Community Health Needs Assessment Bay County, Florida

2015 - 2016

Prepared by:



Community Health Needs Assessment Bay County, Florida 2015 - 2016

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2015-16 Community Health Needs Assessment

Bay County, Florida

Executive Summary

In 2015, Sacred Heart Health System ("SHHS"), the Florida Department of Health - Bay County ("DOH-Bay") and the Bay County Community Health Task Force (CHTF) worked together, in collaboration with other community organizations and agencies, to conduct a community health needs assessment ("assessment") for the approximately 175,000 residents of Bay County, Florida. A Community health needs assessment provides a snapshot in time of the community strengths, needs, and priorities. Guided by the Mobilization for Action through Planning and Partnerships (MAPP) process, this report is a result of a collaborative and participatory approach to community health planning and improvement. Improving the health of the community is critical to enhancing Bay County residents' quality of life and supporting its future prosperity and well-being.

This document is also a resource for the community to inform community decision-making, the prioritization of health problems, and the development, implementation, and evaluation of community health improvement plans.

Community Definition

The area for the purposes of this assessment is defined as the population of Bay county. Bay County has a total area of 1,033 square miles, of which 25% is water. There are seven municipalities in Bay County – Panama City is the county seat and largest city, on the coast. Unincorporated areas, however, comprise nearly half of the total population.

The County's coastal access and low cost of living has driven a 6% growth in population from 2010 and 2014 to 178,985, and is projected to continue to grow 9% to over 197,000 persons by 2020.

Approximately 20% of the total population is African-American, Hispanic, Asian or other race/ethnicity. Overall, the age distribution of Bay County is 28% under 18 years of age, 56% between 19 and 64 years, and 16% over 65. This distribution indicates a younger population than the State of Florida.

Participants in the Assessment Process

The assessment process was led by SHHS and DOH-Bay, with active participation by community organizations and private and public agencies which collectively comprise the Bay County Community Health Task Force. The assessment process included community meetings/workshops and a community survey distributed both on-line and in paper format. More than 81 people representing more than 50 different community agencies and organizations and the general public participated in various meetings throughout the process. In addition, 1,538 Bay County residents completed the community survey. Particular focus was placed on obtaining input from vulnerable population groups.

Methodology & Summary of Findings

Framework: Mobilizing for Action through Planning & Partnerships

With the Florida Department of Health as a partner, the Mobilizing for Action through Planning & Partnerships (MAPP) process was utilized to conduct the CHNA. The MAPP process is a community-driven strategic planning process for improving community health and is comprised of four individual assessments.

Community Themes & Strengths Assessment (CTSA)

Description: CHTF utilizes methods to solicit public input and results in a strong understanding of community issues and concerns, perceptions about quality of life and a map of community assets. The Task Force conducted a Community Health Survey with a total of 1,538 respondents from Bay County.

Themes and Community Concerns:

- Access to health services; lack of affordable health care
- Healthy Weight
- Mental Health and Substance Abuse
- Child abuse/neglect
- Tobacco use

Forces of Change Assessment (FOCA)

Description: The FOCA analyzes the external forces, positive or negative, that impact the promotion and protection of the public's health. Diverse stakeholders, representing the Florida Department of Health in Bay County, Task Force, nonprofit organizations and others, convened to generate answers to the following question: "What is occurring or might occur that affects the health of our community or local public health system?" Participants brainstormed trends, factors, and events, organizing them into common themes and then providing an overarching 'force' for each of the category columns.

Top 5 Themes

- 1. Access to Care
- 2. Behavior
- 3. Mental Health
- 4. Financial Forces
- 5. Municipal Infrastructure

Local Public Health System Assessment (LPHSA)

Partners from each county's local public health system convened and discussed the Model Standard Activities which serve as quality indicators that are aligned with the 10 essential public health service areas. See inset.

None of Model Standard Activities functioned within the *Optimal Activity** category.

*Optimal Activity - Greater than 75% of the activity described within the question is met.

The 10 Essential Public Health Services

- **1. Monitor** health status to identify community health problems.
- 2. **Diagnose and investigate** health problems and health hazards in the community.
- 3. Inform, educate and empower people about health issues.
- **4. Mobilize** community partnerships to identify and solve health problems.
- 5. **Develop policies and plans** that support individual and community health efforts.

- **6. Enforce** laws and regulations that protect health and ensure safety.
- Link people to needed personal health care services and assure the provision of health care when otherwise available.
- 8. **Assure** a competent public health and personal health care workforce.
- **9. Evaluate** the effectiveness, accessibility, and quality of personal and population-based health services.
- **10. Research** for new insights and innovative solutions to health problems.

Community Health Status Assessment (CHNA)

The CHNA is a process assessing the current health status of a community through the selection and collection of relevant data elements (indicators) and the analysis of trends and comparisons to benchmarks. The Task Force collected county-level data for 163 health status indicators and 28 demographic indicators. As a benchmark, individual performance of Bay County was compared to that of Florida state as a whole. To identify overall themes, results were analyzed using the *County Health Rankings* Model for population health that emphasized the impact of health factors, such as behavior, clinical care, socioeconomic and physical environment, on the health outcomes of mortality, *length of life*, morbidity and *quality of life*.

Results

In one hundred sixty-three indicators, Bay County performed worse than the state in 105 of them. About half of them, 61 indicators, showed a worsening trend. The major themes revealed included:

Mental Health & Substance Abuse

13 related indicators

11 indicators perform worse than the state for the community

5 indicators with a worsening trend: 1) Unhealthy mental days, 2) average number of days where poor mental or physical health interfered with activities of daily living, 3) Suicide deaths, 4) Increase alcohol consumption and 5) Substance abuse

Healthy Weight/Obesity

23 related indicators

21 indicators perform worse than the state for the two-county community

7 indicators with a worsening trend, including: births to overweight mothers, sedentary adults and adults eating the recommended five servings of fruits and vegetables daily.

Chronic Disease

41 related indicators

27 indicators perform worse than the state

23 indicators with a worsening trend, including: increase in Adults with diabetes, and increase in deaths due to diabetes or chronic lower respiratory disease.

2016 Community Health Priorities

Bay County Community Health Care Task Force completed this process with a holistic review of the data gathered in each of the assessments to identify overarching themes and health issues. The 2016 Community Health Priorities for the Bay County community will be:

- Healthy Weight
- Chronic Disease including Diabetes
- Mental Health & Substance Abuse

In addition to these, the following has been identified as health concerns:

• Preventable Disease

While this concern is not a priority for the County, it is important to understand how this issue can affect the community and provide opportunity for organizations and community groups within the county to address the health concern.

2015-16 Community Health Needs Assessment

Bay County, Florida

INTRODUCTION

In 2015, Sacred Heart Health System ("SHHS"), the Florida Department of Health - Bay County ("DOH-Bay") and the Bay County Community Health Task Force (CHTF) worked together, in collaboration with other community organizations and agencies, to conduct a community health needs assessment ("assessment") for the approximately 175,000 residents of Bay County, Florida. A Community health needs assessment provides a snapshot in time of the community strengths, needs, and priorities. Guided by the Mobilization for Action through Planning and Partnerships (MAPP) process, this report is a result of a collaborative and participatory approach to community health planning and improvement. Improving the health of the community is critical to enhancing Bay County residents' quality of life and supporting its future prosperity and well-being.

This document is also a resource for the community to inform community decision-making, the prioritization of health problems, and the development, implementation, and evaluation of community health improvement plans.

Collaborating Partners

Bay Medical Center, Bay County

Bay Medical Center ("BMC") is a 323-bed acute care facility in Panama City, Bay County. BMC was established as a county hospital in 1949 and then a special hospital district facility in 1995 by the Bay County Board of County Commissioners to ensure access to care for its citizens. The residents of Bay County comprise 73.9% of BMC's hospital discharges (2014). Although BMC operated as a governmental safety net provider, BMC did not receive taxpayer funding. In April 2012, Sacred Heart Health System and LHP entered into a long-term lease and asset purchase of BMC. BMC continues to provide acute care, outpatient and diagnostic services

for the community's poor and vulnerable residents. This safety net role is consistent with Sacred Heart Health System's mission as a Catholic health ministry.



Florida Departments of Health in Bay County



The Florida Department of Health in Bay County endeavors to service the community where good health and wellness are priorities for its people and a place where medical and dental services are accessible and affordable. The Department's goals are to optimize public and private partnerships that work together for the community to assure sustainable, cost effective services are available and utilized to continually improve health outcomes for all community members. The Department's public health professionals are dedicated to improving the health of individuals and communities through the promotion of healthy lifestyles, disease and injury prevention, infectious disease detection and control. Our team is dedicated to the prevention of wide spread health problems through adherence to sound public health policies, educational programs, services, and leadership. Healthcare equity, quality

and accessibility are important in protecting the health of our communities. Alliances with policy makers, stakeholders and community partners serve to identify and engage needed actions to prevent chronic diseases and make public health improvements are important and appreciated. The

improvement of community health is at the center of public health endeavors; therefore, it is vital for everyone to be informed and engaged in these efforts. Communicating health risks and promotion of preventative measures to the public is key.

Bay County Community Health Task Force

The Bay County Community Health Task Force (CHTF) is organized for the purpose of conducting periodic extensive evaluations of the health status of the citizens of the Bay County area in order to develop interventions. The goal of the CHTF is to develop and implement comprehensive, community-based health promotion and wellness programs in the Bay County area and provide a forum where members may join together to plan, share resources, and implement strategies and programs to address the health care needs of citizens.



Community Definition

Bay County has a total area of 1,033 square miles, of which 25% is water. There are seven municipalities in Bay County – Panama City is the county seat and largest city, on the coast. Unincorporated areas, however, comprise nearly half of the total population.



The County's coastal access and low cost of living has driven a 6% growth in population from 2010 and 2014 to 178,985, and is projected to continue to grow 9% to over 197,000 persons by 2020.

Approximately 20% of the total population is African-American, Hispanic, Asian or other race/ethnicity. Bay County has approximately 50% females. Overall, the age distribution of Bay County is 28% under 18 years of age, 56% between 19 and 64 years, and 16% over 65. This distribution indicates a younger population than the State of Florida.

Median household income is the most widely used measure of income. Median is a good predictor of household income because it is less impacted by the income highs and lows and divides the income distribution into two equal parts, one half falling

above the median. Median income can define the ability of a household to have access to affordable housing, health care, higher education opportunities, and food. The average annual wage in Bay County is \$47,274, which is above the State's median. Over one-third of Bay County employment was in the Trade, Transportation and Utilities, Leisure and Hospitality industry sectors, which had the lowest wages, nearly half that of the State's average wage.

In 2014, 14.8% of the population had incomes

Demographics	State	County	
Po	pulation		
Total	19,548,031	174,987	
Female	9,992,462	88,180	
Male	9,555,569	86,807	
Median age	41.8	39.7	
Soci	oeconomic		
Poverty rate	16.3%	34.6%	
% children living below poverty level	23.6%	21.6%	
Median household income	\$47,212	\$45,249	
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Florida

below 100% of the Federal Poverty Level. In Bay County 10,478, 28%, of children live in poverty. In addition to the fact that the population has lower income, approximately 20% are uninsured. Therefore, the general community needs reflected in the CHNA also reflect the needs of low-income and uninsured residents.

below and one-half

Bay

Other notable social determinants of health included a lower high school graduation rate, higher juvenile referral rate, and crime. Demographic and socioeconomic data for Bay County is provided in Appendix I.

METHODOLOGY

Participants in the Assessment Process

The assessment process was led by SHHS and DOH-Bay, with active participation by community organizations and private and public agencies which collectively comprise the Bay County Community Health Task Force. The assessment process included community meetings/workshops and a community survey distributed both on-line and in paper format. More than 81 people representing more than 50 different community agencies and organizations and the general public participated in various meetings throughout the process. In addition, 1,538 Bay County residents completed the community survey. Particular focus was placed on obtaining input from vulnerable population groups.

Participating organizations included:

- Big Bend Community Based Care
- Big Bend AHEC
- Big Bend Health Councils
- LEAD Coalition
- Glenwood Community Partnership
- Early Education and Care, Inc.
- Tyndall Air Force Base
- Medical Reserve Corps
- West Rock
- Renew Counseling
- Anchorage Children's Home
- Department of Children and Families
- Nations Best Health Care
- Bay County Breastfeeding Connection
- St. Andrews Bay Center
- Salvation Army
- Gulf Coast State College
- Gulf Coast Regional Medical Center
- Career Source Gulf Coast
- Covenant Hospice
- Panama City Marina Institute
- Veterans Affairs
- BASIC of Northwest Florida
- Early Learning Coalition of Northwest Florida
- Red Cross of Northwest Florida Department of Health

- Life Management Center
- PanCare, Inc.
- United Way of Northwest Florida
- NCR/St. Andrews Towers
- Victory Temple
- Journey Pure Emerald Coast
- Youth Enrichment Services
- Twelve Oaks Recovery
- Ascendant Healthcare Partners
- West-Rock Paper Mill
- WIC
- Panama City News Herald
- Healthy Start
- 90 Works
- Catholic Charities of Northwest Florida
- Community Health Task Force
- Gulf Coast Children's Advocacy Center
- Global Arts Society
- St. Andrews State Park
- Emerald Coast Behavioral Hospital
- Panama City CRA
- ADA
- iHeart Media
- Second Chance of Northwest Florida
- AARP Bay County Chapter 315

Individual members of these organizations and agencies that participated are listed on the sign-in sheets included in each related workshop reports included in Appendices II-IV.

Process: Assessment

Framework: Mobilizing Action through Planning & Partnerships

With the Florida Department of Health as a partner, the Mobilizing Action through Planning & Partnerships (MAPP) process was utilized to conduct the assessment. The MAPP process is a community-driven strategic planning process for improving community health. The process helps communities apply strategic thinking to identify and prioritize health issues and identify resources to address them.

The MAPP process is comprised of four individual assessments:

Forces of Change Assessment (FOCA)

During the FOC exercise, participants engage in a brainstorming activity to identify forces—such as trends, factors, or events—that are or will be influencing the health and quality of life of the community and the local public health system.

Community Themes & Strengths Assessment (CTSA)

The CTSA Assessment answers questions such as: "What is important to our community?" and "How is quality of life perceived in our community?" This assessment results in a strong understanding of community issues and concerns, perceptions about quality of life, and a map of community assets.



Local Public Health System Assessment (LPHSA)

The LPHSA involves a broad range of organizations and entities that contribute to public health in the community and answers the questions: "What are the components, activities, competencies, and capacities of our local public health system?" and "How are the Essential Services being provided to our community?"

Community Health Status Assessment (CHNA)

The CHNA is a process assessing the current health status of a community through the selection and collection of relevant data elements (indicators) and the analysis of trends and comparisons to benchmarks.

SUMMARY OF FINDINGS

Forces of Change Assessment

A brainstorming session amongst diverse stakeholders was held on September 18th to identify the forces of change that affect the community and public health system operation. A facilitated consensus building process was used to generate answers to the following question: "What is occurring or might occur that affects the health of our community or local public health system?" Participants brainstormed trends, factors, and events, organizing them into common themes and

Top 5 Themes

- 1. Access to Care
- 2. Financial
- 3. Behavior
- 4. Municipal infrastructure
- 5. Mental health

then providing an overarching 'force' for each of the category columns. The following are examples of trends, forces and events:

- **Trends** Patterns over time, such as migration in and out of the community or growing disillusionment with government
- **Factors** Discrete elements, such as a community's large ethnic population, an urban setting, or proximity to a major waterway
- Events One time occurrences, such as a hospital closure, a natural disaster, or the passage of new legislation

Threats Posed Financial Access to Care Decrease in Federal and State funding Low self-care competency: Inability to navigate individual healthcare - health opportunities management, communicate, Shortage of providers, increased inequity; understanding rights and increased disease rates responsibilities, ability to understand Decreasing enrollment in higher education health insurance plans and eligibility for assistance programs. Health care Increase in child abuse and the need for foster provider-patient interaction, clinical parenting encounters, diagnosis and treatment of Poor lifestyle choices: Increase in substance abuse; illness, and medication misinformation. anti-vaccination; unprotected sex Ability to understand and utilize health **Municipal Infrastructure** services; health literacy Poverty; health; access to health Lack of low cost housing providers New construction and migration of stores to Decrease of healthcare funding: Low Panama City Beach Income Pool (LIP) funding; State not **Mental Health** accepting Federal funds; not expanding Limited facilities for patients with mental health Medicaid; ICD-10 conversion conditions but high levels of people with mental Increased mental health issues and lack illness, those who are homeless and with of funding; suicide; morbidity & substance abuse issues mortality; stigma; lack of access to Increase in suicide rate: crime and violence: quality mental health services: limited human trafficking funding for mental health

Additional information regarding the Forces of Change Assessment can be found in Appendix II.

Community Strengths & Themes Assessment

The Task Force meeting on October 16, 2015 centered on identifying common community themes and strengths that can affect the health of the community. For this assessment, community participants broke out into four (4) groups to answer a series of open ended questions, participants identified several reoccurring themes throughout the community. Following submission of ideas by individual participants, a full group discussion among all participants identified several key themes.

What is important to our community?

Very Important	Fairly Important	Less Important
Mental Health	Access to Clinical Services	Injury Prevention
Obesity / Diabetes	Chronic Disease Prevention and Control	Emergency Preparedness
Maternal Child Health	Health Education and Promotion	Literacy

	Themes		
	Open Ended Questions		Common Themes
	What makes you most proud of our community?	•	Community Collaboration
i	What would excite you enough to be involved or more involved in improving our community?		Expansion of affordable housing More effective transportation system Visible outcomes
(What do you believe is keeping our community from doing what needs to be done to improve health and quality of life?	•	Governmental apathy Lack of follow through Lack of funding/prioritization of funds
1	What are two to three important issues that must be addressed in order to improve the quality of life in our community?	•	Access to mental health services Affordable housing Transportation system
	What initiative would you support toward establishment of a healthier community	•	Transportation system Affordable housing Expansion of mental health services and access for the working poor.

Additional information regarding Community Themes and Strengths can be found in Appendix III.

Community Survey

Between September 18 and October 19, 2015, the Task Force conducted a Community Health Survey with a total of 1,538 respondents from Bay County. Those who responded were categorized as either General Population or Vulnerable Population. The breakdown of these categories follows:

County	General	Vulnerable	Total
	Population	Population	Respondents
Bay	960	570	1,538

Overall themes and Community Concerns included: Access to health services; obesity/excess weight; mental health care; drug and alcohol abuse. Full Survey and Responses are included in Appendix III.

Summary of Responses			
Question : The top responses of each population grouping are shown below.	General Population	Vulnerable Population	
Features of a Healthy Community	Access to health services; active lifestyles/outdoor activities; employers that provide a sustainable living wage	Access to health services	
Most Important Health Issues*	Drug abuse; obesity/excess weight; lack of affordable health care	Fire-arm related injuries; motor vehicle crash; child abuse	
Most Concerning Unhealthy Behaviors	Drug abuse; alcohol abuse; excess weight	Drug abuse; alcohol abuse; homelessness	
Hard to get Health Services	Mental health services	Dental care	
Reasons for Delaying Medical Care	No, I did not have a delay in getting care; could not afford	Could not afford; No, I did not have a delay in getting care	

Summary of Responses (cont.)			
Question : The top responses of each population grouping are shown below.	General Population	Vulnerable Population	
My health today	Healthy	Healthy	
The Health of my community	Good	Fair	
Quality of Health Services	Somewhat healthy	Somewhat healthy	
Where to go when sick	My family doctor	My family doctor	
Where to go for Mental Health Services	Private psychologist, psychiatrist or other mental health professional	I do not know where to go for mental health care	
Factors preventing Healthy Eating and Active Lifestyle	Do not have time to be more active; too expensive to cook/eat healthy foods	Too expensive to cook/eat healthy foods	

Local Public Health System Assessment

Partners from Bay County's local public health system convened on September 18, 2015 to initiate the LPHSA.

Each Essential Health Service was discussed using the Model Standard. The 30 Model Standards serve as quality indicators that are aligned with the 10 essential public health service areas.

Participants scored responses to assessment questions using individual voting cards corresponding to the scale below. Each participant's vote was counted and recorded. Each Model Standard was discussed as a group before voting was tallied.

Participants were encouraged to vote on the areas of service they were familiar with. Participants were also encouraged to voice concerns about areas of service that would impact their organization. The complete report provides a breakdown of those comments, concerns, and opinions categorized by each Essential Service.

The 10 Essential Public Health Services

- Monitor health status to identify community health problems.
- Diagnose and investigate health problems and health hazards in the community.
- Inform, educate and empower people about health issues.
- Mobilize community partnerships to identify and solve health problems.
- Develop policies and plans that support individual and community health efforts.
- Enforce laws and regulations that protect health and ensure safety.
- Link people to needed personal health care services and assure the provision of health care when otherwise available.
- Assure a competent public health and personal health care workforce.
- Evaluate the effectiveness, accessibility, and quality of personal and population-based health services.
- Research for new insights and innovative solutions to health problems.

	Essential Service Rating System – Performance Relative to Optimal Activity
Optimal Activity (76-100%)	Greater than 75% of the activity described within the question is met.
Significant Activity (51-75%)	Greater than 50%, but no more than 75% of the activity described within the question is met.
Moderate Activity (26-50%)	Greater than 25%, but no more than 50% of the activity described within the question is met.
Minimal Activity (1-25%)	Greater than zero, but no more than 25% of the activity described within the question is met.
No Activity (0%)	0% or absolutely no activity.

The following charts provide a composite summary of the performance measures for all 10 Essential Services.

Optimal Optima			
there were no optimal results			
Significant	Moderate		
Monitor Health Status	Monitor Health Status		
Community health	Communication of data		
Diagnose and Investigate	<u>Diagnose and Investigate</u>		
Identification/ Surveillance	Natural and intentional disaster response		
Educate/ Empower	<u>Develop Policies/Plans</u>		
 Health Communication Health Education/ Promotion Mobilize Partnerships Community Partnerships Evaluate Services Evaluation of Population Health Evaluation of Personal Health Services Evaluation of Local Public Health System 	 Government Presence Policy Development Community Health Improvement/ Strategic Planning Mobilize Partnerships Constituency Development 		
<u>Link to Health Services</u>	Minimal		
 Personal Health Service Needs Assure Linkage Enforce Laws 	Mobilize Partnerships • Academic and research institutions		
Review Laws			
Assure Competent Workforce			
Workforce Standards Continuing Education			

Additional information regarding Local Public Health System Assessment can be found in Appendix II.

Community Health Status Assessment

Indicator Selection

A review of health status assessments from the following organizations: Healthy People 2020, Community Commons, Florida CHARTS' County Health Profile, Robert Wood Johnson's County Health Rankings, and previous assessments revealed a cross section of many common indicators. From this cross section, state and county data for 163 health status indicators and 28 demographic indicators were collected.

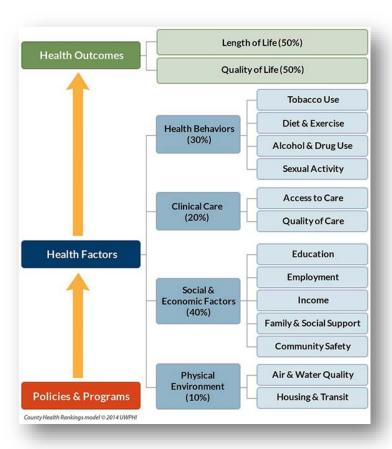
Data Sources

Data sources included: Florida CHARTS, Florida Department of Health, Agency for Health Care Administration, County Health Rankings and Roadmaps, Florida Department of Children and Families, US Department of Health & Human Services, Feeding America, USDA Economic Research Service, Florida Department of Law Enforcement, US Census Bureau, Federal Bureau of Labor and Statistics, and US Department of Housing and Urban Development. A complete list of data sources can be found in Appendix I.

Framework for Analysis

To identify the issues that hold the greatest priority for the community, the indicator results were evaluated within the framework of the **County Health Rankings Model** created by the *University of Wisconsin Population Health* and the *Robert Wood Johnson Foundation*. The framework emphasizes factors, that when improved, can help improve the overall health of a community. This model is comprised of three major components:

- Health Outcomes This component evaluates the health of a community as measured by two types of outcomes: how long people live (Mortality/Length of Life) and how healthy people are when they are alive (Morbidity/Quality of Life).
- Health Factors Factors that influence the health of a community including the activities and behavior of individuals (*Health Behaviors*), availability of and quality of health care services (Clinical Care), the socio-economic environment that people live and work in (Social and Economic Factors) and the attributes and physical conditions in which we live (Physical Environment). Although an individual's biology and genetic plays a role in determining health, the community cannot influence or modify these conditions and therefore these factors are not included in the model. These factors are built from the concept of Social Determinants of Health.



• Programs and Policies - Policies and programs local, state and federal level have the potential to impact the health of a population as a whole (i.e. smoke free policies or laws mandating childhood immunization). As illustrated, *Policies & Programs* influence *Health Factors* which in turn causes the *Health Outcomes* of a community. *Health Outcomes* are improved when *Policies & Programs* are in place to improve *Health Factors*.

Benchmarking

For comparison, each indicator was measured against the performance of the state of Florida as a whole. According to United Health Foundation's, *America's Health Rankings* 2015, the state of Florida ranked just in the bottom third (33rd) of all states across the core measures of Behaviors, Community & Environment, Policy, Clinical Care, and Outcomes. Florida's rank for each dimension is shown in the accompanying table. Lower scores indicate a healthier

America's Health Rankings - Florida		
Dimension	Rank	
Overall	33	
Behaviors	27	
Community & Environment	30	
Policy	47	
Clinical Care	33	
Outcomes	33	
Source: United Health Foundation		

population; thus the health status of Florida residents ranks near the bottom of the nation. Our local community aspires to be healthier than the state average.

County Health RankingsRankDimensionBayHealth Outcomes47Length of Life (Mortality)43Quality of Life (Morbidity)53Health Factors42Health Behaviors51Clinical Care39Socioeconomic21		
Health Outcomes47Length of Life (Mortality)43Quality of Life (Morbidity)53Health Factors42Health Behaviors51Clinical Care39	County Health Rankings	Rank
Length of Life (Mortality)43Quality of Life (Morbidity)53Health Factors42Health Behaviors51Clinical Care39	Dimension	Bay
Quality of Life (Morbidity)53Health Factors42Health Behaviors51Clinical Care39	Health Outcomes	47
Health Factors42Health Behaviors51Clinical Care39	Length of Life (Mortality)	43
Health Behaviors 51 Clinical Care 39	Quality of Life (Morbidity)	53
Clinical Care 39	Health Factors	42
ommour our o	Health Behaviors	51
Socioeconomic 21	Clinical Care	39
	Socioeconomic	21
Physical Environment 64	Physical Environment	64
Source: County Health Rankings - 2015	Source: County Health Rankings - 2015	

County Health Rankings produces a similar report ranking the counties in each state. In a state that does poorly across the nation, Bay County performs poorly with a rank of 47 out of the 67 counties in Health Outcomes and 42 in Health Factors. The concern for Bay County, however, is that the ranking for Health Factors has dropped from 32 (2013) to 38 (2014) and now 42. The continuation of this trend will lead to poorer performance in overall Health Outcomes. Current, Health Outcomes and Health Factors rankings and are displayed here.

Results

Out of the 163 indicators, Bay County performed worse than the state in 105 of them. About half of them, 61 indicators, showed a worsening trend. Below is a summary of the indicators performing worse than the state for Bay County. Individual indicator results can be found in Appendix I.

Health Outcomes

Mortality - Length of Life

- · Premature death
- Heart disease deaths
- Chronic lower respiratory deaths
- Deaths from smoking-related cancers
- Lung cancer deaths
- Diabetes deaths
- Cancer deaths
- Injury deaths
- Suicide deaths
- Chronic Liver disease

- Pneumonia
- Nephritis
- Motor vehicle accident deaths
- Infant mortality
- Neonatal deaths
- Stroke deaths
- Homicide
- Post neonatal deaths
- Prostate cancer deaths

Morbidity - Quality of Life

- Total cancer incidence
- Prostate cancer incidence
- Lung cancer incidence

- Breast cancer incidence
- High blood pressure (Adult)
- Diabetic monitoring

Health Factors

Health Behaviors

- Smokers (Adult)
- Live births with mother smoking during pregnancy
- Secondhand smoke exposure (children)
- Smoked in last 30 days (Adolescents)
- Never smoked (Adult)
- Tobacco Quit attempt (Adult)
- Former smokers (Adult)
- Alcohol consumption in past 30 days (adolescents)
- Cigarette use (adolescents)
- Binge drinking (adolescents)
- Alcohol Consumption in Lifetime (Adolescents)
- Marijuana or Hashish Use (Adolescents)
- Blacking out from drinking Alcohol (Adolescents)
- Sedentary Adults
- Obesity (Adult)
- Overweight (Youth)
- Food Insecurity
- Food Access Low Low Income Population
- SNAP Participants
- Healthy Weight (Adult)
- Fruits and Vegetables Consumption 5 servings per day (Adult)
- Grocery Store Access
- Vigorous physical activity recommendations met (Adult)

- **Clinical Care**
- Dental Care Access by Low Income Persons
- Population Receiving Medicaid Rate per 100,00
- Primary Care Access
- Percentage of adults who could not see a doctor at least once in the past year due to cost
- Diabetic Annual Foot Exam (Adults)
- Diabetic Semi-Annual A1C Testing (Adult)
- Adults who have a personal doctor
- Cancer Screening in past two years PSA (Men age 50 & older)
- Cancer Screening Mammogram
- Cancer Screening Pap Test
- Vaccination (kindergarteners)
- Salmonellosis
- Meningitis, Other Bacterial, Cryptococcal, or Mycotic
- Whooping Cough
- Vaccine Preventable Disease for All Ages
- ED Visits Acute Conditions Hypoglycemia
- ED Visits Avoidable Conditions Dental
- ED Visits Chronic Conditions Angina
- Dentists (per population)
- Adult substance abuse beds (per population)
- Skilled nursing beds (per population)
- Mental health providers (per population)
- Family Practice Physicians (per population)
- Internists (per population)
- Physicians (per population)
- Unhealthy mental days
- Adults with good to excellent overall health
- Poor or fair health
- Average number of days where poor mental or physical health interfered with activities of daily living in the past 30 days
- Prenatal Care Begun in First Trimester
- Prenatal Care Begun Late or No Prenatal Care
- Births to Mothers Ages 10-14 (Resident)
- Births to Mothers Ages 10-16
- Births to Mothers Ages 15-19 (Resident)
- Live births where mother smoked during pregnancy (rate)
- Medicaid birth rate
- Births to Obese Mothers (rate)
- Breast feeding Initiation

Socioeconomic

- High school graduation (rate)
- Real Per Capita Income
- Poverty Rate
- Population > 25 without a high school diploma
- Households with No Motor Vehicle
- Domestic Violence Offenses
- Forcible Sex Offenses
- Aggravated Assault
- Murder
- Property Crimes
- Violent Crime

Physical Environment

- Driving alone to work
- Use of Public Transportation
- Air pollution particulate matter
- Drinking water violations

COMMUNITY HEALTH PRIORITIES

Process

Representatives of Bay Medical Center, Sacred Heart Health System, Department of Health in Bay County, Gulf Coast State College and the Bay County Community Task Force met on November 11, 2015 to review indicator data collected to identify issues in which Bay County performed worse than the state of Florida. The Data Review Committee utilized "PEARL" criteria (below) to identify key health priorities for further community input.

- **P** Propriety, is the problem one that falls within the overall mission?
- **E** Economic Feasibility, does it make economic sense or are there economic consequences if the issue is not addressed?
- **A** Acceptability, will the community accept the problem being addressed?
- **R** Resources, are resources available?
- **L** Legality, do current laws allow the problem to be addressed?

On November 20, 2015 a presentation of the assessment and indicator findings was provided to nineteen community partners which included the MAPP process, the health indicators by performance. Again, the PEARL criteria was used in consideration of the key health issues facing Bay County. Following the presentation and discussion, the community selected three health priority areas on which to focus efforts. Additional information regarding Community Health Assessment meeting can be found in Appendix IV.

The responsibility to improve the health of the community does not and should not fall to the shoulders of one person, one community group, or one organization. It will take a coordinated community effort across all sectors (education, health care, business, government, etc.) to improve the health of Bay County. Success depends on the ability to rally the community to address the selected priority.

Community Health Priorities

The Bay County Community Health Care Task Force completed this process with a holistic review of the data gathered in each of the assessments to identify overarching themes and health issues. The Community Health Priorities for the Bay County community will be:

- Healthy Weight
- Chronic Disease Including Diabetes
- Mental Health & Substance Abuse

In addition to these, the following has been identified as health concerns:

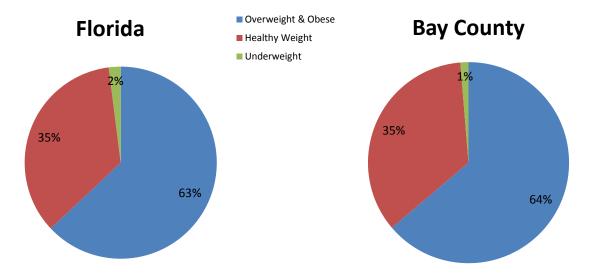
• Preventable Disease

While this concern is not a priority for the County, it is important to understand how this issue can affect the community and provide opportunity for organizations and community groups within the county to address the health concern.

To better understand the impact these health issues have on the community, the Community Health Priorities are discussed in greater detail in the following sections.

Healthy Weight

The Centers for Disease Control and Prevention (CDC) reports that more than one third of adults in the United States are obese. With an estimated medical cost of \$147 billion in 2008, annual medical costs for obese people was \$1,429 higher than normal weight people (CDC-Overweight and Obesity).



As shown above, in Bay County 64% of total adult population is overweight or obese. Looking at overweight and obese populations separately, the percent of the population overweight for Bay County is below the state of Florida. However, Bay County has a higher rate of obese adults than Florida.

Overweight and obesity are measured by Body Mass Index (BMI), an estimate of body fat as seen in the illustration to the right.

