Community Health Improvement Plan

Putnam County July 2014

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Putnam County Community Health Improvement Plan
Work Group Acknowledgments

Mary L. Garcia
Administrator
Putnam County Health Department

Gerald S. Christine
Chief Executive Officer
Putnam Community Medical Center

John Whiteside
Interim Chief Executive Officer
Putnam Community Medical Center

Kena Foster RN, SANE/A, SANE/P, FNCC
Senior Community Health
Nursing Director
Putnam County Health Department

Jane Zentko MS, RD, LD/N
WIC/Chronic Disease Program Director
Putnam County Health Department

Karl Flagg
Commissioner
Putnam Board of County Commissioners

John Bergquist
Mayor
Town of Pomona Park

Gordon Sands
Mayor
Town of Welaka

John Nelson
Executive Director
Palatka Housing Authority

Rosemary Anderson
President
Arts Council of Greater Palatka

Sheila McCoy
Executive Director
Palatka Christian Service Center

Benjie Bates
Partner - *Bates Hewitt and*
Board Member
Stewart Marchman-Act Behavioral
Healthcare

Laura M. Spencer
President & CEO
Rural Health Care, Inc.
d/b/a Family Medical & Dental Centers

Deborah Wood, BSN, MBA, HCRM
Vice President &
Clinical Operations Officer
Rural Health Care, Inc.
d.b.a. Family Medical & Dental Centers

Dr. Bonnie Harrison
Chairman, Board of Directors
Putnam Family Fitness Center

Kraig McLane, AICP
Vice-Chairman
Putnam County Trails Council

Tom J. Rodgers
Pastor
Bethlehem Baptist Church

Florida HEALTH Putnam County

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Overview

The Putnam County L.O.G.I.C. (Local Government in Collaboration) is a long standing Team comprised of a key State, County, City or Township appointed and elected officials, government representatives and Community Stakeholders that meet quarterly to improve communications and interactions within the county. In June 2013, then Board of County Commissioner Chair Nancy Harris appointed co-chairs and the new Health Officer to a sub-committee to address the 2013 Robert Wood Johnson County Health Rankings. This sub-committee focused on measures to improve Putnam County and to move L.O.G.I.C. to the focus on the Collaboration for Putnam's Future.

In the fall of 2013, a task force gathered to review data to assess changes to Putnam County's health status, impacts of the ACA and access to care, the 2013 Robert Wood Johnson County Health Rankings and shared goals to improve health. The issues are interconnected and affect the entire county: Economic Development, Education, Health, Transportation, Public Safety and Communications. The task force recommended that L.O.G.I.C. establish workgroups and have members serve on one or more of the six workgroups.

A key component of Putnam County's 2012 CHIP was to create a permanent and ongoing health issues task force or coordinating body to lead community projects to address health issues and to shepherd ongoing needs assessment and community health improvement activities. The L.O.G.I.C-Health Workgroup brought together L.O.G.I.C members, individuals that had served on the 2012 Community Health Improvement Plan (CHIP), public and private health communities, governmental services, public housing, and citizens.

The 2014 Community Health Improvement Plan (CHIP) for Putnam County is the result of a community-driven planning process and is designed to address specific opportunities for improved health that have been identified by the community.

The 2014 CHIP planning process employed an abbreviated Mobilizing for Action through Planning and Partnerships (MAPP) framework, developed by the National Association of County and City Health Officials and the Centers for Disease Control (www.naccho.org/topics/infrastructure/mapp/). For purposes of the 2014 CHIP revision and

realignment, the CHIP Planning Team (aka L.O.G.I.C-Health Workgroup) reviewed Phases 1-4 of the MAPP process completed during the development of the 2012 CHIP. The CHIP Planning Team concluded much of the current situation in Putnam County remained unchanged from 2012.

It became clear that the fragmented approach to addressing discrete components of the health care system had failed to bring about improvements in the overall health or reduction of health disparities among Putnam County residents. In fact, in several areas, according to the 2013 Robert Wood Johnson County Health Rankings, Putnam County had either not measurably improved or had taken a step backward since the previous CHIP was implemented.

The team concluded concentrated efforts were needed in relation to Obesity, Nutrition, and Physical Activity; Adolescent Health; Mental Health; and Dental/Oral Health. The team also determined the **process used to deliver these initiatives was** as important to the outcome as was the **focusing of resources** on specific goals and objectives.

Key Community Health Needs Assessment

The CHIP Planning Team held four meetings to address the analysis and refinement of the existing 2012 CHIP plan. During the first two meetings, held on 4/25/2014 and 5/14/2014, the CHIP Planning Team conducted an analysis of the existing CHIP, including

1. A review of the Basic themes, Priority Issues, and Goals from the previous Community Health Improvement Plan (CHIP) completed in 2012.
2. A discussion of the alignment of Putnam's CHIP and the overall State CHIP
3. A discussion of the alignment of Putnam's Strategic Plan and the State Department of Health's Strategic Plan.

