Board of County Commissioners
Leon County, Florida

Tallahassee Memorial HealthCare 2025 Community Health Needs Assessment Workshop

Tuesday,
October 27, 2026
1:00 p.m.

Judge Augustus D. Aikens, Jr. Courthouse
County Commission Chambers, 5th Floor
301 S. Monroe St. Tallahassee, FL 32301

The media and the public can access the meeting in real time on Comcast channel 16, the Leon County Florida channel on Roku, the County's Facebook page, YouTube channel, Twitter and County web site.

Leon County
Board of County Commissioners

Notes for Workshop
Agenda Item #1

Leon County Board of County Commissioners

Healthcare Workshop Item

October 27, 2026

To: Honorable Chairman and Members of the Board

From: Vincent S. Long, County Administrator

Title: Healthcare Workshop on Leon County Efforts Related to the Tallahassee Memorial HealthCare 2025 Community Health Needs Assessment with Healthcare Partners

Review and Approval:	Vincent S. Long, County Administrator
Department / Division Review:	Ken Morris, Assistant County Administrator Shington Lamy, Assistant County Administrator
Lead Staff / Project Team:	Abigail Thomas, Director, Office of Human Services and Community Partnerships Shauna Houston, Healthcare Services Coordinator

Statement of Issue:

As requested by the Board at the March 10, 2026 meeting, this workshop item provides a status report on the Tallahassee Memorial HealthCare 2025 Community Health Needs Assessment Report (CHNA Report) and Leon County's ongoing efforts to address the community's most significant health-related through strategic investments, programs, and community partnerships. Representatives from Tallahassee Memorial HealthCare, FSU Health, and the County's community health partners—including Apalachee Center, Big Bend Cares, Bond Community Health Center, Capital Area Healthy Start, Capital Medical Society, FAMU Pharmacy, the Florida Department of Health, and Neighborhood Medical Center—will participate in the workshop to highlight their respective programs, services, and collaborative initiatives that address the priority health needs identified in the CHNA Report.

Fiscal Impact:

This item has no fiscal impact.

Staff Recommendations:

Option #1: Accept the status report on Leon County's ongoing efforts and healthcare partner activities related to the Tallahassee Memorial HealthCare 2025 Community Health Needs Assessment.

Report and Discussion

Background:

As requested by the Board at the March 10, 2026 meeting, this workshop item provides a status report on the Tallahassee Memorial HealthCare 2025 Community Health Needs Assessment Report (CHNA Report) (Attachment #1) and Leon County's ongoing efforts to address the community's most significant health-related needs as reflected in the CHNA Report through strategic investments and community partnerships. Representatives from Tallahassee Memorial HealthCare, FSU Health, and the County's community health partners—including Apalachee Center (Apalachee), Big Bend Cares, Bond Community Health Center (Bond), Capital Area Healthy Start (Healthy Start), Capital Medical Society Foundation/WeCare Network (WeCare), FAMU Pharmacy, the Florida Department of Health (FDOH), and Neighborhood Medical Center (Neighborhood), —will participate in the workshop to highlight their respective programs, services, and collaborative efforts related to addressing the CHNA Report.

On March 10, 2026, the Board received a status report on the 2025 CHNA Report, including TMH's 2026–2028 CHNA Implementation Strategy (Attachment #2), the County's existing investments and partnerships supporting community health, and ongoing efforts to strengthen coordination and align available resources. At that meeting, the Board requested a workshop on the CHNA Report with community healthcare providers. On July 14, 2026, the Board approved scheduling the workshop for October 27, 2026.

Building on the March 2026 status report, this workshop provides a more comprehensive review of the community's priority health needs, the County's existing programs and investments, and the services and initiatives of local healthcare partners.

The healthcare workshop advances the following FY 2022 – FY 2026 Strategic Initiatives:

- *Continue County support of primary healthcare through participation in CareNet in order to increase access to affordable healthcare for those in need. (2022-24)*
- *Identify opportunities to support the findings of the Community Health Needs Assessment Report to improve overall health outcomes by addressing the community's most significant health-related needs. (2026-111)*

These Strategic Initiatives align with the Board's Quality of Life Strategic Priorities:

- *(Q3) Provide essential public safety infrastructure and services while supporting early intervention and prevention strategies.*
- *(Q4) Support and promote access to basic healthcare, mental health, affordable housing, and homeless prevention services to our community members most in need.*

As a nonprofit hospital, TMH is required by federal law to conduct a CHNA Report every three years to identify significant health needs within its service areas, and inform health initiatives, services, and strategic planning to address those needs. In developing the 2025 CHNA Report, TMH aligned its assessment with Florida's 2022–2026 State Health Improvement Plan, a statewide

initiative led by FDOH to strengthen the public health system and improve health outcomes across the state by addressing seven priority health areas, as follows chronic diseases and conditions; mental well-being and substance abuse; social and economic conditions affecting health; Alzheimer's disease and related dementias; maternal and child health; injury, safety and violence; and transmissible and emerging diseases.

To develop the CHNA Report, TMH conducted community surveys, evaluated quantitative data, and held stakeholder meetings to identify key health challenges, disparities, and unmet needs within its four-county service area (Leon, Gadsden, Jefferson, and Wakulla counties) based on the seven identified priority health areas. The County actively participated in the assessment process by attending all stakeholder meetings, promoting community surveys, and meeting directly with the TMH team.

As a result of the extensive community engagement and evaluation of quantitative data, the CHNA Report prioritized the following three health areas for Leon County:

- **Chronic Diseases and Conditions**: Addresses reducing chronic health conditions such as diabetes, hypertension and obesity – which are major contributors to illness and death in Florida – through effective management and preventive strategies.
- **Mental Well-Being and Substance Abuse Prevention**: Aims to effectively address mental health events, prevent substance use disorders and expand accessible, high-quality treatment for mental health and addiction challenges.
- **Social and Economic Conditions Affecting Health**: Addresses health inequities stemming from social and economic factors, emphasizing interventions that improve housing stability, food security, healthcare access, and overall community resilience.

The CHNA Report also highlighted challenges within the other following four priority areas identified by the FDOH, which the County also addresses through investments and partnerships:

- **Alzheimer's Disease & Related Dementias:** Addresses the growing burden of Alzheimer's disease and related dementias due to an aging population through improved access to specialty care, early detection, caregiver support, and resources that promote healthy aging.
- **Maternal and Child Health**: Addresses disparities in maternal and child health outcomes by improving access to prenatal and pediatric care, supporting healthy pregnancies and child development, and reducing preventable adverse outcomes.
- **Injury, Safety, and Violence**: Addresses preventable injuries and violence such as firearm-related deaths, motor vehicle deaths, domestic violence, and childhood injuries through evidence-based prevention strategies, community education, improved access to supportive services, and interventions that promote safety and reduce risk.
- **Transmissible and Emerging Diseases**: Addresses the prevention and control of communicable and emerging diseases such as HIV and sexually transmitted infections through targeted prevention, education, early detection, treatment, and outreach to vulnerable populations.

On September 10, 2025, the TMH Board of Directors approved the 2025 CHNA Report. Subsequently, TMH developed its 2026–2028 CHNA Implementation Strategy (Attachment #2), which was approved by the TMH Board of Directors on February 11, 2026.

The following Analysis section provides an overview of the seven priority areas identified by the CHNA Report and highlights the County's programs, initiatives, and partnerships that address the identified health needs within each priority area. The Analysis also examines how ongoing local efforts complement the CHNA and supports continued coordination among existing programs and resources to strengthen access to care and improve health outcomes for County residents. As previously mentioned, representatives from Tallahassee Memorial HealthCare, FSU Health, and the County's community health partners—including Apalachee, Big Bend Cares, Bond, Healthy Start, WeCare, FAMU Pharmacy, FDOH, and Neighborhood, —will participate in the workshop to highlight their respective programs, services, and collaborative efforts related to addressing the CHNA Report.

Analysis:

The 2025 CHNA Report provides a high-level overview of significant health needs and disparities across TMH's four-county service areas which includes Leon, Gadsden, Jefferson, and Wakulla Counties. In total, more than 1,700 individuals across the four-county service area completed the survey. According to the CHNA Report, Leon County residents account for 56% of total patient volume at TMH from Fiscal Year (FY) 2022 to FY 2024. Leon County residents also represented 80% of respondents to TMH's community health survey, reflecting strong participation by County residents in the assessment process. As previously detailed, Leon County survey respondents identified chronic diseases and conditions, mental health and substance abuse, and social and economic conditions affecting health as the top three priority health areas.

To address the findings of the CHNA Report, TMH developed its 2026–2028 Implementation Strategy, which establishes goals and objectives to improve access to care, strengthen coordination among healthcare providers and community partners, and expand health education and preventive services across its four-county service area.

Leon County has a longstanding commitment to addressing the community's health needs through strategic investments, programs, and partnerships that support access to healthcare and address the broader social and economic factors affecting health outcomes. As detailed below, these existing efforts address needs across all seven health areas identified in the CHNA Report and complement the initiatives outlined in TMH's Implementation Strategy. The following sections provide an overview of the findings within each health area, the County's corresponding investments and programs, and the collaborative efforts of local healthcare partners to improve health outcomes for Leon County residents.

Priority Area: Chronic Diseases and Conditions

Chronic diseases and conditions are long-lasting and can require ongoing medical attention, limit daily activity, and generally worsen over time. Chronic diseases include heart disease, cancer, strokes, diabetes, and hypertension. According to the CHNA Report, deaths due to chronic conditions such as cancer, heart disease, and diabetes in Leon County exceeded the state of Florida

mortality rates. Further, the CHNA Report stated challenges persist in care coordination, access to affordable services and addressing the root causes of chronic disease, particularly among underinsured and rural populations. Approximately 20% of Leon County survey respondents identified barriers in accessing chronic pain management and other specialty clinicians, including rheumatologists, cardiologists, neurologists, and endocrinologists.

TMH Implementation Strategy

In the area of chronic diseases and conditions, TMH is increasing telehealth initiatives with community partners, enhancing health screenings for chronic conditions, and providing continuing education to healthcare professionals. TMH is also collaborating with social services providers and academic health and clinic partners to increase access to services and educate residents on how to manage chronic conditions.

Leon County Investments, Programs & Partnerships

For more than 20 years, Leon County has ensured that low-income residents have access to high quality healthcare services which help prevent and address chronic health conditions. The County invests $1.75 million annually in the Healthcare Program (i.e., CareNet), which provides low-income uninsured and underinsured residents access to primary care, dental, mental health, specialty care, and/or pharmaceutical services. The County contracts with Bond, Neighborhood, Apalachee, We Care, and FAMU Pharmacy to provide these services that result in more than 6,000 visits, 1,600 referrals for specialty care, and approximately 2,600 prescriptions annually.

As part of the CareNet program, $1.3 million of Primary Healthcare funding is allocated to the Healthcare Competitive Pool. Through this funding, eligible Leon County residents receive primary care, dental care, and mental health services at no cost from Bond, Neighborhood, and Apalachee. To qualify, patients must be Leon County residents with an income at or below 100% of the current federal poverty level. Access to primary healthcare significantly reduces chronic illness through early detection, management of existing conditions, and the promotion of preventative lifestyle changes. Additionally, it can help control conditions such as diabetes and hypertension.

Through CareNet, the County also partners with We Care to provide low-income uninsured residents with access to specialty care essential to address chronic conditions. We Care utilizes a network of volunteer specialty care physicians to provide specialized medical and dental services that cannot be provided by a primary care physician, including services to address and manage chronic diseases. Patients are referred to We Care by primary care providers such as Bond and Neighborhood for specialty services, which include, but are not limited to, cardiology, pain management, oncology, and wound care. In FY 2026, We Care reported over 1,600 uninsured Leon County residents were referred for specialty care and more than $5.5 million in donated specialty services were provided to Leon County residents.

Furthermore, FAMU Pharmacy provides coordinated pharmaceutical services for low-income County residents with Bond and Neighborhood for medications necessary to manage the symptoms of chronic conditions. As part of its partnership and annual contract with the County, FAMU Pharmacy also provides a Diabetes Education and Empowerment Program to address

morbidity and mortality of African Americans with Type 2 diabetes and provide coordinated services to residents with diabetes. In FY 2026, FAMU Pharmacy filled over 2,600 prescriptions with a reported retail value of nearly $400,000.

In addition to CareNet, the County, in partnership with the City, provides annual funding to over 40 nonprofit human services organizations through the Community Human Services Partnership (CHSP). Several agencies, including Big Bend Cares, receive funding through the health services category to support primary healthcare. Big Bend Cares receives $77,000 for the indigent health program, which also serves uninsured and underinsured patients within the Promise Zone. In FY 2026, the program served nearly 100 patients.

The County's CareNet program, CHSP, and the County's network of healthcare partners complement TMH's 2026-2028 Implementation Strategy by addressing key barriers to chronic disease prevention and management, particularly among uninsured and underinsured residents. These established partnerships provide opportunities to align efforts in referrals, chronic-care navigation, targeted screenings, and health education.

Priority Area: Mental Well-Being and Substance Abuse Prevention

According to the Centers for Disease Control and Prevention, mental health is the most critical indicator for productivity, emotional resilience, and overall well-being. The CHNA survey results found that only 24% of Leon County respondents reported using mental health services. Additionally, 28% of Leon County respondents noted difficulty accessing psychiatry, behavioral health, and substance abuse services. Furthermore, data collected by TMH reported that hospitalizations for mental health disorders have increased in all four service area counties while the State level average for hospitalizations has decreased.

TMH Implementation Strategy

In the area of mental well-being and substance abuse prevention, TMH is improving access to mental health and community-based services through several initiatives. TMH has expanded outpatient programs to provide treatment for co-occurring mental health and substance use disorders and provided mental health counseling groups in partnership with Apalachee. Further, TMH is partnering with the Mental Health Council of the Big Bend to educate stakeholders on the resources available at its Behavioral Health Center, which provides outpatient treatment to address mental health concerns.

Leon County Investments, Programs & Partnerships

To respond to the mental health and substance abuse needs, Leon County provides significant funding to local service providers and participates in coordination calls to enhance available services in the community. As it relates to mental health, Leon County provides more than $1 million annually to support Apalachee's mental health and substance use crisis programs and services. As the region's designated central receiving facility, Apalachee delivers critical services under the Baker and Marchman Acts, ensuring timely mental health and substance use crisis intervention for individuals in acute need. In FY 2026, Apalachee's Central Receiving Facility conducted 2,905 mental health inpatient screenings, including screenings for 2,140 Leon County

residents. Additionally, 1,591 unduplicated County residents received inpatient treatment during the year. Furthermore, the County support for Baker and Marchman Act services contributed to 5,057 crisis stabilization patient days and 1,194 detoxification patient days in FY2026. In addition, the County partners with the Mental Health Council of the Big Bend by sponsoring mental health awareness events to promote available resources.

As previously mentioned, through the County's Health Care Program, the County reimburses Apalachee, Bond, and Neighborhood for the provision of mental health services to low-income residents, further expanding access to essential care across the community. In FY 2026, CareNet supported more than 1,000 mental health visits for County residents.

Also, in 2023, the County was awarded nearly $14 million over an 18-year period as a result of national and statewide settlements with opioid manufacturers responsible for the opioid epidemic. Annually, the Board allocates the funding in accordance with strict terms established by the State for prevention and substance use treatment services. This includes funding to DISC Village for medication assisted treatment for opioids and other substances, LCSO for prevention education through the Council on the Status of Men and Boys; and 2-1-1 Big Bend, Inc., for free transportation services through the Lyft Program for individuals seeking treatment services. In FY 2026, DISC Village provided over 2,800 Medication-Assisted Treatment sessions to more than 1,360 residents, which helps address opioid withdrawal.

The implementation strategy for mental well-being and substance abuse prevention includes continued collaboration with community health partners to expand outpatient mental health services, increase access to psychotherapy and medication management, provide mental health first aid, and strengthen the behavioral health workforce. The County's CareNet program enhances these efforts by supporting access to mental health services for low-income residents through Apalachee, Bond, and Neighborhood, while County funding for Apalachee supports crisis intervention and treatment. In addition, the opioid settlement funding is being utilized to increase access to outpatient services and provide medication management.

Priority Area: Social and Economic Conditions Affecting Health

According to the CHNA Report, 72% of survey respondents identified social and economic conditions as a top-ranked issue impacting their health outcomes. Social and economic conditions include income, housing stability, and access to services (i.e., healthcare, food, transportation, etc.). Higher poverty levels are often associated with negative health outcomes in a community compared to affluent communities with contrasting economic conditions.

TMH Implementation Strategy

TMH is collaborating with local colleges and universities to train future health professionals to better respond to these conditions through health screenings and partnerships. TMH is screening patients for social determinants of health to identify non-medical factors, such as housing instability, food insecurity, and transportation barriers that drive poor health outcomes. TMH also partners with community agencies, including Second Harvest of the Big Bend, to promote available resources and address the social determinants of health.

Leon County Investments, Programs & Partnerships

In recognition of these social and economic challenges, Leon County has long been committed to reducing poverty and inequity in the community. Since 2021, the County has strengthened its efforts to address poverty and has dedicated more than $34 million in human services programs, healthcare, housing, and economic development, to improve the lives of residents in high poverty neighborhoods such as Bond, Frenchtown, Griffin Heights, and South City.

The County's ongoing efforts to reduce poverty and improve economic prosperity for residents have been critical to improving the health outcomes of County residents. Annually, the County provides access to a range of resources, social services, and short-term financial assistance programs designed to promote stability and well-being. As previously mentioned, through CHSP, the County, in partnership with the City, provides approximately $4.8 million to over 40 local nonprofit organizations to provide essential human services to residents, including food, emergency support, and case management. Big Bend Cares and Healthy Start, both participants in this workshop, are healthcare partners supported through CHSP. The County also operates the Direct Emergency Assistance Program (DEAP) and Veterans Emergency Assistance Program (VEAP) to provide emergency financial assistance to residents for rent and utilities.

Additionally, the County has placed a high priority in reducing food insecurity in the community in recognition that it correlates with poverty and health outcomes. This has resulted in over $7.5 million provided by the County for the delivery of nearly 55 million meals to low-income households over the last five years. This investment includes annual funding through CHSP to support food programs by Second Harvest of the Big Bend, Good News Outreach, and Elder Care Services. In addition, four County library locations served as Summer Break Spot sites for children to receive nutritious food during the summer months in 2026 and provided 13,355 meals. Further, building on this commitment, the County recently partnered with Farm Share, Inc., to conduct quarterly food distribution events that will provide fresh produce and nutritious meals to residents that live in the neighborhoods with the highest food insecurity rates. In 2026, the County's partnership with Farm Share will serve over 2,000 households. This ensures the most vulnerable areas of the County have access to food and meals that are essential to a healthy diet.

The County also works to address healthcare access in areas with high poverty and limited access to care. Through CareNet, the County partners with Bond and Neighborhood to provide healthcare services through mobile health units in federally designated medically underserved areas, including Bond, Frenchtown, Griffin Heights, and South City. The County also partners with Big Bend Area Health Education Center (Big Bend AHEC) to provide health insurance navigation services, helping residents identify available subsidies and enroll in coverage through the Federal Health Insurance Marketplace. Together, these efforts address financial, geographic, and informational barriers to healthcare access.

In order to ensure that residents are aware of the resources available in the community, the County provides annual funding in the amount of $112,500 to 2-1-1 Big Bend to support the 24/7 Helpline and the Lyft Transportation Program. In addition, the County created the Neighborhood Engagement and Community Partnership manager position in 2022 to support coordinated

community engagement, identify emerging community needs, and connect residents and organizations with County and community resources.

The County's investments in human services, food security, healthcare access, and community-based organizations provide an existing network of resources that address many of the concerns identified in health care provider screenings for the social determinants of health. In addition, the County actively promotes community resources to ensure that residents are aware of and can access available resources. Partners consistently coordinate and participate in various committees to further address community issues and ensure that each organization is aware of available resources to share with clients.

Priority Area: Alzheimer's Disease & Related Dementias

Alzheimer's disease and related dementias are a growing public health concern as the population ages and increasing numbers of individuals and families require access to diagnosis, treatment, caregiver support, and long-term services. Dementia can significantly affect an individual's ability to live independently and places substantial physical, emotional, and financial demands on caregivers and families. While the prevalence of Alzheimer's disease and related dementias across the four-county service area is slightly below the state average, stakeholders and survey respondents expressed concern over increasing mortality, emergency department utilization, and demand for long-term support. Addressing these needs requires coordination across healthcare providers, community organizations, and support services to promote early identification, connect individuals to appropriate care, and provide resources that support individuals and their caregivers.

TMH Implementation Strategy

In the area of Alzheimer's disease and related dementias, the TMH Memory Disorder Clinic is expanding dementia awareness and education efforts, with an emphasis on early detection, timely intervention, and caregiver support. These efforts include training healthcare providers and offering mobile memory assessments in underserved communities to improve access to screening and early identification. Earlier detection can help individuals and families connect with appropriate services, treatment options, and support resources sooner. To further strengthen these efforts, TMH is also exploring a pilot program to establish community-based dementia navigators who would help families navigate care options, connect with available resources, and better manage the challenges associated with dementia.

Leon County Investments, Programs & Partnerships

The County has undertaken long-term efforts to address these concerns, including investment in respite care and access to specialty care. The County and City provide nearly $315,000 annually through CHSP to support senior services, including over $80,000 in annual funding to Elder Care Services and Alzheimer's Project to support the Elder Day Stay and Caregiver Support Services respectively. These programs provide caregivers with a safe place to bring their loved ones for enrichment and caregiving, while offering respite for family members of individuals with Alzheimer's and related dementias. In FY 2026, these programs provide respite care to more than 250 families. In addition, the County provides $179,000 in annual funding to the Tallahassee Senior Citizens Foundation to support senior services, including specialized programs, support

groups and resource coordination which can help families navigate available resources on aging in the community.

Further, as previously mentioned, the County also supports access to specialty care through its partnership with We Care. The County provides $183,826 in annual funding to We Care for case management services which connect low-income uninsured and underinsured residents with access to specialty care. We Care utilizes a network of volunteer specialty care physicians to provide specialized medical and dental services that cannot be provided by a primary care physician, including services to address and manage chronic diseases. These services include referrals to specialists such as neurologists who provide evaluation and treatment related to Alzheimer's disease and other dementias. In FY 26, WeCare case managers referred 51 individuals to neurology.

The County's investments in respite and caregiver services, senior programs, and specialty care complement the TMH Implementation Strategy efforts by addressing access and support needs beyond the hospital setting.

Priority Area: Maternal and Child Health

According to the CHNA Report, Leon County overall demonstrates high rates of adequate prenatal care; however, many lower income communities still have a higher proportion of mothers who do not receive sufficient prenatal care and experience higher rates of maternal and infant mortality. These disparities highlight the importance of early access to prenatal care, care coordination, transportation, and other supports that address barriers to healthy pregnancies and positive birth outcomes.

TMH Implementation Strategy

In collaboration with academic health partners, TMH plans to expand obstetric training within its Family Medicine Residency Program, including outreach to underserved communities to improve access to prenatal care. TMH will also partner with social service organizations, including Healthy Start, to develop breastfeeding support programs for new mothers. Additionally, the strategy identifies opportunities to expand access to pediatric specialty care through subcontracting arrangements with specialty physicians, helping address gaps in the availability of specialized services for children.

Leon County Investments, Programs & Partnerships

To address these disparities, the County coordinates with Healthy Start and the Children's Services Council of Leon County (CSC Leon) to develop targeted outreach and intervention programs to identify and address issues related to maternal and child health. Through CHSP, the City of Tallahassee and the County partner to provide $22,000 to Healthy Start to help achieve maternal and child health outreach and intervention programs through the Sister Friends Tallahassee Birthing Project. The County also participates in regular coordination meetings with Healthy Start to identify opportunities to improve services. As previously mentioned, the Board also provides dedicated funding to the 2-1-1 Big Bend Lyft Program to enhance transportation access, which provided nearly 4,000 rides in FY 2026.

In addition, CSC Leon partners with Healthy Start on the Perinatal Navigator Program, which provides care coordination and case management, including coordination of rides to ensure expectant and new mothers have reliable transportation to medical appointments and services. As of March 2026, the program had enrolled over 1,000 mothers in ongoing services, including home visiting, mental health counseling, and other healthcare services.

Bond and Neighborhood contribute to maternal and child health through primary care services that support women, children, and families. Their services provide opportunities for prenatal care, preventive screenings, health education, and ongoing primary care, while connecting patients to specialty and community-based resources when additional support is needed. Through their participation in CareNet, these organizations help extend access to care for low-income and underserved residents and provide an important connection between primary care and the broader maternal and child health system.

FDOH also provides a range of services that support maternal and child health, including family planning, pregnancy testing and counseling, nutrition services, WIC, immunizations, and Healthy Start services. Clinical services are available to uninsured and underinsured residents through discounted fees based on eligibility, and WIC provides nutrition assistance and breastfeeding support to eligible pregnant and postpartum women, infants, and children.

The County's investments and coordination efforts support the broader network of resources and programs supporting maternal and child health, while partner organizations contribute specialized services, outreach, care coordination, and other interventions. Given the lasting impact of maternal health, prenatal care, and early childhood experiences on lifelong health outcomes, continued collaboration among TMH, the County, CareNet providers, Healthy Start, FDOH, CSC Leon, and other community partners is critical to improving maternal and child health outcomes for Leon County residents.

Priority Area: Injury, Safety, and Violence

The CHNA Report identified injury, safety, and violence as areas of concern across the TMH service area, with Leon County experiencing higher rates than the state average for several indicators, including child abuse, violent crime, and certain firearm- and motor vehicle-related deaths. Homicide mortality was also higher than the state average in Leon and Gadsden counties. These findings, along with disparities in childhood injuries and domestic violence, demonstrate the need for prevention, community education, early intervention, and coordinated support for individuals and families affected by violence and injury.

TMH Implementation Strategy

TMH addresses injury, safety, and violence through its trauma services, community education, and prevention initiatives. As the region's Level II Trauma Center, TMH provides a continuum of trauma care from emergency treatment through rehabilitation and injury prevention. TMH's Pathways to Prevention program provides safety education to local students on topics including distracted driving, bicycle and sports safety, falls, substance use, and other preventable injuries. TMH also partners with community organizations and public safety agencies on initiatives such as Safe Kids events and Operation Prom Night.

Leon County Investments, Programs & Partnerships

The County has partnered with local stakeholders to reduce violence primarily to youth, women, and children. In 2022, the Leon County Sheriff's Office (LCSO), in partnership with Leon County Government, the City of Tallahassee, and Leon County Schools, established the Tallahassee–Leon County Council on the Status of Men & Boys. The Council is focused on preserving life by preventing homicides and non-fatal shootings in Leon County. Through targeted supports and services for men and boys at highest risk, and by addressing the root causes of violence, the Council works to enhance public safety, reduce injuries, and improve quality of life in communities most impacted by violent crime.

The County also provides funding for services supporting survivors of domestic violence and sexual assault. Through CHSP, the County provides $82,185 annually to Refuge House and Survive and Thrive Advocacy Center for services to domestic violence and human trafficking survivors, including counseling, survivor advocacy, and community education. Additionally, the County in partnership with the City and CSC Leon provide more than $50,000 in line-item funding to support Refuge House shelter operations and case management. These services provide immediate safety and ongoing support to individuals and families affected by domestic and sexual violence.

Furthermore, to respond to instances of suspected child abuse, the County provides annual funding to the University of Florida to conduct examinations of allegedly abused, abandoned, or neglected children as required by Florida Statutes. These evaluations help determine the immediate safety of the child and inform protective services on next steps to ensure the safety of children. The child protection teams also provide training to professionals involved in identifying and responding to child abuse.

Other community partners provide prevention and early intervention services that address risk factors associated with injury and violence. CSC Leon provides funding to the Children's Home Society to operate Family Resource Centers that connect families with practical resources, education, and services intended to strengthen family stability and resilience. These community-based resources complement efforts to prevent adverse childhood experiences and reduce the potential long-term health consequences associated with exposure to violence and trauma.

The County's violence-prevention initiatives and support for survivors and child protection services complement the efforts of TMH to expand child safety and injury-prevention efforts. Moreover, LCSO, CSC Leon, and other community partners provide additional prevention, education, assessment, and support services.

Priority Area: Transmissible and Emerging Diseases

The CHNA Report noted ongoing concerns with HIV, STDs, and other communicable diseases as rates of STDs in the four-county service area are significantly higher than the state average. The report indicated a need for stronger prevention strategies, early detection, and targeted outreach among vulnerable populations. These efforts are important to reducing transmission, improving health outcomes, and limiting the broader impact of communicable diseases on individuals and the community.

FDOH serves as the primary public health partner responsible for preventing, detecting, and responding to transmissible and emerging diseases to protect public health. This work includes ongoing surveillance of reportable communicable diseases, investigation of individual cases and outbreaks, and implementation of control measures to limit the spread of illness. FDOH also coordinates with healthcare providers, schools, long-term care facilities, and other community partners to support timely identification, testing, and response activities. In State FY 2026, FDOH reported 12,576 clinic visits, an increase of over 1,500 visits or 14% from the prior year.

TMH Implementation Strategy

In the area of transmissible and emerging diseases, TMH partners with TMH Physician Partners, Big Bend Cares, and other local community and social services agencies to increase access to screening and treatment. This includes screening of pregnant and high-risk individuals for syphilis, gonorrhea, and chlamydia, and screening adults for HIV and Hepatitis C. TMH is also working with TMH Physician Partners to increase vaccinations through education and outreach to prevent and reduce the transmission of flu and pneumonia.

Leon County Investments, Programs & Partnerships

To support these efforts, the County provides annual funding in the amount of $237,345 to provide state-mandated public health services in Leon County, including communicable disease control services, primary care services, and environmental health services. FDOH leads prevention and preparedness efforts through immunization programs, public education, and emergency response planning related to emerging infectious disease threats. The department monitors state, national, and global disease trends, provides risk communication to residents and stakeholders, and ensures coordination and reporting with FDOH and the Centers for Disease Control and Prevention to align local actions with state and federal public health guidance. In addition, during public health emergencies, FDOH coordinates with Leon County Emergency Management to address and respond to community needs.

Community-based organizations also play an important role in prevention, testing, treatment, and outreach. Through CHSP, the County and City provide $157,120 annually to Big Bend Cares to support HIV and sexually transmitted disease healthcare, prevention, education, testing, and outreach. In FY 2026, Big Bend Cares served more than 650 patients through these programs. By providing services in community settings, Big Bend Cares helps connect individuals with testing, treatment, education, and ongoing support, particularly among populations that may experience barriers to accessing traditional healthcare services.

Together, FDOH, Big Bend Cares, healthcare providers, and other community partners provide a coordinated network for disease surveillance, prevention, testing, treatment, and public education. These efforts complement TMH's 2026-2028 Implementation Strategy, which emphasizes collaboration with community partners to improve prevention, early identification, access to care, and health education related to communicable and emerging diseases.

Conclusion

The 2025 CHNA Report provides a comprehensive analysis of the significant health needs in Leon County and the surrounding service area. The County's existing investments and partnerships address many of the barriers identified in the CHNA, including access to care for chronic diseases and conditions, mental well-being and substance abuse prevention, and social and economic conditions that affect health.

Continued coordination with TMH and community partners will support alignment with the 2026-2028 CHNA Implementation Strategy, strengthen referral pathways, identify service gaps, and maximize existing resources. The County will continue to coordinate with healthcare partners, monitor service utilization and program outcomes, and identify opportunities to improve health outcomes across the priority areas. Should voters approve the proposed property tax amendment in November, County funding in support of community healthcare programs will be evaluated as part of the broader financial and organizational restructuring process anticipated during the FY 2028 budget development cycle. Any opportunities requiring additional Board action will be presented through the appropriate agenda or budget process.

Options:

1. Accept the report on Leon County's ongoing efforts and healthcare partner activities related to the Tallahassee Memorial HealthCare 2025 Community Health Needs Assessment.
2. Do not accept the report on Leon County's ongoing efforts and healthcare partner activities related to the Tallahassee Memorial HealthCare 2025 Community Health Needs Assessment.
3. Board direction.

Recommendation:

Option #1

Attachments:

1. Tallahassee Memorial HealthCare 2025 Community Health Needs Assessment Report
2. 2026 Tallahassee Memorial HealthCare CHNA Implementation Strategy



COMMUNITY HEALTH NEEDS ASSESSMENT REPORT 2025

TALLAHASSEE MEMORIAL HEALTHCARE

A healthier community begins with you.

Approved by Tallahassee Memorial HealthCare Board of Directors

TABLE OF CONTENTS

ACKNOWLEDGEMENTS AND CONSIDERATIONS 6
TALLAHASSEE MEMORIAL HEALTHCARE CHNA ADVISORY TEAM . . . 6
COMMUNITY ENGAGEMENT . . . 7
Partners and Stakeholders List . . . 7
EXECUTIVE SUMMARY . . . 10
Methodology . . . 11
Community Served . . . 11
State of Florida Health Improvement Plan Priority Areas . . . 11
Demographics of the Community . . . 12
Significant Health Needs of the Community . . . 12
Prioritization of Needs . . . 13
COMMUNITY HEALTH IMPROVEMENT PROCESS . . . 14
Phase 1: Conduct Community Health Needs Assessment . . . 15
- The Florida State Health Improvement Priority Area Meetings . . . 15
- Community Stakeholder Survey . . . 15
- Community Health Survey . . . 15
- Secondary Data Collection . . . 15
- Prioritization . . . 16
- Community Health Needs Assessment Report . . . 16

Phase 2: Implementation Strategy Development . . . 16
Phase 3: Program Implementation . . . 16
Phase 4: Evaluation . . . 16
COMPREHENSIVE TALLAHASSEE MEMORIAL HEALTHCARE 2025 COMMUNITY HEALTH NEEDS ASSESSMENT REPORT . . . 17
Definition of the Community Served by the Hospital Facility . . . 18
Demographics of the Community . . . 18
Community Demographic and Socioeconomic Characteristics . . . 20
PRIMARY DATA . . . 22
State of Florida Health Improvement Plan (SHIP) Priority Area Meetings . . . 22
Injury, Safety and Violence . . . 23
Stakeholder Meeting SWOT Analysis: Injury, Safety and Violence . . . 23
Maternal and Child Health . . . 24
Stakeholder Meeting SWOT Analysis: Maternal and Child Health . . . 25
Chronic Disease Prevention and Management . . . 26
Stakeholder Meeting SWOT Analysis: Chronic Disease Prevention and Management . . . 26
Mental Well-Being and Substance Abuse Prevention . . . 27
Stakeholder Meeting SWOT Analysis: Mental Well-Being and Substance Abuse Prevention . . . 28
Transmissible and Emerging Diseases . . . 29
Stakeholder Meeting SWOT Analysis: Transmissible and Emerging Diseases . . . 29

Alzheimer's Disease and Related Dementias . . . 30
Stakeholder Meeting SWOT Analysis: Alzheimer's Disease and Related Dementias. . . . 30
Social and Economic Conditions Affecting Health . . . 31
Stakeholder Meeting SWOT Analysis: Social and Economic Conditions Affecting Health . . . 31
COMMUNITY STAKEHOLDER SURVEY . . . 32
Three Most Important Issues . . . 32
Barriers to Health . . . 33
Missing Resources . . . 33
Healthcare Providers and Facilities . . . 34
Transportation . . . 34
Insurance and Healthcare Costs . . . 34
Navigators and Health Literacy . . . 34
Populations With Targeted Needs . . . 35
Populations With Unmet Needs . . . 35
Localities With Unmet Needs . . . 35
Discrimination . . . 36
One Change . . . 37
COMMUNITY HEALTH SURVEY . . . 39
Methodology . . . 39
Who Participated in the Community Health Survey? . . . 40
County of Residence . . . 40
Age . . . 41
Sex and Gender . . . 41
Race and Ethnicity . . . 41
PARTICIPANT CHARACTERISTICS BY RACE/ETHNICITY AND COUNTY OF RESIDENCE . . . 42
Race/Ethnic Identity by County . . . 42
Educational Attainment . . . 43
Highest Level of Educational Attainment . . . 43
Employment . . . 44
Employment by County . . . 45
Employment by Race/Ethnicity . . . 45
Income . . . 46
Income by Race/Ethnicity . . . 46
Housing and Food Insecurity . . . 47
COMMUNITY HEALTH SURVEY RESULTS . . . 48
Introduction . . . 48
Community Health Priorities . . . 48
ACCESS TO CARE . . . 49
Medical Care . . . 49
Dental Health . . . 50
Mental Health . . . 51
Barriers to Healthcare . . . 52

Health Insurance . . . 54
HEALTH CARE VISITS . . . 56
Routine Care . . . 56
Clinical Preventive Care . . . 56
Emergency Care . . . 56
Unmet Needs . . . 57
Pregnant Women and New Mothers . . . 58
HEALTH-ENHANCING BEHAVIORS . . . 59
Exercise . . . 60
Diet . . . 60
CHILD HEALTH . . . 61
SECONDARY DATA . . . 64
Demographic and Socioeconomic Indicators . . . 65
Population Size . . . 65
Age Distribution . . . 66
Race & Ethnic Identification . . . 66
Nativity . . . 67
Families and Households . . . 67
Household Economic Status . . . 68
Educational Attainment and Enrollments . . . 69
Additional Adult Characteristics . . . 70
HEALTH INDICATORS . . . 70
Tallahassee Memorial HealthCare 2025 Community Health Needs Assessment . . . 70
Life Expectancy . . . 72
Mortality and Morbidity . . . 72
Alzheimer's Disease & Related Dementias . . . 73
Chronic Diseases & Conditions . . . 74
Injury, Safety & Violence . . . 75
Maternal and Child Health . . . 77
Mental Well-Being and Substance Abuse Prevention . . . 79
Social & Economic Factors Contributing to Health . . . 80
Transmissible & Emerging Diseases . . . 82
SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY . . . 83
COMMUNITY HEALTH NEEDS: PRIORITIES, THEMES AND NEXT STEPS . . . 84
Methodology . . . 84
For the 2025 Community Health Needs Assessment, the health priority areas for TMH are: . . . 85
PRIOR CHNA (2022) ACTIONS AND IMPACT . . . 86
APPENDIX 1 – COMMUNITY STAKEHOLDER SURVEY . . . 92
APPENDIX 2 – COMMUNITY HEALTH SURVEY . . . 96

ACKNOWLEDGEMENTS AND CONSIDERATIONS



The Regional Development and Population Health Department at Tallahassee Memorial HealthCare (TMH) produced this report to benefit the community. TMH encourages using this report for planning purposes and is interested in learning how it benefits others. TMH welcomes comments, questions and collaborative interests, which can be submitted by U.S. Mail, phone, or email to: Community Health Manager for Regional Development, Population Health and Telehealth, Tallahassee Memorial HealthCare, 1300 Miccosukee Road, Tallahassee, FL 32308, 850-431-4018, CHNA@TMH.ORG.

Members of the Community Health Needs Assessment (CHNA) Advisory Committee reviewed and contributed to all documents prior to publication. The Committee made every effort to ensure the accuracy of the information presented in this report.

Success of the TMH 2025 CHNA was due to the strong leadership of the CHNA Advisory Committee, community partners and stakeholders. The Committee extends a special thank you to the consulting firm, M13 Management Partners, and to the Florida State University Center for Demography and Population Health for their valuable insight and contributions to this project. Thank you to all community members in Leon, Gadsden, Jefferson and Wakulla counties who participated in the stakeholder meetings and completed the survey. Finally, thank you to the TMH Board of Directors and Executive Leadership Team for their support of the Community Health Improvement Process.

TALLAHASSEE MEMORIAL HEALTHCARE CHNA ADVISORY TEAM

COMMITTEE SUPPORT TEAM:

Dawn Springs, Community Health Manager

Kristen Booker, Regional Development, Population Health and Telehealth Director

Kelly Leffler, Senior IT Application Analyst, Epic Healthy Planet

Afaf Qasem, Community Health Advisor

COMMITTEE SPONSOR:

Dean Watson, MD, Vice President and Chief Integration Officer

COMMITTEE MEMBERS:

Wade Baggs, MD, Family Medicine Physician

Alanda Beal, TMH Physician Partners

Karin Brewster, PhD, Professor of Sociology and Research Associate, FSU Center for Demography & Population Health

Natalie Edwards-Heller, Marketing and Communication Strategist

Rachel Frances, Controller

Justin Kennett, Trauma Program Manager

Rebeccah Lutz, Director, TMH Foundation

Mary Matthews, Corporate Compliance and Privacy Officer

Jenna Pope-Martinez, Clinical Engagement Advisor

Nakeisha Rodgers, MD, Internal Medicine Residency Program Physician

Aaron Walker, MD, Internal Medicine Residency Program Director

COMMUNITY ENGAGEMENT

Tallahassee Memorial HealthCare's (TMH) Community Health Needs Assessment (CHNA) is a community-driven project, and success is highly dependent on the involvement of citizens, health and human service agencies, businesses and community leaders. Community partner and stakeholder collaboration was essential in the distribution and collection of community health surveys. Community partners and stakeholders consist of health and human service agency leaders, persons with special knowledge of or expertise in public health, local health departments, leaders and representatives of the medically underserved, people with chronic diseases and low-income and minority populations.

The CHNA Advisory Committee and support team invited partners and stakeholders to attend the CHNA Community Health Partners meeting in January 2025 and a follow-up report/prioritization of needs meeting in May 2025. Stakeholders and partners were also invited to a series of meetings held throughout the month of February 2025, focused on the seven Florida State Health Improvement Plan (SHIP) priority areas. The following partners and stakeholders attended at least one of these meetings.

