2021-2026
Martin County
Community Health Improvement Plan

Updated February 2022

Facilitated by: HCSEF Health Council of Southeast Florida

MARTIN COUNTY

2021 COMMUNITY HEALTH IMPROVEMENT PLAN

JUNE 2021 – JUNE 2026

UPDATED FEBRUARY 2022

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HCSEF Health Council of Southeast Florida

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EXECUTIVE SUMMARY

The Florida Department of Health in Martin County (DOH-Martin) conducts the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) process every five years to make meaningful improvements in community health. In 2019, DOH-Martin engaged the Health Council of Southeast Florida (HCSEF) to facilitate a comprehensive CHA and CHIP using the National Association of City and County Health Official (NACCHO) strategic planning framework Mobilizing for Action through Planning and Partnerships (MAPP) to guide the process.

The resulting CHIP was developed thanks to the community partners who took a meaningful part in the process and who comprised the Martin County Community Health Advisory Council. The Council included diverse representation from across the local public health system. During this process, the Martin County Community Health Advisory Council reviewed, analyzed, and synthesized CHA data, which informed the 2021 Martin County CHIP.

From December 2020 to May 2021, HCSEF facilitated the examination of cross-cutting strategic issues that emerged from the CHA to identify strategic priority areas. Then, throughout several meetings, the Martin County Community Health Advisory Council developed goals, objectives, and strategies to address each priority area, refined each priority area, and prioritized goals and strategies to focus on based on community resources and community support to ultimately develop the CHIP.

The Martin County CHIP addresses public health priorities and defines how partners will implement health improvement initiatives in Martin County. The following are the **2021 Martin County CHIP Strategic Priority Areas:**

- Access to Health and Human Services
- Mental Health and Substance Use
- Economic and Social Mobility

Thanks to the dedication of the Martin County Community Health Advisory Council, the CHIP plan is a thorough and executable plan that all Martin County partners can use to guide community health planning activities in the coming years. This Plan outlines the goals, objectives, and strategies that Martin County Community Health Advisory Council developed to address the community health priority areas identified in the CHA. We hope that you will review this Plan and consider how you can play a role in achieving a healthier Martin County.

DOH-MARTIN PUBLIC HEALTH LEADERSHIP

In an effort to establish public health policies, practices and capacity to improve the health of Martin County residents, the Florida Department of Health in Martin County (DOH-Martin) engaged the Health Council of Southeast Florida (HCSEF) to facilitate a county-wide health assessment and the development of a Community Health Improvement Plan (CHIP) using the Mobilizing Action through Planning and Partnership (MAPP) model. MAPP is a community-driven process used to mobilize and engage the community, conduct community-driven planning, and develop partnerships to strengthen Martin County's public health system and infrastructure.

Through each planning activity, DOH-Martin ensured that a health equity lens be applied and that social determinants of health were addressed. In partnership with HCSEF, DOH-Martin disaggregated data to identify health disparities and meaningful differences among subpopulations in Martin County. DOH-Martin used this health equity data to inform strategic priority areas, develop data-informed and evidence-based strategies, and identify strategic public health practices to address health issues and the social determinants of health. Informed by this data, the plan specifically addresses access to health and human services, mental health and substance use, poverty, and transportation.

In addition, to ensure the integration of the community voice, effective community engagement, and to build public health capacity, DOH-Martin and HCSEF identified and invited partners from diverse sectors of the public health system to join the Martin County Community Health Advisory Council and participate in strategic planning meetings. These partners include behavioral health professionals, first responders, community-based organizations, and educational organizations. Moreover, to increase equitable representation and ensure community buy-in, DOH-Martin and HCSEF engaged Martin County residents through four Community Input events. These events included a session at a local church, two local libraries, a fast-food establishment and a mental health awareness community event.

During the Community Health Advisory Council meetings, DOH-Martin and HCSEF used data and evidence to highlight health benefits and consequences of proposed policies and programs. In addition, DOH-Martin and HCSEF conducted literature reviews to ensure evidence-based public health practices, the integration of cultural competence, the application of health equity, and the incorporation of system-level changes to address social determinants. Two examples of proposed organizational policies within the 2021 Community Health Improvement Plan are the implementation of cultural competency and health literacy trainings for health and human service providers and the revision of client intakes for health and human services to include an insurance status screen.

Alongside the Martin County Community Health Advisory Council, the DOH-Martin leadership team developed and refined the goals, objectives, and strategies outlined in the 2021 Martin County Community Health Improvement Plan to address the most pressing health and social service needs identified in the 2020 Martin County Community Health Assessment. This Plan

incorporates health equity goals and metrics into each evidence-informed strategy, program and policy selected.

Dedicated partners collaborated, brainstormed, reviewed and discussed strategies for improving health outcomes in Martin County and developed the 2021 CHIP, which is a thorough and executable plan that can be used in the community's health planning activities in the coming years. To ensure shared responsibility throughout the CHIP process, DOH-Martin uses a highly collaborative process to develop the CHIP. A lead agency is responsible for both overseeing implementation efforts for each of the strategies within each priority area and tracking and reporting progress toward meeting the objectives. During Community Health Advisory Council meetings, all Community Health Advisory Council members are encouraged to provide updates on the status of current health indicators and to propose new activities to further improve outcomes.

As the CHIP is implemented, DOH-Martin will provide support and technical assistance to priority area leads as needed. To track the CHIP progress, DOH-Martin engaged HCSEF to develop a tracking tool to collect updated data on the selected objectives from partner organizations and secondary sources. The Community Health Advisory Council will meet to review the Plan and discuss progress, successes, challenges, and barriers. The Community Health Advisory Council members will have opportunities to propose new goals, strategies or objectives to the Plan during these meetings. If changes are necessary or requested, a majority consensus will be used to determine if a priority area will be reassessed or revised, and the annual progress report will include these revisions.

ACKNOWLEDGEMENTS

The Florida Department of Health in Martin County (DOH-Martin) and the Health Council of Southeast Florida (HCSEF) would like to recognize the diverse community members and partners who contributed to the development of the 2021 Martin County Community Health Improvement Plan (CHIP). This Plan is the product of a series of strategic planning meetings held with the Martin County Community Health Advisory Council and reflects the input of diverse Martin County residents and organizations. Each participant in this process is an advocate for their agencies, their community, the populations they serve, and the overall health of Martin County. Therefore, we extend our appreciation and gratitude to Martin County residents and the Martin County Community Health Advisory Council partner agencies. Thank you for your dedication on working collaboratively to create a healthier Martin County and improve and enhance services to better the entire Martin County community.

211 Palm Beach/Treasure Coast
AmBetter
Children's Services Council of Martin County
City of Stuart
Communities Connected for Kids
Florida Community Health Center
Florida Rural Legal Services
Healthy Start of Martin County
House of Hope/Golden Gate Center
IMOVEU
Indian River State College
IRMO Early Learning Coalition
Kane Center/Council on Aging of Martin County
Light of the World Charities
Love and Hope in Action (LAHIA)
Martin County Board of County Commissioners
Martin County Fire Rescue
Martin County Health and Human Services
Martin County Library System
Martin County Pre-K Programs/Head Start
Martin County Public Transit
Martin County School Board
Martin County Sheriff's Department
Mary's Home
Palm Beach County Behavioral Health Coalition
Pentecostal Church of God/Hands of Hope
Project Lift
The Council on Aging of Martin County
The Healing Center of Martin County
The Salvation Army
Treasure Coast Food Bank
Florida KidCare Coalition
Treasure Coast Hospice
Tykes & Teens, Inc
UF/IFAS Family Nutrition Program
United Way of Martin County
Volunteers in Medicine

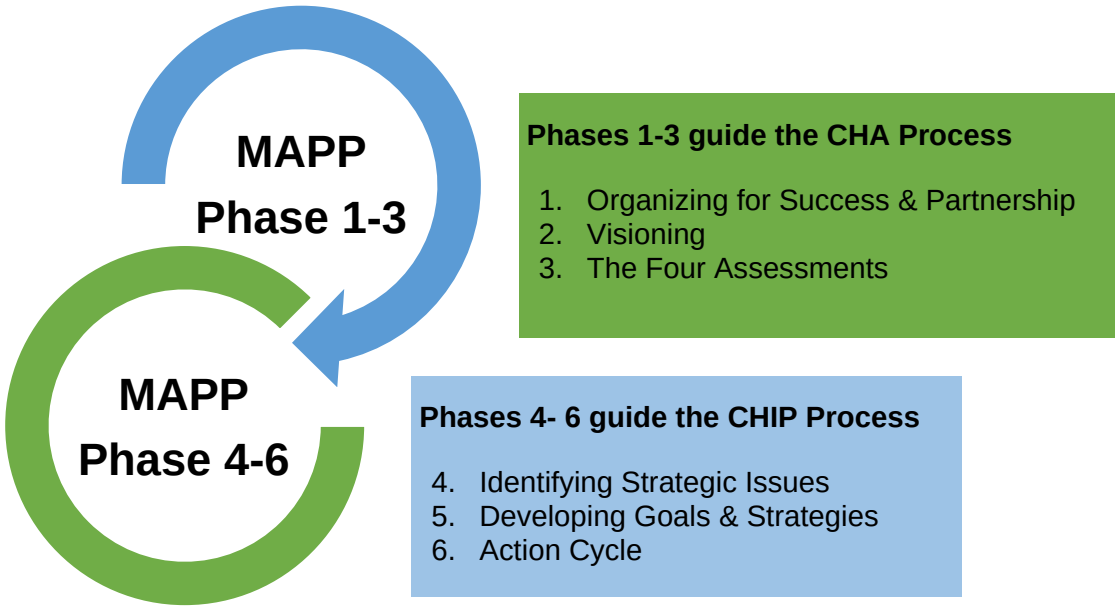
INTRODUCTION

The 2021 Martin County Community Health Improvement Plan (CHIP) is a long-term, strategic plan that defines how local public health systems partners will work collaboratively to improve the health of Martin County. The local public health system includes people and organizations in Martin County that contribute to the health of those who live, work, learn and play in the community.

In 2019, the Florida Department of Health in Martin County engaged the Health Council of Southeast Florida (HCSEF) to facilitate a comprehensive Community Health Assessment (CHA) and the development of the CHIP for Martin County. HCSEF facilitated the CHA and CHIP process using the Mobilizing for Action through Planning and Partnerships (MAPP) model. The National Association of County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC) developed this model to provide a strategic approach to community health improvement. MAPP is an interactive process that can improve local public health system efficiency, effectiveness, and performance. The CDC designed MAPP to help communities achieve optimal health and high quality of life for all residents.

The MAPP process consists of six (6) phases. Phases 1 through 3 guided the CHA process and Phases 4 through 6 guided the CHIP process (see Figure 1).

Figure 1:The Six Phases of the MAPP Process



HCSEF collected, analyzed, and compiled health and human service data throughout the MAPP process. The Martin County Community Health Advisory Council used this data to identify

strategic health issues within Martin County that present areas of concern, gaps in care or services, and overall opportunities for improvement. The strategic priority areas identified include:

- Access to Health and Human Services
- Mental Health and Substance Use
- Economic and Social Mobility

HCSEF then guided the Martin County Community Health Advisory Council to develop the goals, objectives, strategies, actions, and performance measures for each of the selected priority areas outlined below in the 2021 Martin County CHIP. This Plan focuses on improving the most pressing health and social service needs identified in the CHA by utilizing community resources efficiently and forming collaborative partnerships for strategic action while accounting for community needs.

CAPACITY, COLLABORATION AND CONTINUED INVOLVEMENT

Community health improvement efforts are grounded in collaboration, partnership, and cooperation to help achieve common priorities and goals through aligned strategies. Multi-sector community ownership is a fundamental part of both the community health needs assessment and the community health improvement plan, including assessing, planning, investing, implementing, and evaluating.

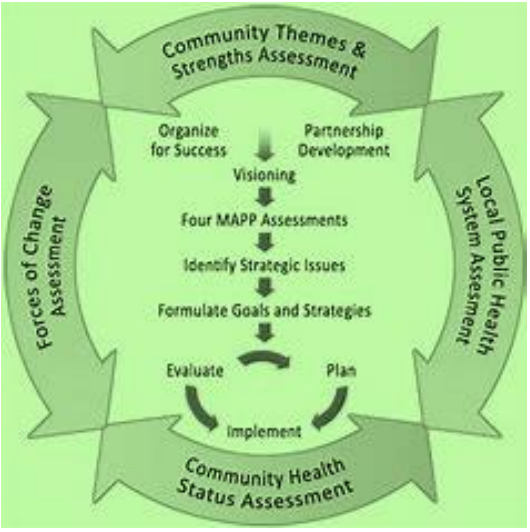
Therefore, in 2015, the Martin County Community Health Advisory Council was established by DOH-Martin and HCSEF. The objective of this diverse group of community stakeholders is to improve the quality of life and the health status of Martin County residents and guide ongoing CHA and CHIP processes.

