# 2021-2026 Martin County

## Community Health Improvement Plan

July 2021 - June 2026
Updated May 2024

Facilitated by: HCSEF Health Council of Southeast Florida

# TABLE OF CONTENTS

Table of Tables ... iv

Table of Figures ... iv

Executive Summary ... 5

DOH-Martin Public Health Leadership ... 6

Acknowledgements ... 8

Introduction ... 9

Capacity, Collaboration and Continued involvement ... 11

Mobilizing Action Through Planning and Partnership ... 12

- Overview of the 2020 CHA Process ... 13
  - MAPP Phase 1: Organizing for Success and Partnership ... 13
  - MAPP Phase 2: Visioning ... 13
  - MAPP Phases 3: The Four Assessments ... 14
- Overview of the 2021 CHIP Process ... 21
  - Phase 4: Identifying Strategic Issues ... 21
  - Phase 5: Developing Goals and Strategies ... 21
  - Phase 6: Action Cycle ... 23

Community Health Improvement Plan ... 25

- Purpose ... 25
- Methods ... 25

Strategic Health Priority and action plans ... 27

- Access to Health and Human Services ... 28
  - Access To Health and Human Services – Why Address It? ... 28
  - Access To Health and Human Services Priority Area Update – May 2024 ... 35
  - Access to Health and Human Services Priority Area Accomplishments ... 39
  - Access to Health and Human Services Priority Area Opportunities for Improvement and Next Steps ... 39
  - Best Practices and Evidence-Supported Initiatives ... 40
  - Community Resources ... 42
- Mental Health and Substance Use ... 45
  - Mental Health and Substance Use – Why Address It? ... 45
  - Mental Health and Substance Use Priority Area Update – May 2024 ... 49
  - Mental Health and Substance Use Priority Area Accomplishments ... 51

Mental Health and Substance Use Priority Area Opportunities for Improvement and Next Steps ....... 51
Best Practices and Evidence-Supported Initiatives ....... 52
Community Resources ....... 53
Economic and Social Mobility ....... 55
Economic and Social Mobility – Why Address It? ....... 55
Economic and Social Mobility Priority Area Update – May 2024 ....... 62
Economic and Social Mobility Priority Area Accomplishments ....... 65
Economic and Social Mobility Opportunities for Improvement and Next Steps ....... 65
Best Practices and Evidence-Supported Initiatives ....... 67
Community Resources ....... 68
Summary of Changes ....... 71
Community Engagement ....... 79
Using the Plan ....... 80
Appendices ....... 81
Appendix A: Martin County Community Health Advisory Council List ....... 81
Appendix B: Martin County Community Health Improvement Plan Policy/Law Review ....... 86
Get Involved! ....... 89

## TABLE OF TABLES

Table 1: Martin County Local Public Health Assessment ....................14
Table 2: Demographic and Socioeconomic Profile ....................15
Table 3: Health Status Profile....................16
Table 4: Health Resources Availability and Access....................18
Table 5: Developing Goals Facilitation Questions ....................21
Table 6: Developing Objectives Facilitation Questions....................22
Table 7: Developing Strategies and Activities Facilitation Questions....................23
Table 8: Implementing the Plan - The Action Cycle....................23
Table 9: Goals, Strategies, Objectives, and Activities for Priority Area #1 ....................28
Table 10: Access to Health and Human Services Progress....................35
Table 11: Goals, Strategies, Objectives, and Activities for Priority Area #2 ....................45
Table 12: Mental Health and Substance Use Progress ....................49
Table 14: Goals, Strategies, Objectives, and Activities for Priority Area #3 ....................56
Table 15: Economic and Social Mobility Progress....................62
Table 16: Top Community Supported Goals ....................79

## TABLE OF FIGURES

Figure 1:The Six Phases of the MAPP Process .................... 9
Figure 2: Healthy Martin County Vision ....................13
Figure 3: 2020 CSTA Themes....................20
Figure 4: Priority Area Refinement ....................22
Figure 5: Pentecostal Church of God Community Input Session ....................79

# EXECUTIVE SUMMARY

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

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

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

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

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

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

## DOH-MARTIN PUBLIC HEALTH LEADERSHIP

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

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

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

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

Alongside the Martin County Community Health Advisory Council, the DOH-Martin leadership team developed and refined the goals, objectives, and strategies outlined in the 2021 Martin County Community Health Improvement Plan to address the most pressing health and social service needs identified in the 2020 Martin County Community Health Assessment. This Plan incorporates goals and metrics into each evidence-informed strategy, program and policy selected.

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

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

# ACKNOWLEDGEMENTS

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

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

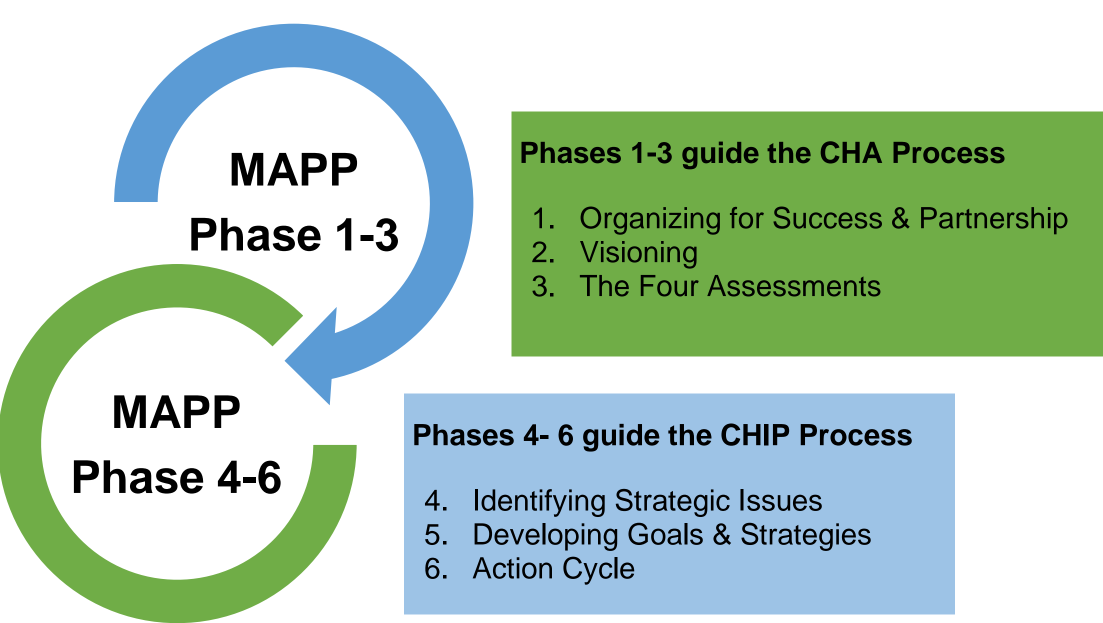
## INTRODUCTION

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

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

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

*Figure 1:The Six Phases of the MAPP Process*




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

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

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

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

## CAPACITY, COLLABORATION AND CONTINUED INVOLVEMENT

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

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

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

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

## MOBILIZING ACTION THROUGH PLANNING AND PARTNERSHIP

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

# OVERVIEW OF THE 2020 CHA PROCESS

## MAPP PHASE 1: ORGANIZING FOR SUCCESS AND PARTNERSHIP

Phase one of the MAPP process answers the following questions:

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

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

## MAPP PHASE 2: VISIONING

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

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

*Figure 2: Healthy Martin County Vision*

**2020 Healthy Martin County Vision**

A Martin County Community...

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

## MAPP PHASES 3: THE FOUR ASSESSMENTS

**Local Public Health System Assessment (LPHSA)**

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

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

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

*Table 1: Martin County Local Public Health Assessment*

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

| 10 | Research for new insights and innovative solutions to health problems | Moderate |
|---|---|---|

**Community Health Status Assessment (CHSA)**

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

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

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

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

*Table 2: Demographic and Socioeconomic Profile*

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

Table 3 highlights the health status profile of Martin County.

*Table 3: Health Status Profile*

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

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

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

*Table 4: Health Resources Availability and Access*

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

**Forces of Change Assessment (FOCA)**

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

The FOCA is designed to answer the following questions:

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

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

**Community Themes and Strengths Assessment (CTSA)**

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

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

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

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

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

*Figure 3: 2020 CSTA Themes*

## Community Strengths in Martin County

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

## Populations with unmet needs

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

## Key Health Issues

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

## Challenges & Opportunities for Improvement

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

# OVERVIEW OF THE 2021 CHIP PROCESS
## PHASE 4: IDENTIFYING STRATEGIC ISSUES

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

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

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

## PHASE 5: DEVELOPING GOALS AND STRATEGIES

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

*Table 5: Developing Goals Facilitation Questions*

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

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

*Table 6: Developing Objectives Facilitation Questions*

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

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

*Figure 4: Priority Area Refinement*

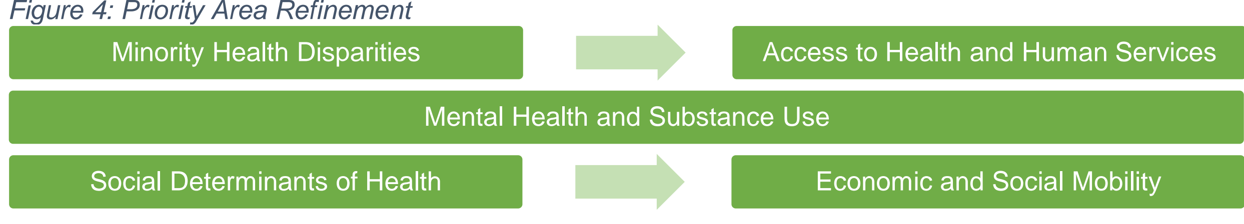


*Table 7: Developing Strategies and Activities Facilitation Questions*

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

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

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

## PHASE 6: ACTION CYCLE

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

*Table 8: Implementing the Plan - The Action Cycle*

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

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

# COMMUNITY HEALTH IMPROVEMENT PLAN

## PURPOSE

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

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

## METHODS

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

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

**Approach**

The intervention strategies in the CHIP attempt to:

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

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

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

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

## STRATEGIC HEALTH PRIORITY AND ACTION PLANS

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

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

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

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

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

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

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

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

# ACCESS TO HEALTH AND HUMAN SERVICES

## Access To Health and Human Services – Why Address It?

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

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

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

| **Priority Area 1: Access to Health and Human Services** |
|---|
| **Goal 1.A: Create a community where all Martin County residents have access to health and human services.** |
| **Strategy 1.A.1: Between July 1, 2021 – June 30, 2026, promote a community wide campaign to increase the awareness of low-to-no cost services available to Martin County residents, especially Hispanic and Spanish-speaking residents.** |

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

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

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

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

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

| **Objective 1.A.1: By June 30, 2026, reduce the proportion of Martin County residents, especially Hispanic residents, who cannot get medical care then they need it due to cost from 42.0% in 2016 to 32.0%.** | | | |
|---|---|---|---|
| **National/State Priorities Alignment: HP2030: AH-01, AHS-04, AHS-07, AHS-09. HP2020: AHS-1, AHS-5, AHS-6. SHIP: HE3.3.1.** | | | |
| **Activities** | **Key Action Steps** | **Measures** | **Key Partners** |
| **<u>Activity 1.A.1.1:</u>**<br><br>Create a social marketing awareness campaign targeting Martin County residents, especially Hispanic residents, and community stakeholders on low-to-no cost health and human services available in Martin County, including those in Spanish and available to undocumented individuals. | Research low-to-no cost health and human services in Martin County, including those tailored for Hispanic, undocumented, and Spanish-speaking residents.<br><br>Promote and distribute marketing material and the resource guide to service providers, community stakeholders, and community members. | Percent of residents who cannot get medical care when they need it.<br><br>Baseline: 42% of Hispanic Martin County residents could not see a doctor at least once in the past year due to cost, compared to 10.9% of White residents (Florida Health CHARTS, 2016)<br><br>Number of marketing material and resource guides distributed.<br><br>Baseline: 0 marketing material distributed (2021) | Florida Community Health Center<br><br>Volunteers in Medicine<br><br>Light of the World Little Light Dentistry<br><br>Florida Department of Health—Martin County<br><br>211 Palm Beach/Treasure Coast |
| **Strategy 1.A.2: Between July 1, 2021 – June 30, 2026, implement organizational processes to screen clients for insurance status and refer to health insurance enrollment services.** | | | |
| **Objective 1.A.2.1: By June 30, 2026, increase the proportion of Black Martin County residents with health insurance from 78.0% in 2019 to 83.0% and among Hispanic residents from 77.3% in 2019 to 82.3%.** | | | |