There is a significant disparity between obesity and race/ethnicity throughout the United States. Non-Hispanic blacks have the highest age-adjusted obesity rates (49.5%) compared with Mexican Americans (40.4%), all Hispanics (39.1%) and non-Hispanic whites (34.3%). With non-Hispanic black men and Mexican American black men, those with higher income are more likely to be obese than those with low income. Higher income women are less likely to be obese than

Body Mass Index (BMI)

Adults (21 and over)

Obesity 30.0 or higher

Overweight 25.0 and 29.9

Children & Adolescents (2-20 years)

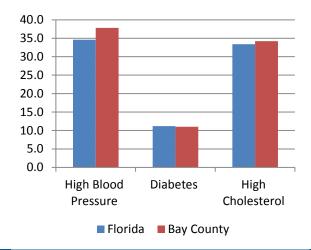
Obesity above the 95th percentile of the sex-specific CDC BMI for-age growth charts

low-income women, and women with college degrees are less likely to be obese compared to women with less education. There is no significant relationship between obesity and education among men (CDC-Overweight and Obesity). The obesity rate in Bay County (28%) has been slowly increasing over the last three years, and remains higher than the Florida rate (26%). Childhood obesity is an even greater growing concern for the entire nation. Obesity now affects 17% of all children and adolescents in the United States, triple the rate from just one generation ago (CDC-Overweight and Obesity). While child obesity rates are difficult to measure at a county level, it remains a community problem.

The graph to the right shows rates for Diabetes, High Blood Pressure and High Cholesterol. Community wide improvements in healthy weight will impact the associated chronic diseases. Albeit, it will take years for the impact of the improvements made by the community to affect related chronic disease outcomes.

Influences on Weight

To insure the effectiveness of interventions, it is important to understanding the personal, social, economic, and environmental barriers to and facilitators of changes in diet or physical activity including:



Diet

- Knowledge and attitudes
- Skills social support
- Food and agricultural policies
- Food assistance programs
- Economic price systems
- Marketing also influences people's particularly children's—food choices
- Access and availability of healthier foods
- Dining out influences a person's diet as they often have a higher in calories.

Physical Activity

- Low income
- Lack of time
- Low motivation
- Rural residency
- Lack of social support from peers, family, or spouse
- Overweight or obesity
- Physical environment
- Presence of sidewalks
- Access to public transportation

Resources in Bay County potentially available to address the Healthy Weight priority health issue include the following:

- Community Health Task Force
- FDOH-Bay County's Healthy Bay
- Sacred Heart-Bay Medical Center
- Gulf Coast Medical Center
- Community Health Center of Bay County
- St Andrew Community Medical Center
- Agency for Health Care Administration (Medicaid, KidCare)
- County government
- Bay Medical Bay Medical Healthplex
- Bay County Fitness Improvement Team
- Bay District Schools

- Homeless & Hunger Coalition County/City Parks and Recreation
- Panama City Women's Club
- FDOH-Bay County Women, Infants and Children (WIC)
- Local gyms
- University of Florida Extension Office
- Diabetes Action Team
- Nation's Best Wellness Program
- NAMI
- AHEC

Healthy Weight and Related Indicators

Legend:

County Performance	County Trend:	
Better than Florida	Worsening: increasing or decreasing	+ +
Worse than Florida	Improving: increasing or decreasing	+ +
Same as Florida	No Change	•

Health Outcome - Mortality (Deaths)				
Indicator	Latest Data Period	Performance	Trend	
Premature Death	2010-12	8,475	•	
Cancer Deaths	2012-14	170.7	+	
Colon, Rectal or Anus Cancer Deaths	2012-14	10.7	+	
Diabetes Deaths	2012-14	35.4	•	
Heart Disease Deaths	2012-14	206.2	1	
Stroke Deaths	2012-14	34.0	1	
Health Outcome - Morbidity (Quality of Life)				
Indicator	Latest Data Period	Performance	Trend	
Total Cancer Incidence	2009-11	515.6	1	
Breast Cancer Incidence	2009-11	121.7	•	

Indicator	Latest Data Period	Performance	Trend
Total Cancer Incidence	2009-11	515.6	•
Breast Cancer Incidence	2009-11	121.7	•
Colon and Rectum Cancer Incidence	2009-11	36.8	
Diabetic monitoring	2012	75.0	•
Diabetes (Adult)	2013	11.0	1
High Blood Pressure (Adult)	2013	37.8	
High Cholesterol (Adult)	2013	34.2	•
High Blood Pressure Controlled (Adult)	2013	72.3	•
Heart Disease (Adult)	2013	11.9	•
Low birth weight	2012-14	7.8	
Poor or fair health	2013	20.0	•

Health Behavior - Diet and Exercise			
Indicator	Latest Data Period	Performance	Trend
Healthy Weight (Adult)	2013	34.9	1
Overweight (Adult)	2013	35.7	
Obesity (Adult)	2013	28.1	
Births to Obese Mothers	2012-14	24.0	1
Births to overweight mothers	2012-14	22.6	1
Breast feeding Initiation	2012-14	72.6	•
Overweight (Adolescents)	2014	16.3	•
Overweight or Obesity (Adolescents)	2014	27.6	•
Healthy Weight (Adolescents)	2014	68.1	•
Vigorous physical activity recommendations met (Adult)	2007	22.9	
Exercise opportunities	2013 & 10	0.8	•
Sedentary Adults	2013	29.6	1
Fruits and Vegetables Consumption 5 servings per day (Adult)	2013	13.2	•
Food Insecurity	2013	17.4	1
Grocery Store Access	2013	20.0	•
Food Access Low - Low Income Population	2010	0.1	•
Fast Food Restaurant Access	2013	26.5	•
SNAP Participants	2011	17.7%	•
Clinical Care	- Quality of 0	Care	
Diabetic Annual Foot Exam (Adults)	2013	56.4	+
Diabetic Semi-Annual A1C Testing (Adult)	2013	63.4	+
ED Visits - Acute Conditions - Hypoglycemia	2014	0.3	
ED Visits - Chronic Conditions - Congestive Heart Failure	2014	1.0	•
ED Visits - Chronic Conditions - Diabetes	2014	4.4	•
ED Visits - Chronic Conditions - Hypertension	2014	7.8	•
Physical Environment			
Households with No Motor Vehicle	2013	5.7%	•
Driving alone to work	2013	83.3%	•
Use of Public Transportation	2013	0.6%	•

Chronic Disease including Diabetes

Chronic diseases and conditions such as type 2 diabetes, heart disease, stroke, cancer, are among the most common, costly, and preventable of all health problems.

As of 2012, about half of all adults (117 million people) had one or more chronic health conditions. One of four adults had two or more chronic health conditions. Seven of the top 10 causes of death in 2010 were chronic diseases. Two of these chronic diseases, heart disease and cancer, together accounted for nearly 48% of all deaths. Diabetes is the leading cause of kidney failure, lower-limb amputations other than those caused by injury, and new cases of blindness among adults.

Diabetes

Over 29 million people, or 9.3% of the adult population in the United States, have diagnosed or undiagnosed diabetes.26 Another 86 million people, or 37%, have prediabetes. Without lifestyle changes to improve their health, 15% to 30% of people with prediabetes will develop type 2 diabetes within five years. Many people with diabetes also have other chronic conditions, including 71% who have high blood pressure. There is a disproportionate burden of diabetes among racial and ethnic minorities including American Indian/Alaska Natives (15.9%), Non-Hispanic Blacks (13.2%) and Hispanics (12.8%). CHWs have unique and important roles to play in programs to prevent and control diabetes and other chronic conditions.

Hypertension (High Blood Pressure)

Hypertension is a major risk factor for heart disease, stroke, and renal disease. Hypertension affects almost one-third of the United States adults aged 18 and over (systolic blood pressure \geq 140 mmHg or diastolic \geq 90 mmHg). In 2009- 2010, over 80% of adults with hypertension were aware of their status and 76% were taking medications for hypertension. Among hypertensive adults, 70% were using antihypertensive medications, and 46% of those treated had their hypertension controlled. National Health and Nutrition Examination Survey (NHANES) data for 1999 to 2006 estimate that 30% of adults have prehypertension (blood pressure \geq 120–139/80–89 mmHg). Not surprisingly, hypertension affects certain subpopulations more than others. The prevalence of hypertension increases with age and is highest among older adults. Hypertension is also highest among non-Hispanic black adults, at approximately 42%.

Cancer

According to United States Cancer Statistics: 1999–2011 Incidence and Mortality Web-based Report, which tracks incidence for about 96% of the United States population and mortality for the entire country, in 2011 more than 576,000 Americans died of cancer and more than 1.53 million were diagnosed with that disease. Cancer does not affect all races and ethnicities equally; for example, African Americans are more likely to die of cancer than members of any other racial or ethnic group. In 2011, the age-adjusted death rate for both sexes per 100,000 people for all cancers combined was 199 for African Americans, 169 for whites, 112 for American Indians/Alaska Natives, 118 for Hispanics, and 106 for Asians/ Pacific Islanders.

Asthma

Asthma is a common, chronic disorder of the airways characterized by wheezing, breathlessness, chest tightness, and coughing at night or early in the morning; these episodes are known as asthma exacerbations or attacks. Airflow is obstructed by factors that narrow the airways in the lungs in reaction to certain exposures or "triggers," making it hard to breathe. Asthma continues to be a major public health concern. The number of reported cases has steadily increased since 1980. In 2001, 20 million people (1 in 14) in the United States had asthma. By 2011, that number had grown to 26 million

(1 in 12). The highest rates of asthma occur among children, women, multi-race and black Americans, and American Indians and Alaska Natives. In 2009 alone, there were over two million asthma-related emergency department visits and almost half a million hospitalizations; in 2010, 156 children and 3,248 adults died from asthma.

Resources in Bay County potentially available to address the Chronic Disease priority health issue include the following:

- Community Health Task Force
- Sacred Heart-Bay Medical Center
- Gulf Coast Medical Center
- Community Health Center of Bay County
- St Andrew Community Medical Center
- Agency for Health Care Administration (Medicaid, KidCare)
- County government
- Healthy Start
- Bay District Schools
- OB/GYNs

- Department of Children and Families
- FDOH-Bay County's Diabetes Services Program
- FDOH-Bay County School Health program
- FDOH-Bay County Abstinence Education Program
- Teen pregnancy centers and programs
- FDOH-Bay County Women, Infants and Children (WIC)
- BASIC NWFL
- CDC

Chronic Disease and Related Indicators

Legend:

County Performance	County Trend:	
Better than Florida	Worsening: increasing or decreasing	+ +
Worse than Florida	Improving: increasing or decreasing	+ +
Same as Florida	No Change	•

Health Outcome - Mortality (Deaths)				
Indicator	Latest Data Period	Performance	Trend	
Premature Death	2010-12	8,475	•	
Diabetes Deaths	2012-14	35.4	•	
Heart Disease Deaths	2012-14	206.2	•	
Stroke Deaths	2012-14	34.0	•	
Chronic Liver Disease, Cirrhosis Deaths	2012-14	17.5	•	
Nephritis, Nephritic Syndrome, and Nephrosis Deaths	2012-14	14.7	•	
Chronic Lower Respiratory Disease Deaths	2012-14	71.7	•	
HIV/AIDS Deaths	2012-14	4.1	1	

Health Outcome - Morbidity (Quality of Life)

Indicator	Latest Data Period	Performance	Trend
Diabetic monitoring	2012	75.0	•
Diabetes (Adult)	2013	11.0	•
High Blood Pressure (Adult)	2013	37.8	•
High Cholesterol (Adult)	2013	34.2	•
High Blood Pressure Controlled (Adult)	2013	72.3	•
Heart Disease (Adult)	2013	11.9	•
Asthma (Adult)	2013	8.4	•
Hepatitis C, Acute	2012-14	0.8	•
HIV	2012-14	22.1	
AIDS	2012-14	8.7	
Tuberculosis	2012-14	1.7	
Adults with good to excellent overall health	2013	80.0	•
Poor or fair health	2013	20.0	1

Clinical Care - Access to Health Care

Indicator	Latest Data Period	Performance	Trend
Primary Care Access	2012	54.1	•
Physicians	FY 11/12 - FY 13/14	229.0	•
Family Practice Physicians	FY 11/12 - FY 13/14	20.0	•
Internists	FY 11/12 - FY 13/14	47.8	•
Acute Care Beds	2012-14	295.7	•
Rehabilitation beds	2012-14	43.9	

Clinical	Care -	Quality	of Care
	Gaio	L acinty	

Indicator	Latest Data Period	Performance	Trend
Diabetic Annual Foot Exam (Adults)	2013	56.4	
Diabetic Semi-Annual A1C Testing (Adult)	2013	63.4	•
HIV Testing (Adult age 65 and over)	2013	52.9	1
ED Visits - Acute Conditions - Hypoglycemia	2014	0.3	•
ED Visits - Avoidable Conditions - Dental	2014	20.2	•
ED Visits - Chronic Conditions - Angina	2014	0.4	
ED Visits - Chronic Conditions - Asthma	2014	9.8	•
ED Visits - Chronic Conditions - Congestive Heart Failure	2014	1.0	•
ED Visits - Chronic Conditions - Diabetes	2014	4.4	•
ED Visits - Chronic Conditions - Hypertension	2014	7.8	•
Preventable hospital stays	2011-13	1,441	•

Physical Environment

Indicator	Latest Data Period	Performance	Trend
Air pollution - particulate matter	2008	0.3	•
Air Quality - Ozone	2008	0.00	•
Drinking water violations	FY 2013-14	31.00	•

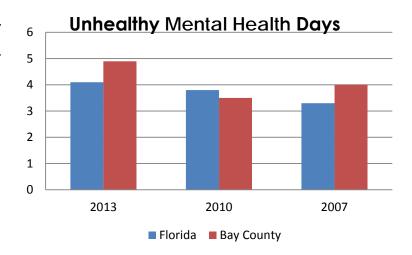
Mental Health and Substance Abuse

Mental Health

Overall health depends on both physical and mental well-being. Measuring the number of days when people report that their mental health was not good, i.e., poor mental health days, represents an important facet of health-related quality of life. Mental health includes emotional, psychological and social well-being. It affects how we think, feel and act. It also helps determine how we handle stress, relate to others and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

In Bay County, Life Management Center and Emerald Coast Behavorial Hospital offer emergency services for psychiatric needs, and several organizations offer community based outpatient programs and residential treatment centers. While data is available for those who receive treatment, data on mental health of the general population

is very limited, especially at the local level. According to the Center for Disease Control the citizens of Bay County experience a higher number of mentally unhealthy days in comparison to the state at 4.5 days with top performers in the U.S. at 2.3 days, see chart above. Health-related quality of life (HRQoL) is a multidimensional concept that includes domains related to physical, mental, emotional and social functioning. It goes beyond direct measures of population health, life expectancy and causes of death and focuses on the impact health status has on quality of



life. The CDC has defined HRQoL as "an individual's or group's perceived physical and mental health over time."

Nationally, males are about four times more likely to commit suicide than females. Older males have higher rates of suicide than younger males. In 2015, residents had 4.9 poor mental health days. The suicide death rate of Bay County residents' deaths is more than 20 per 100,000.

Mental health and wellness

Positive mental health allows people to:

- Realize their full potential
- Cope with the stresses of life
- Work productively
- Make meaningful contributions to their communities

Ways to maintain positive mental health include:

- Getting professional help if you need it
- Connecting with others
- Staying positive
- Getting physically active
- Helping others
- Getting enough sleep
- Developing coping skills

Substance Abuse

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues.

The effects of substance abuse are cumulative and significantly contribute to costly social, physical, mental, and public health problems. These problems include, but are not limited to:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence

- Child abuse
- Motor vehicle crashes
- Crime
- Homicide
- Suicide

Resources in Bay County potentially available to address this priority include the following:

- Community Health Task Force
- FDOH-Bay County
- Sacred Heart-Bay Medical Center
- Gulf Coast Medical Center
- Community Health Center of Bay County
- St Andrew Community Medical Center
- Life Management Center
- HealthSouth
- Chemical Addiction Recovery Effort
- Emerald Coast Behavioral Hospital
- Gulf Coast Children's Advocacy Center
- Anchorage Children's Home

- Childhood System of Care (DCF & Partners)
- Florida Therapy
- Department of Juvenile Justice
- 14th Circuit Judicial Court
- Salvation Army Domestic Violence
- Big Bend Community Based Care
- JourneyPure
- Private Providers
- Bay County School Board
- Rescue Mission
- Vet Center

Mental Health and Substance Abuse, and related indicators

Legend:

County Performance	County Trend:	
Worse than Florida	Worsening: increasing or decreasing	+ +
Better than Florida	Improving: increasing or decreasing	+ +
Same as Florida	No Change	•

Health Outcome - Mortality (Deaths)			
Indicator	Latest Data Period	Performance	Trend
Infant Mortality	2012-14	8.7	1
Neonatal Deaths (0-27 days)	2012-14	5.9	1
Post neonatal Deaths (28-364 days)	2012-14	3.2	
Chronic Liver Disease, Cirrhosis Deaths	2012-14	17.5	•
HIV/AIDS Deaths	2012-14	4.1	1
Suicide Deaths	2012-14	20.9	1
Motor Vehicle Accident Deaths	2012-14	14.8	1
Injury Deaths	2012-14	48.7	1
Homicide	2012-14	7.8	1

Health Outcome - Morbidity (Quality of Life)

Indicator	Latest Data Period	Performance	Trend
Low birth weight	2012-14	7.8	
Hepatitis C, Acute	2012-14	0.8	•
HIV	2012-14	22.1	
AIDS	2012-14	8.7	
Unhealthy mental days	2013	4.9	1
Average number of days where poor mental or physical health interfered with activities of daily living in the past 30 days	2013	6.1	•

Health Behavior - Alcohol / Substance Abuse

Indicator	Latest Data Period	Performance	Trend
Alcohol-related Motor Vehicle Traffic Crash Deaths	2012-14	7.4	•
Alcohol-related Motor Vehicle Traffic Crashes	2012-14	202.6	
Blacking out from drinking Alcohol (Adolescents)	2014	28.5	•
Marijuana or Hashish Use (Adolescents)	2014	14.7	1
Alcohol Consumption in past 30 days (Adolescents)	2014	31.1	1
Alcohol Consumption in Lifetime (Adolescents)	2014	51.1	+
Binge Drinking (Adolescents)	2014	12.5	•

Health Behavior - Sexual Activity

Indicator	Latest Data Period	Performance	Trend
Infectious Syphilis	2012-14	1.2	•
Sexually transmitted infections	2012-14	500.1	•
Births to Mothers under the age of Majority (10-14)	2012-14	0.5	
Births to Mothers under the age of Majority (10-16)	2012-14	3.5	•

Clinical Care - Access to Health Care								
Indicator	Latest Data Period	Performance	Trend					
Adult psychiatric beds	2012-14	39.8	↑					
Adult substance abuse beds	2012-14	0.0	•					
Pediatric psychiatric beds	2012-14	10.5						
Clinical Care - Quality of Care								
Indicator	Latest Data Period	Performance	Trend					
ED Visits - Chronic Conditions - Mental Health	2014	17.5	•					
Social and Ed	conomic Fa	ictors						
Indicator	Latest Data Period	Performance	Trend					
Domestic Violence Offenses	2014	818.6	+					
Forcible Sex Offenses	2014	66.4	+					
Aggravated Assault	2014	369	↑					
Murder	2014	9.9	↑					
Property Crimes	2014	4,166	↑					
Violent Crime	2014	526.3	•					

Health Issue: Preventable Disease

In America, the system has focused on treating people after they become sick. By shifting more resources to preventing disease and promoting good health—not only in the doctor's office but in our neighborhoods—we can help everyone in our community live as healthy as they can be. America spends \$2.7 trillion annually on health care—more than any other nation. Too often, however, the health care system focuses more on treating disease and injury after they happen. The United States spends hundreds of billions of dollars annually to treat preventable illnesses and diseases. For instance, health care expenditures tied to smoking total \$96 billion. Costs associated with conditions caused by obesity include more than \$43 billion for hypertension and nearly \$17 billion for diabetes.

Part of the reason the United States spends so much on health care is that millions of Americans are in poor health. Chronic conditions such as heart disease, cancer, stroke and diabetes are responsible for seven in 10 deaths among Americans each year, and account for nearly 75 percent of the nation's health spending. Approximately 45 percent of the population has at least one chronic health condition.

Creating a culture of health in the United States requires a commitment to prevention. Preventing disease and injury is the most cost-effective, common-sense way to improve health.

Promote Disease Prevention

- More than half of all Americans live with one or more chronic disease, like heart disease, diabetes and stroke.
- Seven out of 10 deaths in the United States are due to chronic diseases.
- According to the U.S. Centers for Disease Control and Prevention (CDC), the majority of chronic diseases could be prevented through lifestyle and environmental changes. For example:
 - Reducing adult smoking rates by one percent could result in more than 30,000 fewer heart attacks, 16,000 fewer strokes, and savings of more than \$1.5 billion over five years.
 - o If one-tenth of Americans began a regular walking program, \$5.6 billion could be saved in the treatment of heart disease.
 - o Routine childhood vaccinations prevent more than 14 million cases of disease annually.
 - o Routine childhood vaccinations result in \$50 billion saved annually in direct and indirect costs.
- Bay County residents show of an increasing trend of people of all ages that do not receive a vaccine for preventable diseases as well as meningitis and whooping cough.

Next Steps

The next step in the Bay County Health Improvement process will be to focus on community implementation planning, which include program planning and evaluation metrics for each priority. Specific objectives for this phase will include, but not be limited to:

- **★** Organizing work groups to develop action plan(s)
- * Identifying health improvement initiatives that are best practices for each priority
- * Establishing an evaluation plan, including measurable outcome indicators
- ***** Communicating progress and results to the Bay County community.

Appendix I Health Status Indicators, Definitions and Sources

Legend:

County Performance	County Trend:	
Better than Florida	Worsening: increasing or decreasing	+ +
Worse than Florida	Improving: increasing or decreasing	+ +
Same as Florida	No Change	•

Health Outcome - Mortality (Deaths)						
		Bay Cou	nty	Related Priorities		ties
Indicator	Latest Data Period	Performance	Trend	Healthy Weight	Mental Health / Substance Abuse	Chronic Disease
Premature Death	2010-12	8,475	•	✓		✓
Cancer Deaths	2012-14	170.7		✓		
Breast Cancer Deaths	2012-14	20.2				
Prostate Cancer Deaths	2012-14	18.3				
Lung Cancer Deaths	2012-14	59.5				
Deaths from Smoking-related Cancers	2010-12	87.6	•			
Colon, Rectal or Anus Cancer Deaths	2012-14	10.7		✓		
Diabetes Deaths	2012-14	35.4	•	✓		✓
Heart Disease Deaths	2012-14	206.2	•	✓		✓
Stroke Deaths	2012-14	34.0	•	✓		✓
Infant Mortality	2012-14	8.7	•		✓	
Neonatal Deaths (0-27 days)	2012-14	5.9	•		✓	
Post neonatal Deaths (28-364 days)	2012-14	3.2			✓	
Chronic Liver Disease, Cirrhosis Deaths	2012-14	17.5	•		✓	✓
Nephritis, Nephritic Syndrome, and Nephrosis Deaths	2012-14	14.7	•			✓
Chronic Lower Respiratory Disease Deaths	2012-14	71.7	•			✓
Pneumonia, Influenza Deaths	2012-14	13.5	•			
HIV/AIDS Deaths	2012-14	4.1	•		✓	✓

		Bay Cou	Bay County Related Priorit			ties
Indicator	Latest Data Period	Performance	Trend	Healthy Weight	Mental Health / Substance Abuse	Chronic Disease
Suicide Deaths	2012-14	20.9	•		✓	
Motor Vehicle Accident Deaths	2012-14	14.8	•		✓	
Injury Deaths	2012-14	48.7	•		✓	
Homicide	2012-14	7.8	•		✓	
Health Outco	me - M	orbidity ((Qua	lity of	Life)	
Total Cancer Incidence	2009-11	515.6	•	✓		
Breast Cancer Incidence	2009-11	121.7	•	✓		
Prostate Cancer Incidence	2009-11	171.5	+			
Lung Cancer Incidence	2009-11	89.3	+			
Colon and Rectum Cancer Incidence	2009-11	36.8	•	✓		
Melanoma Cancer Incidence	2009-11	20.8	1			
Cervical Cancer Incidence	2009-11	9.4	•			
Diabetic monitoring	2012	75.0	•	✓		✓
Diabetes (Adult)	2013	11.0	•	✓		✓
High Blood Pressure (Adult)	2013	37.8	+	✓		✓
High Cholesterol (Adult)	2013	34.2	•	✓		✓
High Blood Pressure Controlled (Adult)	2013	72.3	•	✓		✓
Heart Disease (Adult)	2013	11.9	1	✓		✓
Asthma (Adult)	2013	8.4	•			✓
Low birth weight	2012-14	7.8	•	✓	✓	
Disability (Any)	2013	15.6%	•			
Hepatitis C, Acute	2012-14	0.8	•		✓	✓
HIV	2012-14	22.1	+		✓	✓
AIDS	2012-14	8.7	+		✓	✓
Salmonellosis	2014	34.9	•			
Meningitis, Other Bacterial, Cryptococcal, or Mycotic	2012-14	11.1	•			

		Bay County		Related Prioritie		ties
Indicator	Latest Data Period	Performance	Trend	Healthy Weight	Mental Health / Substance Abuse	Chronic Disease
Tuberculosis	2012-14	1.7				✓
Chicken Pox	2012-14	1.2	•			
Whooping Cough	2012-14	7.6	•			
Vaccine (selected) Preventable Disease for All Ages	2014	9.9	•			
Unhealthy mental days	2013	4.9	•		✓	
Average number of days where poor mental or physical health interfered with activities of daily living in the past 30 days	2013	6.1	•		√	
Adults with good to excellent overall health	2013	80.0				✓
Poor or fair health	2013	20.0	•	✓		✓

Health Behavior - Tobacco Use

		Bay County		Related Priorities		ties
Indicator	Latest Data Period	Performance	Trend	Healthy Weight	Mental Health / Substance Abuse	Chronic Disease
Smokers (Adult)	2013	25.7	•			
Former Smokers (Adult)	2013	32.4	•			
Never Smoked (Adult)	2013	41.9				
Tobacco Quit Attempt (Adult)	2013	67.1	•			
Smoked Cigarettes in last 30 days (Adolescents)	2014	7.8	•			
Cigarette Use (Adolescents)	2014	13.2	•			
Secondhand Smoke exposure (Children)	2014	41.8	•			
Live births where mother smoked during pregnancy	2012-14	16.0				

Health Behavior - Alcohol / Substance Abuse

		Bay Cou	nty	Rel	ated Priori	ties
Indicator	Latest Data Period	Performance	Trend	Healthy Weight	Mental Health / Substance Abuse	Chronic Disease
Alcohol-related Motor Vehicle Traffic Crash Deaths	2012-14	7.4	•		✓	
Alcohol-related Motor Vehicle Traffic Crashes	2012-14	202.6			✓	
Blacking out from drinking Alcohol (Adolescents)	2014	28.5	•		✓	
Marijuana or Hashish Use (Adolescents)	2014	14.7	•		✓	
Alcohol Consumption in past 30 days (Adolescents)	2014	31.1	•		✓	
Alcohol Consumption in Lifetime (Adolescents)	2014	51.1			✓	
Binge Drinking (Adolescents)	2014	12.5	•		✓	

Health Behavior - Diet and Exercise

		Bay County		Related Priorities		ties
Indicator	Latest Data Period	Performance	Trend	Healthy Weight	Mental Health / Substance Abuse	Chronic Disease
Healthy Weight (Adult)	2013	34.9	•	✓		
Overweight (Adult)	2013	35.7		✓		
Obesity (Adult)	2013	28.1		✓		
Births to Obese Mothers	2012-14	24.0	•	✓		
Births to overweight mothers	2012-14	22.6	•	✓		
Breast feeding Initiation	2012-14	72.6	•	✓		
Overweight (Adolescents)	2014	16.3	•	✓		
Overweight or Obesity (Adolescents)	2014	27.6	•	✓		
Healthy Weight (Adolescents)	2014	68.1	•	✓		
Vigorous physical activity recommendations met (Adult)	2007	22.9	•	✓		
Exercise opportunities	2013 & 10	0.8	•	✓		
Sedentary Adults	2013	29.6	•	✓		

		Bay Cou	nty	Rel	lated Priori	ties	
Indicator	Latest Data Period	Performance	Trend	Healthy Weight	Mental Health / Substance Abuse	Chronic Disease	
Fruits and Vegetables Consumption 5 servings per day (Adult)	2013	13.2	•	✓			
Food Insecurity	2013	17.4	•	✓			
Grocery Store Access	2013	20.0	•	✓			
Food Access Low - Low Income Population	2010	0.1	+	✓			
Fast Food Restaurant Access	2013	26.5	•	✓			
SNAP Participants	2011	17.7%	•	✓			
Health I	Health Behavior - Sexual Activity						
Infectious Syphilis	2012-14	1.2	•				
Sexually transmitted infections	2012-14	500.1	•				
Births to Mothers under the age of Majority (10-14)	2012-14	0.5					
Births to Mothers under the age of Majority (10-16)	2012-14	3.5	•				
Clinical Ca	are - Ac	cess to I	Heal	th Ca	re		
Uninsured Adults	2013	19.3	+				
Uninsured Children	2013	9.5	+				
Adults who could not see a doctor at least once in the past year due to cost	2013	21.1	1				
Population Receiving Medicaid	2013	18,475	•				
Medicaid births	2012-14	53.7	+				
Dental Care Access by Low Income Persons	2010-12	24.0	•				
Primary Care Access	2012	54.1				✓	
Mental health providers	2014	483:1	•				
Physicians	FY 11/12 - FY 13/14	229.0	•			✓	
Family Practice Physicians	FY 11/12 - FY 13/14	20.0	•			✓	
Internists	FY 11/12 - FY 13/14	47.8	•			✓	

		Bay County		Related Priorities		
Indicator	Latest Data Period	Performance	Trend	Healthy Weight	Mental Health / Substance Abuse	Chronic Disease
Pediatricians	FY 11/12 - FY 13/14	53.0	•			
OB/GYN	FY 11/12 - FY 13/14	10.4	•			
Dentists	FY 11/12 - FY 13/14	44.3	•			
Acute Care Beds	2012-14	295.7	•			✓
Adult psychiatric beds	2012-14	39.8	•		✓	
Adult substance abuse beds	2012-14	0.0	•		✓	
Pediatric psychiatric beds	2012-14	10.5	•		✓	
Rehabilitation beds	2012-14	43.9	•			✓
Nursing Home Beds	2012-14	570.3	•			
Clinical Care - Quality of Care						
Lack of Prenatal Care	2012-14	0.6				
Prenatal Care Begun Late or No Prenatal Care	2012-14	6.8				
Prenatal Care Begun in First Trimester	2012-14	73.7	•			
Adults who have a personal doctor	2013	72.1	•			
Cancer Screening - Mammogram	2013	51.1				
Cancer Screening in past two years - PSA (Men age 50 & older)	2010	72.2	•			
Cancer Screening - Sigmoidoscopy or Colonoscopy	2013	63.0	•			
Cancer Screening - Pap Test	2013	47.0				
Diabetic Annual Foot Exam (Adults)	2013	56.4	•	✓		✓
Diabetic Semi-Annual A1C Testing (Adult)	2013	63.4		✓		✓
HIV Testing (Adult age 65 and over)	2013	52.9	•			✓
Flu Vaccination in the Past Year (Adult age 65 and over)	2013	65.0	•			_
Flu Vaccination in the Past Year (Adult)	2013	33.5	•			
Pneumonia Vaccination (Adult age 65 and over)	2013	71.3	•			

		Bay Cou	nty	Related Priorities		
Indicator	Latest Data Period	Performance	Trend	Healthy Weight	Mental Health / Substance Abuse	Chronic Disease
Pneumonia Vaccination (Adult)	2013	33.8	•			
Vaccination (kindergarteners)	2012-14	95.0	•			
ED Visits - All Ambulatory Care Sensitive Conditions	2014	208.6	•			
ED Visits - Acute Conditions - Hypoglycemia	2014	0.3		✓		✓
ED Visits - Avoidable Conditions - Dental	2014	20.2				✓
ED Visits - Avoidable Conditions - Dental (from health dept)	2014	0.2	•			
ED Visits - Chronic Conditions - Angina	2014	0.4				✓
ED Visits - Chronic Conditions - Asthma	2014	9.8	•			✓
ED Visits - Chronic Conditions - Congestive Heart Failure	2014	1.0	•	✓		✓
ED Visits - Chronic Conditions - Diabetes	2014	4.4	•	✓		✓
ED Visits - Chronic Conditions - Diabetes (from Health Dept)	2012-14	39.8	•			
ED Visits - Chronic Conditions - Mental Health	2014	17.5	•		✓	
ED Visits - Chronic Conditions - Hypertension	2014	7.8		✓		✓
ED Visits - STDs	2014	0.5	•			
Preventable hospital stays	2011-13	1,441	•			✓
Admitted ED Visits - All Ambulatory Care Sensitive Conditions	2012-14	295.7	•			
Admitted ED Visits - Dental	2014	162.7	•			
Admitted ED Visits - Diabetes	2014	1.1	•			
Admitted ED Visits - STDs	2014	28.4	•			
Socia	and Ec	onomic	Fact	ors		
High school graduation	2013	70.8%	•			
Population 18 - 25 without a high school diploma	2013	18.2%	•			
Unemployment	2015 AUG	5.2	+			
Real Per Capita Income	2013	37,915	•			

		Bay Cou	nty	Related Priorities		
Indicator	Latest Data Period	Performance	Trend	Healthy Weight	Mental Health / Substance Abuse	Chronic Disease
Median Household Income	2013	47,461	•			
Poverty	2013	34.6%				
Children in poverty (based on household)	2013	21.6%				
Children Eligible for Free/Reduced Price Lunch	2013-14	58.0%	•			
Income - Public Assistance Income	2013	29.1%	•			
Housing Cost Burden	2009-13	36	•			
Children in single-parent households	2013	32.4%				
Population with Limited English Proficiency	2013	1.1%	•			
Domestic Violence Offenses	2014	818.6			✓	
Forcible Sex Offenses	2014	66.4			✓	
Aggravated Assault	2014	369	•		✓	
Murder	2014	9.9	•		✓	
Property Crimes	2014	4,166	•		✓	
Violent Crime	2014	526.3	•		✓	
Pł	nysical E	Environm	ent			
Air pollution - particulate matter	2008	0.3	•			✓
Air Quality - Ozone	2008	0.00	•			✓
Drinking water violations	FY 2013-14	31.00	•			✓
Severe housing problems	2008-12	17.5%	•			
Households with No Motor Vehicle	2013	5.7%	•	✓		
Driving alone to work	2013	83.3%	•	✓		
Use of Public Transportation	2013	0.6%	•	✓		

Population C	haracte	ristics	
		Bay County	
Indicator	Latest Data Period	Performance	Trend
Median Age	2014	39.7	•
Population Under Age 0-17	2014	37,585	1
Population Age 18-24	2014	15,454	•
Population Age 25-34	2014	23,549	•
Population Age 35-44	2014	20,839	•
Population Age 45-54	2014	24,677	•
Population Age 55-64	2014	22,634	•
Population Age 65+	2014	27,023	•
Total Population (ACS)	2013	170,704	•
Total Population (FL CHARTS)	2014	171,761	•
Female Population	2014	86,805	1
Female Population Age 10-14	2014	5,141	1
Female Population Age 15-19	2014	5,039	•
Female Population Age 20-44	2014	27,367	1
Male Population	2014	84,956	•
Male Population Age 50+	2014	29,711	•
Families with Children	2013	37.1%	•
Births to Mothers Ages 15-19	2012-14	39.5	•
Births to Mothers Ages 15-44	2012-14	34.7	•
Total Births (resident)	2014	2,328	1
Population by Race - White	2013	140,914	•
Population by Race - Black	2013	17,593	•
Population by Race - Native American	2013	971	1
Population by Race - Asian/Pacific Islander	2013	3,643	1
Population by Race - 2 or more races	2013	6,928	•
Population by Race - Other	2013	655	1
Veteran Population	2013	17.0%	•

Health Outcome - Mortality (Deaths)

Premature Death - Years of Potential Life Lost (YPLL) - Years of potential life lost (YPLL) before age 75 per 100,000 population (age-adjusted) The YPLL measure is presented as a rate per 100,000 population and is age-adjusted to the 2000 US population. Weblink:

http://www.countyhealthrankings.org/app/florida/2015/downloads

Data collection period: 3-year rolling

Source Data type: Rate
Smallest geographic level: County

Desired Target Direction: Low/Decrease

Note: Data collected is 3-year rolling average, must use 2015,2014 and 2012 for 3 data points

Source: CHR County Health Rankings. Original Data Source: National Center for Health

Statistics - Mortality Files.