Participation from a broad community spectrum is essential in identifying effective strategies to complex community health problems and developing a comprehensive implementation plan in a community. Proactive and diverse community engagement improves results by garnering a shared commitment to improve health outcomes, forming a continuous stream of open communication, and creating a shared measurement and evaluation process to assure efficient progress.

The Martin County Community Health Advisory Council has representation from the following sectors: healthcare, education, public health, mental health, substance abuse, law enforcement, parks and recreation, business and industry, volunteer and non-profit organizations, and organizations known for serving the underserved and vulnerable populations. You can find a complete listing of community partners in Appendix A. Their continued involvement in the community is an invaluable component of the community health improvement plan.

MOBILIZING ACTION THROUGH PLANNING AND PARTNERSHIP

Every five years, the Florida Department of Health in Martin County (DOH-Martin) works with community partners to assess the health of Martin County. In September of 2019, DOH-Martin engaged HCSEF to facilitate the community health assessment and the community health improvement plan process using the Mobilizing for Action through Planning and Partnerships (MAPP) model. MAPP is a community-wide strategic community planning tool widely used for its strength in bringing together diverse community stakeholders to collaboratively determine the most effective way to improve the community's health. DOH-Martin adopted MAPP as the primary tool to conduct the Community Health Needs Assessment and Community Health Improvement Plan processes. MAPP was developed by the National Association of County and City Health Officials (NACCHO) in cooperation with the Public Health Practice Program Office of the Centers for Disease Control and Prevention (CDC). Martin County seeks to create an optimal community for health by identifying and using existing and potential resources widely using the MAPP model.



OVERVIEW OF THE 2020 CHA PROCESS

MAPP PHASE 1: ORGANIZING FOR SUCCESS AND PARTNERSHIP

Phase one of the MAPP process answers the following questions:

- Who should be included in the MAPP process?
- Is the community ready to conduct the MAPP process?
- What resources are needed to implement the MAPP process?
- How will the community proceed through the MAPP process?

In 2019, DOH-Martin contracted HCSEF to facilitate the MAPP process in Martin County. During this planning phase, DOH-Martin and HCSEF planned the new CHA and CHIP engagement activities and identified new partners to join the Martin County Community Health Advisory Council.

MAPP PHASE 2: VISIONING

During the Visioning phase, the community members and local public health system partners are guided through the process of collaboratively determining a focus, purpose, and direction for the MAPP process that results in a shared vision and corresponding value statements.

Figure 2: Healthy Martin County Vision

2020 Healthy Martin County Vision

A Martin County Community...

- That **addresses social determinants of health and** root causes of health inequities;
- Where residents have **access to health and human services** that are equitable, affordable, and available;
- That uses **a holistic approach** to identify and address residents' mental, physical, and spiritual needs; and
- Where l**eaders and residents are equal partners** in community initiatives.
- We want to create a **healthier and equitable community** for residents to thrive and live a healthy life.

In February 2020, HCSEF facilitated the process of developing visions and values to guide the new CHA and CHIP process with the Martin County Community Health Advisory Council. The HCSEF team reminded the Martin County Community Health Advisory Council members of the guiding vision and values during each CHA and CHIP meeting.

MAPP PHASES 3: THE FOUR ASSESSMENTS

Local Public Health System Assessment (LPHSA)

The Local Public Health System Performance Assessment is a broad assessment of the organizations and entities that contribute to the public's health and addresses the following questions:

- What are the activities, competencies, and capacities of our local health system?
- How are Essential Services being provided to our community?

Martin County's Local Public Health System Assessment indicated that one (10%) of the essential public health services was optimal, two (20%) were moderate, and seven (70%) were significant. Essential service areas with the lowest scores were "Essential Service 7: Link people to needed personal health services and assure healthcare provision when otherwise unavailable" and "Essential Service 10: Research for new insights and innovative solutions to health problems." These findings provided insight on areas that the local public health system could focus on in the 2021 CHIP.

Table 1: Martin County Local Public Health Assessment

#	Essential Public Health Service	Assessment
1	Monitor health status to identify community health problems	Significant
2	Diagnose and investigate health problems and health hazards	Optimal
3	Inform, educate and empower people about health issues	Significant
4	Mobilize community partnerships to identify and solve health problems	Significant
5	Develop policies and plans that support individual and community health efforts	Significant
6	Enforce laws and regulations that protect health and ensure safety	Significant
7	Link people to needed personal health services and assure the provision of healthcare when otherwise unavailable	Moderate
8	Assure a competent public and personal healthcare workforce	Significant
9	Evaluate effectiveness, accessibility, and quality of personal and population-based health services	Significant
10	Research for new insights and innovative solutions to health problems	Moderate

Community Health Status Assessment (CHSA)

The Community Health Status Assessment helps identify priority issues related to community health and quality of life by compiling and analyzing secondary local, state and peer community data. The collected data identifies health disparities concerning age, gender, race and other demographics. It answers the questions:

- How healthy are Martin County residents?
- What does the health status of our community look like?

From February to December 2020, HCSEF conducted a comprehensive review of secondary data sources to obtain the most reliable and current data for the Community Health Assessment. The Martin County Community Health Advisory Council vetted this data over a series of five meetings during this time-frame. Below is a snapshot of the Community Health Assessment results, which informed the selection the 2021 CHIP priority areas.

Table 2 below highlights the demographic and socioeconomic profile of Martin County.

Table 2: Demographic and Socioeconomic Profile

Demographic and Socioeconomic Profile		
2019	Total Population	158,006 (0.7% of Florida's population)
	Population Aged 65 and Older	30.9%
	Identified as Hispanic or Latino	13.9%
	Speak a language other than English at home	13.0%; 43.2% of these individuals speak English less than very well
	Homeless Count	219 adults and 86 children (total: 305)
	Unemployment Rate	4.5%
2018	Poverty	• 11% of the population lived below the poverty level • Percent 2.5 times higher among Black residents than White residents • Percent 3 times higher among residents who identify as some other race than White residents • Percent 2.5 times higher among Hispanic residents than Non-Hispanic residents
	High school graduation rate	88% (compared to 86.1% in Florida)

Table 3 highlights the health status profile of Martin County.

Table 3: Health Status Profile

Health Status Profile		
Notable	Leading Causes of Death	1. Heart Disease: 22.7% of total deaths; age-adjusted death rate of 111 per 100,000 population 2. Cancer: 22.6% of total deaths; age-adjusted death rate of 129 per 100,000 population
2019	Prenatal care	One quarter of mothers had less than adequate prenatal care; More Black mothers had less than adequate prenatal care (39.2%) compared to White mothers (21.5%)
	Suicide age-adjusted rate	16 per 100,000 population (higher than the state at 14.5 per 100,000 population); Suicide rate higher among White residents than Black residents (16.8 and 5.8 per 100,000 population respectively)
	Coronary heart disease hospitalization rate	204 per 100,000 population (lower than the state at 274 per 100,000 population). Rate higher among Black residents than White residents (286 and 195 per 100,000 population respectively)
	Diabetes hospitalization rate	1,380 per 100,000 population (lower than the state at 2,350 per 100,000 population). Rate higher among Black residents than White residents (4,249 and 1,176 per 100,000 population respectively)
	Stroke hospitalization rate	228 per 100,000 population (lower than the state at 237 per 100,000 population). Rate higher among Black residents than White residents (270 and 217 per 100,000 population respectively)
	Chronic lower respiratory disease hospitalization rate	308 per 100,000 population (higher than the state at 237 per 100,000 population). Rate higher among Black residents or residents who identified as other race than White residents (546 and 276 per 100,000 population respectively).
	Non-fatal unintentional falls hospitalization rate	547 per 100,000 population (higher than the state at 354 per 100,000 population). Rate four times higher

		among Black residents than White residents (547 and 354 per 100,000 population respectively)
	Dental conditions hospitalization rate (under 65)	10 per 100,000 population (lower than the state at 12 per 100,000 population)
2018	Overweight or obese middle school students	21% (lower than the state at 30%).
	Overweight or obese high school students	27% (lower than the state at 31%)
2017	Cancer incidence rate	455 per 100,000 population (higher than the state at 442 per 100,000 population)
2016	Overweight or obese adults	56% (lower than the state at 63%)

Table 4 below highlights health resources availability and access in Martin County, including important shortage areas.

Table 4: Health Resources Availability and Access

Health Resources Availability and Access		
2020	Health professional shortage areas	• Two primary care health professional and mental health professional shortage areas/populations: Indiantown and the Martin Correctional Institution • Medically underserved area: Indiantown • Two dental health professional shortage areas/populations: low-income population and the Martin Correctional Institution
2019	Population without health insurance	Uninsured: • 11.5% of Martin County population • 40% of residents who identified as "some other race" • 27% of American Indian residents • 23% of Black residents • Over a quarter of the Hispanic residents • 29% of 26 to 34-year-olds

Forces of Change Assessment (FOCA)

The Forces of Change Assessment (FOCA) focuses on the identification of forces, such as trends, factors or events that affect the context in which the community and its public health system operate. These may include legislation, technology, and the social-economic trends that impact the community and local public health system.

The FOCA is designed to answer the following questions:

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

In September 2020, HCSEF guided Martin County Community Health Advisory Council members through a brainstorming session to identify trends, factors and events that impact the community and its public health system. Emerging trends, such as rising evictions due to COVID-19, the Martin County Opioid Overdose Data to Action Grant, a growing non-English speaking population, and others, informed the selection of goals and strategies outlined in the 2021 CHIP.

Community Themes and Strengths Assessment (CTSA)

The Community Strengths and Themes Assessment provides an understanding of the thoughts, opinions and concerns of community residents concerning the health issues they feel are important by answering the questions:

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

HCSEF conducted the CTSA from September 2020 to November 2020 using the following methods:

- Provider Community Health Survey (45 responses)
- Resident Community Health Survey (153 responses)
- Key Informant Interviews (17 participants)
- Virtual Community Focus Groups (18 participants)

Figure 3 below provides a snapshot of the CSTA themes, which informed the selection the 2021 CHIP priority areas.

Figure 3: 2020 CSTA Themes

Community Strengths in Martin County

- Community libraries that provide programs and Wifi access
- Good place to raise children
- Good schools and education
- Good place to grow old
- Healthy schools
- Many non-profits serving residents in need
- Low crime and safe neighborhoods
- Parks and recreation
- Support groups for mental health support and post-partum mothers

Populations with unmet needs

- The Hispanic/Latino and Black/African American communities
- Non–English speakers
- Low-income adults and children

Key Health Issues

- Aging problems
- Alcohol and drug abuse
- Diabetes
- Heart conditions (e.g., stroke, high blood pressure, etc.)
- Mental Health
- Obesity

Challenges & Opportunities for Improvement

- Availability and cost of healthy foods
- Appointment availability and wait times
- Cost of medical care and services
- Life stressors
- Services not covered by insurance
- Offer community support groups
- Conduct door to door canvassing in multiple languages (e.g., Mayan dialect, Haitian Creole and Spanish)
- Provide counseling services for adults and children, especially those who are uninsured

OVERVIEW OF THE 2021 CHIP PROCESS

PHASE 4: IDENTIFYING STRATEGIC ISSUES

In December 2020, the Martin County Community Health Advisory Council transitioned into developing the CHIP. HCSEF staff presented a summary of the results from the four MAPP assessments to Advisory Council members. During this session, council members reviewed the data and generated a list of the most pressing health and human service issues affecting the health of Martin County residents.

