DOH-PUTNAM

HEALTH EQUITY PLAN

July 2022 – June 2025

Updated 8/24/2022

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I. VISION

Visioning was facilitated using *Technology of Participation (ToP)* Facilitation Methods' Consensus Workshop procedures. During the meeting, context was discussed, including differences between a mission statement and a vision statement. The Task Force came to the consensus that a vision statement focused on the ideal result of actions presented in the mission statement. The agenda was reviewed, followed by a brief Focused Conversation. During brainstorming, the Task Force was asked, individually, to list 8-10 ideas that align with their perception of the overarching vision. Each member then selected their three clearest ideas, which were placed on the working board in no particular order. Questions of clarity were addressed, as needed.

Ideas were subsequently grouped into clusters, resulting in the formation of five separate categories. Upon review, the Task Force was asked if there were any important ideas which had not yet been addressed. These were then added to their appropriate groupings. Clusters were further organized from largest to smallest and given a categorical name. The activity was then resolved with another brief Focused Conversation. Following the initial meeting, Task Force members were given vision statement examples and brainstorming worksheets to help create the finalized vision statement.

We envision a thriving community in which every person creates, shares, and enjoys equitable opportunities and resources across a dignified life journey—regardless of race, ethnicity, age, gender, sexual orientation, religion, income, or other physical or social characteristic—fostered via culturally and linguistically sensitive information addressing personal, social, systemic, and structural areas.

II. PURPOSE OF THE HEALTH EQUITY PLAN

Health Equity is achieved when everyone can attain optimal health.

The Florida Department of Health's Office of Minority Health and Health Equity (OMHHE) works with government agencies and community organizations to address the barriers inhibiting populations from reaching optimal health. A focus on health equity means recognizing and eliminating the systemic barriers that have produced disparities in achieving wellness. In response to Chapter 2021-1700 of the Florida Statutes, effective July 1, 2021, each county health department (CHD) has been provided resources to create a Health Equity Plan to address health disparities in their communities.

The Health Equity Plan should guide counties in their efforts to create and improve systems and opportunities to achieve optimal health for all residents, especially priority populations. County organizations have a critical role in addressing the social determinants of health (SDOHs) by fostering multi-sector and multi-level partnerships, conducting surveillance, integrating data from multiple sources, and leading approaches to develop upstream policies and solutions. This plan acknowledges that collaborative initiatives to address the SDOHs are the most effective at reducing health disparities.

The purpose of the Health Equity Plan is to increase health equity within Putnam County, Florida. To develop this plan, The Florida Department of Health in Putnam County (DOH-Putnam) followed the Florida Department of Health's approach of multi-sector engagement to analyze data and resources, coordinate existing efforts, and establish collaborative initiatives. This plan addresses key SDOH indicators affecting health disparities within Putnam County. This Health Equity Plan is not a county health department plan; it is a county-wide Health Equity Plan through which the Health Equity Taskforce, including a variety of government, non-profit, and other community organizations, align to address the SDOH impact health and well-being in the county.

III. DEFINITIONS

- **Health equity** is achieved when everyone can attain optimal health.
- **Health inequities** are systematic differences in the opportunities groups have to achieve optimal health, leading to avoidable differences in health outcomes.
- **Health disparities** are the quantifiable differences, when comparing two groups, on a particular measure of health. Health disparities are typically reported as rate, proportion, mean, or some other measure.
- **Equality** is achieved when each individual or group of people is given the same resources or opportunities.
- **Social determinants of health** are the conditions in which people are born, grow, learn, work, live, worship, and age that influence the health of people and communities.

IV. PARTICIPATION

Cross-sector collaborations and partnerships are essential components of improving health and well-being. Cross-sector collaboration uncovers the impact of education, health care access and quality, economic stability, social and community context, neighborhood and built environment and other factors influencing the well-being of populations. The range of expertise provided by cross-sector partners is necessary to develop and implement the Health Equity Plan.

Cross-sector partners were initially recruited via outreaches and associations, including members of the 2021-2025 *Community Health Improvement Plan* (CHIP) Steering Committee. These community partners and stakeholders were then invited to consider additional potential partners with shared goals who would benefit from involvement in the creation and maintenance of the Health Equity Plan. Initial meetings summarized infrastructure and expectations, and were held monthly. Additional meetings were held to assess the health needs of underserved communities, prioritize health disparities, and

devise a strategic action plan. As relevant Social Determinants of Health (SDOHs) were discussed, coalitions and teams considered areas which might need additional representation, whereupon the Minority Health Liaison reached out to additional potential partners to increase recruitment and collaboration development.

On December 21, 2021, members of the community were engaged and agreed to form the Putnam County Health Equity Coalition and were charged with the duty to review the health equity plan for feasibility to ensure maximum impact. On March 31, 2022, representatives from a diverse group of community leaders and members further met to install the Putnam County Health Equity Taskforce.

Members include representatives from multiple local civic sectors, including health care, social service, education, community development, philanthropy, city and county government, and business. As planning continued, coordination was further facilitated via the creation of Microsoft TEAMS channels and e-mail chains to accommodate for input from interested partners who could not attend scheduled meetings.

A. Minority Health Liaison

The Minority Health Liaison supports the Office of Minority Health and Health Equity in advancing health equity and improving health outcomes of racial and ethnic minorities and other priority populations through partnership engagement, health equity planning, and implementation of health equity projects to improve social determinants of health. The Minority Health Liaison facilitates health equity discussions, initiatives, and collaborations related to elevating the shared efforts of the county.

Minority Health Liaison: Jessica L. Bishop, AP, CLC, Dipl. O.M. (NCCAOM)
Minority Health Liaison Backup: Carol Kazounis, MS, RD, LDN

B. Health Equity Team

The Health Equity Team includes individuals that each represent a different program within the CHD. The Health Equity Team explores opportunities to improve health equity efforts within the county health department. Members of the Health Equity Team assess the current understanding of health equity within their program and strategize ways to

improve it. The Health Equity Team also relays information and data concerning key health disparities and SDOH in Putnam County to the Health Equity Taskforce. The

Minority Health Liaison guides these discussions and the implementation of initiatives. The membership of the Health Equity Team is listed below.

Name	Title	Program
Jessica Bishop AP, CLC, Dipl OM (NCCAOM)	Minority Health and Health Equity Liaison	Minority Health and Health Equity
Diana Duque, MPH	Administrator	DOH-Putnam
Laura Hubbell MA, RDN, LDN	Senior Public Health Nutritionist	WIC
Carol Kazounis MS, RD, LDN	Director of Community Health Programs	MCH Healthy Babies
Melissa White EFDA, RDH	Government Operations Consultant I	Quality Improvement and Accreditation
Kathy Wright	Administrative Assistant	WIC

The Health Equity Team met on the below dates during the health equity planning process. Since the Health Equity Plan was completed, the Health Equity Team has met regularly to track progress.

Meeting Date	Topic/Purpose
December 21, 2021	Introductory Meeting
March 24, 2022	Review of SDOHs and Choosing a Health Disparity
May 4, 2022	Internal and external HE trainings; assessment updates
May 19, 2022	Assessment and training updates; Health Disparity Objective

C. Health Equity Taskforce

The Health Equity Taskforce includes CHD staff and representatives from various organizations that provide services to address various SDOH. Members of this Taskforce brought their knowledge about community needs and SDOH. Collaboration within this group addresses upstream factors to achieve health equity. The Health Equity Taskforce wrote the Putnam County Health Equity Plan and oversaw the design and implementation of projects. Health Equity Taskforce members are listed below.

Name	Title	Organization	Social Determinant of Health
Cristina Benitez	Fair Housing Outreach Advocate	Florida Legal Services	Neighborhood and Built Environment
Jessica Bishop AP, CLC, Dipl OM (NCCAOM)	Minority Health and Health Equity Liaison	DOH-Putnam	Social and Community Context
Joseph Cordova, Esq	Fair Housing Education & Outreach Initiative Project Manager	Florida Legal Services	Neighborhood and Built Environment
Kimberly Dugger, Ed D	Professional Educator	Unaffiliated	Education Access and Quality
Elois Dunnell, MA	Community Partner	Unaffiliated	Social and Community Context
Larry Harvey	County Commissioner, District 4	Board of County Commissioners	Economic Stability
Terrill Hill, PA	Mayor	City of Palatka	Social and Community Context
Carol Kazounis, MS, RD, LDN	Director of Community Health Programs	DOH-Putnam	Health Care Access and Quality
Aaron Robinson	Director of Social Services	Palatka Housing Authority	Neighborhood and Built Environment
Lakesha Session	ROSS Grant Coordinator	Palatka Housing Authority	Social and Community Context
Laura Spencer	Chief Executive Officer	AZA Health	Health Care Access and Quality
Letichi Tookes-Foster, RN, MSN-CBHCMS, CAP	Director of Operations	SMA Healthcare	Health Care Access and Quality

The Health Equity Taskforce met on the below dates during the health equity planning process. Since the Health Equity Plan was completed, the Health Equity Taskforce has continued to meet regularly to track progress.

Meeting Date	Organizations	Topic/Purpose
April 19, 2022	City of Palatka, DOH-Putnam, Florida Legal Services, Palatka Housing Authority	Overview and discussion of SDOHs including data, barriers, potential partners, and projects
May 3, 2022	DOH-Putnam, Florida Legal Services, Palatka Housing Authority	Discussion regarding vision statement, length of HE Plan, and partner-specific barriers
May 11, 2022	AZA Health, DOH-Putnam, Florida Legal Services, Palatka Housing Authority	Presentation of evidence-based strategies to address barriers; projects logic model with associated trackable indicators
May 23, 2022	AZA Health	Finalization of projects, HE Assessment for CHD

D. Coalition

The Coalition discussed strategies to improve the health of the community. The strategies focused on the social determinants of health: education access and quality, health care access and quality, economic stability, social and community context, and neighborhood and built environment. Membership includes community leaders working to address each SDOH, as well as any relevant sub-SDOHs. The Coalition assisted the Health Equity Taskforce by reviewing their Health Equity Plan for feasibility and approval. See section XII: addendum for a list of Coalition members.

E. Regional Health Equity Coordinators

There are eight Regional Health Equity Coordinators. These coordinators provide the Minority Health Liaison, Health Equity Team, and Health Equity Taskforce with technical assistance, training, and project coordination.

Name	Region	Expertise
Carrie Rickman	Emerald Coast	Nursing
Quincy Wimberly	Capitol	Inclusive Strategies in Public Health and Technical Assistance

Diane Padilla	North Central	Non-Profit Engagement
Ida Wright	Northeast	Community Engagement, Project Management
Rafik Brooks	West	Health Care Leadership
Lesli Ahonkhai	Central	Faith-Based Engagement, Public Health Leadership, and PH Workforce Capacity Building and Mentoring
Natasha McCoy (interim)	Southeast	Public Health Practice, Grant Writing, and Partnerships
Frank Diaz-Gines	Southwest	Health Insurance

V. HEALTH EQUITY ASSESSMENT, TRAINING, AND PROMOTION

A. Health Equity Assessments

To improve health outcomes in Florida, it is critical to assess the knowledge, skills, organizational practices, and infrastructure necessary to health inequities. Health equity assessments are needed to achieve:

- ✓ Establish a baseline measure of capacity, skills, and areas for improvement to support health equity-focused activities
- ✓ Meet Public Health Administration Board (PHAB) Standards and Measures 11.1.4A which states, "The health department must provide an assessment of cultural and linguistic competence."
- ✓ Provide ongoing measures to assess progress towards identified goals developed to address health inequities
- ✓ Guide CHD strategic, health improvement, and workforce development planning
- ✓ Support training to advance health equity as a workforce and organizational practice

The Health Equity Assessment is currently pending approval from the Florida Department of Health Executive Management. As soon as the assessment is approved, the Putnam County Health Equity Team will conduct a health equity assessment to examine the capacity and knowledge of DOH-Putnam staff and County partners to address Social Determinants of Health.

B. County Health Equity Training

Assessing the capacity and knowledge of health equity through currently available means helped the Minority Health Liaison identify knowledge gaps and create training plans for the Health Equity Taskforce, the Coalition, and other county partners.

The Minority Health Liaison provided the Putnam County Health Equity Taskforce and Coalition members with opportunities for Health Equity Training. Prior to each training

session, members received handouts and infographics to advance comprehension of health equity principles. Trainings included an overview of health equity-focused goals, objectives, and activities to ensure equitable delivery of services and care; as well as a focus on Social Determinants of Health and priority populations served at the county level.

In addition to the trainings provided directly by the Minority Health Liaison, Taskforce and Coalition members also received information about other health equity training opportunities. Below are the dates, SDOH training topics, and organizations who attended training:

Date	Topics	Organization(s) receiving trainings
12/15/2021	Health Equity Infrastructure	The Turning Table, Palatka Housing Authority, Florida Legal Services
3/30/2021	Social Determinants of Health and Priority Populations	Palatka Housing Authority, Florida Legal Services, Baby Brain Builders
Tuesdays, 5/10/2022-6/14/2022	Grant Writing Training	Shared with the following partner organizations: Florida Legal Services, City of Palatka, Palatka Housing Authority, The Turning Table, Baby Brain Builders, Heart2Heart Family Practice, Race Issues Study Circles of Putnam County
Asynchronous: Invitations sent 5/23/22	Communication; Community Engagement; Cross-Sector Collaboration; Cultural and Linguistic Competence; Disability; Diversity and Inclusion in the Workplace; Economy; Health Equity; Health Literacy; Historical Perspectives; Implicit	Shared with the following partner organizations: Florida Legal Services, The Turning Table, Heart2Heart Family Practice, Putnam County Board of Commissioners, City of Palatka, Baby Brain Builders, Putnam County School District, Palatka Housing

	Bias; LGBTQ+; Place-based Risk.	Authority, AZA Health, SMA Healthcare

C. County Health Department Health Equity Training

The Florida Department of Health in Putnam County recognizes that ongoing training in health equity and cultural competency are critical for creating a sustainable health equity focus. At a minimum, all DOH-Putnam staff receive the *Cultural Awareness: Introduction to Cultural Competency* and *Addressing Health Equity: A Public Health Essential* training. In addition, the Health Equity Team provides regular training to staff on health equity and cultural competency. The training is recorded below.

Date	Topics	Number of Staff in Attendance
July 15, 2022	*From Concepts to Practice: Health Equity, Health Inequities, Health Disparities, and Social Determinants of Health*	60

D. Minority Health Liaison Training

The Office of Minority Health and Health Equity and the Health Equity Regional Coordinator provide training and technical support to the Minority Health Liaison on topics such as: health equity planning process and goals, facilitation and prioritization techniques, reporting requirements, and taking a systems approach to address health disparities. The Minority Health Liaison training is recorded below.

Date	Topics
February 22-25, 2022	Roles and Responsibilities; Elements of Healthy, Equitable Communities and Prioritizing Social Determinants of Health; Developing Health Equity Plans; Building Engaged Community Partnerships; Health Equity in COVID; Technology of Participation (ToP) Facilitation Methods.

March 17, 2022	ClearPoint Strategy Project Management Training
May 10, 2022	Building BRIDGES: Understanding our Position in Multi-Sector Communication
May 12, 2022	From Concepts to Practice: Health Equity, Health Inequities, Health Disparities, and Social Determinants of Health
May 19, 2022	FLHealthCHARTS Training
June 24, 2022	Achieving Health Equity
June 24, 2022	FDOH SpNS: The 411 on Special Needs Shelters—Information for working in a Special Needs Shelter FDOH SpNS: Special Needs Shelter Operations—An Online Overview FDOH SpNS: Caring for Those with Memory Impairment FDOH SpNS: Oxygen in Shelters

E. National Minority Health Month Promotion

The month of April is recognized in the United States as National Minority Health Month—a month-long initiative to advance health equity across the country on behalf of all racial and ethnic minorities. In celebration and collaboration, DOH-Putnam participated in two separate promotional events:

- On **April 14th, 2022**, DOH-Putnam held its **First Annual Black Maternal Health Week Event**. This year's theme was "Building for Liberation: Centering Black Mamas, Black Families and Black Systems of Care"—a theme which reflects the Black Mamas Matter Alliance's work in centering Black women's scholarship,

maternity care work, and advocacy across the full-spectrum of sexual, maternal, and reproductive health care services, programs, and initiatives.

Our event was held at 2801 Kennedy Street in Palatka. Offerings included: hurricane kits, breastfeeding and nutrition information, domestic violence information, access to free contraception, tobacco cessation information, breast and cervical cancer information, screenings for blood pressure and diabetes, dental information, healthy families/parent support information, as well as representation from the Minority Health Liaison and Florida Legal Services' Fair Housing program.

- On **April 23rd, 2022**, DOH-Putnam also participated in the **St. Johns River Bartram Frolic on the Riverfront**. The event itself included local historic education stations, as well as opportunities for physical activity such as kayaking, equestrian riding, and bicycle and walking tours.

  In celebration of Minority Health Month—and considering Bartram's associated focus on physical activities—employees from *WIC, MCH Healthy Babies, and Minority Health and Health Equity* came out to encourage nutrition and physical activity, as a segue into introducing the community to the Health Equity Plan.

  Children's activity bags were distributed by all programs, as well as educational materials regarding activity and movement for every age and ability. The community was also given additional tools for success, including cookbooks and MyPlate reusable shopping bags. Fruit and vegetable vouchers were distributed to encourage and assist healthy eating—all focused around our chosen disparity: healthiest weight.

These events provided opportunities to interface with the community through several angles—leading to creation and solidification of potential partner connections, as well as creating opportunity for direct service to priority populations.