Cancer Deaths - ICD-10 Code(s): C00-C97. Weblink:

http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0097

Breast Cancer Deaths - ICD-10 Code(s): C50. Weblink:

http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0084

Prostate Cancer Deaths - ICD-10 Code(s): C61. Weblink:

 $http://www.floridacharts.com/charts/DataViewer/DeathViewer/\underline{DeathViewer.aspx?indNumber=0093}$

Lung Cancer Deaths - ICD-10 Code(s): C33-C34. Weblink:

http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0092

Deaths from Smoking-related Cancers - Cancers include: Lip, Oral Cavity, Pharynx (C00-C14), Esophagus (C15), Larynx (C32), Trachea, Bronchus, Lung (C33-C34), Kidney & Renal Pelvis (C64-C65), Bladder (C67), Other/Unspecified Sites In Urinary Tract (C66, C68). Weblink:

 $\underline{http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndDataViewer.aspx?cid=0268}$

Colon, Rectal or Anus Cancer Deaths - Colorectal Cancer Deaths. Weblink:

http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0089

Diabetes Deaths - ICD-10 Code(s): E10-E14. Weblink:

http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0090

Heart Disease Deaths - ICD-10 Code(s): I00-I09, I11, I13, I20-I51. Weblink:

http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0098

Stroke Deaths - ICD-10 Code(s): I60-I69. Weblink:

http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0086

Infant Mortality - Deaths occurring within 364 days of birth. Weblink:

 $\underline{http://www.floridacharts.com/charts/DataViewer/InfantDeathViewer/InfantDeathViewer/InfantDeathViewer/InfantDeathViewer.aspx?indNumber=0053$

Neonatal Deaths (0-27 days) - Deaths occurring within 27 days of birth. Beginning in 2004, the state total for the denominator in this calculation may be greater than the sum of county totals due to an unknown county of residence on some records. Weblink:

http://www.floridacharts.com/charts/DataViewer/InfantDeathViewer/InfantDeathViewer.aspx?

Post neonatal Deaths (28-364 days) - Deaths occurring 28 to 364 days from birth. Note: Beginning in 2004, the state total for the denominator in this calculation may be greater than the sum of county totals due to an unknown county of residence on some records. Count Available. Weblink: http://www.floridacharts.com/charts/DataViewer/InfantDeathViewer/InfantDeathViewer.aspx?indNumber=0055

Chronic Liver Disease, Cirrhosis Deaths - Deaths from Chronic Liver Disease and Cirrhosis Deaths. Weblink:

http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0091

Nephritis, Nephritic Syndrome, and Nephrosis Deaths - Nephritis Deaths. ICD-10 Code(s): N17-N19. Weblink:

http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0391

Chronic Lower Respiratory Disease Deaths - ICD-10 Code(s): J40-J47. Weblink:

http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0088

Pneumonia, Influenza Deaths - CD-10 Code(s): J09-J18. Weblink:

 $\underline{http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0125}$

HIV/AIDS Deaths - ICD-10 Code(s): B20-B24. Weblink:

 $\underline{http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0122}$

Suicide Deaths - Suicide (All Means) Deaths. Weblink:

http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0116

Motor Vehicle Accident Deaths - Motor Vehicle Crashes Deaths. Weblink:

 $\underline{http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0110}$

Injury Deaths - Unintentional Injuries Deaths. Weblink:

http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0109

Homicide - Homicide (All Means) Deaths. Weblink:

http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0118

Data collection period: 3-year rolling

Source Data type: Rate
Smallest geographic level: County

Desired Target Direction: Low/Decrease

Note: Counts Available

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida

Charts. Original Data Source: FL DOH, Bureau of Vital Statistics

Health Outcome - Morbidity (Quality of Life)

Total Cancer Incidence - Cancer Incidence. Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndDataViewer.aspx?cid=0460

Breast Cancer Incidence - ICD-10 Code(s): C50. Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndDataViewer.aspx?cid=0448

Prostate Cancer Incidence - ICD-10 Code(s): C61. Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndDataViewer.aspx?cid=0450

Lung Cancer Incidence - ICD-10 Code(s): C33-C34. Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndDataViewer.aspx?cid=0446

Colon and Rectum Cancer Incidence - Colorectal Cancer Incidences. Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndDataViewer.aspx?cid=0445

Melanoma Cancer Incidence - New cases during time period. CD-10 Code(s): C43. Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndDataViewer.aspx?cid=0447

Cervical Cancer Incidence - New cases during time period. ICD-10 Code(s): C53. Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndDataViewer.aspx?cid=0449

Data collection period: 3-year rolling

Source Data type: Rate
Smallest geographic level: County

Desired Target Direction: Low/Decrease

Note: Rates are not displayed for fewer than 10 cases.

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: UM(FL) MS, Florida Cancer Data System

Diabetic monitoring - Percentage of Diabetic Medicare patients ages 65-75 whose blood sugar control was monitored in the past year using a test of their HbA1c levels. Weblink: http://www.countyhealthrankings.org/app/florida/2015/measure/factors/7/data

Data collection period:
Source Data type:
Smallest geographic level:
County

Desired Target Direction: High/Increase

Source: County Health Rankings and Roadmaps Dartmouth Atlas Project. Original Data Source:

Dartmouth Atlas of Health Care: CMS.

Diabetes (Adult) - Adults who have ever been told they had diabetes. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=21

High Blood Pressure (Adult) - Adults who have ever been told they had hypertension. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=15

High Cholesterol (Adult) - Adults who have ever been told they had high blood cholesterol.

Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=19

High Blood Pressure Controlled (Adult) - Adults with hypertension who currently take high blood pressure medicine. Weblink:

http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=72

Heart Disease (Adult) - Adults who have ever been told they had coronary heart disease, heart attack, or stroke. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=46

Asthma (Adult) - Adults who currently have asthma. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=20

Data collection period: Triennial

Source Data type: %
Smallest geographic level: County

Desired Target Direction: Low/Decrease

Note: Caution should be taken when comparing 2013 data with previous years due to changes in

survey methodology to include respondents via cellular phones in addition to land lines.

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: Florida BRFSS

Low birth weight - Live Births under 2,500 Grams. Weblink:

http://www.floridacharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=0021

Data collection period: 3-year rolling

Source Data type: Rate
Smallest geographic level: County

Desired Target Direction: Low/Decrease

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: Merlin.

Disability (Any) - Disability Status. Weblink:

http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t. Table name - s1810.

Data collection period:
Source Data type:
Smallest geographic level:
Desired Target Direction:

Annual
%
County
Neutral

Source: US Census Fact Finder. Original Data Source: US Census.

Hepatitis C, Acute - ICD Code(s): 07051. Cases are assigned to Florida counties based on the county of residence at the time of the disease identification, regardless of where they became ill or were hospitalized, diagnosed, or exposed. Counts and rates include confirmed and probable cases of Hepatitis C, Acute (Merlin code 07051). Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=8651

Data collection period: 3-year rolling

Source Data type: Rate
Smallest geographic level: County

Desired Target Direction: Low/Decrease

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: Merlin.

HIV - Human immunodeficiency virus. HIV and AIDS cases by year of report are NOT mutually exclusive and should NOT be added together Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalHIVAIDSViewer.aspx?cid=0471

AIDS - Acquired immunodeficiency syndrome. HIV and AIDS cases by year of report are NOT mutually exclusive and should NOT be added together. Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalHIVAIDSViewer.aspx?cid=0141

Data collection period: Annual

Source Data type: Rate per Population

Smallest geographic level: County
Desired Target Direction: Low/Decrease

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts. Original

Data Source: FL DOH, Bureau of HIV/AIDS.

Salmonellosis - ICD-9-CM: 003.00. Counts and rates include confirmed and probable cases of Salmonellosis (Merlin code 00300). Weblink:

http://www.floridacharts.com/charts/CommunicableDiseases/default.aspx

Meningitis, Other Bacterial, Cryptococcal, or Mycotic - Includes the following types of Meningitis: group b strep, listeria monocytogenes, other meningitis, strep pneumoniae. beginning in 2007, data includes both probable and confirmed cases. Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0160

Tuberculosis - Tuberculosis ICD-10 Case Definitions. Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0148

Chicken Pox - Varicella. ICD-10 Case Definition. Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=8633

Whooping Cough - Pertussis. ICD-9-CM: 033.90. Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0156

Vaccine (selected) Preventable Disease for All Ages - Includes: diphtheria, acute hepatitis b, measles, mumps, pertussis, rubella, tetanus, and polio. Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0194

Data collection period:

Source Data type:

Smallest geographic level:

Annual
Rate
County

Desired Target Direction: Low/Decrease

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: Merlin.

Unhealthy mental days - Average number of unhealthy mental days in the past 30 days. Survey Question: Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good? Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=65

Average number of days where poor mental or physical health interfered with activities of daily living in the past 30 days - Among adults who responded that they have had at least one day of poor mental or physical health, the average number of days where poor mental or physical health interfered with activities of daily living in the past 30 days. Weblink:

http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=70

Data collection period: Triennial

Source Data type: Count (average)

Smallest geographic level: County

Desired Target Direction: Low/Decrease

Note: Caution should be taken when comparing 2013 data with previous years due to changes in

survey methodology to include respondents via cellular phones in addition to land lines.

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: Florida BRFSS

Adults with good to excellent overall health - Weblink:

http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=60

Data collection period: Triennial
Source Data type: Rate
Smallest geographic level: County

Desired Target Direction: High/Increase

Note: Caution should be taken when comparing 2013 data with previous years due to changes in

survey methodology to include respondents via cellular phones in addition to land lines.

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: Florida BRFSS

Poor or fair health - Adults who said their overall health was "fair" or "poor". Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=1

Data collection period:

Source Data type:

Smallest geographic level:

Desired Target Direction:

Annual

Rate

County

Low/Decrease

Note: Caution should be taken when comparing 2013 data with previous years due to changes in

survey methodology to include respondents via cellular phones in addition to land lines.

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: Florida BRFSS

Health Behavior - Tobacco Use

Smokers (Adult) - Combination of everyday smoker and some day smoker. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=8

Former Smokers (Adult) - Currently quit smoking. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=85

Never Smoked (Adult) - Adults who reported smoking less than 100 cigarettes in their lifetime.

Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=86

Tobacco Quit Attempt (Adult) - Adult current smokers who tried to quit smoking at least once in the past year. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=9

Data collection period: Triennial
Source Data type: Rate
Smallest geographic level: County

Desired Target Direction: High/Increase

Note: Caution should be taken when comparing 2013 data with previous years due to changes in

survey methodology to include respondents via cellular phones in addition to land lines.

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: Florida BRFSS

Smoked in last 30 days (Adolescents) - Ages 11-17 years, smoked cigarettes on one or more of the last 30 days. Weblink: http://www.floridahealth.gov/statistics-and-data/survey-data/fl-youth-tobacco-survey/documents/2014-county/index.html

Secondhand Smoke exposure (Children) - Middle school children exposed to secondhand smoke during the past 7 days. Weblink: http://www.floridahealth.gov/statistics-and-data/survey-data/fl-youth-tobacco-survey/_documents/2014-county/index.html

Data collection period:
Source Data type:
Smallest geographic level:
Biennial
Rate
County

Desired Target Direction: Low/Decrease

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: FYTS.

Live births where mother smoked during pregnancy - Resident live births. Weblink: http://www.floridacharts.com/charts/DataViewer/BirthViewer.aspx?cid=343

Data collection period: 3-year rolling

Source Data type: Rate
Smallest geographic level: County

Desired Target Direction: Low/Decrease

Note: Race/ethnicity data also available

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: FL DOH, Bureau of Vital Statistics.

Health Behavior - Alcohol / Substance Use

Alcohol-related Motor Vehicle Traffic Crash Deaths - A crash involving a driver and/or pedestrian for whom alcohol use was reported (does not presume intoxication) that results in one or more fatalities within thirty days of occurrence. Any crash involving a driver or non-motorist for whom alcohol use was suspected, including those with a BAC greater than 0.00 and those refusing to submit to an alcohol test. Weblink:

 $\underline{http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0303}$

Alcohol-related Motor Vehicle Traffic Crashes - A crash involving a driver and/or pedestrian for whom alcohol use was reported (does not presume intoxication). Any crash involving a driver or non-motorist for whom alcohol use was suspected, including those with a BAC greater than 0.00 and those refusing to submit to an alcohol test. Weblink:

 $\underline{http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0302}$

Data collection period: 3-year rolling

Source Data type: rate
Smallest geographic level: County

Desired Target Direction: Low/Decrease

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: FDHSMV.

Blacking out from drinking Alcohol (Adolescents) - Ages 14-17 who reported on how many occasions in their lifetime they woke up after drinking and did not remember the things they did or the places they went. Weblink: http://www.myflfamilies.com/service-programs/substance-abuse/fysas.
Note: New for 2014. Indicator focuses toward negative consequence of behavior.

Cigarette Use (Adolescents) - Ages 10-17 who reported having used Cigarettes in the past 30 days. Weblink: http://www.myflfamilies.com/service-programs/substance-abuse/fysas.

Marijuana or Hashish Use (Adolescents) - Ages 10-17 who reported having used alcohol in the past 30 days. Weblink: http://www.myflfamilies.com/service-programs/substance-abuse/fysas.

Alcohol Consumption in past 30 days (Adolescents) - Ages 10-17 who reported having used alcohol in the past 30 days. Weblink: http://www.myflfamilies.com/service-programs/substance-abuse/fysas.

Alcohol Consumption in Lifetime (Adolescents) - Ages 10-17 who reported having used alcohol or any illicit drug in their lifetimes. Weblink: http://www.myflfamilies.com/service-programs/substance-abuse/fysas. Note: This indicator is helpful in understanding effectiveness of early intervention and education programs.

Binge Drinking (Adolescents) - Aaes 10-17 who reported having used alcohol in the past 30 days. Binge drinking is defined as having had five or more alcoholic drinks in a row in the past two weeks.

Weblink: http://www.myflfamilies.com/service-programs/substance-abuse/fysas

Data collection period:
Source Data type:
Smallest geographic level:
Biennial
Rate
County

Desired Target Direction: Low/Decrease

Note: 30-day rates tend to be more indicative of regular or more frequent use. Lifetime usage

captures experimentation as well as ongoing use.

Source: FL DCF FYSAS - FL Department of Children and Families. Original Data Source: FYSAS - FL

Department of Children and Families.

Health Behavior - Diet and Exercise

Healthy Weight (Adult) - Having a body mass index (BMI) ranging from 18.5 to 24.9; BMI is calculated using self-reported height and weight. Weblink:

http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=80

Data collection period: Triennial

Source Data type: %
Smallest geographic level: County

Desired Target Direction: High/Increase

Note: Caution should be taken when comparing 2013 data with previous years due to changes in

survey methodology to include respondents via cellular phones in addition to land lines.

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts -

Healthiest Weight Profile. Original Data Source: Florida BRFSS

Overweight (Adult) - Body Mass Index (BMI) 25.0 to 29.9. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=5

Obesity (Adult) - Body Mass Index (BMI) 30.0 or higher. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=6

Data collection period: Triennial

Source Data type: %

Smallest geographic level: County

Desired Target Direction: Low/Decrease

Note: Caution should be taken when comparing 2013 data with previous years due to changes in

survey methodology to include respondents via cellular phones in addition to land lines.

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts -

Healthiest Weight Profile. Original Data Source: Florida BRFSS

Births to Obese Mothers - Births to obese mothers (BMI 30.0 or higher) at the time pregnancy occurred. Weblink:

http://www.floridacharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=0606

Births to overweight mothers - Births to overweight (BMI 25.0 to 29.9) mothers at the time pregnancy occurred. Weblink:

http://www.floridacharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=0607

Data collection period: 3-year rolling

Source Data type: Rate
Smallest geographic level: County

Desired Target Direction: Low/Decrease

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: FL DOH, Bureau of Vital Statistics.

Breast feeding Initiation - Infant was being breastfed at the time the birth certificate was completed. Weblink:

http://www.floridacharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=637

Data collection period: Annual Source Data type: %
Smallest geographic level: County

Desired Target Direction: High/Increase

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts -

Pregnancy and Young Child Profile. Original Data Source: FL DOH, Bureau of Vital

Statistics.

Overweight (Adolescents) - Middle and High School Students. Body Mass Index (BMI) 25.0 to 29.9. Weblink: http://www.floridahealth.gov/statistics-and-data/survey-data/fl-youth-tobacco-survey/_documents/2014-county/index.html

Obesity (Adolescents) - Middle and High School Students. Body Mass Index (BMI) 30.0 or higher.

Weblink: http://www.floridacharts.com/charts/SpecReport.aspx?RepID=1235&tn=31.

Healthy Weight (Adolescents) - Middle and High School Students. Having a body mass index (BMI) ranging from 18.5 to 24.9. Weblink:

http://www.floridacharts.com/charts/SpecReport.aspx?RepID=1235&tn=31.

Data collection period: Biennial Source Data type: %

Smallest geographic level: County

Desired Target Direction: High/Increase

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts -

Healthiest Weight Profile. Original Data Source: FYTS.

Vigorous physical activity recommendations met (Adult) - 75 minutes of vigorous aerobic activity per week in the past 30 days. Weblink:

http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=4

Data collection period: Triennial
Source Data type: Rate
Smallest geographic level: County

Desired Target Direction: High/Increase

Note: Caution should be taken when comparing 2013 data with previous years due to changes in

survey methodology to include respondents via cellular phones in addition to land lines.

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: Florida BRFSS

Exercise opportunities - Percentage of population with adequate access to locations for physical activity. Locations for physical activity (parks or recreation facilities); Urban pop. resides within 1 mile and rural resides within 3 miles of recreational facility. Weblink:

http://www.countyhealthrankings.org/app/florida/2015/overview

Data collection period: Annual
Source Data type: %
Smallest geographic level: County

Desired Target Direction: High/Increase

Source: CHR County Health Rankings. Original Data Source: Business Analyst, Delorme map data,

ESRI, & US Census Tigerline files.

Sedentary Adults - Participating in no leisure-time physical activity in the past 30 days. Weblink: http://www.floridacharts.com/charts/Brfss.aspx

Data collection period: 5-year Source Data type: Rate Smallest geographic level: County

Desired Target Direction: Low/Decrease

Note: Caution should be taken when comparing 2013 data with previous years due to changes in

survey methodology to include respondents via cellular phones in addition to land lines.

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts -

Healthiest Weight Profile. Original Data Source: Florida BRFSS

Fruits and Vegetables Consumption 5 servings per day (Adult) – Weblink:

http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=7

Data collection period: 5-year
Source Data type: %
Smallest geographic level: County

Desired Target Direction: High/Increase

Note: Caution should be taken when comparing 2013 data with previous years due to changes in

survey methodology to include respondents via cellular phones in addition to land lines.

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts -

Healthiest Weight Profile. Original Data Source: Florida BRFSS

Food Insecurity - Lack of access, at times, to enough food for an active, healthy life for all household members, and limited or uncertain availability of nutritionally adequate foods. Weblink: http://map.feedingamerica.org/county/2011/overall/florida/county/

Data collection period:

Source Data type:

Smallest geographic level:

Annual
Rate
County

Desired Target Direction: Low/Decrease

Source: Feeding America Map the Meal Gap 2015: Food Insecurity and Child Food Insecurity

Estimates at the County Level. Original Data Source: US Census.

Grocery Store Access - Population that live within a 1/2 mile of a healthy good source, including grocery stores and produce stands/farmers' markets. Weblink:

http://www.floridacharts.com/charts/default.aspx

Data collection period:
Source Data type:
Smallest geographic level:
County

Desired Target Direction: High/Increase

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: Florida Department of Agriculture and Consumer Services, U.S. Census

Bureau, FDOH, Environmental Public Health Tracking.

Food Access - **Low Income Population** - Percentage of population who are low-income and do not live close to a grocery store. In rural areas, it means living less than 10 miles from a grocery store; in nonrural areas, less than 1 mile. Low income is defined as having an annual family income of less than or equal to 200 percent of the federal poverty threshold for the family size. Weblink: http://www.countyhealthrankings.org/app/florida/2013/measure/factors/83/map

Data collection period:
Source Data type:
Smallest geographic level:
County

Desired Target Direction: Low/Decrease

Source: CHR County Health Rankings. Original Data Source: US DoA.

Fast Food Restaurant Access - Population that live within a 1/2 mile of a fast food restaurant.

Weblink:

http://www.floridacharts.com/charts/HealthiestWeightProfile.aspx?county=17&profileyear=2013&tn=31

Data collection period:

Source Data type: Rate
Smallest geographic level: County

Desired Target Direction: Low/Decrease

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts -

Healthiest Weight Profile. Original Data Source: Florida Department of Agriculture and Consumer Services, U.S. Census Bureau, FDOH, Environmental Public Health Tracking.

SNAP Participants - Weblink: http://www.ers.usda.gov/data-products/food-environment-atlas/go-

to-the-atlas.aspx

Data collection period: Annual

Source Data type: Rate per Population

Smallest geographic level: County

Desired Target Direction: Low/Decrease

Source: USDA Economic Research Service Food Environment Atlas. Original Data Source: US DoA.

Health Behavior - Sexual Activity

Infectious Syphilis - Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0144

Data collection period: 3-year rolling
Source Data type: Rate per Population

Smallest geographic level: County

Desired Target Direction: Low/Decrease

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: FL DOH, Bureau of STD Prevention & Control.

Sexually transmitted infections - Total gonorrhea, chlamydia, infectious syphilis cases. Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0203

Data collection period: Annual
Source Data type: Rate
Smallest geographic level: County

Desired Target Direction: Low/Decrease

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: FL DOH, Bureau of STD Prevention & Control.

Births to Mothers under age of majority (Resident) - Live Births. Does not include pregnancies that end with miscarriages, elective and spontaneous abortions or fetal deaths. Births to mothers in a specific age group divided by females in the same age group. Weblink:

http://www.floridacharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=0001.

Data collection period: 3-year rolling

Source Data type: Rate

Desired Target Direction: Low/Decrease

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida

Charts. Original Data Source: FL DOH, Bureau of Vital Statistics

Clinical Care - Access to Health Care

Uninsured Adults - Percent Uninsured (ages < 65). Weblink:

http://www.census.gov/did/www/sahie/data/interactive/cedr/sahie.html

Uninsured Children - Percent Uninsured (ages < 19). Weblink:

http://www.census.gov/did/www/sahie/data/interactive/cedr/sahie.html

Data collection period:
Source Data type:
Smallest geographic level:
Annual
%
County

Desired Target Direction: Low/Decrease

Source: US Census SAHIE Interactive Data Tool. Original Data Source: US Census.

Percentage of adults who could not see a doctor at least once in the past year due to cost -

Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=13

Data collection period: Triennial

Source Data type: %
Smallest geographic level: County

Desired Target Direction: High/Increase

Note: Caution should be taken when comparing 2013 data with previous years due to changes in

survey methodology to include respondents via cellular phones in addition to land lines.

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: Florida BRFSS

Population Receiving Medicaid - Medicaid Program Enrollment Totals (Including Medikids

population). Weblink:

http://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml

Data collection period: Monthly Source Data type: Rate Smallest geographic level: County

Desired Target Direction: Low/Decrease

Note: Data is available through August 2015, but June 2013, June 2012 & 2011 was collected

Source: FL AHCA (AHCA) Comprehensive Medicaid Managed Care Enrollment Reports. Original

Data Source: FL AHCA (AHCA).

Medicaid births - Births covered by Medicaid. Weblink:

http://www.floridacharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=0595

Data collection period: 3-year rolling

Source Data type: Rate
Smallest geographic level: County

Desired Target Direction: Low/Decrease

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: FL DOH, Bureau of Vital Statistics.

Dental Care Access by Low Income Persons - Access to Dental Care by Low Income Persons,

Single Year. Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0266

Data collection period:

Source Data type:

Smallest geographic level:

Annual
Rate
County

Desired Target Direction: High/Increase

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: FL DOH, Public Health Dental Program.

Primary Care Access - Primary care physicians per 100,000 population by year. This figure represents all primary care physicians practicing patient care, including hospital residents. Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. Weblink: http://assessment.communitycommons.org/CHNA/report?page=4.

Data collection period:
Source Data type:
Smallest geographic level:
Annual
Rate
County

Desired Target Direction: High/Increase

Source: US DoHHS, Area Health Resource File. http://arf.hrsa.gov/overview.htm Area Health

Resource File. Original Data Source: US DoHHS.

Mental health providers - Mental Health Providers is the ratio of the county population to the number of mental health providers including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists and advanced practice nurses specializing in mental health care. In 2015, marriage and family therapists and mental health providers that treat alcohol and other drug abuse were added to this measure. Weblink:

http://www.countyhealthrankings.org/app/florida/2015/measure/factors/62/datasource.

Data collection period:
Source Data type:
Smallest geographic level:
Annual
Ratio
County

Desired Target Direction: High/Increase

Source: CHR County Health Rankings. Original Data Source: CMS (CMS), National Provider

Identification.

Physicians - Per population rate of people with active physician licenses only. Licensure data is for a fiscal year (July 1-June 30). Weblink:

 $\frac{http://www.floridacharts.com/charts/LoadPage.aspx?l=\sim/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0327}{ewer.aspx?cid=0327}$

Family Practice Physicians - Per population rate of people with active physician licenses in Florida who report family practice as their specialty. Licensure data is for a fiscal year (July 1-June 30). Weblink:

 $\frac{http://www.floridacharts.com/charts/LoadPage.aspx?l=\sim/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0328}{ewer.aspx?cid=0328}$

Internists - Per population rate of people with active physician licenses in Florida who report internal medicine as their specialty. Licensure data is for a fiscal year (July 1-June 30). Weblink: http://www.floridacharts.com/charts/LoadPage.aspx?l=~/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0329.

Pediatricians - Per population rate of people with active physician licenses in Florida who report pediatric medicine as their specialty. Licensure data is for a fiscal year (July 1-June 30). Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0331.

 $\label{lem:population} \textbf{Dentists} - \text{Per population rate of people with active licenses to practice dentistry in Florida. Weblink: $$ \underline{\text{http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0326}$$$

Data collection period: 3-year rolling

Source Data type: Rate Smallest geographic level: County

Desired Target Direction: High/Increase

Note: http://www.floridahealth.gov/licensing-and-regulation/index.html

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: FL DOH, Division of Medical Quality Assurance.

Acute Care Beds - Acute care is necessary treatment of a disease for only a short period of time in which a patient is treated for a brief but severe episode of illness. The term is generally associated with care rendered in an emergency department, ambulatory care clinic, or other short-term stay facility. Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0314

Data collection period: 3-year rolling

Source Data type: Rate
Smallest geographic level: County

Desired Target Direction: High/Increase

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: FL AHCA (AHCA), Certificate of Need Office.

Adult psychiatric beds - The number of beds indicates the number of people who may receive adult psychiatric care on an inpatient basis. Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0318.

Adult substance abuse beds - The number of beds indicates the number of people who may receive adult substance abuse treatment on an in-patient basis. Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0321

Pediatric psychiatric beds - Child and Adolescent Psychiatric Beds. Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0319

Rehabilitation beds - The number of rehabilitation beds indicates the number of people who may receive rehabilitative care in the hospital on an in-patient basis. Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0324

Nursing Home Beds - Skilled Nursing Unit Beds. A nursing home, skilled nursing facility (SNF), or skilled nursing unit (SNU), also known as a rest home, is a type of care of residents: it is a place of residence for people who require constant nursing care and have significant deficiencies with activities of daily living. Residents include the elderly and younger adults with physical or mental disabilities. Adults 18 or older can stay in a skilled nursing facility to receive physical, occupational, and other rehabilitative therapies following an accident or illness. Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0325

Data collection period: 3 year rolling Source Data type: Rate per 100,000

Smallest geographic level: County

Desired Target Direction: High/Increase

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: FL AHCA (AHCA), Certificate of Need Office.

Clinical Care - Quality of Care

Lack of Prenatal Care - Births to mothers with no prenatal care. Trimester prenatal care began is calculated as the time elapsed from the date of the last menstrual period to the date of the first prenatal care visit. Weblink:

http://www.floridacharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=16

Prenatal Care Begun Late or No Prenatal Care - Births to Mothers with 3rd Trimester or No Prenatal Care. Weblink:

http://www.floridacharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=17

Prenatal Care Begun in First Trimester - Births to Mothers with 1st Trimester Prenatal Care. Weblink: http://www.floridacharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=18

Data collection period: 3-year rolling

Source Data type: Rate
Smallest geographic level: County

Desired Target Direction: Low/Decrease

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: FL DOH, Bureau of Vital Statistics.

Adults who have a personal doctor - Weblink:

http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=12

Cancer Screening - Mammogram - Women 40 years of age and older who received a mammogram in the past year. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=24

Cancer Screening in past two years - PSA (Men age 50 & older) - Men 50 years of age and older who received a PSA test in the past two years. Weblink:

http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=39

Cancer Screening - Sigmoidoscopy or Colonoscopy - Adults 50 years of age and older who received a sigmoidoscopy or colonoscopy in the past five years, Overall. Weblink: http://www.floridacharts.com/CHARTS/Brfss/DataViewer.aspx?bid=39

Cancer Screening - Pap Test - Women 18 years of age and older who received a Pap test in the past year. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=25

Diabetic Annual Foot Exam (Adults) - Adults with diabetes who had an annual foot exam.

Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=49

Diabetic Semi-Annual A1C Testing (Adult) - Adults with diabetes who had two A1C tests in the past year. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=49

HIV Testing (Adult age 65 and over) - Adults less than 65 years of age who have ever been tested for HIV, Overall. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=29

Flu Vaccination in the Past Year (Adult age 65 and over) - Adults 65 years of age and older who received a flu shot in the past year. Weblink:

http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=75

Flu Vaccination in the Past Year (Adult) - Adults who received a flu shot in the past year. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=22

Pneumonia Vaccination (Adult age 65 and over) - Adults 65 years of age and older who have ever received a pneumococcal vaccination. Weblink:

http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=88

Pneumonia Vaccination (Adult) - Adults who have ever received a pneumococcal vaccination, Overall. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=23

Data collection period: Triennial

Source Data type: %
Smallest geographic level: County

Desired Target Direction: High/Increase

Note: Caution should be taken when comparing 2013 data with previous years due to changes in

survey methodology to include respondents via cellular phones in addition to land lines.

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: Florida BRFSS

Vaccination (kindergarteners) - Fully immunized against diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, haemophilus, influenzae type b, hepatitis B and varicella (chicken pox). Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0075

Data collection period: 3-year rolling

Source Data type: Rate
Smallest geographic level: County

Desired Target Direction: High/Increase

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: FL DOH, Bureau of Immunization.

ED Visits - Acute Conditions - Hypoglycemia - Hypoglycemia Primary ICD9 251.2

ED Visits - Avoidable Conditions - Dental - Dental Conditions Primary ICD9 521-523,525,528

ED Visits - Chronic Conditions - Angina - Angina Primary ICD9 411.1, 411.8, 413. Excludes cases with a surgical procedure 01-86.99

ED Visits - Chronic Conditions - Asthma - Asthma Primary ICD9 493

ED Visits - Chronic Conditions - Congestive Heart Failure - Congestive Heart Failure Primary ICD9 402.01, 402.11, 402.91, 428, 518.4. Excludes cases with the following surgical procedures: 36.01, 36.02, 36.05, 36.1, 37.5, or 37.7

ED Visits - Chronic Conditions - Diabetes - Diabetes Primary ICD9 250.0 - 250.3, 250.8 - 250.9.

