabetes, elevated blood pressure, heart disease, stroke and sleep apnea. Over half of adults report being overweight or obese and this is similar to the Regional and State levels.

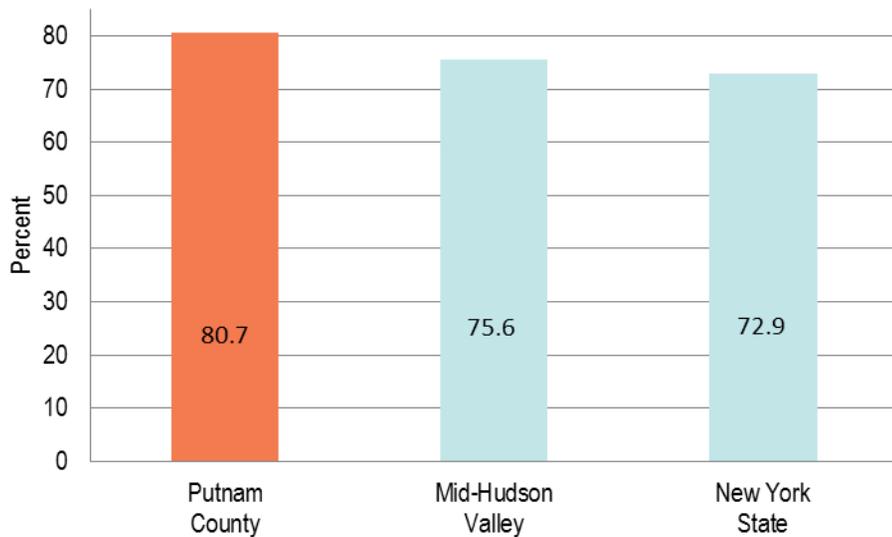
ADULTS WHO ARE OBESE



ADULTS WHO ARE OVERWEIGHT OR OBESE

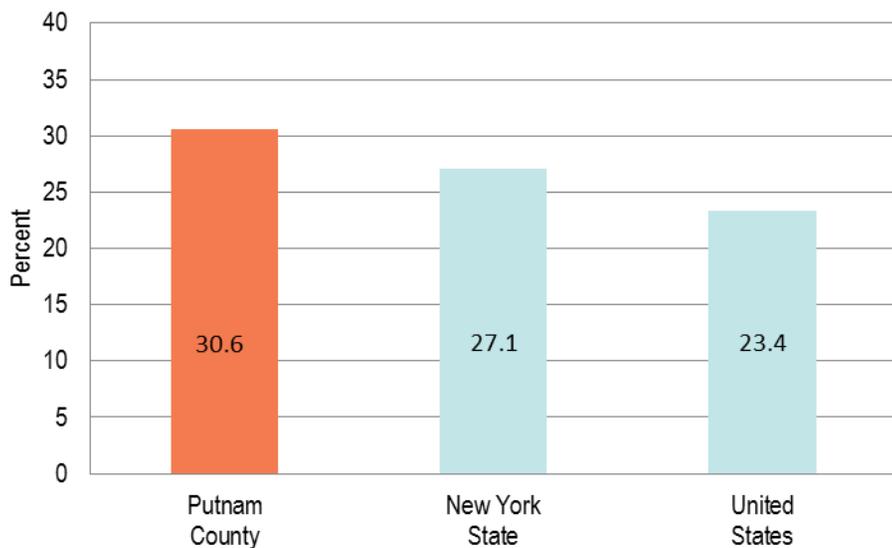


ADULTS WHO PARTICIPATED IN LEISURE TIME ACTIVITY



Being sedentary can increase the risk of developing many chronic diseases as well as contributing to a poor quality of life. Regardless of age, disease status, or disability, regular activity can promote a person's health and decrease the risks for developing disease. Over three-quarters of Putnam residents report engaging in leisure time activity. This exceeds the State and meets the Healthy People 2020 goal of 67.4%.

ADULT CONSUMPTION OF FRUITS AND VEGETABLES



Consumption of fruits and vegetables is an important part of eating a healthy and well-balanced diet. Links have been established between diet, particularly the amount and variety of fruits and vegetables consumed, and the development of chronic diseases and cancers. Less than a third of residents reported consuming five or more fruits and vegetables a day which is more than the State and Country.

FOOD INSECURITY

A healthy food environment increases the ability of all residents to access grocery stores which provide a wider variety of foods and often more healthy options than a convenience store. Food insecurity is a report of limited or uncertain access and availability of nutritionally adequate foods. 5.5% of residents report food insecurity. The food environment index is a measure of two factors: limited access to healthy foods by low income residents and food insecurity estimates; therefore this measure accounts for proximity to healthy foods and income availability. Despite the rural/suburban makeup of Putnam County, the food environment index is 9.1 (out of 10) suggesting that most residents have access to a healthy food environment.

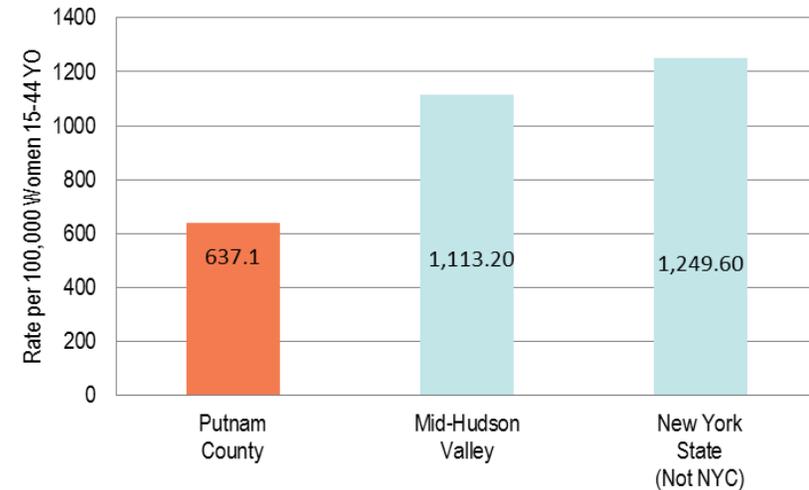
SEXUAL HEALTH

Despite advances in clinical testing and wide-spread screening the incidence of sexually transmitted diseases (STD) are on the rise as are the health and economic costs associated with these diseases. STDs can cause clinical complications, including reproductive health problems for women, newborn health problems and increased occurrences of some cancers. Also contributing to this disease burden is the fact that many STDs go undiagnosed, so reported cases only reflect a fraction of the true case load.

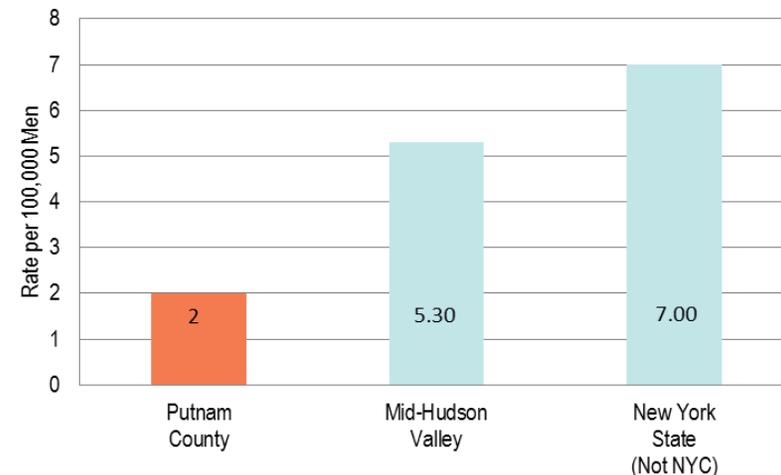
Putnam County has lower rates of Chlamydia than the Region and the State (without New York City), but rates have been increasing in all three geographic areas. The greatest rise in incidence of Chlamydia has been in Putnam, which saw a 24% increase in cases, compared to 4% for New York State (without New York City) and 0.66% for the United States.

Putnam County has lower rates of Syphilis than the Region and the State (without New York City) and rates have been increasing across the State and the County. Syphilis has been on the rise in Putnam, with cases more than doubling in 2016.

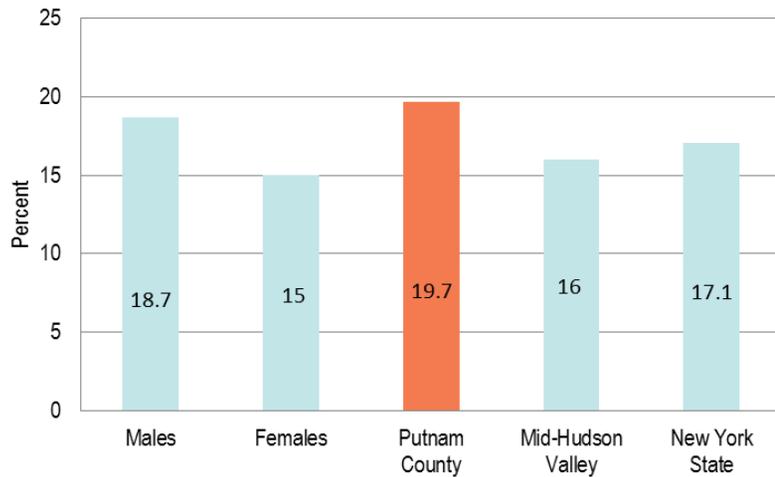
CHLAMYDIA INCIDENCE (2014)



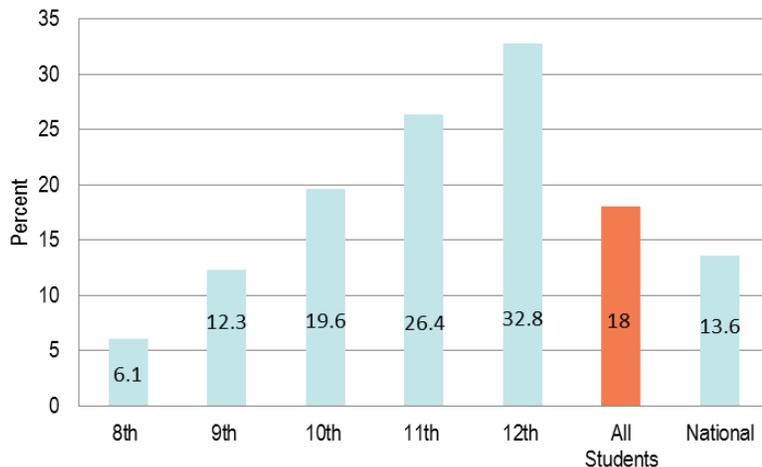
SYPHILIS INCIDENCE (2014)



ADULT BINGE DRINKING



ADOLESCENT BINGE DRINKING



SUBSTANCE ABUSE

Reducing substance abuse, whether drugs or alcohol, is a major public health priority. The abuse of alcohol, use of illicit drugs and epidemic of addiction to prescription pain medications and heroin are all linked to serious health and social issues that can impact individuals, families and the community.

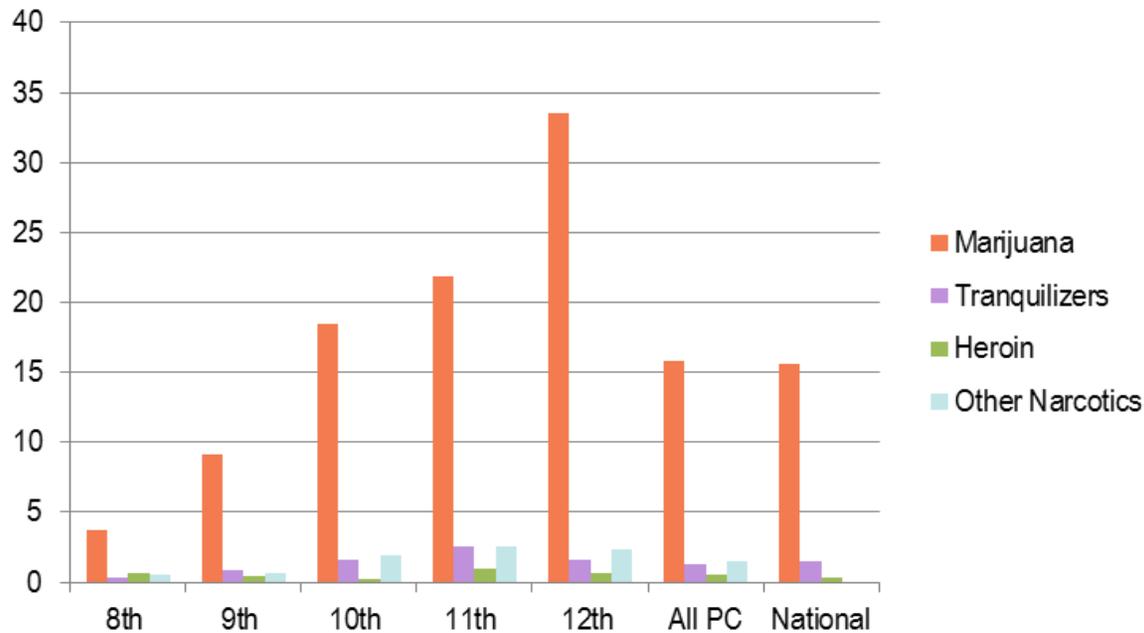
When people drink in excess they place themselves at a greater risk for developing health and social problems like alcohol-impaired driving, sexually transmitted diseases and domestic violence and family disputes. Binge drinking (men who have five or more drinks and women who have four or more drinks on one occasion) has been an identified health issue in Putnam County for many years. In Putnam, one in ten adults report binge drinking which exceeds both the Region and the State. More men than women report binge drinking which is similar to national trends. Despite these trends, Putnam County meets the Healthy People 2020 goal of 24.4%.

Binge drinking is also a concern for school aged children. Rates of binge drinking (five or more alcoholic drinks in a row in the past two weeks one or more times) in students have been declining over the past six years; however, Putnam County students have greater reports of binge drinking than the national average. Youth who drink alcohol are more likely to experience school and social problems as well as health problems due to unprotected sexual activity, alcohol-impaired driving and higher risk of suicide.

