Franklin County Community Health Improvement Plan

2020 – 2023

"A United, Healthy and Prosperous Franklin County."

Franklin County Community Health Improvement Plan

Lead Project Staff:

Sarah Hinds
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Sean Golder

CHIP STEERING COMMITTEE:

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John Griggs My Gulf Care	Lori LaCivita My Gulf Care
Sean Golder PanCare	Mary Harrell Sacred Heart Clinic
David Walker Weems CEO	Suzie Buskirk Weems Memorial Hospital Clinic
Suzy Nadler Healthy Start Coalition	Patricia Richards DOH-Franklin Healthy Start
Erica Head Holy Family Senior Center	Ivy Nixon Elder Care Services
Phil Carter Connect Program	April Rester Franklin County WIC Program
Stephanie Cash Healthy Families Program	Ivy Nixon Elder Care Services
April Landrum Apalachee Center	Jennifer Travieso DISC Village
Hunter Bailey Big Bend AHEC	Emily Kohler Big Bend AHEC
Myrtis Wynn Community Representative	Burt Boyd Franklin County Board of County Commissioners
Talitha Robinson DOH-Franklin/Gulf Closing the Gap	Alma Pugh DOH-Franklin/Gulf Closing the Gap
Marquita Thompkins DOH-Franklin Tobacco Prevention Program	Nicole Sandoval DOH-Franklin Preparedness Planner
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Sarah Hinds DOH-Franklin Administrator	DT Simmons DOH-Franklin County CHIIP Coordinator

Implementation Members:

Access to Care Subcommittee:	
Team Member	**Organization**
Sean Golder	PanCare
David Walker	Weems Memorial Hospital Clinic
Suzie Buskirk	Weems Memorial Hospital Clinic
Mary Harrell	Sacred Heart Clinic
Lori LaCivita	My Gulf Care
John Griggs	My Gulf Care
Erica Head	Holy Family Senior Center
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Ivy Nixon	Elder Care Services
April Rester	Franklin County WIC Program
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Team member	**Organization**
April Landrum	Apalachee Center
Stephanie Cash	Healthy Families Program
Phil Carter	Connect Program
Suzy Nadler	Healthy Start Coalition
Patricia Richards	DOH-Franklin Healthy Start

Substance Abuse Subcommittee:	
Team Member	**Organization**
Hunter Bailey	Big Bend AHEC
Jennifer Travieso	DISC Village
Emily Kohler	Big Bend AHEC
Marquita Thompkins	DOH-Franklin Tobacco Prevention Program
Jessie Pippin	DOH-Franklin/Gulf Health Education Program
Talitha Robinson	Closing The Gap Program/PACE-EH
Alma Pugh	Closing The Gap Program/PACE-EH
Megan Bennefield	DOH-Franklin CHOICES Program

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COMMUNITY HEALTH IMPROVEMENT PLAN
Franklin County, Florida

Executive Summary

The health status of a community plays a large role in social and economic prosperity, therefore it is important that a community strives to continually improve and maintain its health. Government agencies (city, county, state) may provide health services; however, successful health programs require an active partnership between all community agencies.

Building a healthier Franklin County began as a community-wide initiative with the goal of establishing an ongoing process for identifying and addressing health needs. The intent of this project was to foster successful partnerships within the community in order to improve the health of Franklin County residents.

The Public Health Accreditation Board defines a Community Health Improvement Plan (CHIP) as "a long-term, systematic effort to address health problems on the basis of the results of assessment activities and the community health improvement process."

A CHIP can be used by health departments, as well as other government, community, education or human service agencies, to coordinate efforts and target resources that promote health. A CHIP serves to address health issues, roles, and common goals and objectives throughout the community. The plan can be used to guide action and monitor and measure progress toward achievement of goals and objectives. The plan, along with a Community Health Assessment (CHA), can be utilized as justification for support of certain public health initiatives, as part of funding proposals, and for attracting other resources toward building programs that improve the overall quality of life of the community.

Health Priorities and Recommendations

Franklin County Community Health Improvement Partners have identified three key health priorities **– *Access to Care, Mental Health, and Substance Abuse.*** Action steps and recommendations were developed based on evidence-based practices. It was recommended for the Community Health Action Plans to be incorporated into the work of the Florida Department of Health in Franklin County, local initiatives, existing community groups, and health care partners.

Franklin County CHIP Vision

The Community Health Improvement Plan (CHIP) Steering Committee's vision for Franklin County is **"A United, Healthy and Prosperous Franklin County."**

Introduction

Community health improvement planning is a long-term, systematic effort that addresses health problems on the basis of the results of community health assessment activities and the community health improvement process.

A CHIP is critical for developing policies and defining actions to target efforts that promote health. It defines the vision for the health of the community through a collaborative process and addresses the strengths, weaknesses, challenges, and opportunities that exist in the community in order to improve the health status of that community.

