

MONROE COUNTY

COMMUNITY HEALTH IMPROVEMENT PLAN 2019—2022



Florida
Department
of Health in
Monroe County

Submitted by:



ASCENDANT
HEALTHCARE PARTNERS

Transforming communities for healthier lives

Adopted March 2019

Table of Contents

Executive Summary	4
Monroe County Community Health Improvement Plan.....	6
Background	6
Moving from Assessment to Planning	6
2019 Community Health Priorities	9
Overview of the Community Health Improvement Plan	11
What is a Community Health Improvement Plan?	11
How to Use the CHIP	11
Relationship Between the CHIP and Other Guiding Documents and Initiatives	11
Process from Planning to Action	12
Community Engagement.....	12
Development of Data-Based, Community-Identified Health Priorities.....	12
Issues and Themes identified in the Community Health Assessment	12
Process to Set Health Priorities	12
Development of the CHIP Strategic Components.....	14
CHIP Framework.....	14
Goals, Objectives, Strategies, Key Partners, and Outcome Indicators.....	14
Health Priority: Health in All Policies.....	14
The Five Key Elements of Health in All Policies	16
Health in All Policy Indicators	17
Alignment with National Standards.....	20
Aligning Characteristics of Healthy People 2020 & HiAP includes:.....	20
Action Step & Recommendation Plan	21
Health Priority: Access to Care	21
Understanding Access to Health Services	22
Coverage	22
Services	22
Timeliness.....	23
Workforce	23
Best Practices	27
Alignment with National Standards.....	27
Action Step & Recommendation Plan	27

Health Priority 3: Mental Health & Substance Abuse.....	29
Mental Health	29
Mental Health and Wellness	30
Substance Abuse	30
Mental Health & Substance Abuse Indicators	31
Best Practices	32
Alignment with National Standards.....	34
Action Step & Recommendation Plan	35
Next Steps: Implementation Phase	38
Sustainability Plan	38
Appendix A: Participants	39
Community Health Advisory Group (CHAG) Members.....	39
Accreditation Steering Committee Members.....	39
Performance Management Council.....	39
Health Priority Planning Session Participants.....	40
Florida Department of Health in Monroe County Support Staff	42
Ascendant Healthcare Partners Facilitator	42
Appendix B: Glossary of Terms.....	43
Appendix C: Acronyms	45
Appendix D: Partners and Resources.....	46

Executive Summary

Where and how we live, learn, work, and play affect our health. Understanding how these factors influence health is critical for developing the best strategies to address them. To accomplish these goals, the Florida Department of Health in Monroe County led a comprehensive community health planning effort to measurably improve the health of Monroe County residents. This effort included two major phases:

1. A community health assessment (CHA) to identify the health-related needs and strengths of Monroe County
2. A community health improvement plan (CHIP) to determine major health priorities, overarching goals, and specific objectives and strategies that can be implemented in a coordinated way across Monroe County

In addition to guiding future services, programs, and policies for community agencies and organizations, the CHA and CHIP are also required for the health department to earn accreditation by the Public Health Accreditation Board (PHAB), a distinction which indicates that the agency is meeting national standards for public health system performance.

The 2019 Monroe County Community Health Improvement Plan was developed over the period of February-March 2019, using the key findings from the CHA, which included qualitative data as well as quantitative data from local, state and national indicators to inform discussions and determine health priority areas.

To develop a shared vision, plan for improved community health, and help sustain implementation efforts, the Monroe County assessment and planning process engaged community members and local public health partners through different avenues:

- a. The Accreditation Steering Committee, comprised of health department leadership, was responsible for overseeing the community health assessment and the development of the community health improvement plan
- b. The Performance Management Council, comprised of health department staff, was responsible for reviewing documents and providing subject matter expertise and data for defined priorities
- c. The CHIP Workgroups, representing broad and diverse sectors of the community and organized around each health priority area, were responsible for developing the goals, objectives and strategies for the CHIP
- d. The Community Health Advisory Group (CHAG) was comprised of diverse leaders from Monroe County, representing sectors, such as government, non-profit organizations and coalitions, business and industry, health, education, and community services. This group was responsible for ensuring buy in from key stakeholders as well as alignment with the county's strategic goals and priorities.

CHAG and community partners used common criteria and a multi-voting process to identify the following priority health issues that would be addressed in the CHIP:

Priority Area 1: Health in All Policies (HiAP)

Goal 1: Promote Health in All Policies with local governments and agencies.

Priority Area 2: Access to Care

Goal 1: To increase access to community wide comprehensive primary care services for uninsured, Medicaid and underinsured populations.

Goal 2: To establish a network increasing access to specialty, secondary and ancillary medical services, such as specialty care, tertiary care, cardiology, radiology, cancer, surgery, and other services that take Medicaid/Medicare.

Priority Area 3: Mental Health and Substance Abuse

Goal 1: Support and enhance the mental, behavioral, and emotional health of all, and reduce the impact of alcohol, tobacco and other drugs.

Monroe County Community Health Improvement Plan

Background

Where and how we live, learn, work, and play affect our health. Understanding how these factors influence health is critical for developing the best strategies to address them. To accomplish these goals, the Community Health Advisory Group (CHAG) led a comprehensive community health planning effort to measurably improve the health of Monroe County residents.

The community health improvement planning process included two major components:

1. A CHA to identify the health-related needs and strengths of Monroe County
2. A CHIP to determine major health priorities, overarching goals, and specific objectives and strategies that can be implemented in a coordinated way across Monroe County

The 2019 Monroe County Community Health Improvement Plan was developed over the period of February-March 2019, using the key findings from the CHA, which included qualitative data as well as quantitative data from local, state and national indicators to inform discussions and determine health priority areas.

Moving from Assessment to Planning

Similar to the process for the CHA, the CHIP utilized a participatory, collaborative approach guided by the Mobilization for Action through Planning and Partnerships (MAPP) process.¹ MAPP, a comprehensive, community-driven planning process for improving health, is a framework that local public health departments across the country have employed to help direct their strategic planning efforts. MAPP comprises distinct assessments that are the foundation of the planning process and includes the identification of strategic issues and goal/strategy formulation as prerequisites for action. Since health needs are constantly changing as a community and its context evolve, the cyclical nature of the MAPP planning/implementation/evaluation/correction process allows for the periodic identification of new priorities and the realignment of activities and resources to address them. A summary of these assessments and their related findings are presented on the following pages.

¹ Advanced by the National Association of County and City Health Officials (NACCHO), MAPP's vision is for communities to achieve improved health and quality of life by mobilizing partnerships and taking strategic action. Facilitated by public health leaders, this framework helps communities apply strategic thinking to prioritize public health issues and identify resources to address them. More information on MAPP can be found at: <http://www.naccho.org/topics/infrastructure/mapp/>

Community Themes & Strengths Assessment (CTSA)



Ascendant Healthcare Partners utilizes methods to solicit public input and results in a strong understanding of community issues and concerns, perceptions about quality of life and a map of community assets.

The Community Health Survey had a total of **720 respondents** all of whom were residents of **Monroe County**. The survey was available in English, Spanish and Creole.

Key Findings:

1. Access to Healthcare
2. Age related conditions
3. Mental Health and Substance Abuse
4. Bike Safety

Forces for Change Assessment (FOCA)

The FOCA analyzes the external forces, positive or negative, that impact the promotion and protection of the public's health. Diverse stakeholders from Monroe County convened to generate answers to the following question: "What is occurring or might occur that affects the health of our community or local public health system?" Participants brainstormed trends, factors, and events, organizing them into common themes and then providing an overarching 'force' for each of the category columns.

Themes:



Local Public Health System Assessment (LPSHA)



Partners from the county's local public health system convened and discussed the Model Standard Activities which serve as quality indicators that are aligned with the 10 essential public health service areas.

The majority of the Model Standard Activities functioned with *Significant Activity* (51-75%). There were no indicators that performed with *Minimal Activity* (less than 25%) for Monroe County.

The 10 Essential Public Health Services

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

CDC, (2018) "The Public Health System & the 10 Essential Public Health Services."

Community Health Assessment (CHA)

The major themes:		
<p>Health in All Policies (HiAP)</p> <ul style="list-style-type: none"> 63 related indicators All indicators showed structural drivers of inequities. Recurring health disparities and priority issues which need to be addressed using a framework that incorporates all sectors in the process. These continuing issues include: 1) Bike and pedestrian improvements, 2) Affordable housing development, 3) Program development to address substance and alcohol abuse, and 4) Addressing mental health and emotional wellbeing 	<p>Access to Care</p> <ul style="list-style-type: none"> 84 related indicators 30 indicators perform worse than the state indicators with a worsening trend, including: uninsured adults and children; preventative care such as, mammography screenings; increased outcomes of various cancers; access by low income persons, and percentage of adults who could not see a doctor at least once in the past year due to cost. 	<p>Mental Health & Substance Abuse</p> <ul style="list-style-type: none"> 25 related indicators 14 indicators perform worse than the state Five indicators with a worsening trend: 1) Unhealthy mental days, 2) Average number of days where poor mental or physical health interfered with activities of daily living, 3) Suicide deaths, 4) Alcohol consumption and 5) Substance abuse
<p>The CHA is a process assessing the current health status of a community through the selection and collection of relevant data elements (indicators) and the analysis of trends and comparisons to benchmarks. Ascendant Healthcare Partners collected county-level data for 265 health status indicators and 22 demographic indicators. As a benchmark, individual performance of Monroe County was compared to that of Florida state as a whole. To identify overall themes, results were analyzed using the <i>County Health Rankings</i> Model for population health that emphasized the impact of health factors, such as behavior, clinical care, socioeconomic and physical environment, on the health outcomes of mortality, <i>length of life</i>, morbidity and <i>quality of life</i>.</p>		

2019 Community Health Priorities

Monroe County completed this process with a holistic review of the data gathered in each of the assessments to identify overarching themes and health issues.

