



# Pinellas County:

Community Health Assessment 2023





# Pinellas County: Community Health Assessment 2023

Ron DeSantis  
Governor

Joseph Ladapo, MD, PhD  
Florida State Surgeon General

Ulyee Choe, DO  
Director, Florida Department of Health in Pinellas County  
County Health Systems Statewide Medical Director

Production of the Florida Department of Health in Pinellas County  
Compiled and edited by the Division of Community Health and Performance Management

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# Table of Contents

Introduction .....	5
ALL4HealthFL Collaborative .....	8
Community Health Assessment .....	6
Background .....	6
MAPP Framework.....	7
Overview.....	9
Secondary Data Sources & Analysis .....	9
Primary Data Collection & Analysis.....	10
Community Survey.....	11
Focus Groups .....	12
Data Synthesis & Prioritization .....	13
Data Synthesis .....	13
Prioritization .....	13
Prioritized Significant Health Needs .....	14
Pinellas County Overview.....	15
Pinellas County Demographics.....	16
Geography and Data Sources .....	16
Population.....	16
Age .....	18
Sex.....	19
Race and Ethnicity.....	19
Language and Immigration .....	20
Social & Economic Determinants of Health.....	22
Geography and Data Sources .....	22
Income .....	23
Poverty.....	24
Employment.....	26
Education .....	26
Housing .....	28
Neighborhood and Built Environment.....	29

Disparities and Health Equity.....	30
Health Equity .....	30
Race, Ethnicity, Age & Gender Disparities .....	30
Secondary Data.....	30
Geographic Disparities .....	32
Health Equity Index.....	32
Food Insecurity Index.....	34
Mental Health Index .....	35
Pinellas County Health Needs .....	36
Prioritized Health Topic: Access to Health & Social Services .....	36
Access to Health & Social Services.....	36
Primary Data: Community Survey & Focus Groups.....	36
Barriers and Disparities: Access to Healthcare Services.....	37
Barriers and Disparities: Access to Dental Health Services .....	38
Barriers and Disparities: Access to Care in the Emergency Room .....	38
Secondary Data .....	38
Barriers and Disparities: Social Determinants of Health & Quality of Life .....	39
Prioritized Health Topic: Mental Health & Substance Abuse.....	41
Mental Health .....	41
Alcohol and Substance Abuse.....	44
Prioritized Health Topic: Health Promotion & Behavior .....	47
Exercise, Nutrition & Weight .....	47
Cancer .....	49
Heart Disease and Stroke.....	49
Immunizations & Infectious Diseases.....	49
COVID-19 Pandemic.....	50
Community Lived Experiences Around Diversity, Equity & Inclusion.....	51
Additional Opportunities for Impact.....	52
Conclusion and Next Steps.....	52
References.....	53
Appendices.....	54

## Introduction

There are many factors that influence the health and well-being of a community. These include health behaviors, access to health care, social and economic status, and the physical environment. To improve community health outcomes, it is important to identify and measure all these factors and understand the inequities that prevent some people from living long and happy lives.

The Pinellas County Community Health Assessment (CHA) is a compilation of community input and primary survey data designed to measure the health of Pinellas County. This assessment was completed through the All4HealthFL collaborative effort that integrated the processes of the hospitals and community partners. The All4HealthFL Collaborative partnered with Conduent Healthy Communities Institute (HCI) to conduct this assessment.

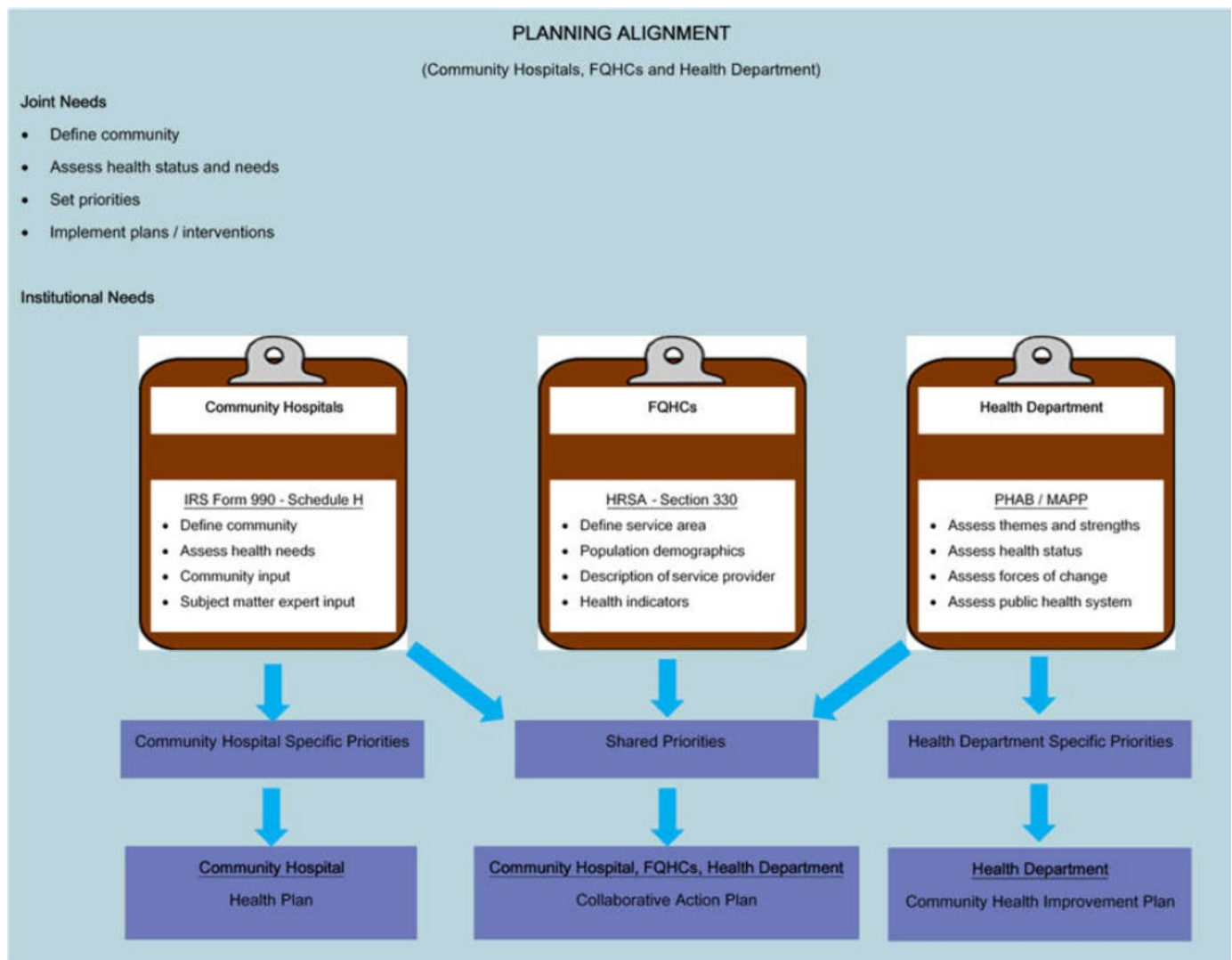
As a result, the Pinellas CHA now exists as a resource for identifying the community's health priorities. It will serve as the basis of the Community Health Improvement Plan (CHIP), a community-based strategic plan that outlines how to address areas of need. The data and information provided here should be reflected on by all members of the community. As a snapshot of the health and wellbeing of residents living in Pinellas County, this report is intended to serve as a road map for addressing quality of life.

# Community Health Assessment

## Background

Section 330 of the Public Health Service Act (42 U.S.C.254b) requires that health centers demonstrate and document the needs of their target populations. Accredited health departments have similar requirements to meet the standards established by the Public Health Accreditation Board (PHAB). Also, under the Federal Revenue Code of the Internal Revenue Service (IRS), Section 501(c) (3), not-for-profit hospitals must complete a Community Health Needs Assessment (CHNA) and Implementation Plan every three years to maintain their tax-exempt status. The CHNA is conducted to assess and identify the needs of the community, while the Implementation Plan provides the framework for addressing these needs. Federally Qualified Health Centers (FQHCs) are not-for-profit private or public entities that provide health care to medically underserved populations. Figure 2 shows the alignment between the Local Health Department, Community Hospitals, and FQHCs assessment needs.

Figure 2. CHA Planning Alignment



## MAPP Framework

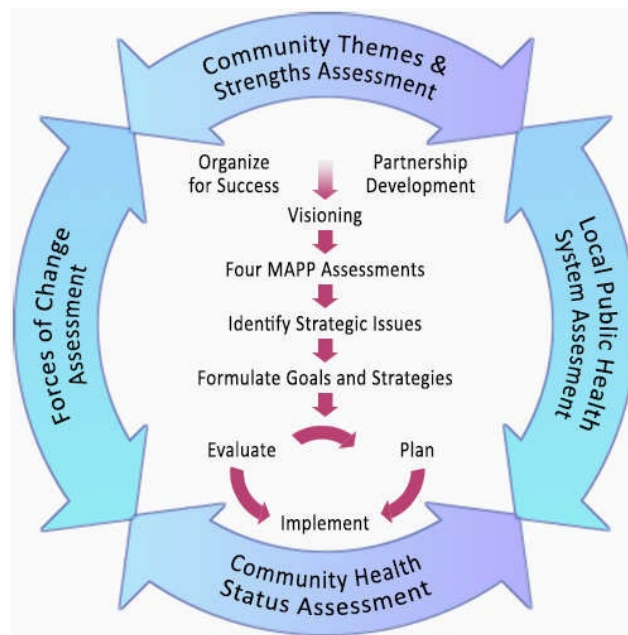
The 2023 Pinellas CHA was guided and informed by the Mobilizing for Action through Planning and Partnerships (MAPP) framework: a community-driven strategic planning process for improving community health. The comprehensive framework of MAPP integrates previous and current work to prioritize health issues for developing and implementing strategic actions.

The MAPP process used during this assessment applied strategic thinking for prioritizing public health issues. MAPP, like other strategic planning models, provides a framework for previous and current work to be integrated into the process. MAPP is not an agency-focused assessment process; rather, it is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems.

There are six phases of the MAPP process. The first two phases are comprised of visioning, organizing, and partner development. Phase three is the assessment phase, encompassing four distinct assessments (Community Themes & Strengths, Local Public Health System, Community Health Status, and Forces of Change). Strategic issues are identified in phase four by converging the results of the assessments in phase three. Goals and strategies are formulated in phase five to address the issues and achieving goals of the community's vision. Phase six is the action cycle and links planning, implementation and evaluation by building upon each activity in a continuous and interactive manner. **Even though the MAPP process is iterative, the framework is flexible and can be tailored to fit the needs of the community.**

According to the National Association of County & City Health Officials (NACCHO), the four MAPP assessments form the core of the MAPP process. See Figure 3.

Figure 3. MAPP Academic Model

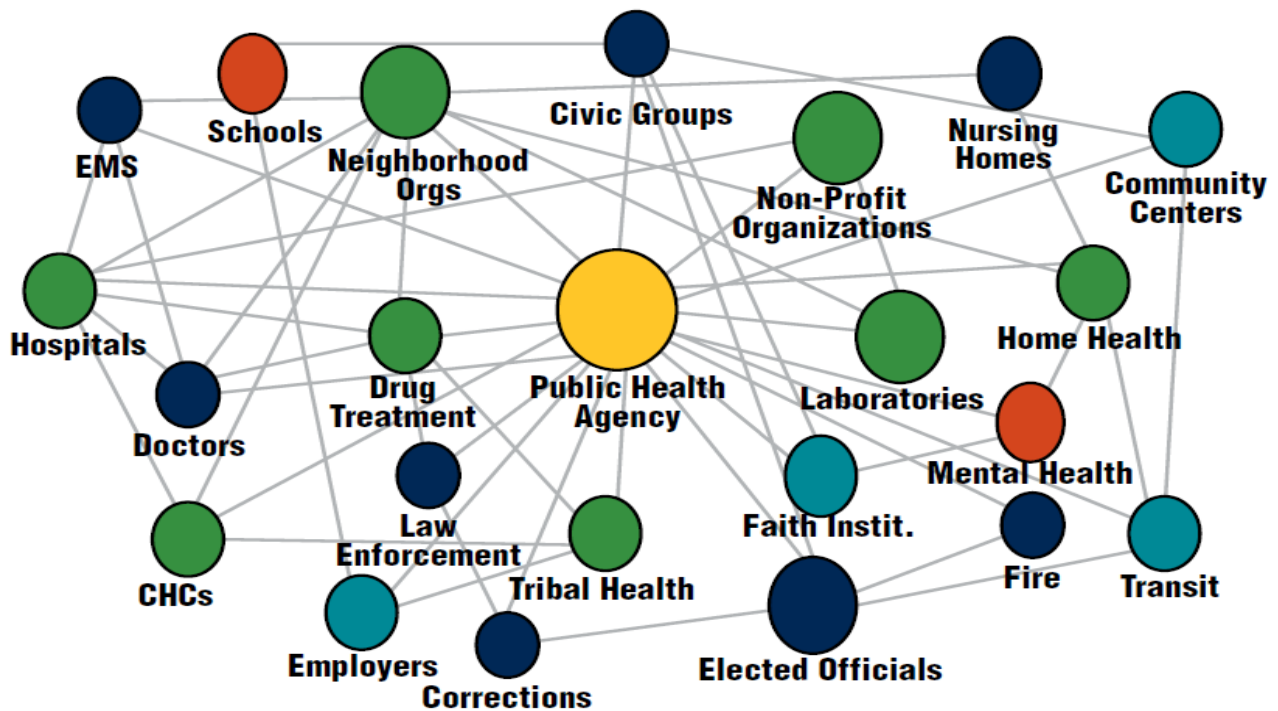


\*Source: MAPP: User's Handbook (2013)

## ALL4HealthFL Collaborative

A local public health system is a complex network made up of all public, private, and voluntary entities that contribute to the delivery of essential public health services within a community. In Pinellas County, the local public health system is made up of the Health Department, hospitals, doctors, primary and emergency care providers, and many other partners shown in the diagram below.

Figure 1. Local Public Health System Jellybean Diagram



\*Source: <https://www.datacounts.net/lphsa/about.asp>

The purpose of the All4HealthFL Collaborative is to unite public health agencies and organizations who share a mutual interest in improving outcome-driven health initiatives that have been prioritized through community health assessments. Membership in All4Health consists of the departments of health in Pinellas, Hillsborough, Pasco, and Polk counties in partnership with the not-for-profit hospitals in the respective counties. Together, the group strives to make West Central Florida the healthiest region in the state.

To learn more about the All4HealthFL Collaborative, access local data on a wide selection of health indicators, and explore best practices in community health, visit their website <http://www.all4healthfl.org/>.



# Methodology

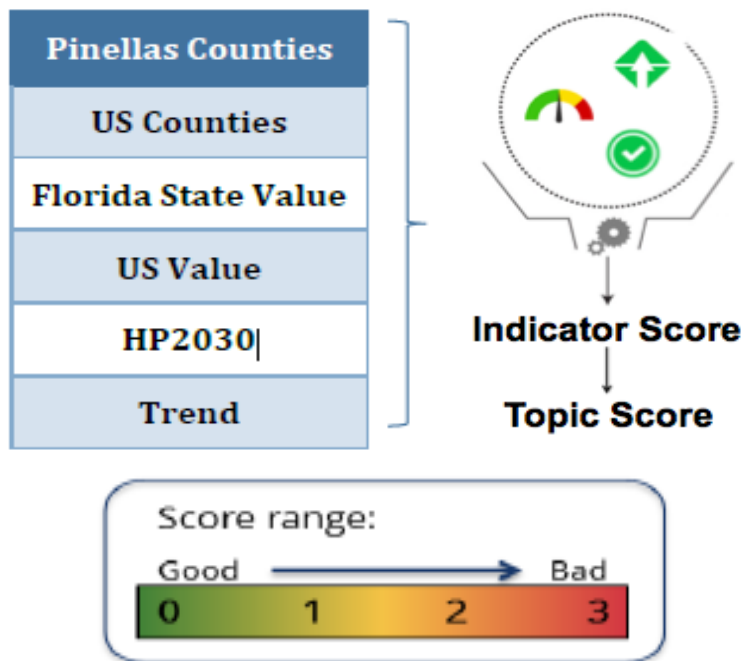
## Overview

Through the CHA, public health professionals seek to answer the question, “How healthy is the community?” To answer this question, it was important to identify both existing (secondary) health data and new (primary) data. The methods used to analyze each type of data are outlined below. The findings from each data source were then synthesized and organized by health topic to present a comprehensive overview of health needs in Pinellas County.

## Secondary Data Sources & Analysis

Secondary data used for this assessment were collected and analyzed with the All4HealthFL Community Dashboard developed by Conduent Healthy Communities Institute (HCI). The Community Dashboard includes over 150 community indicators, spanning at least 24 topics in the areas of health, determinants of health, and quality of life. The data are primarily derived from state and national public secondary data sources. HCI’s Data Scoring Tool® was used to systematically summarize multiple comparisons across the Community Dashboard to rank indicators based on highest need. For each indicator, Pinellas County value was compared to a distribution of Florida and US counties, state and national values, Healthy People 2030, and significant trends (Figure 4).

Figure 4. Secondary Data Scoring



Indicators are rolled up into health and quality of life topic areas, then ranked. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected from other communities, and changes in methodology over time. The analysis of national, state, and local indicators that contributed to the CHNA can be viewed in full in Appendix A.

Table 1 shows the health and quality of life topic scoring results for Pinellas County, with Other Conditions scored as the poorest performing topic area with a score of 1.96, followed by Older Adults with a score of 1.89. Topics that received a score of 1.50 or higher were considered a significant health need. Eleven topics scored at or above the threshold. Topic areas with fewer than three indicators were considered a data gap.

Table 1. Secondary Data Topic Scoring Results

<b>Health Topic</b>	<b>Score</b>
Other Conditions	1.96
Older Adults	1.89
Prevention & Safety	1.77
Women's Health	1.75
Mental Health & Mental Disorders	1.73
Sexually Transmitted Infections	1.71
Heart Disease & Stroke	1.67
Cancer	1.62
Alcohol & Drug Use	1.57
Children's Health	1.56
Tobacco Use	1.51
Wellness & Lifestyle	1.40
Respiratory Diseases	1.32
Physical Activity	1.26
Immunizations & Infectious Diseases	1.23
Weight Status	1.21
Oral Health	1.19
Adolescent Health	1.16
Maternal, Fetal & Infant Health	1.08
Health Care Access & Quality	1.06
Diabetes	0.89

### Primary Data Collection & Analysis

To ensure the perspectives of community members were considered, input was collected from Pinellas County residents. Primary data used in this assessment consisted of focus group discussions, and a community survey. These findings expanded upon the information gathered from the secondary data analysis.

## Community Survey

Community input was collected via a survey that was made available online and via paper copies in English, Spanish, and Creole from January 3, 2022, through February 28, 2022. The survey consisted of 59 questions related to top health needs in the community, individuals' perceptions of their overall health, individuals' access to health care services, as well as social and economic determinants of health. The list of survey questions is available in Appendix C.

The All4HealthFL Collaborative worked extensively with community and organizational leads to market, outreach, and track survey responses to ensure an equitable representation of community voices was captured. Survey marketing and outreach efforts included email invitations, social media, and coordination of onsite paper survey distribution events in collaboration with community-based organizations. A community assessment dashboard was created to track and monitor survey respondents by Zip code, age, gender, race, and ethnicity to ensure targeted outreach for at risk populations. A total of 5,048 residents responded for Pinellas County.

### *Community Survey Analysis Results*

Survey participants were asked about the top three pressing health and quality of life issues they believe should be addressed in their community. In Figure 5, the "Top Three Health Issues" were, mental health problems including suicide (41% of respondents), aging problems (38%), and being overweight (31%). The "Top Three Risky Behaviors" included illegal drug use/abuse of misuse of prescription medications (50% of respondents), alcohol abuse/drinking too much alcohol to include beer, wine, spirits, or mixed drinks (47% of respondents), and distracted driving such as, texting, eating, and talking on the phone (43% of respondents). Lastly, the "Top Three Quality of Life Issues" included low crime/safe neighborhoods (45% of respondents), access to healthcare (37% of respondents), and good schools (24% of respondents).

Figure 5. Top 3 Health & Quality of Life Issues

Top 3 Health Issues	Top 3 Risky Behaviors	Top 3 Quality of Life Issues
<ol style="list-style-type: none"><li>1. Mental health problems including suicide</li><li>2. Aging problems (i.e., difficulty getting around, dementia, arthritis)</li><li>3. Being overweight</li></ol>	<ol style="list-style-type: none"><li>1. Illegal drug use/abuse or misuse of prescription medications</li><li>2. Alcohol abuse/drinking too much alcohol (i.e., beer, wine, spirits, mixed drinks)</li><li>3. Distracted driving (texting, eating, talking on the phone)</li></ol>	<ol style="list-style-type: none"><li>1. Low crime/safe neighborhoods</li><li>2. Access to health care</li><li>3. Good schools</li></ol>

## Focus Groups

The All4HealthFL Collaborative partnered with St. Petersburg College Collaborative Labs in Clearwater, Florida to conduct five focus group discussions to gain deeper understanding of health issues impacting residents living in Pinellas County. Focus groups aimed to understand the different health experiences for Black/African American, LGBTQ+, Hispanic/Latino, Children, and Older Adults. Members of these communities were selected to participate in the focus group discussions.

Focus Group discussions took place in November 2021, with a total of 38 community participants. Due to the ongoing COVID-19 pandemic these discussions were conducted virtually. A questionnaire was developed to guide the conversations which includes topics such as Community Strengths & Assets, Top Health Problems, Access to Health, and Impact on Health. A list of questions utilized for focus group discussions can be found in Appendix C. To help inform an assessment of community assets participants were asked to list and describe resources available in the community, the list is available in Appendix C.

The project team captured detailed transcripts of the focus group sessions. The transcripts were analyzed using the qualitative analysis program Dedoose®2. Text was coded using a pre-designed codebook-organized by themes and analyzed for significant observations. The findings from the analysis were combined with findings from other primary and secondary data and incorporated into the Data Synthesis, and Prioritized Health Needs. Themes across all focus groups are seen in Figure 6. Appendix C provides a more detailed report of the main themes that trended across the individual focus group conversations.

Figure 6. Themes Across All Focus Groups

Top Health Issues	Barriers/Social Determinants of Health	Populations Most Impacted
<ul style="list-style-type: none"> <li>• Access to healthcare</li> <li>• Government/policy</li> <li>• Mental health &amp; mental disorders</li> <li>• Nutrition and health eating</li> <li>• Safety</li> </ul>	<ul style="list-style-type: none"> <li>• Discrimination/bias</li> <li>• Economy</li> <li>• Employment</li> <li>• Environmental &amp; food security/access</li> <li>• Health behaviors (fear or stigma &amp; knowledge or navigation of health system)</li> <li>• Housing</li> <li>• Lack of/or limited health insurance</li> <li>• Language/culture</li> <li>• Medication cost</li> <li>• Social environment</li> <li>• Transportation</li> </ul>	<ul style="list-style-type: none"> <li>• Adolescents</li> <li>• Black/African American</li> <li>• Children</li> <li>• Latino/Hispanic</li> <li>• LGBTQ+ population</li> <li>• Older adults</li> </ul>

# Data Synthesis & Prioritization

## Data Synthesis

All forms of data may present strengths and limitations. Each data source used in this CHA process was evaluated based on such strengths and limitations and should be kept in mind when reviewing this report. Each health topic presented a varying scope and depth of quantitative data indicators and qualitative findings. For both quantitative and qualitative data, immense efforts were made to include as wide a range of secondary data indicators, Focus group participants, and community survey participants as possible. To gain a comprehensive understanding of the significant health needs for Pinellas County, the findings from all three data sets were compared and studied simultaneously. The secondary data scores, focus group themes, and survey responses were considered equally important in understanding the health issues of the community. The top health needs identified from data sources were analyzed for areas of overlap. Six health issues were identified as significant health needs across all three data sources and were used for further prioritization. Figure 7 shows the final six trending health topics for consideration.

Figure 7. Trending Health Topic for Consideration



## Prioritization

On April 19, 2022, participants from collaborating organizations, as well as other community partners, came together to prioritize the significant health needs for Pinellas County. To better target issues regarding the most pressing health needs, the All4HealthFL Collaborative conducted a two-hour virtual Prioritization Session facilitated by the Tampa Bay Healthcare Collaborative (TBHC). A total of 101 individuals attended the prioritization session, representing a broad cross section of experts and organizational leaders with an extensive knowledge of the health needs in the community. The meeting objectives included: reviewing analyzed health data pertaining to health needs and disparities, discussing significant health needs that were identified, gathering additional community input on health topics, and prioritizing significant health needs. An additional discussion was hosted to close out the session with generating preliminary ideas on how the broader community could collaborate to address top community health needs.

The prioritization session included a data presentation highlighting community survey, focus group, and secondary data findings for the six significant health issues. Session participants were then directed to breakout groups to process their initial thoughts about the data and social determinants of health. Groups then discussed one of the six significant health needs identified through the assessment process. Discussions were supported with additional data placemats about each need area. Data placemats and an overview of discussion themes can be found in Appendix D.

After group discussions concluded, a ranking process was conducted to determine top ranked health needs. Participants ranked each of the health categories individually using the dual criteria of scope and severity and ability to impact. Criteria scores were then combined to generate an overall ranking of health needs. A total of 79 individuals completed the online prioritization activity and a cumulative total score of each health topic can be seen in Figure 8. The top prioritized health topics that emerged from the prioritization activity included Access to Health & Social Services; Behavioral Health (Mental Health & Substance Misuse); Exercise, Nutrition & Weight; and Heart Disease & Stroke.

Figure 8. Cumulative Total Score of Significant Health Topics (n=79)

Health Topics	Cumulative Total Score
Access to Health & Social Services	211.5
Behavioral Health (Mental Health & Substance Misuse)	205.5
Exercise, Nutrition & Weight	188.5
Immunizations & Infectious Diseases	173
Heart Disease & Stroke	169.5
Cancer	152

On September 6, 2022, a follow-up meeting was held with community partners to further discuss the prioritized health topics to begin planning for the Community Health Improvement Plan (CHIP). At this meeting it was decided to combine the topics of Exercise, Nutrition & Weight with Heart Disease & Stroke under the title of Health Promotion & Behavior.

## Prioritized Significant Health Needs

Figure 9. 2023 Priority Health Needs



## Pinellas County Overview

Pinellas County occupies the Pinellas peninsula in West Central Florida, between Tampa Bay and the Gulf of Mexico. In the pre-Columbian era, Pinellas County was home to the Weeden Island Culture from approximately 300 AD to 800 AD, followed by the Safety Harbor Culture of Tocobaga Indians until they were wiped out by disease and war by approximately 1700 AD. Pánfilo de Narvaez is believed to be the first European to land on the Pinellas peninsula in 1528. Later Spanish explorers would eventually dub the peninsula Punta Piñal. The Pinellas peninsula was utilized by indigenous peoples and early settlers for various agricultural and fishing endeavors with very little development.

Cuban fishermen mainly utilized the area for transient fishing camps into the 19<sup>th</sup> century. In 1819, Florida was ceded to the United States through the Adams-Onís Treaty and officially became part of the U.S in 1821. The area that is now Pinellas and Hillsborough Counties was established as Hillsborough County in 1834. Odet Philippe became the first permanent, non-Native resident in that same year.

In 1841, Fort Harrison was established on the peninsula as a convalescence post during the Second Seminole War and Tarpon Springs became the first incorporated city of West Hillsborough in 1887. In 1888 the Orange Belt Railway was extended southward, and St. Petersburg was established. During this period, agriculture, especially citrus production, was the area's most important industry.



*\*Image: Pinellas County Health Department Director Dr. Robert D. Hollowell, who served during 1941-1948, at the door of the St. Petersburg center.*

Dissatisfied with the allocation of funds and political power in Hillsborough County, which were funneled toward the development of Tampa in East Hillsborough, West Hillsborough split itself from Hillsborough County and the peninsula took on its own governance in 1912 as Pinellas County. Pinellas experienced rapid growth and development during the late 19<sup>th</sup> and early 20<sup>th</sup> century, with the railroad bringing a tourism economy to life as more Americans experienced leisure time and travel. During the early 1920s, along with the rest of the state, Pinellas flourished during a land boom. However, Pinellas experienced financial downturn starting with the land bust of 1926 and would not have any significant growth until after World War II because of the bust and the Great Depression.

During World War II, thousands of troops were trained in Pinellas County. After the War, many of these troops returned as tourists and to settle in the area. The post-war era began another period of rapid development in Pinellas County and influenced Pinellas' economic growth. Today, tourism is Pinellas County's number one industry, followed by manufacturing (including aviation and aerospace, defense and national security, and medical technology), and then other sectors of business such as information technology and finance.

## Pinellas County Demographics

The demographics of a community significantly impact its health profile. Different racial, ethnic, age, and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts. The following section explores the demographic profile of the community residing in Pinellas County.

### Geography and Data Sources

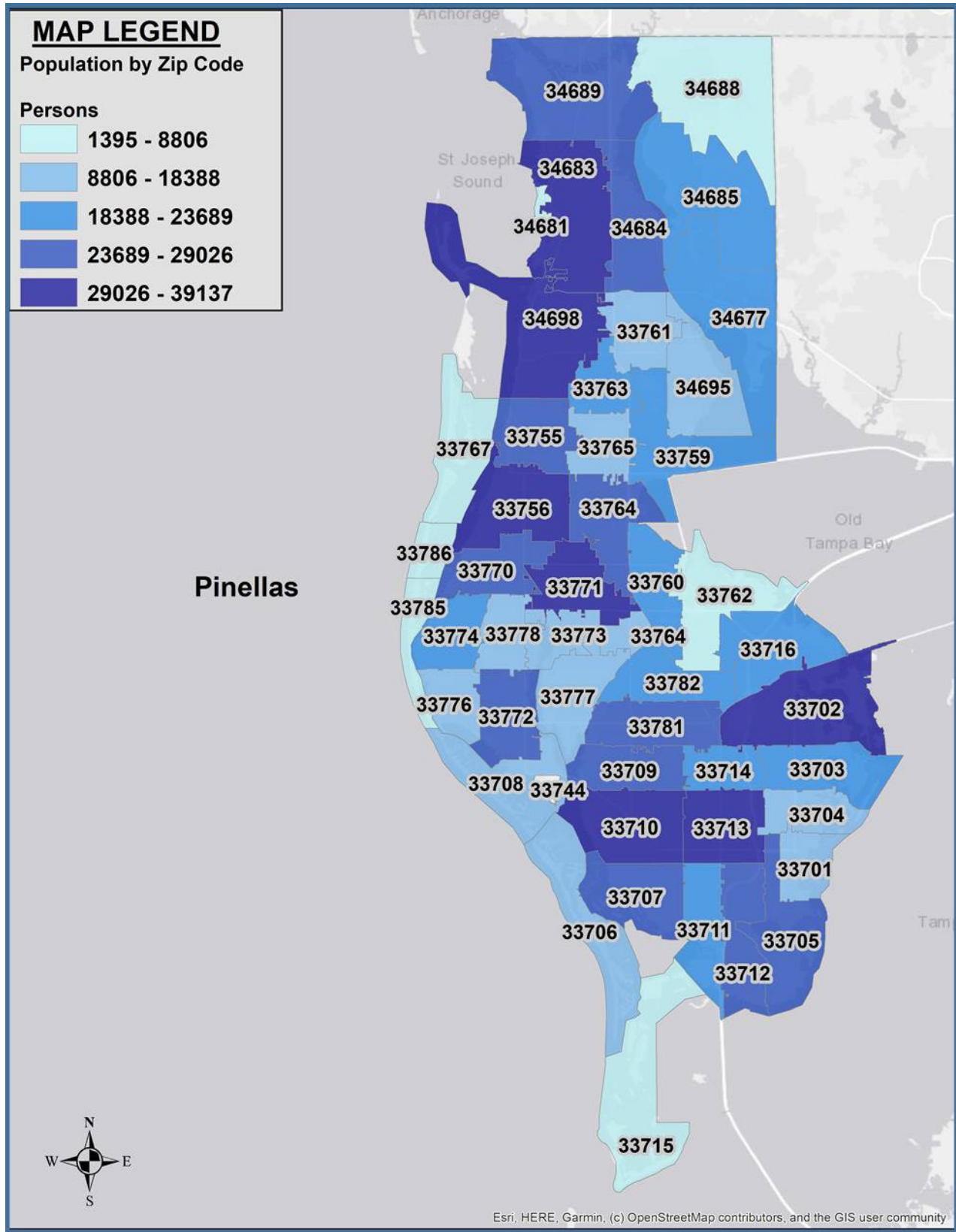
Data are presented in this section at the geographic level of Pinellas County. Comparisons to the county, state, and national value are also provided when available. All demographic estimates are sourced from Claritas Pop-Facts® (2022 population estimates)<sup>1</sup> and American Community Survey<sup>2</sup> one-year (2019) or five-year (2016-2020) estimates unless otherwise indicated.

### Population

According to the 2022 Claritas Pop-Facts® population estimates, Pinellas County has an estimated population of 982,142 persons. Figure 10 shows the population size by each Zip code, with the darkest blue representing the Zip codes with the largest population. Appendix A, provides the actual population estimates for each Zip code. The most populated Zip code area within Pinellas County is Zip code 34698 (Dunedin) with a population of 39,137 residents.



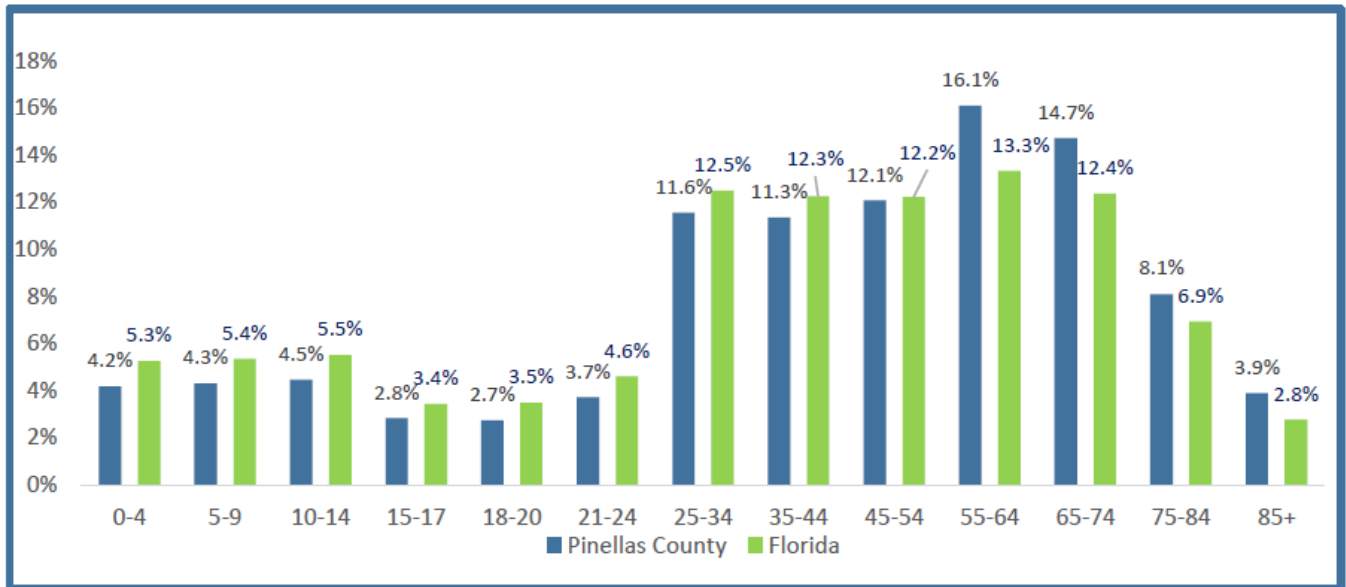
Figure 10. Population by Zip Code by Age Under 18: Pinellas County



## Age

Children (0-17) comprised 15.8% of the population in Pinellas County. When compared to Florida and the U.S., Pinellas County has lower proportion of children population (age 0-17) and a higher proportion of residents aged 65+ (Figure 11) shows further breakdown of age categories.

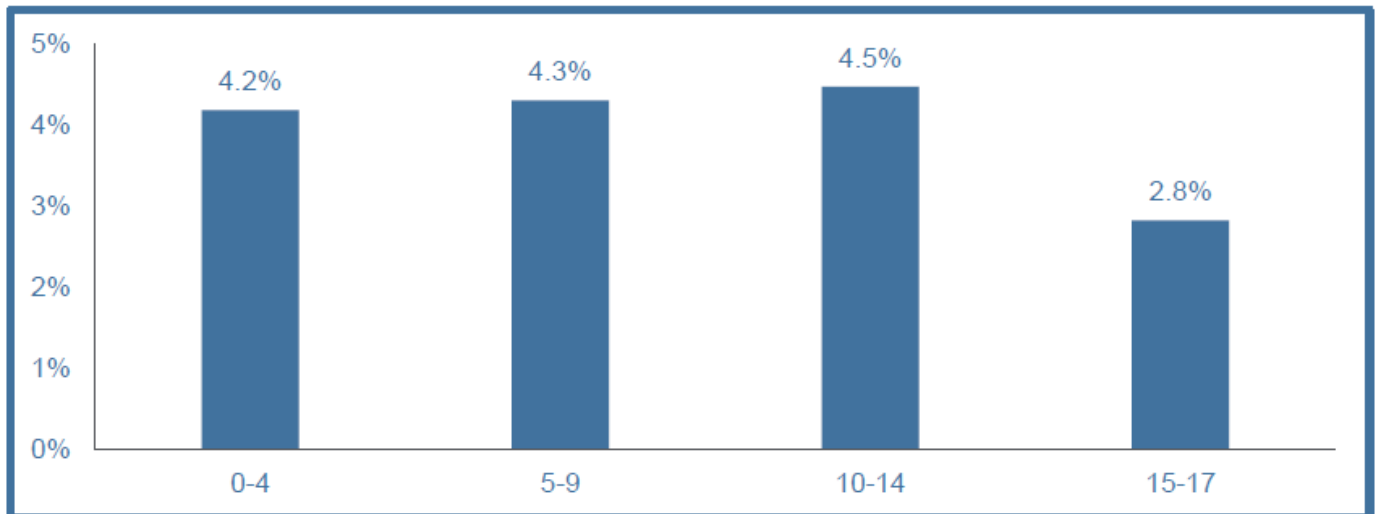
Figure 11. Population by Age: County, State, and U.S. Comparisons



\*County and state values- Claritas Pop-Facts® (2022 population estimates)

Figure 12 shows the population of Pinellas County by age group under 18 years.

Figure 12. Population by Age Under 18: Pinellas County

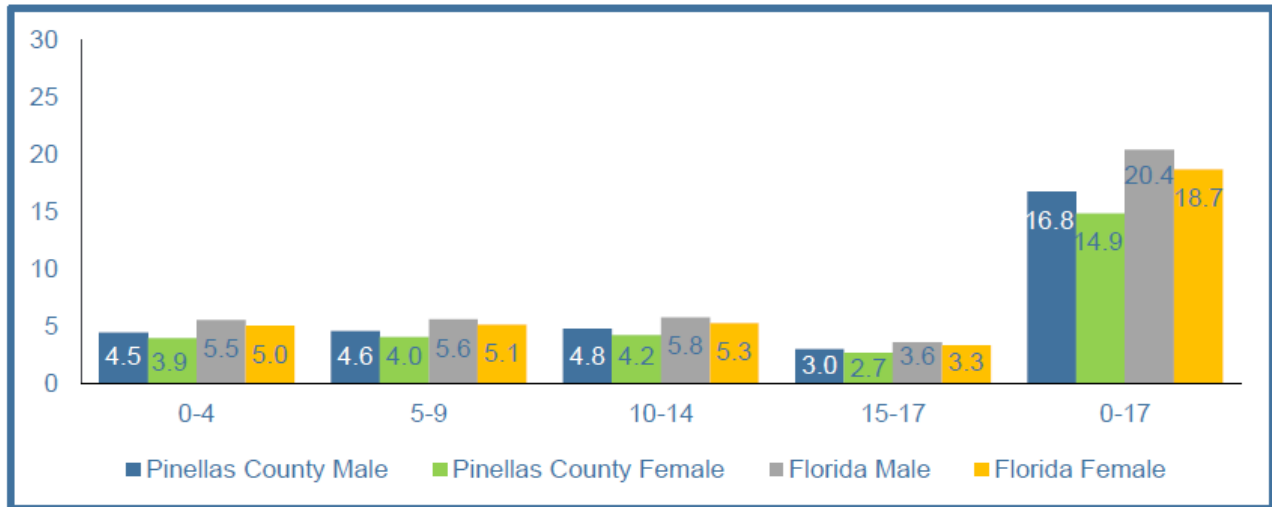


\*County values- Claritas Pop-Facts® (2022 population estimates)

## Sex

Figure 13 shows the children (under 18) population of Pinellas County by sex. Males comprise 16.7% of the population, whereas females comprise 14.8% of the population in the county.

Figure 13: Population by Sex Under 18: County, State and U.S. Comparisons



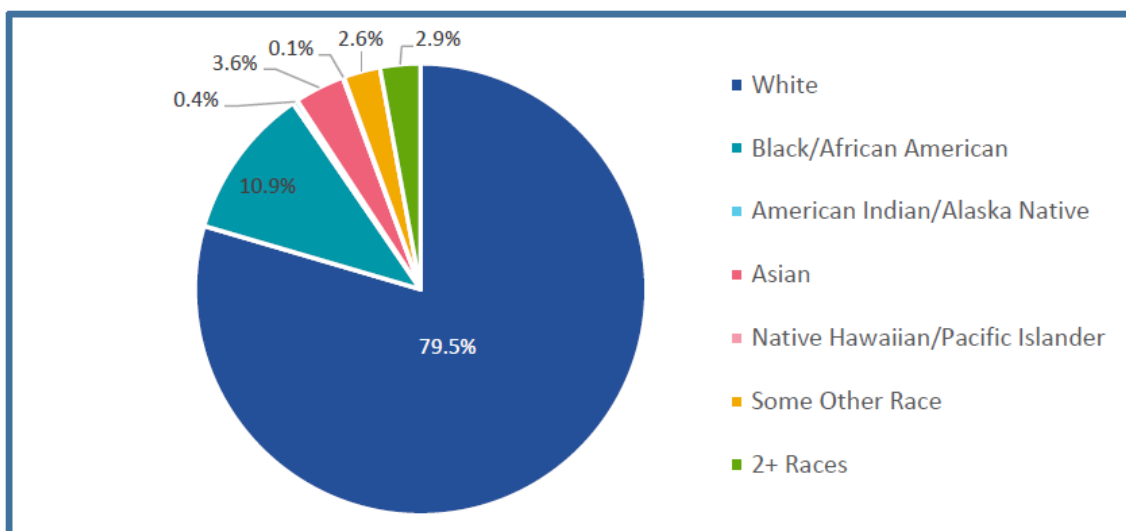
\*County values- Claritas Pop-Facts® (2022 population estimates)

## Race and Ethnicity

The racial and ethnic composition of a population is important in planning for future community needs, particularly for schools, businesses, community centers, health care, and childcare. Analysis of health and social determinants of health data by race/ethnicity can also help identify disparities in housing, employment, income, and poverty.

The racial makeup of Pinellas County area shows 79.5% of the population identifying as White, as indicated in Figure 14. The proportion of Black/African American community members is the second largest of all races in Pinellas County at 10.9%.

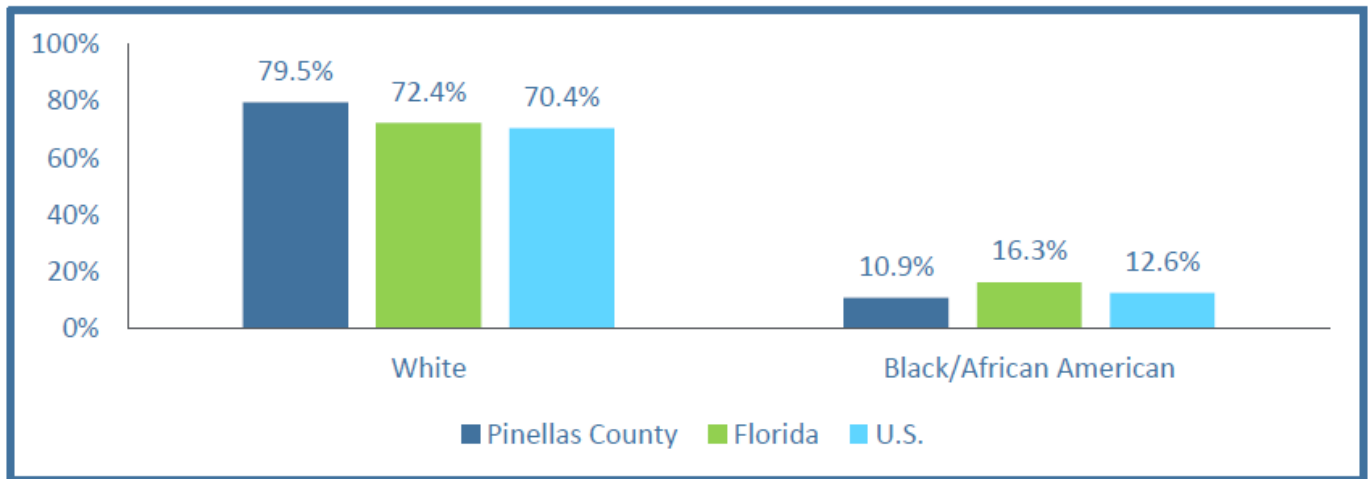
Figure 14. Population by Race: Pinellas County



\*County values- Claritas Pop-Facts® (2022 population estimates)

Those community members identifying as White represent a higher proportion of the population in Pinellas County (79.5%) when compared to Florida (72.4%) and the U.S. (70.4%), while Black/African American community members represent a lower proportion of the population in Pinellas County (10.9%) when compared to Florida (16.3%) and the U.S. (12.6%). See Figure 15.

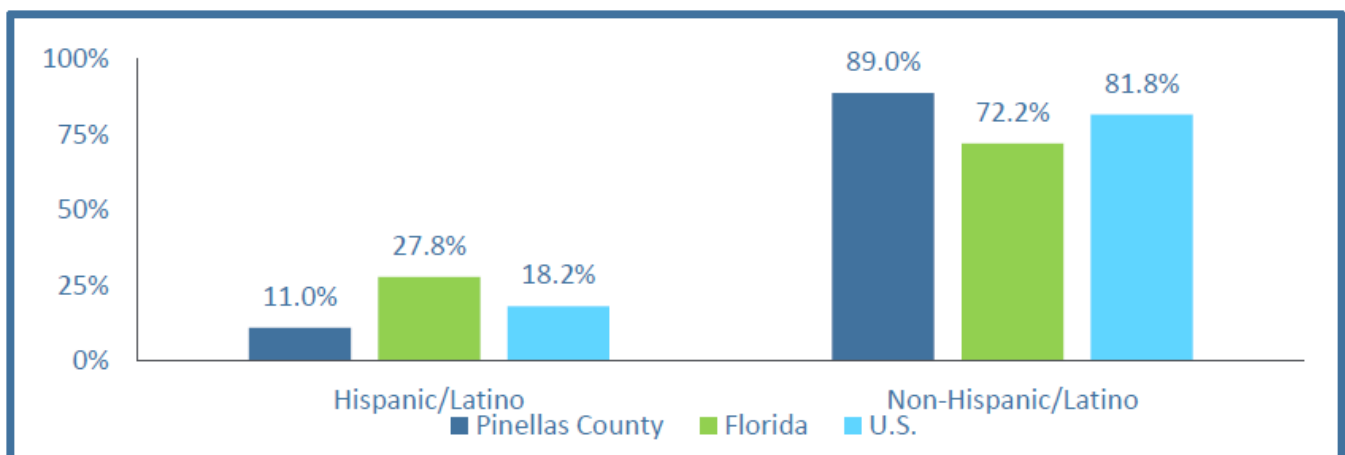
Figure 15. Population by Race: Pinellas County, State, and U.S. Comparisons



\*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

As shown in Figure 16, 11.0% of the population in Pinellas County identify as Hispanic/Latino. This is a smaller proportion of the population when compared to Florida and the U.S.

