Community Health Needs Assessment

St. Anthony Community Hospital, Warwick, NY
Bon Secours Charity Health System
Executive Summary

St. Anthony Community Hospital is a member of Bon Secours Charity Health System (BSCHS) which consists of three hospitals: Bon Secours Community Hospital, Port Jervis, NY; Good Samaritan Hospital, Suffern, NY and St. Anthony Community Hospital, Warwick, NY. Additionally, BSCHS provides the services of a Certified Home Health Agency, two long-term care facilities; an assisted living and adult home facility and several other off-site medical programs.

St. Anthony Community Hospital is a non-profit, acute care hospital providing comprehensive care to residents in and around the Warwick, NY area. The hospital provides acute and medical/surgical care, long-term care, as well as laboratory and imagining services. The Emergency Department operates 24 hours per day providing vital, life-saving services. The hospital also offers a wide range of diagnostic, health education and support services for the community.

Over the period of nine months, St. Anthony Community Hospital worked collaboratively with the Orange County Department of Health (OCDOH) on a Community Health Needs Assessment that included community surveys and interviews with representatives of our community with a knowledge of public health. Additionally, the New York State Department of Health (NYSDOH) Indicators for Tracking Public Health Priority Areas, 2013 – 2017 helped form the foundation for the needs assessment process.

In addition to performing a Community Health Needs Assessment, all hospitals in New York State (NYS) are required to submit a three year Community Service Plan to the NYS Department of Health by November 2013. NYS mandates that each Community Service Plan is based on the NYS Prevention Agenda 2013-17. This Prevention Agenda is the blueprint for state and local action to improve the health of New Yorkers in five priority areas and to reduce health disparities for racial, ethnic, disability, socioeconomic and other groups who experience them.

Based on data from the above mentioned community assessment activities and the NYS Prevention Agenda priorities, the most significant health needs of our service area are as follows:

- Chronic Disease prevention
- Healthy and Safe environments
- Healthy Women, Infants and Children
- Mental Health and Substance Abuse
- Communicable Diseases

In this report we have identified community wide resources that can assist in addressing the health needs of our community. We will work with many of these community partners to develop plans and programs designed to improve the health of our community.

If you would like additional information on this Community Health Needs Assessment (CHNA) please contact St. Anthony Community Hospital at 845-986-2276.
FACILITY DESCRIPTION AND VISION

St. Anthony Community Hospital is geographically desirable for residents of New York, New Jersey and Pennsylvania alike as it is located in the town of Warwick in western Orange County, NY. St. Anthony Community Hospital has 73 beds for acute care and medical/surgical services. The hospital Emergency Department features highly trained physicians, nurses and technicians, providing the community with a vital, life-saving service 24 hours per day.

The St. Anthony campus also includes a long term residential care facility, an Assisted Living and Adult home facility and a medical-model adult day care center. The hospital also serves the community through a newly opened Pediatric Sleep Center designed to meet the needs of pediatric patients who suffer from sleep disorders.

As a member of Bon Secours Health System, Inc., the Mission of St. Anthony Community Hospital is to make visible God’s love and to be Good Help to Those in Need, especially those who are poor, vulnerable and dying. As a System of caregivers, we commit ourselves to help bring people and communities to health and wholeness as part of the healing ministry of Jesus Christ and the Catholic Church.

Inspired by the Healing Ministry of Jesus and the Charisms of Bon Secours and the Sisters of Charity of Saint Elizabeth, the Bon Secours Charity Health System by the year 2015, will be distinguished as the leading provider of quality, compassionate and community based health care services in the Hudson-Delaware Valley.
SECTION I: FACILITY SERVICE AREA AND DESCRIPTION OF COMMUNITY

St. Anthony Community Hospital is located in the town of Warwick, NY which is the largest geographical town in Orange County. Orange County is in the lower Hudson River Valley area and it borders New Jersey and Pennsylvania to the south and west. The County comprises approximately 816 square miles.

Orange County continues to experience steady population growth as the second fastest growing county in the state of NY. The 2010 Census indicates that Orange County grew 9.2% from 2000 to 2010, and now includes 372,813 residents.

Based on 2010 U.S. Census population estimates, the median age in Orange County has increased by more than 2 years since 2007, to 36.6 years; the largest cohort of residents is age 45-49. The number of residents ages 65-69 is forecasted to more than double from 2000-2020 primarily due to the entry of ‘baby boomers’ into these age ranges.

According to the U.S. Census, 11.1% of residents in Orange County were foreign born, with 22.3% of persons over the age of five speaking a language other than English at home.

Poverty rates in Orange County vary greatly based on municipality. Poverty rates exceeding 25% for families with related children under 18 are found in Orange County’s three cities (Middletown, Newburgh, and Port Jervis), as well as in the town of Monroe, largely due to the impact of the village of Kiryas Joel, where the poverty rate is more than 4 times the county average.
SECTION II: METHODOLOGY

In January 2013, Bon Secours Charity Health System created an internal steering committee to manage our participation in the system-wide Community Health Need Assessment process. The steering committee members included Clare Brady, SVP Mission; Sr. Madeline Cipriano, Director Mission; Barbara Demundo, RN, Director Community Outreach; Deborah Marshall, VP Planning, Marketing and Strategic Initiatives; and Jason Rashford, Director Building Healthy Communities. Through the leadership of this steering committee, St. Anthony Community Hospital worked collaboratively with the OCDOH to conduct a Community Health Needs Assessment.

In partnership with the OCDOH, led by Health Commissioner Jean Hudson, MD, Jacqueline Lawler, MPH Epidemiologist, and Colleen Larsen, RN, MPA, OCDOH Nurse Epidemiologist, we designed a community health assessment survey tool. The survey was produced in both English and Spanish translations (Appendix B) and was circulated throughout Orange County from June 2013 through August 2013. St. Anthony Community Hospital had paper copies available at the hospital’s reception desk and a computer kiosk was available in the hospital cafeteria to enable the community to complete the assessment questionnaire online.

Other hospitals to contribute in the data collection process included Bon Secours Community Hospital, Orange Regional Medical Center, and St. Luke’s Cornwall Hospital. Other agencies with specific knowledge of the medically underserved and minority populations who partnered in this process include Middletown Community Health Center, Greater Hudson Valley Family Health Center, and Hudson River Healthcare. In addition, data from the Orange County Indicators for Tracking Public Health Priority Areas, 2013 - 2017 was used to further define areas of community need (Appendix C).
SECTION III: IDENTIFIED HEALTH NEEDS

The New York State (NYS) Prevention Agenda 2013-17 is the blueprint for state and local action to improve the health of New Yorkers in five priority areas and to reduce health disparities for racial, ethnic, disability, socioeconomic and other groups who experience them. The Prevention Agenda is a 5-year effort to make New York the healthiest state. Developed in collaboration with 140 organizations, the plan identifies New York’s most urgent health concerns, and suggests ways local health departments, hospitals and partners from the health, business, education and nonprofit organizations can work together to solve them.

The Prevention Agenda is designed to serve as a guide to local health departments as they work with their community to develop mandated Community Health Assessments and to hospitals as they develop mandated Community Service Plans and Community Health Needs Assessments required by the Affordable Care Act.

The Prevention Agenda identifies key strategies and interventions to address critical health issues and reduce health disparities in five priority areas:

**Chronic Disease**
Chronic diseases such as cancer, heart disease, stroke and asthma are among the leading cause of death and disability for New Yorkers, accounting for approximately 70 percent of all deaths. In addition, chronic diseases affect the daily living of one out of every ten New Yorkers. Key focus areas include reducing obesity in adults and children; reducing death, disability and illness related to tobacco use and secondhand smoke exposure; and increasing access to high-quality chronic disease preventive care and management in clinical and community settings.