Partners and Stakeholders List

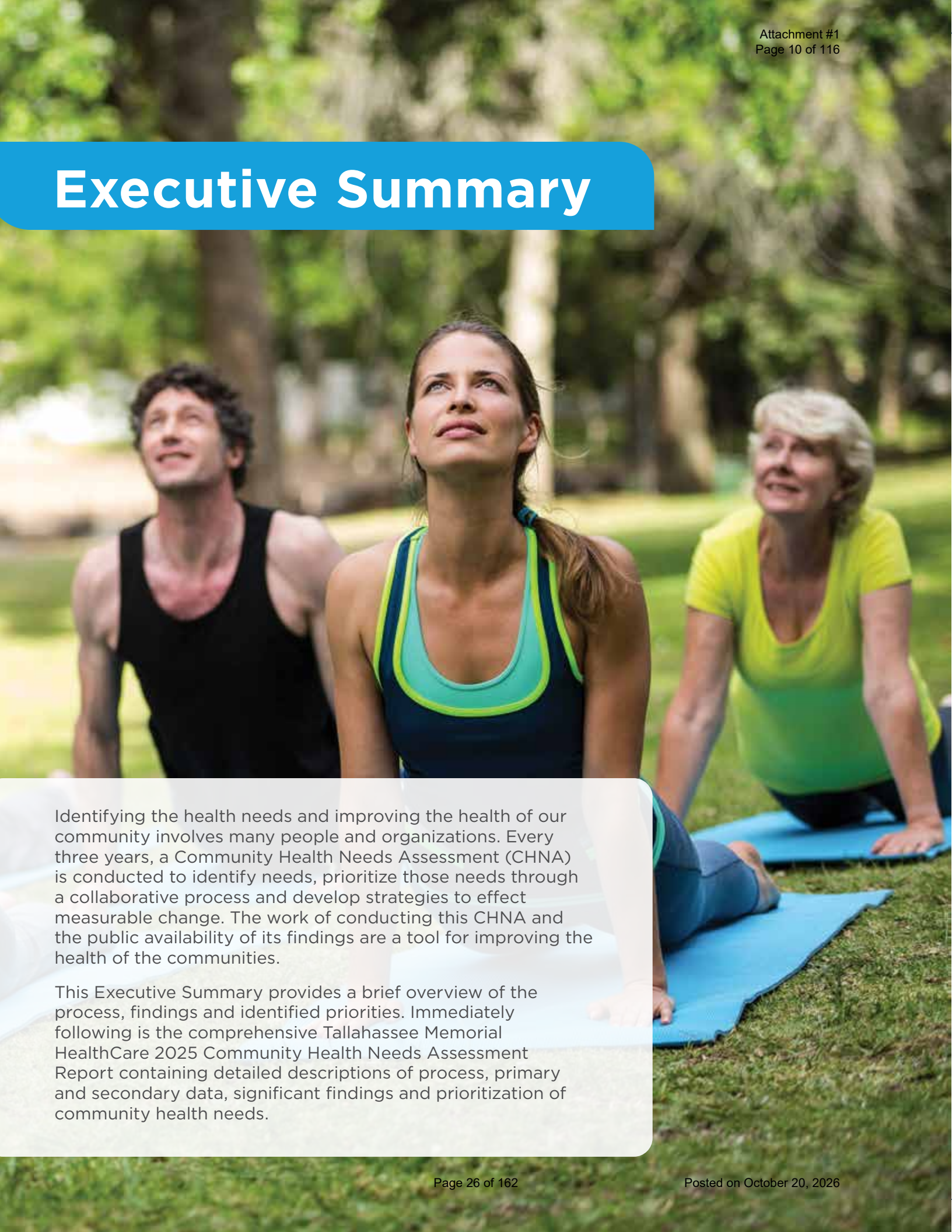
Name	Organization
Chad Abrams	Leon County Emergency Medical Services
Labake Ajayi	Florida Department of Health
Nora Albibi	Florida State University, College of Medicine, Healthy Start
Judy Bailey Morgan	Tallahassee Memorial HealthCare, Employee Assistance Program (formerly)
Patty Ballantine	Florida State University, Florida Medical Practice Plan, Head of Clinical Operations
Mary Barley	Leon County Government and Working Well
Alanda Beal	TMH Physician Partners
Diana Bixler	Capital Medical Society Foundation, Inc., We Care Network Program
Tom Block	Capital Medical Society
Tammy Boone	Florida Department of Health in Wakulla County
Lisa Bretz	Area Agency on Aging for North Florida
Jazmyne Bryant	Commission on the Status of Women and Girls
Lindy Burnett	Tallahassee Memorial Behavioral Health Center
Leigh Cahoon	Florida Department of Health in Leon County
Joe Camps	Tallahassee Memorial HealthCare, Administration
Sarah Cannon	Tallahassee Memorial HealthCare, Marketing and Communications
Taylor Carmody	FSU Florida Medical Practice Plan, Behavioral Health
Allison Castillo	Tallahassee Memorial Healthcare, Organizational Improvement
Lori Clemmons	Capital Health Plan, Alzheimer's Project
Travis Coker	North Florida Medical Centers (formerly)
Ramona Coleman	Florida State University, Florida Medical Practice Plan
Adrian Cooksey	Florida Department of Health in Gadsden County
Berneice Cox	United Way of the Big Bend
Sally Davis	Leon County Emergency Medical Services
Latasha Davis	Wisdom Adult Day Care
Todd Del Calzo	Premier Health & Fitness Center
Amber Dudek	Florida State University, College of Medicine, Healthy Start
Donnell Durden	Bond Community Health Center, Inc.
Monique Ellsworth	Second Harvest of the Big Bend
Kristen Eppers	Big Bend Area Health Education Center (BBAHEC)

Name	Organization
Heather Flynn	Florida State University, College of Medicine
Tanya Footman	Florida Department of Health in Gadsden County
Carol Gagliano	Center for Health Equity
Yolanda Gillette-Carlson	Big Bend Area Health Education Center (BBAHEC)
Mary Goble	Capital Health Plan
Lashawn Gordon	United Partners for Human Services
Susan Gormley	Tallahassee Memorial HealthCare
Cecka Rose Green	Children's Services Council of Leon County
Darryl Hall	Leon County Emergency Medical Services
Barbara Hanks	Tallahassee Memorial Behavioral Health Center
Brittainie Hay	Florida Department of Elder Affairs
Tonya Hobby	Florida Department of Health in Taylor and Wakulla Counties
Jill Hodges	Apalachee Center, Inc.
Tina Hollie	Tallahassee Memorial Behavioral Health Center
Shauna Houston	Leon County Government
Raven James	Oasis Center for Women and Girls
Frances Jarvis	DaVita Kidney Care
Keshia Jenkins	Capital Area Healthy Start Coalition
Lynn Jones	Capital Health Plan
Shannon Jones	Bond Community Health Center
Sherry Kendrick	Tallahassee Memorial HealthCare, Women's & Children's Services
Justin Kennett	Tallahassee Memorial HealthCare, Emergency Services
Amy Kessler	TMH Physician Partners
Andrea Kirkland	Capital Health Plan
Brandi Knight	Florida Department of Health in Leon County
Amber Ladd	Florida Department of Elder Affairs
James Lewis	Florida Department of Health in Wakulla County
Justice Lewis	Tallahassee Memorial HealthCare, Memory Disorder Clinic
Sharon Liebrich	Florida State University, Office of Research
Heather Lincicome	Tallahassee Memorial Behavioral Health Center
Sandi Lodge	Tallahassee Medical Group
Rebeccah Lutz	TMH Foundation
Amanda Madden	Capital Area Healthy Start Coalition
Arlesia Mathis	Florida Agricultural and Mechanical University, Institute of Public Health
Mary Matthews	Tallahassee Memorial HealthCare, Corporate Compliance
Kimberly Mattox	Clinical Research, Florida State University
Chastity McCarthy	Florida Department of Health in Jefferson and Madison Counties
Coco McClelland	Leon County Schools
Chelsea McCoy	Florida Department of Health in Jefferson and Madison Counties
Wachell McKendrick	Commission on the Status of Women and Girls
Mallory Meadows	Tallahassee Memorial HealthCare, Heart and Vascular Center
Carolina Mérida	Florida Department of Elder Affairs
Miaisha Mitchell	Greater Frenchtown Revitalization Council and Tallahassee Food Network
Christine Morse	Premier Health and Fitness Center

Name	Organization
Amy Mullins	University of Florida, Institute of Food and Agricultural Sciences (UF-IFAS) Extension
Ed Murray	NAI TALCOR, TMH Board of Directors
David O'Keefe	Leon County Commission
Olivia Piazza	Tallahassee Memorial HealthCare, Women's & Children's Services
Kim Outlaw	Tallahassee Memorial HealthCare, Women's & Children's Services
Kayleen Pafford	Florida Department of Health in Wakulla County
Hyejin Park	Florida State University, College of Nursing
Min Sook Park	Florida State University
Natisha Penn	Florida Department of Health in Leon County
Jay Reeve	Apalachee Center, Inc.
Rob Renzi	Big Bend Cares
Terri Repasky	Tallahassee Memorial HealthCare, Heart & Vascular Center (former)
Michael Roberts	Capital Health Plan
Temple Robinson	Bond Community Health Center, Inc.
Nakeisha Rodgers	Florida State University, Internal Medicine Residency Program
Leila Rykard	Florida Department of Health in Jefferson and Madison Counties
Hannah Sanders	Capital Health Plan
Meaghan Sapp	Florida State University, Clinical Research,
Shannon Smith	Florida Agricultural and Mechanical University
Amberly Smith	Apalachee Center, Inc.
Sharon Spooner	Tallahassee Memorial HealthCare
Lucille Stringer	Tallahassee Memorial HealthCare, Organizational Improvement
Chris Szorcsik	Capital Area Healthy Start Coalition
Tanya Tatum	Florida Agricultural and Mechanical University
Tamikka Thomas	Tallahassee Memorial Home Health Care
Kaizsa Threatt	Mothers Against Drunk Driving (MADD)
Phillip Treadwell	Tallahassee Memorial HealthCare, Family Medicine Residency Program
Amber Tynan	Big Bend Cares
Byron Wade	Florida Department of Children and Families
Mike Wallace	Leon County Sherriff's Office
Ursula Weiss	Florida State University, College of Medicine
Sonya Wilson	The Kearney Center, CESC Inc.
Allison Wiman	Big Bend Area Health Education Center (BBAHEC)



Executive Summary



Identifying the health needs and improving the health of our community involves many people and organizations. Every three years, a Community Health Needs Assessment (CHNA) is conducted to identify needs, prioritize those needs through a collaborative process and develop strategies to effect measurable change. The work of conducting this CHNA and the public availability of its findings are a tool for improving the health of the communities.

This Executive Summary provides a brief overview of the process, findings and identified priorities. Immediately following is the comprehensive Tallahassee Memorial HealthCare 2025 Community Health Needs Assessment Report containing detailed descriptions of process, primary and secondary data, significant findings and prioritization of community health needs.

Methodology

The Tallahassee Memorial HealthCare (TMH) Community Health Needs Assessment (CHNA) Advisory Committee directed the planning and execution of the CHNA process and activities. Committee members were engaged based on knowledge, skills and professional role. The CHNA Advisory Committee began meeting in November 2024. The committee and its support team developed a timeline for activities, reviewed and updated survey tools, created lists of stakeholders and community partners, engaged necessary consultants and planned and scheduled community meetings.

In January 2025, a kick-off meeting was hosted with community partners and stakeholders to:

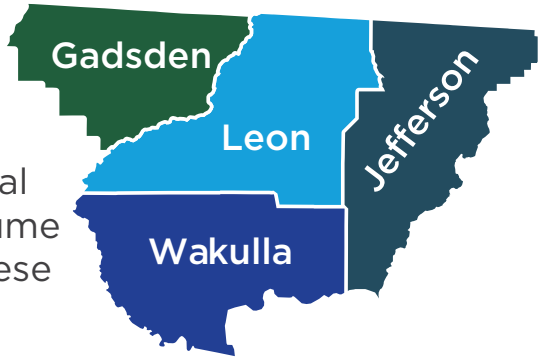
- Introduce the CHNA process
- Review the most current secondary data
- Provide an update of 2022 CHNA initiatives
- Share the Community Stakeholder Survey
- Leverage partners and stakeholders to drive responses to the Community Health Survey

Primary data collection was coupled with secondary data collection that included demographic and socioeconomic indicators as well as health indicators aligned with the priority areas defined by the State of Florida Health Improvement Plan (SHIP).

Community Served

TMH determined the definition and scope of the community served by assessing the geographic area representing approximately 80% of its inpatient discharges and ambulatory surgery services. For this CHNA, the defined service area includes Gadsden, Jefferson, Leon and Wakulla counties. These counties comprised 78% of TMH's annual patient volume from fiscal year 2022 to fiscal year 2024 (Q4 2021 – Q3 2024) with Leon County alone accounting for 56% of patient volume. (Data Source: Florida Agency for Health Care Administration, Hospital Inpatient and Ambulatory Surgery datasets).

Nearly of **80%** TMH's annual patient volume are from these counties.



State of Florida Health Improvement Plan Priority Areas

TMH made a strategic shift in 2025 to integrate the State of Florida's Health Improvement Plan (SHIP) priority health areas into the community health needs assessment. This shift improves alignment of TMH's CHNA efforts with established state and national public health initiatives. The health priority areas addressed in this year's CHNA include:

- Alzheimer's Disease and Related Dementias
- Chronic Diseases and Conditions
- Injury, Safety and Violence
- Maternal and Child Health
- Mental Well-Being and Substance Abuse Prevention
- Social and Economic Factors Contributing to Health

Partners and stakeholders representing an interest in these priority health areas were engaged for feedback and secondary data collection was focused on health indicators impacting these conditions.

Demographics of the Community

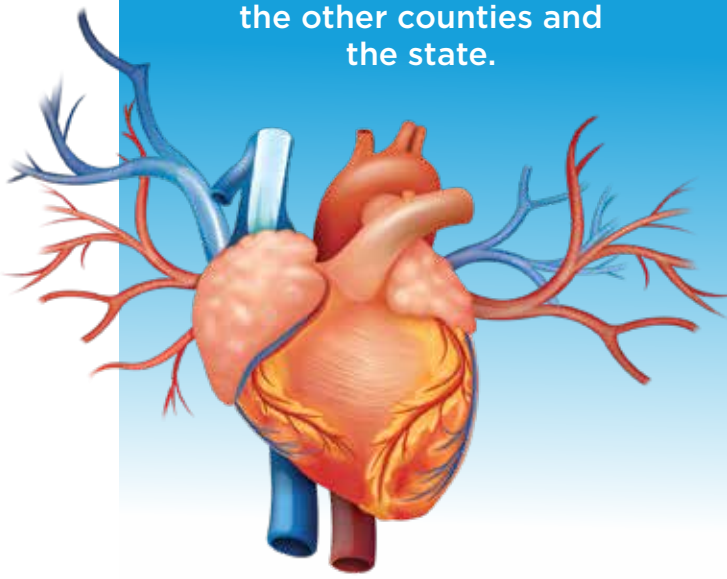
TMH's primary service area, comprised of Gadsden, Jefferson, Leon and Wakulla counties, has a total population of over 397,000 according to the most recent American Community Survey by the United States Census Bureau. This represents a growth of 3% in the service area population since the 2022 CHNA. Seventy-six percent of the population lives in Leon County with Gadsden, Wakulla and Jefferson comprising 11%, 9% and 4%, respectively. The four counties differ greatly in age, race, socioeconomic status and health outcomes of residents.

Significant Health Needs of the Community

The 2025 CHNA revealed notable disparities in health outcomes across the service area, influenced by county, neighborhood, age and race/ethnicity. Poverty and lower educational attainment were most pronounced in Gadsden, Wakulla and Jefferson counties.

Life expectancy was lowest in Gadsden County (72.8 years vs. Florida's 78.6). Heart disease remained the leading cause of death in all counties except Wakulla, where cancer was the leading cause. Gadsden had the highest heart disease death rate, and Wakulla had the highest cancer mortality. Additional trends included rising cancer deaths in Wakulla, increasing stroke deaths in Gadsden and higher-than-average mortality from unintentional injury and cerebrovascular disease in some areas.

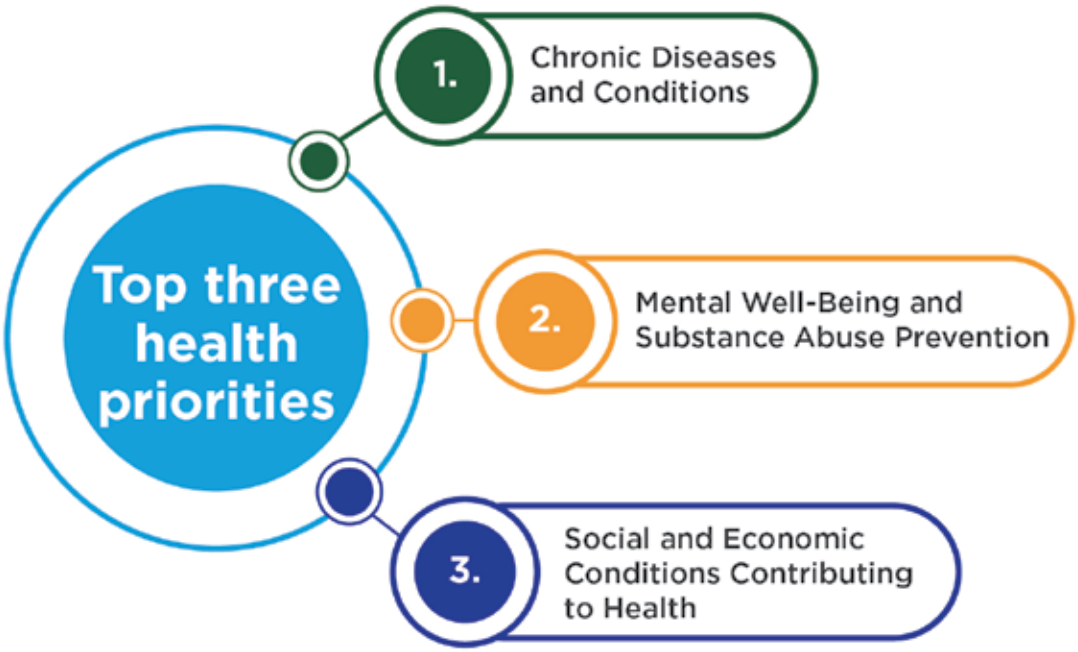
Heart disease was the leading cause of death in all counties except Wakulla County, where cancer was the leading cause of death. The mortality rate due to cancer in Wakulla County was notably higher than the rate of the other counties and the state.



Mental health concerns emerged as a growing need, with hospitalizations for mental disorders and suicide deaths increasing in all service area counties, despite flat or improving state-level indicators.

Access challenges were underscored by physician and dentist shortages in Gadsden, Jefferson and Wakulla counties, forcing many residents to seek care outside their communities.

Community and stakeholder surveys consistently identified the same top three health priorities:



Key barriers to health included high costs of care and prescriptions, long wait times and difficulty finding providers. Populations most at risk were low-income individuals and families, homeless individuals and immigrants.

Finally, partner and stakeholder discussions emphasized three recurring themes critical to improving community health: access to health services, care coordination and prevention.

Prioritization of Needs

On May 16, 2025, the CHNA Advisory Committee, CHNA support team, community partners and stakeholders met in a hybrid format at the main branch of the Leon County Library. During the meeting, FSU's Dr. Karin Brewster, TMH leaders and the CHNA Support Team provided an overview of the CHNA process, a snapshot of the service area demographics, key health indicator statistics, summaries of the Community Health Survey, and Community Stakeholder Survey and themes from the Florida State Health Improvement Plan (SHIP).

Attendees at the May 16 meeting were asked for feedback on the identified themes of Access, Care Coordination and Prevention, as well as the prioritized health areas. Overall, while stakeholders saw needs in all priority health areas, the group voiced general agreement with the themes and suggested additional stakeholder meetings to continue to evaluate data and jointly develop actionable strategies to address these needs.

In the summer of 2025, the CHNA Advisory Committee reconvened to confirm the health priorities and discuss approaches to address identified needs. Due to the overlap in the priority health areas, the Committee opted to move ahead with evaluating resources and developing implementation strategies for all seven Florida SHIP health priority areas. The "top three" areas would be prioritized, using a framework that addresses Access, Care Coordination and Prevention, across the health needs in the development of the implementation plan.

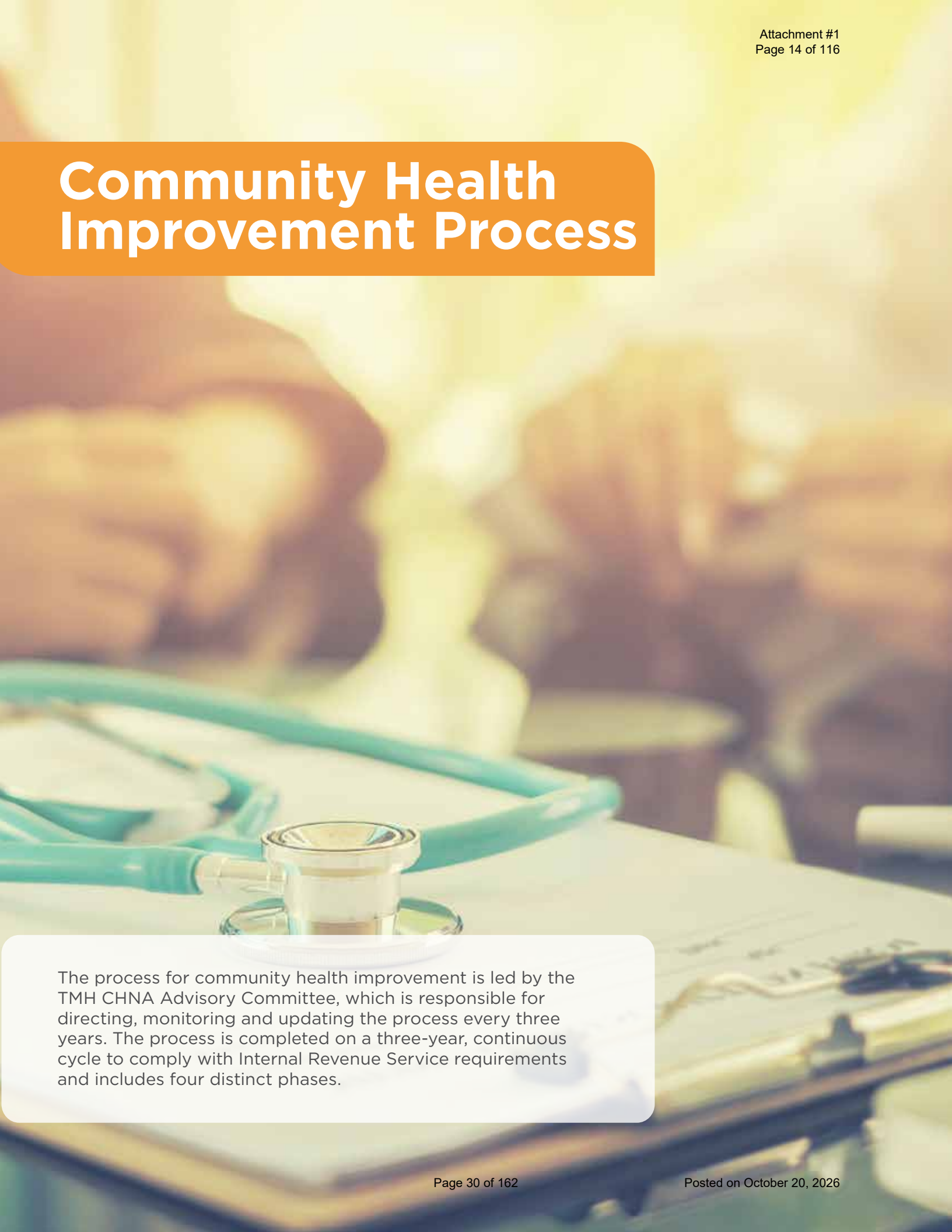
For the 2025 Community Health Needs Assessment, the health priority areas for TMH are:

1. **Chronic Diseases and Conditions**
2. **Mental Well-Being and Substance Abuse Prevention**
3. **Social and Economic Factors Contributing to Health**
4. **Alzheimer's Disease and Related Dementias**
5. **Maternal and Child Health and Violence**
6. **Injury, Safety and Violence**
7. **Transmissible and Emerging Diseases**

In alignment with the TMH Mission, Vision and Strategic Plan, TMH will work with partners and stakeholders in the fall and winter of 2025-2026 to develop an implementation strategy with tactics and interventions to address the identified health needs utilizing the framework of Access to Health Services, Care Coordination, and Prevention, and beginning with the top three areas identified in the CHNA surveys.



Community Health Improvement Process



The process for community health improvement is led by the TMH CHNA Advisory Committee, which is responsible for directing, monitoring and updating the process every three years. The process is completed on a three-year, continuous cycle to comply with Internal Revenue Service requirements and includes four distinct phases.

PHASE 1: CONDUCT COMMUNITY HEALTH NEEDS ASSESSMENT

The first step of conducting a CHNA is to create a project plan and timeline. This plan documents the tasks needed to conduct the CHNA, who is responsible for each task and the start and end dates for each task.

The next step in the CHNA process is to collect relevant primary and secondary data. Primary data for this year's report included facilitated meetings to address community health priority areas, a Community Stakeholder Survey and a Community Health Survey. Secondary data included a review of scientific samples and population records from state and federal sources specific to the service area. A description of each type of data is found below.

The Florida State Health Improvement Priority Area Meetings

In 2021, Florida implemented a State Health Improvement Plan (SHIP) focused on seven priority areas. TMH facilitated meetings focused on each of the seven priority areas as a framework to ensure local feedback in alignment with the State's public health priorities:

- Injury, Safety and Violence
- Maternal and Child Health
- Mental Well-Being and Substance Abuse Prevention
- Alzheimer's Disease and Related Dementias
- Chronic Diseases and Conditions
- Transmissible and Emerging Diseases
- Social and Economic Factors Contributing to Health

Representatives from community organizations in Leon, Gadsden, Jefferson and Wakulla counties were invited to participate. This included health departments, government officials, schools and universities, health agencies, city and county services and other community health partners. Meetings were held throughout February 2025 and offered participants an opportunity to attend in person or remotely. An analysis of strengths, weaknesses, opportunities and threats, organized by priority area was developed using feedback from participants.

Community Stakeholder Survey

The Community Stakeholder Survey was an electronic survey, developed specifically for the community health partners representing at-risk or under-represented populations in the service area. The Community Stakeholder Survey consisted of eleven questions focused on the populations served, critical health needs, barriers to health and opportunities to improve the health of the community. See Appendix 1 for the Community Stakeholder Survey.

Community Health Survey

The main Community Health Survey consisted of 53 questions designed to assess the health and Well-Being of people living in the TMH service area. In addition to demographic information, there were questions about access and barriers to healthcare, current health status, health behaviors and lifestyle and social determinants of health. The survey also included an additional 18 questions focused on child health needs. See Appendix 2 for the Community Health Survey.

Secondary Data Collection

Secondary data included a review of publicly available data from the Florida Department of Health, Bureau of Vital Statistics, and other state and federal sources, to better understand. the health of and social factors that impact the community served. Trended data were available for each county and compared to the State as a benchmark.

Prioritization

After all primary and secondary data were collected, a CHNA Prioritization of Needs meeting was held to review the quantitative and qualitative data with the CHNA Advisory Committee, stakeholders and partners. Attendees were asked to share feedback about common themes that emerged and suggest any additional needs that might not have been included. Then, the top areas of health needs and additional feedback were evaluated by the CHNA Advisory Committee to determine final CHNA priorities.

Community Health Needs Assessment Report

The last step of the CHNA was publishing the primary and secondary data, significant findings and the prioritization of needs into the final CHNA report. The CHNA report was approved by the TMH Board of Directors and was published in the same fiscal year as the data collection and written document. The CHNA report was made widely available to the community via the TMH website at TMH.org/CHNA. Print copies are also available through the TMH Marketing and Communications Department. Stakeholder and partner organizations may also publish data on their websites with proper citation and attribution.

PHASE 2: IMPLEMENTATION STRATEGY DEVELOPMENT

Now that the CHNA has been completed and approved by the TMH Board of Directors, TMH will develop a written Implementation Strategy that specifies what health needs were identified in the CHNA and what needs the organization plans to address along with its community health partners. Any health needs that the organization does not plan to address, along with reasons for each, will be included in this report.

The document will include proposed evidence-based interventions for each prioritized health area along with specific goals and objectives. Progress will be tracked over time with both process and outcome measures. The TMH Board of Directors will approve the Implementation Strategy. TMH will align the Implementation Strategy with existing organizational and community plans and will host a community event in early 2026 to share the CHNA results along with the corresponding Implementation Strategy. The Implementation Strategy will be reported to the Internal Revenue Service on the organization's Form 990.

PHASE 3: PROGRAM IMPLEMENTATION

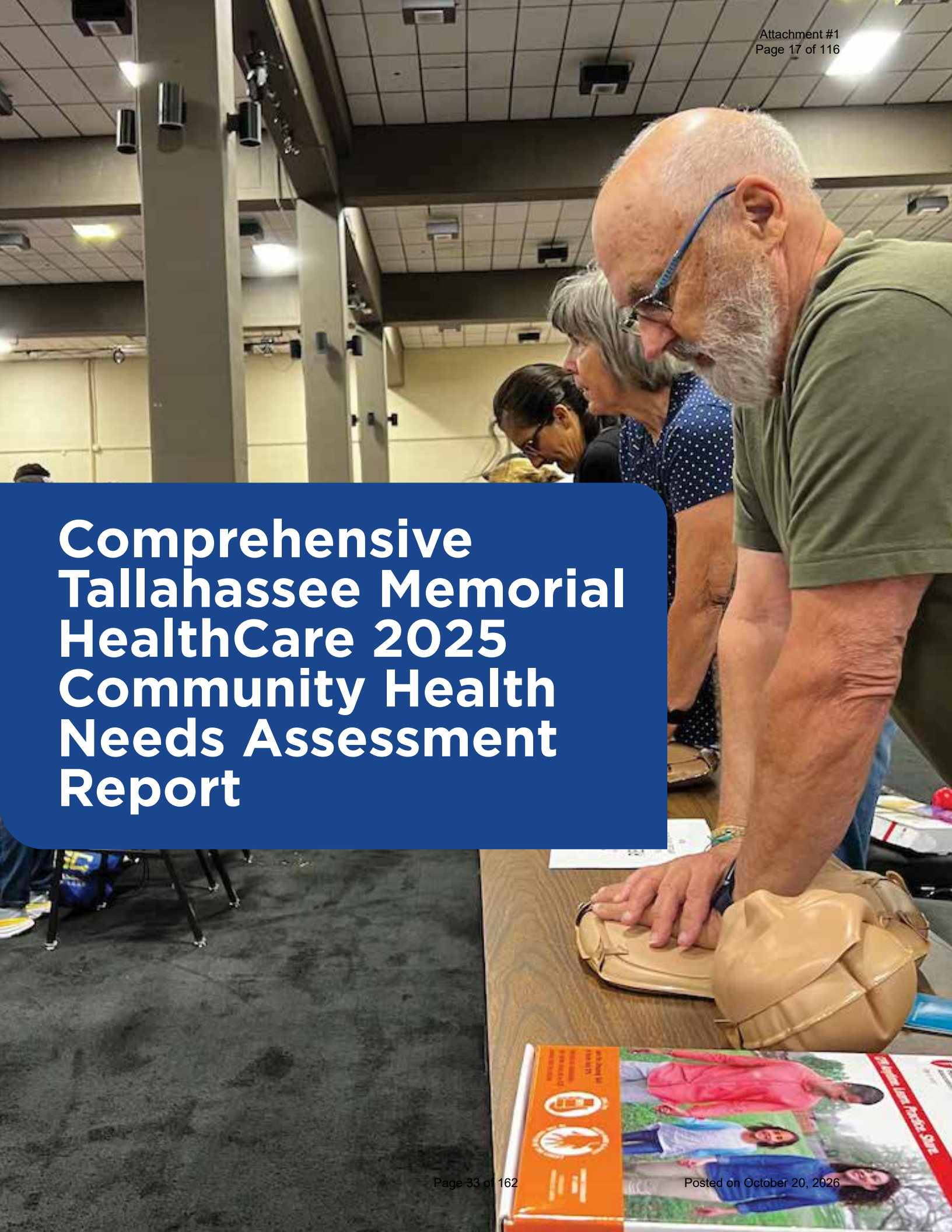
TMH will respond to the community health needs identified in the CHNA by utilizing and expanding existing programs and community partnerships while also establishing new programs and initiatives where needed.

PHASE 4: EVALUATION

TMH's Regional Development and Population Health Department and the CHNA Advisory Committee will monitor process and outcome measures associated with the Implementation Strategy.

TMH will provide a written report of progress made toward goals and objectives identified in the Implementation Strategy on the annual Internal Revenue Service Form 990.

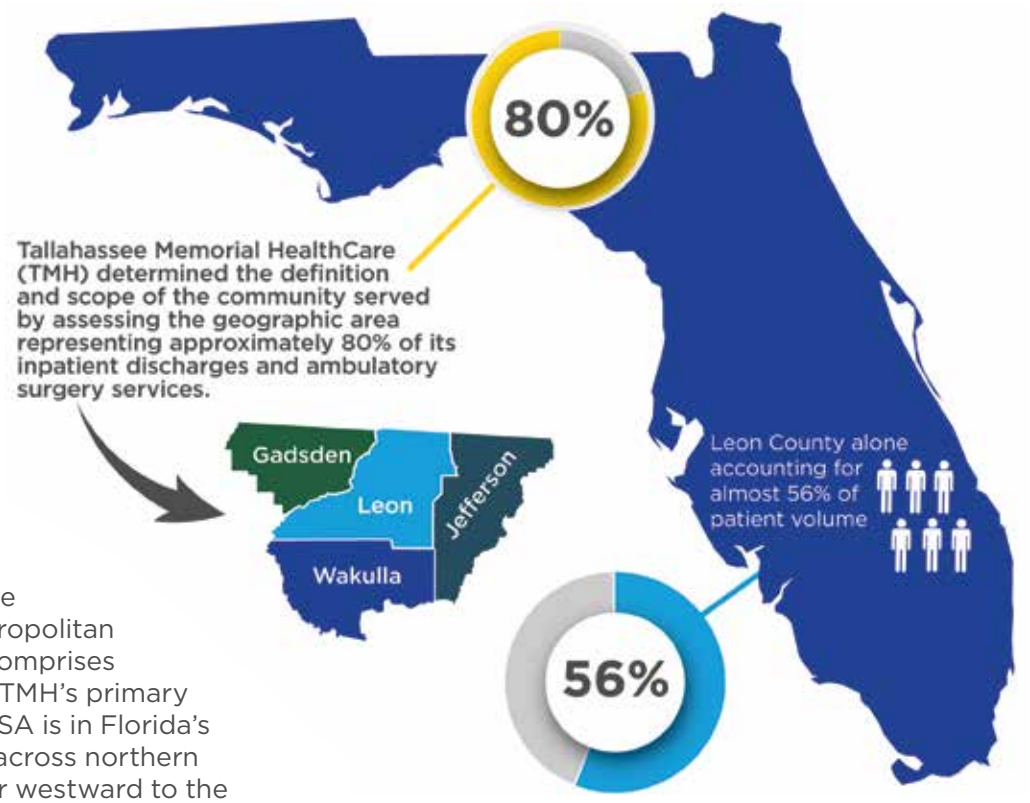




Comprehensive Tallahassee Memorial HealthCare 2025 Community Health Needs Assessment Report

Definition of the Community Served by the Hospital Facility

Tallahassee Memorial HealthCare (TMH) determined the definition and scope of the community served by assessing the geographic area representing approximately 80% of its inpatient discharges and ambulatory surgery services. For this CHNA, the defined service area includes Gadsden, Jefferson, Leon and Wakulla counties. These counties comprised 78% of TMH's annual patient volume from fiscal year 2022 to fiscal year 2024 (Q4 2021 – Q3 2024) with Leon County alone accounting for 56% of patient volume. (Data Source: Florida Agency for Health Care Administration, Hospital Inpatient and Ambulatory Surgery datasets).



Demographics of the Community

TMH is based in Tallahassee, the core city in the Tallahassee Metropolitan Statistical Area (MSA)[1], which comprises the four counties that make up TMH's primary service area. The Tallahassee MSA is in Florida's Big Bend region and stretches across northern Florida from the St. John's River westward to the Apalachicola National Forest. The MSA has an estimated 2024 population of 397,675, 76% of whom reside in Leon County, the most densely populated county in the MSA. Leon County is bounded to the south by Wakulla County and to the east by Jefferson County. Gadsden County lies to its west and, like both Leon and Jefferson counties, is bordered to the north by southwest Georgia. The Gulf of Mexico demarcates the southern borders of Jefferson and Wakulla counties, and their landscapes include salt marshes, oyster reefs, hardwood and pine forests, lakes, swamps, freshwater springs and the mix of agricultural land that characterize the Big Bend region.

Characteristics of the Tallahassee MSA and its Component Counties

	Total Area (square miles)	Land area (square miles)	Estimated population, 2024	Density (population per square mile)
Leon	702	667	300,488	450.5
Gadsden	529	516	44,151	83.5
Jefferson	637	598	15,921	25.0
Wakulla	736	606	37,115	50.4
MSA total	**2,604**	**2,387**	**397,675**	**166.6**

Table 1: Characteristics of the Tallahassee MSA and its Component Counties. Sources: Geographic information from https://www.census.gov/quickfacts/; population estimates from Metropolitan and Micropolitan Statistical Areas Population Totals: 2020-2024, www.census.gov/data/tables/time-series/demo/popest/2020s-total-metro-and-micro-statistical-areas.html. Accessed June 2, 2025.

[1] Metropolitan Statistical Areas consist of a county containing an Urban Area that has a population of at least 50,000 and any adjacent counties whose commuting patterns suggest social and economic integration with that urban area (U.S. Bureau of the Census, 2025: https://www.census.gov/programs-surveys/geography/about/glossary.html).

In 2024, the Tallahassee MSA had an estimated population of 397,675. As Leon County's population density suggests, the largest share of the MSA's population (75.6%) resides in Leon County, followed by Gadsden (11.1%), Wakulla (9.3%) and Jefferson (4.0%) counties. The MSA population is 3% larger in 2025 than in 2022, when TMH conducted its last CHNA.

Population of the Tallahassee MSA by County, Select Years						
	2013	2016	2019	2022	2024	2021
Gadsden	46,084	46,069	45,670	43,714	44,151	43,714
Jefferson	14,212	13,985	14,280	14,555	15,921	14,555
Leon	282,006	286,960	293,866	292,817	300,488	292,817
Wakulla	31,009	31,894	33,636	34,690	37,115	34,690
Total	**373,311**	**378,908**	**387,452**	**385,776**	**397,675**	**385,776**

Table 2: Population of the Tallahassee MSA by County, Select Years. Sources: U.S. Census Bureau, October 2021, Annual Resident Population Estimates for Metropolitan and Micropolitan Statistical Areas. http://www.census.gov/programs-surveys-popest/technical-documentation/research/evaluation-estimates/2020-evaluation-estimates/2010s-totals-metro-and-micro-statistical-areas.html, accessed May 26, 2022. U.S. Census Bureau, March 2025, Metropolitan and Micropolitan Statistical Areas Population Totals: 2020-2024, www.census.gov/data/tables/time-series/demo/popest/2020s-total-metro-and-micro-statistical-areas.html, accessed June 2, 2025.

Tallahassee, the only incorporated municipality in Leon County, is the state capital and the largest city in Florida's Panhandle. Tallahassee serves as the agricultural and commercial hub for the Tallahassee MSA and is home to state government offices as well as two of Florida's public universities—Florida State University (FSU) and Florida A&M University (FAMU)—and Tallahassee State College (TSC), part of the Florida College System. Student enrollments at these three schools exceeded 59,000 in 2024, comprising almost 15% of Tallahassee's total population.

Leon County also serves as the hub for health and service agencies serving residents of the Tallahassee MSA. Its resources include a Level II Trauma Center (TMH), the Sergeant Ernest I. "Boots" Thomas VA Clinic, a non-profit mental health center offering inpatient, outpatient and residential services and two hospitals: TMH and HCA Florida Capital Hospital.

All three post-secondary institutions in Tallahassee offer educational and training programs for health professions: FSU has a College of Nursing, a College of Medicine and a recently launched public health program (Bachelor of Science in Public Health and Masters of Public Health). FAMU has a College of Pharmacy and Pharmaceutical Sciences, a School of Nursing and an Institute of Public Health, in addition to programs in physical and occupational therapy. TSC's programs include degrees in nursing (Associate of Science in Nursing and Bachelor of Science in Nursing), dental hygiene, EMS technology, medical assisting, medical sonography, radiologic technology, respiratory care and surgical technology.

Residents of the four-county area do not benefit equally from these resources, a disparity that is evident in the designation of Gadsden and Wakulla counties as medically underserved areas (MUA) and the low-income populations of Jefferson and Leon counties designated as medically underserved populations (MUP). Evaluation of medical underservice is based on the ratio of primary care providers to population, rates of infant mortality and percentage of the population that is poor, elderly or both.

Gadsden, Jefferson and Wakulla counties are designated Geographic Health Professional Shortage Areas (HPSA), with too few primary care physicians, dentists, dental hygienists and mental health professionals. Leon County's low-income population is also designated as Population HPSA.

Because of these designations, the TMH MSA has fifteen Federally Qualified Health Center locations: eleven in Leon County and four in Gadsden County. In addition, the health departments of all four counties provide free or low-cost medical and dental services and an array of other health and social services intended to provide more access to care for under- and uninsured residents.

Medical Underservice Designations in the Tallahassee MSA	
Designation:	Index of Medical Underservice Score[2]
Medically Underserved Area:	
Gadsden County	53.7
Wakulla County	55.7
Medically Underserved Population:	
Low-income population of Jefferson County	51.5
Low-income population of Leon County	59.5

Table 3: Medical Underservice Designations in the Tallahassee MSA. Source: Health Resources & Services Administration: https://data.hrsa.gov/tools/data-explorer, accessed June 2, 2025. [2] The IMUS score ranges from 0 to 100, with 0 representing the greatest need. To be designated a Medically Underserved Area or Medically Underserved Population, an area must score less than 62. See https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation for more information.

Community Demographic and Socioeconomic Characteristics

The four counties that comprise the Tallahassee MSA are demographically and socioeconomically diverse, with differences in the distributions of their respective populations by age, education, economic status, race/ethnicity and nativity. A brief consideration of these characteristics illuminates the area's medically underserviced designation. Greater detail is included in tables presented later in this report, with the Community Health Needs Assessment Secondary Data.

Age: The Tallahassee MSA is younger than the state population, with a median age of 35.6 compared to the Florida median age of 42.6. Jefferson County has the oldest population in the Tallahassee MSA with nearly one-quarter of its population age 65 or older and a median age of 47. The age distributions for Wakulla and Gadsden counties describe somewhat younger populations, with median ages respectively of 42.5 and 42. Nearly 17% of the Wakulla County population is 65 or older as is about 19% of the Gadsden County population. Leon County has the youngest population of the four-county area, a reflection in part of the large student population. The median age in Leon County is 31.9 and almost 15% of its population is age 65 or older.

Distribution of Population Across Age Groups, 2023					
	Gadsden	Jefferson	Leon	Wakulla	Tallahassee MSA
Under 18 years	22.2	17.2	18.6	20.7	19.1
Under 5 years	5.8	4.1	5.2	5.2	5.2
18 to 64 years	64.2	58.3	67.9	64.2	66.5
65 years and over	19.4	24.5	13.4	15.7	14.4
85 years and over	1.3	1.8	1.5	0.9	1.5
Median age (years)	42.0	47.0	31.9	42.5	35.6

Table 4: Distribution of Population Across Age Groups, 2023
Source: Estimated using data from the 2019-2023 American Community Survey, accessed at https://data.census.gov, February 3, 2025.

Educational attainment: The four counties differ markedly with respect to the educational attainment of their adult populations. About half the residents of the Tallahassee MSA have an Associate's degree or higher, but this reflects the educational profile of Leon County, home of the state capital, two universities and a state college. As might be expected, more than 57% of Leon County adults ages 25 and older have at least an Associate's degree. In contrast, less than one-third of the population in Gadsden, Jefferson and Wakulla counties, hold an Associate's or higher degree. The percentage of adults without a high school diploma or its equivalent is notably higher in these three counties when compared to Leon County.

Highest Level of Educational Attainment by Adults Aged 25 and Older, 2023					
	Gadsden	Jefferson	Leon	Wakulla	Tallahassee MSA
Did not complete high school	18.7	12.2	6.3	12.5	8.7
High school graduate or GED	55.0	60.4	36.4	58.5	42.1
Associate degree	6.2	8.5	8.7	7.7	8.3
Bachelor's degree	13.0	11.8	27.6	13.6	23.6
Graduate or professional degree	7.1	7.1	21.0	7.6	17.3

Table 5: Highest Level of Educational Attainment by Adults Aged 25 and Older, 2023
Source: Estimated using data from the 2019-2023 American Community Survey, accessed at https://data.census.gov, February 3, 2025.

Economic Status: The Tallahassee MSA had a median household income in 2023 of about $ 63,078, significantly lower than the Florida median of $ 71,711. Within the MSA, median household income was lowest in Gadsden County, where nearly 28% had household incomes at or below the federal poverty level. Fewer people lived in poverty in Leon County (18.5%) and Jefferson County (20.3%) than in Gadsden County, and median household income was higher in both. Wakulla County had the highest median household income in the MSA and the smallest portion living in poverty. Consistent with its

lower economic status, Gadsden County also has the highest percentage of residents lacking health insurance at 16.4%. Medically uninsured rates in Jefferson, Leon and Wakulla counties are under 10%.

Economic Status Indicators, 2023					
	Gadsden	Jefferson	Leon	Wakulla	Tallahassee MSA
Median household income ($)	46,047	56,984	65,074	74,183	63,078
Persons in poverty (%)	27.7	20.3	18.5	5.6	18.5
Persons without health insurance (%)	16.4	9.8	7.7	6.6	8.6

Table 6: Economic Status Indicators, 2023
Source: Estimated using data from the 2019-2023 American Community Survey, accessed at https://data.census.gov, February 3, 2025.

Race/Ethnicity: Most residents of the Tallahassee MSA identify as either non-Hispanic White (53%) or non-Hispanic Black (32%), but the distribution of these two groups varies significantly by county. For example, over half of Gadsden County residents identify as Black while about 77% of Wakulla County residents identify as White. Persons of Hispanic descent comprise about 8% of the MSA population, with the highest shares in Gadsden and Leon counties (12% and 8%, respectively).

Percentage of Distribution of the Population by Race and Hispanic Origin, 2023					
	Gadsden	Jefferson	Leon	Wakulla	Tallahassee MSA
Not Hispanic:	88.1	95.2	92.1	95.3	91.8
White alone	31.5	60.1	53.9	76.9	52.6
Black alone	54.6	30.0	30.4	13.9	31.6
Asian alone	0.1	0.7	3.4	0.5	2.9
Alaskan Native or Native American alone	0.1	0.2	0.1	0.2	0.0
Hawaiian / Pacific Islander alone	0.0	0.0	0.0	0.0	0.0
Other race	0.1	0.5	0.5	0.7	0.6
Two or more races	1.7	3.8	3.8	3.2	4.1
Hispanic, any race	11.9	4.8	7.9	4.7	8.2

Table 7: Percentage of Distribution of the Population by Race and Hispanic Origin, 2023
Source: 2019-2023 American Community Survey, accessed at https://data.census.gov, February 3, 2025.

