Pinellas County

COMMUNITY HEALTH IMPROVEMENT PLAN

2013 - 2017

Healthier People in a Healthier Pinellas

PINELLAS COUNTY

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2013 - 2017

Produced by: Florida Department of Health in Pinellas County

Table of Contents

Executive Summary 3
I. Introduction 5
Moving from Assessment to Planning: What is the CHIP? 6
How to use the Community Health Improvement Plan 6
II. Methods 6
Community Engagement 7
Visioning 7
Setting Strategic Priorities 8
Development of Goals, Strategies, and Objectives 10
Development of the Action Plan 11
III. Health Priority Areas 16
Access to Care 17
Behavioral Health 19
Health Promotion and Disease Prevention 21
Healthy Communities and Environments 23
IV. Next Steps 25
V. Acknowledgements 25
VI. Appendices 29
Appendix A: Alignment 29
Appendix B. 2013 – 2014 Action Plans 33
Access to Care 33
Behavioral Health 44
Health Promotion and Disease Prevention 55
Healthy Communities and Environments 65

Executive Summary

The Florida Department of Health in Pinellas County (DOH-Pinellas) initiated the community health improvement planning process for Pinellas County in 2012, following the release of the 2012 Pinellas County Community Health Assessment. Over the past year, local public health system partners have convened a Community Health Action Team (CHAT) to guide the development of this 2013 - 2017 Community Health Improvement Plan (CHIP) for Pinellas County. A CHIP is a long-term, systematic plan to address public health problems in a community. The purpose of the CHIP is to define how DOH-Pinellas and the community will work together to improve the health of Pinellas County.

Using the Mobilizing for Action through Planning and Partnerships (MAPP) framework, CHAT identified access to care, behavioral health, health promotion and disease prevention, and healthy communities and environments as health priority areas for the Pinellas CHIP. CHAT and four health priority work teams have formulated goals, strategies, and objectives to address each of these areas. Additionally, 2013 - 2014 action plans outlining specific activities to achieve objectives have been developed for each priority area.

ACCESS TO CARE is a cross-cutting priority focused on reducing barriers to good health and improving health outcomes. Goals to ensure equal access to care include: (1) provide equal access to appropriate health care services and providers (2) use health information technology to improve collaboration among providers and increase efficiency in services to consumers and (3) reduce infant mortality and morbidity. Strategies to address these goals are standardizing training for community health workers, promoting the use of One-e-App as a common eligibility tool, and addressing disparities in infant mortality.

BEHAVIORAL HEALTH includes mental health, substance abuse, violence and other trauma. Goals to improve behavioral health outcomes include: (1) increase access to behavioral health services (2) reduce substance abuse among children and adults and (3) reduce violence among children and families. Among the strategies to address these goals is strengthening the integration of behavioral and primary health care services, advocating for changes in policy and practices related to prescription drugs, and promoting awareness related to domestic violence.

HEALTH PROMOTION AND DISEASE PREVENTION encompasses a range of health concerns including the leading causes of death in Pinellas County, cancer and heart

disease. Goals to address health promotion and disease prevention include: (1) increase the percentage of adults and children at a healthy weight (2) increase behaviors that improve chronic disease health outcomes and (3) increase protection against the spread of infectious disease. These goals will be addressed through strategies including promoting healthy eating habits and active lifestyles, increasing screening and education for chronic disease, and promoting childhood immunizations.

HEALTHY COMMUNITIES AND ENVIRONMENTS ensures access to opportunities for safe and healthy lifestyles. Goals for healthy communities and environments include (1) establish integrated planning and assessment processes to promote health in community level policies and plans (2) increase access to nutritious and affordable foods and (3) increase access to safe opportunities for physical activity. Strategies to achieve these goals include forming safe transportation linkages, promoting access to nutritious foods, and including health in the community planning process.

Over the next five years, DOH-Pinellas and the Community Health Action Team will lead Pinellas County in implementation of the Community Health Improvement Plan. These efforts will be evaluated annually and updated as necessary to align with community resources, activities, and partnerships.

As a member of the Pinellas community, we welcome your feedback and collaboration on future activities to achieve the goals set forth by CHAT. To become involved, visit www.PinellasCHAT.com or contact the Florida Department of Health in Pinellas County, Office of Performance and Quality Improvement.

I. Introduction

In 2011 and 2012, the Florida Department of Health in Pinellas County brought together the diverse entities and interests of Pinellas County to complete a Community Health Assessment (CHA). A CHA assesses the health of the population and identifies areas for health improvement. The CHA consisted of four assessments: Community Themes and Strengths Assessment, Local Public Health System Performance Assessment, Forces of Change Assessment, and Community Health Status Assessment. The Community Themes and Strengths Assessment utilized two approaches, a collaborative engagement and community survey, to better understand the perceived quality of life, current assets, and health issues of importance within the county. The collaborative engagement brought together nearly 70 community partners representing more than 30 organizations to assess the 10 Essential Public Health Services, including themes, strengths, and forces of change that affect Pinellas County and the Local Public Health System. The community survey spanned over five weeks, with more than eight hundred respondents who assessed perceived community health and quality of life issues within the county. The Forces of Change Assessment identified trends, factors, events, and other impending changes that influence the health and quality of life of Pinellas residents. It was conducted as part of the collaborative engagement previously described. The Local Public Health System Performance Assessment addressed the capacity of the local public health system and explored how the Essential Public Health Services are provided to the community. The Community Health Status Assessment determined the health status of the community through review of county-level data. This assessment also explored the socioeconomic factors influencing health and quality of life in the community, lifestyle behaviors, and how the health status of our community compares to that of other counties, the state, and the nation.

Following the Community Health Assessment, the Pinellas County Community Health Action Team (CHAT) convened in September 2012 to identify areas for health improvement and guide the development of the 2013 – 2017 Community Health Improvement Plan for Pinellas County.

Moving from Assessment to Planning: What is the CHIP?

A Community Health Improvement Plan (CHIP) is a long-term, systematic plan to address public health problems in a community. The purpose of the CHIP is to define how DOH-Pinellas and the community will work together to improve the health of Pinellas County. It provides the link between assessment and action. The CHIP was developed through collaboration among community partners to provide a framework to address the most pressing health issues in Pinellas County. The CHIP outlines goals, strategies, and objectives that the Community Health Action Team (CHAT) will address between 2013 and 2017. The CHIP action plan also identifies activities and measures to ensure progress towards these goals.

How to use the Community Health Improvement Plan

The CHIP will be used to engage the wide breadth of organizations that participate in the health and wellbeing of those residing in Pinellas County. The plan provides shared goals towards a common vision that will be used to direct activities to create *healthier people in a healthier Pinellas*. The CHIP action plans can be modified as resources, health concerns, and the environment change.

II. Methods

The Community Health Improvement Plan was developed using the Mobilizing for Action through Planning and Partnerships (MAPP) framework pictured at right. MAPP is a community-driven strategic approach to community health improvement planning developed collaboratively by the National Association of County and City Health Officials and Centers for Disease Control and Prevention.

Community Engagement

Community engagement is essential to creating a Community Health Improvement Plan that ensures effective, sustainable solutions. Using existing public and private partnerships, a diverse group of community partners collaborated to convene the Community Health Action Team (CHAT). Sectors represented on CHAT include local hospitals and health care organizations, local government, community based organizations, social service organizations, and schools. For a complete listing of CHAT members and work team and collaborative engagement participants, see Acknowledgements in Section V.

Visioning

During the community health assessment process 24 visioning themes for community health improvement in Pinellas County were identified. Of the themes identified, the top ten emerged as:

1. Access to care
2. Coordinated system of care
3. Integrated system of care
4. Comprehensive continuum of care
5. Prevention and wellness focus
6. Chronic disease prevention
7. Expanded use of technology
8. Accessible health information and data
9. Improved quality and outcomes
10. Accountability at the individual, institutional and community levels

Using the top ten identified vision themes, CHAT members developed a vision statement for community health improvement in Pinellas County. The purpose of the vision statement is to provide focus and direction for community health improvement planning. The vision encourages participants and the community to collectively achieve a shared image of the future. The CHAT vision is:

Healthier People in a Healthier Pinellas

Setting Strategic Priorities

CHAT members utilized the Community Health Assessment results to identify strategic issues in Pinellas County. Strategic issues are those issues critical to achieving the vision of Healthier People in a Healthier Pinellas. Team members individually noted strategic issues and then grouped them into common priority areas as seen in the following table.

Chronic Disease Prevention	• chronic disease prevention • asthma hospitalizations • better management of chronic diseases • health behaviors • chronic diseases (CHF, diabetes, obesity) • obesity/diabetes/high blood pressure and cholesterol • prevention/sedentary lifestyle • adults and children who are overweight • reduce hospitalizations for preventable diseases • understanding preventative care • chronic disease prevention (diabetes prevention, partnerships with community organizations) • educate/empower community to become engaged in their wellness
Access to Care	• access to care (those with no health insurance, transportation, health education/prevention/marketing) • adults and dentists • access to care • patient-centered care • patient empowerment/engagement • insurance • accessible quality care • access to primary care (physicians, ARNPs, P.A.s, alternatives to the ER) • access to prevention and wellness • access to health and dental care • learning how to access care • investing in children's health • medical home for all people who are not eligible for health insurance/Medicaid/Medicare • education and health care to prevent and treat chronic diseases • access to preventative care • access to health care – including specialists • language and cultural competency in delivery of hospital and clinic care

Maternal/Child Health	• infant mortality and pre-term births • birth control • family planning • teen births • increase pre-contraceptive resources • infant mortality
Health Protection	• immunization rates • bacterial STDs in the I-4 corridor • STD rates • health protection
Behavioral Health	• substance abuse/addiction • mental illness/suicide • substance abuse prevention and treatment • better understand complex casual pathways • substance abuse/prescription drugs • domestic violence/child abuse • addiction/substance abuse • juvenile justice referrals • drug education and treatment programs at all levels of treatment needed (detox to in-patient) for youth and adults • the true impact stress has on a family and head of household
Education	• address summer learning loss • 4th and 8th grade reading proficiency • education • increase high school education rates
Technology	• technology • EHR integrated between healthcare providers • system of care through HIE • coordinated/comprehensive electronic medical records

Community/ Environment	• improve sidewalks and bike lanes • increase access to fresh fruits and veggies • increase funding for a health promotion focus • create/sustain safe environments • socioeconomic disparities that impact a community's health and wellness • safety • access to health food choices in a "food desert" • transportation is a huge factor in obesity • built environment • walkable communities • safe communities • promote opportunities for families to be active together • community redevelopment • livable communities • public transportation • community partnerships • research that targets certain communities

After further discussion of these common priority areas, four health priority areas emerged as being critical to achieving the vision:

1. Access to Care
2. Behavioral Health
3. Health Promotion and Disease Prevention
4. Healthy Communities and Environments

During discussion, education and technology emerged as reoccurring themes that should be addressed through strategy development in each priority area.

Development of Goals, Strategies, and Objectives

Work teams were convened for each of the four health priority areas. CHAT members and additional community stakeholders were invited to participate on work teams based upon their expertise. The work teams developed goals and strategies, and set measurable objectives based upon available data and the issues identified under *Setting Strategic Priorities*. The teams also worked to identify activities for each objective to address selected strategies. CHAT work teams met monthly between January 2013 and June 2013. Over the six-month period, draft goals, strategies, and objectives were presented to CHAT for feedback and discussion. Alignment of CHIP

objectives with local, state, and national plans is outlined in Appendix A. The final draft of goals, strategies, objectives, and suggested activities was used at the collaborative engagement during the CHIP action planning process.

