Nassau County Community Health Improvement Plan (CHIP) 2019-2021

Presented by Partnership for a Healthier Nassau

January 30, 2019
Agenda

1. CHIP Overview
2. Guest Speaker, State Attorney Melissa Nelson
3. CHIP Accomplishments
4. CHIP 2019-2021 details
5. Future plans
PARTNERSHIP FOR A HEALTHIER NASSAU

Vision: To have healthy communities in Nassau County that support optimal health and quality of life through collaboration, strong leadership, policy and environmental change, and resident empowerment.
PARTNERSHIP FOR A HEALTHIER NASSAU (PHN)

• PHN Steering Committee facilitates CHIP
  • 3 Year Action Plan for Improved Health
  • Began in 2010, assessments 2011, finished product commenced July 2012.
    • CHIP 2012-2015
    • CHIP 2016-2018
    • CHIP 2019-2021

• Meet quarterly, monitor CHIP progress and produce community messaging regarding status.
MAPP Process

- MAPP = Mobilizing for Action through Planning and Partnerships
- Community driven strategic planning process
- A “tool” used nationally used by health leaders to facilitate prioritization of health concerns and resources
CHIP Structure and Reporting
2019-2021

Nassau County Commissioners

PHN Steering Committee

FDOH Administrative Support

Access To Care
Behavorial Health and Substance Abuse

Community Support
Health Disparities

Housing and Safe Places
At Large Member
Communications
At Large Member
NASSAU COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN
JULY 2012 — DECEMBER 2015

A countywide plan for community health system partners and resource providers to improve the health and wellbeing of its residents

Prepared by: Partnership for a Healthier Nassau

Vision:
“To have healthy Communities in Nassau County that support optimal health and quality of life through collaboration, strong leadership, policy and environmental change, and resident empowerment.”

Community Health Improvement Plan
2016-2018
Nassau County, Florida
Partnership for a Healthier Nassau

Prepared by: Partnership for a Healthier Nassau

COMMUNITY HEALTH IMPROVEMENT PLANS
Striving for Community Wellness Progress Report

Teen Health Story:
John, age 15, a Teen Health participant shared, “the classes taught me how to make good choices for my body. I feel more comfortable saying no to sex and peer pressure. I now know how to prevent pregnancy and STD’s which can help me plan for my future. The teachers were cool and it was easy to talk about really private health stuff. The Teen project gave me the strength to deliver comprehensive sex education. My combined based on real health talk about relationships, healthy relationships, and self respect. This program provides the message of abstinence and safe sex.

Adult Health Story:
When Mr. L began to have difficulty swallowing and breathing in the past February, he contacted a local hospital, and was quickly assessed for appropriate health care services to save his life. Mr. L was 62 years old, with a history of COPD, heart disease, and limited lung function. After consulting with the Barnabas Urgent Care Doctor that February, he learned that he had a malignant tumor in his throat. Mr. L was transferred to a Barnabas Primary Care doctor, and connected with a bilingual Community Health Specialist who could translate for him. The doctor next took him to a cancer specialist who sometimes serves Barnabas patients at no cost, and the translator accompanied him during the specialist’s exams and tests. Mr. L’s situation turned out to be so severe that Mr. L, along with his health care specialist, was taken to the UF Shands emergency room. The very next day, Mr. L underwent surgery to remove the dangerous mass in his throat. As a result, his cancer is expected to be cured. Today Mr. L is stable and beginning radiation treatment with the same community health team. Without the Barnabas Community Health Team, Mr. L would have died within a month. As we can see from Mr. L’s story, collaboration, leadership, and empowerment can truly make a difference in our community.

Strategic Areas:
- Access to Care
- Behavioral Health
- Chronic Disease
- Injury & Violence
- Maternal & Child Health
September 30th Planning Meeting
PHN Steering Committee with new Health Issues
PHN Steering Committee

- Kerrie Albert
- Barbara Baptista
- Adrienne Burke
- Karrin Clark
- Mike Hays
- Wanda Lanier
- Renae Lewin
- Eugenia Ngo-Seidel
- Valerie Ray
- Lisa Rozier
- Mary von Mohr *
CHIP Priorities 2019-2021

Access to Care
Behavioral Health/Substance Abuse
Community Support
Health Disparities
Housing & Safe Places

Local Public Health System
- Mobilize Community Partnerships +
- Evaluate Services
- Linking People to Services +
- Educate and empower for personal health +
- Research/innovations -

Community Themes & Strengths
- Access to Healthcare (hours/cost)
- Lack of Medicaid Providers
- Lack of Specialty Medical Care
- Lack of Substance Abuse Services
- Lack of Mental Health services
- Domestic Violence

Community Health Assessment
- Health disparities (cancer, heart disease, infant mortality)
- Health Professional Shortages
- Chronic Disease
- Increase in Suicide/Baker Acts