Figure 16. Population by Ethnicity: Pinellas County, State, and U.S. Comparisons



\*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

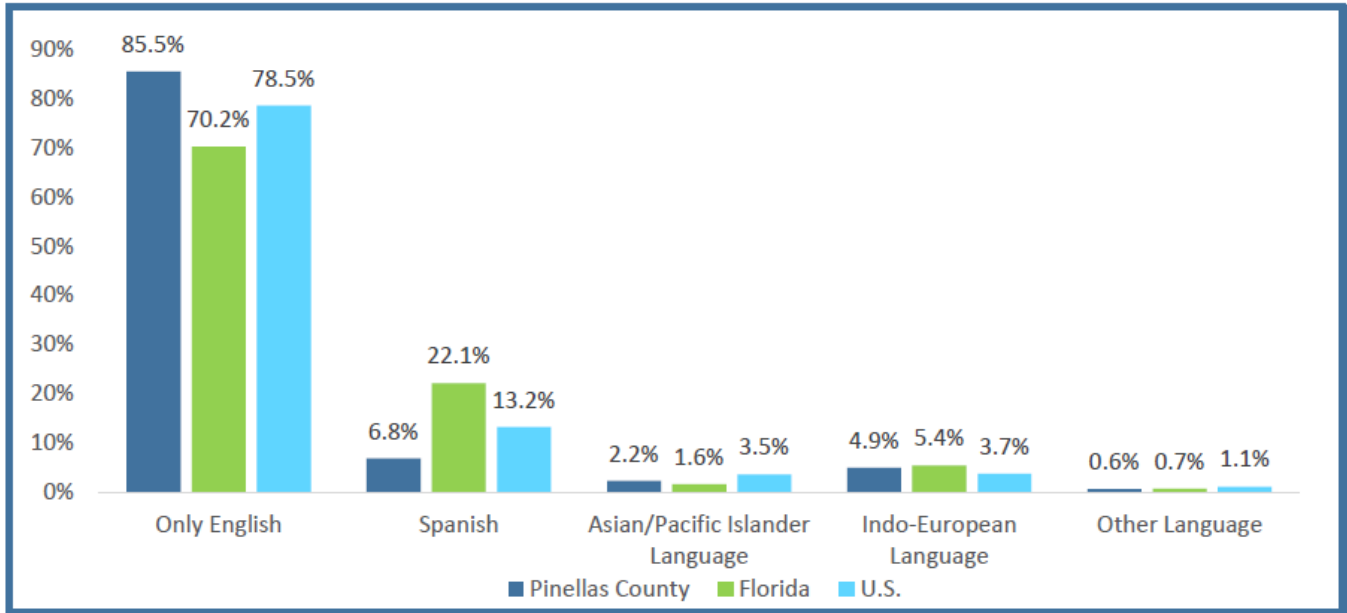
## Language and Immigration

Understanding countries of origin and language spoken at home can help inform the cultural and linguistic context for the health and public health system. According to the American Community Survey,

12% of residents in Pinellas County are born outside the U.S., which is slightly lower than the national value of 13.6%.<sup>3</sup>

In Pinellas County, 85.5% of the population age five and older speak only English at home, which is higher than both the state value of 70.2% and the national value of 78.5% (Figure 17). This data indicates that 6.8% of the population in Pinellas County speak Spanish, and 0.6% speak languages other than English at home.

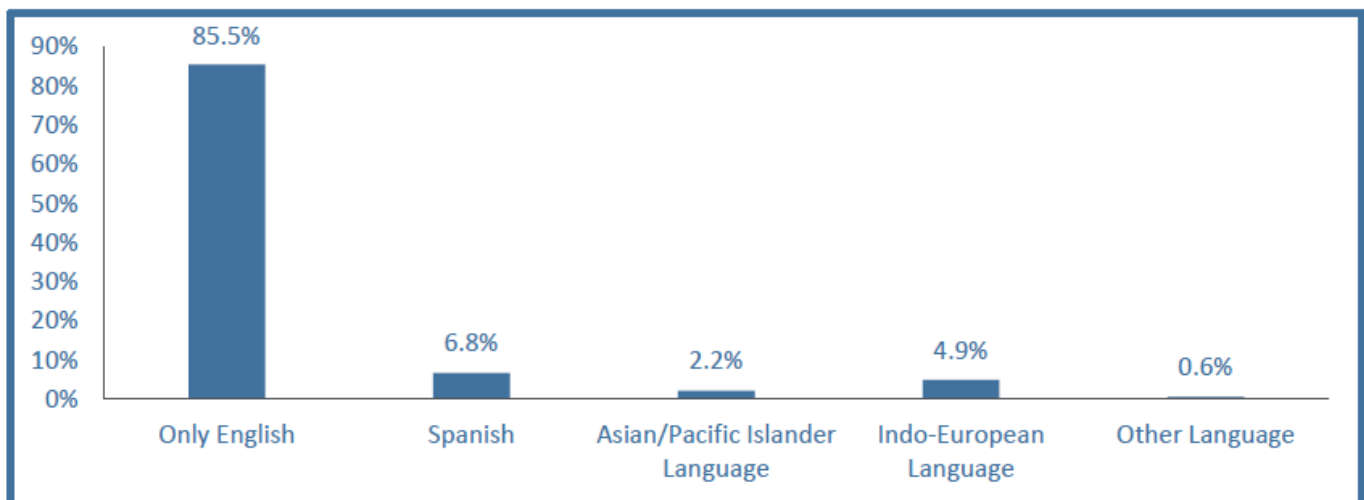
Figure 17. Population 5+ by Language Spoken at Home: County, State and U.S. Comparisons



\*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

The most common languages spoken at home are English (85.5%), Spanish (6.8%), and Indo-European languages- like English, French, Portuguese, Russian, Dutch, and Spanish<sup>4</sup> (4.9%). See Figure 18.

Figure 18. Population 5+ by Language Spoken at Home: Pinellas County



## Social & Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health impacting the Pinellas County communities. Social determinants are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. The Social Determinants of Health (SDOH) can be grouped into five domains (see Figure 19).

Figure 19. Healthy People 2030 Social Determinants of Health Domains



### Geography and Data Sources

Data in this section are presented at various geographic levels (Zip code and/or county) depending on data availability. When available, comparisons to county, state, and/or national values are provided. It should be noted that county level data can sometimes mask what could be going on at the Zip code level in many communities. While indicators may be strong when examined at a higher level, Zip code level analysis can reveal disparities.

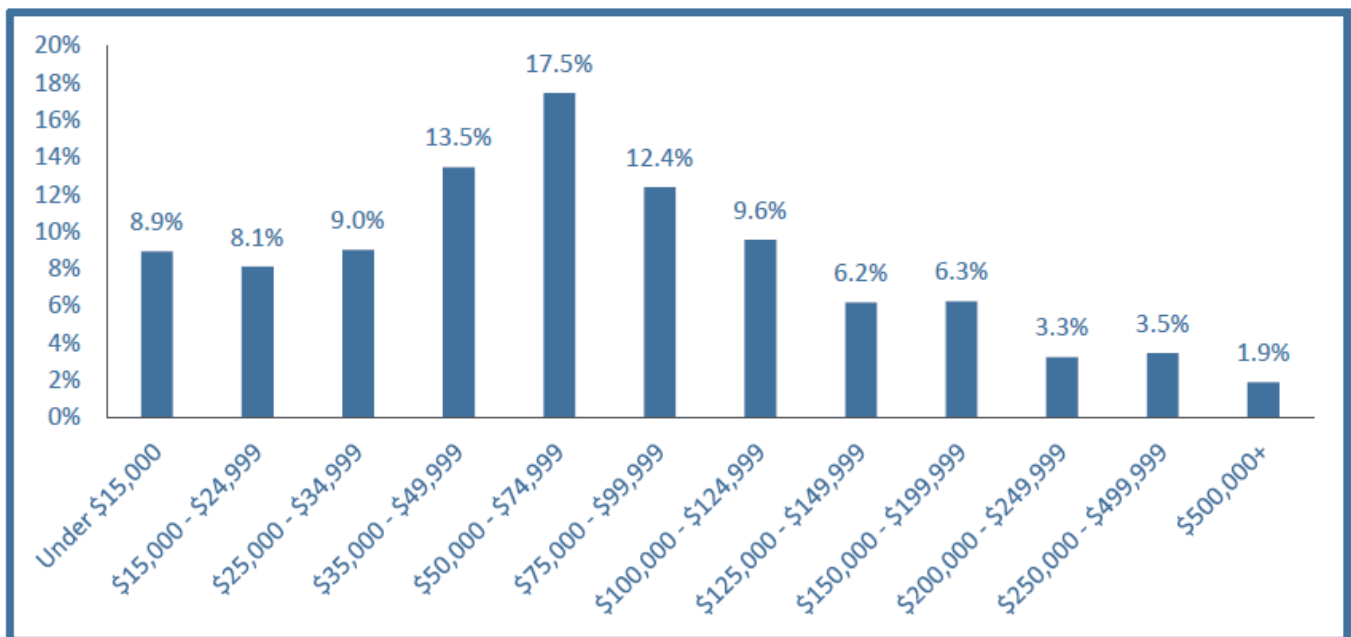
All demographic estimates are sourced from Claritas Pop-Facts® (2022 population estimates) and American Community Survey one-year (2019) or five-year (2016-2020) estimates unless otherwise indicated.

### Income

Income has been shown to be strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social, and environmental factors. Those with greater wealth are more likely to have higher life expectancy and reduced risk of a range of health conditions including heart disease, diabetes, obesity, and stroke. Poor health can also contribute to reduced income by limiting one’s ability to work.<sup>5</sup>

Figure 20 provides a breakdown of households by income in Pinellas County. A household income of \$50,000 - \$74,999 is shared by the largest proportion of households in Pinellas County (17.5%). Households with an income of less than \$15,000 make up 8.9% of households in Pinellas County.

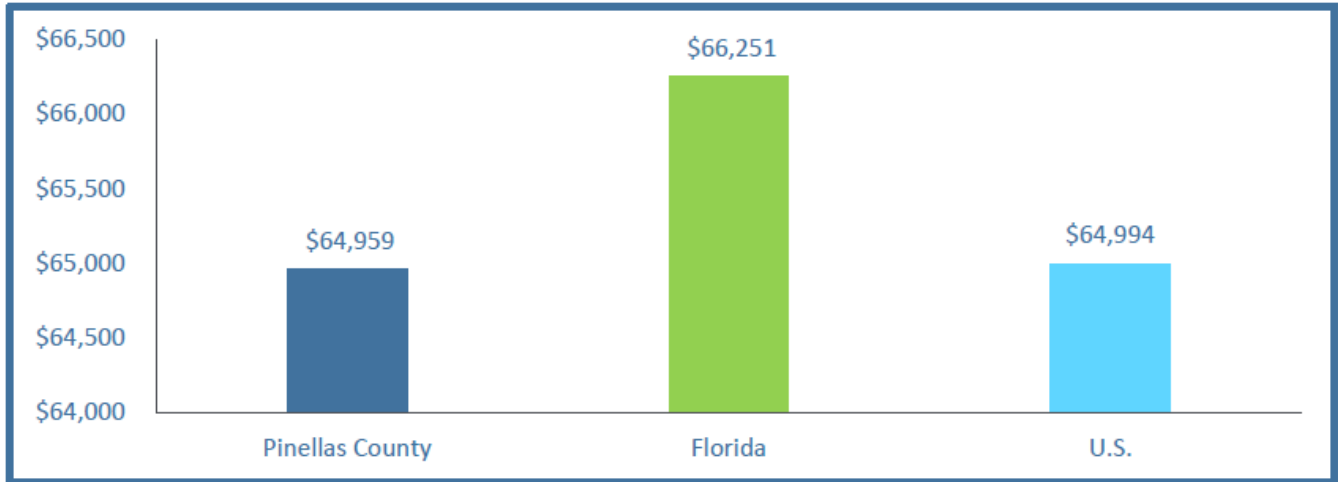
Figure 20. Households by Income, Pinellas County



\*County values- Claritas Pop-Facts® (2022 population estimates)

The median household income for Pinellas County is \$64,959, which is lower than the state value of \$66,251 and national value of \$64,994 (Figure 21).

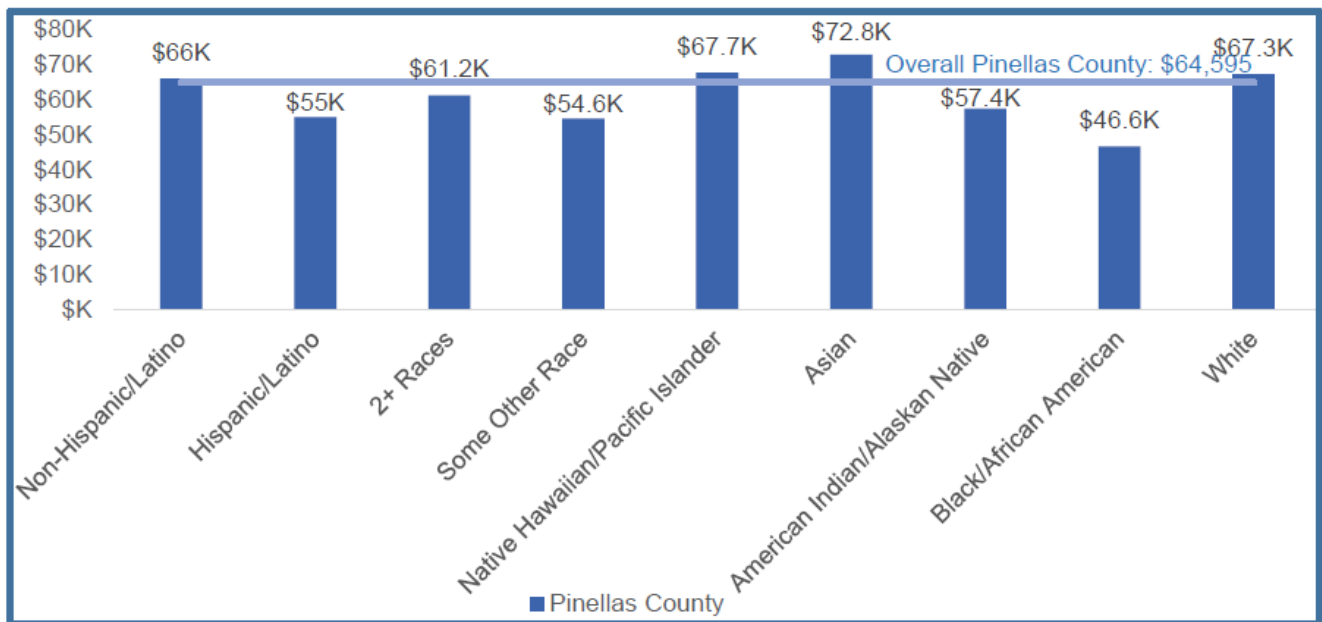
Figure 21. Households Income by County, State and U.S. Comparisons



\*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

Figure 22 shows the median household income by race and ethnicity. Four racial/ethnic groups – White, Asian, Non-Hispanic/Latino, and Native Hawaiian/Pacific Islander – have median household incomes above the overall median value. All other races have incomes below the overall value, with the Black/African American populations having the lowest median household income at \$46,614.

Figure 22. Median Household Income by Race/Ethnicity, Pinellas County



\*County values- Claritas Pop-Facts® (2022 population estimates)

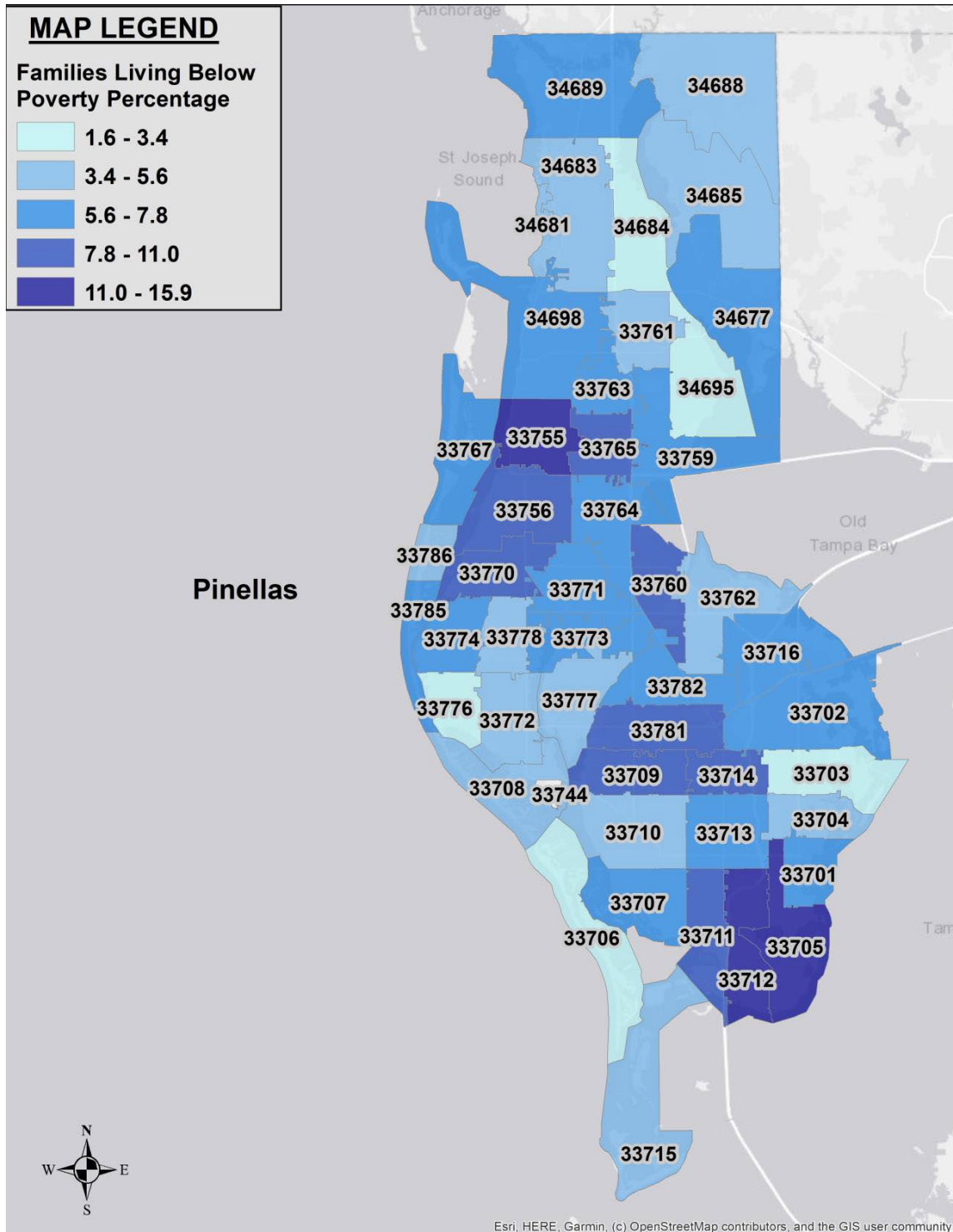
### Poverty

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. People living in poverty are less likely to have access to health care, healthy food, stable housing, and opportunities for physical activity. These disparities mean people living in poverty are more likely to experience poorer health outcomes and premature death from preventable diseases.<sup>6</sup>



Figure 23 shows the percentage of families living below the poverty level by Zip code. The darker blue colors represent a higher percentage of families living below the poverty level, with Zip codes 33755 (Clearwater) and 33712 (St. Petersburg) having the highest percentages at 15.9% and 14.2%, respectively. Overall, 7.0% of families in Pinellas County live below the poverty level, which is lower than both the state value of 9.3% and the national value of 9.1%. The percentage of families living below poverty for each Zip code in Pinellas County is provided in Appendix A.

Figure 23. Families Living Below Poverty: Pinellas County



## Employment

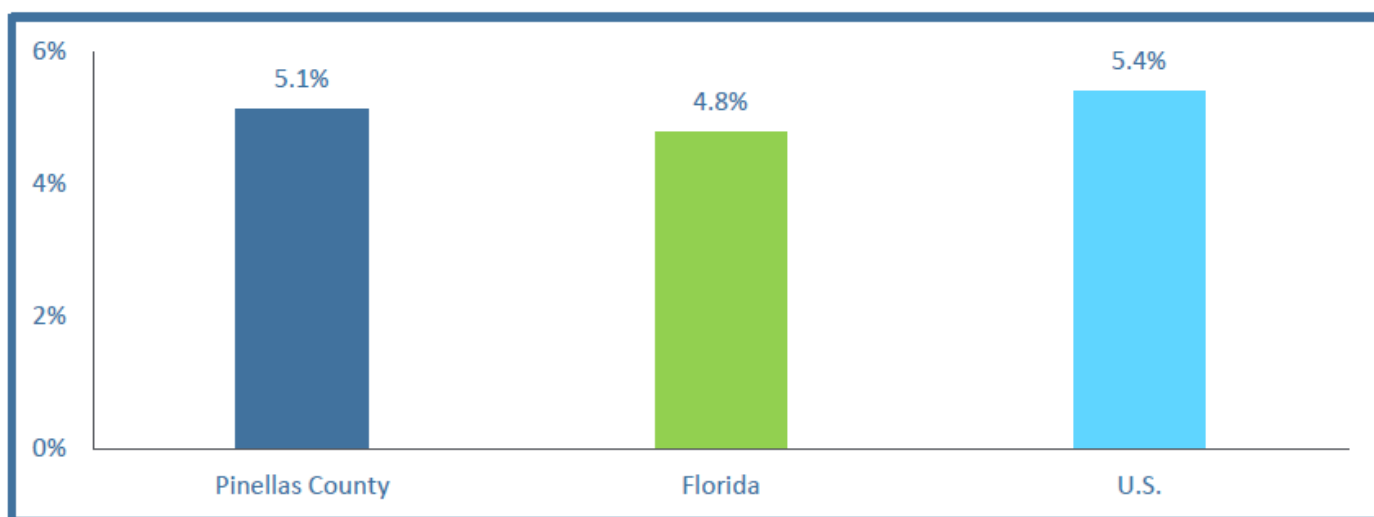
A community's employment rate is a key indicator of the local economy. An individual's type and level of employment impacts access to health care, work environment, health behaviors, and health outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, poor or unstable work and working conditions are linked to poor physical and mental health outcomes.<sup>7</sup>

Unemployment and underemployment can limit access to health insurance coverage and preventive care services. Underemployment is described as involuntary part-time employment, poverty-wage employment, and insecure employment.<sup>7</sup>

Type of employment and working conditions can also have significant impacts on health. Work-related stress, injury, and exposure to harmful chemicals are examples of ways employment can lead to poorer health.<sup>7</sup>

Figure 24 shows the population aged 16 and over who are unemployed. The unemployment rate for Pinellas County is 5.1%, which is higher than the state value of 4.8% and lower than the national value of 5.4%.

Figure 24. Population 16+ Unemployed



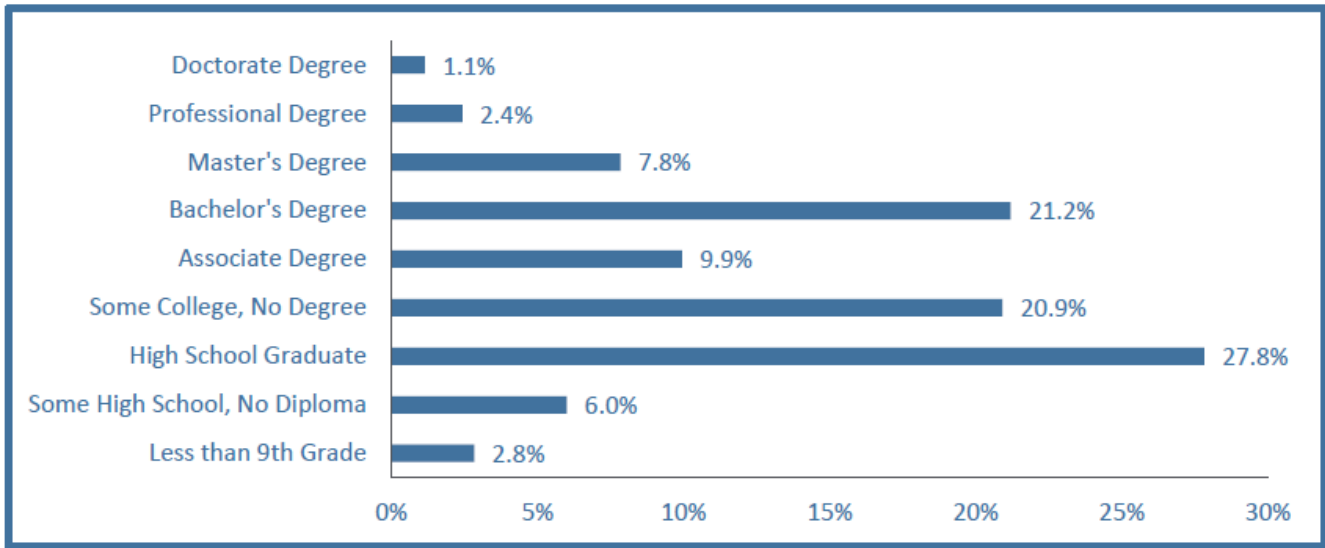
\*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

## Education

Education is an important indicator for health and wellbeing. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health. People with higher levels of education are likely to live longer, to experience better health outcomes, and practice health-promoting behaviors.<sup>8</sup>

Figure 25 shows the percentage of the population 25 years or older by educational attainment.

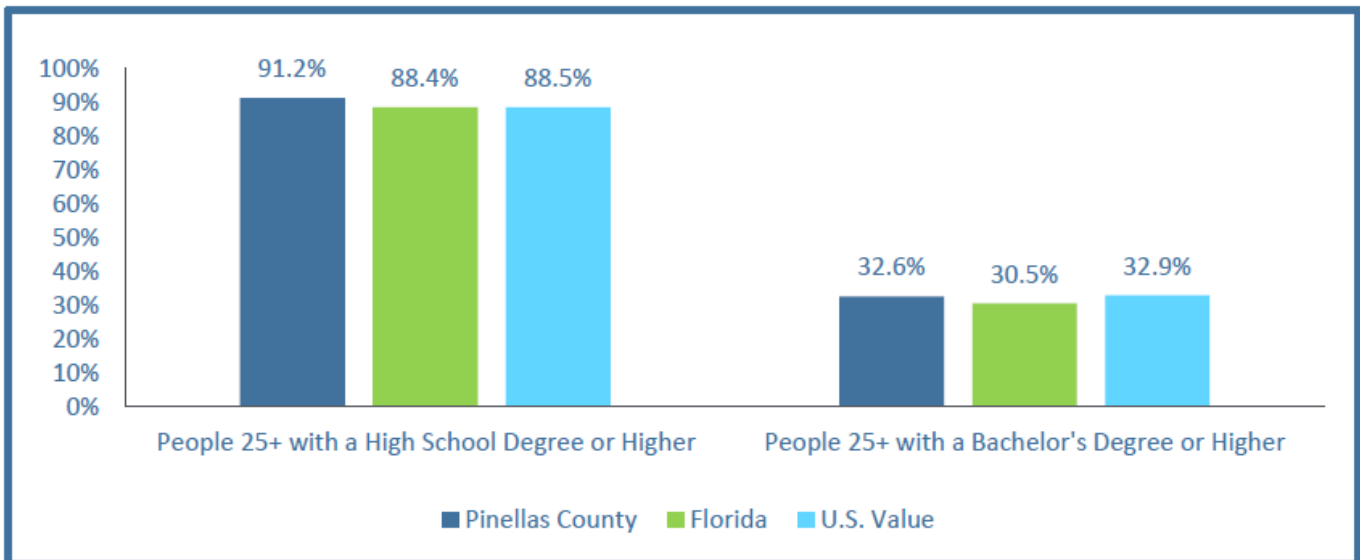
Figure 25. Population 25+ by Education Attainment, Pinellas County



\*County values- Claritas Pop-Facts® (2022 population estimates)

Another indicator related to education is on-time high school graduation. A high school diploma is a requirement for many employment opportunities and for higher education. Not graduating high school is linked to a variety of negative health impacts, including limited employment prospects, low wages, and poverty.<sup>9</sup> Figure 26 shows that Pinellas County has a higher percentage of residents with a high school degree and bachelor's degree when compared to the state.

Figure 26. Population 25+ by Education Attainment, FL and U.S. Comparisons

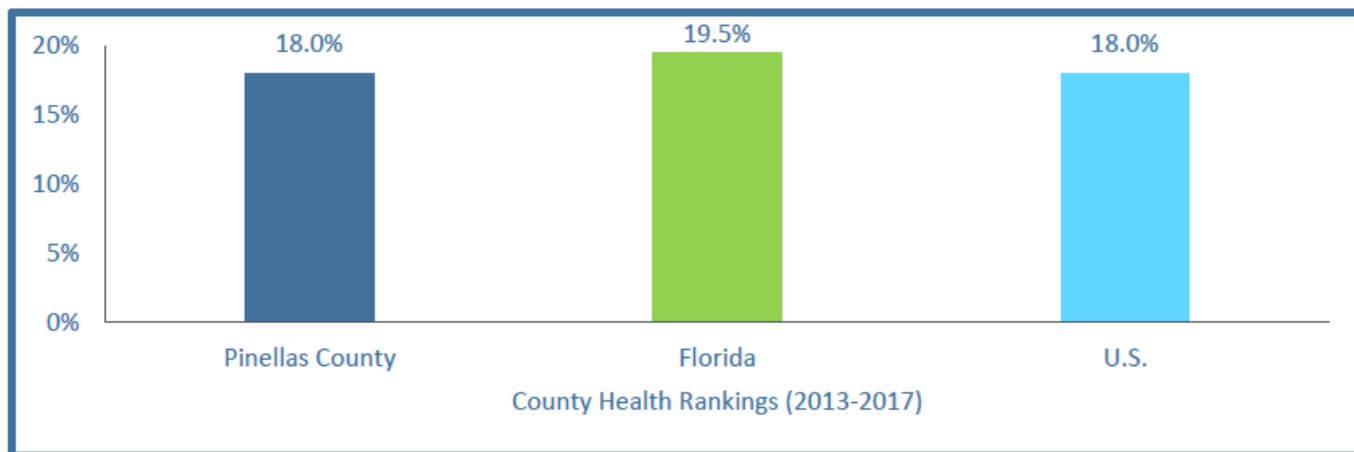


\*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

## Housing

Safe, stable, and affordable housing provides a critical foundation for health and wellbeing. Exposure to health hazards and toxins in the home can cause significant damage to an individual or family's health.<sup>10</sup> Figure 27 shows the percentage of houses with severe housing problems. This indicator measures the percentage of households with at least one of the following problems: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities. In Pinellas County, 18.0% of households were found to have at least one of those problems, which is lower than the state value (19.5%), but the same as the national value (18.0%).

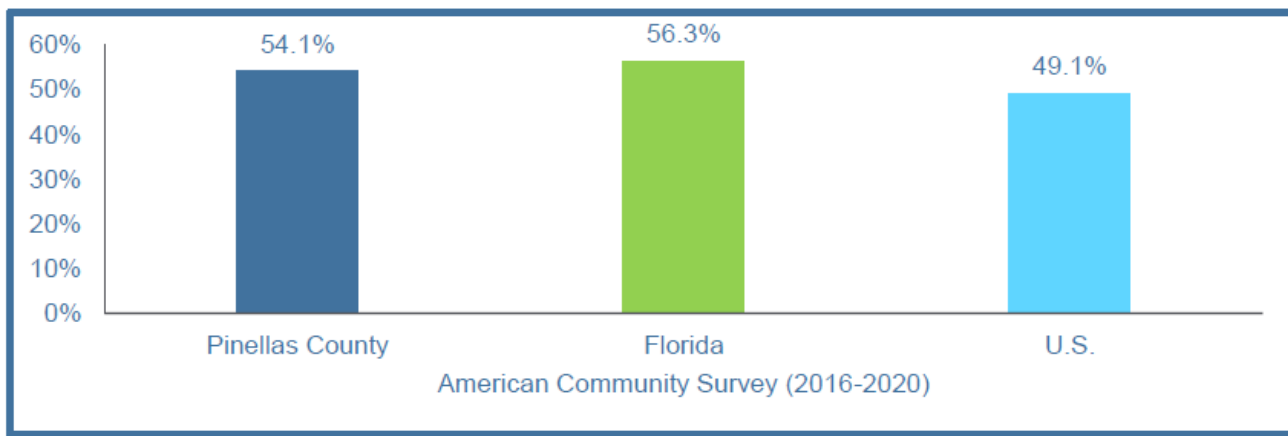
Figure 27. Severe Housing Problems: County, State, and U.S. Comparisons



\*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

When families must spend a large portion of their income on housing, they may not have enough money to pay for things like healthy foods or health care. This is linked to increased stress, mental health problems, and an increased risk of disease.<sup>11</sup> Figure 28 shows the percentage of renters who are spending 30% or more of their household income on rent. The value in Pinellas County, 54.1%, is higher than the national value (49.1%), and lower than the state value (56.3%).

Figure 28. Renters Spending 30% or More of Income on Rent: County, State, U.S. Comparisons



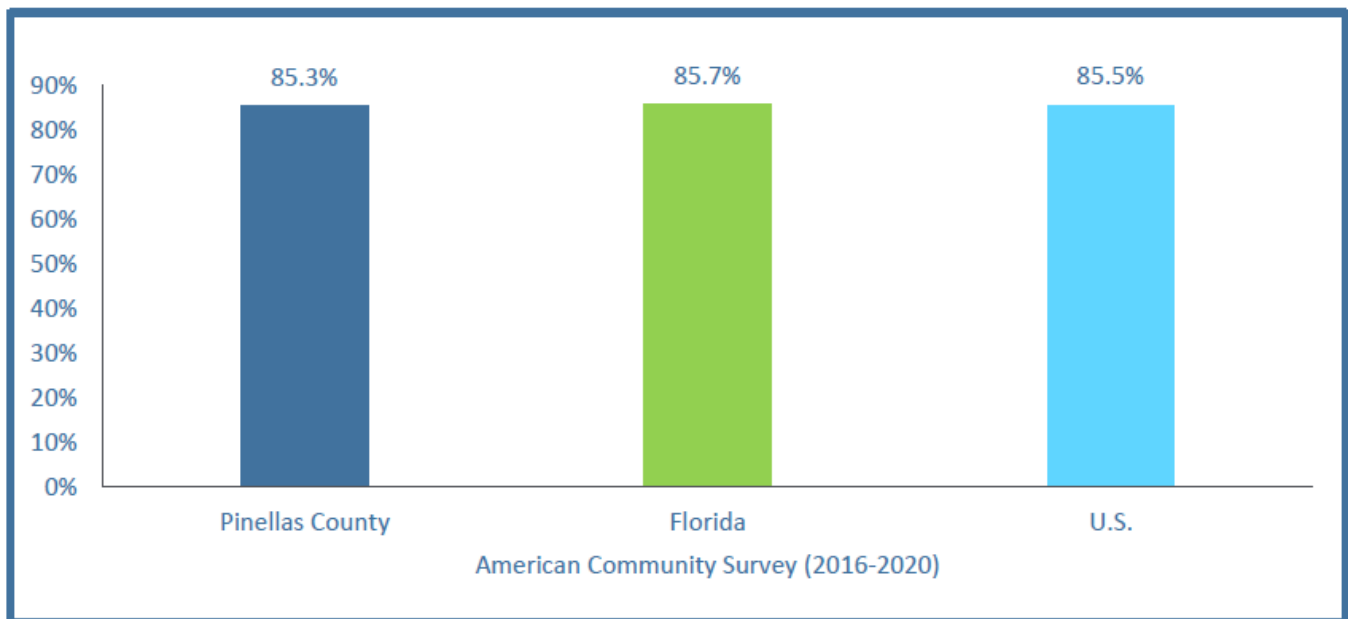
\*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

## Neighborhood and Built Environment

Internet access is essential for basic health care access, including making appointments with providers, getting test results, and accessing medical records. Access to the internet is also increasingly essential for obtaining home-based telemedicine services.<sup>12</sup> Internet access may also help individuals seek employment opportunities, conduct remote work, and participate in online educational activities.<sup>12</sup>

Figure 29 shows the percentage of households that have an internet subscription. The rate in Pinellas County, 85.3%, is lower than the state value (85.7%), and lower than the national value (85.5%).

Figure 29. Households with an Internet Subscription: County, State and U.S. Comparison



## Disparities and Health Equity

Identifying disparities by population groups and geography helps to inform and focus priorities and strategies. Understanding disparities also helps us better understand root causes that impact health in a community and inform action towards health equity.

### Health Equity

Health equity focuses on the fair distribution of health determinants, outcomes, and resources across communities.<sup>13</sup> National trends have shown that systemic racism, poverty, and gender discrimination have led to poorer health outcomes for groups such as Black/African American, Hispanic/Latino, and Indigenous communities with incomes below the federal poverty level, and LGBTQ+ communities.

### Race, Ethnicity, Age & Gender Disparities

Primary and secondary data revealed significant community health disparities by race, ethnicity, gender, and age. It is important to note that the data is presented to show differences and distinctions by population groups. For instance, Asian or Asian and Pacific Islander persons encompasses individuals from over 40 different countries with very different languages, cultures, and histories in the U.S. Information and themes captured through key informant interviews, a focus group discussion, and an online community survey have been shared to provide a more comprehensive and nuanced understanding of each community's experiences.

### Secondary Data

Community health disparities were assessed in the secondary data using the Index of Disparity<sup>14</sup> analysis, which identifies disparities based on how far each subgroup (by race, ethnicity, or gender) is from the overall county value. For more detailed methodology related to the Index of Disparity, see Appendix A.

Table 2 below identifies secondary data indicators with a statistically significant race, ethnicity, or gender disparity for Pinellas County, based on the Index of Disparity.

Table 2. Indictors with Significant Race, Ethnicity or Gender Disparities

Health Indicator	Group Negatively Impacted
Age-Adjusted Death Rate due to Motor Vehicle Collisions	Black/African American, Male
Adults Who Currently Use E-Cigarettes	Black/African American, Hispanic/Latino
Age-Adjusted Death Rate due to Diabetes	Black/African American, Hispanic/Latino, Male
Age-Adjusted Death Rate due to Kidney Disease	Black/African American, Hispanic/Latino, Male
Age-Adjusted Death Rate due to Prostate Cancer	Black/African American
Babies with Low Birth Weight	Black/African American
Children Living Below Poverty Level	Black/African American, Multiple Races, Hispanic/Latino
Families Living Below Poverty Level	Black/African American, American Indian/Alaska Native, Multiple Races, Other Race, Hispanic/Latino
HIV Incidence Rate	Black/African American, Hispanic/Latino, Male
Infant Mortality Rate	Black/African American, Hispanic/Latino
Melanoma Incidence Rate	White
People 65+ Living Below Poverty Level	Black/African American, Asian, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Multiple Races, Other Race, Hispanic/Latino
Teen Birth Rate: 15-19	Black/African American, Hispanic / Latino
Workers Commuting by Public Transportation	White, Asian

The Index of Disparity analysis for Pinellas County reveals that the Black/African American and Latino/Hispanic populations are disproportionately impacted for several chronic diseases, including Diabetes, Kidney Disease, Prostrate Cancer. Furthermore, Black/African American, and Latino/Hispanic populations are disproportionately impacted in Infant Mortality Rate and Teen Birth Rate: 15-19.

Multiple race and ethnic groups are disproportionately impacted across various measures of poverty, which is often associated with poorer health outcomes. These indicators include Families Living Below Poverty, Children Living Below Poverty Level and People 65+ Living Below Poverty Level. Finally, White, and Asian populations are disproportionately impacted across measures of public transportation (Table 2).

## Geographic Disparities

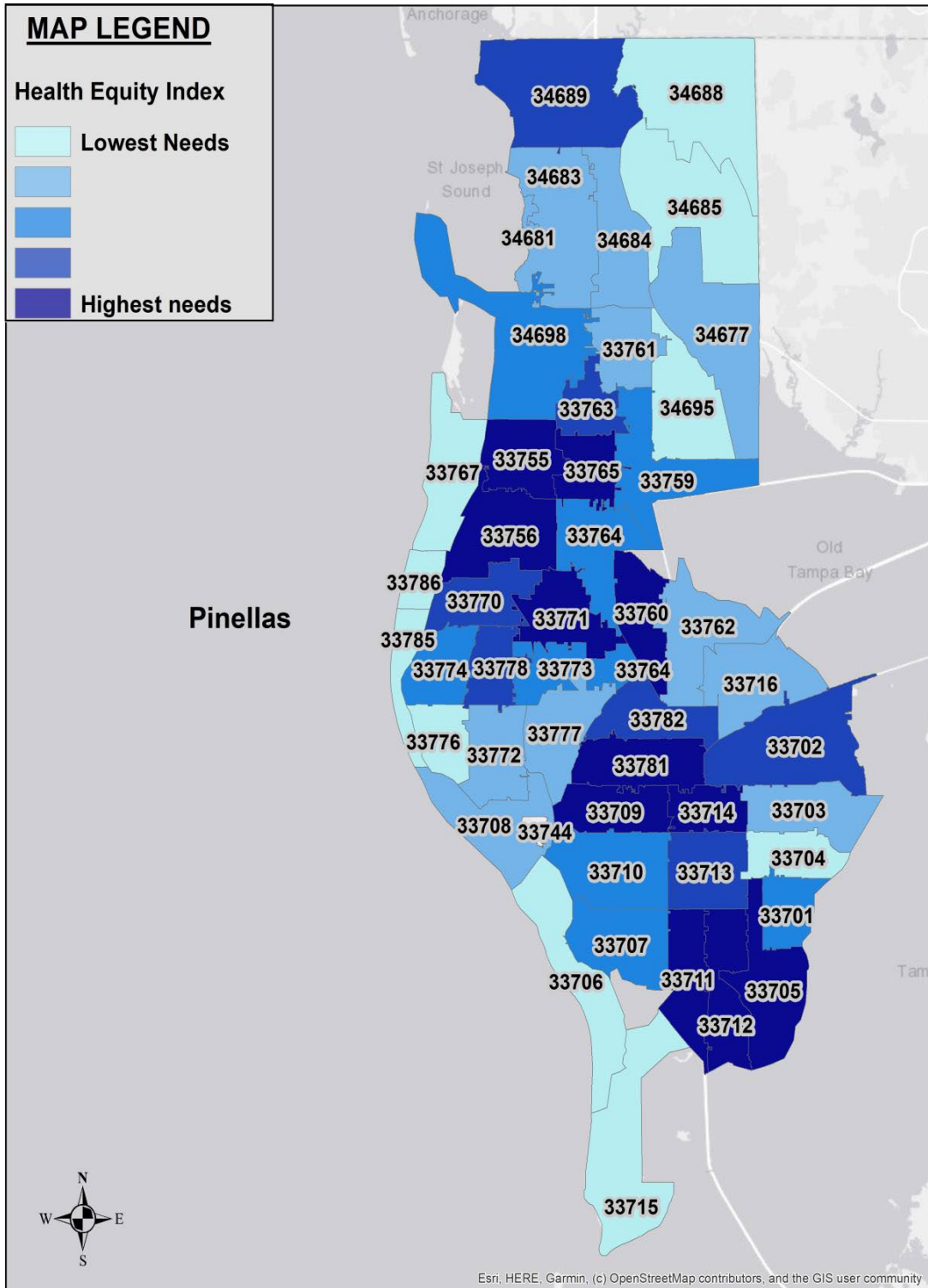
In addition to disparities by race, ethnicity, gender, and age, this assessment also identified specific Zip codes/municipalities with differences in outcomes related to health and social determinants of health. Geographic disparities were identified using the Health Equity Index, Food Insecurity Index, and Mental Health Index. These indices have been developed by Conduent Healthy Communities Institute to easily identify areas of high socioeconomic need, food insecurity and mental health. Conduent's Health Equity Index estimates areas of highest socioeconomic need correlated with poor health outcomes. Conduent's Food Insecurity Index estimates areas of low food accessibility correlated with social and economic hardship. Conduent's Mental Health Index (MHI) is a measure of socioeconomic and health factors correlated with self-reported poor mental health. For all indices, counties, Zip codes, and census tracts with a population over 300 are assigned index values ranging from 0 to 100, with higher values indicating greater need. Understanding where there are communities with higher need is critical to targeting prevention and outreach activities.

### Health Equity Index

Conduent's Health Equity Index estimates areas of high socioeconomic need, which are correlated with poor health outcomes. Zip codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 30. The following Zip codes in Pinellas County had the highest level of socioeconomic need (as indicated by the darkest shades of blue): 33714 (St. Petersburg) and 33711 (St. Petersburg) with index values of 85.4 and 74.9, respectively. Appendix A provides the index values for each Zip code.



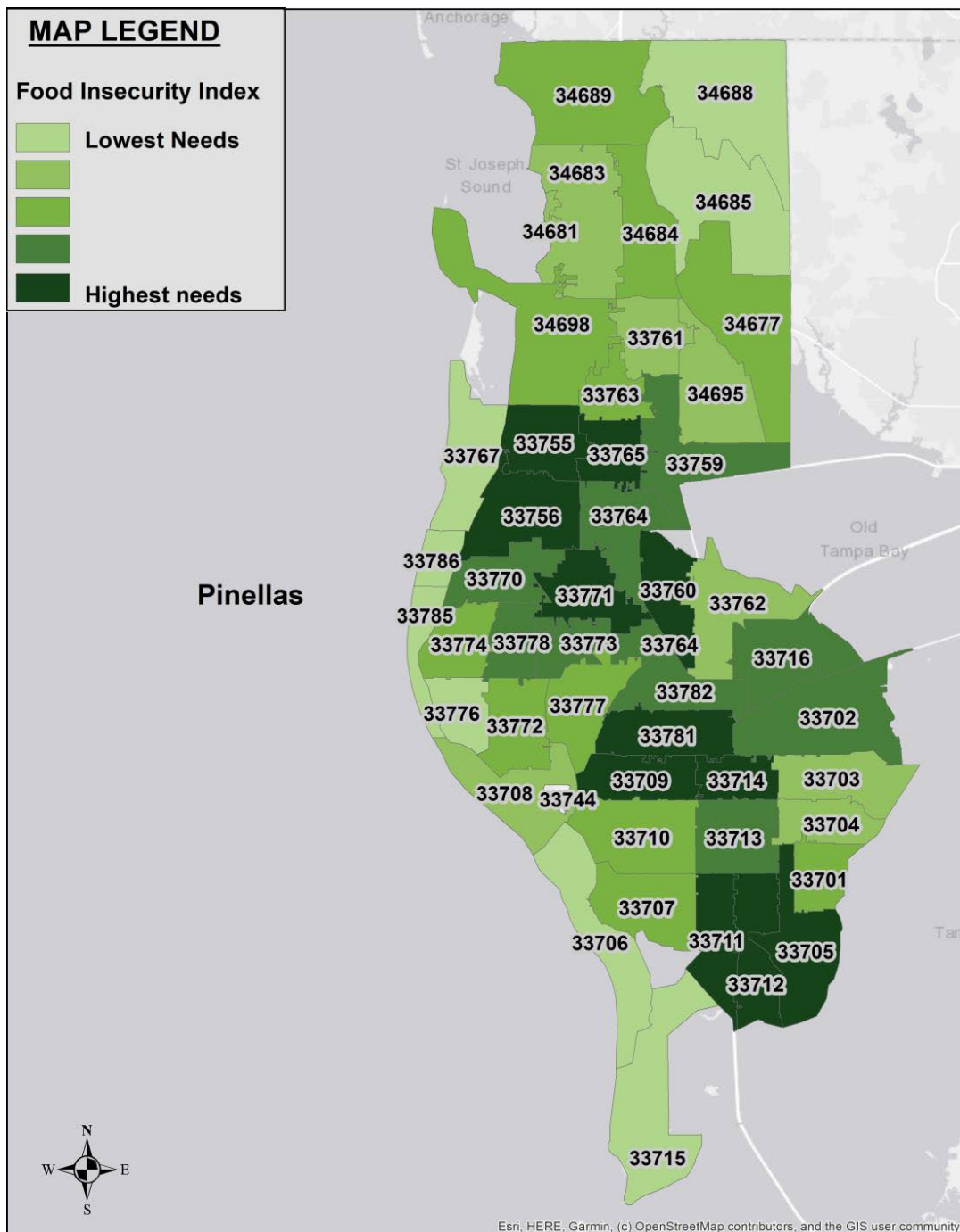
Figure 30. Health Equity Index



## Food Insecurity Index

Conduent's Food Insecurity Index estimates areas of low food accessibility correlated with social and economic hardship. Zip codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 31. The following Zip codes had the highest level of food insecurity (as indicated by the darkest shades of green): 33712 (St. Petersburg) and 33755 (Clearwater) with index values of 89.7 and 81.9, respectively. Appendix A provides the index values for each Zip code.

