PUTNAM COUNTY
COMMUNITY HEALTH IMPROVEMENT PLAN
2021-2025

Putnam.FloridaHealth.gov

Joseph A. Ladapo, MD, PhD
State Surgeon General

Diana Duque
Health Officer

A plan for improving the health and well-being of Putnam County residents

Published March 2021

Revised 03-01-2022

This page is intentionally left blank.

Record of Changes

Date of Revision	Revision Description	Section/Component	Revision Completed By
03/01/2022	~~Scott A. Rivkees, MD~~ **Joseph A. Ladapo, MD, PhD**	Cover Page	Melissa White
03/01/2022	~~Mary L. Garcia~~ **Diana Duque**	Cover Page	Melissa White

This page is intentionally left blank.

Contents

Executive Summary of the Putnam County Community Health Improvement Plan 2021-2025 1

Putnam County Community Health Improvement Plan Strategic Priorities and Goals 1

Overview of Community Health Improvement Planning 6

Community Health Needs Assessment and Health Improvement Planning 6

The Role of Social Determinants of Health and Health Equity in Community Health Improvement Planning 8

Putnam County Community Health Improvement Plan (CHIP) Process 10

Methodology 10

MAPP Phase 1: Organizing for success and Partnership Development 10

MAPP Phase 2: Envisioning Health in Putnam County 10

MAPP Phase 3: Two MAPP Assessments 12

MAPP Phase 4: Identifiying Strategic Issues 17

MAPP Phase 5: Formulate Goals and Strategies 18

MAPP Phase 6: Action Cycle 18

Putnam County Community Health Assessment and Health Improvement Timeline 19

Putnam County CHIP Goals, Strategies, Objectives and Related Resources 20

Putnam County CHIP Alignment with State and National Priorities 24

Appendix 28

Organizations, Agencies and Individuals Participating in the Putnam County Community Health Assessment and Health Improvement Planning Process 29

Putnam County CHIP Implementation Action Plan Template 31

Executive Summary of the Putnam County Community Health Improvement Plan 2021-2025

PUTNAM COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN STRATEGIC PRIORITIES AND GOALS

Strategic Priority: Access to Mental and Behavior Healthcare Services

- **Goal MH1**: Improve access to mental healthcare services including substance misuse treatment for drugs and alcohol
- **Goal MH2**: Promote mental wellness and prevention services

Strategic Priority: Maternal and Child Health

- **Goal MCH1**: Promote healthy birth outcomes
- **Goal MCH2**: Ensure child health and safety

Strategic Priority: Access to Primary Care and Preventive Services

- **Goal PC1**: Improve access to primary care services
- **Goal PC2**: Enhance access to dental care and oral health services
- **Goal PC3**: Promote primary prevention of chronic diseases

In November 2020, the Florida Department of Health in Putnam County initiated a new community health assessment and health improvement planning cycle. Putnam County community partners employed a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) framework to assure a comprehensive community health assessment would inform the development of the community health improvement plan. Guided by community partners in the Putnam County Community Health Assessment Steering Committee, the MAPP process yielded a wealth of data (see companion document, *2020-2021 Putnam County Community Health Assessment*; referred to as the CHA going forward in this document) that were used to identify strategic priorities for the coming five years of 2021-2025. The strategic priorities and the data-driven rationales for their selection are described below.

- **Access to Mental and Behavioral Healthcare Services**: Mental, behavioral, and physical health are equally important for overall wellness and quality of life. Mental and behavioral health in this context includes emotional, psychological, behavioral, and social well-being and impacts how stress is handled, interpersonal relationships cultivated and managed, and healthy decision-making. Concerns about mental and behavioral health, including substance misuse in the form of drugs and alcohol, arose in both MAPP assessments. Alongside these concerns for health outcomes, surfaced the corollary issues of access to services for persons with mental and/or behavioral health problems and resources for primary prevention of these issues. Secondary data reviews found in 2016-2019 rising rates of Putnam County residents hospitalized for mental health reasons with subgroup analysis by age pinpointing a rise in rates among Putnam County children ages 0 to 17 years (7.0 per 100,000 population) that exceeded state rates (6.3 per 100,000 population (CHA, Table TA 26, Technical Appendix). Rates of Emergency Department (ED) visits for mental health reasons by Putnam County residents have exceeded state rates for the report period of 2016-2019. As an example, the July 2018-July 2019 rate of ED visits for mental health reasons by Putnam County residents of all ages was 136.6 per 1,000 population which was more than twice the state rate of 63.2 per 1,000 population (CHA, Table TA 27, Technical Appendix). Rates of involuntary exam initiations, commonly referred to as Baker Act initiations, increased between 2007 and 2017 (CHA, Table TA 28, Technical Appendix). Age-adjusted suicide death rates for Putnam County residents have been higher than state rates since 2008. For 2017-2019, Putnam County's suicide death rate was 22.3 per 100,000 population compared to the state rate of 14.6 per 100,000 (CHA, Tables TA 19 and 20, Technical Appendix). An uptick in opioid overdose deaths and overall drug overdose deaths was found in the course of the assessment (CHA, Table TA 35, Technical Appendix) and Neonatal Abstinence Syndrome (NAS) was noted as a rising problem. Between 2015-2018 Putnam County had NAS rates that were significantly higher than state rates (268.0 per 10,000 live births and 62.1 per 10,000 live births, respectively: CHA, Table TA 35, Technical Appendix).

  Primary data collected from Putnam County residents through a community survey pointed to mental and behavioral health-related problems not only as personal and population health issues but also as noted gaps in services and barriers to accessing care. Drug and alcohol abuse were the first and second ranked behaviors, respectively, among behaviors with greatest negative impact on overall health in Putnam County (CHA, Table 9). Putnam County survey

participants ranked mental health problems as the top or biggest problem for residents with substance and drug abuse also ranking in the top ten at ninth place (CHA, Table 10). Mental and behavioral healthcare services ranked fourth among 18 service types as difficult to obtain in Putnam County by survey respondents (CHA, Table 11). When probed further about access to care for mental health or substance use issues, more than half (53.0 percent) of survey respondents reported that in the past year they did not receive needed care. Almost 40 percent cited lack of availability of mental health providers or substance use therapists or counselors as the reason for not getting care (CHA, Table 14). Nearly 20 percent of the same survey respondents reported mental health or depression as one of their two biggest challenges in past year (CHA, Table 21). The Strengths, Weaknesses, Opportunities, and Threats (SWOT) discussion with CHA Steering Committee members clearly exposed unhealthy behaviors such as drug and alcohol use as problems for Putnam County residents and that access to care issues and barriers were compounding factors (CHA, Table 30).

- **Maternal and Child Health**: Protecting and improving infant health, along with maternal health outcomes, is an investment in the future. Such investments can impact future personal and community health challenges, health outcomes, and healthcare and social service system resource needs. Throughout the assessment process, concerns were raised for maternal and child health which encompassed infant mortality, prevention of child abuse and neglect, and issues related to sexual health. Assessment findings from the study of secondary data point to indicators of challenges for mothers and their infants and children in Putnam County. In 2019 there were ten (10) infant deaths in Putnam County for an infant mortality rate of 12.4 per 1,000 live births compared to the state rate of 6.0 per 1,000 (CHA, Table TA 38, Technical Appendix). Low numbers of births and population size present challenges in interpreting trends; however, any infant death indicates a tragic loss that may have been preventable. The rates of low birthweight births (LBW) to Putnam County mothers of all races (12.1 percent of total births) in 2019 was higher than the state rate (8.8 percent) with disparities in rates among Putnam County by race and ethnicity (CHA Table TA 39, Technical Appendix). Trend and recent data (2019) pointed to late entry into prenatal care as a continuing challenge with only 61.4 percent of births to Putnam County mothers of all races having had first trimester care compared to the state rate of 68.2 percent. Differences were also noted by race and ethnicity with births to Hispanics in Putnam County having the lowest rate of early prenatal care at 56.3 percent compared to 60.4 percent for Whites and 62.8 percent for Blacks (CHA Table TA 40, Technical Appendix).

  Poverty among children in Putnam County is a persistent issue with far-reaching consequences including access to healthcare services and poorer health outcomes. Between 2014-2018, 38.6 percent of children in Putnam County between the ages 0-17 years lived below the 100 percent federal poverty level (FPL) and another 31.6 percent lived at between 100 to 199 percent of FPL (CHA, Table TA 7, Technical Appendix). As an indicator of access to healthcare services, the assessment examined rates of Emergency Department (ED) visits for mental health reasons. For the period from July 2016 – June 2019, Putnam County children ages 0 to 17 years had higher than state rates of ED visits for mental health issues (CHA Table TA 27). The percentage of involuntary exam initiations, commonly referred to as Baker Act initiations, for Putnam County

children under the age of 18 was reported at 22.8 percent, notably higher than the state rate of 16.4 percent (2016; CHA Table TA 28, Technical Appendix).

