Community Health Needs Assessment

2016

Walton County, Florida

WCHIP

Walton Community
Health Improvement Partnership

2016
Community Health Needs Assessment

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Prepared by:

Sacred Heart Hospital on the Emerald Coast

Florida HEALTH
Walton County

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Executive Summary

In 2015, Sacred Heart Health System ("SHHS") and the Florida Department of Health - Walton County ("FDOH-Walton") worked together, in collaboration with other community organizations and agencies, to conduct a community health needs assessment ("CHNA") for the approximately 59,000 residents of Walton County, Florida.

Description of the Community

The area of this needs assessment is defined as the population of Walton County. Walton County is situated in the Panhandle of Florida and encompasses 1,238 square miles. Approximately 15% of Walton County's land mass is water, and an additional 20% is federally owned as part of Eglin Air Force Base. The county seat is the City of DeFuniak Springs, and the City of Freeport and Town of Paxton are the only other incorporated areas.

Historically, Walton County has been one of the fastest growing counties in the United States. The population grew more than 35% between 2000 and 2010. Between 2010 and 2014, Walton County population grew 11.4%, compared to total population growth in the State of 5.5% during that period. In spite of significant population growth, Walton County has a low population density of 50 people per square mile, and is designated as a statutory rural county by the State of Florida.

Minorities represent about 13% of the total population in Walton County, compared to almost 24% of the population of the State. Only 5.7% of the population of Walton County is Hispanic, compared to 23.3% of the State's population.

The median household income in Walton County is $43,640, significantly below that of the State. In 2013, the poverty rate was 33.4%, compared to 29.0% statewide. The unemployment rate as of August 2015 was 4.7%, lower than statewide and a significant improvement from the 9.4% rate reported for 2010.

Participants in the CHNA Process

The CHNA process was led by SHHS and FDOH-Walton, with active participation by community organizations and private and public agencies which collectively comprise the Walton Community Health Improvement Partnership (WCHIP).

The CHNA process included WCHIP meetings, a survey of health and human service organizations, and a community survey distributed both on-line and in paper format. More than 50 people representing more than 30 different community agencies and organizations and the general public participated in various meetings throughout the process. In addition, 253 Walton County residents completed the community survey. Particular focus was placed on obtaining input from vulnerable population groups.

How the Assessment Was Conducted

The CHNA 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:

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

- Unhealthy behaviors are a significant contributor to poor health status in Walton County, including:
  - Substance abuse
  - Excess weight/obesity
  - Poor eating habits/nutrition
  - Tobacco use
  - Sedentary lifestyle/lack of exercise
  - Not seeing doctor/dentist
- Mental health issues are of significant concern in the County
- Heart disease and stroke are of major concern
- Inadequate access to care is a recurring theme, based on a number of factors, including:
  - Lack of availability of providers/services
  - High cost/lack of insurance coverage
  - Lack of awareness of available services, primarily for mental health services

Community Themes & Strengths Assessment

- Recurring themes include:
  - High rate of poverty/working poor; need for help with affordable housing and healthcare
  - Education: schools overcrowded, need vocational education for available jobs
  - Employment is strong, but many jobs are low pay or require more specialized skills
  - Transportation is difficult; many don't have a car and public transportation is limited
  - Need for more cultural diversity in healthcare
  - Access to care is major issue; including lack of certain specialties, lack of insurance, & lack of providers who accept certain plans, Medicaid
- The following were identified as strengths:
  - Good healthcare providers
  - Environment/location/weather
  - Sense of community/low crime rate
  - Churches/faith-based organizations

Local Public Health System Assessment

- The local public health system performs particularly well in the following areas:
  - Contributing to public health policies by engaging in activities that inform the policy development process
  - Establishing a community health improvement process, with broad- based diverse participation, that uses information from both the community health assessment and the perceptions of community members
  - Connecting organizational strategic plans with the Community Health Improvement Plan
  - Planning for Public Health Emergencies
  - Assuring that all enforcement activities related to public health codes are done within the law
  - Evaluating Personal Health Services
- The local public health system could improve performance in the following areas:
  - Use of Technology
  - Research and Innovations

Forces of Change Assessment

- Forces of change were grouped into the following categories:
  - Economic, e.g., Lack of insurance, low wages
  - Environmental, e.g., flooding from storms
  - Legal/political, e.g., no Medicaid expansion
  - Social, e.g., insufficient healthcare services
  - Technological/scientific, e.g., lack of fiber optics and cable providers
- Threats posed by these forces include:
  - No or limited access to healthcare
  - Insufficient infrastructure to handle growth
  - Increase in drug/substance abuse
  - Increase in untreated mental health disorders
  - Poor eating habits and housing conditions
  - Potential water shortages in outlying areas

Based on the results of the assessments, a list of 50 indicators that were of greatest concern in Walton County was compiled. Using the County Health Ranking's model of population health as a framework, the top five (5) priority health issues facing Walton County were identified as the following:

- Provider Availability and Access
- Preventive Care
- Healthy Weight
- Tobacco Use
- Substance Abuse and Mental Health

These top health issues were presented and discussed at a community meeting organized by WCHIP. Participants were asked to consider three criteria for prioritizing the top issues:

- Severity/Magnitude (of the health issue)
- Feasibility to Address (availability of resources, community will)
- Potential Impact (on community health status)

After reviewing the results of the MAPP Assessments and taking into consideration these three prioritization criteria, participants used a hybrid multi-voting/nominal group technique to identify the top health issues facing Walton County.

Top Priority Health Issues

The top priority health issues identified for Walton County were:

- Substance Abuse and Mental Health
- Healthy Weight
- Provider Availability and Access

Next Steps

The next steps in the process will be the development of a community health improvement plan with specific goals, tactics, and evaluation metrics. Activities include:

- Organizing work groups to develop comprehensive action plans to address each priority
- Identifying successful health improvement initiatives to serve as best practices
- Establishing metrics for performance, including measurable outcome indicators
- Continuing to communicate progress and results to the Walton County community

Introduction

In 2015, Sacred Heart Health System ("SHHS") and the Florida Department of Health - Walton County ("FDOH-Walton") worked together, in collaboration with other community organizations and agencies, to conduct a community health needs assessment ("CHNA") for the approximately 59,000 residents of Walton County, Florida.

Collaborative Partners

Sacred Heart Hospital on the Emerald Coast

Sacred Heart Hospital on the Emerald Coast - SHHS operates a 58-bed acute care facility – Sacred Heart Hospital on the Emerald Coast ("SHHEC") – in Miramar Beach, Walton County. SHHEC opened in 2003 and is the only hospital in South Walton County. Walton County residents comprise 43.1% of SHHEC's hospital discharges, with the remaining discharges coming from adjacent coastal zip codes in Okaloosa and Bay Counties and from out of area tourists. SHHEC is one of two acute care hospitals located in Walton County, but is the only nonprofit hospital for more than 50 miles in any direction. SHHEC was established at the request of hundreds of community residents and physicians to provide access to emergency and acute care services, regardless of ability to pay. This safety net role is consistent with the mission of SHHEC as a Catholic health ministry. As a Catholic health ministry, it is dedicated to spiritually centered, holistic care that sustains and improves the health of individuals and communities. SHHS serves as an advocate for a compassionate and just society through actions and words. SHHS' guiding values are as follows:

- ❑ Service to the poor - Generosity of spirit, especially for persons most in need
- ❑ Reverence - Respect and compassion for the dignity and diversity of life
- ❑ Integrity - Inspiring trust through personal leadership
- ❑ Wisdom - Integrating excellence and stewardship
- ❑ Creativity - Courageous innovation
- ❑ Dedication - Affirming the hope and joy of our ministry

Florida Department of Health in Walton County -

The Florida Department of Health - Walton County and the Walton Community Health Center, Inc. ("FDOH-Walton") provide public health and medical services in Walton County. FDOH-Walton began providing services from the upper floor of what is now the DeFuniak Springs Police Department in the early 1950's. Today, FDOH-Walton has more than 100 employees in four locations in Walton County working to serve the needs of Walton County residents in areas that range from controlling infectious diseases to safe drinking water to disaster preparedness. FDOH-Walton works closely with the County Commissioners, the Emergency Response Division and other local and federal agencies to protect the health and welfare of Walton 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. FDOH-Walton's vision is for Walton County to be the Healthiest County in the Healthiest State in the Nation. Its 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

Walton County is situated in the Panhandle of Florida and encompasses 1,238 square miles. Approximately 15% of Walton County's land mass is water, and an additional 20% is federally owned as part of Eglin Air Force Base. The county seat is the City of DeFuniak Springs, and the City of Freeport and Town of Paxton are the only other incorporated areas. Because of extended coastline fronting the Gulf of Mexico, there are a number of unincorporated communities oriented toward tourism and seasonal visitors situated in South Walton County.

Population

Historically, Walton County has been one of the fastest growing counties in the United States. The population grew more than 35% between 2000 and 2010. Between 2010 and 2014, Walton County population grew 11.4%, compared to total population growth in the State of 5.5% during that period.

The population aged 65 and older represent 17.1% of the total population of Walton County, less than the 18.4% this same group represents statewide. Nevertheless, the population of Walton County is somewhat older than that of the State, with a median age of 43.5 compared to 41.8 for the State. Notably, 29.3% of the population of Walton County is between the ages of 45 and 64, compared to 27.0% of the State's population.

In spite of significant population growth, Walton County has a low population density of 50 people per square mile, and is designated as a statutory rural county by the State of Florida. The majority of residents live outside the incorporated cities. Population concentrations are predominantly found in South Walton County along U.S. Route 98 and County Road 30-A, which hug the bay and coast.

Total Population Growth, 2010 - 2014
Walton County and State of Florida

	2010	2014	% Change
State of Florida	18,852,220	19,893,297	5.5%
Walton County	55,255	61,530	11.4%

Source: U.S. Census Bureau, Population Division, December 2014 and March 2015.

Population Characteristics

- Almost 21% of the population of Walton County is less than 18 years of age.
- The majority of Walton County residents are between the ages of 25 and 64, comparable to but more than the percentage of the population in that age bracket in the State.
- 17.1% of the population of Walton County is aged 65 or older; less than the State as a whole.
- Males represent 51% of the population of Walton County, compared to approximately 49% of the population Statewide.
- In the past year, the population aged 55 – 64 in Walton County is growing at the fastest rate (2.0%), followed by the population aged 65 and older (1.9%). These two age groups are also growing at the fastest rate in the State (2.4% and 2.2%, respectively).

Population by Age Cohort – 2014
Walton County and State of Florida

Age Cohort	County	% of Total	State	% of Total
o – 17	12,289	20.7%	4,098,223	21.0%
18 – 24	4,610	7.8%	1,789,068	9.2%
25 – 34	7,385	12.5%	2,448,462	12.5%
35 – 44	7,476	12.6%	2,345,727	12.0%
45 – 54	8,581	14.5%	2,699,859	13.8%
55 – 64	8,776	14.8%	2,574,936	13.2%
65+	10,129	17.1%	3,591,756	18.4%
Total	59,246	100.0%	19,548,031	100.0%
F, 15 – 44	9,842	16.6%	3,622,709	18.5%
Male	30,197	51.0%	9,555,569	48.9%
Female	29,049	49.0%	9,992,462	51.1%
Median Age	43.5		41.8	

Source: Florida Charts, 2015.

Population Growth by Age Cohort, 2013 - 2014
Walton County and State of Florida

	Walton County			State of Florida		
Age Cohort	2013	2014	% Change	2013	2014	% Change
o - 17	12,109	12,289	1.5%	4,064,864	4,098,223	0.8%
18 - 24	4,529	4,610	1.8%	1,762,572	1,789,068	1.5%
25 - 34	7,348	7,385	0.5%	2,403,341	2,448,462	1.9%
35 - 44	7,456	7,476	0.3%	2,362,567	2,345,727	-0.7%
45 - 54	8,646	8,581	-0.8%	2,697,200	2,699,859	0.1%
55 - 64	8,602	8,776	2.0%	2,515,421	2,574,936	2.4%
65+	9,944	10,129	1.9%	3,512,894	3,591,756	2.2%
Total	58,634	59,246	1.0%	19,318,859	19,548,031	1.2%
F, 15 - 44	9,735	9,842	1.1%	3,596,432	3,622,709	0.7%

Source: Florida Charts, 2015.

Population by Race and Ethnicity

Minorities represent about 13% of the total population in Walton County, compared to almost 24% of the population of the State. Consistent with that differential, only 5.7% of the population of Walton County is Hispanic, compared to 23.3% of the State's population.

Population by Race/Ethnicity - 2014
Walton County and State of Florida

Age Cohort	County	% of Total	State	% of Total
White	50,115	86.7%	14,747,196	76.2%
Black	3,162	5.5%	3,114,841	16.1%
Asian/Pacific Islander	754	1.3%	502,961	2.6%
Native American	716	1.2%	59,121	0.3%
Two or More Races	1,112	1.9%	453,399	2.3%
Other	1,962	3.4%	484,274	2.5%
Total	57,821	100.0%	19,361,792	100.0%
Hispanic	3,313	5.7%	4,517,191	23.3%

Source: U.S. Census Bureau, 2010-2014 American Community Survey 5-Year Estimates.

Why are these characteristics important?

- ❑ Population growth can strain health care resources and other infrastructure, particularly where limited resources already exist
- ❑ 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

The median household income in Walton County is $43,640, which is 7.1% below the median household income of the State. The percentage of the population living in poverty in Walton County (33.4%) is significantly greater than the percentage in the State (29.0%), as is the percentage of children living in poverty (28.5% versus 23.6%). In addition, a substantially greater percentage of the population over the age of 25 does not have a high school diploma in Walton County compared to the State (23.9% versus 17.3%). However, the unemployment rate in Walton County is only 4.7%, lower than the statewide unemployment rate of 5.6%.

Socioeconomic Indicators - 2013
Walton County and State of Florida

Indicator	County	State	Difference
Median Household Income	$43,640	$46,956	-7.1%
Real Per Capita Income	$37,976	$41,497	-8.5%
Poverty Rate	33.4%	29.0%	4.4%
Children in Poverty	28.5%	23.6%	4.9%
Unemployment Rate[1]	4.7%	5.6%	35.0%
Population >25 w/o HS Diploma	23.9%	17.3%	6.6%
Population with Limited English Proficiency	9.0%	6.9%	2.1%

Note: [1] Data as of August 2015
Sources: U.S. Bureau of labor Statistics; U.S. Department of Commerce, Bureau of Economic Analysis; U.S. Census Bureau; Florida Charts, 2015

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 work place.
- ❑ Even with the relatively low rate of unemployment in Walton 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 Walton County suggest that access to care may be difficult for much of the population in Walton County.

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

Methodology

Participants in the CHNA Process

The CHNA process was led by SHHS and FDOH-Walton, with active participation by the following community organizations, and private and public agencies which collectively comprise the Walton Community Health Improvement Partnership (WCHIP):

- Sacred Heart Hospital on the Emerald Coast
- Sacred Heart Health System
- Florida Department of Health – Walton County
- Panhandle Warrior Partnership
- COPE – 211
- Goodwill Easter Seals Legacy Corps.
- Florida Department of Children and Families
- NW Florida Health Council/PanCare Health
- Easy Mobile Labs
- Emerald Coast Children's Advocacy Center
- Walton County Housing
- Walton Okaloosa Council on Aging
- COPE Center - Disaster Case Management Program
- Walton County School District
- First Baptist Church of Mossy Head
- Walton County Prevention Coalition
- Friendship House
- City of Freeport
- Walton County Sherriff's Office
- Walton County Baptist Association
- Florida Department of Health – Holmes/Washington Counties
- Walton County District 5 – Board of County Commissioners
- West Florida AHEC
- Catholic Charities of NW Florida
- Tri-County Community Council/Head Start/Early Head Start
- Northwest Florida State College
- Early Learning Coalition of Okaloosa and Walton Counties
- Emerald Coast Hospice
- Keller Williams Realty
- University of Florida Institute of Food and Agricultural Sciences
- Synergy Community Development, Inc.
- Early Learning Coalition of Okaloosa and Walton Counties

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-E.

The CHNA process included WCHIP meetings which occurred between June and December 2015 and continue into 2016, a survey of health and human service organizations, and a community survey distributed both on-line and in paper format. More than 50 people representing more than 30 different community agencies and organizations and the general public participated in various meetings throughout the process. In addition, 253 Walton 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, email 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 vulnerable populations with targeted distribution to area churches, community service provider sites, community centers, and retail outlets. Vulnerable populations were defined to include people who met one of the following criteria: no health insurance; family income of $25,000 or less; or took the survey at site of service for low income populations, e.g., the Department of Health or faith-based health clinics.

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:

- Community Health Status Assessment
- Community Themes and 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 Walton 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 WCHIP meetings, a survey of health and human service organizations, and a community survey distributed both on-line and in paper format to 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:

- Forces of Change Assessment (detailed report, Attachment B)
- Local Public Health System Assessment (detailed report, Attachment C)
- Community Themes and Strengths Assessment (detailed report, Attachment D)
- Community Health Status Assessment (Attachment E)

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

Community Themes and Strengths Assessment

The purpose of the Community Themes and Strengths Assessment ("CTSA") is to gain a better understanding of community perceptions about health and quality of life; to provide useful information for local programmatic and fiscal decision-making; and to inform the development of a strategic community health improvement plan. Surveys and focus groups were used to gather insight into issues of concern, as well as local assets and resources related to health and quality of life.

In July and August 2015, SHHEC, FDOH-Walton, and WCHIP jointly conducted the CTSA. The survey was distributed to the general and vulnerable populations and was made available in paper and on-line formats. WCHIP 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 Spanish version of the survey was also created and distributed. The survey focused on identifying respondent perceptions of the most important factors for a healthy community, most important health problems, and risky behaviors in Walton County. A separate but similar survey was distributed to Health and Human Services organizations covering similar topics. A focus group was also conducted to gather additional insights.

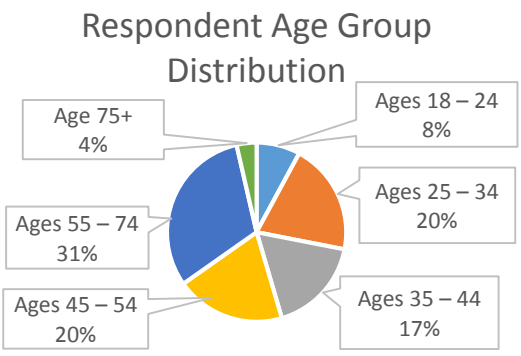
Survey Results

253 community-wide surveys (160 on-line and 93 paper) and 30 surveys from Health and Human Services organizations were completed and used for the CTSA. A demographic breakdown of survey respondents compared to the overall population of Walton County is provided below.

Survey Demographics

	Respondents	Walton Population *
Female	86%	49%
Black/African American	7.5%	5.9%
White/Caucasian	90%	84.2%
Bachelor's Degree or Higher	36.4%	24.1%
Unemployed	4.8%	4.4%
Income Less Than $35,001/Year	45%	Median Income $43,640

* Census "Quick facts."



Responses from the community surveys were analyzed and compared to responses obtained from the survey of Health and Human Services organizations to understand areas of overlap and variance. The following are summaries of the top responses for each group for key survey questions:

What are the most important features of a "Healthy Community?"

Health & Human Services Organizations	Community
• Access to health services, e.g., family doctor, hospitals • Quality hospitals and urgent/emergency services • Good employment opportunities • Good schools • Low alcohol and drug abuse	• Good employment opportunities • Low crime/safe neighborhoods • Access to healthcare services, e.g., family doctor, hospitals • Good schools

Why is this important?

- ❑ Quality of Life ("QOL") reflects an overall sense of well-being when applied to an individual and a supportive environment when applied to a community
- ❑ While some dimensions of QOL can be quantified using indicators, research has shown QOL to be related to determinants of health and community wellbeing.
- ❑ Other valid dimensions of QOL include perceptions of community residents about aspects of their neighborhoods and communities that either enhance or diminish their quality of life.

What are the most important heath issues in the County?

Health & Human Services Organizations	Community
• Heart Disease and Stroke • Mental health problems • Cancers • Obesity/excess weight • Aging problems, e.g., dementia, vision/hearing loss, loss of mobility • Diabetes	• Obesity/excess weight • Mental health problems • Child abuse/neglect • Cancers • Heart disease and stroke • Diabetes

Why is this Important?

- ❑ This information leads to a portrait of the community as seen through the eyes of its residents.
- ❑ Perceptions about health problems that exist in Walton County correlate with county-specific data and help to pinpoint specific concerns.

Which unhealthy behaviors in the County are of greatest concern?

Health & Human Services Organizations	Community
• Drug abuse • Excess weight • Poor eating habits/poor nutrition • Not seeing a doctor or dentist • Alcohol abuse • Lack of exercise • Tobacco use	• Drug abuse • Alcohol abuse • Poor eating habits/poor nutrition • Not seeing a doctor or dentist • Excess weight • Tobacco use

Why is this Important?

- ❑ High-risk behaviors, by definition, are lifestyle activities that place a person at increased risk of suffering a particular condition.
- ❑ Risky behaviors put people at risk for bad consequences, e.g., smoking puts one at risk for cancer and being overweight puts one at risk for a heart attack.
- ❑ Systematic change using evidence-based interventions to change high-risk behaviors is recommended by the Independent Task Force on Community Preventive Services.

Which healthcare services are difficult to get in the County?

Health & Human Services Organizations	Community
• Specialty medical care (specialist doctors) • Primary medical care (a primary care doctor/ clinic) • Alcohol or drug abuse treatment • Mental health services • Services for the elderly • Alternative therapies (acupuncture, herbals, etc.) • Preventative healthcare (routine or wellness check-ups, etc.)	• Specialty medical care (specialist doctors) • Dental care including dentures • Mental health services • Primary medical care (a primary care doctor/ clinic) • Alcohol or drug abuse treatment

Why is this Important?

- ❑ Perceptions of lack of access to healthcare services may arise for several reasons, including absence of resources or lack of sufficient resources, or lack of awareness of their existence or how to access them.
- ❑ Perceptions of lack of access to particular healthcare services can be correlated with health indicator status to increase resources in areas that may have the greatest impact on health status.

In addition to understanding differences in perspectives between Health and Human Services organizations and the general public, the survey also sought to identify specific variances in access to and use of healthcare services between the general population and more vulnerable population groups. The comparison of their perspectives on two key issues is provided below.

In the past 12 months, for what reasons have you delayed getting medical care?

General Population	Vulnerable Population
• Did not have a delay in getting care • Could not get an appointment soon enough • Provider was not taking new patients • Could not afford	• Did not have a delay in getting care • Could not afford • Insurance problems or lack of insurance

Why is this Important?

- ❑ Delayed medical care can result in worsening of conditions and the need for more urgent medical care, frequently in the most expensive setting, e.g., the emergency room.
- ❑ Identification of the causes of delays in obtaining care can provide insights into strategies to improve access and reduce cost.

Where do you go for medical care when someone in the family is sick?

General Population	Vulnerable Population
• My family doctor • Urgent care clinic	• My family doctor • Hospital emergency room • Health Department

Why is this Important?

- ❑ Identifying where members of different population groups seek care can provide better focus for resource development and distribution and/or insights for strategies to steer people into more appropriate, less costly care settings.
- ❑ As borne out in the survey responses, vulnerable population groups tend to utilize the hospital emergency room for basic medical care, which creates a burden on the entire health system through higher costs.

Where do you go for mental health services when someone in the family needs them?

General Population	Vulnerable Population
• Private psychologist, psychiatrist, or other mental health professional • I do not know where to go for mental health care • My family doctor • Mental health clinic in Walton County	• I do not know where to go for mental health care • My family doctor • Mental health clinic in Walton County

Why is this Important?

- ❑ There are many reasons people may not seek healthcare services in a timely manner. Probably the easiest reason to address is lack of awareness. While the general population appears to be very familiar and have access to multiple resources for mental health services, the number one response for vulnerable populations is lack of awareness of resources, which can be addressed through public awareness campaigns and other means.
- ❑ The fact that both populations identify their family doctor as one of the primary resources for mental health services highlights the need to assess the level of awareness of and comfort in handling mental health issues among primary care physicians in the area and to provide additional training and education, if necessary, to accommodate the needs of area residents.

More detailed survey response data are provided in Attachment D.

Focus Group Discussion

On November 17, 2015, a focus group discussion was held to further explore perceptions of health and well-being along Walton County residents. The focus group covered seven questions:

1. Are you satisfied with the quality of life in our community?
2. Is this community a good place to raise children and grow older?
3. What do you believe are the 2 – 3 most important characteristics of a health community?
4. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?
5. What do you believe is keeping our community from doing what needs to be done to improve health and quality of life?
6. What do you believe are the 2 – 3 most important issues that must be addressed to improve the health and quality of life in our community?
7. What makes you most proud of our community?

Following the focus group, the notes from the focus group were reviewed, responses to each question were coded and categorized to identify themes, finding for each question were summarized, and any patterns or connections between questions were identified.

In general, participants discussed several areas where they felt change was needed. Similar issues were mentioned when participants were asked to focus on the most important issues affecting health and quality of life in Walton County. These recurring issues were aggregated into common themes and divided into two main categories; socioeconomic issues and health-related issues. The following is a summary of the themes that emerged from the focus group.

Summary of Themes from Focus Group

Socioeconomic Issues	Health-Related issues
• Poverty • Education • Employment • Transportation	• Access to care • Cultural diversity

A more detailed description of each category and its associated themes is provided in the complete Community Themes and Strengths Assessment, provided in Attachment D.

Community Strengths and Weaknesses

A summary of community strengths and weaknesses (opportunities for improvement) was developed based on the results of the community surveys, Health and Human Service organization surveys, and focus group discussion. The summary is provided below.

Strengths	Weaknesses (Opportunities for Improvement)
• Resources • Volunteers/mentoring • Faith-based organizations • Safety • Good mixture of income levels • Future growth • Collaboration • Low pollution • Technical training in high schools • Future technical skilled jobs • Boys & Girls Club • Environment/location/weather • County finances • Recreational facilities • Good healthcare providers	• Transportation • Quick growth/infrastructure • Jobs with “thrive-able” wage • Substance abuse • Lack of healthcare providers – location • Lack of insurance coverage • Housing – affordable/rentals • Lack of specialty physicians • Lack of empowerment programs • Communication within the community • Health issues: o Obesity/excess weight o Mental health problems o Cancers o Child abuse/neglect o Heart disease and stroke • Health behaviors: o Drug abuse o Alcohol abuse o Poor eating habits/poor nutrition o Not seeing a doctor or dentist o Excess weight

The complete Community Themes and Strengths Assessment is provided in Attachment D.

Forces of Change Assessment

On October 21, 2015, the Walton County MAPP Executive Committee convened to participate in Phase one of the Forces of Change Assessment ("FOCA"). The purpose of the FOCA is to identify forces – such as trends, factors, or events – that are or will be influencing the health and quality of life of the community and the work of the local public health system.

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

Forces considered include the following categories of influence:

(1) Social
(2) Economic
(3) Political
(4) Legal
(5) Environmental
(6) Technological
(7) Scientific

Other categories of forces of change specific to the county were also considered.

Forces of Change in Walton County

Economic	Environmental	Legal/Political	Social
• BP oil spill • New dental school in DeFuniak Springs • Lack of health insurance • Population & wages • Transportation • Business locations • Inadequate education and training for jobs requiring higher skill set • New business growth in unpopulated areas	• Flooding from 2013-2014 storm • Four lining project of Highway 331 • Increasing ethnic population • Limited water supply • Large wetland areas • Large protected areas (Eglin) • Higher density of Cities • New communities being created in rural areas • Increased water use • Increased sewage	• Political elections • Providers retiring due to Affordable care Act ("ACA") • Legalization of medical marijuana • Privatization of primary care (HMOs) • Decrease in Low Income Pool ("LIP") funding • Increase in governmental revenue from BP settlement • Implementation of ACA • Immigration rules and regulations • Lack of expansion of adult Medicaid • Increased drug use • Increased enforcement by DOH and law enforcement (due to increase in staff) • Increase in provider education • Growing disillusionment with Government • Tobacco-free policies and E-cigarette use	• County Health Department shifting focus to core public health • Uneven distribution of healthcare providers • Lack of affordable housing • Inadequate mental health care services • Notable economist prediction of population spike north of the Bay • Residential changes and needs
Technological/ Scientific • Meaningful Use • Availability (lack) of fiber optics and cable providers in Walton County • Infrastructure concerns • Growth in telehealth • Increasing use of social media and smart phones			

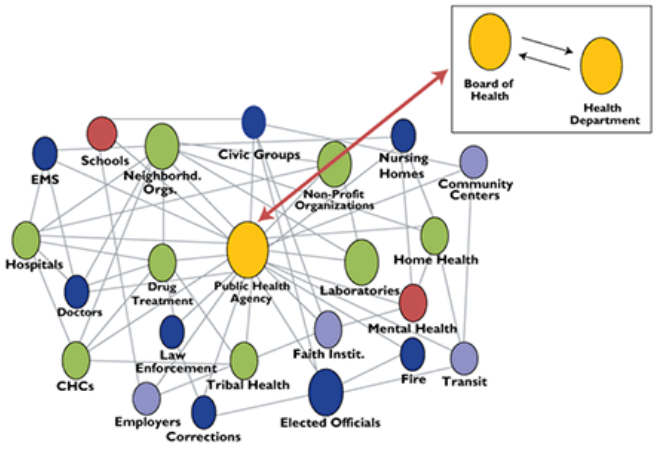
Phase two of the FOCA was completed through use of an online survey in which the MAPP Executive Committee members responded to the following questions for each Force of Change identified in Phase one:

> "When you think about public health and the health of our residents – what is a Threat or Challenge as a result of ...?"
>
> "When you think about public health and the health of our residents – what is an Opportunity as a result of ...?"

Following the collection of the surveys, notes from Phase one were added to the responses and a summary was created, which is provided in the full Forces of Change Assessment, provided in Attachment B.

Local Public Health System Assessment

The LPHS in Walton 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 conducted in January 2016 required participants to think about how well the collective LPHS meets the Ten Essential Public Health Services.

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

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 conveyed satisfaction with the LPHS's level performance with an average overall score in the "Significant" range (62%). Eight (8) out of Ten (10) of the Essential Service poll scores ranked LPHS performance over 50% ("Significant"), with development of policies and plans scoring an "Optimal" score (77.1%), nearly 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 C.

The Ten Essential Public Health Services	
1. Monitor Health Status: What is going on in our community? Do we know how healthy we are? 2. 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? 3. Inform, Educate & Empower: How well do we keep all populations within our community well informed about health issues? 4. Mobilize Community Partnerships: How well do we truly engage people in local health issues? 5. Develop Polices & Plans: What local policies in both government and private sector promote health in our community? How well are we setting local health policies?	6. Enforce Laws: When we enforce health regulations, are we fair, competent and effective? 7. Link People: Are people in the community receiving the health services they need? 8. Assure: A Competent Workforce: Do you have competent healthcare staff? 9. Evaluate: Are we meeting the needs of the population we serve? Are we doing things right? Are we doing the right things? 10. Research: Are we discovering and doing new ways to get the job done?

Community Health Status Assessment

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 140 health status indicators and 30 demographic indicators were collected. Between July and October 2015, WCHIP 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.

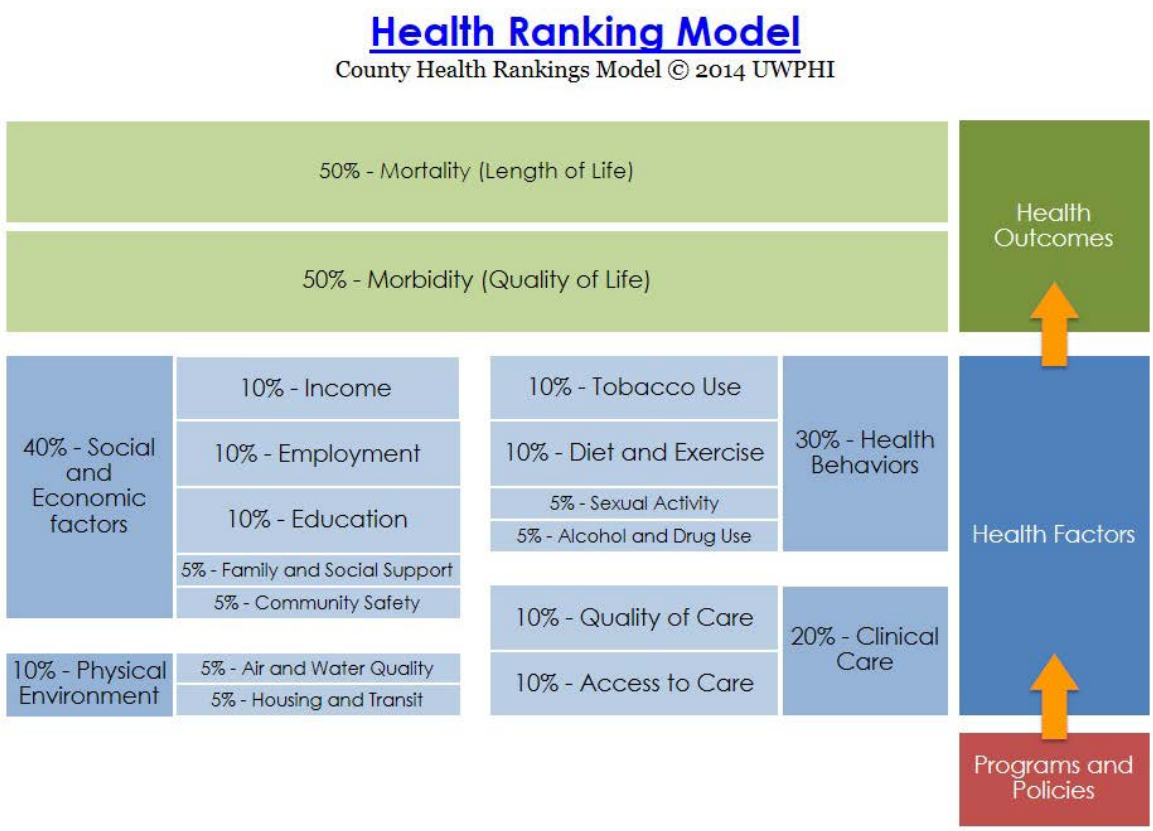
Framework for Analysis

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 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 four months, small committee meetings were held to review and assess the data. In these small committee meetings, over 140 health indicators for Walton County were compared and contrasted to those for the state and surrounding counties. In addition, the committee members also compared local data to previous years' data from Walton County, highlighting improvements and statistical trends.



