2026-2028
COMMUNITY HEALTH NEEDS ASSESSMENT

CARING BEGINS AT
COASTAL FAMILY HEALTH CENTER

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Community Health Needs Assessment

INTRODUCTION Every three years, Coastal Family Health Center, Inc. conducts an assessment of the wellness and needs of community members, as well as the available resources to fulfill their needs. The resulting document which follows is known as the Community Health Needs Assessment (CHNA). It is used as a blueprint over the succeeding years to develop or support programs and services aimed at addressing the identified needs.

THE MISSION Coastal Family Health Center strives to provide quality, comprehensive patient-centered care to the community regardless of one's economic status.

Organizational Overview

Coastal Family Health Center, Inc. (CFHC or Coastal), a Federally Qualified Health Center (FQHC), was established in 1976 as a single-site outpatient clinic offering medical and dental services in Biloxi, MS. Due to its determination to increase access to quality healthcare services for all residents of the Mississippi Gulf Coast, CFHC has spent 49 years expanding its facilities and services throughout Harrison, Hancock, Jackson, Greene, Wayne, George, and Stone counties, now serving more than 36,000 patients per year.

Today, CFHC is an organization providing medical (adult and pediatric), dental, optometry, behavioral health, psychiatry, radiology, pharmacy, and social services through 36 clinics, a medical mobile unit, five pharmacies, and an administrative site spread over the seven-county catchment area.

The Coastal family of healthcare providers not only serves patients but also contributes to an atmosphere of care and compassion for those outside of the health center walls. CFHC strives not only to provide care for the sick but also to offer education and wellness services to improve the health status of the community and eliminate risk factors for more serious health problems.

Signs of Excellence

CFHC's demonstrates commitment to its patients through:

- Consistently high patient satisfaction scores
- Ongoing clinical performance initiatives
- Accreditation by the Joint Commission for both the ambulatory and behavioral health programs
- Recognition as a Patient-Centered Medical Home (PCMH) by the National Committee for Quality Assurance (NCQA)

These outward signs of excellence illustrate CFHC's choice to focus on the patient, extending compassionate, quality care and service that meets changing health care trends.

The Vision

Coastal Family Health Center will have a significant impact on the health and well-being of the communities we serve. To this end, we will work with others to ensure a creative and cost-effective range of health/social services that are accessible to all.

THE SERVICES Coastal Family Health Center's mission is put into action through the offering of various healthcare services provided by highly-qualified, competent and caring multidisciplinary care teams. Services are discussed in detail below.

Family Practice

Primary care is the cornerstone upon which CFHC was founded. As a medical home, CFHC provides comprehensive primary care and preventive medicine including:

- Routine physical exams
- Sport or work physical exams
- Immunizations
- Cancer screenings
- Treatment for acute illnesses and minor injuries
- Chronic disease management

Quality care is our focus. Clinical outcomes for preventive measures and management of chronic diseases are evaluated and reported to ensure optimal care. These include management of diabetes, hypertension, and high cholesterol, as well as immunizations and cancer screening.

Internal Medicine

CFHC provides internal medicine services to treat complex illnesses, promote health, and prevent disease.

Preventative Dental Care

CFHC provides dental care for adults and children at the Biloxi, Gulfport, Moss Point and Leakesville clinics, including:

- Preventative cleaning
- Fillings and extractions
- Emergency dental care
- Limited advanced dental services

THE SERVICES CONTINUED

Women's Health & Prenatal

CFHC's women's health and prenatal care program includes:

- Routine gynecological exams (breast and pelvic exam/pap smear)
- Prenatal care, including ultrasound
- Mississippi Breast & Cervical Cancer Early Detection Program
- Family planning services

Pre-Exposure Prophylaxis (PrEP)

The PATH (Pre-Exposure Prophylaxis Access to Treatment at Home) program is CFHC's newest approach to prescribing PrEP, a once-daily pill that is effective in preventing the contraction of HIV. The PATH Program connects individuals to one of CFHC's providers without having to come into the clinic.

HIV Care

CFHC provides a wide range of services for patients who are HIV-positive, including:

- Primary medical care
- Treatment and management of HIV/AIDS
- Case management
- Behavioral health care
- Medication assistance
- Transportation assistance

Optometry

CFHC offers vision services in Biloxi, Gulfport, and Leakesville. These services include:

- Routine eye exams, including dilated eye exams for chronic illnesses
- Glasses and contact lens fitting at low cost
- Glaucoma and cataract treatment
- Treatment for minor injuries and infections

Behavioral Health

CFHC offers behavioral health services across the Gulf Coast community, including:

- Mental health and substance abuse assessments, brief counseling, and/or referrals for more intensive levels of treatment
- Psychiatry
- Chronic conditions support programs to assist patients in managing and improving their chronic conditions, such as diabetes, hypertension, obesity, asthma and COPD
- Court-ordered substance abuse counseling

Pharmacy

CFHC offers convenient pharmacy services at five locations: Biloxi, Gulfport, Moss Point, Leakesville, and Wiggins. CFHC participates in the federal 340B drug pricing program, which allows us to provide outpatient drugs at reduced prices to all registered patients, with or without prescription coverage. Additional medication assistance programs are available based on income and prescription coverage.

Laboratory

Laboratory services are available on-site for the convenience of all CFHC patients.

Radiology & Mammography

CFHC offers digital radiology and screening mammography at our Biloxi and Leakesville clinics. Fibroscan is also available in Biloxi.

Women, Infants & Children (WIC) Program

WIC is a supplemental food program at the Biloxi Pediatric, Gulfport, and Saucier clinics. Foods in the WIC package provide nutrients based on nutritional or medical needs. The following are provided to eligible patients:

- Monthly package of nutritious foods to supplement the diet
- Nutrition counseling
- Referrals for other health care services

THE SERVICES CONTINUED

Social Services

CFHC's Social Services program enrolls eligible patients for drug manufacturer assistance programs, provides financial assistance to obtain durable medical equipment and specialty care/diagnostic referrals, and schedules transportation assistance free-of-charge.

Outreach & Enrollment

CFHC's Certified Application Counselors assist persons to access the marketplace, identify and compare the available health plans, and complete application and enrollment with Health Coverage Programs under The Affordable Care Act (ACA). Our counselors answer questions about Tax Credit Programs and Cost-Sharing Reductions that can make those health plans more affordable for individuals and families.

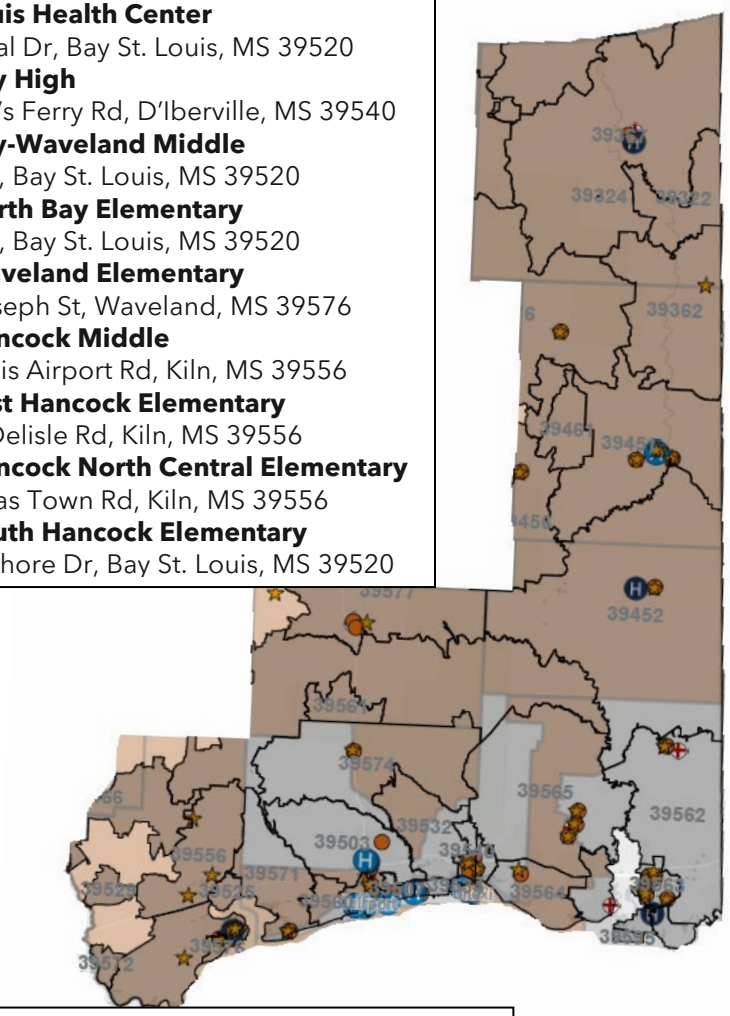
Translation

CFHC offers translation services at all locations, free of charge. Over 20 languages are available, including American Sign Language.

COASTAL FAMILY HEALTH CENTER LOCATIONS

Harrison County
Gulfport Health Center
15024 Martin L. King Jr Blvd, Gulfport, MS 39501
Coastal Family Pharmacy – Gulfport
9113 Hwy 49, Gulfport, MS 39503
D'Iberville Health Center
3446 Popp's Ferry Rd, D'Iberville, MS 39540
Coastal Family Health Center Corporate Office & CFHC Mobile Unit
10467 Corporate Dr, Gulfport, MS 39503
Saucier Health Center
23453 Central Dr, Saucier, MS 39574
Pass Christian Health Center
257 Davis Ave, Pass Christian, MS 39571
Biloxi Health Center
715A Division St, Biloxi, MS 39530
Biloxi Pediatric Health Center
735 Division St, Biloxi, MS 39530
Coastal Family Pharmacy – Biloxi
1025 Division St, Biloxi, MS 39530

Hancock County
Bay St. Louis Health Center
109 Hospital Dr, Bay St. Louis, MS 39520
SBHC – Bay High
3446 Popp's Ferry Rd, D'Iberville, MS 39540
SBHC – Bay-Waveland Middle
600 Pine St, Bay St. Louis, MS 39520
SBHC – North Bay Elementary
602 Pine St, Bay St. Louis, MS 39520
SBHC – Waveland Elementary
1101 St Joseph St, Waveland, MS 39576
SBHC – Hancock Middle
7070 Stennis Airport Rd, Kiln, MS 39556
SBHC – East Hancock Elementary
4221 Kiln-Delisle Rd, Kiln, MS 39556
SBHC – Hancock North Central Elementary
6122 Cuevas Town Rd, Kiln, MS 39556
SBHC – South Hancock Elementary
6590 Lakeshore Dr, Bay St. Louis, MS 39520



Jackson County
Vancleave Health Center
10828 Hwy 57, Vancleave, MS 39565
Moss Point Health Center
4770 Amoco Dr, Moss Point, MS 39563
Coastal Family Pharmacy – Moss Point
7312 Hwy 63, Moss Point, MS 39563
SBHC – Vancleave High
12424 Hwy 57, Vancleave, MS 39565
SBHC – Vancleave Upper Elementary
13901 Hwy 57, Vancleave, MS 39565
SBHC – East Central Upper Elementary
5404 Hurley Wade Rd, Mos Point, MS 39562
SBHC – East Central High
5500 Hurley Wade Rd, Mos Point, MS 39562
SBHC – St, Martin High
11300 Yellow Jacket Rd, Ocean Springs, MS 39563
SBHC – St. Martin North Elementary
16308 Lemoyne Blvd, Biloxi, MS 39532
SBHC – Kreole
6312 Marting L King Blvd, Moss Point, MS 39563
SBHC – Escatawpa
4208 Jamestown Rd, Moss Point, MS 39563
SBHC – Magnolia
4630 Magnolia St, Moss Point, MS 39563
SBHC – Moss Point High
4913 Weems St, Moss Point, MS 39563

George County
Lucedale Health Center
11231 62 S, Suite C-1, Lucedale, MS 39452

Greene County
Leakesville Health Center
951 Main St, Leakesville, MS 39451
SBHC – Greene County High
4336 High School Rd, Leakesville, MS 39451
SBHC – Leakesville Elementary
175 Annex Rd, Leakesville, MS 39451
SBHC – Leakesville Jr. High
620 Main St, Leakesville, MS 39451
SBHC – Sand Hill
39455 Hwy 63 N, Richton, MS 39476
SBHC – McLain
300 Shows St, McLain, MS 39456

Wayne County
State Line Health Center
256 Main St, State Line, MS 39362

Stone County
Wiggins Health Center
1407 Central Ave E, Wiggins, MS 39577

OTHER HEALTH CARE FACILITIES

George County
- **Rural Health Clinics**
  - Community Medical Center – Lucedale
  - Lucedale OB/GYN Center – Lucedale
- **Hospital**
  - George Regional Health System – Lucedale

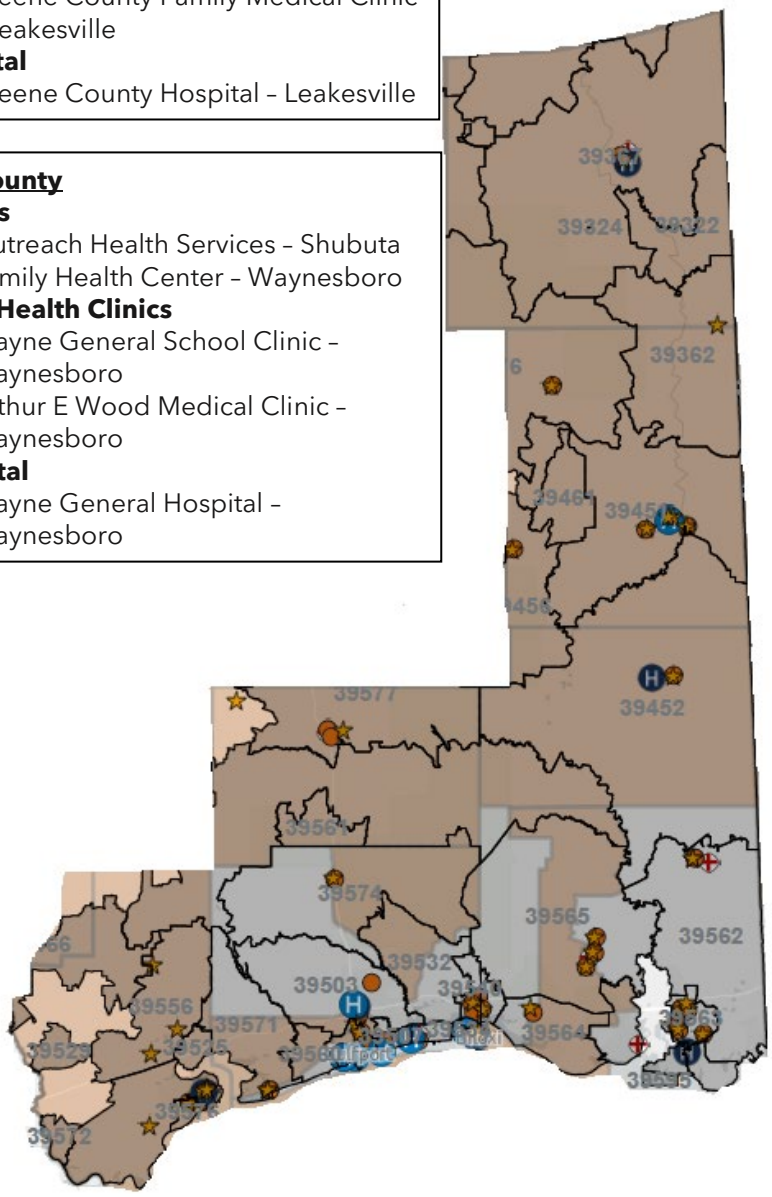
Stone County
- **Rural Health Clinic**
  - Wiggins Primary Care – Wiggins
- **Hospital**
  - Stone County Hospital – Wiggins

Harrison County
- **Rural Health Clinics**
  - Children's International Group – Gulfport & Biloxi
  - Vancleave Medical Center - Vancleave
- **Hospitals**
  - Memorial Hospital – Gulfport & Biloxi
  - Singing River Health System - Gulfport
- **Veterans Affairs Facilities**
  - V.A. Medical Center – Gulfport & Biloxi
  - U.S. Air Force Hospital – Biloxi

Hancock County
- **Rural Health Clinics**
  - Children's International Group – Bay St. Louis
  - Ochsner Health Center port Bienville – Bay St. Louis
- **Hospital**
  - Ochsner Medical Center – Bay St. Louis

Greene County
- **Rural Health Clinic**
  - Greene County Family Medical Clinic – Leakesville
- **Hospital**
  - Greene County Hospital – Leakesville

Wayne County
- **FQHCs**
  - Outreach Health Services – Shubuta
  - Family Health Center – Waynesboro
- **Rural Health Clinics**
  - Wayne General School Clinic – Waynesboro
  - Arthur E Wood Medical Clinic – Waynesboro
- **Hospital**
  - Wayne General Hospital – Waynesboro



Jackson County
- **Rural Health Clinics**
  - East Central Medical Center – Hurley
  - Vancleave Medical Center – Vancleave
- **Hospital**
  - Singing River Health System – Ocean Springs & Pascagoula

Previous Community Needs Rankings

Based on the 2022–2025 assessment activities, CFHC developed a list of community needs.

Rank	Health Need
1	Access to Affordable Healthcare • Insurance coverage • Medication assistance • People with existing challenges of access to care (e.g., disabilities, low income, etc.) • Transportation • Language Barriers
2	Lifestyle-related Conditions • Heart/cardiovascular disease • Diabetes • Food security • Health education • HIV & other STIs • Obesity
3	Behavioral Health Conditions • Mental health • Substance abuse

Coastal Family Health Center has actively developed and implemented programs to address the prioritized needs. The table in Appendix C summarizes activities undertaken by the organization to address the prioritized needs identified within the 2022-2025 CHNA.

SUMMARY OF 2026-2028 PRIORITIZED COMMUNITY NEEDS Several methodologies were combined to develop a comprehensive and prioritized list of 2026-2028 community needs.

The resulting prioritized list of community needs fall into 3 categories: Behavioral Health Conditions, Access to Affordable Health Care, and Lifestyle-related Conditions. The breadth of the categories of needs allows CFHC to continue (or possibly expand) successful existing programs and to develop innovative approaches to possibly address multiple needs simultaneously. The list of the top need categories and more detailed opportunities for improvement are shown below.

Rank	Health Need
1	Behavioral Health Conditions • Mental health • Substance abuse
2	Access to Affordable Healthcare • People with existing challenges of access to care (e.g., disabilities, low income, homeless) • Insurance coverage • Medication assistance • Transportation • Language Barriers
3	Lifestyle-related Conditions • Heart/cardiovascular disease • Diabetes • Food security • Obesity • Health education • HIV & other STIs

ASSESSMENT METHODOLOGY

How To Use This Study

This study provides information about the approach and findings from Coastal Family Health Center's Community Health Needs Assessment (CHNA). It includes a comprehensive review of health data and community input on issues relevant to community health in Harrison, Hancock, Jackson, George, Greene, Wayne & Stoe Counties currently served by CFHC. The assessment covers a wide range of topics and includes community input with the hope to continue ongoing community discussion. We invite the reader to investigate and use the information in this report to help move toward development of solutions, the creation of goals and the implementation of activities leading to improved community health.

Community Health Needs Assessment Participants

Coastal Family Health Center reached out to an expansive and highly varied group of individuals to participate in its CHNA, including CFHC leadership and staff, patients, community members, and community service organizations within the service area. Participants provided insight and feedback regarding perceptions of area health needs during the CHNA process.

Methodology Components

Coastal Family Health Center's CHNA methodology includes a combination of quantitative and qualitative research methods designed to evaluate perspectives and opinions of area stakeholders and healthcare consumers – especially those from underserved populations. The methodology used helped prioritize needs and establish a basis for continued community engagement – in addition to simply developing a broad, community-based list of needs.

The major sections of the methodology include the following:

- **Strategic secondary research** – This type of research includes a thorough analysis of previously published materials that provide insight regarding the community profile and health-related measures. The "demographics and key indicators" table is shown below while others follow or are included in the appendices of this report.
- **Qualitative Interviews** – This primary research includes interviews with CFHC health care consumers (n=40).
- **Qualitative Surveys** – Community partners completed survey regarding needs within their various communities (n=11).
- **Quantitative Community Survey** – Surveys were sent out to CFHC consumers via text message. 573 were completed. The survey included representation of all seven counties served with proportional representation of African Americans and other racial groups, as well as a varied mix of economic status.
- **Multivariate Data Analysis, Information Synthesis, and Report Creation** – CFHC analyzed response data and developed tables and graphs that illustrate the results found in this report.

HIGHLIGHTS OF A CHANGING POPULATION HEALTH ENVIRONMENT The period from 2021-2024 saw multiple population health changes across Coastal Family Health Center's service area.

Overview of Health Status Changes

Several longitudinal data sources were combined to develop an overview of the key changes in the service area Most notably:

Demographics			
Measure	**Service Area (2021)**	**Service Area (2023)**	**% Change**
Total Population	476,183	480,839	+0.9%
Income	$47,500	$56,639	+19.2%
Living in Poverty	17.8%	16.9%	-5.1%
Disabled	19.4%	20.5%	+5.7%

SOURCE: American Community Survey, 2021 & 2023

- Population has increased by 4,656.
- The median income has risen 19.2%, but the percentage living in poverty has only decreased by 5.1%.
- The percent of disabled individuals has risen by 5.7%.

Health Outcomes			
Measure	**Service Area (2021)**	**Service Area (2024)**	**Change**
Premature Deaths*	10,071	9,629	-4.4%
Self-Report Fair or Poor Health	23%	21%	-8.7%
Poor Mental Health Days	5.3	5.1	-3.8%
Low Birth Weight	9.8%	9.9%	+1 .0%

SOURCE: County Health Rankings, 2021 & 2024
*Years of potential life lost before age 75 per 100,000 population

- Both reports of poor physical and mental health have decreased from 2021 to 2024 within the service area.

Clinical Care			
Measure	**Service Area (2021)**	**Service Area (2024)**	**% Change**
Uninsured	16.3%	13.7%	-16.0%
Patient to PCP Ratio*	4,190:1	4,077:1	-2.7%

SOURCE: County Health Rankings, 2021& 2024
*Number of residents per provider

- The uninsured rate has decreased within the service area, and the patient to primary care provider ratios have improved from 2021 to 2024.

Social and Economic Factors			
Measure	**Service Area (2021)**	**Service Area (2024)**	**Change**
HS Graduation Rate	85%	90%	+5.9%
Unemployment	8.9%	3.9%	-56.2%
Children in Poverty	22.8%	26.1%	+14.5%

SOURCE: County Health Rankings, 2021 & 2024

- The number of children in poverty has significantly increased in the service area from 2021 to 2024.
- Unemployment rate has significantly decreased.
- A higher percentage of the population in 2024 are high school graduates.

Strategic Secondary Research

DEMOGRAPHIC AND ECONOMIC INDICATORS Population, age and disability status tend to drive the need for health care services, while income, education and poverty level are highly correlative. The following analysis of demographic factors highlight the growing need for health care services in the area and identifies structural causes of health care service usage.

As identified in the most recent U.S. Census, residents tend to share multiple characteristics that heighten the urgency of developing a clear, proactive approach to meeting the health needs in the service area. The following demographic tables and discussion present key data reflecting these points and highlight the impact on community needs and the prioritization of issues.

Key Population Measures

Measure	United States	Mississippi	George County	Greene County	Hancock County	Harrison County	Jackson County	Stone County	Wayne County
Population	342,034,432	2,943,045	25,619	13,601	46,159	210,612	146,389	18,756	19,703
Median Age	38.2	38.7	36.6	40.1	44.7	36.5	38.9	39.7	41.1
Median Household Income	$75,149	$54,915	$54,822	$55,838	$67,728	$57,233	$64,756	$59,307	$36,791
% Living in Poverty	11.1%	19.2%	14.4%	22.1%	15.6%	16.0%	13.4%	15.6%	21.0%
Ethnicity									
% White	76.3%	58.7%	89.2%	72.6%	87.4%	67.3%	73.1%	78.6%	57.4%
% African American	13.4%	37.8%	8.0%	25.7%	8.4%	26.2%	21.6%	18.5%	40.7%
% Hispanic or Latino	18.5%	3.9%	3.3%	1.5%	4.2%	6.8%	7.8%	2.7%	1.9%
% Asian or Pacific Islander	5.9%	1.2%	0.8%	0.2%	1.0%	2.9%	2.3%	0.5%	0.3%
% Two or More Races	2.8%	1.5%	1.5%	1.1%	2.3%	3.0%	2.4%	1.7%	1.2%
% No High School Diploma	11.5%	13.4%	16.1%	19.4%	10.3%	10.8%	11.2%	12.0%	16.0%
% 16+ Unemployed	4.1%	3.3%	4.6%	4.3%	3.5%	3.2%	3.7%	3.8%	4.2%

SOURCE: U.S. Census Bureau, 2023 & 2024 and Mississippi Department of Employment Security, 2022 & 2024

- Wayne County is the poorest in the service area, with a Median Household Income of $36,791 and 21% living in poverty.
- The overall service area's poverty rate (16.9%) is lower than the Mississippi average (19.2%) but higher than the National average (11 .1%).
- Harrison County is the largest of the seven counties making up the CFHC service area, with a population of 210,612.
- Three counties within the service area (George, Greene and Wayne) have a higher percentage of the population without a high school diploma than the Mississippi average (13.4%).
- All but one county within the service area (Harrison) has a higher unemployment rate than the Mississippi average (3.3%), and three counties (George, Greene, and Wayne) have a higher unemployment rate than the National average (4.1%).

Median Age and Sex

The large difference between the median ages of African American and white community members indicates that programs designed to meet the needs of particular age groups may also benefit from an additional focus on cultural issues or other factors present in different racial groups.