VI. PRIORITIZING A HEALTH DISPARITY

Health Disparities are differences in any health-related factor—disease burden, diagnosis, response to treatment, quality of life, health behaviors and access to care, to name only a few—that exist among population groups. Social-environmental factors such as residential segregation, discrimination, immigration, social mobility, work, retirement, education, income, and wealth can also have a serious impact on health and well-being. Many of these factors are broad, complex, and interrelated.

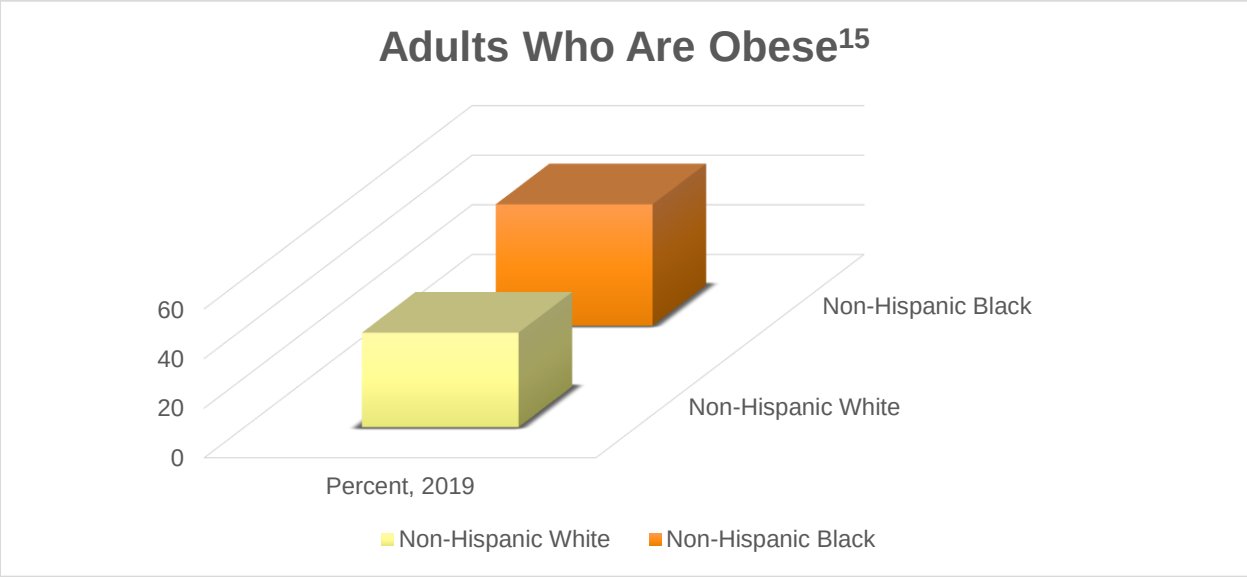
The Health Equity Team identified and reviewed health disparities data in Putnam County. Data was pulled from multiple sources including: *the U.S. Census Bureau, 2021-2025 Community Health Assessment for Putnam County, County Health Rankings from the University of Wisconsin Population Health Institute, Florida Behavioral Risk Factor Surveillance System and FLHealthCHARTS Health Equity Profile (2020)*, among others. Information from these resources were used in addition to:

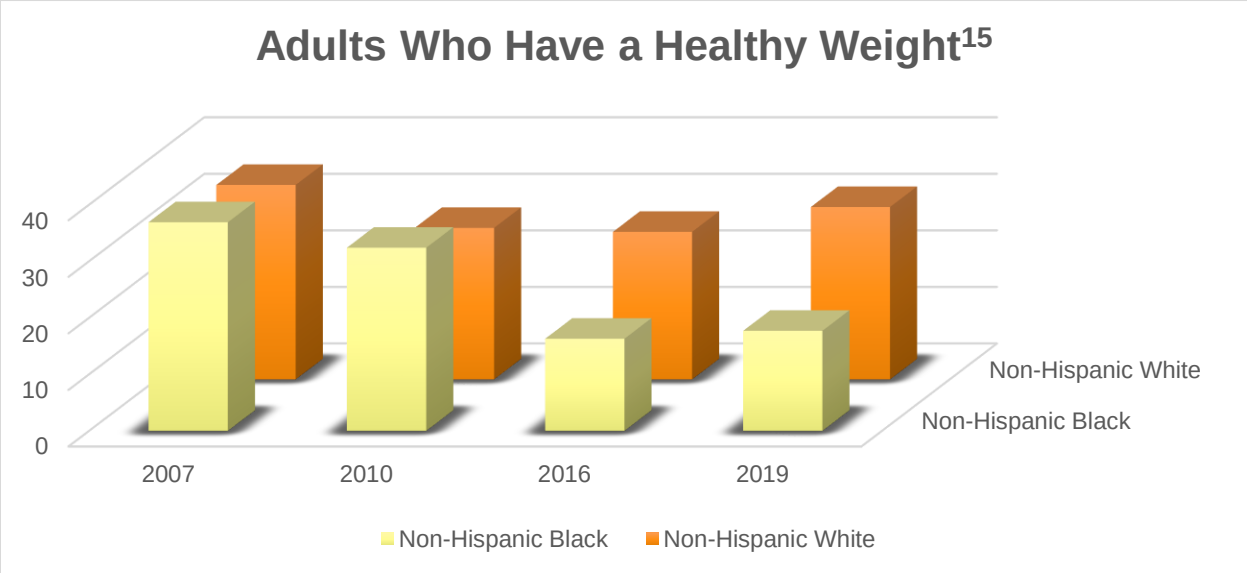
- Research journal articles
- Current events news periodicals
- Communications with community partners
- Peer review publications

The following health disparities were identified in Putnam County: underweight and overweight; prenatal care, birthing, and breastfeeding; prostate cancer; asthma; HIV/AIDS; congestive heart failure; diabetes mellitus; and kidney disease. Using a modified *Nominal Group Technique (NGT),* the Health Equity Team decided to work on **healthiest weight** [defined as covering any weight that falls below or above what is considered a healthy range] in the Health Equity Plan.

Disaggregated data concerning healthiest weight can be found below:

Disparities in Adult Obesity





- In 2019, the percentage of Non-Hispanic Black *adults who were obese* was 48.9%, compared to Non-Hispanic White adults at 38.1%. The line graph shows change. Since 2015, the percentage of **Non-Hispanic Black residents** in Putnam County who maintain a healthy weight is just over half of Non-Hispanic White adults.

Although no county-level data was obtained during the disaggregation process, federal studies demonstrate additional disparities in obesity for **U.S. Veteran** and **Immigrant populations**. The 2014 Clinical Practice Guidelines for the VA and Department of Defense classify 78% of **Veterans** as being overweight or obese—a significant deviation from the 41.9% of the total population that is classified as overweight or obese by the Centers for Disease Control and Prevention (CDC)[9].

Similarly, while state-level data did not indicate specific healthy weight disparities for persons who identify as **LGBTQ+**, a study[4] published in the *International Journal of Environmental Research and Public Health* in 2019 looked at data from 2019 looked at data from 2014 to 2017 Behavioral Risk Factor Surveillance System (BRFSS) surveys and found that bisexual and lesbian women were more likely to be overweight or obese than women who identify as heterosexual. In addition, eating disorders and body image disorders may be more common among gay and bisexual men than heterosexual men, per a study[40] published in the *Archives of Pediatrics and Adolescent Medicine*.

Immigrant disparities in weight were also noted at the federal level, where research suggests that immigrants can experience disparities in weight as they become more acculturated. After adjusting for age, sociodemographic, and lifestyle factors, studies[43] demonstrate that living in the United States for at least 10 years was significant for all immigrant subgroups except foreign-born blacks. Additionally, immigrants were less likely than US-born individuals to report discussing diet and exercise with clinicians. These differences were not accounted for by sociodemographic characteristics, illness burden, BMI, or access to care among some subgroups of immigrants. Compared with native-born white children, the adjusted odds of obesity were found to be 64% higher for native-born blacks, 55% higher for second-generation Hispanic immigrants, and 63% lower for first-generation Asian immigrants.

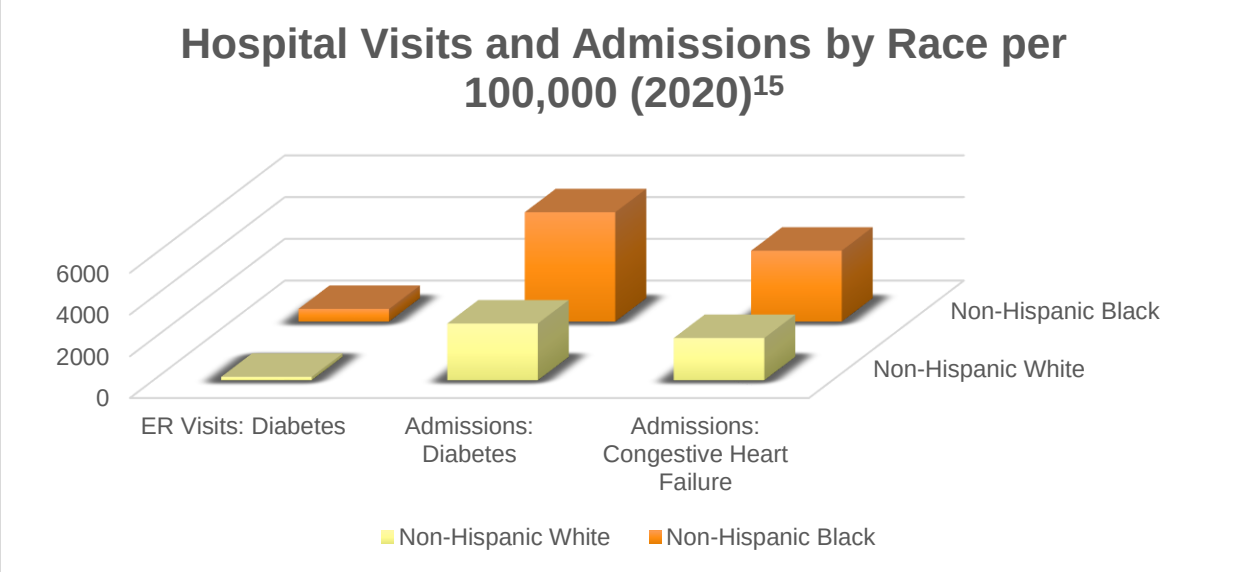
Data[10] from the *Centers for Disease Control and Prevention (CDC)* suggests that **adults living with disabilities** in Florida experience disparities in healthy weight—including obesity rates, incidence of Diabetes mellitus, and presence of heart disease. While these disparities are noted in adults with disabilities, it is important to recognize that associated intersectionality may warrant relegation to correlation instead of causation.

State-level data[13] from the United Health Foundation suggests that disparities in weight are also significantly influenced by **socioeconomic status**. For the year 2020, individuals who made less than $25,000 per year were over four percent more likely to

have obesity than those who made $25,000-$49,999, and almost 10% more likely have obesity than those who made upwards of $75,000 per year—a trend which has continued without notable variation for the last five years.

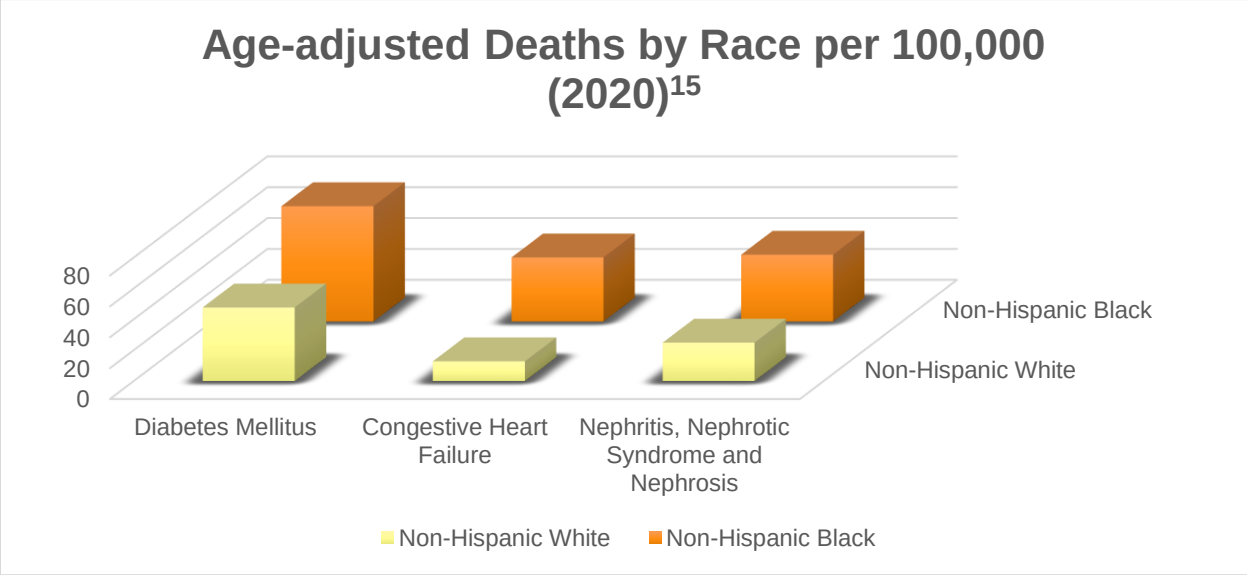
The causes of health disparities are dynamic and multidimensional, and to address them adequately, environmental, social-cultural, behavioral, and biological factors must be considered.

Disparities in Hospital Visits and Admissions



- In 2020, the *age-adjusted rate of Emergency room visits due to diabetes* for **Black adults** in Putnam County was 607.8 per 100,000 population, compared to White adults at 165.3 per 100,000.
- Hospitalizations From or With Diabetes for **Black adults** in Putnam County was 5,242.2 per 100,000 population, compared with White adults at 2,725.2 per 100,000.
- The *age-adjusted rate for Hospitalizations from Congestive Heart Failure* for **Black adults** in Putnam County, Florida was 3,400.2 per 100,000 population, compared with White adults at 2,025.7 per 100,000.

Disparities in Age-adjusted Death Rates

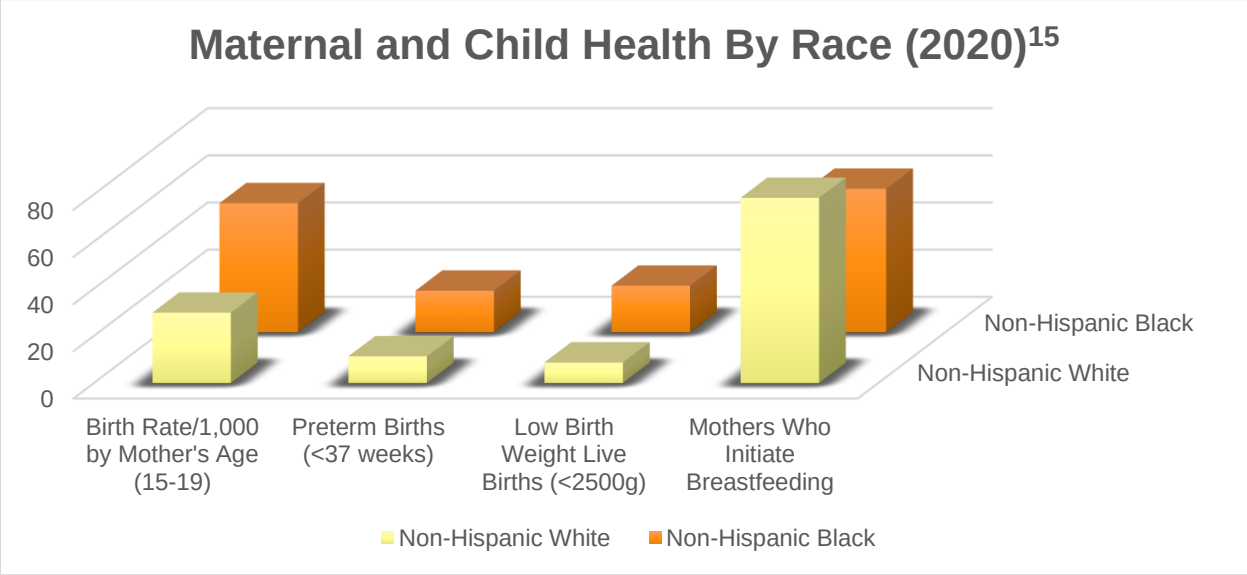


- In 2020, the *age-adjusted death rate from diabetes* for **Black adults** in Putnam County was 74.7 per 100,000 population, compared with White adults at 47.7 per 100,000.

- In 2020, the *age-adjusted death rate from Congestive Heart Failure* for **Black adults** in Putnam County was 41.5 per 100,000 population, compared with White adults at 12.8 per 100,000.

- In 2020, the *age-adjusted death rate from Nephritis, Nephrotic Syndrome and Nephrosis* for **Black adults** in Putnam County, Florida was 43.3 per 100,000 population, compared with White adults at 24.9 per 100,000.

Disparities in Maternal and Child Health



- In 2020, the *Birth Rate by Mothers' Age – Ages 15-19* for **Black mothers** was 54.8 per 1,000 females, compared with White mothers at 29.9 per 100,000.
- In 2020, the *percent of Births to Mothers with 1st Trimester Prenatal Care* for **Hispanic adults** in Putnam County, Florida was 57.7%, compared with Non-Hispanic adults at 65%.
- In 2020, the percent of *Preterm Births (<37 weeks gestation)* to **Black mothers** in Putnam County, Florida was 17.7%, compared with White mothers at 11.4%.
- In 2020, the percent of *Live Births Under 2500 Grams (Low Birth Weight)* to **Black mothers** in Putnam County, Florida was 19.8%, compared with White mothers at 8.8%.
- In 2020, the percent of *Mothers who initiate breastfeeding* for **Black mothers** in Putnam County, Florida was 60.9%, compared with White mothers at 78.6%.

