

# 2025 COMMUNITY HEALTH ASSESSMENT

Executive Summary



## Letter from the Health Administrator

Dear Residents of Nassau County,

It is my honor to present to you the 2025–2030 **Community Health Assessment (CHA)**, a powerful reflection of where we stand as a community and where we have the opportunity to grow.

At the Florida Department of Health in Nassau County, we believe that every resident deserves the chance to live a healthy, connected, and meaningful life. That belief guided every step of this CHA process. From town halls to surveys, interviews to data dashboards, we listened. We learned. And most importantly, we asked: What do we need to do together to build a healthier future?

This report answers that question with honesty and clarity. It highlights real concerns: barriers to care, transportation challenges, rising mental health needs, and gaps in preventive services. It also shines a light on our strengths: strong schools, dedicated providers, and a community that cares deeply about its neighbors.

The CHA process, guided by the nationally recognized MAPP 2.0 framework, combined rigorous data with lived experience. It reflects your voice, your priorities, and your resilience. Our next step is clear. With this assessment in hand, we will work side-by-side with our partners to shape a **Community Health Improvement Plan (CHIP)** that turns insight into action. One that invests in the people and places who need it most.

To every resident who completed a survey, shared a story, or showed up, we thank you. Your input is the foundation of this work.

Together, we can build a Nassau County where health is not a privilege, but a promise kept for every single one of us.

In Service,

*Cara Gluck, MPH*

Health Administrator Florida Department of  
Health in Nassau County



# How to Use This Report

## *A Clear, Actionable Guide for Everyone in Nassau County*

This report was written for *you*, the people who live, work, serve, and lead in Nassau County. It's more than charts and data. It's a tool to help us create real, lasting change.

Whether you're a concerned parent, a nonprofit leader, a business owner, or a neighbor who just wants to understand what's going on, this report will help you see where we are and where we need to go together.

### What You'll Find Inside

*This report includes:*

- **Your voice:** What more than 5,000 residents shared through surveys, interviews, and focus groups.
- **Our data:** The facts about health, access, and community conditions across Nassau County.
- **Shared challenges:** That's getting in the way of health and opportunity for our neighbors.
- **Clear priorities:** The top three health areas we'll focus on between 2025–2030.
- **Next steps:** How we'll use this assessment to shape solutions and action plans.

### How to Read This Report

We've made this report easy to understand, no public health degree needed.

*You'll find:*

- Plain language and story-driven highlights.
- Sidebars and quotes from real residents
- Infographics that explain key findings at-a-glance.
- Clear takeaways so you can act, share, and lead.

**Who Is This For?** This CHA is designed for **residents** who want to better understand their community; **organizations** working to improve health, housing, food access, and more; **local governments and funders** seeking direction for investment; and **schools, churches, and businesses** who want to contribute to real solutions.

### What Can You Do Next?

*Read with curiosity:*

Share it with others in your network

Look for yourself and your neighbors in the data

Join the conversation, because change starts with awareness

# Our Community At-a-Glance

## *A Snapshot of Who We Are and How We Live in Nassau County*

Nassau County is a place where tradition meets growth, where rural roads lead to beaches, schools are deeply connected to neighborhoods, and families know their neighbors by name. But it’s also a place where access to care, rising costs, and long travel times create barriers that can no longer be ignored. This Community Profile provides a picture of *who* lives here, *how* we’re doing, and *what conditions shape our health*.

Population	90,000+ Residents and Growing Steadily Each Year
Geography	Rural, suburban, and coastal communities
Households	41% are ALICE (Asset Limited, Income Constrained, Employed)
Age	Older adults (65+) make up nearly 22% of residents
Race/Ethnicity	84% White, 8% Black, 5% Hispanic/Latino, 1% Asian, 2% Multiracial
Veterans	8.6% of adult residents

**What This Means:** Nassau is aging, working-class, and mostly rural, with growing pockets of racial, cultural, and economic diversity.