**Healthy and Safe Environments**
Enhancing the quality of our physical environment – air, water and the "built" environment – can have a major impact on public health and safety. The Prevention Agenda establishes four focus areas to achieve this objective: improving outdoor air quality; increasing the percentage of New Yorkers who receive fluoridated water and reducing health risks associated with drinking water and recreational waters; enhancing the design of communities to promote healthy physical activity and reducing exposure to lead, mold and toxic chemicals; and decreasing injuries, violence and occupational health risks.

**Healthy Women, Infants and Children**
Recognizing that key population indicators related to maternal and child health have remained stagnant, or in some cases worsened in the past decade, the Prevention Agenda has established focus areas for maternal and infant health; child health; and reproductive, pre-conception and inter-conception (between pregnancies) health. Goals include reducing pre-term births and maternal mortality; promoting breastfeeding; increasing the use of comprehensive well-child care; preventing
dental cavities in children; preventing adolescent and unintended pregnancies; and promoting greater utilization of health care services for women of reproductive age.

**Promote Mental Health and Prevent Substance Abuse**
At any given time, almost one in five young people in the U.S. is affected by mental, emotional or behavioral disorders such as conduct disorders, depression or substance abuse. The Prevention Agenda recognizes that the best opportunities to improve mental health are to initiate interventions before a disorder manifests itself. The Prevention Agenda calls for greater utilization of counseling and education; clinical and long-lasting protective interventions to promote mental, emotional and behavioral well-being in communities; preventing substance abuse; and strengthening the infrastructure across various systems to promote prevention and better health.

**Communicable Diseases**
The Prevention Agenda strategy will promote community-driven prevention efforts to promote healthy behaviors, increase HIV testing, and reduce the incidence of diseases. The Prevention Agenda focuses on promoting early diagnosis and treatment of HIV and sexually transmitted diseases (STDs); improving rates of childhood immunizations, especially children aged 19-35 months; and encouraging greater utilization of sanitary procedures in hospitals and other health care facilities to reduce the potential for healthcare-associated infections.

The NYS Prevention Agenda goals and objectives for 2017 include:

- Reduce the number of adults who are obese by 5 percent so that the age-adjusted percentage of adults ages 18 years and older who are obese is reduced from 24.2 percent (2011) to 23 percent
- Expand the role of health care and health service providers and insurers in obesity prevention and treatment
- Decrease the prevalence of cigarette smoking among adults with incomes less than $25,000 by 30 percent, from 28.5 percent (2011) to 20 percent
- Reduce the newly diagnosed HIV case rate by 25 percent to no more than 14.7 new diagnoses per 100,000
- Stop the annual increase of the rate of hospitalizations due to falls among residents ages 65 and over by maintaining the rate at 204.6 per 10,000 residents (2008-2010)
- Reduce the percentage of preterm births (less than 37 weeks gestation) by 12 percent to 10.2 percent (Baseline: 11.6 percent)
SECTION IV: PRIORITY NEEDS

St. Anthony Community Hospital has identified two priority areas as the main objectives of our community health improvement strategies over the next three years. We determined these priority areas in partnership with the Bon Secours Charity Health System CHNA steering committee and the Orange County DOH Epidemiologist using the Orange County Health Assessment survey results and the New York State Prevention Agenda. Both priority areas fall within the NYS Prevention Agenda Priority to Prevent Chronic Disease and they are as follows:

1) Reduce Obesity in Children and Adults

2) Increase Access to High-Quality Chronic Disease Preventive Care and Management in Clinical and Community Settings

St. Anthony Community Hospital has established a Three Year Implementation Plan to address these Priority Needs in conjunction with other resources in our community. The Implementation Plan may be found at the end of this document (Appendix A).
SECTION V: DESCRIPTION OF EXISTING HEALTH CARE FACILITIES AND COMMUNITY RESOURCES AVAILABLE TO MEET IDENTIFIED COMMUNITY NEEDS

Several partner organizations that have additional expertise to assist in addressing the NYS Prevention Agenda Priority Areas are identified below. In addition to those mentioned below, a listing of other NYS Prevention Agenda Partners for Orange County and their activities is attached to this document (Appendix D).

Chronic Disease Prevention:
In addition to St. Anthony Community Hospital's planned interventions the following hospitals and healthcare organizations have the expertise and resources available to address chronic diseases:
- Bon Secours Community Hospital
- St. Luke’s Cornwall Hospital
- Orange Regional Medical Center
- Hudson River Healthcare
- Greater Hudson Valley Family Health Center
- Middletown Community Health Center
- Ezra Choilim Health Center

Healthy and Safe Environments:
Healthy and Safe Environments encompasses air and water quality issues, access to healthy foods, assault-related hospitalizations, and hospitalizations/ED visits related to falls. We are partnered with the Orange County Department of Health along with their public health outreach initiative Healthy Orange to help address these concerns.

Healthy Orange is an initiative through the Orange County Department of Health that addresses vital issues of improved nutrition, increased physical activity and movement, and a tobacco-free lifestyle to improve the overall health of Orange County residents. It addresses issues surrounding obesity and chronic disease, utilizing best practices to make policy, systems and environmental changes relative to exercise, nutrition, and tobacco control. Healthy Orange has become the umbrella for many programs that address these core goals.

Healthy Women, Infants and Children:
In addition to St. Anthony Community Hospital’s maternal and infant health services, we are working closely with Maternal Infant Services Network who has expertise and resources available to address these concerns. MISN is dedicated to family and community health and wellness. Who they serve:
- Pregnant women and women of childbearing age
- Parents of infants and young children
- Schools concerned with pregnant and parenting teens
- Health and Human Service providers
Promote Mental Health and Prevent Substance Abuse
St. Anthony Community Hospital works with fellow Bon Secours facility, Bon Secours Community Hospital, who provides psychiatric, psychological, medical and neurological care in a supportive environment. Their New Directions Program utilizes a multidisciplinary treatment team consisting of psychiatrists, nurses, case managers, social workers, and CASAC counselors. The Adult Inpatient Program at Bon Secours Community Hospital is designed to provide a patient-centered and comprehensive treatment program for adults ages 18 and older who are struggling with an acute phase of mental illness.

The Orange County Department of Mental Health exists to ensure that quality Mental Health, Developmental Disabilities and Chemical Dependency services are accessible to all the people of Orange County, that such services are delivered in a cost effective, timely and culturally sensitive manner under the jurisdiction of the Mental Hygiene Law of New York State and provided within the rules, regulations, policies and procedures of the licensing authority of appropriate State Offices. Additional mental health and substance abuse resources are available at Orange Regional Medical Center.

Communicable Diseases:
Along with our efforts at St. Anthony Community Hospital to prevent communicable diseases, the following public health and healthcare organizations have the expertise to address communicable diseases:

- Bon Secours Community Hospital
- St. Luke’s Cornwall Hospital
- Orange Regional Medical Center
- Hudson River Healthcare
- Greater Hudson Valley Family Health Center
- Middletown Community Health Center
- Ezra Choilim Health Center
- Orange County Department of Health
- New York State Department of Health
APPENDIX A: THREE YEAR IMPLEMENTATION PLAN

St. Anthony Community Hospital has identified two priority areas as the main objectives for our community health improvement strategies over the next three years:

1) *Reduce Obesity in Children and Adults*

2) *Increase Access to High-Quality Chronic Disease Preventive Care and Management in Clinical and Community Settings*

**Focus Area 1: Reduce Obesity in Children and Adults**

The goal of the following interventions is to reduce the incidence of obesity in our targeted population. The interventions outlined below are planned as a means to achieving the NYS 2017 objectives for obesity incidence in Orange County.

St. Anthony Community Hospital supports the concept of population health as it relates to health improvement strategies, and by positively impacting the health of our local community, we will lay the foundation for effecting positive health changes throughout the broader population we serve.