The 2019 Community Health Priorities for the Monroe County community will be:

- Health in All Policies
- Access to Care
- Mental Health & Substance Abuse

To develop a shared vision, plan for improved community health, and help sustain implementation efforts, the Monroe County assessment and planning process engaged community members and local public health partners through different avenues:

- a. The Accreditation Steering Committee, comprised of health department leadership, was responsible for overseeing the community health assessment, and overseeing the development of the community health improvement plan
- b. The Performance Management Council, was responsible for reviewing documents and providing subject matter expertise and data for defined priorities
- c. The CHIP Workgroups, representing broad and diverse sectors of the community and organized around each health priority area, were responsible for developing the goals, objectives and strategies for the CHIP
- e. The Community Health Advisory Group (CHAG), was comprised of diverse leaders from Monroe County, representing sectors, such as government, non-profit organizations and coalitions, business and industry, health, education, and community services. This group was responsible for ensuring buy in from key stakeholders as well as alignment with the county's strategic goals and priorities.

In 2018, the Florida Department of Health in Monroe County (FDOH-Monroe) hired Ascendant Healthcare Partners (AHP), as a consulting partner to provide strategic guidance and facilitation of the CHA-CHIP process, collect and analyze data, and develop the resulting reports and plan. AHP has extensive experience developing health assessments and health improvement plans locally, regionally, and nationally. Over the past twenty years, AHP has assisted both local and state health departments in meeting the required assessment and planning standards for Public Health Accreditation Board (PHAB) accreditation.

In December 2018, a summary of the CHA findings was presented to community partners, subject matter experts, and representatives from Monroe County for review and refinement, and to serve as the official launching point for the CHIP.

During three meetings, CHIP workgroups, which included some members from the Accreditation Steering Committee, Performance Management Council and staff, as well as the Community Health Advisory Group identified issues and themes from which priority health issues were identified and subcategories developed. While many areas are significant, it was emphasized that identifying a few priority areas would enable more focus and collaboration for impacting the community. For a complete description of the selection process, please see "Process from Planning to Action" on page 12.

Overview of the Community Health Improvement Plan

What is a Community Health Improvement Plan?

A community health improvement plan, or CHIP, is an action-oriented strategic plan that outlines the priority health issues for a defined community and how these issues will be addressed, including strategies and measures, to ultimately improve the health of the community. CHIPs are created through a community-wide, collaborative planning process that engages partners and organizations to develop, support, and implement the plan. A CHIP is intended to serve as a vision for the health of the community and a framework for organizations to use in leveraging resources, engaging partners, and identifying their own priorities and strategies for community health improvement.²

Building upon the key findings and themes identified in the 2019 Monroe County Community Health Assessment, the CHIP:

- Identifies priority issues for action to improve community health
- Outlines an implementation and improvement plan with performance measures for evaluation
- Guides future community decision-making related to community health improvement

In addition to guiding future services, programs, and policies for community agencies and organizations, the CHIP demonstrates the agency's commitment to improving quality and public health system performance. This fulfills one of the required prerequisites for the Florida Department of Health in Monroe County to be eligible for national accreditation.

How to Use the CHIP

A CHIP is designed to be a broad, strategic framework for community health, and should be modified and adjusted as conditions, resources, and external environmental factors change. It is developed and written in a way that engages multiple perspectives so that all community groups and sectors—private and nonprofit organizations, government agencies, academic institutions, community and faith-based organizations, and citizens— can unite to improve the health and quality of life for all people who live, learn, work, and play in Monroe County. We encourage community partners to review the priorities and goals, reflect on the suggested strategies, and consider how to participate in whole or in part.

Relationship Between the CHIP and Other Guiding Documents and Initiatives

The CHIP was designed to complement and build upon other guiding documents, plans, initiatives, and coalitions already in place to improve the public health of Monroe County. Rather than conflicting with or duplicating the recommendations and actions of existing frameworks and coalitions, the participants of the CHIP planning process identified potential partners and resources wherever possible.

² As defined by the Health Resources in Action, Strategic Planning Department, 2013

Process from Planning to Action

Community Engagement

The Community Health Advisory Group (CHAG) led the planning process for Monroe County and oversaw all aspects of the CHIP development, including the establishment of CHIP workgroups and the refinement of details for identified health priorities. The Accreditation Steering Committee continued to convene from the Assessment Phase to the Planning Phase, guiding all aspects of planning and offering expert input on plan components.

CHIP session participants included over 30 individuals with expertise and interest in priority areas identified in the CHA and who represented broad and diverse sectors of the community. See Appendix A for workgroup participants.

Development of Data-Based, Community-Identified Health Priorities

Issues and Themes identified in the Community Health Assessment

In October-December 2018, a summary of the 2019 Monroe County Community Health Assessment findings was presented to the CHIP workgroup members for further discussion. The following themes emerged most frequently from review of the available data and were considered in the selection of the CHIP health priorities:

Health in All Policies

- Housing affordability
- Bike safety

Access to Care

- Availability of clinics
- Health insurance costs
- Navigating the healthcare system
- After hours care
- Awareness of services
- Coordination of care

Mental Health

- Depression
- Anxiety
- Social isolation
- Stigma
- Trauma

Substance Abuse

- Prescription drug misuse
- Alcohol
- Marijuana
- Tobacco

Process to Set Health Priorities

Ascendant Healthcare Partners presented the finding of the 2019 Community Health Priorities as part of the process to identify the most important public health issues for Monroe County from the list of major themes identified from the CHA.

The community and CHAG feedback led to an additional refinement of the identified priority areas. Mental/behavioral health and substance abuse were seen as issues that are so often interlinked that they could be combined into one priority area. Careful review of these areas also showed similarity and overlap in strategies—consistent with the Florida Department of Health Improvement Plan (SHIP) and national plans—which also led to combining the two areas.

Also suggested was that health equity/social justice be included as cross-cutting strategies for each of the CHIP priorities, as appropriate. It was determined that all priorities identified should be aimed at addressing issues of health inequity in Monroe County. As a result of these additional refinements, the CHIP includes three priority areas.

The three health priority areas for the CHIP are based on the results of the presentation and agreed upon by community partners. They include:

1. Health in All Policies
2. Access to Care
3. Mental Health & Substance Abuse

Initially, **health equity/social justice** were identified (**lack of affordable housing and homelessness**) as priority areas for the CHIP, but they are now presented in the plan as **cross-cutting strategies** similar to other communities pursuing national accreditation who have adopted this approach. These issues have been identified as key focal points for integration across all three priority areas in the plan and are incorporated into each priority area as a cluster of related strategies.

Health Equity and Social Justice: Addressing health issues for disadvantaged or vulnerable populations with significant health disparities.

Vulnerable Populations

- Seniors
- Adolescents/youth
- Homeless
- Low-income residents

Social Determinants of Health

- Housing affordability
- Homelessness
- Employment

Health equity exists when everyone has the opportunity to attain their full potential and no one is disadvantaged.³ Social determinants of health are the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances in turn are shaped by a wider set of forces: economics, social policies, and politics.⁴ Addressing the role of social determinants of health is therefore important as a primary approach to achieving health equity.

³ Brennan Ramirez LK, B.E., Metzler M., Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health, Centers for Disease Control and Prevention, Editor. 2008, Department of Health and Human Services, Atlanta, GA.

⁴ The World Health Organization
http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/index.html

Development of the CHIP Strategic Components

The Community Health Advisory Group convened three two-hour planning sessions held in March of 2019. These sessions were facilitated by AHP. FDOH-Monroe staff, community members and stakeholders, as well as local content experts, participated in the planning sessions. Participants broke into workgroups, each workgroup for each health priority identified were responsible for drafting goals, objectives, strategies, outcome indicators, community partners and resources. See Appendix A for a list of workgroup participants and Appendix D for a full list of partners/resources that were identified during these sessions. AHP provided sample evidence-based strategies from a variety of resources including **The Community Guide to Preventive Services, County Health Rankings, Florida Health Community Health Assessment Resource Tool Set, and the National Prevention Strategy** for the planning sessions. As policy is inherently tied to sustainability and effectiveness, workgroups indicated whether or not strategy implementation would necessitate policy changes.

Following the planning sessions, subject matter experts from within CHAG and AHP reviewed the draft output from the workgroups and edited material for clarity, consistency, and evidence base. This feedback has been incorporated into the final versions of the CHIP contained in this report.

CHIP Framework

Goals, Objectives, Strategies, Key Partners, and Outcome Indicators

Real, lasting community change stems from critical assessment of current conditions, an aspirational framing of the desired future, and a clear evaluation of whether efforts are making a difference. Outcome indicators tell the story about where a community is in relation to its vision, as articulated by its related goals, objectives, and strategies.

The following pages outline the Goals, Objectives, Strategies, and Outcome Indicators for the three health priority areas outlined in the CHIP. A list of potential partners and resources for each health priority area is located in Appendix D. Data from the CHA are included in the beginning section of each health priority area. See Appendix B for a glossary of terms used in the CHIP.