The Process

Franklin County selected the Mobilizing for Action through Planning and Partnerships (MAPP) process for community planning because of its strength in bringing together diverse interests to collaboratively determine the most effective way to improve community health.

Picture: MAPP Roadmap to Health

MAPP is a strategic approach to community health improvement. Using MAPP, Franklin County seeks to create an optimal environment for health by identifying and using resources wisely,

taking into account our unique circumstances and needs, and forming effective partnerships for strategic action. The MAPP method of community planning 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).

MAPP employs four assessments, which offer critical insights into challenges and opportunities throughout the community.

- The Community Strengths and Themes Assessment provides an understanding of the issues residents feel are important by answering the questions *"What is important to our community?", "How is quality of life perceived in our community?"* and *"What assets do we have that can be used to improve community health?"*
- The Local Public Health System Performance Assessment is a comprehensive assessment of the organizations and entities that contribute to the public's health. The Local Public Health System Performance Assessment addresses the questions *"What are the activities, competencies, and capacities of our local health system?"* and *"How are Essential Services being provided to our community?"*
- The Community Health Status Assessment identifies priority issues related to community health and quality of life. Questions answered during this phase include *"How healthy are our residents?"* and *"What does the health status of our community look like?"*
- The Forces of Change Assessment focuses on the identification of forces such as legislation, technology and other issues that affect the context in which the community and its public health system operates. This answers the questions *"What is occurring or might occur that affects the health of our community or the local health system?"* and *"What specific threats or opportunities are generated by these occurrences?"*

The assessment process included CHIP meetings and workshops which occurred between June and December 2015. Each assessment was conducted and described in a written report and the findings of all the assessments were summarized in the 2015-16 Community Health Profile. Each assessment was reviewed by partners involved in each workshop. For example, the Local Public Health System Performance report was reviewed by the same community members who were involved in the assessment.

The summaries of the assessment reports are available in the 2015-2016 Community Health Assessment Report.

Additionally, during this timeframe, a community survey was distributed both on-line and in paper format to provide information about perceptions of health of the community, its residents, and the health care system. CHIP partners helped to disseminate the surveys, collecting 428

completed surveys from residents. The survey response report can also be found in the 2015-2016 Community Health Assessment Report.

Picture below: CHIP participants received "Success Express" tickets to begin the MAPP Process.

Data Resources Utilized

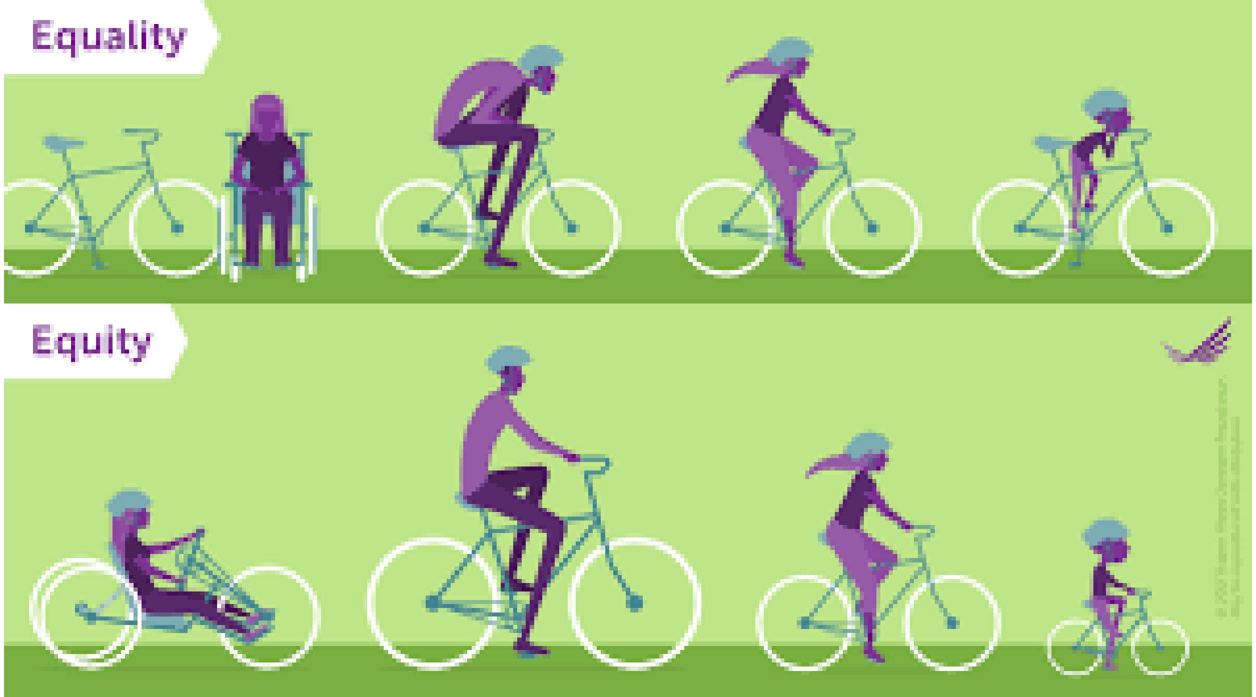
Data sources included: Florida CHARTS, Florida Department of Health, Agency for Health Care Administration, County Health Rankings and Roadmaps, Florida Department of Children and Families, U.S. Department of Health & Human Services, Feeding America, USDA Economic Research Service, Florida Department of Law Enforcement, US Census Bureau, Federal Bureau of Labor and Statistics, and U.S. Department of Housing and Urban Development. Between the months of August through November 2015, small committee meetings were held to review and assess the data. In these small committee meetings, over 140 health indicators for Franklin County were compared and contrasted to those for the state and surrounding counties. In addition, the committee members also compared local data to previous years' data from Franklin County, highlighting improvements and statistical trends.