The Advisory Council then participated in a formal voting process to identify top priorities. HCSEF categorized these strategic issues into three overarching priority areas, and the Community Health Advisory Council agreed on these overarching focus areas, which included:

- Minority Health Disparities (later redefined as Access to Health and Human Services)
- Mental Health and Substance Abuse
- Social Determinants of Health (later redefined as Economic and Social Mobility)

PHASE 5: DEVELOPING GOALS AND STRATEGIES

To develop goals and objectives outlined in the 2021 CHIP, HCSEF created a facilitation guide. Then from March 2020 to May 2020, HCSEF facilitated four meetings with the Martin County Community Health Advisory Council. During the first meeting in March 2021, HCSEF gave an overview of the critical findings of the 2020 CHA for each priority area. Then the HCSEF team split the council members into small groups related to their sector to develop goals for each priority. In these groups, HCSEF facilitated goal development by asking the following questions:

Table 5: Developing Goals Facilitation Questions

Meeting Session	Question
High Needs Issues & Developing Goals	Now based on knowledge of the community as well as the data we've presented, we are going to develop an overarching goal for each priority area. Close your eyes and envision Martin County four years from now. What does the county without minority health disparities/mental health and substance use issues/inequitable social determinants of health look like?
	For each priority area what specific issues are of high needs in the community we must focus on over the next 3-4 years?
	Which of these specific issues are feasible and impactful areas of focus? What makes them feasible? (consider: existing programs, funds, etc.) And what makes it impactful? (number of people who will be impacted, significance of this problem, etc.) Are there existing community resources to address each of these key issues? (consider: community partners, community buy-in, policies or funds)

These goals were then reviewed and compiled by the HCSEF team. At the second meeting, HCSEF provided an overview of the goals developed for each priority area with the Community Health Advisory Council, and they approved without changes through a majority vote. Then, HCSEF split the council members into small groups related to their sectors to develop Specific, Measurable, Achievable, Relevant, and Time-Oriented (S.M.A.R.T.) objectives for each priority area. In these groups, HCSEF staff facilitate with the following questions:

Table 6: Developing Objectives Facilitation Questions

Meeting Session	Questions
S	What specific outcomes do we have to see to ensure we are meeting our goal? (e.g., changes in health or quality of life, knowledge change, environmental change, behavior change, etc.)
M	How will we measure the completion of these objectives? And what existing data do you have that we can use to assess our outcomes? (example: increase awareness of resources by 25%).
A R	What resources, partnerships, and windows of opportunity are available to ensure these outcomes are attainable?
T	What is a feasible timeline to achieve these outcomes?
S.M.A.R.T. Objective	Now let's put this information together to create SMART objectives for each priority area. (Ex. By 2030, the rate of sports-related traumatic brain injury among soccer players in Sailfish, FL will decrease by 10 percent.) Are each of these relevant to meeting our overarching goal?

These objectives were then reviewed and compiled by the HCSEF team. During the third meeting, the HCSEF team reported the objectives for each priority area to the group, which were then approved through a majority vote. In addition, HCSEF refined the original priority areas identified in December 2020 based on the performance measures determined by the Community Health Advisory Council (Figure 4). The refined priority areas were presented to the group and approved through a majority vote. The HCSEF team then guided the Community Health Advisory Council through the following questions in Table 7 to identify existing community resources for the 2021 CHIP.

Figure 4: Priority Area Refinement

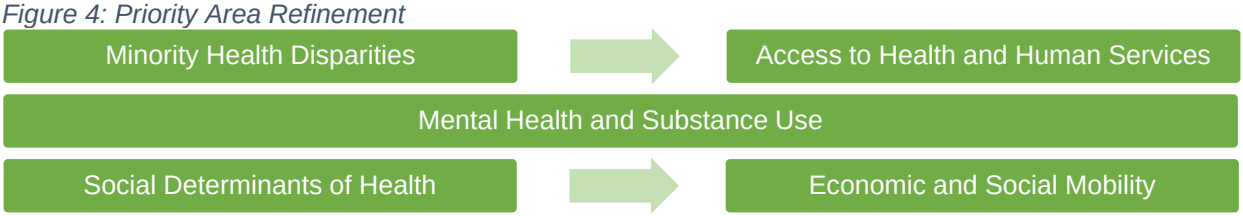


Table 7: Developing Strategies and Activities Facilitation Questions

Meeting Session	Questions
Strategies and Activities	Let's revisit our goals for each priority area. What specific strategies can we implement to achieve our goal? (examples: campaigns, programs, policies, etc.)
	Now thinking about our objectives for each priority area, what specific activities, existing or new, can we implement and track to ensure we are meeting our objectives?
	How will we monitor the progress of these activities? (examples: # of people trained, # of events/classes, etc.)
	What agencies are doing work related to these activities that we can invite to be a lead agency?
	What policies, funding opportunities or other windows of opportunity exist that can support these activities?
	When will we complete each activity?

During the fourth meeting, the Martin County Community Health Advisory Council reviewed the goals, objectives, strategies, and activities outlined in this Plan. HCSEF staff then presented the findings from the Community Input Sessions designed to gather community feedback and input on the 2021 Martin CHIP. Based on these findings, the group voted high-priority goals to focus on implementing.

HCSEF then facilitated a discussion to identify specific partners and community resources to address each goal and its respective objectives. The product of these meetings is the 2021 Martin County CHIP, which will be implemented over the next 3-5 years. The specific objectives, measures, strategies and action steps for each of the priorities are outlined in the Strategies and Action Steps section of this Plan.

PHASE 6: ACTION CYCLE

The Martin County Community Health Advisory Council will be implementing the 2021-2026 Martin County CHIP as outlined in this Plan over the next three to five years. The Advisory Council will meet quarterly to monitor and evaluate progress.

Table 8: Implementing the Plan - The Action Cycle

Meeting Sessions	Actions Taken
Implementing the Plan	Each Priority Area Workplan was reviewed along with updated objective data
	Subcommittees were established for each Priority Area and Chairs were identified
	Subcommittee sessions took place during the Advisory Council meetings so that key partners could review the plan, discuss action steps, and set deadlines for completing them

During the first three quarterly meetings since the development of the 2021-2026 Martin County CHIP, the Martin County Community Health Advisory Council met to discuss the CHIP workplan and most recent objective data, establish Priority Area Subcommittees, identify Chairs for the Subcommittees, and have Subcommittee Sessions to discuss implementation of the strategies for each priority area. Each of the strategies are currently in the process of implementation. During these meetings, the Martin County Community Health Advisory Council was very intentional about reviewing the latest data to determine whether the priorities needed to be revised and, based on the data, the Martin County Community Health Advisory Council determined that they did not. Moving forward, the Martin County Community Health Advisory Council will continue to meet quarterly to discuss implementation and opportunities to refine and enhance the plan. Each suggested edit will be brought to a formal vote before the revising the plan accordingly.

COMMUNITY HEALTH IMPROVEMENT PLAN

PURPOSE

The Martin County Community Health Improvement Plan (CHIP) is a three-to-five-year, systematic plan to address health problems based on the results of the Martin County Community Health Assessment. The CHIP was designed and will be used by stakeholders in the local public health system, including health and other governmental education and human service agencies, many of whom will be involved with implementation.

The Martin County CHIP is critical for developing and defining specific actions to target efforts that promote health and wellness in Martin County. In collaboration with community partners, this Plan will coordinate and target resources to address the identified health priorities. The Plan defines specific goals, strategic objectives, measures and existing resources for the selected priorities.

METHODS

The Community Health Improvement Plan focuses on the top three priorities that were selected and refined by the Advisory Council throughout several meetings and prioritization activities. There were several other health indicators that emerged, and though they are not addressed in this Plan, they remain critical and should be considered for future health planning activities in Martin County.

The Martin County Community Health Advisory Council emphasized the importance of identifying, reaching and serving underserved populations to increase health equity and mitigate health disparities throughout this process and Plan. In addition, throughout the planning for all priorities, the group also stressed the inclusion of increasing access to important information and services through strengths-based and culturally and linguistically appropriate language.

Approach

The intervention strategies in the CHIP attempt to:

- Address the structural issues and root causes of the identified health priorities
- Utilize data to identify existing disparities and, therefore, priorities, and to measure the impact of interventions
- Outline approaches that are relevant and realistic in the community given the available time, resources, and competing priorities
- Devise an action plan that can have a wide-reaching community-wide impact
- Detail measurable objectives to evaluate progress
- Engage a broad range of community stakeholders
- Support ongoing and existing efforts in the community, leveraging partnerships and increasing collaboration
- Implement evidence-based interventions and models for community health improvement

- Include interventions that encourage healthy behavior changes, while also addressing structural barriers
- Focus on improving conditions and health outcomes in the community

We provide descriptions of evidence-based interventions and programs related to the selected priority areas to guide how detailed CHIP strategies are modeled. Ongoing evaluation is an important element in this process, which will allow for monitoring the progress toward specific goals and outcomes, with opportunity for adjustments to be made as necessary and appropriate. Evaluation through the course of this Plan will also help guide future planning activities in Martin County, as the success of strategies and activities will be assessed.

The overarching goal for this CHIP is a county-wide implementation, which will organize community partners into priority-specific working groups to address the identified issues (i.e., Access to Health and Human Services, Mental Health and Substance Use, and Economic and Social Mobility). The ability to evaluate the outcomes and measure progress in a community typically takes a few years. For this reason, community members and stakeholders are focused on specific local measures to assess progress for the priority areas. Ongoing success concerning the priority area goals is key to the improvement of Martin County health outcomes.

STRATEGIC HEALTH PRIORITY AND ACTION PLANS

This section of the report presents the culmination of the perspective, input and effort of community members and stakeholders in this improvement planning process.

The sections below detail each of the three priorities addressed in this CHIP and each of their goals, specific objectives, strategies, action steps, and evaluation methods.

The goal is a broad, general statement about a desired outcome. It represents the destination the community hopes to reach with regard to the priority.

The objectives are more specific and detail what the community hopes to achieve and by when. Whenever feasible, this plan's objectives are S.M.A.R.T., meaning they are specific, measurable, achievable, relevant and realistic and time-bound.

The strategies detailed in the Plan represent ways to achieve the objectives and the action steps provide more detail and specific steps to outline how the strategies should be approached.

The information in this Plan aims to lay a solid foundation and provide direction for the community health improvement planning efforts in the community. This CHIP is a 'living document' and can be adapted throughout the planning cycle to meet the community's emerging needs.

The goals, objectives, and strategies outlined in this CHIP do not necessitate policy changes to accomplish and reach stated goals.

Although the Martin Community Health Advisory Council will work collaboratively and leverage existing community resources to implement the CHIP, key partners listed in the action plan under each goal have relevant service provision experience and expertise. Serving as lead agencies, these key partners will oversee implementation efforts for each of the strategies within each priority area and report progress during the Martin Community Health Advisory Council meetings.

ACCESS TO HEALTH AND HUMAN SERVICES

ACCESS TO HEALTH AND HUMAN SERVICES- WHY ADDRESS IT?

Access to health and human services is integral to maintaining a healthy community. Barriers to healthcare can result in residents delaying healthcare needs, the progression of preventable diseases, financial burden from costlier emergency care, and premature death.[1] Barriers to accessing appropriate health care services include the inability to pay and the lack of health insurance. Previous research suggests that health insurance coverage is correlated with increased healthcare access. There is also strong evidence to suggest that health insurance coverage is associated with improved prescription drug utilization, increased preventative care visits, and higher numbers of screenings for chronic conditions that can help to maintain or improve health.[2][3] The percentage of Martin County residents under the age of 65 years who lack health insurance may be as high as 16.0%, a rate that is higher than the national average of 12.1%.[4] [5] The provision of healthcare services from local organizations and government-funded health center locations is, thus, a key component to reducing cost, distance and other accessibility barriers to receiving health care services for Martin County residents.

The following table shows the goals, objectives, strategies, and activities that will provide direction for the community health improvement planning efforts in the community for priority area #1.

Table 9: Goals, Strategies, Objectives, and Activities for Priority Area #1

Goal 1.A: Create a community where all Martin County residents have access to health and human services.
Strategy 1.A.1: Promote a community wide campaign to increase the awareness of low-to-no cost services available to Martin County residents, especially Hispanic, undocumented and Spanish-speaking residents.
Objective 1.A.1: By 2025, reduce the proportion of Martin County residents, especially Hispanic residents, who cannot get medical care when they need it by 10%.

[1] Allegheny County Health Department. Health Equity Brief. https://www.alleghenycounty.us/uploadedFiles/Allegheny_Home/Health_Department/Resources/Data_and_Reporting/Chronic_Disease_Epidemiology/HEB-ACCESS.pdf

[2] Sommers, B. D., Gawande, A. A., & Baicker, K. (2017). Health insurance coverage and health—what the recent evidence tells us. N Engl J Med, 377(6), 586-593.

[3] McWilliams, J Michael. "Health consequences of uninsurance among adults in the United States: recent evidence and implications." The Milbank quarterly vol. 87,2 (2009): 443-94. doi:10.1111/j.1468-0009.2009.00564.x

[4] United States Census Bureau. QuickFacts: Martin County, Florida. https://www.census.gov/quickfacts/fact/dashboard/martincountyflorida/BZA210219

[5] Centers for Disease Control and Prevention. National Center for Health Statistics. Health Insurance Coverage. https://www.cdc.gov/nchs/fastats/health-insurance.htm

<table>
<tr><td colspan="4">National/State Priorities Alignment: HP2030: AH-01, AHS-04, AHS-07, AHS-09. HP2020: AHS-1, AHS-5, AHS-6. SHIP: HE3.3.1.</td></tr>
<tr><td>Activities</td><td>Key Action Steps</td><td>Measures</td><td>Key Partners</td></tr>
<tr><td rowspan="3"><u>Activity 1.A.1.1:</u>

Create a social marketing awareness campaign targeting Martin County residents, especially Hispanic residents, and community stakeholders on low-to-no cost health and human services available in Martin County, including those in Spanish and available to undocumented individuals.</td><td>Research low-to-no cost health and human services in Martin County, including those tailored for Hispanic, undocumented, and Spanish-speaking residents.</td><td rowspan="3">Percent of residents who cannot get medical care when they need it.