Health Priority: Health in All Policies

Growing evidence on the social determinants of health has found the conditions in which people live, learn, work, and play to contribute to their overall health and well-being.

The World Health Organization (WHO) defines health as “the state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity. This means that health is more than being free of disease or not feeling sick; it is also a state of physical, mental, and social well-being. This state can bring about such feelings as happiness, contentment, and security.”⁵ In the United States, while an estimated 96% of health expenditures are directed toward health care, access to health care only accounts for 10% of a person’s health. Conversely, the environment and personal behavior, which is directly influenced by environmental conditions, account for nearly 70% of what determines a person’s health.^{6 7} Unfortunately, many Americans do not live and work in communities that were designed with health in mind. This explains some of why certain Americans are healthier than others and why Americans generally are not as healthy as they could be. For example, Healthy People 2020 states that “a lack of options for healthy, affordable food or safe places to play in some neighborhoods makes it nearly impossible for residents to make healthy choices. In contrast, people living in neighborhoods with safe parks, good schools, and high employment rates are provided with some of the key requirements to better health.”^{8 9}

Social Determinants of Health

The social determinants of health are “the structural determinants and conditions in which people are born, grow, live, work and age.”

The Centers of Disease Control and Prevention (CDC) defines Health in All Policies (HiAP) as a collaborative approach to improving the health of all people by incorporating health considerations into decision-making in non-health sectors and policy areas. The goal of HiAP is to ensure that all decisions have neutral or beneficial impacts on health determinants (e.g., informed on the health, equity, and sustainability consequences of various policy options during the policy development process).

A HiAP approach provides a systematic way to address important factors that determine health: environment and behavior. By considering health in governmental operations and policy decisions, communities have the opportunity to improve health outcomes. HiAP explicitly recognizes that health and wellbeing are largely influenced by measures that are often managed by non-health department government agencies. In this vein, a HiAP approach focuses on changing systems of decision-making, rather than changing a single decision. It engages diverse partners and stakeholders to work together to improve health and simultaneously advance other goals, such as promoting job creation and economic stability, transportation access and mobility, a strong agricultural system, environmental sustainability, and educational attainment.

⁵ Gase, L. N., Pennotti, R., & Smith, K. D. (2013). “Health in All Policies”: Taking Stock of Emerging Practices to Incorporate Health in Decision Making in the United States. *Journal of Public Health Management and Practice*, 19(6), 529-540.

⁶ NACCHO Fact Sheet. (December 2014). All Policies [Fact sheet]. Retrieved from http://archived.naccho.org/topics/environmental/HiAP/upload/factsheet_hiap_dec2014-1.pdf

⁷ “Closing the Gap in a Generation” in 2008. Marmot, M., Friel, S., Bell, R., Houweling T. A., Taylor, S., & Commission on Social Determinants of Health. (2008). Closing the gap in a generation: health equity through action on the social determinants of health. *The Lancet*, 372(9650), 1661-1669.

⁸ Kickbusch, I. (2010). Health in all policies: where to from here? *Health promotion International*, 25(3), 261-264.

⁹ Peters, D., Harting, J., van Oers, H., Schuit, J., de Vries, N., & Stronks, K. (2016). Manifestations of integrated public health policy in Dutch municipalities. *Health promotion international*, 31(2), 290-302.

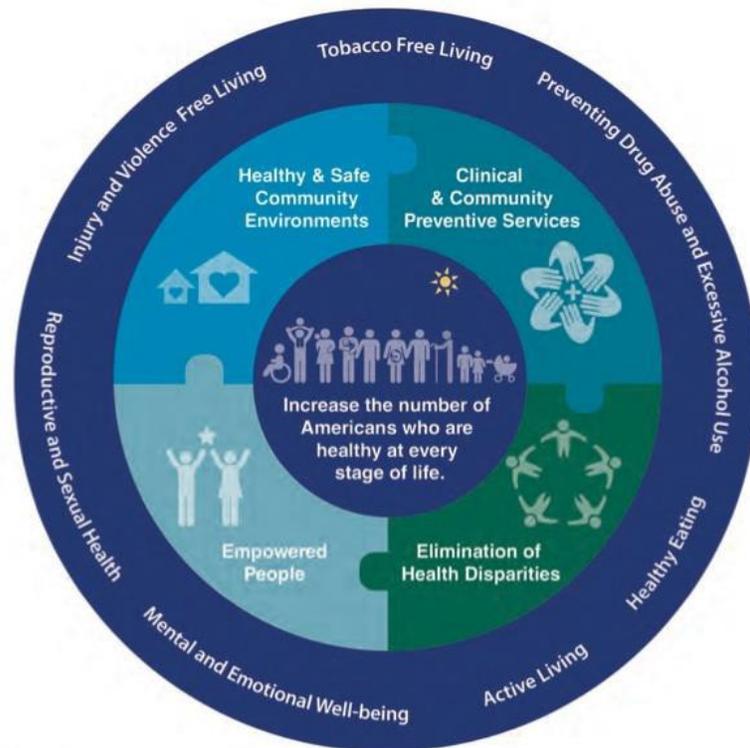
The Five Key Elements of Health in All Policies

1. **Promote health, equity, and sustainability.** Health in All Policies promotes health, equity, and sustainability through two avenues:

- incorporating health, equity, and sustainability into specific policies, programs, and processes, and
- embedding health, equity, and sustainability considerations into government decision-making processes so that healthy public policy becomes the standard way of doing business. Promoting equity is an essential part of Health in All Policies, given the strong ties between inequity and poor health outcomes for all members of society.

2. **Support intersectoral**

collaboration. In recognition that many of the Social Determinants of Health are outside the control of health departments, HiAP brings together partners from many sectors to recognize the links between health and other issues and policy domains, break down silos, build new partnerships to promote health and equity, and increase implementation efficiency. Agencies not typically considered health agencies play a major role in shaping the economic, physical, social, and service environments in which people live, and therefore have an important role to play in promoting health and equity. A Health in All Policies approach focuses on deep and ongoing collaboration, rather than taking a superficial or one-off approach.



Centers for Disease Control and Prevention, Office of the Associate Director for Policy; National Prevention Strategy, June 16, 2011.

3. **Benefit multiple partners.** Health in All Policies is built upon the idea of “co-benefits” and “win wins.” HiAP work should benefit multiple partners, simultaneously addressing the goals of public health agencies and other agencies to benefit more than one end (achieve co-benefits) and create efficiencies across agencies (find win-wins). This concept is essential for securing support from partners and can reduce redundancies and ensure more effective use of scarce government resources. Finding a balance between multiple goals can sometimes be difficult, and requires negotiation, patience, and learning about and valuing others’ priorities.

4. **Engage stakeholders.** Health in All Policies engages a variety of stakeholders, such as community members, policy experts, advocates, members of the private sector, and funders. Robust stakeholder

engagement is essential for ensuring that work is responsive to community needs and for garnering valuable information necessary to create meaningful and impactful change.

5. Create structural or procedural change. Over time, HiAP creates permanent changes in how agencies relate to each other and how government decisions are made. This requires maintenance of structures which can sustain intersectoral collaboration and mechanisms which can ensure a health and equity lens in decision-making processes across the whole of government. This can be thought of as “embedding” or “institutionalizing” HiAP within existing or new structures and processes of government.

The following examples illustrate a variety of windows of opportunity that lead to intersectoral, health promoting projects:

- Local comprehensive plan revision/adoption
- Addressing injury and violence prevention
- Redevelopment/infill
- Brownfield redevelopment
- New developments
- Bike and pedestrian improvements/master planning
- Affordable housing development
- Program development to address substance abuse
- Addressing mental health and emotional wellbeing

Health in All Policy Indicators

Health Equity Profile						
RACE/ETHNICITY						
Indicator	Total	White	Black	Other Race	Hispanic	Non-Hispanic
Structural Drivers (inequitable distribution of power, income, opportunity and resources)						
Income Inequality (index)	0.4996					
Median household income	\$60,303	\$64,866	\$37,604	\$30,682	\$52,752	\$69,823
Households with 1 worker	36.8%					
Occupied households with monthly housing costs of 30% or more of household income	43.7%					
Occupied housing units without a vehicle	7.8%					
Individuals below poverty level	12.7%	11.6%	21.6%	20.9%	16.2%	10.5%
Children under 18 below poverty level	16.7%	13.7%	32.3%	67.6%	21.1%	10.4%
Unemployed civilian labor force	3.7%	3.5%	6.4%	3.2%	4.4%	3.2%
Civilian labor force employed in management, business, science, or arts	30.80%					
Median owner-occupied housing unit value	\$429,000					
Owner-occupied housing units	58.7%	61.1%	26.3%	23.5%	43.6%	64.9%

