Community Health Needs Assessment

Bay County, Florida

2015 - 2020

Prepared June 2016 by:

Florida HEALTH Bay County

COMMUNITY HEALTH TASK FORCE Bay

Bay Medical Sacred Heart

Community Health Needs Assessment

Bay County, Florida

2015 - 2016

EXECUTIVE SUMMARY **1**

INTRODUCTION **4**

COLLABORATING PARTNERS **4**

COMMUNITY DEFINITION **5**

METHODOLOGY **6**

- Participants in the Assessment Process
- Process: Assessment
- Framework: Mobilizing Action through Planning & Partnerships

SUMMARY OF FINDINGS

- Forces of Change Assessment (FOCA) 7
- Community Strengths & Themes Assessment 8
- Local Public Health System Assessment 10

COMMUNITY HEALTH STATUS ASSESSMENT **12**

- Indicator Selection
- Data Sources
- Framework for Analysis
- Results

COMMUNITY HEALTH PRIORITIES

- Process 15

2016 COMMUNITY HEALTH PRIORITIES

HEALTHY WEIGHT **16**

CHRONIC DISEASE INCLUDING DIABETES **20**

MENTAL HEALTH/SUBSTANCE ABUSE **24**

Health Issue: Preventable Disease 28

APPENDICES:

I. Indicator References and Sources
II. Forces of Change
III. Community Themes and Strengths and the Local Public Health System
IV. Community Health Assessment
V. 2013 – 2015 Bay Medical Sacred Heart Strategy Progress Report

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.
7. **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	Healthy Weight/Obesity	Chronic Disease
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	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.	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

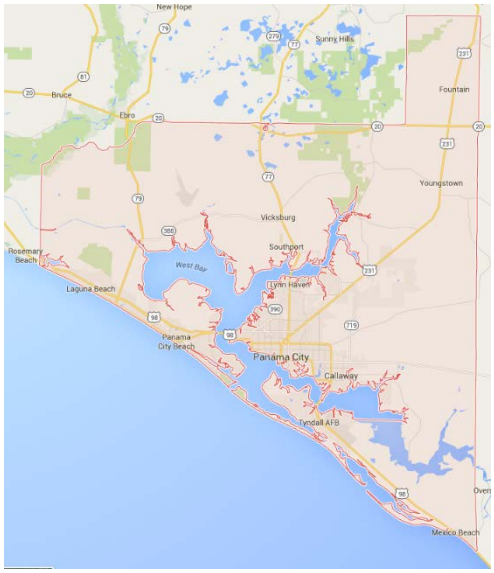
improvement of community health is at the center of public health endeavors; therefore, it is vital for everyone to be informed and engaged in these efforts. Communicating health risks and promotion of preventative measures to the public is key.

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 below and one-half 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.

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

In 2014, 14.8% of the population had incomes 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.

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

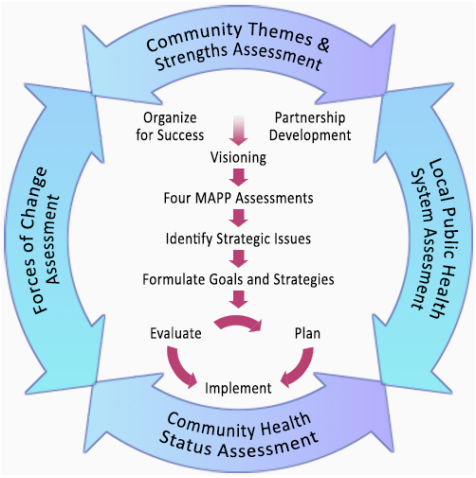
Individual members of these organizations and agencies that participated are listed on the sign-in sheets included in each related workshop reports included in Appendices II-IV.

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

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**
1. What makes you most proud of our community?	• Community Collaboration
2. 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
3. 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
4. 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
5. 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 Population	Vulnerable Population	Total 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

- there were no optimal results

Significant

Monitor Health Status

- Community health

Diagnose and Investigate

- Identification/ Surveillance

Educate/ Empower

- 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

Link to Health Services

- Personal Health Service Needs
- Assure Linkage

Enforce Laws

- Review Laws

Assure Competent Workforce

- Workforce Standards
- Continuing Education

Moderate

Monitor Health Status

- Communication of data

Diagnose and Investigate

- Natural and intentional disaster response

Develop Policies/Plans

- Government Presence
- Policy Development
- Community Health Improvement/ Strategic Planning

Mobilize Partnerships

- Constituency Development

Minimal

Mobilize Partnerships

- Academic and research institutions

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.

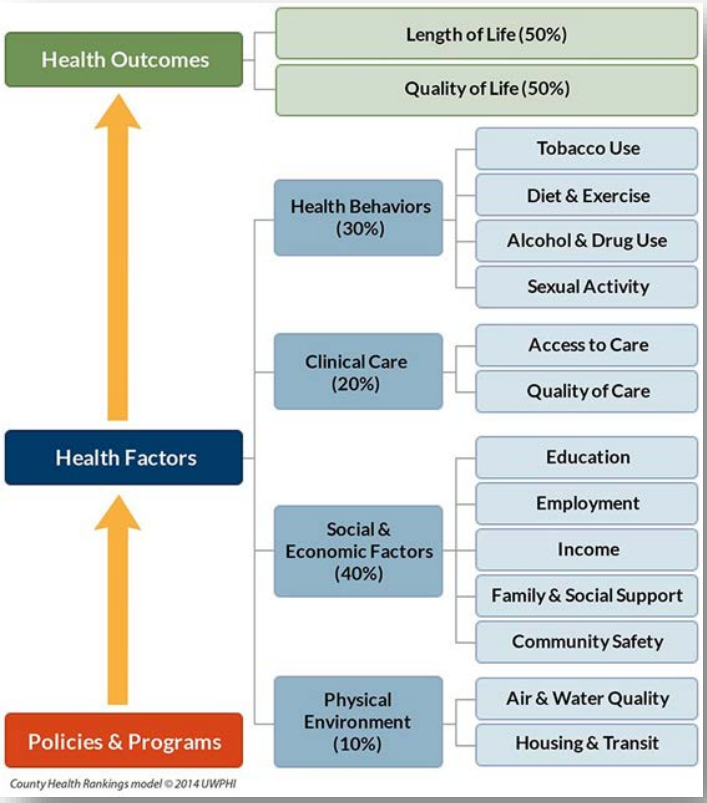
Data Sources

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 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.

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

County Health Rankings	Rank
Dimension	***Bay***
Health Outcomes	**47**
Length of Life (Mortality)	43
Quality of Life (Morbidity)	53
Health Factors	**42**
Health Behaviors	51
Clinical Care	39
Socioeconomic	21
Physical Environment	64

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:

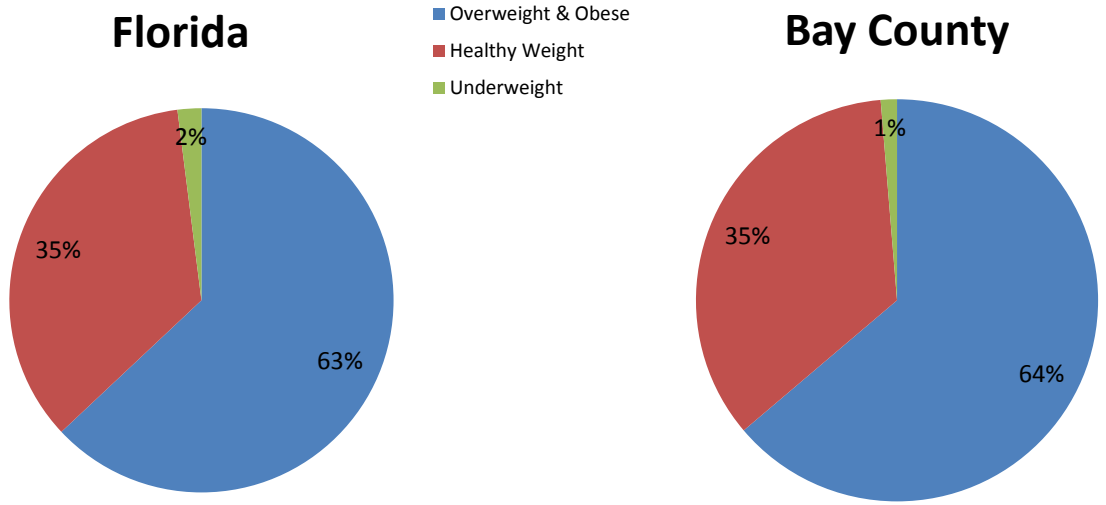
- Preventable Disease

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.

Body Mass Index (BMI)

Adults (21 and over)

Obesity 30.0 or higher

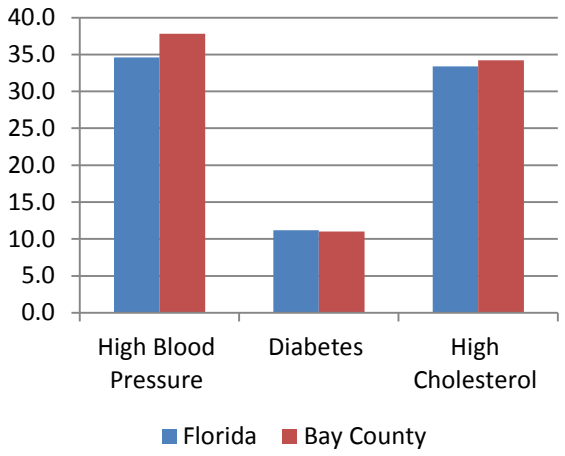
Overweight 25.0 and 29.9

Children & Adolescents (2-20 years)

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

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 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	Physical Activity
♦ Knowledge and attitudes	♦ Low income
♦ Skills social support	♦ Lack of time
♦ Food and agricultural policies	♦ Low motivation
♦ Food assistance programs	♦ Rural residency
♦ Economic price systems	♦ Lack of social support from peers, family, or spouse
♦ Marketing also influences people's—particularly children's—food choices	♦ Overweight or obesity
♦ Access and availability of healthier foods	♦ Physical environment
♦ Dining out influences a person's diet as they often have a higher in calories.	♦ 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	↑
Stroke Deaths	2012-14	34.0	↑

Health Outcome - Morbidity (Quality of Life)			
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	↑
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	↑
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	↑
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%	●
Clinical Care – Quality of 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 ≥ 140 mmHg or diastolic ≥ 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 ≥ 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	↑

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	↑

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			
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	↑
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	↑

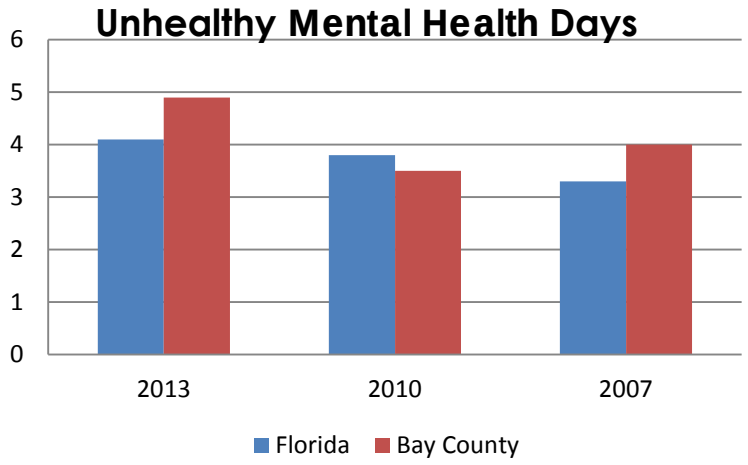
Physical Environment			
Indicator	**Latest Data Period**	**Performance**	**Trend**
Air pollution - particulate matter	2008	0.3	↑
Air Quality - Ozone	2008	0.00	●
Drinking water violations	FY 2013-14	31.00	↑

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 multi-dimensional 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	↑
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	●
HIV/AIDS Deaths	2012-14	4.1	↑
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 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	↑
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	↑
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 - 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 Economic Factors

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.
    - If one-tenth of Americans began a regular walking program, $5.6 billion could be saved in the treatment of heart disease.
    - Routine childhood vaccinations prevent more than 14 million cases of disease annually.
    - 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 County		Related Priorities		
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 County		Related Priorities		
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 Outcome - Morbidity (Quality 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	↑			
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	↑	✓		✓
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 Priorities		
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		
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 County		Related Priorities		
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		
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 County		Related Priorities		
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 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 Care – Access to Health Care						
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	↑			
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 County		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	↑			
Social and Economic Factors						
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 County		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	↑		✓	
Physical Environment						
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 Characteristics

		Bay County	
Indicator	**Latest Data Period**	**Performance**	**Trend**
Median Age	2014	39.7	⬇
Population Under Age 0-17	2014	37,585	⬆
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	⬆
Female Population Age 10-14	2014	5,141	⬆
Female Population Age 15-19	2014	5,039	⬇
Female Population Age 20-44	2014	27,367	⬆
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	⬆
Population by Race - White	2013	140,914	⬆
Population by Race - Black	2013	17,593	⬇
Population by Race - Native American	2013	971	⬆
Population by Race - Asian/Pacific Islander	2013	3,643	⬆
Population by Race - 2 or more races	2013	6,928	⬆
Population by Race - Other	2013	655	⬆
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/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: 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: http://www.floridacharts.com/charts/DataViewer/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: http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0125

HIV/AIDS Deaths - ICD-10 Code(s): B20-B24. Weblink: 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: 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:	Annual
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:	Annual
Source Data type:	%
Smallest geographic level:	County
Desired Target Direction:	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:	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: 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:	Annual
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*. 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:	Biennial
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: FYTS.