The following interventions are planned:

**Year 1:** Launch a series of communications to familiarize the community as well as hospital employees with our CHNA. Empower employees to become a resource for referrals to community resources and wellness services, and provide information regarding physical recreational activities in the community.

**Specifically:**

- Post CHNA on hospital websites and present at local hospital director’s meetings beginning in January 2014.
- Develop listing of accessible community resources for wellness services and free and/or low cost physical fitness and recreational activities.
- Identify internal champions from among hospital staff to work with community outreach to help disseminate the abovementioned listing through the hospital service area.
Year 2: Work closely with local health departments and community partners to implement physical activity and nutrition programs.

Specifically:
- Develop and promote walking programs within hospital service area
- Create connections between local farmers and local food systems, i.e. hospitals, schools, senior nutrition programs and grocery stores.
- Offer health screenings and educational sessions on healthy behaviors including diet and exercise as measures to achieve and maintain a healthy BMI.

Year 3: Develop worksite wellness initiative that encourages employees to incorporate physical activity into their daily routine and model healthy behaviors.

Specifically:
- Launch worksite wellness initiative at St. Anthony Community Hospital
- Assist other employers to personalize a worksite wellness program to meet the needs of their employees.
- Partner with worksite wellness sites to offer on-site screenings and educational programs.

Focus Area 2: Increase Access to High-Quality Chronic Disease (Diabetes) Preventive Care and Management in Clinical and Community Settings

The goal of the following interventions is to improve the overall health of people within our service area who are living with diabetes. The objective is to reduce hospitalizations due to short-term complications of diabetes and achieve the NYS 2017 target objectives for Rockland and Orange counties.

In addition to the above, St. Anthony Community Hospital will specifically address the disparity and lack of diabetes education for the Spanish speaking communities within our health system’s service area.

Year 1: Work with St. Anthony Community Hospital Certified Diabetes Educators to determine current practices and set goals to expand internal and community outreach programs.

Specifically:
- Develop listing of all diabetes education programs provided by BSCHS for in-patients, employees and community members by March 2014
- Work with local health departments and other health care providers to develop comprehensive listing of all diabetes education programs offered within Orange County.
- In November 2014, host community Diabetes Expo in recognition of American Diabetes Month in Orange County.
Year 2: Perform diabetes education gap analysis to determine specific populations and geographical locations where additional resources are needed. Identify Spanish speaking neighborhoods and/or populations in need of diabetes education and launch educational programs.

Specifically:
- Utilize community partners/focus groups to perform gap analysis and determine locations and audiences for expanded diabetes education programs by March 2015.
- Launch one, new community-based pilot diabetes education program in Orange County by June 2015.
- Launch one Spanish language community-based diabetes education program in Orange Counties by Sept. 2015.

Year 3: Evaluate effectiveness of pilot programs launched in 2015. If programs are determined to have been successful, continue to host additional programs. If programs are not considered successful, determine new location(s) for second pilot programs.

Specifically:
- Host three additional community-based diabetes education programs in Orange County by Dec. 2016
- Host three additional Spanish language community-based diabetes education programs in Orange County by Dec. 2016
APPENDIX B: 2013 ORANGE COUNTY COMMUNITY HEALTH ASSESSMENT (English and Spanish)

Orange County Department of Health
Edward A. Diana  Jean M. Hudson, MD, MPH
County Executive  Commissioner of Health

2013 Orange County Community Health Assessment
In collaboration with Bon Secours Charity Health System, Orange Regional Medical Center and St. Luke’s Cornwall Hospital

1. What is your zip code? __ __ __ __ __

2. What is your age?
   - 18-24 years
   - 25-34
   - 35-44
   - 45-54
   - 55-64
   - 65-74
   - 75 years and older

3. What category best describes your race?
   - White
   - Black or African American
   - Asian or Pacific Islander
   - Native American
   - Hispanic/Latino
   - Other (please tell us) ______________

4. What is your gender?
   - Male
   - Female

5. What was the highest level of education you received?
   - Less than high school
   - High school graduate/GED
   - Some college
   - Bachelor’s degree
   - Graduate/Doctoral/Post doctoral

6. Are you currently employed?
   - Yes, full-time
   - Yes, part-time
   - No, currently seeking employment
   - No
   - Retired
   - Stay at home parent

7. During the past 12 months, what was your total household income before taxes?
   - Less than $24,999
   - $25,000 - $49,999
   - $50,000 - $74,999
   - $75,000 - $99,999
   - $100,000 or more
   - Prefer not to answer

8. What is your main source of transportation?
   - Car
   - Bus
   - Taxi/Car Service
   - Medicaid Transport
   - Walking
   - Other (please tell us) ___________

9. How tall are you without shoes? ______ Feet _______ Inches

10. How much do you weigh? _______ Pounds

11. Do you have health insurance?  Yes  No

12. Where do you go most often when you are sick?
   - Doctor’s office
   - Emergency Room
   - Medical Clinic
   - Urgent Care Center
   - Other (please tell us) ______________
13. When you have a health question or concern, where do you go for information?
☐ Doctor/Nurse Practitioner  ☐ Media (TV)
☐ Family/Friends  ☐ Don’t know where to go
☐ Internet (Web MD/CDC/Mayo Clinic)  ☐ Other (please tell us)____________________

14. How long has it been since you visited a doctor for a routine physical exam or check-up?
☐ In the past year  ☐ In the past 5 years  ☐ Never
☐ In the past 2 years  ☐ Five or more years ago  ☐ Don’t Know

15. In the past two years, what is the main reason you did not have a routine physical exam or check-up?
☐ I had a physical in the past 2 years  ☐ Cannot find a doctor who speaks my language
☐ No health insurance  ☐ Health Care Provider said it was not needed
☐ Cannot afford  ☐ Do not like going / Afraid to go
☐ Co-pay or deductible too high  ☐ Did not have childcare
☐ Insurance does not cover  ☐ Didn’t know where to go
☐ Too far to travel  ☐ Couldn’t get an appointment
☐ Did not have transportation  ☐ The wait was too long
☐ Did not have the time  ☐ Other (please tell us)____________________

16. In the past 12 months, how did you pay for medicine prescribed by your doctor?
☐ Did not have any prescriptions to fill  ☐ Out of pocket (paid on my own)
☐ Insurance  ☐ Could not afford to fill the prescription
☐ Insurance plus co-pay

17. Do you have children under the age of 18 years old?  ☐ Yes  ☐ No

18. In the past 12 months, did your children have a routine physical exam or check-up?
☐ Yes  ☐ Only some  ☐ No  ☐ Not Applicable

19. Do your children have health insurance coverage?
☐ Yes  ☐ Only some  ☐ No  ☐ Don’t Know  ☐ Not Applicable

20. Are you aware of no or low cost health insurance programs available for your children (e.g., Child Health Plus or Medicaid)?
☐ Yes  ☐ No  ☐ Not Applicable

21. In a typical day, how many servings of fruit do you eat?
A serving is equal to 1 medium piece of fruit, ¼ cup of fruit salad, ¼ cup of dried fruit, 6 oz of 100% fruit juice
☐ 0 (none)  ☐ 1  ☐ 2  ☐ 3  ☐ 4 (or more)

22. In a typical day, how many servings of vegetables do you eat?
A serving is equal to 1 medium carrot, 1 small bowl of green salad, ¼ cup cooked vegetables, ¼ cup vegetable soup
☐ 0 (none)  ☐ 1  ☐ 2  ☐ 3  ☐ 4 (or more)

23. How often do you dine out (for any meal)?
☐ Never  ☐ 1-3 times a week  ☐ Every day
☐ Seldom/Rarely  ☐ 4-6 times a week
24. How many times per week do you engage in physical activity or exercise lasting at least a half an hour?
   □ 0 (none)  □ 1-2  □ 3-4  □ 5 (or more)