As with binge drinking, substance use increases each year, peaking in 12th grade. Marijuana is the most used drug in the middle and high school settings. Marijuana use increases nine fold between 8th and 12th grade, with a third of 12th grade students reporting use of marijuana at least one or more times in the past month. This is similar to the national average. Tranquilizers and other narcotics are used by fewer

students than marijuana and 11th grade is the peak usage. Less than one percent of students report using heroin; however, more Putnam students report trying heroin than the national average. When asked the same question for using these drugs during their lifetime, all grades reported higher usage than during the past thirty days suggesting that many kids experiment with trying these drugs.

ADOLESCENT DRUG USE PAST 30 DAYS (PERCENT)



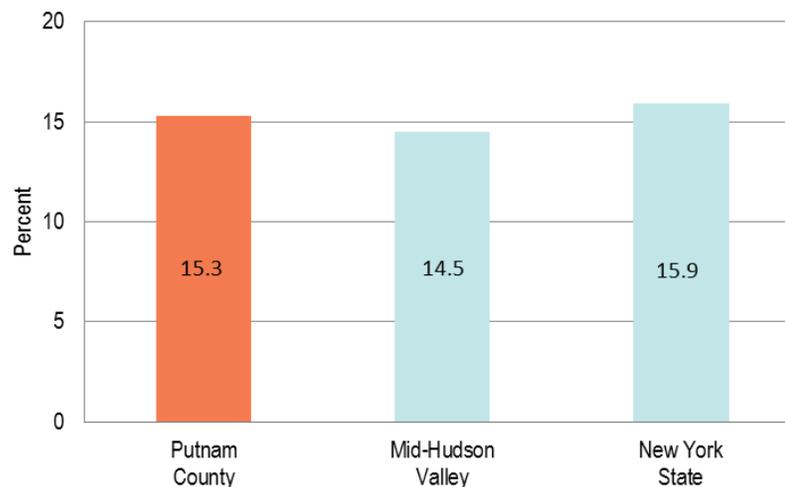
TOBACCO

According to the Centers for Disease Control and Prevention, smoking is the leading cause of preventable death. Smoking, second-hand smoke, and smokeless tobacco all increase the risk of health problems such as cancer, heart disease, stroke, asthma and increased respiratory infections.

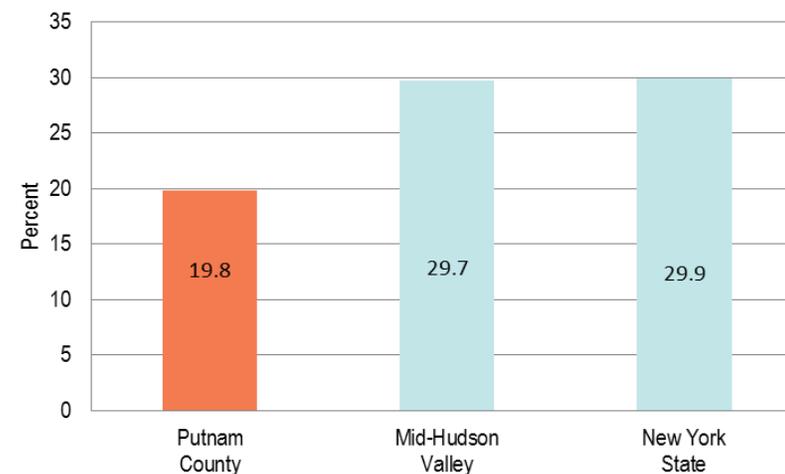
Putnam has similar smoking rates as the Region and the State. These are adults who report having smoked at least 100 cigarettes in their lifetime and currently smoke every day or most days. Of those residents who report general poor mental health, smoking rates were higher than compared to all residents. Of note is that smoking rates in this population are lower than the Region and the State for this population, unlike the general smoking rate.

There is limited data on the use of electronic cigarettes; however, a local survey conducted by POW'R Against Tobacco included questions regarding this form of smoking. Nearly a quarter of respondents reported trying an electronic cigarette at least once and 11% report smoking them every day.

SMOKING, ALL ADULTS

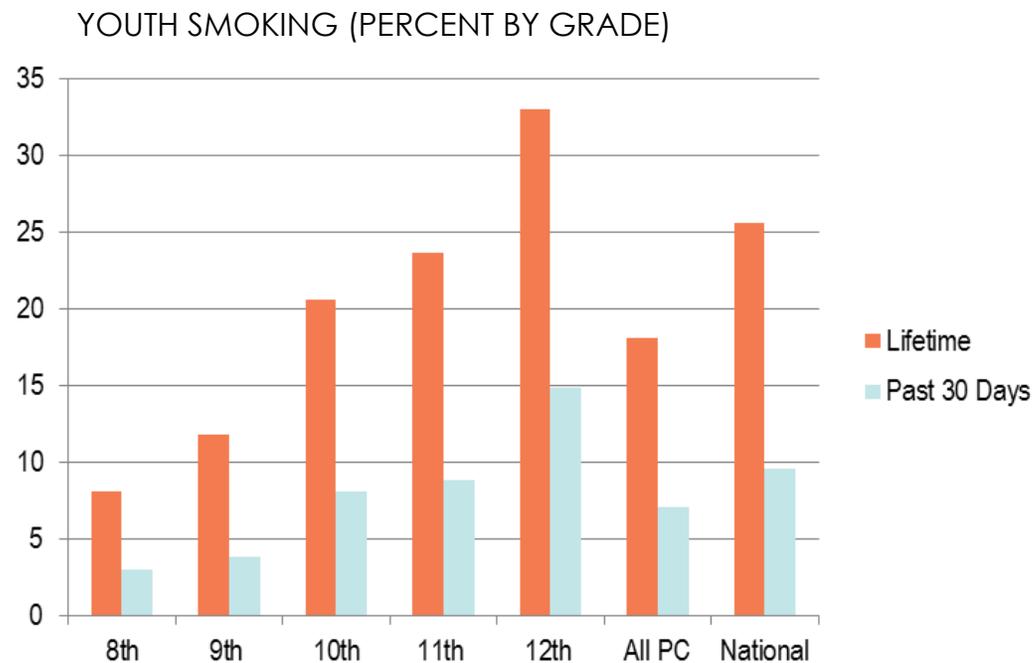


SMOKING, ADULTS REPORTING POOR MENTAL HEALTH



According to the Centers for Disease Control and Prevention tobacco use is established primarily during adolescence and nearly nine out of ten cigarette smokers first tried smoking by age 18. In Putnam, cigarette smoking increases each year as children reach 12th grade with 15% of seniors students reporting they are current smokers. In general rates of smoking are lower than compared to the

National average. Of note is that almost double the number of students have attempted to smoke as compared to current smokers. This survey does not currently ask about electronic cigarettes but partners are aware of the targeted marketing to this population and are working on local policy to limit this form of smoking.



CLINICAL AND ACCESS TO CARE

Access to health care allows residents to receive health services and achieve positive health outcomes. Having health insurance is a direct path to accessing the health care system and ensuring that timely diagnosis and care are provided.

health care. The Mental Health Provider ratio in Putnam is the third best in the Mid-Hudson Valley and is better than New York State.

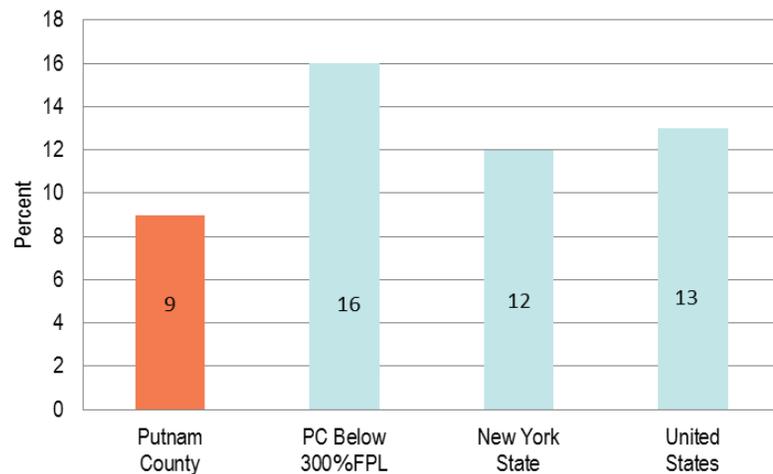
Putnam County has only one local hospital and trauma level care is only available outside of the County. The federally qualified health center has expanded services to include oral health as well as physical and behavioral health. Despite the high ratio of mental health providers to population, there is a gap for child and adolescent providers not reflected in this number.

Putnam County has less Primary Care Physicians in comparison to the Mid-Hudson Valley and New York State. This is consistent with findings from previous local and regional surveys where residents report leaving Putnam for

HEALTH CARE SYSTEM ASSETS

Healthcare Resources	Putnam
Facilities	
Local Hospital	1 (164 beds)
Trauma Center	0
Federally Qualified Health Center	1
Nursing Homes	2 (320 beds)
Assisted Living Facility	1 (40)
Adult Day Care	3
Providers (ratio of population to providers)	
Primary Care Physician (MD and DO)	1,993:1
Primary Care Non-Physician (NP or PA)	2,163:1
Mental Health Providers (Psychiatrist, Psychologist, LCSW or Counselor)	368:1
Dentist	1,842:1

POPULATION UNDER AGE 65 WITHOUT HEALTH INSURANCE

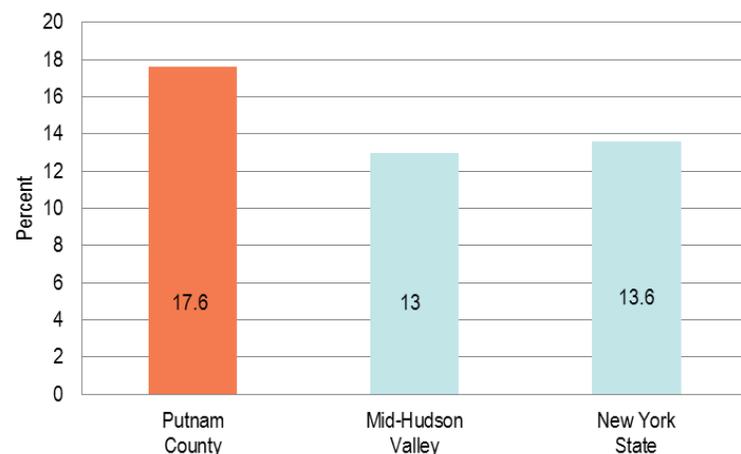


Putnam County has generally had less uninsured residents when compared to the State and the US. Residents living below 300% of the Federal Poverty Level experience a much higher level of uninsurance. Despite these high levels of insurance, the Healthy People target is universal coverage (0% uninsured) which has yet to be met.

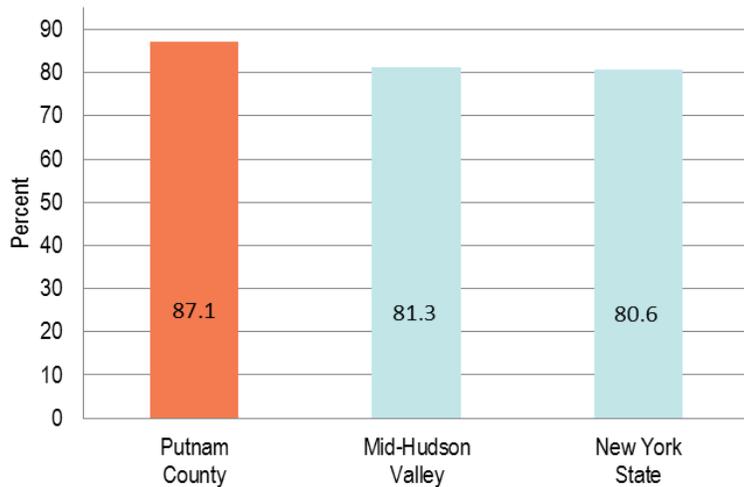
Healthy People 2020 describes access to health services as the timely use of personal health services leading to the best health outcomes. In order to achieve these outcomes a person must gain entry into the health care system, access a health care location and find a health care provider who they can communicate with and trust.

Despite having health insurance, many residents report being unable to access their health care needs due to the high costs of having health insurance, the co-pays, or high deductible plans. By not accessing timely health services individuals have unmet health needs which lead to preventable hospital stays and later stage disease progression at time of diagnosis. More residents in Putnam, compared to the Mid-Hudson Valley and New York State, report not receiving medical care because of cost. Community Asset Survey respondents also reported high deductible insurance limiting ability to go to the doctor (5.3%).

DIFFICULTY ACCESSING HEALTH CARE DUE TO COST



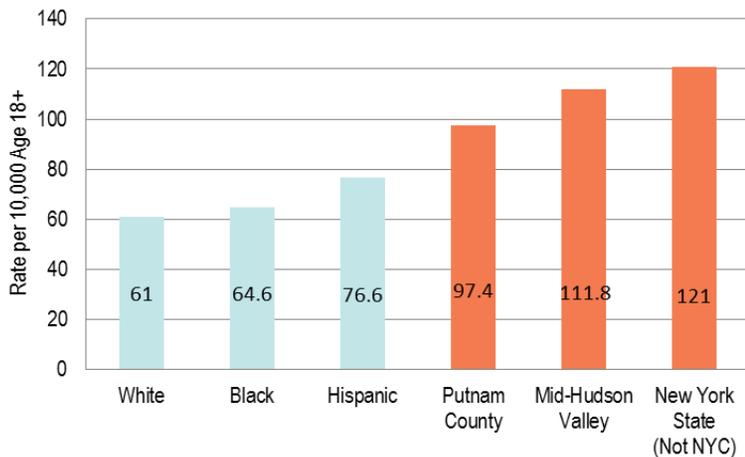
ADULTS WHO HAVE A REGULAR HEALTH CARE PROVIDER



Individuals who do not have a regular source of health care are less likely to have routine check-ups, receive appropriate screenings, and delay seeking treatment in general. Children and the elderly are more likely to have a health care provider that they have a relationship with and routinely see. Putnam County has a slightly higher reporting of residents having a regular health care provider and meets the Healthy People 2020 goal of 83.9%; however, this does not meet the Prevention Agenda Goal of 90.8%.