ED Visits - Chronic Conditions - Mental Health - ICD-9 Dx Group: Mental Disorders

ED Visits - Chronic Conditions - Hyper Tension - Hypertension Primary ICD9 401.0, 401.9, 402.00, 402.10, 402.90.

Data collection period: Quarterly

Source Data type: Rate/1000 Visits

Smallest geographic level: Zip

Desired Target Direction: Low/Decrease

Note: Ambulatory Care Sensitive Conditions:

http://www.floridacharts.com/charts/documents/ACS Conditions Definition UPDATE.pdf

Source: AHCA IntelliMed - Export. Original Data Source: IntelliMed © Custom Report

Preventable hospital stays - Ambulatory Care Sensitive conditions such as asthma, diabetes or dehydration are hospitalization conditions where timely and effective ambulatory care can decrease hospitalizations by preventing the onset of an illness or condition, controlling an acute episode of an illness or managing a chronic disease or condition. High rates of Ambulatory Care Sensitive hospitalizations in a community may be an indicator of a lack of or failure of prevention efforts, a primary care resource shortage, poor performance of primary health care delivery systems, or other factors that create barriers to obtaining timely and effective care. Weblink:

http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=8598.

Data collection period: 3-year rolling

Source Data type: Rate
Smallest geographic level: County

Desired Target Direction: Low/Decrease

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: FL AHCA (AHCA).

Social and Economic Factors - Education

High school graduation - Percentage of students who graduated within four years of their initial enrollment in ninth grade, not counting deceased students or students who transferred out to attend another public school outside the system, a private school, a home education program. Incoming transfer students are included in the appropriate cohort (the group whose progress is tracked) based on their grade level and year of entry. Data are for school years (September-June). Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndRateOnlyDataViewer.aspx?cid=05

Data collection period:
Source Data type:
Smallest geographic level:
County

Desired Target Direction: High/Increase

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: Florida Department of Education, Education Information and

Accountability Services (EIAS).

Population 18-24 without a high school diploma - Population 18 to 24 years with educational attainment of less than high school graduate. (Target %, Total 18 to 24 population estimate) Weblink: http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t. Table name - s1501.

Data collection period: Annual Source Data type: %
Smallest geographic level: County

Desired Target Direction: Low/Decrease

Source: Fact Finder. Original Data Source: US Census.

Social and Economic Factors - Employment

Unemployment - Number of unemployed people as a percentage of the civilian labor force (not seasonally adjusted). Weblink: http://data.bls.gov/map/MapToolServlet

Data collection period: Annual Source Data type: %

Desired Target Direction: Low/Decrease

Source: US DoL, Bureau of Labor Statistics. Original Data Source: US DoL, Bureau of Labor

Statistics.

Social and Economic Factors - Income

Real Per Capita Income - Real per capita income represents the total GDP of the county, adjusted for inflation and divided by the population. Weblink:

 $\underline{http://www.bea.gov/iTable.iTable.cfm?reqid=70\&step=1\&isuri=1\&acrdn=5\#reqid=70\&step=30\&isuri=1\&7022=20\&7023=7\&7024=non-1\&isuri=1\&acrdn=5\#reqid=70\&step=30\&isuri=1\&7022=20\&7023=7\&7024=non-1\&isuri=1\&acrdn=5\#reqid=70\&step=30\&isuri=1\&7022=20\&7023=7\&7024=non-1\&isuri=1\&acrdn=5\#reqid=70\&step=30\&isuri=1\&7022=20\&7023=7\&7024=non-1\&isuri=1\&acrdn=5\#reqid=70\&step=30\&isuri=1\&7022=20\&7023=7\&7024=non-1\&isuri=1\&7022=20\&7023=7\&7024=non-1\&isuri=1\&7022=20\&7023=7\&7024=non-1\&isuri=1\&7022=20\&7023=7\&7024=non-1\&isuri=1\&7022=20\&7023=7\&7024=non-1\&isuri=1\&7022=20\&7023=7\&7024=non-1\&isuri=1\&7022=20\&7023=7\&7024=non-1\&isuri=1\&7022=20\&7023=7\&7024=non-1\&isuri=1\&7022=20\&7023=7\&7024=non-1\&isuri=1\&7022=20\&7023=7\&7024=non-1\&isuri=1\&7022=20\&7023=7\&7024=non-1\&isuri=1\&7022=20\&7023=7\&7024=non-1\&7022=20\&7023=7\&7024=non-1\&7022=20\&7023=7\&7024=non-1\&7022=20\&7023=7\&7024=non-1\&7022=20\&7023=7\&7024=non-1\&7022=20\&7023=20\%$

 $\frac{ndustry\&7033=1\&7025=4\&7026=12005,12033,12037,12043,12113,12131\&7027=2013\&7001=720\&7028=-1\&7031=12000\&7040=-1\&7083=levels\&7029=20\&7090=7.$

Data collection period: Annual Source Data type: S

Desired Target Direction: High/Increase Source: US DoC, Bureau of Economic Analysis.

Median Household Income - Weblink:

http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t. Table name - S1903.

Data collection period: Annual

Source Data type: \$

Desired Target Direction: High/Increase

Source: US Census Fact Finder. Original Data Source: US Census.

Poverty - Following the Office of Management and Budget's (OMB's) Directive 14, the Census Bureau uses a set of money income thresholds that vary by family size and composition to determine who is in poverty. If the total income for a family or unrelated individual falls below the relevant poverty threshold, then the family (and every individual in it) or unrelated individual is considered in poverty. Weblink: http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t. Table name - s1701.

Data collection period: 5-year estimate

Source Data type: %

Desired Target Direction: Low/Decrease

Source: US Census Fact Finder. Original Data Source: US Census.

Children in poverty (based on household) - Number individuals below poverty under the age of 18 divided by the number of individuals under the age of 18, expressed as a percentage. Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndRateOnlyDataViewer.aspx?cid=02

Data collection period: Annual Source Data type: %

Desired Target Direction: Low/Decrease

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: US Census.

Children Eligible for Free/Reduced Price Lunch - Children from families with incomes at or below 130 percent of the poverty level are eligible for free meals. Those with incomes between 130 percent and 185 percent of the poverty level are eligible for reduced-price meals, for which students can be charge no more than 40 cents. Weblink:

http://assessment.communitycommons.org/CHNA/report?page=2&id=209

Data collection period: Annual Source Data type: %

Desired Target Direction: Low/Decrease

Source: Common Core of Data. Original Data Source: National Center for Education Statistics,

NCES.

Income - **Public Assistance Income** - Living in household with Supplemental Security Income (SSI), cash public assistance income, or Food Stamps/SNAP in the past 12 months. Weblink: http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t. Table name - B09010.

Data collection period: Annual

Source Data type: % calculated from ACS population estimates

Desired Target Direction: Low/Decrease

Source: US Census Fact Finder. Original Data Source: US Census.

Housing Cost Burden (30%) - Percentage of the households where housing costs exceed 30% of total household income. Weblink:

http://assessment.communitycommons.org/CHNA/report?page=2&id=240

Data collection period: 5-year estimate

Source Data type: %

Desired Target Direction: Low/Decrease

Source: US Census ACS. Original Data Source: US Census.

Social and Economic Factors - Family and Social Support

Children in single-parent households - Excludes single parents living with unmarried partners. Weblink: http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t. Model Studer Institute: Table name - B09002 ("In Other Families"/"Total)

Data collection period: Annual Source Data type: %

Desired Target Direction: Low/Decrease

Source: US Census Fact Finder. Original Data Source: US Census.

Population with Limited English Proficiency - No one age 14 and over speaks English only or speaks English "very well" No one age 14 and over speaks English only. Weblink:

http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t. Table name - S1602.

Data collection period:

Source Data type:

Desired Target Direction:

Annual

Neutral

Source: US Census Fact Finder. Original Data Source: US Census.

Social and Economic Factors - Community Safety

Domestic Violence Offenses - Domestic Violence in Florida is tracked specifically for the following reported offenses: Murder, Manslaughter, Forcible Rape, Forcible Sodomy, Forcible Fondling, Aggravated Assault, Aggravated Stalking, Simple Assault, Threat/Intimidation, and Simple Stalking.

Forcible Sex Offenses - Legacy (prior to 2013) UCR definition of rape: The carnal knowledge of a female forcibly and against her will. Revised (2013-forward) UCR definition of rape: Penetration, no matter how slight, of the vagina or anus with any body part or object, or oral penetration by a sex organ of another person, without the consent of the victim.

Aggravated Assault - FBI's Uniform Crime Reporting (UCR) Program defines aggravated assault as an unlawful attack by one person upon another for the purpose of inflicting severe or aggravated bodily injury. The UCR Program further specifies that this type of assault is usually accompanied by the use of a weapon or by other means likely to produce death or great bodily harm. Attempted aggravated assault that involves the display of—or threat to use—a gun, knife, or other weapon is included in this crime category because serious personal injury would likely result if the assault were completed. When aggravated assault and larceny-theft occur together, the offense falls under the category of robbery.

Murder - Murder and nonnegligent manslaughter. FBI's Uniform Crime Reporting (UCR) Program defines murder and nonnegligent manslaughter as the willful (nonnegligent) killing of one human being by another. The classification of this offense is based solely on police investigation as opposed to the determination of a court, medical examiner, coroner, jury, or other judicial body. The UCR Program does not include the following situations in this offense classification: deaths caused by negligence, suicide, or accident; justifiable homicides; and attempts to murder or assaults to murder, which are scored as aggravated assaults.

Property Crimes - Property crime (burglary, larceny-theft, and motor vehicle theft) FBI's Uniform Crime Reporting (UCR) Program, property crime includes the offenses of burglary, larceny-theft, motor vehicle theft, and arson. The object of the theft-type offenses is the taking of money or property, but there is no force or threat of force against the victims. The property crime category includes arson because the offense involves the destruction of property; however, arson victims may be subjected to force.

Violent Crime - FBI's Uniform Crime Reporting (UCR) Program, violent crime is composed of four offenses: murder and nonnegligent manslaughter, forcible rape, robbery, and aggravated assault. Violent crimes are defined in the UCR Program as those offenses which involve force or threat of force.

Weblink: https://www.fdle.state.fl.us/Content/FSAC/Menu/Data---

Statistics-(1)/UCR-Offense-Data.aspx

Data collection period: Annual

Source Data type: Rate per 100,000

Smallest geographic level: County

Desired Target Direction: Low/Decrease

Source: FDLE FDLE. Crime in Florida, Florida uniform crime report, 2014 [Computer program].

Tallahassee, FL: FDLE. Florida Statistical Analysis Center. Original Data Source: FDLE.

Crime in Florida, Uniform Crime Reports

Physical Environment - Environmental Quality

Air pollution - **particulate matter** - Within the report area, 0, or 0% of days exceeded the emission standard of 75 parts per billion (ppb). This indicator reports the percentage of days per year with Ozone (O3) levels above the National Ambient Air Quality Standard of 75 parts per billion (ppb). Weblink: http://assessment.communitycommons.org/CHNA/report?page=3&id=409

Data collection period:

Source Data type:

Smallest geographic level:

Annual

%

County

Desired Target Direction: Low/Decrease

Source: EPA (EPA) National Environmental Public Health Tracking Network (NEPHTN) Air Quality

Data web page. Original Data Source: CDC, National Environmental Public Health Tracking

Network.

Air Quality - Ozone - Percentage of days with particulate matter 2.5 levels above the National Ambient Air Quality Standard (35 micrograms per cubic meter) per year, calculated using data collected by monitoring stations and modeled to include counties where no monitoring statistics are collected.

Weblink: http://assessment.communitycommons.org/CHNA/report?page=3&id=410

Data collection period: Annual Source Data type: %
Smallest geographic level: County

Desired Target Direction: Low/Decrease

Source: EPA (EPA) National Environmental Public Health Tracking Network (NEPHTN) Air Quality

Data web page. Original Data Source: CDC, National Environmental Public Health Tracking

Network.

Drinking water violations - Percentage of population potentially exposed to water exceeding a violation limit during the past year. Weblink:

http://www.countyhealthrankings.org/app/florida/2015/measure/factors/124/data

Data collection period:
Source Data type:
Smallest geographic level:
Desired Target Direction:

Annual
%
County
Low/Decrease

Source: CHR County Health Rankings. Original Data Source: EPA (EPA): Safe Drinking Water

Information System.

Physical Environment - Built Environment

Severe housing problems - The four severe housing problems are: incomplete kitchen facilities, incomplete plumbing facilities, more than 1 person per room, and cost burden greater than 50%. Weblink: http://www.huduser.gov/portal/datasets/cp/CHAS/data_querytool_chas.html.

Data collection period: 4-year Source Data type: % Smallest geographic level: County

Desired Target Direction: Low/Decrease

Source: US Department of Housing and Urban Development CHAS Data Query. Original Data

Source: US Department of Housing and Urban Development.

Households with No Motor Vehicle - Weblink:

 $\underline{http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_13_5YR_B08201\&prodType=table.}$

Table name - B08201: Household size by vehicles available

Data collection period:

Source Data type:

Smallest geographic level:

County

Desired Target Direction: High/Increase

Source: US Census Fact Finder. Original Data Source: US Census.

Driving alone to work - Commuting (Journey to Work) refers to a worker's travel from home to work. Place of work refers to the geographic location of the worker's job. Workers 16 years and over. http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t. Table name - s0802.

Data collection period: 5-year estimate

Source Data type: % calculated on ACS population estimate

Smallest geographic level: County

Desired Target Direction: Low/Decrease

Source: US Census ACS. Original Data Source: US Census.

Use of Public Transportation - "Public transportation" includes workers who used a bus, trolley, streetcar, subway or elevated rail, railroad, or ferryboat. Weblink:

http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t. Table name - s0802.

Data collection period: Annual
Source Data type: %
Smallest geographic level: County

Desired Target Direction: High/Increase

Source: US Census Fact Finder. Original Data Source: US Census.

Population Characteristics

Median Age - Weblink:

http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP 2014 PEPAG

ESEX&prodType=table. Table name - PEPAGESEX.

Data collection period: Annual

Source: FL DOH, Office of Health Statistics and Assessment in consultation with the FL EDR.

Total Population (ACS) - Weblink:

http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t. Table name - PEPANNRES.

Data collection period: Annual Source Data type: Count

Source: US Census Fact Finder. Original Data Source: US Census.

Total Population (FL CHARTS)

Female / Male Population

Weblink: http://www.floridacharts.com/FLQUERY/Population/PopulationRpt.aspx

Data collection period: Annual Source Data type: Count

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: FL DOH, Office of Health Statistics and Assessment in consultation

with the FL EDR.

Families with Children - Households with one or more people under 18 years. (%/total hhs).

Weblink:

http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_13_5YR_S110

1&prodType=table. Table name - S1101

Data collection period: Annual Source Data type: %

Source: US Census Fact Finder. Original Data Source: US Census.

Births to Mothers by age group (Resident) - Live Births. Does not include pregnancies that end with miscarriages, elective and spontaneous abortions or fetal deaths. Births to mothers in a specific age group divided by females in the same age group. Weblink:

http://www.floridacharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=0001.

Data collection period: 3-year rolling

Source Data type: Rate

Source: FL DOH, Division of Public Health Statistics & Performance Management. Florida Charts.

Original Data Source: FL DOH, Bureau of Vital Statistics

Total Births (resident) - Number of infants born to residents regardless of county of birth. Weblink: http://www.floridacharts.com/FLQUERY/Birth/BirthRpt.aspx

Population by Race - Weblink:

http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t. Table name - B02001.

Veteran Population - Person 18 years old or over who has served (even for a short time), but is not now serving, on active duty in the U.S. Army, Navy, Air Force, Marine Corps, or the Coast Guard, or who served in the U.S. Merchant Marine during World War II. People who serve People who served in the National Guard or military Reserves are classified as veterans only if they were ever called or ordered to active duty, not counting the 4-6 months for initial training or yearly summer camps. Weblink: http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t. Table name - S2101.

Data collection period: Annual Source Data type: Count

Source: US Census Fact Finder. Original Data Source: US Census.

Abbreviations and Acronyms

Andread Company Compan
Ambulatory Care Sensitive Conditions - ICD-9-CM Codes
http://www.floridacharts.com/charts/documents/ACS Conditions Definition UPD
ATE.pdf
American Community Survey
Florida Behavioral Risk Factor Surveillance System - county-level telephone survey
conducted by the CDC and FL DOH Bureau of Epidemiology.
Centers for Disease Control and Prevention
County Health Rankings, Robert Wood Johnson Foundation
Centers for Medicare and Medicaid Services
Environmental Protection Agency
Florida Department of Highway Safety and Motor Vehicles
Florida Department of Law Enforcement
Florida Agency for Health Care Administration
Florida Department of Children and Families
Florida Department of Education, Education Information and Accountability Services
Florida Department of Health
Florida Legislature's Office of Economic and Demographic Research
Florida Youth Substance Abuse Survey
Florida Youth Tobacco Survey

N f1!	Mala EDOU Diagram Compilation of December 2
Merlin	Merlin, FDOH Disease Surveillance and Reporting System
NCES	National Center for Education Statistics
NCHS	National Center for Health Statistics
SAHIE	Small Area Health Insurance Estimates (US Census)
UM(FL) MS	University of Miami (FL) Medical School
US Census	US Census Bureau
US DoA	US Department of Agriculture, Food Environment Atlas
US DoC	US Department of Commerce
US DoHHS	US Department of Health & Human Services, Health Resources and Services Administration
US DoHUD	US Department of Housing and Urban Development
US DoL	US Department of Labor



Florida Department of Health in Bay County Community Health Task Force Meeting Bay Medical Center- Sacred Heart, Walsingham Board Room Friday, September 18, 2015, 8:00 – 11:30 a.m. (Hot Breakfast – 8:00 a.m.)

AGENDA

<u>Purpose:</u> Solicit input from the community on community health needs assessment through open two-way dialogue.

Topic	Lead
Welcome/Call to Order Introductions Brief review of agenda Prompt attendees to sign-in	Lisa Rahn
Review Previous Minutes	Lisa Rahn
Status Update of Previous Actions • Item 1: Partnership Opportunity with Sacred Heart Health System • Item 2: Potential Partnership with United Way of NW FL Task Force • Item 3: Open Floor for Community Input/Vote to Proceed	Lisa Rahn/ Becky Bray Washler/ April Wisdom
Introduce Topic Introduction to the MAPP Process and Proposed Strategy • Methodology for Identifying 3-10 Target Areas for the Community Health Improvement Plan (CHIP) • Community Health Assessment (CHA) Survey Methodology • Local Public Health System (LPHS) Survey • Definitions of "Forces of Change" and "Strengths and Themes"	April Wisdom
 Discuss Supporting Information Development of CHA Survey Distribution Strategy Review of LPHS Survey Methodology 	April Wisdom/ Becky Bray Washler/ Lisa Rahn/
 Open Floor for Community Input Invite suggestions of additional audiences for community survey Discuss additional community members to be invited to future meetings 	April Wisdom
Actions Assign action items Set future meeting dates	April Wisdom
Meeting Evaluation	Lisa Rahn
Adjourn	



2015 Community Health Needs Assessment Indicators

ΛA	OI	Ťα	litv.

- 1. Premature Death
- 2. Infant Mortality
- 3. Cancer Deaths
- 4. Breast Cancer Deaths
- 5. Prostate Cancer Deaths
- 6. Deaths from Smoking-related Cancers
- 7. Lung Cancer Deaths
- 8. Colon, Rectal or Anus Cancer Deaths
- 9. Diabetes Deaths
- ___ 10. Heart Disease Deaths
 - 11. Ischemic Heart Disease Deaths
 - 12. Stroke Deaths
 - 13. Neonatal Deaths (0-27 days)
 - 14. Post neonatal Deaths (28-364 days)
 - 15. Chronic Liver Disease, Cirrhosis Deaths
 - 16. Suicide Deaths
 - 17. Chronic Lower Respiratory Disease Deaths
 - 18. Pneumonia, Influenza Deaths
 - 19. HIV/AIDS Deaths
 - 20. Motor Vehicle Accident Deaths
 - 21. Injury Deaths
 - 22. Homicide
- 23. Nephritis, Nephritic Syndrome, and Nephrosis Deaths

Chronic Conditions

- 24. Breast Cancer Incidence
- 25. Melanoma Cancer Incidence
- 26. Total Cancer Incidence
- 7. Prostate Cancer Incidence
- ತಿ. Cervical Cancer Incidence
- 29. Colon and Rectum Cancer Incidence
- 30. Lung Cancer Incidence
- 31. Diabetes (Adult)
- 32. Diabetic monitoring
- 33. High Blood Pressure (Adult)
- -34. High Cholesterol (Adult)
 - 35. High Blood Pressure Controlled (Adult)
- 36. Heart Disease (Adult)
 - 37. Asthma Incidence (Adult)
 - 38. Asthma Incidence (Child)

Tobacco Use

- 39. Tobacco Expenditures
- 40. Smokers (Adult)
- 41. Smoked in last 30 days (Adolescents)
- 42. Former Smokers (Adult)
- 43. Live Births w Mother Smoking During Pregnancy
- 44. Never Smoked (Adult)
- 45. Tobacco Quit Attempt (Adult)
- 46. Secondhand Smoke exposure (Children)
- 47. Secondhand Smoke exposure (Non-smoking Adult)
- 48. WATCH: E-cigarettes

Alcohol / Substance Use

- Adults who, in the past 30 days, drove a vehicle after consuming too many alcoholic beverages
- 50. Alcohol-related Motor Vehicle Traffic Crash Deaths
- 51. Alcohol-related Motor Vehicle Traffic Crashes
- 52. Illicit substance use any except alcohol (Adolescents)
- Alcohol Consumption (Adolescents)
 - Binge Drinking (Adolescents)

Diet and Exercise

- 55. Vigorous physical activity recommendations met (Adult)
- __ 56. Exercise opportunities
- ___ 57. Sedentary Adults
 - 58. Participation in community sponsored organized sports (youth)
 - 59. Participation in school sponsored organized sports (youth)
 - 60. Sedentary at work
 - 61. Food Insecurity
 - 62. Grocery Store Access
 - 63. Food Access Low Low Income Population
 - 64. Fast Food Restaurant Access
 - 65. SNAP Benefits Recipients
 - 66. Soda Expenditures
 - 67. Fruits and Vegetables Consumption 5 servings per day (Adult)
 - 68. Fruits and Vegetables Consumption 5 servings per day(Youth)
- 69. Obesity (Adult)
- 70. Obesity (Children and Adolescents)
- 71. Overweight (Adult)
- 72. Healthy Weight (Adult)
- 73. Overweight (Youth)
- _ 74. Healthy Weight (Youth)

Access to Care

- 75. Dental Care Access by Low Income Persons
- 76. Insurance Population Receiving Medicaid
- 77. Insurance Uninsured Adults
- 78. Insurance Uninsured Children
- 79. Uninsured
- 80. Lack of Prenatal Care
- 81. Primary Care Access
- 82. Percentage of adults who could not see a doctor at least once in the past year due to cost
- 33. Children, adolescents, and adults who visited the dentist in the past year

Care Management

- 84. Poor Dental Health
- 85. Persons with diagnosed diabetes whose A1c value is >9 percent
- 86. Diabetic Annual Foot Exam (Adults)
- 87. Diabetic Semi-Annual A1C Testing (Adult)
 - 88. Adults who have a personal doctor
 - 89. Cancer Screening in past two years PSA (Men age 50 & older)
 - 90. Cancer Screening Sigmoidoscopy or Colonoscopy
 - 91. HIV Testing (Adult age 65 and over)
 - 92. Cancer Screening Mammogram
 - 93. Cancer Screening Pap Test
 - 94. Flu Vaccination in the Past Year (Adult age 65 and over)
 - 95. Flu Vaccination in the Past Year (Adult)
 - 96. Flu Vaccination Skipped in the Past Year Due to Cost or Availability Issues (Adult)
 - 97. Pneumonia Vaccination (Adult age 65 and over)
 - 98. Pneumonia Vaccination (Adult)
 - 99. Vaccination (kindergarteners)

Preventable ED Use

- 100. ED Visits Acute Conditions Hypoglycemia
 - 101. ED Visits Avoidable Conditions Dental
- 102. ED Visits Avoidable Conditions Dehydration
- 103. ED Visits Avoidable Conditions Vaccine Preventable
- 104. ED Visits Chronic Conditions Angina
- 105. ED Visits Chronic Conditions Asthma
- 106. ED Visits Chronic Conditions Congestive Heart Failure
 107. ED Visits Chronic Conditions Chronic Obstructive Pulmonary Disease
- --- 108. ED Visits Chronic Conditions Diabetes
 - 109. ED Visits Chronic Conditions Mental Health
 - 110. ED Visits Chronic Conditions Hyper Tension

Appendix II Page 3 of 51

Health System

- 111. Preventable hospital stays
- 112. Preventable Hospital Events
- 113. Dentists (per population)
- 114. Acute Care Beds (per population)
- 115. Adult psychiatric beds (per population)
- 116. Adult substance abuse beds (per population)
- Pediatric psychiatric beds (per population) 117.
- Pediatric substance abuse beds (per population)
- 119.
- Rehabilitation beds (per population)
- 120. Skilled nursing beds (per population)
- Mental health providers (per population) 121.
- 122. OB/GYN (per population)
- 123. Family Practice Physicians (per population)
- 124. Internists (per population)
- Pediatricians (per population)
- 126. Primary care physicians (FP, IM, Peds, OB/GYN) (per population)
- 127. Physicians (per population)
- -128. Health Professional Shortage Area Population (%)
- 129. Mental Health Professional Shortage Area Population (%)
- 130. Health Professional Shortage Area Population (%)
- 131. Primary Care Health Professional Shortage Area Population (%)
- Dental Health Professional Shortage Area Population (%) 132.
- 133. Urgent Care Facilities (after hours/weekend)
- 134. Medicare Readmissions

Mental

- 135. Adults who always or usually receive the social and emotional support
- Adolescents who experience major depressive episodes
- 137. Poor mental health days

General Health

- Adults with good to excellent overall health
- 139. Poor or fair health
- 140. Average number of days where poor mental or physical health interfered with activities of daily living in the past 30 days

Mother Infant Child

- 141. Prenatal Care Begun in First Trimester
- Prenatal Care Begun Late or No Prenatal Care 142.
- 143. Births to Mothers Ages 10-14 (Resident)
- 144. Births to Mothers Ages 15-19 (Resident)
- Births to Mothers Ages 15-44 (Resident) 145.
- 146. Live births where mother smoked during pregnancy (rate)
- 147. Medicaid birth rate
- _148. Births to Obese Mothers (rate)
- -149. Births to overweight mothers (rate)
- 150. Low birth weight
- 151. Breastfeeding Initiation
- 152. Breastfeeding Duration

Socio-Economic & Environment

- 153. Unemployment
- 154. Housing Cost Burden (30%)
- 155. Income - Per Capita Income
- 156. Poverty Rate
- 157. Children in poverty (based on household)
- 158. Income inequality (80th percentile vs 20th percentile)
- Children Eligible for Free/Reduced Price Lunch 159.
- 160. Children receiving for Free/Reduced Price Lunch
- 161. Population eligible for SNAP Benefits (ACS)
- 162. Population Receiving SNAP Benefits (ACS)
- 163. Income - Public Assistance Income
- 164. High school graduation (rate)
- 165. Population > 25 without a high school diploma (rate)
- 166. Households with No Motor Vehicle
- 167. Air pollution - particulate matter
- 168. Drinking water violations
- 169. Air Quality - Ozone

Injury Crime Violence

Domestic Violence Offenses

Severe housing problems

Use of Public Transportation

Driving alone to work

- 174. Forcible Sex Offenses
- 175. Aggravated Assault
- 176. Murder rate
- 177. **Property Crimes rate**
- 178. Violent Crime rate
- 179. Adult seat belt usage

Communicable Disease

- 180. Salmonellosis
- 181. AIDS

170.

171.

172.

- 182. HIV
- 183. Infectious Syphilis
- 184. Sexually transmitted infections
- 185.
- Meningitis, Other Bacterial, Cryptococcal, or Mycotic 186.
- 187. Measles
- 188. Mumps
- 189. Whooping Cough (Pertussis)
- 190. Rubella
- Vaccine Preventable Disease for All Ages 191.
- 192. Tuberculosis
- 193. Chicken Pox (Varicella)

Demographics

- 194. Disability (Any)
- 195. Population Under Age 18
- 196. Population Age 25-34
- Population Age 35-44
- 198. Population Age 45-54
- Population Age 55-64 199. 200. Population Age 65+
- 201. Female Population Age 10-14
- 202. Female Population Age 15-19
- 203. Female Population Age 20-44
- 204. Male Population Age 50+ 205. Median Age
- 206. **Total Population**
- 207. Female Population
- 208. Male Population
- 209. Median Household Income
- Families with Children
- 211. Children in single-parent households 212.
- Total Births (resident) 213.
- Population by Race Asian/Pacific Islander
- Population by Race Black
- 215. Population by Race - Native American Population by Race - Other 216.
- Population by Race White
- Veteran Population
- 219. Population with Limited English Proficiency

Forces of Change Brainstorming Worksheet

The following two-page worksheet is designed for MAPP Committee members to use in preparing for the Forces of Change brainstorming session.

What are Forces of Change?

Forces are a broad all-encompassing category that includes trends, events, and factors.

- Trends are patterns over time, such as migration in and out of a community or a growing disillusionment with government.
- Factors are discrete elements, such as a community's large ethnic population, an urban setting, or a jurisdiction's proximity to a major waterway.
- Events are one-time occurrences, such as a hospital closure, a natural disaster, or the passage of new legislation.

What Kind of Areas or Categories Are Included?

Be sure to consider any and all types of forces, including:

- social
- economic
- political
- technological
- environmental
- scientific
- legal
- ethical

How To Identify Forces of Change

Think about forces of change — outside of your control— that affect the local public health system or community.

- 1. What has occurred recently that may affect our local public health system or community?
- 2. What may occur in the future?
- 3. Are there any trends occurring that will have an impact? Describe the trends.
- 4. What forces are occurring locally? Regionally? Nationally? Globally?
- 5. What characteristics of our jurisdiction or state may pose an opportunity or threat?
- 6. What may occur or has occurred that may pose a barrier to achieving the shared vision?

Also, consider whether or not forces identified were unearthed in previous discussions.

- 1. Was the MAPP process spurred by a specific event such as changes in funding or new trends in public health service delivery?
- 2. Did discussions during the Local Public Health System Assessment reveal changes in organizational activities that were the result of external trends?
- 3. Did brainstorming discussions during the Visioning or Community Themes and Strengths phases touch upon changes and trends occurring in the community?

Forces of Change Brainstorming Worksheet (Page 2)

Using the information from the previous page, list all brainstormed forces, including factors, events, and trends. Continue onto another page if needed. Bring the completed worksheet to the brainstorming session

1.	
11.	
12.	

Florida Department of Health in Bay County CHIP Meeting Bay Medical/Washington Room September 18, 2015 8:00a.m. to 11:30a.m.

COMMUNITY MEETING MINUTES



Florida Department of Health in Bay County Community Health Improvement Plan Update Committee Bay Medical Center-Sacred Heart, Walsingham Board Room 615 N Bonita Ave, Panama City, FL 32401 September 18, 2015 - 8:30 am

Sign In Sheet

Purpose:

Engage community partners in the Mobilizing for Action through Planning and Partnerships (MAPP) process.

Attendees

Name	Organization or Community Representative	Email	Phone
Was Mully hat	DOHIWIC	Kay. Judge 1 Heal	872-4641
Rebecca Murti	DOH-Bay WIC	Rebecca Curti antheast	gov 872-44da
Sandy mcGroan	- DOH - Bay WIC	Sandy McCroan@FII	trapth gov 4woo
7 Honny NEUK		tammy newton@	xymolicil, o
Suzalmeclo		SUZ Clark130	747-6981
Ann win	BBCBC	anningo Bigh	147-5755
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Prestan Whathaus	Big Bend All Fee	pmathewsobig bandelice	on 386.95652
BarbarasDay	AHRP 3.C. Chp 1215	busy day 42@ concast	
Bekan Taylor	Life Management Conter	braylor elmicares org	
Deshry Young	Calibra Ats Society	glubalats swelf graits	
By now Algason	ST. ANDREWS STATE PURK	BRINN. ADDIEN & DEP. STA	TE. FL. US 233
NAMES L TIAPS	FLOOT BAY CITY	Nancy toppostheach.	Cary 822 4458
Sherriebock'	GC5C	Slocka gulleast.e	
Tara Martine	Tyndall AF3	tara martine e gmail.	
BRANDI HULLES	FLOOH -BAY	PRANOIL Humber Ditter	CAL. GOV 87>4
Daug KenT	FDOIL - BHS CH.D	Doughs-KertaFihea HL	
Julie Tindall	FOOH - BOUNG (HO)	Julie. Tindall Of I heatt	
Gina Watsch	United Way -211		· ·
Soula Lucyton			
Rocal Mills	FAOH-BAY		872-4660X/2
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		batlook.com	

Florida Department of Health in Bay County **CHIP Meeting** Bay Medical/Washington Room September 18, 2015 8:00a.m. to 11:30a.m.