Summary of Findings

Of those approximately 140 health status indicators, the following 95 indicators performed worse than the State for Walton County.

Health Outcomes		
Mortality – *Length of Life*	• Alcohol-Related Motor Vehicle Traffic Crash Deaths Cancer Deaths • Chronic Liver Disease, Cirrhosis Deaths • Chronic Lower Respiratory Disease Deaths • Colon, Rectal or Anus Cancer Deaths • Deaths from Smoking-related Cancers • Diabetes Deaths • Heart Disease Deaths	• Infant Mortality • Injury Deaths • Lung Cancer Deaths • Motor Vehicle Accident Deaths • Neonatal Deaths (0-27 Days) • Nephritis, Nephritic Syndrome, and Nephrosis Deaths • Post Neonatal Deaths (28-364 Days) • Premature Death • Prostate Cancer Deaths • Suicide Deaths

Morbidity – *Quality of Life*	• Average number of days where poor mental or physical health interfered with activities of daily living in the past 30 days • Cervical Cancer Incidence • Chicken Pox • Heart Disease (Adult) • High Cholesterol (Adult)	• Lung Cancer Incidence • Meningitis, Other Bacterial, Cryptococcal, or Mycotic • Salmonellosis • Tuberculosis • Vaccine Preventable Disease for All Ages • Whooping Cough (Pertussis)
Health Factors		
Health Behaviors	• Aggravated Assault • Alcohol Consumption in Past 30 Days (Adolescents) • Alcohol Consumption in Lifetime (Adolescents) • Alcohol-Related Motor Vehicle Traffic Crashes • Binge Drinking (Adolescents) • Births to Mothers Ages 10-14 • Births to Mothers Ages 15-19 • Births to Mothers Ages 15-44 • Births to Obese Mother (Rate) • Blacking Out from Drinking Alcohol (Adolescents) • Breast feeding Initiation • Cancer Screening: PSA in past 2 years (Men 50 and up) • Cigarette Use (Adolescents)	• Diabetic monitoring • Domestic Violence Offenses • Exercise Opportunities • Forcible Sex Offenses • Fruits and Vegetables Consumption 5 Servings per Day • Healthy Weight (Youth) • Live Births Where Mother Smoked During Pregnancy • Medicaid Birth Rate • Middle and High School Students Who Are Overweight or Obese • Never Smoked (Adult) • Obesity (Adult) • Secondhand Smoke Exposure (Youth) • Sedentary Adults • Smoked in Last 30 Days (Youth) • Smokers (Adult)
Clinical Care	• Acute Care Beds • Adult Psychiatric Beds • Adult substance abuse beds • Cancer Screening – Mammogram • Cancer Screening – Pap Test • Child and Adolescent Psychiatric Beds • Dental Care Access by Low Income Persons • Dentists • Diabetic Annual Foot Exam (Adults) • Diabetic Semi-Annual A1C Testing (Adult) • ED Visits - Avoidable Conditions - Dental • ED Visits - Chronic Conditions - Angina • ED Visits - Chronic Conditions - Congestive Heart Failure	• ED Visits - Chronic Conditions – Diabetes • ED Visits - Chronic Conditions – Hypertension • Family Practice Physicians • Flu Vaccination in the Past Year (Adult) • Flu Vaccination in the Past Year (Adult Age 65 and Older) • Insurance – Uninsured Adults • Insurance – Uninsured Children • Internists • Mental Health Providers • OB/GYNs • Pediatricians • Physicians • Pneumonia Vaccination (Adult) • Prenatal Care Begun Late or No Prenatal Care • Primary Care Access • Rehabilitation Beds (per Population
Socioeconomic	• Children in Poverty (Based on Household) • Food Access Low – Low Income Population	• Poverty Rate • Public Assistance Income • Real Per Capita Income • Unemployment
Physical Environment	• Air Quality – Ozone • Drinking Water Violations	• Grocery Store Access • Severe Housing Problems

A detailed listing of the health status indicators, definitions and sources for the State and Walton County are provided in Attachment A.

Priority Setting Process

In November 2015, the Walton County MAPP Executive Committee formed a Data Committee which met to review the results of all of the data and Assessments that had been collected and developed to-date. The Committee compiled a list of 50 indicators that were of greatest concern (where Walton County performed the worst compared to the State and to prior year results). Using this list of indicators and the County Health Ranking's model of population health depicted on page 10 as a framework, the Committee identified the top five (5) priority health issues facing Walton County. The top health issues identified were:

- ❑ Provider Availability and Access
- ❑ Preventive Care
- ❑ Healthy Weight
- ❑ Tobacco Use
- ❑ Substance Abuse and Mental Health

On November 17, 2015, WCHIP held a community meeting to identify the top priority health issues for the County. The results of the MAPP Assessments were presented to the 26 participants representing health and human service providers in the community. In reviewing the identified top five health issues, the participants were asked to consider three criteria for prioritizing the top issues:

1. Severity/Magnitude (of the health issue)
2. Feasibility to Address (availability of resources, community will)
3. Potential Impact (on community health status)

After reviewing the results of the MAPP Assessments and taking into consideration these prioritization criteria, participants used a hybrid multi-voting/nominal group technique to identify the top health issues facing Walton County.

The complete Community Health Status Assessment is provided in Attachment E.

Top Priority Health Issues for Walton County

The top priority health issues identified were:

- ❑ Substance Abuse and Mental Health
- ❑ Healthy Weight
- ❑ Provider Availability and Access

A synopsis of each of these issues is provided in the following sections.

Substance Abuse and Mental Health

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 Walton County, the primary substance abuse problem appears to be alcohol consumption, particularly among adolescents. Rates for adolescents in Walton County are higher than rates statewide for all alcohol-related health indicators. However, Walton County improved in all categories compared to the prior period.

Poor performing indicators for Walton County (compared to the State or the prior year for the County) related to substance abuse are highlighted below.

Indicator	Walton County		State of Florida
	Most Recent Period	Prior Period	
Alcohol Consumption in Past 30 Days – Adolescents (Rate)	21.8	26.9	20.5
Alcohol Consumption in Lifetime – Adolescents (Rate)	50.3	52.0	48.5
Binge Drinking – Adolescents (Rate)	10.4	14.7	9.5
Blacking Out from Drinking Alcohol – Adolescents (Rate)	23.4	N/A	18.9

Despite the high rate of adolescent alcohol use, there are currently no substance abuse beds located in Walton County, compared to 1.7 adult substance abuse beds per population in the State.

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

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Crime
- Homicide
- Suicide

Not surprisingly, given the prevalence of substance abuse in Walton County, particularly among adolescents, the County has a higher (and, in some cases, a substantially higher) rate of many of these problems than statewide. Of particular concern are the rates of alcohol-related motor vehicle traffic crashes and deaths which, although they have improved compared to the prior period, are almost double and triple, respectively, those rates statewide. The rate of teenage pregnancy is also of concern in Walton County, with rates substantially higher than statewide and higher than in the prior period.

Poor performing indicators for Walton County (compared to the State or the prior year for the County) related to these negative outcomes are highlighted below.

Indicator	Walton County		State of Florida
	Most Recent Period	Prior Period	
Births to Mothers Age 10 – 14 – Resident (Rate)	0.4	0.4	0.3
Births to Mothers Age 15 – 19 – Resident (Rate)	39.6	38.6	24.3
Domestic Violence Offenses (Rate per 100,000)	756	795	547
Alcohol-Related Motor Vehicle Traffic Crashes (Rate)	162.0	173.7	89.9
Alcohol-Related Motor Vehicle Traffic Crash Deaths (Rate)	13.2	14.7	4.4
Aggravated Assault (Rate per 100,000)	307	290	298
Violent Crime (Rate per Population)	397	356	466
Suicide Deaths (Rate)	17.0	19.9	14.0

It should be noted that, despite the substance abuse problem in the County and the high rates of many of the problems associated with substance abuse, the rates of sexually transmitted diseases, including HIV/AIDS and infectious syphilis, are substantially lower in the County than they are statewide.

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 are 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 Walton County, 29.6% 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, ranking it second only to obesity/excess weight as an area of concern to county residents. Social Service organizations also rated it second highest of the most important health issues facing the County (43.3% of responses). However, only 4.9% of respondents indicated that they had been told by a health professional that they had a mental health problem. Of course, this finding could be misleading due to the self-reported nature of the survey and self-selection, i.e., people suffering from mental health problems may be less likely to have completed the survey.

The County performed relatively well compared to the State with regard to mental health-related health status indicators. For instance, although slightly higher than the prior year, there were 22.27 ED visits per 1,000 visits for mental health issues in Walton County compared to 25.71 per 1,000 ED visits in the State. The relatively high number of such visits in the County and the State suggests that mental health problems may be a significant problem statewide. In addition, Walton County experienced an average of 3.3 unhealthy mental health days, compared to 4.1 for the State.

There are currently no adult or pediatric psychiatric beds located in Walton County, compared to 20.0 and 2.70 beds per population, respectively, in the State. In addition, there are many fewer mental health

providers in the County to serve the population in need compared to the State. In Walton County, there is one mental health provider per 1,495 people compared to one per 744 people in the State.

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

- ARC
- Area Agency on Aging
- Caring & Sharing
- Catholic Charities
- Children in Crisis
- Children's Volunteer Health Network
- COPE Center, Inc.
- Covenant Hospice
- Department of Children & Families
- Elder Affairs
- Emerald Coast Children's Advocacy Ctr.
- Families First Network
- Healthmark Regional Medical Center
- Lutheran Services
- Sacred Heart Health Systems
- Shelter House
- The Matrix Community Outreach Center
- Tri-County Community Council
- 211 Panhandle HelpLine
- United Way
- Walton County Prevention Coalition
- Walton County Sheriff's Office
- West Florida AHEC

Mental Health and Substance Abuse, and related indicators

Legend:

County Performance	County Trend:	
Worse than Florida	Worsening: increasing or decreasing	↑ ↓
Better than Florida	Improving: increasing or decreasing	↑ ↓
Same as Florida	No Change	●

Health Outcome - Mortality (Deaths)			
		Walton County	
Indicator	Latest Data Period	Performance	Trend
Infant Mortality	2012-14	8.8	↓
Neonatal Deaths (0-27 days)	2012-14	4.2	↓
Post neonatal Deaths (28-364 days)	2012-14	4.7	↑
Chronic Liver Disease, Cirrhosis Deaths	2012-14	13.2	↑
HIV/AIDS Deaths	2012-14	1.1	↑
Suicide Deaths	2012-14	17.0	↓
Motor Vehicle Accident Deaths	2012-14	20.7	↓
Injury Deaths	2012-14	48.8	↑
Homicide	2012-14	1.5	↓
Health Outcome - Morbidity (Quality of Life)			
		Walton County	
Indicator	Latest Data Period	Performance	Trend
Low birth weight	2012-14	7.7	↓
Hepatitis C, Acute	2012-14	1.1	↓

HIV	2012-14	3.4	⬇
AIDS	2012-14	3.4	⬇
Unhealthy mental days	2013	3.3	⬇
Average number of days where poor mental or physical health interfered with activities of daily living in the past 30 days	2013	6.2	⬆

Health Behavior - Alcohol / Substance Abuse			
		Walton County	
Indicator	**Latest Data Period**	**Performance**	**Trend**
Alcohol-related Motor Vehicle Traffic Crash Deaths	2012-14	13.2	⬇
Alcohol-related Motor Vehicle Traffic Crashes	2012-14	162.0	⬇
Blacking out from drinking Alcohol (Adolescents)	2014	23.4	⬆
Marijuana or Hashish Use (Adolescents)	2014	10.5	⬇
Alcohol Consumption in past 30 days (Adolescents)	2014	21.8	⬇
Alcohol Consumption in Lifetime (Adolescents)	2014	50.3	⬇
Binge Drinking (Adolescents)	2014	10.4	⬇

Health Behavior - Sexual Activity			
		Walton County	
Indicator	**Latest Data Period**	**Performance**	**Trend**
Births to Mothers under the age of Majority (10-14)	2012-14	0.4	●
Births to Mothers under the age of Majority (10-16)	2012-14	1.4	⬇

Clinical Care – Access to Health Care			
		Walton County	
Indicator	**Latest Data Period**	**Performance**	**Trend**
Adult psychiatric beds	2012-14	0.0	●
Adult substance abuse beds	2012-14	0.0	●
Pediatric psychiatric beds	2012-14	0.0	●

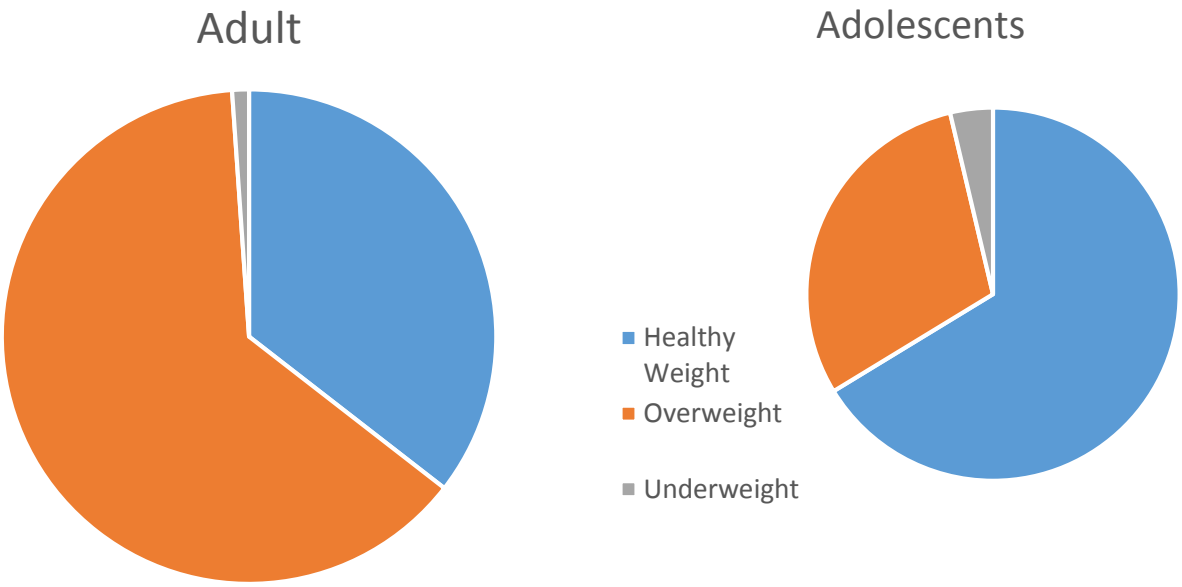
Clinical Care – Quality of Care			
		Walton County	
Indicator	Latest Data Period	Performance	Trend
ED Visits - Chronic Conditions - Mental Health	2014	22.3	⬆
Social and Economic Factors			
		Walton County	
Indicator	Latest Data Period	Performance	Trend
Domestic Violence Offenses	2014	756.2	⬇
Forcible Sex Offenses	2014	72.6	⬆
Aggravated Assault	2014	307	⬆
Murder	2014	0.0	⬇
Property Crimes	2014	2,530	⬇
Violent Crime	2014	396.7	⬆

Healthy Weight

Obesity is common, serious, and costly. According to the Florida Department of Health, the number one public health threat to Florida's future is unhealthy weight. The estimated annual medical cost for people who are obese is $1,429 higher than that for people of healthy weight. Currently, only 36 percent of Floridians are at healthy weight. With the current national trend, by 2030, almost 60 percent will be obese. Additionally, six out of ten children born today will be obese by the time they graduate high school.

Walton County Weight Status -

Body Mass Index (BMI)



<u>Adults (21 and over)</u>

Obesity 30.0 or higher

Overweight 25.0 and 29.9

<u>Children & Adolescents (2-20 years)</u>

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

In Walton County, excess weight and obesity is a serious problem. 39.9% of respondents to the Community Health Status Assessment survey indicated that obesity/excess weight is one of the most important health issues facing the County, ranking it first as an area of concern to county residents. Among Social Service organizations, it tied for third highest ranked of the most important health issues facing the County (33.3% of responses). These perceptions are supported by the data. In most of the indicator categories directly related to weight, Walton County performs worse than the State overall and, in many, the problem has gotten worse compared to the prior period. In addition, despite the beautiful surroundings and environment in many parts of the County, Walton County residents are far less active than residents of the State overall. A lack of proper exercise habits contributes to making excess weight and obesity a priority health issue in Walton County.

Poor performing indicators for Walton County (compared to the State or the prior year for the County) related to weight are highlighted below.

Indicator	Walton County		State of Florida
	Most Recent Period	Prior Period	
Healthy Weight (Adolescents)	66.3%	66.0%	67.6%
Obesity (Adult)	29.2%	28.6%	26.4%
Overweight and Obese (Adolescents)	30.0%	29.6%	28.2%
Births to Obese Mothers	21.,3	20.9	21.1
Fruits and vegetables Consumption (5 Servings)	15.1%	26.3%	18.3%
Exercise Opportunities	66%	38%	93%
Sedentary Adults	26.2%	28.1%	27.7%

Obesity is a major contributor to many preventable chronic diseases and other poor health outcomes, including, but not limited to:

- ❑ Premature death
- ❑ Type 2 diabetes (noninsulin-dependent diabetes)
- ❑ Some cancers
- ❑ Heart disease
- ❑ High blood pressure (hypertension)
- ❑ High cholesterol (dyslipidemia)
- ❑ Osteoarthritis
- ❑ Complications during pregnancy

Not surprisingly, given the prevalence of weight problems in Walton County, the rates of many of these diseases and poor health outcomes in Walton County are higher than statewide. The good news is that many of these rates have improved compared to the prior period in Walton County.

Poor performing indicators for Walton County (compared to the State or the prior year for the County) related to these chronic diseases and outcomes are highlighted here.

Indicator	Walton County		State of Florida
	Most Recent Period	Prior Period	
Premature Death (per Population)	7,712	9,002	6,893
Diabetes Deaths (per Population)	23.2	31.0	19.8
ED Visits - Diabetes (per 1,000 Visits)	5.28	5.57	4.55
Cancer Deaths (per Population)	165	163	158
Heart Disease (Adult)	10.9	11.8	10.3
Heart Disease Deaths (per Population)	181	183	155
High Blood Pressure (Adult)	36.6	65.4	34.6

Unhealthy weight is a complicated issue to address. To insure the effectiveness of interventions, it is important to understanding the personal, social, economic, and environmental barriers to and facilitators of changes in diet or physical activity including:

Factors Influencing Diet	Factors Influencing Physical Activity
• Knowledge and attitudes • Skills • Social support • Societal and cultural norms • Food and agricultural policies • Food assistance programs • Economic price systems • Marketing/advertising (which influences people's, particularly children's, food choices) • Access to and availability of healthier foods • Where people eat (at home or away from home), e.g., foods eaten away from home often have more calories and are of lower nutritional quality than foods prepared at home	• Low income • Lack of time • Low motivation • Rural residency • Lack of social support from peers, family, or spouse • Overweight or obesity • Age and/or Disabilities (inaccessibility) • Physical environment: • Presence of sidewalks • Access to public transportation • Access to neighborhood or school play area and/or recreational equipment • Lack of transportation to facilities • Fear of injury

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

- COPE Center, Inc.
- Department of Children & Families
- Florida Department of Health, Walton County
- Early Learning Coalition
- Emerald Coast Children's Advocacy Ctr.
- Families First Network
- Healthmark Regional Medical Center
- North West Florida State College
- Sacred Heart Health Systems
- Walton Board of County Commissioners
- Walton Community Health Center, Inc.
- Walton County School District

Healthy Weight and related indicators

Legend:

County Performance	County Trend:	
Worse than Florida	Worsening: increasing or decreasing	↑ ↓
Better than Florida	Improving: increasing or decreasing	↑ ↓
Same as Florida	No Change	●

Health Outcome - Mortality (Deaths)			
		Walton County	
Indicator	Latest Data Period	Performance	Trend
Premature Death	2010-12	7,712	↓
Cancer Deaths	2012-14	165.3	↑
Colon, Rectal or Anus Cancer Deaths	2012-14	14.9	↓
Diabetes Deaths	2012-14	23.2	↓
Heart Disease Deaths	2012-14	181.3	↓
Stroke Deaths	2012-14	28.6	↓
Health Outcome - Morbidity (Quality of Life)			
		Walton County	
Indicator	Latest Data Period	Performance	Trend
Total Cancer Incidence	2009-11	440.7	↓
Breast Cancer Incidence	2009-11	89.5	↑
Colon and Rectum Cancer Incidence	2009-11	31.0	↑
Diabetic monitoring	2012	78.0	↑
Diabetes (Adult)	2013	9.9	↓
High Blood Pressure (Adult)	2013	36.6	↓
High Cholesterol (Adult)	2013	30.4	↓
High Blood Pressure Controlled (Adult)	2013	88.7	↑
Heart Disease (Adult)	2013	10.9	↓
Low birth weight	2012-14	7.7	↓
Poor or fair health	2013	19.4	↑

Health Behavior - Diet and Exercise			
		Walton County	
Indicator	Latest Data Period	Performance	Trend
Healthy Weight (Adult)	2013	35.5	↑
Overweight (Adult)	2013	34.2	↓
Obesity (Adult)	2013	29.2	↑
Births to Obese Mothers	2012-14	21.3	↑
Births to overweight mothers	2012-14	22.9	↓
Breast feeding Initiation	2012-14	77.7	↑
Overweight (Adolescents)	2014	15.8	↓
Overweight or Obesity (Adolescents)	2014	30.0	↑
Healthy Weight (Adolescents)	2014	66.3	↑
Vigorous physical activity recommendations met (Adult)	2007	30.1	↑
Exercise opportunities	2013 & 10	0.7	↑
Sedentary Adults	2013	36.2	↑
Fruits and Vegetables Consumption 5 servings per day (Adult)	2013	15.1	↓
Food Insecurity	2013	15.3	↑
Grocery Store Access	2013	7.1	↑
Food Access Low - Low Income Population	2010	0.1	↑
Fast Food Restaurant Access	2013	6.6	↓
SNAP Participants	2011	10.2%	↑

Clinical Care - Access to Care			
		Walton County	
Indicator	Latest Data Period	Performance	Trend
Diabetic Annual Foot Exam (Adults)	2013	62.4	↑
Diabetic Semi-Annual A1C Testing (Adult)	2013	74.8	↑
ED Visits - Acute Conditions - Hypoglycemia	2014	0.2	↓
ED Visits - Chronic Conditions - Congestive Heart Failure	2014	2.0	↑
ED Visits - Chronic Conditions - Diabetes	2014	5.3	↓
ED Visits - Chronic Conditions – Hypertension	2014	9.3	↑
Admitted ED Visits – Diabetes	2014	0.5	↑

Physical Environment			
		Walton County	
Indicator	Latest Data Period	Performance	Trend
Households with No Motor Vehicle	2013	5.5%	↓
Driving alone to work	2013	82.5%	↑
Use of Public Transportation	2013	9.6%	↑

Provider Availability and Access

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

Access to health services encompasses four main components:

Coverage

Health insurance coverage helps patients get into the health care system. Uninsured (and underinsured) people are less likely to receive medical care, more likely to die early, and are more likely to have poor health status.

The percentage of the population that is uninsured in Walton County is substantially lower than it is statewide. However, the percentage in Walton County increased slightly compared to the prior period. Of greater concern is the rate of uninsured among children, which is higher than statewide and increased in Walton compared to the prior period. In addition, these rates do not account for those who are underinsured or who have coverage in high deductible plans, which are becoming increasingly prevalent. As a result, median household and per capita income are important indicators of access to care. The low relative income levels of the population in Walton County suggest that access to care may be difficult due to coverage issues for an even larger percentage of the population.

Poor performing indicators for Walton County (compared to the State or the prior year for the County) related to coverage issues are highlighted below.

Indicator	Walton County		State of Florida
	Most Recent Period	Prior Period	
Population Receiving Medicaid (Rate/100,000)	13,140	12,344	16,601
Insurance – Uninsured Adults	13.8	24.0	24.3
Insurance – Uninsured Children	13.8	13.3	11.9
Median Household Income	$43,640	$44,254	$46,956
Real Per Capita Income	$37,976	$38,072	$41,497

Services

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. The Health Resources and Services Administration ("HRSA") defines areas and populations as Medically Underserved based on four weighted variables - ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over.

In Walton County, only about 20% of the adult population does not have a personal doctor, compared to more than 25% statewide. However, this percentage increased in Walton County from the prior period. Despite the high percentage of adults who have a personal doctor, the County has far fewer primary care physicians per population than overall for the State, including family practitioners,

internists, OB/GYN physicians, and pediatricians. Other services that are not available in Walton County include adult and pediatric psychiatric beds, adult substance abuse beds, and physical rehabilitation beds. These findings suggest that access to care may be limited in Walton County due to lack of available services.

Poor performing indicators for Walton County (compared to the State or the prior year for the County) related to services are highlighted below.

Indicator	Walton County		State of Florida
	Most Recent Period	Prior Period	
Adults who have a personal doctor	78.4	81.0	73.2
Family Practice Physicians (per Population)	18.2	17.4	24.5
Internists (per Population)	10.6	9.6	49.7
Pediatricians (per Population)	7.0	5.0	21.3
OB/GYN (per Population)	5.9	6.6	9.8
Infant Mortality	8.8	9.7	6.1
Poverty Rate	33.4%	29.8%	29.0%
Percentage of Population Age 65 or Older	17.1%	17.0%	18.4%

Timeliness

Timeliness is the health care system's ability to provide health care quickly after a need is recognized. Timeliness issues include the time between identifying a need for specific tests and treatments and actually receiving those services. Actual and perceived difficulties or delays in getting care when patients are ill or injured likely reflect significant barriers to care.

One of the questions asked in the Community Health Status Assessment survey was, “In the past 12 months, did you delay getting needed medical care for any of the following reasons.” Respondents were told to check all answers that applied (to them). 42.6% of respondents said that they did not delay in getting care and 10.8% said they did not need medical care. The following reasons were given for delaying care:

Reason for Delay	Percent Responding
Could not get an appointment soon enough	24.1%
Could not afford	22.5%
Insurance problems or lack of insurance	14.9%
Provider was not taking new patients	14.9%
Could not get a weekend or evening appointment	11.6%
Provider did not take insurance	9.2%
Lack of transportation	2.0%

Probably related to the high percentage of adults who have a personal doctor, only 17.7% of Walton County adults could not see a doctor at least once in the past year due to cost, compared to 19.3% in the prior period and 20.8% statewide.

Workforce

Primary care physicians (“PCP”) play an important role in the general health of the communities they serve because they typically develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. However, adequate availability of specialty physicians also impacts the overall health of a community.

As noted above, Walton County has substantially fewer PCPs of all types per population than in the State as a whole. In addition, the County has substantially fewer physicians overall (of all specialties) per population and fewer dentists per population than statewide. Dental health has significant implications for overall health, so the relatively low number of dentists per population is particularly alarming. The lack of sufficient workforce is clearly an impediment to access to care in Walton County. The Health Resources & Services Administration (HRSA) has designated all of Walton County as a health professional shortage area (HPSA) for primary care, mental health and dental care.

Health Resources & Services Administration (HRSA) - Health Professional Shortage Area

Poor performing indicators for Walton County (compared to the State or the prior year for the County) related to workforce are highlighted below.

Indicator (Rate per Population)	Walton County		State of Florida
	Most Recent Period	Prior Period	
Internists	10.6	9.6	49.7
Pediatricians	7.0	5.0	21.3
OB/GYN	5.9	6.6	9.8
Physicians	146	140	267
Dentists	39.9	37.2	54.0

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

- ARC
- Area Agency on Aging
- Caring & Sharing
- Children's Volunteer Health Network
- COPE Center, Inc.
- Covenant Hospice
- Department of Children & Families
- Florida Department of Health, Walton County
- Early Learning Coalition
- Elder Affairs
- Emerald Coast Children's Advocacy Ctr.
- Families First Network
- Healthmark Regional Medical Center
- Lutheran Services
- Muscogee Nation of Florida
- North West Florida State College
- Okaloosa Walton Healthy Start Coalition
- Opportunity, Inc.
- Sacred Heart Health Systems
- Shelter House
- South Walton Fire District
- Stanley House
- The Matrix Community Outreach Center
- Tri-County Community Council
- 211 Panhandle HelpLine
- United Way
- Walton Board of County Commissioners
- Walton Community Health Center, Inc.
- Walton County Prevention Coalition
- Walton County School District
- Walton County Sheriff's Office
- Walton-Okaloosa Council on Aging
- West Florida AHEC
- West Florida Regional Planning Council
- WZEP

Provider Availability and Access, and related indicators

Legend:

County Performance	County Trend:	
Worse than Florida	Worsening: increasing or decreasing	↑ ↓
Better than Florida	Improving: increasing or decreasing	↑ ↓
Same as Florida	No Change	●

Health Outcome - Mortality (Deaths)			
		Walton County	
Indicator	Latest Data Period	Performance	Trend
Premature Death	2010-12	7,712	↓
Cancer Deaths	2012-14	165.3	↑
Breast Cancer Deaths	2012-14	19.5	↑
Prostate Cancer Deaths	2012-14	22.1	↓
Lung Cancer Deaths	2012-14	53.0	↑
Deaths from Smoking-related Cancers	2010-12	69.4	↓
Colon, Rectal or Anus Cancer Deaths	2012-14	14.9	↓
Diabetes Deaths	2012-14	23.2	↓
Heart Disease Deaths	2012-14	181.3	↓
Stroke Deaths	2012-14	28.6	↓
Infant Mortality	2012-14	8.8	↓
Neonatal Deaths (0-27 days)	2012-14	4.2	↓
Post neonatal Deaths (28-364 days)	2012-14	4.7	↑
Chronic Liver Disease, Cirrhosis Deaths	2012-14	13.2	↑
Chronic Lower Respiratory Disease Deaths	2012-14	59.6	↓
Pneumonia, Influenza Deaths	2012-14	9.1	↑
HIV/AIDS Deaths	2012-14	1.1	↑

Health Outcome - Morbidity (Quality of Life)			
		Walton County	
Indicator	Latest Data Period	Performance	Trend
Diabetic monitoring	2012	78.0	↑
Low birth weight	2012-14	7.7	↓
Disability (Any)	2013	17.1%	↑
Hepatitis C, Acute	2012-14	1.1	↓
HIV	2012-14	3.4	↓
AIDS	2012-14	3.4	↓
Salmonellosis	2014	42.2	↑
Meningitis, Other Bacterial, Cryptococcal, or Mycotic	2012-14	18.6	↑
Tuberculosis	2012-14	3.4	↑

Chicken Pox	2012-14	5.0	↑
Whooping Cough	2012-14	8.4	↑
Vaccine (selected) Preventable Disease for All Ages	2014	8.4	↑
Unhealthy mental days	2013	3.3	↓
Adults with good to excellent overall health	2013	80.6	↓
Fast Food Restaurant Access	2013	6.6	↓
SNAP Participants	2011	10.2%	↑

Clinical Care – Access to Health Care

		Walton County	
Indicator	**Latest Data Period**	**Performance**	**Trend**
Uninsured Adults	2013	24.4	↑
Uninsured Children	2013	13.8	↑
Adults who could not see a doctor at least once in the past year due to cost	2013	17.7	↓
Population Receiving Medicaid	2013	13,140	↑
Medicaid births	2012-14	53.4	↓
Dental Care Access by Low Income Persons	2010-12	18.0	↑
Primary Care Access	2012	48.6	↑
Mental health providers	2014	1,495:1	↑
Physicians	FY 11/12 - FY 13/14	145.5	↑
Family Practice Physicians	FY 11/12 - FY 13/14	18.2	↑
Internists	FY 11/12 - FY 13/14	10.6	↑
Pediatricians	FY 11/12 - FY 13/14	7.0	↑
OB/GYN	FY 11/12 - FY 13/14	5.9	↓
Dentists	FY 11/12 - FY 13/14	39.9	↑
Acute Care Beds	2012-14	186.1	↓
Adult psychiatric beds	2012-14	0.0	●
Adult substance abuse beds	2012-14	0.0	●
Pediatric psychiatric beds	2012-14	0.0	●
Rehabilitation beds	2012-14	0.0	●
Nursing Home Beds	2012-14	477.3	↓

Clinical Care – Quality of Care			
		Walton County	
Indicator	Latest Data Period	Performance	Trend
Lack of Prenatal Care	2012-14	0.7	●
Prenatal Care Begun Late or No Prenatal Care	2012-14	5.2	⬆
Prenatal Care Begun in First Trimester	2012-14	80.8	⬇
Adults who have a personal doctor	2013	78.4	⬇
Cancer Screening - Mammogram	2013	50.7	⬇
Cancer Screening in past two years - PSA (Men age 50 & older)	2010	71.1	⬆
Cancer Screening - Sigmoidoscopy or Colonoscopy	2013	56.2	⬇
Cancer Screening - Pap Test	2013	47.4	⬇
Diabetic Annual Foot Exam (Adults)	2013	62.4	⬆
Diabetic Semi-Annual A1C Testing (Adult)	2013	74.8	⬆
HIV Testing (Adult age 65 and over)	2013	36.0	⬇
Flu Vaccination in the Past Year (Adult age 65 and over)	2013	49.7	⬇
Flu Vaccination in the Past Year (Adult)	2013	24.7	⬇
Pneumonia Vaccination (Adult age 65 and over)	2013	67.4	⬇
Pneumonia Vaccination (Adult)	2013	30.3	⬇
Vaccination (kindergarteners)	2012-14	96.2	⬆
ED Visits - Acute Conditions - Hypoglycemia	2014	0.2	⬇
ED Visits - Avoidable Conditions - Dental	2014	22.0	⬆
ED Visits - Chronic Conditions - Angina	2014	0.7	⬇
ED Visits - Chronic Conditions - Asthma	2014	9.3	⬇
ED Visits - Chronic Conditions - Congestive Heart Failure	2014	2.0	⬆
ED Visits - Chronic Conditions - Diabetes	2014	5.3	⬇
ED Visits - Chronic Conditions - Mental Health	2014	22.3	⬆
ED Visits - Chronic Conditions - Hypertension	2014	9.3	⬆
ED Visits - STDs	2014	0.2	⬆
Preventable hospital stays	2011-13	951	⬇
Admitted ED Visits - All Ambulatory Care Sensitive Conditions	2012-14	186.1	⬇
Admitted ED Visits - Dental	2014	153.1	⬆
Admitted ED Visits - Diabetes	2014	0.5	⬆
Admitted ED Visits - STDs	2014	34.7	⬆

Social and Economic Factors			
		Walton County	
Indicator	Latest Data Period	Performance	Trend
Unemployment	2015 AUG	4.6	↓
Poverty	2013	33.4%	↓
Children in poverty (based on household)	2013	28.5%	↓
Income - Public Assistance Income	2013	32.9%	↑
Population with Limited English Proficiency	2013	0.9%	↓

Physical Environment			
		Walton County	
Indicator	Latest Data Period	Performance	Trend
Households with No Motor Vehicle	2013	5.5%	↓
Use of Public Transportation	2013	9.6%	↑

Additional Significant Health Concerns

Although not selected as one of the top three health priorities for Walton County, tobacco use was also identified as a significant health issue in Walton County. Although smoking is a problem statewide, Walton County rates for almost all smoking-related indicators is worse than statewide. Of particular concern is the rate of live births where the mother smoked during pregnancy, which is more than double the rate in the State overall. However, the County rates in most of these areas improved compared to the prior period. In addition, Walton County residents appear to be attempting to quit more frequently than Florida residents overall.

