Community Health Needs Assessment

Implementation Strategy Report

2026-2028

TALLAHASSEE MEMORIAL HEALTHCARE

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2026

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Approved by Tallahassee Memorial HealthCare

Board of Directors

February 11, 2026

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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.

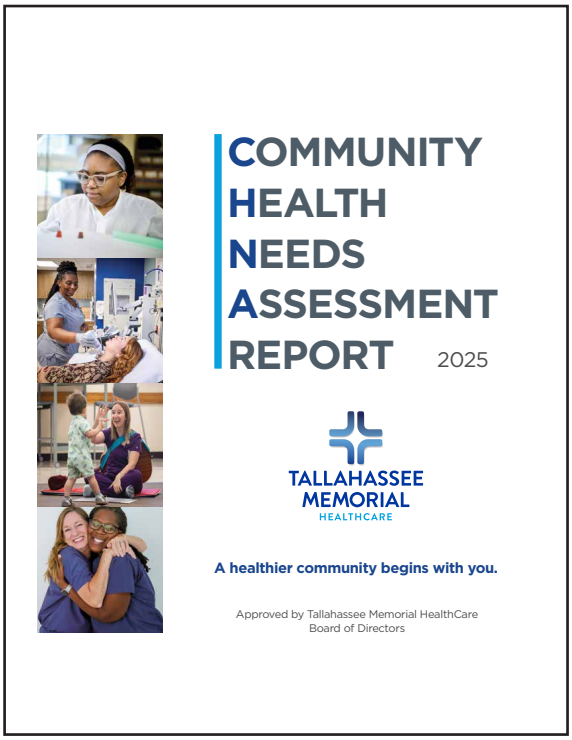
Characteristics of the Tallahassee MSA and its Component Counties				
	Total Area (square miles)	**Land area (square miles)**	**Estimated population, 2024**	**Density (population per square mile)**
Leon	702	667	300,488	450.5
Gadsden	529	516	44,151	83.5
Jefferson	637	598	15,921	25.0
Wakulla	736	606	37,115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

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