Owner-occupied households with monthly housing costs of 30% or more of household income	34.5%					
Renter-occupied housing units	41.3%	38.9%	73.7%	76.5%	56.4%	35.1%
Renter-occupied households with gross rent costing 30% or more of household income	60.2%					
Rental vacancy rate	21.70%					
Severe housing problems	25.90%					
Occupied housing units with more than 1 occupant per room	3.5%	2.8%	13.1%	11.8%	6.3%	2.1%
Homeless (counts)	631					
Incarceration rate (per 100,000 population)	6.7					
Children under 18 in single-parent households	34.40%					
High school graduation rate ³	79.20%	86.5%	73.1%		68.4%	
Individuals 25 years and over with no high school diploma	8.80%	8.4%	14.8%	13.9%	22.3%	4.6%
Out-of-school suspensions grades K-12 (per 100,000 population)	3,962.8					
Racial residential segregation (index)	0.4221					
Adults who could not see a doctor at least once in the past year due to cost	15.3%	13.5%			22.6%	
Community Determinants						
Life expectancy and population migration						
Life expectancy in years	80					
Individuals 1 year and over that lived in a different house 1 year earlier	17.8%	17.3%	22.6%	22.0%	17.9%	17.0%
Inmate Admissions (count)	179					
College-age population (18-22)	4.8%	4.6%	6.7%	7.3%	6.4%	4.4%
Retirement-age population (65 or older)	21.7%	23%	10%	11.3%	11.7%	24.7%
Physical/built environment						
Population living within ½ mile of a park	53.7%					
Population living within ½ mile of a fast food restaurant	32.9%					
Workers who walked to work	4.6%					
Food insecurity rate	11.4%					
Child food insecurity rate	17.7%					
Economic environment						
Civilian non-institutionalized population with health insurance (per 100,000 population)	80.7	81.3	75.8	63.8	73.6	83.8
Households receiving cash public assistance or food stamps	7.6%					

Behaviors and Exposures						
Adults who are current smokers	13.6%	17.3%			4.1%	
Adults who engage in heavy or binge drinking	24.1%	28.5%			15.9%	
Adults who meet muscle strengthening recommendations	32.7%	33.5%			14.9%	
Diet/nutrition (per 100,000 population)						
Preventable Hospitalizations Under 65 from nutritional deficiencies (per 100,000 population)	26.40					
Health Outcomes						
Infant Death						
Infant deaths (per 1,000 births)	5.5	5.3	0	0	8.6	2
Heart Disease Per 100,000 population						
Heart disease deaths	147.5	145.8	234.1	80.5	119.6	152.2
Stroke						
Hospitalizations from stroke	184.8	169.1	530.7	192.2	169.1	180
Stroke deaths	24.8	23.6	64.1	0	31.6	23.9
Diabetes						
Hospitalizations from or with diabetes	1264.7	1180.2	2939.2	787.3	1734	1138.3
Preventable hospitalizations under 65 from diabetes	74.3					
Emergency room visits due to diabetes	142.3	115.7	473.6	139.8	207.6	119.4
Diabetes deaths	18.4	16.7	48.8	41.2	21.7	18.7
Cancer						
Cancer cases	379.5	378.7	382	231.7	225.5	405.3
Cancer deaths	147.5	145.7	247	43.1	108.4	154
CLRD						
Hospitalizations from C.L.R.D. (including asthma)	214.5	209.8	390.9	151	255.3	207.1
Chronic Lower Respiratory Disease (CLRD) deaths	26.4	27.1	26.2	0	5.5	29.5
Injury						
Unintentional injury deaths	50.6	55.3	0	41.2	52	50.7
Unintentional falls deaths	6.3	6.9	0	0	0	7.9
Unintentional poisoning deaths	23.6	26.6	0	0	26.6	23.6
Drug poisoning deaths	20.3	22.9	0	0	31.9	17.8
Suicides	22.2	24.8	0	0	22.7	21.7
Homicides	5.7	4.6	13.2	0	0	7.1
HIV/AIDS						
HIV cases	22	15.3	21.1	41.5	39.3	16.8
Persons living with HIV	838.3	863.8	1794.4	331.8	577.9	916.3
AIDS cases	5.2	3.8	21.1	0	5.6	5
HIV/AIDS deaths	3	3.4	0	0	5.5	3.3

Liver disease						
Chronic liver disease and cirrhosis deaths	18.1	16.2	48.8	59.5	10.1	19
Kidney disease						
Preventable hospitalizations under 65 from kidney/urinary infection	21.5					
Nephritis, nephrotic syndrome & nephrosis deaths	16.7	16.5	0	48.7	18.9	16.4
Mental health conditions and trauma						
Hospitalizations for mental disorders	679.8	667.8	745.8	257.3	461.2	728.2

Key:
 Red represents the highest disparity in race/ethnicity in Monroe County

Alignment with National Standards

Through proven and promising best practices, effective programs will be better able to help achieve the Healthy People 2020 Health in All Policies (Public Health Infrastructure, 11.7 - Policy Development).

Objectives to improve health equity through prevention and ensure access to appropriate policies are supported.

Aligning Characteristics of Healthy People 2020 & HiAP includes:

- Health starts in our homes, schools, workplaces, neighborhoods, and communities.
- We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health.
- We also know that our family histories can play a role in our health.
- Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships.
- The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.

Alignment with State Health Improvement Plan

Health in All Policies aligns with State Health Improvement Plan Goal ISV1.6.1, which focuses on policy development in Injury and Violence Prevention and Safety.

Action Step & Recommendation Plan

Goal 1: Promote Health in All Policies with local governments and agencies.

Objective 1.1: By June 30, 2022, increase the number of municipalities/agencies that incorporate HiAP into their processes from 0 to 1.

Outcome Indicator	Baseline	2022 Target	Data Source	Responsible Agency
Number of trainings held among stakeholders, decision-makers, workgroup members, and jurisdictional staff.	0	4	Number of trainings	HiAP Workgroup
Number of community presentations given by staff or partners to stakeholders.	0	15	Number of presentations	HiAP Workgroup
Number of media channels used to educate on topic.	0	12	Number of times media channels used	HiAP Workgroup
Number of decision-makers met with on topic.	0	25	Number of meetings	HiAP Workgroup
Number of policy implementations.	0	1	Agency that adopts policy	HiAP Workgroup

Strategies

- 1.1.1 Meet with stakeholders and decision-makers one-on-one to educate on the topic.
- 1.1.2 Hold trainings on the HiAP topic .
- 1.1.3 Meet with governments, agencies, stakeholders and decision-makers to educate on the topic.
- 1.1.4 Prepare presentation that HiAP workgroup can use to perform presentations and train them on how to use it in the community.
- 1.1.5 Educate on Benefits of Policy Change via Other Communication Methods: FDOH and workgroup will confirm those listed in email distribution list.
- 1.1.6 Develop HiAP materials to be used for media channels to educate and engage the community on topic.
- 1.1.7 HiAP Workgroup will solicit earned media by sending out information via their own channels of media.
- 1.1.8 Provide technical assistance to municipalities/agencies who want to adopt HiAP .

Health Priority: Access to Care

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. Access to health care impacts one's overall physical, social, and mental health status, and quality of life.

Access to health care impacts:

- Overall physical, social, and mental health status
- Prevention of disease and disability
- Preventable hospitalization
- Detection and treatment of health conditions
- Quality of life
- Preventable death
- Life expectancy

Barriers to health services include:

- High cost of care
- Inadequate or no insurance coverage
- Lack of availability of services
- Lack of culturally competent care

These barriers to accessing health services lead to:

- Unmet health needs
- Delays in receiving appropriate care
- Inability to get preventive services
- Financial burdens
- Preventable hospitalizations

Understanding Access to Health Services

Access to health services is a broad and complex issue that encompasses four main components: coverage, services, timeliness, and workforce.

Coverage

Uninsured people are less likely to receive medical care, more likely to die early and are more likely to have poor health status. The underinsured face a similar dilemma, despite having insurance. High out-of-pocket costs or deductibles create financial barriers to receiving care. Twenty-two (22%) percent of adults and 13% of children are uninsured which is higher than the state average. According to the Kaiser Family Foundation analysis of federal marketplace signup data by zip code, in 2015 in Monroe County:

- 9,810 people signed up for Marketplace coverage
- 18,478 is the estimated number of potential Marketplace enrollees in this area
- 53% percent of this area's potential market signed up for coverage

Services

Improving access to health care services depends in part on ensuring that people have a usual and ongoing source of care (that is, a provider or facility where one regularly receives care). People with a usual source of care have better health outcomes, fewer disparities, and lower costs.

Having a primary care provider (PCP) who serves as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

- Greater patient trust in the provider
- Better patient-provider communication
- Increased likelihood that patients will receive appropriate care
- Lower mortality from all causes
- Improving health care services includes increasing access to and use of evidence-based preventive services.

Clinical preventive services are services that:

- Prevent illness by promoting healthy behaviors in people without risk factors (e.g., diet and exercise counseling)
- Prevent illness by providing protection to those at risk (e.g., childhood vaccinations)
- Identify and treat people with no symptoms, but who have risk factors, before the clinical illness develops (e.g., screening for hypertension or colorectal cancer)

Timeliness

Timeliness issues include the time between identifying a need for specific tests and treatments and actually receiving those services. Actual and perceived difficulties or delays in getting care when patients are ill or injured likely reflect significant barriers to care. The delay in time between identifying a need for a specific test or treatment and actually receiving those services can negatively impact health and costs of care. For example, delays in getting care can lead to:

- Increased emotional distress
- Increased complications
- Higher treatment costs
- Increased hospitalizations

Workforce

There has been a decrease in the number of medical students interested in working in primary care. Primary care physicians (PCPs) as a usual source of care allows physicians to develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Shortages exist in other key specialties, such as dental and mental health professionals. The Healthcare Resources and Service Administration (HRSA) may designate some geographic areas as a Health Professional Shortage Area based on the rate of full-time equivalent professionals per resident.

As health care reform seeks to expand access to health care by improving affordability, significant nonfinancial barriers also prevent many adults from seeking or delaying the care they need.

