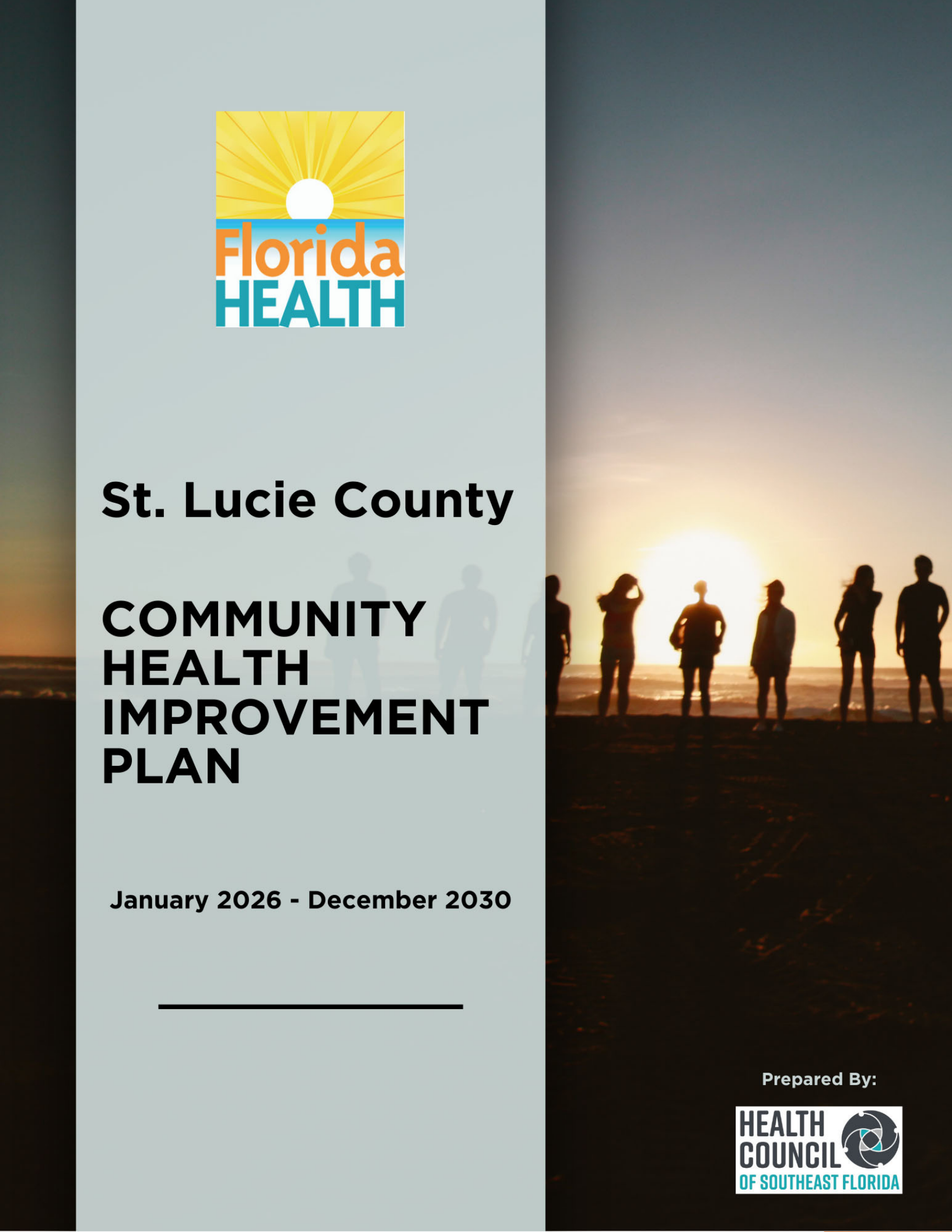


St. Lucie County

COMMUNITY HEALTH IMPROVEMENT PLAN

January 2026 - December 2030

Prepared By:

HEALTH COUNCIL OF SOUTHEAST FLORIDA

Table of Contents

Table of Figures ii
Table of Tables ii
Executive Summary iii
Acknowledgments iv
Introduction 1
Purpose 1
Methods 2
How to use the 2026-2030 St. Lucie County CHIP 2
MAPP 2.0 Process Overview 3
Phase 1: Build the Community Health Improvement Foundation 3
Collective Vision and Value Setting 3
Phase 2: Tell the Community Story 4
Phase 3: Continuously Improve the Community 5
Issue Prioritization 5
CHIP Development 5
Health Status Overview 7
Strategic Health Priorities and Action Plans 26
Overview of CHIP Priority Areas 27
Priority Area: Mental and Behavioral Health 28
Mental and Behavioral Health – Why Address It? 28
Mental and Behavioral Health – Priority Area Action Plan 30
Mental and Behavioral Health – Best Practices and Evidence-Supported Initiatives 33
Priority Area: Chronic Diseases and Conditions 34
Chronic Diseases and Conditions – Why Address It? 34
Chronic Diseases and Conditions – Priority Area Action Plan 36
Chronic Diseases and Conditions – Best Practices and Evidence-Supported Initiatives 39
Priority Area: Health Literacy 40
Health Literacy – Why Address It? 40
Health Literacy – Priority Area Action Plan 42
Health Literacy – Best Practices and Evidence-Supported Initiatives 44
Sustainability of Efforts 45
Tracking Progress 45
Get Involved 45

Table of Figures

Figure 1: MAPP 2.0 Phases Overview 1
Figure 2: CHIP Development Guiding Questions 6
Figure 3: Licensed Healthcare Facilities - Overall, St. Lucie County, As of February 2025 12
Figure 4: Percent Uninsured, Percent of Individuals per Census Tract, St. Lucie County, 2023 14
Figure 5: CCA Resident Group Discussion Highlights 15
Figure 6: CCA Key Informant Interview Highlights 16

Table of Tables

Table 1: CSA Demographic Highlights – Race, 2019-2023 7
Table 2: CSA Demographic Highlights – Ethnicity, 2019-2023 8
Table 3: CSA Demographic Highlights – Sex, 2019-2023 8
Table 4: CSA Demographic Highlights - Age, 2019-2023 8
Table 5: CSA Socioeconomic Data Highlights, 2023 9
Table 6: CSA Maternal and Child Health Data Highlights, 2023 9
Table 7: CSA Morbidity Data Highlights, 2023 10
Table 8: CSA Mortality Data Highlights, 2023 11
Table 9: CSA Mental and Behavioral Health Data Highlights, 2023 11
Table 10: CSA Hospital Utilization Data Highlights, 2023 12
Table 11: CSA Health Care Facility Capacity Data Highlights, 2023 13
Table 12: CSA Health Care Provider Supply Data Highlights, FY 2022-2023 13
Table 13: CSA Health Insurance Data Highlights, 2023 14
Table 14: Strategic Health Priorities & Action Plans Overview 26

Executive Summary

In 2025, the Florida Department of Health in St. Lucie County (DOH-SLC) engaged the Health Council of Southeast Florida (HCSEF) to facilitate a Community Health Assessment (CHA) and a Community Health Improvement Plan (CHIP) in St. Lucie County. HCSEF used, as a guide, the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework developed by the National Association of County and City Health Officials (NACCHO). The efforts were also informed by the Healthy St. Lucie Steering Committee, a multidisciplinary group of stakeholders representing various sectors and communities within St. Lucie County. Notably, through their involvement, the Healthy St. Lucie Steering Committee played a vital role in ensuring that the process identified, analyzed, and addressed key health needs of residents.

In the early stages of the CHA process, the Healthy St. Lucie Steering Committee met regularly to discuss emerging trends and key factors impacting the health of St. Lucie County residents, as well as opportunities to address gaps and improve health outcomes. The group reviewed both primary qualitative and secondary quantitative data to inform CHA efforts and discuss ultimate findings, which resulted in the identification of three strategic priority areas:

- **Chronic Diseases and Conditions**
- **Mental and Behavioral Health**
- **Health Literacy**

Once the group determined the priority areas of focus, HCSEF facilitated development of the CHIP, which is an actionable plan to bring improvement to the priority areas identified through the CHA process. Through a series of collaborative meetings, the Healthy St. Lucie Steering Committee established goals, objectives, strategies, as well as activities for each priority area. Important to note, the St. Lucie County CHIP seeks to effectively address the priority areas through systematically engaging partners and stakeholders whose influence, resources, and support can positively impact each priority and advance health improvement efforts across the county.

The Healthy St. Lucie Steering Committee will continue to meet regularly to monitor implementation efforts as outlined in the plan, evaluate progress, and refine the plan as appropriate to reflect the evolving needs of the community. Additionally, the group will maintain receptivity to new perspectives through expanded partnerships and an open invitation to the group's activities. This commitment is important as it will help to ensure that the CHIP remains reflective of the needs of the community.

The Healthy St. Lucie Steering Committee encourages all residents and stakeholders to explore this plan and consider how they may contribute to creating a healthier St. Lucie County.

Acknowledgments

This plan is dedicated to the residents of St. Lucie County.

"Unity is strength... when there is teamwork and collaboration, wonderful things can be achieved."

-Mattie Stepanek

Many thanks are extended to the Healthy St. Lucie Steering Committee for their dedication throughout the CHA and CHIP development process. The group's collaborative engagement led to a comprehensive and actionable CHIP that will guide community health improvement efforts in St. Lucie County over the next several years.

Sincere appreciation is extended to the residents, community partners, and local organizations whose time, insight, and expertise guided the development of this Community Health Improvement Plan. Their collective efforts reflect a shared commitment to fostering a healthier and stronger St. Lucie County – rooted in a belief that lasting progress can be achieved when communities work together for the well-being of all.

Introduction

Purpose

The 2026-2030 St. Lucie County Community Health Improvement Plan (CHIP) serves as a shared roadmap for improving the health and well-being of residents in three key priority areas. Developed through collaboration among community partners, residents, and the Florida Department of Health in St. Lucie County (DOH–St. Lucie), the CHIP builds upon the findings from the Community Health Assessment (CHA) that was completed in June 2025. Guided by the findings of the CHA, this CHIP identifies priority areas that reflect opportunities for community health improvement, and it includes Action Plans that outline goals, objectives, strategies, and activities to guide collective action over the next five-year period. By aligning the work of local organizations, the CHIP aims to strengthen coordination, enhance existing initiatives, and support a healthier St. Lucie County.

Importantly, HCSEF collaborated with key staff at DOH-St. Lucie to adapt elements of the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework to meet local needs and priorities. This national framework was initially developed by the National Association of County and City Health Officials (NACCHO) and consists of three phases: Building the Foundation, Telling the Community Story, and Continually Improving the Community. The process is outlined in the figure below.

Figure 1: MAPP 2.0 Phases Overview

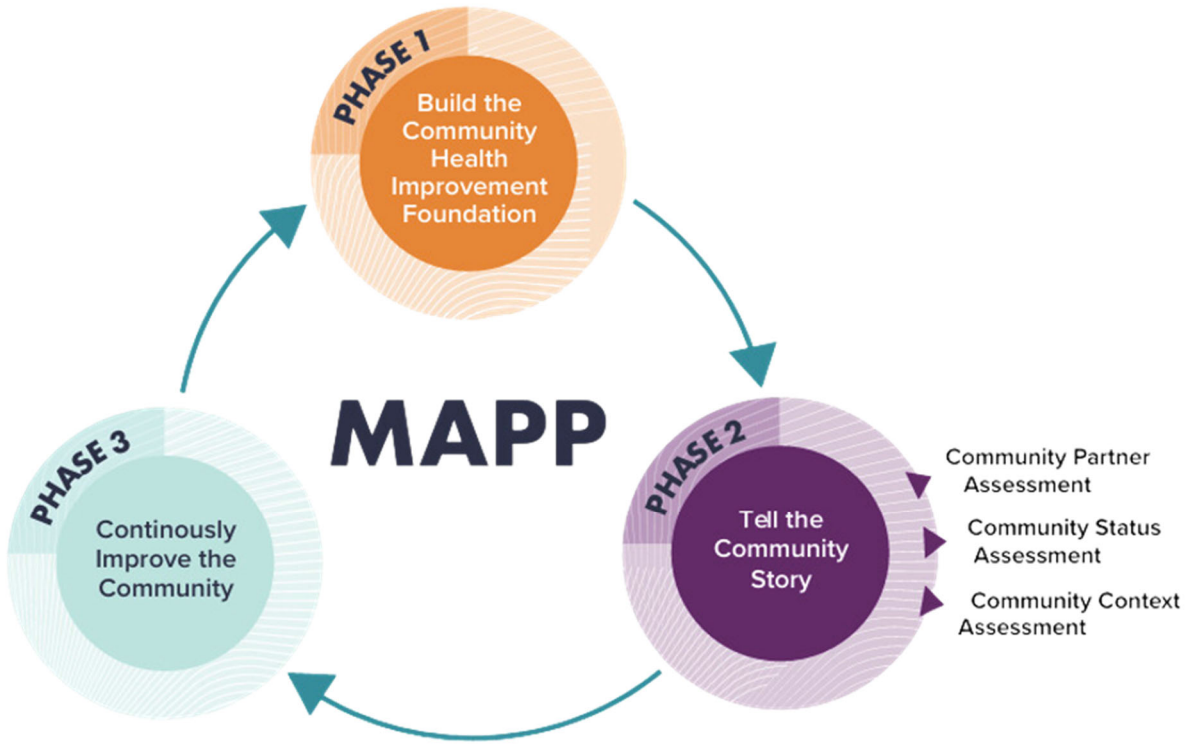


Image Source: NACCHO. (n.d.). Mobilizing for Action through Planning and Partnerships 2.0. Retrieved from https://www.naccho.org/resource-hub-articles/mapp-2-0.

Methods

Building on to the successes of MAPP 2.0 Phases 1 and 2, the Health Council of Southeast Florida (HCSEF) began Summer 2025, with facilitating Phase 3 of the process, which resulted in the development of the 2026–2030 St. Lucie County CHIP. Between September and November 2025, the Healthy St. Lucie Steering Committee participated in a series of meetings that included generative discussions to review key observations and findings from the CHA, identify the root causes of priority area topics, and develop a comprehensive action plan to guide and measure progress. Details of the complete CHA and CHIP processes are included in the MAPP 2.0 Process Overview section of this report.

Figure 2: CHIP Priority Areas

The Healthy St. Lucie Steering Committee, comprising representatives from public health, healthcare, education, social service, nonprofit organizations, and other sectors, contributed their expertise and perspectives to ensure that this CHIP reflects shared priorities and realistic solutions for St. Lucie County. Throughout the process, the Steering Committee considered alignment with other health improvement efforts such as Healthy People 2030, the Florida State Health Improvement Plan, and the National Action Plan to Improve Health Literacy, to ensure local alignment with national and state-level efforts.

How to use the 2026-2030 St. Lucie County CHIP

The 2026-2030 St. Lucie County CHIP is intended to be both a planning tool and a 'working document.' It provides a structure for tracking progress, coordinating community efforts, and promoting accountability among the stakeholders. Each priority area includes an Action Plan that outlines the goals, objectives, and organizations engaged in the implementation of activities. It is important to note that this Plan was developed by organizations and residents of the community, for the community. Community members, organizations, and agencies are encouraged to review the Plan, reflect on the content, and consider how they may participate to help improve the health of the St. Lucie County community. Below are a few suggestions for local stakeholders:

- Promote the CHIP efforts in the community.
- Support programs, policies, and initiatives that align with the CHIP priorities.
- Consider alignment between local programs and resources with shared community goals.
- Identify opportunities for partnership and continued collaboration.
- Monitor progress through shared indicators and performance measures.
- Leverage the CHA and CHIP to inform funding, policy, and strategic planning decisions.

The Healthy St. Lucie Steering Committee will review this plan and track progress on a regular basis. Formal updates to the plan will be conducted annually to report on progress and adjust strategies as needed, ensuring the continued relevance and impact for the residents of St. Lucie County.

MAPP 2.0 Process Overview

Phase 1: Build the Community Health Improvement Foundation

Phase 1 of the MAPP 2.0 process in St. Lucie County focused on establishing a strong base for collaboration and coordinated action. During this phase, the Health Council of Southeast Florida (HCSEF) worked closely with the Florida Department of Health in St. Lucie County (DOH–St. Lucie) to adapt elements of the Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 national framework to fit the local context and build a process that reflected the community's structure and needs.

HCSEF conducted a stakeholder analysis to identify key partners and worked with DOH-St. Lucie to engage partners in the Healthy St. Lucie Steering Committee, which served as the guiding body for the 2025 St. Lucie County Community Health Assessment (CHA) process. In January 2025, HCSEF hosted an orientation session to introduce the adapted MAPP 2.0 approach, establish a shared understanding of the CHA and CHIP process, and reflect on insights from the previous CHIP cycle. This provided an important opportunity for the Steering Committee to consider past successes and lessons learned and to understand and refine a framework to move forward. HCSEF shared preliminary county-level data, showcasing county demographics, health outcomes, and additional measures that impact quality of life. This gave the group important context and helped to frame data-driven discussions among the Healthy St. Lucie Steering Committee.

Collective Vision and Value Setting

In February 2025, HCSEF facilitated a visioning and value-setting session, during which the Healthy St. Lucie Steering Committee developed a unified community vision and guiding values that would shape the facilitation and development of the CHA and CHIP.

To develop their vision, the Steering Committee considered the following questions:

1. What does a healthy St. Lucie County mean to you?
2. What are important characteristics of a healthy community for all who work, learn, live, and play here?
3. What would be different in our community if all people had circumstances in which they could live healthy and flourishing lives?
4. How do you envision the local health system in the next 5 years?