Poor performing indicators for Walton County (compared to the State or the prior year for the County) related to tobacco use are highlighted below.

Indicator	Walton County		State of Florida
	Most Recent Period	Prior Period	
Never Smoked – Adult (Rate)	45.9	45.7	55.0
Tobacco Quit Attempt – Adult (Rate)	63.8	63.9	61.1
Smokers – Adult (Rate)	23.2	24.3	16.8
Smoked in Last 30 Days – Adolescents (Rate)	6.6	12.2	4.3
Live Births Where Mother Smoked During Pregnancy (Rate)	15.9	17.3	6.4
Second-Hand Smoke Exposure – Children (Rate)	41.8	53.7	35.9
Lung Cancer Incidence (Rate)	64.1	63.1	63.4
Cancer Deaths (Rate)	165	163	158
Lung Cancer Deaths (Rate)	53.0	50.4	43.4
Deaths from Smoking-Related Cancers (Rate)	69.4	77.5	61.2

Next Steps

The next step in the Walton County CHNA process will be the development of a community health improvement plan with specific goals, tactics, and evaluation metrics. Activities include:

- Organizing work groups to develop comprehensive action plans to address each priority
- Identifying successful health improvement initiatives to serve as best practices
- Establishing metrics for performance, including measurable outcome indicators
- Continuing to communicate progress and results to the Walton County community

Attachment A - Health Status Indicators, Definitions and Sources

Legend:

County Performance	County Trend:	
Worse than Florida	Worsening increasing or decreasing	⬆ ⬇
Better than Florida	Improving increasing or decreasing	⬆ ⬇
Same as Florida	No Change	●

Health Outcome - Mortality (Deaths)						
		Walton County		Related Priorities		
Indicator	Latest Data Period	Performance	Trend	Healthy Weight	Access to Care	Mental Health / Substance Abuse
Premature Death	2010-12	7,712	⬇	✓	✓	
Cancer Deaths	2012-14	165.3	⬆	✓	✓	
Breast Cancer Deaths	2012-14	19.5	⬆		✓	
Prostate Cancer Deaths	2012-14	22.1	⬇		✓	
Lung Cancer Deaths	2012-14	53.0	⬆		✓	
Deaths from Smoking-related Cancers	2010-12	69.4	⬇		✓	
Colon, Rectal or Anus Cancer Deaths	2012-14	14.9	⬇	✓	✓	
Diabetes Deaths	2012-14	23.2	⬇	✓	✓	
Heart Disease Deaths	2012-14	181.3	⬇	✓	✓	
Stroke Deaths	2012-14	28.6	⬇	✓	✓	
Infant Mortality	2012-14	8.8	⬇		✓	✓
Neonatal Deaths (0-27 days)	2012-14	4.2	⬇		✓	✓
Post neonatal Deaths (28-364 days)	2012-14	4.7	⬆		✓	✓
Chronic Liver Disease, Cirrhosis Deaths	2012-14	13.2	⬆		✓	✓
Nephritis, Nephritic Syndrome, and Nephrosis Deaths	2012-14	17.9	⬆			
Chronic Lower Respiratory Disease Deaths	2012-14	59.6	⬇		✓	
Pneumonia, Influenza Deaths	2012-14	9.1	⬆		✓	
HIV/AIDS Deaths	2012-14	1.1	⬆		✓	✓
Suicide Deaths	2012-14	17.0	⬇			✓
Motor Vehicle Accident Deaths	2012-14	20.7	⬇			✓
Injury Deaths	2012-14	48.8	⬆			✓
Homicide	2012-14	1.5	⬇			✓

Health Outcome - Morbidity (Quality of Life)						
		Walton County		Related Priorities		
Indicator	Latest Data Period	Performance	Trend	Healthy Weight	Access to Care	Mental Health / Substance Abuse
Total Cancer Incidence	2009-11	440.7	⬇	✓		
Breast Cancer Incidence	2009-11	89.5	⬆	✓		
Prostate Cancer Incidence	2009-11	71.7	⬇			
Lung Cancer Incidence	2009-11	64.1	⬆			
Colon and Rectum Cancer Incidence	2009-11	31.0	⬆	✓		
Melanoma Cancer Incidence	2009-11	15.2	⬆			
Cervical Cancer Incidence	2009-11	9.9	⬆			
Diabetic monitoring	2012	78.0	⬆	✓	✓	
Diabetes (Adult)	2013	9.9	⬇	✓		
High Blood Pressure (Adult)	2013	36.6	⬇	✓		
High Cholesterol (Adult)	2013	30.4	⬇	✓		
High Blood Pressure Controlled (Adult)	2013	88.7	⬆	✓		
Heart Disease (Adult)	2013	10.9	⬇	✓		
Asthma (Adult)	2013	6.9	⬆			
Low birth weight	2012-14	7.7	⬇	✓		✓
Disability (Any)	2013	17.1%	⬆		✓	
Hepatitis C, Acute	2012-14	1.1	⬇		✓	✓
HIV	2012-14	3.4	⬇		✓	✓
AIDS	2012-14	3.4	⬇		✓	✓
Salmonellosis	2014	42.2	⬆		✓	
Meningitis, Other Bacterial, Cryptococcal, or Mycotic	2012-14	18.6	⬆		✓	
Tuberculosis	2012-14	3.4	⬆		✓	
Chicken Pox	2012-14	5.0	⬆		✓	
Whooping Cough	2012-14	8.4	⬆		✓	
Vaccine (selected) Preventable Disease for All Ages	2014	8.4	⬆		✓	
Unhealthy mental days	2013	3.3	⬇		✓	✓
Average number of days where poor mental or physical health interfered with activities of daily living in the past 30 days	2013	6.2	⬆			✓
Adults with good to excellent overall health	2013	80.6	⬇		✓	
Poor or fair health	2013	19.4	⬆	✓		

Health Behavior - Tobacco Use						
		Walton County		Related Priorities		
Indicator	Latest Data Period	Performance	Trend	Healthy Weight	Access to Care	Mental Health / Substance Abuse
Smokers (Adult)	2013	23.2	↓			
Former Smokers (Adult)	2013	30.9	↑			
Never Smoked (Adult)	2013	45.9	↑			
Tobacco Quit Attempt (Adult)	2013	63.8	↓			
Smoked Cigarettes in last 30 days (Adolescents)	2014	6.6	↓			
Cigarette Use (Adolescents)	2014	10.1	↓			
Secondhand Smoke exposure (Children)	2014	41.8	↓			
Live births where mother smoked during pregnancy	2012-14	16.4	↓			

Health Behavior - Alcohol / Substance Abuse						
		Walton County		Related Priorities		
Indicator	Latest Data Period	Performance	Trend	Healthy Weight	Access to Care	Mental Health / Substance Abuse
Alcohol-related Motor Vehicle Traffic Crash Deaths	2012-14	13.2	↓			✓
Alcohol-related Motor Vehicle Traffic Crashes	2012-14	162.0	↓			✓
Blacking out from drinking Alcohol (Adolescents)	2014	23.4	↑			✓
Marijuana or Hashish Use (Adolescents)	2014	10.5	↓			✓
Alcohol Consumption in past 30 days (Adolescents)	2014	21.8	↓			✓
Alcohol Consumption in Lifetime (Adolescents)	2014	50.3	↓			✓
Binge Drinking (Adolescents)	2014	10.4	↓			✓

Health Behavior - Diet and Exercise

		Walton County		Related Priorities		
Indicator	**Latest Data Period**	**Performance**	**Trend**	**Healthy Weight**	**Access to Care**	**Mental Health / Substance Abuse**
Healthy Weight (Adult)	2013	35.5	⬆	✓		
Overweight (Adult)	2013	34.2	⬇	✓		
Obesity (Adult)	2013	29.2	⬆	✓		
Births to Obese Mothers	2012-14	21.3	⬆	✓		
Births to overweight mothers	2012-14	22.9	⬇	✓		
Breast feeding Initiation	2012-14	77.7	⬆	✓		
Overweight (Adolescents)	2014	15.8	⬇	✓		
Overweight or Obesity (Adolescents)	2014	30.0	⬆	✓		
Healthy Weight (Adolescents)	2014	66.3	⬆	✓		
Vigorous physical activity recommendations met (Adult)	2007	30.1	⬆	✓		
Exercise opportunities	2013 & 10	0.7	⬆	✓		
Sedentary Adults	2013	36.2	⬆	✓		
Fruits and Vegetables Consumption 5 servings per day (Adult)	2013	15.1	⬇	✓		
Food Insecurity	2013	15.3	⬆	✓		
Grocery Store Access	2013	7.1	⬆	✓		
Food Access Low - Low Income Population	2010	0.1	⬆	✓		
Fast Food Restaurant Access	2013	6.6	⬇	✓		
SNAP Participants	2011	10.2%	⬆	✓		

Health Behavior - Sexual Activity

		Walton County		Related Priorities		
Indicator	**Latest Data Period**	**Performance**	**Trend**	**Healthy Weight**	**Access to Care**	**Mental Health / Substance Abuse**
Infectious Syphilis	2012-14	1.7	⬇			
Sexually transmitted infections	2012-14	297.1	⬇			
Births to Mothers under the age of Majority (10-14)	2012-14	0.4	●			✓
Births to Mothers under the age of Majority (10-16)	2012-14	1.4	⬇			✓

Clinical Care – Access to Health Care						
		Walton County		Related Priorities		
Indicator	Latest Data Period	Performance	Trend	Healthy Weight	Access to Care	Mental Health / Substance Abuse
Uninsured Adults	2013	24.4	↑		✓	
Uninsured Children	2013	13.8	↑		✓	
Adults who could not see a doctor at least once in the past year due to cost	2013	17.7	↓		✓	
Population Receiving Medicaid	2013	13,140	↑		✓	
Medicaid births	2012-14	53.4	↓		✓	
Dental Care Access by Low Income Persons	2010-12	18.0	↑		✓	
Primary Care Access	2012	48.6	↑		✓	
Mental health providers	2014	1,495:1	↑		✓	
Physicians	FY 11/12 - FY 13/14	145.5	↑		✓	
Family Practice Physicians	FY 11/12 - FY 13/14	18.2	↑		✓	
Internists	FY 11/12 - FY 13/14	10.6	↑		✓	
Pediatricians	FY 11/12 - FY 13/14	7.0	↑		✓	
OB/GYN	FY 11/12 - FY 13/14	5.9	↓		✓	
Dentists	FY 11/12 - FY 13/14	39.9	↑		✓	
Acute Care Beds	2012-14	186.1	↓		✓	
Adult psychiatric beds	2012-14	0.0	●		✓	✓
Adult substance abuse beds	2012-14	0.0	●		✓	✓
Pediatric psychiatric beds	2012-14	0.0	●		✓	✓
Rehabilitation beds	2012-14	0.0	●		✓	
Nursing Home Beds	2012-14	477.3	↓		✓	

Clinical Care – Quality of Care						
		Walton County		Related Priorities		
Indicator	Latest Data Period	Performance	Trend	Healthy Weight	Access to Care	Mental Health / Substance Abuse
Lack of Prenatal Care	2012-14	0.7	●		✓	
Prenatal Care Begun Late or No Prenatal Care	2012-14	5.2	↑		✓	
Prenatal Care Begun in First Trimester	2012-14	80.8	↓		✓	

Adults who have a personal doctor	2013	78.4	⬇		✓	
Cancer Screening - Mammogram	2013	50.7	⬇		✓	
Cancer Screening in past two years - PSA (Men age 50 & older)	2010	71.1	⬆		✓	
Cancer Screening - Sigmoidoscopy or Colonoscopy	2013	56.2	⬇		✓	
Cancer Screening - Pap Test	2013	47.4	⬇		✓	
Diabetic Annual Foot Exam (Adults)	2013	62.4	⬆	✓	✓	
Diabetic Semi-Annual A1C Testing (Adult)	2013	74.8	⬆	✓	✓	
HIV Testing (Adult age 65 & over)	2013	36.0	⬇		✓	
Flu Vaccination in the Past Year (Adult age 65 and over)	2013	49.7	⬇		✓	
Flu Vaccination in the Past Year (Adult)	2013	24.7	⬇		✓	
Pneumonia Vaccination (Adult age 65 and over)	2013	67.4	⬇		✓	
Pneumonia Vaccination (Adult)	2013	30.3	⬇		✓	
Vaccination (kindergarteners)	2012-14	96.2	⬆		✓	
ED Visits - Acute Conditions - Hypoglycemia	2014	0.2	⬇	✓	✓	
ED Visits - Avoidable Conditions - Dental	2014	22.0	⬆		✓	
ED Visits - Chronic Conditions - Angina	2014	0.7	⬇		✓	
ED Visits - Chronic Conditions - Asthma	2014	9.3	⬇		✓	
ED Visits - Chronic Conditions - Congestive Heart Failure	2014	2.0	⬆	✓	✓	
ED Visits - Chronic Conditions - Diabetes	2014	5.3	⬇	✓	✓	
ED Visits - Chronic Conditions - Mental Health	2014	22.3	⬆		✓	✓
ED Visits - Chronic Conditions - Hypertension	2014	9.3	⬆	✓	✓	
ED Visits - STDs	2014	0.2	⬆		✓	
Preventable hospital stays	2011-13	951	⬇		✓	
Admitted ED Visits - All Ambulatory Care Sensitive Conditions	2012-14	186.1	⬇		✓	
Admitted ED Visits - Dental	2014	153.1	⬆		✓	
Admitted ED Visits - Diabetes	2014	0.5	⬆		✓	
Admitted ED Visits - STDs	2014	34.7	⬆		✓	

Social and Economic Factors						
		Walton County		Related Priorities		
Indicator	Latest Data Period	Performance	Trend	Healthy Weight	Access to Care	Mental Health / Substance Abuse
High school graduation	2013	68.4%	↓			
Population 18 - 25 without a high school diploma	2013	23.9%	↓			
Unemployment	2015 AUG	4.6	↓		✓	
Real Per Capita Income	2013	37,976	↓			
Median Household Income	2013	43,640	↓			
Poverty	2013	33.4%	↓		✓	
Children in poverty (based on household)	2013	28.5%	↓		✓	
Children Eligible for Free/Reduced Price Lunch	2013-14	53.1%	↑			
Income - Public Assistance Income	2013	32.9%	↑		✓	
Housing Cost Burden	2009-13	36.76	↑			
Children in single-parent households	2013	33.3%	↑			
Population with Limited English Proficiency	2013	0.9%	↓		✓	
Domestic Violence Offenses	2014	756.2	↓			✓
Forcible Sex Offenses	2014	72.6	↑			✓
Aggravated Assault	2014	307	↑			✓
Murder	2014	0.0	↓			✓
Property Crimes	2014	2,530	↓			✓
Violent Crime	2014	396.7	↑			✓

Physical Environment						
		Walton County		Related Priorities		
Indicator	Latest Data Period	Performance	Trend	Healthy Weight	Access to Care	Mental Health / Substance Abuse
Air pollution - particulate matter	2008	0.2	↑			
Air Quality - Ozone	2008	0.00	●			
Drinking water violations	FY 2013-14	27.00	↑			
Severe housing problems	2008-12	22.6%	↑			
Households with No Motor Vehicle	2013	5.5%	↓	✓	✓	
Driving alone to work	2013	82.5%	↑	✓		
Use of Public Transportation	2013	9.6%	↑	✓	✓	

Population Characteristics			
		Walton County	
Indicator	Latest Data Period	Performance	Trend
Median Age	2014	43.5	⬆
Population Under Age 0-17	2014	12,289	⬆
Population Age 18-24	2014	4,610	⬆
Population Age 25-34	2014	7,385	⬆
Population Age 35-44	2014	7,476	⬆
Population Age 45-54	2014	8,581	⬇
Population Age 55-64	2014	8,776	⬆
Population Age 65+	2014	10,129	⬆
Total Population (ACS)	2013	56,590	⬆
Total Population (FL CHARTS)	2014	59,246	⬆
Female Population	2014	11,631	⬇
Female Population Age 10-14	2014	1,710	⬆
Female Population Age 15-19	2014	1,426	⬇
Female Population Age 20-44	2014	8,416	⬆
Male Population	2014	30,197	⬆
Male Population Age 50+	2014	11,346	⬆
Families with Children	2013	26.6%	⬆
Births to Mothers Ages 15-19	2012-14	39.6	⬆
Births to Mothers Ages 15-44	2012-14	34.1	⬆
Total Births (resident)	2014	725	⬇
Population by Race - White	2013	59,055	⬆
Population by Race - Black	2013	3,033	⬇
Population by Race - Native American	2013	534	⬆
Population by Race - Asian/Pacific Islander	2013	710	⬆
Population by Race - 2 or more races	2013	1,365	⬆
Population by Race - Other	2013	1,893	⬆
Veteran Population	2013	14.7%	⬇

Health Outcome - Mortality (Deaths)

Premature Death - Years of Potential Life Lost (YPLL) - Years of potential life lost (YPLL) before age 75 per 100,000 population (age-adjusted) The YPLL measure is presented as a rate per 100,000 population and is age-adjusted to the 2000 US population. Weblink: http://www.countyhealthrankings.org/app/florida/2015/downloads

Data collection period:	3-year rolling
Source Data type:	Rate
Smallest geographic level:	County
Desired Target Direction:	Low/Decrease

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

Source: CHR *County Health Rankings.* Original Data Source: National Center for Health Statistics - Mortality Files.

Cancer Deaths - ICD-10 Code(s): C00-C97. Weblink: http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0097

Breast Cancer Deaths - ICD-10 Code(s): C50. Weblink: http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0084

Prostate Cancer Deaths - ICD-10 Code(s): C61. Weblink: http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0093

Lung Cancer Deaths - ICD-10 Code(s): C33-C34. Weblink: http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0092

Deaths from Smoking-related Cancers - Cancers include: Lip, Oral Cavity, Pharynx (C00-C14), Esophagus (C15), Larynx (C32), Trachea, Bronchus, Lung (C33-C34), Kidney & Renal Pelvis (C64-C65), Bladder (C67), Other/Unspecified Sites In Urinary Tract (C66, C68). Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndDataViewer.aspx?cid=0268

Colon, Rectal or Anus Cancer Deaths - Colorectal Cancer Deaths. Weblink: http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0089

Diabetes Deaths - ICD-10 Code(s): E10-E14. Weblink: http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0090

Heart Disease Deaths - ICD-10 Code(s): I00-I09, I11, I13, I20-I51. Weblink: http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0098

Stroke Deaths - ICD-10 Code(s): I60-I69. Weblink: http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0086

Infant Mortality - Deaths occurring within 364 days of birth. Weblink: http://www.floridacharts.com/charts/DataViewer/InfantDeathViewer/InfantDeathViewer.aspx?indNumber=0053

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

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

Chronic Liver Disease, Cirrhosis Deaths - Deaths from Chronic Liver Disease and Cirrhosis Deaths. Weblink: http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0091

Nephritis, Nephritic Syndrome, and Nephrosis Deaths - Nephritis Deaths. ICD-10 Code(s): N17-N19. Weblink: http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0391

Chronic Lower Respiratory Disease Deaths - ICD-10 Code(s): J40-J47. Weblink: http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0088

Pneumonia, Influenza Deaths - CD-10 Code(s): J09-J18. Weblink: http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0125

HIV/AIDS Deaths - ICD-10 Code(s): B20-B24. Weblink: http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0122

Suicide Deaths - Suicide (All Means) Deaths. Weblink: http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0116

Motor Vehicle Accident Deaths - Motor Vehicle Crashes Deaths. Weblink: http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0110

Injury Deaths - Unintentional Injuries Deaths. Weblink: http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0109

Homicide - Homicide (All Means) Deaths. Weblink: http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0118

Data collection period: 3-year rolling
Source Data type: Rate
Smallest geographic level: County
Desired Target Direction: Low/Decrease

Note: Counts Available
Source: FL DOH, Division of Public Health Statistics & Performance Management. *Florida Charts.* Original Data Source: FL DOH, Bureau of Vital Statistics

Health Outcome - Morbidity (Quality of Life)

Total Cancer Incidence - Cancer Incidence. Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndDataViewer.aspx?cid=0460

Breast Cancer Incidence - ICD-10 Code(s): C50. Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndDataViewer.aspx?cid=0448

Prostate Cancer Incidence - ICD-10 Code(s): C61. Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndDataViewer.aspx?cid=0450

Lung Cancer Incidence - ICD-10 Code(s): C33-C34. Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndDataViewer.aspx?cid=0446

Colon and Rectum Cancer Incidence - Colorectal Cancer Incidences. Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndDataViewer.aspx?cid=0445

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

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

Data collection period:	3-year rolling
Source Data type:	Rate
Smallest geographic level:	County
Desired Target Direction:	Low/Decrease

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

Source: FL DOH, Division of Public Health Statistics & Performance Management. *Florida Charts.* Original Data Source: UM(FL) MS, Florida Cancer Data System

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

Data collection period:	Annual
Source Data type:	%
Smallest geographic level:	County
Desired Target Direction:	High/Increase

Source: County Health Rankings and Roadmaps *Dartmouth Atlas Project.* Original Data Source: Dartmouth Atlas of Health Care; CMS.

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

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

High Cholesterol (Adult) - Adults who have ever been told they had high blood cholesterol. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=19

High Blood Pressure Controlled (Adult) - Adults with hypertension who currently take high blood pressure medicine. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=72

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

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

Data collection period:	Triennial
Source Data type:	%
Smallest geographic level:	County
Desired Target Direction:	Low/Decrease

Note: Caution should be taken when comparing 2013 data with previous years due to changes in survey methodology to include respondents via cellular phones in addition to land lines.

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

Low birth weight - Live Births under 2,500 Grams. Weblink: http://www.floridacharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=0021

Data collection period:	3-year rolling
Source Data type:	Rate
Smallest geographic level:	County
Desired Target Direction:	Low/Decrease

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

Disability (Any) - Disability Status. Weblink: http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t. Table name - s1810.

Data collection period:	Annual
Source Data type:	%
Smallest geographic level:	County
Desired Target Direction:	Neutral

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

Hepatitis C, Acute - ICD Code(s): 07051. Cases are assigned to Florida counties based on the county of residence at the time of the disease identification, regardless of where they became ill or were hospitalized, diagnosed, or exposed. Counts and rates include confirmed and probable cases of Hepatitis C, Acute (Merlin code 07051). Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=8651

Data collection period:	3-year rolling
Source Data type:	Rate
Smallest geographic level:	County
Desired Target Direction:	Low/Decrease

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

HIV - Human immunodeficiency virus. HIV and AIDS cases by year of report are NOT mutually exclusive and should NOT be added together Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalHIVAIDSViewer.aspx?cid=0471

AIDS - Acquired immunodeficiency syndrome. HIV and AIDS cases by year of report are NOT mutually exclusive and should NOT be added together. Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalHIVAIDSViewer.aspx?cid=0141

Data collection period:	Annual
Source Data type:	Rate per Population
Smallest geographic level:	County
Desired Target Direction:	Low/Decrease

Source: FL DOH, Division of Public Health Statistics & Performance Management. *Florida Charts.* Original Data Source: FL DOH, Bureau of HIV/AIDS.

Salmonellosis - ICD-9-CM: 003.00. Counts and rates include confirmed and probable cases of Salmonellosis (Merlin code 00300). Weblink: http://www.floridacharts.com/charts/CommunicableDiseases/default.aspx

Meningitis, Other Bacterial, Cryptococcal, or Mycotic - Includes the following types of Meningitis: group b strep, listeria monocytogenes, other meningitis, strep pneumoniae. beginning in 2007, data includes both probable and confirmed cases. Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0160

Tuberculosis - Tuberculosis ICD-10 Case Definitions. Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0148

Chicken Pox - Varicella. ICD-10 Case Definition. Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=8633

Whooping Cough - Pertussis. ICD-9-CM: 033.90. Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0156

Vaccine (selected) Preventable Disease for All Ages - Includes: diphtheria, acute hepatitis b, measles, mumps, pertussis, rubella, tetanus, and polio. Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0194

Data collection period:	Annual
Source Data type:	Rate
Smallest geographic level:	County
Desired Target Direction:	Low/Decrease

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

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

Average number of days where poor mental or physical health interfered with activities of daily living in the past 30 days - Among adults who responded that they have had at least one day of poor mental or physical health, the average number of days where poor mental or physical health interfered with activities of daily living in the past 30 days. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=70

Data collection period:	Triennial
Source Data type:	Count (average)
Smallest geographic level:	County
Desired Target Direction:	Low/Decrease

Note: Caution should be taken when comparing 2013 data with previous years due to changes in survey methodology to include respondents via cellular phones in addition to land lines.

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

Adults with good to excellent overall health - Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=60

Data collection period:	Triennial
Source Data type:	Rate
Smallest geographic level:	County
Desired Target Direction:	High/Increase

Note: Caution should be taken when comparing 2013 data with previous years due to changes in survey methodology to include respondents via cellular phones in addition to land lines.

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

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

Data collection period: Annual
Source Data type: Rate
Smallest geographic level: County
Desired Target Direction: Low/Decrease

Note: Caution should be taken when comparing 2013 data with previous years due to changes in survey methodology to include respondents via cellular phones in addition to land lines.

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

Health Behavior - Tobacco Use

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

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

Never Smoked (Adult) - Adults who reported smoking less than 100 cigarettes in their lifetime. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=86

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

Data collection period: Triennial
Source Data type: Rate
Smallest geographic level: County
Desired Target Direction: High/Increase

Note: Caution should be taken when comparing 2013 data with previous years due to changes in survey methodology to include respondents via cellular phones in addition to land lines.

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

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

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

Data collection period: Biennial
Source Data type: Rate
Smallest geographic level: County
Desired Target Direction: Low/Decrease

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

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

Data collection period:	3-year rolling
Source Data type:	Rate
Smallest geographic level:	County
Desired Target Direction:	Low/Decrease

Note: Race/ethnicity data also available

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

Health Behavior - Alcohol / Substance Use

Alcohol-related Motor Vehicle Traffic Crash Deaths - A crash involving a driver and/or pedestrian for whom alcohol use was reported (does not presume intoxication) that results in one or more fatalities within thirty days of occurrence. Any crash involving a driver or non-motorist for whom alcohol use was suspected, including those with a BAC greater than 0.00 and those refusing to submit to an alcohol test. Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0303

Alcohol-related Motor Vehicle Traffic Crashes - A crash involving a driver and/or pedestrian for whom alcohol use was reported (does not presume intoxication). Any crash involving a driver or non-motorist for whom alcohol use was suspected, including those with a BAC greater than 0.00 and those refusing to submit to an alcohol test. Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0302

Data collection period:	3-year rolling
Source Data type:	rate
Smallest geographic level:	County
Desired Target Direction:	Low/Decrease

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

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

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

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

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

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

Binge Drinking (Adolescents) - Aaes 10-17 who reported having used alcohol in the past 30 days. Binge drinking is defined as having had five or more alcoholic drinks in a row in the past two weeks. Weblink: http://www.myflfamilies.com/service-programs/substance-abuse/fysas

Data collection period: Biennial
Source Data type: Rate
Smallest geographic level: County
Desired Target Direction: Low/Decrease

Note: 30-day rates tend to be more indicative of regular or more frequent use. Lifetime usage captures experimentation as well as ongoing use.

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

Health Behavior - Diet and Exercise

Healthy Weight (Adult) - Having a body mass index (BMI) ranging from 18.5 to 24.9; BMI is calculated using self-reported height and weight. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=80

Data collection period: Triennial
Source Data type: %
Smallest geographic level: County
Desired Target Direction: High/Increase

Note: Caution should be taken when comparing 2013 data with previous years due to changes in survey methodology to include respondents via cellular phones in addition to land lines.

Source: FL DOH, Division of Public Health Statistics & Performance Management. *Florida Charts - Healthiest Weight Profile.* Original Data Source: Florida BRFSS

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

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

Data collection period: Triennial
Source Data type: %
Smallest geographic level: County
Desired Target Direction: Low/Decrease

Note: Caution should be taken when comparing 2013 data with previous years due to changes in survey methodology to include respondents via cellular phones in addition to land lines.

Source: FL DOH, Division of Public Health Statistics & Performance Management. *Florida Charts - Healthiest Weight Profile.* Original Data Source: Florida BRFSS

Births to Obese Mothers - Births to obese mothers (BMI 30.0 or higher) at the time pregnancy occurred. Weblink: http://www.floridacharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=0606

Births to overweight mothers - Births to overweight (BMI 25.0 to 29.9) mothers at the time pregnancy occurred. Weblink: http://www.floridacharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=0607

Data collection period:	3-year rolling
Source Data type:	Rate
Smallest geographic level:	County
Desired Target Direction:	Low/Decrease

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

Breast feeding Initiation - Infant was being breastfed at the time the birth certificate was completed. Weblink: http://www.floridacharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=637

Data collection period:	Annual
Source Data type:	%
Smallest geographic level:	County
Desired Target Direction:	High/Increase

Source: FL DOH, Division of Public Health Statistics & Performance Management. *Florida Charts - Pregnancy and Young Child Profile.* Original Data Source: FL DOH, Bureau of Vital Statistics.

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

Obesity (Adolescents) - Middle and High School Students. Body Mass Index (BMI) 30.0 or higher. Weblink: http://www.floridacharts.com/charts/SpecReport.aspx?RepID=1235&tn=31.

Healthy Weight (Adolescents) - Middle and High School Students. Having a body mass index (BMI) ranging from 18.5 to 24.9. Weblink: http://www.floridacharts.com/charts/SpecReport.aspx?RepID=1235&tn=31.

Data collection period:	Biennial
Source Data type:	%
Smallest geographic level:	County
Desired Target Direction:	High/Increase

Source: FL DOH, Division of Public Health Statistics & Performance Management. *Florida Charts - Healthiest Weight Profile.* Original Data Source: FYTS.

Vigorous physical activity recommendations met (Adult) - 75 minutes of vigorous aerobic activity per week in the past 30 days. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=4

Data collection period:	Triennial
Source Data type:	Rate
Smallest geographic level:	County
Desired Target Direction:	High/Increase

Note: Caution should be taken when comparing 2013 data with previous years due to changes in survey methodology to include respondents via cellular phones in addition to land lines.

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

Exercise opportunities - Percentage of population with adequate access to locations for physical activity. Locations for physical activity (parks or recreation facilities); Urban pop. resides within 1 mile and rural resides within 3 miles of recreational facility. Weblink: http://www.countyhealthrankings.org/app/florida/2015/overview

Data collection period: Annual
Source Data type: %
Smallest geographic level: County
Desired Target Direction: High/Increase

Source: CHR *County Health Rankings.* Original Data Source: Business Analyst, Delorme map data, ESRI, & US Census Tigerline files.

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

Data collection period: 5-year
Source Data type: Rate
Smallest geographic level: County
Desired Target Direction: Low/Decrease

Note: Caution should be taken when comparing 2013 data with previous years due to changes in survey methodology to include respondents via cellular phones in addition to land lines.

Source: FL DOH, Division of Public Health Statistics & Performance Management. *Florida Charts - Healthiest Weight Profile.* Original Data Source: Florida BRFSS

Fruits and Vegetables Consumption 5 servings per day (Adult) – Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=7

Data collection period: 5-year
Source Data type: %
Smallest geographic level: County
Desired Target Direction: High/Increase

Note: Caution should be taken when comparing 2013 data with previous years due to changes in survey methodology to include respondents via cellular phones in addition to land lines.

Source: FL DOH, Division of Public Health Statistics & Performance Management. *Florida Charts - Healthiest Weight Profile.* Original Data Source: Florida BRFSS

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

Data collection period: Annual
Source Data type: Rate
Smallest geographic level: County
Desired Target Direction: Low/Decrease

Source: Feeding America *Map the Meal Gap 2015: Food Insecurity and Child Food Insecurity Estimates at the County Level.* Original Data Source: US Census.

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

Data collection period: Annual
Source Data type: Rate
Smallest geographic level: County
Desired Target Direction: High/Increase

Source: FL DOH, Division of Public Health Statistics & Performance Management. *Florida Charts.* Original Data Source: Florida Department of Agriculture and Consumer Services, U.S. Census Bureau, FDOH, Environmental Public Health Tracking.

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

Data collection period: Annual
Source Data type: %
Smallest geographic level: County
Desired Target Direction: Low/Decrease

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

Fast Food Restaurant Access - Population that live within a 1/2 mile of a fast food restaurant. Weblink: http://www.floridacharts.com/charts/HealthiestWeightProfile.aspx?county=17&profileyear=2013&tn=31

Data collection period:
Source Data type: Rate
Smallest geographic level: County
Desired Target Direction: Low/Decrease

Source: FL DOH, Division of Public Health Statistics & Performance Management. *Florida Charts - Healthiest Weight Profile.* Original Data Source: Florida Department of Agriculture and Consumer Services, U.S. Census Bureau, FDOH, Environmental Public Health Tracking.

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

Data collection period: Annual
Source Data type: Rate per Population
Smallest geographic level: County
Desired Target Direction: Low/Decrease

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

Health Behavior - Sexual Activity

Infectious Syphilis - Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0144

Data collection period: 3-year rolling
Source Data type: Rate per Population
Smallest geographic level: County
Desired Target Direction: Low/Decrease

Source: FL DOH, Division of Public Health Statistics & Performance Management. *Florida Charts.* Original Data Source: FL DOH, Bureau of STD Prevention & Control.

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

Data collection period: Annual
Source Data type: Rate
Smallest geographic level: County
Desired Target Direction: Low/Decrease

Source: FL DOH, Division of Public Health Statistics & Performance Management. *Florida Charts.* Original Data Source: FL DOH, Bureau of STD Prevention & Control.

