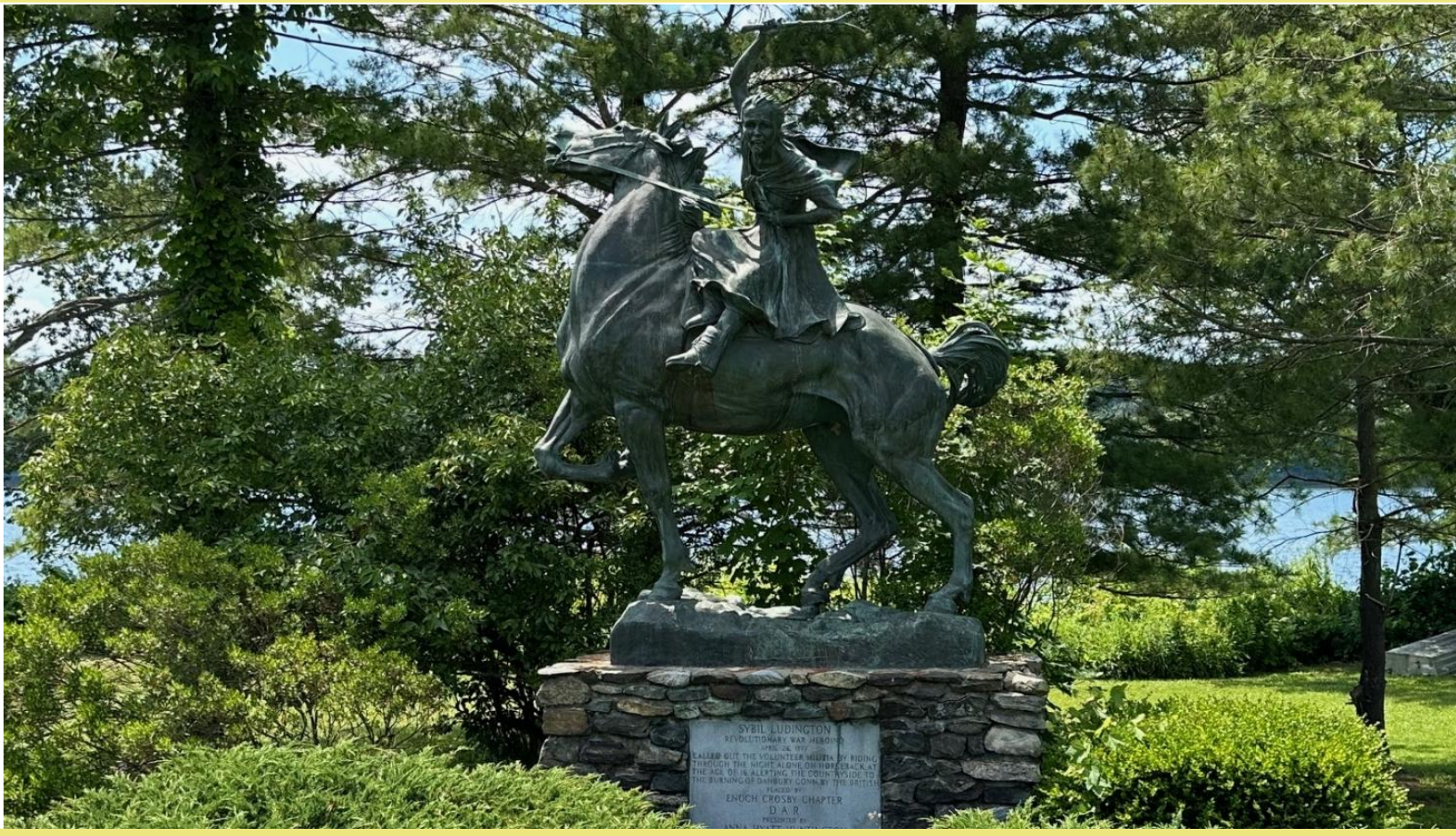
PUTNAM COUNTY



Community Health Improvement Plan
2025-2030

ACKNOWLEDGMENTS

The Putnam County 2025-2030 Community Health Improvement Plan covers Putnam County, New York.

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Putnam County Department of Health
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COMMUNITY HEALTH IMPROVEMENT PLAN

EXECUTIVE SUMMARY

PREVENTION AGENDA PRIORITIES

In formulating the Putnam County Community Health Improvement Plan (CHIP) 2025—2030, the Putnam County Department of Health (PCDOH) has identified three priorities to be addressed from the New York State Department of Health's Prevention Agenda 2025—2030. They are Poverty, Anxiety and Stress, and Preventive Services.

