Florida Department of Health in St. Johns County

COMMUNITY HEALTH IMPROVEMENT PLAN ANNUAL PROGRESS REPORT

2019

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Introduction

This is the 2019 annual report for the *2017-2020 St. Johns County Community Health Improvement Plan (CHIP)*. The activities and collaborative efforts of the Florida Department of Health in St. Johns County (DOH-St. Johns) and Community Partners are reflected within this report. This document serves as a progress report of the strategies that were developed and the activities that were implemented. While the CHIP is a community-driven and collectively-owned health improvement plan, DOH-St. Johns is the convener and Chief Health Strategist charged with tracking statistical data for community health and also provides administrative support to the collaborative efforts and the preparation of the annual report.

DOH-St. Johns, in partnership with our community hospital known now as Flagler Health+, champions the St. Johns County Health Leadership Council (SJC-HLC), our collaborative of executive level decision-makers and boots-on-the-ground members from organizations that make up the local public health system. Since 2004, this collaborative has grown to about 30 active members who complete a comprehensive, triennial Community Health Assessment (CHA) to improve community health outcomes. A summary of successes is provided in the following section. The SJC-HLC employs a Community Balanced Scorecard (CBS) which outlines identifies the community's strategic health objectives, and includes performance measures, targets, and critical actions needed to affect improvement for each objective.

This report is the calendar year 2019 annual evaluation report and update of the *2017-2020 St. Johns County CHIP*. The 2019 review of the CHIP was completed at the SJC-HLC meeting that took place on December 18, 2019. A facilitated review and discussion of the CBS was completed with those in attendance. Following the meeting, a call was made to the complete roster of the SJC-HLC to ask members to provide final 2019 results.

The SJC-HLC uses a research-based CBS as the means to convey our CHIP Priorities and Objectives. The CBS uses four standard Strategic Priorities (Issue). These are:

> ***1.0 Community Assets****: Focuses on engagement of community members and partners and having a competent public health workforce*
>
> ***2.0 Community Learning and Planning****: Focuses on development of policies and plans, evaluation, health status monitoring, and research*
>
> ***3.0 Community Implementation****: Focuses on investigations, enforcement, health promotion, and health services*
>
> ***4.0 Community Health Status****: Focuses on having excellent health outcomes*

The concept of the CBS is that Priority #1 is the driver for Priority #2, and that Priority #2 is the driver for Priority #3, and that Priority #3 is the driver for Priority #4. The associated Goals, Objectives, and Performance targets will result in the improvement of and the provision of the Ten Essential Services of Public Health to Saint Johns County, Florida.

Overview of CHIP & Annual Review Meeting

Background: In June 2016, the St. Johns County Health Leadership Council (SJC-HLC) began the 18-month process to re-assess and improve the health of St. Johns County for the fifth time resulting in the: The *2017 Community Health Assessment (CHA) and 2018–2020 Community Health Improvement Plan (CHIP)* for St. Johns County, Florida. Facilitated by the Florida Department of Health in St. Johns (DOH-St. Johns), the SJC-HLC utilized the National Association of City and County Health Official's "*Mobilizing for Action through Planning and Partnerships"* (MAPP) strategic planning model to complete this project.

During MAPP Phase 4 - Identify Strategic Issues, which was completed during January through March 2018, SJC-HLC developed a Community Balanced Scorecard (CBS) which serves as the framework for this *2018 - 2020 Community Health Improvement Plan* and aligns the identified strategic issues to the goals and strategies formulated in the following MAPP Phase 5 – Formulate Goals and Strategies. SJC-HLC established a sub-committee who took the following into consideration and presented their recommendations and rationale to the SJC-HLC for approval:

- ***Statistical Data**: Is the data trending up or down? Is it significantly better or worse than the state or the peer county average, or the national average?*
- ***Perceptual Data**: What does the community believe our main health concerns are?*
- ***Opportunities for Greatest Probable Impact**: Where can the greatest impact be made over the next three years when considering the available resources and capacity in St. Johns County and its Public Health System? What is the risk of not addressing an issue?*

The rationale the subcommittee used to develop the 2017-2020 CHIP Strategic Objectives using the CBS Concept as previously referenced is shown below:

	2017 – 2020 Strategic Objectives (Community Health Priorities)	Rationale
4	Improve Overall Health Outcomes	Large Black/White disparity in infant mortality
	Reduce Chronic Disease and Related Health Inequities (Health Equity)	Cancer and Heart Disease are greatest causes of death, large black/white disparity for Heart Disease and Diabetes
	Reduce Communicable Disease Incidence	Large disparities in HIV incidence, Trended increase in STI's
	Reduce Crime and Injury	Increasing crime rate, Unintentional injury is now leading cause for Years of Potential Life Lost, Major concern in community survey and focus groups
3	Improve Child Safety and Well-being	Major concern in the Community Survey, Large Black/White disparity in infant mortality, Overall child death rate has increased since 2010
	Reduce Risky Behaviors	Major concern in Forces of Change and Community Survey, High rates of Substance Abuse and Opioid-caused deaths
	Increase Access to Dental Care	Major concern in Community Survey and Focus Groups, Low rate of dentists in county per population, Large numbers of adults without oral healthcare
	Increase Access to Mental Health Care	Major concern in Forces of Change, Community Survey, and Focus Groups, Low rate of Mental Health providers in county per population
2	Assure Linkage to Care	Major concern in Forces of Change and Public Health System Assessments, Health Equity Concerns throughout
	Improve Community Livability to Address Social Determinants of Health (Health Equity)	Major concern in Forces of Change Assessment, Community Survey, and Focus Groups, Health Equity Concerns throughout
	Protect Population from Emerging Health Threats	Major concern in Community Surveys and Focus Groups
1	Increase Access to Transportation	Major concern in Community Surveys and Focus Groups, Health Equity Concerns throughout
	Increase Resources for Community Health Improvement	Concern in Public Health System Assessment, Community Survey and Focus Groups

As a result, the Saint Johns County Health Leadership Council (SJC-HLC) agreed on the selection of priorities based on this rationale and reached consensus on the following four Strategic Priorities (Issue) and Goals as shown in the table below:

Strategic Priorities (Issues)	Goals
4 - Community Health Status	4.1 Improve Overall Health Outcomes
	4.2 Reduce Chronic Disease and Related Health Inequities
	4.3 Reduce Communicable Disease Incidence
	4.4 Reduce Crime and Injury
3 - Community Implementation	3.1 Improve Child Safety and Wellbeing
	3.2 Reduce Risky Behaviors
	3.3 Increase Access to Dental Care
	3.4 Increase Access to Mental Health Care
2 - Community Learning & Planning	2.1 Assure Linkage to Care
	2.2 Improve Community Livability to address social determinants of health
	2.3 Protect Population from Emerging Health Threats
1 - Community Assets	1.1 Increase Access to Transportation
	1.2 Increase Resources for Community Health Improvement

The 2019 annual review of the St. Johns County Community Health Improvement Plan (CHIP) was conducted with the SJC-HLC on December 18, 2019. A draft Community Balanced Scorecard (CBS) with updated performance measures was presented and reviewed during that annual meeting. Throughout January and February of 2020, a follow up calls were made to the complete roster of SJC-HLC members regarding final 2019 results for the purpose of the annual report.

Monitoring of progress toward Strategic Goals is monitored at least annually with results reported to the SJC-HLC and compiled on a Community Balanced Scorecard. The Scorecard is reviewed during SJC-HLC meetings, at least quarterly during normal seasons. Key topics discussed in this annual review meeting included the following:

- Hepatitis A public health emergency, and the community-wide immunization effort to mitigate this public health threat in support CHIP Priority 2.*3 (Protect the public from emerging and re-emerging public health threats)* and CHIP Priority 4.3 (*Reduce Communicable Disease Incidence*).
- E-vaping and efforts being made to reduce this new health threat to our youth.
- The re-branding of local community hospital formerly known as Flagler Hospital to the new name of “Flagler Health +” and its expansion in the community “Health Villages” and through its St. Johns Care Connect which is focused on making impact on the social determinants of Health.
- As part of a new initiative, DOH-SJC and Key Community Leaders, to participate in the National Learning Collaborative Communities of Excellence allowing the community to will expand the focus of the SJC-HLC to a wider range of impacts on social determinants of health and economic vitality of the community.
- The continued participation and sharing of the statewide learning collaborative through Trust for America Health’s “Age-friendly Public Health”.

2019 Progress and 2020 Revisions

Strategic Issue #1: Increase Community Assets

As a result of the Community Health Assessment (CHA) and the use of the Health Leadership Council's (SJC-HLC) prioritization matrix, it was determined that the most pressing needs for additional assets include improved access to community transportation and the need for additional resources for community health improvement. These goals are primarily being addressed through the Sunshine Bus administered through the local Council on Aging (COA) community transit system and through community partnerships facilitated through the St. Johns Care Connect system administered by Flagler Health+.

Goal 1.1: Increase access to public transportation

- **Strategy 1.1.1: Increase public transportation ridership**
  - Objective 1.1.1a: By 12/31/2020, increase number Sunshine Bus riders to at least 309,820 per year.
  - Objective 1.1.1b: By 12/31/2020, increase paratransit riders to at least 7,100.
  - Objective 1.1.1c: By 12/31/2020, increase CTD passes to at least 755 each month.
  - Objective 1.1.1d: By 12/31/2020, increase Sunshine Bus Routes to at least 10 routes.

Key Partners: Council on Aging's Sunshine Transit Service.

2019 Performance							
Objective Number	**Objective**	**2017 Baseline**	**2019 Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.1.1a	By 12/31/2020, increase Sunshine Bus riders to at least 309,820 per year.	283,609	279,311	309,820	12/31/2020	▼	*Not on Track*
1.1.1b	By 12/31/2020, increase paratransit ridership to at least 7,100.				12/31/2020	▲	*On Track*
1.1.1c	By 12/31/2020, increase total monthly CTD passes to at least 755.	670	3,059	755	12/31/2020	▲	*Completed*
1.1.1d	By 12/31/2020, increase Sunshine Bus Routes to 10 routes.	8	9	10	12/31/2020	▲	*On Track*
2020 Revisions							
1.1.1a	By December 2020 increase Sunshine Bus riders to at least 280,000 annually.	279,311		280,000	12/31/2020		
Rationale							
Revision made due to available funding and resource constraints on COA transit service.							