25a. If you do not engage in physical activity, what is the reason you do not exercise for at least a half hour during a normal week?
   □ Exercise is not important to me
   □ I don’t have access to a facility that has the things I need (example-pool)
   □ I don’t have enough time to exercise
   □ I do not have childcare
   □ I don’t know how to find exercise partners
   □ I don’t like to exercise
   □ It costs too much to exercise
   □ There is no safe place to exercise
   □ I am too tired to exercise
   □ I am physically disabled
   □ I don’t know
   □ Other (please tell us)

25b. If you engage in physical activity at least once per week, where do you go to exercise or engage in physical activity?
   □ YMCA
   □ Park
   □ Public Recreation Center
   □ Private Gym
   □ Home
   □ Other (please tell us)

26. In general, how would you describe your health?
   □ Excellent  □ Very Good  □ Good  □ Fair  □ Poor

27. In the past year, have you been advised to lose weight by your health care provider?
   □ Yes  □ No  □ I have not seen a health care provider in the past year

28. How would you describe your weight?
   □ Underweight  □ Normal weight  □ Overweight  □ Obese

29. Do you currently smoke?
   □ Yes  □ No

30. Have you been told by a health care provider that you have?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Diabetes</td>
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<td>High Blood Pressure</td>
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<td>High Cholesterol</td>
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<td>Cancer</td>
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<td>Asthma</td>
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<td>Depression or Anxiety</td>
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<td>Osteoporosis</td>
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<td>Overweight/Obesity</td>
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<tr>
<td>Heart Disease</td>
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31. When was the last time you saw any health care provider for?

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<thead>
<tr>
<th>Condition</th>
<th>In the past 6 months</th>
<th>In the past year</th>
<th>2+ years ago</th>
<th>Not Applicable</th>
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<tr>
<td>Diabetes</td>
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32. What are the top five (5) health priorities for you and your family living in Orange County?

- Routine Care for Adults
- Routine Care for Children
- Prenatal & Pregnancy Care
- Family Planning
- Women’s Health
- Dental Care
- Obesity
- Diabetes
- Heart Disease
- Asthma
- Tobacco
- Cancer
- HIV/AIDS
- Domestic Violence
- Sexually Transmitted Diseases
- Substance Abuse
- Mental Illness
- Intellectual/Developmental Disabilities
- Health Care Coverage
- Other (please tell us) ____________

33. What types of health care services do you receive OUTSIDE of Orange County?

Check all that apply.

- Routine Care for Adults
- Routine Care for Children
- Pediatric specialty care
- OB/GYN Services
- Cancer care
- Cardiology
- Dental Care
- Dermatology
- Infectious Diseases
- Digestive Diseases
- Geriatrics
- HIV/AIDS care
- Mental Health
- Neurology (Brain)
- Allergy, Immunology, Pulmonology (Example:asthma)
- Substance Abuse treatment
- Hematology (blood disorders)
- Intellectual/Developmental Disabilities
- Diabetes and Endocrinology
- Other (please tell us) ____________

34. What additional services would you like to see in Orange County?

Thank you for your time and effort in completing this survey. Your input will help shape future health initiatives in Orange County.
Evaluación de Salud de la Comunidad del Condado de Orange 2013
En colaboración con Bon Secours Charity Health Systems, Orange Regional Medical Center y St. Luke’s Cornwall Hospital

1. ¿Cuál es su código postal? __________

2. ¿Cuál es su edad?
   - 18-24 years
   - 25-34
   - 35-44
   - 45-54
   - 55-64
   - 65-74
   - 75 y mayor

3. ¿Qué categoría mejor describe su raza?
   - Blanca
   - Negra o Africana Americana
   - Asiática
   - Nativa Americana
   - Hispano/a / Latino/a
   - Otro (favor detallar) __________

4. ¿Cuál es su sexo?
   - Masculino
   - Femenina

5. ¿Cuál es su nivel de educación más alto?
   - Menos que bachiller
   - Licenciatura
   - Un poco de universidad
   - Bachiller/Equivalente
   - Graduado/Doctorado/Pos-doctorado

6. ¿Tiene empleo?
   - Sí, tiempo completo
   - Sí, tiempo parcial
   - No, estoy buscando
   - No
   - Estoy retirado/a
   - Soy ama/o de casa

7. ¿Cuál fue su salario antes de impuestos durante los últimos 12 meses?
   - Menos de $24,999
   - $25,000-$49,999
   - $50,000-$74,999
   - $75,000-$99,999
   - $100,000 o más
   - Prefiero no contestar

8. ¿Cuál es su principal método de transporte?
   - Auto
   - Autobus
   - Taxi
   - Transporte medico
   - Caminando
   - Otro (Explicar) __________

9. ¿Cuál es su estatura sin los zapatos puestos? _______ Pies _________ Pulgadas

10. ¿Cuál es su peso? _______ Libras

11. ¿Tiene seguro médico? Sí ______ No _______

12. ¿Adónde asiste la mayoría de veces que se enferma?
   - Oficina de doctor
   - Sala de Emergencia
   - Clínica Médica
   - Centro Médico de Urgencias
   - Otro (Explicar) __________
13. Cuando tiene alguna pregunta sobre la salud, ¿Adónde busca información?
- [ ] Doctor
- [ ] Familia/Amigos
- [ ] Internet
- [ ] Televisión/Radio
- [ ] No se adonde ir
- [ ] Otro (Explicar) ____________

14. ¿Qué tiempo ha transcurrido desde que ha visitado a un médico para un examen físico o chequeo de rutina?
- [ ] Durante el pasado año
- [ ] Durante los pasados 2 años
- [ ] Cinco años o más
- [ ] Nunca
- [ ] No tengo conocimiento

15. Durante los pasados 12 2 años, cual es la razón(es) principal(es) por la que no tuvo un examen físico o chequeo de rutina?
- [ ] Tuve un examen físico hace 2 años
- [ ] No tengo seguro médico
- [ ] No tenía para pagar
- [ ] Copago o deductible muy alto
- [ ] Seguro no lo cubre
- [ ] Muy lejos para viajar
- [ ] No tuve transporte
- [ ] No tuve tiempo
- [ ] No encontre un medico que hablara mi idioma
- [ ] Proveedor de Salud expreso que no lo necesitaba
- [ ] No me deje el la idea de ir / tuve miedo de ir
- [ ] No tuve quien me cuidara los niños
- [ ] No sabia adonde ir
- [ ] No pude hacer cita
- [ ] La espera era muy larga
- [ ] Otro (Favor detalizar) ____________

16. ¿Durante los pasados 12 meses, como ha pagado la medicina recetada por su médico?
- [ ] No tuve la necesidad de llenar alguna receta médica
- [ ] Seguro
- [ ] Seguro mas copago
- [ ] Efectivo (dinero) de su bolsillo (pagado por mi misma/o)
- [ ] No tuve los dineros para llenar la receta médica

17. ¿Tiene un hijo(s) bajo la edad de 18 años de edad?  [ ] Sí  [ ] No

18. ¿Si es sí, durante los pasados 12 meses, tuvieron todos un examen físico o chequeo de rutina?
- [ ] Sí
- [ ] Algunos
- [ ] No
- [ ] No Aplicable

19. ¿Sus hijos, tienen cubierta de seguro de salud?
- [ ] Sí
- [ ] Algunos
- [ ] No
- [ ] No tengo conocimiento
- [ ] No Aplicable

20. ¿Está usted al tanto de cero o bajo costo, de pagare por programas de seguro de cubierta de salud disponible para sus hijos (ejemplo: "Child Health Plus" o "Medicaid")?
- [ ] Sí
- [ ] No
- [ ] No Aplicable

21. En un día típico, ¿Cuántas porciones de frutas consume?
Una porción es igual a una fruta mediana, ⅓ taza de ensalada de frutas, ⅓ de frutas secas, 6 oz. de 100% jugo de fruta.
- [ ] 0 (Ninguna)
- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4 (o más)