Number of marketing material and resource guides distributed.

Baseline: 42% of Hispanic Martin County residents could not see a doctor at least once in the past year due to cost, compared to 10.9% of White residents (Florida Health CHARTS, 2019)

Baseline: 0 marketing material distributed (2021)</td><td rowspan="3">Florida Community Health Center

Volunteers in Medicine

Light of the World Little Light Dentistry

Florida Department of Health Children Emergency Services</td></tr>
<tr><td>Hire a marketing firm and a translation service provider to develop marketing material, including a resource guide, in culturally appropriate and accessible language.</td></tr>
<tr><td>Promote and distribute marketing material and the resource guide to service providers, community stakeholders, and community members.</td></tr>
<tr><td colspan="4">Strategy 1.A.2: Screen for insurance status and medical home engagement to identify the need for a health insurance enrollment and primary care referral.</td></tr>
<tr><td colspan="4">Objective 1.A.2.1: By 2025, increase the proportion of Martin County residents, especially Black and Hispanic residents, who have insurance and are engaged in care by 5%.</td></tr>
<tr><td colspan="4">National/State Priorities Alignment: HP2030: AHS-01, AHS-02. HP2020: AHS-1. SHIP: HE3.3.1.</td></tr>
</table>

Activities	Key Action Steps	Measures	Key Partners
Activity 1.A.2.1: Engage health and human service providers throughout Martin County through professional networks.	Conduct outreach to health and human service providers around the importance of screening their clients for health insurance status and available benefits navigation services in the county. Add and promote the addition of screening for health insurance status and medical home engagement on organization intake forms to identify the need for health insurance/benefits enrollment services.	Insurance enrollment numbers. Referrals for insurance enrollment with CACs. Baseline: 78% of Black and 77% of Hispanic Martin County residents are insured compared to 91% of White residents (Florida Health CHARTS, 2019) Baseline: 0 referrals for insurance enrollments through this effort (2021)	Florida Community Health Center Volunteers in Medicine Light of the World Little Light Dentistry Florida Department of Health Children Emergency Services
Goal 1.B: Create a community where all Martin County residents have access to culturally and linguistically appropriate services.			
Strategy 1.B.1: Promote a community wide campaign to increase the awareness of free and available diversity, cultural competency, and health literacy trainings among health and human service professionals throughout Martin County.			
Objective 1.B.1: By 2025, at least 100 health and human service professionals and paraprofessionals will complete cultural competency and health literacy trainings.			
National/State Priorities Alignment: HP2030: HC/HIT-D11. HP2020: HC/HIT-1.1. SHIP: HE1.1.			
Activities	**Key Action Steps**	**Measures**	**Key Partners**

Activity 1.B.1.1: Disseminate list of available cultural competency and diversity trainings to health and human service professionals.	Research and explore free and available cultural humility and diversity trainings and courses. Promote and disseminate information on free and available trainings to health and human service professionals and agencies in Martin County.	Total lists distributed to agencies. Total training sessions. Total training participants. Baseline: 0 lists distributed to agencies (2021) Baseline: 22 Implicit Bias trainings in the Treasure Coast, 7 in Martin County (2020).	Martin County School District (Diversity Training Resources) Tykes and Teens (Implicit Bias Trainings)
Goal 1.C: Create a community where all Martin County residents live healthy, long lives.			
Strategy 1.C.1: Promote a community wide campaign to increase awareness of chronic disease self-management trainings.			
Objective 1.C.1.1: By 2025, reduce the rate of hospitalizations from or with coronary heart disease among Black Martin County residents by 50 per 100,000 population			
Objective 1.C.1.2: By 2025, reduce the rate of hospitalizations from or with diabetes among Black and Hispanic Martin County residents by 100 per 100,000 population			
National/State Priorities Alignment: HP2030: D-06, D-09, HDS-09. HP2020: D-2, D-7, HRQOL/WB-1.1. SHIP: CD1, CD2.			
Activities	**Key Action Steps**	**Measures**	**Key Partners**
Activity 1.C.1.1: Disseminate information to Black and Hispanic Martin County residents	Research and explore free and available chronic disease self-management trainings for community members.	Rate of diabetes-related and coronary heart disease-related hospitalizations.	Florida Department of Health in Martin County

and community stakeholders on available chronic disease self-management trainings.	Develop a training catalog to be shared with Martin County residents. Dissemination methods will include engaging multiple sectors serving Martin County Black and Hispanic residents.	Number of training catalogs distributed. Number of trainings or workshops held. Number of community participants. Baseline: Rate of hospitalizations among Black residents from or with coronary heart disease at 259 per 100,000 population, compared to 195 per 100,000 among White residents and 155 per 100,000 population among Hispanic residents (Florida Health CHARTS, 2019) Baseline: Rate of hospitalizations from or with diabetes among Black residents at 3,648 per 100,000 population and Hispanic residents at 1965 per 100,000 population, compared to White residents at 1,176 per 100,000 population (Florida	Area Agency on Aging Cleveland Clinic at Treasure Coast Medical Pavilion Cleveland Clinic and House of Hope (Fruit and Vegetable Rx) University of Florida - Family Nutrition Health Eating Program
Activity 1.C.1.2: Engage community agencies and stakeholders to serve as ambassadors and promote chronic disease self-management trainings among their client population.	Promotional methods will include engaging multiple sectors serving Martin County residents. Contact and ask local service providers to provide Martin County residents with information on available chronic disease self-management courses.		

		Health CHARTS, 2019) Baseline: 0 training catalogs distributed (2021). Baseline: 4 workshops, 42 participants (2020).	

Access to Health and Human Services Progress Tracking – Activities and Objectives

The table below shows the progress that the Martin County Community Health Advisory Council has made towards implementing the Access to Health and Human Services strategies. Each strategy and activity are listed, along with the baseline measures and updated process measures to track implementation progress.

Table 10: Access to Health and Human Services Activity Progress

Strategy 1.A.1: Promote a community wide campaign to increase the awareness of low-to-no cost services available to Martin County residents, especially Hispanic, undocumented and Spanish-speaking residents.		
Activity	**Baseline - 2021**	**Progress – 2022 Update**
Create a social marketing awareness campaign targeting Martin County residents, especially Hispanic residents, and community stakeholders on low-to-no cost health and human services available in Martin County, including those in Spanish and available to undocumented individuals.	No marketing materials distributed, as the CHIP had just been developed (2021)	The social marketing awareness campaign is in the planning stages. Key partners are currently planning to implement a campaign to mail residents of specific neighborhoods post-cards with low-to-no cost health and human services and will update the Martin County Guide to Community Services with pertinent information on how to access services if under- or uninsured.
Strategy 1.A.2: Screen for insurance status and medical home engagement to identify the need for a health insurance enrollment and primary care referral.		
Engage health and human service providers throughout Martin County through professional networks.	In 2021, the baseline was 0 referrals for insurance enrollments through this effort, as the CHIP had just been developed.	Key partners are beginning to engage service providers through different community events to gauge whether they are currently screening for insurance status and primary care referral needs. Key partners will begin to track the number of referrals for insurance enrollments through these efforts.
Strategy 1.B.1: Promote a community wide campaign to increase the awareness of free and available diversity, cultural competency, and health literacy trainings among health and human service professionals throughout Martin County.		
Disseminate list of available cultural competency and	In 2021, the baseline was 0 lists distributed to agencies, as the CHIP	The list of available cultural competency, diversity, health literacy, and health equity-

diversity trainings to health and human service professionals.	had just been developed (2021) In 2020, there were 22 Implicit Bias trainings in the Treasure Coast, 7 in Martin County provided by Tykes and Teens.	related trainings is currently being developed by the Florida Department of Health – Martin County Health Equity Team and will be disseminated to health and human service providers throughout the county. 2021: 10 external implicit bias trainings; 245 participants (Tykes and Teens) 10 anti-racism trainings; 105 participants (Tykes and Teens)
Strategy 1.C.1: Promote a community wide campaign to increase awareness of chronic disease self-management trainings.		
Disseminate information to Black and Hispanic Martin County residents and community stakeholders on available chronic disease self-management trainings.	In 2021, 0 training catalogs had been developed or distributed, as the CHIP had just been developed. Baseline: 4 chronic disease self-management workshops, 42 participants (2020).	The Access to Health and Human Services Subcommittee discussed different partners to engage with respect to both the provision of chronic disease self-management trainings and the promotion of them. In addition, they discussed the coordination of a mobile medical unit to get important chronic disease self-management services and education out to the communities, meeting them where they are.
Engage community agencies and stakeholders to serve as ambassadors and promote chronic disease self-management trainings among their client population.		

The table below shows the progress that the Martin County Community Health Advisory Council has made towards meeting the Access to Health and Human Services objectives. Each objective is listed, along with the baseline data, the latest available data, and a trend description in an effort to evaluate progress.

Table 11: Access to Health and Human Services Objective Progress

Objective 1.A.1: By 2025, reduce the proportion of Martin County residents, especially Hispanic residents, who cannot get medical care when they need it by 10%.		
Baseline Data in 2021	Latest Available Data in 2022	Trend
Baseline: 42% of Hispanic Martin County residents could not see a doctor at least once in the past year due to cost, compared to 10.9% of White residents (Florida Health CHARTS, 2019).	24.7% of Hispanic Martin County residents could not see a doctor at least once in the past year due to cost, compared to 9.9% of White residents (Florida Health CHARTS, 2020).	**On track!** There has been a 17.3% reduction in the proportion of Hispanic Martin County residents who could not see a doctor at least once in the past year due to cost, and a 1% reduction among White residents. While this meets our objective among Hispanic residents, these numbers do not fully capture the effect of the COVID-19 pandemic and are also pre-CHIP implementation numbers, so more recent data is needed to determine whether efforts have improved this metric.
Objective 1.A.2.1: By 2025, increase the proportion of Martin County residents, especially Black and Hispanic residents, who have insurance and are engaged in care by 5%.		
Baseline: 78% of Black and 77% of Hispanic Martin County residents are insured compared to 91% of White residents (Florida Health CHARTS, 2019).	No updated data available at this time: 78% of Black and 77% of Hispanic Martin County residents are insured compared to 91% of White residents (Florida Health CHARTS, 2019).	**In progress.** The Martin County Community Health Advisory Council is taking steps to ensure residents are being screened and referred to health insurance enrollment assistance as appropriate; however, given the COVID-19 pandemic and its economic impact, updated data is needed to determine what health

		insurance coverage looks like currently in the county.
Objective 1.B.1: By 2025, at least 100 health and human service professionals and paraprofessionals will complete cultural competency and health literacy trainings.		
Baseline: 22 Implicit Bias trainings in the Treasure Coast, 7 in Martin County (Tykes and Teens, 2020).	10 external implicit bias trainings; 245 participants and 10 anti-racism trainings; 105 participants (Tykes and Teens, 2021)	**On track!** While the data from 2021 shows that we've exceed the objective, the Martin County Community Health Advisory Council will like to target health and human service providers more broadly and a current countywide list of trainings is being developed.
Objective 1.C.1.1: By 2025, reduce the rate of hospitalizations from or with coronary heart disease among Black Martin County residents by 50 per 100,000 population.		
Baseline: Rate of hospitalizations among Black residents from or with coronary heart disease at 259 per 100,000 population, compared to 195 per 100,000 among White residents and 155 per 100,000 population among Hispanic residents (Florida Health CHARTS, 2019).	Rate of hospitalizations among Black residents from or with coronary heart disease at 235 per 100,000 population, compared to 164 per 100,000 among White residents and 176 per 100,000 population among Hispanic residents (Florida Health CHARTS, 2020).	**On track!** The rate of coronary heart disease-related hospitalizations among Black Martin County residents decreased from 259 per 100,000 population in 2019 to 235 per 100,000 population in 2020; however, more recent data is needed to determine current rates.
Objective 1.C.1.2: By 2025, reduce the rate of hospitalizations from or with diabetes among Black and Hispanic Martin County residents by 100 per 100,000 population.		
Baseline: Rate of hospitalizations from or with diabetes among Black residents at 3,648 per 100,000 population and Hispanic residents at 1965 per 100,000 population, compared to White residents at 1,176 per 100,000 population (Florida Health CHARTS, 2019).	Rate of hospitalizations from or with diabetes among Black residents at 3,607 per 100,000 population and Hispanic residents at 1,890 per 100,000 population, compared to White residents at 1,134 per 100,000 population (Florida Health CHARTS, 2020).	**On track!** The diabetes-related hospitalizations decreased by 41 per 100,000 population among Black residents and by 75 per 100,000 population among Hispanic residents from 2019 to 2020; however, more recent data is needed to determine the current rates.