Live births where mother smoked during pregnancy - Resident live births. Weblink: http://www.floridacharts.com/charts/DataViewer/BirthViewer/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: 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: 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:	Biennial
Source Data type:	Rate
Smallest geographic level:	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:	Annual
Source Data type:	Rate
Smallest geographic level:	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: Annual
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: 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: Annual
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:	Annual
Source Data type:	%
Smallest geographic level:	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: Annual
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, 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: Annual
Source Data type: Rate
Smallest geographic level: 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:	Annual
Source Data type:	Ratio
Smallest geographic level:	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: http://www.floridacharts.com/charts/LoadPage.aspx?l=~/OtherIndicators/NonVitalIndNoGrpDataViewer.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: http://www.floridacharts.com/charts/LoadPage.aspx?l=~/OtherIndicators/NonVitalIndNoGrpDataViewer.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.

OB/GYN (per population) - Per population rate of people with active physician licenses in Florida who report OB/GYN 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=0330

Dentists - Per population rate of people with active licenses to practice dentistry in Florida. Weblink: 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=0552

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*. 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: 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-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: $
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=0295

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: Annual
Source Data type: %
Desired Target Direction: 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:	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.

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: Annual
Source Data type: %
Smallest geographic level: County
Desired Target Direction: 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: 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: Annual
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_PEPAGESEX&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_S1101&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

ACSC	Ambulatory Care Sensitive Conditions - ICD-9-CM Codes http://www.floridacharts.com/charts/documents/ACS_Conditions_Definition_UPDATE.pdf
ACS	American Community Survey
BRFSS	Florida Behavioral Risk Factor Surveillance System - county-level telephone survey conducted by the CDC and FL DOH Bureau of Epidemiology.
CDC	Centers for Disease Control and Prevention
CHR-RWJ	County Health Rankings, Robert Wood Johnson Foundation
CMS	Centers for Medicare and Medicaid Services
EPA	Environmental Protection Agency
FDHSMV	Florida Department of Highway Safety and Motor Vehicles
FDLE	Florida Department of Law Enforcement
FL AHCA	Florida Agency for Health Care Administration
FL DCF	Florida Department of Children and Families
FL DOE, EIAS	Florida Department of Education, Education Information and Accountability Services
FL DOH	Florida Department of Health
FL EDR	Florida Legislature's Office of Economic and Demographic Research
FYSAS	Florida Youth Substance Abuse Survey
FYTS	Florida Youth Tobacco Survey

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

Purpose: *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	

PARTNERSHIP
FOR A HEALTHY COMMUNITY

2015 Community Health Needs Assessment Indicators

Mortality

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
27. Prostate Cancer Incidence
28. 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

49. 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)
53. Alcohol Consumption (Adolescents)
54. 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
83. 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

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)
117. Pediatric psychiatric beds (per population)
118. Pediatric substance abuse beds (per population)
119. Rehabilitation beds (per population)
120. Skilled nursing beds (per population)
121. Mental health providers (per population)
122. OB/GYN (per population)
123. Family Practice Physicians (per population)
124. Internists (per population)
125. 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 (%)
132. Dental Health Professional Shortage Area Population (%)
133. Urgent Care Facilities (after hours/weekend)
134. Medicare Readmissions

Mental

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

General Health

138. 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
142. Prenatal Care Begun Late or No Prenatal Care
143. Births to Mothers Ages 10-14 (Resident)
144. Births to Mothers Ages 15-19 (Resident)
145. Births to Mothers Ages 15-44 (Resident)
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)
159. Children Eligible for Free/Reduced Price Lunch
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
170. Severe housing problems
171. Driving alone to work
172. Use of Public Transportation

Injury Crime Violence

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

Demographics

194. Disability (Any)
195. Population Under Age 18
196. Population Age 25-34
197. Population Age 35-44
198. Population Age 45-54
199. Population Age 55-64
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
210. Families with Children
211. Children in single-parent households
212. Total Births (resident)
213. Population by Race - Asian/Pacific Islander
214. Population by Race - Black
215. Population by Race - Native American
216. Population by Race - Other
217. Population by Race - White
218. 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?

October 16th

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. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

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
Kay Mulley-Jent	DOH / WIC	Kay.Jent@FLHealth	872-4641
Rebecca Curti	DOH - Bay / WIC	Rebecca.Curti@flhealth.gov	872-4666
Sandy McCroan	DOH - Bay WIC	Sandy.McCroan@FLHealth.gov	872-4666
Tammy Newton	BAY MEDICAL SACRED	tammy.newton@baymedical.org	
Suzanne Clark	Mental Health FIRST AID	suz.clark13@gmail	747-6581
Ann Wing	BCBC	ann.wing@bigbendcle.org	747-5755
Missy Lee	DCF-SAMH	mylisa.lee@myFLFamilies.com	251-7351
Preston Matthews	Big Bend CH/FEC	pmatthews@bigbendcle.org	785-956-5781
Barbara Day	AARP B.C. Chp 1215	busyday42@comcast.net	
Bekah Taylor	Life Management Center	btaylor@lmccares.org	522-4485 x 1110
Destiny Young	Global Arts Society	globalartssociety@gmail	315-316-2787
Brian Addison	St. Andrews State Park	Brian.Addison@dep.state.fl.us	233-5191
Nancy L Tipps	FDOH Bay CHD	Nancy.tipps@flhealth.gov	872-4455
Sherrie Lock	GCSC	slock@gulfcoast.edu	872-3819
Tara Martine	Tyndall AFB	tara.martine@gmail.com	910-409-3996
Brandi Hughes	FLDOH - BAY	Brandi.Hughes@flhealth.gov	872-4455
Doug Kent	FDOH - Bay CHD	Douglas.Kent@FLhealth.gov	
Julie Tindall	FDOH - Bay CHD	Julie.Tindall@flhealth.gov	
Gina Watsch	United Way - 211		
Sonya Lueyhanh	Lead Coalition		
Rachel Miller	FDOH - BAY		872-4660 x 1228
Nicole Flynn	Emerald Coast Behavioral Hospital	nicole.flynn@uhsinc.com	527-7126
Becky Christner	SHHS	on file	
Cacee Fiss	SHHS	"	
Amanda Alexander	Victory Temple Church	miracles still happen81@hotlook.com	319-7060

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
Marguez Alexander	Victory Temple Church	marquezalexander@knology.net	319-7016
Don Rich	FDOH - Bay	don.rich@flhealth.gov	227-4448
Carol Miller	Gulf Coast State College	cmiller@gulfcoast.edu	769-1551 3346
Randy Chitwood	GCSC	rchitwood@gulfcoast.edu	769 1551 3340
Mike Hill	BBHC/PanCare of FL, Inc	mhill@pancare.org	747-5577
Joni Shamplain	P.C.C.A.	tshamplain@pcgov.org	215-3869
Natasha Coleman	FDOH Diabetes Services	natasha.coleman@flhealth.gov	872 4455 x 203
PAM DORWARTH	Health Task Force / ADA	pamdorwarth@yahoo.com	850-230-3232
Dawn Rose-Cotton	Global Arts Society	globalartssociety@gmail	315-316-5787
Jackie Rinker	iHeart Media	jackierinker@iheartmedia.com	850 392 1176
Chisa Rahn	FDOH - Bay		
April Wisdom	Tyndall AFB		
Becky Washler	Sacred Heart Health		
Carter Ross	" " "		

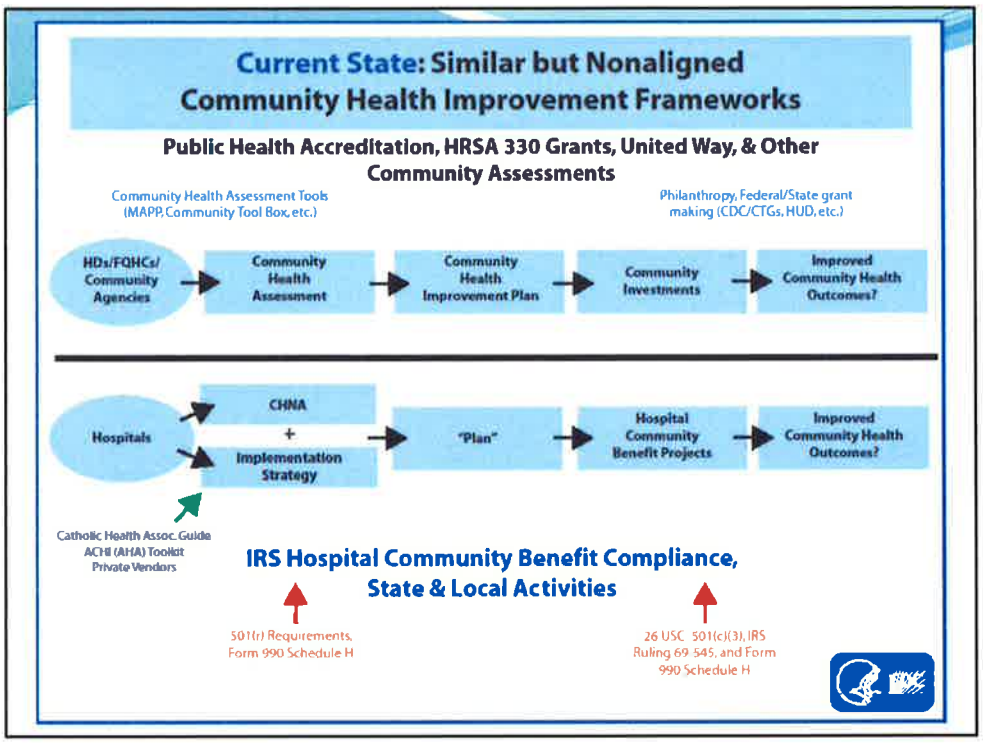
COMMUNITY HEALTH
Bay
TASK FORCE
Welcome
Community Health Assessment Work Session 9/18/15
Florida
HEALTH
Bay County

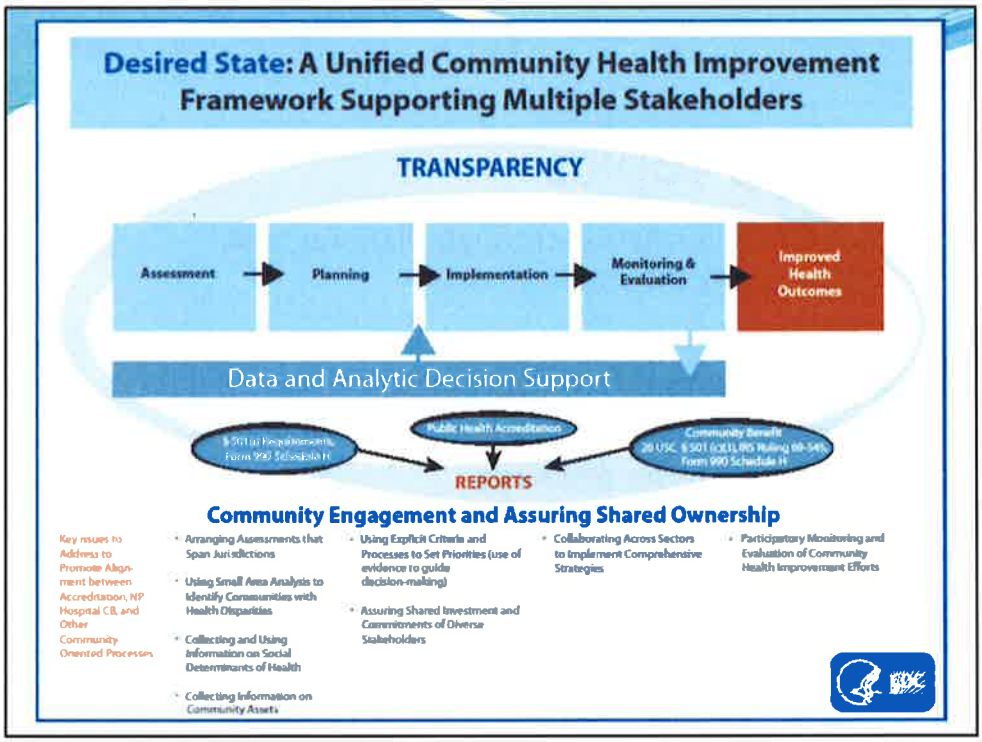
Today's Agenda

- 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


Current State: Similar but Nonaligned
Community Health Improvement Frameworks
Public Health Accreditation, HRSA 330 Grants, United Way, & Other Community Assessments
Community Health Assessment Tools (MAPP, Community Tool Box, etc.)
Philanthropy, Federal/State grant making (CDC/CTGs, HUD, etc.)
HDs/FQHCs/ Community Agencies
Community Health Assessment
Community Health Improvement Plan
Community Investments
Improved Community Health Outcomes?
Hospitals
CHNA
+
Implementation Strategy
"Plan"
Hospital Community Benefit Projects
Improved Community Health Outcomes?
Catholic Health Assoc. Guide
ACHI (AHA) Toolkit
Private Vendors
IRS Hospital Community Benefit Compliance, State & Local Activities
501(r) Requirements, Form 990 Schedule H
26 USC 501(c)(3), IRS Ruling 69-545, and Form 990 Schedule H