Median Age & Sex									
Measure	**United States**	**Mississippi**	**George County**	**Greene County**	**Hancock County**	**Harrison County**	**Jackson County**	**Stone County**	**Wayne County**
Median Age	38.2	38.7	36.6	40.1	44.7	36.5	38.9	39.7	41.1
Median Age by Ethnicity									
White	41.1	41.7	36.7	41.5	45.5	40.4	41.3	40.0	44.1
African American	34.3	33.6	31.8	38.6	39.2	31.9	35.4	40.5	31.2
Hispanic or Latino	29.5	26.3	27.5	50.1	33.1	28.2	28.5	27.6	14.9
Asian or Pacific Islander	37.2	36.6	33.8	*	55.0	40.8	36.7	*	63.2
Two or More Races	24.1	20.8	36.3	40.4	20.8	16.8	22.3	19.7	15.0
Sex									
Female, percent	50.5%	51.5%	49.5%	41.2%	51.1%	51.3%	50.8%	49.5%	51.5%
Male, percent	49.5%	48.5%	50.5%	58.8%	48.9%	48.7%	49.2%	50.5%	48.5%

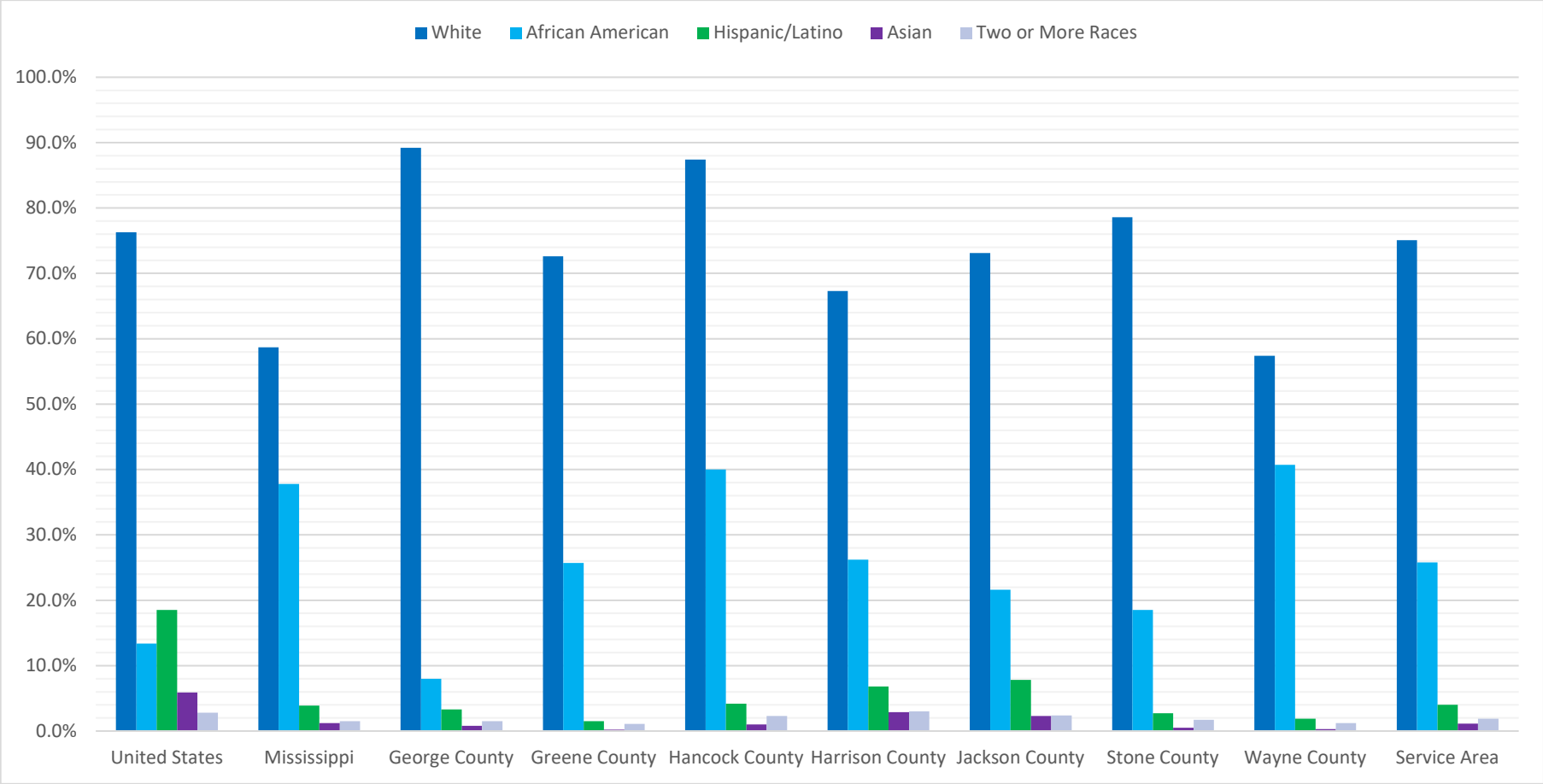
SOURCE: U.S. Census Bureau, 2021 & 2023

*No data available

- Hancock County has the highest median age of the counties within the service area.
- The median age of whites in Wayne County is nearly 200% higher than that of Hispanics/Latinos.
- Greene County has the highest variation of sex, with 58.8% males.
- Average median age for Whites in the service area (41.4) is 16.6% higher than for Blacks/African Americans (25.5) and 38.0% higher than Hispanics/Latinos (30.0).

Ethnicity/Race

The population is highly varied among racial characteristics – reflecting the rich cultural qualities and demographic variations of the region. Given the differences, analysis of the needs (and development of programs to address the needs) may benefit from consideration of cultural nuances.



SOURCE: American Community Survey, 2023

- All counties are predominantly white. The highest African American population is in Wayne County (40.7%).
- The service area has a higher African American population than the national average but a lower population than the Mississippi average.
- Although the service area has a lower ratio of Hispanic/Latino population when compared to the U.S. (18.5%), Hancock (4.2%), Harrison (6.8%), and Jackson Counties (7.8%) have a higher percentage of this population versus the Mississippi average (3.9%).
- Harrison (2.9%) and Jackson Counties (2.3%) have a higher population of Asians than the Mississippi average (1.2%).

Cultural Influence

White Race & Culture:

- *As recorded by the U.S. Census Bureau, the White population accounts for 75.1% of the service area. Calculation of the non-Hispanic White patient population equals 53.3% of CFHC's total patient population (2024 UDS, Table 3B).*
- The Census Bureau projects that by the year 2060, White Americans will comprise less than 50% of the total U.S. population. Whites represent both extremes of socioeconomic and health status as measured by the U.S. Census and CDC. The health status of Whites is often used as the "baseline" against which other racial and ethnic groups are measured; however, Whites experience many of the same health problems as other groups. Factors contributing to poor health among Whites include a lack of access to healthcare and a lack of health insurance.[1]

African American/Black Race & Culture

- *As recorded by the U.S. Census Bureau, the African American/Black population accounts for 25.8% of the service area. Calculation of the non-Hispanic African American/Black patient population equals 28.2% of CFHC's total patient population (2024 UDS, Table 3B).*
- Among the larger population, experiences within the healthcare community involving cultural insensitivity and deeply rooted prejudice, along with lack of cross-cultural study by professionals resulting in failure to consider patients' cultural backgrounds, contributes to misdiagnoses and poor treatment plans for elderly African American/Black individuals. Traditionally, the elderly within the African American/Black community have been treated with great respect in the family and community. The elders tend to be knowledge bearers within the family, and the passing down of bias from generation to generation could impact future generations' perceptions of health.[2]
- When it comes to specific health disparities within the African American/Black population, recent studies suggest poorer African American/Black people under age 50 are more than three times as likely to have a heart attack, stroke or other cardiovascular ailment as Black people with the highest wealth.[3]
- Additional disparities include higher uninsured rates, being more likely to go without care due to cost, and worse reported health status. Their life expectancy is nearly five years shorter compared to White people (72.8 years vs. 77.5 years). Black infants have a more than two times higher infant mortality rate than White infants (10.6 per 1,000 v. 4.4 per 1,000 as of 2021), and Black people are nearly three times more likely than White people to die due to pregnancy-related reasons (39.9 vs. 14.1 per 100,000 live births between 2017-2019).[4]

Hispanic/Latino Ethnicity & Culture

- *The Hispanic or Latino population in CFHC's service area accounts for 4%, according to the U.S. Census Bureau. According to the 2024 UDS, Hispanics/Latinos make up at least 11.6% of CFHC's current patient population.*
- In the U.S., Hispanics/Latinos are the largest growing racial/ethnic minority population.
- Heart disease and cancer in Hispanics are the two leading causes of death, accounting for about 2 of 5 deaths, which is about the same for Whites. Hispanics have lower deaths than Whites from most of the 10 leading causes of death with three exceptions – more deaths from diabetes and chronic liver disease, and similar

[1] http://www.cdc.gov/omhd/Populations/White.htm
[2] http://web.stanford.edu/group/ethnoger/african.html
[3] https://www.nlm.nih.gov/medlineplus/africanamericanhealth.html
[4]Samantha Artiga, L. H. (2024, February 22). How present-day health disparities for black people are linked to past policies and events. KFF.

numbers of deaths from kidney diseases. Health risks can vary by Hispanic subgroup – for example, 66% more Puerto Ricans smoke than Mexicans. Health risks also depend partly on whether the individual was born in the U.S. Hispanics are almost 3 times more likely to be uninsured as Whites and are, on average, nearly 15 years younger than Whites.[5]

- Factors contributing to poor health outcomes among the Hispanic/Latino population include discrimination, access barriers to healthcare and cultural and linguistic barriers. 10.1% of CFHC's patient population were better served in a language other than English, per the 2024 UDS.
- Hispanic communities across the county have been deeply affected by the zero-tolerance policy. Immigrants and U.S. citizens alike are experiencing heightened levels of fear as a result, according to two studies, one by George Washington University and the other by the UCLA Civil Rights Project.[6] Kathleen Roche, the author of the George Washington University study outlines a "pyramid of vulnerability," with the top tier including people who are being placed in detention centers and/or deported, followed by legal immigrants afraid their status may be revoked, then children born in the U.S. whose parents may be detained or deported, those children's classmates and teachers, and, finally, U.S. citizens, especially in communities where friends or neighbors may be affected.
- Fears are also influencing access and/or utilization of health services by Hispanic/Latino patients, with fewer residents applying for health coverage or seeking healthcare services (even life-saving treatments in some cases), with "some patients asking to be removed from [facility] records for fear that the information could be used to aid in deportation hearings" for themselves or family members with an unstable status.[7] Healthcare workers will need to be especially sensitive to these concerns and actively address patient fears.

[5] http://www.cdc.gov/vitalsigns/hispanic-health/

[6] https://www.vox.com/policy-and-politics/2018/3/5/17071648/impact-trump-immigration-policy-children

[7] https://www.washingtonpost.com/politics/hispanics-forgo-health-services-to-avoid-officials-attention-advocates-say/2018/01/21/3555412e-ff1d-11e7-9d31-d72cf78dbeee_story.html?utm_term=.1faa872cbbdf

EDUCATIONAL ATTAINMENT Educational attainment is highly correlated to income and health needs. Typically, those with more advanced education and higher household incomes tend to exhibit healthier lifestyles and lower health service needs. In Coastal Family Health Center's service area, there is an educationally varied population.

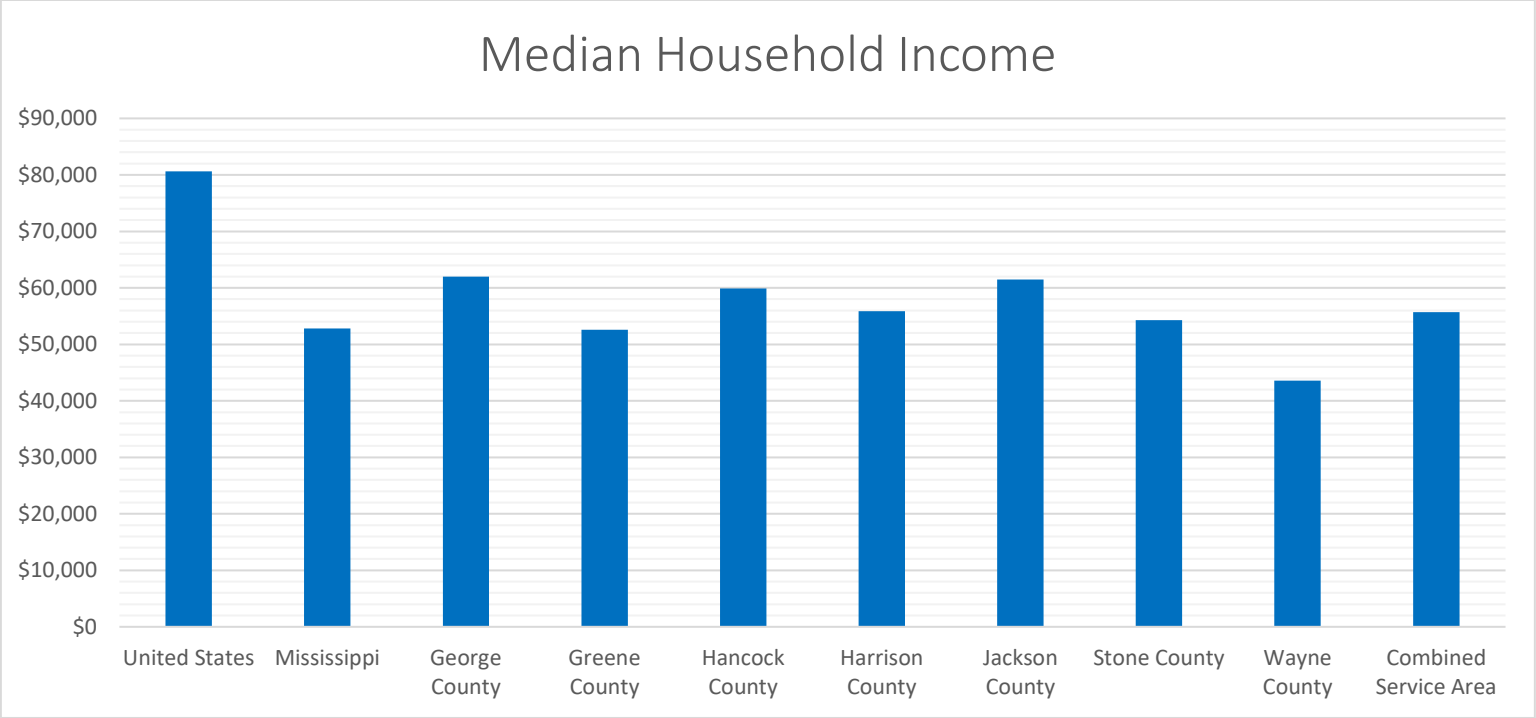
Educational Attainment (Over 25 Years Old)									
Measure	**United States**	**Mississippi**	**George County**	**Greene County**	**Hancock County**	**Harrison County**	**Jackson County**	**Stone County**	**Wayne County**
<9th grade	*	4.6%	3.3%	5.9%	3.3%	3.2%	4.1%	4.1%	7.6%
9th-12th (no diploma)	8.9%	9.1%	8.8%	13.5%	6.9%	7.7%	7.2%	8.0%	8.5%
High School Graduate or Equivalent	27.9%	29.8%	39.1%	39.5%	30.7%	28.6%	26.8%	35.7%	39.2%
Some College (no degree)	14.9%	21.9%	20.7%	21.0%	23.6%	23.3%	25.1%	23.9%	19.3%
Associate's Degree	10.5%	10.6%	11.0%	8.2%	10.8%	12.4%	12.0%	13.8%	8.8%
Bachelor's Degree	23.5%	14.5%	12.2%	7.1%	13.7%	15.3%	16.6%	9.0%	8.4%
Graduate or Professional Degree	14.4%	9.3%	4.9%	4.8%	10.8%	9.5%	8.3%	5.6%	8.3%

SOURCE: American Community Survey 5-Year Survey, 2024
*No data available

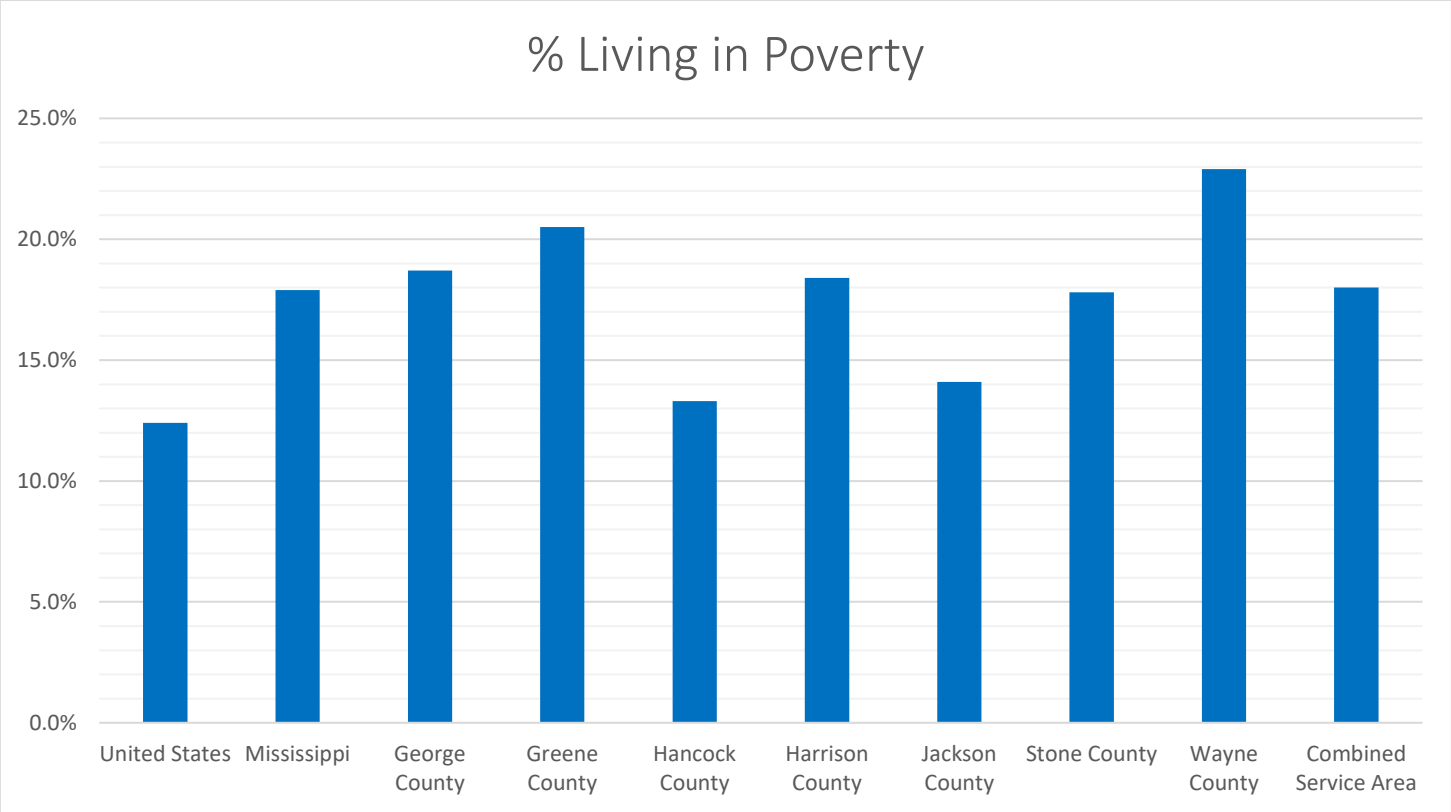
- The overall service area attainment of High School Diploma (34.2%) is higher than both the national and state average, but the service area attainment of a graduate or professional degree (7.5%) is lower than both the national and state average.
- Greene County has the lowest percentage of individuals obtaining a college degree (20.1%), and Harrison County has the highest (37.2%).

POVERTY STATUS Residents of impoverished communities are at increased risk for chronic disease, mental illness, higher mortality, and lower life expectancy.

One of the biggest challenges facing the region is economic stress – the median income ranges from $43,600 in Wayne County to $62,000 in George County. For comparison, the U.S. median household income is $80,610.



SOURCE: Community Health Rankings, 2024



SOURCE: U.S. Census Bureau, 2021

- The overall service area's poverty rate (18.0%) is higher than the Mississippi (17.9%) and National averages (12.4%).

EMPLOYMENT/OCCUPATION Along the coastal region of CFHC's service area, most major employers require specific skill sets and/or some form of higher education/training; this leaves many people out of the running for the best paying jobs in the area.

Jackson County:

Employers with Over 1,000 Workers		
Employer	**Type of Operation**	**Number of Employees**
Chevron Pascagoula Refinery	Petroleum Refining	3,600
Ingalls Shipbuilding	Manufacturing	11,300
Singing River Health System	Healthcare Services	2,300
Jackson County School District	Education	1,350
Pascagoula School District	Education	1,300
Source: http://www.jcedf.org/index.php/workforce/top-ten-employers		

Harrison County:

Employers with Over 1,000 Workers		
Employer	**Type of Operation**	**Number of Employees**
Keesler Air Force Base	Military	11,276
Naval Construction Battalion Center	Military	5,500
Memorial Hospital	Healthcare Services	3,331
Beau Rivage Resort & Casino	Gaming	2,928
Harrison County School District	Education	1,802
Veterans Administration	Healthcare Services	1,605
IP Casino Resort Spa	Gaming	1,457
Island View Casino Resort	Gaming	1,206
Golden Nugget Casino	Gaming	1,067
Hard Rock Hotel & Casino	Gaming	1,018
Source: http://mscoast.org/industry/major_employers/harrison_county		

Hancock County:

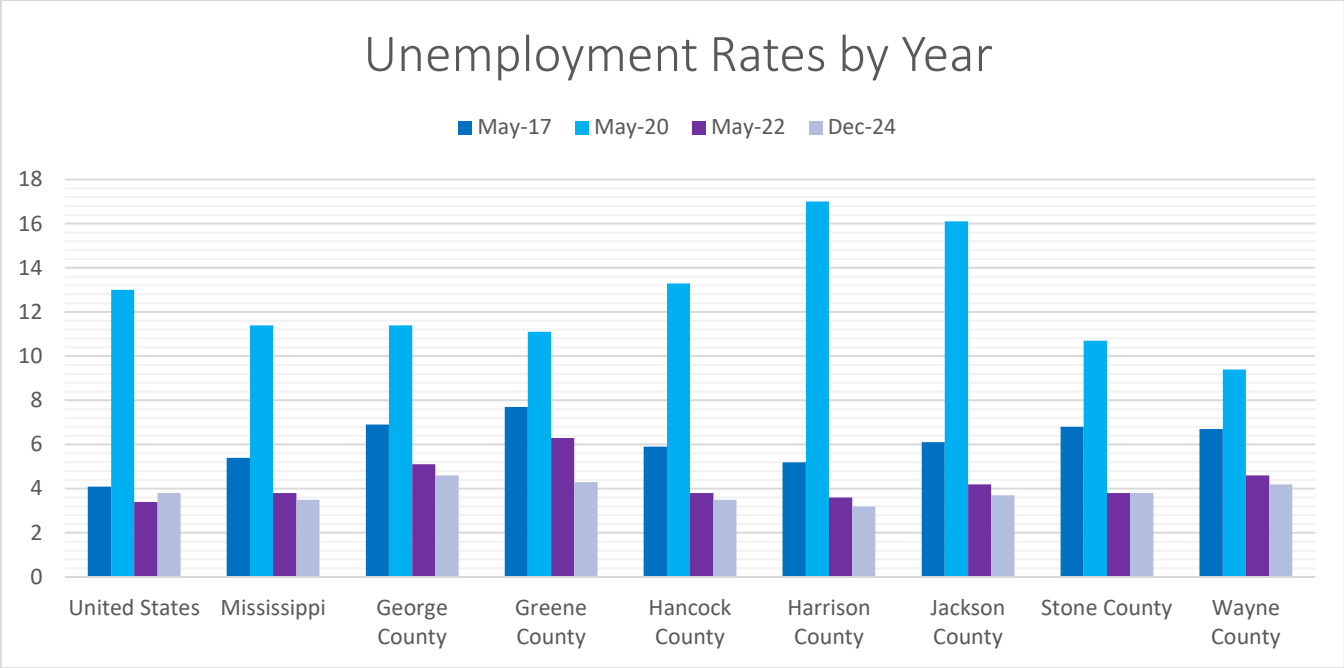
Top 10 Employers		
Employer	**Type of Operation**	**Number of Employees**
Naval Meteorological Command	Government Services	1,049
Syncom Space Services	Government Services	682
NASA Shared Services	Government Services	539
Hollywood Casino	Gaming	375
Silver Slipper Casino	Gaming	325
NASA Stennis Space Center	Government Services	302
Ochsner Medical Center	Healthcare Services	276
U.S. Navy Special Boat Team	Military	262
Source: http://mscoast.org/industry/major_employers/hancock_county		

George, Greene, Stone & Wayne Counties:

In the more rural counties without some of the data resources/publications that other counties have, CFHC relies on the people residing in these counties for information about occupations within these areas. Individuals within these counties report top employers in these areas are agriculture, forestry, specialty trade, local government, school district and correctional institutions.