Community leaders who participated in assessment discussions and Putnam County residents who completed the community health survey expressed concerns for the health, safety and future of children and families. Almost ten percent of survey respondents ranked child abuse and neglect among the top three (3) health issues in Putnam County (CHA Table 10). Survey respondents included many conditions that create safe and healthful communities for children and family among the top ranked factors for a healthy community. Among those factors were access to affordable healthcare services (selected by 42.9 percent of survey respondents), access to affordable and nutritious foods (23.0 percent), safe neighborhoods with low crime rates (20.5 percent), job opportunities (18.3 percent), and good schools (14.7 percent; CHA Table 8).

- **Access to Primary Care and Preventive Services**: Cultivating informed decision-making that results in healthy behaviors is among primary prevention efforts that aim to prevent illness and chronic conditions. The need for community-wide, coordinated, and collaborative efforts to address root causes of chronic diseases surfaced in the assessment. Secondary data point to higher than state rates of the leading causes of death for Putnam County residents from cancer and heart disease (CHA Table TA 23, Technical Appendix). Data also point to differences between racial groups in mortality rates and disease patterns. For example, Blacks in Putnam County experienced consistently higher mortality rates from heart disease and diabetes when compared to Whites (CHA Tables TA 19 and 20, Technical Appendix). Avoidable or preventable hospitalizations are admissions and discharges for acute illnesses or worsening chronic conditions that might not have required hospitalization had the condition been managed successfully by primary care providers in outpatient settings. In 2018-2019 avoidable hospital discharge rates for Putnam County residents ages 0 to 64 years at 23.3 per 1,000 population were almost twice the state rate (12.8 per 1,000; CHA Table TA 54, Technical Appendix). About 18.4 percent of Putnam County adults indicated that they could not see a doctor in the past year (2016) due to cost; the state percentage was 16.6 percent. Only 53.2 percent of Putnam County adults reported they had seen a dentist in the past year (2016) compared to 63.0 percent statewide (CHA Table TA 43).

  Primary data collected from Putnam County residents showed the common theme of barriers and/or lack of access to primary care services and dental care. Lack of access to primary/family care services was the second highest ranked health issue for Putnam County and dental problems were ranked seventh (CHA Table 10). Dental/oral health care was the top ranked healthcare service that is difficult to obtain in Putnam county. Primary/family care was ranked third (CHA Table 11). About 58.5 percent of survey respondents reported that they did not receive needed primary care in past year. Availability of primary care providers, work-related issues, and appointment availability were frequently cited as barriers (CHA Table 12). Similarly, 59.2 percent of survey respondents said they did not receive needed dental care in the past year with reported barriers being lack of availability of dentists, no appointments or long waits for appointments, and work-related issues (CHA Table 13). When respondents were asked about the

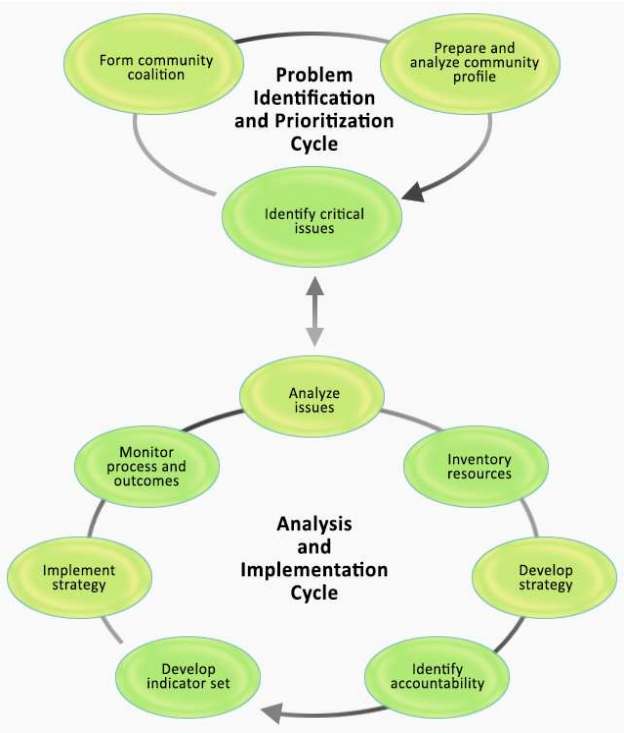
biggest challenges that they faced as individuals, those in two of the higher income brackets reported access to a doctor or dentist among their top three challenges in the past year. According to survey respondents the Coronavirus (COVID-19) pandemic had a negative impact on many of their health-related activities. Almost 60 percent of respondents said they or a member of their household delayed getting healthcare services because of the pandemic and nearly 40 percent reported the pandemic had a negative impact on getting routine or needed dental care (CHA Table 25 and Figure 30).

Overview of Community Health Improvement Planning

COMMUNITY HEALTH NEEDS ASSESSMENT AND HEALTH IMPROVEMENT PLANNING

In the Institute of Medicine's (IOM) 1997 foundational publication *Improving Health in the Community,* the community health improvement planning process was described as the required framework within which a community takes a comprehensive approach to improving health. That framework includes assessing the community's health status and needs, determining health resources and gaps, identifying health priorities, and developing and implementing strategies for action. Notably, in this comprehensive approach there are two cycles; that is, an assessment or problem identification and prioritization cycle followed by an implementation cycle. By 2000 the National Association of County and City Health Officials (NACCHO) in conjunction with the Centers for Disease Control and Prevention's (CDC) Public Health Practice Office had developed Mobilizing for Action through Planning and Partnerships (MAPP) as a strategic approach to community health improvement.

FIGURE 1: COMMUNITY HEALTH IMPROVEMENT PLANNING FRAMEWORK, IOM, 1997



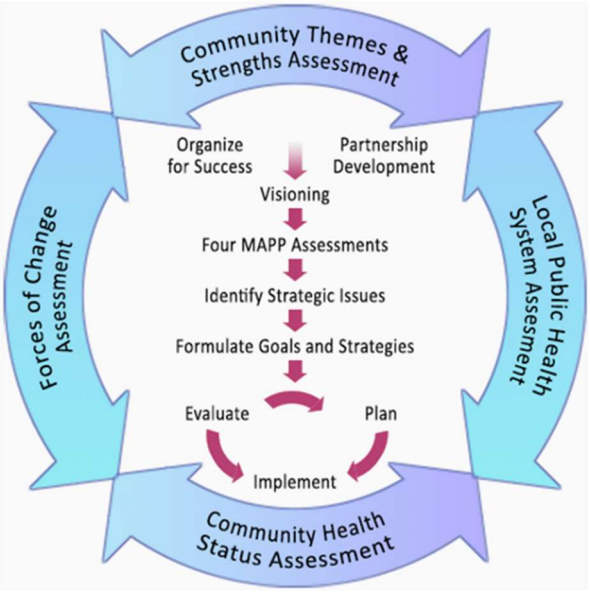
Source: J.S. Durch, L.A. Bailey, and M.A. Stoto, eds. (1997) Improving Health in the Community, Washington, DC: National Academy Press. Retrieved: January 19, 2021, https://ctb.ku.edu/en/table-of-contents/overview/models-for-community-health-and-development/chip/main

NACCHO and the CDC's vision for implementing MAPP remains today as "Communities achieving improved health and quality of life by mobilizing partnerships and taking strategic action."
At the heart of the Putnam County MAPP process were the following core MAPP assessments:

- Community Health Status Assessment
- Community Themes and Strengths Assessments

The findings from these MAPP assessments informed the detection of common themes and issues in order to identify and prioritize the key community health needs. Prioritized strategic community health issues were documented and addressed in the MAPP action cycle phase to complete the comprehensive health improvement planning cycle.

FIGURE 2: MOBILIZING FOR PLANNING THROUGH PLANNING AND PARTNERSHIPS (MAPP)



Source: National Association of County and City Health Officials (N.D.). *Community Health Assessment and Improvement Planning.* Retrieved January 19, 2021, https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment

The Public Health Accreditation Board (PHAB), the voluntary accrediting body for public health agencies in the United States, deems community health, community health assessment and health improvement planning as foundational functions and core to the mission of public health. Community health assessment is defined in the PHAB Standards and Measures as a tool "to learn about the community: the health of the population, contributing factors to higher health risks or poorer health outcomes of identified populations, and community resources available to improve the health status." The community health improvement plan is described as a "long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process." Further, the community health improvement process "involves an ongoing collaborative, community-wide effort to identify, analyze and address health problems; assess applicable data; develop measurable health objectives and indicators; inventory community assets and resources; identify community perceptions; develop and implement coordinated strategies; identify accountable entities; and cultivate community ownership of the process." Public Health Accreditation Board (December 2013). *PHAB Standards and Measures.* Retrieved January 21, 2021, http://www.phaboard.org/wp-content/uploads/SM-Version-1.5-Board-adopted-FINAL-01-24-2014.docx.pdf

THE ROLE OF SOCIAL DETERMINANTS OF HEALTH AND HEALTH EQUITY IN COMMUNITY HEALTH IMPROVEMENT PLANNING

FIGURE 3: SOCIAL DETERMINANTS OF HEALTH (SDOH)

Source: Healthy People 2020: Social Determinants of Health," Office of Disease Prevention and Health Promotion, Centers for Disease Control and Prevention. Retrieved January 22, 2021, https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

According to the World Health Organization and depicted above by the Centers for Disease Control and Prevention (CDC), the social determinants of health (SDOH) include the "conditions in the environments in which people are born, live, learn, work, play and age that shape and affect a wide range of health, functioning, and quality of life outcomes and risks". (About Social Determinants of Health," World Health Organization, accessed January 22, 2021 https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1). The SDOH include factors such as socioeconomic status, education, neighborhood and physical environment, employment and social networks as well as access to health care. Addressing social determinants of health is important for improving health and reducing health disparities. Research suggests that health behaviors such as smoking and diet and exercise, are the most important determinants of premature death. There is growing recognition that social and economic factors shape individuals' ability to engage in healthy behaviors. Evidence shows that stress negatively affects health across the lifespan and that environmental factors may have multi-generational impacts. Addressing social determinants of health is not only important for improving overall health, but also for reducing health disparities that are often rooted in social and economic disadvantages.