Desired State: A Unified Community Health Improvement Framework Supporting Multiple Stakeholders
TRANSPARENCY
Assessment
Planning
Implementation
Monitoring & Evaluation
Improved Health Outcomes
Data and Analytic Decision Support
Public Health Accreditation
REPORTS
Community Engagement and Assuring Shared Ownership
Key issues to Address to Promote Alignment between Accreditation, NP Hospital CB, and Other Community Oriented Processes
Arranging Assessments that Span Jurisdictions
Using Small Area Analysis to Identify Communities with Health Disparities
Collecting and Using Information on Social Determinants of Health
Collecting Information on Community Assets
Using Explicit Criteria and Processes to Set Priorities (use of evidence to guide decision-making)
Assuring Shared Investment and Commitments of Diverse Stakeholders
Collaborating Across Sectors to Implement Comprehensive Strategies
Participatory Monitoring and Evaluation of Community Health Improvement Efforts

Today's Topics

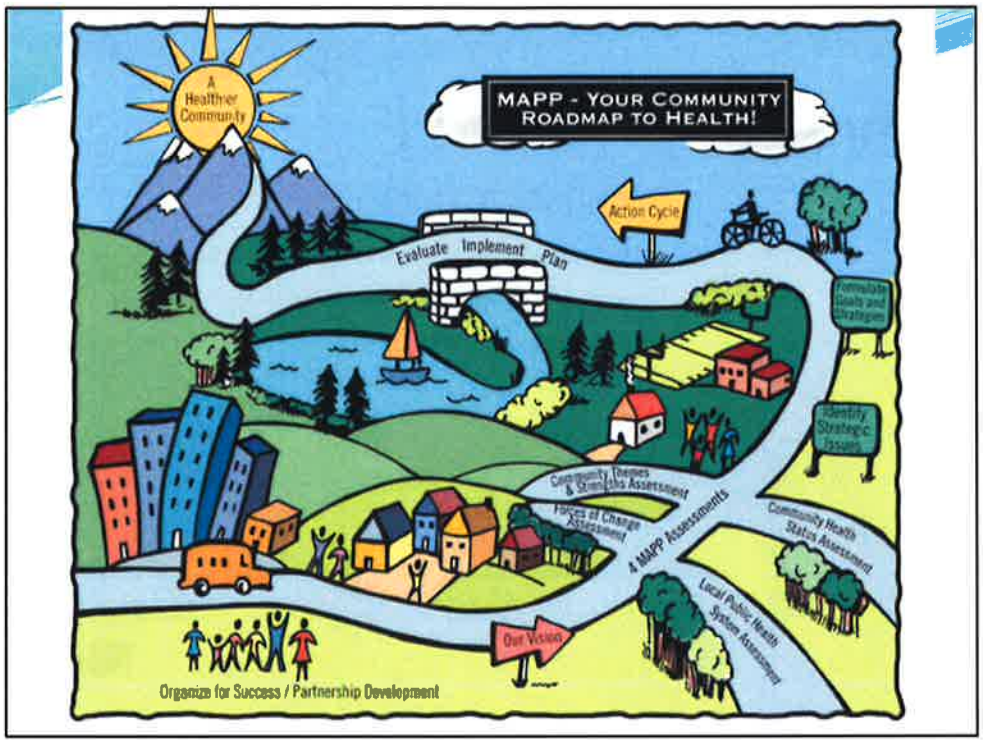
- Mobilizing for Action through Planning and Partnerships (MAPP) overview
- CHA Survey
- LPHS background info and survey
- Forces of Change and Strengths and Themes Defined/plans for assessing
- Moving forward (dates, plans, etc)
- CHIP subcommittee/working group volunteer solicitations

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) Community Themes and Strengths 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.
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 Local Public Health System Assessment, 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.

NACCHO

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.

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.

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)

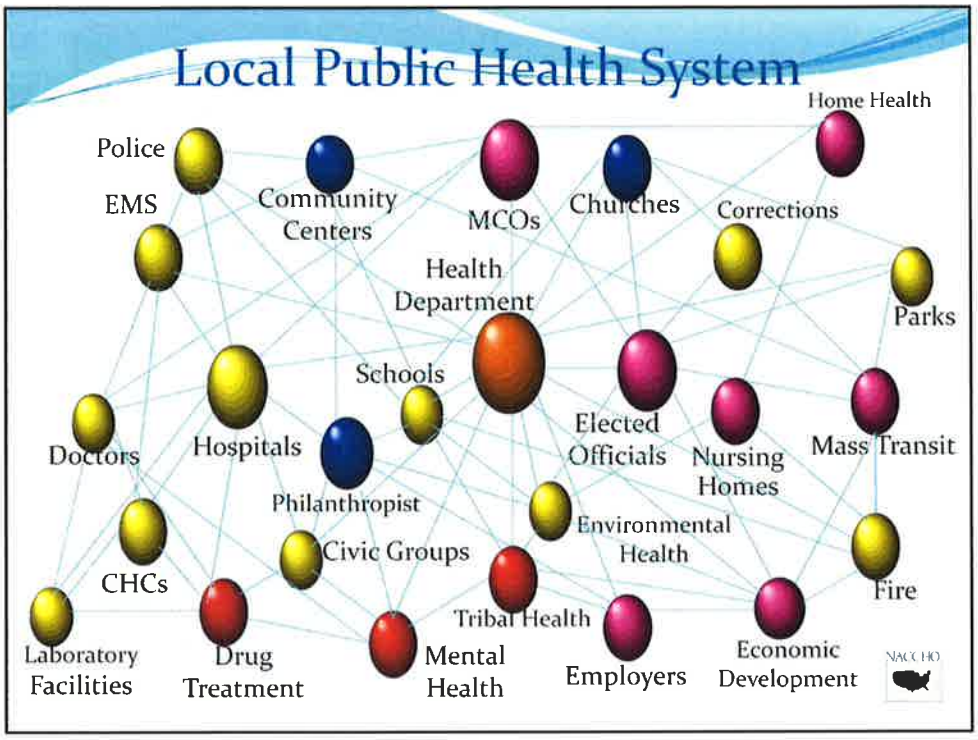
CHA Survey Marketing

Email/Social Media/Print Tools

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

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.



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

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

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
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems

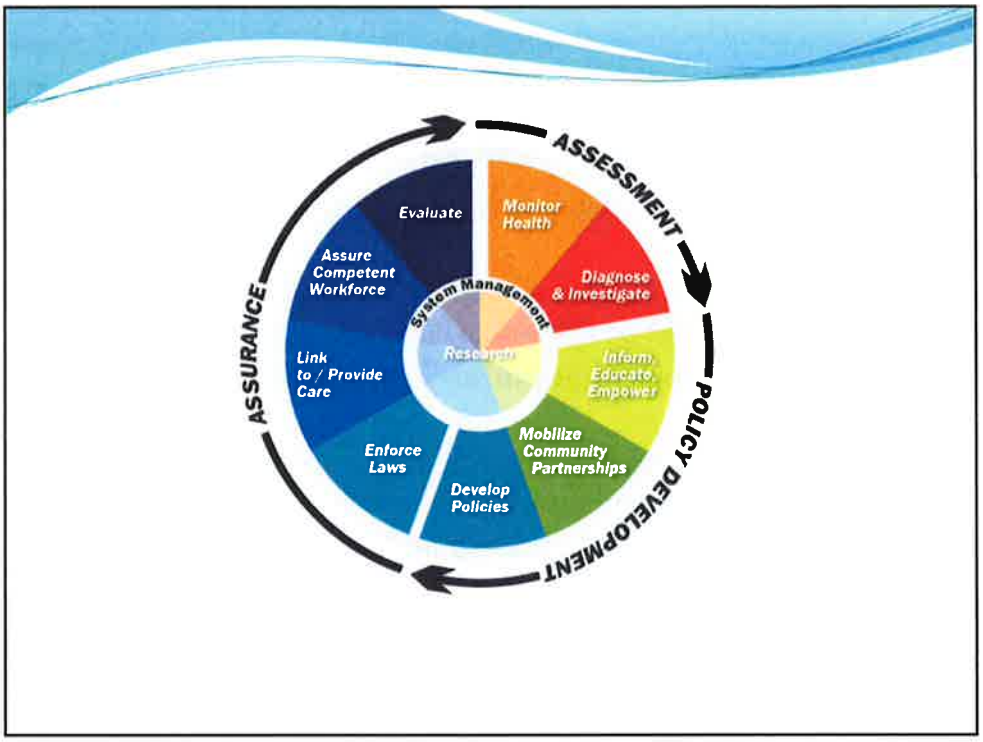
These are the foundation of any public health activity.

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

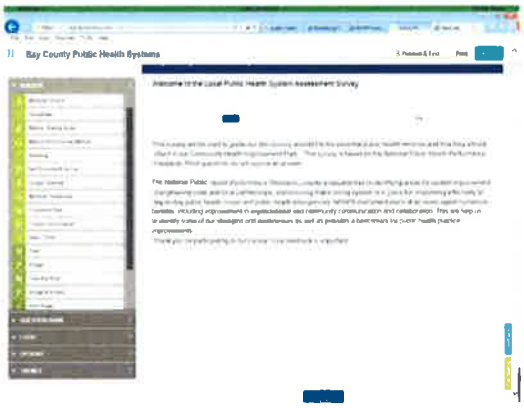
- **Evaluation must be ongoing and should examine:**
  - Personal health services
  - Population based services
  - The public health system
- **Quality Improvement**
- **Performance Management**

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**

Survey Time

- CHA/CHIP Committee participate by October 1st, 2015
- Sent out via email this afternoon



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.

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?

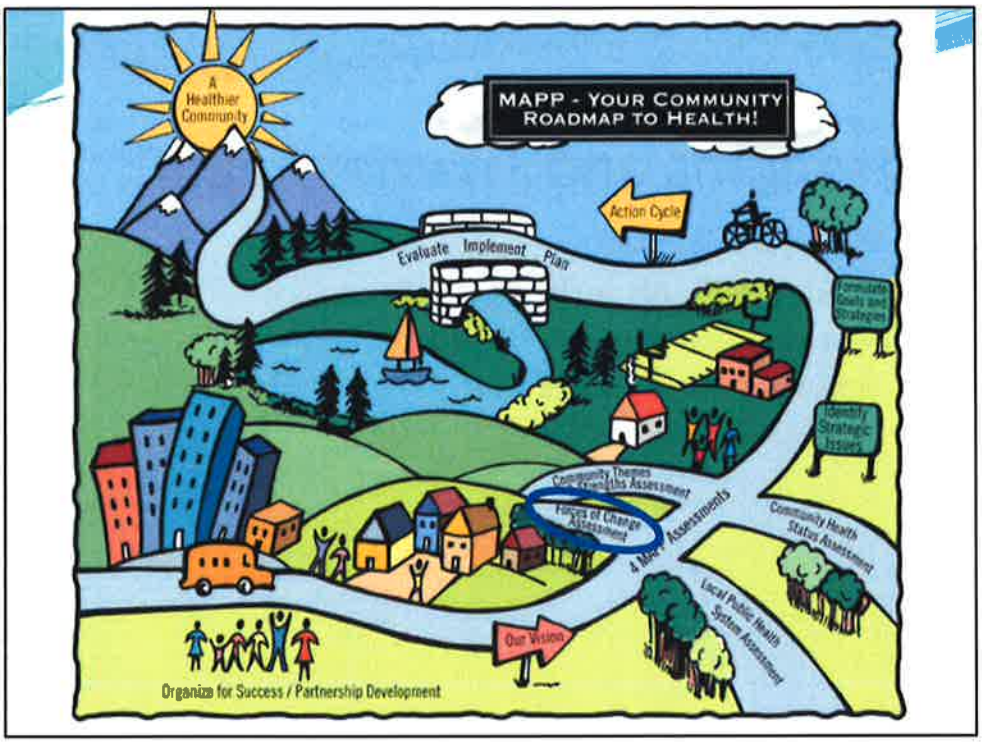
- Questions from the MAPP manual as a starting point for developing discussion lead ins
  - What do you believe are the 2-3 most important characteristics of a healthy community?
  - What makes you most proud of our community?
  - What are some specific examples of people or groups working together to 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



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.

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
Consider Possible Directions • 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 6th, 13th or 20th)***	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 *Community 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.