Identifying Health Priorities

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

- Broad applicability of solution set
- Timeframe require to support efforts

- Alignment with vision (To enhance health for all generations in Franklin County)
- Community support for the problem
- Resource availability to address the problem
- Potential to reduce health disparities



Picture above: Health Equality vs. Equity,
Source: Robert Wood Johnson Foundation

The potential to reduce health disparities became an important area of focus for partners. The above picture was utilized to understand health equality vs. health equity. Giving everyone a fair chance to be healthy does not necessarily mean offering everyone the same resources to be healthy, but rather offering people specific resources necessary for their good health. Consider four people of varying heights and abilities. Offering them all the same size bicycle to ride on would mean that wheelchair bound participant, the tallest rider and shortest child does not have a fair chance to be as mobile as the others. Offering each rider, a bicycle suitable that is the right size for their height and ability gives all participants a fair chance to utilize the bikes.

Attendees were able to discuss the issues and then vote based on their ranking of relevant factors. As a result, Mental Health/Substance Abuse, Access to Care and Healthy Weight were the top priority health issues identified for Franklin County. Workshop documentation can be found in Attachment A of this plan.

The CHA to CHIP Transition

The CHIP Steering Committee reviewed the priorities, the rationale for including them and the votes of the community members. Using quality planning techniques and National Association of County and City Health Officials (NACCHO) framework models, the Steering Committee selected Goals and supporting objectives for each health priority in December 2020. They then discussed strategic approaches that could be employed to achieve the goals, keeping in mind best practices to improve health equity. In subsequent meetings, which included members of the Steering Committee and other community representatives, the goals, objectives, performance measures and implementation plans were developed. Healthy Priority Subcommittee groups continue to meet regularly to continue progress of strategies and tactics.

Goals

Selection of the Strategic Goals was done within the context of the work done by the University of Wisconsin through County Health Rankings and Roadmaps. The summary of the literature describing the factors affecting health outcomes is displayed in a chart on the website www.countyhealthrankings.org.

The model is comprised of three major components:

- Health Outcomes – This component evaluates the health of a community as measured by two types of outcomes: how long people live (Mortality/Length of Life) and how healthy people are when they are alive (Morbidity/Quality of Life).

- Health Factors – The factors influencing health outcomes are organized into four categories and weighted based on their relative effect on health outcomes. The analysis indicates that the factors and their relative contributions are:
  - Health Behaviors: 30%
  - Clinical Care: 20%
  - Social and Economic Factors: 40%
  - Physical Environment: 10%

  The *Physical Environment* includes environmental quality and the built environment. The category *Social and Economic Factors* includes education, employment, income, family and social support, and community safety. *Clinical Care* is defined as access to care and quality of care. *Health Behaviors* includes tobacco use, diet, exercise, alcohol use and sexual activity.

A Franklin County detailed report of County Health Rankings Health Factors can be found in Attachment A.

- Programs and Policies – Policies and programs at the local, state and federal level have the potential to impact the health of a population as a whole (i.e. smoke free policies or laws mandating childhood immunization). As illustrated, Health Outcomes are improved when Policies & Programs are in place to improve Health Factors.

The selection of the goals for the CHIP was done with an eye to the relative importance of the influence of the various factors described above, tempered by the community perspective on needs, and policy-changing potential.

The goals selected for the Franklin County CHIP are:

- Increase access to healthcare in Franklin County.
- Enhance mental health awareness in Franklin County.
- Improve mental health services in Franklin County.
- Reduce alcohol abuse/consumption in youth and adults in Franklin County.
- Reduce substance abuse in Franklin County.