Federally Qualified Health Care Centers

Low-income families and undocumented individuals, who are less likely to have a consistent source of medical care or to have visited a doctor in the past year as compared to the native U.S. population, may currently seek limited non-emergency care at community health centers or safety-net hospitals.[6] Federal grant funding is provided to support Federally Qualified Health Centers (FQHCs), which are community health centers that provide coverage for uninsured and underinsured individuals regardless of immigration status.[7] However, these facilities are limited in practice and scope—only 1,400 health centers are operating across the country to meet the needs of millions of uninsured families and undocumented individuals. As such, improving health care access among these vulnerable populations in Martin County is a key goal.

Health Literacy Trainings

Factors influencing health care access also include health literacy. Health literacy is defined as "the ability to obtain, process, and understand basic health information and services to make appropriate health decisions" and is heavily influenced by education level.[8] Low health literacy is associated with delayed care-seeking, reduced number of preventative care visits, and increased number of emergency department visits for health care services.[9] Patients with low health literacy also tend to be diagnosed later and may have difficulty providing informed consent for treatment.[10]

Improving health literacy levels in Martin County is thus a crucial endeavor. To that end, previous research supports the use of health literacy trainings for health and human service professionals and patients as a useful strategy for increasing literacy levels.[11] Health literacy trainings for health and human service providers are warranted considering that providers often overestimate the

[6] Chang, C. D. (2019). Social determinants of health and health disparities among immigrants and their children. Current problems in pediatric and adolescent health care, 49(1), 23-30.

[7] Beck, T. L., Le, T. K., Henry-Okafor, Q., & Shah, M. K. (2019). Medical Care for Undocumented Immigrants: National and International Issues. Physician assistant clinics, 4(1), 33–45. https://doi.org/10.1016/j.cpha.2018.08.002

[8] Office of Disease Prevention and Health Promotion. Health Communication Activities. America's Health Literacy: Why We Need Accessible Health Information. http://www.aaaceus.com/courses/nl0610/article2.html

[9] American Hospital Association. The Importance of Health Coverage. https://www.aha.org/system/files/media/file/2019/10/reportimportance-of-health-coverage_1.pdf

[10] Mazor, K. M., Roblin, D. W., Williams, A. E., Greene, S. M., Gaglio, B., Field, T. S., ... & Cowan, R. (2012). Health literacy and cancer prevention: two new instruments to assess comprehension. Patient education and counseling, 88(1), 54-60.

[11] Walters, R., Leslie, S. J., Polson, R., Cusack, T., & Gorely, T. (2020). Establishing the efficacy of interventions to improve health literacy and health behaviours: a systematic review. BMC public health, 20(1), 1-17.

clarity of their recommendations and underestimate their use of medical jargon during consultations.[12]

Medical Interpreters and Cultural Sensitivity Trainings

Limited English proficiency (LEP) is another factor influencing health care access. Research has linked Low English literacy to lower healthcare service utilization rates and an increased likelihood of experiencing discrimination during healthcare encounters.[13] Language discordance between a patient and their provider has also been found to reduce patient satisfaction with their health care experience.[14] The use of interpreters to facilitate culturally and linguistically appropriate care and the promotion of cultural sensitivity training for health care professionals in Martin County are potential solutions.[15] [16]

Chronic Disease Self-Management

Improving health care access can also work to reduce disparities in health outcomes. Black and Hispanic populations exhibit worse chronic disease management and health outcomes as compared to their White counterparts.[17] Existing research suggests that improved access to health care coverage may lead to improvements in managing chronic diseases among Black and Hispanic populations.[18] Previous research also indicates that chronic disease self-management trainings for patients and providers can be an effective tool for improving health outcomes for chronic diseases, such as diabetes and congestive heart failure.[19] [20]

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[12] Hadden, K., Coleman, C., & Scott, A. (2018). The bilingual physician: Seamless switching from medicalese to plain language. Journal of graduate medical education, 10(2), 130.

[13] Lemus, A.G. (2020) Examining the Relationship between English Proficiency and Health Care Experiences in the United States. https://digital.library.txstate.edu/bitstream/handle/10877/12249/LEMUS-THESIS-2020.pdf?sequence=1&isAllowed=y

[14] Dunlap, J. L., Jaramillo, J. D., Koppolu, R., Wright, R., Mendoza, F., & Bruzoni, M. (2015). The effects of language concordant care on patient satisfaction and clinical understanding for Hispanic pediatric surgery patients. Journal of Pediatric Surgery, 50(9), 1586-1589

[15] Betancourt, J. R., Green, A. R., Carrillo, J. E., & Owusu Ananeh-Firempong, I. I. (2016). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public health reports.

[16] Govere, Linda, and Ephraim M. Govere. "How effective is cultural competence training of healthcare providers on improving patient satisfaction of minority groups? A systematic review of literature." Worldviews on Evidence-Based Nursing 13.6 (2016): 402-410.

[17] Laurencin, C. T., & McClinton, A. (2020). The COVID-19 pandemic: a call to action to identify and address racial and ethnic disparities. Journal of racial and ethnic health disparities, 7(3), 398-402.

[18] Christopher A.S., McCormick D., Woolhandler S., Himmelstein D.U., Bor D.H., Wilper A.P. (2016) Access to care and chronic disease outcomes among Medicaid-insured persons versus the uninsured. Am J Public Health. 106:63-9.

[19] Mamykina, L., Smaldone, A. M., & Bakken, S. R. (2015). Adopting the sensemaking perspective for chronic disease selfmanagement. Journal of biomedical informatics, 56, 406-417

[20] Ditewig, J. B., Blok, H., Havers, J., & van Veenendaal, H. (2010). Effectiveness of self-management interventions on mortality, hospital readmissions, chronic heart failure hospitalization rate and quality of life in patients with chronic heart failure: a systematic review. Patient education and counseling, 78(3), 297-315.

COMMUNITY RESOURCES

Partner/Agency	Relevant Services
211 Palm Beach/Treasure Coast	Help Line with crisis intervention, suicide prevention, information, assessment and referral to community services
Area Agency on Aging	Self-management programs for people with chronic conditions such as high blood pressure, asthma, arthritis, chronic obstructive pulmonary disease (COPD), diabetes, and many other conditions
Children's Emergency Resources	Medical exams, prescription medications, dental services, optical exams and glasses, and crisis intervention to low SES children and youth in Martin County.
Children's Services Council of Martin County	Invests in multiple programs that improve health outcome, specifically among children and families in Martin County
Christian Care Dental Services	Free emergency dental care, complete dental care to Medicaid and low-income patients
Cleveland Clinic Martin County	Preventive, primary and acute hospital care, as well as cancer care, a heart center, wellness and rehabilitation services. The organization also offers nutritional education and diabetes self-management programs
DiversityFIRST Certification Program	Comprehensive certificate program (available at a fee) that pushes the work of systems and processes within entire organizations
El Sol Jupiter's Neighborhood Resource Center (Jupiter)	Health fairs, workshops, healthier together initiative, promotores de salud, etc.
Epilepsy Foundation of Florida (Jensen Beach)	Information, Referral and Support
Florida Community Health Centers, Inc.	Primary and preventative care services

Florida Department of Health in Martin County	Clinical, nutritional and wellness services
Florida Diversity Council	Different diversity and cultural competency trainings (some at a low cost, others free) available dependent upon interest and need
Florida Rural Legal Services	Migrant legal services
Hands of Hope	Food pantry services
House of Hope	Client choice pantry, fruit and vegetable, health produce program
Jupiter Medical Center	Hospital providing health education
Kane Center Council on Aging of Martin County	Therapeutic, social and health services for impaired seniors who are 60 or older
Light of the World Charities, Little Lights Dentistry	Free dental care for uninsured, low-income children living on Florida's Treasure Coast
Martin County Board of County Commissioner's Health & Human Services	Information & referral services, homeless prevention services, and hospitalization assistance
Martin County School District	Diversity training courses available in Professional Learning Management System (Frontline).
Martin Health System Hospital South	Hospital providing health education
Martin Health System Medical Center	Hospital providing health education
South Florida SE AIDS Education and Training Center (AETC)	Provides ongoing, high-quality training and support, essential for clinicians, including cultural competency and health literacy trainings
The Robert & Carol Weissman Cancer Center (Stuart)	Comprehensive cancer care

TRAIN Learning Network	National learning network that provides quality training opportunities for professionals who protect and improve the public's health
Treasure Coast Hospice	Palliative care, hospice care, counseling
Tykes and Teens	Diversity, inclusion, equity and bias trainings available
University of Florida/IFAS Extension Family Nutrition Program	Free nutrition education programs for SNAP-eligible clients
University of South Florida	Free 14-hour Diversity, Equity, and Inclusion in the Workplace certificate course that is available to the public.
Visiting Nurse Association of Florida, Inc. (Stuart)	Assistance in home-based care
Volunteers in Medicine	Network of free primary health care clinics emphasizing the use of retired and practicing medical and community volunteers

MENTAL HEALTH AND SUBSTANCE USE

MENTAL HEALTH AND SUBSTANCE USE- WHY ADDRESS IT?

Untreated mental health conditions and substance use disorders can have devastating effects on an individual's physical and social well-being.[21] Mental health disorders are associated with reductions in life expectancy, quality of life, and financial stability. [22] [23] However, less than half of individuals with mental disorders and only one-tenth of those with substance use disorders receive any treatment.[24] And although health care coverage improves access to behavioral health and substance use disorder treatment, the uninsured rate remains higher among individuals with mental and substance use disorders.[25] Existing research suggests that individuals utilize mental health services more often when insured as opposed to uninsured.[26] As such, improving mental health and substance use treatment among the uninsured and underinsured in Martin County is a high priority.

The following table shows the goals, objectives, strategies, and activities that will provide direction for the community health improvement planning efforts in the community for priority area #2.

Table 12: Goals, Strategies, Objectives, and Activities for Priority Area #2

Goal 2.A: Create a community where all Martin County residents are able to seek mental health and substance use services.
Strategy 2.A.1: Promote a community wide campaign to increase awareness of available mental health providers and services throughout Martin County.
Objective 2.A.1: By 2025, increase the number of mental health providers available to serve the uninsured and underinsured Martin County residents by 15 per 100,000 population.

[21] Hendriks, S. M., Spijker, J., Licht, C. M., Hardeveld, F., de Graaf, R., Batelaan, N. M., ... & Beekman, A. T. (2015). Long-term work disability and absenteeism in anxiety and depressive disorders. Journal of affective disorders, 178, 121-130.

[22] Walker, E. R., McGee, R. E., & Druss, B. G. (2015). Mortality in mental disorders and global disease burden implications: a systematic review and meta-analysis. JAMA psychiatry, 72(4), 334-341

[23] Bayliss, M., Rendas-Baum, R., White, M. K., Maruish, M., Bjorner, J., & Tunis, S. L. (2012). Health-related quality of life (HRQL) for individuals with self-reported chronic physical and/or mental health conditions: panel survey of an adult sample in the United States. Health and Quality of life outcomes, 10(1), 1-10.

[24] Substance Abuse and Mental Health Services Administration. 2019 National Survey of Drug Use and Health Releases. https://www.samhsa.gov/data/sites/default/files/reports/rpt29392/Assistant-Secretary-nsduh2019_presentation/Assistant-Secretarynsduh2019_presentation.pdf

[25] Saloner, B., Bandara, S., Bachhuber, M., & Barry, C. L. (2017). Insurance coverage and treatment use under the Affordable Care Act among adults with mental and substance use disorders. Psychiatric services, 68(6), 542-548.

[26] Antwi, Y. A., Moriya, A. S., & Simon, K. I. (2015). Access to health insurance and the use of inpatient medical care: Evidence from the Affordable Care Act young adult mandate. Journal of health economics, 39, 171-187.