Priority Populations

It is important to note that, while attempts were made to disaggregate by other key populations, such as those who have been historically marginalized based on their sexual and/or gender identity ***(LGBTQ+), veterans, immigrants, persons experiencing an economic disadvantage, those with inadequate insurance, and individuals who live in specific ZIP codes and/or census tracts****, currently, there is no available county-level data concerning healthy weight for these specific populations. While data is not available at the county level for* ***Native Hawaiian and Other Pacific*** *Islander populations, nationally, 44.6% of this cohort is considered compared to 28.2% of White residents. Similarly,* ***American Indian and Alaska Native*** *resident populations experienced much higher proportions of adults who were obese (48.1%) while lower proportions of* ***Asian*** *residents were found to have this condition[9].*

The Putnam County Health Equity Taskforce will consider future community projects aimed at addressing these data gaps, as it is important to apply an intersectional lens to health equity work—focusing on groups which experience health disparities. Several state and federal efforts are occurring to address these gaps, and the Putnam County health Equity Taskforce is interested in supporting these initiatives. Where county-level data is currently unavailable, data at the state or federal level has been used in its place.

After extensive research, and because of a lack of sufficient evidence base for populations experiencing disparities in healthiest weight, the following populations will not be considered a prioritized population for our efforts to increase healthy weight in Putnam County: **uninsured/underinsured, older adults (65+), and rural populations***. While specific weight disparities do not appear to exist for* ***LGBTQ+*** *at the state level, the existence of secondary factors which potentially influence healthiest weight—including (but not limited to) food insecurity and chronic disease—have led to the continued inclusion of these populations for these efforts.*

VII. SDOH DATA

Social Determinants of Health (SDOHs) are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes. The SDOHs can be broken into the following categories: education access and quality, health care access and quality, neighborhood and built environment, social and community context, and economic stability. The Health Equity Team identified multiple SDOHs that impact healthiest weight.

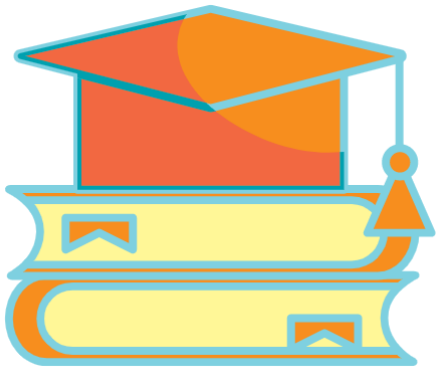
Social determinants have a major impact on health outcomes—especially for the most priority populations. Factors such as a patient's education, income level, and environment must be considered when providing treatment and care. Priority populations potentially affected include *persons living with chronic disease, racial and ethnic minorities, those who are economically disadvantaged (including suffering from homelessness), uninsured and under-insured populations, elderly individuals, infants, and toddlers (0-5), rural populations, LGBTQ+ individuals, persons living with addiction, individuals who are (or have been) incarcerated, people living with disabilities, women of childbearing age, and veterans.* For more information about how these priority populations are reflected in our county, please see associated data from the *Access and Functional Needs Profile (*FLHealthCHARTS, 2020) provided below:

Florida Access and Functional Needs Profile, Putnam County (2020)			
Indicator	**County Count**	**County Rate**	**Measure**
Demographic Data			
Total Population	73,355		Count
Resident Live Births	835	11.4	Per 1,000 Population
Population 65-84 Years Old	15,577	21.2%	Percent of Total Population
Population 85+ Years Old	1,821	2.5%	Percent of Total Population
Individuals 65 years and over living alone	4,950	29.8%	Percent of Population 65+
Children Under 18 in Foster Care	273	1771.1	Per 100,000 Population, Under 18
Socioeconomic Data			
Population Below Poverty Level (Census)	16,235	22.4%	Population for Whom Poverty Status is Determined
Population Uninsured Under Age 65 (Census)	11,919		Count

Households receiving cash, public assistance, or food stamps	6,119	20.5%	Percent of Households
Median Monthly Medicaid Enrollment	24,296	33,121.1	Per 100,000 Population
WIC Eligibles	3,773	5.1%	Percent of Total Population
WIC Eligibles Served	2,614	69.3%	Percent of WIC Eligibles
Homeless Estimate	178	0.2%	Percent of Total Population
Population 5+ that speak English less than very well	3,197	4.6%	Percent of Census Population 5+
Population that speak Spanish among Population 5+ that speak English less than very well	2,778	86.9%	Limited English Proficiency Ages 5 and Over
Vulnerability Data			
Percent of Adults Limited in Activities because of Physical, Mental, or Emotional Problems		33.8%	Percent
Percent of Adults Who Use Special Equipment because of a Health Problem		20.3%	Percent
Civilian non-institutionalized population with a disability	12,638	17.4%	Percent of Civilian non-institutionalized population
Developmentally Disabled Clients	284		Count
Clients with a Brain and/or Spinal Cord Injury			Count
Seriously Mentally Ill Adults	2,260		Count
Population Ages 18-64 with Vision Difficulty (Census)	1,387	3.4%	Percent of Census Population 18-64
Population Ages 18-64 with Hearing Difficulty (Census)	1,009	2.5%	Percent of Census Population 18-64

Medicare Beneficiaries Enrolled in Medical Essential Electric Utility Program	1,049		Count
Substance Abuse Program Enrollees – Adult	157		Count
Population Ages 18-64 with an Independent Living Disability (Census)	2,652	6.4%	Percent of Census Population 18-64
Children Through Age 20			
Estimated Seriously Emotionally Disturbed Youth 9-17	703		Count
Population Under Age 18 with Vision Difficulty (Census)	129	0.8%	Percent of Census Population Under 18
Population Under Age 18 with hearing Difficulty (Census)	100	0.6%	Percent of Census Population Under 18
Medical Foster Care Children	0		Count
CMS Clients	319	1.8%	Percent of Population Under 21
Substance Abuse Program Enrollees - Children	21		Count
Elderly Ages 65+			
Population Age 65+ with Vision Difficulty (Census)	885	5.2%	Percent of Census Population 65+
Population Age 65+ with hearing Difficulty (Census)	2,038	12.1%	Percent of Census Population 65+
Probable Alzheimer's Cases (65+)	2,030	11.7%	Percent of Population 65+

A. Education Access and Quality



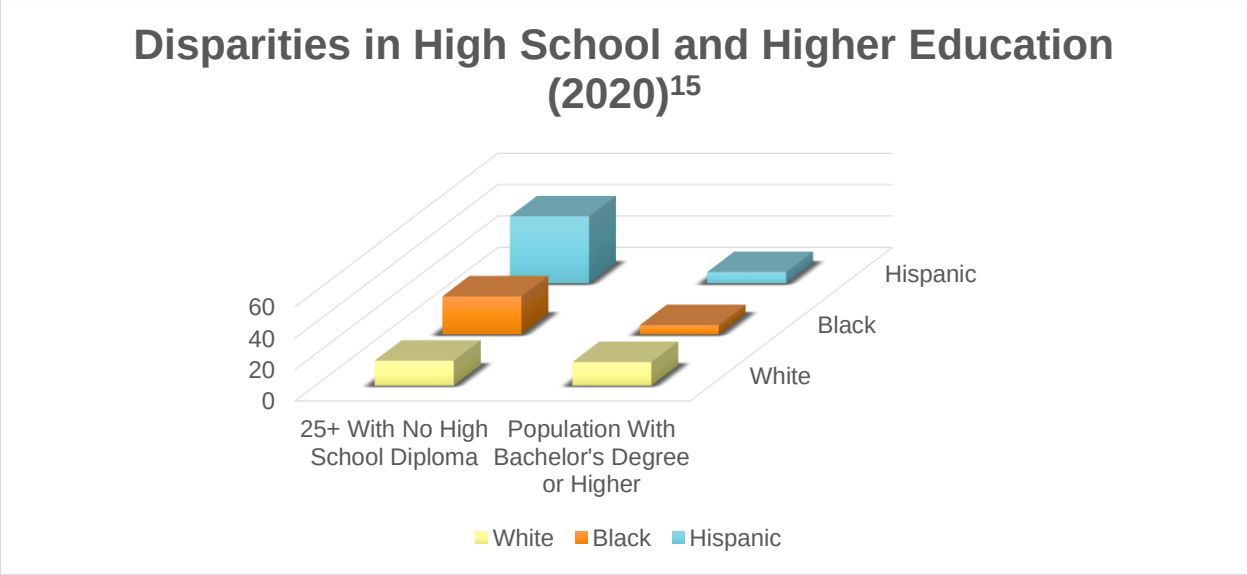
Literacy

Based on the 2020 *NCES PIAAC U.S. Skills Map: County Summary Card,* Putnam County was estimated as having 31% of the total population performing at, or below, the Level 1 literacy level (below basic literacy levels), while 43% of the County performed at Level 2 (basic literacy levels). An additional 26% of the County performed at or above Level 3 (intermediate or proficient). Current average grade level performance for 3rd graders on ELA standardized tests is 2.9, ranking Putnam's overall performance as 64th out of 67 counties in the State *(County Health Rankings, 2021)*. Results from the National Assessment of Adult Literacy demonstrated that **Hispanic adults** have the lowest average health literacy scores of all racial/ethnic groups, followed by **Black** and then **American Indian/Alaska native adults**.

Language

Based on data from the *PIAAC Skills Map,* 22% of the County's population is speaking English at a level of "Not Well/Not At All". According to data from the *U.S. Census Bureau,* 9.0% of residents in Putnam County speak a language other than English in the home; 6.96% of residents in County are considered as being a **Linguistically Isolated Population** *(US Census Bureau, 2015-2019 ACS).* Of those speaking a language other than English at home, 85 percent spoke Spanish and 15 percent spoke some other language.

High School and Higher Education



- In 2020, the percentage of **Hispanic individuals 25 years and over** with no high school diploma in Putnam County was 42.6%, compared to non-Hispanic individuals at 13.9%. The line graph shows change.

- In 2020, the percentage of **Black individuals** with a bachelor's degree or higher in Putnam County was 5.9%, compared to White individuals at 15.0%.

According to both State and Federal level data, **LGBTQ+** students face significant hurdles in the domain of access to quality education. Florida's *Youth Risk Behavior Survey* (2015) found that LGBTQ+ students were more likely to report being bullied at school (33.0% vs. 12.7%) and electronically bullied (25.5% vs. 9.6%) in the 12 months prior to the survey than non-LGBTQ+ counterparts. Additionally, GLSEN's (formerly the Gay, Lesbian & Straight Education Network) *2015 National School Climate Survey* of LGBTQ+ middle- and high school students found that 73% of respondents in the State stated that they had experienced verbal harassment based on their sexual orientation at school, while 56% said that they had experienced verbal harassment based on their gender expression at school in the year prior to the survey. Numerous students also reported experiencing physical harassment based on their sexual orientation (28%) or gender identity (22%) at school in the year prior to the survey. LGBTQ+ students in the state of Florida were more likely than non-LGBTQ+ students to report missing school because of feeling unsafe at least once in the month prior to being surveyed[30]. Data compiled by the Claude Pepper

Center at Florida State University shows that persons living with disabilities continue to face educational disparities at the state level, as well.

Lack of education affects healthiest weight by:

- ✓ Studies have indicated a direct correlation between general literacy rates and healthy BMI scores
- ✓ U.S. studies indicate that rates of obesity are higher for residents who are **English Language Learners**
- ✓ **Children of foreign-born parents** have a higher prevalence of obesity and higher growth in BMI from childhood to adolescence.
- ✓ Researchers have found that lower education levels in a household translate to higher obesity rates.
- ✓ Proliferating the existence of homogenous social circles
- ✓ Potentially relegating individuals and families to resource-deprived neighborhoods
- ✓ Breeding a lack of access to informed choices
- ✓ Encouraging stressors and related medical consequences
- ✓ Enabling lack of access to adequate health care coverage via a deficit in sustainable employment opportunities.

These deficits may predispose affected individuals to economic instability, reduced access to healthy foods and assistance, poor health and associated co-morbidities, and lack of access to care. To encourage healthiest weight, Putnam County is addressing disparities related to achieving increased levels of education.

Impact of Education Access and Quality on Healthiest Weight		
SDOH	**Priority Populations Affected**	**How the SDOH Affects Healthy Weight**
Literacy[31,34,42,44]	Low-income people of color; pregnant and postpartum women; and people who are deaf or hard-of-hearing	Studies demonstrated a direct correlation between literacy rates (both general and health-specific) and healthy BMI (Body Mass Index) scores. Deficits in general literacy can also affect health literacy rates, resulting in a decreased ability to make informed health decisions, including menu choices. The *National Institute for Literacy* estimates that 43% of adults with very low literacy skills live in poverty, which can limit

		opportunities for physical activity via disparities in other SDOHs, including Built Environment.
Language[5,18, 29]	Infants & Toddlers (0-5); Immigrants; Women of Childbearing Age	U.S. studies indicate that rates of obesity are higher for residents who are English Language Learners. Limited English proficiency has also been found to be a barrier to the receipt of advice about physical activity and diet from health care providers. Past research on young children has consistently found that children of foreign-born parents have a higher prevalence of obesity and higher growth in BMI from childhood to adolescence, especially among the more recently arrived immigrants, and this remains significant after controlling for race/ethnicity, socioeconomic factors, and family characteristics.
High School & Higher Education[2]	Black/African-American; Hispanic; Women of Childbearing Age	In a report from the *National Center for Health Statistics,* researchers found that lower education levels in a household translated into higher obesity rates. Less education also impacted other health markers. While there is a correlation between lack of education and health indicators, it is not necessarily a causative factor. Causation may be related to additional available resources – from built environment to economic stability.

B. Economic Stability

Putnam County has a diverse economic makeup—containing both urban and rural areas. Considered a rural county, Putnam has many unpaved roads and forested areas. In 2016, fewer Putnam County (59.3%) households reported household earnings compared

to State counterparts (72.1%). Additionally, almost one-quarter (22.5%) of the county's households received Food Stamp/SNAP benefits, while 2.8% reported receiving cash public assistance income. In 2016, the median household income in Putnam County was $33,003. Although this amount increased from 2015 to 2016, it remains significantly lower than the state's median household income of $48,900[16].

Unique challenges faced by **residents in lower socioeconomic brackets** include low access to communications, little or no access to cellular phone, internet services, volunteer emergency services, long distances from medical care, and lack of transportation. When people struggle with financial security, they have less hope, age faster, and die prematurely[50]. Stigma and discrimination against certain groups can lead to economic instability, including lower wages and higher rates of poverty[19].

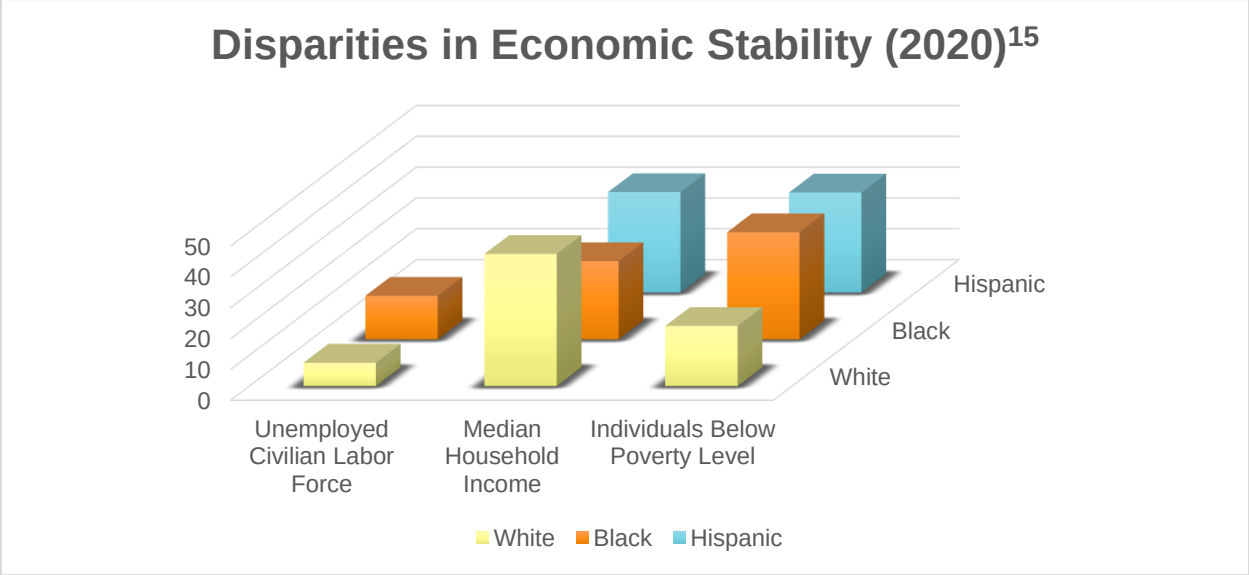
An inclusive economy revolves around all residents of a community being able to have fairly paid, secure, and meaningful work. Communities that don't have a healthy economy can find it difficult to attract people to live or work there. This can make it difficult to have enough resources for good schools, parks, roads, and other conditions that create well-being. The absence of these structures can lead to a cycle of hopelessness and intergenerational poverty[50].

Household Economic Status

Based on *U.S. News Healthiest Communities Report*, the total average number of work hours needed to pay for affordable housing in Putnam County is 46.4 hours per week.