The Community Themes/Priority Issues and Goals from the previous Community Health Improvement Plan (CHIP) completed in 2012 included:

1. **Community Themes/Priority Issues:**

- **Population disparities** - Low income, high poverty and limited economic base continue to be leading predictors of health outcome and health access in Putnam County both on an individual and county-wide basis. Racial disparities are present in Putnam County as in the rest of the state. In particular, during 2006-2008, black residents in Putnam County had a 22% higher overall age-adjusted mortality rate compared to white residents (1091.8 and 894.1 per 100,000, respectively). Life expectancies of black residents are 5-6 years shorter than that of white residents.
- **Accessibility-financial constraints -** Census Small Area Health Insurance Estimates (SAHIE) program released 2009 estimates of health insurance coverage by age at the county-level for 2009. SAHIE estimated that 25.4% of the Putnam County adult population was uninsured compared to 24.2% for Florida.
- **Accessibility – physical constraints** – Access to transportation is one of the highest rated needs by Putnam residents. The lack of transportation resources to low and moderate income residents affects access to healthcare as well as adherence to ongoing medical treatment. Transportation has been linked to isolation and depression as well as placing limits on access to exercise options.

- **Inappropriate use of resources**. Putnam County's rate of avoidable hospitalizations is nearly 28% higher than the state rate.

Goals from the previous CHIP

a. Strengthen community partnerships
b. Reduce inappropriate access
c. Increase access to care

2. The Alignment of Putnam's CHIP and Strategic Plan with the Florida CHIP and Strategic Plan revealed that areas perhaps requiring additional consideration in Putnam's planning efforts included:

- Health issues such as:
  - Overweight and Obesity
  - Maternal / Child Health
  - Behavioral Health
  - Nutrition and Food Related Issues
  - Healthy Lifestyles
  - STDs and Infectious Disease
- Strategic issues including:
  - Maximizing funding
  - Optimizing Communications and Partnerships
  - Attracting, Recruiting and Retaining Workforce

Finally, the CHIP Planning Team conducted a brief Health Needs Assessment including both quantitative and qualitative factors. The qualitative review included a discussion of anecdotal information presented by the Planning Team members and the quantitative review included an analysis of the Health Behaviors and Clinical Care components of the County Health Rankings over the period since the last CHIP, or from 2012 to 2014. The conclusion of these discussions and analyses highlighted several Health Behaviors and Clinical Care Resources that were considerably worse than State and National referents and/or were either not improving or actually getting worse.

The following Tables present comparative data on the relative health of Putnam County residents and their access to health care. These data target those health factors and clinical care resources that are most pressing / challenging for residents of Putnam County and, as such, are not intended to be encompassing of all health behaviors and clinical resources.

Data on the tables is expressed in ratio form, with factoring adjusted so that higher numbers are always indicative of a higher rate of the problem behavior or lower access to clinical care. Hence, in the area of Access to Exercise Options, Putnam residents are confronted by over twice (2.05) the limitations as are other State residents and 3 times the limitations identified as a national norm. Similarly, the Teen Birth Rate is 1.89 times the rate for all of Florida and 3.6 times the rate for the national norm. The far right column indicates the trend for Putnam residents over the past 3 years.

TABLE 1: Relationship between the Health Behaviors of Putnam Residents, State Data, and National Norms

Health Behaviors	Relation to:		Trend Line for Putnam
	State	Nation	
Access to Exercise Options (variance from 100%)	2.05	3.00	N/A
Teen Birth Rate	1.89	3.60	Worsening
Smoking	1.50	1.93	Improving
Food Environment Index (variance from 10)	1.43	3.08	N/A
Obesity	1.31	1.36	Worsening
Sexually Transmitted Diseases	1.03	3.34	Improving

Access to Clinical Care is also presented in comparative form, such that Putnam residents have less access to Mental Health Providers by a factor of over 2.5 times the State average and 4.5 times the national norm. Mammography screening is present not because the rate of screening is so much worse than State or national norms, but that the trend is worsening.

TABLE 2: Relationship between Access to Clinical Care by Putnam Residents, State Data, and National Norms

Clinical Care	Relation to:		Trend Line
	State	Nation	
Mental Health Providers	2.65	4.50	N/A
Mammography Screening	1.13	1.24	Worsening

Putnam County CHIP (Goals, Strategies and Objectives)

CHIP Planning Summary

The 2014 CHIP does not break new ground in the identification of new or emerging issues in the health of residents. In fact, most Putnam County residents can identify the issues that confront the local population- the challenge lies in how to effectively address them. In response, the 2014 CHIP focused on a changing the County's approach to addressing those problems.

Because the CHIP Planning Team is also the comprised of L.O.G.I.C-Health Workgroup members, it was the consensus this sustainable organization should specifically be utilized in implementing new CHIP strategies. This is particularly important because the CHIP Planning initiative, itself, takes a subordinate role after the CHIP realignment effort is completed. However, the L.O.G.I.C-Health Workgroup has a standing, ongoing role in the community and, can therefore act to steer and oversee CHIP implementations, not just the development of the Plan.