[1]Refer to the trend and status descriptions on page 32

Goal 1.2: Increase resources for Community Health Improvement

- **Strategy 1.2.1: Increase the number of agencies participating in St. Johns Care Connect.**
  - Objective 1.2.1: By 12/31/2020, increase the number of agencies participating in St. Johns Care Connect to at least 30.

Key Partners: Flagler Health+, SJC Behavioral Health Consortium, and other partner agencies

2019 Performance							
Objective Number	Objective	2017 Baseline	2019 Performance	Target Value	Target Date	Trend[1]	Status[1]
1.2.1	By 12/31/2020,increase the number of Care Connect Community Partners to 30.	11	41	30	12/31/20	▲	*Complete*

[1]Refer to the trend and status descriptions on page 32

Progress in 2019

Significant progress was made in pursuing Strategic Issue One, ***Increase Community Assets***. Flagler Health + Care Connect is a community alliance established to connect residents in need with available services and address social determinants of health in a coordinated way throughout all of St. Johns County. The services provided are: access to dental services, prescription assistance program, rental assistance, utility payment assistance, transportation assistance, homeless prevention services, access to local food banks, community resource navigation, case management services, and assistance in establishing a medical home for primary care services. By aligning community resources into a single access point, Flagler Health + and Saint John's Care Connect increases coordination and access of available resources. In 2019, the Flagler Health+ Care Connect expanded to include 41 community-based organizations that collectively serve 4,927 clients. In addition, several new programs were also launched, including BRAVE. BRAVE stands for-Be Resilient and Voice Emotions. It is a collaboration with the St. Johns County School District to reduce the stigma and increase access for youth behavioral health resources and made possible through a $1 million grant from THE PLAYERS.

To further increase resources throughout St. Johns County, Flagler Health+ expanded to include Health Villages throughout St. Johns County. Health Villages include dedicated green spaces for healthy lifestyle and art activities, a community education and partnership center, family practice, pediatrics, specialty care, and women's health services. Currently, the Flagler Health + Village at MuraBella is open and accepting patients. The next location to open in Summer of 2020 is the Flagler Health+ Village at Nocatee. Currently under construction is the Flagler Health + Village at Palm Coast set to open in 2021.

In early 2019, Publix Pharmacy and Flagler Health+ announced an exclusive collaboration to improve the delivery of health care to the residents of St. Johns County. The collaboration initially included three Flagler Health+ branded telehealth sites at Publix locations throughout St. Johns County and an on-site Publix Pharmacy at Flagler Health+. In the latter half of 2019, Flagler Health+ and Publix Super Markets announced that they teamed up to open the first in a series of new telehealth clinics inside Publix locations throughout St. Johns County.

How Targets Were Monitored *Targets for this Strategic Issue are monitored by the lead partner agencies for each goal using locally developed information. Results are provided to the St. Johns County Health Leadership Council (SJC-HLC) on at least an annual basis.*

Strategic Issue #2: Community Learning & Planning

The Community Balanced Scorecard's (CBS) Strategic Issue Two focuses on improving ***Community Learning and Planning***. As a result of the Community Health Assessment (CHA) and the usage of the prioritization matrix and SJC-HLC consensus process, it was determined that the most pressing needs for Learning and Planning include: better assurance of linkage to high quality care by community partners; improvement of community livability through increase in availability of affordable housing; and protecting the population from emerging and re-emerging health threats. These needs are primarily being addressed by community partnerships facilitated through the St. Johns Care Connect system administered by, Flagler Health+, St. Johns County Health and Human Services (HHS), St. Johns County Emergency Management, and Florida Department of Health in St. Johns County (DOH-St. Johns).

Goal 2.1: Assure Linkage to Care

- **Strategy 2.1.1: Increase the percentage of identified needs successfully linked to care by St. Johns Care Connect.**
    - Objective 2.1.1: By 12/31/2020, increase percentage of identified needs successfully linked to care by St. Johns Care Connect to at least 75%.

Key Partners: Flagler Health +, St. Johns Care Connect and numerous partner agencies

2019 Performance							
Objective Number	Objective	2017 Baseline	2019 Performance	Target Value	Target Date	Trend[1]	Status[1]
2.1.1	By 12/31/2020, increase the percentage of identified needs successfully linked to care by St. Johns Care Connect to at least 75%.	66%	96% (2018) 2019 not available	75%	12/31/20	▲	*Complete*

Goal 2.2: Improve Community Livability to address Social Determinants of Health

- Strategy 2.2.1: Maintain County Health Ranking
    - Objective 2.2.1: By 3/31/2020, St. Johns County Health Rankings Report Ranking for Health Factors will remain among the top 10% (Top 7) of counties in Florida.

Key Partners: Florida Department of Health in St. Johns Count, Flagler Health+, Behavioral Health Consortium and other partner agencies

2019 Performance							
Objective Number	Objective	2017 Baseline	2019 Performance	Target Value	Target Date	Trend[1]	Status[1]
2.2.1	By 3/31/2020, St. Johns County Health Rankings Report Ranking for Health Factors will remain among the top 10% (Top 7) of counties in Florida.	First in State	First in State	Top 10% in State (Top 7)	3/31/20	▲	*Complete*

[1]Refer to the trend and status descriptions on page 32

Goal 2.2: Improve Community Livability to address Social Determinants of Health

- Strategy 2.2.2: Increase Affordable Housing Accessibility
  - Objective 2.2.2a: By 12/31/2020, increase the number of affordable housing units created (or rehabbed) to at least 75 units per year.
  - Objective 2.2.2b: By 12/31/2020, increase the percentage of participants counselled in Home-buyer Education program (those who purchase a home) to 30% or more.
  - Objective 2.2.2c: By 12/31/2020, increase the number of smoke-free properties in Saint Johns County to 6 or more properties.
  - Objective 2.2.2d: By 12/31/2020, increase the number of homeless individuals who are linked to housing to at least 60.
  - Objective 2.2.2e: By 12/31/2020, increase the percentage of indigent people linked to housing within 30 days of program release, to at least 75%.

Key Partners: St. Johns County Health and Human Services (HHS), Flagler Hospital's St. Johns Care Connect, Tobacco Free St. Johns, and other Community Partners.

2019 Performance							
Objective Number	Objective	2017 Baseline	2019 Performance	Target Value	Target Date	Trend[1]	Status[1]
2.2.2a	By 12/31/2020, increase the number of affordable housing units created/ rehabbed to at least 75 units per year.	0	51 (2018-19)	75	12/31/2020	▲	*On Track*
2.2.2b	By 12/31/2020, increase the percentage of participants counselled through the Homebuyer Education Program who purchased a home to at least 30%.	0	28% (2018-19)	30%	12/31/2020	▲	*On Track*
2.2.2c	By 12/31/2020, increase the number of smoke-free properties to at least 6.	5	11	6	12/31/2020	▲	*Completed*
2.2.2d	By 12/31/2020, increase the number of individuals who are homeless that are linked to housing to at least 60people.	0	63 (2018) *2019 not yet available*	60	12/31/2020	▲	*Completed*
2.2.2e	By 12/31/2020, increase the percentage of indigent people linked to housing within 30 days of release, to at least 75%.	0	79% (2018) *2019 not yet available*	75%	12/31/2020	▲	*Completed*

[1]Refer to the trend and status descriptions on page 32

Goal 2.3: Protect the population from Emerging Health Threats

- Strategy 2.3.1: Increase the number of agencies active in the Long-Term Recovery Committee
  - Objective 2.3.1: By 12/31/2020, increase the number of actively participating agencies in the St. Johns Long-Term Recovery Committee to at least 25.

Key Partners: St. Johns County Emergency Management, Flagler Health+ and numerous other partner agencies

2019 Performance							
Objective Number	Objective	2017 Baseline	2019 Performance	Target Value	Target Date	Trend[1]	Status[1]
2.3.1	By 12/31/2020, increase the number of agencies actively participating in the St. Johns Long-term Recovery Committee to at least 25.	0	12	25	12/31/2020	▲	*On Track*

[1]Refer to the trend and status descriptions on page 32

Goal 2.3: Protect the population from Emerging Health Threa*ts* *(continued)*

- NEW Strategy 2.3.2: Increase the number of Hepatitis A vaccinations in response to Public Health Emergency
  - NEW Objective 2.3.2 By 12/31/2020, provide Hepatitis A vaccinations to at least 80% of at-risk county population.

Key Partners: Florida Department of Health in St. Johns County (DOH-St. Johns) and multiple partner organizations

2019 Performance							
Objective Number	Objective	2017 Baseline	2019 Performance	Target Value	Target Date	Trend[1]	Status[1]
2.3.2	By 12/31/2020, provide Hepatitis A vaccinations to at least 80% of at-risk in the St. Johns County population.	NA	63%	80%	12/31/ 2020	▲	*On Track*
Rationale							
NEW Objective 2.3.2, In Support of 2.3 and 4.3, this objective was added in response to ongoing Public Health emergency due to statewide outbreak of Hepatitis A cases.							

[1]Refer to the trend and status descriptions on page 32

Progress in 2019

There is strong evidence of successful ***Community Learning and Planning*** as demonstrated by St. Johns County being ascribed by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute the Healthiest County in the State for eight straight years in terms of Health Factors in the County Health Rankings report. Response to the social determinants of health can be clearly seen in ongoing increase in the number of affordable housing units, and successful linkage to care through the new and expanding St. Johns Care Connect led by Flagler Health+.

Responsiveness to emergent public health threats is shown in the operation of the Special Needs Shelter by the Florida Department of Health in St. Johns (DOH-St. Johns) during Hurricane Dorian and, the very successful efforts to prepare and respond to that serious threat by St. Johns County Emergency Management (St. Johns-EOC) and many community partner agencies.

The most recent and ongoing public health threat is the Hepatitis A outbreak. In August of 2019, the Florida Surgeon General Dr. Scott Rivkees declared a Public Health Emergency to address the increase in Hepatitis A cases in Florida. Following are key steps taken in response:

- An Incident Command Team (IMT) was set up and briefed the Health Leadership Council (SJC-HLC) on the Hepatitis A Public Health Emergency. Educational messaging was provided to partners.
- Community outreach efforts began as a means of preventing the spread of Hepatitis A. With collaboration from our community partners outreach vaccination efforts took place at numerous county locations where the at-risk population is likely to congregate which includes the local hospital, local jail system and parole programs, drug recovery treatment facilities, and others.
- By year-end 2019, 63% of the target population had been vaccinated with a goal of reaching 80% to provide herd immunity to this population.

