Georgia Department of Public Health

North Central Health District

2016 COUNTY HEALTH RANKINGS PUTNAM COUNTY

DATA REQUEST

This data was requested by Dr. David Harvey, North Central Health District Health Director

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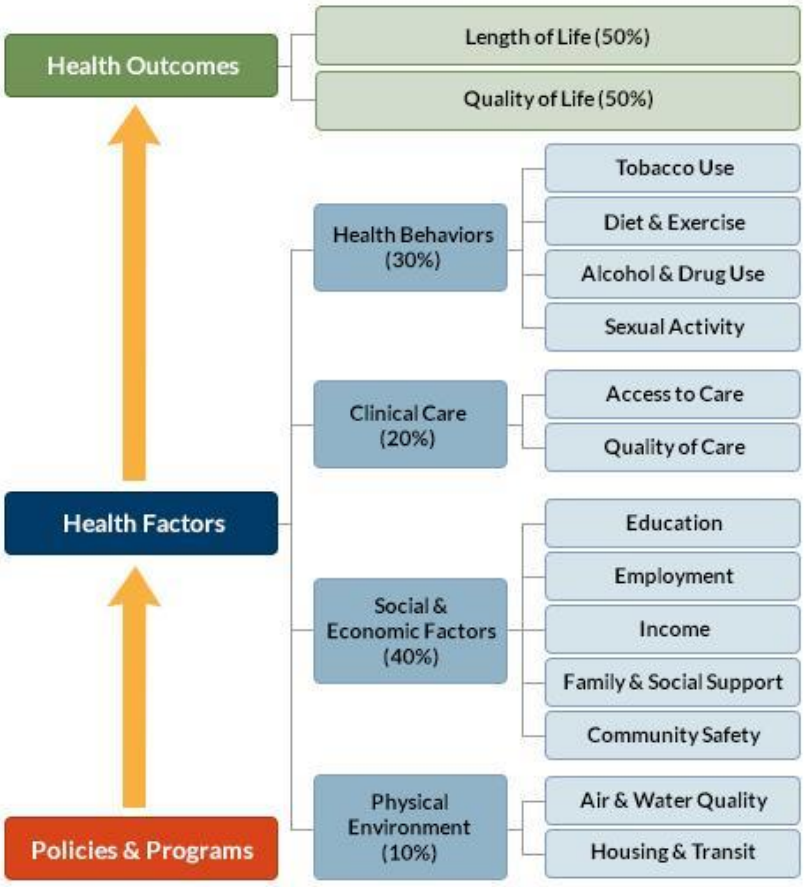
Overview of County Health Rankings

The *County Health Rankings* rank the health of nearly every county in the nation and show that much of what affects health occurs outside of the doctor's office. The *County Health Rankings* confirm the critical role that factors such as education, jobs, income, and environment play in how healthy people are and how long they live. Published by the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation, the Rankings help counties understand what influences how healthy residents are and how long they will live. The information is compiled for the *Rankings* by using county-level measures from a variety of national data sources. These measures are standardized and combined using scientifically-informed weights. We then rank counties by state, providing two overall ranks:

1. Health outcomes: how healthy a county is now.
2. Health factors: how healthy a county will be in the future.

In addition to the ranks, the *Rankings* provide communities with county-level data for a variety of factors that affect health such as high school graduation rates, access to healthier foods, air pollution levels, income, and rates of smoking, obesity and teen births. Based on the latest data publically available for each county, the *Rankings* are unique in their ability to measure the overall health of each county in all 50 states on the multiple factors that influence health.; The following model describes the approach.



What Are Health Gaps And Why Do They Matter?

As a country, we have achieved significant health improvements over the past century. We have benefited from progress in automobile safety, better workplace standards, good schools and medical clinics, and reductions in smoking or infectious diseases. But when you look closer, within each state across the country—including Georgia—there are significant differences in health outcomes according to where people live, learn, work, and play. It is clear that not all Americans have the means and opportunity to be their healthiest.