For Franklin County, the selection of Health Priority goals addresses overall health outcomes and factors of *Clinical Care*, *Health Behaviors, and support statistics of Social and Economic Factors*.

Expanding on CHIP goals is being developed in a county-wide collaboration with the Florida Department of Health in Franklin County, which has organized other community partners into working groups to address the social determinants of health. The CHIP is integrated into this community fabric and planning process. The partners included in the community-wide strategic planning process include representatives from the school district, law enforcement, child care, child abuse prevention, substance abuse treatment and prevention, mental health, community service providers and juvenile justice.

Engaging the Community

Community ownership is a fundamental component of community health assessment and health improvement planning. Community participation leads to the collective thinking and commitment required for implementation of effective, sustainable solutions to complex problems. Broad community participation is essential because a wide range of organizations and individuals contribute to the public's health.

Creating a healthy community and strong local public health systems require a high level of mutual understanding and collaboration. Franklin County is working to strengthen and expand community connections and provide access to the collective wisdom necessary to addressing community concerns.

The process resulting in the 2016 Community Health Improvement Plan began in April of 2016 and concluded in August of 2016. It has been characterized by several key features:

- Inclusiveness: multiple stakeholders were included throughout the process
- Comprehensiveness: many dimensions of health were addressed
- Local Ownership: the process linked expertise and experience to generate a sustainable plan that includes community ownership and responsibility

The partners who have participated in the assessment and planning process have agreed to participate in the implementation plan. Specific community members have agreed to conduct the activities described in the work plan. In addition, many members have agreed to support the CHIP implementation through participation on one or more of the implementation oversight committees.

Pictured Above: CHIP Meetings

About the Current Plan

The Franklin County Community Health Improvement Plan includes goals and objectives in 1 - 3 year intervals with work plans that are intended to be updated periodically. The goals, strategies and objectives are aligned with national initiatives such as Healthy People 2030 and the Florida State Health Improvement Plan (SHIP). The specific alignments are indicated by reference in the Goals and Objectives section. The format used for the Goals and Objectives are also aligned with the Florida SHIP and use the same format as the state plan. The objectives include quantifiable performance measures based primarily on data included in the community health assessment.

Monitoring the CHIP will be done by the priority focus groups established in the CHIP. The Franklin County Health Department (DOH-Franklin) will assemble the performance measures described in the objectives in the spring of each year or when they are available and submit them to the three committees for review. In addition, the party responsible for each activity will present to the committee at least annually to report progress, successes, challenges and needs. Leadership (Steering Committee) of the three committees will meet at least quarterly. At the December

meeting of each group, the goals, strategies and objectives will be reviewed and adjusted as needed.

The sustainability of the CHIP was discussed during meetings and was an important consideration in plan development. The work plan includes activities that community partners have agreed to conduct. The agreements are based on the mission and resources of each agency and built on evidence-informed best practices. The activities included in the plan include a reference to the best practice and ability to support the activity and ongoing needs. If a program is an event, the date is given or the effective starting date is provided for programs and initiatives. If it is expected to be sustainable in the long term (at least the next two years), the activity effective date is given in the time frame. Work plans for each Strategy are still in progress as of August 2016.

The community members identified as “responsible” are making a good faith statement of intent and will be using their existing resources to establish, expand initiate or maintain a program or service. The hope and expectation, in many cases, is that the inclusion of the activity in this community plan will document the community support for this activity and lead to additional/external funding.

Selected Priorities
Goals, Objectives, & Strategies

Access to Care

Research, Data and statistics:

- The number of teen births is 65.4 (per 1,000 female age 15-19 pop.) compared to only 25.3 in the State of Florida (CHR, 2019).
- The leading cause of death is cancer, heart disease, and COPD, all preventable chronic diseases (FlHealthCharts, 2019).
- 17.1% of the population under age 65 is uninsured, compared to just 11% nationally (CHR, 2019).
- The ratio of local population to physicians is 2,940:1 compared to 1376:1 statewide (CHR, 2019).
- 37.8% of adults are obese compared to 27.4% of adults statewide (FlHealthCharts, 2019).
- Excess weight/obesity was considered a major health concern for 67.6% of survey respondents (CHSA, 2019).
- Nearly 36% of children under age 18 live in poverty, compared to only 21.3% of children statewide (CHR, 2019).

Goals:

1. Increase access to healthcare in Franklin County

Objectives:

1. Increase the number of participants to the chronic disease education classes by 10% for individual entities by Feb 28, 2021. (Source: Weems, Sacred Heart)
2. Increase the number of participants in youth nutrition classes by 15% by February 28, 2021. (Source: Closing the Gap Program, IFAS Nutrition Program)

Strategies for Access to Care:

Strategy 1: Create more opportunities for the community to receive free health access and resources
Tactic A: CHIP partners will participate in health fairs throughout the county promoting chronic disease prevention.
Tactic B: Partners will collaborate to host diabetes self-management classes throughout county.