Poverty, which is a social determinant of health, is the first priority area selected. The group identified as facing disparities in this priority area are older adults, who are living in poverty at a higher percentage than the general population. While Putnam County may fare well compared to other counties, there is serious concern in this area because rates of poverty have been worsening over time.

Anxiety and Stress is the second priority area selected for the CHIP. The group identified as facing disparities in this area are lower income households and those facing economic instability. Other groups facing disparities in this area that will be considered include households with a person with a disability and those with students who are considered economically disadvantaged.

Preventive Services is the third and final priority area selected. The groups identified as facing disparities in this priority area have been identified by geographic location in four zip code areas where completion of the Human Papillomavirus (HPV) vaccination series in 13-year-old adolescents is lowest.

DATA REVIEW

Identification of the priorities listed in the CHIP was informed by the data sources used in the development of Putnam County's Community Health Assessment (CHA), which included primary data collection and secondary data review. More details about each of the data sources can be found in Putnam County's CHA.

PARTNERS AND ROLES

Putnam County's CHA includes partners and their roles in the assessment of the health of the county and region. Implementation of the CHIP will involve additional partners. To address the poverty priority area, PCDOH will work with two other county agencies: the Department of Social Services and Mental Health (DSS) and the Office for Senior Resources (OSR). Their roles will primarily revolve around training PCDOH staff and establishing a formal referral pathway for social services and programs.

The Hudson Valley Public Health Collaborative (HVPHC), a partner for the CHA, will also be involved in the priority area addressing preventive services by collaborating on a social media campaign focused

on increasing vaccination rates. Additional partners addressing this priority area include local vaccination providers, who will implement intervention protocols in their practices with support from the PCDOH. The community at large was engaged in identifying which priority areas were chosen. They were given the opportunity to review the CHA at community presentations and online and provide input on which of the areas they felt would be most impactful. During implementation, the community will be kept up to date through updates that will be posted online and on social media.

INTERVENTIONS AND STRATEGIES

Evidence-based interventions to confront the priority area of Poverty involve coordination between the health department and its partners at DSS. Together, the agencies have identified an evidence-informed and multi-faceted plan focused on strengthening collaboration to improve community outcomes. This involves creating formal pathways with both DSS as well as OSR to be able to address economic disparities among residents 65 years and older. Other activities include co-hosting community outreach, cross-training staff on services, and fostering leadership support from both agencies. The feasibility/impact assessment for these activities is informed by the strong collaboration between DSS and PCDOH and the is mutual recognition of the benefits for community members. Putnam County has an aging population, and the health department has many community touch points involving older adults, which will expand the already vast reach of both DSS and OSR. This, combined with the cross-training of health department staff, will address the disproportionate impact of poverty on some of Putnam's most vulnerable residents.

The evidence-based intervention to improve outcomes related to Anxiety and Stress will be to expand implementation of Mental Health First Aid courses. Coordinated emphasis will be placed on reaching disparate populations, including those with lower household incomes and those facing economic instability. PCDOH health education staff will assist with this priority area, which ensures expanding both Putnam County's Mental Health First Aid (MHFA) and Youth Mental Health First Aid trainings is highly feasible. This intervention provides the potential for significant community impact— particularly when focused on expanding access to this no-cost training among populations facing disparities. With more people trained to recognize signs of mental health and substance use challenges, residents and professionals alike can facilitate and provide pathways to help.

The evidence-based intervention to address the priority area of Preventive Services involves a community-wide educational campaign and implementing vaccination provider strategies. These provider strategies are informed by the American Cancer Society National HPV Vaccination Roundtable, and include establishing provider reminder/recall systems, standing orders, and practice-based education. The feasibility/impact assessment for this priority is grounded on the department's robust social media program and its past successful experience working with providers to increase Putnam County vaccination rates for the 14 vaccine-preventable childhood diseases (launched in 2023, as part of the previous CHIP cycle). Special consideration will be given to pediatric providers with patients in specific zip code areas where vaccination rates appear lower.