Objective 2.A.2: By 2025, decrease the rate of hospitalizations for mental health disorders, especially Black residents, by 100 per 100,000 population.			
National/State Priorities Alignment: HP2030: MHMD-04, MHMD-07. HP2020: MHMD-5, MHMD-6, MHMD-9, MHMD-10, HRQOL/WB-1.2. SHIP: BH1.2.			
Activities	**Key Action Steps**	**Measures**	**Key Partners**
<u>Activity 2.A.1.1:</u> Develop a mental health and substance use counseling resource guide for referrals and dissemination to Martin County residents.	Research current mental health providers available to provide services to uninsured and underinsured Martin County residents, including Federally Qualified Health Centers, school health clinics, and non-profit organizations. Develop a referral process for mental health and substance use services. Promote and distribute marketing material and the resource guide to service providers, community stakeholders, and community members.	Number of marketing material and resource guides distributed. Rate of Behavioral/Mental Health Providers in Martin County. Rate of mental health disorder-related hospitalizations. Baseline: 0 marketing material and resource guides distributed (2021). Baseline: Current rate of Behavioral/Mental Health Providers in Martin County at 141 per 100,000 population Baseline: current mental health disorder hospitalizations at 1255 for Black	Tykes and Teens Coral Shores Behavioral Health NAMI Martin County Helping People Succeed New Horizons Suncoast Behavioral Health Drug Abuse Treatment Association Project Lift

		residents compared to 871 per 100,000 for White residents (Florida Health CHARTS, 2019).	
Goal 2.B: Create a community where all Martin County residents are empowered to seek mental health services.			
Strategy 2.B.1: Promote a community wide campaign to increase awareness on mental health issues and normalize seeking services.			
Objective 2.B.1: By December 2023, create a social marketing campaign to address stigma among Martin County residents seeking help for mental health conditions.			
Objective 2.B.1: By 2025, reduce the age-adjusted suicide death rate in Martin County to be at least 2.0 less than the rate for Florida.			
National/State Priorities Alignment: HP2030: MHMD-04, MHMD-07. HP2020: MHMD-6, MHMD-9, MHMD-10, HRQOL/WB-1.2. SHIP: BH4.2.			
Activities	**Key Action Steps**	**Measures**	**Key Partners**
<u>Activity 2.B.1.1:</u> Create a marketing awareness campaign targeting Martin County residents and community stakeholders with messaging normalizing mental health care seeking behaviors and mental health struggles.	Hire a marketing firm to create innovative approaches to address the stigma associated with mental illness and mental health care seeking behaviors and educate Martin County residents. Promote and disseminate messaging on the importance of seeking mental health and counseling services.	Total reach of marketing awareness campaign. Age-adjusted suicide death rate. Baseline: Total reach pending marketing awareness campaign launch (2021). Baseline: Current age-adjusted suicide death rate at 16 per 100,000 population in	Martin County Health and Human Services 211 Palm Beach/Treasure Coast Area Agency on Aging and Morse Life Love and Hope in Action (LAHIA) Southeast Florida Behavioral Health Network

		Martin County compared to 14.5 per 100,000 population in Florida (Florida Health CHARTS, 2019)	Martin County School Board Cleveland Clinic and House of Hope Health Fairs Community Health Advisory Council Partners

MENTAL HEALTH AND SUBSTANCE USE PROGRESS TRACKING – ACTIVITIES AND OBJECTIVES

The table below shows the progress that the Martin County Community Health Advisory Council has made towards implementing the Mental Health and Substance Use strategies. Each strategy and activity are listed, along with baseline measures and updated process measures to track implementation progress.

Table 13: Mental Health and Substance Use Activity Progress

Strategy 1.A.1: Promote a community wide campaign to increase the awareness of low-to-no cost services available to Martin County residents, especially Hispanic, undocumented and Spanish-speaking residents.		
Activity	**Baseline - 2021**	**Progress – 2022 Update**
Develop a mental health and substance use counseling resource guide for referrals and dissemination to Martin County residents.	In 2021, there had been 0 marketing material and resource guides distributed, as the CHIP had just been developed.	A campaign is in progress. The Martin County Community Health Advisory Council Mental Health and Substance Use Subcommittee is currently conducting an inventory of all free and preventative mental health and substance use services and resources to develop a resource guide for dissemination. Once finalized, the resource guide will be shared widely via partners and social media marketing.
Strategy 2.B.1: Promote a community wide campaign to increase awareness on mental health issues and normalize seeking services.		
Create a marketing awareness campaign targeting Martin County residents and community stakeholders with messaging normalizing mental health care seeking behaviors and mental health struggles.	Baseline: Total reach pending marketing awareness campaign launch (2021).	In progress. The Mental Health and Substance Use Subcommittee is currently in the process of engaging partners who are well trusted in the community to engage community members in conversations to understand the source and impact of mental health-related stigma. This community input will then be used to develop key messaging to normalize mental health issues and care seeking behaviors.

The table below shows the progress that the Martin County Community Health Advisory Council has made towards meeting the Mental Health and Substance Use objectives. Each objective is listed, along with the baseline data, the latest available data, and a trend description in an effort to evaluate progress.

Table 14: Mental Health and Substance Use Objective Progress

Objective 2.A.1: By 2025, increase the number of mental health providers available to serve the uninsured and underinsured Martin County residents by 15 per 100,000 population.		
Baseline Data in 2021	Latest Available Data in 2022	Trend
Baseline: Current rate of Behavioral/Mental Health Providers in Martin County at 141 per 100,000 population (Florida Health CHARTS, FY 20-21)	No updated data available yet: 141 mental health providers per 100,000 population (Florida Health CHARTS, FY 20-21)	**To be determined.** More recent data is needed to determine the current rate.
Objective 2.A.2: By 2025, decrease the rate of hospitalizations for mental health disorders, especially Black residents, by 100 per 100,000 population.		
Baseline: current mental health disorder hospitalizations at 1,255 per 100,000 population for Black residents compared to 871 per 100,000 for White residents (Florida Health CHARTS, 2019).	There is a rate of 896 mental health disorder hospitalizations per 100,000 population among Black residents, compared to 846 per 100,000 population among White residents (Florida Health CHARTS, 2020).	**On track!** There has been a 359 per 100,000 population reduction of mental health disorder hospitalizations among Black residents; however, these numbers do not fully capture the effect of the COVID-19 pandemic and are also pre-CHIP implementation numbers, so more recent data is needed to determine whether efforts have improved this metric.
Objective 2.B.1: By December 2023, create a social marketing campaign to address stigma among Martin County residents seeking help for mental health conditions.		
Baseline: Total reach pending marketing awareness campaign launch (2021).	Campaign in progress with appropriate partners; total reach pending launch.	**In progress.** Status update pending launch.
Objective 2.B.2: By 2025, reduce the age-adjusted suicide death rate in Martin County to be at least 2.0 less than the rate for Florida.		

Baseline: Age-adjusted suicide death rate at 16 per 100,000 population in Martin County compared to 14.5 per 100,000 population in Florida (Florida Health CHARTS, 2019)	13.9 per 100,000 age-adjusted suicide deaths in Martin County compared to 13.1 per 100,000 population in Florida (Florida Health CHARTS, 2020)	**On track!** There has been a 2.1 per 100,000 population reduction of age-adjusted suicide deaths, closing the gap between the county and the state with just an 0.8 per 100,000 population difference; however, these numbers do not fully capture the effect of the COVID-19 pandemic and are also pre-CHIP implementation numbers, so more recent data is needed to determine whether efforts have improved this metric.

Primary Care and Emergency Service Screenings and Referrals

Increasing mental health screenings and creating a referral process are important strategies for addressing mental health in Martin County. Research has shown that mental health screenings increase identification and referrals related to mental illness.[27] Mental health and substance use disorder screenings by primary care providers and the use of care managers who can direct patients to appropriate resources have likewise been implicated in increased use of preventative services and improved health outcomes as compared to those treated without such a screening and evaluation process.[28] [29] Referrals from emergency care providers to outpatient medical follow ups have also demonstrated success.[30]

Mental Health First Aid and Social Media Campaigns

One of the major barriers to receiving mental health treatment is the social stigma surrounding mental health treatment. Thus, reducing stigma regarding mental health and substance use treatment is crucial. Importantly, social media and informational campaigns have shown some promise as an effective way to increase awareness of mental health issues and reduce stigma surrounding mental health in ways that can increase treatment-seeking behaviors.[31] [32] Programs such as Mental Health First Aid have been shown to be effective at increasing knowledge regarding mental health, reducing stigma and negative attitudes against mental health, and increasing supportive behaviors towards individuals with mental health problems. [33]

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[27] Hacker, Karen, et al. "Referral and follow-up after mental health screening in commercially insured adolescents." Journal of Adolescent Health 55.1 (2014): 17-23

[28] Druss, B. G., von Esenwein, S. A., Compton, M. T., Rask, K. J., Zhao, L., & Parker, R. M. (2010). A randomized trial of medical care management for community mental health settings: the Primary Care Access, Referral, and Evaluation (PCARE) study. The American journal of psychiatry, 167(2), 151–159. https://doi.org/10.1176/appi.ajp.2009.09050691

[29] Jones, Q., Johnston, B., Biola, H., Gomez, S., & Crowder, C. (2018). Implementing standardized substance use disorder screening in primary care. Journal of the American Academy of PAs, 31(10), 42-45

[30] Griswold KS, Servoss TJ, Leonard KE, Pastore PA, Smith SJ, Wagner C, Stephan M, Thrist M. Connections to primary medical care after psychiatric crisis. The Journal of the American Board of Family Practice / American Board of Family Practice. 2005;18(3):166–72.

[31] Collins, R. L., Wong, E. C., Breslau, J., Burnam, M. A., Cefalu, M., & Roth, E. (2019). Social marketing of mental health treatment: California's mental illness stigma reduction campaign. American journal of public health, 109(S3), S228-S235.

[32] Livingston, J.D., Tugwell, A., Korf-Uzan, K. et al. Evaluation of a campaign to improve awareness and attitudes of young people towards mental health issues. Soc Psychiatry Psychiatr Epidemiol 48, 965–973 (2013). https://doi.org/10.1007/s00127-012-0617-3

[33] Hadlaczky, G., Hökby, S., Mkrtchian, A., Carli, V., & Wasserman, D. (2014). Mental Health First Aid is an effective public health intervention for improving knowledge, attitudes, and behaviour: A meta-analysis. International Review of Psychiatry, 26(4), 467-475.

COMMUNITY RESOURCES

Partner/Agency	Relevant Services
211 Palm Beach/Treasure Coast	Help Line with crisis intervention, suicide prevention, information, assessment and referral to community services
4Cs- Caring Children Clothing Children	Free clothing for low-income youth
ARC of Martin County	Provides a learning environment for children and adolescents with developmental disabilities in an after-school, out-of-school summer camp and respite setting.
Alzheimer's Association	Alzheimer's Support Groups (Martin County)
Area Agency on Aging and Morse Life	Counseling services for older adults
Catholic Charities	Counseling and Immigration Legal Services to the local community on a sliding scale
Coral Shores Behavioral Health	High-quality behavioral health treatment in a therapeutic and secure setting with specialized units to meet individual needs
FAU Center for Autism and Related Disabilities (Jupiter)	Training, support, and counseling
House of Hope	Treatment and support of those suffering from substance use and mental illness
Love And Hope in Action (LAHIA)	Free case management services to help connect individuals with social services and medical or mental health assistance
Martin County Board of County Commissioner's Health & Human Services	Substance use services

Martin County Health and Human Services	Information, referrals, resources, and services
Martin County School Board	School board that can educate and disseminate mental health messaging to students and their families
National Alliance of Mental Illness (NAMI) Martin County	Programs support, educate and advocate in areas related to mental illness and mental health
New Horizons	Mental health services
Project LIFT	Mental health/substance abuse therapy and mentoring for at-risk youth
SafeSpace	Education and support to domestic violence victims
Sandy Pines Residential Treatment Center	Behavioral health treatment for children and adolescents
Southeast Florida Behavioral Health Network	Mental health, substance abuse, and prevention services, as well as anti-stigma campaigns and messaging
Suncoast Behavior Health Center	Behavioral health services for children, adolescents, and adults
Suncoast Drug Abuse Treatment Association (DATA)	Residential, outpatient and school-based substance use behavioral health programs
Tykes & Teens	Evidence-based mental health services and programs for children and adolescents, including group therapy for substance use in youth

ECONOMIC AND SOCIAL MOBILITY

ECONOMIC AND SOCIAL MOBILITY- WHY ADDRESS IT?

