



Hillsborough County Health Department



Community Health Profile Report

2006/2007

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Introduction

The Hillsborough County Health Department's Community Health Profile represents our efforts over several months to gather and analyze relevant data to assist us in our vision to provide the highest level of public health services. Mobilizing for Action through Planning and Partnerships (MAPP) was the process or model used as the framework for this project. MAPP was developed by the National Association of County and City Health Officials (NACCHO) in cooperation with the Centers for Disease Control and Prevention (CDC). The MAPP tool, while data driven, encourages community engagement, systems thinking, dialogue, visioning and strategic thinking. It also incorporates acknowledgment of resource contributions and strengths that exist within communities.

This report contains as much up-to-date information as possible in order to provide a better picture of the current health status of residents in Hillsborough County. The profile report looks broadly at core health indicators, the leading causes of death and illness, as well as the socio-demographic and economic factors that impact health in Hillsborough County and how these compare to other peer counties and the state. Some comparisons to national objectives, specifically Healthy People 2010, have also been included. In addition, the assessment of trends in specific areas can enable individuals and health care professionals to devise strategies that reduce illness and enhance the well-being of our residents.

Listening to our community is also essential to identifying the important issues and formulating possible solutions. Therefore, open discussions using various methods were utilized to elicit concerns, comments and opinions from members of the community, policy makers and health care providers. This document provides information on residents' perceptions of the health of their community, quality of life, and health issues that they deem as important. Also, included is a section which defines the local public health system.

This report has been shared with partners and is made available to citizens in this county. It is anticipated that this information will be useful as a resource to raise awareness and promote the dialogue necessary for ongoing strategic planning. Readers are encouraged to use this information for community priority-setting as well as grant writing to sustain existing programs or initiate new programs to address specific health concerns. This report will also assist the local health department in its community capacity-building efforts, the formation of coalitions, and in motivating leaders to take appropriate action. Planned ongoing future discussions will further enhance our efforts to understand resources, opportunities, trends and other factors that may impact the public's health.

For further information and to respond to questions on the health profile document, please contact the Community Health Division of the Hillsborough County Health Department, Florida Department of Health at (813) 307-8071 or [e-mail](mailto:) us at www.hillscountyhealth.org.

Demographic and Socio-Economic Characteristics

Population Overview

Hillsborough County is located midway along the west coast of Florida, in the Tampa-Saint Petersburg metro area (Figure 1). One of 67 counties in Florida, with its 1,050.9 sq. miles in land area and a population density of 1,047.9 per sq. mile, Hillsborough County is the fourth largest county in Florida. The estimated population reported by the U.S. Census Bureau in 2005 was 1,132,152, an increase of 13.3% from the 2000 census and 36% from 1990.¹ It is projected that by the year 2015, Hillsborough County will see a population of 1,382,700.² The overall geographic composition of the county consists of approximately 30 individual communities and 50 zip codes. The city of Tampa, the county seat, has a population of over 300,000 and is one of three municipalities in the county, the other two being Temple Terrace and Plant City.

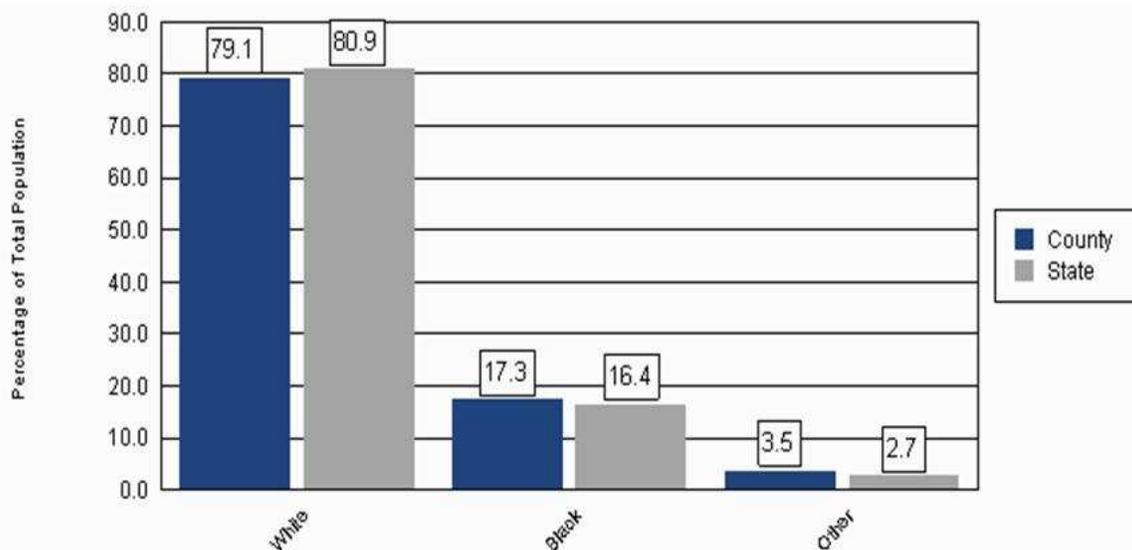


Population by Race and Ethnicity

Hillsborough County has a predominantly White population as illustrated by the racial breakdown in Figure 2. According to current data from Florida Community Health Assessment Resource Tool Set (CHARTS) and the 2005 American Community Survey, of those 1,132,152 residents who reported being of one race, about 80% were White and 17% were Black or African American (Figure 2). Collectively, Asian, American Indian, Native Alaskan, Native Hawaiian, and Pacific Islander accounted for 3.3% of the population. In addition, about 21% of the population reported being of Hispanic or Latino origin (Figure 3). Of this percentage, Puerto Ricans (7%) comprised the largest portion of the Hispanic population.

Figure 2.

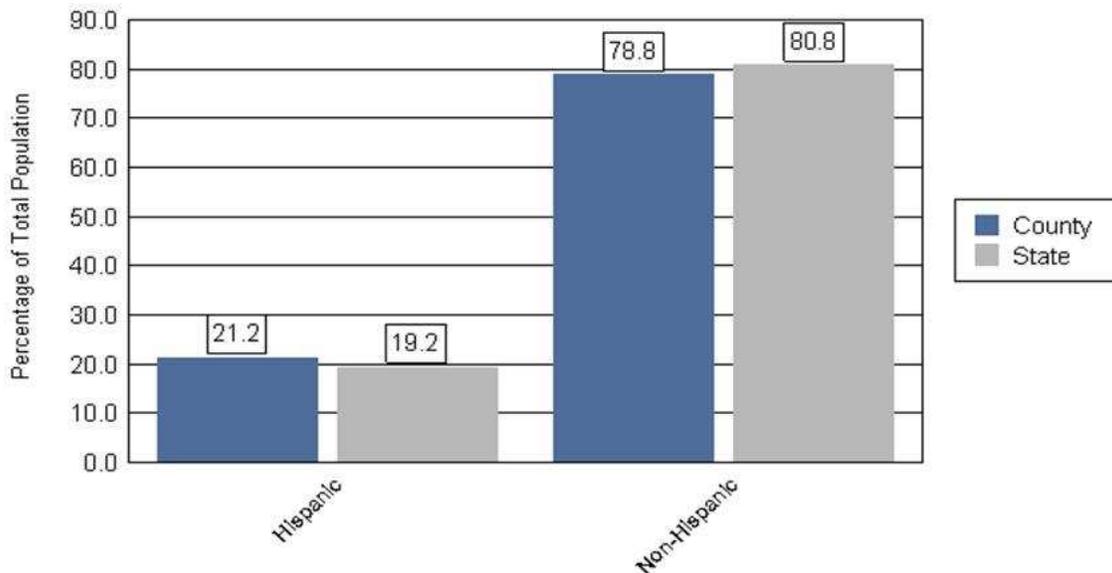
Population Percentage by Race, County and State, 2005



Data Source: Florida CHARTS, 2005

Figure 3.

Hispanic Population Percentage, County and State, 2005

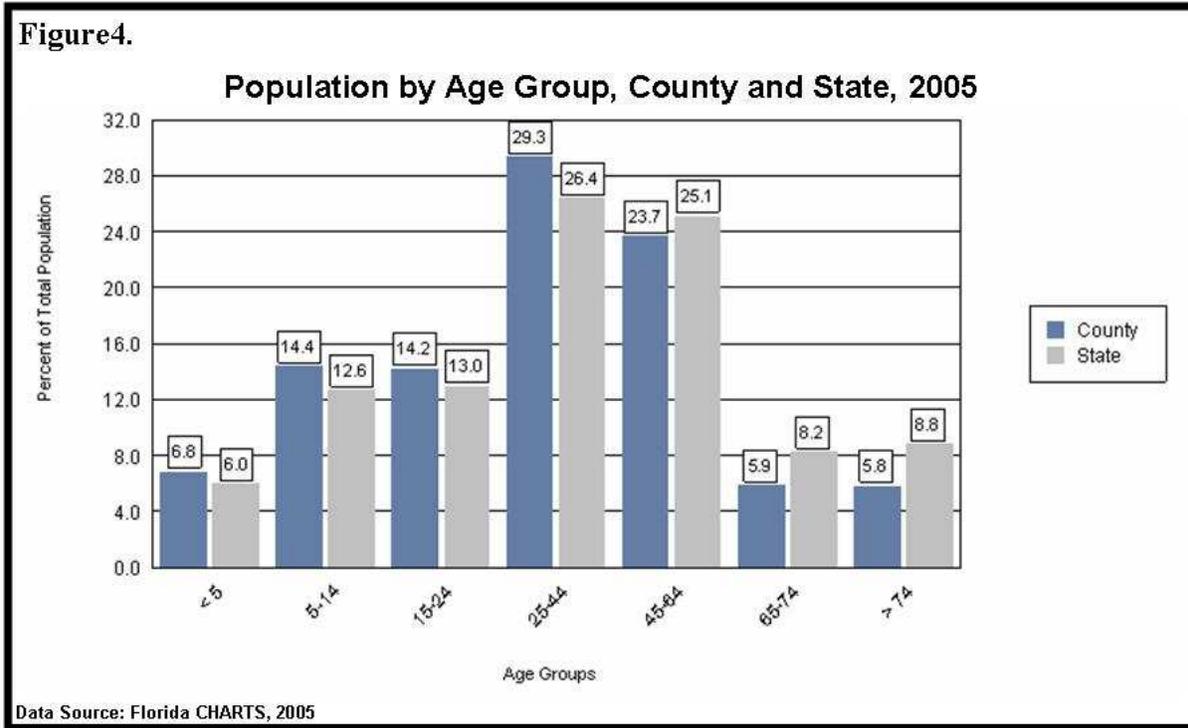


Data Source: Florida CHARTS, 2005

Population by Age and Gender

Hillsborough County has a slightly younger age distribution than the rest of the state, but comparable to Duval, Miami-Dade, and Orange Counties. Twenty-nine percent of the population falls within the 25-44 age group (Figure 4). The median age is 35.9 years. Notably, over 70% of the county's population is 18 years and older, with the adult male (49.3) to adult female (50.7%) ratio being almost equal.

Figure 4.



SOCIO-ECONOMIC CHARACTERISTICS

Households and Families

In 2005, there were 450,000 households reported in Hillsborough County with an average household size of 2.5 persons. Families made up 63% of the households in Hillsborough County. This percentage includes both married-couple families (45%) and other families (19%). Non-family households made up 37% of all households in the county. Most of the non-family households were people living alone, but some were comprised of people living in households in which no one was related to the householder. Female-headed family households accounted for 13.7% of the total households.³

Nativity and Language

Approximately 14% of people residing in the county in 2005 were foreign born; 86% were native, including 38% who were born in Florida. Among those at least 5 years old, 23% spoke a language other than English in the home. Of these 78% spoke Spanish, 22% spoke some other language and 38% did not speak English “very well.” Census data shows the foreign-born population grew more than 80% during the 1990s, 4 times the growth rate of the overall population.

Income

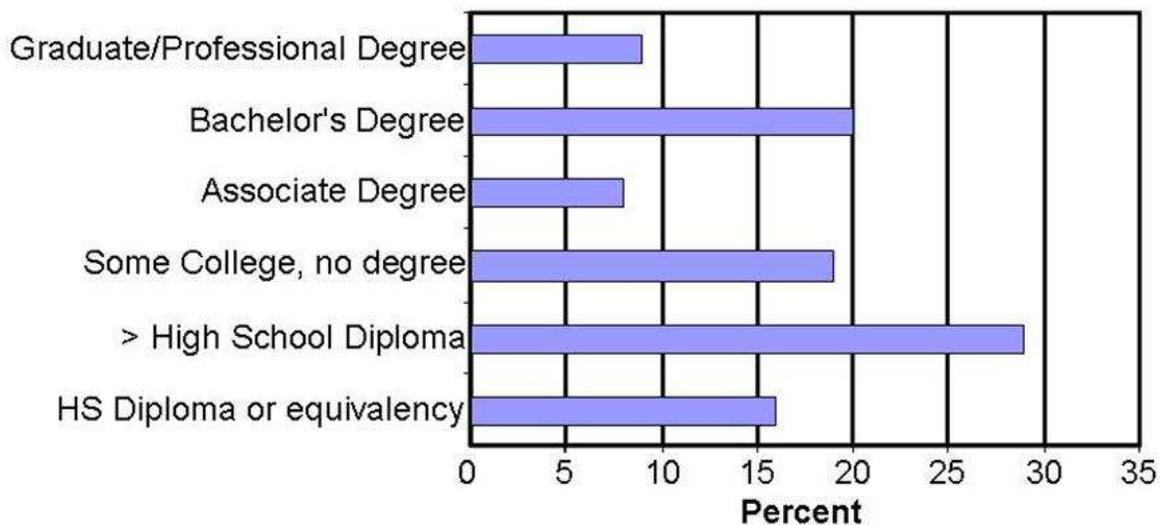
The median household income in 2005 was reported at \$45,129, which is higher than the state. Data compiled from the census indicated 82% of the households received earnings, while 16% received retirement income other than Social Security. Twenty-five percent of the households received social security benefits which averaged approximately \$12,803; 1% received cash public assistance and another 7% had received food stamp benefits in the past 12 months.

Education

In 2005, an estimated 84% of the population 25 years and older had at least a high school diploma, 27% had a bachelor’s degree or higher; 9% had an advanced degree (Figure 5). Among individuals 16 to 19 years old 10% were high school dropouts. Census data indicates that there are approximately 233,471 school-aged children (between ages 5-19 years old) residing in the county. The total school enrollment in the county in 2005 was 283,000.

Figure 5.

Educational Attainment of Population in Hillsborough County, FL 2005



Data Source: US Census Bureau, 2005

Employment

Recent 2005 data from the Greater Tampa Chambers of Commerce⁴ indicated that 51% of the population is in the labor force. The county's primary sources of employment are local government and major private sector employers. Eighty-two percent employed in the private sector are in professional or business services. The leading industries in the county for the employed population 16 years and older were educational, health, and social services (18%). The Hillsborough County School Board, Hillsborough County Government, the University of South Florida, MacDill Air Force Base, Verizon Communications, St. Joseph's Hospital, and Publix Super Markets are the largest employers in the county. The unemployment rate for the county is 3.5%.

Poverty

In 2005, an estimated 11% of the population in the county reported income in the past 12 months below the poverty level. Eight percent of all families reportedly were below poverty level of which 25% were families with female headed holder, no husband present. Of these families 32% had related children under 5 years old. Fifteen percent of related children under 18 were below the poverty level, compared with 8% of people 65 years and older. Reports generated from Florida CHARTS also indicated that 44% of the population falls below 200% of the federal poverty level.

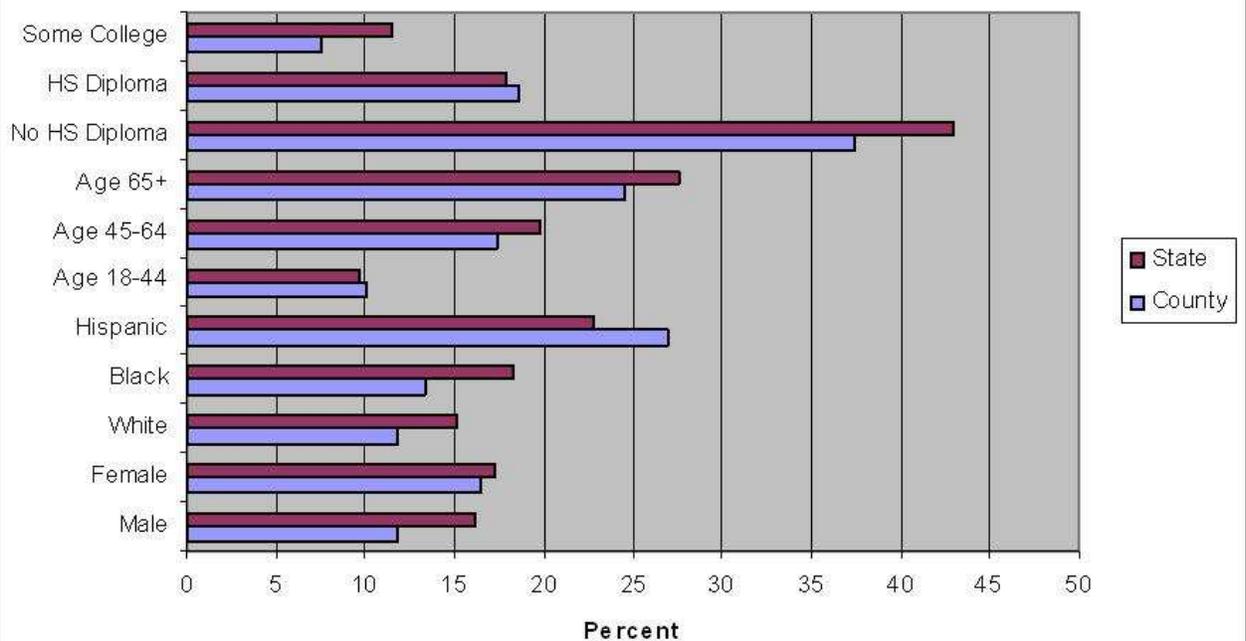
Health Status Indicators: Mortality and Morbidity

Health Status Among Hillsborough County Adults

How people rate their own health is a good indication of the overall perception of health of a community. According to reports generated from CHARTS, approximately 14% of the county's population perceived their health status as fair or poor, which is slightly lower than the state total (17%). Groupings according to selected demographic characteristics such as race, ethnicity, gender, age, and educational level indicated 37% of those with no high school diploma reported their health status as fair or poor. Notably, 27% of Hispanics perceived their health status as being fair or poor compared to Blacks (13%) and Whites (12%). For the age group 65 years and over, nearly 25% described their health status as being fair or poor (Figure 6).