From this reflection, the Steering Committee developed the following vision:

"A Healthy St. Lucie is one where all residents, from youth to seniors, feel heard, supported, and connected to resources and spaces that advance their well-being. In a Healthy St. Lucie, there are opportunities to enrich the lives of all residents through systems that are easy to navigate, led by a united front of stakeholders who focus on up-stream approaches."

Following the development of the vision, HCSEF facilitated a brainstorming session to develop shared values with the Healthy St. Lucie Steering Committee. The group was encouraged to consider values that would represent the core principles that should guide the development of the CHA and CHIP. The Steering Committee used small groups to identify two to three key values. Once the groups had an initial list, they discussed and reflected on each group's ideas and identified cross-cutting themes. Once all values were presented, each attendee received three stickers to vote for the values they felt were most important.

Through this collaborative process, the Steering Committee established the following values:

Phase 1

December 2024: A stakeholder analysis was conducted and the Healthy St. Lucie Steering Committee for the new CHA and CHIP cycle was established.

January 2025: The first St. Lucie County CHA meeting was held to review progress from the previous CHIP cycle and share preliminary secondary data findings from the CHA.

February 2025: The second St. Lucie County CHA meeting was held to develop a collective community vision and set of guiding values for the CHA and CHIP process.

Phase 2

February-April 2025: HCSEF conducted 10 resident group discussions with St. Lucie County residents and service recipients. Sessions were hosted in English, Spanish, and Haitian Creole at various locations throughout the county. HCSEF also conducted 10 Key Informant Interviews with community leaders.

April 2025: The third St. Lucie County CHA meeting was held to review primary and secondary data and discuss emerging themes. The Community Partner Assessment (CPA) was also analyzed, with input from 27 respondents.

Phase 3

May 2025: The final St. Lucie County CHA meeting was held to review CPA findings and conduct an issue prioritization exercise.

The final Priority Areas included:

- Chronic Diseases and Conditions
- Mental and Behavioral Health
- Health Literacy

- **No Resident Left Behind:** All community members are seen, heard, and helped through programs and services that strive to meet the needs of our community.
- **Collaboration:** Stakeholders from across sectors work together for the good of the community.
- **Empathy:** We work to operate out of empathy to understand the needs and wants of community members from their perspectives.
- **Integrity:** We act with strong moral principles to help all residents of the community achieve optimal health.
- **Connectors:** Service providers prioritize a "no wrong door" approach in which residents can be connected directly to the resources and services that they need in a timely and cohesive manner.

Together, these activities created the foundation for meaningful participation and sustained collaboration throughout the remaining MAPP 2.0 phases.

Phase 2: Tell the Community Story

Between December 2024 and May 2025, HCSEF collected and analyzed both quantitative and qualitative data to develop a comprehensive understanding of health in St. Lucie County. Quantitative data were compiled from sources such as FL Health CHARTS, the U.S. Census Bureau, the Florida Agency for Health Care Administration (AHCA), the Florida Department of Education (DOE), and several others. When possible and appropriate, data was disaggregated by factors such as age, sex, and geographic subdivisions. The most recent full-year datasets were prioritized across all indicators to present the most current picture of health in St. Lucie County.

HCSEF shared quantitative findings with the Healthy St. Lucie Steering Committee, whose members reviewed the data, validated key trends, and contributed additional insights based on their local experience and organizational perspectives. Their feedback informed the selection of additional indicators and prompted HCSEF to extract additional secondary data to provide a deeper context.

To complement the quantitative analysis, HCSEF hosted 10 resident group discussions on six dates during March and April 2025. During these sessions, HCSEF reached 86 residents in English, Spanish, and Haitian Creole. HCSEF also conducted ten key informant interviews with

local leaders. These qualitative Community Context Assessment (CCA) efforts captured community perspectives and provided insights into local strengths and existing community assets, barriers to health, and opportunities for improvement across St. Lucie County. HCSEF conducted an analysis of the CCA findings to identify recurring themes, which were shared with supporting data as a springboard for the Healthy St. Lucie Steering Committee to define local Priority Areas.

The third assessment in the MAPP 2.0 process was the Community Partner Assessment (CPA), which replaced the previous Local Public Health System Assessment (LPHSA). The CPA is provided as a means to assess capacity and collaboration among the partners involved in the CHA and CHIP process. All members of the Healthy St. Lucie Steering Committee were invited to complete the assessment, and a total of 27 representatives from various community organizations across St. Lucie County completed the survey. Altogether, these three assessments were designed to provide a comprehensive understanding of the health and well-being of residents in St. Lucie County, grounded in data, enriched by community voice, and guided by partner insight.

Phase 3: Continuously Improve the Community

Phase 3, Continuously Improve the Community is the final phase of the MAPP 2.0 framework, where data insights are translated into actionable planning through the development of a Community Health Improvement Plan (CHIP). Building upon the findings from Phases 1 and 2, this third phase focused on identifying priority issues and moving data to action through the coordination of resources to improve health and well-being across St. Lucie County.

Issue Prioritization

In May 2025, HCSEF presented triangulated findings from three assessments – the CPA, CCA, and CSA – to the Healthy St. Lucie Steering Committee, marking the transition from data collection to collaborative planning for action. Guided by NACCHO's prioritization criteria, the Healthy St. Lucie Steering Committee reviewed the triangulated findings, discussed additional factors and ideas, and worked together to ultimately identify potential areas of focus. Six initial topics emerged from this process, including mental and behavioral health, chronic disease, health literacy, access to care, maternal and child health, and economic stability.

To refine these ideas and ultimately establish the CHIP Priority Areas, HCSEF facilitated an interactive multi-voting exercise. Each of the Healthy St. Lucie Steering Committee members in attendance at the final meeting were given "CHA Bucks" to allocate across the six areas accordingly. This structured activity encouraged participants to weigh quantitative findings with lived experience, consider local capacity, and identify where efforts could have the greatest impact. Following thoughtful discussion and voting, the Healthy St. Lucie Steering Committee selected three health priorities to guide the 2026 – 2030 Community Health Improvement Plan:

- **Chronic Diseases and Conditions**
- **Mental and Behavioral Health**
- **Health Literacy**

HCSEF subsequently developed detailed issue profiles for each selected priority area, summarizing key data, contributing factors, and existing community assets. These profiles were included in the 2025 St. Lucie County Community Health Assessment (CHA) report, which was completed and published in July 2025.

CHIP Development

Between September and November 2025, the Healthy St. Lucie Steering Committee convened four times to engage in in-depth discussions on each identified priority area and collaboratively develop the 2026 – 2030 St. Lucie County CHIP. At the start of each session, HCSEF reviewed the Healthy St. Lucie shared vision and values to center the committee and guide decision-making throughout the process.

The Steering Committee examined each priority area individually, beginning with Mental and Behavioral Health, then Chronic Diseases and Conditions, and concluding with Health Literacy. For each priority area, HCSEF presented triangulated data findings from the CHA to establish a shared understanding and ensure data-informed discussions based on the CHA process. The Healthy St. Lucie Steering Committee then engaged in Root Cause Analysis for each priority area, using the "5 Why's" approach, which is a structured process for identifying key factors or "root causes" that contribute to community health challenges. This exercise required participants to repeatedly answer "why?" to move beyond surface-level causes and gain a deeper understanding of the factors influencing health outcomes.

The Root Cause Analysis helped guide the development of the subsequent Action Plan for each priority area. HCSEF facilitated a series of exercises and group discussions to help the Healthy St. Lucie Steering Committee develop their Action Plans. Guiding questions that framed these discussions are included in the figure below, and ultimately, each priority area's Action Plan consists of goals, strategies, SMART objectives, activities, and key action steps with major partners identified to spearhead the efforts. This structure will provide a means to track progress over the course of the five-year plan.

At each meeting, the Healthy St. Lucie Steering Committee was asked to reflect on the root cause analyses and preliminary CHIP Action Plan tables to ensure that the findings accurately reflected their discussions and ideas for action. This collaborative and continual review enabled the Steering Committee to provide additional insight and refine the proposed Action Plans throughout the CHIP development process. Additionally, in between meetings, HCSEF engaged additional stakeholders to gather relevant and informative input, with the goal to further strengthen the Action Plans. In November 2025, the Healthy St. Lucie Steering Committee convened for the final time to review and finalize any remaining elements of the CHIP Action Plan tables. This session also served as a reflective moment to confirm partner commitment for the next phase of CHIP implementation.

The community will implement the 2026 – 2030 St. Lucie County CHIP Action Plans beginning in January 2026. Once implementation begins, the Healthy St. Lucie Steering Committee will meet on a quarterly basis to monitor implementation activities, evaluate progress, and update the Action Plans as needed to reflect any new developments.

Figure 2: CHIP Development Guiding Questions

CHIP Development Guiding Questions

Developing CHIP Goals:

1. What do we care deeply about?
2. Where should we go from here?
3. What is our most compelling aspiration?
4. What strategic initiative would support our aspirations?

Developing CHIP Strategies:

1. What resources are available and is implementation of this strategy feasible?
2. What is the acceptability of the selected strategy to the priority population?
3. Are there effective strategies that have previously been used?
4. Will a simple strategy or multiple strategies be used?

Developing SMART Objectives:

1. How do we know we are succeeding?
2. What meaningful measures can we use?
3. What three to five indicators can we track for each priority area?

Health Status Overview

The Healthy St. Lucie Steering Committee consistently referenced findings from the 2025 Community Health Assessment (CHA) to guide the development of the 2026 – 2030 CHIP. The following section summarizes key findings from the 2025 St. Lucie County Community Health Assessment, which was developed based on three assessments:

1. **The Community Status Assessment (CSA):** Quantitative data was gathered from sources such as U.S. Census Bureau, Florida Health CHARTS, the Florida Department of Education, and other state and national datasets. This assessment provides valuable insight into the community's demographics, key health outcomes, and other factors that influence health.
2. **The Community Partner Assessment (CPA):** Anonymous surveys were conducted with partner organizations across St. Lucie County to gain insight into the local public health system. This assessment evaluated both the organizational capacity and readiness of individual partners, as well as their collective ability to work collaboratively in addressing the county's identified health issues.
3. **The Community Context Assessment (CCA):** Qualitative data from resident group discussions and key informant interviews were conducted to gain a deeper understanding of community members' lived experiences and perspectives. This assessment provided context and depth to the quantitative findings, ensuring that residents' voices were central to the overall assessment process.

While this section presents key highlights, additional indicators and supporting information for each component are available in the full 2025 St. Lucie County Community Health Assessment.

CHA Snapshot: Community Status Assessment Highlights

Demographic Data Highlights

Most recently, in 2023, 59.8% of St. Lucie County residents were White, 21.0% were Black or African American, and 2.0% were Asian.

Table 1: CSA Demographic Highlights – Race, 2019-2023

Race (%) *(CHA Pages 16-17)*	2019	2020	2021	2022	2023
White	73.1%	70.3%	66.5%	63.1%	59.8%
Black or African American	20.2%	20.3%	20.4%	20.4%	21.0%
American Indian and Alaska Native	0.4%	0.4%	0.3%	0.3%	0.3%
Asian	2.0%	2.0%	2.0%	2.0%	2.0%
Some other race	1.9%	2.5%	3.2%	4.3%	4.6%
Two or more races	2.4%	4.3%	7.6%	9.8%	12.4%

Source: U.S. Census Bureau, American Community Survey, DP05, 2019-2023

Between 2019 to 2023, proportion of residents who were Hispanic in St. Lucie County slightly increased from 19.0% (2019) to 21.1% (2023).

Table 2: CSA Demographic Highlights – Ethnicity, 2019-2023

Ethnicity (%) *(CHA Pages 18-20)*	2019	2020	2021	2022	2023
Hispanic	19.0%	19.3%	20.0%	20.6%	21.1%
Non-Hispanic	81.0%	80.7%	80.0%	79.4%	78.9%

Source: U.S. Census Bureau, American Community Survey, DP05, 2019-2023

From 2019- 2023, the proportion of male versus female residents stayed relatively consistent. Most recently, in 2023, 50.9% of the population was female while 49.1% of the population was male.

Table 3: CSA Demographic Highlights – Sex, 2019-2023

Sex *(CHA Page 12)*	2019	2020	2021	2022	2023
Male	48.8%	48.9%	49.1%	49.2%	49.1%
Female	51.2%	51.1%	50.9%	50.8%	50.9%

Source: U.S. Census Bureau, American Community Survey, DP05, 2019-2023

The age distribution in St. Lucie County shifted between 2019 to 2023, with declines observed among younger age groups and increases among middle aged and older adults, particularly those aged 60-64, 65-74, and 75-84 years. Overall, the population proportions have remained relatively stable over the five-year period.

Table 4: CSA Demographic Highlights - Age, 2019-2023

Age (%) *(CHA Page 13)*	2019	2023
< 5 years	5.2%	5.0%
5-9 years	5.2%	5.1%
10-14 years	6.1%	6.1%
15-19 years	5.6%	5.6%
20-24 years	5.3%	5.0%
25-34 years	11.3%	11.4%
35-44 years	11.1%	11.5%
45-54 years	12.5%	11.8%
55-59 years	7.3%	6.7%
60-64 years	6.6%	7.3%
65-74 years	13.0%	13.6%
75-84 years	8.0%	8.4%
85 years and over	2.8%	2.4%

Source: U.S. Census Bureau, American Community Survey, DP05, 2019, 2023

Socioeconomic Data Highlights

The following table summarizes three socioeconomic status indicators:

- **Poverty Status – Percent Below Poverty Level:** In 2023, 11.6% of St. Lucie County residents were living below poverty, which was lower than the statewide percentage of 12.6%.
- **Educational Attainment – High School Graduate or Higher:** In 2023, 30.7% of St. Lucie County residents were high school graduates or equivalent, compared to 27.4% across Florida.
- **Occupied Households with High Monthly Housing Costs:** In 2023, 34.1% of occupied households in St. Lucie County experienced high monthly housing costs, which was slightly below the state average of 35.7%. High monthly housing costs refer to households spending 30% or more of their income on housing-related expenses.

Table 5: CSA Socioeconomic Data Highlights, 2023

Select Socioeconomic Indicators, 2023 (%)	St. Lucie County	Florida
Poverty Status – Percent Below Poverty Level *(CHA Pages 39-43)*	11.6%	12.6%
Educational Attainment – High School Graduate or Equivalent *(CHA Pages 52-63)*	30.7%	27.4%
Occupied Households with High Monthly Housing Costs *(CHA Pages 69- 75)*	34.1%	35.7%

Source: U.S. Census Bureau, American Community Survey, S1701, 5-Year Estimate, 2023
Source: Florida Health CHARTS, United States Census Bureau, American Community Survey, S2503, 5-Year Estimates, 2023

Maternal and Child Health Highlights

The following table summarizes five key maternal and child health indicators:

- **Births to Mothers with Adequate Prenatal Care:** In 2023, 68.6% of births in St. Lucie County were to mothers who received adequate prenatal care, compared to the statewide percentage of 64.4%
- **Births to Overweight Mothers:** In 2023, 29.3% of mothers in St. Lucie County were classified as overweight at the time of birth, compared to 29.0% statewide.
- **Births to Obese Mothers:** In 2023, 35.0% of mothers were classified as obese at the time of birth, exceeding the statewide percentage of 30.0%.
- **Preterm births:** In 2023, the percentage of preterm births in St. Lucie County was 11.2%, slightly higher than Florida's percentage of 10.7%
- **Infant Mortality:** In 2023, the infant mortality rate in St. Lucie County was 5.1 deaths per 1,000 live births, lower than the statewide rate of 6.0.

Table 6: CSA Maternal and Child Health Data Highlights, 2023

Select Maternal and Child Health Indicators, 2023 (%)	St. Lucie County	Florida
Births to Mothers with Adequate Prenatal Care *(CHA Page 89)*	68.6%	64.4%
Births to Overweight Mothers *(CHA Page 92)*	29.3%	29.0%
Births to Obese Mothers *(CHA Page 93)*	35.0%	30.0%
Preterm Births *(CHA Page 99)*	11.2%	10.7%
Infant Mortality (Rate per 1,000 live births) *(CHA Page 103)*	5.1	6.0

Source: Florida Health CHARTS, Florida Department of Health, Bureau of Vital Statistics, 2023

Morbidity Data Highlights

The following table summarizes six key morbidity data:

- **Coronary Heart Disease Age-adjusted Hospitalizations:** In 2023, the age-adjusted hospitalization rate attributed to coronary heart disease in St. Lucie County was 287.0 per 100,000 population, compared to Florida's statewide rate of 245.7 per 100,000 population.
- **Congestive Heart Failure Age-adjusted Hospitalizations:** In 2023, the age-adjusted hospitalization rate due to congestive heart failure in St. Lucie County was 1,680.3 per 100,000 population, notably higher than Florida's statewide rate of 1,415.6 per 100,000 population.
- **Cancer Age-adjusted Incidence:** In 2021, the age-adjusted cancer incidence rate in St. Lucie County was 472.9 per 100,000 population, similar to Florida's rate of 471.0 per 100,000 population.
- **Stroke Age-adjusted Hospitalizations:** The age-adjusted hospitalization rate due to stroke in St. Lucie County was 293.6 per 100,000 in 2023, compared to the statewide rate of 241.5 per 100,000 population.
- **Diabetes Age-adjusted Hospitalizations:** In 2023, the age-adjusted hospitalization rate for diabetes in St. Lucie County was 2,682.2 per 100,000, compared to 2,264.9 per 100,000 population in Florida overall.
- **Preventable Hospitalizations:** In 2023, the rate of preventable hospitalizations was 1,155.8 per 100,000 in St. Lucie County, compared to 838.2 per 100,000 population in the state of Florida overall.