Nativity: Most residents of the Tallahassee MSA were born in the United States; with just 6.5% of the MSA population born abroad to non-native parents. Within the MSA, Leon County has the highest share of foreign-born residents (7.3%) and Jefferson County has the lowest (2.7%). Gadsden County has the largest percentage of Florida natives (73%) and Leon County has the smallest (57.3%).

Percentage Distribution of the Population by Birthplace, 2023					
	Gadsden	Jefferson	Leon	Wakulla	Tallahassee MSA
U.S. Native:	93.8	95.3	90.9	94.9	91.7
Born in Florida	72.6	59.1	57.3	58.9	59.1
Born in different state	21.3	36.3	33.5	38.6	32.6
Born in Puerto Rico, U.S. territory, or born abroad to U.S. parents	1.3	2.0	1.8	1.8	1.7
Foreign born	4.9	2.7	7.3	3.3	6.5

Table 8: Percentage Distribution of the Population by Birthplace, 2023
Source: 2019-2023 American Community Survey, accessed at https://data.census.gov, February 3, 2025.

PRIMARY DATA

Tallahassee Memorial HealthCare (TMH) engaged the community and collected primary data using various methods. This included soliciting input from community stakeholders and partners through meetings and an online stakeholder survey during the Community Health Needs Assessment (CHNA) process. Detailed descriptions of each method and results can be found in the following sections: State of Florida Health Improvement Plan (SHIP) Priority Area Meetings, Community Stakeholder Survey and the Community Health Survey.

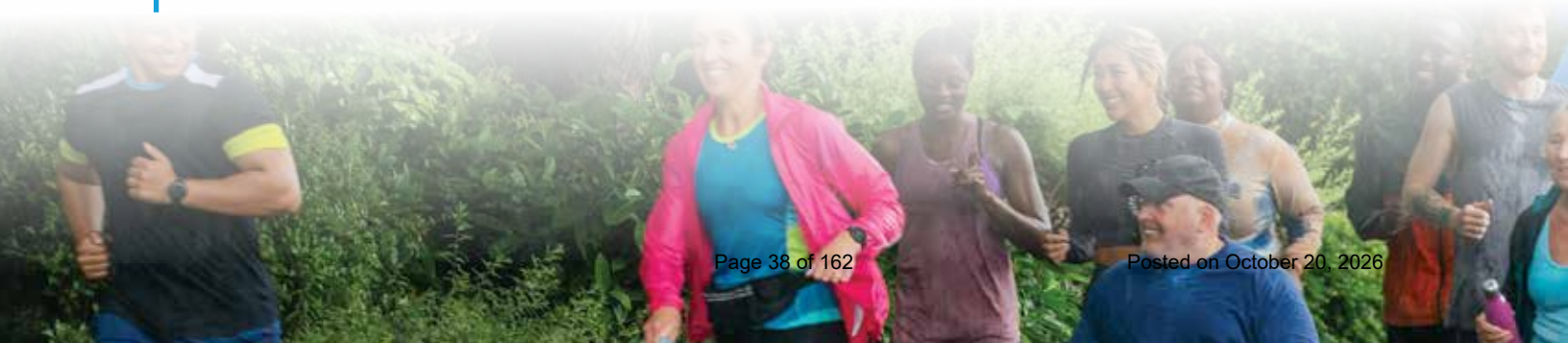
State of Florida Health Improvement Plan (SHIP) Priority Area Meetings

To improve the alignment of the TMH CHNA with existing state and national public health initiatives, TMH made a strategic shift to integrate the State of Florida's Health Improvement Plan into the community health planning process. This shift ensures that the CHNA initiatives complement and enhance the goals outlined by state health agencies, driving greater impact and fostering collaboration across various levels of public health work.

In February 2025, TMH facilitated seven meetings to collect feedback from stakeholders.

The Florida SHIP outlines key priority areas that guide health improvement efforts across the state:

1. **Injury, Safety, and Violence**
   Seeks to decrease preventable injuries like vehicle accidents, falls and violence-related trauma by implementing educational programs, policies and targeted community interventions.
2. **Maternal and Child Health**
   Focuses on the health of mothers and children by addressing maternal and infant mortality, enhancing prenatal care and supporting early childhood development and wellness.
3. **Chronic Disease Prevention and Management**
   Addresses reducing chronic health conditions such as diabetes, hypertension and obesity—which are major contributors to illness and death in Florida—through effective management and preventive strategies.
4. **Mental Well-Being and Substance Abuse Prevention**
   Aims to effectively address mental health events, prevent substance use disorders and expand accessible, high-quality treatment for mental health and addiction challenges.
5. **Transmissible and Emerging Diseases**
   Focuses on mitigating the spread and impact of infectious diseases through robust vaccination initiatives, disease monitoring and rapid responses to emerging health threats.
6. **Alzheimer's Disease and Related Dementias**
   Centers on improving early diagnosis, care and support systems for individuals with Alzheimer's and related dementias, while providing crucial resources for their caregivers and families.
7. **Social and Economic Conditions Affecting Health**
   Addresses health inequities stemming from social and economic factors, emphasizing interventions that improve housing stability, food security, healthcare access and overall community resilience.



The CHNA Advisory Committee engaged community health partners based on their knowledge of existing healthcare resources and needs, their outreach to specific populations and their interest in engaging in the Community Health Needs Assessment process. The Committee also invited individuals from health departments, government agencies, schools and other community organizations in Leon, Gadsden, Wakulla, and Jefferson counties to participate. In total, over 150 individuals participated in these meetings in person or remotely, providing invaluable insights to help guide the strategic direction of health interventions in our region.

These meetings created an inclusive forum for discussing health care data, sharing knowledge of population needs from various viewpoints, and providing feedback on challenges and opportunities within the priority areas. For each priority area, the Committee completed a strengths, weaknesses, opportunities and threats (SWOT) analysis to summarize the discussion and feedback.

Injury, Safety and Violence

Preventable injuries and acts of violence continue to impact health outcomes and community well-being across the TMH service area. Local data highlighted disparities in firearm-related deaths, motor vehicle deaths, domestic violence and childhood injuries. While the region benefits from strong cross-sector collaboration and public health engagement, significant challenges remain. This includes fragmented data systems, limited access to follow-up care for high-risk populations and uneven prevention efforts across counties.

Stakeholders reviewed state and local trends and discussed opportunities to address key indicators related to violence, unintentional injuries and public safety.

Stakeholder Meeting SWOT Analysis: Injury, Safety and Violence

S Strengths

- Engagement across healthcare, public health, law enforcement, education and community organizations supports collective responses
- Initiatives such as Operation Prom Night, Stop the Bleed, Narcan distribution and drowning prevention indicate strong local commitment
- TMH and partners use injury data to inform planning and interventions
- TMH screens patients for domestic and partner violence, facilitating early detection
- Joint efforts between law enforcement and EMS address traffic safety, bicycle injuries and pedestrian risks
- Stakeholders expressed shared willingness to improve coordination and expand resources

W Weaknesses

- Injury and violence prevention programs are often siloed across agencies with limited integration
- Many programs depend on time-limited or unstable grant funding
- Providers and the public often lack awareness of available safety and support services
- High-risk populations—especially the uninsured or unhoused—lack rehabilitation services access or follow-up support after injury
- Programs like D.A.R.E. and injury prevention are no longer widely implemented
- Despite robust data collection, findings are not consistently translated into local policy
- EMS frequently identifies safety risks but lacks mechanisms for community referrals



Opportunities

- A centralized data-sharing platform across EMS, hospitals, public health and law enforcement could enhance surveillance and prevention
- Social media campaigns targeting youth could elevate awareness on gun safety, safe driving and injury prevention
- Local advocacy could support stronger safety laws and regulations
- Expanding transitional care and post-injury rehabilitation for vulnerable populations would reduce readmissions
- Establishing a respite facility for unhoused patients could improve recovery outcomes and reduce emergency department burden
- Reviving injury prevention education in schools and workplaces would address root causes earlier
- Mobile outreach through paramedicine programs could identify risks, such as fall hazards, overdose potential or domestic violence indicators

Threats

- Political opposition to firearm laws, traffic safety regulations or injury prevention mandates could stall progress
- Prevention programs reliant on short-term grants face sustainability risks
- Resistance to behavioral change (e.g., seatbelts, helmet laws) may limit the effectiveness of interventions
- Domestic violence and gun-related threats are often underreported due to fear or stigma
- A limited healthcare and social service workforce reduces capacity to expand trauma, mental health and prevention services
- Many trauma survivors lack access to mental health services or coverage for post-injury recovery, leading to repeat ER visits and long-term disability
- Resource gaps in low-income and rural communities create higher risk for preventable injury and violence
- Cell phone use, vaping and impaired driving trends continue to escalate crash risks without stricter enforcement

In summary, the TMH service area has opportunities to prevent injuries and reduce violence, particularly in Gadsden, Jefferson and Leon counties. Strong foundations in collaboration, data collection and existing prevention programs create an opportunity for coordinated, data-driven responses. Community education, post-injury support and trauma-informed interventions would be additional key factors in reducing disparities and improving safety outcomes across the service area.

Maternal and Child Health

Maternal and child health remains a significant concern across the TMH service area, particularly among economically vulnerable and rural populations. Participants reviewed trends in Medicaid coverage, prenatal care access, birth outcomes and pediatric service utilization across Leon, Gadsden, Jefferson and Wakulla counties. The findings highlight both areas of progress and ongoing disparities that require targeted intervention and coordinated care strategies.

The region benefits from strong partnerships, including TMH's investments in pediatric subspecialty care and established community support through Healthy Start and local health departments. However, coordination gaps, behavioral health shortages and socioeconomic stressors continue to strain services for families and children.

Stakeholder Meeting SWOT Analysis: Maternal and Child Health

S Strengths

- TMH, Healthy Start, county health departments and other agencies such as Capital Health Plan and United Partners for Human Services, provide a wide range of maternal and pediatric services
- 61% of births are covered by Medicaid, reducing financial barriers and ensuring baseline access to prenatal and delivery care
- Leon and Wakulla counties exceed the state average for adequate prenatal care, driven by screening, education and doula services
- Community outreach and support programs have contributed to a reduction in racial disparities in infant mortality from 3.5% to 1.5% in 2023
- Ongoing development of pediatric cardiology, neonatology, neurology and behavioral health services is improving local capacity to manage high-risk conditions

W Weaknesses

- Lack of centralized coordination between maternal health programs creates duplication, inefficiencies and gaps in care
- Gadsden and Jefferson counties continue to report outcomes significantly worse than the state average for high infant mortality and stillbirth rates
- Delays in maternal-fetal medicine (MFM) referrals and pediatric behavioral health evaluations impact early diagnosis and intervention
- Inconsistent ride services result in missed prenatal and pediatric appointments, particularly in rural counties
- Stagnant commercial insurance rates limit options for middle-income families who fall outside Medicaid eligibility but cannot afford private insurance
- Lack of postpartum mental health services and long waits for pediatric behavioral care impact long-term outcomes

O Opportunities

- Telemedicine can improve access to prenatal and pediatric services, especially for rural residents with transportation or provider access challenges
- Incentives, such as provider loan repayment and public-private partnerships with medical schools, can strengthen regional pipelines for OB/GYNs, MFMs and pediatric subspecialists
- Extending postpartum Medicaid eligibility and improving transportation services can address major care gaps
- One-stop maternal and child health centers integrating WIC, doula support, behavioral health and home visitation programs can improve continuity and reduce disparities
- Expanding reproductive health education in schools in high-need counties can address teen pregnancy prevention



Threats

- Staffing limitations, especially in OB/GYN, nursing and pediatric subspecialties, limit regional capacity and drive long wait times
- Inflation and inadequate insurance coverage for working families create financial barriers to maternal and newborn care
- Families lacking affordable childcare may miss follow-up care or delay seeking services
- Current Medicaid policies exclude many working families and lack robust maternal mental health provisions
- Increasing rates of gestational hypertension, diabetes and preterm birth—especially among Black and Hispanic women—highlight the need for targeted chronic disease management and culturally responsive care

In summary, maternal and child health outcomes reflect both systemic strengths and structural barriers in the TMH service area. While strong community partnerships and expanded Medicaid access have supported many families, elevated rates of infant mortality, teen births and stillbirths in rural counties signal the need for renewed focus. Enhanced care coordination, equitable access to specialty care and investments in maternal mental health and workforce development will be key factors in improving outcomes for mothers and children throughout the region.

Chronic Disease Prevention and Management

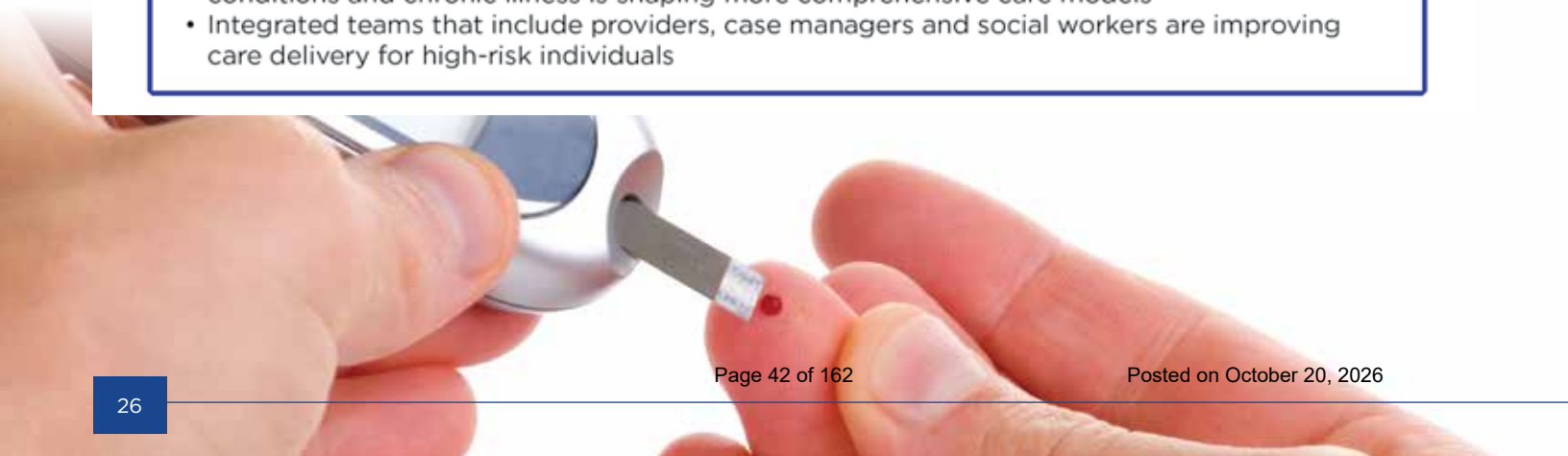
Chronic disease continues to be one of the most pressing health challenges within the TMH service area. Conditions such as hypertension, diabetes and obesity contribute significantly to poor health outcomes, health disparities and preventable hospitalizations. Stakeholders reviewed current initiatives, barriers, and strategic opportunities to improve chronic disease management through community-based services, provider collaboration and attention to social determinants of health.

Despite strong community partnerships and promising models of care, challenges persist in care coordination, access to affordable services and addressing the root causes of chronic disease, particularly among underinsured and rural populations.

Stakeholder Meeting SWOT Analysis: Chronic Disease Prevention and Management

Strengths

- We Care network and the TMH Transition Center provide crucial access points for vulnerable populations
- Partnerships between health systems, social service agencies and community organizations help address complex patient needs
- Increasing awareness of the relationship between socioeconomic conditions and chronic illness is shaping more comprehensive care models
- Integrated teams that include providers, case managers and social workers are improving care delivery for high-risk individuals



Weaknesses

- Residents in Gadsden, Jefferson and Wakulla Counties face transportation and provider access barriers, limiting chronic disease prevention and specialty care
- High out-of-pocket costs and limited insurance coverage deter individuals from seeking medications, labs and follow-up visits
- Poor communication between providers and lack of interoperable systems lead to care gaps and confusion for patients
- Substantial share of residents continue to lack consistent access to preventive and chronic disease care

Opportunities

- Virtual care and mobile clinics offer potential to reach rural residents and reduce transportation burdens
- The Live Healthy Act and Medicaid eligibility expansion could extend preventive care and reduce financial hardship for low-income patients
- Churches, schools and community-based organizations can support outreach, education and chronic disease navigation
- Training and deploying peer support specialists and community health workers can extend chronic disease education and follow-up into underserved neighborhoods

Threats

- Lack of specialists and primary care providers limits the region's capacity to manage complex, chronic conditions
- Food insecurity, housing instability and transportation limitations make disease management more difficult and increase risk for complications
- Racial, ethnic and language barriers persist in healthcare access, particularly among migrant and Spanish-speaking communities.
- Fee-for-service reimbursement models deprioritize chronic disease prevention and care continuity, as many chronic disease programs remain underfunded and unable to meet population needs

In summary, chronic disease prevention and management remain a central priority for the TMH service area. Programs, such as WE CARE and the TMH Transition Center, provide strong foundations. However, disparities in access, affordability and care coordination continue to limit health outcomes for many residents—especially those in rural and low-income communities. Continued investment in integrated care models, community partnerships and upstream social supports will be key factors into closing these gaps and improving long-term health across the region.

Mental Well-Being and Substance Abuse Prevention

Mental health and substance abuse remain critical and interconnected public health challenges across the TMH service area. Stakeholders emphasized the rising demand for behavioral health services, especially in the wake of the COVID-19 pandemic. A broad cross-section of health systems, behavioral health providers and community organizations participated in the meeting.

While local initiatives have made strides in expanding services—particularly through telehealth and integrated care models—significant gaps persist. Rural areas face barriers to accessing providers, stigma remains a barrier to care, and youth substance use is on the rise.

Stakeholder Meeting SWOT Analysis: Mental Well-Being and Substance Abuse Prevention

S Strengths

- Strong partnerships exist among hospitals, behavioral health providers, public agencies and nonprofits, enabling shared initiatives, such as Live Oak Behavioral Health
- Telehealth has expanded significantly since the pandemic, improving behavioral health access in rural and underserved areas
- Community programs are increasingly targeting adolescents, pregnant women and individuals with co-occurring disorders through tailored interventions and support

W Weaknesses

- Region lacks sufficient licensed providers, resulting in long waitlists and unmet needs
- Mental health and substance use services are often disconnected, with limited care coordination and duplication of efforts
- Despite progress, stigma related to mental illness and addiction continues to deter individuals from seeking help, particularly in rural communities

O Opportunities

- Expanded state and federal funding—particularly for school-based programs, integrated care models and Medicaid reimbursement—can strengthen behavioral health infrastructure
- Embedding prevention and resilience programs into school curriculums offers early intervention opportunities for at-risk youth
- Naloxone distribution, needle exchange programs and outreach to high-risk populations can reduce overdose deaths and prevent the spread of infectious diseases

T Threats

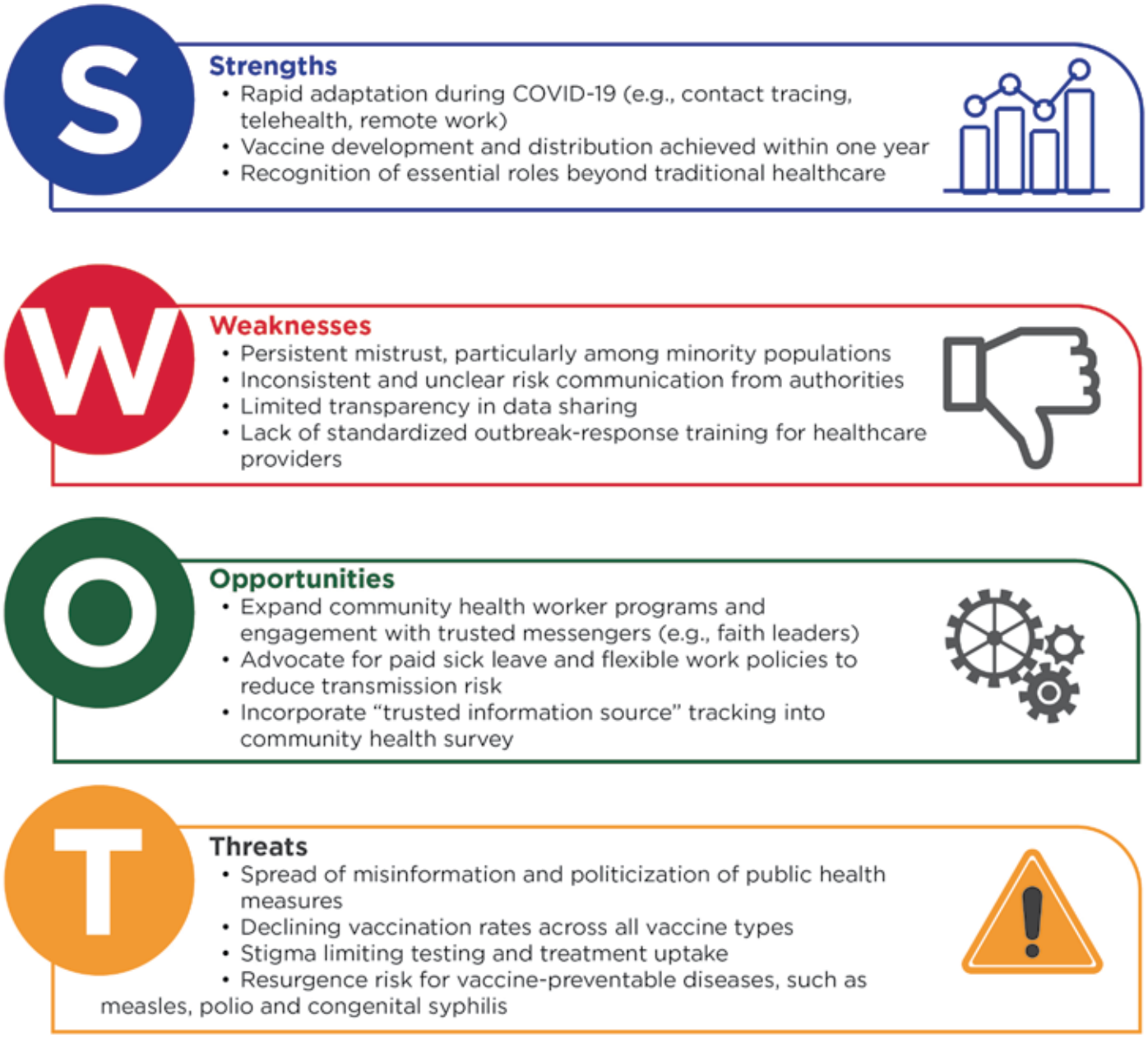
- Behavioral health programs often rely on short-term grants and inconsistent state support, which may limit growth and stability
- Continued increases in opioid and methamphetamine use may overwhelm healthcare and emergency response systems without sufficient prevention and treatment investment
- Financial constraints, provider training gaps and organizational silos continue to hinder progress toward fully integrated behavioral health systems

In summary, similar to other regions of the country, the TMH Service Area is experiencing increasing mental health and substance use needs that require a multifaceted response. While community partnerships and telehealth have expanded access, provider shortages, service fragmentation and rising substance use—particularly among youth—continue to strain the system. Prevention, workforce investment, integrated care and targeted outreach will be key factors in improving behavioral health outcomes in the years ahead.

Transmissible and Emerging Diseases

Infectious diseases continue to present significant challenges for the service area, with impacts ranging from long-standing conditions, such as HIV and sexually transmitted diseases, to novel threats, like COVID-19. The COVID-19 pandemic highlighted both the adaptability and vulnerabilities of the public health infrastructure and underscored the importance of disease surveillance, rapid response systems and vaccination outreach. For at-risk and vulnerable populations in the service area, the impact of transmissible and infectious diseases can be compounded by access barriers.

Stakeholder Meeting SWOT Analysis: Transmissible and Emerging Diseases



In summary, while the community has grown more resilient and resourceful in response to recent public health crises, there are still substantial barriers to preparedness and trust. Where rapid vaccine development, telehealth adoption and cross-sector collaboration were cited as successes, persistent misinformation, stigma and inconsistent messaging remain challenges.

Data trends point to ongoing concerns with HIV, STDs and other communicable diseases. Stronger prevention strategies, early detection, and targeted outreach—especially among older adults, unhoused people and minority populations—will be key factors in improving public response and outcomes in transmissilble and infectious diseases.

Alzheimer's Disease and Related Dementias

The burden of Alzheimer's disease and related dementias (ADRD) is growing across the TMH service area due to an aging population, limited access to specialty care and persistent gaps in caregiver support. While prevalence estimates in Leon, Gadsden, Jefferson and Wakulla counties remain slightly below state averages, stakeholders expressed concern over increasing Alzheimer's-related mortality, emergency department utilization and rising demand for long-term supports.

TMH and community partners have made progress through early detection efforts and increased awareness campaigns. However, gaps in dementia care remain—particularly in rural areas—and are compounded by financial, workforce and transportation barriers.

Stakeholder Meeting SWOT Analysis: Alzheimer's Disease and Related Dementias

S Strengths

- TMH's Memory Disorder Clinic serves as a regional resource for comprehensive diagnosis and care planning
- Local organizations, such as the Alzheimer's Project, provide caregiver education, respite support and community outreach
- Leon County has access to specialized services, including neurologists and dementia-capable primary care providers
- Increased awareness and early detection efforts supported through campaigns help encourage earlier testing and diagnoses
- Collaboration among hospitals, senior centers and aging advocacy groups is growing

W Weaknesses

- Diagnostic and specialty care services are difficult to access in Gadsden, Jefferson and Wakulla counties
- Caregivers face long wait times for assessments, minimal access to home health services and limited coordination across care providers
- Delays in response time by Elder Helpline can discourage caregivers from seeking assistance
- Many healthcare and social service professionals are not adequately trained to manage ADRD-related challenges

O Opportunities

- Mobile memory screening initiatives and cognitive assessments integrated into routine primary care can improve early detection
- Expansion of dementia-friendly strategies and support networks can alleviate caregiver burden
- Public awareness campaigns focused on dementia education can reduce stigma and promote earlier engagement with services
- Community-based dementia navigator roles can support families in understanding options, applying for services and coordinating care
- Advocating for increased funding for in-home care, respite care and caregiver support programs
- Leveraging remote monitoring tools, smart home technologies and telehealth platforms for follow-up appointments, caregiver support and behavioral symptom management can improve access

Threats

- Aging population is outpacing the development of local aging services infrastructure
- High levels of caregiver stress increase risks of poor patient outcomes and caregiver burnout
- Lack of sustainable funding for respite care, home health services and support programs
- Misconceptions about Alzheimer's leads to individuals who avoid seeking early diagnosis.

In summary, as the number of individuals living with Alzheimer's disease and related dementias grows, the TMH service area must continue building a dementia-capable system of care. While existing programs offer a solid foundation, further investment in early detection, community-based support and care coordination—especially in rural areas—will be key factors in meeting the needs of patients and caregivers alike.

Social and Economic Conditions Affecting Health

Social and economic conditions—such as education, income, housing stability and access to services—directly influence health outcomes across the TMH service area. In addition to reviewing data from Florida Charts, community partner presentations helped to identify disparities and strengths in the regional landscape.

Stakeholder Meeting SWOT Analysis: Social and Economic Conditions Affecting Health

Strengths

- Strong cross-sector engagement from healthcare, food and housing sectors
- Robust specialty care donations through Capital Medical Society's We Care Network
- Second Harvest Food Bank's innovative food distribution models and on-site food pantries
- Big Bend Continuum of Care and The Kearney Center focused on preventing and addressing homelessness in a diverse population
- Regional leadership in data-driven planning and community collaboration

Weaknesses

- Significant disparities in access to providers and insurance, especially in rural areas
- Underreported community needs due to outdated eligibility criteria
- Inconsistent access to key specialists
- Food infrastructure gaps (e.g., refrigeration, delivery capacity)

Opportunities

- Expand We Care eligibility while monitoring provider capacity
- Increase investment in transitional and extremely low-income housing
- Embed food security and other social drivers of health screenings in all major healthcare settings
- Leverage mobile health and food services for rural outreach

Threats

- Rising housing costs leading to increased homelessness
- Provider burnout from increasing demand for services
- Insufficient long-term funding for essential services
- Systemic policy barriers limiting service expansion and flexibility

In summary, addressing social and economic barriers is essential for improving population health. Regional disparities in poverty, provider access and housing stability present both challenges and opportunities to advance equity and more effectively address social determinates of health.

COMMUNITY STAKEHOLDER SURVEY

The Community Stakeholder Survey (Appendix 1) was shared electronically in January and early February 2025 to a distribution list of Community Health Partners and Stakeholders. This survey solicited input about the barriers and challenges faced by our residents and the agencies that serve them. Forty-three individuals completed the online survey.

The Community Stakeholder Survey was designed to collect insights on populations represented by community health partners, critical health needs, barriers to health and opportunities to improve the health of the community.

This section provides a summary of the partner and stakeholder perspectives, based on the collective responses to the Community Stakeholder Survey. The number of responses to each question varied, with a range of 26 to 43 responses.

Three Most Important Issues

The survey presented a list of priority areas in the Florida State Health Improvement Plan (SHIP). When asked to select the "three most important issues to address for the community or communities you serve," Social and Economic Conditions Affecting Health, Mental Well-Being and Chronic Diseases and Conditions, were ranked as the top three most important issues. Their responses are summarized in Figure 1.

Of the priority areas identified by the Florida SHIP, which three do you think are the most important for the community or communities you serve?

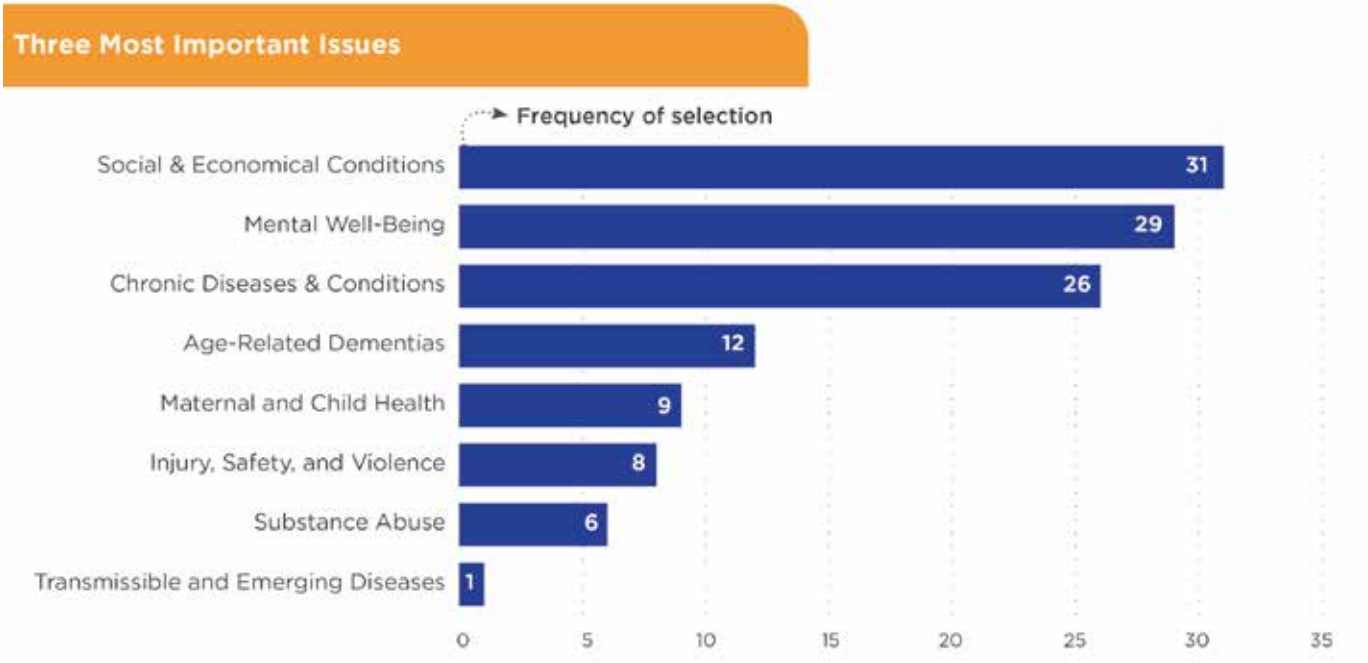


Figure 1: Community Stakeholder Survey – Three Most Important Issues

The responses suggest a consensus among participating stakeholders of the SHIP priority areas most

pertinent to health and Well-Being in the TMH service area. Social and Economic Conditions Affecting Health was selected as a "top three" issue by 72% of stakeholders, followed by Mental well-being (67%) and Chronic Diseases and Conditions (60%). Responses suggest less agreement among stakeholders about the prioritization of the remaining SHIP areas.

Barriers to Health

To identify barriers to health in our community from the perspective of community stakeholders, the Community Stakeholder Survey asked respondents, "What are the barriers to health for the populations you serve?" The question was followed by a list of nine specific response options, and stakeholders were allowed to choose all applicable responses.

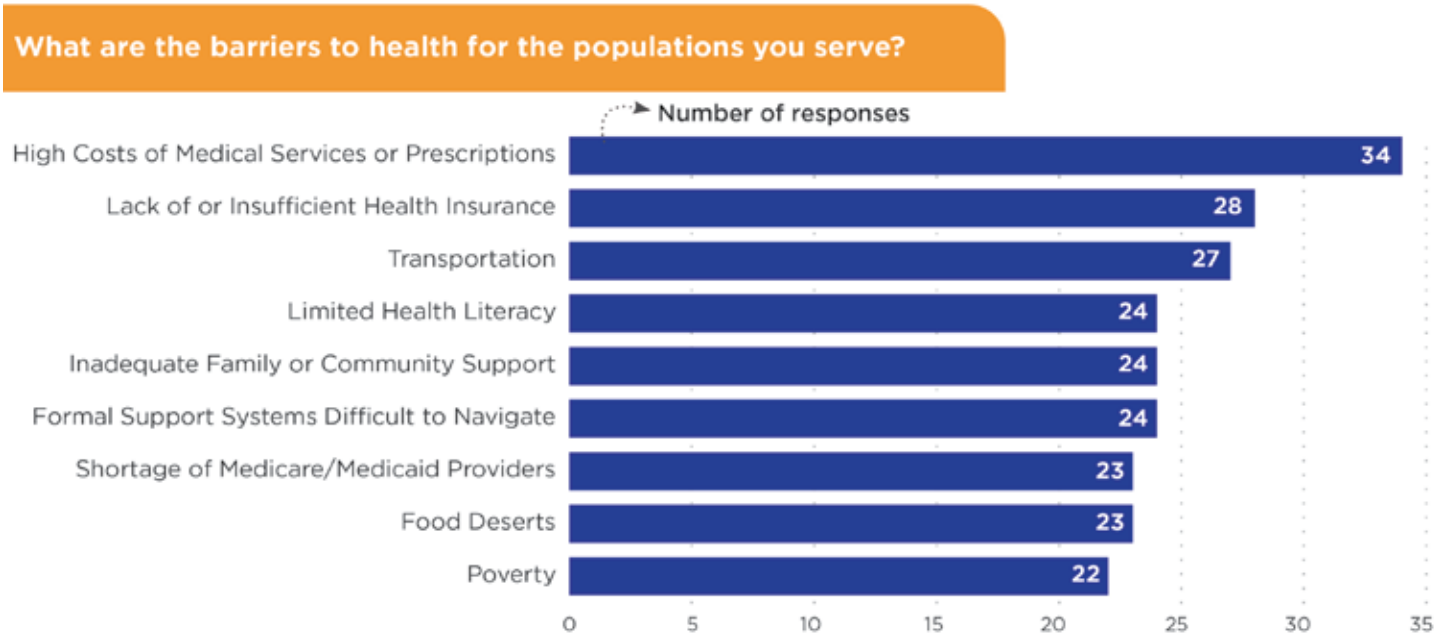


Figure 2: Community Stakeholder Survey – Barriers to Health

Respondents identified cost and insurance as top barriers to health for the populations served. Almost four-fifths (79%) selected the High Cost Of Medical Services and Prescriptions, and nearly two-thirds (65%) selected Lack of or Insufficient Health Insurance. In the 2022 CHNA Community Stakeholder Survey, Transportation and Poverty were cited as the top barriers for the populations served. This year, transportation ranked third and was identified as a health barrier by 63% of stakeholders. Additional barriers noted by at least half of the respondents were: Limited Health Literacy, Inadequate Support, a Shortage of Medicare and/or Medicaid Providers, Food Deserts and Poverty. In addition to asking community stakeholders about specific barriers, the question included an open-ended option, inviting respondents to include other health barriers for the populations they serve. Four respondents provided feedback, including, "education," "financial," "jobs," "lack of quality providers" and "not prioritizing health or wellbeing."

Missing Resources

Stakeholders were next asked, "What healthcare resources are missing for the population(s) you serve?" Of the 43 responses, 28 answered this open-ended question. Responses were categorized into 12 distinct resources, listed in Table 9, below.

Themes and keywords with this theme	Responses including
Medical healthcare providers Primary care doctors, specialty care, donating/affordable providers, quality providers	7
Mental and behavioral health providers Psychiatrists, counselors	7
Transportation Affordable, accommodating, timely	7

Health insurance Affordable, comprehensive, universal, counseling/navigation, underwriting for exercise	7
Accessible medical facilities & related services Provider offices, urgent care, home healthcare, mammography services, infusion centers, mobile health care	5
Maternal, infant, child health and well-being Cribs, breastfeeding, prenatal care, screenings (inc. ASD), birth control, culturally competent maternal healthcare	4
Health care navigators Medicaid, case management, follow-up care	4
Health literacy and education Nutrition counseling, patient educational materials in plain language	3
Affordable prescriptions	2
Dental services Affordable, children	2
Services for elders and those with Alzheimer's Disease and Related Dementias (ADRD) Providers with knowledge of dementia and aging, respite care	2

Table 9: Community Stakeholder Survey – Missing Resources

Healthcare Providers and Facilities

The most frequently mentioned "missing resource" is healthcare providers, and most responses noted the need for providers and/or medical facilities. Medical providers, including primary care physicians and specialty care physicians, were explicitly noted in seven responses, as were behavioral and mental health providers, including counselors and psychiatrists. Five stakeholders also noted the need for medical facilities—including urgent care and infusion centers—and two indicated a need for affordable dental services, particularly for children covered by Medicaid.

Transportation

Seven stakeholders described the lack of transportation to medical services as a pressing need. As one respondent noted, "The rural counties are geographically large," making it difficult for those without private vehicles to access providers. The three rural counties included in the TMH Primary Service Area cover nearly 2,000 square miles, and residents of these counties lack access to public transit. One respondent pointed to the need for affordable transportation services that can accommodate special needs (e.g., wheelchairs, stretchers), while also suggesting more home health providers could better serve those with transportation challenges.

Insurance and Healthcare Costs

Health insurance, along with the cost of care, was a frequent response to this question about barriers. Six stakeholders noted a need for more affordable and more comprehensive health insurance, and two indicated that the populations they serve have difficulty paying for prescription medications. One respondent described the "increasing numbers of patients who do not have insurance, or they have poor insurance that does not cover much and has an incredibly high deductible." Others, too, cited the limited range of services covered by some insurers and a shortage of providers for community members with Medicaid. Relatedly, four stakeholders noted a need for health insurance and medical service navigators, a possible indicator that insurance coverage alone is not sufficient for at-risk populations to access necessary services.

Navigators and Health Literacy

Two themes emerged that suggested a need for support systems to help community members navigate health services (healthcare navigators) and proactively engage in health-promoting behaviors (healthcare literacy and navigation). Four individuals noted people need assistance understanding health insurance, selection and services and follow-up care after illness and injury. Three responses point to a need for increasing health literacy through, for example, patient educational materials written in "plain language,"

and counseling. One respondent further noted, "Issue[s] start long before they reach us… but some sort of counseling [about] how to eat healthy on a small budget and then someone to hold them accountable would be great."

Populations With Targeted Needs

Six responses addressed resources needed for two specific populations: (1) mothers, infants and children (four responses) and (2) seniors (two responses). Needed resources for infants and children include early childhood screening for autism spectrum disorders and safe sleep equipment to reduce risk of injury and death, such as cribs and/or portable cribs, often called "Pack-and-Plays." Resources needed for mothers include breastfeeding and nutrition education, and culturally competent maternal health care. Resources needed for seniors include healthcare providers with knowledge of the aging process, Alzheimer's disease and other age-related dementias, and respite care to support family members.

Populations With Unmet Needs

Stakeholders were asked to rank eight population groups with unmet needs in order of greatest concern. The top three population groups for unmet needs in this year's survey were: low-income individuals or families, homeless individuals or families, and immigrants.

Over 80% of stakeholders rated low-income individuals and families as having high or very high levels of unmet need, while 70% did the same for homeless individuals and families. More than half of the stakeholders also rated immigrants and racial and ethnic minorities as having high or very high levels of unmet need. In contrast, the remaining groups—children, single parents, seniors, and sexual and gender minorities—were more frequently seen as having moderate, low, or very low levels of unmet need.

Thinking about the county or counties you serve, how would you assess the level of unmet need in each of the groups below?

Population groups	Rank
Low-income individuals or families	1st
Homeless individuals or families	2nd
Immigrants	3rd
Racial or ethnic minorities	4th
Single parents	5th
Children	6th
Seniors	7th
Sexual or gender minorities	8th

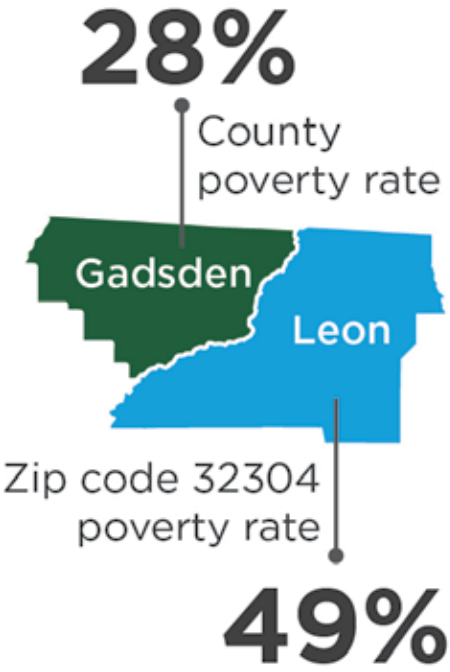
Table 10: Community Stakeholder Survey – Populations with Unmet Needs

Localities With Unmet Needs

Respondents were asked, "Identify the neighborhood or locality with the greatest unmet need in the county or counties you serve." Twenty-eight stakeholders responded, using ZIP codes, county names and specific neighborhoods.

Stakeholders most frequently mentioned the 32304 ZIP code, with a 2023 poverty rate of 49%, and Gadsden County, with a 2023 poverty rate approaching 28%. Specific localities identified by stakeholders include Tallahassee's Southside and Frenchtown neighborhoods, the town of Quincy, and the rural and unincorporated parts of the TMH service area.

In follow up, stakeholders were asked, "What specific resources are missing for this neighborhood or locality?" Twenty-six stakeholders responded with comments summarized in Figure 3. While these responses generally echoed earlier responses, there was a more pronounced level of need, with one individual describing a "lack of all resources" and another noting that "there are many unmet needs."