Development of the Action Plan

On May 22, 2013, CHAT and work teams came together with additional community stakeholders to complete the CHIP Action Cycle. Action planning occurred through a half-day Collaborative Engagement at the St. Petersburg College EpiCenter Collaborative Labs. During this engagement, CHAT members and community stakeholders indicated available resources and discussed how these resources may be used to achieve CHIP goals and objectives. The results of this activity are listed in the table that follows.

CHAT members and community stakeholders also worked on action planning for each health priority area, including review of activities and selection of timeframes, coordinating agency, partner agencies, and process measures for monitoring and evaluation. This process resulted in a draft Action Plan for each health priority area. The Real Time Record for the Collaborative Engagement, outlining this process in detail, is located on the St. Petersburg College website at: http://www.spcollege.edu/central/collaborative/13/PCCHAT/PCCHIP_RTR.pdf.

Following the collaborative engagement, CHAT and work team members met in June 2013 to prioritize activities for the July 2013 – December 2014 Action Plan. Coordinating agencies will be contacted to review the CHIP monitoring and evaluation plan between July and December 2013. Over the next five years, DOH-Pinellas and the Community Health Action Team will lead Pinellas County in implementation of the Community Health Improvement Plan. These efforts will be evaluated annually and updated as necessary to align with community resources, activities, and partnerships.

Goal	Community Partner Alignment and Community Resources
ACCESS TO CARE	
Equal Access to Health Care Services and Providers	• DOH-Pinellas – Pinellas provider of medical homes for uninsured/low income • Pinellas County Health and Human Services – Primary care services, specialty care, and mobile medical unit • St. Petersburg Free Clinic – Access to adults who are uninsured • St. Joseph's Children's Hospital – Provide free well-child physicals and immunizations through the mobile medical clinic • DOH-Pinellas – Breast and Cervical Early Detection and Screening Program - Cancer screening for uninsured women, family planning services on sliding fee scale • Homeless Leadership Board – Coordination and planning for homeless services • Moffitt Cancer Center – Connecting community to health resources and agencies and increasing access to care • Pinellas KidCare Coalition – Providing insurance options for uninsured children • DOH-Pinellas – Increase access to dental care • All Children's Hospital • Tampa Bay Healthcare Collaborative – Collaborate and advocate for the healthcare underserved and work to connect these individuals with available resources • Juvenile Welfare Board – Works with 211 Tampa Bay Cares to connect people with resources; planning a study on the at risk areas of Pinellas County • 2-1-1 Tampa Bay Cares – Provide referrals for health and mental health services • Healthy Start for Pinellas – Working with KidCare to get kids insured in Pinellas County • St. Petersburg College – Networking; Community Health Worker Initiative • Hispanic Outreach Center • Lealman and Asian Neighborhood Family Center
Use of Health Information Technology to Improve Collaboration	• DOH-Pinellas – Use of direct secure messaging, health information exchange, and One E-app • USF Health – Working to implement Paperfree Florida – HItech, EHR/EMR – DSM & HIE

Reduce Infant Mortality & Morbidity	• DOH-Pinellas - Maternal & Child Health – Address issues that affect women and babies, increasing access to care and providing home visiting to interconceptual and pregnant women • Juvenile Welfare Board – Advocacy, planning, funding • All Children's Hospital • Healthy Start Coalition of Pinellas • Operation PAR
BEHAVIORAL HEALTH	
Increase Access to Behavioral Health Services	• SEDNET/PCSB – training, facilitate connections • BayCare Behavioral Health – Centralized access, primary care integration • Homeless Leadership Board – Coordination and planning of services • Juvenile Welfare Board – Funding and planning • DOH-Pinellas – Referral and counseling services • Peace4Tarpon TICI – Trauma informed care and behavioral health • Directions for Living – Provide a variety of mental health and substance abuse services • Operation PAR
Reduce Substance Abuse Among Children and Adults	• Public Defender's Office– Working to reduce incidence and effects of prescription drug abuse • WestCare – Adolescent and family prevention services, education, and family counseling • Juvenile Welfare Board – Funding and planning of services • DrugFree America Foundation – Education, advocacy, research • SEDNET/PCSB – Navigation of the healthcare system for children and families • Peace4Tarpon TICI • Healthy Start Coalition of Pinellas – PAT + Program • Operation PAR • DOH-Pinellas – Home visiting services to pregnant women and families • Substance Exposed Newborn task force • LiveFree! Substance Abuse Prevention Coalition
Reduce Violence Among Children & Families	• DOH-Pinellas – Home Visiting for pregnant women • SEDNET/PCSB - Helps children and families to navigate the healthcare system • R' Club Childcare Inc. – Provides before and after school care for children throughout Pinellas County • Juvenile Welfare Board – Funding, planning, advocacy

	• Drug Free America Foundation – Working to reduce and prevent drug abuse, which directly correlates to violence • Peace4Tarpon TICI • LiveFree! Substance Abuse Prevention Coalition • The Haven of RCS
HEALTH PROMOTION AND DISEASE PREVENTION	
Increase the percentage of Adults & Children Who are at Healthy Weight	• UF/IFAS – Pinellas County Extension – Outreach and education in community; provide nutrition education; encourage policy change related to healthy behaviors and worksite wellness • R'Club Childcare Inc. – Align with A Healthier Generation guidelines and before and after school care • Moffitt Healthy Kidz Program – Moffitt Cancer Center • USF Health Patient Portal & Patient Education • All Children's Hospital – Works with families to maintain healthy weight; prenatal health programs • ONE BAY: Healthy Communities – Focusing on 8 counties to increase the percentage of residents who are at a healthy weight • DOH-Pinellas - Home visiting weight management classes • Healthy Start Coalition of Pinellas Inc. • YMCA – Healthy eating and physical activity programs in after school care; diabetes prevention program to help combat chronic disease • Peace4Tarpon TICI
Increase Behaviors that Improve Chronic Disease Health Outcomes	• DOH-Pinellas – Tobacco Program • HEDIS Measures include preventive services in provision of primary care • GulfCoast North Area Health Education Center (AHEC)– Provides free tobacco cessation services • Homeless Leadership Board Planning and Coordination • All Children's Hospital • Pinellas County Extension - Nutrition Education • Moffitt Cancer Center – Work with organizations to provide cancer education and services • YMCA • Peace4Tarpon TICI • St. Petersburg Free Clinic – Comprehensive education-based model for diabetes
Increase Protection Against Spread of Infectious Diseases	• DOH-Pinellas – Promotion of immunization; STD/HIV education and prevention • St. Joseph's Children's Hospital – Immunization education and services • All Children's Hospital – immunizations, Back to School physicals

HEALTHY COMMUNITIES AND ENVIRONMENTS	
Integrate Planning and Assessment	• DOH-Pinellas – Strategic planning and community health improvement planning • Juvenile Welfare Board – Strategic alignment, planning, advocacy, and building community partnerships • Homeless Leadership Board – planning and coordination of services • Healthy Start Coalition of Pinellas • St. Petersburg College – Networking and training initiatives
Increase Access to Nutritious/Affordable Foods	• DOH-Pinellas – WIC – Advocate for farmer's market accepting EBT/SNAP • UF/IFAS – Pinellas County Extension – Works on access to nutritious foods through farmer's markets, gardens, and nutrition education • Homeless Leadership Board - Coordination and planning • All Children's Hospital – Nutrition Education programs for families • Pinellas County Schools, Food Services – Nutrition Education; provides nutritious food to children: breakfast, lunch, dinner, summer meals (breakfast and lunch)
Increase Access to Safe Physical Activity	• DOH-Pinellas – Find the Fun Now! Website; Communities Putting Prevention to work program provided fitness zones and encouraged policy change • City of Largo – Recreation programs, playgrounds, trails, pools, fitness zones • Juvenile Welfare Board – Out of school time activities • R'Club Childcare Inc. • All Children's Hospital – Safe Routes to School Program

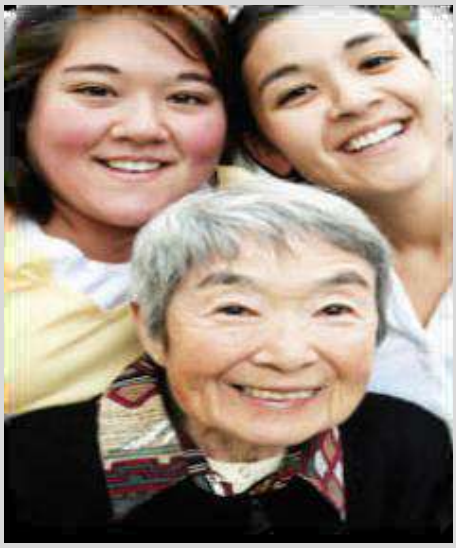
III. Health Priority Areas

Each health priority area, a summary of the data supporting it, and related goals, strategies, and objectives are described in the pages that follow. A corresponding action plan has also been produced for each health priority area, found in Appendix B. Planned activities for 2013 and 2014 are described in detail in these action plans. Action plans for years 2015, 2016, and 2017 will be available as addendums to the 2013 – 2017 Pinellas County Community Health Improvement Plan as they become available. Updates to the CHIP and subsequent action plans will be available at the Pinellas County Community Health Action Team website, www.PinellasCHAT.com.

Access to Care

Why address Access to Care?

Addressing access to care can reduce barriers to health such as inadequate transportation, cultural or linguistic barriers, technical infrastructure, and social and economic barriers. Disparities in access to care have been linked to disparities in health outcomes. Such disparities can be seen in deaths due to chronic disease and in infant mortality rates in Pinellas County.



Community Perspective

Concerns regarding access to care were prevalent in the 2012 Pinellas County Community Health Assessment. In the Community Themes and Strengths Assessment, access to care was the most frequently cited factor needed for a healthy community, selected by 59.4% of Pinellas County Community Health Survey respondents.

Consulting the Data

- The majority of Pinellas adults (88.7%) had a personal doctor in 2010
- However, 16% of Pinellas adults could not see a doctor at least once in the past year due to cost in 2010
- 78.8% of Pinellas adults had a medical checkup in the past year in 2010
- 7.5% of Pinellas adults thought they would get better medical care if they belonged to a different race or ethnic group (2010)
- Community Health Workers presence and increased use of technology, such as the health information exchange, can help shape access to care
- The percentage of low birth weight live births (less than 2,500 grams) in Pinellas was 8.9%, higher than Florida at 8.7% (2010 – 2012)
- Only 78.0% of Pinellas women received first trimester prenatal care services (2009-2011)
- Infant mortality in Pinellas was 6.7 per 1,000 live births (6.3 per 1,000 live births FL) and for Black infants, this rate increased to 13.9 per 1,000 live births (2010 – 2012)

*Additional data, resources, and citations are listed in the 2012 Pinellas County Community Health Assessment. Data provided was obtained through Florida CHARTS, located at www.floridacharts.com.

Strategic Issue: How can we ensure equal access to health care services in Pinellas County?