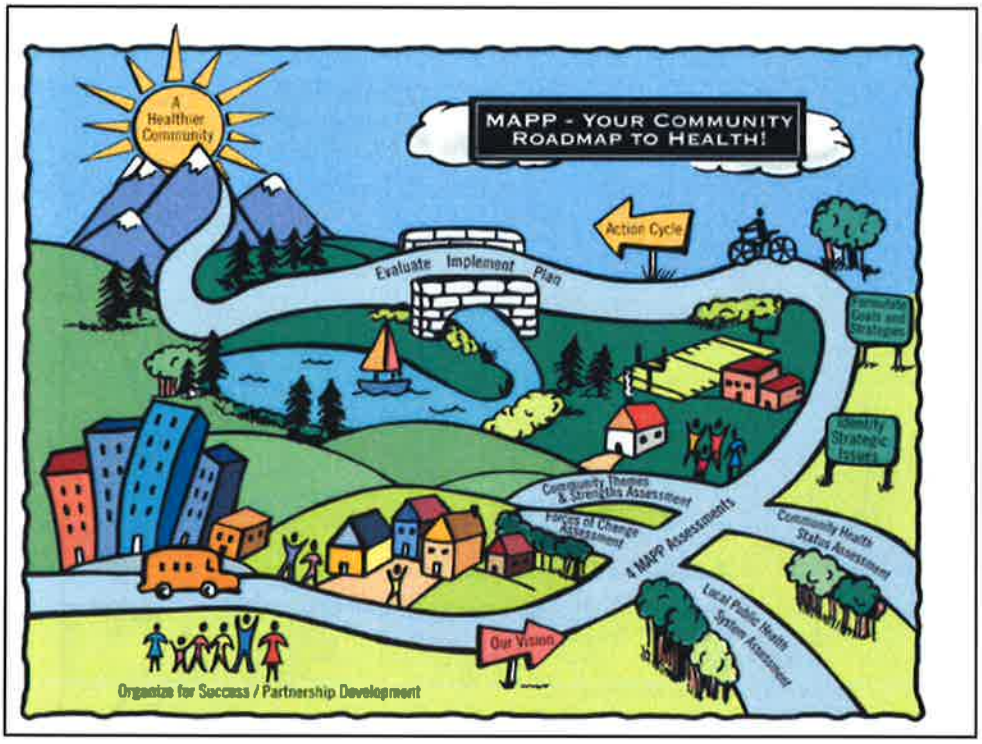
Attendees – PLEASE PRINT LEGIBLY

Name	Organization or Community Representative	Email	Phone
Tammy Stewart	FDOH-Bay - Community Projects	tammy.stewart@flhealth.gov	850 872 4455 x1252
Claire Henninger	FDOH - Bay - WIC	Claire.Henninger@flhealth.gov	ext 1162
Julie Tindall	FDOH-Bay - Diabetes	Julie.Tindall@flhealth.gov	ext 1293
Matthew Standefer	GCSC RN-BSN	Matthew.Standefer@gmail.com	850-624-8203
Rebekah Taylor	Life Management Center	btaylor@lmcenter.org	522-4485
Sandy McCroan	FDOH-Bay - WIC	Sandy.McCroan@flhealth.gov	872-4400 ext 1363
April Wisdom	Tyndall AFB	april.wisdom@us.af.mil	850-283-7100
Carole Summey	St Andrew Medical	director@sacmc.org	785-1419 ext 6
Nancy L Tibbs	FDOH Bay CHA	Nancy.Tibbs@FLHEALTH.GOV	872.4455
Bryan Russell	Career Source EC	brussell@careersourceec.com	872-4340
Jo Coville	FDOH-Bay County-DSP	jo.coville@flhealth.gov	872-4455
Joel Booth	Anchorage Children's Home	JBooth@AnchorageChildrenHome.org	763-7102
Ann Wing	BBCBC - MS	ann.wing@bigbandcbc.com	747-5755
Curtis Williams	St Andrew Comm. Med Cent	—	
Brooke Bullard	Anchorage Children's Home	bbullard@achkids.org	763 7102
Sharon Owens	Healthy Start	healthystart@comcast.net	872-4130
Sofia Elsaga	FDOH-Bay	sofia.elsaga@flhealth.gov	381-6096
Shelley Berry	90 Works	SBERRY@90WORKS.org	630-9082
Preston Mathews	BBAHEC	pmathews@bigbendahec.org	386-956-5785
Grace Aiyegbokiki	Early Education & Care	grace@eeckids.org	872-7550
William C Swift	Glenwood Working Partnership	wcswift316@gmail.com	(410) 499-5908
Betsie Kummer	Catholic Charities NWFL	kummerb@ccpdiocese.org	850-435-3578
Tammy Newton	Baymed	tammy.newton@baymedical.org	
Mike Hill	Big Bend Health Council	mhill@pancarefl.org	747-5599
Lisa Rahn	FDOH / CHTF		

COMMUNITY HEALTH
Bay
TASK FORCE
Welcome
Community Health Assessment Work Session 10/16/15
Florida
HEALTH
Bay County

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



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.

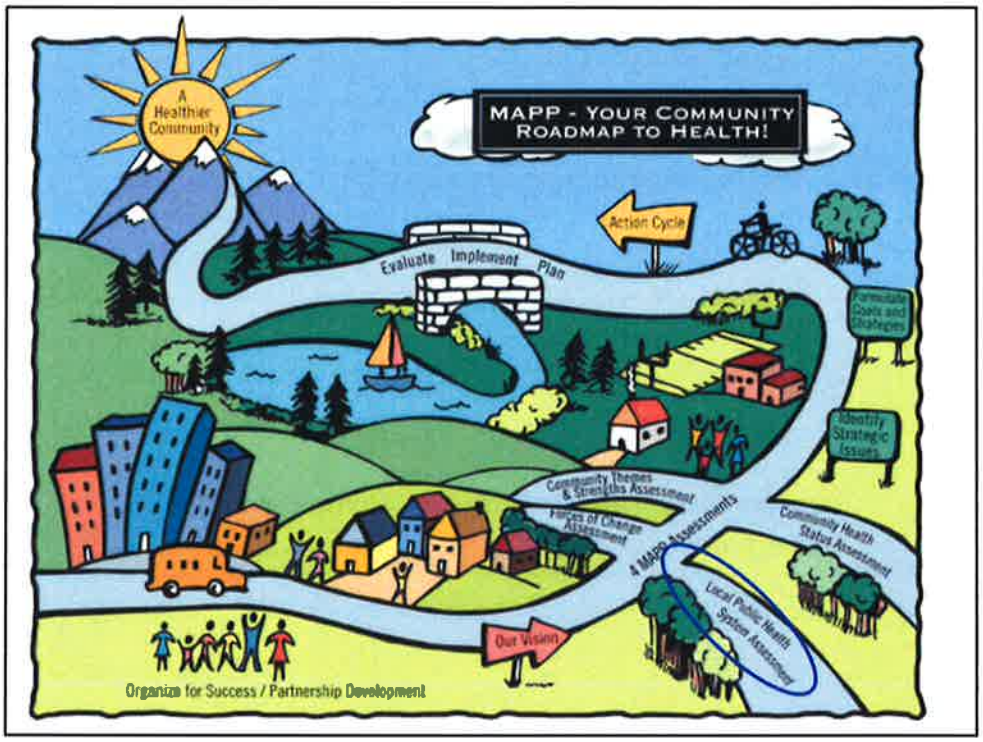
Put another way, using MAPP is like taking a trip. MAPP can help you figure out where you want to go, how to get there, and who needs to be in the car. You may need to pick up extra people along the way to help you reach your destination. And, by the time you get there, MAPP may have helped you figure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

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.

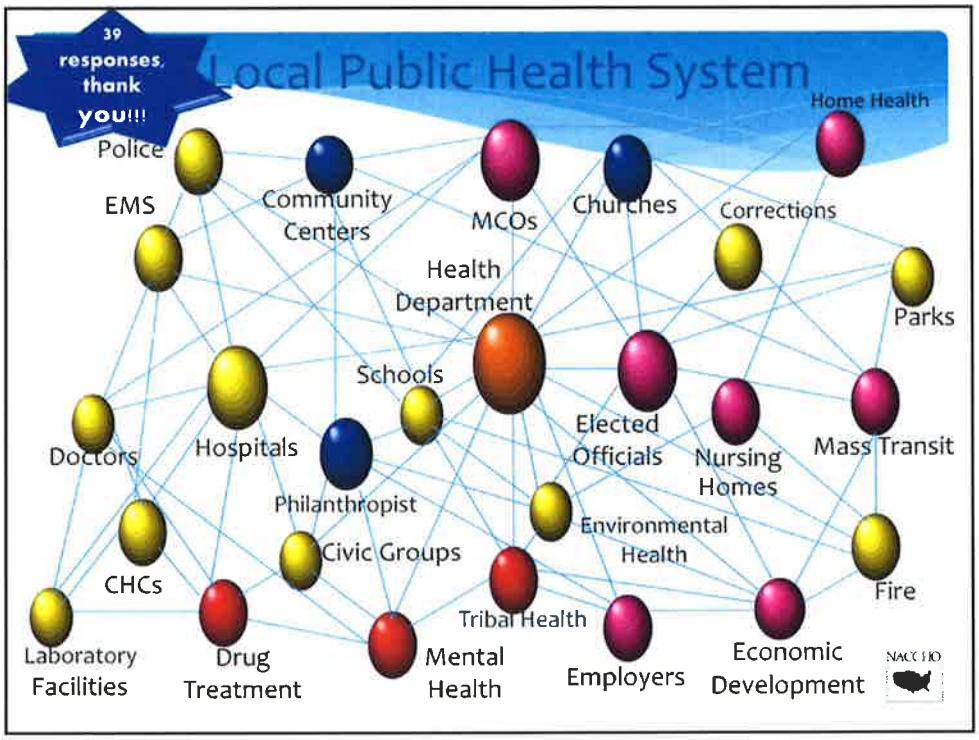
Community Health Assessment Survey update

* ~950 online surveys
* 1538 paper surveys collected
* Lisa needs information about who/when/where/how surveys were distributed



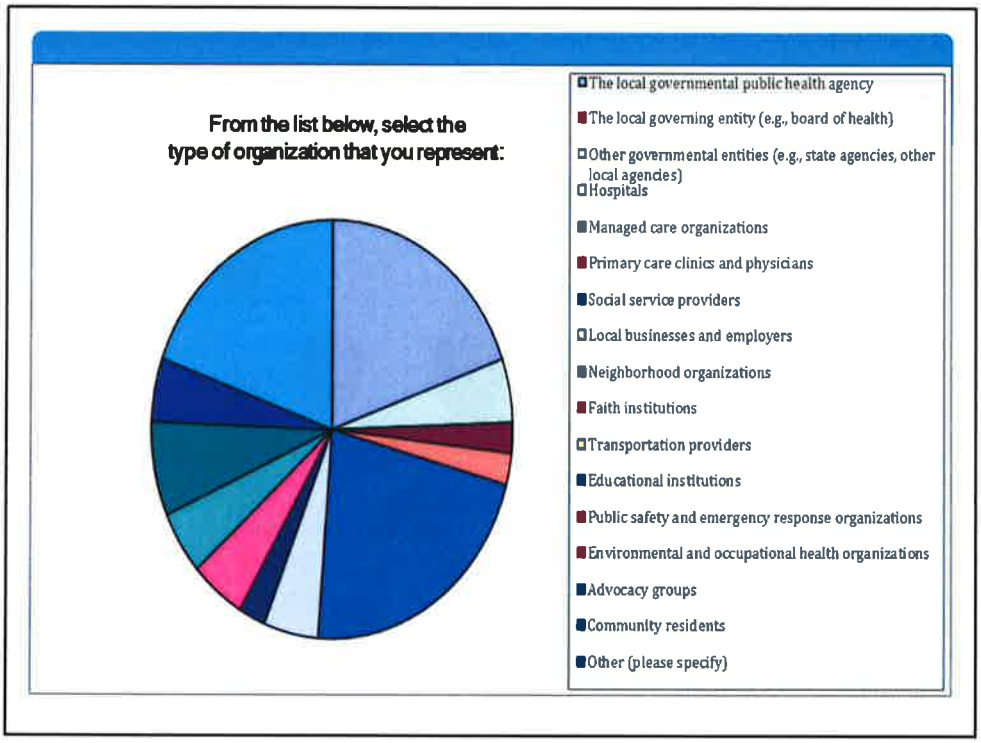
This is one of 2 models showing how the MAPP process works – and is an especially good image for connecting to communities. The phases of MAPP are shown along a road that leads to "A Healthier Community". The 4 MAPP Assessments are shown on the main road and represent the core activities in the process. 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.



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.


From the list below, select the type of organization that you represent:
The local governmental public health agency
The local governing entity (e.g., board of health)
Other governmental entities (e.g., state agencies, other local agencies)
Hospitals
Managed care organizations
Primary care clinics and physicians
Social service providers
Local businesses and employers
Neighborhood organizations
Faith institutions
Transportation providers
Educational institutions
Public safety and emergency response organizations
Environmental and occupational health organizations
Advocacy groups
Community residents
Other (please specify)

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.

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

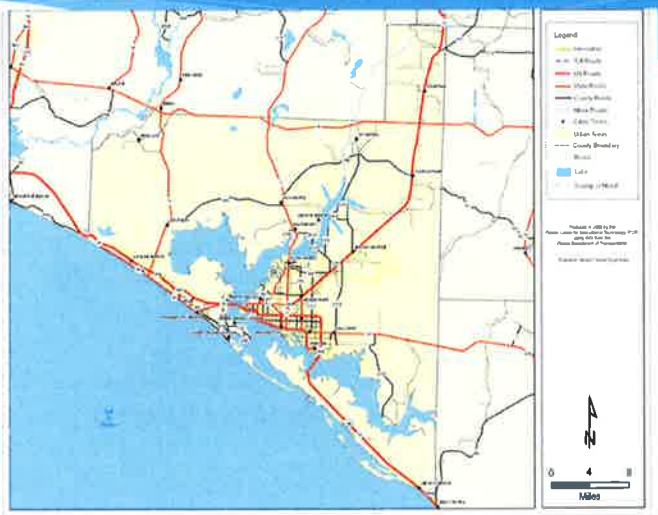
* Answer the following questions on an index card in front of you

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 where the majority of your clients live. List all that apply.

