Healthy Ulster: A Public Health Approach

Building bridges to improve the health of Ulster County

Prepared by the Ulster County Department of Health, June 2010

Contents

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June 9, 2010

Dear Friends,

Shortly after taking office, I presented the goal of making Ulster County the healthiest county in New York. Achieving this goal requires forging strategic partnerships with a wide array of public and private stakeholders, including community, faith-based, education, youth, government, business, and public health groups. It also requires a transformation of the Ulster County Department of Health into an effective organization that will become fully capable of providing the leadership necessary to bring key individuals and organizations together to develop a plan of action, with measurable results.

"Healthy Ulster: A Public Health Approach" is the result of the Ulster County Health Department's transformation under the leadership of Dr. La Mar Hasbrouck. Over 100 community participants were brought together to help inform the ideas and priorities articulated in this plan.

We now have a solid road map that will guide us towards the goal of making Ulster County the healthiest county in New York State. I would like to offer a special recognition to Dr. Karnasiewicz for her efforts to improve public health in Ulster County. Additionally, I would like to thank everyone who has participated in this process and invite every Ulster County resident to take a personal stake in making Ulster County a healthier place to live, work and raise a family.

Very Truly Yours,

Michael P. Hein

Ulster County Website: www.ulstercountyny.gov

"My administration is committed to making Ulster County the Healthiest County in New York State."

Ulster County Executive Michael Hein

Introduction

As the lead public health agency for Ulster County, the Department of Health (UCDOH) will play a key role in helping to make Ulster one of the healthiest counties in New York.

In addition providing core public health services to the residents of the county, the UCDOH has firmly embraced the New York's statewide Prevention Agenda, thus putting a far greater emphasis on health promotion and disease prevention than in recent years.

Community health assessment, systematic use and dissemination of data, targeted programs/initiatives, tracking progress, and ongoing community engagement will be essential strategies for achieving the vision of a healthier Ulster County.

This report includes the following sections:

- Summary findings from the *Healthy Ulster Summit*
- Description of the Partners in Public Health (*PiPH*) Planning Councils
- Priority Health Indicators for Ulster County
- Report Card
- A narrative about next steps

Healthy Ulster Summit

For any strategy to be successful in improving the health of Ulster County, it must be supported by many individuals and organizations that care about the health of the community. On March 2, 2010 the UCDOH sponsored a *Healthy Ulster Summit* to provide a unique opportunity to gather a diverse group of community partners to work together to define the next steps for making Healthy Ulster a reality.

> *"We cannot galvanize a community response required to make Ulster County one of the healthiest counties in the state without hearing the voices of the leaders who are on the front lines."*
>
> *La Mar Hasbrouck, MD, MPH*
> *Public Health Director*

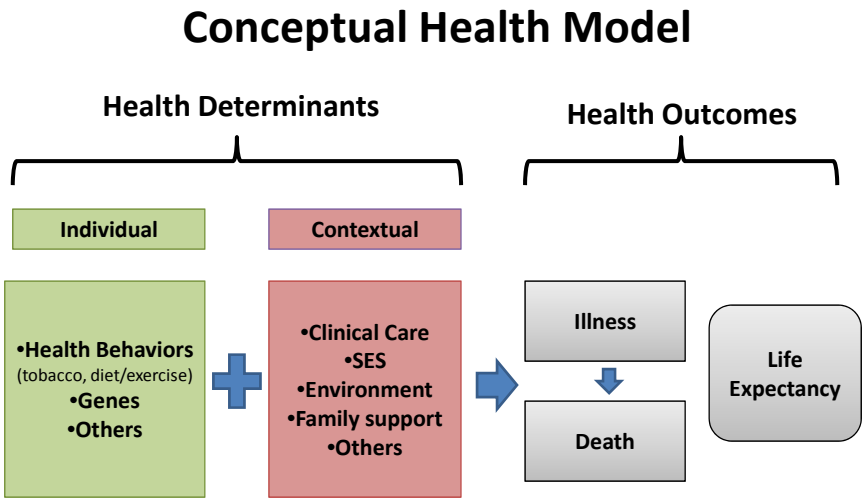
The half-day meeting attracted nearly one hundred public and private stakeholders, including community, faith-based, education, youth, government, business, and public health groups for a community conversation that helped shape the Department's Prevention Agenda.

During this meeting, the UCDOH reviewed health information for the county, including details from a recent report that ranked Ulster County 33rd in health outcomes and 30th in health factors compared to other counties (62) in New York State (www.countyhealthrankings.org/new-york). Brainstorming sessions about community health gaps and priorities, barriers to care, best (or promising practices), emerging trends, and discussions about available resources, were also on the agenda.

The health information presented was intended to give the diverse audience a "profile" of the health status of the community. This information was aimed at stimulating discussions between all participants through a shared fund of knowledge, regardless of their professional backgrounds and health-related exposures.

Importantly, a conceptual health model was presented. The model examined the relationship between health determinants (or risk factors) and health outcomes.

As discussed, health determinants include both individual factors and contextual factors. Some of the individual factors are modifiable, such as health behaviors (e.g., smoking, diet, risky sexual practices) while others are non-modifiable, such as a person's genetic background. Examples of contextual factors include access to and quality of clinical care services, social economic status, and environment.



The model suggests that individual and contextual-level factors combine in a complex way to determine health outcomes which can be measured in terms of illness, death rates, and ultimately life expectancy. It was explained that while outcome measures are important indicators of the health of communities, the health determinants hold the greatest promise for public health and community action. Activities, initiatives, and programs aimed at improving risk factors (e.g., lowering tobacco use, increasing access to quality healthcare) will result in improved health outcomes and heightened wellness for communities.

Health Profile

Following the description of the conceptual model, specific risk factor and outcome information for Ulster County was reviewed. The entire presentation is available upon request. Some selected slides are presented here.

Leading Causes of Death

Indicator	Number	Ulster County Rate	NYS Rate
Total	1,539	846.3	757.9
Heart disease	422	232.0	255.5
Lung cancer	99	54.4	48.3
Breast cancer	22	24.1	27.3
Cervical cancer	7	7.7	3.0
CVD	77	42.3	30.5
Unintent. Injury	65	35.7	25.5
Motor vehicle	31	17.0	7.3
Non-motor vehicle	34	18.7	18.2
Suicide	19	9.3	7.1
Cirrhosis	11	6.0	6.7

Source: NYSDOH, 2007

Leading causes of death for Ulster County, heart disease, cancer, and stroke, mirror the leading causes of death for NYS and the country.