Goal AC 1: Provide equal access to appropriate health care services and providers	**Strategy 1.1**: Address barriers in accessing existing health care services and consumer utilization in underserved communities. ❖ ***Objective 1.1.1***: *By Dec 31, 2017, decrease the percentage of Pinellas adults who are unable to access a health care provider due to cost from 16% (2010) to 14.4%.*
	Strategy 1.2: Develop and implement a standardized training program for Community Health Workers. ❖ ***Objective 1.2.1***: *By Dec 31, 2017, increase the number of trained Community Health Workers in Pinellas by 25% over baseline.*
	Strategy 1.3: Promote the completion of a cultural and linguistic competence organizational self-assessment to improve access to culturally competent care. ❖ ***Objective 1.3.1***: *By Dec 31, 2016, decrease the percentage of Pinellas adults who believe they would receive better medical care if they belonged to a different race/ethnic group from 7% (2010) to 6.3%.*
Goal AC 2: Use health information technology to improve collaboration among providers and increase efficiency in services to consumers	**Strategy 2.1**: Promote provider usage of the One-e-App as a common eligibility tool to streamline access to services. ❖ ***Objective 2.1.1***: *By Dec 31, 2017, increase consumer utilization of One-E-App in Pinellas by 25% over baseline.*
	Strategy 2.2: Improve communication among health providers and coordination of care for consumers through data sharing. ❖ ***Objective 2.2.1***: *By Dec 31, 2017, at least 50% of licensed registered Direct Secured Messaging (DSM) providers in Pinellas will be able to exchange data by using a Florida Health Information Exchange (HIE).* ❖ ***Objective 2.2.2***: *By Dec 31, 2017, no less than 25% of health services providers will be able to exchange data by using Direct Secured Messaging (DSM).*
Goal AC 3: Reduce infant mortality and morbidity	**Strategy 3.1**: Raise awareness among providers and consumers on the importance and benefits of being healthy prior to pregnancy. ❖ ***Objective 3.1.1***: *By Dec 31, 2017, decrease the percentage of low-birth weight (less than 2,500 grams) infants in Pinellas from 8.9% (2010-2012) to 8%.*
	Strategy 3.2: Increase access to prenatal services and education. ❖ ***Objective 3.2.1***: *By Dec 31, 2017, increase the percentage of births to Pinellas mothers receiving first trimester prenatal care from 79.1% (2010-2012) to 87%.*
	Strategy 3.3: Address disparities in Black and Hispanic infant mortality. ❖ ***Objective 3.3.1***: *By Dec 31, 2017, reduce the infant mortality rate of Black infants in Pinellas from 13.9 per 1,000 live births (2010-2012) to 11.5 per 1,000 live births.* ❖ ***Objective 3.3.2***: *By Dec 31, 2017, reduce the infant mortality rate of Hispanic infants in Pinellas from 8.1 per 1,000 live births (2010-2012) to 7.3 per 1,000 live births.*

Behavioral Health

Why address Behavioral Health?

Substance abuse, mental health, and violence among children and families affect not only the individual, but also the community. Further, behavioral health needs can go neglected and violence unreported due to stigma and other barriers to services. A focus on behavioral health creates an opportunity to address these barriers and improve the community's overall health and quality of life.

Community Perspective

Concern for behavioral health is found throughout the 2012 Pinellas Community Health Assessment. In the Community Themes and Strength Assessment, addiction was the top health problem of concern. Similarly, alcohol and drug abuse was the most frequently selected behavior of concern. Smoking was the fifth most prevalent behavior of concern.

Consulting the Data

- In 2010, 83.3% of Pinellas adults always or usually received the social and emotional support they needed
- The suicide age-adjusted death rate within the county was 17.7 per 100,000 population, increasing to 28.9 per 100,000 men (2009 – 2011)
- In 2012 the percentage of Pinellas youth who reported illicit drug use was 31.1%.
- In 2010, there were 153 newborn withdrawal cases in Pinellas County, up from just 22 in 2005.
- There were 201 accidental deaths due to prescription drugs in 2012
- The rate of Pinellas children 5 -11 experiencing child abuse was 18.8 compared to 11.4 per 1,000 population in Florida (2009 – 2011)
- The county domestic violence rate was 772.8 compared to 605 per 100,000 population in Florida (2009- 2011)
- The rate of non-fatal hospitalizations for self-inflicted injuries in Pinellas youth ages 12 to 18 was 72.9 per 100,000 population (2008 – 2010)

*Additional data, resources, and citations are listed in the 2012 Pinellas County Community Health Assessment. Data provided was obtained through Florida CHARTS, located at www.floridacharts.com.

Strategic Issue: How can we ensure access to behavioral health services and improve behavioral health outcomes in Pinellas County?

Goal BH 1: Increase access to behavioral health services	**Strategy 1.1**: Strengthen the integration of behavioral and primary health care service delivery. ❖ ***Objective 1.1.1***: *By Dec 31, 2016, increase the percentage of Pinellas adults who always or usually receive the social and emotional support they need from 83.3% (2010) to 90%.*
	Strategy 1.2: Integrate trauma-informed care practices across care settings with emphasis on Adverse Childhood Experiences (ACEs). ❖ ***Objective 1.2.1***: *By Dec 31, 2017, reduce the rate of non-fatal hospitalizations for self-inflicted injuries from 72.9 per 100,000 (2008-2010) to 65.6 per 100,000 among Pinellas youth 12-18.*
	Strategy 1.3: Engage targeted at-risk populations to better understand behavioral health care needs and prevent barriers to access. ❖ ***Objective 1.3.1***: *By Dec 31, 2017, decrease the suicide age-adjusted death rate in Pinellas from 17.7 per 100,000 (2010-2012) to 16.2 per 100,000.*

Goal BH 2: Reduce substance abuse among children and adults	**Strategy 2.1**: Advocate for changes in policy and practices related to substance abuse, including more stringent regulations for prescription drugs classified as controlled substances. ❖ ***Objective 2.1.1***: *By Dec 31, 2017, reduce the number of accidental drug or toxin related deaths in Pinellas from 201 (2012) to 181.*
	Strategy 2.2: Raise awareness among providers, parents, youth, and businesses on emerging substance abuse trends to improve and inform practices. ❖ ***Objective 2.2.1***: *By Dec 31, 2016, reduce the number of Pinellas youth who report lifetime drug use from 31.1% (2012) to 26.1%.*
	Strategy 2.3: Increase access to substance abuse services for prenatal and postpartum women. ❖ ***Objective 2.3.1***: *By Dec 31, 2017, reduce the rate of Neonatal Abstinence Syndrome in Pinellas from 27.1 per 1,000 births (2009-2011) to 24.4 per 1,000 births.*

Goal BH3: Reduce violence among children and families	**Strategy 3.1**: Promote community programs that maximize healthy development and interaction among children, families, schools, and communities. ❖ ***Objective 3.1.1***: *By Dec 31, 2017, reduce the rate of Pinellas children under 18 experiencing child abuse from 24.0 per 1,000 (2012) to 16.9 per 1,000.*
	Strategy 3.2: Promote awareness, training, and advocacy to improve and inform practices related to domestic violence. ❖ ***Objective 3.2.1***: *By Dec 31, 2017, reduce the domestic violence rate in Pinellas from 772.8 per 100,000 (2009-2011) to 695.5 per 100,000.*

Health Promotion and Disease Prevention

Why address Health Promotion and Disease Prevention?

Health promotion and disease prevention encompasses a range of health concerns, including chronic and infectious disease prevention and the behaviors contributing to a healthy lifestyle. Among these health concerns are the leading causes of death within Pinellas County, cancer and heart disease. Improvement in the behaviors affecting health outcomes is needed, notably the county's high rate of tobacco use and low rate of childhood immunizations.

Community Perspective

In the Community Themes and Strengths Assessment, healthy behaviors was the second most frequent factor chosen when residents were asked the top three factors needed for a healthy community. Similarly, among the top health problems of concern were obesity (#2) and chronic diseases (#3). The most frequent behaviors of concern included: poor nutrition (#2), lack of physical activity (#3), being overweight (#4), and smoking (#5).

Consulting the Data

- The leading causes of death in Pinellas County are cancer and heart disease
- Many adults do not receive routine cancer screenings – putting them at risk of late stage diagnoses
- The majority of adults, 60.1%, did not meet daily fruit and vegetable consumption recommendations and many (25.5%) are sedentary
- Nearly 20% of the adult population (19.3%) smoked tobacco in 2010
- Of the 2012 middle school students in Pinellas County, 28.1% of middle school students and 37.1% of high school students did not receive sufficient vigorous physical activity
- In 2010, 36.6% of Pinellas County adults had hypertension and 47.9% had high blood cholesterol
- In 2010, 65.9% of Pinellas County adults were either overweight or obese
- In 2009 – 2011, Pinellas County fell within the fourth quartile ranking of completing immunizations by Kindergarten

*Additional data, resources, and citations are listed in the 2012 Pinellas County Community Health Assessment. Data provided was obtained through Florida CHARTS, located at www.floridacharts.com.

Strategic Issue: How can we promote healthy lifestyles and prevent disease in Pinellas County?

Goal HPDP 1: Increase the percentage of adults and children who are at a healthy weight	**Strategy 1.1**: Promote healthy eating habits and active lifestyles in adults. ❖ ***Objective 1.1.1***: *By Dec 31, 2017, decrease the percentage of Pinellas adults who are either overweight or obese from 65.6% (2010) to 59%.*
	Strategy 1.2: Promote healthy eating habits and active lifestyles in children ❖ ***Objective 1.2.1***: *By Dec 31, 2017, increase the proportion of Pinellas children (1st, 3rd, 6th grade) who are at a healthy weight from 65.1% (2010 - 2011) to 71.6%.* ❖ ***Objective 1.2.2***: *By Dec 31, 2017, decrease the percentage of Pinellas high school students reporting BMI at or above 95th percentile from 10.3% (2012) to 9.3%.*
Goal HPDP 2: Increase behaviors that improve chronic disease health outcomes	**Strategy 2.1**: Promote screening, education, and referral to treatment related to cancer. ❖ ***Objective 2.1.1***: *By Dec 31, 2017, increase the percentage of Pinellas adults age 50 or older who received a colorectal screening in the past five years from 73.5% (2010) to 80.9%.* ❖ ***Objective 2.1.2***: *By Dec 31, 2017, increase the percentage of Pinellas women age 40 or older who received a mammogram in the past year from 61.5% (2010) to 67.7%.*
	Strategy 2.2: Promote screening, education, and referral to treatment related to heart disease. ❖ ***Objective 2.2.1***: *By Dec 31, 2017, decrease deaths due to heart disease in Pinellas from 155.5 per 100,000 (2010-2012) to 139.9 per 100,000.*
	Strategy 2.3: Promote activities to reduce tobacco use and exposure in adults and youth. ❖ ***Objective 2.3.1***: *By Dec 31, 2017, increase the number of committed never smokers among Pinellas youth, ages 11 - 17 from 64.1% (2012) to 70.5.* ❖ ***Objective 2.3.2***: *By Dec 31, 2016, decrease the percentage of Pinellas adults who are current smokers from 19.3% (2010) to 17.4%.*
Goal HPDP 3: Increase protection against the spread of infectious disease	**Strategy 3.1**: Provide targeted education on the benefits of receiving immunizations to increase the percentage of children who are fully immunized. ❖ ***Objective 3.1.1***: *By Dec 31, 2017, increase the percentage of Pinellas two-year-olds who are fully immunized from 75.3% (2012/2013) to 90%.* ❖ ***Objective 3.1.2***: *By Dec 31, 2017, increase the percentage of Pinellas Kindergarteners who are fully immunized from 89.8% (2012/2013) to 94%.*

Healthy Communities and Environments

Why address Healthy Communities and Environments?

Creating healthy communities and environments provides opportunity for residents to live a healthy lifestyle more easily. This priority addresses the effects that the physical and built environment has on health. Access to fresh fruits and vegetables, as well as to physical activity, can improve chronic disease health outcomes and the rates of obesity within the county.

Community Perspective

Creating a healthy community and environment addresses many of the concerns found throughout the 2012 Pinellas County Community Health Assessment. The top health problems of concern within the community included obesity (#2) and chronic diseases (#3) – both influenced by the environment in which a person is living. A clean environment and safe neighborhood ranked #3 and #4 as the most important factors for a healthy community.