**How We Work and Learn**

**Median household income:** ~\$74,000  
**Top industries:** Education, healthcare, manufacturing, retail, logistics  
**High school graduation rate:** 93.1% (above FL average)  
**Preschool enrollment (ages 3-4):** 39.2% (below FL average of 46.1%)

**Where and How We Live**

**Homeownership rate:** 78%  
**Mobile homes:** 14% of all housing  
**Median rent:** \$1,300/month  
**Renters spending 30%+ of income on housing:** 36%  
**Households without a vehicle:** 6.8%



## Our Daily Realities

**SNAP participation:** 10.8%

**Broadband access:** 88%, but with major gaps in speed and affordability in rural ZIP codes

**Well & septic use:** 23% of homes use private systems, not municipal water

**Top reported barriers to health:**

- ◆ Transportation
- ◆ Cost of care
- ◆ Mental health access
- ◆ Limited provider availability



# What We Heard from You

## *The Heart of This Report Starts Here*

This report wouldn't exist without the people of Nassau County. More than 5,000 voices shaped every page, from local leaders to working parents, students, seniors, and volunteers.

We asked:

- What keeps you healthy?
- What gets in the way?
- What would make the biggest difference?

You answered with honesty, insight, and urgency.

### Getting There is a Barrier

"If you don't have a car or can't drive, you're stuck."

- 30-45 minute drives to the nearest provider (common in western Nassau)
- 6.8% of households have no access to a vehicle
- No full-service public transit system
- Missed appointments due to transportation and gas costs

### Mental Health Needs Are Growing

"There's so much stress, and so few places to turn."

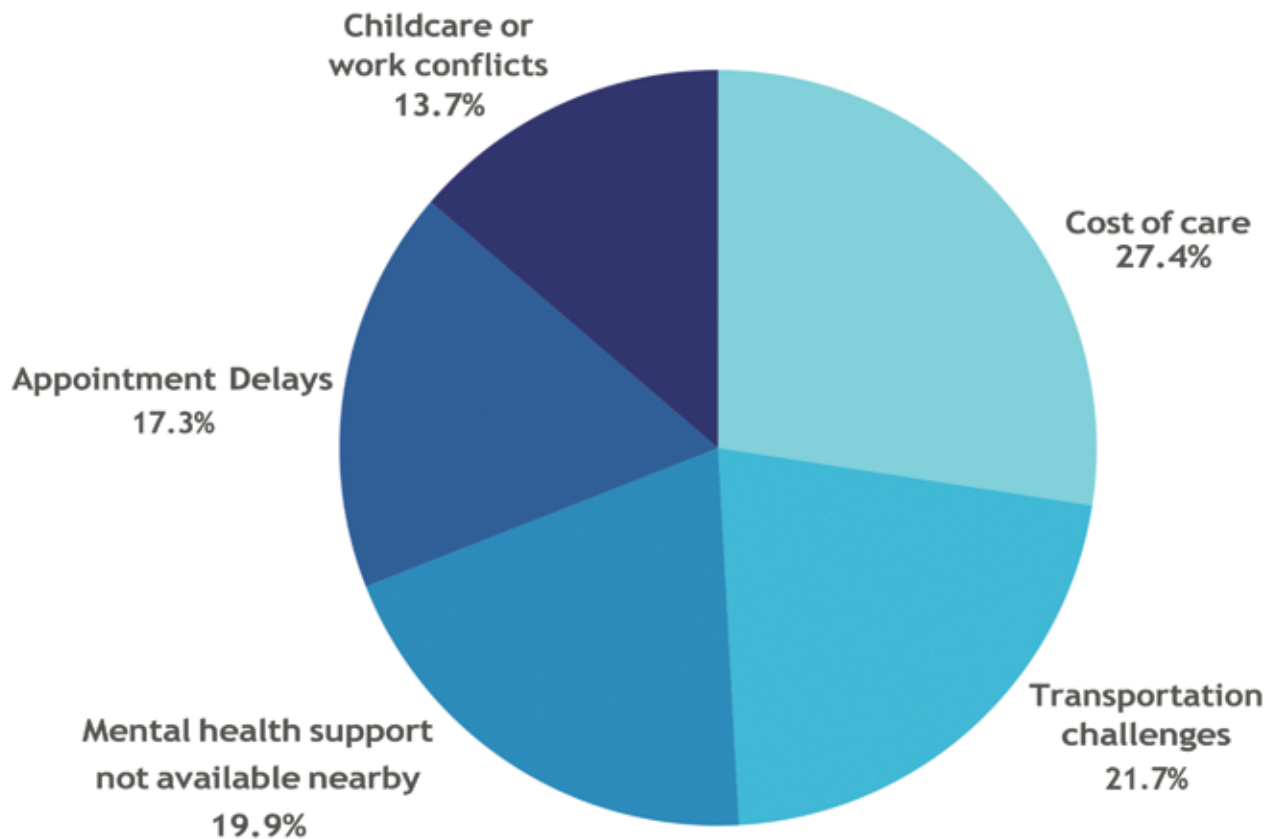
- Long wait times for counseling or psychiatric care
- Shortages of bilingual, trauma-informed, and school-based providers
- Stigma still prevents many from asking for help
- Caregiver burnout and youth anxiety were top concerns