Bayou George
Callaway
Cedar Grove
Econfina
Econfina Creek
Glenwood
Hiland Park
Laguna Beach
Lower Grand Lagoon
Lynn Haven
Mexico Beach
Millville
Other (please specify)
Panama City
Panama City Beach
Parker
Pinelog
Pretty Bayou
Resota Beach
Southport
Upper Grand Lagoon
Vicksburg
West Bay
Youngstown



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

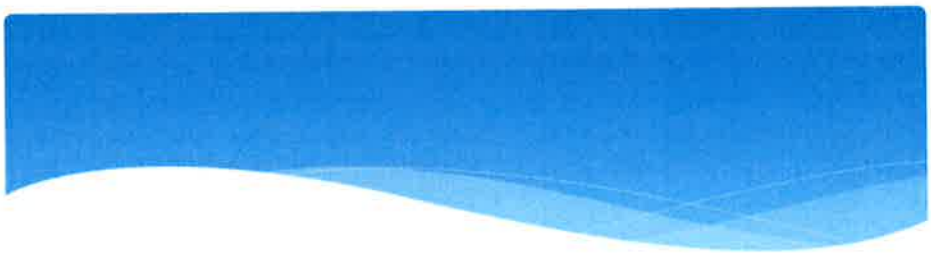
Below is a list of 26 public health issues that your clients may face. Based on your organization, please put these public health issues into one of three boxes (TRY for only three per box):

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



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?

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?

What are some specific examples of people or groups working together to improve the health and quality of life in our community?

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.

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
- ◯ Healthy
- ◯ Somewhat Healthy
- ◯ Unhealthy
- ◯ Very Unhealthy

2. Do you currently use any tobacco products?

- ◯ Yes, I currently smoke cigarettes or cigars
- ◯ Yes, I currently use chewing tobacco, snuff or snus
- ◯ Yes, I currently use e-cigarettes
- ◯ No, I quit 12 months ago or less
- ◯ No, I quit 1 or more years ago
- ◯ No, I have never used tobacco products

3. Please indicate how strongly you agree or disagree with the following statement as it applies to you personally: I am confident that I can make changes to achieve and/or maintain a healthy lifestyle, like eating right, exercising, or not smoking.

- ◯ Strongly Agree
- ◯ Agree
- ◯ Disagree
- ◯ Strongly Disagree

* 4. What are the top three (3) reasons that prevent you from eating healthier foods and/or being active? **Check only three.**

- [ ] Do not know how to change my diet
- [ ] Do not know how much more active I need to be
- [ ] Fear of failure
- [ ] Tried before and failed to change
- [ ] Healthier food is not available in my neighborhood
- [ ] Cannot afford exercise equipment / gym membership
- [ ] Do not want to change what I eat
- [ ] Do not want to be more active
- [ ] It is not safe to exercise in my neighborhood
- [ ] It is too expensive to cook / eat healthy foods
- [ ] Do not have time to be more active
- [ ] Do not have time to cook or shop for healthy foods
- [ ] I am happy the way I am
- [ ] I already eat healthy and am active

5. Have you ever been told by a health professional that you have any of the following: (Check all that apply)

- [ ] Alcohol or drug addiction
- [ ] Asthma
- [ ] Chronic Obstructive Pulmonary Disease (COPD)
- [ ] Dementia / Alzheimer's disease
- [ ] Depression
- [ ] Diabetes
- [ ] Heart disease
- [ ] Other (please specify)
- [ ] High cholesterol
- [ ] High blood pressure
- [ ] HIV / AIDS
- [ ] Mental health problem or disease
- [ ] Obesity
- [ ] Tuberculosis (TB)
- [ ] None of the above

6. What is the primary source of your health care insurance coverage?

- ( ) Insurance from an employer or union
- ( ) Insurance that you pay for yourself, including Affordable Care Act (sometimes called "Obamacare") plans
- ( ) Indian or Tribal Health Services
- ( ) Medicare
- ( ) Medicaid (such as Medipass, Medicaid HMO)
- ( ) TRICARE, military or VA benefits
- ( ) Other
- ( ) I do not have any health insurance

7. How long has it been since your last dental exam or cleaning?

- ( ) Within past 12 months
- ( ) 1 to 2 years ago
- ( ) 2 to 5 years ago
- ( ) 5 or more years ago
- ( ) Do not know / Not sure

8. How long has it been since your last visit to a doctor for a wellness exam or routine check-up? (Does *not include an exam for a specific injury, illness or condition)*

- ◯ Within past 12 months
- ◯ 2 to 5 years ago
- ◯ Do not know / Not sure
- ◯ 1 to 2 years ago
- ◯ 5 or more years ago

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.

- ☐ 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, have you had any of the following tests in the last year? (check all that apply)

- ◯ Colonoscopy
- ◯ None of the above were reccomended
- ◯ Pap Smear
- ◯ One or more were recommended but I did not participate in the screening
- ◯ Mammogram

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 those provided by Pan Care Community Health Center, St. Andrew Free Clinic, FDOH-Bay County Health Dept.
- ◯ Go without medicine
- ◯ Buy an over the counter medicine

12. When you or someone in your family is sick during typical business hours (8 a.m. - 5 p.m., Monday through Friday), where do you go for health care?

- ◯ 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
- ◯ Health Department

13. If you felt that you or someone in your family needed mental health services (including emergency mental health services), where would you go for care?

- ◯ Hospital Emergency Room in Bay County
- ◯ Hospital Emergency Room in another County
- ◯ My family doctor
- ◯ Private psychologist, psychiatrist or other mental health professional
- ◯ Mental health clinic in Bay County
- ◯ Mental health clinic in another County
- ◯ VA / Military facility
- ◯ I do not know where to go for mental health care

14. Do you or any of member of your household participate in any of the following behaviors? (check all that apply)

	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/booster 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 vegetables per day	◯	◯	◯

15. What do you think are the most important features of a “Healthy Community”? (Those factors that would most improve the quality of life in this community.) Check only THREE (3).

- ☐ 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
- ☐ Good race relations
- ☐ Good schools
- ☐ Good transportation options
- ☐ Healthy food options
- ☐ Low numbers of homeless
- ☐ Low alcohol & drug abuse
- ☐ Low crime / safe neighborhoods
- ☐ Low percent of population that are obese
- ☐ Low numbers of sexually transmitted disease (STDs)
- ☐ Low tobacco use
- ☐ Mental health services
- ☐ Quality education
- ☐ Quality hospitals and urgent / emergency services
- ☐ Religious or spiritual values
- ☐ Social support services (such as Salvation Army, food pantries, Catholic charities, Red Cross, etc.)

16. What do you think are the most important health issues in your County? (Those problems that have the greatest impact on overall community health.) Check only THREE (3)

- ☐ Accidental injuries (at work, home, school, farm)
- ☐ Aging problems(e.g. dementia, vision/hearing loss, loss of mobility)
- ☐ Cancers
- ☐ Child abuse / neglect
- ☐ Dental problems, including access to care
- ☐ Diabetes
- ☐ Domestic violence
- ☐ Drug use / abuse
- ☐ Fire-arm related injuries
- ☐ Heart disease and stroke
- ☐ HIV / AIDS
- ☐ Homelessness
- ☐ Homicide
- ☐ Infant death
- ☐ Infectious diseases (e.g. hepatitis, TB, etc.
- ☐ Lack of affordable health care or co-payments/deductables
- ☐ Mental health problems, including depression
- ☐ Motor vehicle crash injuries
- ☐ Obesity / Excess weight
- ☐ Rape / sexual assault
- ☐ Respiratory / lung disease
- ☐ Sexually Transmitted Diseases (STDs)
- ☐ Suicide
- ☐ Teenage pregnancy
- ☐ Tobacco use

17. Overall, how would you rate the health of people who live in your County?

- ○ Very Healthy
- ○ Healthy
- ○ Somewhat Healthy
- ○ Unhealthy
- ○ Very Unhealthy

* 18. Which of the following behaviors or conditions in the County concern you the most? Those behaviors that have the greatest impact on overall community health. Check only three (3)

- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Excess weight
- ☐ Homelessness
- ☐ Lack of exercise
- ☐ Poor eating habits / poor nutrition
- ☐ Not getting shots to prevent disease
- ☐ Not using seat belts / child safety seats
- ☐ Not seeing a doctor or dentist
- ☐ Tobacco use
- ☐ Unprotected / unsafe sex

19. Which health care services are difficult to get in your County?
Check all answers that apply.

- [ ] Alternative therapies (acupuncture, herbals, etc.)
- [ ] Dental care including dentures
- [ ] Emergency medical care
- [ ] Family Planning (including birth control)
- [ ] Hospital care
- [ ] Laboratory services
- [ ] Mental Health services
- [ ] Physical Therapy / Rehabilitation
- [ ] Preventative health care (routine or wellness check-ups, etc.)
- [ ] Prescriptions / Pharmacy services
- [ ] Primary medical care (a primary doctor/clinic)
- [ ] Services for the elderly
- [ ] Specialty medical care (specialist doctors)
- [ ] Alcohol or drug abuse treatment
- [ ] Vision care (eye exams and glasses)
- [ ] X-Rays or mammograms
- [ ] Do not know
- [ ] None

20. Overall, how would you rate the quality of health care services available in your County?

- ( ) Excellent
- ( ) Very Good
- ( ) Good
- ( ) Fair
- ( ) Poor
- ( ) Not sure / do not know

21. Please indicate how strongly you agree or disagree with the following statement: I support the creation of a dedicated funding source (such as a sales tax) to address health care needs (mental health, health clinic, ambulance, and dental accessibility) for the working poor, indigent and uninsured in Bay county.

- ( ) Strongly Agree
- ( ) Agree
- ( ) Disagree
- ( ) Strongly Disagree

* 22. What is the zip code where you live?

[ ]

23. Are you male or female?

- ( ) Male
- ( ) Female

24. What is your race?

- ◯ Black/African-American, non-Hispanic
- ◯ Black/African-American, Hispanic
- ◯ White/Caucasian, non-Hispanic
- ◯ White/Caucasian, Hispanic
- ◯ Asian
- ◯ American Indian / Alaska Native
- ◯ Pacific Islander
- ◯ Bi-racial or multiple races

25. What is your age?

- ◯ Less than 18
- ◯ 18-24
- ◯ 25-34
- ◯ 35-44
- ◯ 45-54
- ◯ 55-74
- ◯ 75+

26. What is the highest level of school you have completed or highest degree you have received?

- ◯ Grades 1 through 8
- ◯ Some high school (grades 9 through 11)
- ◯ High school diploma / GED
- ◯ Vocational/Tech School
- ◯ Some college
- ◯ 2-year college degree
- ◯ 4-year college degree
- ◯ Graduate or professional degree

27. What is your current employment status?

- ◯ Disabled / unable to work
- ◯ Employed full-time
- ◯ Employed part-time
- ◯ Homemaker
- ◯ Retired
- ◯ Seasonal worker
- ◯ Student
- ◯ Self-employed
- ◯ Unemployed

28. What is your annual family income?

- ◯ Less than $15,000/year
- ◯ $15,001 - $25,000/year
- ◯ $25,001 - $35,000/year
- ◯ $35,001 - $50,000/year
- ◯ $50,001 - $75,000/year
- ◯ $75,001 - $100,000/year
- ◯ $100,001 or more/year

29. Where did you take this survey?

- ◯ Church
- ◯ Health Fair
- ◯ WIC
- ◯ Health Department
- ◯ Health Clinic

Other (please specify) _____

Thank you for taking this survey.

	On-Line Surveys		Paper Surveys		All Responses	
	Response Percent	Response Count	Response Percent	Response Count	Response Percent	Response Count
1. How would you rate your own health today?						
Very Healthy	13.1%	126	13.3%	76	13.2%	202
Healthy	**51.1%**	**491**	**42.1%**	**240**	**47.8%**	**731**
Somewhat Healthy	30.4%	292	35.3%	201	32.2%	493
Unhealthy	4.4%	42	7.9%	45	5.7%	87
Very Unhealthy	0.9%	9	1.4%	8	1.1%	17
answered question		960		570		1,530
skipped question		5		3		8
2. Do you currently use any tobacco products?						
Yes, I currently smoke cigarettes or cigars	7.5%	72	**26.7%**	**151**	14.6%	223
Yes, I currently use chewing tobacco, snuff or snus	1.5%	14	0.9%	5	1.2%	19
Yes, I currently use e-cigarettes	1.6%	15	2.7%	15	2.0%	30
No, I quit 12 months ago or less	1.6%	15	7.2%	41	3.7%	56
No, I quit 1 or more years ago	**26.1%**	**251**	18.2%	103	23.2%	354
No, I have never used tobacco products	**61.8%**	**593**	**44.3%**	**251**	**55.3%**	**844**
answered question		960		566		1,526
skipped question		5		7		12
3. Please indicate how strongly you agree or disagree with the following statement as it applies to you personally: I am confident that I can make changes to achieve and/or maintain a healthy lifestyle, like eating right, exercising, or not smoking.						
Strongly Agree	**41.5%**	**398**	**46.1%**	**263**	**43.2%**	**661**
Agree	**53.9%**	**517**	**50.0%**	**285**	**52.5%**	**802**
Disagree	3.8%	36	2.8%	16	3.4%	52
Strongly Disagree	0.8%	8	1.1%	6	0.9%	14
answered question		959		570		1,529
skipped question		6		3		9
4. What are the top three (3) reasons that prevent you from eating healthier foods and/or being active?Check only three.						
I already eat healthy and am active	**36.7%**	**354**	**36.7%**	**201**	**36.7%**	**555**
It is too expensive to cook / eat healthy foods	**32.3%**	**312**	**32.2%**	**176**	**32.3%**	**488**
Do not have time to be more active	**36.3%**	**350**	22.3%	122	**31.2%**	**472**
Do not have time to cook or shop for healthy foods	23.8%	230	15.7%	86	20.9%	316
I am happy the way I am	15.6%	151	28.5%	156	20.3%	307
Cannot afford exercise equipment / gym membership	16.9%	163	24.9%	136	19.8%	299
Tried before and failed to change	16.1%	155	13.0%	71	14.9%	226
Do not want to change what I eat	14.2%	137	14.3%	78	14.2%	215
Fear of failure	10.1%	97	9.1%	50	9.7%	147
Do not know how much more active I need to be	9.3%	90	9.9%	54	9.5%	144
Do not know how to change my diet	6.3%	61	9.9%	54	7.6%	115
Do not want to be more active	5.3%	51	4.8%	26	5.1%	77
It is not safe to exercise in my neighborhood	5.1%	49	4.0%	22	4.7%	71
Healthier food is not available in my neighborhood	1.8%	17	1.6%	9	1.7%	26
answered question		965		547		1,512
skipped question		0		26		26
5. Have you ever been told by a health professional that you have any of the following: (Check all that apply)						
High blood pressure	**35.2%**	**331**	**27.8%**	**152**	**32.5%**	**483**
High cholesterol	**27.7%**	**261**	18.3%	100	**24.3%**	**361**
Obesity	**24.2%**	**228**	16.3%	89	**21.3%**	**317**
Depression	17.7%	167	**21.9%**	**120**	19.3%	287
Asthma	8.8%	83	14.8%	81	11.0%	164
Diabetes	10.2%	96	11.3%	62	10.6%	158
Heart disease	4.5%	42	5.3%	29	4.8%	71
Mental health problem or disease	3.4%	32	6.2%	34	4.4%	66
Chronic Obstructive Pulmonary Disease (COPD)	2.2%	21	3.7%	20	2.8%	41
Alcohol or drug addiction	0.6%	6	3.7%	20	1.7%	26
HIV / AIDS	0.4%	4	0.9%	5	0.6%	9
Tuberculosis (TB)	0.2%	2	0.7%	4	0.4%	6
Dementia / Alzheimer's disease	0.0%	0	0.4%	2	0.1%	2
None of the above	**30.2%**	**284**	**37.7%**	**206**	**32.9%**	**490**
Other (please specify)	10.9%	103	10.1%	55	10.6%	
A/V heart block						2
acid reflux						1
ACID REFLUX, HIATAL HERNIA, DERMATOGRAPHIA						2
ADHD						3
anemia						6
Anxiety						1
anxiety,fibromalgia,gerd, chf						4
arthritis						1
Atrial fibrulation, osteoporosis very bad						1
autoimmune difficulties possibly due to gluten sensitivity						1
Auto-immune disorders and arthritis						1