The CHIP Planning Team identified, for itself, a Leadership role in developing Strategies and Implementations that can cut across all LOGIC Work Groups. Specifically

- Leadership- Identify an agency to spearhead CHIP implementations, with preference being an agency from the private sector
- Support – Health Subcommittee members to provide strategic planning, policy, and programmatic support

The CHIP Planning Team was clear about the need to strike a balance between Programmatic and Policy activities in the CHIP implementations and suggested that Implementation Activities should be framed within a community and environmental context following a systematic process such as that specified in the *Protocol for Assessing Community Excellence in Environmental Health (PACE EH).* While the CHIP Planning Team did not specify a formal implementation of PACE-EH, the consensus of members was that an **environmental health** model of implementation to selected communities was a way to maximize the impact of scarce resources and provide a mechanism that this impact can be seen, assessed, and reported to the County at-large.

The following pages present the Goals, Strategies, and Objectives defined for the 2014 CHIP. Some of these have been developed for all areas of the County while others are suggested for targeted implementation for residents of the Palatka Housing Authority and two neighborhoods selected by need and the willingness of residents to provide local leadership.

GOAL 1. Identify and precisely define two neighborhoods within Putnam County that will be addressed through an **environmental health** model of public health implementation focusing on Adult and Youth Nutrition/Exercise/Obesity; Adolescent Health; Mental Health; and Oral Health.

Strategy 1.1 Select two Neighborhoods and a Lead Agency for each to guide and lead initiatives to address community health.

Objective 1.1.1: Two neighborhoods will be selected with precise geographic boundaries by November 1, 2014[1]

Objective 1.1.2: A Lead Agency for each neighborhood will be selected by December 1, 2014

Objective 1.1.3: A Community Coordinating Team of neighborhood residents will be formed and fully functional by February 1, 2015

Strategy 1.2 Conduct a SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis of the selected neighborhoods

Objective 1.2.1: Identify the Strengths of each neighborhood, including: community and recreational facilities, infrastructure and public service improvements; community leadership; resident engagement; code enforcement; and housing by March 1, 2015.

Objective 1.2.2: Identify the Weaknesses of each neighborhood, including: low socio-economic conditions; poor access to healthy foods; poor access to community and recreational facilities; high crime rates; low access to transportation; and low utilization of primary care, mental health and oral health services by March 1, 2015.

Objective 1.2.3: Identify the Opportunities of each neighborhood, including: underutilized community and recreational facilities, resources for Infrastructure and public service improvements; engagement of faith community; private, state, and federal funding opportunities by March 1, 2015.

Objective 1.2.4: Identify the Threats to each neighborhood, including: community perception of health resources and services; impact of low educational levels on community empowerment; reductions in public funding for health services by March 1, 2015.

Strategy 1.3 Seek funding to support health initiatives

Objective 1.3.1: Develop resources needed to prepare and submit three-four state, federal, or major private grant requests annually by January 1, 2015.

Objective 1.3.2: Provide quarterly reports on the results of grant writing beginning April 1, 2015.

[1] Preliminary discussions have pointed toward including the "Lemon Heights" neighborhood and the blocks in North Palatka behind the Wendy's Restaurant on Crill Avenue, Final decisions will be reached based on a consideration of both risk factors and community commitment to change

GOAL 2. Implement Adult/Youth Nutrition and Physical Exercise Programs to reduce the prevalence of obesity – related health factors

Strategy 2.1 Implement Strategic Planning activities related to Adult/Youth Nutrition and Physical Exercise in the targeted neighborhoods.

Objective 2.1.1: Conduct neighborhood-level baseline surveying of residents (two targeted neighborhoods and Palatka Housing Authority) to determine % of adults w/Diabetes who have received self-management education by March 1, 2015

Objective 2.1.2: Conduct neighborhood-level baseline surveying of residents (two targeted neighborhoods and Palatka Housing Authority) to determine % of youth and adults who eat 5 servings of fresh fruits and vegetables each day by March 1, 2015

Objective 2.1.3: Conduct neighborhood-level baseline surveying of residents (two targeted neighborhoods and Palatka Housing Authority) to determine % of mothers who breastfed their newborns during the first 6 months by March 1, 2015

Objective 2.1.4: Conduct neighborhood-level baseline surveying of residents (two targeted neighborhoods and Palatka Housing Authority) to determine % of middle/high school youth who report sufficient levels of vigorous physical exercise by March 1, 2015

Objective 2.1.5: Conduct neighborhood-level baseline surveying of residents (two targeted neighborhoods and Palatka Housing Authority) to determine % of adults who report regular physical activity by March 1, 2015

Objective 2.1.6: Conduct neighborhood-level baseline surveying of residents (two targeted neighborhoods and Palatka Housing Authority) to determine % of adults who report they have access to safe, affordable options for physical activity by March 1, 2015

Objective 2.1.6: Conduct neighborhood-level baseline surveying of residents (two targeted neighborhoods and Palatka Housing Authority) to determine % of youth and adults who use Emergency Rooms for healthcare interventions by March 1, 2015.

Objective 2.1.7: Provide regular reports on the impact of health implementations - July 1, 2015, and quarterly thereafter

Strategy 2.2 Implement Public Policy initiatives related to Adult/Youth Nutrition and Physical Exercise in the targeted neighborhoods.