Consulting the Data

- 32.7% of adults believed they did not have public recreation facilities that they could access in 2010
- In 2010, 7.8% of the population was living within 500 feet of a busy roadway
- Approximately half (50.6%) of the population lived within 0.5 miles (10 minute walk) from a park in 2010
- Only 20.4% of the population lived within a 0.5 miles of an off street trail system in 2010
- Over one-quarter of adults (25.5%) disagreed or strongly disagreed that it was easy to purchase affordable fresh fruits and vegetables in their neighborhood (2010)
- Nearly all adults, 96.2%, live 5 miles or less from the grocery store where they did most of their family's grocery shopping (2010)
- Over half (54.6%) of adults do not have access to a farmers market within their neighborhood (2010)
- 41% of the county population lives within 0.5 mile of a fast food restaurant; 43.2% of the population lives within 0.5 mile of a healthy food source

*Additional data, resources, and citations are listed in the 2012 Pinellas County Community Health Assessment. Data provided was obtained through Florida CHARTS, located at www.floridacharts.com.

Strategic Issue: How can we ensure an environment that is safe and provides access to opportunities for a healthy lifestyle?

Goal HCE 1: Establish integrated planning and assessment processes that promote health in community level policies and plans

Strategy 1.1: Include a public health component in community planning processes to increase awareness and opportunity of the built environment's impact on healthy behaviors.

- ***Objective 1.1.1***: *By Dec 31, 2016, increase activity related to the development of policies and plans that support individual and community health within Pinellas from a score of 82% (2012) to 90%.*

Goal HCE 2: Increase access to nutritious and affordable foods

Strategy 2.1: Promote options for access to nutritious foods throughout Pinellas County.

- ***Objective 2.1.1***: *By Dec. 31, 2016, increase the percentage of Pinellas adults who meet both of the daily recommendations for fruit and vegetable consumption from 9.3% (2010) to 11.5%.*

Strategy 2.2: Support a focused effort to increase access to nutritious and affordable foods for children

- ***Objective 2.2.1***: *By Dec 31, 2017, increase the percentage of Pinellas middle school students who consume at least five servings of fruits and vegetables a day from 21.2% (2012/2013) to 23.3%.*

Goal HCE 3: Increase access to safe opportunities for physical activity

Strategy 3.1: Promote collaborative efforts to form safe transportation linkages to schools, work, home, and recreation.

- ***Objective 3.1.1***: *By Dec 31, 2017, complete 15 transportation linkages in Pinellas through infrastructure and programming improvements.*
- ***Objective 3.1.2***: *By Dec. 31, 2016, decrease the percentage of Pinellas adults who were sedentary, or did not participate in any leisure-time activity in the past 30 days from 25.5% (2010) to 22%.*

IV. Next Steps

CHAT members and community stakeholders will begin implementation of the Community Health Improvement Plan in July 2013 (See Appendix B: 2013 – 2014 Action Plan). Progress on activities will be evaluated annually by CHAT with updates to the action plans as needed. Program monitoring and annual evaluation updates will be available at www.PinellasCHAT.com.

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VI. Appendices

Appendix A: Alignment

Aligned National, State, and Local Measures	
Access to Care	**Alignment**
Goal AC 1: Provide equal access to appropriate health care services and providers	
Strategy 1.1	Florida SHIP Strategy AC1.1, Healthy People 2020 AHS 6, PHAB 7.1
Objective 1.1.1	Florida SHIP AC 1.1.1
Objective 1.2.1	Florida SHIP HI3.4
Strategy 1.3	Florida SHIP Goal AC7/ Strategy AC7.1, Strategy CR3.2, PHAB Measure 11.1.3 (4)
Objective 1.3.1	Florida SHIP AC7.1.2 & 1.3, Key Health Disparity Objective and Measures (Appendix E), National Prevention Strategy, 2011-2016 Pinellas County Healthy Start Service Delivery Plan: B-3-1 (2)
Goal AC 2: Use health information technology to improve collaboration among providers and increase efficiency in services to consumers	Florida SHIP Goal HI1
Strategy 2.2	Florida SHIP Strategy HI1.1
Objective 2.2.1	Florida SHIP Strategy HI1.1
Objective 2.2.2	Florida SHIP Goal HI1/Strategy HI11.1
Goal AC 3: Reduce infant mortality and morbidity	Florida SHIP Goal AC5, Healthy People 2020 MICH1.3
Strategy 3.1	Florida SHIP Strategy AC5.1, Healthy People 2020 MICH 16.1, 2011-2016 Pinellas County Healthy Start Service Delivery Plan: Strategies B-2-3, C-2-1, C-2-2
Objective 3.1.1	Healthy People 2020 MICH 8.1, 2011-2016 Pinellas County Healthy Start Service Delivery Plan: Strategy B-4-1 (5)
Strategy 3.2	Healthy People 2020 MICH – 10

Objective 3.2.1	Healthy People 2020 MICH 10.1
Strategy 3.3	Florida SHIP Strategy AC5.4, Key Health Disparity Objective and Measures (Appendix E), Healthy People 2020 MICH 1.3
Objective 3.3.1	Florida SHIP Objective AC5.4.4
Behavioral Health	**Alignment**
Goal BH 1: Increase access to behavioral health services	Florida SHIP AC 3
Strategy 1.1	Florida SHIP AC 3.1, Healthy People 2020 MHMD-5, Recommended by the Centers for Disease Control and Prevention's Community Guide
Objective 1.3.1	Healthy People 2020 MHMD-1
Goal BH 2: Reduce substance abuse among children and adults	Florida SHIP AC 3.2
Objective 2.2.1	Healthy People 2020 SA- 2.4
Goal BH3: Reduce violence among children and families	
Objective 3.1.1	Healthy People 2020 IVP 37; IVP 38
Strategy 3.2	Healthy People 2020 IVP 39
Objective 3.2.1	Healthy People 2020 IVP 39.1; IVP 39.2; IVP 39.3; IVP 39.4
Health Promotion and Disease Prevention	**Alignment**
Goal HPDP 1: Increase the percentage of adults and children who are at a healthy weight	Florida SHIP Goal CD 1, Healthy People 2020 NWS-8, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity, One Bay Regional Plan Focus
Strategy 1.1	Healthy People 2020 NWS-8, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity, One Bay Regional Plan Focus
Objective 1.1.1	Healthy People 2020 NWS-8, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity, One Bay Regional Plan Focus
Strategy 1.2	Healthy People 2020 NWS-10, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity, One Bay Regional Plan Focus
Objective 1.2.1	Florida SHIP CD 2.3.4, Healthy People 2020 NWS-10, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity, One Bay Regional Plan Focus
Objective 1.2.2	Florida SHIP CD 2.3.4, Healthy People 2020 NWS 10.3; NWS-10, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity, One Bay Regional Plan Focus

Goal HPDP 2: Increase behaviors that improve chronic disease health outcomes	Florida SHIP CD 3, Healthy People 2020 NWS D-1
Strategy 2.1	Florida SHIP CD3.2
Objective 2.1.1	Florida SHIP CD 3.2.1, Healthy People 2020 C-3; C-17
Objective 2.1.2	Florida SHIP CD 3.2.2, Healthy People 2020 C-5; C-16
Strategy 2.2	Florida SHIP CD 3.2, Healthy People 2020 HDS-1
Objective 2.2.1	Healthy People 2020 HDS; HDS-1
Strategy 2.3	Florida SHIP Goal CD4, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity
Objective 2.3.1	Florida SHIP CD 4.1.1, Healthy People 2020 TU-3
Objective 2.3.2	Florida SHIP CD 4.2.1, Healthy People 2020 TU-4, TU-5, TU-7, Recommended by the Centers for Disease Control and Prevention's Community Guide
Goal HPDP 3: Increase protection against the spread of infectious disease	Florida SHIP Goal HP1, Healthy People 2020 IID-7
Strategy 3.1	Florida SHIP Strategy HP 1.1, Healthy People 2020 IID-7, Recommended by the Centers for Disease Control and Prevention's Community Guide
Objective 3.1.1	Florida SHIP Objective HP 1.1.1, Healthy People 2020 IID-7, DOH Long Range Plan Objective 1B
Objective 3.1.2	Healthy People 2020 IID-7; IID-10
Healthy Communities and Environments	**Alignment**
Goal HCE 1: Establish integrated planning and assessment processes that promote health in community level policies and plans	Florida SHIP CR 1, Public Health Law and Policy
Strategy 1.1	Florida SHIP CR 1.1, Public Health Law and Policy
Objective 1.1.1	Florida SHIP CR 1.1, Public Health Law and Policy
Goal HCE 2: Increase access to nutritious and affordable foods	Florida SHIP CD 1.3, Healthy People 2020 NWS Objectives, Public Health Law and Policy, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity
Strategy 2.1	Florida SHIP CD 1.3, Healthy People 2020 NSW 12; NSW 13, Public Health Law and Policy, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity
Objective 2.1.1	Florida SHIP CD 1.3, Healthy People 2020 NWS 15.1; NWS 15.2, Public Health Law and Policy, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity
Strategy 2.2	Florida SHIP CD 1.3.6, Healthy People 2020 NWS 15.1; NWS 15.2, Public Health Law and Policy, CDC Winnable Battle:

	Nutrition, Physical Activity, and Obesity
Goal HCE 3: Increase access to safe opportunities for physical activity	Florida SHIP CR2.2, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity, Recommended by the Centers for Disease Control and Prevention's Community Guide
Strategy 3.1	CDC Winnable Battle: Nutrition, Physical Activity, and Obesity, Recommended by the Centers for Disease Control and Prevention's Community Guide
Objective 3.1.1	Florida SHIP CR 2.1.1; CR 2.2.2, Healthy People 2020 PA-15 (PA 15.1; PA 15.2; PA 15.3), CDC Winnable Battle: Nutrition, Physical Activity, and Obesity, Recommended by the Centers for Disease Control and Prevention's Community Guide
Objective 3.1.2	Florida SHIP CR 2.1.1; CR 2.2.2, Healthy People 2020 PA-1, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity, Recommended by the Centers for Disease Control and Prevention's Community Guide

Appendix B: 2013 – 2014 Action Plan

Access to Care

How can we ensure equal access to health care services in Pinellas County?

Goal AC 1: Provide equal access to appropriate health care services and providers

Policy Component (Y/N): No

Performance Measures

Objectives	Data Source	Frequency
Objective 1.1.1: By Dec 31, 2017, decrease the percentage of Pinellas adults who are unable to access a health care provider due to cost from 16% (2010) to 14.4%.	BRFSS	3 years
Objective 1.2.1: By Dec 31, 2017, increase the number of trained Community Health Workers (CHWs) in Pinellas by 25% over baseline.	Florida Community Health Worker Coalition/SPC	As needed
Objective 1.3.1: By Dec 31, 2016, decrease the percentage of Pinellas adults who believe they would receive better medical care if they belonged to a different race/ethnic group from 7% (2010) to 6.3%.	BRFSS	3 years

Outcomes

At least 10 agencies have completed an assessment workshop training; Four agencies have completed a cultural and linguistic competence assessment and developed an action plan; Program is implemented and students are enrolled in the certification program; 15% of CHWs have enrolled in or completed a standardized training within the calendar year

Alignment with Local, State, and National Priorities	
Obj. 1.1.1	Florida SHIP AC 1.1.1
Obj. 1.2.1	Florida SHIP HI3.4

Strategy 1.1: Address barriers in accessing existing health care services and consumer utilization in underserved communities

Objective 1.1.1: By Dec 31, 2017, decrease the percentage of Pinellas adults who are unable to access a health care provider due to cost from 16% (2010) to 14.4%.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Establish baseline of existing health care resources and current consumer utilization in targeted communities as identified in the Economic Impact of Poverty Report	DOH-Pinellas and Pinellas County Healthy Communities	2-1-1, Children's Medical Services, JWB, Suncoast Health Council	July 2013-July 2014	Completed assessment of health resources and consumer utilization
2	Collaborate with Pinellas Suncoast Transit Authority council to identify and eliminate transportation barriers in vulnerable communities	CHAT- Access to Care	Pinellas Suncoast Transit Authority	July 2013-December 2014	A Community Health Action Team Member will have been appointed to the PSTA Transit Advisory Committee

2015 – 2017 Activities

- Conduct asset mapping of existing services in medically underserved communities
- Develop and implement a health services assessment for providers and implement a consumer utilization survey

Strategy 1.2: Develop and implement a standardized training program for Community Health Workers.