Gaps in length and quality of life.

Residents in one county are more likely to die prematurely or not be as healthy as residents in another county in the same state if they do not have the same kinds of opportunities to be their healthiest.

Gaps in the factors that influence health.

Health is influenced by every aspect of how and where we live. Access to affordable housing, safe neighborhoods, job training programs and quality early childhood education are examples of important changes that can put people on a path to a healthier life even more than access to medical care. But access to these opportunities varies county to county. This limits choices and makes it hard to be healthy. Poor health disproportionately burdens people who live in places that limit opportunities to live long and well. These gaps in health outcomes are costly and preventable. Gaps in health could be narrowed, if not eliminated, if we took steps to create more equitable opportunities. Improving education in counties that need it most is one example. That step and others can lead to higher incomes and more lifetime stability. Most of Georgia's 5,600 excess deaths tend to occur in counties with higher populations (such as Bibb). However, some counties with smaller populations also have a disproportionate share of avoidable lives lost. Of course, population size is not the only factor that state leaders should take into account when selecting strategies to solve health gaps. We know that there are many factors that shape health.

Every year, **nearly 5,600 deaths in Georgia could be avoided** if all residents in the state had a fair chance to be healthy.

If residents of all counties in Georgia had the same opportunities for health, there could be:

292,000 fewer adult smokers
181,000 fewer adults who are obese
284,000 fewer adults who drink excessively
273,000 fewer people who are uninsured
182,000 more adults, ages 25-44, with some education beyond high school
72,000 fewer people who are unemployed
194,000 fewer children in poverty
220,000 fewer households with severe housing problems

Overview of North Central Health District Rankings

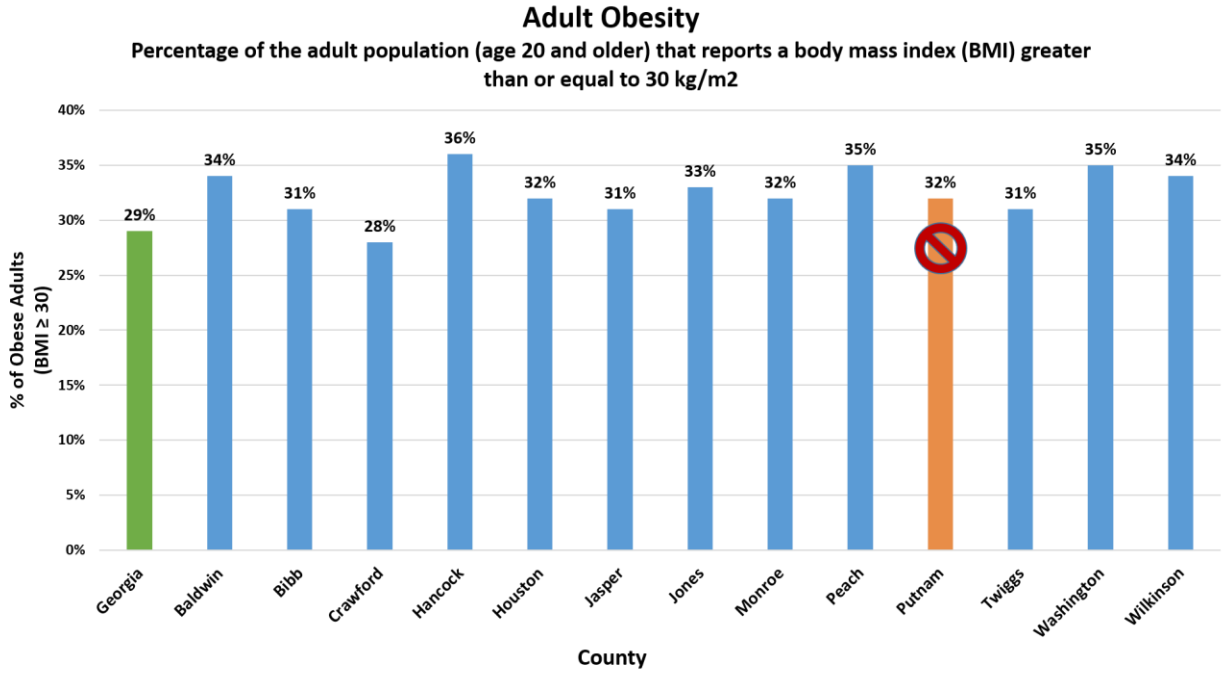
The overall rankings in health outcomes represent how healthy counties are within the state. The healthiest county in the state is ranked #1. Ranks for health outcomes are based on an equal weighting of length and quality of life. Ranks for health factors are based on weighted scores for health behaviors, clinical care, social and economic factors, and the physical environment. Overall health outcomes and health factor ranks have been compared to 2015 ranks. A red number indicates a negative move in rank and a green number indicates a positive move in rank.