| **Objective 1.A.2.2: By June 30, 2026, increase the proportion of adults in Martin County who have a personal doctor from 77.6% in 2019 to 81.3%.** | | | |
|---|---|---|---|
| **National/State Priorities Alignment: HP2030: AHS-01, AHS-02. HP2020: AHS-1. SHIP: HE3.3.1.** | | | |
| **Activities** | **Key Action Steps** | **Measures** | **Key Partners** |
| **<u>Activity 1.A.2.1:</u>**<br><br>Engage health and human service providers throughout Martin County through professional networks. | Conduct outreach to health and human service providers around the importance of screening their clients for health insurance status and available benefits navigation services in the county. | Insurance enrollment numbers.<br><br>Baseline: 78% of Black and 77% of Hispanic Martin County residents are insured compared to 91% of White residents (Florida Health CHARTS, 2019)<br><br>Referrals for insurance enrollment with CACs.<br><br>Baseline: 0 referrals for insurance enrollments through this effort (2021) | Florida Community Health Center<br><br>Volunteers in Medicine<br><br>Light of the World Little Light Dentistry<br><br>Florida Department of Health—Martin County<br><br>Epilepsy Alliance Florida<br><br>Helping People Succeed |
| | Add and promote the addition of screening for health insurance status and medical home engagement on organization intake forms to identify the need for health insurance/benefits enrollment services. | | |
| **<u>Activity 1.A.2.2:</u>**<br><br>Provide information to residents to increase health insurance coverage (e.g., information on health insurance options, the enrollment process, and insurance enrollment resources) | Provide information to residents to increase health insurance coverage | | |

| Goal 1.B: Create a community where all Martin County residents have access to culturally and linguistically appropriate services. | | | |
|---|---|---|---|
| **Strategy 1.B.1: Between July 1, 2021 – June 30, 2026, promote a community wide campaign to increase the awareness of free and available diversity, cultural competency, and health literacy trainings among health and human service professionals throughout Martin County.** | | | |
| **Objective 1.B.1: By June 30, 2026, at least 100 health and human service professionals and paraprofessionals will complete cultural competency and health literacy trainings.** | | | |
| **National/State Priorities Alignment: HP2030: HC/HIT-D11. HP2020: HC/HIT-1.1. SHIP: HE1.1.** | | | |
| **Activities** | **Key Action Steps** | **Measures** | **Key Partners** |
| **Activity 1.B.1.1:**<br><br>Disseminate list of available cultural competency and diversity trainings to health and human service professionals. | Research and explore free and available cultural humility and diversity trainings and courses.<br><br>Promote and disseminate information on free and available trainings to health and human service professionals and agencies in Martin County. | Total lists distributed to agencies.<br><br>Baseline: 0 lists distributed to agencies (2021)<br><br>Total training sessions.<br><br>Total training participants.<br><br>Baseline: 22 Implicit Bias trainings in the Treasure Coast, 7 in Martin County (2020). | Martin County School District (Diversity Training Resources)<br><br>Tykes and Teens (Implicit Bias Trainings)<br><br>Florida Department of Health—Martin County |
| **Goal 1.C: Create a community where all Martin County residents live healthy, long lives.** | | | |
| **Strategy 1.C.1: Between July 1, 2021 – June 30, 2026, promote a community wide campaign to increase awareness of chronic disease self-management trainings.** | | | |
| **Strategy 1.C.2.: Between July 1, 2021 – June 30, 2026, promote policy recommendations to standardize evidence-based chronic disease management best-** | | | |

**practices across healthcare systems, with a focus on ensuring comprehensive disease management and prevention strategies to reduce health disparities.**

**Objective 1.C.1: By June 30, 2026, reduce the rate of hospitalizations from or with coronary heart disease among Black Martin County residents from 203.6 per 100,000 population in 2019 to 153.6.**

**Objective 1.C.2: By June 30, 2026, reduce the rate of hospitalizations from or with diabetes among Black Martin County residents from 3,648 per 100,000 population in 2019 to 3,548, and among Hispanic residents from 1,965 per 100,000 population in 2019 to 1,865.**

**National/State Priorities Alignment: HP2030: D-06, D-09, HDS-09. HP2020: D-2, D-7, HRQOL/WB-1.1. SHIP: CD1, CD2.**

| Activities | Key Action Steps | Measures | Key Partners |
|---|---|---|---|
| **<u>Activity 1.C.1.1:</u>**<br><br>Disseminate information to Black and Hispanic Martin County residents and community stakeholders on available chronic disease self-management trainings. | Research and explore free and available chronic disease self-management trainings for community members. | Rate of diabetes-related and coronary heart disease-related hospitalizations.<br><br>Baseline: Rate of hospitalizations among Black residents from or with coronary heart disease at 259 per 100,000 population, compared to 195 per 100,000 among White residents and 155 per 100,000 population among Hispanic residents (Florida Health CHARTS, 2019) | Florida Department of Health in Martin County<br><br>Area Agency on Aging<br><br>Cleveland Clinic at Treasure Coast Medical Pavilion<br><br>Cleveland Clinic and House of Hope (Fruit and Vegetable Rx)<br><br>University of Florida - Family Nutrition Health Eating Program<br><br>American Heart Association |
| | Develop a training catalog to be shared with Martin County residents. | | |
| | Dissemination methods will include engaging multiple sectors serving Martin County Black and Hispanic residents. | | |
| **<u>Activity 1.C.1.2:</u>**<br><br>Engage community agencies and stakeholders to serve as ambassadors and | Promotional methods will include engaging multiple sectors serving Martin County residents. | | |

| | | | |
|---|---|---|---|
| promote chronic disease self-management trainings among their client population. | Contact and ask local service providers to provide Martin County residents with information on available chronic disease self-management courses. | Baseline: Rate of hospitalizations from or with diabetes among Black residents at 3,648 per 100,000 population and Hispanic residents at 1965 per 100,000 population, compared to White residents at 1,176 per 100,000 population (Florida Health CHARTS, 2019)<br><br>Number of training catalogs distributed.<br><br>Baseline: 0 training catalogs distributed (2021).<br><br>Number of trainings or workshops held.<br><br>Number of community participants.<br><br>Baseline: 4 workshops, 42 participants (2020). | |
| **Activity 1.C.2.1**<br><br>Promote the implementation of policies and strategies in | Engage clinics to promote participation in Target: BP TM<br><br>Assist clinics in implementing blood | Number of clinics that have implemented evidence-based | American Heart Association |

| | | | |
|---|---|---|---|
| healthcare settings to integrate best practices in hypertension management. | pressure control quality improvement projects | blood pressure control policies | |
| **Activity 1.C.2.2**<br><br>Implement policies within healthcare organizations to integrate best practices in diabetes management and enhance the availability and accessibility of diabetes education and self-management programs. | Engage clinics to promote participation in Target Type 2 Diabetes SM<br><br>Assist clinics in implementing diabetes control projects | Number of clinics that have implemented evidence-based diabetes control policies and practices | American Heart Association |

## Access To Health and Human Services Priority Area Update – May 2024

The table below shows the progress that the Martin County Community Health Advisory Council has made In the Access to Health and Human Services Priority Area.

*Table 10: Access to Health and Human Services Progress*

| CHIP Priority Area: Access to Health and Human Services | | | | | | |
|---|---|---|---|---|---|---|
| **Objective** | **Responsible Partner** | **Baseline** | **Progress Measure** | **Plan Target** | **Trend** | **Status** |
| Objective 1.A.1: By June 30, 2026, reduce the proportion of Martin County residents, especially Hispanic residents, who cannot get medical care when they need it due to cost from 42.0% in 2016 to 32.0%. | • Florida Community Health Center<br>• Volunteers in Medicine<br>• Light of the World Little Light Dentistry<br>• Florida Department of Health – Martin County<br>• Epilepsy Alliance Florida<br>• 211 Palm Beach/Treasure Coast | 42.0% (2016) | 24.7% (2019) | 32.0% | ▼ | Objective is: Completed/Met – The proportion of Hispanic residents who cannot get care then they need it due to cost is has fallen below the target goal. Partners continue to work on action steps and activities in this area.<br>This objective focuses on Strategy 1.A.1 (promote a community wide campaign to increase the awareness of low-to-no cost services available to Martin County residents, especially Hispanic and Spanish-speaking residents). Partners have led a campaign to educate residents and stakeholders on low-to-no cost health and human services available in Martin County. As of this update, 3,909 marketing materials and resource guides have been distributed among service providers, community stakeholders, and community members. |
| Objective 1.A.2.1: By June 30, 2026, increase the proportion of Black Martin County residents with health insurance from 78.0% in 2019 to | • Florida Community Health Center<br>• Volunteers in Medicine | Black residents: 78.0% (2019) | Black residents: 85.1% (2021) | Black residents: 83.0% | ▲ | Objective is: On Track – The proportion of Black residents with health insurance has exceeded the target goal, and the proportion of Hispanic residents with health insurance has slightly decreased since baseline data collection. The partners continue to work on action steps and activities in this area to connect residents with health insurance. |

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|---|---|---|---|---|---|---|
| 83.0% and among Hispanic residents from 77.3% in 2019 to 82.3%. | • Light of the World Little Light Dentistry<br>• Florida Department of Health–Martin County<br>• Epilepsy Alliance Florida<br>• Helping People Succeed | Hispanic residents: 77.3% (2019) | Hispanic residents: 76.9% (2021) | Hispanic residents: 82.3% | ▼ | Partners need to identify opportunities to increase health insurance status among Hispanic residents.<br>This objective focuses on Strategy 1.A.2 (implement organizational processes to screen clients for insurance status and refer to health insurance enrollment services). Partners have engaged health and human services providers to disseminate information and create connections between residents and insurance enrollment assistance programs. As of this update, 2,296 referrals for insurance enrollment with Certified Application Counselors (CACs) and health insurance navigators have been made. |
| Objective 1.A.2.2: By June 30, 2026, increase the proportion of adults in Martin County who have a personal doctor from 77.6% in 2019 to 81.3%. | • To be determined | 77.6% (2019) | N/A | 81.3%. | *Pending data update* | This objective was approved for inclusion in the CHIP by the CHIP Advisory Council on May 15, 2024. Progress toward meeting this objective will be monitored and tracked from this date onward. |
| Objective 1.B.1: By June 30, 2026, at least 100 health and human service professionals and paraprofessionals will complete cultural competency and health literacy trainings. | • Martin County School District<br>• Tykes and Teens<br>• Florida Department of Health–Martin County | 7 (2021) | 293 (2024) | 100 | ▲ | Objective is: Completed/Met – The number of health and human service professionals and paraprofessionals who have been trained has exceeded the target goal. Partners continue to identify, participate in, and raise awareness about trainings.<br>This objective focuses on Strategy 1.B.1 (promote a community wide campaign to increase the awareness of free and available diversity, cultural competency, and health literacy trainings among health and human service professionals throughout Martin County). Partners have disseminated a list of available trainings to health and human service professionals. As of this update, 5 training catalogues were distributed, and 293 professionals were trained through 19+ trainings. |
| Objective 1.C.1.1: By June 30, 2026, reduce the rate of hospitalizations from or | • Florida Department of Health–Martin County | 203.6 (2019) | 196.8 (2022) | 153.6 | ▼ | Objective is: On Track – The rate of hospitalizations from or with coronary heart disease among Black Martin County residents has decreased since baseline data collection but has not yet met the target. Partners continue to focus on strategies and activities to improve this health outcome. |

