Franklin County Community Health Needs Assessment

August 2018 – August 2019
Updated June 2020

Community Partners Vision:
"A united, healthy and prosperous Franklin County"

Prepared by:

TABLE OF CONTENTS

EXECUTIVE SUMMARY 4

Description of The Community 5
Participants in The Assessment Process 5
How the Assessment Was Conducted 5
Priority Health Issues 7

INTRODUCTION 8

COLLABORATING PARTNERS 8

Florida Department of Health in Franklin County 9

COMMUNITY DEFINITION 9

Population 9
Population Characteristics *10*
Population by Race and Ethnicity *11*
Socioeconomic Indicators *11*
ALICE *12*
What Is Health 16
County Health Rankings 2019 17

METHODOLOGY 19

Participants in the Assessment Process 19

ASSESSMENT PROCESS - MAPP 19

SUMMARY OF FINDINGS: 20

Vision and the Local Public Health System Workshop 21
Vision *21*
Local Public Health System *21*
The Ten Essential Public Health Services 22
Themes & Strengths Assessment and the Forces of Change Workshop 23
Themes and Strengths *23*
Quality of Life Survey *23*
Asset Inventory *24*
Forces of Change *25*
Opportunities and Threats *26*
Community Health Status Assessment Workshop 28
Health Status Indicators *28*
Framework for Analysis *28*
Summary of Findings *29*
Weems Memorial Hospital *31*
Chronic Disease Profile *33*
Chronic Disease Risk and Protective Factors *34*
Leading Causes of Death *35*

Vulnerable Population Health Status *35*
Community Health Status Assessment Survey *36*
Survey Results *36*

COMMUNITY HEALTH PRIORITIES 40

Priority Setting Process 40
Priority Selection Matrix 41

COMMUNITY HEALTH PRIORITY AREAS 41

Mental Health 41
Limited Access to Care 42
Substance Abuse 42

ATTACHMENTS

A. Franklin County and Florida Indicator References and Sources
B. Vision and Local Public Health System Workshop Minutes
C. *Themes and Strengths and the Forces of Change Workshop Minutes*
D. *Community Health Status Assessment Workshop Minutes*

2018-19
Community Health Needs Assessment
Franklin County, Florida

Executive Summary

During the 2018-2019 timeframe, health partners and the Florida Department of Health - Franklin County ("DOH-Franklin") worked together, in collaboration with other community organizations and agencies, to conduct a community health needs assessment for the approximately 12,000 residents of Franklin County, Florida.

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

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

Description of the Community

The area for the purposes of this assessment is defined as the population of Franklin County. Franklin County has a total area of 1,026 square miles, of which 47.9% is water. There are two main population centers in Franklin County - Carrabelle in the eastern part of the County and Apalachicola, the County seat and largest city, on the coast. Between the two cities are smaller unincorporated communities.

The population in Franklin County increased by 1.6% between 2010 and 2018, although the growth rate was less than the State of Florida (13.3%) over the same period. Minorities represent about 16% of the total population.

The most current Census Bureau, ACS 5-year estimates (2013-17) approximates median household income in Franklin County at $41,267, significantly below that of the State. In 2018, the poverty rate was 21.3%, compared to 14.0% statewide.

Participants in the Assessment Process

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

The assessment process included CHIP meetings and workshops and a community survey distributed both on-line and in paper format. More than 20 people representing more than 15 different community agencies and organizations and the general public participated in various meetings throughout the process. In addition, 150 Franklin County residents completed the community survey. Particular focus was placed on obtaining input from vulnerable population groups.

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

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

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

Community Health Status Profile	**Community Themes & Strengths Assessment**
One hundred and fifty community residents completed the Community Health Status Survey. Excessive alcohol use, drug abuse, obesity are top three community health concerns. Favorable statistics and health indicators: ▪ Health factors have consistently improved in rank since 2016. ▪ Social and economic factors Opportunities for improvement: ▪ Personal health behavior factors The top priority health issues identified for Franklin County were: ▪ Strategic Issue #1: Mental Health ▪ Strategic Issue #2: Limited Access to Care ▪ Strategic Issue #3: Substance Abuse	The Themes and Strengths portion of the assessment asked three significant questions: "What is important to our community?", "How is quality of life perceived in our community?" and "What assets do we have that can be used to improve community health?" Recurring themes include: ▪ Strong believe that the community is a good place to grow old and there are networks of support for individuals and families. The following were identified as assets and strengths: ▪ Multiple individuals, associations, public and private institutions, and ongoing local projects ▪ The safety and overall quality of life in the community
Local Public Health System Assessment	**Forces of Change Assessment**
The LPHS Assessment required participants to think about how well the collective LPHS meets the Ten Essential Public Health Services. Overall survey participants responded: ▪ No Activity – 7% ▪ Minimal – 12% ▪ Moderate – 33% ▪ Significant – 38% ▪ Optimal – 11%	To assess the forces of change, participants were asked, "What is currently happening or could happen that would affect the health of our community?" Key forces of change identified include: ▪ Funding for Services ▪ Political Influence ▪ Economy ▪ Environmental Factors ▪ Quality of School Education ▪ Substance use

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

- Broad applicability of solution set
- Time frame required to support efforts
- Potential to reduce health disparities
- Alignment with vision ("A united, healthy and prosperous Franklin County.")
- Community support for the problem
- Resource availability to address problem

Priority Health Issues

The top priority health issues identified for Franklin County were:

- Strategic Issue #1: Mental Health
- Strategic Issue #2: Limited Access to Care
- Strategic Issue #3: Substance Abuse

2018-19
Community Health Needs Assessment
Franklin County, Florida

Introduction

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

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

Collaborating Partners

- Apalachee Center
- Basic of NWFL, Inc
- Big Bend AHEC
- Big Bend Community Based Care
- Career Source Gulf Coast
- Department of Juvenile Justice
- DOH – Franklin County – Environmental Health
- Eastpoint Medical Center
- Florida Agricultural and Mechanical University Extension Office
- Florida Department of Health – Closing the Gap
- Florida Department of Health – Franklin County
- Florida Department of Health – Gulf County
- Franklin County District Schools
- Franklin County Sheriff's Department
- Franklin's Promise
- Healthy Start Coalition
- Liberty County Senior Citizens
- North Florida Child Development
- Pan Care
- Sacred Heart Health System
- Sacred Heart Hospital on the Gulf
- Weems Memorial Hospital

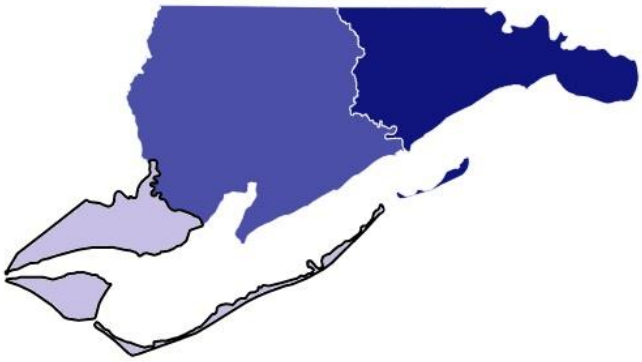
Florida Department of Health in Franklin County

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

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

Community Definition

Franklin County has a total area of 1,026 square miles, of which 47.9% is water. There are two main population centers in Franklin County - Carrabelle in the eastern part of the County and Apalachicola, the County seat and largest city, on the coast. Sandwiched between the two communities is Eastpoint, a less populated unincorporated community.



The area is insulated by St. George Island and several other barrier islands, separating the Gulf of Mexico and the Apalachicola Bay. The area is low in density, featuring mainly single-family homes and tourist rentals. The County jurisdiction also includes a St. George Island State Park and portions of the Apalachicola National Forest, the largest U.S. National Forest in the state of Florida.

Population

Franklin County has a low population density of a little less than 22 persons per land mass square mile, compared to 348 persons per square mile in the State of Florida. The county has an estimated population of 12,161 and is expected to grow to nearly 12,863 by the year 2025.

The significant majority of Franklin County residents are older than 65 (24.0%), which accounts for more than the percentage of the population in that age bracket statewide (20.1%). Only 16.1% of the population of Franklin County is under 18 years of age, compared to 20.0% of the State's population. In addition, the population is skewed heavily in favor of males over females, with almost 56% of the population of Franklin County being male compared to slightly less than 50% of the male population of the State.

Franklin County Population Estimates July 1, 2018		
Demographics	**Franklin County**	**State of Florida**
Estimated Total Population July 1, 2018	**11,736**	**21,299,325**
Age and Sex		
5 years old and under	4.5%	5.40%
18 years old and under	16.1%	20.00%
65 years old and over	24.0%	20.10%
Female (add males here also)	44.2%	51.10%
Males	55.8%	48.9%
Race and Hispanic Origin		
White	84.1%	77.40%
Black or African American	12.4%	16.90%
American Indian and Alaska Native	1.0%	0.50%
Asian	0.5%	2.90%
Hispanic or Latino	5.6%	25.60%
White (not Hispanic or Latino)	79.4%	54.10%
Two or more races	2.0	2.1

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

Percent Change in Population by Age/Sex Cohort, 2017-2020-2025					
Age Cohort	**Estimated Population 2017**	**Projected Population 2020**	**Projected Population 2025**	**Percent Change 2017-2020**	**Percent Change 2017-2025**
0-17	2,102	2,161	2,241	2.8%	6.6%
Female 18-44	1,443	1,475	1,497	2.2%	3.7%
Male 18-44	2,703	2,718	2,760	0.6%	2.1%
45-64	3,351	3,313	3,295	-1.1%	-1.7%
65+	2,562	2,781	3,070	8.5%	19.8%
Total	12,161	12,448	12,863	2.4%	5.8%

Source: Florida Demographic Estimating Conference, December 2017 and the University of Florida, Bureau of Economic and Business Research, Florida Population Studies, Bulletin 181, June 2018

Population Characteristics

- Sixteen percent of the population of Franklin County is less than 18 years old.
- Twenty-four percent of the population of Franklin County is aged 65 or older; which is above the State as a whole.
- At nearly 56% of the population, males represent more than half of all residents in Franklin County, compared to being slightly underrepresented in the state as a whole accounting for only 48.9% of the population of Florida.

Population by Race and Ethnicity

Minorities represent about 16% of the total population in Franklin County, comparable to the nearly 45% minority composition of the population of the State. A lower percentage of the population in Franklin County is African-American (slightly more than 12%) than in the State (about 16.9%). Unlike the State, only 5.6% of the population of Franklin County is Hispanic, compared to 25.6% statewide.

Why are these characteristics important?

- Population growth can strain health care resources and other infrastructure, particularly where limited resources already exist
- Different gender and age groups utilize significantly different types and levels of health care services, particularly male versus female, pediatric versus adult, and elderly patient populations.
- The elderly (population aged 65 and older) utilize 3 to 4 times the healthcare services required by younger populations.
- Language and cultural differences create the need for different approaches to improving access to health services

Socioeconomic Indicators

The Census Bureau, ACS 5-year estimates (2012-16) approximates median household income in Franklin County at $40,301, which is below the median household income of the State of $48,9006. Over 30% of the population has an income of less than $25,000. Noticeably more than the state rate of only 23.6%.

Income & Poverty 2017

Area	Occupied Housing Units	Median household income	Percent less than $25,000/year (2016)	Percent less than $50,000 per year
Franklin	4,250	$40,301	30.1%	62.1%
Florida	7,393,262	$48,900	23.6%	48.3%

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

A substantially greater percentage of the population over the age of 25 does not have a high school diploma in Franklin County compared to the State (20.4% versus 12.8%). Finally, 22.3% of the local population is living with a disability compared to 13.3% of Floridians statewide.

Other Socioeconomic Indicators, 2016

Area	Population 25+ w/out High School Diploma	Population with Disability
Franklin	20.4%	22.3%
Florida	12.8%	13.3%
U.S.	13.0%	12.5%

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

ALICE

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

What does it cost to afford the basic necessities?

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

Household Survival Budget - Franklin, Florida, 2016

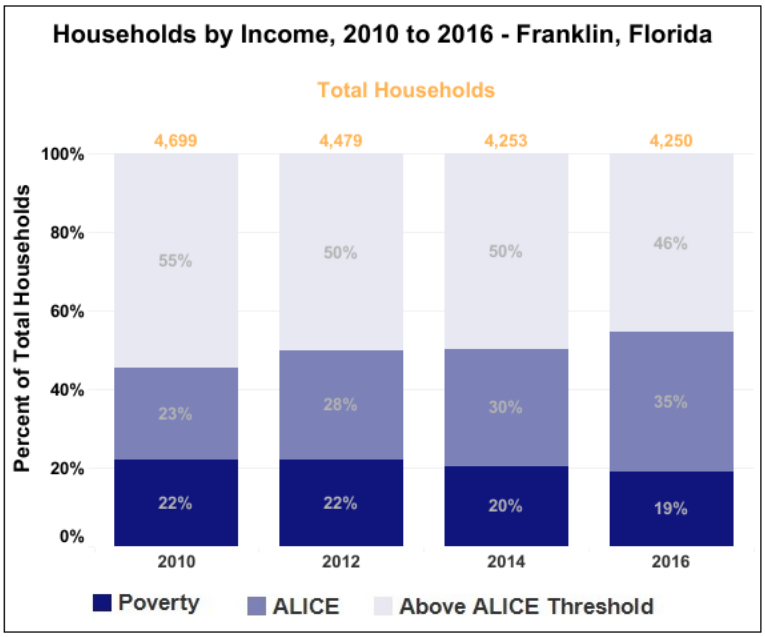
	Single Adult	2 Adults, 1 Infant, 1 Preschooler
Housing	$588	$723
Child Care	$0	$1,035
Food	$164	$542
Transportation	$322	$644
Health Care	$196	$726
Technology	$55	$75
Miscellaneous	$153	$403
Taxes	$201	$281
Monthly Total	$1,679	$4,429
ANNUAL TOTAL	$20,148	$53,148
Hourly Wage	$10.07	$26.57

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

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

The ALICE Income Assessment measures:

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



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

How has the number of struggling households changed over time?