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Name	Organization or Community Representative	Email	Phone
Marguez Alexander		morguezalexandere Knot	94 net 319-7216
Don Kich	FDOW - BAY	don, nich O FLHERLTH. Gu	327-4448
Carol Miller	Gulf coast State College	rchitwood eguttooas	t.edu 769-1551
Randy Chitwood		CMiller@galfcoast.e	du 7691557
MIKEHILL	BBHC/TONIREOTT INC	Mhill Dancavery, OK	747-5597
PORI Shamplan	P.C. C.LA.	tshamplan Oucgovio	
Votastu (Ubumu)	Floth Dachetes, Sources	nataska colenano A	8724455 130:
PAM DORWART	Health Tack Force ADA	prandorwarthough	OCOM 230325
Dovern Rosser-Cort	in Global Arts Joices	globalassociety egma	1 315-316-5
Jockiekinka	itean Media	Jackier inker & i keau	rmelia. com
Lisa Rahn	PDOH-Bay	•	850 39211
April Wisdom	Tyndall AFB		
Becky Washler	Socred Heart Health		
Carter Ross	If w ii		
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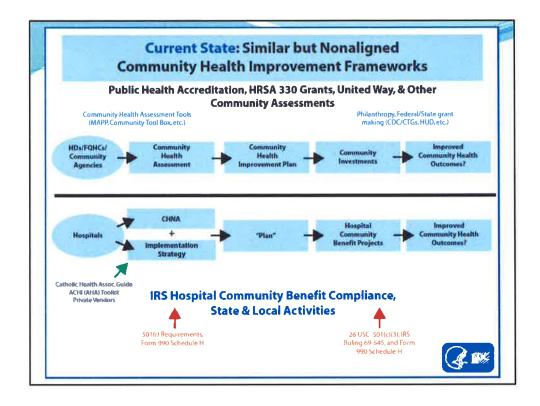


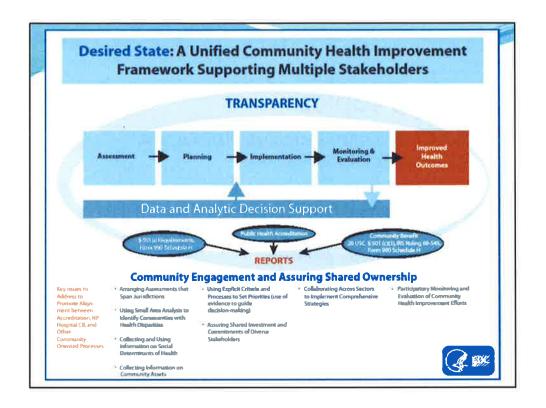
Today's Agenda

- Intros/sign-in please
- Review previous minutes
- Status updates: partnerships (Sacred Heart, United Way)
- MAPP intro/future plans
- CHA Survey Distribution Strategy
 - Who/when/where?
- LPHS/Survey
- FOC/Strengths and Themes
- Action Items/Future meeting dates

Partnerships and Opportunities

• Lisa, Becky and Gina





Today's Topics

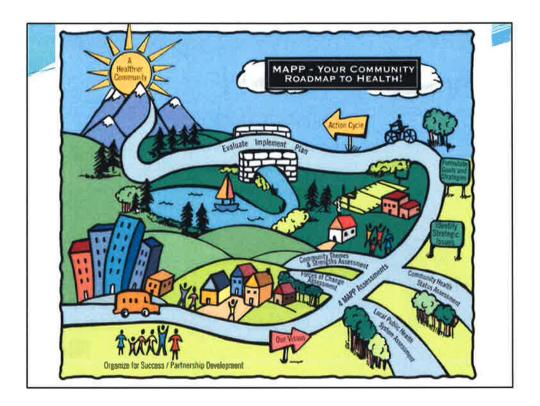
- Mobilizing for Action through Planning and Partnerships (MAPP) overview
- CHA Survey
- LPHS background info and survey
- Forces of Change and Strengths and Themes Defined/plans for assessing
- Moving forward (dates, plans, etc)
- CHIP subcommittee/working group volunteer solicitations

10 Steps in Community Health Assessment and Improvement Plan Development Process

- 1. Establishing the assessment team.
- 2. Identifying and securing resources.
- 3. Identifying and engaging community partners.
- 4. Collecting, Analyzing, and Presenting Data.
- 5. Setting Health Priorities.
- 6. Clarifying the Issue.
- 7. Setting Goals and Measuring Progress.
- 8. Choosing the Strategy.
- 9. Developing the Community Health Assessment document.
- 10. Managing and sustaining the process.

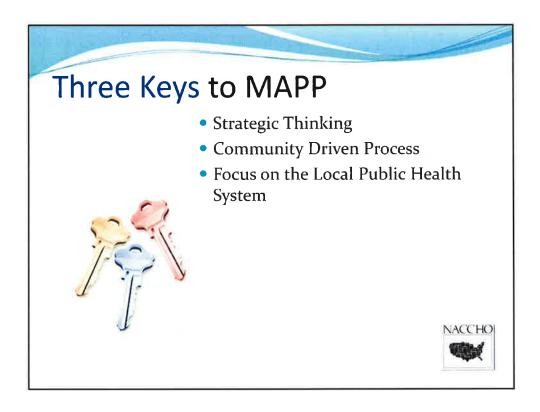
10 Steps in Community Health Assessment and Improvement Plan Development Process

- 1. Establishing the assessment team.
- 2. Identifying and securing resources.
- 3.Identifying and engaging community partners.
- 4. Collecting, Analyzing, and Presenting Data
- Secondary data/indicators (list on a handout FYI)
- Community Data (our job!)



This is one of 2 models showing how the MAPP process works – and is an especially good image for connecting to communities. The phases of MAPP are shown along a road that leads to "A Healthier Community". The 4 MAPP Assessments are shown on the main road and represent the core activities in the process. MAPP is a way to define your interim goals between where you are and "A Healthier Community." It also helps prioritize, set realistic action plans to get there, and celebrate your successes along the way. One challenge with this image is that it makes the MAPP process look linear when it's actually cyclical.

Put another way, using MAPP is like taking a trip. MAPP can help you figure out where you want to go, how to get there, and who needs to be in the car. You may need to pick up extra people along the way to help you reach your destination. And, by the time you get there, MAPP may have helped you figure out an even better destination.



State: There are three keys to MAPP.

The first key is strategic thinking. MAPP is unique because it is based on strategic planning concepts, and - in order to be successful - requires creative, long-term strategic thinking.

The second key to MAPP is that MAPP is a community driven process. MAPP relies on participation from a wide range of individuals, groups, and constituencies in the community. Since the community drives the process, the process has credibility, ensures buy-in and creates sustainability over time. It can also create greater advocacy for public health. This is a community driven process.

The third key to making MAPP successful is the use of a broad definition of the Local Public Health System.

Next slide



This is the second, more academic model that describes how the MAPP process works. The four assessments shown in a circle around the process illustrate how the assessments drive the process.

The **Organize for Success and Partnership Development** phase allows communities to plan a MAPP process that builds commitment, engages participants, uses their time well, and results in a plan that can be implemented successfully. During this phase, initiators begin to design the process and build interest and support from partners.

Then, all partners and the broader community develop a shared vision, and values for the community. The **visioning process** is a collaborative and creative approach that leads to a shared community vision and common values. This phase defines where the community is going and what the process will look like.

The next step is the real "meat" of the MAPP process – **the four assessments**. In these assessments, the community identifies:

1) <u>Community Themes and Strengths</u> or "what is important to community members and what assets do we have?"; This assessment is about identifying community assets and strengths, it shouldn't focus on community perceptions of health status.

focus on community perceptions of health status.

2) Forces of Change or "what is occurring or might occur that will affect the community or public health system?"; This assessment is similar to a business SWOT analysis – it looks at the external forces you can't control but impact your ability to do your work – these can be "good" or "bad."

3) Community Health Status Assessment or "what does our data tell us about our health status?" and

4) Finally, the <u>Local Public Health System Assessment</u>, also known as the National Public Health Performance Standards (NPHPS) Local Instrument which tells us about the capacity of our local public health system and its ability to provide the 10 Essential Public Health Services.

After conducting the four assessments, the community uses the information from the assessments to Identify Strategic Issues, Formulate Goals and Strategies, and lastly, conduct the Action Cycle in which action plans are implemented and evaluated.

- The Identify Strategic Issues phase uses the information gathered from the four assessments to
 determine the strategic issues for the community. Essentially, the community looks across the
 data to see what data themes emerge, and asks: "what are the big picture issues that once
 addressed, will help our community reach its vision?"
- In Formulate Goals and Strategies, specific goals are devised for each of the strategic issues identified in the previous phase.
- The Action Cycle includes planning, implementation, and evaluation (who, what, when, where,

and evaluation).

STOP: ask: does this sound like efforts you have already been involved in? When have you done one or more of these phases in the past? (explain how to build on those experiences). CONCLUSION: MAPP is not unique as it builds from the existing literature and knowledge about strategic planning, and can build off of the work you are already doing. MAPP is a framework, not a completely new project.

MAPP's six phases:

- Organize for Success.
- Visioning.
- The Assessments: Community Themes and Strengths Assessment, Local Public Health System Assessment, Community Health Status Assessment, Forces of Change Assessment. (ALL four to be discussed today)
- Strategic Issues.
- Goals/ Strategies.
- Action Cycle.



Benefits

- Increases visibility of public health.
- Creates advocates for public health.
- Anticipates and manages change.
- Creates a stronger public health infrastructure.
- Builds stronger partnerships.
- Builds public health leadership.



The benefits of MAPP include

- Increases visibility of public health within the community.
- **Creates advocates** for public health which helps to put public health issues as a priority in local government decision making.
- There are so many new emergent threats, its difficult to be proactive. However, since 9/11 there has been a huge push for to be prepared. The MAPP process helps communities design plans that **Anticipates and manages the change** and new threats we face.
- And through the use of the Performance Standards, it creates a **stronger public** health infrastructure.
- Because it is not a tool for the LHD, but for all partners within the public health system to work on collaboratively, it **Builds stronger partnerships.**
- As partners begin to have a better understanding of their role within the LPHS (as not all of them will initially understand that what they do necessarily impacts public health) the local public health department's leadership strengthens among is partners.

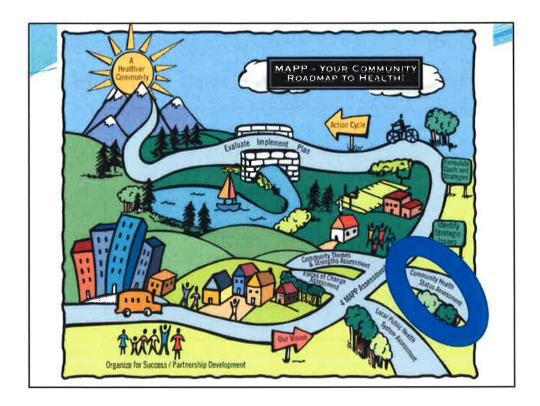


By bringing together the collective wisdom of the community, MAPP can serve as the boat for a community. In any community there are many oars in the water, just as there are new and ongoing initiatives. MAPP is the process that gives unified direction to the various initiatives in a local community.

Oftentimes many different local organizations are doing lots of great work; however, none of it is coordinated. By aligning our efforts, we can move more efficiently across the river.

MAPP includes other community initiatives that have been undertaken or are currently occurring in the community.

For example, the United Way may be conducting a community survey, the local hospital may be undertaking a community health assessment, or a community may have conducted a visioning process in the past year. All of these efforts fit together. The United Way's survey and the hospital's data may tell a similar story, but there is no way to find out if coordination doesn't exist. MAPP can help bring the participants and results of these efforts together into one comprehensive process.



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CHA Survey Distribution Strategy

- In small groups, list audiences specific to you/your organization (with some cross-over expected)
 - Can they access the web/need paper copies?
 - How many people can you reach per audience?
 - Ask yourselves/each other about populations that may not be represented here today
 - What vulnerable populations can we reach out to?
- Target/goals (due date of October 10th)

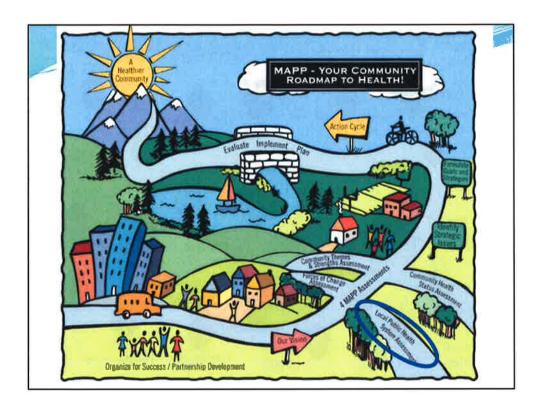
CHA Survey Marketing

Email/Social Media/Print Tools

- Distribution kit available
- Includes social media messages
- Printed advertising materials
- Vulnerable population distribution (and data input)

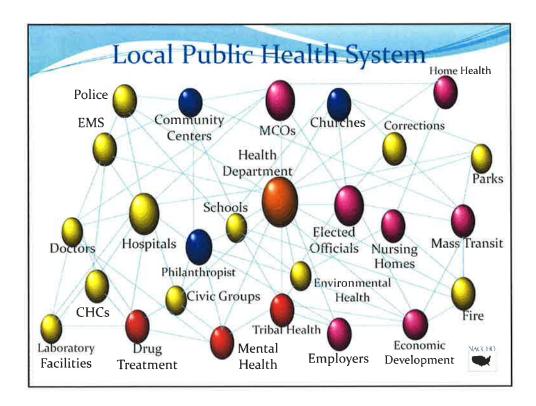






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This recognizes that public health is provided by more than just the local health department. Other organizations such as hospitals, businesses, faith organizations, and community-based organizations play a critical role in assuring the public's health. The local public health system includes all public, private and voluntary entities, as well as individuals and informal associations that contribute to public health services.

A Public Health System is complex. Here is a depiction of the complexity of a public health system and examples of organizations and groups that comprise the network. You can see many of the system partners represented who contribute to health and delivery of the Essential Public Health Services.

The 10 Essential Public Health Services as a Framework

- □ Provide a foundation for any public health activity
- □ Describe public health at both the state and local levels
- □ Serve as a structure for the NPHPS Instruments which include sections addressing each essential service
- □ Provide a foundation for accreditation standards and measures

The Essential Public Health Services

- Monitor health status to identify and solve community health problems
- 2. Diagnose and investigate health problems and health hazards in the community
- 3. Inform, educate, and empower people about health issues
- 4. Mobilize community partnerships to identify and solve health problems
- 5. Develop policies and plans that support individual and community health efforts

The ten essential services are shown here on the screen and include

- 1. Monitor health status to identify and solve community health problems
- 2. Diagnose and investigate health problems and health hazards in the community
- 3. Inform, educate, and empower people about health issues
- 4. Mobilize community partnerships to identify and solve health problems
- 5. Develop policies and plans that support individual and community health efforts
- 6. Enforce laws and regulations that protect health and ensure safety
- 7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- 8. Assure a competent public and personal health care workforce
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- 10. Research for new insights and innovative solutions to health problems

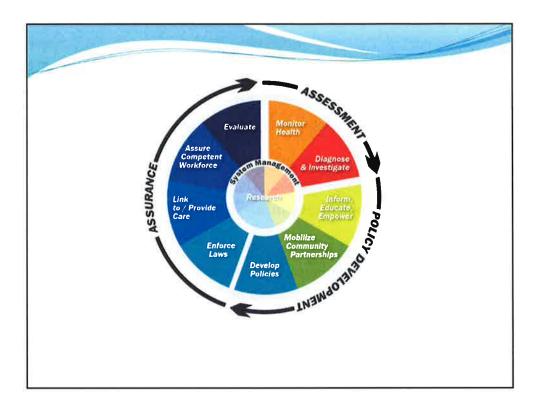
These are the foundation of any public health activity.

For example, any public health program needs data to operate. Essential Service #1 includes activities such as data collection, community health assessments and the maintenance of population health registries. As another example, Essential Service #7 includes personal health care services, transportation, and other enabling services such as assuring the availability of culturally appropriate personnel and materials.

Since the Ten Essential Services were released, numerous initiatives have explored the utility and feasibility of these services and have found them to be a good descriptor of public health practice.

The Essential Public Health Services cont

- 6. Enforce laws and regulations that protect health and ensure safety
- 7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- 8. Assure a competent **public and personal health care** workforce
- 9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- 10. Research for new insights and innovative solutions to health problems



The Public Health Wheel shows the three core functions (assessment, policy development, and assurance) in black around the "wheel" of essential services. In essence, the essential services can be grouped under the three core functions.

Essential services 1 and 2 fit under the core function of assessment. Essential services 3, 4, and 5 fit under policy development while essential services 6, 7, 8, and 9 fit under assurance. Research (essential service 10) and system management form the center of the wheel since these activities are included within all three core functions.

Adopted: Fall 1994, Source: Public Health Functions Steering Committee, Members (July 1995):

American Public Health Association-Association of Schools of Public Health-Association of State and Territorial Health Officials-Environmental Council of the States-National Association of County and City Health Officials-National Association of State Alcohol and Drug Abuse Directors-National Association of State Mental Health Program Directors-Public Health Foundation-U.S. Public Health Service—Agency for Health Care Policy and Research-Centers for Disease Control and Prevention-Food and Drug Administration-Health Resources and Services Administration-Indian Health Service-National Institutes of Health-Office of the Assistant Secretary for Health-Substance Abuse and Mental Health Services Administration

Essential Service (ES) 1 – Monitor Health to Identify and Solve Community Health Problems

- Accurate, periodic assessment of the community's health status
 - Identification of health risks
 - Attention to vital statistics and disparities
 - Identification of assets and resources
- Use of methods and technology (e.g., mapping technology) to interpret and communicate data
- Maintenance of population health registries

S 1 answers these questions: What's going on in our state/community? Do we know how healthy we are?

Accurate, periodic assessment of the community's health status, including Identification of health risks, determinants of health, and determination of health service needs

Attention to the vital statistics and health status indicators of groups that are at higher risk than the total population

Identification of community assets that support the local public health system (LPHS) in promoting health and improving quality of life

Use of appropriate methods and technology, such as geographic information systems (GIS), to interpret and communicate data to diverse audiences

Collaboration among all LPHS components, including private providers and health benefit plans, to establish and use population health registries, such as disease or immunization registries

Example From Local Tool

1.1.1 Has the LPHS conducted a community health assessment?

If so:

1.1.1.1 Is the community health assessment updated at regular intervals?

1.1.1.2 Are data from the assessment compared to data from other representative areas or populations?

1.1.1.3 Does the LPHS use data from community health assessments to monitor progress towards health-related objectives?

ES 2 – Diagnose and Investigate Health Problems and Hazards in the Community

- Timely identification and investigation of health threats
- Availability of diagnostic services, including laboratory capacity
- Response plans to address major health threats

ES 3 – Inform, Educate, and Empower People About Health Issues

- Initiatives using health education and communication sciences to
 - Build knowledge and shape attitudes
 - Inform decision-making choices
 - Develop skills and behaviors for healthy living
- Health education and health promotion partnerships within the community to support healthy living
- Media advocacy and social marketing

ES 4 – Mobilize Community Partnerships to Identify and Solve Health Problems

- Constituency development
- Identification of system partners and stakeholders
- Coalition development
- Formal and informal partnerships to promote health improvement

ES 5 – Develop Policies and Plans That Support Individual and Community Health Efforts

- Policy development to protect health and guide public health practice
- Community and state improvement planning
- Emergency response planning
- Alignment of resources to assure successful planning

ES 6 – Enforce Laws and Regulations That Protect Health and Ensure Safety

- Review, evaluation, and revision of legal authority, laws, and regulations
- Education about laws and regulations
- Advocating for regulations needed to protect and promote health
- Support of compliance efforts and enforcement as needed

ES 7 – Link People to Needed Personal Health Services and Assure the Provision of Health Care When Otherwise Unavailable

- Identification of populations with barriers to care
- Effective entry into a coordinated system of clinical care
- Ongoing care management
- Culturally appropriate and targeted health information for at risk population groups
- Transportation and other enabling services

ES 8 – Assure a Competent Public and Personal Healthcare Workforce

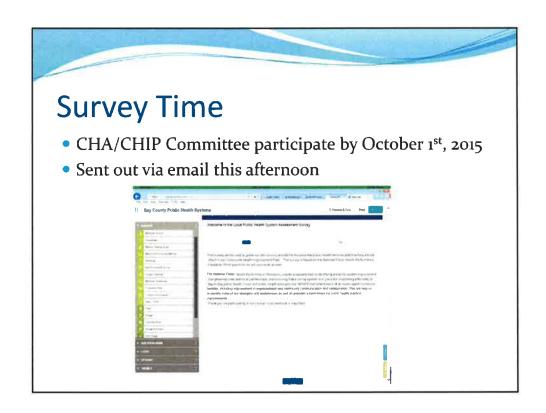
- Assessing the public health and personal health workforce
- Maintaining public health workforce standards
 - Efficient processes for licensing /credentialing requirements
 - Use of public health competencies
- Continuing education and life-long learning
 - Leadership development
 - Cultural competence

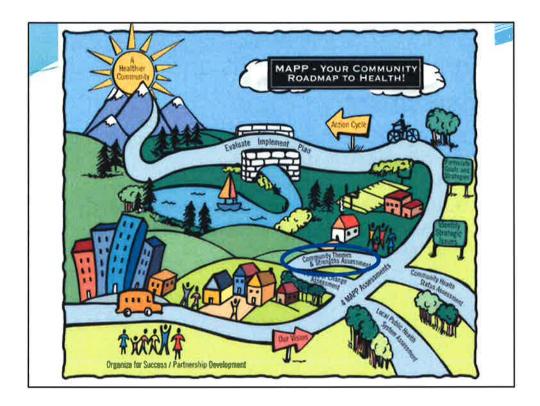
ES 9 – Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services

- Evaluation must be ongoing and should examine:
 - Personal health services
 - Population based services
 - The public health system
- Quality Improvement
- Performance Management

ES 10 – Research for New Insights and Innovative Solutions to Health Problems

- Identification and monitoring of innovative solutions and cutting-edge research to advance public health
- Linkages between public health practice and academic/research settings
- Epidemiological studies, health policy analyses and public health systems research





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Community Strengths and Themes Assessment

- In groups, please discuss who is not represented here that can answer the questions:
 - "What is important to our community?"
 - "How is quality of life perceived in our community?"
 - "What assets do we have that can be used to improve community health?"

What do we talk about?

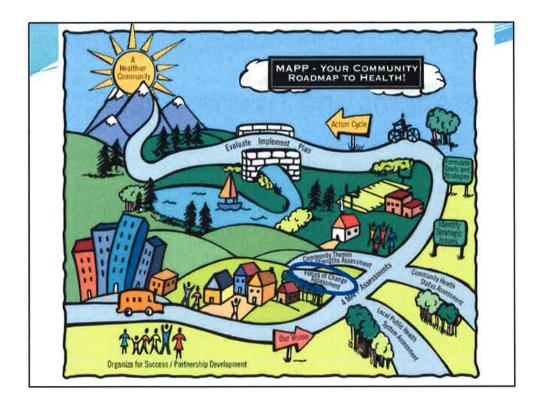
- Questions from the MAPP manual as a starting point for developing discussion lead ins
 - What do you believe are the 2-3 most important characteristics of a healthy community?
 - What makes you most proud of our community?
 - What are some specific examples of people or groups working together to improve the health and quality of life in our community?
 - What do you believe are the 2-3 most important issues that must be addressed to improve the health and quality of life in our community?
 - What do you believe is keeping our community from doing what needs to be done to improve health the quality of life?
 - What actions, policy, or funding priorities would you support to build a healthier community?
 - what would excite you enough to become involved (or more involved) in improving our community.

What do we talk about?

- Questions from the MAPP manual as a starting point for developing questions and discussion lead ins about the quality of life
 - Are you satisfied with the quality of life in our community?
 - · Are you satisfied with the health care system in the community?
 - Is this community a good place to raise children?
 - · Is this community a good place to grow older?
 - · Is there economic opportunity in the community?
 - Is the community a safe place to live?
 - · Are there networks of support for individuals and families?
 - Do all individuals and groups have the opportunity to contribute to and participate in the community's
 quality of life?
 - Do all residents perceive that they individually and collectively can make the community a better place to live?
 - · Are community assets broad based and multi-sectoral?
 - Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?
 - Is there an active sense of civic responsibility and engagement, and of civic pride in shared accomplishments?

Strengths and Themes Team!

- Who wants to join?
- Need to use tools such as
 - conduct interviews
 - facilitate focus groups
 - use photovoice



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Forces of Change

- Trends, factors or events that influence the health and quality of life of the community and LPHS
- Homework/work session: take the time to fill out the brainstorming worksheet and then return it to April
- Identify possible impacts/potential threats and opportunities for each force (will be done at next meeting with consolidated list)

Future Meeting Dates for CHA/CHIP committee

- Proposed:
 - October 16th (Friday) or October 15th
 - Review results from CHA survey/LPHS/FOC Assessments
- Assess Community Strengths and Themes***LARGE focus group***-TBD Date/location (perhaps several dates/locations)
 - November 6th (Friday) or November 5th
 - · Data summaries and identification of issues/strategic planning
 - November 17th or 19th
 - · Action Planning/mobilization/responsibilities
 - Evaluation tools/measurable outcomes



Florida Department of Health in Bay County Community Health Task Force Meeting Bay Medical Center- Sacred Heart, Walsingham Board Room Friday, October 16, 2015, 8:30 – 10:30 a.m. (Breakfast – 8:00 a.m.)

AGENDA

Purpose: Solicit input on community health needs assessment through open two-way dialogue.

Topic	Lead
Welcome/Call to Order Introductions Brief review of agenda Prompt attendees to sign-in	Lisa Rahn
Review Previous Minutes	Lisa Rahn
 Status Update of Previous Actions Item 1: Community Health Assessment Survey – how, when and with whom was the survey shared? (input from participants) Item 2: Local Public Health System Survey 	April Wisdom
Introduce Topic Community Strengths and Themes Assessment	April Wisdom
Discuss Supporting Information	April Wisdom
Open Floor for Community Input Small Group Break Outs	April Wisdom Lisa Rahn Sandy McCroan Julie Tindal Tammy Stewart
Our next meeting involve strategic planning for the CHIP using county-wide statistics alongside the data and the information gathered from our surveys and work sessions	April Wisdom
Actions Set date for the next meeting (Nov 6 th , 13 th or 20 th)	Lisa Rahn
Meeting Evaluation	Lisa Rahn
Adjourn	





Florida Department of Health in Bay County CHIP Meeting Bay Medical/Washington Room October 16, 2015 8:30 a.m. to 10:30 a.m.

COMMUNITY MEETING MINUTES

Purpose:

Solicit input on Community Health Needs Assessment through open two-way dialogue.

Attendees (See Attached Sign-In Sheet)

Speaker	Topic	Discussion
Lisa Rahn	 Welcome/Call to Order Introductions Brief review of agenda Prompt attendees to sign-in 	
Lisa Rahn	Review Previous Minutes	The minutes from the 9/18/15 meeting were reviewed. ? moved to accept them; ? seconded, and the motion passed.
April Wisdom	Status Update of Previous Actions • Item 1: Community Health Assessment – how, when and with whom was the survey shared? (input from participants) • Item 2: Local Public Health System Survey	April and Lisa provided an update on the Community Health Assessment survey process. There are almost 1,000 surveys entered already with a large stack still to be entered. Three people have been doing most of the entry. Attendees were asked to note any vulnerable populations they had targeted on index cards that were collected. April commented that 41 people (out of 112) representing diverse community interests had taken the time to complete the Local Public Health System Survey.
April Wisdom	Introduce Topic Community Strengths and Themes Assessment	April introduced the <i>Community</i> Strengths and Themes Assessment and described the process.
April Wisdom	Discuss Supporting Information	
April Wisdom Lisa Rahn Sandy McCroan Julie Tindall Tammy Stewart	Open Floor for Community Input Small Group Break Outs	The attendees were divided into four small groups to discuss the three questions comprising the Community Strengths and Themes Assessment. A representative from each breakout shared the

Florida Department of Health in Bay County CHIP Meeting Bay Medical/Washington Room October 16, 2015 8:30 a.m. to 10:30 a.m.

COMMUNITY MEETING MINUTES

		information with the larger group. Certain themes were common to more than one group (i.e. one of Bay County's greatest strengths is community partnerships; there is a need to educate policy makers on mental health issues, etc.)
April Wisdom	Consider Possible Directions Our next meeting involves strategic planning for the CHIP using county- wide statistics alongside the data and the information gathered from our surveys and work sessions.	
Lisa Rahn	Actions Set date for the next meeting (11/6, 11/13 or 11/20)	Next meeting date was set for Friday, 11/20 8:30 – 10:30 am at Bay Medical Center (room TBA).
Lisa Rahn	Meeting Evaluation	Meeting evaluations were distributed and collected.
	Adjournment	The meeting was adjourned at approximately 10:30 am.



Florida Department of Health in Bay County Community Health Improvement Plan Update Committee Bay Medical Center-Sacred Heart, Walsingham Board Room 615 N Bonita Ave, Panama City, FL 32401 October 16, 2015 - 8:30 am

Sign In Sheet

Purpose:

Engage community partners in the Mobilizing for Action through Planning and Partnerships (MAPP) process.

Attendees - PLEASE PRINT LEGIBLY

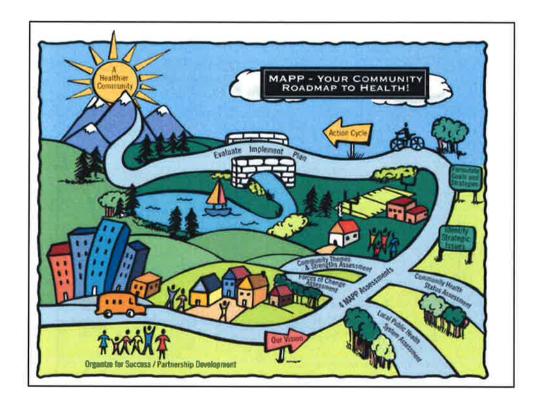
Name	Organization or Community Representative	Email	Phone
Tammy Stewart	FDOH-Bay-Community Projects	tammy stewart of thealth	
Claire Henry	Ser FDOH - Boy - WIC	Claine Hearingere Flh	
Julie Inclal1	FDUH-Ray- Diahetes	Julie. Tindall@ flheath	
Marthur Stander	GCSC RN-BSN	at Matthew Standeregmail	com 80-624-8203
Rebekon taylor	Life Managenut Center	bty lo Clineans 02	522-4485
Sandym Croan	FDOH-Bay-WIC	Sandy mc Croan@ FIll	we to 900 136
April Wisdan	Tyndal (AB	apriliwisdonas	F.m. 1 850-287
Carole Sunne	y St Andrew Medical	director @sauncion	785-14190
NANCY / TIPPS	FROH BAY CHA	Waney TIPBS OF HEADIN	
TO CONVILLE	FOOH-BOI COUNTY-JSP	10. CONILLE OF STORATOR	DOY 872-4451
JOIL BOOM	preprost groppes ibné	BUNKAYARAK CHUM	5 763-7102
Ann Din	BBCBC-ME	id agice 200	bardiber
CurtisWilliams	St andrew Comm. Med Cent		2
Brocke Bullard	Anchorage Childrens Home	bbullard @achkids.	org 7637102
Theospers	Healthy Start	healthyster to concort	14-228 +an.
Song Elsaga	FDOH-Pony	sofia, esseggith healthic	W 381-60%
Shelley Berry	90Works	SBERRYE 90 WORKS OF	630-908
iveston Mathy		mathews Colings of when Co	16 386954578
Grace Higegbox		grace a @ eeckids on	8721550
William Csalift	Clencood Working Paturship	WSWift316 Ogmail.com	(c/10) 499-5908
Bosie Hummer	Catholic Charities NWFL	kummer bloce plainese	ore 850435-35
TammyNauton	Baymed	tammy neuton@b	igmedical or
MIKE HILL	BIGBEND HENLTHCOUNG	mhille provered is	747-5599
Lisa Rahn	FDOH / CHTF	,	



Today's Agenda

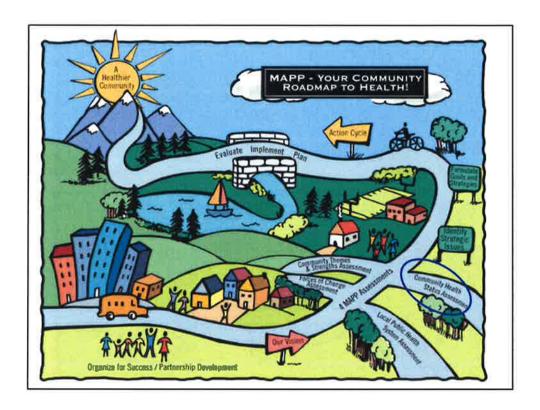
- * Intros/sign-in please
- * Review previous minutes
- * MAPP review
- * CHA Survey Status update
- * LPHS Survey update
- * Preliminary data insight
- * Community Strengths and Themes analysis
- * Action Items/Future meeting dates





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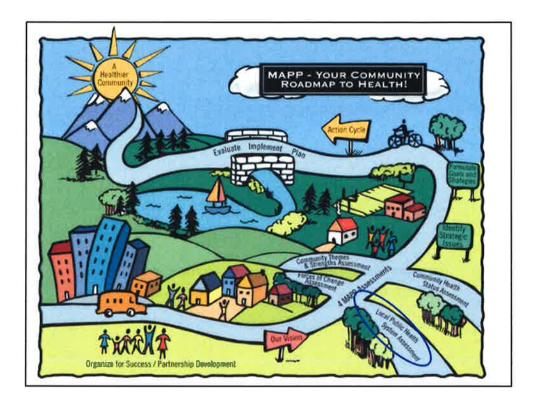


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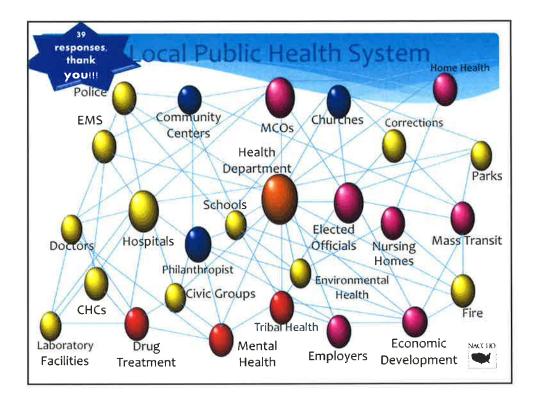
Community Health Assessment Survey update

- * ~950 online surveys
- * paper surveys collected
- * Lisa needs information about who/when/where/how surveys were distributed



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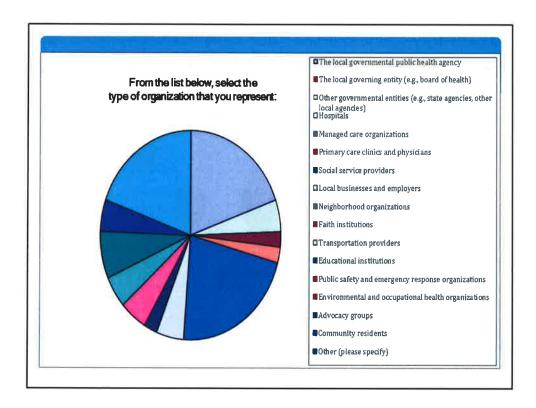
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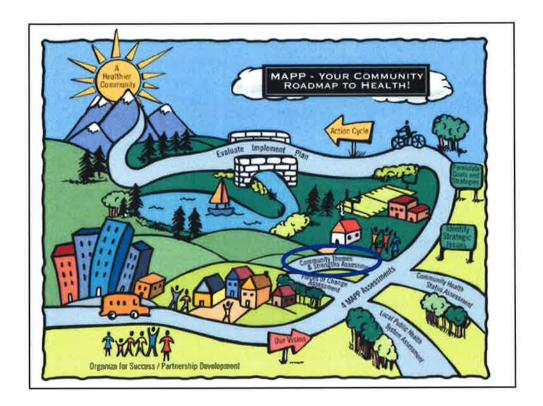


This recognizes that public health is provided by more than just the local health department. Other organizations such as hospitals, businesses, faith organizations, and community-based organizations play a critical role in assuring the public's health. The local public health system includes all public, private and voluntary entities, as well as individuals and informal associations that contribute to public health services.