Communities where not all people have equitable access to good jobs experience income inequality. This can lead to poorer health outcomes and higher health care costs[50]. While county-level data was not found for certain cohorts, the state workforce is varied, and it is still important to consider the contributions and tribulations of these individual cohorts. In 2016, one out of four individuals working within the state was classified as an **immigrant**. During this same year, immigrant-owned businesses in Florida employed 847,000 workers in 2016[32]. Considering another group at the state level, **LGBTQ+** individuals experience higher rates of unemployment, food insecurity, and low-income status than both their national LGBTQ+ counterparts and non-LGBTQ+ persons housed within their home state[19].

At a national level, the 2011 National Transgender Discrimination Survey report found that 81% of the transgender respondents from Florida reported experiencing harassment or mistreatment on the job, where 36% lost a job, 46% were not hired, and 29% were denied a promotion because of their gender identity or expression. In correlative fashion, the 2019 *Behavioral Risk Factor Surveillance System* (BRFSS) results for the State indicated a significant disparity in households presenting below the Federal Poverty Level (FPL) for those households identifying themselves as LGBTQ+.



- In 2020, the percentage of **Black civilian labor force** which was unemployed in Putnam County was 14.1%, compared to White civilian labor force which was unemployed at 7.6%. The line graph shows change.

- In 2020, the median household income for a **Black household** in Putnam County was $25,337.00, compared to White households at $42,846.00. In 2019, the median household income for a Hispanic household in Putnam County was $32,525.00, compared to Non-Hispanic households at $41,388.00.

- In 2020, the population percentage of **Black individuals** below poverty level in Putnam County was 34.7%, compared to White individuals at 19.5%. In 2020, the population percentage of Hispanic individuals below poverty level in Putnam County was 32.4%, compared to Non-Hispanic individuals at 18.6%.

Expenses

People feel financially secure when they can take care of their basic needs and handle unexpected costs that might come up[50]; however, Gallup polling data from 2012 to 2014 indicates that 28% of **LGBTQ+** adults in Florida reported they did not have enough money for food compared to 19% of non-LGBTQ+ adults in the state. Likewise, data from the 2019 BRFSS results for the state demonstrated a statistically significant disparity in the ability of LGBTQ+ adults to afford to eat balanced meals, as well as highlighted an inability to pay mortgage, rent, or utility bills during the previous 12 months.

Debt (including medical bills)

According to *Urban Institute* the share of the population in Putnam County, Florida with any debt in collections during the year 2020 was 46%. When assessing for the share of the County population with medical debt in collections, this number was calculated to be 30%.

<u>Economic stability affects healthiest weight by:</u>

- ✓ Researched associations between income and higher risk for obesity
- ✓ Reverse causality: including labor-market discrimination and stigmatization
- ✓ Encouraging reliance on inexpensive, high-calorie foods
- ✓ Decreasing access to opportunities for physical activity because of limited resources
- ✓ Potentially skewing the immediate hierarchy of needs in decision making
- ✓ Exacerbating physiological stress response due to increased burden of cost of living
- ✓ Causing an avoidance in seeking care because of a potential lack of ability to cover medical-associated costs.

These deficits may predispose affected individuals to discrimination and stigmatization, reduced access to healthy foods and assistance, poor health and associated co-morbidities, potential safety concerns, lack of access to medical care. To encourage healthiest weight, Putnam County is addressing disparities related to achieving increased levels of economic stability.

The Impact of Economic Stability on Healthiest Weight		
SDOH	**Priority Populations Affected**	**How the SDOH Affects Healthy Weight**
Employment[23,25,27]	Black/African-American; Women of Childbearing Age; Immigrants, Persons Living with Disabilities, LGBTQ+.	Research shows that unemployment is associated with underweight and, in nonsmokers, obesity. While there is clear correlation, causation is not understood to be linear and may affect priority populations in different ways. Underweight and overweight associations were more apparent for longer-term jobseekers, men, and jobseekers from lower-income households.
Income[11,26]	Black/African-American; Hispanic, Elders, Infants & Toddlers (0-5), Persons living with Disabilities, Women of Childbearing Age	While much has been documented in the literature showing that lower income is associated with higher risks for subsequent obesity; there is evidence to support that reverse causality may pose a more consistent relation owing to labor-market discrimination and public stigmatization. In the simplest view, obesity in developed results from an overabundance of inexpensive food calories combined with decreases in daily physical activity in the industrialized world and its built environment (Mattson et al., 2014; Mullan et al., 2017). Evidence shows that decisions regarding food intake fall under more immediate risks and concerns for limited-income populations, than long-term mortality risk of being obese (Dittmann and Maner, 2017; Dohle and Hafmann, 2017; Mani et al., 2013, Smith, 2017).
Expenses[12]	All	According to a report from George Washington University, direct and indirect non-medical costs of obesity include annual lost wages, sick leave, level of productivity, gasoline use (morbidly obese only), life insurance premiums, and value of lost life due to premature mortality. Anecdotal evidence suggests that there are other consumer-related costs significantly affected, such as clothing, air travel, automobile size or furniture.
Debt[3]	Women of Childbearing Age, Black/African-	Holding credit card debt is positively correlated with being overweight or obese for both men and women even when controlling for various covariates. Having trouble paying bills is negatively correlated with the probability of being overweight or obese for

	American, Hispanic	men but positively and significantly correlated with all three outcomes for women. A direct causal relationship running from debt to obesity is possible if those in debt must cut back on food expenditures and thus rely on more calorie-dense foods. Energy-dense food such as sweets or fatty snacks are often less expensive compared to food with lower energy density, such as fruit or vegetables. Indebtedness can cause substantial stress, and this may manifest itself in excess caloric intake. Those in debt may also suffer from food insecurity and behavioral biology indicates that those who are food insecure may develop eating habits that lead to being overweight (Smith, Stoddard and Barnes, 2009).
Medical Bills[7,21,47]	Black/African American, Hispanic, Women of Childbearing Age, Infants & Toddlers (0-5), LGBTQ+	Several investigators have evaluated the cost of obesity on an individual level. Finkelstein and colleagues found that in 2006, per capita medical spending for obese individuals was an additional $1,429 (42 percent higher) compared to individuals of normal weight. Cawley and Meyerhoefer, meanwhile, found that per capita medical spending was $2,471 higher for obese individuals than for individuals who were not obese – a 150 percent increase. Thompson and colleagues concluded that, over the course of a lifetime, per-person costs of obesity were like those for smoking. In middle-aged men, treatment of five common obesity-related conditions (CVA, CAD, DM, HTN, and elevated cholesterol) resulted in roughly $9,000 to $17,000 higher costs compared to normal-weight adults.

C. Neighborhood and Built Environment

Access to Nutritional Food

US news Healthiest Communities Report allotted Putnam County a *Food Environment Index Score* of 7.53 vs the State score of 9.65, wherein higher scores indicate healthier food availability. The report also stated that 15.6% of the population of Putnam County lives without access to large grocery stores. In 2021, *County Health Rankings* cited drinking water violations.

Broadband Access

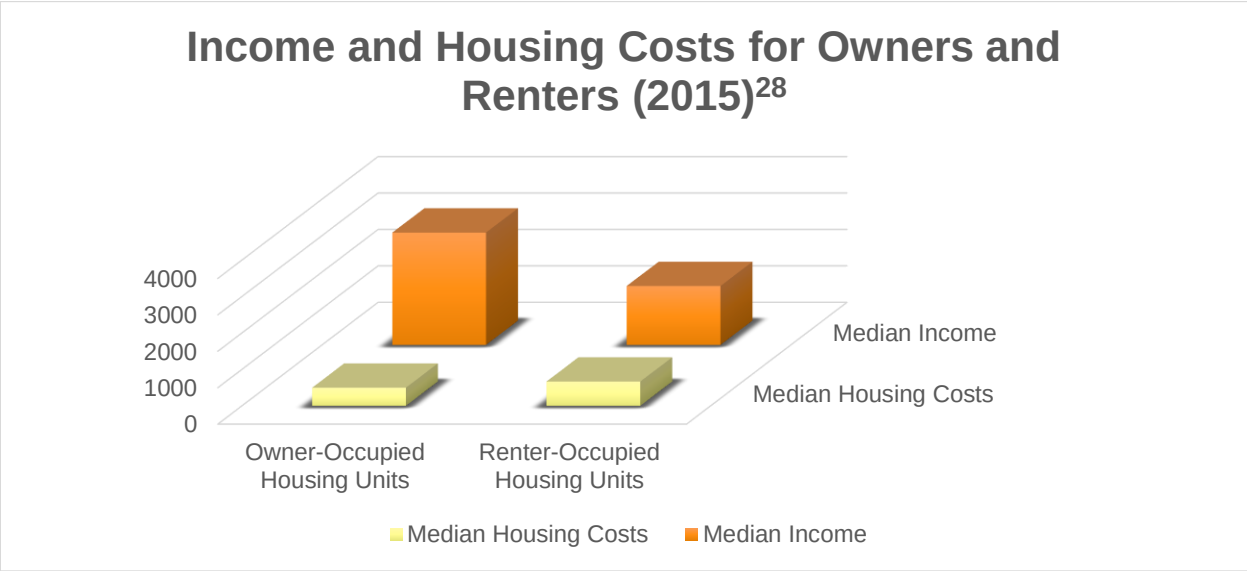
The *ACS 2020* estimated statistic for households in the county with the presence of a computer and type of internet subscription was calculated at 29,822 households. *County Health Rankings* currently lists 72% of households within the county as having access to a broadband internet connection within the home.

Percent Housing Problems

(overcrowding, high costs, lack of kitchen/plumbing)

County Health Rankings (2021) stated that 13% of households in the county currently spend over 50% of their household income on housing, while 19% of households exist with at least 1 of 4 housing problems: *overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities* [55th/67 counties].

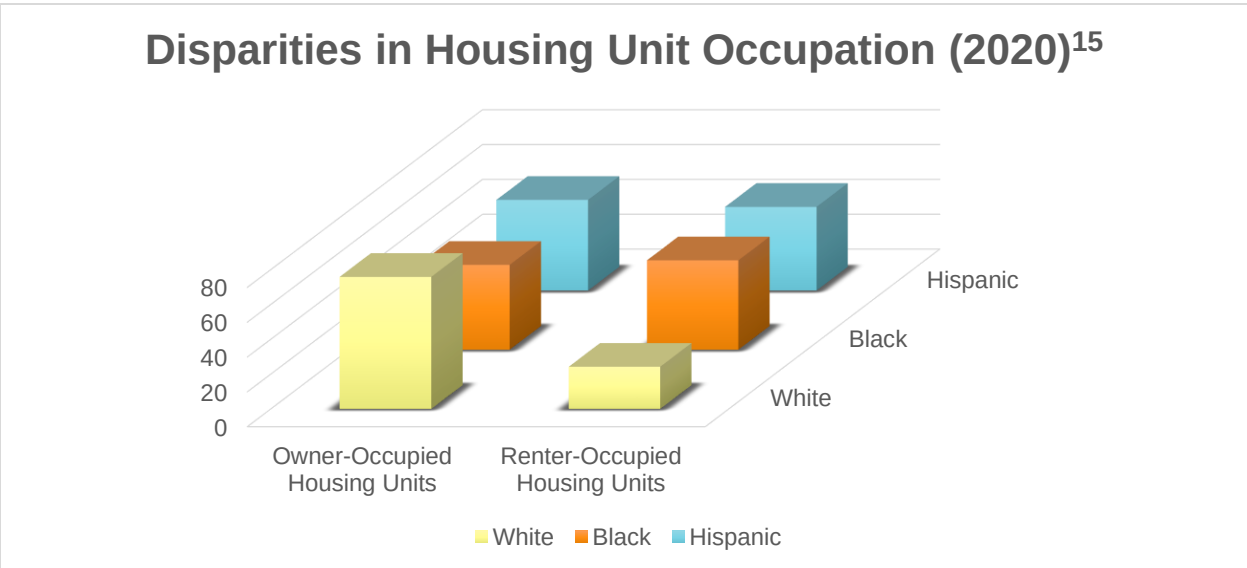
Affordable Housing Shortfall



- In *US News' Healthiest Communities Report*, Putnam County's *Affordable Housing Shortfall*, which indicates the availability of affordable housing relative to a community's low-income population, scored in at -82.3 vs the national average of -62.3. Negative numbers indicate a shortfall.

Occupied Housing Units

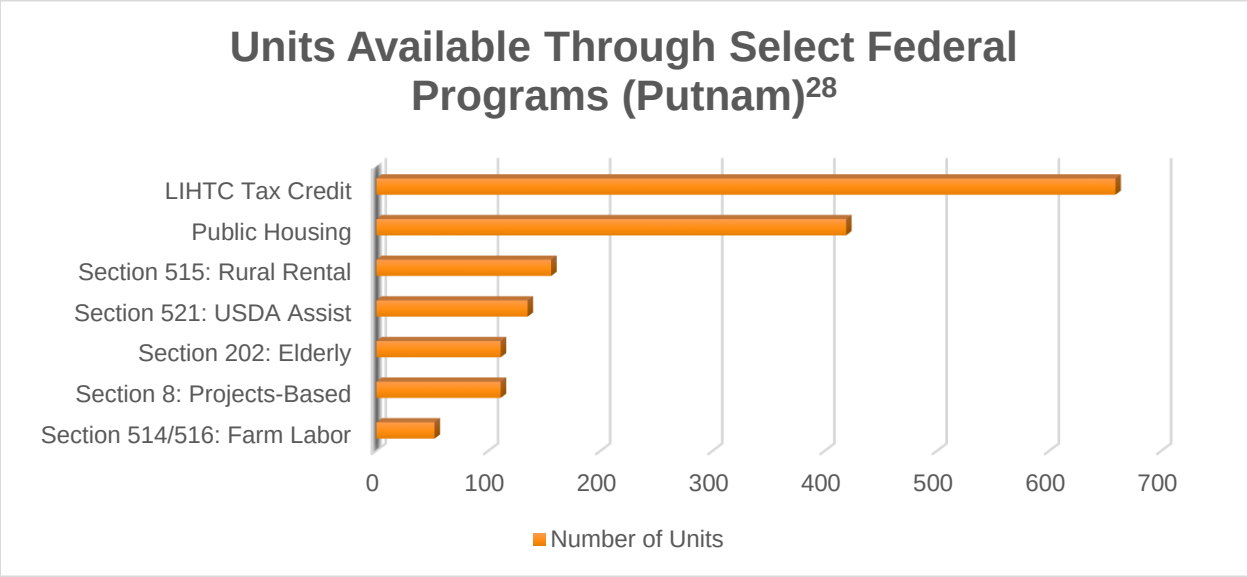
During the *2011 National **Transgender** Discrimination Survey*, 14% of respondents from Florida reported they had been denied a home or apartment.



- In 2020, the population percentage of **Black individuals** living in owner-occupied housing units in Putnam County was 48.7%, compared to White individuals at 75.8%. In 2020, the population percentage of **Hispanic individuals** living in owner-occupied housing units in Putnam County was 52%, compared with Non-Hispanic individuals at 77.6%.

- In 2020, the population percentage of **Black individuals** living in renter-occupied housing units in Putnam County was 51.3%, compared to White individuals at 24.2%. In 2020, the population percentage of **Hispanic individuals** living in renter-occupied housing units in Putnam County was 48%, compared with Non-Hispanic individuals at 22.4%.

Affordable Housing Availability through Federal Programs



- There are 27 low-income housing apartment communities offering 1,420 affordable apartments for rent in Putnam County, Florida. Putnam County features 806 income-based apartments. Tenants of income-based apartments typically pay no more than 30% of their income towards rent and utilities. There are 562 rent subsidized apartments that do not provide direct rental assistance but remain affordable to **low-income households** in Putnam County. On average, Section 8 Housing Choice vouchers pay Putnam County landlords $500 per month towards rent. In Putnam County, the average voucher holder contributes $300 towards rent. The maximum amount a voucher would pay on behalf of a low-income tenant

in Putnam County, Florida for a two-bedroom apartment is between $693 and $847. The chart below lists Fair Market Rent and Payment Standard Range as provided by federal housing data and AffordableHousingOnline.com research[28].

	Studio	One Bedroom	Two Bedroom	Three Bedroom	Four Bedroom
Fair Market Rent (Putnam)	$581	$585	$770	$987	$1,095
Payment Standard Range (Putnam)	$523 to $639	$527 to $644	$693 to $847	$888 to $1,086	$986 to $1,205

Transportation

From the *US News Healthiest Communities Report*, Putnam demonstrated almost double (16.4%) the State average (8.5%) of workers who commute 60 or more minutes to work, with a vehicle crash fatality rate over 250% higher (43.9/100,000) than the State average (16.7/100,000). According to this same report, 7.3% of households were listed as having no access to a vehicle. Further county-level data compiled by *KnowLi Data Science* and *The Claude Pepper Center at Florida State University* indicated statistically significant ($p<.05$) disparities in the delay of medical care because of transportation for individuals in the county **living with disabilities**.

Safety

In Putnam County, 29.5% of the population is said to live close to emergency facilities. According to *County Health Rankings (2021)*, the County is rated at 55th in the State for violent crimes, 57th for homicides, 66th for deaths due to injury, and 66th for firearm fatalities.