Table 7: CSA Morbidity Data Highlights, 2023

Select Morbidity Indicators, 2023 (Rate per 100,000 Population)	St. Lucie County	Florida
Coronary Heart Disease Age-adjusted Hospitalizations *(CHA Page 134)*	287.0	245.7
Congestive Heart Failure Age-adjusted Hospitalizations *(CHA Page 135)*	1,680.3	1,415.6
Cancer Age-adjusted Incidence (2021) *(CHA Pages 136-137)*	472.9	471.0
Stroke Age-adjusted Hospitalizations *(CHA Page 138)*	293.6	241.5
Diabetes Age-adjusted Hospitalizations *(CHA Pages 146-147)*	2,682.2	2,264.9
Preventable Hospitalizations *(CHA Page 160)*	1,155.8	838.2

Source: Florida Department of Health, Bureau of Communicable Diseases, 2023
Source: Florida Health CHARTS, Florida Agency for Health Care Administration (AHCA), 2023

Mortality Data Highlights

The following table summarizes mortality data for six key health indicators:

- **All Causes:** In 2023, the age-adjusted death rate for all causes in St. Lucie County was 698.3 per 100,000 population, higher than the statewide rate of 671.5 per 100,000 population.
- **Coronary Heart Disease:** In 2023, the age-adjusted death rate for coronary heart disease in St. Lucie County was 144.2 per 100,000 population, compared to 135.6 per 100,000 population statewide.
- **Cancer:** The age-adjusted cancer death rate in St. Lucie County was 135.3 per 100,000 population in 2023, compared to 133.4 per 100,000 population in the state of Florida overall.
- **Stroke:** In 2023, the age-adjusted death rate due to stroke in St. Lucie County was 65.3 per 100,000 population, notably higher than Florida's rate of 44.6 per 100,000 population.
- **Unintentional Injury:** In 2023, the age-adjusted death rate due to unintentional injury in St. Lucie County was 61.9 per 100,000 population, compared to 63.9 per 100,000 population in the state of Florida overall.
- **HIV/AIDS:** In 2023, the age-adjusted death rate due to HIV/AIDS in St. Lucie County was 2.6 per 100,000 population, compared to 2.1 per 100,000 population in the state of Florida overall.

Table 8: CSA Mortality Data Highlights, 2023

Select Age-Adjusted Deaths, 2023 (Rate per 100,000 Population)	St. Lucie County	Florida
All Causes *(CHA Pages 161)*	698.3	671.5
Coronary Heart Disease *(CHA Pages 162-163)*	144.2	135.6
Cancer *(CHA Pages 162-163)*	135.3	133.4
Stroke *(CHA Pages 162-163)*	65.3	44.6
Unintentional Injury *(CHA Pages 162-163; 166-169)*	61.9	63.9
HIV/AIDS *(CHA Page 170)*	2.6	2.1

Source: Florida Department of Health, Bureau of Vital Statistics, 2023

Mental and Behavioral Health Data Highlights

The following table summarizes three key mental and behavioral health indicators:

- **Age-adjusted Suicide Deaths:** In 2023, the age-adjusted suicide death rate was 13.1 per 100,000 population in St. Lucie County, compared to 14.1 per 100,000 population in the state of Florida.
- **Age-adjusted Opioid Overdose Deaths:** In 2022, the age-adjusted opioid overdose death rate in St. Lucie County was 20.5 per 100,000 population, compared to 29.0 per 100,000 population in the state of Florida.
- **Age-adjusted Unintentional Injury by Drug Poisoning:** In 2023, the age-adjusted death rate from unintentional injury by drug poisoning in St. Lucie County was 28.6 per 100,000 population, compared to 29.2 per 100,000 population in the state of Florida overall.

Table 9: CSA Mental and Behavioral Health Data Highlights, 2023

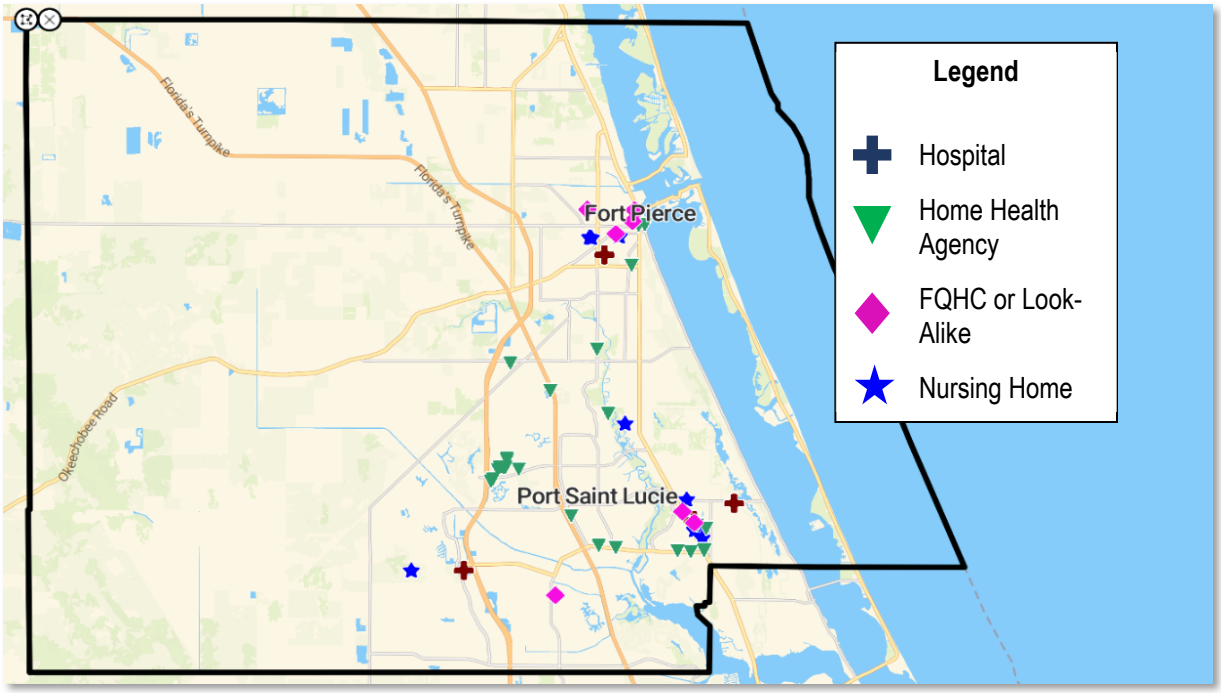
Select Mental and Behavioral Health Indicators, 2023 (Rate per 100,000 Population)	St. Lucie County	Florida
Age-adjusted Suicide Deaths *(CHA Pages 110-111)*	13.1	14.1
Age-adjusted Opioid Overdose Deaths (2022) *(CHA Pages 125-129)*	20.5	29.0
Age-adjusted Unintentional Injury by Drug Poisoning Deaths *(CHA Page 168)*	28.6	29.2

Source: Florida Department of Health, Division of Public Health Statistics and Performance Management, 2022
Source: Florida Health CHARTS, Florida Department of Health, Bureau of Vital Statistics, 2023

Health Resource Availability and Access

As of February 2025, St. Lucie County had four licensed hospitals, nine licensed nursing homes, 32 licensed home health agencies, and nine federally qualified health centers or look-alike facilities. These providers represent key components of the local healthcare infrastructure, spanning a continuum of care from inpatient to community-based services.

Figure 3: Licensed Healthcare Facilities - Overall, St. Lucie County, As of February 2025



Source: Florida Health Finder, Agency for Healthcare Administration (ACHA), 2025 and Health Resources and Services Administration (HRSA), 2025

Hospital Utilization Data Highlights

In 2023, "Sepsis, unspecified organism" was the most common principal diagnosis grouping for an inpatient discharge among residents of St. Lucie County. Inpatient discharges are based on ZIP Code of resident, not where an individual receives care.

Table 10: CSA Hospital Utilization Data Highlights, 2023

Principal Diagnosis Group, 2023 (CHA Page 171)	Inpatient Discharge (Count)	Inpatient Discharge (Percent)
Sepsis, unspecified organism (A41.9)	3,323	5.8%
Single liveborn infant, delivered vaginally (Z38.00)	2,276	4.0%
Hypertensive heart disease with heart failure (I11.0)	1,173	2.0%
Single liveborn infant, delivered by cesarean (Z38.01)	1,166	2.0%

Source: Florida Health CHARTS, Florida Agency for Health Care Administration (AHCA), 2023

Health Care Facility Capacity Data Highlights

In 2023, St. Lucie County reported lower facility capacity rates for hospital and nursing home beds compared to the state of Florida. Conversely, the county reported higher capacity rates for psychiatric and substance abuse beds than the state overall.

Table 11: CSA Health Care Facility Capacity Data Highlights, 2023

Bed Capacity by Facility Type, 2023 (Rate per 100,000 Population)	St. Lucie County	Florida
Hospital Beds *(CHA Page 179)*	251.8	304.5
Nursing Home Beds *(CHA Page 180)*	290.9	366.3
Adult Psychiatric Beds *(CHA Page 181)*	23.3	18.0
Child & Adolescent Psychiatric Beds *(CHA Page 182)*	3.3	3.1
Adult Substance Abuse Beds *(CHA Page 183)*	4.2	1.5

Source: Florida Health CHARTS, Florida Agency for Health Care Administration (AHCA), 2023

Health Care Provider Supply Data Highlights

The table below presents the rate of licensed healthcare professionals in St. Lucie County relative to the state of Florida. In fiscal year 2022-23, St. Lucie County had higher rates of Emergency Medical Technicians, Licensed Practical Nurses, and Registered Nurse, whereas the rates of physicians and dentists were considerably lower than the statewide rates.

Table 12: CSA Health Care Provider Supply Data Highlights, FY 2022-2023

Provider Type, Fiscal Year 2022-2023 (Rate per 100,000 Population) *(CHA Page 194)*	St. Lucie County	Florida
MD/Physicians	115.8	261.2
Dentists	29.4	61.5
Advance Registered Nurse Practitioner	158.2	190.1
Emergency Medical Technician	240.5	166.0
Licensed Practical Nurse	413.9	278.9
Registered Nurse	1,690.2	1,441.2
Licensed Clinical Social Workers	52.4	56.4
Licensed Mental Health Counselor	54.3	65.4
Occupational Therapist	33.2	43.8

Source: Florida Department of Health, Division of Medical Quality Assurance, 2023

Health Insurance Data Highlight

The table and figure below showcase health insurance coverage in St. Lucie in 2023.

- **Health Insurance Coverage:** In 2023, 87.9% of St. Lucie County residents had health insurance coverage, slightly below the statewide percentage of 88.1%.

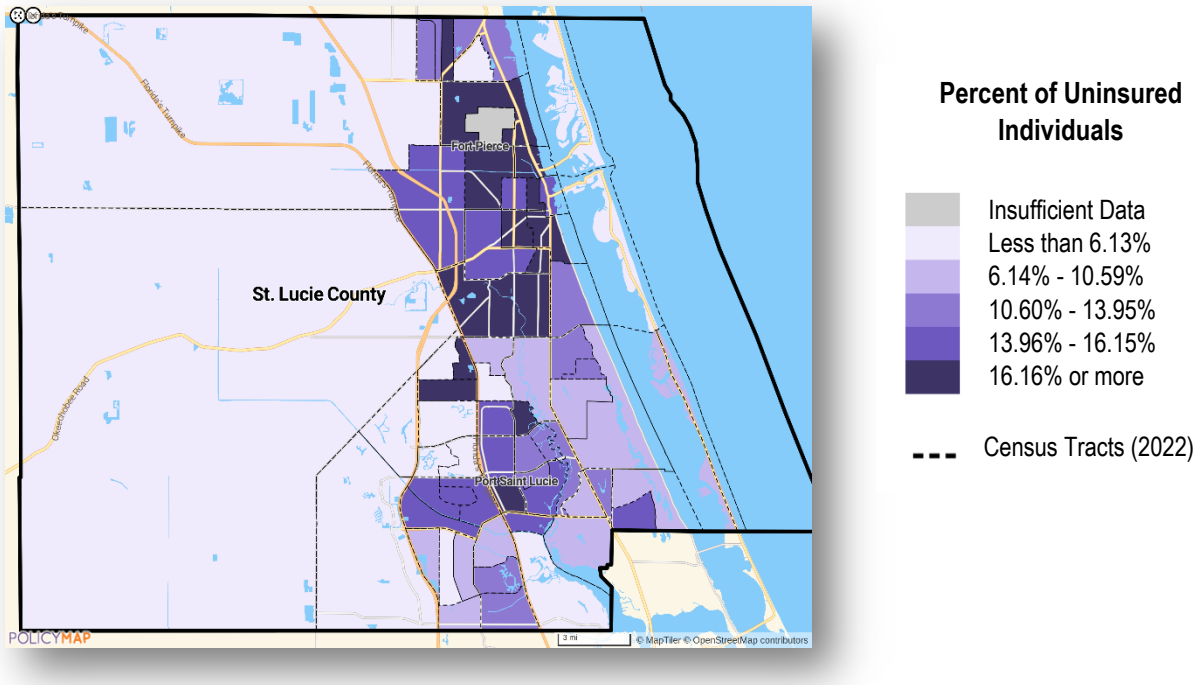
Table 13: CSA Health Insurance Data Highlights, 2023

Percent of Population, 2023 *(CHA Pages 201-203)*	St. Lucie County	Florida
Health Insurance Coverage	87.9%	88.1%

Source: Florida Health CHARTS, Florida Agency for Health Care Administration (AHCA), 2023

In 2023, 12.1% of St. Lucie County residents were uninsured, slightly higher than the statewide rate of 11.9%. The map below displays the proportion of the population who was uninsured by census tract. Darker shades represent areas with a higher proportion of uninsured individuals, ranging from 0.0% to 32.94% primarily in the Fort Pierce area.

Figure 4: Percent Uninsured, Percent of Individuals per Census Tract, St. Lucie County, 2023



Source: PolicyMap, U.S Census Bureau, American Community Survey, S2701, 5-Year Estimate, 2023
Note: Shaded by Census Tract

CHA Snapshot: Community Context Assessment Highlights

Resident Focus Group Highlights

Across six session dates, ten resident group discussions were held, engaging a total of 86 participants that lived or received services within St. Lucie County. These sessions provided participants with the opportunity to share their health-related experiences, challenges, and needs within St. Lucie County through an open, discussion-based format. The insights gathered from these conversations helped contextualize the quantitative data collected during the Community Status Assessment and offered a more comprehensive view of community needs. The key findings are summarized below:

Figure 5: CCA Resident Group Discussion Highlights

Current Community Strengths

- **Community-based Services:** Shelter support, Community organizations (e.g. UP center, Mustard Seed), mobile food pantries and health clinics, law enforcement
- **Built Environment:** Access to parks, walking paths and nature trails, free bus service, well-maintained public areas
- **Neighborhood Solidarity:** resource sharing and support as a result of strong social networks

Common Health Issues

- **Mental Health**
- **Substance use**
- **Chronic Conditions**
  - Dementia
  - Diabetes
  - High blood pressure

Service Gaps and Other Barriers to Health

- **Service Gaps:** Health Literacy, System Navigation, Housing Assistance, Transportation
- **Additional health barriers:** high cost of medical services, stress, limited availability of healthcare providers, economic challenges, language barriers, limited job opportunities, housing instability, limited access to affordable healthcare, insurance-related barriers, language barriers, lack of health education and awareness, access to affordable healthy food

Needed Support

- **Enhanced outreach and advertisement** of services
- **Opportunities for expanded services** and programs to access medical appointments and jobs
- **Support related to elements of health literacy**, including education and support around communication with medical and service providers, and navigation of healthcare and insurance coverage options.

Healthcare and Health Education

- **Sources of health information:** social media, Internet searches, word-of-mouth (e.g. friends, family, church groups, coworkers), doctors, and clinics
- **Sources of medical care:** primary care services at local clinics and doctor offices
- **Reiterated barriers to care including:** limited availability or quality of local care, reliance on urgent care, resulting in limited continuity of care or missed diagnoses

Final Thoughts

- **Desire for community unity and leadership to fill service gaps,** noting that community-based organizations and churches are overwhelmed
- An emphasis on the need for **access to services for all populations**
- The influence of social media and other factors that contribute to the **youth mental health crisis**
- **The role of attitudes toward health,** including stigma surrrounding seeking medical care, particularly noted by men.