	Health Outcomes	Length of Life	Quality of Life	Health Factors	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment
Baldwin	97	67	126	102	93	26	128	137
Bibb	146	150	138	97	120	12	122	101
Crawford	53	61	54	68	39	120	73	108
Hancock	151	121	156	152	148	82	150	156
Houston	15	17	30	32	35	67	27	113
Jasper	74	76	81	65	69	92	56	100
Jones	32	30	37	26	33	56	22	77
Monroe	55	62	57	27	36	47	24	93
Peach	122	141	88	134	124	119	132	52
Putnam	83	102	69	86	48	101	97	130
Twiggs	104	66	137	142	94	80	156	141
Washington	67	41	117	90	127	13	110	43
Wilkinson	103	101	110	106	104	126	83	126

Putnam County

	Putnam	Georgia
Population	21,192	10,097,343
% below 18 years of age	21.30%	24.70%
% 65 and older	21.50%	12.40%
% Non-Hispanic African American	26.70%	30.70%
% American Indian and Alaskan Native	0.40%	0.50%
% Asian	0.60%	3.80%
% Native Hawaiian/Other Pacific Islander	0.30%	0.10%
% Hispanic	6.60%	9.30%
% Non-Hispanic White	65.00%	54.30%
% not proficient in English	3.00%	3.00%
% Females	51.50%	51.20%
% Rural	80.90%	24.90%

The following information is a snapshot of the Putnam County Health Rankings Data with focus on measures that are suggested by County Health Rankings as an area to explore and those areas that match Strategic Plan and/or Community Health Improvement Plan objectives.



Identified as a priority in the 2015 Community Health Improvement Plan (CHIP)
Priority #1: Chronic Disease-Focus on Obesity

- Goal 1-A: Reduce burden of chronic disease caused by obesity among all NCHD residents
    - Objective 1.1: By 2020 increase by 5% the percent of adults and children in the NCHD who meet or exceed physical activity guidelines for health.
        - Strategy: Increase access to local school facilities, fields, basketball courts, community recreational facilities, parks, playgrounds, etc. by establishing new joint-use agreements and improving adherence to existing joint-use agreements.