How Targets Were Monitored - *Targets for Strategic Issue Two are monitored by the lead partner agencies for each goal primarily using locally developed information. Results for most indicators are provided to the St. Johns Health Leadership Council (SJC-HLC) on an annual basis.*

Strategic Issue #3: Community Implementation

The Community Balanced Scorecard's (CBS) Strategic Issue Three focuses on ***Community Implementation*** of evidence base practices and services by community partners. Those practices will result in mitigation and prevention of behaviors that often cause poor health outcomes. As a result of the Community Health Assessment (CHA) and the usage of a prioritization matrix and SJC-HLC consensus process, it was determined the most pressing needs for Community Implementation include the following: improved child safety and well-being; reduction of risky behaviors; and improved access to care (dental care and behavioral health care). These goals are primarily being addressed through community partners that focus on these services. These include: Saint Johns County's Health and Human Services (HHS), St. Johns County Schools, The Florida Department of Health in St. Johns (DOH-St. Johns), EPIC Behavioral Health, Stuart Marchman Act (SMA), Tobacco Free St. Johns, and other Community Partners.

Goal 3.1: Improve Child Safety and Well-being

- Strategy 3.1.1: Increase the Immunization Rates for Children
  - Objective 3.1.1a: By 12/31/2020, increase the immunization rates for St. Johns County Kindergarten Students to at least 95%.
  - Objective 3.1.1b: By 12/31/2020, increase the immunization rates for St. Johns County 7th Grade Students to at least 95%.

Key Partners: St. Johns County School District, DOH St. Johns, and other Community Partners

2019 Performance							
Objective Number	**Objective**	**2017 Baseline**	**2019 Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
3.1.1a	By 12/31/2020, increase the immunization coverage rates for St. Johns County Kindergarten Students to at least 95%	94.1%	93.5%	95%	12/31/20	▼	***Not on Track***
3.1.1b	By 12/31/2020 increase the immunization coverage rates for St. Johns County 7th Grade Students to at least 95%	95.5%	97.0%	95%	12/31/20	▲	***On Track***

[1]Refer to the trend and status descriptions on page 32

Goal 3.1: Improve Child Safety and Well-being

- Strategy 3.1.2: Reduce Child Neglect or Abuse
  - Objective 3.1.2a: By 12/31/2020, increase the percentage of children not neglected or abused after receiving services to at least 95%.
  - Objective 3.1.2b: By 12/31/2020, increase the percentage of children diverted from out of home care to at least 90%.

Key Partners: St. Johns County School District

2019 Performance							
Objective Number	Objective	2017 Baseline	2019 Performance	Target Value	Target Date	Trend[1]	Status[1]
3.1.2a	By 12/31/2020, increase the percentage children not neglected or abused after receiving services to at least 95%.	94.3%	93.7% (FY18-19)	95%	12/31/20	▼	Not on Track
3.1.2b	By 12/31/2020, increase the percentage of children diverted from out of home care to at least 90%.	87.6%	95.7.0% (FY18-19)	90%	12/31/20	▲	On Track

Goal 3.2: Reduce Risky Behaviors

- Strategy 3.2.1: Reduce percentage of Population Reporting Inhaled Nicotine Use
  - Objective 3.2.1a: By 12/31/2020, decrease adult cigarette usage to less than 12%.
  - Objective 3.2.1b: By 12/31/2020, decrease youth cigarette usage to less than 3.4%.
  - Objective 3.2.1c: By 12/31/2020, decrease adult e-cigarette usage to less than 4.7%. THIS DOES NOT MATCH TABLE
  - Objective 3.2.1d: By 12/31/2020, decrease youth e-vaping usage to less than 13.1%.

Key Partners: Tobacco Free St. Johns, Wildflower Healthcare, Flagler Health+, and others.

2019 Performance							
Objective Number	Objective	2017 Baseline	2019 Performance	Target Value	Target Date	Trend[1]	Status[1]
3.2.1a	By 12/31/2020, decrease adult cigarette usage to less than 12%.	12.2%	TBD 2019 BRFSS	12%	12/31/20	▼	On Track
3.2.1b	By 12/31/2020, decrease youth cigarette usage to less than 3.4%.	3.5%	2.3% (2018)	3.4%	12/31/20	▼	On Track
3.2.1c	By 12/31/2020, decrease adult e-cigarette usage to less than 12%.	4.8%	TBD 2019 BRFSS	4.7%	12/31/20	▼	On Track
3.2.1d	By 12/31/2020, decrease youth e-vaping usage to less than 4.7%.	13.5%	20.8%	13.1%	12/31/20	▼	Not on Track
2020 Revisions							
3.2.1d	By 12/31/2020, decrease youth e-vaping usage to less than 20%.	20.8% (2018)		20%	12/31/20		
Rationale							
These indicators reflect the outcomes of the efforts being made to reverse youth e-vaping state and national trend through policy change and education							

[1]Refer to the trend and status descriptions on page 32

Goal 3.2: Reduce Risky Behaviors (continued)

- Strategy 3.2.2: Reduce Binge Drinking
  - Objective 3.2.2a: By 12/31/2020, decrease the estimated proportion of adult binge drinking in the county to less than 19.5%.
  - Objective 3.2.2b: By 12/31/2020, decrease the estimated proportion of youth binge drinking in the county to less than 6.7%.

Key Partners: EPIC Behavioral Health, PACT Prevention Coalition, and other Community Partners

2019 Performance							
Objective Number	Objective	2017 Baseline	2019 Performance	Target Value	Target Date	Trend [1]	Status[1]
3.2.2a	By 12/31/2020, decrease adult binge drinking to less than 19.5%.	20.1%	NA waiting for 2019 BRFSS	19.5%	12/31/20	▼	*On Track*
3.2.2b	By 12/31/2020, decrease youth binge drinking to less than 6.7%.	6.9%%	7.9% (2018)	6.7%	12/31/20	▼	*Not on Track*

- Strategy 3.2.3: Reduce Marijuana Usage
  - Objective 3.2.3a: By 12/31/2020, decrease the estimated proportion of adult marijuana usage in the county to less than 7.6%.
  - Objective 3.2.3b: By 12/31/2020, decrease the estimated proportion of youth marijuana usage in the county to less than 11.4%.

Key Partners: EPIC Behavioral Health, PACT Prevention Coalition, and other Community Partners

2019 Performance							
Objective Number	Objective	2017 Baseline	2019 Performance	Target Value	Target Date	Trend[1]	Status[1]
3.2.3a	By 12/31/2020, decrease adult marijuana usage to less than 7.6%.	7.8%	NA waiting for 2019 BRFSS	7.6%	12/31/20	▼	*On Track*
3.2.3b	By 12/31/2020, decrease youth marijuana usage to less than 11.4%.	11.7%	11.8% (2018)	11.4%	12/31/20	▼	*On Track*

[1]Refer to the trend and status descriptions on page 32

Goal 3.2: Reduce Risky Behaviors (continued)

- Strategy 3.2.4: Reduce Opioid Abuse
  - Objective 3.2.4: By 12/31/2020, Reduce the number of drug poisoning deaths to less than 30 per year.

Key Partners: St. Johns County Opioid Task Force, St. Johns County Health and Human Services (HHS), Florida National Guard, The Florida Department of Health in St. Johns (DOH-St. Johns), EPIC Behavioral Health, PACT Prevention Coalition, Betty Griffin Center, and other Community Partners

2019 Performance							
Objective Number	**Objective**	**2017 Baseline**	**2019 Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
3.2.4	By 12/31/2020, reduce the number of drug-related poisoning deaths to less than 30 deaths per year.	40	32 (2018) *(2019 Data not yet available)*	30	12/31/2020	▼	*On Track*

[1]Refer to the trend and status descriptions on page 32

Goal 3.3: Increase Access to Dental Care

- Strategy 3.3.1: Reduce ER Admissions for Dental Emergencies
  - Objective 3.3.1: By 12/31/2020, reduce local hospital Emergency Room admissions for dental emergencies (for people ages 5 years old and older) to less than 1,000 admissions per year.

Key Partners: Flagler Health+, Wildflower clinic, and Florida Department of Health in St. Johns County

2019 Performance							
Objective Number	**Objective**	**2017 Baseline**	**2019 Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
3.3.1	By 12/31/20, reduce emergency room admissions for dental emergencies (ages 5 and older) to less than 1,000 per year.	1,116	967 (2018) *2019 TBD*	1,000	12/31/20	▲	*Completed*

NOTE: Data source changed to FLCHARTS

[1]Refer to the trend and status descriptions on page 32

Goal 3.3: Increase Access to Dental Care (continued)

- Strategy 3.3.2: Increase the number of dental client visits to Wildflower Clinic
  - Objective 3.3.2: By 12/31/2020, Increase the number of client dental visits to Wildflower Clinic to more than 1,708 per year.

Key Partners: Wildflower Healthcare Clinic

2019 Performance							
Objective Number	Objective	2017 Baseline	2019 Performance	Target Value	Target Date	Trend[1]	Status[1]
3.3.2	By 12/31/2020, Increase the number of client dental visits to Wildflower Clinic to more than 1,708 per year.	NA	1,553 (2018) 2019 TBD	1,708	12/31/20	▲	*On Track*

[1]Refer to the trend and status descriptions on page 32

- Strategy 3.3.3: Increase the number of schools participating in school-based pediatric dental program
  - Objective 3.3.3: By 12/31/2020, Increase the number of participants in school-based dental program to at least 6 schools.

Key Partners: Florida Department of Health in St. Johns County, St. Johns County Schools.

2019 Performance							
Objective Number	Objective	2017 Baseline	2019 Performance	Target Value	Target Date	Trend[1]	Status[1]
3.3.3	By 12/31/2020, Increase the number of participants in school-based dental program to at least 6 schools.	4	5	6	12/31/2020	▲	*On Track*

[1]Refer to the trend and status descriptions on page 32

Goal 3.4: Increase Access to Mental Health Care

- Strategy 3.4.1: Reduce the percentage of adult Baker Act crisis readmissions.
  - Objective 3.4.1: By 12/31/2020, reduce the percentage adult Baker Act crisis readmission to less than 15.5%.

Key Partners: Flagler Health+, Behavioral Health Consortium, Lutheran Services.

2019 Performance							
Objective Number	Objective	2017 Baseline	2019 Performance	Target Value	Target Date	Trend[1]	Status[1]
3.4.1	By 12/31/2020, reduce the percentage adult Baker Act crisis readmission to less than 15.5%.	17.5%	Not Available Yet	15.5%	12/31/20	▲	*Not known*

[1]Refer to the trend and status descriptions on page 32

Goal 3.4: Increase Access to Mental Health Care (continued)

- Strategy 3.4.2: Reduce the wait time for initial mental health outpatient assessment and appointment
  - Objective 3.4.2: By 12/31/2020, Maintain the wait times for the initial outpatient assessment and appointment to less than one day.