Objective 1.2.1: By Dec 31, 2017, increase the number of trained Community Health Workers (CHWs) in Pinellas by 25% over baseline.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Work with St. Petersburg College in their development/implementation of a Community Health Worker certification program (on-line, if possible)	Florida Community Health Worker Coalition (Pinellas County Chapter)	St. Petersburg College	July 2013-December 2014	Curriculum is fully developed and adopted by St. Petersburg College Academic Council
2	Develop a Community Health Worker registry and a standardized training and professional development toolkit.	Florida Community Health Worker Coalition	St. Petersburg College, DOH-Pinellas	July 2013 - December 2014	A baseline has been determined and the number of Pinellas County CHWs and their training needs have been identified

2015 – 2017 Activities

- Identify paid and volunteer community health workers and determine their training level.
- Collaborate with the Florida Community Health Workers Coalition in their efforts to implement CHW legislation

Strategy 1.3: Promote the completion of a cultural and linguistic competence organizational self-assessment to improve access to culturally competent care.

Objective 1.3.1: By Dec 31, 2016, decrease the percentage of Pinellas adults who believe they would receive better medical care if they belonged to a different race/ethnic group from 7% (2010) to 6.3%.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Provide cultural and linguistic self-assessment workshops to health services providers, including developing an awareness campaign.	Tampa Bay Healthcare Collaborative and DOH-Pinellas	Center for Equal Health, Moffitt Diversity, Florida Diversity Council, TBCCN	July 2013-December 2014	Assessment committee is developed and trained in how to administer the assessment tool and has identified organizations that demonstrate a willingness to participate in assessment workshop training. At least three workshops have been conducted.
2	Distribute and implement the use of a CLAS self-assessment tool	TBHC and DOH-Pinellas	Center for Equal Health, Moffitt Diversity, Florida Diversity Council, TBCCN	September 2013-December 2014	At least 5 agencies are in process of completing a Cultural and Linguistic Self-Assessment

2015 – 2017 Activities

- Provide technical support and oversight to organizations conducting an organizational CLAS self-assessment

Access to Care

How can we ensure equal access to health care services in Pinellas County?

Goal AC 2: Use health information technology to improve collaboration among providers and increase efficiency in services to consumers

Policy Component (Y/N): No

Performance Measures

Objectives	Data Source	Frequency
Objective 2.1.1: By Dec 31, 2017, increase consumer utilization of One-e-App in Pinellas by 25% over baseline.	JWB	By request
Objective 2.2.1: By Dec 31, 2017, at least 50% of licensed registered Direct Secured Messaging (DSM) providers in Pinellas will be able to exchange data by using a Florida Health Information Exchange (HIE).	USF Health Regional Extension Center	By request
Objective 2.2.2: By Dec 31, 2017, no less than 25% of health services providers will be able to exchange data by using Direct Secured Messaging (DSM).	USF Health Regional Extension Center	By request

Outcomes

A 25% increase above baseline in consumer utilization of One-e-App; At least 10% of the participants active in DSM will have sent a transaction at least one time and 50% are now familiar with the Florida HIE.

Alignment with Local, State, and National Priorities	
Obj. 2.2.1	SHIP Strategy HI1.1

Strategy 2.1: Promote provider usage of the One-e-App as a common eligibility tool to streamline access to services.

Objective 2.1.1: By Dec 31, 2017, increase consumer utilization of One-E-App in Pinellas by 25% over baseline.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Promote consumer usage of One-E-App at agencies that currently have access to One-E-App.	JWB	2-1-1, DOH-Pinellas, Pinellas County Health & Human Services, Directions for Living, Suncoast Center, BayCare, Early Learning Coalition	July 2013 - December 2014	A baseline of consumer utilization will be determined. 100% of frontline staff are offering consumers the option of using the One-E-App tool.

2015 – 2017 Activities

- Enroll new providers into One-E-App services
- Agencies currently using One -E-App will track consumer utilization
- Build data bridges from One-E-App to local agency systems.
- Insure vendor develops the functionality to feed the eligibility status back to the system.
- Client portal capabilities for clients to apply directly.
- Determine the number of agencies that may utilize One-E-App
- Develop an online overview/app (i.e. smart phone) of One E-App.

Strategy 2.2: Improve communication among health providers and coordination of care for consumers through data sharing.

Objective 2.2.1: By Dec 31, 2017, at least 50% of licensed registered Direct Secured Messaging (DSM) providers in Pinellas will be able to exchange data by using a Florida Health Information Exchange (HIE).

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Align a Health Information Exchange with Florida State Health Improvement plan Strategy HI1.1	DOH-Pinellas	USF Health	September 2013-December 2014	Establish baseline of Pinellas providers active in DSM; information about the Florida Health Information Exchange distributed to active providers

2015 – 2017 Activities

- Recruit organization for participation in the Florida Health Information Exchange
- Improve communication among health providers and consumers. (Patient portal)

Objective 2.2.2: By Dec 31, 2017, no less than 25% of health services providers will be able to exchange data by using Direct Secured Messaging (DSM).

2015 – 2017 Activities

- Align Direct Secured Data system with Florida State Health Improvement Plan goals
- Recruit organizations for participation in the DSM
- Work with the Harris Corporation and AHCA conduct a media campaign for DSM enrollment focused in Pinellas County

Access to Care

How can we ensure equal access to health care services in Pinellas County?

Goal AC 3: Reduce infant mortality and morbidity

Policy Component (Y/N): No

Performance Measures

Objectives	Data Source	Frequency
Objective 3.1.1: By Dec 31, 2017, decrease the percentage of low-birth weight (less than 2,500 grams) infants in Pinellas from 8.9% (2010-2012) to 8%.	Florida CHARTS	Annually
Objective 3.2.1: By Dec 31, 2017, increase the percentage of births to Pinellas mother's receiving first trimester prenatal care from 79.1% (2010-2012) to 87%.	Florida CHARTS	Annually
Objective 3.3.1: By Dec 31, 2017, reduce the infant mortality rate of Black infants in Pinellas from 13.9 per 1,000 live births (2010-2012) to 11.5 per 1,000 live births.	Florida CHARTS	Annually
Objective 3.3.2: By Dec 31, 2017, reduce the infant mortality rate of Hispanic infants in Pinellas from 8.1 per 1,000 live births (2010-2012) to 7.3 per 1,000 live births.	Florida CHARTS	Annually

Outcomes

Participants will be able to articulate and explain to others how each health behavior impacts the health of a baby; a work plan that details a culturally competent initiative to engage and educate

Alignment with Local, State, and National Priorities	
Obj. 3.1.1	Other: 2011-2016 Pinellas County Healthy Start Service Delivery Plan: Strategy B-4-1 (5)
Obj. 3.3.1	Florida SHIP Objective AC5.4.4

Strategy 3.1: Raise awareness among providers and consumers on the importance and benefits of being healthy prior to pregnancy.

Objective 3.1.1: By Dec 31, 2017, decrease the percentage of low-birth weight (less than 2,500 grams) infants in Pinellas from 8.9% (2010-2012) to 8%.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Sponsor health-focused events/classes on pre-conception health in the community.	Healthy Start Coalition of Pinellas	Neighborhood Family Centers, Lealman, Sanderlin, Greenwood, Early Learning Coalition, DOH-Pinellas,	July 2013-December 2014	At least 2 bi-annual events are conducted and at least 50 women of child bearing age attend.
2	Collaborate with Healthy Start to promote trainings to providers and education to consumers about smoking cessation, substance abuse, obesity, and dental care and the relationship to birth outcomes.	DOH-Pinellas	Healthy Start Coalition of Pinellas, Community Health Workers Coalition, WIC, Pinellas County Dental Coalition	July 2013-December 2014	At least 2 bi-annual presentations to providers of health care services are conducted and at least 2 bi-annual presentations for consumers are conducted.

2015 – 2017 Activities

- Partner with health care providers and universities to provide education and research about preconception health.
- Develop a campaign that educates women on the correlation between STDs and low-birth weight births.
- Work together with medical providers, law enforcement and health & human service agencies to address substance abuse.
- Place base initiative to identify high concentration of low birth weight infants.
- Develop policy recommendations promoting full term gestation vs. delivery prior to 39 weeks.

Strategy 3.2: Increase access to prenatal services and education.
Objective 3.2.1: By Dec 31, 2017, increase the percentage of births to Pinellas mother's receiving first trimester prenatal care from 79.1% (2010-2012) to 87%.
2015 – 2017 Activities
o Educate women about healthy start screenings and Healthy Start services o Develop a campaign to educate women on prenatal oral health care services o Work with the DOH-Pinellas Centering Pregnancy program for Hispanic women to increase enrollment. o Develop a campaign to promote Women, Infants, and Children (WIC) services.

Strategy 3.3: Address disparities in Black and Hispanic infant mortality.

Objective 3.3.1: By Dec 31, 2017, reduce the infant mortality rate of Black infants in Pinellas from 13.9 per 1,000 live births (2010-2012) to 11.5 per 1,000 live births.

Objective 3.3.2: By Dec 31, 2017, reduce the infant mortality rate of Hispanic infants in Pinellas from 8.1 per 1,000 live births (2010-2012) to 7.3 per 1,000 live births.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Partner with Pinellas County Healthy Start to identify strategies to engage and provide education to African American/Black and Hispanic/Latina women about prenatal behaviors that reduce infant mortality and low-birth weight infants.	Healthy Start Coalition/ WIC	Healthy Start Federal Project, USF, Women of Distinction, NAACP, ACNW, Sororities, Urban League	July 2013-December 2014	Healthy Start will have conducted at least 4 presentations and roundtable and panel discussions in collaboration with minority community based organization

2015 – 2017 Activities

- Work with the St. Petersburg Healthy Start Federal project to raise awareness about black infant mortality and prematurity and increase health screenings for black women and infants.
- Support the efforts of Addressing Racism Achieving Health Equity (ARCHE) in identifying social factors that contribute to infant mortality and premature births
- Partner with therapeutic health agencies to promote awareness of the benefits of stress management.
- Partner with therapeutic health agencies to educate staff about the impact of racism on healthy birth outcomes within the cultural setting.
- Provide culturally-sensitive cooking classes focusing on modifying recipes to cook what they eat in a healthier manner.

Behavioral Health

How can we ensure access to behavioral health services and improve behavioral health outcomes in Pinellas County?

Goal BH 1: Increase access to behavioral health services

Policy Component (Y/N): No

Performance Measures

Objectives	Data Source	Frequency
Objective 1.1.1: By Dec 31, 2016, increase the percentage of Pinellas adults who always or usually receive the social and emotional support they need from 81.3% (2010) to 89.4%.	BRFSS	3 Years
Objective 1.2.1: By Dec 31, 2017, reduce the rate of non-fatal hospitalizations for self-inflicted injuries from 72.9 per 100,000 (2008-2010) to 65.6 per 100,000 among Pinellas youth 12-18.	Florida CHARTS	Annually
Objective 1.3.1: By Dec 31, 2017, decrease the suicide age-adjusted death rate in Pinellas from 17.7 per 100,000 (2010-2012) to 16.2 per 100,000.	Florida CHARTS	Annually

Outcomes

Standardized behavioral health screening tools; Common trauma-informed education materials

Alignment with Local, State, and National Priorities	
Obj. 1.3.1	Healthy People 2020 MHMD-1

Strategy 1.1: Strengthen the integration of behavioral and primary health care service delivery.