Figure 6.

Percentage of Adults with Health Status "Fair" or "Poor", County and State, 2002



Source: Florida CHARTS. County Behavioral Risk Factor Surveillance System, 2002.

MORTALITY

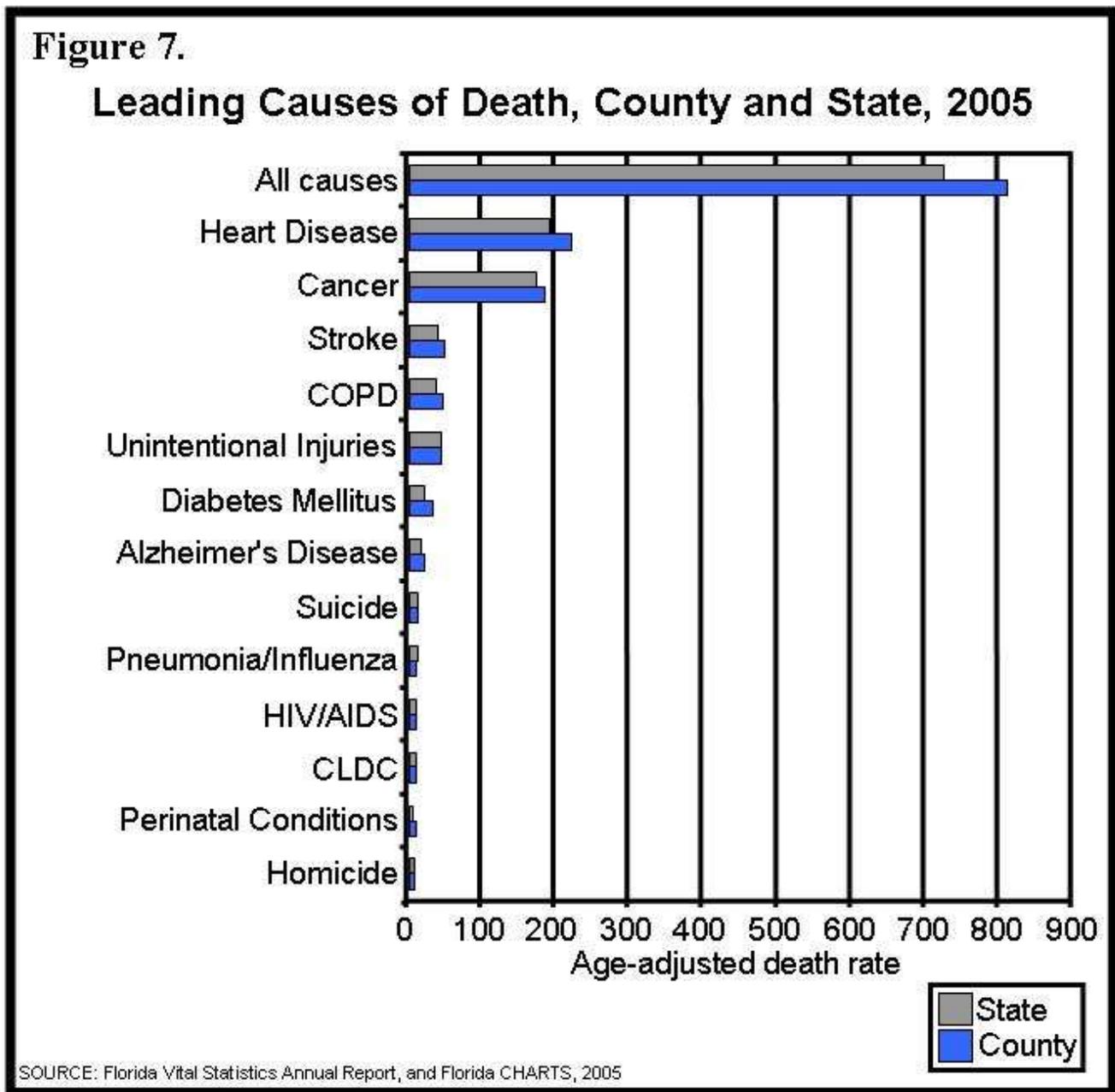
LEADING CAUSES OF DEATH

In 2005, there were 8,944 deaths among Hillsborough County residents, which translate to an overall age-adjusted mortality rate of 812.8 deaths per 100,000. This was a 3% increase in the number of cases reported in 2000. Statewide, the estimated age-adjusted mortality rate for 2005 was 723.4 deaths per 100,000.

Of the 8,944 deaths in 2005, males accounted for 52% (4,687) of the deaths and females accounted for 48% (4,256). There were 7,600 (85%) deaths for Whites, 1,224 (14%) for Blacks, 116 (1%) for other. Ages 55 and over accounted for the greatest number of deaths in the county (7,331) during 2005.

In Hillsborough County, the top 3 leading causes of death for the last 3 years have been heart disease, cancer, and stroke. Heart disease accounted for 26% of total deaths in the county, cancer accounted for

24% and stroke accounted for 5%. The 10 leading causes of death accounted for 78% of all deaths in 2005 (Figure 7).



In general, mortality rates for the leading causes were progressively higher with age (Table 1). Unintentional injuries was the first leading cause of death for Hillsborough County residents ages 1 through 44. The highest number of deaths was incurred by residents ages 35-44. Cancer was the 1st leading cause of death for age groups 45-54, 55-64, 65-74, and the 2nd leading cause for ages 75 and over. Heart disease was the 1st leading cause of death for age groups 75 and over, with the highest number of deaths in residents over age 85.

Table 1.

Leading Causes of Death by Age Group, Age-Specific Rates, Hillsborough County, 2005

Age Group	Cause of Death	Count (3)
Ages <1	Perinatal Period Conditions	94
	Congenital Malformations	15
	Unintentional Injuries	6
	Homicide	4
Ages 1 - 9	Unintentional Injuries	13
	Cancers	5
	Congenital Malformations	3
	Perinatal Conditions	1
Ages 10-19	Unintentional Injuries	40
	Suicide	7
	Homicide	6
	Cancer	5
	Congenital Malformations	3
Ages 20-24	Unintentional Injuries	55
	Homicide	13
	Suicide	6
	Cancer	1
	Stroke	2
Ages 25-34	Unintentional Injuries	83
	Suicide	20
	Cancer	15
	Homicide	11
	HIV	11
Ages 25-34	Unintentional Injuries	83
	Suicide	20
	Cancer	15
	Homicide	11
	HIV	11
Ages 35-44	Unintentional Injuries	84
	Cancer	55
	Heart Disease	51
	HIV/AIDS	34
	Suicide	20
Ages 45-54	Cancer	201
	Heart Disease	143
	Unintentional Injuries	80
	HIV/AIDS	41
	Chronic Liver Disease	32
Ages 55-64	Cancer	414
	Heart Disease	271
	Chronic Lower Respiratory Disease	54
	Stroke	48
	Unintentional Injuries	45
Ages 65-74	Cancer	524
	Heart Disease	351
	Chronic Lower Respiratory Disease	126
	Stroke	75
	Diabetes	60
Ages 75-84	Heart Disease	707
	Cancer	614
	Chronic Lower Respiratory Disease	205
	Stroke	149
	Diabetes	111
Age 85+	Heart Disease	791
	Cancer	288
	Chronic Lower Respiratory Disease	163
	Stroke	165
	Alzheimer's Disease	151

SOURCE: Florida Vital Statistics Annual Report, 2005

INJURY-RELATED DEATHS⁵

Injury-related deaths include unintentional injuries (such events as fires, falls, unintentional poisonings, motor vehicle crashes, and pedestrians injured by motor vehicles), suicide, homicide and deaths by undetermined intent (table 2). In 2005, there were 713 injury-related deaths reported in the county which translate into an age-adjusted injury mortality rate of 62.7 per 100,000, which was slightly lower than the state (63.7 per 100,000). Injury-related deaths accounted for close to 8% of total deaths in 2005. Table 2 summarizes data from 2004 based on specific characteristics; however the data is comparable to 2005.

Of all the injury-related fatalities, unintentional injuries were the leading cause of deaths, particularly among people ages 1-54 (table 3). In 2005 alone, there were 533 deaths due to unintentional injuries, of which motor vehicle crashes (19.9 per 100,000) ranked number one as primary mechanism of death, followed by poisoning (12.5 per 100,000), and falls (7.7 per 100,000).

The rate of injury-related fatalities is further worsened by alcohol-related motor vehicle traffic crashes. Between 2003-2005, there was an average of 1,967 alcohol-related motor vehicles crashes, of which 69 ended in death.

The number of deaths from suicide ranked second highest on the list of injury deaths. In 2005, there were 129 suicides committed (age-adjusted rate of 11.5), which was lower in comparison to the state. The primary method of suicide was by firearm (62 counts), followed by hanging/strangulation (30 counts), and poisoning (28 counts). The age-group that suffered the largest number of suicides was 45-54.

Homicide disproportionately affects adolescents and young adults. In the county⁶, it is the 2nd leading cause of death among those ages 10-24. Homicide by firearm ranked number 1 as the primary method of death, followed by being cut or pierced.

Table 2.

Total Injury Deaths, By Intent and Age Group, 2004

Rank/Intent	<1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Unk	Total	Adj. rate	FL rate
1. Unintentional	12	13	60	64	79	83	50	30	51	50	-	492	44.22	43.44
2. Suicide	-	-	10	23	23	27	23	9	9	5	1	129	11.51	12.86
3. Homicide	1	2	13	17	11	8	4	2	-	1	-	60	5.25	6.09
4. Undetermined	-	-	-	-	1	2	1	1	-	1	-	6	0.54	0.81
Total	13	15	83	104	114	120	78	42	60	57	1	687	61.51	63.20

SOURCE: Office of Vital Statistics, March 2006

Table 3.

Top 10 Deaths from Unintentional Injury, By Mechanism and Age Group, 2004

Rank/Intent	<1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Unk	Total	Adj. rate	FL rate
1. Poisoning	-	-	14	25	29	38	14	6	3	1	-	130	11.59	10.74
2. MV Crash	1	5	29	22	17	9	17	7	6	4	-	117	10.40	12.04
3. Fall	-	-	2	1	1	3	7	10	30	35	-	89	8.18	6.21
4. Pedestrian, All	2	2	7	2	13	7	2	2	3	1	-	41	3.73	3.02
5. Drowning	3	3	2	2	7	4	4	2	-	-	-	27	2.43	2.21
6. Airway Obstr.	5	1	-	-	-	2	-	1	6	5	-	20	1.82	1.73
7. Motorcycle, All	-	-	3	7	1	6	1	-	-	-	-	18	1.58	2.56
8. Pedal Cyclist	-	1	1	2	3	2	1	1	-	-	-	11	0.99	0.74
9. Fire	-	-	-	-	1	-	2	-	1	-	-	4	0.35	0.71
10. Other transport	1	-	-	2	-	-	-	-	-	-	-	3	0.27	0.37
Total	12	12	58	63	72	71	48	29	49	46	0	460	41.34	40.33

SOURCE: Office of Vital Statistics, March 2006

MORBIDITY AND DISEASE PREVALENCE

COMMUNICABLE DISEASES

Communicable diseases are illnesses such as sexually transmitted diseases (STD's), enteric infections, hepatitis A, tuberculosis, and various vaccine-preventable illnesses, caused by various organisms, including bacteria, viruses, protozoa, parasites, fungi, and others. They can be transmitted directly from person to person or from animal to person, or through vectors such as insects, contaminated food or water or infected objects. Prevention of communicable diseases depends on the particular disease, and its mode of transmission.

Sexually Transmitted Diseases (Std's)

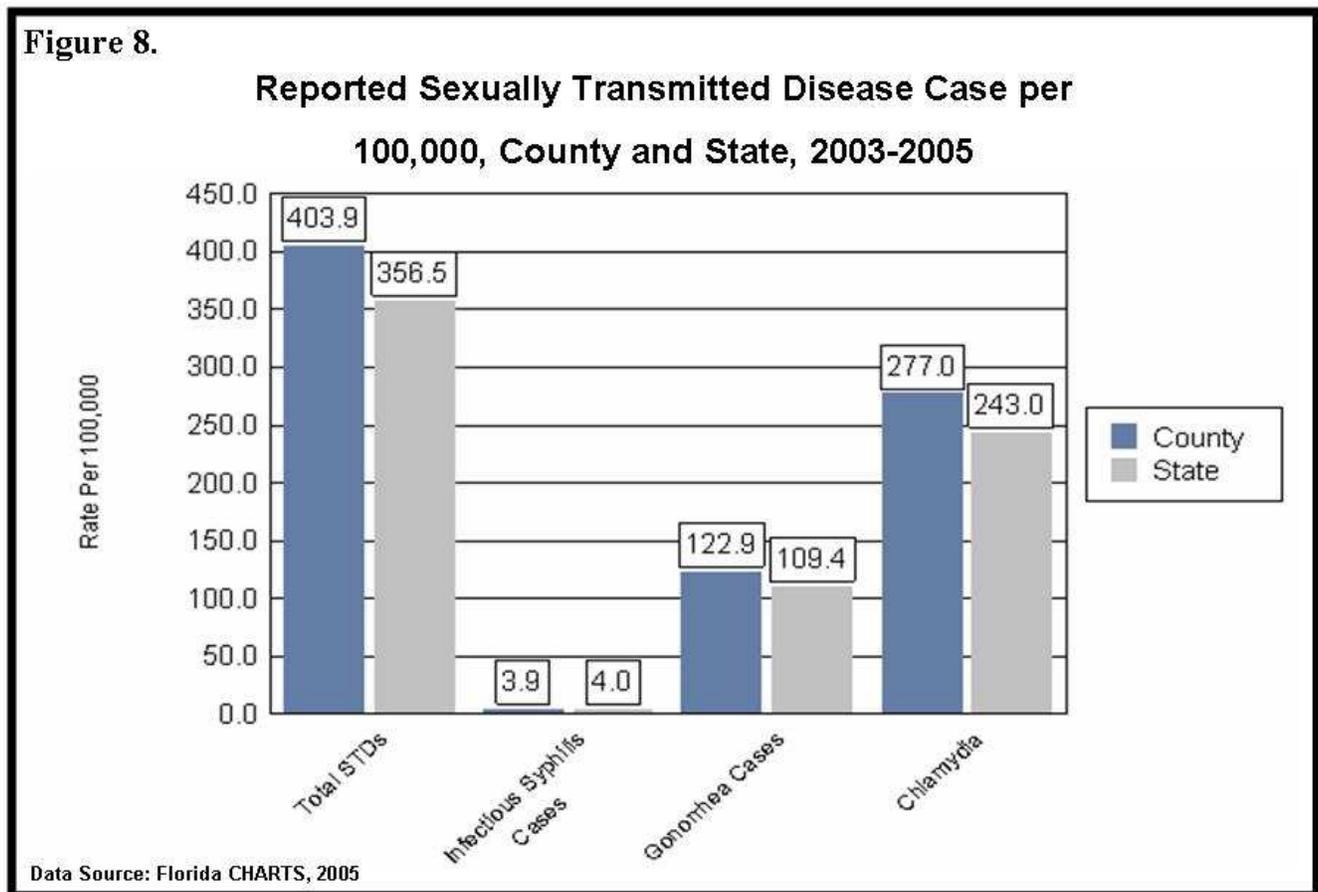
More than 25 diseases can be transmitted sexually. Chlamydia, gonorrhea, and syphilis are the most common sexually transmitted diseases (STD's)⁷ and occur largely among women between the ages of 15-24⁸. Between 2003-2005, average cases of these common STD's reported annually in Hillsborough County (Figure 8).

Chlamydia is a bacterial disease caused by the bacterium, *chlamydia trachomatis*, which can cause significant reproductive complications, including infertility, if left untreated.⁹ On average, there are 3,082 cases of chlamydia reported annually. In 2005, 3,211 new cases of chlamydia were reported in the Hillsborough County, which translates into a rate of 282.3 cases per 100,000 people. This indicates an 8.3% increase in cases from the previous year.

Gonorrhea is a common cause of pelvic inflammatory disease (PID) and ectopic (tubal) pregnancies in women.¹⁰ In 2005, a total of 1,263 cases of gonorrhea were reported in the county, a rate of 111 per 100,000 persons, an increase of almost 6% from the previous year.

Syphilis is also a bacterial disease that, if left untreated, can have health complications. Pregnant women can pass on the disease to their newborns, resulting in infant death, preterm delivery, low birth weight, deafness, and seizures.¹¹ In 2005, 41 cases of infectious syphilis cases were reported in the

county (rate of 3.6 cases per 100,000); 69 cases of early latent syphilis and 106 cases of late latent syphilis, and 1 case of congenital syphilis.