Strategy 2: Improve youth access to chronic disease awareness and prevention information
Tactic A: Partner with afterschool program to provide classes to youth.
Tactic B: Increase presentations/promotion campaigns to educational stakeholders in order to increase support for nutrition curriculum

Mental Health

Related Research, Data and statistics:

- Average number of adult unhealthy mental health days in Franklin County is 4.0 compared to the state count of 3.8 days (CHR 2019).
- 38.6% of all survey respondents think that depression and anxiety is a top health concern in Franklin County. (CHSA, 2019)
- Suicide is the 9th leading cause of death (FlHealthCharts, 2018).
- The 14th most common patient principal diagnosis is anxiety disorder (Weems Hospital Discharge Data, FY 2018)
- The ratio of population to mental health providers in Franklin County is 1,984:1, compared to the state's ratio of just 703:1 (CHR, 2019).

Goals:

1. Enhance mental health awareness in Franklin County.
2. Improve mental health services in Franklin County.

Objectives:

1. By December 31, 2020, host two mental health first aid trainings in Franklin County.
2. By July 31, 2020 CHIP will create and produce an mental health inventory of care/resource guide.

Strategies for Mental Health:

Strategy 1: Decrease stigmatization of Mental Health Illness in Franklin County

Tactic A: Host Mental Health First Aid Trainings for Adults and/or Youth
Tactic B: Provide prenatal and postnatal depression screenings to parents enrolled in the Connect program.
Tactic B: Refer screened individuals to providers as necessary.

Strategy 2: Provide information to the community about mental health services available
Tactic A: Collaborate with other CHIP partners to create wellness events to promote mental health resources.
Tactic B: Distribute an inventory of care/resource guide to critical points of distribution.

Substance Abuse

Related Research, Data and statistics:

- The 5th leading cause of death in Franklin County is due to Chronic Liver Disease and Cirrhosis (FlHealthCharts 20190)
- 18.2% of adults smoke, compared to only 15% of adults throughout the state (CHR 2019).
- 24.7% of adults reported binge or heavy drinking compared to just 17.% for adults in Florida(CHR 2019).
- 35.7% of all driving deaths have alcohol involvement compared to just 26.4% statewide (CHR 2019).
- 86.9% of all survey respondents think that drug abuse is a major health concern in Franklin County. (CHSA, 2019)
- 41.4% of all survey respondents think that alcohol abuse is a major health concern in Franklin County. (CHSA, 2019)
- 37.9% of all survey respondents think that tobacco use is a major health concern in Franklin County. (CHSA, 2019)

Goal:

1. Reduce alcohol abuse/consumption in youth and adults in Franklin County.
2. Reduce substance abuse in Franklin County.

Objectives:

1. Decrease the number of Franklin County adults who report binge or heavy drinking from 24.7% to 22% by the end of March 2022. (County Health Rankings)
2. Decrease the percent of Franklin County youth who currently use some form of tobacco products from 25% to 22% by the end of March 2022. (Source: Youth Tobacco Survey, FYSS)

Strategies for Substance Abuse

Strategy 1: Provide evidence-based information to youth about the of using alcohol, drugs & tobacco products.
Tactic A: Collaborate with CHIP partners and they school system to deliver substance abuse resistance education curriculum to students (SWAT, DARE, Choices Program, other).
Tactic B: Collaborate with other CHIP subcommittees to host health fairs and community outreach promoting alcohol, drug and tobacco abstinence and/or cessation.

Strategy 2: Reduce the access of alcohol in the community.
Tactic A: Work with law enforcement to do local vendor compliance checks on alcohol sales to minors.
Tactic B: Restrict the content and placement of alcohol advertisements via local ordinances, state laws, or industry self-regulation (FCSO, Tobacco Prevention Program).

Tactic C: Increase awareness, accessibility and availability of support programs (Faith-based, DISC Village, FCSO, Big Bend Community Based Care).

CHIP Next Steps

The Franklin County Community Health Improvement Partners will collaborate with other community stakeholders, policy makers, the business community, and public health partners to determine action steps, implement strategic tasks and evaluate action plans to gage overall impact. Implementation of the action plans will ultimately strengthen the public health infrastructure, enhance the planning, research and development of community health partnerships, and promote and support the health, wellbeing, and quality of life of Franklin County residents.

The partnership will meet quarterly throughout the duration of this CHIP cycle to report on objectives. At the end of the each calendar year committee members will gather to review implementation, evaluate progress and update the plan as necessary.

Alignment With National And State Initiatives

The references included in the Goals and Objectives section refer to the initiatives listed below.