Forces of Change
- Rapid Expansion - Yulee
- Lack of safe walking paths
- Limited resources for Spanish speaking
- Lack of Affordable Housing
- Increased gun violence
Guest Speaker

State Attorney, Melissa Nelson
2016-2018 Accomplishments

• Mental Health First Aid Trainings
  
  Year 2016 – 363 + 179 = 542
  Year 2017 – 1018 + 205 = 1,223
  Year 2018 – 881 + 225 = 1,106

• Total of 2,871 persons trained by Starting Point Behavioral and NACDAC
# 2016-2018 Accomplishments

Reflecting on our accomplishments from 2013 to 2015, and from 2016 to 2018, we have been dedicated to providing reliable transportation options for our community. Our mission is to ensure that everyone, regardless of their circumstances, can access the services they need. Here’s a breakdown of our passenger statistics over these periods:

## PASSENGERS SERVED

<table>
<thead>
<tr>
<th></th>
<th>TRANSPORTATION DISADVANTAGED</th>
<th>MEDICAID</th>
<th>TOTAL</th>
<th>PUBLIC TRANSIT</th>
<th>GRAND TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2013 - 2015</strong></td>
<td>119,887</td>
<td>17,138</td>
<td>137,025</td>
<td>24,276</td>
<td>161,301</td>
</tr>
<tr>
<td><strong>2016 - 2018</strong></td>
<td>122,027</td>
<td>1,779</td>
<td>123,806</td>
<td>36,684</td>
<td>160,490</td>
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<tr>
<td><strong>CHANGE</strong></td>
<td><strong>2,140</strong></td>
<td><strong>(15,359)</strong></td>
<td><strong>(13,219)</strong></td>
<td><strong>12,408</strong></td>
<td><strong>(811)</strong></td>
</tr>
<tr>
<td></td>
<td><strong>1.8%</strong></td>
<td><strong>(89.6)%</strong></td>
<td><strong>(9.6)%</strong></td>
<td><strong>51.1%</strong></td>
<td><strong>(0.5)%</strong></td>
</tr>
</tbody>
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Nassau County Council on Aging

Powered by Nassau County Council on Aging
Your health and the health of your community should not depend on a massive amount of luck.

Shifting from Chance to Change....

This chip is your reminder that we count on you to “play” a role on the other CHIP – Community Health Improvement Plan of Nassau County, FL.
Priority #1

ACCESS TO CARE
Access to Care

Goal 1: Patient Barriers to Care
- Transportation Support
- Social Media Use
Access to Care
Goal 2: Western Nassau Health Needs

- Create a West Nassau Health Team
- Policy recommendation: to expand broadband to support telehealth care.
Goal 3: High Risk/Marginalized Population Health Needs

- Facilitate Safety Net Provider Coordination
Priority #2

BEHAVIORAL HEALTH & SUBSTANCE ABUSE
Behavioral Health and Substance Abuse

Goal 1: Decrease the incidence of suicides in Nassau County

Collect data:
1. Medical examiner data – cause of death
2. CHARTS injury data
3. Baker Act Admissions
Behavioral Health and Substance Abuse

Goal 2: Create a Trauma-Informed Community

Provide education to increase awareness of trauma on child development & health

1. Identify who will be trained
2. Ensure uniformity
3. Training tools
4. Identify trainers
NASSAU COUNTY COMMUNITIES THAT ARE...

STIGMA FREE

There is no health without mental health.

Goal is to have......
Priority #3

COMMUNITY SUPPORT
Community Support

Goal 1: To decrease social isolation among seniors and increase support to caregivers.

- Promote community connections/social programs for seniors (Yulee/Westside)
- Create social linkage program for teens and seniors
- Recruit champions to be leads for the Nassau Age-Friendly in Public Health Initiative.
Age-Friendly Nassau County Initiative

Bridging the Years.....Teens and Seniors Mix it Up!
Priority #4

HEALTH DISPARITIES
Health Disparities

Goal 1: To understand the leading causes of health disparities as it relates to breast cancer, prostrate cancer and colorectal cancer and develop strategies to improve the health status in those areas.

- Educate on preventative health care
- Expand the faith-based health ministry.
Equality

Equity
COlON POlYP$ ANO EARlY COlON CANCER CAN OEVElY WITHOUT $YMPTOM$, WAITING UNTll $YMPTOM! OCCUR CAN MEAN THE CANCEl IS MORE ADVANCED ANO lIlE$ llKElY TO BE CURABlE,
The federal government estimates that men have about a one-in-seventeen chance of developing prostate cancer at some point during their lifetime.
Health Disparities

Goal 2: To reduce the incidence of black preterm birth & low birth weight rates by 5% by December 31, 2021.