National research has suggested that four nonfinancial barriers were more frequent reasons for unmet need or delayed care (21%) compared to affordability, the only cost-related dimension (18.5%).

The top nonfinancial barriers include:

- Accommodation (17.5%) —busy with work or other commitments
- Availability (8.4%)—couldn't get appointment soon enough
- Accessibility (4.4%)—took too long to get to the doctor's office or clinic
- Acceptability (4.0%) —doctor or hospital wouldn't accept health insurance

Access and Functional Needs Profile		
Indicator	County Rate	State Rate
Demographic Data		
Resident Live Births	9.6	11.1
Total Population		
Children under 18 in Foster Care	985.4	534.5
Population 65-84 Years Old	18.8	16.8
Population 85+ Years Old	2.2	2.7
Individuals 65 years and over living alone	25.3	24.8
Socioeconomic Data		
WIC Eligibles Served	74.5	72.2
WIC Eligibles	2.1	3.3
Census Population Below Poverty Level	13.0	16.1
Population 5+ that speak English less than very well	9.3	11.7
Median Monthly Medicaid Enrollment	11,660.8	19,672.2
Households receiving cash public assistance or food stamps	7.6	15.3
Homeless Estimate	0.8	0.2
Health Status and Access to Care		
Adults with health insurance coverage	79.0	83.6
Adults who have a personal doctor	65.2	72
Adults who could not see a doctor at least once in the past year due to cost	15.3	16.6
Adults who had a medical checkup in the past year	67.7	76.5
Total Licensed Florida Family Practice Physicians (FP - FAMILY PRACTICE)	18.2	15.8
Total Licensed Florida Dentists	49	57.4
Total hospital beds	307	312.9
County Health Department Full-Time Employees	104.4	48
Adults who received a flu shot in the past year	27.1	35
Adults who have ever received a pneumonia vaccination	30.3	34.6
Women 40 years of age and older who received a mammogram in the past year	47.3	60.8
Women 18 years of age and older who received a Pap test in the past year	39.8	48.4
Men 50 years of age and older who received a PSA test in the past two years	40.7	54.9
Adults ages 50 years and older who received a blood stool test in the past year	7.5	16

Adults 50 years of age and older who received a sigmoidoscopy or colonoscopy in the past five years	44.2	53.9
Adults less than 65 years of age who had an HIV test in the past 12 months	17.7	19.7
County Health Department Expenditures Per Person	101.5	36
Adults who have Medicare (Medicare is a coverage plan for people 65 or over and for certain disabled people)	40.7	37.9
Adults who said their overall health was "fair" or "poor"	14.6	19.5
Adults who said their overall health was "good" to "excellent"	85.4	80.5
Adults whose poor physical or mental health kept them from doing usual activities on 14 or more of the past 30 days (Among adults who have had at least one day of poor mental or physical health)	19.0	18.6
Average number of days where poor mental or physical health interfered with activities of daily living in the past 30 days (Among adults who have had at least one day of poor mental or physical health)	5.6	5.7
Adults with good physical health	86.8	87.1
Adults who had poor physical health on 14 or more of the past 30 days	13.2	12.9
Average number of unhealthy physical days in the past 30 days	4	4
Adults with good mental health	90.1	88.6
Adults who had poor mental health on 14 or more of the past 30 days	9.9	11.4
Average number of unhealthy mental days in the past 30 days	3.2	3.6
Adults who have ever been told they had a depressive disorder	10.7	14.2
Vulnerability Data		
Percent of Adults Limited in Activities because of Physical, Mental, or Emotional Problems	19.3	21.2
Percent of Adults Who Use Special Equipment because of a Health Problem	7.8	9.9
Civilian non-institutionalized population with a disability	12.2	13.3
Seriously Mentally Ill Adults	3.6	3.7
Census Population 18-64 with Vision Difficulty	1.5	1.9
Census Population 18-64 with Hearing Difficulty	1.8	1.8
Census Population 18-64 with Independent Living Difficulty	3.4	3.6
Children Through Age 20		
Seriously Emotionally Disturbed Children	4.3	4.6
Census Population Under 18 with Vision Difficulty	0.2	0.7
Census Population Under 18 with Hearing Difficulty	0.6	0.5
CMS Clients	0.6	1.9
Elderly Ages 65+		
Census Population 65+ with Vision Difficulty	5.5	6.2
Census Population 65+ with Hearing Difficulty	13.4	13.7
Probable Alzheimer's Cases (65+)	10.7	12.9

Chronic Diseases		
Coronary heart disease age-adjusted death rate	102.7	95.2
Coronary heart disease age-adjusted hospitalization rate	282.0	293.7
Lung Cancer		
Lung cancer age-adjusted death rate	36.8	38.6
Lung cancer age-adjusted incidence rate	58.9	58.9
Colorectal Cancer		
Colorectal cancer age-adjusted death rate	14.6	13.5
Colorectal cancer age-adjusted incidence rate	34.6	36.6
Breast Cancer		
Breast cancer age-adjusted death rate	20.6	19.3
Breast cancer age-adjusted incidence rate	105.5	118.6
Prostate Cancer		
Prostate cancer age-adjusted death rate	19.1	17
Prostate cancer age-adjusted incidence rate	76.6	86.9
Cervical Cancer		
Cervical cancer age-adjusted death rate	2	2.6
Cervical cancer age-adjusted incidence rate	11.5	8.5
Melanoma		
Melanoma age-adjusted death rate	3.7	2.4
Melanoma age-adjusted incidence rate	30.1	24
Reportable & Infectious Diseases		
Campylobacteriosis	32.8	18
Cyclosporiasis	0.4	0.3
Giardiasis, acute	7.9	5.2
Hepatitis A	1.3	0.9
Hepatitis B, acute	0.9	3.3
Legionellosis	3.1	1.8
Listeriosis	0.9	0.2
Salmonellosis	47.3	29.8
Shiga toxin-producing Escherichia coli (STEC) infection	0.9	0.7
Tetanus	0	11
Tuberculosis cases	2.6	2.9
Varicella	5.3	3.5
Vibriosis (excluding cholera)	3.9	1.1
Maternal, Infant & Young Child Health		
Early prenatal care (care began 1st trimester)	82.3	78.3
Preterm with Low Birth Weight	4.8	6

Key: Red is worse than the State. Green is better than the State. Yellow is equal to the State.

Best Practices

The following program has been reviewed and have proven strategies to improve Access to Care:

The Guide to Clinical Preventive Services 2014: Recommendations of the U.S. Preventive Services Task Force: The Guide to Clinical Preventive Services includes U.S. Preventive Services Task Force (USPSTF) recommendations on screening, counseling, and preventive medication topics. It presents clinical considerations for each topic. The guide comprises 64 preventive services presented in an easy-to-use, one-page summary table format. In addition, the guide provides information on resources that clinicians can use to educate their patients on appropriate preventive services as well as brief descriptions of and links to tools that they can use to improve their practices. USPSTF is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services.

Alignment with National Standards

Through proven and promising best practices, effective programs will be better able to help achieve the Healthy People 2020 Access to Care's Goal is to Improve access to comprehensive, quality health care services.

Healthy People 2020 Goals include:

AHS-1 Increase the proportion of persons with health insurance

AHS-3 Increase the proportion of persons with a usual primary care provider

Action Step & Recommendation Plan

Goal 1: To increase access to community wide comprehensive primary care services for uninsured, Medicaid and underinsured populations.

Aligns with State Health Improvement Plan Goal HE3.3, which focuses on increasing access to uninsured populations.

Objective 1.1: By December 31, 2022, decrease the percentage of Monroe County residents who are uninsured from 19.3% to the state's average, 15%.

Outcome Indicator	Baseline	2022 Target	Data Source	Responsible Agency	Population(s) Served
Percent of uninsured in Monroe County	19.3%	15%	Census, 2017 5-Year Estimate	Access to Care Workgroup	Uninsured

Strategies:

- 1.1.1 Work with local Federal Qualified Health Center (FQHC) to access Federal support of medical services filling gaps in coverage and care.
- 1.1.2 Work with local government and taxing district to support local health care service providers providing gap services and programs, such as, HIV, women's health, pre-natal care, pediatric services, dental, mental health and others.

Goal 2: To establish a network increasing access to specialty, secondary and ancillary medical services, such as, specialty care, tertiary care, cardiology, radiology, cancer, surgery, and other services that take Medicaid/Medicare.

Aligns with State Health Improvement Plan, Goal MCH3.1, which focuses on increased patient health care; and CD1.1., which promotes policy and systems change to health care.

Objective 2.1: By December 31, 2022, increase the number of medical providers by 10% in Monroe County who offer specialty care and take Medicaid/Medicare.