Key Partners: SMA, EPIC Behavioral Services, Flagler Health+, and other Community Partners.

2019 Performance							
Objective Number	Objective	2017 Baseline	2019 Performance	Target Value	Target Date	Trend[1]	Status[1]
3.4.2	By 12/31/2020, Maintain the wait times for the initial outpatient assessment and appointment to less than one day.	0-1 day	0-1 day	Less than 1 day	12/31/20	▲	*On Track*

[1]Refer to the trend and status descriptions on page 32

- Strategy 3.4.3: Increase the number of mental health clinic clients seen
  - Objective 3.4.3: By 12/31/2020, increase the number of adult and child/adolescent mental health clients seen by EPIC and SMA to more than 2,200 annually.

Key Partners: SMA, EPIC Behavioral Services, Flagler Health+

2019 Performance							
Objective Number	Objective	2017 Baseline	2019 Performance	Target Value	Target Date	Trend[1]	Status[1]
3.4.3	By 12/31/20, increase the number of adult and child/adolescent mental health clients seen by EPIC and SMA to 2,200 annually or greater.	1,959	Not Yet Available	2,200	12/31/20	▲	*Not known*

[1]Refer to the trend and status descriptions on page 32

- Strategy 3.4.4: Increase the availability of FACT and Mobile Crisis response team to 168 hours per week
  - Objective 3.4.4: By 12/31/2020, increase the number of available hours for FACT and Mobile Crisis Response teams to 168 hours weekly.

Key Partners: St. Johns County Behavioral Health Consortium

2019 Performance							
Objective Number	Objective	2017 Baseline	2019 Performance	Target Value	Target Date	Trend[1]	Status[1]
3.4.4	By 12/31/2020, increase the number of available hours for FACT and Mobile Crisis Response teams to 168 hours weekly.	168	168	168	12/31/20	▲	*Completed*

[1]Refer to the trend and status descriptions on page 32

Progress in 2019

There is strong evidence of successful ***Community Implementation*** as seen by St. Johns County being ascribed the Healthiest County in the State for eight straight years in terms of Health Factors in the County Health Rankings report through the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. Response to the social determinants of health can be clearly seen in ongoing increase in the number dental and mental health services available, along with, new policy regarding under 21 usage of tobacco and vaping products. Key partners in the success include: Florida Department of Health in St. Johns County (DOH-St. Johns), Flagler Health+, Tobacco Free St. Johns, the St. Johns County Behavioral Health Consortium, EPIC Behavioral Services, Stuart Marchman Act (SMA), Wildflower Healthcare, and other Community Partners.

How Targets Were Monitored: *Targets for Issue Three are monitored by the lead partner agencies for each goal primarily using locally developed information. Some results are tracked via the Florida Health Charts and the Behavioral Risk Factors Surveillance System (BRFSS) survey done every three years at the county level. Results for most indicators are provided to the St. Johns County Health Leadership Council (SJC-HLC) on an annual basis.*

Strategic Issue #4: Community Health Status

The Community Balanced Scorecard's (CBS) Strategic Issue Four focuses on ***Community Health Status***. Strategic Issue Four provides information pertaining to key health outcomes and long-term health indicators that show evidence of the success of the programs and services shown in Strategic Issue 1, 2, and 3. As a result of the Community Health Assessment (CHA) and the usage of a prioritization matrix, it was determined the most pressing needs to improve Community Health Status include: improvement of overall health outcomes, reduction in chronic disease and health inequities, reduction of communicable disease, and reduction of crime and injury. These goals are primarily being addressed through the community partners that focus on these issues. These include, the Florida Department of Health in St. Johns County (DOH-St. Johns), Flagler Health +, the St. Johns County Behavioral Health Consortium, Florida Department of Children and Families (DCF), St. Johns County Sherriff's Department, St. Johns County Council on Aging (COA), Betty Griffin Center, and other community partners.

Goal 4.1: Improve Overall Health Outcomes

- Strategy 4.1.1: Maintain County Rankings for Health Outcomes in top 10%
    - Objective 4.1.1: By 3/31/2020, St. Johns County Ranking in the Health Rankings Report Ranking for Health Outcomes will remain among the top 10% (Top 7) of counties in Florida.

Key Partners: DOH-St. Johns, Flagler Health+, Behavioral Health Consortium, Sherriff's Department, Council on Aging, and other partner agencies

2019 Performance							
Objective Number	**Objective**	**2017 Baseline**	**2019 Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
4.1.1	By 3/31/2020, St. Johns County Health Rankings Report Ranking for Health Outcomes will remain among the top 10% (Top 7) of counties in Florida.	First in State	First in State	Top 10% in State (Top 7)	3/31/20	▲	*Completed*

[1]Refer to the trend and status descriptions on page 32

- Strategy 4.1.2: Reduce Infant Mortality Rate
  - Objective 4.1.2a: By 12/31/2020, Reduce Overall Infant Mortality Rate to less than 5.2 per 1,000 live births *(Three year rolling rate)*.
  - Objective 4.1.2b: By 12/31/2020, Reduce Black Infant Mortality Rate to less than 9.8 per 1,000 live births *(Three year rolling rate)*.
  - Objective 4.1.2c: By 12/31/2020, Reduce White Infant Mortality Rate to less than 4.6 per 1,000 live births *(Three year rolling rate)*.

Key Partners: The Florida Department of Health in St. Johns County (DOH-St. Johns), Flagler Health+, Behavioral Health Consortium, Sherriff's Department, Council on Aging (COA), and other partner agencies.

2019 Performance							
Objective Number	**Objective**	**2017 Baseline**	**2019 Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
4.1.2a	By 12/31/2020, Reduce Overall Infant Mortality Rate to less than 5.2 per 1,000 live births *(Three year rolling rate).*	5.4 *(2014-16 Rolling)*	4.3 *(2016-18 Rolling)*	5.2	12/31/2020	▲	***On Track***
4.1.2b	By 12/31/2020, Reduce Black Infant Mortality Rate to less than 9.8 per 1,000 live births *(Three year rolling rate).*	10.1 *(2014-16 Rolling)*	14.8 *(2016-18 Rolling)*	9.8	12/31/2020	▼	***Not on Track***
4.1.2c	By 12/31/2020. Reduce White Infant Mortality Rate to less than 4.6 per 1,000 live births *(Three year rolling rate).*	4.7 *(2014-16 Rolling)*	3.4 *(2016-18 Rolling)*	4.6	12/31/2020	▲	***On Track***
2020 Revisions							
4.1.2b	*By 12/31/2020, Reduce Black Infant Mortality Rate to less than 12.0 per 1,000 live births (Three year rolling rate).*	14.8 *(2016-18 Rolling)*		12.0	12/31/2020		
Rationale							
Three black infant deaths occurred in 2018. This will impact the rolling rate for the next two years.							

[1]Refer to the trend and status descriptions on page 32

Goal 4.2: Reduce Chronic Disease and Related Health Inequities (Health Equity)

- Strategy 4.2.1: Reduce Death Rate due to Cancer
  - Objective 4.2.1a: By 12/31/2020, Reduce Overall Death Rate due to Cancer to less than 155.0 per 100,000 population *(Three year rolling rate).*
  - Objective 4.2.1b: By 12/31/2020, Reduce Black Death Rate due to Cancer to less than 164.8 per 100,000 population *(Three year rolling rate).*
  - Objective 4.2.1c: By 12/31/2020, Reduce White Death Rate due to Cancer to less than 156.6 per 100,000 population *(Three year rolling rate).*

Key Partners: Flagler Health+, The Florida Department of Health in St. Johns County (DOH-St. Johns), Behavioral Health Consortium, Tobacco Free St. Johns, and other partner agencies

2019 Performance							
Objective Number	**Objective**	**2017 Baseline**	**2019 Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
4.2.1a	By 12/31/2020, Reduce Overall Death Rate due to Cancer to less than 155.0 per 100,000 population *(Three year rolling rate).*	159.8 *(2014-16 Rolling)*	149.4 *(2016-18 Rolling)*	155.0	12/31/2020	▲	*On Track*
4.2.1b	By 12/31/2020, Reduce Black Death Rate due to Cancer to less than 164.8 per 100,000 population *(Three year rolling rate).*	169.9 *(2014-16 Rolling)*	155.5 *(2016-18 Rolling)*	164.8	12/31/2020	▲	*On Track*
4.2.1c	By 12/31/2020, Reduce White Death Rate due to Cancer to less than 156.6 per 100,000 population *(Three year rolling rate).*	161.4 *(2014-16 Rolling)*	151.1 *(2016-18 Rolling)*	156.6	12/31/2020	▲	*On Track*

[1]Refer to the trend and status descriptions on page 32

- Strategy 4.2.2: Reduce Death Rate Due to Coronary Heart Disease
  - Objective 4.2.2a: By 12/31/2020, Reduce Overall Death Rate due to Coronary Heart Disease to less than 75.6.0 per 100,000 population *(Three year rolling rate).*
  - Objective 4.2.2b: By 12/31/2020, Reduce Black Death Rate due to Coronary Heart Disease to less than 90.1 per 100,000 population *(Three year rolling rate).*
  - Objective 4.2.2c: By 12/31/2020, Reduce White Death Rate due to Coronary Heart Disease to less than 75.6 per 100,000 population *(Three year rolling rate).*
  -

Key Partners: Flagler Health+, DOH-St. Johns, Tobacco Free St. Johns, and other agencies

2019 Performance							
Objective Number	**Objective**	**2017 Baseline**	**2019 Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
4.2.2a	By 12/31/2020, Reduce Overall Death Rate due to Coronary Heart Disease to less than 75.6.0 per 100,000 population. *(Three year rolling rate)*	77.9 *(2014-16 Rolling)*	75.3 *(2016-18 Rolling)*	75.6	12/31/2020	▲	*On Track*
4.2.2b	By 12/31/2020, Reduce Black Death Rate due to Coronary Heart Disease to less than 90.1 per 100,000 population. *(Three year rolling rate)*	92.9 *(2014-16 Rolling)*	91.8 *(2016-18 Rolling)*	90.1	12/31/2020	▲	*On Track*
4.2.2c	By 12/31/2020, Reduce White Death Rate due to Coronary Heart Disease to less than 75.6 per 100,000 population. *(Three year rolling rate)*	77.9 *(2014-16 Rolling)*	75.7 *(2016-18 Rolling)*	75.6	12/31/2020	▲	*On Track*

[1]Refer to the trend and status descriptions on page 32

Goal 4.2: Reduce Chronic Disease & Related Health Inequities (Health Equity) (Continued)

- Strategy 4.2.3: Reduce Hospitalizations from Diabetes
  - Objective 4.2.3a: By 12/31/2020, Reduce Overall Hospitalizations from or with Diabetes to less than 1,557.7 per 100,000 population *(Three year rolling rate).*
  - Objective 4.2.3b: By 12/31/2020, Reduce Black Hospitalizations from or with Diabetes to less than 4,510.1 per 100,000 population *(Three year rolling rate).*
  - Objective 4.2.3c: By 12/31/2020, Reduce White Hospitalizations from or with Diabetes to less than 1,401.5 per 100,000 population *(Three year rolling rate).*
  - Objective 4.2.3d: By 12/31/2020, Increase Diabetic Medicare Enrollees that receive HbA1C monitoring to at least 87%.