The five-tier health impact pyramid depicts the potential impacts of different types of public health interventions. Efforts that address the SDOH are at the base of the pyramid, indicating their higher

potential for positive impact. Interventions at the pyramid base tend to be effective because of their broad societal reach. CHIP interventions are targeted at all levels to attain the best and most sustainable health benefits.

FIGURE 4: HEALTH IMPACT PYRAMID

Source: Frieden, T.R. (2010). A framework for public health action: The health impact pyramid. *American Journal of Public Health*, 100(4):590-595. Retrieved January 22, 2021 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836340/

Putnam County Community Health Improvement Plan (CHIP) Process

METHODOLOGY

Development of the Putnam County CHIP is a continuation of the county's efforts to better understand and address health issues. Community health assessment work began in November 2020 and concluded in January 2021. The phases of MAPP that constituted the community health assessment process are briefly described below. Soon after finalizing the community health assessment, Putnam County partners launched into planning for the CHIP process and completed the final two MAPP phases that resulted in the CHIP and its ongoing implementation.

MAPP PHASE 1: ORGANIZING FOR SUCCESS AND PARTNERSHIP DEVELOPMENT

To assure a successful community health assessment and health improvement planning process, the Florida Department of Health in Putnam County engaged partners to launch process that built upon existing relationships, used resources wisely, and demonstrated a commitment to making positive, collective impact on health and quality of life in Putnam County. A listing of the Putnam County Community Health Assessment Steering Committee members and their affiliations can be found in the *2020-2021 Putnam County Community Health Assessment* report. Steering Committee members were routinely encouraged to invite additional community partners to participate in the process towards the goal of having a diverse and representative group at the helm of the assessment.

MAPP PHASE 2: ENVISIONING HEALTH IN PUTNAM COUNTY

At their kick-off meeting on December 18, 2020, the Putnam County Community Health Assessment Steering Committee members engaged in a modified Strengths, Weaknesses, Opportunities and Threats (SWOT) discussion to envision how Putnam County could use their assets, resources, and shared aspirations to improve health in their county. The strengths discussion considered unique resources and abilities, Putnam County's advantages, and recent achievements. The examination of weaknesses considered needed improvements, resources lacking and why, and any disadvantages. The discussion of opportunities centered on using strengths wisely, focusing on what can be done immediately, and capitalizing on trends in healthcare and public health that are changing. Threats and challenges considered obstacles, competing forces, and staying abreast of changing policies and regulations that could negatively impact health and health behaviors. These qualitative, primary data are presented in Table 1. Content analysis was used to extract themes from the data to compile a list of issues for consideration in the prioritization process.

TABLE 1: THEMES FROM SWOT DISCUSSION WITH STEERING COMMITTEE MEMBERS, SORTED BY CATEGORIES, 2020

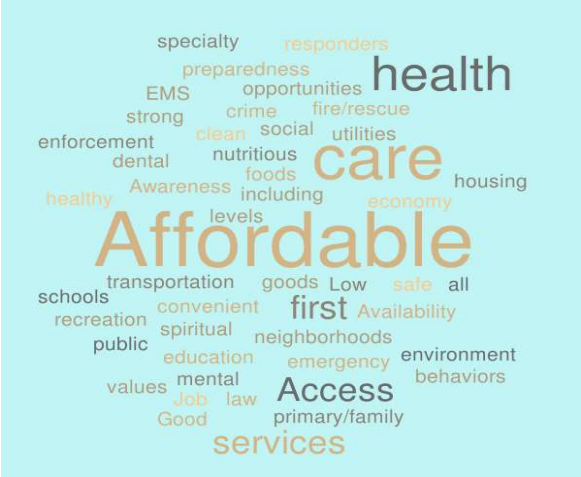
Social Determinants of Health
Poverty
Food insecurity
Limited employment opportunities
Strong health career program
Ability to address social determinants as a whole
Transportation
Health Status and Health Behaviors
Unhealthy behaviors such as tobacco, alcohol and drug use, poor nutrition
Poor food choices
Lack of nutrition education
Need to address root causes of unhealthy behaviors
Hopelessness
Bias and stigma about certain health conditions and health behaviors
Lack of motivation to change
Generational ideas and attitudes about health and health programs
Access to Care and Utilization of Healthcare Services and Resources
Lack of Medicaid expansion
Potential to build on telehealth
Aging healthcare professional workforce
Strong community partnerships
Community resources are shared widely
Communication improvements needed among community partners and organizations
Low health literacy on how to use health and social services appropriately
Lack of a leadership council or group to guide and promote health improvement efforts
Need for more diversity in community leadership related to health

Source: Putnam County Community Health Assessment Steering Committee Meeting notes, December 18, 2020

The more than 1,500 participants in the community health survey shared their perceptions about the characteristics that define a healthy community. Among the categories of characteristics and traits were social determinants of health-related factors attributes such as affordable, accessible and nutritious food; safe neighborhoods; affordable goods and services; job opportunities; good schools; public transportation; and affordable housing and utilities. The behavioral and environmental-related factors and attributes that were used to define health and a healthy community included residents engaging in healthy behaviors, low prevalence of child abuse and domestic violence, clean environment, good race and ethnic relations, availability of recreational and cultural opportunities, and the practice of religious or spiritual values. Rated most frequently were attributes related to the healthcare system including

access to affordable healthcare that incorporates primary, specialty, dental, and mental health care and the awareness and ability to navigate the healthcare system to get needed care.

FIGURE 5: VISIONING WORD CLOUD, PUTNAM COUNTY, 2021



Source: *Putnam County Community Health Survey*, 2021. Prepared by WellFlorida Council, 2021

MAPP PHASE 3: TWO MAPP ASSESSMENTS

Both of the assessments in the modified MAPP process gathered data essential for creating a comprehensive picture of health status, health behaviors, and health resources and capacities in Putnam County. Key findings and highlights from each of the assessments are summarized below.

Community Health Status:

A comprehensive review of secondary data for Putnam County examined demographic and socioeconomic indicators, mortality and morbidity, healthcare access and utilization, and racial and ethnic disparities. The *2020-2021 Putnam County Community Health Assessment* was developed as part of this assessment and to serve as a community resource for planning and decision making. The key findings that emerged from the overall community health status review are highlighted below.

Social Determinants of Health (SDOH)

As described earlier, the SDOH have been shown to have impacts on overall health. In addition, the SDOH can cause health disparities that are often rooted in social and economic disadvantages. Data show Putnam County has continuing challenges with SDOH-related issues as listed below (table references are from the *2020-2021 Putnam County Community Health Assessment, Technical Appendix* unless otherwise noted).

- **Poverty** [$35,649 median household income, all races, Putnam County, $53,267 Florida (CHA Table TA 9, Technical Appendix); $19,976 per capita income, all races Putnam County, $30,197 Florida (CHA Table TA 8, Technical Appendix);24.8 percent of individuals living below poverty level, Putnam County, 14.8 percent Florida; 43.0 percent of Blacks, 20.8 Whites living in poverty, Putnam County, 23.5 percent and 12.7 percent, respectively, Florida; 38.6 percent of children 0

to 17 years live at 100 percent federal poverty level, Putnam County, 21.3 percent, Florida (CHA Table TA 7, Technical Appendix)]

- **Barriers to education and job training** [19.1 percent did not receive a high school diploma, Putnam County, 12.0 percent Florida; 20.3 percent college degree as the highest level of school completed Putnam County, 39.0 percent Florida (CHA Table TA 11, Technical Appendix)]
- **Transportation** [3.7 percent have no vehicle, Putnam County, 2.9 percent Florida; 0.5 percent use public transportation to commute to work, Putnam County, 2.0 percent Florida; 14.0 percent have a travel time to work of 60 minutes or more, Putnam County, 8.1 percent Florida (CHA Table TA 13)]
- **Healthcare service access** [80.8 total physicians/100,000 Putnam County, 310.6/100,000 Florida; 17.8 dentists/100,000 Putnam County, 56.7/100,000 Florida (CHA Table TA 50, Technical Appendix); 134.8 hospital beds/100,000 Putnam County, 308.2/100,000 Florida (CHA Table TA 49, Technical Appendix)]

Health Status

Disease and death rates are the most direct measures of health and well-being in a community. In Putnam County, as in Florida and the rest of the United States, premature disease and death are primarily attributable to chronic health issues. That is, medical conditions that develop throughout the life course and typically require careful management for prolonged periods of time. While Putnam County is similar to Florida in many health indicators, some differences exist. In Putnam County for 2019, the age-adjusted death rates of the leading causes of death for all races that are higher than state rates include the five causes listed below (CHA Table TA 19, Technical Appendix) as well as infant mortality for which Putnam County exceeded the state rate for 2019 (CHA Table TA 38 Technical Appendix).