Unemployment

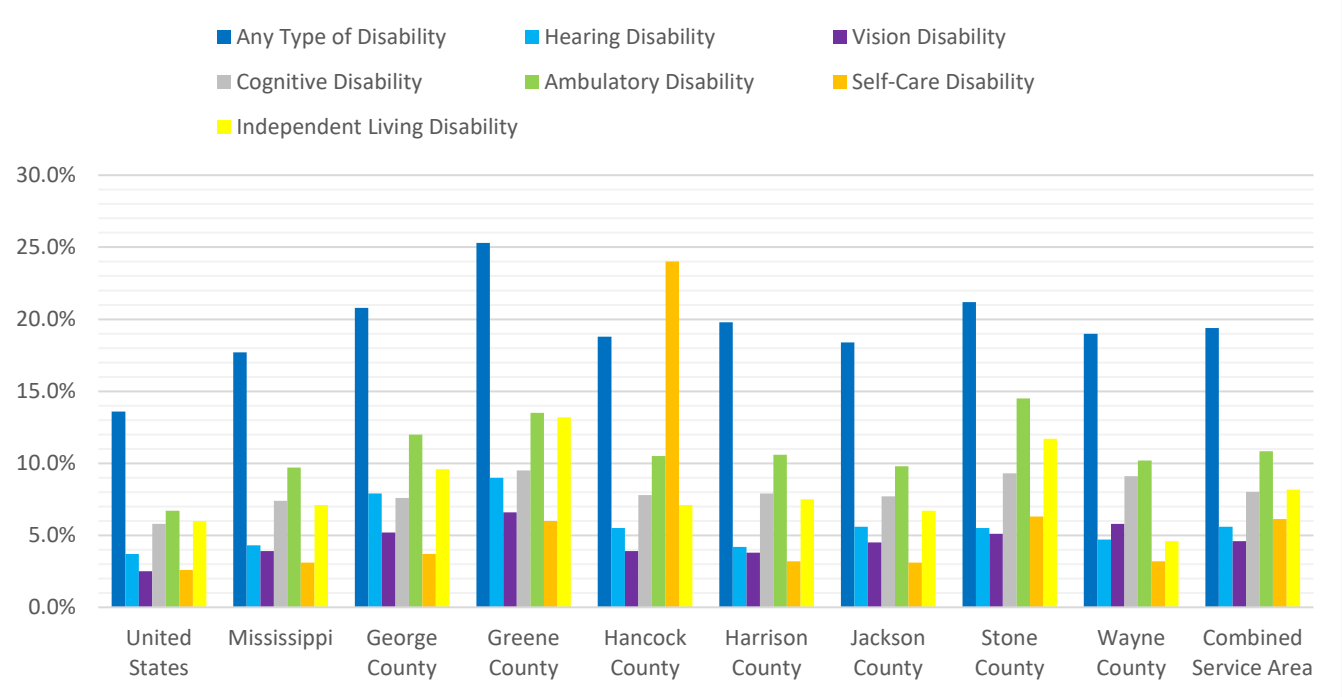
According to Healthy People 2020, those who are unemployed report feelings of depression, anxiety, low self-esteem, demoralization, worry and physical pain. Unemployed individuals tend to suffer more from stress-related illnesses, such as high blood pressure, stroke, heart attack, heart disease and arthritis. In addition, experiences such as perceived job insecurity, downsizing or workplace closure, and underemployment also have implications for physical and mental health.



SOURCE: Mississippi Labor Market Data, December 2024

- Unemployment rates skyrocketed in 2020 after the onset of the pandemic but have since fallen below 2017 rates.
- George County has the highest unemployment rate in the service area (4.6), ranking 62nd out of 82 counties in the state.
- Harrison County has the lowest unemployment rate in the service area (3.2), ranking 10th in the state.

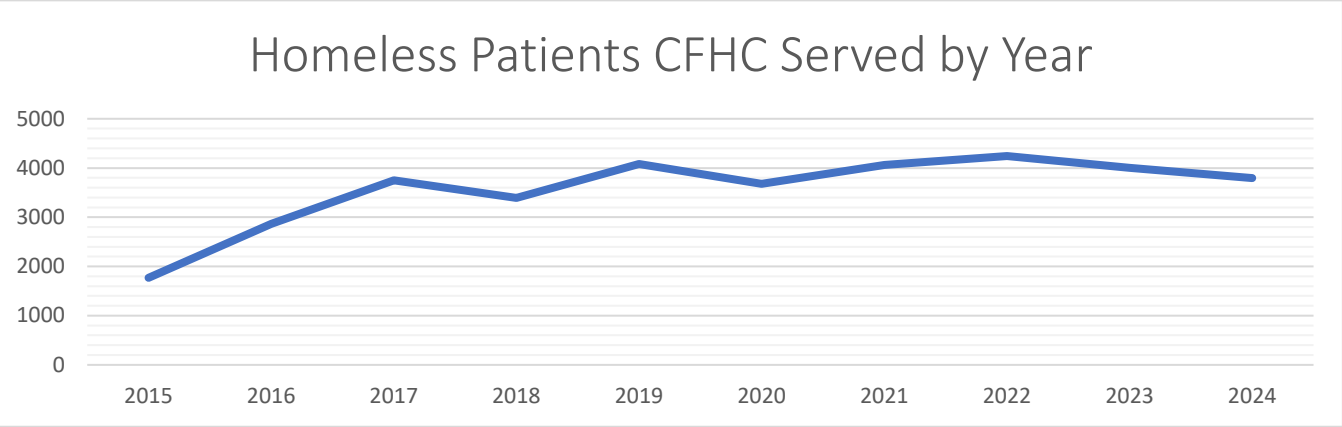
DISABILITY STATUS Disability rates have a direct correlation to health care service utilization. CFHC's service area experiences disabilities at a higher rate than the Mississippi average.



SOURCE: American Community Survey, 2023

- Greene County has the highest service area average of people with disability (25.3%).
- The most common disability in the service area is Ambulatory Disability, which is also the most common throughout Mississippi.

HOUSING STATUS According to the Mississippi Balance of State Continuum of Care, the most recent Point-In-Time Count was conducted in August 2024, measuring the number of homeless individuals on any given night throughout the state of Mississippi. The total number of homeless individuals identified during this count was 470 across the state, although 5 out of the 7 counties served by CFHC were not represented within this count. The rate of homelessness within Mississippi is 3.3 individuals per 10,000 people in the general population. While the Point-In-Time Count reports a decrease in homelessness between 2015-2024, the number of homeless patients served per year by CFHC has inversely increased by 115% between 2015-2024, serving 3,795 homeless patients in 2024 (UDS Report, 2015-2024).



Many factors contribute to someone becoming homeless. When there is a lack of affordable housing, a high percentage of poverty, a lack of employment opportunities and few options for affordable healthcare, this can create an environment where homelessness becomes an ongoing issue for the community. A lack of affordable housing and the limited scale of housing assistance programs has contributed to the current homeless crisis in the service area. Amid rising mortgage rates and falling home sales, foreclosures are a major issue with the state. The foreclosure rate in Mississippi is currently 1 in every 10,950 (ranked 42nd out of the 50 states).[8]

According to the National Coalition for the Homeless, homelessness and poverty are inextricably linked. People of lower socioeconomic status are frequently unable to pay for housing, food, childcare, health care and education. Difficult choices must be made when limited resources cover only some of these necessities. Often, housing must be dropped, since it absorbs such a large portion of household income. If you are poor, you are essentially one illness, one accident or one paycheck away from living on the streets. The declining value and availability of public assistance is another contributor to increasing poverty and homelessness. Many families leaving welfare struggle to get medical care, food and housing as a result of lost benefits, low wages and unstable employment. Additionally, most states have not replaced the old welfare system with an alternative that enables families and individuals to obtain above-poverty employment and to sustain themselves when work is not available or possible.

Other areas of specific note within the homeless population include:

- **Lack of Affordable Healthcare** – For families and individuals struggling to pay the rent, a serious illness or disability can trigger a downward spiral into homelessness, beginning with a lost job, followed by depletion of savings and eventual eviction.
- **Domestic Violence** – Battered women who live in poverty are often forced to choose between an abusive relationship and homelessness. Between 22-57% of all homeless women report that domestic violence was the immediate cause of their homelessness, and 38% of all victims of domestic violence become homeless at some point in their lives.[9]
- **Mental Health & Substance Abuse Disorders –** According to the National Institute of Health (NIH), many of the individuals who lack a permanent residence suffer from mental health disorders and/or substance use disorders that prevent them from finding safe living conditions. NIH estimates that in 2021, 76.2% of chronically homeless individuals suffered from a chronic substance abuse problem, severe mental illness or comorbid condition.[10]

[8] SoFi Learn, *Foreclosure Rates for All 50 States in March 2024*, Retrieved from https://www.sofi.com/learn/content/foreclosure-rates-for-50-states/

[9] National Network to End Domestic Violence, *Domestic Violence, Housing and Homelessness*, Retrieved from https://nnedv.org/wp-content/uploads/2019/07/Library_TH_2018_DV_Housing_Homelessness.pdf

[10] Gutwinski S, Schreiter S, Deutscher K, Fazel S. The prevalence of mental disorders among homeless people in high-income countries: An updated systematic review and meta-regression analysis. PLoS Med. 2021 Aug 23

HEALTH STATUS VARIABLES

Health Outcomes								
Measure	**Mississippi**	**George County**	**Greene County**	**Hancock County**	**Harrison County**	**Jackson County**	**Stone County**	**Wayne County**
Poor or fair health	21%	22%	22%	18%	20%	19%	23%	24%
Poor physical health days*	3.7	4.1	4.0	3.7	3.8	3.6	4.1	4.1
Poor mental health days*	4.7	5.0	5.0	4.9	5.2	4.9	5.3	5.2
Life Expectancy	72.5	70.9	76.1	75.5	73.1	73.8	71.5	72.8
Infant Mortality**	9	N/A	N/A	21	136	83	N/A	N/A
Low birthweight	12%	8%	6%	8%	11%	10%	12%	14%
Diabetes Prevalence	14%	11%	12%	11%	12%	11%	12%	13%
Premature Death	62,211	565	246	992	4,184	2,810	428	404

SOURCE: County Health Rankings, 2024
*Average number of unhealthy days reported in the past 30 days.
**Number of infant deaths within 1 year per 1,000 live births.

- Wayne County has the overall highest population identified as having poor health within the service area.
- Average life expectancy within the service area is higher than the Mississippi average.
- Infant mortality is highest in Harrison County (136).
- Wayne County is the only county in the area with higher average of low birth weight as compared to the Mississippi average.
- Overall, diabetes prevalence within the service area is lower than the Mississippi average.

Measure	Mississippi	George County	Greene County	Hancock County	Harrison County	Jackson County	Stone County	Wayne County
Adult Smoking*	20%	21%	21%	19%	20%	18%	22%	21%
Adult Obesity	39%	39%	39%	37%	36%	35%	41%	42%
Low Healthy Food Access	4	6	7	6	6	6	6	7
Physical Inactivity	30%	31%	29%	26%	29%	27%	31%	33%
Access to Exercise Opportunities	58%	35%	14%	55%	68%	77%	76%	42%
Excessive Drinking	16%	16%	16%	15%	16%	16%	15%	13%
Alcohol Impaired Driving Deaths	19%	17%	24%	11%	18%	26%	21%	11%
Teen Birth Rate**	29	38	37	22	26	23	24	51

SOURCE: County Health Rankings, 2020-2023
*Age-adjusted
**Rate per 100,000 population

- Adult smoking rate (22%) is highest in Stone County.
- Obesity rate (42%) is highest in Wayne County.
- Obesity for all counties within the service area is lower than or equal to the Mississippi average (39%) with the exception of Stone and Wayne Counties.
- Physical inactivity rate (33%) is highest in Wayne County.
- Excessive drinking is the highest in George, Greene, Harrison and Jackson Counties (17%), and alcohol impaired driving deaths are highest in Jackson County.
- Teen births are highest in Wayne County (50%) and lowest in Jackson and Stone Counties (26%).

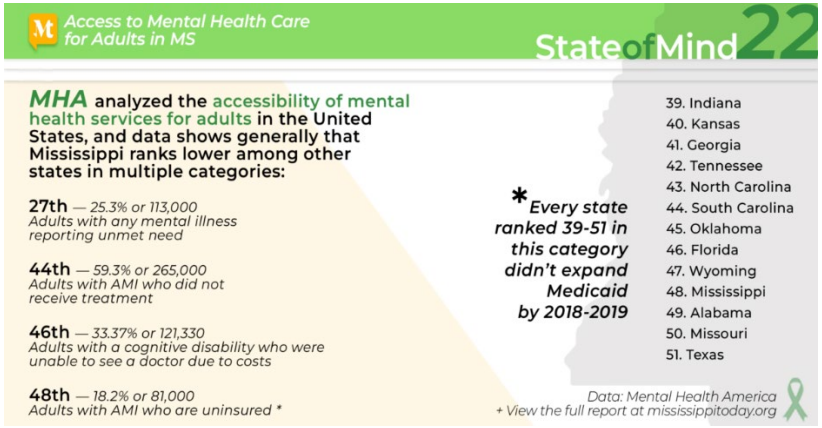
Behavioral Health Conditions

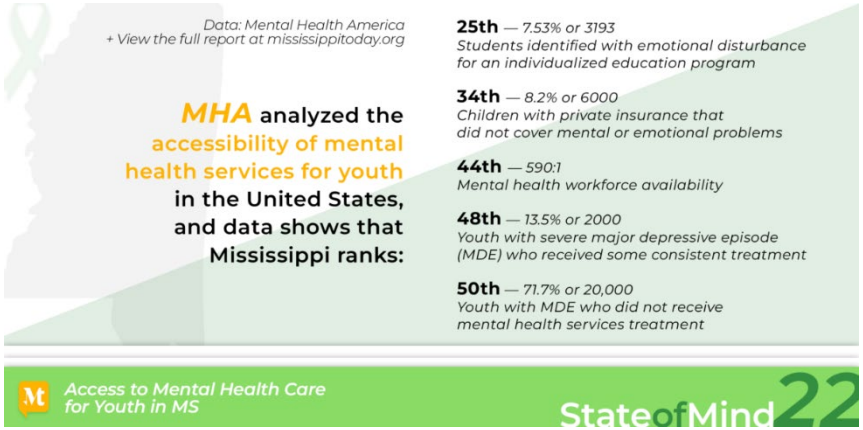
Nationally:

- 1 in 5 U.S. adults experience mental illness each year.
- 1 in 20 U.S. adults experience serious mental illness each year.
- 1 in 6 U.S. youth aged 6-17 experience a mental health disorder each year.
- 50% of all lifetime mental illness begins by age 14, and 75% by age 24.
- Suicide is the 2nd leading cause of death among people aged 10-14.[11]

In Mississippi:

- In 2023, 39.2% of adults in Mississippi reported signs or symptoms of anxiety and/or depression (per the PHQ-2/GAD-2 Scale with a score of 3 of more), compared to 32.3% of U.S. adults.
- Drug overdose death rates increased in Mississippi from 10.7 per 100,000 in 2011 to 28.4 per 100,000 in 2021. 556 opioid overdose deaths took place in Mississippi in 2021, which accounted for 71% of overdose deaths in the state.[12]
- According to an analysis done by Mental Health America (MHA), Mississippi ranks lower in multiple categories when analyzing the accessibility of mental health services for adults and youth (see figures 1 & 2 below).





Overall, the greatest barrier faced is not only adequate access to mental health services, but the shortage of mental health professionals to carry out those services. Mississippi ranks #7 in mental health care deserts and is one of five critical needs areas. Ongoing barriers include cost, transportation, lack of insurance, stigma, availability of provider, specialty area (i.e. eating disorder, autism), and lack of knowledge of behavioral health services.

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[11] https://www.nami.org/get-involved/awareness-events/suicide-prevention-month/#:~:text=79%25%20of%20all%20people%20who,death%20overall%20in%20the%20U.S.

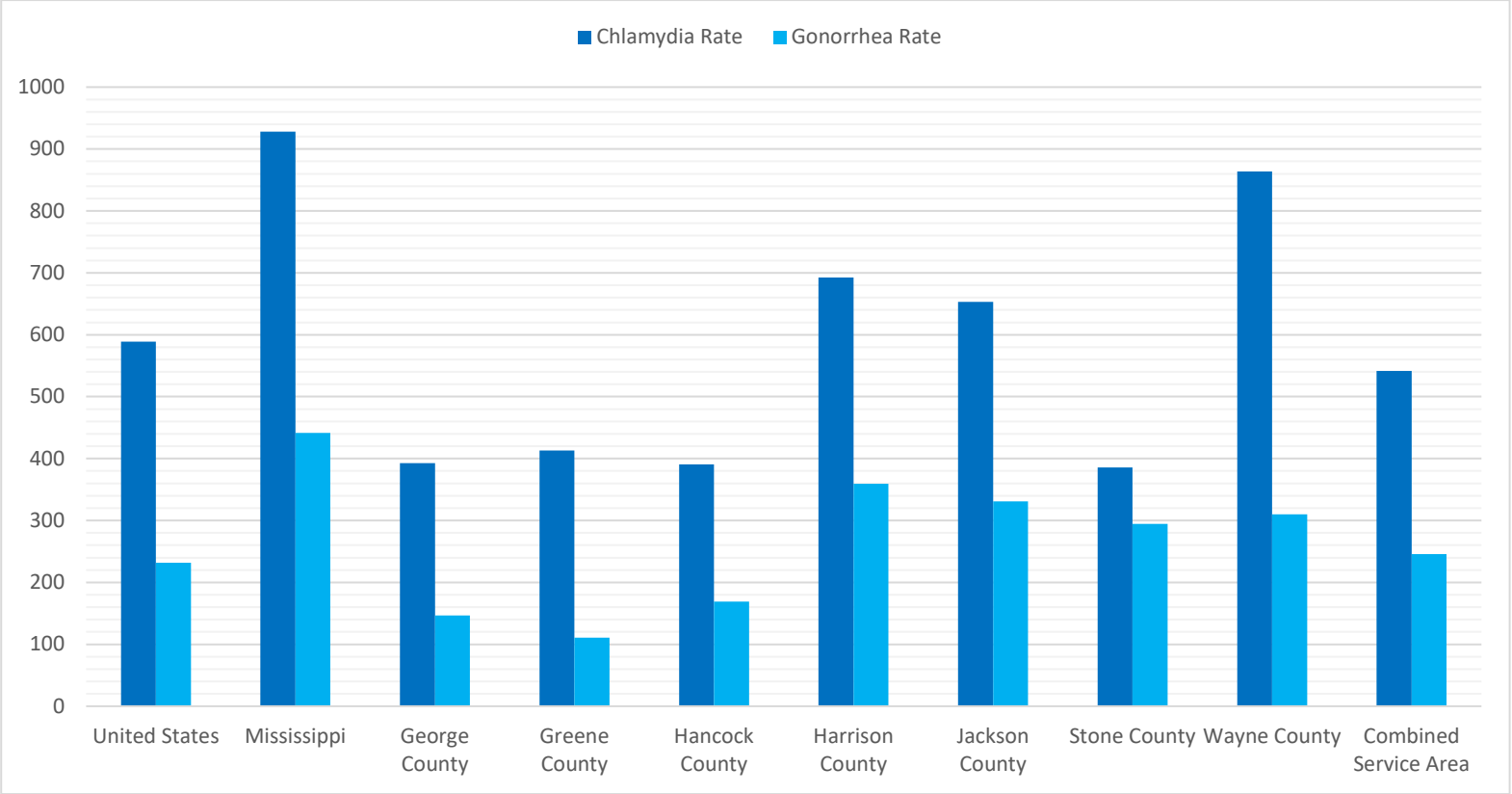
[12] https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/mississippi/

Sexually Transmitted Infections

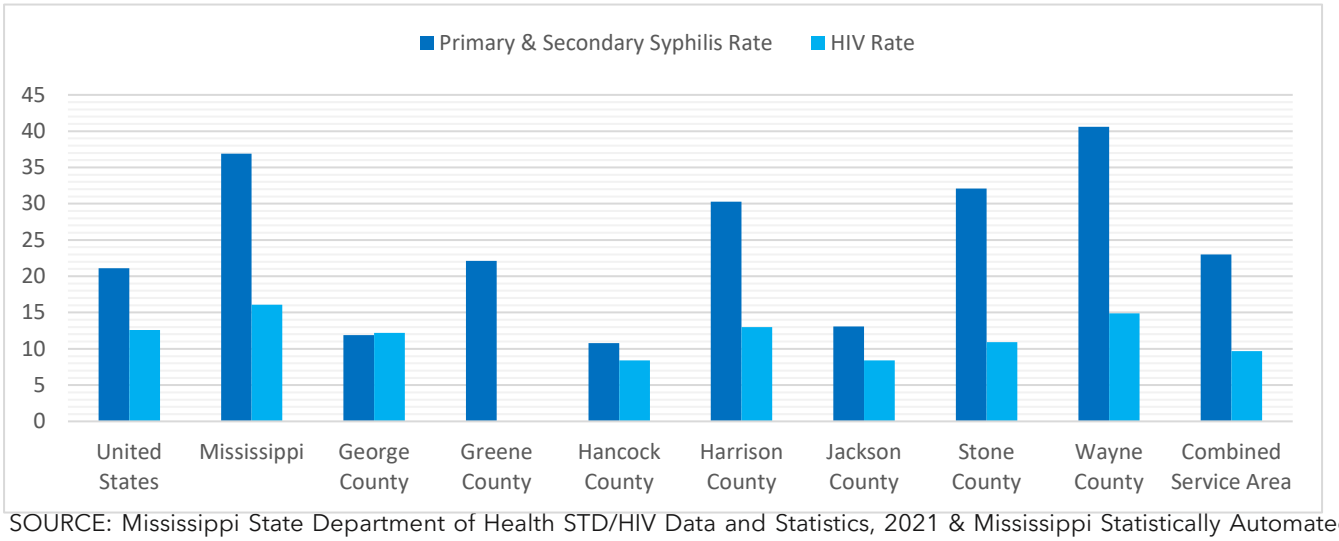
Sexually transmitted infection rates, while lower than Mississippi rates on average, are higher in the service area than the U.S. averages, especially in Harrison County. These numbers show potential need for education and prevention programs.

STI Measures									
Measure	**United States**	**Mississippi**	**George County**	**Greene County**	**Hancock County**	**Harrison County**	**Jackson County**	**Stone County**	**Wayne County**
Chlamydia Rate*	588.7	928.2	392.8	413.2	390.5	692.3	653.2	385.7	863.8
Gonorrhea Rate*	231.6	441.7	146.8	110.7	169.2	359.2	331.1	294.6	309.9
Primary & Secondary Syphilis Rate*	21.1	36.9	11.9	22.1	10.8	30.3	13.1	32.1	40.6
HIV Rate*	12.6	18	32	84	91	684	287	35	35
HIV Prevalence**	386.6	401.2	146.6	641.9	209.2	397.9	246.3	214.6	215.0

SOURCE: Mississippi State Department of Health STD/HIV Data and Statistics, 2021 & Mississippi Statistically Automate Health Resource System, 2022
*Number of new diagnoses per 100,000 population
**Number of people 13 and older living with a diagnosis of HIV per 100,000 population



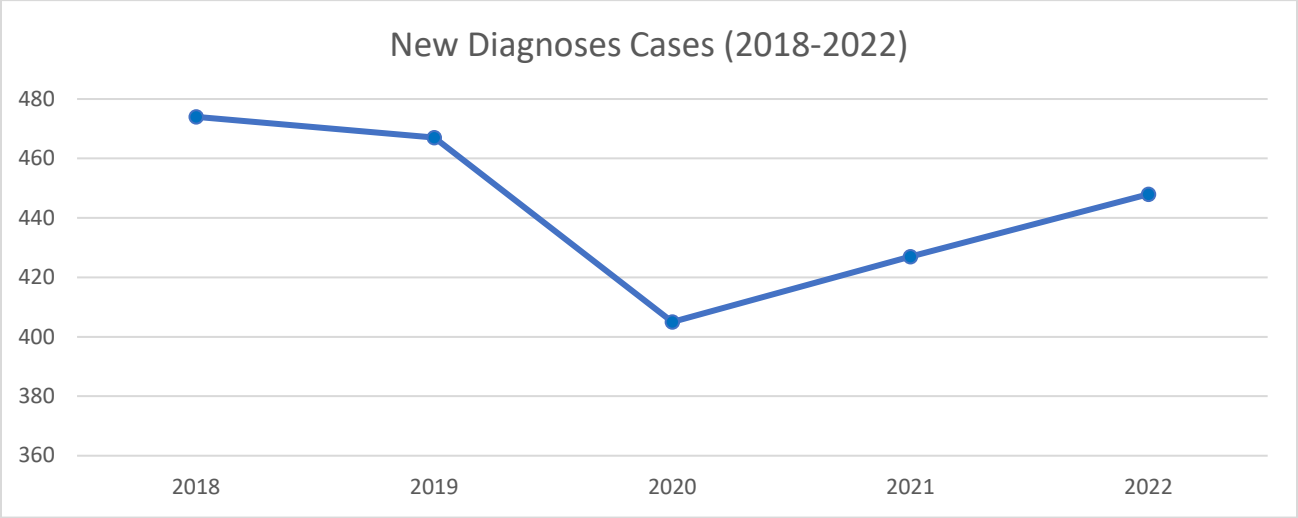
- Rate of gonorrhea is highest in Wayne County, and rate of chlamydia is highest in Harrison County.
- Rates of chlamydia are lower within all counties in the service area as compared to the Mississippi average, and five counties (George, Greene, Hancock, Stone and Wayne) have lower rates than the U.S. average.
- All counties within the service area have lower rates of gonorrhea than the Mississippi average; however, only three counties (George, Greene and Hancock) have a lower rate than the U.S. average.

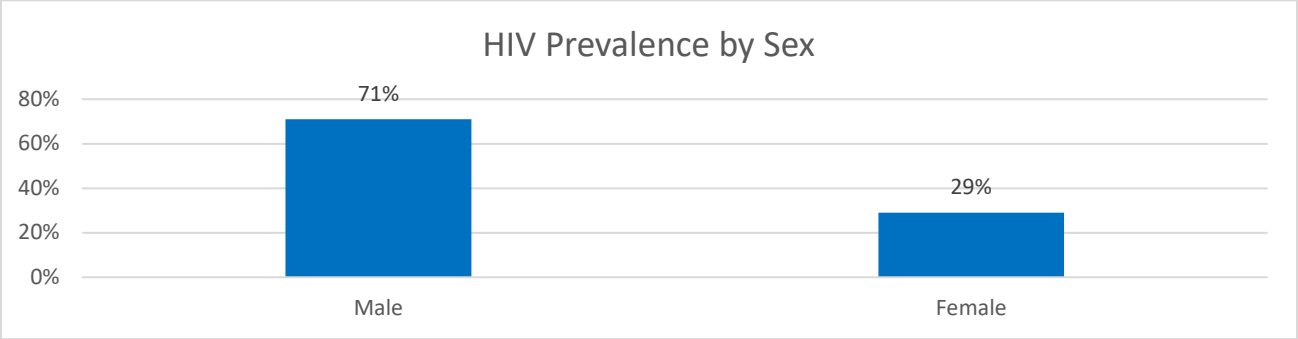


SOURCE: Mississippi State Department of Health STD/HIV Data and Statistics, 2021 & Mississippi Statistically Automated Health Resource System, 2022

- With the exception of Wayne County (40.6), all other counties within the service area have a lower rate of syphilis than the Mississippi average. Hancock County has the lowest rate of primary and secondary syphilis (10.1).
- All counties within the service area have a lower rate of HIV than the Mississippi average.