A Public Health System is complex. Here is a depiction of the complexity of a public health system and examples of organizations and groups that comprise the network. You can see many of the system partners represented who contribute to health and delivery of the Essential Public Health Services.

Appendix III Page 12 of 41





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The Community Themes and Strengths Assessment answers the following questions:

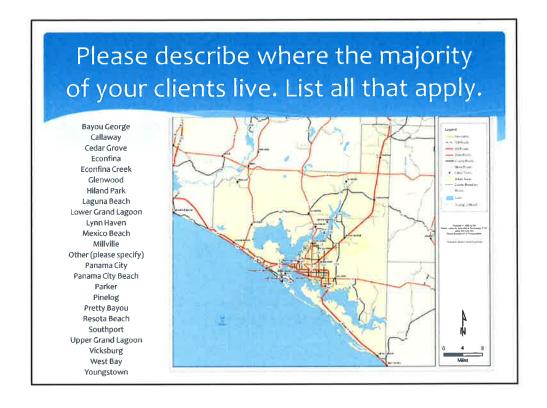
- * "What is important to our community?"
- * "How is quality of life perceived in our community?"
- * "What assets do we have that can be used to improve community health?"

Step 1: Gather information about who is represented today

* Answer the following questions on an index card in front of you

Community Strengths and Themes Assessment: who is represented today?

- * Which age description best describes the clients your organization serves? Please list all that apply:
 - * Infants and children (0-12)
 - * Teenagers (13-17 years)
 - * Young Adults (18-24 years)
 - * Adults (25-64 years)
 - * Older adults (65+ years)



Please describe the social elements reflected by the majority of your clients. List all that apply.

Poor
Lower middle class
Upper middle class
Wealthy
Elementary school students (K-5)
Middle school students (6-8)
High school students (9-12)
High school drop-out
High school graduate with no college
Some college
College graduate
Living in stable families
Living in unstable families
Other (please explain)

Describe your organizations long range planning. Choose one only.

- * Year to year
- * Less than a 5 year strategic plan
- * 5 year strategic plan
- * More than a 5 year strategic plan but less than a 10 year strategic plan
- * 10 year strategic plan
- * More than a 10 year strategic plan
- * I don't know if my organization has a strategic/long-range plan
- * My organization does not have any strategic/long-range planning

Below is a list of 26 public health issues that your clients may face. Based on your organization, please put these public health issues into one of three boxes (TRY for only three per box):

Very important public health issue for my organizations clients Fairly important public health issue for my organizations clients

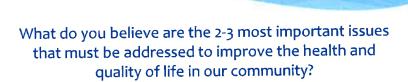
Not an important public health issue for my organizations clients

- Access to clinical services
- Adolescent health
- Cancer
- Chronic Disease Prevention and Control
- · Communicable Disease
- Community Health
- Cultural Barriers
- Diabetes
- Drug and alcohol use
- · Emergency preparedness/response
- Environmental health
- Health education/health promotion
- Heart problems
- Help connecting to services
- Hunger

- Illiteracy
- Injury prevention
- Laboratory services
- Language barriers
- Maternal and child health
- Mental health
- Obesity
- Other (specify)
- Overweight
- Poor nutrition
- Sexually Transmitted diseases/infections
- · Social determinants of health

Break-out into 4 groups!

* Answer 6 questions as small groups



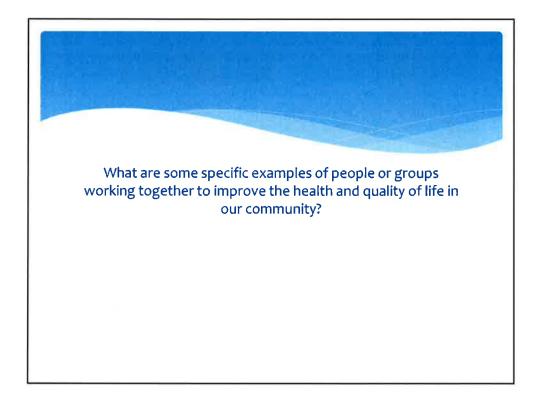
Are there commonalities/themes?

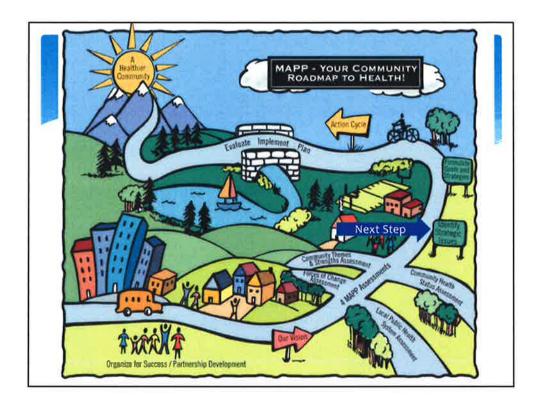
What do you believe is keeping our community from doing what needs to be done to improve health and the quality of life? (3-5 words)

Are there commonalities/themes?

What actions, policy, or funding priorities would you support to build a healthier community?

Are there commonalities or themes?





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Community Health Survey - Bay County

The purpose of the following survey is to get your opinions about community health issues in Bay County. The Bay County Community Health Task Force will use the results of this survey to identify health priorities for community action. This survey will take about 5-10 minutes to complete. Your opinion is important. This survey is valid through October 15, 2015, so please respond by that date to have your opinions counted.

Thank you for taking the time to provide it. If you have any questions, please contact april.wisdom@us.af.mil.

1. How would you rate your own health today?	
Very Healthy	Unhealthy
Healthy	Very Unhealthy
Somewhat Healthy	
2. Do you currently use any tobacco products?	
Yes, I currently smoke cigarettes or cigars	No, I quit 12 months ago or less
Yes, I currently use chewing tobacco, snuff or snus	No, I quit 1 or more years ago
Yes, I currently use e-cigarettes	No, I have never used tobacco products
 Please indicate how strongly you agree or disagr personally: I am confident that I can make changes eating right, exercising, or not smoking. 	
Strongly Agree	Disagree
Agree	Strongly Disagree

Appendix III

. What are the top three (3) reasons the check only three.	t prevent you from eating healthier foods and/or being அங்கூடி 28 of
Do not know how to change my diet	Do not want to be more active
Do not know how much more active I need	be
Fear of failure	It is too expensive to cook / eat healthy foods
Tried before and failed to change	Do not have time to be more active
Healthier food is not available in my neighb	hood Do not have time to cook or shop for healthy foods
Cannot afford exercise equipment / gym me	nbership I am happy the way I am
Do not want to change what I eat	I already eat healthy and am active
. Have you ever been told by a health pply)	rofessional that you have any of the following: (Check all that
Alcohol or drug addiction	High cholesterol
Asthma	High blood pressure
Chronic Obstructive Pulmonary Disease (C	PD) HIV / AIDS
Dementia / Alzheimer's disease	Mental health problem or disease
Depression	Obesity
Diabetes	Tuberculosis (TB)
Heart disease	None of the above
Other (please specify) . What is the primary source of your he	alth care insurance coverage?
Insurance from an employer or union	Medicaid (such as Medipass, Medicaid HMO)
Insurance that you pay for yourself, includir Act (sometimes called "Obamacare") plans	
Indian or Tribal Health Services	Other
Medicare	I do not have any health insurance
. How long has it been since your last	ental exam or cleaning?
Within past 12 months	2 to 5 years ago Do not know / Not sure
) ····································	\smile

Appendix III

Within past 12 months 2 to 5 years	ago Do not know / Not sure
1 to 2 years ago 5 or more y	ears ago
	eded medical or dental care for any of the following
easons? Check all answers that apply.	
Could not afford	Provider was not taking new patients
Insurance problems or lack of insurance	Could not get an appointment soon enough
Lack of transportation	Could not get a weekend or evening appointment
Language barriers or could not communicate	No, I did not have a delay in getting care
Provider did not take my insurance	No, I did not need medical or dental care
10. If a health care provider has recommended it, (check all that apply)Colonoscopy	have you had any of the following tests in the last year? None of the above were reccomended
Pap Smear	One or more were recommended but I did not participate in
Mammogram	the screening
11. When a doctor prescribes medicine for you or	a family member, what do you do?
Fill the prescription at a pharmacy	Use someone else's medicine
Use leftover medicine already at home	Use herbal or natural therapies instead
Use a Prescription Assistance Program (PAP) such as the provided by Pan Care Community Health Center, St. And Free Clinic, FDOH-Bay County Health Dept.	
Buy an over the counter medicine	
12. When you or someone in your family is sick duthrough Friday), where do you go for health care?	uring typical business hours (8 a.m 5 p.m., Monday
Hospital Emergency Room	Community health center
My family doctor	Free clinic
Any available doctor	VA / Military facility
Urgent care clinic	I usually go without care

Hospital Emergency Room in Bay County	Mental health cli	nic in Bay County	/	
Hospital Emergency Room in another County	Mental health cli	nic in another Co	unty	
My family doctor	VA / Military facil	ity		
Private psychologist, psychiatrist or other mental health professional	I do not know wh	nere to go for me	ntal health care	•
4. Do you or any of member of your household par nat apply)	rticipate in any of the	following beh	aviors? (che	eck all
		Never	Sometimes	Frequently
Smoke indoors or in a car when others (adult or children) are	present			
Drive or ride in a vehicle without a seatbelt				
Children ride in a vehicle without an age/size appropriate car/l	pooster seat			
Drive after having two or more alcoholic beverages				
Watch two or more hours of television per day				
Eat less than 5 servings (fist sized portions) of fruits and/or ve		nmunity"? (Th	ose factors	that
Eat less than 5 servings (fist sized portions) of fruits and/or ve 5. What do you think are the most important featur yould most improve the quality of life in this commu	es of a "Healthy Cor nity.) Check only TH	REE (3).	ose factors	that
Eat less than 5 servings (fist sized portions) of fruits and/or ve	res of a "Healthy Cornity.) Check only TH	REE (3).	ose factors	that
Eat less than 5 servings (fist sized portions) of fruits and/or ve 5. What do you think are the most important featur yould most improve the quality of life in this commu Access to health services(e.g. family doctor, hospitals,	es of a "Healthy Cor nity.) Check only TH	REE (3). homeless	ose factors	that
Eat less than 5 servings (fist sized portions) of fruits and/or ve 5. What do you think are the most important featur yould most improve the quality of life in this commu Access to health services(e.g. family doctor, hospitals, dentist)	res of a "Healthy Cornity.) Check only TH Low numbers of Low alcohol & dr	REE (3). homeless		that
Eat less than 5 servings (fist sized portions) of fruits and/or versions. 5. What do you think are the most important feature yould most improve the quality of life in this community. Access to health services(e.g. family doctor, hospitals, dentist) Active lifestyles / outdoor activities	res of a "Healthy Cornity.) Check only TH Low numbers of Low alcohol & dr Low crime / safe Low percent of p	REE (3). homeless rug abuse neighborhoods	e obese	
Eat less than 5 servings (fist sized portions) of fruits and/or versions. 5. What do you think are the most important feature yould most improve the quality of life in this communication. Access to health services(e.g. family doctor, hospitals, dentist) Active lifestyles / outdoor activities Affordable housing	res of a "Healthy Cornity.) Check only TH Low numbers of Low alcohol & dr Low crime / safe Low percent of p	REE (3). homeless rug abuse neighborhoods oppulation that are sexually transmit	e obese	
Eat less than 5 servings (fist sized portions) of fruits and/or versions. 5. What do you think are the most important feature yould most improve the quality of life in this communication. Access to health services(e.g. family doctor, hospitals, dentist) Active lifestyles / outdoor activities Affordable housing Arts and cultural events	res of a "Healthy Cornity.) Check only TH Low numbers of Low alcohol & dr Low crime / safe Low percent of p	REE (3). homeless rug abuse neighborhoods oppulation that are sexually transmit	e obese	
Eat less than 5 servings (fist sized portions) of fruits and/or versions. 5. What do you think are the most important feature yould most improve the quality of life in this communication. Access to health services(e.g. family doctor, hospitals, dentist) Active lifestyles / outdoor activities Affordable housing Arts and cultural events Clean environment (clean water, air, etc.)	Low numbers of Low percent of p Low numbers of Low percent of p Low numbers of Low percent of p Low numbers of Low numbers of Low numbers of Low tobacco use	REE (3). homeless rug abuse neighborhoods oppulation that are sexually transmit	e obese	
Eat less than 5 servings (fist sized portions) of fruits and/or versions. 5. What do you think are the most important feature yould most improve the quality of life in this communication. Access to health services(e.g. family doctor, hospitals, dentist) Active lifestyles / outdoor activities Affordable housing Arts and cultural events Clean environment (clean water, air, etc.) Employers that provide a sustainable living wage	Low numbers of Low percent of p Low numbers of Low percent of p Low tobacco use Quality education	REE (3). homeless rug abuse neighborhoods oppulation that are sexually transmit	e obese ited disease (S	·TDs)
Eat less than 5 servings (fist sized portions) of fruits and/or versions. 5. What do you think are the most important feature yould most improve the quality of life in this communication. Access to health services(e.g. family doctor, hospitals, dentist) Active lifestyles / outdoor activities Affordable housing Arts and cultural events Clean environment (clean water, air, etc.) Employers that provide a sustainable living wage Family doctors and specialists	Low numbers of Low percent of p Low numbers of Low percent of p Low tobacco use Quality education	REE (3). homeless rug abuse neighborhoods copulation that are sexually transmit	e obese ited disease (S	·TDs)
Eat less than 5 servings (fist sized portions) of fruits and/or versions. 5. What do you think are the most important feature yould most improve the quality of life in this communication. Access to health services(e.g. family doctor, hospitals, dentist) Active lifestyles / outdoor activities Affordable housing Arts and cultural events Clean environment (clean water, air, etc.) Employers that provide a sustainable living wage Family doctors and specialists Good employment opportunities	es of a "Healthy Cornity.) Check only TH Low numbers of Low alcohol & dr Low crime / safe Low percent of p Low tobacco use Mental health se Quality education Religious or spiri	REE (3). homeless rug abuse neighborhoods copulation that are sexually transmit	e obese ited disease (S ergency service	·TDs)
Eat less than 5 servings (fist sized portions) of fruits and/or versions. 5. What do you think are the most important feature yould most improve the quality of life in this communication. Access to health services(e.g. family doctor, hospitals, dentist) Active lifestyles / outdoor activities Affordable housing Arts and cultural events Clean environment (clean water, air, etc.) Employers that provide a sustainable living wage Family doctors and specialists Good employment opportunities Good place to raise children	res of a "Healthy Cornity.) Check only TH Low numbers of Low alcohol & di Low crime / safe Low percent of p Low numbers of Low tobacco use Mental health se Quality educatio Quality hospitals Religious or spir	REE (3). homeless rug abuse neighborhoods oppulation that are sexually transmit everyices n and urgent / em itual values	e obese tted disease (S ergency service Salvation Army	·TDs)

Accidental injuries (at work, home, school, farm)	Infant death
Aging problems(e.g. dementia, vision/hearing loss, loss of	Infectious diseases (e.g. hepatitis, TB, etc.
mobility)	Lack of affordable health care or co-payments/deductables
Cancers	Mental health problems, including depression
Child abuse / neglect	Motor vehicle crash injuries
Dental problems, including access to care	Obesity / Excess weight
Diabetes	Rape / sexual assault
Domestic violence	Respiratory / lung disease
Drug use / abuse	Sexually Transmitted Diseases (STDs)
Fire-arm related injuries	Suicide
Heart disease and stroke	Teenage pregnancy
HIV / AIDS	Tobacco use
Homelessness	
Homicide	
Very Healthy	Unhealthy
Healthy	Very Unhealthy
Somewhat Healthy	
at have the greatest impact on overall community h	_
	Not getting shots to prevent disease
Alcohol abuse	
Alcohol abuse Drug abuse	Not using seat belts / child safety seats
_	
Drug abuse	Not using seat belts / child safety seats
Drug abuse Excess weight	Not using seat belts / child safety seats Not seeing a doctor or dentist
Drug abuse Excess weight Homelessness	Not using seat belts / child safety seats Not seeing a doctor or dentist Tobacco use

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19. Which health care ser Check all answers that a	-	
Alternative therapies (acup	ouncture, herbals, etc.)	Prescriptions / Pharmacy services
Dental care including dent	ures	Primary medical care (a primary doctor/clinic)
Emergency medical care		Services for the elderly
Family Planning (including	birth control)	Specialty medical care (specialist doctors)
Hospital care		Alcohol or drug abuse treatment
Laboratory services		Vision care (eye exams and glasses)
Mental Health services		X-Rays or mammograms
Physical Therapy / Rehabi	ilitation	Do not know
Preventative health care (r	outine or wellness check-ups,	etc.) None
0. Overall, how would yo	ou rate the quality of heal	th care services available in your County?
Excellent	Good	Poor
Very Good 21. Please indicate how sof a dedicated funding so	urce (such as a sales tax	Not sure / do not know agree with the following statement: I support the creation to address health care needs (mental health, health working poor, indigent and uninsured in Bay county.
Very Good 21. Please indicate how sof a dedicated funding so	trongly you agree or disa urce (such as a sales tax	agree with the following statement: I support the creation t) to address health care needs (mental health, health
Very Good 21. Please indicate how sof a dedicated funding sof slinic, ambulance, and de Strongly Agree	trongly you agree or disa urce (such as a sales tax	agree with the following statement: I support the creation t) to address health care needs (mental health, health
Very Good 21. Please indicate how s of a dedicated funding sort clinic, ambulance, and de Strongly Agree Agree	trongly you agree or disa urce (such as a sales tax	agree with the following statement: I support the creation t) to address health care needs (mental health, health
Very Good 21. Please indicate how sof a dedicated funding sof slinic, ambulance, and de Strongly Agree Agree Disagree Strongly Disagree	trongly you agree or disaurce (such as a sales tax ntal accessibility) for the	agree with the following statement: I support the creation t) to address health care needs (mental health, health
Very Good 21. Please indicate how sof a dedicated funding sof linic, ambulance, and de Strongly Agree Agree Disagree Strongly Disagree 22. What is the zip code very some code were code to the code were code to the code were code were code were code to the code were code	trongly you agree or disaurce (such as a sales tax ntal accessibility) for the	agree with the following statement: I support the creation t) to address health care needs (mental health, health
Very Good 21. Please indicate how sof a dedicated funding sof elinic, ambulance, and de Strongly Agree Agree Disagree Strongly Disagree 22. What is the zip code very some some some some some some some some	trongly you agree or disaurce (such as a sales tax ntal accessibility) for the	agree with the following statement: I support the creation t) to address health care needs (mental health, health
Very Good 21. Please indicate how sof a dedicated funding sof slinic, ambulance, and de Strongly Agree Agree Disagree Strongly Disagree 22. What is the zip code very service and service are service as a service and service are service as a service and service are service as a service are s	trongly you agree or disaurce (such as a sales tax ntal accessibility) for the	agree with the following statement: I support the creation t) to address health care needs (mental health, health

24. What is your race?		Page 33 of
Black/African-American, non-His	panic	Asian
Black/African-American, Hispani	С	American Indian / Alaska Native
White/Caucasian, non-Hispanic		Pacific Islander
White/Caucasian, Hispanic		Bi-racial or multiple races
25. What is your age?		
Less than 18		45-54
18-24		55-74
25-34		75+
35-44		
26. What is the highest level of	f school you have con	mpleted or highest degree you have received?
Grades 1 through 8		Some college
Some high school (grades 9 thro	ough 11)	2-year college degree
High school diploma / GED		4-year college degree
Vocational/Tech School		Graduate or professional degree
27. What is your current emplo	yment status?	
Disabled / unable to work	Homemaker	Student
Employed full-time	Retired	Self-employed
Employed part-time	Seasonal work	rker Unemployed
28. What is your annual family	income?	
Less than \$15,000/year	\$35,001 - \$50	0,000/year \$100,001 or more/year
\$15,001 - \$25,000/year	\$50,001 - \$75	5,000/year
\$25,001 - \$35,000/year	\$75,001 - \$10	00,000/year
29. Where did you take this su	rvey?	
Church	WIC	Health Clinic
Health Fair	Health Depart	tment
Other (please specify)		

Thank you for taking this survey.

	On-Line	Surveys	Paper	r Surveys	All Res	
	Response	Response	Response		Response	Respo
	Percent	Count	Percent	Count	Percent	Cou
How would you rate your own health today Healthy	ay? 13.1%	126	13.3%	76	13.2%	202
ealthy	51.1%	491	42.1%	240	47.8%	731
omewhat Healthy	30.4%	292	35.3%	201	32.2%	493
nhealthy	4.4%	42	7.9%	45	5.7%	87
ery Unhealthy	0.9%	9	1.4%	8	1.1%	17
answered question	0.070	960	11.170	570	11170	1,
skipped question		5		3		
Do you currently use any tobacco produc	cts?					
es, I currently smoke cigarettes or	7.5%	72	26.7%	151	14.6%	223
gars	4 50/		0.00/	_	4.00/	40
es, I currently use chewing tobacco, snuff	1.5%	14	0.9%	5	1.2%	19
es, I currently use e-cigarettes	1.6%	15	2.7%	15	2.0%	30
o, I quit 12 months ago or less	1.6%	15	7.2%	41	3.7%	56
o, I quit 12 months ago of less o, I quit 1 or more years ago	26.1%	251	18.2%	103	23.2%	354
o, I have never used tobacco products	61.8%	593	44.3%	251	55.3%	844
·						
answered question skipped question		960 5		566 7		1
Diagram in diagram beautiful in the control of the	di	المسالم والمسامل	- la!! a			
Please indicate how strongly you agree a aintain a healthy lifestyle, like eating right			is it applies to you perso	onally: I am conti	ent that I can make changes to achieve	e and/o
rongly Agree	41.5%	398	46.1%	263	43.2%	66
gree	53.9%	517	50.0%	285	52.5%	802
isagree	3.8%	36	2.8%	16	3.4%	52
trongly Disagree	0.8%	8	1.1%	6	0.9%	14
answered question	0.070	959	1.170	570	0.370	1
skipped question		6		3		
\A/h-4 ab - 4 ab (0) ab -4			- d/ b - i			
What are the top three (3) reasons that p					20.70/	
already eat healthy and am active	36.7%	354	36.7%	201	36.7%	55
is too expensive to cook / eat healthy ods	32.3%	312	32.2%	176	32.3%	48
not have time to be more active	36.3%	350	22.3%	122	31.2%	47:
o not have time to cook or shop for	23.8%	230	15.7%	86	20.9%	310
ealthy foods						
am happy the way I am	15.6%	151	28.5%	156	20.3%	30
annot afford exercise equipment / gym	16.9%	163	24.9%	136	19.8%	299
embership						
ied before and failed to change	16.1%	155	13.0%	71	14.9%	220
o not want to change what I eat	14.2%	137	14.3%	78	14.2%	215
ear of failure	10.1%	97	9.1%	50	9.7%	147
o not know how much more active I need be	9.3%	90	9.9%	54	9.5%	144
	6.3%	61	9.9%	54	7.6%	115
o not know how to change my diet o not want to be more active						
is not safe to exercise in my	5.3% 5.1%	51 49	4.8%	26 22	5.1% 4.7%	77 71
eighborhood						
ealthier food is not available in my	1.8%	17	1.6%	9	1.7%	26
eighborhood answered question		965		547		1,
skipped question		0		26		
Have you ever been told by a health pro	fessional tha	t vou have an	ng: (Check all that apply))		
gh blood pressure	35.2%	331	27.8%	152	32.5%	483
gh cholesterol	27.7%	261	18.3%	100	24.3%	36
besity	24.2%	228	16.3%	89	21.3%	317
epression	17.7%	167	21.9%	120	19.3%	287
sthma	8.8%	83	14.8%	81	11.0%	164
abetes	10.2%	96	11.3%	62	10.6%	158
eart disease	4.5%	42	5.3%	29	4.8%	71
ental health problem or disease	3.4%	32	6.2%	34	4.4%	66
nronic Obstructive Pulmonary Disease	2.2%	21	3.7%	20	2.8%	41
OPD) cohol or drug addiction	0.6%	6	3.7%	20	1.7%	26
V / AIDS		4	0.9%	20 5	0.6%	9
	0.4%	2	0.9%	4	0.6%	6
harculasis (TR)	0.2% 0.0%	0	0.4%	2	0.4%	2
	U.U /0		37.7%	206	32.9%	49
mentia / Alzheimer's disease		284		200		431
mentia / Alzheimer's disease ne of the above	30.2%	284 103			10.6%	
mentia / Alzheimer's disease ne of the above her (please specify)		284 103	10.1%	55	10.6%	າ
ementia / Alzheimer's disease one of the above her (please specify) V heart block	30.2%				10.6%	
ementia / Alzheimer's disease one of the above her (please specify) V. heart block old reflux	30.2% 10.9%				10.6%	1
ementia / Alzheimer's disease one of the above ther (please specify) /V heart block cid reflux CID REFLUX, HIATAL HERNIA, DERMAT	30.2% 10.9%				10.6%	1 2
ementia / Alzheimer's disease one of the above ther (please specify) // heart block cid reflux CID REFLUX, HIATAL HERNIA, DERMAT DHD	30.2% 10.9%				10.6%	1 2 3
uberculosis (TB) ementia / Alzheimer's disease one of the above ther (please specify) // heart block cid reflux CID REFLUX, HIATAL HERNIA, DERMAT DHD nemia	30.2% 10.9%				10.6%	2 3 6
ementia / Alzheimer's disease one of the above ther (please specify) // heart block oid reflux CID REFLUX, HIATAL HERNIA, DERMAT OHD nemia	30.2% 10.9%				10.6%	1 2 3 6 1
ementia / Alzheimer's disease one of the above ther (please specify) V heart block cid reflux CID REFLUX, HIATAL HERNIA, DERMAT DHD neemia nxiety pixiety fibromalgia, gerd, chf	30.2% 10.9%				10.6%	1 2 3 6 1 4
ementia / Alzheimer's disease one of the above ther (please specify) // heart block cid reflux CID REFLUX, HIATAL HERNIA, DERMAT DHD nemia	30.2% 10.9%				10.6%	1 2 3 6 1

On-Line Surveys Paper Surveys All Responses Response Response Percent Count Response Count Response Response Response Percent Count Percent 5. ****CONTINUED - 'Other' ***** Have you ever been told by a health professional that you have any of the following: (Check all that apply) border line diabetic Both are controlled via meds 2 Breast Cancer 1 breast cancer and am obese but not told by MD CKD. prev OV cancer patient. fibromyalgia. mild carotid blockage. COLON CANCER 2000, some block arteries, but now doing great through a changed diet! Common Variable Immune Deficiency/Chronic Fatigue Crohn's disease DIVERTICULITIS Diverticulosis DJD, arthritis, spinal stenosis fibromalagia, chronic fatigue syndrone, hyperparathyroidism fibromyalgia and chronic fatigue Fibromyalgia, Arthritis, IBS, Chronic Fatigue Syndrome Genetic Heart Conditon gestational diabetes with my last pregnancy glaucoma Gout had gestational diabetese Нер С hormone issues Hyperactive Thyroidism Hypoglycemia 11 Hypothyroidism Kidney cancer, severe arthritis Kidney stones and chronic UTIs Low HDL low HDL levels (total cholesterol was okay) Low kidney level low testosterone Lyme Disease, Chronic Fatigue, Fibro lymphoma Mitral valve prolapse Mixed connective tissue disorders no longer have a depression diagnosis; have learned to maintain my emotional health non smokers emphazema Non-Hodgkins Lymphoma obesity Osteoarthritis OSTEOPORASIS AND SPINAL STENOSIS osteoporosis PCOS, high triglycerides Pinched nerves in neck, bad disk in lower back Platelet disorder, Vitamin deficiency, Thyroid problems Polycystic Ovarian Syndrome Polycystic Ovarian Syndrome, thyroidism Pre diabetes Pre-diabetic; fatty liver Pre-Hypertensive pseudo tumor cerebri Psoriasis, chemical, food and environmental allergies, panic disorder RA remission of breast cancer Renards phenomenon, arthritis Rheumatoid Arthitis Sarcoidosis / Polycystic Ovary Syndrome scoliosis Sleep apnea Thyroid Issue Ulcerative colitis ADD ADHD, Anxiety, Learning disability ALERGIES anemia, PE anxiety, torn rotor cuff BAD HIPS, KNEES WEIGHT IN GENERAL borderline high blood pressure Breast Cancer and Skin Cancer chronic migraines GBS CIDP GERD heart murmer heart palpatations high anxiety, back injury, stomach gevo, more high white blood cell count kidney disease leakage in mitro valve, heart murmer low blood pressure low blood pressure, low blood sugar, MRSA LUNG CANCER mitro valve prolapse MULTIPLE SCLEROSIS Nash,Fibromyalgia,RA,food allergies,bi-polar, more

On-Line Surveys Paper Surveys All Responses Response Response Response Response Response Response Percent Count Percent Count Count Percent 5. ****CONTINUED - 'Other' ***** Have you ever been told by a health professional that you have any of the following: (Check all that apply) overweight but not obese palpitations **PCOS** prostate cancer RA, Lupus, Fibromyalgia **SEIZURES** Stroke Affective Disorder subclavian steal syndrome. blocked subclavian arteries thvroid cancer, tbs, ic thvroiditis 547 answered question 941 1,488 skipped question 6. What is the primary source of your health care insurance coverage? 72.0% 24.5% 127 55.3% 818 Insurance from an employer or union Insurance that you pay for yourself, 4.1% 39 4.6% 24 4.3% 63 including Affordable Care Act (sometimes called "Obamacare") plans Indian or Tribal Health Services 0.1% 1 0.0% 0 0.1% Medicare 9.0% 86 9.5% 49 9.1% 135 Medicaid (such as Medipass, Medicaid 1.0% 10 16.4% 85 6.4% 95 HMO) TRICARE, military or VA benefits 84 5.4% 28 8 8% 7.6% 112 13 Other 14% 3.9% 20 2 2% 33 I do not have any health insurance 35.7% 185 15.0% 221 3.8% 36 518 1,478 answered question 960 skipped question 60 7. How long has it been since your last dental exam or cleaning? Within past 12 months 67.5% 647 40.9% 228 57.7% 875 1 to 2 years ago 13.0% 125 15.8% 88 14.0% 213 2 to 5 years ago 10.0% 96 18.3% 102 13.1% 198 5 or more years ago 6.8% 65 14.0% 78 9.4% 143 Do not know / Not sure 2.7% 26 11.1% 62 5.8% 88 answered question 1,517 skipped question 8. How long has it been since your last visit to a doctor for exam or routine check-up? (Does not incli de an exam for a specific injury, illness or condition) Within past 12 months 725 60.7% 343 1068 1 to 2 years ago 10.6% 101 12.7% 72 11.4% 173 2 to 5 years ago 6.9% 66 9.7% 55 8.0% 121 5 or more years ago 4.2% 40 7.4% 42 5.4% 82 Do not know / Not sure 2.4% 23 9 4% 53 5.0% 76 answered question 955 565 1,520 skipped auestion 10 9. In the past 12 months, did you delay getting needed medical or dental care for any of the following reasons? Check all answers that apply. No, I did not have a delay in getting care 652 44.9% 52.8% 480 31.7% 205 39.6% 215 28.9% 420 Could not afford 22.6% Insurance problems or lack of insurance 11.6% 105 23.9% 130 16.2% 235 No, I did not need medical or dental care 128 15.0% 14.1% 16.6% 90 218 Could not get a weekend or evening 9.5% 86 5.9% 32 8.1% 118 appointment Could not get an appointment soon enough 52 6.6% 6.1% 88 37 6.3% 4.9% Provider did not take my insurance Lack of transportation 0.4% 7.0% 38 2.9% 42 4 Provider was not taking new patients 1.8% 16 3.7% 20 2.5% 36 Language barriers or could not 0.8% 7 0.2% 1 0.6% 8 communicate answered question 909 543 1,452 skipped question 86 10. If a health care provider has recommended it, have you had any of the following tests in the last year? (check all that apply) None of the above were recommended 36.7% 313 48.2% 266 41.2% 579 Pap Smear 34 2% 292 156 31.9% 448 28.3% 423 36.1% 308 20.8% 30.1% Mammogram 115 133 14.9% Colonoscopy 15.6% 13.9% 77 210 88 50 One or more were recommended but I did 10.3% 9.1% 9.8% 138 not participate in the screening 854 552 1,406 answered question 132 skipped question 111

