

2018-19 Community Health Needs Assessment

Gulf County, Florida

Community Partners Vision:
“Working together to empower Gulf
County to improve quality of life for
generations to come.”

Prepared by:



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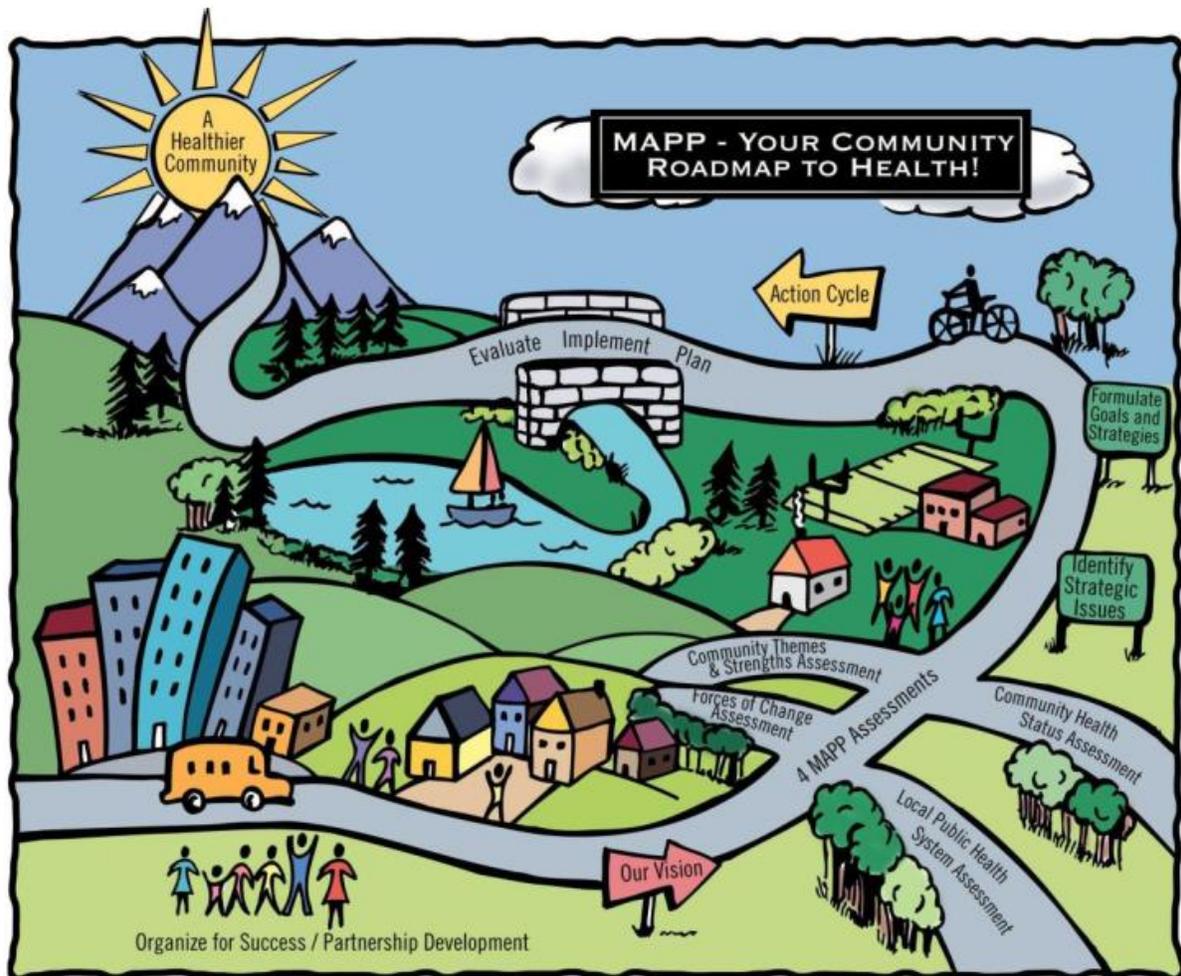
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Executive Summary

During the 2018-2019 timeframe, health partners and the Florida Department of Health - Gulf County (“DOH-GULF”) worked together, in collaboration with other community organizations and agencies, to conduct a community health needs assessment (“assessment”) for the approximately 16,000 residents of Gulf County, Florida.

A Community health needs assessment provides a snapshot in time of the community strengths, needs, and priorities. Gulf County selected the Mobilizing for Action through Planning and Partnerships (MAPP)¹ process for community assessment planning because of its strength in bringing together diverse interests to collaboratively determine the most effective way to improve health.



¹ National Association of County and City Health Officials. <https://www.naccho.org/programs/publichealth-infrastructure/performance-improvement/community-health-assessment>

Description of the Community

The area for the purposes of this assessment is defined as the population of Gulf County. Gulf County has a total area of 745 square miles, of which 25% is water. The population density of the county is 19.2%. There are two main population centers in Gulf County - Wewahitchka in the northeast part of the County and Port St. Joe, the County seat and largest city, on the coast. Between the two cities are smaller unincorporated communities.

From 2017 to 2020 the population in Gulf County is projected to increase by 3%. Minorities represent about 20% of the total population, comparable to the composition of the State.

According to Census estimated gathered in 2017, the median household income in Gulf County is \$44,647, significantly below that of the State amount of \$57,652 per household.

Approximately 21.6% of people are believed to live in poverty compared to 12.3% statewide.

Participants in the Assessment Process

The assessment process was led by the DOH-GULF, with active participation by community organizations and private and public agencies which collectively comprise the Community Health Improvement Partnership (CHIP).

The assessment process included CHIP meetings and workshops and a community survey distributed both on-line and in paper format. More than 25 people representing more than 15 different community agencies and organizations and the general public participated in various meetings throughout the process. In addition, 310 Gulf County residents completed the community survey with an additional 58 completing the Community Assessment for Public Health Emergency Response (CASPER). A Significant focus was placed on obtaining input from vulnerable population groups.

How the Assessment Was Conducted

The assessment was developed using the Mobilization for Action through Planning and Partnership (MAPP) method, which was developed by the National Association of City and County Health Officials in concert with the U.S. Centers for Disease Control and Prevention.

The MAPP process has four elements:

- Community Health Status Profile
- Local Public Health System Assessment
- Community Themes and Strengths Assessment
- Forces of Change Assessment

Quantitative and qualitative data was collected and aggregated in support of the four MAPP elements. Quantitative data were obtained from county, state, and national sources. Qualitative information was obtained through regular CHIP meetings and workshops and a community survey distributed both on-line and in paper format. A summary of key findings from each MAPP Assessment is provided below.

Community Health Status Profile

310 community residents completed the Community Health Status Survey, 229 of those being from the PACE-EH Survey process.

Drug abuse, depression/anxiety, alcohol abuse, and diabetes are the top four community health concerns.

Favorable statistics and health indicators:

- Health factors have consistently improved in rank since 2016.
- Social and economic factors

Opportunities for improvement:

- Personal health behavior factors

The top priority health issues identified for Franklin County were:

- Strategic Issue #1: Mental Health/Substance Abuse
- Strategic Issue #2: Limited Access to Care
- Strategic Issue #3: Physical Activity
- Strategic Issue #4: Socioeconomic Enhancement

Community Themes & Strengths Assessment

The Themes and Strengths portion of the assessment asked three significant questions: “What is important to our community?”, “How is quality of life perceived in our community?” and “What assets do we have that can be used to improve community health?”

Recurring themes include:

- Education, economy, healthcare, and safety are highly important characteristics of a healthy community.

The following were identified as assets and strengths:

- Multiple individuals, associations, public and private institutions, and ongoing local projects
- The safety and overall quality of life in the community

Local Public Health System Assessment

The LPHS Assessment required participants to think about how well the collective LPHS meets the Ten Essential Public Health Services. Overall survey participants responded:

- No Activity – 7%
- Minimal – 12%
- Moderate – 33%
- Significant – 38%
- Optimal – 11%

Forces of Change Assessment

To assess the forces of change, participants were asked, “What is currently happening or could happen that would affect the health of our community?”

Key forces of change identified include:

- Substance use
- Change in funding to provide services
- Access to health-related resources
- Environmental Factors
- Lifestyle Education
- Community Development

The last workshop conducted as part of the assessment process was The Community Health Status Assessment Workshop, which began with an in-depth review of data collected and analyzed throughout the process, including specific health status indicators and results of a Community Health Status Assessment Survey. The data review was followed by a decision matrix and ended with selection of health priorities based on the following criteria:

- Broad applicability of solution set
- Time frame required to support efforts
- Potential to reduce health disparities
- Alignment with vision (“Working together to empower Gulf County to improve quality of life for generations to come.”)
- Community support for the problem
- Resource availability to address problem

Priority Health Issues

The top priority health issues identified for Gulf County were:

- Strategic Issue #1: Mental Health/Substance Abuse
- Strategic Issue #2: Physical Activity
- Strategic Issue #3: Access to Care
- Strategic Issue #4: Socioeconomic Enhancement

2018-19 Community Health Needs Assessment Gulf County, Florida

Introduction

In 2018, the Florida Department of Health - Gulf County (“DOH-GULF”) worked together, in collaboration with other community organizations and agencies, to conduct a community health needs assessment (“assessment”) for Gulf County. The overarching goals of this report include:

- Examination of the current health status across Gulf County as compared to Florida
- Identification of the current health concerns among Gulf County residents within the social and economic context of the community
- Documentation of community strengths, resources, forces of change, and opportunities for health service provision to inform funding and programming priorities of Gulf County.

Collaborating Partners

- Big Bend AHEC
- Big Bend Community Based CARE
- Career Source Gulf Coast
- Community Care Center of Gulf County
- Department of Juvenile Justice
- DOH – Gulf County – Environmental Health
- DOH – Gulf County – Tobacco Prevention Program
- Florida Agricultural and Mechanical University Extension Office
- Florida Department of Health – Closing the Gap
- Florida Department of Health – Franklin County
- Florida Department of Health – Gulf County
- Gulf Coast State College
- Gulf County District Schools
- Gulf County Sheriff’s Office
- Healthy Start Coalition
- Healthy Families
- Life Management Center
- Long Term Recovery Group
- Morning Light Wellness Center
- MyGulfCare – Sacred Heart
- North Florida Child Development
- Pan Care
- Philadelphia Baptist Church
- Project Area Coalition (PAC)
- Sacred Heart Health Systems
- Sacred Heart Hospital on the Gulf
- Tyndall Air Force Base
- University of Florida Institute of Food and Agricultural Sciences-Gulf County
- Wewahitchka Medical Center

Florida Department of Health in Gulf County

The Florida Department of Health in Gulf County is the area's public health agency. DOH-Gulf provides programs and services to prevent disease and promote health in the following areas: clinical and nutritional services, wellness programs, community health planning and statistics, environmental health, emergency preparedness and response, and infectious disease surveillance. DOH-GULF works closely with the County and City Commissioners, the Emergency Response Division, and other local, state and federal agencies to protect the health and welfare of Gulf County residents and visitors. Its mission is to protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts. Its core values (ICARE) are:



- Innovation - Searching for creative solutions and managing resources wisely
- Collaboration - Using teamwork to achieve common goals and solve problems
- Accountability - Performing with integrity and respect
- Responsiveness – Achieving its mission by serving its customers and engaging its partners
- Excellence - Promoting quality outcomes through learning and continuous performance improvement

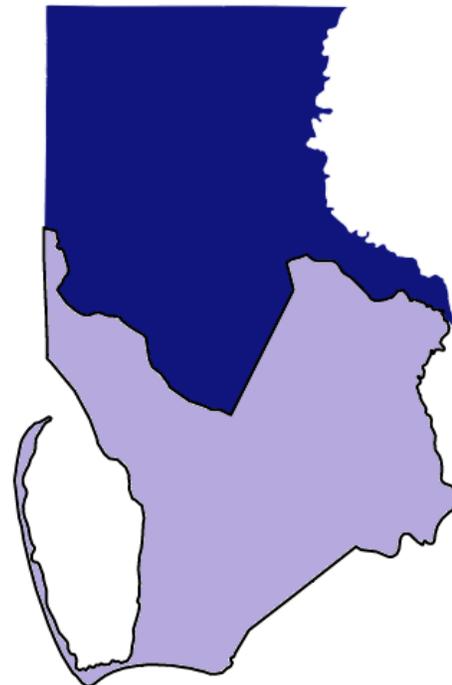
Community Definition

Gulf County has a total area of 745 square miles, of which 25% is water. There are two main population centers in Gulf County - Wewahitchka in the northeast part of the County and Port St. Joe, the County seat and largest city, on the coast. Sandwiched between the two cities are several unincorporated communities. Cape San Blas is a narrow strip of land jutting out into the Gulf, separating the Gulf of Mexico and St. Joseph Bay.

The area is low in density, featuring mainly single-family homes and tourist rentals. The County jurisdiction also includes a 15-mile long barrier island which contains the St. Joseph Peninsula State Park.

Population

Gulf County has a low population density of a little less than 30 persons per land mass square mile, compared to 348 persons per square mile in the State of Florida. The county has an estimated population of 16,164.



The population aged 65 and older represent 20.7% of the total population of Gulf County, similar to the state rates for that demographic of 20.1%. The significant majority of Gulf County residents are between the ages of 25 and 64 (63.7%), which accounts for more than the percentage of the population in that age bracket statewide (59.9%). Only 15.6% of the population of Gulf County is under 18 years of age, compared to 20.0% of the State's population. In addition, the population is skewed heavily in favor of males over females, with almost 60% of the population of Gulf County being male compared to slightly less than 50% of the population of the State.

Gulf County Population Estimates July 1, 2018		
Demographics	Gulf	Statewide
Estimated Total Population July 1, 2018	16,164	21,299,325
Age and Sex		
5 years old and under	4.00%	5.40%
18 years old and under	15.60%	20.00%
65 years old and over	20.70%	20.10%
Female	41.40%	51.10%
Males	58.60%	48.9%
Race and Hispanic Origin		
White	79.70%	77.40%
Black or African American	17.20%	16.90%
American Indian and Alaska Native	0.60%	0.50%
Asian	0.60%	2.90%
Hispanic or Latino	4.50%	25.60%
White (not Hispanic or Latino)	75.60%	54.10%
Two or more races	1.9	2.1

Source: U.S. Census Bureau, Quick Facts 2019

Population Characteristics

- Nearly 15% of the population of Gulf County is less than 18 years old.
- The significant majority of Gulf County residents are between the ages of 25 and 64 (63.7%), compared to 59.9% statewide.
- At 58.6% of the population, males represent more than half of all residents in Gulf County, compared to being slightly underrepresented in the state as a whole accounting for only 48.9% of the population of Florida.

Population by Race and Ethnicity

Minorities represent about 23% of the total population in Gulf County, comparable to the nearly 45% minority composition of the population of the State. A slightly higher percentage of the population in Gulf County is African-American (slightly more than 17.2%) than in the State (about 16.9%). Unlike the State, only 4.5% of the population of Gulf County is Hispanic, compared to 25.6% statewide.

Why are these characteristics important?

- Population growth can strain health care resources and other infrastructure, particularly where limited resources already exist
- Different gender and age groups utilize significantly different types and levels of health care services,

particularly male versus female, pediatric versus adult, and elderly patient populations.

- The elderly (population aged 65 and older) utilize 3 to 4 times the healthcare services required by younger populations.
- Language and cultural differences create the need for different approaches to improving access to health services

Socioeconomic Indicators

In 2018, the median household income in Gulf County is \$44,291, which is below the median household income of the State of \$53,267. Over 30% of the population has an income of less than \$25,000, noticeably more than the state rate of only 23.6%. More than half of households (56.1%) have incomes below \$50,000, a rate that is higher than Florida and U.S. rates. In Gulf County, 24.8% of households in ZIP Code 32456 and 37.7% in ZIP Code 32465 have incomes below \$25,000.

Income & Poverty				
Area	Occupied Housing Units	Median household income	Percent less than \$25,000/year (2016)	Persons in poverty
Gulf	5,349	\$40,822	30.6%	15.3%
Florida	7,393,262	\$48,900	23.6%	16.1%

Source: U.S. Census Bureau, ACS 5-year estimates, 2012-2016.

A substantially greater percentage of the population over the age of 25 does not have a high school diploma in Gulf County compared to the State (17.5% versus 12.8%). Finally, 19.2% of the local population is living with a disability compared to 13.3% of Floridians statewide.

Other Socioeconomic Indicators, 2016		
Area	Population 25+ w/out High School Diploma	Population w/ Disability
Gulf	17.5%	19.2%
Florida	12.8%	13.3%
U.S.	13.0%	12.5%

Source: U.S. Census Bureau, ACS 5-year estimates, 2012-2016.

ALICE

Another measure of socioeconomic status is the ALICE (Asset Limited, Income Constrained, Employed) Report. ALICE research quantifies and describes number of households that are struggling financially. This effort provides a framework, language, and tools to measure and understand the struggles of the growing number of households in our communities that do not earn enough to afford basic necessities.

What does it cost to afford the basic necessities?

The Household Survival Budget gives the cost of housing, child care, food, transportation, and health care at a bare-minimum “survival” level. It does not include any savings, leaving households without a cushion for unexpected expenses and unable to invest in the future. Yet even this minimal budget was much higher than the adjusted Federal Poverty Level of \$11,880 for a single adult and \$24,300 for a family of four in 2016.

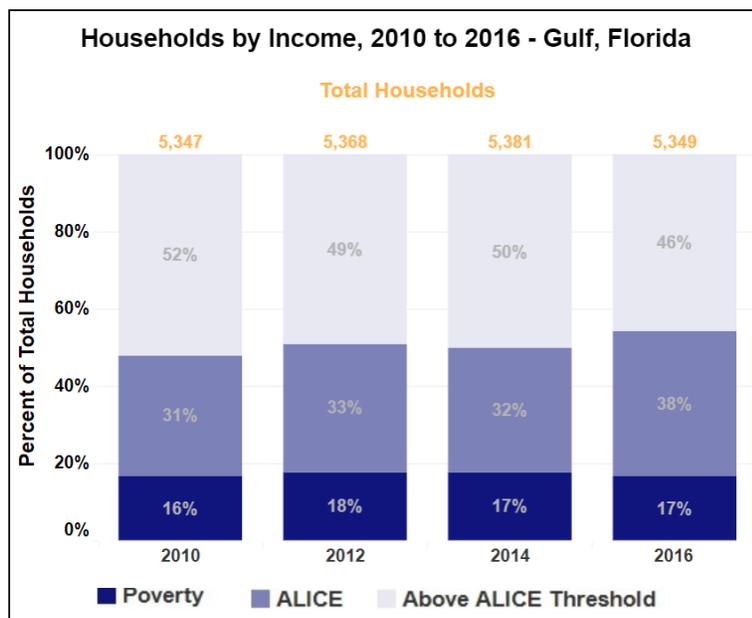
Household Survival Budget - Gulf, Florida, 2016		
	Single Adult	2 Adults, 1 Infant, 1 Preschooler
Housing	\$543	\$738
Child Care	\$0	\$1,035
Food	\$164	\$542
Transportation	\$322	\$644
Health Care	\$196	\$726
Technology	\$55	\$75
Miscellaneous	\$147	\$405
Taxes	\$191	\$286
Monthly Total	\$1,618	\$4,451
ANNUAL TOTAL	\$19,416	\$53,412
Hourly Wage	\$9.71	\$26.71

Source: U.S. Department of Housing and Urban Development; U.S. Department of Agriculture; Bureau of Labor Statistics; Internal Revenue Service; Tax Foundation; and Office of Early Learning, 2016.

The ALICE research team developed new measures to identify and assess financial hardship at a local level and to enhance existing local, state, and national poverty measures.