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

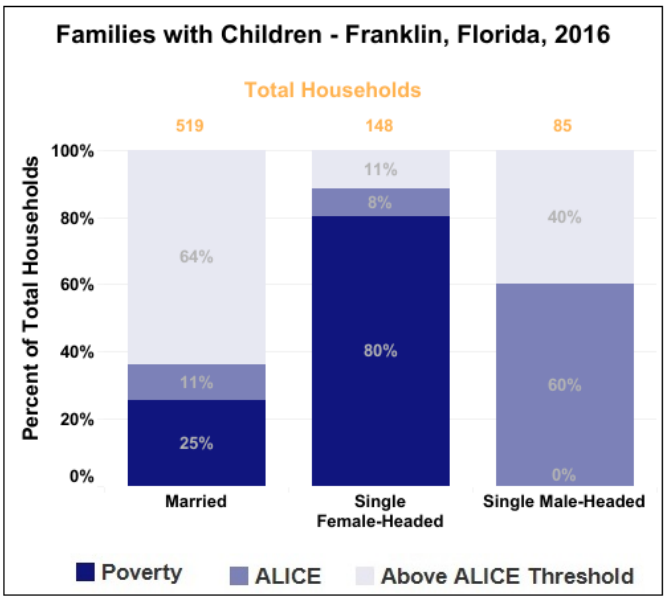
ALICE Household Data 2016				
Name	**Total Households**	**# of Poverty Households**	**# of ALICE Households**	**% of ALICE Households**
Apalachicola	933	131	366	39.2%
Carrabelle	733	174	312	42.6%

Source: ACS (5year)

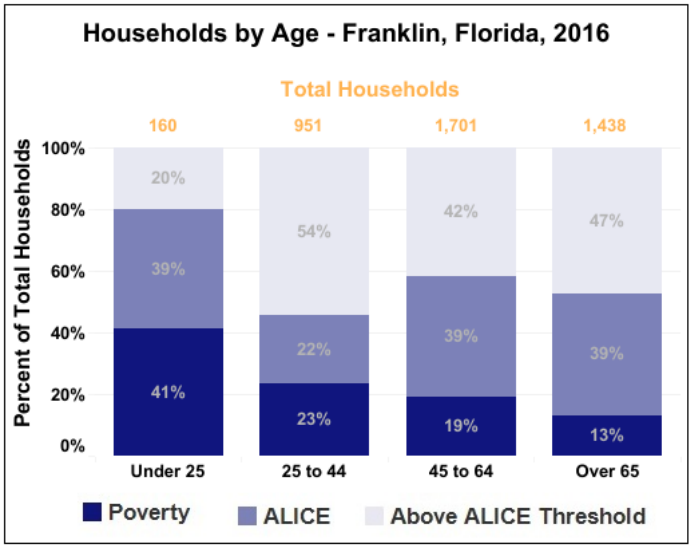
While over 1/5 of the population of Franklin County lives in poverty nearly 39% of Apalachicola residents and 43% of Carrabelle locals struggle to afford basic necessities.

How many families with children are struggling?

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



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



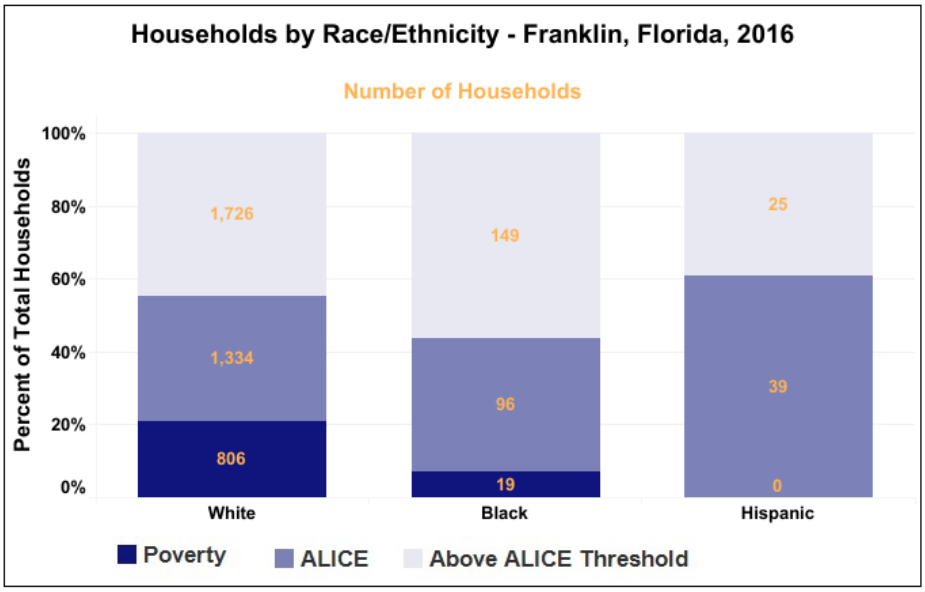
Source: American Community Survey, 2016, and the ALICE Threshold, 2016.

What are the differences in ALICE households by age?

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

What races and ethnicities are ALICE families?

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



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

Nearly half of all white residents are either ALICE or living in poverty. A slight majority of the White population in Franklin County are considered to live at or below the ALICE threshold. Hispanics also a have similar classification. The majority of Hispanic residents have the same experience. While slightly less than half of the Black residents are considered at the ALICE threshold or below, a significant portion are not.

Why are these characteristics important?

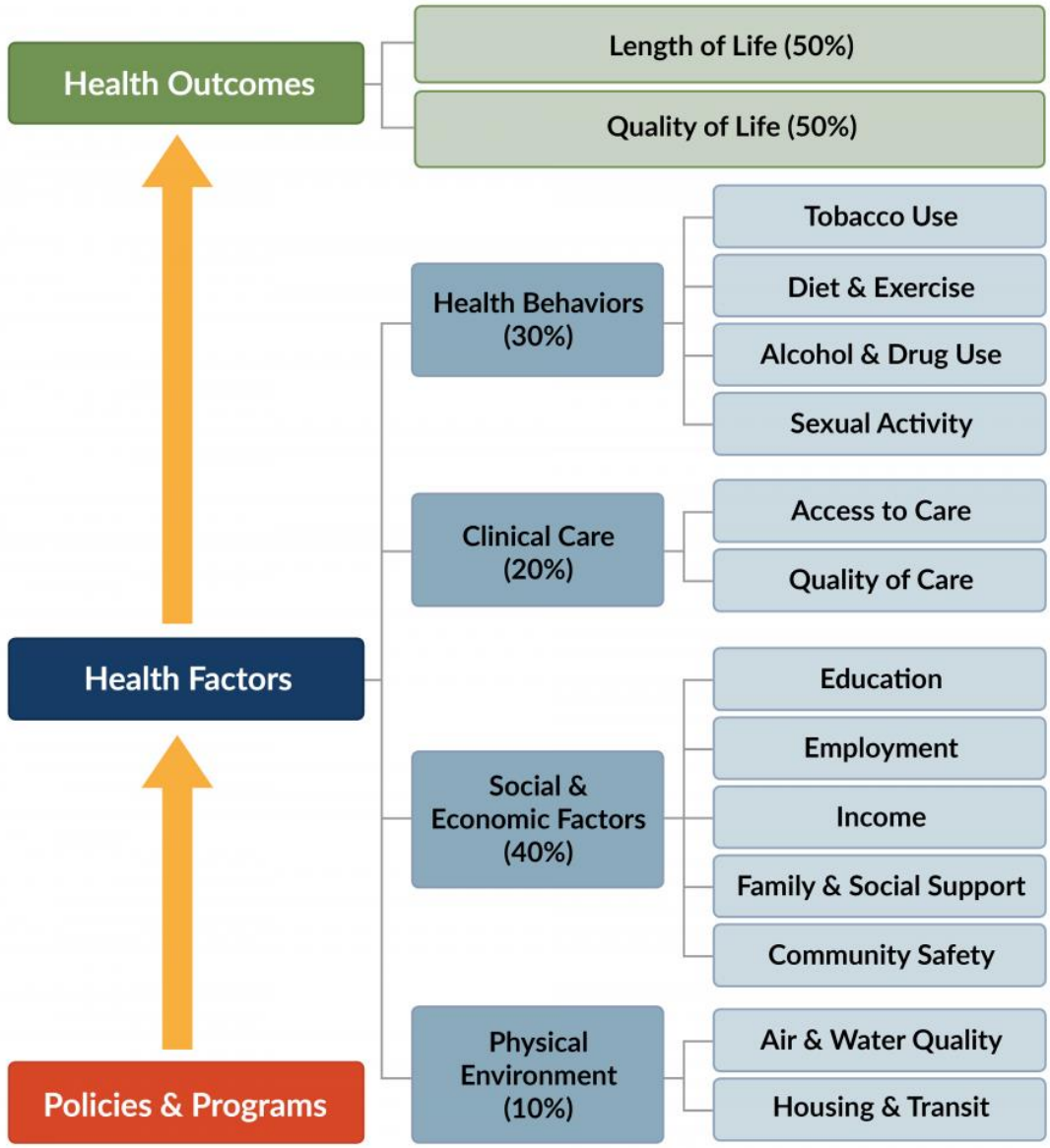
- Socioeconomic status plays a major role in health and healthcare. It affects access to healthcare services as well as diet, housing conditions, and other environmental conditions that affect health.
- Generally, the higher your socioeconomic status, the better health care coverage you have, which allows 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 lower rate of unemployment in Franklin 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 Franklin County suggest that access to care may be difficult for much of the population in Franklin County.
- A huge but hidden segment of our community that is struggling to afford basic necessities. The success of a community is directly related to the financial stability of its members.

What is Health?

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

Health Is More Than Health Care

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



County Health Rankings model © 2014 UWPHI

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

County Health Rankings 2019		Franklin County	Current Trend	Error Margin	State of Florida	Rank (of 67)
Health Outcomes						**39**
Length of Life (50%)						**41**
Premature death		9,000		6,900-11,000	7,200	
Quality of Life (50%)						**35**
Poor or fair health		19%		18-19%	19%	
Poor physical health days		4.3		4.2-4.4	3.8	
Poor mental health days		4.0		3.9-4.2	3.8	
Low birthweight		9%		7-11%	9%	
Health Factors						**45**
Health Behaviors (30%)						**53**
Adult smoking		18%		18-19%	15%	
Adult obesity		34%		29-39%	27%	
Food environment index		7.5			6.9	
Physical inactivity		31%		27-35%	25%	
Access to exercise opportunities		88%			88%	
Excessive drinking		25%		24-25%	18%	
Alcohol-impaired driving deaths		36%		20-52%	25%	
Sexually transmitted infections		323.1			467.4	
Teen births		63		51-77	23	
Clinical Care (20%)						**45**
Uninsured		15%		13-17%	15%	
Primary care physicians		3,970:1			1,390:1	
Dentists		3,910:1			1,700:1	
Mental health providers		1,680:1			670:1	
Preventable hospital stays		4,520			5,066	
Mammography screening		34%			42%	
Flu vaccinations		26%			41%	
Social & Economic Factors (40%)						**43**
High school graduation		79%			82%	
Some college		38%		30-45%	62%	

County Health Rankings 2019		Franklin County	Current Trend	Error Margin	State of Florida	Rank (of 67)
Unemployment		3.6%			4.2%	
Children in poverty		34%		24-44%	21%	
Income inequality		5.3		3.8-6.7	4.7	
Children in single-parent households		33%		21-45%	38%	
Social associations		11.8			7.1	
Violent crime		268			484	
Injury deaths		94		71-122	76	
Physical Environment (10%)						**53**
Air pollution - particulate matter		9.1			8.2	
Drinking water violations		Yes				
Severe housing problems		18%		14-22%	21%	
Driving alone to work		80%		77-83%	79%	
Long commute - driving alone		20%		14-25%	40%	

Methodology

Participants in the Assessment Process

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

- Apalachee Center
- Basic of NWFL, Inc
- Big Bend AHEC
- Big Bend Community Based Care
- Career Source Gulf Coast
- Department of Juvenile Justice
- DOH – Franklin County – Environmental Health
- Eastpoint Medical Center
- Florida Agricultural and Mechanical University Extension Office
- Florida Department of Health – Closing the Gap
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- Florida Department of Health – Gulf County
- Franklin County District Schools
- Franklin County Sheriff's Department
- Franklin's Promise
- Healthy Start Coalition
- Liberty County Senior Citizens
- North Florida Child Development
- Pan Care
- Sacred Heart Health System
- Sacred Heart Hospital on the Gulf
- Weems Memorial Hospital

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

The assessment process included CHIP meetings and workshops which occurred between August 2018 and continued into August 2019. Partners promoted and helped populate a community survey, distributed both on-line and in paper format. More than 20 people representing more than 15 different community agencies/organizations and the general public participated in various meetings throughout the process. In addition, 150 Franklin County residents completed a community survey to provide information about perceptions of the health of the community, its residents, and the health care system.

To ensure input was obtained from persons with a broad knowledge of the community, e-mail notifications and invitations were sent to numerous stakeholders and representatives of the public. In addition to soliciting input from the general population, special attention was given to obtaining input from traditionally underserved populations by distributing surveys at a local culture and heritage festival.

Assessment Process - MAPP

The assessment was developed using the Mobilization for Action through Planning and

Partnership (MAPP) method, which was developed by the National Association of City and County Health Officials in concert with the U.S. Centers for Disease Control and Prevention. MAPP is a community-driven strategic planning framework that assists communities in developing and implementing efforts around the prioritization of public health issues and the identification of resources to address them as defined by the Ten Essential Public Health Services.

The MAPP process includes four assessment tools listed below and depicted in the graphic that follows:

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

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

Summary of Findings:

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

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

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

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

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

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

The work that was performed, findings reviewed, and conclusions reached in each of these

workshops is summarize below.

Vision and the Local Public Health System Workshop

The Vision and Local Public Health System ("LPHS") Community Health Assessment ("CHA") Workshop centered on creating a shared collective vision to guide participants throughout the CHA process and gauging the ideas, thoughts, and opinions of the community regarding their knowledge and experience dealing with the LPHS throughout the County. The workshop was held on August 16, 2018. Twenty (20) people from 10 community organizations participated in the Workshop.