The benefits of financial well-being and stable employment are varied and plentiful. For instance, financial well-being makes it more likely that families will secure and maintain health insurance. To that point, 73.7% of uninsured nonelderly adults referenced an inability to afford health insurance as a reason for their lack of coverage according to the 2019 National Health Interview Survey.[34] Economic and social mobility is also correlated with the availability of reliable transportation and affordable housing.[35] Employment and financial stability can be pre-requisites for reliable transportation and vice-versa, underscoring the inter-related nature of social determinants of economic and social mobility. A lack of economic and social mobility opportunities is also correlated with increases in precarious employment, defined as the employment of workers who fill permanent job needs but are denied permanent employee rights.[36] Precarious employment is subsequently associated with increases in chronic stress and worse physical and mental health outcomes[37]. Moreover, historical legacies of redlining and zoning regulations have hindered economic and social mobility possibilities, particularly in minority communities.[38] The result of these discriminatory structural forces has been unequal distributions of education, health care, financial capital and other opportunities that are predominately determined by place. Addressing Martin County residents' transportation, employment, and financial stability to ensure social and economic mobility is thus a priority area.

The following table shows the goals, objectives, strategies, and activities that will provide direction for the community health improvement planning efforts in the community for priority area #3.

Table 15: Goals, Strategies, Objectives, and Activities for Priority Area #3

Goal 3.A: Create a community where Martin County residents are financially thriving and employed.
Strategy 3.A.1: Promote consistent information/material to Martin County residents on employment assistance, job training, and job fairs.

[34] Centers for Disease Control and Prevention. National Center for Health Statistics. National Health Interview Survey. https://www.cdc.gov/nchs/nhis/index.htm

[35] Park, H. J., & Choi, K. (2020). Affordable housing program tenants and their access to public transportation and employment. Journal of Housing and the Built Environment, 1-21.

[36] International Labor Rights Forum. Issues. Precarious Work. https://laborrights.org/issues/precarious-work#:~:text=Precarious%20workers%20are%20those%20who,right%20to%20join%20a%20union.

[37] Marmot, M. G.; Rose, G.; Shipley, M.; Hamilton, P. J. (1978). "Employment grade and coronary heart disease in British civil servants". Journal of Epidemiology and Community Health. 32 (4): 244–249. doi:10.1136/jech.32.4.244. PMC 1060958. PMID 744814.

[38] Mitchell, B., & Franco, J. (2018). HOLC "redlining" maps: The persistent structure of segregation and economic inequality.

Objective 3.A.1: By 2025,1,000 residents will receive information about employment assistance and job training opportunities.			
National/State Priorities Alignment: HP2030: SDOH-01, SDOH-02. HP2020: SDOH-1, SDOH-3. SHIP: HE3.1.			
Activities	**Key Action Steps**	**Measures**	**Key Partners**
<u>Activity 3.A.1.1:</u> Disseminate information to Martin County residents and community stakeholders on available employment assistance, job trainings, and job fairs.	Research available employment assistance, job training, and job fairs occurring in Martin County on an annual basis. Develop a resource list and event schedule for dissemination to Martin County residents. Engage service providers to promote resource list and schedule among their clients.	Number of resource lists and training/event schedules disseminated to residents. Baseline: 0 resource lists and training/event schedules disseminated to residents (2021)	Martin County School District (College and Career Readiness) Project Lift (Trades Training) Love and Hope in Action (LAHIA; Culinary Arts Training) Martin Board of County Commissioners (Vocational Training Center) House of Hope (Soft-skills Training) Helping People Succeed (Job Coaching and Employment) Aging Resource Center of Martin County Treasure Coast Food Bank

Goal 3.B: Create a community where all Martin County residents are able to commute to work, school, health care appointments, and social events.			
Strategy 3.B.1: Support residents with attaining transportation to and from work and health care appointments.			
Objective 3.B.1.1: By 2025, increase the annual amount of MARTY commuters by 5%.			
National/State Priorities Alignment: HP2030: EH-02. HP2020: SDOH-1, AHS-6.1. SHIP: ISV1.6.			
Activities	**Key Action Steps**	**Measures**	**Key Partners**
<u>Activity 3.B.1.1:</u> Disseminate information to Martin County residents and community stakeholders on available MARTY programs and initiatives (information available in Spanish), including: • Travel training for organizations, staff and clients • Fare-free day • Veteran door-to-door services (must complete applications and have proof of	Engage service providers to promote MARTY program services to their clients, via social media accounts and other mechanisms. Distribute MARTY program flyers, pamphlets, and brochures to service providers for dissemination to their clients.	Number of informational materials distributed. Percent of ridership increase. Baseline: 0 informational materials distributed (2021) Baseline: 93,000 riders on fixed routes (2020)	MARTY IMOVEU Love and Hope in Action (LAHIA; Doctor and Legal Appointment Rides) Veteran Services Kane Center

Veteran status)			
Activity 3.B.1.2: Disseminate information on transportation services and assistance provided by organizations in Martin County.	Research transportation services provided by organizations in Martin County.		
	Develop a resources list for distribution to Martin County residents.		
	Engage service providers to promote resource list among their clients via social media and other mechanisms.		
Strategy 3.B.2: Promote a community wide campaign on Martin Community Coach program availability and eligibility requirements among Martin County residents.			
Objective 3.B.1.2: By 2025, increase the number of transportation disadvantaged Martin County residents referred to the Martin Community Coach program by 5%.			
National/State Priorities Alignment: HP2030: EH-02. HP2020: SDHOH-1, AHS-6.1. SHIP: ISV1.6			
Activities	**Key Action Steps**	**Measures**	**Key Partners**
Activity 3.B.2.1: Disseminate information on Martin Community Coach to Martin County residents and community stakeholders.	Research Community Coach Program eligibility requirements, application process, and related material for distribution.	Referrals to Martin Community Coach among eligible participants. Baseline: 0 referrals to Martin Community Coach among eligible participants through these efforts (2021)	MARTY Senior Resource Association
	Engage service providers to promote resource list among their clients via social media and other mechanisms and make referrals.		

Goal 3.C: Create a Martin County community where all residents have access to stable and affordable housing.			
Strategy 3.C.1: Promote a community wide campaign to increase awareness of free and available financial literacy among Martin County residents.			
Objective 3.C.1.1: By December 2023, improve financial literacy for Martin County residents, measured by pre- and post-test scores from free workshops.			
National/State Priorities Alignment: HP2030: SDOH-01. HP2020: SDOH-3. SHIP: HE3.1.			
Activities	**Key Action Steps**	**Measures**	**Key Partners**
<u>Activity 3.C.1.1:</u> Promote financial literacy trainings among Martin County residents.	Research and explore free and available financial literacy trainings for community members. Develop a training calendar to be shared with Martin County residents. Dissemination methods will include engaging multiple sectors serving Martin County residents.	Number of financial literacy trainings conducted. Number of training participants. Pre-and post-test scores. Baseline: 17 unduplicated financial literacy trainings and 30 participants from March 1, 2019 to February 28, 2020.	House of Hope (Free financial literacy trainings)
Strategy 3.C.2: Develop a unified referral process for existing housing services in Martin County.			
Objective 3.C.2.1: By 2025, a referral process will be identified to educate and link homeless and unstably housed individuals to affordable housing and housing services in Martin County.			
National/State Priorities Alignment: HP2030: SDOH-04. HP2020: SDOH-4. SHIP: HE3.4.			
Activities	**Key Action Steps**	**Measures**	**Key Partners**
<u>Activity 3.C.2.1:</u>	Research and explore available affordable housing	Number of residents who receive	Elev8 Hope

Engage community agencies and stakeholders to serve as ambassadors and promote and link clients to affordable housing and housing services.	and housing services in Martin County. Promotional methods will include engaging and disseminating information on available resources to multiple sectors serving Martin County residents. Contact and ask local service providers to provide Martin County residents with information on available housing-related services.	information about affordable housing and housing services. Total homeless population. Baseline: 0 residents who received information about affordable housing through these efforts (2021) Baseline: Homeless – 305 (2019); Severe Housing Problems – 30% (2017) (Florida Health CHARTS)	House of Hope Love and Hope in Action (LAHIA Project for Assistance for Transition and Homelessness)

ECONOMIC AND SOCIAL MOBILITY PROGRESS TRACKING – ACTIVITIES AND OBJECTIVES

The table below shows the progress that the Martin County Community Health Advisory Council has made towards implementing the Economic and Social Mobility strategies. Each strategy and activity are listed, along with baseline measures and updated process measures to track implementation progress.

Table 16: Economic and Social Mobility Activity Progress

Strategy 3.A.1: Promote consistent information/material to Martin County residents on employment assistance, job training, and job fairs.		
Activity	**Baseline - 2021**	**Progress – 2022 Update**
Disseminate information to Martin County residents and community stakeholders on available employment assistance, job trainings, and job fairs.	In 2021, there had been no employment assistance, job trainings, or job fair information disseminated, as the CHIP had just been developed.	Resource list and event schedule development in progress with appropriate partners. The Martin County Community Health Advisory Council Economic and Social Mobility Subcommittee has developed a white paper of nine job boards and staffing agencies, with plans to develop a map with career and training resources. Once finalized, the white paper and map will be shared widely with community members via partners, existing career resource sites, and social media marketing.
Strategy 3.B.1: Support residents with attaining transportation to and from work and health care appointments.		
Strategy 3.B.2: Promote a community wide campaign on Martin Community Coach program availability and eligibility requirements among Martin County residents.		
Disseminate information to Martin County residents and community stakeholders on available MARTY programs and initiatives (information available in Spanish).	In 2021, 0 informational materials had been distributed, as the CHIP had just been developed.	The Martin County Community Health Advisory Council Economic and Social Mobility Subcommittee is currently developing a funnel guide of levels of accessing transportation, qualifications, and how-to's (MARTY and Martin County Community Coach specific), training agencies on fixed routes, filling out the NCSET Riders Guide
Disseminate information on Martin Community Coach to	In 2021, 0 informational materials had been distributed, as the CHIP had just been developed.	

Martin County residents and community stakeholders.		for Seniors, and training service providers to refer to IMOVEU when there is a gap in transportation services.
Disseminate information on transportation services and assistance provided by organizations in Martin County.	In 2021, 0 informational materials had been distributed, as the CHIP had just been developed.	
Strategy 3.C.1: Promote a community wide campaign to increase awareness of free and available financial literacy among Martin County residents.		
Promote financial literacy trainings among Martin County residents.	In 2021, the CHIP had just been developed so financial literacy trainings had not been promoted widely among residents.	The Economic and Social Mobility Subcommittee is in the process of engaging additional partners who provide financial literacy trainings in partnership with banks and expanding the trainings across Martin County.
Strategy 3.C.2: Develop a unified referral process for existing housing services in Martin County.		
Engage community agencies and stakeholders to serve as ambassadors and promote and link clients to affordable housing and housing services.	In 2021, no community agencies and stakeholders had been engaged to serve as ambassadors, as the CHIP had just been developed.	The Economic and Social Mobility Subcommittee is in the process of engaging additional partners who they know provide housing services to the community. In addition, the Subcommittee is developing a comprehensive list of affordable housing resources for dissemination to Martin County residents.

The table below shows the progress that the Martin County Community Health Advisory Council has made towards meeting the Economic and Social Mobility objectives. Each objective is listed, along with the baseline data, the latest available data, and a trend description in an effort to evaluate progress.

Table 17: Economic and Social Mobility Objective Progress

Objective 3.A.1: By 2025,1,000 residents will receive information about employment assistance and job training opportunities.		
Baseline Data in 2021	Latest Available Data in 2022	Trend
Baseline: In 2021, there had been no employment assistance, job trainings, or job fair information disseminated, as the CHIP had just been developed.	Not available. Total reach pending launch.	**In progress.** Resource list and event schedule development in progress with appropriate partners; total reach pending launch.
Objective 3.B.1.1: By 2025, increase the annual amount of MARTY commuters and Martin Community Coach by 5%.		
Baseline: 93,000 riders on fixed routes.	Pending 2021 ridership numbers.	**In progress.** Funnel guide currently in development process.
Objective 3.C.1.1: By December 2023, improve financial literacy for Martin County residents, measured by pre- and post-test scores from free workshops.		
Baseline: 17 unduplicated financial literacy trainings and 30 participants from March 1, 2019 to February 28, 2020.	Pending countywide inventory of financial literacy trainings for 2021 – currently in progress.	**In progress.** Countywide inventory list of financial literacy trainings currently in the development process.
Objective 3.C.2.1: By 2025, a referral process will be identified to educate and link homeless and unstably housed individuals to affordable housing and housing services in Martin County.		
Baseline: Homeless – 305 (2019); Severe Housing Problems – 30% (2017)	Homeless – 305 (2020); Severe Housing Problems – 16% (2018)	**On track!** While the number of homeless individuals according to a point in time count remained the same for 2020, this data doesn't fully account for the COVID-19 pandemic and was collected prior to CHIP implementation.