The ALICE Income Assessment measures:

1. The income households need to reach the ALICE Threshold
2. The income they actually earn
3. How much public and nonprofit assistance is provided
4. The Unfilled Gap – how much more money is needed to reach the ALICE Threshold despite both income and assistance



Source: American Community Survey, 2016, and the ALICE Threshold, 2016.

How has the number of struggling households changed over time?

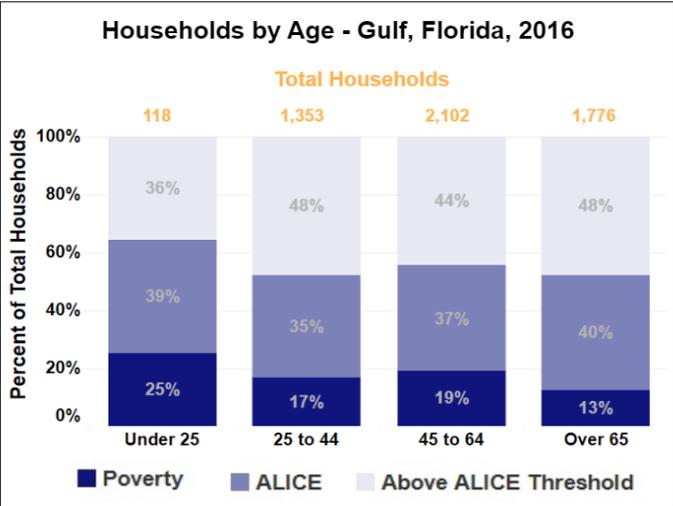
The number of households below the ALICE Threshold fluctuates throughout the year. Households move in and out of poverty and ALICE as their circumstances worsen or improve. The general trend has been a flat recovery since 2010, the end of the Great Recession. In many locations, the cost of basics has increased more than wages, leading to an increase in the number of ALICE households.

ALICE Household Data, 2016

Name	Total Households	# of Poverty Households	# of ALICE Households	% of ALICE Households
Port St. Joe	1,245	121	615	49.4%
Wewahitchka	940	274	333	35.4%

Source: ACS (5year)

While over 18% of the population of Gulf County lives in poverty nearly 49% of Port St. Joe residents and 35% of Wewahitchka locals struggle to afford basic necessities.



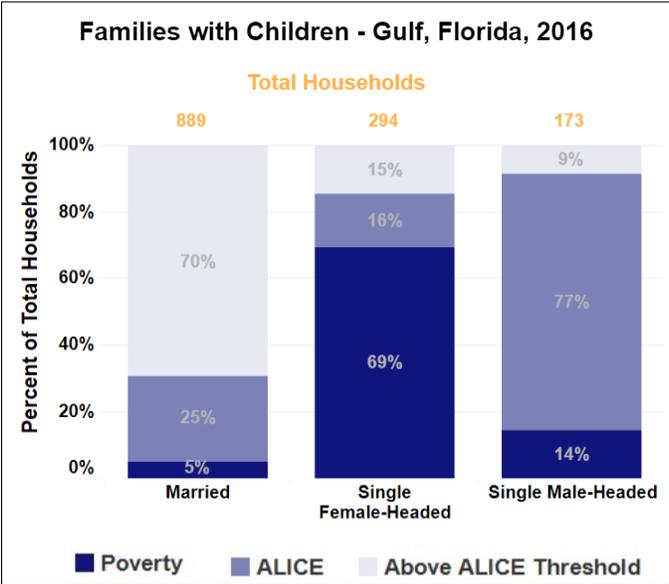
Source: American Community Survey, 2016, and the ALICE Threshold, 2016.

What are the differences in ALICE households by age?

There are ALICE households in every age bracket. The youngest group (people under 25) is more likely to be in poverty, and both the youngest and the oldest (people 65 and older) are more likely to be ALICE.

How many families with children are struggling?

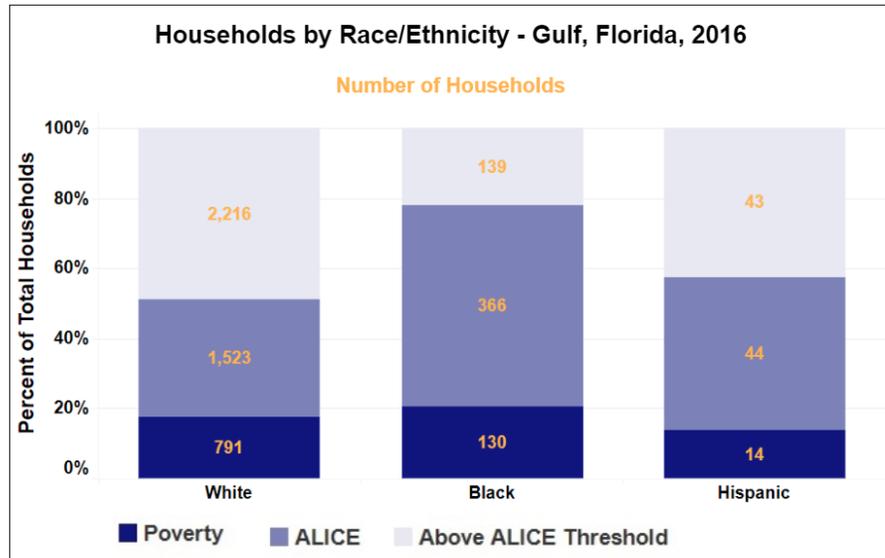
Children add significant expense to a family budget, so it is not surprising that many families with children live below the ALICE Threshold. Though more families are headed by married parents, those families with a single parent are more likely to have income below the ALICE Threshold.



Source: American Community Survey, 2016, and the ALICE Threshold, 2016.

What races and ethnicities are ALICE families?

Overall, the race and ethnicity of ALICE households fairly closely mirrors that of the total population. Yet some groups still face economic and legal barriers that limit their earnings and make them more likely to live below the ALICE Threshold.



Source: American Community Survey, 2016, and the ALICE Threshold, 2016.
 Note: Data in all categories except Two or More Races is for one race alone. Because race and ethnicity are overlapping categories, the totals for each income category do not add to 100 percent exactly.

Nearly half of all white residents are either ALICE or living in poverty. A vast majority of the Black population in Gulf County is categorized as ALICE. And nearly 80% of all Black residents are considered to live at or below the ALICE threshold. Hispanics also have similar classification.

Why are these characteristics important?

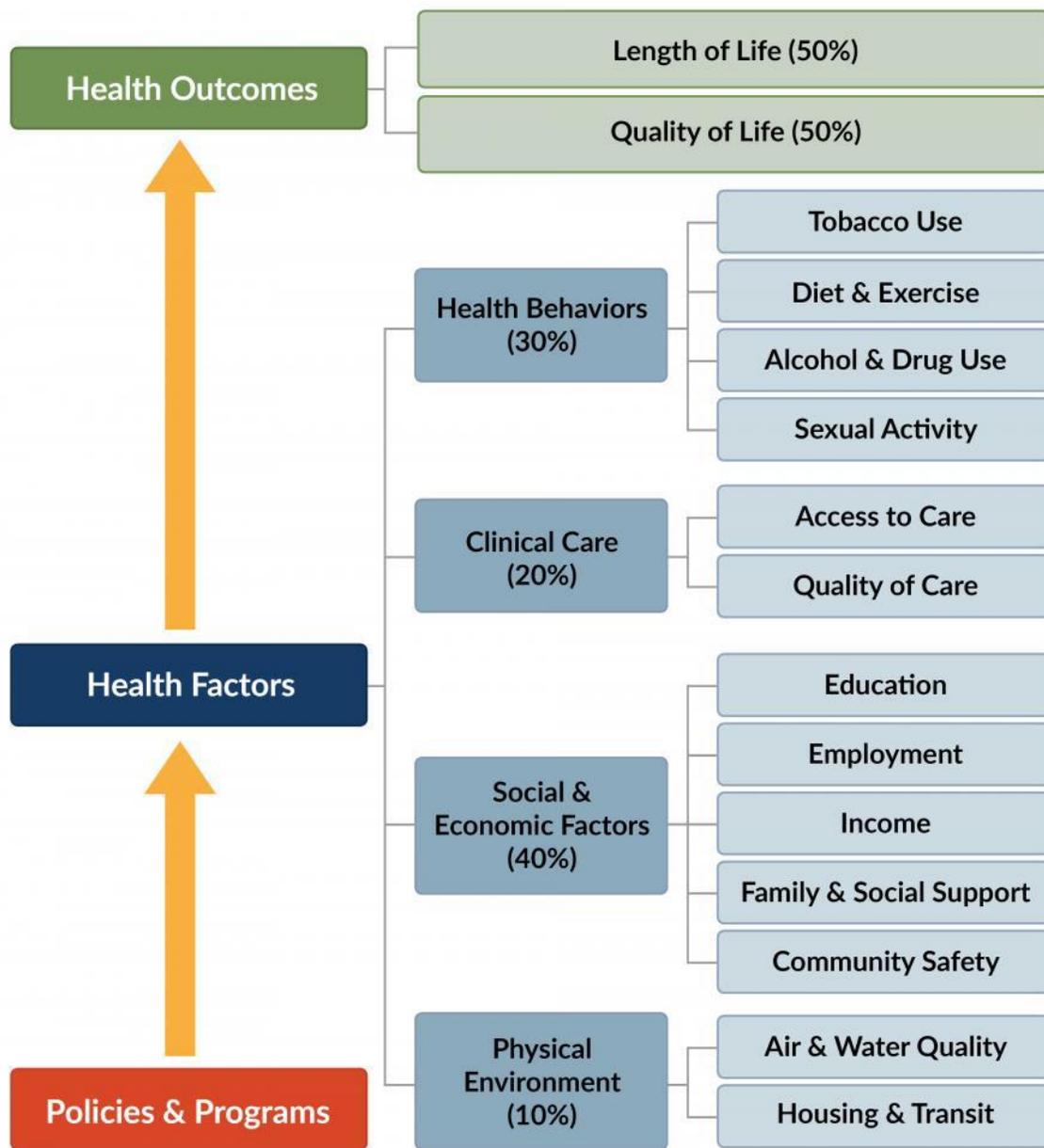
- Socioeconomic status plays a major role in health and healthcare. It affects access to healthcare services as well as diet, housing conditions, and other environmental conditions that affect health.
- Generally, the higher your socioeconomic status, the better health care coverage you have, which allows you to get routine check-ups as well as surgery, if and when needed, at lower out-of-pocket cost. It also can enable better access to providers outside of health plan provider networks.
- The rate of employment is directly correlated with health insurance coverage, since most people still get health insurance through their employer. To some degree, this has changed under the Affordable Care Act through the creation of health insurance exchanges which provide access to health insurance to individuals and families outside of the workplace.
- Even with the relatively lower rate of unemployment in Gulf County, access to health care services may still be problematic. Employers who do provide health insurance are shifting a greater share of the cost of such coverage to employees through plans with higher deductibles and co-pays. As a result, median household and per capita income are important indicators of access to care. The very low relative income levels of the population in Gulf County suggest that access to care may be difficult for much of the population in Gulf County.
- A huge but hidden segment of our community that is struggling to afford basic necessities. The success of a community is directly related to the financial stability of its members.

Health Definition

Health is living long and well. It's where we live, work, learn, and play. It's opportunity—for all of us—to strive and thrive.

Beyond Health Care

Health is more than what happens at the doctor's office. As illustrated in the model at right, a wide range of factors influence how long and how well we live from education and income to what we eat and how we move to the quality of our housing and the safety of our neighborhoods. For some people, the essential elements for a healthy life are readily available; for others, the opportunities for healthy choices are significantly limited.



County Health Rankings model © 2014 UWPHI

Let's learn more about Gulf County and what it looks like through this lens.

County Health Rankings 2019	Gulf County	Current Trend	Error Margin	State of Florida	Rank (of 67)
Health Outcomes					34
Length of Life (50%)					42
Premature death	9,000		7,000-11,000	7,200	
Quality of Life (50%)					19
Poor or fair health	21%		21-22%	19%	
Poor physical health days	4.7		4.5-4.8	3.8	
Poor mental health days	3.9		3.8-4.1	3.8	
Low birthweight	7%		5-9%	9%	
Health Factors					34
Health Behaviors (30%)					42
Adult smoking	18%		18-19%	15%	
Adult obesity	36%		31-40%	27%	
Food environment index	7.2			6.9	
Physical inactivity	34%		30-38%	25%	
Access to exercise opportunities	54%			88%	
Excessive drinking	22%		21-23%	18%	
Alcohol-impaired driving deaths	25%		12-39%	25%	
Sexually transmitted infections	270.9			467.4	
Teen births	37		29-45	23	
Clinical Care (20%)					36
Uninsured	13%		11-15%	15%	
Primary care physicians	2,280:1			1,390:1	
Dentists	8,080:1			1,700:1	
Mental health providers	1,800:1			670:1	
Preventable hospital stays	<u>5,043</u>			5,066	
Mammography screening	33%			42%	
Flu vaccinations	36%			41%	
Social & Economic Factors (40%)					17

County Health Rankings 2019		Gulf County	Current Trend	Error Margin	State of Florida	Rank (of 67)
High school graduation		85%			82%	
Some college		49%		39-58%	62%	
Unemployment		3.9%			4.2%	
Children in poverty		27%		19-35%	21%	
Income inequality		4.4		3.4-5.5	4.7	
Children in single-parent households		31%		21-41%	38%	
Social associations		15.6			7.1	
Violent crime		392			484	
Injury deaths		70		53-91	76	
Physical Environment (10%)						32
Air pollution - particulate matter		9.1		6.1		
Drinking water violations		Yes				
Severe housing problems		18%		14-22%	21%	
Driving alone to work		71%		64-78%	79%	
Long commute - driving alone		32%		24-40%	40%	

Additional demographic and socioeconomic data for Gulf County are provided in Attachment A.

Methodology

Participants in the Assessment Process

The assessment process was led by the DOH-GULF, with active participation by the following community organizations and private and public agencies which collectively comprise the Community Health Improvement Partnership (CHIP).

- Big Bend AHEC
- Big Bend Community Based CARE
- Career Source Gulf Coast
- Community Care Center of Gulf County
- Department of Juvenile Justice
- DOH – Gulf County – Environmental Health
- DOH – Gulf County – Tobacco Prevention Program
- Florida Agricultural and Mechanical University Extension Office
- Florida Department of Health – Closing the Gap
- Florida Department of Health – Franklin County
- Florida Department of Health – Gulf County
- Gulf Coast State College
- Gulf County District Schools
- Gulf County Sheriff's Office
- Healthy Start Coalition
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- Morning Light Wellness Center
- MyGulfCare – Sacred Heart
- North Florida Child Development
- Pan Care
- Philadelphia Baptist Church
- Project Area Coalition (PAC)
- Sacred Heart Health Systems
- Sacred Heart Hospital on the Gulf
- Tyndall Air Force Base
- University of Florida Institute of Food and Agricultural Sciences-Gulf County
- Wewahitchka Medical Center

Individual members of these organizations and agencies that participated are listed on the sign-in sheets included in each related workshop reports included in Attachments B-D.

The assessment process included CHIP meetings and workshops which occurred between August 2018 and continued into August 2019. Partners promoted and helped populate a community survey, distributed both on-line and in paper format. More than 25 people representing more than 15 different community agencies/organizations and the general public participated in various meetings throughout the process. In addition, 310 Gulf County residents completed a community survey to provide information about perceptions of the health of the community, its residents, and the health care system.

To ensure input was obtained from persons with a broad knowledge of the community, e-mail notifications and invitations were sent to numerous stakeholders and representatives of the

public. In addition to soliciting input from the general population, special attention was given to obtaining input from traditionally underserved populations through the Protocol for Accessing Community Excellence in Environmental Health model for change (PACE-EH).

In addition to the 310 Gulf County residents reached during the local survey distribution, 58 Community Assessment for Public Health Emergency Response (CASPER) assessments were completed from November 5 to 7, 2019, as part of the response to the 2018 hurricane season that included impacts from Hurricane Michael and Tropical Storms Alberto and Gordon.

Assessment Process - MAPP

The assessment was developed using the Mobilization for Action through Planning and Partnership (MAPP) method, which was developed by the National Association of City and County Health Officials in concert with the U.S. Centers for Disease Control and Prevention. MAPP is a community-driven strategic planning framework that assists communities in developing and implementing efforts around the prioritization of public health issues and the identification of resources to address them as defined by the Ten Essential Public Health Services. The MAPP process includes four assessment tools listed below and depicted in the graphic that follows:



- Community Health Status Assessment
- Community Themes & Strengths Assessment
- Forces of Change Assessment
- Local Public Health System Assessment

Each of these elements provided a platform for assessing multiple factors – from lifestyle behaviors (e.g., diet and exercise) to clinical care (e.g., access to health care services) to social and economic factors (e.g., employment opportunities) to the physical environment.

Summary of Findings:

Quantitative and qualitative data were collected and aggregated in support of the four MAPP elements.

Quantitative data were obtained from county, state, and national sources in order to develop a social, economic, and health assessment of Gulf County. Sources of data included, but were not limited to, the U.S. Census Bureau, U.S. Centers for Disease Control and Prevention, Florida Department of Law Enforcement, United States Department of Labor, Community Commons, U.S. Department of Commerce, County Health Rankings, Florida Department of Health CHARTS and Environmental Public Health Tracking Network, U.S. Department of Housing and urban Development, and Florida Agency for Health Care Administration. Types of data included public health surveillance data, such as deaths and births.

Qualitative information was obtained through regular CHIP meetings and workshops and a community survey distributed both on-line and in paper format to solicit perceptions of health status, concerns, and programs, services, or initiatives which would best address those concerns.

While much data analysis was conducted throughout the assessment period, review of the data and information and community participation in development of the findings and conclusions of each MAPP Assessment occurred in a series of community workshops. These workshops

encompassed the following topics:

Workshop 1: Vision and Local Public Health System (detailed report, Attachment B)

Workshop 2: Themes & Strengths Assessment and the Forces of Change Assessment (detailed report, Attachment C)

Workshop 3: Community Health Status Assessment (detailed report, Attachment D)

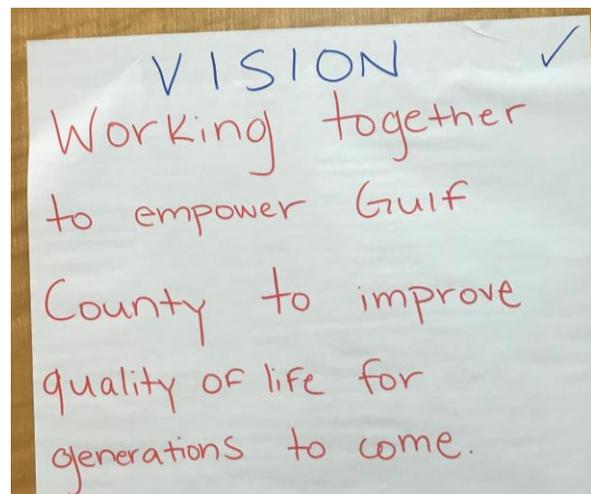
The work that was performed, findings reviewed, and conclusions reached in each of these workshops is summarize below.

Vision and the Local Public Health System Workshop

The Vision and Local Public Health System (“LPHS”) Community Health Assessment (“CHA”) Workshop centered on creating a shared collective vision to guide participants throughout the CHA process and gauging the ideas, thoughts, and opinions of the community regarding their knowledge and experience dealing with the LPHS throughout the County. The workshop was held on August 14, 2018. Twenty-five (25) people from 10 community organizations participated in the Workshop.