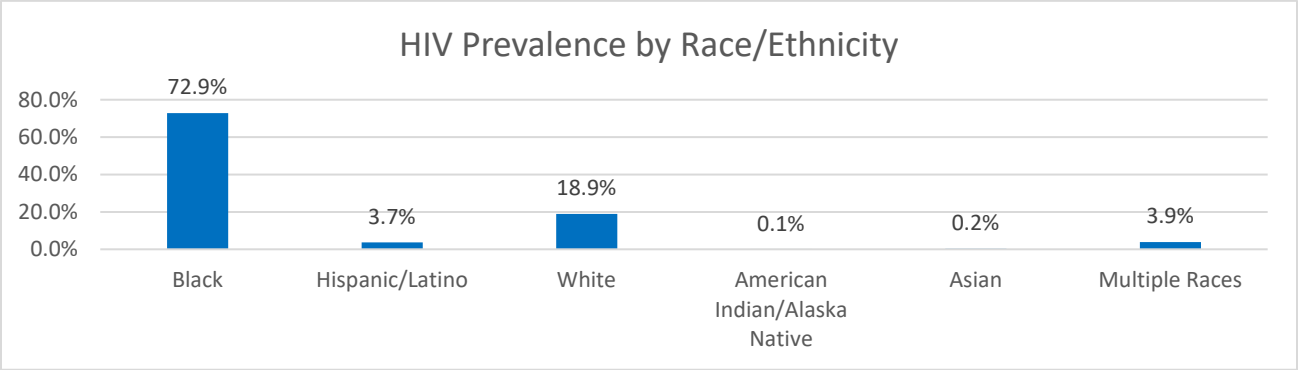
HIV Prevalence





SOURCE: AIDSVu, 2022

- Males had a significantly higher number of HIV cases per year than females.



SOURCE: AIDSVu, 2022

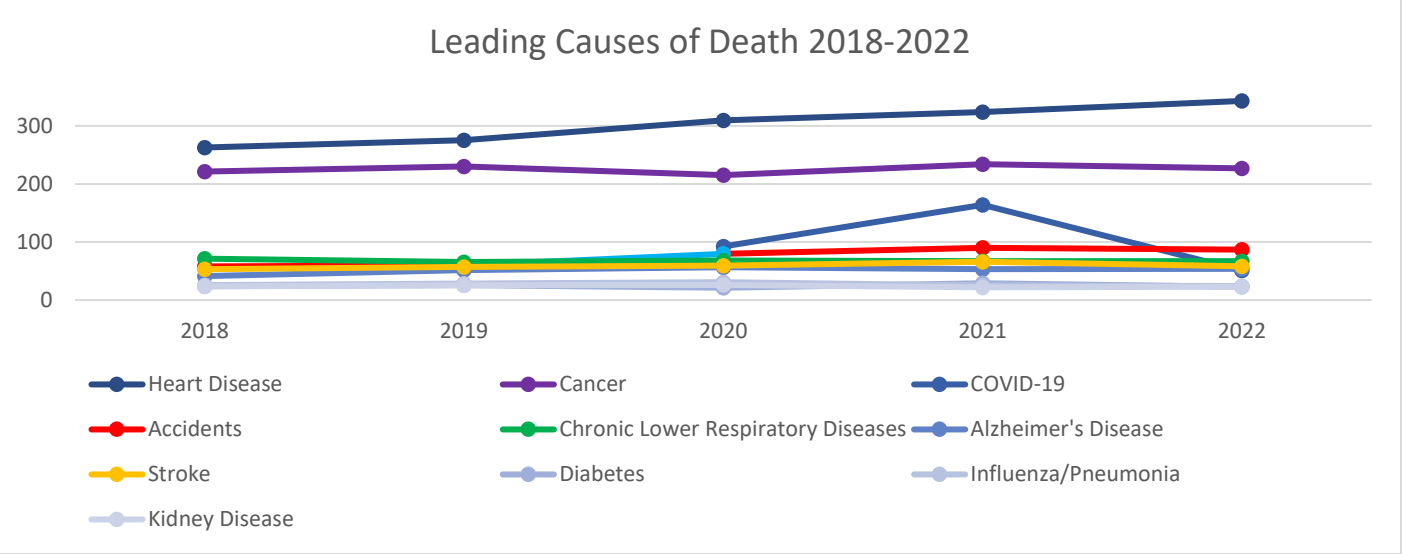
- African Americans had a significantly higher number of HIV cases per year than other races.

LEADING CAUSES OF DEATH The deaths that occur in Coastal Family Health Center's service area mirror causes of death reported statewide; heart disease and cancer are the most common causes.

Leading Causes of Death*					
Combined Service Area	**White**	**African American**	**Other**	**Total**	**Percent change rates 2018-2022**
Heart Disease	380.0	277.6	116.1	343.3	+30.6%
Cancer	255.7	169.9	68.	226.6	+2.4%
Accidents (Unintentional Injury)	97.2	62.2	44.0	86.6	+49.3%
COVID-19	54.5	46.4	20.0	50.9	-45.0%
Chronic Lower Respiratory Diseases	86.0	17.6	8.0	66.6	-6.6%
Stroke	62.0	50.1	44.0	58.4	+9.8%
Alzheimer's Disease	64.1	27.9	20.0	53.6	+29.8%
Diabetes	24.0	23.2	4.0	22.7	-4.6%
Influenza/Pneumonia	25.7	24.1	4.0	24.1	-5.1%
Kidney Disease	24.8	26.9	12.0	23.2	-0.9%

*Crude rates expressed as per 100,000 population

SOURCE: Mississippi State Department of Health, Mississippi Statistically Automated Health Resource System, 2018-2022



- Heart disease is the leading cause of death in the service area.
- COVID-19 and chronic lower respiratory disease deaths have declined most.
- Deaths related to accidents have increased dramatically since 2018 (+49.3%).

ACCESS TO CARE Patient access to care sets the baseline for all patient encounters within the healthcare industry. When patients cannot access their clinicians, it is impossible to receive medical care and achieve overall wellness.

Provider Concentrations by County			
Area	**Patient to Primary Care Provider Ratio**	**Patient to Mental Health Provider Ratio**	**Patient to Dental Provider Ratio**
Mississippi	1,880:1	460:1	1,940:1
George County	2,250:1	1,800:1	3,150:1
Greene County	13,630:1	1,940:1	6,780:1
Hancock County	2,300:1	2,300:1	3,840:1
Harrison County	1,790:1	390:1	1,380:1
Jackson County	2,180:1	570:1	2,380:1
Stone County	3,110:1	2,670:1	4,670:1
Wayne County	3,280:1	1,790:1	6,560:1

SOURCE: County Health Rankings, 2024

- Greene County has the lowest concentration of Primary Care Providers (13,630:1) and Dental Providers (6,780:1).
- Stone County has the lowest concentration of Mental Health Providers (2,670:1).
- Harrison County is the only county in the service area that has a higher concentration of all provider types than the state averages.

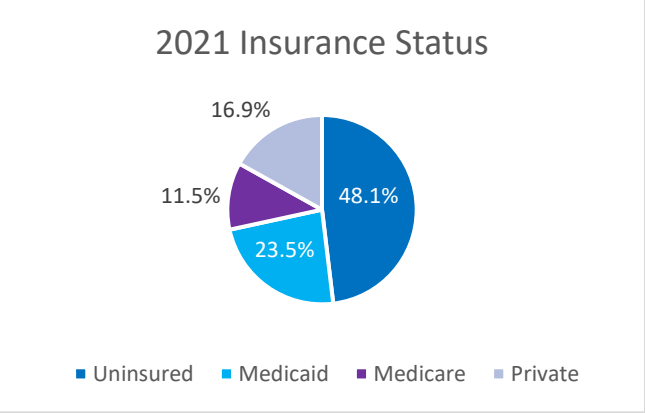
Health Insurance

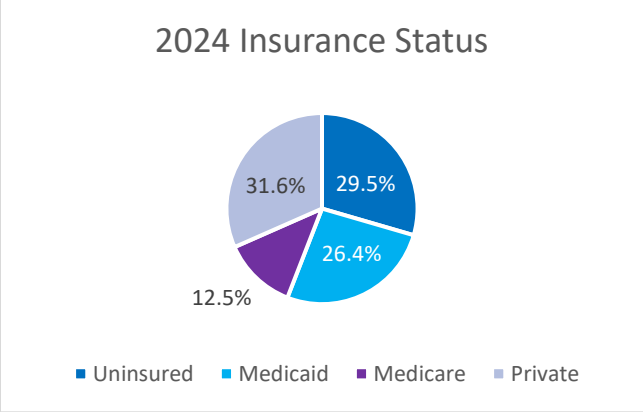
Uninsured Rate by County									
Measure	**United States**	**Mississippi**	**George County**	**Greene County**	**Hancock County**	**Harrison County**	**Jackson County**	**Stone County**	**Wayne County**
Uninsured 2024	8%	14%	15%	13%	12%	14%	14%	16%	17%
Uninsured 2021	10%	15%	17%	16%	16%	17%	14%	17%	17%

SOURCE: County Health Rankings, 2021 & 2024

- The service area has less uninsured residents today than in 2021.
- George, Stone, and Wayne Counties have a higher uninsured rate than the state average.
- Counties within the service area have between 50-113% higher uninsured rates when compared to the national average.

Insurance Status Comparison 2021 vs. 2024 – CFHC Patients





SOURCE: UDS Report, 2021 & 2024

Transportation

Transportation by County								
Measure	**Mississippi**	**George County**	**Greene County**	**Hancock County**	**Harrison County**	**Jackson County**	**Stone County**	**Wayne County**
Driving Alone to Work	84%	80%	67%	78%	81%	85%	86%	84%
Long Commute Driving Alone	34%	50%	56%	50%	27%	36%	55%	42%

SOURCE: County Health Rankings, 2024

The street network across the three coastal counties (Hancock, Harrison and Jackson) includes a mixture of rural to city roads, some intercity roads, and grid roadway systems centered on existing and historic city/town centers and government complexes. Serving as the main resource for public transit, Coast Transit Authority (CTA) offers urban fixed-route public transportation, ADA paratransit transportation, carpool, vanpool, park-and-ride, bike-

and-bus and senior transportation throughout these counties.[13] CTA operates with a system of fare zones, and no free or reduced-price transfers are allowed. Customers pay a fare when they board the vehicle and must pay an additional fare each time they cross a zone.[14]

Jackson County also has additional options for public and health related transportation through Jackson County Civic Action Committee (transportation for elderly and persons with disabilities) and Singing River Hospital System (transportation for elderly and persons with disabilities and patients of SRHS and Clinics).

In the much more rural areas of George, Greene, Stone and Wayne Counties, people are accustomed to traveling longer distances to access services; an issue that compounds other barriers to care. Especially challenging for the people of the area, no public transit services are available in these counties. The only resources found are through private companies (such as Grove Transit and Mobile One) and Medicaid offering non-emergency transportation throughout the Greater Mississippi Pine Belt Region and surrounding areas. With this, those who do not have their own transportation must rely on family and friends for rides to and from appointments.

[13] https://coasttransit.com/wp-content/uploads/2016/04/Final-Report-TDP-Update-3_10_11-No-Appendices.pdf
[14] https://coasttransit.com/fares-fare-zones/

SERVICE ACCESS & UTILIZATION

Patient Origin Analysis

Jackson County					
Zip Codes	**Total Population**	**Low Income Population**	**Total Patients Served in 2024**	**Penetration of Total Population**	**Penetration of Low Income**
39552, 39563, 39569	12,099	5,713	1,653	14%	29%
39553	17,768	7,249	784	4%	11%
39555, 39562	16,574	5,870	1,817	11%	31%
39564, 39566	41,748	9,321	1,458	3%	16%
39565	20,954	5,939	1,026	5%	17%
39567, 39568, 39595	10,191	4,494	358	4%	8%
39581	11,755	6,091	489	4%	8%
TOTALS	131,089	44,677	7,585	6%	17%

Harrison County					
Zip Codes	**Total Population**	**Low Income Population**	**Total Patients Served in 2024**	**Penetration of Total Population**	**Penetration of Low Income**
39501, 39502, 39505	24,091	15,662	2,811	12%	18%
39503	53,049	17,789	3,530	7%	20%
39506, 39507	18,151	7,522	1,010	6%	13%
39530	8,170	4,409	1,494	18%	34%
39531, 39535	18,766	6,113	1,340	7%	22%
39532	36,004	12,586	2,008	6%	16%
39533, 39540	12,922	5,040	1,011	8%	20%
39534	1,898	-	-	0%	0%
39560	18,289	4,610	797	4%	17%
39571	14,010	4,759	1,027	7%	22%
39574	13,937	4,929	1,396	10%	28%
TOTALS	219,287	83,419	16,424	7%	20%

Hancock County					
Zip Codes	**Total Population**	**Low Income Population**	**Total Patients Served in 2024**	**Penetration of Total Population**	**Penetration of Low Income**
39520, 39521, 39558	15,281	5,737	1,776	12%	31%
39525	9,360	1,272	496	5%	39%
39556, 39522, 39529	7,907	3,514	826	10%	24%
39572	1,049	299	128	12%	43%
39576	6,228	2,090	746	12%	36%
TOTALS	39,825	12,912	3,972	10%	31%

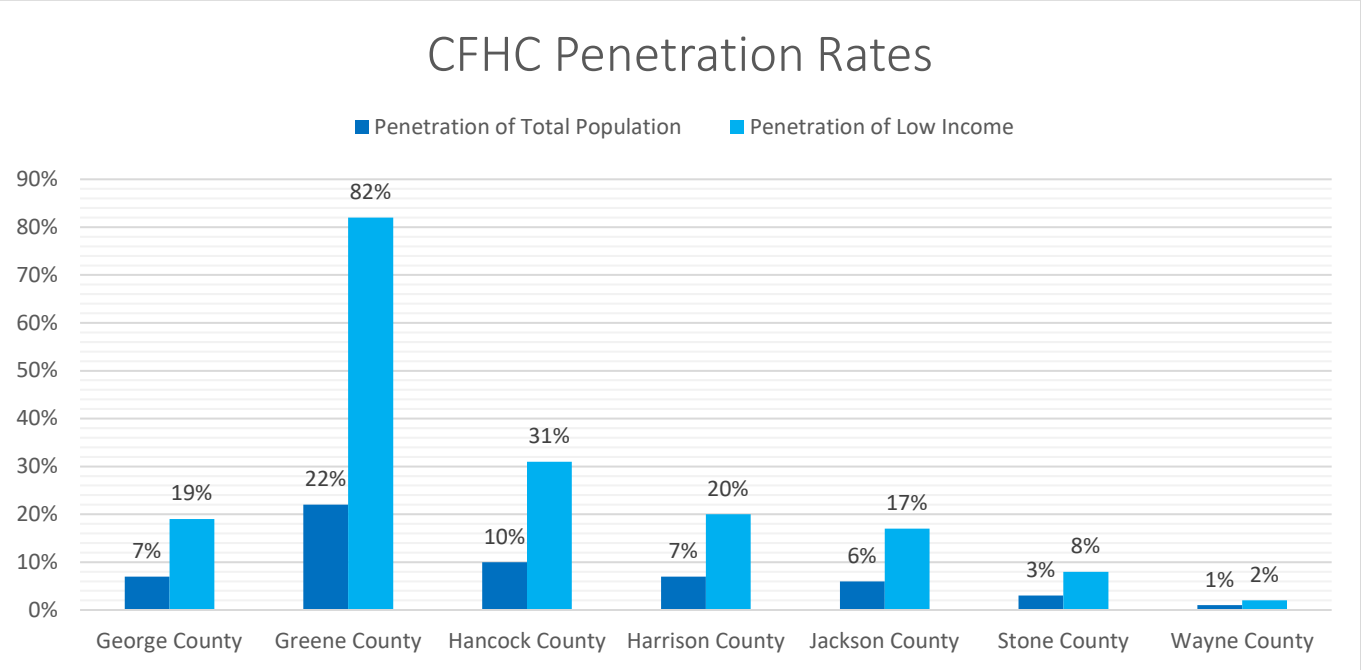
Greene County					
Zip Codes	**Total Population**	**Low Income Population**	**Total Patients Served in 2024**	**Penetration of Total Population**	**Penetration of Low Income**
39362	3,333	1,295	771	23%	60%
39451	7,728	1,541	1,492	19%	97%
39456	632	275	232	37%	84%
39461	560	99	143	26%	144%
TOTALS	12,253	3,210	2,638	22%	82%

Stone County					
Zip Codes	**Total Population**	**Low Income Population**	**Total Patients Served in 2024**	**Penetration of Total Population**	**Penetration of Low Income**
39561	1,770	584	116	7%	20%
39573	9,196	3,164	352	4%	11%
39577	11,133	4,984	207	2%	4%
TOTALS	22,099	8,732	675	3%	8%

Wayne County					
Zip Codes	**Total Population**	**Low Income Population**	**Total Patients Served in 2024**	**Penetration of Total Population**	**Penetration of Low Income**
39322	1,784	787	69	4%	9%
39324, 39367	14,332	7,041	56	<1%	<1%
TOTALS	16,116	7828	125	<1%	2%

George County					
Zip Codes	**Total Population**	**Low Income Population**	**Total Patients Served in 2024**	**Penetration of Total Population**	**Penetration of Low Income**
39452	28,368	11,128	2,077	7%	19%
TOTALS	28,368	11,128	2,077	7%	19%

HEALTH CENTER PENETRATION

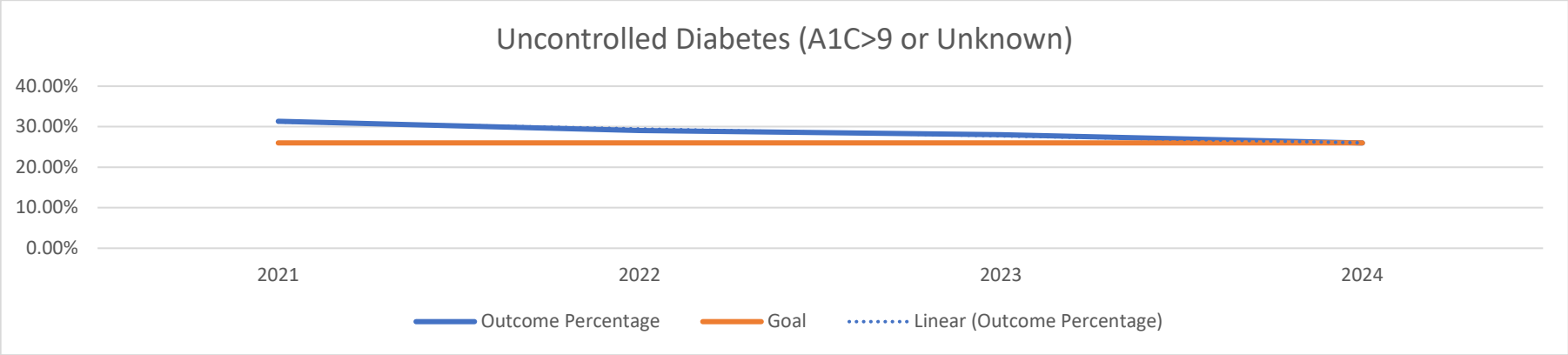


Principal Diagnosis Groupings of CFHC Patients (2024) - UDS Report Data Table 6A – Selected Diagnoses and Services Rendered	
Selected Infectious Diseases	**Patients**
Symptomatic and Asymptomatic HIV	547
Tuberculosis	6
Syphilis and other sexually transmitted diseases	477
Hepatitis B	69
Hepatitis C	429
Novel coronavirus (SARS-CoV-2) disease	841
Long COVID	21
Selected Diseases of the Respiratory System	
Asthma	1234
Chronic bronchitis and emphysema	1326
Acute respiratory illness due to novel coronavirus	4
Selected Other Medical Conditions	
Abnormal breast findings, female	377
Abnormal cervical findings	148
Diabetes mellitus	4563
Heart disease (selected)	1396
Hypertension	10638
Contact dermatitis and other eczema	669
Dehydration	66
Exposure to heat or cold	16
Overweight and obesity	18183
Selected Childhood Conditions	
Otitis media and eustachian tube disorders	1202
Selected perinatal medical conditions	85
Lack of expected normal physiological development	219
Selected Mental Health and Substance Abuse Conditions	
Alcohol related disorders	536
Other substance related disorders	862
Tobacco use disorder	2601
Depression and other mood disorders	4144
Anxiety disorders including PTSD	3737

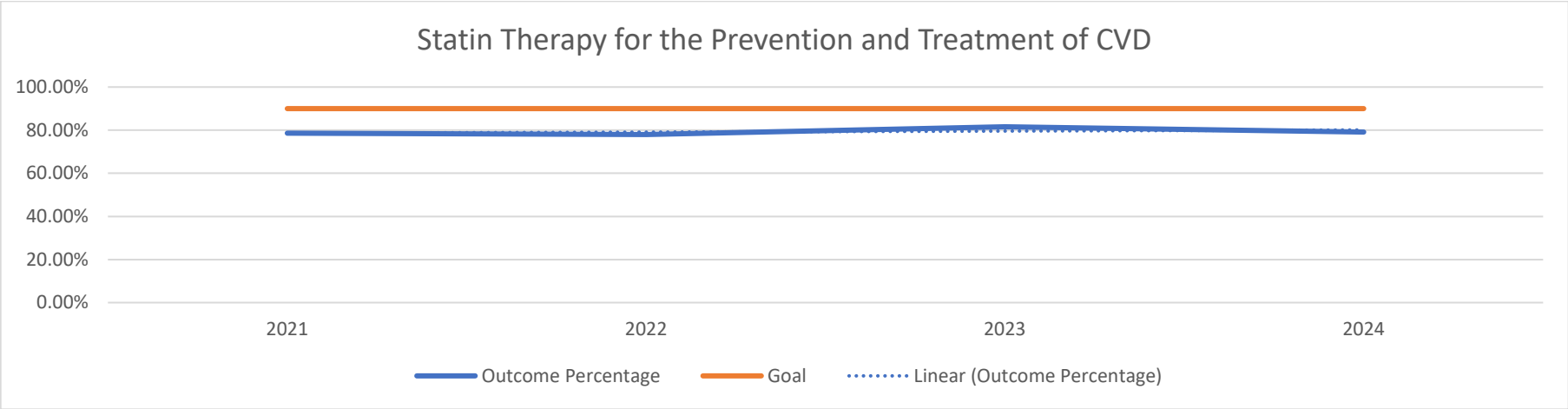
Attention deficit and disruptive behavior disorders	1435
Other mental disorders, excluding drug or alcohol dependence	2266
Human Trafficking	1
Intimate Partner Violence	2
Selected Diagnostic Tests / Screening / Preventive Services	
HIV test	5295
Hepatitis B test	1772
Hepatitis C test	3963
Novel coronavirus (SARS-Cov-2) diagnostics test	4937
Novel Coronavirus (SARS-CoV-2) antibody test	0
PrEP-associated manage (Azara)	31
Mammogram	2123
Pap test	1763
Selected immunizations	3019
Seasonal Flu vaccine	2798
Coronavirus (SARS-CoV-2) Vaccine	99
Contraceptive management	1282
Health supervision of infant or child (ages 0 through 11)	2997
Childhood lead test screening (ages 9-72 months)	1152
Screening, brief intervention, and referral to treatment	1
Smoke and tobacco use, cessation counseling	11731
Comprehensive and intermediate eye exams	3206
Childhood development screenings (<18 years)	1561
Selected Dental Services	
Emergency services	911
Oral exams	2530
Prophylaxis - adult or child	848
Sealants	12
Fluoride treatment - adult or child	159
Restorative services	1033
Oral surgery (extractions and other surgical procedures)	942
Rehabilitative services (Endo, Perio, Prostho, Ortho)	500

CLINICAL INDICATORS OF CFHC PATIENT WELL-BEING

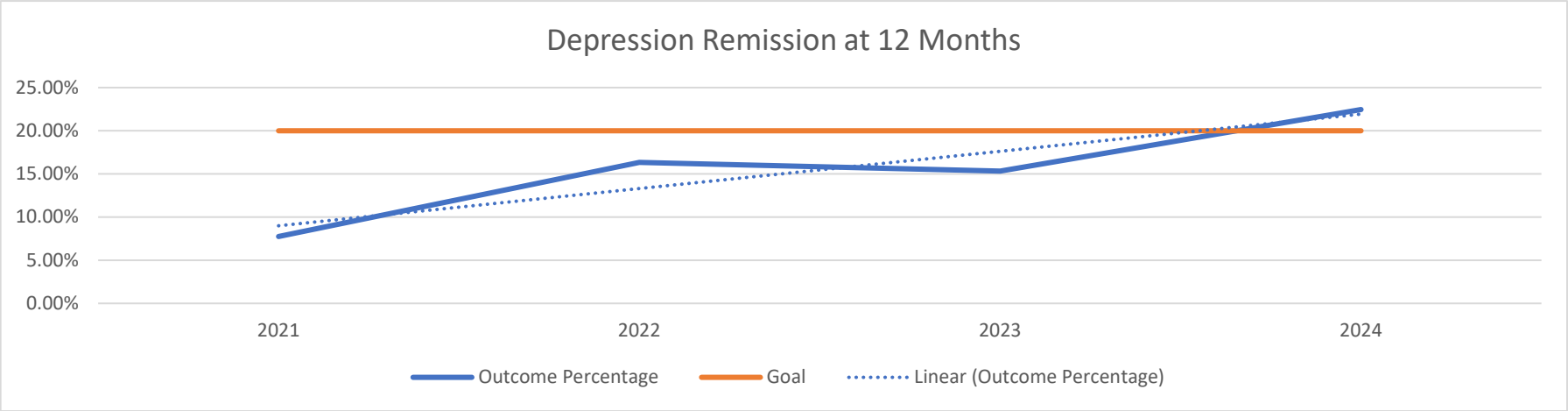
Disease Management



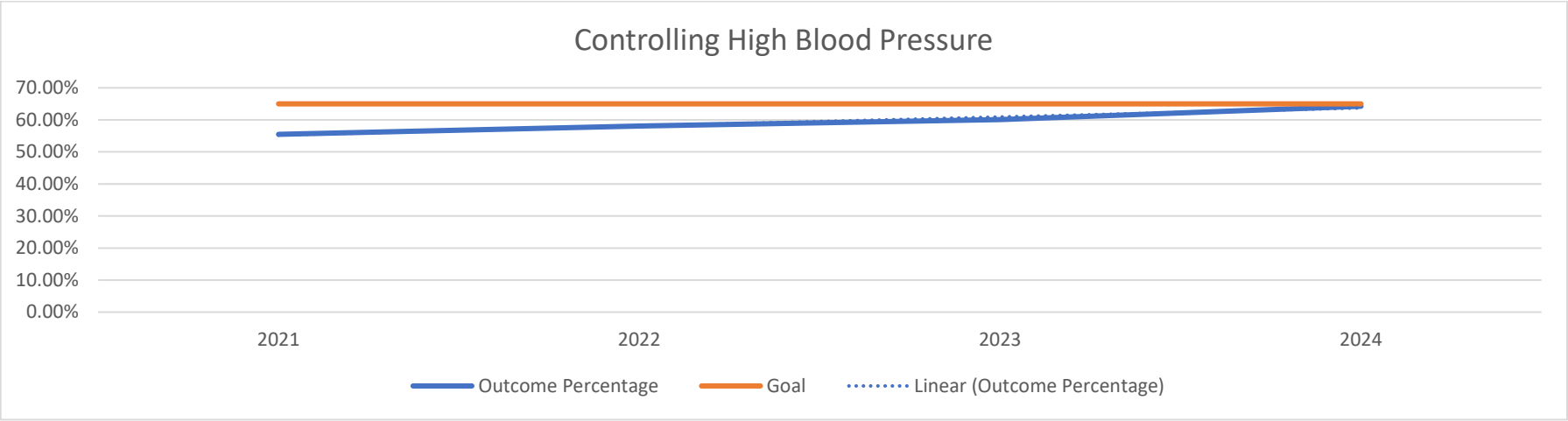
In 2024, CFHC decreased the percentage of uncontrolled diabetes patients by 17%, meeting the goal of 26% or below. Medication adherence monitoring strategies and curbside consultations with specialists have allowed providers to better assist our patients with diabetes disease management. To continue to address this measure, CFHC will increase recall efforts to decrease the number of patients with unknown A1Cs.