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| with coronary heart disease among Black Martin County residents from 203.6 per 100,000 population in 2019 to 153.6. | • Area Agency on Aging<br>• Cleveland Clinic at Treasure Coast Medical Pavilion<br>• Cleveland Clinic and House of Hope (Fruit and Vegetable Rx)<br>• University of Florida - Family Nutrition Health Eating Program<br>• American Heart Association | | | | | This objective focuses on Strategy 1.C.1 (promote a community wide campaign to increase awareness of chronic disease self-management trainings), Strategy 1.C.2 (promote policy recommendations to standardize evidence-based chronic disease management best-practices across healthcare systems, with a focus on ensuring comprehensive disease management and prevention strategies to reduce health disparities), and Activity 1.C.2.1 (promote the implementation of policies and strategies in healthcare settings to integrate best practices in hypertension management). Partners have disseminated information to residents and community stakeholders on available chronic disease self-management trainings as well as engage community agencies and stakeholders to serve as ambassadors and promote chronic disease self-management trainings among their client population. As of this update, 15 chronic disease self-management trainings were held, and 62 residents were trained so far in the CHIP cycle. Additionally, 8 clinics have implemented evidence-based blood pressure control policies. |
| Objective 1.C.1.2: By June 30, 2026, reduce the rate of hospitalizations from or with diabetes among Black Martin County residents from 3,648 per 100,000 population in 2019 to 3,548, and among Hispanic residents from 1,965 per 100,000 population in 2019 to 1,865. | • Florida Department of Health in Martin County<br>• Area Agency on Aging<br>• Cleveland Clinic at Treasure Coast Medical Pavilion<br>• Cleveland Clinic and House of Hope (Fruit and Vegetable Rx)<br>• University of Florida - Family | Black residents: 3,648 per 100,000 (2019)<br><br>Hispanic residents: 1,965 per 100,000 (2019) | Black residents: 4,104 (2022)<br><br>Hispanic residents: 2,116.1 per 100,000 (2022) | Black residents: 3,548 per 100,000<br><br>Hispanic residents: 1,865 per 100,000 | ▲ | Objective Status: In Progress – The rate of hospitalizations from or with diabetes among Black and Hispanic residents has increased since the baseline year, highlighting additional efforts needed to reduce hospitalizations due to these conditions. In recognition of additional efforts needed to meet the target outlined, partners identified and adopted additional strategies and activities to reduce hospitalizations from or with diabetes.<br><br>This objective focuses on Strategy 1.C.1 (promote a community wide campaign to increase awareness of chronic disease self-management trainings) and Strategy 1.C.2 (promote policy recommendations to standardize evidence-based chronic disease management best-practices across healthcare systems, with a focus on ensuring comprehensive disease management and prevention strategies to reduce health disparities), and Activity 1.C.2.2 (Implement policies within healthcare |

| | | | | | | |
|---|---|---|---|---|---|---|
| | Nutrition Health Eating Program<br>• American Heart Association | | | | | organizations to integrate best practices in diabetes management and enhance the availability and accessibility of diabetes education and self-management programs). Partners adopted Strategy 1.C.2 and Activity 1.C.2.2 to build out efforts to reduce hospitalizations from or with diabetes, in recognition of additional support needed to address this health issue. Partners are continuing to share information about available chronic disease self-management training for residents. Community agencies and stakeholders have been engaged to serve as ambassadors to promote these trainings among their client population. As of this update, 15 chronic-disease self-management trainings were held, and 62 residents were trained so far in the CHIP cycle Additionally, 8 clinics have implemented evidence-based diabetes control policies and practices in the CHIP cycle. |

## Access to Health and Human Services Priority Area Accomplishments

Martin CHIP partners have made significant progress towards advancing the goals of the Access to Health and Human Services priority area. Among the accomplishments this year, partner efforts to increase health insurance coverage among Martin County residents have expanded. CHIP partners have worked to identify, refer, and raise awareness about resources within the community to assist residents with insurance enrollment to improve outcomes in this area. Notably, over 2,200 referrals for insurance enrollment with Certified Application Counselors (CACs) and health insurance navigators were made as a part of the CHIP efforts so far.

To better serve residents who are in need of this assistance, CHIP partners prioritized efforts to provide residents with information on health insurance coverage, including information on health insurance options, eligibility, the enrollment process, and insurance enrollment resources. Utilizing the wide network of the CHIP group, the partners increased their reach and worked to engage residents at various touchpoints, including during appointments and screenings. The partners expanded the activities in this priority area to build momentum behind efforts and to increase the tracking capabilities of this work. As the group moves forward, they will continue to monitor progress in this area and work together to identify and mitigate barriers that may be impacting health insurance enrollment among Martin County residents.

## Access to Health and Human Services Priority Area Opportunities for Improvement and Next Steps

Martin County CHIP partners have identified opportunities for improvement and outlined next steps to meet the goals of this priority area. One focus is on expanding efforts to promote medical home engagement. To this end, partners established a new CHIP objective aimed at increasing the proportion of adults in Martin County who have a personal doctor from 77.6% in 2019 to 81.3% by June 30, 2026. This indicator will provide insights into medical home engagement moving forward, as residents who have a personal doctor are more likely to experience benefits from continuity of care, such as long-term relationships with their provider and increased engagement in care.[6]

As a next step to work towards this target, partners discussed the need to increase awareness of available primary care services in the county, specifically those that provide care to individuals covered by Medicaid and residents who are uninsured, underinsured, and underserved. This includes promoting awareness of services offered through organizations such as Florida Community Health Centers, Inc. and Volunteers and Medicine. Additionally, as a next step, partners identified the need to identify and engage providers who offer healthcare services to these populations. The group will continue to work on these efforts in the next year of CHIP implementation.

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[6] Healthy People 2030. (n.d.). Increase the proportion of people with a usual primary care provider – AHS-07. https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality/increase-proportion-people-usual-primary-care-provider-ahs-07

## Best Practices and Evidence-Supported Initiatives

### Federally Qualified Health Care Centers

Low-income families and undocumented individuals, who are less likely to have a consistent source of medical care or to have visited a doctor in the past year as compared to the native U.S. population, may currently seek limited non-emergency care at community health centers or safety-net hospitals.[7] Federal grant funding is provided to support Federally Qualified Health Centers (FQHCs), which are community health centers that provide coverage for uninsured and underinsured individuals regardless of immigration status.[8] However, these facilities are limited in practice and scope—only 1,400 health centers are operating across the country to meet the needs of millions of uninsured families and undocumented individuals. As such, improving health care access among these vulnerable populations in Martin County is a key goal.

### Health Literacy Trainings

Factors influencing health care access also include health literacy. Health literacy is defined as "the ability to obtain, process, and understand basic health information and services to make appropriate health decisions" and is heavily influenced by education level.[9] Low health literacy is associated with delayed care-seeking, reduced number of preventative care visits, and increased number of emergency department visits for health care services.[10] Patients with low health literacy also tend to be diagnosed later and may have difficulty providing informed consent for treatment.[11]

Improving health literacy levels in Martin County is thus a crucial endeavor. To that end, previous research supports the use of health literacy trainings for health and human service professionals and patients as a useful strategy for increasing literacy levels.[12] Health literacy trainings for health and human service providers are warranted considering that providers often overestimate the clarity of their recommendations and underestimate their use of medical jargon during consultations.[13]

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

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

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

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

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

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

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

### Medical Interpreters and Cultural Sensitivity Trainings

Limited English proficiency (LEP) is another factor influencing health care access. Research has linked Low English literacy to lower healthcare service utilization rates and an increased likelihood of experiencing discrimination during healthcare encounters.[14] Language discordance between a patient and their provider has also been found to reduce patient satisfaction with their health care experience.[15] The use of interpreters to facilitate culturally and linguistically appropriate care and the promotion of cultural sensitivity training for health care professionals in Martin County are potential solutions.[16] [17]

### Chronic Disease Self-Management

Improving health care access can also work to reduce disparities in health outcomes. Black and Hispanic populations exhibit worse chronic disease management and health outcomes as compared to their White counterparts.[18] Existing research suggests that improved access to health care coverage may lead to improvements in managing chronic diseases among Black and Hispanic populations.[19] Previous research also indicates that chronic disease self-management trainings for patients and providers can be an effective tool for improving health outcomes for chronic diseases, such as diabetes and congestive heart failure.[20] [21]

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

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

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

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

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

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

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

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

## Community Resources

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

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

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

# MENTAL HEALTH AND SUBSTANCE USE

## Mental Health and Substance Use – Why Address It?

Untreated mental health conditions and substance use disorders can have devastating effects on an individual's physical and social well-being.[22] Mental health disorders are associated with reductions in life expectancy, quality of life, and financial stability. [23] [24] However, less than half of individuals with mental disorders and only one-tenth of those with substance use disorders receive any treatment.[25] And although health care coverage improves access to behavioral health and substance use disorder treatment, the uninsured rate remains higher among individuals with mental and substance use disorders.[26] Existing research suggests that individuals utilize mental health services more often when insured as opposed to uninsured.[27] As such, improving mental health and substance use treatment among the uninsured and underinsured in Martin County is a high priority.

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

*Table 11: Goals, Strategies, Objectives, and Activities for Priority Area #2*

| **Priority Area 2: Mental Health and Substance Use** |
|---|
| **Goal 2.A: Create a community where all Martin County residents are able to seek and receive mental health and substance use services.** |
| **Strategy 2.A.1: Between July 1, 2021 – June 30, 2026, promote a community wide campaign to increase awareness of available mental health providers and services throughout Martin County.** |

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

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

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

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

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

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

| **Objective 2.A.1: By June 30, 2026, increase the number of mental health providers available to serve uninsured and underinsured Martin County residents from 138.5 per 100,000 population in FY 20-21 to 153.5 per 100,000 population.** | | | |
|---|---|---|---|
| **Objective 2.A.2: By June 30, 2026, decrease the rate of hospitalizations for mental health disorders, especially among Black residents, from 1250.6 per 100,000 population in 2019 to 1150.6 per 100,000 population.** | | | |
| **National/State Priorities Alignment: HP2030: MHMD-04, MHMD-07. HP2020: MHMD-5, MHMD-6, MHMD-9, MHMD-10, HRQOL/WB-1.2. SHIP: BH1.2.** | | | |
| **Activities** | **Key Action Steps** | **Measures** | **Key Partners** |
| **<u>Activity 2.A.1.1:</u>**<br><br>Update, promote, and disseminate the local 211 Resource Guide to inform residents of currently available and accessible mental health and substance use services in Martin County. | Research current mental health providers available to provide services to uninsured and underinsured Martin County residents, including Federally Qualified Health Centers, school health clinics, and non-profit organizations.<br><br>Develop a referral process for mental health and substance use services.<br><br>Promote and distribute marketing material and the resource guide to service providers, community stakeholders, and community members. | Number of marketing material and resource guides distributed.<br><br>Baseline: 0 marketing material and resource guides distributed (2021).<br><br>Rate of Behavioral/Mental Health Providers in Martin County.<br><br>Baseline: Current rate of Behavioral/Mental Health Providers in Martin County at 141 per 100,000 population<br><br>Rate of mental health disorder-related hospitalizations. | Tykes and Teens<br><br>Coral Shores Behavioral Health<br><br>NAMI Martin County<br><br>Helping People Succeed<br><br>New Horizons<br><br>Suncoast Behavioral Health<br><br>Drug Abuse Treatment Association<br><br>Project LIFT |

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| | | Baseline: Age-adjusted mental health disorder hospitalizations at 1250.6 per 100,000 population for Black residents (Florida Health CHARTS, 2019) | |
| **Goal 2.B: Create a community where all Martin County residents are empowered to seek mental health services.** | | | |
| **Strategy 2.B.1: Between July 1, 2021 – June 30, 2026, promote a community wide campaign to increase awareness on mental health issues and normalize seeking services.** | | | |
| **Objective 2.B.1: By June 30, 2026, reduce the age-adjusted suicide death rate in Martin County from 16 per 100,000 population in 2019 to 12.5 per 100,000 population.** | | | |
| **National/State Priorities Alignment: HP2030: MHMD-04, MHMD-07. HP2020: MHMD-6, MHMD-9, MHMD-10, HRQOL/WB-1.2. SHIP: BH4.2.** | | | |
| **Activities** | **Key Action Steps** | **Measures** | **Key Partners** |
| **Activity 2.B.1.1:**<br><br>Research and utilize national, state, and/or local campaigns that are relevant to Martin County residents and community stakeholders to | Utilize national, state, and/or local campaigns that address mental health to reach residents through all avenues possible, including community events, local meetings, and other opportunities and earned media methods to normalize mental health seeking behaviors and mental health struggles. | Age-adjusted suicide death rate.<br><br>Baseline: Current age-adjusted suicide death rate at 16 per 100,000 population in Martin County compared to 14.5 | Martin County Health and Human Services<br><br>211 Palm Beach/Treasure Coast |

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| normalize mental health care seeking behaviors and mental health struggles through upstream approaches. | Promote and disseminate messaging on the importance of seeking mental health and counseling services. | per 100,000 population in Florida (Florida Health CHARTS, 2019)<br><br>Total reach of marketing awareness campaign.<br><br>Baseline: Total reach pending marketing awareness campaign launch (2021). | Area Agency on Aging and Morse Life<br><br>Love and Hope in Action (LAHIA)<br><br>Southeast Florida Behavioral Health Network<br><br>Martin County School Board<br><br>Cleveland Clinic and House of Hope Health Fairs |
| **<u>Activity 2.B.1.2:</u>**<br><br>By December 2023, create a social marketing campaign to address stigma among Martin County residents seeking help for mental health conditions. | | | |
| **<u>Activity 2.B.1.3:</u>**<br><br>Engage Martin County residents, providers, and first-responders in Mental Health First Aid (MHFA), QPR, and S.A.V.E courses. | Research and compile available training opportunities in Martin County.<br><br>Promote trainings among residents, providers, and first-responders.<br><br>Deliver trainings to residents, providers, and first-responders in the county. | Number of Martin residents trained in MHFA<br><br>Number of Martin residents trained in QPR<br><br>Number of Martin residents trained in S.A.V.E. | Community Health Advisory Council Partners<br><br>West Palm Beach VA Health Care System |

## Mental Health and Substance Use Priority Area Update – May 2024

The table below shows the progress that the Martin County Community Health Advisory Council has made In the Mental Health and Substance Use Priority Area.