Vision

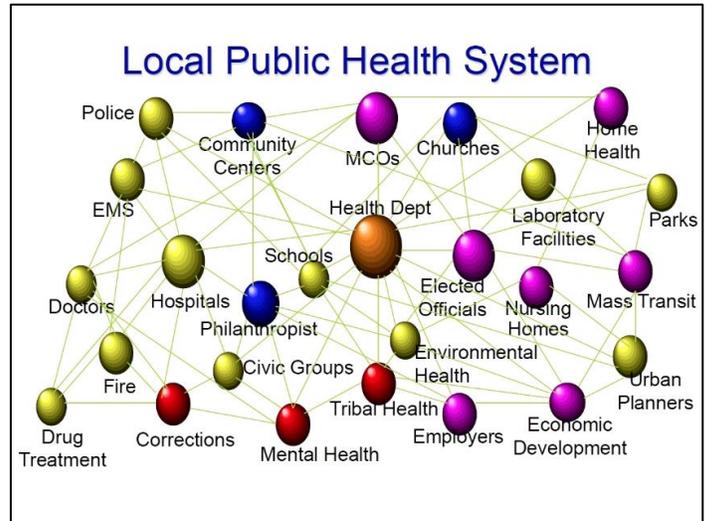
Participants were led through a process to understand the importance of developing a shared vision and were given time to consider what that shared vision might be. Many participants shared vision statements they had developed with the group and, although the statements were all different, several key values such as “enhancing community health for all,” “making Gulf County a great place to live, work, and play,” “making Gulf County the healthiest county in the nation,” and “improving the quality of the Gulf...” were consistent throughout. Ultimately the workshop members unanimously settled on “Working together to empower Gulf County to improve quality of life for generations to come.”



Local Public Health System

The LPHS in Gulf County is a diverse mix of organizations and institutions in both the public and private sector. The diagram displays the various relationships local entities have within the interconnected web of the LPHS.

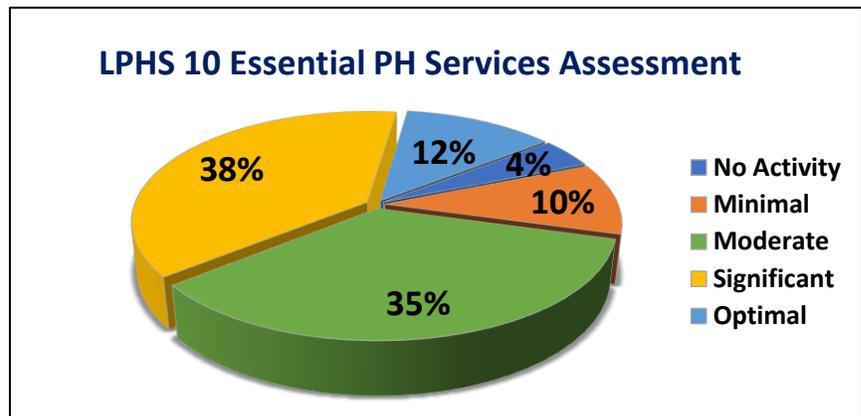
The LPHS Assessment required participants to think about how well the collective LPHS meets the Ten Essential Public Health Services.



The Ten Essential Public Health Services	
<ul style="list-style-type: none"> ▪ Monitor Health Status: What is going on in our community? Do we know how healthy we are? ▪ Diagnose and Investigate: Are we ready to respond to healthy problems in our community? How quickly do we find about problems? How effective is our response? ▪ Inform, Educate & Empower: How well do we keep all populations within our community well informed about health issues? ▪ Mobilize Community Partnerships: How well do we truly engage people in local health issues? ▪ Develop Policies & Plans: What local policies in both government and private sector promote health in our community? How well are we setting local health policies? 	<ul style="list-style-type: none"> ▪ Enforce Laws: When we enforce health regulations, are we fair, competent and effective? ▪ Link People: Are people in the community receiving the health services they need? ▪ Assure: A Competent Workforce: Do you have competent healthcare staff? ▪ Evaluate: Are we meeting the needs of the population we serve? Are we doing things right? Are we doing the right things? ▪ Research: Are we discovering and doing new ways to get the job done?

Participants were asked to think about their personal experiences and knowledge of events over the past three years and answer a series of questions centering on the LPHS's community engagement as it relates to the Ten Essential Public Health Services. Each question started with "At what level does the LPHS ..." and was evaluated on the following scale:

- Optimal (greater than 75%)
- Significant (50 – 75%)
- Moderate (26 – 50%)
- Minimal (1 – 25%)
- No Activity (0%)
- I Don't Know



Overall the community is split on how well the local public health system is functioning. Just under 50% of those

surveyed felt that the local public health system has no activity to moderate performance. While half of the participants polled (50%) agree that the system is functioning significant to optimal.

The first set of questions polled all relate to the Essential Public Health Service #1 and answer the questions, “What is going on in our community?” and “Do we know how healthy we are?” The feedback from the Essential Service #1 questions conveyed a general satisfaction with the LPHS’s level of community engagement. In all Essential Service #1 polls, 50% of participants responded that the LPHS is doing an optimal or significant job.

Detailed results on these and all other polled questions related to the Ten Essential Public Health Services are provided in the full Workshop Report, provided in Attachment B.

Themes & Strengths Assessment and the Forces of Change Workshop

The Themes and Strengths and the Forces of Change CHA Workshop centered on establishing a collective vision to guide participants throughout the CHA process, identifying common community themes and strengths, and identifying the forces of change that can affect the health of the community. The workshop was held on September 18, 2018. Eighteen (18) people from 12 community organizations participated in the Workshop.

Themes and Strengths

Themes	
Open Ended Questions	Common Themes
1. What makes you most proud of our community?	<ul style="list-style-type: none"> ▪ Family/coming together. ▪ New organizations/services like the hospitals, clinics, and Morning Light Wellness Center help increase access to care.
2. What would excite you enough to be involved or more involved in improving our community?	<ul style="list-style-type: none"> ▪ Listening and understanding. ▪ More acceptance of ideas ▪ More community involvement, momentum and understand.
3. What do you believe is keeping our community from doing what needs to be done to improve health and quality of life?	<ul style="list-style-type: none"> ▪ Funding shortages. ▪ Lack of interest and understanding. ▪ Difficulty thinking outside of the box
4. What do you believe are the 2-3 most important characteristics of a healthy community?	<ul style="list-style-type: none"> ▪ Education. ▪ Economy. ▪ Healthcare. ▪ Safety.

The Themes and Strengths portion of the assessment asked three significant 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?

To answer these questions, community members participated in three (3) specific community-led sessions: Themes, Quality of Life Survey, and an Asset Inventory.

Through 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.

Quality of Life Survey

The Quality of Life Survey answered the question, “How is quality of life perceived in our community?” The survey asked participants to think about their quality of life throughout the County as it relates to the health care system, raising children, growing old, affordable housing, economic opportunity, and civic responsibility, among other issues. Each question was evaluated on the following scale:

- Most Unsatisfied
- Slightly Unsatisfied
- Neutral
- Slightly Satisfied
- Most Satisfied

The first question was: “Are you satisfied with the quality of life in our community?” 75% of all participants responded that they were slightly unsatisfied with the quality of life in the community, while 25% each responded that they were only slightly satisfied. The question, “Is there economic opportunity in the community?” nearly 70% of respondents reported a being slightly to most unsatisfied with local opportunities. In regard to the question “Is the community a safe place to live?” Over 80% was slightly satisfied to most satisfied.

Detailed results for all polled questions regarding the quality of life in the community are provided in Attachment C.

Asset Inventory

The final session within the Themes and Strengths Assessment was the asset inventory. Participants were tasked with answering the question, “What assets do we have that can be used to improve community health?” Having just established a shared vision, community members were asked to list all of the community resources that may contribute to reaching the shared vision.

Workshop participants identified resources in four (4) major categories as summarized below.

Community assets identified by each work group are provided in the full Themes and Strengths and the Forces of Change Workshop Report, provided in Attachment C.

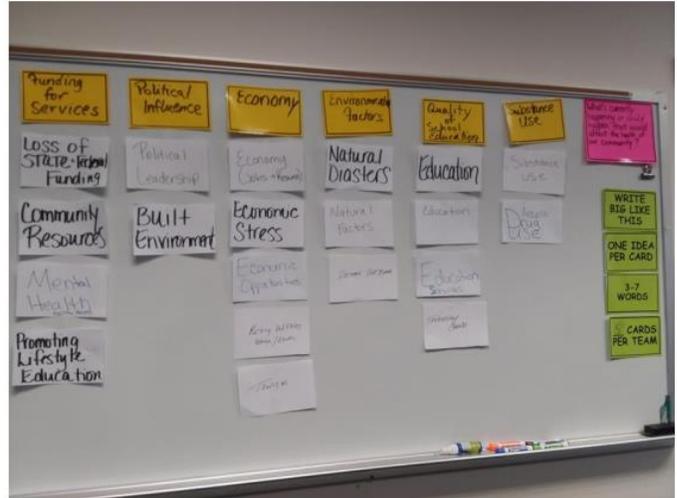
Collective Assets Inventory	
<p><u>Individuals (w/ Knowledge & Skills):</u></p> <ol style="list-style-type: none"> 1. Superintendent 2. Commissioners 3. Pastors 4. Teachers 5. Youth Group Leaders 	<p><u>Citizen Associations:</u></p> <ol style="list-style-type: none"> 1. Community Service Orgs. 2. Northside Port St. Joe Project Area Coalition (PAC) 3. Junior Service League 4. Lions Club 5. Kiwanis 6. Mason

<p><u>(Private) Institutions:</u></p> <ol style="list-style-type: none"> 1. Sacred Heart Hospital 2. Morning Light Wellness Center 3. Childcare Facilities 4. School Clubs 5. St. Joe Foundation 6. Churches 	<p><u>(Public) Institutions:</u></p> <ol style="list-style-type: none"> 1. FL Dept. of Health 2. ARC Transportation 3. University of Florida Extension Office 4. Sexual Assault Response Team (SART) 5. Law Enforcement 6. Schools/Colleges 7. Big Bend Community Based Care 8. Life Management Center 9. Chemical Addictions Recovery Effort (CARE) 10. Alcoholics Anonymous
<p><u>Other Category: Gov. Agencies/Depts.</u></p> <ol style="list-style-type: none"> 1. Center for Disease Control and Prevention (CDC) 	<p><u>Other Category: Ongoing Initiatives and Projects</u></p> <ol style="list-style-type: none"> 1. Protocol for Assessing Community Excellence in Environmental Health (PACE-EH)

Forces of Change

The second half of the Themes and Strengths and the Forces of Change Workshop centered on the forces of change that directly or indirectly affect the health of our community. These forces can be one-time only events, growing trends, or existing underlying factors. They are largely predictable but rarely controllable. Understanding these potential forces helps the community to reduce potential risk and, ultimately, improve its chances of reaching the shared vision.

In order to better aid the community members brainstorm the forces of change, participants were asked, “What is currently happening or could happen that would affect the health of our community?” A consensus workshop helped everyone to identify, categorize, and label the many forces of change. Participants identified and categorized forces of change into seven (7) major categories as shown on the following page:



Substance Use	Change in Funding to Provide Services	Access to Health-Related Resources
<ul style="list-style-type: none"> Increased drug use among youth and adults Increase in substance use The opioid/drug crisis 	<ul style="list-style-type: none"> Funding Funding decrease 	<ul style="list-style-type: none"> Mental health intervention Walk-in Clinic Access to healthcare Lack of after school programs
Environmental Factors	Lifestyle Education	Community Development
<ul style="list-style-type: none"> Natural disasters Preparing for natural disasters 	<ul style="list-style-type: none"> Chronic disease Stores to purchase healthy food options to reduce disease Access to physical activity Education on healthy lifestyle choices Water quality 	<ul style="list-style-type: none"> Unemployment and Low paying jobs Address developments from incoming companies Change in Economy Education Housing Affordable housing Employment and good paying jobs

Opportunities and Threats

Each of the seven (7) major forces of change categories creates various opportunities and/or poses various threats. Community members reviewed all of the forces of change and listed the potential threats and/or opportunities associated with the items. The list is intended to help communities better strategize the next steps towards achieving the shared vision.

Forces of Change Assessment		
Force of Change	Potential Opportunity	Potential Threat
Substance use	More resources/partners at the table	Stigma and access
Change in funding to provide services	Sustainability, knowing support in the community	Loss of services and jobs. Adverse effect on community health. Elections and voting.
Access to health-related resources	Healthier people, healthier families	Closing of facilities. Transportation Affordable healthcare
Environmental Factors	Increase awareness, to elevate priority level in community	Loss of hope/life/resources/homes (displacement is expensive and time consuming) Mental health (coping with disaster)
Lifestyle Education	Improved health decreased need for funding. Reaching diverse audiences	Lack of participation venues Lack of trust Community safety
Community Development	Jobs, stability, increase in income to afford housing. Impact built environmental	Forced relocation Job loss
Political Influence	Voting, more buy-in	Less buy-in Changes in platforms/support.

Community Health Status Assessment Workshop

The Community Health Status Assessment Workshop began with an in-depth review of data collected and analyzed throughout the process, including specific health status indicators and results of a Community Health Status Assessment Survey. The data review was followed by a decision matrix and ended with selection of health priorities. The workshop was held on November 14, 2019. Sixteen people consisting of residents and partners from various community organizations participated in this workshop.

Health Status Indicators

A review of health status assessments from the following organizations: Healthy People 2020, Community Commons, Florida CHARTS' County Health Profile, University of Wisconsin and 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 nearly 100 health status and demographic indicators were collected. For nearly one year, CHIP analyzed these health status indicators using County Health Ranking's model of population health as a framework. This model, depicted below, emphasizes that many factors, when addressed, can improve the overall health of a community.

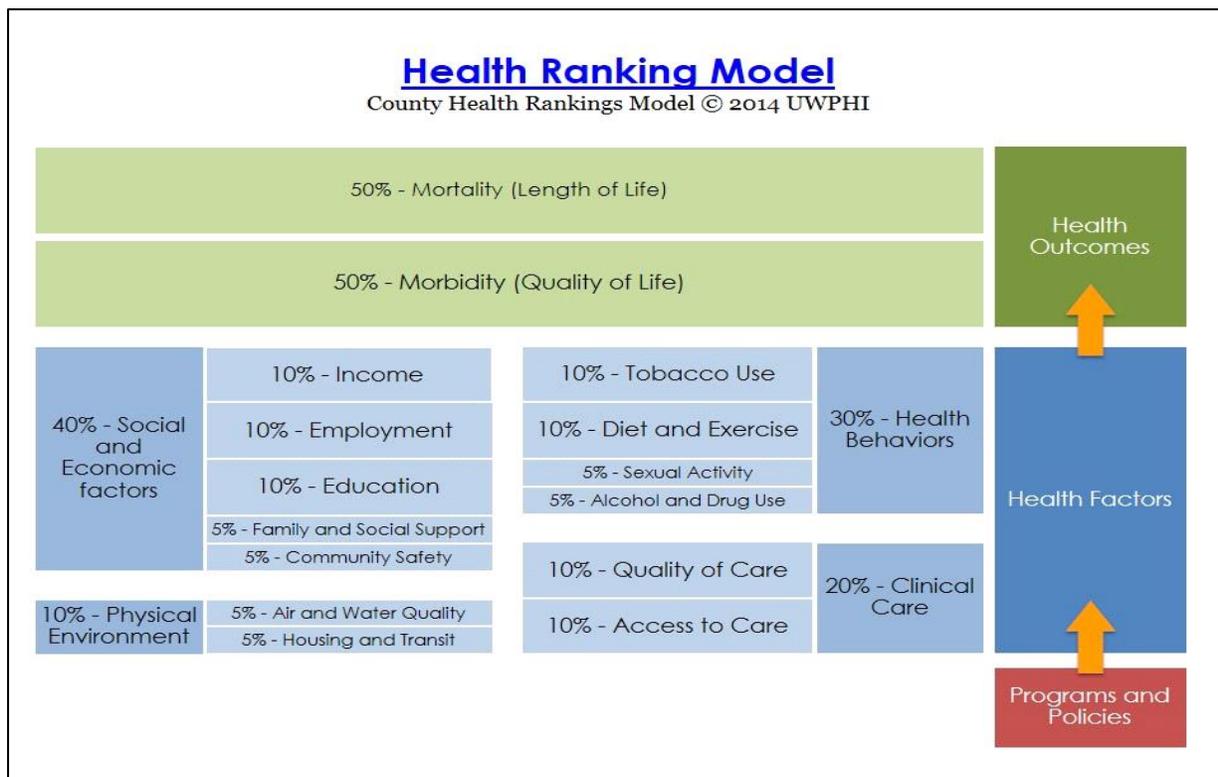
Framework for Analysis

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 annual Rankings provide a revealing snapshot of how health is influenced by where we live, learn, work and play. They provide a starting point for change in communities. This 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 genetics play 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 (see inset).
- **Programs and Policies** - Policies and programs at the 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, Health Outcomes are improved when Policies & Programs are in place to improve Health Factors.

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

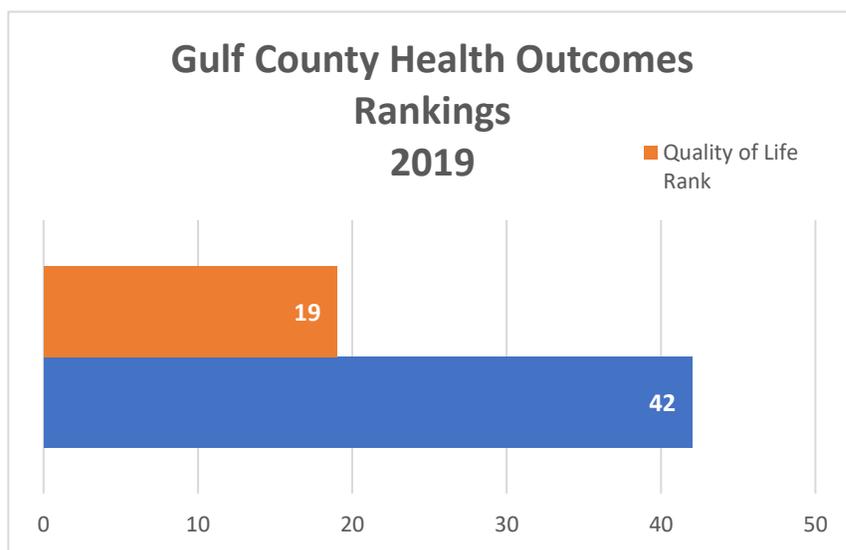
Research Service, Florida Department of Law Enforcement, US Census Bureau, Federal Bureau of Labor and Statistics, and US Department of Housing and Urban Development.

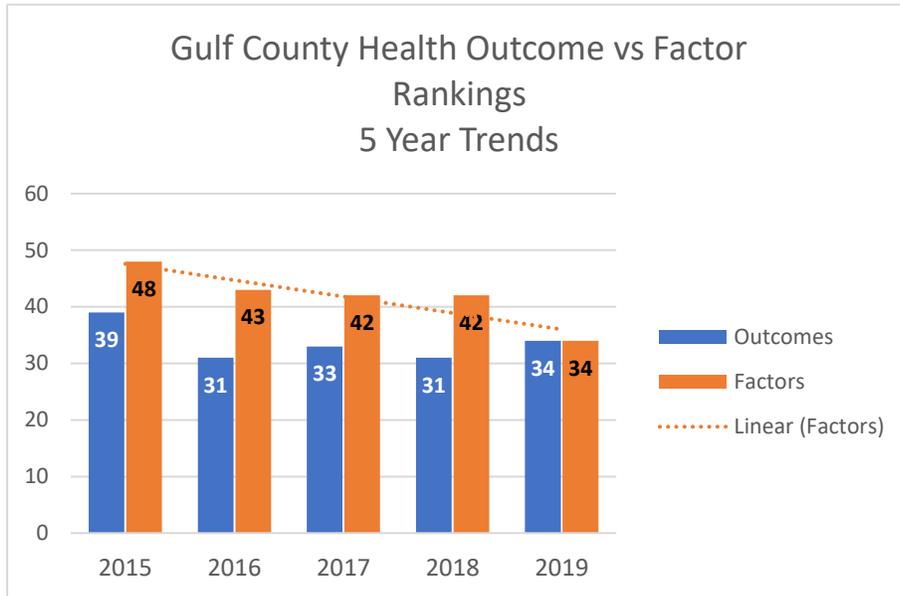


Over the course of the 12 months, local county data was gathered, analyzed, and review. In these small committee meetings, roughly 100 health indicators for Gulf County were compared and contrasted to those for the state and surrounding counties. Additionally, the data was also compared prior years’ results to highlight successes and opportunities for improvement.