22. En un día típico, ¿Cuántas porciones de vegetales consume?
Una porción es igual a una zanahoria mediana, una ensalada verde pequeña, ⅓ de taza de vegetales cocinados, ⅓ de taza de sopa de vegetales.
- [ ] 0 (Ninguna)
- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4 (o más)
23. ¿Cuántas veces sale a comer?
☐ Nunca  ☐ 1-3 Veces a la semana  ☐ Todos los días
☐ De vez en cuando  ☐ 4-6 Veces a la semana

24. ¿Cuántas veces a la semana hace ejercicios que duren por lo menos media hora?
☐ 0 (Ninguna)  ☐ 1-2  ☐ 3-4  ☐ 5 (o más)

25a. Sí no hace ejercicios, ¿Cuál es la razón que no los hace por lo menos media hora en una semana?
☐ El ejercicio no tiene impotancia para mí  ☐ Cuesta mucho
☐ No tengo acceso a gimnasio  ☐ No hay un lugar sano para hacer ejercicios
☐ No tengo suficiente tiempo  ☐ Paso muy cansado
☐ No tengo niñera  ☐ Estoy desabrilado/a
☐ No tengo pareja para hacer ejercicios  ☐ No sé
☐ No me gusta hacer ejercicios  ☐ Otro (Explicar) ______________________

25b. Sí hace ejercicios por lo menos una vez a la semana, ¿Adónde hace ejercicios?
☐ YMCA  ☐ Gymnasio Privado
☐ Parque  ☐ En Casa
☐ Centro de Recreación  ☐ Otro (Explicar) ______________________

26. En general, ¿Cómo puede describir su salud?
☐ Excelente  ☐ Muy Buena  ☐ Buena  ☐ Favorable  ☐ Mala

27. ¿Durante el pasado año, se le ha recomendado rebajar en peso por su proveedor de cuidado de la salud?
☐ Sí  ☐ No
☐ No he visitado al proveedor de cuidado de la salud durante el pasado año

28. ¿Cómo describiría su peso?
☐ Bajo peso  ☐ Peso normal  ☐ Sobre peso  ☐ Obeso

29. ¿Usted fuma actualmente?
☐ Sí  ☐ No

30. ¿Alguna vez le ha dicho su doctor que tiene....?

<table>
<thead>
<tr>
<th>enfermedad</th>
<th>Sí</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presión Alta</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colesterol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cáncer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asma</td>
<td></td>
<td></td>
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<td>Depresión/Ansiedad</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteoporosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sobre Peso/Obesidad</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enfermedades del Corazón</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
31. ¿Cuando fue la ultima vez que asistio al doctor para.....?

<table>
<thead>
<tr>
<th>Salud</th>
<th>Hace 6 meses</th>
<th>El año pasado</th>
<th>mas de 2 años</th>
<th>No Aplicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presión Alta</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colesterol</td>
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<tr>
<td>Cáncer</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Asma</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depresión/Ansiedad</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Osteoporosis</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Sobre Peso/Obesidad</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enfermedades del Corazón</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

32. ¿Cuáles 5 condiciones de salud considera que son prioridades para usted y su familia que vive en el Condado de Orange? (marcar todo lo que aplique)

- Atención Primaria para Adultos
- Atención Primaria para niños
- Atención Pre-natal y Embarazo
- Planificación Familiar
- Salud de la Mujer
- Cuidado Dental

- Diabetes
- Enfermedades del Corazón
- Asma
- Fumar
- Cancer
- VIH/SIDA
- Violencia Domestica
- Enfermedades Venereas
- Abuso de Sustancias
- Enfermedad Mental
- Discapacidades del Desarrollo
- Cobertura Médica
- Otro (Explicar) ____________

33. ¿Qué tipo de servicios de salud recibe usted afuera del Condado de Orange? (marcar todo lo que aplique)

- Atención Primaria para Adultos
- Atención de Pediatría
- Atención de Pediatría especial
- Ginecología
- Atención Primaria para el Cancer
- Cardiología
- Cuidado Dental
- Dermatología
- Enfermedades Infecciosas

- Enfermedades del Aparato Digestivo
- Geriatria
- Cuidado para el VIH/SIDA
- Cuidado Mental
- Neurología (Cerebro)
- Alergia, inmunología
- Neurología (E. Asma)
- No Aplicable

- Tratamiento para el Abuso de Sustancias
- Hematología (Enfermedades de la sangre)
- Discapacidades del Desarrollo
- Diabetes y Endocrinología
- Otro (Explicar) ____________

34. ¿Qué servicios adicionales quisiera ver en el Condado de Orange?

Gracias por su tiempo y esfuerzo en completar esta encuesta. Sus respuestas ayudaran a formar iniciativas de salud en el Condado de Orange.
## APPENDIX C: ORANGE COUNTY INDICATORS FOR TRACKING PUBLIC HEALTH PRIORITY AREAS, 2013 - 2017

### Orange County Indicators for Tracking Public Health Priority Areas, 2013-2017

#### Improve Health Status and Reduce Health Disparities

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Years</th>
<th>Orange County</th>
<th>New York State</th>
<th>NYS 2017 Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Percentage of premature death (before age 65 years)</td>
<td>2008-2010</td>
<td>27.6</td>
<td>24.3</td>
<td>21.8</td>
</tr>
<tr>
<td>2. Ratio of Black non-Hispanics to White non-Hispanics</td>
<td></td>
<td>1.88</td>
<td>2.12</td>
<td>1.87</td>
</tr>
<tr>
<td>3. Ratio of Hispanics to White non-Hispanics</td>
<td></td>
<td>2.04</td>
<td>2.14</td>
<td>1.86</td>
</tr>
<tr>
<td>4. Age-adjusted preventable hospitalizations rate per 10,000 - Ages 18+ years</td>
<td>2008-2010</td>
<td>150.0</td>
<td>155.0</td>
<td>133.3</td>
</tr>
<tr>
<td>5. Ratio of Black non-Hispanics to White non-Hispanics</td>
<td></td>
<td>1.63</td>
<td>2.09</td>
<td>1.85</td>
</tr>
<tr>
<td>6. Ratio of Hispanics to White non-Hispanics</td>
<td></td>
<td>0.85</td>
<td>1.47</td>
<td>1.38</td>
</tr>
<tr>
<td>7. Percentage of adults with health insurance - Ages 18-64 years</td>
<td>2010</td>
<td>85.0 (83.8-86.2)</td>
<td>83.1 (82.9-83.3)</td>
<td>100</td>
</tr>
<tr>
<td>8. Age-adjusted percentage of adults who have a regular health care provider - Ages 18+ years</td>
<td>2008-2009</td>
<td>83.1 (77.8-88.3)</td>
<td>83.0 (80.4-85.5)</td>
<td>90.8</td>
</tr>
</tbody>
</table>

#### Promote a Healthy and Safe Environment

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Years</th>
<th>Orange County</th>
<th>New York State</th>
<th>NYS 2017 Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Rate of hospitalizations due to falls per 10,000 - Ages 65+ years</td>
<td>2008-2010</td>
<td>220.9</td>
<td>204.6</td>
<td>Maintain</td>
</tr>
<tr>
<td>10. Rate of emergency department visits due to falls per 10,000 - Ages 1-4 years</td>
<td>2008-2010</td>
<td>506.0</td>
<td>476.8</td>
<td>429.1</td>
</tr>
<tr>
<td>11. Assault-related hospitalization rate per 10,000</td>
<td>2008-2010</td>
<td>3.0</td>
<td>4.8</td>
<td>4.3</td>
</tr>
<tr>
<td>12. Ratio of Black non-Hispanics to White non-Hispanics</td>
<td></td>
<td>5.54</td>
<td>7.43</td>
<td>6.69</td>
</tr>
</tbody>
</table>
### 13. Ratio of Hispanics to White non-Hispanics