*Table 12: Mental Health and Substance Use Progress*

| CHIP Priority Area: Mental Health and Substance Use | | | | | | |
|---|---|---|---|---|---|---|
| **Objective** | **Responsible Partner** | **Baseline** | **Progress Measure** | **Plan Target** | **Trend** | **Status** |
| Objective 2.A.1: By June 30, 2026, increase the number of mental health providers available to serve uninsured and underinsured Martin County residents from 138.5 per 100,000 population in FY 20-21 to 153.5 per 100,000 population. | • Tykes and Teens<br>• Coral Shores Behavioral Health<br>• NAMI Martin County<br>• Helping People Succeed<br>• New Horizons<br>• Suncoast Behavioral Health<br>• Drug Abuse Treatment Association<br>• Project LIFT | 138.5 per 100,000 population (FY 20-21) | 148.1 per 100,000 population (FY 22-23) | 153.5 per 100,000 population | ▲ | Objective 2.A.1 is: On Track – The rate of available mental health providers has increased since baseline data collection, although the target has not yet been reached. The partners are working on action steps and activities to increase the availability of mental health providers in Martin County.<br>Objective 2.A.2 is: In Progress – The rate of hospitalizations for mental health disorders has unfortunately increased since baseline data collection. The community is continuing intentional distribution of marketing materials and resource guides to increase awareness of mental health services in order to address this objective to reach their goal.<br>Both objectives focus on Strategy 2.A.1 (Promote a community wide campaign to increase awareness of available mental health providers and services throughout Martin County), including Activity 2.A.1.1 (Update, promote, and disseminate the local 211 Resource Guide to inform residents of currently available and accessible mental health and substance use services in Martin County). As of this update, the guide has been successfully reviewed and updated by partners, and 1,509 guides have been distributed to residents. |
| Objective 2.A.2: By June 30, 2026, decrease the rate of hospitalizations for mental health disorders, especially among Black residents, from 1250.6 per 100,000 population in 2019 to 1150.6 per 100,000 population. | | 1250.6 per 100,000 population (2019) | 1602.8 per 100,000 population (2022) | 1150.6 per 100,000 population | ▲ | |

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|---|---|---|---|---|---|---|
| Objective 2.B.1: By June 30, 2026, reduce the age-adjusted suicide death rate in Martin County from 16 per 100,000 population in 2019 to 12.5 per 100,000 population. | • Martin County Health and Human Services<br>• 211 Palm Beach/Treasure Coast<br>• Area Agency on Aging and Morse Life<br>• Love and Hope in Action (LAHIA)<br>• Southeast Florida Behavioral Health Network<br>• Martin County School Board<br>• Cleveland Clinic and House of Hope Health Fairs<br>• West Palm Beach VA Health Care System<br>• Community Health Advisory Council Partners | 16 per 100,000 population (2019) | 13.9 per 100,000 population (2022) | 12.5 per 100,000 population | ▼ | Objective 2.B.1 is: On Track – The suicide death rate has decreased since baseline data collection but has not yet reached the target.<br>This objective focuses on Strategy 2.B.1 (promote a community wide campaign to increase awareness on mental health issues and normalize seeking services), including Activity 2.B.1 (research and utilize national, state, and/or local campaigns that are relevant to Martin Couty residents and community stakeholders to normalize mental health care seeking behaviors and mental health struggles through upstream approaches), Activity 2.B.1.2 (by December, 2023, create a social marketing campaign to address stigma among Martin County residents seeking help for mental health conditions), and Activity 2.B.1.3 (engage Martin County residents, providers, and first-responders in Mental Health First Aid (MHFA), QPR, and S.A.V.E courses).<br>As of this update, the group has distributed a total of 1,991 Substance Abuse and Mental Health Services Administration (SAMHSA) Serious Mental Illness campaign resources and other materials to reach residents through all avenues possible, including community events, local meetings, and other opportunities and earned media methods to normalize mental health seeking behaviors and mental health struggles. Additionally, 2,537 residents have been trained in MHFA, 16 residents have been trained in QPR, and 20 residents have been trained in the VA S.A.V.E courses. |

## Mental Health and Substance Use Priority Area Accomplishments

Through collaborative efforts, the Martin County CHIP Advisory Council saw accomplishments within the Mental Health and Substance Use priority area. Partners increased marketing and distribution efforts across by continuously updating and sharing the local 211 Resource Guide and SAMHSA's Serious Mental Illness campaign with service providers, community stakeholders, and community members. Over time, such efforts work to normalize seeking services and increase awareness of mental health providers and resources available in the county with consistent messaging. Notably, as of Spring 2024, the group has distributed approximately 2,000 materials to reach residents and provide critical education and linkages to target populations.

Additionally, partners recognized an emerging need to address the suicide death rate in the county, and as a group they researched and developed a new activity to address this need. The CHIP partners analyzed the gaps in services and noted that peers and fellow residents could play a role in identifying and addressing suicide in the community. A collective focus was shifted to build community capacity to address this issue, and trainings such as Mental Health First Aid (MHFA), QPR, and S.A.V.E. were added to the CHIP in an effort to build this capacity. These educational opportunities offer an avenue for residents to not only build knowledge and awareness of the issue, but to also gain critical skills and insight to be able to prevent suicide in some instances. As new efforts in the CHIP, the group is eager to track progress in this area and continue to build capacity within the community to improve health outcomes.

## Mental Health and Substance Use Priority Area Opportunities for Improvement and Next Steps

The Martin County CHIP Advisory Council has made significant progress towards creating a community where all residents are able to seek and receive mental health and substance use services. In order to maintain the achieved successes and make further strides, partners continue to research and identify current mental health providers available to provide services to uninsured and underinsured Martin County residents, including Federally Qualified Health Centers (FQHCs), school health clinics, and non-profit organizations. These efforts will be particularly beneficial as partners further explore the potential of a referral platform to raise awareness of the available mental health providers and services in the community. The group will continue to work together to successfully connect residents to necessary services under the Mental Health and Substance Use umbrella and positively influence the outlined health indicators in this area.

Additionally, the group is taking next steps related to the recent addition of Mental Health First Aid (MHFA), QPR, and S.A.V.E. trainings to raise awareness about suicide and better equip residents with knowledge and skills related to prevention. The CHIP partners will be further disseminating this information to targeted resident groups. These efforts reflect the ongoing commitment of the CHIP partners to adapt, expand, and refine their strategies to meet community needs and drive change in areas related to mental health and substance use.

## Best Practices and Evidence-Supported Initiatives

### Primary Care and Emergency Service Screenings and Referrals

Increasing mental health screenings and creating a referral process are important strategies for addressing mental health in Martin County. Research has shown that mental health screenings increase identification and referrals related to mental illness.[28] Mental health and substance use disorder screenings by primary care providers and the use of care managers who can direct patients to appropriate resources have likewise been implicated in increased use of preventative services and improved health outcomes as compared to those treated without such a screening and evaluation process.[29] [30] Referrals from emergency care providers to outpatient medical follow ups have also demonstrated success.[31]

### Mental Health First Aid and Social Media Campaigns

One of the major barriers to receiving mental health treatment is the social stigma surrounding mental health treatment. Thus, reducing stigma regarding mental health and substance use treatment is crucial. Importantly, social media and informational campaigns have shown some promise as an effective way to increase awareness of mental health issues and reduce stigma surrounding mental health in ways that can increase treatment-seeking behaviors.[32] [33] Programs such as Mental Health First Aid have been shown to be effective at increasing knowledge regarding mental health, reducing stigma and negative attitudes against mental health, and increasing supportive behaviors towards individuals with mental health problems. [34]

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

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

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

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

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

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

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

## Community Resources

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

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

# ECONOMIC AND SOCIAL MOBILITY

## Economic and Social Mobility – Why Address It?

The benefits of financial well-being and stable employment are varied and plentiful. For instance, financial well-being makes it more likely that families will secure and maintain health insurance. To that point, 73.7% of uninsured nonelderly adults referenced an inability to afford health insurance as a reason for their lack of coverage according to the 2019 National Health Interview Survey.[35] Economic and social mobility is also correlated with the availability of reliable transportation and affordable housing.[36] Employment and financial stability can be pre-requisites for reliable transportation and vice-versa, underscoring the inter-related nature of quality of life and economic and social mobility. A lack of economic and social mobility opportunities is also correlated with increases in precarious employment, defined as the employment of workers who fill permanent job needs but are denied permanent employee rights.[37] Precarious employment is subsequently associated with increases in chronic stress and worse physical and mental health outcomes[38]. Moreover, historical legacies of redlining and zoning regulations have hindered economic and social mobility possibilities, particularly in minority communities.[39] The result of these discriminatory structural forces has been unequal distributions of education, health care, financial capital and other opportunities that are predominately determined by place. Addressing Martin County residents' transportation, employment, and financial stability to ensure social and economic mobility is thus a priority area.

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

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

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

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

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

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

*Table 13: Goals, Strategies, Objectives, and Activities for Priority Area #3*

| **Priority Area 3: Economic and Social Mobility** | | | |
|---|---|---|---|
| **Goal 3.A: Create a community where Martin County residents are financially thriving and employed.** | | | |
| **Strategy 3.A.1: Between July 1, 2021 – June 30, 2026, promote consistent information/material to Martin County residents on employment assistance, job training, and job fairs.** | | | |
| **Objective 3.A.1: By June 30, 2026, increase the percentage of population with income greater than 200% of poverty in Martin County from 73.6% in 2021, to 75.9%.** | | | |
| **Objective 3.A.2: By June 30, 2026, decrease the rate of unemployment in Martin County from 3.6% in 2021 to 2.4%.** | | | |
| **National/State Priorities Alignment: HP2030: SDOH-01, SDOH-02. HP2020: SDOH-1, SDOH-3. SHIP: HE3.1.** | | | |
| **Activities** | **Key Action Steps** | **Measures** | **Key Partners** |
| **<u>Activity 3.A.1.1:</u>**<br><br>Disseminate information to Martin County residents and community stakeholders on available employment assistance, job trainings, and job fairs. | Research available employment assistance, job training, and job fairs occurring in Martin County on an annual basis.<br><br>Develop a resource list and event schedule for dissemination to Martin County residents.<br><br>Engage service providers to promote CareerSource Research Coast resource list and schedule among their clients. | Number of resource lists and training/event schedules disseminated to residents.<br><br>Baseline: 189 resource lists and training/event schedules disseminated to residents (Oct- Dec 2022)<br><br>Number of residents who sought CareerSource Research Coast services. | CareerSource Research Coast<br><br>Martin County School District (College and Career Readiness)<br><br>Project Lift (Trades Training)<br><br>Love and Hope in Action (LAHIA; Culinary Arts Training)<br><br>Martin Board of County Commissioners (Vocational Training Center) |

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| | | Baseline: 63 residents sought CareerSource Research Coast services (Oct - Dec 2022)<br><br>Number of residents who were connected to employment opportunities through CareerSource Research Coast.<br><br>Baseline: 339 residents were connected to employment opportunities through CareerSource Research Coast (Oct - Dec 2022) | House of Hope (Soft-skills Training)<br><br>Helping People Succeed (Job Coaching and Employment)<br><br>Aging Resource Center of Martin County<br><br>Treasure Coast Food Bank |
| **Goal 3.B: Create a community where all Martin County residents are able to commute to work, school, health care appointments, and social events.** | | | |
| **Strategy 3.B.1: Between July 1, 2021 – June 30, 2026, support residents with attaining transportation to and from work and health care appointments.** | | | |
| **Objective 3.B.1: By June 30, 2026, increase the annual ridership of MARTY from 93,000 rides in 2020 to 97,650 and other transportation options from 9,330 rides in 2022 to 9,797 rides** | | | |
| **National/State Priorities Alignment: HP2030: EH-02. HP2020: SDOH-1, AHS-6.1. SHIP: ISV1.6.** | | | |
| **Activities** | **Key Action Steps** | **Measures** | **Key Partners** |
| **Activity 3.B.1.1:**<br><br>Disseminate information to | Engage service providers to promote MARTY program and other transportation services to their clients, via | Number of informational materials distributed. | 211 Palm Beach/Treasure Coast |