HIV/AIDS

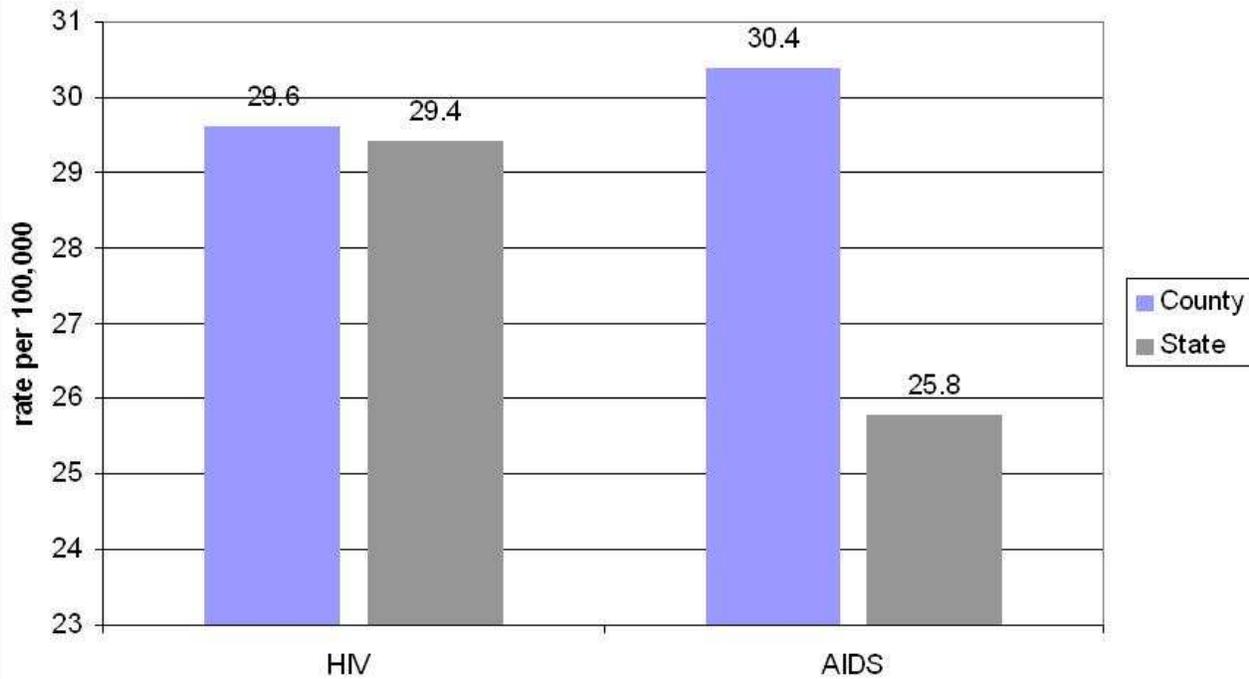
HIV (Human Immunodeficiency Virus) is a retrovirus that causes the immune system to fail increasing the susceptibility of opportunistic infections such as tuberculosis. The virus is spread through direct contact (either sexually or intravenous drug use) with bodily fluids. In 2005 alone, there were 332 HIV positive cases and 343 AIDS cases reported in the county (Figure 9)¹².

Enteric Diseases

Enteric diseases, or foodborne illnesses, are caused by consuming contaminated food or water. Enteric diseases may also be transmitted person-to-person (fecal-oral). Enteric diseases are caused by a variety of organisms, including bacteria, viruses, and parasites, and affect the gastrointestinal system. Infants, the elderly, and persons with weakened immune systems are at the highest risk of serious infection. Enteric illness can occur sporadically or in outbreak. The rate of enteric disease in the county in 2005 was 51.1 cases per 100,000 persons.

Figure 9.

HIV and AIDS Cases, County and State, 2005



Data Source: Florida Department of Health, Division of Disease Control Surveillance Report, 2006

Vaccine-Preventable Diseases¹³

Vaccine-preventable diseases are those which can be prevented through immunization. Examples of vaccine-preventable diseases include polio, hepatitis, influenza, measles, mumps and pertussis. Transmission depends on the specific disease and may include airborne transmission via direct contact with an infected individual, or through his/her body fluids (such as blood), or through ingestion (Figure 10).

Hepatitis

- Hepatitis A (HAV)

Hepatitis A is a liver disease caused by the hepatitis A virus (HAV) and causes only acute (short term) infection. HAV infection is primarily spread person-to-person by the fecal-oral route. Individuals at greatest risk include household and sexual contacts of infected persons, people traveling to areas where HAV infections are common, and men who have sex with men. On an annual basis, there are 24 cases of hepatitis A reported in the county. A vaccine to prevent HAV infection was introduced in the late 1990s.

- Hepatitis B (HBV)

Hepatitis B is a liver disease caused by the hepatitis B virus (HBV) and causes both acute and chronic infection. HBV is primarily spread through unprotected sex with an infected person, sharing needles for injection drug use, or from an infected mother to her baby during birth. In 1982, a vaccine was introduced for the prevention of HBV infection.¹⁴ In 2005, there were 57 hepatitis B cases reported (rate of 5.1 cases per 100,000 persons), which is a 21% decrease from the previous year. There were no cases of hepatitis B reported in infants under the age of 1. The annual average rate of hepatitis cases is 5.8 cases per 100,000 persons.

Measles, Mumps and Rubella

Measles, mumps and rubella are highly contagious, respiratory diseases that are spread from person-to-person through the air. Symptoms for measles typically begin with a fever that lasts for a couple of days, followed by a cough, runny nose, and conjunctivitis (pink eye). A rash starts on the face and upper neck, spreads down the back and trunk, then extends to the arms and hands, as well as the legs and feet. After about 5 days, the rash fades in the same order it appeared. In 2004, there was only 1 case of measles reported in the county, however on average over the last few years there have been no reportable cases of measles.

Mump

Mumps is an acute viral illness that causes fever, headache, muscle aches, tiredness, and loss of appetite; followed by swelling of salivary glands. On average, there is only 1 reported case of mumps annually.

Rubella (German Measles)

The symptoms for rubella are usually a rash and fever for 2 to 3 days, but can cause serious birth defects when acquired by pregnant women. No cases have been reported since 2003.

Tetanus (Lockjaw)

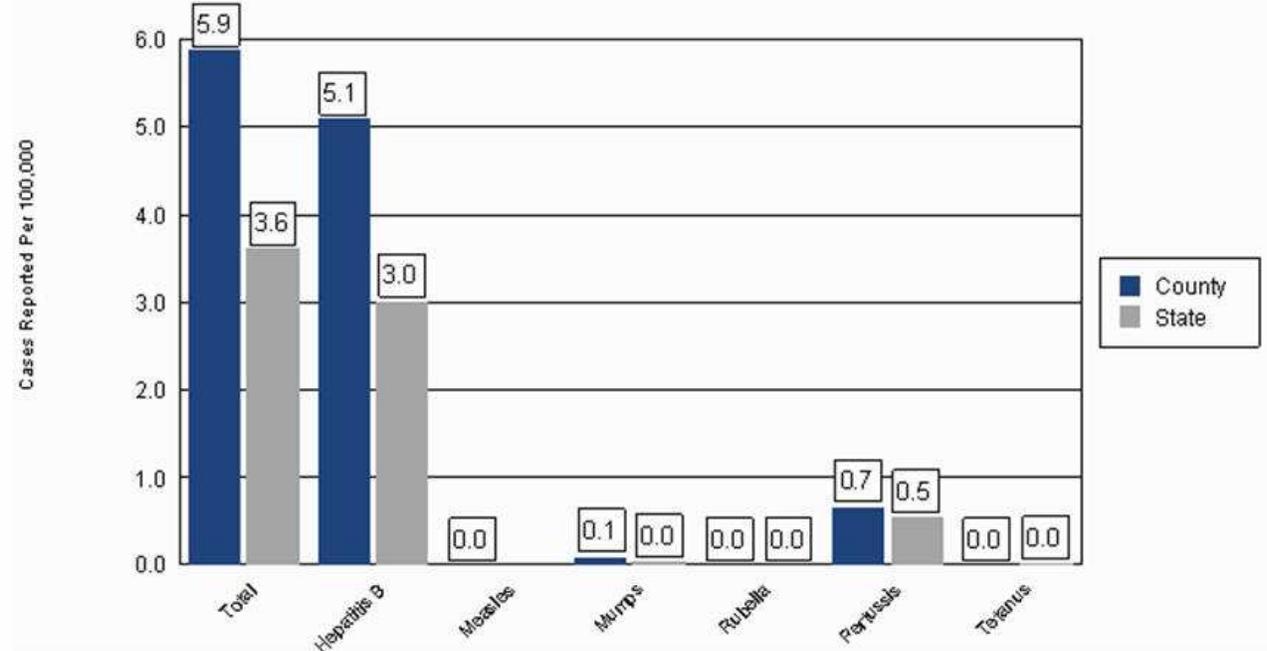
Tetanus is caused by a toxin or poison produced by a bacteria that enters the body through a cut or wound. Tetanus causes serious, painful spasms and stiffness of all muscles in the body and can lead to “locking” of the jaw so that a person is unable to open his or her mouth, swallow, or breathe. In Hillsborough County, that have been no tetanus cases in the past 5 years.

Pertussis

Also known as “whooping cough,” pertussis is an acute bacterial disease involving the respiratory tract. It is transmitted from person to person through direct contact with airborne droplets from mucous membranes. A characteristic symptom of pertussis is prolonged and severe coughing spasms, which may persist for weeks. In 2005, there were 19 cases of pertussis reported in the county, a rate of 1.7 per 100,000. This is a significant increase from the 2 cases reported in 2004.

Figure 10.

Reported Vaccine-Preventable Disease Cases per 100,000, County and State, 2003-2005



Data Source: Florida CHARTS, 2005

Tuberculosis

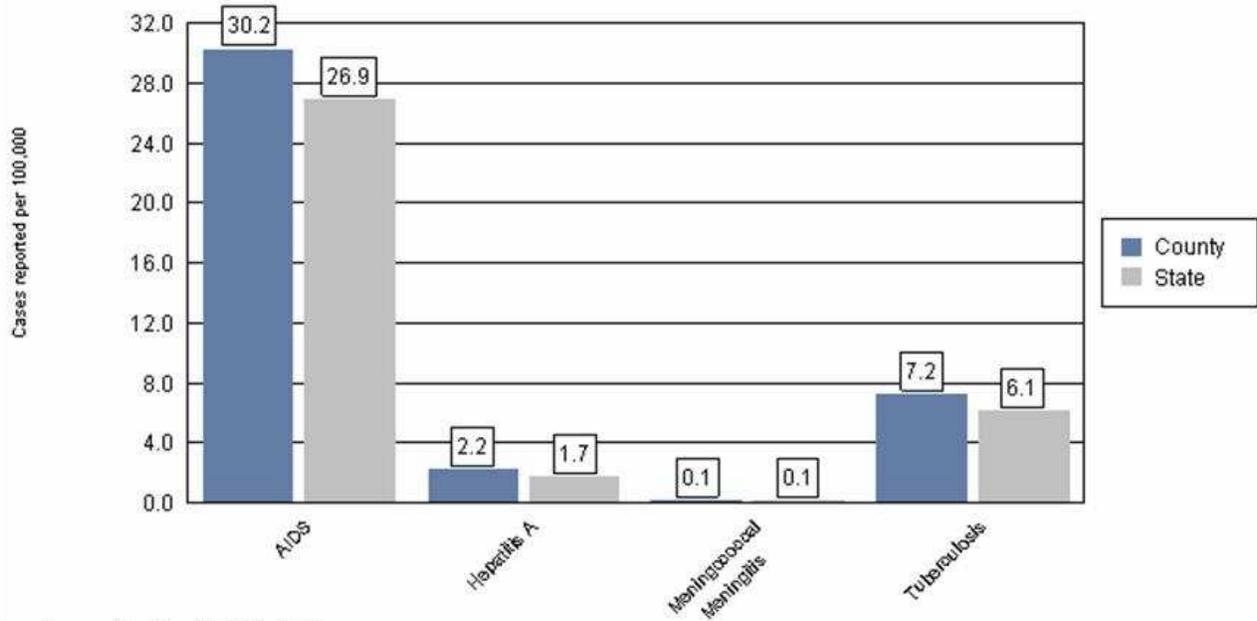
Tuberculosis is a bacterial infection which primarily affects the lungs. It is transmitted through airborne droplets created by activities such as sneezing, coughing, or spitting. Some people develop “active tuberculosis” (TB disease) which is usually associated with symptoms such as prolonged cough, chest pain, fatigue, fever, and weight loss. TB disease can be transmitted from person to person. Other people with TB have latent infection, which does not cause symptoms and cannot be transmitted (Figure 11).

Meningitis

Meningitis is an infection of the tissues surrounding the brain and spinal cord, and can be caused by bacteria, viruses, fungi, or parasites. Meningitis can range from a mild illness that resolves without specific treatment, to a very severe illness that may result in brain damage, hearing loss, or learning disability. A major cause of bacterial meningitis is *Neisseria meningitidis*, which causes both sporadic disease and outbreaks. Persons at risk for infection include infants and young children, household contacts of persons with infection, and college freshmen who live in dormitories. In 2003 and 2004 there were 2 cases of meningitis reported in the county each year. No cases were reported in 2005.

Figure 11.

**Reported Cases of AIDS, Hepatitis A, Meningitis and TB, County and State
2003-2005**



Data Source: Florida CHARTS, 2005

MATERNAL AND CHILD HEALTH

Birth Rate

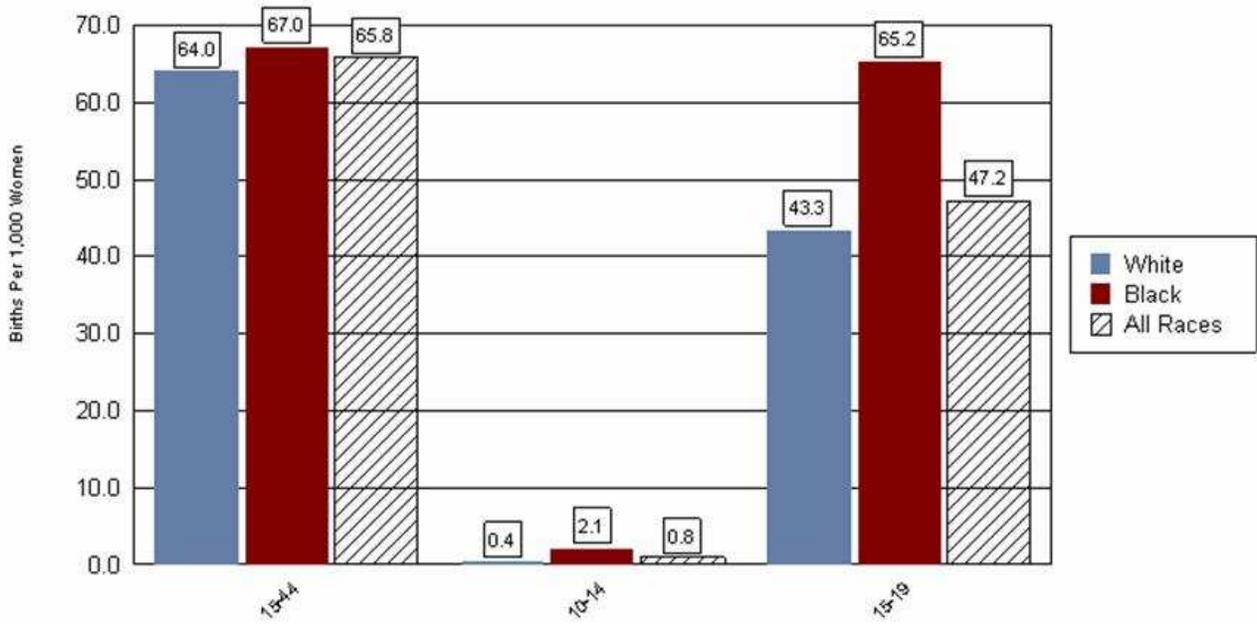
In 2005 there were 16,753 births in Hillsborough County, which translates to an overall birth rate of 14.7 per 1,000 for all races, higher than the state's rate of 12.6 births per 1,000. This represents an increase of 712 live births in 1 year (Figure 12).

The rate of non-White births in the county was 17.4 births per 1,000 population, the state's non-White birth rate of 17.8 births per 1,000 population. Birth to Black mothers accounted for approximately 19% of the total births (3,132 births) and was consistently higher in all age-groups.

The highest number of births occurred in the age groups 20-24 (4,364 births) and 25-29 (4,451 births). Births to adolescents age 15-19 accounted for 11.1% (1,856 births) of the total births in the county.

Figure 12.

Births per 1,000 Women by Age and Race of Mother, County, 2003-2005

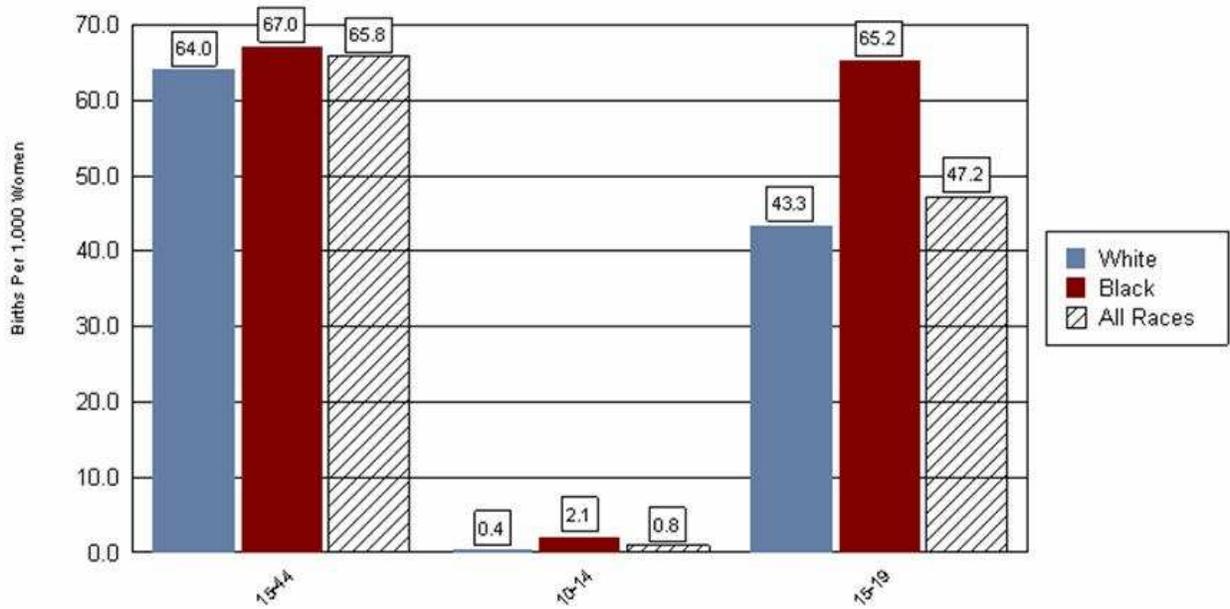


Data Source: Florida CHARTS, 2005

Of the 16,753 live births reported in the county in 2005, approximately 42% were births to unmarried mothers. This was slightly higher than the state's rate (41%). Once again, Black unwed mothers accounted for the highest rates of births in the county (Figure 13).

Figure 13.