Objective 2.2.1: Collaborate with the University of Florida's Institute for Food and Agricultural Sciences and USDA's Supplemental Nutrition Assistance Program Education (SNAP-Ed) to publish and distribute a Putnam County breastfeeding collaboration plan to all public and private health providers by July 1, 2015

Objective 2.2.2: Complete BMI assessments on all school-aged children residing in the targeted neighborhoods and distribute results to parents by July 1, 2015

Objective 2.2.3: Participate with School Wellness Committee to encourage that school lunches, and snacks are prepared with fresh fruits and vegetables and sugary drinks and foods are removed from vending machines July 1, 2015

Objective 2.2.4: Collaborate with local governmental agencies to install such lighting and security as is needed based on the work completed under Goal 1. Identify methods to capture utilization for all parks/recreation areas in targeted neighborhoods by July 1, 2015

Objective 2.2.5: Negotiate agreements with local grocers to offer a healthy food check-out lane by July 1, 2015

Objective 2.2.5: Identify and implement targeted environmental health strategies in two additional neighborhoods by July 1, 2016

Strategy 2.3 Implement Programmatic initiatives related to Adult/Youth Nutrition and Physical Exercise in the targeted neighborhoods.

Objective 2.3.1: Conduct regular nutrition and physical exercise training at public health facilities and churches, retailers, beauty salons, and other community services utilized by neighborhood residents, with at least monthly trainings provided by March 1, 2015

Objective 2.3.2: Provide access FOR targeted neighborhood residents to fresh produce, either through contracting for mobile grocers to bring fresh food into the neighborhoods or developing regular transit shuttles to transport neighborhood residents to produce stands by June 1, 2015

Objective 2.3.3: Develop at least one church/school/community garden in each targeted neighborhoods by June 1, 2015

Objective 2.3.4: Develop at least one indoor recreation program that serves community residents by June 1, 2015

GOAL 3. Implement Adolescent Health programs to reduce the prevalence of chronic disease and high risk behavior among adolescents

Strategy 3.1 Implement Strategic Planning activities related to Adolescent Health in the targeted neighborhoods in conjunction with Strategies 2.1, 2.2, and 2.3, above.

Strategy 3.2 Implement Public Policy initiatives related to Adolescent Health in the targeted neighborhoods.

Objective 3.2.1: Develop a plan to implement 1:1 training in the management of chronic diseases for adults and youth in the targeted neighborhoods by February 1, 2015

Objective 3.2.2: Implement training in the management of chronic diseases for adults and youth in the targeted neighborhoods by March 1, 2015

Objective 3.2.3: Develop a plan to expand training in the management of chronic diseases to additional targeted neighborhoods by July 1, 2016

Strategy 3.3 Implement Programmatic initiatives related to Adolescent Health in the targeted neighborhoods.

Objective 3.3.1: Develop smoking cessation programs for residents of Palatka Housing Authority and two neighborhoods identified for targeted environmental health programs by September 1, 2015

Objective 3.3.2: Develop substance abuse prevention programs for residents of Palatka Housing Authority and two neighborhoods identified for targeted environmental health programs by September 1, 2015

Objective 3.3.2: Develop adolescent peer group counseling programs for high risk girls, aged 12-19, who are residents of Palatka Housing Authority and two neighborhoods identified for targeted environmental health programs by September 1, 2015

GOAL 4. Implement Mental Health programs to reduce the prevalence of risk factors for mental health, substance abuse and other and high risk behavior among youth and adolescents

Strategy 4.1 Implement Strategic Planning activities related to Mental Health in the targeted neighborhoods in conjunction with Strategies 2.1, 2.2, and 2.3, above.

Strategy 4.2 Implement Public Policy initiatives related to Mental Health in the targeted neighborhoods.

Objective 4.2.1: Collaborate with Putnam County School District to introduce formalized "exposure" programs within the school system to address issues of cyber bullying by April 1, 2015.

Objective 4.2.2: Identify comprehensive mental health assessment tools which have predictive validity in identifying youth and adolescent mental health challenges by January 1, 2015.

Strategy 4.3 Implement Programmatic initiatives related to Mental Health in the targeted neighborhoods.

Objective 4.3.1: Implement Homework Café programs in schools that serve targeted neighborhoods and PHS residents by March 1, 2015.

Objective 4.3.2: Complete mental health assessments for all youth in schools that serve targeted neighborhoods and PHS residents by October 1, 2015.

GOAL 5. Implement Oral Health programs to reduce the prevalence of chronic disease and high risk behavior among adolescents

Strategy 5.1 Implement Strategic Planning activities related to Oral Health in the targeted neighborhoods in conjunction with Strategies 2.1, 2.2, and 2.3, above.

Strategy 5.2 Implement Public Policy initiatives related to Oral Health in the targeted neighborhoods.

Objective 5.2.1: Collaborate with the Putnam County School District to gain agreement for initiating school-based sealants program to youth aged 3-13.

Strategy 5.3 Implement Programmatic initiatives related to Oral Health in the targeted neighborhoods.

Objective 5.3.1: Provide oral health training to children and adults at PHA community centers, schools, and churches serving residents of the targeted neighborhoods beginning March 1, 2014

Objective 5.3.2: Deliver oral health services, including sealants and topical fluoride treatments, preventative, and restorative oral health to children as identified through the PHA community, schools, and churches serving residents of the targeted neighborhoods beginning March 1, 2014

Objective 5.3.3: Continue community education on the benefits of fluoride on oral health.