- **Cancer** (171.5/100,000 Putnam County, 144.1/100,000 Florida)
- **Heart Disease** (154.7/100,000 Putnam County, 145.1/100,000 Florida)
- **Chronic Lower Respiratory Disease** (83.1/100,000 Putnam County, 36.8/100,000 Florida)
- **Diabetes** (45.4/100,000 Putnam County, 19.8/100,000 Florida)
- **Unintentional Injuries including alcohol-related motor vehicle crash deaths** (107.2/100,000 Putnam County, 57.0/100,000 Florida)
- **Infant Mortality** (12.4/1,000 live births Putnam County, 6.0/1,000 live births Florida)

Health Behaviors and Conditions that Contribute to Poor Health Outcomes

Health behavior data pointed to serious challenges facing Putnam County residents. The issues listed below require multi-faceted approaches to improve existing health problems with simultaneous primary prevention strategies to help ensure healthy futures for all segments of the population. The chronic conditions and behaviors that were considered as priority health issues include the following:

- **Mental health problems** [19.9 percent adults with depressive disorder Putnam County, 14.2 percent Florida; 12.8 percent adults who had poor mental health on 14 or more of the past 30 days Putnam County, 11.4 percent Florida (CHA Table TA 43, Technical Appendix)]

- **Tobacco use including e-cigarettes and smokeless tobacco products** [21.6 percent adults who are current smokers Putnam County, 15.5 percent Florida; 46.3 percent adults who have never smoked Putnam County, 58.0 percent Florida (CHA Table TA 43, Technical Appendix)]
- **Dental and oral health issues** [53.2 percent adults who had seen a dentist in the past year Putnam County, 63.0 percent Florida; 67.2 percent adults who had a permanent tooth removed because of decay or gum disease Putnam County, 47.3 percent Florida (CHA Table TA 43, Technical Appendix)]
- **Overweight and obesity** [43.5 percent adults who are obese Putnam County, 27.4 Florida; 73.6 percent adults who are overweight or obese Putnam County, 63.2 percent Florida (CHA Table TA 43, Technical Appendix)]
- **Late entry into prenatal care** [61.4 percent births that received care in first trimester, all races Putnam County, 68.2 percent Florida (2019, CHA Table TA 40, Technical Appendix); 8.4 percent of births that received late (third trimester) or no prenatal care Putnam County, 6.7 percent Florida (2019, CHA Table TA 41, Technical Appendix)]

Racial and Ethnic Disparities

Some disparities were found in the course of Putnam County's community health assessment process and these preventable differences were given serious consideration and importance in CHIP discussions. Areas of particular concern include:

- **Data pointed to some racial and ethnic disparities in mortality rates** among Putnam County residents. Unique patterns of disease were observed among Putnam County residents. Unintentional Injury death rates are higher for White residents of Putnam County than Black residents. In 2019, the Unintentional Injury death rate for White residents of Putnam County was 112.5 per 100,000 population; the state had a rate of 60.3 per 100,000 population (CHA Table TA 21, Technical Appendix). Among the Black population in 2019, the Unintentional Injury death rate was 91.7 per 100,000 at the county level; the state had a rate of 41.2 per 100,000 population (CHA Table TA 21, Technical Appendix). In 2019, Black residents of Putnam had a higher cause of death rate for Diabetes (73.7 per 100,000 population) compared to the state (37.6 per 100,000 population) (Table TA 21, Technical Appendix).

  Finally, the rate of years of potential life lost (YPLL), a reflection of premature death, for Putnam County residents has been consistently higher than the state rate. In 2019, Putnam County experienced a rate of 12,793.7 years of life lost per 100,000 population, more than the state rate of 7,646.8 per 100,000 (Table TA 24, Technical Appendix). Since 2016, the rate of YPLL has been higher for Black residents of Putnam County than White residents; the same trend can be observed at the state level. In 2019, the rate of YPLL for Black residents of Putnam County was 16,449.3 per 100,000 population, while White residents' rate of YPLL was 12,290.4 per 100,000 population (Table TA 24, Technical Appendix).

- **Infant mortality rates for all races, Whites, Blacks, and Hispanics** were higher than state rates in Putnam County from 2017-2019. In 2019 there were 10 infant deaths for all races in Putnam County resulting in an infant mortality rate of 12.4 per 1,000 live births. The comparable state

rate for all races was 6.0 per 1,000 live births (CHA Table TA, Technical Appendix). The infant death rate for Putnam County Blacks for 2019 was 37.2 per 1,000 live births which was more than three times the state rate for Black infant deaths (10.9 per 1,000 live births). For 2019, the percentage of total births that received care in the first trimester for all races, Whites, and Hispanics in Putnam County were lower (61.4, 60.4, and 56.3 percent, respectively) than for the state (68.2, 70.5, and 68.1 percent, respectively; CHA Table TA 40, Technical Appendix). Similarly, in 2019 the percentages of low birthweight births to Putnam County mothers were higher for all races, Blacks, Whites and Hispanics (12.1, 16.0, 10.9, and 14.3 percent, respectively) compared to Florida (8.8, 14.0, 7.2, and 7.5, respectively; CHA Table TA 39, Technical Appendix).

Healthcare Resources, Assets, and Utilization

Although health insurance and access to health care do not necessarily prevent illness, early intervention and long-term management resources can help to maintain quality of life and minimize premature death and disability. Rural communities like Putnam County face many barriers in accessing healthcare services. Utilization and health professional shortage data illuminated the depth of access to care issues in Putnam County. The major issues related to healthcare resources, access and utilization fall into the groups listed below.

- **Use of Emergency Departments** for routine primary and mental health care [Rate of Emergency Department visits per 1,000 population for mental health reasons Putnam County residents, all ages at 136.3/1,000 (July 2018-June 2019), 63.2/1,000 Florida (CHA Table TA 27, Technical Appendix); avoidable Emergency Department visit rate per 1,000 for Putnam County residents at 237.7/1,000, 192.8 for Florida (2017, CHA Table TA 60, Technical Appendix)]
- **Lack of healthcare providers and services, specialty care physicians, and dentists** [80.8 total physicians/100,000 Putnam County, 310.6/100,000 Florida; 17.8 dentists/100,000 Putnam County, 56.7/100,000 Florida (CHA Table TA 50, Technical Appendix); 134.8 hospital beds/100,000 Putnam County, 308.2/100,000 Florida (CHA Table TA 49, Technical Appendix)]
- **Rising costs of health care and prescription drugs** [percent of hospital discharges by payor sources for Putnam County residents at 52.1 percent for Medicare, 22.4 percent Medicaid, 13.9 percent private insurance, 8.8 percent self or non-payment; for Florida 46.2 percent Medicare, 18.8 percent Medicaid, 19.4 percent private insurance, 6.8 percent self or nonpayment (CHA Table TA 52, Technical Appendix); 18.4 percent Putnam County adults who could not see a doctor in the past year due to cost, 16.6 percent Florida (CHA, Table TA 43, Technical Appendix)]
- **Lack of affordable health insurance with sufficient coverage** [18.1 percent civilian population under the age of 65 uninsured, Putnam County; 16.1 percent Florida (2018, CHA Table TA 12, Technical Appendix); percent uninsured by age groups, ages 18-64 Putnam County at 22.4 percent, Florida 19.2 percent (CHA Table TA 12, Technical Appendix)]

Community Themes and Strengths:

Through the community themes and strengths assessment, the opinions, perspectives and concerns of Putnam County residents were collected via a community survey. In addition, input from the Putnam County Community Health Assessment Steering Committee was collected through a facilitated

discussion of Strengths, Weaknesses, Opportunities and Threats (SWOT). The community themes and strengths assessment sought to better understand what is important to the community and barriers and obstacles to obtaining needed services. There were 1,526 completed community surveys included in the analysis. Although a convenience sampling method was used to collect survey data and results are not generalizable to the general population, the survey data provide insights into prevailing opinions on health issues, barriers to needed services, and available resources. Results showed that about 41.5 percent of community survey respondents rated the overall health of Putnam County residents as healthy, followed closely by another 41.2 percent who rated overall health as somewhat healthy. Mental health problems (27.3 percent) and access to primary/family care (24.1 percent) were ranked as health issues that are the biggest problems for residents of Putnam County (CHA Table 10). Relatedly, drug abuse (41.2 percent) and alcohol abuse (28.2) were ranked by survey respondents as the behaviors with the greatest negative impact on health in Putnam County. Other highlights from the analysis are provided below. For detailed results, please refer to the *2020-2021 Putnam County Community Health Assessment*.