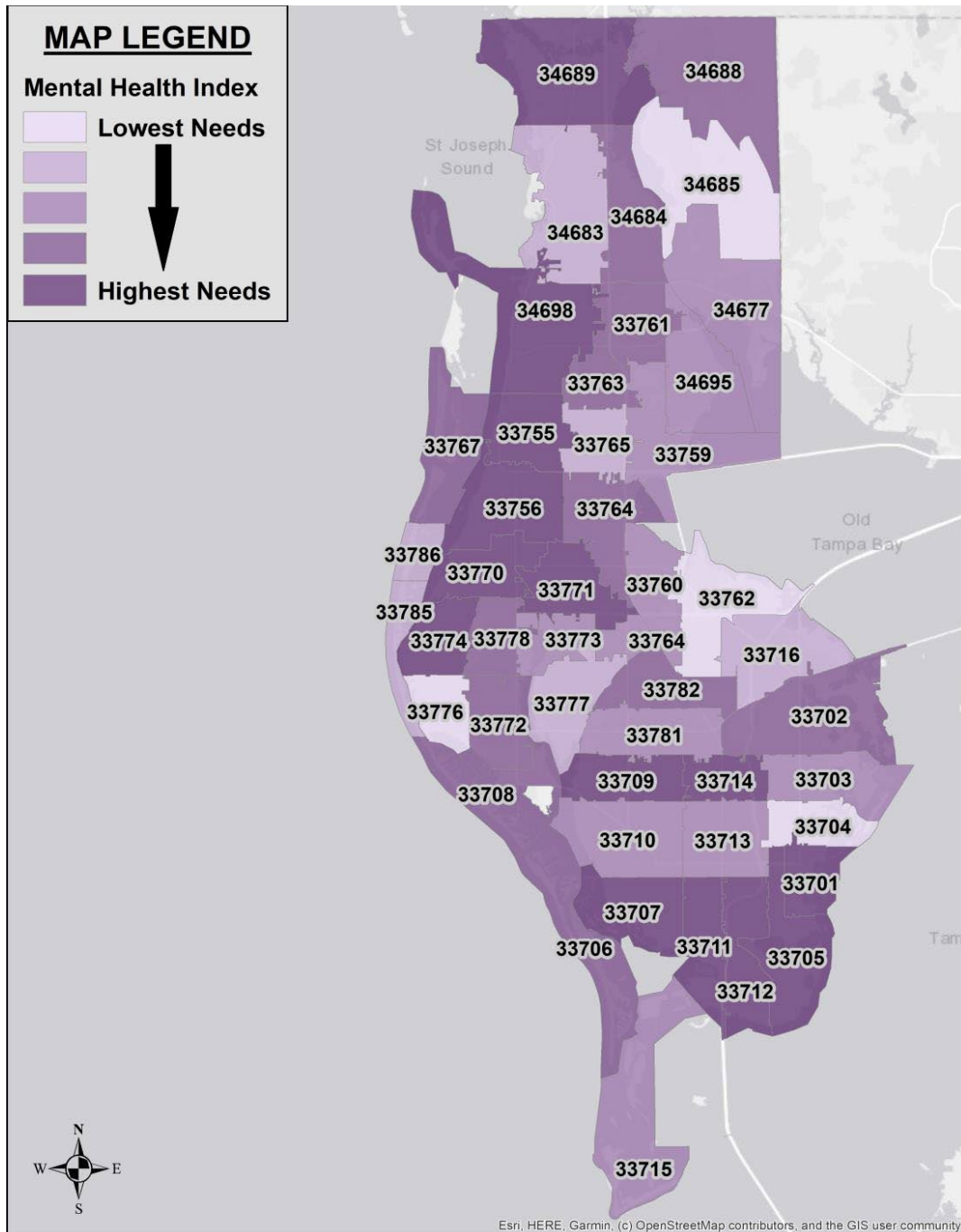
Figure 31. Food Insecurity Index



## Mental Health Index

Conduent's Mental Health Index (MHI) is a measure of socioeconomic and health factors correlated with self-reported poor mental health. Based on the MHI, in 2021, Zip codes were ranked based on their index value to identify the relative levels of need, as illustrated by the map in Figure 32. The following two Zip codes are estimated to have the highest need (as indicated by the darkest shades of purple): 33711 and 33712 (St. Petersburg). Appendix A provides the index values for high needs Zip codes.

Figure 32. Mental Health Index



# Pinellas County Health Needs

## Prioritized Health Topic: Access to Health & Social Services

### Access to Health & Social Services

#### Key Themes from Community Input



- 36% of survey respondents ranked Access to Health Care as a pressing quality of life issue
- Gentrification/Built Environment reduces accessibility to services
- Cultural competency training for physicians on treating the transgender community
- Fear & trust of government and health & social services because of trauma, discrimination, immigration status, systemic racism
- Barriers include: transportation, lack of or limited health insurance coverage (high out of pocket costs), knowledge & navigation of health system, affordable care/insurance, medication costs, long referral wait times, work/school schedules, increased risk of COVID through service industry jobs, disconnect between mental health care & health care access

#### Warning Indicators



- Adults without Health Insurance
- Median Household Gross Rent
- People 65+ Living Below Poverty



The whole medical system is problematic for all race/ethnicities. There is a lack of knowledge in cultural competency.



-Black/African American Focus Group Participant

#### Primary Data: Community Survey & Focus Groups

Access to Health Services was a top health need identified from both the community survey and the five focus group discussions. Of survey respondents, 36% ranked Access to Health Care as a pressing quality of life issue. Reasons that kept survey respondents from getting medical care they needed included inability to schedule an appointment when needed, inability to afford to pay for care, cannot take time off work, doctor's office does not have convenient hours, and others including Medicaid changes, higher than anticipated co-payments, COVID-19 restrictions, and long wait times to see a medical provider.

Focus group discussion highlighted barriers to accessing care specifically for Black/African American, LGBTQ+, Children, Older Adult, and Hispanic/Latino. These barriers included affordable medications and lack of or limited health insurance coverage, healthcare knowledge, navigation of the health system, and

experiencing a disconnection between health care and mental health care services was also mentioned throughout the focus groups. Often, participants’ work and school schedules did not align with provider office hours or there were long wait times to see a specialist. Many also indicated not having transportation to get to medical appointments. Barriers to accessing care by focus group community are seen in Table 3.

Table 3. Focus Group Overall Barriers to Accessing Care

<b>Black/African Americans</b>	<ul style="list-style-type: none"> <li>• Fear due to experienced trauma of discrimination</li> <li>• Lack of trust because of systemic racism</li> <li>• Gentrification/built environment reduces accessibility to services</li> </ul>
<b>Hispanic/Latino</b>	<ul style="list-style-type: none"> <li>• Lack of bilingual providers/staff</li> <li>• Discrimination because of their belief and opinion of prenatal care, disease prevention</li> <li>• Fear/trust of government, health, and social services because of trauma, discrimination, or immigration status</li> </ul>
<b>LGBTQ+</b>	<ul style="list-style-type: none"> <li>• Lack of trust in health system</li> <li>• Lack of support programs for treating trans community</li> </ul>
<b>Older Adults</b>	<ul style="list-style-type: none"> <li>• Affordable care for daily living caregivers</li> <li>• Fixed incomes</li> <li>• Technological barriers</li> <li>• Stereotyping</li> </ul>



We’re working with a community that is very hardworking. For them to go and see a doctor and have to lose a day of work and pay, they prefer to ignore any signal or symptom, they need options for the schedules they work.

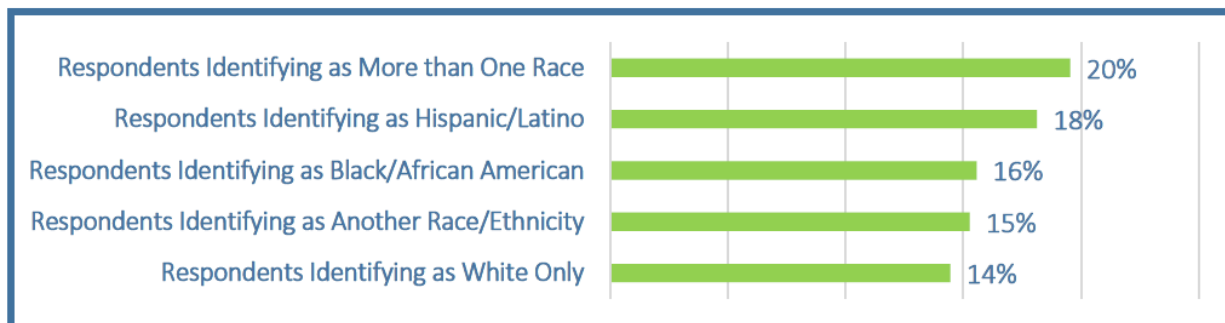


-Hispanic/LatinX Focus Group Participant

Barriers and Disparities: Access to Healthcare Services

For community survey respondents who indicated they experienced unmet health needs within the past 12 months, a percentage was calculated for each race and ethnic group to better understand the racial inequities. The percentage of respondents by racial/ethnic group with unmet health needs in the past 12 months can be seen in Figure 33.

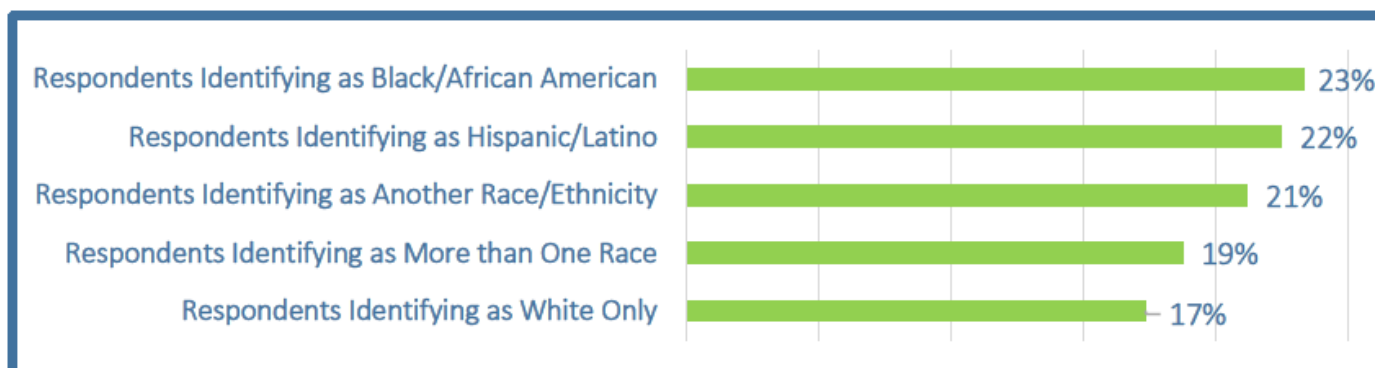
Figure 33. Percentage of respondents by race/ethnic group with unmet health needs in past 12 months



## Barriers and Disparities: Access to Dental Health Services

Access to dental health services was mentioned in the community survey as an important health issue. Twenty-two percent (22%) of survey respondents mentioned they had unmet dental needs. There were five top reasons that kept respondents from getting the dental care they needed which included inability to afford to pay for care, not having insurance to cover dental care, inability to schedule an appointment when needed, inability to take time off work, and dentist offices do not have convenient hours. The percentage of respondents by racial/ethnic group with unmet health needs in the past 12 months can be seen in Figure 34.

Figure 34. Percentage of respondents by race/ethnic group with unmet dental health needs in the past 12 months



## Barriers and Disparities: Access to Care in the Emergency Room

Barriers in access to care for non-emergency needs was captured within the community survey. Fifty-nine percent (59%) of survey respondents declared using the emergency room instead of going to a doctor's office or clinic for non-emergency needs. The main reasons the emergency room was used for non-emergent needs included after hours/weekend services, long wait for an appointment with primary physician, do not have a doctor/clinic, and do not have insurance. Additional reasons why respondents visited the emergency room for non-emergent needed included being referred by a doctor, experiencing pain, needing advice or consultation, experienced a fall, or needing diagnostic testing.

## Secondary Data

From the secondary data scoring results, Health Care Access & Quality, also known as Access to Health & Social Services, indicator of concern was Adults without Health Insurance. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 4 below. For each indicator, there is an indicator score, county value, state value, and national value (where available). Additionally, there are state and national county distributions for comparison along with indicator trend information. See Appendix A for the full list of indicators categorized within this topic.

Table 4. Data Scoring Results for Healthcare Access & Quality

SCORE	HEALTH CARE ACCESS & QUALITY	Pinellas County	HP2030	Florida	U.S.	Florida Counties	U.S. Counties	Trend
1.76	Adults without Health Insurance (2018) percent	18.7	--	--	12.2			--

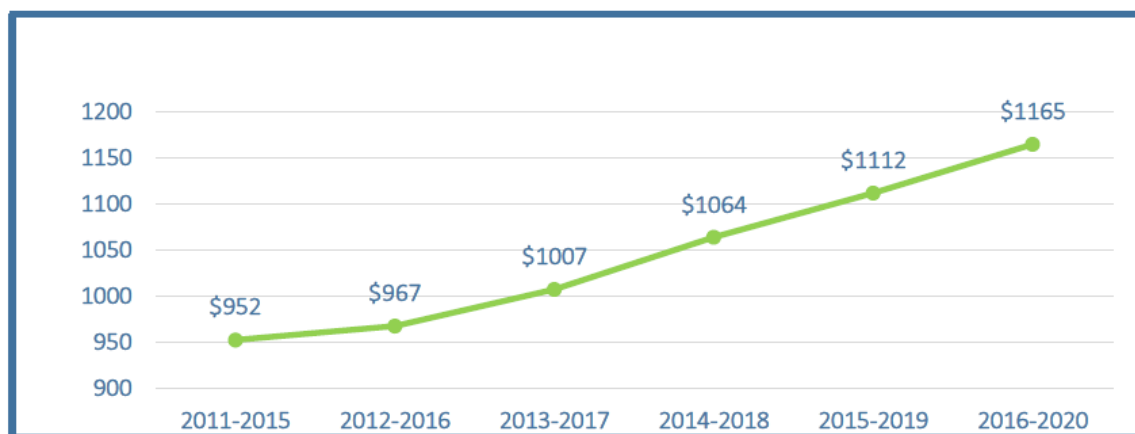
\*HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

### Barriers and Disparities: Social Determinants of Health & Quality of Life

The percentage of Adults without Health Insurance in Pinellas County is 18.7%. For this indicator, which shows the percentage of adults aged 18-64 that do not have any kind of health insurance coverage, Pinellas is in the worst 25% of all counties in the nation. Medical costs in the United States are extremely high, so people without health insurance may not be able to afford medical treatment or prescription drugs. They are also less likely to get routine checkups and screenings, so if they do become ill, they will not seek treatment until the condition is more advanced and therefore more difficult and costly to treat. Many small businesses are unable to offer health insurance to employees due to rising health insurance premiums.

Where people live is a large indicator of their health. Sixty-nine percent (69%) of community survey respondents say there are not affordable places to live in Pinellas County. Secondary data indicators confirm that rental costs are rising to national highs in the Tampa Bay region. These rising rental costs are negatively impacting communities especially those that identify as LGBTQ+ and older adults 65+. Figure 35 shows the trend for the median gross household rent in Pinellas County from 2011 through 2020. In 2016-2020 median household gross rent of Pinellas County residents was \$1,165 which is higher than U.S value of \$1,096, but it is lower than state value of \$1,218.

Figure 35. Median Household Gross Rent, Pinellas County



\*American Community Survey, 2020



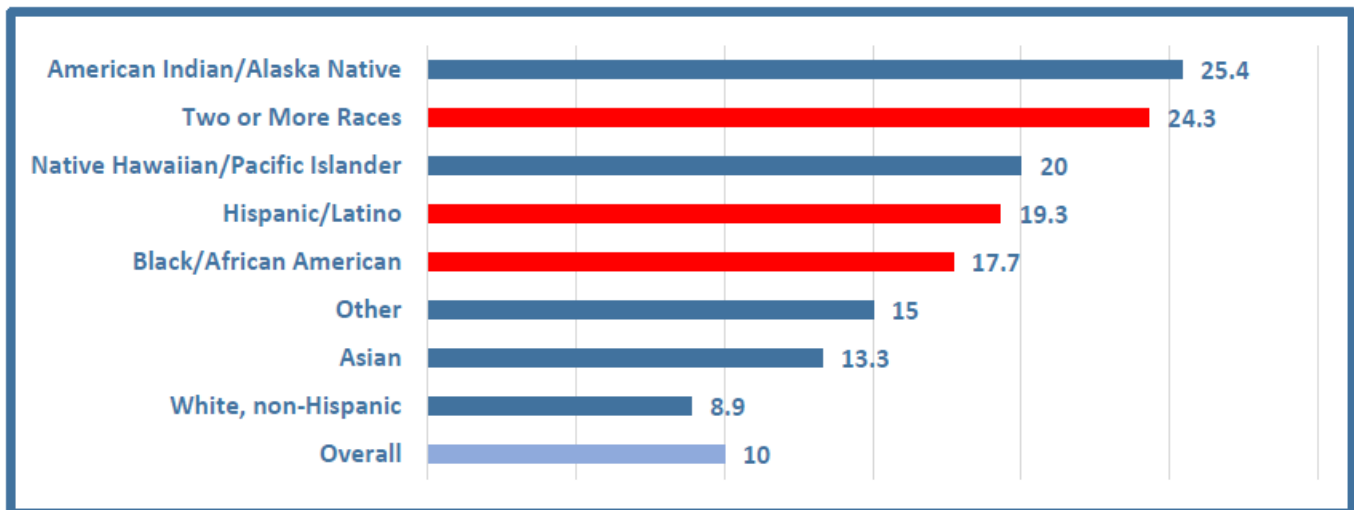
LGBTQ+ people also tend to have a harder time finding a safe place to live and affordable house, especially trans people.



- LGBTQ+ Focus Group Participant

The rising rental costs are affecting all race and ethnic groups of the older adult population 65+. See Figure 36 for the race and ethnicity disparities by percentage that are higher than the over the overall 10% Pinellas County value. People identifying as Hispanic/Latino, Black/African American, or as Two or More Races seem to be affected by poverty significantly worse than other racial and ethnic groups in Pinellas County.

Figure 36. People 65+ Living Below Poverty Level by Race/Ethnicity



\*American Community Survey, 2015-2019



## Prioritized Health Topic: **Mental Health & Substance Abuse**

### Mental Health

#### Key Themes from Community Input



- **41%** of survey respondents ranked Behavioral Health (Mental Health and Substance Misuse) as the most pressing health issue
- Top Reasons that prevented you from getting mental health care: Unable to afford to pay for care; Unable to schedule an appointment when needed; Cannot take time off work; Do not have insurance to cover mental health care; Other (including) Long wait lists, not taking new patients, out of pocket costs, COVID, trust in providers, stigma
- Lack of acknowledgement about minority stress impacting both physical and mental/emotional well-being
- External political factors, coupled with discrimination contribute to trauma experienced in LGBTQ+ community, Hispanic community, Black community

#### Warning Indicators



- Alzheimer's Disease or Dementia: Medicare Population
- Depression: Medicare Population
- Age-Adjusted Death Rate due to Suicide
- Frequent Mental Distress



Mental health should be easier to access for an affordable price. It's a problem, especially in the LGBTQ+ community. Obviously, we have higher rates of mental health suicidal thoughts.



-LGBTQ+ Focus Group Participant

#### *Primary Data: Community Survey & Focus Groups*

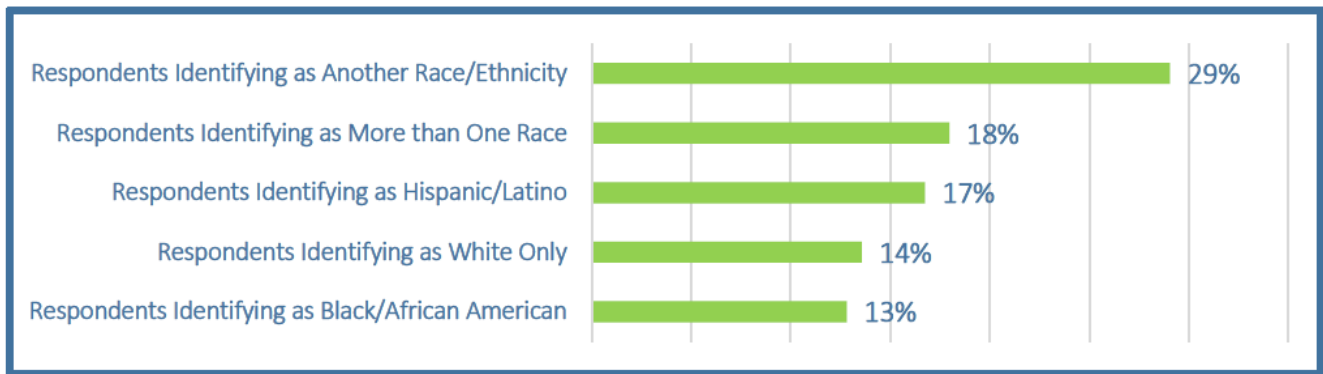
Mental Health and Substance Misuse were identified as top health needs from the secondary data, community survey, and focus groups. The two were combined into Behavioral Health for this assessment. Forty-one percent (41%) of community survey respondents ranked Mental Health as a pressing health issue. Thirty-two percent (32%) of community survey respondents indicated being diagnosed as having depression or anxiety. The top five reasons respondents cited include inability to access the mental health care they needed included inability to afford to pay for care, inability to schedule an appointment when needed, cannot take time off work, and do not have insurance to cover mental health care. Additional reasons cited by survey respondents included experiencing long wait times for scheduling an appointment, doctors' offices did not take new patients, and trust and fear of the health system due to COVID-19.

Mental Health was also a top health issue discussed during the five focus groups. Specifically, barriers to care due to fear and stigma of seeking help was brought up. Additionally, lack of affordable resources and long wait times to see a medical professional were also discussed. The LGBTQ+, Black/African American, and Hispanic/Latino communities stressed the importance of political and provider acknowledgement about minority stress, discrimination, and external factors that have contributed to experienced trauma. These populations seem to experience more difficulty accessing mental health services.

*Barriers and Disparities*

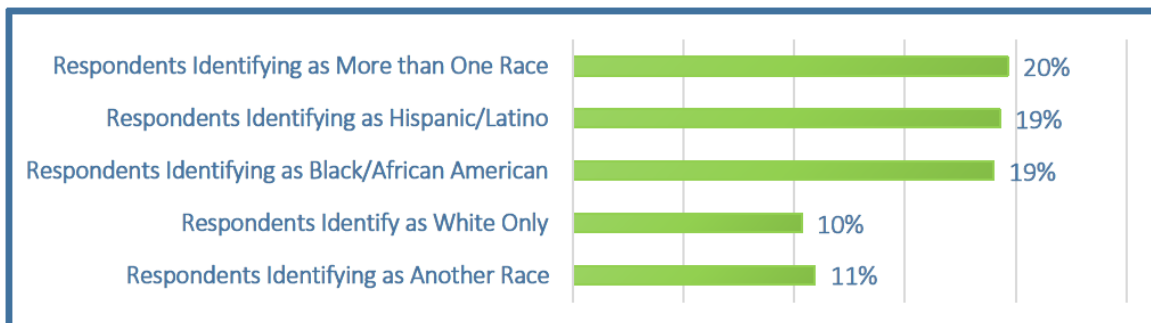
Figure 37 shows the percentage of respondents by race/ethnic group with unmet mental health needs within the past 12 months.

Figure 37. Percentage of respondents by race/ethnic group with unmet mental health needs in the past 12 months



The community survey captured a question about Adverse Childhood Experiences (ACEs). ACE scores can help health providers tell the likelihood of increased risk of psychological and medical problems. As an individual’s ACE score increases so does the risk of disease, social, and emotional problems. In Pinellas County, 19% of survey respondents reported experiencing four or more ACEs before age 18. The top five reported ACEs included parent(s) were separated or divorced, lived with anyone who was a problem drinker or alcoholic, parent(s) or adult verbally harmed them (swear, insult, or put down), lived with anyone who was depressed, mentally ill, or suicidal, and/or parent(s) or adult physically harmed you (slap, hit, kick, etc.). The percentage of respondents by race/ethnic group who reported experiencing four or more ACEs are seen in Figure 38.











Figure 38. Percentage of respondents by race/ethnic group who reported experiencing 4 or more ACEs



*Secondary Data*

From the secondary data scoring results, Mental Health & Mental Disorders had the 5th highest data score of all topic areas. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 5 below. See Appendix A for the full list of indicators categorized within this topic.

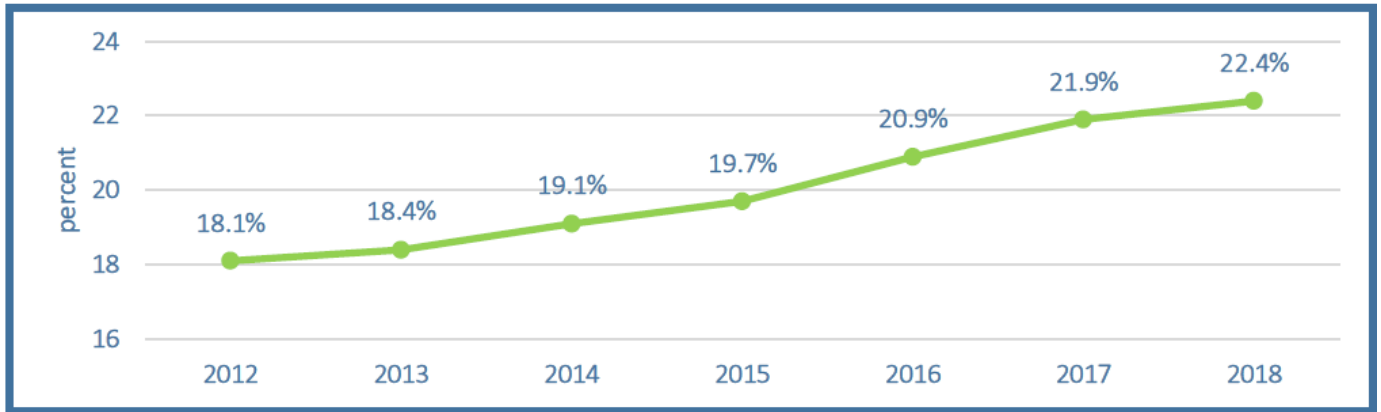
Table 5. Data Scoring Results for Behavioral Health (Mental Health)-Pinellas County

SCORE	MENTAL HEALTH & MENTAL DISORDERS	Pinellas County	HP2030	Florida	U.S.	Florida Counties	U.S. Counties	Trend
3.00	Alzheimer's Disease or Dementia: Medicare Population (2018) percent	14.2	--	12.6	10.8			
3.00	Depression: Medicare Population (2018) percent	22.4	--	19.5	18.4			
1.79	Age-Adjusted Death Rate due to Suicide (2019) deaths/100,000 population	16.6	12.8	14.5	13.9		--	
1.50	Frequent Mental Distress (2018) percent	14.7	--	13.4	13			--

\*HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Depression and Alzheimer’s Disease in Medicare population are top areas of concern related to Mental Health & Mental Disorders in Pinellas County. The percentage of Medicare beneficiaries treated for Alzheimer’s disease or dementia is 14.2% in Pinellas County, which is in the worst 25% of counties in both the state and nation. The indicator Depression: Medicare Population shows the percentage of Medicare beneficiaries who were treated for depression. Figure 39 shows the increasing percentage of depression among the Medicare population. The value for Pinellas County, 22.4%, is in the worst 25% of counties in the state and nation. Furthermore, Age-Adjusted Death Rate due to Suicide in Pinellas County are 16.6 deaths/100,000 population. The other indicator of concern is Frequent Mental Distress that shows the percentage of adults who stated that their mental health, which includes stress, depression, and problems with emotions, was poor for 14 or more of the past 30 days. The value for Pinellas County, 14.7%, is higher than the national value of 13%.

Figure 39. Depression percentage in Medicare population from 2012-2018



\*Centers for Medicare & Medicaid Services, 2018

## Alcohol and Substance Abuse

### Key Themes from Community Input



- **30%** of survey respondents ranked Illegal Drug Use/Abuse of prescription medications and Alcohol Abuse/Drinking too much as an important health issue to address
- Deaths due to drug poisoning and opioid overdose is an increasing concern
- COVID-19 has helped remove stigma attached to seeking help

### Warning Indicators



- Death Rate due to Drug Poisoning
- Age-Adjusted Drug and Opioid-Involved Overdose Death Rate
- Adults who Drink Excessively
- Adults who Binge Drink
- Driving Under the Influence Arrest Rate
- Adults Who Currently Use E-Cigarettes
- Adolescents who Use Electronic Vaping: Lifetime
- Adolescents who Use Electronic Vaping: Past 30 Days
- Adults who Smoke

### Secondary Data:

Substance Misuse is a health topic that is analyzed from two secondary data health topics, i.e., Alcohol and Drug Use and Tobacco Use. From the secondary data scoring results, Alcohol & Drug Use had the 9<sup>th</sup> and Tobacco Use had the 11<sup>th</sup> highest data score of all topic areas. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 6 below. See Appendix A for the full list of indicators categorized within this topic.

Table 6. Data Scoring Results for Alcohol and Substance Misuse



SCORE	ALCOHOL & DRUG USE	Pinellas County	HP2030	Florida	U.S.	Florida Counties	U.S. Counties	Trend
3.00	Death Rate due to Drug Poisoning (2017-2019) deaths/100,000 population	32.5	--	23.6	21			
2.29	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate (2018-2020) Deaths per 100,000 population	43.2	--	27.8	23.5			--
2.03	Adults who Drink Excessively (2017-2019) percent	24.2	--	18	--		--	--
1.94	Adults who Binge Drink (2018) percent	17.1	--	--	16.4			--
1.88	Driving Under the Influence Arrest Rate (2019) arrests/100,000 population	235.2	--	159.7	--		--	--

\*HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

In the community survey 30% of respondents ranked illegal drug use/abuse of prescription medications and alcohol abuse/drinking too much as important health issues to address. From the secondary data results, there are several indicators within Alcohol and Drug Use health topic that raise concerns for Pinellas County. The worst performing indicator under this health topic is the Death Rate due to Drug Poisoning. In Pinellas County, there were 32.5 deaths due to drug poisoning per 100,000 people in 2017-2019, which is higher than both the state and national values, and in the worst 25% of counties in the

U.S. White males in the county are twice as likely to experience opioid involved deaths than females. Additionally, Age-Adjusted Drug and Opioid-Involved Overdose Death Rate in Pinellas County is 35.7 deaths per 100,000 population. Other indicators of concern are related to alcohol use and include both behavioral and outcome measures. The percentage of adults in the county who drink excessively (24.2%), and binge drink (17.1%) is higher than the Florida state and are among the worst 25% of counties in the state. Finally, the percentage of arrests that involve driving under the influence is higher in Pinellas County (235.2 arrests per 100,000 population) than in Florida (159.7 arrests per 100,000 population).

Table 7. Data Scoring Results for Tobacco Use

SCORE	TOBACCO USE	Pinellas County	HP2030	Florida	U.S.	Florida Counties	U.S. Counties	Trend
2.03	Adults Who Currently Use E-Cigarettes (2017-2019) percent	8.9	--	7.5	--		--	--
1.91	Adolescents who Use Electronic Vaping: Lifetime (2020) percent	29.7	--	26.4	--	--	--	--
1.91	Adolescents who Use Electronic Vaping: Past 30 Days (2020) percent	18.9	--	14.5	--	--	--	--
1.85	Adults who Smoke (2017-2019) percent	19.7	5	14.8	--		--	--

\*HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

From the secondary data results, there are several indicators in Tobacco Use topic areas that raise concern. Pinellas County has the highest rates of adults and adolescents who vape and use e-cigarettes compared to other counties in Florida.

## Prioritized Health Topic: Health Promotion & Behavior

### Exercise, Nutrition & Weight

#### Key Themes from Community Input



- Built Environment: Inequitable access to affordable healthy food
- Nutritional awareness
- Economy (cost of living): healthy food not a priority

#### Warning Indicators



- Adults Who Are Obese
- Fast Food Restaurant Density
- SNAP Certified Stores
- Teens without Sufficient Physical Activity



For South St. Pete, not every parent wants to stand to get access to free food. What they want is access to the same quality of food that everyone else in other areas have access to.



-Black/African American Focus Group Participant

#### *Primary Data: Focus Group*

Focus group discussions identified built environment as a topic of concern. Specifically, inequitable access to affordable healthy foods was cited. Participants also mentioned the need for nutritional awareness and cultural competency due to some racial/ethnic groups not prioritizing healthy eating.

#### *Secondary Data*

Secondary data for Exercise, Nutrition & Weight included Physical Activity data scoring. Physical Activity had the 14th highest data score of all topic areas indicating a definite need in Pinellas County. Further analysis was done to identify specific indicators of concern which include indicators with high data scores (scoring at or above the threshold of 1.50) and seen in Table 8. See Appendix A for the full list of indicators categorized within this topic.

Table 8. Data Scoring Results for Physical Activity

SCORE	PHYSICAL ACTIVITY	Pinellas County	HP2030	Florida	U.S.	Florida Counties	U.S. Counties	Trend
2.00	Fast Food Restaurant Density (2016) restaurants/ 1,000 population	0.7	--	--	--			
1.82	SNAP Certified Stores (2017) stores/ 1,000 population	0.8	--	--	--			--
1.65	Teens without Sufficient Physical Activity (2020) percent	81.2	--	82.3	--		--	
1.50	Adults Who Are Obese (2017-2019) percent	28.4	--	27	--		--	--
1.50	Farmers Market Density (2018) markets/ 1,000 population	0	--	--	--	--	--	--
1.50	People 65+ with Low Access to a Grocery Store (2015) percent	2.8	--	--	--			--

\*HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Some of the worst performing indicators within this topic are related to the built environment and food access. The number of fast-food restaurants per 1,000 people in Pinellas County is in the worst 25% of counties in Florida, and trending in a negative direction. The indicator SNAP Certified Stores shows the number of stores per 1,000 population certified to accept Supplemental Nutrition Assistance Program benefits, including supermarkets, convenience stores, warehouse club stores, and specialized food stores. While the value for Pinellas County is increasing in a desirable direction, the county still performs in the worst 50% of counties in the state. Other poorly performing indicators that are measures of food access include Farmers Market Density and People 65+ with Low Access to Grocery Store. HCI’s Food Insecurity Index®, discussed earlier in this report, can be used to help identify geographic areas of low food accessibility within Pinellas County community.

Other poorly performing indicators under Physical Activity health topics are percentage of Teens without Sufficient Physician Activity (81.2%) and Adults who are Obese (28.4%) in Pinellas County. Studies have shown that sedentary lifestyles and a lack of fruits and vegetables can increase the risk of many chronic diseases including obesity, heart disease and type 2 diabetes.<sup>15</sup>



## Cancer

Seventeen percent (17%) of survey respondents ranked cancer as a pressing health issue and 11% reported being told by a medical provider that they have been diagnosed with cancer. Secondary data warning indicators of concern included Melanoma Incidence Rate which was 32.7 cases per 100,000 population for 2016-2018 which is higher than the Florida state value of 25.2 cases per 100,000 population.

## Warning Indicators



- Melanoma Incidence Rate
- Adults with Cancer
- Cancer: Medicare Population
- Cervical Cancer Incidence Rate
- Oral Cavity and Pharynx Cancer Incidence Rate
- Pap Test in Past Year
- Mammogram in Past Year: 40+
- Prostate Cancer Incidence Rate
- Breast Cancer Incidence Rate
- Mammogram in Past 2 Years: 50-74
- Age-Adjusted Death Rate due to Breast Cancer

## Warning Indicators



- Ischemic Heart Disease: Medicare Population
- Atrial Fibrillation: Medicare Population
- Stroke: Medicare Population
- Hyperlipidemia: Medicare Population
- Hypertension: Medicare Population
- Age-Adjusted Death Rate due to Coronary Heart Disease
- High Blood Pressure Prevalence
- Adults who Experienced a Stroke
- Adults who Experienced Coronary Heart Disease
- Heart Failure: Medicare Population

## Heart Disease and Stroke

Heart Disease and Stroke as a topic on its own did not come through as a top community health issue within the community survey or focus groups. Although 41% of survey respondents reported being told by a medical provider that they have hypertension and/or heart disease, the raised concern was related to nutrition and obesity and could best be addressed within the Exercise, Nutrition, and Weight health topic.

## Immunizations & Infectious Diseases

A secondary data warning indicator of concern includes Syphilis Incidence Rate in Pinellas County (21.9 cases per 100,000 population) in 2020 which is over the U.S value (11.9 cases per 100,000 population) and the Florida value of (16.2 cases per 100,000 population). There are opportunities to improve education on prevention of syphilis incidence rates as cases in Pinellas County have increased gradually since 2017.

## Warning Indicators

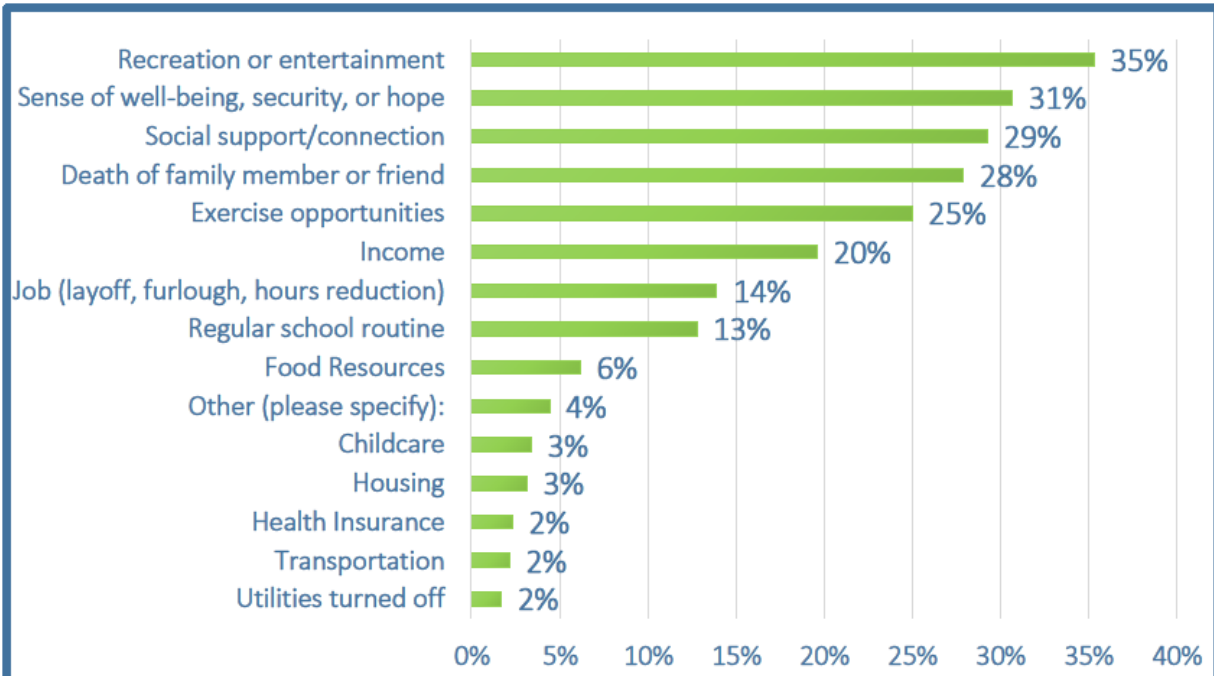


- Syphilis Incidence Rate
- Kindergartners with Required Immunizations
- Tuberculosis Incidence Rate
- HIV Incidence Rate
- Overcrowded Households
- Chlamydia Incidence Rate

## COVID-19 Pandemic

The community survey served to assess the impact of COVID-19 pandemic by asking respondents to report the losses they have experienced since the start of the pandemic. Recreation or entertainment was the top loss reported, followed by sense of well-being, security, or hope, and social support/connection. There were many that also reported death of a family member or friend. See Figure 40 for the complete list of reported losses related to COVID-19. These types of experienced losses can help to pinpoint where the community is going to need special attention and assistance to recover.

Figure 40. Percentage of respondents who reported experienced losses related to COVID-19



## Community Lived Experiences Around Diversity, Equity & Inclusion

For the 2022 CHA process, the All4HealthFL Collaborative included a survey question to specifically assess experiences of discrimination by community respondents. In addition to understanding the overall experiences of discrimination, the Collaborative wanted to understand different groups' unique experiences and their perception of why they felt they were discriminated against. Figure 41 shows the percentage of survey respondents who reported experiencing discrimination by discrimination type.

Figure 41: Percentage of respondents who reported experiencing discrimination by discrimination type

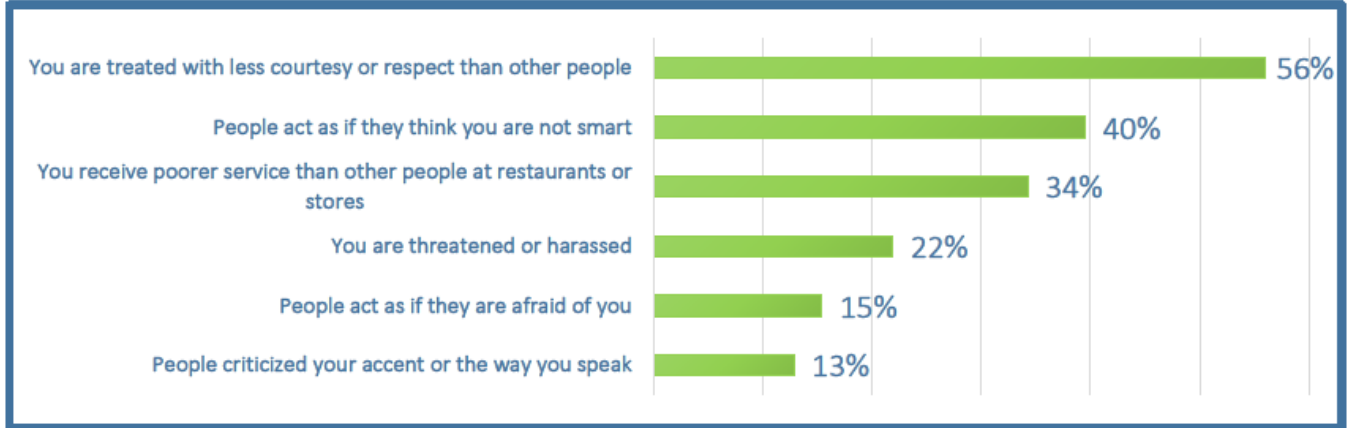
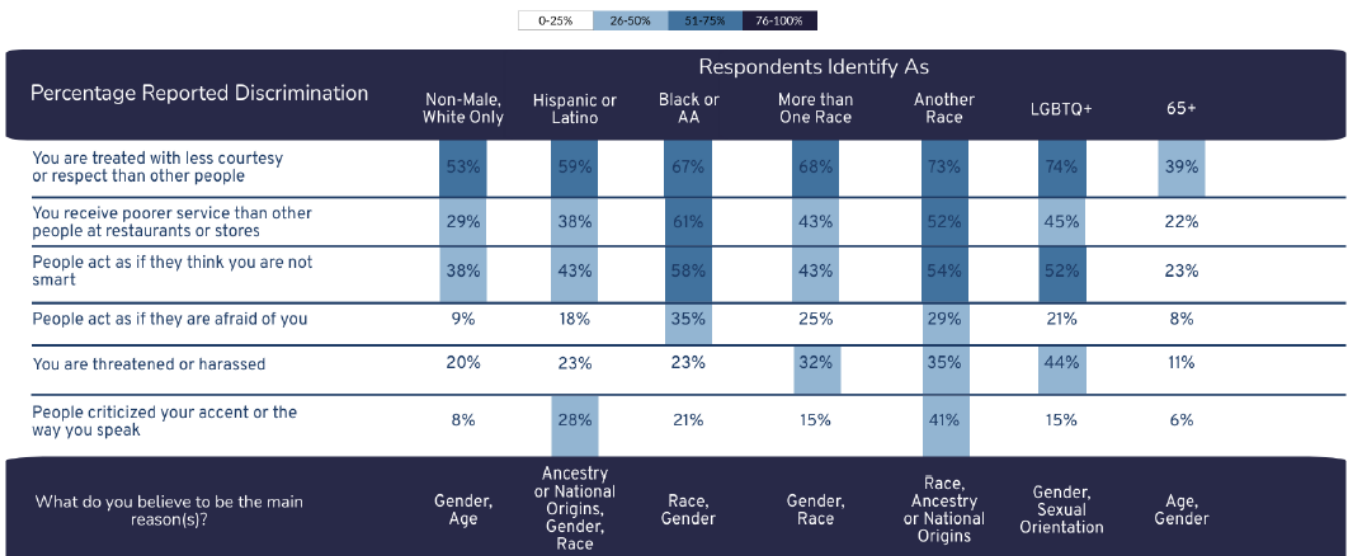


Figure 38 breaks down the percentages of reported discrimination by respondents' identity of themselves, as well as why they believe they experienced this discrimination. For example, in what ways did Hispanic/Latino community members report experiencing discrimination and what did they believe was the main reason they were discriminated against? The highest level of discrimination they reported having experienced was being treated with less courtesy or respect than others. They felt they had experienced this type of discrimination because of their ancestry or national origin, their gender, and/or their race. These two charts were provided to participants at the prioritization session to inform and deepen conversations and to garner additional feedback around addressing health inequities in Pinellas County.

Figure 38: Percentage of respondents who reported experiencing discrimination by discrimination type



## Additional Opportunities for Impact

When possible, data from the community survey was analyzed by demographic factors to help identify vulnerable groups that may be at higher health risks in Pinellas County. This data was used to support the prioritization process and provides additional community context to consider alongside the secondary data. It is important to note that not all differences have been included in this report, as the report focuses primarily on the prioritized health topics.

## Conclusion and Next Steps

The preceding Community Health Assessment (CHA) describes barriers to health faced by the community, putting its priority health areas into focus and providing information necessary to all levels of stakeholders to build upon each other's work. The All4HealthFL Collaborative has established clear priorities based on the results of this community health assessment to improve health outcomes for residents in Pinellas County. Over the next several years, DOH-Pinellas will lead the efforts in the development of strategies to address the priorities outlined in the report, which will inform the Community Health Improvement Plan for Pinellas County.