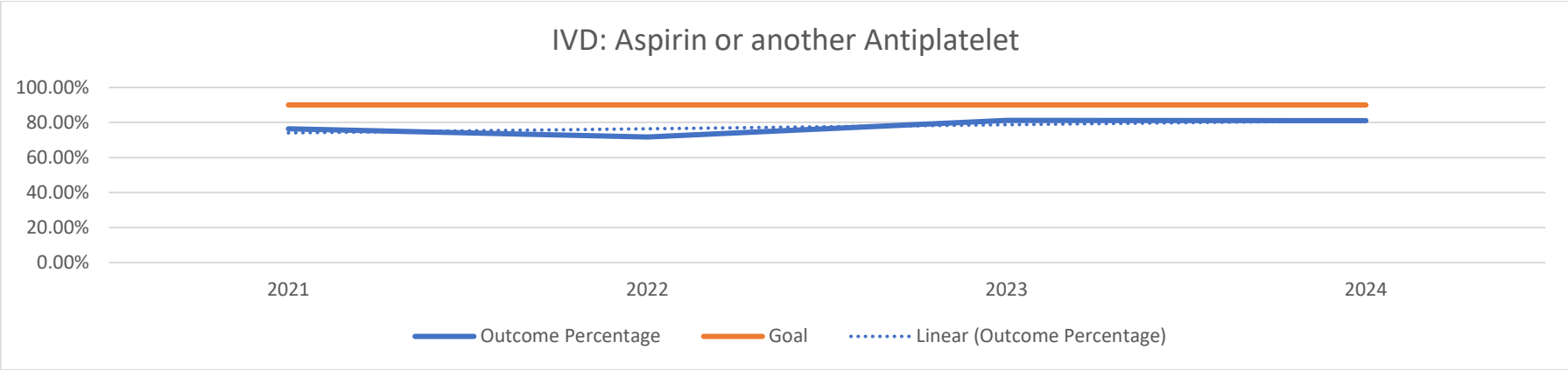
The weight assessment and counseling for children and adolescents measure significantly increased over the 2018-2021 time period and is currently above the established goal. Increased well-child visits have given providers the opportunity to assess this measure with their patients.



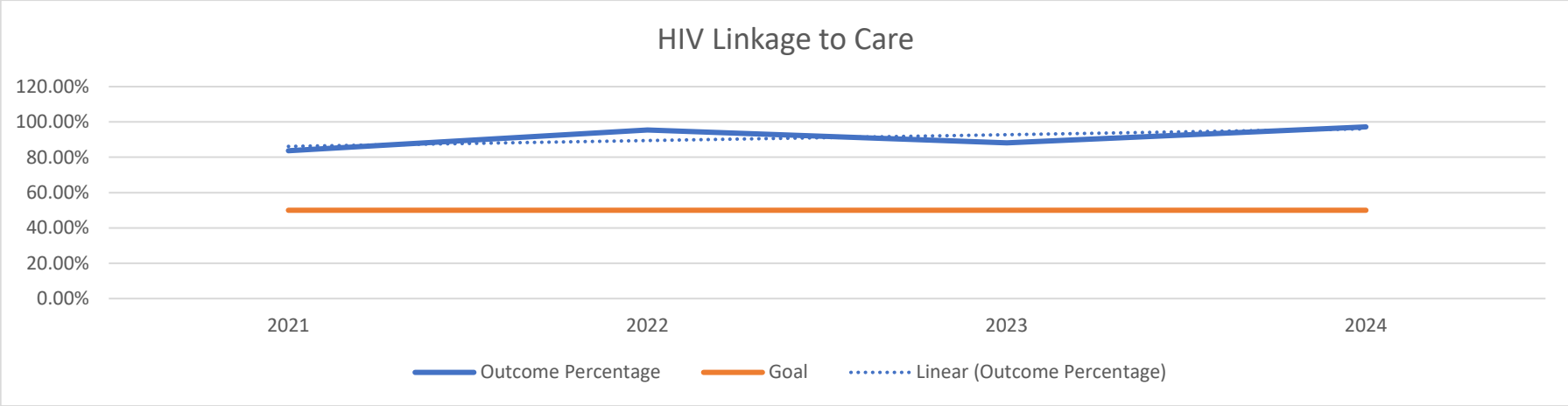
CFHC has significancy increased the outcome for this measure between 2021 and 2024 by 190%. The implementation of the PHQ-9 at every visit allows providers to readily capture changes in depression that can be addressed at each visit by the primary care provider and clinic mental health provider.



CFHC significantly increased the controlled blood pressure outcome goal between 2021 and 2024 by 15.8%. Remote patient monitoring for blood pressures was implemented in late 2021, as well as the chronic care navigation program. The Chronic Care Management program for Medicare patients allows us to reach patients with chronic conditions, including hypertension through our ChartSpan partner. Improvements in clinical training for nurses to better capture accurate blood pressures have also assisted in the improvements in the measure outcomes.

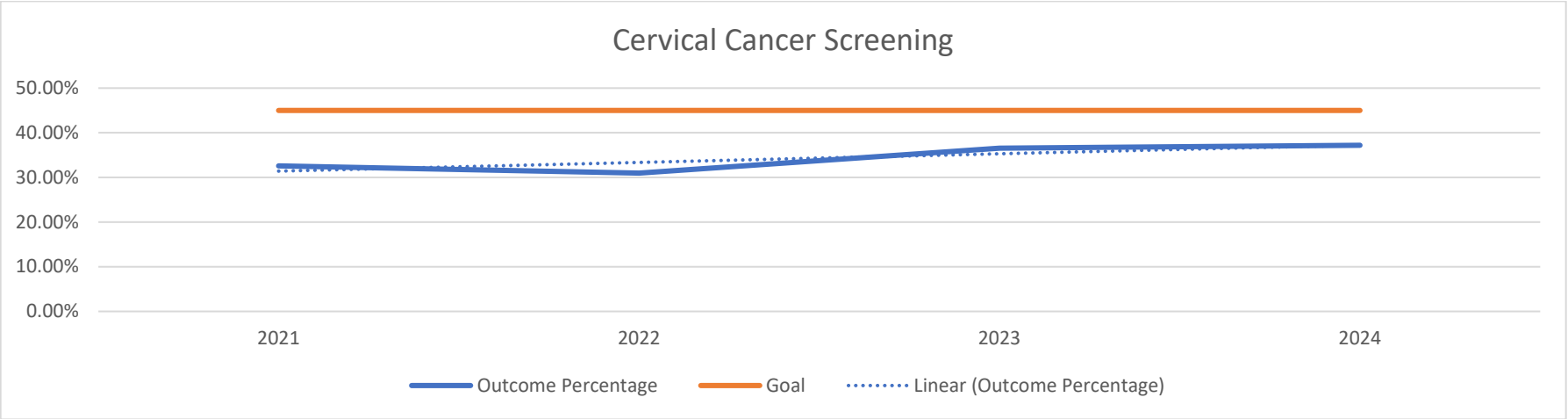


The IVD measure has increased between 2021 and 2024 by 6.1%. CFHC will continue to monitor this measure and work on recall efforts to ensure that patients are coming in for routine care. CFHC will also ensure that aspirin is being documented properly in the medication module for over-the-counter supplies.

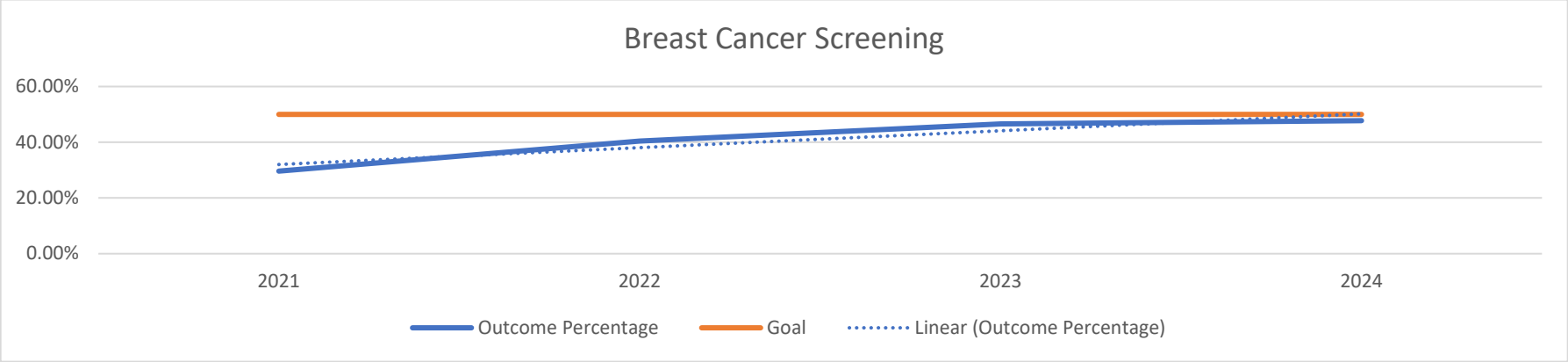


The HIV Linkage to Care measure has significantly increased between 2021 and 2024 by 16.1%. This measure continues to be a primary measure of access to proper HIV care, and protocols have been placed to ensure that patients are linked to a provider within 30 days of an HIV diagnosis. CFHC will continue to monitor this measure and work on recall efforts to ensure that patients are coming in for routine care.

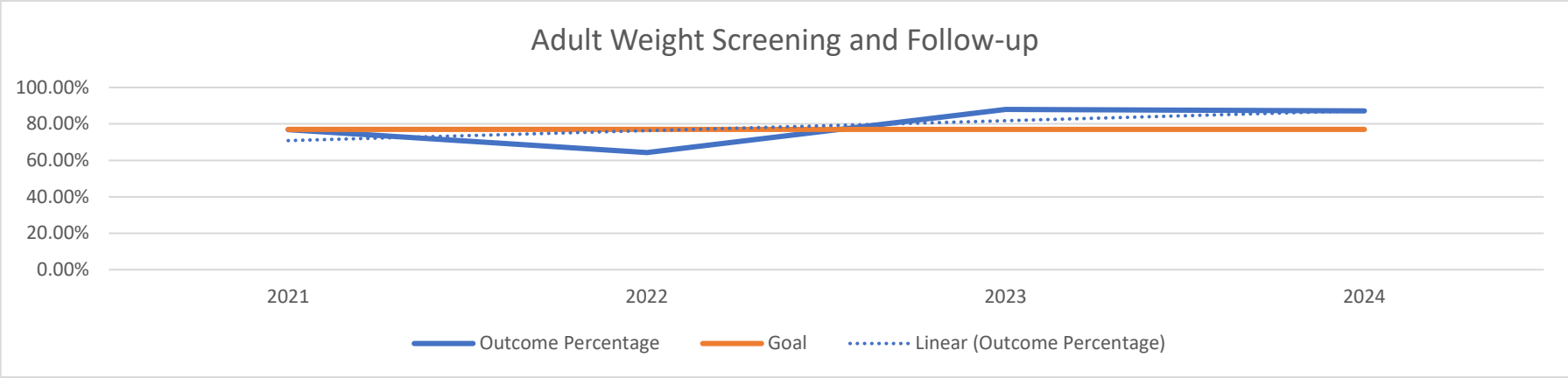
Preventative Measures



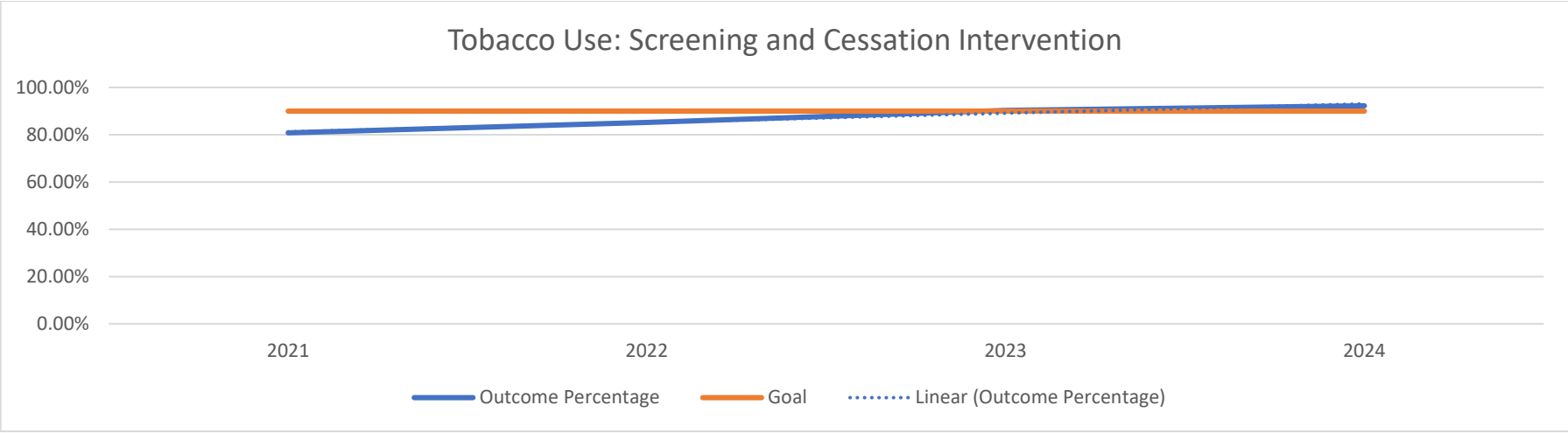
CFHC has significancy increased the outcome for this measure between 2021 and 2024 by 14%. The process for ensuring that screening and preventive services are reviewed during clinic huddles has been improved and women's health days have been held in order to increase cervical cancer screening awareness campaigns.



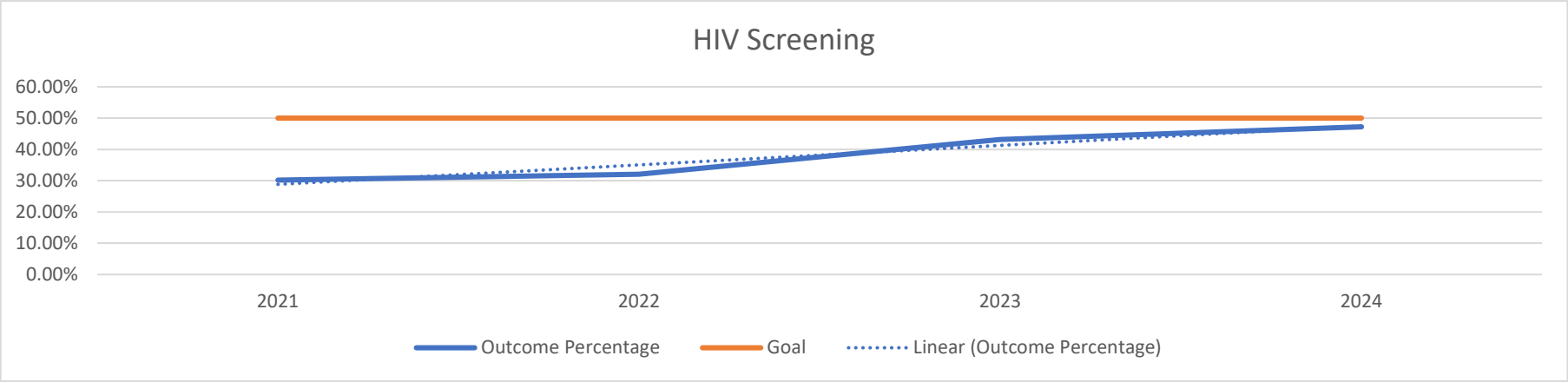
CFHC has significancy increased the outcome for this measure between 2021 and 2024 by 61%. CFHC has improved the process for ensuring that screening and preventive services are reviewed during clinic huddles and have implemented women's health days in order to increase breast cancer screening awareness campaigns. We have also participated in a project through the T.H. Chan Harvard School of Public Health in order to develop workflows and screening tools to improve breast and colorectal cancer screening and abnormal follow-up efforts.



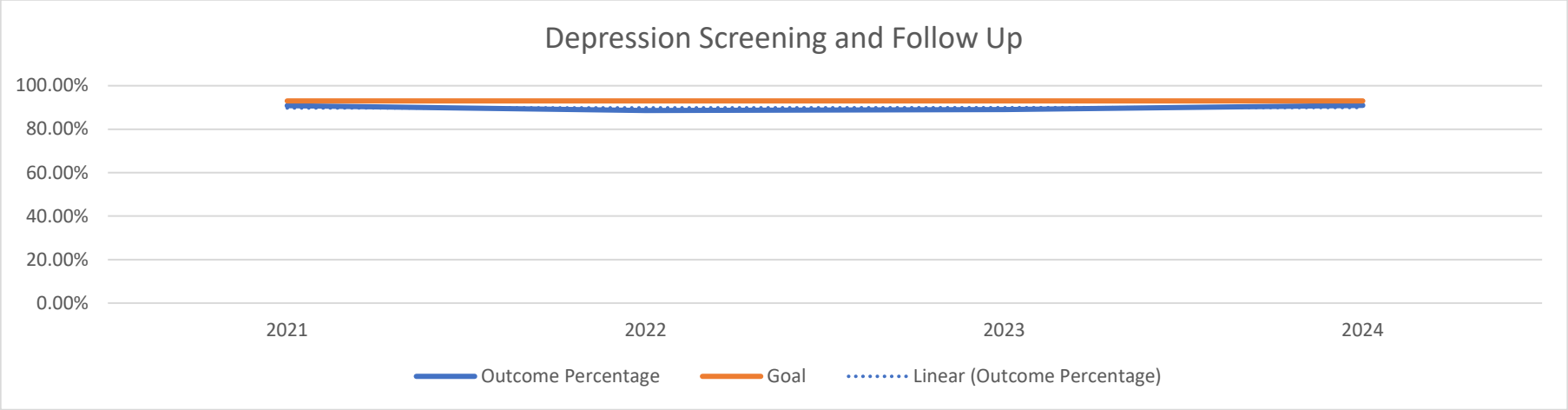
CFHC has significancy increased the outcome for this measure between 2021 and 2024 by 13.4% and has surpassed our goal of 77% in 2023 and 2024. Improvements in documentation have allowed us to better capture this measure. We will continue to monitor this measure and will increase our goal to 90%.



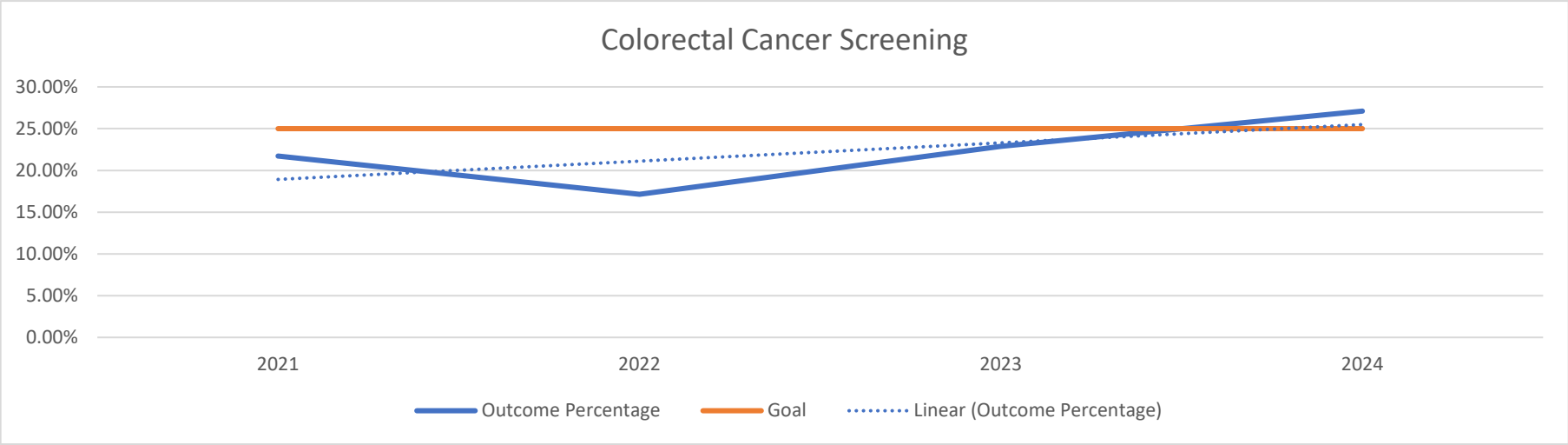
CFHC has significancy increased the outcome for this measure between 2021 and 2024 by 14.2% and has surpassed our goal of 90% in 2023 and 2024. Improvements in documentation have allowed us to better capture this measure. We will continue to monitor this measure and will increase our goal to 93%.



CFHC has significancy increased the outcome for this measure between 2021 and 2024 by 56%. We have implemented increased efforts to screen patients during annual well visits.

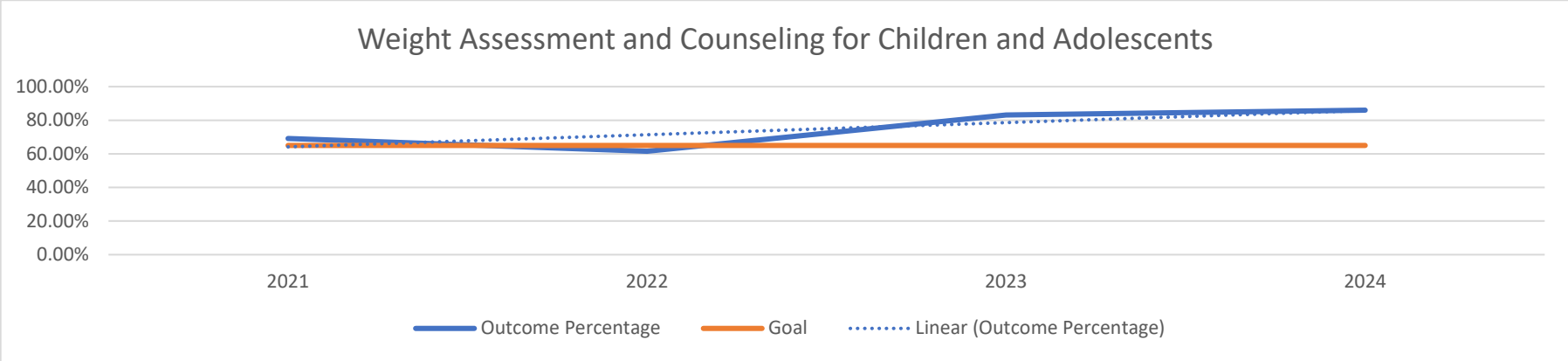


CFHC has increased the outcome for this measure between 2021 and 2024 by 0.5%. The implementation of the PHQ-9 at every visit allows providers to readily capture changes in depression that can be addressed at each visit by the primary care provider and clinic mental health provider. We have also implemented electronic processes so that patients can complete the PHQ-9 prior to their visit.