	On-Line Surveys		Paper Surveys		All Responses	
	Response Percent	Response Count	Response Percent	Response Count	Response Percent	Response Count
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						1
Both are controlled via meds						2
Breast Cancer						1
breast cancer and am obese but not told by MD						4
Cancer						1
CKD. prev OV cancer patient. fibromyalgia. mild carotid blockage.						1
COLON CANCER 2000, some block arteries, but now doing great through a changed diet!						1
Common Variable Immune Deficiency/Chronic Fatigue						1
Crohn's disease						1
DIVERTICULITIS						1
Diverticulosis						1
DJD, arthritis, spinal stenosis						1
fibromalagia, chronic fatigue syndrone, hyperparathyroidism						1
fibromyalgia and chronic fatigue						1
Fibromyalgia, Arthritis, IBS, Chronic Fatigue Syndrome						1
Genetic Heart Conditon						1
gestational diabetes with my last pregnancy						1
glaucoma						1
Gout						1
had gestational diabetese						3
Hep C						1
hormone issues						1
Hyperactive Thyroidism						4
Hypoglycemia						11
Hypothyroidism						1
Kidney cancer, severe arthritis						1
Kidney stones and chronic UTIs						1
Low HDL						1
low HDL levels (total cholesterol was okay)						1
Low kidney level						1
low testosterone						1
Lyme Disease, Chronic Fatigue, Fibro						1
lymphoma						2
Mitral valve prolapse						1
Mixed connective tissue disorders						1
no longer have a depression diagnosis; have learned to maintain my emotional health						1
non smokers emphazema						1
Non-Hodgkins Lymphoma						1
obesity						1
Osteoarthritis						1
OSTEOPORASIS AND SPINAL STENOSIS						3
osteoporosis						1
PCOS, high triglycerides						1
Pinched nerves in neck, bad disk in lower back.						1
Platelet disorder, Vitamin deficiency, Thyroid problems						1
Polycystic Ovarian Syndrome						1
Polycystic Ovarian Syndrome, thyroidism						5
Pre diabetes						1
Pre-diabetic; fatty liver						1
Pre-Hypertensive						1
pseudo tumor cerebri						1
Psoriasis, chemical, food and environmental allergies, panic disorder						3
RA						1
remission of breast cancer						1
Renards phenomenon, arthritis						1
Rheumatoid Arthitis						1
Sarcoidosis / Polycystic Ovary Syndrome						1
scoliosis						2
Sleep apnea						9
Thyroid Issue						1
Ulcerative colitis						1
ADD						1
ADHD, Anxiety, Learning disability						1
ALERGIES						1
anemia, PE						1
anxiety, torn rotor cuff						1
BAD HIPS, KNEES WEIGHT IN GENERAL						1
borderline high blood pressure						1
Breast Cancer and Skin Cancer						1
chronic migraines						1
GBS CIDP						1
GERD						1
heart murmer						1
heart palpatations						1
high anxiety, back injury, stomach gevo, more						1
high white blood cell count						2
kidney disease						1
leakage in mitro valve, heart murmer						3
low blood pressure						1
low blood pressure, low blood sugar, MRSA						1
LUNG CANCER						1
m.s.						1
mitro valve prolapse						1
MULTIPLE SCLEROSIS						1
Nash,Fibromyalgia,RA,food allergies,bi-polar, more						1

	On-Line Surveys		Paper Surveys		All Responses	
	Response Percent	Response Count	Response Percent	Response Count	Response Percent	Response Count
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						1
palpitations						1
PCOS						1
prostate cancer						1
RA, Lupus, Fibromyalgia						1
SEIZURES						1
Stroke Affective Disorder						1
subclavian steal syndrome. blocked subclavian arteries						1
thyroid cancer, tbs, ic						1
thyroiditis						1
answered question		**941**		**547**		**1,488**
skipped question		**24**		**26**		**50**
6. What is the primary source of your health care insurance coverage?						
Insurance from an employer or union	**72.0%**	**691**	**24.5%**	**127**	**55.3%**	**818**
Insurance that you pay for yourself, including Affordable Care Act (sometimes called "Obamacare") plans	4.1%	39	4.6%	24	4.3%	63
Indian or Tribal Health Services	0.1%	1	0.0%	0	0.1%	1
Medicare	9.0%	86	9.5%	49	9.1%	135
Medicaid (such as Medipass, Medicaid HMO)	1.0%	10	16.4%	85	6.4%	95
TRICARE, military or VA benefits	8.8%	84	5.4%	28	7.6%	112
Other	1.4%	13	3.9%	20	2.2%	33
I do not have any health insurance	3.8%	36	**35.7%**	**185**	15.0%	221
answered question		**960**		**518**		**1,478**
skipped question		**5**		**55**		**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		**959**		**558**		**1,517**
skipped question		**6**		**15**		**21**
8. How long has it been since your last visit to a doctor for a wellness exam or routine check-up? (Does not include an exam for a specific injury, illness or condition)						
Within past 12 months	**75.9%**	**725**	**60.7%**	**343**	**70.3%**	**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 question		**10**		**8**		**18**
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	**52.8%**	**480**	**31.7%**	**172**	**44.9%**	**652**
Could not afford	**22.6%**	**205**	**39.6%**	**215**	**28.9%**	**420**
Insurance problems or lack of insurance	11.6%	105	**23.9%**	**130**	16.2%	235
No, I did not need medical or dental care	14.1%	128	16.6%	90	15.0%	218
Could not get a weekend or evening appointment	9.5%	86	5.9%	32	8.1%	118
Could not get an appointment soon enough	5.7%	52	6.6%	36	6.1%	88
Provider did not take my insurance	4.1%	37	6.3%	34	4.9%	71
Lack of transportation	0.4%	4	7.0%	38	2.9%	42
Provider was not taking new patients	1.8%	16	3.7%	20	2.5%	36
Language barriers or could not communicate	0.8%	7	0.2%	1	0.6%	8
answered question		**909**		**543**		**1,452**
skipped question		**56**		**30**		**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	28.3%	156	31.9%	448
Mammogram	36.1%	308	20.8%	115	30.1%	423
Colonoscopy	15.6%	133	13.9%	77	14.9%	210
One or more were recommended but I did not participate in the screening	10.3%	88	9.1%	50	9.8%	138
answered question		**854**		**552**		**1,406**
skipped question		**111**		**21**		**132**

	On-Line Surveys		Paper Surveys		All Responses	
	Response Percent	Response Count	Response Percent	Response Count	Response Percent	Response Count
11. When a doctor prescribes medicine for you or a family member, what 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

12. When you or someone in your family is sick during typical business hours (8 a.m. - 5 p.m., Monday through Friday), where do you go for health care?						
My family doctor	**67.9%**	**651**	**43.5%**	**209**	**59.7%**	**860**
Urgent care clinic	16.2%	155	7.9%	38	13.4%	193
I usually go without care	5.2%	50	15.0%	72	8.5%	122
Hospital Emergency Room	2.4%	23	17.9%	86	7.6%	109
VA / Military facility	2.9%	28	2.5%	12	2.8%	40
Any available doctor	2.3%	22	2.3%	11	2.3%	33
Community health center	1.5%	14	3.5%	17	2.2%	31
Free clinic	1.1%	11	4.0%	19	2.1%	30
Health Department	0.5%	5	3.5%	17	1.5%	22
answered question		959		481		1,440
skipped question		6		92		98

13. If you felt that you or someone in your family needed mental health services (including emergency mental health services), where would you go for 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 health care	17.4%	167	**25.9%**	**127**	**20.3%**	**294**
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 County	0.1%	1	1.6%	8	0.6%	9
answered question	*961*	961	*490*	490		1,451
skipped question	*4*	4	*83*	83		87

14. Do you or any of member of your household participate in any of the following behaviors? (check all that apply)

Answer Options	Never	Sometimes	Freq.	Response Count	Never	Sometimes	Freq.	Response Count	Never	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 question				5				14				19

	On-Line Surveys		Paper Surveys		All Responses	
	Response Percent	Response Count	Response Percent	Response Count	Response Percent	Response Count
15. What do you think are the most important features of a "Healthy Community"? (Those factors that would most improve the quality of life in this community.) Check only THREE (3).						
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 important health issues in your County? (Those problems that have the greatest impact on overall community health.) Check only THREE						
Drug use / abuse	**46.8%**	**448**	14.8%	81	**35.1%**	**529**
Obesity / Excess weight	**35.9%**	**344**	12.6%	69	**27.4%**	**413**
Lack of affordable health care or co-payments/deductables	**35.0%**	**335**	13.9%	76	**27.3%**	**411**
Child abuse / neglect	**20.3%**	**194**	**22.3%**	**122**	**21.0%**	**316**
Cancers	18.8%	180	**21.7%**	**119**	19.9%	299
Fire-arm related injuries	2.7%	26	**43.6%**	**239**	17.6%	265
Homelessness	**23.4%**	**224**	7.5%	41	17.6%	265
Mental health problems, including depression	**23.1%**	**221**	5.7%	31	16.7%	252
Diabetes	15.7%	150	17.2%	94	16.2%	244
Motor vehicle crash injuries	8.7%	83	**26.6%**	**146**	15.2%	229
Aging problems(e.g. dementia, vision/hearing loss, loss of mobility)	14.5%	139	11.5%	63	13.4%	202
Domestic violence	11.1%	106	15.1%	83	12.6%	189
Dental problems, including access to care	11.5%	110	12.8%	70	12.0%	180
Tobacco use	14.5%	139	4.9%	27	11.0%	166
Heart disease and stroke	12.3%	118	6.0%	33	10.0%	151
Homicide	1.6%	15	**22.3%**	**122**	9.1%	137
Respiratory / lung disease	3.0%	29	18.6%	102	8.7%	131
Teenage pregnancy	6.1%	58	10.2%	56	7.6%	114
Accidental injuries (at work, home, school, farm)	4.5%	43	12.4%	68	7.4%	111
Rape / sexual assault	1.5%	14	12.4%	68	5.4%	82
HIV / AIDS	4.0%	38	7.8%	43	5.4%	81
Sexually Transmitted Diseases (STDs)	4.5%	43	3.8%	21	4.3%	64
Suicide	2.7%	26	2.6%	14	2.7%	40
Infectious diseases (e.g. hepatitis, TB,	2.8%	27	2.2%	12	2.6%	39
Infant death	1.7%	16	4.0%	22	2.5%	38
answered question		957		548		1,505
skipped question		8		25		33

17. Overall, how would you rate the health of people who live in your County?						
Very Healthy	0.3%	3	1.3%	7	0.7%	10
Healthy	5.1%	48	12.5%	69	7.8%	117
Somewhat Healthy	**57.6%**	**545**	**57.5%**	**318**	**57.5%**	**863**
Unhealthy	**33.7%**	**319**	**24.8%**	**137**	**30.4%**	**456**
Very Unhealthy	3.4%	32	4.0%	22	3.6%	54
answered question		947		553		1,500
skipped question		18		20		38