Priority #3: Maternal, Infant, and Child Health

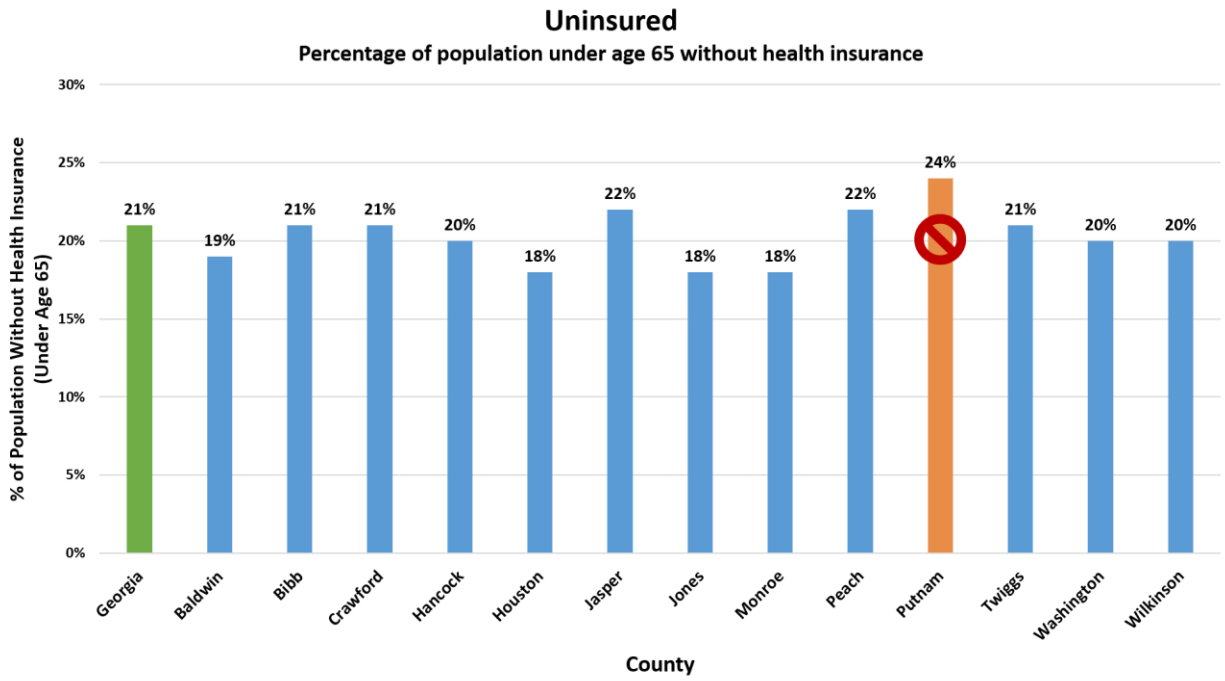
- Goal 3-A: Improve the health of mothers, infants, and children before, during, and after pregnancy to live healthy lives.
    - Objective 3.1: By 2020, reduce infant mortality rates by 5%.
        - Strategy: Promote healthy BMI's to include waist circumference education and monitoring.

Identified as a priority in the 2016-2020 NCHD Strategic Plan
Strategic Issue: Chronic Disease-Focus on Obesity

- Goal 1: Increase awareness and education regarding obesity in the Community. Obesity is one of the biggest health threats of our time and is a primary risk factor for many chronic diseases including diabetes, hypertension, cardiovascular disease, and cancers. The NCHD will focus on educating clients about the risk of obesity and related chronic diseases.
    - Objective 1: By 2020, 80% of NCHD facilities waiting room televisions will incorporate the use of health education media to promote chronic disease and obesity topics.
        - Action Steps: Development of health education material and provide health education media to NCHD facilities.