Transportation Support Services

Transportation services are a critical component to ensuring opportunities for stable employment, economic mobility, and health care. Evidence exists to support the use of bus passes for reliable transportation to employment locations resulting in improvements in quality of life, employment stability, and, thus, financial stability.[39] Transportation support services, including Uber Health, have also been found to have health benefits by facilitating attendance at health care appointments and increasing screenings for chronic diseases. [40] [41]

Financial Literacy Trainings

Financial literacy and stable housing are other important variables with regards to economic and social mobility. Increasing financial literacy trainings in Martin County can be one way to improve financial decision-making and facilitate opportunities for economic mobility.[42]

Housing Insecurity Referrals

Housing insecurity is another important determinant which threatens physical and psychological well-being as well as economic mobility.[43] Referral processes have shown promise for improving housing stability and may be beneficial to Martin County residents facing housing insecurity.[44]

[39] Mackett R. Impact of Concessionary Bus Travel on the Well-Being of Older and Disabled People. Transportation Research Record. 2013;2352(1):114-119. doi:10.3141/2352-13

[40] Starbird, L. E., DiMaina, C., Sun, C. A., & Han, H. R. (2019). A systematic review of interventions to minimize transportation barriers among people with chronic diseases. Journal of community health, 44(2), 400-411.

[41] Ivanics MS, C., Lau, E., Fynke MPH, J., Williams MD, R., & Binienda PhD, J. (2020). Outcomes of Utilizing Uber Health to Improve Access to Healthcare at an Urban Student Run Free Clinic.

[42] Mandell, L. Klein, L.S. (2009) Association for Financial Counseling and Planning Education. The Impact of Financial Literacy Education on Subsequent Financial Behavior

[43] Cutts, D. B., Meyers, A. F., Black, M. M., Casey, P. H., Chilton, M., Cook, J. T., ... & Frank, D. A. (2011). US housing insecurity and the health of very young children. American journal of public health, 101(8), 1508-1514.

[44] Byrne, T., Fargo, J. D., Montgomery, A. E., Roberts, C. B., Culhane, D. P., & Kane, V. (2015). Screening for homelessness in the Veterans Health Administration: monitoring housing stability through repeat screening. Public Health Reports, 130(6), 684-692.

COMMUNITY RESOURCES

Partner/Agency	Relevant Services
Aging Resource Center of Martin County	Resources and programs that enhance independence, personal growth, health, and self-esteem among aging Martin County residents
Banner Lake Club	Youth financial literacy trainings, debt management and credit counseling
Boys and Girls Club	Vocational training for teens and the AmeriCorps Program
Elev8 Hope	Youth training programs, community outreach, and homeless services
Faith-based Organizations	Provide food, clothing, health education, referrals for Martin County residents in need
Family Partners	Adult day services and resources for those seeking a complement to nursing home care, in-home care, independent living, or assisted living
Florida Housing Coalition	Affordable housing solutions
Goodwill	Vocational training and development program
House of Hope	Provides food, clothing, furniture, financial assistance, financial literacy training, soft skills training, housing assistance, information and referral, and lifechanging case management services to Martin County residents in need (available in Spanish)
Helping People Succeed	Provides opportunities and choices that help children, families and adults improve their quality of life through education, job coaching, training, and employment
IMOVEU	Mobility management and transportation coordination advocacy for the transportation disadvantaged and agencies that assist them

Indian River State College	Education resources and career training programs for community residents
Kane Center	Health appointment transportation services for aging adults in Martin County
Love And Hope in Action (LAHIA)	Meals, prescriptions, eyeglasses, transportation assistance for health and legal appointments, culinary arts training, and basic services for the homeless; Project for Assistance for Transition and Homelessness (PATH) program assists persons with mental illness with housing via three months of rent assistance and connects individuals to local housing and resources
Martha's House	Emergency and temporary housing solutions for domestic violence victims and houseless women
Martin Board of County Commissioners	Vocational training center
Martin County Career Center – CareerSource Research Coast	Connects employers with qualified, skilled talent and Floridians with employment and career development opportunities
Martin County Housing Assistance	Emergency rental and utility payment assistance and affordable housing assistance services
Martin County School District	College and career readiness programs
MARTY – Martin County Public Transit	Fixed route and commuter bus services; provides door-to-bus transportation services for veteran's living in Martin County
Mary's Home	Faith-based transitional home that provides residential and non-residential services for pregnant, homeless women
Project LIFT	Vocational skills training and mentoring
SafeSpace	Certified Domestic Violence Center providing 24/7 services and refuge and preventing domestic violence

Salvation Army Basic Needs Program	Rent, utility, and prescription assistance; employment services programs provide skills and strengths assessments, job-search counseling and support, and several programs that teach new job skills
Senior Research Association	Martin County Community Coach Program for the transportation disadvantaged
Treasure Coast Developmental Mobility Advantage Ride Program	Door-to-Door Service Transportation for persons with developmental disabilities
Treasure Coast Food Bank	Food distribution, benefits assistance, workforce development, and other essential services
Uber Health	Free or subsidized transportation to healthcare appointments
United Way of Martin County	Education, health and financial stability programs
YMCA of the Treasure Coast	Strong Families Program provides assistance to youth, adults, and families based on individual needs and circumstances; financial assistance

SUMMARY OF CHANGES

February 2022
Phase 6: Action Cycle quarterly meetings were added to the CHIP process (p. 23) • Also included in this section are descriptions on: 1) how the Martin County Community Health Advisory Council members review the latest data to review and reassess the CHIP priority areas and 2) the process for revising and updating the plan
The Access to Health and Human Services Activity and Objective Progress Tracking section was added to the document (p. 34) • In this section, a table highlighting activity progress and a table highlighting progress towards meeting objectives have been included
The Mental Health and Substance Use Activity and Objective Progress Tracking section was added to the document (p. 47) • In this section, a table highlighting activity progress and a table highlighting progress towards meeting objectives have been included
The Economic and Social Mobility Activity and Objective Progress Tracking section was added to the document (p. 59) • In this section, a table highlighting activity progress and a table highlighting progress towards meeting objectives have been included
The Summary of Changes section was added to the CHIP to highlight key changes to this evolving document over time (p. 66)
The Martin County Community Health Advisory Council List in the Appendix has been updated to reflect the new partners engaged during the CHIP implementation phase (p. 69)

COMMUNITY ENGAGEMENT

During May 2021, HCSEF conducted four Community Input meetings across Martin County to provide community members and Martin County residents the opportunity to participate in the CHIP process. HCSEF selected communities to host these sessions with a large racial or ethnic minority population, low-socioeconomic status, or a geographically disadvantaged area. HCSEF held meetings at the following locations:

- Pentecostal Church of God in Christ/Hands of Hope in East Stuart (1)
- Elisabeth Lahti Library and Subway in Indiantown (1)
- Blake Library and Downtown in Stuart (2)

Figure 5: Pentecostal Church of God Community Input Session

During these community input meetings, HCSEF provided over 60 residents with an overview of the community health assessment and engaged them in a voting activity to prioritize CHIP goals and provide recommendations for modifications and partners. While all goals resonated with the community members, below are the results of a prioritization activity, which reflect the goals that residents felt were most important to focus on based on their lived experiences. The majority of community residents shared that the following goals for each priority area resonated with them most:

Table 18: Top Community Supported Goals

Priority 1: Access to Health and Human Services	Priority 2: Mental Health and Substance Use	Priority 3: Economic and Social Mobility
Goal 1: Create a community where all Martin County residents have access to health and human services	Goal 2: Create a community where all Martin County residents are empowered to seek mental health and substance use services	Goal 3: Create a community where all Martin County residents have access to stable and affordable housing

USING THE PLAN

Martin County has a lot to be proud of in terms of its community health; however, there are always opportunities for improvement. The implementation of the CHIP will help strengthen the public health infrastructure, aid and guide planning, foster collaboration and capacity-building and, ultimately, promote the well-being and quality of life for Martin County residents. Health improvement does not occur only at the governmental or agency level, but must be practiced in our homes, our schools, our workplaces and our faith-based organizations. The Martin County CHIP created by community stakeholders broadens and builds upon successful local initiatives. Below are some suggestions and strategies of ways that you can play a part in achieving a healthier community.

- Promote the health priorities in the community and the CHIP
- Support programs, policies, initiatives and campaigns aimed to address the health priorities in the community
- Be an advocate in the community for healthy behaviors and for health improvement
- Lead by example and practice healthy behaviors in your home, workplace and social circle
- Share your resources whether it be time, support, funding, or expertise to strengthen the health improvement efforts

APPENDICES

APPENDIX A: MARTIN COUNTY COMMUNITY HEALTH ADVISORY COUNCIL LIST

First Name	Last Name	Agency
Ruby	Aguirre	Treasure Coast Food Bank - Whole Child Connection
Blaine	Albright	Christ Fellowship Church
Anastasia	Anderson	Florida Department of Health in Martin County
Angela	Aulisio	Cleveland Clinic Martin Health
Margaret (Peggy)	Brassard	Martin County Public Transit
Jennifer	Buntin	UF/IFAS Family Nutrition Program
Audrey	Burzynski	Hobe Sound Resident
Angelica	Castillo Da Silva	Florida Department of Health in Martin County
Gabriela	Chavez-Munden	Florida Department of Health in Martin County
Jackie	Clark	Indiantown Council Member
Janet	Cooper	Helping People Succeed
Victoria	Defenthaler	Martin County School Board
Maryann	Diaz	Florida Rural Legal Services
Jennifer	Doak, PhD	Indian River State College
Anthony	Dowling	Village of Indiantown
Lynn	Frank	Health Council of Southeast Florida
Randee	Gabriel	211 Palm Beach/Treasure Coast

Donna	Gardner	Mary's Home
Diana	Gomez	AmBetter
Jerry	Gore	Pentecostal Church of God in Stuart/ Hands of Hope
Valerie	Graham	Quit Doc/Tobacco Free Partner
Yvette	Gregory	Love and Hope in Action (LAHIA)
Janice	Greller	NAMI Martin County
Kevin	Herndon	Martin County Fire Rescue
Darryl	Houston	Community Foundation of Palm Beach & Martin Counties
Pat	Houston	IRMO Early Learning Coalition
Chris	Jackson	Project LIFT
Chris	Kammel	Martin County Fire Rescue
Nicole	King	Children's Services Council of Martin County
Robert	King	Florida Department of Health in Martin County
Deirda	Kinnaman	House of Hope/Golden Gate Center
Patsy	Lindo-Wood	Florida Department of Health in Martin County
Annette	Lopez	Kane Center/ Council on Aging of Martin County
Jeff	Marquis	The Salvation Army
Dr. Agnieszka	Marshall	Tykes & Teens, Inc.
Michelle	Miller	Martin County Health and Human Services
Sheila	Moore	Martin County Pre-K Programs/Head Start
Kim	Ouellette	Volunteers in Medicine

Christine	Palaez-Pena	Epilepsy Florida
Caitlynne	Palmieri	Boys & Girls Club of Martin County
Natalie	Parkell	UF/IFAS Family Nutrition Program
Karlette	Peck	The Healing Center of Martin County
Marybeth	Pena	Florida Department of Health in Martin County
John	Perez	Martin County Sheriff's Department
Craig	Perry	Treasure Coast Hospice
Robert	Ranieri	House of Hope/Golden Gate Center
Richard	Reilly	Martin County Library System
Karen	Ripper	The Council on Aging of Martin County
Micah	Robbins	Palm Beach County Behavioral Health Coalition
Renay	Rouse	Florida Department of Health Martin County
Bonnie	Russo	Helping People Succeed
Lori	Sang	Light of the World Charities
Kameliya	Sapundzhieva	Coral Shores Behavioral Health
Natasha	Serra	IMOVEU
Sherry	Siegfried	Treasure Coast Food Bank and Florida KidCare Coalition
Doug	Smith	Martin County Board of County Commissioners
Jimmy	Smith	Martin NAACP
Chris	Stephenson	Senior Resource Association
Samantha	Suffich	Healthy Start of Martin County

Rachel	Terlizzi	United Way of Martin County
Jessica	Tharp	City of Stuart
Colleen	Walts	211 Palm Beach/Treasure Coast
Denise	Waniger	Communities Connected for Kids
Carol	Wegener-Vitani	Florida Department of Health in Martin County
Cayuna	Williams	Martin County School District
Shauna	Young	Florida Department of Health in Martin County
Bob	Zaccheo	Project LIFT

GET INVOLVED!

Community health improvement is improvement of the community and it is done largely by the community. To that end, all stakeholders and residents are invited to participate in improving Martin County's health.

For more information or to get involved in the County's health improvement activities, please contact:

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