PROGRESS AND EVALUATION

Monitoring progress for each priority area will involve tracking process measures, including measuring short-term and intermediate outcomes. Short-term measures for the priority area of Poverty include numbers of PCDOH staff trained to identify clients' social needs and the services available through DSS. Intermediate outcomes to be measured include the number of "warm hand-offs" from PCDOH to DSS, utilizing a newly created procedure that will include a direct introduction. Quarterly meetings between the PCDOH and DSS will serve as a forum to update and record numbers and to make any necessary adjustments. Impact will be evaluated by measuring the long-term outcome of the number of people living in poverty in the general population as well as in the age group of 65 and older.

Progress for the priority area of Anxiety and Stress will be monitored by tracking the number of trainings serving as short-term outcomes and the number of people who complete the trainings as intermediate outcomes. Putnam County has an established and committed Co-Occurring Systems of Care Coalition (COSOCC) that has been involved in bringing these trainings to the County and already had a procedure for tracking these metrics. COSOCC meetings will be the setting for making adjustments to implementation. Impact will be evaluated by measuring the long-term outcome of the number of people in Putnam County experiencing mental distress, specifically measuring those with lower household incomes.

Progress for the priority area of Preventive Services will be monitored by tracking social media analytics for the public educational campaign and the number of practices recruited into the vaccination provider directed intervention. Intermediate outcomes monitored will include changes in practice level HPV vaccination rates among the participating vaccination provider practices and month over month HPV vaccination rates in the zip codes with disparities. Regular check-ins with participating provider practices will serve as an opportunity to refine methods. The impact of the interventions will be evaluated by measuring the overall percentage of 13-year-old adolescents with a complete HPV vaccine series in Putnam County.

MAJOR COMMUNITY HEALTH NEEDS

The 2025 CHA identified eight focus areas as major community health needs. They were: alcohol and tobacco use, childhood preventive services, economic stability, food access and healthy eating, healthcare access, maternal child health, mental health and suicide prevention, and tickborne disease.

The comprehensive CHA is an amalgamation of component assessments. All component assessments contributing to the CHA were reviewed side by side to present the fullest possible picture of health in Putnam County. These components included both primary and secondary data sources. Primary data, collected locally for the purpose of the CHA, include a trio of community surveys: the 2025 Mid-Hudson Region Community Health Survey and the Community Health Experience Survey (CHES), were administered to the public, while the Community-based Organization Survey (CBOS), was administered to employees of partner organizations located in the Nuvance Health service area. Secondary data sources include federal agency sources such as the U.S. Census Bureau's American Community Survey and the USDA's Food Environment Atlas; New York State agency sources such as New York State Department

of Health (NYSDOH) Vital Statistics and the NYS Education Department; and non-governmental organizations such as Feeding America and Bach Harrison LLC's Prevention Needs Assessment Survey.

The 2025 CHA was submitted to the NYSDOH in December 2025 and has been shared with the community, and feedback received has informed development of the CHIP. Community partners were sent a copy of the CHA via email, followed by an in-person presentation describing the eight focus areas on January 12, 2026. This was followed by community-level presentations between January and May. This launched the process described in the Prioritization Methods section.

The chosen priorities for Putnam County's CHIP:

Priority Area One: Poverty
Addressing Putnam County's focus areas of economic stability

Priority Area Two: Anxiety and Stress
Addressing Putnam County's focus area of mental health and suicide prevention

Priority Area Three: Preventive Services
Addressing Putnam County's focus area of childhood preventive services

PRIORITIZATION METHODS

DESCRIPTION OF PRIORITIZATION PROCESS

The process to select the three above priorities was conducted using three sources. One level of prioritization involved gathering input and support from key stakeholders, including community partners and elected officials. A second level of the prioritization process involved internal input from the health department divisions, the CHA/CHIP committee, and the Department Leadership Council (DLC). The department's CHA/CHIP Committee is an advisory committee consisting of staff representing all departmental divisions, and the DLC consists of the Public Health Director and supervisory staff from all departmental divisions. The third component or level of the process was focused on community engagement. This was the most complex source, conducted over multiple months and frequently in evenings to meet the public where—and when—they were available. It is described in detail in the section on page nine titled: "Community Engagement." The final selection of each priority area and interventions was based on the widespread consensus of the high feasibility and meaningful impact of these activities.