Potentially preventable hospitalizations are admissions to a hospital for certain acute illnesses or worsening chronic conditions that might not have required hospitalization had these conditions been managed successfully by primary care providers in the outpatient settings. These admissions are costlier and can sometimes require a change in patient behavior for some populations. They are also a marker of health care system efficiency. Putnam County has less preventable hospitalizations when compared to the Region and the State. Within Putnam County, White residents have the lowest rate of preventable hospitalization and Blacks and Hispanics have progressively higher rates. These racial and ethnic disparities are similar to National trends. Within the local public health system of Putnam County many partners are actively engaged in the Delivery System Reform Incentive Payment Program attempting to transform the health care system and decrease avoidable hospital stays by 25% over five years.

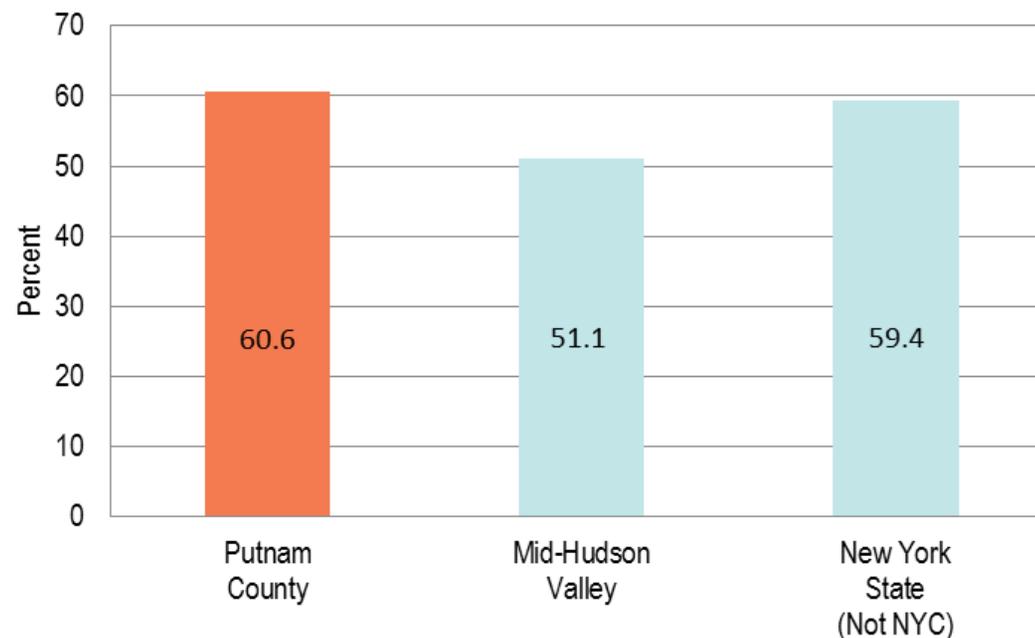
PREVENTABLE HOSPITALIZATION RATES



PERCENTAGE OF CHILDREN WITH 4:3:1:3:3:1:4 IMMUNIZATION SERIES

Immunization against vaccine preventable diseases is a major medical advancement that has reduced morbidity and mortality as well as decreased health care costs associated with disease sequela. Globalization and fears about vaccine safety have led to increased outbreaks of diseases that have been eradicated or previously at very low levels. Disparities still exist for those living in poverty and non-White children. The Advisory Committee on Immunization Practice

recommends that all children 19-35 months receive 4 DTap: 3 Polio: 1 MMR: 3 Hep B: 3 Hib: 1 Varicella: 4 PCV13 immunizations. Putnam County exceeds the Mid-Hudson Valley and is similar to New York State (without New York City) but does not meet the Healthy People 2020 and Prevention Agenda Goal of 80%.



SOCIAL AND ECONOMIC FACTORS

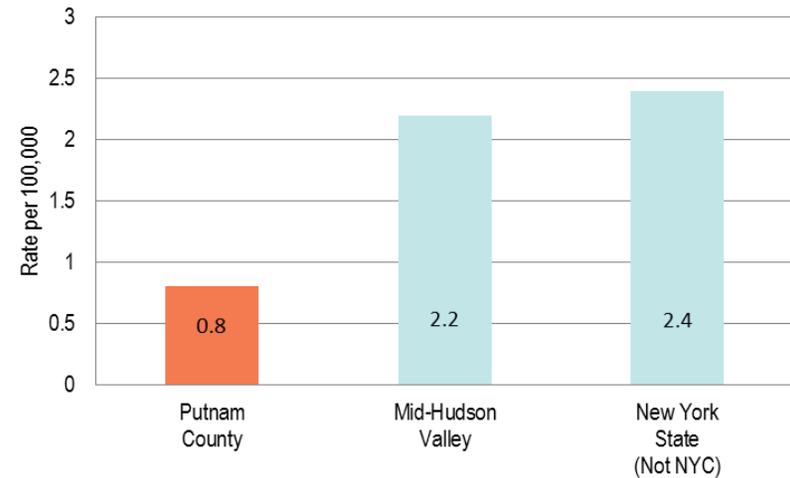
Social and economic factors have a great influence on the health of individuals and a community and can strongly influence health behaviors. Education, employment status, housing, and violence all play a part in determining the make-up of a community.

Putnam County has a low assault-related hospitalization incidence, and is lower than the Region and State (without New York City), which contributes to the perception that this is a safe county to live in.

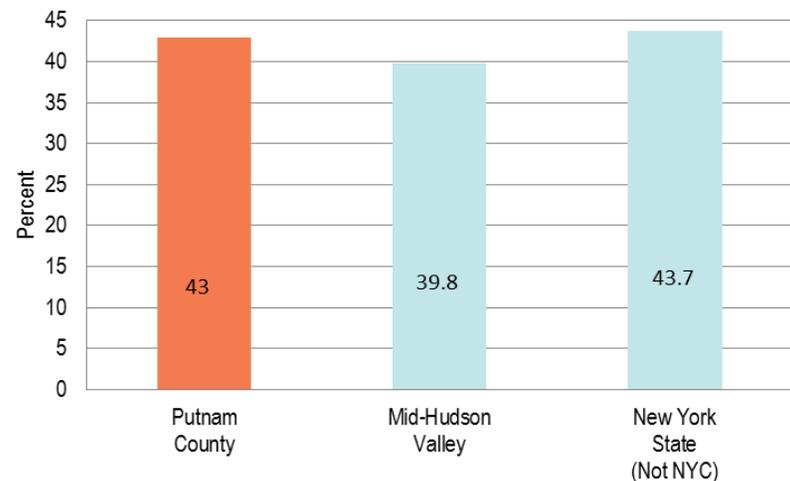
Putnam County is similar to the Region and the State (without New York City) in residents reporting being worried or stressed about having enough money to pay the rent or mortgage. Increased levels of stress are associated with residents worrying about paying for housing and not having a stable home environment.

As previously discussed, Putnam County has a well-educated population with low levels of poverty and is considered a safe community to live in. These positive social and economic factors translate to better health outcomes.

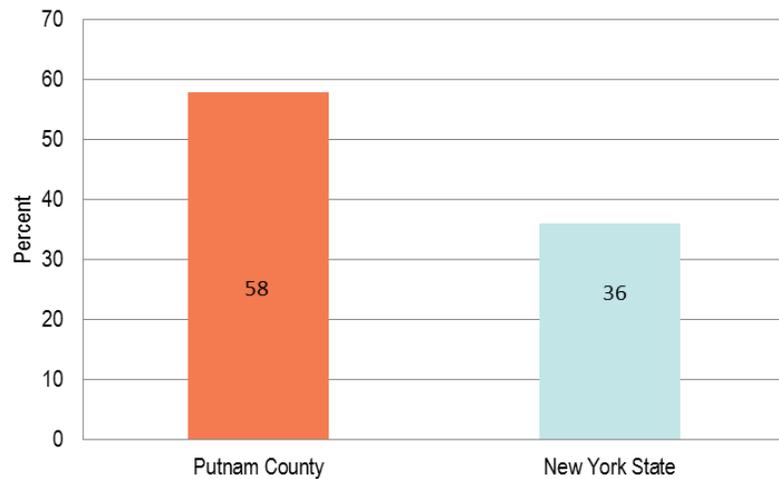
ASSAULT-RELATED HOSPITALIZATION



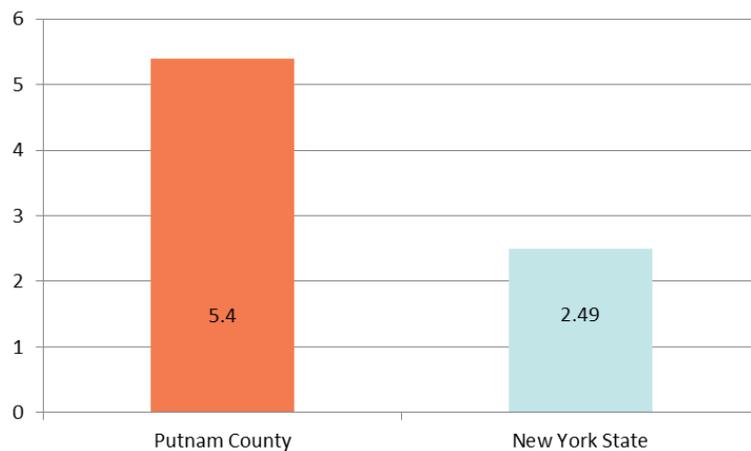
HOUSING INSECURITY



DRIVING ALONE WITH LONG COMMUTE TIME



LOW INCOME AND LOW ACCESS TO A GROCERY STORE



PHYSICAL ENVIRONMENT

Living in a healthy environment is a key factor to increasing the quality of life and health of residents. Community design, access to various health-related resources (healthy foods, parks and recreation), and exposure to air pollution and other toxic substances can all directly impact the health outcomes of a community.

Putnam County has the second highest rate of residents commuting more than 30 minutes, alone in a car. This exceeds the State rate and places these residents at an increased risk of developing an increased body mass index and hypertension. Commuting alone also contributes to traffic congestion and air pollution.

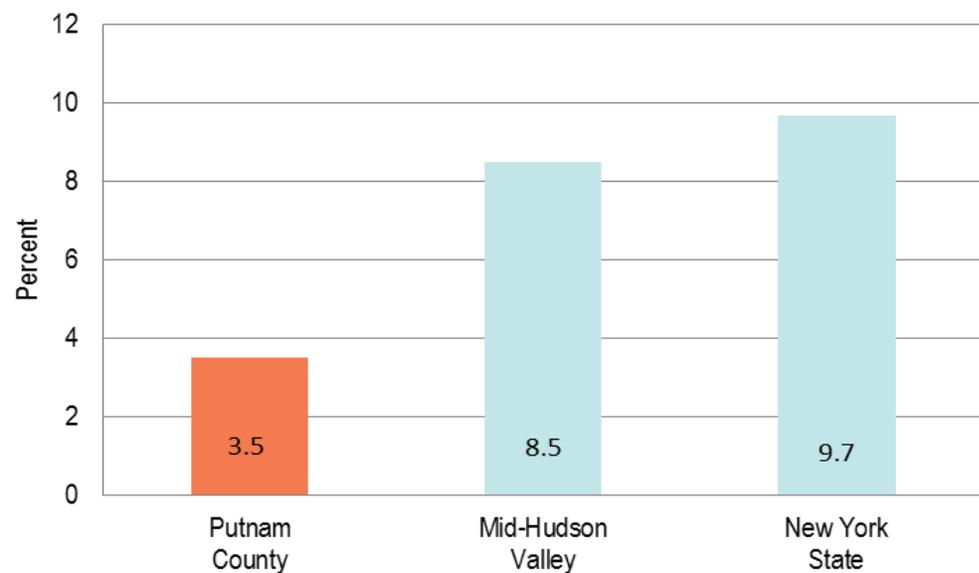
The percentage of Putnam residents who are low income and living more than 10 miles from a supermarket is more than double that of New York State and exceeds the Prevention Agenda goal of 2.24%. This is an important indicator of the built environment of a community because if residents can't access healthy and varied foods and live farther from a grocery store they have less food options that support a nutritious diet. Accessibility, availability and affordability are key components to all residents having a healthy diet.

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 United States. Health behaviors 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 for a healthier lifestyle and less chronic disease.

Learning to manage and live with a chronic disease improves quality of life and lowers health care costs. Putnam has lower reports of adults taking self-management courses for high blood pressure, arthritis or diabetes when compared to the Region and the State. This level rises to 11.4% in those over 65.

ADULTS WHO HAVE TAKEN COURSE TO MANAGE THEIR CHRONIC DISEASE OR CONDITION



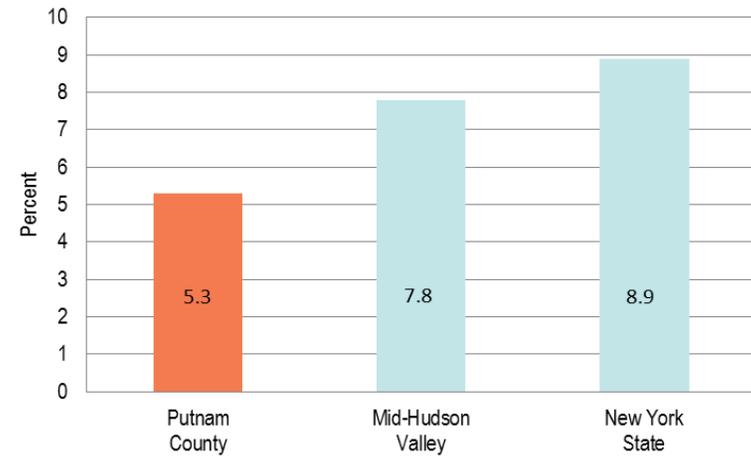
DIABETES

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.

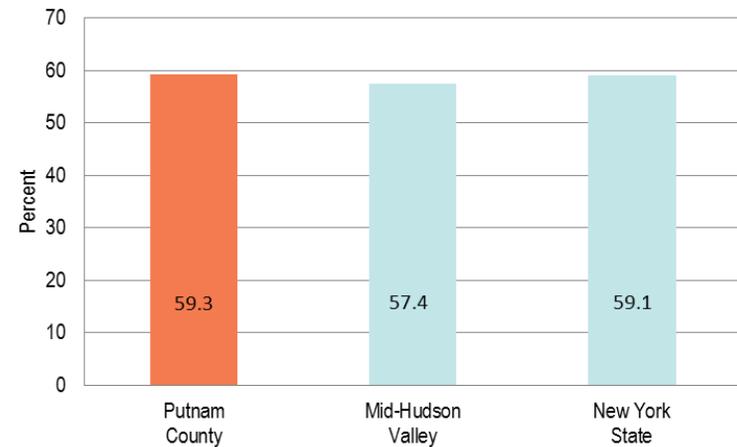
There are less reports of diabetes in Putnam adults compared to the Region and the State. When looking at those 65+, 22.7% of Putnam residents report a diabetes diagnosis versus 20.7% for the Region. With the aging population in Putnam these numbers are expected to continue to rise

Undiagnosed and poorly treated diabetes can have harmful effects on most of the major organ systems. Early diagnosis of diabetes and proper treatment can prevent or delay diabetic complications. More than half of Putnam residents are tested for diabetes which is similar to the State. When looking at testing in those 45-64 years old and 65+, the testing rises to about three quarters.