Births to Mothers under age of majority (Resident) - Live Births. Does not include pregnancies that end with miscarriages, elective and spontaneous abortions or fetal deaths. Births to mothers in a specific age group divided by females in the same age group. Weblink: http://www.floridacharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=0001.

Data collection period: 3-year rolling
Source Data type: Rate
Desired Target Direction: Low/Decrease

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

Clinical Care – Access to Health Care

Uninsured Adults - Percent Uninsured (ages < 65). Weblink: http://www.census.gov/did/www/sahie/data/interactive/cedr/sahie.html

Uninsured Children - Percent Uninsured (ages < 19). Weblink: http://www.census.gov/did/www/sahie/data/interactive/cedr/sahie.html

Data collection period: Annual
Source Data type: %
Smallest geographic level: County
Desired Target Direction: Low/Decrease

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

Percentage of adults who could not see a doctor at least once in the past year due to cost – Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=13

Data collection period: Triennial
Source Data type: %
Smallest geographic level: County
Desired Target Direction: High/Increase

Note: Caution should be taken when comparing 2013 data with previous years due to changes in survey methodology to include respondents via cellular phones in addition to land lines.

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

Population Receiving Medicaid - Medicaid Program Enrollment Totals (Including Medikids population). Weblink: http://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml

Data collection period: Monthly
Source Data type: Rate
Smallest geographic level: County
Desired Target Direction: Low/Decrease

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

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

Medicaid births - Births covered by Medicaid. Weblink: http://www.floridacharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=0595

Data collection period: 3-year rolling
Source Data type: Rate
Smallest geographic level: County
Desired Target Direction: Low/Decrease

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

Dental Care Access by Low Income Persons - Access to Dental Care by Low Income Persons, Single Year. Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0266

Data collection period: Annual
Source Data type: Rate
Smallest geographic level: County
Desired Target Direction: High/Increase

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

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

Data collection period: Annual
Source Data type: Rate
Smallest geographic level: County
Desired Target Direction: High/Increase

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

Mental health providers - Mental Health Providers is the ratio of the county population to the number of mental health providers including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists and advanced practice nurses specializing in mental health care. In 2015, marriage and family therapists and mental health providers that treat alcohol and other drug abuse were added to this measure. Weblink: http://www.countyhealthrankings.org/app/florida/2015/measure/factors/62/datasource.

Data collection period:	Annual
Source Data type:	Ratio
Smallest geographic level:	County
Desired Target Direction:	High/Increase

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

Physicians - Per population rate of people with active physician licenses only. Licensure data is for a fiscal year (July 1-June 30). Weblink: http://www.floridacharts.com/charts/LoadPage.aspx?l=~/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0327

Family Practice Physicians - Per population rate of people with active physician licenses in Florida who report family practice as their specialty. Licensure data is for a fiscal year (July 1-June 30). Weblink: http://www.floridacharts.com/charts/LoadPage.aspx?l=~/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0328

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

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

OB/GYN (per population) - Per population rate of people with active physician licenses in Florida who report OB/GYN as their specialty. Licensure data is for a fiscal year (July 1-June 30). Weblink: http://www.floridacharts.com/charts/LoadPage.aspx?l=~/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0330

Dentists - Per population rate of people with active licenses to practice dentistry in Florida. Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0326

Data collection period:	3-year rolling
Source Data type:	Rate
Smallest geographic level:	County
Desired Target Direction:	High/Increase

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

Source: FL DOH, Division of Public Health Statistics & Performance Management. *Florida Charts.* Original Data Source: FL DOH, Division of Medical Quality Assurance.

Acute Care Beds - Acute care is necessary treatment of a disease for only a short period of time in which a patient is treated for a brief but severe episode of illness. The term is generally associated with care rendered in an emergency department, ambulatory care clinic, or other short-term stay facility. Weblink:
http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0314

Data collection period:	3-year rolling
Source Data type:	Rate
Smallest geographic level:	County
Desired Target Direction:	High/Increase

Source: FL DOH, Division of Public Health Statistics & Performance Management. *Florida Charts.*
Original Data Source: FL AHCA (AHCA), Certificate of Need Office.

Adult psychiatric beds - The number of beds indicates the number of people who may receive adult psychiatric care on an inpatient basis. Weblink:
http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0318.

Adult substance abuse beds - The number of beds indicates the number of people who may receive adult substance abuse treatment on an in-patient basis. Weblink:
http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0321

Pediatric psychiatric beds - Child and Adolescent Psychiatric Beds. Weblink:
http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0319

Rehabilitation beds - The number of rehabilitation beds indicates the number of people who may receive rehabilitative care in the hospital on an in-patient basis. Weblink:
http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0324

Nursing Home Beds - Skilled Nursing Unit Beds. A nursing home, skilled nursing facility (SNF), or skilled nursing unit (SNU), also known as a rest home, is a type of care of residents: it is a place of residence for people who require constant nursing care and have significant deficiencies with activities of daily living. Residents include the elderly and younger adults with physical or mental disabilities. Adults 18 or older can stay in a skilled nursing facility to receive physical, occupational, and other rehabilitative therapies following an accident or illness. Weblink:
http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0325

Data collection period:	3 year rolling
Source Data type:	Rate per 100,000
Smallest geographic level:	County
Desired Target Direction:	High/Increase

Source: FL DOH, Division of Public Health Statistics & Performance Management. *Florida Charts.*
Original Data Source: FL AHCA (AHCA), Certificate of Need Office.

Clinical Care – Quality of Care

Lack of Prenatal Care - Births to mothers with no prenatal care. Trimester prenatal care began is calculated as the time elapsed from the date of the last menstrual period to the date of the first prenatal care visit. Weblink:
http://www.floridacharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=16

Prenatal Care Begun Late or No Prenatal Care - Births to Mothers with 3rd Trimester or No Prenatal Care. Weblink:
http://www.floridacharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=17

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

Data collection period:	3-year rolling
Source Data type:	Rate
Smallest geographic level:	County
Desired Target Direction:	Low/Decrease

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

Adults who have a personal doctor - Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=12

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

Cancer Screening in past two years - PSA (Men age 50 & older) - Men 50 years of age and older who received a PSA test in the past two years. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=39

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

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

Diabetic Annual Foot Exam (Adults) - Adults with diabetes who had an annual foot exam. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=49

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

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

Flu Vaccination in the Past Year (Adult age 65 and over) - Adults 65 years of age and older who received a flu shot in the past year. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=75

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

Pneumonia Vaccination (Adult age 65 and over) - Adults 65 years of age and older who have ever received a pneumococcal vaccination. Weblink: http://www.floridacharts.com/charts/Brfss/DataViewer.aspx?bid=88

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

Data collection period:	Triennial
Source Data type:	%
Smallest geographic level:	County
Desired Target Direction:	High/Increase

Note: Caution should be taken when comparing 2013 data with previous years due to changes in survey methodology to include respondents via cellular phones in addition to land lines.

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

Vaccination (kindergarteners) - Fully immunized against diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, haemophilus, influenzae type b, hepatitis B and varicella (chicken pox). Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0075

Data collection period:	3-year rolling
Source Data type:	Rate
Smallest geographic level:	County
Desired Target Direction:	High/Increase

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

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

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

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

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

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

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

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

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

Data collection period:	Quarterly
Source Data type:	Rate/1000 Visits
Smallest geographic level:	Zip
Desired Target Direction:	Low/Decrease

Note: Ambulatory Care Sensitive Conditions: http://www.floridacharts.com/charts/documents/ACS_Conditions_Definition_UPDATE.pdf

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

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Preventable hospital stays - Ambulatory Care Sensitive conditions such as asthma, diabetes or dehydration are hospitalization conditions where timely and effective ambulatory care can decrease hospitalizations by preventing the onset of an illness or condition, controlling an acute episode of an illness or managing a chronic disease or condition. High rates of Ambulatory Care Sensitive hospitalizations in a community may be an indicator of a lack of or failure of prevention efforts, a primary care resource shortage, poor performance of primary health care delivery systems, or other factors that create barriers to obtaining timely and effective care. Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=8598.

Data collection period:	3-year rolling
Source Data type:	Rate
Smallest geographic level:	County
Desired Target Direction:	Low/Decrease

Source: FL DOH, Division of Public Health Statistics & Performance Management. *Florida Charts.* Original Data Source: FL AHCA (AHCA).

Social and Economic Factors - Education

High school graduation - Percentage of students who graduated within four years of their initial enrollment in ninth grade, not counting deceased students or students who transferred out to attend another public school outside the system, a private school, a home education program. Incoming transfer students are included in the appropriate cohort (the group whose progress is tracked) based on their grade level and year of entry. Data are for school years (September-June). Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndRateOnlyDataViewer.aspx?cid=0552

Data collection period: Annual
Source Data type: %
Smallest geographic level: County
Desired Target Direction: High/Increase

Source: FL DOH, Division of Public Health Statistics & Performance Management. *Florida Charts.* Original Data Source: Florida Department of Education, Education Information and Accountability Services (EIAS).

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

Data collection period: Annual
Source Data type: %
Smallest geographic level: County
Desired Target Direction: Low/Decrease

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

Social and Economic Factors - Employment

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

Data collection period: Annual
Source Data type: %
Desired Target Direction: Low/Decrease

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

Social and Economic Factors - Income

Real Per Capita Income - Real per capita income represents the total GDP of the county, adjusted for inflation and divided by the population. Weblink: http://www.bea.gov/iTable/iTable.cfm?reqid=70&step=1&isuri=1&acrdn=5#reqid=70&step=30&isuri=1&7022=20&7023=7&7024=non-ndustry&7033=1&7025=4&7026=12005,12033,12037,12043,12113,12131&7027=2013&7001=720&7028=-1&7031=12000&7040=-1&7083=levels&7029=20&7090=7.

Data collection period: Annual
Source Data type: $
Desired Target Direction: High/Increase

Source: US DoC, Bureau of Economic Analysis.

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

Data collection period: Annual
Source Data type: $
Desired Target Direction: High/Increase

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

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

Data collection period: 5-year estimate
Source Data type: %
Desired Target Direction: Low/Decrease

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

Children in poverty (based on household) - Number individuals below poverty under the age of 18 divided by the number of individuals under the age of 18, expressed as a percentage. Weblink: http://www.floridacharts.com/charts/OtherIndicators/NonVitalIndRateOnlyDataViewer.aspx?cid=0295

Data collection period: Annual
Source Data type: %
Desired Target Direction: Low/Decrease

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

Children Eligible for Free/Reduced Price Lunch - Children from families with incomes at or below 130 percent of the poverty level are eligible for free meals. Those with incomes between 130 percent and 185 percent of the poverty level are eligible for reduced-price meals, for which students can be charge no more than 40 cents. Weblink: http://assessment.communitycommons.org/CHNA/report?page=2&id=209

Data collection period: Annual
Source Data type: %
Desired Target Direction: Low/Decrease

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

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

Data collection period: Annual
Source Data type: % calculated from ACS population estimates
Desired Target Direction: Low/Decrease

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

Housing Cost Burden (30%) - Percentage of the households where housing costs exceed 30% of total household income. Weblink: http://assessment.communitycommons.org/CHNA/report?page=2&id=240

Data collection period: 5-year estimate
Source Data type: %
Desired Target Direction: Low/Decrease

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

Social and Economic Factors - Family and Social Support

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

Data collection period: Annual
Source Data type: %
Desired Target Direction: Low/Decrease

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

Population with Limited English Proficiency - No one age 14 and over speaks English only or speaks English "very well" No one age 14 and over speaks English only. Weblink: http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t. Table name - S1602.

Data collection period: Annual
Source Data type: %
Desired Target Direction: Neutral

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

Social and Economic Factors - Community Safety

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

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

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

aggravated assault and larceny-theft occur together, the offense falls under the category of robbery.

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

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

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

Weblink:	https://www.fdle.state.fl.us/Content/FSAC/Menu/Data---Statistics-(1)/UCR-Offense-Data.aspx
Data collection period:	Annual
Source Data type:	Rate per 100,000
Smallest geographic level:	County
Desired Target Direction:	Low/Decrease

Source: FDLE *FDLE. Crime in Florida, Florida uniform crime report, 2014 [Computer program]. Tallahassee, FL: FDLE. Florida Statistical Analysis Center.* Original Data Source: FDLE. Crime in Florida, Uniform Crime Reports

Physical Environment - Environmental Quality

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

Data collection period:	Annual
Source Data type:	%
Smallest geographic level:	County
Desired Target Direction:	Low/Decrease

Source: *EPA (EPA) National Environmental Public Health Tracking Network (NEPHTN) Air Quality Data web page.* Original Data Source: CDC, National Environmental Public Health Tracking Network.

Air Quality - Ozone - Percentage of days with particulate matter 2.5 levels above the National Ambient Air Quality Standard (35 micrograms per cubic meter) per year, calculated using data collected by monitoring stations and modeled to include counties where no monitoring statistics are collected. Weblink: http://assessment.communitycommons.org/CHNA/report?page=3&id=410

Data collection period: Annual
Source Data type: %
Smallest geographic level: County
Desired Target Direction: Low/Decrease

Source: *EPA (EPA) National Environmental Public Health Tracking Network (NEPHTN) Air Quality Data web page.* Original Data Source: CDC, National Environmental Public Health Tracking Network.

Drinking water violations - Percentage of population potentially exposed to water exceeding a violation limit during the past year. Weblink: http://www.countyhealthrankings.org/app/florida/2015/measure/factors/124/data

Data collection period: Annual
Source Data type: %
Smallest geographic level: County
Desired Target Direction: Low/Decrease

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

Physical Environment - Built Environment

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

Data collection period: 4-year
Source Data type: %
Smallest geographic level: County
Desired Target Direction: Low/Decrease

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

Households with No Motor Vehicle - Weblink: http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_13_5YR_B08201&prodType=table. Table name - B08201: Household size by vehicles available

Data collection period: Annual
Source Data type: %
Smallest geographic level: County
Desired Target Direction: High/Increase

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

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

Data collection period: 5-year estimate
Source Data type: % calculated on ACS population estimate
Smallest geographic level: County
Desired Target Direction: Low/Decrease

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

Use of Public Transportation - "Public transportation" includes workers who used a bus, trolley, streetcar, subway or elevated rail, railroad, or ferryboat. Weblink: http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t. Table name - s0802.

Data collection period: Annual
Source Data type: %
Smallest geographic level: County
Desired Target Direction: High/Increase

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

Population Characteristics

Median Age - Weblink: http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2014_PEPAGESEX&prodType=table. Table name - PEPAGESEX.
Data collection period: Annual

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

Total Population (ACS) - Weblink: http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t. Table name - PEPANNRES.

Data collection period: Annual
Source Data type: Count

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

Total Population (FL CHARTS)

Female / Male Population

Weblink: http://www.floridacharts.com/FLQUERY/Population/PopulationRpt.aspx
Data collection period: Annual
Source Data type: Count

Source: FL DOH, Division of Public Health Statistics & Performance Management. *Florida Charts*. Original Data Source: FL DOH, Office of Health Statistics and Assessment in consultation with the FL EDR.

Families with Children - Households with one or more people under 18 years. (%/total hhs). Weblink: http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_13_5YR_S1101&prodType=table. Table name - S1101

Data collection period: Annual
Source Data type: %

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

Births to Mothers by age group (Resident) - Live Births. Does not include pregnancies that end with miscarriages, elective and spontaneous abortions or fetal deaths. Births to mothers in a specific age group divided by females in the same age group. Weblink: http://www.floridacharts.com/charts/DataViewer/BirthViewer/BirthViewer.aspx?cid=0001.
Data collection period: 3-year rolling
Source Data type: Rate
Source: FL DOH, Division of Public Health Statistics & Performance Management. *Florida Charts*.
Original Data Source: FL DOH, Bureau of Vital Statistics

Total Births (resident) - Number of infants born to residents regardless of county of birth. Weblink: http://www.floridacharts.com/FLQUERY/Birth/BirthRpt.aspx
Population by Race - Weblink: http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t. Table name - B02001.

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

Data collection period: Annual
Source Data type: Count

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

Abbreviations and Acronyms

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

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

Walton Community Health Improvement Partnership (WCHIP)

Forces of Change Assessment

Mobilizing for Action through Planning and Partnerships (MAPP)

Vision:

Prepared by the Florida Department of Health in Walton County
November 2015
For more information, contact Jamie.Carmichael@flhealth.gov 850-892-8040 x 1266

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Introduction

June of 2015, the Walton County MAPP Executive Committee (WCHIP Steering Committee) embarked on a journey to develop a Community Health Assessment (CHA) using the Mobilizing for Action through Planning and Partnerships (MAPP) process. 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.

A community health needs assessment is a process that:

- Describes the state of health of the local population;
- Enables the identification of the major risk factors and causes of ill health; and
- Enables the identification of the actions needed to address these identified issues.

The MAPP process includes four assessment tools, as shown in the graphic below.

MAPP Model, Achieving Healthier Communities MAPP User's Handbook

http://www.naccho.org

Within the MAPP process, there are four assessment tools. One of these assessment tools is the Forces of Change Assessment (FOCA). The FOCA is aimed at identifying forces – such as trends, factors, or events – that are or will be influencing the health and quality of life of the community and the work of the local public health system.

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

During the FOCA, participants answer the following questions:

- What is occurring or might occur that affects the health of our community or the local public health system?
- What specific threats or opportunities are generated by these occurrences?

Forces considered include the following categories of influence:

(1) Social (2) Economic
(3) Political (4) Legal
(5) Environmental (6) Technological
(7) Scientific

The group also considered other categories of forces of change specific to the county.

Assessment Methodology

On October 21, 2015, the Walton County MAPP Executive Committee convened to participate in Phase one of the Forces of Change Assessment (FOCA). Participants were guided through the following process:

1. The definitions and components of the FOCA were reviewed.
2. Flip charts for each category of influence were placed around the room.
3. The participants in the room were divided into two small groups, each of which took half of the categories of influence.
4. Each group brainstormed and listed on post-it notes the relevant forces of influence (events, factors, trends) for the categories on their side of the room.
5. Participants were also encouraged to contribute to the categories on the other side of the room.
6. The post-it notes were placed on the flip charts by the participants for each category as an event, factor, or trend.
7. After a specified period of time, the groups collectively discussed each category of influence and the rationale for the selections. Notes were taken to be combined with results of Phase two at a later date.
8. The meeting convened, and the facilitator created a Forces of Change worksheet (Appendix A) to be used in the next phase of the process –to identify the potential threats and opportunities presented by the forces.

Phase two of the FOCA was completed through use of an online survey in which the MAPP Committee responded answering the following questions for each Force of Change provided in Phase one:

> "When you think about public health and the health of our residents – what is a Threat or Challenge as a result of …?"
>
> "When you think about public health and the health of our residents – what is an Opportunity as a result of …?"

Following the collection of the surveys notes from Phase one were added to the responses and a summary was created. The forces identified on the following pages and the results of the other three assessments will serve as the foundation for identifying Strategic Issues, in the final MAPP process.

Forces of Change in Walton County

Included in the following table are the seven categories of forces that were identified by the Walton MAPP Committee as influencing Walton County's health system and community health, along with the associated threats and opportunities.

Forces	Threats Posed	Opportunities Created
Economic		
BP oil spill	Negatively affected tourism resulting in loss of jobs and increased mental health issues. Unknown effect of chemicals in the ocean & the effect of these on the fish that we eat. Initially the oil spill affected tourism greatly and many people lost income, so mental health was a great threat. Also, what research is being done to prove or disprove the effect of the spill on the fish we eat from the gulf? The impact on the economy from the oil spill certainly caused harm in 2010 and 2011, but tourism numbers rebounded and surpassed pre-spill numbers, so hopefully any negative effects have been restored by now. I don't see a threat or challenge.	Enhance health care services to address mental health issues. New research that can be done. Millions spent by BP and given to groups like LPHI to assist FQHCs like ours. The settlement for the BP Oil Spill provides the opportunity for the community to build additional healthcare coordination and infrastructure to be developed. The oil spill brought national attention and a focused media campaign to our area, which generated new interest and tourists. A strong coastal economy impacts the whole county. There were jobs created from the BP monies
New Dental School opened in DeFuniak	Competition for local dentists. Although the pricing for having dental work completed there is still somewhat expensive, it is still not affordable for everyone. It is the only reduced rate resource for adults in our county.	Educate residents about the dental school and criteria for patients. Increase access to dental services that more people can afford. The new dental school provides residents with an increase in local availability of dentist services. It also brings in dental educations to the community who have highly skilled jobs, corresponding salaries, and families. Educated students are trained to become dentists and have the opportunities to practice and live in Walton County. New opportunity for provider training and increased access to free cleanings and screenings.

Forces	Threats Posed	Opportunities Created
Economic		
Lack of health insurance	No or limited access to health care that does not require insurance. Without health insurance, the population will use hospital E.R.s for many health needs instead of finding a primary care doctor and using preventative services, which increased usage of the E.R. ends up costing the county, etc.	Educate residents on insurance coverage (Health Marketplace) - ACA.
Population & Wages	Low wages result in not being able to afford healthcare so several will go without insurance. Poor access to health care, transportation to health care, not eating healthy due to lack of choices and cost, not being able to take the medication properly. Wages are very low in Walton County, which lends to lower levels for living, poor food choices, resistance to seek medical care, etc. Salary is low so they cannot afford insurance and living a healthy lifestyle.	Educate residents re: healthcare choices. South Walton does have the tourist dollars to help support agencies county wide. The increase in local wages will increase the number of residents that qualify for health insurance. Increased wages will also empower residents to improve their health through purchasing more healthy food options which are often more costly than processed foods. Our population continues to increase, and new businesses are opening in Walton County, so that will have a positive impact on our community's health.
Transportation	Lack of transportation and the distance that is required to travel for healthcare. Tri-county does what they can to provide for our residents, but they can only travel to certain locations on specific days of the week, limiting availability for travel to doctor appointments, etc.	The system that we have people know about. Having an existing public transportation system provides the opportunity to expand the service without having to build the initial infrastructure required for start-up. Staff members of the public transportation system area also already trained and versed in the available resources available throughout the county. Enhance transportation system.

Forces	Threats Posed	Opportunities Created
Economic		
Where businesses are	Too far in relation to the distance from where people live. Residents in the rural parts of the county (North) will pay more, drive more and sometimes go in to Alabama to spend their money. Residents in South Walton may actually spend more too because prices are driven by tourism. The majority of current business locations are spread out and do not encourage walking during the work day and throughout communities in which they are built.	Expansion in North end.
Higher required skill set for jobs, inadequate education and job training	Not being able to bring jobs into the area. There are places to learn skills and institutions for higher education close by, but the cost of these will keep the population from learning. Companies need to fund educational opportunities for their employees to learn new skill sets. Shortage of healthcare professionals.	More options for health care & the Available to afford care.
FedEx opened in Mossy Head & New Business growth in unpopulated areas	Not enough health care services. Increase of use of the health care system. There will always be resistance to change, but hopefully the residents in Mossy Head view the new growth as an opportunity. It will bring more people to the area and there are not enough providers to service them.	Increase health care services. Increase wages so more can afford health care. When people have jobs and increased wages, they may be able to added insurance and provider healthier options for their families' i.e. healthier food, vacation time away from stress. Larger national businesses like FedEx provide the community the opportunity to have more families covered under adequate health insurance that includes preventable care benefits. New opportunities for jobs, career advancement, etc., lead to higher pay and better health choices. It will allow for more job opportunities for our residents.

Forces	Threats Posed	Opportunities Created
Environmental		
Flooding from storm 2013-2014	Increase health issues that are just now showing up. People's homes were damaged and left unsanitary. Environmental health issues raised. Dealing with these issues will raise mental health issues as well. Homeless residents.	New grants/funding to help residents effected. Educate residents on post-storm EH issues.
Four lining project of Highway 331	There are more accidents from traffic issues. Evacuation pre/post storm.	More construction jobs which hopefully gives families mental stability and health insurance. The Highway 331 4-lane project provides the opportunity to increase the development of the corridor and decrease the traffic backing up into the central portion of the county. This increase in development will allow for medical complexes that offer multiple services within a single location and increased service availability. Educate residents about evacuation pre/post storm.
Ethnic population increasing	Lack of access/language barrier - need for interpreters. Different type of care needed. Many of the ethnic population are uninsured, which puts a strain on our citizens to pay for their healthcare. A challenge presented by increase in the number of Spanish speaking residents is ensuring that the health services available throughout the county are culturally competent and accessible.	More care might be coming into the area. They are willing to do jobs that a lot of our population will not do. They help in rural areas (farmers) with jobs that may not otherwise be able to get completed. Hire more interpreters.
Limited water supply	Wells running dry and not having access to clean water in outlying areas. Limited water supply can affect farmers who produce goods. Could eventually lead to shortage of water.	Currently since it is good it allows people to continue to live in outlying areas. The limited water supply provides the opportunity to place value in water conservation efforts. Educate residents on rationing of water.
Large wetland areas	Having to use chemicals to control pest in the areas. This can affect our cattle and food supply as well. Storm water run-off mitigation and waste water treatment are a challenge in wetland areas. Increase in mosquito borne viruses.	Lack of building in those areas. Large wetland areas offer the opportunity to incorporate healthy nature and outdoor activities into communities. Educate residents on prevention of Mosquito borne viruses, i.e. West Nile Virus.

Forces	Threats Posed	Opportunities Created
Environmental		
Large protected areas (Eglin)	Large swathes of protected land present a transportation challenge for residents who live on the edge of these areas and away from the county's available health services which cluster in the developed areas.	Large protected areas offer the opportunity to incorporate healthy nature and outdoor activities into family activities.
Higher density of cities	Maybe more crime, drug use, etc. Higher populated areas may hold a higher threat of the spread of disease.	Able to access other items without driving, more walking, and more options. Infrastructure. Increased density offers the opportunity to develop comprehensive health care service centers that are accessible to a larger number of residents.
New communities being made in rural areas	Infrastructure. Too many people, not enough healthcare services.	New communities being made in rural areas will provide the opportunity to expand the distribution of health care providers into areas that are not currently served by a local provider. Better housing opportunities. Increase healthcare services to all.
Increased water use	Running out of water and not having water tanks/holding tanks. Infrastructure. Could lead to shortage of water.	Making cities using water systems instead of wells. Educate residents on water rationing.
Increased sewage	More septic tanks, more need of treatment plants and placement of plants, what happen when flooding / other type of storms hits. Infrastructure. Could lead to pump failure resulting in raw sewage creating health hazard.	An increase in the amount of sewage needing to be treated provides an opportunity to develop sewer systems in areas that have a high potential for generating negative health impacts from waste water contamination. Educate residents, revise rules and regulations.
Legal/Political		
Political Elections	Those elected may not be educated about the threats to our community, which may differ from other communities. Healthy policies can change.	Hopefully those elected will have interest in the uninsured and their health to make changes to the healthcare system. Educate elected officials on healthcare issues.
Providers retiring due to Affordable Care Act (ACA)	Lack of care. Lack of Family practice physicians. Decreased amount of healthcare providers (shortage).	New providers might be coming in with new ideas. Recruit medical students before graduating. Use staffing agencies.

Forces	Threats Posed	Opportunities Created
Legal/Political		
Legalization of Medical Marijuana	Not being able to control. Increased drug use. Fraud. The increase use of marijuana as a result of legalization increases the number of residents who are addicted to marijuana which increases the negative consequences associated with its use. Legalization of marijuana use has also been shown to increase your marijuana use rates, which could lead to the legalization of marijuana.	Helping with pain and other items without drugs. If regulated properly, some economic impact for residents moving in to have access. Improving the health of those who truly need it. Education regarding medical marijuana.
Privatization of Primary Care (HMOs)	Limit of access. Too many unknowns. Will the health of the patient be the highest priority? Privatization will hurt the economy overall. Have limited choices for healthcare.	Healthcare for all? Educate residents on various managed care healthcare companies and the benefits.
Decrease in Low Income Pool (LIP) funding, i.e. less government funding for programs	Less access for people that need these services. When hospitals and clinics loose funding of any type, programs disappear for those that need medical assistance. Decreased healthcare services.	Less government can be good. It's just hard to start a program and then take it away. Look for other funding sources to replace LIP.
Increase in governmental revenue from BP settlement	Where the funding can go. Just because you have been given the money, it has to be spent. Not always in the most sensible and logistical way. Spend revenue as appropriate on healthcare services.	More funding to other items so that maybe current funding can be used for services. If spent properly, it could assist in infrastructure to increase and sustain growth for our communities. Expand healthcare services.
Implementation of ACA	Paying more for insurance and getting less coverage. Some restrictions for medical benefits.	Coverage for children up to age 26, coverage for pre-existing conditions. Educate residents on ACA.
Immigration rules and regulations	Illegals going to ER.	Educate lawmakers on the effects of the rules and regulations on healthcare.
Did not expand adult Medicaid	Lack of access of services. Still a great amount of residents that cannot afford health insurance. If Medicaid is expanded to include adults, the cost to the state would be significant. Some residents will not be able to obtain Medicaid (Insurance).	More adults will have opportunities to seek health care on a regular basis.

Forces	Threats Posed	Opportunities Created
Legal/Political		
Increased drug use	More use of the system. No affordable treatment centers. Increased drug use is linked to increases in domestic violence, child abuse, violent crime, property crime, accidental injuries, motor vehicle crashes, and the need for social services. Increase STD/STIs. Not enough substance abuse treatment facilities in county.	STD Education. Increase number of substance abuse treatment facilities in county.
Increased enforcement by DOH & Law enforcement (more staff)	Some people that really needed pain meds now cannot get them. Increased payroll for state and county government. Not enough employees / law enforcement.	Taking meds off of the streets. Keeping everyone safer. Increased enforcement efforts by law enforcement provides the opportunity to raise awareness of these efforts to reduce drug use and it associated consequences. Hire more staff / law enforcement.
Increase provider education	Education takes away from the provider seeing patients. Cost of education. Impacts time and cost.	Able to give out more information and to be able to keep current with all changes. Up to date of latest medical advances, medications, etc. Increasing provider education to the community will provide the opportunity to increase their awareness of available health services and effective self-care options. Find ways to educate at no cost to provider.
Growing disillusionment with Government	A continuous feeling that government controls too many aspects of our lives. Residents not obeying rules / regulations.	Education.
Tobacco free policies & E-cig use	Currently not be able to enforce use and not updating as fast as needed. Only to the economy, not the health of our residents. Residents switching to e-cigs thinking they are healthier.	Including e-cigs in policies and getting the word out on health issues with e-cigs. Keeping our children from trying tobacco of any kind. Increasing the number of tobacco free policies that include e-cigarettes provides the opportunity to reduce the number of residents who start using tobacco products and encourages tobacco cessation by current tobacco users. Educate residents on the dangers of e-cigs.

Forces	Threats Posed	Opportunities Created
Social		
County Health Department moving to core public health	Primary care in Walton county is very limited, the health department provides a much needed service to Walton Co. through its healthcare providers. Lack of primary care services.	Redirecting the majority of the county health department's expertise and resources into public health services will provide the opportunity to assist in developing the capacity within Walton County to prevent significant health issues by addressing the contributing community factors that drive these population level changes in health. Expand other services (core public health).
Uneven distribution of health care providers	Not being able to get care where you live. Residents will travel out of area for providers.	Specialists should provide clinics at the north end of the county.
Lack of affordable housing	The lack of affordable housing threatens the overall health of the county by pushing low wage earning residents farther away from population centers that centralize medical services and other supports for developing healthy lifestyles. More people living in homes that have issues. Family forced to live together in housing that is too small or does not provide sanitary conditions. Homelessness.	Developing communities that offer affordable housing for residents increases the density of healthcare consumers which provides the opportunity to fund sustainable satellite health care service centers within these areas. Options to build decent housing & maybe funding from grants. County government could work with developers to assist with building affordable housing by offering incentives or tax breaks. Educate BOCC on the need for affordable housing due to public health issues.
Inadequate mental health care	Untreated mental health disorders contribute to lower physical health for residents. People are not using the care when needed. There are not enough available resources or mental health providers to handle the amount of residents that need counseling. Need to educate families of resources that are available. Increase usage of ERs.	Including mental health treatment services into health care service centers will provide the opportunity for residents to receive additional treatment services at a convenient setting.

Forces	Threats Posed	Opportunities Created
Social		
Notable economist predicts population spike North of the Bay	It will be a challenge to expand sanitation services, and healthcare infrastructure to serve the proposed significant population increase in the population for the central and northern portions of Walton County. Lack of infrastructure, housing, medical providers. Limited healthcare services north of Bay.	Expanding the population of communities in the central and northern areas of Walton County will provide the opportunity to increase the available healthcare resource capacity in these areas through the development of sustainable clinics and specialized service providers. Increase in economy, more jobs with better income opportunities and medical insurance availability through employers. Increase healthcare services north of Bay.
Residential changes and needs	Infrastructure. Not enough healthcare services to meet the changes & needs.	Better housing opportunities. Increase healthcare services to meet needs.
Technological/Scientific		
Meaningful Use	Some facilities may not have funding, even with incentives to implement HER and keep it sustained. Some patients do not have computers.	The idea of being able to have your health records available wherever you are is portable and convenient. Opportunities for better health care. Enhance primary care efficiency.
Availability of fiber optics & cable providers county wide	Lack of. None	Increasing the quality of local computer networking infrastructure will provide providers with the opportunity to implement Electronic Medical Record systems that improve their efficiency in record keeping, data sharing, and communicating with other community groups to improve health coordination efforts. None. Growing opportunities for Telemedicine and state of the art equipment. Enhance IT infrastructure. Improve communication.
Infrastructure concerns	Money and upkeep of the infrastructure.	Growing opportunities for Telemedicine and state of the art equipment. Educating.

Forces	Threats Posed	Opportunities Created
Technological/Scientific		
Growing Telehealth	Access. Being able to provide maintenance to the system. Obtain funding for Telemedicine.	Expanding telemedicine services provides an opportunity to increase access to medical expertise, improve responsiveness to medication adjustments, and expand the self-care strategies being implemented by residents to manage their own health. Access. Jobs and better health systems. To use telemedicine in our rural clinics.
Increasing use of Social Media and Smart Phones	Harder to police and disseminate fact from fiction. DOH-Walton communicates limited amounts of healthcare information via social media.	Increasing the use of social media to disseminate information about disease prevention, healthy lifestyles, and available healthcare services by providers will provide the opportunity to increase the number of informed health consumers. Most everyone has a smart phone, so information is easier to get to outlying areas. Increase communication of healthcare services and educational info via social media.