### Preventative Care Often Comes Too Late

"People don't go unless they're very sick, because they can't afford to."

- Wellness visits, cancer screenings, and dental care underused
- 67.1% of pregnant people receive early prenatal care (HP2030 goal = 80.5%)
- Working adults report missing appointments due to cost or scheduling

<p><b>Targeted Support for Seniors</b></p>	<p>“We’re seeing more and more seniors who need specialized care, but we don’t have the infrastructure to meet those needs.”</p> <ul style="list-style-type: none"> <li>• Aging population support is needed, including in-home care and caregiver relief</li> <li>• A significant portion of residents are aged 65 or above which has implications for healthcare (greater needs for senior services, chronic disease management, etc.)</li> </ul>
<p><b>People Want Care That Meets Them Where They Are</b></p>	<p>“We need mobile care. School clinics. Places we can actually get to.”</p> <ul style="list-style-type: none"> <li>• Strong demand for services closer to home, in trusted spaces</li> <li>• Interest in mobile units, school-based care, and after-hours appointments</li> <li>• Residents emphasize the need for culturally relevant and accessible options</li> </ul>



# What We Heard from Partners

## *Insights from the People Working on the Front Lines of Health Every Day*

Behind every clinic, classroom, food pantry, and church in Nassau County is someone who sees the system up close. We spoke directly with 22 cross-sector partners, including healthcare providers, educators, housing advocates, law enforcement, behavioral health counselors, and nonprofit leaders.

**Their message was clear:** The barriers are real. The needs are rising. And the opportunity for change is now.

<p><b>Mental Health Is a Crisis, Not a Category</b></p>	<p>“Our kids are not okay. Our seniors are isolated. We don’t have enough trained people to help.”</p> <ul style="list-style-type: none"><li>• Long wait times (6-12 weeks) for behavioral health appointments</li><li>• ER visits for mental health are rising: 85.1 per 10,000 (FL avg = 74.3)</li><li>• No in-county psychiatric hospital; many youth referred out-of-county</li><li>• Partners reported youth suicide ideation, caregiver burnout, and trauma across all age groups</li></ul>
<p><b>Preventive Care Is Delayed Until It Becomes a Crisis</b></p>	<p>“We see people show up in the ER for things that could’ve been prevented with early care.”</p> <ul style="list-style-type: none"><li>• Diabetes hospitalizations: 172.3 per 100,000</li><li>• Early prenatal care: 67.1% (HP2030 goal = 80.5%)</li><li>• Many families are unaware of available screenings or free programs</li><li>• Behavioral care and dental services often require travel and time off work</li></ul>

**Transportation Is a System-Wide Limiter**

“Everything goes back to transportation. If you can’t get there, you can’t get help.”