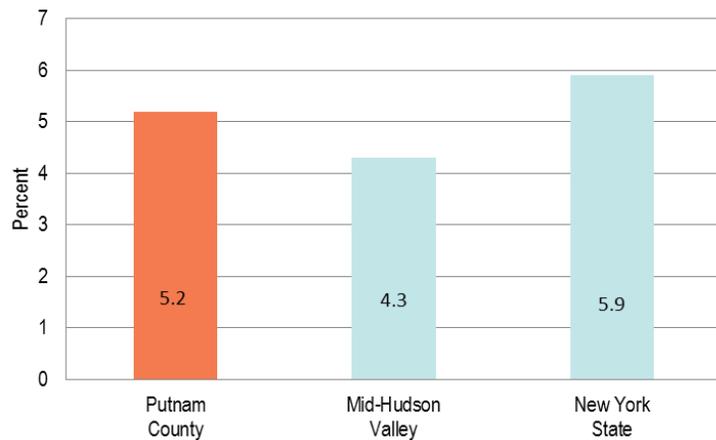
ADULTS WITH PHYSICIAN-DIAGNOSED DIABETES



ADULTS WITH TEST FOR HIGH BLOOD SUGAR OR DIABETES IN PAST 3 YEARS



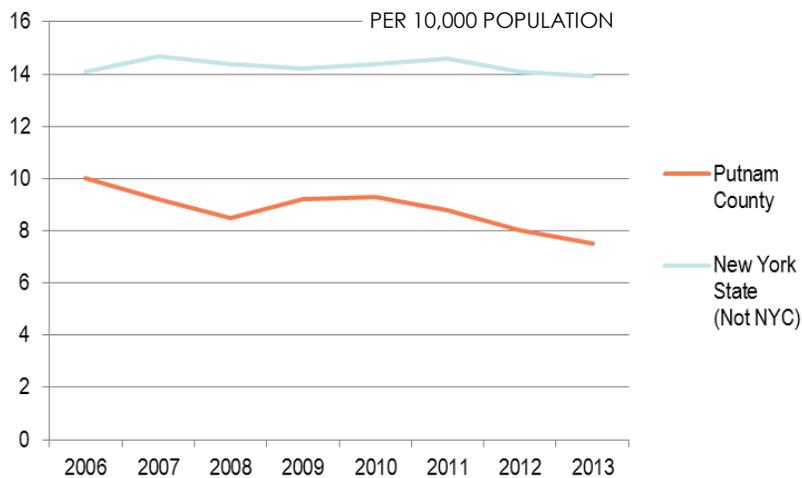
ADULTS WITH PHYSICIAN-DIAGNOSED PREDIABETES



A person with prediabetes has an elevated blood sugar that is higher than normal but not high enough to be diagnosed with diabetes. In those with prediabetes, losing weight and increasing physical activity can delay or even prevent the development of diabetes, improving long term health benefits. Residents in Putnam have similar levels of prediabetes as the State and higher levels than the Region.

Hospitalizations for those with diabetes (primary diagnosis) can be due to severe diabetes, diabetic complications or poorly managed diabetes. Regardless of the reason, managing diabetes in the outpatient setting is less costly and provides better outcomes for individuals. The rate of hospitalizations in Putnam has been declining over the past ten years. Putnam residents have lower rates of admission than New York State (without New York City). Recent data for the United States was not available but for 2009 the US rate was 21.5 per 10,000 which is higher than Putnam.

DIABETES HOSPITALIZATION 3-YEAR RATES



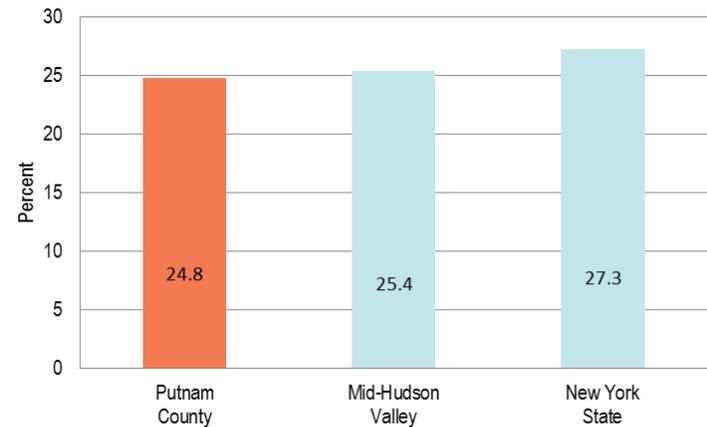
HEART DISEASE

Heart disease is the leading cause of death in Putnam and nationally. High blood pressure, elevated LDL cholesterol and smoking are all health behaviors that put someone at risk for heart disease, as well as the risk associated with having diabetes, obesity, poor diet and low levels of physical activity.

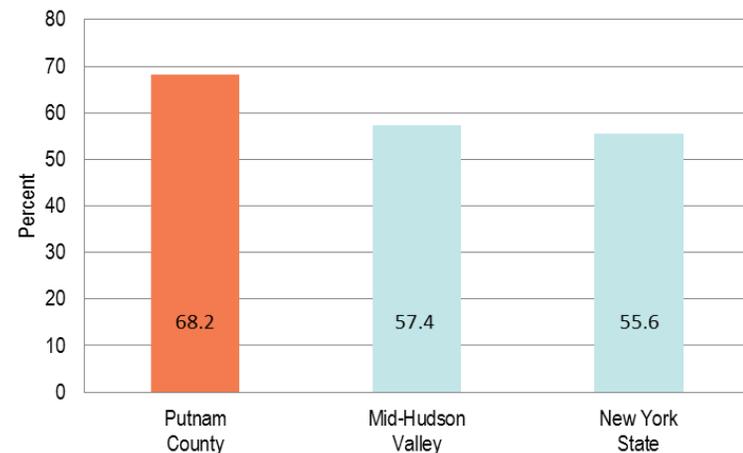
Putnam County has similar rates of physician diagnosed high blood pressure compared to the Region and a lower rate than the State. This meets the Healthy People 2020 target of 26.9%. When this is looked at in terms of age the level rises to 31.1% for those 45-64 years old and 55.3% for those 65+.

More Putnam residents who have physician diagnosed high blood pressure take medication than the Region and the State. This percent rises to 85.9% in those residents 45-64 years old and 93.9% in those 65+.

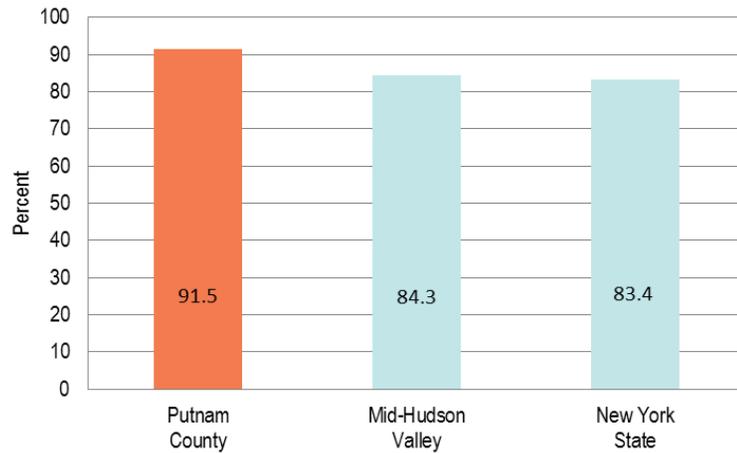
ADULTS WITH PHYSICIAN-DIAGNOSED HIGH BLOOD PRESSURE



ADULTS WITH PHYSICIAN-DIAGNOSED HIGH BLOOD PRESSURE TAKING BLOOD PRESSURE MEDICATION



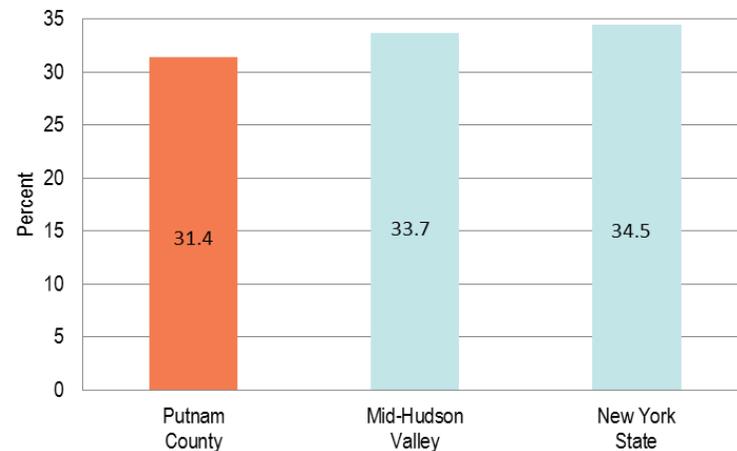
ADULTS WITH CHOLESTEROL CHECKED



More Putnam residents have their cholesterol checked by a health professional than the State and the Region. When this is looked at in terms of age the level rises to 97.7% for those 45-64 years old and 98.3% for those 65+. This exceeds the Healthy People 2020 target of 82.1%.

Putnam has lower levels of elevated cholesterol in comparison to the Region and the State. This does not meet the Healthy People 2020 target of 13.5%. When this is looked at in terms of age the level rises to 50.6% for those 45-64 years old.

ADULTS WITH ELEVATED CHOLESTEROL



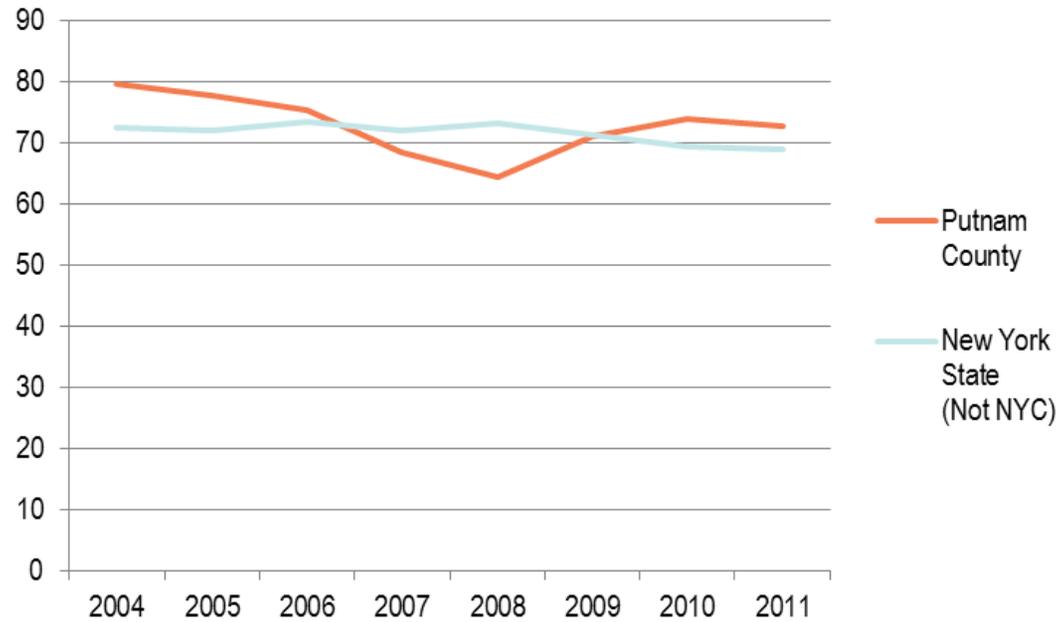
LUNG AND BRONCHUS CANCER

Cigarette smoking is the number one risk factor for developing lung cancer and according to the Centers for Disease Control and Prevention, 80-90% of diagnosed lung cancers are linked to smoking. Secondhand smoke and radon exposure also contribute to the development of lung cancer.

Putnam County had a greater incidence (newly diagnosed cases) of lung and bronchus cancer for the past three years. Despite smoking rates currently being similar to the State they have only recently decreased to these levels

and have usually been higher than the State. Putnam is considered to be a “high-risk radon zone” by the Environmental Protection Agency with elevated radon levels commonly occurring in homes.