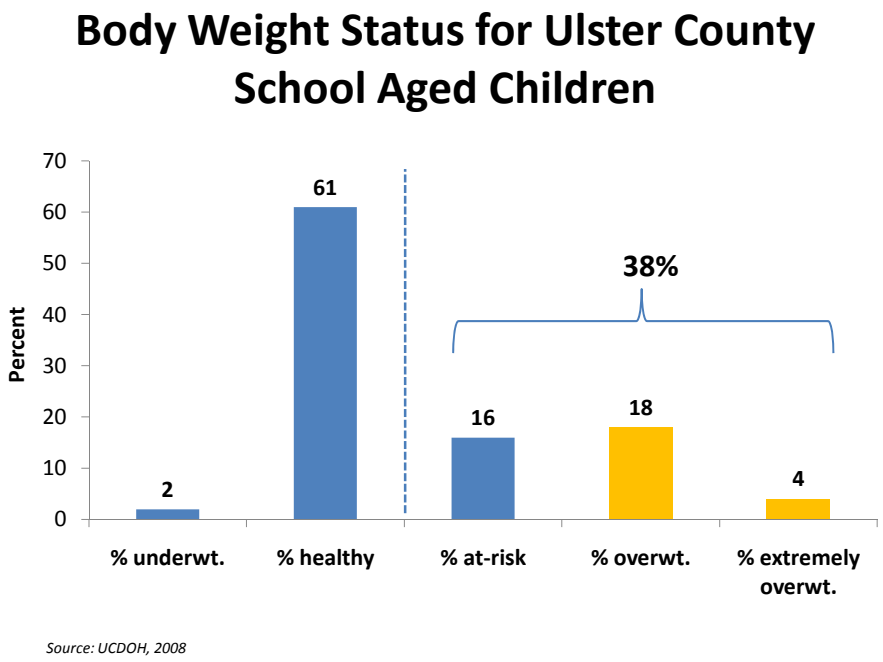
Chronic Disease: Obesity

- Based on self-reported height & weight: 35% normal weight
  - 34% overweight
  - 30% obese

  64% overweight/obese
- Yet, only 29% were advised to lose weight by their HCP
- And, only 55% described self as overweight

Source: HVRHON HEAL 9, NYSDOH

According to a recently conducted consumer health survey (HVRON HEAL 9, NYSDOH), 64% of adults surveyed were overweight or obese based on their reported height and weight. Yet only 29% were advised to lose weight by their health care provider; and, only 55% described themselves as overweight.



Source: UCDOH, 2008

A recent body mass index (BMI) study conducted by the UCDOH showed that among school aged children in first and third grades, 38% of students surveyed were at risk for being overweight, overweight, or extremely overweight.

The consumer health survey (above) also revealed that there is a concerning disconnect regarding important chronic diseases. Namely, persons that are aware of having diabetes or heart disease, but fail to see a health care provider for these conditions for prolonged periods of time. According to the survey, 10% of the adults reported that they were told by their health care provider that they had diabetes. Yet, 26% reported that they had not seen a health care provider (HCP) in the past year or longer. Seven percent reported being told that they had heart disease. Yet, 26% reported not seeing a HCP for heart related care for two or more years.

Cancer Deaths

Indicator	Ulster County Rate	NYS Rate
Oral	2.1	2.3
Colorectal	20.9	18.3
Lung	54.5	46.2
Skin	3.7	2.2
Breast	29.1	24.5
Ovary	11.3	8.7
Prostate	26.6	24.4

Source: NYSDOH, 2007

Cancer deaths in Ulster County have been above the rates for all of NYS. Of particular concern are the higher rates for skin, breast, and colorectal cancer. These types of cancer can be detected early through screening programs. For several types of cancer, including these, early detection greatly increases the likelihood that treatment will be successful.

Maternal and Child Care Birth Measures

Measure	Ulster County	NYS
Short gestation (<37 weeks)	10.4%	12.3%
Neonatal mort. (< 28 days)	4.5/1000	4.0/1000
Infant mort.	7.8/1000	5.8/1000
Very low birthweight (<1500 gms)	1.6%	1.6%
Low birthweight (<2500 gms)	8.3%	8.3%

Source: NYSDOH, 2004 -2006

Information about maternal and child birth measures (NYSDOH, 2004-2006) showed that Ulster County lags NYS in important outcomes, especially infant mortality.

Breakout Groups

Breakout groups followed the presentation of health information for Ulster County. Brainstorming sessions were organized around four concurrent facilitated tracks:

- Healthy Youth
- Healthy Seniors
- Healthy Women
- Healthy Places (Environments)

The participants in each group represented a diverse cross section of key individuals and organizations, including the YMCA, YWCA, Ellenville Regional Hospital, SUNY Ulster, United Way, Rondout Valley School District, Tobacco Free Action Coalition (TFAC), Cornell Cooperative Extension (CCEUC), UC Trials Advisory Committee, Maternal Infant Services Network, Healthy Start, Cancer

Services Program, Catskills Hudson AHEC, Rose Women's Care Center, Health Alliance of the Hudson Valley, Pegasus Athletic Sistem Care, Kingston School District, Pine Street Pediatrics, Family of Woodstock, SUNY New Paltz, Emergency One, Riverview Baptist Church, other community service organizations, county legislators, and several county agencies. A full list of participants (by breakout group) is included in **Appendix A**.

The charge was for each group to reflect the overall idea that in order to create a Healthy Ulster, the community must work collectively to promote and ensure healthy youth, healthy women, healthy seniors, and healthy places to live, work, and play. As such, groups were tasked with answering the following five questions from the perspective of youth, women, and seniors:

- What are the community health need, gaps, and priorities?
- What are the barriers to appropriate care?
- What are notable best (or promising) practices (or models) for meeting the needs of the community?
- What are the emerging trends that impact availability, affordability, and quality of care?
- What are the strengths and weaknesses in the public health care delivery system?

The group that focused on healthy environments used a slightly different framework for dialogue.

At the conclusion of the breakout sessions, each group reported out to all participants. The reports included a summary of their process, findings, and consensus recommendations for the UCDOH to consider for implementing a health promotion and prevention agenda. Listed below are summary tables for each group.

Healthy Youth			
Gaps	**Barriers**	**Best practices**	**Emerging trends**
Alternate sex educ.	Location	Healthy Start	Reduced funding
Coordination	Trust	YMCA, expanded	Disintegrated family
Parenting skills	Transportation	Kids Together	Pink poverty
Access healthy foods	Awareness	TFAC	Household heads
Mental health	Social stigma	Prevention Connections	Medicaid changes
Recommendations 1. Inventory of services for coordination and activation 2. Classroom on Wheels (COW) to improve access to services 3. Use of technology to access services			

Healthy Seniors			
Gaps	**Barriers**	**Best practices**	**Emerging trends**
Mental health	Insurance	Aging in place	Practitioner shortage
Specialists	Stigma	Skilled volunteers	Technology use
Aging in place	Myth of aging	Senior run centers	Medicare cuts
Pharmacy education	Rural providers	Retirement communities	Shortage specialists
Transportation	Home health aides	Senior clubs	Limited transportation
Recommendations 1. Improve management of medications (poly pharmacological) and improve case management. 2. Enhance in-home services (access to personal care aides, stay in place programs). 3. Shift from medical to wellness model - Aging successfully, develop infrastructure.			