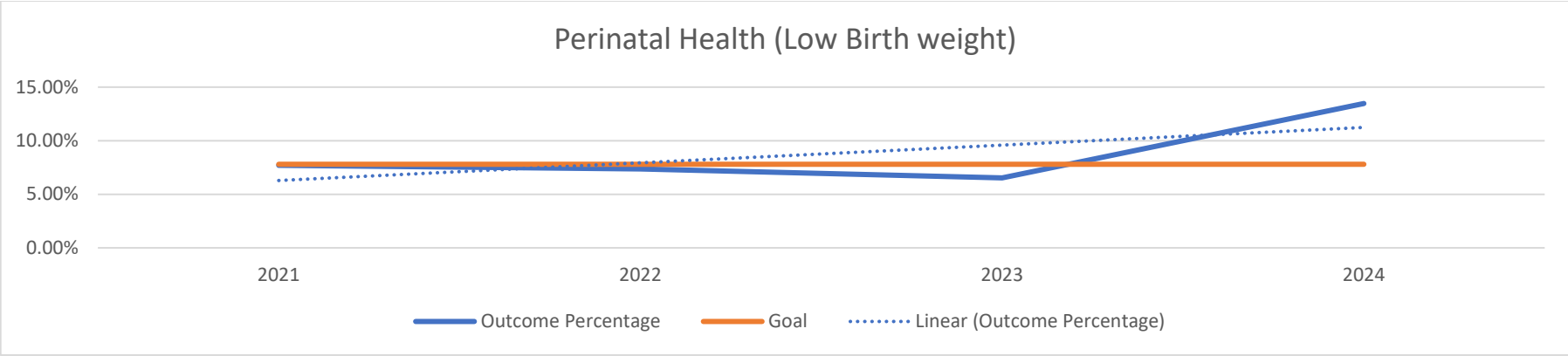


CFHC has significancy increased the outcome for this measure between 2021 and 2024 by 25%. We have improved our process for ensuring that screening and preventive services are reviewed during clinic huddles, and we have implemented improved colorectal cancer screening processes. We have also participated in a project through the T.J. Chan Harvard School of Public Health in order to develop workflows and screening tools to improve breast and colorectal cancer screening and abnormal follow-up efforts.

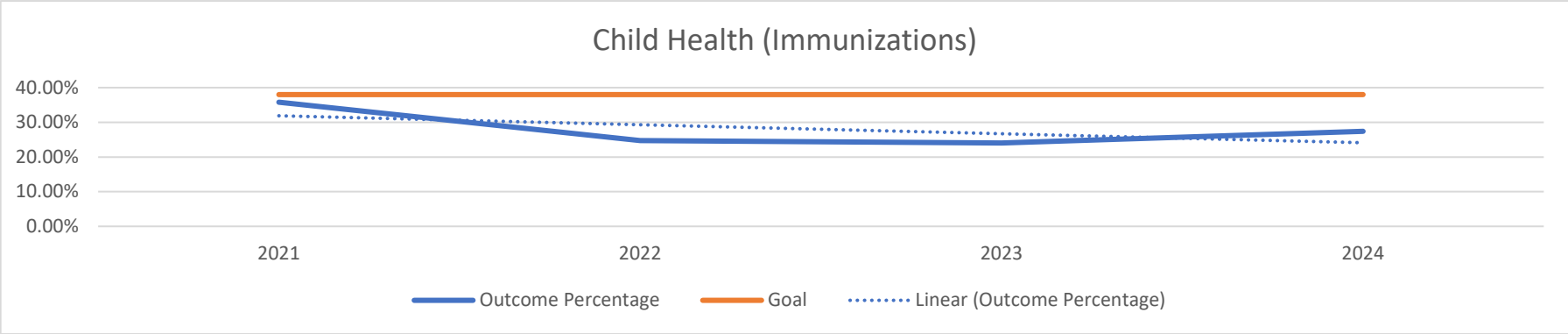
Maternal Care & Child Health



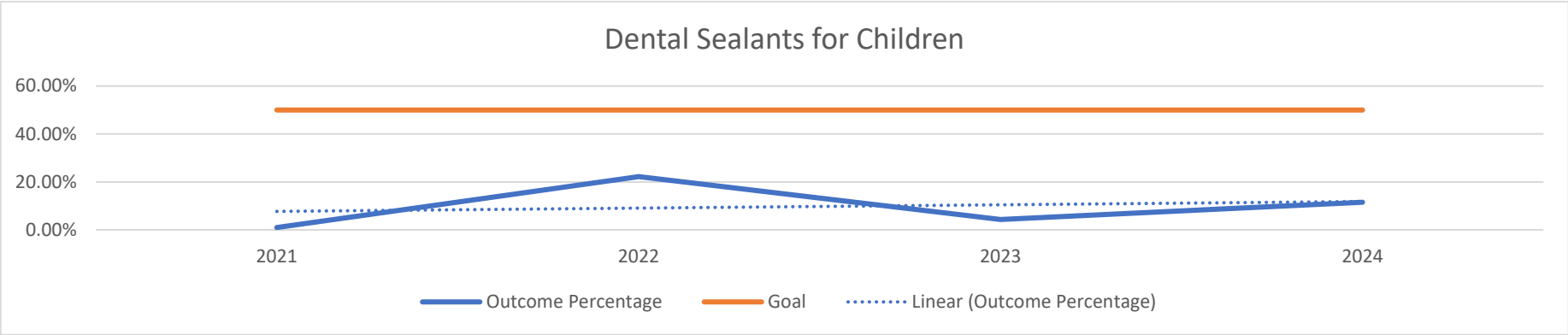
CFHC has significantly increased our weight assessment and counseling for children and adolescents outcomes over the 2021-2024 time period by 24%, and we have surpassed our goal of 65%. Increased well child visit efforts have given providers the opportunity to assess this measure with their patients.



CFHC increased our low birth-weight in 2024 significantly. Increased efforts to obtain birth weight reports after delivery provided additional information, including low birthweight deliveries. We will be analyzing the increased birth weight metrices in order to propose opportunities to reduce the number of babies born with low birth weights in 2025.



CFHC has significantly decreased our childhood immunization rates from 2021-2024, although we increased our outcomes between 2023 and 2024. We have implemented a recall program through Pfizer for monthly immunization and well visit recalls. We have also implemented a monthly review for immunizations that may have been documented in MIIX from another healthcare organization and not updated in our EHR.



CFHC significantly increased our outcomes for this measure between 2021 and 2024; however, this measure remains a challenge for our clinics. Chart audits revealed that sealant plans were in patient charts; however, the actual sealants were not completed. In 2025, we will run reports of patients that have sealant plans in their charts to increase the number of patients completing their sealant plans.

Qualitative and Quantitative Primary Data Collection

QUALITATIVE INTERVIEWS & SURVEYS Qualitative and quantitative data collection are the core of the research portions of the needs assessment. The secondary data research provides a framework with which to build a better understanding of the community. However, the qualitative and quantitative primary research techniques provided insight and color that illuminate the unique aspects of community needs in Coastal Family Health Center's service area.

CFHC's CHNA Planning Group conducted a series of individual interviews and surveys with community members in addition to surveys with community partners with the purpose of soliciting consumers' insights, experiences and expectations regarding healthcare-related needs within the community.

Consumer Interviews

The interviews were held with a varied group of consumers to gain additional perspectives on key topics. A total of 40 interviews were conducted. George, Harrison, Hancock, and Jackson counties were represented. Interviewees were asked 17 questions.

Barriers to Accessing Care

- All counties except for George identified cost and lack of insurance as barriers to accessing health care for themselves and their loved ones.
- All counties except Jackson also identified transportation as a barrier.
- Hancock and Harrison counties identified appointment availability as a barrier faced in the past.

Access to Specialty Care

- 88% of interviewees indicated that they have access to specialty referrals.

Relationship with Primary Care Provider

- 100% of interviewees described their primary care providers as understanding, active listeners.

Hospital Utilization

- 45% of interviewees indicated that they receive services from local hospitals rarely, as needed for emergencies.
- 33% of interviews indicated that they never receive services from local hospitals.

Affordability of Prescription Medications

- 67% of interviewees indicated that their prescription medication is affordable.
- 63% of interviewees were aware of medication assistance programs available.

Transportation to Medical Appointments

- 100% of interviewees indicated that it is easy or somewhat easy to get to medical appointments.

Improving the Health of the Community

- All counties identified increased access to affordable healthcare as a method for improving community health.

Access to Healthy Foods

- 15% of interviewees indicated limited access to healthy foods where they reside.
- Some interviewees stated that while healthy food is available, it is too expensive to purchase.

Top Community Health Issues

- All counties within the service area identified heart disease/hypertension as a top health issue within their communities.
- Obesity and diabetes were collectively the second and third top identified needs by interviewees.
- Harrison, Hancock & Jackson County interviewees identified mental health as a top issue.

Community Partner Surveys

Surveys were sent to a varied group of community partners to gain additional perspectives on key topics. A total of 11 surveys were completed. All counties were represented. Respondents were asked 9 questions.

When asked what are the top community health issues:

- Affordable healthcare was the top identified unmet need (50%).
- 75% of respondents indicated lack of transportation as a barrier to care.

When asked for suggestions to improve community health, the following were identified:

- Additional access to medical care
- Health education
- Transportation assistance
- Community health workers

Quantitative Community Online Survey An online survey was conducted via text message among CFHC patients (n=573) in the primary service area. The survey included representation of all counties within the service area and proportional representation of African Americans and other racial groups. Sample design details are listed below.

Survey Instrument

The questionnaire included 16 need-specific evaluation questions as well as demographic questions. A full list of questions can be found in Appendix A.

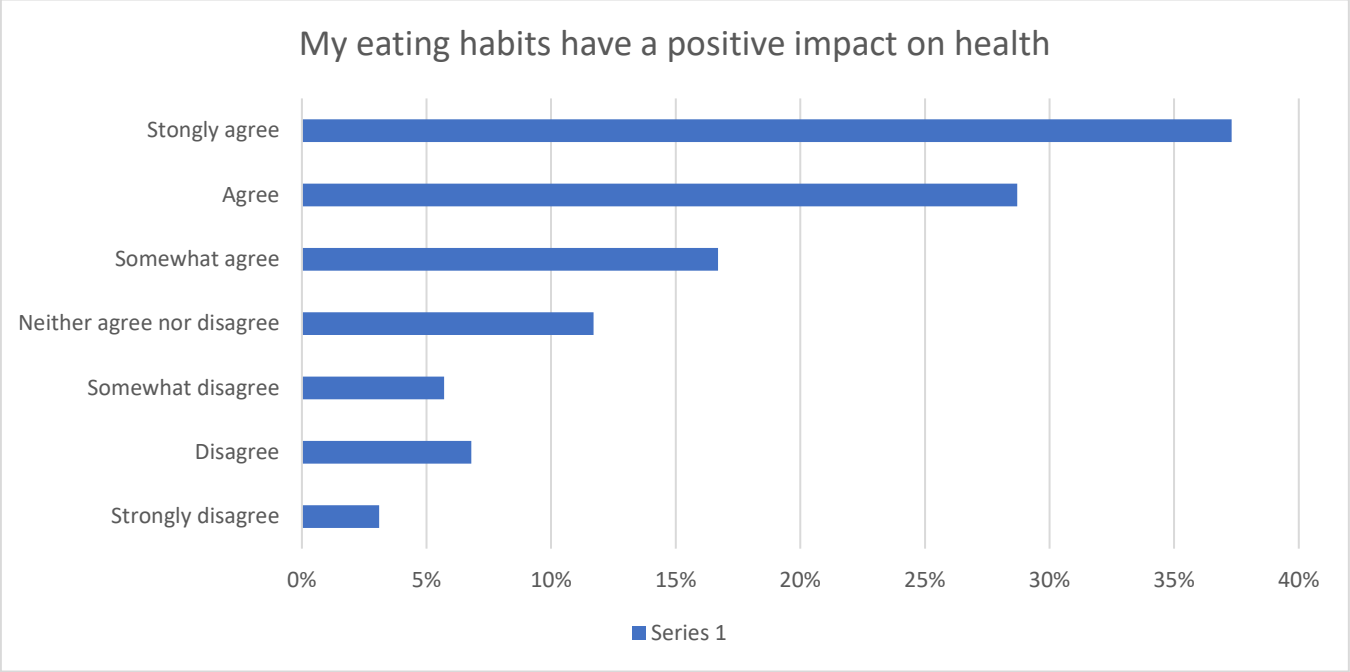
Respondent profiles (N=573)

Community Survey Residence Characteristics		
County	**Number of Respondents**	**Percent of Respondents**
Greene	41	7.3%
Wayne	5	0.9%
George	29	5.2%
Jackson	125	22.4%
Harrison	265	47.4%
Hancock	63	11.3%
Stone	12	2.1%
Other	19	3.4%

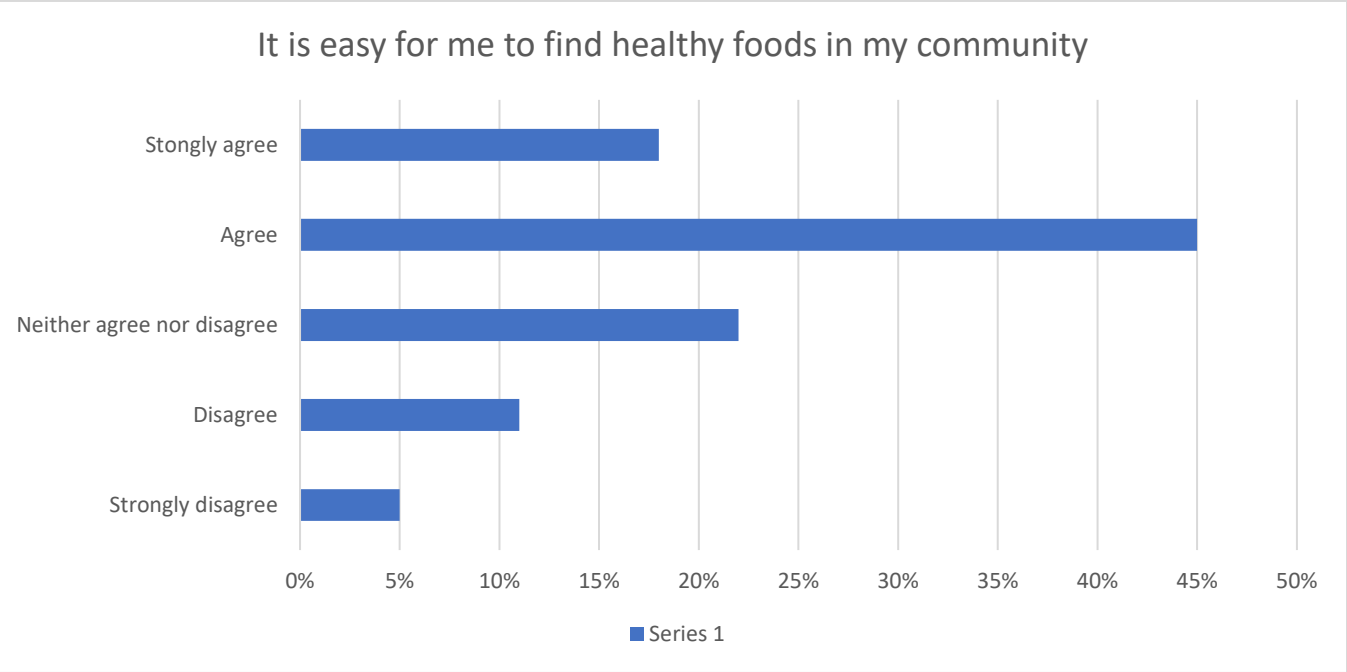
Community Survey Race/Ethnicity Characteristics		
Race	**Number of Respondents**	**Percent of Respondents**
American Indian/Alaskan Native	9	1.6%
Asian/Asian American	2	0.3%
Black/African American	144	26.1%
Native Hawaiian/Other Pacific Islander	1	0.2%
White	342	62.1%
More Than One Race	15	2.7%
Hispanic	41	8.0%

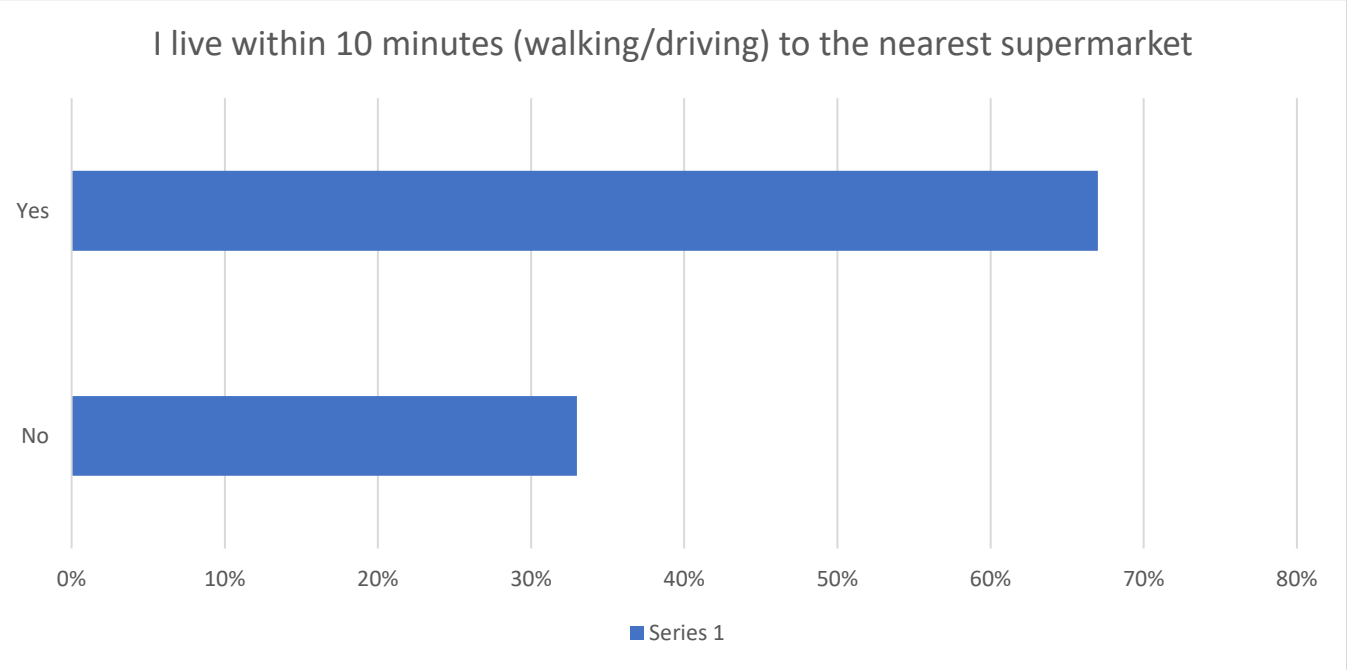
Community Survey Age Characteristics		
Age Range	**Number of Respondents**	**Percent of Respondents**
18-24	16	2.9%
25-34	37	6.6%
35-39	30	5.4%
40-44	30	5.4%
45-49	38	6.8%
50-54	71	12.7%
55-59	79	14.1%
60-64	103	18.4%
65-69	76	13.6%
70-74	47	8.4%
75-79	27	4.8%
80-84	2	0.4%
85+	4	0.7%