LUNG AND BRONCHUS CANCER INCIDENCE PER 100,000 POPULATION

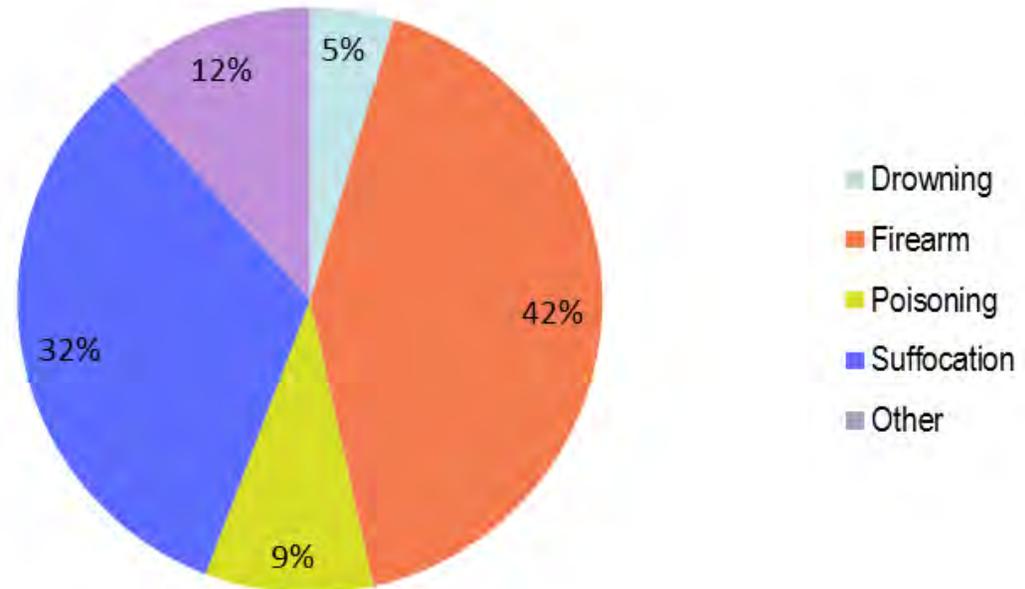


MENTAL HEALTH

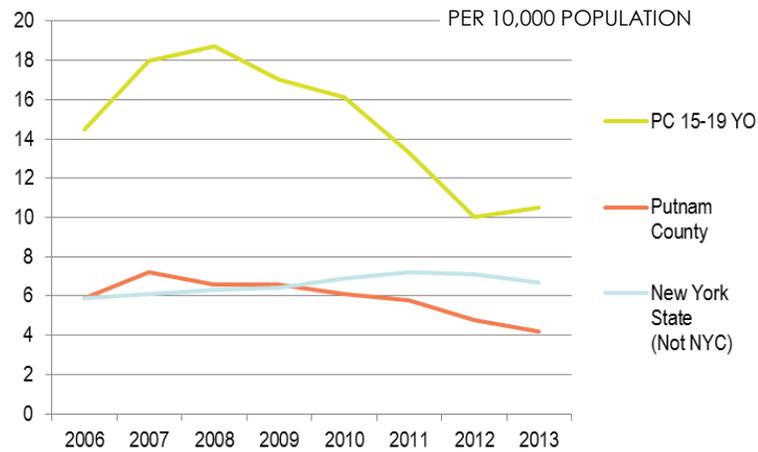
Mental health conditions, such as depression and anxiety, affect an individual's ability to engage in positive health behaviors. In turn, problems with physical health, such as chronic disease and risky behaviors, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

There have been 43 suicides in Putnam County between 2013 and November 2016. The leading cause of suicide is by firearm and then suffocation, including: hanging, asphyxiation and suffocation. This is similar to National trends.

2013-2015 SUICIDES BY CATEGORY



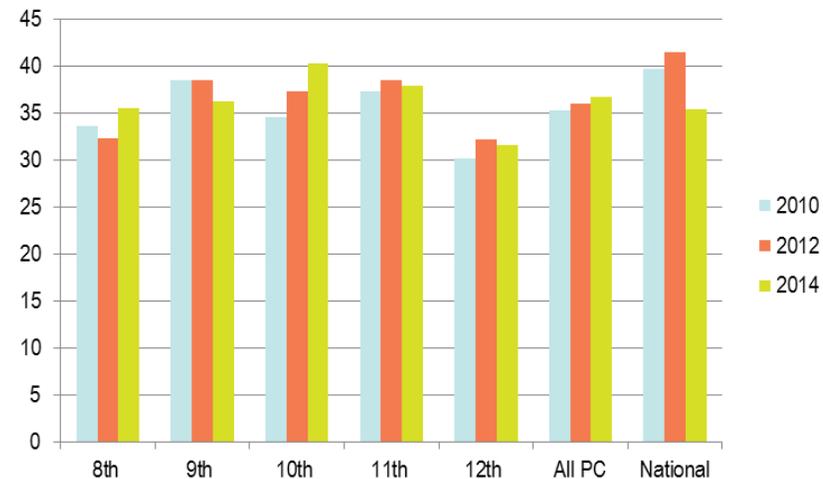
SELF-INFLICTED INJURY HOSPITALIZATION RATE



A self-inflicted injury occurs when someone intentionally harms them self, and there are many types of self-inflicted injury. A common reason for self-injury is to cope with emotional pain or deal with pressure and relationship issues. The self-inflicted injury hospitalization rate has been on the decline in Putnam County and is now lower than the State (without New York City) rate. Similar to the National trend, the 15-19 year old population has an increased incidence of self-inflicted injury which is also seen in Putnam County youth. There has been a decline in youth self-inflicted injuries over the past five years with an uptick for 2012-2014.

Middle and high school students face many challenges and increasing pressures to fit in and succeed. Teenage depression, which is sometimes hard to distinguish from “moodiness,” can lead to serious health problems and impact all aspects of a teen’s life. In Putnam County the percent of children reporting depressive symptoms has fluctuated over the past five years. For the 2010 and 2012 surveys, all grades had lower reports of depressive symptoms than the National average. In 2014 all grades and the Putnam total (excluding 12th grade) exceeded the National average. Of note, depressive symptoms were measured as depressed or sad most days over the past year.

DEPRESSIVE SYMPTOMS BY GRADE



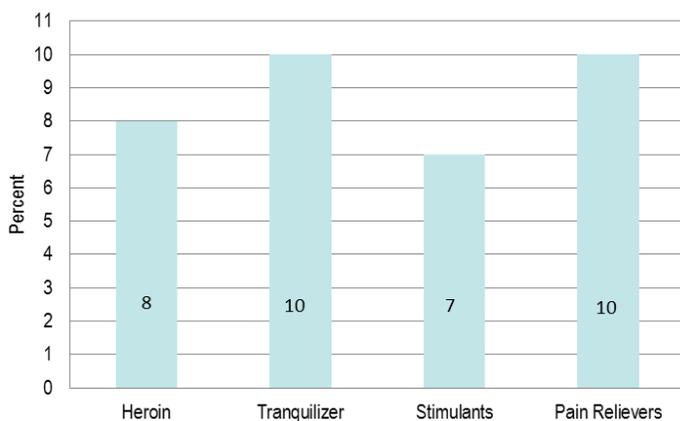
SUBSTANCE ABUSE

Substance abuse, whether from drugs or alcohol or both, has a significant impact on mental, physical, social and public health. There are also economic costs associated with the health issues, lost work productivity and criminal related costs. The current opioid epidemic highlights the complexity of this public health crisis and the inability of the public health system to prevent this from re-occurring.

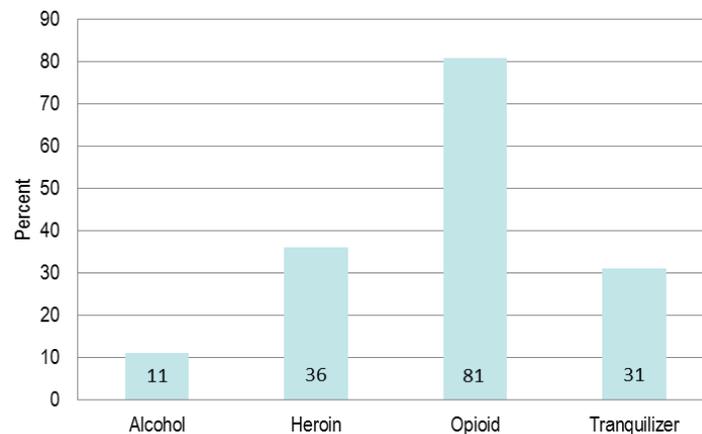
A local survey was conducted in the 18-25 year old population for the Partnership for Success grant. Results revealed that the use of prescription tranquilizers, stimulants and pain relievers, as well as heroin, are being used by 1 in 10 respondents. When compared to the middle and high school data previously reported, the rates increase dramatically. For heroin use there is a 1500% increase in use and for prescription tranquilizers there is a 525% increase in usage.

There were 36 overdose deaths between 2013 and 2015. The majority of the deaths involved opioid ingestion. A third involved either heroin or prescription tranquilizer ingestion. One in ten involved alcohol. Many drug overdose deaths involve mixed intoxication and 61% of these deaths were from multiple drugs and/or alcohol being ingested. Finally, 64% of these deaths were in those 25-54 years old.

ANY DRUG USE—PAST 30 DAYS YOUNG ADULT (18-25 YO)



OVERDOSE DEATHS 2013-2015



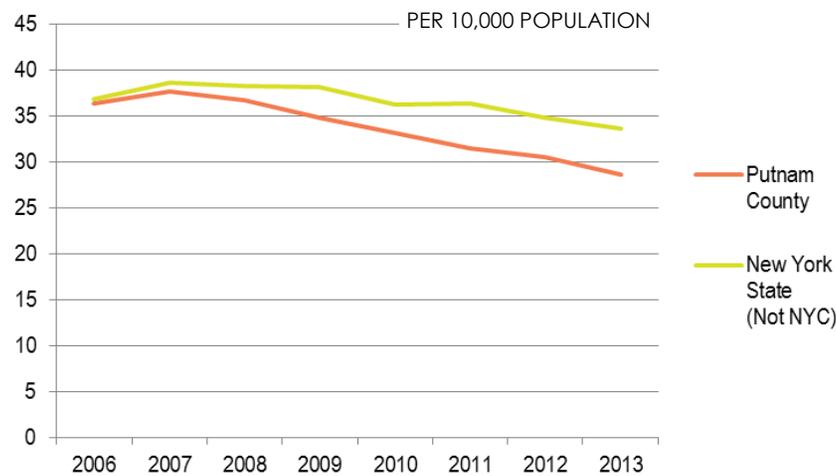
FALLS

For those 65 and older, falls are the leading cause of injury and hospitalization. According to the Centers for Disease Control and Prevention nearly one in five falls cause serious injury and one in three older adults fall each year. There are various causes for these falls but more research is showing that the risk for falls can be reduced.

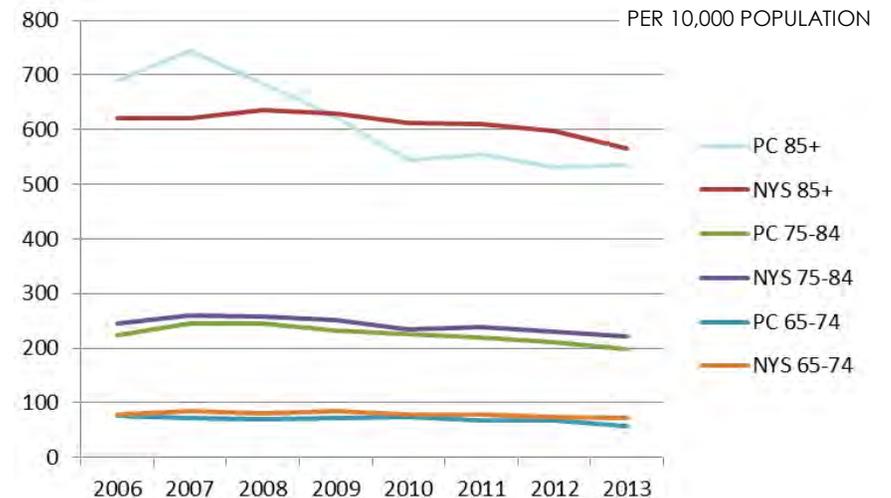
The rate of falls for all age groups has been on the decline in Putnam County. In comparison to the State (without New York City) Putnam has a lower fall rate and the difference in these rates has been increasing.

As with National trends the majority of hospitalizations occur in residents over 65 years old. The greatest rate of hospitalization is in those over 85+. Rates drop considerably for those 75 – 84 years old and then further drop for those 65 – 74 years old. Rates for all age groups below 65 are below the combined Putnam County rate. All Putnam County rates are below the State rates.

FALL HOSPITALIZATION RATE FOR ALL AGES



FALL HOSPITALIZATION RATE FOR RESIDENTS OVER 65 YEARS



Traumatic Brain Injuries (TBI) are caused by a blow to the head that disrupts the normal function of the brain. The severity of a TBI can be mild to severe, but according to the Centers for Disease Control and Prevention (CDC) most of the yearly TBIs would be considered mild and more commonly called concussions. The CDC reports that more than half of TBIs in children 0-14 years old (YO) were caused by falls. For those 65+ more than two-thirds of TBIs are caused by falls.

When looking at the rates of ED visits for TBIs in Putnam, the highest rates occur in children less than 19 YO. The highest rate overall was in children less than one year. The 15 – 19 YO, 1 – 4 YO, and 10 – 14 YO groups all have similar rates that are all above 1,000 per 100,000. Those 65+ had a higher rate of TBIs than the Putnam average but it did not exceed those in the pediatric population.

TRAUMATIC BRAIN INJURIES EMERGENCY DEPARTMENT (ED) VISITS 2011—2013

Population	Mean Annual Frequency	Rate per 100,000 Residents
Total Putnam County	622	624.0
0 – <1 YO	15	1,830.5
1 – 4 YO	45	1,159.1
5 – 9 YO	38	635.1
10 – 14 YO	73	1,033.7
15 – 19 YO	91	1,298.6
20 – 24 YO	40	718.0
25 – 44 YO	103	446.2
45 – 64 YO	105	321.3
65+	112	821.0

LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

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

THE TEN ESSENTIAL PUBLIC HEALTH SERVICES

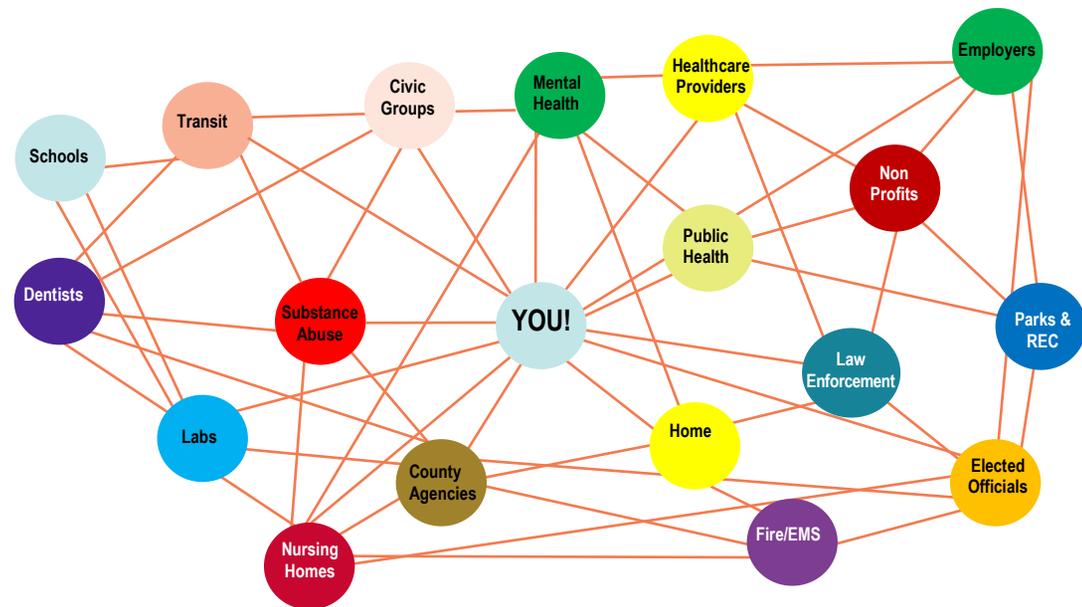
1. Monitor health status to identify community health problems
2. Diagnose and investigate health problems and health hazards
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships to identify and solve health problems
5. Develop policies and plans that support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



THE LOCAL PUBLIC HEALTH SYSTEM

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

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



ASSESSMENT

This assessment will assist in identifying paths for improvement, ensuring the provisions of quality services, and the means for implementing more efficient responses to public health challenges.