Healthy Women			
Gaps	**Barriers**	**Best practices**	**Emerging trends**
Free cancer screening	No medical home	Health center model	Medicaid availability
Medical education	Funding	Worksite programs	More nutritional info
Transportation	Health literacy	Mobile clinics	Alternative exercise
Disease prevention	Mistrust, fear	Health policy	Elective c-sections
Reproductive health	Lack local services	Health education	Limited mental health
Recommendations 1. Public Partnerships- Directory of Existing Services- bringing all groups and agencies together 2. Community Needs Assessment 3. Community Healthcare Reform Forum for Ulster County			

Healthy Places (Environments)			
Gaps	**Barriers**	**Best practices**	**Emerging trends**
Education/Promotion	Weather	Technology	Increased technology
Funding	Access to schools	Volunteers	Tele-commuting
Senior services	Funding	Silver Sneakers, YMCA	Tele-medicine
Pediatric services	Liability issues	Aging in place	Green buildings
	Geography	Policy	Wellness promotion
Recommendations Continue dialogue to include the following key partners and organizations that were not present: youth, alternative medicine, first responders (e.g., fire, police, and rescue), arts, and agriculture.			

The transcript from each group is included in **Appendix B**.

Partners in Public Health

At the conclusion of the Summit, and for weeks to follow, numerous participants expressed a desire to stay actively engaged with the UCDOH. Most wanted to build on the successful dialogue and momentum established during the half-day meeting. Others wanted to explore ways to collaborate in an effort to "connect the dots" with ongoing and future UCDOH activities and initiatives related to the prevention agenda.

> *"As the lead public health agency for the county, we must reach out to partners in unprecedented ways."*
>
> *La Mar Hasbrouck, MD, MPH*

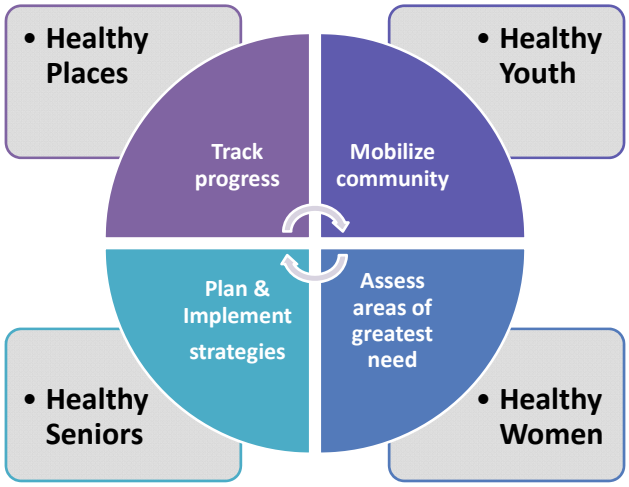
Several participants remarked that there had not been a successful forum for energetic collaboration from such a diverse group of community groups in the recent past and was long overdue. Many inquired about next steps in the cooperative planning process.

Likewise, recognizing the tremendous expertise, knowledge and experience of the participants, the UCDOH wanted to take advantage of the enthusiasm and interest to form community partnerships. Moreover, it was noted that several key member of the community were not present. However, a number of smaller conferences between the UCDOH and other key stakeholders confirmed that a more formal structure to facilitate community input would be beneficial.

This led to the development of the Partners in Public Health (*PiPH*) Planning Councils. The councils were established by reaching out to participants in the breakout groups as well as extending an invitation to other key community partners. The groups will be organized along the four thematic areas: youth, women, seniors, and environment.

The purpose of the *PiPH* planning councils is to have an established link with a dynamic core group of community individuals and organizations that will assist the Department with developing strategic direction for UCDOH health initiatives, activities, and campaigns related to the Prevention Agenda.

PiPH Planning Councils



The plan is for each group to meet with the UCDOH on a regular basis, likely quarterly. Members of the *PiPH* Planning Councils are included in **Appendix C**. However, membership is expected to be dynamic, with members rotating onto and off of the councils depending on their commitment to being a sustained part of the process, and the required expertise needed.

As a matter of process, the UCDOH will work with each planning council to "MAP-IT," that is, Mobilize, Assess, Plan, Implement, and Track, for each focal area. The MAP-IT approach is a strategy recommended by Healthy People 2010 (www.healthypeople.gov/publications/HealthyCommunities2001/) to help individuals, coalitions, and organizations work together to improve the health of their community.

In summary, **Mobilize** refers to mobilizing individuals and organizations that care about the health of Ulster County into a coalition. In our case, this coalition is called a planning council.

Assess refers to assessing the areas of greatest need in Ulster County, as well as the resources and other strengths that can be tapped into to address those areas. This work began with small conferences between the UCDOH and key

stakeholders, continued with the *Healthy Ulster Summit*, and will be an ongoing process with the *PiPH* planning councils.

Plan refers to planning an approach. The vision has been set by the County Executive, namely to make Ulster County the healthiest county in New York state. The *PiPH* planning councils will need to work together to add strategies and action steps to help achieve this vision.

After developing a plan of action, the UCDOH will begin to **implement** the plan (or our part of the plan) using concrete action steps that can be monitored on a regular interval.

The final step in the MAP-IT strategy is to **track** progress over time. To effectively track progress towards the overall goal of making Ulster County the healthiest in NYS, there must be established health indicators to measure over time. In addition, there must be a standardized, objective process for measuring such indicators. The UCDOH has established both a set of core priority indicators as well as a standardized grading system to monitor Healthy Ulster progress. This is the subject of the following two sections.

Priority Health Indicators

When evaluating and tracking the health of a community, there are many health indicators to consider. Health indicators include individual and contextual-level risk factors or markers (sometimes referred to as "determinants"), and health outcomes such as disease rates, death rates, and life expectancy.

Healthy People 2010 (HP 2010), a broad-based collaborative effort among Federal, State, and Territorial governments, and hundreds of private, public, and nonprofit organizations, has set national disease prevention and health promotion objectives to be achieved by 2010 (www.healthpeople.gov). The leading health indicators are:

- Physical Activity
- Overweight and Obesity
- Tobacco Use
- Substance Abuse
- Responsible Sexual Behavior
- Mental Health
- Injury and Violence
- Environmental Quality
- Immunization
- Access to Health Care

Similarly, the New York's Prevention Agenda identifies ten comparable priorities for improving the health of all New Yorkers (www.health.state.ny.us/prevention/prevention_agenda/). The goal of the Prevention Agenda is to prevent health problems before they occur, or before they worsen. The ten priority areas are:

- Access to Quality Health Care
- Chronic Disease
- Community Preparedness
- Healthy Environment
- Healthy Mothers, Healthy Babies, Healthy Children
- Infectious Disease
- Mental Health and Substance Abuse

- Physical Activity and Nutrition
- Tobacco Use
- Unintentional Injury

The Healthy People 2010 objectives, NYS Prevention Agenda Goals for 2013, and community guidance influenced the selection of indicators to be tracked by the UCDOH using a biennial ***Health Report Card***. The following eight priority areas (12 indicators in total) were selected on the basis of their ability to motivate action, the availability of data to measure progress (both intermediate and long-term), and their importance as public health issues for Ulster County.

Other important considerations for selecting indicators included their relative impact on the lifespan continuum, a desire to represent health determinants and health outcomes; and, an assessment of current/potential resources, activities, programs, and evidence base to impact change.

Lastly, indicators were chosen that are clearly in the domain of the UCDOH. Mental health, substance abuse, and social economic indicators, for example, were not chosen because these more closely align with the Departments of Mental Health and Social Services, respectively.