A: Community Tool Box. (2020)
https://ctb.ku.edu/en/table-of-contents/structure/strategic-planning

B: Centers for Disease Control. (2010-2015.) Winnable Battles.
http://www.cdc.gov/winnablebattles/

C: Florida Department of Health. (2021.) Strategic Plan.

D: Florida Department of Health. (2017 - 2021.) State Health Improvement Plan.
http://www.floridahealth.gov/about/state-and-community-health-assessment/ship-process/index.html

E: Healthy People 2030. (2020.) 2020 Topics and Objectives.
https://www.healthypeople.gov/2020/About-Healthy-People/Development-Healthy-People-2030

F: Public Health Accreditation Board. (2013) Standards and Measures.
https://www.phaboard.org/wp-content/uploads/2019/01/PHABSM_WEB_LR1.pdf

G: Public Health Law. (2020.) Change Lab Solutions. https://www.changelabsolutions.org/

H: US Department of Health and Human Services. (2011.) Action Plan to Reduce Racial and Ethnic Health Disparities.
https://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

I: US Department of Health and Human Services. (2011.) National Prevention Strategy.
https://www.hhs.gov/sites/default/files/disease-prevention-wellness-report.pdf

J: HealthData.gov (2020.)
https://healthdata.gov/

THE FOLLOWING PAGES INCLUDE CURRENT WORK PLANS BASED ON HEALTH PRIORITY STRATEGIES IDENTIFIED. CREATION OF WORK PLANS ARE IN PROGRESS.

What Works for Health – County Health Rankings

What Works for Health provides communities with information to help select and implement evidence-informed policies, programs, and system changes that will improve the variety of factors we know affect health. The following lists includes strategies backed by scientific evidence which align with the selected health priorities and can be used during the CHIP Implementation process. To view electronically, hit the "Ctrl" key on your keyboard and click the blue topic of interest.

Access to Care

Centering pregnancy

Scientifically Supported
Provide prenatal care in a group setting, integrating health assessment, education, and support
Access to Care

Community water fluoridation

Scientifically Supported
Adjust and monitor fluoride in public water supplies to reach and retain optimal fluoride concentrations

Federally qualified health centers (FQHCs)

Scientifically Supported
Increase support for non-profit health care organizations that receive federal funding and deliver comprehensive care to uninsured, underinsured, and vulnerable patients regardless of ability to pay
Access to Care

Medical homes

Scientifically Supported
Provide continuous, comprehensive, whole person primary care that uses a coordinated team of medical providers across the health care system
Quality of Care · Access to Care

Mental health benefits legislation

Scientifically Supported
Regulate mental health insurance to increase access to mental health services, including treatment for substance use disorders
Access to Care

Nurse practitioner scope of practice

Scientifically Supported
Use regulation to extend nurse practitioner's (NP's) scope of practice to provide primary care to the full scope of their training and skills without physician oversight
Access to Care

Rural training in medical education

Scientifically Supported
Expand medical school training and learning experiences focused on the skills necessary to practice successfully in rural areas
Access to Care

School dental programs

Scientifically Supported
Provide sealants, fluoride treatment, screening, and other basic dental care on school grounds via partnerships with dental professionals
Access to Care

Telemedicine

Scientifically Supported
Deliver consultative, diagnostic, and treatment services remotely for patients who live in areas with limited access to care or would benefit from frequent monitoring; also called telehealth
Access to Care

Mental Health

Community policing

Scientifically Supported
Implement a policing philosophy based on community partnership, organizational transformation, and problem solving techniques to proactively address public safety issues
Community Safety

Early childhood home visiting programs

Scientifically Supported
Provide parents with information, support, and training regarding child health, development, and care from prenatal stages through early childhood via trained home visitors
Community Safety · Family and Social Support

Functional family therapy (FFT)

Scientifically Supported
Introduce a short-term family-based intervention therapy focused on strengths, protective factors and risk factors for youth with delinquency, violence, or substance abuse problems, and their families
Community Safety

Mentoring programs: delinquency

Scientifically Supported
Enlist mentors to develop relationships and spend time individually with at-risk mentees for an extended period; mentors have greater knowledge, skills, etc. than mentees
Alcohol and Drug Use · Community Safety

Neighborhood watch

Scientifically Supported
Support the efforts of neighborhood residents to work together in preventing crime by reporting suspicious or potentially criminal behavior to local law enforcement
Community Safety

Substance Abuse

Drug courts

Scientifically Supported
Use specialized courts to offer criminal offenders with drug dependency problems an alternative to adjudication or incarceration
Community Safety · Alcohol and Drug Use

Family treatment drug courts

Scientifically Supported
Use specialized courts to work with parents involved in the child welfare system who may lose custody of their children due to substance abuse
Community Safety · Alcohol and Drug Use

Functional family therapy (FFT)