The Local Public Health System Assessment helps to answer the questions:

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

METHODOLOGY

Putnam County conducted The National Public Health Performance Standards Program, a local public health system assessment, which is framed around the 10 Essential Public Health Services (EPHS). This program is used throughout the United States to evaluate the performance of local public health systems. It was developed in 2001 as a collaboration of the Centers for Disease Control and Prevention and the National Association of County and City Officials.

The assessment included model standards for each EPHS that describe the key aspects of an optimally performing public health system. Each model standard is followed by assessment questions that serve as measures of performance. Each individual's responses to these questions indicate how well the model standard, which portrays the highest level of performance, is being met. Partici-

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

pants responded to assessment questions using the response options above. These same categories are used in this report to characterize levels of activity for each Essential Service.

PROCESS

The assessment was conducted during multiple sessions with key community partners including: the Live Healthy Putnam Coalition, Community Health Needs Committee, Putnam County DOH staff and key informant partners representing the public health system. Sessions were organized by Essential Public Health Service. Scoring is based on the knowledge and perception of participants in each EPHS group. This perception may not always be a true reflection of activity that is or is not taking place in the county.

STRENGTHS

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

Number One Strength: ESSENTIAL SERVICE 4—Mobilize Community Partnerships to Identify and Solve Health Problems

- Strong community partnerships due to small county size with only one hospital, familiarity within community organizations.
- Focused coalitions that meet regularly are working on specific priorities: chronic disease, mental health, substance abuse and emergency preparedness.

Number Two Strength: ESSENTIAL SERVICE 1—Monitor Health Status to Identify Community Health Problems

- Utilization of the MAPP process with multi-faceted assessments strengthens resulting community needs assessment and strategic planning.
- 6th year of conducting the annual Public Health Summit, good venue to share data, discuss public health priorities, assess strengths and gaps in service.

SUMMARY OF ESSENTIAL PUBLIC HEALTH SERVICES SCORES		
EPHS1	Monitor health status to identify community health problems	91
EPHS2	Diagnose and investigate health problems and health hazards	73
EPHS3	Inform, educate, and empower people about health issues	72
EPHS4	Mobilize community partnerships to identify and solve health problems	96
EPHS5	Develop policies and plans that support individual and community health efforts	83
EPHS6	Enforce laws and regulations that protect health and ensure safety	78
EPHS7	Link people to needed personal health services and assure the provision of health	78
EPHS8	Assure a competent public and personal health care workforce	58
EPHS9	Evaluate effectiveness, accessibility, and quality of personal and population health services	44
EPHS10	Research for new insights and innovative solutions to health problems	46
OVERALL SCORE		72

Number Three Strength: ESSENTIAL SERVICE 5—Develop Policies and Plans that Support Individual and Community Health Efforts

- Community Health Improvement Plan includes specific targeted strategies at the individual and community level to improve health status of county residents.
- Town and county legislative policies have been enacted to improve residents' health.

CHALLENGES

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

Number One Challenge: ESSENTIAL SERVICE 9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population Health Services

- Most individuals identified the need for greater emphasis on evaluation in their agencies, but due to lack of staff and limited expertise in this area it is difficult to attain.
- Evaluation of services is often eliminated when staff vacancies arise and an already overtaxed workforce is asked to do more with less.

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

- There is no college or university within Putnam County to offer support in this area. Although there are strong alliances with universities outside of the county this ES would be improved with research expertise within the county.
- Most organizations, including the health department, have small staff with limited resources for research and development activities.

Number Three Challenge: ESSENTIAL SERVICE 8: Assure a Competent Public and Personal Health Care Workforce

- Decreased funding for staff development has curtailed workforce development and training, particularly in-person training.
- Time constraints due to lack of adequate staffing lead to decreased opportunities for training.

FORCES OF CHANGE ASSESSMENT

The most recent Forces of Change assessment was completed at the 2015 Public Health Summit. It was conducted as a brainstorming session with significant community partner discussion, looking for possible threats and opportunities. It identified forces—trends, factors or events—which will affect the health and quality of life of residents and the local public health system. These forces may be social, economic, political/legal, technological/scientific, environmental or ethical in nature. Although this assessment was formally conducted at the summit, these discussions are ongoing at committee and coalition meetings held throughout the year.

OVERARCHING THEMES

ACCESS TO CARE ISSUES

The Affordable Care Act aims to increase accessibility and affordability of health services. Locally, this has increased the number of individuals enrolled in a health insurance plan, but it has also resulted in higher co-pays and deductibles and increased costs for some. Limited availability of mental health therapists and providers is also a serious issue in the county. Quality of health services may also be in jeopardy with these changes. The shift toward a patient centered care model and electronic health records should help offset and correct quality issues down the line.

DISCUSSION DETAILS

SOCIAL FORCES	TREATS POSED	OPPORTUNITIES CREATED
Domestic Violence	<ul style="list-style-type: none"> Victims of violence don't have the ability to live healthily and safely in Putnam Many kids may turn to drugs when involved in violence at home or elsewhere 	<ul style="list-style-type: none"> We can create partnerships and coalitions to educate the public and make it easier for a person to leave an abusive environment (help with housing, substance abuse, etc.)
ECONOMIC FORCES	TREATS POSED	OPPORTUNITIES CREATED
Affordable Care Act	<ul style="list-style-type: none"> Increased costs for some Unknown future due to recent enactment Availability of mental health therapists, providers Higher co-pay for mental health services 	<ul style="list-style-type: none"> Decreased cost for some Greater access to care Mental health parity
Health Republic Bankruptcy	<ul style="list-style-type: none"> Small and Non-Profit companies may not be able to find affordable coverage for their employees 	<ul style="list-style-type: none"> FQHC sliding scale services
Essential Plan (EP)	<ul style="list-style-type: none"> Higher income residents excluded Small and Non-Profit company employees at risk for EP exclusion and staff reductions to afford insurance payments. May also need Broker or Navigator to take advantage of cost-sharing and tax credits 	<ul style="list-style-type: none"> Increased coverage for low income residents Cost-sharing and tax credits available to Small and Non-Profit companies.
Dental Insurance	<ul style="list-style-type: none"> High cost of service 	<ul style="list-style-type: none"> Federally qualified health clinics provide services on a sliding scale fee

OPIOID ADDICTION

The overprescribing of opioid-based pain medication has resulted in high rates of substance abuse throughout the county. Heroin addiction is at an all-time high and overdose rates in the county have increased at alarming rates. Narcan administration has without a doubt prevented deaths, but has not solved the root causes and the epidemic continues. There is targeted focus on community-based education and intervention to assist with these crises.

TRANSPORTATION AND HOUSING LIMITATIONS

The lack of quality transportation services in the county is a major stumbling block to accessing healthcare, quality food, and employment. The lack of adequate affordable housing for lower income households as well as those individuals with mental illness is also a major concern.

DISCUSSION DETAILS

POLITICAL/LEGAL FORCES	THREATS POSED	OPPORTUNITIES CREATED
Healthcare reform (ACA)	<ul style="list-style-type: none"> • Preventable readmissions will impact providers (reimbursement and penalties) • Patients who do not utilize services appropriately will have preventable hospital admissions • Substance abuse and mental health clients difficult to insure appropriate access 	<ul style="list-style-type: none"> • Increased number of residents with coverage • Value based payment system • Possibility for more collaborative discharge planning with all agencies
HIPAA	<ul style="list-style-type: none"> • There's not enough infrastructure to be Medicaid reimbursable which leads to uncertainty about the stability of the agency 	<ul style="list-style-type: none"> • Strategic partnering and coordinating helps provide more service to more people
Mentally Ill Within the Legal System	<ul style="list-style-type: none"> • There may not be enough funding and staff 	<ul style="list-style-type: none"> • Potential to bring back mental health court which leads to fewer mentally ill individuals in the prison system
Medicaid Redesign and DSRIP	<ul style="list-style-type: none"> • Five-day maximum stay at Rose House • Mental health care needs to be integrated into primary care 	<ul style="list-style-type: none"> • Safe place to stay provides those with mental illness and substance abuse issues chance to recover • Close surveillance can identify those with depression and other mental illnesses sooner
Money Follows the Person (MFP)	<ul style="list-style-type: none"> • Not enough housing in its current state 	<ul style="list-style-type: none"> • MFP gets people out of nursing homes and into where they want to be • Foreclosed and abandoned homes can be renovated into affordable homes

DISCUSSION DETAILS

TECHNOLOGICAL/ SCIENTIFIC FORCES	THREATS POSED	OPPORTUNITIES CREATED
Opioid Epidemic	<ul style="list-style-type: none"> • Pain needs to be managed and opioid based pain relievers provide the best pain management 	<ul style="list-style-type: none"> • Non-physician pain management assistance can begin to be instated • Alternative pain relievers that are less addictive are being administered
Addressing Addiction in Putnam County	<ul style="list-style-type: none"> • Narcan funding may not be sustained • Addiction and abuse continue in prisons even after the user is incarcerated 	<ul style="list-style-type: none"> • Narcan training is available to anyone • Fixes the overdose problem briefly but does not solve the epidemic
Telemedicine	<ul style="list-style-type: none"> • Unreliable practitioners may take advantage to make a profit • Deceit and decreased health 	<ul style="list-style-type: none"> • More rural areas have access to very highly specialized care
Community Paramedicine	<ul style="list-style-type: none"> • Putnam is an aging community and there is more need than ever for ER visits from our population 	<ul style="list-style-type: none"> • Offers successful glucose and vitals monitoring • Doctors can partner with this program and keep individuals out of the ER
ETHICAL FORCES	THREATS POSED	OPPORTUNITIES CREATED
Housing for the Homeless Population	<ul style="list-style-type: none"> • People with mental illness often have co-morbidities such as substance abuse and chronic diseases 	<ul style="list-style-type: none"> • Search For Change offers housing opportunities for homeless with a set of regulations that the client must meet in order to be considered
ENVIRONMENTAL FORCES	THREATS POSED	OPPORTUNITIES CREATED
Transportation Limitations of Suburban/Rural Community	<ul style="list-style-type: none"> • Aging population is unable to access healthcare due to lack of transportation 	<ul style="list-style-type: none"> • Use of technology and telehelp to reach patients who cannot access healthcare due to lack of transportation

PHASE FOUR: STRATEGIC ISSUES

During this phase of the MAPP process, Putnam County DOH, Putnam Hospital Center, and many community agencies and partners identified the most important issues facing the community. Priorities were selected by exploring the convergence of the results of the four MAPP Assessments, partner input and review of priorities selected during the previous CHIP process.

Promote Mental Health and Prevent Substance Abuse was again selected as a Putnam County CHIP priority. Within this priority, preventing suicides among youth and adults, with emphasis on veterans, is a focus area. The Suicide Prevention Task Force is spearheading these efforts toward zero suicides. Promoting mental, emotional and behavioral well-being in the community is another focus area which falls within this priority.

Prevent Chronic Disease remains the second of three identified Putnam County CHIP priorities. Selected focus areas include reducing obesity in children and adults, preventing

childhood obesity through partnership with early childcare centers and schools, prevention and cessation of tobacco use, and chronic disease prevention and management.

Through discussions with Putnam Hospital Center and the Putnam County Office for Senior Resources, a third priority has been added to the CHIP this year—Promote a Healthy and Safe Environment. More specifically the focus is to “Reduce Factors that Increase Risk of Falls, Particularly Among the Elderly” and both agencies are already involved in planning programs to prevent falls in the elderly population. A county committee is being formed to identify evidence-based initiatives that will help support the efforts and extend the reach of these programs.

PHASE FIVE: FORMULATE GOALS AND STRATEGIES

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



PRIORITY AREA: PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE

FOCUS AREA: Promote Mental, Emotional and Behavioral Well-Being

GOAL: Improve the Mental Health of Residents and Decrease the Suicide Rate.

Outcome Objective 1: By December 31, 2018, decrease the percentage of adults reporting poor mental health by 5%. (Baseline: 17.6%; Source eBRFSS)

Outcome Objective 2: By December 31, 2018, decrease the number of residents that commit suicide to zero. (Local data)

Intervention	Best Practice/ Evidence- Based	Addresses Disparity	Activities	By When	Partner Resources / Partner Role	Process Measures
Prevent suicides among youth and adults	Y	Y	Offer gatekeeper training: SafeTALK, ASIST, Restrict Means & Crisis Intervention Training	Ongoing	Suicide Prevention Taskforce – Lead PHC, MHA , PCCAC & PCDOH – Partners	# of persons trained in SafeTALK, ASIST, Restrict Means & Crisis Intervention Training
			Share data on suicides, attempts, and prevention efforts	Ongoing	PC Coroner – Lead PCDOH, SPTF, PHC – Partners	
			Connect suicide postvention training	Q3 2017	SPTF & Mental Health Provider Group – Lead	# of meetings to develop system
Promote mental, emotional, and behavioral wellbeing in community.	Y	Y	Support the provision of basic mental health “first aid” training for youth and adults.	Ongoing	PC Mental Health – Lead SPTF, PHIP, PHC & PCDOH – Partners	# of adult Mental Health First Aid Trainings Provided # of youth Mental Health First Aid Trainings Provided

PHC – Putnam Hospital Center PCDOH – Putnam County Department of Health SPTF – Suicide Prevention Taskforce MHA – Mental Health Association
PCCAC – Putnam County Child Advocacy Center PHIP – Population Health Improvement Project

PRIORITY AREA: PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE

FOCUS AREA: Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders

GOAL: Prevent Drug and Alcohol Initiation and Decrease Substance Abuse.