Births per 1,000 Women by Age and Race of Mother, County, 2003-2005



Data Source: Florida CHARTS, 2005

The age group with the largest number of births to unwed mothers was 20-24, followed by age group 25-29 as the 2nd largest.

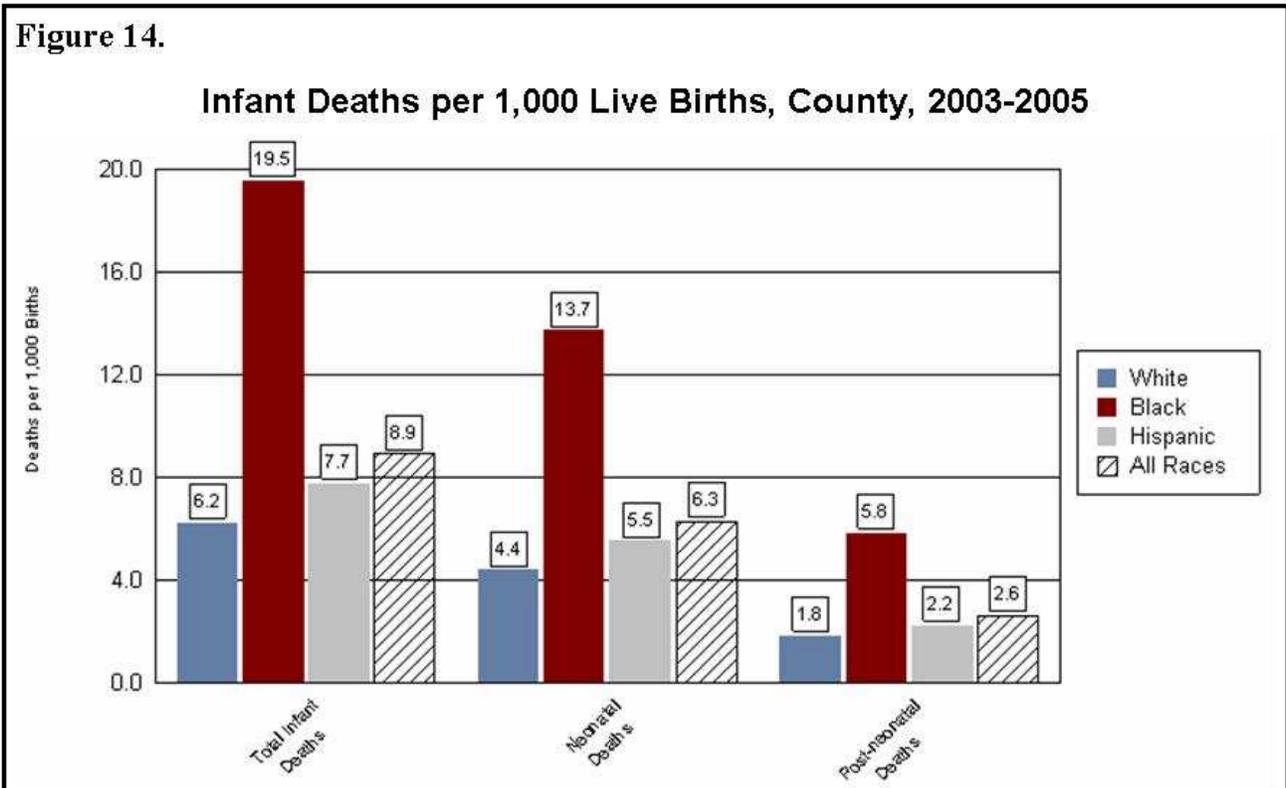
In regards to resident live births by mother’s education, data shows that mothers with a high school diploma accounted for approximately 27% of the total births (4,497 births).

In 2005, 1.7% (278 births) of all live births weighed less than 1500 grams (low birth weight) compared to 9.0% with a birth weight of less than 2500 grams (very low birth weight). These rates mirror those of the state.

Of the 3,132 births to Black mothers, 109 (3.5%) babies weighed less than 1500 grams and 423 (14%) babies weighed less than 2500 grams. In comparison, of the 12,602 births to White mothers, 156 (1.2%) was low birth weight and 986 (7.8%) was very low birth weight. Low birth weight and very low birth weight may be contributing factors to the higher infant mortality rates among Blacks, even though a little over 80% of Black mothers began prenatal care during the 1st trimester.

Infant Deaths

In 2005, the overall infant mortality rate was 8.9% deaths per 1,000 births, higher than the state’s 7.2 deaths per 1,000 births. However, the county’s Black infants had the highest infant mortality rate among all race/ethnicity groups. The infant mortality rates for Blacks was 19.5 deaths per 1,000 live births, substantially higher than the overall county’s and state’s rates, and more than three times the rate for Whites. This large disparity has been consistent over the past 10 years. The leading causes of death for resident live births were perinatal period conditions and congenital anomalies (Figure 14).



The number of resident fetal deaths (stillbirth occurring at 20 or more weeks of gestation) in 2005 was 104 (6.2 deaths per 1,000 live births), a 27% decrease from the previous year. The rates for the non-White population, which was almost double that of the White population (13.7 vs. 6.9 deaths per 1,000 live births) in 2004, also saw about a 44% (7.7) decrease in resident fetal deaths. The highest numbers of fetal deaths were to mothers between the ages of 20-29.

CHRONIC DISEASES & BEHAVIORAL RISK FACTORS

Cardiovascular Diseases

Cardiovascular disease refers to a wide variety of heart and blood vessel diseases including coronary heart disease, hypertension and stroke. The 2 major forms of cardiovascular disease that make the greatest contribution to mortality are coronary heart disease and stroke. Although cardiovascular disease usually manifests itself clinically in middle age, the disease process begins in childhood and is associated with several modifiable risk factors including: high cholesterol, high blood pressure, tobacco use, physical inactivity, diabetes, overweight and obesity.¹⁵

In 2005, a total of 3,011 (rate of 272.1 per 100,000) people died from cardiovascular disease and 20,960 (rate of 1,885 per 100,000) were hospitalized. In regards to stroke, 481 people died of a stroke in 2005 (rate of 43.5 per 100,000) and 3,785 (rate of 332.7 per 100,000) were hospitalized. Fortunately, the rate of hospitalization due to cardiovascular diseases has been on the decrease and is lower than the rate of the state. Primary and secondary prevention efforts have focused on reducing the risk factors for heart disease and stroke, especially for women because they are disproportionately affected by this disease.

Diabetes

Diabetes (mellitus) is a group of diseases characterized by high levels of blood glucose resulting from defects in insulin production, insulin action, or both. Diabetes can be associated with serious complications that may include blindness, kidney damage, heart disease, stroke, nervous system disease, amputation and complications in pregnancy and even premature death. However, people with diabetes can take steps to control the disease and lower the risk of complications.¹⁶

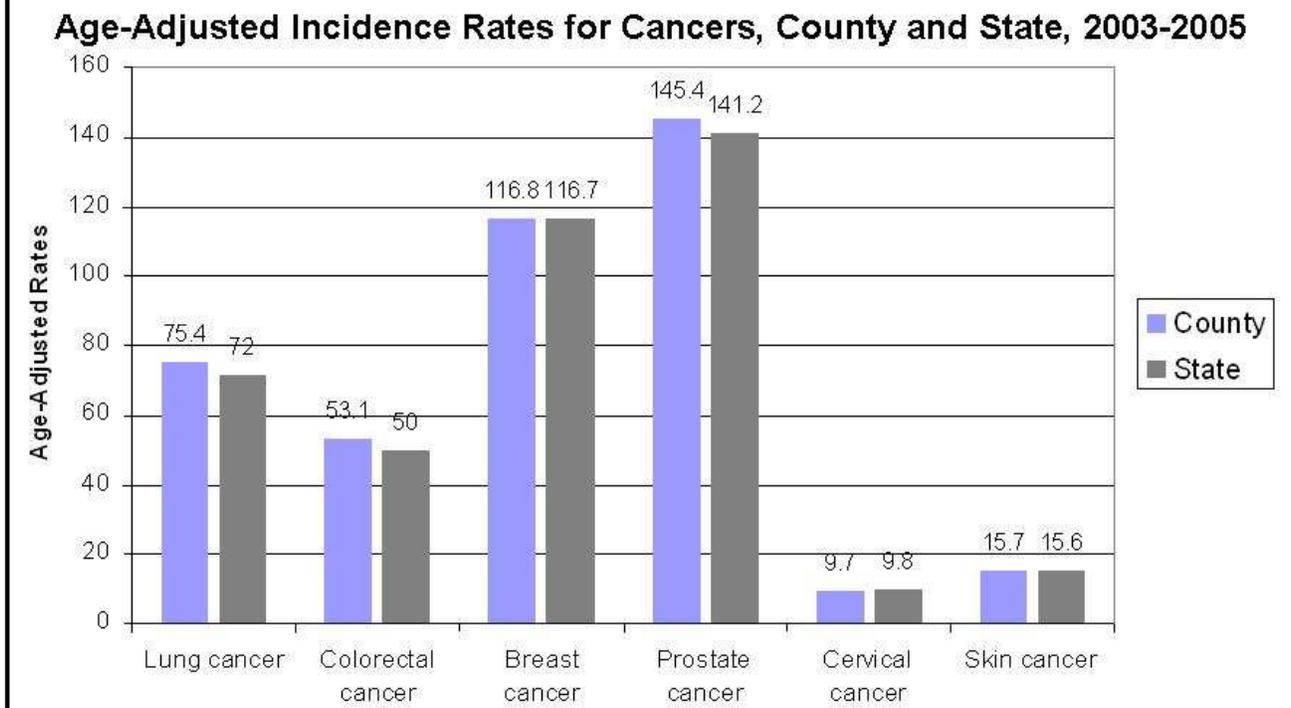
When compared with the state of Florida, a lower percentage of the population in Hillsborough County has diabetes – 8.2 % and 6.3%, respectively. However, Black females had the highest rates of diabetes in the county (11.4%). The number of diabetes-related hospitalizations in the county is comparable to the statewide level; however, both rates are on the rise. As of 2005 in Hillsborough County, approximately 1,932 people per 100,000 were admitted from or with diabetes, compared to a rate of 1,719 in 1999.

Cancers

Approximately 1 out of every 2 American men and 1 out of every 3 American women will have some type of cancer at some point during their lifetime. Anyone can get cancer at any age; however, about 77% of all cancers are diagnosed in people age 55 and older.¹⁷ While the specific causes of cancer have not yet been identified, it appears to involve a combination of environmental, behavioral and genetic factors. Adopting a healthy lifestyle by achieving optimal weight, exercising regularly, avoiding tobacco, eating nutritiously and reducing sun exposure may significantly reduce the risk of cancer. In addition, regular cancer screenings are strongly recommended.

The overall cancer incidence in Hillsborough County is lower than in the state (452 versus 572 per 100,000, respectively). However, the incidence rate among women in particular is higher in the county. In 2003, White women had the highest incidence rate, averaging approximately 378 new cases per 100,000, compared to a rate of 288 new cases among Black women. In 2001, approximately 43.1% of the new cases among men and women in the county were diagnosed at an advanced stage (regional or metastatic spread) (Figure 15).

Figure 15.



BEHAVIORAL RISK FACTORS, COUNTY AND STATE 2004¹⁸

The prevalence of several health conditions (acute and/or chronic) in the county can also give a snapshot of the health status of population. In 2002, the County Behavioral Risk Factors Survey (BRFSS) was used to assess the various risk factors prevalent in the community that may contribute to certain adverse health outcomes (Table 4). Some behavioral risk factors that contribute to chronic diseases are high blood pressure, physical inactivity, overweight/obesity and high blood cholesterol. According to the Centers for Disease Control and Prevention, poor diet and physical inactivity are the second actual cause of death in the US. The findings from this survey indicated 57% had no regular vigorous physical activity; 34% were overweight and 77% consumed less than 5 servings of fruits and vegetable a day. In addition, 23% were current smokers, 14% engaged in heavy or binge drinkers. Twenty-five percent had high blood pressure of which 72% were taking medication. Thirty-four percent of those who had their blood cholesterol checked reported it being high. Fifty-eight percent had asthma and 6% had diabetes.¹⁹

Hypertension

Hypertension or high blood pressure contributes substantially to the risks of coronary heart disease and stroke. In many cases, the cause of high blood pressure is unknown; however, for some people this condition can be prevented or controlled by modifying their unhealthy habits, to include a healthier diet and exercise routine. In Hillsborough County, 25% of adults in 2002 were told that they had high blood pressure of which 72% were taking medication.

Table 4.**Behavioral Risk Factors, County and State, 2002**

Risk Factors	County (%)	State (%)
No leisure time physical activity	27.4	26.4
No regular moderate physical activity	56.7	55.1
No regular vigorous physical activity	75.1	75.6
Are overweight (BMI >25)	34.3	35.1
Are obese (BMI \geq 30)	24.3	22.3
Consume <5 fruits and vegetables a day	76.8	74.3
Are a current smoker	22.8	22.2
Engage in heavy or binge drinking	14.0	14.1
Have been told their blood cholesterol is high	36.9	35.2
Have been told their blood pressure is high	25.1	27.7
Adults under 65 ever been tested for HIV	45.4	47.7

Source: Florida Department of Health, Bureau of Epidemiology

Physical Activity

Regular physical activity improves health by reducing the risk of dying prior to reaching average life expectancy, dying from heart disease, developing diabetes, and/or high blood pressure. Regular physical activity also reduces feelings of depression, anxiety and aids in weight control.

In Hillsborough County, more than 60% of adults do not achieve the recommended amount of regular physical activity, a cumulative 30 minutes of moderate activity per day on most days of the week. Physical inactivity increases with age and is more common among women than men, among those with lower incomes and less education than among those with higher incomes and education.

Overweight/Obesity

Overweight and obesity are functions of nutrition and physical activity. Many diseases are associated with overweight and obesity. People who are overweight or obese are at increased risk for high blood pressure, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea, respiratory problems and some types of cancer.

In Hillsborough County, 34% of the population is overweight and 24% is obese. Interestingly, more men than women were overweight (43% vs. 27%) and obese (26% vs. 23%). However, when looking at the breakdown of between race and sex, there was a higher percentage of White men (45%) who were overweight, and a higher percentage of Black females who were obese (36%). Black women overall were more greatly affected than White women; they had higher rates of both overweight and obesity, and were more often given weight and nutrition advice by their doctors in the previous 12 months.

Injury-Related Hospitalizations

Non-fatal (table 5 & 6)²⁰

On average Hillsborough County's injury-related hospitalization rate is lower than the state, 531 vs. 622 per 100,000. Unintentional injury by a fall was the leading cause of hospitalization, especially for age group 75-84. Motor vehicle crashes and poisoning were the 2nd and 3rd leading cause of deaths, 53.2 and 22.1, respectively. However, between 2002-2004, there was an average of 1,967 alcohol-related motor vehicles crashes, of which 1,462 resulted in injury. The rate of alcohol-related motor vehicle crashes with injuries averages about 134.4 per 100,000.

Interestingly, of the 549 cases of non-fatal self-inflicted injury hospitalizations, adolescents and young adults (age 15-44) had the highest number (388). This age group also showed high numbers in regards to hospitalization due to non-fatal assault injury.

Table 5.

Total Nonfatal Injury Hospitalizations, By Intent and Age Group, 2004

Rank/Intent	<1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Total	Adj. rate	FL rate
1. Unintentional	216	275	436	383	469	489	395	393	726	550	4,332	393.07	407.15
2. Self-inflicted	-	14	140	103	145	95	31	11	8	2	549	49.07	47.36
3. Assault	9	1	72	71	54	38	11	2	2	2	262	23.28	26.37
4. Undetermined	2	3	20	15	20	14	3	6	4	-	87	7.85	12.51
Total	227	293	668	572	688	636	440	412	740	554	5,230	473.27	493.38

Data Source: Hospital Discharge Database (Public Version), Florida Agency of Health Care Administration, Office of Injury Prevention, April 2006.

Table 6.

Nonfatal Unintentional Injury Hospitalizations, By Mechanism and Age Group, 2004

Rank/Intent	<1-4	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Total	Adj. rate	FL rate
1. Fall	58	95	53	70	116	189	202	268	601	508	2,160	198.17	200.62
2. MV Crash	10	28	167	94	80	89	61	33	30	6	598	53.25	57.61
3. Poisoning	39	7	35	35	40	39	21	9	15	6	246	22.05	23.81
4. Motorcycle, All	-	6	28	33	45	28	17	4	-	-	161	14.36	15.39
5. Struck By	2	33	33	21	18	11	9	10	3	5	145	13.02	14.78
6. Other Transport	2	16	25	22	20	11	11	6	3	1	117	10.46	9.63
7. Pedestrian, All	10	14	18	9	19	23	8	4	7	2	114	10.24	9.20
8. Pedal Cycle, All	3	25	12	9	9	18	-	6	3	2	87	7.86	9.44
9. Bite/Sting	8	5	8	8	21	10	7	7	2	-	76	6.89	7.34
10. Cut/Pierce	1	8	9	21	17	8	4	4	2	1	75	6.76	7.98
Total	133	237	388	322	385	426	340	351	666	531	3,779	343.06	355.80

Data Source: Hospital Discharge Database (Public Version), Florida Agency of Health Care Administration, Office of Injury Prevention, April 2006.

Access to Health Care & Coverage

Health Resources Availability

The amount of health resources available is a proxy measure for access to health care. Hillsborough County residents can access a variety of health care resources and services, provided by licensed physicians, hospitals, nursing homes and the county health department. Table 7 provides a breakdown of the various health resources available to the residents in the county.

Table 7.

Health Resource Availability

	COUNTY			STATE
	Number 2005	Rate per 100,000 2005	Quartile 2005	Rate per 100,000 2005
Providers*				
Total Licensed Dentists (Fiscal Year)	606	53.3	4	61.4
Total Licensed Physicians (Fiscal Year)	3,004	264.1	4	279.7
Total Licensed Family Practice Physicians (Fiscal Year)	131	11.5	3	16.6
Total Licensed Internists (Fiscal Year)	469	41.2	4	45.2
Total Licensed OB/GYN (Fiscal Year)	107	9.4	4	9.5
Total Licensed Pediatricians (Fiscal Year)	238	20.9	4	17.1
Facilities				
Total Hospital Beds	3,615	317.8	4	320.4
Total Acute Care Beds	3,094	272.0	3	266.5
Total Specialty Beds	521	45.8	3	53.9
Total Nursing Home Beds	3,951	347.3	1	459.6
County Health Department				
County Public Health Department Full-Time Employees	466	41.0	1	61.0
County Public Health Department Expenditures	35,839,901	3,150,530.6	1	3,849,945.9

Data Sources: Division of Medical Quality Assurance and Office of Planning, Evaluation and Data Analysis, Florida Dept. of Health; Florida Agency for Health Care Administration
 *Data for providers are for a fiscal year, not a calendar year.