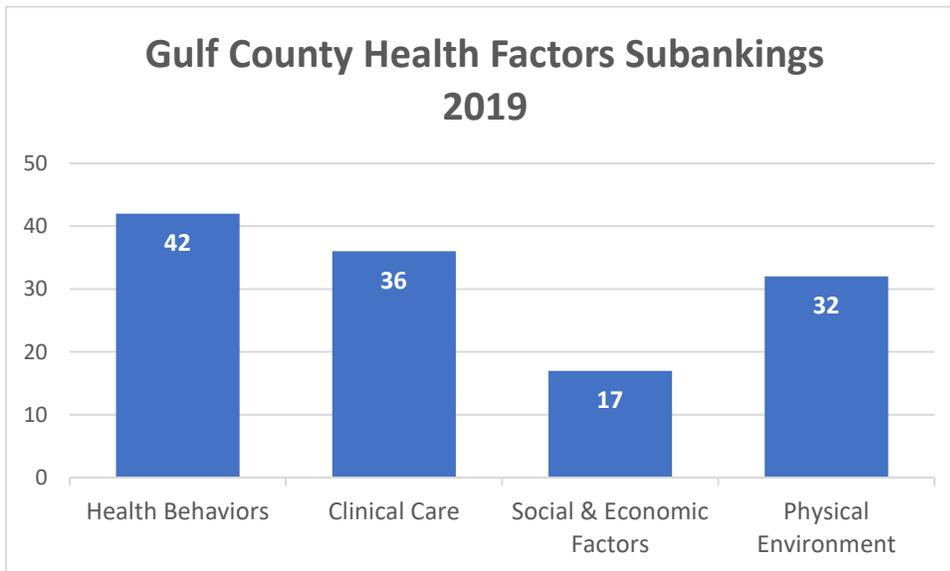
Summary of Findings

Gulf County ranked 19th and 42nd in quality of life (morbidity) and length of life (mortality) respectively. While overall health outcomes (comprised of 50% mortality and 50% morbidity) have remained fairly steady over the past half-decade, individual factors that influence health outcomes have seen a consistent improvement in rank since 2015.





Amongst the determinants influencing overall quality of life, social and economic factors appear to be a local strength, while personal health behaviors (obesity, smoking, diet, physical activity, etc.) ranked number 42. Local partners should consider exploring opportunities to improve the elements and conditions making up this factor.



For a complete listing of the County Health Rankings, visit https://www.countyhealthrankings.org/app/florida/2019/rankings/gulf/county/outcomes/overall/snaps_hot

Health Status Indicators

While some of the subfactors like the percent of low birthweight, environmental factors and housing demographics ranked better than their corresponding statewide averages, there appears to be much room for improvement in overall mortality/morbidity, personal behavior and clinical factors.

Chronic Disease Profile

The chronic disease profile provides local data on chronic diseases and related risk factors. The profiles describe the risk of chronic disease, including socioeconomic conditions, risk behaviors and conditions, preventive care utilization, and adult chronic disease incidence and/or prevalence. The diseases are ranked in quartiles. The quartiles allow you to compare your county's data with other counties. Indicators categorized in the first quartiles (green cells) have the most favorable results, while those within the 4th quartile (red cells) have the least favorable results. Many chronic diseases are also found to be in the top 10 leading causes of death.

Gulf County Chronic Disease Profile 2018					
Indicator	Measure	Year(s)	County (Percent or Rate)	County Quartile	State
Cardiovascular Disease					
Coronary Heart Disease					
Adults who have ever been told they had angina or coronary heart disease	Percent	2016	10.5%	4 th	4.7%
Heart Attack					
Adults who have ever been told they had a heart attack	Percent	2016	9%	3 rd	5.2%
Stroke					
Adults who have ever been told they had a stroke	Percent	2016	6%	3 rd	3.5%
Cancer					
Breast Cancer					
Incidence (new cases): Age-adjusted incidence rate per 100,000 total population	Per 100,000 Females	2014-16	122.0	3 rd	
Women 40 years of age and older who received a mammogram in the past year	Percent	2016	51.3%	1 st	60.8%
Cervical Cancer					
Incidence (new cases): Age-adjusted incidence rate per 100,000 total population	Per 100,000 Females	2014-16	14.7	4 th	
Women 18 years of age and older who received a Pap test in the past year	Percent	2016	37.8%	4 th	48.4%
Colorectal Cancer					
Incidence (new cases): Age-adjusted incidence rate per 100,000 total population	Per 100,000 Total Population	2014-16	48.2	4 th	36.4
Adults 50 years of age and older who received a sigmoidoscopy	Percent	2016	55.2%	2 nd	53.9%

or colonoscopy in the past five years					
Lung Cancer					
Incidence (new cases): Age-adjusted incidence rate per 100,000 total population	Per 100,000 Total Population	2014-16	70.0	3 rd	57.8
Melanoma					
Incidence (new cases): Age-adjusted incidence rate per 100,000 total population	Per 100,000 Total Population	2014-16	17.6	1 st	24.6
Prostate Cancer					
Incidence (new cases): Age-adjusted incidence rate per 100,000 total population	Per 100,000 Males	2014-16	55.7	1 st	
Men 50 years of age and older who received a PSA test in the past two years	Percent	2016	47.4%	1 st	54.9%
Diabetes					
Adults who have ever been told they had diabetes	Percent	2016	18.8%	4 th	11.8%
Respiratory Diseases					
Asthma					
Adults who currently have asthma	Percent	2016	9.6%	4 th	6.7%
Adults who have ever been told they had asthma	Percent	2016	12.4%	3 rd	11%
Chronic Lower Respiratory Diseases (CLRD)					
Hospitalizations: Age-adjusted hospitalization rate per 100,000 total population	Per 100,000 Total Population	2016-18	337.4	2 nd	334.6

Chronic Disease Risk and Protective Factors 2018					
Indicator	Measure	Year(s)	County (Percent or Rate)	County Quartile	State
Adults who are sedentary	Percent	2016	38.9%	3 rd	29.8%
Adults who are inactive or insufficiently active	Percent	2016	58.7%	3 rd	56.7%
Adults who meet aerobic recommendations	Percent	2016	42.5%	3 rd	44.8%
Adults who meet muscle strengthening recommendations	Percent	2016	27.4%	4 th	38.2%

Adults who are overweight	Percent	2016	33.7%	2 nd	35.8%
Adults who are obese	Percent	2016	34.9%	3 rd	27.4%
Adults who are at a healthy weight	Percent	2016	29.9%	3 rd	34.5%
Adults who are current smokers	Percent	2016	15.7%	2 nd	15.5%

Leading Causes of Death - Gulf County, Florida 2018						
#	Causes of Death	Deaths	Percent of Total Deaths	Crude Rate Per 100,000	Age-Adjusted Death Rate Per 100,000	YPLL < 75 Per 100,000 Under 75
	ALL CAUSES	197	100.00	1,213.4	869.6	10,365.5
1	Heart Disease	42	21.32	258.7	179.0	2,005.4
2	Cancer	39	19.80	240.2	157.3	1,703.6
3	Chronic Lower Respiratory Disease	24	12.18	147.8	92.2	509.7
4	Unintentional Injury	10	5.08	61.6	50.5	1,294.4
5	Stroke	10	5.08	61.6	45.0	409.1
6	Alzheimer's Disease	10	5.08	61.6	45.6	0.0
7	Chronic Liver Disease And Cirrhosis	5	2.54	30.8	18.9	348.8
8	Diabetes	5	2.54	30.8	19.9	194.5
9	Hypertension	4	2.03	24.6	18.0	214.6
10	Suicide	3	1.52	18.5	15.8	342.1

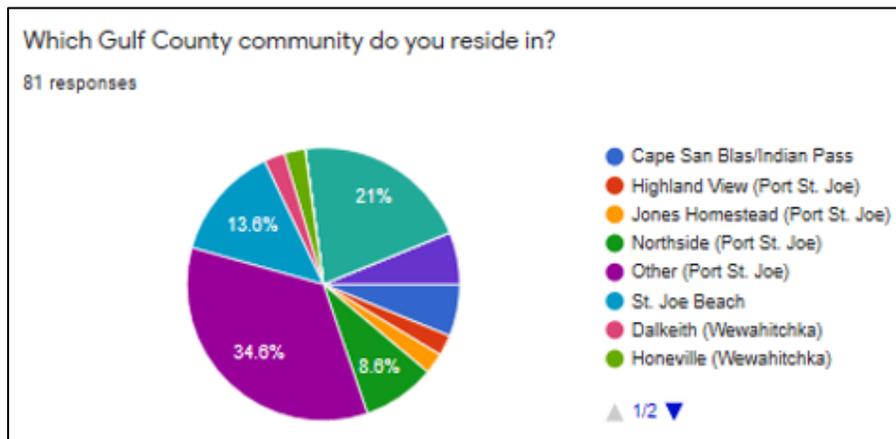
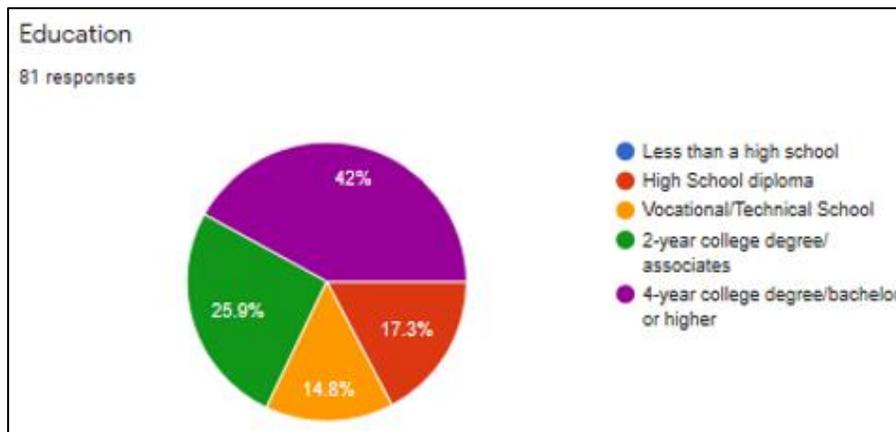
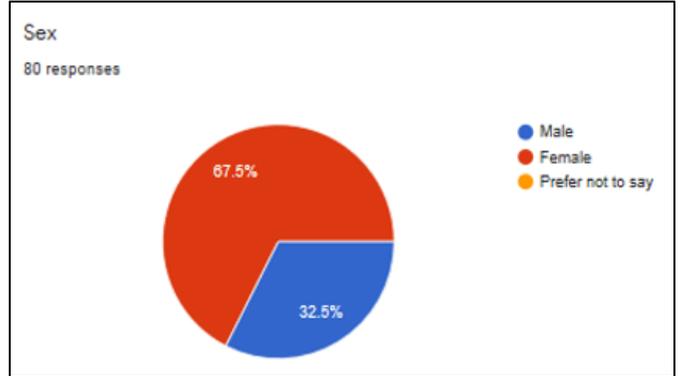
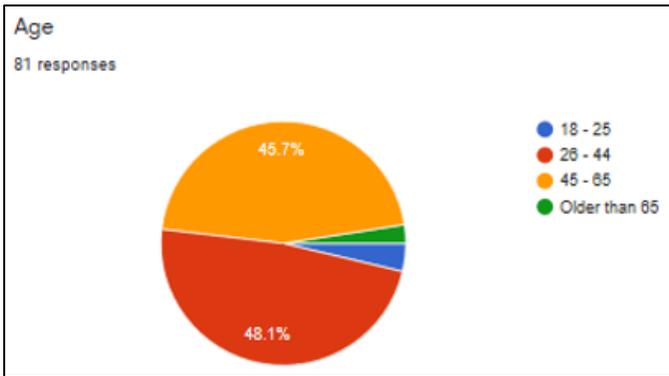
Source: Florida Department of Health, Bureau of Vital Statistics

Community Health Status Assessment Survey

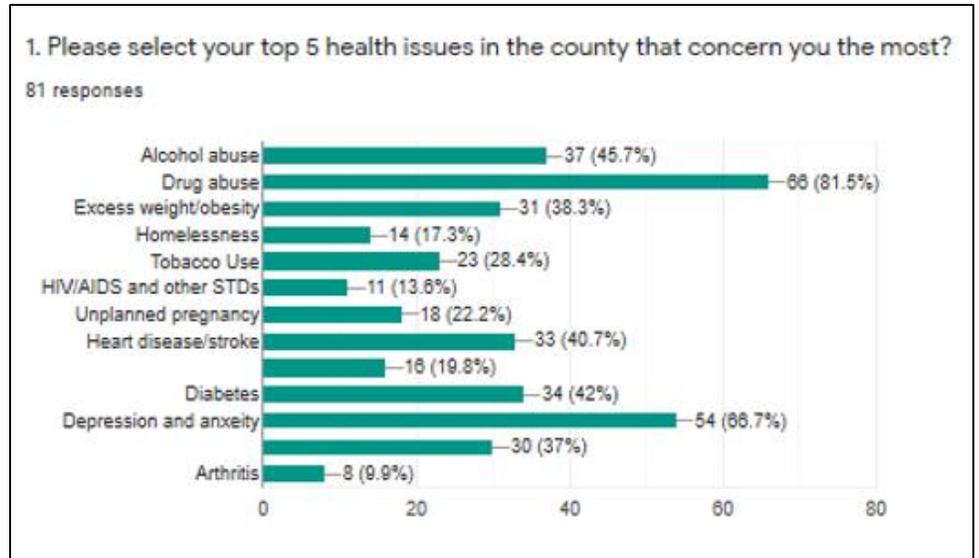
From February to mid-April the CHIP distributed a Community Health Status Assessment Survey, both on-line and in paper format at festivals, community gatherings, partner offices and the local health department clinic lobby. The survey asked 12 questions ranging from health-related opinions, ideas, the community quality of life, statistics, and basic demographic information. In order to reduce health outcome gaps and disparities, the survey was distributed to the general population and specifically within communities with highly vulnerable populations. CHIP members identified and distributed paper surveys to key populations based on geography, income, and race. In some cases, volunteers were made available to assist in completion of the survey.

A copy of CHSA survey is provided in Attachment D.

Survey Results



Residents were asked to pick their top five concerns within the community from a broad bank of pre-listed responses. Drug abuse, depression and anxiety, alcohol abuse, and diabetes were the most commonly reported health concerns overall.



Results from multiple communities were extracted from the survey. These communities included residents with less than a 4-year degree, residents from the northern end of the county (Wewahitchka, White City and surrounding areas), residents from the southern end of the county (Port St. Joe and surrounding areas) and residents experiencing difficulties in paying their bills. While all the communities showed some variation in the top five health issues, all four of them had drug abuse and/or depression & anxiety as their top two concerns.

Top 5 Health Issues Identified By Residents Experiencing Difficulties in Paying Their Bills		
#	Leading Issues	Total
1	Drug Abuse	73.3%
2	Depression and Anxiety	53.3%
3	Heart Disease/Stroke	50.0%
4	High Cholesterol/High Blood Pressure	46.7%
5	Alcohol Abuse	43.3%

Top 5 Health Issues Identified By Residents w/ Less Than a 4yr College Degree		
#	Leading Issues	Total
1	Drug Abuse	74.5%
2	Depression & Anxiety	63.8%
3	Heart Disease/Stroke	44.7%
3	Alcohol Abuse	44.7%
4	Diabetes	40.4%
4	High Cholesterol/High Blood Pressure	40.4%

Top 5 Health Issues Identified By Residents In Northern Gulf County (Wewa, White City & Surrounding Areas)		
#	Leading Issues	Total
1	Depression & Anxiety	70.0%
2	Alcohol Abuse	50.0%
2	Drug Abuse	50.0%
3	Diabetes	40.0%
4	Excess Weight/Obesity	35.0%
4	Tobacco Use	35.0%

Top 5 Health Issues Identified By Residents Southern Gulf County (Port St. Joe & Surrounding Areas)		
#	Leading Issues	Total
1	Drug Abuse	76.7%
2	Depression & Anxiety	63.3%
3	High Cholesterol/High Blood Pressure	45.0%
4	Alcohol Abuse	45.0%
5	Heart Disease/Stroke	43.3%

Additional concerns with the county were led by abandoned/rundown structures, affordable housing, drug activity and lack of jobs. The majority of the 81 respondents have seen a doctor within the last year, while slight over 12% hasn't had a wellness exam or routine check-up for more than one year.

Protocol for Assessing Community Excellence in Environmental Health Survey

From December 2018 to late February 2019 the Protocol for Assessing Community Excellence in Environmental Health (PACE-EH) Taskforce distributed a survey to assess the health and quality of life via the built environment in the Northside Port St. Joe community. The task force distributed the survey by going door-to-door, passing them out during church services, and providing them at vendor booths during local events and festivals.

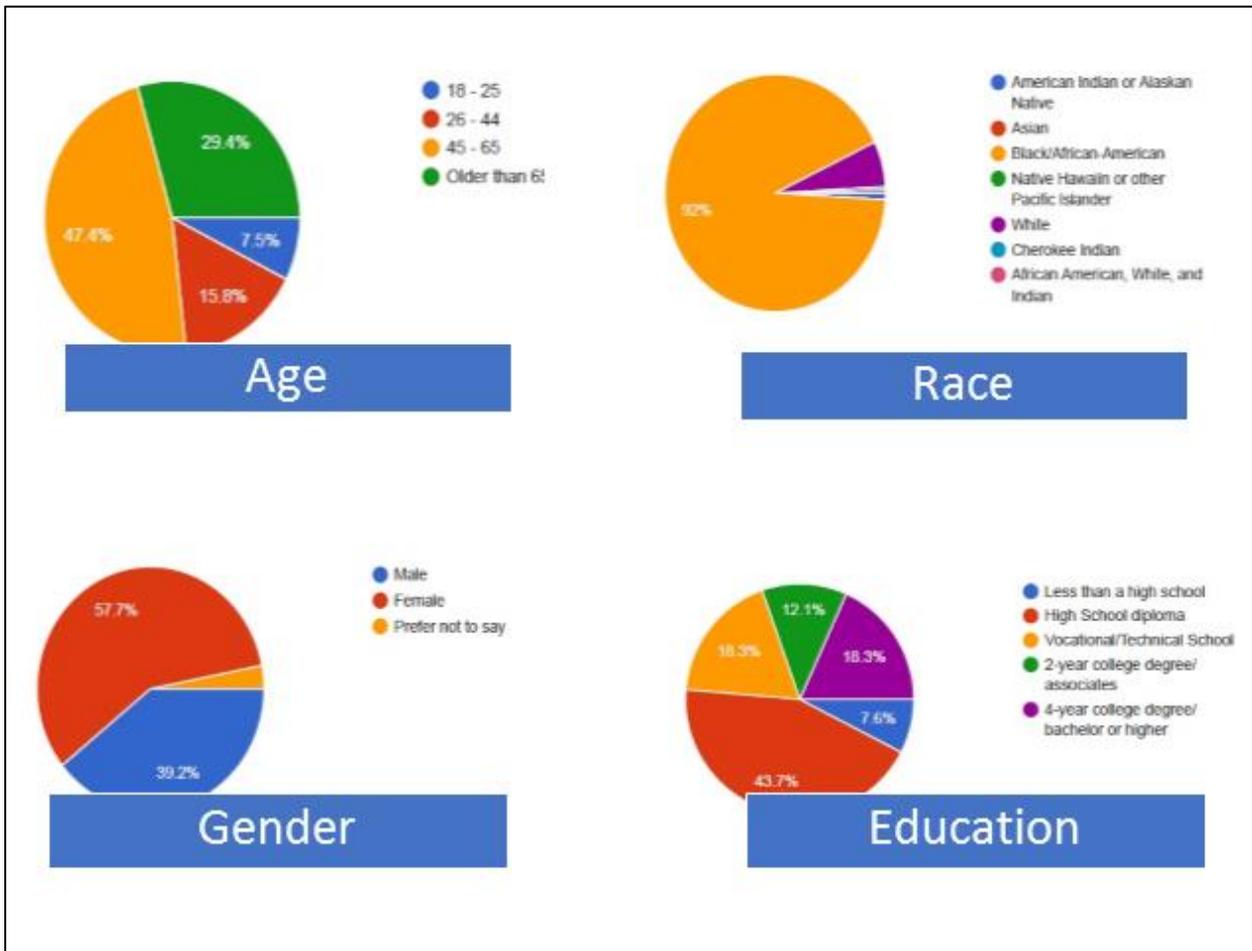


In total around 161 households were reached through this survey (229 individuals). The taskforce used GIS mapping and a tracking system to identify which houses had completed surveys and which streets were incomplete.