Objective 1.1.1: By Dec 31, 2016, increase the percentage of Pinellas adults who always or usually receive the social and emotional support they need from 81.3% (2010) to 89.4%.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Promote the use of evidence-based behavioral health screenings across care settings, including screening for trauma and violence	BayCare Behavioral Health	National Center for Trauma Informed Care, Peace4Tarpon, Directions for Living, Operation PAR, WestCare, Haven of RCS, CASA, Suncoast Center, DOH-Pinellas, Homeless Leadership Board, primary care practices, including FQHCs and County medical homes	October 2013 - December 2014	Increase the number of providers using evidence behavioral health based screening tools (baseline TBD)

2015 – 2017 Activities

- Co-locate primary care providers in behavioral health care settings
- Co-locate behavioral health care providers in primary care settings
- Improve communication and coordination of care among providers though health information exchange
- Develop cross training programs for allied staff in primary and behavioral health care settings
- Develop an integrated system with the jails and linkage to community services upon release

Strategy 1.2: Integrate trauma-informed care practices across care settings with emphasis on Adverse Childhood Experiences (ACEs).

Objective 1.2.1: By Dec 31, 2017, reduce the rate of non-fatal hospitalizations for self-inflicted injuries from 72.9 per 100,000 (2008-2010) to 65.6 per 100,000 among Pinellas youth 12-18.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Promote provider and agency education on trauma-informed approaches and practices via Pediatric Grand Rounds	All Children's Hospital (proposed)	National Center for Trauma-Informed Care/Peace4Tarpon, Directions for Living, Operation PAR, WestCare, Haven of RCS, CASA, Suncoast Center, PEMHS, DCF, CFBHN, LiveFree!, primary and behavioral health care providers,	July 2013 – June 2014	3 Grand Rounds focused on trauma – informed approaches and practices
2	Provide community education on trauma-informed approaches and practices	Peace4Tarpon, Directions for Living	LiveFree!, Suncoast Center	July 2013 – June 2014	Educational materials developed and distributed - need baseline of what already exists

2015 – 2017 Activities

- Pilot risk assessment and screening in Pinellas County Schools
- Develop cross training programs for allied staff in primary and behavioral health care settings

Strategy 1.3: Engage targeted at-risk populations to better understand behavioral health care needs and prevent barriers to access

Objective 1.3.1: By Dec 31, 2017, decrease the suicide age-adjusted death rate in Pinellas from 17.7 per 100,000 (2010-2012) to 16.2 per 100,000.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Conduct further behavioral health related data collection and analysis in 5 at-risk zones (identified in Pinellas County Economic Impact of Poverty report) and for identified at-risk populations (start with South St. Petersburg Zone)	Pinellas County Health and Human Services and/or JWB	Suncoast Health Council, DOH-Pinellas, Homeless Leadership Board, PEMHS, Operation PAR, LiveFree!	October 2013 - December 2014	Complete analysis of each at-risk zone
2	Conduct surveys and/or focus groups of men in at-risk demographic for high suicide rates	TBD	Suncoast Health Council, DOH-Pinellas, Homeless Leadership Board, PEMHS, Operation PAR, LiveFree!, Neighborhood Family Centers	January 2014 - December 2014	Conduct a minimum of 5 surveys and/or focus groups

2015 – 2017 Activities

- Promote targeted evidence-informed community level interventions in geographic areas of high need (including 5 at risk zones identified in Pinellas County Economic Impact of Poverty report) based on analysis completed in 2013-2014

Behavioral Health

How can we ensure access to behavioral health services and improve behavioral health outcomes in Pinellas County?

Goal BH 2: Reduce substance abuse among children and adults

Policy Component (Y/N): Yes

Performance Measures

Objectives	Data Source	Frequency
Objective 2.1.1: By Dec 31, 2017, reduce the number of accidental drug or toxin related deaths in Pinellas from 201 (2012) to 181.	District 6 Medical Examiner Annual Report	Annually
Objective 2.2.1: By Dec 31, 2016, reduce the number of Pinellas youth who report lifetime drug use from 31.1% (2012) to 27.9%.	Florida Youth Substance Abuse Survey	Biennially
Objective 2.3.1: By Dec 31, 2017, reduce the rate of Neonatal Abstinence Syndrome in Pinellas from 27.1 per 1,000 births (2009-2011) to 24.4 per 1,000 births.	Florida Agency for Healthcare Administration (AHCA)	Annually

Outcomes

Increased use of prescription drug monitoring program; successful campaign to educate on dangers of prescription and designer drugs; repository of video testimonials/materials portraying the effects of substance use/abuse while pregnant

Alignment with Local, State, and National Priorities	
Obj. 2.2.1	Healthy People 2020 SA- 2.4

Strategy 2.1: Advocate for changes in policy and practices related to substance abuse, including more stringent regulations for prescription drugs classified as controlled substances.

Objective 2.1.1: By Dec 31, 2017, reduce the number of accidental drug or toxin related deaths in Pinellas from 201 (2012) to 181.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Partner Agencies	Timeframe	Process Measure
1	Work with policymakers to mandate use of state prescription drug monitoring program by physicians prescribing controlled substances	Pinellas County Justice and Consumer Services	LiveFree!, Public Defenders Office, PDAB, State partners, Pinellas County Medical Association	2014	number of meetings with policy makers held
2	Work with pharmacies and prescribers to educate and increase use of state prescription drug monitoring program database	Pinellas County Justice and Consumer Services	LiveFree!, Public Defenders Office, PDAB, State partners, Pinellas County Medical Association	2014	number of pharmacists and number of prescribers, including dentists, who receive education

2015 – 2017 Activities

- Review current laws and ordinances to determine needed policy changes related to "pill mills"
- Develop cooperative trends analysis across stakeholders to develop targeted approaches to solving problems in prescription drug abuse

Strategy 2.2: Raise awareness among providers, parents, youth, and businesses on emerging substance abuse trends to improve and inform practices.

Objective 2.2.1: By Dec 31, 2016, reduce the number of Pinellas youth who report lifetime drug use from 31.1% (2012) to 27.9%.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Partner Agencies	Timeframe	Process Measure
1	Develop and implement campaign to educate parents on dangers of emerging designer drugs and prescription drugs	LiveFree!, Pinellas County Justice and Consumer Services	Providers of youth services, Drug Free America Foundation (DFAF)	January 2014 – December 2014	Educational materials distributed/parents educated
2	Develop and implement campaign to educate businesses on designer drugs and prescription drugs to reduce sales of these products	LiveFree!, Pinellas County Justice and Consumer Services	Providers of youth services, DFAF, National Drug-Free Workplace Alliance, Operation PAR	January 2014 – December 2014	Number of businesses educated
3	Develop and implement campaign to educate youth on dangers of emerging designer drugs and prescription drugs, including social media	LiveFree!, Pinellas County Justice and Consumer Services	Providers of youth services	January 2014 – December 2014	Number of youth led groups who receive campaign materials

2015 – 2017 Activities

- Host collaborative lab for up to 60 community providers/partners to develop awareness and actions to protect youth from emerging substance abuse trends
- Develop store review teams for community based reporting of observed activity related to non-synthetic designer drugs and prescription drugs

Strategy 2.3: Increase access to substance abuse services for prenatal and postpartum women.

Objective 2.3.1: By Dec 31, 2017, reduce the rate of Neonatal Abstinence Syndrome in Pinellas from 27.1 per 1,000 births (2009-2011) to per 24.4 per 1,000 births.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Partner Agencies	Timeframe	Process Measure
1	Work with OB/GYNs to provide warnings to their patients on the dangers of substance use/abuse while pregnant and provide supports to address underlying issues	Substance Exposed Newborns Taskforce (SEN)	Operation PAR, Healthy Start Coalition, Birth Hospitals, BayCare, DOH-Pinellas	July 2013 – December 2014	Number of providers who receive education
2	Develop education campaign library of video testimonial portraying the effects of substance use/abuse while pregnant that includes providers and patients	Public Defender's Office	SEN, Operation PAR, FADA, BayCare, Born Drug-free Florida; DOH-Pinellas	July 2013 – June 2014	Video testimonials developed

2015 – 2017 Activities

- Promote the use of evidence-based screening practices for prenatal substance abuse by OB/GYNs and other prenatal and postpartum providers
- Promote pregnancy testing by providers prior to prescribing prescription drugs classified as controlled substances

Behavioral Health		
How can we ensure access to behavioral health services and improve behavioral health outcomes in Pinellas County?		
Goal BH3: Reduce violence among children and families		
Policy Component (Y/N): Yes		
Performance Measures		
Objectives	**Data Source**	**Frequency**
Objective 3.1.1: By Dec 31, 2017, reduce the rate of Pinellas children under 18 experiencing child abuse from 24.0 per 1,000 (2012) to 16.9 per 1,000.	Florida Department of Children and Families	Quarterly
Objective 3.2.1: By Dec 31, 2017, reduce the domestic violence rate in Pinellas from 772.8 per 100,000 (2009-2011) to 695.5 per 100,000.	Florida CHARTS	Annually
Outcomes		
Best practice model for domestic violence screening and counseling and related training; common screening policies/practices for violence and trauma		

Alignment with Local, State, and National Priorities	
Obj. 3.1.1	Healthy People 2020 IVP 37; IVP 38
Obj. 3.2.1	Healthy People 2020 IVP 39.1; IVP 39.2; IVP 39.3; IVP 39.4

Strategy 3.1: Promote community programs that maximize healthy development and interaction among children, families, schools, and communities.

Objective 3.1.1: By Dec 31, 2017, reduce the rate of Pinellas children under 18 experiencing child abuse from 24.0 per 1,000 (2012) to 16.9 per 1,000.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Partner Agencies	Timeframe	Process Measure
1	Work with Home Visiting programs and Pinellas County Schools, especially drop out prevention programs within schools, to increase staff awareness, improve screening policies, and increase behavioral health and other services for those who may be experiencing family violence, abuse, or other trauma. Evaluate current practices and develop and implement common screening process if needed.	DOH-Pinellas, Pinellas County Schools	SEDNET, Pinellas County Schools Student Services, The Haven Of RCS, CASA, 211 Tampa Bay Cares, Courts, Sheriff's Office/ school resource officers, DJJ/Juvenile Justice Collaboration Team, JWB, LiveFree!, Operation PAR	September 2013 - December 2014	Number of schools and program staff trained

2015 – 2017 Activities

- Increase integration of trauma informed practices and education into early learning services, parenting groups, teacher education, community based initiatives promoting healthy family outcomes

Strategy 3.2: Promote awareness, training, and advocacy to improve and inform practices related to domestic violence.

Objective 3.2.1: By Dec 31, 2017, reduce the domestic violence rate in Pinellas from 772.8 per 100,000 (2009-2011) to 695.5 per 100,000.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Partner Agencies	Timeframe	Process Measure
1	Develop a best practice model for domestic violence screening and counseling and related training to support providers with new women's preventive services requirements of the Affordable Care Act	DOH-Pinellas	Domestic Violence Task Force	July 2013 – December 2014	Number of agencies/providers who receive training on model

2015 – 2017 Activities

- Implement and expand plan developed between Operation PAR and the Domestic Violence Task Force for use in substance abuse treatment and outpatient settings, to include training staff about effective interventions
- Work with Pinellas County Domestic Violence Taskforce to expand Be a Better Bystander training and reinvest in the Elementary/Middle Peacemaker program model via Haven/CASA.