Top ranked health-related problems in Putnam County included: (percentages of responses are shown, CHA Table 10)

- Mental health problems (27.3 percent)
- Access to primary/family care (24.1 percent)
- Access to long-term care (21.8 percent)
- Affordable assisted living facilities (lack of; 15.3 percent)
- Access to sufficient and nutritious foods (15.3 percent)

Behaviors with the greatest negative impact in Putnam County included: (percentages of responses are shown, CHA Table 9)

- Drug abuse (41.2 percent)
- Alcohol abuse (28.2 percent)
- Not using healthcare services appropriately (18.7 percent)
- Distracted driving (18.5 percent)
- Eating unhealthy foods/drinking sugar-sweetened beverages (17.6 percent)

Healthcare services that were rated as the most difficult to obtain included: (percentages of responses are shown, CHA Table 11)

- Dental/oral care (29.2 percent)
- Physical therapy, rehabilitation therapy and services (28.3 percent)
- Primary/family care (28.2 percent)
- Mental/behavioral health care (26.9)
- Specialty care (25.0 percent)

Barriers to accessing primary, dental, and mental health care most commonly cited were: (percentages of responses of those who reported not getting needed care in the past 12 months, CHA Figure 27)

- No providers available (34.2, 31.7, 39.7 percent for primary, dental, mental health care, respectively)
- Work-related issues (33.7, 28.8, 29.2 percent for primary, dental, mental health care, respectively
- Appointment availability (26.9, 30.8, 26.0 percent for primary, dental, mental health care, respectively)
- Cost (22.6, 26.7, 22.2 percent for primary, dental, mental health care, respectively)

MAPP PHASE 4: IDENTIFIYING STRATEGIC ISSUES

Essential components of bridging the community health assessment with the development of a community health improvement plan include identifying strategic issues, formulating goals and strategies, and implementation. These steps are also referred to as MAPP phases four through six. On January 15, 2021, the Putnam County Health Assessment Steering Committee began the process of identifying strategic priorities. This included the review of the community health status data, community themes and strengths findings from the community survey, and SWOT discussion key points. The Steering Committee discussed the characteristics of strategic priorities to assure a common understanding of scope, scale, and purpose. Prioritization criteria included issue importance, urgency, impact, feasibility and resource availability. Table 2 below lists the characteristics of each criterion. Virtual meeting attendees then participated in a facilitated consensus discussion to condense the list to about two dozen issues. Immediately following the virtual meeting, Steering Committee members were invited to participate in an electronic survey to score each of the remaining issues for their magnitude which included importance and urgency, and confidence in the community's ability impact the issue which examined factors of feasibility, impact and resource availability. Survey respondents also voted on the three issues they thought should be the community's strategic priorities. Descriptive analysis was used to synthesize results and a list of four potential priorities was produced. At their January 29th virtual meeting, the Steering Committee discussed and debated the priorities and landed on three priorities which are listed below. At this point, the Putnam County community partners transitioned from the assessment phase to the active community health improvement plan development phase of MAPP.

TABLE 2: CRITERIA FOR RANKING STRATEGIC PRIORITY ISSUES, PUTNAM COUNTY, 2020-2021

Importance and Urgency	Impact	Feasibility	Resource Availability
•Issue severity •Burden to large or priority populations •Of great community concern •Focus on equity	•Potential effectiveness •Cross cutting or targeted reach •Ability to demonstrate progress	•Community capacity •Political will •Acceptability to the community	•Financial costs •Staffing •Stakeholder support •Time

Source: Adapted from National Association of County and City Health Officials (N.D.). *Community Health Assessment and Improvement Planning.* Retrieved January 11, 2021, https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp/phase-4-identify-strategic-issues

Strategic Priority Issue Areas Identified

- **Access to Mental and Behavioral Healthcare Services**, including:
  - Substance misuse treatment for drug and alcohol
  - Counseling and prevention services
- **Maternal and Child Health**, with emphasis on:
  - Prenatal care for healthy birth outcomes including
    - Lower infant mortality and fewer low birthweight births
  - Prevention of child abuse and neglect
  - Sexual health services to prevent Sexually Transmitted Diseases (STDs)
- **Access to Primary Care and Preventive Services**, including:
  - Dental/oral healthcare services
  - Chronic disease prevention

As mentioned above, the list of priorities included a fourth area that proposed to focus on essential services to protect and ensure quality of life. This area intended to address housing, food security, job opportunities, and transportation. After spirited debate, Steering Committee members agreed that these issues, while critically important and related to the social determinants of health, were beyond the scope of the CHIP alone. Leaders pointed out that other groups and organizations in Putnam County were already addressing these problems. Steering Committee members pledged to represent the health perspective on the various committees and workgroups addressing these problems. As a step to assure that the social determinants of health are incorporated into CHIP strategies, the Putnam CHIP Action Plan includes a section for each goal where a description of how the social determinants of health are considered and addressed.

MAPP PHASE 5: FORMULATE GOALS AND STRATEGIES

The purpose of this phase is for community partners to develop goals, identify strategies and write measurable objectives for each of the strategic priority areas. At its January 29th meeting, the Putnam County Community Health Assessment Steering Committee embarked on this work. After reviewing the data and key findings from the two MAPP assessments, the group reconfirmed and refined the strategic priority issue statements, and set a timeline for developing the final CHIP, and organized into action planning workgroups. The three workgroups met at least twice virtually and remained in contact electronically to dissect the proposed goal statements, enhance and add strategies, and craft objectives. Evidence-based and promising practices were researched, considered, and included as appropriate. To ensure the ability to monitor and report on progress, all objectives include a timeframe, baseline and target performance measure, data source, and identification of a lead entity.

MAPP PHASE 6: ACTION CYCLE

The action cycle includes implementation and evaluation as well as opportunities to incorporate continuous quality improvement strategies. Please see the companion document, Putnam County CHIP

Action Plan Compendium, to review the background information for each goal on evidence-based practice, policy change, health disparities and/or equity issues, and relationship to the social determinants of health. The Putnam County CHIP action cycle is not only guided by the goals, strategies, and objectives set through the MAPP process, but the action plans developed for CHIP objectives. Progress, challenges, and accomplishments of the Putnam County CHIP will be monitored and tracked by semi-annual reporting to the Putnam County Steering Committee and an annual CHIP review. If appropriate, revisions to the CHIP and/or action plans will be made and documented.

PUTNAM COUNTY COMMUNITY HEALTH ASSESSMENT AND HEALTH IMPROVEMENT TIMELINE

November 2020	Organizational meetings, partner identification, timeline development
December 18, 2020	Community health assessment kick-off meeting, visioning
November 2020–January 2021	Secondary data collection and analysis
December 2020–January 2021	Primary data collection via community survey
January 2021	CHIP organizational discussions, timeline development
January 15, 2021	Presentation of community health assessment findings and prioritization
January 29, 2021	CHIP goal and strategy writing workshop
February 3rd and 5th, 2021	CHIP goal and objective writing workgroup meetings
February 19th, 2021	CHIP objective writing and action planning workgroup meetings
February 26, 2021	CHIP action plan completion
March 8, 2021	2021-2025 Putnam County Community Health Improvement Plan published

Putnam County CHIP Goals, Strategies, Objectives and Related Resources

The Putnam County 2021-2025 Community Health Improvement Plan focuses on three strategic priority areas. For each priority issue goals have been set and will be addressed by a variety of strategies. Objectives provide the basis for performance and outcome tracking, measuring and reporting. Each goal area has its own action plan with activities, baseline and target data, accountability measures, and progress reporting mechanisms as well as background on related evidence-based strategies and programs, listing of proposed policy changes, notations of health disparity and equity concerns, and link to social determinants of health. Please see the Appendix for the action plan template and the separate companion Action Plan Compendium that will be updated regularly to reflect progress towards achieving objectives and goals.