Outcome Indicator	Baseline	2022 Target	Data Source	Responsible Agency	Population(s) Served
Number of licensed active medical doctors in Monroe County	211	232 (increase of 10%)	www.FLHealthSource.gov 2019	Access to Care Workgroup	Monroe County
Number of medical providers with specialties related to “cancer” that take Medicare in Monroe County	48	53 (increase of 10%)	www.medicare.gov 2019	Access to Care Workgroup	Monroe County

Strategies:

2.1.1 Creating a primary care service delivery system that supports secondary care that then contracts and supports specialty, ancillary and tertiary care needs of this identified population

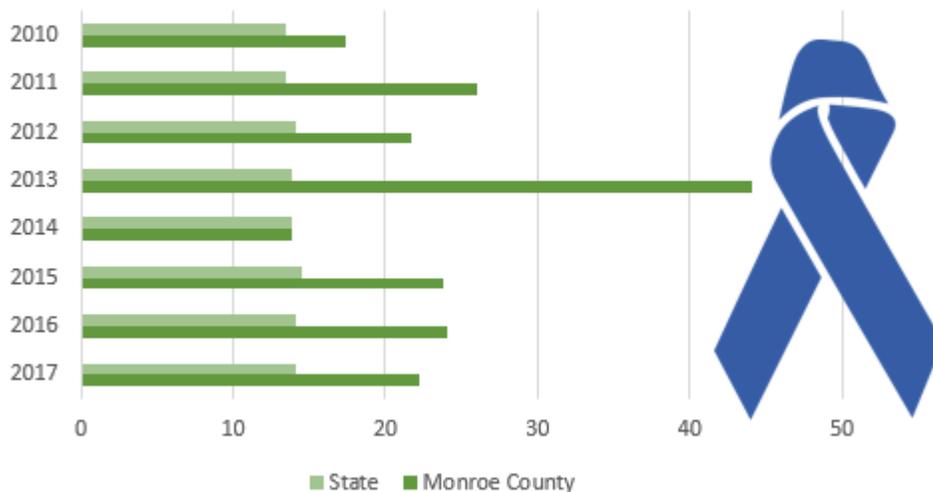
Health Priority 3: Mental Health & Substance Abuse

Mental Health

Overall health depends on both physical and mental well-being. Measuring the number of days when people report that their mental health was not good, i.e., poor mental health days, represents an important facet of health-related quality of life. Mental health includes emotional, psychological and social well-being. It affects how we think, feel and act. It also helps determine how we handle stress, relate to others and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood. In 2016, Monroe County residents reported 3.7 poor mental health days per month.

While data is available for those who receive treatment, data on mental health of the general population is very limited, especially at the local level. Nationally, males are about four times more likely to commit suicide than females. Older males have higher rates of suicide than younger males. Monroe County has Florida's highest suicide rate at 27.7 per 100,000 residents, determined by 66 suicides over a three-year period from 2013 to 2015, which is nearly twice as high as the state.

Figure 17: Suicide Age-Adjusted Death Rate, Single Year Rates



Mental Health and Wellness

Positive mental health allows people to:

- Realize their full potential
- Cope with the stresses of life
- Work productively
- Make meaningful contributions to their communities

Maintaining positive mental health:

- Getting professional help if you need it
- Connecting with others
- Staying positive
- Getting physically active
- Helping others
- Getting enough sleep
- Developing coping skills

Substance Abuse

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. The effects of substance abuse are cumulative and significantly contribute to costly social, physical, mental, and public health problems. These problems include, but are not limited to:

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

Use of both illegal and controlled substances is believed to be widespread in the Florida Keys, based on the number of arrests made on substance-related charges. Monroe County is ranked 17 out of the 67 counties for drug overdose deaths. Drug overdose deaths are a leading contributor to premature death and are largely preventable. Currently, the United States is experiencing an epidemic of drug overdose deaths. Furthermore, Monroe County also ranks number one in the state for excessive drinking with the rate of alcohol-related car crashes in Monroe County typically being more than double the number per 100,000 persons than the statewide average. The rate of hospitalization and Emergency Room visits due to excessive alcohol among Monroe County residents is twice as high as the rest of the state.

Mental Health & Substance Abuse Indicators

Mental Health & Substance Abuse Profile		
Health Outcomes (Mortality/Death)		
Indicator	County	State
Infant deaths (per 1,000 births)	5.4	6.1
Neonatal Deaths (0-27 days)	4.5	4.2
Post neonatal Deaths (28-364 days)	0.9	2
Motor Vehicle Accident Deaths	19.1	14.8
Drug poisoning deaths	31.9	17.8
Drug Overdose Deaths	26	17
Suicides	23.3	14.2
Homicides	0	7.1
HIV/AIDS deaths	5.5	3.3
Chronic liver disease and cirrhosis deaths	10.1	19
Low birth weight	6.3	8.7
HIV	21.5	23.8
AIDS	3.4	3.7
Hospitalizations for mental disorders	461.2	728.2
Adults whose poor physical or mental health kept them from doing usual activities on 14 or more of the past 30 days (Among adults who have had at least one day of poor mental or physical health)	19	18.6
Average number of days where poor mental or physical health interfered with activities of daily living in the past 30 days (Among adults who have had at least one day of poor mental or physical health)	5.6	5.7
Adults who have ever been told they had a depressive disorder	10.7	14.2
Alcohol-related Motor Vehicle Traffic Crash Deaths	11.8	4.6
Alcohol-related Motor Vehicle Traffic Crashes	87	51.3
Excessive Drinking	26	18
18-44 years	30.9	23.1
45-64 years	24.5	17.2
65 & older	18.4	8.7
Sexually Transmitted Disease	245	454
Social and Economic Factors		
Domestic Violence Offenses	407	504
Murder/Homicide	6	605
Violent Crime	515	500

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Best Practices

The following programs and policies have been reviewed and have proven strategies to increase mental health services:

1. **All Stars:** All Stars is a school-based program for middle school students (11-14 years old) designed to prevent and delay the onset of high-risk behaviors, such as drug use, violence, and premature sexual activity.
2. **Apple A Day K-6:** An Apple A Day (AAAD) is a universal literacy-based program that helps to build and reinforce resiliency skills for substance abuse prevention and mental health promotion in children in kindergarten through 4th grade.
3. **Alcohol Literacy Challenge:** Alcohol Literacy Challenge (ALC) is a brief classroom-based program designed to alter alcohol expectancies and reduce the quantity and frequency of alcohol use among high school and college students.
4. **Nurturing Parenting Program (parenting):** The Nurturing Parenting Programs (NPP) are family-based programs for the prevention and treatment of child abuse and neglect. The programs were developed to help families who have been identified by child welfare agencies for past child abuse and neglect or who are at high risk for child abuse and neglect.
5. **Mental Health First Aid:** Mental Health First Aid is an adult public education program designed to improve participants' knowledge and modify their attitudes and perceptions about mental health and related issues, including how to respond to individuals who are experiencing one or more acute mental health crises (i.e., suicidal thoughts and/or behavior, acute stress reaction, panic attacks, and/or acute psychotic behavior) or are in the early stages of one or more chronic mental health problems (i.e., depressive, anxiety, and/or psychotic disorders, which may occur with substance abuse). The intervention is delivered by a trained, certified instructor through an interactive 12-hour course, which can be completed in two 6-hour sessions or four 3-hour sessions. The course introduces participants to risk factors, warning signs, and symptoms for a range of mental health problems, including comorbidity with substance use disorders; builds participants' understanding of the impact and prevalence of mental health problems; and provides an overview of common support and treatment resources for those with a mental health problem. Participants also are taught a five-step action plan, known as ALGEE, for use when providing Mental Health First Aid to an individual in crisis:
 - A--Assess for risk of suicide or harm
 - L--Listen nonjudgmentally
 - G--Give reassurance and information
 - E--Encourage appropriate professional help
 - E--Encourage self-help and other support strategies in addition, the course helps participants to not only gain confidence in their capacity to approach and offer assistance to others, but also to improve their personal mental health. After completing the course and passing an examination, participants are certified for 3 years as a Mental Health First Aider.

In the studies reviewed for this summary, Mental Health First Aid was delivered as a 9-hour course, through three weekly sessions of 3 hours each.

6. **Parent Project**®: The Parent Project is an evidence/science-based parenting skills program specifically designed for parents with strong-willed or out-of-control children. Parents are provided with practical tools and no-nonsense solutions for even the most destructive of adolescent behaviors. The Parent Project is the largest court mandated juvenile diversion program in the country and for agencies, the least expensive intervention program available today.

There are two highly effective Parent Project® programs serving families:

- Loving Solutions is a 6 to 7-week program written for parents raising difficult or strong-willed children, 5 to 10 year of age. Designed for classroom instruction, this program has special application to ADD and ADHD issues, and was written for the parents of more difficult children.
- Changing Destructive Adolescent Behavior is a 10 to 16-week program designed for parents raising difficult or out-of-control adolescent children, ages 10 and up. Also designed for classroom use, it provides concrete, no-nonsense solutions to even the most destructive of adolescent behaviors.

7. **PHQ-9**: The PHQ-9 is the nine-item depression scale of the Patient Health Questionnaire. The PHQ-9 is a powerful tool for assisting primary care clinicians in diagnosing depression as well as selecting and monitoring treatment. The primary care clinician and/or office staff should discuss with the patient the reasons for completing the questionnaire and how to fill it out. After the patient has completed the PHQ-9 questionnaire, it is scored by the primary care clinician or office staff. There are two components of the PHQ-9:

- Assessing symptoms and functional impairment to make a tentative depression diagnosis, and
- Deriving a severity score to help select and monitor treatment the PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV).

For more information, go to:

<http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/>

8. **Project SUCCESS Middle & High School**: Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) is designed to prevent and reduce substance use among students 12 to 18 years of age. The program was originally developed for students attending alternative high schools who are at high risk for substance use and abuse due to poor academic performance, truancy, discipline problems, negative attitudes toward school, and parental substance abuse.