- 6.8% of households have no vehicle. No county-wide public transit system
- Providers cite high no-show rates due to distance or car trouble
- Social services, counseling, and even job training are often out of reach

**Infrastructure Gaps Undermine Health Progress**

“We’re growing fast, but our roads, water systems, and broadband aren’t keeping up.”

- 23% of homes rely on well/septic, creating safety and cost issues
- Broadband access remains unreliable in rural ZIPs
- New housing growth is outpacing infrastructure upgrade

Mental Health	Preventive Care	Access & Infrastructure
85.1 mental health ER visits/10K	67.1% early prenatal care	6.8% of homes with no vehicle
No in-county psych beds	172.3 diabetes hospitalizations/100K	23% of homes rely on well/septic
Long wait times, lack of bilingual care	Missed screenings, delayed diagnosis	Broadband gaps in west/north Nassau

# The Real-Life Barriers We Face

## *Where Health Meets Real Life in Nassau County*

This assessment revealed what many already know: Nassau County is full of hardworking families, generous neighbors, and committed providers. But too often, the systems we rely on are stretched too thin, or too far away, to keep up.

The most persistent barriers reported in surveys, interviews, and meetings weren't abstract. They were real, everyday challenges with real consequences.

### **Barrier #1: Distance + Time = Delayed or Missed Care**

"If it's 45 minutes each way and you're taking unpaid time off work, you just don't go."

- Western Nassau residents report 30–45 minute travel times to the nearest providers
- 6.8% of households have no vehicle
- Lack of full-service public transit leaves many isolated
- 49% of surveyed residents cited transportation as a top barrier to care

### **Barrier #2: Working Families Are Falling Through the Cracks**

"We don't qualify for help, but we can't afford to get sick."

- 41% of households are ALICE (Asset Limited, Income Constrained, Employed)
- 62% of survey respondents cited cost as a barrier, even with insurance
- 36% of renters are cost-burdened (spend 30%+ of income on housing)
- 10.8% rely on SNAP, while many others earn just above the cutoff

### **Barrier #3: Mental Health Is Hard to Access, And Talk About**

"We need help, but we're scared to ask. And there's nowhere close to go."

- Youth and caregiver stress topped focus group concerns
- Waitlists for mental health care can stretch over 2 months
- No inpatient psychiatric facility in-county
- 85.1 ER visits per 10,000 for behavioral health, above state average

### **Barrier #4: Infrastructure That Can't Keep Up**

"Some families don't have clean water or fast internet. How can they manage their health?"

- 23% of homes use private wells and septic, raising cost and contamination risks
- Broadband access is below 80% in northwest Nassau
- Residents report spotty internet and slow speeds, even when coverage maps say "served"
- New developments often outpace utility and road upgrades

<p><b>Transportation</b></p>	<p><b>Working Families</b></p>
<p>6.8% have no vehicle 49% cite transportation as a barrier</p>	<p>41% of households are ALICE 62% cite cost of care as a barrier</p>
<p><b>Mental Health</b></p>	<p><b>Infrastructure</b></p>
<p>85.1 ER Visits per 10K for mental health Waitlists up to 12 weeks</p>	<p>23% rely on well/septic Broadband gaps in rural ZIP codes</p>

“Barriers stack up. If you don’t have a car, can’t miss work, and the clinic’s too far your health takes a back seat.”  
– Resident, Hilliard



# The Health of Our County At-a-Glance

## *A Check-Up on the Health of Nassau County, and Where We're Headed*

The Community Status Assessment (CSA) uses hard data to answer an important question: *How healthy are we, really?* It looks at key indicators like screenings, ER visits, chronic disease, and access to care, comparing Nassau County to the rest of Florida and national goals.