The PACE-EH survey asked 11 questions ranging neighborhood health and safety concerns, basic demographic information and the impact of Hurricane Michael within the community.

A copy of the PACE-EH surveys is provided in Attachment D.

PACE-EH Survey Result

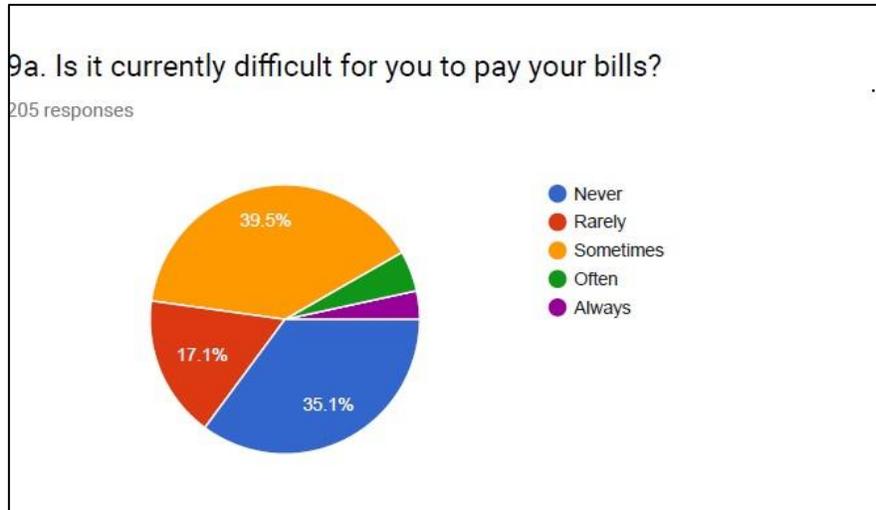


While the overwhelming majority of the 229 respondents were middle aged, black women with a high school diploma or higher, survey data shows a vast array of representation amongst the community participants.

Residents were asked to pick their top five concerns within the community from a broad bank of pre-listed responses.

Over half of all those surveys believe that abandoned and rundown structures, affordable housing and lack of jobs are the most pressing concerns within the North Port St. Joe community. In a follow up townhall meeting, community members in attendance selected the top three concerns as their priorities and through follow up meetings created action plans to address the respective priorities.

#2. Please select your top 5 concerns in North Port St. Joe		
Rank	Response	Percentage
1	Abandoned & Rundown Structures	58.7%
2	Affordable Housing	54.2%
3	Lack of Jobs	52.9%
4	Affordable, Safe, Clean Water	38.2%
5	Rundown Vacant Lots	35.6%
6	Drug Activity	34.7%
7	Not Enough Minority Educators	31.6%
8	Lack of Services/Community Centers for Youth or Seniors	30.2%
9	Limited Job Training	29.3%
10	Poor Road Conditions	27.1%



Question nine inquired about the respondent's ability to financially support him or herself. The findings indicate that approximately 65% of community residents rarely to always experienced some difficulty in paying their bills.

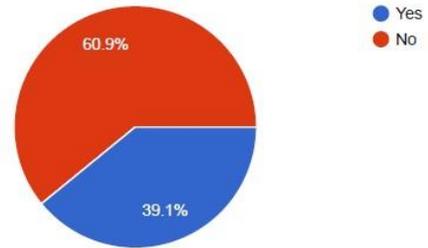
In some cases, we found this hardship was the effect of Hurricane Michael, a Category 5 storm that hit the Gulf Coast in September 2018. Much of the community is still trying to recover from the catastrophic effects of the storm.

In addition to financial security being affected by Hurricane Michael, housing stability was also greatly affected. As a result, many homes experienced a great deal of damage that lead to costly repairs for an already vulnerable community.

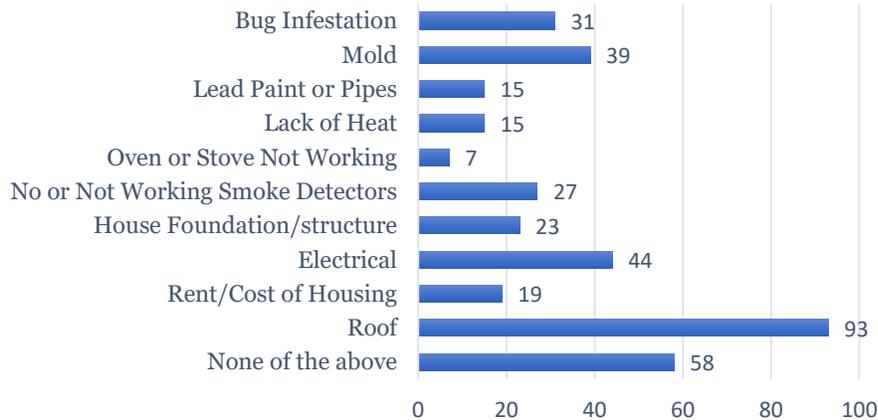
When asked about the health and safety of their housing condition, 93 of the 201 respondents shared that they had roof problems, while 44 and 39 respondents experienced electrical issues and mold problems.

9b. If so, was this a result of the storm?

110 responses



#3. Think about the place you live right now. Do you have any problems with any of the following? (Check all that apply.)

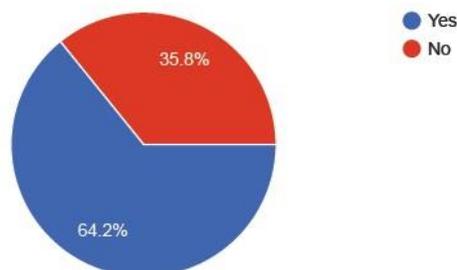


More than 2/3 of the problems identified were due to Hurricane Michael.

For a complete listing of the survey results see Appendix D.

4. Were any of these problems a result of the storm?

201 responses



Community Assessment for Public Health Emergency Response (CASPER)

The Community Assessment for Public Health Emergency Response or CASPER is an epidemiologic technique designed to provide public health leaders and emergency managers household-based information about a community. It is quick, reliable, relatively inexpensive, and flexible. CASPER uses valid statistical methods to gather information and can be conducted throughout the disaster cycle (preparedness, response, recovery, mitigation) and in non-disaster situations. The information generated can be used to initiate public health action; identify information gaps; facilitate disaster planning, response and recovery activities; allocate resources; and assess new or changing needs in the community². The modified cluster sampling methodology used for CASPER involves two-stages and provides estimates for the population. In 2009, the Centers for Disease Control and Prevention (CDC) developed the CASPER Toolkit to standardize the assessment methodology and provided a CASPER guidance document for public health practitioners and emergency management officials³.

For three days in November 2019, volunteers from the state and within the county distributed a CASPER survey to randomized groups in various neighborhoods. During a disaster response, CASPER provides situational awareness about the community decision-makers. CASPER can confirm rumors or anecdotal reports, identify immediate needs in the community (e.g., food, water, medication), provide estimates on the scope and magnitude of the needs, and help establish priorities. In non-disaster situations, CASPER can also determine current health status; assess public health perceptions; estimate community awareness, opinions, and concerns regarding the impact.

CASPER Survey Results

The CASPER assessment that occurred in Gulf County in 2019 included 4 CDC-sampled clusters (26 interviews) and 4 additional clusters (32 interviews), for a total of 58 completed interviews.

Of all those surveyed in Gulf County, this included 45 (77.6%) single family homes, 8 (13.8%) mobile homes, 1 (1.7%) multiple unit structure, and 4 (6.9%) RVs/travel trailers. The average household size was 2.3 individuals (range: 1-7), including an average of 1.8 individuals 18 years and older (range: 1-5) and 0.5 individuals under the age of 18 (range: 0-4) per household. The majority of households were owned (46, 79.3%) by their occupants. Most reported no change in combined household income in the past 12 months (58.6%), while just over one-fourth (25.9%) reported a decrease.

In response to Hurricane Michael, 56.9% of respondents reported that their homes were damaged during the hurricane but repairable, while 32.8% reported minimal to no damage and 10.3% reported their homes were destroyed. In total, 86.2% reported that their home feels safe to live in, with 10.3% reporting that their home does not feel safe.

Very little impact was reported on post-hurricane employment issues, from these specific sample clusters.

² CASPER Methodology Overview. Available at <https://www.cdc.gov/nceh/hsb/disaster/casper/overview.htm>

³ CASPER Toolkit. Available at https://www.cdc.gov/nceh/hsb/disaster/casper/docs/CASPER-toolkit-3_508.pdf

While a variety of illnesses were reported, the most common post-hurricane new illnesses reported included anxiety, allergies, depression, cough and asthma/COPD/respiratory difficulties with 39.6% of responders reported trouble sleeping/nightmares for themselves or someone in the household. See Table 8 for more details.

For the complete Gulf County CASPER Preliminary results see Attachment D.

Table 8. New or Worsening Illnesses Since Hurricane Michael		
	Frequency	Percent
Since the storm, has anybody in your household experienced:		
Rash	4	6.90
Nausea	8	13.79
Diarrhea	5	8.62
Cough	19	32.76
Fever	6	10.34
Red eyes	7	12.07
Allergies	28	48.28
Asthma/COPD/respiratory difficulties	23	39.66
Anxiety	28	48.28
Depression	21	36.21
Since Hurricane Michael, have you or any members of your household experienced worsening of:		
Asthma/COPD/respiratory complications	11	18.97
Allergies	17	29.31
Diabetes	3	5.17
Hypertension	13	22.41
Anxiety	22	37.93
Insomnia	15	25.86
Poor appetite	7	12.07
Fatigue	20	34.48
Depression	17	29.31
Since the storm, have you or members of your household had:		
Difficulty concentrating	17	29.31
Trouble sleeping/nightmares	23	39.66
Loss of appetite	10	17.24
Agitated behaviors	14	24.14
Personally, witness violent behaviors/threats	5	8.62
Increased alcohol consumption	3	5.17
Increased drug use	0	0.00

Community Health Priority Selection

Priority Setting Process

Prioritization of the community health issues was a multi-step process that included:

- Review and discussion of all of the top health concerns and associated indicator data.
- Identification and discussion of consequences to the community of not addressing the issue.
- Consideration of key criteria for impacting change.

During the final workshop, participants identified and discussed responses to the question: “What are the consequences of not addressing this concern/issue?” The table below reflects the participants’ collective responses.

“What are the consequences of not addressing this concern/issue”?				
Access to Care	Mental Health	Obesity Related	Substance Abuse	Tobacco Use
<ul style="list-style-type: none"> • Shortages of services • Inability to work • Premature death • Mental health • Unused grant money • Impaired dental health among others 	<ul style="list-style-type: none"> • Increased substance abuse • Increase in family instability • Increased financial issues • Lack of self esteem 	<ul style="list-style-type: none"> • Increased cardiac disease • Adolescent issues • Bullying • Continued generation 	<ul style="list-style-type: none"> • Death from overdose • False perceptions • Poverty • Domestic violence • Economic instability • Educational struggles for youth 	<ul style="list-style-type: none"> • Cancers • Increased healthcare cost • Reduction in County growth/population • Secondhand smoke impact

As part of the workshop, participants also sought to align prioritization of health issues in the County with the recently adopted shared vision: “Working together to empower Gulf County to improve quality of life for generations to come.” Participants agreed that, in order to achieve the shared vision, community partners must address disparities and that, doing so will help participants identify and implement ways for everyone to have a fair chance to lead the healthiest life possible.

Participants discussed the CHIP’s role of improving health equity and disparities and their impact on community health. Participants reflected on the fact that addressing disparity is often linked to creating and encouraging equity (race, ethnicity, age, income, education, and being able-bodied). However, participants discussed the fact that identifying the disparities within a community is not just about equality and giving everyone a level playing field anymore because still not everyone has the means and opportunity to be their healthiest.

Detailed participant commentary and results of the Community Health Status Assessment Workshop are provided in Attachment D.

Priority Selection Matrix

To better prioritize the identified areas of concern, the workshop participants examined and discussed the health issues based on key criteria that provided the best opportunity for creating change and achieving our shared vision. The issues were then weighted based on participant input.

The top priority health issues identified for Gulf County were:

- Strategic Issue #1: Mental Health/Substance Abuse
- Strategic Issue #2: Access to Care
- Strategic Issue #3: Physical Activity
- Strategic Issue #4: Socioeconomic Enhancements



Community Health Priority Areas

Mental Health/Substance Abuse

Mental Health

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental illness is the term that refers, collectively, to all diagnosable mental disorders.

Mental disorders contribute to a host of problems that may include disability, pain, or death. Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases. In addition, mental health and physical health is closely connected. Mental health plays a major role in people's ability to maintain good physical health and participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

In Gulf County, 66.7 % of respondents to the Community Health Status Assessment survey indicated that they felt that mental health problems were one of the most important health issues facing the County.

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.

In Gulf County, 81.5% of respondents to the Community Health Status Assessment survey indicated that they felt that drug abuse was one of the most important health issues facing the County, with alcohol abuse at 45.7%.

Access to Care

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. Access to health care impacts:

- Overall physical, social, and mental health status
- Prevention of disease and disability
- Preventable hospitalization
- Detection and treatment of health conditions
- Quality of life
- Preventable death
- Life expectancy

Physical Activity

Obesity is common, serious, and costly. Physical activity is a major component of a healthy lifestyle. Maintaining an active lifestyle can have a positive impact on general health plus is related to stress reduction, increase in energy, and enhanced concentration and sleep. Currently, only 36 percent of Floridians are at a healthy weight. According to the Florida Department of Health, heart disease accounts for approximately 1 in 3 deaths in Florida.

In Gulf County, excess weight and obesity is a major problem. In most of the indicator categories directly related to physical activity, Gulf County performs substantially worse than the State overall. In addition, despite the beautiful surroundings, Gulf County residents are far less active than residents of the State overall. A lack of proper eating and exercise habits contribute to making excess weight and obesity a major health issue in Gulf County.

In Gulf County, many of the identified health issues fall into this priority area of Physical Activity. For instance, 42% of respondents to the Community Health Status Assessment survey indicated that they felt diabetes was one of the most important health issues facing the County, with excessive weight/obesity at 38.3% and heart disease and stroke at 40.7%.

Socioeconomic Enhancements

Recent public health efforts have identified a broader range of conditions affecting health, including community design, housing, employment, access to health care, access to healthy foods, environmental pollutants, and occupational safety⁴. It is understood that unfair distribution of these conditions across various populations is a significant contributor to persistent and pervasive health disparities. With the goal of improving the health of Gulf County, unique community partners needed to be included in the conversation of health equity to truly make an impact.

⁴ Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health. Available at <https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/SDOH-workbook.pdf>

As mentioned previously in this report, since 2018, Gulf County partners and the Department of Health have initiated a PACE-EH project in North Port St Joe, an underserved neighborhood in Gulf County. Around the same time PACE-EH project implementation, category five Hurricane Michael made landfall, impacting the entire county, including North Port St. Joe.

Following Hurricane Michael impact and PACE-EH project implementation, many civic groups and organizations have joined together to take on the long-term recovery efforts needed in Gulf County. State initiated surveying, such as CASPER, as well as local efforts have helped identify the needs of Gulf County with a unique health equity lens. This lens allows the CHIP partners to review critical needs such as housing, job opportunity, childcare, job training, and so much more.

In Gulf County, many of the identified health issues fall into this priority area of socioeconomic enhancements. For instance, 31% of children under the age of 18 live in poverty compared to the states average of 11%. In addition, 45% of respondents to the Community Health Status Assessment indicated that they felt affordable housing was one of the most critical concerns facing the County, with run down structures at 64%, lack of jobs at 32% and homelessness at 17%.