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## Appendices

## Appendix A. Secondary Data Methodology and Data Scoring Tables

SCORE	ADOLESCENT HEALTH	UNITS	PINELLAS COUNTY	HP2030	Florida	U.S.	MEASUREMENT PERIOD	RACE DISPARITY	Source
1.91	Adolescents who Use Electronic Vaping: Lifetime	<i>percent</i>	29.7		26.4		2020		23
1.91	Adolescents who Use Electronic Vaping: Past 30 Days	<i>percent</i>	18.9		14.5		2020		23
1.65	Teens without Sufficient Physical Activity	<i>percent</i>	81.2		82.3		2020		13
1.41	Teens who Use Marijuana: High School Students	<i>percent</i>	17.7		15.9		2020		22
1.18	Teens who Use Alcohol	<i>percent</i>	19.6		19.9		2020		22
1.09	Adolescents who Use Smokeless Tobacco: Lifetime	<i>percent</i>	3.1		3.7		2020		23
1.09	Teen Birth Rate: 15-19	<i>live births/ 1,000 females aged 15-19</i>	16.2		16.2	16.7	2019	Black (31.7) White (9) Hispanic/Latino (17.7)	18
1.09	Teens who have Used Methamphetamines	<i>percent</i>	0.2		0.8		2020		22
0.97	Teens who are Obese: High School Students	<i>percent</i>	11.5		15.4		2020		13
0.97	Teens who Smoke Cigarettes: High School Students	<i>percent</i>	1.4		1.5		2020		23

## Appendix A. Secondary Data Methodology and Data Scoring Tables

0.79	Adolescents who Use Smokeless Tobacco: Past 30 Days	<i>percent</i>	0.8		1.3		2020		23
0.53	Teens who Binge Drink: High School Students	<i>percent</i>	7.2		9.2		2020		22
0.53	Teens with Asthma	<i>percent</i>	17		21.3		2020		23
<b>SCORE</b>	<b>ALCOHOL &amp; DRUG USE</b>	<b>UNITS</b>	<b>PINELLAS COUNTY</b>	<b>HP2030</b>	<b>Florida</b>	<b>U.S.</b>	<b>MEASUREMENT PERIOD</b>	<b>RACE DISPARITY</b>	<b>Source</b>
3.00	Death Rate due to Drug Poisoning	<i>deaths/ 100,000 population</i>	32.5		23.6	21	2017-2019		7
2.29	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	<i>Deaths per 100,000 population</i>	43.2		27.8	23.5	2018-2020	Black (21.3) White (40.3) Hispanic/Latino (19.8)	4
2.03	Adults who Drink Excessively	<i>percent</i>	24.2		18		2017-2019		10
1.94	Adults who Binge Drink	<i>percent</i>	17.1			16.4	2018		3
1.88	Driving Under the Influence Arrest Rate	<i>arrests/ 100,000 population</i>	235.2		159.7		2019		20
1.41	Health Behaviors Ranking	<i>ranking</i>	19				2021		7
1.41	Teens who Use Marijuana: High School Students	<i>percent</i>	17.7		15.9		2020		22
1.18	Teens who Use Alcohol	<i>percent</i>	19.6		19.9		2020		22



## Appendix A. Secondary Data Methodology and Data Scoring Tables

1.09	Teens who have Used Methamphetamines	<i>percent</i>	0.2		0.8		2020		22
0.53	Alcohol-Impaired Driving Deaths	<i>percent of driving deaths with alcohol involvement</i>	21.4	28.3	22.3	27	2015-2019		7
0.53	Teens who Binge Drink: High School Students	<i>percent</i>	7.2		9.2		2020		22
<b>SCORE</b>	<b>CANCER</b>	<b>UNITS</b>	<b>PINELLAS COUNTY</b>	<b>HP2030</b>	<b>Florida</b>	<b>U.S.</b>	<b>MEASUREMENT PERIOD</b>	<b>RACE DISPARITY</b>	<b>Source</b>
2.47	Melanoma Incidence Rate	<i>cases/ 100,000 population</i>	32.7		25.2		2016-2018	Black (2.1) White (35.7)	32
2.29	Adults with Cancer	<i>percent</i>	9			6.9	2018		3
2.18	Cancer: Medicare Population	<i>percent</i>	10.1		10.1	8.4	2018		5
2.12	Cervical Cancer Incidence Rate	<i>cases/ 100,000 females</i>	9.5		9		2016-2018		32
2.00	Oral Cavity and Pharynx Cancer Incidence Rate	<i>cases/ 100,000 population</i>	16.3		13.5		2016-2018		32
2.00	Pap Test in Past Year	<i>percent</i>	40.8		48.4		2016		10
1.94	Mammogram in Past Year: 40+	<i>percent</i>	60		60.8		2016		10
1.94	Prostate Cancer Incidence Rate	<i>cases/ 100,000 males</i>	89		89.6		2016-2018		32
1.82	Breast Cancer Incidence Rate	<i>cases/ 100,000 females</i>	130.2		121.2		2016-2018		32

## Appendix A. Secondary Data Methodology and Data Scoring Tables

1.59	Mammogram in Past 2 Years: 50-74	<i>percent</i>	71.3	77.1		74.8	2018		3
1.53	Age-Adjusted Death Rate due to Breast Cancer	<i>deaths/ 100,000 females</i>	10.9	15.3	10.4		2017-2019		18
1.41	Colon Cancer Screening	<i>percent</i>	65.9	74.4		66.4	2018		3
1.24	Age-Adjusted Death Rate due to Lung Cancer	<i>deaths/ 100,000 population</i>	39.5	25.1	35.3		2017-2019		18
1.24	Cervical Cancer Screening: 21-65	<i>Percent</i>	84.1	84.3		84.7	2018		3
1.18	Colorectal Cancer Incidence Rate	<i>cases/ 100,000 population</i>	34.3		35.6		2016-2018		32
1.12	Age-Adjusted Death Rate due to Prostate Cancer	<i>deaths/ 100,000 males</i>	6.5	16.9	7.4		2017-2019	Black (16) White (6.2) Hispanic/Latino (6.5)	18
1.06	Age-Adjusted Death Rate due to Cancer	<i>deaths/ 100,000 population</i>	148.8	122.7	146.1		2017-2019		18
1.06	Lung and Bronchus Cancer Incidence Rate	<i>cases/ 100,000 population</i>	61.4		56.6		2016-2018		32
0.71	Age-Adjusted Death Rate due to Colorectal Cancer	<i>deaths/ 100,000 population</i>	12.1	8.9	13.1		2017-2019		18
<b>SCORE</b>	<b>CHILDREN'S HEALTH</b>	<b>UNITS</b>	<b>PINELLAS COUNTY</b>	<b>HP2030</b>	<b>Florida</b>	<b>U.S.</b>	<b>MEASUREMENT PERIOD</b>	<b>RACE DISPARITY</b>	<b>Source</b>
2.00	Kindergartners with Required Immunizations	<i>percent</i>	92.2		93.5		2020		15
1.88	Child Abuse Rate	<i>cases/ 1,000 children aged 5-11</i>	12.4		6.6		2019		11

## Appendix A. Secondary Data Methodology and Data Scoring Tables

1.50	Child Food Insecurity Rate	<i>percent</i>	16.5		17.1	14.6	2019		8
1.41	Children with Health Insurance	<i>percent</i>	93.5		92.4	94.3	2019		1
1.41	Projected Child Food Insecurity Rate	<i>percent</i>	19.1		19.1		2021		8
1.15	Children with Low Access to a Grocery Store	<i>percent</i>	2.6				2015		29
<b>SCORE</b>	<b>COMMUNITY</b>	<b>UNITS</b>	<b>PINELLAS COUNTY</b>	<b>HP2030</b>	<b>Florida</b>	<b>U.S.</b>	<b>MEASUREMENT PERIOD</b>	<b>RACE DISPARITY</b>	<b>Source</b>
2.38	Median Monthly Owner Costs for Households without a Mortgage	<i>dollars</i>	545		505	500	2015-2019		1
2.18	Social Associations	<i>membership associations/ 10,000 population</i>	7.3		7	9.3	2018		7
2.12	People 65+ Living Alone	<i>percent</i>	30.1		23.7	26.1	2015-2019		1
2.06	Single-Parent Households	<i>percent</i>	30.6		29	25.5	2015-2019		1
2.06	Total Employment Change	<i>percent</i>	0.6		2.2	1.6	2018-2019		28
2.03	Median Household Gross Rent	<i>dollars</i>	1112		1175	1062	2015-2019		1
2.03	Mortgaged Owners Median Monthly Household Costs	<i>dollars</i>	1490		1503	1595	2015-2019		1
1.88	Child Abuse Rate	<i>cases/ 1,000 children aged 5-11</i>	12.4		6.6		2019		11

## Appendix A. Secondary Data Methodology and Data Scoring Tables

<b>1.88</b>	Driving Under the Influence Arrest Rate	<i>arrests/ 100,000 population</i>	235.2		159.7		2019		20
<b>1.71</b>	Domestic Violence Offense Rate	<i>offenses/ 100,000 population</i>	617.8		496.5		2019		20
<b>1.65</b>	Population 16+ in Civilian Labor Force	<i>percent</i>	54.9		55.2	59.6	2015-2019		1
<b>1.59</b>	Households without a Vehicle	<i>percent</i>	7.7		6.3	8.6	2015-2019		1
<b>1.47</b>	Workers Commuting by Public Transportation	<i>percent</i>	1.7	5.3	1.8	5	2015-2019	Black (4.9) White (1) Asian (1.1) American Indian/Alaskan Native (3.4) Native Hawaiian/Pacific islander (8.9) Multiracial (3.1) Other (2) Hispanic/Latino (3.4)	1
<b>1.41</b>	Persons with an Internet Subscription	<i>percent</i>	85.9		85.7	86.2	2015-2019	Black (72.2) White (87.8) Asian (91.9) American Indian/Alaskan Native	1

## Appendix A. Secondary Data Methodology and Data Scoring Tables

								(82) Native Hawaiian/Pacific islander (92.2) Multiracial (86.9) Other (82.7) Hispanic/Latino (82.2)	
1.29	Solo Drivers with a Long Commute	<i>percent</i>	33.8		42.4	37	2015-2019		7
1.24	Consumer Expenditures: Local Public Transportation	<i>average dollar amount per consumer unit</i>	101.4		107.5	148.8	2021		6
1.24	Homeownership	<i>percent</i>	53.6		53.5	56.2	2015-2019		1
1.24	Juvenile Justice Referral Rate	<i>referrals/ 10,000 population</i>	187.6		160.6		2019		19
1.24	Median Household Income	<i>dollars</i>	54090		55660	62843	2015-2019	Black (39080) White (56696) Asian (59894) American Indian/Alaskan Native (49091) Multiracial	1

## Appendix A. Secondary Data Methodology and Data Scoring Tables

								(51601) Other (45634) Hispanic/La tino (46567)	
<b>1.24</b>	Social and Economic Factors Ranking	<i>ranking</i>	15				2021		7
<b>1.15</b>	Households with an Internet Subscription	<i>percent</i>	83.2		83.3	83	2015-2019		1
<b>1.15</b>	Households with One or More Types of Computing Devices	<i>percent</i>	90.4		91.5	90.3	2015-2019		1
<b>1.15</b>	Median Housing Unit Value	<i>dollars</i>	201200		215300	217500	2015-2019		1
<b>1.12</b>	Mean Travel Time to Work	<i>minutes</i>	24.5		27.8	26.9	2015-2019		1
<b>1.00</b>	Female Population 16+ in Civilian Labor Force	<i>percent</i>	54.7		54.3	58.3	2015-2019		1
<b>0.97</b>	Households with No Car and Low Access to a Grocery Store	<i>percent</i>	0.9				2015		29
<b>0.97</b>	Median Monthly Medicaid Enrollment	<i>enrollments/ 100,000 population</i>	16074.3		19940.3		2020		9
<b>0.97</b>	Violent Crime Rate	<i>crimes/ 100,000 population</i>	345.5		382.4	379.4	2019		20
<b>0.88</b>	Voter Turnout: Presidential Election	<i>percent</i>	79.3		77.2		2020		21

## Appendix A. Secondary Data Methodology and Data Scoring Tables

0.71	Workers who Drive Alone to Work	<i>percent</i>	77.9		79.1	76.3	2015-2019	Black (75.6) White (79.2) Asian (75.2) American Indian/Alaskan Native (69.4) Native Hawaiian/Pacific islander (77.4) Multiracial (72.9) Other (72.8) Hispanic/Latino (72.4)	1
0.53	Age-Adjusted Death Rate due to Motor Vehicle Collisions	<i>deaths/ 100,000 population</i>	11.6		14.7		2019	Black (23.3) White (10.6) Hispanic/Latino (10.1) Male (18.8) Female(6.3)	18
0.53	Alcohol-Impaired Driving Deaths	<i>percent of driving deaths with alcohol involvement</i>	21.4	28.3	22.3	27	2015-2019		7

## Appendix A. Secondary Data Methodology and Data Scoring Tables

0.53	People 25+ with a Bachelor's Degree or Higher	<i>percent</i>	31.7		29.9	32.1	2015-2019	Black (19) White (33.3) Asian (41.9) American Indian/Alaskan Native (17.3) Native Hawaiian/Pacific islander (35.9) Multiracial (32.5) Other (24.2) Hispanic/Latino (26.2)	1
0.53	People 25+ with a High School Degree or Higher	<i>percent</i>	91.3		88.2	88	2015-2019	Black (84.8) White (93.2) Asian (82.4) American Indian/Alaskan Native (81.7) Native Hawaiian/Pacific islander	1



## Appendix A. Secondary Data Methodology and Data Scoring Tables

								(93) Multiracial (88.1) Other (85.9) Hispanic/La tino (82.9)	
<b>0.53</b>	People Living Below Poverty Level	<i>percent</i>	12.2	8	14	13.4	2015-2019	Black (23.5) White (10) Asian (10.9) American Indian/Alas kan Native (20.6) Native Hawaiian/P acific islander (9) Multiracial (18.6) Other (11.9) Hispanic/La tino (16.6)	1
<b>0.35</b>	Children Living Below Poverty Level	<i>percent</i>	16.9		20.1	18.5	2015-2019	Black (36.5) White (10.5) Asian (15.8) American Indian/Alas kan Native	1

## Appendix A. Secondary Data Methodology and Data Scoring Tables

								(13.5) Native Hawaiian/P acific islander (0) Multiracial (22.5) Other (10.9) Hispanic/La tino (20.8)	
<b>0.18</b>	Per Capita Income	<i>dollars</i>	35196		31619	34103	2015-2019	Black (21119) White (39411) Asian (31353) American Indian/Alas kan Native (38810) Native Hawaiian/P acific islander (31455) Multiracial (15663) Other (22418) Hispanic/La	1

## Appendix A. Secondary Data Methodology and Data Scoring Tables

								mino (24143)	
SCORE	COUNTY HEALTH RANKINGS	UNITS	PINELLAS COUNTY	HP2030	Florida	U.S.	MEASUREMENT PERIOD	RACE DISPARITY	Source
1.41	Health Behaviors Ranking	<i>ranking</i>	19				2021		7
1.41	Mortality Ranking	<i>ranking</i>	29				2021		7
1.24	Clinical Care Ranking	<i>ranking</i>	11				2021		7
1.24	Morbidity Ranking	<i>ranking</i>	10				2021		7
1.24	Physical Environment Ranking	<i>ranking</i>	10				2021		7
1.24	Social and Economic Factors Ranking	<i>ranking</i>	15				2021		7
SCORE	DIABETES	UNITS	PINELLAS COUNTY	HP2030	Florida	U.S.	MEASUREMENT PERIOD	RACE DISPARITY	Source
1.15	Adults with Diabetes	<i>percent</i>	10.7		11.7		2017-2019		10
1.06	Age-Adjusted Death Rate due to Diabetes	<i>deaths/ 100,000 population</i>	19.2		19.7	21.6	2019	Black (42.2) White (18.3) Hispanic/Latino (27.1)	18

## Appendix A. Secondary Data Methodology and Data Scoring Tables

								Male (27.1) Female(14)	
<b>0.47</b>	Diabetes: Medicare Population	<i>percent</i>	24.2		27.8	27	2018		5
<b>SCORE</b>	<b>ECONOMY</b>	<b>UNITS</b>	<b>PINELLAS COUNTY</b>	<b>HP2030</b>	<b>Florida</b>	<b>U.S.</b>	<b>MEASUREMENT PERIOD</b>	<b>RACE DISPARITY</b>	<b>Source</b>
<b>2.38</b>	Median Monthly Owner Costs for Households without a Mortgage	<i>dollars</i>	545		505	500	2015-2019		1
<b>2.12</b>	People 65+ Living Below Poverty Level	<i>percent</i>	10		10.4	9.3	2015-2019	Black (17.7) White (8.9) Asian (13.3) American Indian/Alaskan Native (25.4) Native Hawaiian/Pacific islander (20) Multiracial (24.3) Other (15) Hispanic/Latino (19.3)	1
<b>2.06</b>	Total Employment Change	<i>percent</i>	0.6		2.2	1.6	2018-2019		28

## Appendix A. Secondary Data Methodology and Data Scoring Tables

<b>2.03</b>	Median Household Gross Rent	<i>dollars</i>	1112		1175	1062	<i>2015-2019</i>		1
<b>2.03</b>	Mortgaged Owners Median Monthly Household Costs	<i>dollars</i>	1490		1503	1595	<i>2015-2019</i>		1
<b>2.00</b>	Renters Spending 30% or More of Household Income on Rent	<i>percent</i>	53.3		56.3	49.6	<i>2015-2019</i>		1
<b>1.82</b>	SNAP Certified Stores	<i>stores/ 1,000 population</i>	0.8				<i>2017</i>		29
<b>1.71</b>	Households with Cash Public Assistance Income	<i>percent</i>	2.4		2.1	2.4	<i>2015-2019</i>		1
<b>1.68</b>	Food Insecurity Rate	<i>percent</i>	12.6		12	10.9	<i>2019</i>		8
<b>1.68</b>	Households that are Asset Limited, Income Constrained, Employed (ALICE)	<i>percent</i>	34.6		33		<i>2018</i>		31
<b>1.65</b>	Population 16+ in Civilian Labor Force	<i>percent</i>	54.9		55.2	59.6	<i>2015-2019</i>		1
<b>1.59</b>	Overcrowded Households	<i>percent of households</i>	1.9		3		<i>2015-2019</i>		1
<b>1.59</b>	Projected Food Insecurity Rate	<i>percent</i>	14.2		13.3		<i>2021</i>		8
<b>1.50</b>	Child Food Insecurity Rate	<i>percent</i>	16.5		17.1	14.6	<i>2019</i>		8
<b>1.41</b>	Homeowner Vacancy Rate	<i>percent</i>	2.3		2.3	1.6	<i>2015-2019</i>		1
<b>1.41</b>	Mortgaged Owners Spending 30% or More of	<i>percent</i>	29.5		32.2	26.5	<i>2019</i>		1

## Appendix A. Secondary Data Methodology and Data Scoring Tables

	Household Income on Housing								
<b>1.41</b>	Projected Child Food Insecurity Rate	<i>percent</i>	19.1		19.1		2021		8
<b>1.41</b>	Severe Housing Problems	<i>percent</i>	18		19.5	18	2013-2017		7
<b>1.32</b>	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	<i>percent</i>	54.1		54		2018		31
<b>1.32</b>	WIC Certified Stores	<i>stores/ 1,000 population</i>	0.1				2016		29
<b>1.24</b>	Consumer Expenditures: Homeowner Expenses	<i>average dollar amount per consumer unit</i>	7346.1		7675.2	8900.1	2021		6
<b>1.24</b>	Homeownership	<i>percent</i>	53.6		53.5	56.2	2015-2019		1
<b>1.24</b>	Median Household Income	<i>dollars</i>	54090		55660	62843	2015-2019	Black (39080) White (56696) Asian (59894) American Indian/Alaskan Native (49091) Multiracial (51601) Other (45634)	1

## Appendix A. Secondary Data Methodology and Data Scoring Tables

								Hispanic/Latino (46567)	
<b>1.24</b>	Social and Economic Factors Ranking	<i>ranking</i>	15				2021		7
<b>1.15</b>	Households that are Below the Federal Poverty Level	<i>percent</i>	11.3		13		2018		31
<b>1.15</b>	Low-Income and Low Access to a Grocery Store	<i>percent</i>	3.9				2015		29
<b>1.15</b>	Median Housing Unit Value	<i>dollars</i>	201200		215300	217500	2015-2019		1
<b>1.06</b>	Consumer Expenditures: Home Rental Expenses	<i>average dollar amount per consumer unit</i>	4192.9		4431	5460.2	2021		6
<b>1.06</b>	Size of Labor Force	<i>persons</i>	515290				Jul-21		27
<b>1.00</b>	Female Population 16+ in Civilian Labor Force	<i>percent</i>	54.7		54.3	58.3	2015-2019		1
<b>1.00</b>	Students Eligible for the Free Lunch Program	<i>percent</i>	43.1				2019-2020		25
<b>0.76</b>	Unemployed Workers in Civilian Labor Force	<i>percent</i>	4.4		5.1	5.7	Jul-21		27
<b>0.53</b>	People Living 200% Above Poverty Level	<i>percent</i>	69.4		65.8	69.1	2015-2019		1

## Appendix A. Secondary Data Methodology and Data Scoring Tables

0.53	People Living Below Poverty Level	<i>percent</i>	12.2	8	14	13.4	2015-2019	Black (23.5) White (10) Asian (10.9) American Indian/Alaskan Native (20.6) Native Hawaiian/Pacific islander (9) Multiracial (18.6) Other (11.9) Hispanic/Latino (16.6)	1
0.53	Persons with Disability Living in Poverty (5-year)	<i>percent</i>	23.4		24.6	26.1	2015-2019		1
0.35	Children Living Below Poverty Level	<i>percent</i>	16.9		20.1	18.5	2015-2019	Black (36.5) White (10.5) Asian (15.8) American Indian/Alaskan Native (13.5) Native Hawaiian/Pacific islander (0)	1



## Appendix A. Secondary Data Methodology and Data Scoring Tables

								Multiracial (22.5) Other (10.9) Hispanic/Latino (20.8)	
<b>0.18</b>	Families Living Below Poverty Level	<i>percent</i>	7.8		10	9.5	2015-2019		1
<b>0.18</b>	Per Capita Income	<i>dollars</i>	35196		31619	34103	2015-2019	Black (21119) White (39411) Asian (31353) American Indian/Alaskan Native (38810) Native Hawaiian/Pacific islander (31455) Multiracial (15663) Other (22418) Hispanic/Latino (24143)	1

## Appendix A. Secondary Data Methodology and Data Scoring Tables

SCORE	EDUCATION	UNITS	PINELLAS COUNTY	HP2030	Florida	U.S.	MEASUREMENT PERIOD	RACE DISPARITY	Source
2.00	8th Grade Students Proficient in Math	<i>percent</i>	28		37		2021		12
1.65	8th Grade Students Proficient in Reading	<i>percent</i>	50		52		2021		12
1.65	Student-to-Teacher Ratio	<i>students/ teacher</i>	16.4				2019-2020		25
1.29	4th Grade Students Proficient in Math	<i>percent</i>	61		53		2021		12
1.24	Consumer Expenditures: Education	<i>average dollar amount per consumer unit</i>	957.7		1056	1492.4	2021		6
1.18	4th Grade Students Proficient in Reading	<i>percent</i>	55		52		2021		12
0.88	High School Graduation	<i>percent</i>	91.5	90.7	90		2019-2020		12
0.53	People 25+ with a Bachelor's Degree or Higher	<i>percent</i>	31.7		29.9	32.1	2015-2019	Black (19) White (33.3) Asian (41.9) American Indian/Alaskan Native (17.3) Native Hawaiian/Pacific islander (35.9) Multiracial	1

## Appendix A. Secondary Data Methodology and Data Scoring Tables

								(32.5) Other (24.2) Hispanic/La tino (26.2)	
<b>0.53</b>	People 25+ with a High School Degree or Higher	<i>percent</i>	91.3		88.2	88	2015-2019	Black (84.8) White (93.2) Asian (82.4) American Indian/Alas kan Native (81.7) Native Hawaiian/P acific islander (93) Multiracial (88.1) Other (85.9) Hispanic/La tino (82.9)	1
<b>SCORE</b>	<b>ENVIRONMENTAL HEALTH</b>	<b>UNITS</b>	<b>PINELLAS COUNTY</b>	<b>HP2030</b>	<b>Florida</b>	<b>U.S.</b>	<b>MEASUREMENT PERIOD</b>	<b>RACE DISPARITY</b>	<b>Source</b>
<b>2.24</b>	Asthma: Medicare Population	<i>percent</i>	5.6		5.2	5	2018		5

## Appendix A. Secondary Data Methodology and Data Scoring Tables

2.03	Adults with Current Asthma	<i>percent</i>	10.6		7.4		2017-2019		10
2.00	Fast Food Restaurant Density	<i>restaurants/ 1,000 population</i>	0.7				2016		29
1.94	Number of Extreme Heat Events	<i>events</i>	8				2016		26
1.82	SNAP Certified Stores	<i>stores/ 1,000 population</i>	0.8				2017		29
1.65	Number of Extreme Heat Days	<i>days</i>	44				2016		26
1.65	Number of Extreme Precipitation Days	<i>days</i>	29				2016		26
1.59	Overcrowded Households	<i>percent of households</i>	1.9		3		2015-2019		1
1.50	Farmers Market Density	<i>markets/ 1,000 population</i>	0				2018		29
1.50	People 65+ with Low Access to a Grocery Store	<i>percent</i>	2.8				2015		29
1.47	Houses Built Prior to 1950	<i>percent</i>	6.5		4.1	17.5	2015-2019		1
1.41	Severe Housing Problems	<i>percent</i>	18		19.5	18	2013-2017		7
1.35	PBT Released	<i>pounds</i>	844.2				2019		30
1.32	Annual Ozone Air Quality		B				2017-2019		2
1.32	WIC Certified Stores	<i>stores/ 1,000 population</i>	0.1				2016		29
1.24	Annual Particle Pollution		A				2017-2019		2
1.24	Physical Environment Ranking	<i>ranking</i>	10				2021		7

## Appendix A. Secondary Data Methodology and Data Scoring Tables

1.15	Children with Low Access to a Grocery Store	<i>percent</i>	2.6				2015		29
1.15	Grocery Store Density	<i>stores/ 1,000 population</i>	0.2				2016		29
1.15	Low-Income and Low Access to a Grocery Store	<i>percent</i>	3.9				2015		29
0.97	Households with No Car and Low Access to a Grocery Store	<i>percent</i>	0.9				2015		29
0.97	Recreation and Fitness Facilities	<i>facilities/ 1,000 population</i>	0.1				2016		29
0.65	Food Environment Index	<i>index</i>	7.9		6.9	7.8	2021		7
0.62	Access to Exercise Opportunities	<i>percent</i>	97.2		88.7	84	2020		7
0.53	Teens with Asthma	<i>percent</i>	17		21.3		2020		23
<b>SCORE</b>	<b>HEALTH CARE ACCESS &amp; QUALITY</b>	<b>UNITS</b>	<b>PINELLAS COUNTY</b>	<b>HP2030</b>	<b>Florida</b>	<b>U.S.</b>	<b>MEASUREMENT PERIOD</b>	<b>RACE DISPARITY</b>	<b>Source</b>
1.76	Adults without Health Insurance	<i>percent</i>	18.7			12.2	2018		3
1.41	Children with Health Insurance	<i>percent</i>	93.5		92.4	94.3	2019		1
1.41	Consumer Expenditures: Health Insurance	<i>average dollar amount per consumer unit</i>	4168.1		4247.2	4321.1	2021		6
1.32	Adults with a Usual Source of Health Care	<i>percent</i>	76.1		72		2017-2019		10

## Appendix A. Secondary Data Methodology and Data Scoring Tables

1.24	Adults who Visited a Dentist	<i>percent</i>	65.1			66.5	2018		3
1.24	Adults with Health Insurance	<i>percent</i>	82.3		80.5	87.1	2019	Black (81) White (84) Asian (78.2) Multiracial (82) Other (72.3) Hispanic/Latino (74.9)	1
1.24	Clinical Care Ranking	<i>ranking</i>	11				2021		7
1.15	Primary Care Provider Rate	<i>providers/ 100,000 population</i>	87.8		72.2		2018		7
1.06	Adults who have had a Routine Checkup	<i>percent</i>	79.6			76.7	2018		3
0.97	Median Monthly Medicaid Enrollment	<i>enrollments/ 100,000 population</i>	16074.3		19940.3		2020		9
0.44	Mental Health Provider Rate	<i>providers/ 100,000 population</i>	208.5		169		2020		7
0.26	Dentist Rate	<i>dentists/ 100,000 population</i>	72.3		60.8		2019		7
0.26	Non-Physician Primary Care Provider Rate	<i>providers/ 100,000 population</i>	135		120.6		2020		7
<b>SCORE</b>	<b>HEART DISEASE &amp; STROKE</b>	<b>UNITS</b>	<b>PINELLAS COUNTY</b>	<b>HP2030</b>	<b>Florida</b>	<b>U.S.</b>	<b>MEASUREMENT PERIOD</b>	<b>RACE DISPARITY</b>	<b>Source</b>
2.65	Ischemic Heart Disease: Medicare Population	<i>percent</i>	34.4		34.3	26.8	2018		5

## Appendix A. Secondary Data Methodology and Data Scoring Tables

<b>2.35</b>	Atrial Fibrillation: Medicare Population	<i>percent</i>	10.1		10.1	8.4	2018		5
<b>2.24</b>	Stroke: Medicare Population	<i>percent</i>	5.1		4.7	3.8	2018		5
<b>2.18</b>	Hyperlipidemia: Medicare Population	<i>percent</i>	58		59.2	47.7	2018		5
<b>1.94</b>	Hypertension: Medicare Population	<i>percent</i>	61.2		62.4	57.2	2018		5
<b>1.91</b>	Age-Adjusted Death Rate due to Coronary Heart Disease	<i>deaths/ 100,000 population</i>	93.9	71.1	88.6	88	2019		18
<b>1.85</b>	High Blood Pressure Prevalence	<i>percent</i>	39.4	27.7	33.5		2017-2019		10
<b>1.76</b>	Adults who Experienced a Stroke	<i>percent</i>	4.2			3.4	2018		3
<b>1.76</b>	Adults who Experienced Coronary Heart Disease	<i>percent</i>	9.3			6.8	2018		3
<b>1.65</b>	Heart Failure: Medicare Population	<i>percent</i>	14.7		14.8	14	2018		5
<b>1.41</b>	High Cholesterol Prevalence: Adults 18+	<i>percent</i>	37			34.1	2017		3
<b>1.35</b>	Age-Adjusted Hospitalization Rate due to Heart Attack	<i>hospitalizations/ 10,000 population 35+ years</i>	32.2		29.7		2018		26
<b>1.24</b>	Adults who Have Taken Medications for High Blood Pressure	<i>percent</i>	78.6			75.8	2017		3

## Appendix A. Secondary Data Methodology and Data Scoring Tables

1.03	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	<i>deaths/ 100,000 population</i>	31.7	33.4	41.4	37	2019		18
0.88	Cholesterol Test History	<i>percent</i>	84			81.5	2017		3
0.53	Age-Adjusted Death Rate due to Heart Attack	<i>deaths/ 100,000 population 35+ years</i>	36.7		42.8		2018		26
<b>SCORE</b>	<b>IMMUNIZATIONS &amp; INFECTIOUS DISEASES</b>	<b>UNITS</b>	<b>PINELLAS COUNTY</b>	<b>HP2030</b>	<b>Florida</b>	<b>U.S.</b>	<b>MEASUREMENT PERIOD</b>	<b>RACE DISPARITY</b>	<b>Source</b>
2.44	Syphilis Incidence Rate	<i>cases/ 100,000 population</i>	22.5		15.1	11.9	2019		16
2.00	Kindergartners with Required Immunizations	<i>percent</i>	92.2		93.5		2020		15
1.88	Tuberculosis Incidence Rate	<i>cases/ 100,000 population</i>	2.4	1.4	1.9		2020		17
1.82	HIV Incidence Rate	<i>cases/ 100,000 population</i>	20		21.6		2019	Black (44.6) White (11.3) Hispanic/Latino (25.9)	14
1.59	Overcrowded Households	<i>percent of households</i>	1.9		3		2015-2019		1
1.50	Chlamydia Incidence Rate	<i>cases/ 100,000 population</i>	470.7		525.5	551	2019		16
1.15	Adults 65+ with Influenza Vaccination	<i>percent</i>	62.6		58.3		2017-2019		10
1.09	Gonorrhea Incidence Rate	<i>cases/ 100,000 population</i>	157.6		174.9	187.8	2019		16



## Appendix A. Secondary Data Methodology and Data Scoring Tables

0.97	Adults 65+ with Pneumonia Vaccination	<i>percent</i>	76.7		66.8		2017-2019		10
0.97	Salmonella Infection Incidence Rate	<i>cases/ 100,000 population</i>	20.4	11.1	33.4		2019		13
0.79	Persons Fully Vaccinated Against COVID-19	<i>percent</i>	59.3				Nov 5,2021		4
0.44	Age-Adjusted Death Rate due to Influenza and Pneumonia	<i>deaths/ 100,000 population</i>	7.2		8.4	12.3	2019		18
0.44	COVID-19 Daily Average Case-Fatality Rate	<i>deaths per 100 cases</i>	0		0	3.4	Nov 5,2021		24
0.18	COVID-19 Daily Average Incidence Rate	<i>cases per 100,000 population</i>	5.2		6	31.2	Nov 5,2021		24
<b>SCORE</b>	<b>MATERNAL, FETAL &amp; INFANT HEALTH</b>	<b>UNITS</b>	<b>PINELLAS COUNTY</b>	<b>HP2030</b>	<b>Florida</b>	<b>U.S.</b>	<b>MEASUREMENT PERIOD</b>	<b>RACE DISPARITY</b>	<b>Source</b>
1.21	Mothers who Received Early Prenatal Care	<i>percent</i>	80.5		75.9	75.8	2019		18
1.21	Preterm Births	<i>percent</i>	9.9	9.4	10.6	10	2019		18
1.09	Teen Birth Rate: 15-19	<i>live births/ 1,000 females aged 15-19</i>	16.2		16.2	16.7	2019	Black (31.7) White (9)Hispanic/ Latino (17.7)	18
1.00	Infant Mortality Rate	<i>deaths/ 1,000 live births</i>	5.4	5	6		2019	Black (14.3) White (3.9)Hispani c/Latino (6.4)	18

## Appendix A. Secondary Data Methodology and Data Scoring Tables

<b>0.91</b>	Babies with Low Birth Weight	<i>percent</i>	8		8.8	8.3	2019	Black (14.3) White (6.1)Hispanic/Latino (6)	18
<b>SCORE</b>	<b>MENTAL HEALTH &amp; MENTAL DISORDERS</b>	<b>UNITS</b>	<b>PINELLAS COUNTY</b>	<b>HP2030</b>	<b>Florida</b>	<b>U.S.</b>	<b>MEASUREMENT PERIOD</b>	<b>RACE DISPARITY</b>	<b>Source</b>
<b>3.00</b>	Alzheimer's Disease or Dementia: Medicare Population	<i>percent</i>	14.2		12.6	10.8	2018		5
<b>3.00</b>	Depression: Medicare Population	<i>percent</i>	22.4		19.5	18.4	2018		5
<b>1.79</b>	Age-Adjusted Death Rate due to Suicide	<i>deaths/ 100,000 population</i>	16.6	12.8	14.5	13.9	2019		18
<b>1.50</b>	Frequent Mental Distress	<i>percent</i>	14.7		13.4	13	2018		7
<b>1.24</b>	Poor Mental Health: 14+ Days	<i>percent</i>	13.4			12.7	2018		3
<b>1.15</b>	Self-Reported General Health Assessment: Good or Better	<i>percent</i>	81.8		80.3		2017-2019		10
<b>0.44</b>	Mental Health Provider Rate	<i>providers/ 100,000 population</i>	208.5		169		2020		7
<b>SCORE</b>	<b>OLDER ADULTS</b>	<b>UNITS</b>	<b>PINELLAS COUNTY</b>	<b>HP2030</b>	<b>Florida</b>	<b>U.S.</b>	<b>MEASUREMENT PERIOD</b>	<b>RACE DISPARITY</b>	<b>Source</b>
<b>3.00</b>	Alzheimer's Disease or Dementia: Medicare Population	<i>percent</i>	14.2		12.6	10.8	2018		5

## Appendix A. Secondary Data Methodology and Data Scoring Tables

<b>3.00</b>	Depression: Medicare Population	<i>percent</i>	22.4		19.5	18.4	2018		5
<b>2.65</b>	Chronic Kidney Disease: Medicare Population	<i>percent</i>	29.4		28.2	24.5	2018		5
<b>2.65</b>	Ischemic Heart Disease: Medicare Population	<i>percent</i>	34.4		34.3	26.8	2018		5
<b>2.53</b>	Osteoporosis: Medicare Population	<i>percent</i>	9.1		8.3	6.6	2018		5
<b>2.35</b>	Atrial Fibrillation: Medicare Population	<i>percent</i>	10.1		10.1	8.4	2018		5
<b>2.24</b>	Asthma: Medicare Population	<i>percent</i>	5.6		5.2	5	2018		5
<b>2.24</b>	Stroke: Medicare Population	<i>percent</i>	5.1		4.7	3.8	2018		5
<b>2.18</b>	Cancer: Medicare Population	<i>percent</i>	10.1		10.1	8.4	2018		5
<b>2.18</b>	Hyperlipidemia: Medicare Population	<i>percent</i>	58		59.2	47.7	2018		5
<b>2.12</b>	People 65+ Living Alone	<i>percent</i>	30.1		23.7	26.1	2015-2019		1
<b>2.12</b>	People 65+ Living Below Poverty Level	<i>percent</i>	10		10.4	9.3	2015-2019	Black (17.7) White (8.9) Asian (13.3) American Indian/Alaskan Native (25.4) Native Hawaiian/Pacific	1

## Appendix A. Secondary Data Methodology and Data Scoring Tables

								islander (20) Multiracial (24.3) Other (15) Hispanic/Latino (19.3)	
<b>2.12</b>	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	<i>percent</i>	36.7		37.5	33.5	2018		5
<b>2.00</b>	COPD: Medicare Population	<i>percent</i>	14.3		13.5	11.5	2018		5
<b>1.94</b>	Hypertension: Medicare Population	<i>percent</i>	61.2		62.4	57.2	2018		5
<b>1.65</b>	Heart Failure: Medicare Population	<i>percent</i>	14.7		14.8	14	2018		5
<b>1.59</b>	Adults with Arthritis	<i>percent</i>	30			25.8	2018		3
<b>1.50</b>	People 65+ with Low Access to a Grocery Store	<i>percent</i>	2.8				2015		29
<b>1.41</b>	Colon Cancer Screening	<i>percent</i>	65.9	74.4		66.4	2018		3
<b>1.24</b>	Adults 65+ who Received Recommended Preventive Services: Females	<i>percent</i>	31.2			28.4	2018		3
<b>1.24</b>	Adults 65+ with Total Tooth Loss	<i>percent</i>	14			13.5	2018		3
<b>1.15</b>	Adults 65+ with Influenza Vaccination	<i>percent</i>	62.6		58.3		2017-2019		10
<b>1.41</b>	Colon Cancer Screening	<i>percent</i>	65.9	74.4		66.4	2018		3

## Appendix A. Secondary Data Methodology and Data Scoring Tables

1.06	Adults 65+ who Received Recommended Preventive Services: Males	<i>percent</i>	32.5			32.4	2018		3
0.97	Adults 65+ with Pneumonia Vaccination	<i>percent</i>	76.7		66.8		2017-2019		10
0.47	Diabetes: Medicare Population	<i>percent</i>	24.2		27.8	27	2018		5
<b>SCORE</b>	<b>ORAL HEALTH</b>	<b>UNITS</b>	<b>PINELLAS COUNTY</b>	<b>HP2030</b>	<b>Florida</b>	<b>U.S.</b>	<b>MEASUREMENT PERIOD</b>	<b>RACE DISPARITY</b>	<b>Source</b>
2.00	Oral Cavity and Pharynx Cancer Incidence Rate	<i>cases/ 100,000 population</i>	16.3		13.5		2016-2018		32
1.24	Adults 65+ with Total Tooth Loss	<i>percent</i>	14			13.5	2018		3
1.24	Adults who Visited a Dentist	<i>percent</i>	65.1			66.5	2018		3
0.26	Dentist Rate	<i>dentists/ 100,000 population</i>	72.3		60.8		2019		7
<b>SCORE</b>	<b>OTHER CONDITIONS</b>	<b>UNITS</b>	<b>PINELLAS COUNTY</b>	<b>HP2030</b>	<b>Florida</b>	<b>U.S.</b>	<b>MEASUREMENT PERIOD</b>	<b>RACE DISPARITY</b>	<b>Source</b>
2.65	Chronic Kidney Disease: Medicare Population	<i>percent</i>	29.4		28.2	24.5	2018		5
2.53	Osteoporosis: Medicare Population	<i>percent</i>	9.1		8.3	6.6	2018		5
2.12	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	<i>percent</i>	36.7		37.5	33.5	2018		5

## Appendix A. Secondary Data Methodology and Data Scoring Tables

1.76	Adults with Kidney Disease	<i>Percent of adults</i>	3.5			3.1	2018		3
1.59	Adults with Arthritis	<i>percent</i>	30			25.8	2018		3
1.12	Age-Adjusted Death Rate due to Kidney Disease	<i>deaths/ 100,000 population</i>	10.1		9.9	12.9	2017-2019	Black (25.4) White (9) Hispanic/Latino (10.2)	4
<b>SCORE</b>	<b>PHYSICAL ACTIVITY</b>	<b>UNITS</b>	<b>PINELLAS COUNTY</b>	<b>HP2030</b>	<b>Florida</b>	<b>U.S.</b>	<b>MEASUREMENT PERIOD</b>	<b>RACE DISPARITY</b>	<b>Source</b>
2.00	Fast Food Restaurant Density	<i>restaurants/ 1,000 population</i>	0.7				2016		29
1.82	SNAP Certified Stores	<i>stores/ 1,000 population</i>	0.8				2017		29
1.65	Teens without Sufficient Physical Activity	<i>percent</i>	81.2		82.3		2020		13
1.50	Adults Who Are Obese	<i>percent</i>	28.4		27		2017-2019		10
1.50	Farmers Market Density	<i>markets/ 1,000 population</i>	0				2018		29
1.50	People 65+ with Low Access to a Grocery Store	<i>percent</i>	2.8				2015		29
1.41	Health Behaviors Ranking	<i>ranking</i>	19				2021		7
1.32	WIC Certified Stores	<i>stores/ 1,000 population</i>	0.1				2016		29
1.15	Adults who are Overweight or Obese	<i>percent</i>	63.8		64.6		2017-2019		10

## Appendix A. Secondary Data Methodology and Data Scoring Tables

1.15	Children with Low Access to a Grocery Store	<i>percent</i>	2.6				2015		29
1.15	Grocery Store Density	<i>stores/ 1,000 population</i>	0.2				2016		29
1.15	Low-Income and Low Access to a Grocery Store	<i>percent</i>	3.9				2015		29
0.97	Adults who are Sedentary	<i>percent</i>	22	21.2	26.5		2017-2019		10
0.97	Households with No Car and Low Access to a Grocery Store	<i>percent</i>	0.9				2015		29
0.97	Recreation and Fitness Facilities	<i>facilities/ 1,000 population</i>	0.1				2016		29
0.65	Food Environment Index	<i>index</i>	7.9		6.9	7.8	2021		7
0.62	Access to Exercise Opportunities	<i>percent</i>	97.2		88.7	84	2020		7
<b>SCORE</b>	<b>PREVENTION &amp; SAFETY</b>	<b>UNITS</b>	<b>PINELLAS COUNTY</b>	<b>HP2030</b>	<b>Florida</b>	<b>U.S.</b>	<b>MEASUREMENT PERIOD</b>	<b>RACE DISPARITY</b>	<b>Source</b>
3.00	Death Rate due to Drug Poisoning	<i>deaths/ 100,000 population</i>	32.5		23.6	21	2017-2019		7
2.12	Age-Adjusted Death Rate due to Unintentional Injuries	<i>deaths/ 100,000 population</i>	72.3	43.2	55.5	49.3	2019		18
1.41	Severe Housing Problems	<i>percent</i>	18		19.5	18	2013-2017		7
0.53	Age-Adjusted Death Rate due to Motor Vehicle Collisions	<i>deaths/ 100,000 population</i>	11.6		14.7		2019	Black (23.3) White (10.6) Hispanic/La	18

## Appendix A. Secondary Data Methodology and Data Scoring Tables

								tino (10.1) Male (18.8) Female(6.3)	
SCORE	RESPIRATORY DISEASES	UNITS	PINELLAS COUNTY	HP2030	Florida	U.S.	MEASUREMENT PERIOD	RACE DISPARITY	Source
2.24	Asthma: Medicare Population	<i>percent</i>	5.6		5.2	5	2018		5
2.03	Adults Who Currently Use E-Cigarettes	<i>percent</i>	8.9		7.5		2017-2019		10
2.03	Adults with Current Asthma	<i>percent</i>	10.6		7.4		2017-2019		10
2.00	COPD: Medicare Population	<i>percent</i>	14.3		13.5	11.5	2018		5
1.91	Adolescents who Use Electronic Vaping: Lifetime	<i>percent</i>	29.7		26.4		2020		23
1.91	Adolescents who Use Electronic Vaping: Past 30 Days	<i>percent</i>	18.9		14.5		2020		23
1.88	Tuberculosis Incidence Rate	<i>cases/ 100,000 population</i>	2.4	1.4	1.9		2020		17
1.85	Adults who Smoke	<i>percent</i>	19.7	5	14.8		2017-2019		10
1.76	Adults with COPD	<i>Percent of adults</i>	9.3			6.9	2018		3
1.24	Age-Adjusted Death Rate due to Lung Cancer	<i>deaths/ 100,000 population</i>	39.5	25.1	35.3		2017-2019		18
1.15	Adults 65+ with Influenza Vaccination	<i>percent</i>	62.6		58.3		2017-2019		10



## Appendix A. Secondary Data Methodology and Data Scoring Tables

1.09	Adolescents who Use Smokeless Tobacco: Lifetime	<i>percent</i>	3.1		3.7		2020		23
1.06	Lung and Bronchus Cancer Incidence Rate	<i>cases/ 100,000 population</i>	61.4		56.6		2016-2018		32
0.97	Adults 65+ with Pneumonia Vaccination	<i>percent</i>	76.7		66.8		2017-2019		10
0.97	Teens who Smoke Cigarettes: High School Students	<i>percent</i>	1.4		1.5		2020		23
0.79	Adolescents who Use Smokeless Tobacco: Past 30 Days	<i>percent</i>	0.8		1.3		2020		23
0.53	Teens with Asthma	<i>percent</i>	17		21.3		2020		23
0.44	Age-Adjusted Death Rate due to Influenza and Pneumonia	<i>deaths/ 100,000 population</i>	7.2		8.4	12.3	2019		18
0.44	COVID-19 Daily Average Case-Fatality Rate	<i>deaths per 100 cases</i>	0		0	3.4	Nov 5,2021		24
0.18	COVID-19 Daily Average Incidence Rate	<i>cases per 100,000 population</i>	5.2		6	31.2	Nov 5,2021		24
<b>SCORE</b>	<b>SEXUALLY TRANSMITTED INFECTIONS</b>	<b>UNITS</b>	<b>PINELLAS COUNTY</b>	<b>HP2030</b>	<b>Florida</b>	<b>U.S.</b>	<b>MEASUREMENT PERIOD</b>	<b>RACE DISPARITY</b>	<b>Source</b>
2.44	Syphilis Incidence Rate	<i>cases/ 100,000 population</i>	22.5		15.1	11.9	2019		16
1.82	HIV Incidence Rate	<i>cases/ 100,000 population</i>	20		21.6		2019	Black (44.6) White	14



## Appendix A. Secondary Data Methodology and Data Scoring Tables

SCORE	WEIGHT STATUS	UNITS	PINELLAS COUNTY	HP2030	Florida	U.S.	MEASUREMENT PERIOD	RACE DISPARITY	Source
1.50	Adults Who Are Obese	<i>percent</i>	28.4		27		2017-2019		10
1.15	Adults who are Overweight or Obese	<i>percent</i>	63.8		64.6		2017-2019		10
0.97	Teens who are Obese: High School Students	<i>percent</i>	11.5		15.4		2020		13
SCORE	WELLNESS & LIFESTYLE	UNITS	PINELLAS COUNTY	HP2030	Florida	U.S.	MEASUREMENT PERIOD	RACE DISPARITY	Source
1.85	High Blood Pressure Prevalence	<i>percent</i>	39.4	27.7	33.5		2017-2019		10
1.50	Insufficient Sleep	<i>percent</i>	38	31.4	37.3	35	2018		7
1.50	Life Expectancy	<i>years</i>	79.2		80.2	79.2	2017-2019	Black (74.86) White (79.06) Asian (88.37) American Indian/Alaskan Native (96.7) Hispanic/Latino (84.78)	7
1.41	Poor Physical Health: 14+ Days	<i>percent</i>	14.2			12.5	2018		3
1.32	Frequent Physical Distress	<i>percent</i>	12.5		12.6	11	2018		7



## Appendix A. Secondary Data Methodology

### Population Estimates for each Zip Code (Figure 1)

ZIP CODE	CITY	POPULATION
33701	Saint Petersburg	18,204
33702	Saint Petersburg	32,346
33703	Saint Petersburg	23,689
33704	Saint Petersburg	16,330
33705	Saint Petersburg	28,221
33706	Saint Petersburg	16,444
33707	Saint Petersburg, Gulfport, South Pasadena, Saint Pete Beach, Bear Creek	25,580
33708	Saint Petersburg, Madeira Beach, North Redington Beach, Redington Shore	16,180
33709	Saint Petersburg, Kenneth City, Pinellas Park, Seminole, Lealman	27,559
33710	Saint Petersburg	33,593
33711	Saint Petersburg, Gulfport	19,921
33712	Saint Petersburg	27,185
33713	Saint Petersburg	31,220
33714	Saint Petersburg, Pinellas Park, Lealman	20,713
33715	Saint Petersburg, Tierra Verde	8,110
33716	Saint Petersburg, Pinellas Park, Gandy	19,079

ZIP CODE	CITY	POPULATION
33755	Clearwater, Dunedin	27,576
33756	Clearwater, Belleair, Largo, Belleair Bluffs	33,093
33759	Clearwater	19,628
33760	Largo, Pinellas Park, Highpoint	20,974
33761	Clearwater, Safety Harbor	18,263
33762	Saint Petersburg, Feather Sound, Largo, Pinellas Park, Highpoint	5,917
33763	Clearwater, Dunedin	19,324
33764	Clearwater, Largo, Pinellas Park	28,075
33765	Clearwater	13,807
33767	Clearwater, Dunedin	8,496
33770	Largo, Belleair Bluffs, Harbor Bluffs	25,885
33771	Largo	33,588
33772	Seminole	24,039
33773	Largo, Pinellas Park	18,090
33774	Largo, Ridgecrest	18,707
33776	Seminole	12,462
33777	Seminole, Bardmoor, Pinellas Park	18,388
33778	Largo, Seminole, Ridgecrest	14,764

## Appendix A. Secondary Data Methodology

### Population Estimates for each Zip Code (Figure 1)

ZIP CODE	CITY	POPULATION
33781	Pinellas Park, Lealman	27,479
33782	Pinellas Park	22,354
33785	Indian Rocks Beach, Indian Shores	5,560
33786	Belleair Beach, Belleair Shore	1,564
34677	Oldsmar, East Lake	23,189
34681	Palm Harbor	1,395
34683	Palm Harbor, Dunedin	33,537