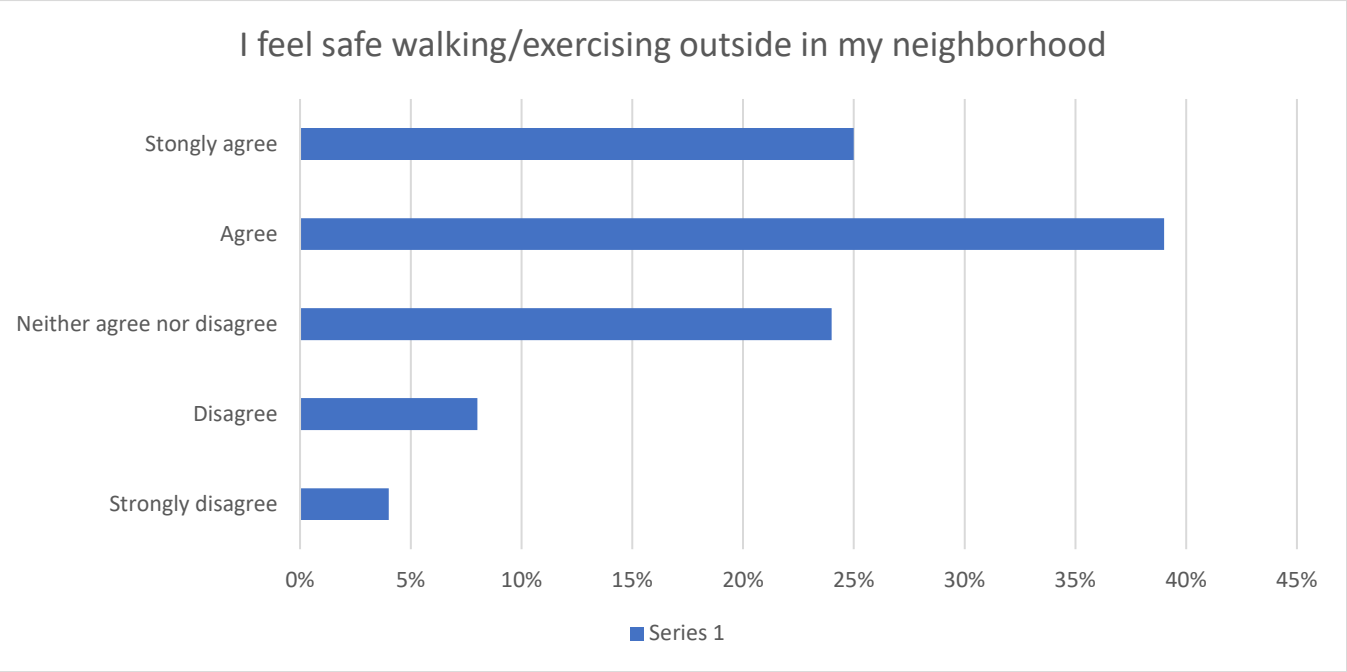
Consumer Health Behaviors

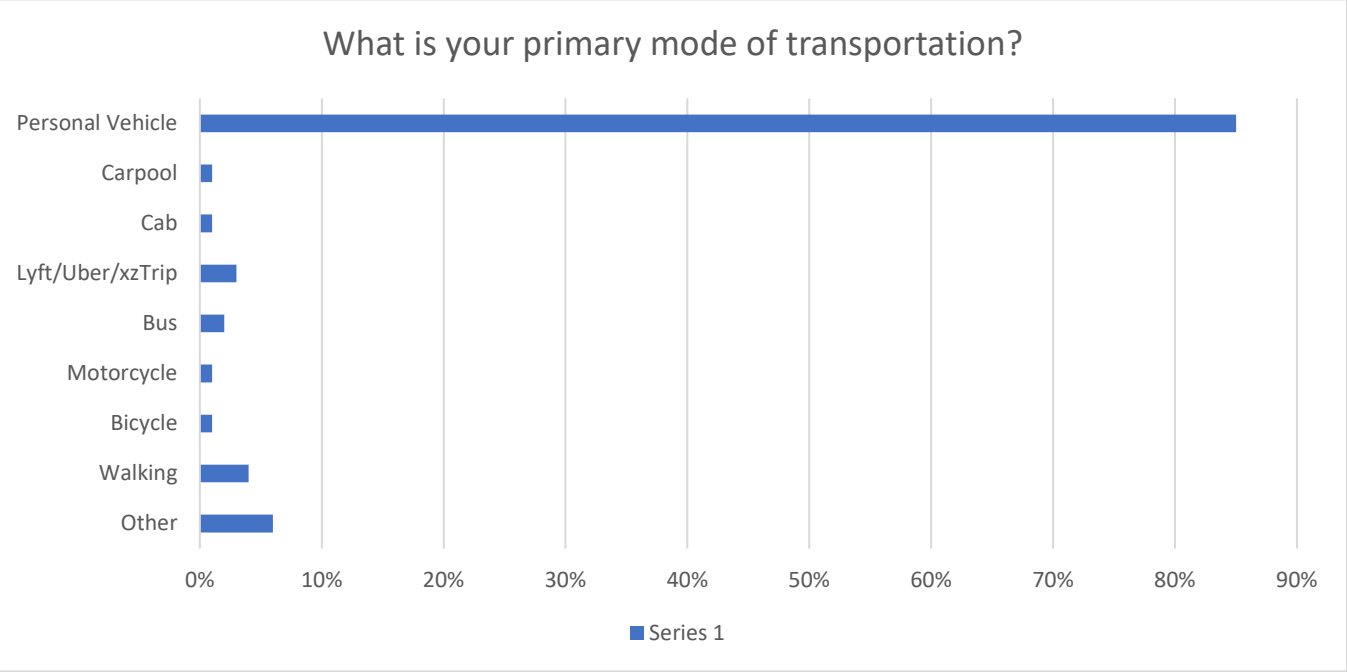


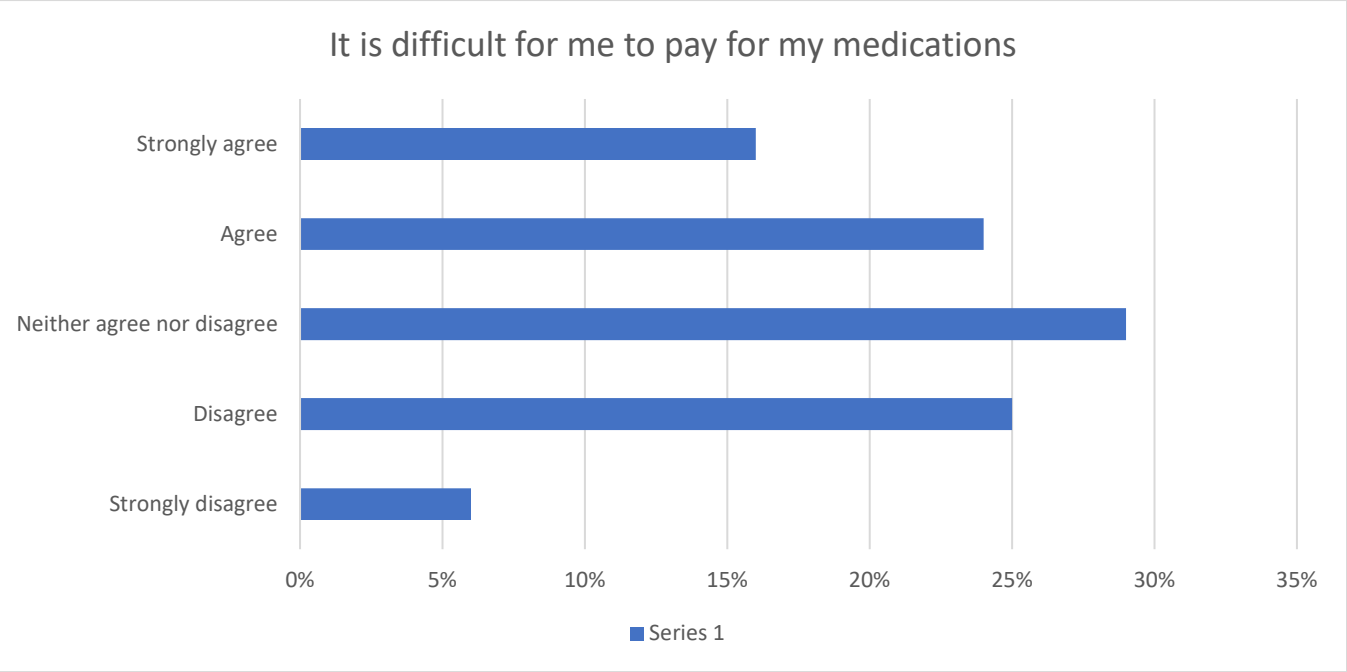
Barriers to Care



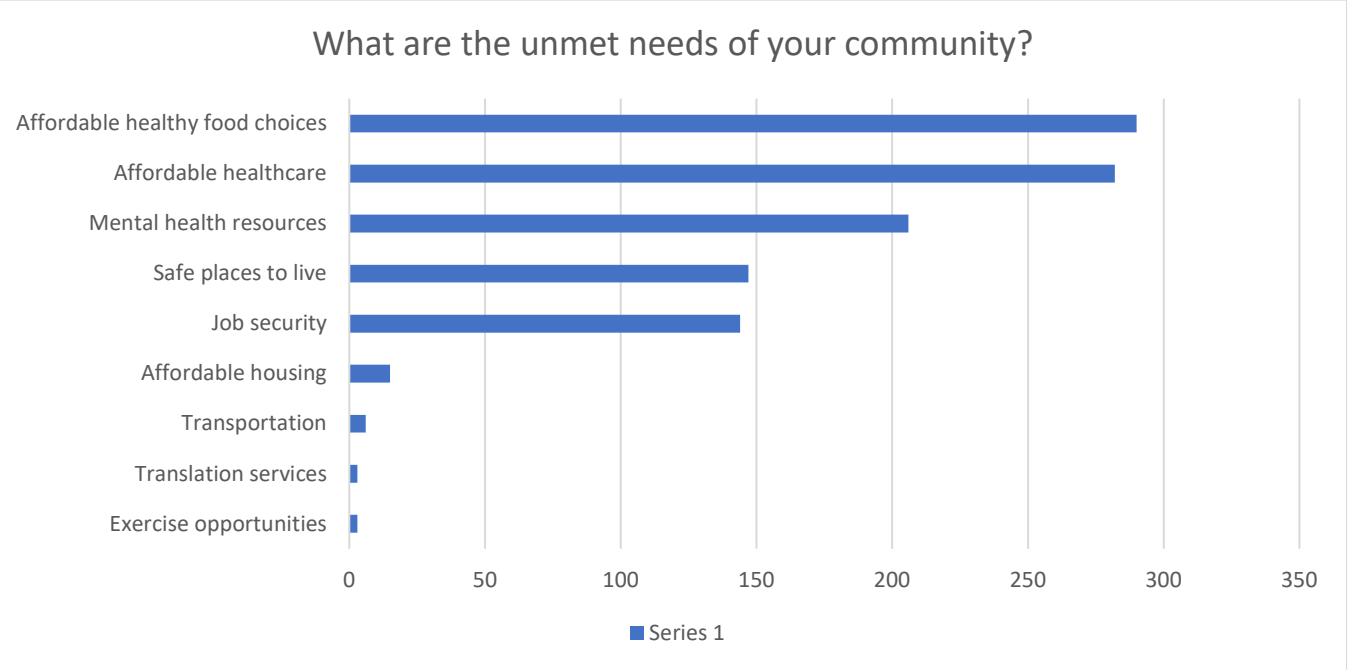



I feel safe walking/exercising outside in my neighborhood
Stongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree
0%
5%
10%
15%
20%
25%
30%
35%
40%
45%
Series 1


What is your primary mode of transportation?
Personal Vehicle
Carpool
Cab
Lyft/Uber/xzTrip
Bus
Motorcycle
Bicycle
Walking
Other
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
Series 1



Health Issues Needing More Focus



Two-Phase Needs Prioritization Process

PHASE 1 PRIORITIZED LIST OF NEEDS

Following the secondary research, qualitative interviews, and quantitative and qualitative community surveys, CHNA group members conducted a need prioritization activity within the various communities served. During this activity, community members at all freestanding clinics were asked first to identify the top five needs in the community and place a sticker in these categories. Next, community members were asked if they had $1,000 to allocate to the resources identified, how would they allocate these resources to meet the needs of the community. 187 members of the various communities served participated in this activity through the seven-county catchment area.

The table below indicates the top needs identified within each community. Needs indicated as 10% or above have been bolded.

Top Needs Identified in Each Community

	Access to Affordable Healthcare					Lifestyle-Related Conditions						Behavioral Health	
	Insurance Coverage	Medication Assistance	People with Existing Challenges	Transportation	Language Barriers	Heart Disease	Diabetes	Food Security	Health Education	HIV & STIs	Obesity	Mental Health	Substance Abuse
George													
Lucedale	**16%**	**13%**	**13%**	6%	1%	4%	4%	**11%**	4%	0%	3%	**19%**	6%
Greene													
Leakesville	3%	9%	**13%**	5%	0%	3%	10%	3%	7%	0%	**13%**	**17%**	**17%**
Hancock													
Bay St. Louis	**14%**	9%	**14%**	7%	4%	6%	4%	5%	5%	2%	5%	**14%**	12%
Harrison													
Biloxi	7%	**10%**	**10%**	**11%**	**10%**	1%	1%	6%	9%	5%	4%	**14%**	**11%**
Biloxi Pediatric	7%	7%	7%	5%	**20%**	2%	5%	9%	5%	5%	4%	**16%**	5%
D'Iberville	**13%**	7%	**16%**	3%	3%	3%	4%	4%	4%	6%	6%	**20%**	10%
Gulfport	**10%**	9%	6%	9%	9%	2%	8%	7%	2%	6%	5%	**17%**	**13%**
Pass Christian	7%	4%	**13%**	4%	4%	**13%**	0%	7%	4%	0%	2%	**13%**	11%
Saucier	**15%**	11%	**14%**	**11%**	0%	5%	9%	1%	3%	0%	5%	**20%**	6%
Jackson													
Moss Point	**11%**	9%	**14%**	7%	4%	**10%**	6%	1%	7%	6%	9%	**11%**	4%
Vancleave	8%	5%	5%	8%	5%	5%	**10%**	3%	0%	**13%**	8%	**18%**	**15%**
Stone													
Wiggins	**10%**	**12%**	**14%**	**10%**	2%	2%	4%	8%	6%	6%	4%	**16%**	6%
Wayne													
State Line	5%	5%	**10%**	5%	0%	**10%**	**10%**	5%	**10%**	**10%**	5%	**10%**	**15%**
TOTAL	**10%**	9%	**12%**	7%	5%	4%	6%	5%	5%	4%	6%	**16%**	**10%**

The table below indicates how community members would allocate limited resources to address various needs of the community. As is evidenced, the table below does not always align with the table above. This could be due to various reasons. If a need was identified as a top need but not allocated resources, this could indicate that resources other than financial may be needed to address the particular need. If a need was not identified as a top need but was allocated resources, this could indicate that only limited financial resources have historically been invested in this particular need.

Resource Allocations for Each Community

	Access to Affordable Healthcare					Lifestyle-Related Conditions						Behavioral Health	
	Insurance Coverage	Medication Assistance	People with Existing Challenges	Transportation	Language Barriers	Heart Disease	Diabetes	Food Security	Health Education	HIV & STIs	Obesity	Mental Health	Substance Abuse
George													
Lucedale	**10%**	9%	**10%**	**10%**	2%	8%	5%	**10%**	5%	4%	5%	**13%**	**10%**
Greene													
Leakesville	3%	8%	**11%**	**11%**	0%	4%	9%	3%	5%	0%	**11%**	**17%**	**17%**
Hancock													
Bay St. Louis	**10%**	**10%**	**10%**	6%	4%	5%	6%	4%	8%	4%	7%	**13%**	**12%**
Harrison													
Biloxi	7%	8%	8%	**10%**	8%	4%	5%	7%	**10%**	**10%**	6%	**10%**	8%
Biloxi Pediatric	9%	8%	8%	6%	**13%**	5%	6%	9%	5%	1%	6%	**16%**	5%
D'Iberville	**10%**	6%	**12%**	4%	2%	5%	**10%**	3%	7%	6%	6%	**18%**	**11%**
Gulfport	5%	6%	7%	9%	**11%**	4%	5%	**10%**	5%	8%	7%	**13%**	**12%**
Pass Christian	6%	9%	7%	2%	4%	**10%**	9%	7%	8%	1%	4%	**19%**	**14%**
Saucier	**16%**	8%	**13%**	9%	2%	6%	7%	4%	4%	3%	7%	**16%**	6%
Jackson													
Moss Point	**11%**	**12%**	6%	4%	5%	8%	5%	5%	7%	6%	7%	**13%**	**12%**
Vancleave	**1%**	8%	**10%**	8%	9%	9%	9%	1%	3%	6%	6%	**18%**	**14%**
Stone													
Wiggins	6%	**11%**	9%	7%	2%	7%	7%	7%	8%	6%	8%	**14%**	8%
Wayne													
State Line	9%	6%	**11%**	6%	0%	9%	9%	3%	**11%**	6%	6%	**14%**	**11%**
TOTAL	8%	8%	9%	7%	5%	6%	7%	6%	7%	5%	7%	**14%**	**11%**

After conduction of this activity, information collected was combined with information collected from secondary research as well as other primary research methods to compile a phase 1 list of prioritized needs, as shown below.

Top Health Issues in the Community from Phase 1 of the Prioritization

Issues	Ranking
Mental Health	1
Disabilities	2
Affordable Care	3
Access to Care	4
Heart Disease	5
Medication Assistance	6
Transportation	7
Diabetes	8
Access to Healthy Foods	9
Obesity	10
Language Barriers	11
Health Education	12
Substance Abuse	13
Homelessness	14
HIV/STIs	15

PHASE 2 PRIORITIZED LIST OF NEEDS In Phase 2 the top needs were then evaluated to arrive at the key areas of priority emphasis for future years. The process included a meeting where the leadership team was asked to evaluate the secondary data results, the qualitative and quantitative results, and the priority needs results from Phase 1.

The resulting prioritized list of community needs fall into three categories: Access to Affordable Health Care, Lifestyle-related Conditions and Behavioral Health Conditions. The breadth of the categories of needs allows Coastal Family Health Center to continue (or possibly expand) successful existing programs and to develop innovative approaches to possibly address multiple needs simultaneously. The list of the top need categories and more detailed opportunities for improvement are shown below.

Prioritized Community Needs	
Rank	**Health Need**
1	Behavioral Health Conditions • Mental health • Substance abuse
2	Access to Affordable Healthcare • People with existing challenges of access to care (e.g., disabilities, low income, homeless, etc.) • Insurance coverage • Medication assistance • Transportation • Language Barriers
3	Lifestyle-Related Conditions • Heart/cardiovascular disease • Diabetes • Food security • Obesity • Health education • HIV & other STIs

IMPLEMENTATION STRATEGY CONSIDERATIONS During the final meeting, Leadership Team members (with the guidance and support of CHNA group members) worked collaboratively to build the foundation for Implementation Plan activities. Group members undertook efforts to identify an initial list of activities designed to address high priority need categories and several detailed opportunities for improvement. A summary of potential interventions which may be used to guide implementation strategies is listed below.

Behavioral Health Conditions

- **Mental Health**: Expand tele-psych partnership with UMMC to offer services to additional clinics. Hire additional behavioral health specialists to offer services within clinics with limited access. Offer telehealth to patients seen at clinics without a behavioral health specialist.
- **Substance Abuse**: Pursue formal MOUs with community substance abuse providers for patient referral. Hire additional behavioral health specialists who specialize in substance abuse counseling. Offer telehealth to patients seen at clinics without a behavioral health specialist. Implement medications for opioid use disorder (MOUD) at various clinic sites.

Access to Affordable Healthcare

- **Existing Challenges for Disabled & Low-income Populations**: Enhance marketing efforts in counties with low penetration rates. Promote telehealth for disabled patients to reduce the need to present in-clinic. Promote availability of expanded hours. Renovate Moss Point Pharmacy to include convenient care services. Increase utilization of the mobile unit within rural counties. Promote social services available, such as vouchers. Offer optometry and dental services within Hancock County. Offer expanded dental services in Harrison and Jackson counties. Review sliding fee scale for feasibility for low-income patients. Open additional clinic in Jackson County.
- **Insurance Coverage**: Assist patients in navigating resources to apply for eligible coverage.
- **Medication Assistance**: Promote 340B pharmacies, including mail order services, to patients and the community as a whole. Promote patient assistance programs available via assistance of social services. Open pharmacy accessible to Hancock County residents.
- **Transportation**: Promote current transportation options for patients with transportation as a barrier. Promote after-hours access to telehealth services.
- **Language Barriers**: Increase number of publications available in Spanish and Vietnamese.

Lifestyle-related Conditions

- **Heart Disease**: Hold community health education events to screen for heart disease and connect with further care. Offer remote patient monitoring to patients with hypertension. Participate in Aledade Hypertension Collaborative to improve blood pressure control among hypertensive patients.
- **Diabetes**: Hold community health education events to screen for diabetes and connect with further care. Implement diabetes support group. Offer remote patient monitoring to patients with diabetes.
- **Food Security**: Partner with food distribution programs to offer healthy foods to patients.
- **Obesity**: Renovate portion of Leakesville Clinic to include a Wellness Center available to CFHC patients and the community. Deliver fresh produce to clinics for staff and/or patients.
- **Health Education**: Partner with local colleges and churches to provide in-person health education on a variety of topics.
- **HIV/STIs**: Increase education provided related to HIV, STIs, pregnancy and sexual activity.

Appendices

This document contains the following appendices:

APPENDIX A: Community Health Needs Assessment Patient Survey
APPENDIX B: Community Health Needs Assessment Partner Survey
APPENDIX C: Activities in response to 2022-2025 Prioritized Needs
APPENDIX D: Patient Interview Guide
APPENDIX E: Leadership Prioritization Presentation
APPENDIX F: Organizations Included in CHNA Research Efforts
APPENDIX G: Community Services Resource Guide

APPENDIX A: COMMUNITY HEALTH NEEDS ASSESSMENT PATIENT SURVEY

Coastal Family Health Center
COMMUNITY HEALTH NEEDS ASSESSMENT

Patient Survey

1. What is your county of residence?
2. What is your income range?
3. Which of the following best describes your current housing?
4. What is your primary mode of transportation?
5. Which Coastal Family Health Center location do you visit primarily?
6. What is your race?
7. What is your ethnicity?
8. What is your sex?
9. What is your age range?
10. My family, friends, and community members have a positive impact on my mental health.
11. Making decisions about how to manage my health makes me feel depressed or anxious.
12. When I am feeling upset, I am able to (select all that apply)…
13. My eating habits have a positive impact on health.
14. It is easy for me to find healthy foods in my community.
15. I live within 10 minutes (either walking or driving) from the nearest supermarket.
16. What do you feel are the unmet needs of your community?
17. What do you think are the strengths of your community?
18. My personal health goals are to…
19. I feel that my health is _____.
20. Are there any specific programs or services that you feel your community needs?
21. I feel safe walking or exercising outside in my neighborhood.
22. It is challenging to find places in my community for religious services, holidays, community events or family get-togethers.
23. I belong to a community that supports my mental and physical well-being.
24. It is difficult for me to pay for my medications.
25. I have had to go without medications because of the cost.

APPENDIX B: COMMUNITY HEALTH NEEDS ASSESSMENT PARTNER SURVEY

Coastal Family Health Center
COMMUNITY HEALTH NEEDS ASSESSMENT

Community Partner Survey

1. What is the name of your organization?
2. Please select the counties your organization serves.
3. Please describe the services your organization provides.
4. What do you see ass the top community health issues in your area?
5. Are there barriers to accessing medical care in your community? If so, what are the barriers you see?
6. Please select the services below that are available and accessible in your area.
7. What resources are needed to address the health issues in your community?
8. What suggestions do you have for addressing and improving the health issues in your community?
9. Please provide any additional feedback you may have.

APPENDIX C: ACTIVITIES IN RESPONSE TO 2022-2025 PRIORITIZED NEEDS

Need	Results
Access to Affordable Healthcare	
Insurance Coverage	• American Rescue Plan enhancements to the Affordable Care Act were promoted to uninsured patients. 91 people were signed up by Outreach and Enrollment representatives during the 2024 open enrollment period. • CFHC advocated for Medicaid expansion within the state along with the American Cancer Society and the American Heart Association. As a result, 12-month postpartum insurance is now in place.
Medication Assistance	• 340B pharmacies, including mail order services, were promoted to patients and the community as a whole. • Co-pay cards are promoted to CFHC patients and added to prescriptions when applicable. • An increase in medication vouchering has taken place over the last three years.
Existing Challenges for Disabled & Low-Income Populations	• Telehealth may be utilized for disabled patients to reduce the need to present in-clinic. • Patient self-scheduling has been expanded to the entire patient population. • Same-day access is being enhanced through the expansion of after-hours appointment availability at multiple sites. The Convenient Care Center, offering appointments after-hours and on Saturdays, will be opened by 2026. • A prompt pay discount (25%) is provided to patients completing office visits. • CFHC's website was updated to enhance usability.
Transportation	• Partnership with Uber Health has been utilized to provide increased transportation options for patients with transportation as a barrier.
Language Barriers	• Virtual translation services were expanded to all sites. • The patient registration packet was revamped and translated into Spanish. The Vietnamese version is currently in progress.
Lifestyle-Related Conditions	
Cardiovascular/Heart Disease	• CFHC completed partnership with Dario for remote patient monitoring for blood pressure. This partnership demonstrated success, as evidenced by the 15.8% increase in controlled blood pressure from 2021 to 2024. • CFHC offered three cohorts of individuals participation in the MAGnet program, aimed towards improving chronic conditions, including hypertension. During these cohorts, healthy cooking demonstrations were performed, and participants were offered the chance to meet with a nutritionist, free of charge. • CFHC's Community Health Worker enrolled patients in the Chronic Disease program aimed towards improving chronic conditions, such as hypertension.
Diabetes	• CFHC offered three cohorts of individuals participation in the MAGnet program, aimed towards improving chronic conditions, including diabetes. During these cohorts, healthy cooking demonstrations were performed, and participants were offered the chance to meet with a nutritionist, free of charge.

	• CFHC's Community Health Worker enrolled patients in the Chronic Disease program aimed towards improving chronic conditions, such as diabetes. • Within CFHC's current partnership with Picasso, CFHC has been assigned an endocrinologist to consult with medical providers concerning patients with uncontrolled diabetes.
Food Security	• CFHC implemented the employee targeted food bank. Over 100 food bags are delivered per month.
Health Education	• CFHC offered three cohorts of individuals participation in the MAGnet program, aimed towards improving chronic conditions. During these cohorts, healthy cooking demonstrations were performed, and participants were offered the chance to meet with a nutritionist, free of charge.
HIV/STIs	• From 2021 to 2024, CFHC has increased the HIV screening measure by 56%. HIV screenings are completed in clinic and during community outreach events. • Providers in rural areas have been educated regarding the rates of STIs in their service area, increasing testing rates. • HIV care as a primary care service has been expanded, increasing availability of treatment services. • PrEP program has been expanded to reach additional patients.
Obesity	• CFHC implemented the employee targeted food bank. Over 100 food bags are delivered per month. • CFHC offered three cohorts of individuals participation in the MAGnet program, aimed towards improving chronic conditions. During these cohorts, healthy cooking demonstrations were performed, and participants were offered the chance to meet with a nutritionist, free of charge.
Behavioral Health Conditions	
Mental Health	• Additional billable Behavioral Health Specialists were hired to increase reimbursement along this service line. • In 2025, expanded hours will allow behavioral health services to be available after traditional business hours. • CFHC executed agreement with the University of Mississippi Medical Center (UMMC) wherein UMMC provides virtual access to psychiatric nurse practitioners for CFHC patients.
Substance Abuse	• SBIRT (Screening, Brief Intervention, and Referral for Treatment) has been implemented at all clinic sites in order to increase referrals to Behavioral Health Specialists for further screening.

APPENDIX D: PATIENT INTERVIEW GUIDE

COASTAL FAMILY HEALTH CENTER
COMMUNITY HEALTH NEEDS ASSESSMENT

Introduction and Objective

- Explain the general purpose of the interview. "The purpose of the discussion is to learn more about community health-related needs and currently available resources, and to collect your insights regarding service gaps and ways to better meet needs."
- Explain the necessity for notetaking and reporting. I will be describing our discussion in a written report. However, individual names will not be used.
- Seek participants' honest thoughts and opinions. "Frank opinions are the key to this process. There are no right or wrong answers to questions I'm going to ask. I'd like to hear from each of you and learn more about your opinions, both positive and negative."
- "Do you have any questions for me before we start?"

Interview Questionnaire

Current Perceptions about Healthy Communities, Access and Top Needs

1. Where do you go for medical information?
2. What's the biggest barrier to accessing care for you and your loved ones?
3. How often do you see your primary care provider?
4. Are there any barriers to you seeing your primary care provider more often? If so, what are the barriers?
5. Do you have access to specialty healthcare?
6. Describe your relationship with your medical provider. Do you feel like they listen to you and understand your needs?
7. How often do you go to the hospital to receive healthcare?
8. Are your medications affordable?
9. Are you aware of any medication assistance programs?
10. How easy is it to get to your medical appointments?
11. When I say, "improving the health of your community," what comes to mind?
12. Do you have access to healthy food in your community?
13. Do you have access to physical activity and exercise in your community?
14. Have you completed an annual wellness visit within the last year?
15. Within the last year, have you received any behavioral health services, such as counseling, therapy, support groups, or psychological medications management?
16. Do you see your provider for preventative healthcare services, such as mammograms, pap smears, colorectal cancer screening, diabetes screening, vaccinations, etc.?
17. From your perspective, what are the top community health issues?