Key Partners: Flagler Health+, The Florida Department of Health in St. Johns County (DOH-St. Johns), Tobacco Free St. Johns, other partner agencies

2019 Performance							
Objective Number	**Objective**	**2017 Baseline**	**2019 Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
4.2.3a	By 12/31/2020, Reduce Overall Hospitalizations from or with Diabetes to less than 1557.7 per 100,000 population *(Three year rolling rate)*	1605.9 *(2014-16 Rolling)*	1532.1 *(2016-18 Rolling)*	1557.7	12/31/20	▲	**On Track**
4.2.3b	By 12/31/2020, Reduce Black Hospitalizations from or with Diabetes to less than 4510.1 per 100,000 population *(Three year rolling rate)*	4649.6 *(2014-16 Rolling)*	4120.0 *(2016-18 Rolling)*	4510.1	12/31/20	▲	**On Track**
4.2.3c	By 12/31/2020, Reduce White Hospitalizations from or with Diabetes to less than 401.5 per 100,000 population *(Three year rolling rate)*	1444.8 *(2014-16 Rolling)*	1387.1 *(2016-18 Rolling)*	1401.5	12/31/20	▲	**On Track**
4.2.3d	By 12/31/2020, Increase Diabetic Medicare Enrollees that receive HbA1C monitoring to at least 87%. (Replaced see below)	86.2%	Data Source No longer available	87%	12/31/20		**NA**
2020 Revisions							
4.2.3d	By 12/31/2020, reduce preventable hospitalizations from diabetes under age 65 to less than 100.0 per 100,000 population.	103.7 (2016-18)		100.0	12/31/20		
Rationale							
Objective 4.2.3 d was revised due to indicator source no longer being available.							

[1]Refer to the trend and status descriptions on page 32

Goal 4.3: Reduce Communicable Disease Incidence

- Strategy 4.3.1: Increase Percent of HIV patients with Suppressed Viral Load
  - Objective 4.3.1: By 12/31/2020, increase percent of HIV patients with suppressed viral load to at least 80%.

Key Partners: DOH-St. Johns, and other partner agencies.

2019 Performance							
Objective Number	Objective	2017 Baseline	2019 Performance	Target Value	Target Date	Trend[1]	Status[1]
4.2.1	By 12/31/2020, increase percent of HIV patients with suppressed viral load to at least 80%.	85% (2016)	92%	80%	12/31/2020	▲	*On Track*

[1]Refer to the trend and status descriptions on page 32

Goal 4.4: Reduce Crime and Injury

- Strategy 4.4.1: Reduce Domestic Violence Offense Rate
  - Objective 4.4.1: By 12/31/2020, reduce the domestic violence offense rate to less than 362.7 per 100,000 population.

Key Partners: Betty Griffin Center, Department of Children and Families (DCF), Council on Aging (COA), and other partner agencies.

2019 Performance							
Objective Number	Objective	2017 Baseline	2019 Performance	Target Value	Target Date	Trend[1]	Status[1]
4.4.1	By 12/31/2020, reduce domestic violence offense rate to less than 362.7 per 100,000 population.	373.9 (2014-16)	328.2	362.7	12/31/2020	▲	*On Track*

[1]Refer to the trend and status descriptions on page 32

Goal 4.4: Reduce Crime and Injury (continued)

- Strategy 4.4.2: Reduce Unintentional Injuries
  - Objective 4.4.2a: By 12/31/2020, reduce the unintentional injury death rate to less than 42.4 per 100,000 population.
  - Objective 4.4.2b: By 12/31/2020, reduce the number of injuries from falls among adults over age 60 to less than 1,580.

Key Partners: Council on Aging, Florida Department of Health in St. Johns County and others.

2019 Performance							
Objective Number	**Objective**	**2017 Baseline**	**2019 Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
4.4.2a	By 12/31/2020 reduce unintentional injury death rate to less than 42.4 per 100,000 population	43.7 (2014-16)	47.5 (2016-18)	42.4	12/31/20	▼	***Not on Track***
4.4.2b	By 12/31/2020 reduce number of injuries from falls among adults over age 60 to less than 1,580 (Replaced see below)	1,755	*Data Source No longer available*	1,580	12/31/20		**NA**
2020 Revisions							
4.4.2b	By 12/31/2020, reduce number of deaths from falls among adults over age 65 to less than 22.	23 (2018)		22	12/31/20		
Rationale							
Strategy 4.4.2b was revised due to inability to obtain data for previous indicator.							

[1]Refer to the trend and status descriptions on page 32

- Strategy 4.4.3: Reduce Suicide Rate
  - Objective 4.4.3: By 12/31/2020 reduce overall suicide rate to less than 16.9 per 100,000 population.

Key Partners: EPIC Behavioral Health, and other partner agencies

2019 Performance							
Objective Number	**Objective**	**2017 Baseline**	**2019 Performance**	**Target Value**	**Target Date**		
4.4.1	By 12/31/2020 reduce overall suicide rate to less than 16.9 per 100,000 population.	17.4 (2014-16)	18.6	16.9	12/31/2020	▼	***Not on Track***

[1]Refer to the trend and status descriptions on page 32

Progress in 2019

There is strong evidence of excellent results for ***Community Health Status*** in St. Johns County as seen by St. Johns County being ascribed the Healthiest County in the State for eight straight years in terms of both Health Outcome and Health Factors in the County Health Rankings report by the *Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute.* Excellent services and Care Coordination that contribute to good health outcomes are provided by Flagler Health+ for Cancer, Coronary Heart Disease, and Diabetes treatment and education. Excellent services and Care Coordination are provided for HIV clients by the Florida Department of Health in St. Johns County (DOH-St. Johns). A new contract through Currant Health has enabled certain HIV clients to have better access to their needed medications at no cost or at very low cost. Additionally, excellent service provided by the Council on Aging (COA) has enabled older residents the ability to continue to live in their homes that have been made more fall proof and accident proof by the services provided.

How Targets Were Monitored

Most targets for Issue four are monitored by DOH-St. Johns from information available through Florida Health CHARTS, County Health Rankings or other publicly available reputable sources. A few of these results are tracked via locally developed data sources. Results for most indicators are available and provided to the St. Johns County Health Leadership Council (SJC-HLC) on an annual basis.

Trend and Status Descriptions

***Trend Descriptions**:

▲ = Data trend is upward and in the desired direction for progress
▼ = Data trend is downward and in the desired direction for progress
▲ = Data trend is upward and in the undesired direction for progress
▼ = Data trend is downward and in the undesired direction for progress

****Status Descriptions**:

- **On Track** = Objective progress is exceeding expectations or is performing as expected at this point in time
- **Not on Track** = Objective progress is below expectations at this point in time
- **Decision Required** = Objective is at risk of not completing/meeting goal. Management decision is required on mitigation/next steps.
- **Completed** = Objective has been completed or has been met and the target date has passed
- **Not Completed** = Objective has not been completed or has not been met and the target date has passed

Enhanced Objectives

Goal 2.3: Protect the population from emerging health threats

New Strategy 2.3.2: Increase the number of Hepatitis A vaccinations in response to Public Health Emergency

New Objective 2.3.2 By 12/31/2020, provide Hepatitis A vaccinations to at least 80% of at-risk county population.

Key Partners: Florida Department of Health in St. Johns (DOH-St. Johns) and multiple partner organizations.

New Objective Number	New Objective	2018 Baseline	Target Value	Target Date
2.3.2	By 12/31/2020, provide Hepatitis A vaccinations to at least 80% of at-risk county population.	0	80%	12/31/2020
New Objective Rationale				
In support of Priority 4.3 and 2.3, Objective 2.3.2 was added in response to ongoing Public Health emergency due to statewide outbreak of Hepatitis A cases.				

Accomplishments

Goal	Objective	Accomplishment
1.2.1: Increase the number of agencies participating in St. Johns Care Connect.	By 12/31/2020, increase the number of partners of St. Johns Care Connect System to at least 30 members.	The goal was to expand the number of partner members of the newly established St. Johns Care Connect partnering system to at least 30-members. As of this date there are now 41 member organizations.
Why This Accomplishment is Important for Our Community		
St. Johns Care Connect is a community alliance established to connect residents in need with available services and address social determinants of health in a coordinated way throughout all of St. Johns County. Some of the services provided are; access to dental services, prescription assistance program, rental assistance, utility payment assistance, transportation assistance, homeless prevention services, access to local food banks, community resource navigation, case management services, and assistance in establishing a medical home for primary care services. By aligning community resources into a single access point, St. Johns Care Connect increases coordination and access of available resources. In 2019, Flagler Health+ Care Connect expanded to include 41 community-based organizations that collectively serve 4,927 clients.		

Goal	Objective	Accomplishment
2.3.2: Increase the number of Hepatitis A vaccinations in response to Public Health Emergency.	By 12/31/2020, provide Hepatitis A vaccinations to at least 80% of at-risk county population.	In response to the public health emergency the Florida Department of Health in St. Johns County (DOH-St. Johns) was charged to work with community partners to administer more than 4,000 Hepatitis A vaccinations to the at-risk population.
Why This Accomplishment is Important for Our Community		
This recent and ongoing public health threat is the Hepatitis A outbreak. In August of 2019, the Florida Surgeon General Dr. Scott Rivkees declared a Public Health Emergency to address the increase in Hepatitis A cases in Florida. Following are key steps taken in response: • Incident Command Team was set up and briefed the Health Leadership Council on the Hepatitis A Public Health Emergency. Educational messaging was provided to partners • Community outreach efforts began as a means of preventing the spread of Hepatitis A • With collaboration from our community partners outreach vaccination efforts took place at numerous county locations where the at-risk population is likely to congregate. • By year-end 2019, 63% of the target population had been vaccinated with a goal of reaching 80% to provide herd immunity to this population.		