	On-Line	Surveys		Paper S	Surveys	All Res	ponses
	Response	Response		Response	Response	Response	Response
	Percent	Count		Percent	Count	Percent	Count
11. When a doctor prescribes medicine for	you or a fam	ily member, w	/hat do you do?				
Fill the prescription at a pharmacy	95.4%	911		88.1%	467	92.8%	1,378
Go without medicine	1.6%	15		4.5%	24	2.6%	39
Use a Prescription Assistance Program (PAP) such as those provided by Pan Care Community Health Center, St. Andrew Free Clinic, FDOH-Bay County Health Dept.	0.5%	5		3.8%	20	1.7%	25
Use herbal or natural therapies instead	1.5%	14		0.4%	2	1.1%	16
Buy an over the counter medicine	0.3%	3		2.3%	12	1.0%	15
Use leftover medicine already at home	0.6%	6		0.9%	5	0.7%	11
Use someone else's medicine	0.1%	1		0.0%	0	0.1%	1
answered question		955			530		1,485
skipped question		10			43		53

When you or someone in your family is	sick during t	ypical busines	m 5 p.m., Monday throu	gh Friday), who	ere do you go for health care?
ly family doctor	67.9%	651	43.5%	209	59.7%
Urgent care clinic	16.2%	155	7.9%	38	13.4%
I usually go without care	5.2%	50	15.0%	72	8.5%
Hospital Emergency Room	2.4%	23	17.9%	86	7.6%
VA / Military facility	2.9%	28	2.5%	12	2.8%
Any available doctor	2.3%	22	2.3%	11	2.3%
Community health center	1.5%	14	3.5%	17	2.2%
Free clinic	1.1%	11	4.0%	19	2.1%
Health Department	0.5%	5	3.5%	17	1.5%
answered question		959		481	
skipped question		6		92	

13. If you felt that you or someone in your f	amily needed	mental healt	h services (including emerg	jency mental i	health service	es), where would you go fo	r care?	
Private psychologist, psychiatrist or other mental health professional	32.6%	313		10.8%	53		25.2%	366
My family doctor	22.6%	217		17.3%	85		20.8%	302
I do not know where to go for mental	17.4%	167		25.9%	127		20.3%	294
health care								
Mental health clinic in Bay County	17.4%	167		20.2%	99		18.3%	266
Hospital Emergency Room in Bay County	5.5%	53		21.0%	103		10.8%	156
VA / Military facility	3.5%	34		2.4%	12		3.2%	46
Mental health clinic in another County	0.9%	9		0.6%	3		0.8%	12
Hospital Emergency Room in another	0.1%	1		1.6%	8		0.6%	9
County								
answered question	961	961		490	490			1,45
skipped question	4	4		83	83			8

14. Do you or any of member of your house	ehold particin	pate in any of t	the following	na behaviors?	? (ch	eck all that a	(vlaa							
Answer Options	Never	Sometimes	Freq.	Response Count		Never	Sometimes	Freq.	Response Count	Ne	ever	Sometimes	Freq.	Response Count
Smoke indoors or in a car when others (adult or children) are present	93.8%	4.6%	1.6%	933		82.5%	13.4%	4.1%	538	89	.7%	7.8%	2.5%	1,471
Drive or ride in a vehicle without a seatbelt	87.9%	10.2%	1.9%	934		74.7%	19.9%	5.4%	538	83	.1%	13.7%	3.2%	1,472
Children ride in a vehicle without an age/size appropriate car/booster seat	96.8%	1.6%	1.6%	925		94.4%	3.1%	2.5%	520	94	.2%	2.1%	1.9%	1,445
Drive after having two or more alcoholic beverages	86.8%	13.1%	0.1%	929		90.9%	8.2%	1.0%	525	87	.2%	11.3%	0.4%	1,454
Watch two or more hours of television per day	8.9%	55.5%	35.6%	954		13.7%	50.0%	36.3%	542	10	.8%	53.5%	35.9%	1,496
Eat less than 5 servings (fist sized portions) of fruits and/or vegetables per day	6.9%	64.0%	29.1%	950		14.9%	58.6%	26.5%	544	10	.0%	62.0%	28.1%	1,494
answered question				960					559					1,519
skipped auestion				5					14					19

	On-Line	Surveys	Paper :	Surveys		All Res	ponses
	Response	Response	Response	Response		Response	Response
	Percent	Count	Percent	Count		Percent	Count
15. What do you think are the most importa	ant features o	f a "Healthy (community"? (Those factors that would r	nost improve t	the quality of life in this cor	nmunity.) Che	eck only
Access to health services(e.g. family doctor, hospitals, dentist)	51.5%	494	60.1%	331		54.6%	825
Active lifestyles / outdoor activities	35.4%	340	31.9%	176		34.1%	516
Employers that provide a sustainable living wage	35.4%	340	14.2%	78		27.7%	418
Clean environment (clean water, air, etc.)	22.5%	216	28.9%	159		24.8%	375
Good employment opportunities	26.9%	258	13.2%	73		21.9%	331
Affordable housing	17.6%	169	28.1%	155		21.4%	324
Healthy food options	19.6%	188	16.5%	91		18.5%	279
Low crime / safe neighborhoods	18.9%	181	15.2%	84		17.5%	265
Good place to raise children	11.4%	109	27.4%	151		17.2%	260
Quality education	20.7%	199	10.2%	56		16.9%	255
Quality hospitals and urgent / emergency services	11.6%	111	16.7%	92		13.4%	203
Religious or spiritual values	15.3%	147	10.2%	56		13.4%	203
Family doctors and specialists	7.1%	68	23.8%	131		13.2%	199
Low numbers of homeless	7.3%	70	21.6%	119		12.5%	189
Low percent of population that are obese	8.4%	81	19.1%	105		12.3%	186
Low alcohol & drug abuse	12.2%	117	10.5%	58		11.6%	175
Social support services (such as Salvation Army, food pantries, Catholic charities, Red Cross, etc.)	8.1%	78	13.1%	72		9.9%	150
Good schools	10.9%	105	7.8%	43		9.8%	148
Good transportation options	7.2%	69	10.9%	60		8.5%	129
Mental health services	9.4%	90	6.9%	38		8.5%	128
Good race relations	3.6%	35	16.0%	88		8.1%	123
Low tobacco use	8.1%	78	7.1%	39		7.7%	117
Arts and cultural events	4.8%	46	5.6%	31		5.1%	77
Low numbers of sexually transmitted disease (STDs)	3.8%	36	5.1%	28		4.2%	64
answered question		960		551			1,511
skipped question		5		22			27

16. What do you think are the most importa	nt health iss	ues in your Co	ounty? (Those problems that have the g	reatest impact	on overall community health.) Check of	nly THF
Drug use / abuse	46.8%	448	14.8%	81	35.1%	5
Obesity / Excess weight	35.9%	344	12.6%	69	27.4%	4
Lack of affordable health care or co-	35.0%	335	13.9%	76	27.3%	4
payments/deductables						
Child abuse / neglect	20.3%	194	22.3%	122	21.0%	3.
Cancers	18.8%	180	21.7%	119	19.9%	29
Fire-arm related injuries	2.7%	26	43.6%	239	17.6%	26
Homelessness	23.4%	224	7.5%	41	17.6%	26
Mental health problems, including depression	23.1%	221	5.7%	31	16.7%	25
Diabetes	15.7%	150	17.2%	94	16.2%	24
Motor vehicle crash injuries	8.7%	83	26.6%	146	15.2%	22
Aging problems(e.g. dementia, vision/hearing loss, loss of mobility)	14.5%	139	11.5%	63	13.4%	20
Domestic violence	11.1%	106	15.1%	83	12.6%	18
Dental problems, including access to care	11.5%	110	12.8%	70	12.0%	18
Tobacco use	14.5%	139	4.9%	27	11.0%	16
Heart disease and stroke	12.3%	118	6.0%	33	10.0%	15
Homicide	1.6%	15	22.3%	122	9.1%	13
Respiratory / lung disease	3.0%	29	18.6%	102	8.7%	13
Teenage pregnancy	6.1%	58	10.2%	56	7.6%	11
Accidental injuries (at work, home, school,	4.5%	43	12.4%	68	7.4%	11
farm)						
Rape / sexual assault	1.5%	14	12.4%	68	5.4%	8:
HIV / AIDS	4.0%	38	7.8%	43	5.4%	8
Sexually Transmitted Diseases (STDs)	4.5%	43	3.8%	21	4.3%	6-
Suicide	2.7%	26	2.6%	14	2.7%	4
nfectious diseases (e.g. hepatitis, TB,	2.8%	27	2.2%	12	2.6%	39
Infant death	1.7%	16	4.0%	22	2.5%	3
answered question		957		548		1
skipped question		8		25		

17. Overall, how would you rate the	health of people wh	o live in vour		
Very Healthy	0.3%	3	1.3%	7
Healthy	5.1%	48	12.5%	69
Somewhat Healthy	57.6%	545	57.5%	318
Unhealthy	33.7%	319	24.8%	137
Very Unhealthy	3.4%	32	4.0%	22
answered que	estion	947		553
skipped que	estion	18		20

						ı aş
	On-Line Surveys		Pape	r Surveys	All Res	ponse
	Response	Response	Respons	e Response	Response	Respo
	Percent	Count	Percent		Percent	Cou
18. Which of the following behaviors or cor	nditions in the	County conce	you the most? Those behaviors th	at have the grea	itest impact on overall community health	n. Check
hree (3)						
Drug abuse	64.1%	619	67.0%	372	65.2%	99
Alcohol abuse	36.2%	349	40.0%	222	37.6%	57
Homelessness	33.8%	326	34.4%	191	34.0%	51
Poor eating habits / poor nutrition	35.0%	338	27.0%	150	32.1%	48
Excess weight	35.4%	342	22.0%	122	30.5%	46
Not seeing a doctor or dentist	24.1%	233	27.6%	153	25.4%	38
Tobacco use	18.5%	179	17.7%	98	18.2%	27
_ack of exercise	17.2%	166	13.9%	77	16.0%	24
Jnprotected / unsafe sex	11.5%	111	23.2%	129	15.8%	24
Not getting shots to prevent disease	9.0%	87	12.3%	68	10.2%	15
Not using seat belts / child safety seats	7.0%	68	12.6%	70	9.1%	13
answered question		965	5.	<i>55</i> 555		1
skipped question		0		<i>18</i> 18		
9. Which health care services are difficult	to get in you	r County? Che	all answers that anniv			
o not know	26.6%	255	27.9%	152	27.1%	40
Pental care including dentures	19.3%	185	33.6%	183	24.5%	36
Mental Health services	26.5%	254	17.2%	94	23.2%	34
Alternative therapies (acupuncture,	26.0%	249	15.8%	86	23.2%	33
uternative therapies (acupuncture, erbals, etc.)	20.070	243	15.8%	00	22.3%	33
• •	22.1%	212	13.9%	76	19.2%	28
Alcohol or drug abuse treatment				76 85		28 27
Specialty medical care (specialist	20.0%	192	15.6%	85	18.4%	2/
loctors)	10.70	400	10.55	7-	17.00	
Services for the elderly	19.7%	189	13.8%	75	17.6%	26
Preventative health care (routine or	14.9%	143	13.6%	74	14.4%	21
vellness check-ups, etc.)	4					
Primary medical care (a primary	10.9%	104	16.0%	87	12.7%	19
loctor/clinic)						
None	11.6%	111	11.0%	60	11.4%	17
Prescriptions / Pharmacy services	8.1%	78	13.9%	76	10.2%	15
/ision care (eye exams and glasses)	7.4%	71	11.4%	62	8.8%	13
Emergency medical care	6.9%	66	8.6%	47	7.5%	11
lospital care	4.5%	43	9.2%	50	6.2%	93
aboratory services	4.5%	43	7.7%	42	5.7%	8!
Family Planning (including birth control)	4.9%	47	6.2%	34	5.4%	8
Physical Therapy / Rehabilitation	4.2%	40	6.2%	34	4.9%	74
X-Rays or mammograms	3.2%	31	5.9%	32	4.2%	63
answered question	J.Z /0	958	3.970	545		1
skipped question		7		28		
00 OII bII	- £ k		ble le come Occupt O			
20. Overall, how would you rate the quality				20	2.00/	40
Excellent	1.9%	18	5.0%	28	3.0%	46
/ery Good	10.8%	103	12.9%	72	11.5%	17
Good	40.6%	389	31.4%	176	37.2%	56
air	36.0%	345	32.5%	182	34.7%	52
Poor	6.6%	63	9.6%	54	7.7%	11
Not sure / do not know	4.2%	40	8.6%	48	5.8%	88
answered question		958		560		1
skipped question		7		13		
21. Please indicate how strongly you agree nealth care needs (mental health, health cl						ddress
trongly Agree	23.4%	223	32.7%	177	26.7%	40
gree	41.2%	393	51.1%	277	44.8%	67
Disagree	19.9%	190	12.2%	66	17.1%	25
Strongly Disagree	15.5%	148	4.1%	22	11.4%	17
answered question		954		542		1
skipped question		11		31		
2 What is the Time and sub						
2. What is the zip code where you live?	10.00/	174	00.004	110	40.007	0.0
2401	18.0%	174	20.8%	116	19.0%	29
2402	0.3%	3	0.2%	1	0.3%	4
2403	0.5%	5	0.4%	2	0.5%	7
2404	16.7%	161	25.4%	142	19.9%	30
2405	18.4%	178	16.6%	93	17.8%	27
2407	6.5%	63	0.2%	1	4.2%	6-
	C 49/	62	4.3%	24	5.6%	8
	6.4%		6.1%	34	5.6%	8
2408		51				
2408 2409	5.3%		2.0%	11	11.9%	1
2408 2409 2411	5.3% 0.2%	2	2.0% 0.5%	11	0.9% 0.3%	
2408 2409 2411 2412	5.3% 0.2% 0.1%	2 1	0.5%	3	0.3%	4
:2408 :2409 :2411 :2412 :2413	5.3% 0.2% 0.1% 5.0%	2 1 48	0.5% 2.7%		0.3% 4.1%	6
2408 2409 2411 2412 2413 2417	5.3% 0.2% 0.1% 5.0% 0.2%	2 1 48 2	0.5% 2.7% 0.0%	3 15	0.3% 4.1% 0.1%	6: 2:
2408 2409 2411 2412 2413 2417 2438	5.3% 0.2% 0.1% 5.0% 0.2% 1.1%	2 1 48 2 11	0.5% 2.7% 0.0% 5.5%	3 15 31	0.3% 4.1% 0.1% 2.8%	6 2 4
2408 2409 2411 2412 2413 2417 2438 2444	5.3% 0.2% 0.1% 5.0% 0.2% 1.1% 17.7%	2 1 48 2 11 171	0.5% 2.7% 0.0% 5.5% 7.3%	3 15 31 41	0.3% 4.1% 0.1% 2.8% 13.9%	4 6 2 4 21
2408 12409 12411 12412 12413 12417 12438 12444 12456	5.3% 0.2% 0.1% 5.0% 0.2% 1.1% 17.7% 0.7%	2 1 48 2 11 171 7	0.5% 2.7% 0.0% 5.5% 7.3% 0.2%	3 15 31 41 1	0.3% 4.1% 0.1% 2.8% 13.9% 0.5%	4 63 2 42 21 8
2408 2409 2411 2412 2413 2417 2438 2444 2456	5.3% 0.2% 0.1% 5.0% 0.2% 1.1% 17.7% 0.7%	2 1 48 2 11 171 7	0.5% 2.7% 0.0% 5.5% 7.3% 0.2% 0.2%	3 15 31 41 1	0.3% 4.1% 0.1% 2.8% 13.9% 0.5% 0.1%	4 63 2 42 21 8
32408 32409 32411 32412 32413 32417 32438 32444 32456 32466	5.3% 0.2% 0.1% 5.0% 0.2% 1.1% 17.7% 0.7%	2 1 48 2 11 171 7 1 25	0.5% 2.7% 0.0% 5.5% 7.3% 0.2%	3 15 31 41 1 1 43	0.3% 4.1% 0.1% 2.8% 13.9% 0.5%	4 63 2 42 21 8 2 68
12408 12409 12411 12412 12413 12417 12438 12444 12446	5.3% 0.2% 0.1% 5.0% 0.2% 1.1% 17.7% 0.7%	2 1 48 2 11 171 7	0.5% 2.7% 0.0% 5.5% 7.3% 0.2% 0.2%	3 15 31 41 1	0.3% 4.1% 0.1% 2.8% 13.9% 0.5% 0.1%	13 4 63 2 42 21: 8 2 68

		Surveys
	Response Percent	Response Count
	Percent	Count
3. Are you male or female?		
Male	25.0%	239
Female	75.0%	716
answered question	7	955
skipped question	7	10
. What is your race?		
lack/African-American, non-Hispanic	7.9%	75
lack/African-American, Hispanic	0.7%	7
/hite/Caucasian, non-Hispanic	79.3%	749
/hite/Caucasian, Hispanic	7.0%	66
sian	0.7%	7
merican Indian / Alaska Native	1.5%	14
cific Islander	0.3%	3
racial or multiple races	2.5%	24
answered question		945
skipped question		20
A/bet is very exe?		
What is your age?	0.10/	1
ss than 18	0.1%	1
3-24	2.5%	24
5-34	14.1%	135
5-44	20.5%	197
5-54	27.4%	263
5-74	33.5%	322
5+	1.9%	18
answered question		960
skipped question	7	5
6. What is the highest level of school yo		
rades 1 through 8	0.2%	2
some high school (grades 9 through 11)	0.2%	2
ligh school diploma / GED	8.0%	77
ocational/Tech School	3.3%	32
ome college	19.0%	182
	15.2%	146
		233
year college degree	24.3%	
-year college degree -year college degree iraduate or professional degree	29.7%	285
year college degree raduate or professional degree <i>answered questio</i>	29.7%	285 959
year college degree raduate or professional degree	29.7%	285
year college degree aduate or professional degree <i>answered question</i> <i>skipped question</i>	29.7%	285 959
year college degree raduate or professional degree answered question skipped question 7. What is your current employment sta	29.7% 7 7	285 959 6
year college degree raduate or professional degree answered question skipped question 7. What is your current employment sta	29.7% 7 7 tus?	285 959 6
year college degree raduate or professional degree answered question skipped question 7. What is your current employment states sabled / unable to work mployed full-time	29.7% 7 7 80.0%	285 959 6
year college degree raduate or professional degree answered question skipped question 7. What is your current employment state isabled / unable to work mployed full-time mployed part-time	29.7% 7 7 1.3% 80.0% 6.5%	285 959 6
year college degree raduate or professional degree answered question skipped question 7. What is your current employment state isabled / unable to work mployed full-time mployed part-time omemaker	29.7% 7 1.3% 80.0% 6.5% 0.9%	285 959 6
year college degree raduate or professional degree answered question skipped question 7. What is your current employment states is abled / unable to work mployed full-time mployed part-time omemaker etired	29.7% 1.3% 80.0% 6.5% 0.9% 7.4%	285 959 6 12 767 62 9 71
year college degree raduate or professional degree answered question skipped question 7. What is your current employment sta sabled / unable to work mployed full-time mployed part-time omemaker etired easonal worker	29.7% 7 1.3% 80.0% 6.5% 0.9% 7.4% 0.3%	285 959 6
year college degree aduate or professional degree answered question skipped question 7. What is your current employment state sabled / unable to work nployed full-time nployed part-time premaker eitred basonal worker udent	29.7% 7 1.3% 80.0% 6.5% 0.9% 7.4% 0.3% 0.6%	285 959 6
vear college degree aduate or professional degree answered question skipped question What is your current employment state sabled / unable to work nployed full-time nployed part-time memaker titred assonal worker udent If-employed	29.7% 7 1.3% 80.0% 6.5% 0.9% 7.4% 0.3% 0.6% 2.0%	285 959 6
ear college degree aduate or professional degree answered question skipped question What is your current employment sta abled / unable to work ipployed full-time ployed part-time memaker tired asonal worker ident f-employed employed employed employed employed	29.7% 7 1.3% 80.0% 6.5% 0.9% 7.4% 0.3% 0.6% 2.0% 1.0%	285 959 6 12 767 62 9 71 3 6 19 10
ear college degree aduate or professional degree answered question skipped question . What is your current employment state aployed full-time uployed part-time memaker tired assonal worker ident if-employed	29.7% 7 1.3% 80.0% 6.5% 0.9% 7.4% 0.3% 0.6% 2.0% 1.0%	285 959 6
ear college degree aduate or professional degree answered question skipped question what is your current employment sta abled / unable to work uployed full-time ployed part-time memaker tired asonal worker ident f-employed employed answered question	29.7% 1.3% 80.0% 6.5% 0.9% 7.4% 0.3% 0.6% 2.0% 1.0%	285 959 6
year college degree aduate or professional degree answered question skipped question skipped question 7. What is your current employment state sabled / unable to work inployed full-time inployed part-time inmemaker stired sasonal worker udent self-employed answered question skipped question skipped question skipped question skipped gestion	29.7% 7 1.3% 80.0% 6.5% 0.9% 7.4% 0.3% 0.6% 2.0% 1.0%	285 959 6
year college degree raduate or professional degree answered question skipped question 7. What is your current employment state isabled / unable to work isabled / unable to	29.7% 7 1.3% 80.0% 6.5% 0.9% 7.4% 0.3% 0.6% 2.0% 1.0% 7.4%	285 959 6
year college degree raduate or professional degree answered question skipped question 7. What is your current employment states isabled / unable to work mployed full-time mployed part-time omemaker ettired easonal worker udent elf-employed answered question skipped question skipped question ess than \$15,000/year	29.7% 7 1.3% 80.0% 6.5% 0.9% 7.4% 0.3% 0.6% 2.0% 1.0% 7	285 959 6 12 767 62 9 71 3 6 19 10 959 6
year college degree raduate or professional degree answered question skipped question skipped question 7. What is your current employment state sabled / unable to work imployed full-time imployed part-time comemaker stired seasonal worker udent self-employed answered question skipped question skipped question skipped question skipped question skipped question stipped span \$15,000/year 55,001 - \$25,000/year 55,001 - \$35,000/year	29.7% 7 1.3% 80.0% 6.5% 0.9% 7.4% 0.3% 0.6% 2.0% 1.0% 7 1.0% 1.0% 1.0%	285 959 6 12 767 62 9 71 3 6 19 10 959 6
year college degree raduate or professional degree answered question skipped question 7. What is your current employment state sabled / unable to work mployed full-time mployed part-time omemaker etired easonal worker rudent elf-employed answered question skipped question skipped question gas what is your annual family income? ess than \$15,000/year 15,001 - \$25,000/year 15,001 - \$35,000/year 15,001 - \$50,000/year	29.7% 7 1.3% 80.0% 6.5% 0.9% 7.4% 0.3% 0.6% 2.0% 1.0% 7 4.6% 8.6% 10.8% 21.1%	285 959 6 12 767 62 9 71 3 6 19 10 959 6
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vear college degree aduate or professional degree answered question skipped question skipped question what is your current employment states abled / unable to work apployed full-time apployed part-time assonal worker deep description which is your annual family income? what is your annual family income? ss than \$15,000/year 5,001 - \$25,000/year 5,001 - \$35,000/year 0,001 - \$75,000/year 0,001 - \$75,000/year 5,001 - \$100,000/year 5,001 - \$100,000/year	29.7% 7 1.3% 80.0% 6.5% 0.9% 7.4% 0.3% 0.6% 2.0% 1.0% 7 4.6% 8.6% 10.8% 21.1% 20.7% 16.4%	285 959 6 12 767 62 9 71 3 6 19 10 959 6 43 80 100 196 192 152
rear college degree aduate or professional degree answered question skipped question skipped question white is your current employment state stabled / unable to work aployed full-time apployed part-time memaker tired assonal worker ident if-employed employed answered question skipped question skipped question skipped question skipped question state in the college of the college of the college source of the college of the college of the college answered puestion skipped question state of the college of the colle	29.7% 7 1.3% 80.0% 6.5% 0.9% 7.4% 0.3% 0.6% 2.0% 1.0% 7 4.6% 8.6% 10.8% 21.1% 20.7% 16.4% 17.7%	285 959 6 12 767 62 9 71 3 6 19 10 959 6 43 80 100 196 192 152 164
year college degree raduate or professional degree answered question skipped question 7. What is your current employment state sabled / unable to work imployed full-time imployed part-time immemaker setired seasonal worker udent self-employed answered question skipped question skipped question skipped question skipped question skipped 3. What is your annual family income? 15,001 - \$25,000/year 15,001 - \$35,000/year 15,001 - \$35,000/year 15,001 - \$35,000/year	29.7% 7 1.3% 80.0% 6.5% 0.9% 7.4% 0.3% 0.6% 2.0% 1.0% 7 4.6% 8.6% 10.8% 21.1% 20.7% 16.4% 17.7%	285 959 6 12 767 62 9 71 3 6 19 10 959 6 43 80 100 196 192 152

	On-Line Surveys			Paper 9	Surveys	All Res	3
	Response	Response		Response	Response	Response	
	Percent	Count		Percent	Count	Percent	
9. Where did you take this survey?							
			Church	14.9%	42		
			Health Fair	1.1%	3		
			WIC	10.3%	29		
			Health Departme	65.5%	184		
			Health Clinic	8.9%	25		
			Other (please sp	344	344		
			AARP meeting		8		
			All About Worn	en OBGYN	1		
			Avicenna		8		
			Bay County Fa		25		
			Catholic Charit		9		
			children's dent	istry clinic	1		
			Dental Clinic		7		
			dsme support	group	1		
			Food Bank		1		
			Glenwood Con	nmunity Cent			
			Healthy Start		9		
			Home/Healthy	Start	5		
			NDPP		4		
			Pam Dorwarth	interviewed	4		
			PC Mall		73		
			Piggley Wiggly		38		
			Rainbow Food	5	21		
			rehab		1		
			school/work		5		
			St. Andrews C.		18		
			Valarie Myer's		39		
			Village Health	Center	44		
			VM .		3		
					1		
			work		- 4		
			work Youngstown Swered question		11 281		

^{*} Source: Quick Facts, US Census Bureau. (note, some categories do not align with survey and are used for general reference only)



AGENDA

<u>Purpose:</u> Solicit input from the community on community health needs assessment through open two-way dialogue.

Topic	Lead
Welcome/Call to Order Introductions Brief review of agenda Prompt attendees to sign-in	Julie Tindall
Review Previous Minutes	April Wisdom
Status Update of Previous Actions Item 1: MAPP Process Item 2: Local Public Health System Survey-complete Item 3: Community Health Assessment (CHA) Survey-complete Item 4: Community Themes & Strengths Assessment-complete Item 5: Review of Data Generated from CHA	April Wisdom
Introduce Next Topic Determination of Top Three Priority Issues to Address in the 2016 Community Health Improvement Plan	Julie Tindall
Discuss Supporting Information	Julie Tindall
Open Floor for Community Input	Julie Tindall
Our next meeting will focus on formulation of goals and strategies to address the top three health issues selected by today's vote which will be addressed in the 2016 community health improvement plan	Julie Tindall
Actions Set date for the next meeting(Jan 8 th , 22 nd or 29th)	Julie Tindall
Meeting Evaluation	Julie Tindall
Adjourn	1. 1. 1. 1.



Florida Department of Health in Bay County Community Health Improvement Plan Update Committee Bay Medical Center-Sacred Heart, Walsingham Board Room 615 N Bonita Ave, Panama City, FL 32401 November 20, 2015

Sign In Sheet

Purpose:

Engage community partners in the Mobilizing for Action through Planning and Partnerships (MAPP) process.

Attendees - PLEASE PRINT LEGIBLY

Name	Organization or Community Representative	Email	Phone
Py 4 L MILLES	FLON	Rock mure Theor	5- 872-466è
To Colulle	1 DOH	p. colville @ SThealth . gov	872-4435 111
Marsha Summer	FROH	marsha. summer of flherith.	W 872-4455 × 128
Doug Kent	FDOH	Douglas Kent@Flhealth	
TANYA SHARP	FDOH	Joann @ascendant health	lugor 872-44
JoAnn Vanlleter		Joann @ascendart health	cre partners. com
Carol Miller	Gulf Coast State College	cmillere gutcoast. edu	
Kuphael Graham	West-Rock - Paper Mill	raphgratian@hotmail.com	404-759-800Z
BRAND AUGUT	FDOH-BAY	BRANDI HUTHERD FILTER	
Preston Mathea	5 Big Bend A HEC	pmather wie bigbon dake	E OVY 386 95659
34 4 3 W	10 10 PHA	had been one	(D) 122 1/16
Julie linan.	FOCH - 1001	Julie tindou(@+1heat	AUV COLL
facilitationa	1540 6 17	Teller Hood	
Vanide Lucas	LEAD Coalition	850/ead@gmail.com	913-3263
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Florida Department of Health in Bay County Community Health Improvement Plan Update Committee Bay Medical Center-Sacred Heart, Walsingham Board Room 615 N Bonita Ave, Panama City, FL 32401 November 20, 2015

Sign In Sheet

Purpose:

Engage community partners in the Mobilizing for Action through Planning and Partnerships (MAPP) process.

Attendees – PLEASE PRINT LEGIBLY

Name	Organization or Community	Email	Phone
7	Representative	01 0	872-4640
Rebecca Custi	WIC	Rebecça. Curti @ 9 he	oth and
Octashar Oliman	FOOH	Notosha. Coloman Pt	heath gover
y Milligan- Tudely	FDOH/WIC K	Judal & Al. heatt. gg	v 872-4/del
andors Sped	la FDOHLBAY So	inda Speds allholl.	gart 872-448
Ersca Meday	FOOT Bdy	Erica. Myland OH h	ofth gove
Train Adami	FOOH 1 Bag	tray adams of Thick	CV 8724455
Bookysashle	SHHS	onfile	onsale
AHRUMOS	Tradall ARB	4.	R
Shelly Berry	90 WORKS	Sherry 90works.or	g 630-9083
Carry & Loney	LEAD	Slower la gutterst. eal in	307-3102
Hatie Landel	News Herald	klandeck@panh.com	413-284-9040
	<u> </u>	91	
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MEETING MINUTES

<u>Purpose:</u> Solicit input from the community on community health needs assessment through open two-way dialogue.

Speaker	Topic	Discussion
Julie Tindall	Welcome/Call to Order Introductions Brief review of agenda Prompt attendees to sign-in	Meeting called to order. Appreciation expressed to Bay Medical/Sacred Heart for the hot breakfast that was provided. Round table introductions were made and participants were reminded to sign in and be sure to list contact information.
Julie Tindall	Review Previous Minutes	The minutes from the 10/16/2015 meeting were reviewed. Motion made to accept the minutes as presented, motion seconded, motion carried.
Julie Tindall	Status Update of Previous Actions Item 1: MAPP Process Item 2: Local Public Health System Survey- complete Item 3: Community Health Assessment (CHA) Survey-complete Item 4: Community Themes & Strengths Assessment-complete Item 5: Review of Data Generated from CHA	Previous Actions of the Community Health Assessment were reviewed in order to remind participants of previous meetings as well as bring new meeting participants up to date.
Julie Tindall	Introduce Next Topic Determination of Top Three Priority Issues to Address in the 2016 Community Health Improvement Plan	Community Health Assessment Survey data review was discussed and audience was offered the names of the review committee: • April Wisdom, GS-11 USAF • Becky Washler, MPA, AICP • JoAnn Vanfleteren, Consultant • Randy Chitwood, DNP, RN • Douglas Kent, MPH • Julie Tindall, MSN, RN The review resulted in 4 priority community health issues being identified: 1. chronic disease including diabetes, 2. healthy weight/healthy lifestyle education, 3. preventable disease/screenings/behaviors and 4. mental health/substance abuse.

MEETING MINUTES

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Julie Tindall	Discuss Supporting Information	1538 survey were completed (~950 were electronic). Julie, April & Becky provided data collection information and included information about the use of PEARL, a group of factors which have a high degree of influence in determining whether a particular problem can be addressed: P – Propriety, is the problem one that falls within the overall mission? E – Economic Feasibility, does it make economic sense or are there economic consequences if the issue is not addressed? A – Acceptability, will the community accept the problem being addressed? R – Resources, are resources available? L – Legality, do current laws allow the problem to be addressed? The need to focus the 4 priority issues to 3 priority issues was proposed. It was proposed that each participant select 3 issues that he/she would like to see addressed in the 2016 Community Health Improvement Plan through vote.
Julie Tindall	Open Floor for Community Input	Julie opened the floor to discussion. Group discussion was conducted and consensus to vote on 3 priority issues (without priority weight) was determined with no dissenters. Each participant was offered three sheets of paper, they were then asked to place their 3 choices for priority issues into 3 of 4 boxes. Following completion of the vote, April Wisdom, Brandy Hughes and Marsha Sumner tallied the votes which determined that: Mental Health/Substance Abuse Healthy Weight/Healthy Lifestyle Education and, Chronic Disease Including Diabetes Would be the three priority issues to be addressed in the 2016 CHIP.

MEETING MINUTES

Julie Tindall	Our next meeting will focus on formulation of goals and strategies to address the top three health issues selected by today's vote which will be addressed in the 2016 community health improvement plan	Julie Tindall proposed next steps of focusing on formulation of goals and strategies to address the top three health issues selected by today's vote. Participants were encouraged to offer other suggestions or recommendations
Julie Tindall	Actions Set date for the next meeting(Jan 8 th , 22 nd or 29th)	Next scheduled meeting January 22, 2016 at Bay Medical-Sacred Heart, Walshingham Board Room 8:30-10:30. Hot breakfast to be provided at 8:00am by Bay Medical-Sacred Heart.
	Meeting Evaluation	Participants were reminded to complete evaluation prior to departing.
	Adjourn	Meeting adjourned at approximately 9:45 a.m.

[₹]rom:

Sharp, Tanya

:ent

Wednesday, November 25, 2015 9:18 PM

To:

Kent, Doug M; Tindall, Julie A; Speedling, Sandon S; Hughes, Brandy L

Subject:

CHTF Meeting in the news

fyi -In the news:)

http://www.newsherald.com/article/20151124/NEWS/151129590



Bay County Community Health Task Force sets priorities ...

Mental health and substance abuse, healthy weight and healthy lifestyle, and chronic diseases including diabetes will be the focus of the Bay County Community Health ...