KEY STAKEHOLDER SOURCE

Early in 2026, the 2025 CHA findings were presented to the Live Healthy Putnam (LHP) coalition. The mission of this group of community partners, which includes both community-based organizations and other Putnam County agencies, is to improve individual and community health and well-being for all Putnam residents by addressing social determinants of health through education, advocacy, and collaboration. The process began with an extended meeting hosted by the health department. More than four dozen representatives from 22 community organizations and four Putnam County government agencies attended the four-hour event that opened with a slide presentation on the CHA findings by the health department's epidemiologist. The eight focus areas that had been identified and their central

associated indicators were reviewed. After the data presentation, attendees were asked to rank the importance of the eight focus areas. This was then followed by participation in "Turn and Talk" discussions. This is a strategy used in public health that has been described as an active learning technique to encourage sharing and increase understanding in a more intimate, lower-stakes environment of a small group. By pairing up with two or three partners, attendees had the opportunity to consider different perspectives prior to a second vote, which revealed if opinions about priorities shifted after the small group discussions.

During this early phase of the prioritization process, elected officials were informed of the 2025 CHA results and the plans to engage their constituents. This included presentations of the eight focus areas identified in the CHA to both the Putnam County Executive and Putnam County Legislature along with a more detailed look at the plan to involve the community in prioritization.

INTERNAL INPUT SOURCE

Input on the county's health priorities and CHIP interventions also occurred within the health department. The 2025 CHA was shared with staff, and the epidemiologist presented the eight focus areas at a departmentwide meeting. Staff were asked to review the focus areas as well as identify priorities within their division for alignment with the NYS Prevention Agenda. The focus areas were discussed and ranked during division meetings, and staff were asked to vote for the top five focus areas impacting the community for potential inclusion in the CHIP.

The Health Education Division tabulated results gathered from all three sources for prioritization. Five focus areas from the eight consistently emerged that were of the most concern: healthcare access, mental health and suicide prevention, economic stability, food access and healthy eating, and childhood preventive services. This information was shared with the health department's departmentwide CHA/CHIP Committee and the DLC for a more nuanced look at the objectives and interventions associated with the focus areas. A Feasibility/Impact matrix was utilized at this time to assist in identifying interventions. CHIP objectives and interventions were finalized through consensus-based decision making at a meeting between the Public Health Director and the DLC, along with representatives from the CHA/CHIP committee, facilitated by the health education staff in late May.

Prioritization Process

The Putnam County Department of Health used a multi-source approach to the prioritization process that spanned five months. It kicked off with an extended community partner meeting in January during which LHP coalition members were presented with the CHA findings. The final prioritization took place at the end of May with representatives from the CHA/CHIP Committee, the DLC, and the Public Health Director.

	Key Stakeholders	Community Engagement	Internal Input
January	**1/12** – LHP extended meeting with community partners	**January and February** – Communications materials developed for LHP meeting and *Let's Talk Health* sessions: posters, one-pagers, social media graphics, voting cards, and presentation slides.	
February	**February** – Elected official presentations		
March		**3/1**- First *Let's Talk Health* session **3/13**, **3/24**, **3/25** – Three *Let's Talk Health* sessions	**3/23** – Departmentwide meeting **March to May** – CHA/CHIP Committee meetings
April		**4/2, 4/14, 4/15, 4/21, 4/23, 4/30** – Eight *Let's Talk Health* sessions **4/26** – Autism Acceptance walk	**April** – Division Meetings
May		**4/30** – Casa Servir Church **5/14** – Community Baby Shower	**5/21** – DLC Meeting discussion **5/27** – Final prioritization
June			

COMMUNITY ENGAGEMENT

A major component to creating the CHIP is listening to the community and their concerns. Prioritization based on community input was both personnel- and labor-intensive. This CHIP cycle focused extensively on community involvement. The health department engaged multiple audiences to compile a broad perspective. Resident input was gathered at a variety of different community forums and locations, including the four senior centers in the county, each of the six town board meetings, at three rotary groups, a food pantry and community baby shower. These community listening sessions were branded as "Let's Talk Health" conversations, and were promoted via traditional print and digital press, social media, email, and phone calls. They began in early March and continued over the following 11 weeks and sought to capture the voices of the community, including those who may be underrepresented.

At each of the 15 Let's Talk Health sessions, an overview of each of the eight focus areas was presented. Participants were invited to share their thoughts about each of the topics, focusing on the following questions, with discussions facilitated by health department staff:

- What is known?
- What is the impact on individuals, families and communities?
- What resources or actions could be used to address the issue?
- Which of the issues matter most?

Following the discussions, participants individually voted for the five health issues they wanted prioritized.