<table>
<thead>
<tr>
<th>Years</th>
<th>Orange County</th>
<th>New York State</th>
<th>NYS 2017 Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.66</td>
<td>3.06</td>
<td>2.75</td>
</tr>
</tbody>
</table>

### 14. Ratio of low income ZIP codes to non-low income ZIP codes

<table>
<thead>
<tr>
<th>Years</th>
<th>Orange County</th>
<th>New York State</th>
<th>NYS 2017 Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0.20</td>
<td>3.25</td>
<td>2.92</td>
</tr>
</tbody>
</table>

### 15. Rate of occupational injuries treated in ED per 10,000 adolescents - Ages 15-19 years

<table>
<thead>
<tr>
<th>Years</th>
<th>Orange County</th>
<th>New York State</th>
<th>NYS 2017 Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2008-2010</td>
<td>55.1</td>
<td>36.7</td>
</tr>
</tbody>
</table>

### 16. Percentage of population that lives in a jurisdiction that adopted the Climate Smart Communities pledge

<table>
<thead>
<tr>
<th>Years</th>
<th>Orange County</th>
<th>New York State</th>
<th>NYS 2017 Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>100.0</td>
<td>26.7</td>
</tr>
</tbody>
</table>

### 17. Percentage of commuters who use alternate modes of transportation

<table>
<thead>
<tr>
<th>Years</th>
<th>Orange County</th>
<th>New York State</th>
<th>NYS 2017 Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2007-2011</td>
<td>26.5</td>
<td>44.6</td>
</tr>
</tbody>
</table>

### 18. Percentage of population with low-income and low access to a supermarket or large grocery store

<table>
<thead>
<tr>
<th>Years</th>
<th>Orange County</th>
<th>New York State</th>
<th>NYS 2017 Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2010</td>
<td>4.5</td>
<td>2.5</td>
</tr>
</tbody>
</table>

### 19. Percentage of homes in Healthy Neighborhood Program that have fewer asthma triggers during the home revisits

<table>
<thead>
<tr>
<th>Years</th>
<th>Orange County</th>
<th>New York State</th>
<th>NYS 2017 Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2008-2011</td>
<td>5.9*</td>
<td>12.9</td>
</tr>
</tbody>
</table>

### 20. Percentage of residents served by community water systems with optimally fluoridated water

<table>
<thead>
<tr>
<th>Years</th>
<th>Orange County</th>
<th>New York State</th>
<th>NYS 2017 Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>37.0</td>
<td>71.4</td>
</tr>
</tbody>
</table>

### Prevent Chronic Diseases

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Years</th>
<th>Orange County</th>
<th>New York State</th>
<th>NYS 2017 Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>21.</td>
<td>2008-2009</td>
<td>25.9 (20.9-30.9)</td>
<td>23.2 (21.2-25.3)</td>
<td>23.2</td>
</tr>
<tr>
<td>22.</td>
<td>2010-2012</td>
<td>17.5</td>
<td>17.6</td>
<td>NYC: 19.7, ROS: 16.7</td>
</tr>
<tr>
<td>23.</td>
<td>2008-2009</td>
<td>20.3 (14.8-25.8)</td>
<td>16.8 (15.1-18.6)</td>
<td>15.0</td>
</tr>
<tr>
<td>24.</td>
<td>2008-2009</td>
<td>69.9 (62.9-76.1)</td>
<td>66.3 (63.5-69.1)</td>
<td>71.4</td>
</tr>
<tr>
<td>25.</td>
<td>2008-2010</td>
<td>66.7</td>
<td>83.7</td>
<td>75.1</td>
</tr>
<tr>
<td>26.</td>
<td>2008-2010</td>
<td>92.4</td>
<td>221.4</td>
<td>196.5</td>
</tr>
<tr>
<td>27.</td>
<td>2010</td>
<td>20.4</td>
<td>15.5</td>
<td>14.0</td>
</tr>
<tr>
<td>28.</td>
<td>2008-2010</td>
<td>2.0</td>
<td>3.2</td>
<td>3.06</td>
</tr>
</tbody>
</table>
### Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infections

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Years</th>
<th>Orange County</th>
<th>New York State</th>
<th>NYS 2017 Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>31. Percentage of adolescent females with 3-dose HPV immunization - Ages 13-17 years</td>
<td>2011</td>
<td>12.4</td>
<td>26.0</td>
<td>50</td>
</tr>
<tr>
<td>32. Percentage of adults with flu immunization - Ages 65+ years</td>
<td>2008-2009</td>
<td>74.6 (67.1-82.2)</td>
<td>75.0 (71.5-78.5)</td>
<td>66.2</td>
</tr>
<tr>
<td>33. Newly diagnosed HIV case rate per 100,000</td>
<td>2008-2010</td>
<td>7.8</td>
<td>21.6</td>
<td>14.7</td>
</tr>
<tr>
<td>34. Difference in rates (Black and White) of new HIV diagnoses</td>
<td></td>
<td>29.1</td>
<td>59.4</td>
<td>45.7</td>
</tr>
<tr>
<td>35. Difference in rates (Hispanic and White) of new HIV diagnoses</td>
<td></td>
<td>14.9</td>
<td>31.1</td>
<td>22.3</td>
</tr>
<tr>
<td>36. Gonorrhea case rate per 100,000 women - Ages 15-44 years</td>
<td>2010</td>
<td>75.2</td>
<td>203.4</td>
<td>183.1</td>
</tr>
<tr>
<td>37. Gonorrhea case rate per 100,000 men - Ages 15-44 years</td>
<td>2010</td>
<td>45.8</td>
<td>221.7</td>
<td>199.5</td>
</tr>
<tr>
<td>38. Chlamydia case rate per 100,000 women - Ages 15-44 years</td>
<td>2010</td>
<td>977.3</td>
<td>1619.8</td>
<td>1,458</td>
</tr>
<tr>
<td>39. Primary and secondary syphilis case rate per 100,000 males</td>
<td>2010</td>
<td>3.2*</td>
<td>11.2</td>
<td>10.1</td>
</tr>
<tr>
<td>40. Primary and secondary syphilis case rate per 100,000 females</td>
<td>2010</td>
<td>0.5*</td>
<td>0.5</td>
<td>0.4</td>
</tr>
</tbody>
</table>