- To be accomplished by supporting the Nassau Infant Mortality Taskforce with their Best Babies Zone project.
- Create and implement a marketing plan for Best Babies Zone.
Priority #5

HOUSING AND SAFE PLACES
Housing and Safe Places

Goal 1: Create a Housing Coalition to address housing needs on a spectrum from homelessness to home ownership.
- Expand cold night shelters across the county
- Establish a Family Promise program
Housing and Safe Places

Goal 1: Create a Housing Coalition to address housing needs on a spectrum from homelessness to homeownership.

- Coordinate with the Nassau County Affordable Housing Advisory Committee regarding housing policy
  - Use 2018 Housing Affordability Assessment as baseline
  - Ex: accessory dwelling ordinance, impact fee withholding, inclusionary zoning, aging in place

Four Key Areas for Local Affordable Housing Strategies

- **Diverse Housing Stock**
  - Expand multi-family and single-family attached alternatives to single-family detached housing

- **Affordable Rental Housing**
  - Preserve + expand supply
  - Focus on 0-50% AMI households
  - Look at naturally occurring + subsidized

- **Affordable Homeownership**
  - Expand supply of affordable for sale units between $149-219,000 sales price
  - Focus on 50-80% AMI households

- **Jobs-Housing-Transportation Link**
  - Locate affordable housing for low-moderate wage workers on the Island
  - Ensure affordable transportation to the Island
Policy Areas

• Policy change and new ones—laws, ordinances, resolutions, mandates, regulations, or rules that will greatly influence the decisions individuals make about health promotion and health care

• **Systems Change**—made to the rules within an organization and will often focus on changing infrastructure within a school, worksite or health setting

• **Environmental Change**—made to the physical environment to help promote healthy behaviors (e.g., assuring sidewalks are built to link a neighborhood to an area of physical activity and social connections).
Best practices around the nation include

Healthy Lifestyles
- Tobacco Product use - Reduce illness, disability and death related to tobacco product use and secondhand smoke exposure.
- Physical Activity - Improve health and the quality of life through daily physical activity.
- Healthy Eating - Promote health and reduce overweight and obesity through the availability and consumption of healthy foods.

Access to Health Services
- Plan for and invest in pedestrian and bicycling infrastructure and transit-oriented development.
- Expand Safe Routes to Schools programs (e.g., improved sidewalks, crosswalks and bike areas.
- Pursue joint use agreements to share facilities with schools.
- Increase the amount of time students spend in moderate or vigorous-intensity physical activity during PE class and adding 30 minutes of physical activity outside of PE and recess during the elementary schoolday).
- Increase incentives for business supporting access to healthy and affordable foods in food desert communities.
- Increase organizational and programmatic changes focused on healthy eating.

Policy Changes to Consider to Alleviate Health Inequity
- Promote Access to Care
- Increase community resources to provide support to direct health care systems
- Provide fast-track permitting for grocery stores in underserved areas.
- Identify sites for farmers’ markets and community gardens.
- Encourage farmers’ markets and other healthy food retailers to accept federal nutrition programs such as WIC and SNAP (food stamps)
- Offer bus service from underserved neighborhoods to healthy food retail stores.
- Reduce barriers to accessing clinical and community preventive services, especially among populations at greatest risk, by increasing the care capacity of safety net providers.
- Streamline implementation of school-based health centers in low-income communities.
- Incentivize implementation of school and childcare center based vaccination programs.
- Provide technical assistance to improve the quality and efficacy of the safety net providers.
- Create interconnected systems to exchange clinical, public health and community data, streamline eligibility requirements, and expedite enrollment processes to facilitate access to clinical preventive services.
- Expand the use of community health workers and home visiting programs.
- Health Benefits: Give employees time off to access clinical preventive services.
- Establish patient and clinical reminder systems for preventive services.
FACEBOOK

The latest way to keep up with community health in Nassau County……..

The Partnership for a Healthier Nassau (PHN) Facebook page!

Events, news, reports, successes.

Like us on Facebook!
IMPLEMENTING THE PLAN

• Community partners complete strategies.

• Facilitator works with partners to monitor and measure progress (successes and obstacles).

• PHN reports to the Nassau Board of County Commissioners
IMPLEMENTING THE PLAN...

Steering Committee Monitors progress monthly
Future Plans

• Partnership Steering Committee
  – Meet quarterly to assure progress
  – Produce Mid Cycle Report
  – Communicate progress via email and online newsletter
Celebrate the Accomplishments
Keep the Momentum Going!

• STAY CONNECTED & INVOLVED!
• Join an existing Coalition or Partnership
• Join a new effort to improve community health in Nassau County
• Invite others to come along
For more information go to:

OUR FACEBOOK PAGE....

Like us and stay informed!

Our vision is to have healthy communities in Nassau County that support optimal health and quality of life.
Questions

Contact:

Mary von Mohr, FDOH-Nassau
Health Strategist and CHIP Facilitator

Phone: 904-557-9133
Email: mary.vonmohr@flhealth.gov