Key Informant Interview Highlights

Between March and April 2025, ten key informant interviews were conducted to gather first-hand insights from a leaders and stakeholders in St. Lucie County. These informants shared their insights on the community's health, resources, and challenges. Participants included education professionals, representatives of medically underserved and low-income populations, philanthropic organizations, community- and faith-based groups, and others. The key findings are presented below:

Figure 6: CCA Key Informant Interview Highlights

Current Community Strengths

- **Valued community organizations**
- Availability of **health and mental health access** points
- **Collaboration** among local public health system agencies
- **Community development,** noting new sidewalks, safe parks, and ongoing housing developments
- The **built environment**

Challenges and Barriers in Maintaining Health

- **Limited access to heatlhcare,** noting factors related to affordability and availability of providers
- **Housing insecurity**
- **Transportation challenges**
- **Behavioral health,** citing concerns such as mental health and substance use challenges, suicide rates, and persistent stigma with seeking help
- **Food insecurity and rising food costs**

Populations with Unmet Needs

- Haitian residents
- Hispanic residents
- Seniors
- Low-income families
- Fort Pierce residents
- Families living in rural areas

Key health issues

- **Mental health concerns**
- **Chronic health conditions,** such as diabtes, hypertesnion, cardiovascular disease, and respiratory conditions
- **Substance use and overdose**, particularly among individuals experiencing homelessness, those without support, and youth

Suggestions for Improvement

- **Expanded mental health services**
- Greater investment in **youth activities and mentorship programs**
- **Hiring more multilingual staff**
- **Trainings** to support respecful and effective engagement across different backgrounds
- **Expanded efforts** to focus on service navigation, shared resource directories, building trust, and outreach

Opportunities

- **Opportunities to meet residents where they are** with the expansion of mobile clinics and food pantries
- **Affordable housing options**, particularly for seniors, individuals with diasbilities, and those transitioning from incarceration or homelessness

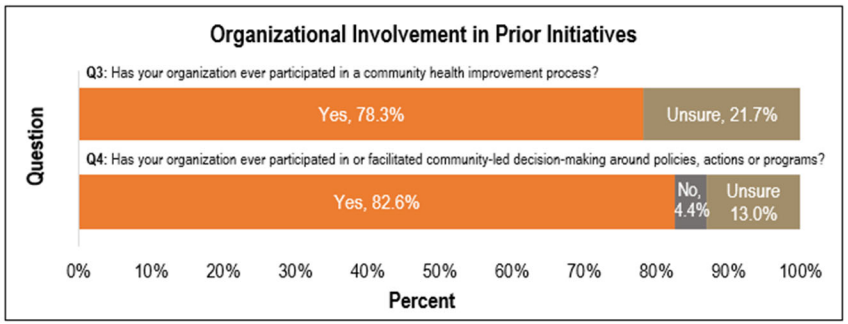
CHA Snapshot: Community Partner Assessment Highlights

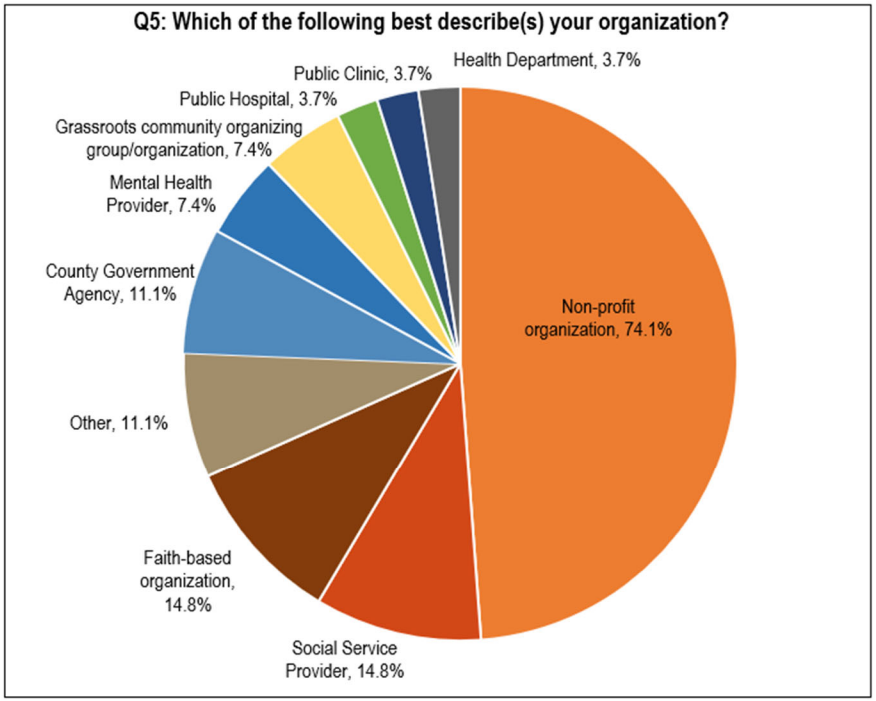
A total of 27 organizations participated in the Community Partner Assessment, representing a mix of nonprofit organizations, local government agencies, philanthropic organizations, and health and social service providers across St. Lucie County.

Overall Characteristics of Organizations

Key Takeaways

- Most survey respondents represented a non-profit organization (74.1%), followed by faith-based organizations and social service providers (each 14.8%). *(CPA Question 5)*
- Most respondents reported holding leadership roles within their organizations, with 31.8% identifying as senior management or program leads, 27.3% identifying as administrative staff, and 27.3% identifying as leadership team members. *(CPA Question 2)*
- More than three-quarters of respondents reported that their organization had previously participated in a community health improvement process. *(CPA Question 3).* Furthermore, a majority of respondents indicated that their organization had previously participated in community-led decision-making efforts. *(CPA Question 4)*

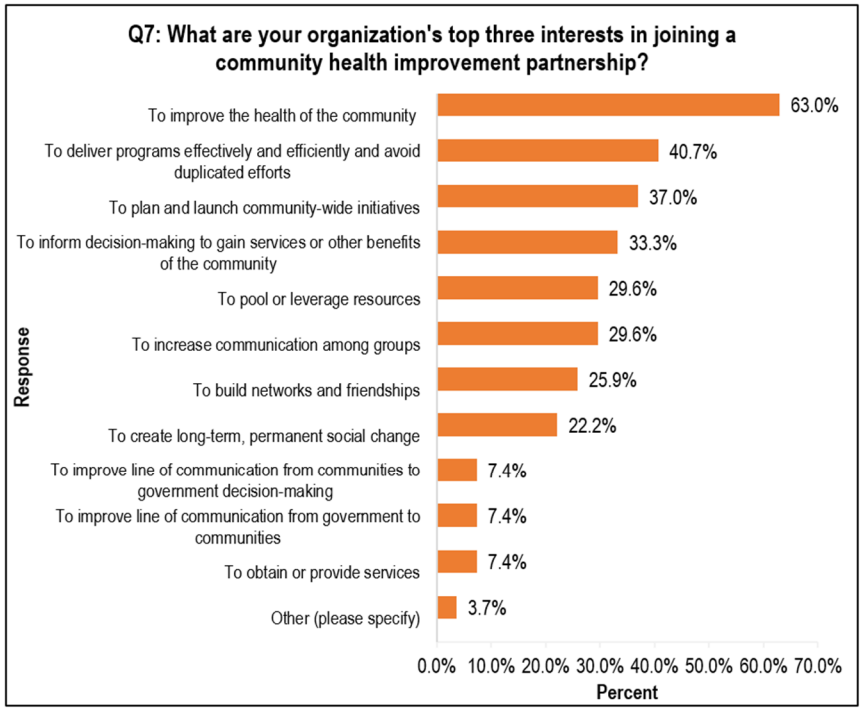


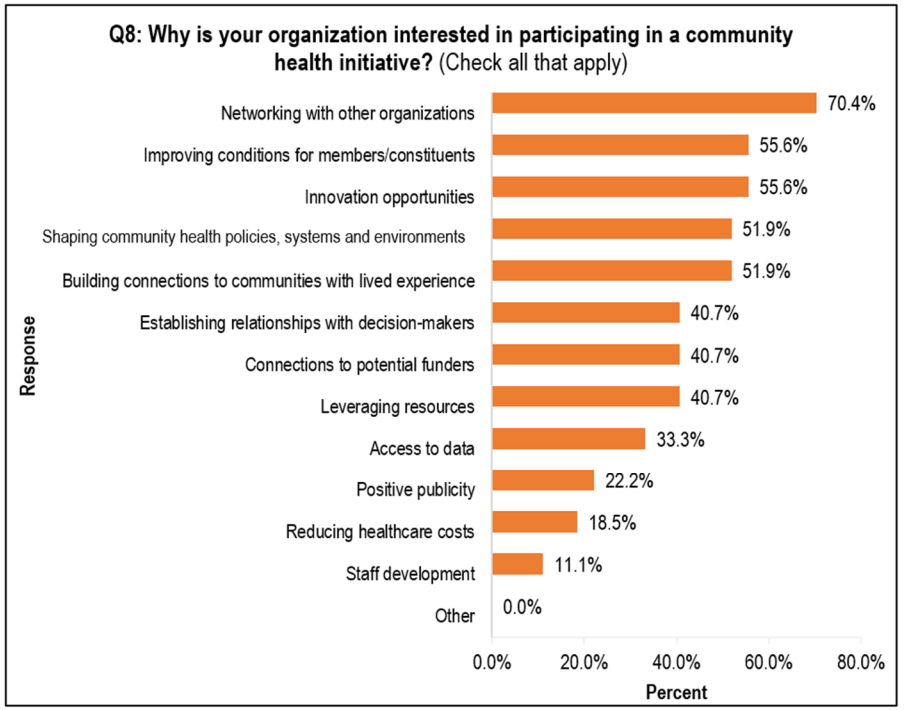


Factors Driving Participation

Key Takeaways

- Respondents identified a range of reasons for joining a community health improvement partnership. The most frequently cited interest was to improve the health of the community (63.0%). This was followed by interests in delivering programs more effectively and efficiently while avoiding duplicated efforts (40.7%), planning and launching community-wide initiatives (37.0%), and informing decision-making to gain services or other benefits of the community (33.3%). *(CPA Question 7)*
- Regarding their reasons for participating in community health initiatives, there was a substantial interest in networking with other organizations (70.4%). Notably, improving constituent conditions (55.6%) and exploring opportunities for innovation (55.6%) were also key interests. *(CPA Question 8)*

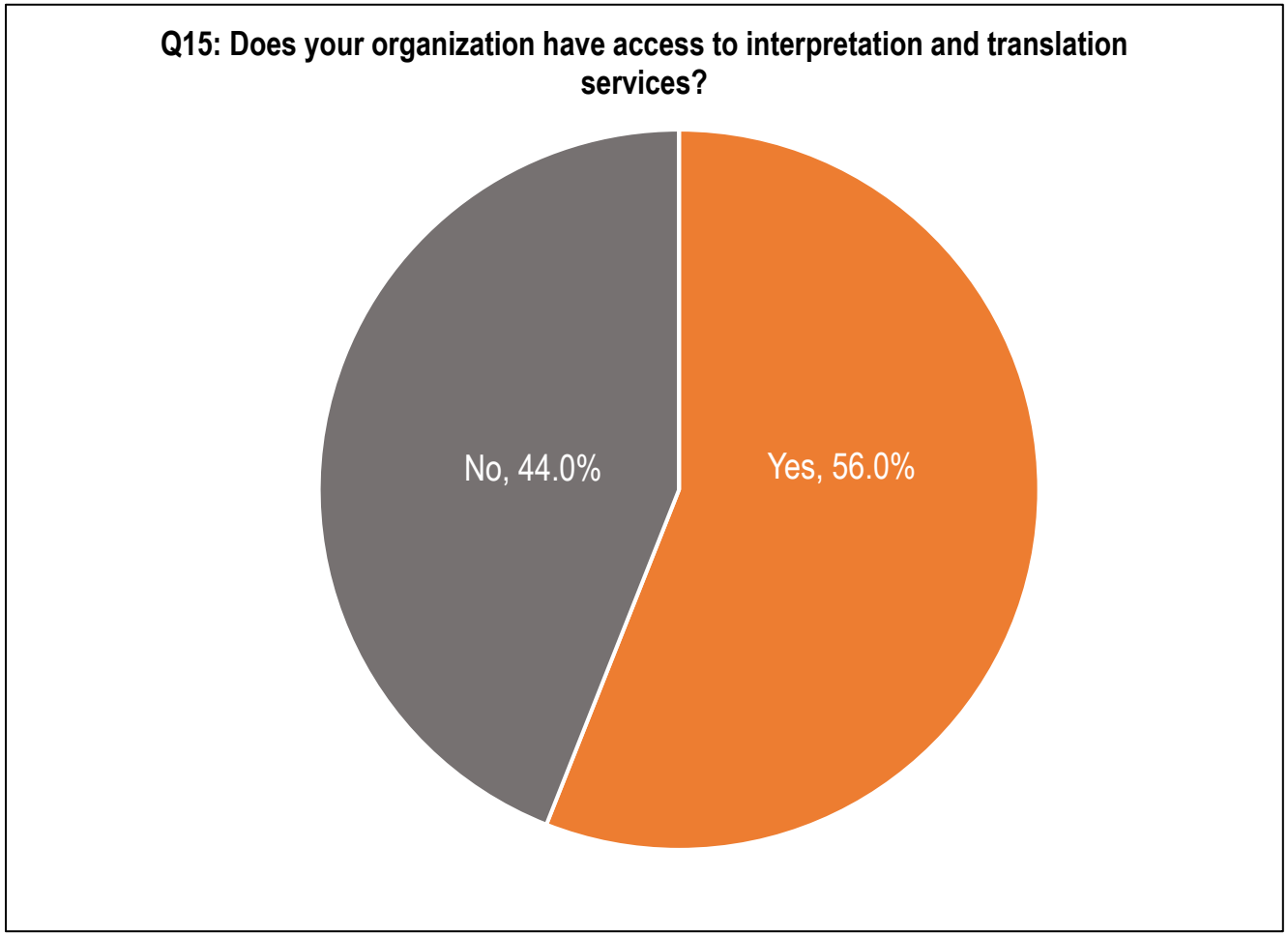




Populations Served

Key Takeaways

- The majority of respondents (56.0%) reported that their organizations had access to interpretation and translation services. Conversely, 44.0% respondents reported that their organization lacked access to interpretation or translation services. *(CPA Question 15)*

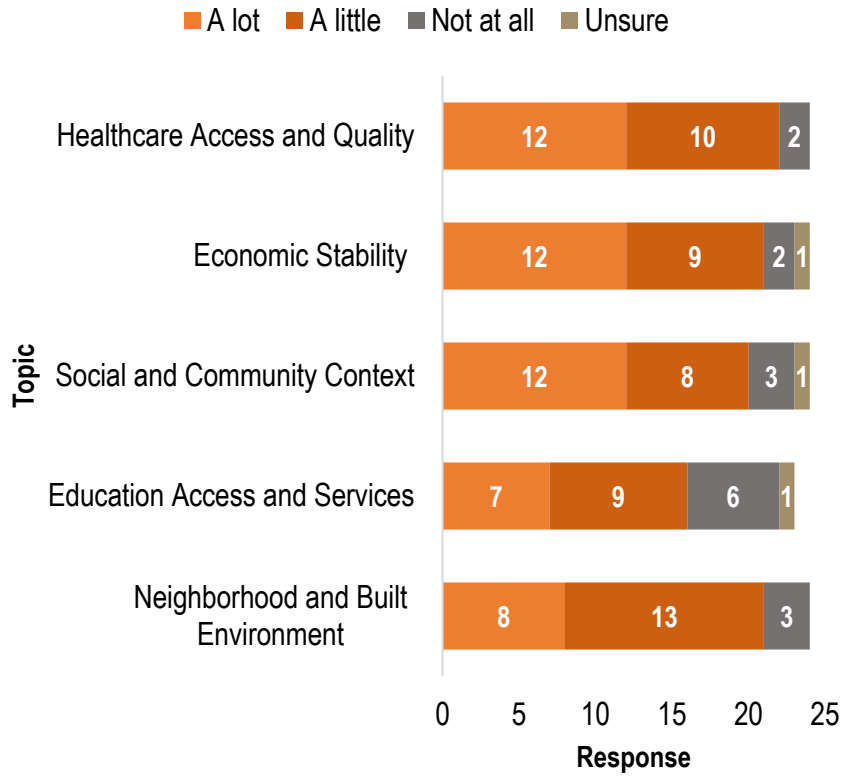


Organizational Focus Area

Key Takeaways

- Respondents reported that their organizations were actively involved in addressing healthcare access and quality (12 of 24), economic stability (12 of 24) and social and community context (12 of 24). *(CPA Question 20)*
- Respondents indicated involvement across a broad range of topic areas, with the highest levels of engagement in human services (62.5%), family well-being (45.8%), community economic development (45.8%), and education (45.8%). *(CPA Question 21)*

How much does your organization focus on each of these topics?
(For each topic, select one option.)



Q21: Which of the following categories does your organization work on/with?