Data Source: Florida CHARTS, 2005

Despite the number of health care resources in the county, 23% of adults surveyed in 2002 had no personal health care provider, which is comparable to state (23.9%). Those who were never married, had a household income of \$24,999 or less, Hispanics, and young adults (18-44) were more likely to report not having a personal health care provider. In addition, approximately 10% of the adults surveyed were unable to get medical care in last 12 months. Hispanic women (19%) were the most likely to report an inability to access medical care when compared to Black and White women (14.7% and 11%).

According to data from the Florida Department of Health, there are several areas in the county classified as “Health Professional Shortage Areas (HPSAs)” and “Medically Underserved Areas (MUAs).” The following locations in the county have been designated as HPSAs and MUAs²¹:

- East Tampa/Ybor City
- Gibsonton/Palm River
- Lithia/Wimauma
- Mango

- Plant City/Dover/Seffner
- Port Tampa
- University area
- West Tampa

Health Insurance Coverage

According to data from CHARTS and the 2004 Florida Uninsured Survey²², between 14%-16% of adults reported being uninsured, which is an increase from 1999 (13.9%) yet lower than the state total (18.7%). Thirty one percent of those reporting no health care coverage were Hispanic, compared to Blacks (23.3%) and Whites (10.5%). This trend is comparable to that of the state. In addition, approximately 26% of Black men in the county reported no health care coverage.

Table 8 below presents estimates for the number of Hillsborough non-elderly uninsured by income group using data from the Agency for Health Care Administration's 2004 Survey of Florida's uninsured and the 2003 US Census Bureau's American Household Survey.

INCOME GROUP (% OF FEDERAL POVERTY LEVEL)	POPULATION		UNINSURED		
	ALL AGES	< 65 YRS.	% OF < 65 YRS.	POP.	% OF ALL UNINSURED
<100% FPL	144,071	128,903	27.9%	35,964	27.4%
100% to 150% FPL	102,997	75,276	30.8%	23,185	17.7%
150% to 200% FPL	93,769	80,882	30.2%	24,426	18.6%
>200% FPL	706,567	644,654	7.4%	47,515	36.2%
TOTAL	1,047,404	929,715	14.1%	131,090	100.0%

Data Source: 2004 Florida Uninsured Survey (AHCA) and 2003 US Census Bureau

As shown in the chart, approximately 14% of Hillsborough residents below 65 years of age are uninsured. By applying this percentage to the 2003 U.S. Census data, it is estimated that there are 131,090 Hillsborough residents under 65 years of age who are uninsured. Approximately 60,000 or less than half (45%) of the 131,090 persons have income below 150% of federal poverty level (FPL). Almost 36,000 or over one-quarter (27%) of the non-elderly uninsured persons have income below 100% of the federal poverty level.

Medicaid provides compensation for individuals who are at or below 185% of the FPL. Locally, the Hillsborough County Health Care Plan (HCHCP) covers residents of the County who are at or below 100% of the FPL. Table 9 provides a profile of the uninsured in the county.

Table 9.

PROFILE OF THE UNINSURED IN HILLSBOROUGH COUNTY, 2004

Health Care Coverage and Access, County 2002 BRFSS			
Characteristics	No Health Care Coverage	No Personal health care provider	Unable to get medical care in past 12 mos
	%	%	%
All	16.4	23.1	9.6
Sex:			
Men	18.8	29.1	5.4
Women	14.2	17.7	13.3
Race/ethnicity:			
NH White	10.5	19.4	8.8
NH Black	23.3	23.3	10.3
Hispanic	31.1	34	12.2
Race/ethnicity-Sex:			
NH White Men	12	24.6	6.4
NH White women	9.1	14.5	11.2
NH Black men	25.6	27.4	5.5
NH Black women	21.3	19.6	14.7
Hispanic men	-	-	-
Hispanic women	18.3	20.4	19
Age:			
18-44	20.4	30.5	8.1
45-64	15.3	15.5	12.5
65 and older	3.3	11.4	8.1
Marital Status			
Never married	21.7	37.1	9.9
Married/living together	11.6	14.7	7
Divorced/widowed/separated	22.8	30.8	15.5
Education			
0-11 years	29.7	35.2	23.1
HS Grad/GED	23.4	30.8	8.2
1 or more years of college	9.8	16.2	7.8
Employment			
Wages	16.5	25.2	9.6
Household income			
\$24,999 or less	29.5	35.7	15.9
\$25,000 - \$49,999	17.2	21	10.3
\$50,000 or more	3.9	14.9	5

Data Source: Bureau of Epidemiology, Florida Department of Health. County Behavioral Risk Factor Surveillance System Survey, 2002.

Selected Health Care Challenges

Uncompensated Prenatal Care in Hillsborough County²³

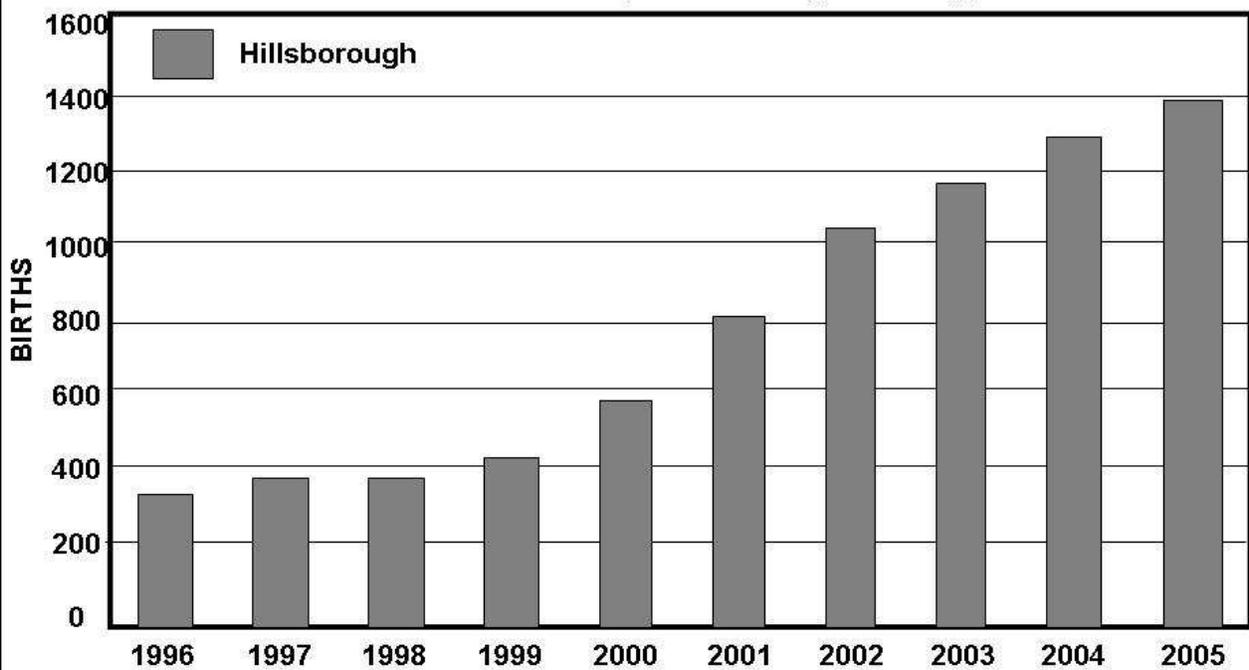
Prenatal care in Hillsborough County is typically paid for through private health insurance, Medicaid or personal income. The number of pregnant women receiving care through private insurance varies depending on the types of jobs available in the community that provide health insurance benefits. In the county, Medicaid provides coverage for prenatal care to women who are at or below 185% of the FPL. In addition, non-citizen women are covered by Emergency Medicaid at delivery. Locally, the Hillsborough County Health Care Plan covers residents of the county who are at or below 100% of the FPL and not covered by Medicaid.

As the number of legal and illegal immigrants has increased in the state and the county, so has the debate about providing and paying for health services including pregnancy-related services. Welfare reform changed immigrants' eligibility for publicly funded services such as Medicaid. New restrictions were placed on the use of federal Medicaid funds for some legal immigrants and all illegal immigrants except for emergency services. For pregnancy, this means providing Medicaid coverage only for labor and delivery services, but not reimbursing health care providers for prenatal care. Many states, including Florida, have adopted these federal eligibility criteria.

Since Emergency Medicaid will not cover prenatal care services, childbearing women with no source of insurance are faced with finding alternatives for prenatal care. They turn to safety net providers, such as the health department, Federally Qualified Health Centers in their communities for prenatal care services for free or at reduced cost. With the increasing rate of pregnant women seeking assistance due to either an increase in the number of non-US citizens giving birth or the number of pregnant women lacking coverage, many safety net providers are stretched to capacity and are no longer able to provide this level of uncompensated care. In 2005 alone, there were 1,394 Emergency Medicaid deliveries in the county. Using the average Medicaid reimbursement rate for a low risk pregnancy as an estimate (\$520 per pregnancy), the estimated cost of this uncompensated prenatal care was \$724,880. Subsequently, this has led to an increase in the number of Emergency Medicaid deliveries across the state as well as in the county (see Figure 16).²⁴ These numbers provide an estimate of the number of those women who had no compensation for their prenatal care. Between 1996 and 2005, the number of deliveries covered by Emergency Medicaid increased by 300% in the county to almost 1,400 deliveries. In 1996, deliveries funded through Emergency Medicaid represented 2.5% of all live births, whereas in 2005 they were 8%.

Figure 16.

Medicaid Deliveries for Non-US Citizens, Hillsborough County, Florida 1996-2005



Data Source: Healthy Start Coalition of Hillsborough County, August 2006

Racial/Ethnic Health Disparities

Health disparities are differences in the incidence, prevalence, mortality, (Figure 17) and burden of diseases and other adverse health conditions that exist among specific population groups. These differences exist due to underlying causes which include:

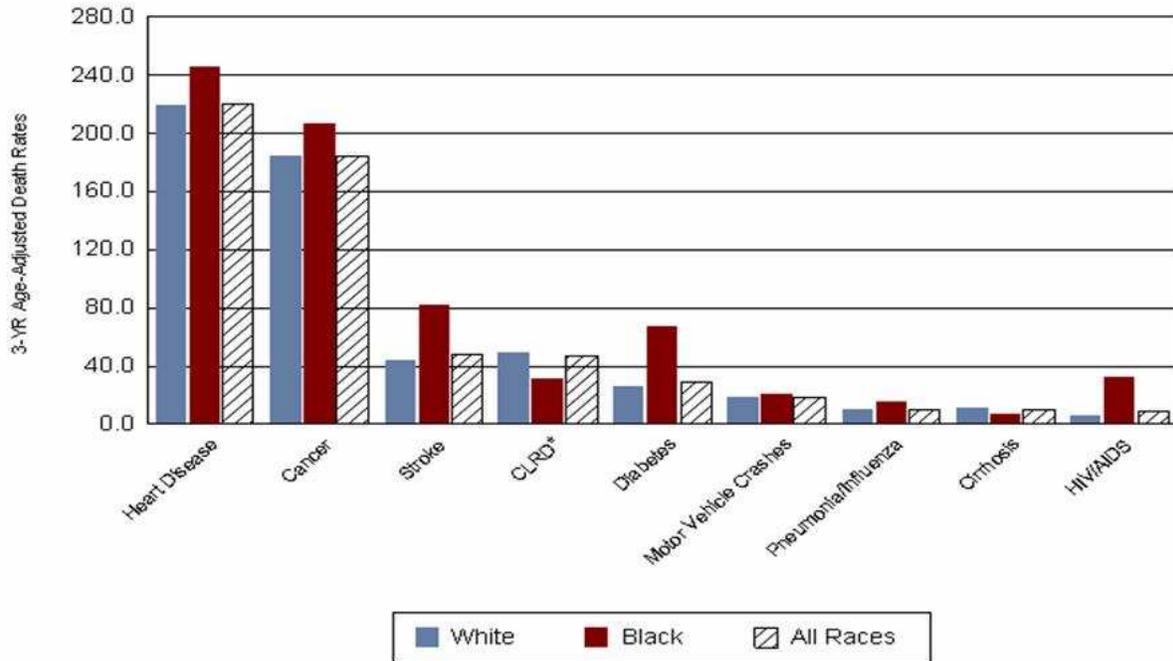
- Socio-economic factors such as poverty, education, income
- Occupational conditions such as underemployment
- Living conditions such as inadequate housing and transportation
- Individual health behaviors such as high risk behavior, substance abuse
- Discriminatory treatment based on race, gender, sexual orientation, disability, etc
- Differential use of health services based on health insurance status, patient preferences, provider bias, or the limited availability of providers.²⁵

Data compiled by the Florida Department of Health indicates that incidence rates for Hillsborough County for White and Black groups are different in regards to certain diseases including:

- Diabetes: Blacks have a much higher incidence rate than Whites and Hispanics.
- Heart Disease: Blacks have a higher incidence rate than Whites.
- Hypertension: Blacks have a much higher rate. Hispanics have the lowest.
- HIV/AIDS: Blacks are disproportionately affected compared to Whites.
- Infant Deaths: Blacks have a higher rate of infant mortality than Whites.
- Obesity: Higher rate in Black women compared to their White counterpart.

Figure 17.

3-Year Age-Adjusted Death Rates for Major Causes of Death by Race, County, 2003-2005



* - Chronic lower respiratory disease

Data Source: Florida CHARTS, 2005

Chronic Diseases

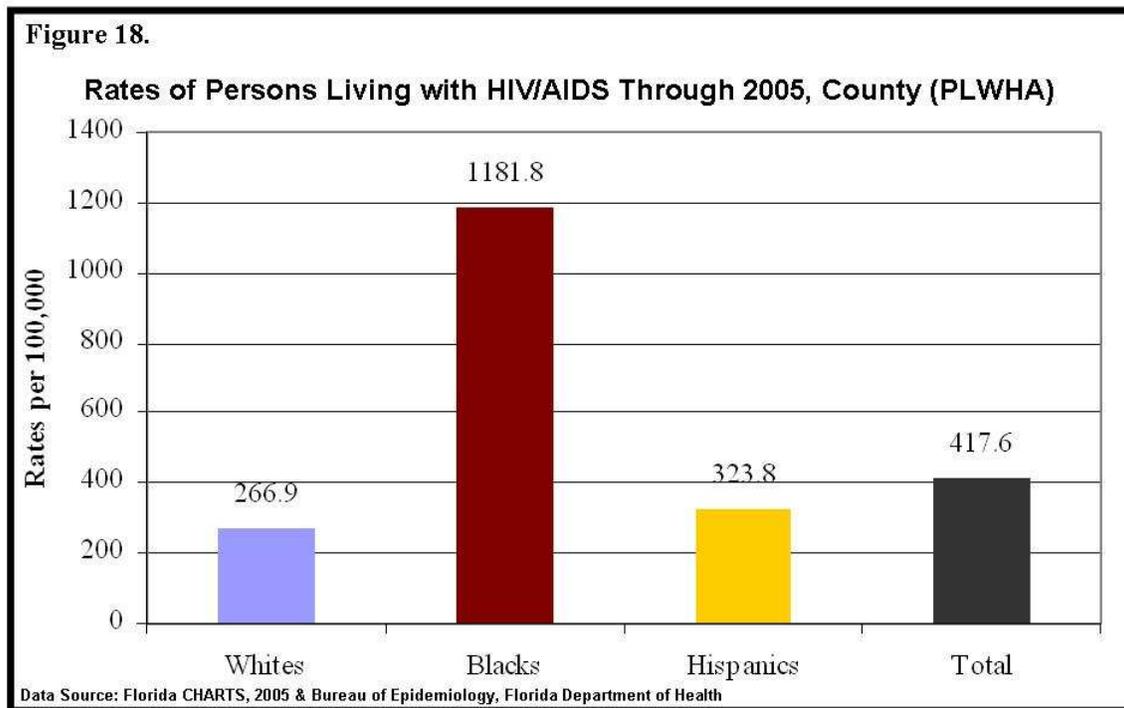
Although Blacks accounted for 12.8% of total deaths, the rates were significantly higher than their White counterparts in at least 6 of the 10 leading causes of deaths. Heart disease, cancer, and stroke were the 3 leading causes of death for both Blacks and White; however Blacks consistently had the highest rates. The death rate from heart disease was close to 13% higher for Blacks than White, 16% higher for cancer, and 37% higher for stroke. Looking at the mortality rates, the county fares worse overall than the state of Florida, with Black women suffering the worst diabetes-related mortality rates overall. In 2002, the death rate for this group was approximately 76 deaths per 100,000 women, compared to 27 for White women and 31 for Hispanic women.

HIV/AIDS

All available HIV/AIDS (Figure 18) surveillance indicators based on reportable data point to blatant racial/ethnic disparities. There are HIV disparities between Blacks compared with Whites, and between Hispanics compared with Whites, but the Black-White gaps are the widest by far. HIV infection rates among Blacks doubled in the county over a decade, while rates among Whites held steady.