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| Martin County residents and community stakeholders on available MARTY programs and initiatives (information available in Spanish), including:<br>• Travel training for organizations, staff and clients<br>• Fare-free day<br>• Veteran door-to-door services (must complete applications and have proof of Veteran status) | social media accounts and other mechanisms. | Baseline: 0 informational materials distributed (2021)<br><br>Percent of ridership increase.<br><br>Baseline: 93,000 riders on fixed MARTY routes (2020)<br><br>Baseline: 9,330 riders on Other Transportation Options | MARTY<br><br>Love and Hope in Action (LAHIA; Doctor and Legal Appointment Rides)<br><br>Veteran Services<br><br>Kane Center<br><br>United Way of Martin County (Ride United Program)<br><br>Senior Resource Association |
| | Distribute MARTY program flyers, pamphlets, and brochures to service providers for dissemination to their clients. | | |
| **<u>Activity 3.B.1.2:</u>**<br><br>Disseminate information on transportation services and assistance provided by organizations in Martin County. | Research transportation services provided by organizations in Martin County. | | |
| | Update, promote, and disseminate the local 211 Resource Guides to inform residents of currently available and accessible transportation options in Martin County | | |
| | Engage service providers to promote 211 Resources | | |

| | (211 website catalog and printed Resource Guides) among their clients via social media and other mechanisms. | | |
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| **Strategy 3.B.2: Between July 1, 2021 – June 30, 2026, promote a community-wide campaign on transportation programs availability and eligibility requirements among Martin County residents to help improve access and environmental resiliency within underserved communities.** | | | |
| **Objective 3.B.2: By June 30, 2026, increase the number of transportation disadvantaged Martin County Residents enrolled with Martin County transportation agencies from 283 in 2021 to 297 residents.** | | | |
| **National/State Priorities Alignment: HP2030: EH-02. HP2020: SDHOH-1, AHS-6.1. SHIP: ISV1.6** | | | |
| **Activities** | **Key Action Steps** | **Measures** | **Key Partners** |
| **Activity 3.B.2.1:**<br><br>Disseminate information on Martin County transportation agencies to Martin County residents and community stakeholders. | Research Community Coach Program eligibility requirements, application process, and related material for distribution. | Referrals to Martin Community Coach among eligible participants.<br><br>Baseline: 0 referrals to Martin Community Coach among eligible participants through these efforts (2021)<br><br>Referrals to Veterans Transportation Program.<br><br>Baseline: 0 referrals to Veterans Transportation Program through these efforts (2023) | Martin Community Coach<br><br>Veterans Transportation Program<br><br>MARTY<br><br>Senior Resource Association |
| | Engage service providers to promote resource list among their clients via social media and other mechanisms and make referrals. | | |

| **Goal 3.C: Create a Martin County community where all residents have access to stable and affordable housing.** | | | |
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| **Strategy 3.C.1: Between July 1, 2021 – June 30, 2026, promote a community wide campaign to increase awareness of free and available financial literacy among Martin County residents.** | | | |
| **Objective 3.C.1: By June 30, 2026, decrease the percentage of housing cost-burdened households from 30.0% in 2021 to 29.0%.** | | | |
| **National/State Priorities Alignment: HP2030: SDOH-01. HP2020: SDOH-3. SHIP: HE3.1.** | | | |
| **Activities** | **Key Action Steps** | **Measures** | **Key Partners** |
| **Activity 3.C.1.1:** Promote financial literacy trainings among Martin County residents. | Research and explore free and available financial literacy trainings for community members. | Number of financial literacy trainings conducted. Number of training participants. Baseline: 17 unduplicated financial literacy trainings and 30 participants from March 1, 2019 to February 28, 2020. | House of Hope (Free financial literacy trainings) Indian River State College (IRSC) Center for Financial Literacy |
| | Develop a training calendar to be shared with Martin County residents. | | |
| | Dissemination methods will include engaging multiple sectors serving Martin County residents. | | |

| Strategy 3.C.2: Between July 1, 2021 – June 30, 2026, develop a unified referral process for existing housing services in Martin County. | | | |
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| **Objective 3.C.2: By June 30, 2026, decrease the estimate of those experiencing homelessness from 248 in 2022 to 236.** | | | |
| **National/State Priorities Alignment: HP2030: SDOH-04. HP2020: SDOH-4. SHIP: HE3.4.** | | | |
| **Activities** | **Key Action Steps** | **Measures** | **Key Partners** |
| **Activity 3.C.2.1:**<br><br>Engage community agencies and stakeholders to serve as ambassadors and promote and link clients to affordable housing and housing services. | Research and explore available affordable housing and housing services in Martin County.<br><br>Update, promote, and disseminate the local 211 Resource Guides to inform residents of currently available and accessible housing options in Martin County<br><br>Contact and ask local service providers to provide Martin County residents with information on available housing-related services. | Number of residents who receive information about affordable housing and housing services.<br><br>Baseline: 0 residents who received information about affordable housing through these efforts (2021)<br><br>Total homeless population.<br><br>Baseline: Homeless – 305 (2019); Severe Housing Problems – 30% (2017) (Florida Health CHARTS) | 211 Palm Beach/Treasure Coast<br><br>Elev8 Hope<br><br>House of Hope<br><br>Love and Hope in Action (LAHIA Project for Assistance for Transition and Homelessness) |

## Economic and Social Mobility Priority Area Update – May 2024

The table below shows the Martin County Community Health Advisory Council's progress in the Economic and Social Mobility Priority Area.

*Table 14: Economic and Social Mobility Progress*

| CHIP Priority Area: Economic and Social Mobility | | | | | | |
|---|---|---|---|---|---|---|
| **Objective** | **Responsible Partner** | **Baseline** | **Progress Measure** | **Plan Target** | **Trend** | **Status** |
| Objective 3.A.1: By June 30, 2026, increase the percentage of the population with income greater than 200% of poverty in Martin County from 73.6% in 2021 to 75.9%. | • CareerSource Research Coast<br>• Martin County School District<br>• Project Lift<br>• Love and Hope in Action<br>• Martin Board of County Commissioners<br>• House of Hope<br>• Helping People Succeed<br>• Aging Resource Center of Martin County<br>• Treasure Coast Food Bank | 73.6% (2021) | 74.5% (2022) | 75.9% | ▲ | Objective 3.A.1 is: On Track – The percentage of the population with income greater than 200% of the poverty level has increased since baseline data collection but has not yet reached the target. The partners are working on action steps and activities to impact this data.<br><br>Objective 3.A.2 is: On Track – The rate of unemployment has decreased since baseline data collection but has not yet reached the target. The partners are working on action steps and activities to continue efforts in this area.<br><br>Both objectives focus on Strategy 3.A.1 (promote consistent information/material to Martin County residents on employment assistance, job training, and job fairs) and Activity 3.A.1 (disseminate information to Martin County residents and community stakeholders on employment assistance, job training, and job fairs). As of this update, 3,218 residents received employment assistance/ job training information. Additionally, 2,388 residents sought CareerSource Research Coast services and 640 residents were connected to employment opportunities. |
| Objective 3.A.2: By June 30, 2026, decrease the rate of unemployment in Martin County from 3.6% in 2021 to 2.4%. | | 3.6% (2021) | 2.7% (2022) | 2.4% | ▼ | |

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| Objective 3.B.1 By June 30, 2026, increase the annual ridership of MARTY from 93,000 rides in 2020 to 97,650 and other transportation options from 9,671 rides in 2022 to 9,797 rides. | • MARTY<br>• United Way Martin County<br>• Martin MPO | 93,000 MARTY rides (Oct 2020 - Jun 2021)<br><br>9,671 Other Transportation rides (Jan - Dec 2022) | 101,241 MARTY Rides (Oct 2022 – Jun 2023)<br><br>23,635 Other Transportation rides (Jan – Dec 2023) | 97,650 MARTY rides<br><br>9,797 Other Transportation rides | ▲ | Objective 3.B.1 is: Completed/Met – Ridership of Marty and other transportation services has exceeded the target goals. The community is still working on action steps and activities to increase the ridership of MARTY and other transportation options in Martin County. Process measures are being tracked to continue to evaluate the group's impact in this area.<br><br>Partners have focused on Strategy 3.B.1 (support residents with transportation to and from work and health care appointments) to advance these efforts. Through partner collaboration, 2,146 residents received informational materials on transportation services and assistance provided by organizations in Martin County. |
| Objective 3.B.2: By June 30, 2026, increase the number of transportation disadvantaged Martin County Residents enrolled with Martin County transportation agencies from 283 in 2021 to 297 residents. | • Martin Community Coach Veterans Transportation Program<br>• MARTY<br>• Senior Resource Association | 283 residents (2021) | 829 residents (2023) | 297 residents | ▲ | Objective 3.B.2 is: Completed/Met – The number of transportation disadvantaged residents enrolled with Martin County transportation agencies has exceeded the target goals. The community continues to work on action steps and activities to increase enrollment in transportation programs for transportation-disadvantaged residents in Martin County.<br><br>Partners have focused on Strategy 3.B.2 (promote a community-wide campaign on transportation program availability and eligibility requirements among Martin County residents to help improve access and environmental resiliency within underserved communities). As of this update, Martin Community Coach has had 1,436 referrals and 27 new Martin resident veterans have registered with the Veterans Transportation Program. |

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| Objective 3.C. 1: By June 30, 2026, decrease the percentage of housing cost-burdened households from 30.0% in 2021 to 29.0%. | • House of Hope<br>• IRSC | 30.0% (2021) | 29.6% (2022) | 29.0% | ▼ | Objective 3.C.1 is: On Track – The percentage of housing cost-burdened households in Martin County has decreased since baseline data collection but has not yet reached the target. The community is continuing to work on action steps to continue addressing this objective to reach its goal.<br>To accomplish this objective, partners have focused on Strategy 3.C.1 (promote a community-wide campaign to increase awareness of free and available financial literacy among Martin County residents). In September of 2023, 1 financial literacy workshop (2-day series) was hosted by IRSC with 300 participants from across the Treasure Coast (Martin, Indian River, St. Lucie, and Okeechobee Counties). |
| Objective 3.C.2: By June 30, 2026, decrease the estimate of those experiencing homelessness from 248 in 2022 to 236. | • 211 Palm Beach/ Treasure Coast<br>• Elev8 Hope<br>• House of Hope<br>• Love and Hope in Action (LAHIA Project for Assistance for Transition and Homelessness) | 248 (2022) | 195 (2024) | 236 | ▼ | Objective 3.C.2 is On Track – The estimate of those experiencing homelessness in Martin County has fallen below the target. Partners continue to monitor and identify affordable housing options and housing services in Martin County.<br>Partners have worked towards Strategy 3.C.2 (develop a unified referral process for existing housing services in Martin County). The group is tracking process measures to understand the impact of this linkage process and increase community awareness of the 211 Resource Guide as a tool to connect with affordable housing. Through partner collaboration 3,065 marketing materials and 211 resource guides were distributed as a part of the CHIP efforts. |

## Economic and Social Mobility Priority Area Accomplishments

The Martin County Community Health Improvement Plan partners achieved notable successes in advancing transportation objectives within the Economic and Social Mobility priority area. Among their accomplishments are the significant increases in MARTY and other transportation option ridership. CHIP partners have worked to update marketing materials and enhance communication efforts to raise awareness of available transportation options among residents. In the most recent fiscal year, MARTY ridership reached an all-time high of over 100,000 rides provided. Concurrently, other transportation services saw an increase from 9,671 rides in 2022 to 23,635 rides in 2023, surpassing the target goal of 9,797 rides by 2026. United Way of Martin County's Ride United program noted great success in this area, as well. Through Ride United, residents can access Lyft services for education, employment, healthcare, and critical service needs. Participating agencies help residents with eligibility and transportation scheduling. In February 2024, there were 19 affiliated partners enrolled in the program. By May 2024, 28 partners were affiliated after an emphasis was placed on this through the CHIP efforts.

Furthermore, the CHIP partners actively supported the Martin Metropolitan Planning Organization's Transportation Development Plan (TDP), a comprehensive strategy to improve transportation based on community feedback. Community feedback was solicited through surveys and open-house events to enhance the transportation services in Martin County, a key component of this priority area. During the TDP initiatives, residents were encouraged to experience MARTY bus services firsthand, fostering familiarity and comfort with public transportation. The CHIP partners aided in promoting the TDP planning initiatives with residents. Ultimately, more than 700 surveys were completed and six successful open houses were conducted. Through these efforts, the CHIP partners are working to further engage residents in community health improvement processes.