APPENDIX A
PUTNAM COUNTY PUBLIC HEALTH LOGIC MODELS

LOGIC MODEL
OBESITY/NUTRITION/PHYSICAL FITNESS

ADULT NUTRITION

<table>
<tr><th>INPUTS</th><th>STRATEGIC PLANNING ACTIVITIES</th><th>IMPLEMENTATION ACTIVITIES</th><th>OUTPUTS</th><th>OUTCOMES</th></tr>
<tr><td rowspan="10">Nutrition training personnel at Health Department, Azalea, Community Medical

Outreach personnel for presentations and social marketing

Funding for transportation

Funding for data gathering and reporting

Supplies for community and church gardens</td><td rowspan="10">Strategic Planning:
• Baseline data on adult eating behaviors
• Resource Assessment – existing services and resources
• Connecting the unlinked resources
• Implementation Monitoring – quarterly feedback/reporting to LOGIC
• Funding for Inputs</td><td>Evidence-based individual and group nutrition education</td><td># trainings at Health Department, Azalea, Community Medical</td><td rowspan="10">Increase % of adults w/Diabetes who have received self-management education
Increased % adults reporting that they are:
1. Eating smaller portions
2. Drinking fewer sugary drinks
3. Reducing sodium intake
4. Increasing potassium intake
5. Increase percentage eating 5 servings/day of fresh fruits and vegetables
Increased % mothers with newborns who report they breastfeed their infants during the first 6 months
Reduce percent of adults with BMI>30 by 10% (from 34% to 31% 0f adults on 2016 County Health Rankings)</td></tr>
<tr><td rowspan="4">Social marketing at community agencies and events</td><td># Church presentations</td></tr>
<tr><td># Community center presentations</td></tr>
<tr><td># Presentations at Wal-Mart and SAMS</td></tr>
<tr><td># beauty salons distributing nutrition information</td></tr>
<tr><td># presentations at community events</td></tr>
<tr><td>Deliver cooking/shopping classes</td><td># classes at churches, community service organizations,</td></tr>
<tr><td>Collaborate with transit providers to develop shuttles to produce vendors
Develop WIC vouchers for use at produce vendors</td><td># produce shuttles / # low income passengers
WIC vouchers used at produce stands</td></tr>
<tr><td>Develop community gardens in low-income areas</td><td># church and community gardens developed</td></tr>
<tr><td>Work with grocers to create incentives for purchasing healthy foods</td><td># grocers offering healthy food checkout lane</td></tr>
<tr><td>Work with WIC, SNAP, State Breastfeeding Coordinator to refine/target breastfeeding messages</td><td>Publish Putnam breastfeeding collaboration plan</td></tr>
<tr><td>Distribute information to pediatricians on breast feeding</td><td># pediatricians distributing breastfeeding info to mothers</td></tr>
</table>

YOUTH NUTRITION

INPUTS	STRATEGIC PLANNING ACTIVITIES	IMPLEMENTATION ACTIVITIES	OUTPUTS	OUTCOMES
Nutrition training personnel at Health Department, Azalea, Community Medical Nursing personnel for school-based BMI assessments and social marketing Supplies for school gardens	Strategic Planning: • Baseline data on youth eating behaviors • Conduct pre-post testing on youth knowledge about nutrition • Resource Assessment – existing services and resources • Connecting the unlinked resources • Implementation Monitoring – quarterly feedback/ reporting to LOGIC • Funding for inputs----	Training classes for teachers regarding nutrition and how to offer non-food rewards for in-class reinforcement	# teachers trained	Increased % youth reporting that they are: 1. Eating smaller portions 2. Drinking fewer sugary drinks 3. Reducing sodium intake 4. Increasing potassium intake 5. Increase percentage eating 5 servings/day of fresh fruits and vegetables Reduce percent of middle school youth with BMIs at or above 95 percentile by 10% (from 18.1% to 16% - 0 FL-CHARTS)
		Increase BMI assessments to include all grades(currently K, 1, 3, 5,and 9)	# BMI assessments completed on school-aged youth	
		Collaborate with school officials to increase the nutritional quality of school lunches and after school snacks	# school lunches prepared with fruit and vegetables # vending machines dispensing sugary foods and drinks #snacks prepared with fresh fruit and/or vegetables	
		Collaborate with school to inform parents about the health of their children	# BMI report cards distributed to parents	
		Collaborate with school nutrition personnel to improve school policies regarding nutrition	# Wellness Committee meetings attended	
		Develop school gardens	# school gardens open and operational	