Most Commonly Reported

- Human services (62.5%),
- Family well-being (45.8%), Community economic development (45.8%), Education (45.8%)
- Youth development and leadership, seniors/elder care, healthcare access/utilization, faith communities (each 41.7%)

Commonly Reported

- Public health and housing (each 37.5%)
- Veterans' Issues, Transportation, Food access and affordability (e.g., food bank), Disability/Independent Living, Criminal legal system (each 33.3%)
- Utilities, Early childhood development/childcare (each 29.2%)

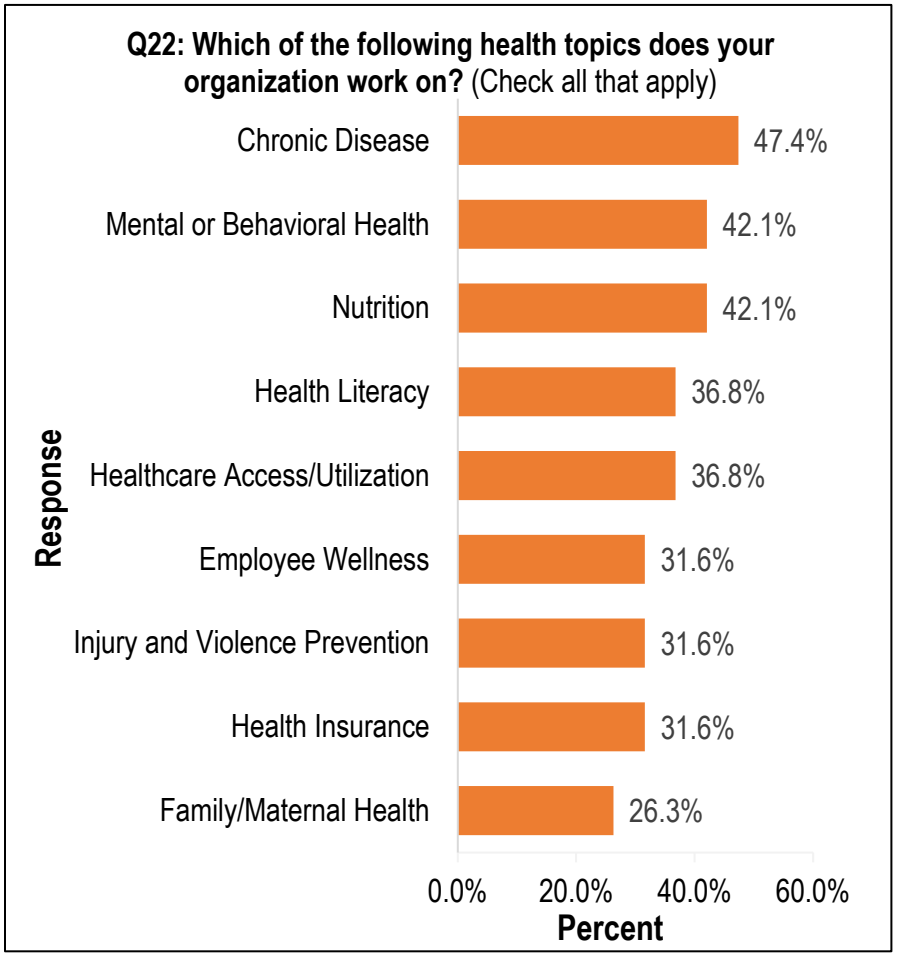
Less Commonly Reported

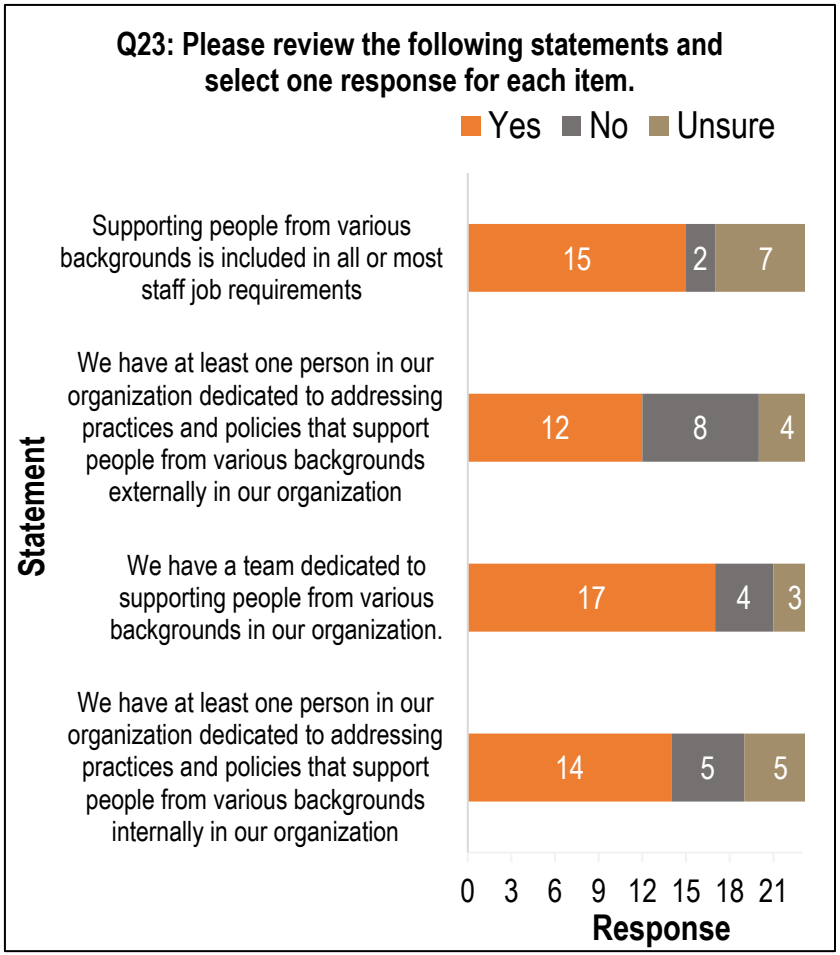
- Public safety/violence, Economic security (each 25.0%)
- Businesses and for-profit organizations (20.8%)
- Arts and culture (16.7%)
- Jobs/labor conditions/wages and income, Government accountability, Food service/restaurants, Financial institutions (e.g., banks, credit unions)

Community Priorities

Key Takeaways

- When asked about the health topics their organization addressed, respondents reported a variety of focus areas. The most frequently reported were chronic disease (47.4%), mental or behavioral health (42.1%), nutrition (42.1%), health literacy (36.8%), and healthcare access/utilization (36.8%). *(CPA Question 22)*
- Most respondents indicated that their organizations have a team dedicated to supporting people from various backgrounds (17 of 27) and that this responsibility is included in the job description (15 of 27). However, fewer organizations reported having designated staff or teams responsible for these efforts, either internally (14 of 27) or externally (12 of 27). *(CPA Question 23)*

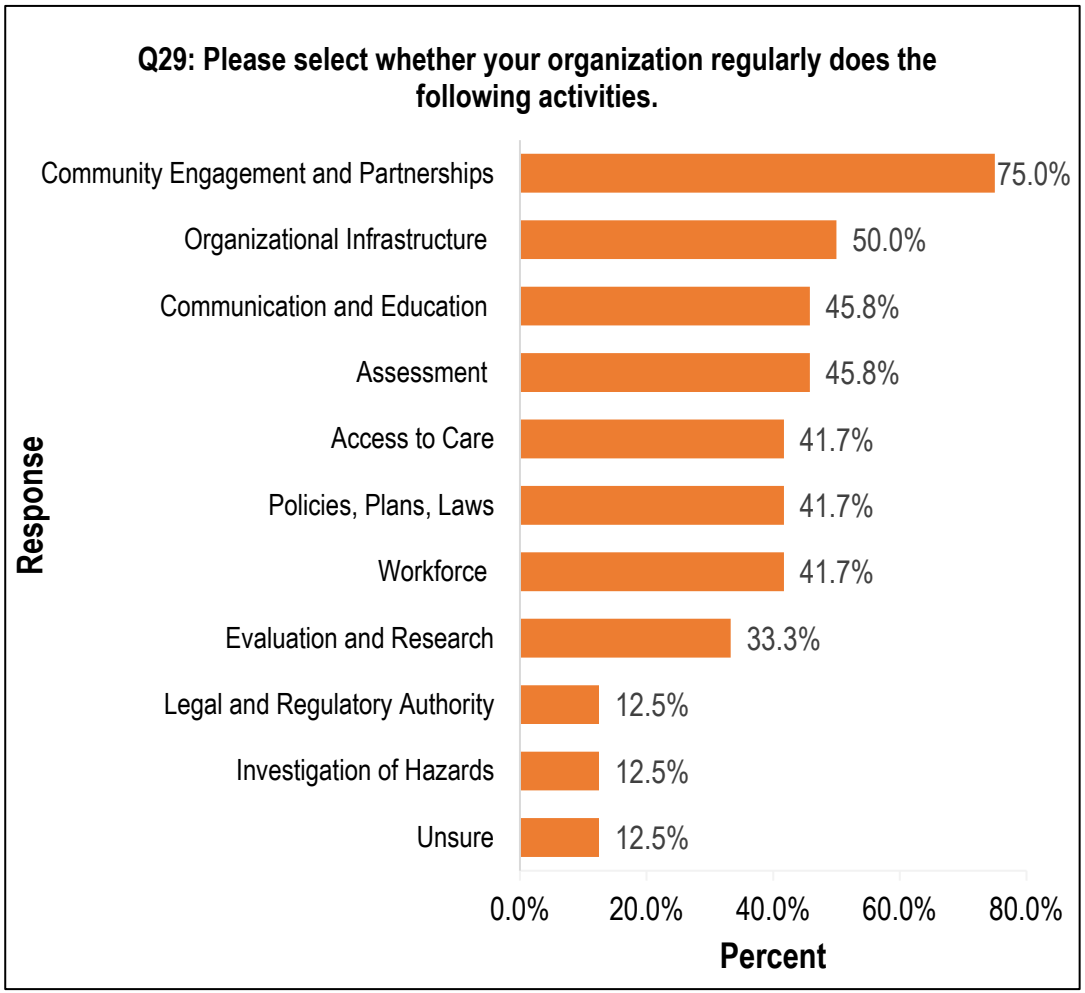


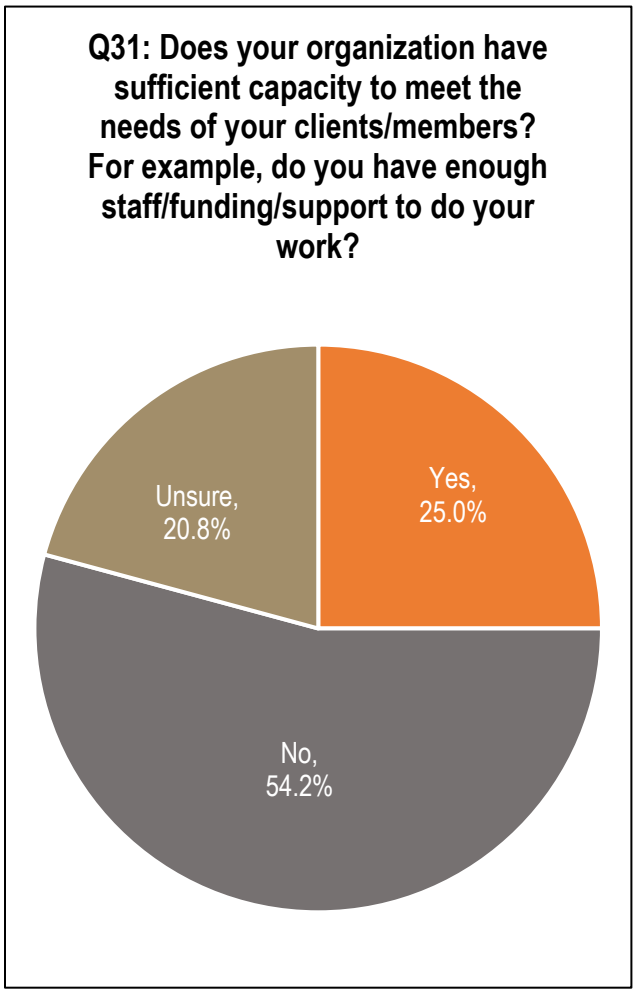


Organizational Capacities

Key Takeaways

- When asked about activities regularly done, 75% of respondents noted that they worked on community engagement and partnerships, followed by organizational infrastructure (50.0%), assessment (45.8%), and communication and education (45.8%). *(CPA Question 29)*
- When asked if their organization had sufficient capacity to meet the needs of their clients or members, over half of respondents (54.2%) stated that they did not, while 25.0% reported that they did, and 20.8% were unsure. *(CPA Question 31)*

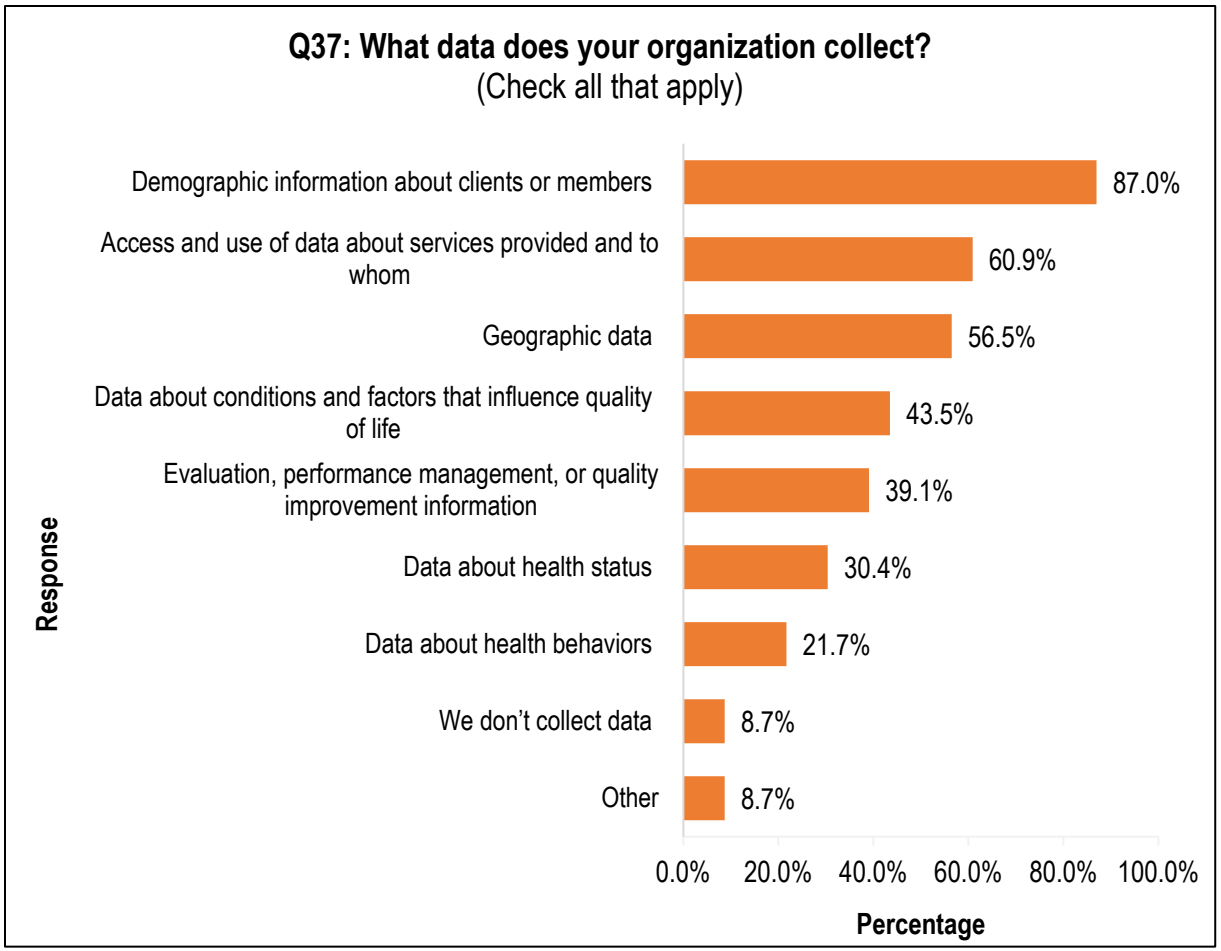


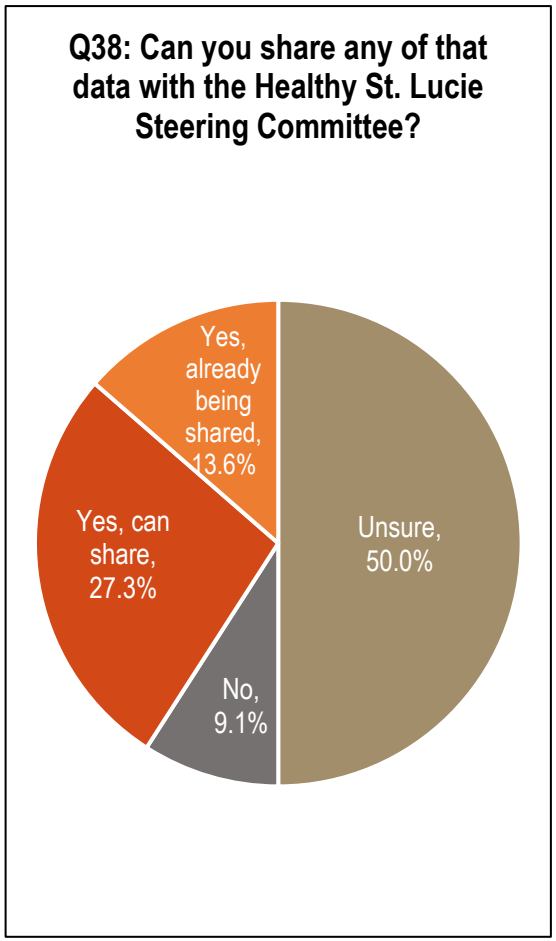


Data Collection & Analysis

Key Takeaways

- The most frequently collected data among organizations were demographic information about clients or members (87.0%), followed by data on service access and utilization (60.9%), and geographic data (56.5%). *(CPA Question 37)*
- When asked about their ability to share data with the Healthy St. Lucie Steering Committee, 13.6% of respondents indicated that their organization already shares findings, while 27.3% reported that they are able to share data. Notably, half of respondents (50.0%) were unsure whether their organization could share data, and 9.1% indicated that their organization could not share data. *(CPA Question 38)*