## Economic and Social Mobility Opportunities for Improvement and Next Steps

The Martin County Community Health Improvement Plan partners have made significant progress towards ensuring Martin County residents' financial well-being and employment, and this group has outlined opportunities for improvement and next steps for the remainder of the CHIP cycle. Environmental resilience has become a new focus, particularly concerning ongoing transportation planning activities. Partners recognize that environmental threats and infrastructure changes can disproportionately affect transportation-disadvantaged individuals, leading to disruptions in accessing essential services and managing priorities. To address these challenges, partners actively reviewed existing environmental resiliency projects better to inform their efforts and priorities in this domain. As a next step, the partners will increase their focus on these areas in the next implementation year.

Looking ahead, the collaborative group is exploring opportunities to expand partnerships with additional coalitions and networks in the county. The group will collaborate with the Treasure Coast Homeless Services Council to understand factors that affect homelessness and the ability to be stably housed. Additionally, CHIP partners have discussed building on existing partnerships with Indian River State College Center for Financial Literacy to advance the CHIP goals related

to financial stability, recognizing the importance of empowering residents with essential financial skills. These endeavors reflect the ongoing commitment of the CHIP partners to adapt, expand, and refine their strategies based on annual reviews, capacity changes, and emerging priorities, ultimately striving towards comprehensive economic and social mobility within Martin County.

## Best Practices and Evidence-Supported Initiatives

### Transportation Support Services

Transportation services are a critical component to ensuring opportunities for stable employment, economic mobility, and health care. Evidence exists to support the use of bus passes for reliable transportation to employment locations resulting in improvements in quality of life, employment stability, and, thus, financial stability.[40] Transportation support services, including Uber Health, have also been found to have health benefits by facilitating attendance at health care appointments and increasing screenings for chronic diseases. [41] [42]

### Financial Literacy Trainings

Financial literacy and stable housing are other important variables with regards to economic and social mobility. Increasing financial literacy trainings in Martin County can be one way to improve financial decision-making and facilitate opportunities for economic mobility.[43]

### Housing Insecurity Referrals

Housing insecurity is another important determinant which threatens physical and psychological well-being as well as economic mobility.[44] Referral processes have shown promise for improving housing stability and may be beneficial to Martin County residents facing housing insecurity.[45]

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

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

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

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

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

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

## Community Resources

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

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

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

## SUMMARY OF CHANGES

| May 2024 |
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| The Access to Health and Human Services Goals, Strategies, Objectives, and Activities for Priority Area #1 Table was updated as follows:<br><br>• Strategy 1.A.1 was updated to include a specific timeframe (July 1, 2021 – June 30, 2026) (p. 28).<br>• Objective 1.A.1 was updated from "By 2025, reduce the proportion of Martin County residents, especially Hispanic residents, who cannot get medical care when they need it by 10%" to "By June 30, 2026, reduce the proportion of Hispanic Martin County residents who cannot get medical care then they need it due to cost from 24.7% in 2019 to 14.7%" (p. 29).<br>• Objective 1.A.2.1 was updated from "By 2025, increase the proportion of Martin County residents, especially Black and Hispanic residents, who have insurance and are engaged in care by 5%" to "By June 30, 2026, increase the proportion of Black Martin County residents with health insurance from 78.0% in 2019 to 83.0% and among Hispanic residents from 77.3% in 2019 to 82.3%" (p. 29).<br>• Strategy 1.A.2 was updated to include a specific timeframe (July 1, 2021 – June 30, 2026) (p. 29).<br>• Objective 1.A.2.2 was added to include "By June 30, 2026, increase the proportion of adults in Martin County who have a personal doctor from 77.6% in 2019 to 81.3%" (p. 30).<br>• Strategy 1.B.1 was updated to include a specific timeframe (July 1, 2021 – June 30, 2026) (p. 31).<br>• Objective 1.C.1 was updated from "By 2025, reduce the rate of hospitalizations from or with coronary heart disease among Black Martin County residents by 50 per 100,000 population" to "By June 30, 2026, reduce the rate of hospitalizations from or with coronary heart disease among Black Martin County residents from 203.6 in 2019 to 153.6." (p. 32).<br>• Objective 1.C.2. was updated from "By 2025, reduce the rate of hospitalizations from or with diabetes among Black and Hispanic Martin County residents by 100 per 100,000 population" to "By June 30, 2026, reduce the rate of hospitalizations from or with diabetes among Black Martin County residents from 3,648 in 2019 to 3,548, and among Hispanic residents from 1,965 in 2019 to 1,865" (p. 32).<br>• Strategy 1.C.1 was updated to include a specific timeframe (July 1, 2021 – June 30, 2026) (p. 31).<br>• Under Objective 1.C.1, the following activity was added "Promote the implementation of policies and strategies in healthcare settings to integrate best practices in hypertension management" (p. 33-34). |

- Under Objective 1.C.2, the following activity was added "Promote the implementation of policies and strategies in healthcare settings to integrate best practices in hypertension management" (p. 33-34).

The Mental Health and Substance Use Goals, Strategies, Objectives, and Activities for Priority Area #2 Table was updated as follows:

- Goal 2.A was updated from "Create a community where all Martin County residents are able to seek mental health and substance use services" to "Create a community where all Martin County residents are able to seek and receive mental health and substance use services" (p. 45).
- Strategy 2.A.1 was updated to include a specific timeframe (July 1, 2021 – June 30, 2026) (p. 45).
- Objective 2.A.1 was updated from "By 2025, increase the number of mental health providers available to serve the uninsured and underinsured Martin County residents by 15 per 100,000 population" to "By June 30, 2026, increase the number of mental health providers available to serve uninsured and underinsured Martin County residents from 138.5 per 100,000 population in FY 20-21 to 153.5 per 100,000 population" (p. 46).
- Objective 2.A.2 was updated from "By 2025, decrease the rate of hospitalizations for mental health disorders, especially among Black residents, by 100 per 100,000 population" to "By June 30, 2026, decrease the rate of hospitalizations for mental health disorders, especially among Black residents, from 1250.6 per 100,000 population in 2019 to 1150.6 per 100,000 population" (p. 46).
- Strategy 2.B.1 was updated to include a specific timeframe (July 1, 2021 – June 30, 2026) (p.47).
- Objective 2.B.1 "By December 2023, create a social marketing campaign to address stigma among Martin County residents seeking help for mental health conditions" was removed as an objective and will continue to be reported as Activity 2.B.1.2 (p. 47).
- Objective 2.B.2 was updated from "By 2025, reduce the age-adjusted suicide death rate in Martin County to be at least 2.0 less than the rate for Florida" to "Objective 2.B.1: By June 30, 2026, reduce the age-adjusted suicide death rate in Martin County from 16 per 100,000 population in 2019 to 12.5 per 100,000 population" (p. 47).
- Under Objective 2.B.1, the following Activity was added "Activity 2.B.1.3: Engage Martin County residents, providers, and first-responders in Mental Health First Aid (MHFA), QPR, and S.A.V.E. courses" (p. 48).
- Under Objective 2.B.1 and Activity 2.B.1.3, the following Action Steps were added: "(1) Research and compile available training opportunities in Martin County, (2) Promote trainings among residents, providers, and first-responders, and (3) Deliver trainings to residents, providers, and first-responders in the county" (p. 48).
- Under Objective 2.B.1 and Activity 2.B.1.3, the following Measures were added: "number of Martin residents trained in MHFA, number of Martin residents trained in QPR, and number of Martin residents trained in S.A.V.E." (p. 48).

- Under Objective 2.B.1, the following lead partner has been added: “West Palm Beach VA Health Care System” (p. 48).

The Economic and Social Mobility Goals, Strategies, Objectives, and Activities for Priority Area #3 Table was updated as follows:

- Strategy 3.A.1 was updated to include a timeframe (July 1, 2021 – June 30, 2026) (p. 56).
- Objective 3.A.1 “By 2025, 500 residents per agency annually will receive information about employment assistance and job training opportunities” was replaced with “By June 30, 2026, increase the percentage of population with income greater than 200% of poverty in Martin County from 73.6% in 2021, to 75.9%.” The original objective will continue to be tracked as an activity. (p. 56)
- Under Activity 3.A.1.1 “Disseminate information to Martin County residents and community stakeholders on available employment assistance, job trainings, and job fairs” all baseline measures were updated (p. 56)
- Objective 3.A.2 “By June 30, 2026, decrease the rate of unemployment in Martin County from 3.6% in 2021 to 2.4%” was added. (p. 56)
- The baseline number of residents connected to CareerSource Research Coast services was updated (p. 57)
- Strategy 3.B.1 was updated to include a timeframe (July 1, 2021 – June 30, 2026) (p. 57).
- Objective 3.B.1 “By 2025, increase the annual amount of MARTY and other transportation options by 5%” was updated to “By June 30, 2026, increase the annual ridership of MARTY from 93,000 rides in 2020 to 97,650 and other transportation options from 9,330 rides in 2022 to 9,797 rides.” (p. 57)
- Under Goal 3B, “Create a community where all Martin County residents are able to commute to work, school, health care appointments, and social events” the following Lead Agency updates were made:
    - IMOVEU was removed as a lead agency as the program is no longer operational. (p. 57)
    - United Way of Martin County’s Ride United Program was added as a lead agency (p. 58)
    - Senior Resource Association was added as a lead agency (p. 58)
- Strategy 3.B.2 was updated to include a timeframe (July 1, 2021 – June 30, 2026) and expanded to “Between July 1, 2021 – June 30, 2026, promote a community-wide campaign on transportation programs availability and eligibility requirements among Martin County residents to help improve access and environmental resiliency within underserved communities.” (p. 59).
- Objective 3.B.2 “By 2025, increase the number of transportation disadvantaged Martin County residents referred to Martin County transportation agencies by 5%” was updated to “By June 30, 2026, increase the number of transportation disadvantaged

Martin County Residents enrolled with Martin County transportation agencies from 283 in 2021 to 297 residents.” (P. 59)

- Under Goal 3C “Create a Martin County community where all residents have access to stable and affordable housing,” Indian River State College (IRSC) Center for Financial Literacy was added as a lead agency. (p. 60)
- Strategy 3.C.1 was updated to include a timeframe (p. 60).
- Objective 3.C.1 “By December 2023, improve financial literacy for Martin County residents, measured by pre- and post-test scores from free workshops” was replaced with “By June 30, 2026, decrease the percentage of housing cost-burdened households from 30.0% in 2021 to 29.0%.” (p. 60)
- Objective 3.C.2 “By 2025, a referral process will be identified to educate and link homeless and unstably housed individuals to affordable housing and housing services in Martin County” was removed as an objective and replaced with “By June 30, 2026, decrease the estimate of those experiencing homelessness from 248 in 2022 to 236.” (p. 61)

In the Economic and Social Mobility Area Community Resources table, relevant resources for and partner agencies descriptions were updated:

- IMOVEU was removed as the program has discontinued. (p.68)
- Information about the Veteran’s Transportation Program was added to the MARTY – Martin County Public Transit informational section. (p. 69)
- Information about Ride United was added to the Under United Way of Martin County informational section. (p. 70)

In each priority area section, a Progress Table was added with updated data to reflect the status of objectives, strategies, and activities in the priority area. (p. 35-38, p. 49-50, and p. 62-64)

In each priority area section, a narrative on accomplishments was added (p. 39, p. 51, and p. 65).

In each priority area section, a narrative on opportunities for improvement and next steps was added (p. 39, p. 51, and p. 65).

The Martin County Community Health Advisory Council List in the Appendix (Appendix A) has been updated to reflect the new partners engaged during the CHIP implementation phase (p. 81-85).