EXERCISE AND PHYSICAL ACTIVITY

INPUTS	STRATEGIC PLANNING ACTIVITIES	IMPLEMENTATION ACTIVITIES	OUTPUTS	OUTCOMES
Scholarship funding for low income participation in private exercise activities	Strategic Planning: • Baseline data on youth/ adult utilization of physical activity services and resources • Resource Assessment– utilization of existing park and recreational resources • Resource Assessment – surveying neighborhoods on Physical Activity Questionnaire • Resource Assessment- compilation of existing exercise programs • Connecting the unlinked resources • Implementation Monitoring – quarterly feedback/reporting to LOGIC • Funding	Collaborate with law enforcement, public safety, parks and recreation personnel	# parks/recreation areas with lighting # parks/recreation areas with security # parks with mechanism to capture utilization	Reduce the percent of middle and high school aged youth without sufficient vigorous physical activity by 10% (36% to 31%- FL-CHARTS) Increase the percent of adults with adequate access to exercise options by 10% (from 55% to 60% of adults on 2016 County Health Rankings) Reduce percent of adults with no physical activity by 10% (from 34% to 31% of adults on 2016 County Health Rankings
		Collaborate with schools to measure and increase sports and activity programs	# unduplicated middle and high school youth engaged in physical activity programs in schools	
		Collaborate with private entities having access to safe, secure resources for physical activity	# programs at the Community Life Center, other indoor/secure facilities	
		Encourage soccer, group exercise, running clubs, group biking, pickle ball, yoga, pole walking, Zumba, group exercise programs, and resources for personal trainers	# youth and adults actively participating # youth involved with summer camp programs	
		Encourage club sports, Zumba, personal trainers, senior exercise programs, low-impact cardio programs	# youth and adults actively participating	

LOGIC MODEL
ADOLESCENT HEALTH

ADOLESCENT HEALTH - CHRONIC DISEASE

INPUTS	STRATEGIC PLANNING ACTIVITIES	IMPLEMENTATION ACTIVITIES	OUTPUTS	OUTCOMES

Expanded staffing resources to compile Care Plans of youth with Chronic Disease
 	
Funding for focus group facilitation, surveying, and data gathering/reporting
	Strategic Planning:
	• Baseline data on number of youth monitored for chronic disease:
	  • Asthma
	  • ADD/ADHD
	  • Type 2 Diabetes
	  • Number of public/private schools served
	  • Existing utilization of health resources
	• Conduct focus groups with adolescents on health knowledge and self-esteem
	• Compile adolescent groups/clubs as basis for gathering data
	• Implementation Monitoring – quarterly feedback/reporting to LOGIC
	• Funding
		Compile utilization and screening data from Health Dept, Azalea Health, and Community Medical Center
		
		Survey pediatricians regarding adolescents with chronic disease
		
		Provide training to adults and children regarding the management of chronic diseases
			# of youth with chronic disease care plans in public schools (currently appx 1,200)
			
			# of youth and families who have received training in the management of chronic disease
				Increase the number of youth monitored for chronic disease who have a primary care home
				
				Increase the school attendance rate of youth monitored for chronic disease
				
				Decrease the use of Emergency Rooms by youth monitored for chronic disease

ADOLESCENT HEALTH – BEHAVIORAL RISK/PROTECTIVE FACTORS

INPUTS	STRATEGIC PLANNING ACTIVITIES	IMPLEMENTATION ACTIVITIES	OUTPUTS	OUTCOMES
Substance abuse and smoking cessation trainers Peer Training curriculum and Instructors	Strategic Planning: • Compile baseline data on youth substance abuse, tobacco, alcohol use from 2014 Florida Youth Substance Abuse Survey • Compile baseline data on STDs and teen birth rates • Compile baseline data on youth crime and other non-social behavior • Resource Assessment– utilization of existing park and recreational resources • Resource Assessment-compilation of high risk behavior programs • Implementation Monitoring – quarterly feedback/reporting to LOGIC • Funding	Collaborate with Housing Authority to deliver tobacco cessation, alcohol and substance abuse programs at PHA Resource Centers Develop Peer group training initiative for sexually active adolescent girls	# PHA residents in smoking cessation # PHA residents in substance abuse prevention programs # peer group trainers # high risk adolescent girls in peer group counseling	Reduce the percent of middle and high school students who smoked cigarettes in the past 30 days by 10% (FL-CHARTS) Reduce the percent of middle and high school students who used alcohol in the past 30 days by 10% (FL-CHARTS) Reduce the percent of middle and high school students who used marijuana/hashish in the past 30 days by 10% (FL-CHARTS) Reduce the percent of middle and high school students who reported binge drinking by 10% (FL-CHARTS) Reduce the 3-year rate of new STD cases in adolescents (15-19) by 10% (FL-CHARTS) Reduce the rate of teenage (15-19) births by 10% (FL-CHARTS) Reduce the rate of repeat teenage (15-19) births by 10% (FL-CHARTS)

MENTAL HEALTH / BEHAVIORAL HEALTH

INPUTS	STRATEGIC PLANNING ACTIVITIES	IMPLEMENTATION ACTIVITIES	OUTPUTS	OUTCOMES
Compiling, analyzing, reporting risk and protective factor data at neighborhood levels Youth leadership curriculum, Instructors, and sponsors	Strategic Planning: • Compile baseline data on youth substance abuse, tobacco, alcohol use from 2014 Florida Youth Substance Abuse Survey • Compile neighborhood level data on youth risk behavior through needs assessments and data mining of existing reports • Resource Assessment-compilation of high risk behavior programs • Implementation Monitoring – quarterly feedback/reporting to LOGIC • Funding	Program - Implement one Homework Café program in each targeted PACE-EH neighborhood Policy - Identify one or more MH assessment tools for use in schools, health agencies, other locations frequented by high risk youth Policy -Work with schools, churches, other community organizations to identify "exposure" opportunities to address cyber aggression	# Homework Café programs – youth and parents attending MH assessment tools for youth # youth receiving MH assessment # Formal exposure programs operating within schools and community organizations	Reduce the percent of middle and high school students who smoked cigarettes in the past 30 days by 10% (FL-CHARTS) Reduce the percent of middle and high school students who used alcohol in the past 30 days by 10% (FL-CHARTS) Reduce the percent of middle and high school students who used marijuana/hashish in the past 30 days by 10% (FL-CHARTS) Reduce the percent of middle and high school students who reported binge drinking by 10% (FL-CHARTS) Increase the number of high risk youth engaged in ongoing mental health services Increase the number of high risk adults engaged in ongoing mental health services