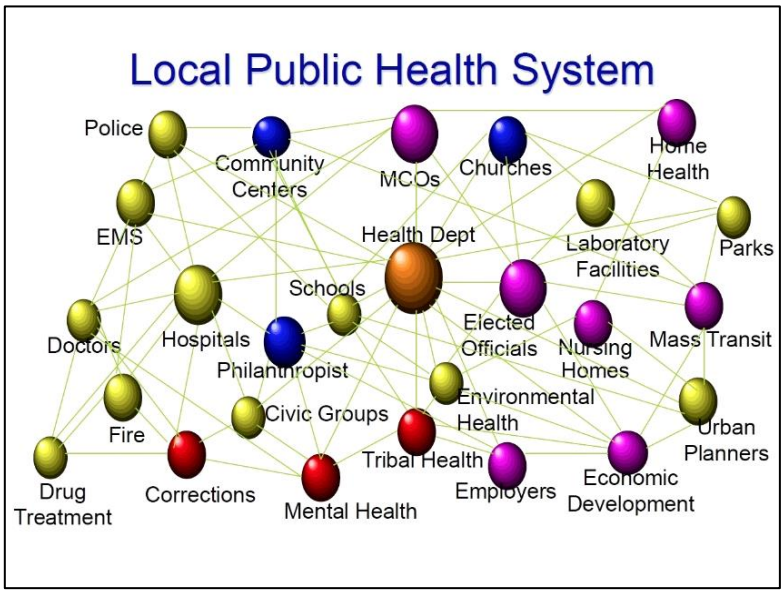
Vision

Participants were led through a process to understand the importance of developing a shared vision and were given time to consider what that shared vision might be. Many participants shared vision statements they had developed with the group and, although the statements were all different, several key values such as "enhancing community health for all," "making Franklin County a great place to live, work, and play," "making Franklin County the healthiest county in the nation," and "improving the quality of the Franklin…" were consistent throughout. Ultimately the workshop members unanimously settled on "A united, healthy and prosperous Franklin County."

Local Public Health System

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

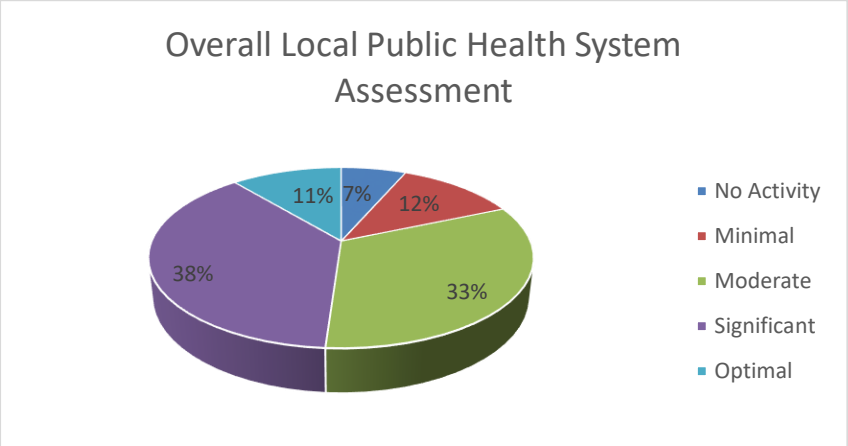
The LPHS Assessment required participants to think about how well the collective LPHS meets the Ten Essential Public Health Services.



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

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

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



Overall the community is split on how well the local public health system is functioning. Just over 50% of those surveyed felt that the local public health system has no activity to moderate performance. While nearly half of the participants polled (49%) agree that the system is functioning significant to optimal.

The first set of questions polled all relate to the Essential Public Health Service #1 and answer the questions, "What is going on in our community?" and "Do we know how healthy we are?" The feedback from the Essential Service #1 questions conveyed a general satisfaction with the LPHS's level of community engagement. In all Essential Service #1 polls, 74% of participants responded that the LPHS is doing an moderate to significant job.

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

Themes & Strengths Assessment and the Forces of Change Workshop

The Themes and Strengths and the Forces of Change CHA Workshop centered on establishing a collective vision to guide participants throughout the CHA process, identifying common community themes and strengths, and identifying the forces of change that can affect the health of the community. The workshop was held on September 20, 2018.

Themes and Strengths

Themes	
Open Ended Questions	**Common Themes**
1. What makes you most proud of our community?	▪ Coming together in time of need. ▪ The connection and support. ▪ Community offering. ▪ Safe place
2. What would excite you enough to be involved or more involved in improving our community?	▪ More people involved. ▪ Open minded. ▪ Family oriented.
3. What do you believe is keeping our community from doing what needs to be done to improve health and quality of life?	▪ Access to affordable housing, good jobs, and transportation. ▪ Substance abuse, mental health issues and negative cycles and perceptions
4. What do you believe are the 2-3 most important characteristics of a healthy community?	▪ Education. ▪ The economy and job opportunities. ▪ Active engagement/involvement. ▪ Healthy choices and healthy choice options.

The Themes and Strengths portion of the assessment asked three significant questions:

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

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

Through a series of open ended questions, participants identified several reoccurring themes throughout the community. Following submission of ideas by individual participants, a full group discussion among all participants identified several key themes.

Quality of Life Survey

The Quality of Life Survey answered the question, "How is quality of life perceived in our

community?" The survey asked participants to think about their quality of life throughout the County as it relates to the health care system, raising children, growing old, affordable housing, economic opportunity, and civic responsibility, among other issues. Each question was evaluated on the following scale:

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

The first question was: "Are you satisfied with the healthcare system in our community?" After considering access, cost, availability, quality and options, more than 50% of all participants responded that they were slightly to most unsatisfied with the local healthcare system. The question, "Is there economic opportunity in the community?" nearly 90% of respondents reported a being slightly unsatisfied with local opportunities. Regarding the question "Is the community a safe place to live?" Eighty percent was slightly satisfied to most satisfied.

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

Asset Inventory

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

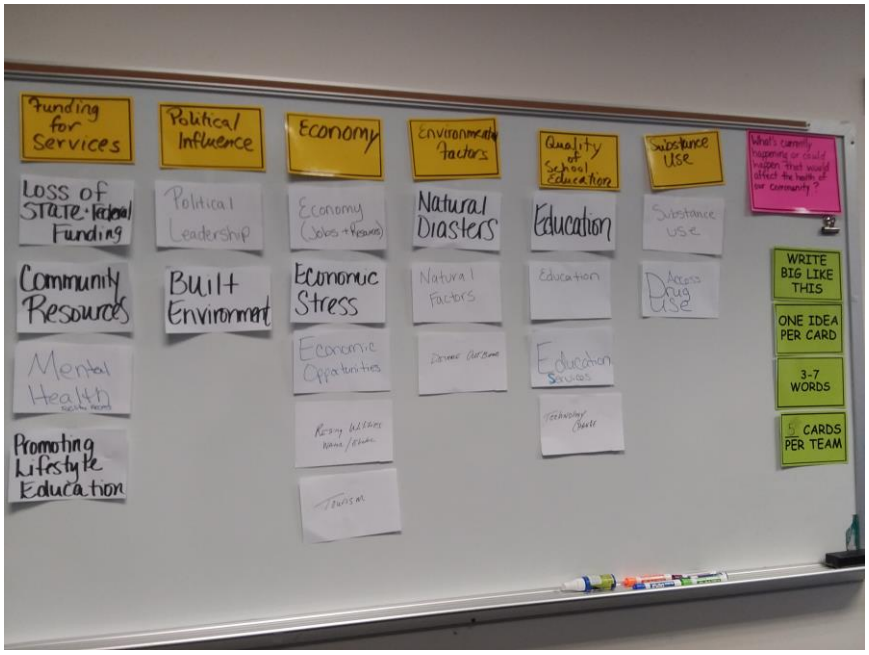
Workshop participants identified resources in four (4) major categories as summarized below.

Collective Assets Inventory	
Individuals (w/ Knowledge & Skills):	**Citizen Associations:**
1. Commissioners	1. Holy Family Senior Center
2. Pastors	2. H'COLA
3. Teachers	3. Franklin's Promise
4. Mayor Johnson	4. Rotary Club
5. Sheriff AJ Smith	5. Chamber of Commerce
6. Rose McCoy	6. SWAT
7. Mark Willis	7. Shriners

(Private) Institutions:	(Public) Institutions:
1. Weems Hospital 2. Church Community 3. Daycare Facilities 4. Media 5. School Clubs 6. Churches 7. Banks 8. Private Clinics	1. FL Dept. of Health 2. ARC Transportation 3. FCSO 4. Gulf Coast State College 5. Career Source 6. County Library 7. Oyster Radio 8. Apalachicola Times 9. School Systems 10. AHEC 11. Youth Clubs

Forces of Change

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

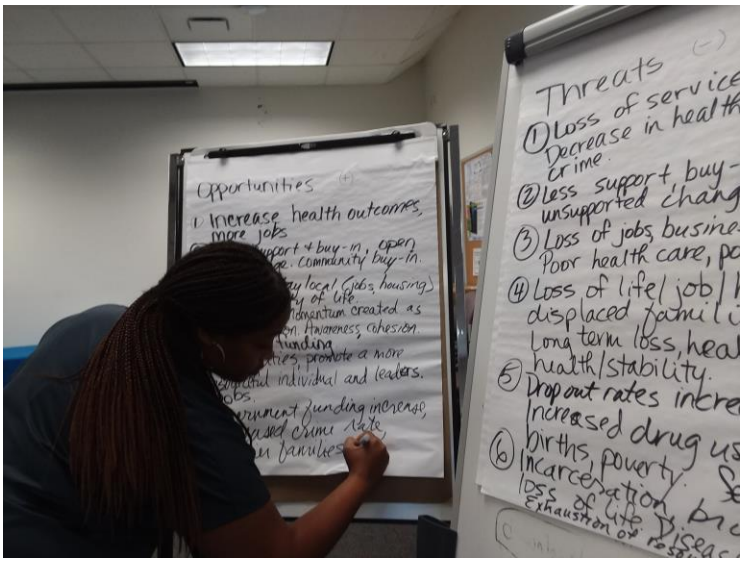


In order to better aid the community members brainstorm the forces of change, participants were asked, "What is currently happening or could happen that would affect the health of our community?" A consensus workshop helped everyone to identify, categorize, and label the many forces of change. Participants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

Funding for Services	Political Influence	Economy
▪ Loss of state & federal funding ▪ Community resources ▪ Mental health facility access ▪ Promoting Lifestyle ▪ Education	▪ Political Leadership ▪ Built Environment	▪ Economy (jobs and resources) ▪ Economic opportunities ▪ Tourism ▪ Unemployment and low paying jobs ▪ Affordable housing ▪ Employment and good paying jobs
Environmental Factors	**Quality of School Education**	**Substance Use**
▪ Natural disasters ▪ Natural factors ▪ Disease outbreaks	▪ Education ▪ Educational services ▪ Technological change	▪ Increased drug use among youth and adults ▪ Increase in substance use/access ▪ The opioid/drug crisis

Opportunities and Threats

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



Forces of Change Assessment		
Force of Change	**Potential Opportunity**	**Potential Threat**
Funding for Services	▪ Improvement in desirable health outcomes ▪ More jobs	▪ Loss of service ▪ Decrease in health outcomes ▪ Possible for more crime
Political Influence	▪ More support & Buy-in, open …	▪ Less support, buy-in ▪ Unsupported changes
Economy	▪ Jobs, stability, increase in income to afford housing. Impact built environmental	▪ Loss of jobs, businesses ▪ Poor health care
Environmental Factors	▪ Increase awareness, to elevate priority level in community	▪ Loss of life, jobs ▪ Displaced families ▪ Long term losses
Quality of School Education		▪ Dropout rates increase ▪ Increased drug use, teenage births, poverty
Substance Use	▪ More resources/partners at the table	▪ Incarceration ▪ Loss of life ▪ Diseases increase ▪ Exhaustion of resources.

Community Health Status Assessment Workshop

The Community Health Status Assessment Workshop began with an in-depth review of data collected and analyzed throughout the process, including specific health status indicators and results of a Community Health Status Assessment Survey. The data review was followed by a decision matrix and ended with the selection of health priorities. The workshop was held on Tuesday, August 27, 2019. Over 25 people consisting of residents and partners from various community organizations participated in this workshop.

Health Status Indicators

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

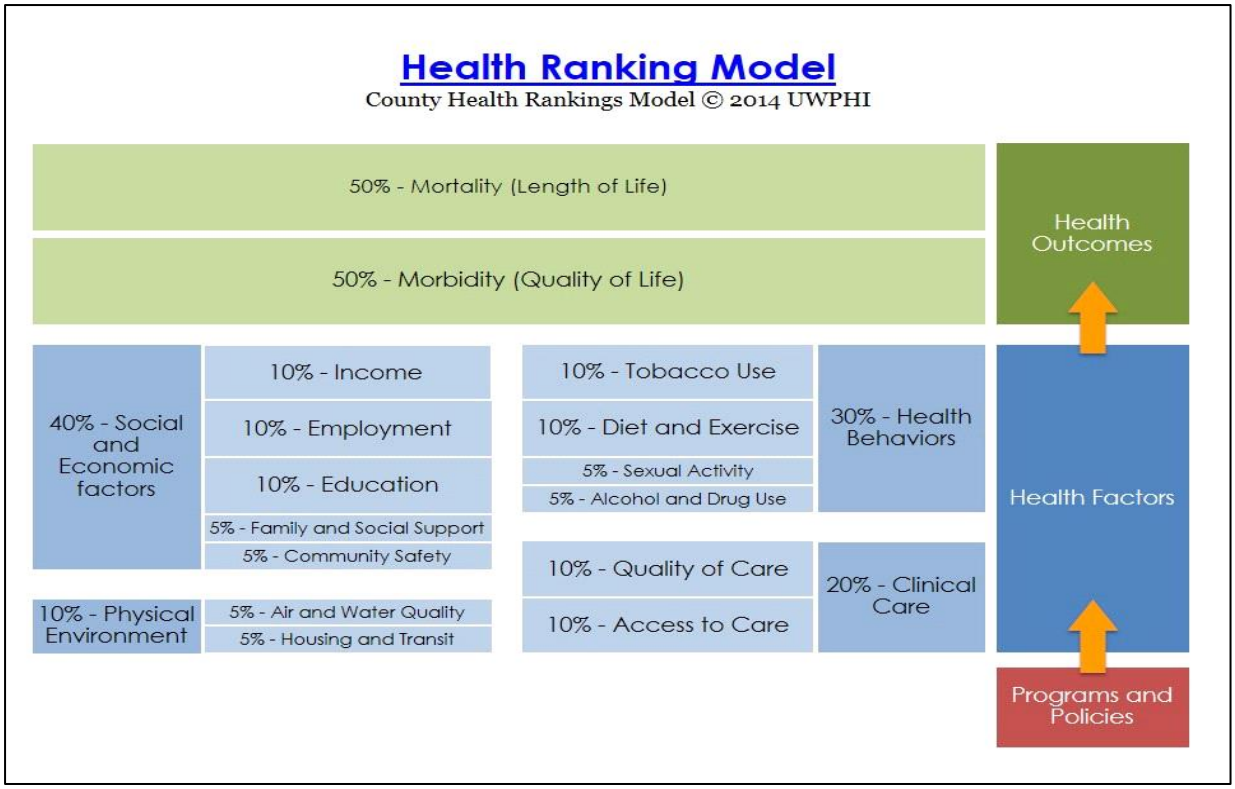
Framework for Analysis

To identify the issues that hold the greatest priority for the community, the indicator results were evaluated within the framework of the County Health Rankings Model created by the University of Wisconsin Population Health and the Robert Wood Johnson Foundation. The annual Rankings provide a revealing snapshot of how health is influenced by where we live, learn, work and play. They provide a starting point for change in communities. This framework emphasizes factors that, when improved, can help improve the overall health of a community. This model is comprised of three major components:

- **Health Outcomes** - This component evaluates the health of a community as measured by two types of outcomes: how long people live (Mortality / Length of Life) and how healthy people are when they are alive (Morbidity / Quality of Life).
- **Health Factors** - Factors that influence the health of a community including the activities and behavior of individuals (Health Behaviors), availability of and quality of health care services (Clinical Care), the socio-economic environment that people live and work in (Social and Economic Factors) and the attributes and physical conditions in which we live (Physical Environment). Although an individual's biology and genetics play a role in determining health, the community cannot influence or modify these conditions and therefore these factors are not included in the model. These factors are built from the concept of Social Determinants of Health (see inset).
- **Programs and Policies** - Policies and programs at the local, state and federal level have the potential to impact the health of a population as a whole (i.e. smoke free policies or laws mandating childhood immunization). As illustrated, Health Outcomes are improved when Policies & Programs are in place to improve Health Factors.