HEALTH PROMOTION AND DISEASE PREVENTION

How can we promote healthy lifestyles and prevent disease in Pinellas County?

Goal HPDP 1: Increase the percentage of adults and children who are at a healthy weight

Policy Component (Y/N): No

Performance Measures

Objectives	Data Source	Frequency
Objective 1.1.1: By Dec 31, 2017, decrease the percentage of Pinellas adults who are either overweight or obese from 65.6% (2010) to 59%.	BRFSS	3 years
Objective 1.2.1: By Dec 31, 2017, increase the proportion of Pinellas children (1st, 3rd, 6th grade) who are at a healthy weight from 65.1% (2010 - 2011) to 71.6%.	Pinellas County Schools	Annually
Objective 1.2.2: By Dec 31, 2017, decrease the percentage of Pinellas high school students reporting BMI at or above 95th percentile from 10.3% (2012) to 9.3%.	BRFSS	3 years

Outcomes

Adults who are eating more fruits and vegetables; adults who are exercising more frequently; children receiving more vigorous physical activity

Alignment with Local, State, and National Priorities	
Obj. 1.1.1	Florida SHIP Goal CD 1, Healthy People NWS-8, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity; One Bay Regional Plan Focus
Obj. 1.2.1	Florida SHIP Goal CD 1 and CD 2.3.4, Healthy People NWS-10, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity; One Bay Regional Plan Focus
Obj. 1.2.2	Florida SHIP Goal CD 1 and CD 2.3.4, Healthy People NWS-10 and NWS-10.3, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity; One Bay Regional Plan Focus

Strategy 1.1: Promote healthy eating habits and active lifestyles in adults.

Objective 1.1.1: By Dec 31, 2017, decrease the percentage of Pinellas adults who are either overweight or obese from 65.6% (2010) to 59%.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Provide educational sessions demonstrating healthy and culturally appropriate cooking and grocery shopping on a budget	Pinellas County Extension, DOH-Pinellas	Pinellas County Schools, All Children's Hospital, WIC, YMCA, R'Club, Tampa Bay Network to End Hunger, Sustainable Urban Agriculture Coalition	July 2013-December 2014	Conduct 75 educational series annually
2	Promote usage of county parks, trails, and recreational facilities through Find the Fun Now! and community outreach.	DOH-Pinellas	Pinellas County Parks & Conservation Resources, SalterMitchell, Municipal Governments, Pinellas County Schools, All Children's Hospital, Early Learning Coalition, BayCare, Veteran's Administration, YMCA	July 2013-December 2014	Increase Park usage at a sample of county parks by 10% annually, evaluated monthly; Increase utilization of Find the Fun Now evaluated through Google analytics, 2% increase in organizations posting activities
3	Promote and expand healthy lifestyle activities among senior citizens.	YMCA	Senior Centers, Silver Sneakers, Municipal recreation sites, Area Agency on Aging, Neighborly Care Network, POC/RSVP	July 2013-December 2014	Reach 8000 participants in Seniors in Silver Sneakers, YMCA or other recreation activities

2015 – 2017 Activities

- Educate on the benefits of workplace wellness

Strategy 1.2: Promote healthy eating habits and active lifestyles in children.

Objective 1.2.1: By Dec 31, 2017, increase the proportion of Pinellas children (1st, 3rd, 6th grade) who are at a healthy weight from 65.1% (2010 - 2011) to 71.6%.

Objective 1.2.2: By Dec 31, 2017, decrease the percentage of Pinellas high school students reporting BMI at or above 95th percentile from 10.3% (2012) to 9.3%.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Conduct inventory based self-assessments of Pinellas County Schools on the Alliance for Healthier Generation guidelines	Pinellas County Schools	Alliance for a Healthier Generation, DOH-Pinellas	August 2013- June 2014	Increase schools qualifying for a "gold" "silver" or "bronze" rating from Alliance for Healthier Generation by 5% annually
2	Provide ongoing information to parents regarding the health of their children through Being Fit Matters	Pinellas County Schools	Human Kinetics, YMCA, R'Club	July 2013 - December 2014	100% of Pinellas County Students Grades 3-12 enrolled in PE will receive annual report on health status.
3	Provide weight intervention through the Fit4All Kids Program	All Children's Hospital	YMCA, Pinellas County Schools, pediatricians and family practice providers, R'Club	July 2013- December 2014	Increase participating physicians by 10%; Increase child participation by 10%
4	Provide nutrition education to school age children	Pinellas County Schools	Pinellas County Extension, All Children's Hospital, DOH-Pinellas, YMCA, Front Porch	August 2013- June 2014	40 sites will receive nutrition training annually.
5	Increase awareness of the importance of consuming fruits and vegetables by providing nutrition education to schools with 51% or more Free/Reduced school meal status	Pinellas County Extension	Pinellas County Schools	July 2013- December 2014	500 students will complete nutrition education program

2015 – 2017 Activities
o Coordinate efforts to provide nutritious foods to children in early education settings. o Provide nutrition education to early education providers.

HEALTH PROMOTION AND DISEASE PREVENTION

How can we promote healthy lifestyles and prevent disease in Pinellas County?

Goal HPDP 2: Increase behaviors that improve chronic disease health outcomes

Policy Component (Y/N): Yes

Performance Measures

Objectives	Data Source	Frequency
Objective 2.1.1: By Dec 31, 2017, increase the percentage of Pinellas adults age 50 or older who received a colorectal screening in the past five years from 73.5% (2010) to 80.9%.	BRFSS	3 years
Objective 2.1.2: By Dec 31, 2017, increase the percentage of Pinellas women age 40 or older who received a mammogram in the past year from 61.5% (2010) to 67.7%.	BRFSS	3 years
Objective 2.2.1: By Dec 31, 2017, decrease deaths due to heart disease in Pinellas from 155.5 per 100,000 (2010-2012) to 139.9 per 100,000.	Florida CHARTS	Annually
Objective 2.3.1: By Dec 31, 2017, increase the number of committed never smokers among Pinellas youth, ages 11 - 17 from 64.1% (2012) to 70.5%.	Florida Youth Tobacco Survey	Annually
Objective 2.3.2: By Dec. 31, 2016, decrease the percentage of Pinellas adults who are current smokers from 19.3% (2010) to 17%.	BRFSS	3 years

Outcomes

Formed SWAT chapters; adults who have had blood cholesterol checked in the past two years; adults who have had a blood stool test in the past year; adults who have had a colorectal exam in the past year; clinical breast cancer exam; adults who have ever had a heart attack, angina, or coronary heart disease; adults who diabetes who have had diabetes self-management education

Alignment with Local, State, and National Priorities	
Obj. 2.1.1	Florida SHIP CD 3.2.1, Healthy People 2020 C-3 and C-17
Obj. 2.1.2	Florida SHIP CD 3.2.2, Healthy People 2020 C-5 and C-16
Obj. 2.2.1	Healthy People 2020 HDS and HDS-1
Obj. 2.3.1	Florida SHIP CD 4.1.1, Healthy People 2020 TU-3
Obj. 2.3.2	Florida SHIP CD 4.2.1, Healthy People 2020 TU-4, TU-5, TU-7

Strategy 2.1: Promote screening, education, and referral to treatment related to cancer.

Objective 2.1.1: By Dec 31, 2017, increase the percentage of Pinellas adults age 50 or older who received a colorectal screening in the past five years from 73.5% (2010) to 80.9%.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Collaborate with partners to provide information and education pertaining to colorectal cancer prevention, treatment, and screening	DOH-Pinellas	Moffitt Cancer Center, Sanderlin Center, YMCA, Southwest Cancer Collaborative, Front Porch, Screen for Life Program	July 2013-August 2015	Participants in Moffitt colorectal screening intervention

2015 – 2017 Activities

- Increase awareness and education regarding the Screen for Life Program
- Register and coordinate local colorectal cancer screening and referral opportunities

Objective 2.1.2: By Dec 31, 2017, increase the percentage of Pinellas women age 40 or older who received a mammogram in the past year from 61.5% (2010) to 67.7%.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Promote awareness of the Florida Breast and Cervical Cancer Early Detection Program and Mammography Voucher Program	DOH-Pinellas, Mammo-graphy Voucher Program	St. Petersburg Free Clinic, Susan G. Komen, BayCare medical facilities and other private providers	July 2013-December 2013	Number of women engaged in the BCC Program; 725 women screened in the MVP program in the 2013 calendar year
2	Provide wellness programs for cancer survivors to increase overall health during recovery	YMCA	Moffitt M-power, CaPSS	July 2013-December 2014	150 Livestrong participants at Pinellas County YMCA branches

2015 – 2017 Activities

- Increase awareness and education regarding the need for mammography screening; breast cancer prevention, early detection, and treatment
- Coordinate and provide referral services

Strategy 2.2: Promote screening, education, and referral to treatment related to heart disease.

Objective 2.2.1: By Dec 31, 2017, decrease deaths due to heart disease in Pinellas from 155.5 per 100,000 (2010-2012) to 139.9 per 100,000.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Provide evidence-based diabetes prevention for community members with pre-diabetes	YMCA	Pinellas County Extension, St. Petersburg Free Clinic, Community Health Centers, DOH-Pinellas, medical residency programs, American Heart Association	July 2013 - December 2014	Provide the Diabetes Prevention Program to 250 each year

Additional activities related to heart disease reduction can be found under Goal 1, Strategy 1, lifestyle changes related to weight and physical activity.

2015 – 2017 Activities

- Provide blood pressure screenings
- Provide a comprehensive program for diagnosed diabetics
- Cholesterol screenings
- Coordinate and provide referral services

Strategy 2.3: Promote activities to reduce tobacco use and exposure in adults and youth.

Objective 2.3.1: By Dec 31, 2017, increase the number of committed never smokers among Pinellas youth, ages 11 - 17 from 64.1% (2012) to 70.5%.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Create and maintain local SWAT chapters	DOH-Pinellas	Pinellas County Schools, Tobacco Free Coalition	July 2013 - December 2014	170 students will serve as an active member of SWAT (middle/high)

2015 – 2017 Activities

- Promote municipality-level resolutions to ban candy-flavor tobacco products

Objective 2.3.2: By Dec. 31, 2016, decrease the percentage of Pinellas adults who are current smokers from 19.3% (2010) to 17.0%.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Distribute "Quitkits" to clients who are smokers within DOH-Pinellas clinics	DOH-Pinellas	St. Petersburg Free Clinic	July 2013 - December 2014	4,800 Quitkits will be distributed
2	Educating healthcare professional students about tobacco cessation	Gulfcoast North AHEC	St. Petersburg College nursing and dental hygiene programs	July 2013 - December 2014	250 healthcare professional students will be educated

2015 – 2017 Activities

- Conduct tobacco cessation services

HEALTH PROMOTION AND DISEASE PREVENTION		
How can we promote healthy lifestyles and prevent disease in Pinellas County?		
Goal HPDP 3: Increase protection against the spread of infectious disease		
Policy Component (Y/N): Yes		
Performance Measures		
Objectives	**Data Source**	**Frequency**
Objective 3.1.1: By Dec 31, 2017, increase the percentage of Pinellas two-year-olds who are fully immunized from 75.3% (2012/2013) to 90%.	Florida CHARTS; Florida Department of Health Immunization Report	Annually
Objective 3.1.2: By Dec 31, 2017, increase the percentage of Pinellas Kindergarteners who are fully immunized from 89.8% (2012/2013) to 94%.	Florida CHARTS; Florida Department of Health Immunization Report	Annually
Outcomes		
Formed Immunization Task Force; Developed parent campaign materials; Developed provider education materials		

Alignment with Local, State, and National Priorities	
Obj. 3.1.1	Florida SHIP Objective HP 1.1.1, Healthy People 2020 IID-7, Other: DOH Long Range Plan Objective 1B
Obj. 3.1.2	Healthy People 2020 IID-7 and IID-10

Strategy 3.1: Provide targeted education on the benefits of receiving immunizations to increase the percentage of children who are fully immunized.