	On-Line Surveys		Paper Surveys		All Responses	
	Response Percent	Response Count	Response Percent	Response Count	Response Percent	Response Count
18. Which of the following behaviors or conditions in the County concern you the most? Those behaviors that have the greatest impact on overall community health. Check only three (3)						
Drug abuse	**64.1%**	**619**	**67.0%**	**372**	**65.2%**	**991**
Alcohol abuse	**36.2%**	**349**	**40.0%**	**222**	**37.6%**	**571**
Homelessness	**33.8%**	**326**	**34.4%**	**191**	**34.0%**	**517**
Poor eating habits / poor nutrition	**35.0%**	**338**	**27.0%**	**150**	**32.1%**	**488**
Excess weight	**35.4%**	**342**	**22.0%**	**122**	**30.5%**	**464**
Not seeing a doctor or dentist	**24.1%**	**233**	**27.6%**	**153**	**25.4%**	**386**
Tobacco use	18.5%	179	17.7%	98	18.2%	277
Lack of exercise	17.2%	166	13.9%	77	16.0%	243
Unprotected / unsafe sex	11.5%	111	**23.2%**	**129**	15.8%	240
Not getting shots to prevent disease	9.0%	87	12.3%	68	10.2%	155
Not using seat belts / child safety seats	7.0%	68	12.6%	70	9.1%	138
answered question		965	*555*	555		1,520
skipped question		0	*18*	18		18
19. Which health care services are difficult to get in your County? Check all answers that apply.						
Do not know	**26.6%**	**255**	**27.9%**	**152**	**27.1%**	**407**
Dental care including dentures	19.3%	185	**33.6%**	**183**	**24.5%**	**368**
Mental Health services	**26.5%**	**254**	17.2%	94	**23.2%**	**348**
Alternative therapies (acupuncture, herbals, etc.)	**26.0%**	**249**	15.8%	86	**22.3%**	**335**
Alcohol or drug abuse treatment	**22.1%**	**212**	13.9%	76	19.2%	288
Specialty medical care (specialist doctors)	**20.0%**	**192**	15.6%	85	18.4%	277
Services for the elderly	19.7%	189	13.8%	75	17.6%	264
Preventative health care (routine or wellness check-ups, etc.)	14.9%	143	13.6%	74	14.4%	217
Primary medical care (a primary doctor/clinic)	10.9%	104	16.0%	87	12.7%	191
None	11.6%	111	11.0%	60	11.4%	171
Prescriptions / Pharmacy services	8.1%	78	13.9%	76	10.2%	154
Vision care (eye exams and glasses)	7.4%	71	11.4%	62	8.8%	133
Emergency medical care	6.9%	66	8.6%	47	7.5%	113
Hospital care	4.5%	43	9.2%	50	6.2%	93
Laboratory services	4.5%	43	7.7%	42	5.7%	85
Family Planning (including birth control)	4.9%	47	6.2%	34	5.4%	81
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		958		545		1,503
skipped question		7		28		35
20. Overall, how would you rate the quality of health care services available in your County?						
Excellent	1.9%	18	5.0%	28	3.0%	46
Very Good	10.8%	103	12.9%	72	11.5%	175
Good	**40.6%**	**389**	**31.4%**	**176**	**37.2%**	**565**
Fair	**36.0%**	**345**	**32.5%**	**182**	**34.7%**	**527**
Poor	6.6%	63	9.6%	54	7.7%	117
Not sure / do not know	4.2%	40	8.6%	48	5.8%	88
answered question		958		560		1,518
skipped question		7		13		20
21. Please indicate how strongly you agree or disagree with the following statement: I support the creation of a dedicated funding source (such as a sales tax) to address health care needs (mental health, health clinic, ambulance, and dental accessibility) for the working poor, indigent and uninsured in Bay county.						
Strongly Agree	**23.4%**	**223**	**32.7%**	**177**	**26.7%**	**400**
Agree	**41.2%**	**393**	**51.1%**	**277**	**44.8%**	**670**
Disagree	19.9%	190	12.2%	66	17.1%	256
Strongly Disagree	15.5%	148	4.1%	22	11.4%	170
answered question		954		542		1,496
skipped question		11		31		42
22. What is the zip code where you live?						
32401	18.0%	174	20.8%	116	19.0%	290
32402	0.3%	3	0.2%	1	0.3%	4
32403	0.5%	5	0.4%	2	0.5%	7
32404	16.7%	161	25.4%	142	19.9%	303
32405	18.4%	178	16.6%	93	17.8%	271
32407	6.5%	63	0.2%	1	4.2%	64
32408	6.4%	62	4.3%	24	5.6%	86
32409	5.3%	51	6.1%	34	5.6%	85
32411	0.2%	2	2.0%	11	0.9%	13
32412	0.1%	1	0.5%	3	0.3%	4
32413	5.0%	48	2.7%	15	4.1%	63
32417	0.2%	2	0.0%		0.1%	2
32438	1.1%	11	5.5%	31	2.8%	42
32444	17.7%	171	7.3%	41	13.9%	212
32456	0.7%	7	0.2%	1	0.5%	8
32462	0.1%	1	0.2%	1	0.1%	2
32466	2.6%	25	7.7%	43	4.5%	68
answered question		965		559		1,524

	On-Line Surveys		Paper Surveys		All Responses		
	Response Percent	Response Count	Response Percent	Response Count	Response Percent	Response Count	Bay - Census Bureau*
23. Are you male or female?							
Male	25.0%	239	22.2%	124	24.0%	363	50%
Female	75.0%	716	77.8%	434	76.0%	1,150	50%
answered question		955		558		1,513	
skipped question		10		15		25	
24. What is your race?							
Black/African-American, non-Hispanic	7.9%	75	19.3%	105	12.1%	180	11.3%
Black/African-American, Hispanic	0.7%	7	2.4%	13	1.3%	20	
White/Caucasian, non-Hispanic	79.3%	749	62.9%	342	73.3%	1,091	77.7%
White/Caucasian, Hispanic	7.0%	66	10.5%	57	8.3%	123	5.6%
Asian	0.7%	7	0.7%	4	0.7%	11	2.3%
American Indian / Alaska Native	1.5%	14	0.9%	5	1.3%	19	0.1%
Pacific Islander	0.3%	3	0.4%	2	0.3%	5	
Bi-racial or multiple races	2.5%	24	2.9%	16	2.7%	40	3.1%
answered question		945		544		1,489	
skipped question		20		29		49	
25. What is your age?							**Median Age***
Less than 18	0.1%	1	0.7%	4	0.3%	5	
18-24	2.5%	24	21.9%	119	9.5%	143	
25-34	14.1%	135	25.7%	140	18.3%	275	
35-44	20.5%	197	12.9%	70	17.8%	267	37 years old
45-54	27.4%	263	14.9%	81	22.9%	344	
55-74	33.5%	322	20.2%	110	28.7%	432	
75+	1.9%	18	3.7%	20	2.5%	38	
answered question		960		544		1,504	
skipped question		5		29		34	
26. What is the highest level of school you have completed or highest degree you have received?							
Grades 1 through 8	0.2%	2	2.2%	12	0.9%	14	
Some high school (grades 9 through 11)	0.2%	2	10.6%	58	4.0%	60	
High school diploma / GED	8.0%	77	30.4%	167	16.2%	244	
Vocational/Tech School	3.3%	32	7.1%	39	4.7%	71	
Some college	19.0%	182	23.9%	131	20.8%	313	
2-year college degree	15.2%	146	10.0%	55	13.3%	201	
4-year college degree	24.3%	233	7.3%	40	18.1%	273	
Graduate or professional degree	29.7%	285	8.6%	47	22.0%	332	
answered question		959		549		1,508	
skipped question		6		24		30	
27. What is your current employment status?							**Bay - Census**
Disabled / unable to work	1.3%	12	7.8%	42	3.6%	54	
Employed full-time	80.0%	767	38.3%	206	65.0%	973	
Employed part-time	6.5%	62	16.2%	87	10.0%	149	
Homemaker	0.9%	9	7.1%	38	3.1%	47	
Retired	7.4%	71	9.3%	50	8.1%	121	
Seasonal worker	0.3%	3	0.6%	3	0.4%	6	
Student	0.6%	6	1.9%	10	1.1%	16	
Self-employed	2.0%	19	2.8%	15	2.3%	34	
Unemployed	1.0%	10	16.2%	87	6.5%	97	5.2%
answered question		959		538		1,497	
skipped question		6		35		41	
28. What is your annual family income?							**Median Income***
Less than $15,000/year	4.6%	43	37.6%	193	16.4%	236	
$15,001 - $25,000/year	8.6%	80	21.2%	109	13.1%	189	
$25,001 - $35,000/year	10.8%	100	12.9%	66	11.5%	166	
$35,001 - $50,000/year	21.1%	196	10.7%	55	17.4%	251	$47,000
$50,001 - $75,000/year	20.7%	192	8.4%	43	16.3%	235	
$75,001 - $100,000/year	16.4%	152	5.5%	28	12.5%	180	
$100,001 or more/year	17.7%	164	3.7%	19	12.7%	183	
answered question		927		513		1,440	
skipped question		38		60		98	

	On-Line Surveys			Paper Surveys		All Responses	
	Response Percent	Response Count		Response Percent	Response Count	Response Percent	Response Count
29. 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 Women OBGYN		1		
			Avicenna		8		
			Bay County Fair		25		
			Catholic Charities of NWFL		9		
			children's dentistry clinic		1		
			Dental Clinic		7		
			dsme support group		1		
			Food Bank		1		
			Glenwood Community Cent		5		
			Healthy Start		9		
			Home/Healthy Start		5		
			NDPP		4		
			Pam Dorwarth interviewed		4		
			PC Mall		73		
			Piggley Wiggly Fountain		38		
			Rainbow Foods		21		
			rehab		1		
			school/work		5		
			St. Andrews Clinic		18		
			Valarie Myer's House		39		
			Village Health Center		44		
			VM		3		
			work		1		
			Youngstown		11		
			answered question		**281**		
			skipped question		**292**		

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

Florida Department of Health in Bay County
Community Health Task Force Meeting
Bay Medical Center- Sacred Heart, Walsingham Board Room
Friday, November 20, 2015, 8:30 – 10:30 a.m.
(Breakfast – 8:00 a.m.)

AGENDA

Purpose: *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
Consider Possible Directions • 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 8th, 22nd or 29th)***	Julie Tindall
Meeting Evaluation	Julie Tindall
Adjourn	

Florida HEALTH

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
Ryal Miller	FDOH	Ryal.miller@flhealth.gov	872-4655
Jo Colville	FDOH	jo.colville@flhealth.gov	872-4455 x1199
Marsha Sumner	FDOH	marsha.sumner@flhealth.gov	872-4455 x1284
Doug Kent	FDOH	Douglas.Kent@flhealth.gov	872-4455
Tanya Sharp	FDOH	Tanya.Sharp@flhealth.gov	872-4455
JoAnn Vanfleteren	Ascendant Healthcare Partners	Joann@ascendanthealthcarepartners.com	850-221-5384
Carol Miller	Gulf Coast State College	cmiller@gulfcoast.edu	769-1551 ext. 3360
Raphael Graham	WestRock - Paper Mill	raphgraham@hotmail.com	404-759-8002
Brandi Hughes	FDOH - Bay	Brandi.Hughes@flhealth.gov	850 872 4459
Preston Matthews	BigBendAHEC	pmatthews@bigbendahec.org	386 956 5288
James Lewis	BBAHEC		718 793
Julie Tindall	FDOH - Bay	julie.tindall@flhealth.gov	850 872-4455
Sandy Clifford	GCSC	[illegible]	913-3262
Janice Lucas	LEAD Coalition	850lead@gmail.com	913-3263
Sonya Lowery	LEAD Coalition	slowery1@gulfcoastcc.edu	769-1551 ext. 4050
William G Swift	Glenwood Working Partnership Inc.	WSwift31K@gmail.com	(410) 499-5908
Doug Kent	FDOH - Bay CHD	—	850 872-4455
Amanda Alexander	Victory Temple	miraclestillhappen81@outlook.com	319-7060
Grace Aiyegbusi	KIC Early Edu. and Care	grace@eackids.org	

Florida HEALTH

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
Rebecca Curti	WIC	Rebecca.Curti@flhealth.gov	872-4466
Natasha Coleman	FDOH	Natasha.Coleman@flhealth.gov	872-4711/203
Kay Milligan-Judah	FDOH / WIC	Kay.Judah@fl.health.gov	872-4466
Sandra Spradley	FDOH/Bay	Sandra.Spradley@flhealth.gov	872-4455
Erica Melvin	FDOH / Bay	Erica.Melvin@flhealth.gov	
Tracy Adams	FDOH / Bay	tracy.adams@flhealth.gov	872-4451 x 1161
Bobby Franklin	SHHS	on file	on file
[illegible]	Tyndall AFB		
Shelley Berry	90 WORKS	sberry@90works.org	630-9082
Sonya Lowery	LEAD	slowery@gulfcoast.edu	302-3102
Katie Landeck	News Herald	klandeck@pcnh.com	413-284-9040

Florida Department of Health in Bay County
Community Health Task Force Meeting
Bay Medical Center- Sacred Heart, Walsingham Board Room
Friday, November 20, 2015, 8:30 – 10:30 a.m.
(Breakfast – 8:00 a.m.)

MEETING MINUTES

Purpose: *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.

Florida Department of Health in Bay County
Community Health Task Force Meeting
Bay Medical Center- Sacred Heart, Walsingham Board Room
Friday, November 20, 2015, 8:30 – 10:30 a.m.
(Breakfast – 8:00 a.m.)