The bottom line: Nassau is doing well in some areas, but we're falling behind in others, especially when it comes to **mental health, preventable hospital visits, and early intervention.**

### Screenings & Preventive Care

Indicator	Nassau	FL Avg	HP2030
Child Wellness Visits (0-5)	72.5	78.1%	80.0%
Early Prenatal Care (1st Trimester)	67.1%	69.3%	80.5%
Colorectal Cancer Screening (50-75)	66.8%	68.4%	74.4% (C-09)
Adult Dental Visit (past 12)	59.0%	61.7%	74.0% (OH-08)

### Emergency Room & Mental Health Trends

Indicator	Nassau	FL Avg	HP2030
Mental Health ER Visits (per 10,000)	85.1	74.3	↓ (MHMD-01, MHMD-04)
Behavioral Health Wait Time (local est.)	6-12 weeks	N/A	N/A
Suicide-Related ER Visits (Youth)	↑ (local report)	N/A	↓ (MHMD-01)

## Preventable Hospitalizations

Condition	Nassau Rate/100K	FL Rate/100K	HP2030 Target (where applicable)
Diabetes	172.3	149.8	150.0 (D-05)
Asthma	89.6	78.4	75.0 (RD-02)
Hypertension	154.0	133.2	143.0 (HDS-06)
COPD	185.1	161.5	N/A



## Preventable Conditions & ER Trends

### *When Gaps in Care Become Costly, and Dangerous*

One of the clearest warning signs in any community's health system is the number of people who end up in the **emergency room for conditions that could have been prevented**. In Nassau County, those warning signs are flashing.

Hospital data and state comparisons show a steady increase in **chronic disease complications, mental health crises, and ER reliance** on issues that could be treated earlier with access to consistent, affordable care.

### Preventable Hospitalizations

Condition	Nassau Rate/100K	FL Rate/100K	HP2030 Target
Diabetes Complications	172.3	149.8	150.0 (D-05)
Asthma	89.6	78.4	75.0 (RD-02)
Hypertension (HTN)	154.0	133.2	143.0 (HDS-06)
COPD	185.1	161.5	N/A

### Mental Health ER Usage

Indicator	Nassau	FL Avg	HP2030 Target
Mental Health ER Visits (per 10,000)	85.1	74.3	↓ (MHMD-01, -04)
Youth Suicide Ideation (ER reports)	Elevated	N/A	↓ (MHMD-01)
Local Provider Waitlist (estimate)	6 - 12 Weeks	N/A	N/A

# Access to Care, Screenings & Prevention

## *Early Care Saves Lives. But Too Many Are Missing It.*

In a healthy system, people get checkups before problems start. They get screenings early. They know who to call. But in Nassau County, many residents delay or avoid care, not because they don't want it, but because they can't access it.

The Community Status Assessment shows that **preventive services are underused**, especially in lower-income ZIP codes, among older adults, and in rural communities. When people wait until something becomes urgent, the cost, to their health and our system, is even greater.

### Screening & Prevention Rates

Indicator	Nassau County	FL Avg	HP2030 Target
Child Wellness Visits (0-5)	72.5%	78.1%	80.0%
Early Prenatal Care (1st Trimester)	67.1%	69.3%	80.5% (MICH-10)
Colorectal Screening (Ages 50-75)	66.8%	68.4%	74.4% (C-09)
Dental Visit in Past 12 Months	59.0%	61.7%	74.0% (OH-08)
Flu Vaccine (Adults 18+)	48.9%	50.2%	70.0% (IID-09)

### Barriers to Accessing Preventive Care

From survey data and stakeholder interviews:

- 62% of residents said cost was a barrier to care
- 49% cited lack of transportation
- 39% reported long waits or appointment delays
- 31% cited conflicts with childcare or work
- Provider shortages are most severe in west and northwest Nassau

# Community Conditions Scorecard

## *The Structures Behind Every Health Outcome*

Health is about more than hospitals. It's about where we live, how we get around, what we earn, and what resources we can count on. This scorecard reveals how Nassau County's infrastructure, economy, and public systems are helping, or hindering, our ability to thrive.

Each indicator shown here contributes to **long-term health, access to care, and community resilience**, especially for ALICE households, older adults, and rural families.