Data sources included: Florida CHARTS, Florida Department of Health, Agency for Health Care Administration, County Health Rankings and Roadmaps, Florida Department of Children and Families, US Department of Health & Human Services, Feeding America, USDA Economic

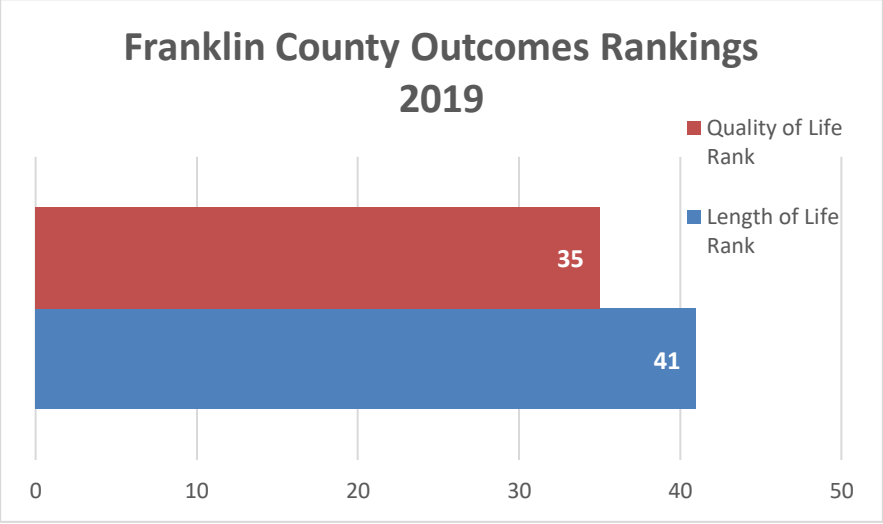
Research Service, Florida Department of Law Enforcement, US Census Bureau, Federal Bureau of Labor and Statistics, and US Department of Housing and Urban Development.

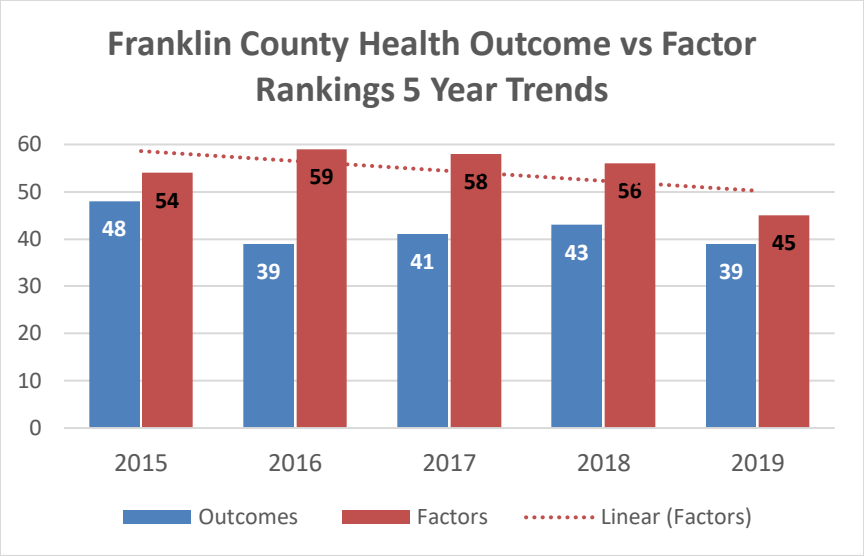


Over the course of the 12 months, local county data was gathered, analyzed, and review. In these small committee meetings, roughly 100 health indicators for Franklin County were compared and contrasted to those for the state and surrounding counties. Additionally, the data was also compared prior years'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

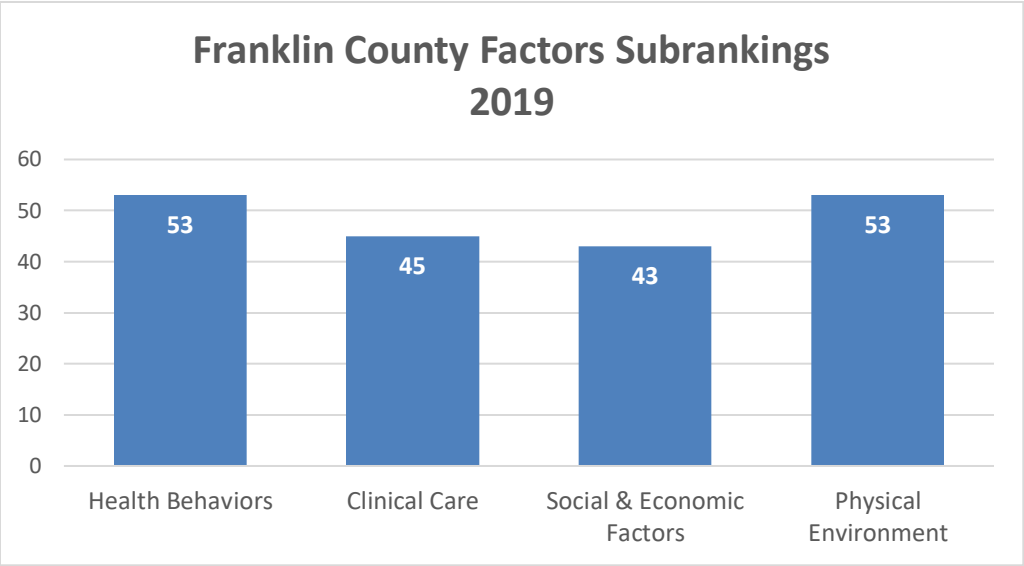
Summary of Findings

Franklin County ranked 35th and 41st in quality of life (morbidity) and length of life (mortality) respectively. While overall health outcomes (comprised of 50% mortality and 50% morbidity) have remained fairly steady over the past half-decade, individual factors that influence health outcomes have seen a consistent improvement in rank since 2016.





Amongst the determinants influencing overall quality of life, social and economic factors appear to be a local strength, while personal health behaviors (obesity, smoking, diet, physical activity, etc.) and physical environment ranked number 53. Local partners should consider exploring opportunities to improve the elements and conditions making up this factor.



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

Health Status Indicators

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

Weems Memorial Hospital

George E. Weems Memorial Hospital's mission is to improve the health status of the residents and visitors to Franklin County, by providing quality, compassionate, cost effective and convenient health care through community leadership and in collaboration with other healthcare organizations which serve our communities. This 25-bed critical access hospital is staffed 24/7 by residency trained, board certified physicians. In addition to emergency services, the hospital also provides inpatient, outpatient, and swingbed services. While the hospital provides services to Franklin County and the surrounding area's residents and visitors alike, the primary service spans from lower Gulf County (Port St. Joe) to east of Franklin County (Lanark Village).

The hospital provided services to 6, 257 patients from a variety of backgrounds. Half of which were women, 44% identified as men and several of whom either chose not to identify or left the selection blank. The majority of patients are white, followed by 15% black, and about 3% had a different racial identity.

Hospital Primary Service Area		
Patient Residence	Total Discharges	Percentage of Total
Total Discharges	6,257	100%
Apalachicola	2,438	39.0%
Eastpoint/SGI	1,622	25.9%
Carrabelle	944	15.1%
Port St. Joe	55	0.9%
Lanark Village	41	0.7%
Service Area Totals	5,100	81.5%

Hospital Services		
Services	Total Discharges	Percentage of Total
Emergency	5,836	93.3%
Inpatient	129	2.1%
Observation	271	4.3%
Outpatient	6	0.1%
Swingbed	15	0.2%
Total Services	6,257	100.0%

Weems Patient Profile		
Patient Profile	Total Discharges	Percentage of Total
Men	2,727	44%
Women	3,109	50%
White	5,063	81%
Black	943	15%
Asian	22	0.4%
Other Race	208	3%

In 2018 alone, Weems saw more than 280 cases of acute upper respiratory infection in addition to a host of other respiratory issues like COPD (5), bronchitis (#8) and pneumonia (#15). The top 15 principal diagnosis of emergency room patients account for slightly over 23% of all ER visits. Visits account for a range of health conditions including those due to infectious disease, chronic disease like hypertension (#9), and mental health issues such as anxiety disorder (#14), among others. Over 100 patients or about 1.75% left the facility before treatment could be carried out.

Weems Top 15 Patient Principal Diagnosis
FY 2018

No.	ICD-10 Code	Admitted Diagnosis	Frequency of Diagnosis	Percent of Discharges	Cumulative Percent
1	**J069**	Acute upper respiratory infection	284	4.59	4.59
2	**N390**	Urinary tract infection	129	2.08	6.67
3	**J029**	Acute pharyngitis, unspecified	122	1.97	8.65
4	**R0789**	Other chest pain	117	1.89	10.54
5	**J441**	Chronic obstructive pulmonary disease with (acute) exacerbation	108	1.75	12.28
6	**Z5321**	Procedure and treatment not carried out due to patient leaving prior to being seen by health care provider	108	1.75	14.03
7	**B349**	Viral infection	93	1.5	15.53
8	**J209**	Acute bronchitis	84	1.36	16.89
9	**I10**	Essential (primary) hypertension	77	1.24	18.13
10	**K529**	Noninfective gastroenteritis and colitis	77	1.24	19.38
11	**G43909**	Migraine (without status migrainosus)	69	1.12	20.49
12	**E860**	Dehydration	55	0.89	21.38
13	**S39012A**	Strain of muscle (fascia and tendon of lower back)	52	0.84	22.22
14	**F419**	Anxiety disorder	51	0.82	23.04
15	**J189**	Pneumonia	51	0.82	23.87

Chronic Disease Profile

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

Franklin County Chronic Disease Profile 2018					
Indicator	**Measure**	**Year(s)**	**County (Percent or Rate)**	**County Quartile**	**State**
Cardiovascular Disease					
Coronary Heart Disease					
Adults who have ever been told they had angina or coronary heart disease	Percent	2016	10.9%	4th	4.7%
Heart Attack					
Adults who have ever been told they had a heart attack	Percent	2016	10.6%	4th	5.2%
Stroke					
Adults who have ever been told they had a stroke	Percent	2016	6.8%	4th	3.5%
Cancer					
Breast Cancer					
Incidence (new cases): Age-adjusted incidence rate per 100,000 total population	Per 100,000 Females	2014-16	90.1	1st	
Women 40 years of age and older who received a mammogram in the past year	Percent	2016	44.6%	1st	60.8%
Cervical Cancer					
Incidence (new cases): Age-adjusted incidence rate per 100,000 total population	Per 100,000 Females	2014-16	6.3	1st	
Women 18 years of age and older who received a Pap test in the past year	Percent	2016	42.2%	3rd	48.4%
Colorectal Cancer					
Incidence (new cases): Age-adjusted incidence rate per 100,000 total population	Per 100,000 Total Population	2014-16	29.1	1st	36.4
Adults 50 years of age and older who received a sigmoidoscopy	Percent	2016	55.6%	2nd	53.9%

or colonoscopy in the past five years					
Lung Cancer					
Incidence (new cases): Age-adjusted incidence rate per 100,000 total population	Per 100,000 Total Population	2014-16	68	3rd	57.8
Melanoma					
Incidence (new cases): Age-adjusted incidence rate per 100,000 total population	Per 100,000 Total Population	2014-16	21	2nd	24.6
Prostate Cancer					
Incidence (new cases): Age-adjusted incidence rate per 100,000 total population	Per 100,000 Males	2014-16	66.1	1st	
Men 50 years of age and older who received a PSA test in the past two years	Percent	2016	55.8%	3rd	54.9%
Diabetes					
Adults who have ever been told they had diabetes	Percent	2016	17%	3rd	11.8%
Respiratory Diseases					
Asthma					
Adults who currently have asthma	Percent	2016	9.4%	3rd	6.7%
Adults who have ever been told they had asthma	Percent	2016	14.6%	4th	11%
Chronic Lower Respiratory Diseases (CLRD)					
Hospitalizations: Age-adjusted hospitalization rate per 100,000 total population	Per 100,000 Total Population	2016-18	290.8	1st	334.6

Chronic Disease Risk and Protective Factors 2018					
Indicator	**Measure**	**Year(s)**	**County (Percent or Rate)**	**County Quartile**	**State**
Adults who are sedentary	Percent	2016	32.8%	2nd	29.8%
Adults who are inactive or insufficiently active	Percent	2016	56.2%	2nd	56.7%
Adults who meet aerobic recommendations	Percent	2016	45.1%	2nd	44.8%
Adults who meet muscle strengthening recommendations	Percent	2016	27.1%	4th	38.2%

Adults who are overweight	Percent	2016	28.4%	1st	35.8%
Adults who are obese	Percent	2016	37.8%	4th	27.4%
Adults who are at a healthy weight	Percent	2016	29.9%	3rd	34.5%
Adults who are current smokers	Percent	2016	14.4%	2nd	15.5%

Leading Causes of Death - Franklin County, Florida 2018						
#	**Causes of Death**	**Deaths**	**Percent of Total Deaths**	**Crude Rate Per 100,000**	**Age-Adjusted Death Rate Per 100,000**	**YPLL < 75 Per 100,000 Under 75**
	ALL CAUSES	125	100.0	1,011.3	748.0	7,827.3
1	Cancer	31	24.8	250.8	149.7	1,493.9
2	Heart Disease	26	20.8	210.4	152.0	910.5
3	Chronic Lower Respiratory Disease	10	8.0	80.9	53.3	123.8
4	Unintentional Injury	7	5.6	56.6	54.9	1,542.5
5	Chronic Liver Disease and Cirrhosis	5	4.0	40.5	33.2	892.8
6	Septicemia	5	4.0	40.5	34.6	459.6
7	Influenza and Pneumonia	3	2.4	24.3	24.2	247.5
8	Stroke	3	2.4	24.3	19.5	26.5
9	Suicide	2	1.6	16.2	11.6	88.4
10	Hypertension	2	1.6	16.2	13.7	194.5
Source: Florida Department of Health, Bureau of Vital Statistics						

Vulnerable Population Health Status

Despite the variety of indicators and data sources used to demonstrate Franklin County's health status, quality information on the overall health of the underserved, vulnerable, and/or higher-risk population is difficult to obtain. In addition to a well-established African American population, the community has a growing Hispanic and/or Latino population yet significant health data on this population is largely unavailable at this time. To help counter the lack of available health information, the CHA steering committee took extra steps ensure the Community Health Status Assessment Survey was distributed to the aforementioned populations.