ZIP CODE	CITY	POPULATION
34684	Palm Harbor	26,901
34685	East Lake, Oldsmar	19,579
34688	Tarpon Springs, East Lake	8,806
34689	Tarpon Springs	29,026
34695	Safety Harbor	18,165
34698	Dunedin	39,137
	<b>Pinellas County</b>	982,142
	<b>Florida</b>	21,976,313
	<b>U.S.</b>	326,569,308

\*County index values are calculated separately from zip code index values, and the two should not be compared to each other. While index values range from 0-100 at both the county and zip code level, zip code index values represent the percentile of each zip code among all U.S. zip codes, while county index values represent the percentile of each county among all U.S. counties

## Appendix A. Secondary Data Methodology

### Families Below Poverty by Zip Code (Figure 14)

ZIP CODE	CITY	FAMILIES BELOW POVERTY LEVEL (%)
<b>33701</b>	Saint Petersburg	7.8%
<b>33702</b>	Saint Petersburg	7.0%
<b>33703</b>	Saint Petersburg	3.4%
<b>33704</b>	Saint Petersburg	4.0%
<b>33705</b>	Saint Petersburg	13.3%
<b>33706</b>	Saint Petersburg	2.5%
<b>33707</b>	Saint Petersburg, Gulfport, South Pasadena, Saint Pete Beach, Bear Creek	6.0%
<b>33708</b>	Saint Petersburg, Madeira Beach, North Redington Beach, Redington Shore	4.6%
<b>33709</b>	Saint Petersburg, Kenneth City, Pinellas Park, Seminole, Lealman	8.8%
<b>33710</b>	Saint Petersburg	4.8%
<b>33711</b>	Saint Petersburg, Gulfport	10.4%
<b>33712</b>	Saint Petersburg	14.2%
<b>33713</b>	Saint Petersburg	7.9%
<b>33714</b>	Saint Petersburg, Pinellas Park, Lealman	10.6%
<b>33715</b>	Saint Petersburg, Tierra Verde	4.5%
<b>33716</b>	Saint Petersburg, Pinellas Park, Gandy	6.4%
<b>33755</b>	Clearwater, Dunedin	15.9%

ZIP CODE	CITY	FAMILIES BELOW POVERTY LEVEL (%)
<b>33756</b>	Clearwater, Belleair, Largo, Belleair Bluffs	11.1%
<b>33759</b>	Clearwater	6.2%
<b>33760</b>	Largo, Pinellas Park, Highpoint	9.0%
<b>33761</b>	Clearwater, Safety Harbor	5.7%
<b>33762</b>	Saint Petersburg, Feather Sound, Largo, Pinellas Park, Highpoint	5.2%
<b>33763</b>	Clearwater, Dunedin	6.6%
<b>33764</b>	Clearwater, Largo, Pinellas Park	6.3%
<b>33765</b>	Clearwater	9.3%
<b>33767</b>	Clearwater, Dunedin	6.5%
<b>33770</b>	Largo, Belleair Bluffs, Harbor Bluffs	9.1%
<b>33771</b>	Largo	5.9%
<b>33772</b>	Seminole	4.9%
<b>33773</b>	Largo, Pinellas Park	5.9%
<b>33774</b>	Largo, Ridgecrest	7.2%
<b>33776</b>	Seminole	1.7%
<b>33777</b>	Seminole, Bardmoor, Pinellas Park	5.6%
<b>33778</b>	Largo, Seminole, Ridgecrest	5.6%
<b>33781</b>	Pinellas Park, Lealman	9.1%

## Appendix A. Secondary Data Methodology

### Families Below Poverty by Zip Code (Figure 14)

ZIP CODE	CITY	FAMILIES BELOW POVERTY LEVEL (%)
<b>33782</b>	Pinellas Park	6.4%
<b>33785</b>	Indian Rocks Beach, Indian Shores	6.4%
<b>33786</b>	Belleair Beach, Belleair Shore	4.0%
<b>34677</b>	Oldsmar, East Lake	5.8%
<b>34681</b>	Palm Harbor	5.0%
<b>34683</b>	Palm Harbor, Dunedin	4.2%
<b>34684</b>	Palm Harbor	2.9%
<b>34685</b>	East Lake, Oldsmar	5.5%
<b>34688</b>	Tarpon Springs, East Lake	5.2%
<b>34689</b>	Tarpon Springs	6.4%
<b>34695</b>	Safety Harbor	2.1%
<b>34698</b>	Dunedin	7.4%
	Pinellas County	7.0%
	Florida	9.3%
	U.S.	9.1%

\*County index values are calculated separately from zip code index values, and the two should not be compared to each other. While index values range from 0-100 at both the county and zip code level, zip code index values represent the percentile of each zip code among all U.S. zip codes, while county index values represent the percentile of each county among all U.S. counties



# Appendix B. Index of Disparity

## Health Equity Index (Figure 21)

ZIP CODE	CITY	INDEX SCORE
33701	Saint Petersburg	31
33702	Saint Petersburg	45.2
33703	Saint Petersburg	17.6
33704	Saint Petersburg	10.5
33705	Saint Petersburg	61
33706	Saint Petersburg	14.3
33707	Saint Petersburg, Gulfport, South Pasadena, Saint Pete Beach, Bear Creek	39.9
33708	Saint Petersburg, Madeira Beach, North Redington Beach, Redington Shore	17.8
33709	Saint Petersburg, Kenneth City, Pinellas Park, Seminole, Lealman	63.5
33710	Saint Petersburg	31
33711	Saint Petersburg, Gulfport	74.9
33712	Saint Petersburg	72.2
33713	Saint Petersburg	49.9
33714	Saint Petersburg, Pinellas Park, Lealman	85.4
33715	Saint Petersburg, Tierra Verde	7.9
33716	Saint Petersburg, Pinellas Park, Gandy	23.5
33755	Clearwater, Dunedin	73.7
33756	Clearwater, Belleair, Largo, Belleair Bluffs	72.2
33759	Clearwater	36
33760	Largo, Pinellas Park, Highpoint	67.6
33761	Clearwater, Safety Harbor	19.2
33762	Saint Petersburg, Feather Sound, Largo, Pinellas Park, Highpoint	16.5
33763	Clearwater, Dunedin	49.5

33764	Clearwater, Largo, Pinellas Park	38.8
33765	Clearwater	62
33767	Clearwater, Dunedin	10.1
33770	Largo, Belleair Bluffs, Harbor Bluffs	57.2
33771	Largo	61.3
33772	Seminole	26.6
33773	Largo, Pinellas Park	37.6
33774	Largo, Ridgecrest	42.6
33776	Seminole	10.5
33777	Seminole, Bardmoor, Pinellas Park	25.5
33778	Largo, Seminole, Ridgecrest	45.2
33781	Pinellas Park, Lealman	62.9
33782	Pinellas Park	51.2
33785	Indian Rocks Beach, Indian Shores	12.7
33786	Belleair Beach, Belleair Shore	9.9
34677	Oldsmar, East Lake	20.9
34681	Palm Harbor	20.4
34683	Palm Harbor, Dunedin	19.3
34684	Palm Harbor	23.8
34685	East Lake, Oldsmar	10.8
34688	Tarpon Springs, East Lake	8.6
34689	Tarpon Springs	47.3
34695	Safety Harbor	13.3
34698	Dunedin	39.4
-	<b>Pinellas county</b>	21.2

\*County index values are calculated separately from zip code index values, and the two should not be compared to each other. While index values range from 0-100 at both the county and zip code level, zip code index values represent the percentile of each zip code among all U.S. zip codes, while county index values represent the percentile of each county among all U.S. counties.

## Appendix B. Index of Disparity

### Food Insecurity Index (Figure 22)

ZIP CODE	CITY	INDEX VALUE
33701	Saint Petersburg	33.7
33702	Saint Petersburg	51
33703	Saint Petersburg	23.9
33704	Saint Petersburg	14.8
33705	Saint Petersburg	73.1
33706	Saint Petersburg	6.7
33707	Saint Petersburg, Gulfport, South Pasadena, Saint Pete Beach, Bear Creek	39.1
33708	Saint Petersburg, Madeira Beach, North Redington Beach, Redington Shore	17.3
33709	Saint Petersburg, Kenneth City, Pinellas Park, Seminole, Lealman	63.1
33710	Saint Petersburg	36.2
33711	Saint Petersburg, Gulfport	80.3
33712	Saint Petersburg	89.7
33713	Saint Petersburg	51.2
33714	Saint Petersburg, Pinellas Park, Lealman	81.6
33715	Saint Petersburg, Tierra Verde	0.7
33716	Saint Petersburg, Pinellas Park, Gandy	46
33755	Clearwater, Dunedin	81.9
33756	Clearwater, Belleair, Largo, Belleair Bluffs	69.4
33759	Clearwater	54.4
33760	Largo, Pinellas Park, Highpoint	68
33761	Clearwater, Safety Harbor	27.5
33762	Saint Petersburg, Feather Sound, Largo, Pinellas Park, Highpoint	13.9

33763	Clearwater, Dunedin	40.3
33764	Clearwater, Largo, Pinellas Park	48
33765	Clearwater	67.3
33767	Clearwater, Dunedin	1.9
33770	Largo, Belleair Bluffs, Harbor Bluffs	60
33771	Largo	67.5
33772	Seminole	38.5
33773	Largo, Pinellas Park	50
33774	Largo, Ridgecrest	39.6
33776	Seminole	12.6
33777	Seminole, Bardmoor, Pinellas Park	39
33778	Largo, Seminole, Ridgecrest	48.9
33781	Pinellas Park, Lealman	64.2
33782	Pinellas Park	49.2
33785	Indian Rocks Beach, Indian Shores	5.4
33786	Belleair Beach, Belleair Shore	2.5
34677	Oldsmar, East Lake	31.9
34681	Palm Harbor	18.3
34683	Palm Harbor, Dunedin	27.8
34684	Palm Harbor	35.9
34685	East Lake, Oldsmar	12.1
34688	Tarpon Springs, East Lake	8.3
34689	Tarpon Springs	37.3
34695	Safety Harbor	16.2
34698	Dunedin	40.4
	<b>PINELLAS COUNTY</b>	26.4

\*County index values are calculated separately from zip code index values, and the two should not be compared to each other. While index values range from 0-100 at both the county and zip code level, zip code index values represent the percentile of each zip code among all U.S. zip codes, while county index values represent the percentile of each county among all U.S. counties.

## Appendix B. Index of Disparity

### Mental Health Index (Figure 23)

ZIP CODE	CITY	INDEX VALUE
33701	Saint Petersburg	94
33702	Saint Petersburg	84.2
33703	Saint Petersburg	73.1
33704	Saint Petersburg	52
33705	Saint Petersburg	95.2
33706	Saint Petersburg	81.6
33707	Saint Petersburg, Gulfport, South Pasadena, Saint Pete Beach, Bear Creek	92.4
33708	Saint Petersburg, Madeira Beach, North Redington Beach, Redington Shore	81.6
33709	Saint Petersburg, Kenneth City, Pinellas Park, Seminole, Lealman	90.8
33710	Saint Petersburg	70.4
33711	Saint Petersburg, Gulfport	97
33712	Saint Petersburg	96.8
33713	Saint Petersburg	75.5
33714	Saint Petersburg, Pinellas Park, Lealman	91.7
33715	Saint Petersburg, Tierra Verde	70.2
33716	Saint Petersburg, Pinellas Park, Gandy	62
33755	Clearwater, Dunedin	92.9
33756	Clearwater, Belleair, Largo, Belleair Bluffs	95.4
33759	Clearwater	76.2
33760	Largo, Pinellas Park, Highpoint	72
33761	Clearwater, Safety Harbor	80.4
33762	Saint Petersburg, Feather Sound, Largo, Pinellas Park, Highpoint	49.5
33763	Clearwater, Dunedin	87.4

33764	Clearwater, Largo, Pinellas Park	82.1
33765	Clearwater	60.9
33767	Clearwater, Dunedin	81.4
33770	Largo, Belleair Bluffs, Harbor Bluffs	92.6
33771	Largo	94
33772	Seminole	84.4
33773	Largo, Pinellas Park	74.4
33774	Largo, Ridgecrest	91.6
33776	Seminole	56.5
33777	Seminole, Bardmoor, Pinellas Park	60.4
33778	Largo, Seminole, Ridgecrest	84.8
33781	Pinellas Park, Lealman	77.9
33782	Pinellas Park	85.3
33785	Indian Rocks Beach, Indian Shores	63.4
33786	Belleair Beach, Belleair Shore	64.1
34677	Oldsmar, East Lake	73.9
34683	Palm Harbor, Dunedin	64
34684	Palm Harbor	86.5
34685	East Lake, Oldsmar	50.2
34688	Tarpon Springs, East Lake	81.6
34689	Tarpon Springs	95
34695	Safety Harbor	69.4
34698	Dunedin	89.2
-	<b>PINELLAS COUNTY</b>	97.9

\*County index values are calculated separately from zip code index values, and the two should not be compared to each other. While index values range from 0-100 at both the county and zip code level, zip code index values represent the percentile of each zip code among all U.S. zip codes, while county index values represent the percentile of each county among all U.S. counties.

# Appendix C. Community Input Assessment Tools

## Community Health Survey



### 2022 All4HealthFL Community Health Survey

This community health survey is supported by the All4HealthFL Collaborative comprised of local not-for-profit hospitals and the departments of health in Hillsborough, Pasco, Pinellas, and Polk counties. Our goal is to understand the health needs of the community members we serve. Your feedback is important for us to implement programs that will benefit everyone in the community.

We encourage you to take 15 minutes to fill out the survey below. Survey results will be available and shared broadly in the community within the next year. The responses that you provide will remain anonymous and not be attributed to you personally in any way. Your participation in this survey is completely voluntary and greatly appreciated.

Thank you for your time and feedback. Together we can improve health outcomes for all.

If you have any questions or concerns regarding this survey, please contact Corinna Kelley by email at [corinna.kelley@conduent.com](mailto:corinna.kelley@conduent.com).



## DEMOGRAPHICS

Please answer a few questions about yourself so that we can see how different types of people feel about local health issues.

**1. In which county do you live? (Please choose only one)**

- Hillsborough       Pasco       Pinellas       Polk       Sarasota       Other

**2. In which ZIP code do you live? (Please write in)**

**3. What is your age? (Please choose only one)**

- 18 to 24     25 to 34     35 to 44     45 to 54     55 to 64     65 to 74     75 or older

**4. Are you of Hispanic or Latino origin or descent? (Please choose only one)**

- Yes, Hispanic or Latino       No, not Hispanic or Latino       Prefer not to answer

**5. Which race best describes you? (Please choose only one)**

- |  |  |
|--|--|
| <input type="checkbox"/> More than one race                  | <input type="checkbox"/> African American or Black |
| <input type="checkbox"/> American Indian or Alaska Native    | <input type="checkbox"/> Asian                     |
| <input type="checkbox"/> Native Hawaiian or Pacific Islander | <input type="checkbox"/> White                     |
| <input type="checkbox"/> I identify in another way: _____    | <input type="checkbox"/> Prefer not to answer      |

**6. What is your current gender identity? (Please choose only one)**

- |  |   |
|--|---|
| <input type="checkbox"/> Man   | <input type="checkbox"/> Trans Woman/ Trans Feminine Spectrum |
| <input type="checkbox"/> Woman   | <input type="checkbox"/> Non-Binary/ Genderqueer              |
| <input type="checkbox"/> Trans Man/Trans Masculine Spectrum                | <input type="checkbox"/> Prefer not to answer                 |
| <input type="checkbox"/> I identify in another way (Please Specify): _____ |   |

**7. Do you identify as LGBTQ+?**

- Yes                       No                       Prefer not to answer

**8. What language do you MAINLY speak at home? (Please choose only one)**

- |   |                                  |                                     |
|---|----------------------------------|-------------------------------------|
| <input type="checkbox"/> Arabic   | <input type="checkbox"/> Russian | <input type="checkbox"/> French     |
| <input type="checkbox"/> Haitian Creole                                   | <input type="checkbox"/> English | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Chinese  | <input type="checkbox"/> Spanish | <input type="checkbox"/> German     |
| <input type="checkbox"/> I speak another language (Please specify): _____ |                                  |                                     |

**9. How well do you speak English? (Please choose only one)**

- Very Well       Well       Not Well       Not at All

**10. What is the highest level of school that you have completed? (Please choose only one)**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Less than high school   | <input type="checkbox"/> Some high school, but no diploma                   | <input type="checkbox"/> High school diploma or GED |
| <input type="checkbox"/> Some college, no degree | <input type="checkbox"/> Vocational/Technical School                        | <input type="checkbox"/> Associate degree           |
| <input type="checkbox"/> Bachelor's degree       | <input type="checkbox"/> Master's/Graduate or professional degree or higher |   |

**11. How much total combined money did all people living in your home earn last year?**

**(Please choose only one)**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> \$0 to \$9,999       | <input type="checkbox"/> \$10,000 to \$19,999   | <input type="checkbox"/> \$20,000 to \$29,999   |
| <input type="checkbox"/> \$30,000 to \$39,999 | <input type="checkbox"/> \$40,000 to \$49,999   | <input type="checkbox"/> \$50,000 to \$59,999   |
| <input type="checkbox"/> \$60,000 to \$69,999 | <input type="checkbox"/> \$70,000 to \$79,000   | <input type="checkbox"/> \$80,000 to \$89,999   |
| <input type="checkbox"/> \$90,000 to \$99,999 | <input type="checkbox"/> \$100,000 to \$124,999 | <input type="checkbox"/> \$125,000 to \$149,999 |
| <input type="checkbox"/> \$150,000 or more    | <input type="checkbox"/> Prefer not to answer   |   |

**12. Which of the following categories best describes your employment status?**

**(Choose all that apply)**

- |   |  |
|---|--|
| <input type="checkbox"/> Employed, working full-time        | <input type="checkbox"/> Retired                             |
| <input type="checkbox"/> Employed, working part-time        | <input type="checkbox"/> Disabled, not able to work          |
| <input type="checkbox"/> Not employed, looking for work     | <input type="checkbox"/> Student (If so, what school: _____) |
| <input type="checkbox"/> Not employed, NOT looking for work |  |

**13. What transportation do you use most often to go places? (Please choose only one)**

- |   |  |
|---|--|
| <input type="checkbox"/> I drive a car                  | <input type="checkbox"/> Someone drives me   |
| <input type="checkbox"/> I take the bus                 | <input type="checkbox"/> I walk              |
| <input type="checkbox"/> I ride a bicycle               | <input type="checkbox"/> I take a taxi/cab   |
| <input type="checkbox"/> I ride a motorcycle or scooter | <input type="checkbox"/> I take an Uber/Lyft |
| <input type="checkbox"/> Some other way                 |  |

**14. Are you**

- |   |   |
|---|---|
| <input type="checkbox"/> A Veteran      | <input type="checkbox"/> National Guard/Reserves                        |
| <input type="checkbox"/> In Active Duty | <input type="checkbox"/> None of the above <b>(Skip to question 16)</b> |

**15. If Veteran, Active Duty, National Guard, or Reserves, are you receiving care at the VA?**

- Yes       No

**16. How do you pay for most of your health care? (Please choose only one)**

- |  |   |
|--|---|
| <input type="checkbox"/> I pay cash / I don't have insurance         | <input type="checkbox"/> TRICARE                  |
| <input type="checkbox"/> Medicare or Medicare HMO                    | <input type="checkbox"/> Indian Health Services   |
| <input type="checkbox"/> Medicaid or Medicaid HMO                    | <input type="checkbox"/> Veteran's Administration |
| <input type="checkbox"/> Marketplace insurance plan                  |   |
| <input type="checkbox"/> County health plan                          |   |
| <input type="checkbox"/> Commercial health insurance (from Employer) |   |
| <input type="checkbox"/> I pay another way: _____                    |   |

**17. Including yourself, how many people currently live in your home? (Please choose only one)**

- 1     2     3     4     5     6 or more

**18. Are you a caregiver to an adult family member who cannot care for themselves in your home?**

- Yes       No

**19. How many CHILDREN (under age 18) currently live in your home? (Please choose only one)**

- None **(Skip to question 28)**     1     2     3     4     5     6 or more

## CHILDRENS SECTION

**(Please only answer questions in this section if you have children under the age of 18 living in your home. If you do not, please skip to Question 28 in the next section.)**

The goal of the next question is to understand what you think are the most important HEALTH needs for children in your community. Please answer the next question about children who live in your community, not just your children.

20. Was there a time in the PAST 12 MONTHS when children in your home needed medical care but did NOT get the care they needed?

Yes       No **(skip to question 22)**

21. What are some reasons that kept them from getting the medical care they needed?  
(Choose all that apply)

- Am not sure how to find a doctor  
 Cannot take time off work  
 Cannot take child out of class  
 Doctor's office does not have convenient hours  
 Unable to schedule an appointment when needed  
 Unable to find a doctor who knows or understands my culture, identity, or beliefs  
 Unable to afford to pay for care  
 Unable to find a doctor who takes my insurance  
 Do not have insurance to cover medical  
 Transportation challenges  
 Other (please specify): \_\_\_\_\_

22. Was there a time in the PAST 12 MONTHS when children in your home needed dental care but did NOT get the care they needed?

Yes       No **(skip to question 24)**

23. What are some reasons that kept them from getting the dental care they needed?  
(Choose all that apply)

- Am not sure how to find a dentist  
 Cannot take time off work  
 Cannot take child out of class  
 Dentist's office does not have convenient hours  
 Unable to schedule an appointment when needed  
 Unable to find a dentist who knows or understands my culture, identity, or beliefs  
 Unable to afford to pay for care  
 Unable to find a dentist who takes my insurance  
 Do not have insurance to cover dental care  
 Transportation challenges  
 Other (please specify): \_\_\_\_\_

24. Was there a time in the PAST 12 MONTHS when children in your home needed mental and/or behavioral health care but did NOT get the care they needed?

Yes       No **(skip to question 26)**

**25. What are some reasons that kept them from getting the mental and/or behavioral health care they needed? (Choose all that apply)**

- Am not sure how to find a doctor/counselor
- Unable to afford to pay for care
- Unable to find a doctor / counselor who takes my insurance
- Cannot take time off work
- Do not have insurance to cover mental health care
- Cannot take child out of class
- Doctor/counselor's office does not have convenient hours
- Afraid of what people might think
- Unable to schedule an appointment when needed
- Transportation challenges
- Unable to find a doctor/counselor who knows or understands my culture, identity, or beliefs
- Other (please specify) \_\_\_\_\_

**--Children's Section Continues on Next Page --**



The goal of the next question (Question 26) is to understand what you think are the most important HEALTH needs for children in your community. Please answer the next question about children who live in your community, not just your children.

In this survey “community” refers to the primary areas where your children live, play, learn and get services.

26. When you think about the most important HEALTH needs for children in your community, please select the top 3 most important health needs to address. If you think of a health concern that is not listed here, please write it in under “other”. (Please choose only 3)

<b><u>Please choose only 3</u></b>	
<input type="checkbox"/>	Accidents and Injuries
<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Respiratory Health Other than Asthma (RSV, cystic fibrosis)
<input type="checkbox"/>	Dental Care
<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Drug or Alcohol Use
<input type="checkbox"/>	Eye Health (vision)
<input type="checkbox"/>	Healthy Pregnancies and Childbirth (not teen pregnancy)
<input type="checkbox"/>	Immunizations (common childhood vaccines, like mumps, measles, chicken pox, etc.)
<input type="checkbox"/>	Infectious Diseases (including COVID-19)
<input type="checkbox"/>	Special Needs (Physical / Chronic / Behavioral / Developmental / Emotional)
<input type="checkbox"/>	Medically Complex
<input type="checkbox"/>	Attention-Deficit/Hyperactivity Disorder (ADHD)
<input type="checkbox"/>	Mental or Behavioral Health
<input type="checkbox"/>	Healthy Food / Nutrition
<input type="checkbox"/>	Obesity
<input type="checkbox"/>	Physical activity
<input type="checkbox"/>	Safe Sex Practices and Teen Pregnancy
<input type="checkbox"/>	Sexual Identity of Child
<input type="checkbox"/>	Suicide Prevention
<input type="checkbox"/>	Vaping, Cigarette, Cigar, Cigarillo, or E-cigarette Use
<input type="checkbox"/>	Other (please specify concern):

The goal of the next question (Question 27) is to understand what you think are OTHER important needs or concerns that affect child health in your community. Please answer the next question about children who live in your community, not just your children.

27. When you think about OTHER important needs or concerns that affect child health in your community, please rank the top 3 critical needs or concerns most important to address. If you think of a concern that is not listed here, please write it under “other”. (Please choose only 3)

<b><u>Please choose only 3</u></b>	
<input type="checkbox"/>	Access to benefits (Medicaid, WIC, SNAP/Food Stamps)
<input type="checkbox"/>	Access to or cost of childcare
<input type="checkbox"/>	Bullying and other stressors in school
<input type="checkbox"/>	Domestic violence, child abuse and/or child neglect
<input type="checkbox"/>	Crime and community violence
<input type="checkbox"/>	Educational needs
<input type="checkbox"/>	Family member alcohol or drug use
<input type="checkbox"/>	Housing
<input type="checkbox"/>	Human trafficking
<input type="checkbox"/>	Hunger or access to healthy food
<input type="checkbox"/>	Lack of employment opportunities
<input type="checkbox"/>	Legal problems
<input type="checkbox"/>	Language Barriers
<input type="checkbox"/>	Parenting education (parenting skills for child development)
<input type="checkbox"/>	Safe neighborhoods and places for children to play
<input type="checkbox"/>	Social media
<input type="checkbox"/>	Traffic safety
<input type="checkbox"/>	Transportation challenges
<input type="checkbox"/>	Other (please specify concern):

--End Children's Section --

**These next questions are about your view or opinion of the community in which you live. In this survey “community” refers to the primary areas where you live, shop, play work, and get services**

**28. Overall, how would you rate the health of the community in which you live? (Please choose only one)**

- Very unhealthy    Unhealthy    Somewhat healthy    Healthy    Very healthy  
 Not sure

**29. Please read the list of risky behaviors listed below. Which 3 do you believe are the most harmful to the overall health of your community? (Please choose only 3)**

<b><u>Please choose only 3</u></b>	
<input type="checkbox"/>	Alcohol abuse/drinking too much alcohol (beer, wine, spirits, mixed drinks)
<input type="checkbox"/>	Dropping out of school
<input type="checkbox"/>	Illegal drug use/abuse or misuse of prescription medications
<input type="checkbox"/>	Lack of exercise
<input type="checkbox"/>	Poor eating habits
<input type="checkbox"/>	Not getting “shots” to prevent disease
<input type="checkbox"/>	Not wearing helmets
<input type="checkbox"/>	Not using seat belts/not using child safety seats
<input type="checkbox"/>	Vaping, Cigarette, Cigar, Cigarillo, or E-cigarette Use
<input type="checkbox"/>	Unsafe sex including not using birth control
<input type="checkbox"/>	Distracted driving (texting, eating, talking on the phone)
<input type="checkbox"/>	Not locking up guns
<input type="checkbox"/>	Not seeing a doctor while you are pregnant

30. Read the list of health problems and think about your community. Which of these do you believe are most important to address to improve the health of your community?  
(Please choose only 3)

<b><u>Please choose only 3</u></b>	
<input type="checkbox"/>	Aging Problems (for example: difficulty getting around, dementia, arthritis)
<input type="checkbox"/>	Cancers
<input type="checkbox"/>	Child Abuse / Neglect
<input type="checkbox"/>	Clean Environment / Air and Water Quality
<input type="checkbox"/>	Climate Change
<input type="checkbox"/>	Dental Problems
<input type="checkbox"/>	Diabetes / High Blood Sugar
<input type="checkbox"/>	Domestic Violence / Rape / Sexual Assault / Human Trafficking
<input type="checkbox"/>	Gun-Related Injuries
<input type="checkbox"/>	Being Overweight
<input type="checkbox"/>	Mental Health Problems Including Suicide
<input type="checkbox"/>	Illegal Drug Use/Abuse of Prescription Medications and Alcohol Abuse/Drinking Too Much
<input type="checkbox"/>	Heart Disease / Stroke / High Blood Pressure
<input type="checkbox"/>	HIV/AIDS / Sexually Transmitted Diseases (STDs)
<input type="checkbox"/>	Homicide
<input type="checkbox"/>	Infectious Diseases Like Hepatitis, TB, and COVID-19
<input type="checkbox"/>	Motor Vehicle Crash Injuries
<input type="checkbox"/>	Infant Death
<input type="checkbox"/>	Respiratory / Lung Disease
<input type="checkbox"/>	Teenage Pregnancy

31. Please read the list below. Which do you believe are the 3 most important factors to improve the quality of life in a community? (Please choose only 3)

<b><u>Please choose only 3</u></b>	
<input type="checkbox"/>	Good Place to Raise Children
<input type="checkbox"/>	Low Crime / Safe Neighborhoods
<input type="checkbox"/>	Good Schools
<input type="checkbox"/>	Access to Health Care
<input type="checkbox"/>	Parks and Recreation
<input type="checkbox"/>	Clean Environment / Air and Water Quality
<input type="checkbox"/>	Low-Cost Housing
<input type="checkbox"/>	Arts and Cultural Events
<input type="checkbox"/>	Low-Cost Health Insurance
<input type="checkbox"/>	Tolerance / Embracing Diversity
<input type="checkbox"/>	Good Jobs and Healthy Economy
<input type="checkbox"/>	Strong Family Life
<input type="checkbox"/>	Access to Low-Cost, Healthy Food
<input type="checkbox"/>	Healthy Behaviors and Lifestyles
<input type="checkbox"/>	Sidewalks / Walking Safety
<input type="checkbox"/>	Public Transportation
<input type="checkbox"/>	Religious or Spiritual Values
<input type="checkbox"/>	Disaster Preparedness
<input type="checkbox"/>	Emergency Medical Services
<input type="checkbox"/>	Access to Good Health Information
<input type="checkbox"/>	Strong Community/Community Knows and Supports Each Other

**32. Below are some statements about your local community. Please tell us if you agree or disagree with each statement.**

	Agree	Disagree	Not Sure
Illegal drug use/prescription medicine abuse is a problem in my community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have no problem getting the health care services I need.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
We have great parks and recreational facilities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Public transportation is easy to get to if I need it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are plenty of jobs available for those who want them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crime is a problem in my community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Air pollution is a problem in my community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel safe in my community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are affordable places to live in my community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The quality of health care is good in my community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are good sidewalks for walking safely.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am able to get healthy food easily.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**33. Below are some statements about your connections with the people in your life. Please tell us if you agree or disagree with each statement.**

	Agree	Disagree	Not Sure
I am happy with my friendships and relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have enough people I can ask for help at any time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My relationships and friendships are as satisfying as I would want them to be	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**34. Over the past 12 months, how often have you had thoughts that you would be better off dead or of hurting yourself in some way? (Please choose only one)**

- Not at all       Several days       More than half the days       Nearly every day

**If you would like help with or would like to talk about these issues, please call the National Suicide Prevention Hotline at 1-800-273-8255.**

35. **In the past 12 months, I worried about whether our food would run out before we got money to buy more. (Please choose only one)**  
 Often true     Sometimes true     Never true
36. **In the past 12 months, the food that we bought just did not last, and we did not have money to get more. (Please choose only one)**  
 Often true     Sometimes true     Never true
37. **In the last 12 months, did you or anyone living in your home ever get emergency food from a church, a food pantry, or a food bank, or eat in a soup kitchen?**  
 Yes     No
38. **Do you eat at least 5 cups of fruits or vegetables every day?**  
 Yes     No
39. **How many times a week do you usually do 30 minutes or more of moderate-intensity physical activity or walking that increases your heart rate or makes you breathe harder than normal? (Please choose only one)**  
 5 or more times a week     3-4 times a week     1-2 times a week     none
40. **Has there been any time in the past 2 years when you were living on the street, in a car, or in a temporary shelter?**  
 Yes     No
41. **Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay?**  
 Yes     No
42. **In the past 12 months, has your utility company shut off your service for not paying your bills?**  
 Yes     No

--Survey continues on next page --

## PERSONAL HEALTH

These next questions are about your personal health and your opinions about getting health care in your community. In this survey “community” refers to the primary areas where you live, shop, work, and get services.

- 43. Overall, how would you rate YOUR OWN PERSONAL health? (Please choose only one)**  
 Very unhealthy    Unhealthy    Somewhat healthy    Healthy    Very healthy  
 Not sure
- 44. Was there a time in the PAST 12 MONTHS when you needed medical care but did NOT get the care you needed?**  
 Yes    No **(Skip to question 46)**
- 45. What are some reasons that kept you from getting medical care? (Choose all that apply)**  
 Unable to schedule an appointment when needed    Am not sure how to find a doctor  
 Unable to find a doctor who takes my insurance    Unable to afford to pay for care  
 Doctor’s office does not have convenient hours    Transportation challenges  
 Do not have insurance to cover medical care    Cannot take time off work  
 Unable to find a doctor who knows or understands  
 Other (please specify) \_\_\_\_\_  
my culture, identity, or beliefs
- 46. Thinking about your MENTAL health, which includes stress, depression, and problems with emotions, how would you rate your overall mental health? (Please choose only one)**  
 Excellent    Very good    Good    Fair    Poor    Not Sure
- 47. Was there a time in the PAST 12 MONTHS when you needed mental health care but did NOT get the care you needed?**  
 Yes    No **(Skip to question 49)**
- 48. What are some reasons that kept you from getting mental health care? (Choose all that apply)**  
 Am not sure how to find a doctor / counselor  
 Unable to schedule an appointment when needed  
 Do not have insurance to cover mental health care  
 Unable to find a doctor / counselor who takes my insurance  
 Doctor / counselor office does not have convenient hours  
 Unable to find a doctor / counselor who knows or understands my culture, identity, or beliefs  
 Unable to afford to pay for care  
 Transportation challenges  
 Fear of family or community  
 Cannot take time off work  
 Other (please specify): \_\_\_\_\_
- 49. Was there a time in the PAST 12 MONTHS when you needed DENTAL care but did NOT get the care you needed?**  
 Yes    No **(Skip to question 51)**



**50. What are some reason(s) that kept you from getting dental care? (Choose all that apply)**

- Unable to schedule an appointment when needed
- Do not have insurance to cover dental care
- Dentist office does not have convenient hours
- Unable to find a dentist who takes my insurance
- Unable to find a dentist who knows or understands
- Am not sure how to find a dentist
- Unable to afford to pay for care
- Transportation challenges
- Cannot take time off work
- Other

\_\_\_\_\_  
my culture, identity, or beliefs

**51. In the past 12 months, how many times have you gone to a hospital emergency room (ER) about your own health? (Please choose only one)**

- 1time       2 times       3-4 times       5-9 times       10 or more times
- I have not gone to a hospital ER in the past 12 months **(Skip to question 53)**

**52. What are the MAIN reason(s) you used the emergency room INSTEAD of going to a doctor's office or clinic? (Choose all that apply)**

- After hours / Weekend
- Long wait for an appointment with my regular doctor
- Emergency / Life-threatening situation
- Other
- I don't have a doctor / clinic
- Cost
- I don't have insurance

**53. Have you ever been told by a doctor or other medical provider that you had any of the following health issues? (Choose all that apply)**

Cancer	<input type="checkbox"/>
Depression or Anxiety	<input type="checkbox"/>
Diabetes / High Blood Sugar	<input type="checkbox"/>
HIV / AIDS	<input type="checkbox"/>
COPD	<input type="checkbox"/>

Heart disease	<input type="checkbox"/>
High blood pressure / Hypertension	<input type="checkbox"/>
Obesity	<input type="checkbox"/>
Stroke	<input type="checkbox"/>
None of These	<input type="checkbox"/>

**54. How often do you use any of the following products: chewing tobacco, snuff, snus, dip, cigarettes, cigars or little cigars? (Please choose only one)**

- I do not use these products
- Once a day
- On some days
- More than once a day

**55. How often do you use any of the following electronic vapor products: e-cigarettes, e-cigars, e-hookahs, e-pipes, hookah pens, vape pipes, and vape pens? (Please choose only one)**

- I do not use these products
- Once a day
- On some days
- More than once a day

**56. Have you experienced any losses related to the COVID-19 pandemic? (Choose all that apply)**

- |  |  |
|--|--|
| <input type="checkbox"/> None                        | <input type="checkbox"/> Job (layoff, furlough, hours reduction) |
| <input type="checkbox"/> Income                      | <input type="checkbox"/> Housing                                 |
| <input type="checkbox"/> Health Insurance            | <input type="checkbox"/> Transportation                          |
| <input type="checkbox"/> Childcare                   | <input type="checkbox"/> Regular school routine                  |
| <input type="checkbox"/> Social support/connection   | <input type="checkbox"/> Sense of well-being, security, or hope  |
| <input type="checkbox"/> Recreation or entertainment | <input type="checkbox"/> Food Resources                          |
| <input type="checkbox"/> Exercise opportunities      | <input type="checkbox"/> Death of family member or friend        |
| <input type="checkbox"/> Utilities turned off        | <input type="checkbox"/> Other (please specify): _____           |

**57. In your day-to-day life how often have any of the following things happened to you?**

	At least once a week	A few times a month	A few times a year	Never
You are treated with less courtesy or respect than other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
You receive poorer service than other people at restaurants or stores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People act as if they think you are not smart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People act as if they are afraid of you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
You are threatened or harassed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
People criticized your accent or the way you speak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**58. What do you think is the main reason(s) for these experiences? (Choose all that apply)**

- |  |   |
|--|---|
| <input type="checkbox"/> Your Ancestry or National Origins             | <input type="checkbox"/> Your Gender                      |
| <input type="checkbox"/> Your Race                                     | <input type="checkbox"/> Your Age                         |
| <input type="checkbox"/> Your Religion                                 | <input type="checkbox"/> Your Height                      |
| <input type="checkbox"/> Your Weight                                   | <input type="checkbox"/> Your Sexual Orientation          |
| <input type="checkbox"/> Some other Aspect of Your Physical Appearance | <input type="checkbox"/> A physical disability            |
| <input type="checkbox"/> Your Education or Income Level                | <input type="checkbox"/> I have not had these experiences |

## ADVERSE CHILDHOOD EXPERIENCES

The final question is about ACEs, adverse childhood experiences, that happened during your childhood. This information will allow us to better understand how problems that may occur early in life can have a health impact later in life. This is a sensitive topic, and some people may feel uncomfortable with these questions. If you prefer not to answer these questions, you may skip them.

**For this question, please think back to the time BEFORE you were 18 years of age.**

**59. From the list of events below, please check the box next to events you experienced BEFORE the age of 18. (Choose all that apply)**

- Lived with anyone who was depressed, mentally ill, or suicidal
- Lived with anyone who was a problem drinker or alcoholic
- Lived with anyone who used illegal street drugs or who abused prescription medications
- Lived with anyone who served time or was sentenced to serve time in prison, jail, or other correctional facility
- Parents were separated or divorced
- Parents or adults experienced physical harm (slap, hit, kick, etc.)
- Parent or adult physically harmed you (slap, hit, kick, etc.)
- Parent or adult verbally harmed you (swear, insult, or put down)
- Adult or anyone at least 5 years older touched you sexually
- Adult or anyone at least 5 years older made you touch them sexually
- Adult or anyone at least 5 years older forced you to have sex

Thank you for taking the time to participate in this community survey. Your feedback and insight are vital as we work to improve and address issues impacting our community's health.

**--Helpful community resource information is provided on the next page --**

## RESOURCE LIST

Please find the list of community resources used for this Community Health Needs Assessment Survey.

### [FindHelp.org](#)

Search and connect to support. Financial assistance, food pantries, medical care, and other free or reduced-cost help starts here.

### [United Way 211](#)

Simply call 211 to speak to someone now, or search by location for online resources and more contact information.

### [National Suicide Prevention Lifeline](#)

The Lifeline provides 24/7, free and confidential support for people in distress and prevention and crisis resources for you or your loved ones.

1-800-273-8255

### [Crisis Text Line](#)

Crisis Text Line provides free, 24/7 support via text message. We're here for everything: anxiety, depression, suicide, school.

Text HOME to 741741

### [Hillsborough County](#)

Resources to Help You with Mental Health

### [Pasco County](#)

*National Alliance on Mental Illness, Pasco County*

NAMI Pasco, an affiliate of the National Alliance on Mental Illness is a 501(c)3 not-for-profit organization that provides free support, advocacy, outreach, and education to those with mental health conditions and their loved ones.

### [Pinellas County](#)

*National Alliance on Mental Illness, Pinellas County*

NAMI (National Alliance on Mental Illness) Pinellas supports individuals & loved ones affected by mental illness so that they can build better lives.

### [Polk County](#)

*Peace River Center*

Peace River Center's Mobile Crisis Response Team (MCRT) is a free 24-hour community resource available to anyone experiencing emotional distress.

The free 24-hour Crisis Line is (863) 519-3744 or (800) 627-5906.

### [Information on Adverse Childhood Experiences](#)

*PACEs Connection*

PACEs Connection is a social network that recognizes the impact of a wide variety of adverse childhood experiences (ACEs) in shaping adult behavior and health, and that promotes trauma-informed and resilience-building practices and policies in all families, organizations, systems and communities.

### [Recognizing and Treating Child Traumatic Stress](#)

Learn about the signs of traumatic stress, its impact on children, treatment options, and how families and caregivers can help.

### [TedTalk: How Childhood Trauma Affects Health Across a Lifetime](#)

Nadine Burke Harris reveals a little-understood, yet universal factor in childhood that can profoundly impact adult-onset disease

# Appendix C. Community Input Assessment Tools

## Focus Group Discussion Questions & Summary of Responses

### Community Engagement 4

### Black/African American



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**Real-Time Record**

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November 16, 2021, 2:00pm-3:30pm

## Table of Contents

Welcome .....3

Pinellas County Focus Group .....7

    Community Strengths & Assets .....7

    Identify Top Health Problems .....7

    Access to Health .....7

    Impact on Health .....8

Haitian Community Focus Group .....8

    Community Strengths & Assets .....8

    Identify Top Health Problems .....9

    Access to Health .....9

    Impact on Health .....10

Wrap-Up and Next Steps .....10

## Welcome



**All4HealthFL**  
Four Counties. One Vision.

### Community Engagement

November 16, 2021




Expert facilitators in strategic collaboration since 2004

**Your Collaborative Labs team**

**Tina Fischer** manager/facilitator  
**Karin Carlan** documenter  
**Andrea Henning** executive director/facilitator  
**Carrie Hepburn-Brown** facilitator  
**Marilyn Shaw** facilitator  
**PJ Petrick** technologist


**Facilitator, Collaborative Labs:** Welcome to the All4HealthFL community engagement this afternoon! St. Petersburg College Collaborative Labs is proud to be a partner today. Thank you for being here with us today.



### Process for today's community engagement

- Welcome: Why your voice matters
- Small focus groups to hear your perspective
- Report outs/Wrap-up

### Demographic Survey



Today, we will hear why your voice matters, break out into focus groups, and then hear reports from the groups and wrap up.

We also have a demographic survey we ask you to complete to tell us about yourself, which will be used later to understand diversity of the focus group. Everything is anonymous and there will be no names in the final report. Perspective of entire community.

Our Purpose:  
Improve health by leading regional, outcome-driven health initiatives that have been prioritized through community health assessments.

All4HealthFL Collaborative

Hello! Thank you for being here today. The purpose of the All4HealthFL Collaborative is to improve health by leading regional, outcome-driven health initiatives that have been prioritized through community health assessments. The All4HealthFL Collaborative includes all of the not-for-profit hospitals and the department of health for Hillsborough, Pasco, Pinellas, and Polk counties.

We are so pleased to have each and every one of you present and participating in these focus groups today. We value the unique perspectives and lived experiences you bring with you today. We'll be asking you for your thoughts, opinions, and experiences about the strengths of our community, the challenges or barriers that exist to accessing care and resources, and who in our community is most impacted by those challenges.

We have the opportunity to go deep today. Let's be caring, kind, and respectful today as we share with one another, acknowledging the courage and bravery it takes to share from our personal experiences. Know that your personal identity stays within this group and will not be



shared in any of our summary reports or information used to inform our efforts. Your overall feedback will help us create stronger programs and services to meet the needs of our community over the next three to four years.

Thank you again for participating with us today. We know your time is valuable and are grateful you have shared this day with us. Welcome!

We have a quick warm up activity to start with. What are some things you feel make a community healthy?




*Comments from Chat:*

- The feeling of being safe
- Time with people who are good for us
- Mental wellbeing and working together for the same outcome
- Access to free mental health services
- A healthy community needs access to health care
- Us come together
- Communities that are not food deserts.
- Arts and Culture
- Communication
- Access to healthcare
- Communication with one another
- Education pro-active healthcare
- Agreed. Communication.
- Food Banks
- Equitable access
- Opportunities
- Definitely the networking and communication of all the above
- Healthy workplace

- Having community outreach programs that continue to target the homeless and those not open to visiting hospitals
- Drug-free community

**Focus Group Topics**



- **Community Strengths and Assets**
- **Identify Top Health Problems**
- **Access to Health**
- **Impact on Health**

**Focus Groups will be organized by County**

These are our topics for today and we have four counties represented and a bonus Haitian community.

**Focus Group Process**



**Roles:**

- **Your Facilitator will ask questions and take notes**
- **Participants – YOU! 😊**

Please respond candidly to the prompts and share your stories. Individual names will not be included in the final report. Thank you for your engagement!

- **Brief Team Report Outs**

\*\*\* Focus Groups will be recorded \*\*\*

## Pinellas County Focus Group

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### Community Strengths & Assets

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#### What is something that you enjoy about your community or is a strength of your community?

- Togetherness (neighbor native), village concept (huge loss for youth), caring neighbors
- Walkable community, easy access to businesses
- Working with those dedicated to common goals
- Building homes (Habitat for Humanity) - adding value
- Access to healthcare facilities – beyond hospitals, clinics – developed in our community
- Tight-knit, good communication, willing to ask for help

#### *From Chat:*

- Growth in the city in itself
- The blue card is good but some of the services that are needed that the blue card does not provide

### Identify Top Health Problems

---

#### What do you see as the 2-3 most important issues that must be addressed to improve health and quality of life in your community?

- Limited healthcare services
- Housing – lack of availability; affordable housing, stressful process to find adequate housing and additional fees (1<sup>st</sup> and last deposit, application fee, background checks, etc.)
- Mental health services
- Alcohol and drug abuse assistance
- Awareness of need – accountability and follow-through, application
- Language and literacy barriers
- Economic development – things available for sustainability
- Infrastructure to sustain healthy lifestyle
- A need to reimagine how the community functions as its core

#### *From Chat:*

- Being in the hospital, some services that are needed as an outpatient are limited
- Continuing education on routine examinations
- Affordable housing
- Witnessed yesterday brown and black folks with language and literacy barriers
- There is a problem with compliance of individuals not following up with providers as instructed, even when things are set up and medications are provided prior to discharge along with education

### Access to Health

---

**Do you think everyone has access to what they need to be healthy?**

- Income – access to resources; greater or less access, lack of finances
- Self-advocacy and healthy lifestyle (preventative measures)
- Resources – availability of and utilization of programs and services
- Level of awareness
- Public and personal distrust
- Community buy-in

**From Chat:**

- Economic status plays a major role
- The resources are there but getting people to take part in the programs available is the barrier, now how do we go about getting the public to participate in the things is the problem

**Impact on Health****What external factors do you feel have an impact on your health, based on aspects of your identity?**

- Black man – fear of what may happen, judgement? Created stress – impacted jobs and clients pursued (did some personal work)
- Racism as a black woman – media, portrayal and what is happening to others; mental health is impacted; stigma associated with mental health
- Always trying to uphold the role of being a strong leader as a black women can be stressful
- Black man, parent of two children – provision of child support; stress of comparison and trying to prove self (“man, figure it out”), time consuming, low income, cycle of trying to make it
- Work environment and working conditions
- Cost of medication; having to prioritize food/medicine
- Adequate income sometimes limiting access to needed services; stressful

**From Chat:**

- Public and personal distrust and a lack of finances will lead many to stay away from seeking assistance regardless of if the help is there...
- Applaud Audrey for being her own self advocate
- We need more people that look like you to assist
- Always trying to uphold the role of being a strong leader as a black women can be stressful

**Haitian Community Focus Group****Community Strengths & Assets****What is something that you enjoy about your community or is a strength of your community?**

- (Two mentions) Resources: A lot of resources, not a lot of awareness of those resources and making sure people trust us when using those resources.
- Assets: People don't know where to find them and how to use them when they're struggling.
- Connection: We work with sister churches and work with one another to serve the community. People feel comfortable in the church.
- School resources: Resources are available even to online services, such as financial aid, mental health, and tutoring.