Priority Health Indicators for Ulster County:

- Access to Health Care
- Tobacco Use
- Overweight and Obesity
- Vaccine Preventable Disease
- Chronic Disease
- Maternal and Child Health
- Unintentional Injury
- Environmental Quality

The definition, description, and county context for each priority indicator are listed below. The data source for each indicator is noted in brackets.

Access to Health Care

Definition: Percentage of adults aged 18 and older with regular health care providers *[1]*

Having a regular health care provider is a key factor in achieving high quality health care. In Ulster County, 82.4% of adult residents have regular health care providers. The Healthy People 2010 (HP 2010) objective is 84%, while NYS has set a goal for 96% by 2013.

Tobacco Use

Definition: Percentage of adults aged 18 and older who are current smokers *[3]*
Definition: Percentage of cigarette smoking among adolescents *[2]*

Tobacco use and dependence is the leading preventable cause of illness and death in NYS and in the US. Cigarette use alone results in an estimated 25,500 deaths in NYS. In Ulster County, 22.7% of adult residents are current smokers. HP 2010 goal is 12%. NYS has set a goal of 12% by 2013. According to a recent Youth Development Survey, 13% adolescents reported smoking cigarettes. This is well below the established national objective of 21%.

Overweight and Obesity

Definition: Percentage of adults aged 18 and older who are obese *[1]*
Definition: Percentage of children and adolescents that are overweight/obese *[3]*

For both adults and children, poor nutrition and physical inactivity can contribute to the development of chronic diseases and other disabilities that impact quality of life. Obesity, a major risk factor for many chronic diseases (e.g., diabetes, heart disease) has reached epidemic proportions in NYS and in Ulster County. In Ulster County, 24.9% of adult residents are obese. Also, nearly a quarter of school aged children are overweight or obese. The HP 2010 targets are 15% and 5%, respectively.

Vaccine Preventable Disease

Definition: Percentage of adults aged 65 and older who had flu shots in the past year *[1]*

Vaccine preventable infections such as pneumonia and influenza are a major cause of illness and deaths in NYS, especially among seniors. Vaccination is an effective strategy to reduce illness and deaths due to these causes. In Ulster County, 69.2% of adult residents aged 65 and older had flu shots in the past year. HP 2010 has set a goal of 90% which NYS aims to meet by 2013.

Chronic Disease

Definition: Coronary heart disease deaths per 100,000 (age-adjusted) *[4]*
Definition: Stroke deaths per 100,000 (age-adjusted) *[4]*
Definition: Breast cancer deaths among females per 100,000 (age-adjusted) *[5]*

Heart disease, stroke, and cancer are the leading causes of death for all Americans. Health disease and stroke are linked closely to other health behaviors such as tobacco use, physical activity, nutrition, and obesity, and therefore risk for these causes is modifiable. For many cancers, including breast cancer, early screening exams can be life saving.

In Ulster County, heart disease, stroke, and cancer represent the leading causes of death. However, for coronary heart disease and stroke, death rates are lower than the HP 2010 goals by 15% and 30%, respectively. Combined cancer rates are higher compared to NYS and HP 2010 objectives. Breast cancer death rates, for example, are 30% higher compared to the HP 2010 goal (27.3 vs. 22.3).

Maternal and Child Health

Definition: Infant deaths (less than 1 year) per 1,000 live births (age-adjusted) *[6]*

There are many health indicators for maternal and child health ranging from percent of cesarean section to very low birth weight). Infant mortality is a

suitable outcome measure to monitor because it is strongly associated with other measures (e.g., birth weight, premature births) and can be impacted by strategies (e.g., prenatal care) aimed at improving other MCH related indicators. In Ulster County, the infant mortality rate of 6.7 is nearly 50% higher than the HP 2010 goal of 4.5.

Unintentional Injury

Definition: motor vehicle crash deaths per 100,000 (age-adjusted) *[7]*

Unintentional injury is the top killer of persons in NYS aged 1-44 years. Young drivers are at particular risk due to inexperience, risk taking behavior, and alcohol use. In Ulster County, motor vehicle crash deaths exceeded the HP 2010 objective by 66% (15.3 vs. 9.2).

Environmental Quality

Definition: number of high ozone days *[8]*

Air pollution is a real threat to public health. An estimated 25 percent of preventable illness worldwide can be attributed to poor environmental quality. Poor air quality can cause a host of alarming symptoms, ranging from shortness of breath and asthma attacks, to chest pain, heart attacks, and even premature death. Two indicators of air quality are ozone (outdoor) and environmental tobacco smoke (indoor). A recent report gave Ulster County a "C" rating based on the number of ozone days. Although Ulster County did better than other counties in the region, improvements lead to a healthier county in which to live, work, and play.

Data Sources

1. NYS (statewide) and US Data Source: CDC, Behavioral Risk Factor Surveillance System, http://www.nyhealth.gov/statistics/brfss/expanded/2009/county/docs/ulster.pdf

2. New York Office of Alcoholism and Substance Abuse Services (OASAS) Youth Development Survey 2008 Results Report for Ulster County, http://www.oasas.state.ny.us/prevention/needs/documents/UlsterCounty.pdf

3. UCDOH, Healthy Eating and Living (HEAL) Body Mass Index Screening Study, April 2008, http://www.ulstercountyny.gov/health/UCHDBMIStudyfinal.pdf

4. NYS (statewide and county level) NYS Department of Health Vital Statistics, NYS Community Health Data Set, http://www.nyhealth.gov/statistics/chac/chai/docs/chr_ulster.htm

5. NYS (statewide and county level) NYS Cancer Registry, http://www.health.state.ny.us/statistics/cancer/registry/vol1/v1culster.htm

6. NYS (statewide and county level) NYS Department of Health Vital Statistics, NYS Community Health Data Set, http://www.nyhealth.gov/statistics/chac/chai/docs/mih_ulster.htm

7. NYS (statewide and county level) NYS Department of Health Vital Statistics, NYS Community Health Data Set, http://www.nyhealth.gov/statistics/chac/chai/docs/inj_ulster.htm

8. American Lung Association State of the Air 2010 Report Card: New York, http://www.stateoftheair.org/2010/states/new-york/

Report Card

ULSTER COUNTY PRIORITY HEALTH INDICATORS	REPORT CARD NO. 1 (baseline) 2010
	GRADES (A-F)
ACCESS TO HEALTH CARE	
Percent of adults with a regular (usual) primary care provider.	C
TOBACCO USE	
Percent of cigarette smoking among adolescents.	B+
Percent of cigarette smoking among adults.	C-
OVERWEIGHT & OBESITY	
Percent of children and adolescents that are overweight or obese.	F
Percent of adults that are obese (BMI $\geq$ 30).	C
VACCINE PREVENTABLE DISEASE	
Percent of adults 65+ years with flu shot in past year.	D
CHRONIC DISEASE	
Coronary heart disease deaths (per 100,000).	C+
Stroke deaths (per 100,000).	B
Breast cancer deaths among females (per 100,000).	D
MATERNAL & CHILD HEALTH	
Infant deaths (< 1 year) per 1,000 live births.	F
UNINTENTIONAL INJURY	
Motor vehicle crash deaths (per 100,000).	F
ENVIRONMENTAL QUALITY	
Air quality (ozone pollutants).	C
Prepared by the Ulster County Department of Health, June 2010.	