Community Health Status Assessment Survey

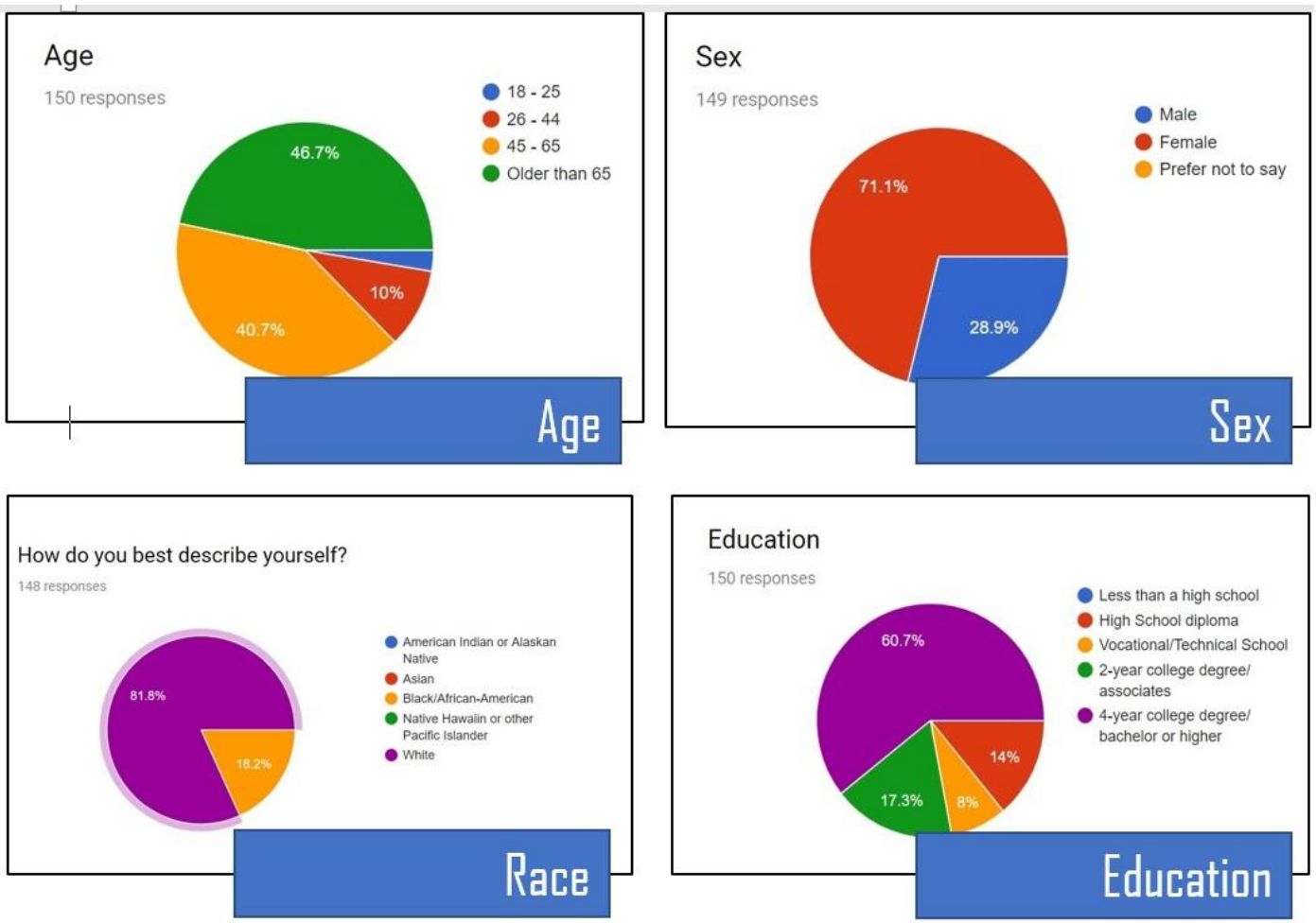
From February to mid-April the CHIP distributed a Community Health Status Assessment Survey, both on-line and in paper format at festivals, community gatherings, partner offices and the local health department clinic lobby. The survey asked 12 questions ranging from health-related opinions, ideas, the community quality of life, statistics, and basic demographic

information. In order to reduce health outcome gaps and disparities, the survey was distributed to the general population and specifically within communities with highly vulnerable populations. CHIP members identified and distributed paper surveys to key populations based on geography, income, and race. In many cases, volunteers were made available to assist in completion of the survey.

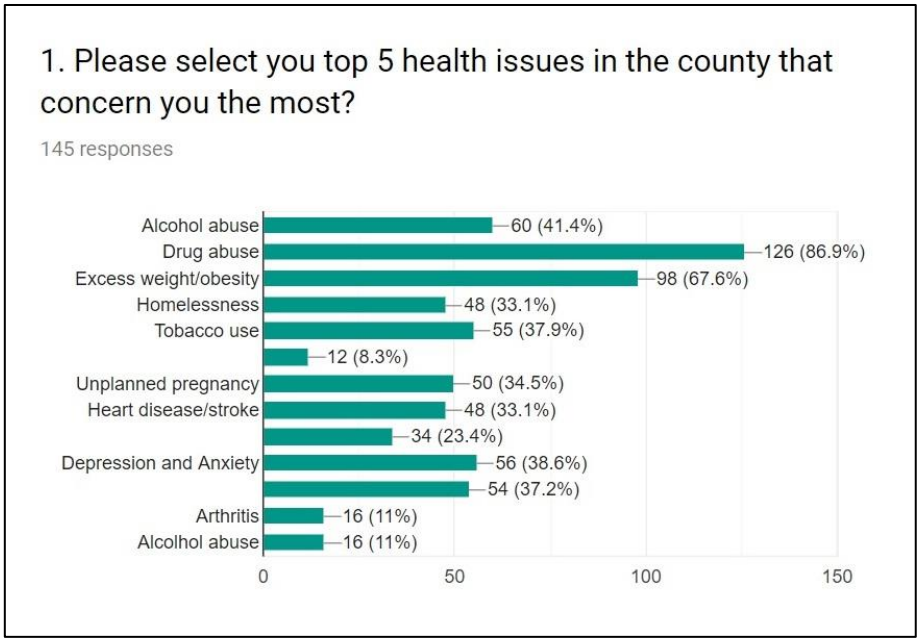
A copy of CHSA survey is provided in Attachment D.

Survey Results

While the overwhelming majority of the 150 respondents were middle aged, white women with a 4-year college degree, survey data shows a vast array of representation amongst the community participants.



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



Results from multiple communities were extracted from the survey. These communities included residents with less than a 4 year degree, residents from the Hillside community in Apalachicola (a historical community of color), Apalachicola at large, residents from Carrabelle, residents from Eastpoint and St. George Island, and residents in Lanark Village and Other areas of Franklin County. While all of these community showed some variation in the top five health issues, all seven of them listed drug abuse as their top concern.

Top 5 Health Issues Identified by Residents w/ Less Than 4yr Degree

#	Concerns	Total
1	Drug Abuse	49
2	Excess Weight/Obesity	34
3	Depression and Anxiety	29
4	Unplanned Pregnancy	20
5	Homelessness	19

Top 5 Health Issues Identified by Residents in Apalachicola

#	Concerns	Total
1	Drug Abuse	63
2	Excess Weight/Obesity	54
3	Alcohol Abuse	36
4	Depression and Anxiety	34
5	High Cholesterol/High Blood Pressure	34

Top 5 Health Issues Identified by Residents in Hillside Community

#	Concerns	Total
1	Drug Abuse	26
2	Excess weight/obesity	25
3	Tobacco Use	13
4	High Cholesterol/High Blood Pressure	13
5	Depression and Anxiety	12

Top 5 Health Issues Identified by Residents in St. George Island		
#	Concerns	Total
1	Drug Abuse	40
2	Excess Weight/Obesity	30
3	Alcohol Abuse	25
4	Unplanned Pregnancy	18
5	Homelessness & Tobacco Use (tied)	17

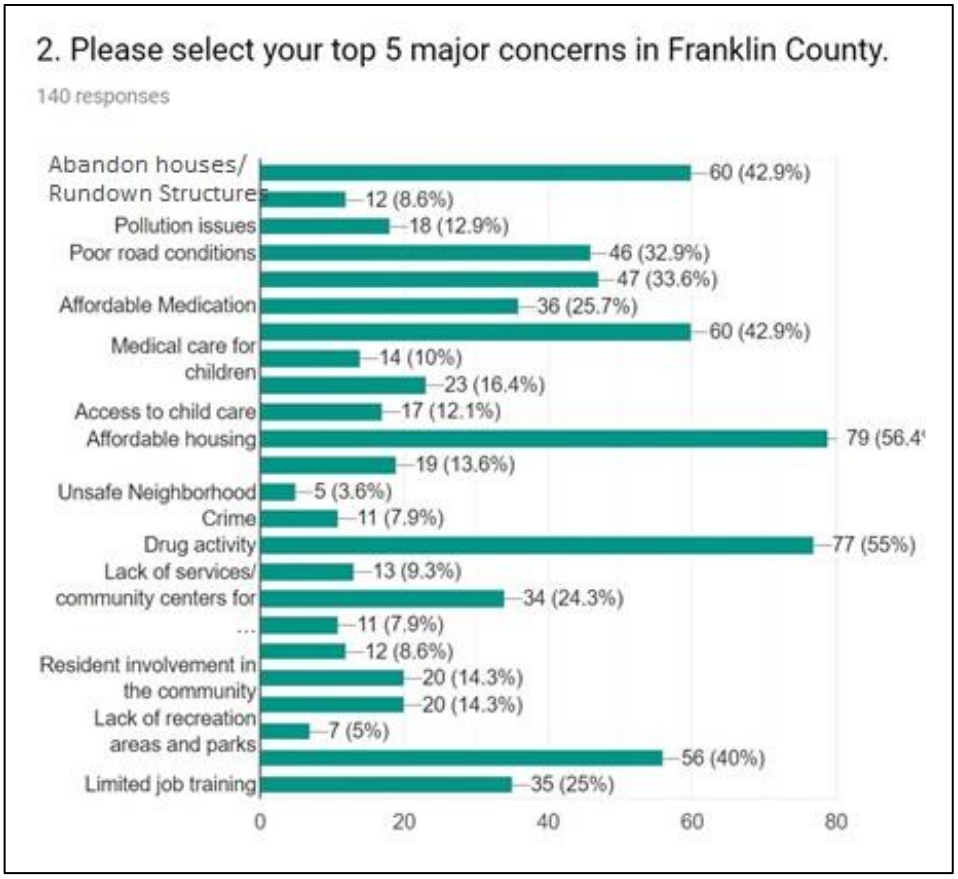
Top 5 Health Issues Identified by Residents in Eastpoint		
#	Concerns	Total
1	Drug Abuse	11
2	Alcohol Abuse	6
3	Excess Weight/Obesity	6
4	Tobacco Use	6
5	Depression and Anxiety	6

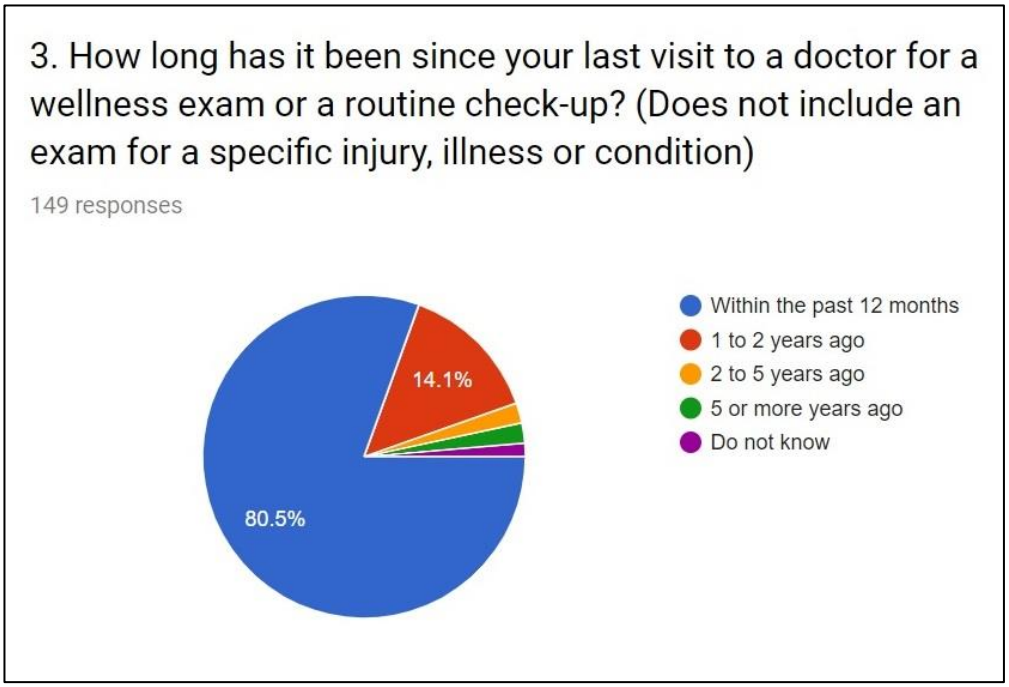
Top 5 Health Issues Identified by Residents in Carrabelle		
#	Concerns	Total
1	Drug Abuse	6
2	Excess Weight/Obesity	6
3	Alcohol Abuse	5
4	Tobacco Use	4
5	Depression and Anxiety	3

Top 5 Health Issues Identified by Residents in Lanark Village & Other		
#	Concerns	Total
1	Drug Abuse	6
2	Homelessness	3
3	HIV/AIDS and Other STDs	3
4	Heart Disease/Stroke	3
5	Alcohol, Weight, Tobacco, Pregnancy, and Depression	2

Additional concerns with the county were lead by abandon houses/rundown structures, affordable housing, drug activity, lack of jobs.