## Identify Top Health Problems

### What do you see as the 2-3 most important issues that must be addressed to improve health and quality of life in your community?

- (3 mentions) Suicide/mental health/wellbeing: especially among teens in high school/college, stress and anxiety that goes unaddressed, isolation. Not enough services for children transitioning from school to school (e.g., elementary to middle, middle to high).
- Chronic diseases: diabetes, cardiovascular disease, especially in the minority community.
- (2 mentions) Food insecurity: lots of food deserts, just liquor stores; need land to plant vegetables and raise animals, too many dollar stores
- Access to care: high cost of drugs, low access to pharmaceuticals
- Transportation: Roads are not safe to walk, no sidewalks in some areas, no crosswalks in others
- (2 mentions) Stigma – black men don't want to go to the doctor and be told something is wrong, there's a fear and a stigma, pride, "they don't tell me what I don't know. I don't want to know." Harder for men than for women.
- Physical well-being: lower stigma associated with going to the doctor
- (2 mentions) Trust: Tuskegee and other betrayals among black community, the pain of black men and women is not trusted by doctors or rated as truthful

## Access to Health

### Do you think everyone has access to what they need to be healthy?

- (2 mentions) Cost of care: people lack insurance, the cost of the care with or without insurance may be too much, providers should offer various options for payment even if they have insurance.
- (2 mentions) Knowledge/Access: People may not know how much the cost is or how to approach paying. People don't know if they will even see a doctor.
- Stigma: people don't know and don't want to ask how to get care
- Food: providers don't speak about health differently than people may understand.
- Quality of care: providers may work quantity over quality
- (2 mentions) Trust: people don't trust free clinics "They're gonna want something," will wait until they end up in the ER, "they see you for five seconds, don't like your insurance, and treat you differently."

- Whole person care: providers need to ask about things beyond your physical health: how to pay, if you need prayer, if you are doing okay, exercise, are you taking care of yourself

## Impact on Health

### What external factors do you feel have an impact on your health, based on aspects of your identity?

- (3 mentions) Culture: "We don't seek help, there is no mental health, we take care of this in the family." In Haitian culture, we have alternative treatments (e.g., herbal tea) we depend on before we go to the doctor.
- Delay of care: care is put off for chronic conditions and mental health until it is too late and not prevented.
- (3 mentions) Cost: only went to doctor if it was absolutely necessary because funds were tight, even with insurance, weighing the cost of the care with taking care of family, "I'd rather not pay hundreds of dollars to then be told to buy some pills." A lot of people are only paid monthly, so when the money goes short at the end of the month, you aren't thinking about going to the doctor, you never want your kids or your family to know you're broke. We didn't have notebooks, we had slate and scratched it off when we were done.
- Insurance: only those with full-time jobs and/or a college education have insurance
- Time of care: parents don't want kids to miss school
- Being female: there are things you are not taught that you should be taught as a woman
- (2 mentions) Dentistry: we used salt to brush our teeth because we didn't have toothpaste. I didn't go to dentist until my spouse forced me to, "Why would I pay someone to brush my teeth?"
- Knowledge: if we are not familiar with the language of health, then I'm afraid you're trying to trick me.
- Fear/stigma/(shame?): when you don't have care as a kid, you don't want to go to find out how bad it has become
- \*Copy comment about AdventHealth and collaborative for support and assistance, great quote to use for report (Grace comment at the end)

## Wrap-Up and Next Steps

Welcome back! We are now going to share some of the "golden nuggets" from each of the breakout groups.

### Team 3 – Pinellas County

Strengths: togetherness and caring of community members, working together on dedicated goals, service providers, and good communication

- Problems: housing, mental health services, awareness of need, literacy barriers, economic need, and infrastructure to support a healthy lifestyle
- Access to health: personal distrust, community buy-in and self-advocacy

- Impact: fear, judgement, comparison to others, stereotypes and expectations, incomes that do not allow you to qualify for needed services



Thank you all for your participation today and providing your stories. Your information will be collected into community health needs assessment. Have a wonderful day!

## Community Engagement 6 Hispanic



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**Real-Time Record**

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November 17, 2021, 2:00pm-3:30pm



*EXPERT FACILITATORS IN  
STRATEGIC COLLABORATION*



## Table of Contents

Welcome .....	3
Pinellas County Focus Group .....	7
Community Strengths & Assets .....	7
Identify Top Health Problems .....	7
Access to Health .....	8
Impact on Health .....	8
Impact on Health .....	9
Wrap-Up and Next Steps .....	9

## Welcome



**All4HealthFL**  
Four Counties. One Vision.

### Participación Comunitaria

17 de noviembre de 2021




**Collaborative LABS**  
Facilitadores expertos en colaboración estratégica desde 2004

**Su equipo de Collaborative Labs**

**Tina Fischer** manager/facilitator  
**Karin Carlan** documenter  
**Andrea Henning** executive director  
**Laurie Hill** branding & business development  
**PJ Petrick** technologist


**Facilitator, Collaborative Labs:** Welcome to the All4HealthFL community engagement. I am with Collaborative Labs at St. Petersburg College, and we are facilitating today's meeting. Thank you for joining us!



### El proceso de hoy para la participación comunitaria

- Bienvenidos: Por qué su voz es importante
- Grupos pequeños de discusión para escuchar su perspectiva
- Reportes / Resumen

### Encuesta demográfica



Today we will hear why your voice matters, break out into focus groups, and then hear reports from the groups and wrap up.

We also have a demographic survey we ask you to complete to tell us about yourself, which will be used later to understand diversity of the focus group. Everything is anonymous and there will be no names in the final report. Perspective of entire community.

Hello everyone, thank you for joining us today in this important conversation.

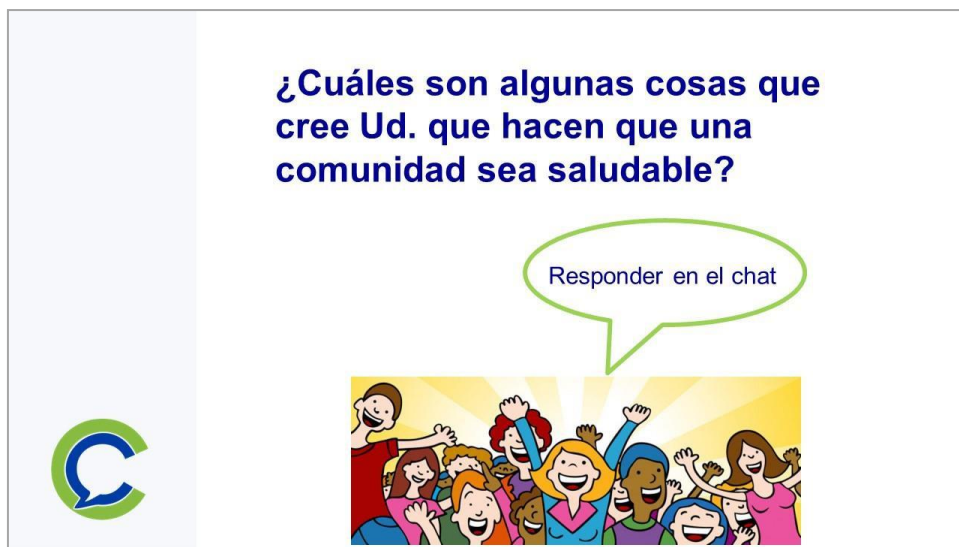
The purpose of the All4HealthFL Collaborative is to improve health by leading regional, outcome-driven health initiatives that have been prioritized through community health assessments. The All4HealthFL Collaborative includes all of the not-for-profit hospitals and the department of health for Hillsborough, Pasco, Pinellas, and Polk counties.

We are so pleased to have each and every one of you present and participating in these focus groups today. We value the unique perspectives and lived experiences you bring with you today. We'll be asking you for your thoughts, opinions, and experiences about the strengths of our community, the challenges or barriers that exist to accessing care and resources, and who in our community is most impacted by those challenges.

We have the opportunity to go deep today. Let's be caring, kind, and respectful today as we share with one another, acknowledging the courage and bravery it takes to share from our personal experiences. Know that your personal identity stays within this group and will not be shared in any of our summary reports or information used to inform our efforts. Your overall feedback will help us create stronger programs and services to meet the needs of our community over the next 3-4 years.

Thank you again for participating with us today. We know your time is valuable and are grateful you have shared this day with us.

We have a quick warm up activity to start with. What are some things you feel make a community healthy? Please respond in chat.




**From Chat:**


¿Cuáles son algunas cosas que cree Ud. que hacen que una comunidad sea saludable?

- Welcoming environment
- Education
- Access to health care
- Educacion
- Access to health care and education
- Amor, energia, solidaridad, humildad
- A united community
- Equal access to care and education on health
- Access to healthy foods
- Access to basic services gives
- Access to healthcare
- Services to be accessible
- Having a shared sense of community
- Fair and equal treatment
- Transportation services

- Seguridad, safety
- Transportation
- Que tengan acceso a salud mental, comida saludable, y acceso doctores que entiendan la comunidad
- Not being alone!
- Mental health
- Cultura - culture "la cultura cura"
- Access to health care and health plan to cover wellness programs and nutritionist professionals
- Education + Awareness + access to available resources
- Education, transportation, access to resources, parks and recreation, healthy foods
- Educacion de salud y alimentacion saludable
- Services in your own language
- Access to affordable care

<p><b>Temas de grupos de enfoque</b></p> 	<ul style="list-style-type: none"> <li>• <b>Fortalezas de la comunidad</b></li> <li>• <b>Identificar los problemas principales de salud</b></li> <li>• <b>Acceso a la salud</b></li> <li>• <b>Impacto en la salud</b></li> </ul> <p><b>Los grupos de enfoque están organizados por condado</b></p>
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These are our topics for today and we have four counties represented.

<p style="text-align: center;"><b>Proceso de grupos de enfoque</b></p> 	<p><b>Roles:</b></p> <ul style="list-style-type: none"> <li>• <b>Su facilitador hará preguntas</b></li> <li>• <b>Su escriba tomará notas</b></li> <li>• <b>Participantes – USTEDES 😊</b></li> </ul> <p style="color: #76923c;">Respondan con franqueza a las indicaciones y compartan sus historias.</p> <p style="color: #76923c;">Los nombres de las personas no se incluirán en el informe final.</p> <p style="color: #76923c;">¡Gracias por su compromiso!</p> <ul style="list-style-type: none"> <li>• <b>Reportes breves de cada equipo</b></li> </ul> <p style="color: #e69d00;">*** Los grupos de enfoque estarán grabados***</p>
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## Pinellas County Focus Group

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### Community Strengths & Assets

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**What is something that you enjoy about your community or is a strength of your community?**

- The number of parks and recreation available
- Sense of not feeling alone. Sense of community at a countywide level
- Pinellas schools, Health Department, County – information in both languages
- Internal diversity as LatinX community
- Change in food diversity and sense of culture
- TB Rays – diverse team, very involved within the community

**From Chat:**

- I enjoy the diversity of food and the community surrounding it

### Identify Top Health Problems

---

**What do you see as the 2-3 most important issues that must be addressed to improve health and quality of life in your community?**

- Health care system for the elderly is very fragmented. Information and services are very confusing. Not enough in Spanish.
- Hispanic community suffers from the same problems as the rest of the communities. Mental health is at the extreme.

- Too many expenses - don't take medications or follow up health care because of paying for other things. English speaking community has more access to entities that help them. There is a need for entities that help both.
- The information is very fragmented, especially for those that do not speak English as a primary language. I would add the stigma of talking about communicable diseases especially those sexually transmitted or related to drug use. Family is important to our community and if you can't speak to family, you can feel isolated.
- Latino patients wait a long time to get tested for HIV - drugs are too expensive.
- Hospice - patients come in telling everything that has happened to them through the process.
- Microaggressions - patients hear comments in the hospital that prevent the patient from pursuing medical care.
- Educate providers from first responders to doctors.
- Immunizations and physical exams for children in school - because of COVID and families who have recently moved to the area, they don't know the requirements, and the children will not be able to get into school.

## Access to Health

### Do you think everyone has access to what they need to be healthy?

- No, there is a PCP crisis, health insurance under the Affordable Care Act has a high premium.
- I can tell you that some clients would rather make the effort to speak English than ask for a Spanish speaking provider or translator. They may feel they are not going to get the same attention as their English-speaking counterparts. Their whole demeanor changes when I speak to them in Spanish, and they feel they are going to get the attention that others get.
- Diabetes programs are not enough
- Access challenges when medical diagnosis is made early.
- Access in Spanish is not enough
- Housing assistance - have to fill out a form that is confusing English and Spanish; difficult to fill out.
- Lack of cultural access
- Medicaid correspondence is difficult to understand
- Language is obsolete in medical media
- Lack of trust in government agencies and police - there should be assistance in locations away from these two agencies

## Impact on Health

### What external factors do you feel have an impact on your health, based on aspects of your identity?

- Last administration president - there was a lot of conversation about public charge policy to obtain citizenship or residency - because of the immigration process, Hispanics are afraid to even go to the pharmacy to pick up medicine.
- Hospice - not having citizenship or residency impacted how much Hispanics sought help.

- Sense of family unity - society in general sees the family unit as the immediate family. Family unit that includes everyone equally - in-laws, grandchildren, etc.
- Schools - provider for grandchildren, they are not recognized.
- Alzheimer's Society - want to help. Few Hispanics know these organizations exist.
- No positive or negative stereotypes limit access to medical care.
- Patient does not always have family members nearby
- Not all Latino families are large.
- Economic status
- Large majority of the Hispanic community works in the hospitality field
- Having work schedules that offer time to be able to get to medical appointments
- Feeling of responsibility
- Discrimination and/or prejudice - sense that the person is illegal. They are refused services.

## Impact on Health

### What external factors do you feel have an impact on your health, based on aspects of your identity?

- Appearance can lead to different treatment of individuals regardless of education and wealth – can deter accessing healthcare services or asking for services
- Racist undertones even among Hispanics based on country of origin – social status/educational background – another barrier to access services
- Fear perception also provides barrier to access.

## Wrap-Up and Next Steps

Welcome back! We are now going to share some of the “golden nuggets” from each of the breakout groups.

### Team 3 – Pinellas County

We talked about fear in the Latinx community that prevents accessing healthcare, language access and understanding the technical terms, cultural humility, and the fragmentation in the system that prevents community access.





Thank you all for your participation today. Your information will be collected into community health needs assessment. Have a wonderful day!

## Community Engagement 3 Kids Population (All Counties)



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**Real-Time Record**

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November 16, 2021, 9:00am-10:30am



*EXPERT FACILITATORS IN  
STRATEGIC COLLABORATION*

## Table of Contents

Welcome .....	3
Pinellas County Focus Group .....	7
Community Strengths & Assets .....	7
Identify Top Health Problems .....	7
Access to Health .....	8
Impact on Health .....	8
Wrap-Up and Next Steps .....	8

## Welcome



**All4HealthFL**  
Four Counties. One Vision.

**Community Engagement**

November 16, 2021




**Collaborative LABS**  
Expert facilitators in strategic collaboration since 2004

**Your Collaborative Labs team**

- Tina Fischer** manager/facilitator
- Karin Carlan** documenter/facilitator
- Andrea Henning** executive director/facilitator
- Marilyn Shaw** facilitator
- PJ Petrick** technologist

**Facilitator, Collaborative Labs:** Good morning, it is good to see you today! Collaborative Labs is proud to support the All4Health Collaborative. Thank you for being with us.




**All4HealthFL**  
Four Counties. One Vision.

**Process for today's community engagement**

- Welcome: Why your voice matters
- Small focus groups to hear your perspective
- Report outs/Wrap-up

**Demographic Survey**



Today, we will hear why your voice matters, break out into focus groups, and then hear reports from the groups and wrap up.

We also have a demographic survey we ask you to complete to tell us about yourself, which will be used later to understand diversity of the focus group. Everything is anonymous and there will be no names in the final report.

Good morning, everyone! Thank you for being here this morning. The purpose of the All4HealthFL Collaborative is to improve health by leading regional, outcome-driven health initiatives that have been prioritized through community health assessments. The All4HealthFL Collaborative includes all of the not-for-profit hospitals and the department of health for Hillsborough, Pasco, Pinellas, and Polk counties.

We are so pleased to have each and every one of you present and participating in these focus groups today. We value the unique perspectives and lived experiences you bring with you today. We'll be asking you for your thoughts, opinions, and experiences about the strengths of our community, the challenges or barriers that exist to accessing care and resources, and who in our community is most impacted by those challenges.

We have the opportunity to go deep today. Let's be caring, kind, and respectful today as we share with one another, acknowledging the courage and bravery it takes to share from our personal experiences. Know that your personal identity stays within this group and will not be shared in any of our summary reports or information used to inform our efforts. Your overall feedback will help us create stronger programs and services to meet the needs of our community over the next 3-4 years.

Thank you again for participating with us today. We know your time is valuable and are grateful you have shared this day with us.

You are representing the four counties today and we are thankful for your help. We have a quick warm up activity to start with. What are some things you feel make a community healthy?




**From Chat:**

- Inclusiveness
- Support system
- Community connectedness
- Wellness efforts addressing the whole person
- Access to services
- Holistic care
- Support system - neighborhood
- Supportive relationships
- Sense of belonging
- Access to resources
- Teamwork, cultural competency
- Clean environments
- Proper nutrition
- Support for youth
- Green space, safety
- Access to proper care

- Caring individuals
- Safety
- Supportive Services
- Support and safety
- Strong families
- Safe spaces to ask questions and have discussions
- Safe, stable, nurturing parents and caregivers
- Inclusive supports
- Equality and equity
- Social support

**Focus Group Topics**



- **Community Strengths and Assets**
- **Identify Top Health Problems**
- **Access to Health**
- **Impact on Health**

**Focus Groups will be organized by County**

These are our topics for today and we have four counties represented; All4Health represents the four counties.

**Focus Group Process**



**Roles:**

- **Your Facilitator will ask questions and take notes**
- **Participants – YOU! 😊**

Please respond candidly to the prompts and share your stories. Individual names will not be included in the final report. Thank you for your engagement!

- **Brief Team Report Outs**

\*\*\* Focus Groups will be recorded \*\*\*

*Tina reviewed the breakout process and participants moved into breakout groups by county for discussions and feedback.*

## Pinellas County Focus Group

### Community Strengths & Assets

#### What is something that you enjoy about your community or is a strength of your community?

- Availability and accessibility of resources
- Resource rich – Pinellas has a lot of programs and services to support a child's development and support families, personal support system
- Partnerships with rec centers and the school system

#### *From Chat:*

- I like the availability of resources; I feel that they are accessible
- That there are many partnerships that utilize rec centers and other community locations that make things accessible to families. At the school district, we have many before, during, and after school activities

### Identify Top Health Problems

#### What do you see as the 2-3 most important issues that must be addressed to improve health and quality of life in your community?

- Mental health – behavior issues, trauma, results of Covid. Providers learning to manage behaviors and fill the gap.
- Middle and high school kids (mental health) – transportation issues, not enough counselors for number of kids
- Teens (mental health) - access to providers to learn more and be better trained about mental health – it is a general pediatric problem, provide more resources
- Substance abuse
- Eating disorders
- Access to quality early learning (early childcare, 0-3 years) that is affordable and accessible (transportation and enrollment)
- Covid has brought more awareness of mental health issues
- Housing: in St. Petersburg, lack affordability of housing causes displacement, which results in lack of continuity in child's life
- Safety: gunshots and murders/violence a part of everyday life, which causes stress on young people's mind. Safety in school is also an issue.
- Child abuse and domestic violence cases up
- Kids need to be taught tools to about how to deal with emotions and talk openly about and normalize mental health (fear around stigma, expense)
- School is limited about how they present mental health presentations, not having the "right" people to present material

#### *From Chat:*

- Mental health
- Eating disorders
- I agree with the mental health



- Mental Health, substance abuse,
- Assistance with access to care
- Housing, education, mental health
- Safety
- Broad lens
- Child abuse and domestic violence cases are up as well.
- Have we considered asking our Youth how they believe it could be presented?
- It's difficult in a town hall for people even adults to ask questions

## Access to Health

### Do you think everyone has access to what they need to be healthy?

- On the providers' side, there are insurance barriers – Medicare/Medicaid, there is less training or appropriate training for issues; private pay list has “better” providers – in mental health and eating disorders (167% increase)
- Affordability, access to transportation, trust factor/relationship building needs to happen
- Inadequate sleep affects children's health
- Dealing with racism, cultural competency
- Healthy food: access to good quality food everyone has (St. Pete)
- In the Hispanic community, supplement with food that families are accustomed to culturally
- In the Hispanic community, there are language barriers to getting care and services

### From Chat:

- Food deserts are an issue...good point.

## Impact on Health

### What external factors do you feel have an impact on your health, based on aspects of your identity?

- As person born in Caribbean, racism is high on the list. People are uncomfortable talking about it and appearance dictates treatment of a person, which causes anxiety. Roots of it need to be addressed.
- Gender/gender identity, women paid less in male-based institutions – children experiencing the same issues with different tools
- Racism is a public health crisis. There is a lot of racism in Pinellas County. Lack of affordable housing has displaced the black community that impacts the quality of life. Address racism as a community. White doctors ignore patients based on color of skin and biases. Kids feel the pressure of race.
- Education is a huge issue. Inequity in the quality of education based on zip code and location of school.
- Jobs/lack of jobs; higher arrest rates without same level of legal defense makes it harder to put food on the table for a family

## Wrap-Up and Next Steps

Welcome back! We are now going to share some of the “golden nuggets” from each of the breakout groups.

### Team 3 – Pinellas County

Strengths: the community is resource-rich with a lot of programs and services and partnerships

- Problems: mental health – providers need to learn to manage behaviors, providers need to be better trained and accessible, and kids need to be taught how to deal with emotions, and normalize mental health, access to quality early learning and childcare that is affordable
- Access to health: there are insurance barriers that affect the quality of care, access to good quality food, language barriers in the Hispanic community make it difficult to get care and services and they give up
- Impact: racism is a public health crisis in Pinellas County, the lack of affordable housing leads to displacement that impacts quality of life, doctors ignore patients based on biases, the quality of education based on location, gender, lack of jobs.
- elled “hypochondriacs”)



Thank you all for your participation today. Your information will be confidential and provided to our vendor to do some data analysis to make changes in our communities. Have a wonderful day!

## Community Engagement 2 LGBTQ+



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**Real-Time Record**

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November 15, 2021, 2:00pm-3:30pm



*EXPERT FACILITATORS IN  
STRATEGIC COLLABORATION*

## Table of Contents

Welcome .....	3
Pinellas County Focus Group .....	7
Community Strengths & Assets .....	7
Identify Top Health Problems .....	7
Access to Health .....	7
Impact on Health .....	8
Wrap-Up and Next Steps .....	8

## Welcome



**All4HealthFL**  
Four Counties. One Vision.

### Community Engagement

November 15, 2021




Expert facilitators in strategic collaboration since 2004

**Your Collaborative Labs team**

**Tina Fischer** manager/facilitator  
**Karin Carlan** documenter/facilitator  
**Andrea Henning** executive director/facilitator  
**Laurie Hill** branding & business development/  
 facilitator  
**PJ Petrick** technologist


**Facilitator, Collaborative Labs:** Welcome everyone, we are happy to have you on our call today. Thank you for joining us!



### Process for today's community engagement

- Welcome: Why your voice matters
- Small focus groups to hear your perspective
- Report outs/Wrap-up

### Demographic Survey



Today, we will hear why your voice matters, break out into focus groups, and then hear reports from the groups and wrap up.

We also have a demographic survey we ask you to complete to tell us about yourself, which will be used later to understand diversity of the focus group. Everything is anonymous and there will be no names in the final report.

Our Purpose:  
Improve health by leading regional, outcome-driven health initiatives that have been prioritized through community health assessments.

All4HealthFL Collaborative

Good afternoon, thank you for joining us today. I wanted to share the purpose of today and why we asked you to be here.

The purpose of the All4HealthFL Collaborative is to improve health by leading regional, outcome-driven health initiatives that have been prioritized through community health assessments. The All4HealthFL Collaborative includes all of the not-for-profit hospitals and the department of health for Hillsborough, Pasco, Pinellas, and Polk counties.

We are so pleased to have each and every one of you present and participating in these focus groups today. We value the unique perspectives and lived experiences you bring with you today. We'll be asking you for your thoughts, opinions, and experiences about the strengths of our community, the challenges or barriers that exist to accessing care and resources, and who in our community is most impacted by those challenges.

We have the opportunity to go deep today. Let's be caring, kind, and respectful today as we share with one another, acknowledging the courage and bravery it takes to share from our personal experiences. Know that your personal identity stays within this group and will not be shared in any of our summary reports or information used to inform our efforts. Your overall feedback will help us create stronger programs and services to meet the needs of our community over the next 3-4 years.

Thank you again for participating with us today. We know your time is valuable and are grateful you have shared this day with us.


We have a quick warm up activity to start with. What are some things you feel make a community healthy?



***From Chat:***

What are some things you feel make a community healthy?

- Improved education and access to resources
- Accessibility to care
- Access to fresh food
- Diversity
- Diversity and inclusion
- Inclusivity
- Equity in healthcare
- Access to quality education, safety, transportation, physical health, and healthcare
- Equity in resources and equity in access to those resources

<p><b>Focus Group Topics</b></p> 	<ul style="list-style-type: none"><li>• <b>Community Strengths and Assets</b></li><li>• <b>Identify Top Health Problems</b></li><li>• <b>Access to Health</b></li><li>• <b>Impact on Health</b></li></ul> <p><b>Focus Groups will be organized by County</b></p>
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These are our topics for today and we have four counties represented.

<p><b>Focus Group Process</b></p> 	<p><b>Roles:</b></p> <ul style="list-style-type: none"><li>• <b>Your Facilitator will ask questions and take notes</b></li><li>• <b>Participants – YOU! 😊</b></li></ul> <p style="text-align: center;">Please respond candidly to the prompts and share your stories. Individual names will not be included in the final report. Thank you for your engagement!</p> <ul style="list-style-type: none"><li>• <b>Brief Team Report Outs</b></li></ul> <p style="text-align: center;">*** Focus Groups will be recorded ***</p>
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## Pinellas County Focus Group

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### Community Strengths & Assets

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#### What is something that you enjoy about your community or is a strength of your community?

- Local businesses, St. Pete is a unique home; supportive, helpful, outreach as an identity; family
- Visibility, pride of living in the city and an open environment, lot to take advantage of in the area for quality of life
- Desire to do good, quality of life
- Overlapping of the circles of community, connectedness, and willingness to include others
- Facebook groups help with local events and organizations and streamline info

### Identify Top Health Problems

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#### What do you see as the 2-3 most important issues that must be addressed to improve health and quality of life in your community?

- Accuracy of info – get it out, repeat the info, direct it to the community, build trust
- Let the communities know about resources, screenings
- Mental health access and affordability – make it easier to get healthcare, especially when you are dealing with symptoms; the in LGBTQ+ community has higher rates of mental health issues and housing issues
- Equity and access - focus on local and personal – a lot of people don't have access
- Equal protection under the law
- To improve quality of life, you have to connect the personal stories to the data

#### *From Chat:*

- Equity and Access
- Accurate information, meeting communities where they are so they can tap into that access
- Mental health access and affordability
- Affordable housing
- Equal protection under the law

### Access to Health

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#### Do you think everyone has access to what they need to be healthy?

- Money, jobs – not having a career job to afford insurance
- Location
- Health literacy basics, selecting a health care plan is confusing – reeducation on being a healthy individual
- Finding a doctor who is familiar with trans care; healthcare providers do not know how to serve the LGBTQ+ community

- Trans patients not feeling comfortable seeking healthcare
- Financially - affording good food, transportation to healthcare, and jobs that allow you to schedule appointments
- Kinds of access is determined by your community
- Childcare

***From Chat:***

- I'm trying to think of anything other than "money" and I really can't...
- Childcare; I'm so lucky I don't have children

**Impact on Health****What external factors do you feel have an impact on your health, based on aspects of your identity?**

- Political climate/societal factors - 94% negatively impacted with the way we are talking about LGBTQ issues; people are exhausted about talking about issues and it has an impact on health
- People that are not accepting of LGBTQ lifestyle can impact lives and health
- Gatekeepers/decision-makers – people with power and responsibility not being part of the planning, connecting, and creating the solution
- Covid – high number of LGBTQ being in the service industry – more insecurity in jobs

**Wrap-Up and Next Steps**

Welcome back! We are now going to share some of the “golden nuggets” from each of the breakout groups.

**Team 3 – Pinellas County**

- Strengths: community is supportive, helpful, visible, desires to do good, and provides a good quality of life
- Challenges: accuracy of health information, mental health access and affordability, connecting the personal stories to the data
- Access: money and jobs that provide health plans, healthcare literacy and understanding options, finding doctors that are familiar with trans care and issues around it
- Impacts: political and societal factors that result in exhaustion and mental toll of dealing with issues related to being LGBTQ, decision makers and gatekeepers having power and responsibility that are not part of the planning and connecting to those who are making the solutions.



Thank you all for your participation today. Your information will be collected into community health needs assessment and have a great impact. Have a wonderful day!

# Community Engagement 1 Older Adult Population



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**Real-Time Record**

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November 15, 2021, 9:00am-10:30am



*EXPERT FACILITATORS IN  
STRATEGIC COLLABORATION*

## Table of Contents

Welcome .....	3
Pinellas County Focus Group .....	6
Community Strengths & Assets .....	6
Identify Top Health Problems .....	7
Access to Health .....	8
Impact on Health .....	8
Wrap-Up and Next Steps .....	10

## Welcome



**All4HealthFL**  
Four Counties. One Vision.

### Community Engagement

November 15, 2021




Expert facilitators in strategic collaboration since 2004

**Your Collaborative Labs team**

**Tina Fischer** manager/facilitator  
**Karin Carlan** documenter/facilitator  
**Andrea Henning** executive director/facilitator  
**Carrie Hepburn-Brown** facilitator  
**PJ Petrick** technologist

**Facilitator, Collaborative Labs:** Good morning and thank you for spending part of your morning with us!




**All4HealthFL**  
Four Counties. One Vision.

### Process for today's community engagement

- Welcome: Why your voice matters
- Small focus groups to hear your perspective
- Report outs/Wrap-up

### Demographic Survey



Today we will hear why your voice matters, break out into focus groups, and then hear reports from the groups and wrap up.

We also have a demographic survey we ask you to complete to tell us about yourself, which will be used later to understand diversity of the focus group. Everything is anonymous and there will be no names in the final report.



We are happy you are here today. We are one of the partners with All4HealthFL Collaborative. There are a number of focus groups happening this week. As you can see, there are a number of organizations you probably recognize behind this initiative.

The purpose of the All4HealthFL Collaborative is to improve health by leading regional, outcome-driven health initiatives that have been prioritized through community health assessments. The All4HealthFL Collaborative includes all of the not-for-profit hospitals and the department of health for Hillsborough, Pasco, Pinellas, and Polk counties.

We are so pleased to have each and every one of you present and participating in these focus groups today. We value the unique perspectives and lived experiences you bring with you today. We'll be asking you for your thoughts, opinions, and experiences about the strengths of our community, the challenges or barriers that exist to accessing care and resources, and who in our community is most impacted by those challenges.

We have the opportunity to go deep today. Let's be caring, kind, and respectful today as we share with one another, acknowledging the courage and bravery it takes to share from our personal experiences. Know that your personal identity stays within this group and will not be shared in any of our summary reports or information used to inform our efforts. Your overall feedback will help us create stronger programs and services to meet the needs of our community over the next 3-4 years.

Thank you again for participating with us today. We know your time is valuable and are grateful you have shared this day with us.


You are representing the four counties today and we are thankful for your help. We have a quick warm up activity to start with. What are some things you feel make a community healthy?

**From Chat:**

What are some things you feel make a community healthy?

- Access to good food
- Service providers working together
- Access to health care needs
- Paying attention to the needs of the community, providing bike paths, parks, exercise areas, etc.
- Low mortality rate, low morbidity rate
- Well-informed collaborators
- Access to affordable health care and addiction services
- Access to basic life necessities food, shelter, employment, etc.
- Partnership between community organizations
- The ability to provide suggestions without fear of animosity. In other words, respectful communication.
- Ease to access healthcare
- Access to transportation
- I agree with service providers/organizations working TOGETHER.
- Outdoor-green space for recreational activities
- Affordable transportation
- Good mental health
- Getting to know neighbors and welcoming people who are not from this area
- Affordable housing
- Knowing the community resources available to meet people needs.
- Recycling efforts
- Access to mental health services
- Mental health
- Obesity
- Mental health



<p><b>Focus Group Topics</b></p> 	<ul style="list-style-type: none"> <li>• <b>Community Strengths and Assets</b></li> <li>• <b>Identify Top Health Problems</b></li> <li>• <b>Access to Health</b></li> <li>• <b>Impact on Health</b></li> </ul> <p style="text-align: center;"><b>Focus Groups will be organized by County</b></p>
--	---

These are our topics for today and we have four counties represented.

<p><b>Focus Group Process</b></p> 	<p><b>Roles:</b></p> <ul style="list-style-type: none"> <li>• <b>Your Facilitator will ask questions and take notes</b></li> <li>• <b>Participants – YOU! 😊</b></li> </ul> <p style="text-align: center; color: #76b82a;">Please respond candidly to the prompts and share your stories. Individual names will not be included in the final report. Thank you for your engagement!</p> <ul style="list-style-type: none"> <li>• <b>Brief Team Report Outs</b></li> </ul> <p style="text-align: center; color: #e67e22;">*** Focus Groups will be recorded ***</p>
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## Pinellas County Focus Group

### Community Strengths & Assets

**What is something that you enjoy about your community or is a strength of your community?**

- Nice people in community who care for people
- Community feeling, diversity, small town feel, neighbors

- Medical care

***From Chat:***

- I like the multiple transportation systems available. It is generally easy to get around.
- I like the diversity.
- Small town feel, many community events that bring people together
- As a senior citizen, I am most pleased with the services provided to us in this area of Florida. I grew up here and have really enjoyed seeing the direction our community has traveled.
- We enjoy the neighbor and are friendly with our neighbors. Locally a lot of activities to use.
- Close knit Greek community
- Seminole has grown in the last 20 years in an orderly fashion.
- It seems the medical community is attracting excellent practitioners.
- A lot of activities for all ages.
- Excellent medical facilities locally. Caring doctors.
- Weather!

## Identify Top Health Problems

**What do you see as the 2-3 most important issues that must be addressed to improve health and quality of life in your community?**

- Young people should work to pay taxes and support infrastructure
- Affordability of healthcare
- Infrastructure issues
- Housing costs
- Access to mental services – combine physical and mental healthcare for a better level of service at a lower cost
- The healthcare system is difficult to work in and it is hard to find out how to get help in the community – there is no budget for getting into the community and informing citizens
- Having continuous healthcare, for example, the high cost of COBRA makes it too expensive to have healthcare during a job change or loss. Make healthcare easier and affordable.

***From Chat:***

- Affordability of healthcare.
- Some infrastructural issues, public utilities and some continued drainage issues. Hard to address.
- Mental health clinics easy access, affordable healthcare
- Housing costs (understanding it seems to be a national issue).
- Getting information to homebound clients
- Problem - increased traffic
- Quicker and better access to mental health services
- Lack of information needs to be publicized, public presentations at community gatherings; get into the many mobile home places.
- Problem - increased cost of food and gas

- I would like to see the RAM concept (Remote Area Medicine) in Pinellas. I would like to see the integration of mental health care and primary care. Integration here is the key concept.
- Affordable help with activities of daily living for people with dementia and their caregivers

## Access to Health

---

### **Do you think everyone has access to what they need to be healthy?**

- Remote area medicine (RAM) – ability to get healthcare when they need it; it is not always due to geographic distance
- Appointments are difficult to get to

#### ***From Chat:***

- Sometimes the challenge is trying to get an appointment. If you are referred out, you might have to wait up to 6 weeks for an appointment
- There is no way to learn of all services in the community; people do not understand where to go for help.
- The issues are, of course, how to pay for expansion and so forth. I believe it is a very complicated issue.
- I think that some people don't have the access to transportation, appointments are hard to get

## Impact on Health

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### **What external factors do you feel have an impact on your health, based on aspects of your identity?**

- Being older, there is lessened communication with others, family may be in another state, and we are losing friends and people looking out for you. Isolation.
- Stereotyping of older people based on physical appearance
- Fixed income vs. increasing costs of healthcare
- Lack of education about healthcare - seniors may be technologically behind or have access to internet, publication of local newspapers has been cut back to two times/week (online the other days)

**From Chat:**

- I am careful to make sure that health care professionals take into account age when I get medical care. Mostly they do. But not always.
- I feel that, as I get older, "some" professionals and staff seem to feel my cognitive abilities are declined at the same rate as my physical abilities. This stereotype, along with so many others (race, disability, etc.), are ingrained but can be helped with training. By and large, staff want to be helpful and aren't aware of these biases.
- Continuing inflation makes it very difficult to find care many cannot afford & do not know where to go for assistance.
- I suspect there is an issue with the lack of public information for many of these problems.
- We know that a biopsychosocial approach is important generally in medical care. This is even more true with older adults. However, I have yet to have medical professionals ask me about "social" part of biopsychosocial assessments. The "psychological" part is very cursory.
- Need multiple ways to relay information to the public, more community events to inform.
- We feel lucky, as our primary asks all those questions at each annual visit that is longer than a regular follow-up visit.
- I will say my PCP has asked me about how I spend free time in retirement.
- James' comments are 100% correct!
- Need more focus on nutrition and healthy cooking to maintain health, i.e., cooking demo, etc.
- Lack of education; the cultural people come from is very different than just "landing" in a new community - many cannot cope with such a drastic change & hesitate to find out about such things as Senior Centers, etc.
- It seems a bit as though, if you are not technologically trained, you are at a great disadvantage in finding information. I believe there needs to be more focus in public areas (local television and radio), with these bits of information.
- An example - the *Tampa Bay Times* no longer covers this subject; it is only published 2x a week now; technology is impossible - cannot afford a computer & know where to take lessons, etc.
- The lack of local newspapers is a great disadvantage.
- Public libraries used to be more used, as well.
- Not sure how Spectrum and/or Comcast can help here, but they used to have channels with "community bulletin board info"
- Consider expanding the school system and SPC adult side to provide the classes free or at a lower cost.
- Many folks I meet do have a radio - but there is no publication as to where programs are on.

## Wrap-Up and Next Steps

Welcome back! We are now going to share some of the “golden nuggets” from each of the breakout groups.

### Team 3 – Pinellas County

- Strengths: small town/neighborhood feel, with caring people and diversity
- Problems: affordability and accessibility of healthcare, need to combine physical and mental healthcare for a better level of service
- Access to health: remote area medicine (RAM) – the ability to get healthcare when needed, appointments are difficult to get to
- Impact: lessened communication with and support from friends and family, and lack of education about healthcare – seniors may be technologically behind or have limited access to the Internet



Thank you all for your participation today. Your information will be collected into community health needs assessment. Have a wonderful day!

## Appendix C. Community Input Assessment Tools Prioritization Session Attendees

Pinellas County prioritization session was conducted on April 19, 2022, 77 individuals were in attendance from the organizations listed in the table below. These organizations played a pivotal role in providing feedback on significant health needs identified within the data analysis, developing preliminary ideas on ways to collaborate to address needs, and prioritizing community health needs for the next three years. The list of participating organizations and discussion feedback can be viewed in this appendix.

Participating Organizations	
Feeding Tampa Bay	Judeo Christian Health Clinic
AdventHealth Carrollwood	Metro Inclusive Health
AdventHealth Tampa	Moffitt Cancer Center
American Cancer Society	Northside Behavioral Health Center
Bartow Regional Medical Center	OASIS Opportunities
BayCare Health System	RGA Advisory
BayCare Home Care, Inc	Tampa Bay Thrives
CARD USF	Tampa Fire Rescue
Central Florida Behavioral Health Network	Tampa General Hospital
Children's Board of Hillsborough County	The Family Healthcare Foundation
Cove Behavioral Health, Inc	The Salvation Army Tampa Area Command
Dawning Family Services	The Skills Center
Florida Department of Health-Hillsborough	Transcare\Crisis Center of Tampa Bay
Gulfcoast North AHEC	UF IFAS Extension-EFNEP
Hillsborough County	UF/IFAS Extension Hillsborough County
Hillsborough County Government	University Area CDC
Hillsborough County Public Schools	Urban League of Hillsborough County
Hispanic Services Council	Ybor Youth Clinic
IDEA Public Schools	IDEA Public Schools

# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

### Access to Health Services

#### Breakout Room #1 Access to Health Services

##### **Breakout 1, Part 1: Discuss significant health needs identified within the data analysis and feedback gathered from the community**

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDoH?

- 33712 and surrounding areas has many concerns for poverty
- 33709 high for every category to include the need for food access which falls within the Feeding Pinellas
- 69% do not have affordable places to live and that are moving into homelessness, including high amount of seniors
- There has not been a huge change since 2013 census maps (within the last 15 years): housing, employment, etc.
- There is major concern for backward sliding for homelessness within the area
- 41% say mental health is a pressing health issue. There are access issues to include insurance
- High percentages of the population using the ER with nonemergent needs
- What percent of the ER visits have cost-share, which often encourage ER as a path to coverage?

##### **Breakout 1, Part 2: Gather Community Input especially from public health experts and vulnerable populations**

- 1) **What social determinants are impacting this health issue?**
  - Affordability and availability of appointments; long wait times for appointments
  - Environment availability: childcare, transportation, and taking off work are huge barriers
  - Cognitive barriers: they are avoiding healthcare until they are extremely ill
  - Mental and behavioral health are the base for many of the issues mentioned
- 2) **From your perspective, what has caused this to improve/worsen/remain the same?**
  - Pandemic has increased childcare issues
  - Telehealth services have helped access for some
  - Maintaining Medicaid through pandemic efforts
  - Housing has become worse which was associated with mental health
  - Food insecurity has been a rising concern for many
  - Anxiety and depression have caused more grinding and breaking with teeth, as people are not seeking help as much
- 3) **What efforts have you experienced that are working and how?**
  - Nonprofits are working together to provide resources for the community to connect community members to have an easier navigation of services.
  - Increase collaboration between mental health providers and decreasing unnecessary competition.
  - Creating a clear entry to those within the community that everyone can and will access
  - Decreasing wait times for mental health services

# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

- Increased telehealth services from all levels to increase tools to expand access
- 4) **From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?**
- Non-organization specific tool to help build data to help community members better flow through the various health services
  - Increase communication to address different languages and technology skills to access information and services
  - More qualified navigators/advocates to help those in crisis
  - Increase more resources to single residents (compared to family assistance)
  - In person access and understanding to Medicaid is lacking or nonexistent
  - Communication for Medicaid is lacking and lengthy
  - Note: Include more homelessness data on placemats

### **Breakout 2: Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs**

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- Maintaining communication about access to refer participants/patients to other needed services
- All services are integrated and having a walk-in place to have navigators to gain accesses to services, like the empowerment centers
- Having a better understanding of how to find access to food, which can help with the exercise, nutrition, and weight.
- Addressing fear and the lack of communication skills by having a layout of what to expect within their appointment.
- Increase behavior change marketing within Pinellas County to approach individuals and systems
- Continue efforts around decreasing the stigma related to mental health and food insecurity services.

### **Breakout Room #2 Access to Health Services**

#### **Breakout 1, Part 1: Discuss significant health needs identified within the data analysis and feedback gathered from the community**

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDoH?

- Reports on discrimination- micro aggression, multiple populations- people may be afraid to experience the discrimination
- High level stated they are not treated with the same courtesy as others
- Feelings of mistrust with the health system
- Increase of depression in the Medicare population
- AA and black population low for in need of mental health- surprising
- Stigmatism
- Technology is barrier

#### **Breakout 1, Part 2: Gather Community Input especially from public health experts and vulnerable populations**



# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

- 1) What social determinants are impacting this health issue?
  - Digital Gap – not have accessing to internet, or technology
  - Lack of health insurance – decreasing coverage among minorities
  - Providing more options to access the care- space a work potentially, accessing care
  - Health literacy – navigating the health system, impacts their ability to understand what providers saying/medication information are - Knowing how to discuss issues w/providers and feeling empowered to do so
  - learning how to be comfortable with the uncomfortable.
- 2) From your perspective, what has caused this to improve/worsen/remain the same?
  - Flexibility in the employment setting - in recent times has improved, remote able positions, but some other jobs are not able to offer this
  - Increasing access to care- local, and state level – goes hand and hand with employment / remained the same
  - Economic factor – cost/inflation, ability to live in Pinellas and afford care – worsen- has put pressure on other factors/insurance
- 3) What efforts have you experienced that are working and how?
  - Covid has increased our technology, can improve / Telehealth
  - Labor market, job choice and benefits
  - Addition of clinics in retail space (CVS, Walgreens, etc.) – COVID vaccines for example
  - Coordinated care- positions who help navigate the system (patient navigator, case manager)
  - Pop up sites are also a positive feature such as covid testing/vaccinations, health screenings at public events, etc.
- 4) From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
  - **Increasing coordinated care, and cultural competency (easy to understand documents, etc.)**
  - **Community representation on the provider side- helps to bridge the gap**

### ***Breakout 2: Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs***

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- Broaden scope – bring into police departments, parks & rec, etc.- not just health systems with other health systems, etc. –also on a political level (state, and local level) – multiple level advocacy
- Increase outreach- target high level organizations (large employers, faith-based organizations, schools, etc.), branch information network
- Look at how the 3 topics intersect – what high level organizations can work together for these to connect
- Utilizing our front level workers- what are people communicating them as concerns
- Increased education- organizational or capacity building – increased training, having open conversations on hard topics in a safe environment

# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

### Behavioral Health (Mental Health and Substance Misuse)

#### Breakout Room #3. Behavioral Health (Mental Health and Substance Misuse)

##### **Breakout 1, Part 1: Discuss significant health needs identified within the data analysis and feedback gathered from the community**

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDOH?

- Lack of economic opportunity
- Lack of prevention education in the community
- Access issues: hours of service, inability to take time off work
- ACE's data: parent separation, problems with drinking
- Zip Codes of high need were not surprising

##### **Breakout 1, Part 2: Gather Community Input especially from public health experts and vulnerable populations**

- 1) What social determinants are impacting this health issue?
  - Social isolation and loneliness
  - Large retirement community and many people coming to Pinellas to “escape” without support
  - Veterans/family- lack of resources for families of Veterans leading to generational trauma, Vet Center has eligibility requirements for treatment, Blue Star Families trying to get data of Veteran population living in Pinellas, Women Vets do not have resources leading to homelessness due to not addressing MST, Women of Color have different experiences due to intersectionality and compounding identities (disproportionately homeless, MST), lack of cultural competence in the VA leads to lack of trust (Women Veterans have 50% more suicides than nonwomen Veterans. MST is the main driver)
- 2) From your perspective, what has caused this to improve/worsen/remain the same?
  - Policy/lack of policy, leadership
  - Lack of understanding of concepts like SDOH, health equity
  - COVID-19 measures: initially more people turning to unhealthy coping skills; provided more awareness of these issues (policy has yet to follow, and resources are needed due to provider shortages)
  - Veteran/military population: high rates of suicide ideation, inability to get access to care, more stressors during COVID-19, homeless Veteran disbursement is \$700
  - Economic concerns: cost of housing, affordability, homelessness leading to more stressors
  - Increase in First Responder suicide rates
- 3) What efforts have you experienced that are working and how?
  - St. Pete Free Clinic: all policies and practices governed by trauma informed approach, leads to higher patient satisfaction with 20% increase (more dignified, respected form of treatment)
  - Trauma Informed Care and Mental Health First Aid programs in the community
  - Pinellas Hope: housing shelter, respite program

# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

- Drug Court Outcomes: justice system has improved their policy for drug court, 988, Veteran Treatment Court (partnership with the VA for substance use disorder treatment, but gaps in treatment for families of Vets), crisis intervention team for mental health (coordination with police)
- 4) From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
  - Justice/Legal System: decriminalization of substance use disorder and utilizing public health approach to treat these health issues
  - Improving the Workforce/Employer family friendly and health policies, Foster Care System, More Peer-to-Peer support
  - Addressing the technology divide and negative outcomes

### Key Takeaways:

**Importance of addressing mental health using an intersectional lens, especially in the Veteran population but more specifically Veterans families that lack access.**

**Trauma informed care proves effective, and decriminalization of substance use disorder by utilizing public health framework to treat these health issues.**

**Breakout 2: Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs**

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- Access to Health & Social Services
  - More flexible hours aside from 8-5
  - Get ALIGNED on Social Health Access Referral Processes and platforms. How can EHR/EMR integrate better with Community Health, non-profit, and government supports to be aware of gaps & effective programs?
  - Technological advances/telemedicine from the pandemic need to be sustained and built upon how we can better provide medical appointments virtually and for folks who can't access for 8-5 hours
  - Better education for healthcare providers on sickle cell
  - Knowledge/navigation: people largely unaware of available resources, mailings to people moving into the community regarding community resources
- Behavioral Health (Mental and Substance Abuse)
- Exercise, Nutrition, & Weight
  - Food insecurity deeply tied into nutrition and impacts future generations' poor health outcomes
- General Ideas/Population-specific:
  - Veterans and their families: we must be intentional in creating federal, state, county, public organization collaborative efforts to address behavioral health, substance use disorder, access to health/social services
  - More collaboration with Faith-based organizations
  - Sickle Cell: unsure which category it belongs in but has wide ranging effects (mental health, & creates health disparities)
  - All4Health dashboard doesn't include families of Veterans

# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

### Breakout Room # 4 Behavioral Health (Mental Health & Substance Misuse)

#### **Breakout 1, Part 1: Discuss significant health needs identified within the data analysis and feedback gathered from the community**

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the **SDoH**?