Outcome Objective 1: By December 31, 2018, decrease the number of substance abuse related deaths to zero. (Baseline: TBD; Source: Local data)

Intervention	Best Practice/ Evidence- Based	Addresses Disparity	Activities	By When	Partner Resources / Partner Role	Process Measures
Prevent underage drinking, non-medical use of prescription pain relievers by youth and excessive alcohol consumption by adults.	Y	Y	Community-based prevention education: Too Good For Drugs	Ongoing	PFCS – Lead Mahopac Central School District, Putnam Valley Central School District, Haldane Central School District, and Garrison Central School district – Partners	# of community based prevention education sessions held
			Supply reduction and diversion control: Medication Take Back Day	Ongoing	PCCTC – Lead PCDOH, PHC & PCSD – Partners	# of Medication Take Back Day events # of pounds of medication returned
			Harm reduction including Naloxone training	Ongoing	Arms Acres – Lead Drug Crisis in our Backyard, PCSD, PCCTC & PCDOH – Partners	# of Naloxone trainings provided
			Share data on drug overdose deaths, attempts, and usage of Naloxone	Ongoing	PC Coroner – Lead PHC, Local Law Enforcement, PCDA, PCDOH, SPTF, Partnership for Success – Partners	
			Social marketing campaign: youth and young adult perceptions that prescription drugs have immediate and serious consequences.	Ongoing	Partnership for Success – Lead NCADD, PCCTC, LHP & SPTF – Partners	# of public service announcements and billboards # of newspaper display ads # of social media page views # of posters distributed

PFCS – Putnam Family & Community Services PCCTC – Putnam County Communities That Care Coalition PCDOH – Putnam County Department of Health LHP – Live Healthy Putnam

PCSD – Putnam County Sheriff's Department SPTF – Suicide Prevention Taskforce PCDA – Putnam County District Attorney PHC – Putnam Hospital Center

PRIORITY AREA: PROMOTE MENTAL HEALTH AND PREVENT SUBSTANCE ABUSE

FOCUS AREA: Strengthen Infrastructure						
GOAL: Strengthen Infrastructure for Mental Emotional and Behavioral Health Promotion and Disorder Prevention						
Outcome Objective 1: By December 31, 2018, develop a shared purpose and identify Suicide Prevention Taskforce goals.						
Intervention	Best Practice/ Evidence- Based	Addresses Disparity	Activities	By When	Partner Resources / Partner Role	Process Measures
Conduct a Strategic Planning Process	N	N	Meet with Suicide Prevention Taskforce partners to complete the Strategic Planning process	Q4 2017	SPTF & SPC of NYS – Lead Suicide Prevention Taskforce Members – Partners	Development of a Strategic Plan
SPTF – Suicide Prevention Taskforce SPC of NYS – Suicide Prevention Center of NYS						

PRIORITY AREA: PREVENT CHRONIC DISEASES

FOCUS AREA: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings.
GOAL: Promote Evidence-Based Care to Prevent and Manage Chronic Diseases

Outcome Objective: By December 31, 2018, increase percentage of Putnam County adults with one or more chronic diseases who have attended a prevention or self-management program by 5%. (Baseline: 3.5%; Source: eBRFSS)

Intervention	Best Practice/ Evidence- Based	Addresses Disparity	Activities	By When	Partner Resources / Partner Role	Process Measures
Promote the use of evidence-based interventions (EBI) to prevent or manage chronic disease	Y	Y	Provide training/refresher training to maintain adequate number of facilitators	Q1 2017	PCOSR & VNA – Co-Leads PCOSR & VNA – Staff time PCOSR - Data	# of partners trained to facilitate an EBI
			Provide outreach to healthcare providers for EBI	Ongoing through Q4 2018	PCDOH – Lead (data) PHC – Partners PCDOH & PHC – Staff Time	# of outreach events
			Promote EBI interventions for chronic disease prevention or self-management	Ongoing through Q4 2018	PCOSR, PCDOH, PHC & VNA – Leads & Staff time	# of marketing initiatives
			Offer chronic disease prevention or self-management EBI programs to community	Ongoing through Q4 2018	OSR, PCDOH, PHC & VNA – Leads & Staff time Community Peer Leaders – Partners	# of chronic disease EBI's offered by community partners # of EBI participants
PCOSR – Putnam County Office of Senior Resources VNA – Visiting Nurse Association of Hudson Valley PCDOH – Putnam County Department of Health PHC – Putnam Hospital Center						

PRIORITY AREA: PREVENT CHRONIC DISEASES

FOCUS AREA: Reduce Obesity in Children and Adults

GOAL: Prevent Childhood Obesity Through Child Care

Outcome Objective: By December 31, 2018, increase implementation of evidenced-based nutrition education and obesity prevention interventions in the child care, school and community-based settings in Putnam County by 5%. (Baseline: TBD; Source: Local data)

Intervention	Best Practice/ Evidence- Based	Addresses Disparity	Activities	By When	Partner Resources / Partner Role	Process Measures
Encourage child care providers, schools and community-based organizations to implement best-practice nutrition education and obesity prevention strategies.	Y	Y	Implement the USDA “Seed to Supper” (Oregon University-based) initiative with community-based organizations in Putnam County focusing on low SES populations.	Q4 2017	CCE – Lead Eat Smart New York, Studio Around the Corner, Brewster Library, Patterson Library, PCDOH, PCCAP, Camp Herrlich, The Longview School, WCC Davis Scholars – Partners	# of small-spaced gardens planted; # of lbs. of fresh vegetables donated to pantries and soup kitchens # of participating youth willing to try new vegetables.
	Y	N	Utilize the USDA “Dig-In Program” to implement gardens with 5 th and 6 th graders in after-school programs as well as interested summer camps.	Q4 2017	CCE – Lead Camp Herrlich & PCDOH – Partners	# of children who successfully grow and eat their own vegetables.
	Y	N	Investigate utilization of the USDA “Garden Detective” Program with interested 3 rd and 4 th grade children.	Q4 2017	CCE – Lead Kent Primary School, Carmel Girl Scout Troop 1086 & PCDOH – Partners	# of children who successfully grow and eat their own vegetables.

CCE – Cornell Cooperative Extension PCDOH – Putnam County Department of Health PCCAP – Putnam County Community Action Program WCC – Westchester Community College

PRIORITY AREA: PREVENT CHRONIC DISEASES

FOCUS AREA: Reduce Obesity in Children and Adults

GOAL: Expand the Role of Public and Private Employers in Obesity Prevention

Outcome Objective: By December 31, 2018, decrease by 5% the number of adults who are overweight or obese. (Baseline: 20.5%; Source: eBRFSS)

Intervention	Best Practice/ Evidence-Based	Addresses Disparity	Activities	By When	Partner Resources / Partner Role	Process Measures
Work with worksite wellness partner organizations to implement *nutrition standards at meetings and events	Y	N	Provide each partner worksite with* NYSDOH food and beverage standards for meetings and events	Q2 2017	PCDOH – Lead (data) Worksite Wellness Committees – Partners	# of worksites to receive NYSDOH food and beverage standard guidelines
			Educate Wellness Committee about benefits of food and beverage standards for meetings and events.	Q2 2017		# of Wellness Committees to receive education of food and beverage standard benefits
			Educate employees about benefits of standards through Wellness Board displays	Q3 2017		# of Wellness Board display sites
			Provide policy template for food and beverage standards to worksite partners	Q4 2017		# of worksites to implement a wellness policy for food and beverages at meetings and events.

PCDOH – Putnam County Department of Health

*http://www.health.ny.gov/diseases/cardiovascular/heart_disease/toolkits/docs/meetings_events.pdf

PRIORITY AREA: PREVENT CHRONIC DISEASES

FOCUS AREA: Reduce Illness, Disability and Death Related to Tobacco use and Secondhand Smoke Exposure

GOAL: Prevent Initiation of Tobacco Use by Youth and Young Adults

Outcome Objective: By December 31, 2018, decrease youth smoking rate by 5%. (Baseline: 7.1%: Source: Putnam County Prevention Needs Assessment)

Intervention	Best Practice/ Evidence-Based	Addresses Disparity	Activities	By When	Partner Resources / Partner Role	Process Measures
Encourage municipalities to implement policies that protect youth from tobacco marketing in the retail environment, also known as point-of-sale (POS)	Y (NYSDOH Refresh Chart Page 4 of 42)	Y	Participate in annual statewide coordinated earned media activities, including Kick Butts Day, World No Tobacco Day and the Great American Smoke-Out	Q1 2017	POW'R – Lead PCDOH – Partner	# of media campaigns
			Utilize social media including Facebook and Twitter to communicate key messages	Ongoing	POW'R – Lead PCDOH – Partner	# social media posts
			Testify at public hearing about the impact of retail tobacco marketing on youth.	Q4 2017	POW'R – Lead PCDOH – Partner LHP Partners – Support	# of public meetings attended # of county and/or town officials contacted about restricting tobacco marketing in stores
			Educate and communicate with elected officials about the impact of retail tobacco marketing in youth.	Q3 2017	POW'R – Lead PCDOH – Support LHP Partners – Partner	# of municipalities that implement policies.
POW'R – Putnam Orange Westchester & Rockland Counties PCDOH – Putnam County Department of Health LHP Partners – Live Healthy Putnam Coalition Partners						

PRIORITY AREA: PREVENT CHRONIC DISEASES

FOCUS AREA: Reduce Illness, Disability and Death Related to Tobacco use and Secondhand Smoke Exposure

GOAL: Prevent Initiation of Tobacco Use by Youth and Young adults

Outcome Objective: By December 31, 2018, decrease the percentage of adults who smoke. (Baseline: 20%; Source: POW'R survey)

Intervention	Best Practice/ Evidence- Based	Addresses Disparity	Activities	By When	Partner Resources / Partner Role	Process Measures
Encourage P.C. businesses, community based organizations and municipalities to implement policies that restrict smoking in outdoor areas.	Y	Y	Disseminate information at community events regarding the danger of second-hand smoke.	Q2 2017	POW'R – Lead PCDOH – Partner	# of community events
			Provide opportunities for allies to publicly support and call for action to increase the number of tobacco-free outdoor policies.	Q3 2017	POW'R – Lead PCDOH – Partner PC Legislature PC Town Supervisors PC Town Board Members	# of businesses & community based organizations and municipalities that implement policies restricting smoking in outdoor areas.
			Provide technical assistance and signage to area businesses, CBOs, etc. who want to adopt tobacco-free outdoor policies.	Ongoing 2017		
POW'R – POW'R Against Tobacco (Putnam Orange Westchester & Rockland Counties) PC – Putnam County PCDOH – Putnam County Department of Health LHP Partners – Live Healthy Putnam Coalition Partners						

PRIORITY AREA: PREVENT CHRONIC DISEASES

FOCUS AREA: Reduce Illness, Disability and Death Related to Tobacco use and Secondhand Smoke Exposure GOAL: Promote Tobacco Use Cessation, Especially Among Low SES Populations and Those with Poor Mental Health.						
Outcome Objective: By December 31, 2018, Increase the number of providers who deliver evidence-based assistance to their patients who smoke including brief counseling, medications and follow-up. (Baseline: TBD; Source: Center for a Tobacco Free Hudson Valley)						
Intervention	Best Practice/ Evidence- Based	Addresses Disparity	Activities	By When	Partner Resources / Partner Role	Process Measures
Promote the use of evidence-based tobacco dependence treatment among those who use tobacco.	Y (NYSDOH Refresh Chart Page 4 of 42)	Y	Provide the American Lung Association Freedom From Smoking Program to PC Employees	Ongoing	PCDOH – Lead Center for a Tobacco Free-Hudson Valley – Support	# of PC employees who participate in FFS Program
			Provide the American Lung Association Freedom From Smoking Program to PFCS Employees.	Ongoing	PFCS – Lead Center for a Tobacco Free-Hudson Valley & PCDOH – Support	# of PFCS employees who participate in FFS Program
			Provide the 5 A's to Arms Acres' Clients with an enhancement of the Assessment by using the Fagerstrom nicotine addiction scale, & then focusing on the Assist, utilizing NRT, MI counseling, & arrange for follow-up.	Ongoing	Arms Acres – Lead Center for a Tobacco Free-Hudson Valley – Partner	# of Arms Acres' clients who are Assisted , Referred, and then Follow-up by Arms Acres' Tracking Data
Utilize Electronic Medical Record (EMR) to increase the number of providers who screen patients for tobacco use and referral to NYS Smokers Quitline	Y	Y	Continue to work with Putnam Hospital Center and ensure tobacco cessation policies utilizing the electronic medical record are working effectively.	Ongoing	PHC – Lead ODB FQHC – Lead PCDOH – Support	# of PHC patients referred to NYS Smokers Quitline
			Provide the 5A's to ODB Federal Qualified Health Center patients, focusing on the Assist, Refer and Arrange for follow-up included in their EMR.	Ongoing	Center for a Tobacco Free-Hudson Valley – Partner NYS Smokers Quitline – Resource	# of ODB patients who are Assisted, Referred, and then followed-up by ODB Tracking data provided by ODB.
PHC – Putnam Hospital Center ODB FQHC – Open Door Brewster Federally Qualified Health Center PCDOH – Putnam County Department of Health						

PRIORITY AREA: PROMOTE A HEALTHY AND SAFE ENVIRONMENT

FOCUS AREA: Injuries, Violence and Occupational Health

GOAL: Reduce Factors that Increase the Risk of Falls, Particularly Among the Elderly

Outcome Objective: By December 31, 2018 reduce the number of hospitalizations of adults 65 years and older due to falls by 5%. (Baselines: 57.4 per 10,000 for 65 to 74 YO, 198.5 per 10,000 for 75 to 84 YO, 556.2 per 10,000 for 85+ YO; Source SPARCS data)

Intervention	Best Practice/ Evidence-Based	Addresses Disparity	Activities	By When	Partner Resources / Partner Role	Process Measures
Promote the implementation of Tai Chi for Arthritis	Y	Y	Promote and provide Tai Chi for Arthritis Workshops to Putnam County senior citizens	Ongoing	PCOSR – Lead, Staff Time & Data PCDOH & PHC – Partner	# of workshops offered # of people who completed Tai Chi for Arthritis program
			Form a subcommittee to explore other evidence-based fall prevention interventions	Q2 2017	PCDOH – Lead PHC, PCOSR & VNSW – Partners	EBI Selected

PCOSR – Putnam County Office for Senior Resources PCDOH – Putnam County Department of Health PHC – Putnam Hospital Center
VNSW – Visiting Nurse Service of Westchester and Putnam

PHASE SIX: ACTION CYCLE

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

The Live Healthy Putnam Coalition, Mental Health Provider Group, Putnam Hospital Center Community Health Needs Committee, Communities That Care Coalition, Suicide Prevention Task Force and the newly formed Fall Prevention Committee will plan, implement and monitor the progress

toward meeting the goals set forth in this plan. This will include a quarterly evaluation process whereby process measures will be tracked and interventions adjusted accordingly.