The majority of the nearly 150 respondents have seen a doctor within the last year, while slight over 14% hasn't had a wellness exam or a routine check-up for more than one year.





Community Health Priorities

Priority Setting Process

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

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

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

Health Issues	Potential Consequences of Not Addressing Issue:
Substance Abuse:	More premature death. Violent crime. Suicide rates increase. Increase in child and elder abuse. Increase in ACES.
Access to Care:	Premature death (mortality). Increase in chronic disease comorbidities.
Environmental Health:	Increase in comorbidities. Drain on Medicaid and Medicare. Increase in obesity.
Socioeconomic Status (SES):	Wider poverty gap. Increase in brain drain (young people exiting community for work and opportunity).
Mental Health:	Increase in suicide and substance abuse, arrest and crime, poverty, stigma. Increase in ACEs. More youth go undiagnosed.

As part of the workshop, participants also sought to align prioritization of health issues in the County with the recently adopted shared vision: "A united, healthy and prosperous Franklin County." Participants agreed that, in order to achieve the shared vision, community partners must address disparities and that, doing so will help participants identify and implement ways for everyone to have a fair chance to lead the healthiest life possible.

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

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

Priority Selection Matrix

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

The top priority health issues identified for Franklin County were:

- Strategic Issue #1: Mental Health
- Strategic Issue #2: Limited Access to Care
- Strategic Issue #3: Substance Abuse

Community Health Priority Areas

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.

Limited Access to Care

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

- Overall physical, social, and mental health status

- Prevention of disease and disability
- Preventable hospitalization
- Detection and treatment of health conditions
- Quality of life
- Preventable death
- Life expectancy

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 Franklin County, substance abuse appears to be a substantial problem, particularly among adolescents, for whom most indicators are substantially higher than statewide.

Attachment A

Health Outcomes					
Focus Area	**Measure**	**Description**	**Weight**	**Source**	**Year(s)**
Length of life (50%)	Premature death	Years of potential life lost before age 75 per 100,000 population	50%	National Center for Health Statistics – Mortality files	2015-2017
Quality of life (50%)	Poor or fair health	% of adults reporting fair or poor health	10%	Behavioral Risk Factor Surveillance System	2016
	Poor physical health days	Average # of physically unhealthy days reported in past 30 days	10%	Behavioral Risk Factor Surveillance System	2016
	Poor mental health days	Average # of mentally unhealthy days reported in past 30 days	10%	Behavioral Risk Factor Surveillance System	2016
	Low birthweight	% of live births with low birthweight (< 2500 grams)	20%	National Center for Health Statistics – Natality files	2011-2017

Health Behaviors (30%)					
Focus Area	**Measure**	**Description**	**Weight**	**Source**	**Year(s)**
Tobacco use (10%)	Adult smoking	% of adults who are current smokers	10%	Behavioral Risk Factor Surveillance System	2016
Diet and exercise (10%)	Adult obesity	% of adults that report a BMI ≥ 30	5%	CDC Diabetes Interactive Atlas	2015
	Food environment index	Index of factors that contribute to a healthy food environment, (0-10)	2%	USDA Food Environment Atlas, Map the Meal Gap	2015 & 2016
	Physical inactivity	% of adults aged 20 and over reporting no leisure-time physical activity	2%	CDC Diabetes Interactive Atlas	2015
	Access to exercise opportunities	% of population with adequate access to locations for physical activity	1%	Business Analyst, Delorme map data, ESRI, & U.S. Census Files	2010 & 2018
Alcohol and drug use (5%)	Excessive drinking	% of adults reporting binge or heavy drinking	2.5%	Behavioral Risk Factor Surveillance System	2016
	Alcohol-impaired driving deaths	% of driving deaths with alcohol involvement	2.5%	Fatality Analysis Reporting System	2013-2017
Sexual activity (5%)	Sexually transmitted infections	# of newly diagnosed chlamydia cases per 100,000 population	2.5%	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention	2016
	Teen births	# of births per 1,000 female population ages 15-19	2.5%	National Center for Health Statistics – Natality files	2011-2017

Clinical Care (20%)					
Focus Area	**Measure**	**Description**	**Weight**	**Source**	**Year(s)**
Access to care (10%)	Uninsured	% of population under age 65 without health insurance	5%	Small Area Health Insurance Estimates	2016
	Primary care physicians	Ratio of population to primary care physicians	3%	Area Health Resource File/American Medical Association	2016
	Dentists	Ratio of population to dentists	1%	Area Health Resource File/National Provider Identification file	2017
	Mental health providers	Ratio of population to mental health providers	1%	CMS, National Provider Identification file	2018
Quality of care (10%)	Preventable hospital stays	# of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees	5%	Mapping Medicare Disparities Tool	2016
	Mammography screening	% of female Medicare enrollees ages 65-74 that receive mammography screening	2.5%	Mapping Medicare Disparities Tool	2016
	Flu vaccinations	% of Medicare enrollees who receive an influenza vaccination	2.5%	Mapping Medicare Disparities Tool	2016

Social and Economic Environment (40%)					
Focus Area	**Measure**	**Description**	**Weight**	**Source**	**Year(s)**
Education (10%)	High school graduation	% of ninth-grade cohort that graduates in four years	5%	State-specific sources & EDFacts	Varies
	Some college	% of adults ages 25-44 with some post-secondary education	5%	American Community Survey	2013-2017
Employment (10%)	Unemployment	% of population aged 16 and older unemployed but seeking work	10%	Bureau of Labor Statistics	2017
Income (10%)	Children in poverty	% of children under age 18 in poverty	7.5%	Small Area Income and Poverty Estimates	2017
	Income inequality	Ratio of household income at the 80th percentile to income at the 20th percentile	2.5%	American Community Survey	2013-2017
Family and social support (5%)	Children in single-parent households	% of children that live in a household headed by a single parent	2.5%	American Community Survey	2013-2017
	Social associations	# of membership associations per 10,000 population	2.5%	County Business Patterns	2016
Community safety (5%)	Violent crime	# of reported violent crime offenses per 100,000 population	2.5%	Uniform Crime Reporting – FBI	2014 & 2016
	Injury deaths	# of deaths due to injury per 100,000 population	2.5%	CDC WONDER mortality data	2013-2017

Physical Environment (10%)					
Focus Area	**Measure**	**Description**	**Weight**	**Source**	**Year(s)**
Air and water quality (5%)	Air pollution - particulate matter[1]	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	2.5%	Environmental Public Health Tracking Network	2014
	Drinking water violations	Indicator of the presence of health-related drinking water violations. Yes - indicates the presence of a violation, No - indicates no violation.	2.5%	Safe Drinking Water Information System	2017
Housing and transit (5%)	Severe housing problems	% of households with overcrowding, high housing costs, or lack of kitchen or plumbing facilities	2%	Comprehensive Housing Affordability Strategy (CHAS) data	2011-2015
	Driving alone to work	% of workforce that drives alone to work	2%	American Community Survey	2013-2017
	Long commute - driving alone	Among workers who commute in their car alone, % commuting > 30 minutes	1%	American Community Survey	2013-2017

Health Outcomes				
Indicator Category	**Indicator**	**Franklin County**	**Florida**	**U.S.**
Length of life	Years of potential life lost before age 75 per 100,000 population (age-adjusted)	9,380	6,803	6,700
Quality of life	Percentage of adults reporting fair or poor health (age-adjusted)	18.9%	18.5%	16.0%
Quality of life	Average number of physically unhealthy days reported in past 30 days (age-adjusted)	4.3	3.8	3.7
Quality of life	Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	4.0	3.8	3.8
Quality of life	Percentage of live births with low birthweight (< 2500 grams)	8.1%	8.6%	8.0%

Health Factors – Health Behaviors				
Indicator Category	**Indicator**	**Franklin County**	**Florida**	**U.S.**
Adult smoking	Percentage of adults who are current smokers	18.2%	15.5%	17.0%
Adult obesity	Percentage of adults that report a BMI of 30 or more	33.1%	25.9%	28.0%
Food environment index	Index of factors that contribute to a healthy food environment, 0 (worst) to 10 (best)	7.5	6.7	7.7
Physical inactivity	Percentage of adults age 20 and over reporting no leisure-time physical activity	27.2%	23.8%	23.0%
Access to exercise opportunities	Percentage of population with adequate access to locations for physical activity	88.4%	87.0%	83.0%
Excessive drinking	Percentage of adults reporting binge or heavy drinking	24.7%	17.5%	18.0%
Alcohol-impaired driving deaths	Percentage of driving deaths with alcohol involvement	35.7%	26.4%	29.0%
Sexually transmitted infections	Number of newly diagnosed chlamydia cases per 100,000 population	347.0	454.8	478.8
Teen births	Number of births per 1,000 female population ages 15-19	65.4	25.3	27.0

Health Factors – Clinical Care				
Indicator Category	**Indicator**	**Franklin County**	**Florida**	**U.S.**
Uninsured	Percentage of population under age 65 without health insurance	17.1%	16.3%	11.0%
Primary care physicians	Ratio of population to primary care physicians	2,940:1	1376:1	1,320:1
Dentists	Ratio of population to dentists	3,967:1	1735:1	1,480:1
Mental health providers	Ratio of population to mental health providers	1,984:1	703:1	470:1
Preventable hospital stays	Number of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees	69.8	53.6	49.0
Diabetes monitoring	Percentage of diabetic Medicare enrollees ages 65-75 that receive HbA1c monitoring	82.2%	85.6%	85.0%
Mammography screening	Percentage of female Medicare enrollees ages 67-69 that receive mammography screening	53.0%	67.9%	63.0%

Health Factors – Social and Economic Environment				
Indicator Category	**Indicator**	**Franklin County**	**Florida**	**U.S.**
High school graduation	Percentage of ninth-grade cohort that graduates in four years	47.5%	77.9%	83.0%
Some college	Percentage of adults ages 25-44 with some post-secondary education	36.2%	61.8%	65.0%
Unemployment	Percentage of population ages 16 and older unemployed but seeking work	4.3%	4.9%	4.9%
Children in poverty	Percentage of children under age 18 in poverty	35.9%	21.3%	20.0%
Income inequality	Ratio of household income at the 80th percentile to income at the 20th percentile	5.2	4.7	5.0
Children in single-parent households	Percentage of children that live in a household headed by single parent	31.1%	38.5%	34.0%
Social associations	Number of membership associations per 10,000 population	11.9	7.1	9.3
Violent crime	Number of reported violent crime offenses per 100,000 population	456.8	499.6	380.0
Injury deaths	Number of deaths due to injury per 100,000 population	95.3	72.3	65.0

Health Factors – Physical Environment				
Indicator Category	**Indicator**	**Franklin County**	**Florida**	**U.S.**
Air pollution - particulate matter	Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5)	7.1	7.4	8.7
Severe housing problems	Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities	18.4%	21.5%	19.0%
Driving alone to work	Percentage of the workforce that drives alone to work	77.8%	79.5%	76.0%
Long commute - driving alone	Among workers who commute in their car alone, the percentage that commute more than 30 minutes	23.6%	39.5%	35.0%

Attachment B

Florida Department of Health in Franklin County
Franklin County Community Health Assessment Workshop
DOH-Franklin Large Conference Room
Thursday, August 16, 2018 9:00a.m. – 12:00p.m. EST

MINUTES

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

Topic	Discussion
Welcome/Call to Order ▪ Introductions ▪ Brief review of agenda ▪ Prompt attendees to sign-in	Sarah Hinds, DOH-Gulf/Franklin Administrator welcomed all partners. Suzy Nadler of the Healthy Start Coalition commended partner introductions, reviewed the agenda, informed everyone of basic housekeeping (bathroom locations, mute mobile phones, etc), and conducted the raffle for the prize giveaway. April Landrum of Apalachee Center won the prize, which was donated by the closing the DOH Gap Program.
Status Update of Previous Actions ▪ CHIP Progress Report Highlights ▪ How are our partners enhancing health for all those who live work and play in Gulf County? 1. CTG – Healthy Weight 2. North Florida Medical – Diabetes Management 3. AHEC – Access To Care 4. PanCare of Florida – Access To Care 5. Apalachee Center – Mental Health/Substance Abuse	Deanna "DT" Simmons, DOH-Gulf/Franklin CHA Coordinator facilitated the meeting. She opened by reviewing the highlights of the CHIP Progress Report and told the attendees to write their name and email on the evaluation at the end of the meeting if they wished to received an electronic copy of the most recent progress reports. In order to shed light the success our partners have had in helping make Franklin County the healthiest county in the nation, the facilitator asked several organizations to share their experience as they work to address the goals/priorities of the current CHIP cycle (2016-19). Alma Pugh and Talitha Robinson of the Closing the Gap program talked about their previous engagements working with the local faith-based community to promote healthy eating and physical activity among minorities in order to reduce the disparities in obesity and chronic disease. Talitha shared that Currently the group is working with youth using the CATCH curriculum. Amy Anderson of Eastpoint Medical Center shared that they now have a new Diabetes Educator/Case Manager. The manager provides support to diabetes via 10 diabetes control and educational sessions. Emily Kohler of AHEC spoke about the services that AHEC offers and provided handouts detailing times and dates that local counseling is available. Sean Golder, of PanCare of Florida spoke about the dental services the org has offered to students at the local schools. Mr. Golder also, talked about how much of

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Florida Department of Health in Franklin County
Franklin County Community Health Assessment Workshop
DOH-Franklin Large Conference Room
Thursday, August 16, 2018 9:00a.m. – 12:00p.m. EST