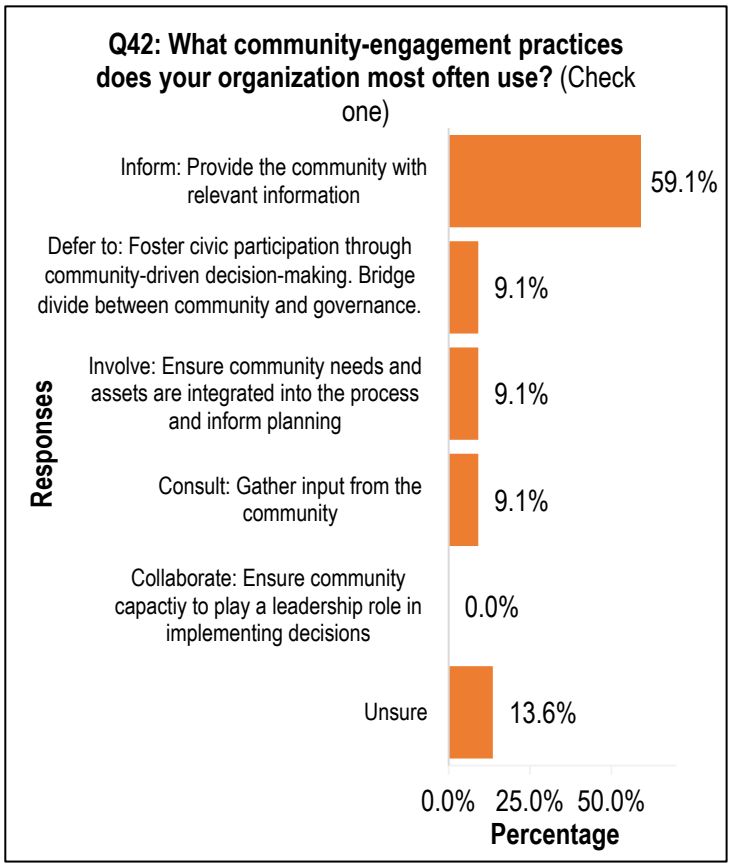


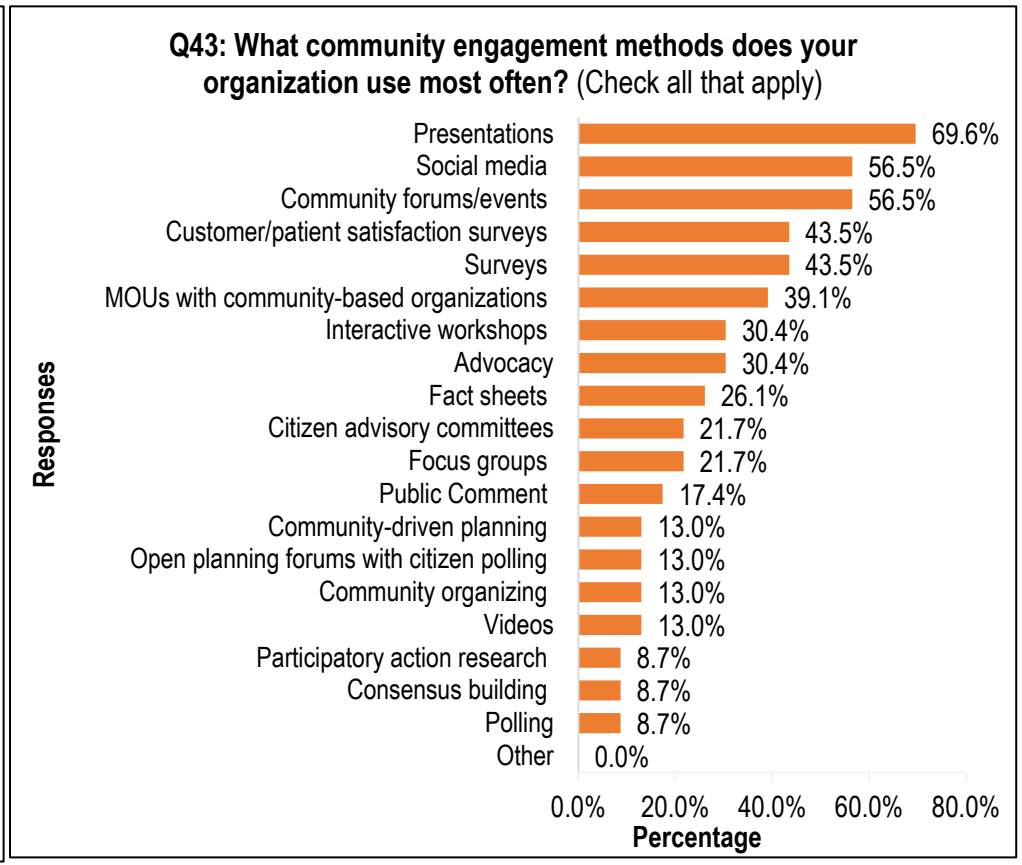


Community Engagement Practices

Key Takeaways

- Most organizations engaged the community primarily through information sharing, with 59.1% selecting “Inform” as their primary engagement method. Fewer respondents reported using more participatory approaches: 9.1% used the “Consult” approach to gather community input, another 9.1% used the “Involve” approach to integrate community needs and assets into planning, and 9.1% selected “Defer to”, reflecting a commitment to community-driven decision-making and civic participation. *(CPA Question 42)*
- When asked about the methods most often used (in a check all that apply format), a significant portion of responses noted presentations (69.6%), followed closely by community forums or events (56.5%) and social media (56.5%). *(CPA Question 43)*

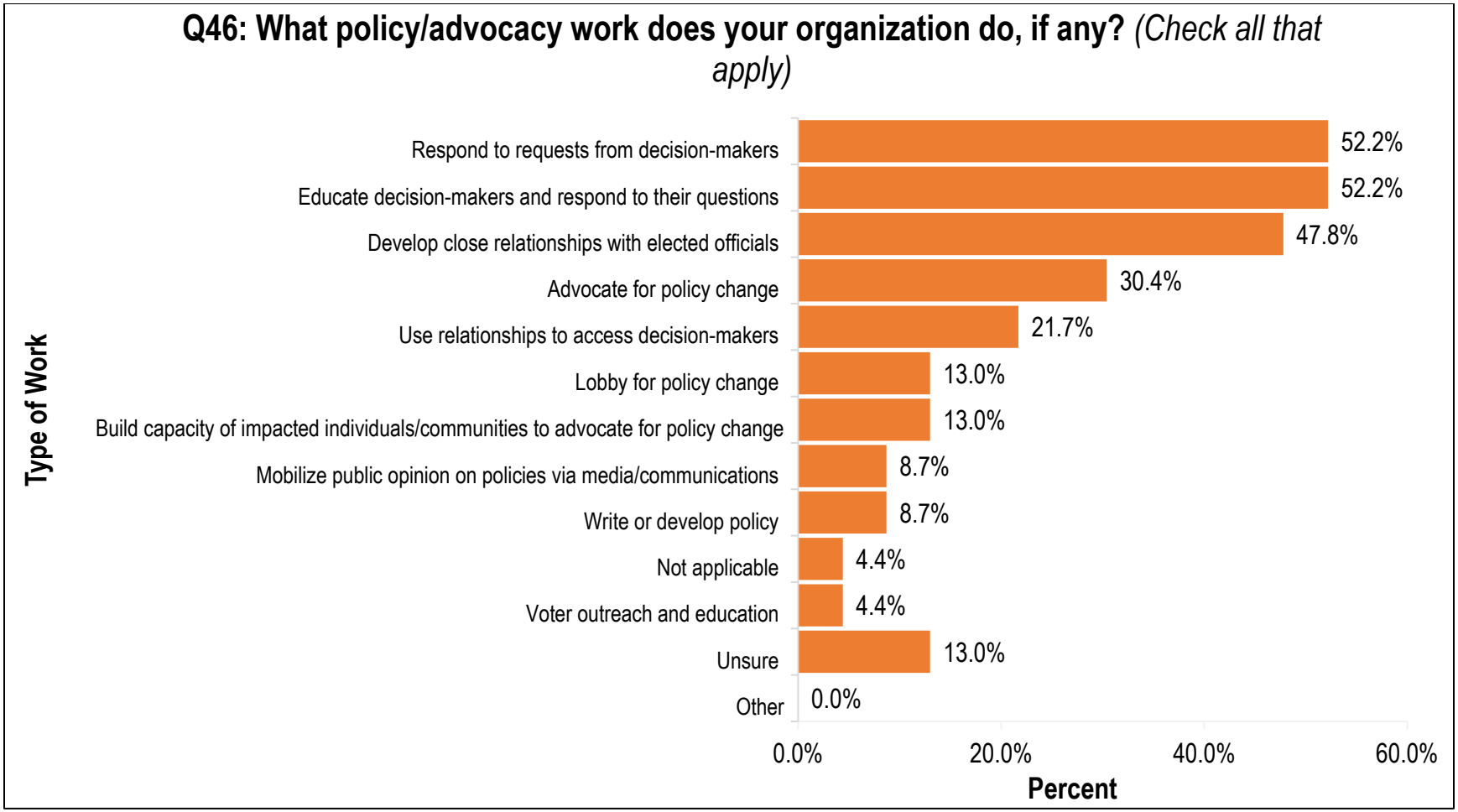




Policy and Advocacy Efforts

Key Takeaways

- When asked about policy and advocacy work (in a check all that apply format), most respondents noted that they respond to requests from decision-makers (52.2%) and educate decision-makers and respond to their questions (52.2%). *(CPA Question 46)*



Strategic Health Priorities and Action Plans

The St. Lucie County Community Health Improvement Plan (CHIP) is a five-year plan to address the health priorities identified based on the Community Health Assessment (CHA) findings. This section of the report presents the actionable plan developed by the Health St. Lucie Steering Committee based on the culmination of perspective, input, and effort of community members and stakeholders throughout the community health improvement planning process. Each priority area includes defined goals, strategies, and objectives, activities, key action steps, measures, and lead community partners. Together, these components will guide collaboration for this five-year CHIP.

The goal of the 2026 – 2030 St. Lucie County CHIP is to guide community health improvement planning efforts. The Healthy St. Lucie Steering Committee will collaborate to implement the Community Health Improvement Plan (CHIP) and progress will be continuously evaluated to ensure meaningful impact. Any updates to the plan will be reviewed and approved by the Healthy St. Lucie Steering Committee and published annually.

Definitions of each of these components are detailed in the table below.

Table 14: Strategic Health Priorities & Action Plans Overview

Goals	A **goal** is a broad statement describing a desired outcome. It represents the destination the community aims to achieve within each priority area.
Objectives	**Objectives** provide clear targets for what the community intends to achieve and are written using the **S.M.A.R.T.** framework (**S**pecific, **M**easurable, **A**chievable, **R**ealistic/**R**elevant, and **T**ime-bound). Where possible, alignment is shown between the objective and similar Healthy People 2030 and Florida State Health Improvement Plan (SHIP) objectives.
Strategies	**Strategies** are the general approaches taken to meet goals and objectives. The CHIP includes examples of evidence-based interventions and programs for each priority to guide how the detailed CHIP strategies are modeled. General strategies within the CHIP can include efforts such as education, health engineering, community mobilization, health communications, health policy and enforcement, health-related community service, and more.
Activities, Action Steps, and Measures	Supporting **activities, action steps,** and **measures** specify how the strategies will be put into practice over the course of the CIHP. These provide a depiction of the efforts that will be taken, and how their progress will be measured over the course of the five-year CHIP.
Key Partners	**Key partners** are listed for each activity. These partners were identified by the Healthy St. Lucie Steering Committee for their expertise and experience related to the priority area activities. These key partners will serve as lead agencies to guide implementation, advance strategies, and report progress to the Healthy St. Lucie Steering Committee throughout the implementation efforts. Notably, the Healthy St. Lucie Steering Council will also collaborate and leverage broader partnerships throughout the process. As additional partners are identified throughout the CHIP implementation process, updates will be made to these areas of the plan to depict community efforts.

The information in this plan is designed to guide St. Lucie County's community health improvement efforts for the next five years. The Steering Committee will continuously evaluate the goals, activities, and outcomes to ensure their work is effective. Because the plan is a "living" document, it can be updated as needed to meet the community's evolving needs. This ongoing evaluation will also help determine the success of current strategies and guide future planning.

Overview of CHIP Priority Areas

The following graphic depicts a summary view of the CHIP Priority Areas and the associated goals, strategies, and objectives for each area. Additional detail, including related activities, action steps, measures, and key partners, may be found in the subsequent sections of this report.

ST. LUCIE CHIP PRIORITY AREA: MENTAL AND BEHAVIORAL HEALTH

Goal 1.A: Improve the mental health and well-being of St. Lucie County residents

Strategy 1.A.1: Increase community capacity to address mental health issues

- **Objective 1.A.1.1:** Increase the proportion of St. Lucie adults with good mental health from 86.4% in 2022 to 87.5% in 2030 [Source: FL Health CHARTS, BRFSS]
- **Objective 1.A.1.2:** Decrease the proportion of St. Lucie County students who, in the past year, felt sad or hopeless for two or more weeks in a row and stopped doing usual activities from 23.2% in 2024 to 22.2% in 2030 [Source: FL Health CHARTS, FYTS]
- **Objective 1.A.1.3:** Maintain the age-adjusted rate of emergency department visits from mental disorders at 996.2 per 100,000 population in St. Lucie County in 2024 to 2030 [Source: FL Health CHARTS, AHCA]

Goal 1.B: Improve quality of life among St. Lucie County residents through substance use prevention and care

Strategy 1.B.1: Strengthen a comprehensive continuum of care that reduces the burden of substance use disorder by expanding prevention education, improving access to evidence-based treatment services, supporting long-term recovery, and implementing new or increasing existing harm reduction practices.

- **Objective 1.B.1.1:** Reduce the proportion of St. Lucie County middle and high school students who report using an illicit drug other than marijuana in the past 30 days from 4.7% in 2024 to 4.0% in 2030 [Source: FL Dept of Children and Families, FYTS]
- **Objective 1.B.1.2:** Reduce the count of all-drug nonfatal overdose emergency department visits (among all ages) from 480 in St. Lucie County in 2024 to 386 in 2030 [Source: FL Health CHARTs, Substance Use Dashboard]
- **Objective 1.B.1.3:** Reduce the drug overdose annual age-adjusted death rate (among all ages) from 29.6 per 100,000 persons in St. Lucie County in 2023 to 26.3 in 2030 [Source: FL Health CHARTs, Substance Use Dashboard]

ST. LUCIE CHIP PRIORITY AREA: CHRONIC DISEASES AND CONDITIONS

Goal 2.A: Increase quality of life for St. Lucie County residents by enhancing policies, systems, and environments that support healthy decision-making

Strategy 2.A.1: Support system-level and environmental interventions that promote healthy decision-making for St. Lucie County residents

- **Objective 2.A.1.1:** Decrease the age-adjusted rate of hospitalizations from coronary heart disease from 281.4 per 100,000 population in St. Lucie County in 2024 to 160.4 per 100,000 population in 2030 [Source: FL Health CHARTS, AHCA]
- **Objective 2.A.1.2:** Decrease the age-adjusted rate of hospitalizations from hypertension from 426.8 per 100,000 population in St. Lucie County in 2024 to 405.0 per 100,000 population in 2030 [Source: FL Health CHARTS, AHCA]
- **Objective 2.A.1.3:** Decrease the age-adjusted rate of hospitalizations from diabetes from 274.3 per 100,000 population in St. Lucie County in 2024 to 266.0 per 100,000 population in 2030 [Source: FL Health CHARTS, AHCA]

Goal 2.B: Promote physical wellbeing through healthy lifestyle choices.

Strategy 2.B.1: Build community capacity through health education and programming to support the prevention and management of chronic diseases.

- **Objective 2.B.1.1:** Reduce the percentage of St. Lucie County middle and high school students who are overweight or obese from 31.4% in 2024 to 26.0% in 2030 [Source: FL Health CHARTS, FYTS]
- **Objective 2.B.1.2:** Increase the proportion of St. Lucie County adults who are at a healthy weight from 26.1% in 2022 to 27.0% in 2030 [Source: FL Health CHARTS, BRFSS]

ST. LUCIE CHIP PRIORITY AREA: HEALTH LITERACY

Goal 3.A: Improve St. Lucie residents' capacity to access, understand, and use health information to make informed decisions

Strategy 3.A.1: Increase access to accurate, plain-language health information

- **Objective 3.A.1.1:** Increase the proportion of Adults Who Had a Medical Checkup in the Past Year from 77.3% in 2022 to 80.0% in 2030 [Source: BRFSS]

Goal 3.B: Expand organizational capacity to improve the health literacy of residents

Strategy 3.B.1: Unify community and organizational efforts to improve understanding of health information and services

- **Objective 3.B.1.1:** Reduce Ambulatory Care Sensitive Hospitalizations from All Conditions (Aged 0-64 Years), from 1,155.8 per 100,000 population (Aged 0 – 64 years) in 2023 to 1,045.0 in 2030 [Source: FL Health CHARTS, AHCA]

St. Lucie County Community Health Improvement Plan (Jan. 2026 – Dec. 2030)

Priority Area: Mental and Behavioral Health

Mental and Behavioral Health – Why Address It?

Mental and behavioral health are essential components of overall wellness, shaping how individuals think, feel, and act in daily life. Mental health refers to emotional, psychological, and social well-being, influencing how people handle stress, relate to others, and make decisions.[1] Behavioral health is a broader term that includes mental health, substance use, and the everyday actions that affect physical and emotional wellness.[2] Together, these health topics form a foundation for healthy growth, positive relationships, and productive participation in school, work, and community life.