Attachment A

Health Outcomes						
Focus Area	Measure	Description	Weight	Source	Year(s)	
Length of life (50%)	Premature death	Years of potential life lost before age 75 per 100,000 population	50%	National Center for Health Statistics – Mortality files	2015-2017	
	Quality of life (50%)	Poor or fair health	% of adults reporting fair or poor health	10%	Behavioral Risk Factor Surveillance System	2016
		Poor physical health days	Average # of physically unhealthy days reported in past 30 days	10%	Behavioral Risk Factor Surveillance System	2016
		Poor mental health days	Average # of mentally unhealthy days reported in past 30 days	10%	Behavioral Risk Factor Surveillance System	2016
	Low birthweight	% of live births with low birthweight (< 2500 grams)	20%	National Center for Health Statistics – Natality files	2011-2017	
Health Behaviors (30%)						
Focus Area	Measure	Description	Weight	Source	Year(s)	
Tobacco use (10%)	Adult smoking	% of adults who are current smokers	10%	Behavioral Risk Factor Surveillance System	2016	
Diet and exercise (10%)	Adult obesity	% of adults that report a BMI ≥ 30	5%	CDC Diabetes Interactive Atlas	2015	
	Food environment index	Index of factors that contribute to a healthy food environment, (0-10)	2%	USDA Food Environment Atlas, Map the Meal Gap	2015 & 2016	
	Physical inactivity	% of adults aged 20 and over reporting no leisure-time physical activity	2%	CDC Diabetes Interactive Atlas	2015	
	Access to exercise opportunities	% of population with adequate access to locations for physical activity	1%	Business Analyst, Delorme map data, ESRI, & U.S. Census Files	2010 & 2018	
Alcohol and drug use (5%)	Excessive drinking	% of adults reporting binge or heavy drinking	2.5%	Behavioral Risk Factor Surveillance System	2016	
	Alcohol-impaired driving deaths	% of driving deaths with alcohol involvement	2.5%	Fatality Analysis Reporting System	2013-2017	
Sexual activity (5%)	Sexually transmitted infections	# of newly diagnosed chlamydia cases per 100,000 population	2.5%	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2016	
	Teen births	# of births per 1,000 female population ages 15-19	2.5%	National Center for Health Statistics – Natality files	2011-2017	
Clinical Care (20%)						
Focus Area	Measure	Description	Weight	Source	Year(s)	
Access to care (10%)	Uninsured	% of population under age 65 without health insurance	5%	Small Area Health Insurance Estimates	2016	
	Primary care physicians	Ratio of population to primary care physicians	3%	Area Health Resource File/American Medical Association	2016	
	Dentists	Ratio of population to dentists	1%	Area Health Resource File/National Provider Identification file	2017	
	Mental health providers	Ratio of population to mental health providers	1%	CMS, National Provider Identification file	2018	
Quality of care (10%)	Preventable hospital stays	# of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees	5%	Mapping Medicare Disparities Tool	2016	
	Mammography screening	% of female Medicare enrollees ages 65-74 that receive mammography screening	2.5%	Mapping Medicare Disparities Tool	2016	
	Flu vaccinations	% of Medicare enrollees who receive an influenza vaccination	2.5%	Mapping Medicare Disparities Tool	2016	
Social and Economic Environment (40%)						
Focus Area	Measure	Description	Weight	Source	Year(s)	
Education (10%)	High school graduation	% of ninth-grade cohort that graduates in four years	5%	State-specific sources & EDfacts	Varies	
	Some college	% of adults ages 25-44 with some post-secondary education	5%	American Community Survey	2013-2017	
Employment (10%)	Unemployment	% of population aged 16 and older unemployed but seeking work	10%	Bureau of Labor Statistics	2017	
Income (10%)	Children in poverty	% of children under age 18 in poverty	7.5%	Small Area Income and Poverty Estimates	2017	
	Income inequality	Ratio of household income at the 80th percentile to income at the 20th percentile	2.5%	American Community Survey	2013-2017	
Family and social support (5%)	Children in single-parent households	% of children that live in a household headed by a single parent	2.5%	American Community Survey	2013-2017	
	Social associations	# of membership associations per 10,000 population	2.5%	County Business Patterns	2016	
Community safety (5%)	Violent crime	# of reported violent crime offenses per 100,000 population	2.5%	Uniform Crime Reporting – FBI	2014 & 2016	
	Injury deaths	# of deaths due to injury per 100,000 population	2.5%	CDC WONDER mortality data	2013-2017	
Physical Environment (10%)						
Focus Area	Measure	Description	Weight	Source	Year(s)	
Air and water quality (5%)	Air pollution - particulate matter ¹	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	2.5%	Environmental Public Health Tracking Network	2014	
	Drinking water violations	Indicator of the presence of health-related drinking water violations. Yes - indicates the presence of a violation, No - indicates no violation.	2.5%	Safe Drinking Water Information System	2017	
Housing and transit (5%)	Severe housing problems	% of households with overcrowding, high housing costs, or lack of kitchen or plumbing facilities	2%	Comprehensive Housing Affordability Strategy (CHAS) data	2011-2015	
	Driving alone to work	% of workforce that drives alone to work	2%	American Community Survey	2013-2017	
	Long commute - driving alone	Among workers who commute in their car alone, % commuting > 30 minutes	1%	American Community Survey	2013-2017	

Health Outcomes				
Indicator Category	Indicator	Gulf County	Florida	Top U.S. Performers
Length of life	Years of potential life lost before age 75 per 100,000 population (age-adjusted)	9,000	7,200	5,400
Quality of life	Percentage of adults reporting fair or poor health (age-adjusted)	21%	19%	12%
Quality of life	Average number of physically unhealthy days reported in past 30 days (age-adjusted)	4.7	3.8	3.0
Quality of life	Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	3.9	3.8	3.1
Quality of life	Percentage of live births with low birthweight (< 2500 grams)	7%	9%	6%

Health Factors – Health Behaviors				
Indicator Category	Indicator	Gulf County	Florida	Top U.S. Performers
Adult smoking	Percentage of adults who are current smokers	18%	15%	14%
Adult obesity	Percentage of adults that report a BMI of 30 or more	36%	27%	26%
Food environment index	Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	7.2	6.9	8.7
Physical inactivity	Percentage of adults age 20 and over reporting no leisure-time physical activity	34%	25%	19%
Access to exercise opportunities	Percentage of population with adequate access to locations for physical activity	54%	88%	91%
Excessive drinking	Percentage of adults reporting binge or heavy drinking	22%	18%	13%
Alcohol-impaired driving deaths	Percentage of driving deaths with alcohol involvement	25%	25%	13%
Sexually transmitted infections	Number of newly diagnosed chlamydia cases per 100,000 population	270.9	467.4	152.8
Teen births	Number of births per 1,000 female population ages 15-19	37	23	14

Health Factors – Clinical Care				
Indicator Category	Indicator	Gulf County	Florida	Top U.S. Performers
Uninsured	Percentage of population under age 65 without health insurance	13%	15%	6%
Primary care physicians	Ratio of population to primary care physicians	2,280:1	1,390:1	1,050:1
Dentists	Ratio of population to dentists	8,080:1	1,700:1	1,260:1
Mental health providers	Ratio of population to mental health providers	1,800:1	670:1	310:1
Preventable hospital stays	Number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	5,043	5,066	2,765
Mammography screening	Percentage of female Medicare enrollees ages 67-69 that receive mammography screening	33%	42%	49%

Health Factors – Social and Economic Environment				
Indicator Category	Indicator	Gulf County	Florida	Top U.S. Performers
High school graduation	Percentage of ninth-grade cohort that graduates in four years	85%	96%	82%
Some college	Percentage of adults ages 25-44 with some post-secondary education	49%	73%	62%
Unemployment	Percentage of population ages 16 and older unemployed but seeking work	3.9%	2.9%	4.2%
Children in poverty	Percentage of children under age 18 in poverty	31%	11%	21%
Income inequality	Ratio of household income at the 80th percentile to income at the 20th percentile	4.4	3.7	4.7
Children in single-parent households	Percentage of children that live in a household headed by single parent	31%	20%	38%
Social associations	Number of membership associations per 10,000 population	15.6	21.9	7.1
Violent crime	Number of reported violent crime offenses per 100,000 population	392	484	63
Injury deaths	Number of deaths due to injury per 100,000 population	70	76	57

Health Factors – Physical Environment				
Indicator Category	Indicator	Gulf County	Florida	Top U.S. Performers
Air pollution - particulate matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	9.1	6.1	8.2
Severe housing problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities	18%	9%	21%
Driving alone to work	Percentage of the workforce that drives alone to work	71%	72%	79%
Long commute - driving alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes	32%	15%	40%

Attachment B



**Florida Department of Health in Gulf County
Gulf County Community Health Assessment Workshop
DOH-Gulf Large Conference Room
Tuesday, August 14, 2018 9:00a.m. – 12:00p.m. EST**

MINUTES

Purpose: *Solicit input from the community on the MAPP vision and local public health system assessment through open dialogue.*

Topic	Discussion
<p>Welcome/Call to Order</p> <ul style="list-style-type: none"> ▪ Introductions ▪ Brief review of agenda ▪ Prompt attendees to sign-in 	<p>DT Simmons, DOH-Gulf/Franklin CHA facilitator welcomed all partners. Suzy Nadler of the Healthy Start Coalition was initially suppose open the meeting but she was unable to attend the meeting. Ms. Simmons kicked off the introductions asking participants to state their name, organization, and an animal that they'd like to be. After overiewing the agenda and encouraging everyone to sign in, Ms. Simmons reminded everyone of the current CHIP cycle priorities.</p>
<p>Status Update of Previous Actions</p> <ul style="list-style-type: none"> ▪ CHIP Progress Report Highlights ▪ How are our partners enhancing health for all those who live work and play in Gulf County? <ol style="list-style-type: none"> 1. CTG – Healthy Weight 2. North Florida Medical – Diabetes Management 3. AHEC – Access To Care 4. Morning Light – Mental Health/Substance Abuse 	<p>Deanna “DT” Simmons, DOH-Gulf/Franklin CHA Coordinator facilitated the meeting. She opened by reviewing the highlights of the CHIP Progress Report and told the attendees to write their name and email on the evaluation at the end of the meeting if they wished to receive an electronic copy of the most recent progress reports.</p> <p>In order to highlight the success our partners have had in helping make Gulf County the healthiest county in the nation, the facilitator asked several organizations to share their experience as they work to address the goals/priorities of the current CHIP cycle (2016-19).</p> <p>Alma Pugh and Talitha Robinson of the Closing the Gap program talked about their previous engagements working with the local faith-based community to promote healthy eating and physical activity among minorities in order to reduce the disparities in obesity and chronic disease. Talitha shared that Currently the group is working with youth using the CATCH curriculum.</p> <p>Katrina Saunders of Wewa Medical Center shared that their new Diabetes initiatives and data on how many patients they've served.</p> <p>AHEC was not able to attend the meeting so, DT Simmons shared briefly on the Quitline and tobacco cessation services. She also encouraged partners to provide referrals to their clients who want help breaking their tobacco addiction.</p>

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MINUTES

	<p>Lastly Chuck Coker, newly hired director of Morning Light Wellness Center, introduced himself to the partnership again and shared information on the MLWC resources and services. Mr. Coker also had brochures for the group.</p>
<p>What is MAPP? On the Road-MAPP for Community Health Assessment (CHA)?</p>	<p>DT Simmons, gave a high-level overview of the Mobilizing for Action through Planning and Partnerships (MAPP) process, stressing that this is a community-driven process that focuses on strategic approaches to addressing identified selected priorities.</p>
<p>Introduce Topic: Community Health Assessment - Mobilizing for Action through Planning and Partnerships Workshop: <ol style="list-style-type: none"> 1. Visioning a healthier community together 2. Local Public Health System Assessment process </p>	<p>DT Simmons, introduced the second step in the MAPP process to the group. She detailed the concept of collective or shared visioning with the partnership, followed by defining health and the local public health system (LPHS). She informed the group that today they would be creating a vision to guide them throughout this MAPP process and ultimately throughout the future Community Health Improvement Plan for 2019-2022. Additionally, she shared with the group that they would also be assessing the effectiveness and efficiency of LPHS.</p>
<p>Discuss Supporting Information:</p> <ul style="list-style-type: none"> ▪ Vision – Meghalaya’s Living Bridge ▪ Local Public Health System Assessment 	<p>To get the participants minds thinking about the significance vision plays in community planning DT Simmons, played the mini documentary film “Meghalaya’s Living Bridge” for the partners. Following the short video, the group engaged in a focused discussion on their sentiments of the video. Read below for discussion questions and response highlights.</p> <p>1. What is one scene that stayed with you? <i>Responses included: Teaching from one generation to another the methods to improvement.</i></p> <p>2. In one word, how did the video make you feel? <i>Responses included: Empowered.</i></p> <p>3. What is one message that you internalized from this video about their project or projects in general? <i>Responses included: Teaching takes time and effort but its worth it.</i></p> <p>4. How can you apply the message of this video to future projects? <i>Responses included: The work of one or a few can benefit a community.</i></p>

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MINUTES

	<p>After the video, partners were asked to partake in an activity. Partners were instructed to close their eyes, turn around slowly and point towards Timbuktu, Mali.</p> <p>1. When you opened your eyes, what did you observe first? <i>Responses included: Everyone was pointing in a different direction.</i></p> <p>2. How did this task make you feel? <i>Responses included: Confused. Lost.</i></p> <p>3. What was the main problem with the task? <i>Responses included: We didn't know where Timbuktu was. We didn't have a map. We all had different starting points. We didn't know which way was north.</i></p> <p>4. How could this have been done differently to produce a collectively successful result? <i>Responses included: Provide a map. Let us communicate. Keep eyes open. No spinning..</i></p> <p>Simmons told the group that not having a shared vision in community planning is like closing your eyes, spinning around and simply pointing to a direction, with no understanding of where you are and how you will get where you want to go.</p> <p>After that activity, Torie Burgess, DOH-Gulf Environmental Health Specialist and Megan Bennefield, CHOICES Program Health Educator, facilitated an activity designed to help the group create their own vision statement. Partners were asked to close their eyes and envision a future Gulf County. Then when they opened their eyes, they were asked what they saw and what were their hopes and dreams for this county and the people. Partners verbalized their ideas, while Robinson wrote them all down inside a large circled, coined the "Ball of Hope". [see accompanying photo for details]. Afterward Simmons gave the partners 5 tips for creating a vision and attendees were divided into smaller groups. Each person was given a note card to practice creating a vision. The mini groups voted amongst themselves on the best vision within their groups. The top vision was then posted on board and voted on by the participants at large. After tweaking the vision statements the partners created a unique vision to guide their efforts throughout the next several years.</p>
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**Florida Department of Health in Gulf County
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	<p>The selected: “Working together to empower Gulf County to improve quality of life for generations to come.”</p> <p>As the LPHS Assessment began, Simmons highlighted the web of public and private organizations, agencies, and partnerships that are all included within the LPHS, emphasizing that the system is much more than the local clinics and the local health department. She shared that some entities work on multiple essential public health services while others only work on a few, such as those with Policy Development function, or Assurance or only the Assessment sector. Participants remained in their smaller groups and discussed several activities, competencies and other aspects of the LPHS.</p> <p>Once group discussions were finished the group through 23 assessment questions in the first four (4) of the Ten Essential Public Health Services. The group voted privately on a piece of paper, ranking how well the LPHS performs each task, from No Activity, Minimally, Moderately, Significantly, or Optimally. Once finished they turned their assessments in. The partnership was told that future essential services will be assessed at the end of the next CHA workshop.</p>
<p>Consider Possible Directions and or Needs</p> <ul style="list-style-type: none"> ■ Community Health Status Survey ■ MAPP workshops moving forward 	<p>DT Simmons, reminded some partners and introduced to others the Community Health Status (CHS) Survey which is a portion of the CHS Assessment. This assessment is designed to survey the thoughts, ideas and concerns of our community via the lens of the community. She said that this time around the survey will not only inquire about the issues and problems in the community, but it will also ask the community for possible solutions to address the issues as well.</p> <p>After defining the CHS Survey, Ms. Simmons showed the RoadMAPP, an illustration of the steps in the MAPP process. While reviewing the illustration Ms. Simmons highlighted the four (4) MAPP assessments and briefly summaries the purpose and main actions of each assessment. She closed by saying that if all steps in the process are conducted collectively with the community, then together the partnership would see their selected vision come into fruition.</p>

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Open Floor for Community Input	<p>Maryann Roberts invited everyone to this Saturdays, “A Walk To Remember” at St. Andrews Oaks By the Bay park. This national event aims to honor the lives of the babies who die each year through miscarriage, ectopic pregnancy, stillbirth or newborn death. The remembrance ceremony is open to everyone. The walk starts at 9a.m. CST.</p> <p>Maryann also inquired about partnership interest in an interagency meeting, designed to help organizations stay in the know on current community events and initiatives.</p> <p>Sean Golder had to leave early, so Jessie Pippin of DOH Gulf/Franklin told everyone about PanCare’s open house, next Friday August 24th from 10:30 – 12:30. This open house encourages the community to come out to the clinic on Garrison Ave. in Port St. Joe, FL to meet and greet the new providers. PanCare is now fully staffed with a doctor, an arnp, a lcsw, and a therapist. Lunch will be served.</p> <p>Gulf Coast Family Health Day is on the 18th at Frank Pate Park.</p> <p>Eileen Booth with LMC detailed the new CAT program for high risk youth in Gulf County.</p> <p>Matt Standish with the Bay County Vet Center provided information on the multi-county services offered to vets and their families.</p> <p>Also, Jordan Miles introduced the four new LCSWs and Counsellors for the Gulf County School District. Each school will have its own LSCW.</p>
Actions	<p>DT Simmons, asked everyone to be on the lookout for the upcoming CHIP Meeting/CHA Workshop and to be prepared to help disseminate the Community Health Status Survey.</p>
Meeting Evaluation	<p>Kayleigh Cosson, of the Chemical Addictions Recovery Effort (CARE), who was distributed and collected the post meeting evaluation.</p>

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Adjourn	DT Simmons, once again thanked everyone for coming and actively participating in the CHA workshop. She adjourned the meeting at 12:05p and encouraged everyone to eat at a local restaurant before returning to their offices.
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SIGN-IN SHEET

Purpose: Solicit input from the community on the MAPP vision and local public health system assessment through open dialogue.

#	Name	Organization or Community Representative	Email	Phone
1	Matt Standish	Bay County Vet Center	matthew.standish@va.gov	850-520-6102
2	Robert Yates	BASIC NWFL	Robert.Yates@BasicNWFL.com	850-788-1085 ext 137
3	RON CEROT	WJHG	RonCEROT@Comcast.net	167
4	Ashley Wooten	Gulf Co School District	awooten@gulf.k12.fl.us	227-4011
5	Katrina Saunders	Newa Medical Ctr	KSaunders@nmc.org	1039-5828
6	Ram Jones	Gulf Co School Dist	rajones@gulf.k12.fl.us	505-301-1960
7	Paula Bides	Ascension FL/Sacred Heart	paula.bides@ascension.org	904-296-4673
8	Jordan Miles	Gulf Co. Schools	jmiles@gulf.k12.fl.us	850-514-6185
9	Alma Pugh	CTG Doh Gulf/Franklin	alma.pugh@flhealth.gov	850-653-211
10	Chuck Coker	Morning Light Wellness	chuck.c.coker@mlwc-fl.com	850-705-1766
11	Kyle Merritt	Choices	kmerritt@flhealth.gov	850-819-2713
12	Kyleigh Cossan	CARE	kcossan@care4000.com	850-624-2916
13	Lesia McDaniel	GCHD	lesia.mcdaniel@flhealth.gov	705-6124
14	Talitha Robinson	Gulf-Franklin CHD	talitha.robinson@flhealth.gov	653-2111
15	Zach Hodges	Gulf-Franklin CHD	zachary.hodges@flhealth.gov	227-5350
16	Eileen Booth	LMC	ebooth@lmc-cares.org	522-4485
17	Amy Pitts	Gulf Co. Schools	apitts@gulf.k12.fl.us	850-323-0212
18	Sarah Hinds	Doh-Gulf/Franklin	Sjahinds@flhealth.gov	850-227-8366
19	Helen Cook	Doh Gulf/Franklin	helen.cook@flhealth.gov	850-653-2111
20	Sean Golden	Panacea Health	sgolden@panaceafl.org	850-210-2526
21	Sean Golden	Big Bend Health Council		
22	Maryann Roberts	Healthy Start	maryann@healthystartbfg.com	774-5867
23	Jessie Pippin	Doh-Gulf	Jessie.Pippin@flhealth.gov	
24	Cathy Marcus	LMC - Foster Support	charcus@lmc-cares.org	522-4485 x8404
25	Megan Bennefield	FL Doh - Gulf/Franklin	megan.bennefield@flhealth.gov	850-226-1276
26				
27				

Attachment C



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Purpose: *Solicit input from the community on the MAPP Community Themes and Strengths and Forces of Change assessment through open dialogue.*

Topic	Discussion
Welcome/Call to Order <ul style="list-style-type: none"> ▪ Introductions ▪ Brief review of agenda ▪ Prompt attendees to sign-in 	DT Simmons, DOH-Gulf/Franklin CHA facilitator welcomed all partners. Suzy Nadler of the Healthy Start Coalition, kicked off the introductions by asking participants to state their name, organization, and their favorite place. Ms. Nadler provided basic housekeeping guidance and then reviewed an outline of the meeting agenda.
Review Previous Meeting	Ms. Simmons recapped the previous CHIP Meeting/CHA Workshop by reminding partners current CHIP cycle priorities and the newly crafted CHA cycle vision, “Working together to empower Gulf County to improve quality of life for generations to come.” Then she shared some information on the first segment of LPHS network and the Assessment process. DT Simmons recapped what our clinical partners PanCare and North Florida medical doing to improve access to care.
Status Update of Previous Actions <ul style="list-style-type: none"> ▪ How are our partners enhancing health for all those who live work and play in Gulf County? <ol style="list-style-type: none"> 1. Healthy Weight – UF IFAS Extension Office 	Kay Freeman of IFAS was in attendance at the partnership meeting but due to time constraints the status updates on current priorities were postponed to the next meeting. DT Simmons reminded the partnership of our priorities and goals and encouraged the subcommittees to stay motivated as they strive to carryout strategies that support our stated objectives.
What is MAPP? On the Road-MAPP for Community Health Assessment (CHA)?	DT Simmons, gave a high-level overview of the Mobilizing for Action through Planning and Partnerships (MAPP) process. She started by defining the framework as a community-driven strategic planning process for improving community health. She then stressed that the process focuses on strategic approaches to prioritizing issues and identifying resources to address them.
Introduce Topic: <ul style="list-style-type: none"> ▪ Community Health Assessment - Mobilizing for Action through Planning and Partnerships Workshop: <ol style="list-style-type: none"> 1. Community Themes and Strengths 2. Forces of Change 	Ms. Simmons introduced both the Community Themes and Strengths Assessment (CTSA) and the Forces of Change Assessment (FOCA). To paint a clearer picture of the CTSA she used a PowerPoint presentation displaying the three significant questions asked by the CTSA: “What is important to our community?” “How is quality of life perceived in our community?” and “What assets do we have that can be used to improve community health?” To answer these questions community members participated in three (3) specific community-led sessions: Themes, Quality of Life Survey and an Asset Inventory. Next the CHA facilitator introduced the major points of the forces of change that directly or indirectly affect the health of