Scientifically Supported

Introduce a short-term family-based intervention therapy focused on strengths, protective factors and risk factors for youth with delinquency, violence, or substance abuse problems, and their families
Community Safety

Mass media campaigns against alcohol-impaired driving

Scientifically Supported
Use mass media campaigns to persuade individuals to avoid drinking and driving or to prevent others from doing so; campaigns often focus on fear of arrest or injury to self, others, or property
Alcohol and Drug Use

Mentoring programs: delinquency

Scientifically Supported
Enlist mentors to develop relationships and spend time individually with at-risk mentees for an extended period; mentors have greater knowledge, skills, etc. than mentees
Alcohol and Drug Use · Community Safety

Multi-component community interventions against alcohol-impaired driving

Scientifically Supported
Work to reduce alcohol-impaired driving via sobriety checkpoints, responsible beverage service training, education and awareness activities, and other efforts
Alcohol and Drug Use

Florida Department of Health in Franklin County
Franklin County Community Health Improvement Partners Meeting
DOH-Franklin Large Conference Room
January 29, 2020 10:00a.m. - 12:00p.m. EST

AGENDA

Purpose: *Solicit input from the community on the community health plan goals, objectives and strategies to support selected health priorities through open dialogue.*

Topic	Lead
Welcome/Call to Order ▪ Introductions ▪ Brief review of agenda ▪ Prompt attendees to sign-in	CHIP Partner
Priorities Overview	Sarah Hinds, DOH-Franklin/Gulf Administrator
Work with What We've Got ▪ Activity #1: Priority Match Up ▪ Review the priority sheets ▪ Group Together	DT Simmons, DOH-Franklin Operations Manager
Group Discussion	Talitha Robinson, DOH-Franklin Health Educator
Goals and Objectives Overview and Samples	DT Simmons, DOH-Franklin Operations Manager
Activity #2: Creating Objectives (In Groups	Alma Pugh, DOH-Franklin Health Educator Jessie Pippin, DOH-Gulf Operations Manager
Activity 3#: Creating Strategies (In Groups)	DT Simmons, DOH-Franklin Operations Manager
What's Next	CHIP Partner
Open Floor for Community Input	Mary Whitesell, DOH-Franklin SWAT Coordinator Pat O'Connell, Chair Franklin County Complete Count Committee
Meeting Evaluations and Adjourn	

Gulf/Franklin County Community Health Improvement Partners

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Florida Department of Health in Franklin County
Community Health Improvement Partnership Workshop
DOH-Franklin Apalachicola Campus
January 29, 2020, 10:00 a.m. – 12:00 p.m.

SIGN-IN SHEET

Purpose: *Solicit input from the community on goals, objectives and strategies to support selected health priorities through open two-way dialogue.*

#	Name	Organization or Community Representative	Email	Phone
1	Lori LaCivita	Ascension Sacred	Lori.LaCivita@Ascension.org	
2	John Griggs	Sacred Health	john.griggs@ascension.org	229-5620
3	Talitha Robinson	DOH-Franklin	Talitha.Robinson@flhealth.gov	323-6002
4	Alma Pugh	DOH-Franklin/Gulf	alma.Pugh@flhealth.gov	323-6025
5	Jessie Pippin	DOH-Franklin/Gulf	Jessie.Pippin@flhealth.gov	227-4193
6	Maryann Roberts	Healthy Start	Maryann@HealthyStartHSFG.org	774-5867
7	Brad Addison	FDOH-FC	Charles.Addison@flhealth.gov	323-6026
8	Pat O'Connell		poconnell1414@gmail.com	
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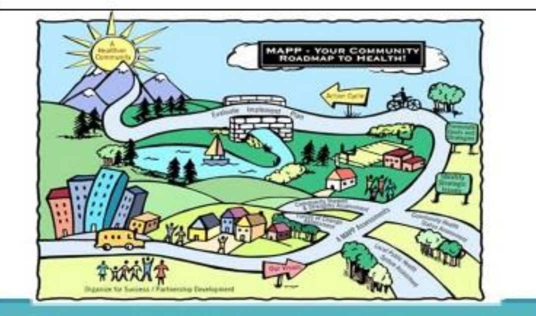
Community Health Improvement Meeting

WEDNESDAY, JANUARY 29, 2020
10:00AM

Work With What We Have



Activity #1: Priority Match Up

- **Think** on specific program activities and requirements you're agency is working on that directly link to one of our 3 priorities.
- Ask yourself: **Can CHIP help you achieve this deliverable?**
- **If so**, write it down on a post-it note and place it with the appropriate priority area poster on the wall.
- When everyone is finished, volunteers for each priority sheet will **read** off what has been added.