Strategic Priority: Access to Mental and Behavioral Healthcare Services (MH)
Goal MH1: Improve access to mental healthcare services including substance misuse treatment services for drug and alcohol
Strategies MH1.1: Telehealth service enhancement, expansion of services, reduction of barriers to services
Objective MH1.1.1: By December 31, 2025, increase the rate per population of Licensed Clinical Social Workers by 10% (Baseline: 13.7/100,000 (2019), Target: 15.0/100,000 (State rate = 46.8), Data Source: FLCHARTS)
Objective MH1.1.2: By December 31, 2025, reduce the rate of hospitalizations for drug- and alcohol-induced mental disorders for Putnam County residents of all ages by 6% (Baseline: 178.1/100,000 (2019), Target: 167/100,000 (State rate 167), Data Source: AHCA, FLCHARTS)
Objective MH1.1.3: By December 31, 2025, reduce the rate of hospitalizations attributable to mental disorders for Putnam County residents of all ages by 2.8% (Baseline: 1,035.5/100,000 (2019), Target: 1006.0/100,000 (State rate 1006.0), Data Source: AHCA, FLCHARTS)
Objective MH1.1.4: By December 31, 2022, Putnam County government will expand broadband internet services throughout the county (Baseline: No expansion, Target: Expanded service areas, Data Source: Board of County Commissioners meeting minutes)
Resources to Address Goal MH1: Putnam Behavioral Health Consortium, SMA Healthcare, Aza Health, Putnam County District Schools, Family Resource Connection, North Florida Psychological Services, ARC of Putnam County, Florida Department of Children and Families, Florida Department of Health, community partner expertise, funding for school-based Mental Health Assistance plan
Goal MH2: Improve access to mental healthcare services including substance misuse treatment services for drug and alcohol
Strategies MH2.1: Community health education, health promotion
Objective MH2.1.1: By December 31, 2025, decrease the percentage of adults who had poor mental health on 14 or more of the past 30 days by 10% (Baseline: 12.8% (2016), Target: 11.6%, (State rate 11.4%), Data Source: BRFSS FLCHARTS)
Objective MH2.1.2: By December 31, 2025, decrease the percent of students, ages 11-17 (middle and high school students), who in the past year, did something to purposely hurt themselves without wanting to die by 10% (Baseline: 15.0% (2020), Target: 13.5%, (State rate 12.4%) Data Source: FYTS FLCHARTS)

Objective MH2.1.3: By December 31, 2025, decrease the percent of students, ages 11-17 (middle and high school students), who in the past year, felt sad or hopeless for two or more weeks in a row and stopped doing usual activities by 4.7% (Baseline: 31.4% (2020), Target: 30%, (State rate 30.0%), Data Source: FYTS FLCHARTS)
Objective MH2.1.4: By December 31, 2023, provide Mental Health First Aid training to community groups in Putnam County (Baseline: 0 (currently not offered to the community at large), Target: 5 (number of trainings offered), Data Source: Behavioral Health Consortium)
Resources to Address Goal MH2: Putnam Behavioral Health Consortium, SMA Healthcare, Aza Health, Putnam County District Schools, Family Resource Connection, North Florida Psychological Services, ARC of Putnam County, Florida Department of Children and Families, Redlands Christian Migrant Association, Florida Department of Health, SMA Helpline, Eating Disorder Hotline, LGBTQ Crisis Line, National Suicide Prevention Lifeline, local and regional community partner expertise and commitment, school-based Mental Health Assistance plan

Strategic Priority: Maternal and Child Health (MCH)
Goal MCH1: Promote healthy birth outcomes
Strategies MCH 1.1: Address prenatal care options and services, provide risk-appropriate prenatal, preconception and interception care, educate on safe sleep, healthy weight and nutrition, tobacco, alcohol and drug use
Objective MCH1.1.1: By December 31, 2025, increase the percent of births to mothers with 1st trimester prenatal care by 5.5% (Baseline: 69.8% (2017-2019), Target: 73.8% (State rate: 76.5%), Data Source: FLCHARTS)
Objective MCH1.1.2: By December 31, 2025, decrease the percentage of Black and White infant mortality gap by 290% (Baseline: 1.62% (2017-2019), Target: 0.56% (State rate: 0.66%), Data Source: FLCHARTS)
Objective MCH1.1.3: By December 31, 2025, reduce the rate of births to Putnam County mothers who smoked during pregnancy by 30% (Baseline: 16.3% of births (2017-2019), Target: 11.46% (State rate 4.4%), Data Source: FLCHARTS)
Objective MCH1.1.4: By December 31, 2025, increase the percentage of mothers who initiate breastfeeding by 4.8% (Baseline: 72.1% (2017-2019), Target: 75.5% (State rate 86.1%), Data Source: FLCHARTS)
Resources to Address Goal MCH1: Healthy Start of Putnam County, Heart of Putnam, Florida Department of Health in Putnam County WIC Program, Women's Resource Center, Healthy Families, Healthy Start of North Central Florida Coalition, Putnam County Resource Directory, community partner expertise on maternal and child health issues in Putnam County and the region, regional maternity care centers, birthing centers, and hospitals
Goal MCH2: Ensure child health and safety
Strategies MCH 2.1: Policy change; remove and/or reduce barriers to services and professional support; health education with emphasis on preconception, pre- and post-natal; expand and enhance community partnerships
Objective MCH 2.1.1: By December 31, 2025, reduce the rate of Sudden Unexpected Infant Deaths (SUIDs) among Putnam County infants by 100% (Baseline: 1.2/1,000 live births (3-yr rolling rate, 2017-2019), Target: 0/1,000 live births (State rate 1.0/1,000), Data Source: FLCHARTS)

Objective MCH2.1.2: By December 31, 2025, reduce the percentage of K-12 students in Putnam County who are absent 21 or more days by 20.4% (Baseline 25.5% of students (2019), Target: 20.3% (State rate 11.3%), Data Source: FLCHARTS)
Resources to Address Goal MCH2: Healthy Start of Putnam County, Heart of Putnam, Florida Department of Health in Putnam County WIC Program, Women's Resource Center, Healthy Families, Healthy Start of North Central Florida Coalition, Putnam County School District, Redlands Christian Migrant Association, Department of Juvenile Justice, Early Learning Coalition, Putnam County Resource Directory, community partner expertise on infant and child health issues in Putnam County and the region
Goal MCH3: Reduce the incidence and prevalence of Sexually Transmitted Diseases (STDs)
Strategies MCH 3.1: Health education, remove barriers to primary and secondary preventive services and resources
Objective MCH3.1.1: By December 31, 2025, reduce the rate of bacterial STDs among Putnam County residents by 15% (Baseline: 882.0/100,000 population (2019), Target: 747.0/100,000 (State rate 758.0), Data Source: FLCHARTS)
Objective MCH3.1.2: By December 31, 2025, all public schools within the Putnam County School District will provide comprehensive sexual health education (CSHE) for grades 3-12 (Baseline: To Be Determined (TBD) of students who complete curriculum, Target: 62% (National rate 62%, CDC), Data Source: Putnam County School District)
Objective MCH3.1.3: By December 31, 2025, increase the percentage of Putnam County women aged 21 to 65 who report having had a Pap test in the past 3 years by 13% (Baseline: 66.8% 2016), Target: 75.6% (State rate 78.98%), Data Source: BRFSS, FLCHARTS)
Objective MCH3.1.4: By December 31, 2025, increase the percentage of reproductive age adults (18-44) in Putnam County who had a medical checkup in the past year by 8% (Baseline: 60.5% 2016), Target: 65.3% (State rate 76.5%), Data Source: BRFSS, FLCHARTS)
Resources to Address Goal MCH3: Putnam County School District Comprehensive Health Education Curriculum, School Health Advisory Committee, Florida Department of Health in Putnam County, Heart of Putnam, Women's Resource Center, Healthy Families, Healthy Start Coalition of North Central Florida, Redlands Christian Migrant Association, Putnam County Resource Directory, local and regional healthcare providers

Strategic Priority: Access to Primary Care and Preventive Services (PC)
Goal PC1: Improve access to primary care
Strategies PC1.1: Reduction of barriers to primary care access, health education, community education and awareness of services
Objective PC1.1.1: By December 31, 2025, increase the percentage of Putnam County adults with good physical health for the past 30 days by 2% (Baseline: 80.5% (2016), Target: 82% (State rate 87.1%), Data Source: BRFSS, FLCHARTS)
Resources to Address Goal PC1: Aza Health, Florida Department of Health in Putnam County, Putnam County Medical Mission, Women's Resource Center, Edgar Johnson Senior Center, Melrose Senior Community Center, Heart of Putnam, Redlands Christian Migrant Association, Florida Department of Children and Families Medicaid Program, Medicare Hotline, Serving Health Insurance Needs for Elders (SHINE), local and regional healthcare providers
Goal PC2: Enhance access to dental care and oral health services

Strategies PC2.1: Policy change, expansion of services, integration with primary care, community oral health education, extension of services to homeschoolers
Objective PC2.1.1: By December 31, 2025, increase the percent of Putnam County adults who report visiting a dentist or dental clinic in the past year by 3.2% (Baseline: 53.2% (2016), Target: 55% (State rate: 63%), Data Source: FLCHARTS)
Objective PC2.1.2: By December 31, 2025, increase the number of participants in the school-based dental sealant program in Putnam County by six (6) times or 600% (Baseline: 124 (2018), Target: 750 (State: 117,703 (2017-18), Data Source: Florida Department of Health, Public Health Dental Program)
Resources to Address Goal PC2: Putnam County District Schools, Florida Department of Health in Putnam County Dental Clinic, Aza Health Dental Clinic, Florida Baptist Convention Mobile Dentistry Unit, local and regional dental providers
Goal PC3: Promote primary prevention of chronic diseases
Strategies PC3.1: Health education, access to primary and secondary preventive services, collaboration with local and regional partners
Objective PC3.1.1: By December 31, 2025, reduce the age-adjusted death rate from Diabetes for Putnam County residents (Baseline: 39.7/100,000 (2017-19), Target: 37.0/100,000 (State rate 20.3), Data Source: FLCHARTS)
Objective PC3.1.2: By December 31, 2025, decrease the percentage of Putnam County middle and high school students who have smoked 100 or more cigarettes in their lifetime by 71.5% (Baseline: 1.4% (2020), Target: 1.0% (State rate 0.9%), Date Source: FYTS FLCHARTS)
Resources to Address Goal PC3: Florida Department of Health in Putnam County, Aza Health, Redlands Christian Migrant Association, American Diabetes Association, Putnam County School District School Health Advisory Committee

Putnam County CHIP Alignment with State and National Priorities

The strategic priorities, goals, strategies and objectives in the Putnam County CHIP align with several state and national initiatives. These include the Florida Department of Health's State Health Improvement Plan (SHIP) for 2017-2021, Healthy People 2030, and the U.S. Health and Human Service (HHS) Office of Minority Health National Stakeholder Strategy for Achieving Health Equity. These shared priorities present opportunities for collaboration, resource sharing, and collective impact in improving health outcomes and quality of life for Putnam County residents.