An objective grading scale was created using the HP 2010 targets. Given that the HP 2010 objectives establish a threshold for a "minimal acceptable standards," meeting the objective equates to a passing grade of C.

Outperforming (e.g., lower rates of cancer or higher percentage of person immunized) the HP 2010 objective by 20% and 40% equates to B and A grades, respectively. Indicators measured worse (e.g., higher percentage obesity or lower rates of mammograms) than the HP 2010 objective by 20% and 40% results in a grade of D and F, respectively.

For HP 2010 objectives valued at a percentage less than or equal to 25%, a modified scale was used. This is indicated by an asterisk in the table showing the actual rates (see % difference column).

Grading Scale				
Better by:		**HP 2010 objective**	**Worse by:**	
40% or more	20% to 39%	Approximates	20% to 39%	40% or more
A	**B**	**C**	**D**	**F**
4-fold	2-fold	Approximates	2-fold	4-fold

modified scale

According to the first report card for Ulster County (2010) using the priority indicators, five indicators have failing or D grades (e.g., overweight/obesity in children, infant deaths, motor vehicle deaths, immunization, breast cancer deaths), while only two indicators (e.g., cigarette smoking among adolescents, stroke deaths) do better than the HP 2010 standards. The remaining priority health indicators meet or approximate the minimum acceptable standards for the nation as established by HP 2010.

Specific percentages, rates, and numerical scores for each indicator are summarized in the table below.

HEALTH INDICATOR	Rate	HP 2010	% diff	Grade
ACCESS TO HEALTH CARE				
% adults with a regular provider.	83	85	2	C
TOBACCO USE				
% cigarette smoking among adolescents.	13	21	*	B+
% cigarette smoking among adults.	22	12	*	C-
OVERWEIGHT & OBESITY				
% children and adolescents overweight or obese.	24	5	*	F
% adults that are obese (BMI ≥ 30).	25	15	*	C
VACCINE PREVENTABLE DISEASE				
% adults 65+ years with flu shot in past year.	69	90	23	D
CHRONIC DISEASE				
Coronary heart disease deaths.	142	166	15	C+
Stroke deaths.	33.8	48	30	B
Breast cancer deaths among females.	27.3	22.3	30	D
MATERNAL & CHILD HEALTH				
Infant deaths (< 1 year) per 1,000 live births.	6.7	4.5	49	F
UNINTENTIONAL INJURY				
Motor vehicle crash deaths.	15.3	9.2	66	F
ENVIRONMENTAL QUALITY				
Air quality (ozone pollutants).	2	N/A	N/A	C

Next Steps

By selecting from among the national objectives, and prioritizing other health indicators that are meaningful for Ulster County, individuals and organizations can build an agenda for community health improvement and can monitor results over time.

With the creation of a ***Health Report Card***, individuals and organizations can work in partnership to address those priority health areas that are lagging behind, but are essential to the vision of becoming the healthiest county in NYS.

As the leading health agency for the county, the UCDOH is poised to take the lead by mobilizing the *PiPH* Planning Councils to work through the other steps in the MAP-IT process.

Mobilization has begun in earnest and is ongoing. However, the UCDOH believes that it is important to broaden the range of resources to address important health issues.

"Too many New Yorkers experience poor health as a result of obesity, tobacco use, and lack of preventive health services. The Prevention Agenda is a call to action to local health departments, health care providers, health plans, schools, employers, and businesses to collaborate at the community level to improve the health status of New Yorkers through increased emphasis on prevention."

Richard F. Daines, MD
State Health Commissioner

Assessing community needs, strengths, and resources, and refining priorities is an important next step. Gathering and evaluating data, and discussing this information with the planning councils will better inform UCDOH sponsored initiatives related to the Prevention Agenda. In this regard the 2010 ***Health Report Card*** will serve as baseline information for the eight priority areas.

From the perspective of the UCDOH, planning the approach, with concrete action steps and timelines, will involve partnerships beyond those established through the planning councils. Establishing short, intermediate, and long-term targets for Ulster County is most effectively done through continued active partnership with

organizations that are fully invested in these priority areas of health. For example, invaluable partnerships with the Tobacco Free Action Coalition (TFAC) and the American Lung Association will assist with our tobacco efforts.

The Institute for Family Health, a Federally Qualified Health Center, and Health Alliance will be invaluable partners in addressing access to health. The Dutchess-Ulster American Heart Association, American Cancer Society, Cancer Prevention Services, Maternal Infant Services Network, and many others are all essential strategic partners. As illustrated in the figure below, the UCDOH intends to implement the Prevention Agenda by "working together."

The NYS Prevention Agenda calls on local health departments and hospitals to identify two or three of the ten Prevention Agenda priorities and to work with community providers, insurers, community based organizations and others to address them. The UCDOH has chosen eight areas and a total of 12 priority indicators to address.

Despite this aggressive approach, many health indicators that are important to individuals and organizations are not included. Due to limited resources the UCDOH understands well that there remains a gap between what can be done

and what individuals and organizations would like to do. However, it is important to note that the eight areas of focus are related to other areas of health that may not be directly represented. For example, while asthma (hospitalizations or deaths) is not listed as a specific priority indicator, tobacco and ozone pollutants are listed. Likewise, diabetes is not included among priority areas, but obesity, the major risk factor for type-2 diabetes, is listed.

The next step for the UCDOH is to convene the planning councils and discuss the ***Health Report Card***. Based on the results of this initial report card those health areas that received a failing grade are expected to rise to the top of the priority list. Implementation of programs and strategies, and the encouragement of policies, directed at making a difference for these areas as well as other important health areas for Ulster County will follow.

It should also be noted that the UCDOH does not intend to focus only on the priority indicators discussed. Efforts will continue to address the other needs of Ulster County such as Lyme disease, teen pregnancy, communicable diseases, public health preparedness, rabies, and other environmental threats and clinical services.

The Prevention Agenda should be viewed as complimentary to the core public health functions that are provided by the UCDOH. The Prevention Agenda represents a shift in the paradigm for how the UCDOH will engage with the community regarding health promotion and prevention. Most importantly, it represents a forward leaning approach towards embracing the New York statewide Prevention Agenda, and a willingness to lead in efforts (and partner) with individuals and organizations to make Ulster County one of the healthiest counties in New York State.