Input was also gathered from residents unable to attend a community listening session via a QR code that linked to a Community Brainstorming Form. Each of the eight focus areas were explained in text. Respondents were then asked two questions: "How does this impact your health and well-being or that of

your family or community?" and "What resources or actions would you like to see as an effort to address this issue in your community?" This Community Brainstorming Form was posted on the Putnam County website, promoted through the health department's three social media accounts, and shared with youth at the Putnam County Youth Forum, a day of interactive workshops for county teens.

Lastly, community members were engaged during the Putnam County Autism Acceptance Walk. One-page summaries for each of the eight focus areas from the 2025 CHA were displayed and families were asked to vote for the five health topics they thought should be prioritized.

JUSTIFICATION FOR UNADDRESSED HEALTH NEEDS

Health focus areas identified in the CHA that are unaddressed in this CHIP include: healthcare access, food access and healthy eating, alcohol and tobacco use, maternal child health, and tickborne disease. Healthcare access indicators in the CHA pertain to overall barriers in accessing healthcare including disparities in health insurance coverage and costs and do not align with prevention agenda priorities. Instead, the PCDOH is establishing a workgroup as part of the LHP coalition to tackle this focus area.

Food access and healthy eating are not addressed in the CHIP as there are many food security programs already in place in Putnam County led by community partners. PCDOH supports and amplifies the ongoing work for this health issue. Additionally, the PCDOH is looking at innovative ways of bridging food access and healthy eating and continuing to enhance and build new partnerships with organizations working in this area.

Alcohol and tobacco use were also not selected for inclusion in this CHIP. The impact and feasibility conversations on alcohol and tobacco use determined the impact of alcohol and tobacco use interventions would be low. This was attributed to the fact that this focus area was not flagged among the "top five" by either residents or community partners, and tobacco cessation programming has not been heavily utilized by residents in recent years. Nonetheless, work in these areas will continue in partnership with established community partners including the Prevention Council of Putnam and the American Lung Association as well as through tobacco enforcement, education, prevention, and cessation programs. Work addressing alcohol use will be integrated and expanded through Putnam County's Bridge Alliance, a cross-sector harm reduction coalition.

Feasibility to address Maternal Child Health, which shows a documented need with respect to birth disparities, was determined to be low both among community partners and the health department. Currently, PCDOH Maternal Child Health programs focus on the postpartum population. The health department is working to strengthen relationships with community partners who are working with people before and during pregnancy to be able to better address the disparities that were identified in the CHA. Community partners working in Maternal Child Health have indicated that the political climate may also have an impact on the ability or willingness of portions of the target population to access services.

Tickborne disease continues to be a major concern in Putnam. PCDOH has ongoing efforts to alert residents at risk for tickborne disease, promote personal protection strategies and educate healthcare providers on early diagnosis. Staff attending community events provide hands-on tickborne disease

education and distribute tick removal kits. This work will continue despite its exclusion from the Prevention Agenda.

OBJECTIVES, INTERVENTIONS, ACTION PLAN

Domain: Economic Stability

Priority Area: Poverty

Objective 1.0: Putnam County interventions will contribute to the state level objective to reduce the percentage of people living in poverty from the 2018-2022 baseline of 13.6% to 12.5% by 2030. In Putnam County, our objective is to reduce the county level percentage from the 2020-2024 baseline of 7.1% to 6.5% by 2030.

Objective 1.1: Putnam County interventions will contribute to the state level objective to reduce the percentage of people aged 65 years and older living in poverty from the 2018-2022 baseline of 12.2% to 11% by 2030. In Putnam County, our objective is to reduce the county level percentage from the 2020-2024 baseline of 7.8% to 7% by 2030.[1]

Evidence Based Strategies

Collaborate with local DSS:

- Establish joint needs assessment, creating formal referral pathways;
- Co-host community outreach;
- Cross-train staff on services;
- Develop shared data systems;
- Foster leadership support from both agencies

Actions and Impact

Actions

Input

1. A training curriculum will be developed to cross-train PCDOH staff on DSS and OSR programs.
2. PCDOH will establish referral procedures to DSS and OSR for residents ages 60 and older.

Output

1. Number of PCDOH staff trained.
2. Number of residents referred by PCDOH to DSS and OSR.

Impact

Short-Term Outcomes

Increase PCDOH staff knowledge of service eligibility criteria and improved confidence in identifying client social needs.