Putnam County CHIP Objectives	• **Florida SHIP = Florida State Health Improvement Plan, 2017 – 2021** • **HP 2030 = Healthy People 2030** • **NSS Health Equity: National Stakeholder Strategy for Achieving Healthy Equity**
Strategic Priority: Access to Mental and Behavioral Healthcare Services (MH)	
Objective MH1.1.1: By December 31, 2025, increase the rate per population of Licensed Clinical Social Workers by 10% (Baseline: 13.7/100,000 (2019), Target: 15.0/100,000 (State rate = 46.8), Data Source: FLCHARTS)	**Florida SHIP:** BH1 **HP2030:** MHMD-04, MHMD-05 **NSS Health Equity**: Goal 3 Health System and Life Experience, Strategy 8: Access to Care, Strategy 13: Social and Economic Conditions
Objective MH1.1.2: By December 31, 2025, reduce the rate of hospitalizations for drug- and alcohol-induced mental disorders for Putnam County residents of all ages by 6% (Baseline: 178.1/100,000 (2019), Target: 167/100,000 (State rate 167), Data Source: AHCA, FLCHARTS)	**Florida SHIP**: BH1, BH4 **HP 2030**: MHMD-07, MHMD-08, MPS-02 **NSS Health Equity**: Goal 3 Health System and Life Experience, Strategy 8: Access to Care, Strategy 13: Social and Economic Conditions
Objective MH1.1.3: By December 31, 2025, reduce the rate of hospitalizations attributable to mental disorders for Putnam County residents of all ages by 2.8% (Baseline: 1,035.5/100,000 (2019), Target: 1006.0/100,000 (State rate 1006.0), Data Source: AHCA, FLCHARTS)	**Florida SHIP**: BH1, BH4 **HP 2030**: MHMD-07, MHMD-08 **NSS Health Equity**: Goal 3 Health System and Life Experience, Strategy 8: Access to Care, Strategy 13: Social and Economic Conditions
Objective MH1.1.4: By December 31, 2022, Putnam County government will expand broadband internet services throughout the county (Baseline: No expansion, Target: Expanded service areas, Data Source: Board of County Commissioners meeting minutes)	**Florida SHIP**: HE2, HE3 **HP 2030**: AHS-R02 **NSS Health Equity**: Goal 2 Leadership, Strategy 6: Funding Priorities; Goal 3 Health System and Life Experience, Strategy 8: Access to Care, Strategy 13: Social and Economic Conditions
Objective MH2.1.1: By December 31, 2025, decrease the percentage of adults who had poor mental health on 14 or more of the past 30 days by 10% (Baseline: 12.8% (2016), Target: 11.6%, (State rate 11.4%), Data Source: BRFSS FLCHARTS)	**Florida SHIP**: BH1, BH4 **HP 2030**: MHMD-04, MHMD-05 **NSS Health Equity**: Goal 3 Health System and Life Experience, Strategy 8: Access to Care, Strategy 11: Health Communications, Strategy 13: Social and Economic Conditions
Objective MH2.1.2: By December 31, 2025, decrease the percent of students, ages 11-17	**Florida SHIP**: ISV1

Putnam County CHIP Objectives	• **Florida SHIP = Florida State Health Improvement Plan, 2017 – 2021** • **HP 2030 = Healthy People 2030** • **NSS Health Equity: National Stakeholder Strategy for Achieving Healthy Equity**
(middle and high school students), who in the past year, did something to purposely hurt themselves without wanting to die by 10% (Baseline: 15.0% (2020), Target: 13.5%, (State rate 12.4%) Data Source: FYTS FLCHARTS)	**HP 2030**: MDMD-03, EMC-D04, EMC-D06, MHMD-06, MHMD-D01 **NSS Health Equity**: Goal 1 Awareness, Strategy 2: Partnerships, Strategy 4: Communication; Goal 3 Health System and Life Experience, Strategy 8: Access to Care, Strategy 9: Children, Strategy 13: Social and Economic Conditions
Objective MH2.1.3: By December 31, 2025, decrease the percent of students, ages 11-17 (middle and high school students), who in the past year, felt sad or hopeless for two or more weeks in a row and stopped doing usual activities by 4.7% (Baseline: 31.4% (2020), Target: 30%, (State rate 30.0%), Data Source: FYTS FLCHARTS)	**Florida SHIP**: ISV1, ISV1.5 **HP 2030**: MDMD-03, EMC-D04, EMC-D06, MHMD-06, MHMD-D01 **NSS Health Equity**: Goal 1 Awareness, Strategy 2: Partnerships, Strategy 4: Communication; Goal 3 Health System and Life Experience, Strategy 8: Access to Care, Strategy 9: Children, Strategy 13: Social and Economic Conditions
Objective MH2.1.4: By December 31, 2023, provide Mental Health First Aid training to community groups in Putnam County (Baseline: 0 (currently not offered to the community at large), Target: 5 (number of trainings offered), Data Source: Behavioral Health Consortium)	**Florida SHIP**: HE1, BH1, BH2, BH3, BH4 **HP 2030**: ECBP-D07 **NSS Health Equity**: Goal 1 Awareness, Strategy 2: Partnerships, Strategy 4: Communication; Goal 3 Health System and Life Experience, Strategy 8: Access to Care, Strategy 13: Social and Economic Conditions
Strategic Priority: Maternal and Child Health (MCH)	
Objective MCH1.1.1: By December 31, 2025, increase the percent of births to mothers with 1st trimester prenatal care by 5.5% (Baseline: 69.8% (2017-2019), Target: 73.8% (State rate: 76.5%), Data Source: FLCHARTS)	**Florida SHIP**: MCH1.2, MCH2.1 **HP 2030**: MICH-08 **NSS Health Equity:** Goal 3 Health System and Life Experience, Strategy 8: Access to Care
Objective MCH1.1.2: By December 31, 2025, decrease the percentage of Black and White infant mortality gap by 290% (Baseline: 1.62% (2017-2019), Target: 0.56% (State rate: 0.66%), Data Source: FLCHARTS)	**Florida SHIP**: MCH1, MCH1.2, MCH2 **HP 2030**: MICH-02 **NSS Health Equity:** Goal 3 Health System and Life Experience, Strategy 8: Access to Care; Goal 4 Cultural and Linguistic Competency
Objective MCH1.1.3: By December 31, 2025, reduce the rate of births to Putnam County mothers who smoked during pregnancy by 30% (Baseline: 16.3% of births (2017-2019), Target: 11.46% (State rate 4.4%), Data Source: FLCHARTS)	**Florida SHIP**: MCH1, MCH1.2, CD1 **HP 2030**: MICH-10, TU-15 **NSS Health Equity:** Goal 3 Health System and Life Experience, Strategy 8: Access to Care
Objective MCH1.1.4: By December 31, 2025, increase the percentage of mothers who initiate breastfeeding by 4.8% (Baseline: 72.1% (2017-	**Florida SHIP**: MCH1, HW1.2 **HP 2030**: MICH-15, MICH-16