Read more...

. Bay County Community Health Task Force sets priorities

- Mental health and substance abuse, healthy weight and healthy lifestyle, and chronic diseases including diabetes will be the focus of the Bay County Community Health Task Force for the next three years.
- Posted Nov. 24, 2015 at 4:17 PM Updated Nov 24, 2015 at 4:18 PM

PANAMA CITY — Mental health and substance abuse, healthy weight and healthy lifestyle, and chronic diseases including diabetes will be the focus of the Bay County Community Health Task Force for the next three years.

Task force members selected their priorities Friday in a blind vote after reviewing data generated from a recent community health assessment. The assessment looked at the results of 1,583 surveys filled out by members of the community as well as data points such as mortality rates.

"I'm very happy with the priorities," said Julie Tindall, who ran the meeting and is the Florida Health Department diabetes services program director in Bay County. "It's a preventive health model, and it is so much more sensible to try to prevent something from happening than it is to try to treat it."

Florida Department of Health in Bay County CHIP Meeting



Participant Ballot

Please choose 2 days in January 2016 which will be most convenient for you to attend the next Community Health Improvement Plan meeting:

- Tuesday, January 19, 2016
- Wednesday, January 20, 2016
- Thursday, January 21, 2016
- Friday, January 22, 2016
- Tuesday, January 26, 2016
- Wednesday, January 27, 2016
- Thursday, January 28, 2016
- Friday, January 29, 2016

Tindall, Julie A

ubject:

CHA/CHIP Work Session

Location:

Walsingham Board Room, Bay Medical Center

Start: End: Fri 11/20/2015 8:30 AM Fri 11/20/2015 10:30 AM

Recurrence:

(none)

Meeting Status:

Accepted

Organizer:

Rahn, Lisa A

Required Attendees:

Amanda Alexander; Ann Wing; April C Wisdom (april.wisdom@tyndall.af.mil); Barbara Day - AARP; Bekah Taylor; Ben Kleine; Beth Couillette; Beth Deluzain; Betsie Kummer; Betty Gehrken (BettyFSA@comcast.net); Beverley; Brandi Yant; Breaux, Collin; Brian Addison (brian.addison@dep.state.fl.us); Brooke Bullard; Bryan Russell

(brussell@r4careersourcegc.com); C. R. Corky Young (cyoung@baycountyfl.gov); Caleb

Prieto; Carla Hightower; Carol Miller ; Carter Ross; Cathy Howell

(chowell@standrewbaycenter.org); Cindy Olszowy; Coleman, Natasha M; Colville, Jo M; 'Cox, Robert'; Curti, Becky L; Dan Rowe; Dave Chodorowski; David Gibson; David Sasser (david.sasser@bayso.org); Delbert Horton; Delbert Summey; Denise Vaughan; Destiny & Deveron; Diana Connell; Elsagga, Sofia Y; Fletcher-Altman, Wendy; Flynn, Nicole; Food Pantry; Gayle Oberst; Gina Romans (gromans@familiescount.net); Gina Watson; Gina Watson; Grace Aiyegbokiki (gracea@eeckids.org); Greg Brudnicki; Gregory Dossie; Guy Tunnell; Haralson, Nancy A; Harned, Robert L.; Hassan, Merfat E; Henninger, Claire M; Hughes, Brandy L; James Lewis; Janice Lucas (850lead@gmail.com); Jerry Kindle; Jo

Schaffer; Joe Smiley (joe.smiley@bayso.org); Joel Booth; Jon M. Cupp

(safeharbourjon@yahoo.com); Judah, Kay C; Julie Kitzerow; Julie Tindall; Justin

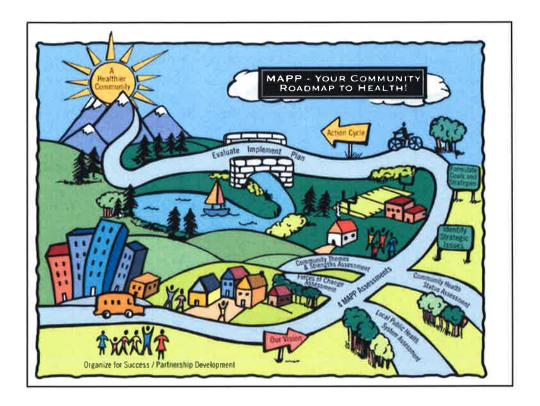
Omorinola; Kathie Riley; Kent, Doug M; Kim Bodine (kbodine@r4careersourcegc.com); Kris Nelson; Kyla McKenzie; Lee, Mylisa; Leslie Fuqua; Lori Allen; Lori Combs; Margo Anderson; Marian Gitchell; Marquez Alexander (marquezalexander@knology.net); Matthew Standefer; McCroan, Sandy M; Michael McNamara; Mike Hill; Miller, Ralph E.; Morgan Burleson (hhcnwfl.hmis@gmail.com); Nanisa Anderson; Pam Blumenthal; Pam Dorwarth; Patricia Byrd; Paul Mosca; Preston Mathews; Rachel Duvall; Randy Chitwood (rchitwood@gulfcoast.edu); Raphael (Ralph) Graham (raphgraham@hotmail.com); Regina Becker; Rich, Don; Rinker, Jackie; Robert Pearce; Ron Boyce (panamacity-ed@AMIkids.org); Sean Golder; Sharon Owens; Shelley Mason Berry; Sherl Morden; Sherrie Lock; Speedling, Sandon S; Standish, Matthew R.; Stewart, Tammy K; Suzanne Clark; Tammy Newton - Bay Medical; Tara Martine (tara.martine.ctr@us.af.mil); Terry Gainer; Tipps, Nancy L; Toni Shamplain; Valerie Mincey; Vitale, Rick E; Washler, Becky Bray; William Swift

Please SAVE THE DATE for our last community health assessment meeting for 2015! We will be identifying Bay County's top 3-5 health priorities on which to work over the next three years and need your input. Minutes, agenda and more information to follow. To start off the holiday eating season, Bay Medical Center will be graciously providing a HOT BREAKFAST again at 8:00 am. Hope you can join us!



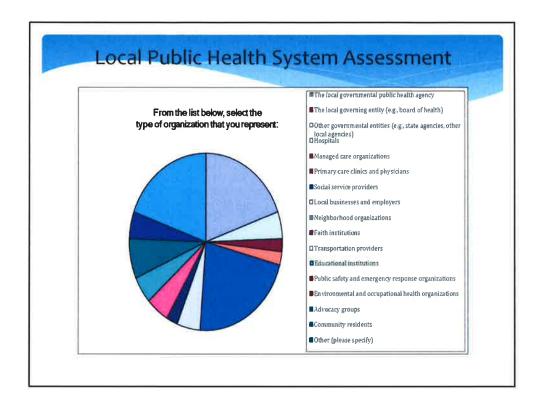
Today's Agenda

- * Introductions/sign-in please
- * Review previous minutes
- * MAPP process review
- * CHA Survey Status update
- * Data Review Findings
- * Determination of Top Health Issues for CHIP
- * Action Items/Future meeting dates



This is one of 2 models showing how the MAPP process works – and is an especially good image for connecting to communities. The phases of MAPP are shown along a road that leads to "A Healthier Community". The 4 MAPP Assessments are shown on the main road and represent the core activities in the process. MAPP is a way to define your interim goals between where you are and "A Healthier Community." It also helps prioritize, set realistic action plans to get there, and celebrate your successes along the way. One challenge with this image is that it makes the MAPP process look linear when it's actually cyclical.

Put another way, using MAPP is like taking a trip. MAPP can help you figure out where you want to go, how to get there, and who needs to be in the car. You may need to pick up extra people along the way to help you reach your destination. And, by the time you get there, MAPP may have helped you figure out an even better destination.



	Assessment	
Very Important	Fairly Important	Not Important
Mental Health	Access to clinic services	Injury prevention
Obesity/Diabetes	Chronic disease prevention and control	Emergency preparedness
Maternal Child Health	Health education/ Health promotion	Illiteracy

This data was determined by analysis of the information you provided at our last meeting-the list is generated from . You were asked to tank public health issues faced by your clients and for your organization.

	orces of	Change	Assessm	ent
What makes you proud of our community?	What would excite you enough to increase your involvement in community	What issues must be addressed to improve quality of life in our community?	What is keeping our community from improving health and quality of life?	What initiatives would you support toward establishment of a healthier community?
Community Collaboration	Expansion of affordable housing	Access to mental health services	Governmental apathy	Transportation system
	More effective transportation system	Affordable housing	Lack of follow through	Affordable housing
	Visible outcomes	Transportation systems	Lack of funding/ prioritization of funds	Expansion of mental health services and access for the working poor

This data was determined by analysis of the information you provided at our last meeting-the list is generated from . You were asked to provide answers to 4 questions about your community which are typically associated with driving change: the answers were analyzed to determine repetitive theme demonstrated in the chart above and only answers that were repeated are documented



Hy

The Community Health Assessment Survey

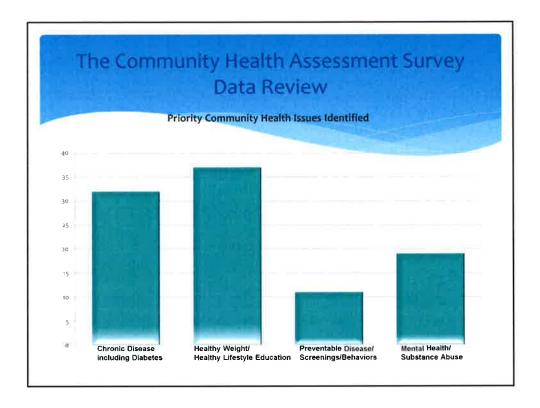
1538 surveys completed

(~950 were completed electronically)

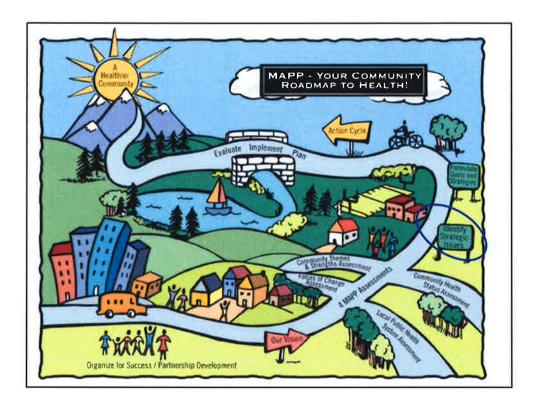
The Community Health Assessment Survey Data Review

- P Propriety, is the problem one that falls within the overall mission?
- **E** Economic Feasibility, does it make economic sense or are there economic consequences if the issue is not addressed?
- **A** Acceptability, will the community accept the problem being addressed?
- **R** Resources, are resources available?
- L Legality, do current laws allow the problem to be addressed?

The PEARL is a group of factors that, although not directly related to the health problem, have a high degree of influence in determining whether a particular problem can be addressed.



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You've been provided with 3 sheets of paper which are labeled with 1, 2, 3

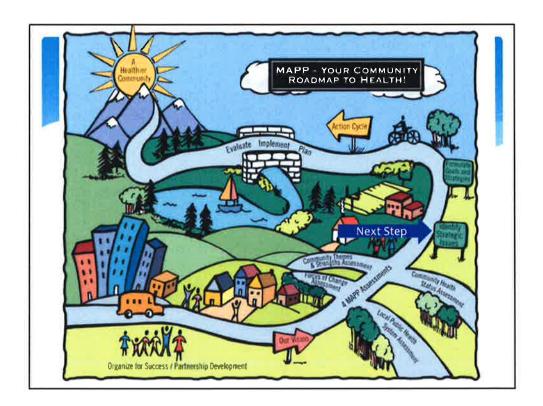
There are 4 boxes which are labeled with the issues which the CHA data has identified as priority issues

Please place one of your numbered slips of paper in the boxes identified as the issues which you believe should be addressed in the CHIP

Next Step

Our next meeting will focus on formulation of goals and strategies to address the top three health issues selected by today's vote which will be addressed in our community health improvement plan

Please indicate on the provided ballot, which 2 days in January would be most convenient for you to attend the next Community Health Improvement Plan Meeting



This is one of 2 models showing how the MAPP process works – and is an especially good image for connecting to communities. The phases of MAPP are shown along a road that leads to "A Healthier Community". The 4 MAPP Assessments are shown on the main road and represent the core activities in the process. MAPP is a way to define your interim goals between where you are and "A Healthier Community." It also helps prioritize, set realistic action plans to get there, and celebrate your successes along the way. One challenge with this image is that it makes the MAPP process look linear when it's actually cyclical.

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Bay Medical Center - Sacred Heart Community Health Implementation Strategy Progress Report 2013-2015

Priority Area:	Improve Awareness of Community Resources	
Goal:	Utilize 211 for community information and referral	
Objective:	As part of the Bay County Community Health Task Force (CHTF) Access Team, develop an action plan to develop and implement (if financially sustainable) a "211" system to improve public access to information and referral for needed health and social services	

Activity / Accomplishments:

Access Team worked with community partners including the United Way, Florida Department of Health in Bay County, PanCare, the Homeless and Hunger Coalition of NW Florida and the Bay County Commission to bring 2-1-1 service to the area in August 2013. Promotion of 2-1-1 and updating of community resource listings are an on-going process. In the first year 2-1-1 Northwest Florida call volume increased by 48 percent for Bay County alone. 2-1-1 Northwest Florida has added a searchable database online at www.211nwfl.org.

Impact:

Bay County 211 - Health/Health Care (HC) Related Referrals

	2013		2014	
	Total	% of Total HC Calls	Total	% of Total HC Calls
Food and Nutrition	276	14.9%	356	52.3%
Prescription Assistance and Medical Equipment Assistance	81	8.5%	96	14.1%
Mental Health and Substance Abuse	66	31.9	122	17.9%
Free/Low Cost Healthcare	28	17.0%	64	9.4%
Health Insurance	45	17.0%	19	2.8%
Dental Services	13	10.6%	16	2.3%
Vision Services			8	1.2%
Total Calls	509		681	

Source: 211 Service Provider for Bay County (United Way of Escambia County)

Goal:	Obesity & Diabetes Education - Inform and educate the health care professional community.
Objective:	Contribute to the development of a community database of primary care providers and certified diabetic education resources for messaging and educational support.

Activity / Accomplishments:

- Diabetes education is featured on weekly BMSH news segment televised on NBC affiliate, WJHG.
- Diabetes educational materials are being provided at food giveaway.
- Approximately ten (10) case managers are being trained about community diabetes resources and provided with brochures.

Objective: As a member of the Bay County Community Health Task Force - Diabesity Team, develop and deliver evidenced-based education, training and tools on Metabolic Syndrome to primary care providers.

Activity / Accomplishments:

- In conjunction with Health Dept. CHTF representative, presented diabetes management and education program to 30 area physician office managers.
- Health Dept. presented diabetes management and education program to hospitalist director and administration.

Objective:	Encourage BMC affiliated primary care providers to refer appropriate patients
	to the National Diabetes Prevention Program (NDPP) as an option for early
	intervention.

Activity / Accomplishments:

• Met with all seven (7) employed primary care providers to discuss diabetes education and management program, and referral processes.

RESOLUTIONS OF THE BOARD OF DIRECTORS OF SACRED HEART HEALTH SYSTEM, INC.

The Board of Directors of Sacred Heart Health System, Inc. ("Corporation") adopts the following resolutions at a meeting duly held on June 8, 2016, at which a quorum of Directors was present.

RECITALS

- A. Section 501(r) of the Internal Revenue Code and the regulations promulgated hereunder (collectively, "501(r)") imposes certain requirements on 501(c)(3) "hospital organizations" and "hospital facilities" (as those terms are defined in 501(r)). Each hospital facility is required, among other things, to conduct a community health needs assessment ("CHNA") and adopt an implementation strategy ("IS") to meet the identified health needs at least once every three (3) tax years.
- B. Pursuant to 501(r), Bay County Health System, LLC ("Hospital"), a Delaware Limited Liability Company in which Corporation has an ownership interest, conducted a CHNA for the community the Hospital serves. The CHNA is attached as **Exhibit A**.
- C. The Hospital completed the following steps in conducting its CHNA in compliance with 501(r): (1) defining the "community" served; (2) assessing the health needs of that community; (3) soliciting and taking into account input received from persons who represent the broad interests of the community, including those with special knowledge of or expertise in public health; and (4) documenting the CHNA in a written report.
- D. Pursuant to 501(r), a Hospital needs to prepare an IS to meet the community health needs identified through the CHNA (each a "health need") that, with respect to each significant health need, either (1) describes how the Hospital plans to address the health need, or (2) identifies the health need as one the Hospital does not intend to address and explains the reason(s) for that determination.
- E. 501(r) requires that the Corporation's Board of Directors adopts the CHNA, attached as **Exhibit A**.

NOW, THEREFORE, in consideration of the foregoing:

BE IT RESOLVED that the Board of Directors hereby approves and adopts the CHNA attached as **Exhibit A**.

BE IT FURTHER RESOLVED that the officers and management of Corporation be, and they hereby are authorized and directed to make the CHNA widely available to the public in compliance with 501(r).

BE IT FINALLY RESOLVED that the officers and management of Corporation be, and they hereby are authorized and directed to take such other actions as are necessary to prepare the IS and, thereafter, seek approval and adoption of the IS by the Hospital's Board of Directors, the Corporation's Board of Directors and the Gulf Coast Health System Board of Directors.

The above resolutions are adopted this 8th day of June, 2016, and made effective as of the same day.

Did Baken

RESOLUTIONS OF THE BOARD OF DIRECTORS OF BAY COUNTY HEALTH SYSTEM, LLC

In lieu of meeting, the Board of Directors of Bay County Health System, LLC ("Corporation" or "Hospital") adopts the following resolution by unanimous written consent, effective June 29, 2016.

RECITALS

- A. Section 501(r) of the Internal Revenue Code and the regulations promulgated hereunder (collectively, "501(r)") imposes certain requirements on 501(c)(3) "hospital organizations" and "hospital facilities" (as those terms are defined in 501(r)). Each hospital facility is required, among other things, to conduct a community health needs assessment ("CHNA") and adopt an implementation strategy ("IS") to meet the identified health needs at least once every three (3) tax years.
- B. Pursuant to 501(r), Hospital conducted a CHNA for the community the Hospital serves. The CHNA is attached as **Exhibit A**.
- C. The Hospital completed the following steps in conducting its CHNA in compliance with 501(r): (1) defining the "community" served; (2) assessing the health needs of that community; (3) soliciting and taking into account input received from persons who represent the broad interests of the community, including those with special knowledge of or expertise in public health; and (4) documenting the CHNA in a written report.
- D. Pursuant to 501(r), a Hospital needs to prepare an IS to meet the community health needs identified through the CHNA (each a "health need") that, with respect to each significant health need, either (1) describes how the Hospital plans to address the health need, or (2) identifies the health need as one the Hospital does not intend to address and explains the reason(s) for that determination.
- E. 501(r) requires that the Corporation's Board of Directors adopts the CHNA, attached as **Exhibit** $\underline{\mathbf{A}}$.

NOW, THEREFORE, in consideration of the foregoing:

BE IT RESOLVED that the Board of Directors hereby approves and adopts the CHNA attached as **Exhibit A**.

BE IT FURTHER RESOLVED that the officers and management of Corporation be, and they hereby are authorized and directed to make the CHNA widely available to the public in compliance with 501(r).

BE IT FINALLY RESOLVED that the officers and management of Corporation be, and they hereby are authorized and directed to take such other actions as are necessary to prepare the IS and, thereafter, seek approval and adoption of the IS by the Corporation's Board of Directors.

The above resolutions are adopted this 29th day of June, 2016, by unanimous written consent of the Board of Directors, and made effective as of the same day.

Styra J Julho Secretary

From:

Davis, Susan (Sacred Heart, Pensacola) <Susan.Davis2@shhpens.org>

Sent:

Tuesday, June 14, 2016 7:34 AM

To:

Barbara Nazaruk

Subject:

RE: VOTE REQUIRED: Bay Co Community Health Assessment Report

Barbara

I am fine with the resolution

Susan

Susan Davis RN, Ed.D, FACHE

Ascension Health Market Executive Gulf Coast

President & CEO Sacred Heart Health System 5151North 9th Avenue Pensacola, FL 32504 850-416-7010 (office) 203-767-0174 (cell)

From: Barbara Nazaruk [mailto:Barbara.Nazaruk@baymedical.org]

Sent: Monday, June 13, 2016 11:30 AM

To: Barbara Nazaruk

Cc: Barbara Nazaruk; David Marks; Donna Baird; Jeanne Reeves; John Osgood; Joseph Ketterer; Julie Traugott; Ron

Patrick; Stephen Grubbs; Tammy Newton

Subject: VOTE REQUIRED: Bay Co Community Health Assessment Report

Importance: High

Good afternoon Joint Venture Board of Directors,

The Bay County Community Health Assessment report and the Bay - Resolution to adopt CHNA document are attached for your review.

Once you have reviewed the report, please return your response to approve or not approve via email by close of business on Tuesday, June 21st.

Respectfully,

Barbara Nazaruk

Administration Office Director and Executive Assistant to Mr. Steve Grubbs, President/CEO Bay Medical Center Sacred Heart Health System 615 N. Bonita Avenue Panama City, FL 32401

O: 850-747-6045 C: 850-866-6520

From:

Bill Greenhut <Bill@greenhut.com>

Sent:

Monday, June 13, 2016 12:40 PM

To:

Barbara Nazaruk

Subject:

Re: VOTE REQUIRED: Bay Co Community Health Assessment Report

Approve. Thanks.

Bill Greenhut Chief Executive Officer Greenhut Construction Co., Inc P.O. Box 12603 Pensacola, Fl 32591 850.433-5421

On Jun 13, 2016, at 11:31 AM, Barbara Nazaruk < Barbara. Nazaruk@baymedical.org > wrote:

<image001.jpg>
Good afternoon Joint Venture Board of Directors,

The Bay County Community Health Assessment report and the Bay - Resolution to adopt CHNA document are attached for your review.

Once you have reviewed the report, please return your response to approve or not approve via email by close of business on Tuesday, June 21st.

Respectfully,

Barbara Nazaruk

Administration Office Director and Executive Assistant to Mr. Steve Grubbs, President/CEO Bay Medical Center Sacred Heart Health System 615 N. Bonita Avenue Panama City, FL 32401 O: 850-747-6045

C: 850-866-6520 F: 850-763-8827

Barbara.nazaruk@baymedical.org

<image004.jpg>

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From:

Cornejo, Susan <susan.cornejo@providencehospital.org>

Sent:

Wednesday, June 22, 2016 1:13 PM

To:

Barbara Nazaruk

Subject:

RE: VOTE REQUIRED: Bay Co Community Health Assessment Report

Approved

From: Barbara Nazaruk [mailto:Barbara.Nazaruk@baymedical.org]

Sent: Monday, June 13, 2016 11:30 AM

To: Barbara Nazaruk

Cc: Barbara Nazaruk; David Marks; Donna Baird; Jeanne Reeves; John Osgood; Joseph Ketterer; Julie Traugott; Ron

Patrick; Stephen Grubbs; Tammy Newton

Subject: VOTE REQUIRED: Bay Co Community Health Assessment Report

Importance: High

Good afternoon Joint Venture Board of Directors,

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Once you have reviewed the report, please return your response to approve or not approve via email by close of business on Tuesday, June 21st.

Respectfully,

Barbara Nazaruk

Administration Office Director and Executive Assistant to Mr. Steve Grubbs, President/CEO Bay Medical Center Sacred Heart Health System 615 N. Bonita Avenue Panama City, FL 32401 O: 850-747-6045

C: 850-866-6520 F: 850-763-8827

Barbara.nazaruk@baymedical.org



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From:

Kennedy, Todd S. <Todd.Kennedy@providencehospital.org>

Sent:

Friday, June 24, 2016 10:16 AM

To:

Barbara Nazaruk

Subject:

Re: VOTE REQUIRED: Bay Co Community Health Assessment Report

Attachments:

image001.jpg; image004.jpg

Approved.

Todd Kennedy

Sent from my iPhone

> On Jun 13, 2016, at 11:38 AM, Barbara Nazaruk < Barbara.Nazaruk@baymedical.org > wrote:

>

>

- > Good afternoon Joint Venture Board of Directors,
- > The Bay County Community Health Assessment report and the Bay Resolution to adopt CHNA document are attached for your review.
- > Once you have reviewed the report, please return your response to approve or not approve via email by close of business on Tuesday, June 21st.

>

> Respectfully,

>

- > Barbara Nazaruk
- > Administration Office Director and
- > Executive Assistant to Mr. Steve Grubbs, President/CEO Bay Medical
- > Center Sacred Heart Health System
- > 615 N. Bonita Avenue
- > Panama City, FL 32401
- > O: 850-747-6045
- > C: 850-866-6520
- > F: 850-763-8827
- > Barbara.nazaruk@baymedical.org<mailto:Barbara.nazaruk@baymedical.org>
- > [BMSH LOGO small]

>

> Confidentiality Notice: This email message and any attachments from Bay Medical Center Sacred Heart Health System, its subsidiaries and affiliates, are confidential and for the sole use of the intended recipient. This communication may contain privileged, proprietary, or confidential information (i.e., including Protected Health Information), which may only be used or disclosed in accordance with applicable law. If you are not the intended recipient of this email or the employee or agent responsible for delivering the communication to the intended recipient, then you may not read, copy, distribute or otherwise use or disclose the information contained in this message. If you received this message in error, please notify us by an email to Rostmaster@baymedical.org. Please indicate that you were not the intended recipient, and confirm that you

From:

phillip nunnery <phillipnunnery@gmail.com>

Sent:

Monday, June 27, 2016 8:00 PM

To: Cc: Barbara Nazaruk Janice Floyd

Subject:

Re: FW: VOTE REQUIRED: Bay Co Community Health Assessment Report

Yes, I approve.

On Fri, Jun 24, 2016 at 10:33 AM Barbara Nazaruk < Barbara. Nazaruk@baymedical.org > wrote:

Good morning everyone,

Becky Washler-Sr. Planner, Sacred Heart Health System, noted that we will need a vote from all members of the Joint Venture Board of Directors. If you are receiving this email, I will need to receive an email vote from you of approved or unapproved for this resolution to be completed/passed.

Respectfully,

Barbara Nazaruk

Administration Office Director and

Executive Assistant to Mr. Steve Grubbs, President/CEO

Bay Medical Center Sacred Heart Health System

615 N. Bonita Avenue

Panama City, FL 32401

O: 850-747-6045

C: 850-866-6520

F: 850-763-8827

Barbara.nazaruk@baymedical.org

[BMSH LOGO small]

From: Barbara Nazaruk

Sent: Monday, June 13, 2016 11:30 AM

To: Barbara Nazaruk

Cc: Barbara Nazaruk; David Marks; Donna Baird; Jeanne Reeves; John Osgood; Joseph Ketterer; Julie

Traugott; Ron Patrick; Stephen Grubbs; Tammy Newton

Subject: VOTE REQUIRED: Bay Co Community Health Assessment Report

Importance: High

Good afternoon Joint Venture Board of Directors,

The Bay County Community Health Assessment report and the Bay - Resolution to adopt CHNA document are attached for your review.

Once you have reviewed the report, please return your response to approve or not approve via email by close of business on Tuesday, June 21st.

Respectfully,

Barbara Nazaruk

From:

John Holland < John. Holland@lhphospitalgroup.com>

Sent:

Wednesday, June 15, 2016 9:09 AM

To:

Barbara Nazaruk

Cc:

David Marks; Donna Baird; Jeanne Reeves; John Osgood; Joseph Ketterer; Julie Traugott;

Ron Patrick; Stephen Grubbs; Tammy Newton

Subject:

Re: VOTE REQUIRED: Bay Co Community Health Assessment Report

l approve.

John Holland President & CEO LHP Hospital Group

On Jun 13, 2016, at 11:30 AM, Barbara Nazaruk < <u>Barbara.Nazaruk@baymedical.org</u> > wrote:

<image001.jpg>

Good afternoon Joint Venture Board of Directors,

The Bay County Community Health Assessment report and the Bay - Resolution to adopt CHNA document are attached for your review.

Once you have reviewed the report, please return your response to approve or not approve via email by close of business on Tuesday, June 21st.

Respectfully,

Barbara Nazaruk

Administration Office Director and Executive Assistant to Mr. Steve Grubbs, President/CEO Bay Medical Center Sacred Heart Health System 615 N. Bonita Avenue Panama City, FL 32401 O: 850-747-6045

C: 850-866-6520 F: 850-763-8827

Barbara.nazaruk@baymedical.org

<image004.jpg>

<Bay County - Community Health Assessment Report 2015-16 - Bay Medical SH.pdf>

<Bay- Resolution to adopt CHNA.docx>

From:

John Ehrie < John. Ehrie@lhphospitalgroup.com>

Sent:

Monday, June 13, 2016 3:08 PM

To:

Barbara Nazaruk

Subject:

RE: VOTE REQUIRED: Bay Co Community Health Assessment Report

I approve. Thanks, John

From: Barbara Nazaruk [mailto:Barbara.Nazaruk@baymedical.org]

Sent: Monday, June 13, 2016 11:30 AM

To: Barbara Nazaruk < Barbara. Nazaruk @baymedical.org >

Cc: Barbara Nazaruk Barbara Nazaruk@baymedical.org; David Marks David.Marks@baymedical.org; David.Marks@baymedical.org; David.Marks@baymedical.org

<Donna.Baird@baymedical.org>; Jeanne Reeves <Jeanne.Reeves@baymedical.org>; John Osgood

<<u>John.Osgood@baymedical.org</u>>; Joseph Ketterer <<u>Joseph.Ketterer@baymedical.org</u>>; Julie Traugott

<<u>Julie.Traugott@baymedical.org</u>>; Ron Patrick <<u>Ron.Patrick@baymedical.org</u>>; Stephen Grubbs

<<u>Stephen.Grubbs@baymedical.org</u>>; Tammy Newton <<u>Tammy.Newton@baymedical.org</u>>

Subject: VOTE REQUIRED: Bay Co Community Health Assessment Report

Importance: High

Good afternoon Joint Venture Board of Directors,

The Bay County Community Health Assessment report and the Bay - Resolution to adopt CHNA document are attached for your review.

Once you have reviewed the report, please return your response to approve or not approve via email by close of business on Tuesday, June 21st.

Respectfully,

Barbara Nazaruk

Administration Office Director and Executive Assistant to Mr. Steve Grubbs, President/CEO Bay Medical Center Sacred Heart Health System 615 N. Bonita Avenue Panama City, FL 32401

O: 850-747-6045 C: 850-866-6520 F: 850-763-8827

Barbara.nazaruk@baymedical.org



From:

Paul Kappelman < Paul. Kappelman@Ihphospitalgroup.com>

Sent:

Wednesday, June 15, 2016 9:05 AM

To:

Barbara Nazaruk

Cc:

Stephen Grubbs; Ron Patrick; Richard Haun; John Ehrie; John Holland; Rebecca Hurley

Subject:

Re: VOTE REQUIRED: Bay Co Community Health Assessment Report

Attachments:

image001.jpg; image004.jpg

We have reviewed internally and are ok with this resolution. I vote to approve.

Please make sure that if any other discussions or documents about 501r compliance come from SHHS, that you loop in Becky and Richard.

Paul

Paul Kappelman Division President LHP Hospital Group

On Jun 13, 2016, at 11:30 AM, Barbara Nazaruk < Barbara. Nazaruk@baymedical.org > wrote:

From:

Tom Neubauer <tom@panamacityera.com>

Sent:

Monday, June 27, 2016 11:51 PM

To:

Barbara Nazaruk

Subject:

RE: VOTE REQUIRED: Bay Co Community Health Assessment Report

Barbara, please register my vote in support of adopting the CHNA resolution. Thanks, Tom

70m Neubauer

850-522-7450 — Office 850-819-1955 — Cell



From: Barbara Nazaruk [mailto:Barbara.Nazaruk@baymedical.org]

Sent: Friday, June 24, 2016 10:34 AM

To: Barbara Nazaruk **Cc:** Janice Floyd

Subject: FW: VOTE REQUIRED: Bay Co Community Health Assessment Report

Importance: High

Good morning everyone,

Becky Washler-Sr. Planner, Sacred Heart Health System, noted that we will need a vote from all members of the Joint Venture Board of Directors. If you are receiving this email, I will need to receive an email vote from you of approved or unapproved for this resolution to be completed/passed.

Respectfully,

Barbara Nazaruk

Administration Office Director and
Executive Assistant to Mr. Steve Grubbs, President/CEO
Bay Medical Center Sacred Heart Health System
615 N. Bonita Avenue
Panama City, FL 32401

O: 850-747-6045 C: 850-866-6520 F: 850-763-8827

Barbara.nazaruk@baymedical.org



From: Barbara Nazaruk

Sent: Monday, June 13, 2016 11:30 AM

To: Barbara Nazaruk

Janice Floyd

From:

Barbara Nazaruk

Sent:

Monday, June 13, 2016 11:30 AM

To:

Barbara Nazaruk

Cc:

Barbara Nazaruk; David Marks; Donna Baird; Jeanne Reeves; John Osgood; Joseph

Ketterer; Julie Traugott; Ron Patrick; Stephen Grubbs; Tammy Newton

Subject:

VOTE REQUIRED: Bay Co Community Health Assessment Report

Attachments:

Bay County - Community Health Assessment Report 2015-16 - Bay Medical SH.pdf; Bay-

Resolution to adopt CHNA.docx

Importance:

High

Good afternoon Joint Venture Board of Directors,

The Bay County Community Health Assessment report and the Bay - Resolution to adopt CHNA document are attached for your review.

Once you have reviewed the report, please return your response to approve or not approve via email by close of business on Tuesday, June 21st.

Respectfully,

Barbara Nazaruk

Administration Office Director and Executive Assistant to Mr. Steve Grubbs, President/CEO Bay Medical Center Sacred Heart Health System

/ approve

615 N. Bonita Avenue

Panama City, FL 32401

O: 850-747-6045 C: 850-866-6520 F: 850-763-8827

Barbara.nazaruk@baymedical.org