- Behavioral Health
  - Individuals turned away due to lack of available services / providers
  - Strongly related to medical health & care plan compliance
  - Strong correlation between substance abuse and mental health
  - Need for legislation to allow counselors to bill Medicare
- Barriers to Access
  - Time off work, cost, transportation, availability of appointment are barriers across all types of health
- Adverse Childhood Experience (ACE)
  - High scores as a community
  - Impact on health, especially behavioral health, and continuum of care
- Discrimination
  - Impact on EDI practices, acts as a barrier
  - “Why would I seek care if I think I’m going to be discriminated against?”
- Social Determinants of Health
  - We deal with health downstream when it should be upstream
  - Found the “More than one race” correlation very interesting
- Food insecurity
  - Illness is strongly related to diet

#### **Breakout 1, Part 2: Gather Community Input especially from public health experts and vulnerable populations**

1. What social determinants are impacting this health issue?
  - Cultural differences
    - How different cultures view mental health / different opinions
  - Destigmatizing access
    - Substance use is equally stigmatized
  - Money / economic stability
    - Job, income & insurance status are linked
    - Care needs to be affordable
    - Money is first spent on necessities, and mental health is secondary
  - Affordable housing
    - Rent is increasing in Pinellas County
2. From your perspective, what has caused this to improve/worsen/remains the same?
  - COVID-19 has worsened mental health
    - COVID raised awareness, increased demand, same lack of providers
  - Telehealth
    - Internet access can still be a barrier
3. What efforts have you experienced that are working and how?
  - St. Anthony Nurse/St. Pete Police PATH (Police Assisting the Homeless) Program
    - Helps keep people out of ER

## Appendix C. Community Input Assessment Tools

### Prioritization Session Questions and Summary of Responses

- Police department social work team
  - Repeat engagement are worked with to connect with individuals for mental health
- 4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
  - Destigmatizing
    - Public services announcements help raise awareness and lower stigma
  - Public/Private collaboration
    - Working across counties and systems to provide patient centered care

#### ***Breakout 2: Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs***

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- Access to Health & Social Services
  - [Pinellas County Coordinated Access Model](#)
    - Primarily behavioral health, but also connects to social services
    - Call number, case manager connects you to provider / appointment (1.5+ years out)
  - [Family Services Initiative](#)
    - Helps connect individuals and families to social services
- Behavioral Health (Mental Health & Substance Abuse)
  - [You Good Campaign](#)
    - Behavioral health campaign improves access to mental health services
- Exercise, Nutrition & Weight
  - [Family Nutrition at UF/IFAS](#)
    - Using SNAP dollars best, cooking, gardening, and other classes
- General
  - Collaboration update meetings to discuss and learn what different organizations are doing

# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

### Cancer

#### Breakout Room # 5. Cancer

##### **Breakout 1, Part 1: Discuss significant health needs identified within the data analysis and feedback gathered from the community**

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDoH?

- 69% of respondents said that they can't afford somewhere to live. If you don't have a safe, secure housing situation, it is challenging to focus on other areas of health.
- Transportation jumped out – we can schedule appointments, etc., but if a person can't get to and from where they need to go, they can't access the care they need. Transportation issues lead to medical non-compliance.
- 67% of respondents had full time jobs but they still struggled with accessing housing/ transportation.
- Transportation is a major issue – good infrastructure is not available (takes a long time to get anywhere, many can't afford Uber). Care providers in medical field schedules cater to those who can get a day off work (providers only offer appointments from 9-5)
- 53% of those who responded had a master's/bachelor's degree. The survey respondents are from populations that experiences much less barriers. For other community members it would be even more profound.
  - “We may just be seeing the tip of the iceberg”
  - Regarding the respondent population having more education -- A lot of times the barrier in navigating social services is in literacy (e.g., knowing how to access different services). People get overwhelmed completing applications, turning in documents, having the necessary documents. We have educated individuals experiencing these barriers according to the survey, but among populations with less education the issue is likely even bigger.
    - There is no repository that holds information to help people get to where they need for help.
- Use of ER. The ERs don't charge if individual doesn't have the funds. The problem with ER utilization is that takes resources away from emergency needs. Education on how access to non-emergency care is key.
  - This issue extends to the barriers posed by limited doctor's office hours. For those who experiences challenges in being able to take time of work – the ER is open 24/7, making it more accessible.

##### **Breakout 1, Part 2: Gather Community Input especially from public health experts and vulnerable populations**

- 1) What social determinants are impacting this health issue?
  - Florida did not expand Medicaid. Adults 18+ fall through the cracks. When it comes to cancer diagnoses – they may experience delays getting care. When they go in, the cancer is more advanced. If after diagnosis, the time it takes to get benefits is often unbelievable—increase delays in care.
  - Because of COVID-19, people were staying in and not getting diagnosed/treatment out of fear of catching the virus.

## Appendix C. Community Input Assessment Tools

### Prioritization Session Questions and Summary of Responses

- Cultural competency. Doctors treat individuals differently and don't alter care needs depending on the risks of specific populations, using a one-size-fits all approach.
  - On high melanoma rates -- Getting an appointment with a dermatologist is not easy. The capacity of dermatologists is limited. If someone is on Medicaid or uninsured, getting in and having to self-pay or find a specialist that accepts Medicaid is difficult. For HPV, getting vaccination rates up is important
    - Increasing vaccination rates among male adolescents is key.
- 2) From your perspective, what has caused this to improve/worsen/remain the same?
- COVID-19/pandemic has exacerbated barriers to access to care. There was already limited capacity, and with social distancing, limited numbers allowed in waiting rooms, etc., it has become worse.
  - From a transportation perspective -- older people have a hard time getting around. That can contribute to the rise in cancer. People can't get to the doctor or get the care they need, and as a result they may be getting diagnoses when it's too late.
  - When looking at the needs of the underserved, particularly regarding the transportation and housing issues, we need to make efforts to meet people where they are. As health care providers, we often expect individuals to come to us, but how do we go into the community (so community members don't have to travel). Healthcare should be more available to the underserved communities in this way.
  - Hospitals are still restricting visitors. People may be reticent to go to the hospital knowing their family members cannot visit.
- 3) What efforts have you experienced that are working and how?
- Education, including community meetings not in the hospital, that talk about these issues can help.
    - Getting into the schools to provide education can help. Have community gardens to encourage healthy behaviors, etc.
  - There is a need for a common information site. It is difficult to understand what your solutions are unless you have one place to go to be understand which resources are available.
- 4) From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
- Access. We don't have reliable, convenient transportation. Non-profits that provide transportation assistance could provide rides to healthcare to improve access.
  - Testing and screening for everyone.
  - A place to go to know how to access care – for example, a one-stop website to know where you can get a mammogram, for example.
  - Incentives for testing (like the blood bus providing gift cards).
  - Breaking down siloes across the non-profits. FindHelp.Org provides a hub for community-based resources.
  - Communicating at a literacy level everyone can understand and engage with.

#### ***Breakout 2: Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs***

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- The resources are out there. Community based orgs need to find a focus -- a concise focus in what they excel at (e.g., nutrition security). If we support each other collectively/collaboratively, it will increase our bandwidth. We need to think less competitively.

# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

- Salvation Army – worked with 211 in this area. We need to know which specialty each agency/provider has and how to better collaborate with each other and find the touch points. 211 has connections with many agencies. People may not know to call 211 for a listing of agencies to meet their needs.
- On the county level, each department is siloed. It is a struggle to work across departments/agencies.
- Need to work together better!
  - Agencies want to keep their identify, but we need to increase partnering w/ other orgs.
  - The more we invest into meeting people where they are at, the more successful we will be. We need to work with faith-based orgs that are trusted, services outside of the clinical setting (barbers, for example).

### Breakout Room # 6. Cancer

#### **Breakout 1, Part 1: Discuss significant health needs identified within the data analysis and feedback gathered from the community**

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDoH?

Income, financial means to access to health care

- Access to health care-work schedules
- Discrimination experiences
- Data informed with “covid lens”
- Rental costs-housing affordability, skyrocketed since survey
- Anxiety-mental health stress the last 3 years
- Access to food-5 food deserts in Pinellas, not much has changed since the last survey, why? Need better plan
- Surprised about the lack of dental care as a health concern-infection
- Vision and hearing also lack of care
- We have work to do-health equity is huge!

#### **Breakout 1, Part 2: Gather Community Input especially from public health experts and vulnerable populations**

1. What social determinants are impacting this health issue?
  - Based on Race- have a higher Cancer death rate
  - Smoking and Lung Cancer
  - Male death rate significantly higher
  - Food access- 3 servings daily-fruits and vegetables
  - 19% smokers (older people smoking?)
  - Is prostate an age cancer?
  - Are these older people cancers?
  - Behavior is a key factor
  - Need prevention data-see what’s working?
  - Florida Health Chart viewed (late stage)
2. From your perspective, what has caused this to improve/worsen/remain the same?
  - Screening for cancers (smoking)
  - Early screenings for breast cancer have been very successful
  - Cultural competency



## Appendix C. Community Input Assessment Tools

### Prioritization Session Questions and Summary of Responses

- Healthcare navigation to screening and someone helps you along the way to navigate through the process
- Create a path to prevention
- 3. What efforts have you experienced that are working and how?
  - Mobile screening for intervention
  - Healthcare navigator to screening
- 4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
  - Free access to quality medical care
  - Access for all
  - Rethink qualifications to access care
  - Make it the norm in school that there is community access to care
  - Advocate the health care system-start education early in life
  - More education for cancer screening
  - How can we provide more resources for bilingual

#### ***Breakout 2: Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs***

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- **Access to Care**
- Push for more accessible hours for employees who have insurance.
- Make changes in our own organizations
- General funds for social service safety nets for constituents
- Find out how to navigate access
- Medicaid expansion-show data on how it will provide relief for the community
- Individuals access for medical records-education for continued care
- Universal release form for medical records
- Overcome barriers to access for medical records (fatigue from having to fill out forms repeatedly)
- **Mental Health**
- Help navigate services-long wait times, after hours services
- Finding appropriate care
- Exercise, Nutrition, Weight

# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

### Exercise, Nutrition, and Weight

#### Breakout Room # 7. Exercise, Nutrition, and Weight

##### **Breakout 1, Part 1: Discuss significant health needs identified within the data analysis and feedback gathered from the community**

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDoH?

- Access to Health Care- Use of the word “lack of trust” among most all the groups. What is perceived as a ‘lack of trust” with health providers? Would like to know more.
- Access to Health Care- Many parents bring children to school without immunizations because they do not trust the health care system. They fear that there may be something in the immunization that they are not being made aware of that may cause more trouble to child.
- Access to Health Care- We, as a hospital system, could be creating a sense of distress through our own physical nature as a hospitalist system.
- Access to Health Care- Comments about not being able to access appointments- think there may be a lack of understanding about how to get to that point of care rather than the care not being available.
- Access to Health Care- Suggestion that the Health Department explain to community why children need immunization shots and the Covid vaccine but should be explained in terms that lay people can understand and not in medical, scientific terms.
- Access to Health Care- Sometimes people need someone to help walk them through getting the access to care and meeting people where they are.
- Access to Health Care- barriers may include transportation, lack of internet access, substance abuse or mental health issues can cause a struggle to even get out of bed, individuals who are homeless may not be able to get to where they need to get the care or may have a fear of it.
- Looking at the indicators of all the categories, it shows we may not be getting better over time so it poses the question, are we making an impact and if not, how can we pivot to improve? Is it pandemic related, a sign of the times, or a call to action to keep doing what we are doing to try to improve?
- Some responses to the above questions were education, pandemic, and many things going on in the lives of the community members.

##### **Breakout 1, Part 2: Gather Community Input especially from public health experts and vulnerable populations**

- 1) What social determinants are impacting this health issue?
  - Parents are working crazy hours and are afraid to miss work (mainly due to pandemic) and are working so much that they may not have time or access to exercise or eat healthy.
  - Lack of transportation
  - Noticed that food insecurity was mainly among young adult population (18-24 yr.).
  - Pinellas has a great park infrastructure but doesn’t have a means to get people to access these.
  - How do we get people to use the infrastructure that is already in place?
  - Trust factor is involved because if people do not feel safe in their neighborhoods and parks

## Appendix C. Community Input Assessment Tools

### Prioritization Session Questions and Summary of Responses

then there will always be an issue using these facilities.

- 2) From your perspective, what has caused this to improve/worsen/remain the same?
  - Stress of jobs/ children.
  - Depression- reduced energy and emotional eating of non-nutritious foods.
  - Single parents may put children's nutrition priorities over their own and then they eat what is left available.
  - Financial stress
  - Increased use of food pantries, even among individuals who have never had to do this before.
  
- 3) What efforts have you experienced that are working and how?
  - Triathlon partnership with schools is working. St. Anthony's identifies kids to participate in their triathlon. Need to increase this intervention.
  - Screenings at hospital level to provide nutrition bags for patients at discharge at St. Anthony's is working but need to increase the scale of the programs.
  - When programs are focused on the family unit (parents and children) work best.
  - Nutrition/weight loss programs that can be qualified through insurance is also helpful.
  
- 4) From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
  - Need more collaboration across organizations to increase access to programs.
  - Need a program for parents with Medicaid, that are like the programs offered for the children, so that the parents can participate with their children.

#### ***Breakout 2: Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs***

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- **Access to Health-**
  - Health Navigators going door to door using iPads to record and provide information. Help individuals to access the information and get them connected to the resources they need.
- **Behavioral Health/Mental Health/Substance Misuse-**
  - Monthly Pinellas County Behavioral System of Care meeting that includes partners from different areas (not just behavioral health providers). Need to look at who we are inviting and can expand this. Take information from meeting into community and go out into community to advocate funding and increase capacity in services.
  - Need more convening meetings across different agencies/systems to conversate about what's available and how to coordinate.
- **Exercise, Nutrition, Weight-**
  - Modeling parents getting involved with kids for programs (i.e., walking clubs).
  - "Walking school bus program"- parents get together and walk kids to school.
  - Ideal goal is for this to be the norm so that others will want to join in.
  - Not separating out health needs in convening meetings but talk about health in general since these all typically intersect.

# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

### Breakout Room # 8. Exercise, Nutrition, and Weight

#### **Breakout 1, Part 1: Discuss significant health needs identified within the data analysis and feedback gathered from the community**

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDoH?

- Same issues, nothing is getting fixed (at least not quickly)
- Same areas and same needs, no sustainable plan of action
- Not surprising at all, challenge is reaching those areas that need the help

#### **Breakout 1, Part 2: Gather Community Input especially from public health experts and vulnerable populations**

1. What social determinants are impacting this health issue?
  - Disproportionate amount of respondents based on race
  - Would like to see better representation of median income
  - Health being put on backburner; they can't focus on it due to other issues such as housing
2. From your perspective, what has caused this to improve/worsen/remain the same?
  - Pandemic, rise of cost of everyday things, transportation issues
3. What efforts have you experienced that are working and how?
  - Door to door is a better way to reach communities (Red Wagon Campaign); meeting people where they are
  - Outreach in general, people not aware of services available to them (health fairs, community events)
  - Way for non-profits to advertise better, getting the information out there, need to on-going and current
4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
  - Policies, are preventing us from doing good, need to be revisited
  - Proper linkage to other areas, closed loop referral system
  - Involvement and engagement of stakeholders from the beginning of the process, tend to have more buy-in
  - Stakeholders are quick to tell us what to do, but then no one takes it on, needs to be accountability
  - Communication: failure to communicate on our end to the community
  - Make it a collaborative effort, people/groups can speak up on projects they are willing to take on; helps eliminate silos, allows groups working on same ideas to work together

#### **Breakout 2: Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs**

What are potential ways organizations can work together to transform the conditions we discussed earlier?

# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

- Hosting community events, free to attend, in areas not normally in (1k, 5k, etc.)
- Find a way to destigmatize weight; be inclusive in what is being shown as an example
- Start small – tasks at home that get them moving, helps build confidence; use advertising to show examples
- Food – ideas of healthy food people might already have
- Exercise – incorporate into daily activities (walking vs driving, taking stairs)

## Heart Disease and Stroke

### Breakout Room # 9. Heart Disease and Stroke

#### **Breakout 1, Part 1: Discuss significant health needs identified within the data analysis and feedback gathered from the community**

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDOH?

- Value the survey asking about multi-racial and including important information and details.
- Confidence in medical providers and understanding this is a concern for many people.
- Access to health services and the long wait time for appointments. Do we have enough providers? Is funding an issue to support the number of providers needed.
- High cancer rates in Pinellas County is alarming compared to the state and national average.
- Cervical cancer rates are alarming. Linking this to the vaccine rates to prevent cervical cancer.
- Overall concerns with vaccine implementation.
- Rental and house rates are concerning.
- Nutrition challenges direct correlation to the heart disease rates.
- Access to care is concerning, unable to schedule appointments when needed. Disconnect and continued challenges navigating the process to be seen by medical providers.
- Stigma for mental health for those seeking care.
- Employment information would be interesting to add to the survey moving forward for future surveys. Take a deeper dive into salary/hourly/shift positions and the challenges in making medical appointments.

#### **Breakout 1, Part 2: Gather Community Input especially from public health experts and vulnerable populations**

- 1) What social determinants are impacting this health issue?
  - AA higher rate of heart disease relates back to lack of access and knowledge
  - Access to specialist is challenging, high co-pays, more expensive medications
  - Medications are complicated and often takes multiple visits to adjust meds and dosages
  - Healthy eating is a direct correlation to these rates. Access to health foods can be challenging.
- 2) From your perspective, what has caused this to improve/worsen/remain the same?
  - COVID created challenges with people not keeping up with medical appointments

# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

- Heart disease can be “silent killer” people may not be aware they are having health/heart problems. Preventive care is not a priority especially if symptoms are not present.
  - Stress contributes to this health challenge. The SDOH of health can cause great stress in one’s life (food security, being financially stable, transportation challenges)
- 3) What efforts have you experienced that are working and how?
- Barber shop and beauty shop health education programs. Meeting people where they live and frequent (places of trust).
- 4) From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
- More cultural/diverse programs that include healthy eating information and resources. Need sustainable solutions.
  - Improved Access
  - Information is presented in easy to understand formats, including videos
  - Health literacy should be a priority in getting the information out to the community
  - Meet people where they are, use of social media.

### **Breakout 2: Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs**

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- Hours of care to be extended to meet the needs of the community.
- Funding free clinic (off hours in the community)- multi-level, multi-resources, include dental, hearing, food available- Cigna wellness Center model
- Evaluate ROI for these services
- One central location (one Hub) for resources, multiple organization involved
- 211 is underutilized, challenges have contributed to the under utilization
- Transportation partners for medical resources
- Education for the community at large regarding stigmas (health conditions, race, accessing services, mental health)
- Overall experiences in seeking medical help needs to improve, will help with people wanting to access care.

### **Breakout Room # 10. Heart Disease and Stroke**

#### **Breakout 1, Part 1: Discuss significant health needs identified within the data analysis and feedback gathered from the community**

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDOH?

- Those who identify as mixed race/ other race are disproportionality affected by health issues.
- Even with all the education that we provide, heart disease is still so prevalent.
- The data shows that behavioral health is impacting overall health and is exacerbated by the COVID-19 pandemic.
- We need to listen to the populations we serve and focus on those issues
- Mental health needs are not being met due to long wait times and insurance issues. These people are turning to the ER instead

# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

- Not enough mental health providers in the area to serve our population. People cannot afford mental health and other services due to the pervasive housing crisis
- How does housing data match up with health indicators broken out based on property ownership vs. rental. Corporate rental entity vs. privately owned rental properties.
- What is the intersectionality of the data as it related to frontline providers?
- What is the extent to the miscommunication on housing support and how that affect individual ability to afford other expenses? What are the parts of this intersectionality

### **Breakout 1, Part 2: Gather Community Input especially from public health experts and vulnerable populations**

1. What social determinants are impacting this health issue?
  - Food insecurity and access to food
  - Diagnoses and access to care
  - Stigma and misinformation and mistrust
  - Healthcare navigation and health literacy and appt. availability
  - Receiving regular primary and preventative care
  - Built environment and transportation/ public transportation
  - Access to technology
2. From your perspective, what has caused this to improve/worsen/remain the same?
  - Cost of living is a barrier, especially for older populations on a fixed income
  - Lack of transportation
  - Lack of relevant data on this issue
  - Education has helped increased awareness and culturally competent education
  - Navigating the healthcare system is a big barrier for individuals
  - Lack of communication between providers that are not in the same system
  - Lack of cultural competency among providers
  - COVID-19 has exacerbated heart issue and caused stress
  - Providers are very busy and not able to make meaningful connection with their pt.
  - Need more providers and support provided to those providers
  - Social service workforce needs to earn more income
  - Providers not always willing to take Medicare/Medicaid pt. because of low payments
3. What efforts have you experienced that are working and how?
  - Caring support workers- contact pt. in between appt. to ask pts. If they need anything or if they have questions. Make pt. feel comfortable asking question.
  - CHW's build relationship with the community and provide holistic care to family's
  - Accountable care organizations work to provide preventative care
  - Field health navigators are becoming more popular across service areas. provider that faces to face interaction and allow the pt. to have a point of contact that is not a healthcare provider and can build a confident relationship
  - Early health literacy
  - Paying people well helps with employee attrition
  - Expanding Medicaid

## Appendix C. Community Input Assessment Tools

### Prioritization Session Questions and Summary of Responses

4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
- Incentivize workers in the healthcare field such as paying off loans.
  - Improving the workforce with easy to access training programs and consistent and streamlined programs that are equitable and EASIER to use.
  - We need to do something about the housing crisis
  - Targeted campaigns at the community level such as the Hep A Vaccine campaign (using health navigators and CHWs).
  - Up to date data on our specific communities. Building on existing community programs

#### ***Breakout 2: Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs***

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- Increasing collaboration among providers (this happens in behavioral health with the CFBHN and Wellness connection and the behavioral health system of care meetings) but need to do this in the other areas of health. Could do separate meetings and then come together as a large group to talk about the intersections
- Increase the collaboration between behavioral health and physical health providers
- Develop relationship between providers to improve the transition of care
- School based health centers that include mental health and other services. Including telehealth opportunities. Comprehensive health centers in schools.
- Increasing the number of hours of mental health curriculum in schools.
- Community programs to improve mental health literacy in our communities and help individual be self-advocates
- Engage in faith-based organizations

## Immunizations & Infectious Diseases

### **Breakout Room #11. Immunizations & Infectious Diseases**

#### ***Breakout 1, Part 1: Discuss significant health needs identified within the data analysis and feedback gathered from the community***

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDoH?

- A lot of mental health needs presented – education focused on physical, what about holistic approach? Are they teaching children mental health education?
- Immunizations & ID – stats about babies being born with syphilis - with focus on covid, have we lost our focus on other ID and the immunizations available?
- General categories of needs haven't changed much from the prior CHNA – would like to know if we made any progress in the existing categories
- Zip codes – 33714 zip code was in the highest in majority of categories – cost of homes / SES correlation



# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

- What would a focus on overall healthy behaviors have on diseases and mental health?
- Idea of access and availability
- minority pop looking for nontraditional hours
  - participant's wife works in specialty and a lot of people visit on Saturdays
- What are new ways that we can address the repeat needs?
  - Precision public health
- People are using technology to engage in risky behaviors – as tech progresses, so should our responses
- Are there any health departments or healthcare offices in the zip codes that were the darkest / highest need?
- Can we use education to combat fear?
- Needs to be a mix of education and trust building to make impact in the community – utilize community leadership to build trust (example of community policing, where police officers would take cars home, so community members knew where the police lived)

### **Breakout 1, Part 2: Gather Community Input especially from public health experts and vulnerable populations**

- 1) What social determinants are impacting this health issue?
  - Economic driven to a degree; disparity on the graphs between ethnicity/race
  - Education
  - What happens to you or around you as a child makes an impact on your life as an adult
  - Rate of HIV/AIDS infection – much higher in the African American community – would like a deeper data dive – gender, LGBTQ+, zip code
  - Housing and the cost of housing; the financial struggle people are experiencing to maintain housing
  - Noticed low level of flu vaccines in 2019
- 2) From your perspective, what has caused this to improve/worsen/remain the same?
  - Market rate for housing/space has tripled
  - Caused displacement for a lot of people
  - With the growth of St Pete, is that also bringing increased services and funding?
  - HIV/AIDS – large increase in the past few years of cases in black / African American community
  - Resource rich, coordination poor in Pinellas County
  - Locate services within communities – need creative ways
    - Ex – nurse navigators in low-income housing
  - Using the school as a hub for resources – embedding requirements for health screenings
  - Focus on teaching children whole body care (mind and body)
  -
- 3) What efforts have you experienced that are working and how?
- 4) From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?

### **Breakout 2: Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs**

# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

### Reminder – Top 3 needs are:

1. Access to Health & Social Services
2. Behavioral Health (Mental Health and Substance Misuse)
3. Exercise, Nutrition, and Weight

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- Co-locating health / mental health providers and housing providers
  - Homeless empowerment program has a collab with ARNP onsite
- Funding for locations in heart of high need areas that focus on removing fear to make people comfortable with their healthcare (first step into health journey)
  - Identify local orgs already in those areas
- Continue/expand partnerships with orgs in the community
- Identify local community leaders to be champions for the programs and be at the table when creating programs

### Breakout Room #12. Immunization and Infectious Disease

#### **Breakout 1, Part 1: Discuss significant health needs identified within the data analysis and feedback gathered from the community (15 min)**

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDoH?

- What are the underlying factors? Goes back to eating right, exercise, social support
- Developmental assets
- Work on developing community leaders, support
- Who are our natural mentors in the community?
- Hard to find doctors that certain populations feel comfort with
- Incentive cultural awareness
- Need additional resources for dentist (share space at different times)
- Community kitchens (culturally relevant recipes), shared spaces
- Maximize key themes (using our resources to the max)
- Surprised by the lack of housing security concerns
- We often don't associate housing with healthcare
- Access to health care, dental care, behavioral health is common theme, transportation
  - Access is more than having insurance, we need to have care available at more convenient times (7 AM – 11 PM)
  - Some pediatric providers are offering longer hours
  - Many people rely on the ER due to “convenience” of time (not all can access doctors during “business hours”)
  - Big copy differential for ER and urgent care
  - Telehealth bringing value, increasing access
  - Dental services from state health plan, long wait times (not many take the insurance)
  - Need for personal advocacy in getting needs met
  - Hard to get timely appts, especially with dental

# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

- Many providers behind in appts
- Top risky behaviors/concerns are affecting populations most in need of advocates for care (experiencing several barriers to care); some people felt discounted, not treated well, not heard by providers; affecting most vulnerable populations
- Need for advocates, care coaches

### **Breakout 1, Part 2: Gather Community Input especially from public health experts and vulnerable populations (25 min)**

1. What social determinants are impacting this health issue?
  - Cultural aspects, babies not getting fully immunized
  - At DOH, saw trend of Hispanic/Latinx community babies not getting childhood immunization. They were not in daycare; parents did not see the need. Not accessing systems that require immunization early. Leads to a system of thinking that believes immunizations are not important/needed
  - Minority populations choosing not to get vaccinated for COVID, need for trust building in medical community
  - COVID vaccination journey shed light on the mistrust of health care providers, history of mistrust emerged
  - Don't tend to have PCP's, don't get checkups, not getting vaccines
  - Let's keep politics out of public health!
  - We do a better job immunizing kids than adults. Many adults hesitant to vaccinate.
  - High vaccine rates for kids, adult rates much lower (flu is a high risk for our aging population); perhaps bc vaccines are required for kids for schools/immigration, etc.
2. From your perspective, what has caused this to improve/worsen/remains the same?
  - Many vaccines are very expensive (esp. without insurance)
  - Past trauma combined with expensive cost of vaccines (ex, shingles, Hep B)
3. What efforts have you experienced that are working and how?
  - Free vaccines, widespread availability
  - State vaccine registry (FL Shots); would be helpful to know that all pharmacies, clinics are contributing data; helps with tracking accurate records "The more you use the systems, the better the data gets"
4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
  - Keep politics out of public health
  - Listen to what barriers are for specific populations
  - Learn more about cultural differences and beliefs (beliefs in natural healing/medicine)

### **Breakout 2: Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs (20 min)**

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- Top priority areas- Access to Health Services, Behavioral Health, Exercise/Nutrition/Weight
- Incentivizing – access to services (tax breaks for sharing office space, scholarships for health-related fields/health navigators, free cultural training/awareness activities, more than just CEU's)

## Appendix C. Community Input Assessment Tools

### Prioritization Session Questions and Summary of Responses

- Cooking demos with free meals
- New doctors commit to time at a clinic, esp. underserved areas/low access areas (define areas and care needed)
- Focus group with providers! How to expand hours?
- Shared space
- Extended hours
- Access goes beyond health insurance
- Developmental assets – weave throughout systems (coaches, teachers, scout leaders, faith community, other leaders in community)
- Transportation and lack of- challenges ongoing
- Mass transportation is not great in Pinellas (multiple connecting buses, not convenient, takes too long to get from A to B)
- Ride share and other options not known/used
- How can we leverage technology? Access can be a barrier, but it's becoming less expensive. Can help us meet people where they are at
- Physically getting to places seems to have gotten harder
- Many people have smart phones, can help increase access via telehealth

## Appendix D. Data Placemats

Placemats were utilized during prioritization session breakout discussions to discuss thoughts about quantitative and qualitative data collected and analyzed. A placemat was created for each health topic.

- **Access to Health and Social Services**
- **Behavioral Health**
- **Cancer**
- **Exercise, Nutrition, and Weight**
- **Heart Disease and Stroke**
- **Immunizations and Infectious Diseases**



# PINELLAS COUNTY DEMOGRAPHICS

## PINELLAS COUNTY POPULATION BY AGE AND GENDER 2021



982,142 People

Median Age

49.0



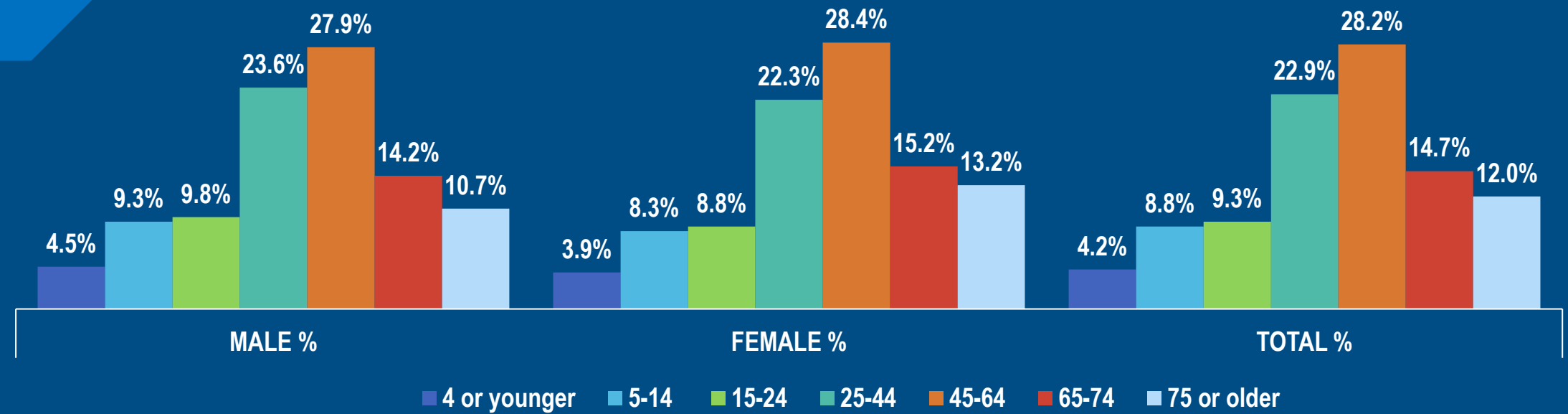
48.0%

Male



52.0%

Female

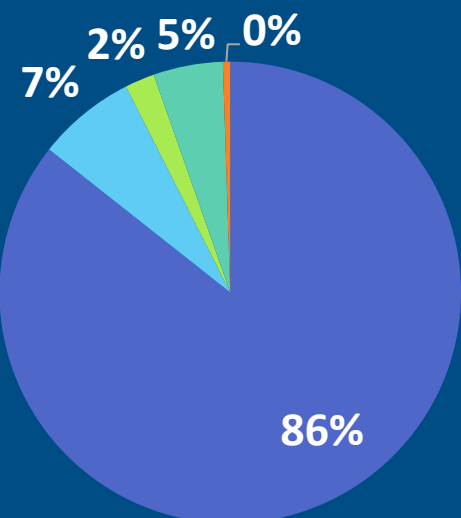


Level of Education, Age 25+	Pinellas County	Florida	U.S.
Less than 9 <sup>th</sup> Grade	2.8%	4.6%	4.8%
9 <sup>th</sup> to 12 <sup>th</sup> Grade, No Diploma	6.0%	7.0%	6.6%
High School Graduate or G.E.D	27.8%	28.5%	26.9
Some College, No Degree	20.9%	19.5%	20.0%
Associate's Degree	9.9%	9.9%	8.6%
Bachelor's Degree	21.2%	19.2%	20.3%
Graduate or Professional Degree	11.4%	11.3%	12.8%

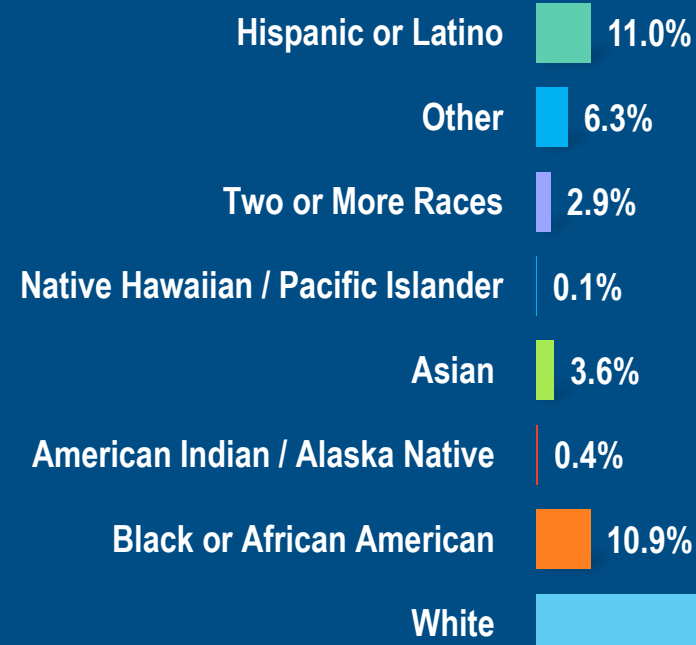
12.1% Of the Population Foreign Born



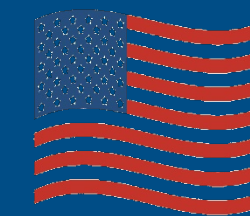
### Population Age 5+ by Language Spoken at Home



- Speak Only English
- Speak Spanish
- Speak Asian/Pac Islander Lang
- Speak Indo-European Lang
- Speak Other Lang



### RACE & ETHNICITY



9.7% Of the Population are Veterans

# PINELLAS COUNTY ECONOMIC BREAKDOWN

## Median Household Income



**\$64,959**

With a \$24.89  
Mean Hourly Wage, 2020



## Unemployment Rate

**5.1%** Age 16+, 2022

Workers by Means of Transportation to Work, 2022	Pinellas County	Florida
Worked at Home	7.7%	6.6%
Walked	1.6%	1.5%
Bicycle	.6%	.6%
Carpooled	9.2%	9.2%
Drove Alone	78.3%	78.6%
Public Transport	1.2%	1.7%
Other	1.4%	1.8%



**7.2%** Population  
Change 2010-2022

**\$241,892**

## Median Property Value

**16.8%** Growth 2010-2021



**85.9%**

Have Internet  
Subscriptions

## Inflation Rate

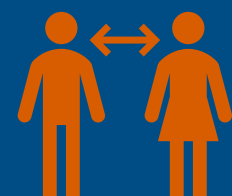


12-month percentage changes  
Tampa-St. Petersburg-  
Clearwater Data



**70.4%**

Of the total number of  
survey respondents  
experienced one or more  
losses due to COVID



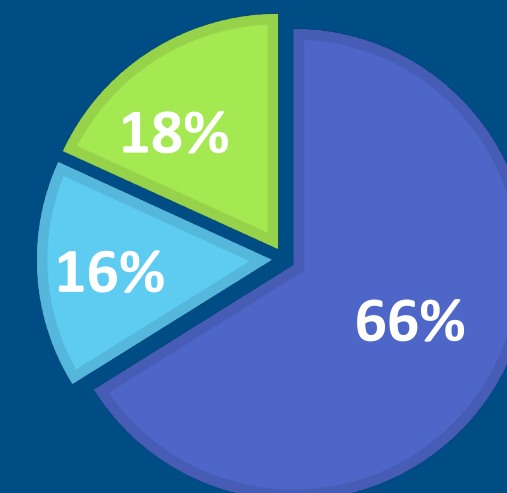
### Some of the top losses include:

- Recreation or entertainment
- Sense of well-being, security, or hope
- Death of family or friend
- Exercise opportunities
- Income



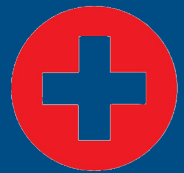
## PINELLAS EMPLOYED CIVILIAN 16+ BY OCCUPATION GROUP

- White Collar
- Blue Collar
- Service and Farming Industries



**13.0%** Of  
Individuals are Below  
Poverty Level

**ACCESS TO HEALTH & SOCIAL SERVICES PINELLAS COUNTY**



**88** Primary Care Providers  
rate per 100,000 population



**59** Dentists  
rate per 100,000 population



**209** Mental Health Providers  
rate per 100,000 population

*“We’re working with a community that is very hardworking. For them to go and see a doctor and have to lose a day of work and pay, they tend to ignore any signal or symptom, they need options for the schedules they work.”*

-Hispanic/Latinx Group Participant

“Was there a time in the last 12 months when you needed medical care but did not get the care you needed?”

**18.2%** Responded ‘Yes’

**Top 5 Reasons Why Respondents Say They Didn’t Get The Medical Care They Needed**

1. Unable to schedule an appointment when needed
2. Unable to afford to pay for care
3. Cannot take time off work
4. Doctor’s office does not have convenient hours
5. Unable to find a doctor who takes my insurance

Low-income populations in the following cities are federally designated Primary Care and/or Dental Provider Shortage Areas

- Bayview
- Clearwater
- Largo
- Pinellas Park
- St. Petersburg
- Tarpon Springs

All of Pinellas County is considered a Mental Health Provider shortage area.

**82.3%** Of adults with health insurance, 2019

**76.1%** Of adults who have a personal doctor, 2019

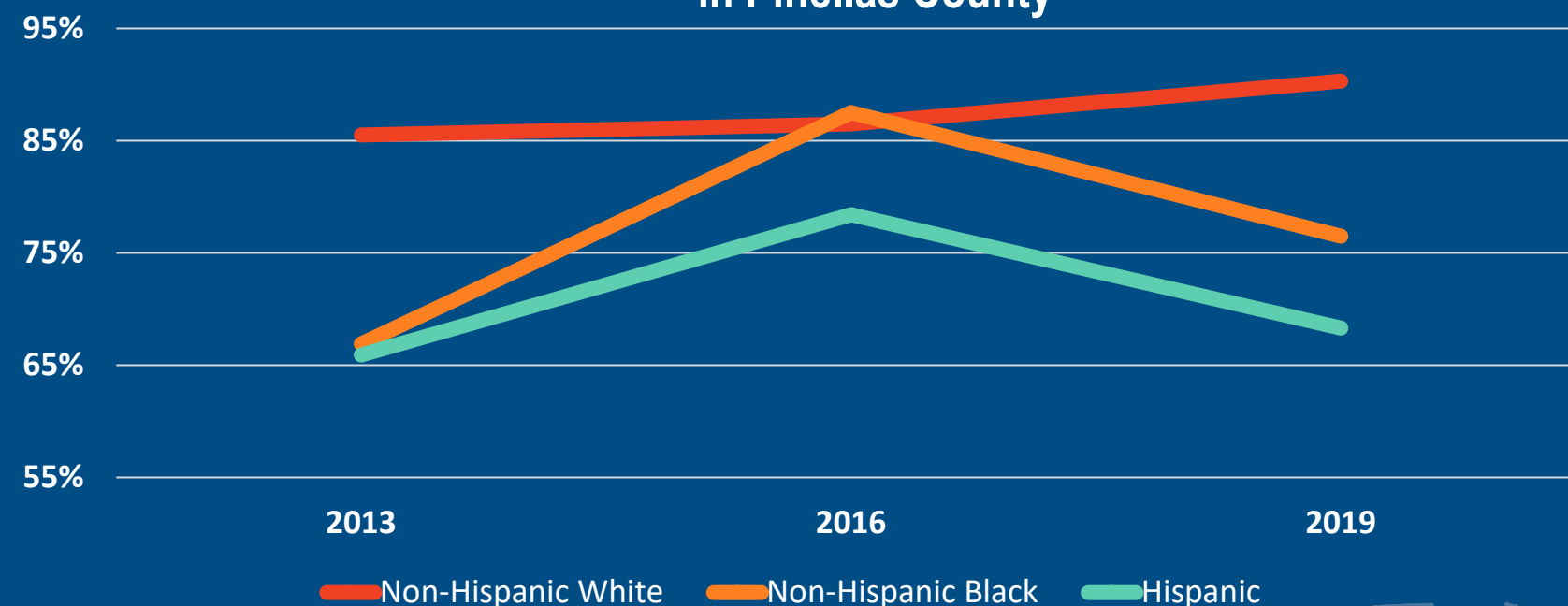
**24.7%** Of high school students have not visited a doctor’s office in the past 12 months, 2020

**14.5** Preventable hospitalizations under 65 from dental conditions, 3 year rolling 2018-20, rate per 100,000



**93.5%** Of children in Pinellas County have health insurance, 2019

Adults With Health Care Insurance Coverage in Pinellas County







# BEHAVIORAL HEALTH PINELLAS COUNTY

(Mental Health and Substance Misuse)

**41%**

Of survey respondents ranked mental health as the most pressing health issue

**19%**

Of survey respondents reported experiencing 4 or more Adverse Childhood Experiences (ACEs) before age 18

**30.1%** of Middle School Students Report having used alcohol or illicit drugs in their lifetime

**24.2%** of Adults engage in heavy or binge drinking

**34.1** Alcohol-Confirmed Motor Vehicle Traffic Crashes per 100,000 Pop.

**50.6%** of High School Students Report having used alcohol or illicit drugs in their lifetime

**41.3%** of high school students have used a vaporizer/E-cigarette, 2018

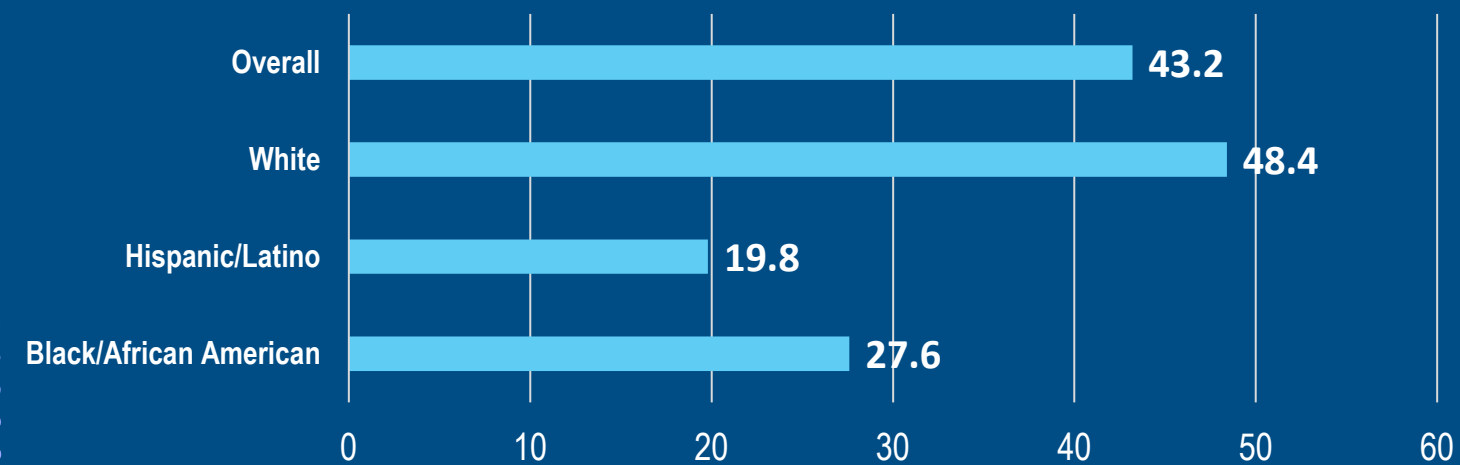
**17.7%** of middle school students have used a vaporizer/E-cigarette, 2018

**19.7%** of adults currently smoke cigarettes, 2017-2019

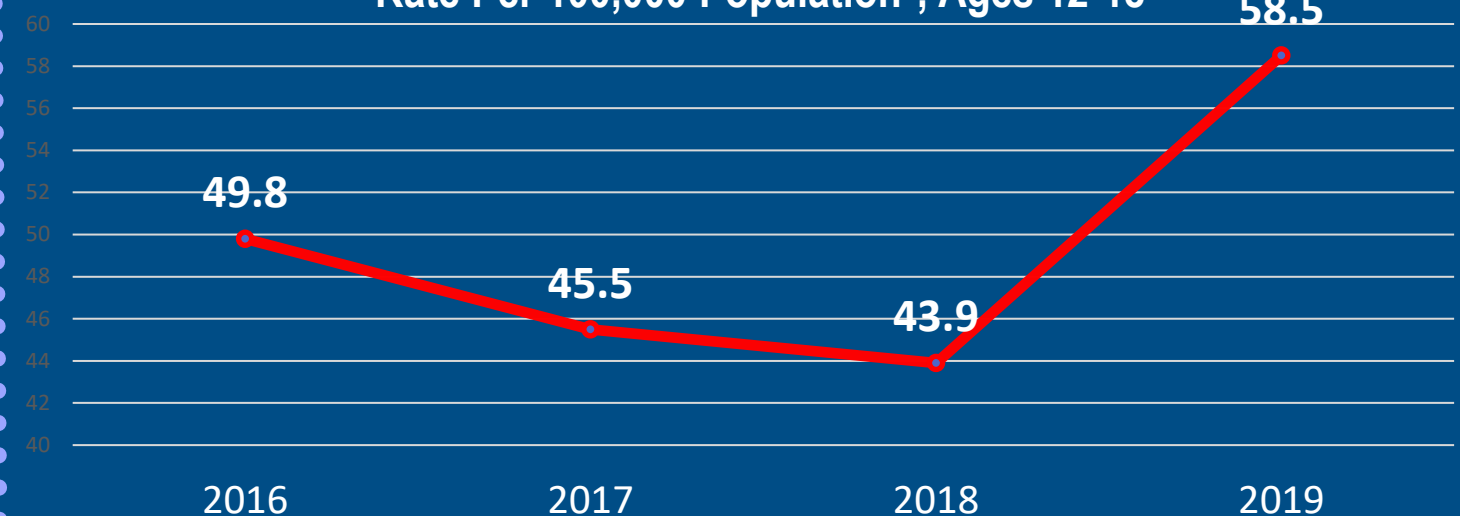


## Age-Adjusted Drug and Opioid Involved Overdose Death Rate, 2018-2020

193



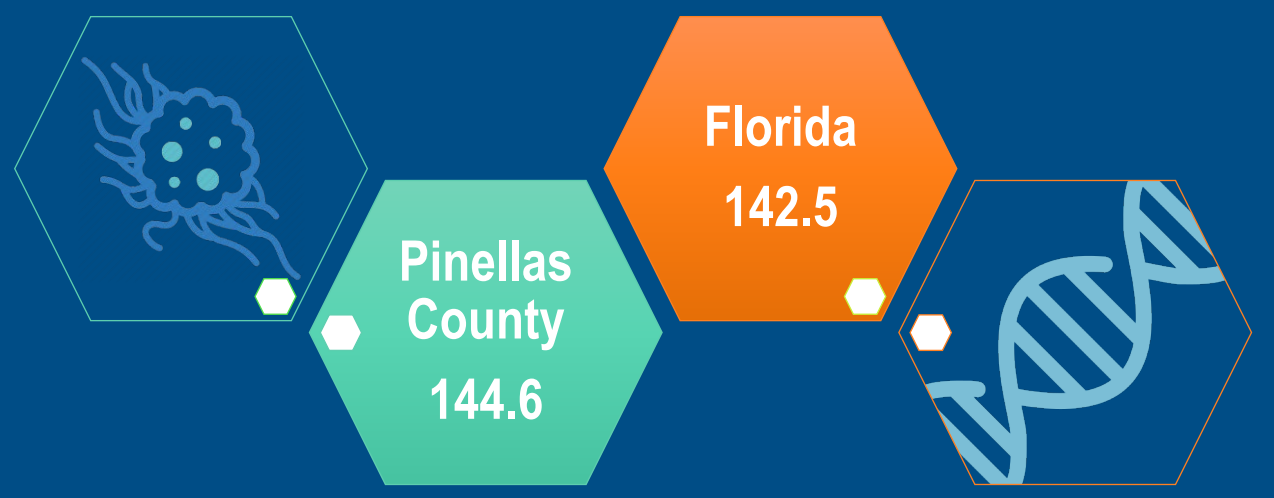
## Pinellas Hospitalizations for Eating Disorders Rate Per 100,000 Population\*, Ages 12-18



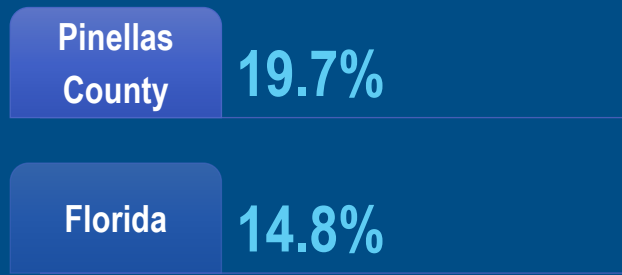
**11.5%** of survey respondents indicated they had thoughts that they would be better off dead or of hurting themselves in some way for several days, more than half of the days or nearly every day over the last 12 months.