Mental and behavioral health concerns are widespread and have a profound impact on individuals and society. According to 2022 data from the Centers for Disease Control and Prevention (CDC), more than 1 in 5 adults in the United States live with a mental illness, and nearly 1 in 25 live with a serious mental illness.[3] Depression and anxiety remain leading causes of disability worldwide and are associated with increased risk of chronic diseases such as heart disease and diabetes.[4] In addition, many individuals experience both mental illness and substance use disorders at the same time, a combination known as co-occurring disorders, which can complicate care and recovery.

Multiple factors influence mental and behavioral health. Adverse childhood experiences, trauma, and chronic stress can disrupt healthy brain development and increase vulnerability to mental illness later in life. Barriers such as stigma, limited health literacy, lack of access to services, workforce shortages, and cost can prevent individuals from receiving appropriate treatment. Notably, limited health literacy can increase stigma and reduce help-seeking, creating another barrier to receiving timely mental and behavioral health care.[5] When mental health challenges are untreated, they can worsen physical health outcomes, increase healthcare costs, and place a burden on families and communities.[6] Left unaddressed, these conditions can lead to lower educational attainment, reduced workforce participation, family stress, and increased use of emergency and inpatient services, all of which raise community health care costs.[7]

[1] Magomedova, A., & Fatima, G. (2025). Mental Health and Well-Being in the Modern Era: A Comprehensive Review of Challenges and Interventions. Cureus. https://doi.org/10.7759/cureus.77683
[2] About behavioral health. (2025, June 9). Mental Health. Retrieved September 9, 2025, from https://www.cdc.gov/mental-health/about/about-behavioral-health.html
[3] About behavioral health. (2025, June 9). Mental Health. Retrieved September 9, 2025, from https://www.cdc.gov/mental-health/about/about-behavioral-health.html
[4] About chronic diseases. (2024b, October 4). Chronic Disease. Retrieved September 11, 2025, from https://www.cdc.gov/chronic-disease/about/index.html
[5] Fleary, S. A., Joseph, P. L., Gonçalves, C., Somogie, J., & Angeles, J. (2022). The relationship between health literacy and mental health attitudes and beliefs. HLRP Health Literacy Research and Practice, 6(4), e270–e279. https://doi.org/10.3928/24748307-20221018-01
[6] Mongelli, F., Georgakopoulos, P., & Pato, M. T. (2020). Challenges and opportunities to meet the mental health needs of underserved and disenfranchised populations in the United States. FOCUS the Journal of Lifelong Learning in Psychiatry, 18(1), 16–24. https://doi.org/10.1176/appi.focus.20190028
[7] National Alliance on Mental Illness. (2025, September 12). *Mental health in schools | National Alliance on Mental Illness (NAMI)*. National Alliance on Mental Illness (NAMI). Retrieved November 13, 2025, from https://www.nami.org/advocacy/policy-priorities/improving-health/mental-health-in-schools/

The Healthy St. Lucie Steering Committee identified mental and behavioral health as a top priority area because of its broad impact on health outcomes and community well-being. The following table highlights high-level Community Health Assessment (CHA) data findings that further support the prioritization of mental health and behavioral health:

Mental and Behavioral Health CHA Findings	
Community Context Assessment Findings	• Mental health and substance use are exacerbated by stress, the economy, social isolation, and trauma • Concern expressed over the mental health crisis and suicide rates among youth • Impact of access to care barriers, including access to mental health professionals • Persistent stigma around seeking mental health support
Community Status Assessment Findings	• In 2023, the hospitalization rate from mental disorders in St. Lucie County was 1,112.8 per 100,000 population, compared to 959.0 per 100,000 population in Florida[i] • In 2023, the suicide death rate in St Lucie County was 13.1 per 100,000 population (Florida: 14.1 per 100,000 population)[i] • In 2023, the opioid overdose death rate in St. Lucie County was 20.5 per 100,000 population (Florida: 29.0 per 100,000 population)[i]
Community Partner Assessment Findings	• 43.5% of participating organizations focus on mental or behavioral health • 40.0% of participating organizations primarily work with individuals experiencing mental health issues, and 32.0% experiencing substance use disorders
Prioritization Discussions	• The Steering Committee noted that behavioral and mental health are often long-term challenges and chronic issues • Challenges were noted such as gaps in services, smaller networks, and insurance or waitlist issues • The Steering Committee noted a call for trauma-informed community interventions and wrap around care • The opioid crisis was highlighted as a concern • The Steering Committee noted that youth may be interested in seeking help/education, but limited resources are a barrier

[i]Source: Florida Department of Health, Division of Public Health Statistics and Performance Management, 2023

Mental and Behavioral Health – Priority Area Action Plan

The following table details the goals, strategies, objectives, activities, and key action steps that will guide community action through the CHIP. The table also provides insight into plan alignment with Healthy People 2030 and the Florida State Health Improvement Plan (SHIP).

St. Lucie CHIP Priority Area: Mental and Behavioral Health				
Goal 1.A: Improve the mental health and wellbeing of St. Lucie County residents.				
Strategy 1.A.1: Increase community capacity to address mental health issues.				
• **Objective 1.A.1.1:** Increase the proportion of St. Lucie adults with good mental health from 86.4% in 2022 to 87.5% in 2030 [Source: FL Health CHARTS, BRFSS] • **Objective 1.A.1.2:** Decrease the proportion of St. Lucie County students who, in the past year, felt sad or hopeless for two or more weeks in a row and stopped doing usual activities from 23.2% in 2024 to 22.2% in 2030 [Source: FL Health CHARTS, FYTS] • **Objective 1.A.1.3:** Maintain the age-adjusted rate of emergency department visits from mental disorders at 996.2 per 100,000 population in St. Lucie County in 2024 to 2030 [Source: FL Health CHARTS, AHCA]			**Alignment:** Florida SHIP: MW1.1, MW1.2, MW2.1, MW2.2 Healthy People 2030: MHMD-07	
Activities	**Key action steps**	**Measures**	**Key partners**	**Timeframe**
Implement Zero Suicide practices into organizations throughout St. Lucie County	• Provide information on Zero Suicide to organizations • Provide technical assistance to organizations	# of organizations implementing Zero Suicide	• RiteLife Services	January 2026 – December 2030
Educate and train support systems and community members through MHFA and Teen MHFA	• Share information on available trainings • Conduct trainings with community members, including teens and adults	# of St. Lucie County residents trained	• St. Lucie County Roundtable	
Promote Trauma-Informed Care best practices and trainings	• Conduct trauma-informed care organizational assessments • Conduct trauma-informed care trainings	# of organizations assessed # of people trained	• Tykes & Teens • St. Lucie County Roundtable	
Provide certified peer support specialist training	• Identify and train peer support specialists	# of people trained	• RiteLife Services	
Provide community trainings on mental health topics, stigma, and/or resources	• Identify training needs • Collaborate and coordinate trainings	# of people trained	• St. Lucie RISE & Roundtable • New Horizons • SEFBHN	

			• Tykes and Teens • West Palm Beach VA • Indian River State College - Blackburn Campus	
Goal 1.B: Improve quality of life among St. Lucie County residents through substance use prevention and care.				
Strategy 1.B.1: Strengthen a comprehensive continuum of care that reduces the burden of substance use disorder by expanding prevention education, improving access to evidence-based treatment services, supporting long-term recovery, and implementing new or increasing existing harm reduction practices.				
• **Objective 1.B.1.1:** Reduce the proportion of St. Lucie County middle and high school students who report using an illicit drug other than marijuana in the past 30 days from 4.7% in 2024 to 4.0% in 2030 [Source: Florida Department of Children and Families, Florida Youth Substance Abuse Survey] • **Objective 1.B.1.2:** Reduce the count of all-drug nonfatal overdose emergency department visits (among all ages) from 480 in St. Lucie County in 2024 to 386 in 2030. [Source: FL Health CHARTs, Substance Use Dashboard] • **Objective 1.B.1.3:** Reduce the drug overdose annual age-adjusted death rate (among all ages) from 29.6 per 100,000 persons in St. Lucie County in 2023 to 26.3 in 2030. [Source: FL Health CHARTs, Substance Use Dashboard]			**Alignment:** • Florida SHIP: MW3.4 • Healthy People 2030: SU-03, SU-05, SU-D04	
Activities	**Key action steps**	**Measures**	**Key partners**	**Timeline**
Provide referrals to family-focused evidence-based programs for DJJ	• Identify referral partners and opportunities • Educate residents on available resources and services • Connect residents with family-focused evidence-based programs	# of referrals from DJJ	• DATA • Healthy St. Lucie Partners	January 2026 – December 2030
Increase awareness of services and providers through the promotion of local resource guides and the St. Lucie Cares Behavioral Health Guide	• Connect residents with local resource guides • Educate residents on available resources and services for behavioral health care	# utilization # people who access online and # of physical guides distributed	• St. Lucie County Roundtable • Healthy St. Lucie Partners	
Increase St. Lucie County engagement in formal, collaborative groups such as the Treasure Coast Overdose Taskforce and the Overdose Fatality Review Board	• Identify St. Lucie County individuals/organizations to participate • Promote the Treasure Coast Overdose Taskforce and the Overdose Fatality Review Board	# St. Lucie County participants on the Treasure Coast Overdose Taskforce # recommendations made and assigned to community	• Treasure Coast Overdose Taskforce • Florida Department of Health in St. Lucie County (Fatality Review Board)	

	• Attend regular meetings of the Treasure Coast Overdose Taskforce and the Overdose Fatality Review Board	partners from case review from the Overdose Fatality Review		

Mental and Behavioral Health – Best Practices and Evidence-Supported Initiatives

Mental Health First Aid

Mental Health First Aid is an evidence-based training program that teaches community members how to recognize and respond to signs of depression, anxiety, substance use, and other mental health concerns. This strategy uses an eight- to twelve-hour course and a five-step action plan to assess risk, listen non-judgmentally, provide reassurance, and encourage professional and self-help support. The expected benefits include increased knowledge of mental health and reduced stigma toward individuals experiencing mental health challenges.[8]

Trauma-Informed Health Care

Trauma-informed care (TIC) is an evidence-supported framework that recognizes the widespread impact of trauma and integrates policies and practices to promote healing and prevent re-traumatization. This strategy uses patient-centered communication and screening, creates safe and supportive environments, and engages patients in shared decision-making to improve care. The expected benefits include improved patient engagement, greater trust in care, and better mental and behavioral health outcomes, particularly for people with histories of violence, abuse, or other traumatic events.[9]

Naloxone Education and Distribution Programs

Naloxone (also referred to as Narcan) is a medication that reverses overdoses caused by opioids. Naloxone access laws have worked to increase naloxone distribution from pharmacies in an effort to reach people at risk of overdose. Notably, access can be expanded through community efforts that provide naloxone education, training, and distribution programming to reach individuals who misuse opioids and their networks. Efforts can also help to expand access for first responders, ensuring that they are trained and authorized to administer naloxone. The expected benefits include increased knowledge of appropriate overdose response, and potential benefits include reduced overdose deaths and increased self-confidence.[10]

[8] Mental health first aid. (2019, January 25). County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/mental-health-first-aid

[9] Trauma-informed health care. (2024, October 24). County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/trauma-informed-health-care

[10] Naloxone education and distribution programs. (2024, April 22). County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/naloxone-education-distribution-programs

Priority Area: Chronic Diseases and Conditions

Chronic Diseases and Conditions – Why Address It?

Chronic diseases, such as heart disease, cancer, diabetes, and obesity are among the leading causes of death and disability in the United States.[11] These conditions last one year or more and typically require ongoing medical care or limit daily activities. In 2023, nearly 6 in 10 U.S. adults live with at least one chronic disease, and 4 in 10 live with two or more, making chronic disease prevention and management an urgent public-health priority.[12] Although many chronic diseases are prevalent, a considerable number are preventable and frequently influenced by modifiable lifestyle risk factors such as tobacco use, excessive alcohol consumption, physical inactivity, and poor nutrition. Additionally, social and environmental conditions can magnify these challenges.

Chronic conditions often develop gradually, and early issues such as high blood pressure, high cholesterol, or obesity can progress to more serious illnesses including cardiovascular disease, chronic respiratory disease, diabetes, certain cancers, and arthritis.[13] Additional contributors, including chronic stress, limited access to healthy foods and safe spaces for exercise, unstable housing, economic hardship, and the health impacts of an aging population further exacerbate such risk factors.[14] For example, individuals living in food deserts may struggle to obtain fresh produce and healthy options, leading to poor dietary habits and associated health issues, and residents facing chronic stress from financial instability or unsafe housing may have less capacity to engage in preventive health measures, creating a cycle of declining health. Together, these factors not only impact individual well-being, but also influence health care costs and reduce productivity across families, workplaces, and communities, underscoring the importance of prevention and early management throughout the life course.[15] Chronic disease also intersects with mental and behavioral health, as individuals managing long-term conditions frequently experience stress, anxiety, or depression, which can limit motivation and make daily disease management more challenging.[16] Health literacy further influences this relationship, as individuals with limited understanding of their condition or care instructions may struggle to follow treatment plans, monitor symptoms, or seek timely assistance, increasing the risk of complications.[17]

[11] About chronic diseases. (2024, October 4). Chronic Disease. Retrieved September 11, 2025, from https://www.cdc.gov/chronic-disease/about/index.html

[12] Watson, K. B., Wiltz, J. L., Nhim, K., Kaufmann, R. B., Thomas, C. W., & Greenlund, K. J. (2025). Trends in multiple chronic conditions among US adults, by life Stage, Behavioral Risk Factor Surveillance System, 2013–2023. Preventing Chronic Disease, 22. https://doi.org/10.5888/pcd22.240539

[13] World Health Organization: WHO. (2024, December 23). Noncommunicable diseases. https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases

[14] Garg, R. K. (2025). The alarming rise of lifestyle diseases and their impact on public health: A comprehensive overview and strategies for overcoming the epidemic. *Journal of Research in Medical Sciences*, *30*(1). https://doi.org/10.4103/jrms.jrms_54_24

[15] World Health Organization: WHO. (2024, December 23). *Noncommunicable diseases*. https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases

[16] *Understanding the link between chronic disease and depression*. (n.d.). National Institute of Mental Health (NIMH). Retrieved November 13, 2025, from https://www.nimh.nih.gov/health/publications/chronic-illness-mental-health

[17] Wieczorek, M., Meier, C., Vilpert, S., Reinecke, R., Borrat-Besson, C., Maurer, J., & Kliegel, M. (2023). Association between multiple chronic conditions and insufficient health literacy: cross-sectional evidence from a population-based sample of older adults living in Switzerland. *BMC Public Health*, *23*(1), 253. https://doi.org/10.1186/s12889-023-15136-6

The Healthy St. Lucie Steering Committee chose Chronic Diseases and Conditions as a top priority area to improve residents' quality of life. The following table highlights high-level CHA data findings that further support the prioritization of chronic diseases and conditions:

Chronic Diseases and Conditions CHA Findings	
Community Context Assessment Findings	• Concerns about obesity, diabetes, high blood pressure, heart disease and respiratory issues • Shortage of providers and long wait times for appointments • Limited access to nutritious food and safe, free spaces for physical activity • Highlighted need for nutrition education
Community Status Assessment Findings	• In 2023, heart disease and chronic lower respiratory disease (CLRD) were among the top five leading causes of death in St. Lucie County[ii] • In 2023, the rate of heart disease in St. Lucie County was 144.2 per 100,000 population [ii] • In 2023, the rate of CLRD in St. Lucie County was 34.7 per 100,000 population[ii] • In 2023, only 18.5% of residents lived within a ½ mile of a healthy food source[iii]
Community Partner Assessment Findings	• 43.5% of organizations who participated in the CPA work in the chronic disease space covering topics such as asthma, diabetes, obesity, cardiovascular diseases and more
Prioritization Discussions	• The Steering Committee discussed screening capacity and limitations, noting that while basic screenings for blood pressure, oxygen levels, diabetes, and other indicators are available at health fairs, more advanced screening options may be needed. • The Steering Committee also highlighted cancer care challenges, including delayed diagnoses, insurance gaps, high costs, and limited access to advanced screening services. • The Steering Committee noted that promoting healthy lifestyles, such as nutrition, physical activity, and vaccinations, continues to be a priority for the partners. • Partners emphasized ties to health literacy and health education, noting that residents need consistent and ongoing support, as one-time resources are not sufficient.

[ii]Source: Florida Agency for Healthcare Administration (AHCA), 2023

[iii]Source: Florida Department of Health, Florida Environmental Public Health Tracking, 2022

Chronic Diseases and Conditions – Priority Area Action Plan

The following table details the goals, strategies, objectives, activities, and key action steps that will guide community action through the CHIP. The table also provides insight into plan alignment with Healthy People 2030 and the Florida State Health Improvement Plan (SHIP).