APPENDIX A

Forces of Change Worksheet

Forces of Change Affecting Health in Walton County			
	Events	**Factors**	**Trends**
Economic	FedEx opened in Mossy Head	Population & Wages	BP
	New Dental School opened in DFS		Road/transportation infrastructure, i.e. four laning project of Highway 331
	Flooding from storm 2013-2014	Transportation	Where businesses are
	BP oil spill		Higher required skill set for jobs
			Lack of health insurance
Environmental	Four laning project of Highway 331	Ethnic population increasing	Higher density of cities
	BP oil spill	Limited water supply	New communities being made in rural areas
	Flooding from storm 2013-2014	Large wetland areas	Increased water use
		Large protected areas (Eglin)	Increased sewage
Legal/Political	Political Elections	Immigration rules and regulations	Growing disillusionment with Government
	Providers retiring due to Affordable Care Act (ACA)	Did not expand adult Medicaid	Tobacco free policies
	Legalization of Medical Marijuana	Increased drug use	
	Privatization of Primary Care (HMOs)	Increased enforcement by DOH & Law enforcement (more staff)	
	Decrease in Low Income Pool (LIP) funding, i.e. less government funding for programs	Increase provider education	
	Increase in governmental revenue from BP settlement		
	Implementation of ACA		
Social	*BP oil spill*	Increase in ethnic population	Notable economist predicts population spike North of the Bay
	County Health Department moving to core public health	Uneven distribution of health care providers	Residential changes and needs
		Inadequate education & job training	E-cigarette use
		Lack of affordable housing	New business growth in unpopulated areas
		Inadequate mental health care	
Technological/	Meaningful Use	Availability of fiber optics county wide	Growing Telehealth
Scientific		Availability of cable providers county wide	Increasing use of Social Media
		Infrastructure concerns	

Walton Community Health Improvement Partnership
STEERING COMMITTEE
Date: October 21, 2015

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National Public Health Performance Standards

Local Assessment Report

FDOH Walton
2/17/2016

Program Partner Organizations

American Public Health Association
www.apha.org

Association of State and Territorial Health Officials
www.astho.org

Centers for Disease Control and Prevention
www.cdc.gov

National Association of County and City Health Officials
www.naccho.org

National Association of Local Boards of Health
www.nalboh.org

National Network of Public Health Institutes
www.nnphi.org

Public Health Foundation
www.phf.org

National Public Health Performance Standards

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Acknowledgements

The National Public Health Performance Standards (NPHPS) was developed collaboratively by the program's national partner organizations. The NPHPS partner organizations include: Centers for Disease Control and Prevention (CDC); American Public Health Association (APHA); Association of State and Territorial Health Officials (ASTHO); National Association of County and City Health Officials (NACCHO); National Association of Local Boards of Health (NALBOH); National Network of Public Health Institutes (NNPHI); and then Public Health Foundation (PHF). We thank the staff of these organizations for their time and expertise in the support of the NPHPS.

Background

The NPHPS is a partnership effort to improve the practice of public health and the performance of public health systems. The NPHPS assessment instruments guide state and local jurisdictions in evaluating their current performance against a set of optimal standards. Through these assessments, responding sites can consider the activities of all public health system partners, thus addressing the activities of all public, private and voluntary entities that contribute to public health within the community.

The NPHPS assessments are intended to help users answer questions such as "What are the components, activities, competencies, and capacities of our public health system?" and "How well are the ten Essential Public Health Services being provided in our system?" The dialogue that occurs in the process of answering the questions in the assessment instrument can help to identify strengths and weaknesses, determine opportunities for immediate improvements, and establish priorities for long term investments for improving the public health system.

Three assessment instruments have been designed to assist state and local partners in assessing and improving their public health systems or boards of health. These instruments are the:

- State Public Health System Performance Assessment Instrument,
- Local Public Health System Performance Assessment Instrument, and
- Public Health Governing Entity Performance Assessment Instrument.

The information obtained from assessments may then be used to improve and better coordinate public health activities at state and local levels. In addition, the results gathered provide an understanding of how state and local public health systems and governing entities are performing. This information helps local, state and national partners make better and more effective policy and resource decisions to improve the nation's public health as a whole.

Introduction

The NPHPS Local Public Health System Assessment Report is designed to help health departments and public health system partners create a snapshot of where they are relative to the National Public Health Performance Standards and to progressively move toward refining and improving outcomes for performance across the public health system.

The NPHPS state, local, and governance instruments also offer opportunity and robust data to link to health departments, public health system partners and/or community-wide strategic planning processes, as well as to Public Health Accreditation Board (PHAB) standards. For example, assessment of the environment external to the public health organization is a key component of all strategic planning, and the NPHPS assessment readily provides a structured process and an evidence-base upon which key organizational decisions may be made and priorities established. The assessment may also be used as a component of community health improvement planning processes, such as Mobilizing for Action through Planning and Partnerships (MAPP) or other community-wide strategic planning efforts, including state health improvement planning and community health improvement planning. The NPHPS process also drives assessment and improvement activities that may be used to support a Health Department in meeting PHAB standards. Regardless of whether using MAPP or another health improvement process, partners should use the NPHPS results to support quality improvement.

The self-assessment is structured around the Model Standards for each of the ten Essential Public Health Services, (EPHS), hereafter referred to as the Essential Services, which were developed through a comprehensive, collaborative process involving input from national, state and local experts in public health. Altogether, for the local assessment, 30 Model Standards serve as quality indicators that are organized into the ten essential public health service areas in the instrument and address the three core functions of public health. Figure 1 below shows how the ten Essential Services align with the three Core Functions of Public Health.

Figure 1. The ten Essential Public Health Services and how they relate to the three Core Functions of Public Health.

Purpose

The primary purpose of the NPHPS Local Public Health System Assessment Report is to promote continuous improvement that will result in positive outcomes for system performance. Local health departments and their public health system partners can use the Assessment Report as a working tool to:

- Better understand current system functioning and performance;
- Identify and prioritize areas of strengths, weaknesses, and opportunities for improvement;
- Articulate the value that quality improvement initiatives will bring to the public health system;
- Develop an initial work plan with specific quality improvement strategies to achieve goals;
- Begin taking action for achieving performance and quality improvement in one or more targeted areas; and
- Re-assess the progress of improvement efforts at regular intervals.

This report is designed to facilitate communication and sharing among and within programs, partners, and organizations, based on a common understanding of how a high performing and effective public health system can operate. This shared frame of reference will help build commitment and focus for setting priorities and improving public health system performance. Outcomes for performance include delivery of all ten essential public health services at optimal levels.

About the Report

Calculating the Scores

The NPHPS assessment instruments are constructed using the ten Essential Services as a framework. Within the Local Instrument, each Essential Service includes between 2-4 Model Standards that describe the key aspects of an optimally performing public health system. Each Model Standard is followed by assessment questions that serve as measures of performance. Responses to these questions indicate how well the Model Standard - which portrays the highest level of performance or "gold standard" - is being met.

Table 1 below characterizes levels of activity for Essential Services and Model Standards. Using the responses to all of the assessment questions, a scoring process generates score for each Model Standard, Essential Service, and one overall assessment score.

Table 1. Summary of Assessment Response Options

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

Understanding Data Limitations

There are a number of limitations to the NPHPS assessment data due to self-report, wide variations in the breadth and knowledge of participants, the variety of assessment methods used, and differences in interpretation of assessment questions. Data and resultant information should not be interpreted to reflect the capacity or performance of any single agency or organization within the public health system or used for comparisons between jurisdictions or organizations. Use of NPHPS generated data and associated recommendations are limited to guiding an overall public health infrastructure and performance improvement process for the public health system as determined by organizations involved in the assessment.

All performance scores are an average; Model Standard scores are an average of the question scores within that Model Standard, Essential Service scores are an average of the Model Standard scores within that Essential Service and the overall assessment score is the average of the Essential Service scores. The responses to the questions within the assessment are based upon processes that utilize input from diverse system participants with different experiences and perspectives. The gathering of these inputs and the development of a response for each question incorporates an element of subjectivity, which may be minimized through the use of particular assessment methods. Additionally, while certain assessment methods are recommended, processes differ among sites. The assessment methods are not fully standardized and these differences in administration of the self-assessment may introduce an element of measurement error. In addition, there are differences in knowledge about the public health system among assessment participants. This may lead to some interpretation differences and issues for some questions, potentially introducing a degree of random non-sampling error.

Presentation of results

The NPHPS has attempted to present results - through a variety of figures and tables - in a user-friendly and clear manner. For ease of use, many figures and tables use short titles to refer to Essential Services, Model Standards, and questions. If you are in doubt of these definitions, please refer to the full text in the assessment instruments.

Sites may have chosen to complete two additional questionnaires, the Priority of Model Standards Questionnaire assesses how performance of each Model Standard compares with the priority rating and the Agency Contribution Questionnaire assesses the local health department's contribution to achieving the Model Standard. Sites that submitted responses for these questionnaires will see the results included as additional components of their report.

Results

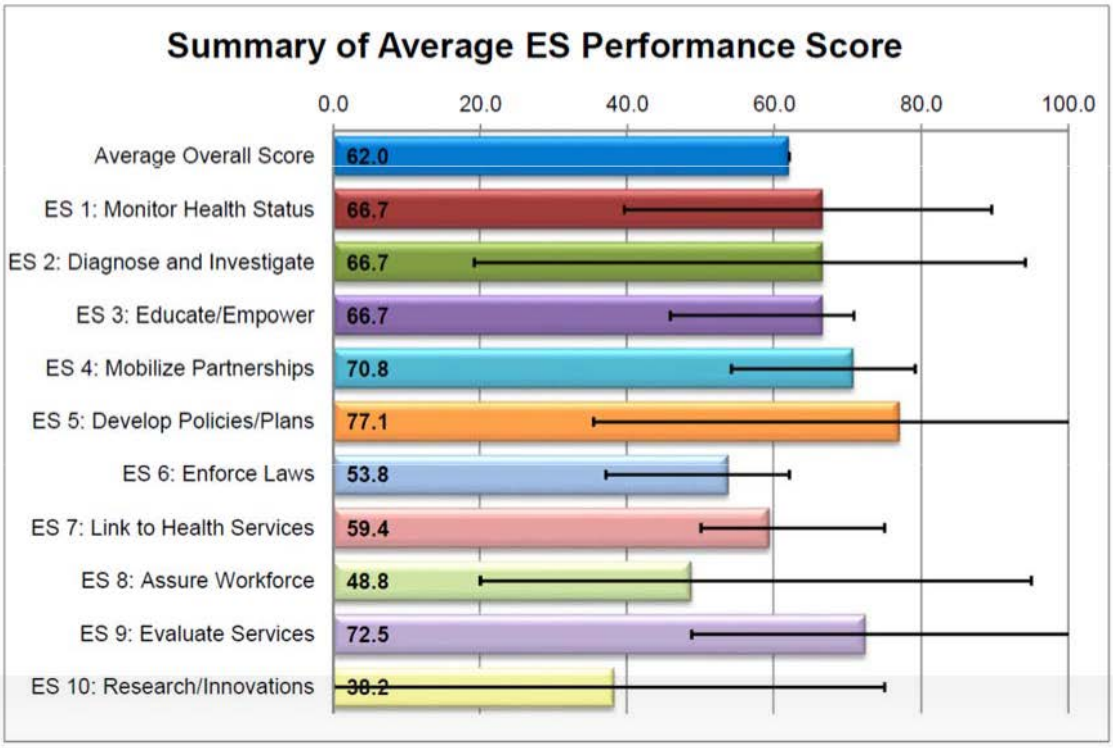
Now that your assessment is completed, one of the most exciting, yet challenging opportunities is to begin to review and analyze the findings. As you recall from your assessment, the data you created now establishes the foundation upon which you may set priorities for performance improvement and identify specific quality improvement (QI) projects to support your priorities.

Based upon the responses you provided during your assessment, an average was calculated for each of the ten Essential Services. Each Essential Service score can be interpreted as the overall degree to which your public health system meets the performance standards (quality indicators) for each Essential Service. Scores can range from a minimum value of 0% (no activity is performed pursuant to the standards) to a maximum value of 100% (all activities associated with the standards are performed at optimal levels).

Figure 2 displays the average score for each Essential Service, along with an overall average assessment score across all ten Essential Services. Take a look at the overall performance scores for each Essential Service. Examination of these scores can immediately give a sense of the local public health system's greatest strengths and weaknesses. Note the black bars that identify the range of reported performance score responses within each Essential Service.

Overall Scores for Each Essential Public Health Service

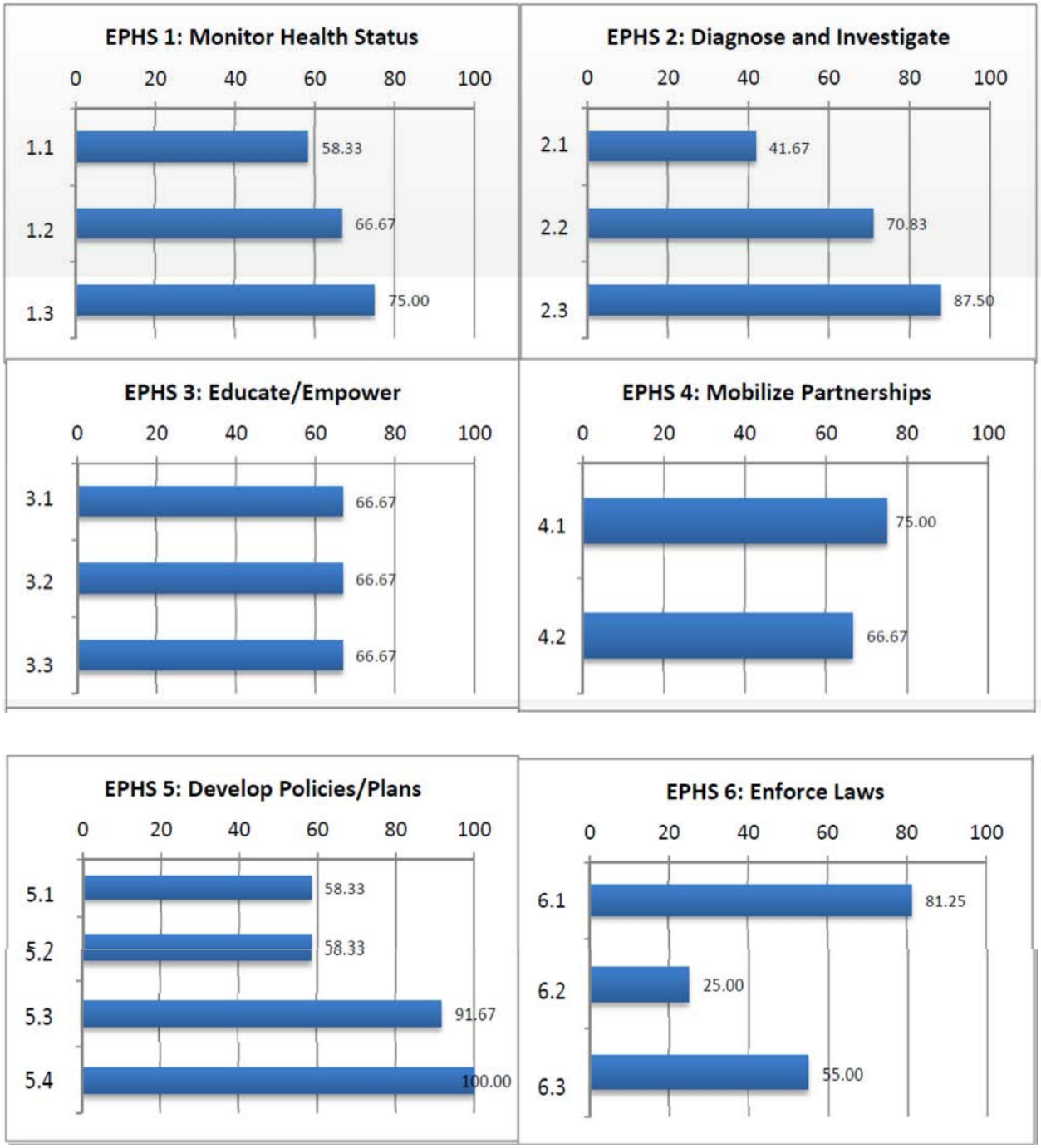
Figure 2. Summary of Average Essential Public Health Service Performance Scores

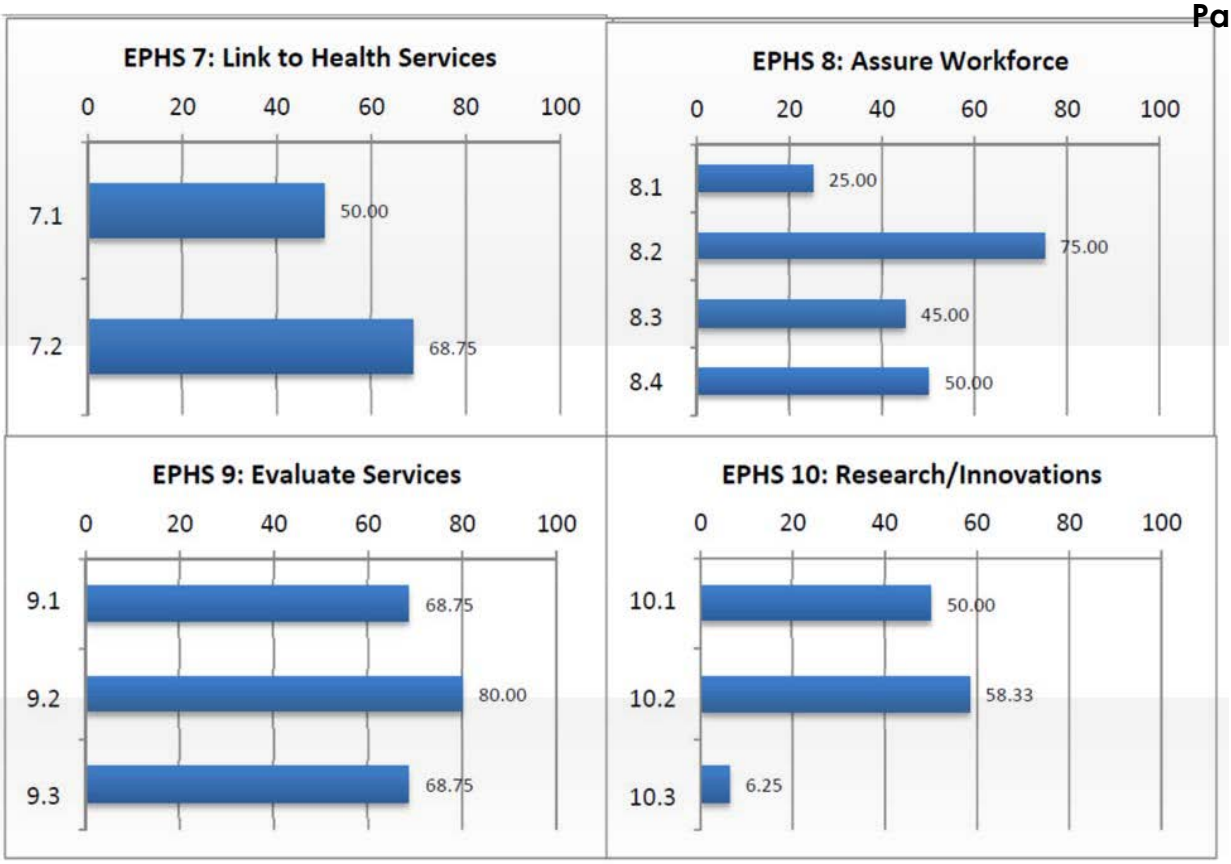


Performance Scores by Essential Public Health Service for Each Model Standard

Figure 3 and Table 2 on the following pages display the average performance score for each of the Model Standards within each Essential Service. This level of analysis enables you to identify specific activities that contributed to high or low performance within each Essential Service.

Figure 3. Performance Scores by Essential Public Health Service for Each Model Standard




EPHS 7: Link to Health Services
0
20
40
60
80
100
7.1
50.00
7.2
68.75
EPHS 8: Assure Workforce
0
20
40
60
80
100
8.1
25.00
8.2
75.00
8.3
45.00
8.4
50.00
EPHS 9: Evaluate Services
0
20
40
60
80
100
9.1
68.75
9.2
80.00
9.3
68.75
EPHS 10: Research/Innovations
0
20
40
60
80
100
10.1
50.00
10.2
58.33
10.3
6.25

In Table 2 below, each score (performance, priority, and contribution scores) at the Essential Service level is a calculated average of the respective Model Standard scores within that Essential Service. Note – The priority rating and agency contribution scores will be blank if the Priority of Model Standards Questionnaire and the Agency Contribution Questionnaire are not completed.

Table 2. Overall Performance, Priority, and Contribution Scores by Essential Public Health Service and Corresponding Model Standard

Model Standards by Essential Services	Performance Scores	Priority Rating	Agency Contribution Scores
ES 1: Monitor Health Status	**66.7**		
1.1 Community Health Assessment	58.3		
1.2 Current Technology	66.7		
1.3 Registries	75.0		
ES 2: Diagnose and Investigate	**66.7**		
2.1 Identification/Surveillance	41.7		
2.2 Emergency Response	70.8		
2.3 Laboratories	87.5		
ES 3: Educate/Empower	**66.7**		
3.1 Health Education/Promotion	66.7		
3.2 Health Communication	66.7		
3.3 Risk Communication	66.7		
ES 4: Mobilize Partnerships	**70.8**		
4.1 Constituency Development	75.0		
4.2 Community Partnerships	66.7		
ES 5: Develop Policies/Plans	**77.1**		
5.1 Governmental Presence	58.3		
5.2 Policy Development	58.3		
5.3 CHIP/Strategic Planning	91.7		
5.4 Emergency Plan	100.0		
ES 6: Enforce Laws	**53.8**		
6.1 Review Laws	81.3		
6.2 Improve Laws	25.0		
6.3 Enforce Laws	55.0		
ES 7: Link to Health Services	**59.4**		
7.1 Personal Health Service Needs	50.0		
7.2 Assure Linkage	68.8		
ES 8: Assure Workforce	**48.8**		
8.1 Workforce Assessment	25.0		
8.2 Workforce Standards	75.0		
8.3 Continuing Education	45.0		
8.4 Leadership Development	50.0		
ES 9: Evaluate Services	**72.5**		
9.1 Evaluation of Population Health	68.8		
9.2 Evaluation of Personal Health	80.0		
9.3 Evaluation of LPHS	68.8		
ES 10: Research/Innovations	**38.2**		
10.1 Foster Innovation	50.0		
10.2 Academic Linkages	58.3		
10.3 Research Capacity	6.3		
Average Overall Score	**62.0**	**NA**	**NA**
Median Score	**66.7**	**NA**	**NA**

Performance Relative to Optimal Activity

Figures 4 and 5 display the proportion of performance measures that met specified thresholds of achievement for performance standards. The five threshold levels of achievement used in scoring these measures are shown in the legend below. For example, measures receiving a composite score of 76-100% were classified as meeting performance standards at the optimal level.

Figure 4. Percentage of the system's Essential Services scores that fall within the five activity categories. This chart provides a high level snapshot of the information found in Figure 2, summarizing the composite performance measures for all 10 Essential Services.

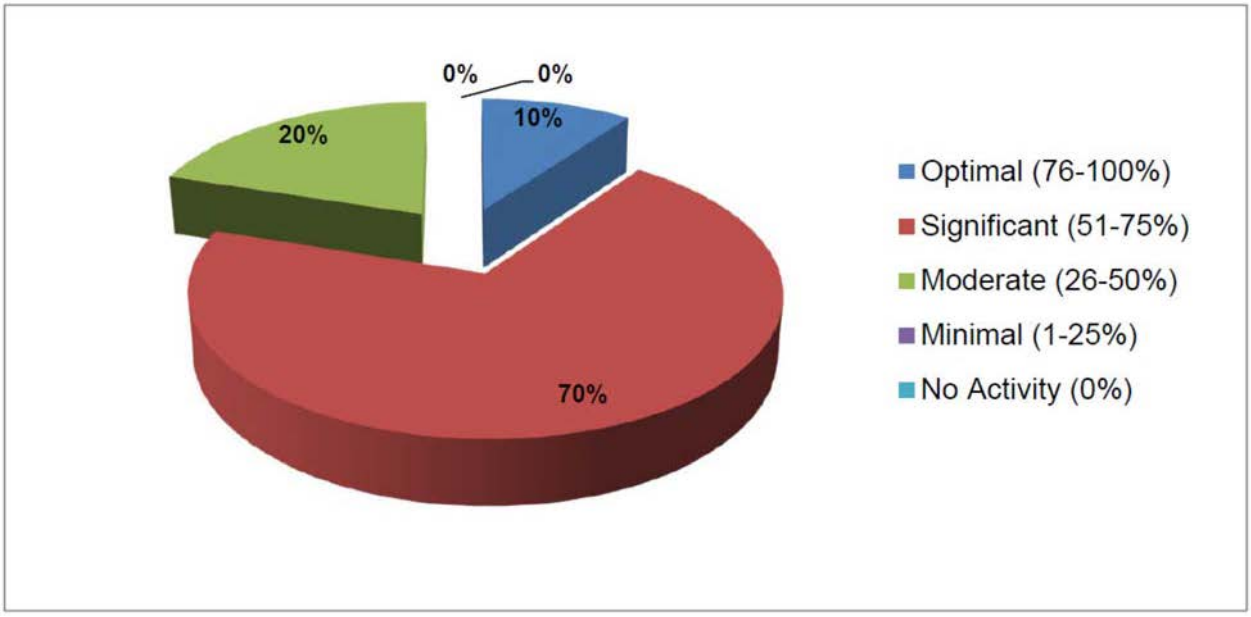
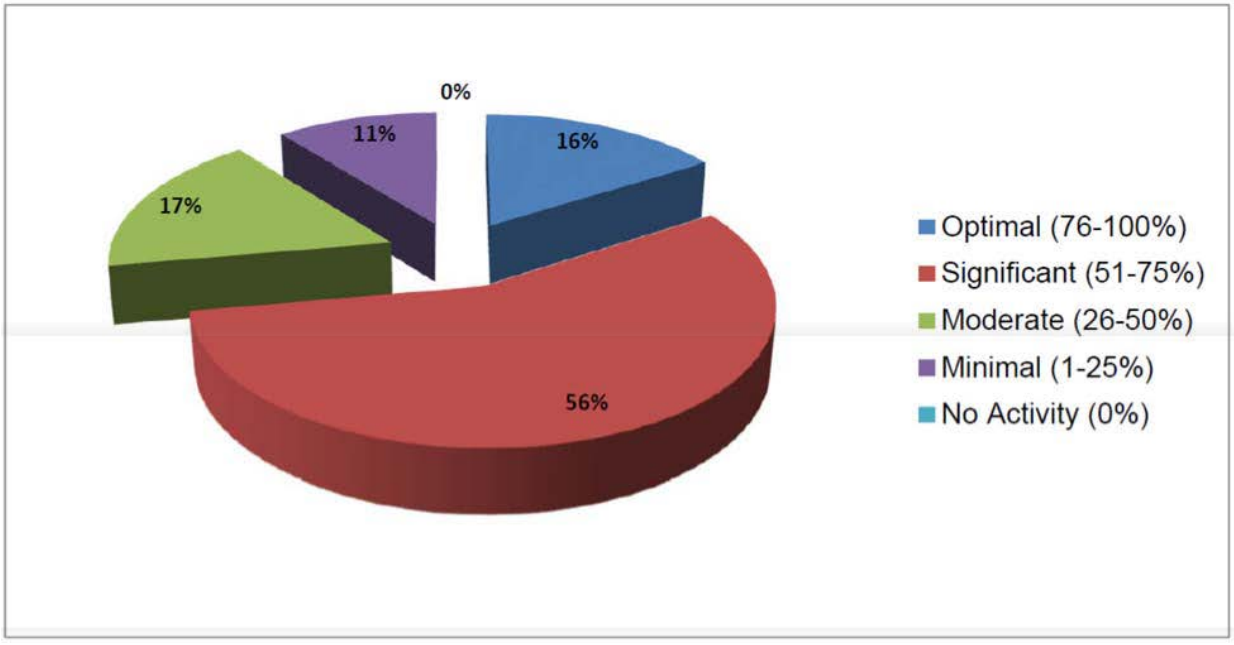


Figure 5. Percentage of the system's Model Standard scores that fall within the five activity categories. This chart provides a high level snapshot of the information found in Figure 3, summarizing the composite measures for all 30 Model Standards.



Analysis and Discussion Questions

Having a standard way in which to analyze the data in this report is important. This process does not have to be difficult; however, drawing some initial conclusions from your data will prove invaluable as you move forward with your improvement efforts. It is crucial that participants fully discuss the performance assessment results. The bar graphs, charts, and summary information in the Results section of this report should be helpful in identifying high and low performing areas. Please refer to Appendix H of the Local Assessment Implementation Guide. This referenced set of discussion questions will to help guide you as you analyze the data found in the previous sections of this report.

Using the results in this report will help you to generate priorities for improvement, as well as possible improvement projects. Your data analysis should be an interactive process, enabling everyone to participate. Do not be overwhelmed by the potential of many possibilities for QI projects – the point is not that you have to address them all now. Consider this step as identifying possible opportunities to enhance your system performance. Keep in mind both your quantitative data (Appendix A) and the qualitative data that you collected during the assessment (Appendix B).

Next Steps

Congratulations on your participation in the local assessment process. A primary goal of the NPHPS is that data is used proactively to monitor, assess, and improve the quality of essential public health services. This report is an initial step to identifying immediate actions and activities to improve local initiatives. The results in this report may also be used to identify longer-term priorities for improvement, as well as possible improvement projects.

As noted in the Introduction of this report, NPHPS data may be used to inform a variety of organization and/or systems planning and improvement processes. Plan to use both quantitative data (Appendix A) and qualitative data (Appendix B) from the assessment to identify improvement opportunities. While there may be many potential quality improvement projects, do not be overwhelmed – the point is not that you have to address them all now. Rather, consider this step as a way to identify possible opportunities to enhance your system performance and plan to use the guidance provided in this section, along with the resources offered in Appendix C, to develop specific goals for improvement within your public health system and move from assessment and analysis toward action.

Note: Communities implementing Mobilizing for Action through Planning and Partnerships (MAPP) may refer to the MAPP guidance for considering NPHPS data along with other assessment data in the Identifying Strategic Issues phase of MAPP.

Action Planning

In any systems improvement and planning process, it is important to involve all public health system partners in determining ways to improve the quality of essential public health services provided by the system. Participation in the improvement and planning activities included in your action plan is the responsibility of all partners within the public health system.

Consider the following points as you build an Action Plan to address the priorities you have identified
• Each public health partner should be considered when approaching quality improvement for your system
• The success of your improvement activities are dependent upon the active participation and contribution of each and every member of the system
• An integral part of performance improvement is working consistently to have long-term effects
• A multi-disciplinary approach that employs measurement and analysis is key to accomplishing and sustaining improvements

You may find that using the simple acronym, 'FOCUS' is a way to help you to move from assessment and analysis to action.

F **Find** an opportunity for improvement using your results.

O **Organize** a team of public health system partners to work on the improvement. Someone in the group should be identified as the team leader. Team members should represent the appropriate organizations that can make an impact.

C **Consider** the current process, where simple improvements can be made and who should make the improvements.

U **Understand** the problem further if necessary, how and why it is occurring, and the factors that contribute to it. Once you have identified priorities, finding solutions entails delving into possible reasons, or "root causes," of the weakness or problem. Only when participants determine why performance problems (or successes!) have occurred will they be able to identify workable solutions that improve future performance. Most performance issues may be traced to well-defined system causes, such as policies, leadership, funding, incentives, information, personnel or coordination. Many QI tools are applicable. You may consider using a variety of basic QI tools such as brainstorming, 5-whys, prioritization, or cause and effect diagrams to better understand the problem (refer to Appendix C for resources).

S **Select** the improvement strategies to be made. Consider using a table or chart to summarize your Action Plan. Many resources are available to assist you in putting your plan on paper, but in general you'll want to include the priority selected, the goal, the improvement activities to be conducted, who will carry them out, and the timeline for completing the improvement activities. When complete, your Action Plan should contain documentation on the indicators to be used, baseline performance levels and targets to be achieved, responsibilities for carrying out improvement activities and the collection and analysis of data to monitor progress. (Additional resources may be found in Appendix C.)

Monitoring and Evaluation: Keys to Success

Monitoring your action plan is a highly proactive and continuous process that is far more than simply taking an occasional "snap-shot" that produces additional data. Evaluation, in contrast to monitoring, provides ongoing structured information that focuses on why results are or are not being met, what unintended consequences may be, or on issues of efficiency, effectiveness, and/or sustainability.

After your Action Plan is implemented, monitoring and evaluation continues to determine whether quality improvement occurred and whether the activities were effective. If the Essential Service performance does not improve within the expected time, additional evaluation must be conducted (an additional QI cycle) to determine why and how you can update your Action Plan to be more effective. The Action Plan can be adjusted as you continue to monitor and evaluate your efforts.