Appendix A—List of all Summit participants

Other Participants

Michael Hein, County Executive
Marshall Beckman, Deputy County Executive
La Mar Hasbrouck, Public Health Director
Debra Karnasiewicz, Women's Health and Fitness Foundation
Virna Little, Institute for Family Health
Oscar Alleyne, Rockland DOH
David Rogers, AARP
John Miller, Stop DWI
Walter Frey, UC Legislature

Track A – Healthy Youth

Facilitator: *Laurie Cassel – Ulster BOCES*
Scribe: *Vanessa Murphy – UC Department of Health*
Sandra Miller – *Kingston School District*
Linda Showers – *Rose Women's Care Center*
Jamie Kesick – *YWCA*
Rita Wood – *UC Department of Social Services – Early Intervention Preschool*
Amy Pollard – *Senator Gillibrand Office*
Pat Cosenza – *SUNY Ulster*
Lois Frozzetta – *Rondout Valley School District*
Stacey Rein – *United Way*
Charles Pegg – *Pegasus Athletic Sistem Care*
Jane Ferguson – *Pine St. Pediatrics*
Ed Brown – *UC Department of Mental Health*
Eleanor Troy – *UC Department of Health*
Ann Marie McCarthy – *Ellenville Regional Hospital*
Samantha Higgins Tiano – *KidsPeace Foster Care Program*
Bob Conklin – *YMCA*
Michael Berg – *Family of Woodstock*
Kathy Lunney – *Health Alliance*
Ivan Godfrey – *NYS Office of Mental Health*
Amy Ansehl – *New York Medical College*
Krista Barringer – *UC Youth Bureau*
Sue Jordan – *UC Department of Health*

Track B – Healthy Seniors

Facilitator: *Sue Hoger - Resource for Accessible Living*
Scribe: *Nereida Veytia – UC Department of Health*
Anne Cardinale – *UC Office for the Aging*
Margo McGilvrey– *Health Alliance*
Rich Matthew – *Health Alliance*
Marge Gagnon – *Rose Women's Care Center*
Amy Wen – *American Cancer Society*
Doug Morris – *Advancing Wellness, Inc.*
Jack Hayes – *UC Legislature*
Sheree Cross – *UC Golden Hill Care Center*
Ellen Pendegar – *Mental Health Association in Ulster*
Mary Jo DeForest – *UC Office for the Aging*
Carol Smith – *Emergency One*
Marianne Collins – *SUNY Ulster*
Nereida Veytia – *UC Department of Health*

Track C – Healthy Women
Facilitator: *Sylvia Murphy - Health Alliance*
Scribe: *Diane Aznoe - UC Department of Health*
Jean Jacobs – *People for People*
Lea Cassarino – *UC ARCS Cancer Services Program*
Cindy Lewis – *Health Alliance*
Susan Warman – *UC Department of Social Services*
Caren Fairweather – *Maternal Infant Services*
Laurie Mozian – *Community Health Coalition*
Colleen Conklin – *YWCA*
Terri Economos – *Health Alliance*
Andrea Park – *YWCA*
Donna Demeter – *UC Department of Health*
Susan Allen – *SUNY New Paltz*
Danielle Heller – *American Cancer Society*
Melvn McFarland – *Immunotec Research*
Elizabeth Mitchell – *Healthy Start*

Track D – Healthy Places

Facilitator: *Dennis Doyle - UC Department of Planning*

Scribe: *Stacy Kraft – UC Department of Health*

Harold Jolley – *Riverview Baptist Church*
Kathleen Nolan – *UC Trails Advisory Committee*
Danielle Heller – *American Cancer Society*
Lawrence Barthholf – *Veterinarian*
Tina Eckert – *American Cancer Society*
David Gilmour – *Gilmour Planning, LLC*
Ward Todd – *UC Chamber of Commerce*
Michael Mally – *SUNY New Paltz*
Mary Marsters – *Cornell Cooperative Extension*
Emily Margulies – *Soltanoff Chiropractic*
Gregory Soltanoff – *Soltanoff Chiropractic*
Kevin DuMond - *UC Department of Health*
Kathy VanBuren – *Health Alliance*
Gary Myers – *UC Department of Health*
Roberto Rodriguez – *UC Department of Social Services*
Michael McFarland – *Immunotec Research*

Appendix B—Transcripts from Healthy Ulster Summit Breakout Groups

TRACK A: Healthy Youth

1. **What are the community health needs (and gaps) and priorities?**

- Need for other options for sex education, instead of an abstinence only approach
- Need mechanisms in place to better take advantage of the programs we already have implemented
- Business, education, and government need to be linked together better
- Need a way to bring parents into the picture in a better way--in a way that further promotes non-adversarial relationships
- Better access to healthy foods
- Increase in mental health issues affecting toddlers and pre-school aged children
- Lack of services to address the needs of this demographic
- Family support in this area also needs to be improved
- Health insurance-coverage/access
- Need to target the money to the populations that need the resources/programs/services the most
- Better access to the jail is needed to meet with the fathers of children
- Evaluation
  - Needs assessments should be done to evaluate whether programs and services are reaching the intended target population. Also, the needs assessment needs to analyze whether the programs are the best fit for the population. Sometimes, evidence based programs are not the best fit for the county population.
  - There also needs to be an evaluation of programs that may not be evidenced based—there are some good programs that fit into this category.
  - Programs that we have in place need to be inventoried and evaluated
  - Compile data to channel resources in a better way
- Faith-based organizations are a great community resource but there needs to be a willingness to discuss issues affecting youth and the community in a religious setting

2. **What are the barriers to appropriate care?**

- Location
- Trust
- Transportation-very difficult unless you have a huge network of people to assist you
- Awareness of services
- Social stigma attached to receiving services
- Fees/costs associated with programs that help with obesity prevention (i.e. karate classes, others sports, etc)
- Willingness to participate

- Parenting skills
- Language
- Time management
- Disconnect between youth and adults in school settings/lack of guidance to make healthy choices
  - School Resource Officers have had a positive impact. Many outlying school districts use the State Police, but that program is ending and the State Police will no longer be a presence within the schools.
- Work schedules don't allow parents to be actively involved/participate in after school events
- Tendency to deal with issues on the ground (from the bottom-up) instead of addressing the issues at the top, policy-making levels
- Lack of affordable housing
- There is an expectation that if services are provided within the school, then the school owns it, or has the responsibility for these services. If the expectation changes where services (i.e. health clinics) provided in schools aren't their responsibility/aren't "owned by them (the schools)," then you may see an increase in access to a variety of health services for children
- School day not long enough/having a longer school day would assist
- Programs ending because grant funding dries up. (i.e. TOPS—Transitional Opportunities Program)
- Licensing and billing protocols, policies, and procedures that need to be in place to provide services are huge barriers
- Silo impact-although collaboration does exist, sometimes there is resistance to share resources and monies
- Perception of vocational training/not valued in our society--this view is barrier to encouraging young people to explore these fields

3. What are some best (or promising) practices (or models) for meeting health needs of the community?

- Healthy Start
- YMCA has wonderful after school programs
  - They are expanding
  - Seeing results—teen participation is increasing
- Kids Together
- TFAC (Tobacco Free Action Coalition)
- Prevention Connections before they lost their funding
  - *Side note:* A total amount of 10,000 dollars was needed to save this program, but it wasn't able to be done.
- Kingston Cares
- SAGE Saugerties
- Children and Family Services Plan--monitors outcomes

- ASARA/Direct Lynx (Adolescent Substance Abuse Risk Assessment)
- YWCA
- Rose Women Care Center programs and services
- Youth sports leagues run by volunteers
- Need to look into home-based family services to overcome the transportation barrier