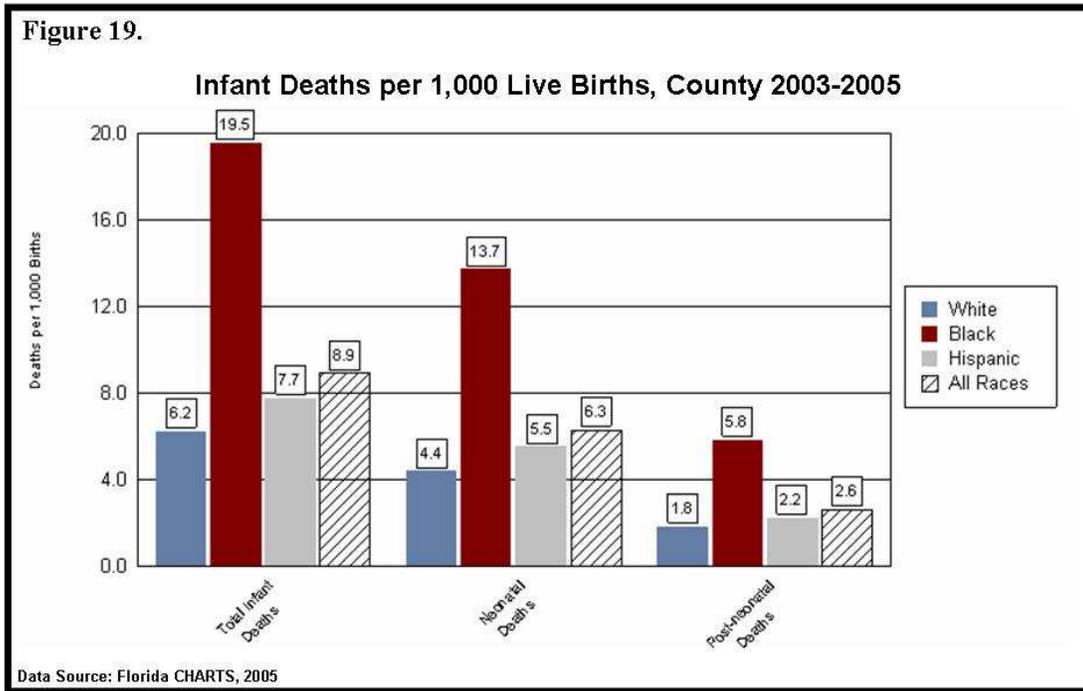
Non-Hispanic Blacks, who represent only 16% of Hillsborough County’s population, account for the majority of recently reported HIV cases, AIDS cases, and HIV/AIDS deaths. In Hillsborough County, 1 in 375 Whites are living with HIV/AIDS, as opposed to 1 in 85 Blacks and 1 in 309 Hispanics. From 1999-2005, there has been a significant reduction in the annual number of new HIV cases among Blacks exceeding 35%. But there are still disparities, because the HIV rates among Blacks remain much higher than that among Whites and Hispanics.

An analysis of HIV and AIDS cases by zip code in Hillsborough County identifies that the majority of both HIV and AIDS cases in the area are originating from specific zip codes (See Appendix 5. Maps 7-9)). Most of these zip codes are in the core, inner city area that have a large concentration of Blacks and the highest poverty rate in the area. These zip codes are 33602, 33603, 33604, 33605, 33607, 33610, 33612, 33613, 33614, 33617, and 33619.

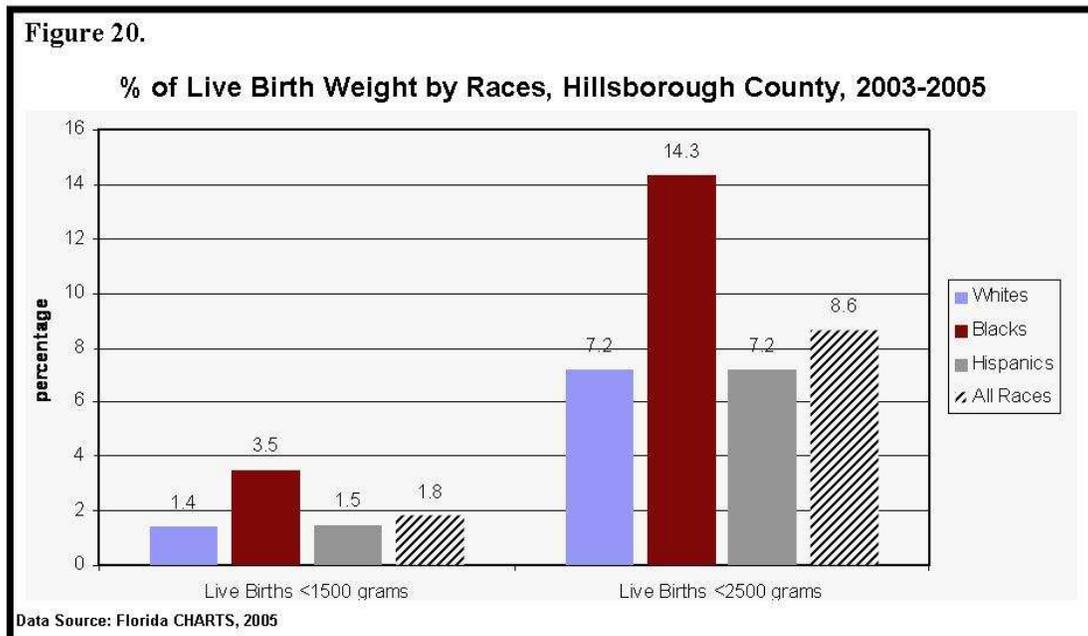


Maternal and Child Health

Even pertaining to maternal and child health indicators (Figure 19), there appears to be wide disparities in the infant mortality statistics between Blacks and Whites. In 2005, the overall infant mortality rate was 8.9 deaths per 1,000 births, higher than the state's 7.3 deaths per 1,000 births. However, the county's Black infants have the highest infant mortality rate among all race/ethnicity groups. The infant mortality rates for Blacks was 16.8 deaths per 1,000 live births, substantially higher than the overall county's and state's rates, and more than double the rate for Whites. This large disparity has been consistent over the past 10 years. The leading causes of death for resident live births were perinatal period conditions and congenital anomalies.



Blacks consistently had the highest percentage of low birth weight and very low birth weight babies compared to Whites and Hispanics, even though 82% of Black mothers commenced prenatal care in their 1st trimester (figure 20).



Overweight/Obesity

Black women overall were more greatly affected than White women; they had higher rate of both overweight 36.8% and obesity 33.8% than White women with percentages of 35.5% and 21.1% respectively. Black women were more often given weight and nutrition advice by their doctors in the previous 12 months.²⁶

A recent trend also indicates that obesity rates are rising among the youth, with 11% of high school students being overweight or obese.

Assessment of Community Health Perceptions and Themes

In public health, the community is our patient, and as we would in a clinical setting, we must gather objective as well as subjective data to complete a well done assessment and plan. The Mobilizing for Action Through Planning and Partnerships (MAPP) process provided the opportunity and some tools that were utilized to listen to our community. Our goal was to gain perceptions on quality of life in the community, what they felt were the important health issues or concerns, how the issues should be addressed, the role of the health department and how we could better communicate with our customers. This was an important first step in engaging the community in future intervention efforts.

MAPP Background

MAPP is a community-wide strategic planning tool for improving public health. It is community driven, promotes strategic thinking and focuses on the local public health system. Benefits of the MAPP model are that it:

- improves the health of the community
- increases visibility of public health
- creates advocates and builds partnerships
- helps us to anticipate and manage change
- creates stronger public health infrastructure
- engages the community.

Prior to initiating MAPP, the health department engaged systems partners in completing the National Public Health Performance Standards Program (NPHPSP) Local Instrument. This tool provides information on system areas for improvement and capacities based on the 10 Essential Public Health Services. This chapter consists of the next step, the Community Themes and Strengths Assessment, where the community is given the opportunity to provide feedback on their health perceptions.

Procedure

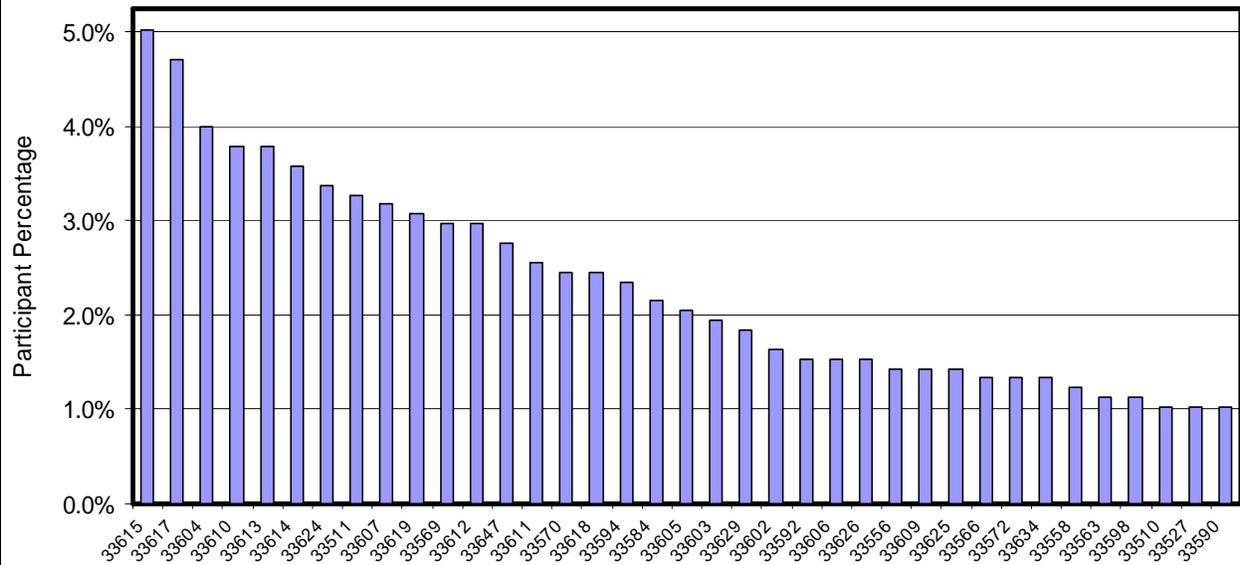
A mixed method approach was used to gather data from respondents. This included self-administered surveys, focus groups and interviews.

Surveys – minor changes were made to the survey tool (Appendix 1) created for the MAPP process. These were additional questions that sought feedback on how best to communicate with residents. In 2006, 1,062 county residents responded to surveys distributed through health department clinics, neighborhood service centers, colleges, WIC, all Hillsborough County libraries, the programs of various community partners and at health fairs. Surveys were administered to adults 18 years and older. Individuals completed the surveys and these were returned to the health department.

Surveys responses from all zip codes except 2 were received. The demographics of respondents covered a wide range of race/ethnic groups, ages, levels of education, economic and ethnic groups. Females and males responded to the survey in nearly equal numbers. Only 20.6 % of survey respondents did not have some form of health insurance. (Figures 21–28)

Figure 21.

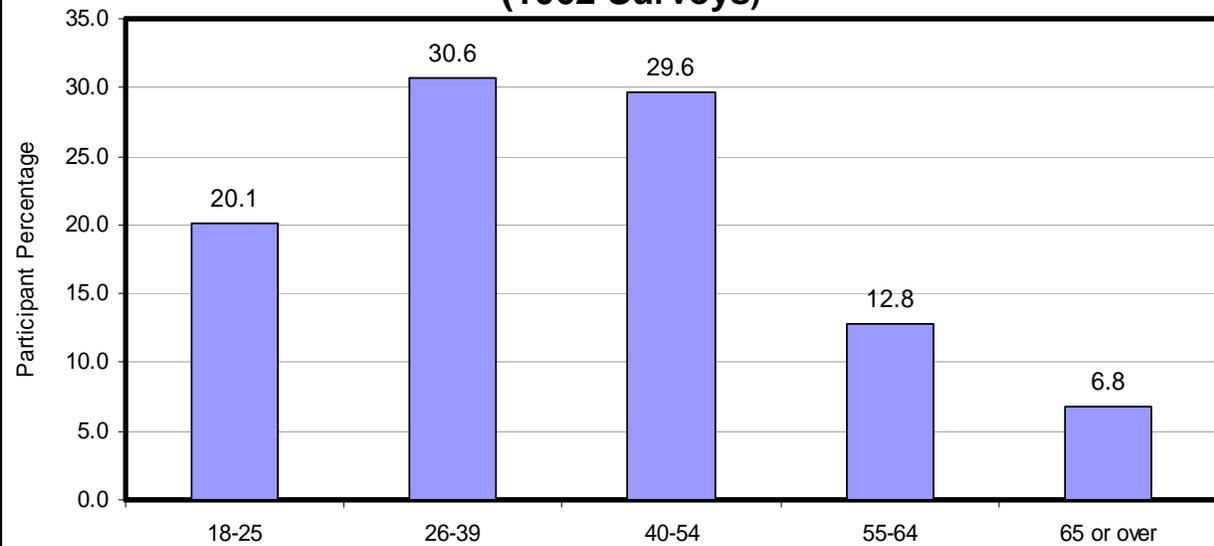
Assessment Zip Codes (>1.0%) (1062 Surveys)



Source: Hillsborough County Health Department MAPP; June 2006

Figure 22.

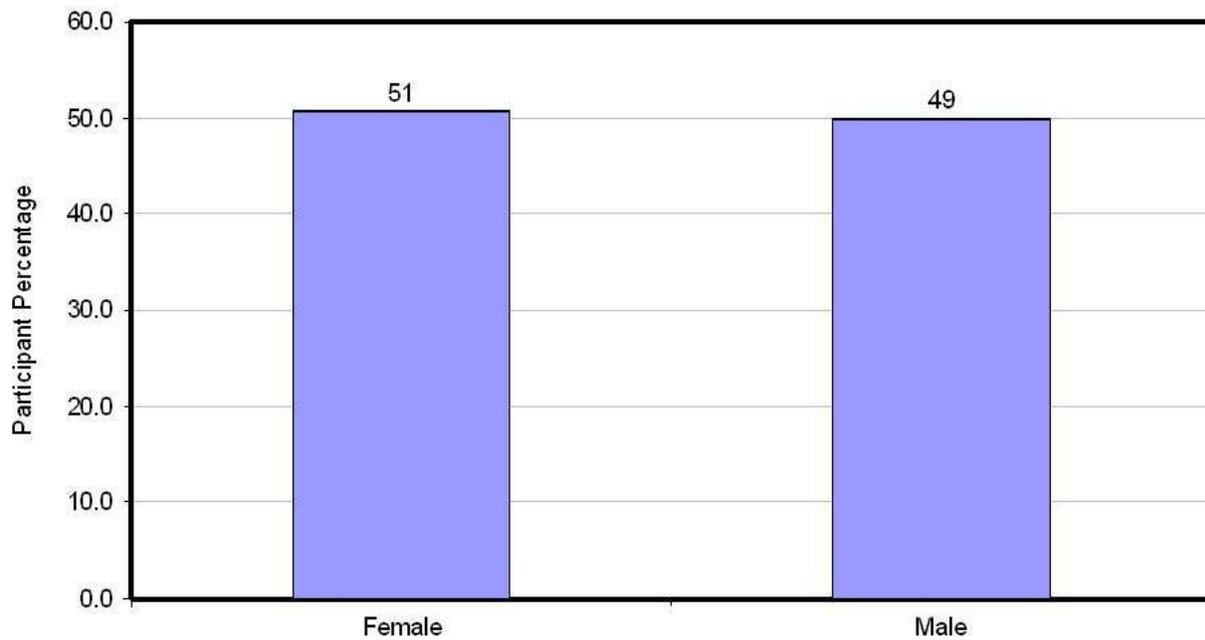
Age (1062 Surveys)



Source: Hillsborough County Health Department MAPP; June 2006

Figure 23.

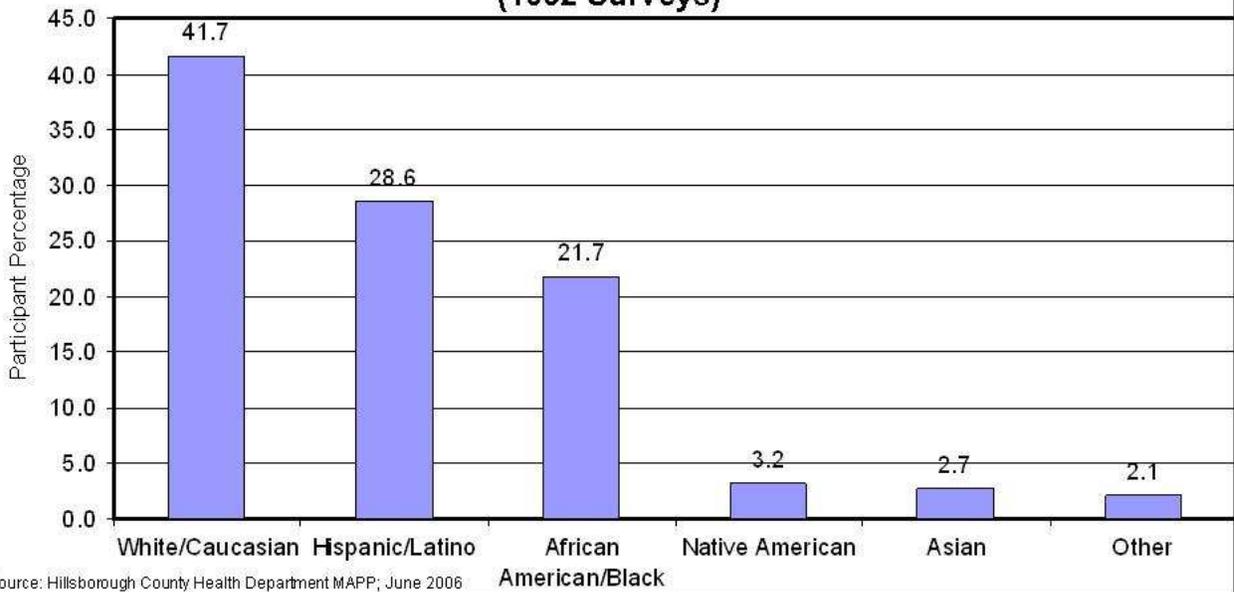
**Sex
(1062 Surveys)**



Source: Hillsborough County Health Department MAPP, June 2006

Figure 24.