Parks

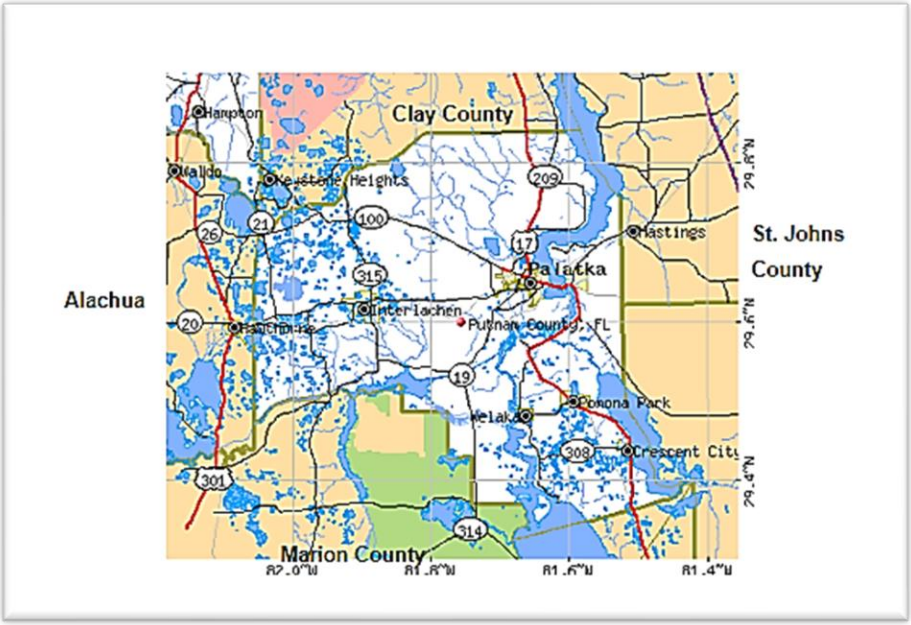
According to *US News Healthiest Communities Report*, 24% of the County population lives within 0.5 miles of a park.

Walkability

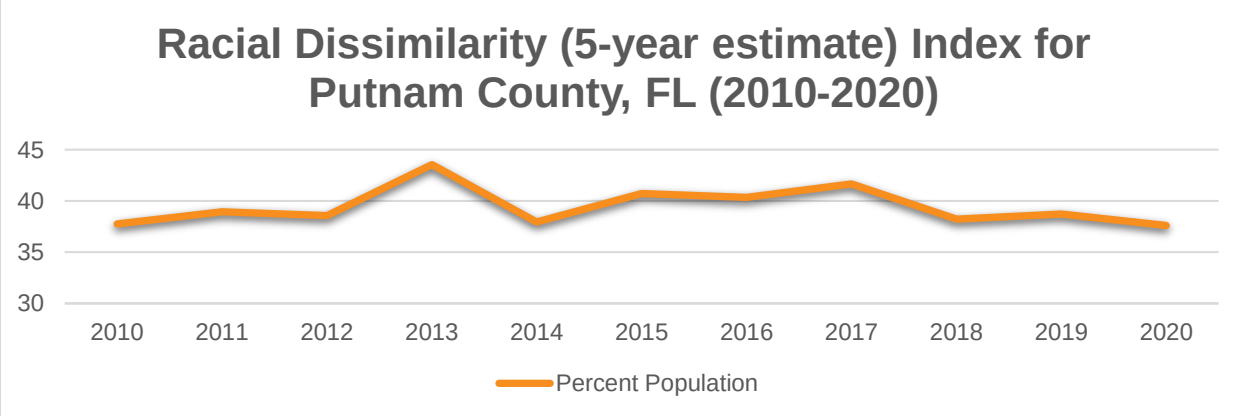
County Health Rankings (2021) considers 56.2% of the county to be rural, with a *walkability index score* of 5.6 versus the State average of 9.4.

Geography

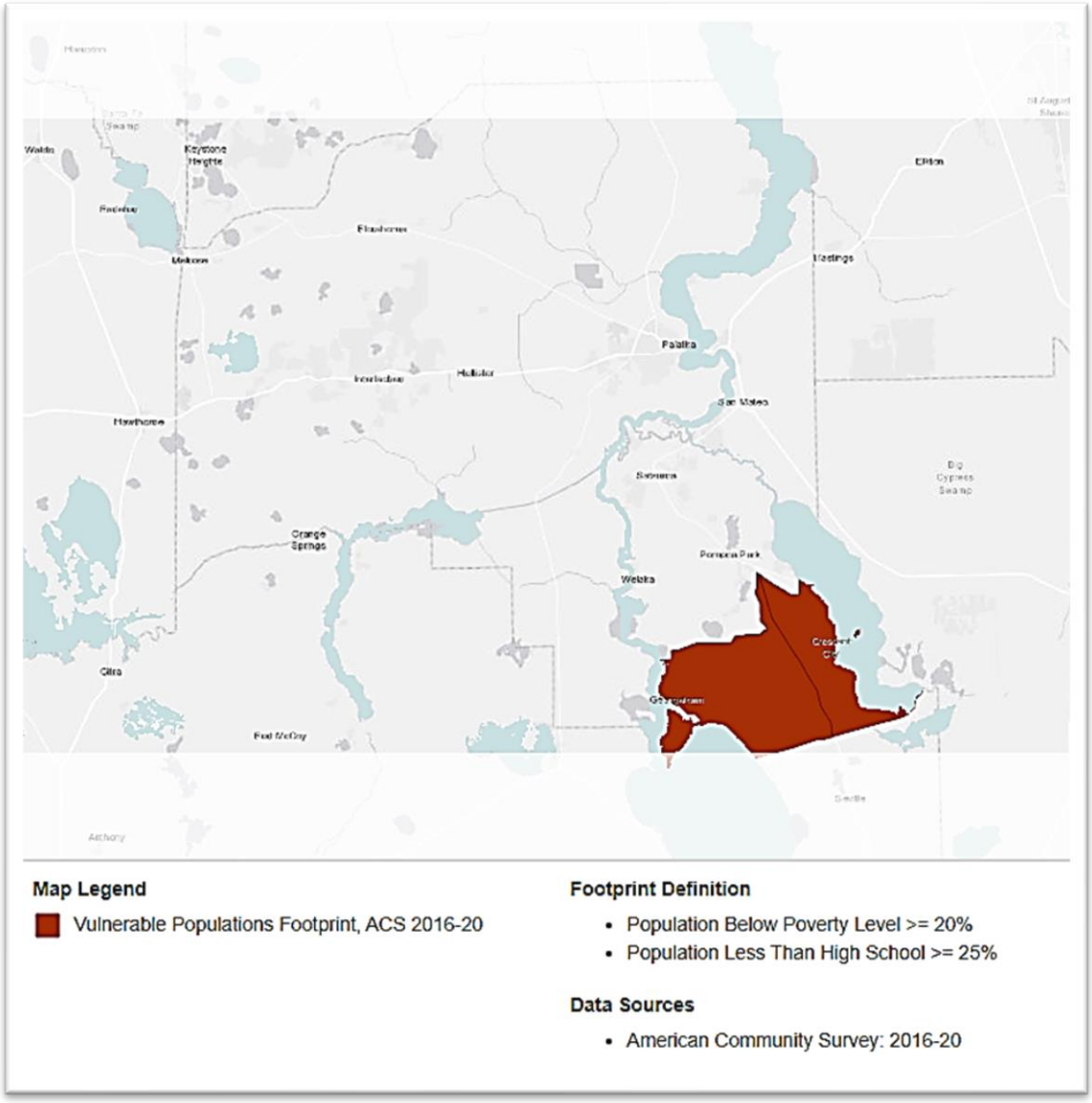
Putnam County is located in northeast Florida and is bordered by Flagler County and St. Johns County to the East. The most populated neighboring county is Alachua County, which forms the western border, along with a small corner of Bradford County. Clay County sits on the northern border. Volusia County and Marion Counties are to the South.



The *Racial Dissimilarity Index 2010-2020* (US Census Bureau, retrieved from FRED, Federal Bank of St. Louis) measures the percentage of the Non-Hispanic White population in a county which would have to change Census tracts to equalize the racial distribution between White and **Non-White population groups** across all tracts in the county. The line graph shows change:

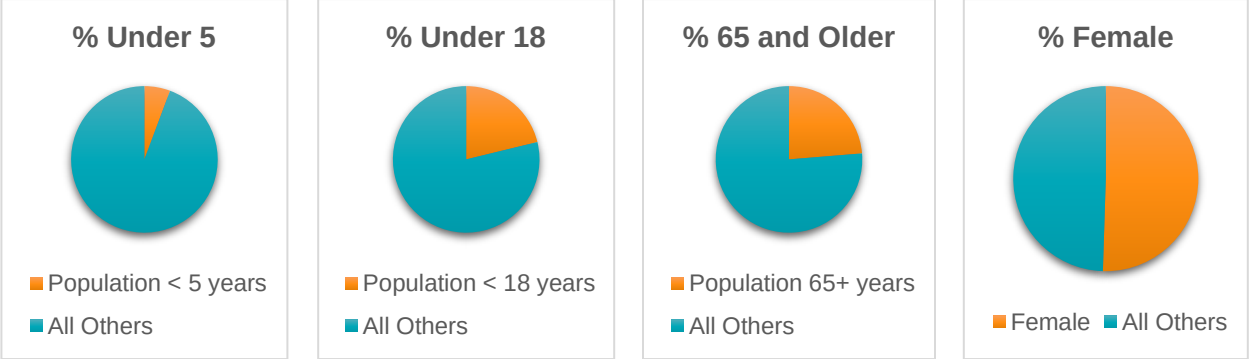


The *ACS Vulnerable Populations Footprint*, which depicts areas of the County that contain populations that are both below the poverty level, and have obtained less than a high school diploma, targets areas in South County, including: Satsuma, Pomona Park, Crescent City, and Georgetown. For the considered population (Total = 7,423), over 54% could be categorized as a **racial or ethnic minority**, over 52% were **female**, and over half fell into the provider and **reproductive age groups (18-64)**. In this same shaded demographic area, over 34% of the total population was considered to be **socioeconomically disadvantaged**--living below 100% of the Federal Poverty Level (FPL), with over 50% of total area **children** living in poverty. 16% of the aforementioned population is classified as **linguistically isolated** (*n=1,109)* and over 33% have not attained a high school diploma.



County Demographics

Putnam County is comprised of five municipalities: Palatka, Interlachen, Pomona Park, Welaka, and Crescent City. The most densely populated portion of the county is the central eastern portion, in and around Palatka. US Census Data estimates the 2017 Putnam County Population to be 74,521 with the following breakout by age and gender, see table below:



Neighborhood and built environment affect healthiest weight by:

- ✓ Potentially promoting unhealthy food purchases because of a lack of appropriate cooking and food storage amenities
- ✓ Availability of convenient and safe public transit can encourage habits that reduce BMI scores
- ✓ An association between lower levels of perceived neighborhood safety and higher BMI scores
- ✓ Access to clean, safe, neighborhood parks has been associated with lower BMI
- ✓ Playgrounds encourage physical activity for **youth** (and parents!)
- ✓ Segregated land uses are associated with less walking and heavier weight
- ✓ **Rural neighborhoods** often lack access to adequate means of passive transportation and may promote health risk behaviors.
- ✓ Worksites may provide easy access to unhealthy foods
- ✓ Worksites may also increase stressors and work-related fatigue, which are linked to poor diets and reduced physical activity.
- ✓ Evidence exists that **low-income neighborhoods**, as well as **Black or Hispanic** neighborhoods, are less likely to have access to large supermarkets offering high-quality and low-cost food.
- ✓ Convenience stores are more likely to locate in poor neighborhoods and particularly near schools—especially those with a higher population of **Hispanic and Black students**.

These deficits may predispose affected individuals to reduced access to healthy foods and assistance, poor health and associated co-morbidities, lack of access to care, safety concerns, and the potential promotion of health risk behaviors. To encourage healthiest weight, Putnam County is addressing disparities related to achieving increased stability of neighborhoods and built environments.

The Impact of Neighborhood and Built Environment on Healthiest Weight		
SDOH	**Priority Populations Affected**	**How the SDOH Affects Healthy Weight**
Housing[50]	Hispanic; Black/African-American; Persons Living with Disabilities, Immigrants, Elders.	Housing costs often are the foremost financial priority, with food identified as a more flexible and lower financial priority. Lack of appropriate cooking and food storage amenities may promote the purchase of convenient, inexpensive, and shelf-stable foods that are typically unhealthy.
Transportation[35,41]	Elders, Persons Living with Disabilities, Veterans, Infants & Toddlers (0-5), Immigrants, Women of Childbearing Age	Research shows that a one percent increase in county population usage of public transit is associated with a statistically significant decrease in county population obesity prevalence. Both active and public transport are shown to contribute to improvements in BMI. Public transportation systems may substantially influence physical activity at the population level, as users commonly walk or cycle to transportation stops and interchanges. Systematic reviews have found that initiating public transportation use has been associated with modestly lower adiposity. Incorporating public transportation into sustainable urban design should be considered a potential mechanism for reducing overweight and obesity in the general population.
Safety[37]	Infants & Toddlers (0-5), Elders, LGBTQ+, Women of Childbearing Age, Black/African American; Hispanic;	Various studies have demonstrated that living in neighborhoods with higher police-reported crime is associated with higher BMI and obesity levels over the life course. Safety assessments indicate that lower perceived neighborhood safety is associated with higher BMI and obesity. Conversely, increases in perceived safety over time, at both the individual and neighborhood level, have been associated with BMI decreases for the overall population.

	Persons Living with Disabilities	
Parks[46]	All	Studies demonstrate that greater neighborhood park access and greater park cleanliness were associated with lower BMI after adjusting for other neighborhood features such as homicides and walkability, characteristics that could influence park usage.
Playgrounds[14]	Infants & Toddlers (0-5); Women of Childbearing Age	Neighborhood playgrounds provide physical locations for children to engage in outdoor physical activity and to develop physically active lifestyles. The children get to play outdoors and enjoy life much more than those who don't have access to such facilities. Researchers have pointed out that neighborhood parks and playgrounds may make children more fit as they decrease BMI, as well as lower the risk of being overweight or obese. It is estimated that adding parks to a neighborhood may reduce the probability of being overweight or obese by about 3 percentage points for boys and by 5 to 6 percentage points for girls.
Walkability[8]	All	Mixing commercial facilities, single-family housing, and multi-family housing has for centuries enabled residents to walk to multiple near-home destinations. In the US, this long tradition was broken with Euclidian zoning, which allowed localities to separate land uses. Originally intended to protect health by separating noxious industrial land from residential areas, segregated land uses are now implicated in modern health problems associated with less walking, heavier weight, and more automobile pollution. In contrast, mixed use has been conceptualized as a key ingredient needed to support walking and recent studies suggest mixed use is important in maintaining healthy weight as well.
Geography[20]	Hispanic; Black/African-American; Elders; Infants & Toddlers (0-5); Women of Childbearing Age	Compared with their urban counterparts, rural populations have higher rates of preventable conditions such as obesity and related co-morbidities. These adverse health differences observed in rural populations might be due to higher rates of health risk behaviors (e.g., smoking, physical inactivity, poor diet) and passive transportation means in rural areas. Studies have concluded that obesity is markedly higher among

		rural adults than urban adults in the U.S. [39.6% versus 33.4%].
Access to nutritional food[22]	All	One roadblock is that healthy foods, such as vegetables, fruits, and whole grains, are more expensive than less healthful foods. Another is time: it takes longer to prepare healthful meals than to buy convenience foods or fast foods. Worksites often provide easy access to unhealthy foods in vending machines and limited access to healthier options, such as fruits and vegetables. Work environments can also increase the risk of obesity arising from job stress and work-related fatigue, which are linked to poor diets and reduced physical activity. Living in "food deserts" has been associated with lower quality diets and increased risk of obesity in some studies. Evidence exists that low-income neighborhoods, as well as Black or Hispanic neighborhoods, are less likely to have access to large supermarkets offering high-quality and low-cost food, compared to middle-income neighborhoods and white neighborhoods. Greater access to small food stores may increase the risk of obesity as convenience stores often offer less variety, higher prices, and lower quality produce than supermarkets. Convenience stores and other small stores selling unhealthy snack foods are more likely to locate in poor neighborhoods and particularly near schools. They are also more likely to locate near schools with more Hispanic and Black students, even after accounting for students' poverty level. While studies are not conclusive on whether there is a causal relationship found between living in proximity to fast-food restaurants and increased risk of obesity, fast-food restaurants are more likely to be located near schools, which has been linked to increased risk of obesity in schoolchildren.

D. Social and Community Context

Discriminatory environments cause various population cohorts to experience *minority stress*—the stress associated with experiencing both institutional and interpersonal stigmas because of one's identity—which has been associated with negative health outcomes.

Support Systems

Social and Community Context refers to the settings in which people live and work, and includes relationships between people, as well as the connections between people and institutions—social, religious, cultural, or occupational. An important aspect of social and community context is a sense of cohesion and connectedness among community members, which is strongly influenced by racial discrimination and inequaltiy[45]. According to *County Health Rankings (2021)*, 13% of **teen and young adults** (ages 16-19) living in Putnam County are neither working nor in school, while 33% of all resident **children** live in single-parent households—ranking Putnam 59th out of 67 counties in this area.

LGBTQ+ adults in Florida who completed the *2012 Behavioral Risk Factor Surveillance System* assessment were significantly more likely to have been diagnosed with a depressive disorder by a health care professional than non-LGBTQ+ adults who responded in kind (32.6% vs 11.8%). In addition, LGBTQ+ adults were significantly more likely to report binge drinking (26.5% vs 11.8%) and current smoking (34.23% vs 15.1%) than non-LGBTQ+ adults, and according to the *2019 Behavioral Risk Factor Surveillance*

System survey, demonstrated significant disparities in rates of poor mental health, as well as the extent to which the LGBTQ+ population felt stress. Based on additional information compiled by *KnowLi Data Science* and *Florida State University's Claude Pepper Center*, a significant ($p<0.001$) disparity in perceived stress levels also exists between county **residents living with disabilities** and residents who are not.