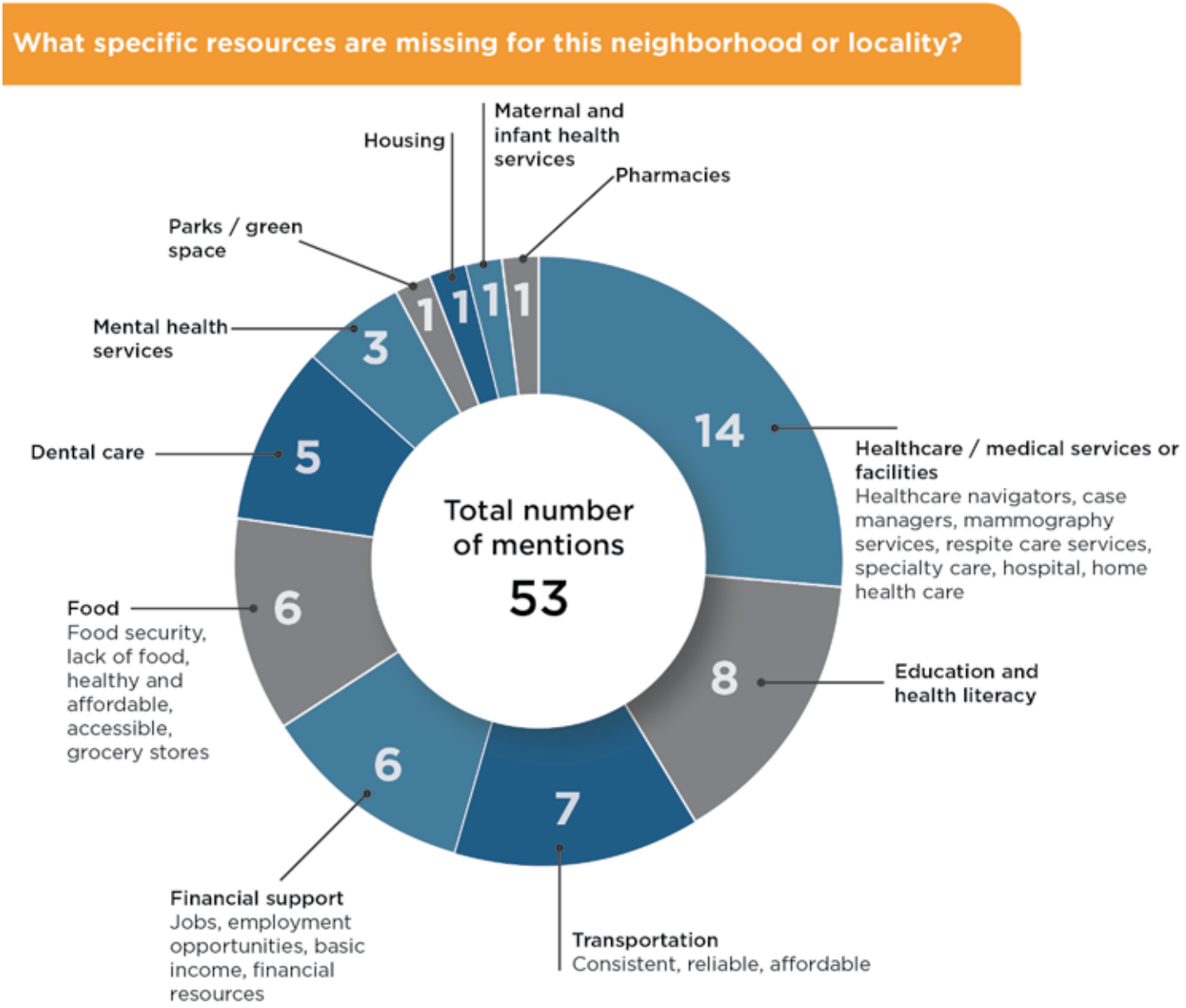


Figure 3: Community Stakeholder Survey – Specific Resources Missing from Locality

The most common concern for these localities was healthcare access. Respondents highlighted the need for more healthcare providers, such as medical doctors, dentists and mental health professionals, as well as improved access to medical facilities and services. Specific services cited by stakeholders included a need for mammography, healthcare clinics, pharmacies and maternal and infant health support. Overall, 24 out of 26 responses mentioned the need for more healthcare providers, services or facilities.

Additionally, respondents identified gaps in essential social and economic resources that impact health and well-being. Eight responses pointed to education as a critical missing resource, and one response described a need for "patient education in plain language." Seven responses cited the lack of accessible, reliable and affordable transportation. Notably, this issue was raised by stakeholders serving both rural areas outside Tallahassee and urban neighborhoods within the city, such as Frenchtown and Southside.

Food insecurity, mentioned by six stakeholders, was also a concern. Stakeholders described challenges in accessing affordable healthy food, a shortage of grocery stores and broader food insecurity issues. Economic instability was also a key issue, with six responses emphasizing the need for more employment opportunities and higher-paying jobs.

Discrimination

Stakeholders were asked whether discrimination affects the populations served and if so, what forms

of discrimination affect the populations served. A total of 34 stakeholders responded to a list of six types of discrimination. Respondents were directed to choose as many as applicable or to indicate that discrimination is not an issue for the populations they serve. Survey responses are included in Figure 4.

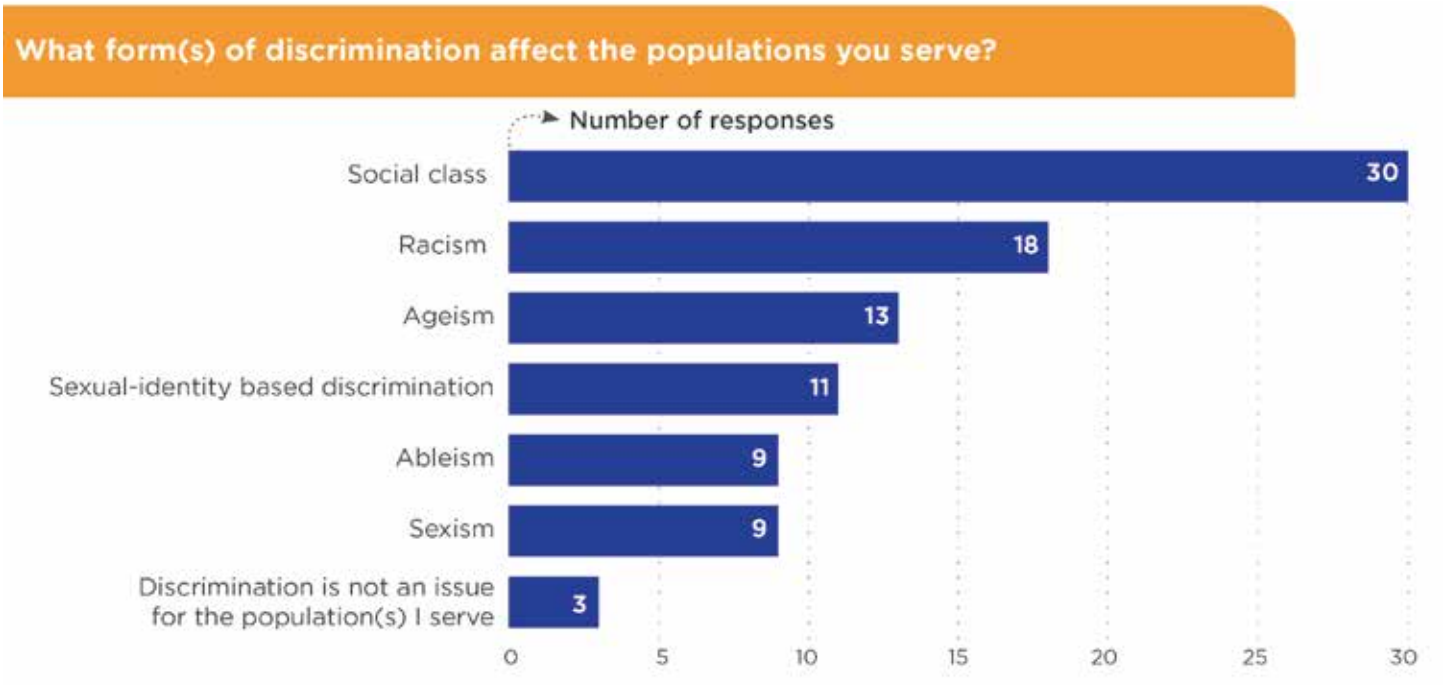


Figure 4: Community Stakeholder Survey – Discrimination

Three stakeholders indicated discrimination is not an issue for the populations they serve. The remainder of responses indicated populations they serve are affected by multiple forms of discrimination. Social class appears to be the most common basis of discrimination in the TMH Service Area, selected by 30 of the 31 stakeholders (97%). Racism was the second most frequently noted form of discrimination, selected by 58% of stakeholders, followed by ageism (42%) and sexual identity-based discrimination (35%). Under 30% of stakeholders noted the populations they serve face sexism or ableism.

One Change

Finally, community stakeholders were asked to describe one change that would allow them to better meet the needs of the populations they serve and to identify barriers to that change. In total, 31 stakeholders answered the first question, suggesting 34 changes that would allow them to better meet the needs of the populations they serve and lower barriers. Twenty-one of their responses suggested themes apparent in their answers to prior questions in this survey (Table 11). Other comments were too specific to be incorporated into a theme, including comments addressing health-specific issues and general advocacy for community change.

The most often mentioned change concerned affordable and accessible healthcare. For some respondents, this change entailed implementing universal care with public underwriting (e.g., “free healthcare” and “universal coverage”). Others suggested more modest change, such as “more medical and dental providers who accept and regularly see patients with Medicaid” or “improvement to health insurance cost and coverage.”

Several responses focused on access, citing specific ways to get health care to patients, such as mobile healthcare units and mobile mammography. An important barrier to healthcare access is transportation, and three respondents called for better options, including “subsidized transportation” and “public transportation.”

Other answers highlighted changes that would help individuals better manage their own health and well-being. One theme in these answers was education aimed at enhanced health literacy. Proposed changes ranged from “health education classes” to “more education about preventable diseases” and “birth control education.” A second type of change was direct assistance to individuals in the form of health navigators and case managers who could help individuals negotiate everything from complex medical needs to health insurance coverage.

What is one change you would like to see that would allow you to better meet the needs of the population(s) you serve and reduce their barriers to health?

Theme and keywords	Number of mentions
Affordability and accessibility Universal and/or free for all; more affordable; more accessible; more providers; more Medicaid-accepting physicians and dentists; mobile healthcare units; mobile mammography	11
Health education and literacy Education about birth control, health, preventable diseases, mental health stigma	4
Healthcare and insurance navigators Whole-health case managers for those with chronic diseases; social workers or peer counselors for connection to community resources; navigators for insurance options and coverage	3
Transportation Accessible, accommodating, public, subsidized	3
Whole-health case managers for those with chronic diseases; social workers or peer counselors for connection to community resources; navigators for insurance options and coverage	
Specific changes related to healthcare (one mention each) CHP to offer expanded services and interventions Birth control distribution Community-wide events to distribute child safety supplies Early childhood interventions Offices and cancer infusion centers for outlying areas Insurance underwriting / subsidies for gym membership More healthcare volunteers Greater collaboration among community NPOs Regularly scheduled respite care	
General changes (one mention each) Greater community engagement More empathy, compassion for disadvantaged Housing separatism by race More jobs and housing	

Table 11: Community Stakeholder Survey – One Change to Better Meet Needs of Population(s) Served

In follow up, thirty respondents shared their perceptions of the biggest barriers to enacting change to better meet the needs of the populations they serve**.** While half pointed to funding, ten respondents noted the systemic problems that discourage change, including politics, a fragmented healthcare system and competing priorities. One respondent noted the biggest barrier to change is a "lack of valuation of [the] social drivers of health." Others pointed to institutional shortcomings, including the nature of health insurance, the "terrible [Medicaid] reimbursement rates in Florida," low pay and lack of support staff and ongoing provider shortages.

What do you perceive as the biggest barrier to enacting this change?

Theme and keywords	Number of mentions
Funding Funding; budget; money, monetary, financial; dollars; economy; resources	15
Systemic problems Politics; failure of will; fragmented health care system; lack of leadership; commitment; competing priorities; getting stakeholders on the same page; egos; racism and classism	10
Institutional problems Medicaid reimbursement system; shortage of reliable providers; insurance costs and coverage constraints	6

Unrecognized needs Need to educate patients and providers about specific health challenges	2

Table 12: Community Stakeholder Survey – Barriers to Enacting Change

COMMUNITY HEALTH SURVEY

The Community Health Survey (CHS) solicited input from residents of the four counties that comprise Tallahassee Memorial HealthCare's (TMH) primary service area (Leon, Gadsden, Jefferson and Wakulla counties). The survey was designed to gain a better understanding of community members' perceptions of community health and well-being and their use of available health services, as well as barriers to maintaining or improving health. The results revealed potential areas for improvement and describe how residents use the health assets available in the community.

This section begins by discussing the survey's development, content and sampling procedures including how the survey was advertised and how individuals were recruited to participate.

Methodology

The Community Health Survey was designed by the CHNA Advisory Committee to assess the health and well-being of residents in TMH's service area. For 2025, the CHNA Advisory Committee priorities for the survey included individuals' views about community health and well-being; evaluating the use of local health resources; and identifying unmet needs across the service area, including those of children and new and expectant mothers.

The resulting survey instrument included 53 questions, of which many were drawn from national health surveys administered annually or biennially by the Centers for Disease Control, including the Behavioral Risk Factor Surveillance Survey, the National Health and Nutrition Examination Survey. Topics covered included:

- Access to and use of medical, dental and mental healthcare
- Health insurance status
- Preventive health services
- Housing and food security
- Health-enhancing behaviors, such as exercise and diet

Supplemental questions were asked of two groups of special interest: (1) Expectant mothers and women who had given birth in the past year, and (2) parents of children ages 17 and under. Expectant and new mothers were asked about unmet needs and medical concerns during their pregnancy. Parents of children ages 17 and under were asked about their youngest child's health and well-being, including access to health services, recent screenings (physical, dental, vision) and physical activity.

The survey collected basic demographic information, including age, sex and race/ethnicity. No identifying information was collected, and participants were assured of complete anonymity. A copy of the survey is included in Appendix 2: Community Health Survey.

The survey's only qualification criteria for participation was residence in one of the four counties comprising the primary service area of TMH: Leon, Gadsden, Jefferson and Wakulla. Nonprobability, or convenience sampling—the approach used in most Community Health Needs Assessments—was used to recruit respondents, with outreach efforts targeted to both the general population of the four counties and specific groups of special interest. This included:

- Low-income and/or uninsured residents
- Racial and ethnic minorities
- Seniors
- Persons living with chronic illness and/or serious long-term health problems

The CHS was available in paper and online formats from January 16 through March 31, 2025. The online version was supported by the Qualtrics platform at Florida State University (FSU) and was accessible through both a QR code for smartphones and a link through the TMH website (https://www.tmh.org/about-us/community-health-needs-assessment/about-chna). Paper versions of the questionnaire were also available at multiple locations serving groups of special interest, and TMH staff facilitated their completion. Methods of survey distribution included:

- Social media, including Facebook, Instagram and X
- Through local press
- Posters in strategic sites, including TMH provider offices, Leon County public facility sites, community health clinics and university campuses
- Flyers posted and cards distributed at sites/agencies that serve the general community and target populations
- Email notices with the survey link to TMH patients and volunteers

Survey participation was voluntary, and TMH offered no incentives for completion.

More than 2,200 people accessed the online version of the CHS, 2,098 of whom were residents of the four eligible counties. An additional 20 individuals from these counties completed paper versions of the questionnaire. Information from the paper surveys was entered into Microsoft Excel by TMH staff and merged with the data from the online surveys. Altogether, the CHS obtained information from 2,118 residents of the four-county area. Their responses were analyzed using Excel and Stata.

Who Participated in the Community Health Survey?

This section describes characteristics of the residents who completed the Community Health Survey. The total number of responses is provided with each chart and table because not all participants responded to every question.

County of Residence

Most respondents to the CHS stated they live in Leon County (80%), with the remaining 20% residing in Wakulla (11%), Gadsden (6%) and Jefferson (3%) counties.

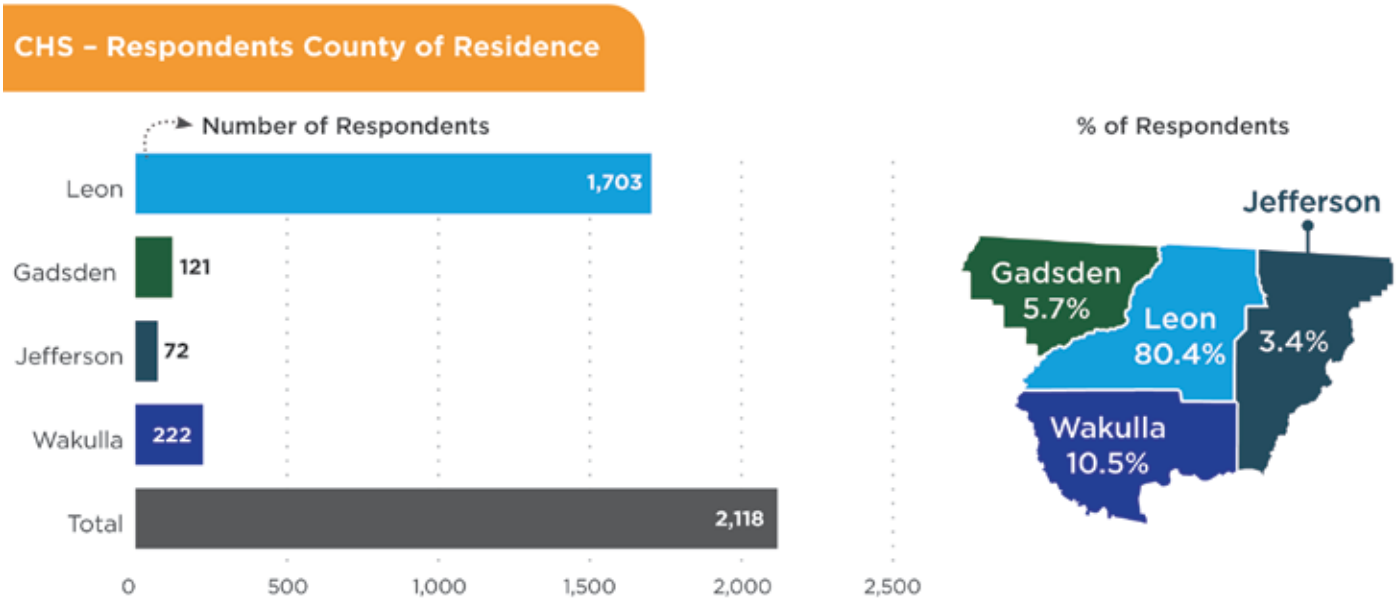


Figure 5: CHS – Respondents County of Residence

Age

Survey respondents ranged in age from 17 to 96, with a median age of 59 years. The largest age group, accounting for over half of the respondents, were adults in the primary working ages of 25 to 64. The second largest age group comprises persons aged 65 and older, who made up 41% of the sample. Roughly 5% of respondents were young adults (ages 17 to 24). Respondents from Leon and Gadsden counties were older, with median ages of 60 and 63, respectively, than respondents from Jefferson and Wakulla counties, with median ages of 58 and 53, respectively.

Age	Total		Leon		Gadsden		Jefferson		Wakulla	
	Count	%	Count	%	Count	%	Count	%	Count	%
17-24	88	5.0	80	5.6	1	1.0	1	1.7	6	3.4
25-64	949	54.1	729	51.3	54	55.1	40	69.0	126	71.6
65+	717	40.9	613	43.1	43	43.9	17	29.3	44	25.0
Total	**1,754**	**100**	**1,422**	**100**	**98**	**100**	**58**	**100**	**176**	**100**

Table 13: CHS – Age

Sex and Gender

More CHS participants identified as female (78%) than male (22%), a pattern that characterized all four counties. Most respondents reported gender identities consistent with their sex at birth.

	Total		Leon		Gadsden		Jefferson		Wakulla	
	Count	%	Count	%	Count	%	Count	%	Count	%
Male	401	22.4	322	22.3	28	27.5	11	18.3	40	21.9
Female	1,391	77.6	1125	77.7	74	72.5	49	81.7	143	78.1
Total	**1,792**	**100**	**1,447**	**100**	**102**	**100**	**60**	**100**	**183**	**100**

Table 14: CHS – Sex

Just over 2% of CHS respondents identified as non-binary, transgender, or another gender category, most of whom reside in Leon County.

	Total		Leon		Gadsden		Jefferson		Wakulla	
	Count	%	Count	%	Count	%	Count	%	Count	%
Man	377	21.8	300	21.5	27	27.8	10	17.5	40	22.9
Woman	1,318	76.3	1,067	76.3	70	72.2	47	82.5	134	76.6
Non-binary / third gender	15	0.9	15	1.1	0	0.0	0	0.0	0	0.0
Transgender man	2	0.1	2	0.1	0	0.0	0	0.0	0	0.0
Transgender woman	1	0.1	1	0.1	0	0.0	0	0.0	0	0.0
Other	14	0.8	13	0.9	0	0.0	0	0.0	1	0.6
Total	**1,727**	**100**	**1,398**	**100**	**97**	**100**	**57**	**100**	**175**	**100**

Table 15: CHS – Gender

Race and Ethnicity

Of the 1,685 respondents willing to provide their racial/ethnic identity, the majority (78%) identified themselves as White and not of Hispanic/Latino ethnicity. About 12% identified as Black, African American or Afro-Caribbean and about 6% identified as members of another race group. The 2025 CHS also allowed respondents to select multiple race categories, and about 4% of respondents did so. Overall, 6% of CHS respondents claim Hispanic or Latino ancestry, while most identify as White.

	All respondents %	Not Hispanic or Latino %	Hispanic or Latino %	Number
One race only:				
American Indian or Alaska Native	0.5	0.5	0.1	9
Asian	1.3	1.0	0.2	21
Black, African American, or Afro-Caribbean	11.9	11.5	0.4	199
Middle Eastern or North African	0.1	0.1	0.1	2
Native Hawaiian or Pacific Islander	0.1	0.1	0.0	1
White or Caucasian	82.2	77.7	4.5	1,380
Two or more races	3.9	2.9	1.0	66
Total	**100**	**93.7**	**6.3**	**1,678**

Table 16: CHS – Race and Ethnicity

Few CHS respondents identified themselves as a race/ethnicity other than Black or Non-Hispanic White. When discussing race/ethnic differences, this report uses a three-category breakdown that combines respondents who identified as Latino or Hispanic with those who identified as other race/ethnic identities. This approach allows efficient presentation of race differences in access to health-related resources and barriers to optimal health.

PARTICIPANT CHARACTERISTICS BY RACE/ETHNICITY AND COUNTY OF RESIDENCE

Race/Ethnic Identity by County

The racial profile of CHS respondents differed across counties. Respondents who identified as White comprised a larger share of Jefferson and Wakulla counties compared to Leon and Gadsden counties. Gadsden County had the largest share of Black-identified respondents, while Wakulla County had the smallest. About 6% of respondents in all four counties identified as races other than White or Black.

	Total		Leon		Gadsden		Jefferson		Wakulla	
	Count	%	Count	%	Count	%	Count	%	Count	%
White or Caucasian	1,385	82.2	1,131	83.0	57	61.3	48	85.7	149	85.6
Black, African American, Afro-Caribbean	200	11.9	147	10.8	32	34.4	7	12.5	14	8.1
Other racial identities	100	5.9	84	6.2	4	4.3	1	1.8	11	6.3
Total	**1,685**	**100**	**1,362**	**100**	**93**	**100**	**56**	**100**	**174**	**100**

Table 17: CHS – Race by County

Educational Attainment

CHS respondents tended to be college educated. Overall, 64% of CHS respondents had a bachelor's or a graduate or professional degree. Nearly 12% had at least some college experience, and about 11% had an associate degree. Around 9% had a high school degree or the equivalent, and 3% had a technical or vocational certification.

Differences in educational attainment across race groups were less pronounced than they were across counties. Fewer Black respondents completed either an associate or bachelor's degree, compared to those identified as White or of another race, but similar portions of all three race groups (about one-third) reported having earned a graduate or professional degree.

	Total		White		Black, Afro-Caribbean, African American		Other Racial Identities	
	Count	%	Count	%	Count	%	Count	%
Have not completed high school	13	0.8	9	0.7	3	1.5	1	1.0
High school diploma or GED	152	9.0	108	7.8	35	17.5	9	9.1
Technical or vocational certificate	55	3.3	39	2.8	12	6.0	4	4.0
Some college but no degree	196	11.7	167	12.1	18	9.0	11	11.1
Associate degree	181	10.8	151	10.9	16	8.0	14	14.1
Bachelor's degree	487	29.0	413	29.9	47	23.5	27	27.3
Graduate or professional degree	596	35.5	494	35.8	69	34.5	33	33.3
	1,680	**100**	**1,381**	**100**	**200**	**100**	**99**	**100**

Table 18: CHS – Educational Attainment

Highest Level of Educational Attainment

Respondents' educational attainment varied across counties. A greater share of respondents in Leon County reported having a bachelor's degree or more, but more than half of respondents in each county had at least an associate's degree. About 39% of Leon County respondents reported having a graduate or professional degree, compared to about 28% of Gadsden County respondents and slightly less than 20% of Jefferson County and Wakulla County respondents.

	Total		Leon		Gadsden		Jefferson		Wakulla	
	Count	%	Count	%	Count	%	Count	%	Count	%
Have not completed high school	13	0.8	7	0.5	1	1.0	0	0.0	5	2.9
High school diploma or GED	154	8.9	104	7.5	11	11.3	7	12.3	32	18.3
Technical / Vocational certification	56	3.3	31	2.2	7	7.2	7	12.3	11	6.3
Some college but no degree	204	11.8	157	11.3	13	13.4	8	14.0	26	14.9
Associate degree	185	10.7	134	9.6	10	10.3	12	21.1	29	16.6

Bachelor's degree	500	29.0	419	30.1	28	28.9	12	21.1	41	23.4
Graduate or Professional degree	610	35.4	541	38.8	27	27.8	11	19.3	31	17.7
Total	**1,722**	**100**	**1,393**	**100**	**97**	**100**	**57**	**100**	**175**	**100**

Table 19: CHS – Educational Attainment by County

Respondents' differences in educational attainment across race groups were less pronounced than they were across counties. Fewer Black respondents completed either an associate's or bachelor's degree, compared to those who identified as White or of another race. Similar percentages of all three race groups—roughly one-third—reported having earned a graduate or professional degree.

	White		Black, Afro-Caribbean, African American		Other Racial Identities		Total	
	Count	%	Count	%	Count	%	Count	%
Have not completed high school	9	0.7	3	1.5	1	1.0	13	0.8%
High school diploma or GED	108	7.8	35	17.5	9	9.1	152	9.0%
Technical or vocational certificate	39	2.8	12	6.0	4	4.0	55	3.3%
Some college but no degree	167	12.1	18	9.0	11	11.1	196	11.7%
Associate degree	151	10.9	16	8.0	14	14.1	181	10.8%
Bachelor's degree	413	29.9	47	23.5	27	27.3	487	29.0%
Graduate or professional degree	494	35.8	69	34.5	33	33.3	596	35.5%
	1,381	**100**	**200**	**100**	**99**	**100**	**1680**	

Table 20: CHS – Educational Attainment by Race

Employment

About half of respondents reported they were working full-time or were self-employed, and less than 9% reported working part-time. Of those who responded that they were not currently working, more than 80% described themselves as retired, about 6% reported caring for their children or other family members, about 5% reported being unemployed, and about 5% indicated they were physically unable to work.

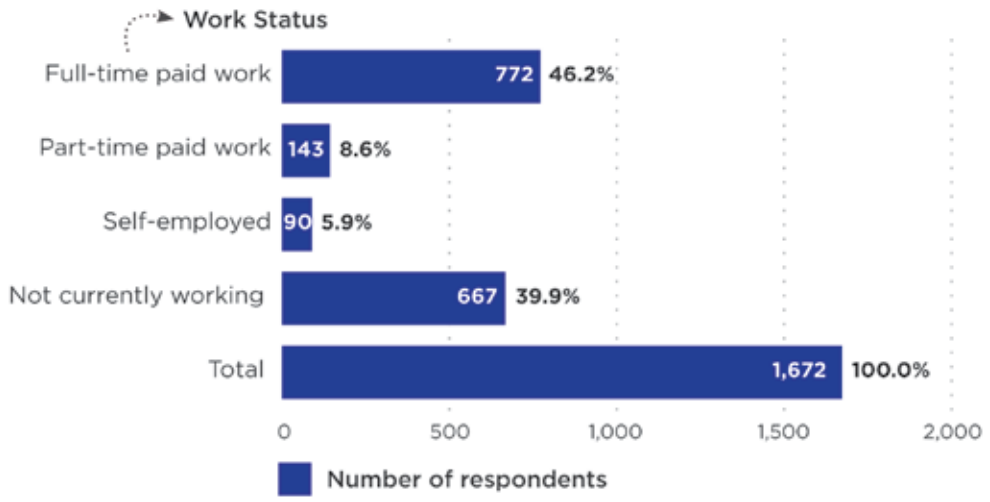


Figure 6: CHS – Employment Status

Employment by County

The employment profile of respondents varied across the four counties in the service area. The percentage that reported employment of any type was highest in Wakulla County (70%) and lowest in Gadsden County, where half of respondents described themselves as not currently working. However, in Leon, Gadsden and Jefferson counties, at least 80% of respondents who said they were not working reported they were retired. In Wakulla County, just less than 70% of those not working described themselves as retired and almost 19% said they were physically unable to work.

Work status	Total		Leon		Gadsden		Jefferson		Wakulla	
	Count	%	Count	%	Count	%	Count	%	Count	%
Full-time paid work	794	45.9	619	44.2	40	41.2	33	57.9	102	58.0
Part-time paid work	148	8.6	122	8.7	6	6.2	4	7.0	16	9.1
Self-employed	97	5.6	88	6.3	3	3.1	0	0.0	6	3.4
Not currently working	690	39.9	570	40.7	48	49.5	20	35.1	52	29.5
Total	**1,729**	**100**	**1,399**	**100**	**97**	**100**	**57**	**100**	**176**	**100**

Table 21: CHS – Employment Status by County

Employment by Race/Ethnicity

By racial identification, more than three-quarters of Black respondents were employed, compared to White respondents (57%) or persons of other identities (67%). Among employed respondents, those who identified as Black more often reported full-time employment (60%) compared to respondents who identified as White (44%) or another race (53%).

Regardless of racial identification, most respondents who were not currently working for pay described themselves as retired. Respondents who identified themselves as Black or of other racial identities more often reported unemployment than White respondents.

Work Status	White		Black, Afro-Caribbean, African American		Other Racial Identities	
	Count	%	Count	%	Count	%
Full-time paid work	602	43.7	118	60.2	52	52.5
Part-time paid work	112	8.1	24	12.2	7	7.1
Self-employed	75	5.4	8	4.1	7	7.1
Not currently working	588	42.7	46	23.5	33	33.3
Total	**1,377**	**100**	**196**	**100**	**99**	**100**

Table 22: CHS – Employment by Race

If not working for pay or profit	White		Black, Afro-Caribbean, African American		Other Racial Identities		Total	
	Count	%	Count	%	Count	%	Count	%
Retired	512	90.8	32	60.4	21	60.0	565	86.
Homemaker or caring for your own children or other family members	27	4.8	8	15.1	6	17.1	41	6.3

Unemployed and looking for work	9	1.6	7	13.2	3	8.6	19	2.9
Unemployed but not looking for work	11	2.0	2	3.8	3	8.6	16	2.5
Physically unable to work	5	0.9	4	7.5	2	5.7	11	1.7
Total	**564**	**100**	**53**	**100**	**35**	**100**	**652**	**100**

Table 23: CHS – Not Currently Working by Race

Income

About 77% of all survey respondents reported their household income, measured in broad categories. Overall, the mid-point of household income distribution (i.e., the median) for respondents was between $75,001 and $100,000 annually. This was consistent for respondents across Leon and Wakulla counties. In Gadsden and Jefferson counties, however, median household income was between $35,001 and $50,000.

	Total		Leon		Gadsden		Jefferson		Wakulla	
	Count	%	Count	%	Count	%	Count	%	Count	%
Under $20,000	85	5.2	61	4.6	8	8.8	5	8.8	11	6.5
$20,001 to $35,000	125	7.7	92	7.0	10	11.0	5	8.8	18	10.7
$35,001 to $50,000	209	12.8	154	11.7	15	16.5	19	33.3	21	12.4
$50,001 to $75,000	274	16.8	216	16.4	20	22.0	7	12.3	31	18.3
$75,001 to $100,000	292	17.9	231	17.6	14	15.4	12	21.1	35	20.7
$100,001 to $150,000	345	21.1	293	22.3	15	16.5	6	10.5	31	18.3
Over $150,001	302	18.5	268	20.4	9	9.9	3	5.3	22	13.0
	1,632	**100**	**1,315**	**100**	**91**	**100**	**57**	**100**	**169**	**100**

Table 24: CHS – Annual Household Income by County

Income by Race/Ethnicity

Household income also varied by racial identity. White respondents reported higher incomes, with a median household income of $75,001 to $100,000. Black respondents and respondents of other racial identities more often reported lower incomes, with a median household income between $35,001 and $75,000.

	White		Black, Afro-Caribbean, African American		Other Racial Identities	
	Count	%	Count	%	Count	%
Under $20,000	57	4.3	22	11.1	5	5.2
$20,001 to $35,000	81	6.2	29	14.6	11	11.5
$35,001 to $50,000	151	11.5	44	22.2	13	13.5
$50,001 to $75,000	207	15.8	41	20.7	20	20.8

$75,001 to $100,000	254	19.3	18	9.1	16	16.7
$100,001 to $150,000	305	23.2	21	10.6	17	17.7
Over $150,001	258	19.6	23	11.6	14	14.6
Total	**1,313**	**100**	**198**	**100**	**96**	**100**

Table 25: CHS – Annual Household Income by Race

Housing and Food Insecurity

Approximately 95% of survey respondents reported having a steady place to live. About 4% described their housing as precarious, and just over 1% reported that they do not have stable living arrangements. Housing insecurity was greater in Jefferson County, with about 5% of Jefferson County respondents reporting they do not have a steady place to live and 7% reporting housing uncertainty.

What is your living situation?	Total		Leon		Gadsden		Jefferson		Wakulla	
	Count	%	Count	%	Count	%	Count	%	Count	%
I have a steady place to live	1,682	94.8	1,367	95.1	92	93.9	52	88.1	171	95.0
I have a place to live today but I am worried about losing it in the future	69	3.9	58	4.0	3	3.1	4	6.8	4	2.2
I do not have a steady place to live	24	1.4	13	0.9	3	3.1	3	5.1	5	2.8
Total	**1,775**	**100**	**1,438**	**100**	**98**	**100**	**59**	**100**	**180**	**100**

Table 26: CHS – Housing Insecurity

Food insecurity was more common than housing insecurity. Over 13% of respondents reported that, over the past year, they sometimes worried that their food would run out before they had money to buy more, and another 2% said this was often the case. Food insecurity was less pronounced in Leon County than in the remainder of the service area. About one-fifth of respondents from Gadsden, Jefferson and Wakulla counties reported that they were sometimes worried they would run out of food before they could afford to buy more, and roughly four percent of Gadsden and Jefferson counties said this had happened often.

Within the past 12 months, you worried that your or your family's food would run out before you got money to buy more.	Total		Leon		Gadsden		Jefferson		Wakulla	
	Count	%	Count	%	Count	%	Count	%	Count	%
Often true	37	2.1	26	1.8	4	4.3	2	3.6	5	2.9
Sometimes true	233	13.5	167	11.9	19	20.2	11	20.0	36	20.7
Never true	1459	84.4	1213	86.3	71	75.5	42	76.4	133	76.4
	1,729	**100**	**1,406**	**100**	**94**	**100**	**55**	**100**	**174**	**100**

Table 27: CHS – Food Insecurity

Housing and food insecurity also varied by race. Less than five percent of White respondents reported housing precarity or a lack of stable housing, compared to about nine percent of those who identified as Black or another race. The same was true of food insecurity. Less than 15% of White respondents reported experiencing food insecurity over the past year, compared to more than 28% of Black respondents and about 26% of respondents who identified as a race other than Black or White.

Within the past 12 months, you found that the food you bought just didn't last and you didn't have money to get more.	White		Black, Afro-Caribbean, African American		Other Racial Identities	
	Count	%	Count	%	Count	%
Often true	30	2.3	9	4.8	1	1.2
Sometimes true	159	12.0	44	23.7	21	24.7
Never true	1,132	85.7	133	71.5	63	74.1
	1,321	**100**	**186**	**100**	**85**	**100**

Table 28: CHS – Food Insecurity by Race

What is your living situation?	Total		White		Black		Other	
	Count	%	Count	%	Count	%	Count	%
I have a steady place to live	1,682	94.8	1,321	95.6	178	90.8	91	91
I have a place to live today but I am worried about losing it in the future	69	3.9	48	3.5	10	5.1	6	6
I do not have a steady place to live	24	1.4	13	0.9	8	4.1	3	3
respondents	**1,775**	**100**	**1,382**	**100**	**196**	**100**	**100**	**100**

Table 29: CHS – Food Insecurity by Race

COMMUNITY HEALTH SURVEY RESULTS

Introduction

This section describes the results from the Community Health Survey (CHS). As noted at the start of this chapter, the CHNA advisory committee's priorities for the survey included gathering community members' views about health care priorities. These priorities are presented first, followed by the results organized by topic areas listed in the description of the survey's development. Much of the discussion focuses on findings for the full sample (all the survey's participants). However, some responses differed by respondents' racial identity, county of residence or age; when this occurred, those differences are described. Additionally, the discussion of healthcare access highlights findings for Leon County ZIP code 32304, one of the state's poorest communities.

Community Health Priorities

Community Health Survey respondents were shown a list of the seven priority areas of the SHIP and asked to identify the three they viewed as most important for our community. The table below shows the results as a tally of the individual "votes" for each area and the corresponding percentage of the total number of responses. The most-frequently selected issue was Chronic Diseases and Conditions, which garnered 22% of all responses; 65% of respondents included this issue in their "top three." Mental Well-Being was the second-ranked choice, accruing 20% of all responses and identified by 57% of CHS respondents as one of the top three priorities for our community. Social and Economic Issues Affecting Health was the third-ranked choice, representing 13% of all selections and included as a "top three" by 38% of respondents.

Priority Areas

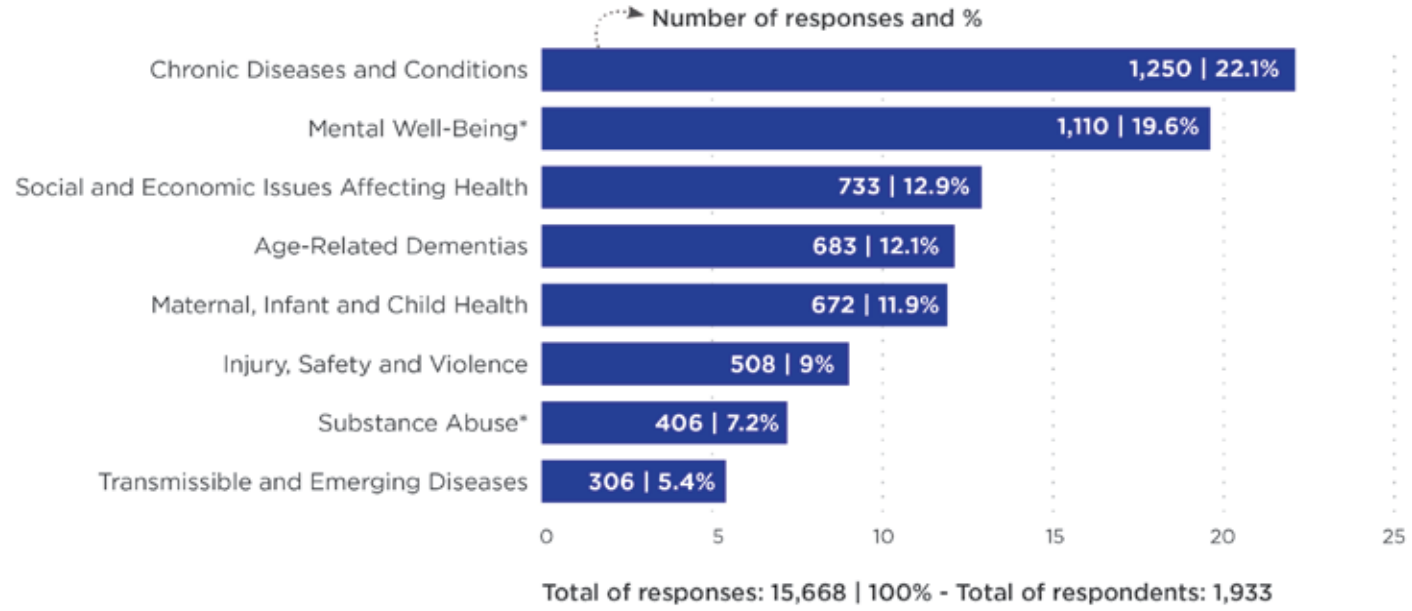


Figure 7: CHS – Community Health Priorities

* these areas are combined in the FL SHIP

Respondents' perceptions of community priorities varied across geographic areas. The table below shows the rankings for the top three areas by county, and, within Leon County, by ZIP code. For respondents from Jefferson and Wakulla counties, Alzheimer's Disease and Related Dementias ranked as the third most important area to address, ahead of Social and Economic Conditions Affecting Health. Leon County respondents living in the 32304 ZIP code viewed Mental Well-Being as the top priority, followed by Social and Economic Conditions Affecting Health and Chronic Diseases and Conditions.

Rankings of the three most important priorities, by residence	Leon	Gadsden	Jefferson	Wakulla	Leon 32304	Leon other ZIP
Chronic Diseases and Conditions	1	1	1	1	3	1
Mental Well-Being	2	2	2	2	1	2
Social and Economic Issues Affecting Health	3	3			2	3
Alzheimer's Disease and Related Dementias			3	3		

Table 30: CHS – Community Health Priorities by Geographic Areas

ACCESS TO CARE

Medical Care

Most CHS respondents (95%) said that they have a particular doctor or clinic they go to when they are sick or need medical advice or referrals. The percentage of respondents who reported having a regular health provider was slightly lower in Gadsden and Jefferson Counties than in Leon and Wakulla Counties. Looking within Leon County, only 77% of respondents in the 32304 ZIP code reported having a regular health provider. While this is twenty percent less than respondents in other Leon County ZIP Codes, the number has increased from 69% in the 2022 TMH CHNA. (Table 31 of the 2022 Community Health Needs Assessment Report)

Is there a particular doctor's office, health center, or other place that you usually go if you are sick or need advice about your health?	Full Sample	Leon	Gadsden	Jefferson	Wakulla	Leon 32304	Leon other ZIP
Yes	94.8%	94.9%	92%	92.5%	96%	77.4%	95.6%
No	5.2%	5.1%	7.5%	7.5%	4%	22.5%	4.4%
Total Respondents	**1,926**	**1,546**	**113**	**67**	**200**	**62**	**1,484**

Table 31: CHS – Access to Primary Care

CHS respondents who said they do not have a usual healthcare provider were asked where they obtained care for illness or medical advice. The three most frequently identified options were urgent care centers, emergency rooms and community health clinics. Twelve respondents provided additional information, with four reporting they were either looking for or unable to find a primary care provider and others reporting they were healthy and have not needed care or that they simply ignore health concerns.

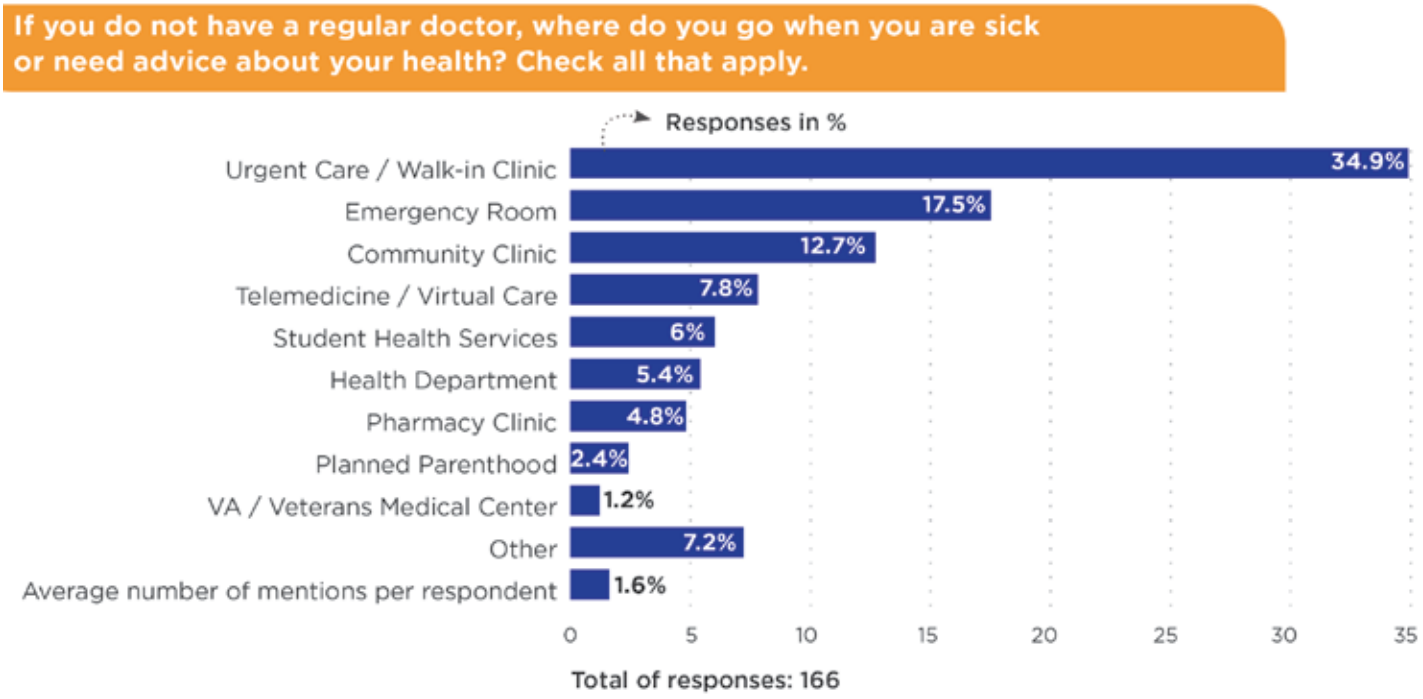


Figure 8: CHS – Accessing Care without a Primary Doctor

Dental Health

Over 92% of CHS respondents used dental services, and most (95%) obtained those services at a private dental office. This percentage was somewhat lower among respondents from Jefferson County (90%), who reported relatively greater use of community (3%) and Veterans Administration (2%) clinics. Overall, few respondents (3%) indicated using an ER or urgent care for dental care needs, though about 6% of respondents from Gadsden and Wakulla Counties reported doing so.