A Law and Policy Review Worksheet has been added in the Appendix section (Appendix B) to evaluate laws/policies related to the CHIP, and to inform decision-making when incorporating laws/policies into the CHIP (p. 86-88).

| May 2023 |
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| The Access to Health and Human Services Goals, Strategies, Objectives, and Activities for Priority Area #1 Table was updated to include additional Lead Community Partners.<br>• 211 Palm Beach/Treasure Coast (p. 29)<br>• Epilepsy Alliance Florida (p. 30)<br>• Helping People Succeed (p. 30)<br>• Florida Department of Health in Martin County (p. 31)<br>• American Heart Association (p. 32) |
| The Access to Health and Human Services Activity Progress Tracking section was updated with the most recent information related to each activity as of 2023 (p. 34-35). |
| The Access to Health and Human Services Objective Progress Tracking section was updated with the most recent data as of 2023 and associated progress updates were provided (p. 36-38). |
| Community Resources (p. 40-42)<br>• In this section, Epilepsy Alliance Jenson Beach was replaced with Epilepsy Alliance Florida. |
| The Mental Health and Substance Use Goals, Strategies, Objectives, and Activities for Priority Area #2 Table was updated as follows:<br>• Activity 2.A.1.1 was updated from "Develop a mental health and substance use counseling resource guide for referrals and dissemination to Martin County residents" to "Update, promote, and disseminate the local 211 Resource Guide to inform residents of currently available and accessible mental health and substance use services in Martin County" (p. 44)<br>• Baseline data for "Baseline: current mental health disorder hospitalizations at 1255 for Black residents compared to 871 per 100,000 for White residents (Florida Health CHARTS, 2019)" was updated from crude data (as originally published) to age-adjusted data to read, "Baseline: Age-adjusted mental health disorder hospitalizations at 1250.6 per 100,000 population for Black residents (Florida Health CHARTS, 2019)" (p. 44).<br>• Activity 2.B.1.1 was updated from "Create a marketing awareness campaign targeting Martin County residents and community stakeholders with messaging normalizing mental health care seeking behaviors and mental health struggles" to "Research and utilize national, state, and/or local campaigns that are relevant to Martin County residents and community stakeholders to normalize mental health care seeking behaviors and mental health struggles through upstream approaches" (p. 45) |

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| • Activity 2.B.1.1, Action Step 1 was updated from “Hire a marketing firm to create innovative approaches to address the stigma associated with mental illness and mental health care seek behaviors and educate martin county residents” to “Utilize national, state, and/or local campaigns that address mental health to reach residents through all avenues possible, including community events, local meetings, and other opportunities and earned media methods to normalize mental health seeking behaviors and mental health struggles” (p. 45). |
| The Mental Health and Substance Use Activity Progress Tracking section was updated with the most recent information related to each activity as of 2023 (p. 47). |
| The Mental Health and Substance Use Objective Progress Tracking section was updated with the most recent data as of 2023 and associated progress updates were provided (p. 48-49). |
| The Economic and Social Mobility Goals, Strategies, Objectives, and Activities for Priority Area #3 Table was updated as follows:<br><br>• Objective 3.A.1 was updated from “By 2025, 1,000 residents will receive information about employment assistance and job training opportunities” to “By 2025, 500 residents per agency annually will receive information about employment assistance and job training opportunities” (p. 54).<br>• Objective 3.A.1 was updated to add CareerSource Research Coast a Lead Community Partner (p. 54).<br>• Objective 3.A.1, Activity 3.A.1.1, Action Step 3 was changed from “Engage service providers to promote resource list and schedule among their clients” to “Engage service providers to promote CareerSource Research Coast resource list and schedule among their clients” and corresponding Process Measures “# of residents who sought CareerSource Research Coast services” and “# of residents who were connected to employment opportunities through CareerSource Research Coast” were included (p. 54).<br>• Objective 3.B.1.1 was updated from “By 2025, increase the annual amount of MARTY commuters by 5%” to “By 2025, increase the annual amount of MARTY and other transportation options by 5%” (p. 55).<br>• Objective 3.B.1.1 was updated to add 211 Palm Beach/Treasure Coast as a Lead Community Partner (p. 55).<br>• Objective 3.B.1.1, Activity 3.B.1.2, Action Step 2 was updated from “Develop a resource list for distribution to Martin County residents” to “Update, promote, and disseminate the local 211 Resource Guides to inform residents of currently available and accessible transportation options in Martin County” (p. 56).<br>• Objective 3.B.1.1, Activity 3.B.1.2, Action Step 3 was updated from “Engage service providers to promote resource list among their clients via social media and other mechanisms” to “Engage service providers to promote 211 Resources (211 website |

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| catalog and printed Resource Guides) among their clients via social media and other mechanisms" (p. 56).<br>• Objective 3.B.2.1 was updated from "By 2025, increase the number of transportation disadvantaged Martin County residents referred to the Martin Community Coach program by 5%" to "By 2025, increase the number of transportation disadvantaged Martin County residents referred to Martin County transportation agencies by 5%." (p. 56-57)<br>• Objective 3.B.2.1 was updated to add Martin Community Coach and Veterans Transportation Program as Lead Community Partners (p. 56-57).<br>• Objective 3.B.2.1, Activity 3.B.2.1 Process Measures were updated to include "# of referrals to the Veterans Transportation Program" (p. 57).<br>• Objective 3.C.2.1 was updated to add 211 Palm Beach/Treasure Coast as a Lead Community Partner (p. 58).<br>• Objective 3.C.2.1, Activity 3.C.2.1, Action Step 2 was updated from "Promotional methods will include engaging and disseminating information on available resources to multiple sectors serving Martin County residents" to "Update, promote, and disseminate the local 211 Resource Guides to inform residents of currently available and accessible housing options in Martin County" (p. 58). |
| The Economic and Social Mobility Activity Progress Tracking section was updated with the most recent information related to each activity as of 2023 (p. 59-60). |
| The Economic and Social Mobility Objective Progress Tracking section was updated with the most recent data as of 2023 and associated progress updates were provided (p. 61-62). |
| The Martin County Community Health Advisory Council List in the Appendix has been updated to reflect the new partners engaged during the CHIP implementation phase (p. 73-76). |
| **February 2022** |
| Phase 6: Action Cycle quarterly meetings were added to the CHIP process (p. 23)<br>• Also included in this section are descriptions on: 1) how the Martin County Community Health Advisory Council members review the latest data to review and reassess the CHIP priority areas and 2) the process for revising and updating the plan. |
| The Access to Health and Human Services Activity and Objective Progress Tracking section was added to the document (p. 34)<br>• In this section, a table highlighting activity progress and a table highlighting progress towards meeting objectives have been included. |

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| The Mental Health and Substance Use Activity and Objective Progress Tracking section was added to the document (p. 47)<br>• In this section, a table highlighting activity progress and a table highlighting progress towards meeting objectives have been included. |
| The Economic and Social Mobility Activity and Objective Progress Tracking section was added to the document (p. 59)<br>• In this section, a table highlighting activity progress and a table highlighting progress towards meeting objectives have been included. |
| The Summary of Changes section was added to the CHIP to highlight key changes to this evolving document over time (p. 66). |
| The Martin County Community Health Advisory Council List in the Appendix has been updated to reflect the new partners engaged during the CHIP implementation phase (p. 69). |

## COMMUNITY ENGAGEMENT

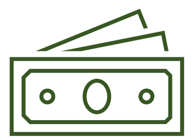
During May 2021, HCSEF conducted four Community Input meetings across Martin County to provide community members and Martin County residents the opportunity to participate in the CHIP process. HCSEF selected communities to host these sessions with a large racial or ethnic minority population, low-socioeconomic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

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

*Figure 5: Pentecostal Church of God Community Input Session*

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

*Table 15: Top Community Supported Goals*

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

## USING THE PLAN

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

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

# APPENDICES

## APPENDIX A: MARTIN COUNTY COMMUNITY HEALTH ADVISORY COUNCIL LIST

| Martin County Community Health Advisory Council | | |
|---|---|---|
| **First Name** | **Last Name** | **Agency** |
| Agnieszka | Marshall | Tykes & Teens, Inc |
| Alejandra | Dixon | Florida Department of Health in Martin County |
| Alessandro | Anzalone | Indian River State College |
| Alicia | Rolle | Sexual Assault Assistance Program of the Treasure Coast |
| Allison | Jimenez | Hanley Foundation |
| Althea | Jefferson | Village of Indiantown |
| Andrea | Greenlee | Tykes & Teens, Inc |
| Angela | Hoffman | Chamber of Commerce (Career Connect) |
| Angela | Bosman | Senior Resource Association, Inc. |
| Angelica | Castillo DaSilva | Florida Department of Health in Martin County |
| Anna | Harper | Sunshine Health |
| Anne | Posey | Tykes & Teens, Inc |
| Annette | Lopez | Kane Center/ Council on Aging of Martin County |
| Anthony | Dowling | Village of Indiantown |
| Araceli | Archuleta | Florida Department of Health in Martin County |
| Audrey | Burzynski | Hobe Sound Resident |
| Ben | Hogarth | City of Stuart |
| Ben | Earman | Senior Resource Association, Inc. |
| Blaine | Albright | Christ Fellowship Church |
| Bob | Zaccheo | Project LIFT |
| Bonnie | Russo | Helping People Succeed |
| Brandi | Ikner | Helping People Succeed |
| Brenda | Matheny | Florida Department of Health in Martin County |
| Brenda | Dickerson | Love and Hope in Action (LAHIA) |
| Brittani | Jean-Philippe | American Heart Association |
| Caitlynne | Palmieri | Boys & Girls Club of Martin County |
| Carol | Fiddis | DATA |
| Carol | Wegener-Vitani | Florida Department of Health in Martin County |
| Carol | Houwaart-Diez | United Way of Martin County |
| Caroline | Valencia | March of Dimes |
| Cecilia | Escorbore | Florida Community Health Centers |
| Cecilia | Baez | West Palm Beach VA Health Care System |
| Chad | Adcock | 211 Palm Beach/Treasure Coast |

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| Charlene | Lyons | YMCA Treasure Coast |
| Chris | Kammel | Martin County Fire Rescue |
| Chris | Jackson | Project LIFT |
| Chris | Stephenson | Senior Resource Association, Inc. |
| Christine | Palaez-Peña | The Health Insurance Navigation Program through Epilepsy Alliance Florida |
| Claudia | Lawler | Easterseals Florda/Treasure Coast Early Steps Program |
| Craig | Perry | Treasure Coast Hospice |
| Daniza | Robinson | Florida Department of Health in Martin County |
| Darryl | Houston | Community Foundation of Palm Beach & Martin Counties |
| David | Hafner | UF/IFAS Extension Martin 4-H |
| Deborah | Resos | Village of Indiantown - Parks |
| Deirda | Kinnaman | House of Hope/Golden Gate Center |
| Denise | Natalizio | Communities Connected for Kids |
| Denise | Lasarte | Healthcare Navigation Program |
| Diana | Gomez | AmBetter |
| Diana | Padgett | Florida Community Health Centers |
| Diana | Owens | Martin County Black Heritage Initiatives (MCBHI) |
| Don | Hill | Area Agency on Aging Palm Beach/Treasure Coast |
| Donna | Gardner | Mary's Home |
| Doug | Smith | Martin County Board of County Commissioners |
| Dr. Jennifer | Doak, PhD | Indian River State College |
| Dr. Maria | Salome E. Davis | Indian River State College |
| Dr. Terri | Graham | Indian River State College |
| Dwanne | Clayton | Palm Beach Neuroscience Institute |
| Frederick | Borowicz | West Palm Beach VA Health Care System |
| Gabriela | Munden | Florida Department of Health in Martin County |
| Gabriela | Chavez-Munden | Florida Department of Health in Martin County |
| Gail | Harvey | Tent City Helpers |
| Gary | Coney | DATA |
| Gina | Masters | Chamber of Commerce (Career Connect) |
| Henry | Estrada | Martin County Parks and Recreation |
| Herla | Arteche | Career Source Research Coast |
| Heyward | Silcox | Love and Hope in Action (LAHIA) |
| Holly | Forde | Martin County Community Action Coalition |
| Jackie | Clarke | Florida Department of Health in Martin County |
| Jacklyn | Rivera | Martin County |
| Jaclyn | Anez | United Way of Martin County |
| Jaime | Franqui | Cleveland Clinic |
| Jamie | Highberg-Romero | The Health Insurance Navigation Program through Epilepsy Alliance Florida |