MINUTES

	the county has suffers with unreliable or inadequate transportation. To fill this need, PanCare has invested in several mobile units which can travel for community outreach events. Lastly April Landrum of Apalachee, informed us that the local center now has a full-time case manager. She also spoke of the new CAT program which helps clients who have not been successful at other interventions. This program will be housed out of Liberty but it will be made available to Franklin County as well. Kari Williams, the Tobacco Prevention Specialist for DOH-Gulf/Franklin shared a success with the group. Recently the City of Apalachicola has passed an Ordinance declaring that the play area of the locally managed parks be tobacco free.
What is MAPP? On the Road-MAPP for Community Health Assessment (CHA)?	DT Simmons, gave a high-level overview of the Mobilizing for Action through Planning and Partnerships (MAPP) process, stressing that this is a community-driven process that focuses on strategic approaches to addressing identified selected priorities.
Introduce Topic: Community Health Assessment - Mobilizing for Action through Planning and Partnerships Workshop: 1. Visioning a healthier community together 2. Local Public Health System Assessment process	DT Simmons, introduced the second step in the MAPP process to the group. She detailed the concept of collective or shared visioning with the partnership, followed by defining health and the local public health system (LPHS). She informed the group that today they would be creating a vision to guide them throughout this MAPP process and ultimately throughout the future Community Health Improvement Plan for 2019-2022. Additionally, she shared with the group that they would also be assessing the effectiveness and efficiency of LPHS.
Discuss Supporting Information: ▪ Vision – Meghalaya's Living Bridge ▪ Local Public Health System Assessment	To get the participants minds thinking about the significance vision plays in community planning DT Simmons, played the mini documentary film "Meghalaya's Living Bridge" for the partners. Following the short video, the group engaged in a focused discussion on their sentiments of the video. Read below for discussion questions and response highlights. **1. What is one scene that stayed with you?** *Responses included: Community. Sustainability. The*

Florida Department of Health in Franklin County
Franklin County Community Health Assessment Workshop
DOH-Franklin Large Conference Room
Thursday, August 16, 2018 9:00a.m. – 12:00p.m. EST

MINUTES

	Father teaching the child. It doesn't happen overnight. **2. In one word, how did the video make you feel?** *Responses included: Amazed. Hopeful. Comforted. Inspired.* **3. What is one message that you internalized from this video about their project or projects in general?** *Responses included: We need each other. We may not see it in our lifetime. We have to have vision.* **4. How can you apply the message of this video to future projects?** *Responses included: Anything can be accomplished. We can guide and teach.* After the video, partners were asked to partake in an activity. Partners were instructed to close their eyes, turn around slowly and point towards Timbuktu, Mali. **1. When you opened your eyes, what did you observe first?** *Responses included: Everyone was pointing in a different direction.* **2. How did this task make you feel?** *Responses included: Unsure. Lost.* **3. What was the main problem with the task?** *Responses included: We didn't know where Timbuktu was.* **4. How could this have been done differently to produce a collectively successful result?** *Responses included: Provide a map. Keep our eyes open. Allow group help. Start with a common location.* Simmons told the group that not having a shared vision in community planning is like closing your eyes, spinning around and simply pointing to a direction, with no understanding of where you are and how you will get where you want to go. After that activity, Hunter Bailey, DOH-Gulf S.W.A.T. Coordinator and Talitha Robinson facilitated an activity designed to help the group create their own vision statement. Partners were asked to close their eyes and envision a future Franklin County. Then when they opened their eyes, they were asked what they saw and what were their hopes and dreams for this county and the people. Partners verbalized their ideas, while Robinson wrote them all down inside a large circled, coined the "Ball of Hope". [see accompanying photo for

Florida Department of Health in Franklin County
Franklin County Community Health Assessment Workshop
DOH-Franklin Large Conference Room
Thursday, August 16, 2018 9:00a.m. – 12:00p.m. EST

MINUTES

	details]. Afterward Simmons gave the partners 5 tips for creating a vision and attendees were divided into smaller groups. Each person was given a note card to practice creating a vision. The mini groups voted amongst themselves on the best vision within their groups. The top vison was then posted on board and voted on by the participants at large. After tweaking the vision statements the partners created a unique vision to guide their efforts throughout the next several years. The selected: **"A united, healthy and prosperous Franklin County."** As the LPHS Assessment began, Simmons highlighted the web of public and private organizations, agencies, and partnerships that are all included within the LPHS, emphasizing that the system is much more than the local clinics and the local health department. She shared that some entities work on multiple essential public health services while others only work on a few, such as those with Policy Development function, or Assurance or only the Assessment sector. Participants remained in their smaller groups and discussed several activities, competencies and other aspects of the LPHS. Once group discussions were finished the group through 23 assessment questions in the first six (6) of the Ten Essential Public Health Services. The group voted privately on a piece of paper, ranking how well the LPHS performs each task, from No Activity, Minimally, Moderately, Significantly, or Optimally. Once finished they turned their assessments in. The partnership was told that future essential services will be assessed at the end of the next CHA workshop.
Consider Possible Directions and or Needs ▪ Community Health Status Survey ▪ MAPP workshops moving forward	DT Simmons, reminded some partners and introduced to others the Community Health Status (CHS) Survey which is a portion of the CHS Assessment. This assessment is designed to survey the thoughts, ideas and concerns of our community via the lens of the community. She said that this time around the survey will not only inquire about the issues and problems in the community, but it will also ask the community for possible solutions to address the issues as well. After defining the CHS Survey, Ms. Simmons showed the RoadMAPP, an illustration of the steps in the MAPP

Florida Department of Health in Franklin County
Franklin County Community Health Assessment Workshop
DOH-Franklin Large Conference Room
Thursday, August 16, 2018 9:00a.m. – 12:00p.m. EST

MINUTES

	process. While reviewing the illustration Ms. Simmons highlighted the four (4) MAPP assessments and briefly summaries the purpose and main actions of each assessment. She closed by saying that if all steps in the process are conducted collectively with the community, then together the partnership would see their selected vision come into fruition.
Open Floor for Community Input	Suzy Nadler invited everyone to this Saturdays, "A Walk To Remember" at St. Andrews Oaks By the Bay park. This event aims to honor the lives of infants lost prematurely while creating awareness and prevention of infant mortality. This free event is open to everyone. The walk starts at 9a.m. CST. Sean Golder had to leave early, so Jessie Pippin of DOH Gulf/Franklin told everyone about PanCare's open house, next Friday August 24th from 10:30 – 12:30. This open house encourages the community to come out to the clinic on Garrison Ave. in Port St. Joe, FL to meet and greet the new providers. PanCare is not fully staffed with a doctor, and arnp, a lcsw, and a therapist. Lunch will be served. Emily Kohler passed out fliers with countywide cessation class information on them.
Actions	DT Simmons, asked everyone to be on the lookout for the upcoming CHIP Meeting/CHA Workshop and to be prepared to help disseminate the Community Health Status Survey.
Meeting Evaluation	Stormy Johnson of the Liberty Senior Citizens Center, who was originally suppose to distribute and collect the post meeting evaluation was unable to make the meeting. Instead Leida Shiver passed them out.
Adjourn	DT Simmons, once again thanked everyone for coming and actively participating in the CHA workshop. She adjourned the meeting at 11:40p and encouraged everyone to eat at a local restaurant before returning to their offices.

(Add LPHS Survey results)

Florida Department of Health in Franklin County
Franklin County Community Health Assessment Workshop
DOH-Franklin Large Conference Room
Thursday, August 16, 2018 9:00a.m. – 12:00p.m. EST

SIGN-IN SHEET

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

#	Name	Organization or Community Representative	Email	Phone
1	Suzy Nadler	Healthy Start	suzy@healthystartbfs.com	850.872.4130
2	Emily Kohler	BBAHEC	ekohler@bigbendahec.org	850-224-1177
3	Frances Williams	Tobacco Prevention	Frances.Williams@flhealth.gov	850-372-0140
4	Sean Golden	PanCare Health	sgolden@pancarefl.org	850-210-2588
5	Sean Golden	Big Bend Health Council		
6	April Landrum	Apalachee Center	april@apalachecenter	850-274-3316
7	Talitha Robinson	DOH-Franklin-Gulf	talitha.robinson@flhealth.gov	653-2111
8	Amy Anderson	Eastpoint Medical	aanderson@nfmc.org	670 8585
9	Stephanie Cash	DOH - HF/HS	Stephanie.Cash@FLHealth.gov	850 323 6015
10	Alma Pusch	DOH CTG	alma.Pusch@flhealth.gov	850-653-2111
11	Randy Merritt	DOH CHOICES	randall.Merritt@flhealth.gov	850-816-2713
12	[illegible]	DOH - HF	phillip.Carter@flhealth.gov	
13	Hunter Bailey	DOH - SWAT	william.bailey@flhealth.gov	850-227-4330
14	Leida Shiver	Liberty Co Sr Citizens	libertysenior@gtcom.net	850-643-5690
15	Ann Kincaid	"	"	"
16	Megan Bennefield	DOH-Gulf/Franklin	megan.bennefield@flhealth.gov	850-227-1274
17	Jessie Pippin	DOH-Gulf/Florida	Jessie.Pippin@flhealth	" "
18	Kari Williams	DOH-Gulf/Franklin	kari.williams@flhealth.gov	850-340-3016
19	Sarah Hinds	DOH-Gulf	Sarah.Hinds@flhealth.gov	850-227-8366
20	Artaueya Ingram	Big Bend AHEC	aingram@bigbendahec.org	850-224-1177
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Attachment C

Florida Department of Health in Franklin County
Franklin County Community Health Improvement Partnership
DOH-Franklin Large Conference Room
Thursday, September 20, 2018 10:00a.m. – 12:00p.m. EST

MINUTES

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

Topic	Discussion
Welcome/Call to Order ▪ Introductions ▪ Brief review of agenda ▪ Prompt attendees to sign-in	DT Simmons, DOH-Gulf/Franklin CHA facilitator welcomed all partners. Suzy Nadler of the Healthy Start Coalition, kicked off the introductions by asking participants to state their name, organization, and their favorite place. Ms. Nadler provided basic housekeeping guidance and then reviewed an outline of the meeting agenda.
Review Previous Meeting	Ms. Simmons recapped the previous CHIP Meeting/CHA Workshop by reminding partners current CHIP cycle priorities and the newly crafted CHA cycle vision, "A united, healthy and prosperous Franklin County." Then she shared some information on the first segment of LPHS network and the Assessment process.
What is MAPP? On the Road-MAPP for Community Health Assessment (CHA)?	DT Simmons, gave a high-level overview of the Mobilizing for Action through Planning and Partnerships (MAPP) process. She started by defining the framework as a community-driven strategic planning process for improving community health. She then stressed that the process focuses on strategic approaches to prioritizing issues and identifying resources to address them. Afterward, Ms. Simmons reviewed what our local partners AHEC, Closing the Gap, and North Florida Medical Center in Eastpoint are doing to improve access to care.
Introduce Topic: ▪ Community Health Assessment - Mobilizing for Action through Planning and Partnerships Workshop: 1. Community Themes and Strengths 2. Forces of Change	Ms. Simmons introduced both the Community Themes and Strengths Assessment (CTSA) and the Forces of Change Assessment (FOCA). To paint a clearer picture of the CTSA she used a PowerPoint presentation displaying the three significant questions asked by the CTSA: "What is important to our community?" "How is quality of life perceived in our community?" and "What assets do we have that can be used to improve community health?" To answer these questions community members participated in three (3) specific community-led sessions: Themes, Quality of Life Survey and an Asset Inventory. Next the CHA facilitator introduced the major points of the forces of change that directly or indirectly affect the health of our community. She noted that these forces can be one time only events, growing trends, or present underlying factors. They are largely predictable but rarely controllable. Understanding these potential forces helps the community to reduce potential risk and ultimately improve their chances of

1

Florida Department of Health in Franklin County
Franklin County Community Health Improvement Partnership
DOH-Franklin Large Conference Room
Thursday, September 20, 2018 10:00a.m. – 12:00p.m. EST

MINUTES

	reaching the shared vision.
Discuss Supporting Information: 1. Community Themes and Strengths Activities ▪ Quality of Life Survey, Asset Inventory, Small Group Discussions 2. Forces of Change ▪ Consensus Workshop among CHA participants	Ms. Simmons and Megan Bennefield, DOH-Franklin/Gulf Health Educator facilitated the CTSA beginning by surveying the quality of life in Franklin County, then a local countywide asset inventory followed by a small group discussion to garner reoccurring community sentiments/themes. The quality of life survey consisted of 8 questions on various core topics like childcare, community relations, education, employment, health, and housing among others. Feedback to the survey questions was measured using a Likert scale ranging from 1. Most Negative to 5. Most Positive. Around the meeting room response stations were designated for each of the possible Likert scale answers. When a question was read from the survey, participant quickly relocated to the portion of the room with the response that most nearly correlated with their belief on the quality of life. (See the attached document for survey data.) Ms. Bennefield led the partnership in a community asset inventory designed to help identify the individuals (with knowledge/skills), the public and private institutions, citizen associations/organizations, and other entities within the community with the means and resources to help the partnership bring our vision into fruition. Many partners were unaware that so many other organizations and/or services were available in Franklin County. (See the attached pages for more information.) During the small group discussion, partners were instructed to rotate around the room to preassigned stations where the following questions were written on flipcharts. Group members added responses to each chart as necessary. **1. What makes you most proud of our community?** Answers include: Coming together in time of need. The connection and support. Community offering. Safe place. **2. What would excite you enough to be involved or more involved in improving our community?** Answers include: More people involved. Open minded. Family oriented. **3. What do you believe is keeping our community from doing what needs to be done to improve the quality of life?**

	Answers include: Access to affordable housing, good jobs, and transportation. Substance abuse, mental health issues and negative cycles and perceptions. **4. What do you believe are the 2-3 most important characteristics of a healthy community?** Answers include: Education. The economy and job opportunities. Active engagement/involvement. Healthy choices and healthy choice options. Once all rotations were complete and all questions have been answered, group leaders reported responses to the attendees at large. After the CTSA, the two facilitators led the group in a Consensus workshop to help identify the FOC. Ms. Bennefield asked the partners what FOC are directly or indirectly affected the health of our community. She followed that up by informing us that these forces can be one time only events, growing trends, or present underlying factors. They are largely predictable but rarely controllable. She stressed that understanding these potential forces will help the community to reduce potential risk and ultimately improve their chances of reaching the shared vision. Responses to the question, "What is currently happening or could happen that would affect the health of our community?" include: Funding for services, Political Influence, Economy, Environmental Factors, Quality of School Education, and Substance Use. After the brainstorming session, the facilitators told the partners that each FOC category creates various opportunities and/or poses various threats. So participants reviewed all of the FOC and listed the potential opportunities and/or threats associated with the items. This list will better help communities to strategize their next steps towards achieve their shared vision. (See the accompanying documents for a complete list of the opportunities and threats.) After completing the major segments of the two assessments, the Ms. Simmons directed the partners attention to the NACCHO RoadMAPP displayed on the PowerPoint presentation. While reviewing the illustration, Ms. Simmons highlighted the four (4) MAPP assessments and briefly summaries the purpose and main actions of each assessment. She closed by saying that if all steps in the process are conducted collectively with the