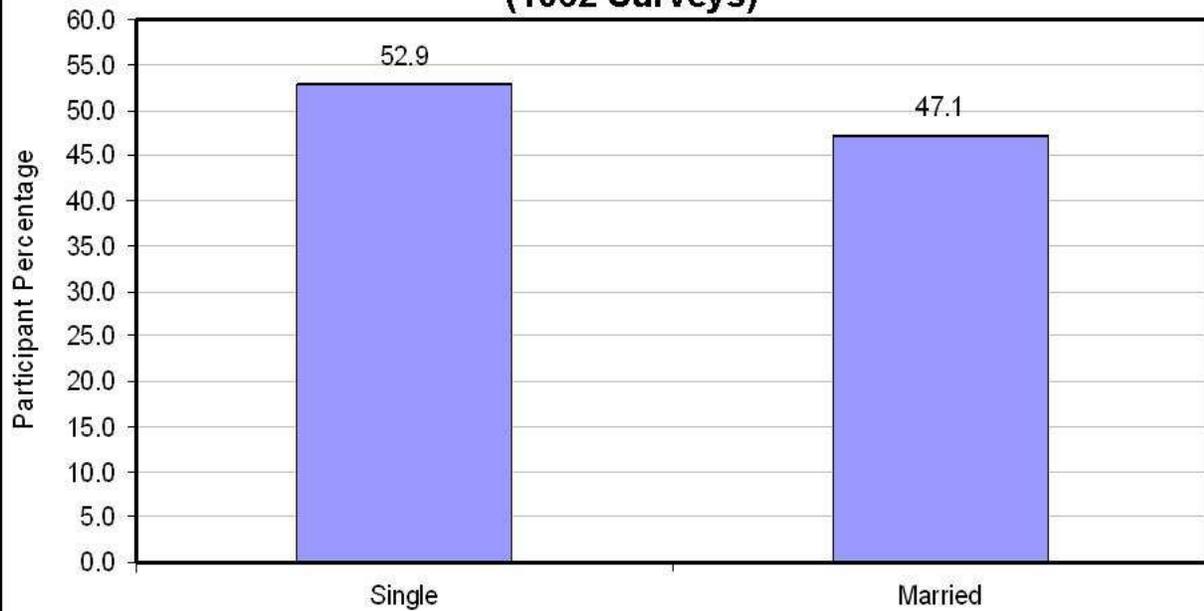
**Ethnic Groups
(1062 Surveys)**



Source: Hillsborough County Health Department MAPP, June 2006

Figure 25.

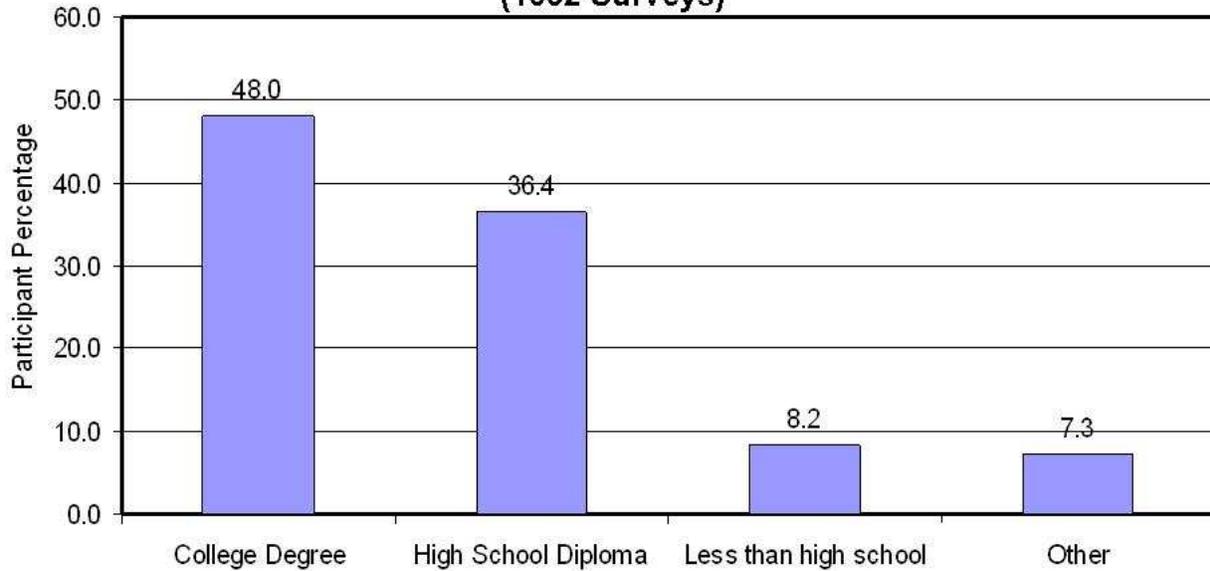
Marital Status (1062 Surveys)



Source: Hillsborough County Health Department MAPP, June 2006

Figure 26.

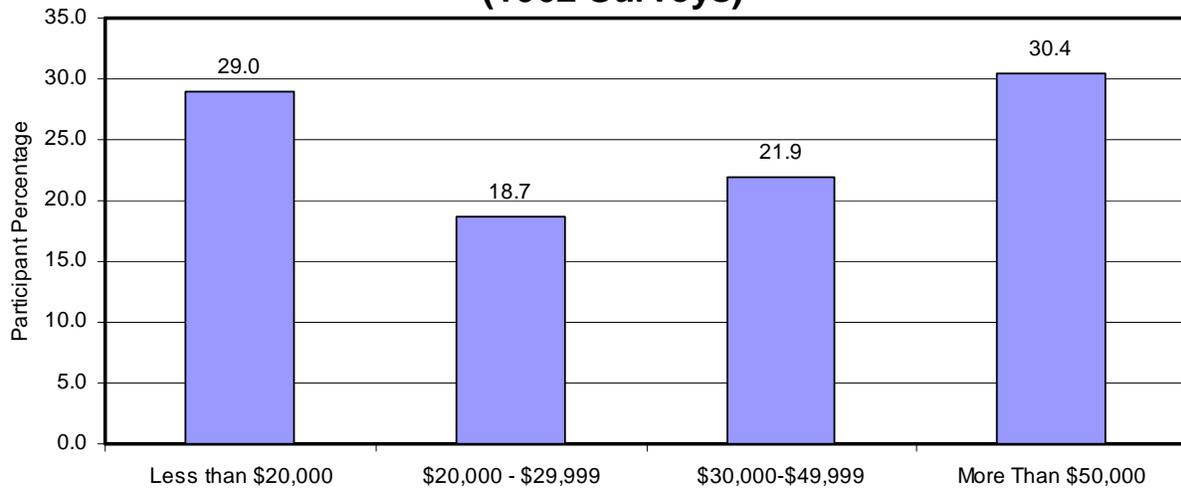
Levels of Education (1062 Surveys)



Source: Hillsborough County Health Department MAPP, June 2006

Figure 27.

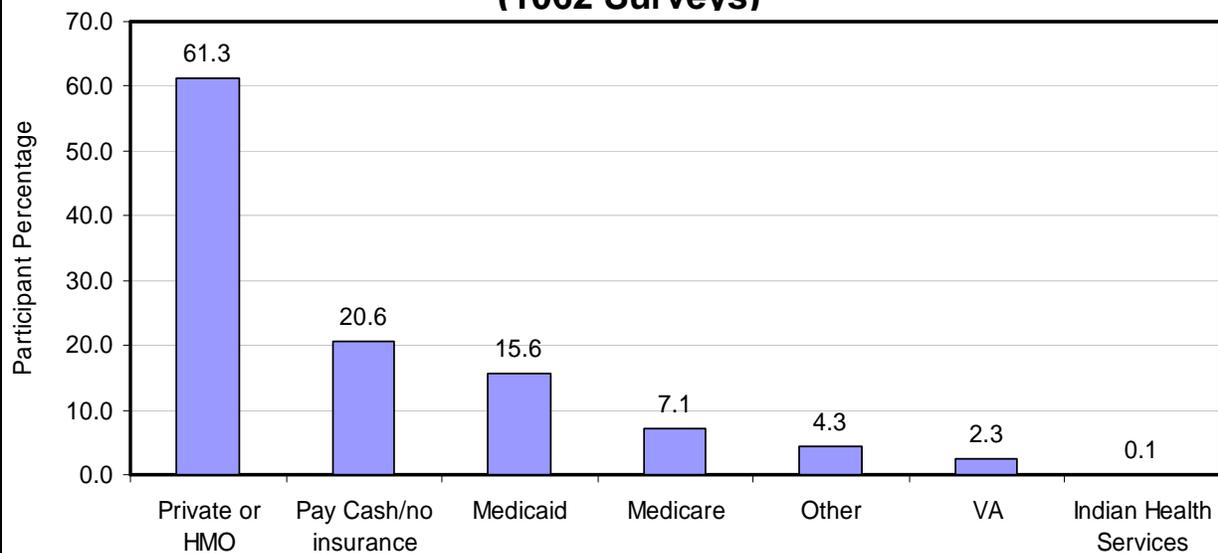
Household Income (1062 Surveys)



Source: Hillsborough County Health Department MAPP; June 2006

Figure 28.

How do you Pay for Health Care (1062 Surveys)



Source: Hillsborough County Health Department MAPP; June 2006

Focus Groups

Staff with expertise in this methodology, a doctoral and master's level student from the University of South Florida, conducted two focus groups. The instrument used for the focus group (Appendix 2) was created by the community assessment work group.

In 1st focus group (nurse's group) conducted on March 28th, 2006, data was gathered from a discussion with 7 health professionals. Four of the participants were between the ages of 45 and 64 and 3 participants were 65 or older. Six of the participants were White and 1 was Black. Five participants reported that they were non-Hispanic, and 2 did not answer. All the participants were well acquainted with each other and were college-educated. One participant had been a resident of the community for 3 to 9 years while the rest had lived in their community for more than 10 years. After the first 3 questions,

1 of the participants had to leave the focus group for an appointment, leaving 6 participants left in the discussion. That participant later sent her written responses to the research team.

In the 2nd second focus group (women's group), conducted on May 17, 2006, data was gathered from a focus group with 5 middle-aged women who attended the Family Support and Resource Center in Town and Country. One participant was aged between 25 and 44, 2 participants were aged between 45 and 64, 1 was over 65 years, and 1 did not specify her age. The educational level varied for the participants: 1 had some high school; 2 had a high school diploma, 1 had some college, and 1 had a college degree. The racial categories were listed as 2 Black, 2 White, and 1 listed as "other", who was of Caribbean ancestry. Three participants listed themselves as non-Hispanic, and 2 did not answer. One participant had been a member of the community for less than 3 years, 1 had spent between 3 and 9 years, and 3 had spent 10 years or more in the community. All members lived in Carrollwood.

The instruments used for data gathering were a digital recorder, the questionnaire and a demographic survey. The digital recorder was used to record the discussion in the focus groups for the purpose of transcription in order to link the transcript with the qualitative analysis software Atlas.ti 5.0. The survey provided personal characteristics of the participant such as age, race/ethnicity, profession, education level, and years of residence in the community.

The participants for the focus groups were recruited by staff at the Hillsborough County Health Department (HCHD). Staff designated the time and place for the focus group. The nurse's group discussion was set from 5:30pm to 6:30pm, and the place was set at the James A. Haley Veterans Hospital Spinal Cord Injury. The women's group took place during the same time slot at the Family Support and Resource Center in Town and Country. For the nurse's group, formal invitation letters on official letterhead and signed by the primary investigator were sent to all participants 1 week before the focus group. The HCHD staff recruiter originally enlisted 11 participants. All participants were contacted for a reminder phone call by the moderator a day before the focus group. The moderator and note-taker were limited to a half an hour before the focus group for set up. The women's group was organized by the staff at the Family Support and Resource Center. Eight participants were invited and 5 participated. For both groups, tables were arranged, signs were placed to direct participants to the focus group, snacks and refreshments were set, and a quick sound check was performed.

When participants arrived they were asked to fill out the demographic survey and name tag. Once participants were seated the moderator made an introduction which included the purpose of the study, the sponsors of the study, notification of recording, and guidelines for the focus group. After the introduction, the recorder was activated and the discussion was guided by the moderator with the use of a question route. The question route included 10 questions. In the nurse's group, after question 3, 1 of the 7 participants had to leave the discussion due to other appointments. In the women's group, 1 of the participants arrived during question 4.

Interviews

In-depth interviews were scheduled with:

- Policy Makers – Senator, Mayor, County Commissioners, Medical School Representative.
- Providers – Doctors, Nurses, Social Services Directors, Mental Health Program Director, Health and Social Services Board Representatives.
- Local Leaders – Pastors, School Officials, CEOs/Chamber of Commerce Representative.

A total of 30 interviews were completed, most taking approximately 1 hour. The questionnaire (Appendix 3), while open-ended reflected, questions similar to those asked in the survey. Additional questions were included to explore their perceptions of the health department and knowledge or understanding on health disparities.

Media Survey

A suggested method for gaining information on perceived needs is to study mass media coverage of health topics over a selected period. A media chart from the US Department of Health and Human Services, “Moving to the Future: Developing Community-Based Nutrition Services”, was utilized to track the results of the media survey (Appendix 4). This effort was limited in scope but was compatible with the MAPP approach and added to the breadth of information.

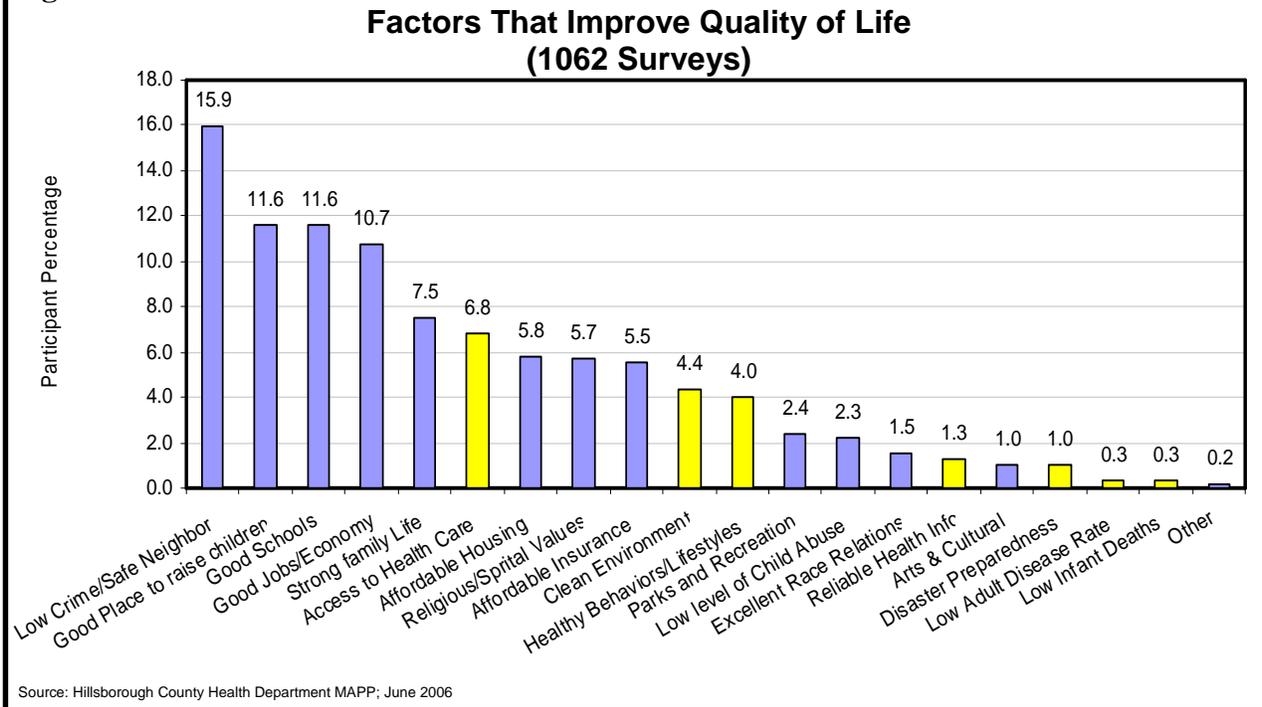
Results and Discussion

Factors for a Healthy Community and Improving the Quality of Life

Question 1 of the community survey asked respondents what they thought were the 3 most important factors for a healthy community. The question further defined this as factors that would improve the quality of life. For most respondents factors that were important for their quality of life related to neighborhood safety, the environment for their children, schools and the economy. Factors more directly related to public health such as access to healthcare, a clean environment and a healthy lifestyle took a lower priority (Figure 29).

There is no doubt that individuals care about these specific health issues but as would be expected, safety, stability and security are viewed as a priority and necessary before other needs are considered. This perspective supports the broader approach to public health which asks us to consider the importance of ensuring that basic needs are addressed through policy and environmental changes while seeking behavioral changes. For example, if individuals do not have a safe community to walk in, it is very difficult to promote increased physical activity as a health promoting behavior.

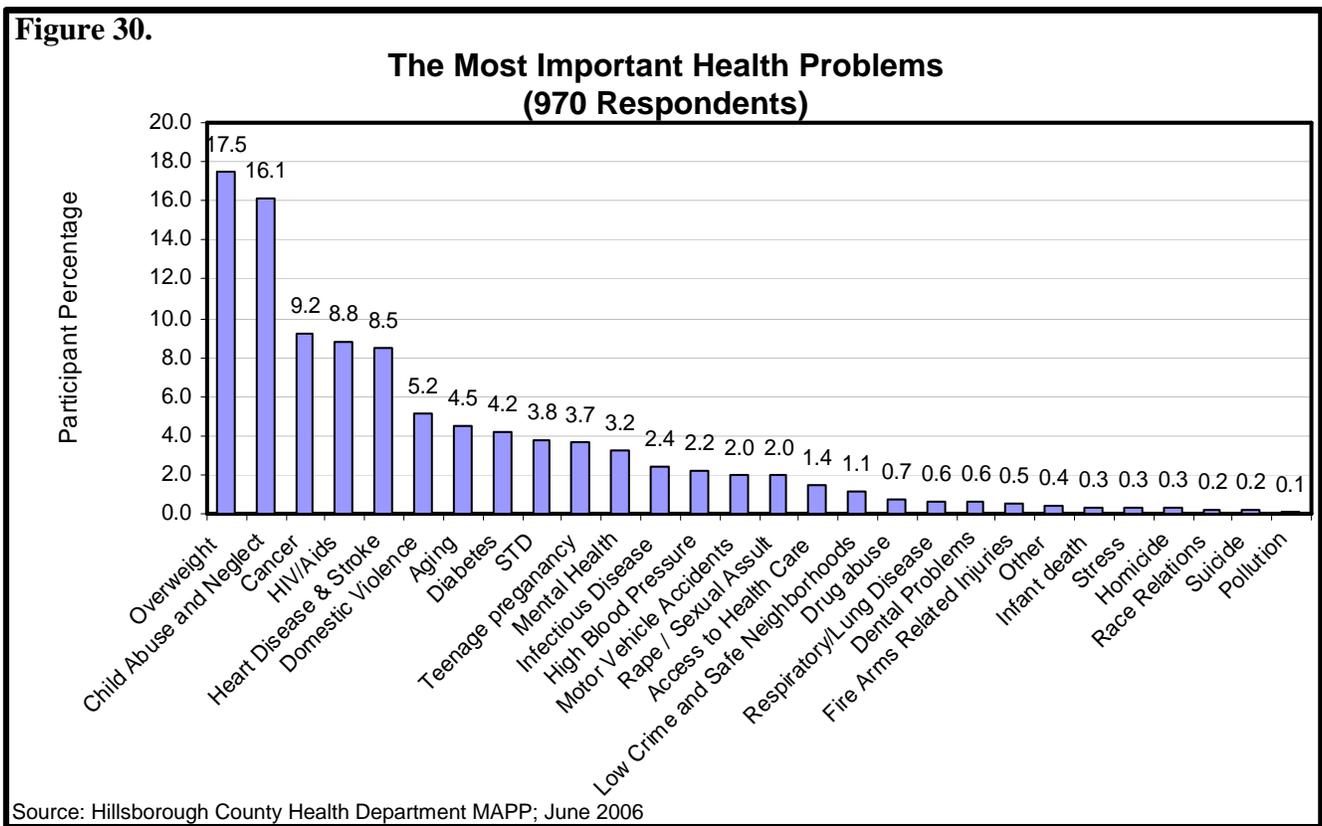
Figure 29.