Selected Priorities

- During our last meeting, we analyzed the data which guided us in our selection of these four priority areas:
  - Access to Care
  - Mental Health
  - Substance Abuse

Group Discussion

- Which activities (deliverables) are you most excited about?
- Did you notice anything that's happening in Franklin County that you didn't know about?
- Is there anything still missing from our priorities that we want to focus on?

Objective

- What needs to be done to achieve the goal
- Smaller steps, often along the way to achieving a long-term goal.
- Example: "I will save $20,000 by the end of this year in order to retire at age 50."

GOALS & OBJECTIVES

SMART Objective

Goals

- What we are trying to achieve.
- Gives us a destination to focus on.
- General goals that are not specific enough to be measured.
- Example: I want to retire before I am old.

SMART Objective Examples

- **Priority:** Access to Care
- **Goal:** Increase access to health support services for chronic disease management.

SMART Objectives:

1. By December 30, 2020 Community Health Improvement Partners will collaborate to provide 4 free health screening events within Franklin County.
2. By the end of December 2020, "XYZ Affordable Health Clinic" will increase Diabetes Self-Management client enrollment by 10%.

Activity #2: Creating Objectives

- With your group, look at what has been placed on your priority poster.
- Combine any deliverables that have common themes **OR** focus on the ones that stand out as something **CHIP can support**. Remember, all of them are important but what can we do together that will impact the priority?
- Create 1-3 SMART objectives for your priority area. Remember our examples:

SMART Objectives:

1. By December 30, 2020, Community Health Improvement Partners will collaborate to provide 4 free health screening events within Franklin County.
2. By the end of December 2020, "XYZ Affordable Health Clinic" will increase Diabetes Self-Management client enrollment by 10%.

Example Strategy

- **Goal:** I want to retire before I am old.
- **Objective:** I will save $20,000 by the end of this year in order to retire at age 50.
- **Strategy:** I will enroll in a personal money management class at Gulf Coast State College.

STRATEGIES & TACTICS

Strategy Examples

- **Priority**: Access to Care
- **Goal**: Increase access to health support services for chronic disease management.
- **Objectives**: By the end of December 2020, "XYZ Health Clinic" will increase Diabetes Self-Management client enrollment by 10%.

Strategy

1. XYZ Health Clinic will increase enrollment by working with partners to increase referrals to the program.

Strategies

- A collection of actions which has a reasoned chance of achieving desired objectives.
- Provides a clear roadmap.
- Smaller steps, often along the way to achieving an objective.

Activity #3: Creating Strategies

- With your group, look at objectives selected for your priorities.
- Create 1-3 strategies for each objective. Remember our examples:

Strategy

1. XYZ Health Clinic will increase enrollment by working with partners to increase referrals to the program.

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OPEN FLOOR:
ANNOUNCEMENTS

County Health Rankings 2019		Franklin County	Current Trend	Error Margin	State of Florida	Rank (of 67)
Health Outcomes						**39**
Length of Life (50%)						**41**
Premature death		9,000		6,900-11,000	7,200	
Quality of Life (50%)						**35**
Poor or fair health		19%		18-19%	19%	
Poor physical health days		4.3		4.2-4.4	3.8	
Poor mental health days		4.0		3.9-4.2	3.8	
Low birthweight		9%		7-11%	9%	
Health Factors						**45**
Health Behaviors (30%)						**53**
Adult smoking		18%		18-19%	15%	
Adult obesity		34%		29-39%	27%	
Food environment index		7.5			6.9	
Physical inactivity		31%		27-35%	25%	
Access to exercise opportunities		88%			88%	
Excessive drinking		25%		24-25%	18%	
Alcohol-impaired driving deaths		36%		20-52%	25%	
Sexually transmitted infections		323.1			467.4	
Teen births		63		51-77	23	
Clinical Care (20%)						**45**
Uninsured		15%		13-17%	15%	
Primary care physicians		3,970:1			1,390:1	
Dentists		3,910:1			1,700:1	

County Health Rankings 2019		Franklin County	Current Trend	Error Margin	State of Florida	Rank (of 67)
Mental health providers		1,680:1			670:1	
Preventable hospital stays		4,520			5,066	
Mammography screening		34%			42%	
Flu vaccinations		26%			41%	
Social & Economic Factors (40%)						**43**
High school graduation		79%			82%	
Some college		38%		30-45%	62%	
Unemployment		3.6%			4.2%	
Children in poverty		34%		24-44%	21%	
Income inequality		5.3		3.8-6.7	4.7	
Children in single-parent households		33%		21-45%	38%	
Social associations		11.8			7.1	
Violent crime		268			484	
Injury deaths		94		71-122	76	
Physical Environment (10%)						**53**
Air pollution - particulate matter		9.1			8.2	
Drinking water violations		Yes				
Severe housing problems		18%		14-22%	21%	
Driving alone to work		80%		77-83%	79%	
Long commute - driving alone		20%		14-25%	40%	