### Housing & Living Costs

Indicator	Nassau County	FL Average
Homeownership Rate	78%	66%
Cost-Burdened Renters (>30% of income)	36%	35%
Mobile Homes as % of Housing	14%	9%
Median Rent	\$1,300/month	\$1,218/month

### Transportation & Physical Access

Indicator	Nassau County	FL Average
Households Without a Vehicle	6.8%	6.5%
Public Transit Availability	None county-wide	Variable
Top Reported Barrier in Surveys	Transportation (49%)	N/A

## Water, Waste, & Broadband Infrastructure

Indicator	Nassau County	FL Average
Homes on Private Well/Septic	23%	18%
Broadband Access (basic coverage)	88%	91%
Areas with Limited Internet Speed/Affordability	Western & Rural ZIPs	N/A

## Education & Early Childhood

Indicator	Nassau County	FL Average
High School Graduation Rate	93.1%	90.1%
Preschool Enrollment (Age 3-4)	39.2%	46.1%
College or Associate Degree (25+)	38%	41.5%



# Nassau County’s Health Priorities

## *What Matters Most for Our Health, Our Families, and Our Future*

After months of listening, analyzing, and comparing data, three urgent and actionable priorities emerged across all assessments:

- The **Community Status Assessment (CSA)** showed population-level health risks and care gaps
- The **Community Partner Assessment (CPA)** revealed frontline provider insights and system failures
- The **Community Context Assessment (CCA)** captured lived experiences across neighborhoods

These top priorities, **Transportation & Infrastructure**, **Preventive Services**, and **Mental Health**, were validated by both data and people. Each one affects thousands of residents every day, especially **ALICE households (41%)**, **older adults**, **youth**, and **rural families**.

### Transportation & Infrastructure

When you can’t get where you need to go, staying healthy becomes nearly impossible.

Key Data	Value
Households with no vehicle	6.8%
County-wide public transit availability	None
Survey respondents citing transportation barrier	49%
ZIPs with longest drive time to care	Bryceville, Hilliard (30–45 mins)

### Preventive Services (Physical & Behavioral Health)

Too many people are going without care until it becomes a crisis.

Key Data	Nassau	HP2030 Goal
Early Prenatal Care	67.1%	80.5%
Child Wellness Visits (0-5)	72.5%	80.0%
Colorectal Screening (Ages 50-75)	66.8%	74.4%
Adult Dental Visit (past 12 mos.)	59.0%	74.0%
Diabetes Hospitalizations (per 100,000)	172.3	≤150

### Preventive Services (Physical & Behavioral Health)

Emotional health touches every part of life, and every generation.

Key Data	Nassau	FL Avg
Mental Health ER Visits (per 10,000)	85.1	74.3
Local provider wait times (estimated)	6-12 weeks	N/A
Suicide-related concerns (ER reports)	Increasing	N/A
School-based behavioral health access	Limited	N/A

### Alignment with Models That Matter

Each priority maps to the University of Wisconsin Population Health Model and national benchmarks through Healthy People 2030.

Priority	Model Domain	HP2030 Objectives
Transportation	Physical Environment, Health Infrastructure	IVP-D01, AHS-5.1, PHI-R02
Preventive Services	Health Infrastructure, Physical Health	C-09, OH-08, SDOH-04, IVP-11
Mental Health	Mental Health, Social Factors, Unwritten Rules	MHMD-01, MHMD-04, MHMD-05, SDOH-01

# Why These Priorities Matter for Nassau County

*Because a Healthy Community is Built on Access, Prevention, and Connection*

*These three health priorities, Transportation & Infrastructure, Preventive Services, and Mental Health, aren't isolated issues. They're deeply connected challenges that affect families across Nassau County every day.*

*They showed up in the data. They came through in every stakeholder meeting. And they were named time and again in resident surveys and focus groups. Together, they reflect the real-life barriers that hold people back from getting care, staying well, and building stable, connected lives.*