<table>
<tr><th colspan="5">St. Lucie CHIP Priority Area: Chronic Diseases and Conditions</th></tr>
<tr><td colspan="5">Goal 2.A: Increase quality of life for St. Lucie County residents by enhancing policies, systems, and environments that support healthy decision-making.</td></tr>
<tr><td colspan="5">Strategy 2.A.1: Support system-level and environmental interventions that promote healthy decision-making for St. Lucie County residents.</td></tr>
<tr><td colspan="3">Objective 2.A.1.1: Decrease the age-adjusted rate of hospitalizations from coronary heart disease from 281.4 per 100,000 population in St. Lucie County in 2024 to 160.4 per 100,000 population in 2030. [Source: FL Health CHARTS, AHCA]
Objective 2.A.1.2: Decrease the age-adjusted rate of hospitalizations from hypertension from 426.8 per 100,000 population in St. Lucie County in 2024 to 405.0 per 100,000 population in 2030. [Source: FL Health CHARTS, AHCA]
Objective 2.A.1.3: Decrease the age-adjusted rate of hospitalizations from diabetes from 274.3 per 100,000 population in St. Lucie County in 2024 to 266.0 per 100,000 population in 2030. [Source: FL Health CHARTS, AHCA]</td><td colspan="2">Alignment:
Florida SHIP: CD 2.1, CD2.4, CD4.1, CD4.2
Healthy People 2030: HDS-01, HDS-02, D-06, D-07, D-09</td></tr>
<tr><th>Activities</th><th>Key action steps</th><th>Measures</th><th>Key partners</th><th>Timeframe</th></tr>
<tr><td>Support clinics in implementing best practices for blood pressure, diabetes, and cholesterol control
*policy effort</td><td>• Provide technical assistance to clinics in identifying and addressing opportunities to implement best practices
• Support clinics in their progression through recognition tiers</td><td># clinics recognized

patients impacted</td><td>• American Heart Association
• Whole Family Health Center</td><td rowspan="3">January 2026 – December 2030</td></tr>
<tr><td>Promote worksite wellness among organizations
*policy effort</td><td>• Promote the American Heart Association Wellbeing Works Better wellness award to employers in the county
• Provide technical assistance in implementing and achieving worksite wellness initiatives</td><td># worksites awarded

employees impacted</td><td>• American Heart Association
• St. Lucie County Public Schools
• Indian River State College</td></tr>
<tr><td>Support community sites in increasing capacity to serve food and provide nutrition education
*environmental resiliency effort</td><td>• Provide technical assistance and resources to community sites to strengthen infrastructure (e.g. fridge, shelving, pantry on site) needed to distribute food</td><td># community sites engaged

people served</td><td>• American Heart Association</td></tr>
</table>

Goal 2.B: Promote physical wellbeing through healthy lifestyle choices.				
Strategy 2.B.1: Build community capacity through health education and programming to support the prevention and management of chronic diseases.				
• **Objective 2.B.1.1:** Reduce the percentage of St. Lucie County middle and high school students who are overweight or obese from 31.4% in 2024 to 26.0% in 2030 [Source: FL Health CHARTS, FYTS] • **Objective 2.B.1.2:** Increase the proportion of St. Lucie County adults who are at a healthy weight from 26.1% in 2022 to 27.0% in 2030 [Source: FL Health CHARTS, BRFSS] *Data note: The Healthy St. Lucie Advisory Committee acknowledges data limitations in behavioral data and recognizes that overweight, obesity, and healthy weight are not the only indicators of lifestyle choices and healthy decision-making as it relates to chronic diseases and conditions.*			**Alignment:** Florida SHIP: ISV2.2, Florida SHIP - CD6.1, CD6.2 Healthy People 2030: NWS-03, NWS-04	
Activities	**Key action steps**	**Measures**	**Key partners**	**Timeline**
Increase awareness of existing programs and services to promote healthy lifestyles such as those available in childcare and school settings	• Research and develop an inventory of existing local programs and services • Promote programs and services on social media • Provide technical assistance and awareness trainings to youth-serving programs	Inventory completed # social media posts # of TA sessions provided	• Roundtable Healthy Weight Subcommittee	January 2026 – December 2030
Provide physical fitness education and resources for seniors	• Promote workshops such as Matter of Balance, Tai Chi, and others • Engage residents in educational workshops	# participants	• Area Agency on Aging Palm Beach/Treasure Coast	
Provide healthy eating education and resources	• Promote classes for residents • Engage residents in educational workshops	# participants	• Area Agency on Aging of Palm Beach/Treasure Coast • Indian River State College • Treasure Coast Food Bank • Serendipity Therapeutic Massage and Body Work • Florida Department of Health in St. Lucie County • Caribbean American Cultural Club • United Against Poverty	

Support clinical and community sites with blood pressure stations or loaner programs	• Identify potential clinic and community sites • Provide technical assistance and support the implementation of blood pressure stations or loaner programs at sites	# sites # people served by sites # people utilizing BP monitors at AHA supported sites	• American Heart Association	
Provide education and technical assistance to local Early Learning Centers through the Go NAPSACC (Nutrition And Physical Activity Self-Assessment for Child Care) platform	• Identify local early learning centers • Provide support and technical assistance	# ECEs registered # children served by those ECEs	• Florida Department of Health in St. Lucie County	

Chronic Diseases and Conditions – Best Practices and Evidence-Supported Initiatives

Community-Based Social Support for Physical Activity

Community-based social support for physical activity is an evidence-supported approach that links physical activity opportunities with peer encouragement to help residents adopt and sustain healthy movement habits. This strategy creates walking groups, exercise buddy systems, and group goal-setting or activity plans, often with educational or counseling components, to maintain motivation and accountability. The expected benefits include increased physical activity, improved physical fitness, and better overall health outcomes.[18] By making exercise enjoyable and socially connected, these programs help residents sustain active lifestyles and reduce risk for chronic diseases.

Activity Programs for Older Adults

Activity programs for older adults are evidence-based group programs that provide educational, creative, musical, social, or physical activities to promote social connection and regular participation. This strategy offers opportunities for engagement that reduce isolation and support both mental and physical health, fostering well-being in later life. The expected benefits include improved overall health outcomes, enhanced mental health, reduced isolation, and better quality of life.[19]

Nutrition and Physical Activity Interventions in Preschool and Child Care

Nutrition and physical activity interventions in preschool and child care are evidence-supported programs that give young children daily opportunities to eat nutritious foods and be physically active. This strategy provides fruits, vegetables, and other healthy foods with simple nutrition education, trains teachers to integrate movement into routines, and improves play spaces while following policies on screen time and physical activity. The expected benefits include improved nutrition, increased physical activity, and healthier weight status, with potential gains in fruit and vegetable consumption and overall physical fitness.[20]

Worksite Obesity Prevention Interventions

Worksite obesity prevention interventions are evidence-supported, multi-component efforts that combine education, environmental changes, healthy food access, and opportunities for physical activity to support healthier behaviors among employees. These strategies may include improving vending or cafeteria options, offering activity opportunities such as walking or standing workstations, and providing materials or counseling that encourage sustained lifestyle change. The expected benefits include increased physical activity and healthier food consumption, with potential improvements in weight status, productivity, and employee well-being.[21]

---

[18] Community-based social support for physical activity. (2024, December 17). County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/community-based-social-support-for-physical-activity

[19] Activity programs for older adults. (2025, April 24). County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/activity-programs-for-older-adults

[20] Nutrition and physical activity interventions in preschool & child care. (2020, January 30). County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/nutrition-and-physical-activity-interventions-in-preschool-child-care

[21] *Worksite obesity prevention interventions*. (2018, April 3). County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/worksite-obesity-prevention-interventions

Priority Area: Health Literacy

Health Literacy – Why Address It?

Health literacy is the ability to find, understand, and use information and services to make informed health decisions. This concept goes beyond reading ability to include listening, speaking, numeracy, and navigation skills that help people follow medical instructions, understand test results, access preventive care, and make healthy decisions. When health information is difficult to locate or understand, individuals may delay needed care, misunderstand medication instructions, or struggle to manage chronic conditions. Low health literacy has been associated with higher rates of hospitalization, increased use of emergency care, and higher healthcare costs.[22]

Notably, health literacy is a pivotal element as residents seek to prevent and manage chronic illnesses, respond to emerging public health threats, and access behavioral and mental health services. Limited understanding of how to use the health system can lead to missed screenings, late diagnoses, and avoidable complications from conditions such as diabetes, hypertension, and heart disease. Additionally, low health literacy can hinder the uptake of preventive measures, such as cancer screenings, ultimately contributing to poorer health outcomes at the population level.[23] Education levels, language barriers, and limited access to reliable information all play a role, as do other factors such as poverty, housing instability, and inadequate access to the internet or technology.[24] Importantly, strengthening health literacy involves clear communication, materials written in plain-language and available in multiple languages, as well as supportive community networks.[25]

[23] Coughlin, S. S., Vernon, M., Hatzigeorgiou, C., & George, V. (2020, December 16). Health literacy, social determinants of health, and disease prevention and control. https://pmc.ncbi.nlm.nih.gov/articles/PMC7889072/

[24] *Language and Literacy - Healthy People 2030 | odphp.health.gov*. (n.d.). https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/language-and-literacy

[25] Caeiros, P., Ferreira, P. P., Chen-Xu, J., Francisco, R., & De Arriaga, M. T. (2024). From Health Communication to Health Literacy: A Comprehensive Analysis of Relevance and Strategies. Portuguese Journal of Public Health, 42(2), 159–164. https://doi.org/10.1159/000537870

The Healthy St. Lucie Steering Committee selected Health Literacy as a top priority area to increase access, understanding, and action among residents when it comes to health information. The following table highlights high-level CHA data findings that further support the prioritization of health literacy:

Health Literacy CHA Findings	
Community Context Assessment Findings	• A strong need for health literacy education and workplace wellness • Coordination between agencies to improve navigation of services • Difficulty navigating healthcare due to language barriers • Lack of awareness of available resources and services
Community Status Assessment Findings	• In 2023, the rate of preventable hospital stays in St. Lucie County was 1,155.8 per 100,000 population[iv] • In 2023, 23.8% of St. Lucie County residents spoke a language other than English at home[v] • In 2023, 30.7% of residents aged 25 years and older completed high school (or equivalent)[vi]
Community Partner Assessment Findings	• 35.0% of participating organizations have a focus on health literacy • 56.0% of participating organizations shared that their organization had access to interpretation and translation services
Prioritization Discussions	• The Steering Committee noted that resident education must extend beyond resource sharing and health fairs, and partners emphasized the need for tools and information that support personal decision-making. • Partners noted that many residents are not fully aware of available resources or encounter difficulties navigating the system, and shared that language differences and communication gaps between residents and providers may hinder access and understanding. • The Steering Committee highlighted the importance of credible sources in communicating health education.

[iv]Source: Florida Agency for Healthcare Administration (AHCA), 2023

[v]Source: U.S Census Bureau, American Community Survey, DP02, 5-Year Estimate, 2023

[vi]Source: U.S. Census Bureau, American Community Survey, S1501, 5-Year Estimate, 2023

Health Literacy – Priority Area Action Plan

The following table details the goals, strategies, objectives, activities, and key action steps that will guide community action through the CHIP. The table also provides insight into plan alignment with Healthy People 2030 and the Florida State Health Improvement Plan (SHIP).

St. Lucie CHIP Priority Area: Health Literacy				
Goal 3.A: Improve St. Lucie County residents' capacity to access, understand, and use health information to make informed decisions.				
Strategy 3.A.1: Increase access to accurate, plain-language health information.				
Objective 3.A.1.1: Increase the proportion of adults who had a medical checkup in the past year from 77.3% in 2022 to 80.0% in 2030 [Source: FL Health CHARTS, BRFSS]			**Alignment:** • Florida SHIP: SEF2.2 • Healthy People 2030: AHS-08	
Activities	**Key action steps**	**Measures**	**Key partners**	**Timeframe**
Expand community engagement to promote Health Literacy	• Promote health literacy workshops across the community • Provide workshops/trainings to residents	# residents engaged # trainings held	• Indian River State College • Access FL	January 2026 – December 2030
Promote resources and tools that increase access to credible materials such as Health Hubs	• Produce or gather health informational materials in plain-language • Identify additional organizations to promote materials • Use trusted community figures to communicate messages • Promote materials and resources via various media, including digital and written modalities	# of sites with a Health Hub	• St. Lucie Roundtable • Florida Department of Health in St. Lucie County • St. Lucie County faith-based organizations • Indian River State College • Access FL • Caribbean American Cultural Group	

Promote access to community screenings at events, such as community health fairs	• Identify organizations who offer screenings • Identify potential host sites for screenings • Build organizational capacity to track the number of residents screened and follow up on needed care • Increase community awareness of available screenings through promotion and outreach through various channels such as social media, trusted community organizations, radio, and more	# screening events	• Florida Department of Health in St. Lucie County • Caribbean American Cultural Group • New Horizons • Serendipity Therapeutics Massage and Body Work • Indian River State College • Treasure Coast Links	
Goal 3.B: Expand organizational capacity to improve the health literacy of residents.				
Strategy 3.B.1: Unify community and organizational efforts to improve understanding of health information and services.				
• **Objective 3.B.1.1:** Reduce ambulatory care sensitive hospitalizations from all conditions (aged 0-64 years) from 1,155.8 per 100,000 population (aged 0-64 years) in 2023 to 1,045.0 per 100,000 population (aged 0-64 years) in 2030 [Source: FL Health CHARTS, AHCA]			**Alignment:** • Florida SHIP: CD4.2	
Activities	**Key action steps**	**Measures**	**Key partners**	**Timeframe**
Develop a Health Literacy Advocate Training program for health care organizations and personnel including community health workers and students in health professions	• Develop the program curriculum • Identify possible Continuing Education credits • Train community partners as Health Literacy advocates	Curricula developed	• Indian River State College • Access Florida	January 2026 – December 2030
Engage local leaders and other key stakeholders to stay informed about CHIP Health Literacy efforts	• Identify potential organizations • Connect with organizations • Engage organizations in the CHIP	# partners engaged	• Healthy St. Lucie Health Literacy Workgroup	
Support residents in navigating health systems and resources	• Engage local health and human service partners • Promote enrollment assistance services among their clients • Identify and engage key partners who provide enrollment assistance	# residents assisted	• Access FL • Area Agency on Aging Palm Beach/Treasure Coast	

Health Literacy – Best Practices and Evidence-Supported Initiatives

Health Literacy Interventions

Health literacy interventions are evidence-based approaches designed to help people obtain, process, and understand essential health information and services needed to make informed health decisions. This strategy improves patient-provider communication, simplifies written and verbal instructions, provides easy-to-read educational materials, offers eHealth tools such as videos and interactive self-help programs, and strengthens basic literacy skills. The expected benefits include improved health-related knowledge and better adherence to treatment, with potential benefits such as enhanced patient-provider communication, improved mental health, and increased patient satisfaction.[26]

Health Insurance Enrollment Outreach and Support

Health insurance enrollment outreach and support programs are evidence-based approaches that help residents understand and access affordable coverage through clear guidance, one-on-one navigation, and community-based enrollment assistance. This strategy connects individuals to trusted partners who can explain eligibility, assist with applications, and provide follow-up support to ensure coverage is maintained. The expected benefits include increased enrollment in health insurance or benefit programs, improved understanding of available options, and strengthened access to preventive and primary care services.[27]

Community Health Workers

Community Health Workers are evidence-supported frontline professionals who bridge the gap between health systems and communities by providing outreach, education, and assistance. This strategy uses trusted messengers to share plain-language materials, promote available resources, and support residents in navigating care and community systems. The expected benefits include increased health knowledge, greater engagement in preventive care, and improved ability for residents to access and use local health and human service resources.[28]

[26] Health literacy interventions. (2019, May 23). County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/health-literacy-interventions
[27] Health insurance enrollment outreach & support. (2022, March 24). County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/health-insurance-enrollment-outreach-support
[28] Community health workers. (2023, February 6). County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/strategies-and-solutions/what-works-for-health/strategies/community-health-workers

Sustainability of Efforts

The 2025–2030 St. Lucie County Community Health Improvement Plan (CHIP) was developed by a collaborative group of stakeholders comprising the Healthy St. Lucie Steering Committee, the Florida Department of Health in St. Lucie County, and HCSEF. Notably, the Healthy St. Lucie Steering Committee will oversee implementation, monitor progress, align strategies, and adjust efforts in response to changing health trends and community needs. This group will be responsible for implementation of plan, and they will meet regularly to discuss the work and consider sustainability of efforts. As a living document, the CHIP will be updated annually to incorporate feedback, as appropriate, from residents and stakeholders. The group will also work to make updates, as needed, to strengthen partnerships, address emerging needs, and consider the sustainability of efforts throughout the course of the five-year plan.

Tracking Progress

The Healthy St. Lucie Steering Committee will meet regularly throughout the five-year implementation period to review progress towards established goals, objectives, and strategies. During these meetings, the group will discuss updates on objective and activity measures, as available, from local data sources and key partners. These measures will be tracked throughout the CHIP to determine progress and continually assess impact. Throughout the process, partners may determine that plan updates are needed to address evolving needs, align resources, and improve outcomes. Any updates made to the plan will be documented in meeting materials to ensure consistent and clear communication of progress to all partners, stakeholders, and residents. Meeting attendees will also have an opportunity to share updates on current activities they are participating in to foster new discussion and collaboration across agencies. Additional communication and collaboration between meetings will be encouraged. Additionally, throughout the CHIP cycle, the Healthy St. Lucie Steering Committee will gather input and feedback from partners and community members to ensure that activities remain effective and aligned with community priorities. Formal annual updates will incorporate the most recent data and findings, and any revisions to the plan will be reviewed and approved by the Healthy St. Lucie Steering Committee before being published with the annual report.

Get Involved

The 2025–2030 St. Lucie County Community Health Improvement Plan (CHIP) is the product of community input and engagement. The Healthy St. Lucie Steering Committee welcomes the participation of residents, stakeholders, and community organizations who wish to support ongoing health initiatives, share resources, or contribute new ideas that strengthen the plan's impact.

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

Stefanie Myers
Community Health Planner
Florida Department of Health in St. Lucie County
5150 NW Milner Drive
Port St. Lucie, FL 34983
772-873-4923