Community Health Needs Assessment Progress

Secondary Data

POPULATION OVERVIEW

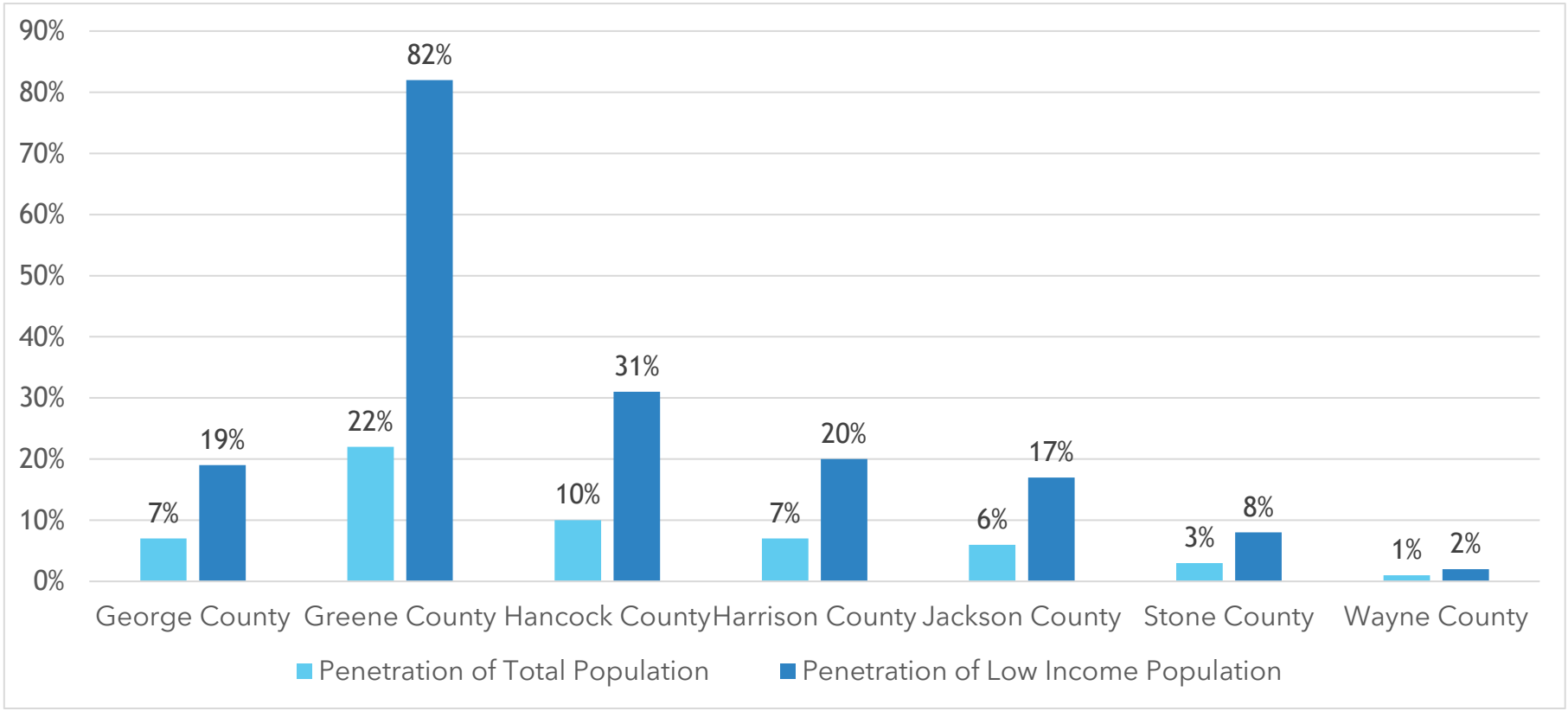
Key Population Measures

Measure	United States	Mississippi	George County	Greene County	Hancock County	Harrison County	Jackson County	Stone County	Wayne County
Population	342,034,432	2,943,045	25,619	13,601	46,159	210,612	146,389	18,756	19,703
Median Age	38.2	38.7	36.6	40.1	44.7	36.5	38.9	39.7	41.1
Median Household Income	$75,149	$54,915	$54,822	$55,838	$67,728	$57,233	$64,756	$59,307	$36,791
% Living in Poverty	11.1%	19.2%	14.4%	22.1%	15.6%	16.0%	13.4%	15.6%	21.0%
% White	76.3%	58.7%	89.2%	72.6%	87.4%	67.3%	73.1%	78.6%	57.4%
% African American	13.4%	37.8%	8.0%	25.7%	8.4%	26.2%	21.6%	18.5%	40.7%
% Hispanic or Latino	18.5%	3.9%	3.3%	1.5%	4.2%	6.8%	7.8%	2.7%	1.9%
% Asian or Pacific Islander	5.9%	1.2%	0.8%	0.2%	1.0%	2.9%	2.3%	0.5%	0.3%
% Two or More Races	2.8%	1.5%	1.5%	1.1%	2.3%	3.0%	2.4%	1.7%	1.2%
% No High School Diploma	11.5%	13.4%	16.1%	19.4%	10.3%	10.8%	11.2%	12.0%	16.0%
% 16+ Unemployed	4.1%	3.3%	4.6%	4.3%	3.5%	3.2%	3.7%	3.8%	4.2%

KEY CHANGES

Demographics			
Measure	**Service Area (2021)**	**Service Area (2024)**	**% Change**
Total Population	476,183	480,839	+0.9%
Income	$47,500	$56,639	+19.2%
Living in Poverty	17.8%	16.9%	-5.1%
Disabled	19.4%	20.5%	+5.7%
Social and Economic Factors			
HS Graduation Rate	85%	90%	+5.9%
Unemployment	8.9%	3.9%	-56.2%
Children in Poverty	22.8%	26.1%	+14.5%
Clinical Care			
Uninsured	16.3%	13.7%	-16.0%
Patient to PCP Ratio	4,190:1	4,077:1	-2.7%
Health Outcomes			
Premature Deaths	10,071	9,629	-4.4%
Self-Report Fair or Poor Health	23%	21%	-8.7%
Poor Mental Health Days	53	5.1	-3.8%
Low Birth Weight	9.8%	9.9%	+1.0%

CFHC PENETRATION RATES



Primary Data Efforts

- 573 patients completed online quantitative surveys
- 11 community partners completed online qualitative surveys
- 40 patients completed qualitative interviews
- 187 community members participated in need prioritization activity

PATIENT SURVEY FEEDBACK

- **Food Security**
  - Lack of affordable health food choices was the top unmet need identified (56.3%).
  - 16% of survey respondents indicated that their eating habits did not have a positive impact on their health and indicated that healthy foods are not easy to find within their communities.
  - 33% reported living greater than 10 minutes away from the nearest supermarket.

- **Affordable Healthcare**
  - Affordable healthcare was the second most identified unmet need (52.8%).
  - 40.3% of respondents indicated that it was difficult for them to pay for their medications, and 35.8% indicated that they have had to go without medications due to cost.

- **Mental Health**
  - Mental health resources was the third most identified unmet need (39.6%).

- **Affordable Housing**
  - 3% of respondents indicated homelessness.

- **Transportation**
  - 85.5% of respondents reported having their own personal vehicle.

COMMUNITY PARTNER SURVEY FEEDBACK

- **Affordable Healthcare**
  - Affordable healthcare was the top identified unmet need (50%).
  - Education regarding available services was the top resource indicated as needed to meet community health needs.

- **Transportation**
  - 75% of respondents reported lack of transportation as the top barrier to receiving care.

PATIENT INTERVIEW FEEDBACK

- **Barriers to Accessing Care**
  - All counties except for George identified cost and lack of insurance as barriers to accessing health care for themselves and their loved ones.
  - All counties except for Jackson identified transportation as a barrier.
  - Hancock and Harrison counties identified appointment availability as a barrier faced.

- **Access to Specialty Care**
  - 88% of interviewees indicated that they have access to specialty referrals.

- **Relationship with Primary Care Provider**
  - 100% of interviewees described their primary care providers as understanding, active listeners.

- **Hospital Utilization**
  - 45% of interviewees indicated that they receive services from local hospitals rarely, as needed for emergencies.
  - 33% indicated that they never utilize services from local hospitals.

- **Affordability of Prescription Medications**
  - 67% of interviewees indicated that their prescription medications are affordable.
  - 63% of interviewees were aware of medication assistance programs available.

- **Transportation**
  - 100% of interviewees indicated that it is easy to get to their medical appointments.

- **Improving the Health of the Community**
  - All counties identified increased access to affordable healthcare as a method for improving community health.

- **Access to Healthy Foods**
  - 15% of interviewees indicated limited access to healthy foods where they reside.
  - Some interviewees stated that while healthy food is available, it is too expensive to purchase.

- **Top Community Health Issues**
  - All counties identified heart disease and/or hypertension as a top health issue within their communities.
  - Harrison, Hancock, and Jackson County interviewees identified mental health as a top issue.

COMMUNITY NEED PRIORITIZATION ACTIVITY

Top Needs Identified in Each Community

	Access to Affordable Healthcare					Lifestyle-Related Conditions						Behavioral Health	
	Insurance Coverage	Medication Assistance	People with Existing Challenges	Transportation	Language Barriers	Heart Disease	Diabetes	Food Security	Health Education	HIV & STIs	Obesity	Mental Health	Substance Abuse
George													
Lucedale	**16%**	**13%**	**13%**	6%	1%	4%	4%	**11%**	4%	0%	3%	**19%**	6%
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Hancock													
Bay St. Louis	**14%**	9%	**14%**	7%	4%	6%	4%	5%	5%	2%	5%	**14%**	12%
Harrison													
Biloxi	7%	**10%**	**10%**	**11%**	**10%**	1%	1%	6%	9%	5%	4%	**14%**	**11%**
Biloxi Pediatric	7%	7%	7%	5%	**20%**	2%	5%	9%	5%	5%	4%	**16%**	5%
D'Iberville	**13%**	7%	**16%**	3%	3%	3%	4%	4%	4%	6%	6%	**20%**	10%
Gulfport	**10%**	9%	6%	9%	9%	2%	8%	7%	2%	6%	5%	**17%**	**13%**
Pass Christian	7%	4%	**13%**	4%	4%	**13%**	0%	7%	4%	0%	2%	**13%**	11%
Saucier	**15%**	11%	**14%**	**11%**	0%	5%	9%	1%	3%	0%	5%	**20%**	6%
Jackson													
Moss Point	**11%**	9%	**14%**	7%	4%	**10%**	6%	1%	7%	6%	9%	**11%**	4%
Vancleave	8%	5%	5%	8%	5%	5%	**10%**	3%	0%	**13%**	8%	**18%**	**15%**
Stone													
Wiggins	**10%**	**12%**	**14%**	**10%**	2%	2%	4%	8%	6%	6%	4%	**16%**	6%
Wayne													
State Line	5%	5%	**10%**	5%	0%	**10%**	**10%**	5%	**10%**	**10%**	5%	**10%**	**15%**
TOTAL	**10%**	9%	**12%**	7%	5%	4%	6%	5%	5%	4%	6%	**16%**	**10%**

DATA BY COUNTY

Service Area

- Heart disease is the leading cause of death (rate of 343.3). This is an increase of 31% since 2018.
- Deaths related to accidents have increased by 49% since 2018
- Most common disability is ambulatory
- Counties within the service area have between 50-113% higher uninsured rates when compared to the national average, and George, Stone, and Wayne Counties have a higher uninsured rate than the Mississippi average
- Community members in all counties within the service area prioritized mental health as the top need

George County

- Residents of George County have, on average, longer commute times driving alone to work (53%)
- Largest population of unemployed residents in the service area (4.6%)
- Largest population of Whites in the service area (89.2%)
- Highest rate of teen births in the service area (38)
- Patients interviewed indicated lack of transportation as a barrier to care
- Community members prioritized mental health, insurance coverage, medication assistance, people with existing challenges to access, and food security
- Community members also indicated that they would allocate resources to addressing transportation and substance abuse

Greene County

- Highest rate of percentage without a high school diploma (19.4%)
- Highest variation of sex (58.8% males)
- Highest percentage of people with a disability (25.3%)
- Lowest concentration of patient to primary care provider (13,630:1) and patient to dental provider (6,780:1)
- Residents have, on average, longer commute times driving alone to work (56%)
- Highest penetration rate of low income (82%)
- Community members prioritized mental health, substance abuse, obesity, and people with existing challenges to access
- Community members also indicated that they would allocate resources to addressing transportation

Hancock County

- Lowest unemployment rate within the service area
- Lowest uninsured rate (12%)
- Highest median age
- Third highest population of Hispanics/Latinos (4.2%)
- Patients interviewed indicated cost as a top barrier to accessing care
- Community members prioritized mental health, insurance coverage, and people with existing challenges to access
- Community members also indicated that they would allocate resources to addressing substance abuse and medication assistance

Harrison County

- Second largest population of Hispanics/Latinos in the service area (6.8%)
- Largest population of Asians (2.9%)
- Highest rate of infant mortality (136)
- Highest rate of premature death (4,184)
- Highest rates of gonorrhea, chlamydia and HIV
- Only county in the service area with a higher concentration of primary care providers than the state average
- Patients interviewed indicated cost as a top barrier to accessing care
- Patients interviewed indicated diabetes and obesity as top community health issues
- Community members prioritized mental health, people with existing challenges to access, insurance coverage, and substance abuse

Jackson County

- Largest population of Hispanics/Latinos in the service area (7.8%)
- Second largest population of Asians (2.3%)
- Highest rate of alcohol impaired driving deaths (26%)
- Patients interviewed indicated cost as a top barrier to accessing care
- 50% of patients interviewed were unaware of medication assistance programs available
- Patients interviewed indicated hypertension as a top community health issue
- Community members prioritized mental health, people with existing challenges to access, & insurance coverage
- Community members also indicated that they would allocate resources to addressing substance abuse and medication assistance

Stone County

- Highest adult smoking rate in the service area (22%)
- Highest number of poor mental health days (5.3)
- Lowest concentration of mental health providers (2,670:1)
- Community members prioritized mental health, people with existing challenges to access, medication assistance, insurance coverage, and transportation

Wayne County

- Highest uninsured rate in the service area
- Poorest county in the service area, with a Median Household Income of $36,791 and 21% of the population living in poverty
- Median age of Whites is nearly 200% higher than that of Hispanics/Latinos
- Highest African American/Black population (40.7%)
- Highest population identified as having poor health
- Highest percentage of low birthweight (14%)
- Highest rate of diabetes prevalence (13%)
- Highest obesity rate (42%)
- Physical inactivity is highest in Wayne County which correlates with this county having least access to exercise opportunities
- Highest rate of teen births (50%)
- Highest rate of primary & secondary syphilis (24.8)
- Lowest penetration rate of low income (2%)
- Community members prioritized substance abuse, mental health, HIV & STIs, health education, diabetes, heart disease & people with existing challenges to access

Prioritization Discussion

Details on Consensus Needs

BEHAVIORAL HEALTH CONDITIONS

- Mental health services
- Substance abuse services

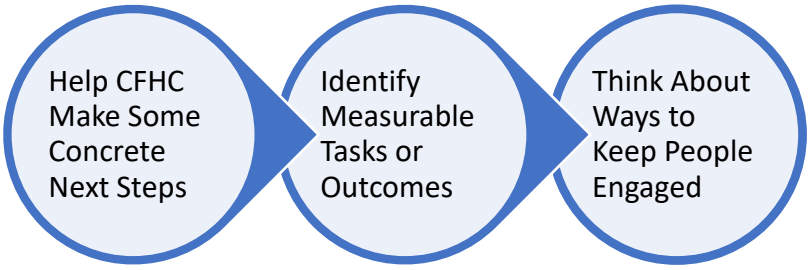
AFFORDABLE HEALTHCARE

- People with existing challenges of access to care (e. g ., disabilities, low-income individuals, etc.)
- Insurance coverage / co-pays / deductible
- Medication assistance
- Transportation barriers
- Language barriers

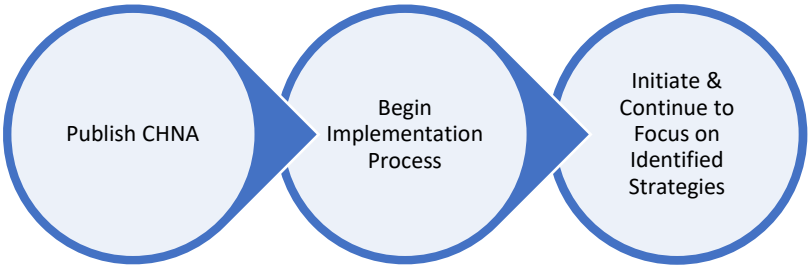
LIFESYLE-RELATED CONDITIONS

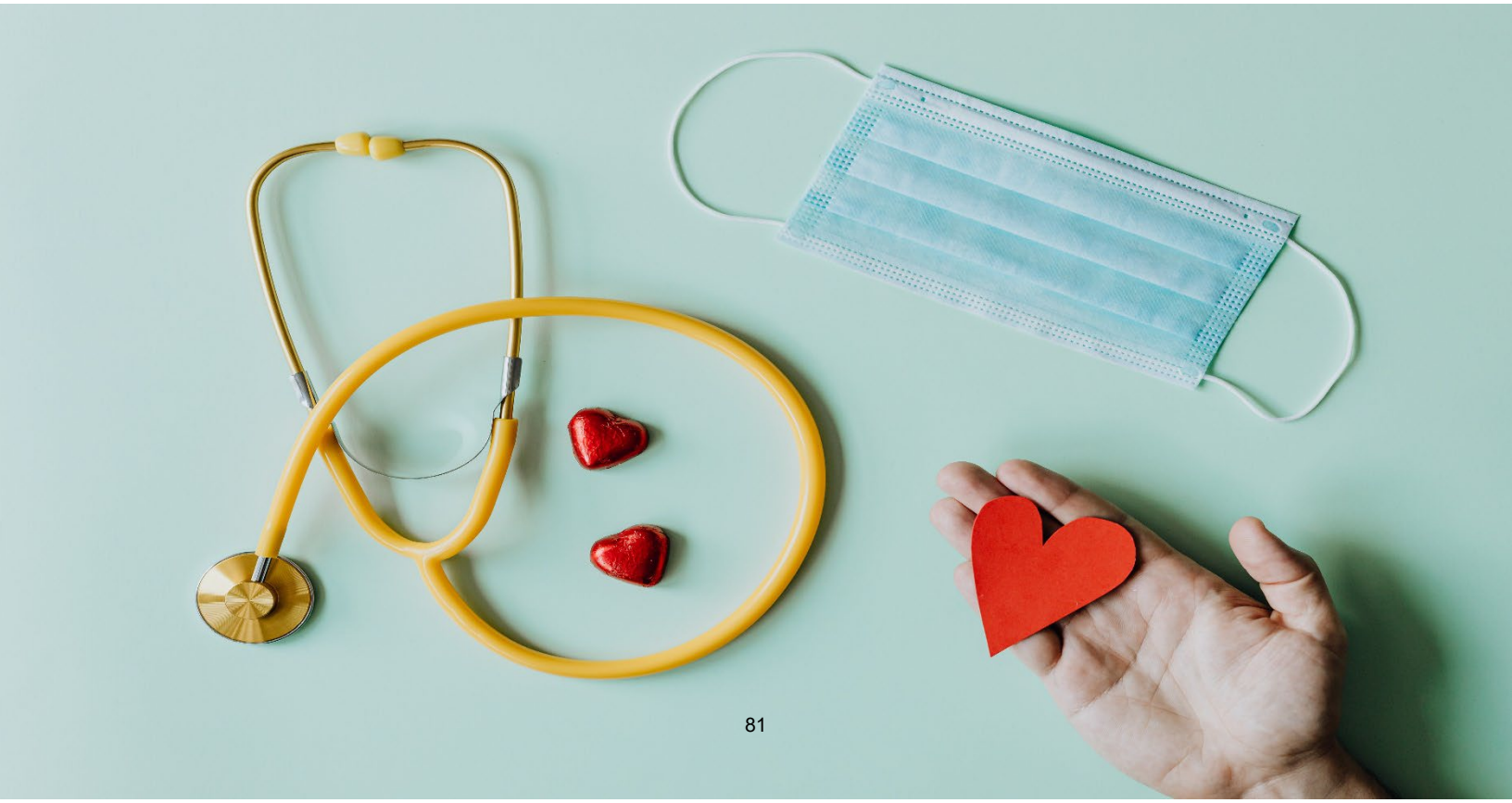
- Heart /cardiovascular health
- Diabetes
- Food security
- Obesity
- Health education
- HIV & other STIs

Goals for Today



Review of Next Steps





APPENDIX F: Organizations Included in CHNA Research Outreach Efforts

A sample of the community groups who were contacted in the research included:

Head Start

MSU Head Start

City of Waveland

Women in Construction

Hospice of Light

Magnolia Medical Foundation

Singing River Education Association

Mercy Housing & Human Development

Mississippi Department of Child Protective Services

City of Moss Point

Appendix G: Community Resource Guide	
Child & Family Services	
Boys & Girls Club of Jackson County	(228) 762 - 3497
Boys & Girls Club of Gulf Coast	(228) 868 - 2526
Canopy Children's Solutions	(228) 863 - 4992
CASA of Hancock County	(228) 344 - 0419
CASA of Harrison County	(228) 865 - 7078
CASA of Jackson County	(228) 762 - 7370
Child Abuse Hotline	(800) 222 - 8000
Children's Health Insurance Program (CHIP)	(800) 318 - 2596
Family First Braille	(228) 224 - 2920
Gulf Coast Family Counseling Agency	(228) 875 - 6113
Harrison County Child Development Center	(228) 863 - 0583
Head Start- - Jackson County Civic Action Committee	(228) 769 - 3292
Head Start- - MS State University-Extension	(228) 224 - 6484
Hope Haven Children's Advocacy Center	(228) 466 - 6395
Make-A-Wish Foundation of Mississippi	(228) 575 - 8691
March Of Dimes Mississippi	(601) 933 - 1071
Moore Community House	(228) 436 - 0633
MS Department of Child Protective Services	(800) 222 - 8000
MS Gulf Coast YMCA	(228) 875 - 5050
Supplemental Nutrition Assistance Program (SNAP)	(228) 897 - 5600
Community Resources	
Advocates for Freedom	(228) 229 - 2754
Back Bay Mission	(228) 432 - 0301
Boat People SOS	(228) 436 - 9999
El Pueblo	(228) 436 - 3986
Fatherless And Widows	(228) 234 - 4567
Gulf Coast Center for Nonviolence	(228) 436 - 3809
Gulf Coast Community Ministries	(228) 868 - 8202
Gulf Coast Rescue	(228) 388 - 3884
Hancock Resource Center	(228) 463 - 8887
Humane Society of South MS	(228) 863 - 3354
Jubilee Havens	(228) 380 - 4566
MS Department Human Services	(601) 359 - 4500
Nourishing Place, The	(228) 596 - 1186
Salvation Army-Southern MS Area Command Office	(228) 374 - 8301
Shepherd of the Gulf	(228) 229 - 8980
Social Security Administration	(877) 897 - 0609

United Way for Jackson & George Counties	(228) 762 - 7662
Women's Resource Center	(228) 897 - 8958
Disability Services	
Arc of the Gulf Coast, The	(228) 325 - 8786
Brain Injury Association of Mississippi	(601) 981 - 1021
Brandi's Hope	(601) 721 - 3496
De L'Epee Deaf Center	(228) 897 - 2280
Disability Connection	(228) 604 - 4020
Gulf Coast Down Syndrome Society	(228) 323-7654
Independent Living for the Blind	(228) 897 - 6925
Institute for Disability Studies	(228) 214 - 3400
LIFE of MS	(228) 357 - 5120
Millcreek	(844) 796 - 7719
MS Centers for Autism & Related Developmental Disabilities	(228) 396 - 4434
MS Hearing-Vision Project	(228) 214 - 3340
Office of Special Disabilities	(228) 575 - 3785
REM	(228) 354 - 9012
Singing River Industries	(228) 497 - 9468
South Mississippi Regional Center	(228) 868 - 2923
Vocational Rehabilitation for the Blind	(228) 897 - 6925
Disaster & Emergency	
American Red Cross – Gulfport	(228) 896-4511
American Red Cross – Pascagoula	(228) 762-2455
MEMA – MS Emergency Management Agency	(866) 519-6362
Education	
CLIMB CDC	(228) 864 - 6677
Families First/MCEC	(228) 897 - 5627
Gulfport Job Corps	(228) 863 - 1141
Hope Adult Learning	(228) 806-4673
Moore Community House-Women in Construction	(228) 436 - 6601
MS Gulf Coast Community College-Harrison County	(228) 896 - 2504
MS Gulf Coast Community College-Perkinston	(601) 928 - 6325
MS Gulf Coast Community College-Jackson County	(228) 497 - 7732
University of Southern Mississippi- Gulf Park Campus	(228) 865 - 4500
Employment	
Ability Works	(228) 897 - 7616
Disability Connection-Supported Employment	(228) 604 - 4020
Goodwill Industries of South Mississippi	(228) 863 - 2323 Ext. 101
Senior Community Service Employment Program	(228) 868 - 2311

WIN Job Center	(228) 897- 6900 (Gulfport), (228) 762 - 4713 (Pascagoula)
Food Resources	
Feed My Sheep	(228) 864 - 2701
Feeding The Gulf Coast	(228) 896 - 6979
Hancock County Food Pantry	(228) 467 - 2790
Loaves And Fishes	(228) 436 - 6172
Lord Is My Help, The	(228) 872 - 2331
Our Daily Bread	(228) 769 - 7510
Seashore Mission	(228) 313 - 1477
Twelve Baskets Food Bank	(228) 822 - 0836
Health & Wellness	
American Heart Association	(228) 604 - 5300
Bethel Free Clinic	(228) 594 - 3640
Bethesda Free Clinic	(228) 818 - 9191
Catholic Charities of South Mississippi	(228) 701 - 0555
George County Health Department	(601) 947 - 4217
Hancock County Health Department	(228) 467 - 4510
Harrison County Health Department	(228) 863 - 1036
Health & Prescription Services	(228) 762 - 0364
Jackson County Health Department	(228) 762 - 1117
Magnolia Medical Foundation	(228) 860 - 7530
MS Division of Medicaid	(601) 359 - 6050
MS State Department of Health	(601) 576 - 7400
MS Tobacco Free Coalition of Harrison County	(601) 385 - 3533
Stone County Health Department	(601) 928 - 5293
Wayne County Health Department	(601) 735-2351
Housing & Utilities	
Biloxi Housing Authority	(228) 374 - 7771
Community Care Network	(228) 215 - 2662
Habitat For Humanity of The MS Gulf Coast	(228) 678 - 9100
Jackson County Civic Action Committee	(228) 769 - 3292
Mercy Housing and Human Development	(228) 896 - 1945
MS Regional Housing Authority No. VIII	(228) 831 - 2992
Open Doors Homeless Coalition	(228) 604 - 2048
PRVO - Pearl River Valley Opportunity	(228) 231 - 1314
Rebekah's House	(228) 388 - 3061
Legal Services	
Disability Rights Mississippi	(800) 772 - 4057
MS Center For Justice	(228) 435 - 7284

MS Center for Legal Services	(228) 896 - 9148
MS Volunteer Lawyers Project	(601) 960 - 9577
Mental Health Services	
Gulf Coast Mental Health Center	(228) 863 – 1132
Gulfport Behavioral Health System	(888) 420 - 5144
Mental Health Association of South MS	(228) 864 - 6274
Senior Services	
Area Agency on Aging	(228) 868 - 2311
Harrison County Senior Resources Agency	(228) 896 - 0214
Meals on Wheels	(228) 868 - 2311
MS Access to Care	(228) 868 - 2311
Senior Companion Program	(228) 896 - 2241
State Health Insurance Program (SHIP)	(228) 868 - 2311
Substance Abuse & Addiction	
City of Refuge for Men, The	(601) 766 - 5033
Crossroads Recovery Center	(228) 863 - 0096
Support Groups	
Alcoholics Anonymous (South MS Intergroup)	(228) 575 - 9225
Divorce & Grief Recovery Workshop	(228) 863 – 0047
Healing Hearts Support Group	(228) 867 - 5000
Transportation	
Coast Transit Authority	(228) 896 - 8080
Veteran & Military Services	
Armed Forces Retirement Home	(228) 897 - 4418
Biloxi VA Medical Center	(800) 827 - 1000
Biloxi Vet Center	(228) 388 - 9938
Disabled American Veterans	(228) 731 - 3874
Fisher House of Keesler	(228) 376 - 5931