- For more information go to: <http://www.parentproject.com>

9. **Teen Intervene Middle School**: Teen Intervene is a brief, early intervention program for 12- to 19-year-olds who display the early stages of alcohol or drug involvement. Integrating stages of change theory, motivational enhancement, and cognitive-behavioral therapy, the intervention aims to help teens reduce and ultimately eliminate their substance use.

Alignment with National Standards

Through proven and promising best practices, effective programs will be better able to help achieve the Healthy People 2020 Mental Health and Mental Disorders Objectives to improve mental health through prevention and ensure access to appropriate quality mental health services.

Healthy People 2020 Goals include:

- **Mental Health and Mental Disorders (MHMD)-1** Reduce the suicide rate
- **Mental Health and Mental Disorders (MHMD)-2** Reduce suicide attempts by adolescents
- **Mental Health and Mental Disorders (MHMD)-3** Reduce the proportion of adolescents who engage in disordered eating behaviors in an attempt to control their weight
- **Mental Health and Mental Disorders (MHMD)-4** Reduce the proportion of persons who experience major depressive episodes (MDEs)
- **Mental Health and Mental Disorders (MHMD)-5** Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral
- **Mental Health and Mental Disorders (MHMD)-6** Increase the proportion of children with mental health problems who receive treatment
- **Mental Health and Mental Disorders (MHMD)-7** Increase the proportion of juvenile residential facilities that screen admissions for mental health problems
- **Mental Health and Mental Disorders (MHMD)-10** Increase the proportion of persons with cooccurring substance abuse and mental disorders who receive treatment for both disorders
- **Mental Health and Mental Disorders (MHMD)-11** Increase depression screening by primary care providers
- **Mental Health and Mental Disorders (MHMD)-12** Increase the proportion of homeless adults with mental health problems who receive mental health services
- **Substance Abuse (SA)-1** Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol
- **Substance Abuse (SA)-2** Increase the proportion of adolescents never using substances
- **Substance Abuse (SA)-3** Increase the proportion of adolescents who disapprove of substance abuse
- **Substance Abuse (SA)-7** Increase the number of admissions to substance abuse treatment for injection drug use
- **Substance Abuse (SA)-8** Increase the proportion of persons who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year
- **Substance Abuse (SA)-9** (Developmental) Increase the proportion of persons who are referred for follow up care for alcohol problems, drug problems after diagnosis, or treatment for one of these conditions in a hospital emergency department (ED)
- **Substance Abuse (SA)-12** Reduce drug-induced deaths
- **Substance Abuse (SA)-14** Reduce the proportion of persons engaging in binge drinking of alcoholic beverages
- **Substance Abuse (SA)-15** Reduce the proportion of adults who drank excessively in the previous 30 days
- **Substance Abuse (SA)-16** Reduce average annual alcohol consumption

Alignment with State Health Improvement Plan

Mental Health and Substance Abuse aligns with State Health Improvement Plan Goal BH1.2, BH3, and BH4, which focus on mental health, substance abuse, and suicide.

The following evidence-based community intervention comes from the **Guide to Community Preventive Services**, Centers for Disease Control and Prevention (CDC) and helps to meet the Healthy People 2020 Objectives.

Collaborative care for the management of depressive disorders is a multicomponent, healthcare system-level intervention that uses case managers to link primary care providers, patients, and mental health specialists. This collaboration is designed to:

1. Improve the routine screening and diagnosis of depressive disorders
2. Increase provider use of evidence-based protocols for the proactive management of diagnosed depressive disorders
3. Improve clinical and community support for active patient engagement in treatment goal setting and self-management.

Action Step & Recommendation Plan

Goal 1: Support and enhance the mental, behavioral, and emotional health of all, and reduce the impact of alcohol, tobacco and other drugs.

Objective 1.1: By December 31, 2022, increase the number of residents who utilize mental trauma services and substance abuse services by 10% in Monroe County by identifying the gaps and services needed.

Outcome Indicator	Baseline	2022 Target	Data Source	Responsible Agency	Population(s) Served	Evidence of Effectiveness
Number of residents in Monroe County who have utilized mental/behavioral health services	4316	Increase of 10%	Guidance Care Center Fiscal Year 2018	Guidance Care Center	Monroe County Residents	Increased number of residents utilizing services.
Percentage of households exhibiting worsening health impacts since Hurricane Irma	17.6%	10%	CASPER study	CASPER study	Monroe County Residents	Decrease in percentage surveyed.
Percentage of households that needed mental health care and were not able to receive it	37.86%	30%	CASPER study	CASPER study	Monroe County Residents	Decrease in percentage surveyed.
Percentage of respondents who have ever thought of killing themselves and exhibited damage to their home	10.1%	5%	CASPER study	CASPER study	Monroe County Residents	Decrease in percentage surveyed.

Strategies

- 1.1.1 Assessment to identify:
 - The existing number of mental/behavioral health care and substance abuse providers/resources currently available for adults, adolescents, and children at each level of care to support collaboration and efficient use of resources among providers.
 - Utilization of mental/behavioral health and substance abuse services to establish baseline for monitoring who currently uses these services in Monroe County.
 - Racial/ethnic/economic barriers that limit access to mental/behavioral health and substance abuse care.
 - Impact on Hurricane Irma and mental health.
- 1.1.2 Establish formal partnerships with two (2) community-based organizations to promote existing culturally competent mental/behavioral health and substance abuse services and address inefficiencies through collaborative planning, service delivery, and resource sharing.
- 1.1.3 Engage media outlets to promote existing mental/behavioral health services in Monroe County.

Objective 1.2: By December 31, 2022, increase the awareness and understanding of mental/behavioral health and mental illness in Monroe County from 42% to 70%.

Outcome Indicator	Baseline	2022 Target	Data Source	Responsible Agency	Population(s) Served	Evidence of Effectiveness
Monroe County residents who are aware of mental/behavioral health and mental/behavioral health services	42%	70%	Facebook Poll for Monroe County residents age 18 and over.	Baywood Health Associates	Monroe County Residents	Assessment shows an increase from baseline.

Strategies

- 1.2.1 Conduct Mental Health First Aid training among public employees and agencies in Monroe County.
- 1.2.2 Conduct racial/economic awareness training for all public employees and agencies in Monroe County as a first step in moving towards social determinants of mental/behavioral health.

Objective 1.3: Reduce the number of annual opioid overdose deaths in Monroe County from 48 to 0 by December 31, 2022.

Outcome Indicator	Baseline	2022 Target	Data Source	Responsible Agency	Population(s) Served	Evidence of Effectiveness
Number of fatal opioid overdoses	48	0	FL Medical Examiner	FDOH-Monroe	Monroe County Residents	N/A

Strategies

- 1.3.1 Train and inform opioid users and bystanders (friends, family, co-users) on overdose risk factors.
- 1.3.2 Train groups who frequently come into contact with opioid users or overdose hot-spots (e.g., non-healthcare staff in police stations, hostels rehabilitation hostels, community agencies, and residential hotels) in the use of overdose reversal strategies, such as the administration of Naloxone/Narcan.
- 1.3.3 Train and inform opioid users and bystanders (friends, family, co-users) on how to appropriately respond to an overdose by performing rescue breathing and administering Narcan.
- 1.3.4 Engage the community and promote safe storage and disposal of prescription drugs through prescription take back day.

Objective 1.4: Reduce the number of annual suicides in Monroe County from 35 to 0 by December 31, 2022.

Outcome Indicator	Baseline	2022 Target	Data Source	Responsible Agency	Population(s) Served	Evidence of Effectiveness
Number of suicides	35	0	CHARTS	FDOH-Monroe	Monroe County Residents	N/A

Strategies

- 1.4.1 Educate families about the risks associated with mental/behavioral health

Next Steps: Implementation Phase

The components included in this report represent the strategic framework for a data-driven community health improvement plan (CHIP). The Community Health Advisory Group (CHAG), including the core agencies, CHIP workgroups, partners, stakeholders, and community residents, will continue finalizing the CHIP by prioritizing strategies, developing specific Year-1 action steps, assigning lead responsible parties, and identifying resources for each priority area. Two interactive meetings that will engage a representative group of stakeholders to identify strategies for Year-1 implementation and develop action plans to carry out these strategies will occur in June and September 2019. These action plans will provide a model for the CHAG to strategize, collaborate, and share information. The Florida Department of Health in Monroe County will provide the county's leadership with a status update in the fall of 2019 and will include CHIP information in its annual reports to the county. CHAG will also produce a CHIP progress report after the first year of implementation that will illustrate performance and guide subsequent annual implementation planning.

Sustainability Plan

As part of the action planning process, partners and resources will be solidified to ensure successful CHIP implementation and coordination of activities and resources among key partners in Monroe County. The CHAG along with the Performance Management Council will serve as the oversight for the improvement plan, progress, and process. The Performance Management Council will meet regularly and will be led by the department's Accreditation Coordinator. Additional workgroup meetings and participants will be identified once the first-year action plan is developed. Community dialogue sessions and forums will occur in order to engage residents in the implementation where appropriate, share progress, solicit feedback, and strengthen the CHIP. Regular communication/reports will be made available via the health department's website and other local media to community members and stakeholders throughout the implementation phase. New and creative ways to feasibly engage all parties will be explored at the aforementioned engagement opportunities.