Florida Department of Health in Franklin County
Franklin County Community Health Improvement Partnership
DOH-Franklin Large Conference Room
Thursday, September 20, 2018 10:00a.m. – 12:00p.m. EST

MINUTES

	community, then together the partnership would see their selected vision come into fruition.
Actions	DT Simmons, asked to be prepared to help disseminate the Community Health Status Survey.
Meeting Evaluation	Emily Kohler, A.H.E.C., who was distributed and collected the post meeting evaluation.
Adjourn	DT Simmons, once again thanked everyone for coming, encouraged everyone to be on the lookout for the upcoming CHA Workshop invitation, and for their continued efforts in advancing our CHIP agenda. The meeting was adjourned at around 12:00p

Florida Department of Health in Franklin County
Franklin County Community Health Assessment Workshop
DOH-Franklin Large Conference Room
Thursday, September 20, 2018 10:00a.m. – 12:00p.m. EST

SIGN-IN SHEET

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

#	Name	Organization or Community Representative	Email	Phone
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3	Emily Kohler	Big Bend AHEC	ekohler@bigbendahec.org	850-224-1177
4	Talitha Robinson	DOH-Franklin	Talitha.Robinson@flhealth.gov	653-2111
5	Alma Push	DOH Franklin/Gulf	Alma.Push@flhealth.gov	653-2111
6	James Lewis	BB AHEC	jlewis@bigbendahec.org	718-7935
7	Valentina Webb	CareerSource FC	vwebb@careersourcefc.com	850 370 0114
8	Kai Williams	DOH-Gulf/Franklin	Kai.williams@flhealth.gov	850-390-3016
9	DT Simmons	DOH - Gulf/Franklin	Deanna.Simmons@flhealth.gov	
10	Jessie Pippin	DOH-Gulf/Franklin	Jessie.Pippin@flhealth.gov	(850) 227-1276
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Attachment D

Florida Department of Health in Franklin County
Franklin County Community Health Assessment Workshop Meeting # 3
DOH-Franklin Large Conference Room
August 27, 2019 10:00a.m. - 12:00p.m. EST

COMMUNITY MEETING MINUTES

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

Speaker	Topic	Discussion
Emily Kohler, Big Bend AHEC Tobacco Program Manager	Welcome/Call to Order ▪ Introductions ▪ Brief review of agenda Prompt attendees to sign-in	Emily Kohler with AHEC opened by welcoming everyone to the meeting, outlining the agenda, reviewing basic housekeeping, and participant introductions.
DT Simmons, DOH-Franklin CHA Coordinator	Review Previous Assessment Findings	DT Simmons reminded everyone of the previously selected vision, "A united healthy and prosperous Franklin County" and highlighted the findings from the Local Public Health System (LPHS) Assessment, the Community Themes and Strengths, and the Forces of Change. **(Note: See previous minutes for more details on the findings from these assessments.)**
Sarah Hinds, DOH-Franklin/Gulf Administrator Talitha Robinson, DOH-Franklin/Gulf Health Educator DT Simmons, DOH-Franklin CHA Coordinator	Introduce Topic: ▪ Overview of the phases of MAPP ▪ Health disparities/gaps within our community ▪ Data Review 1. Discussion of the findings 2. Detail how common concerns/problems were identified	Sarah Hinds directed the group's attention to the MAPP slide on the large screen. Sarah helped viewers to conceptualize how through the four MAPP CHA assessments, the partnership can collectively achieve a desired healthy outcome. She share how integral each component is to achieving our vision. Talitha Robinson of the Closing the Gap Program facilitated a presentation on the significant of health equity. Throughout the presentation she engaged the participants by showing them visual representations of equality vs. equity and questioning them on the difference between the two. She wrapped up the presentation by expressing that there is no one size fits all approach to providing healthcare support. Stressing that in order to really close the health disparity gap, the LPHS must work to meet the diverse needs of the community, providing the, education, resources, services, support, and/or tools necessary to help live healthier lives.

Florida Department of Health in Franklin County
Franklin County Community Health Assessment Workshop Meeting # 3
DOH-Franklin Large Conference Room
August 27, 2019 10:00a.m. - 12:00p.m. EST

COMMUNITY MEETING MINUTES

		The final portion of this segment was the data review. DT Simmons highlighted the data from the Community Health Status Assessment (CHSA). This assessment began in January and finished in July. The assessment was composed of from the RWJ County Health Rankings, Weems Memorial Hospital, Florida Charts, the Community Health Status Survey, and the US Census. In order to share the data collected from the CHSA, Ms. Simmons instructed the workshop attendees to: 1. Divide into small groups. 2. Select a table facilitator. 3. Review the data provided. 4. Discuss interesting findings with your group. 5. Report out to the partnership. After the groups reviewed and discussed the data Ms. Simmons engaged the participants in a focused conversation, asking the following questions: 1. What interesting data have you observed? Lack of access to providers. Mental health disorders like anxiety is a common hospital patient diagnosis. Drug abuse fuels other adverse health outcomes. Low environmental health air quality. Many hospital diagnoses are related to respiratory related issues. Heart health seems to be a constant issue. College attendance is very low. Teen pregnancy rate 3x the state rate. Higher children in poverty and other poor SES data. 2. What seems the most critical? Substance abuse. Mental health access. Overall health care access. Primary care. Environmental quality. Premature death. Obesity. Education. Teen pregnancy.

Florida Department of Health in Franklin County
Franklin County Community Health Assessment Workshop Meeting # 3
DOH-Franklin Large Conference Room
August 27, 2019 10:00a.m. - 12:00p.m. EST

COMMUNITY MEETING MINUTES

		3. What appears to be the central issue of key problem area? - Drug abuse lead to other issues. People are self medicating. - Lack of providers causes issues in access to care overall. - Education. Little emphasis on education is affecting SES. - Environmental health factors like air quality and drinking water is poor. Also may be leading to issues like asthma. 4. What are the consequences of not addressing this issue? See next agenda item.
Jessie Pippin, DOH-Gulf, Operations Manager	Discuss Supporting Information: ▪ Activity #1: What are the consequences of not addressing this issue? Activity #2: Weighted Priority Matrix	What are the consequences of not addressing this issue: Substance Abuse, Access to Care, Environmental Health, SES, and Mental Health? Substance Abuse: - More premature death. Violent crime. Suicide rates increase. Increase in child and elder abuse. Increase in ACES. Access to Care: - Premature death (mortality). Increase in chronic disease comorbidities. Environmental Health: - Increase in comorbidities. Drain on Medicaid and Medicare. Increase in obesity. Socioeconomic Status (SES): - Wider poverty gap. Increase in brain drain (young people exiting community for work and opportunity). Mental Health: - Increase in suicide and substance abuse, arrest and crime, poverty, stigma. Increase in ACEs. More youth go undiagnosed. Jessie Pippin facilitated a weighted priority matrix. Each participant was

Florida Department of Health in Franklin County
Franklin County Community Health Assessment Workshop Meeting # 3
DOH-Franklin Large Conference Room
August 27, 2019 10:00a.m. - 12:00p.m. EST

COMMUNITY MEETING MINUTES

		given 10 voting slips (Post-It Notes) and instructed to vote for the two issues that best correspond to the following 5 statements. 1. Do we have the resources available to address this problem? 2. Does this problem have community support? 3. Which problems align with our vision? 4. Does this problem help to reduce health disparities? 5. Can we do something about this problem within the 3 year CHA cycle? 6. Could working on this problem support other identified problems? The votes for each question were tallied. The results were as follows: Mental Health – 77 votes Limited Access to Care – 76 votes Substance Abuse – 68 votes Socioeconomic Status – 57 votes Environmental Health – 17 votes The partners decided to focus on the top three community health issues: Mental Health, Access to Care, and Substance Abuse.
DT Simmons, DOH-Franklin CHA Coordinator	Actions	DT Simmons urged every partner to take this information back to their offices and share with their teams. Each partner was also encouraged to think about what resources, initiatives, and actions they could dedicate to improving the top three selected focus areas. The next steps will be to gather back as a group and create objectives and supportive task/actions to address the stated objectives.
Hunter Bailey, DOH-Franklin/Gulf Health Educator	Open Floor for Community Input	Hunter Bailey informed the partnership of the new Point of Sale committee and encouraged the group to join the Tobacco Free Partnership. Jessie Pippin invited everyone to the upcoming Mental Health First Aid training hosted by our partner Apalachee Center.

Florida Department of Health in Franklin County
Franklin County Community Health Assessment Workshop Meeting # 3
DOH-Franklin Large Conference Room
August 27, 2019 10:00a.m. - 12:00p.m. EST

COMMUNITY MEETING MINUTES

Emily Kohler, Big Bend AHEC Tobacco Program Manager	Meeting Evaluation	Emily Kohler was assisted by Tammy Davis of the Healthy Families Program in distributing the evaluations.
	Adjourn	The meeting was adjourned at 12:05p.m.

Franklin County Community Health Status Assessment Survey

Age: ___ 18- 25 ___26-44 ___45-65 ___Older than 65

Sex: ____Male ____Female ____ Prefer not to answer

Education: ____Less than high school ____High school Diploma ____Vocational/Technical School ____2-year college Degree/Associates ____4-year college Degree/Bachelors or higher

How do you best describe yourself? ____ American Indian or Alaskan Native ____Asian ____Black or African-American ____Native Hawaiian or Other Pacific Islander ____White ____ Other

Are you Hispanic or Latino? _____ Yes _____ No

Which Franklin County community do you reside in? ____ Airport Community (Apalachicola) ____ Bluff Rd (Apalachicola) ____ Hillside Community (Apalachicola) ____ Two Mile (Apalachicola) ____ Other (Apalachicola) | ____ The Bluff (Eastpoint) ____ Ridge/Wilderness Rd Area (Eastpoint) ____ CC Land Rd Area (Eastpoint) ____ Other (Eastpoint) | ____ St. George Island | ____ Hwy 67 Area (Carrabelle) ____ River Rd Area ____ The Hill (Carrabelle) ____Three Rivers Rd. Area (Carrabelle) ____ Other (Carrabelle) | ____ Lanark Village | ____ Franklin County

1. Please select your top 5 health issues in the county that concern you the most?

- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Excess weight/obesity
- ☐ Homelessness
- ☐ Tobacco Use
- ☐ HIV/AIDS and other STDs
- ☐ Unplanned pregnancy
- ☐ Heart disease/stroke
- ☐ Dementia/Alzheimer's disease
- ☐ Diabetes
- ☐ Depression and Anxiety
- ☐ High Cholesterol/High blood pressure
- ☐ Arthritis

2. Please select your top 5 major concerns in Franklin County.

- ☐ Abandoned/run down structures
- ☐ Quality street lighting
- ☐ Pollution issues
- ☐ Poor road conditions
- ☐ Lack of mental health/substance abuse services
- ☐ Affordable medication
- ☐ Access to health care service
- ☐ Medical care for children
- ☐ Access to healthy food
- ☐ Access to child care
- ☐ Affordable housing
- ☐ Access to transportation
- ☐ Unsafe neighborhood
- ☐ Crime
- ☐ Drug activity
- ☐ Speeding/reckless driving
- ☐ Lack of services/community centers for youth or senior
- ☐ Community resources awareness
- ☐ Not enough minority educators
- ☐ Resident involvement in the community
- ☐ Lack of education on criminal re-entry
- ☐ Lack of recreation areas and parks
- ☐ Lack of jobs
- ☐ Limited job training

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

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

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

- ☐ Bug Infestation
- ☐ Mold
- ☐ Lead paint or pipes
- ☐ Lack of heat
- ☐ Oven or stove not working
- ☐ No or not working smoke detectors
- ☐ Electrical
- ☐ House foundation/structure
- ☐ Rent/Cost of Housing
- ☐ Roof
- ☐ None of the above

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

____Yes ____No

6. Do you currently have a job?

____Yes ____No ____Retired _____ Disabled

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

____Yes ____No ____N/A

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

____Yes ____No _____N/A

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

____Yes ____No ____N/A

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

____Never ____Rarely ____Sometimes ____Often ____Always

If so, was this a result of the storm? ____Yes ____No

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

____0-1 time ____2-3 times ____3 or more times

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

____Yes ____No

Florida Department of Health in Franklin County
Franklin County Community Health Assessment Workshop Meeting #3
DOH-Franklin Large Conference Room
Tuesday, August 27, 2019 10:00a.m. – 12:00p.m. EST

SIGN-IN SHEET

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

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3	Jessie Pippin	DOH Gulf/Franklin	Jessie.Pippin@flhealth.gov	227-4192
4	Erica Head	Holy Family Senior Center	holyfamilyseniorcenter@gmail.com	653-3134
5	Cynthia Mason	" " and ECCC	sprouse mason@live.com	323-0082
6	Mary Whitesell	DOH-Franklin	mary.whitesell@fl.health.gov	323-6021
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8	Sharon Ques	BEG Healthy Start	Weathington@Comcast	872-4130
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12	Myrtis Wynn	Community	[illegible]@gmail.com	774 8844
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15	Sarah Hinds	DOH-Franklin	Sarah.Hinds@flhealth.gov	227-836
16	Jenna Harper	Apalachicola NERR	jennifer.harper@floridadep.gov	670-7716
17	Emily Kohler	Big Bend AHEC	ekohler@bigbendahec.org	850-224-1171
18	George Parsons	PanCare Health	gparsons@pancarefl.org	850-874-6995
19	Kyle Root	Safe Routes to School	kroot@uwchflorida.com	910 622 6992
20	Alma Rush	DOH Franklin/Gulf	alma.rush@flhealth.gov	850-323-6025
21	Shakima Martins	Big Bend Cares	smartins@bigbendcares.org	8505451869
22	Valentina Webb	Career Source Gulf C	VWebb@careersourcegc	850 370 0116
23	Jason Simmons	DCF	Jason.Simmons@myflfamilies.com	850-508-2692
24	Jania Kadar	Carrabelle UMC	pastorjania@gmail.com	954-483-709[illegible]
25	DT Simmons	DOH-Franklin	Deanna.Simmons@flhealth.gov	
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