Intermediate Outcomes

The number of "warm hand-offs" from PCDOH to DSS or OSR utilizing the newly created procedure, completing the successful execution of closed-loop referral systems.

Long-Term Outcomes

Reduce the percentage of people living in poverty, including those aged 65 years and older, in Putnam County.

Geographic Focus: Activities related to this focus area will be implemented in all areas of Putnam County.

[1] Data Source: ACS (table S1701)

Resource Commitment: Resources utilized while implementing these activities include:

- PCDOH, DSS, and OSR staff time and effort
- Educational materials for training

Participant Roles: DSS/OSR staff will develop a training curriculum for PCDOH staff. PCDOH and DSS/OSR staff will create referral procedures, and PCDOH staff will make referrals to DSS or OSR dependent on the age of the resident.

Health Equity: The primary interventions for this focus area will be targeted at older adults in Putnam County, who are living in poverty at a higher percentage than the general population. Implementing poverty prevention interventions in a specific population should bring the percentage closer to that of the general population.

Domain: Social and Community Context

Priority Area: Anxiety & Stress

Objective 5.0: Putnam County interventions will contribute to the state level objective to decrease the percentage of adults who experience frequent mental distress from the 2021 baseline of 13.4% to 12.0% by 2030. In Putnam County, our objective is to decrease the percentage of adults who experience frequent mental distress from the 2024 baseline of 17.5% to 14.1% by 2030.
Objective 5.1: Putnam County interventions will contribute to the state level objective to decrease the percentage of adults with an annual household income of less than $25,000 experiencing frequent mental distress during the past month, aged 18 years and older, from the 2021 baseline of 21.0% to 18.9% by 2030.[2]

Evidence Based Strategies
PCDOH will implement and promote Mental Health First Aid course training.

Actions and Impact
Actions
Input
1. Health department staff to complete MHFA train-the-trainer.

Output
1. The number of health department staff trained to be trainers for MHFA.

Impact
Short-Term Outcomes
An increased number of MHFA training courses are offered in Putnam County.
Intermediate Outcomes
An increased number of people who live or work in Putnam County complete the MHFA training.
Long-Term Outcomes
A reduction in mental distress overall in Putnam County, as well as in the lower income population.

Geographic Focus: Activities related to this focus area will be implemented in all areas of Putnam County.

Resource Commitment: Resources utilized while implementing these activities include PCDOH staff time and effort.

[2] Data Source: NYS Behavioral Risk Factor Surveillance System

Participant Roles: PCDOH staff will become MHFA trainers and will be responsible for planning and implementing trainings.
Health Equity: Activities in this focus area will be targeted to lower income households and those facing economic instability. Households including a person with a disability and those with high school seniors who are considered economically disadvantaged may also be specially considered.

Domain: Healthcare Access & Quality
Priority Area: Preventive Services
Objective 37.0: Putnam County interventions will contribute to the state level objective to increase the percentage of 13-year-old adolescents with a complete HPV vaccine series from the 2024 baseline of 25.7% to 28.7% by 2030. In Putnam County, our objective is to increase the county level percentage from the 2024 baseline of 14.5% to the NYSPA goal of 28.7% by 2030.[3]

Evidence Based Strategies
PCDOH will follow The Community Guide recommendations to use a combination of community-based interventions to increase HPV vaccination rates in targeted populations.
Interventions will include a community-wide educational campaign vaccination provider directed strategies as per the American Cancer Society National HPV Vaccination Roundtable.

Actions and Impact
Actions
Input
1. In collaboration with other LHDs in the Hudson Valley, PCDOH will develop and implement a social media campaign driven by paid advertisements, emphasizing the benefits of HPV vaccination as a cancer preventive. (2026)
2. In 2026 PCDOH will initiate planning and development of an HPV vaccination provider directed intervention with intention to launch in 2027. Planning activities will include a "Call to Action" letter sent to HPV vaccination providers with a link to a survey to assess willingness to participate in the various options included in the suite of systems-level intervention methods recommended by the American Cancer Society National HPV Vaccination Roundtable, and running practice level vaccination rate reports using functions available in the New York State Immunization Information System (NYSIIS).
3. From 2027-2030, PCDOH will recruit practices and launch the HPV vaccination provider directed intervention with the method(s) selected informed by results of the survey done in 2026. Methods under consideration include use of reminder/recall systems, standing orders, and practice-based education.