Strategic Issue: Chronic Disease-Focus on Obesity

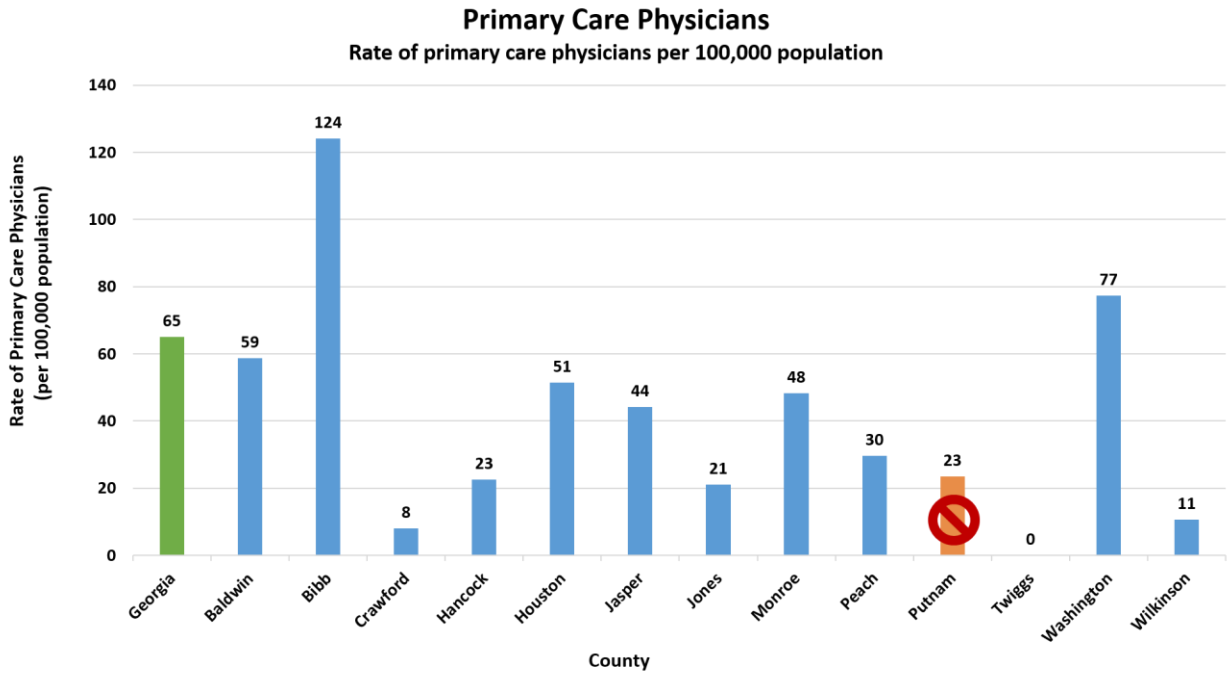
- Goal 2: Increase worksite wellness activities in area workplaces. Adults spend a large portion of their time at work. The workplace is an ideal place to encourage and promote healthy behaviors around physical activity and health eating.
    - Objective 1: By 2017, increase the number of NCHD-area workplaces that have worksite wellness by 5%
        - Action Steps: Development worksite wellness policy template to be shared with area workplaces.
    - Objective 2: 100% compliance with state healthy meals policy by 2020.
        - Action Steps: Adapt the state healthy meals policy to fit district needs.



Identified as a priority in the Community Health Improvement Plan (CHIP) 2016-2020

Priority #2: Access to Quality Health Care and Preventative Services

- Goal 2-B: By 217, increase the capacity of social support networks
    - Objective 2.4: By 2020, increase the number of individuals who have the financial capacity to access primary and specialty care.
        - Strategy: Identify individuals eligible for Medicaid, or other programs offering financial assistance.
        - Strategy: Engage in strategic community/economic development initiatives.



Identified as a priority in the Community Health Improvement Plan (CHIP) 2016-2020
Priority #2: Access to Quality Health Care and Preventive Services

- Goal 2-A: Increase access to quality health services for the underserved.
    - Objective 2.1: By 2019, increase the number of underserved persons who have a medical home.
        - Strategy: Define primary provider availability
        - Strategy: Explore opportunities to reach underserved populations through telemedicine/paramedicine.
        - Strategy: Work with hospitals and social service agencies to disseminate information to at-risk populations regarding access points to care.
    - Objective 2.3: By 2017, increase the number of pro9viders who are aware of and refer patients to social support agencies.
        - Strategy: Partner with the United Way to develop marketing information channels for provider awareness including website/apps.
- Goal 2-A: Increase access to quality health services for the underserved.
    - Objective 2.4: By 2020, increase the number of individuals who have the financial capacity to access primary and specialty care.
        - Strategy: Identify individuals eligible for Medicaid, or other programs offering financial assistance.
        - Strategy: Engage in strategic community/economic development initiatives