Conclusion

A Community Health Improvement Plan (CHIP) is not meant to be a static document, but rather one that changes and evolves over time as new information and issues emerge at the local, state, and national levels. The Community Balanced Scorecard (CBS) approach used by the St. Johns County Health Leadership Council (SJC-HLC) has proven to be an effective tool to track and measure the collective impact on the strategic priorities and objectives identified in the CHIP.

Progress toward the accomplishment of the SJC-HLC's strategic objectives is reported and evaluated at regularly scheduled SJC-HLC meetings, which are held quarterly. The annual review and revision of the St. Johns County CHIP is completed annually, and the recommendations contained in the Community Health Improvement Plan continue to be worked on in collaboration with the members of the SJC-HLC, and other key stakeholders.

In 2019, for the eighth consecutive year, St. Johns County was ranked the healthiest county in Florida, by the Robert Wood Johnson Foundation's County Health Rankings Report. This can be attributed not only to the work of the SJC-HLC, but the entire St. Johns County public health system. Local leadership and effective facilitation provided by DOH-St. Johns has resulted in a collaborative that understands and is more vested in the community they serve. They know and trust each other, and work together effectively, using data to make evidence-based decisions to identify strategic issues, formulate SMART goals and develop strategies to drive community health improvement in St. Johns County.

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Appendix A: Health Leadership Council Annual Meeting Agenda

Agenda

St. Johns County Health Leadership Council Meeting
Wednesday December 18, 2019 beginning at 3:30 PM

Florida Department of Health in St. Johns County (DOH-St. Johns)
Muscovy Conference Room - 200 San Sebastian View, St. Augustine, FL 32084

Champion: Dr. Dawn Allicock, Health Officer & Director of DOH-St. Johns County Health Department
Co-Chairs: John Eaton, Flagler Hospital – and – Noreen Nickola-Williams, DOH-St. Johns

Council Mission: *To promote, protect and improve the health of all people in St. Johns County.*

Council Vision: *St. Johns County will be among the healthiest in the nation – a vibrant, well served community enjoyed by all, and supported by a diverse network of strong partners.*

Council Values: *Accessibility, Compassion, Collaboration, Equity/Ethics, Service Driven, Sustained Excellence through Accountability*

Topic	Lead
Welcome & Introductions • Safety & Housekeeping	• DOH-St. Johns, Director ***Dr. Dawn Allicock MD, MPH, CPH***
HLC Roundtable Introduction	• All
Our Mission, Vision, and Values	• DOH-St. Johns **Noreen Nickola-Williams**
Review • Consideration of Meeting Minutes	• DOH-St. Johns, Executive Assistant ***Gayle Webb***
St. Johns County Health Officer Update / Florida Health Priorities **DOH-SJC: Public Health Safety & Surveillance Update** • Statewide Hepatitis A Immunizations Outreach • Influenza Update • Syringe Exchange Program • Age-friendly Public Health Collaborative	• DOH-St. Johns, Director ***Dr. Dawn Allicock MD, MPH, CPH***
• **Community Health Improvement Action Updates**	• DOH-St. Johns
• **Big Health & Little Health – Communities of Excellence 2026**	• DOH-St. Johns **Dave Klater**
• **Flagler Health + An Update from Your Premier Community Hospital**	• Flagler Health **John Eaton and Gina Magnus**
• **Tobacco Free Saint Johns – Current & Emerging Trends in Our State & Community**	• Tobacco Free St. Johns **Mary Ann Steinberg**
Council Roundtable – By Exception - What's New?	• All
Closing Comments & Schedule for 2020	• DOH-St. Johns, Director ***Dr. Dawn Allicock MD, MPH, CPH***

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Appendix B: Annual CHIP Review Meeting Sign-in Sheet

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Appendix C: Annual CHIP Review Meeting Minutes

St. Johns County Health Leadership Council Meeting Minutes
Wednesday December 18, 2019 beginning at 3:30 PM

Florida Department of Health in St. Johns County (DOH-St. Johns)
Muscovy Conference Room - 200 San Sebastian View, St. Augustine, FL 32084

Co-Chairs: Dr. Dawn Allicock, MD, MPH, CPH, Florida Department of Health in St. Johns County - and - Jason Barrett, FACHE, Flagler Hospital

Facilitators: Noreen Nickola-Williams, Florida Department of Health-St. Johns – and - John Eaton, Flagler Health +

Council Mission: *To promote, protect and improve the health of all people in St. Johns County.*

Council Vision: *St. Johns County will be among the healthiest in the nation – a vibrant, well served community enjoyed by all, and supported by a diverse network of strong partners.*

Council Values: *Accessibility, Compassion, Collaboration, Equity/Ethics, Service Driven, Sustained Excellence through Accountability*

In Attendance

- Dr. Dawn Allicock, DOH-SJC
- Sieglinde Campbell, DOH-SJC
- Amy Castrillo, Azalea Health
- Jenn Corrado, DOH-SJC
- Charles Daly, SJC Medical Society
- Alex Delgado, Azalea Health
- Tracy Dillon, SJC Health & Human Services
- Donna Fenech, SJCSD Head Start Program
- Kay Gaines, Anastasia Mosquito Control
- Patti Greenough, EPIC Behavioral Healthcare
- Susan Grich, Health Planning Council of NE FL
- Paige Hartwell, DOH-SJC
- Sandra Jackson, SMA Behavioral Healthcare
- Susan Jackson, Children's Home Society
- Natasha Khan, DOH-SJC
- Dave Klater, DOH-SJC
- Shandra Koler, The Sontag Foundation
- Gina Mangus, Flagler Health +
- Joanna Nelson, DOH-SJC
- Jacob Quigley, DOH-SJC
- Mary Ann Steinberg, Tobacco Free St. Johns
- Amie Vaden, SJC Health & Human Services
- Gayle Webb, DOH-SJC
- Stephanie Canton-Whaley, SJC Fire Rescue
- Noreen Nickola-Williams, DOH-SJC
- John Eaton, Flagler Health +

I. Meeting was called to order at 3:30PM

II. Dr. Allicock welcomed the Council and conducted the housekeeping rules and fire safety message

III. Roundtable introductions were provided by all in attendance.

IV. A review of the Mission, Vision and Values of the SJC Health Leadership Council's was facilitated by Noreen Nickola-Williams.

V. The meeting minutes from April 23, 2019 were review and a call to approve, as presented, was first motioned provided by Mary Ann Steinberg and a second motion was provided by Paige Hartwell. Minutes were unanimously approved.

VI. County Health Officer / Chief Health Strategist Update provided by Dawn Allicock MD, MPH, CPH and included the following highlights:
- Florida State Surgeon General and Florida Health Priorities
- A Public Health Safety & Surveillance Update: A brief review was provided regarding the hepatitis A emergency declaration as well as the ongoing statewide and local immunizations outreach. Thanks, was given to all partners who provided expertise regarding high-risk target groups and planning of outreach. A Flu-Free Florida message was also provided – and general reminder to get

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your yearly flu shot. An update was provided regarding DOH's efforts to establish Syringe Exchange Programs in each county. An update was provided on Age-Friendly Public Health Collaborative and intent to ensure the age-friendly lens is further enhanced in our Community Health Assessment efforts.

VII. Community Health Improvement Action Updates:

- Noreen Nickola-Williams shared a reminder that HLC is at the end of the year. Most members will be completing a review of their year-end results during the month of January and February. DOH-SJC staff will be reaching out to work with you on end-of-year results for the scorecard. The following Community Health Improvement Update presentation were provided:

1) Community of Excellence 2026 – "Economic Vitality and Building the Big H" — Presentation by Dave Klater for Florida Department of Health *(CHIP Priority 2: Community Learning & Planning)*
   - An overview of Communities of Excellence (COE) and the Mission was provided. Attention was drawn to the relationship of COE as a collaboration with the national Malcolm Baldrige Program. Council members engaged in conversation on the importance of focus on community excellence. An overview of the Baldrige Criteria and the Communities of Excellence Framework was provided. The take-away message was this is a Learning Collaborative that will help us bring the Council's vision to life: *St. Johns County will be among the healthiest in the nation – a vibrant, well served community enjoyed by all, and supported by a diverse network of strong partners!*
   - *The Communities of Excellence Collaborative* will move us to the next level of Community Health Assessment and Improvement Planning by expanding this to include efforts that strengthen the economic vitality of St. Johns County while addressing the Social Determinant of Health. Simply put, we will continue to broaden the focus from small "h" to big "H" – economic vitality – by re-engaging non-traditional partners such as the Chamber of Commerce and the business community.
   - As a subgroup to SJC Health Leadership Council's community health improvement efforts, a call for Council members was made to assist serve on the COE Advisory Workgroup. In addition to DOH-SJC, as anchor, in partnership with Flagler Health +, Saint Johns County Administration, the following HLC members expressed interest:
     - *Kyle Dresback, Saint Johns County School District*
     - *Patti Greenough, Epic Behavioral Healthcare*
     - *Shandra Koler, Sontag Foundation*

2) Flagler Health + Your Premier Community Hospital – Presentation by Flagler Hospital's Gina Magnus (*VP, Marketing & Communication*) & John Eaton (*Executive Director – Flagler Health+ CareConnect*) (CHIP Strategic Objective 1.2: Increase Resources for Community Health Improvement)
   - Presentation highlights include the following: Flagler Health+ and its enterprise strategy
   - Economic Health: Right Care, At the Right Time, At the Right Place
   - Key Community Partnerships
   - Health Village Concept, Value, and Consumerism
   - Addressing Social Determinants of Health through innovative partnerships
     - Publix Pharmacy
     - Impact on Homelessness (Built for Zero)
     - St. Johns Volunteers
     - BRAVE - Be Resilient and Voice Emotions

3) Tobacco, Nicotine, and Vaping: Current & Emerging Public Health Trends in Our Community – Presentation by Mary Ann Steinberg, Program Director for Tobacco-Free St. Johns