Nearly 8% of CHS respondents reported that they did not use dental services. This figure varies by county, ranging from about 5% of Gadsden County respondents to almost 11% of respondents from Jefferson County.

Dental care patterns for respondents from the 32304 ZIP code differed significantly from other Leon County respondents and from respondents in Gadsden, Jefferson and Wakulla counties. More than 26% of 32304 ZIP code respondents reported they did not use dental services, and those who did more often reported visiting the ER or urgent care clinic for dental care (13%).

Where do you go for dental care? Check all that apply.
This pertains to those respondents who used dental services

	Full sample	Leon	Gadsden	Jefferson	Wakulla	Leon 32304	Leon other
Total Respondents	**1,906**	**1,529**	**112**	**66**	**199**	**61**	**1,468**
DO USE dental services	**1,761**	**1,412**	**106**	**59**	**184**	**45**	**1,367**
DO NOT use dental services	**145**	**117**	**6**	**7**	**15**	**16**	**101**
Of those who do NOT use dental services:							
Emergency Room	1.4%	1.2%	1.9%	0	3.3%	6.7%	1%
County Health Department	1%	1%	0.9%	0	1.6%	0	1%
Urgent Care / Walk-in Clinic	1.8%	1.6%	3.8%	1.7%	2.7%	6.7%	1.4%
Community Clinic	1%	1%	0.9%	3.4%	0.5%	2.2%	1%
Tallahassee Community College Dental Health Clinic	0.9%	0.9%	1.9%	0	0.5%	0	1%
VA / Veterans Medical Center	0.3%	0.1%	0%	1.7%	0.5%	0	0.1%

Table 32: CHS – Access to Dental Care

Mental Health

More than 22% of CHS respondents reported using mental or behavioral health services. This rate was double what was reported in the 2022 TMH CHNA where just over 11% of respondents reported using mental or behavioral health services. Like physical and oral healthcare, utilization of mental health services varied by county of residence. Thirteen percent of Gadsden County respondents said they use mental health services, slightly more than half of the percentage of Leon County respondents (24%). Within Leon County, more respondents (29%) from the 32304 ZIP code reported using mental health services compared to other Leon respondents and respondents from the surrounding counties.

Do you use mental or behavioral health services (counseling)?	Full Sample	Leon	Gadsden	Jefferson	Wakulla	Leon 32304	Leon other ZIP
Yes	22.4%	23.6%	12.6%	21.2%	19.2%	29%	23.4%
No	77.6%	76.4%	87.4%	78.8%	80.8%	71%	76.6%
Total Respondents	**1,900**	**1,525**	**111**	**66**	**198**	**62**	**1,463**

Table 33: CHS – Use of Mental or Behavioral Health Services

CHS respondents who use mental health services were presented with a list of provider options and asked to identify those they use. On average, respondents chose an average of 1.2 provider options each, with a private doctor or counselor included in more than half (51%) of all responses, followed by telehealth or virtual care (23%).

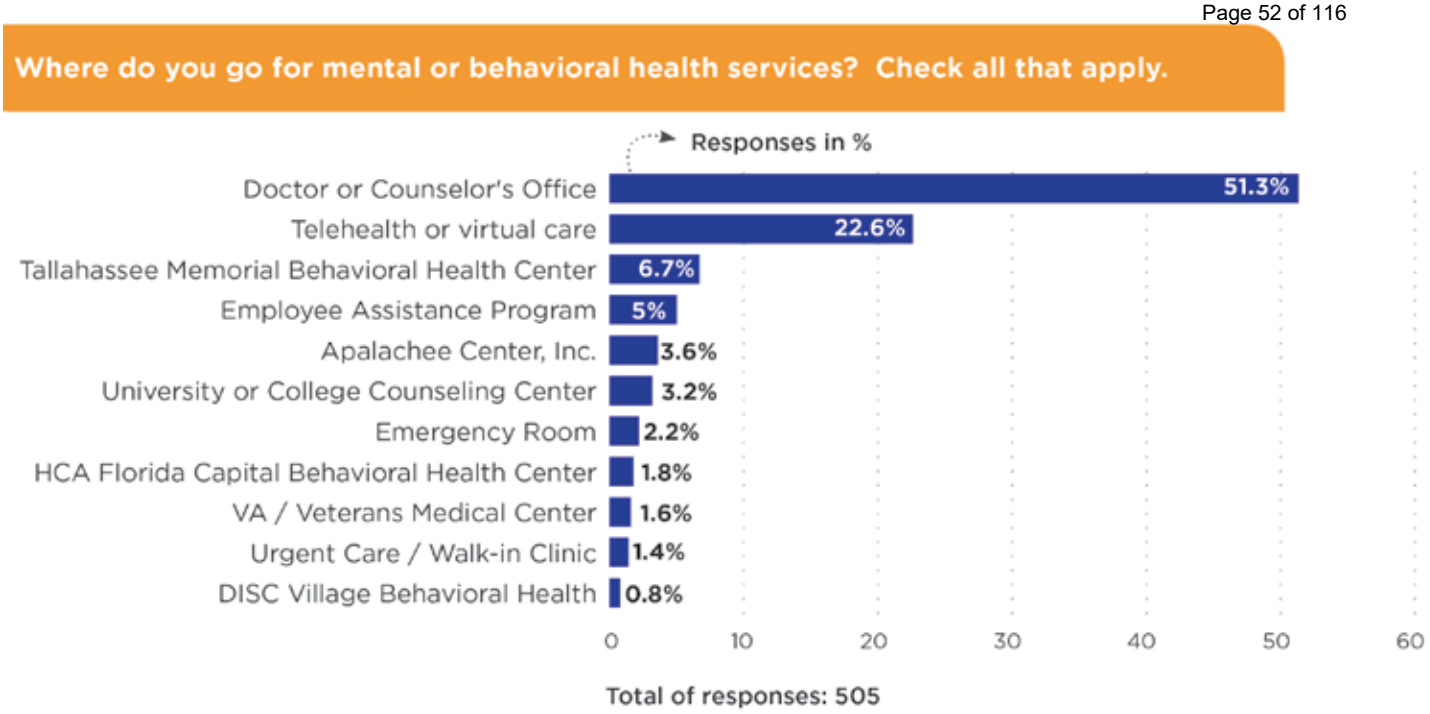


Figure 9: CHS – Mental Health Service Locations

Barriers to Healthcare

When asked about barriers that prevented individuals from accessing medical care, more than half of respondents in each of the counties reported they were unable to get the medical care and services they needed. Smaller percentages of respondents from Gadsden (51%) and Leon (54%) reported an inability to get needed care and services compared to respondents in Jefferson (65%) and Wakulla (61%) counties.

I'm always able to get the medical care and services i need	Full Sample	Leon	Gadsden	Jefferson	Wakulla
Yes	44.8%	45.6%	49%	34.7%	38.7%
No	55.2%	54.4%	51%	65.3%	61.3%
Total Respondents	**1,848**	**1,485**	**104**	**72**	**194**

Table 34: CHS – Access to Care and Services

Respondents who reported an inability to get medical care and services were asked to identify specific barriers to doing so. On average, CHS respondents pointed to an average of 2.6 barriers to obtaining needed medical care and services. The most frequently noted barriers to care were wait-time for appointments (23%), cost (21%), difficulty finding a provider (21%) and a lack of evening or weekend appointments (13%). For respondents in Gadsden, Jefferson, and Leon counties, long wait times topped the list of barriers while respondents in Wakulla County more often cited cost as a constraint on care.

Barriers to receiving medical care and services	Full Sample	Leon	Gadsden	Jefferson	Wakulla
Takes too long to get appointments	23.1%	23.9%	24.3%	21.2%	18%
Cost	21.1%	20.9%	22.1%	18.3%	22.6%
Hard to find a provider accepting new patients	20.9%	21.7%	18.4%	20.2%	17.1%
Lack of evening or weekend services	12.5%	12%	10.3%	15.4%	15.3
I'm too busy to go to the doctor	8.6%	8.4%	6.6%	7.7%	10.7%%
Hard to find a provider that accepts Medicaid	3.6%	3.3%	4.4%	5.8%	4%
I don't trust doctors or other medical people	3.3%	3%	6.6%	1%	4.6%

Fear of getting bad news	2.6%	2.7%	2.9%	1.9%	2.4%
I don't know how to get care or services I need	2.6%	2.5%	1.5%	4.8%	2.8%
I don't have transportation	1.8%	1.5%	2.9%	3.8%	2.4%
Total Responses	**2,627**	**2,060**	**136**	**104**	**327**
Respondents	**1,020**	**808**	**53**	**47**	**119**

Table 35: CHS – Factors that Impact Access to Care

CHS respondents who reported having trouble accessing needed care or services were also asked about the specific types of care and services that they found hard to get. The average CHS respondent characterized three types of care and services as hard to get. More than 40% of respondents noted that they have difficulty getting "doctors who specialize in the kinds of care my family and I need." At least one-fifth of respondents reported difficulty accessing alternative therapies (e.g., massage, acupuncture), dental care, mental health care and wellness care (e.g., nutrition counseling, weight loss support).

What kinds of medical and health-related services are hard for you to get? Check all that apply.	Full Sample	Leon	Gadsden	Jefferson	Wakulla
Doctors who specialize in the kinds of care my family and I need	40.4%	39.6%	37.2%	41.9%	46.7%
Alternative therapies	28.5%	27.5%	34.9%	25.8%	33.3%
Dental care	28.2%	27.2%	25.6%	38.7%	33.3%
Mental health care / counseling	26.9%	28.2%	16.3%	32.3%	21%
Wellness care	23.3%	22.2%	30.2%	35.5%	24.8%
Lab work	20.2%	18%	23.3%	0	33.3%
Vision care	15.3%	14.4%	9.3%	41.9%	16.2%
Medication / medical supplies	12.7%	13%	11.6%	19.4%	9.5%
Physical therapy / Speech therapy / Occupational therapy	12.1%	11.6%	2.3%	22.6%	16.2%
Emergency or Urgent Care	11.3%	8.4%	9.3%	22.6%	28.6%
X-rays or MRI	11.3%	9.5%	7%	19.4%	22.9%
Chiropractic care	10.5%	10.3%	18.6%	9.7%	8.6%
Elder care services	9.6%	9.6%	9.3%	9.7%	9.5%
Preventive screenings like mammograms or colonoscopy	9.2%	7.8%	7%	9.7%	19%
Grief or bereavement counseling	7.4%	6.1%	11.6%	12.9%	12.4%
Hospital care	6.3%	5.3%	9.3%	6.5%	11.4%
Family planning / birth control	4.2%	4.5%	7%	0	2.9%
Immunizations / vaccinations / shots	2.9%	2.5%	2.3%	9.7%	3.8%
End of life / hospice / palliative care	2.7%	2.4%	4.7%	3.2%	3.8%
Ambulance services	2.1%	1.8%	2.3%	6.5%	2.9%
Domestic violence services	2.1%	1.8%	4.7%	3.2%	2.9%
Support services for problems with drug or alcohol use	2.1%	2.4%	0	0	1.9%
Programs or support to stop using tobacco products	1.6%	1.5%	2.3%	0	1.9%
Average number per respondent	**3**	**2.9**	**3**	**3.9**	**3.7**
Total Respondents	**896**	**717**	**43**	**31**	**105**

Table 36: CHS – Medical Services Difficult to Access

Response patterns were largely consistent across counties, with two exceptions. First, vision care tied with doctors for most mentions in Jefferson County, with 42% of respondents identifying both as difficult to access. Second, the share of respondents in Jefferson (23%) and Wakulla (29%) counties noted much more difficulty in obtaining emergency or urgent care services compared to Leon (8%) and Gadsden (9%) respondents.

Respondents who said that it was difficult for them to find doctors were asked a follow-up question: "What kinds of doctors are hard for you to find?" Respondents were presented with a list of medical specialties, and the typical respondent chose 3.6 specialty areas. The top three mentions were Psychiatry/Behavioral Health/Substance Abuse, Family or General Practice, and Rheumatology, but selections varied considerably across counties. Across all survey respondents, the most difficult physician specialties to access were Psychiatry/Behavioral Health/Substance Abuse, Family or General Practice, Rheumatology and Cardiology/Cardiac/Vascular Surgery.

What kinds of doctors are hard for you to find? Check all that apply.	Full Sample	Leon	Gadsden	Jefferson	Wakulla
Allergy, Asthma, Immunology	17.8%	15.8%	0	38.5%	28.6%
Cardiology/Cardiac/Vascular Surgery	25.5%	22.8%	33.3%	38.5%	34.7%
Chronic pain management	20.3%	17.6%	13.3%	46.2%	30.6%
Dermatology	12%	12.5%	6.7%	23.1%	8.2%
Ear, Nose, Throat	16.6%	14.3%	20%	30.8%	24.5%
Endocrinology	22.9%	22.1%	6.7%	30.8%	30.6%
Family or General Practice	26.1%	25%	60%	53.8%	14.3%
Gastrointestinal	23.5%	23.5%	6.7%	38.5%	24.5%
Maternal-Fetal Medicine	3.2%	2.9%	0	0	6.1%
Memory Disorder	8.3%	7.7%	13.3%	23.1%	6.1%
Nephrology/Dialysis	2.9%	1.8%	0	15.4%	6.1%
Neurology/Neurosurgery	22.3%	22.4%	26.7%	30.8%	18.4%
Obesity Medicine/Bariatric Surgery	8.9%	9.2%	13.3%	15.4%	4.1%
Obstetrics/Gynecology	12%	11.4%	6.7%	7.7%	18.4%
Oncology (cancer)	7.2%	6.3%	20%	15.4%	6.1%
Orthopedics	10.9%	11.4%	6.7%	15.4%	8.2%
Pediatrician	8.6%	7.7%	0	15.4%	14.3%
Podiatry	5.2%	5.1%	6.7%	15.4%	2%
Psychiatry/Behavioral Health/Substance Abuse	28.1%	28.3%	33.3%	38.5%	22.4%
Pulmonology/Sleep Medicine	12.9%	11%	13.3%	23.1%	20.4%
Rheumatology	25.8%	24.3%	13.3%	23.1%	38.8%
Surgery (general or specialized)	10.6%	11.4%	13.3%	0	8.2%
Urology	10.9%	9.6%	6.7%	23.1%	12.2%
Wound Care	3.4%	2.6%	6.7%	23.1%	2%
Average Checks per Respondent	**3.6**	**3.4**	**3.3**	**6.3**	**4.1**
Total Respondents	**349**	**272**	**15**	**13**	**49**

Table 37: CHS – Medical Specialties Difficult to Access

Health Insurance

Most respondents (98%) reported having health insurance. Fewer had supplemental insurance, with 35% reporting having dental insurance and 26% stating they have vision insurance. About 15% of respondents reported having a Health Savings or Health Spending Account.

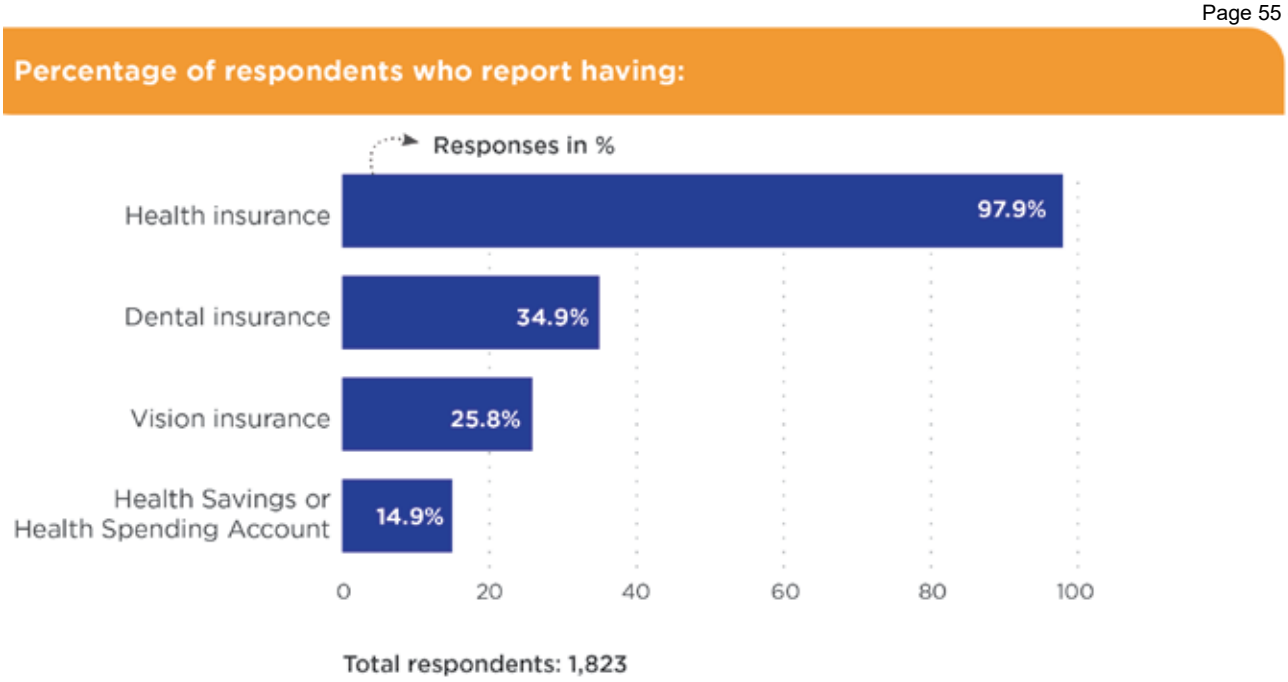


Figure 10: CHS – Health Insurance

Health insurance coverage among respondents varied by racial identity. Less than 2% of White respondents lacked health insurance, compared to 4% of Black respondents and 3% of respondents who identified as another race. Of those with health insurance, coverage type also differed by race. About 10% of Black respondents and 8% of respondents who identified as a race other than White or Black reported health coverage through Medicaid, compared to less than 3% of White respondents.

Health insurance status by racial identity	Full Sample	White	Black	Other Racial Identities
Not insured	2.1%	1.7%	4%	3%
Medicaid	4.1%	2.8%	10%	8.1%
Other health insurance	93.8%	95.5%	86%	88.9%
Total Respondents	**1,823**	**1,381**	**200**	**99**

Table 38: CHS – Health Insurance by Racial Identity

Because most people aged 65 and older are eligible for Medicare, health insurance status was heavily influenced by age. While more than 3% of respondents younger than 65 reported having no insurance, very few respondents (0.1%) age 65 and over did so. Respondents aged 65 and older (85%) reported being covered by Medicare. Medicare coverage can be combined with other insurance types, and many older respondents reported multiple coverage types. Over 45% were covered by employer-provided or private health insurance, and about 3% had Medicaid.

Younger respondents more often reported a single form of health insurance. Nearly three-quarters of respondents age 64 and younger reported having coverage through an employment-based health plan, and nearly 14% said they purchase their own insurance, whether privately, through healthcare.gov or from a COBRA plan.

Health insurance coverage by provider type	Full Sample	Age 64 and Younger	Age 65 and Older
Employer (including military)	52.1%	74%	21.2%
Private purchase	17.5%	13%	24.6%
Medicaid	4.1%	8.9%	2.8%
Medicare	37%	---	85.2%
COBRA	0.5%	0.6%	0.3%

No insurance	2.1%	3.5%	0.1%
Total respondents	**1,734**	**1,018**	**716**

Table 39: CHS – Health Insurance Source by Age

HEALTH CARE VISITS

Routine Care

When asked about routine health care, most respondents reported that, in the year preceding the survey, they had a physical or routine checkup (90%), and many reported routine eye (69%) and dental (74%) exams. These percentages varied by race. White respondents reported higher levels of routine care (91%) than Black respondents (84%) and respondents that identified of another race (84%). White respondents also more frequently reported having had an eye (70%) or dental exam (77%) in the past year than Black respondents (64% and 61%, respectively) and respondents of another race (64% and 65%, respectively).

Routine Care - In the past year, I've had...	Full Sample	White	Black	Other Racial Identities
Eye exam	69%	70.4%	63.6%	63.9%
Routine check-up or physical	89.6%	90.9%	84.1%	83.5%
Routine dental exam	73.9%	76.8%	60.5%	64.9%
Total Respondents	**1,780**	**1,363**	**195**	**97**

Table 40: CHS – Routine Care

Clinical Preventive Care

In addition to their participation in routine care, respondents were asked about their use of clinical preventive services appropriate to their age and sex. Most adults reported being current on recommended preventive screenings, with rates of breast, colon and cervical cancer screenings exceeding 80%. However, percentages varied by racial identity, with White respondents generally reporting higher rates of age- and sex-appropriate screenings. This difference was most pronounced for cervical cancer screening. About 86% of White women ages 21 to 70 reported a Pap smear within the past five years, compared to just 63% of Black women and 68% of women of other races.

Preventive screenings	Full Sample	White	Black	Other Racial Identities
Colon cancer screening within the past 10 years.	85.6%	86.7%	78.3%	77.8%
Respondents ages 45 - 84	**1,197**	**959**	**120**	**54**
Mammogram within the past two years.	84.6%	84.8%	84.6%	73.8%
Female respondents ages 40 - 76	**901**	**690**	**117**	**42**
Pap smear within the past five years.	81.5%	85.8%	63.4%	67.7%
Female respondents ages 21 - 70	**1,210**	**920**	**172**	**34**

Table 41: CHS – Preventive Care by Race

Emergency Care

Respondents were asked about emergency room (ER) visits over the past year. Nearly 10% of respondents reported an ER visit for an injury, and twice as many (20%) were seen for illness. These were significantly higher than the 2022 TMH CHNA results of 7.6% and 15%, respectively. Reported ER visits varied by county of residence. Respondents in Gadsden County reported the lowest share of injury-related ER visits (5%), while those in Leon and Jefferson reported the highest share (8%). Jefferson (30%) and Gadsden (28%) respondents reported ER visits for illness more frequently than respondents from Leon (19%) and Wakulla (17%) counties.

Emergency care - In the past year, I've had...	Full Sample	Leon	Gadsden	Jefferson	Wakulla
An ER visit for injury	9.7%	7.9%	5.4%	7.9%	6.2%
An ER visit for illness	20%	19.4%	28.4%	30.4%	16.8%
Total Respondents	**1,780**	**1,443**	**102**	**56**	**179**

Table 42: CHS – Emergency Care

Unmet Needs

To better understand unmet needs in the service area population, the CHS presented respondents with a list of eight items and asked: "In the past 12 months, have you or family members living with you been unable to get any of the following when it was really needed?"

About 22% of respondents identified, on average, 1.2 items they had been unable to obtain when needed. Medicine or health care was the most frequently noted item, identified as an unmet need by 14% of respondents, followed by groceries (8%) and childcare (5%).

In the past 12 months, have you or family members living with you been unable to get any of the following when it was really needed?	**Percentage (%)**
Medicine or health care	14.3%
Groceries	7.6%
Childcare	4.5%
Transportation	4%
Clothing	3.7%
Utilities	3.2%
Housing	2.8%
Phone	2.4%
Other	2.7%
I have been able to get whatever I needed	78.1%
Respondents	**1,696**
Average number of unmet needs	**1.2**

Table 43: CHS – Unmet Needs

Response frequencies varied across counties and by respondents' racial identity. Considering county differences first, Gadsden County respondents mentioned groceries and transportation more frequently than medicine or health care, and they more often mentioned utilities than respondents in other counties. Respondents from Leon County reported difficulty getting groceries less frequently (7%) than respondents from Gadsden (17%), Jefferson (11%) and Wakulla (9%) counties did.

	Leon	Gadsden	Jefferson	Wakulla
Childcare	4.8%	2.1%	5.3%	3.5%
Clothing	3.6%	6.4%	3.5%	3.5%
Groceries	6.7%	17%	10.5%	8.8%
Housing	2.8%	6.4%	1.8%	0.6%
Medicine or healthcare	14.2%	9.6%	24.6%	14.1%
Phone	2%	6.4%	5.3%	2.9%
Transportation	3.6%	10.6%	5.3%	2.4%
Utilities	3.1%	7.4%	3.5%	2.4%
Other	2.5%	5.3%	1.8%	2.9%
I have been able to get whatever I needed	79.2%	74.5%	66.7%	75.3%
Respondents	**1,375**	**94**	**57**	**170**

Average number of unmet needs	**1.2**	**1.5**	**1.3**	**1.2**

Table 44: CHS – Unmet Needs by County

In comparing racial differences, respondents with a racial identity other than White or Black reported they were able to get "whatever I needed" less often (68%) than either White (81%) or Black respondents (70%). They also more often reported difficulty obtaining medicine or health care (23%) than White (14%) or Black (12%) respondents. More Black respondents reported difficulty getting groceries (14%) than getting medicine or health care, and Black respondents identified clothing as an unmet need about three times more often (9%) than White respondents or respondents of other racial identities (about 3% each).

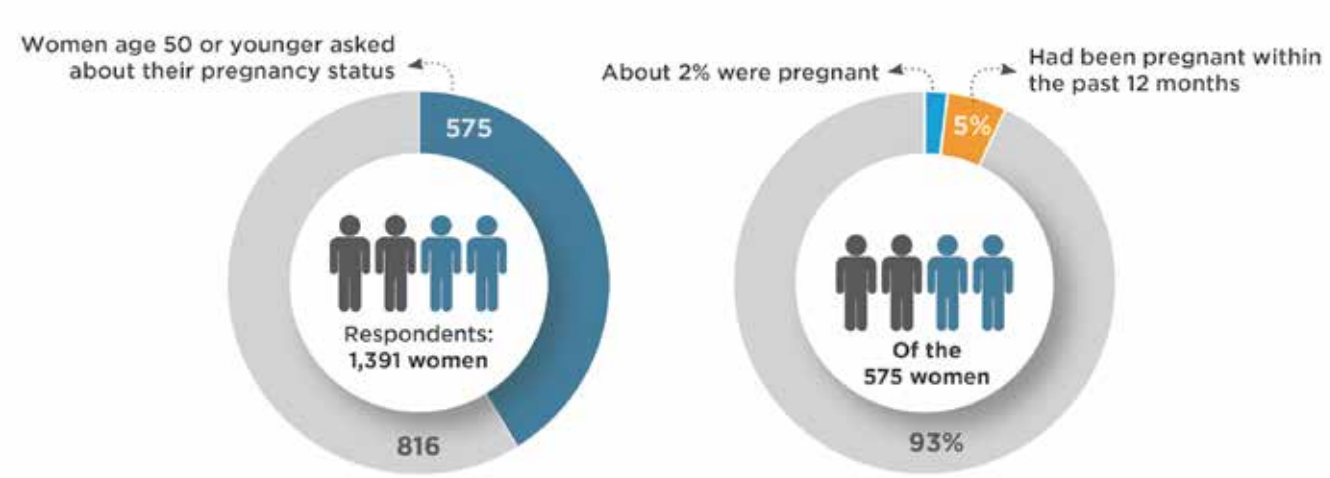
	White	Black	Other
Childcare	3.9%	5.7%	6.7%
Clothing	2.7%	9.4%	3.3%
Groceries	6.2%	13.5%	12.2%
Housing	2.3%	5.7%	2.2%
Medicine or health care	14.1%	11.5%	23.3%
Phone	2.2%	4.7%	1.1%
Transportation	3.2%	7.8%	5.6%
Utilities	2.4%	7.8%	4.4%
Other	2.4%	2.6%	4.4%
I have been able to get whatever I needed	80.5%	70.3%	67.8%
Respondents	**1,347**	**192**	**90**
Average number of unmet needs	**1.2**	**1.4**	**1.3**

Table 45: CHS – Unmet Needs by Race

Respondents had the opportunity to identify other challenges. Although less than 3% did so, their comments highlighted the many challenges confronting some residents within the TMH service area. Some respondents noted that it was difficult for them to afford basic hygiene items, including toothpaste, soap and deodorant. Others pointed to a need for affordable housing and affordable car and home repairs. Many respondents commented on rising prices and the difficulty of juggling bills. As one respondent observed, "It's been hard to make ends meet, meet [since] we get penalized for not having enough money coming in to pay all the minimum expenses. Everything we need costs more than we make."

Pregnant Women and New Mothers

In addition to assessing unmet needs in the service population overall, the CHS included a set of questions for pregnant women and those who had given birth within the past year, asking about their health concerns and unmet needs during pregnancy. Respondents included 1,391 women; 575 of these women, age 50 or younger, were asked about their pregnancy status. Of these, about 2% were pregnant and 5% had been pregnant within the past 12 months.



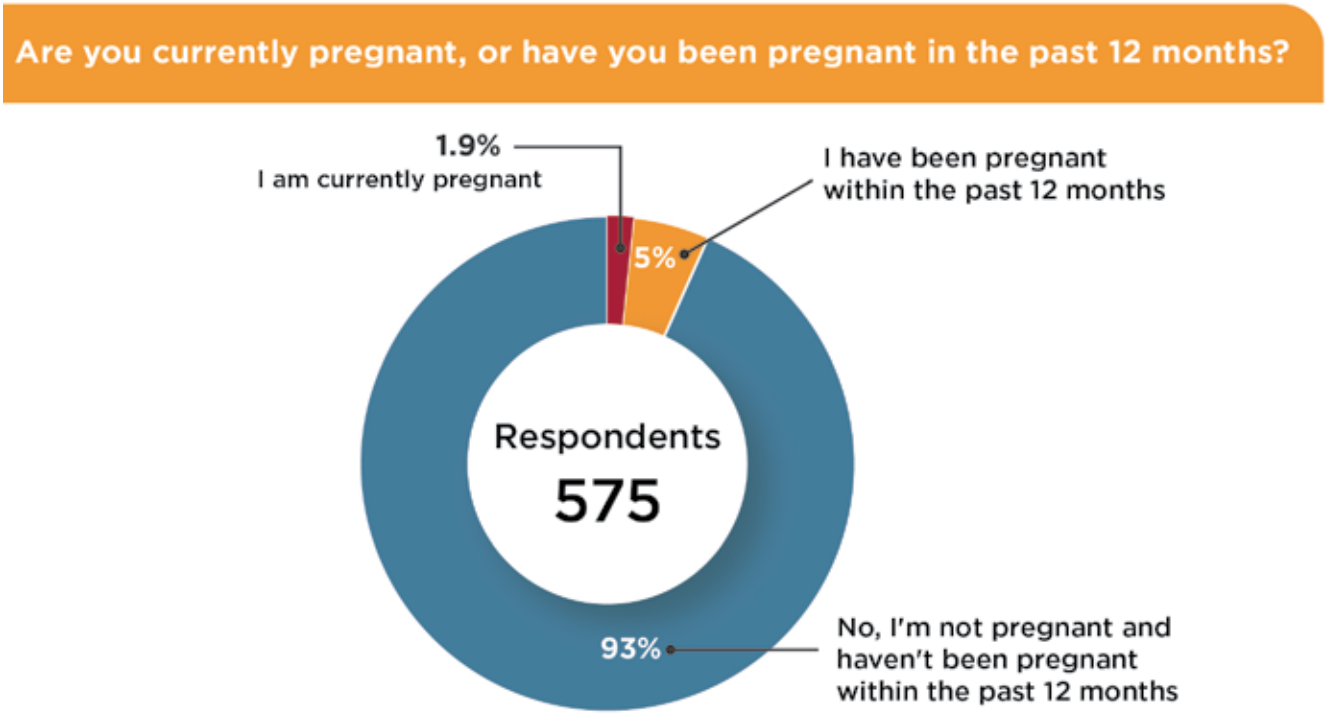


Figure 11: CHS – Pregnancy Status

	%	Respondents
Currently pregnant with unaddressed concerns or medical needs	0%	11
Recently pregnant with unaddressed concerns or medical needs	20.7%	29

Table 46: CHS – Currently Pregnant Concerns

A follow-up question asked respondents about their concerns and unmet needs during their recent pregnancies. On average, the women identified an average of 2.3 concerns each. Cost constraints loomed large, including an inability to pay for the birth (29%), prenatal care (7%) or baby supplies (7%). More than 21% of respondents reported health concerns, including endometriosis and fear of ectopic pregnancy. Others (7%) reported difficulty finding a doctor or midwife and, in open comments, one respondent noted a shortage of providers of color.

What specific concerns or unmet medical needs did you have during your recent pregnancy?	
I was unable to pay for the birth	28.6%
I was scared about health concerns that made my pregnancy or delivery difficult	21.4%
Other	21.4%
It was hard for me to get prenatal care because of my work schedule, difficulty finding childcare, or getting transportation to appointments.	7.1%
I couldn't afford prenatal care	7.1%
I had difficulty finding a doctor or midwife	7.1%
Paying for baby supplies was difficult	7.1%
Responses	**14**
Respondents	**6**

Table 47: CHS – Unmet Needs During Recent Pregnancy

HEALTH-ENHANCING BEHAVIORS

The CHS included four questions about health-enhancing behaviors, two related to activity levels and two concerning diet.

Exercise

Respondents were asked whether they spent any time in a typical week engaging in fitness-related activities—such as swimming, biking or fitness classes—that led to an increase in breathing or their heart rate for at least 10 minutes continuously. More than 72% of respondents said they did, and the median respondent engaged in heart-healthy exercise four days a week.

The percentage of respondents that reported engaging in exercise and the level of engagement among those who did varied across counties. Almost three-quarters of Leon County respondents said they engaged in fitness-related activities weekly, compared to two-thirds of respondents from Gadsden County and about 63% of respondents from Jefferson and Wakulla counties.

In a typical week, do you spend any time doing activities, like walking fast, swimming, biking or fitness classes, that cause an increase in breathing or your heart rate for at least 10 minutes continuously?	Full Sample	Leon	Gadsden	Jefferson	Wakulla
Yes	72.3%	74.2%	66%	62.7%	62.7%
No	27.7%	25.8%	34%	37.3%	37.3%
Respondents	**1,790**	**1,448**	**100**	**59**	**183**

Table 48: CHS – Weekly Minimum Aerobic Exercise

Jefferson County respondents who engaged in fitness activities did so somewhat less often than respondents in other parts of the service area, with 50% of respondents reporting at least 10 minutes of activity 3 or fewer days weekly.

How many days in a typical week do you engage in activities that lead to an increase in breathing or your heart rate?	Full Sample	Leon	Gadsden	Jefferson	Wakulla
1 day	4.3%	4.3%	3.1%	5.4%	4.3%
2 days	11%	10.3%	12.3%	18.9%	13.8%
3 days	22.2%	21.8%	30.8%	29.7%	19%
4 days	16.8%	17.1%	12.3%	8.1%	19.8%
5 days	23.5%	23.5%	21.5%	16.2%	27.6%
6 days	9.3%	9.8%	10.8%	10.8%	3.4%
7 days	12.9%	13.2%	9.2%	10.8%	12.1%
Respondents	**1,291**	**1,073**	**65**	**37**	**116**
Median	**4 days**	**4 days**	**4 days**	**3 days**	**4 days**

Table 49: CHS – Exercise Frequency

Diet

Respondents were asked to identify their typical weekly consumption of fruit or vegetables, whether fresh or frozen. About 3% of respondents reported that they didn't typically eat fruit or vegetables, although this figure was higher (6%) for respondents from Wakulla County. Of those respondents who did consume fruit or vegetables, more than half reported doing so six or fewer days weekly.

In a typical week, how often do you eat fruit or vegetables (fresh or frozen), not including fruit juice or vegetable juice?	Full Sample	Leon	Gadsden	Jefferson	Wakulla
I typically don't eat fruit or vegetables	3.4%	3%	4%	3.4%	6.1%

1 to 3 days	22.8%	20%	29.3%	44.8%	34.3%
4 to 6 days	30.8%	31.6%	29.3%	17.2%	28.7%
Every day	43%	45.3%	37.4%	34.5%	30.9%
Respondents	**1,782**	**1,444**	**99**	**58**	**181**

Table 50: CHS – Frequency of Fruits or Vegetables Consumption

Respondents who reported eating fruit and vegetables at least once weekly were then asked how many servings they consumed. More than half of respondents in all four counties said they ate just one or two servings of fruit or vegetables on a typical day, although this figure varied across counties, from a low of 56% of Leon respondents to 67% of Wakulla respondents. More than one-third of respondents from Leon and Jefferson counties reported eating three to four servings on a typical day, compared to 27% of Gadsden respondents and 24% of respondents from Wakulla County. Less than 10% of respondents who ate any fruit and vegetables reported that they consumed the recommended amount of five or more servings.

In a typical week, how often do you eat fruit or vegetables (fresh or frozen), not including fruit juice or vegetable juice?	Full Sample	Leon	Gadsden	Jefferson	Wakulla
1 or 2 servings	58.1%	56.3%	65.3%	61.4%	67.1%
3 or 4 servings	34.7%	36.4%	27.4%	36.8%	24.1%
5 or more servings	7.3%	7.3%	7.4%	1.8%	8.8%
Respondents	**1,724**	**1,402**	**95**	**57**	**170**

Table 51: CHS – Servings of Fruits or Vegetables Consumption

CHILD HEALTH

The 2025 CHS included a supplemental survey for parents of children under 18 years of age, providing them with the opportunity to share information about their children's health and well-being. Nearly 81% of the 374 respondents who identified themselves as a parent of a child aged 17 or younger and living with them agreed to answer questions about their youngest child's health and healthcare.

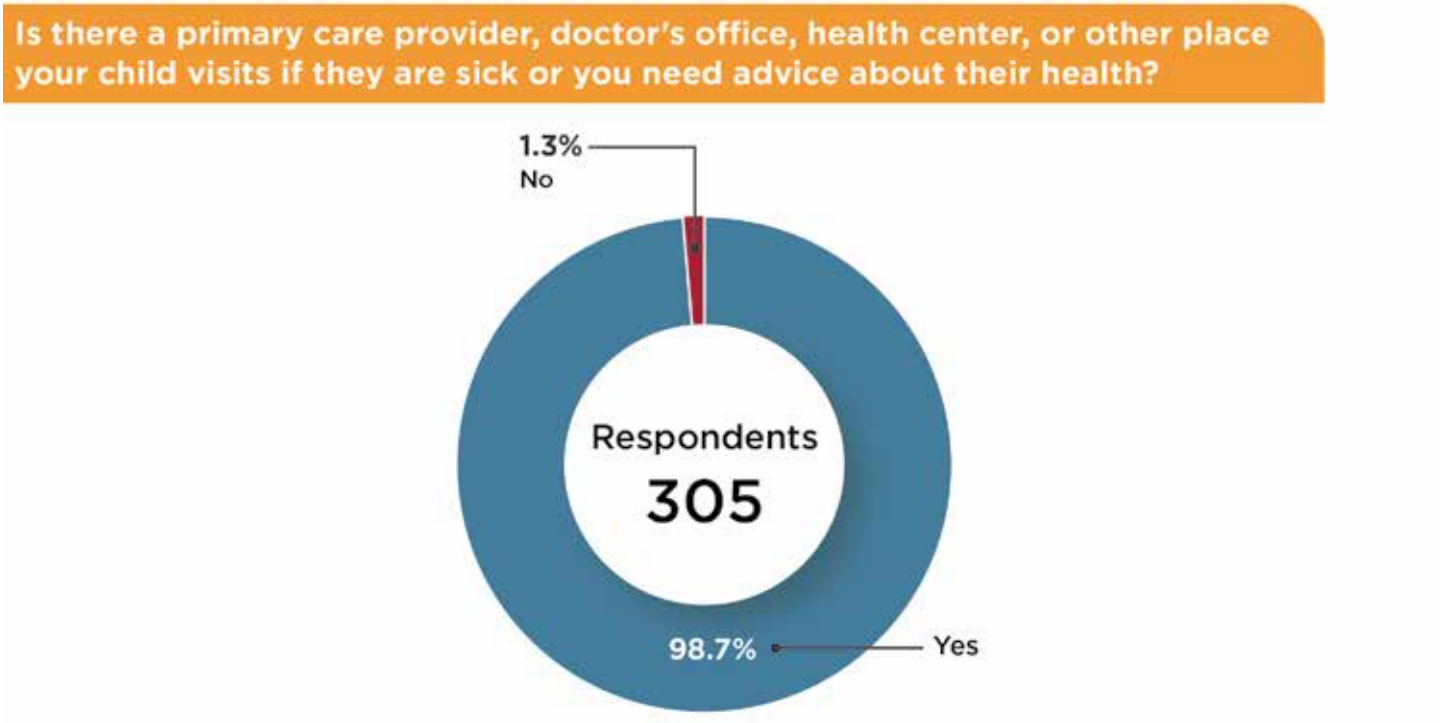


Figure 12: CHS – Children's Health

Where do your children go when they need medical care? Check all that apply (No regular healthcare provider)	
Community clinic	16.7%
Planned Parenthood	16.7%
Urgent care or walk-in clinic	33.3%
Other	33.3%
Respondents	**5**

Table 52: CHS – Children's Health Service Locations (without regular healthcare provider)

Parents also were asked about routine and emergency healthcare over the twelve months preceding the survey. Nearly 90% reported their children had a physical within the past year, and more than half (52%) said their children had an eye exam. Over four-fifths of parents said their children received dental care, and 92% of these parents reported their children had seen a dentist within the past twelve months. Almost 17% of parents say their child had an ER visit for an injury in the past year, and nearly 12% reported an ER visit for illness.

Within the past 12 months, child has...	%
Seen doctor for a routine checkup	89.9
Had an eye exam	51.7
Seen a dentist	92.3
ER visit for illness	16.6
ER visit for injury	11.6

Table 53: CHS – Children's Utilization of Services

Nearly 16% of parents reported that their youngest child used mental health or counseling services. On average, parents relied on 1.2 providers for these services, including in-person care from a doctor or counselor (68%), services from one of the local behavioral health centers (9%), telehealth or virtual care (7%) and school counselors (5%). Some parents shared that they had difficulty finding appropriate care locally, and others reported using providers outside the TMH service area.

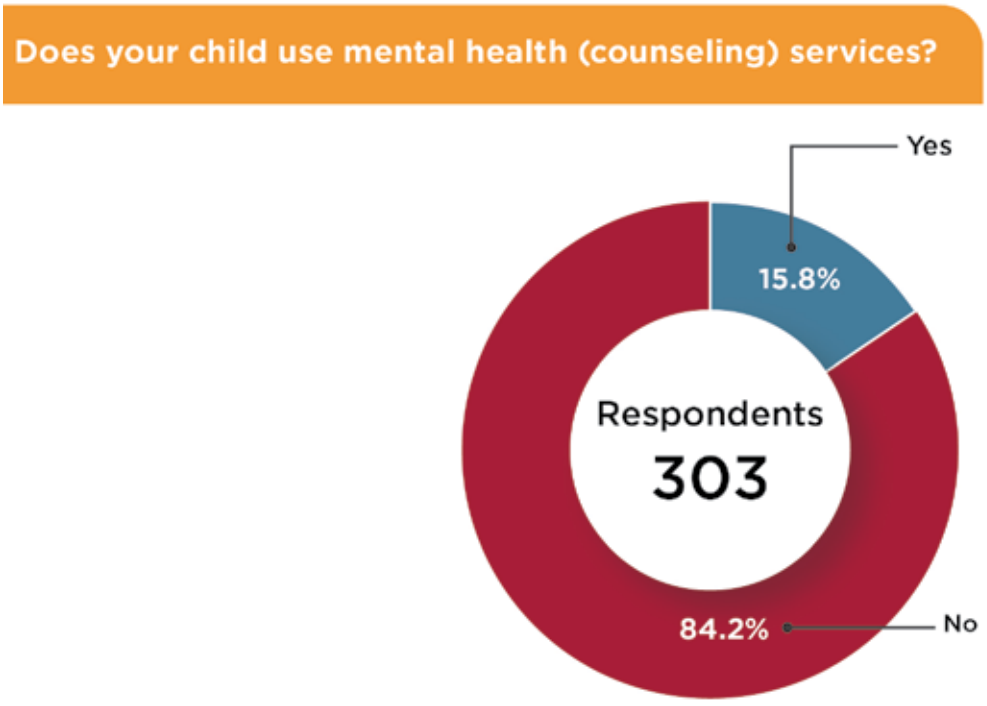


Figure 13: CHS – Children Mental Health Services

Where do they go for these services?	
Doctor or counselor's office	68.4%
Apalachee Center	1.8%
Emergency Room	1.8%
HCA Florida Capital Behavioral Health Center	1.8%
Tallahassee Memorial Behavioral Health Center	5.3%
Telehealth or virtual care	7%
School counselor	5.3%
Other	8.8%
Responses	**57**
Respondents	**48**

Table 54: CHS – Children Mental Health Services Providers

Parents were also asked about difficulty obtaining healthcare or services for their child. Nearly two-thirds of parents (63%) reported they could obtain all needed care. However, this percentage varied by county of residence. Parents from Gadsden (67%) and Leon (64%) counties more frequently reported being able to get needed care than did parents from Jefferson (60%) and Wakulla (54%) counties.