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

Successful achievement of this plan depends upon the continued commitment of all of our community partners and residents.



PARTNER INVOLVEMENT BY CHIP PRIORITY

Organizations	Prevent Chronic Diseases	Promote Mental Health and Prevent Substance Abuse	Promote a Healthy and Safe Environment
Advanced Chiropractic Wellness Care	√		
Akzonobel	√		
American Heart Association	√		
American Lung Association of the NE	√		
Arms Acres-Liberty Management		√	
Boxwood Alliance	√		
Brewster Central School District	√	√	
Camp Wilbur Herrlich	√	√	
Carmel Central School District	√	√	
Center for a Tobacco-Free Hudson Valley	√		
Center for Regional Healthcare Innovation	√	√	
Child Care Council of Dutchess & Putnam	√	√	
Cornell Cooperative Extension	√		
Drug Crisis in our Backyard		√	
Dunmore Corporation	√		
Dutchess County Department of Health	√	√	
Economic Development Corporation	√		
Fishkill Correctional Facility	√		

Organizations	Prevent Chronic Diseases	Promote Mental Health and Prevent Substance Abuse	Promote a Healthy and Safe Environment
Four Winds Hospital		√	
Garrison Union Free School District	√	√	
Green Chimneys		√	
Haldane Central School District	√	√	
Hannaford	√		
Health Quest	√	√	√
Hudson Valley Cerebral Palsy Association		√	
Hudson Valley Community Services		√	
Hudson Valley Farm to School	√		
HYGEIA Integrated Health LLC		√	
Kidz Country Day Care	√		
Live Healthy Putnam Coalition	√	√	√
Mahopac Central School District	√	√	
Maternal Infant Services Network (MISN)	√		
Mental Health Association of Putnam	√	√	
Mental Health Providers Group		√	
National Association of Mental Illness, PC		√	
NCADD, Putnam	√	√	

Organizations	Prevent Chronic Diseases	Promote Mental Health and Prevent Substance Abuse	Promote a Healthy and Safe Environment
New York State Health Foundation	√		
NYP-Lawrence Hospital	√		
NYS Department of Health	√	√	
Open Door Family Medical Center	√	√	
Orange County Department of Health	√	√	
P & N West. Women's Resource Center	√	√	
P.A.R.C		√	
Partnership for Success/NCADD/Putnam	√	√	
PC Board of Health	√	√	√
PC Bureau of Emergency Services		√	
PC Chamber of Commerce	√		
PC Child Advocacy Center		√	
PC Department of DSS, Mental Health		√	
PC Department of Health	√	√	√
PC Disaster Preparedness/Bioterrorism Taskforce		√	
PC Medical Reserve Corps	√	√	

Organizations	Prevent Chronic Diseases	Promote Mental Health and Prevent Substance Abuse	Promote a Healthy and Safe Environment
PC Office for People with Disabilities		√	
PC Office for Senior Resources	√	√	√
PC Parks & Recreation	√		
PC Planning Department	√		
PC Sheriff's Department		√	
PC Veterans Affairs		√	
PC Youth Bureau	√	√	
PEOPLE, Inc.		√	
Planned Parenthood Hudson Peconic	√	√	
POWR Against Tobacco	√		
Public Health Improvement Program	√	√	
Putnam Communities That Care Coalition	√	√	
Putnam Community Action Program	√	√	
Putnam County Courier	√	√	
Putnam Family & Community Services	√	√	

Organizations	Prevent Chronic Diseases	Promote Mental Health and Prevent Substance Abuse	Promote a Healthy and Safe Environment
Putnam Hospital Center	√	√	√
Putnam Independent Living Service	√	√	
Putnam Valley Central School District	√	√	
Putnam/Northern Westchester BOCES		√	
Reality Check	√		
Rockland County Department of Health		√	
Rockland County Office of Mental Health		√	
Rose House (PEOPLE)		√	
Search for Change	√	√	
St. Christopher's Inn	√	√	
Suicide Prevention Taskforce		√	
The Freight House Café	√		
Town of Carmel Parks & Recreation	√		

Organizations	Prevent Chronic Diseases	Promote Mental Health and Prevent Substance Abuse	Promote a Healthy and Safe Environment
Town of Kent Police Department		√	
Town of Patterson Library	√		
Ulster County Department of Health	√	√	
Unilock	√		
United Way of Westchester & Putnam	√		
VET2VET Program of Putnam		√	
Veterans Task Force		√	
Visiting Nurse Association of Hudson Valley	√	√	√
Westchester County Department of Health	√	√	

RESOURCES

Topic	Source	Note
Social Determinants of Health	Office of Disease Prevention and Health Promotion (ODPHP)	Healthy People 2020
Mobilizing for Action through Planning and Partnerships	National Association of County and City Health Officials (NACCHO)	
Community Asset Survey	Putnam County Department of Health (DOH) – 2016	MAPP Phase 3
Prevention Agenda	New York State DOH eBRFSS – 2013-2014 and Prevention Agenda (PA) 2013-2018	
Race or Ethnicity	United States (US) Census – 2015 QuickFacts	
Live or Work in Putnam County	Community Asset Survey – 2016	
Prevention Agenda Priorities	New York State DOH – 2013-2018	
Community Health Status Assessment	NACCHO	MAPP Phase 3
Community Characteristics	US Census – 2015 QuickFacts	
	US Census – 2010-2014 DP04 and DP05	
Social and Economic Factors	US Census – 2010-2014 DP03, S1501, S1701, S2501	
	New York State DOH – Community Health Indicator Report (CHIR) 2014	
	New York State Department of Education – 2014-2015	
	New York State DOH – 2011-2013 Vital Statistics	
	New York State DOH – 2011-2013 Statewide Planning and Research Cooperative System	
2014 All Diseases Mortality – Top 9 Causes	New York State DOH – 2014 Vital Statistics Table 40	
	Centers for Disease Control and Prevention (CDC) – Health, United States, 2015	
Chronic Disease 3-Year Mortality Rates	New York State DOH – 2014 Vital Statistics	
	New York State DOH – 2003-2012 Cancer Registry Data (CHIR)	
	New York State DOH – 2003-2014 Vital Statistics (CHIR)	
Injury and Violence 3-Year Mortality Rates	New York State DOH – 2005-2014 Vital Statistics (CHIR)	Homicides*
Maternal and Infant 3-Year Mortality Rates	New York State DOH – 2005-2014 Vital Statistics (CHIR)	Maternal Mortality*
DATA NOTE:	* Fewer than 10 cases in numerator, caution when interpreting	

Topic	Source	Note
Adults Reporting Poor Physical Health (past 30 days)	ODPHP - 2016	
	New York State DOH Expanded Behavioral Risk Factor Surveillance System – 2013-2014	
	County Health Rankings and Roadmap – 2016	
Adults Reporting Poor Mental Health (≥ 14 Days)	ODPHP – 2016	
	New York State DOH eBRFSS – 2013-2014 and PA Dashboard – 2016	
	County Health Rankings and Roadmap – 2016	
Adults Who are Obese	New York State DOH PA Dashboard – 2016 and eBRFSS – 2013-2014	
	ODPHP – 2016	
Adults Who are Overweight or Obese	New York State eBRFSS – 2013-2014	
	ODPHP – 2016	
Adults Who Participated in Leisure Time Activity	New York State eBRFSS – 2013-2014	
	ODPHP – 2016	
Adult Consumption of Fruits and Vegetables	New York State BRFSS – 2009	
Food Insecurity	HealthlinkNY – Community Dashboard – 2016	
	County Health Rankings and Roadmap – 2016	
Chlamydia Incidence (2014)	New York State DOH PA Dashboard – 2016	
	Putnam County Department of Health – 2016	
	CDC Sexually Transmitted Diseases Surveillance – 2015	
Syphilis Incidence (2014)	New York State DOH PA Dashboard – 2016	
	Putnam County Department of Health – 2016	
Adult Binge Drinking	New York State eBRFSS – 2013-2014	Males**
	ODPHP – 2016	
DATA NOTE:	** Wide confidence interval, caution when interpreting	

Topic	Source	Note
Adolescent Binge Drinking	Prevention Needs Assessment – 2010-2014	
Adolescent Drug Use Past 30 Days (Percent)	Prevention Needs Assessment – 2010-2014	
Smoking, All Adults	New York State DOH eBRFSS – 2013-2014	
Smoking, Adults Reporting Poor Mental Health	New York State DOH eBRFSS – 2013-2014	
Electronic Cigarette Discussion	POW-R Against Tobacco – 2015	
Youth Smoking (Percent by Grade)	Prevention Needs Assessment – 2012-2016	
Health Care System Assets	Putnam County DOH Resource List – 2016	
	County Health Rankings and Roadmap – 2016	
	HealthlinkNY – Community Dashboard – 2016	
Population Under Age 65 Without Health Insurance	US Census – 2013-2015 S2702	
	County Health Rankings and Roadmap – 2016	
	ODPHP – 2016	
Difficulty Accessing Health Care Due to Cost	HealthlinkNY – Community Dashboard – 2016	
	Putnam County Department of Health – 2016	
Adults Who Have a Regular Health Care Provider	New York State DOH PA Dashboard – 2016	
	ODPHP – 2016	
Preventable Hospitalization Rates	NYSDOH Sub-County Health Data Report for County Health Rankings – 2016	
Percent Children with 4:3:1:3:3:1:4 Immunization Series	New York State DOH PA Dashboard – 2016 and NYS Immunization Information System	
Assault-Related Hospitalization	New York State DOH PA Dashboard – 2016 and SPARCS	
Housing Insecurity	New York State DOH eBRFSS – 2013-2014	
Driving Alone With Long Commute	County Health Rankings and Roadmap – 2016	
	HealthlinkNY – Community Dashboard – 2016	
Low Income and Low Access to a Grocery Store	County Health Rankings and Roadmap – 2016	
	HealthlinkNY – Community Dashboard – 2016	

Topic	Source	Note
Adults Who Have Taken Course to Manage Chronic DZ	New York State DOH eBRFSS – 2013-2014	
Adults With Physician-Diagnosed Diabetes	New York State DOH eBRFSS – 2013-2014	
Adults With Test for High Blood Sugar or Diabetes	New York State DOH eBRFSS – 2013-2014	
Adults with Physician-Diagnosed Prediabetes	New York State DOH eBRFSS – 2013-2014	
Diabetes Hospitalization 3-Year Rates	New York State DOH –2012-2014 SPARCS (CHIR)	
Adults With Physician-Diagnosed High Blood Pressure	New York State DOH eBRFSS – 2013-2014	
Adults With Physician-DX High BP Taking BP Medication	New York State DOH eBRFSS – 2013-2014	45-64 YO**
Adults With Cholesterol Checked	New York State DOH eBRFSS – 2013-2014	
	ODPHP – 2016	
Adults With Elevated Cholesterol	New York State DOH eBRFSS – 2013-2014	
Lung and Bronchus Cancer Incidence Per 100,000 Pop	New York State DOH –2003-2012 Cancer Registry (CHIR)	
Radon Levels in Putnam County	US Environmental Protection Agency	
	New York State DOH Radiological Health/Radon	
2013-2015 Suicides by Category	Putnam County Coroner – 2013-2015	
Self-Inflicted Injury Hospitalization Rate Per 10,000 Pop	New York State DOH –2004-2014 SPARCS (CHIR)	
Depressive Symptoms by Grade	Prevention Needs Assessment – 2010-2014	
Any Drug Use – Past 30 Days Young Adult (18-25 YO)	Partnership For Success – 2015	
Overdose Deaths 2013-2015	Putnam County Coroner – 2013-2015	
Fall Hospitalization Rate for All Ages Per 10,000 Pop	New York State DOH –2005-2014 SPARCS (CHIR)	
Fall Hospitalization Rate for Residents Over 65 Years	New York State DOH –2005-2014 SPARCS (CHIR)	
	CDC National Center for Injury Prevention and Control	
Traumatic Brain Injuries Emergency Department Visits	New York State DOH –2011-2013 SPARCS	
	CDC National Center for Injury Prevention and Control	
DATA NOTE:	** Wide confidence interval, caution when interpreting	

Topic	Source	Note
Ten Essential Public Health Services Wheel	CDC	
National Public Health Performance Standards Program	CDC	
	NACCHO	MAPP Phase 3
	Putnam County Local Public Health System	
Forces of Change	NACCHO	MAPP Phase 3
	Putnam County Local Public Health System	
Formulate Goals and Strategies	American Lung Association – Smoking Cessation Evidence-Based Interventions (EBI)	
	CDC – The Community Guide	
	County Health Rankings – What Works for Health EBI	
	NACCHO	MAPP Phase 5
	Natl Institutes of Health Office of Disease Prevention – Evidence-Based Programs and Practices (EBPP)	
	NYSDOH Bureau of Community Chronic Disease Prevention –Food Standards EBI	
	NYSDOH Prevention Agenda Refresh Chart – EBI	
	ODPHP – Healthy People 2020 Interventions and Resources	
	Substance Abuse and Mental Health Services Administration – National Registry of EBPP	
	United States Department of Agriculture Food and Nutrition Service – Educ and Obesity EBI	
	USDA FNS - Garden EBI	
Other General Sources Utilized	Gallatin City-County Health Department CHA and CHIP	
	Northern Kentucky Independent District Health Department CHA and CHIP	
	US Department of Health and Human Services National Prevention Strategy	
	US Department of Health and Human Services Community Health Status Report Card	