## Why These Priorities Rose to the Top

Criteria	Transportation	Prevention	Mental Health
Data-validated in CSA	✓	✓	✓
Named top concern in resident survey	✓ (49%)	✓ (62%)	✓ (45%)
Cited in interviews/focus groups	✓	✓	✓
Aligns with HP2030 National benchmarks	✓	✓	✓
Affects ALICE, rural, youth, and elderly	✓	✓	✓

## Who Is Most Affected?

- **ALICE Households** (41% of all Nassau homes): Working families often can't afford care, time off work, or long drives
- **Older Adults** (22% of population): More likely to face transportation issues and live alone
- **Youth & Students**: Facing rising mental health needs and limited access to school-based services
- **Rural Residents** (West/North Nassau): Farther from care, lower broadband access, and higher rates of delayed care

## Strategic Impact

By focusing on these three areas, Nassau County can:

- Reduce preventable ER visits and hospital costs
- Improve school attendance and early intervention
- Strengthen mental health resilience across all generations
- Expand access to care in hard-to-reach communities
- Build long-term health infrastructure aligned with national and state goals



# What Happens Next: Roadmap to CHIP

## *From Listening to Leading: How Nassau County Will Turn Priorities into Progress*

The CHA process has done more than reveal what’s wrong. It has given Nassau County a clear path forward. Now, it’s time to turn these priorities into **real improvements**, with accountability, collaboration, and measurable outcomes.

The next step is the **Community Health Improvement Plan (CHIP)**, a coordinated strategy that brings together public health, schools, hospitals, faith-based groups, and local leaders to address the most urgent needs identified in this assessment.

### Where We Are in the MAPP 2.0 Cycle

Stage	Status	Description
1. Build the Partnership	Complete	CHA led by Florida DOH–Nassau in partnership with community
2. Assess Where We Are	Complete	CPA, CSA, and CCA findings validated through multi-source data
3. Focus on What’s Important	Complete	Priorities Selected: Transportation, Prevention & Mental Health
4. Choose Effective Strategies	In Progress	CHIP will define what we will do and who’s responsible
5. Act on What’s Important	Launch	CHIP strategies begin implementation
6. Evaluate and Improve	Annual Milestones	Track progress, improve programs, report results

## CHIP Development Timeline

Milestone
CHIP Planning Kickoff
Community Partner Workshops
Strategy Design & Accountability Map
Final CHIP Publication & Launch
Year 1 Progress Report

### Who's Involved?

- Nassau County Community Health Coalition
- Florida Department of Health - Nassau
- Nassau County School District
- Baptist Health
- Council on Aging
- Barnabas
- Local nonprofits
- Faith leaders, veterans' groups, and law enforcement
- Residents, through forums, focus groups, and surveys



**We are not just building a plan. We are building a movement.**

## What You Can Do to Help

### *A Healthier Nassau Starts with You*

The CHA process has shown us what matters, what's broken, and where we need to go next. But the truth is: *We can't do it without you.*

Whether you're a parent, teacher, nurse, business owner, or neighbor, you have a role to play. Here's how you can help build a healthier, more connected Nassau County for everyone.

#### **If You're a Resident**

- **Share your voice** in upcoming CHIP community forums (Spring/Summer 2026)
- **Help your neighbors** find services through the No Wrong Door Directory
- **Support local transit and broadband investments** when they appear on ballots
- **Know your numbers:** Get screened for diabetes, cancer, and heart health
- **Talk openly about mental health**, and encourage others to seek support

"People feel isolated. We need more places where they feel seen."

– CHA Focus Group Participant, Yulee

#### **Data that Matters:**

- 59.0% of adults had a dental visit in the past year (goal = 74%)
- 41% of households are ALICE, meaning just above the poverty line
- 23% of homes rely on wells/septic (no municipal water access)

#### **If You're a Community Leader or Partner**

- **Join the CHIP action planning team** to co-lead one of the three priorities
- **Align your program goals** with CHA findings for stronger grant proposals
- **Co-host health access events** (screenings, mobile clinics, school drives)
- **Expand hours or services** in rural ZIPs or for high-risk populations
- **Train staff** in trauma-informed, bilingual, or culturally competent care

"We need to meet people where they are, literally and emotionally."