**34%** of survey respondents were diagnosed by a medical provider with **Depression or Anxiety**

**CANCER DEATH RATE**  
(Age-adjusted per 100,000 population, 2018-2020)



Adults who currently smoke cigarettes, 2017-2019

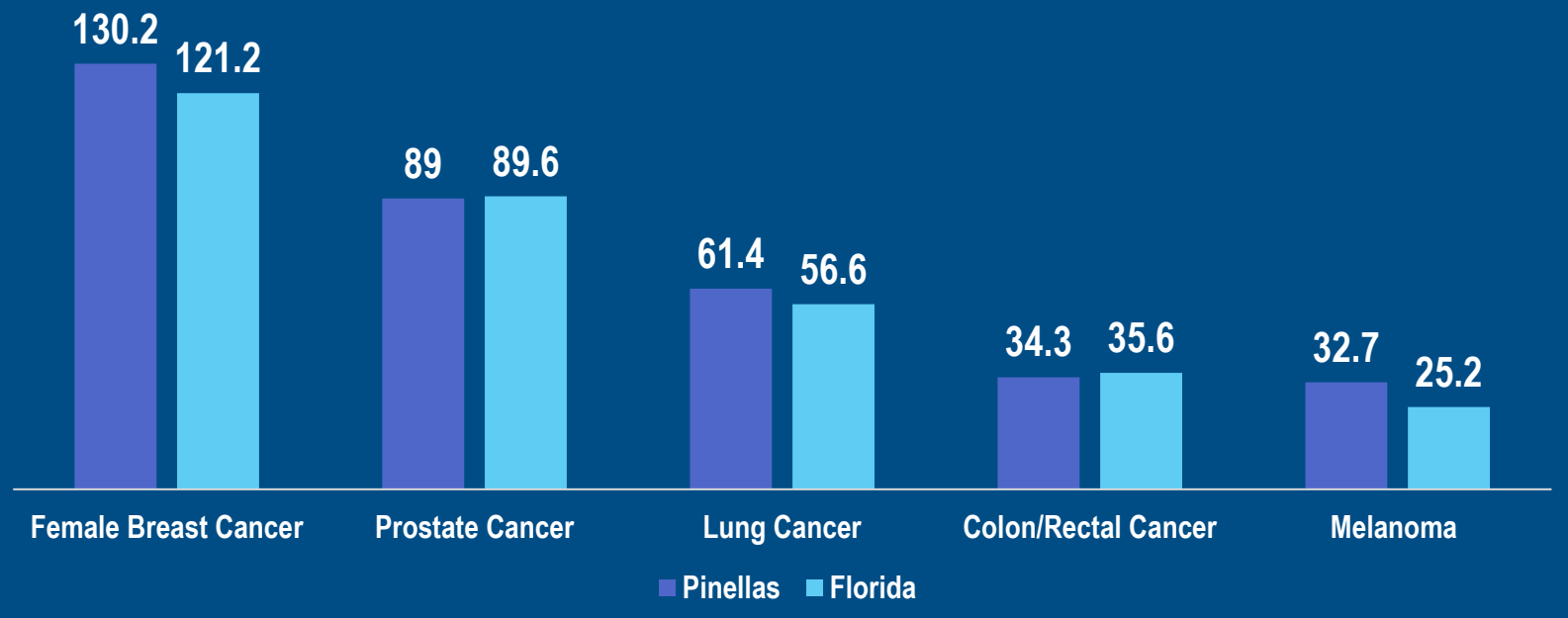


**17%** of survey respondents ranked **Cancer** as a most pressing health issue

**CANCER DEATH RATE IN PINELLAS BY RACE/ETHNICITY**  
(Age-adjusted per 100,000 population, 2018-2020)



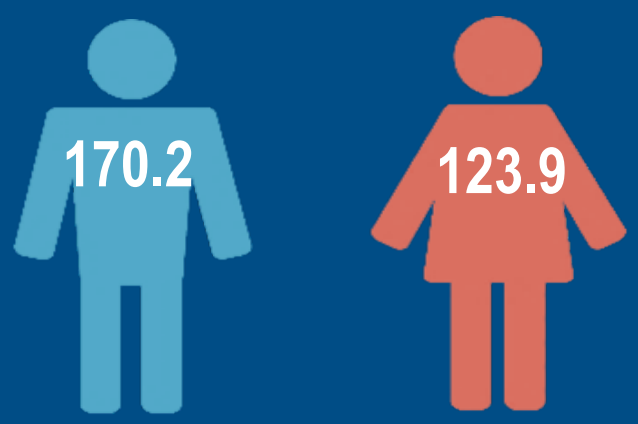
**CANCER INCIDENCE RATE: PINELLAS COUNTY**  
(Average age-adjusted per 100,000 population, 2016-18)



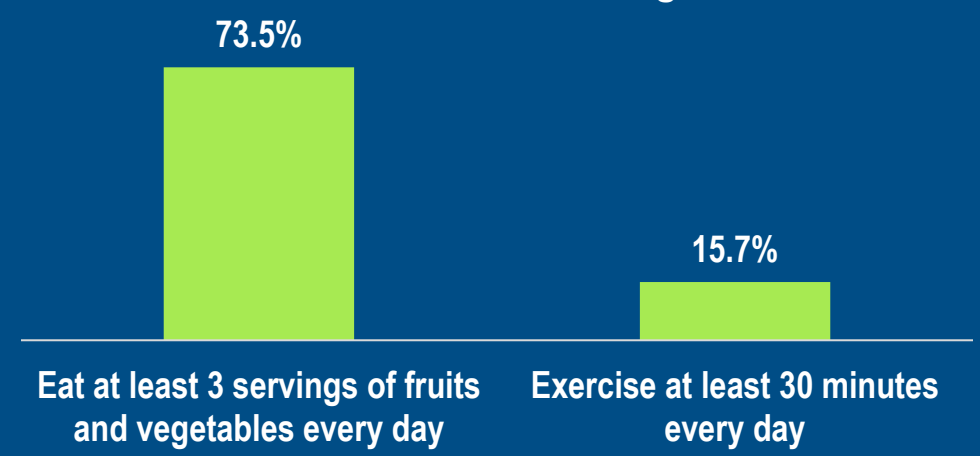
**CANCER DEATH RATES BY TYPE**  
(Average age-adjusted deaths per 100,000 population, 2018-2020)

Type of Cancer	Pinellas County	Florida
Female Breast Cancer	19.6	18.7
Prostate Cancer	15.4	16.5
Lung Cancer	36.1	33.6
Colon/Rectal Cancer	12.1	12.6

**CANCER DEATH RATE BY GENDER**  
(Age-Adjusted per 100,000 Population, 2018-2020)



**Cancer Prevention Indicator:**  
Survey respondents who answered "NO" to the following

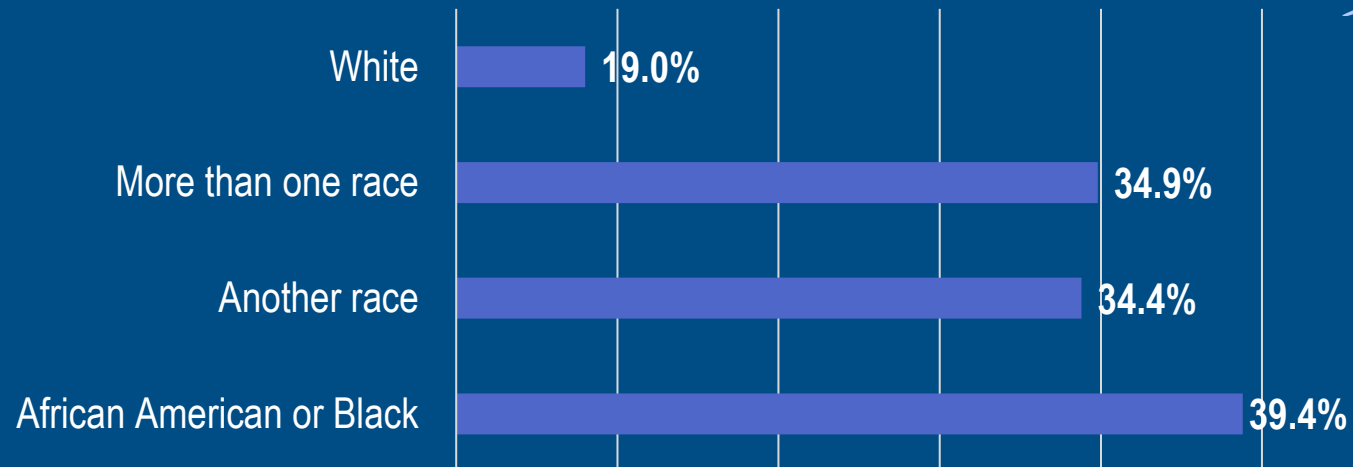


Sources: All4HealthFL.org, FLHealthCharts.gov; CHNA Survey Data

**22.8%** of survey respondents self-reported food insecure

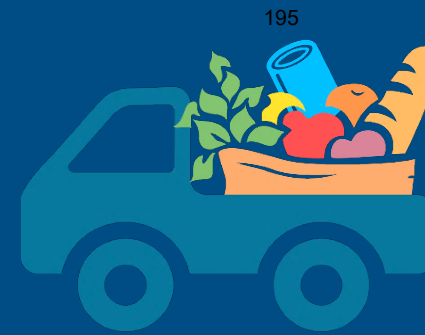


Survey Respondents Food Insecurity by Race

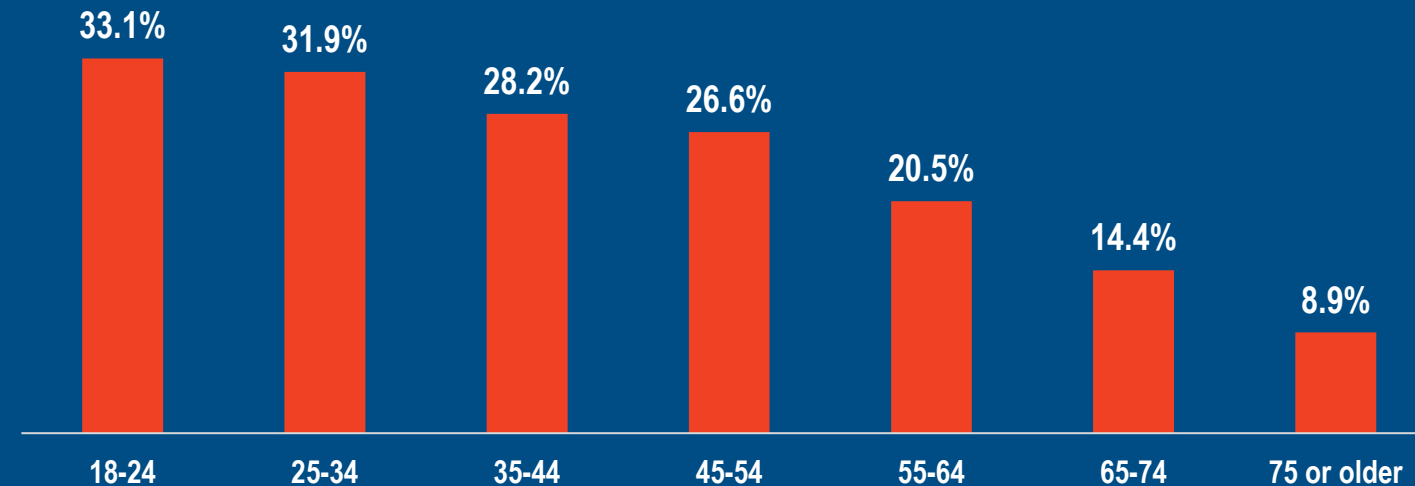


**12.0%** responded 'yes'

In the last 12 months, did you or anyone living in your home ever get emergency food from a church, a food pantry, or a food bank, or eat in a soup kitchen?



Food Insecure Individuals by Age



**29.0%**

Respondents who disagreed with the statement "There are good sidewalks for walking safely in my neighborhood"

**9.6%**

Respondents who disagreed with the statement "We have great parks and recreational facilities"

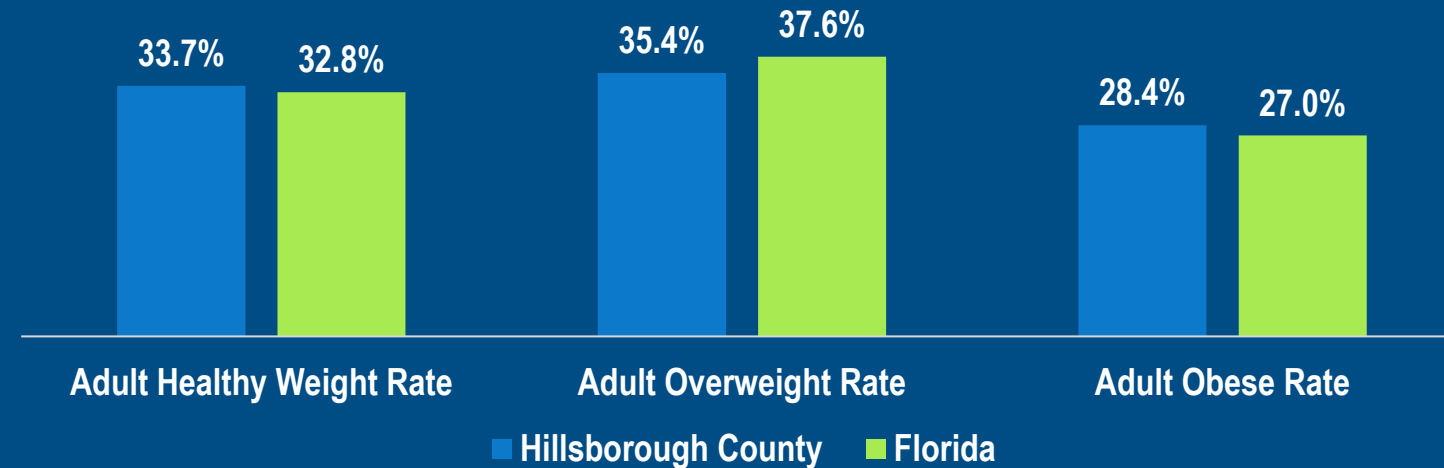
**19.9%**

Respondents who disagreed with the statement "I am able to get healthy food easily"

**12.8%**

Respondents who disagreed with the statement "I feel safe in my own neighborhood"

PINELLAS COUNTY WEIGHT RATES 2019



Survey respondents who answered "NO" to the following:



**73.5%** Eat at least 3 servings of fruits and vegetables every day



**15.7%** Exercise at least 30 minutes every day

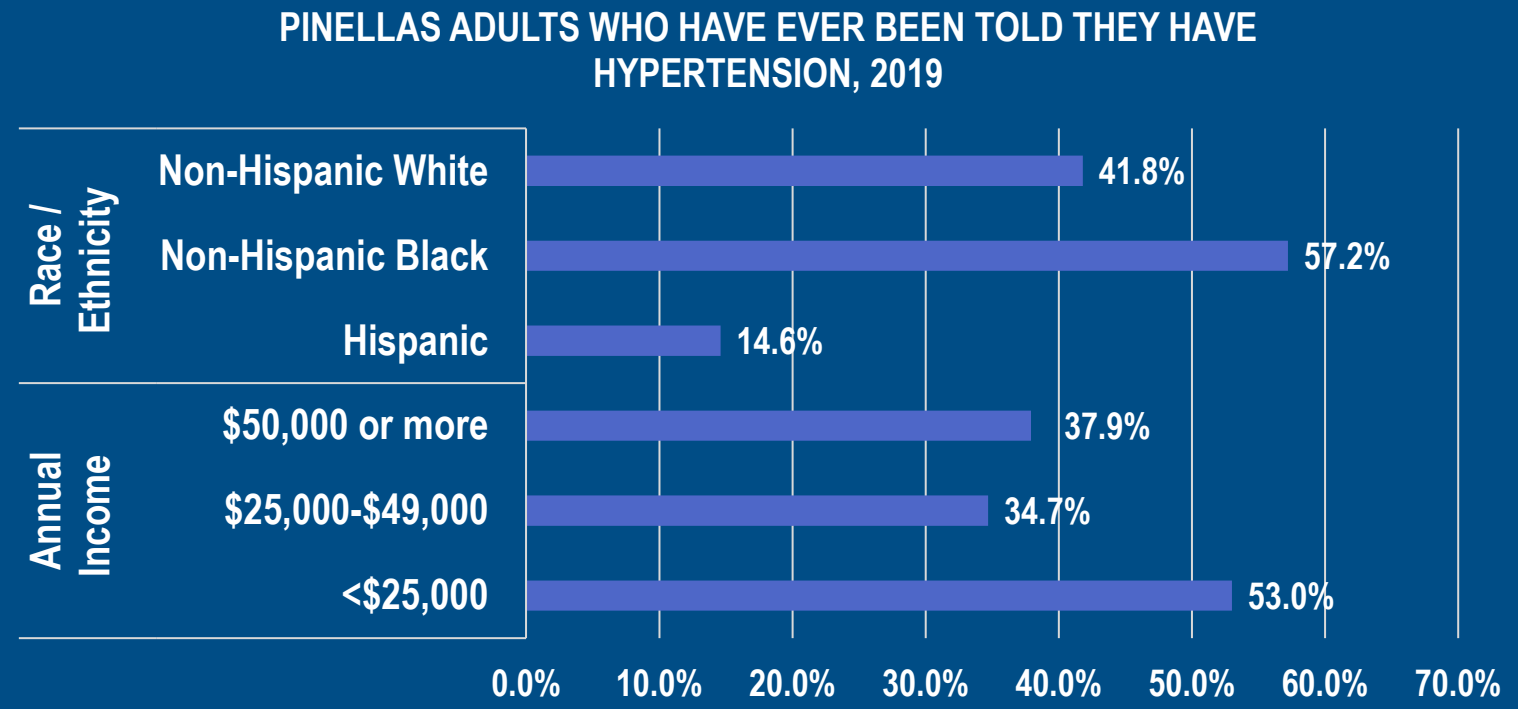
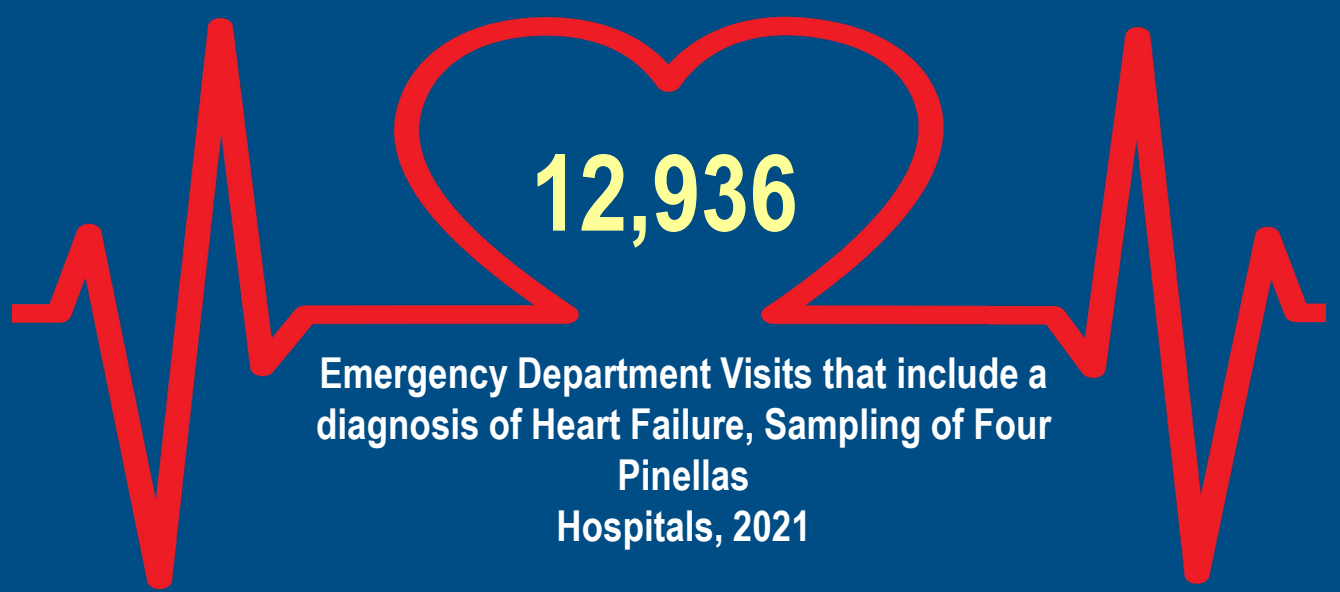
**10.7%**

Adults who have ever been told they have diabetes, 2019

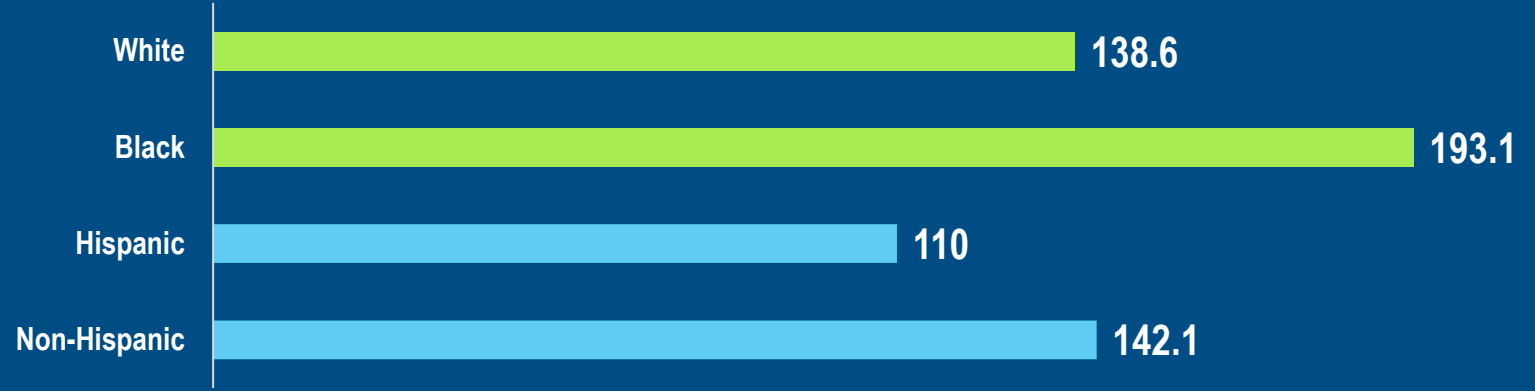
**210.4**

Age adjusted ED visits from diabetes, 3 year rolling 2018-20, rate per 100k





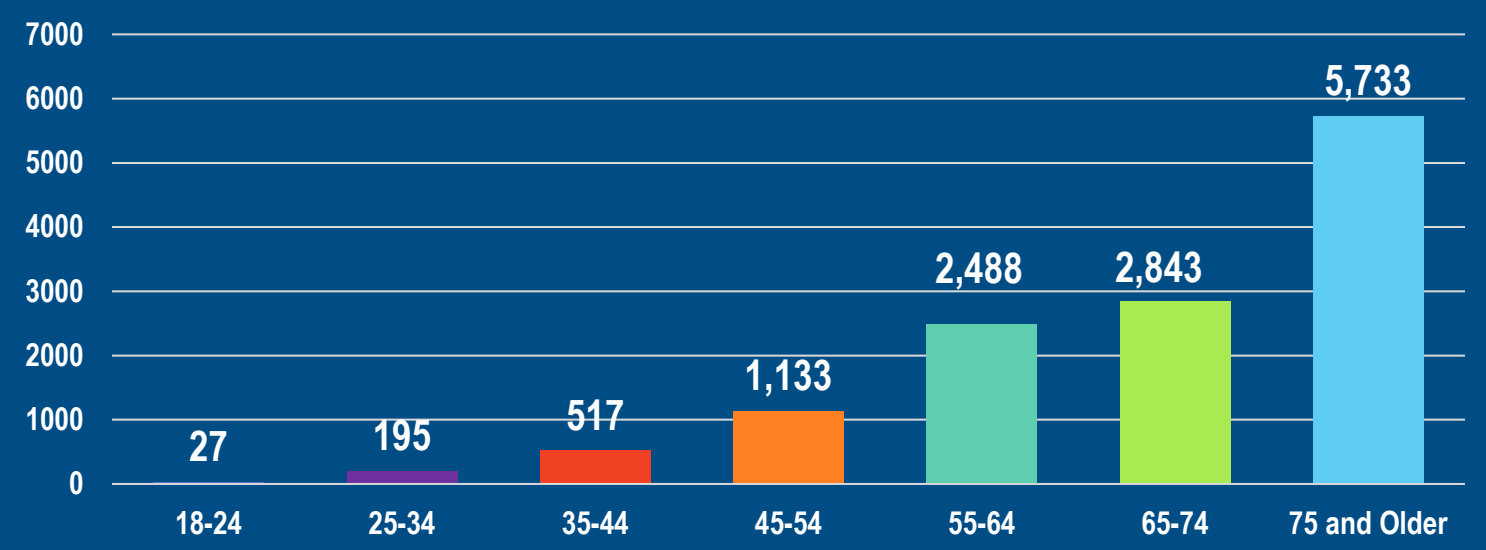
AGE-ADJUSTED DEATHS FROM HEART DISEASES, RATE PER 100,000 POPULATION, 3-YEAR ROLLING, 2018-2020



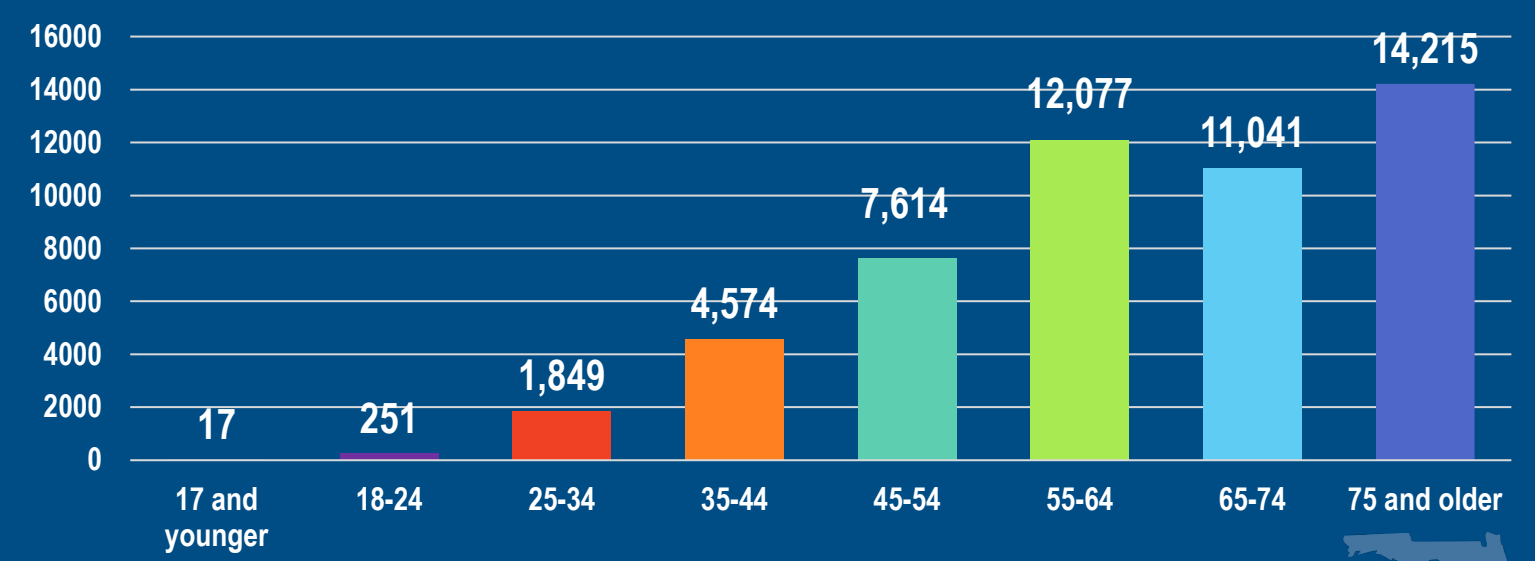
**41%** Of survey respondents told by a medical provider they have Hypertension and/or Heart Disease

**4.2%** Adults who experienced a stroke, 2019

EMERGENCY DEPARTMENT VISITS THAT INCLUDED A DIAGNOSIS OF HEART FAILURE BY AGE (Sampling of four Pinellas hospitals, 2021)

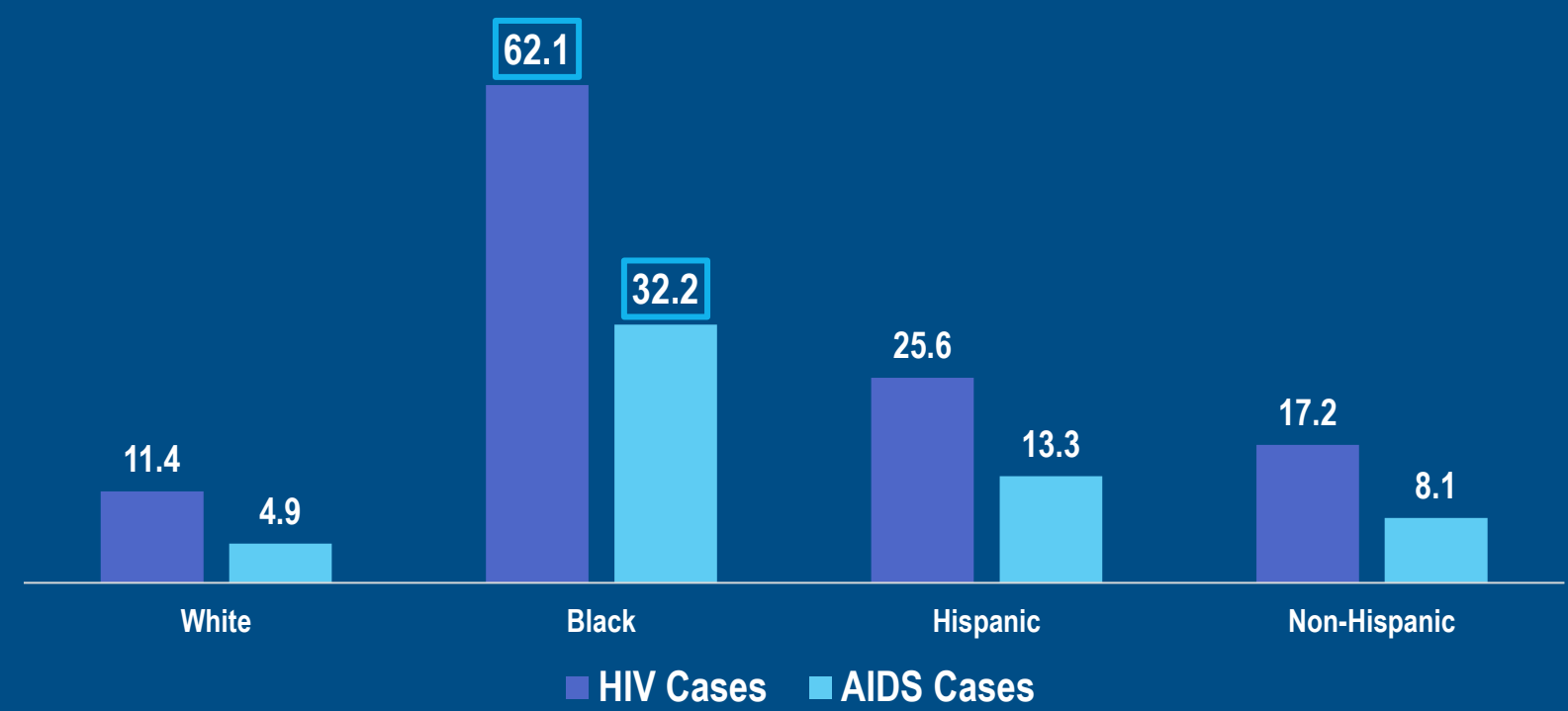


EMERGENCY DEPARTMENT VISITS THAT INCLUDED UNCONTROLLED BLOOD PRESSURE / HYPERTENSION BY AGE (Sampling of four Pinellas hospitals, 2021)

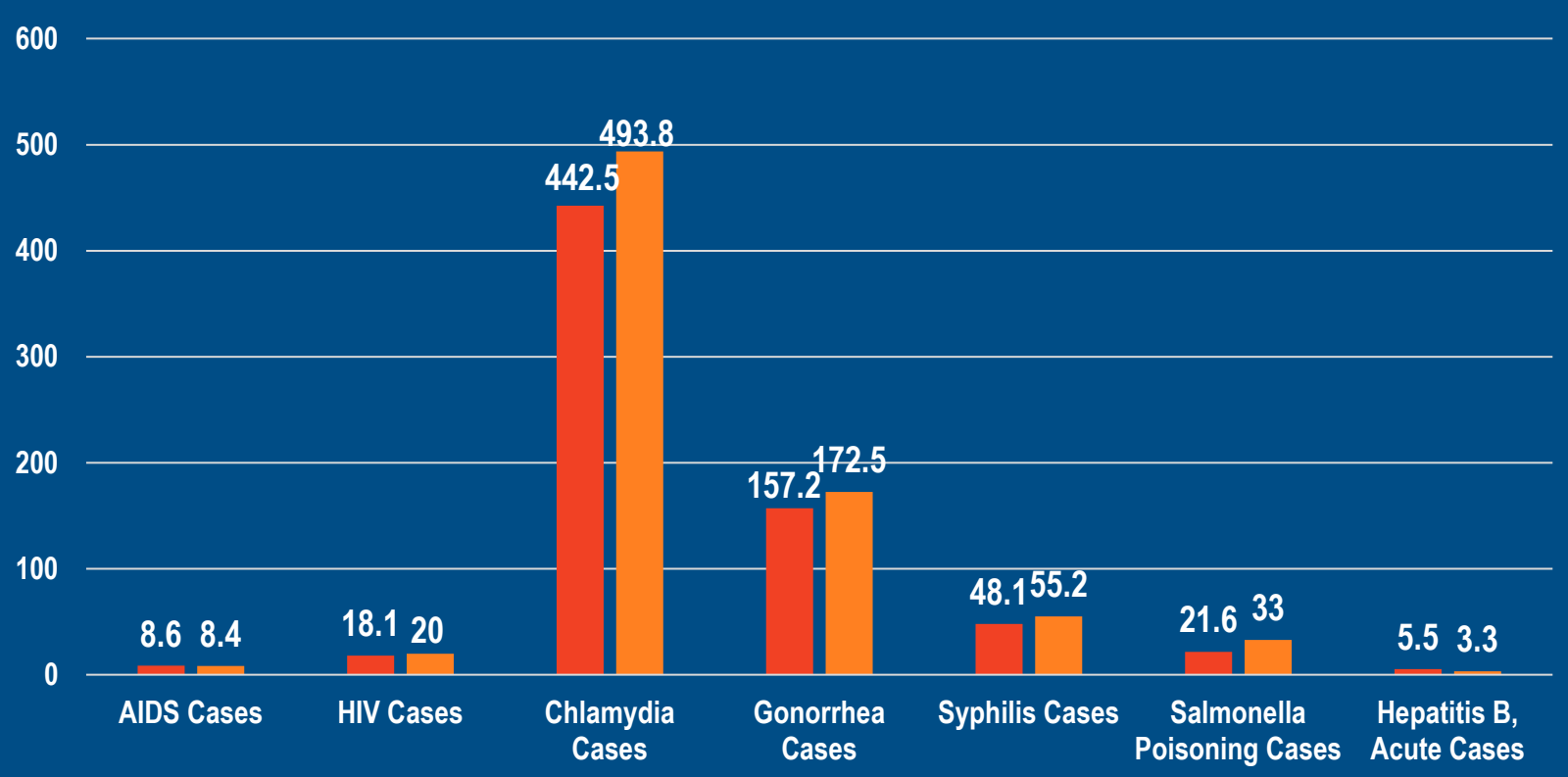


Sources: FLHealthCharts.gov; CHNA Survey Data

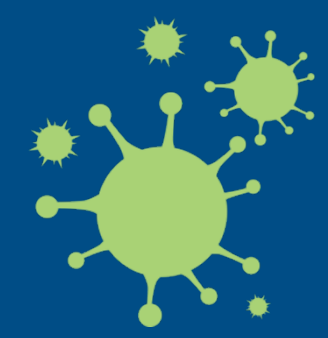
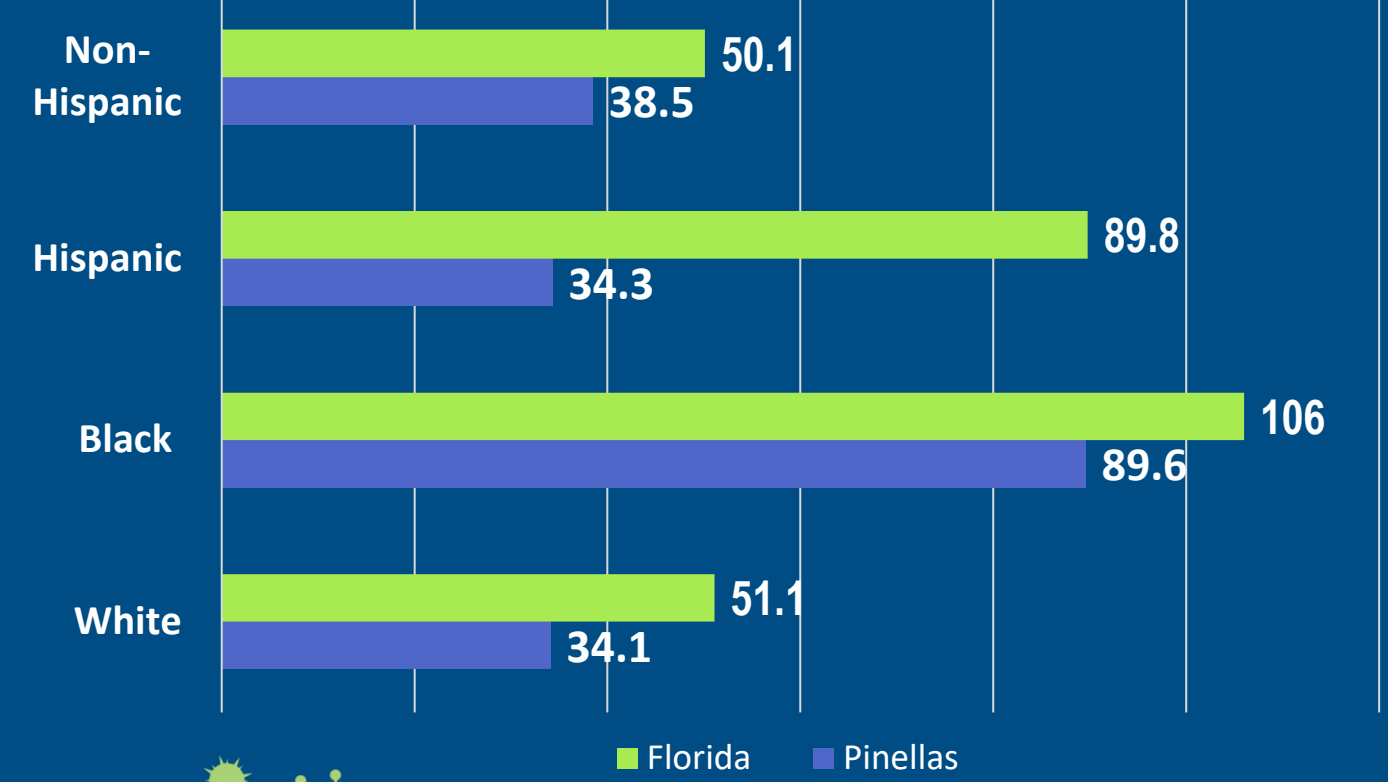
**DISPARITIES IN HIV/AIDS DIAGNOSES**  
(Per 100,000 population, 2018-2020)



**REPORTABLE AND INFECTIOUS DISEASES**  
(Per 100,000 population, 2015-2017)



**Age-adjusted deaths from COVID-19, rate per 100,000 population, by race, 2020**



**64.1%** Persons fully vaccinated against COVID-19



- 42.6%** Adults who received a flu shot in the past year, 2019
- 84.7%** Two-year olds fully immunized, 2019
- 92.2%** Kindergarten children fully immunized, 2021

Sources: FLHealthCharts.gov; CHNA Survey Data

## Appendix E. Community Partners and Resources

The All4HealthFL collaborative gratefully acknowledges the participation of a dedicated group of organizations and individuals that gave generously of their time and expertise to help guide this CHNA report.

### ALL4HEALTHFL COLLABORATIVE LEADING MEMBERS

First & Last Name	Credentials	Title	Organization
<b>Allison Nguyen</b>	MPH, MCHES	Program Manager	Florida Department of Health-Hillsborough County
<b>Alyssa Smith</b>	MPH	Community Benefit Coordinator	AdventHealth
<b>Bradlie Nabours</b>	MPH, CPH	Project Evaluator, Healthy Start Government & Community Affairs	Johns Hopkins All Children's Hospital
<b>Chedeline Apollon</b>		Senior Human Services Program Specialist-The Office of Health Equity	Florida Department of Health in Hillsborough County
<b>Christopher Gallucci</b>	DHSc, MPH, CPH	Public Health Services Manager	Florida Department of Health in Pinellas County
<b>Colleen Mangan</b>	MPH	Community Benefit Data Analyst	BayCare Health System
<b>DAmato Marina</b>		Health Education Consultant/CHA/CHIP Coordinator	Florida Department of Health in Pasco County
<b>Kellie Gilmore</b>		Community Health and Wellness Manager	
<b>Kimberly Berfield</b>		Vice President, Government Affairs and Community Health	Johns Hopkins All Children's Hospital
<b>Kimberly Brown-Williams</b>		Project Director and Interim Principal Investigator, Healthy Start	Johns Hopkins All Children's Hospital
<b>Kimberly Williams</b>		Director of Community Benefit	AdventHealth
<b>Laine Fox-Ackerman</b>			
<b>Lisa Bell</b>	MPH	Community Benefit Manager	BayCare Health System
<b>Megan Carmichael</b>		Community Health Promotion Program Manager	
<b>Nathanael Stanley</b>	PhD	Applied Research Scientist Community Benefit Specialist	Moffitt Cancer Center
<b>Nosakhare Idehen</b>	MD, Ph.D, MHA, RN		Florida Department of Health in Pinellas County
<b>Sara Osborne</b>		Director Community Benefit	Bayfront Health System

## Appendix E. Community Partners and Resources

<b>Stephanie Arguello</b>	MPH, RYT-200	Director of Community Health	AdventHealth
<b>Stephanie Sambatakos</b>	MSEd	Community Health Improvement Supervisor	Johns Hopkins All Children's Hospital
<b>Tamika Powe</b>	MPH, MCHES, CDP	Manager, Community Benefit & Health Education Manager	Tampa General Hospital
<b>Tatiyana Badal</b>		Public Health Educator	Florida Department of Health in Pasco County
<b>Tom Panagopoulos</b>	MPH	Minority Health & Health Equity Coordinator	Florida Department of Health in Pasco County

### FOCUS GROUP SUPPORTING INDIVIDUALS

<b>Names/Organizations</b>	<b>Names/Organizations</b>	<b>Names/Organizations</b>
Audrey Beaton	Gladys Evan	Kyle Olle
Barbara White	Gloria Campbell	Lisa DePaolo
Barbara Williams	Iliana Santana Ramos	Lottie Cuthbertson
Bryan Voliton	Irisann Moon	Mandy Keyes
Candace Gioia	Jacqueline (Diane) Morris	Maria Pepe
Christie Bruner	James Moon	Michael Otto
David Hill	jfrank	Nathan Bruemmer
David Kinnard	Joe Santini	Noliyanda James
David Lomaka	Julia Delmerico	Petra Stanton
Denise Whitfield	Kevin Dorsey	Rebeca Prado
Dr. Sheron Brown	Kim Saberi	Terri Lipsey Scott
Eliseo Santana	Kimberly Brown-Williams	Tiffany scurlock

## Appendix E. Community Partners and Resources

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Pinellas County Partner Organizations		
211 Tampa Bay Cares	Gulfcoast Jewish Family Services	Pinellas County School Board
Access Community Services	Gulfcoast North Area Health Education Center	Pinellas County Sheriff's Office
Access Florida	HCA Healthcare	Pinellas County Urban League
Agency for Persons with Disabilities	HCR Manor	Pinellas Hope
American Heart Association	Health Council of West Central Florida	Pinellas Sheriff's Police Athletic League
Area Agency on Aging of Pasco-Pinellas, Inc.	Healthy St. Pete	Pinellas Suncoast Transit Authority
Behavioral Health Systems of Care	Healthy Start Coalition of Pinellas County	R'Club Child Care
Boys and Girls Club	Healthy Start Federal Project	Red Cross
City of Largo	Homeless Empowerment Program (HEP)	Salvation Army
City of St. Petersburg	InterCultural Advocacy Institute	Seniors in Service of Tampa Bay
Clearwater Free Clinic	Johns Hopkins All Children's Hospital	St. Petersburg College
Clearwater Urban Leadership Coalition (CULC)	Juvenile Welfare Board of Pinellas County	St. Petersburg Free Clinic
Community Dental Clinic	Largo Medical Center	St. Petersburg Police Department
Domestic Violence Task Force of Pinellas County	Lighthouse Pinellas	St. Vincent de Paul
Early Learning Coalition	Limitless Leader Inc.	Suncoast Center Inc.
Ending the HIV Epidemic Council	Local Food Project	Suncoast Health Council
Evara Health	Lutheran Services Florida	Suncoast Hospice
Family Resources	Mothers Against Drunk Driving	Tampa Bay Healthcare Collaborative
Feeding Tampa Bay	NAMI Pinellas County Florida, Inc.	University of Florida IFAS Extension
Florida Center for Community Design & Research	Neighborhood Family Centers	University of South Florida College of Public Health
Florida Consumer Action Network	Operation PAR	Veterans Counseling Veterans
Florida Hospital North Pinellas	Peace for Tarpon	YMCA of St. Petersburg
Forward Pinellas	Pinellas County Health and Human Services	YMCA of the Suncoast



## Appendix E. Community Partners and Resources

Foundation for a Healthy St Petersburg	Pinellas County Housing Authority	
Fresh Initiatives Supply Hub	Pinellas County Planning Department	
Greater Ridgecrest Area Youth Development Initiative - Pinellas County Housing Authority		