ORAL HEALTH

INPUTS	STRATEGIC PLANNING ACTIVITIES	IMPLEMENTATION ACTIVITIES	OUTPUTS	OUTCOMES
Funding and resources for the delivery of fluoride sealants ($22/treatment) Mobile oral health delivery vehicle Oral health trainers	Strategic Planning: • Compile data on the number of public and private water systems in Putnam County • Compile data on the use of oral health providers by neighborhood through needs assessments and data mining of existing reports • Resource Assessment-compilation of existing oral health programs and number of consumers served • Implementation Monitoring – quarterly feedback/reporting to LOGIC • Funding	Program - Deliver on-site oral health services, including sealants, preventive and restorative care in targeted locations (PHA community centers, PACE-EW neighborhoods, schools, churches, etc.) Program - Provide training classes to parents and youth about the need for ongoing oral health care Program - Seek program resources through collaboration with UF College of Dentistry Policy – Develop screening / measurement tools and processes to measure youth and adults receiving oral health	# children, aged 3 – 13 provided sealants and topical Fluoride treatments # children and adults receiving twice yearly preventive care # children and adults trained in proper use of oral health providers	Neighborhood level assessment of household knowledge of oral health and its importance to overall health Increase in number of youth engaged in regular preventive oral health Increase in number of adults engaged in regular preventive oral health Increase in number of youth aged 3-13 who have been treated with sealants and topical Fluoride treatments

DOH-PUTNAM CHIP PRIORITY AREA	DOH-PUTNAM CHIP GOAL	NATIONAL MEASURES HP 2020 CDC NPS	SHIP	2015-2016 DOH-PUTNAM QI PLAN ACTIVITIES ALIGNMENT	2013-2015 DOH-PUTNAM STRATEGIC PLAN OBJECTIVES ALIGNMENT
Develop a PACE-EH like model to implement Public Health Initiatives (Goals 2-5)	*Identify and precisely define two neighborhoods within Putnam County that will be addressed through an environmental health model of public health implementation focusing on Adult and Youth Nutrition/Exercise/Obesity; Adolescent Health; Mental Health; and Oral Health within Putnam County that will be addressed through an environmental health model of public health implementation focusing on Adult and Youth Nutrition/Exercise/Obesity; Adolescent Health; Mental Health; and Oral Health.*	**Goal CD1: Healthy Weight** HP 2020 NWS-8 objective; CDC Winnable Battle: Nutrition, Physical Activity, and Obesity; HP 2020 NWS-5 objective; **Strategy CD2.1**: **Healthy behaviors**- HP 2020 NWS-8 and TU-4. **Goal CD3: Chronic disease** HP 2020 D-1; **Goal CD4: Tobacco use and secondhand smoke exposure** CDC Winnable Battle: Nutrition, Physical Activity, and Obesity; Strategy **CD4.3:Exposure to secondhand tobacco smoke** HP 2020 TU-11; Recommended by the CDC Community Guide; **Objective AC1.1.1** Public Health Accreditation Board (PHAB) community health assessment prerequisite and standard 1.1.2; **Objective AC3.1.1** HP 2020 MHMD-5; **Objective AC4.4.3** CDC Oral Health Strategic Plan, Goal 6; HP 2020 OH-13; **Objective AC5.1.1** Healthy People 2020 MICH-16; HP2020 FP-7; NPS; DOH Long Range Program Plan Objective 4B; **Strategy AC5.3: Abstinence and teen sexual activity** Recommended by the CDC Community Guide	**Chronic Disease Prevention** CD1 pg. 14; CD2 pg 15; CD2.1 pg 15; CD3 & CD3.1 pg 16; CD4 pg 17; CD4.3 pg 17 **Access to Care** AC1.1.1 pg 21;AC 3 pg 24; AC3.1.1 pg 24; AC4 pg 25; AC4.4 pg 26; AC 4.4.3 pg 26; AC5.1.1 pg 26	Healthy Weight Problem Solving Project	2.4 Pursue opportunities to execute community-driven environmental health improvements. Build and revitalize communities so people can live healthy lives 2.5 Implement public-private health improvement project to strengthen physical activity and nutrition in Putnam County.