Output
1. Social media analytics including impressions, reach, shares, clicks, engagement rates, and audience demographics when available. (2026)
2. Number of vaccination provider practices responding to the acceptability survey. (2026)
3. Determination of baseline practice level HPV vaccination rates. (2026)
4. Number of HPV vaccination provider practices recruited to participate in the intervention. (2027)

[3] Data sources: NYSIIS, CIR

Impact

Short-Term Outcomes

HPV vaccination provider directed intervention impact will be optimized by prioritization of practices for recruitment based on practice level vaccination rates and selection of evidence-based intervention methods based on acceptability to potentially participating practices.

Intermediate Outcomes

Change in participating practice and zip code level percentages of 13-year-old adolescents with complete HPV vaccine series.

Long-Term Outcomes

Increase the overall percentage of New York State and Putnam County 13-year-old adolescents with a complete HPV vaccine series.

Geographic Focus: Interventions will be implemented throughout Putnam County, with additional focused efforts in zip codes 10524, 10512, 10516, and 10579 where there was a lower percentage of 13-year-old-adolescents with a complete HPV vaccine series as per NYSIIS as of June 1st, 2026.[4]

Resource Commitment:

Resources utilized while implementing these activities include:

- Funding awarded through the NYSACHO 2026 Immunization Action Plan (IAP) Mini-Grant
- PCDOH immunization, epidemiology and health education staff time and effort
- Digital platforms including but not limited to social media accounts, survey software, and NYSIIS
- NYSDOH, NYS HPV Coalition, and American Cancer Society National HPV Vaccination Roundtable educational materials

Participant Roles: PCDOH staff lead the HVPHC IAP mini-grant project team & will work collaboratively with colleagues from Westchester, Rockland, Orange, and Sullivan counties to plan, develop, implement, and evaluate the impact of the social media campaign.

PCDOH staff will assess acceptability of intervention methods with HPV vaccination providers, develop intervention protocols, and prioritize and recruit vaccination providers to participate. Participating vaccination providers will implement intervention protocols in their practices with technical assistance, assessment, and feedback provided by PCDOH.

Health Equity: Geographic disparities will be addressed by targeting intervention activities to Putnam County zip codes with a lower percentage of 13-year-old-adolescents with a complete HPV vaccine series.

PARTNER ENGAGEMENT

As with the prioritization process, community partners will continue to be engaged throughout the implementation and tracking of this CHIP. There are existing pathways for regular communication between PCDOH and the community partners already working on some of the priority areas. The LHP coalition, which consists of many community partners, meets quarterly and will include CHIP updates. LHP can also act as a venue to discuss and decide on mid-course corrections. Plan progress updates will also be available to community partners through the health department's website.

[4] Data provided by NYSIIS, NYSDOH-Division of Epidemiology, Bureau of Surveillance and Data Systems

The HVPHC Immunization Action Plan mini-grant project team, working to address the preventive services priority area, has established monthly meetings to monitor progress on community-wide educational campaigns. These monthly meetings will also provide an opportunity to make corrections to the plan as needed. Health department staff meet twice per month to monitor and adjust media programming as well. Engagement with participating vaccination providers addressing this priority area will be established by creating a set schedule for regular check-ins through email or telephone calls, customized for each participating vaccination provider.

Quarterly meetings will be established between Putnam County DSS, OSR, and PCDOH to monitor plan progress and make corrections as needed to the intervention and activities addressing the poverty priority area. The Co-Occurring System of Care Coalition meets on a monthly basis and will be the venue for monitoring and discussing plan progress and making corrections for the interventions addressing the mental health and anxiety priority area.

SHARING FINDINGS WITH THE COMMUNITY

The complete Putnam County CHA and CHIP and the Mid-Hudson Region Community Health Assessment (MHRCHA) are available to the public on the PCDOH website at https://www.putnamcountyny.gov/health. Individual CHA component reports are also available on the website, in the Assessments and Data section. PCDOH will promote awareness of the CHA/CHIP for residents through social media posts containing links to the website for the full documents. The completed CHA/CHIP will also be shared with community partners, elected officials, and other key stakeholder groups through email. A media release will be shared with local media representatives informing them of the availability of the complete documents and highlighting key aspects of the executive summary. The media release will also be made available on the PCDOH website and social media posts will provide summaries and links to the full document. Any addendums or updates on CHIP progress will be shared with partners as listed earlier and posted on the website.