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	<p>our community. She noted that these forces can be one time only events, growing trends, or present underlying factors. They are largely predictable but rarely controllable. Understanding these potential forces helps the community to reduce potential risk and ultimately improve their chances of reaching the shared vision.</p>
<p>Discuss Supporting Information:</p> <ol style="list-style-type: none"> 1. Community Themes and Strengths Activities <ul style="list-style-type: none"> ▪ Quality of Life Survey, Asset Inventory, Small Group Discussions 2. Forces of Change <ul style="list-style-type: none"> ▪ Consensus Workshop among CHA participants 	<p>Ms. Simmons and Hunter Bailey, DOH-Gulf S.W.A.T. Coordinator facilitated the CTSA beginning by surveying the quality of life in Gulf County, then a local countywide asset inventory followed by a small group discussion to garner reoccurring community sentiments/themes.</p> <p>The quality of life survey consisted of 13 questions on various core topics like childcare, community relations, education, employment, health, and housing among others. Feedback to the survey questions was measured using a Likert scale ranging from 1. Most Negative to 5. Most Positive. Around the meeting room response stations were designated for each of the possible Likert scale answers. When a question was read from the survey, participant quickly relocated to the portion of the room with the response that most nearly correlated with their belief on the quality of life. (See the attached document for survey data.)</p> <p>Mr. Bailey led the partnership in a community asset inventory designed to help identify the individuals (with knowledge/skills), the public and private institutions, citizen associations/organizations, and other entities within the community with the means and resources to help the partnership bring our vision into fruition. Many partners were unaware that so many other organizations and/or services were available in Gulf County. (See the attached pages for more information.)</p> <p>During the small group discussion, partners were instructed to rotate around the room to preassigned stations where the following questions were written on flipcharts. Group members added responses to each chart as necessary.</p> <p>1. What makes you most proud of our community? Answers include: Family, coming together. New organizations/services like the hospitals, clinics, and Morning Light Wellness Center help increase access to care.</p> <p>2. What would excite you enough to be involved or more involved in improving our community?</p>

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	<p>Answers include: Listening. More acceptance of ideas, more community involvement, momentum and understand.</p> <p>3. What do you believe is keeping our community from doing what needs to be done to improve the quality of life? Answers include: Funding shortages. Lack of interest and understanding. Difficulty thinking outside of the box.</p> <p>4. What do you believe are the 2-3 most important characteristics of a healthy community? Answers include: Education. Economy. Healthcare. Safety.</p> <p>Once all rotations were complete and all questions have been answered, group leaders reported responses to the attendees at large.</p> <p>After the CTSA, Megan Bennefield, DOH-Gulf/Franklin, CHOICES Program & Tori Burgess, DOH-Gulf, EH Specialist led the group in a Consensus workshop to help identify the FOC.</p> <p>Ms. Bennefield asked the partners what FOC are directly or indirectly affected the health of our community. She followed that up by informing us that these forces can be one time only events, growing trends, or present underlying factors. They are largely predictable but rarely controllable. She stressed that understanding these potential forces will help the community to reduce potential risk and ultimately improve their chances of reaching the shared vision. Responses to the question, “What is currently happening or could happen that would affect the health of our community?” include:</p> <p>Substance use, Change in funding to provide services Access to health-related resources, Environmental Factors, Lifestyle Education, Community Development, Political Influence</p> <p>After the brainstorming session, Tori Burgess told the partners that each FOC category creates various opportunities and/or poses various threats. So participants reviewed all of the FOC and listed the potential opportunities and/or threats associated with the items. This list will better help communities to strategize their next steps towards achieve their shared vision. (See the accompanying documents for a complete list of the opportunities and threats.)</p> <p>After completing the major segments of the two assessments, the Ms. Simmons directed the partners attention to the NACCHO RoadMAPP displayed on the PowerPoint presentation. While reviewing the illustration, Ms. Simmons highlighted the</p>
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	four (4) MAPP assessments and briefly summaries the purpose and main actions of each assessment. She closed by saying that if all steps in the process are conducted collectively with the community, then together the partnership would see their selected vision come into fruition.
Open Floor for Community Input	
Actions	DT Simmons, asked everyone to be on the lookout for the upcoming CHIP Meeting/CHA Workshop and to be prepared to help disseminate the Community Health Status Survey.
Meeting Evaluation	Kayleigh Cosson, of the Chemical Addictions Recovery Effort (CARE), who was distributed and collected the post meeting evaluation.
Adjourn	DT Simmons, once again thanked everyone for coming and actively participating in the CHA workshop. She adjourned the meeting at 12:05p and encouraged everyone to eat at a local restaurant before returning to their offices.

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Attached Documents/Supporting Information

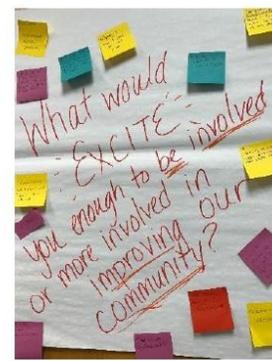
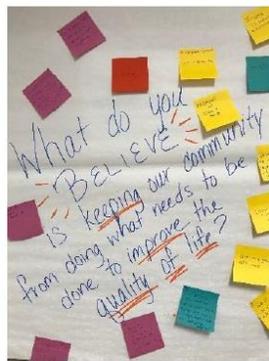
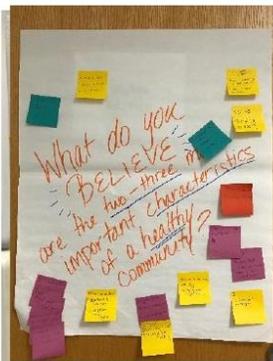
Quality of Life Survey				
1. Are you satisfied with the healthcare system in the community? (Consider access, cost, availability, quality, options in health care, etc.)				
1. Most Unsatisfied = 0	2. Slightly Unsatisfied = 12	3. Neutral = 0	4. Slightly Satisfied = 4	5. Most Satisfied = 0
2. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)				
1. Most Unsatisfied = 2	2. Slightly Unsatisfied = 1	3. Neutral = 7	4. Slightly Satisfied = 6	5. Most Satisfied = 0
3. Is this community a good place to grow old? (Consider elderly friendly housing, transportation to medical services, churches, shopping; elder day care, social support for the elderly living alone, meals on wheels, etc)				
1. Most Unsatisfied = 5	2. Slightly Unsatisfied = 5	3. Neutral = 6	4. Slightly Satisfied = 1	5. Most Satisfied = 0
4. Is there economic opportunity in the community? (Consider locally owned and operated businesses, jobs with career growth, job training/ high education opportunities, affordable housing, reasonable commute, etc.)				
1. Most Unsatisfied = 5	2. Slightly Unsatisfied = 6	3. Neutral = 5	4. Slightly Satisfied = 1	5. Most Satisfied = 0
5. Is the community a safe place to live? (Consider residents' perceptions of safety in the home, the workplace, schools, playgrounds, parks, and the mall. Do neighbors know and trust one another? Do they look out for one another?)				
1. Most Unsatisfied = 0	2. Slightly Unsatisfied = 0	3. Neutral = 5	4. Slightly Satisfied = 7	5. Most Satisfied = 6
6. Are there networks of support for individuals and families (neighbors, support groups, faith community outreach, agencies, and organizations) during times of stress and need.)				
1. Most Unsatisfied = 0	2. Slightly Unsatisfied = 0	3. Neutral = 9	4. Slightly Satisfied = 6	5. Most Satisfied = 2
7. Do residents perceive that they individually and collectively can make the community a better place to live?				
1. Most Unsatisfied = 0	2. Slightly Unsatisfied = 6	3. Neutral = 8	4. Slightly Satisfied = 1	5. Most Satisfied = 2
8. Is there an active sense of community responsibility and engagement, and of community pride in shared accomplishments?				
1. Most Unsatisfied = 0	2. Slightly Unsatisfied = 6	3. Neutral = 6	4. Slightly Satisfied = 3	5. Most Satisfied = 1
Totals:				
=12	=36	=46	=29	=11

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Asset Inventory	
<u>Individuals (w/ Knowledge & Skills):</u> <ol style="list-style-type: none"> 1. Superintendent 2. Commissioners 3. Pastors 4. Teachers 5. Youth Group Leaders 	<u>Citizen Associations:</u> <ol style="list-style-type: none"> 1. Community Service Orgs. 2. Northside Port St. Joe Project Area Coalition (PAC) 3. Junior Service League 4. Lions Club 5. Kiwanis 6. Mason
<u>(Private) Institutions:</u> <ol style="list-style-type: none"> 1. Sacred Heart Hospital 2. Morning Light Wellness Center 3. Childcare Facilities 4. School Clubs 5. St. Joe Foundation 6. Churches 	<u>(Public) Institutions:</u> <ol style="list-style-type: none"> 1. FL Dept. of Health 2. ARC Transportation 3. University of Florida Extension Office 4. Sexual Assault Response Team (SART) 5. Law Enforcement 6. Schools/Colleges 7. Big Bend Community Based Care 8. Life Management Center 9. Chemical Addictions Recovery Effort (CARE) 10. Alcoholics Anonymous
<u>Other Category: Gov. Agencies/Depts.</u> <ol style="list-style-type: none"> 1. Center for Disease Control and Prevention (CDC) 	<u>Other Category: Ongoing Initiatives and Projects</u> <ol style="list-style-type: none"> 1. Protocol for Assessing Community Excellence in Environmental Health (PACE-EH)

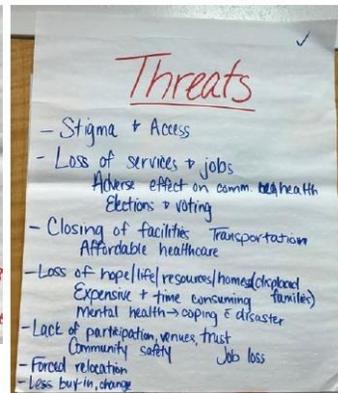
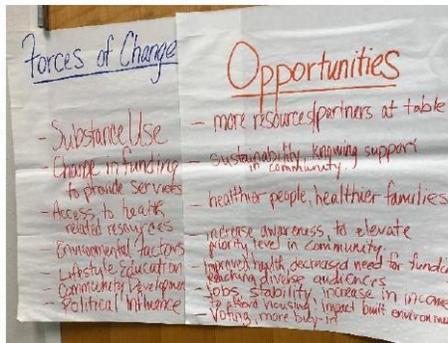
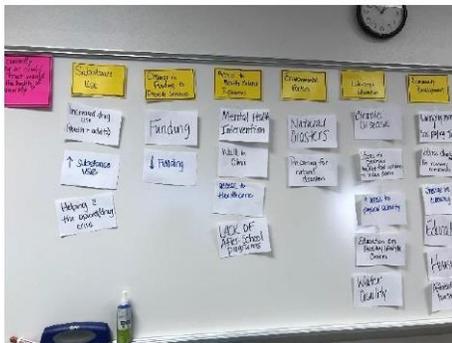
Small Group Discussion Questions



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Forces of Change Assessment		
Force of Change	Potential Opportunity	Potential Threat
Substance use	More resources/partners at the table	Stigma and access
Change in funding to provide services	Sustainability, knowing support in the community	Loss of services and jobs. Adverse effect on community health. Elections and voting.
Access to health-related resources	Healthier people, healthier families	Closing of facilities. Transportation Affordable healthcare
Environmental Factors	Increase awareness, to elevate priority level in community	Loss of hope/life/resources/homes (displacement is expensive and time consuming) Mental health (coping with disaster)
Lifestyle Education	Improved health decreased need for funding. Reaching diverse audiences	Lack of participation venues Lack of trust Community safety
Community Development	Jobs, stability, increase in income to afford housing. Impact built environmental	Forced relocation Job loss
Political Influence	Voting, more buy-in	Less buy-in Changes in platforms/support.



~~End of Attachments~~



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SIGN-IN SHEET

Purpose: Solicit input from the community on the MAPP Community Themes and Strengths and Forces of Change assessment through open dialogue.

#	Name	Organization or Community Representative	Email	Phone
1	Kayleigh Goss	CARE	kgossow@care4000.com	850-819-8627
2	Tonya Wright	Life Management	twright@lmcare.org	(850) 596-2425
3				
4	Rebecca McCarver	Life Management	rmccarver@lmcare.org	850-625-8438
5	Suzy Nadler	Healthy Start	suzy@healthystartfl.com	850-872-4130
6	Alma Pugh	DOH Franklin/Gulf CTG	alma.pugh@flhealth.com	850-653-2111
7	Talitha Robinson	DOH-Franklin Gulf	Talitha.Robinson@flhealth.gov	850-653-2111
8	Chuck Coker	Morning Light Walkers	coker_chuck@yahoo.com	850-705-1766
9	Jessie Pippin	DOH Franklin/Gulf	Jessie.Pippin@flhealth.gov	850-227-4192
10	Kari Williams	DOH-Gulf/Franklin	Kari.Williams@flhealth.gov	850-340-3016
11	Kay Freeman	UF/IFAS/INP	freeman77@ufl.edu	850-639- 3222
12	Lisa Aufdenkamp	Big Bend CBC	lisa.aufdenkamp@bigbend.org	(850) 747-5155
13	John Griags	Sacred Heart	john.griags@ascension.org	(850) 229-5620
14	Shad Smithey	DOH/Gulf		
15	Heather Nowell	DJS	heather.nowell@dj.state.fl.us	850-872-7430
16	DT Simmons	DOH-Gulf/Franklin	Dorinda.Simmons@flhealth.gov	(850) 591-9396
17	Kyle Merritt	DOH-Gulf/Franklin	Randall.Merritt@flhealth.gov	850-818-2713
18	Sarah Plinds	DOH-Gulf/Franklin	Sarah.Plinds@flhealth.gov	850-227- 8526
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Attachment D



**Florida Department of Health in Gulf County
Gulf County Community Health Assessment Workshop Meeting # 3
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COMMUNITY MEETING MINUTES

Purpose: *Solicit input from the community on the community health priority selection through open dialogue.*

Speaker	Topic	Discussion
Maryann Roberts, Healthy Start Coalition	Welcome/Call to Order <ul style="list-style-type: none"> ▪ Introductions ▪ Brief review of agenda Prompt attendees to sign-in	Maryann Roberts with Healthy Start opened by welcoming everyone to the meeting, outlining the agenda, reviewing basic housekeeping, and participant introductions.
DT Simmons, DOH-Franklin CHA Coordinator	Review Previous Assessment Findings	DT Simmons reminded everyone of the previously selected vision, "A united healthy and prosperous Franklin County" and highlighted the findings from the Local Public Health System (LPHS) Assessment, the Community Themes and Strengths, and the Forces of Change. (Note: See previous minutes for more details on the findings from these assessments.)
Sarah Hinds, DOH-Franklin/Gulf Administrator Megan Bennefield, DOH-Franklin/Gulf Health Educator Jessie Pippin, DOH-Gulf Operations Manager/CHA Coordinator	Introduce Topic: <ul style="list-style-type: none"> ▪ Overview of the phases of MAPP ▪ Health disparities/gaps within our community ▪ Data Review <ol style="list-style-type: none"> 1. Discussion of the findings 2. Detail how common concerns/problems were identified 	<p>Sarah Hinds directed the group's attention to the MAPP slide on the large screen. Sarah helped viewers to conceptualize how through the four MAPP CHA assessments, the partnership can collectively achieve a desired healthy outcome. She share how integral each component is to achieving our vision.</p> <p>Megan Bennefield of the CHOICES Program facilitated a presentation on the significant of health equity. Throughout the presentation she engaged the participants by showing them visual representations of equality vs. equity and questioning them on the difference between the two. She wrapped up the presentation by expressing that there is no one size fits all approach to providing healthcare support. Stressing that in order to really close the health disparity gap, the LPHS must work to meet the diverse needs of the community, providing the, education, resources, services, support, and/or tools necessary to help live healthier lives.</p>

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COMMUNITY MEETING MINUTES

		<p>The final portion of this segment was the data review. Jessie Pippin highlighted the data from the Community Health Status Assessment (CHSA). The assessment was composed from the County Health Rankings, Florida Charts, the Community Health Status Survey, and the US Census.</p> <p>In order to share the data collected from the CHSA, Ms. Pippin instructed the workshop attendees to:</p> <ol style="list-style-type: none"> 1. Divide into small groups. 2. Select a table facilitator. 3. Review the data provided. 4. Discuss interesting findings with your group. 5. Report out to the partnership. <p>After the groups reviewed and discussed the data Ms. Pippin engaged the participants in a focused conversation, asking the following questions:</p> <ol style="list-style-type: none"> 1. What interesting data have you observed? Lack of access to providers. Mental health disorders like anxiety is a common hospital patient diagnosis. Drug abuse fuels other adverse health outcomes. Heart health seems to be a constant issue. College attendance is very low. Teen pregnancy rate. Higher children in poverty and other poor SES data. 2. What seems the most critical? Substance abuse. Mental health access. Overall health care access. Primary care. Premature death. Obesity. Education. Chronic Disease and inactivity. Housing. Child Care.
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COMMUNITY MEETING MINUTES

		<p>3. What appears to be the central issue of key problem area?</p> <ul style="list-style-type: none"> - Drug abuse lead to other issues. People are self medicating. - Lack of providers causes issues in access to care overall. - Education. Little emphasis on education is affecting SES. - SES Factors - Housing - Child Care - Inactivity - Mental Health <p>4. What are the consequences of not addressing this issue? See next agenda item.</p>
<p>Jessie Pippin, DOH-Gulf, Operations Manager</p>	<p>Discuss Supporting Information:</p> <ul style="list-style-type: none"> ▪ Activity #1: What are the consequences of not addressing this issue? ▪ Activity #2: Weighted Priority Matrix 	<p>What are the consequences of not addressing this issue:</p> <p>Substance Abuse/Mental Health</p> <ul style="list-style-type: none"> - More premature death. Violent crime. Suicide rates increase. Increase in child and elder abuse. Increase in ACES. - Increase in suicide and substance abuse, arrest and crime, poverty, stigma. Increase in ACEs. More youth go undiagnosed. <p>Access to Care:</p> <ul style="list-style-type: none"> - Premature death (mortality). Increase in chronic disease comorbidities. <p>Socioeconomic Status (SES):</p> <ul style="list-style-type: none"> - Wider poverty gap. Increase in brain drain (young people exiting community for work and opportunity). <p>Inactivity:</p> <ul style="list-style-type: none"> - Obesity, chronic disease, overweight, many issues joined by this one area. <p>Jessie Pippin facilitated a weighted priority matrix. Each participant was given 10 voting slips (Post-It Notes) and instructed to vote for the two issues that</p>