APPENDIX A: Individual Questions and Responses

Performance Scores

ESSENTIAL SERVICE 1: Monitor Health Status to Identify Community Health Problems		
1.1	**Model Standard: Population-Based Community Health Assessment (CHA)** *At what level does the local public health system:*	
1.1.1	Conduct regular community health assessments?	50
1.1.2	Continuously update the community health assessment with current information?	75
1.1.3	Promote the use of the community health assessment among community members and partners?	50
1.2	**Model Standard: Current Technology to Manage and Communicate Population Health Data** *At what level does the local public health system:*	
1.2.1	Use the best available technology and methods to display data on the public's health?	75
1.2.2	Analyze health data, including geographic information, to see where health problems exist?	50
1.2.3	Use computer software to create charts, graphs, and maps to display complex public health data (trends over time, sub-population analyses, etc.)?	75
1.3	**Model Standard: Maintenance of Population Health Registries** *At what level does the local public health system:*	
1.3.1	Collect data on specific health concerns to provide the data to population health registries in a timely manner, consistent with current standards?	75
1.3.2	Use information from population health registries in community health assessments or other analyses?	75

ESSENTIAL SERVICE 2: Diagnose and Investigate Health Problems and Health Hazards		
2.1	**Model Standard: Identification and Surveillance of Health Threats** *At what level does the local public health system:*	
2.1.1	Participate in a comprehensive surveillance system with national, state and local partners to identify, monitor, share information, and understand emerging health problems and threats?	50
2.1.2	Provide and collect timely and complete information on reportable diseases and potential disasters, emergencies and emerging threats (natural and manmade)?	50
2.1.3	Assure that the best available resources are used to support surveillance systems and activities, including information technology, communication systems, and professional expertise?	25

2.2	**Model Standard: Investigation and Response to Public Health Threats and Emergencies** *At what level does the local public health system:*	
2.2.1	Maintain written instructions on how to handle communicable disease outbreaks and toxic exposure incidents, including details about case finding, contact tracing, and source identification and containment?	75
2.2.2	Develop written rules to follow in the immediate investigation of public health threats and emergencies, including natural and intentional disasters?	75
2.2.3	Designate a jurisdictional Emergency Response Coordinator?	100
2.2.4	Prepare to rapidly respond to public health emergencies according to emergency operations coordination guidelines?	50
2.2.5	Identify personnel with the technical expertise to rapidly respond to possible biological, chemical, or and nuclear public health emergencies?	75
2.2.6	Evaluate incidents for effectiveness and opportunities for improvement?	50
2.3	**Model Standard: Laboratory Support for Investigation of Health Threats** *At what level does the local public health system:*	
2.3.1	Have ready access to laboratories that can meet routine public health needs for finding out what health problems are occurring?	75
2.3.2	Maintain constant (24/7) access to laboratories that can meet public health needs during emergencies, threats, and other hazards?	75
2.3.3	Use only licensed or credentialed laboratories?	100
2.3.4	Maintain a written list of rules related to laboratories, for handling samples (collecting, labeling, storing, transporting, and delivering), for determining who is in charge of the samples at what point, and for reporting the results?	100

ESSENTIAL SERVICE 3: Inform, Educate, and Empower People about Health Issues		
3.1	**Model Standard: Health Education and Promotion** *At what level does the local public health system:*	
3.1.1	Provide policymakers, stakeholders, and the public with ongoing analyses of community health status and related recommendations for health promotion policies?	50
3.1.2	Coordinate health promotion and health education activities to reach individual, interpersonal, community, and societal levels?	75
3.1.3	Engage the community throughout the process of setting priorities, developing plans and implementing health education and health promotion activities?	75
3.2	**Model Standard: Health Communication** *At what level does the local public health system:*	

3.2.1	Develop health communication plans for relating to media and the public and for sharing information among LPHS organizations?	75
3.2.2	Use relationships with different media providers (e.g. print, radio, television, and the internet) to share health information, matching the message with the target audience?	75
3.2.3	Identify and train spokespersons on public health issues?	50
3.3	**Model Standard: Risk Communication** *At what level does the local public health system:*	
3.3.1	Develop an emergency communications plan for each stage of an emergency to allow for the effective dissemination of information?	75
3.3.2	Make sure resources are available for a rapid emergency communication response?	75
3.3.3	Provide risk communication training for employees and volunteers?	50

ESSENTIAL SERVICE 4: Mobilize Community Partnerships to Identify and Solve Health Problems		
4.1	**Model Standard: Constituency Development** *At what level does the local public health system:*	
4.1.1	Maintain a complete and current directory of community organizations?	75
4.1.2	Follow an established process for identifying key constituents related to overall public health interests and particular health concerns?	75
4.1.3	Encourage constituents to participate in activities to improve community health?	75
4.1.4	Create forums for communication of public health issues?	75
4.2	**Model Standard: Community Partnerships** *At what level does the local public health system:*	
4.2.1	Establish community partnerships and strategic alliances to provide a comprehensive approach to improving health in the community?	75
4.2.2	Establish a broad-based community health improvement committee?	75
4.2.3	Assess how well community partnerships and strategic alliances are working to improve community health?	50

ESSENTIAL SERVICE 5: Develop Policies and Plans that Support Individual and Community Health Efforts		
5.1	**Model Standard: Governmental Presence at the Local Level** *At what level does the local public health system:*	
5.1.1	Support the work of a local health department dedicated to the public health to make sure the essential public health services are provided?	75

5.1.2	See that the local health department is accredited through the national voluntary accreditation program?	50
5.1.3	Assure that the local health department has enough resources to do its part in providing essential public health services?	50
5.2	**Model Standard: Public Health Policy Development** *At what level does the local public health system:*	
5.2.1	Contribute to public health policies by engaging in activities that inform the policy development process?	100
5.2.2	Alert policymakers and the community of the possible public health impacts (both intended and unintended) from current and/or proposed policies?	75
5.2.3	Review existing policies at least every three to five years?	100
5.3	**Model Standard: Community Health Improvement Process and Strategic Planning** *At what level does the local public health system:*	
5.3.1	Establish a community health improvement process, with broad- based diverse participation, that uses information from both the community health assessment and the perceptions of community members?	100
5.3.2	Develop strategies to achieve community health improvement objectives, including a description of organizations accountable for specific steps?	75
5.3.3	Connect organizational strategic plans with the Community Health Improvement Plan?	100
5.4	**Model Standard: Plan for Public Health Emergencies** *At what level does the local public health system:*	
5.4.1	Support a workgroup to develop and maintain preparedness and response plans?	100
5.4.2	Develop a plan that defines when it would be used, who would do what tasks, what standard operating procedures would be put in place, and what alert and evacuation protocols would be followed?	100
5.4.3	Test the plan through regular drills and revise the plan as needed, at least every two years?	100

ESSENTIAL SERVICE 6: Enforce Laws and Regulations that Protect Health and Ensure Safety		
6.1	**Model Standard: Review and Evaluation of Laws, Regulations, and Ordinances** *At what level does the local public health system:*	
6.1.1	Identify public health issues that can be addressed through laws, regulations, or ordinances?	75
6.1.2	Stay up-to-date with current laws, regulations, and ordinances that prevent, promote, or protect public health on the federal, state, and local levels?	75

6.1.3	Review existing public health laws, regulations, and ordinances at least once every five years?	75
6.1.4	Have access to legal counsel for technical assistance when reviewing laws, regulations, or ordinances?	100
6.2	**Model Standard: Involvement in the Improvement of Laws, Regulations, and Ordinances** *At what level does the local public health system:*	
6.2.1	Identify local public health issues that are inadequately addressed in existing laws, regulations, and ordinances?	25
6.2.2	Participate in changing existing laws, regulations, and ordinances, and/or creating new laws, regulations, and ordinances to protect and promote the public health?	25
6.2.3	Provide technical assistance in drafting the language for proposed changes or new laws, regulations, and ordinances?	25
6.3	**Model Standard: Enforcement of Laws, Regulations, and Ordinances** *At what level does the local public health system:*	
6.3.1	Identify organizations that have the authority to enforce public health laws, regulations, and ordinances?	50
6.3.2	Assure that a local health department (or other governmental public health entity) has the authority to act in public health emergencies?	50
6.3.3	Assure that all enforcement activities related to public health codes are done within the law?	100
6.3.4	Educate individuals and organizations about relevant laws, regulations, and ordinances?	25
6.3.5	Evaluate how well local organizations comply with public health laws?	50

ESSENTIAL SERVICE 7: Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable		
7.1	**Model Standard: Identification of Personal Health Service Needs of Populations** *At what level does the local public health system:*	
7.1.1	Identify groups of people in the community who have trouble accessing or connecting to personal health services?	50
7.1.2	Identify all personal health service needs and unmet needs throughout the community?	50
7.1.3	Defines partner roles and responsibilities to respond to the unmet needs of the community?	50
7.1.4	Understand the reasons that people do not get the care they need?	50

7.2	**Model Standard: Assuring the Linkage of People to Personal Health Services** *At what level does the local public health system:*	
7.2.1	Connect (or link) people to organizations that can provide the personal health services they may need?	75
7.2.2	Help people access personal health services, in a way that takes into account the unique needs of different populations?	75
7.2.3	Help people sign up for public benefits that are available to them (e.g., Medicaid or medical and prescription assistance programs)?	75
7.2.4	Coordinate the delivery of personal health and social services so that everyone has access to the care they need?	50

ESSENTIAL SERVICE 8: Assure a Competent Public and Personal Health Care Workforce		
8.1	**Model Standard: Workforce Assessment, Planning, and Development** *At what level does the local public health system:*	
8.1.1	Set up a process and a schedule to track the numbers and types of LPHS jobs and the knowledge, skills, and abilities that they require whether those jobs are in the public or private sector?	25
8.1.2	Review the information from the workforce assessment and use it to find and address gaps in the local public health workforce?	25
8.1.3	Provide information from the workforce assessment to other community organizations and groups, including governing bodies and public and private agencies, for use in their organizational planning?	25
8.2	**Model Standard: Public Health Workforce Standards** *At what level does the local public health system:*	
8.2.1	Make sure that all members of the public health workforce have the required certificates, licenses, and education needed to fulfill their job duties and meet the law?	100
8.2.2	Develop and maintain job standards and position descriptions based in the core knowledge, skills, and abilities needed to provide the essential public health services?	75
8.2.3	Base the hiring and performance review of members of the public health workforce in public health competencies?	50
8.3	**Model Standard: Life-Long Learning through Continuing Education, Training, and Mentoring** *At what level does the local public health system:*	
8.3.1	Identify education and training needs and encourage the workforce to participate in available education and training?	50
8.3.2	Provide ways for workers to develop core skills related to essential public health services?	50
8.3.3	Develop incentives for workforce training, such as tuition reimbursement, time off for class, and pay increases?	25

8.3.4	Create and support collaborations between organizations within the public health system for training and education?	50
8.3.5	Continually train the public health workforce to deliver services in a cultural competent manner and understand social determinants of health?	50
8.4	**Model Standard: Public Health Leadership Development** *At what level does the local public health system:*	
8.4.1	Provide access to formal and informal leadership development opportunities for employees at all organizational levels?	50
8.4.2	Create a shared vision of community health and the public health system, welcoming all leaders and community members to work together?	50
8.4.3	Ensure that organizations and individuals have opportunities to provide leadership in areas where they have knowledge, skills, or access to resources?	50
8.4.4	Provide opportunities for the development of leaders representative of the diversity within the community?	50

ESSENTIAL SERVICE 9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services		
9.1	**Model Standard: Evaluation of Population-Based Health Services** *At what level does the local public health system:*	
9.1.1	Evaluate how well population-based health services are working, including whether the goals that were set for programs were achieved?	75
9.1.2	Assess whether community members, including those with a higher risk of having a health problem, are satisfied with the approaches to preventing disease, illness, and injury?	75
9.1.3	Identify gaps in the provision of population-based health services?	50
9.1.4	Use evaluation findings to improve plans and services?	75
9.2	**Model Standard: Evaluation of Personal Health Services** *At what level does the local public health system:*	
9.2.1	Evaluate the accessibility, quality, and effectiveness of personal health services?	100
9.2.2	Compare the quality of personal health services to established guidelines?	100
9.2.3	Measure satisfaction with personal health services?	100
9.2.4	Use technology, like the internet or electronic health records, to improve quality of care?	25
9.2.5	Use evaluation findings to improve services and program delivery?	75

9.3	**Model Standard: Evaluation of the Local Public Health System** *At what level does the local public health system:*	
9.3.1	Identify all public, private, and voluntary organizations that provide essential public health services?	100
9.3.2	Evaluate how well LPHS activities meet the needs of the community at least every five years, using guidelines that describe a model LPHS and involving all entities contributing to essential public health services?	75
9.3.3	Assess how well the organizations in the LPHS are communicating, connecting, and coordinating services?	25
9.3.4	Use results from the evaluation process to improve the LPHS?	75

ESSENTIAL SERVICE 10: Research for New Insights and Innovative Solutions to Health Problems		
10.1	**Model Standard: Fostering Innovation** *At what level does the local public health system:*	
10.1.1	Provide staff with the time and resources to pilot test or conduct studies to test new solutions to public health problems and see how well they actually work?	50
10.1.2	Suggest ideas about what currently needs to be studied in public health to organizations that do research?	25
10.1.3	Keep up with information from other agencies and organizations at the local, state, and national levels about current best practices in public health?	75
10.1.4	Encourage community participation in research, including deciding what will be studied, conducting research, and in sharing results?	50
10.2	**Model Standard: Linkage with Institutions of Higher Learning and/or Research** *At what level does the local public health system:*	
10.2.1	Develop relationships with colleges, universities, or other research organizations, with a free flow of information, to create formal and informal arrangements to work together?	75
10.2.2	Partner with colleges, universities, or other research organizations to do public health research, including community-based participatory research?	25
10.2.3	Encourage colleges, universities, and other research organizations to work together with LPHS organizations to develop projects, including field training and continuing education?	75
10.3	**Model Standard: Capacity to Initiate or Participate in Research** *At what level does the local public health system:*	
10.3.1	Collaborate with researchers who offer the knowledge and skills to design and conduct health-related studies?	25
10.3.2	Support research with the necessary infrastructure and resources, including facilities, equipment, databases, information technology, funding, and other resources?	0

10.3.3	Share findings with public health colleagues and the community broadly, through journals, websites, community meetings, etc.?	0
10.3.4	Evaluate public health systems research efforts throughout all stages of work from planning to impact on local public health practice?	0

APPENDIX B: Qualitative Assessment Data

Summary Notes

ESSENTIAL SERVICE 1: Monitor Health Status to Identify Community Health Problems			
STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT/ PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
1.1	Model Standard: Population-Based Community Health Assessment (CHA)		
The CHA is emailed to CHIP partners. Adequate time is given to complete CHA: 2 months Data is being compared to prior years There are posters in the community to promote completing the survey There are 17 Indicators identified There is prioritizing of data and indicators The CHA is based on community needs	Disseminating CHA: there is a breakdown in communication from CHIP partners to other agencies (example-school board), knowledge of state health priorities, knowledge of healthy people 2020, around 250 out of 360 WCHIP partners responded to survey	Get goals from Healthy People 2020, DOH can look at goals, get surveys to hospital staff and doctors' offices, get base data and compare to prior year or two continuous improvement (internal monitoring), sent via email, available on website	Providers look for benchmarks and goals for patient care. (example 10 year national goal), raise awareness of assessment survey, send information home with students and use incentives to increase completion of survey, mosquito control use door hangers, use property appraisers office and clerk's office to share the information
1.2	Model Standard: Current Technology to Manage and Communicate Population Health Data		
Identifies Accessibility and access to care, email results to WCHIP partners, Florida charts: look for areas to help educate the community (example graphics to compare disease trends and averages), agency websites, availability of computers for public use	getting information to the frontline and the community, too much information sent out (too many emails), make data available to the public, geocode by zip code, census, or county	Internal organization assessments (Customer satisfaction surveys), manual bubble sheets in doctor's offices so surveys can be scanned electronically organizations share data with DOH for more specific geographical locations, better communication on websites between organizations, information tailored to audience (community story boards and billboards)	Continuity of data sets between organizations, better communication, GIS mapping system, UWF has more software, Evaluation of data from other organizations, pinpointing accessibility issues
1.3	Model Standard: Maintenance of Population Health Registries		
DOH, Healthy Start, MD offices and Hospitals, DCF, EOC, Standards: Confidentiality, Registries: Florida Shots, Epidemiology, STI	Processes are not always followed, timely reporting by doctors (communicable diseases), Confidentiality issues (depends on registry). Private providers not entering immunization records in Florida Shots. (This falls onto the schools and school health nurses), Communication of reportable diseases from DOH and providers to EOC for patients who are in special needs shelters, duplication of reporting from different agencies, breakdown of communication between agencies	Special needs shelter: export files monthly to registries to qualify patients better (EOC)	better communication between agencies of reporting to registries (child abuse and communicable diseases

ESSENTIAL SERVICE 2: Diagnose and Investigate Health Problems and Health Hazards			
STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT/ PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
2.1	Model Standard: Identification and Surveillance of Health Threats		
Existing Partnerships Knowledgeable Staff Reporting Systems (Merlin, Essence, State Warning Point, etc.)	Communication, Frequency of reporting, tobacco cessation, social media restrictions, education for the public (HIPPA-what to look for), Mental Health (emerging threats), Privacy vs Safety (HIPPA), Bioterrorism (no local team in county)	more referrals, fb promotions, clarify policies on reporting, $ for updated equipment, need for local county team, more frequent hazmat drills	more partnerships, more referrals, fb promotion, $ for specialized equipment and teams
2.2	Model Standard: Investigation and Response to Public Health Threats and Emergencies		
Developing written rules, maintaining written instructions/plans, practice, Incident Command	Practice/Evaluate (communities come together), training, resources, new events (training historically developed from past occurrences)	Need more review and/or follow up after incident	none listed
2.3	Model Standard: Laboratory Support for Investigation of Health Threats		
credential labs, written policies for handling samples	closer local lab	public labs certified so state can use	none listed

ESSENTIAL SERVICE 3: Inform, Educate, and Empower People about Health Issues			
STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT/ PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
3.1	Model Standard: Health Education and Promotion		
Health Education: schools, community, churches, educating veterans. Classes: Smoking cessation, healthy cooking, Get well network for admissions to hospitals, Health promotion through CHIP partners, educating providers about disease outbreaks and prevention, community events: 5210 promotion, child abuse prevention, helping hands, world's greatest baby shower, backpacks, screenings, press the chest	non mentioned	none mentioned	none mentioned

3.2	Model Standard: Health Communication		
Healthy start, DOH, and DCF have communication plans, websites, brochures and educational materials. Social media used by agencies other than DOH. Epidemiology DOH has database of local providers for email alerts, blast fax, media list, Incident Command, PIO talking points spelled out by Tallahassee for DOH, Healthy start has 1 hour to respond to media, DCF. Sheriff, County office and DOH have a PIO, DOH has a trained PIO, DCF has trained Administrators as PIO's Healthy Start has monthly PIO training meetings, Conference: Darkness to light by CAC, Drowning and Safe Sleep by DCF, Outcome based/theory based education, provide policy makers and public with analysis	none listed	non listed	non listed

3.3	Model Standard: Risk Communication		
Incident Command: Ever bridge Serve Florida System, Updating emergency contacts, Voicemail messaging system, hand radios. Face to face meetings to discuss plans, texting, flipchart plan: emergencies, Ex. Active shooter plan, Reports to emergency management, established lines of authority, NIMS, Television/Media, Communications Committee, Phone emergency alerts, Safety Officers	none listed	sharing information about NIMS/Incident Command Structures, knowledge of situation reports to emergency management	none listed

ESSENTIAL SERVICE 4: Mobilize Community Partnerships to Identify and Solve Health Problems

STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT/ PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
4.1	Model Standard: Constituency Development		
Zika Presentation, Immunization updates, WCHIP meetings, Coalition meetings (access) , CAT, 211 system Directory, Provider Facebook page	Getting info to community, reach county wide engagement area agencies, general population awareness of 211 (north end), south end awareness of WCHIP, address uniqueness in geographic areas, assumption community has electronic media access	Agency fair, county wide engagement, 211 agency advertisement	getting information to community, electronic media accessible to community

4.2	Model Standard: Community Partnerships		
WCHIP, BOCC, Animal Control, Healthy Start, COPE/DCF, Sacred Heart, Chamber of Commerce, Hospice, Mental, Jobs plus, Tricounty, Council on aging, Pancare, career source, law enforcement, 5210, surveys, re evaluations	community involvement, transportation, gap between south and north ends of the county	broader distribution of wchip evaluations	transportation, bridge north/south gap, media coverage

ESSENTIAL SERVICE 5: Develop Policies and Plans that Support Individual and Community Health Efforts			
STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT/ PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
5.1	Model Standard: Governmental Presence at the Local Level		
DCF, Birth Certificates, Death Certificates and nutrition, WIC, school health screenings, Healthy start, Tax collectors, Vital Statistics ID's, DCF has PSA's, Tax collectors has a TV channel or videos playing in waiting area, Healthy start does home visits, parenting classes, smoking cessation classes, breast feeding support, DOH extra hours and after hours clinics, statewide public health messages, taxpayers participation outside agencies, sharing information with the public, statutes accreditation boards, standards, audits, monitor to make sure meeting standards. Services: Ob, environmental immunizations dental safe water, healthy start, community health, staff availability	none listed	none listed	none listed

5.2	Model Standard: Public Health Policy Development		
Tax collectors: updates of legislative changes, weekly meetings; DOH: Identify needs guidelines for dealing with hazards, School Health: reviewing policies every 3-5 years and updating policies; (DOH: Ex Tobacco policies)	none listed	none listed	none listed

5.3	Model Standard: Community Health Improvement Process and Strategic Planning		
State plan and CHIP have some shared goals, DCF: Substance abuse/mental health efforts aligned	none listed	put state improvement plan and CHIP plan in alignment	none listed

5.4	Model Standard: Plan for Public Health Emergencies		
coalition of community partners, emergency response plan revised every year, DCF: table tops, call downs, School: Fire Drills	none listed	none listed	none listed

ESSENTIAL SERVICE 6: Enforce Laws and Regulations that Protect Health and Ensure Safety			
STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT/ PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
6.1	Model Standard: Review and Evaluation of Laws, Regulations, and Ordinances		
Keeping up with the laws	look for new issues -get local collaboration, Communication (come county ordinances not passed along), laws aren't always current	Better communication between providers with HIPPA issues. (what is required vs. what is actually provided), better interpretation of what services can be given (waivers), tap into using more social media news, own agency to keep up to date information	none listed
6.2	Model Standard: Involvement in the Improvement of Laws, Regulations, and Ordinances		
EH has input into rules 7 reg with legislature	not all organizations can participate in changing laws	use EH model to gain participation in legislature to change laws/regulations	none listed
6.3	Model Standard: Enforcement of Laws, Regulations, and Ordinances		
Organization staying within laws	not all organizations know how to enforce laws, funding for more education has dropped, people over-educated via internet - often wrong information, time and man power	none listed	none listed

ESSENTIAL SERVICE 7: Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable			
STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT/ PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
7.1	Model Standard: Identification of Personal Health Service Needs of Populations		
DOH, PanCare, Sacred Heart community health needs assessment tool, We Care surveys, BRFFS phone survey	transportation, stigmatism, barriers to care, fear of health issues, providers accepting Medicaid for area, access surveys, funding (meeting needs advertising)	Identify vulnerable population, go where target groups are, incentives	process to identify barriers to personal healthcare
7.2	Model Standard: Assuring the Linkage of People to Personal Health Services		
navigators (ER diversions), WCHIP, Discharge planners, cope, 211 resource, DOH gives sheer with community resources, emergent care, insurance specialists	gaps, no funding for referrals for abnormal results, follow up, tobacco referrals	ensure services provided in correct location (example ER vs clinic)	none

ESSENTIAL SERVICE 8: Assure a Competent Public and Personal Health Care Workforce			
STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT/ PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
8.1	Model Standard: Workforce Assessment, Planning, and Development		
none listed	participation-laws require certain standards	participation	participation
8.2	Model Standard: Public Health Workforce Standards		
none listed	awareness of public health competencies, lack of qualified applicants and job location	none listed	none listed
8.3	Model Standard: Life-Long Learning through Continuing Education, Training, and Mentoring		
none listed	Quality of training provided (I.e. webinars, no hands on experience etc.) no incentive to continue education-no raise, but more	none listed	none listed

	responsibilities, don't always relate training with 10 services		

8.4	Model Standard: Public Health Leadership Development		
none listed	Diverse leadership (weak on recruitment), willingness to participate, create the atmosphere of collaboration, but not all leaders will come together	Incentives	none listed

ESSENTIAL SERVICE 9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services

STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT/ PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
9.1	Model Standard: Evaluation of Population-Based Health Services		
all ages/demographics, monthly review, DOH annual reviews (more often), County Health rankings, customer surveys, evaluating service delivery and adjusting accordingly	system abuse, SSI/Seniors benefits, funding	look at internal process	sufficient income for individuals to survive
9.2	Model Standard: Evaluation of Personal Health Services		
BRFFS, AHEC, LECOM,Pancare, CVHN, Physician portal, HEDIS/ FQHC, Patient advisory, Sacred Heart Council, Organizational survey's	lack of providers for personal healthcare, dental services, lack of connectivity between providers	On line referral program for Quit Tobacco, Connectivity between providers	Providing input from users of services and possible future users, connectivity between providers
9.3	Model Standard: Evaluation of the Local Public Health System		
NACHO, local assessment process, WCHIP Involvement	local partners participation, assumption everyone knows what everyone is doing, countywide engagement	updated participants list, evaluate relationships that comprise LPHS, Facebook page, ESF meetings, survey why participants did not attend assessment	evaluate relationships that comprise LPHS

ESSENTIAL SERVICE 10: Research for New Insights and Innovative Solutions to Health Problems

STRENGTHS	WEAKNESSES	OPPORTUNITIES FOR IMMEDIATE IMPROVEMENT/ PARTNERSHIPS	PRIORITIES OR LONGER TERM IMPROVEMENT OPPORTUNITIES
10.1	Model Standard: Fostering Innovation		
School Health, Healthiest Weight/BMI class in high schools, diabetes A-1C, garden in a bucket, sacred heart get well project	Sharing Best Practices	none listed	none listed
10.2	Model Standard: Linkage with Institutions of Higher Learning and/or Research		
best practices maternal fetal Sacred Heart, DOH LPN/Nurse Practitioners, DCT, Statewide program Smoking during pregnancy, Lecom Internship education only	none listed	none listed	none listed
10.3	Model Standard: Capacity to Initiate or Participate in Research		
Clinical trials-Dr Howell, Dr Chapman, Workforce training	none listed	none listed	none listed

General

APPENDIX C: Additional Resources

Association of State and Territorial Health Officers (ASTHO)
http://www.astho.org/

CDC/Office of State, Tribal, Local, and Territorial Support (OSTLTS)
http://www.cdc.gov/ostlts/programs/index.html

Guide to Clinical Preventive Services http://www.ahrq.gov/clinic/pocketgd.htm

Guide to Community Preventive Services
www.thecommunityguide.org

National Association of City and County Health Officers (NACCHO)
http://www.naccho.org/topics/infrastructure/

National Association of Local Boards of Health (NALBOH)
http://www.nalboh.org

Being an Effective Local Board of Health Member: Your Role in the Local Public Health System
http://www.nalboh.org/pdffiles/LBOH%20Guide%20-%20Booklet%20Format%202008.pdf

Public Health 101 Curriculum for governing entities
http://www.nalboh.org/pdffiles/Bd%20Gov%20pdfs/NALBOH_Public_Health101Curriculum.pdf

Accreditation

ASTHO's Accreditation and Performance Improvement resources
http://astho.org/Programs/Accreditation-and-Performance/

NACCHO Accreditation Preparation and Quality Improvement
http://www.naccho.org/topics/infrastructure/accreditation/index.cfm

Public Health Accreditation Board
www.phaboard.org

Health Assessment and Planning (CHIP/ SHIP)

Healthy People 2010 Toolkit:

Communicating Health Goals and Objectives
http://www.healthypeople.gov/2010/state/toolkit/12Marketing2002.pdf Setting Health Priorities and Establishing Health Objectives
http://www.healthypeople.gov/2010/state/toolkit/09Priorities2002.pdf

Healthy People 2020: www.healthypeople.gov

MAP-IT: A Guide To Using Healthy People 2020 in Your Community
http://www.healthypeople.gov/2020/implementing/default.aspx

Mobilizing for Action through Planning and Partnership:
http://www.naccho.org/topics/infrastructure/mapp/

MAPP Clearinghouse
http://www.naccho.org/topics/infrastructure/mapp/framework/clearinghouse/ MAPP

Framework http://www.naccho.org/topics/infrastructure/mapp/framework/index.cfm

National Public Health Performance Standards Program
http://www.cdc.gov/nphpsp/index.html

Performance Management /Quality Improvement

American Society for Quality; Evaluation and Decision Making Tools: Multi-voting
http://asq.org/learn-about-quality/decision-making-tools/overview/overview.html

Improving Health in the Community: A Role for Performance Monitoring
http://www.nap.edu/catalog/5298.html

National Network of Public Health Institutes Public Health Performance Improvement Toolkit
http://nnphi.org/tools/public-health-performance-improvement-toolkit-2

Public Health Foundation – Performance Management and Quality Improvement
http://www.phf.org/focusareas/Pages/default.aspx

Turning Point
http://www.turningpointprogram.org/toolkit/content/silostosystems.htm

US Department of Health and Human Services Public Health System, Finance, and Quality Program
http://www.hhs.gov/ash/initiatives/quality/finance/forum.html

Evaluation

CDC Framework for Program Evaluation in Public Health
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4811a1.htm

Guide to Developing an Outcome Logic Model and Measurement Plan (United Way)
http://www.yourunitedway.org/media/Guide_for_Logic_Models_and_Measurements.pdf

National Resource for Evidence Based Programs and Practices
www.nrepp.samhsa.gov

W.K. Kellogg Foundation Evaluation Handbook
http://www.wkkf.org/knowledge-center/resources/2010/W-K-Kellogg-Foundation-Evaluation-Handbook.aspx

W.K. Kellogg Foundation Logic Model Development Guide
http://www.wkkf.org/knowledge-center/resources/2006/02/WK-Kellogg-Foundation-Logic-Model-Development-Guide.aspx

Walton Community Health Improvement Partnership (WCHIP)

Community Themes and Strengths Assessment

Mobilizing for Action through Planning and Partnerships (MAPP)

Vision:

Prepared by the Florida Department of Health in Walton County
November 2015
For more information, contact Jamie.Carmichael@flhealth.gov 850-892-8040 x 1266

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Introduction

June of 2015, the Walton County MAPP Executive Committee (WCHIP Steering Committee) embarked on a journey to develop a Community Health Assessment (CHA) using the Mobilizing for Action through Planning and Partnerships (MAPP) process. 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.

A community health needs assessment is a process that:

- Describes the state of health of the local population;
- Enables the identification of the major risk factors and causes of ill health; and
- Enables the identification of the actions needed to address these identified issues.

The MAPP process includes four assessment tools, as shown in the graphic below.

MAPP Model, Achieving Healthier Communities MAPP User's Handbook

http://www.naccho.org

Within the MAPP process, there are four assessment tools. One of these assessment tools is the Community Themes and Strengths Assessment (CTSA). The purpose of the CTSA is to gain a better understanding of community perceptions about health and quality of life; to provide useful information for local programmatic and fiscal decision-making; and to inform the development of a strategic community health improvement plan. Surveys and a focus group were used to gather insight into issues of concern, as well as local assets and resources related to health and quality of life. The report begins with an overall description of community members who participated in the assessment. A summary table of the identified themes is followed by sections highlighting the most frequent themes.

The Community Themes and Strengths Assessment (CTSA) answers the questions: "What is important to our community?" "How is quality of life perceived in our community?" "What assets do we have that can be used to improve community health?" This assessment results in a stronger understanding of community issues and concerns, and perceptions about quality of life.

In July and August of 2015, the Florida Department of Health in Walton County, WCHIP, and Sacred Heart Hospital jointly conducted a Community Health Assessment in Walton County. The survey was distributed to the general and vulnerable populations, and was made available in paper and online format. Recipients were encouraged to complete the survey and to forward to others. The survey focused on identifying respondent perceptions of the most important factors for a healthy community, most important health problems and risky behaviors in Walton County.

CTSA Survey Results - 253 community wide surveys were used for this assessment, along with 30 surveys from Health and Human Services organizations. Community health survey is included as Appendix A. Copy of the e-mail and letter sent to community partners requesting participation in distributing the community surveys is also included as Appendix B.

Demographic questions of the survey concentrated on age, ethnic group and race, educational level, gender, zip code of residence, number of people in household, household income level, and how respondents pay for health care.

Community Surveys

- Health and Human Services Organizations – 30
- Community Wide – 253 (160 online, 93 paper)

	Respondents	Walton Population*
Female	86%	49%
Black/African American	7.5%	5.9%
White/Caucasian	90%	84.2%
Bachelor's degree or higher	36.4%	24.1%
Unemployed	4.8%	4.4%
Income less than $35,001/year	45%	Median Income $43,640

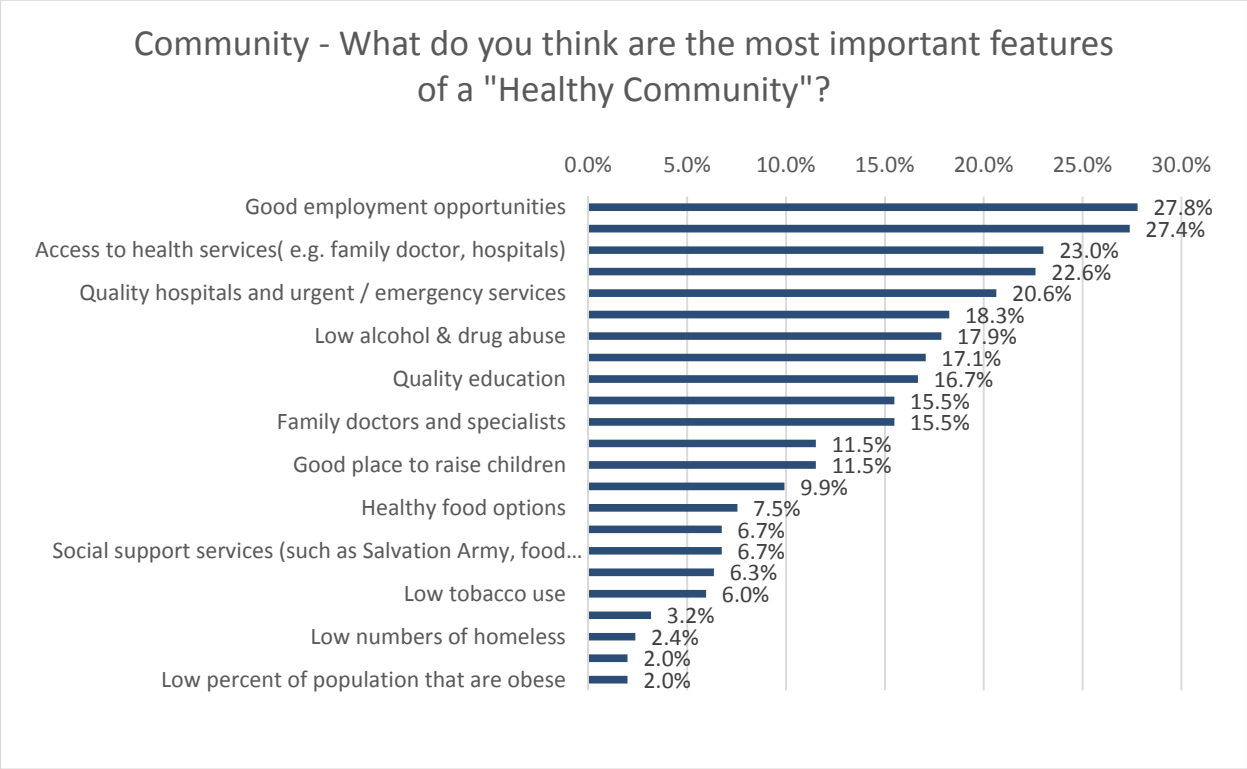
** Census "Quick Facts"*

- **What is your age?**
  - 18 – 24 (20)
  - 25 – 34 (51)
  - 35 – 44 (44)
  - 45 – 54 (50)
  - 55 – 74 (79)
  - 75+ (9)

- **How do you pay for your healthcare?**
  - Cash, i.e., no insurance (20)
  - Health insurance (149)
  - Medicaid (40)
  - Medicare (23)
  - VA or Military (13)
  - Other (3)
  - Skipped question (5)

Healthy Community?