- HLC Reference: CHIP Strategic Objective 3.2: Reduce Risky Behaviors
- How Prevalent is Vaping in Florida? – Youth Ages 11 – 17
- What Do We Know About Nicotine?
- Are There Policy Gaps That Affect Youth?
- Aggressive Marketing
- Largest Growth Brands in Florida
- Tobacco Retail Licensing (TRL)
- Flavored Tobacco and Nicotine Plug-In
- Social Sources & Age of Sale
- Prohibiting Samplings
- Discussion Themes
  - Policy Recommendations
  - Coordinated & Consistent Social Marketing Campaigns
  - Next Steps

VIII. Roundtable Updates & Closing Comments

IX. Review of Tentative Schedule for 2020
- *February 2020*
- *April 2020*
- *June 2020*
- *August 2020*
- *October 2020*
- *December 2020*

X. Meeting Closed at 5pm

Appendix D: St, Johns County Health Leadership Council Membership Roster

St. Johns County Health Leadership Counicl Membership Roster 12/31/2019

First Name	Last Name	Email	Organization
Kay	Gaines	gainesamcd@bellsouth.net	Anastasia Mosquito Control Distict
Rui-De	Xue	xueamcd@gmail.com	Anastasia Mosquito Control Distict
Trish	Becker	tbecker4amcd@protonmail.com	Anastasia Mosquito Control District, Commissioner
Claudia	Portell	Claudia.Portell@ascension.org	Asenccion Health
Alejandra	Delgado-Criado	adelgado-criado@azahealth.org	Azalea Health
Terry	Gilyard	tgilyard@azaleahealth.org	Azalea Health
Kelsey	Lombardo	Kelsey.Lombardo@bmcjax.com	Baptist Health System
Lynn	Sherman	lynn.sherman@bmcjax.com	Baptist Health System
Kelly	Franklin	kellyf@bettygriffincenter.org;	Betty Griffin Center
Joyce	Mahr	joycem@bettygriffincenter.org	Betty Griffin Center
Isabelle	Renault	Isabelle.Renault@sjcchamber.com	Chamber of Commerce
Cathy	Newman	Cathy.Newman@sjcchamber.com	Chamber of Commerce
Bob	Porter	Bob.Porter@sjcchamber.com	Chamber of Commerce
Susan	Jackson	susan.jackson@chsfl.org	Children's Home Society Florida
Jerry	Cameron	came7337@bellsouth.net	Community Management and Consulting
Patti	Greenough	patti@epicbh.org	EPIC Behavioral Healthcare
Melissa	Witmeier	mwitmeier@epicbh.org	EPIC Behavioral Healthcare
Arleen	Dennison	arleen.dennison@stjohns.k12.fl.us	First Coast Technical College
Jason	Barrett	Jason.Barrett@flaglerhospital.org	Flagler Hospital
Colleen	Hobin	colleen.hobin@flaglerhospital.org	Flagler Hospital
John	Eaton	John.Eaton@flaglerhospital.org	Flagler Hospital
Mary	Mantese	mary.mantese@flaglerhospital.org	Flagler Hospital
Gina	Mangus	gina.mangus@flaglerhospital.org	Flagler Hospital
Nathan	Dinger	nathan.j.dinger.mil@mail.mil	Florida Army Reserve and National Guard
Cory	Oswald	cory.j.oswald.mil@mail.mil	Florida Army Reserve and National Guard
Stan	Gustetic	gustetics@fsdb.k12.fl.us	Florida School of the Deaf and Blind
Lynn	Schultz	lynn.b.schultz.ctr@mail.mil	Florida State Coordinator - Building Healthy Military Communities (BHMC)
Kathy	Fernandez	Klfernandez@beyourhaven.org	Haven Hospice
Marie-Carmelle	Elie	Mcelie@beyourhaven.org	Haven Hospice
Joyce	Case	Joyce_case@hpcnef.org	Health Planning Council of NE FL
Susan	Grich	susan_grich@hpcnef.org	Health Planning Council of NE FL

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Appendix D: St, Johns County Health Leadership Council Membership Roster (Continued)

First Name	Last Name	Email	Organization
Susan	Jackson	susan.jackson@chsfl.org	Healthy Families St. Johns
Ann	Breidenstein	Ann.ltrstjohns@gmail.com	Learn to Read St. Johns
Vicki	Evans	vevans@northfloridaahec.org	Northeast Florida AHEC
Lisa	Read	lread@nefhsc.org	Northeast Florida Healthy Start Coalition
Bridget	Hennessy	bridgetpact@yahoo.com	PACT Prevention Coalition of St. Johns County
Laura	McNeil	laura.j.mcneil@citi.com	SJC Resident
Kathy	Harrell	harrellkm@sabpd.org	St. Augustine Beach Police
Ed	Martinez	martineze@sabpd.org	St. Augustine Beach Police
Schuyler	Seifker	schuylers@sayskids.org	St. Augustine Youth Services
Joy	Andrews	jqandrews@sjcfl.us	St. Johns County Administration
Amie	Vaden	avaden@sjcfl.us	St. Johns County Health & Human Services
James	Johns	bcc1jjohns@sjcfl.us	St. Johns County Commissioner, District 1
Melissa	Lundquist	mlundquist@sjcfl.us	Assistant for SJC County Commissioner
Becky	Yanni	byanni@stjohnscoa.com	St. Johns County Council on Aging
Linda	Stoughton	emgmgnt@sjcfl.us	St. Johns County Emergency Management
Stephanie	Canton-Whaley	swhaley@sjcfl.us	St. Johns County Fire Rescue
Shawna	Novak	snovak@sjcfl.us	St. Johns County Health and Human Services
Mike	Jenkins	mjdocmike@cs.com	St. Johns County Health Services Advisory Council
Predrag	Bulic	pbulic@sjcfl.us	St. Johns County Medical Examiner, District 23
Kyle	Dresback	Kyle.Dresback@stjohns.k12.fl.us	St. Johns County School District

Appendix D: St, Johns County Health Leadership Council Membership Roster (Continued)

First Name	Last Name	Email	Organization
Donna	Fenech	donna.fenech@stjohns.k12.fl.us	St. Johns County School District Head Start Program /Early Chilhood Services
Toby	Erwin	terwin@sjso.org	St. Johns County Sheriffs Office
Holly	Coulliette	hollycoulliette@sjrstate.edu	St. Johns River State College
Ivan	Cosimi	icosimi@smabehavioral.org	Stewart-Marchman-Act Behavioral Healthcare
Sandra	Jackson	sjackson@smabehavioral.org	Stewart-Marchman-Act Behavioral Healthcare
Shandra	Koler	skoler@sontagfoundation.org	The Sontag Foundation
Mary Ann	Steinberg	maryann@civcom.com	Tobacco Free St. Johns
Chris	Mastoridis	director@wildflowerhealthcare.org	Wildflower Healthcare
Paul	Studivant	pstudivant@sjcfl.us	St. Johns County Animal Control
Susan	Ponder-Stansel	ceo@communityhospice.com	Community Hospice
Charles	Daly	cdaly218@gmail.com	Community Representative
Ronald	Stafford		New Mt. Moriah Christian Ministry

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Appendix E: St. Johns County Health Leadership Community Balanced Scorecard

2018-2020 ST. JOHNS COUNTY COMMUNITY BALANCED SCORECARD – REVISED 3/31/2020						
STRATEGIC ISSUE	**STRATEGIC OBJECTIVE**	**MEASURE(S)**	**MOST CURRENT PERFORMANCE LEVEL**	**TARGET FOR 2020**	**LEAD AGENCY & CRITICAL ACTIONS**	**STATUS R/Y/G**
4.0 Community Health Status	4.1 Improve overall health outcomes	• 4.1.1 CHR Health Outcomes	2020: First in State[5]	• Top 10%	• Years of potential life lost increasing due to high levels of unintentional injury (See 4.4 below)	GREEN
		• 4.1.2 Infant mortality	2016-18 Overall: 4.3 [9] 2016-18 Black: 14.9[9] 2016-18 White: 3.4[9]	• 5.2* • 12.0* • 4.6*	• **DOH: St. Johns**: Infant Mortality Task Force • **DOH: St. Johns:** Fetal Infant Mortality Review team • **Flagler Health+**: Childbirth Education Class	GREEN RED GREEN
	4.2 Reduce chronic disease and related health inequities (Health Equity)	• 4.2.1a,b,c Death rate due to cancer	2016-18: Overall 149.4[1] 2016-18 Black: 155.5[1] 2016-18 White: 151.1[1]	• 155.0* • 164.8* • 156.6*	• **Flagler Health+**: Cancer education and support groups • **Flagler Health+**: Cancer Outcomes report • **DOH-St. Johns**: HPV Anti-Cancer Vaccines	GREEN GREEN GREEN
		• 4.2.2a,b,c Death rate due to coronary heart disease	2016-18: Overall 75.3[1] 2016-18 Black: 91.8[1] 2016-18 White: 75.7[1]	• 75.6* • 90.1* • 75.6*	• **Flagler Health+**: Various healthcare programs and educational forums	GREEN RED GREEN
		• 4.2.3a,b,c Hospitalizations from or with Diabetes	2016-18: Overall 1,532.1[1] 2016-18: Black 4,120.0[1] 2016-18: White 1,387.1[1]	• 1,557.7* • 4,510.1* • 1,401.5*	• **Flagler Health+**: Diabetes Education/Support Group, Weight Loss Seminar • **DOH-St. Johns**: Healthiest Weight Program	GREEN YELLOW GREEN
		• 4.2.3d Preventable Hospitalizations under 65 from Diabetes	2016-2018: Overall 103.7[1]	• 100		GREEN
	4.3 Reduce communicable disease incidence	• 4.3.1 % HIV patients with suppressed viral load	CY 2019 92%[6]	• 80% (State goal for 2021)	• **DOH-St, Johns**: PEP and PrEP Test and Treat • **DOH-St, Johns**: Reduce communicable disease incidence (Treatment as prevention)	GREEN
	4.4 Reduce Crime & injury	• 4.4.1 Domestic violence offenses rate	2016-2018: 328.2[1]	• 362.7	• **Betty Griffin Center**: Batterer Accountability Program, 24 Hours Hotline, Advocates, By-stander education, All programs Active & Successful • **Betty Griffin/Sherriff/DCF**: InVest Team: SVU initiative to ID high risk domestic violence cases • **Department of Children & Families**: Elder Abuse Hotline	GREEN
		• 4.4.2a Unintentional injury death rate	2016-18: Overall 47.5[1]	• 42.	• **DOH-St Johns**: Child Abuse Death Review Committee • **Council on Aging (COA)**: Falls Coalition Outreach & Education- Safety Training on Slips, Trips & Falls • **COA**: Assistive devices to prevent falls • **DOH-St. Johns**: Florida Age Friendly Public Health System	RED
		• 4.4.2b # of deaths from falls (adults over age 65)	2018: 23[1]	• 22		GREEN
		• 4.4.3 Suicide rate	2016-18: Overall 18.6[1]	• 16.9	• EPIC: Community education and suicide preventions strategies, Suicide Prevention training	RED