		Strategy HI1.1: Providers and electronic health record systems, 42 CFR Parts 412, 413, 422 et al.; Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule; **Strategy HI4.1: Health improvement planning at state and local levels**, HP 2020 PHI 15 **Objective AC4.4.3** CDC Oral Health Strategic Plan, Goal 6; HP 2020 OH-13	**Health Finance & Infrastructure** HI1.1 pg 30; HI2 pg 31; HI3 pg 32; HI4 pg 33; HI4.1 pg 33 **Access to Care** AC4 pg 25; AC4.4 pg 26; AC 4.4.3 pg 26	QI Training Tools/Methods SPIL Review Meetings Communications Plan Rapid Process Improvement Population Based QI Project (School Based Sealant)	5.16 Attract, recruit, and retain a competent and credentialed workforce. 5.18 Use Public Health Information Technology to efficiently improve business practices 5.20 Maximize funding to accomplish Public Health Mission, Vision and Values 1.1 Increase dental services by 10% annually
Obesity/Nutrition / Physical Fitness	*Implement Adult/Youth Nutrition and Physical Exercise Programs to reduce the prevalence of obesity – related health factors*	**Goal CD1: Healthy Weight** HP 2020 NWS-8 objective; CDC Winnable Battle: Nutrition, Physical Activity, and Obesity; HP 2020 NWS-5 objective; **Strategy CD2.1**: **Healthy behaviors**- HP 2020 NWS-8 and TU-4. **Goal CD3: Chronic disease** HP 2020 D-1; **Goal CD4: Tobacco use and secondhand smoke exposure** CDC Winnable Battle: Nutrition, Physical Activity, and Obesity; Strategy **CD4.3:Exposure to secondhand tobacco smoke** HP 2020 TU-11; Recommended by the CDC Community Guide **Strategy CR2.2: Physical activity**, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity—Recommended by the CDC Community Guide; **Objective CR2.2.1,** HP 2020, NWS-8, NWS-9, NWS-10, NWS-11, PA-15	**Chronic Disease Prevention** CD1 pg. 14; CD2 pg 15; CD2.1 pg 15; CD3 & CD3.1 pg 16; CD4 pg 17; CD4.3 pg 17 **Community Redevelopment** CR2.2 pg 21; CR2.2.1 pg 21	Healthy Weight Problem Solving Project	1.2 Increase participation rate of WIC eligible clients from 86% to 90% by December 2015. 2.5 Implement public-private health improvement project to strengthen physical activity and nutrition in Putnam County. 3.8 Increase the percent of WIC infants who ever breastfed by 20.7% to be aligned with the Florida Department of Health target of 81.9%. 3.9 Decrease the percent of overweight/ obese children participating in WIC by

		Objective AC5.1.1 Healthy People 2020 MICH-16; HP2020 FP-7; NPS; DOH Long Range Program Plan Objective 4B	**Access to Care** AC5.1.1 pg 26		5% to 18.8%; currently Putnam is 23.8%.
Chronic Disease and High Risk Behavior	*Implement Adolescent Health programs to reduce the prevalence of chronic disease and high risk behavior among adolescents*	**Strategy CD2.1**: **Healthy behaviors**- HP 2020 NWS-8 and TU-4; **Goal CD4: Tobacco use and secondhand smoke exposure** CDC Winnable Battle: Nutrition, Physical Activity, and Obesity; **Strategy D4.3:Exposure to secondhand tobacco smoke** HP 2020 TU-11; Recommended by the CDC Community Guide **Strategy AC5.3: Abstinence and teen sexual activity** Recommended by the CDC Community Guide	**Chronic Disease Prevention** CD2.1 pg 15; CD3.1 pg 16; CD 4 pg 17; CD4.3 pg 17 **Access to Care** AC5.3 pg 26;	Healthy Weight Problem Solving Project	3.7 Increase the immunization rates for 2 year olds to at least 90%; Kindergarten and 7th grade to at least 95% 3.10 Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure. 4.11 Reduce the Putnam County gonorrhea rate by 10% by December 2015
Mental Health Programs	*Implement Mental Health programs to reduce the prevalence of risk factors for mental health, substance abuse and other and high risk behavior among youth and adolescents*	**Objective AC1.1.1** Public Health Accreditation Board (PHAB) community health assessment prerequisite and standard 1.1.2; **Objective AC2.2.2,** HHS Action Plan to Reduce Disparities, goal 1, measure 3; **Long-range objective AC2.2.4,** HP2020 MHMD-5; **Objective AC3.1.1** HP 2020 MHMD-5	**Access to Care** AC1.1.1 pg 23; AC2.2.2; AC2.2.4 pg 23; AC3 pg 24; AC3.1.1 pg 24		3.10 Reduce illness, disability, and death related to tobacco use and secondhand smoke exposure. 4.11 Reduce the Putnam County gonorrhea rate by 10% by December 2015 5.19 Maximize partnerships and expertise of a community to accomplish its goals
Oral Health	*Implement Oral Health programs to reduce the prevalence of chronic disease and high risk behavior among adolescents*	**Strategy AC4.4: Oral health care delivery practice models** Recommended by the CDC Community Guide **Objective AC4.4.3** CDC Oral Health Strategic Plan, Goal 6; HP 2020 OH-13	**Access to Care** AC4 pg 25; AC4.4 pg 26; AC 4.4.3 pg 26	Population Based QI Project (School Based Sealant) Communications Plan (IT – Electronic Records)	1.1 Increase dental services by 10% annually 5.18 Use Public Health Information Technology to efficiently improve business practices