### Promote Healthy Women, Infants, and Children

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Years</th>
<th>Orange County</th>
<th>New York State</th>
<th>NYS 2017 Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>41. Percentage of preterm births</td>
<td>2008-2010</td>
<td>10.4</td>
<td>12.0</td>
<td>10.2</td>
</tr>
<tr>
<td>42. Ratio of Black non-Hispanics to White non-Hispanics</td>
<td></td>
<td>1.58</td>
<td>1.61</td>
<td>1.42</td>
</tr>
<tr>
<td>43. Ratio of Hispanics to White non-Hispanics</td>
<td></td>
<td>1.29</td>
<td>1.25</td>
<td>1.12</td>
</tr>
<tr>
<td></td>
<td>Measure</td>
<td>2008-2010</td>
<td>2009-2011</td>
<td>2010</td>
</tr>
<tr>
<td>---</td>
<td>------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-----------</td>
<td>-----------</td>
</tr>
<tr>
<td>44.</td>
<td>Ratio of Medicaid births to non-Medicaid births</td>
<td>0.96</td>
<td>1.10</td>
<td>1.00</td>
</tr>
<tr>
<td>45.</td>
<td>Percentage of infants exclusively breastfed in the hospital</td>
<td>2008-2010</td>
<td>44.5</td>
<td>42.5</td>
</tr>
<tr>
<td>46.</td>
<td>Ratio of Black non-Hispanics to White non-Hispanics</td>
<td>0.64</td>
<td>0.50</td>
<td>0.57</td>
</tr>
<tr>
<td>47.</td>
<td>Ratio of Hispanics to White non-Hispanics</td>
<td>0.87</td>
<td>0.55</td>
<td>0.64</td>
</tr>
<tr>
<td>48.</td>
<td>Ratio of Medicaid births to non-Medicaid births</td>
<td>0.84</td>
<td>0.57</td>
<td>0.66</td>
</tr>
<tr>
<td>49.</td>
<td>Maternal mortality rate per 100,000 births</td>
<td>2008-2010</td>
<td>19.4*</td>
<td>23.3</td>
</tr>
<tr>
<td>50.</td>
<td>Percentage of children who have had the recommended number of well child visits in government sponsored insurance programs</td>
<td>2011</td>
<td>67.9</td>
<td>69.9</td>
</tr>
<tr>
<td>51.</td>
<td>Percentage of children ages 0-15 months who have had the recommended number of well child visits in government sponsored insurance programs</td>
<td>2011</td>
<td>76.8</td>
<td>82.8</td>
</tr>
<tr>
<td>52.</td>
<td>Percentage of children ages 3-6 years who have had the recommended number of well child visits in government sponsored insurance programs</td>
<td>2011</td>
<td>78.5</td>
<td>82.8</td>
</tr>
<tr>
<td>53.</td>
<td>Percentage of children ages 12-21 years who have had the recommended number of well child visits in government sponsored insurance programs</td>
<td>2010</td>
<td>58.8</td>
<td>61.0</td>
</tr>
<tr>
<td>54.</td>
<td>Percentage of children with any kind of health insurance - Ages 0-19 years</td>
<td>2010</td>
<td>94.4 (93.3-95.5)</td>
<td>94.9 (94.5-95.3)</td>
</tr>
<tr>
<td>55.</td>
<td>Percentage of third-grade children with evidence of untreated tooth decay</td>
<td>2009-2011</td>
<td>30.0 (23.7-36.3)</td>
<td>24.0 (22.6-25.4)</td>
</tr>
<tr>
<td>56.</td>
<td>Ratio of low-income children to non-low income children</td>
<td>2010</td>
<td>2.04</td>
<td>2.46</td>
</tr>
<tr>
<td>57.</td>
<td>Adolescent pregnancy rate per 1,000 females - Ages 15-17 years</td>
<td>2008-2010</td>
<td>23.9</td>
<td>31.1</td>
</tr>
<tr>
<td>58.</td>
<td>Ratio of Black non-Hispanics to White non-Hispanics</td>
<td>2010</td>
<td>3.48</td>
<td>5.74</td>
</tr>
<tr>
<td>59.</td>
<td>Ratio of Hispanics to White non-Hispanics</td>
<td>2010</td>
<td>4.13</td>
<td>5.16</td>
</tr>
</tbody>
</table>
60. Percentage of unintended pregnancy among live births
   2011 | 28.4 | 26.7 | 24.2

   Ratio of Black non-Hispanics to White non-Hispanics
   2011 | 2.36 | 2.09 | 1.88

   Ratio of Hispanics to White non-Hispanics
   2011 | 2.07 | 1.58 | 1.36

   Ratio of Medicaid births to non-Medicaid births
   2011 | 1.68 | 1.69 | 1.56

64. Percentage of women with health coverage - Ages 18-64 years
   2010 | 87.6 (86.1-89.1) | 86.1 (85.8-86.4) | 100

65. Percentage of live births that occur within 24 months of a previous pregnancy
   2008-2010 | 20.5 | 18.0 | 17.0

**Promote Mental Health and Prevention Substance Abuse**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Years</th>
<th>Orange County</th>
<th>New York State</th>
<th>NYS 2017 Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>66. Age-adjusted percentage of adults with poor mental health for 14 or more days in the last month</td>
<td>2008-2009</td>
<td>7.9 (5.4-10.5)</td>
<td>10.2 (8.7-11.7)</td>
<td>10.1</td>
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<tr>
<td>68. Age-adjusted suicide death rate per 100,000</td>
<td>2008-2010</td>
<td>7.4</td>
<td>6.8</td>
<td>5.9</td>
</tr>
</tbody>
</table>

* Fewer than 10 events in the numerator, therefore the rate is unstable
+ Fewer than 10 events in one or both rate numerators, therefore the ratio is unstable
  
s Data do not meet reporting criteria

1- Alternate modes of transportation include public transportation, carpool, bike, walk, and telecommute
2- Low access is defined as greater than one mile from a supermarket or grocery store in urban areas or greater than ten miles from a supermarket or grocery store in rural areas
3- The 4:3:1:3:3:1:4 immunization series includes: 4 DTaP, 3 polio, 1 MMR, 3 hep B, 3 Hib, 1 varicella, 4 PCV13
4- Government sponsored insurance programs include Medicaid and Child Health Plus
Questions or comments: phiginfo@health.state.ny.us
Revised: August 2013
# APPENDIX D: NYS PREVENTION AGENDA PARTNERS – ORANGE COUNTY, NY