In 2019, there were 490 documented cases of domestic violence offenses in Putnam County, a rate of 671.1 per 100,000 population. The rate of documented cases of domestic violence in Putnam County has fluctuated in both upward and downward trends since 2014[16].

Civic Participation

PACE defines civic engagement as "helping people be active participants in building and strengthening their communities, whether defined as a place or a shared identity or interest". This inclusive definition reflects a spectrum of ways people can participate in their communities—including both public- and private-sector interactions—such as voting, advocating for policy change, joining social and religious groups, volunteering, and donating to charities.

According to a special report by the American Immigration Council, **naturalized citizens and children born of immigrants** since 1965 are becoming powerful in elections as their numbers grow. Major demographic transformations in the U.S. have seen a tremendous increase in native-born children of immigrants, especially among **Latinos and Asians**, as well as immigrants from other countries. Conversely, the report further indicated that the number of native-born white voters is on the decline (Ewing and Canter, 2014). According to US News Healthiest Communities Report, Putnam County has a voter participation rate of 65.3%. 656,000 undocumented immigrants live in Florida. Of these immigrants, 56% have been living in the US for 10+ years[32].

Social Integration

Social integration is focused on the need to move toward a safe, stable, and just society by mending conditions of social conflict, fragmentation, exclusion and polarization, and

by expanding and strengthening conditions towards peaceful relations; it is a dynamic and structured process which is not correlative to forced assimilation.

Stigma and discrimination can take numerous forms, including discrimination and harassment in employment and other settings; bullying and family rejection; overrepresentation in the criminal justice system; and violence. Research has linked stigma and discrimination against various cohorts to negative effects on individuals, business, and the economy.

Putnam County houses a diverse population of residents. In terms of race and ethnicity, 80.2% of Putnam County residents identify as White, while 16.4% of residents identify as **Black/African-American**; while 10.2% of the county identifies as **Hispanic** in ethnicity. Additionally, the *Williams Institute at UCLA (2015)* mapped **same-sex couples** per 1,000 households by Census tract (adjusted). For Putnam County, there are approximately 4.68 same-sex couples per 1,000 households. It is important to note that this data[30] may only represent a small portion of the LGBTQ+ cohort, as the U.S. Census does not ask sexual orientation or gender identity questions on their surveys. Therefore, data has been compiled from couples where both individuals identified as male or both individuals identified as female in the analysis provided.

Social integration can be arduous for minority populations. A study published in the *Journal of Psychological Science*, which surveyed Asian-American and white college students, found **children of immigrants** are often embarrassed by consuming food from their home country in front of others. Sixty-eight percent of the Asian-American respondents recalled food-related insecurities around white peers while growing up, while only 27 percent of white respondents remembered embarrassing food practices from childhood.

Compared to heterosexual and cisgender peer groups**, LGBTQ+** individuals experience unique stressors such as bullying, harassment, fear of rejection, internalized homophobia, body image distress, barriers to accessing medical and mental health treatment, and violence[19]. These stressors place them in a higher risk category for the development of eating disorders and other mental health issues.

Analysis of public opinion data collected from 2011 through 2013 indicates that 80% of Florida residents, non-LGBTQ+ and LGBTQ+, thought that LGBTQ+ people experience discrimination in the state. Another public opinion poll conducted in 2016 found that 57% of Florida residents thought that gay and lesbian people experience "a lot" of discrimination in the U.S. and 58% of Florida residents thought transgender people experience "a lot" of discrimination in the U.S.

Incarceration/Institutionalization

There were an estimated 54,720 **inmates** in Florida's county detention facilities during the month of January 2022. In comparison, in January 2021, there were 52,271 inmates incarcerated by county facilities in Florida. This is a 4.7% increase from last year. According to the Florida Department of Corrections' *County Detention Facilities Average Inmate Population* report for January 2022, Putnam County's incarceration rate is 5.3/1,000 county population.

Social and community context affects healthiest weight by:

- ✓ Evidence suggests that obesity clusters within social networks of family and friends.
- ✓ Higher BMI index has been shown to limit **women's** level of neighborhood engagement, creating a disparity in representation.
- ✓ Estimates suggest that the prevalence of weight discrimination is now comparable to prevalence rates of racial discrimination in the U.S.
- ✓ Active incarceration and institutionalization has been shown to increase BMI; where the effect is more prevalent in the **Black/African-American** cohort, as well as in those individuals holding no more than high school level education.

These deficits may predispose affected individuals to economic instability, potential for reduced representation in civic circles, poor health and associated co-morbidities, and lack of access to quality care. To encourage healthiest weight, Putnam County is addressing disparities related to achieving increased levels of cohesion in social and community context.

The Impact of Social and Community Context on Healthiest Weight		
SDOH	**Priority Populations Affected**	**How the SDOH Affects Healthy Weight**
Support Systems[6]	Youth; women of childbearing age; Infants & Toddlers (0-5); Persons living with disability; immigrants; elders	Evidence suggests that obesity not only spreads through social networks of family and friends but also clusters within them. Christakis and Fowler found that the likelihood of an adult becoming obese increased by 57%, 40%, and 37%, respectively, if a friend, sibling, or spouse became obese. Network-based interaction model simulations show that clusters of overweight and obese people are becoming increasingly more overweight because of social forces within their groups.
Civic Participation[39]	Women of childbearing age, elders, persons living with disability; immigrants; Black/African-American; Hispanic	Studies have observed that larger body sizes limit women's—but not men's—level of neighborhood engagement. This effect was independent of the level of bonding social capital and persisted across neighborhood types and individual characteristics. It suggests the possibility that the gendered, personal social meanings of large body size, such as those connected to discrimination and stigma, may shape broader neighborhood socio-political dynamics. Weight should be added to theoretical models considering how varied forms of disadvantage, such as gender, low income, minority status, and spatial disadvantage, intersect with place to undermine the health and well-being of individuals and their communities.
Social Integration[38]	Black/African-American; Hispanic; LGBTQ+; Persons living with disability; Immigrants	Numerous studies have documented harmful weight-based stereotypes. These stereotypes give way to stigma, prejudice, and discrimination against obese persons in multiple domains of living, including the workplace, health care facilities, educational institutions, the mass media, and even in close interpersonal relationships. Recent estimates suggest that the prevalence of weight discrimination has increased by 66% over the past decade and is now comparable to prevalence rates of racial discrimination in America.
Incarceration/ Institutionalization[24]	Black/African-American;	Studies have found that being currently incarcerated increased BMI, but the effect varied by

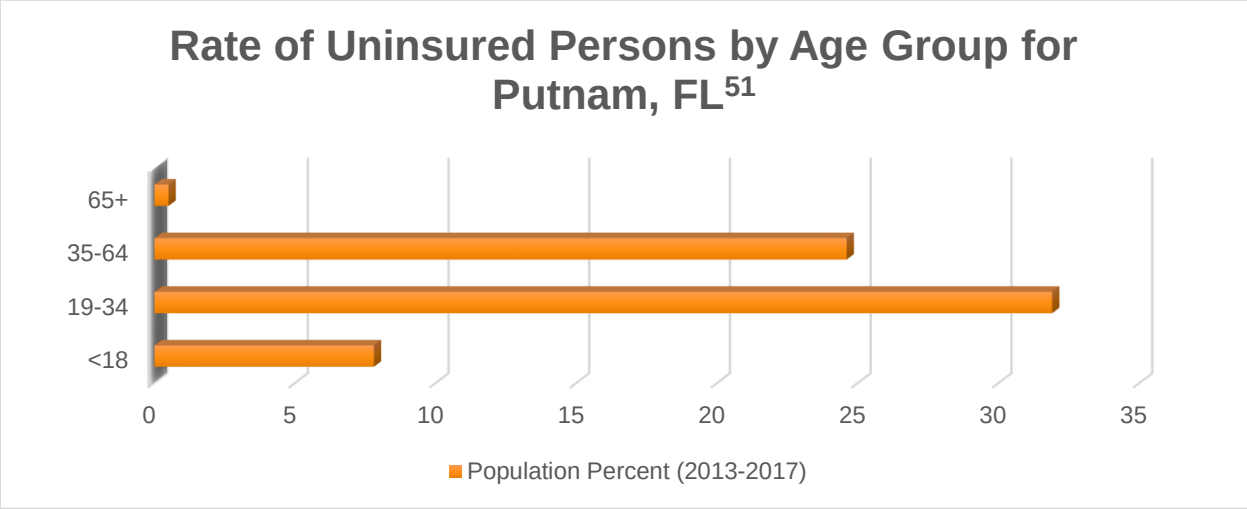
	Hispanic; Women of childbearing age	race/ethnicity and education: blacks experienced the largest increases, while effects were lowered for men with more education than a high school diploma. Cumulative exposure to prison increased BMI for all groups.

E. Health Care Access and Quality

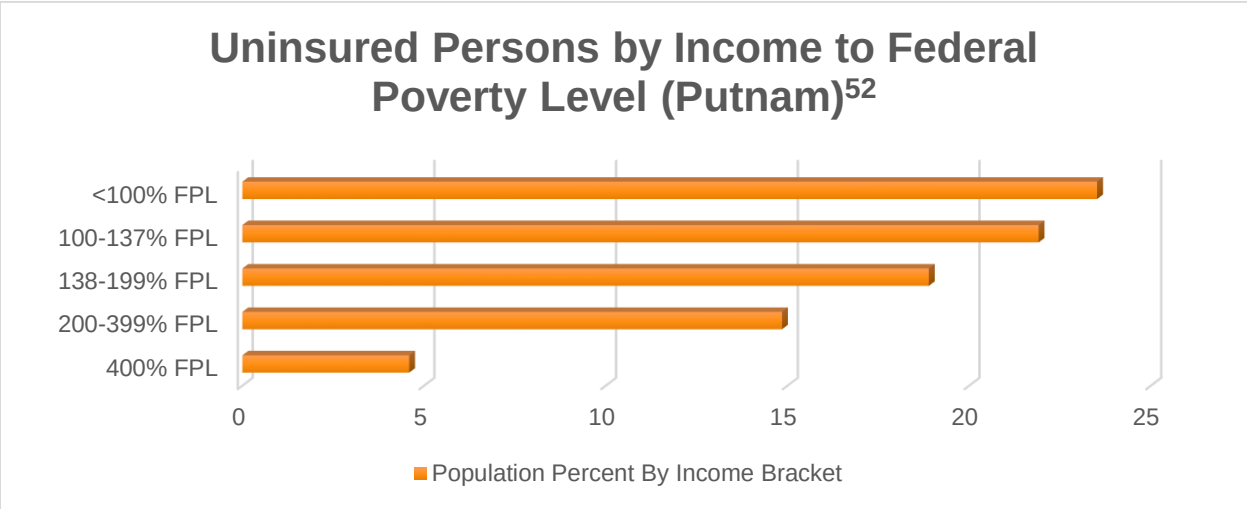
We all rely on health care services in our lives, and many of us take them for granted. But not everybody has the same access to medical advice and treatment. As a result, certain populations suffer poorer health outcomes.

Health Coverage

Age is a critical element in determining a person's eligibility for public insurance, which in large part explains the differences in uninsured rates for different age ranges. For example, Americans **over 65 years of age** are eligible for Medicare. **Children from low-income families** may be eligible for the Children's Health Insurance Program (CHIP), a public means-tested program like Medicaid[50].

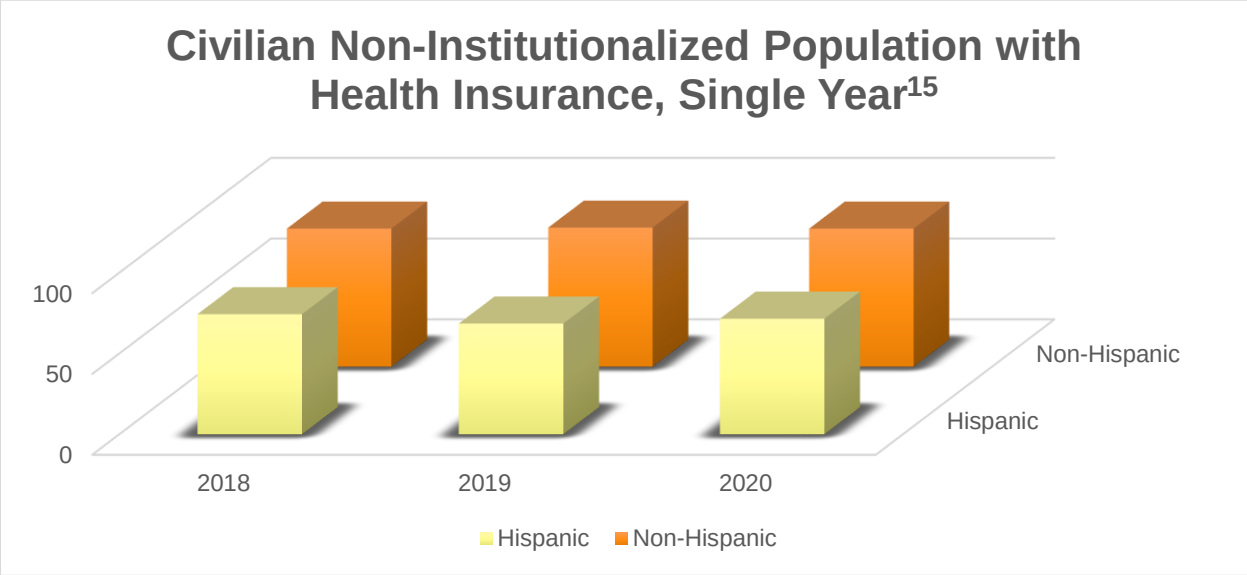


For the year 2022, the federal poverty income threshold for the 48 contiguous states and the District of Columbia is $27,750 for a family of four with two children, and $18,310 for a single parent of one child[48]. If a family's total income is less than the corresponding threshold, then that family and every individual in it is considered in poverty. Poverty is an extreme condition. According to *The National Center for Children in Poverty*, research suggests that families need an income equal to twice the federal poverty threshold (200% FPL) to meet their most basic of needs. The *United States Census Bureau* states: "Although the thresholds in some sense reflect a family's needs, they are intended for use as a statistical yardstick, not as a complete description of what people and families need to live". Provided below are medical coverage rates for residents of Putnam County, Florida, based on personal income bracket:



Apart from data such as age and income bracket, lack of health insurance also affects persons with certain **ethnicities**, **sexual or gender identities**, and/or who are **living with disabilities** at a higher rate than their respective counterparts in the state[17]. According to the *Centers for Disease Control and Prevention*, disability healthcare costs in Florida amount to approximately $53.1 billion per year, or up to 35% of the states' health care expenditures—or about $15,811 per person living with a disability[10]. Additional information compiled by *Knowli Data Science* and *Florida State University's Claude Pepper Center* notes significant (p=<.05) disparities in the ability for **people living with disabilities** to take their medication because of prohibitive costs.

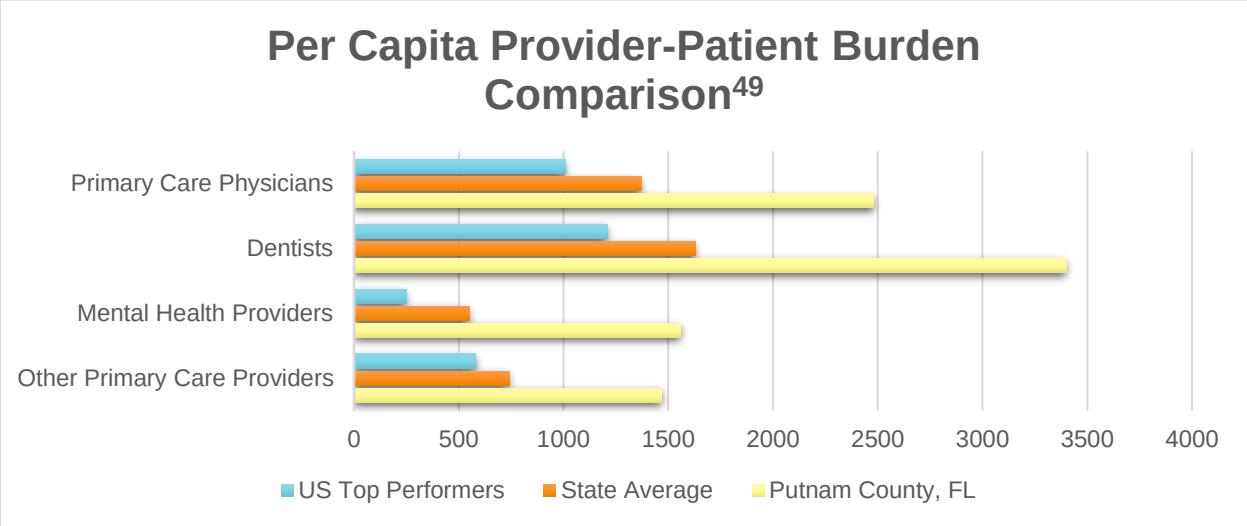
In 2020, the percentage of **Hispanic** civilian non-institutionalized population with Health Insurance in Putnam County was 71.6%, compared to non-Hispanic individuals at 85.5%. There was no disparity found by overall percent between the Black and White population. The line graph shows change.