Objective 3.1.1: By Dec 31, 2017, increase the percentage of Pinellas two-year-olds who are fully immunized from 75.3% (2012/2013) to 90%.

Objective 3.1.2: By Dec 31, 2017, increase the percentage of Pinellas Kindergarteners who are fully immunized from 89.8% (2012/2013) to 94%.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Form an immunization task force to address low immunization rates of children in the Pinellas community	DOH-Pinellas	St. Joseph's, PCSB (DMT), MERCK, Sanofi-pasteur, All Children's Hospital, pediatricians, YMCA, Neighborhood Family Centers, Community Health Centers	July 2013 - December 2014	Complete mission statement; 10 participants engaged; 5 quarterly meetings conducted
2	Collaborate with providers to integrate immunization education into routine client visitation	DOH-Pinellas, Pinellas Immunization Taskforce	Health care providers, hospitals (Grand Rounds)	Jan 2014 - December 2014	10 health care providers will be visited/trained; complete components of the provider tool kit
3	Develop a campaign to educate parents on the benefits of childhood immunizations	DOH-Pinellas, Pinellas Immunization Taskforce	Family support organizations, community centers, Early Learning Coalition, marketing partners, media outlets	Jan 2014 - December 2014	2 media events will be conducted
4	Develop follow up plan for temporary exemptions (explore partnerships and a possible bridge between Focus and Florida SHOTS)	DOH-Pinellas, Pinellas County Schools	Health care providers and volunteers, Pinellas Immunization Task Force	July 2013 - December 2014	Develop report card proposal; conduct 3 meetings with Pinellas County Schools

2015 – 2017 Activities

- Work towards policy change for religious exemption
- Stricter enforcement of immunization policy within Pinellas County Schools

HEALTHY COMMUNITIES AND ENVIRONMENTS		
How can we ensure an environment that is safe and provides access to opportunities for a healthy lifestyle?		
HCE Goal 1: Establish integrated planning and assessment processes that promote health in community level policies and plans		
Policy Component (Y/N): Yes		
Performance Measures		
Objectives	**Data Source**	**Frequency**
Objective 1.1.1: By Dec 31, 2016, increase activity related to the development of policies and plans that support individual and community health within Pinellas from a score of 82% (2012) to 90%.	Community Health Assessment, Local Public Health System Performance Assessment	As needed, 3 – 5 year intervals
Outcomes		
Health element codified into a Comprehensive Plan		

Alignment with Local, State, and National Priorities	
Obj. 1.1.1	Florida SHIP CR 1.1, Other: Public Health Law and Policy; Pinellas County MPO Transportation Plan

Strategy 1.1: Include a public health component in community planning processes to increase awareness and opportunity of the built environment's impact on healthy behaviors.

Objective 1.1.1: By Dec 31, 2016, increase activity related to the development of policies and plans that support individual and community health within Pinellas from a score of 82% (2012) to 90%.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Attend county level planning and development meetings (e.g. MPO)	DOH-Pinellas	Pinellas County Strategic Planning and Initiatives, Pinellas County MPO	August 2013 - December 2014	6 meetings will be attended, to include Pedestrian Safety Subcommittee
2	Create and provide information on topics related to public health, development, the built environment, and community well-being	DOH-Pinellas	Pinellas County Strategic Planning and Initiatives	August 2013 - December 2014	3 presentations, data briefs, or technical reports will be delivered
3	Advocate for a health element within the County Comprehensive Plan and municipal plans	DOH-Pinellas, Pinellas County Strategic Planning and Initiatives	Suncoast Health Council, Community Health Centers of Pinellas, Juvenile Welfare Board, Pinellas County Extension, Pinellas County Parks and Conservation Resources	August 2013 - December 2014	2 meetings or events advocating for the importance of a health element in comprehensive plans will be conducted

2015 – 2017 Activities

- For cities required to produce a comprehensive plan, advocate for a health element
- Create a data partnership made up of health and community development entities
- Identify and implement a policy initiative integrating public health and community development
- Complete a health impact assessment of local policy initiatives

HEALTHY COMMUNITIES AND ENVIRONMENTS		
How can we ensure an environment that is safe and provides access to opportunities for a healthy lifestyle?		
HCE Goal 2: Increase access to nutritious and affordable foods		
Policy Component (Y/N): No		
Performance Measures		
Objectives	**Data Source**	**Frequency**
Objective 2.1.1: By Dec. 31, 2016, increase the percentage of Pinellas adults who meet both of the daily recommendations for fruit and vegetable consumption from 9.3% (2010) to 11.5%.	BRFSS	3 years
Objective 2.2.1: By Dec 31, 2017, increase the percentage of Pinellas middle school students who consume at least five servings of fruits and vegetables a day from 21.2% (2012/2013) to 23.3%.	Pinellas County Schools	Annually
Outcome Measures		
Adults meeting recommended daily consumption of fruits; Adults meeting recommended daily consumption of vegetables		

Alignment with Local, State, and National Priorities	
Obj. 2.1.1	Florida SHIP CD 1.3, Healthy People 2020 NWS 15.1; NWS 15.2, Other: Public Health Law and Policy; CDC Winnable Battle: Nutrition, Physical Activity, and Obesity
Obj. 2.2.1	Florida SHIP CD 1.3.6, Healthy People 2020 NWS 15.1 and NWS 15.2, Other: Public Health Law and Policy; CDC Winnable Battle: Nutrition, Physical Activity, and Obesity

Strategy 2.1: Promote options for access to nutritious foods throughout Pinellas County.

Objective 2.1.1: By Dec. 31, 2016, increase the percentage of Pinellas adults who meet both of the daily recommendations for fruit and vegetable consumption from 9.3% (2010) to 11.5%.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Create environmental awareness of produce stands and farmer's market locations through print material and social media (e.g. bus route maps, trail maps and Find the Fun Now website)	Pinellas County MPO	Pinellas County Extension, PSTA	July 2013 - December 2014	3 media outlets promoting produce stands and farmers market location (e.g. PSTA route maps, Find the Fun Now!, Pinellas trail maps)
2	Create opportunity for SNAP recipients to receive nutrition education and healthy recipes	Pinellas County Extension	WIC, community centers, Neighborhood Family Centers	July 2013 - December 2014	200 SNAP participants completing nutrition education program
3	Provide gardening resources and education for adults to develop urban agriculture skills	Pinellas County Extension	Sustainable Urban Agriculture Coalition	July 2013 - December 2014	8 Healthy Harvest series educational outreach program sessions at local farmers markets

2015 – 2017 Activities

- Increase access to farmer's markets and produce stands through the implementation of SNAP/EBT acceptance at locations

Strategy 2.2: Support a focused effort to increase access to nutritious and affordable foods for children.

Objective 2.2.1: By Dec 31, 2017, increase the percentage of Pinellas middle school students who consume at least five servings of fruits and vegetables a day from 21.2% (2012/2013) to 23.3%.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Increase availability of healthy foods to students through the Summer Meal Program	Pinellas County Schools - Food Services	Juvenile Welfare Board, Neighborhood Family Centers, YMCA, R' Club	July 2013 - December 2014	Reach 120 locations; 8000 meals served; 2 media outlets/press releases
2	Sustain and increase school vegetable gardens to teach agricultural skills and provide produce	Pinellas County Extension	Pinellas County Schools, R' Club, YMCA, parent teacher associations	Aug 2013 - August 2014	5 new school gardens will be created; 50 school gardens will be maintained
3	Ensure support and increase awareness of the school dinner program	Pinellas County Schools - Food Services	YMCA, R' Club	August 2013 - June 2014	Establish school dinner sites

2015 – 2017 Activities

- Include policies for healthy eating in school settings, including providing additional fruits and vegetables at no additional cost when a full meal is purchased
- Increase awareness and ensure continued support of the Weekend Meal Program

HEALTHY COMMUNITIES AND ENVIRONMENTS		
How can we ensure an environment that is safe and provides access to opportunities for a healthy lifestyle?		
HCE Goal 3: Increase access to safe opportunities for physical activity		
Policy Component (Y/N): No		
Performance Measures		
Objectives	**Data Source**	**Frequency**
Objective 3.1.1: By Dec 31, 2017, complete 15 transportation linkages in Pinellas through infrastructure and programming improvements.	Pinellas County Strategic Planning and Initiatives; Pinellas County MPO	As Needed
Objective 3.1.2: By Dec. 31, 2016, decrease the percentage of Pinellas adults who were sedentary, or did not participate in any leisure-time activity in the past 30 days from 25.5% (2010) to 22%.	BRFSS	3 years
Outcome Measures		
Increased park attendance		

Alignment with Local, State, and National Priorities	
Obj. 3.1.1	Florida SHIP CR 2.1.1 and CR 2.2.2, Healthy People 2020 PA-15 (PA 15.1; PA 15.2; PA 15.3), Other: CDC Winnable Battle: Nutrition, Physical Activity, and Obesity; Recommended by the Centers for Disease Control and Prevention's Community Guide
Obj. 3.1.2	Florida SHIP CR 2.1.1 and CR 2.2.2, Healthy People 2020 PA-1, Other: CDC Winnable Battle: Nutrition, Physical Activity, and Obesity; Recommended by the Centers for Disease Control and Prevention's Community Guide

Strategy 3.1: Promote collaborative efforts to form safe transportation linkages to schools, work, home, and recreation.

Objective 3.1.1: By Dec 31, 2017, complete 15 transportation linkages in Pinellas through infrastructure and programming improvements.

Objective 3.1.2: By Dec. 31, 2016, decrease the percentage of Pinellas adults who were sedentary, or did not participate in any leisure-time activity in the past 30 days from 25.5% (2010) to 22%.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Collaborate with the county government, municipal governments and the Metropolitan Planning Organization (MPO) to create capital improvements within Pinellas County	Pinellas County MPO	Municipal governments, Pinellas County Strategic Planning and Initiatives	July 2013 - Dec 2014	Complete 11 capital improvements in the creation of transportation linkages; 4 programmatic or expansion linkages
2	Create, maintain, and expand walking school bus programs	All Children's Hospital	United Way, Pinellas County Schools, DOH-Pinellas, Department of Transportation, R' Club	July 2013 - Dec 2014	Create 1 new Walking School Bus; Maintain 5 Walking School Buses
3	Maintain and increase Auxiliary Ranger Program volunteer efforts to increase visible safety presence on the trail	Pinellas County Parks and Conservation Resources	Auxiliary Rangers, United Way, service organizations, faith-based organizations	July 2013 - Dec 2014	75 Active Auxiliary Rangers will be registered in the program; 3% increase in reported hours (compared to same month for the previous year)
4	Increase the available miles of bike lanes, sidewalks and trails	Pinellas County MPO	Pinellas County Strategic Planning and Initiatives, Department of Transportation, municipal governments	July 2013 - Dec 2014	Biannual count of miles of bike lanes, sidewalks, and trails (3% increase per year)

2015 – 2017 Activities
o Provide community outreach and education to remove impediments that deter use of trails, bike lanes and sidewalks o Remove some of the barriers to walking or biking to school (heavy backpacks, no lockers, locked bike rack access) by implementing technology solutions (iPads, kindle textbooks) and process improvements. o Create new opportunities (i.e. running clubs, etc.) at summer recreation programs to teach skills and encourage participation in physical activity