NYS Prevention Agenda Partners - Orange County, NY

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Focus Area</th>
<th>Partner</th>
<th>Partner Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promote a Healthy and Safe Environment</td>
<td>Water Quality</td>
<td>Orange County</td>
<td>Drinking Water Enhancement</td>
</tr>
<tr>
<td>Promote a Healthy and Safe Environment</td>
<td>Built Environment</td>
<td>Orange County</td>
<td>Childhood Lead Poisoning Primary Prevention Program</td>
</tr>
<tr>
<td>Promote a Healthy and Safe Environment</td>
<td>Built Environment</td>
<td>Orange County</td>
<td>Healthy Neighborhoods Program</td>
</tr>
<tr>
<td>Promote a Healthy and Safe Environment</td>
<td>Built Environment</td>
<td>Orange County</td>
<td>Lead Poisoning Prevention Program</td>
</tr>
<tr>
<td>Promote a Healthy and Safe Environment</td>
<td>Injuries, Violence And Occupational Health</td>
<td>Mental Health Association in Orange County, Inc.</td>
<td>Rape Crisis &amp; Sexual Violence Prevention</td>
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<tr>
<td>Prevent Chronic Diseases</td>
<td>Reduce Obesity In Children And Adults</td>
<td>New York State Association of County Health Officials</td>
<td>ARRA Component II - Menu Labeling</td>
</tr>
<tr>
<td>Prevent Chronic Diseases</td>
<td>Reduce Obesity In Children And Adults</td>
<td>Orange County Health Department</td>
<td>Strategic Alliance for Health (SAH)</td>
</tr>
<tr>
<td>Prevent Chronic Diseases</td>
<td>Reduce Illness, Disability And Death Related to Tobacco Use And Secondhand Smoke</td>
<td>American Lung Association of New York, Inc. for POW’R Against Tobacco Coalition</td>
<td>Prevent initiation of tobacco use by New York youth and young adults, especially among low socioeconomic (SES) populations Eliminate exposure to secondhand smoke</td>
</tr>
<tr>
<td>Prevent Chronic Diseases</td>
<td>Reduce Illness, Disability And Death Related to Tobacco Use And Secondhand Smoke</td>
<td>Orange County Health Department</td>
<td>Tobacco Enforcement Program (ATUPA)</td>
</tr>
<tr>
<td>Prevent Chronic Diseases</td>
<td>Reduce Illness, Disability And Death Related to Tobacco Use And Secondhand Smoke</td>
<td>American Lung Association of New York, Inc. for POW’R Cessation</td>
<td>Promote tobacco use cessation, especially among low SES populations and those with poor mental health</td>
</tr>
<tr>
<td>Prevent Chronic Diseases</td>
<td>Reduce Illness, Disability And Death Related to Tobacco Use And Secondhand Smoke</td>
<td>Orange County Health Department</td>
<td>Prevent initiation of tobacco use by New York youth and young adults, especially among low socioeconomic (SES) populations</td>
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<tr>
<td>Prevent Chronic Diseases</td>
<td>Increase Access To High Quality Chronic Disease Preventive Care And Management In Both Clinical And Community Settings</td>
<td>American Lung Association (Hudson Valley Asthma Coalition)</td>
<td>Regional Asthma Coalitions</td>
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<tr>
<td>Prevent Chronic Diseases</td>
<td>Increase Access To High Quality Chronic Disease Preventive Care And Management In Both Clinical And Community Settings</td>
<td>Clearwater Research Inc.</td>
<td>Sodium Reduction in Communities</td>
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<tr>
<td>Prevent Chronic Diseases</td>
<td>Increase Access To High Quality Chronic Disease Preventive Care And Management In Both Clinical And Community Settings</td>
<td>Middletown YMCA</td>
<td>YMCA-Diabetes Prevention Program (Y-DPP)</td>
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<tr>
<td>Prevent Chronic Diseases</td>
<td>Increase Access To High Quality Chronic Disease Preventive Care And Management In Both Clinical And Community Settings</td>
<td>The New York Academy of Medicine (NYAM)</td>
<td>Designing a Strong and Healthy New York (DASH-NY)</td>
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<tr>
<td>Prevent Chronic Diseases</td>
<td>Increase Access To High Quality Chronic Disease Preventive Care And Management In Both Clinical And Community Settings</td>
<td>YWCA of Orange County</td>
<td>Increase screening rates for cardiovascular disease, diabetes and breast/cervical/colorectal cancer, especially among disparate populations</td>
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<td>Prevent HIV, STDs, Vaccine Preventable Diseases and Healthcare Associated Infections</td>
<td>Prevent HIV and STDS</td>
<td>Hudson River Health Care, Inc.</td>
<td>Hepatitis C - Mono-Infected (State Funded)</td>
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<tr>
<td>Service</td>
<td>Prevent HIV and STDS</td>
<td>Preventable Disease and Healthcare Associated Infections</td>
<td>Hudson Valley Community Services, Inc.</td>
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<tr>
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<tr>
<td>Prevent HIV, STDs, Vaccine Preventable Diseases and Healthcare Associated Infections</td>
<td>Prevent HIV and STDS</td>
<td>Preventable Disease and Healthcare Associated Infections</td>
<td>Hudson Valley Community Services, Inc.</td>
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<tr>
<td>Prevent HIV, STDs, Vaccine Preventable Diseases and Healthcare Associated Infections</td>
<td>Prevent HIV and STDS</td>
<td>Preventable Disease and Healthcare Associated Infections</td>
<td>Hudson Valley Community Services, Inc.</td>
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<tr>
<td>Prevent HIV, STDs, Vaccine Preventable Diseases and Healthcare Associated Infections</td>
<td>Prevent HIV and STDS</td>
<td>Preventable Disease and Healthcare Associated Infections</td>
<td>Hudson Valley Community Services, Inc.</td>
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<tr>
<td>Prevent HIV, STDs, Vaccine Preventable Diseases and Healthcare Associated Infections</td>
<td>Prevent HIV and STDS</td>
<td>Preventable Disease and Healthcare Associated Infections</td>
<td>Hudson Valley Community Services, Inc.</td>
</tr>
<tr>
<td>Prevent HIV, STDs, Vaccine Preventable Diseases and Healthcare Associated Infections</td>
<td>Prevent Vaccine Preventable Diseases</td>
<td>Preventable Disease and Healthcare Associated Infections</td>
<td>Orange County Health Department</td>
</tr>
<tr>
<td>Prevent HIV, STDs, Vaccine Preventable Diseases and Healthcare Associated Infections</td>
<td>Prevent Vaccine Preventable Diseases</td>
<td>Preventable Disease and Healthcare Associated Infections</td>
<td>Orange County Health Department</td>
</tr>
<tr>
<td>Promote Healthy Women, Infants, and Children</td>
<td>Child Health</td>
<td>Preventable Disease and Healthcare Associated Infections</td>
<td>Orange County Health Department</td>
</tr>
<tr>
<td>Promote Healthy Women, Infants, and Children</td>
<td>Maternal and Infant Health</td>
<td>Preventable Disease and Healthcare Associated Infections</td>
<td>Agri-Business Child Development</td>
</tr>
<tr>
<td>Promote Healthy Women, Infants, and Children</td>
<td>Maternal and Infant Health</td>
<td>Preventable Disease and Healthcare Associated Infections</td>
<td>Hudson River HealthCare</td>
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<tr>
<td>Promote Healthy Women, Infants, and Children</td>
<td>Maternal and Infant Health</td>
<td>Preventable Disease and Healthcare Associated Infections</td>
<td>Orange County Health</td>
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<tr>
<td>Promote Healthy Women, Infants, and Children</td>
<td>Maternal and Infant Health</td>
<td>Orange County Health Department</td>
<td>Community Health Worker Program</td>
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<tr>
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<tr>
<td>Promote Healthy Women, Infants, and Children</td>
<td>Child Health</td>
<td>Maternal Infant Services Network of Orange, Suffolk and Ulster Co. Inc.</td>
<td>Comprehensive Prenatal-Perinatal Networks</td>
</tr>
<tr>
<td>Promote Healthy Women, Infants, and Children</td>
<td>Child Health</td>
<td>Middletown Community Health Center</td>
<td>School Based Health Centers</td>
</tr>
<tr>
<td>Promote Healthy Women, Infants, and Children</td>
<td>Child Health</td>
<td>Orange County Health Department</td>
<td>Children with Special Health Care Needs Program</td>
</tr>
<tr>
<td>Promote Healthy Women, Infants, and Children</td>
<td>Child Health</td>
<td>Orange County Health Department</td>
<td>Healthy Mom Healthy Baby</td>
</tr>
<tr>
<td>Promote Healthy Women, Infants, and Children</td>
<td>Child Health</td>
<td>Orange County Health Department</td>
<td>Community Health Worker Program</td>
</tr>
<tr>
<td>Promote Healthy Women, Infants, and Children</td>
<td>Reproductive, Preconception And Inter-Conception Health</td>
<td>Maternal Infant Services Network of Orange, Suffolk and Ulster Co. Inc.</td>
<td>Comprehensive Prenatal-Perinatal Networks</td>
</tr>
<tr>
<td>Promote Healthy Women, Infants, and Children</td>
<td>Reproductive, Preconception And Inter-Conception Health</td>
<td>Maternal Infant Services Network of Orange, Sullivan and Ulster Counties</td>
<td>Comprehensive Adolescent Pregnancy Prevention</td>
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<tr>
<td>Promote Healthy Women, Infants, and Children</td>
<td>Reproductive, Preconception And Inter-Conception Health</td>
<td>Orange County Health Department</td>
<td>Healthy Mom Healthy Baby</td>
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<tr>
<td>Promote Healthy Women, Infants, and Children</td>
<td>Reproductive, Preconception And Inter-Conception Health</td>
<td>Orange County Health Department</td>
<td>Community Health Worker Program</td>
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<tr>
<td>Promote Mental Health and Prevention Substance Abuse</td>
<td>Promote Mental, Emotional and Behavioral (MEB) Well-Being in Communities</td>
<td>Orange County Health Department</td>
<td>Community Health Worker Program</td>
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<tr>
<td><strong>Promote Mental Health and Prevention Substance Abuse</strong></td>
<td><strong>Prevent Substance Abuse And Other MEB Disorders</strong></td>
<td><strong>Orange County Health Department</strong></td>
<td><strong>Community Health Worker Program</strong></td>
</tr>
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</tr>
<tr>
<td><strong>Promote Mental Health and Prevention Substance Abuse</strong></td>
<td><strong>Strengthen Infrastructure Across Systems</strong></td>
<td><strong>Orange County Health Department</strong></td>
<td><strong>Healthy Mom Healthy Baby</strong></td>
</tr>
</tbody>
</table>