Health & Human Services Organizations	Community
• Access to health services(e.g. family doctor, hospitals) • Quality hospitals and urgent / emergency services • Good employment opportunities • Good schools • Low alcohol & drug abuse	• Good employment opportunities • Low crime / safe neighborhoods • Access to health services(e.g. family doctor, hospitals) • Good schools

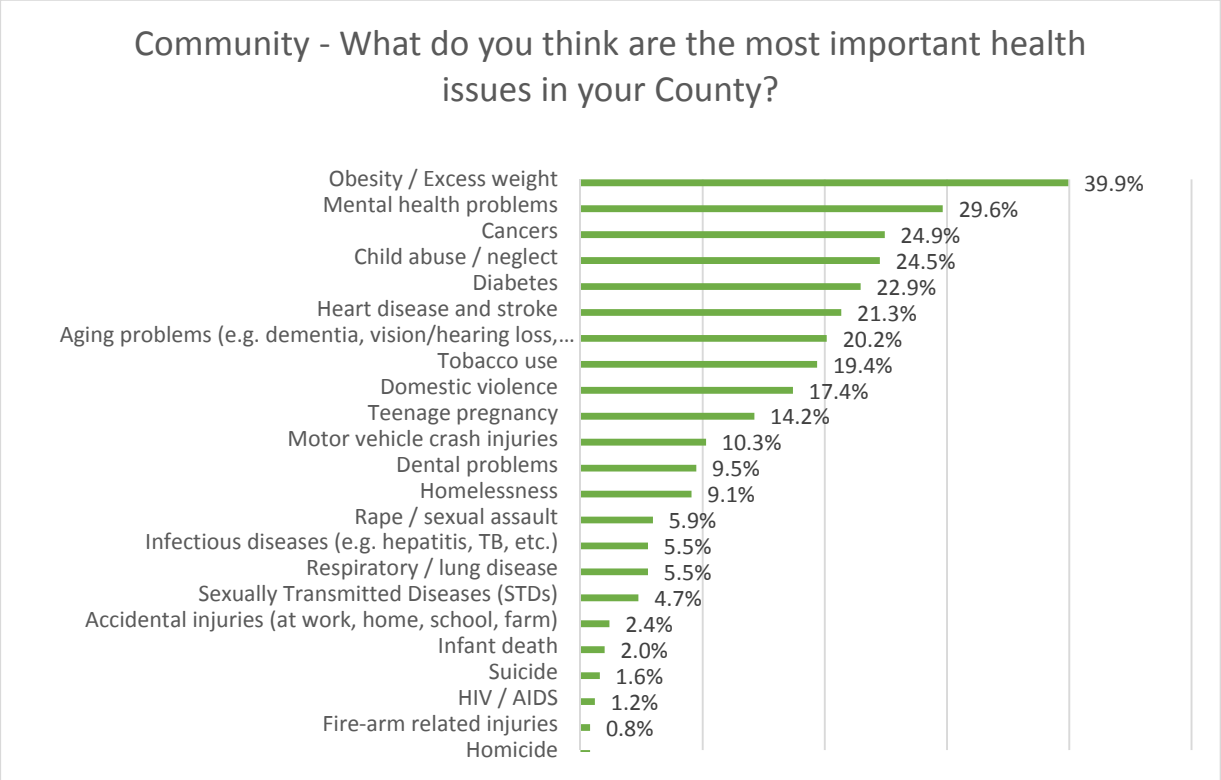


Why is this important?

- Quality of Life (QOL) is a construct that "connotes an overall sense of well-being when applied to an individual" and a "supportive environment when applied to a community" (Moriarty, 1996).
- While some dimensions of Quality of Life can be quantified using indicators, research has shown QOL to be related to determinants of health and community wellbeing.
- Other valid dimensions of QOL include perceptions of community residents about aspects of their neighborhoods and communities that either enhance or diminish their quality of life.

Health Issues in Community?

Health & Human Services Organizations	Community
• Heart disease and stroke	• Obesity / Excess weight
• Mental health problems	• Mental health problems
• Cancers	• Child abuse / neglect
• Obesity / Excess weight	• Cancers
• Aging problems (e.g. dementia, vision/hearing loss, loss of mobility)	• Heart disease and stroke
• Diabetes	• Diabetes

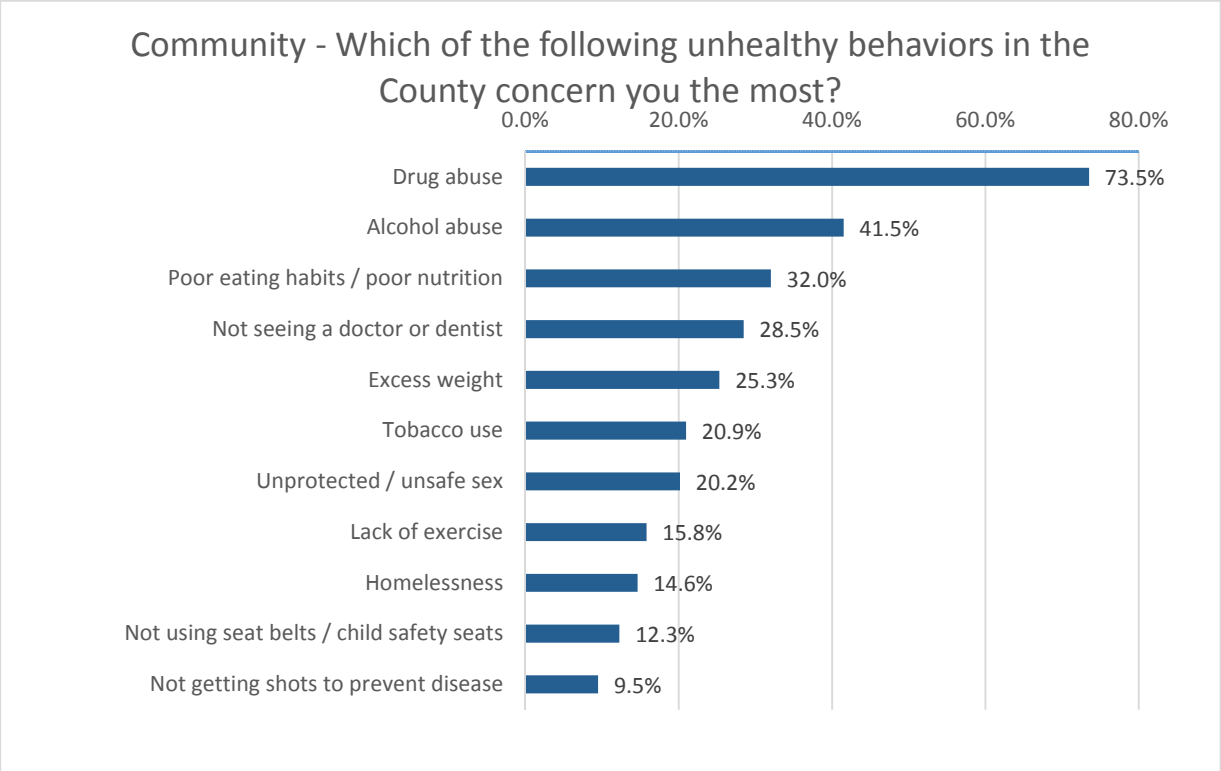


Why is this important?

- This information leads to a portrait of the community as seen through the eyes of its residents.
- Perception about the health problems that exist in Walton County correlate with county-specific data and help to pinpoint specific concerns.

Most Concerning Behaviors?

Health & Human Services Organizations	Community
• Drug abuse	• Drug abuse
• Excess weight	• Alcohol abuse
• Poor eating habits / poor nutrition	• Poor eating habits / poor nutrition
• Not seeing a doctor or dentist	• Not seeing a doctor or dentist
• Alcohol abuse	• Excess weight
• Lack of exercise	• Tobacco use
• Tobacco use	

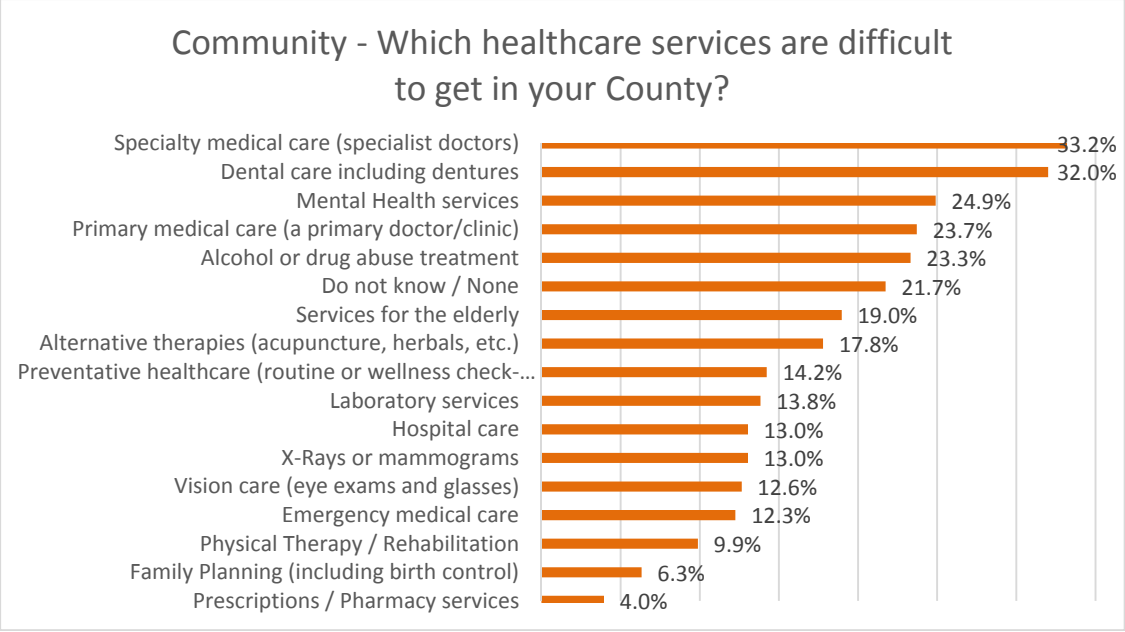


Why is this important?

- High-risk behaviors, by definition, are lifestyle activities that place a person at increased risk of suffering a particular condition.
- Risky behaviors put you at risk for a bad consequence, i.e., smoking puts you at risk for cancer and being overweight puts you at risk for a heart attack.
- Systematic change using evidence-based interventions to change high-risk behaviors is recommended by the Independent Task Force on Community Preventive Services - www.thecommunityguide.org.

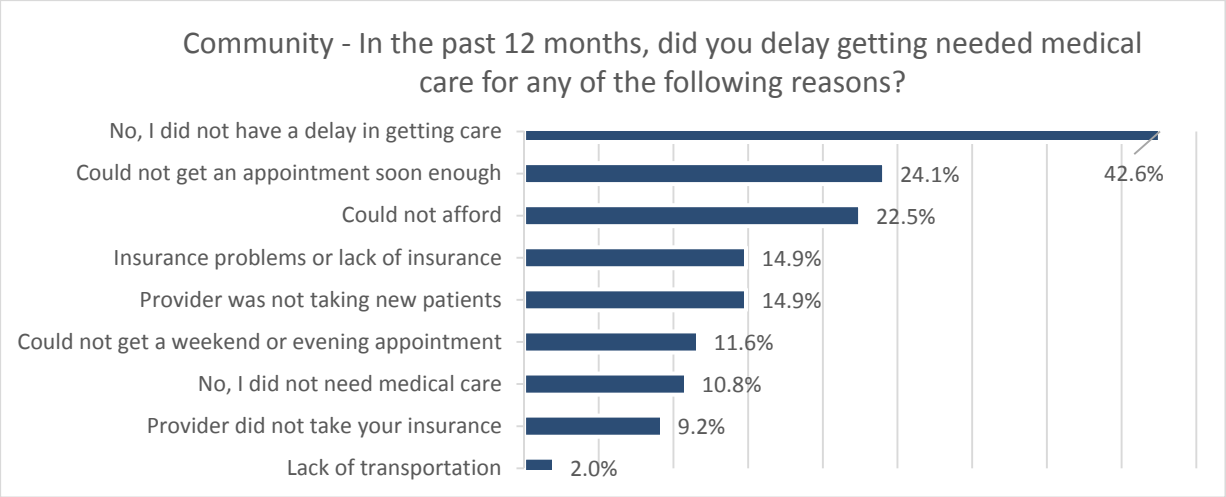
Hard to Get Health Services?

Health & Human Services Organizations	Community
• Specialty medical care (specialist doctors)	• Specialty medical care (specialist doctors)
• Primary medical care (a primary doctor/clinic)	• Dental care including dentures
• Alcohol or drug abuse treatment	• Mental Health services
• Mental Health services	• Primary medical care (a primary doctor/clinic)
• Services for the elderly	• Alcohol or drug abuse treatment
• Alternative therapies (acupuncture, herbals, etc.)	
• Preventative healthcare (routine or wellness check-ups, etc.)	



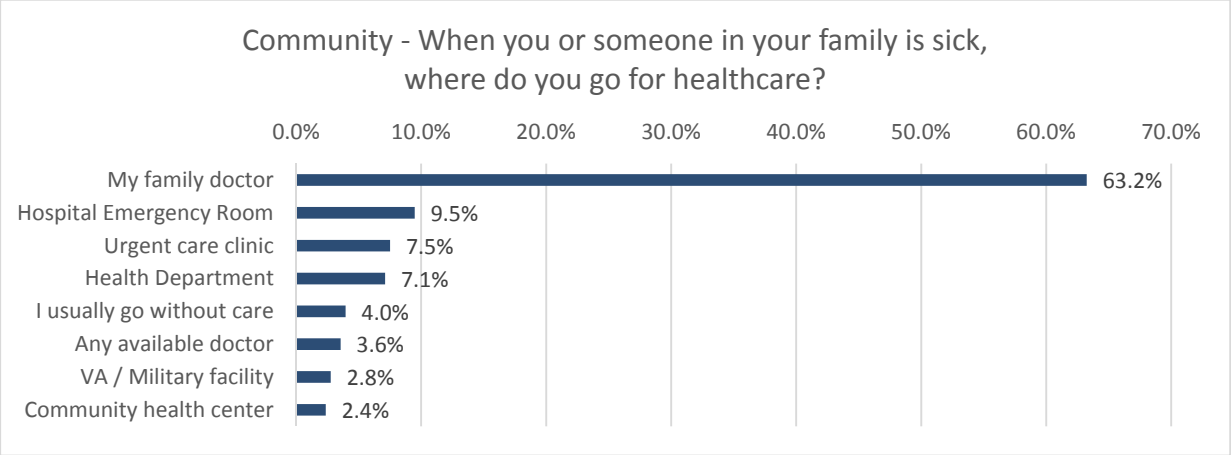
Delayed Medical Care?

General Population	Vulnerable Population
• Did not have a delay in getting care • Could not get an appointment soon enough • Provider was not taking new patients • Could not afford	• Did not have a delay in getting care • Could not afford • Insurance problems or lack of insurance



Where to go for Sick Care?

General Population	Vulnerable Population
• My family doctor • Urgent care clinic	• My family doctor • Hospital Emergency Room • Health Department



CTSA Focus Group Discussion – On November 17, 2015, the Walton County MAPP Executive Committee conducted a focus group discussion to explore perceptions of health and well-being among Walton County residents. The focus group was conducted as part of a comprehensive community health assessment process that utilized the Mobilizing for Action through Planning and Partnerships (MAPP) framework as a guide. The focus group served to meet the intent of the Community Themes and Strengths Assessment (CTSA) from a partnership's perspective.

The focus group lasted approximately 55 minutes and covered seven questions:

1. *Are you satisfied with the quality of life in our community?*
2. Is this community a good place to raise children and grow older?
3. *What do you believe are the 2-3 most important characteristics of a healthy community?*
4. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?
5. What do you believe is keeping our community from doing what needs to be done to improve health and quality of life?
6. *What do you believe are the 2-3 most important issues that must be addressed to improve the health and quality of life in our community?*
7. What makes you most proud of our community?

The narrative summary for questions one, three, and six are combined due to similarity in responses across the three questions.

Questions #1, #3, and #6:

- **Are you satisfied with the quality of life in Walton County?**
- **What do you believe are the 2-3 most important characteristics of a healthy community?**
- **What do you believe are the 2-3 most important issues that must be addressed to improve the health and quality of life in our community?**

The focus group participants stated that they were not happy with the quality of life in Walton County. The poverty level is very concerning and does not seem to improve despite recent business developments that have brought jobs to the area. They are concerned about the availability of affordable housing for low income families and rental properties in general. The schools are overcrowded. There is a high number of single parent (mothers) families in the community. Medicaid providers have declined in the community as a result of the Medicaid program transitioning into managed care. Dental providers that accept Medicaid for children cannot meet the needs of the community.

Participants agreed that the community's infrastructure is the backbone to providing a healthy community. Schools and educational opportunities are also imperative for a healthy community to be able to afford its' residents the opportunities to have careers and thrive able wage incomes. Job opportunities are necessary for a healthy community and we are seeing some come as a result of the new growth. But many new job positions may be filled from

outlying counties because our residents do not have the necessary education, technical training, or job skills. In order to have a healthy community, you need to have adequate access to healthcare. Walton County is considered a medically underserved county. Specialists are in short supply within the county and most are located outside of the county necessitating considerable amount of travel. In addition to location of the care, there is a shortage of providers accepting the medical insurance, Medicare, or Medicaid health plan that the residents have coverage with. Also mentioned was the need for a safe transportation system so that the residents can have access to all services available to them within the county. With a good transportation system, more of the county residents would feel empowered by having the ability to participate in community events and get to where they need to by using a reliable method.

By addressing jobs, wages, and transportation the focus group participants felt we could improve the community's health and quality of life. Having a job helps eliminate stressors affecting mental health, and allows families to interact more socially. Improved wages also relieves some stressors and stimulates involvement within the community. It also affords residents opportunities to obtain insurance and utilize preventive health services. An affordable transit authority would benefit all citizens regardless of age or income. Affordable transportation would increase residents' ability to access medical care, employment, education/job training, and even grocery shopping/access to healthy foods.

Question #2: Is this community a good place to raise children and grow older?

Participants indicated that they enjoy living in Walton County due to the atmosphere and its residents. Walton County has a low crime rate. There are a lot of churches and faith based organizations. There is a good sense of community and it is quiet. It is a great place to live if you have money. However, there is an issue with transportation. And if you can get a job, it is low paying causing stress to build up within the family and children suffer.

Question #4: Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?

Groups provide too many services and government is part of the problem. There are too many free services. The culture of the population may keep people from asking for help. Educate low income population to manage their budgets. Budget management is not being taught in the schools.

Question #5: What do you believe is keeping our community from doing what needs to be done to improve health and quality of life?

Our community does step up when a need is identified. The lack of transportation deters residents from being as involved as they may would like. Residents have little input in increasing the availability of affordable housing. There is a lack of availability and participation in programs that residents can become invested in to improve their situation, i.e. Habitat for

Humanity. We are ineffective in bridging the gap between cultures due to language barriers. Wages from jobs that are available fail to have what is referred to as a "thrive able wage".

Question #7: What makes you most proud of our community?

The focus group participants agreed that the community steps up. Walton County is a working community and always looks out for the wellbeing of the residents within it.

Data Analysis

The following procedure was utilized for data analysis:

- Review the notes from the focus group;
- Code and categorize the responses for each question to identify themes;
- Summarize findings for each question; and
- Identify any patterns or connections between the questions.

RESULTS

This section provides a narrative summary of themes based upon the focus group discussion. The results are reported by question.

Participants did not use one-word answers to describe health and quality of life in Walton County. Participants discussed several areas where they felt change was needed. Similar issues were mentioned when participants were asked to focus on the most important issues affecting health and quality of life in Walton County. These recurring issues were themed and divided into two main categories, socioeconomic issues and health-related issues. Table 1 summarizes the themes that emerged within each category. A narrative description of each category and its associated themes follows.

Table 1: Summary of Themes

Socioeconomic Issues	Health-Related Issues
Poverty Education Employment Transportation	Access to Care Cultural Diversity

The **SOCIOECONOMIC CATEGORY** includes issues related to poverty, affordable housing, education, employment, and transportation. The focus group indicated that socioeconomic issues are more prevalent in the northern part of the county.

Key issues related to the theme of **POVERTY** included:

- A cycle of poverty exists among families in Walton County
- More assistance is needed with affordable housing and health care; especially for "working poor". Concerned with housing shortage
- Residents need to empower themselves
- The cycle of hopelessness – if it is not broken it will continue
- Increase in single mothers

Key issues related to the theme of **EDUCATION** included:

- Schools are overcrowded
- Educate low income population on budget management – children are not being taught budget management in schools
- Need more opportunities for residents to become educated for jobs available in Walton County resulting from growth, i.e. vocational and technical.

Key issues related to the theme of **EMPLOYMENT** included:

- Quality of life is strongly related to quality of jobs within the county
- There is a connection between education and employment; residents are currently limited by lack of education to be qualified for new jobs coming into area due to growth
- The majority of the jobs in the county are of minimal scale and minimal pay - If you can get a job, it is low paying causing stress to build up in family and children suffer
- Residents seek better paying opportunities outside the county
- Youth lack a strong work ethic

Key issues related to the theme of **TRANSPORTATION** included:

- Many residents do not have a vehicle, or their vehicle is unreliable
- Public transportation is very limited and there is a lack of transportation for the disabled
- Northern part of the county seeks services across state lines because it is closer to travel and they have no other option

Common issues mentioned by the focus group in the **HEALTH CATEGORY** included access to care and cultural diversity (language barriers).

Key issues related to the theme of **ACCESS TO CARE** included:

- Lack of "Medicaid" providers for medical and dental services, forcing residents to go out of county for services or do without
- The new dental school is not providing low cost pricing for services
- Residents required to drive more than 20 miles for medical help
- Many residents lack health care insurance
- Walton County lacks specialty doctors

- It is hard to recruit physicians to practice in a rural county
- Community does not use the rural clinics available to them
- Lack of providers accepting the Medicare Advantage plans
- Residents required to drive more than 20 miles to see a provider who accepts their insurance plan

Key issues related to the theme of **CULTURAL DIVERSITY** included:

- More and more residents need interpreters when seeking healthcare services
- Providers need to know how to treat residents from other ethnicities
- The culture of the population may keep people from asking for help
- Anticipated growth will lead to changes in health indicators driven by cultural differences

COMMUNITY STRENGTHS AND WEAKNESSES (OPPORTUNITIES FOR IMPROVEMENT) created from community surveys, health and human service organization surveys, and focus group discussion:

Table 2: Community Strengths and Weaknesses

What are the greatest strengths of Walton County? (Strengths)	What are some of our community weaknesses? (Opportunities for Improvement)
• Resources • Volunteers/Mentoring • Faith Based Organizations • Safety • Good mixture of income levels • Future growth • Collaboration • Low pollution • Technical training in high schools • Future technical skilled jobs • Boys & Girls Club • Environment/Location/Weather • County Finances • Recreational facilities • Good Healthcare providers	• Transportation • Quick growth/Infrastructure • Jobs with thrive able wage • Substance abuse • Lack healthcare providers – location • Lack of insurance coverage • Housing – affordable/rentals • Lack of specialty physicians • Lack of empowerment programs • Communication within the community • Health Issues: **Obesity/Excess Weight, Mental health problems, Cancers,* Child Abuse/Neglect, Heart disease and stroke • Health Behaviors: *Drug abuse,* Alcohol abuse, *poor eating habits/poor nutrition, not seeing a doctor or dentist, excess weight*

Top choices from both the community and health/human service organization surveys

FINAL COMMENTS & NEXT STEPS

The information gathered from the focus group was compiled for consideration along with the other assessments being conducted as part of the overall community health assessment project. Connections between recipients' perceptions of health and wellbeing will be cross referenced with health status indicator data in an effort to identify similar themes that may inform the development of the community health improvement plan.

Community Health Survey

Walton County

The purpose of the following survey is to get your opinions about community health issues in Walton County . The Florida Department of Health offices in Walton Counties will use the results of this survey to identify health priorities for community action. This survey will take about 5-10 minutes to complete. Your opinion is important. This survey is valid through August 28, 2015, so please respond by that date to have your opinions counted.

Thank you for taking the time to provide it. If you have any questions, please contact Laura.Brazell@flhealth.gov

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

- ☐ Good race relations
- ☐ Low numbers of sexually transmitted disease *(STDs)*
- ☐ Good schools
- ☐ Low crime / safe neighborhoods
- ☐ Low tobacco use
- ☐ Low percent of population that are obese
- ☐ Religious or spiritual values
- ☐ Family doctors and specialists
- ☐ Low numbers of homeless
- ☐ Affordable housing
- ☐ Access to health services(*e.g. family doctor, hospitals)*
- ☐ Quality education
- ☐ Social support services *(such as Salvation Army, food pantries, Catholic charities, Red Cross, etc.)*
- ☐ Good transportation options
- ☐ Low alcohol & drug abuse
- ☐ Clean environment *(clean water, air, etc.)*
- ☐ Arts and cultural events
- ☐ Healthy food options
- ☐ Good employment opportunities
- ☐ Active lifestyles / outdoor activities
- ☐ Good place to raise children
- ☐ Mental health services
- ☐ Quality hospitals and urgent / emergency services

Community Health Survey - Walton County VP

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

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

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

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

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

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

Community Health Survey - Walton County VP

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

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

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

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

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

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

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

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

9. When a doctor prescribes medicine for you or a family member, what do you do?

- ○ Use leftover medicine already at home
- ○ Use someone else's medicine
- ○ Fill the prescription at a pharmacy
- ○ Go without medicine
- ○ Use herbal or natural therapies instead
- ○ Buy an over the counter medicine

Community Health Survey - Walton County VP

10. Which healthcare services are difficult to get in your County?

Check all answers that apply.

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

11. In the past 12 months, did you delay getting needed medical care for any of the following reasons?

Check all answers that apply.

- ☐ No, I did not have a delay in getting care
- ☐ Could not get an appointment soon enough
- ☐ No, I did not need medical care
- ☐ Provider did not take your insurance
- ☐ Lack of transportation
- ☐ Could not afford
- ☐ Insurance problems or lack of insurance
- ☐ Could not get a weekend or evening appointment
- ☐ Language barriers or could not communicate
- ☐ Provider was not taking new patients

12. When you or someone in your family is sick, where do you go for healthcare?

- ○ Hospital Emergency Room
- ○ My family doctor
- ○ Any available doctor
- ○ Urgent care clinic
- ○ Health Department
- ○ Community health center
- ○ Free clinic
- ○ VA / Military facility
- ○ I usually go without care

Community Health Survey - Walton County VP

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

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

14. Overall, how would you rate the quality of healthcare services available in your County?

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

15. Do you currently use any tobacco products?

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

16. How would you rate your own health today?

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

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

- ○ Strongly Agree
- ○ Agree
- ○ Disagreee
- ○ Strongly Disagree

Community Health Survey - Walton County VP

18. What are the top three (3) reasons that prevent you from eating healthier foods and being active?

Check only three.

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

19. What is the zip code where you live?

20. Are you male or female?

- ○ Male
- ○ Female

21. What is your race?

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

22. What is your age?

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

Community Health Survey - Walton County VP

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

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

24. What is your current employment status?

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

25. What is your annual family income?

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

26. Where did you take this survey?

- Church
- WIC
- Health Clinic
- Health Fair
- Health Department
- COPE Center

Other (please specify)

Thank you for taking this survey.

Brazell, Laura L

Subject: Action Needed: Assist WCHIP to distribute Community Health Needs Assessment (CHNA)

Attachments: Walton Survey VP.PDF; CHNA Overview 07.27.15.pdf

Importance: High

Dear WCHIP members,

Please assist us to distribute the Walton Community Health Needs Assessment

First, we invite you to share your voice by taking the Community Health Survey found at:
www.surveymonkey.com/r/HealthSurveyWalton.
Completing the survey should take less than 10 minutes.
The survey is open until August 28, 2015.

Second, please distribute the survey link. Please share the survey link with your members, clients, and fellow employees; on your website or in your newsletters; with your friends and church groups; with community or professional organizations; and anyone that lives in Walton County. Sample messages are in the attached CHNA Overview.

Finally, please assist us to distribute hard copy surveys to those that are not able to access the web based survey. These are usually our more vulnerable populations. We would like for you to distribute hard copies of the surveys to your clients and return those hard copies to the Florida Department of Health in Walton County. Brandi.Gill@flhealth.gov and Laura.Brazell@flhealth.gov are available to make copies for you and will accept your completed surveys. Instructions available in the CHNA Overview attached.

Thank you in advance for your assistance to distribute this Community Health Needs Assessment.
Sincerely,
Laura Brazell

Laura L. Brazell, R.N., BS HCA
Registered Nursing Consultant
(850) 892-8040, ext. 1163

Laura.Brazell@flhealth.gov

Mobile Phone (850) 401-4029

Florida Department of Health in Walton County

http://www.floridahealth.gov/chdwalton/

362 State Hwy 83
DeFuniak Springs, FL 32433

Mission:
To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.

Florida HEALTH
Walton County

Vision: To be the **Healthiest State** in the Nation

Rick Scott
Governor

John H. Armstrong, MD, FACS
State Surgeon General & Secretary

July 27, 2015

To Whom It May Concern:

The 2012 Community Health Needs Assessment for Walton County showed an unfavorable comparison to peer county and state rates in many health indicators. In response, the Walton Community Health Improvement Plan was developed as a community resource for strategies that impact the three priority areas for improving our community's health:

1. Improve healthy behaviors,
2. Increase use of screening services, preventive services and /or primary care services, and
3. Increase awareness of local resources

The Florida Department of Health in Walton County is currently working to gain greater insights surrounding the three priority areas as well as residents' perceptions of the community's health and barriers to becoming the healthiest counties in Florida. The information gathered from these surveys will help guide future efforts to improve the health of Walton County residents.

We cannot understand our community fully without your input as a community member.
We invite you to share your voice by taking the Community Health Survey found at:
www.surveymonkey.com/r/HealthSurveyWalton.
Completing the survey should take less than 10 minutes.
The survey is open until August 28, 2015.

Additionally, we hope that you would also help to share the survey further using the same link. Attached are several messages to help pass the word. Suggested distribution includes:

- Your members or clients
- Fellow employees
- Organization website or newsletter
- Blogs and social media
- Friends
- Media
- Church groups
- Community / professional organizations
- Anyone that lives in Walton County

Distribution of the Community Health Needs Assessment to Vulnerable Populations

To ensure that we receive input from our more vulnerable populations without access to the web based survey, please assist us to distribute hard copies of the attached **'Walton Survey VP'**. These paper surveys should ONLY be used for groups and individuals that would otherwise be unheard.

Contact Laura.Brazell@flhealth.gov (850-892-8040 x 1163) or Brandi.Gill@flhealth.gov (850-892-8040 x 1136) if you need for us to make copies of the survey for you to distribute.

Return hard copies of the Walton Survey VP to either Laura or Brandi.

Florida Department of Health
in WALTON COUNTY
362 State Highway 83, DeFuniak Springs, FL 32433-3800
PHONE: 850/892-8015 • FAX: 850/892-8024

www.FloridaHealth.gov
TWITTER:HealthyFLA
FACEBOOK:FLDepartmentofHealth
YOUTUBE: fldoh
FLICKR: HealthyFla
PINTEREST: HealthyFla

Sample message 1 (direct email, newsletters, blogs)

We need your input!

The Florida Department of Health in Walton County is currently working to gain greater insights surrounding perceptions of community health. Citizen opinion and feedback are a critical part of the process to identify priority issues.

We encourage your input by taking the "Community Health Survey". It should take you approximately 7 minutes to complete. You are also encouraged to share this with others in our community for their input.

My Voice Matters.
My Health Matters.
Take the Survey.

The information gathered in the survey will help guide future efforts to improve the health of the residents in our community. Thank you for your help in making Walton County the healthiest in Florida.

Sample message 2 (social media, website postings)

We need your input! The Florida Department of Health in Walton County encourages you to give your input on the "Community Health Survey". It should take you approximately 7 minutes to complete. You are also encouraged to share this with others in our community for their input.

Thank you for your help in making Walton County the healthiest in Florida.

My Voice Matters.
My Health Matters.
Take the Survey.

Sample message 3 (website postings, email signatures)

My Voice Matters.
My Health Matters.
Take the Survey.

Take the Community Health Survey and help make Walton the healthiest in Florida.

Walton Community Health Improvement Partnership
November 17, 2015

Please print clearly. Thanks!

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Walton Community Health Improvement Partnership
November 17, 2015

Please print clearly. Thanks!

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B	DOH-Walton			
Jamie Carmichael	DOH-Walton	jamie.carmichael@flhealth.gov	892-8015	x 1746

Walton Community Health Improvement Partnership (WCHIP)

Community Health Status Assessment

Mobilizing for Action through Planning and Partnerships (MAPP)

Vision:

Prepared by the Florida Department of Health in Walton County
March 2016
For more information, contact Jamie.Carmichael@flhealth.gov 850-892-8040 x 1266

TABLE OF CONTENTS

Introduction

June of 2015, the Walton County MAPP Executive Committee (WCHIP Steering Committee) embarked on a journey to develop a Community Health Assessment (CHA) using the Mobilizing for Action through Planning and Partnerships (MAPP) process. 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.

A community health needs assessment is a process that:

- Describes the state of health of the local population;
- Enables the identification of the major risk factors and causes of ill health; and
- Enables the identification of the actions needed to address these identified issues.

The MAPP process includes four assessment tools, as shown in the graphic below.