4. Are there emerging trends that impact the availability, affordability, and/or quality of care?

- Lack of funding
- Disintegration of family
- Pink-collar poverty (female/single mother-headed household poverty)
- Head of household changes/role change
- Changes to Medicaid services—reliance on managed Medicaid
- No parents at home anymore
- Decrease in prevention funding
- The cutting of what is determined to be "non-essential" programs; need to re-examine what constitutes a non-essential program; define what non-essential services are
- Resources are being tied by contractually by unions
- Our government is outsourcing mandated resources

5. What are the strengths and weaknesses in the public health and health care delivery system?

Strengths	**Weaknesses**
• New public health director—new leadership; wealth of knowledge and information • UCDOH provides a variety of public health services in several areas of the county. (i.e. immunization clinics, H1N1 clinics, seasonal flu clinics, STD clinics, etc) • Communication • Partnerships – Collaboration friendly—people are used to working together – Bruderhof partnership – Preparedness Taskforce partnerships – Partnership between the PRASAD program and the Tischler Dental	• Lack of awareness of public health programs and services (i.e. Hospital ERs sometimes turn into public health-like clinics) • Although communication is listed as a strength, the dissemination of information needs to be more coordinated • Transportation • Dental Health • Lack of community food co-ops

Foundation to provide dental services
- Municipal recreation programs at the town level partnership
- Cornell Cooperative Extension

Consensus recommendations:

1. Inventory of services for coordination and activation
2. Classroom on Wheels (COW) to improve access to services
3. Use of technology to access services
4. Long-term commitment to programs at the county and state level
5. More partnerships with schools and extended days

TRACK B: Healthy Seniors

1. What are the Community's health needs (and gaps) and priorities?

Health Needs

- Need primary mental health services that also include home visits for physical and mental health care needs.
- Need for specialist in providing oral, vision and hearing services.
- Need physicians to be available to patients and assess and evaluate the poly pharmacological situations that occur with multiple numbers of needs.

Gaps

- Provide communities for active living - includes availability of walkways, exercise that allows for independence in home.
- Need for coverage and assessment for appropriate medical needs for the home.
- Surveys are done that don't represent or reach the senior population.
- Need for door to door transportation.
- Lack of physician specialist in gerontology.
- Need to meet the needs of the growing Spanish senior population.

Priorities

- Communication - how we speak with senior population.
- Seniors need aging-in-place services to keep at home.
- Need to provide coordinated services.
- Need to use pharmacist in communities to help with looking at the poly pharmacology that exist.

2. What are the barriers to appropriate care?

- Make information user friendly, especially insurance issues and understanding coverage.
- Financial - many providers don't accept insurance, even Medicare.
- Mental health in senior population still has a stigma attached (perceived within community and how the individual perceives themselves).
- "Myth of Aging" - seniors are suppose to move slower or not eat thus making for professionals not to diagnosis depression in this population. Along with this there is a lack of discussion on the "pathway," what happens next the fear of being non-self sufficient.
- There are not enough alternative community levels of care or infrastructure, i.e. Adult Day Cares.
- Not enough care providers in rural areas: lack centers for senior groups, community meals, no active living walkways.
- Funding cuts have impacted availability of services - need for coordinated services.
- Lack of personal care aides.

3. **What are some best (or promising) practices (or models) for meeting health needs of community?**

- "Staying in place" program (Woodstock Family).
- Senior Centers run by seniors: Chapel Hill North Carolina.
- Healthy partnerships for coordination of services.
- Naturally Occurring Retirement Communities (NORC): need for senior amenities to keep seniors at home.
- Senior Clubs are available but don't reach all seniors.
- Use of my generation approach: Kingston Midtown Recreation.
- Use of skilled volunteer force.
- Use of lobby groups such as AARP to promote best practices.
- Environment: new construction is now taking into consideration the needs of aging population.
- Look at best practices and models that look in surrounding Counties and carry them over to Ulster.

4. **Are there emerging trends that impact the availability, affordability and/or quality of care?**

- Rural areas have fewer practitioners, therefore impact care.
- Need to increase the use of available technology.
- Fixed budgets for seniors is a concern not able to afford all needs, i.e. fresh fruit/vegetables, medications.
- Providers not accepting new patients with Medicare.
- Cuts in Medicare funding for gero-psychiatrist.
- Lack of transportation in rural areas.
- Lack gerontology specialist/services.
- Need to market what is available to seniors better.

5. **What are the strengths and weaknesses in public health and health care delivery system?**

- Public health was seen always focused on communicable diseases, now it is more comprehensive, looking at human behaviors.
- Some community providers are reaching out to the rural areas by changing past practices to increase opportunities.
- Communities have attempt at coordinating efforts such as Single Point of Entry, Ulster County New York Connects Program.
- Community lacks different levels of care programs.
- Need to shift from medical model to social model.
- There has been an increase in looking at suicide risk behaviors for senior population.

Consensus recommendations:

1. Improve management of medications (poly pharmacological) and improve case management.
2. Enhance in-home services (access to personal care aides, stay in place programs).
3. Shift from medical to wellness model - Aging successfully, develop infrastructure.
4. Realistic survey of aging population.
5. Partnership/communications with providers - looking at other regions for best practices, use of senior clubs and existing lobby groups.

TRACK C: Healthy Women

1. What are the community health needs (and gaps) and priorities?

- Need breastfeeding support, free cancer services for uninsured women
- Continue to network and create partnerships; medical education is needed
- Transportation is a barrier
- No chronic disease prevention monies, not much on nutrition
- What are resources for reproductive health issues i.e. incarcerated women
- Low birth weight leads back to diet: nutritional education (esp. women ages 16-20)
- Education on vaccine preventable diseases
- Organize a prenatal mood disorder task force and resource directory- promote awareness of depression of women at reproductive ages and in the first year, less stigma
- More intensive medical care needed, lack of clinical care, people using the ER as alternative
- Education of doctors
- Access to healthcare-issue with uninsured and underinsured re: preventative medicine
- How to get people to attend sessions to enroll in Child Health Plus- one session held and no one attended
- Medicaid: ability to apply will be easier; goes on-line next month, no face to face interview, facilitated enroller in the community

2. What are barriers to appropriate care?

- Transportation
- Create a "one-stop shop" of services for consumers (i.e. in Poughkeepsie, this is done in a former school)- bundling services together for better access- all under one roof
- Funding- budget cuts
- Limited health literacy and functional literacy; language barriers
- People are scared to get testing done- mistrust, fear
- Lack of services locally- consumers consult with out –of- county healthcare in Albany
- No clinic
- Lack of leadership in educating the public and healthcare professionals and healthcare givers
- Lack of funds creates turnover with staff and lack of stability equals lack of education for the consumers
- Need to solve healthcare barriers: need family planning, transportation and dialogue among ourselves-everyone to the table!
- People need to partner within the same complex of services to help patients (Putnam County- multiple services in one group)
- Need to attract specialty services
- Lack of affordable, accessible childcare

3. **What are some best (or promising) practices (or models) for meeting health needs of community?**