Parents who say they can get all of the care their child needs	Full Sample	Leon	Gadsden	Jefferson	Wakulla
	62.8%	64.4%	66.7%	60%	53.8%
Respondents	**277**	**219**	**9**	**10**	**39**

Table 55: CHS – Children Health Needs Met by County

Parents who reported difficulty finding health-related care or services were asked to choose any applicable items from a list of 15 health-related services and were provided space to identify other types of care or services items. The average parent identified two types of care as difficult to obtain. Nearly 41% of parents reported trouble getting specialized medical care, one-third said they have problems obtaining dental care and a similar percentage of respondents (32%) said that mental healthcare was hard to get. Parents' comments identified a range of specialized care that they had been unable to find locally, including pediatric urologists, pediatric allergists, and experts in autism, dyslexia and cognitive challenges. Some parents reported traveling to get specialized care and others noted difficulty finding providers that accepted their insurance.

Types of care parents have difficulty getting for their child	
Specialty medical care	40.8%
Dental care	33%
Mental healthcare / counseling	32%
Medication / medical supplies	19.4%
Physical, occupational, or speech therapy	17.5%
Vision care	10.7%
Lab work	8.7%
Pediatrician	8.7%
School physicals	5.8%
Immunizations / vaccinations / shots	4.9%
Preventive care (yearly checkups)	4.9%
Emergency or urgent care	3.9%
X-rays or MRI	2.9%
Family planning / birth control	1.9%
Inpatient hospital care	1%

Other	13.6%
Respondents	**103**
Average number of answers per respondent	**2.1**

Table 56: CHS – Children's Services that are Difficult to Access

SECONDARY DATA

The primary data collected through the 2025 Community Health Needs Assessment speaks to the attitudes and needs of residents who participated in the CHNA process. Secondary data which describes the community and provides a context for interpretating primary data, is based on scientific samples and population records. The secondary data presented in the tables and graphs in this section originate from multiple sources, including:

- Alzheimer's Association
- American Community Survey (ACS), U.S. Census Bureau
- Florida Department of Children and Families, Florida Safe Families Network
- Florida Department of Education
- Florida Department of Health, Bureau of Communicable Diseases
- Florida Department of Health, Bureau of Epidemiology
- Florida Department of Health, Bureau of Vital Statistics
- Florida Department of Health, Division of Medical Quality Assurance
- Florida Agency for Health Care Administration
- Florida Department of Law Enforcement
- U.S. Bureau of Labor Statistics

The first section of this chapter describes the demographic and socioeconomic characteristics of the population residing in the TMH Primary Service Area (PSA). Estimates are from either the Census Bureau's Population Estimates and Projections program or the American Community Survey Five-Year Estimates for 2019 – 2023. All estimates are provided for the PSA and each of the four counties within the PSA (Leon, Gadsden, Wakulla and Jefferson).

The second section describes health and health-related behaviors that are aligned with each of the State of Florida Health Improvement Plan (SHIP) priority areas. The section begins by looking at life expectancy, mortality and morbidity for the top ten leading causes of death in Florida. Additional health indicators included are specific to each of the SHIP priority areas:

- Alzheimer's Disease and Related Dementias
- Chronic Diseases and Conditions
- Injury, Safety and Violence
- Maternal and Child Health
- Mental Well-Being and Substance Abuse Prevention
- Social and Economic Factors Contributing to Health
- Transmissible and Emerging Diseases

The section considers the population's performance on each of these health indicators at the individual county level, combined service area level, and at the state level. Where available, data are shown for multiple time-points to track trends over time.

Demographic and Socioeconomic Indicators

Tallahassee Memorial Healthcare 2025 Community Health Needs Assessment

Population Size

- Primary Service Area population, 2013 - 2023

Age Distribution

- Population estimates by age group, 2023
- Median age, 2023

Race & Ethnic Identification

- Percentage distribution of the population by race and Hispanic-origin, 2023

Nativity

- Distribution of population by place of birth, 2023
- Language spoken at home and English-language proficiency, 2023

Families & Households

- Percentage distribution by sex and marital status, 2023
- Household relationships, 2023
- Grandparents with resident grandchildren, 2023

Household Economic Status

- Annual income by household, 2023
- Percentage of families and individuals with poverty-level incomes, 2023
- Household computer and internet use, 2023

Educational Attainment and Enrollments

- Adults' highest education level attained, 2023
- Percentage of population aged three and older currently enrolled in school, 2023

Additional Adult Characteristics

- Veteran status, 2023
- Disability status by age group, 2023

Population Size

Tallahassee Memorial HealthCare Primary Service Area Population, by County and Year

	2013	2016	2019	2020	2021	2023
Gadsden	46,084	46,069	45,670	43,701	43,714	43,642
Jefferson	14,212	13,985	14,280	14,560	14,555	14,713
Leon	282,006	286,960	293,866	292,378	292,817	295,335
Wakulla	31,009	31,894	33,636	33,907	34,690	34,608
Total	**373,311**	**378,908**	**387,452**	**384,546**	**385,776**	**388,298**

Table 57: Population by County, 2013 – 2023. Sources: U.S. Census Bureau, 2019-2023 American Community Survey 5-Year Estimates, https://data.census.gov. U.S. Census Bureau, May 2022, Annual Estimates of the Resident Population, 2020-2021, www.census.gov/data/tables/time-series/demo/popest/2020s-total-metro-and-micro-statistical-areas.html

Age Distribution

Percentage and Size Estimates of the Resident Population by Age, 2023					
	Tallahassee Primary Service Area (PSA)	Gadsden	Jefferson	Leon	Wakulla
	Estimate	Estimate	Estimate	Estimate	Estimate
Total population	**388,298**	**43,642**	**14,713**	**295,335**	**34,608**
Under 18 years	19.1%	22.2%	17.2%	18.6%	20.4%
Under 5 years	5.0%	5.8%	4.1%	4.9%	5.0%
5 to 9 years	5.1%	5.9%	3.9%	5.1%	5.0%
10 to 14 years	5.6%	6.7%	5.5%	5.4%	6.7%
15 to 19 years	8.8%	6.2%	6.1%	9.6%	5.9%
20 to 24 years	12.7%	5.3%	6.0%	15.0%	4.8%
25 to 34 years	13.2%	10.9%	11.4%	13.8%	11.4%
35 to 44 years	11.9%	12.9%	10.3%	11.4%	15.5%
45 to 54 years	10.9%	12.6%	12.8%	10.0%	15.1%
55 to 59 years	5.4%	6.2%	8.1%	4.9%	6.6%
60 to 64 years	5.9%	8.0%	7.4%	5.4%	7.5%
65 to 74 years	9.6%	12.1%	14.6%	8.9%	10.7%
75 to 84 years	4.5%	6.0%	8.1%	4.1%	4.9%
85 years and over	1.4%	1.3%	1.8%	1.5%	1.0%
Median age (years)	34.7	42.0	47.0	31.9	42.5

Table 58: Percentage Estimates of the Resident Population by Age Group, 2023
Source: Estimated using data from the U.S. Census Bureau, 2019-2023 American Community Survey 5-Year Estimates

Race & Ethnic Identification

Percentage Distribution of the Resident Population by Race and Hispanic-Origin, 2023					
	Tallahassee PSA	Gadsden	Jefferson	Leon	Wakulla
Non-Hispanic and:					
White	53.7	33.9	62.8	56.5	76.9
Black	31.6	54.6	30.0	30.4	13.9
Asian	2.7	0.1	0.7	3.4	0.5
Alaskan Native / Native American	0.1	0.1	0.1	0.1	0.2
Other	4.0	1.8	4.3	4.3	3.9
Hispanic /Latino	8.0	11.9	4.8	7.9	4.7
Total population	**388,298**	**43,642**	**14,713**	**295,335**	**34,608**

Table 59: Percentage Distribution of the Resident Population by Race and Hispanic-Origin, 2023
Source: Estimated using data from the U.S. Census Bureau, 2019-2023 American Community Survey 5-Year Estimates

Nativity

Percentage Distribution of the Resident Population by Place of Birth, 2023					
	Tallahassee PSA	Gadsden	Jefferson	Leon	Wakulla
Total population	**388,298**	**43,642**	**14,713**	**295,335**	**34,608**
Native Born					
Born in United States:	91.7	93.8	95.3	90.9	94.9
In Florida	59.1	72.6	59.1	57.3	57.5
Another state	32.6	21.3	36.3	33.5	37.3
Born in Puerto Rico, U.S. Island areas, or born abroad to American parent(s)	1.7	1.3	2.0	1.8	1.8
Foreign-born	6.5	4.9	2.7	7.3	3.3

Table 60: Percentage Distribution of the Resident Population by Place of Birth, 2023

Source: Estimated using data from the U.S. Census Bureau, 2019-2023, American Community Survey Five-Year Estimates

Percentage Distribution of the Resident Population Aged Five and Older, by Language Spoken at Home and Spoken English Proficiency, 2023					
	Tallahassee PSA	Gadsden	Jefferson	Leon	Wakulla
Population five years and over	368,840	41,092	14,109	280,775	32,864
English only	90.2	89.8	95.2	89.5	94.2
Language other than English	9.8	10.2	4.8	10.5	5.8
Spanish	5.3	9.6	3.0	5.1	2.9
Speak English less than "very well"	1.6	4.1	1.1	1.3	1.0

Table 61: Percentage Distribution of the Resident Population Aged Five and Older, by Language Spoken at Home and Spoken English Proficiency, 2023

Source: Estimated using data from the U.S. Census Bureau, 2019-2023 American Community Survey Five-Year Estimates

Families and Households

Percentage Distribution of the Resident Population by Sex and Marital Status, 2023					
	Tallahassee PSA	Gadsden	Jefferson	Leon	Wakulla
Males 15 years and over	**155,880**	**16,893**	**6,592**	**116,647**	**15,748**
Never married	46.3	42.4	35.8	49.4	31.8
Currently married	40.7	40.6	45.8	39.4	48.5
Separated	1.4	3.2	1.9	1.1	1.1
Widowed	2.2	2.3	3.4	1.8	4.3
Divorced	9.5	11.5	13.1	8.3	14.4
Females 15 years and over	**171,245**	**18,730**	**6,141**	**133,308**	**13,066**
Never married	43.8	37.1	28.4	47.8	20.0

Currently married	35.8	35.5	43.3	33.0	55.1
Separated	1.7	2.6	3.5	1.5	0.9
Widowed	6.8	8.7	10.1	6.1	10.0
Divorced	12.4	16.0	14.7	11.6	13.9

Table 62: Percentage Distribution of the Resident Population by Sex and Marital Status, 2023

Source: Estimated using data from the U.S. Census Bureau, 2019-2023 American Community Survey 5-Year Estimates

Percentage Distribution of the Resident Population Living in Households by Relationship to Householder, 2023					
	Tallahassee PSA	Gadsden	Jefferson	Leon	Wakulla
Population in households	**155,020**	**16,485**	**5,675**	**120,673**	**12,187**
Married couple HH	36.8	37.2	43.3	34.6	54.2
Cohabitating couple HH	7.4	5.8	5.4	7.6	7.9
Male HH, only	21.0	19.7	17.7	21.7	16.8
Female HH, only	34.9	37.3	33.6	36.0	21.1
HH with one or more people under 18 years	25.1	27.0	25.1	23.8	35.0
HH with one or more people 65 years and over	28.1	38.1	42.8	25.4	34.2

Table 63: Percentage Distribution of the Resident Population Living in Households by Relationship to Householder, 2023
Source: Estimated using data from the U.S. Census Bureau, 2019-2023 American Community Survey 5-Year Estimates
HH: Household

Grandparents with Resident Grandchildren, 2023					
	Tallahassee PSA	Gadsden	Jefferson	Leon	Wakulla
Number of grandparents living with own grandchildren under 18 years	5,851	1,143	245	3,549	914
Percent responsible for grandchildren	30.9	25.4	23.7	37.3	29.8
Number of grandparents responsible for own grandchildren under 18 years	1,807	290	58	1,323	136
Who are female	68.6	81.0	81.0	67.3	49.3
Who are married	59.7	39.7	50.0	66.7	39.0

Table 64: Grandparents with Resident Grandchildren, 2023
Source: Estimated using data from the U.S. Census Bureau, 2019-2023 American Community Survey Five-Year Estimates

Household Economic Status

Income by Household (2023 inflation-adjusted dollars)					
	Tallahassee PSA	Gadsden	Jefferson	Leon	Wakulla
Total Households	**155,020**	**16,485**	**5,675**	**120,673**	**12,187**
Median household income	$63,078	$46,047	$56,984	$65,074	$74,183
Mean household income	$88,953	$60,499	$75,727	$93,105	$92,491

Table 65: Income by Household Type (2023 inflation-adjusted dollars)

Source: Estimated using data from the U.S. Census Bureau, 2019-2023 American Community Survey Five-Year Estimates

Percentage of Families and Individuals with Annual Income below the Poverty Level, 2023					
	Tallahassee PSA	Gadsden	Jefferson	Leon	Wakulla
Total Households	**155,020**	**16,485**	**5,675**	**120,673**	**12,187**
All people	**18.5**	**27.7**	**20.3**	**18.5**	**5.6**
Under 18 years	20.0	41.6	27.7	17.6	6.5
18 years and over	18.1	23.5	18.7	18.7	5.3
18 to 64 years	20.0	26.7	18.4	20.8	4.7
65 years and over	10.7	14.7	19.3	9.7	7.3

Table 66: Percentage of Families and Individuals with Annual Income below the Poverty Level, 2023
Source: Estimated using data from the U.S. Census Bureau, 2019-2023 American Community Survey Five-Year Estimates

Household Computer and Internet Use, 2023					
	Tallahassee PSA	Gadsden	Jefferson	Leon	Wakulla
Total Households	**155,020**	**16,485**	**5,675**	**120,673**	**12,187**
Has one or more computing devices	94.9%	84.8%	85.8%	96.6%	95.2%
Has broadband internet subscription	88.3%	74.9%	73.8%	90.7%	89.5%

Table 67: Household Computer and Internet Use, 2023. Source: Estimated using data from the U.S. Census Bureau, 2019-2023 American Community Survey Five-Year Estimates. Notes: Computing devices include desktop and desktop computers, tablets and internet-enabled cellphones.

Educational Attainment and Enrollments

Percentage Distribution of the Resident Population Aged 25 and Older by Educational Attainment, 2023					
	Tallahassee PSA	Gadsden	Jefferson	Leon	Wakulla
Population 25 years and over	**243,823**	**30,594**	**10,959**	**177,148**	**25,122**
Less than 9th grade	2.6	6.4	4.7	1.7	3.4
9th to 12th grade, no diploma	6.1	12.3	7.5	4.6	9.1
High school graduate (includes equivalency)	23.7	35.9	38.7	18.8	37.0
Some college, no degree	18.4	19.1	21.7	17.6	21.5
Associate degree	8.3	6.2	8.5	8.7	7.7
Bachelor's degree	23.6	13.0	11.8	27.6	13.6
Graduate or professional degree	17.3	7.1	7.1	21.0	7.6

Table 68: Percentage Distribution of the Resident Population Aged 25 and Older by Educational Attainment, 2023
Source: Estimated using data from the U.S. Census Bureau, 2019-2023 American Community Survey Five-Year Estimates

Percentage Distribution of the Resident Population Aged Three Years and Older Enrolled in School, 2023					
	Tallahassee PSA	Gadsden	Jefferson	Leon	Wakulla
Population three years and over enrolled in school	**121,148**	**9,627**	**2,809**	**101,172**	**7,540**

Nursery school, preschool	4.4	9.6	4.7	3.9	5.4
Kindergarten	3.2	5.7	2.8	2.6	7.0
Elementary school (grades 1-8)	27.6	45.8	39.1	24.4	42.4
High school (grades 9-12)	15.2	22.2	29.5	13.7	22.0
College or graduate school	49.6	16.7	23.9	55.4	23.3

Table 69: Percentage Distribution of the Resident Population Aged Three Years and Older Enrolled in School, 2023

Source: Estimated using data from the U.S. Census Bureau, 2019-2023 American Community Survey Five-Year Estimates

Additional Adult Characteristics

Veteran Status of the Civilian Population Aged 18 and Over, 2023					
	Tallahassee PSA	Gadsden	Jefferson	Leon	Wakulla
Civilian population 18 years and over	**313,600**	**33,938**	**12,150**	**239,967**	**27,545**
Veterans (%)	6.4%	6.8%	10.5%	5.7%	9.8%

Table 70: Veteran Status of the Civilian Population Aged 18 and Over, 2023

Source: Estimated using data from the U.S. Census Bureau, 2019-2023 American Community Survey Five-Year Estimates

Disability Status of the Civilian Noninstitutionalized Population, by Age Group, 2023					
	Tallahassee PSA	Gadsden	Jefferson	Leon	Wakulla
Total Civilian Noninstitutionalized Population	**377,782**	**40,994**	**13,530**	**291,499**	**31,759**
With a disability	13.4%	19.6%	20.4%	12.3%	12.6%
Under 18 years	**74,114**	**9,670**	**2,529**	**54,855**	**7,060**
With a disability	5.1%	6.4%	4.7%	5.2%	2.3%
18 to 64 years	**245,124**	**23,047**	**7,608**	**195,366**	**19,103**
With a disability	11.1%	18.1%	15.2%	10.3%	9.7%
65 years and over	**58,544**	**8,277**	**3,393**	**41,278**	**5,596**
With a disability	33.3%	39.4%	43.9%	30.9%	35.7%

Table 71: Disability Status of the Civilian Noninstitutionalized Population, by Age Group, 2023

Source: Estimated using data from the U.S. Census Bureau, 2019-2023 American Community Survey Five-Year Estimates

HEALTH INDICATORS

Tallahassee Memorial HealthCare 2025 Community Health Needs Assessment

Life Expectancy:

- Estimated Life Expectancy

Mortality and Morbidity:

- Mortality Rates by Leading Causes

Alzheimer's Disease & Related Dementias:

- Mortality Rates for Alzheimer's Disease
- Mortality Rates for Organic Dementia
- Emergency Department Visits for Alzheimer's Disease
- Emergency Department Visits for Organic Dementia Disease

- Estimated Percentage of Population with Alzheimer's Cases

Chronic Diseases and Conditions:

- Coronary Heart Disease Death Rates
- Cancer Death Rates
- Stroke Death Rates
- Hypertension Death Rates
- Chronic Lower Respiratory Disease Death Rates
- Diabetes Death Rates
- Hospitalizations from or with Diabetes Rates

Injury, Safety and Violence:

- Non-Fatal Unintentional Falls
- Non-Fatal Unintentional Injury, Aged 5-19
- Domestic Violence Offenses
- Children Experiencing Child Abuse, Aged 5-11
- Homicide Deaths
- Violent Crime Rate
- Death Rates from Firearms Discharges
- Death Rates from Motor Vehicle Crashes

Maternal and Child Health:

- Adequate Prenatal Care
- Low Birth Weight
- Births to Mothers Aged 15-19
- Births to Mothers Aged 35-50
- Percentage of Births Paid for by Medicaid
- Infant Mortality
- Fetal Deaths (Stillbirths)
- Maternal Deaths
- Kindergarten Immunization Rates

Mental Well-Being and Substance Abuse Prevention:

- Hospitalizations for Mental Health Disorders
- Suicide Rates
- Deaths from Alcoholic Liver Disease
- Deaths from Drug Poisoning
- Adult Drug Arrests

- Juvenile Drug Arrests

Social and Economic Factors Contributing to Health:

- Unemployment Rate
- High School Graduation Rate
- Population with Health Insurance
- Health Insurance Status
- Individuals Below Poverty Level
- Licensed Medical Doctors
- Licensed Dentists

Transmissible and Emerging Diseases:

- Pneumonia and Influenza Deaths
- Chlamydia Cases
- Infectious Syphilis Cases
- Gonorrhea Cases
- Human Immunodeficiency Virus (HIV) Diagnoses Rates
- HIV/AIDS Deaths
- COVID-19 Deaths

Life Expectancy

Estimated Life Expectancy at Birth (Years)					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	77.7	72.8	75.9	74.9	78.6
2019 – 2021	77.7	74.6	75.7	74.7	78.5
2018 – 2020	78.6	75.9	77.1	75.6	79.4

Table 72: Estimated Life Expectancy at Birth. Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Mortality and Morbidity

Age-Adjusted Mortality Rates for 100,000 Population for Ten Leading Causes of Death in Florida, 2023					
	Leon	Gadsden	Jefferson	Wakulla	Florida
Heart Diseases	141.4	186.5	165.6	187.3	135.6
Cancers	136.5	169.0	153.1	194.0	133.4
Cerebrovascular Diseases	35.8	60.5	52.7	41.8	44.6
Unintentional Injury	48.7	97.0	52.5	64.4	63.9
Chronic Lower Respiratory Disease	28.5	40.9	25.5	55.1	30.2
Diabetes Mellitus	22.6	47.7	18.0	28.6	21.0
Alzheimer's Disease	18.8	15.3	12.4	20.6	15.6
COVID-19	11.5	13.6	8.3	12.3	9.9
Suicide	13.4	16.3	22.8	21.6	14.1

Chronic Liver Disease & Cirrhosis	15.3	9.2	25.4	13.0	11.7

Table 73: Age-Adjusted Mortality Rates per 100,000 Population for 10 Leading Causes of Death in Florida, 2023
Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Alzheimer's Disease & Related Dementias

Age-Adjusted Mortality Rates per 100,000 Population for Alzheimer's Deaths, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	18.1	15.8	12.3	26.8	17.3
2020 – 2022	19.2	16.0	13.7	35.1	18.9
2019 – 2021	20.8	14.7	17.5	35.1	19.0
2018 – 2020	23.2	16.9	19.3	31.3	19.7
2017 – 2019	25.3	18.8	17.7	24.7	19.9

Table 74: Age-Adjusted Mortality Rates per 100,000 Population for Alzheimer's Deaths, 3-Year Moving Averages. Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Age-Adjusted Mortality Rates per 100,000 Population for Organic Dementia Deaths, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	45.4	39.1	35.9	66.7	20.9
2020 – 2022	44.6	38.0	53.0	63.2	21.1
2019 – 2021	41.1	35.0	60.8	53.8	20.0
2018 – 2020	37.2	34.0	57.3	50.6	20.2
2017 – 2019	32.9	36.7	46.6	40.6	20.6

Table 75: Age-Adjusted Mortality Rates per 100,000 Population for Organic Dementia Deaths, Three-Year Moving Averages.Notes: Organic dementia includes vascular dementia and unspecified dementia, but excludes Alzheimer's disease, dementia caused by other diseases, or substance-induced dementia. Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Age-Adjusted Emergency Department Visits per 100,000 Population for Alzheimer's Disease, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	6.9	2.7	2.8	8.1	2.7
2020 – 2022	5.8	3.3	0	5.3	2.6
2019 – 2021	6.2	1.5	0	7.1	2.8
2018 – 2020	5.8	3.4	3.1	7.4	3.0
2017 – 2019	5.9	4.4	4.3	6.9	3.4

Table 76: Age-Adjusted Emergency Department Visits per 100,000 Population for Alzheimer's Disease, Three-Year Moving Averages. Source: Florida Agency for Health Care Administration, accessed through www.flhealthcharts.gov

Age-Adjusted Emergency Department Visits per 100,000 Population for Organic Dementia Disease, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	22.2	21.4	24.5	21.0	13.1
2020 – 2022	20.8	16.6	21.2	9.8	12.5
2019 – 2021	20.4	20.3	13.2	6.8	12.5
2018 – 2020	20.2	22.3	13.4	14.8	12.8
2017 – 2019	20.8	20.2	15.2	16.6	13.4

Table 77: Age-Adjusted Emergency Department Visits per 100,000 Population for Organic Dementia Disease, Three-Year Moving Averages
Source: Florida Agency for Health Care Administration, accessed through www.flhealthcharts.gov

Estimated Percentage of Aged 65 and Older Population with Alzheimer's Cases, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	10.4	10.7	10.7	9.5	11.5
2020 – 2022	10.7	11.1	11.2	9.8	12.0
2019 – 2021	11.0	11.4	11.4	10.1	12.4
2018 – 2020	11.4	11.7	11.7	10.3	12.9
2017 – 2019	11.6	11.8	11.8	10.4	13.1

Table 78: Estimated Alzheimer's Cases (Aged 65 and older) as a Percentage of Population Aged 65+, Three-Year Moving Averages
Source: Alzheimer's Association, Alzheimer's Disease Facts and Figures, accessed through www.flhealthcharts.gov

Chronic Diseases & Conditions

Age-Adjusted Death Rates per 100,000 Population for Coronary Heart Disease, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	63.4	89.8	88.2	90.4	85.3
2020 – 2022	66.5	90.3	87.0	95.5	89.0
2019 – 2021	66.7	87.8	95.1	100.6	89.0
2018 – 2020	70.6	87.3	86.5	109.7	90.3
2017 – 2019	76.2	83.7	97.1	100.9	91.1

Table 79: Coronary Heart Disease Deaths, Age-Adjusted Death Rates per 100,000 population, Three-Year Moving Averages
Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Age-Adjusted Death Rates per 100,000 Population for Cancer, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	140.8	168.7	135.5	200.0	136.5
2020 – 2022	143.6	157.9	146.3	197.1	138.3
2019 – 2021	144.2	158.7	156.2	174.5	139.7
2018 – 2020	141.3	163.0	151.7	169.9	142.5
2017 – 2019	144.4	164.3	139.3	168.7	146.1

Table 80: Cancer Deaths, Age-Adjusted Death Rates per 100,000 Population, Three-Year Moving Averages
Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Age-Adjusted Death Rates per 100,000 Population for Stroke, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	37.8	61.5	49.1	48.1	45.2
2020 – 2022	38.1	56.0	42.1	63.7	45.2
2019 – 2021	38.1	52.2	32.0	51.9	43.2
2018 – 2020	39.8	42.4	31.0	54.1	42.3
2017 – 2019	40.2	40.2	34.8	36.1	40.7

Table 81: Stroke Deaths, Age-Adjusted Death Rates per 100,000 Population, Three-Year Moving Averages
Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Age-Adjusted Death Rates per 100,000 Population for Hypertension, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	10.1	15.9	10.0	17.0	9.7
2020 – 2022	12.3	17.0	8.7	22.5	9.6

2019 – 2021	11.4	13.0	6.4	20.0	9.2
2018 – 2020	11.8	11.8	5.7	17.4	8.9
2017 – 2019	10.3	13.9	8.6	11.7	8.5

Table 82: Hypertension Deaths, Age-Adjusted Death Rates per 100,000 Population, Three-Year Moving Averages
Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Age-Adjusted Death Rates per 100,000 Population for Chronic Lower Respiratory Disease, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	30.9	39.7	35.8	66.2	30.8
2020 – 2022	31.0	41.9	35.6	63.7	32.2
2019 – 2021	29.1	39.5	26.9	60.6	33.6
2018 – 2020	29.8	38.5	21.9	61.4	36.2
2017 – 2019	29.6	32.8	24.0	66.4	38.1

Table 83: Chronic Lower Respiratory Disease Deaths, Age-Adjusted Death Rates per 100,000 Population, Three-Year Moving Averages
Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Age-Adjusted Death Rates per 100,000 Population for Diabetes, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	22.7	39.3	27.7	23.8	22.6
2020 – 2022	23.6	34.2	40.0	19.1	23.4
2019 – 2021	23.3	29.7	39.6	14.9	22.4
2018 – 2020	24.2	29.4	39.6	20.8	21.1
2017 – 2019	23.4	28.9	35.1	20.5	20.3

Table 84: Diabetes Deaths, Age-Adjusted Death Rates per 100,000 Population, Three-Year Moving Averages
Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Age-Adjusted Hospitalizations per 100,000 Population from or with Diabetes, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	2,368.2	3,433.9	2,487.7	2,362.4	2,246.6
2020 – 2022	2,373.5	3,430.1	2,469.3	2,385.2	2,211.7
2019 – 2021	2,407.3	3,463.6	2,510.0	2,466.8	2,243.4
2018 – 2020	2,434.4	3,508.4	2,553.2	2,555.2	2,259.9
2017 – 2019	2,531.2	3,545.1	2,775.0	2,663.9	2,320.9

Table 85: Hospitalizations from or with Diabetes as Any Listed Diagnosis, Age-Adjusted Rates per 100,000 Population, Three-Year Moving Averages
Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Injury, Safety & Violence

Age-Adjusted Hospitalizations per 100,000 Population from Non-Fatal Unintentional Falls, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	158.4	155.7	132.1	198.9	241.6
2020 – 2022	157.4	146.6	121.5	185.2	235.3
2019 – 2021	156.7	133.8	139.8	164.9	234.0
2018 – 2020	168.3	129.2	176.5	182.7	238.7
2017 – 2019	176.9	146.4	185.8	196.8	242.8

Table 86: Age-Adjusted Hospitalizations from Non-Fatal Unintentional Falls per 100,000 Population, Three-Year Moving Averages
Source: Florida Agency for Health Care Administration, accessed through www.flhealthcharts.gov

Domestic Violence Offenses per 100,000 Population, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	293.3	124.9	119.5	68.9	309.1
2020 – 2022	288.5	127.2	143.1	106.5	301.3
2019 – 2021	292.4	132.8	154.2	143.1	303.0
2018 – 2020	280.2	128.5	141.9	145.7	306.5
2017 – 2019	280.8	143.0	156.5	161.0	317.3

Table 87: Domestic Violence Offenses per 100,000 Population, Three-Year Moving Averages
Source: Florida Department of Law Enforcement, accessed through www.flhealthcharts.gov

Rate of Children Experiencing Child Abuse (Aged 5-11) per 100,000 Population Aged 5-11, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	708.0	653.3	403.9	722.5	483.8
2020 – 2022	664.1	662.1	441.1	770.1	534.3
2019 – 2021	586.8	668.7	404.4	727.0	594.9
2018 – 2020	551.0	788.2	363.2	778.1	674.5
2017 – 2019	571.0	801.4	388.2	655.0	765.9

Table 88: Children Experiencing Child Abuse (Aged 5-11) per 100,000 Population Aged 5-11, Three-Year Moving Averages
Source: Florida Department of Children and Families, Florida Safe Families Network, accessed through www.flhealthcharts.gov

Age-Adjusted Rates of Homicide Deaths per 100,000 Population, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	6.23	24.69	8.31	6.17	6.95
2020 – 2022	6.08	24.44	3.70	3.27	7.40
2019 – 2021	6.23	17.82	2.64	4.96	7.22
2018 – 2020	6.19	13.82	5.82	4.92	7.01
2017 – 2019	5.43	9.43	3.21	4.86	6.59

Table 89: Age-Adjusted Rates of Homicide Deaths per 100,000 Population, Three-Year Moving Averages
Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Rate of Violent Crime per 100,000 Population, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	170.3	163.5	124.1	106.7	151.8
2020 – 2022	163.1	170.4	124.9	114.3	151.8
2019 – 2021	162.7	162.7	136.1	117.2	151.7
2018 – 2020	177.7	172.0	150.9	115.1	157.1
2017 – 2019	187.0	185.1	176.9	117.6	163.9

Table 90: Violent Crime Rate per 100,000 Population, Three-Year Moving Averages
Source: Florida Department of Law Enforcement, accessed through www.flhealthcharts.gov

Age-Adjusted Death Rates per 100,000 Population from Firearms Discharges, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	12.7	31.5	17.4	18.6	13.8
2020 – 2022	12.5	29.2	19.3	13.7	13.9
2019 – 2021	13.1	29.4	18.3	14.9	13.5
2018 – 2020	12.9	23.0	21.4	13.7	13.2

2017 – 2019	11.2	18.5	8.9	17.1	12.8

Table 91: Deaths from Firearms Discharges, Age-Adjusted per 100,000 Population, Three-Year Moving Averages
Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Age-Adjusted Death Rates per 100,000 Population from Motor Vehicle Crashes, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	14.8	32.7	18.5	21.6	15.9
2020 – 2022	13.8	27.1	12.3	23.4	16.2
2019 – 2021	12.6	24.4	15.5	28.9	15.8
2018 – 2020	10.1	21.9	24.2	36.1	15.0
2017 – 2019	9.9	20.1	29.3	39.0	14.8

Table 92: Deaths from Motor Vehicle Crashes, Age-Adjusted per 100,000 Population, Three-Year Moving Averages
Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Maternal and Child Health

Percentage of Births with Adequate Prenatal Care, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	73.6	66.9	74.0	75.9	63.3
2020 – 2022	74.4	66.8	73.1	76.4	64.0
2019 – 2021	73.3	65.9	73.8	75.2	66.6
2018 – 2020	74.7	68.7	74.5	77.4	69.2
2017 – 2019	74.0	67.6	74.2	76.4	70.6

Table 93: Percentage of Births with Adequate Prenatal Care Based on Kotelchuck Index, Three-Year Moving Averages
Note: The Kotelchuck Index, also called the Adequacy of Prenatal Care Utilization (APNCU) Index, assesses the adequacy of prenatal care based on when care began and the number of prenatal visits from when prenatal care began until delivery.
Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Live Births with Low Birth Weight per 1,000 Live Births, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	11.9	14.2	9.2	7.1	9.1
2020 – 2022	11.4	15.0	10.4	7.3	8.9
2019 – 2021	10.9	14.8	12.7	8.6	8.8
2018 – 2020	10.4	12.9	13.4	9.6	8.7
2017 – 2019	10.4	11.8	13.0	9.1	8.8

Table 94: Live Births under 2,500 Grams (Low Birth Rate) per 1,000 Live Births, Three-Year Moving Averages
Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Births to Mothers Aged 15-19 per 1,000 Women Ages 15-19, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	7.2	25.4	20.6	17.3	13.2
2020 – 2022	8.2	25.0	19.9	17.6	13.9
2019 – 2021	9.2	27.2	16.1	18.6	14.9
2018 – 2020	10.1	32.8	15.4	22.7	16.0
2017 – 2019	10.6	35.9	18.2	23.2	17.1

Table 95: Births by Mother's Age (Aged 15-19) per 1,000 Female Population Aged 15-19, Three-Year Moving Averages
Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Births to Mothers Aged 35-50 per 1,000 Women Ages 35-50, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	18.9	15.7	14.4	13.1	21.7
2020 – 2022	19.0	16.0	15.8	12.5	20.8
2019 – 2021	18.5	14.9	16.6	12.7	20.3
2018 – 2020	18.6	13.8	15.0	11.5	20.0
2017 – 2019	18.5	13.2	15.2	12.5	20.0

Table 96: Births by Mother's Age (Aged 35-50) per 1,000 Female Population Aged 35-50, Three-Year Moving Averages. Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Percentage of Births Paid for by Medicaid, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	40.8	56.8	45.6	33.5	43.9
2020 – 2022	41.6	57.1	47.3	33.7	45.5
2019 – 2021	41.4	57.0	48.0	35.0	46.5
2018 – 2020	41.8	59.3	49.6	38.3	47.4
2017 – 2019	41.9	61.0	51.4	41.7	48.1

Table 97: Percentage of Births Paid for by Medicaid, Three-Year Moving Averages. Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Infant Deaths per 1,000 Live Births, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	9.2	11.9	15.4	7.9	6.0
2020 – 2022	10.0	11.0	12.7	8.1	5.9
2019 – 2021	9.8	8.7	8.0	11.6	5.9
2018 – 2020	9.1	10.8	8.4	12.6	6.0
2017 – 2019	7.9	10.3	5.4	9.4	6.0

Table 98: Infant Mortality Rate, Deaths per 1,000 Live Births, Three-Year Moving Averages. Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Fetal Deaths (Stillbirths) per 1,000 Deliveries, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	7.8	8.8	12.3	5.3	7.2
2020 – 2022	7.8	10.4	9.9	3.1	7.1
2019 – 2021	6.1	9.6	7.7	4.1	7.0
2018 – 2020	6.5	7.3	13.8	6.3	6.8
2017 – 2019	5.4	10.2	21.2	9.3	6.8

Table 99: Fetal Deaths (Stillbirths) per 1,000 Deliveries, Three-Year Moving Averages. Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Count of Maternal Deaths					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	7	1	0	0	160
2020 – 2022	9	2	0	0	166
2019 – 2021	8	3	0	0	195
2018 – 2020	5	2	0	0	150
2017 – 2019	4	1	0	0	140

Table 100: Count of Maternal Deaths, Three-Year Moving Averages. Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Percentage of Enrolled Kindergarten Students Who are Immunized, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	94.9	88.0	95.1	90.4	91.8
2020 – 2022	94.9	89.5	95.6	92.9	92.8
2019 – 2021	94.5	95.8	95.7	92.7	93.5
2018 – 2020	94.9	98.1	94.3	94.7	93.6
2017 – 2019	94.6	98.2	95.4	95.1	93.9

Table 101: Percentage of Enrolled Kindergarten Students who are Immunized, Three-Year Moving Averages
Source: Florida Department of Health, Bureau of Epidemiology, accessed through www.flhealthcharts.gov

Mental Well-Being and Substance Abuse Prevention

Age-Adjusted Hospitalizations per 100,000 Population from Mental Disorders, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	1,332.9	1,340.4	1,558.9	1,093.8	963.2
2020 – 2022	1,187.1	1,204.4	1,360.4	1,052.9	962.4
2019 – 2021	1,060.2	1,081.2	1,196.7	1,065.8	986.0
2018 – 2020	974.7	956.2	1,206.1	972.0	1,001.3
2017 – 2019	950.5	930.7	1,105.8	944.3	1,023.3

Table 102: Age-Adjusted Hospitalizations from Mental Disorders per 100,000 Population, Three-Year Moving Averages
Source: Florida Agency for Health Care Administration, accessed through www.flhealthcharts.gov

Age-Adjusted Rates of Suicide Deaths per 100,000 Population, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	12.8	12.3	15.6	23.6	14.0
2020 – 2022	12.6	9.5	17.8	20.9	13.6
2019 – 2021	12.6	16.8	22.7	18.0	13.8
2018 – 2020	10.8	10.1	13.7	17.5	14.1
2017 – 2019	10.9	7.7	12.9	19.5	14.2

Table 103: Age-Adjusted Rates of Suicide Deaths per 100,000 Population, Three-Year Moving Averages
Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Age-Adjusted Deaths from Alcoholic Liver Disease per 100,000 Population, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	7.6	5.6	13.9	5.6	7.2
2020 – 2022	9.0	5.9	9.8	9.1	7.6
2019 – 2021	9.3	9.1	6.8	10.9	7.3
2018 – 2020	8.4	7.4	3.4	10.0	7.0
2017 – 2019	5.9	7.9	1.2	7.5	6.5

Table 104: Age-Adjusted Deaths from Alcoholic Liver Disease per 100,000 Population, Three-Year Moving Averages
Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Age-Adjusted Deaths from Drug Poisoning per 100,000 Population, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	16.4	22.0	19.3	32.5	34.1
2020 – 2022	16.8	18.7	17.7	24.5	35.4

2019 – 2021	14.4	11.2	26.1	18.4	32.2
2018 – 2020	12.5	8.8	19.9	11.5	27.6
2017 – 2019	10.3	4.4	19.3	17.6	24.2

Table 105: Age-Adjusted Deaths from Drug Poisoning per 100,000 Population, Three-Year Moving Averages
Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Adult Drug Arrests per 100,000 Population, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	590.4	301.3	1,320.8	598.8	458.0
2020 – 2022	529.7	240.1	1,090.0	614.3	438.8
2019 – 2021	545.5	297.5	853.7	639.1	486.8
2018 – 2020	631.3	396.9	696.2	672.3	570.3
2017 – 2019	755.4	484.6	773.2	698.4	650.8

Table 106: Adult Drug Arrests per 100,000 Population Aged 18 and Over, Three-Year Moving Averages
Source: Florida Department of Law Enforcement, accessed through www.flhealthcharts.gov

Juvenile Drug Arrests per 100,000 Population, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	118.1	38.5	288.9	126.7	159.1
2020 – 2022	100.7	23.0	321.1	128.8	144.6
2019 – 2021	139.9	44.2	379.8	270.9	189.4
2018 – 2020	269.9	50.7	558.8	384.8	287.8
2017 – 2019	470.7	85.3	680.3	510.7	399.5

Table 107: Juvenile Drug Arrests per 100,000 Population Aged 17 and Under, Three-Year Moving Averages
Source: Florida Department of Law Enforcement, accessed through www.flhealthcharts.gov

Social & Economic Factors Contributing to Health

Average Annual Unemployment Rate (Percent)					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2023	3.1	3.9	3.2	2.7	2.9
2022	3.0	3.8	3.2	2.5	2.9
2021	4.2	5.4	4.2	3.2	4.6
2020	5.8	6.8	5.6	4.5	7.7
2019	3.3	4.3	3.5	3.0	3.3

Table 108: Average Annual Unemployment Rate
Source: U.S. Bureau of Labor Statistics, Local Area Unemployment Statistics, accessed at www.bls.gov/lau/tables.htm#cntyaa

Percentage of High School Students Who Completed High School within Four Years of Starting					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2022 – 2023	86.1	72.9	66.7	97.6	88.0
2021 – 2022	86.8	75.9	76.5	97.0	87.3
2020 – 2021	94.0	82.7	81.8	95.5	90.1
2019 – 2020	94.4	77.1	85.4	93.8	90.0
2018 – 2019	92.4	60.4	62.7	91.6	86.9

Table 109: Percentage of High School Students Graduating within Four Years of Initial Enrollment in Ninth Grade
Source: Florida Department of Education, Education Information and Accountability Services, accessed through www.flhealthcharts.gov

Percentage of Civilian Non-Institutional Population with Heath Insurance					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2023	92.3	83.6	90.2	93.4	88.1
2022	91.8	85.8	90.0	93.0	87.7
2021	91.7	85.5	91.8	93.3	87.4
2020	92.2	87.1	92.6	91.6	87.3
2019	91.9	85.9	92.7	91.1	87.2

Table 110: Percentage of Civilian Non-Institutional Population with Health Insurance

Source: American Community Survey, five-year estimates, Table S2701, accessed through: www.flhealthcharts.gov

Percentage of Population by Health Insurance Status, 2023					
	Leon	Gadsden	Jefferson	Wakulla	Florida
Private	64.4	38.7	42.3	59.2	51.1
Public	28	44.9	47.9	34.2	37.0
None	7.7	16.4	9.8	6.6	11.9

Table 111: Percentage of Civilian Non-Institutional Population with Health Insurance

Source: American Community Survey, five-year estimates, Table DP.03, accessed through: www.flhealthcharts.gov

Percentage of Individuals Below Poverty Level					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2023	18.5	27.7	20.3	5.6	12.6
2022	19.4	25.5	18.3	6.1	12.9
2021	19.3	24.2	17.1	6.2	13.1
2020	19.6	21.3	17.0	7.5	13.3
2019	20.5	22.8	16.5	12.2	14.0

Table 112: Individuals Below Poverty Level as Percentage of Individuals with Known Income

Source: American Community Survey, five-year estimates, Table B17001, accessed through: www.flhealthcharts.gov

Counts of Licensed Medical Doctors					
	Leon	Gadsden	Jefferson	Wakulla	Florida
FY 2022 – 2023	834	8	5	18	59,266
FY 2021 – 2022	845	9	5	18	57,478
FY 2020 – 2021	854	12	7	18	56,666
FY 2019 – 2020	836	12	7	17	54,584
FY 2018 – 2019	821	11	7	18	53,345

Table 113: Counts of Licensed Medical Doctors

Source: Florida Department of Health, Division of Medical Quality Assurance, accessed through: www.flhealthcharts.gov

Counts of Licensed Dentists					
	Leon	Gadsden	Jefferson	Wakulla	Florida
FY 2022 – 2023	155	12	1	7	13,955
FY 2021 – 2022	148	11	1	6	13,182
FY 2020 – 2021	147	6	1	5	13,041
FY 2019 – 2020	143	6	2	4	12,264
FY 2018 – 2019	141	6	2	4	12,283

Table 114: Counts of Licensed Dentists

Source: Florida Department of Health, Division of Medical Quality Assurance, accessed through: www.flhealthcharts.gov

Transmissible & Emerging Diseases

Age-Adjusted Death Rates per 100,000 Population for Pneumonia and Influenza, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	8.5	19.2	6.9	9.7	8.4
2020 – 2022	9.1	17.8	14.2	10.5	8.9
2019 – 2021	9.6	15.2	12.6	7.3	8.9
2018 – 2020	10.0	15.2	12.6	5.3	9.3
2017 – 2019	9.2	15.0	13.2	6.2	9.3

Table 115: Pneumonia and Influenza Deaths, Age-Adjusted per 100,000 Population, Three-Year Moving Averages
Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Chlamydia Cases, Rate per 100,000 Population					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	1,088.2	1,016.7	469.1	373.9	484.3
2020 – 2022	1,062.2	946.2	472.4	401.8	470.9
2019 – 2021	1,066.9	980.2	521.7	430.2	485.5
2018 – 2020	1,094.5	1,012.3	493.3	442.1	493.8
2017 – 2019	1,148.4	956.6	489.8	481.9	503.6

Table 116: Chlamydia Cases per 100,000 Population, Three-Year Moving Averages
Source: Florida Department of Health, Bureau of Communicable Diseases, accessed through www.flhealthcharts.gov

Infectious Syphilis Cases, Rate per 100,000 Population					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	41.5	34.2	31.6	12.3	20.1
2020 – 2022	40.8	30.7	34.1	8.7	19.1
2019 – 2021	37.2	25.6	27.2	13.9	17.3
2018 – 2020	31.1	30.9	18.0	14.3	15.0
2017 – 2019	21.5	29.7	9.1	11.4	13.5

Table 117: Infectious Syphilis Cases per 100,000 Population, Three-Year Moving Averages
Source: Florida Department of Health, Bureau of Communicable Diseases, accessed through www.flhealthcharts.gov

Gonorrhea Cases, Rate per 100,000 Population					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	506.9	526.9	245.8	123.7	202.9
2020 – 2022	481.0	522.1	231.6	133.6	196.5
2019 – 2021	430.2	495.8	229.1	110.3	188.4
2018 – 2020	392.5	426.1	236.5	126.3	172.5
2017 – 2019	366.6	344.6	181.4	133.1	161.4

Table 118: Gonorrhea Cases per 100,000 Population, Three-Year Moving Averages
Source: Florida Department of Health, Bureau of Communicable Diseases, accessed through www.flhealthcharts.gov

Human Immunodeficiency Virus (HIV) Diagnoses, Rate per 100,000 Population					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	23.5	26.8	9.0	5.7	19.6
2020 – 2022	19.2	27.8	9.1	4.8	17.7
2019 – 2021	17.7	19.9	13.6	4.0	17.8

2018 – 2020	21.2	23.2	15.8	4.1	18.7
2017 – 2019	23.2	20.7	15.9	6.2	21.0

Table 119: HIV Diagnoses per 100,000 Population, Three-Year Moving Averages

Source: Florida Department of Health, Bureau of Communicable Diseases, accessed through www.flhealthcharts.gov

Age-Adjusted HIV/AIDS Deaths per 100,000 Population, Three-Year Moving Averages					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2021 – 2023	1.9	7.9	7.0	1.5	2.3
2020 – 2022	2.5	8.3	4.5	1.6	2.5
2019 – 2021	2.8	7.2	5.9	1.6	2.7
2018 – 2020	4.2	8.2	1.5	1.0	2.8
2017 – 2019	4.2	6.8	1.6	0.0	3.0

Table 120: HIV/AIDS Deaths per 100,000 Population, Three-Year Moving Averages
Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

Age-Adjusted COVID-19 Deaths per 100,000 Population					
	Leon	Gadsden	Jefferson	Wakulla	Florida
2023	11.5	13.6	8.3	12.3	9.9
2022	41.8	56.7	45.1	89.0	35.8
2021	103.6	157.0	134.1	144.0	108.8
2020	52.4	87.4	50.5	79.1	57.3

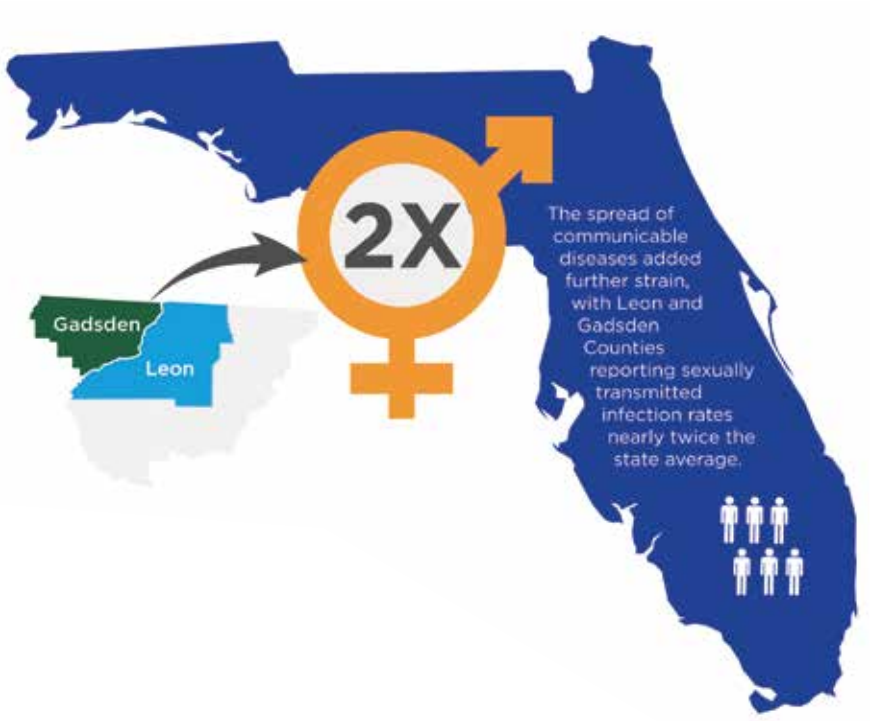
Table 121: Age-Adjusted COVID-19 Deaths per 100,000 Population.