MAPP Model, Achieving Healthier Communities MAPP User's Handbook

http://www.naccho.org

Within the MAPP process, there are four assessment tools. One of these assessment tools is the Community Health Status Assessment (CHSA). The CHSA provides quantitative information on community health conditions and answers the questions "How healthy is the community?" and "What does the health status of the community look like?"

Community Health Status Assessment

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 140 health status indicators and 30 demographic indicators were collected. Between July and October 2015, WCHIP 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 framework emphasizes factors that, when improved, can help improve the overall health of a community. This model is comprised of three major components:

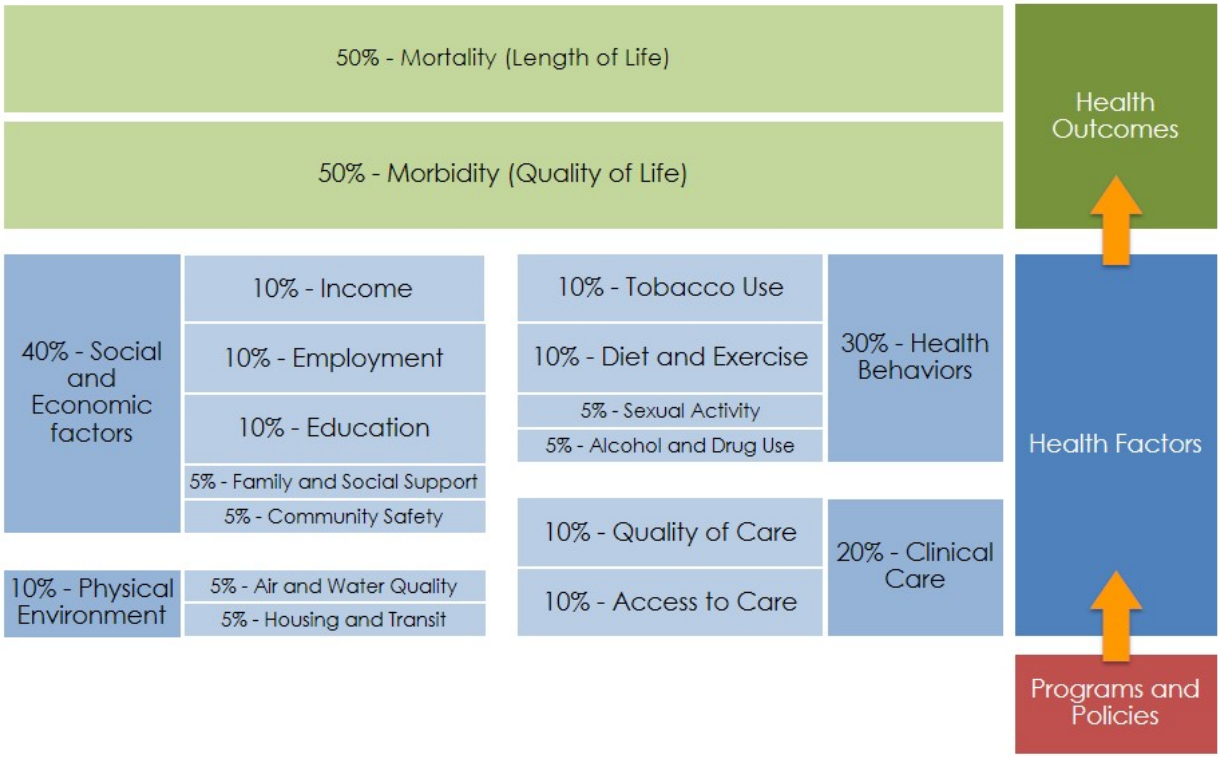
- **Health Outcomes** - This component evaluates the health of a community as measured by two types of outcomes: how long people live (Mortality / Length of Life) and how healthy people are when they are alive (Morbidity / Quality of Life).
- **Health Factors** - Factors that influence the health of 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 four months, small committee meetings were held to review and assess the data. In these small committee meetings, over 140 health indicators for Walton County were compared and contrasted to those for the state and surrounding counties. In addition, the committee members also compared local data to previous years' data from Walton County, highlighting improvements and statistical trends.

Health Ranking Model

County Health Rankings Model © 2014 UWPHI



Summary of Findings

Of those approximately 140 health status indicators, the following 95 indicators performed worse than the State for Walton County.

Health Outcomes		
Mortality – *Length of Life*	• Alcohol-Related Motor Vehicle Traffic Crash Deaths Cancer Deaths • Chronic Liver Disease, Cirrhosis Deaths • Chronic Lower Respiratory Disease Deaths • Colon, Rectal or Anus Cancer Deaths • Deaths from Smoking-related Cancers • Diabetes Deaths • Heart Disease Deaths	• Infant Mortality • Injury Deaths • Lung Cancer Deaths • Motor Vehicle Accident Deaths • Neonatal Deaths (0-27 Days) • Nephritis, Nephritic Syndrome, and Nephrosis Deaths • Post Neonatal Deaths (28-364 Days) • Premature Death • Prostate Cancer Deaths • Suicide Deaths
Morbidity – *Quality of Life*	• Average number of days where poor mental or physical health interfered with activities of daily living in the past 30 days • Cervical Cancer Incidence • Chicken Pox • Heart Disease (Adult) • High Cholesterol (Adult)	• Lung Cancer Incidence • Meningitis, Other Bacterial, Cryptococcal, or Mycotic • Salmonellosis • Tuberculosis • Vaccine Preventable Disease for All Ages • Whooping Cough (Pertussis)

Health Factors		
Health Behaviors	• Aggravated Assault • Alcohol Consumption in Past 30 Days (Adolescents) • Alcohol Consumption in Lifetime (Adolescents) • Alcohol-Related Motor Vehicle Traffic Crashes • Binge Drinking (Adolescents) • Births to Mothers Ages 10-14 • Births to Mothers Ages 15-19 • Births to Mothers Ages 15-44 • Births to Obese Mother (Rate) • Blacking Out from Drinking Alcohol (Adolescents) • Breast feeding Initiation • Cancer Screening: PSA in past 2 years (Men 50 and up) • Cigarette Use (Adolescents)	• Diabetic monitoring • Domestic Violence Offenses • Exercise Opportunities • Forcible Sex Offenses • Fruits and Vegetables Consumption 5 Servings per Day • Healthy Weight (Youth) • Live Births Where Mother Smoked During Pregnancy • Medicaid Birth Rate • Middle and High School Students Who Are Overweight or Obese • Never Smoked (Adult) • Obesity (Adult) • Secondhand Smoke Exposure (Youth) • Sedentary Adults • Smoked in Last 30 Days (Youth) • Smokers (Adult)
Clinical Care	• Acute Care Beds • Adult Psychiatric Beds • Adult substance abuse beds • Cancer Screening – Mammogram • Cancer Screening – Pap Test • Child and Adolescent Psychiatric Beds • Dental Care Access by Low Income Persons • Dentists • Diabetic Annual Foot Exam (Adults) • Diabetic Semi-Annual A1C Testing (Adult) • ED Visits - Avoidable Conditions - Dental • ED Visits - Chronic Conditions - Angina • ED Visits - Chronic Conditions - Congestive Heart Failure	• ED Visits - Chronic Conditions – Diabetes • ED Visits - Chronic Conditions – Hypertension • Family Practice Physicians • Flu Vaccination in the Past Year (Adult) • Flu Vaccination in the Past Year (Adult Age 65 and Older) • Insurance – Uninsured Adults • Insurance – Uninsured Children • Internists • Mental Health Providers • OB/GYNs • Pediatricians • Physicians • Pneumonia Vaccination (Adult) • Prenatal Care Begun Late or No Prenatal Care • Primary Care Access • Rehabilitation Beds (per Population
Socioeconomic	• Children in Poverty (Based on Household) • Food Access Low – Low Income Population	• Poverty Rate • Public Assistance Income • Real Per Capita Income • Unemployment
Physical Environment	• Air Quality – Ozone • Drinking Water Violations	• Grocery Store Access • Severe Housing Problems

Priority Setting Process

On October 21, 2015, the Walton County MAPP Executive Committee formed a Data Committee to review the results of all of the data and Assessments that had been collected and developed to-date. At the conclusion of the Data Committee's meetings, they had compiled a list of 50 indicators that were of greatest concern (where Walton County performed the worst compared to the State and to prior year results). Using this list of indicators (Attachment A) and the County Health Ranking's model of population health depicted on page 5 as a framework, the Committee identified the top five (5) priority health issues facing Walton County. The top health issues identified were:

- ❑ Provider Availability and Access
- ❑ Preventive Care
- ❑ Healthy Weight
- ❑ Tobacco Use
- ❑ Substance Abuse and Mental Health

On November 17, 2015, WCHIP held a community meeting to identify the top priority health issues for the County. The results of the MAPP Assessments were presented to the 26 participants representing health and human service providers in the community (Attachment B). Sacred Heart Hospital shared a presentation (Attachment C) on County Health Ranking's model, community health surveys, and the top health issues compiled by the Data Committee. In reviewing the identified top five health issues, the participants were asked to consider three criteria for prioritizing the top issues:

- ❑ Severity/Magnitude (of the health issue)
- ❑ Feasibility to Address (availability of resources, community will)
- ❑ Potential Impact (on community health status)

After reviewing the results of the MAPP Assessments and taking into consideration these prioritization criteria, participants used a hybrid multi-voting/nominal group technique to identify the top health issues facing Walton County (Attachment D).

Top Priority Health Issues for Walton County

The top priority health issues identified were:

- ❑ Substance Abuse and Mental Health
- ❑ Healthy Weight
- ❑ Provider Availability and Access

Next Steps

The next step in the Walton County CHNA process will be the development of a community health improvement plan with specific goals, tactics, and evaluation metrics. Activities include:

- ❑ Organizing work groups to develop comprehensive action plans to address each priority
- ❑ Identifying successful health improvement initiatives to serve as best practices
- ❑ Establishing metrics for performance, including measurable outcome indicators
- ❑ Continuing to communicate progress and results to the Walton County community

	Indicator	FLORIDA Period 1 (Most Current)	WALTON Period 1 (Most Current)	Desired direction	Walton Compared to the State	Walton Progress (Period 1 vs. Period 2)	Period 2	ISSUE AREA # 1 Preventive Care	ISSUE AREA # 2 Tobacco Use	ISSUE AREA # 3 Substance Abuse and Mental Health	ISSUE AREA # 4 Healthy Weight	ISSUE AREA # 5 Provider Availability and Access
1	Infant Mortality	6.10	8.80	↓	2.7	(0.9)	9.70	x		x		
2	Breast Cancer Deaths	20.20	19.50	↓	0.70	0.70	18.80	x				
3	Prostate Cancer Deaths	17.50	22.10	↓	4.6	(1.0)	23.10	x				
4	Lung Cancer Deaths	43.40	53.00	↓	9.6	2.6	50.40		x			
5	Deaths from Smoking-related Cancers	61.20	69.40	↓	8.2	(8.1)	77.50		x			
6	Diabetes Deaths	19.60	23.20	↓	3.6	(7.8)	31.00				x	
7	Heart Disease Deaths	155	181	↓	26.0	(2.0)	183		x		x	
8	Chronic Lower Respiratory Disease Deaths	39.80	59.60	↓	19.8	(0.6)	60.20		x			
9	Injury Deaths	39.90	48.80	↓	8.9	4.1	44.70			x		
10	Smokers (Adult)	16.80	23.20	↓	6.4	(1.1)	24.30		x			
11	Smoked in last 30 days (Adolescents)	4.30	6.60	↓	2.30	(5.60)	12.20		x			
12	Live Births w Mother Smoking During Pregnancy	6.40	15.90	↓	9.50	(1.4)	17.30		x			
13	Never Smoked (Adult)	55.00	45.90	↑	9.1	0.2	45.70		x			
14	Secondhand Smoke exposure (Children)	35.90	41.80	↓	5.9	(11.9)	53.70		x			
15	Cigarette Use (Adolescents)	4.90	10.10	↓	5.2	(1.4)	11.50		x			
16	Alcohol Consumption in past 30 days	20.50	21.80	↓	1.3	(5.1)	26.90			x		
17	Alcohol Consumption in Lifetime (Adolescents)	48.50	50.30	↓	1.8	(1.7)	52.00			x		
18	Binge Drinking (Adolescents)	9.50	10.40	↓	0.9	(4.3)	14.70			x		
19	Sedentary Adults	27.70	36.20	↓	8.5	8.10	28.10				x	
20	Grocery Store Access	31.80	7.10	↑	24.70	1.30	5.80				x	
21	Fruits and Vegetables Consumption 5 servings	18.30	15.10	↑	3.2	(11.2)	26.30				x	
22	Primary Care Access	77.09	48.63	↑	28.5	5.61	43.02	x				x
23	Cancer Screening - Sigmoidoscopy or	55.30	56.20	↑	0.9	(4.5)	60.70	x				
24	HIV Testing (Adult age 65 and over)	50.60	36	↑	14.6	(11.8)	47.80	x				
25	Flu Vaccination in the Past Year (Adult age 65	54.60	49.70	↑	4.9	(18.6)	68.30	x				
26	Flu Vaccination in the Past Year (Adult)	30.70	24.70	↑	6.0	(10.5)	35.20	x				
27	Pneumonia Vaccination (Adult age 65 and over)	66.20	67.40	↑	1.2	(3.3)	70.70	x				
28	Pneumonia Vaccination (Adult)	33.10	30.30	↑	2.8	(0.2)	30.50	x				
29	ED Visits - Chronic Conditions - Angina	0.43	0.71	↓	0.28	(0.13)	0.84					x
30	ED Visits - Chronic Conditions - Diabetes	4.55	5.28	↓	0.73	(0.29)	5.57				x	x
31	Dentists (per population)	54.00	39.90	↑	14.1	2.7	37.20					x
32	Acute Care Beds (per population)	263	186	↑	77.0	(4.0)	190					x
33	OB/GYN (per population)	9.80	5.90	↑	3.90	(0.70)	6.60					x
34	Family Practice Physicians (per population)	24.50	18.20	↑	6.3	0.8	17.40					x
35	Internists (per population)	49.70	10.60	↑	39.1	1.0	9.60					x
36	Pediatricians (per population)	21.30	7.00	↑	14.30	2.00	5.00					x
37	Physicians (per population)	267	146	↑	121.0	6.0	140					x
38	Births to Mothers Ages 15-19 (Resident)	24.30	39.60	↓	15.3	1.0	38.60					
39	Live births where mother smoked during	6.50	16.40	↓	9.9	(1.2)	17.60		x			
40	Medicaid birth rate	50.90	53.40	↓	2.5	(3.6)	57.00					x
41	Domestic Violence Offenses	547	756	↓	209	(39)	795			x		
42	Forcible Sex Offenses	52.36	72.58	↓	20.2	21.4	51.16			x		
43	Violent Crime	466	397	↓	69.0	41.0	356			x		
44	Meningitis, Other Bacterial, Cryptococcal, or	5.00	18.60	↓	13.6	11.8	6.80	x				
45	Whooping Cough	3.70	8.40	↓	4.7	3.3	5.10	x				
46	Vaccine Preventable Disease for All Ages	5.80	8.40	↓	2.6	1.6	6.80	x				
47	Tuberculosis	3.00	3.40	↓	0.40	1.70	1.70	x				
48	Chicken Pox	2.90	5.00	↓	2.10	3.30	1.70	x				
49	Overweight (Youth)	15.9	16.3	↓	0.40	0.20	16.1				x	
50	Obesity (Children and Adolescents)	12.2	13.1	↓	0.90	0.20	13.3				x	

Walton Community Health Improvement Partnership
November 17, 2015

Please print clearly. Thanks!

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Walton Community Health Improvement Partnership
November 17, 2015

Please print clearly. Thanks!

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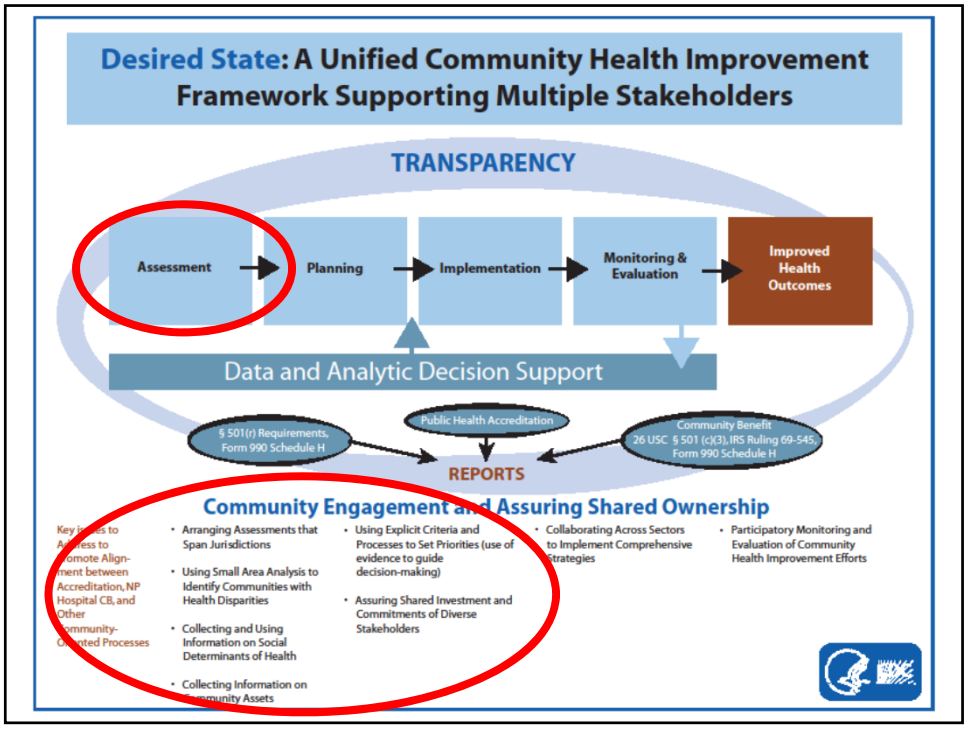
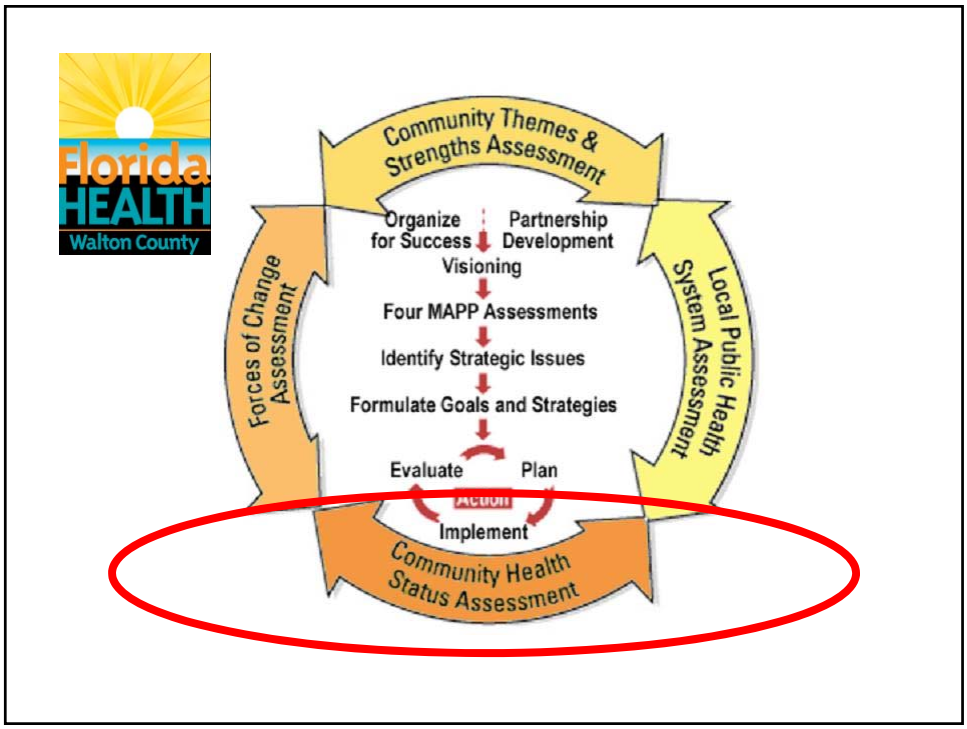
Attachment C





Community Surveys

- Health and Human Services Organizations – 30
- Community Wide – 253 (160 online, 93 paper)

	Respondents	Walton Population*
Female	86%	49%
Black/African American	7.5%	5.9%
White/Caucasian	90%	84.2%
Bachelor's degree or higher	36.4%	24.1%
Unemployed	4.8%	4.4%
Income less than $35,001/year	45%	Median Income $43,640

** Census "Quick Facts"*

Healthy Community?

Health & Human Services Organizations

- Access to health services(e.g. family doctor, hospitals)
- Quality hospitals and urgent / emergency services
- Good employment opportunities
- Good schools
- Low alcohol & drug abuse

Community

- Good employment opportunities
- Low crime / safe neighborhoods
- Access to health services(e.g. family doctor, hospitals)
- Good schools

Health Issues in Community?

Health & Human Services Organizations	Community
• Heart disease and stroke • Mental health problems • Cancers • Obesity / Excess weight • Aging problems (e.g. dementia, vision/hearing loss, loss of mobility) • Diabetes	• Obesity / Excess weight • Mental health problems • Child abuse / neglect • Cancers • Heart disease and stroke • Diabetes

Most Concerning Behaviors?

Health & Human Services Organizations	Community
• Drug abuse • Excess weight • Poor eating habits / poor nutrition • Not seeing a doctor or dentist • Alcohol abuse • Lack of exercise • Tobacco use	• Drug abuse • Alcohol abuse • Poor eating habits / poor nutrition • Not seeing a doctor or dentist • Excess weight • Tobacco use

Hard to Get Health Services?

Health & Human Services Organizations	Community
• Specialty medical care (specialist doctors) • Primary medical care (a primary doctor/clinic) • Alcohol or drug abuse treatment • Mental Health services • Services for the elderly • Alternative therapies (acupuncture, herbals, etc.) • Preventative healthcare (routine or wellness check-ups, etc.)	• Specialty medical care (specialist doctors) • Dental care including dentures • Mental Health services • Primary medical care (a primary doctor/clinic) • Alcohol or drug abuse treatment

Delayed Medical Care?

General Population	Vulnerable Population
• Did not have a delay in getting care • Could not get an appointment soon enough • Provider was not taking new patients • Could not afford	• Did not have a delay in getting care • Could not afford • Insurance problems or lack of insurance

Where to go for Sick Care?

General Population	Vulnerable Population
• My family doctor • Urgent care clinic	• My family doctor • Hospital Emergency Room • Health Department

Where to go for Mental Health Services?

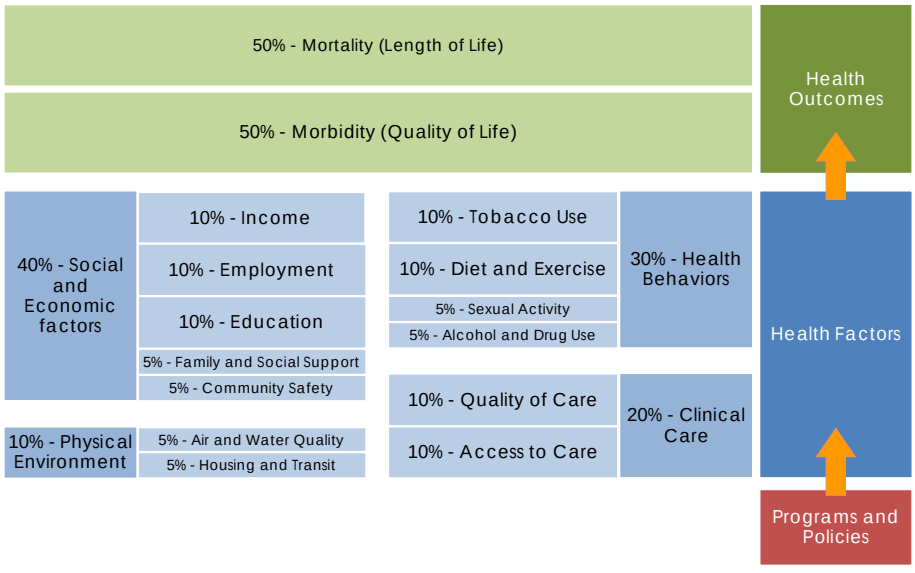
General Population	Vulnerable Population
• Private psychologist, psychiatrist or other mental health professional • I do not know where to go for mental health care • My family doctor • Mental health clinic in Walton County	• I do not know where to go for mental health care • My family doctor • Mental health clinic in Walton County

Top Health Issues

- Provider Availability and Access
- Preventive Care
- Healthy Weight
- Tobacco Use
- Substance Abuse and Mental Health

Health Ranking Model

County Health Rankings Model © 2014 UWPHI



Provider Availability and Access

Morbidity and Mortality

- Premature Death
- Infant Mortality
- Cancer Deaths
- Prostate Cancer Deaths
- Lung Cancer Deaths
- Deaths from Smoking-related Cancers
- Colon, Rectal or Anus Cancer Deaths
- Diabetes Deaths
- Heart Disease Deaths
- Neonatal Deaths (0-27 days)
- Post neonatal Deaths (28-364 days)
- Chronic Liver Disease, Cirrhosis Deaths
- Chronic Lower Respiratory Disease Deaths
- Pneumonia, Influenza Deaths
- HIV/AIDS Deaths
- Breast Cancer Incidence
- High Blood Pressure (Adult)

Clinical Care

- Dental Care Access by Low Income Persons
- Insurance - Uninsured Adults and Children
- Primary Care Access
- Diabetic Annual Foot Exam (Adults)
- Cancer Screening in past two years - PSA (Men age 50 & older)
- Cancer Screening - Mammogram
- Cancer Screening - Pap Test
- Cancer Screening - Sigmoidoscopy or Colonoscopy
- ED Visits - Dental
- ED Visits - Angina
- ED Visits - Congestive Heart Failure
- ED Visits - Diabetes
- ED Visits - Hyper Tension
- ED Visits - Mental Health
- Mental health providers
- Dentists
- OB/GYN
- Family Practice Physicians
- Internists
- Pediatricians
- Physicians
- Acute Care Beds
- Adult psychiatric beds
- Adult substance abuse beds
- Child & Adolescent Psychiatric beds
- Rehabilitation beds
- Skilled nursing beds
- Salmonellosis
- Meningitis, Other Bacterial, Cryptococcal, or Mycotic
- Whooping Cough
- Vaccine Preventable Disease Tuberculosis
- Chicken Pox
- Population Receiving Medicaid
- Adults who have a personal doctor

Preventative Care

Morbidity and Mortality

- Premature Death
- Infant Mortality
- Cancer Deaths
- Prostate Cancer Deaths
- Colon, Rectal or Anus Cancer Deaths
- Diabetes Deaths
- Heart Disease Deaths
- Neonatal Deaths
- Post neonatal Deaths Breast Cancer Deaths
- Pneumonia, Influenza Deaths
- HIV/AIDS Deaths
- Diabetic monitoring

Clinical Care

- Primary Care Access
- Diabetic Annual Foot Exam (Adults)
- Cancer Screening in past two years - PSA (Men age 50 & older)
- Cancer Screening - Mammogram
- Cancer Screening - Pap Test
- Flu Vaccination in the Past Year (Adult age 65 and over)
- Flu Vaccination in the Past Year (Adult)
- Pneumonia Vaccination (Adult)
- Adults who have a personal doctor
- Cancer Screening - Sigmoidoscopy or Colonoscopy
- Pneumonia Vaccination (Adult age 65 and over)
- Prenatal Care Begun in First Trimester
- Prenatal Care Begun Late or No Prenatal Care

Healthy Weight

Morbidity and Mortality	Health Behaviors	Clinical Care
➢ Premature Death ➢ Cancer Deaths ➢ Colon, Rectal or Anus Cancer Deaths ➢ Diabetes Deaths ➢ Heart Disease Deaths ➢ Breast Cancer Incidence ➢ Diabetic monitoring ➢ High Blood Pressure (Adult) ➢ High Cholesterol (Adult) ➢ Heart Disease (Adult)	➢ Exercise opportunities ➢ Sedentary Adults ➢ Grocery Store Access ➢ Food Access Low - Low Income Population ➢ Fruits and Vegetables Consumption 5 servings per day (Adult) ➢ Food Insecurity ➢ SNAP Participants ➢ Obesity (Adult) ➢ Middle and High School Students who are overweight or obese ➢ Healthy Weight (Youth) ➢ Breast feeding Initiation	➢ Diabetic Annual Foot Exam (Adults) ➢ ED Visits - Congestive Heart Failure ➢ ED Visits - Diabetes ➢ ED Visits - Hyper Tension ➢ Births to Obese Mothers (rate)

Tobacco Use

Morbidity and Mortality	Health Behaviors	Clinical Care
➢ Premature Death ➢ Infant Mortality ➢ Cancer Deaths ➢ Lung Cancer Deaths ➢ Deaths from Smoking-related Cancers ➢ Heart Disease Deaths ➢ Pneumonia, Influenza Deaths ➢ Breast Cancer Incidence ➢ Asthma (Adult) ➢ Chronic Lower Respiratory Disease Deaths ➢ Lung Cancer Incidence ➢ High Blood Pressure (Adult) ➢ Heart Disease (Adult)	➢ Smokers (Adult) ➢ Smoked in last 30 days (Adolescents) ➢ Live Births w Mother Smoking During Pregnancy ➢ Never Smoked (Adult) ➢ Secondhand Smoke exposure (Children) ➢ Cigarette Use Adolescents ➢ Tobacco Quit Attempt (Adult)	➢ ED Visits - Chronic Conditions - Congestive Heart Failure ➢ ED Visits - Chronic Conditions - Hyper Tension ➢ Live births where mother smoked during pregnancy

Substance Abuse and Mental Health

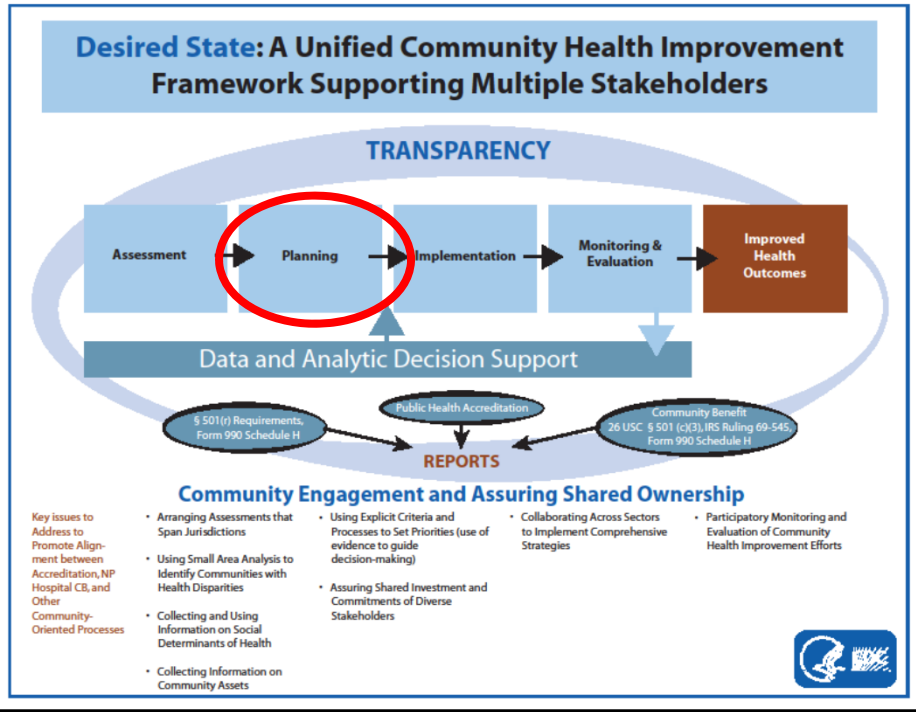
Morbidity and Mortality	Health Behaviors	Clinical Care
➢ Premature Death ➢ Infant Mortality ➢ Neonatal Deaths (0-27 days) ➢ Post neonatal Deaths (28-364 days) ➢ Chronic Liver Disease, Cirrhosis Deaths ➢ Suicide Deaths ➢ Motor Vehicle Accident Deaths ➢ Injury Deaths ➢ Nephritis, Nephritic Syndrome, and Nephrosis Deaths	➢ Alcohol-related Motor Vehicle Traffic Crash Deaths ➢ Alcohol-related Motor Vehicle Traffic Crashes ➢ Blacking out from drinking Alcohol (Adolescents) ➢ Alcohol Consumption in past 30 days (Adolescents) ➢ Alcohol Consumption in Lifetime (Adolescents) ➢ Binge Drinking (Adolescents)	➢ ED Visits - Mental Health ➢ Adult psychiatric beds ➢ Adult substance abuse beds ➢ Child and Adolescent Psychiatric beds ➢ Mental health providers ➢ Average number of days where poor mental or physical health interfered with activities of daily living in the past 30 days

Social Determinants

- ➢ Unemployment
- ➢ Median Household Income
- ➢ Real Per Capita Income
- ➢ Poverty Rate
- ➢ Children in poverty (based on household)
- ➢ Income - Public Assistance Income
- ➢ Children in single-parent households
- Households with No Motor Vehicle
- ➢ High school graduation (rate)
- ➢ Population > 25 without a high school diploma (rate)
- ➢ Drinking water violations
- ➢ Air Quality - Ozone
- ➢ Severe housing problems
- ➢ Driving alone to work
- ➢ Domestic Violence Offenses
- ➢ Forcible Sex Offenses
- ➢ Aggravated Assault
- ➢ Violent Crime

Prioritization

Top Health Issues	Considerations
• Provider Availability and Access • Preventive Care • Healthy Weight • Tobacco Use • Substance Abuse and Mental Health	• MAPP Assessments – Themes and Strengths – Forces of Change – Public Health System – Community Health Status • Severity/Magnitude • Feasibility to Address: Resources / Community Will • Potential Impact



WCHIP Top Health Issues
1
Preventative Care
Mental Health & Substance Abuse
Tobacco Use
Healthy Weight
Provider Availability & Access

WCHIP Top Health Issues
2
Preventative Care
Mental Health & Substance Abuse
Tobacco Use
Healthy Weight
Provider Availability & Access

WCHIP Top Health Issues
3
Preventative Care
Mental Health & Substance Abuse
Tobacco Use
Healthy Weight
Provider Availability & Access

WCHIP Top Health Issues
Tally Sheet
Preventative Care
Mental Health & Substance Abuse
Tobacco Use
Healthy Weight
Provider Availability & Access