**Florida Department of Health in Gulf County
 Gulf County Community Health Assessment Workshop Meeting # 3
 DOH-Gulf Large Conference Room
 November 14, 2019 10:00a.m. - 12:00p.m. EST**

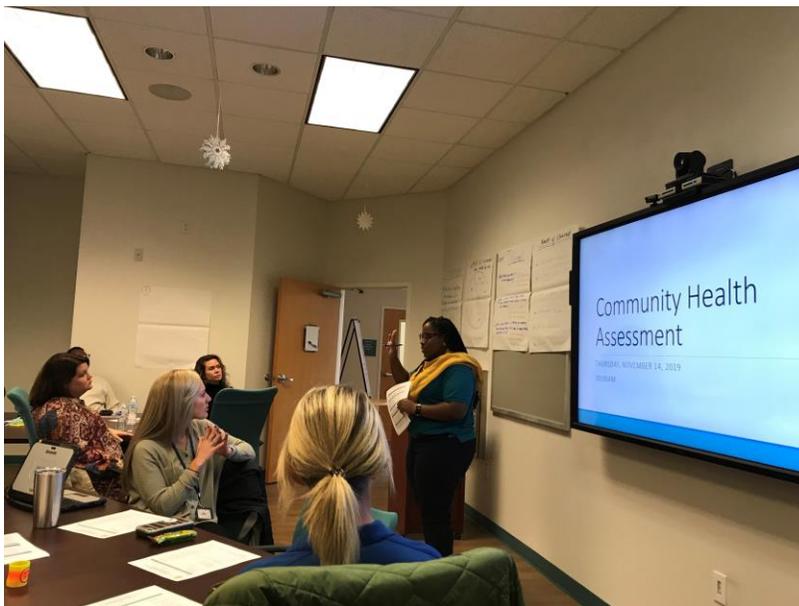
COMMUNITY MEETING MINUTES

		<p>best correspond to the following 5 statements.</p> <ol style="list-style-type: none"> 1. Do we have the resources available to address this problem? 2. Does this problem have community support? 3. Which problems align with our vision? 4. Does this problem help to reduce health disparities? 5. Can we do something about this problem within the 3-year CHA cycle? 6. Could working on this problem support other identified problems? <p>The votes for each question were tallied. The results were as follows: Inactivity – 46 Votes Socioeconomic Status – 35 votes Limited Access to Care – 38 Votes Chronic Disease – 19 votes Mental Health/Substance Abuse – 54 votes</p> <p>The partners decided to focus on the top three community health issues: Mental Health, Access to Care, and Substance Abuse.</p>
<p>DT Simmons, DOH-Franklin CHA Coordinator</p>	<p>Actions</p>	<p>DT Simmons urged every partner to take this information back to their offices and share with their teams. Each partner was also encouraged to think about what resources, initiatives, and actions they could dedicate to improving the top three selected focus areas. The next steps will be to gather back as a group and create objectives and supportive task/actions to address the stated objectives.</p>
<p>Alma Pugh, DOH-Franklin/Gulf Health Educator</p>	<p>Open Floor for Community Input</p>	<p>Alma Pugh invited everyone to the upcoming Mental Health First Aid training hosted by our partner Apalachee Center and encouraged everyone to share updates and upcoming events.</p>

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Maryann Roberts, Healthy Start Coalition	Meeting Evaluation	Maryann Roberts was assisted distributing the evaluations.
	Adjourn	The meeting was adjourned at 12:05p.m.



PACE-EH Survey

Age: ___ 18- 25 ___ 26-44 ___ 45-65 ___ Older than 65

Sex: ___ Male ___ Female ___ Prefer not to answer

Education: ___ Less than high school ___ High school Diploma ___ Vocational/Technical School
___ 2-year college Degree/Associates ___ 4-year college Degree/Bachelors or higher

How do you best describe yourself? ___ American Indian or Alaskan Native ___ Asian
___ Black or African-American ___ Native Hawaiian or Other Pacific Islander ___ White
___ Other

Are you Hispanic or Latino? ___ Yes ___ No

1. What community issues do you see and experience? How would you solve this problem?

1. _____

2. _____

3. _____

2. Please select your top 5 major concerns in North Port St. Joe.

- | | |
|---|---|
| <input type="checkbox"/> Abandoned/run down structures | <input type="checkbox"/> Unsafe Neighborhood |
| <input type="checkbox"/> Run down vacant lots | <input type="checkbox"/> Crime |
| <input type="checkbox"/> Quality street lighting | <input type="checkbox"/> Lack of recreation areas and parks |
| <input type="checkbox"/> Drug activity | <input type="checkbox"/> Need for more street signs |
| <input type="checkbox"/> Poor road conditions | <input type="checkbox"/> Limited job training |
| <input type="checkbox"/> Community resources awareness | <input type="checkbox"/> Speeding |
| <input type="checkbox"/> Resident involvement in the community | <input type="checkbox"/> Lack of jobs |
| <input type="checkbox"/> Affordable, safe, clean water | <input type="checkbox"/> Access to health care service |
| <input type="checkbox"/> Police presence or Limited police presence | <input type="checkbox"/> Access to healthy food |
| <input type="checkbox"/> Lack of mental health/substance abuse services | <input type="checkbox"/> Affordable housing |
| <input type="checkbox"/> Not enough minority educators | <input type="checkbox"/> Access to child care |
| <input type="checkbox"/> Lack of education on criminal re-entry | <input type="checkbox"/> Pollution issues |
| <input type="checkbox"/> Lack of services/community centers for youth or senior | <input type="checkbox"/> Access to transportation |
| <input type="checkbox"/> Medical care for children | <input type="checkbox"/> Affordable Medication |

**3. Think about the place you live right now. Do you have any problems with any of the following?
(check all that apply)**

- | | | |
|--|---|--|
| <input type="checkbox"/> Bug Infestation | <input type="checkbox"/> Mold | <input type="checkbox"/> Lead paint or pipes |
| <input type="checkbox"/> Lack of heat | <input type="checkbox"/> Oven or stove not working | <input type="checkbox"/> No or not working smoke detectors |
| <input type="checkbox"/> Electrical | <input type="checkbox"/> House foundation/structure | <input type="checkbox"/> Rent/Cost of Housing |
| <input type="checkbox"/> Roof | <input type="checkbox"/> None of the above | |

4. Were any of these problems a result of the storm?

___ Yes ___ No

5. Do you currently have a job?

___ Yes ___ No ___ Retired ___ Disabled

6. Do you have job loss related to Hurricane Michael?

___ Yes ___ No ___ N/A

7. Are you satisfied with your current level of employment?

___ Yes ___ No ___ N/A If not, why: _____

8. Do problems getting child care make it difficult for you to work or study?

___ Yes ___ No ___ N/A

9. Is it currently difficult for you to pay your bills:

___ Never ___ Rarely ___ Sometimes ___ Often ___ Always

If so, was this a result of the storm? ___ Yes ___ No

10. How often does someone check-in on your wellbeing in a week?

___ 0-1 time ___ 2-3 times ___ 3 or more times

11. Do you currently use tobacco products (i.e cigarettes, cigars, hookah, e-cigs, dip etc.)?

___ Yes ___ No

Gulf County CASPER
 Preliminary (Unweighted) Results
 December 31, 2019

The CASPER assessment that occurred in Gulf County in 2019 included 4 CDC-sampled clusters (26 interviews) and 4 additional clusters (32 interviews), for a total of 58 completed interviews. Combined, Bay and Gulf Counties had an 85% completion rate (number of completed interviews out of the total number of interviews targeted, and a 41% cooperation rate (number of completed interviews out of all housing units where contact was made, including refusals) on the CDC-sampled clusters. The results presented below represent all 58 completed interviews from both the CDC and additional clusters.

Of all those surveyed in Gulf County, this included 45 (77.6%) single family homes, 8 (13.8%) mobile homes, 1 (1.7%) multiple unit structure, and 4 (6.9%) RVs/travel trailers. The average household size was 2.3 individuals (range: 1-7), including an average of 1.8 individuals 18 years and older (range: 1-5) and 0.5 individuals under the age of 18 (range: 0-4) per household. The majority of households were owned (46, 79.3%) by their occupants. Most reported no change in combined household income in the past 12 months (58.6%), while just over one-fourth (25.9%) reported a decrease.

Hurricane Michael

In total, 48 (82.8%) respondents indicated that the current structure was where their household lived at the time of Hurricane Michael; 10 (17.2%) reported that this was not the same structure. Over three-quarters of participants reported evacuating either before (43, 74.1%) or after (2, 3.5%) landfall, and 12 (20.7%) did not evacuate (Table 1). Among those who evacuated (Table 2, n=46), 18 (39.1%) evacuated to friends/family residences nearby, 16 (34.8%) evacuated to friends/family residences elsewhere, 2 (3.4%) evacuated to a shelter, and 13 (28.3%) reported evacuating to a hotel/motel (or evacuating in vehicles/RVs) outside of the path of the storm. Among those who did not evacuate (Table 3, n=12), reported reasons/barriers included feeling there was no need to go, no time, stayed with pets/animals, caring for a person who could not evacuate, and needing to remain for work.

	Frequency	Percent
Before	43	74.14
After	2	3.45
No	12	20.69
Before & After	1	1.72

	Frequency	Percent
Friends/family (nearby)	18	39.13
Friends/family (elsewhere)	16	34.78
Shelter	0	0.00
Hotel/Motel/RV/Camper (elsewhere)	13	28.26

	Frequency	Percent
No time	1	8.33
Didn't know where to find where the shelters were	0	0.00
No transportation	0	0.00
Fear of theft	0	0.00
Stayed with pets/animals	3	5.17
Caring for person who could not evacuate	1	8.33
No need to go	8	66.67
Work	1	8.33

Emergency Supplies

Among respondents, 39 (67.2%) reported having an emergency supply kit for their household prior to the hurricane (Table 4). Most (58.6%) reported using supplies from this kit following the hurricane, and just over one-third reported that their household needed supplies that were not available in their kits (Table 4). Among those reporting needed and unavailable supplies, the most common items included water (14), food (9), batteries (9), gas/fuel/electricity (8), generator (6), clean-up supplies/tools (5), and medical supplies (3), among others.

	Frequency	Percent
Did your household have an emergency supply kit prior to the hurricane?		
Yes	39	67.24
No	19	32.76
Did your household use supplies from your emergency supply kit following the hurricane?		
Yes	34	58.62
No	16	27.59
N/A	21	36.21
Did your household need emergency supplies that were not included in your emergency supply kit?		
Yes	21	36.21
No	16	27.59
N/A	21	36.21

Most respondents reported that their households had enough non-perishable food (42, 72.4%) and water (42, 72.4%) to last for three days and enough medication to last for 7 days (45, 77.6%). Only 10 (17.2%) reported that a member of their household ran out of medications after the storm.

Damage and Repairs from Hurricane Michael

Of respondents, 33 (56.9%) reported that their homes were damaged during Hurricane Michael but repairable, while 19 (32.8%) reported minimal to no damage and 6 (10.3%) reported their homes were destroyed. Among those who provided damage estimates (n = 41), the average

damage was reported at \$37,757 (median: \$25,000; range: \$300-200,000). In total, 50 (86.2%) reported that their home feels safe to live in, with 6 (10.3%) reporting that it does not feel safe. The majority reported that their home was somewhat repaired (39.7%) or completely repaired (36.2%, Table 5), with the most common barriers to repair being builder or contractor issues (33.1%, including being slow to respond, not having any available, price gouging, etc.) and slow money receipt from insurance or FEMA for repairs (32.5%).

	Frequency	Percent
How close is your home to being how it was prior to the hurricane?		
Completely repaired	21	36.21
Somewhat repaired	23	39.66
Not repaired at all	3	5.17
N/A, home not destroyed	9	15.52
Don't know	2	3.45
What, if any, are barriers to your home repair?		
None, no barriers	14	24.14
Time	7	12.07
Materials/supplies	8	13.79
No money	12	20.69
Slow money	6	10.34
Builder/contractor issues	10	17.24
Denied coverage	5	8.62

All reported having running water (100.0%), and most reported having access to a functioning toilet (98.3%), and city electricity (96.6%). Less than half reported having access to a working generator (46.6%) at the time of the survey. Just under half (44.8%) reported having used a generator since the storm. However, only 26 (44.8%) reporting having a working carbon monoxide detector in their home, with 31 (53.5%) reporting that they did not have one and 1 (1.7%) not knowing.

Employment Post-Hurricane

Post-hurricane employment issues are minimal. In total, only 5 (8.6%) reported having someone in their household struggling to complete duties at work because of emotional issues and 2 (3.4%) reported losing their job after Hurricane Michael and still not having work. Five (8.6%) lost their job initially but later found jobs, 4 (6.9%) reported gaining jobs after Hurricane Michael, and 48 (82.8%) reported neither losing or gaining jobs since the hurricane. Reasons for not finding work since Hurricane Michael included there being no jobs available (2) and physical health/disability (1).

Post-Hurricane Concerns

Residents reported noticing an increase in the following animals/insects since the hurricane: insects (15.5%, including ants, roaches, mosquitos, etc.), raccoons (12.1%), bears (10.3%), foxes (8.6%), snakes (6.9%), squirrels (3.4%), and wild pigs (3.4%).

Residents reported not being generally concerned about mosquito-borne diseases (48.3%) and they would support spraying for mosquitos (93.1%, Table 6). Reasons for not supporting mosquito spraying included concerns about chemicals in the environment (2), concerns over killing bees/bugs (2), and concerns that spraying does not help (1).

Table 6. Mosquito Concerns		
	Frequency	Percent
Currently, how concerned are you and members of your household about getting diseases mosquitoes may carry?		
Very concerned	11	18.97
Somewhat concerned	19	32.76
Not concerned at all	28	48.28
Would your household support any spraying for mosquitos?		
Yes	54	93.10
No	3	5.17
Don't know	1	1.72
If yes, which type(s) of mosquito spraying would you support?		
Any/all means necessary	23	39.66
By hand	0	0.00
By truck	30	51.72
N/A	3	5.17
Don't know/depends	2	3.45

Post-Hurricane Injuries and Illnesses

The majority of respondents (81.0%) reported not having anyone in their household being injured as a result of Hurricane Michael (Table 7). Among those who did report injuries, the most common included slips, trips, and falls (4); unsafe/improper use of equipment (3); bacterial infection (2); walking/standing in flooded water (1); and insect sting (1).

Table 7. Was anyone in your household injured as a result of Hurricane Michael or during cleanup activities?		
	Frequency	Percent
Yes-storm	2	3.45
Yes-cleanup	9	15.52
Yes-both	0	0.00
No	47	81.03

A variety of illnesses were reported by respondents as being experienced since the storm. These are reported in Table 8. The most common new illnesses reported included anxiety, allergies, asthma/COPD/respiratory difficulties, depression, and cough. Others reporting a worsening of pre-existing conditions (Table 8), with the most common being anxiety, fatigue, allergies, and depression. Behavioral issues reported since Hurricane Michael (Table 8) in respondents households included trouble sleeping/nightmares, difficulty concentrating, and agitated behaviors. Relatively few respondents noted that they or someone in their household needed prescription medications to treat pain (15, 25.9%) or sleep disturbances (14, 24.1%).

Table 8. New or Worsening Illnesses Since Hurricane Michael		
	Frequency	Percent
Since the storm, has anybody in your household experienced:		
Rash	4	6.90
Nausea	8	13.79
Diarrhea	5	8.62
Cough	19	32.76
Fever	6	10.34
Red eyes	7	12.07
Allergies	28	48.28
Asthma/COPD/respiratory difficulties	23	39.66
Anxiety	28	48.28
Depression	21	36.21
Since Hurricane Michael, have you or any members of your household experienced worsening of:		
Asthma/COPD/respiratory complications	11	18.97
Allergies	17	29.31
Diabetes	3	5.17
Hypertension	13	22.41
Anxiety	22	37.93
Insomnia	15	25.86
Poor appetite	7	12.07
Fatigue	20	34.48
Depression	17	29.31
Since the storm, have you or members of your household had:		
Difficulty concentrating	17	29.31
Trouble sleeping/nightmares	23	39.66
Loss of appetite	10	17.24
Agitated behaviors	14	24.14
Personally, witness violent behaviors/threats	5	8.62
Increased alcohol consumption	3	5.17
Increased drug use	0	0.00

Access to Healthcare Post-Hurricane

The majority of respondents reporting being able to access necessary healthcare services and medications post-Hurricane Michael (Table 9). Most (77.6%) reported being able to get their medications from their usual source. Most (74.8%) reported needing primary or pediatric care during the past year, and being able to receive the care they needed (74.1%; Table 9). Reasons reported for not receiving the care they needed included cost/uninsured (1), transportation (1), and proximity of providers (2).

Only 10 (17.2%) reported that a member of their household needed care for mental health concerns (Table 9), with the majority of those reporting that they needed it being able to receive the care. Reasons reported for not receiving the care they needed included cost/uninsured (1), transportation (1), and proximity of providers (1). Generally, respondents were supportive of mental health care. When asked whether the statement ("People should generally sort out their own mental health problems.") was true or false, most (70.7%) responded false.

Table 9. Healthcare and Medication Access		
	Frequency	Percent
Since the storm, has it been more difficult to get needed prescription medications for anyone in your household?		
Yes	4	6.90
No-got meds from Red Cross, hospital, etc.	2	3.45
No-got meds from usual source	45	77.59
No-no meds needed	7	12.07
During the past year, has anyone in your household needed primary care or pediatrician?		
Yes	45	77.59
No care needed	13	22.41
Was the household able to receive the required care?		
Yes	43	74.14
No	2	3.45
N/A	12	20.69
Frequency Missing = 1		
During the past year, did anyone in your household need a therapist, psychologist, psychiatrist, social worker, or counselor for mental health care?		
Yes	10	17.24
No	48	82.76
Was anyone in your household able to receive the services they needed?		
Yes	8	13.79
No	2	3.45
N/A	48	82.76

Suicide Ideation and Risk

Using questions from the Suicide Behaviors Questionnaire-Revised (SBQ-R), respondents were asked about different dimensions of suicidality. Each item addresses a different dimension and is summarized in Table 10. Most respondents had low to no risk of suicidality (91.2%) using the standard scoring guidelines for this scale.

Table 10. Suicide Ideation and Risk		
	Frequency	Percent
Item 1: Have you ever thought about or attempted to kill yourself?		
Never	49	84.48
It was just a brief passing thought	3	5.17
I have had a plan at least once to kill myself but did not try to do it	0	0.00
I have had a plan at least once to kill myself and really wanted to die	1	1.72
I have attempted to kill myself, but did not want to die	3	5.17
I have attempted to kill myself, and really hoped to die	1	1.72
Don't know	0	0.00
Refused	1	1.72
Item 2: How often have you thought about killing yourself in the past year?		
Never	53	91.38
Rarely (1 time)	4	6.90

Table 10. Suicide Ideation and Risk		
	Frequency	Percent
Item 1: Have you ever thought about or attempted to kill yourself?		
Sometimes (2 times)	0	0.00
Often (3-4 times)	0	0.00
Very often (5+ times)	0	0.00
Don't know	0	0.00
Refused	1	1.72
Item 3: Have you ever told someone that you were going to attempt suicide, or that you might do it?		
No	54	93.10
Yes, at one time, but did not really want to die	0	0.00
Yes, at one time, and really wanted to die	1	1.72
Yes, more than once, but did not want to do it	1	1.72
Yes, more than once, and really wanted to die	1	1.72
Don't know	0	0.00
Refused	1	1.72
Item 4: How likely is that you will attempt suicide someday?		
Never	49	84.48
No chance at all	4	6.90
Rather unlikely	2	3.45
Unlikely	2	3.45
Refused	1	1.72
Combined SBQ-R Risk Category		
Low to no risk	52	91.23
Moderate to high risk	5	8.77
Frequency Missing = 1		