Appendix E: St. Johns County Health Leadership Community Balanced Scorecard (Continued)

2018-2020 ST. JOHNS COUNTY COMMUNITY BALANCED SCORECARD REVISED 3/31/2020						
STRATEGIC ISSUE	**STRATEGIC OBJECTIVE**	**MEASURE(S)**	**MOST CURRENT PERFORMANCE LEVEL**	**TARGET FOR 2020**	**CRITICAL ACTIONS**	**STATUS R/Y/G**
3.0 Community Implementation	3.1 Improve Child Safety & Well-being	3.1.1a,b % of children Immunized	2017-19 Kindergarten 93.5%[1] 2017-19 7th Grade 97.0%	• 95% • 95%	• **SJC Schools, DOH-St. Johns**: Increase immunization rates	YELLOW GREEN
		3,1.2a % children not neglected or abused after receiving services	FY 2018-19: YE 93.72%	• 95%	• **SJC Family Integrity** Program (FIP): Enhancing & Strengthening Infrastructure to improve delivery of child welfare services • **Behavioral Health Consortium**: March Against Child Abuse • **Betty Griffin Center**: CPI co-located advocate 89 referrals received from 7/118/to 1/31/19	GREEN
		3,1.2b % of children diverted from out of home care	FY 2018-19: YE 95.7%	• 90%		
	3.2 Reduce Risky Behaviors	3.2.1a,b % of population reporting Inhaled Nicotine Use:	2016 Adult BRFSS: Cigarettes: 12.2%[2] 2018 Youth: Cigarettes: 2.3%	• Adult 12.0% • Youth 3.4%	• **Tobacco Free St. Johns**: Policy change for restriction of advertising in the minority community • **Tobacco Free St. Johns**: Policy change for county licensure of tobacco retailers • **Tobacco Free St. Johns**: Increase number of adults using "Quit Your Way" services, Indicator: % in program quitting • **DOH & DOE**: Youth Tobacco Citation program which will be free and would be done at school for youth caught with tobacco or nicotine products. • **Wildflower Healthcare**: Tobacco Cessation program	GREEN GREEN
		3.2.1c,d % of population using Electronic Nicotine Delivery System	2016 Adult BRFSS *E-Cigarettes: 4.8%*[2] 2018 Youth: Electronic Vaping: *20.8%*[4]	• Adult 4.7% • Youth 20.0%		GREEN RED
		3.2.2a,b % of population reporting Binge Drinking	2016 Adult BRFSS: Binge: 20.1%[2] 2018 Youth: *Binge: 7.9%*[4]	• Adult 19.5% • Youth 6.7%	• **EPIC**: Think for SUCCESS (Teens) and BASICS (College) Programs • **EPIC**: Enhance/expand prevention services • **PACT Coalition:** Program focused on alcohol abuses • **Betty Griffin & Stuart-Marchman Act (SMA)** to reduce substance abuse	No Update RED e
		3.2.3a,b % of population using Marijuana	2016 Adult BRFSS Marijuana/Hashish 7.8%[2] 2018 Youth: *Marijuana: 11.8%*[4]	• Adult 7.6% • Youth 11.4%	• **EPIC**: Think for SUCCESS (Teens) and BASICS (College) Programs • **EPIC:** Enhance/expand prevention services	No Update YELLOW
		3.2.4 # Drug Poisoning Deaths	2018: Overall: 32[1]	• 30	• **DOH-St. Johns:** - Develop Neonatal Abstinence Syndrome (Substance exposed newborns) system of care) • **EPIC & Betty Griffin**: FITT (Family Intensive Therapy Team): 21 victims referred to from 3/18 to 1/19 • **SJC & EPIC**: - St. Johns County Opioid Task Force • **EPIC**: Expand MAT services • **EPIC**: Seek funding for Mental Health & Substance Abuse client reentering from corrections • **EPIC**: Develop needle exchange program • **EPIC**: Expand SA & MH bridge services pre/post discharge	YELLOW

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	3.3 Increase Access to Dental Care	• 3.3.1 # ER Admissions for dental emergencies	2018: 967[1]	• 1000	• **St. Johns Care Connect**: Referrals to Dental Provider • **Flagler Health+**: ER Diversion Program • **Flagler Health+**: Oral Health Community Education	GREEN
		• 3.3.2 # of client dental visits to Wildflower Clinic	2018: 1,553 Visits[6]	• 1,708	• **Wildflower Healthcare**: Healthy Lifestyle Screening	GREEN
		• 3.3.3 # schools participating	2019: # Schools participating in school-based sealants program 5[6]	• 6	• **DOH-St. Johns**: School-based sealants program	GREEN
	3.4 Increase Access to Mental Health Care	• 3.4.1 % Adult Baker Act crisis readmissions	FY 16-17: 17.5%[6] No recent update	• 15.5%	• **Flagler Health+**: Behavioral Health Coordination, Telehealth partnership, Collaborate with Lutheran Services	No Update
		• 3.4.2 Wait time to initial MH outpatient assessment & appointment	SMA 2019 Crisis/triage walk in counseling: 0-1 day[6]	• 0 to 1 day	• **SMA**: Individual and other referral to outpatient mental health services • **EPIC/ Betty Griffin FITT:** (Family Intensive Therapy Team) • **Flagler Health+**: Intensive Outpatient Program	GREEN
		• 3.4.3 # of mental health outpatient clinic clients seen	**SMA & EPIC** FY 2018-19 Adult EPIC No recent update Child/Adolescent EPIC No recent update FY 2018-2019 Adult 718 SMA[6] Child/Adolescent 161 SMA[6]	• 2200 EPIC/ SMA Combined	• **EPIC**: Seek funding for re-entry services for MH and SA client re-entering the community from corrections. • **EPIC**: Expand psychiatric services for adults and children. • **EPIC**: Expand hours for accessibility to services.	No Update
		• 3.4.4 # FACT & Mobile Crisis Response Team weekly service hours	**2019 FACT Team** **FACT Team** & **Mobile Crisis Response Team**: # Weekly service hours: 168[6]	• 168	• Behavioral Health Consortium (FACT Team) • St. Augustine Youth Services (Mobile Crisis Response Team)	GREEN

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Appendix E: St, Johns County Health Leadership Community Balanced Scorecard (Continued)

2018-2020 ST. JOHNS COUNTY COMMUNITY BALANCED SCORECARD – REVISED 3/31/2020						
STRATEGIC ISSUE	**STRATEGIC OBJECTIVE**	**MEASURE(S)**	**MOST CURRENT PERFORMANCE LEVEL**	**TARGET FOR 2020**	**CRITICAL ACTIONS**	**STATUS R/Y/G**
2.0 Community Learning and Planning	2.1 Assure linkage to care	• 2.1.1 % Identified needs successfully linked to care	2018: 96% linked through Information Network (58,713 of 60,937)	• 75%	• **St. Johns Care Connect** : Universal Intake Form	GREEN
	2.2 Improve community livability to address social determinants of health (Health Equity)	• 2.2.1 CHR Health Factors	2019: Overall: First in State[5]	• Top 10%	• 61st in State in Excessive Drinking Rate (See SO 3.1) • 26th in MH Providers per population (SO 3.3) • 23rd in % Households with severe problems (SO 2.2)	GREEN
		• 2.2.2a,b,c Affordable Housing created or rehabbed	FY 18-19: 51[6] # New Units Created or rehabbed FY 18-19 % Counselled in Homebuyer Education Program who purchased home: 28%[6] FY 2018-19 # Smoke free Properties: 11[6]	• 75 • 30% • 6	• **SJC Health & Human Services (HHS)**: Homebuyer Education Program • **HHS**: Housing Rehabilitation • **HHS**: Disaster Repair/Mitigation • **HHS**: State Housing Initiative Partnership (SHIP) Strategies • **Tobacco Free St. Johns**: Smoke free housing	GREEN
		• 2.2.2d,e Homeless/ indigent linked to housing	2018: # Homeless linked to housing: 63[6] 2018: % Indigent linked to housing within 30 days of release: 79%[6] (50/63)	• 60 • 75%	• **St. Johns County Continuum of Care:** (Rapid Rehousing)	GREEN
	2.3 Protect population from emerging health threats	• 2.3.1 # Agencies active in Long-term recovery committee	2018: # Agencies: 12[6]	• 25	• **SJC Emergency Management**: "Stop the Bleed" & DOH, 1000+ Attended presentations	GREEN
		• 2.3.2 % Hep A vaccinations to at risk population	2019: 63%[8]	• 80%	• **DOH-St. Johns:** Hepatitis A vaccination program	GREEN
1.0 Community Assets	1.1 Increase access to public transportation	• 1.1.1 a,b,c Public transportation ridership	2019: 279,311 Sunshine Bus Riders 2019: Paratransit Riders[6], 1,447 2019: 3,059 Total Monthly CTD Passes issued (828 Full; 2,231 Half)[6]	• 280,000 • 7,100 • 755	• **Council on Aging (COA)**: Educate residents on current transportation options • **COA**: Provide Bus passes for clients with financial limitations	GREEN
		• 1.1.1d # Sunshine Bus Routes	2019: 9[6]	• 10	• **COA**: Pursue funding to add bus routes	GREEN
	1.2 Increase resources for community health improvement	• # Agencies participating in St. Johns Care Connect	2019: # Agencies participating: 41[6]	• 30	• **St. Johns Care Connect:** Increase enrollment in St. Johns Care Connect	GREEN

Data Sources: 1. FloridaCharts (per 100,000 population) 2. 2016 Behavioral Risk Factor Surveillance System (BRFSS) 3. Florida Youth Tobacco Survey 4. Florida Youth Substance Abuse Survey, 5. County Health Rankings Report 6. Local Data 7. Florida Department of Families & Children 8. FL Medical Examiner 9. FloridaCharts (per 1,000 live births)

* Aligns with Healthy People 2020 target

Status will be reviewed using a stoplight approach:

RED - Not on target

YELLOW - Falling behind

GREEN - On target

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