– Stakeholder Interview, Health Provider

**Data that Matters:**

- ☒ Mental health ER visits: 85.1 per 10,000 (FL avg: 74.3)
- ☒ Survey: 49% cited transportation as a barrier to care
- ☒ 30–45 minute travel times to providers in Bryceville, Hilliard, and the rural area along the State line

**If You're in Government or Public Service**

- ☒ Champion local investments in infrastructure, prevention, and mental health
- ☒ Use this CHA to guide future funding and policy decisions
- ☒ Prioritize ALICE families, veterans, and seniors in new programs
- ☒ Push for county-wide transportation options in collaboration with FDOT
- ☒ Fund school-based health pilots that address care gaps early

“Everything we do should reflect this data, and the people behind it.”

– CHA Steering Committee Member

**Data that Matters:**

- Only 67.1% of pregnancies had early prenatal care (goal = 80.5%)
- Youth behavioral health concerns rising in school and ER settings
- Broadband access is still limited in northwestern rural zones

Group	What You Can Do
Resident	Attend forums, get screened, support neighbors
Nonprofits & Faith	Host health events, align grants, join planning teams
Healthcare	Offer mobile hours, trauma-informed care, outreach clinic
Schools & Youth	Support school-based mental health and health literacy
Local	Fund CHIP priorities, expand transportation & broadband

# Acknowledgments

## *Thank You to the Partners, Providers, and Residents Who Made This CHA Possible*

This report is more than pages and charts, it's a reflection of people who care deeply about the health and well-being of Nassau County. We thank everyone who gave their time, insight, and experiences to build this assessment. Your voices shaped every word.

### **Florida Department of Health – Nassau County**

Cara Gluck, Administrator  
Kenice Taylor, Senior Public Health Services Manager  
Anita Vorreyer, Executive Assistant

### **Community Partners & Organizations**

We are especially grateful to the following organizations for their participation in interviews, surveys, focus groups, and ongoing support:

- Barnabas Center
- Baptist Nassau
- Nassau County School District
- Micah's Place
- Starting Point Behavioral Health
- Council on Aging of Nassau County
- Nassau County Emergency Management
- Nassau County Veterans Services
- ARC of Nassau
- Florida Department of Transportation (District 2)
- Empowerment Resources
- Coalition for the Homeless
- Family Support Services of North Florida
- North Florida TPO
- Take Stock in Children
- Local Pediatricians, Dentists, School Nurses, and Health Navigators

## Resident Contributors

This CHA is grounded in the voices of:

- 5,000+ residents who completed the community survey
- 22 cross-sector stakeholders who shared their professional insights
- 3 community meeting cohorts from Hilliard, Yulee, and Fernandina
- Parents, caregivers, youth, seniors, veterans, and ALICE families who shared stories and lived experiences

Your voice matters, and because of you, this plan is not just data. It's direction.

### CHA Facilitation & Report Prepared By:

#### Ascendant Healthcare Partners

JoAnn Andrews, CEO & Principal Facilitator

Jean Gonzalez, Project Manager and Design

[www.ascendanthp.com](http://www.ascendanthp.com)

Ascendant Healthcare Partners is a designated Healthy People 2030 Champion, a NACCHO Affiliate, and a national leader in MAPP 2.0 community health assessment.

"To the residents of Nassau County, thank you. This is your story. This is your plan. And this is your future."

– JoAnn Andrews, Ascendant Healthcare Partners, CHA Facilitator

### Join the Movement Toward a Healthier Nassau

You've read the data. You've seen the priorities. Now it's your turn.

Get involved in the next phase of the plan, our Community Health Improvement Plan (CHIP), launching in January 2026.

- Attend a community meeting
- Share this report with colleagues
- Use this data to guide funding and programming
- Help us close gaps in care and access



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