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| Janet | Cooper | Helping People Succeed |
| Janet | Hernandez | Village of Indiantown Council |
| Janice | Greller | NAMI Treasure Coast |
| Jay | Biscanin | Tykes & Teens, Inc |
| Jay | Spicer | Martin County Fair Association Inc |
| Jeff | Marquis | The Salvation Army |
| Jennifer (Jenny) | Buntin | UF/IFAS Family Nutrition Program |
| Jenny | Ojeda | Hobe Sound Community Chest |
| Jerry | Gore | Pentecostal Church of God in Stuart/ Hands of Hope |
| Jessica | Tharp | City of Stuart |
| Jill | Taylor | Martin County Healthy Start Coalition |
| Jimmy | Smith | Martin NAACP |
| Joanne | Sweazey | Hope Center for Autism |
| Joe | Malaterra | Boys Town South Florida |
| Joe | Azevedo | Career Source Research Coast |
| Joe | Flanagan | Resident |
| Kaley | Newby | 211 Palm Beach/Treasure Coast |
| Karen | Gitlin | DATA |
| Karen | Ripper | The Council on Aging of Martin County, The Kane Center |
| Karlette | Peck | The Healing Center of Martin County |
| Katherine | Kennedy | Martin County Human Services |
| Kathleen | Murphy Smith | NAMI Treasure Coast |
| Kellie | Hensley | Cleveland Clinic |
| Kim | Tolbert | Salvation Army |
| Kim | Ouellette | Volunteers in Medicine |
| Kimberly | Moore | UF/IFAS Family Nutrition Program |
| Kraig | McHardy | Who Got Game |
| Krista | Puente Trefz, PsyD | Baytree Behavioral Health |
| Laura | Contrera | Boys & Girls Club of Martin County |
| Laura | Kremer | MorseLife |
| Lesley | Frederick | House of Hope |
| Lesley | Vestrich | The Council on Aging of Martin County, The Kane Center |
| Lesli | Ahonkhai | Florida Department of Health in Martin County |
| Leslie | McKay | Florida Department of Health in Martin County |
| Lia | Fields | Big Brothers Big Sisters Palm Beach and Martin County |
| Linda | Roman | Community Foundation of Palm Beach & Martin Counties |
| Linda | Shaifer | The Health Insurance Navigation Program through Epilepsy Alliance Florida |
| Lori | Sang | Light of the World Charities |
| Luci | Delgado | Treasure Coast Food Bank - Whole Child Connection |
| Lucine | Martens | The Martin Metropolitan Planning Organization (MPO) |

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| Lydia | Chappell | YoungLife |
| Lynn | Frank | Health Council of Southeast Florida |
| Margaret (Peggy) | Brassard | Martin County Public Transit |
| Maria | Romo | Suncoast Mental Health Center |
| Mark | Sandler | Acuitim |
| Maryann | Diaz | Florida Rural Legal Services |
| Marybeth | Peña | Hope Center for Autism |
| Maureen | McCarthy | Area Agency on Aging Palm Beach/Treasure Coast |
| McKenzie | O'Neal | Area Agency on Aging Palm Beach/Treasure Coast |
| Michelle | Vicat | City of Stuart |
| Michelle | Cuba | Indian River State College |
| Michelle | Miller | Martin County Health and Human Services |
| Mike | Mortell | City of Stuart |
| Mike | Readling | Habitat for Humanity Martin County |
| Monserrath | Rodriquez | Helping People Succeed |
| Myra | Howie | Florida Community Health Centers |
| Myralda | Jerome | Helping People Succeed |
| Nancy | Yarnall | Area Agency on Aging Palm Beach/Treasure Coast |
| Natalie | Eno | Easterseals Florda/Treasure Coast Early Steps Program |
| Natasha | Serra | IMOVEU |
| Natasha | Ramlagan | Jackson Drugs LLC |
| Niccole | Smith | Area Agency on Aging Palm Beach/Treasure Coast |
| Nicholas | Clifton | Florida Department of Health in Martin County |
| Nicole | King | Children's Services Council of Martin County |
| Octavio | Reis | Tent City Helpers |
| Pat | Houston | IRMO Early Learning Coalition |
| Patricia | Brown | Boys & Girls Club of Martin County |
| Patsy | Lindo-Wood | Florida Department of Health in Martin County |
| Peggy | Hetherington | Love and Hope in Action (LAHIA) |
| Phyllis | Brown | Resident |
| Rachel | Terlizzi | United Way of Martin County |
| Renay | Rouse | Florida Department of Health in Martin County |
| Richard | Reilly | Martin County Library System |
| Robert | Ranieri | House of Hope/Golden Gate Center |
| Robert | Griggs | YMCA Treasure Coast |
| Ruby | Aguirre | Treasure Coast Food Bank - Whole Child Connection |
| Samantha | Suffich | Healthy Start of Martin County |
| Sarah | Henry | Catch the Wave of Hope |
| Sellian | Cruz | Martin County Healthy Start Coalition |
| Shannon | Wilson | Helping People Succeed |
| Shauna | Young | Florida Department of Health in Martin County |
| Sheree | Wolliston | American Heart Association |

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| Sherry | Siegfried | Treasure Coast Food Bank and Florida KidCare Coalition |
| Taisha | Pierre Merite | Hanley Foundation |
| Terri | Graham | Indian River State College |
| Terrico | Poteate | The Council on Aging of Martin County, The Kane Center |
| Tracee | Diaz | Southeast Florida Behavioral Health Network (SEFBHN) |
| Tracy | Bryant | Village of Indiantown |
| Valerie | Graham | Quit Doc/Tobacco Free Partner |
| Vanessa | Camacho | Florida Community Health Centers |
| Veronica Benjamin | Valdez | Resident |
| Vilma | Smith | Florida Department of Health in Martin County |
| Wendy | Rene | Safespace |
| William | Blum | Martin County |
| Xenobia | Poitier-Anderson | E & R Religious Leadership Consulting |
| Yvette | Gregory | Love and Hope in Action (LAHIA) |
| Yvette | Goodiel | US/IFAS Extension Martin County |

## APPENDIX B: MARTIN COUNTY COMMUNITY HEALTH IMPROVEMENT PLAN POLICY/LAW REVIEW

A policy review was conducted on the Target: BP™ program in 2024 to understand evidence-based practices, impacts, stakeholder input, and methods of distribution. The following policy review analyzes the Target: BP™ work and the policy efforts that are a part of this initiative.

| Requirement | Martin County CHIP Policy Review: *Target: BP™* |
|---|---|
| **Review of evidence-based practices, promising practices, or practice-based evidence used.** | **Describe how the health department considered evidence-based practices, promising practices, or practice-based evidence. This may include a comparison to other similar laws/policies, the use of model laws/policies, or an analysis of laws.**<br><br>Target: BP™ is an evidence-based practice that utilizes policy as one component to drive change. It strives to help health care organizations improve blood pressure control through clinical redesign and quality improvement.[46] At the national level, the American Heart Association and the American Medical Association launched Target: BP™ in 2017 to address the high prevalence of uncontrolled blood pressure in the United States. Notably, Target: BP™ emphasizes positive health outcomes for all.[2] In Martin County, Target: BP™, with a focus on policy work, was integrated into the Martin County CHIP in 2024.<br><br>Target: BP™ uses the American Medical Association MAP framework to assist health care teams in organizing evidence-based care while providing resources, professional education, and practice tools to help these organizations improve and sustain blood pressure control. MAP stands for measure accurately, act rapidly, partner with patients. The MAP framework is part of the American Medical Association's MAP BP, which is an evidence-based QI program that has been proven to demonstrate sustained improvement in blood pressure control. The use of this model and its components have been influential in the Target: BP™ work.[2]<br><br>Notably, Target: BP™ is rooted in the 2017 AHA/American College of Cardiology Hypertension Guideline, scientific statements, and peer-reviewed publication. [47] This is important when considering evidence-based practices and the use of model work to drive change in Martin County. |

[46] Valerio-Shewmaker, M. A., Heredia, N. I., Pulicken, C., Mathews, P. D., Chenier, R., Swoboda, T. L., Garza, E. R., Velasco-Huerta, F., & Fernandez, M. E. (2022). Using implementation mapping for the adoption and implementation of Target:BP in community health centers. Frontiers in public health, 10, 928148. https://doi.org/10.3389/fpubh.2022.928148

[47] Smith, A. P., Overton, K., Rakotz, M., Wozniak, G., & Sanchez, E. (2023). Target: BP™: A National Initiative to Improve Blood Pressure Control. Hypertension (Dallas, Tex. : 1979), 80(12), 2523–2532. https://doi.org/10.1161/HYPERTENSIONAHA.123.20389

| Requirement | **Martin County CHIP Policy Review:** *Target: BP™* |
|---|---|
| **Assessment of the impacts of the policy or law on health barriers** | **Assess whether the laws/policies have a disproportionate effect on one or more subpopulations within the jurisdiction.**<br><br>The stakeholders in this work have a focus on assessing the impacts of these policies on health barriers. This initiative was developed with all populations in mind, focusing on efforts to ensure there are not disproportionate effects on subpopulations. Partners in this work, including the American Heart Association, are using policy, systems, and environmental changes at the national, state, and local level to address the root causes of these health outcomes. Notably, the American Heart Association is leveraging partnerships with the American Medical Association to improve blood pressure diagnosis and control in clinical settings through the Target: BP™ work in Martin County. The American Heart Association is also supporting efforts to expand access to blood pressure monitoring services through public policy and private payors, and supporting clinics in Martin County, including Federally Qualified Health Centers, to improve clinical blood pressure measuring and management in Martin County. Furthermore, they are also connecting community organizations, such as faith-based and workplace settings, with the tools and resources needed to support their members in self-monitoring and connecting them to care. All these efforts focus on mitigating any potential disproportionate effects.<br><br>Within the CHIP, this work strives to drive change in an effort to reduce the rate of hospitalizations from or with coronary heart disease among Black Martin County residents by increasing the number of clinics participating in Target: BP™ and increasing the number of clinics that achieve Silver, Gold, or Gold+ Level in Target: BP™. As a note, these achievements are part of the Target: BP™ recognition program, which celebrates physician practices and health systems for completing evidence-based blood pressure activities and achieving certain blood pressure control rates within the population they serve. These efforts emphasize understanding clinic populations and meeting their needs to improve health outcomes, giving careful consideration to factors that can help eliminate health barriers for groups. Additionally, through this work, the partners hope to support two Martin County clinics with implementing blood pressure control quality improvement projects. As this work progresses, impact assessments will be conducted to further understand any barriers or disproportionate effects so those can be addressed through program pivots throughout implementation.<br><br>The partners expect to see more evidence of impact over the next few years as this work becomes more and more established in the local |

| Requirement | Martin County CHIP Policy Review: *Target: BP™* |
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| | community. The key stakeholders continue to look at data to understand where emerging needs are so they can increase access for those populations in intentional and thoughtful ways. |
| **Input gathered from stakeholders or strategic partners** | **Describe how input was gathered from community stakeholders or partners.**<br><br>The Target: BP™ approach focuses on building community clinic capacity to implement and maintain guideline-based care and monitoring to improve patient outcomes.[48] As such, the involvement of clinical stakeholders is critical in this work. At the national level, an advisory group of diverse, multidisciplinary thought leaders including physicians, nurse practitioners, nurses, pharmacists, and physician assistants provides ongoing guidance for the program. [49] At the local level, the American Heart Association meets with clinical leadership, clinicians, and care coordinators to review chronic condition control rates and identify gaps and opportunities for improvement in internal practices and policies. The Martin County Community Health Improvement Plan partners have also been engaged in this work to provide input and create connections in this work as a part of the CHIP efforts outlined in the most recent version of the Action Plan. |
| **Method of distribution (i.e., how the information was shared with policymakers)** | **Method of distribution**<br><br>The primary method of distribution for this information is through meetings with clinic leadership, clinicians, and care coordinators who have the authority to develop and implement these policies in their facilities. The American Heart Association has also embedded activities within the recognition program that focus on raising awareness of these policies and best practices at the state level. Furthermore, as a newer addition to the Martin County CHIP this year, the local methods of distribution will be expanded with the participation and support of the Martin County Community Health Improvement Advisory Council group. This is an opportunity for the next year of implementation in the Martin County CHIP. As one of the key efforts in the CHIP, the group, made up of stakeholders from various sectors of the Local Public Health System, has discussed this topic and its impact on access to care and improved health outcomes for residents. Ultimately, through these discussions and partnerships, the group hopes to increase education and awareness of these policies and their benefit to the community and encourage adoption among other service providers to strengthen the system. |

[48] Valerio-Shewmaker, M. A., Heredia, N. I., Pulicken, C., Mathews, P. D., Chenier, R., Swoboda, T. L., Garza, E. R., Velasco-Huerta, F., & Fernandez, M. E. (2022). Using implementation mapping for the adoption and implementation of Target:BP in community health centers. Frontiers in public health, 10, 928148. https://doi.org/10.3389/fpubh.2022.928148

[49] Smith, A. P., Overton, K., Rakotz, M., Wozniak, G., & Sanchez, E. (2023). Target: BP™: A National Initiative to Improve Blood Pressure Control. Hypertension (Dallas, Tex. : 1979), 80(12), 2523–2532. https://doi.org/10.1161/HYPERTENSIONAHA.123.20389

## GET INVOLVED!

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

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

**Carol Wegener-Vitani, RN**
Health Officer/Administrator
Florida Department of Health in Martin County
Carol.Wegener-Vitani@flhealth.gov
772.221.4000 ext. 2129

**Renay Rouse**
Public Information Officer
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772.631.6008