Source: Florida Department of Health, Bureau of Vital Statistics, accessed through www.flhealthcharts.gov

SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY

The 2025 Community Health Needs Assessment (CHNA) revealed clear disparities in health outcomes across the service area, shaped by geography, socioeconomic status and demographics. Poverty and lower educational attainment were particularly evident in Gadsden, Jefferson, and Wakulla counties. In Leon County, ZIP Code 32304 stood out as one of Florida's poorest communities, where residents reported significantly lower access to health care, higher unmet dental needs and greater reliance on mental health services than the rest of the county.

Overall health outcomes reflected these challenges. Life expectancy in Gadsden County was more than five years below the state average. Heart disease remained the leading cause of death in most counties, while Wakulla County faced disproportionately high cancer mortality rates. Maternal mortality in both Leon and Gadsden Counties far exceeded the state average, despite recent improvements. At the same time, hospitalizations for mental health disorders and suicide deaths rose across all counties, underscoring both the growing need for behavioral health services and the shortage of providers in rural areas.



The spread of communicable diseases added further strain, with Leon and Gadsden counties reporting sexually transmitted infection rates nearly twice the state average.

When asked to identify the most pressing health needs, both community members and stakeholders emphasized three priorities: managing chronic diseases, supporting mental health and substance use prevention and addressing the social and economic conditions that drive health disparities. Low-income families, people experiencing homelessness and immigrants were identified as the populations most at risk.

Three themes emerged repeatedly during data review and stakeholder discussions: the importance of access to care, the need for stronger care coordination and the value of prevention. These themes will shape the next phase of planning and help ensure that strategies to address chronic disease, mental well-being and social determinants of health are both effective and sustainable.

COMMUNITY HEALTH NEEDS: PRIORITIES, THEMES AND NEXT STEPS

Methodology

On May 16, 2025, TMH conducted a CHNA Stakeholder meeting to share preliminary data from the recently administered 2025 Community Health Survey (CHS) survey and solicit feedback on the prioritization of health needs. Over 300 individuals were invited to participate, including the CHNA Advisory Committee, as well as community health partners and stakeholders. Approximately 40 individuals participated in the hybrid in-person and web-based meeting. TMH shared (1) an overview of the CHNA process, (2) a snapshot of the service area demographics, (3) key health indicator statistics, (4) a summary of the Community Health Survey, (5) a summary of the Community Stakeholder Survey and (6) themes from the SHIP Priority Area Meetings.

In both the Community Health Survey and the Community Stakeholder Survey, respondents were asked to rank the SHIP health priority areas. The top three areas of need in both surveys were: Chronic Diseases and Conditions, Mental Well-Being and Social and Economic Conditions Contributing to Health. Age-Related Dementias and Maternal and Child Health received a similar count of responses in the Community Health Survey.

Rank	FL SHIP – Priority Areas	2025 Community Survey Responses (From 1,933 Respondents)	2025 Stakeholder Survey Responses (From 43 Respondents)
1	Chronic Diseases and Conditions	1,250	26
2	Mental Well-Being	1,110	29
3	Social and Economic Conditions Affecting Health	733	31
4	Age-Related Dementias	683	12
5	Maternal and Child Health	672	9
6	Injury, Safety and Violence	508	8
7	Substance Abuse	406	6
8	Transmissible and Emerging Diseases	306	1

Table 122: Ranked Priority Health Areas

Participants, including community stakeholders, discussed each SHIP health priority area during the Priority Area Meetings held in February 2025. Three cross-cutting themes emerged from the meetings' key points:

- Access to Health Services
- Care Coordination
- Prevention

Attendees provided feedback on the themes identified and the prioritized health areas. While stakeholders saw needs in all priority health areas, the group generally agreed with the themes and suggested continuing to evaluate data and jointly developing actionable strategies to address these needs at additional stakeholder meetings.

In the summer of 2025, the CHNA Advisory Committee reconvened to confirm the health priorities and the best approach to address the identified needs. Due to the overlap in the priority health areas, the Committee opted to move ahead with evaluating resources and developing possible implementation strategies for all seven SHIP health priority areas. TMH will use a framework that addresses access to health services, care coordination and prevention across the health needs to develop the implementation plan.

For the 2025 Community Health Needs Assessment, the health priority areas for TMH are:

1. Chronic Diseases and Conditions
2. Mental Well-Being and Substance Abuse Prevention
3. Social and Economic Factors Contributing to Health
4. Alzheimer's Disease and Related Dementias
5. Maternal and Child Health and Violence
6. Injury, Safety and Violence
7. Transmissible and Emerging Diseases

The CHNA Advisory Committee recommends initially prioritizing Chronic Diseases and Conditions, Mental Well-Being and Substance Abuse Prevention, and Social and Economic Factors Contributing to Health since these were the top areas named in the CHNA surveys. TMH will continue to engage community partners and stakeholders in strategy sessions to support developing and executing the implementation plan.



PRIOR CHNA (2022) ACTIONS AND IMPACT

In 2022, Tallahassee Memorial HealthCare (TMH) conducted a Community Health Needs Assessment (CHNA) and prioritized five health need areas including: (1) access to health services, (2) mental health and substance abuse, (3) nutrition, physical activity and obesity, (4) and preventive health services. Through additional discussions, the CHNA Advisory Committee recommended special attention to (5) Maternal, Infant and Child Health. The 2023-2025 CHNA Implementation Strategy document (TMH.ORG/CHNA) highlights the strategies, target populations, activities, expected outcomes and partners for each prioritized health need. The following is a summary of the 2022-2025 CHNA Implementation Strategy results.

Prioritized Health Needs	Strategies	Results
Clinical Preventive Services Enhance health promotion and screening opportunities to focus on key community health issues	1. Support Clinical Quality Measures (CQMs) 2. Address Social Determinants of Health (SDOH) 3. Foster outreach to underserved areas	• TMH increased the number of eye exams completed during fiscal years 2023-2025 (FY 2023-2025) through technological investment that allows eye exams to be completed in primary care offices. This has positively impacted rural health practice sites in Gadsden, Wakulla, Jefferson and Liberty counties. Based on this success, there are plans to expand this service to other practice sites. • TMH successfully implemented measures to better understand and address social factors affecting health outcomes, including integrating Social Determinants of Health (SDOH) screenings in the hospital's electronic health record, Epic. For FY 2024, 93% of adult patients were screened for housing insecurity, food insecurity, transportation, utilities and personal safety. • TMH, in collaboration with 211 Big Bend, developed a community resources brochure for case management teams to distribute to patients in response to needs assessed from the SDOH screenings. • With the conversion to Epic, TMH has a dedicated team that provides content and workflow guidance to enhance the SDOH screening process. • Using social media, print publication, interviews and events, TMH has continued marketing and educational campaigns for health condition awareness and education. TMH has also participated in community outreach events over the past three years, partnering with our regional health departments. In FY 2024, TMH partnered with the Madison and Jefferson County health departments at the Jefferson County Expo to provide colon cancer screening and lipid and A1C testing. TMH has ongoing partnerships with the Madison and Jefferson County Health Departments to address chronic disease management. TMH also partners with Wakulla County at local events, such as the annual story walk, fundraisers, health fairs and health department events. TMH continues to support the "back to school" events and health activities in Gadsden County.

Prioritized Health Needs	Strategies	Results
Maternal, Infant and Child Health Improve maternal health literacy and muti-lingual educational patient resources, expand asthma-friendly educational resources, and connect new and expectant mothers with external resources	1. Address need for multi-lingual educational resources among patient populations served by the Women's & Children's Service Line to address health equity and health disparities among underserved communities 2. Create avenues to increase education related to asthma management among parents and children 3. Increase smoking cessation education with admitted expectant and new mothers. Collaborate with state Connect Partners and local partners to address gaps in connecting new and expectant mothers with community resources. 4. Standardize patient education on sexual wellness and perinatal care	• TMH is translating forms and educational resources for the Maternal, Infant and Child related departments to Spanish. In FY 2024, nine documents were translated to Spanish. • Within Epic, TMH has made more patient education documents available in multiple languages • Through the newly hired Child Health Educator in FY 2024, TMH provided age-appropriate asthma themed educational materials targeted to families in the service area • Using approaches developed by its Family Medicine Residency Program and Connect Partners, TMH identified expectant and new mothers who need smoking cessation support. These partners provide referrals for outpatient/ongoing smoking cessation support. TMH plans to use the assessment of social drivers, such as vaping and e-cigarette use along with substance use of tobacco, to generate referrals, education and support. • In FY 2024, to address gaps in connecting new and expectant mothers with community resources, TMH partnered with Connect Partners and Healthy Start to place a Connect Partners representative in the hospital and area OB/GYN offices. Connect Partners work with patients identified as high risk and directs them to appropriate community resources such as SNAP, WIC, transportation, etc. • To standardize patient education on sexual wellness and perinatal care, TMH partnered with C.O.A.S.T. (Community Outreach and Support Team) to support pregnant and postpartum women who are at risk for poor birthing outcomes or post-partum complications. TMH's Family Practice OB office successfully identifies post-partum patients that need to be seen at various times for follow-up based on health needs.
Access to Health Services Decrease access barriers and provide more flexible options to access healthcare	1. Utilize telemedicine to improve access for healthcare services 2. Increase access to healthcare services for residents of Wakulla County and ZIP Code 32304 3. Improve transportation access for medical services	• TMH developed a regional network with five rural hospitals to provide remote and in-home access to care • During 2022-2023, TMH completed over 10,000 telemedicine visits with patients for primary and specialty care. While telemedicine has decreased post-COVID, it remains a valuable tool to help keep vulnerable patients safe and increase access to care for patients in rural communities. • Telemedicine continues to be a valuable tool to connect patients in the hospital to their physicians. During 2023-2024, over 1,600 telemedicine visits were completed for hospitalized patients. • TMH is currently developing a telemedicine advisory board and collecting telemedicine usage data to evaluate additional opportunities to effectively use telemedicine

Prioritized Health Needs	Strategies	Results
Access to Health Services Decrease access barriers and provide more flexible options to access healthcare	4. Evaluate disparities to identify and address existing service gaps 5. Improve health literacy related to healthcare access	• Transportation continues to be an access to care barrier. During FY 2024, TMH provided 138 patients transportation assistance totaling $4,288. TMH is working with our community partner, 211 Big Bend, to expand transportation options for medical services. • To increase access to non-emergency services for residents living in Leon County, ZIP Code 32304 (Frenchtown residents, identified as an impoverished community), TMH opened an area Urgent Care Center in 2023. An urgent care center in Wakulla County is also currently under construction. • TMH Shared Governance continued to support the Diversity, Equity and Inclusion Council (DEIC). The group's goals included identifying health disparities and gaps in care and developing a standard to review EPIC data. • TMH continued the initiative with Capital Health Plan to proactively address patients with high emergency department utilization. Through more focused care management, this partnership seeked to reduce emergency department visits for this population by 25%.
Nutrition, Physical Activity and Obesity Increase access to nutritious food, including increased fruit and vegetable consumption, increase participation in physical activity and increase water consumption/ decrease sugar-sweetened beverage consumption	1. Educate and support elementary school students in increasing water consumption (and decreasing sugar-sweetened beverage consumption) 2. Support and promote community walking programs 3. Educate and support low-income families in increasing fruit and vegetable consumption at local farmers markets 4. Increase access to nutritious food by addressing food insecurity in the Big Bend region	• As part of the Leon County Health Department's Community Health Improvement Plan (CHIP), TMH developed the Happy Hydrators Challenge in collaboration with Early Childhood Obesity Prevention Work Group (ECOP), Big Bend Area Health Education Center (AHEC), Whole Child Leon, Department of Health in Leon County, FAMU Cooperative Extension and University of Florida Institute for Food and Agricultural Sciences (UF/IFAS) Extension. Since its inception in 2018, the program educated over 900 students, teachers and staff in Title 1 schools on the benefits of water consumption. Eighty percent of children report the program helped them drink more water and 65% report reducing their sugar-sweetened beverage consumption. • TMH supported community walking initiatives with our partner organizations, Premier Health & Fitness, Capital Health Plan and MOVE Tallahassee. These community walks were held in Leon and surrounding counties to promote free, accessible outdoor physical activity. • TMH partnered with the City of Tallahassee Neighborhood Affairs division, FAMU, and Second Harvest of the Big Bend, to promote and support the Southside Farmers Market and Fresh Fruit and Vegetable Rx (FFVRx) Program. This bi-monthly market provides fresh, local fruits and vegetables, eggs, honey and other goods to Southside residents throughout the Spring, Fall and Winter. The FFVRx program also helps participants better manage behaviors affecting nutrition and health. • TMH financially supports the voucher program, and plans to help support additional nutrition access and education with this farmers market

Prioritized Health Needs	Strategies	Results
Nutrition, Physical Activity and Obesity Increase access to nutritious food, including increased fruit and vegetable consumption, increase participation in physical activity and increase water consumption/ decrease sugar-sweetened beverage consumption		• In 2022, the TMH Foundation was awarded a grant to support food insecurity intervention. One of the first initiatives of this project was to implement a food insecurity intervention that combined nutrition and budget education seminars with food vouchers. These seminars started in FY 2023 and continued into FY 2025. TMH partnered with the Leon County Extension Office to implement the seminars in TMH's primary service area. As part of these seminars, the first 30 attendees receive a $30 gift card for attending and learning about eating healthy on a budget. • Ten seminars were held in FY 2023-2025 with a total of 258 attendees and 225 evaluations were completed. Ninety-three percent of respondents planned to make healthier food choices when grocery shopping, 92% of respondents planned to incorporate more fruits and vegetables into their diet, 84% of respondents planned to read food labels to make healthier choices, 87% of respondents planned to prepare and eat more healthy meals at home, 75% of respondents planned to reduce spending, 61% of respondents planned to create a financial plan, 76% of respondents planned to increase savings and 77% planned to reduce debt. These seminars will continue throughout FY 2025.
Mental Health and Substance Use Expand prevention and support services for emotional and social wellbeing. Increase awareness and skills to assist individuals experiencing mental health or substance use-related crisis and to raise public awareness of issues and resources.	1. Improve access to community-based, preventive emotional and social well-being services 2. Improve community members' knowledge and skills to assist individuals in crisis and connect them to mental health services 3. Participate in the Mental Health Council of the Big Bend 4. Expand education services available through TMH's Employee Assistance Program (EAP) and Behavioral Health Center	• The Bridge Program was launched in 2023 by TMH and the Apalachee Center. This program initiates emergency medication assisted treatment (MAT) services in the TMH Emergency Departments and links individuals to longer-term care through the Apalachee Center's community-based MAT program. It has successfully provided timely treatment referrals for those with opioid use disorder. • Expanding upon this program, the Coordinated Opioid Recovery Network (CORE) was initiated in 2024. TMH and the Apalachee Center continue to work together to help address similar needs in the community. • The Apalachee Center and TMH jointly opened the Live Oak Behavioral Health Center in May 2024 for patients to receive outpatient psychiatric, psychological and psychotherapy services. The Live Oak Behavioral Health Center is home to the Florida State University (FSU) College of Medicine's Psychiatry Residency Program. In addition to traditional outpatient services, the Live Oak Behavioral Health Center also facilitates an Intensive Outpatient Program (IOP) that launched in October 2024, and a Partial Hospitalization Program (PHP). Both programs aim to reduce hospitalizations and foster well-being in the community-setting. The Live Oak Behavioral Health Center treats children/adolescents, and adults with mental health and/or substance use disorders.

Prioritized Health Needs	Strategies	Results
Mental Health and Substance Use	5. Expand Critical Incident Stress Management (CISM) program and services available to community stakeholders 6. Improve access to community-based, preventive emotional and social well-being services 7. Improve community members' knowledge and skills to assist individuals in crisis and connect them to mental health services 8. Participate in the Mental Health Council of the Big Bend 9. Expand education services available through TMH's Employee Assistance Program (EAP) and Behavioral Health Center 10. Expand Critical Incident Stress Management (CISM) program and services available to community stakeholders	• In FY 2024, through a partnership between Apalachee Center and Bethel Missionary Baptist Church, 17 individuals received outpatient mental health services from the Apalachee Center Bethel Outpatient location • In FY 2024, the Apalachee Florida Assertive Community Treatment (FACT) program expanded into Gadsden and Wakulla Counties to help individuals with more serious mental health challenges • In 2023, Apalachee Center started the NAVIGATE program to serve individuals with the presence of, or risk for, a major psychiatric disorder. Services were provided to 36 individuals in FY 2024. • TMH partnered with Apalachee Center on Mental Health First Aid (MHFA) to help individuals assist someone experiencing a mental health or substance use-related crisis • MHFA training sessions started in 2021 and continued into FY 2025. In 2023, there were seven MHFA trainings provided with 128 participants. These trainings were provided at agencies/entities such as Keiser University, FAMU, FSU and the Florida Department of Law Enforcement. In FY 2024, 16 MHFA trainings were provided to the community. • TMH partnered with 20 area providers including Apalachee Center, Leon County Health Department, FSU Colleges of Nursing and Medicine and FAMU in the Mental Health Council of the Big Bend. The Mental Health Council improves behavioral healthcare in the Big Bend region and pursues strategies to reduce access barriers. TMH, along with other community partners, continues to support the Council's 4 strategic objectives from 2023-2025: ▪ (1) Evaluate data for specific areas of need in "high impact neighborhoods" and partner with other counties to help evaluate their community health needs; ▪ (2) Expand local pool of mental health professionals. TMH partners with the Apalachee Center and FSU to create a local psychiatric residency program. The Council also supported the establishment of a Psychiatric Advanced Practice Registered Nurse program at FSU; ▪ (3) Educate the community regarding mental health issues via an annual Mental Health Fair in a high impact neighborhood, the production of several public information videos to share on member websites and in waiting rooms, and the development of a web-based provider directory by Council Member agencies (Apalachee Center, TMH, FSU and 211 Big Bend); and ▪ (4) Engage impacted local communities. These projects include a Black Men's Mental Health Awareness program, production and distribution of informational materials related to local mental health resources, "Be Kind to Your Mind" events and other community engagement activities.

Prioritized Health Needs	Strategies	Results
Mental Health and Substance Use		• TMH offers an Employee Assistance Program (EAP) to its colleagues and as a service to other organizations within the Big Bend region. The program has 18 employer contracts, offers counseling and support services to over 17,000 individuals and, including family members, benefits over 30,000 lives. During the past three years, EAP has also added consultations for youth over age 10, virtual access and workplace presentations about its services. • Critical Incident Stress Management (CISM) is an approach designed to alleviate negative reactions to trauma. CISM is offered any time a critical incident occurs in the community. During the FY 2023-2024 period, EAP responded to several CISM debriefings, and five on-site bereavement events with 15 service hours spent supporting approximately 38 employees. In addition, Live Oak Outpatient Center provided outpatient counseling and psychiatry services for community members impacted by Critical Incidents. • TMH has several alternative therapy initiatives to prevent opioid dependence and provide support to patients and community members. These initiatives include Therapeutic Touch, Medical Music Therapy and Animal Therapy. Since 2014, over 3,000 Therapeutic Touch sessions have been provided to TMH patients throughout the hospital. For FY 2023 and 2024, there were over 2,700 TMH Music Therapy referrals. For the same period, there were over 7,700 visits by TMH Animal Therapy provided to TMH patients, Leon, Wakulla and Jefferson County schools and libraries, through the READ® program and for Court House Therapy.

APPENDIX 1 – COMMUNITY STAKEHOLDER SURVEY

TALLAHASSEE MEMORIAL HEALTHCARE

COMMUNITY HEALTH NEEDS ASSESSMENT 2025

Every three years, Tallahassee Memorial Healthcare conducts a Community Health Needs Assessment. As part of this effort, we reach out to our community stakeholders to solicit their input about the barriers and challenges faced by our residents and the agencies that serve them. This survey is intended to provide you with a voice in this important conversation. **Your responses will not be identified, either in written material or verbally, by name or organization. We appreciate your participation!**

Q1.

If you feel comfortable doing so, please provide your organization's name, your name, and your title.

Q1a.

Your organization's name:

Q1b.

Your name:

Q1c.

Your title:

Q2.

Which county or counties do you serve? **Check all that apply.**

- Leon (1)
- Gadsden (2)
- Jefferson (3)
- Wakulla (4)

Q3.

The Florida Department of Health has identified the issues listed below as priorities for improving the health of Florida citizens. Which three do you think are the most important to address for the community or communities you serve? Please check three.

- ☐ **Age-Related Dementias (1)**
  For example, Alzheimer's disease, Lewy body dementia, vascular dementia
- ☐ **Chronic Diseases and Conditions (2)**
  For example, heart disease, type 2 diabetes, cancer, and illnesses related to tobacco use
- ☐ **Injury, Safety, and Violence (3)**
  For example, motor vehicle crashes, falls, and intimate partner violence
- ☐ **Maternal, Infant, and Child Health (4)**
  For example, premature birth, infant death, or not getting healthcare while pregnant
- ☐ **Mental Well-being (5)**
  For example, depression, anxiety, or other behavioral and emotional disorders
- ☐ **Social and Economic Issues Affecting Health (6)**
  For example, educational opportunities, income and employment, transportation, healthy and safe environment, weather-related disasters
- ☐ **Substance Abuse (7)**
  For example, people drinking too much or using drugs illegally
- ☐ **Transmissible and Emerging Diseases (8)**
  For example, sexually transmitted infections like HIV, new diseases like COVID-19

Q4.

What are the barriers to health for the populations you serve? **Check all that apply.**

- ☐ Formal support systems are difficult to navigate (8)
- ☐ High cost of medical services or prescriptions (3)
- ☐ Inadequate family or community support (9)
- ☐ Limited health literacy (7)
- ☐ Lack of or insufficient health insurance (4)
- ☐ Lack convenient access to nutritious foods (food deserts) (5)
- ☐ Poverty (2)
- ☐ Shortage of providers accepting Medicare or Medicaid (6)
- ☐ Transportation (1)
- ☐ Other, please specify: (10)

Q5.

What healthcare resources are missing for the population(s) you serve?

Q6.

Thinking about the county or counties you serve, how would you assess the level of unmet need in each of the groups below? **CHECK ONE BOX PER ROW.**

Children	Very low	Low	Moderate	High	Very high
Homeless individuals or families	Very low	Low	Moderate	High	Very high
Immigrants Very low	Very low	Low	Moderate	High	Very high
Low-income individuals or families	Very low	Low	Moderate	High	Very high
Racial or ethnic minorities	Very low	Low	Moderate	High	Very high
SeniorsVery	Very low	Low	Moderate	High	Very high
Single parentsVery	Very low	Low	Moderate	High	Very high
Sexual or gender minoritiesVery	Very low	Low	Moderate	High	Very high

Online version has a " does not apply.

Q7.

Identify the neighborhood or locality with the greatest unmet need in the county or counties you serve. You may use a name or a ZIP code.

Q8.

What specific resources are missing for this neighborhood or locality?

Q9.

What form(s) of discrimination affect the populations you serve? **Check all that apply.**

- Ageism (discrimination against older people) (1)
- Ableism (discrimination against persons with disabilities) (2)
- LGBTQ discrimination (3)
- Racism (discrimination against racial or ethnic minorities) (4)
- Sexism (discrimination against women) (5)
- Social class (discrimination against people with low income) (7)
- Discrimination is not an issue for the population(s) I serve (8)

Q10.

What is one change you would like to see that would allow you to better meet the needs of the population(s) you serve and reduce their barriers to health?

Q11.

What do you perceive as the biggest barrier to enacting this change?

Q12.

Is there anything we didn't ask in the questions above that you think we should know?

Questions or concerns?

Please call 850-431-3720

THANK YOU FOR YOUR VALUABLE INPUT!

APPENDIX 2 – COMMUNITY HEALTH SURVEY

TALLAHASSEE MEMORIAL HEALTHCARE

COMMUNITY HEALTH NEEDS ASSESSMENT 2025

Every three years, Tallahassee Memorial Healthcare surveys the residents of Gadsden, Jefferson, Leon, and Wakulla counties to learn about your healthcare experiences and hear your thoughts about health and wellbeing in the communities we serve. Your input is vital to our efforts to improve health care for everyone.

We appreciate your time!

Q1.

Please check the box next to the county you live in.

- ☐ Leon (1)
- ☐ Gadsden (2)
- ☐ Jefferson (3)
- ☐ Wakulla (4)

Q2.1

The Florida Department of Health has identified the issues listed below as priorities for improving the health of Florida citizens. Which three do you think are the most important to address in our community? **Please check three**.

- ☐ **Age-Related Dementias (1)**
  For example, Alzheimer's disease, Lewy body dementia, vascular dementia
- ☐ **Chronic Diseases and Conditions (2)**
  For example, heart disease, type 2 diabetes, cancer, and illnesses related to tobacco use
- ☐ **Injury, Safety, and Violence (3)**
  For example, motor vehicle crashes, falls, and intimate partner violence
- ☐ **Maternal, Infant, and Child Health (4)**
  For example, premature birth, infant death, or not getting healthcare while pregnant
- ☐ **Mental Well-being (5)**
  For example, depression, anxiety, or other behavioral and emotional disorders
- ☐ **Social and Economic Issues Affecting Health (6)**
  For example, educational opportunities, income and employment, transportation, healthy and safe environment, weather-related disasters
- ☐ **Substance Abuse (7)**
  For example, people drinking too much or using drugs illegally
- ☐ **Transmissible and Emerging Diseases (8)**
  For example, sexually transmitted infections like HIV, new diseases like COVID-19

The questions on pages 3 – 7 are about your reliance on doctors and other health care providers.

Q3.1

Is there a particular primary care provider, doctor's office, health center, or other place that you usually go if you are sick or need advice about your health?

- ☐ Yes (1)
- ☐ No (2) **Please answer q3.3 below**

Q3.2

Is this where you would go for preventive health care, such as general check-ups, examinations, and immunizations (shots)?

- ☐ Yes (1)
- ☐ No (2)

If you have a regular doctor, please skip to q4.1 on page 5

Q3.3

If you do not have a regular doctor, where do you go when you are sick or need advice about your health? **Check all that apply.**

- ☐ **Emergency Room (1)**
- ☐ **Community Clinic (2)**
  For example, Bond Community Health Center, Carepoint Health and Wellness Center, North Florida Medical Center, Neighborhood Medical Center
- ☐ **Health Department (3)**
- ☐ **Student Health Services (4)**
- ☐ **Pharmacy Clinic (5)**
  For example, CVS Minute Clinic
- ☐ **Planned Parenthood (6)**
- ☐ **VA / Veterans Medical Center (7)**
- ☐ **Urgent Care / Walk-in Clinic (8)**
- ☐ **Telemedicine / Virtual Care (9)**
- ☐ **Other, please specify (10):**

Q4.1

Where do you go for dental care? **Check all that apply.**

- ☐ **Dentist's Office (1)**
- ☐ **Emergency Room (2)**
- ☐ **The Molar Express at Leon County Health Department (3)**

- [ ] **Other County Health Department (4)**
- [ ] **Urgent Care / Walk-in Clinic (5)**
- [ ] **Community Clinic (6)**
  For example, Bond Community Health Center or Neighborhood Medical Center
- [ ] **Tallahassee State College Dental Health Clinic (7)**
- [ ] **Other, please specify (8):**

- [ ] **I don't use dental services (9)**

Q5.1

Do you use mental or behavioral health services (counseling)?

- [ ] Yes (1)
- [ ] No (2) **Please skip to q5.3 On page 7**

Q5.2

Where do you go for mental or behavioral health services (counseling)? **Check all that apply.**

- [ ] **Doctor or Counselor's Office (1)**
- [ ] **Apalachee Center, Inc. (2)**
- [ ] **DISC Village Behavioral Health (3)**
- [ ] **Emergency Room (4)**
- [ ] **Employee Assistance Program (5)**
- [ ] **HCA Florida Capital Behavioral Health Center (6)**
- [ ] **Tallahassee Memorial Behavioral Health Center (7)**
- [ ] **Telehealth or virtual care (8)**
- [ ] **University or College Counseling Center (9)**
- [ ] **Urgent Care / Walk-in Clinic (10)**
- [ ] **Other, please specify (11)**:

Q5.3

Do you use services for problems with alcohol or drug use?

- [ ] Yes (1)
- [ ] No (2) **Please skip to q6.1 on page 8**

Q5.4

Where do you go for help with alcohol or drug use problems? **Check all that apply.**

- ☐ **Doctor or Counselor's Office (1)**
- ☐ **Apalachee Center, Inc. (2)**
- ☐ **DISC Village Behavioral Health (3)**
- ☐ **Employee Assistance Program (4)**
- ☐ **HCA Florida Capital Behavioral Health Center (5)**
- ☐ **Tallahassee Memorial Behavioral Health Center (6)**
- ☐ **Townsend Addiction Recovery Center (7)**
- ☐ **University or College Counseling Center (8)**
- ☐ **Other, please specify (9):**

Sometimes people find it difficult to access medical care or services. In this section, we ask about your experience accessing needed services.

Q6.1

Do any of these factors keep you from getting medical care or services? **Check all that apply.**

Cost (1)

- ☐ **Hard to find provider accepting new patients (2)**
- ☐ **Hard to find a provider that accepts Medicaid (3)**
- ☐ **I'm too busy to go to the doctor (4)**
- ☐ **I don't have transportation (5)**
- ☐ **I don't trust doctors or other medical people (6)**
- ☐ **Lack of evening or weekend services (7)**
- ☐ **Takes too long to get appointments (8)**
- ☐ **Fear of getting bad news (9)**
- ☐ **I don't know how to get care or services I need (10)**
- ☐ **I don't like accepting government assistance (11)**
- ☐ **I'm able to get the care and services that I need (12)** Please skip to Q7.1 on page 12

Q6.2

What kinds of medical and health-related services are hard for you to get? **Check all that apply.**

- ☐ **Alternative therapies (1)**
  For example, acupuncture, massage
- ☐ **Ambulance services (2)**
- ☐ **Chiropractic care (3)**
- ☐ **Dental care (4)**
- ☐ **Doctors who specialize in the kinds of care my family and I need (5)** Please answer q6.2a on page 11
- ☐ **Domestic violence services (6)**
- ☐ **Elder care services (7)**
- ☐ **Emergency or urgent care (8)**
- ☐ **End of life / hospice / palliative care (9)**
- ☐ **Family planning / birth control (10)**
- ☐ **Hospital care (11)**
- ☐ **Grief or bereavement counseling (12)**
- ☐ **Immunizations / vaccinations / shots (13)**
- ☐ **Lab work (14)**
- ☐ **Medication / medical supplies (15)**
- ☐ **Mental health care / counseling (16)**
- ☐ **Physical therapy / Speech therapy / Occupational therapy (17)**
- ☐ **Preventive screenings (18)**
  For example, mammograms, colonoscopy
- ☐ **Programs or support to stop using tobacco products (19)**
- ☐ **Support services for problems with drug or alcohol use (20)**
- ☐ **Vision care (21)**
- ☐ **Wellness care (22)**
  For example, nutrition counseling, weight loss support
- ☐ **X-rays or MRI (23)**
- ☐ **Other, please specify (24):**

If you did not check "doctors who specialize in the kinds of care my family and i need," please skip to q7.1 on page 12

Q6.2a

What kinds of doctors are hard for you to find? **Check all that apply**.

- [ ] **Allergy, Asthma, & Immunology (1)**
- [ ] **Cardiology / Cardiac / Vascular Surgery (2)**
- [ ] **Chronic pain management (3)**
- [ ] **Dermatology (4)**
- [ ] **Ear, Nose, Throat (5)**
- [ ] **Endocrinology (6)**
- [ ] **Family care or general practice doctor (7)**
- [ ] **Gastrointestinal (8)**
- [ ] **Maternal-Fetal Medicine (9)**
- [ ] **Memory Disorder (10)**
- [ ] **Nephrology/Dialysis (11)**
- [ ] **Neurology/Neurosurgery (12)**
- [ ] **Obesity Medicine/Bariatric Surgery (13)**
- [ ] **Obstetrics/Gynecology (14)**
- [ ] **Oncology (cancer) (15)**
- [ ] **Orthopedics (16)**
- [ ] **Pediatrician (17)**
- [ ] **Podiatry (18)**
- [ ] **Psychiatry/Behavioral Health/Substance Abuse (19)**
- [ ] **Pulmonology/Sleep Medicine (20)**
- [ ] **Rheumatology (21)**
- [ ] **Surgery (general or specialized) (22)**
- [ ] **Urology (23)**
- [ ] **Wound Care (24)**
- [ ] **Other, please specify: (25)**

In this section, we ask about health insurance.

Q7.1

Which of the following best describes your health insurance? **Check all that apply.**

- [ ] **I don't have health insurance (1)** Please skip to q7.1c on page 13
- [ ] **I have health insurance through my job or the military (2)**

- [ ] I have COBRA (3)
- [ ] I have health insurance that I pay for on my own, or purchase through a group I belong to, or buy through healthcare.gov (4)
- [ ] I have Medicaid (5)
- [ ] I have Medicare (6)
- [ ] I have dental insurance (7)
- [ ] I have vision insurance (8)
- [ ] Other, please specify (9):

Answer q 7.1a if you have health insurance through your job or the military

Q7.1a

Do you have a Health Savings or Health Spending Account?

- [ ] Yes (1)
- [ ] No (2)

Answer q 7.1b if medicare is your primary form of health insurance

Q7.1b

Do you have a Health Savings or Health Spending Account?

- [ ] Yes (1)
- [ ] No (2)

Answer q 7.1c if you do not have health insurance

Q7.1c

Why don't you have health insurance? **Check all that apply**

- [ ] It's not available through my job (1)
- [ ] I get health care through my school (2)
- [ ] I don't qualify for healthcare.gov / Obamacare or Medicaid (3)
- [ ] I'm over 65, but I didn't pay into Medicare (4)
- [ ] Health insurance costs too much (5)
- [ ] Other, please specify (6):

The next set of questions are about your medical visits and screenings.

Q8.1

Tell us what kinds of medical visits you've had within the past 12 months. **Check all that apply.**

- ☐ **Eye exam (1)**
- ☐ **Routine check-up or physical (2)**
- ☐ **Routine dental exam (3)**
- ☐ **ER for an injury (4)**
- ☐ **ER for illness (5)**

Answer q8.3 If you are aged 45 – 84.
Otherwise, please continue to the next blue box.

Q8.3.

Have you had a colon cancer screening (colonoscopy or stool-based test) within the past ten years.

- ☐ Yes (1)
- ☐ No (2)

If you are a male, please skip to q10.1 On page 18. If you are a female, please continue to q8.4, Page 15

Q8.4

Have you had a Pap smear within the past five years?

- ☐ Yes (1)
- ☐ No (2)

Q8.5

Have you had a mammogram within the past two years?

- ☐ Yes (1)
- ☐ No (2)

Q9.1

Are you currently pregnant, or have you been pregnant in the past 12 months?

- ☐ **I am currently pregnant (1)**
- ☐ **have been pregnant within the past 12 months (2)** Please skip to q9.2a on page 17
- ☐ **No, I'm not pregnant and haven't been pregnant within the last 12 months (3)** Please skip to q10.1 on page 18

Q9.2

Do you have specific concerns about your pregnancy or medical needs that are not being addressed?

- Yes (1)
- No (2) Please skip to q10.1 on page 18

Q9.3

What specific concerns about your pregnancy or unmet needs do you have? **Check all that apply.**

- I can't afford prenatal care (1)
- I can afford prenatal care but I don't have a doctor or midwife (2)
- It's hard for me to get prenatal care because of my work schedule, difficulty finding childcare, or getting transportation to appointments (3)
- I cannot afford to buy baby supplies (4)
- I am unsure how I will pay for the birth (5)
- I am scared about health concerns that may affect my pregnancy or delivery (6)
- Other, please specify: (7)

PLEASE GO TO Q.10.1 ON PAGE 18

Q9.2a

Did you have specific concerns about your recent pregnancy or medical needs that were not addressed?

- Yes (1)
- No (2) Please skip to q10.1 on page 18

Q9.3a

What specific concerns or unmet needs did you experience during your recent pregnancy? **Check all that apply.**

- I couldn't afford prenatal care (1)
- I had difficulty finding a doctor or midwife (2)
- It was hard for me to get prenatal care because of my work schedule, difficulty finding childcare, or getting transportation to appointments (3)
- Paying for baby supplies was difficult (4)
- I was unable to pay for the birth (5)
- I was scared about health concerns that made my pregnancy or delivery difficult (6)
- Other, please specify: (7)

Now we'd like to learn about things you do to take care of your own health and wellbeing.

Q10.1

In a typical week, do you spend any time doing activities, like walking fast, swimming, biking, or fitness classes, that cause an increase in breathing or your heart rate for at least 10 minutes continuously?

- Yes (1)
- No (2)

Q10.1a

How many days in a typical week do you engage in activities that lead to an increase in your breathing or heart rate? Fill in a number from 1 to 7:

_____ days

Q10.2

In a typical week, how often do you eat fruit or vegetables (fresh or frozen), not including fruit juice or vegetable juice?

- I typically don't eat fruit or vegetables (1) **Please skip to q11.1 on page 19**
- 1-3 days (2)
- 4-6 days (3)
- Every day (4)

Q10.2a

On a typical day, how many servings of fruit or vegetables do you eat?

- 1 or 2 servings (1)
- 3 or 4 servings (2)
- 5 or more servings (3)

This section of the survey has a few questions about basic needs related to health and wellbeing: housing, utilities, and food.

Q11.1

What is your living situation?

- I have a steady place to live (1)
- I have a place to live today but I'm worried about losing it in the future (2)
- I do not have a steady place to live (temporarily staying with others, in a hotel or shelter, living in my car, bus station, or abandoned building, or living outside). (3) **Please skip to q11.2 on page 20**

Q11.1a

Do you own or rent your own home, live in group quarters (like a dorm or assisted living facility), or do you stay with others??

- Own or rent my own home (1)
- I live in group quarters (2)
- I stay with others (3)

Q11.1b

In the past 12 months, has the utilities company threatened to shut off services (water, electric, gas) to your home?