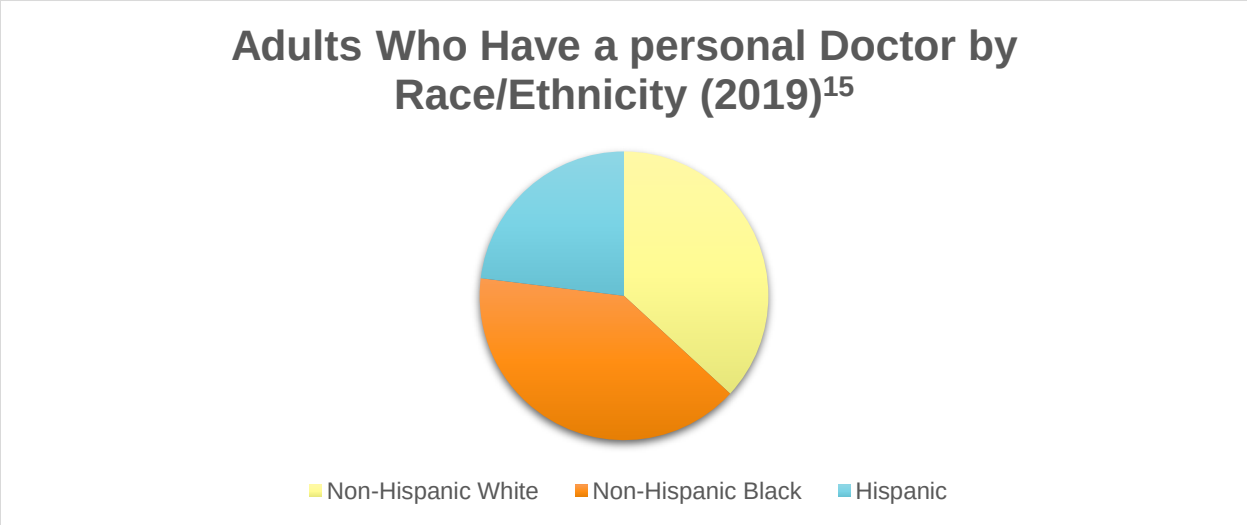
Provider Availability

Immigrants make up a substantial share of Florida's healthcare workforce. 42% of health aides and 24% of nurses in Florida are foreign born, supporting the state's significant **senior population**[32].

According to *County Health Rankings,* Putnam County currently houses 1 Primary Care Physician for every 2,390 residents. For other primary care providers, there is a patient burden of 1,590 patients per Primary Care Provider[49]. Additionally, according to *US News Healthiest Communities Report*, Putnam County has a hospital bed availability rate of 1.3 beds per 1,000 residents.



In 2019, the percentage of **Hispanic adults** who had a personal doctor in Putnam County was 44.6%, compared to non-Hispanic White individuals at 71.3% and non-Hispanic Black individuals at 77.6%.



Quality of Care

The **LGBTQ+** population experiences poorer health than its heterosexual counterpart. Statistics show that individuals within this cohort exhibit higher prevalence, as well as earlier onset, of general disability. For the year 2019, the *Behavioral Risk Factor Surveillance System* presented significant disparities in depression rates, as well as number of individuals who had received a medical checkup in the past year for LGBTQ+ individuals in the state of Florida. Studies show that the population experiences elevated rates of asthma, allergies, osteoarthritis, and gastrointestinal problems. The LGBTQ+ population also experiences higher risks for cardiovascular disease and some cancers. Additionally, gay, and bisexual men continue to account for the highest rates of HIV and new HIV infection in the United States, as well as other sexually transmitted infections. **Transgender women** also face a higher prevalence of HIV. Lastly, LGBTQ+ persons experience higher rates of mental health conditions and substance abuse. These statistics warrant particular attention to LGBTQ+ health care access[17].

Health care access and quality affect healthiest weight by:

- ✓ **Priority populations** are particularly at risk for insufficient health insurance coverage
- ✓ **Uninsured/underinsured** adults are less likely to receive preventive services for co-morbid chronic conditions associated with unhealthy weight.
- ✓ **Children** without health insurance coverage are less likely to receive well-child visits that track developmental milestones—including height, weight, and BMI.
- ✓ Lack of conceptual clarity around cultural/diversity competence results in health disparities, including healthiest weight.
- ✓ Studies show that lack of convenient or reliable transportation can lead to patient populations delaying or skipping medication, rescheduling or missing appointments, and postponing care.
- ✓ Late-stage presentation of certain medical conditions (e.g., cancer) can grossly affect health outcomes, including maintenance of appropriate weight ratios.
- ✓ Provider attitudes regarding obesity as a modifiable risk factor may prevent proper diagnosis and management.
- ✓ Interpersonal and environmental cues may convey that patients with obesity are not welcome.

These deficits may predispose affected individuals to a lack of ability to make informed decisions, poor health and associated co-morbidities, lack of access to quality care, discrimination, and potential lack of proper diagnosis and management. To encourage

healthiest weight, Putnam County is addressing disparities related to achieving increased access to comprehensive, quality care.

The Impact of Health Care Access and Quality on Healthiest Weight		
SDOH	**Priority Populations Affected**	**How the SDOH Affects Healthy Weight**
Health Coverage[33]	Immigrants; Hispanic; LGBTQ+; Infants & Toddlers (0-5)	Inadequate health insurance coverage is one of the largest barriers to health care access, and the unequal distribution of coverage contributes to disparities in health. Priority populations are particularly at risk for insufficient health insurance coverage; people with lower incomes are often uninsured, and minorities account for over half of the uninsured population. Uninsured adults are less likely to receive preventive services for chronic conditions such as diabetes, cancer, and cardiovascular disease. Similarly, children without health insurance coverage are less likely to receive appropriate treatment for conditions like asthma or critical preventive services such as dental care, immunizations, and well-child visits that track developmental milestones.
Provider Linguistic and Cultural Competency; Diversity Competence[1]	Racial/Ethnic Minorities; Persons with Disabilities; LGBTQ+	The Office of Minority health, Department of health and Human Services, established national standards for culturally and linguistically appropriate services in health and health care (National CLAS Standards) to provide a blueprint to implement such appropriate services to improve health care in the U.S. The standards cover areas such as governance, leadership, workforce; communication and language assistance; organizational engagement, continuous improvement, and accountability. However, a lack of conceptual clarity on cultural competence persists in the field and

		the research community. There is confusion about what cultural competence means, and the different ways in which it is conceptualized and operationalized. This confusion leads to disagreement regarding the topic areas and practices in which a provider should train to attain cultural competence. The populations to which the term cultural competence applies are also ill-defined, as cultural competence is often seen as encompassing only racial and ethnic (R/E) differences, omitting other marginalized population groups who are ethnically and racially like a provider but who are at risk for stigmatization or discrimination, are different in other identities, or have differences in healthcare needs that result in health disparities, including healthiest weight.
Transportation Barriers and Residential Segregation[33]	Elders, Persons Living with Disabilities, Veterans, Infants & Toddlers (0-5), Immigrants, Women of Childbearing Age	Health insurance alone cannot remove every barrier to care. It is to be noted that inconvenient or unreliable transportation can interfere with consistent access to health care, potentially contributing to negative health outcomes. Studies have shown that lack of transportation can lead to patients, especially those from priority populations, delaying or skipping medication, rescheduling, or missing appointments, and postponing care. Transportation barriers and residential segregation are also associated with late-stage presentation of certain medical conditions (e.g., breast cancer).
Provider Availability[33]	Rural; Elders; Persons Living with Disabilities; Infants & Toddlers (0-5); LGBTQ+; Women of Childbearing Age	Limited availability of health care resources is another barrier that may reduce access to health services and increase the risk of poor health outcomes. For example, physician shortages may mean that patients experience longer wait times and delayed care. Many health care resources are more prevalent in communities where residents are well-insured, but the type of insurance individuals have may matter as well.

		Medicaid patients, for instance, experience access issues when living in areas where few physicians accept Medicaid because of its reduced reimbursement rate.
Quality of Care[36]	Uninsured/Underinsured; Elders; Infants & Toddlers (0-5); Persons Living with Disabilities; Racial/Ethnic Minorities; Terminally ill; LGBTQ+	Many healthcare providers hold strong negative attitudes and stereotypes about people with obesity. There is considerable evidence that such attitudes influence person-perceptions, judgment, interpersonal behavior, and decision-making. These attitudes may impact the care they provide. Experiences of or expectations for poor treatment may cause stress and avoidance of care, mistrust of doctors and poor adherence among patients with obesity. Stigma can reduce the quality of care for patients with obesity despite the best intentions of healthcare providers to provide high-quality care. This effort may be hindered by interpersonal and environmental cues that convey those patients with obesity are not welcome or by behaviors that lower the quality of communication in the encounter. Healthcare providers often view obesity as an avoidable risk factor that impedes their ability to treat and prevent disease. As this is a largely unchallenged perspective on obesity, healthcare providers may be less self-aware of their propensity to and feel less pressure (internally or from external sources) to behave in a non-prejudicial way towards people living with obesity.

VIII. SDOH PROJECTS

The Minority Health Liaison recruited and engaged members across the county, including government agencies, nonprofits, private businesses, and community organizations, to join the Health Equity Taskforce. The Minority Health Liaison took into consideration the prioritized health disparity and the impactful SDOHs identified by the Health Equity Team during recruitment.

A. Data Review

The Putnam County Health Equity Team engaged in a modified *Nominal Group Technique (NGT)* activity to select healthiest weight as the prioritized health disparity for the Putnam County Health Equity Plan. Data was then reviewed, including health disparities and SDOHs related to healthy weight provided by the Health Equity Team. The Health Equity Task Force also researched evidence-based and promising approaches to improve the identified SDOHs. The Task Force further considered the policies, systems and environments that lead to inequities.

It was determined that communities of color were disproportionately impacted by health and other inequities that impact health outcomes and quality of life. Based on the available data related to healthiest weight, the Task Force resolved that the population which should be prioritized with this plan is Black/African-American adults and infants—who experience lower rates of indicators associated with healthy weight; lower levels of literacy and educational attainment; deficits in economic stability including lower rates of employment, lower income, and higher rates of poverty; an increase in place-based risk including disparities in geographic location and housing; disparities in incarceration and institutionalization; and diminished access to quality and timely health care.

Upon review of the data and an in-depth literature review on how each SDOH impacts healthy weight, the Task Force noted that Neighborhood and Built Environment (i.e., transportation, broadband access, and access to healthy food sources), Economic Stability, and Health Care Quality and Access were the most pressing SDOHs to address

with the first iteration of this plan. However, it has been noted that other Social Determinants of Health, including education, as well as social and community context, also play an integral role in the hindrance of healthy weight, thus, future projects aimed at improving these conditions will also be considered for implementation.

The Task Force highlighted the lack of public transportation infrastructure available in the county, which makes it difficult for residents to access necessary services and resources. It was also noted that numerous households don't fall under "transportation disadvantaged" because they own one car; however, that a family only owning one car can cause a great deal of hardship and reduced opportunities, as well. In terms of education access and quality, literacy, language barriers and higher education deficits were tied into potential for activity programs, effects of health literacy, and even considered in the affective inability to read menu choices. During meetings, key players discussed both the role that place-based risk plays for many Putnam County residents, given the rural landscape and limited health care provider availability, as well as the role that lack of broadband access—whether due to intrinsic or extrinsic factors—plays among notable disparities, and their associated cohorts, within the community.

Throughout the implementation phase, the Putnam County Health Equity Task Force and DOH-Putnam Health Equity Team will meet at least quarterly to monitor community project progress. The Minority Health Liaison will work to collect and track process measure data, besides collecting and reporting back on secondary objective data. The Minority health Liaison will also report on progress to the Health Equity Regional Coordinators and the Office of Minority Health and Health Equity on an as needed basis, at least quarterly.

B. Barrier Identification

Members of the Health Equity Taskforce worked collaboratively to identify their organizations' barriers to fully addressing the SDOHs relevant to their organization's mission. Common themes were explored, as well as collaborative strategies to overcome barriers.

SDOH	Partners	Partner Barriers	Collaborative Strategies
Health Care Access and Quality	AZA Health SMA Healthcare	Transportation Lack of Health Insurance Workforce Development	**Transportation:** Transportation as a barrier to Health Care Access and Quality will be addressed through broadband expansion to increase telehealth options, asset mapping to strengthen infrastructure, and SDOH screenings to assess need. **Lack of Health Insurance:** Lack of health insurance as a barrier to Health Care Access and Quality will be addressed through implementing SDOH screenings to assess need, as well as asset mapping to connect priority populations with available resources. **Workforce Development:** Workforce development as a barrier to Health Care Access and Quality will be addressed by all four proposed projects: broadband expansion will allow for access to education, as well as expansion of application and performance related activities. Asset mapping will help to connect employees with resources available to them. Furthermore, utilization of a HiAP Task Force will support the creation and maintenance of fully informed policy changes. SDOH screens will allow for individual needs to be addressed.

Education Access and Quality	Baby Brain Builders	Lack of Knowledge Lack of Transportation	**Lack of Knowledge:** Lack of knowledge of services and evidence-based practices as a barrier to Education Access and Quality will be addressed by asset mapping, which will allow for priority populations to connect with available services. **Lack of Transportation:** Lack of transportation as a barrier to education access and quality will be addressed via broadband expansion allowing for additional educational opportunities, SDOH screenings to assess priority population needs, and asset mapping to connect populations with additional available opportunities.
Neighborhood and Built Environment	Board of County Commissioners Florida Legal Services Palatka Housing Authority	Housing Discrimination Lack of Knowledge of Fair Housing Act Language Appropriate referrals	**Housing Discrimination:** Housing discrimination as a barrier to equity in Neighborhood and Built Environment will be addressed via SDOH screenings to determine population needs as well as through the creation and maintenance of a HiAP Task Force to help inform policy-level decisions. **Lack of Knowledge of Fair Housing Act:** Lack of knowledge as a barrier to equity in Neighborhood and Built Environment will be addressed via all four project avenues. Broadband expansion will allow for educational opportunities

			associated with fair housing, SDOH screenings will help to define those who deal with housing discrimination, Asset Mapping will help to connect associated populations to available resources, and the findings from the HiAP assessments will inform policy choices. **Language:** Language as a barrier to equity in Neighborhood and Built Environment will be addressed via HiAP assessments that will inform policy decisions regarding linguistic deficits, while SDOH screenings will highlight individuals who may need help because of linguistic barriers.
Social and Community Context	City of Palatka		**None listed.**
Economic Stability	Board of County Commissioners		**None listed.**

C. Community Project Storyboards

The Health Equity Taskforce researched evidence-based strategies to overcome the identified barriers and improve the SDOH that impact the prioritized health disparity. The Health Equity Taskforce used this information to collaboratively design community projects to address the SDOHs. During project design, the Health Equity Taskforce considered the policies, systems, and environments that lead to inequities. Projects included short, medium, and long-term goals with measurable objectives. All proposed objective targets were selected and assessed via the use of target setting and trend analysis tools made available through the National Center for Health Statistics (NCHS). These projects were reviewed, edited, and approved by the Coalition to ensure feasibility.

DOH-Putnam, along with various members of the community, developed four community projects to address the Social Determinants of Health that impact the ability of Putnam County residents to attain and maintain a healthy weight. These projects are the *Broadband Expansion Project*, *Asset Mapping Project*, *Health in All Policies (HiAP) Infrastructure Project*, and *Social Determinants of Health Screening Project*. Each project has a storyboard and corresponding goals and objectives table, which are included below.

Background

There is some disagreement as to the extent of underserved areas in the United States, with estimates of Americans who lack access to broadband reaching as much as 42 million members of the U.S. population.

Although roughly 19% of rural households lack broadband, in absolute numbers, about three times as many households without broadband are in urban development areas.

Many urban families already have broadband network infrastructure available; however, these families may be unable to afford necessary equipment or services.

Addressing urban connectivity as part of a broadband expansion initiative could have significant implications for racial and socioeconomic equity.

BROADBAND EXPANSION PROJECT

PROBLEM | ROOT CAUSES | BARRIERS:

In sparsely populated areas, the returns to internet investment from user fees aren't enough to cover costs of building out network—an issue known as the "last mile" problem. Many remaining unserved areas are geographically difficult to reach, as well. The physical availability of broadband alone does not ensure equitable access. Many low-income families in both urban and rural regions cannot afford broadband services at current prices. Finally, as access to resources increasingly shifts online, the extent of government intervention in the market continues to be a subject of debate.

DISPARITY | EVIDENCE | FEASIBILITY:

Research suggests that the social returns to investment in broadband are significant. Increasing access and usage of broadband infrastructure in rural areas (and the amenities, digital skills, online education, and job opportunities associated with it) lead to higher property values, increased job and population growth, higher rates of new business formation, and lower unemployment rates, according to researchers at the Federal Reserve Bank of Richmond. Broadband expansion can also improve health and life outcomes, offering access to remote healthcare providers, online social networks, and educational opportunities. A cost-benefit analysis of rural broadband installation in Indiana observed three to four-fold returns on investment, not including state and local governments' cost savings on medical expenditures and additional tax revenues from increased incomes.

SCOPE | SDOHs | BENEFICIARIES:

Low income and elderly populations, people with racial or ethnic minorities, and those who live in rural or Tribal areas are disproportionately likely to lack access. The *Pew Research Center* found that 43% of adults with incomes below $30,000 per year report not having home broadband services. Additionally, during school closures related to COVID, approximately 15 million students found themselves without broadband coverage. Access to Broadband Coverage has potential to affect all five main SDOHs (Economic Stability, Built Environment, Education, Access to Health Care and Social and Community Context).