MEETING MINUTES

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.

Florida Department of Health in Bay County
Community Health Task Force Meeting
Bay Medical Center- Sacred Heart, Walsingham Board Room
Friday, November 20, 2015, 8:30 – 10:30 a.m.
(Breakfast – 8:00 a.m.)

MEETING MINUTES

Julie Tindall	Consider Possible Directions • 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 8th, 22nd 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.

Tindall, Julie A

From: Sharp, Tanya
Sent: 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

Subject: CHA/CHIP Work Session
Location: Walsingham Board Room, Bay Medical Center

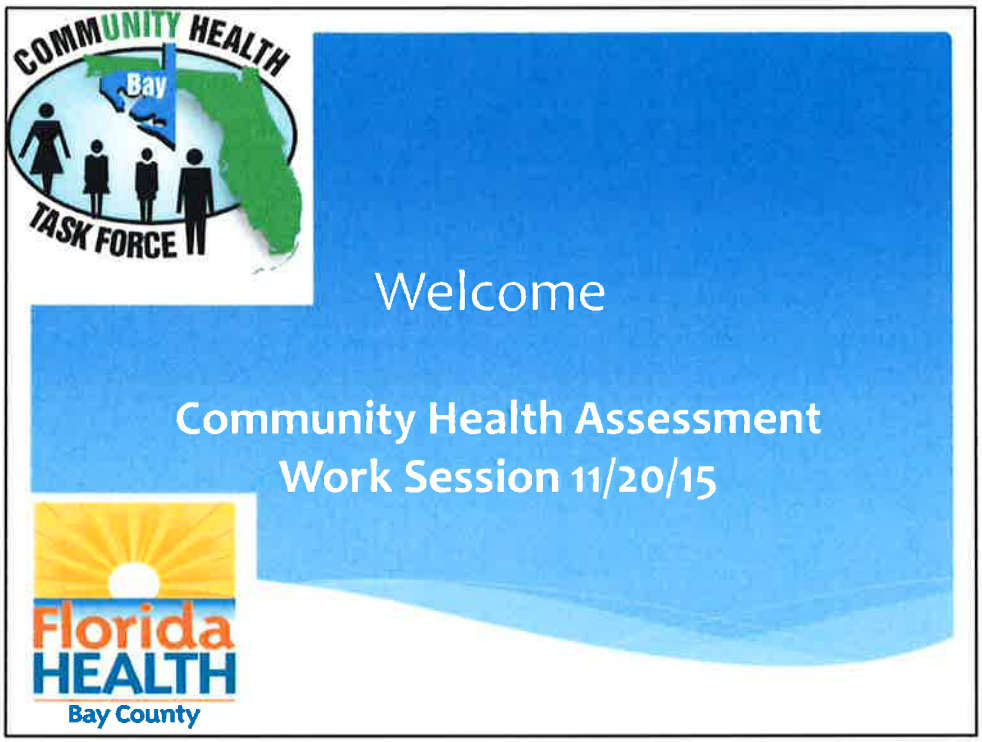
Start: Fri 11/20/2015 8:30 AM
End: Fri 11/20/2015 10:30 AM

Recurrence: (none)

Meeting Status: Accepted

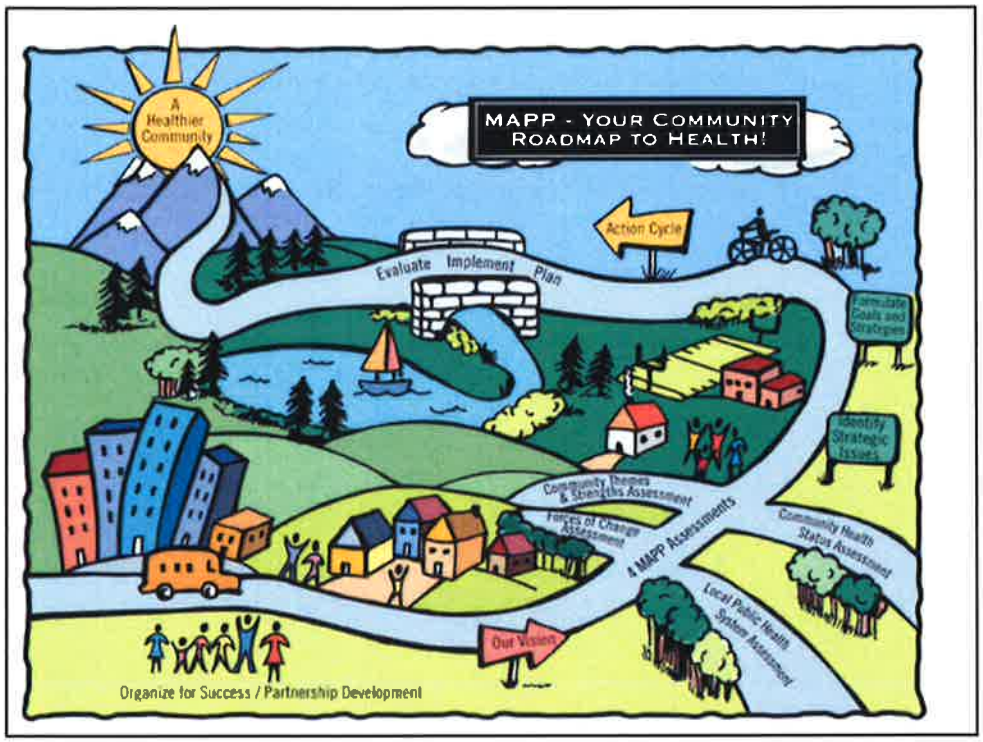
Organizer: Rahn, Lisa A
Required Attendees: Amanda Alexander; Ann Wing; April C Wisdom (april.wisdom@tyndall.af.mil); Barbara Day - AARP; Bekah Taylor; Ben Kleine; Beth Couillette; Beth Deluzain; Betsie Kummer; Betty Gehrken (BettyFSA@comcast.net); Beverley; Brandi Yant; Breaux, Collin; Brian Addison (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!


COMMUNITY HEALTH
Bay
TASK FORCE
Welcome
Community Health Assessment
Work Session 11/20/15
Florida
HEALTH
Bay County

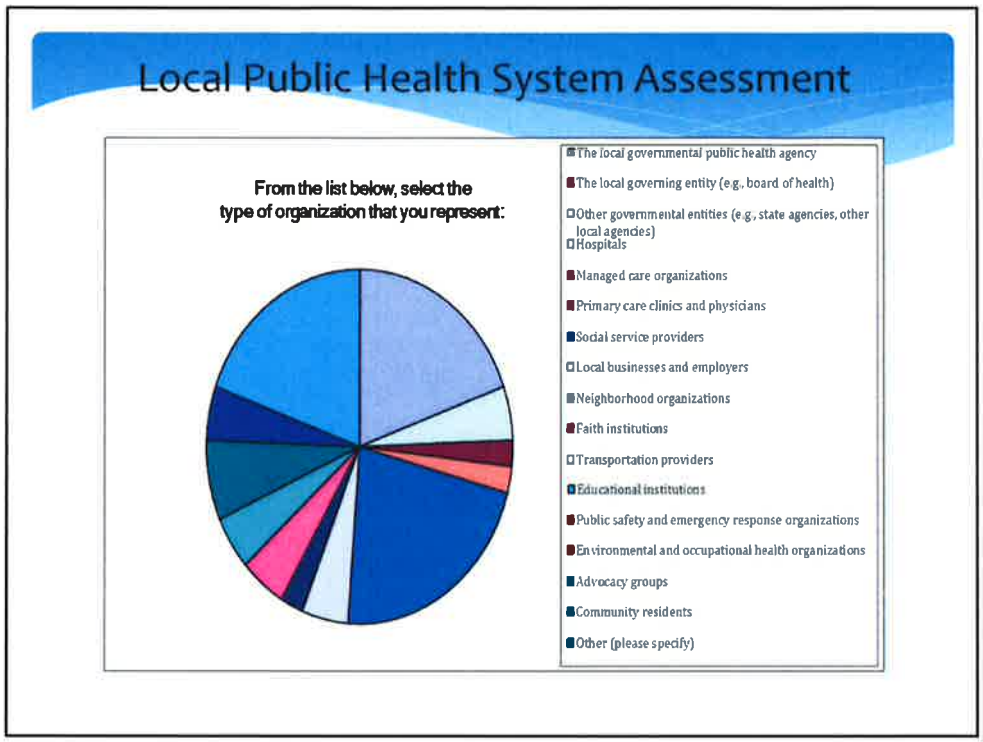
Today's Agenda

* 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.


Local Public Health System Assessment
From the list below, select the type of organization that you represent:
The local governmental public health agency
The local governing entity (e.g., board of health)
Other governmental entities (e.g., state agencies, other local agencies)
Hospitals
Managed care organizations
Primary care clinics and physicians
Social service providers
Local businesses and employers
Neighborhood organizations
Faith institutions
Transportation providers
Educational institutions
Public safety and emergency response organizations
Environmental and occupational health organizations
Advocacy groups
Community residents
Other (please specify)

The Community Themes and Strengths 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.

FYI
SFT

INOT FOC

~~Forces of Change Assessment~~

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

April

Hwr

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?

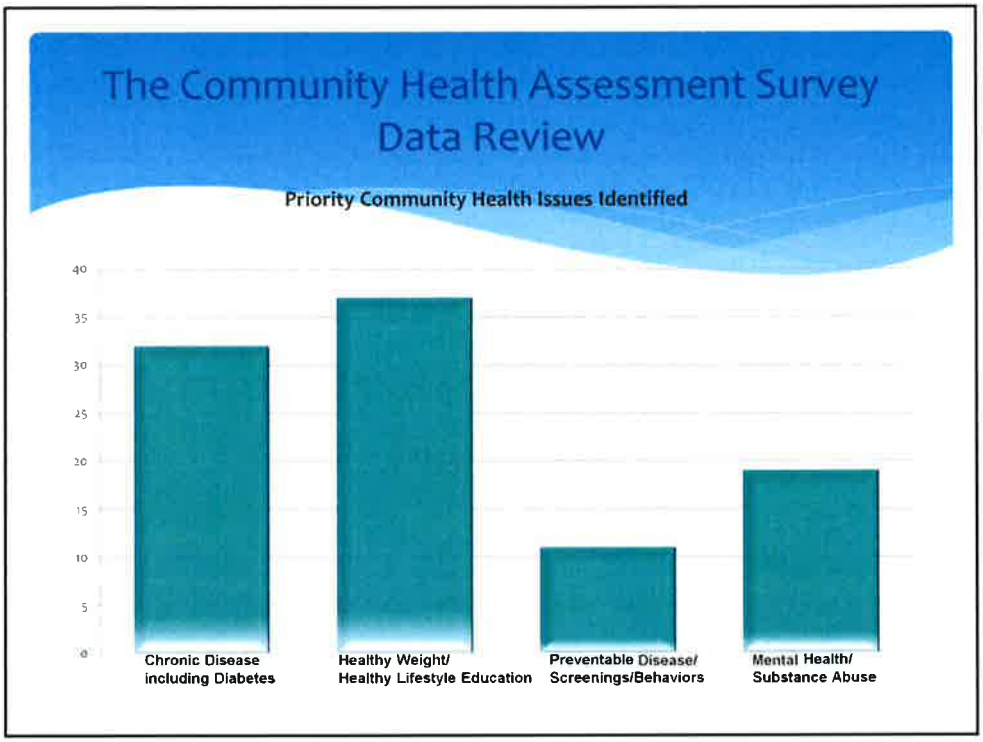
E – Economic Feasibility, does it make economic sense or are there economic consequences if the issue is not addressed?

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.



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.

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.

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.

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.

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.

Rick Bolen

Secretary

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 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.

Secretary

Barbara Nazaruk

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

Barbara Nazaruk

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>

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

Barbara Nazaruk

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,

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

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 Postmaster@baymedical.org. Please indicate that you were not the intended recipient, and confirm that you

Barbara Nazaruk

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 Postmaster@baymedical.org. Please indicate that you were not the intended recipient, and confirm that you

Barbara Nazaruk

From: phillip nunnery <phillipnunnery@gmail.com>
Sent: Monday, June 27, 2016 8:00 PM
To: Barbara Nazaruk
Cc: 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

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

I approve.

John Holland
President & CEO
LHP Hospital Group

On Jun 13, 2016, at 11:30 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>

<Bay County - Community Health Assessment Report 2015-16 - Bay Medical SH.pdf>
<Bay- Resolution to adopt CHNA.docx>

Barbara Nazaruk

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>; Donna Baird <Donna.Baird@baymedical.org>; Jeanne Reeves <Jeanne.Reeves@baymedical.org>; John Osgood <John.Osgood@baymedical.org>; Joseph Ketterer <Joseph.Ketterer@baymedical.org>; Julie Traugott <Julie.Traugott@baymedical.org>; Ron Patrick <Ron.Patrick@baymedical.org>; Stephen Grubbs <Stephen.Grubbs@baymedical.org>; Tammy Newton <Tammy.Newton@baymedical.org>
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

Barbara Nazaruk

From: Paul Kappelman <Paul.Kappelman@lhphospitalgroup.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:

Barbara Nazaruk

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

Tom 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
615 N. Bonita Avenue
Panama City, FL 32401
O: 850-747-6045
C: 850-866-6520
F: 850-763-8827
Barbara.nazaruk@baymedical.org

Bay Medical
Sacred Heart

✓ I approve

Greg England, MD. FACS