Appendix A: Participants

Community Health Advisory Group (CHAG) Members

Area Health Education Center	Michael Cunningham
Monroe Municipal Governments	Kim Romano and Clayton Lopez
Florida Department of Health in Monroe County	Alison Kerr, Donna Stayton, Bob Eadie, Priscilla Bennett, Emily Mutschler
Florida Keys Healthy Start Coalition	Arianna Nesbitt
Guidance Care Center	Maureen Dunleavy
Local Law Enforcement	Sgt. Joe Tripp
Monroe County Coalition	Susan Moore
United Way of the Florida Keys	Leah Stockton
Womankind	Cali Roberts and Mel Gortarez
<u>CHAG Not Present at 3/7 Meeting</u>	
Community Foundation of South Florida	Dianna Sutton
Community Health of South Florida, Inc.	Peter Wood
Key Bridge Treatment Center, Inc.	Elaine McHale
Keys Health Ready Coalition	Cyna Wright
Lower Keys Medical Center	David Clay
Naval Branch Clinic	Ashawn Robinson

Accreditation Steering Committee Members

Bob Eadie, Administrator and Health Officer
Mary Vanden Brook, Deputy Administrator and Administrative Services Director
Donna Stayton, Director of Community Health Improvement and Planning
Nicole Norman, Nursing Director
Dr. Mark Whiteside, Medical Director
Michael Seiler, Budget Director

Performance Management Council

Bob Eadie	Administrator
Mary Vanden Brook	Administrative Services Director
Dr. Mark Whiteside	Medical Director

Nicole Norman	Director Nursing
Mike Seiler	Business Manager
Donna Stayton	Director CHiAP
Alison Kerr	PIO/Health Education Program Consultant
Bill Brookman	Contractor
Cyna Wright	Public Health Services Manager
Danielle McKee	Human Resources
Ruth Kallay	Public Health and Medical Preparedness Program Manager
Renee Parker	Internal Communications Officer/ (OPS) Administrative Assistant-Community Health
Mike Edwards	Sr. Network Analyst
James Rachal	Environmental Manager
Angela Giaquinto	Epidemiology
Jessica Lariz	Healthy Start
Sheila Butler/Lindsay Cavey	Nursing
Suzanne Otto	WIC

Health Priority Planning Session Participants

Health in All Policies

Lauren Cuvillo	AH Monroe County
Donna Stayton	FDOH-Monroe
Emily Mutschler	FDOH-Monroe
Alison Kerr	FDOH-Monroe
Kathleen Daniel	Florida Keys Community College
Arianna Nesbitt	Florida Keys Healthy Start Coalition
Kate Banick	Good Health Clinic
Maureen Dunleavy	Guidance Care Center
Fernanda Kuchkarian	Health Foundation of South Florida
Judy Gross	Leadership Monroe County
Joseph Laino	South Florida Behavioral Health
Leah Stockton	United Way of the Florida Keys

Access to Care

Becky Love	AH of Monroe County
Mike Cunningham	Area Health Education Centers
Christine Mendez	Baptist Health of South Florida and Fishermen's Hospital
Patrice Schwermer	Catholic Charities
Kim Romano	City of Key West, Mayor's Office
Sandra Higgs	Community Member
Alison Kerr	FDOH-Monroe
Bob Eadie	FDOH-Monroe
Donna Stayton	FDOH-Monroe
Priscilla Bennett	FDOH-Monroe
Kathleen Daniel	Florida Keys Community College
Arianna Nesbitt	Florida Keys Healthy Start Coalition
Kate Banic	Good Health Clinic
Maureen Dunleavy	Guidance Care Center
Fernanda Kuchkarian	Health Foundation of South Florida
Jody Gross	Leadership Monroe County
Cali Roberts	Womankind
Mel Gortarez	Womankind

Mental Health & Substance Abuse

Shay Cunningham	AH of Monroe County
Mike Cunningham	Area Health Education Centers
Christine Mendez	Baptist Health and Fishermen's Hospital
Patrice Schwermer	Catholic Charities
Anna Mason	Department of Juvenile Justice
Donna Stayton	FDOH-Monroe
Bob Eadie	FDOH-Monroe
Alison Kerr	FDOH-Monroe

Rita Sneider-Cotter	Florida Council Against Sexual Violence
Kathleen Daniel	Florida Keys Community College
Arianna Nesbitt	Florida Keys Healthy Start Coalition
Maureen Dunleavy	Guidance Care Center
Sherry Read	Guidance Care Center - CAC Board
Fernanda Kuchkarian	Health Foundation of South Florida
Joe Tripp	Key West Police Department
Susan Moore	Monroe County Coalition
Rochelle Pearson	Rural Health Network of Monroe County
Joseph Laino	South Florida Behavioral Health Network
Jaye F. Harkow	Veteran's Affairs

Florida Department of Health in Monroe County, Support Staff

- Bob Eadie, Administrator
- Amos Joe, Community Health Planner
- Emily Mutschler, Health Education Program Manager
- Priscilla Bennett, Tobacco Prevention Program Manager
- Renee Parker, Internal Communications Program Manager
- Ruth Kallay, Public Health and Medical Preparedness Program Manager
- Minorvi Amin, Public Health Preparedness Planner
- Donna Stayton, Director of Community Health Improvement and Planning
- Alison Kerr, Public Information Officer

Ascendant Healthcare Partners, Facilitator

- JoAnn Andrews, President

Appendix B: Glossary of Terms

Behaviorally Integrated Medical Home: Service delivery system that coordinates behavioral care with medical care.

Built Environment: Man-made surroundings that include buildings, public resources, land use patterns, the transportation system, and design features.

Community Health Improvement Plan (CHIP): Action-oriented strategic plan that outlines the priority health issues for a defined community, and how these issues will be addressed.

Complete Streets: Streets that are designed and operated to enable safe access for all users, including people who walk, bike, drive, and ride transit of all ages and abilities.

Comprehensive Care Strategies: The practice of comprehensive care is the concurrent prevention and management of multiple physical and emotional health problems of a patient over a period of time in relationship to family, life events and environment.

Cultural Competence: Set of congruent behaviors, attitudes, and policies that come together in a system or agency or among professionals that enables effective interactions in a cross-cultural framework.

Distribution Point: Physical location where affordable quality nutritious food can be accessed, including, but not limited to, grocery stores, farmers markets, and farm-to-site programs.

Evidence-Based Method: Strategy for explicitly linking public health or clinical practice recommendations to scientific evidence of the effectiveness and/or other characteristics of such practices.

Goals: Identify in broad terms how the efforts will change things to solve identified problems.

Health Disparity: Type of difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who systematically have experienced greater social or economic obstacles to health. These obstacles stem from characteristics historically linked to discrimination or exclusion, such as race or ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, or geographic location. Other characteristics include cognitive, sensory, or physical disability.

Health Equity/Social Justice: When all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social or economic positions or other circumstances.

Health Literacy: Degree to which individuals can obtain, process, and understand the basic health information and services they need to make health decisions.

Linguistic Competence: Providing easy access to oral and written language services to limited English proficiency (LEP) patients through such means as bilingual/bicultural staff, trained medical interpreters, and qualified translators.

Multiple Specified Targets: Objectives that are applicable to more than one target population or indicator.

Objectives: Measurable statements of change that build toward achieving the goals and specify an expected result and timeline.

Patient-Centered Care: Patient-centered care is oriented towards the whole person and is relationship-based. Building a partnership with each patient and his/her family is foundational to the person learning to manage and organize his/her own care at the level he/she chooses. Such a partnership necessitates understanding and respect for each patient's needs (including health literacy, culture, language, values, and preferences).

Percentages: All percentages are relative; absolute change is represented as a percentage of the baseline value.

Performance Measures: Changes that occur at the community level as a result of completion of the strategies and actions taken.

Priority Areas: Broad issues that pose problems for the community.

Social Determinants of Health: The complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities. These social structures and economic systems include the social environment, physical environment, health services, and structural and societal factors. Social determinants of health are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.

Strategies: Action-oriented phrases to describe how the objectives will be approached.

Appendix C: Acronyms

Acquired Immune Deficiency Syndrome (AIDS)

Behavioral Risk Factor Surveillance System (BRFSS)

Community Health Assessment (CHA)

Community Health Improvement Plan (CHIP)

Ascendant Healthcare Partners (AHP)

Florida Department of Health in Monroe County (FDOH-Monroe)

Appendix D: Partners and Resources¹⁰

Health Priority 1: HiAP

Health Priority 2: Access to Healthcare

Health Priority 3: Mental/Behavioral Health and Substance Abuse

Priority Areas			Partners and Resources
1	2	3	Florida Department of Health in Monroe County
1	2	3	AH Monroe County
	2	3	Area Health Education Centers
	2	3	Baptist Health of South Florida and Fishermen's Hospital
	2	3	Catholic Charities
	2		City of Key West, Mayor's Office
	2		Community Member
		3	Department of Juvenile Justice
		3	Florida Council Against Sexual Violence
1	2	3	Florida Keys Community College
1	2	3	Florida Keys Healthy Start Coalition
1	2	3	Good Health Clinic
1	2	3	Guidance Care Center
		3	Guidance Care Center - CAC Board
1	2	3	Health Foundation of South Florida
		3	Key West Police Department
1	2		Leadership Monroe County
		3	Monroe County Coalition
1		3	South Florida Behavioral Health
1			United Way of the Florida Keys
		3	Rural Health Network of Monroe County
		3	Veteran's Affairs
	2		Womankind

¹⁰ This list was generated by CHIP workgroups at the planning sessions; this is not an exhaustive list of all partners and resources. We invite you to consider how you can contribute to this effort, in whole or in part.