TEAM MEMBERS | POPULATIONS:

Larry Harvey, County Commissioner – Team Lead

Putnam County Technology Planning Team

R/E Minorities – Elders – Parents of Children (0-5)

OVERVIEW | STEPS | FUNDING:

See *Section IX: Health Equity Plan Objectives.*

RESULTS | CLAS STANDARDS |+ STEPS:

Project set to commence during FY 2022-2023. More information forthcoming.

Background

Asset mapping is a means of gathering information about the strengths and resources of a community.

The purpose of asset mapping is to help uncover solutions to deficits within the community.

By inventorying and depicting a community's resources and strengths in the form of a visual map, assessments can occur surrounding how to build on these assets to address the needs of the community and improve overall health. Thus, asset mapping helps in community development.

Asset mapping highlights the organizations, structures, institutions, and people within a community that can be used to create a meaningful impact.

ASSET MAPPING PROJECT

PROBLEM | ROOT CAUSES | BARRIERS:

Health factors represent community conditions that be changed to improve health and opportunity. During the past decade, Putnam County has consistently ranked in the lowest four counties in the State for both health factors and health outcomes. Public and private organizations and services in the area tend towards being siloed, and there is a great dearth of available resources met with an even greater need. Barriers to connecting people in need with available resources include an inability to find and communicate with those in need, duplication of assistance efforts, and lack of adequate resources of all types.

DISPARITY | EVIDENCE | FEASIBILITY:

Asset mapping is a useful tool for assessing health-related needs, disparities, and inequities within communities. Ordinarily used to visualize trends in environmental, epidemiological, and analysis of biostatistical data, the use of GIS is currently utilized for the organization of social services available in the community to illustrate geographic proximity or distance to its intended targets. Visually layering sociodemographic data on top of data showing services offered can reveal a variety of community needs in specific neighborhoods or areas. This nuance in community development, if used properly, can aid in the distribution of grants and funds as well as identify organizations and populations that are in need of assistance.

SCOPE | SDOHs | BENEFICIARIES:

While asset mapping supports and involves the whole of the community and is inclusive of all SDOH categories, we perceive that its greatest effects will be felt in the categories of *community and social context, economic stability,* and *health care access and quality,* as resources are categorized, mapped, and noted for future referral purposes—especially targeted at hard-to-reach populations, such as those without phone or internet service, persons who are transportation disadvantaged, and additional at-risk members of the community.

TEAM MEMBERS | POPULATIONS:

Asset mapping should be *participatory and inclusive,* enabling persons of diverse backgrounds the experience to identify what they consider to be assets in the community. Because of this, it is a good way for community members to identify the services, places, and experiences that make the community supportive to each individual and cohort, respectively.

OVERVIEW | STEPS | FUNDING:

See *Section IX: Health Equity Plan Objectives.*

RESULTS | CLAS STANDARDS |+ STEPS:

Project set to commence during FY 2022-2023. More information forthcoming.

Background

Health in All Policies (HiAP) is a collaborative approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity.

The HiAP framework employs tools such as *Health Impact Assessments* (HIA) and *Health Lens Analysis* to identify the ways that policy decisions in sectors such as transportation, education, housing and regional planning may affect population health outcomes.

HEALTH IN ALL POLICIES PROJECT

PROBLEM | ROOT CAUSES | BARRIERS:

Improvements in a community's economic, physical, social, and service environments can help ensure opportunities for health and support healthy behaviors. However, health agencies rarely have the mandate, authority, or organizational capacity to make the policy, systems, and environmental changes that can promote healthy living through healthy environments. That responsibility falls to housing, transportation, education, parks and recreation, criminal justice, and employment agencies, among others.

DISPARITY | EVIDENCE | FEASIBILITY:

Health in All Policies builds on a long and successful public health tradition of intersectoral collaboration based on the wide-ranging issues that fall under the purview of public health and also touch on other sectors—including efforts to fluoridate tap water, reduce lead exposure, restrict tobacco use in workplaces and public spaces, improve sanitation, prevent drunk driving, and require use of seatbelts and child car seats. Health in All Policies takes project collaboration further by formalizing structures and mechanisms to incorporate a health, equity, and sustainability lens across the whole of government.

SCOPE | SDOHs | BENEFICIARIES:

The goal of the HiAP approach is to provide decision makers (eg local legislators and school board members), with data on the potential positive and negative impacts of their decisions on health outcomes, health equity, and healthcare costs so they can use this information to better inform their policies and decisions to minimize risks and maximize health benefits. As such, this project covers all SDOHs and associated priority populations.

TEAM MEMBERS | POPULATIONS:

Incorporating health and health equity into decision making across sectors requires intersectoral collaboration as well as changes in government organizational structures and processes, on order to clarify, support, and advance achievement of the priority goals of diverse stakeholders in and out of government (Stahl et al., 2006).

OVERVIEW | STEPS | FUNDING:

See *Section IX: Health Equity Plan Objectives*.

RESULTS | CLAS STANDARDS |+ STEPS:

Project set to commence during FY 2022-2023. More information forthcoming.

Background

There is a growing body of evidence in support of screening for various aspects of social risk within routine clinical care, as a part of a wider continuum of strategies for improving population health and reducing health inequities.

Screening for Social Determinants of Health can help to identify patients who may benefit from greater support in one or more areas, thus promoting whole-person care for the entire population, and particularly for those who are marginalized and underserved.

SOCIAL DETERMINANTS SCREENING PROJECT

PROBLEM | ROOT CAUSES | BARRIERS:

Despite studies demonstrating the impact of socioeconomic factors on health, there is no evidence-based screening recommendation for social determinants of health from an organization such as the U.S. Preventative Task Force. Without this guidance, it may be challenging to obtain buy-in from local entities which are already part of an over-burdened health care system.

Appropriate referral or linkage to resources to address identified needs should be available, as discovering a need and being ill-equipped to address that need creates potential harm for the patient and can lead to burn-out for the caregiver.

DISPARITY | EVIDENCE | FEASIBILITY:

Although there is not currently an evidence-based screening system, several policy statements support such screening, and a current national initiative through the Centers for Medicare and Medicaid Services (CMS), the *Accountable Health Communities Model*, points toward the impact of screening. Additionally, many community health centers already engage in this practice. Furthermore, the *Community Preventive Services Task Force*, an independent, nonfederal panel of public health and prevention experts that provides evidence-based findings and recommendations, developed a guide for assessing evidence regarding health impacts of social interventions.

SCOPE | SDOHs | BENEFICIARIES:

Because local health care providers are already over-burdened, SDOH screenings should be a team-based effort integrated into care management workflows. In addition to decisions regarding initial delivery of screenings, decisions regarding items such as frequency of repetition, data tallying and storage, need prioritization, and patient follow-up will have to be addressed. Practices will need a list of referral resources to connect patients with, which will be fulfilled via the asset mapping project.

TEAM MEMBERS | POPULATIONS:

Laura Spencer, CEO (AZA Health) – Team Lead

OVERVIEW | STEPS | FUNDING:

See *Section IX: Health Equity Plan Objectives*.

RESULTS | CLAS STANDARDS |+ STEPS:

Project set to commence during FY 2022-2023. More information forthcoming.

IX. HEALTH EQUITY PLAN OBJECTIVES

A. Healthiest Weight in Putnam County, Florida

The Putnam County Health Equity Task Force agreed to focus the comprehensive health disparity objective to decrease the percentage gap between Non-Hispanic Black and Non-Hispanic White residents who have a healthy weight, which was paired into two objectives focused on increasing the proportion of Non-Hispanic Black adults who have a healthy weight (determined via a normal BMI) while simultaneously decreasing the percentage of Non-Hispanic Black live births delivered under 2500 grams (low birth weight). The baseline value was obtained from the latest available data extracted from the Florida Behavioral Risk Factor Surveillance System Survey (2019) and Bureau of Vital Statistics (2020), respectively, via FLHealthCHARTS. Target values for the health disparity objectives and associated projects were determined and selected using the Centers for Disease Control and Prevention's Target-Setting and Trend Analysis Tools made available by the National Center for Health Statistics.

Health Disparity Objective(s):

- **By June 30, 2025, increase the percentage of Non-Hispanic Black adult residents who have a healthy weight (BMI from 18.5 to 24.9) from 17.7% in 2019 to 21.7% [BRFSS; FLCHARTS].**

- **By June 30, 2025, decrease the percentage of Non-Hispanic Black live births under 2500 grams (low birth weight) from 19.8% in 2019 to 16.3% [Bureau of Vital Statistics; FLCHARTS].**

Broadband Expansion Table

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Improve both economic stability and education access and quality.						
Objective: By June 30, 2030, decrease the percentage of Putnam County residents aged 16-19 who are neither working nor in school from 18% (American Community Survey, 2016-2020) to 11%.	Putnam County Technology Planning Team	Larry Harvey	American Community Survey, 5-year estimates, 2016-2020; County Health Rankings, 2022	18%	11%	Putnam CHIP 2021-2025 Objective MH 2.1.3; MCH 2.1.2. FDOH 2017-2021 SHIP Strategy HE 3.2. FDOH 2017-2021 SHIP Strategy HE 3.4 FDOH 2017-2021 SHIP Strategy MCH 2.3. FDOH 2017-2021 SHIP Strategy HW 2.1.
Medium-Term SDOH Goal: Improve access to stable broadband internet throughout the county.						
Objective: By June 30, 2025, increase the percentage of households in Putnam County with broadband	Putnam County Technology Planning Team	Larry Harvey	United States Bureau of the Census, American Community Survey,	76%	89.3%	Putnam CHIP 2021-2025 Objective MH1.1.4. FDOH 2017-2021 SHIP Strategy HE 3.2.

internet connection from 76% (American Community Survey, 2016-2020) to 89.3%.			Table S2801; FLHealthCharts, 2020			FDOH 2017-2021 SHIP Strategy HE 3.3.
Short-Term SDOH Goal: Improve understanding of current broadband baseline data.						
Objective: By June 30, 2023, increase the percent of households who have completed the DEO Broadband Assessment from 1.63% (DEO Broadband Assessment) to 4.1%	Putnam County Technology Planning Team	Larry Harvey	DEO Broadband Assessment for Putnam County	1.63%	4.1%	FDOH 2017-2021 SHIP Strategy HE 3.2. FDOH 2017-2021 SHIP Strategy HE 3.3.

Asset Mapping Table

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Improve social and community context and connectivity.						
Objective: By June 30, 2030, decrease the ratio of household income at the 80th percentile to income at the 20th percentile from 4.4 (American Community Survey, 2016-2020) to 4.0.	TBD	TBD	American Community Survey, 5-year estimates, 2016-2020; County Health Rankings, 2022	4.4	4.0	FDOH 2017-2021 SHIP Strategy HE 3.1.
Medium-Term SDOH Goal: Improve access to and use of assets available within the county.						
Objective: By June 30, 2025, decrease the percentage of population who lack adequate access to food from 17% (County Health Rankings, 2022) to 14.4%	TBD	TBD	Map the Meal Gap 2021; Robert Wood Johnson Foundation 's 2022 County Health Rankings	17%	14.4%	2021-2026 DOH-Putnam Strategic Plan 1.1.2 B FDOH 2017-2021 SHIP Strategy HE 3.4. FDOH 2017-2021 SHIP Strategy HW 1.1.
Short-Term SDOH Goal: Improve knowledge of assets available within the county.						

Objective: By June 30, 2023, increase the number of known resources available to the county from 278 (Putnam County Resource Directory, 2021) to 320.	Putnam County School Board	TBD	Putnam County Resource Directory, 2021	278	320	2021-2026 DOH-Putnam Strategic Plan 3.3.2 C FDOH 2017-2021 SHIP Strategy HE 2.1. FDOH 2017-2021 SHIP Strategy HE 3.1. FDOH 2017-2021 SHIP Strategy HE 3.3. FDOH 2017-2021 SHIP Strategy HE 3.4. FDOH 2017-2021 SHIP Strategy MCH 2.2. FDOH 2017-2021 SHIP Strategy MCH 2.3. FDOH 2017-2021 SHIP Strategy HW 1.1. FDOH 2017-2021 SHIP Strategy CD 1.3.

Health in All Policies (HiAP) Infrastructure Table

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Improve neighborhood and built environment.						
Objective: By June 30, 2030, increase the percentage of the population of Putnam County with adequate access to locations for physical activity from 41% (County Health Rankings, 2022) to 46%.	TBD	TBD	Robert Wood Johnson Foundation 's 2022 County Health Rankings	41%	46%	FDOH 2017-2021 SHIP Strategy HE 3.3. FDOH 2017-2021 SHIP Strategy HE 3.4. FDOH 2017-2021 SHIP Strategy HW 2.1.
Medium-Term SDOH Goal: Improve health equity infrastructure throughout the county.						
Objective: By June 30, 2025, increase the amount of policy recommendations made annually to at least 20 recommendations across all five SDOH domains.	TBD	TBD	HiAP Task Force Meeting Minutes	TBD	20	FDOH 2017-2021 SHIP Strategy HE 2.2. FDOH 2017-2021 SHIP Strategy HE 3.4. FDOH 2017-2021 SHIP Strategy MCH 2.3. FDOH 2017-2021 SHIP Strategy ISV 1.6.

						FDOH 2017-2021 SHIP Strategy HW 1.1. FDOH 2017-2021 SHIP Strategy HW 2.1. FDOH 2017-2021 SHIP Strategy CD 1.1. FDOH 2017-2021 SHIP Strategy CD 2.1.
Short-Term SDOH Goal: Improve understanding and inclusion through assessment.						
Objective: By June 30, 2023, increase the SAMHSA's Center for the Application of Prevention Technologies (CAPT) levels of Collaboration for at least five members of the proposed HiAP Task Force from Networking to Coordination.	DOH-Putnam	Sica Bishop	HiAP Task Force Meeting Minutes	TBD	5	FDOH 2017-2021 SHIP Strategy HE 2.2.

Social Determinants of Health Screening Table

	Lead Entity and Unit	Lead Point Person	Data Source	Baseline Value	Target Value	Plan Alignment
Long-Term SDOH Goal: Improve health care access and quality						
Objective: By June 30, 2030, increase the percent of adults in Putnam County who said their overall health was good to excellent from 73.1% (FLHealthCHARTS, 2019) to 77.4%	AZA Health	Laura Spencer	FLHealth CHARTS, 2019	73.1%	77.4%	Putnam CHIP 2021-2025 Objective PC 1.1.1. 2021-2026 DOH-Putnam Strategic Plan 3.1.1 A
Medium-Term SDOH Goal: Improve health outcomes through referral.						
Objective: By June 30, 2025, increase the percentage of residents who have had a medical check-up in the last year from 75.8% (FLHealthCHARTS, 2019) to 79.9%	AZA Health	Laura Spencer	FLHealth CHARTS, 2019	75.8%	79.9%	Putnam CHIP 2021-2025 Objective MCH 3.1.4. FDOH 2017-2021 SHIP Strategy HE 3.3. FDOH 2017-2021 SHIP Strategy MCH 2.2.
Short-Term SDOH Goal: Improve identification of SDOH barriers.						

Objective: By June 30, 2023, increase the number of health care organizations within Putnam County who utilize SDOH screenings at intake by an additional 10% [baseline to be determined via survey].	DOH-Putnam	Sica Bishop	TBD	TBD	XX%	FDOH 2017-2021 SHIP Strategy HE 1.3. FDOH 2017-2021 SHIP Strategy HE 3.4. FDOH 2017-2021 SHIP Strategy MCH 2.3. FDOH 2017-2021 SHIP Strategy ID 2.2. FDOH 2017-2021 SHIP Strategy CD 1.1. FDOH 2017-2021 SHIP Strategy CD 2.1.

X. PERFORMANCE TRACKING AND REPORTING

Ongoing communication is critical to the achievement of health equity goals and the institutionalization of a health equity focus. The successes of Health Equity Plan projects are shared with OMHHE, partners, other CHDs, CHD staff, and the Central Office through systematic information-sharing, networking, collecting, and reporting on knowledge gained, so that lessons learned can be replicated in other counties and programs. Regional Health Equity Coordinators facilitate systematic communication within their region.

The Minority Health Liaison serves as the point of contact in their county for sharing progress updates, implementation barriers, and practices associated with the Health Equity Plan. The Minority Health Liaison is responsible for gathering data, monitoring and reporting progress achieved on the goals and objectives of the Health Equity Plan. The Minority Health Liaison meets with the Health Equity Taskforce to discuss progress and barriers. The Minority Health Liaison tracks and submits indicator values to the OMHHE within 15 days of the quarter end.

Annually, the Minority Health Liaison submits a Health Equity Plan Annual Report assessing progress toward reaching goals, objectives, achievements, obstacles, and revisions to the Regional Health Equity Coordinator and Coalition. The Regional Health Equity Coordinator and Coalition leaders provide feedback to the Minority Health Liaison and the Health Equity Taskforce from these annual reports. The Minority Health Liaison then submits the completed report to OMHHE by July 15th annually.

XI. REVISIONS

Annually, the Health Equity Taskforce reviews the Health Equity Plan to identify strengths, opportunities for improvement, and lessons learned. This information is then used to revise the plan as needed.

Revision	Revised By	Revision Date	Rationale for Revision

XII. ADDENDUM

UPDATED: 5/2/22	PUTNAM COUNTY HEALTH EQUITY COALITION MEMBERS		
Name	**Title**	**Organization**	**Contact**
Cristina Benitez	Fair Housing Outreach Coordinator	Florida Legal Services	cristina.benitez@floridalegal.org
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