Putnam County CHIP Objectives	• **Florida SHIP = Florida State Health Improvement Plan, 2017 – 2021** • **HP 2030 = Healthy People 2030** • **NSS Health Equity: National Stakeholder Strategy for Achieving Healthy Equity**
2019), Target: 75.5% (State rate 86.1%), Data Source: FLCHARTS)	**NSS Health Equity:** Goal 3 Health System and Life Experience, Strategy 8: Access to Care, Strategy 13: Social and Economic Conditions
Objective MCH 2.1.1: By December 31, 2025, reduce the rate of Sudden Unexpected Infant Deaths (SUIDs) among Putnam County infants by 100% (Baseline: 1.2/1,000 live births (3-yr rolling rate, 2017-2019), Target: 0/1,000 live births (State rate 1.0/1,000), Data Source: FLCHARTS)	**Florida SHIP**: MCH1.1 **HP 2030**: MICH-14, MICH-D03 **NSS Health Equity:** Goal 3 Health System and Life Experience, Strategy 8: Access to Care, Strategy 13: Social and Economic Conditions
Objective MCH2.1.2: By December 31, 2025, reduce the percentage of K-12 students in Putnam County who are absent 21 or more days by 20.4% (Baseline 25.5% of students (2019), Target: 20.3% (State rate 11.3%), Data Source: FLCHARTS)	**Florida SHIP**: BH1 **HP 2030**: AH-07 **NSS Health Equity:** Goal 3 Health System and Life Experience, Strategy 8: Access to Care, Strategy 9: Children, Strategy 13: Social and Economic Conditions
Objective MCH3.1.1: By December 31, 2025, reduce the rate of bacterial STDs among Putnam County residents by 15% (Baseline: 882.0/100,000 population (2019), Target: 747.0/100,000 (State rate 758.0), Data Source: FLCHARTS)	**Florida SHIP**: ID1, ID1.1, ID1.2 **HP 2030**: STI-03, STI-02, STI-06, STI-07 **NSS Health Equity:** Goal 3 Health System and Life Experience, Strategy 8: Access to Care
Objective MCH3.1.2: By December 31, 2025, all public schools within the Putnam County School District will provide comprehensive sexual health education (CSHE) for grades 3-12 (Baseline: To Be Determined (TBD) of students who complete curriculum, Target: 62% (National rate 62%, CDC), Data Source: Putnam County School District)	**Florida SHIP**: ID1, HW1, HW2 **HP 2030**: ECBP-D01, AH-R07 **NSS Health Equity:** Goal 3 Health System and Life Experience, Strategy 8: Access to Care, Strategy 9: Children, Strategy 12: Education, Strategy 13: Social and Economic Conditions
Objective MCH3.1.3: By December 31, 2025, increase the percentage of Putnam County women aged 21 to 65 who report having had a Pap test in the past 3 years by 13% (Baseline: 66.8% 2016), Target: 75.6% (State rate 78.98%), Data Source: BRFSS, FLCHARTS)	**Florida SHIP**: CD1 **HP 2030**: C-09 **NSS Health Equity:** Goal 3 Health System and Life Experience, Strategy 8: Access to Care, Strategy 13: Social and Economic Conditions
Objective MCH3.1.4: By December 31, 2025, increase the percentage of reproductive age adults (18-44) in Putnam County who had a medical checkup in the past year by 8% (Baseline: 60.5% 2016), Target: 65.3% (State rate 76.5%), Data Source: BRFSS, FLCHARTS)	**Florida SHIP**: CD1, MCH2.2 **HP 2030**: AHS-08 **NSS Health Equity:** Goal 3 Health System and Life Experience, Strategy 8: Access to Care, Strategy 13: Social and Economic Conditions

Putnam County CHIP Objectives	• **Florida SHIP = Florida State Health Improvement Plan, 2017 – 2021** • **HP 2030 = Healthy People 2030** • **NSS Health Equity: National Stakeholder Strategy for Achieving Healthy Equity**
Strategic Priority: Access to Primary Care and Preventive Services (PC)	
Objective PC1.1.1: By December 31, 2025, increase the percentage of Putnam County adults with good physical health for the past 30 days by 2% (Baseline: 80.5% (2016), Target: 82% (State rate 87.1%), Data Source: BRFSS, FLCHARTS)	**Florida SHIP**: HW1, HW2, MCH2.2 **HP 2030**: HDS-04, HDS-06, NWS-03 **NSS Health Equity:** Goal 3 Health System and Life Experience, Strategy 8: Access to Care, Strategy 13: Social and Economic Conditions
Objective PC2.1.1: By December 31, 2025, increase the percent of Putnam County adults who report visiting a dentist or dental clinic in the past year by 3.2% (Baseline: 53.2% (2016), Target: 55% (State rate: 63%), Data Source: FLCHARTS)	**Florida SHIP**: HW1, HW2 **HP 2030**: OH-03, OH-08, AHS-05 **NSS Health Equity:** Goal 3 Health System and Life Experience, Strategy 8: Access to Care, Strategy 13: Social and Economic Conditions
Objective PC2.1.2: By December 31, 2025, increase the number of participants in the school-based dental sealant program in Putnam County by six (6) times or 600% (Baseline: 124 (2018), Target: 750 (State: 117,703 (2017-18), Data Source: Florida Department of Health, Public Health Dental Program)	**Florida SHIP**: HW1, HW2 **HP 2030**: OH-01, OH-02, OH-10 **NSS Health Equity:** Goal 3 Health System and Life Experience, Strategy 8: Access to Care, Strategy 9: Children, Strategy 13: Social and Economic Conditions
Objective PC3.1.1: By December 31, 2025, reduce the age-adjusted death rate from Diabetes for Putnam County residents (Baseline: 39.7/100,000 (2017-19), Target: 37.0/100,000 (State rate 20.3), Data Source: FLCHARTS)	**Florida SHIP**: HW1, HW2 **HP 2030**: D-01, D-06, D-07, D-09D-D01, **NSS Health Equity:** Goal 3 Health System and Life Experience, Strategy 8: Access to Care, Strategy 13: Social and Economic Conditions
Objective PC3.1.2: By December 31, 2025, decrease the percentage of Putnam County middle and high school students who have smoked 100 or more cigarettes in their lifetime by 71.5% (Baseline: 1.4% (2020), Target: 1.0% (State rate 0.9%), Date Source: FYTS FLCHARTS)	**Florida SHIP**: HW1, HW2 **HP 2030**: TU-04, TU-05, TU-06, TU-10, TU-22 **NSS Health Equity:** Goal 3 Health System and Life Experience, Strategy 8: Access to Care, Strategy 9: Children, Strategy 13: Social and Economic Conditions

Appendix

This Appendix includes the following sections:

- Organizations, Agencies and Individuals Represented in the Putnam County Community Health Assessment and Health Improvement Planning Process
- Putnam County CHIP Implementation Action Plan Template

ORGANIZATIONS, AGENCIES AND INDIVIDUALS PARTICIPATING IN THE PUTNAM COUNTY COMMUNITY HEALTH ASSESSMENT AND HEALTH IMPROVEMENT PLANNING PROCESS

Below is a list of community partners who assisted in the 2020-2021 Putnam County community health assessment and health improvement planning process. This list is not meant to be exclusive. Our gratitude goes to our many community partners, local residents, non-profit organizations, healthcare professionals, school representatives, and many other community members who lent their support to this assessment and continuing the community's health vision.

- Sica Bishop, Health Educator, Putnam County Health Department
- Cynthia D'Agostine, Program Consultant, Putnam County Health Department
- Flora Davis, St. Johns Rural Health Network
- Karl Flagg, Pastor, Mt. Tabor First Baptist Church; Board Chairman, Putnam Community Medical Center
- Karin Flositz, Chief Executive Officer, Community Partnership for Children
- Mary L. Garcia, Administrator, Putnam County Health Department
- Christina Gillis, Circuit 7 Community Development Administrator, Florida Department of Children and Families
- Robyn Jernigan, Supervisor, Healthy Families, Putnam County Health Department
- Dana Jones, President, Putnam County Chamber of Commerce
- Carol Kazounis, Chronic Disease Program Director, Putnam County Health Department
- Wayne McClain, Chairman, Putnam Chamber of Commerce; Vice President, Beck Auto
- Sheila McCoy, Executive Director, Palatka Christian Service Center
- Kraig McLane, Vice Chairman, Putnam County Trails Council
- Melissa Miller, Senior Vice President, General Counsel, and Executive Director, St. Johns River State College
- Tom J. Rodgers, Pastor, Bethlehem Baptist Church
- Nancy Russo, Vice President, Putnam County, SMA Healthcare
- Lorie Shvets, Director of Communications, United Way of St. Johns County
- Sharon Spell, Transportation Director, Putnam County School District; Board Member, Palatka Housing Authority
- Laura M. Spencer, Chief Executive Officer, Aza Health, Rural Health Care
- Lynda Taurus, PCORP Program Manager, SMA Healthcare
- Randy Terry, Chair, Board of Directors, Ride Solutions, Inc.
- Lucia Valdivia-Sanchez, Director, Florida Migrant Interstate Program; North East Florida Educational Consortium
- Stephanie Wellon, Mental Wellness Counselor, Putnam County School District
- Rhonda J. Williams, Community Member

Other Community Partner Organizations:

- Putnam County Board of County Commissioners
- Putnam County Sheriff's Office
- Putnam County Emergency Operations Center
- City of Palatka
- Putnam Blueways and Trails
- 7th Judicial Circuit, System of Care

Putnam County Community Health Improvement Plan (CHIP) Action Plan

Strategic Priority:
Goal:
Strategy:
Objective: (with baseline, target and data source)
Background on Strategy: ***Source or Evidence-base*:** ***Policy Change*** (yes/no): ***Health equity or disparity to be addressed*** (if applicable): ***Link to Social Determinants of Health:***
Action Plan:

Activity	Lead Person & Organization	Performance Measurement (Product, Deliverable, Result)	Resources Needed	Target Date	Status or Progress