- The health center model (i.e. model of mental health and medical like Institute for Family Health)
- Healthcare reform
- In worksite, purchase health insurance for staff- offer low co-pays, offer more health options. Reach out to smaller employees.
- Mobile clinics, medical van (one being utilized at Margaretville Hospital- large to drive); staffing would be an issue
- Dr. Hasbrouck should connect with Dr. David Meshes (sp?) re: residence in training program at Institute for Family Health- this program is geared for statistics (i.e. mental health, pregnancy), patient volume and satellite sites (like New Paltz) are huge- their data base would help Health Dept.
- Need more policies (like menu labeling law, no smoking for hospital patients) to make health lifestyles and choices easier and affordable; change behavior
- All relates back to education. Suggestion: women, like this group, could meet quarterly, set goals
- Healthcare consultant Jean Jacobs hosts a TV. show on health topics with guests, would like to see the Kingston Classic brought back; 3000 runners will be in Shamrock Race, including kids
- Health Alliance hosts 3 health seminars a month
- Hard to get information to teen parents
- Reach consumers through community groups, such as churches, healthcare committees; use a grass roots approach: Latin community have “advice givers”; could we educate natural leaders to work with the people
- Background on the 211 service; yes it is still working and updated by everyone
- Bringing Agencies Together (BAT) list serve through Cornell Cooperative Extension; there is a Family Partnership Center in Dutchess County
- Can research what other counties are doing
- Albert Lea Minnesota program called The Vitality Project= how to change communities

4. **Are there emerging trends that impact the availability, affordability and/or quality of care?**

- Medicaid Managing Care Plan (MVP): provides physicals, well child check-ups, more are now eligible for medical coverage, have eliminated resource requirements
- More nutritional information is now being posted, more options now available
- Alternative ways to exercise i.e. yoga, but for elite few and not all re: cost
- More options are available for alternative medicine
- Mental Health agencies limitations: i.e. early discharge; need to adapt care to current trends; HMO limitations

- Trend: elective c-sections; unequal health options, early discharges, less federal funding, more research needed in children area and in breast cancer; rejection of breastfeeding with African-American women
- Positive trend- consumers are interacting more with their healthcare providers

5. What are the strengths and weaknesses in the public health and health care delivery system?

- Not many specialists
- No full time nutritionist on county payroll
- Managed care is an issue re: the survival of your practitioner; re-imbursement is critical- money is driving force
- Managed care is helping out re: dental; no dentists were taking Medicaid before
- Amount of services provides locally is good!
- Strength: healthcare professionals are more accessible
- Networking for Dr. Hasbrouck will be key- what's going on

Consensus recommendations:

1. Public Partnerships- Directory of Existing Services- bringing all groups and agencies together
2. Community Needs Assessment
3. Community Healthcare Reform Forum for Ulster County
4. Look to other counties and nationally for working models
5. Utilize current resources- pooling resources

TRACK D: Healthy Places

1. **Define what it means to be a Healthy Place?**

   Multiple levels: Regional, Community, Worksites, Residential.

   Vibrant, Safe (clean air, healthy food sources, water), fun, access to health services, educational, multi-functional, multiple activities, inclusive, diverse, attractive, accessible-transportation, family friendly, flexible workplaces.

   Define Safe:

- Outdoor activities
- Driving Habits
- Security- Police presence
- Lighting
- Cleaned up-maintenance
- Transportation system
- Public spaces-schools, parks, etc.
- Unavoidable, sever accidents
- Accident rates- should expect that when people are more active the accident rates could go up. Need to break out the causes of accidents and what it means to the community.
- Housing without lead paint
- What is the number of Children exposed to lead paint in Ulster County?

Define Fun:

- Satisfying
- Inter-connected, Inter-active, Intergenerational
- Psychological
- Educational
- Arts & Culture

Define Accessibility:

- Language
- Broadly available and affordable services/programs
- Are there disproportional services?
- Define Healthcare services:
- Partnerships/Collaborations:
- Awareness/Promotions
- Neighborhood systems- grass roots
- Transportation-vehicle & pedestrian
- Web/ internet

Define Family Friendly:

- Accessing young families-outreach
- Social Marketing
- Intergenerational
- Convenience/accessibility
- Faith based group & programs in partnership with non-faith based services/agencies
- Community-based thinking
- If not family friendly, why not?

Communication:

- Local media
- Direct mail
- Technology
- Data collection
- Connecting the dots-putting the pieces together
- Multi-level communications/specialized communication
- Grass roots level
- Low/No literacy outreaches
- Healthy Living Directed advertising
- Volunteerism
- Faith-based groups are first in times of emergency and stress

2. What are the Gaps/Barriers to Healthy Environments?

- Education/promotions of available places
- Socio-economic issues- single parent household, two parents working, affordable housing
- Weather-some public spaces not usable in bad weather
- Access to school properties- Capital investment in schools is huge yet we have no access a majority of the year.
- Funding
- Liability issues
- Fragmentation-awareness
- Inability to implement processes
- Geography-rural vs. urban
- Equity/Diversity issues
- Promotions/knowledge of services/ programs
- Need for a critical mass (population) for some technology and specialties to become available.
- Average travel/commute time to work impacting on quality of time with family and for healthful self-development.
- Senior population- trend with people who retire in NY tend to leave then return when they need health care.

- Pediatric services are no longer available for overnight stays at the Hospitals and parents have to travel out of county to visit their children.

3. What are some best practices for creating healthy environments?

- Community/ Government Leadership backing programs
- Address "Brain-train" of youth migrating out of county. How to keep them in the community? Improve employment/ compensation opportunities. Model Program such as New York Conference of Mayors-(NYCOM) that works with young people to determine what would make them stay or come back to a community after college?
- Technology-"Broad-band is the water and sewer of the twenty-first century."
- Senior population- Aging in place focus –access volunteers
- Communicate and Access senior population via Health Care Providers, Office of Aging, Adult Day Care programs.
- Silver Sneakers program offered at the Y is a good model
- 17-44 years age bracket- engage and cultivate this group. Improve housing.
- Policies can change environments and activities
- Make healthy behaviors convenient- if closer to a trail or gym, it will be utilized.
- Changing habits beginning early with children.
- Birth to 3 years old –most development is occurring.
- Social Marketing strategies
- Foster Care- impact on a child's life.

4. Are there emerging trends that impact healthy environments?

- Increased use of technology
- Ability to work from home
- Preventive care- wellness promotion/education
- Doctor works out at the gym with his patients.
- Fiscal austerity-focused and smart investments
- Weekenders-Week "extenders"
- Healthcare partnering- Mergers
- Healthcare technologies-robotics, EMR, Tele-medicine
- Green building/sustainability
- Impact on current infrastructure-compression

Consensus recommendations:

Continue dialogue to include the following key partners and organizations that were not present: youth, alternative medicine, first responders (e.g., fire, police, and rescue), arts, and agriculture.

Appendix C—*PiPH* Planning Councils (as of May 28, 2010)

Healthy Youth

Laurie Cassel – Ulster BOCES
Linda Showers – *Rose Women's Care Center*
Jamie Kesick – *YWCA*
Pat Cosenza – *SUNY Ulster*
Lois Frazzetta – *Rondout Valley School District*
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Kristen Wilson - *CCE*
Robert Conklin – *YMCA*
Jack Bennett - Ulster Prevention Project
Dan Millrood – *Eclipse PT*

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