- Yes (1)
- No (2)
- Already shut off (3)

PLEASE GO TO Q.11.3 ON PAGE 21

PLEASE ANSWER Q11.2 IF YOU DO NOT HAVE A STEADY PLACE TO LIVE

Q11.2

In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?

- Often (1)
- Sometimes (2)
- Never (3)

PLEASE GO ON TO 11.5 ON PAGE 21

Q11.3

Within the past 12 months, you worried that your or your family's food would run out before you got the money to buy more.

- Often true (1)
- Sometimes true(2)
- Never true (3)

Q11.4

Within the past 12 months, you found that the food you bought just didn't last and you didn't have the money to get more.

- Often true (1)
- Sometimes true (2)
- Never true (3)

Q11.5

In the past 12 months, have you or family members living with you been unable to get any of the following when it was really needed? Check all that apply.

- Child care (1)
- Clothing (2)
- Groceries (3)
- Housing (4)
- Medicine or health care (5)
- Phone (6)
- Transportation (7)
- Utilities (8)
- Other, please specify (9)
- I have been able to get whatever I needed (10)

Next, we'd like to ask you about some ways that you might spend your time.

Q12.1

Are you a student?

- Yes (1)
- No (2)

Q12.2

What's your current work status?

- I work for an employer for 35 or more hours weekly (1)
- I work for an employer for less than 35 hours weekly (2)
- I am self-employed (4) **Please skip to q12.5 on page 23**
- Not currently working for pay or profit (3) **Please skip to q12.4 on page 23**

Q12.3

How many paid jobs do you work?

- 1 job (1)
- 2 jobs (2)
- 3 or more jobs (3)

PLEASE SKIP TO Q12.5 ON PAGE 23

Answer q12.4 only if you are not currently working

Q12.4

Are you...?

- ☐ Retired (1)
- ☐ Homemaker or caring for your own children or other family members (2)
- ☐ Unemployed and looking for work (3)
- ☐ Unemployed but not looking for work (4)
- ☐ Physically unable to work (5)

Q12.5

At any point in the past 2 years, has seasonal or migrant farm work been the main source of income for you or your family?

- ☐ Yes (1)
- ☐ No (2)

Your answers to the questions in this section will help us identify group differences in the health and wellbeing of community members.

Q13.0a

How old are you?

Years: _____ (1)

Q13.0b

What sex was put on your birth certificate when you were born?

- ☐ Male (1)
- ☐ Female (2)

Q13.1

What is your ZIP code? _____

Q13.2

Which of the following best represents how you describe your gender?

- ☐ Man (1)
- ☐ Woman (2)
- ☐ Non-binary / third gender / bigender (3)
- ☐ Transgender man (4)
- ☐ Transgender woman (5)
- ☐ Other, please specify: (6) _____

Q13.3

What is your current marital status?

- Married (1)
- Living with a romantic partner (2)
- Widowed (3)
- Divorced or separated (4)
- Never married (5)

Q13.4

What is the highest education level you've completed?

- Have not completed high school (1)
- High school diploma or GED (2)
- Technical / Vocational certification (3)
- Some college but no degree (4)
- Associates degree (5)
- Bachelor's degree (6)
- Graduate or Professional degree (7)

Q13.5

What is your yearly household income?

- Under $20,000 (1)
- $20,001 to $35,000 (2)
- $35,001 to $50,000 (3)
- $50,001 to $75,000 (4)
- $75,001 to $100,000 (5)
- $100,001 to $150,000 (6)
- Over $150,001 (7)

Q13.6

Which of the following best represents how you think of yourself?

- Gay or lesbian (1)
- Straight or heterosexual, not gay or lesbian (2)
- Bisexual (3)
- I don't know (4)
- Other, please specify: (5)

Q13.7

Do you have Hispanic, Latino, or Spanish origins or ancestry?

- ☐ No, I don't have Hispanic, Latino, or Spanish origins or ancestry (1)
- ☐ Yes, I have Hispanic, Latino, or Spanish origins or ancestry (2)

Q13.8

What is your primary language?

- ☐ English (1)
- ☐ Spanish (2)
- ☐ Other, please specify (3): _____

Q13.9

What is your race? **Check all that apply.**

- ☐ White, Caucasian (1)
- ☐ Black, African American, or Afro-Caribbean (2)
- ☐ American Indian or Alaska Native (3)
- ☐ Asian (4)
- ☐ Native Hawaiian or Pacific Islander (5)
- ☐ Middle Eastern or North African (5)

Q13.10

Do you have children?

- ☐ Yes (1)
- ☐ No (2) **Please skip to q15.1 on page 33**

Q13.11

Are any of your children younger than 18 or are they all older?

- ☐ One or more of my children is younger than 18 (1)
- ☐ All of my children are 18 or older (2) **Please skip to q15.1 on page 33**

Q14.1

Do any of your children younger than 18 live with you?

- ☐ Yes (1)
- ☐ No (2) **Please skip to q15.1 on page 33**

Q14.2

Would you be willing to answer some questions about your youngest child's health and health care?

- Yes (1)
- No (2) **Please skip to q15.1 on page 33**

Q14.3

Is there a primary care provider, doctor's office, health center, or other place your child visits if they are sick or you need advice about their health?

- Yes (1)
- No (2) **Please skip to q14.5 on page 29**

Q14.4

Is this where they would go for preventive health care, such as general check-ups, examinations, and immunizations or shots?

- Yes (1)
- No (2)

PLEASE SKIP TO Q14.6 ON PAGE 29

Q14.5

Where do your children go when they need medical care?

- **Emergency Room (1)**
- **Community clinic (2)**
  For example, Bond Community Health Center, Carepoint Health and Wellness Center, North Florida Medical Center, Neighborhood Medical Center
- **Health Department (3)**
- **Pharmacy Clinic (4)**
  For example, CVS Minute Clinic
- **School nurse (5)**
- **Planned Parenthood (6)**
- **Urgent care or walk-in clinic (7)**
- **Telemedicine or virtual care (8)**
- **Other, please specify (9):**

Q14.6

How long has it been since your child last visited a doctor for a routine checkup?

- Within the past 12 months (1)
- More than one year but no more than two years (2)
- More than two years (3)

Q14.7

Does your child get dental care?

- [ ] Yes (1)
- [ ] No (2) Please skip to q14.10 on page 31

Q14.8

Where do they go for dental care?

- [ ] Dentist's office (1)
- [ ] Emergency Room (2)
- [ ] The Molar Express (Leon County Health Department) (3)
- [ ] Other County Health Department (4)
- [ ] Urgent Care or Walk-in clinic (5)
- [ ] Bond Community Health Center, N. Florida Medical Center, or Carepoint Health and Wellness Center (6)
- [ ] Tallahassee Community College Dental Clinic (7)
- [ ] Other, please specify: (8) _____

Q14.9

How long has it been since your child(ren) last visited a dentist or dental clinic for any reason? Please include dental specialists, such as orthodontists.

- [ ] Within the past 12 months (1)
- [ ] More than one year but no more than two years (2)
- [ ] More than two years (3)

Q14.10

Does your child use mental health (counseling) services?

- [ ] Yes (1)
- [ ] No (2) Please skip to q14.13 on page 32

Q14.11

Where do they go for these services? **Check all that apply.**

- [ ] Doctor or counselor's office (1)
- [ ] Apalachee Center (2)
- [ ] DISC Village Behavioral Health (3)
- [ ] Emergency Room (4)
- [ ] HCA Florida Capital Behavioral Health Center (5)
- [ ] Tallahassee Memorial Behavioral Health Center (6)

- [ ] Telehealth or virtual care (7)
- [ ] Urgent Care / Walk-in Clinic (8)
- [ ] Other, please specify (9): _____

Q14.12

Has your child(ren) had a mental health visit within the last 12 months?

- [ ] Yes (1)
- [ ] No (2)

Q14.13

Have you had difficulty getting any of the following care or services for your child? **Check all that apply.**

- [ ] **I'm able to get all of the care my child needs (1)**
- [ ] **Dental care (2)**
- [ ] **Emergency or urgent care (3)**
- [ ] **Family planning / birth control (4)**
- [ ] **Inpatient hospital care (5)**
- [ ] **Immunizations / vaccinations / shots (6)**
- [ ] **Lab work (7)**
- [ ] **Medication / medical supplies (8)**
- [ ] **Mental health care / counseling (9)**
- [ ] **Physical therapy / Occupational therapy / Speech therapy (10)**
- [ ] **Pediatrician (11)**
- [ ] **Preventive care (yearly checkups) (12)**
- [ ] **School physicals (13)**
- [ ] **Specialty medical care for children**
  For example, pediatric cardiology; pediatric oncology (14)
- [ ] **Vision care (15)**
- [ ] **X-rays or MRI (16)**
- [ ] **Other, please specify: (17)**

Q14.14

Has your child(ren) been to the emergency room within the last 12 months for an illness?

- [ ] Yes (1)
- [ ] No (2)

Q14.15

Has your child(ren) have been to the emergency room within the last 12 months for an accident or injury?

- Yes (1)
- No (2)

Q14.16

Has your child(ren) had an eye exam within the last 12 months?

- Yes (1)
- No (2)

Q14.17

Are you able to afford the medications and services needed for any health conditions your child has?

- Yes (1)
- No (2)

Q14.18

Does your child or children get at least 60 minutes of daily physical activity, such as biking, running, swimming, or sports practice?

- Yes (1)
- No (2)

Q15.1

Is there anything else you would like to share about health and wellbeing in our community?

Thank you for participating in the TMH

2025 Community Health Needs Assessment Survey!

Your participation is helping us advance health and improve lives in our community.



TALLAHASSEE
MEMORIAL
HEALTHCARE

1300 Miccosukee Road
Tallahassee, FL 32308

850-431-1155 • TMH.ORG

Community Health Needs Assessment

Implementation Strategy Report

2026-2028









TALLAHASSEE MEMORIAL HEALTHCARE

TALLAHASSEE MEMORIAL HEALTHCARE

2026

Tallahassee Memorial HealthCare

Implementation Strategy Report

Approved by Tallahassee Memorial HealthCare

Board of Directors

February 11, 2026

Questions, comments and collaborative interests may be directed to Dawn Springs, Community Health Manager, at Dawn.Springs@TMH.ORG 850-431-4018.

TABLE OF CONTENTS

INTRODUCTION 4
COMMUNITY SERVED 5
COMMUNITY HEALTH IMPROVEMENT PROCESS 6
Community Health Needs Assessment 6
Significant Health Needs of the Community 6
Significant Health Needs to be Addressed 10
Implementation Strategy Development 11
FISCAL YEARS 2026 – 2028 CHNA IMPLEMENTATION STRATEGY 12
Priority Area: Chronic Diseases and Conditions 13
Priority Area: Mental Well-Being and Substance Abuse Prevention 15
Priority Area: Social and Economic Factors Contributing to Health 18
Priority Area: Alzheimer's Disease and Related Dementias 20
Priority Area: Maternal and Child Health 22
Priority Area: Injury, Safety and Violence 24
Priority Area: Transmissible and Emerging Diseases 25
COMMUNITY BENEFIT PROGRAMS DESCRIPTION 26
Southside Farmers Market and Fresh Fruit and Vegetable Rx Program 27
Happy Hydrators 27
TMH Health and Wellness at Community Events 28
Worksite Wellness 28
IMPLEMENTATION AND MEASUREMENT 29
RESOURCES 29
PRIORITY AREAS NOT BEING ADDRESSED 29

INTRODUCTION



Tallahassee Memorial HealthCare (TMH) is a private, not-for-profit community healthcare system committed to transforming care, advancing health and improving lives with an ultimate vision to be known as the most engaged and supportive organization in America. TMH is comprised of a 772-bed acute care hospital, a surgery and adult ICU center, a psychiatric hospital, multiple specialty care centers, four physician residency programs and 50 affiliated physician practices. TMH has established partnerships with Alliant Management Services, Apalachee Center, Calhoun Liberty Hospital, Capital Health Plan, Doctors' Memorial Hospital, Florida State University, Big Bend Hospice and Radiology Associates. TMH is a key anchor institution focusing on improving the health of the communities we serve. With ongoing dedication to the health of our region, we advance care through clinical services, medical education, research and community health investments. The purpose of this implementation strategy is to describe what TMH plans to do to address the community health needs identified in the Community Health Needs Assessment (CHNA), published September 30, 2025. It is our intention to work and collaborate with stakeholders and partners in our service area to address as many of the health improvement priority area needs identified as possible with the greatest community impact.

COMMUNITY SERVED

TMH's primary service area, comprised of Gadsden, Jefferson, Leon and Wakulla counties, has a total population greater than 397,000, according to the most recent American Community Survey by the United States Census Bureau. Seventy-six percent of the population lives in Leon County, with Gadsden, Wakulla and Jefferson counties comprising 11%, 9% and 4%, respectively. The four counties differ greatly in age, race, socioeconomic status and health outcomes of residents. Please visit TMH.ORG/CHNA to view the demographic data in the full CHNA report.

TMH is based in Tallahassee, the core city in the Tallahassee Metropolitan Statistical Area (MSA), which comprises the four counties that make up TMH's primary service area. The Tallahassee MSA is in Florida's Big Bend region, and stretches across northern Florida from the St. John's River westward to the Apalachicola National Forest, encompassing St. Marks National Wildlife Refuge and the Apalachicola National Forest. Leon County is bordered to the south by Wakulla County and to the east by Jefferson County. Gadsden County lies to the west and, like both Leon and Jefferson counties, is bordered to the north by southwest Georgia.

TMH determined the definition and scope of the community served by assessing the geographic area representing approximately 80% of its inpatient discharges and ambulatory surgery services. For this CHNA, the defined service area includes: Gadsden, Jefferson, Leon and Wakulla counties. These counties comprised 78% of TMH's annual patient volume from fiscal years 2022 to 2024, with Leon County alone accounting for 56% of patient volume. (Data Source: Florida Agency for Health Care Administration, Hospital Inpatient and Ambulatory Surgery datasets)

The target populations for TMH's CHNA project consist of the following groups: low-income individuals, uninsured and under-insured individuals, populations with barriers to accessing healthcare and other necessary resources, populations living with chronic diseases and minority groups facing significant health disparities. Partners and stakeholders were engaged to assist in reaching these target populations because barriers, such as transportation, language, literacy, health and financial situation, may limit participation.

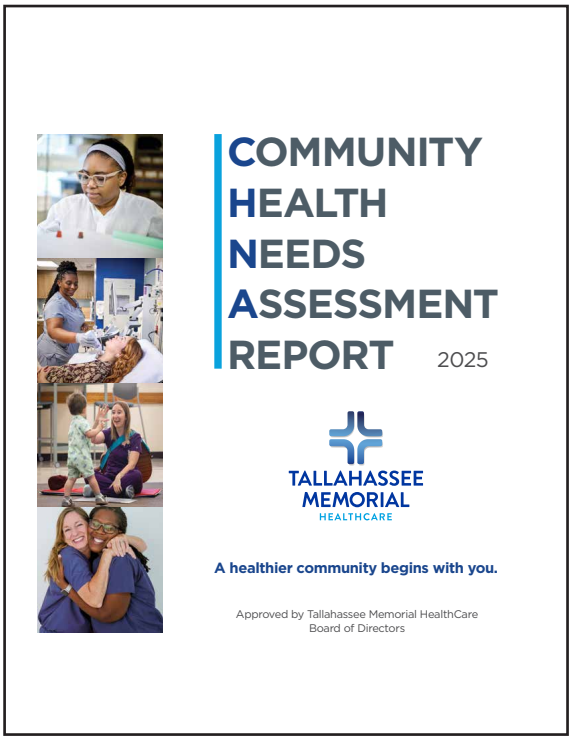
Characteristics of the Tallahassee MSA and its Component Counties				
	Total Area (square miles)	**Land area (square miles)**	**Estimated population, 2024**	**Density (population per square mile)**
Leon	702	667	300,488	450.5
Gadsden	529	516	44,151	83.5
Jefferson	637	598	15,921	25.0
Wakulla	736	606	37,115	50.4
MSA total	**2,604**	**2,387**	**397,675**	**166.6**

Characteristics of the Tallahassee MSA and its Component Counties. Sources: Geographic information from https://www.census.gov/quickfacts/; population estimates from Metropolitan and Micropolitan Statistical Areas Population Totals: 2020-2024, www.census.gov/data/tables/time-series/demo/popest/2020s-total-metro-and-micro-statistical-areas.html. Accessed June 2, 2025.

Percentage of Distribution of the Population by Race and Hispanic Origin, 2023					
	Gadsden	**Jefferson**	**Leon**	**Wakulla**	**Tallahassee MSA**
Not Hispanic:	88.1	95.2	92.1	95.3	91.8
White alone	31.5	60.1	53.9	76.9	52.6
Black alone	54.6	30.0	30.4	13.9	31.6
Asian alone	0.1	0.7	3.4	0.5	2.9
Alaskan Native or Native American alone	0.1	0.2	0.1	0.2	0.0
Hawaiian / Pacific Islander alone	0.0	0.0	0.0	0.0	0.0
Other race	0.1	0.5	0.5	0.7	0.6
Two or more races	1.7	3.8	3.8	3.2	4.1
Hispanic, any race	11.9	4.8	7.9	4.7	8.2

Percentage of Distribution of the Population by Race and Hispanic Origin, 2023
Source: 2019-2023 American Community Survey, accessed at https://data.census.gov, February 3, 2025.

COMMUNITY HEALTH IMPROVEMENT PROCESS



Community Health Needs Assessment

TMH's CHNAs are community-driven projects. The success of the CHNAs is highly dependent on the involvement of citizens, health and human service agencies, businesses and community leaders. The TMH CHNA Advisory Committee directed the planning and execution of the CHNA process and activities. The assessment included primary and secondary data collection, community stakeholder meetings focused on the seven Florida State Health Improvement Plan (SHIP) priority areas, analysis and prioritization of significant health needs.

Community partner and stakeholder collaborations were essential in distributing and collecting community health surveys and soliciting valuable input through the SHIP priority area meetings. The partners and stakeholders consisted of health and human service agency leaders, persons with special knowledge of or expertise in public health, local health departments and leaders/representatives of those who are medically underserved, people with chronic diseases, and low-income and minority populations. The CHNA Advisory Committee invited partners and stakeholders to attend the CHNA Community Health Partners Meeting in January 2025, the SHIP Priority Area Meetings in February 2025, and the Preliminary Data/Prioritization of Needs meeting in May 2025.

The TMH Board of Directors approved the 2025 CHNA on September 10, 2025.
Please visit TMH.ORG/CHNA to view the final report.

SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY

Compared to the 2022 CHNA report, the 2025 CHNA continued to reveal notable disparities in health outcomes across the service area, influenced by county, neighborhood, age and race/ethnicity. Poverty and lower educational attainment were most pronounced in Gadsden and Jefferson counties, compared to Leon and Wakulla counties and statewide averages. Among the four counties, life expectancy was lowest in Gadsden County.

The seven Florida SHIP priority areas that are illustrated below provided the organizing structure for assessing health needs in the CHNA process. Significant needs in these areas reported in the 2025 CHNA are summarized below.



CHRONIC DISEASES AND CONDITIONS



MENTAL WELL-BEING AND SUBSTANCE ABUSE PREVENTION



SOCIAL AND ECONOMIC FACTORS CONTRIBUTING TO HEALTH



ALZHEIMER'S DISEASE AND RELATED DEMENTIAS



MATERNAL AND CHILD HEALTH



INJURY, SAFETY AND VIOLENCE



TRANSMISSIBLE AND EMERGING DISEASES

SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY



Chronic Diseases and Conditions

Heart disease remained the leading cause of death in all counties except Wakulla County, where cancer has overtaken heart disease as the leading cause of death. Deaths due to conditions such as cancer, hypertension, chronic lower respiratory disease and diabetes, in all counties of the service area exceeded the state of Florida death rates as well.

According to the CHNA survey, most adults reported being current on recommended preventive screenings, such as breast, colon and cervical cancer screenings. However, percentages varied by racial identity, especially for cervical cancer screenings. Additionally, more than half of the respondents in each of the counties reported they were unable to get the medical care and services they needed. The most frequently noted barriers were wait-time for appointments, cost, and difficulty finding a provider. More than 40% of respondents noted they have difficulty finding "doctors who specialize in the kinds of care my family and I need." From a health-enhancing behavior perspective, less than 10% of respondents reported consuming the recommended amount of five or more servings of fruits or vegetables daily in an average week and about half engage in activities that lead to an increase in breathing/heart rate most days of the week.



Mental Well-Being and Substance Abuse Prevention

More than 22% of adult CHNA respondents reported using mental or behavioral health services, which is double what was reported from the 2022 survey. For respondents with children, nearly 16% reported using mental health services for their child, but 32% said mental healthcare was hard to get for their children. In Leon County, more respondents from the 32304-zip code (29%) reported using mental health services compared to other Leon County respondents and those from other counties. Unfortunately, mental health concerns continue to rise in need, with hospitalizations for mental disorders increasing in all service area counties, despite flat or improving state levels. Suicide death rates in Wakulla County in particular have been on the increase and are well above the state average.



Social and Economic Factors Contributing to Health

From an economic standpoint, Leon, Jefferson and Gadsden counties all exceeded Florida's unemployment rate and percentage of individuals living below the poverty level. Gadsden County also had a higher rate of uninsured individuals. Gadsden and Wakulla counties are designated as medically underserved areas (MUAs), and the low-income populations of Jefferson and Leon counties are designated as medically underserved populations (MUPs). Despite the academic nature of the service area, Gadsden, Jefferson, and Wakulla counties are all designated as Geographic Health Professional Shortage Areas (HPSAs) with too few primary care physicians, dentists, dental hygienists and mental health professionals.

SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY

About 22% of CHNA survey respondents identified basic needs they were unable to get in the past 12 months. “Medicine or healthcare” was the most common unmet need in Leon, Jefferson, and Wakulla counties. However, in Gadsden County, “groceries” and “transportation” topped the list.

Food insecurity was more common than housing insecurity among CHNA survey respondents. Over 13% of respondents reported that, over the past year, they sometimes worried that their food would run out before they had money to buy more, and another 2% said this was often the case. These numbers were higher in Gadsden, Jefferson, and Wakulla counties than Leon County and were also higher among Black respondents than White respondents.



Alzheimer’s Disease and Related Dementias

Alzheimer’s disease was one of the top three areas of need as reported by survey respondents in Wakulla and Jefferson counties. Wakulla County had the highest rates of death due to Alzheimer’s disease among the four counties surveyed. However, all counties exceeded the state average death rate for organic dementia, with Wakulla County among the highest. Emergency department visits for Alzheimer’s disease were highest in Leon and Wakulla counties, while all counties had rates of Emergency department visits for organic dementia exceeding the state rate. Community stakeholder survey feedback noted a need for “providers with knowledge of dementia and aging and respite care.”



Maternal and Child Health

While the percentage of women receiving adequate prenatal care was above the state average, the incidence of babies born with a low birthweight is above the state average in all but Wakulla County. Infant death rates continue to be above the state average as well as fetal deaths (stillbirth) in most counties. Maternal deaths continue to be a significant concern as well.

Of the 7% of survey respondents who were currently or recently pregnant, cost constraints about paying for the birth, prenatal care, and baby supplies were top concerns. The top concerns for parents of children were obtaining specialty medical care, dental care, and mental healthcare/counseling.

SIGNIFICANT HEALTH NEEDS OF THE COMMUNITY



Injury, Safety and Violence

The CHNA report shared data about the rates of injury and crime in our service area. While rates of unintentional falls were below the state average for all counties, rates of child abuse and violent crime were above for most areas. Deaths due to homicide were above the state average for Leon and Gadsden counties, and Gadsden County saw a significantly higher rate of deaths due to firearm discharges and motor vehicle crashes.

Overall, CHNA survey respondents had nearly double the rate of emergency department visits for injuries and illnesses than in 2022 but varied by county. When asked about emergency or urgent care services that were hard to get, Jefferson and Wakulla counties' residents reported the most needs.



Transmissible and Emerging Diseases

Most counties in the service area continue to see rates of death higher than the state average for pneumonia and influenza. Rates of sexually transmitted diseases are also significantly above the state average for the four-county service area. HIV diagnoses are higher for Gadsden and Leon counties and below the state average in Jefferson and Wakulla counties. Available vaccination rates for students in kindergarten show higher rates of vaccinations in Leon and Jefferson counties, but declining rates in Gadsden and Wakulla counties.

Overall, partners and stakeholders cited high costs of medical services or prescriptions, lack of or insufficient health insurance, transportation, limited health literacy, and inadequate support as the top five major barriers to the populations they serve. The Community Stakeholder Survey also indicated that a significant portion of the populations served experience discrimination based on social class and, to a lesser degree, racism and ageism, resulting in negative impacts on health outcomes.

To prioritize change, partners and stakeholders indicated strategies to address access and affordability of care, care coordination and communication, and educational strategies to better meet the needs of the populations they serve. Funding and systemic challenges were the top perceived barriers to implementing these strategies.

Significant Health Needs to be Addressed

On May 16, 2025, the CHNA Advisory Committee, CHNA support team, and community partners and stakeholders participated in a hybrid meeting to identify the greatest needs in the service area based on the preliminary primary and secondary data presented in addition to key takeaways from the Florida SHIP priority area meetings. Attendees agreed that the themes of "Access, Care Coordination and Communication, and Education" were common among the data presented and suggested additional stakeholder meetings to further review finalized data and jointly develop actionable strategies in the areas of need. After further discussion with the CHNA Advisory Committee during the summer, the Committee opted to move ahead with evaluating resources and developing implementation strategies for all seven Florida SHIP priority areas, with the “top three” areas prioritized for the initial stakeholder meetings in each county.

The areas identified by community survey respondents and stakeholders as priorities are indicated with an asterisk below:

1. *Chronic Diseases and Conditions (all counties)
2. *Mental Well-Being and Substance Abuse Prevention (all counties)
3. *Social and Economic Factors Contributing to Health (Leon and Gadsden counties)
4. *Alzheimer’s Disease and Related Dementias (Wakulla and Jefferson counties)
5. Maternal and Child Health
6. Injury, Safety, and Violence
7. Transmissible and Emerging Diseases



Implementation Strategy Development

The TMH CHNA Implementation Strategy Steering Committee, along with committee members from the designated priority areas, developed this Implementation Strategy based on a full review of the CHNA data, significant health needs to be addressed, existing programs and services, and gaps in care/services. The following team members participated in the Implementation Strategy development:

Steering Committee

- Dawn Springs, Manager, Community Health
- Kristen Booker, Director, Regional Development, Population Health, and Telehealth
- Sarah Cannon, Director, Marketing and Communications

TMH Priority Area Internal Leaders

1. Chronic Diseases and Conditions

- Maria Andrews, MD, Program Director, FSU Family Residency Program at TMH
- Alanda Beal, Quality Improvement Coordinator, TMH Physician Partners
- Amy Kessler, Quality Manager, TMH Physician Partners

2. Mental Well-Being and Substance Abuse Prevention

- Heather Lincicome, Vice President, TMH Behavioral Health Center Operations
- Angela Lee, Director, Live Oak Behavioral Health Outpatient Center

3. Social and Economic Factors Contributing to Health

- Maria Andrews, MD, Program Director, FSU Family Medicine Residency Program at TMH
- Wes Payne, Social Worker, TMH Transitions of Care Center

4. Alzheimer's Disease and Related Dementias

- Whitney Scott, TMH Memory Disorder Clinic Coordinator

5. Maternal and Child Health

- Kim Outlaw, Service Line Administrator, Women's and Children's Services
- Sherry Kendrick, Manager, Outpatient Education & Community Outreach

6. Injury, Safety and Violence

- Justin Kennett, Manager, TMH Trauma Program

7. Transmissible and Emerging Diseases

- Maria Andrews, MD, Program Director, FSU Family Medicine Residency Program at TMH

Fiscal Years 2026 – 2028 CHNA Implementation Strategy





Priority Area: Chronic Diseases and Conditions

2026-2028 Long-Term Goals:

1. Increase access to healthcare for chronic diseases/conditions and prevention
2. Increase care coordination and communication around chronic diseases and conditions
3. Increase chronic disease/condition awareness and educational opportunities for providers, patients and the community

Actions	Initiatives	Dedicated Resources	Potential Partners or Collaborative Interests
Increase technology-facilitated healthcare and coordination	Telehealth initiatives with community partners	Telehealth/IT support - Tools, technology and physical materials	Academic Health Partners - Regional hospital and clinic partners
	Epic electronic health record referral integration with community resources	Telehealth/IT support Case management and Transitions of Care Center support	Social service and community organizations - Big Bend 211
	Expand chronic care navigation initiatives (congestive heart failure, diabetes)	Clinical and IT resources Transitions of Care Center TMH Congestive Heart Failure Clinic	Community/social service organizations providing services to those with chronic conditions

Actions	Initiatives	Dedicated Resources	Potential Partners or Collaborative Interests
Collaborate with community partners to offer specific health screenings and education in targeted communities and populations (focus on underserved and areas with disparities)	Heart and vascular screenings and education Stroke education Cancer screenings and education Diabetes screenings and education Respiratory screenings and education	Accredited TMH programs and services (Heart and Vascular, Cancer, Endocrinology, Respiratory) - Marketing and Communications	Academic Health Partners - Department of Health Big Bend Area Health Education Center (AHEC) American Heart Association Social Service and Community Organizations
Support healthcare professional training and continuing education	Residency training programs Grand Rounds and Clinical Symposiums	Residency programs - Medical, Nursing, Pharmacy, Nutrition, and other Allied Health Personnel	Academic Health Partners



Priority Area: Mental Well-Being and Substance Abuse Prevention

2026-2028 Long-Term Goals:

1. Increase access to mental well-being and substance abuse services
2. Increase care coordination and communication among mental health and substance abuse providers and services
3. Support awareness and understanding of mental well-being and substance abuse conditions, treatments, and resources

Actions	Initiatives	Dedicated Resources	Potential Partners or Collaborative Interests
Improve access to community-based, preventive emotional and social well-being services	Continued collaboration with community and rural health partners to provide outpatient mental health services in areas with access barriers Growth of Intensive Outpatient Program, providing treatment for co-occurring mental health and substance use disorders Growth of Partial Hospitalization Program, providing intensive treatment for co-occurring mental health and substance use disorders Growth of individual child and adult psychotherapy and medication management services (virtual and in-person) to include Panama City Expand Florida Assertive Community Treatment (FACT) Team into Gadsden and Wakulla counties	TMH Behavioral Health Center	Apalachee Center Doctor's Memorial Hospital Calhoun-Liberty County Hospital Madison County Memorial Weems Memorial Bethel Missionary Baptist Church Academic Health Partners

Actions	Initiatives	Dedicated Resources	Potential Partners or Collaborative Interests
Improve access to community-based, preventive emotional and social well-being services (cont.)	Expand referrals to NAVIGATE program Expand Bradley Remote E-Therapy for Children and Adolescents (REACH) at Apalachee Center's virtual partial hospitalization program (PHP) and intensive outpatient program (IOP) to include in-person services Creation of emergency department (ED) psychiatry "pod" for those in mental health crisis and social worker support in ED		
Improve community members' knowledge and skills to assist individuals in crisis and connect to mental well-being services	Collaborate with organizations and other community groups to offer Mental Health First Aid (adult/adolescent) for all surrounding counties	TMH Behavioral Health Center	Apalachee Center Academic Health Partners
Participate in Mental Health Council (MHC) of the Big Bend and outreach-educational initiatives	The aim of the MHC is to foster an evidence-based approach to determine needs and solutions to mental health and substance abuse and to provide a think tank for stakeholders in this region	TMH Behavioral Health Center	Apalachee Center Members of the Mental Health Council of the Big Bend
Community and stakeholder awareness and education on how to access Behavioral Health Center resources	Organize and execute education for stakeholders on how to access resources provided through the Behavioral Health Center	TMH Employee Assistance Programs (EAP) as part of the TMH Behavioral Health Center TMH Marketing	TMH EAP as part of the TMH Behavioral Health Center TMH Marketing

Actions	Initiatives	Dedicated Resources	Potential Partners or Collaborative Interests
Increase numbers of providers for mental health and substance abuse services	Collaborate with community partners to continue to grow psychiatry residency program Continued expansion of services for special populations (e.g., maternal) and geographies (e.g., Bay County) Expansion of Critical Incident Stress Management (CISM) program in communities Collaborate with Community Partners for Opioid overdose access Pilot substance use disorder clinic at TMH Transitions of Care Center	TMH Behavioral Health Center Family Medicine Residency Program TMH EAP	Apalachee Center, TMH, and Academic Health Partners Local government health programs Apalachee Center Disc Village



Priority Area: Social and Economic Factors Contributing to Health

2026-2028 Long-Term Goals:

1. Invest in and support professional healthcare training programs
2. Increase care coordination and communication of assessed needs through Electronic Health Record-embedded community resource referrals
3. Increase internal and external community awareness and education of social and economic factors impacting health

Actions	Initiatives	Dedicated Resources	Potential Partners or Collaborative Interests
Collaborate with community partners to train future healthcare professionals	Family Medicine Residency Program (FMRP) Street Medicine Grant program Psychiatry Residency Program Nursing Training Programs College of Medicine Training Program Pharmacy Training Program Physician AssistantTraining Program	Telehealth/IT support - Tools, technology and physical materials TMH Clinical Preceptors	Local and regional health partners Academic Health Partners

Actions	Initiatives	Dedicated Resources	Potential Partners or Collaborative Interests
Screen for social drivers of health and connect with community resources	Epic Electronic Health Record - Social Determinants of Health - Screening education and referral integration with community resources Screen for Primary Care Physician (PCP) status in Emergency Department and then educate and connect to community resource for needed PCP FMRP pilot of Emergency Department utilizers and follow-up needs Education of residency programs on community resources and Transitions of Care Center Food insecurity initiative with community partners and education/distribution for colleagues	Telehealth/ IT support Case management and Transitions of Care Center support Human Resources FMRP	Telehealth/IT support Case management and Transitions of Care Center support Human Resources FMRP
Support community awareness and promotion of resources for social and economic factors contributing to health	Collaborate with community resources to promote councils, events, and awareness campaigns on social drivers of health Southside Farmers Market Fruit and Vegetable Access Program	TMH Marketing Transitions of Care Center	Social Services and Community Agencies Second Harvest Local Government



Priority Area: Alzheimer's Disease and Related Dementias

2026-2028 Long-Term Goals:

1. Increase access to evaluation and treatment services for Alzheimer's disease and related dementias
2. Increase collaborative efforts between hospitals, senior centers, and aging advocacy groups and coalitions
3. Increase public awareness and education on dementia awareness and resources for early intervention

Actions	Initiatives	Dedicated Resources	Potential Partners or Collaborative Interests
Expand dementia awareness and education efforts	Public awareness campaign focused on dementia education including early-detection and caregiver support.	TMH Memory Disorder Clinic Marketing and Communications	Academic Health Partners Dementia Care and Cure Initiative (DCCI) of the Big Bend Social Services and Community Agencies Departments of Health Department of Elder Affairs Senior Centers Law Enforcement
Provide Alzheimer's and dementia treatment education to health providers	Individual training Annual Symposium support and participation	TMH Memory Disorder Clinic	Academic Health Partners DCCI of the Big Bend Social Services and Community Agencies Department of Elder Affairs Departments of Health

Actions	Initiatives	Dedicated Resources	Potential Partners or Collaborative Interests
Expand mobile memory screening initiatives and cognitive assessments	Connect with community partners in rural, underserved areas to implement memory screenings and education/ training on early detection benefits and healthy aging	TMH Memory Disorder Clinic	Academic Health Partner Social Services and Community Agencies DCCI Rural Taskforce Department of Health Department of Elder Affairs Senior Centers
Explore piloting of community-based dementia navigators	Meet with local community leaders to discuss priority needs, priority areas of concern, staffing and the logistics of having dementia-based navigators tailored to specific parts of the community	TMH Memory Disorder Clinic Epic/IT resources	Academic Health Partners DCCI of the Big Bend Social Services and Community Agencies Department of Elder Affairs Department of Health Senior Centers



Priority Area: Maternal and Child Health

2026-2028 Long-Term Goals:

1. Increase access to prenatal care, pediatric, and pediatric specialty healthcare
2. Expand partnerships to connect women and children with community services and support
3. Increase educational efforts to promote and support healthy behaviors for women and children in communities

Actions	Initiatives	Dedicated Resources	Potential Partners or Collaborative Interests
Residency Obstetric (OB) services outreach	Development of OB Fellows in Residency program Support for current and future expansion of FMRP-OB services to other underserved locations	FMRP TMH Physician Partners - Maternal-Fetal Medicine and other practice locations	Academic health partners Department of health county locations
Expand access to pediatric specialties	Explore sub-contracting relationships for pediatric specialty services	TMH Women's and Children's Service Line TMH Physician Partners	Academic health partners
Increase access, connection and education for lactation support	Develop outpatient breastfeeding support program for Leon and surrounding counties La Belle Breastfeeding Boutique	TMH Women's and Children's Service Line IT/Telehealth support	Social service agencies and other community organizations Healthy Start Department of health county locations

Actions	Initiatives	Dedicated Resources	Potential Partners or Collaborative Interests
Collaborate with state Connect Partner and local resources to address the gap in connecting new and expectant mothers with community resources	Expand areas for Connect Partner and Healthy Start to place OB navigators within hospital Establish a plan to improve enrollment rate of patients who are identified as high risk to appropriate community resources such as the Supplemental Nutrition Assistance Program (SNAP), the Supplemental Nutrition Assistance Program for Women, Infants and Children (WIC), transportation services, etc.	TMH Women and Children's Services	Connect Partner Healthy Start
Community educational events to promote car seat and other safety educational initiatives	Safe Kids events Happy Hydrators Program Operation Prom Night	TMH Women's and Children's program TMH Emergency Services	Safe Kids program Wolfson's Children's Hospital Leon County Schools, Tallahassee Fire Department, FSU Police Department, Survival Flight, Leon County Emergency Services, Mothers Against Drunk Driving (MADD), Florida High



Priority Area: Injury, Safety, and Violence

2026-2028 Long-Term Goals:

1. Increase access to trauma support and care post-discharge
2. Expand safe kids programming and Operation Prom Night

Actions	Initiatives	Dedicated Resources	Potential Partners or Collaborative Interests
Trauma Recovery Program	Explore collaboration with TMH and community partners to develop a Trauma Recovery Program	TMH Trauma Program TMH Behavioral Health Center	Apalachee Center FSU/Academic Partners Local social services agencies and community organizations Local and state government
Community educational events to promote car seat and other public safety and educational initiatives	Safe Kids events Operation Prom Night	TMH Women's and Children's program TMH Emergency Services	Safe Kids program Wolfson's Children's Hospital Tallahassee Fire Department, FSU Police Department, Survival Flight, Leon County Emergency Services, Mothers Against Drunk Driving (MADD), Florida High, County school systems



Priority Area: Transmissible and Emerging Diseases

2026-2028 Long-Term Goals:

1. Increase access to screening and treatment for transmissible and emerging diseases
2. Collaborate with community partners in care coordination for transmissible and emerging disease
3. Target educational messaging with community partners for transmissible and emerging diseases

Actions	Initiatives	Dedicated Resources	Potential Partners or Collaborative Interests
Increase screening and treatment for syphilis, gonorrhea and chlamydia	Screening of pregnant mothers and high-risk individuals for syphilis, gonorrhea, and chlamydia	FMRP	Community and social service agencies TMH Physician Partners
Support HIV and Hepatitis C screenings, education and follow-up care	Screening of adult patients at FMRP for HIV and Hepatitis C Support education and care coordination for those with HIV	FMRP	Care Point Health & Wellness Center Community and social service agencies TMH Physician Partners
Flu and pneumonia vaccine education and outreach	Hospital staff training to support and increase the number of flu and pneumonia vaccines offered to patients	TMH Nursing staff and TMH Colleague Learning and Development	TMH Physician Partners

Community Partnerships



TMH has a deep appreciation for collaborative efforts and partnerships. Collaboration with stakeholders, partners and community members is essential in addressing the complex needs of the communities we serve. TMH continues to participate in and provide financial and in-kind support to many coalitions, non-profit organizations, local government and other entities that address health needs and social determinants of health in our region.

COMMUNITY BENEFIT PROGRAMS DESCRIPTION



Southside Farmers Market and Fresh Fruit and Vegetable Rx Program

The Southside Farmers Market and Fresh Fruit and Vegetable Rx (FFVRx) Program are two initiatives designed to improve access to local, affordable fresh fruits and vegetables and to increase consumption of these foods by Southside Tallahassee residents. Both initiatives began in May 2018 and are implemented in partnership with TMH, City of Tallahassee Neighborhood Affairs and other community partners. In addition to healthy foods, each market features entertainment, health education, cooking demonstrations and exhibitors offering education and resources.

The FFVRx Program expands the concept and provides educational and skill building experience for participants to manage behaviors affecting nutrition and health. Program participants learn how to select local produce and prepare these foods in a delicious and cost-effective way. Program participants receive vouchers to shop for produce at the Farmers Market.



Happy Hydrators

The Happy Hydrators Challenge was initially developed and implemented as part of the Leon County Health Department's Community Health Improvement Plan (CHIP), working collaboratively with Early Childhood Obesity Prevention Work Group (ECOP), Big Bend AHEC, Whole Child Leon, Department of Health in Leon County, FAMU Cooperative Extension and UF/IFAS Extension.
TMH has continued this effort as part of the 2023-2025 CHNA Implementation Strategy.

To promote a positive culture of health and inspire students to make healthy choices, the Happy Hydrators challenge has engaged over 900 students, teachers and staff since its inception in 2018. This educational campaign offers third graders from a Title 1 schools a fun and easy way to #swapwaterforsoda and #rethinkyourdrink. Students are taught the benefits and importance of drinking more water and have the opportunity to get creative and "bling" their "Happy Hydrator" water bottles.



Safe Kids Big Bend

Safe Kids Big Bend, founded in April 2018, and led by TMH, is part of an extensive network of more than 400 coalitions in the United States who work to reduce the number of unintentional injuries and death in children 0-19 years of age through community partnerships, advocacy, public awareness, distribution of safety equipment and education of its proper use.

The Safe Kids Big Bend coalition aims to work diligently to be a resource to communities and create a safe environment for children. With the expertise of individuals from various organizations, such as law enforcement, EMS, service groups, schools, childcare providers, parents and many others, the overall goal is to collectively carry out the Safe Kids mission by addressing safety at home, school, play and on the way.

In addition to various community outreach activities, Safe Kids Big Bend participates in annual programs dedicated to raising awareness on injury prevention.



TMH Health and Wellness at Community Events

TMH continues to offer health education at and to sponsor many community health and wellness events. The most common requests include: education on nutrition, smoking cessation, exercise, preventive health services, stroke and heart health.



Worksite Wellness

TMH supports worksite wellness initiatives through board participation in Working Well, Inc., a local, non-profit organization that helps organizations design and deliver worksite wellness programs, and by providing health screenings and other services to employer groups in the community. TMH sponsors the Working Well CEO Breakfast (CEOB) and the Corporate Cup Challenge each year.

The Working Well CEOB is an annual meeting that gathers community business and government leaders to learn about a topic relevant to the health and wellbeing of individuals and functional organizations. The Corporate Cup Challenge is a physical activity challenge that gathers teams of coworkers from different organizations to compete for awards and recognition.

IMPLEMENTATION AND MEASUREMENT

The CHNA Advisory Committee is responsible for oversight of TMH's Implementation Strategy execution, measurement and reporting. The Advisory Committee will meet regularly to review processes and progress toward goals.

TMH and its partners intend to review priority area data from the 2025 CHNA with community stakeholders in each of the four service area counties and collaboratively develop county-specific actions and initiatives around the "Access, Care Coordination and Communication, and Education" framework in Year 1. Program development, evaluation and sustainability plans will be developed throughout the Implementation Strategy period and annually updated and communicated to the community. TMH will also report Implementation Strategy progress on each annual Internal Revenue Service Form 990.

RESOURCES

TMH dedicates staff time and financial resources toward programming and services that are executed as part of this Implementation Strategy.

PRIORITY AREAS NOT BEING ADDRESSED

At the recommendation of the May Stakeholder meeting and the CHNA Advisory Board, all seven of the State Health Improvement Plan priority areas will be addressed during the Implementation Strategy timeframe (2026-2028), with the following areas to be prioritized initially:

- Chronic Diseases and Conditions
- Mental Well-Being and Substance Abuse Prevention
- Social and Economic Factors Contributing to Health
- Alzheimer's Disease and Related Dementias



TALLAHASSEE
MEMORIAL
HEALTHCARE

1300 Miccosukee Road
Tallahassee, FL 32308

850-431-1155 • TMH.ORG