Most Important Health Problems

Survey respondents indicated that the 3 most important health problems were overweight, child abuse and cancer. Other diseases such as heart disease/stroke, HIV and diabetes were also seen as important (Figure 30). It is also worth noting that domestic violence and aging problems were also seen as factors that impact the overall health of the community.

Individuals responding to interviews and participating in focus groups also highlighted overweight and obesity as our most important health issue. One focus group participant noted that, “*Our elders are aging much healthier than what our children will because of the incidence of obesity and diabetes*”. Other problems such as access to health care, problems of the uninsured, heart disease, diabetes, high blood pressure, sexually transmitted diseases and AIDS were also viewed as important health problems by many.



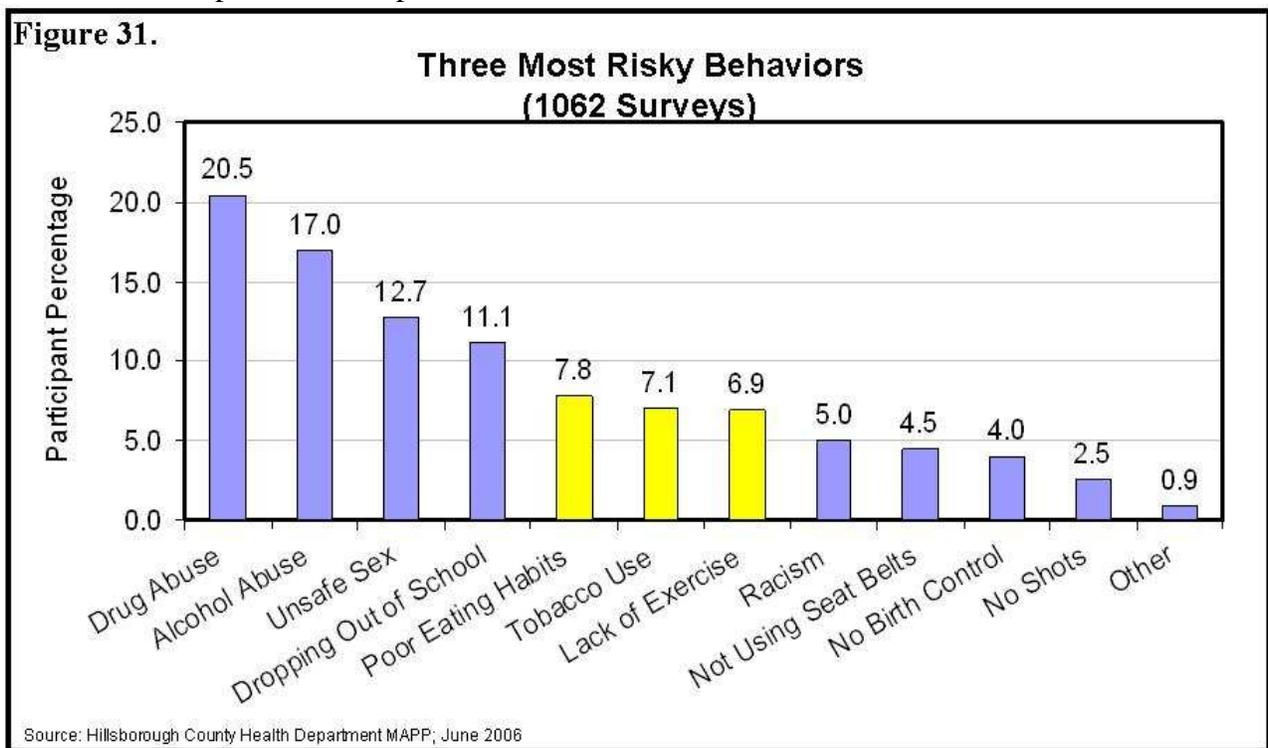
Six of the individuals interviewed were medical doctors. Interestingly, none of them selected obesity as 1 of the 3 most important health problems, all included AIDS and all but 1 selected heart disease.

The concerns of the community are consistent with the concerns of the public health and medical community. While we are seeing some improvements in the trends in deaths from AIDS, heart disease and stroke, deaths from diabetes continue to rise (Figures 47- 49). Also, as we look at comparisons to the state and other peer counties (Table 10), it appears that these concerns are legitimate. Like our peer counties, our rates for many of the leading causes of death exceed the state rates. Unfortunately, our infant death rate, which continues to increase, was not selected as a major health issue by respondents. This may indicate a need to raise awareness on this important indicator of community and national health.

Most Risky Behaviors

In response to our question on risky behaviors that impact overall community health, 20.5% of respondents felt that drug abuse was the most risky behavior, 17.0% indicated alcohol abuse and 12.7% unsafe sex. Behaviors such as poor eating habits, tobacco use and lack of physical activity were not considered the most risky behaviors (Figure 31).

This would appear to be inconsistent with what was selected as the major health problem. Overweight and obesity which were selected as the most important health problem are clearly linked to behaviors such as poor eating habits and lack of exercise, yet these were not selected as any of the 3 most important risky behaviors. Respondents may have taken a very broad view of this question, selecting behaviors like drug abuse which has obvious and dramatic negative impacts. Or it is possible that individuals are not making the connection between the problem and the behavior changes that need to be made to address this problem. According to 2002 Behavioral Risk Factor Surveillance data, 56.7% those sampled have no regular moderate physical activity and 75.1% have no regular vigorous physical activity. Lack of physical activity is not yet being given the necessary attention as a risk factor. There is a need to further explore these implications.



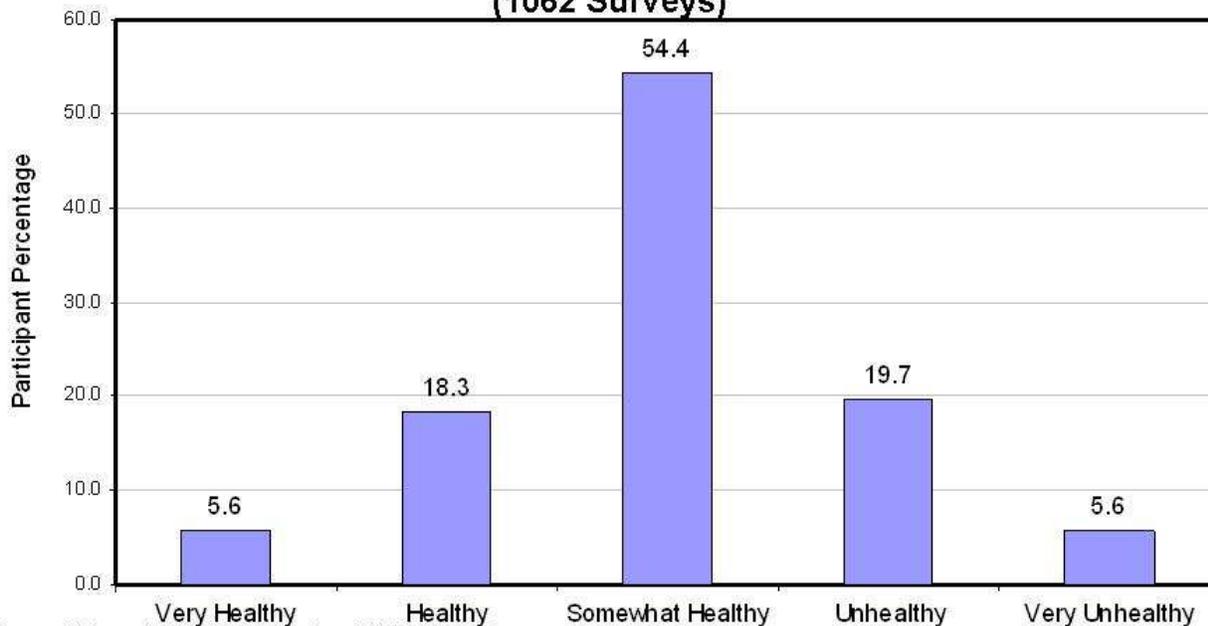
Perceptions of Community and Personal Health Status

Based on the feedback (Figures 32 & 33), respondents had positive perceptions of their community's health status and even more so about their own personal health status. This is consistent with other data which indicates that only 14% of Hillsborough residents feel that their health is only fair or poor. The majority are very positive about their health status.

Based on morbidity and mortality indicators, however, it would appear that the perceptions may not be in line with reality. Further, although minority populations are disproportionately impacted by many diseases with rising incidence rates, they are also positive about their health status. As noted in Figure 6, only 13% of Blacks in our county consider their health fair or poor.

Figure 32.

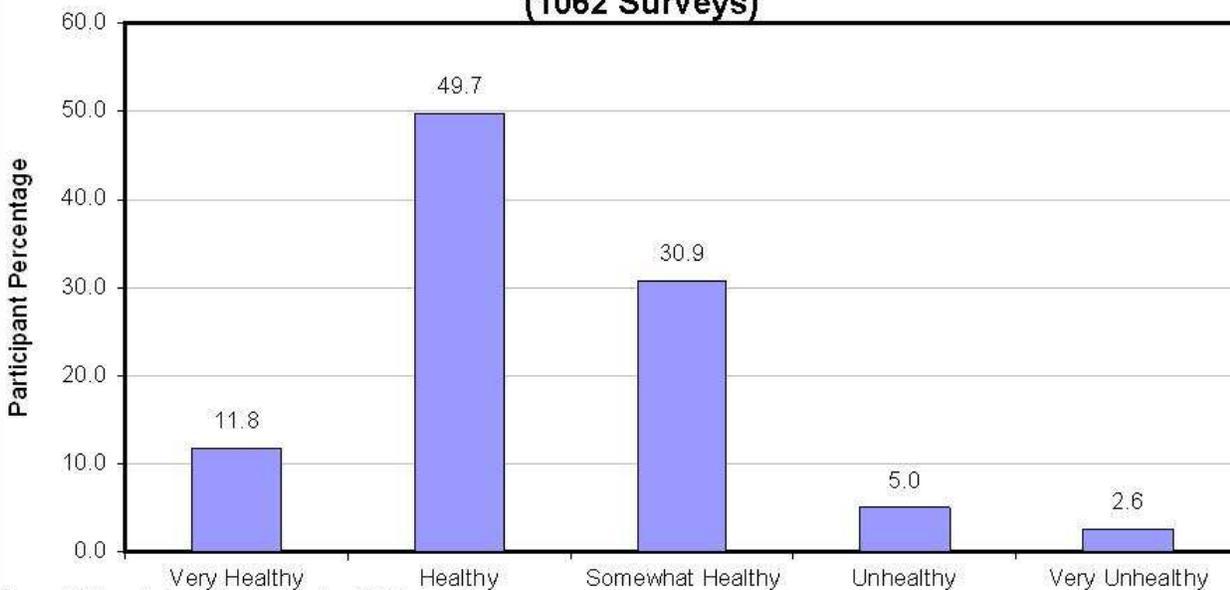
Perceptions of Community Health Status (1062 Surveys)



Source: Hillsborough County Health Department MAPP; June 2006

Figure 33.

Perceptions of Personal Health Status (1062 Surveys)



Source: Hillsborough County Health Department MAPP; June 2006

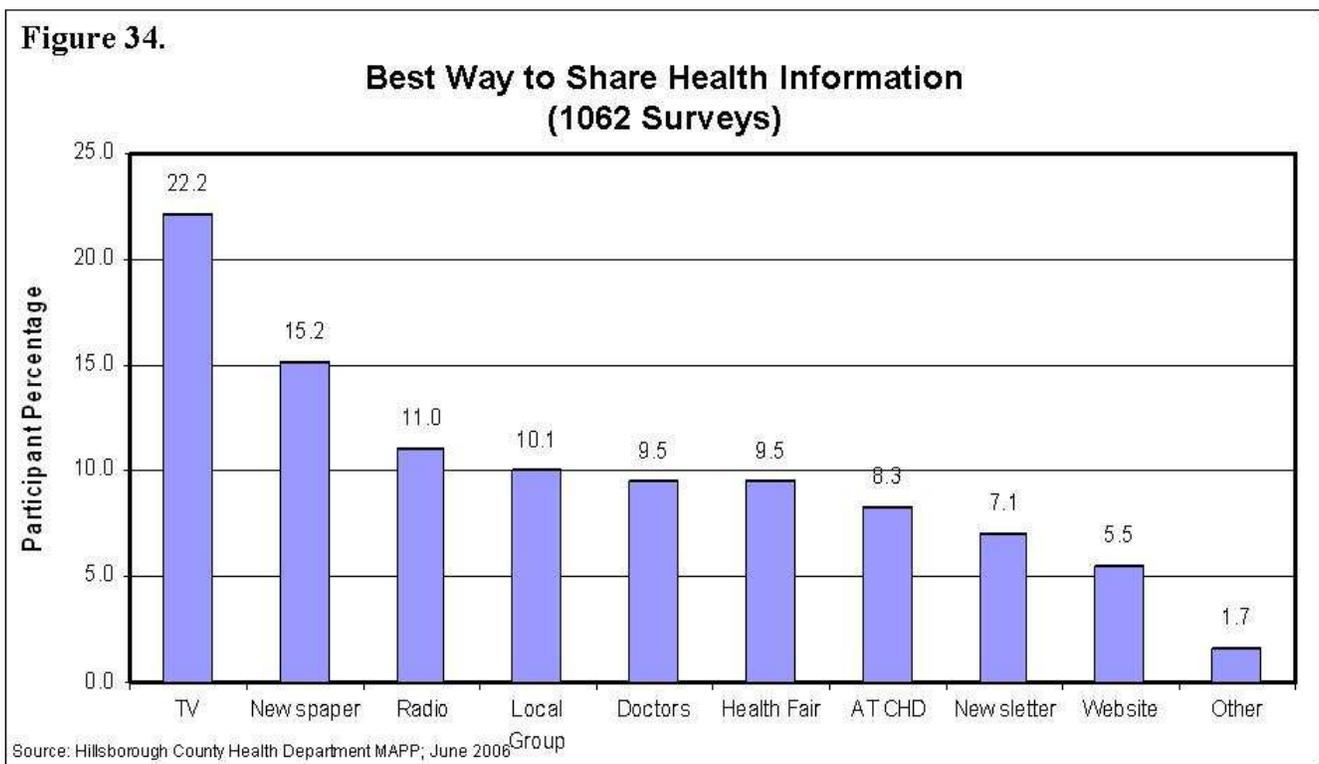
Communicating With Our Community

The majority of respondents felt that the best way to share information with them was through the media, television, newspapers and radio, with television being the most often selected (Figure 34). This included educational as well as event information. Providing information via groups in the community such as church groups was also seen as useful. Communication methods which we have often depended on because of convenience and lower cost such as health fairs, newsletters and websites were not selected as the best ways for sharing information with the community. Creative methods for gaining

media coverage or improving access and interest in web-based information may be necessary to reach our target audience.

Based on the results of our media survey (Appendix 4) there is no shortage of health messages available in mass media. On a daily basis information on a variety of health topics is presented on television, and in the major newspaper and regularly on radio. Smaller newspapers such as the *Florida Sentinel* and *La Gaceta* which target minority populations do not have regular pieces or columns devoted to health issues.

Researchers indicate that mass media, while effective for developing consumer awareness in the short-term may not be effective in changing behavior in the long-term. Face-to-face type programs are more effective in this regard. It is recommended that marketing and media efforts, while useful, must be combined with other approaches to increase knowledge and awareness and promote behavior change. Media messages must also result from analysis of the environment, competition, resources, and market and be carefully targeted to specific market segments.



Addressing Health Issues

Respondents presented a variety of ways to address the various problems selected as health issues in our community. This was 1 of few write-in questions on the survey so respondents were free to suggest any ideas they felt would be useful in addressing what they saw as health issues. They included increasing education and awareness, promoting behavior change and prevention. Many felt that individual personal responsibility and community involvement were necessary solutions. More funding, policy changes and political action were also considered (Figures 35-40). Those interviewed also included increasing partnerships as a solution. The action most often suggested regardless of the health problem was education and awareness. County residents want to be informed and educated and this is crucial for promoting health and preventing disease.

A number of interviewed respondents advised that the health department needed to “listen” to their community. One noted that we needed to, “get as much programmatic advice from non-health

professionals in the community and establish formal processes and structures to listen to the wisdom of the community”.

The challenge lies in moving from knowing to doing, how we change behavior. Individuals may know what the leading causes of death are but may not be following through with behaviors that would reduce deaths from these causes. Additional steps will need to be taken by providers to encourage the necessary action needed for disease prevention. Some of these additional steps have been suggested by respondents.

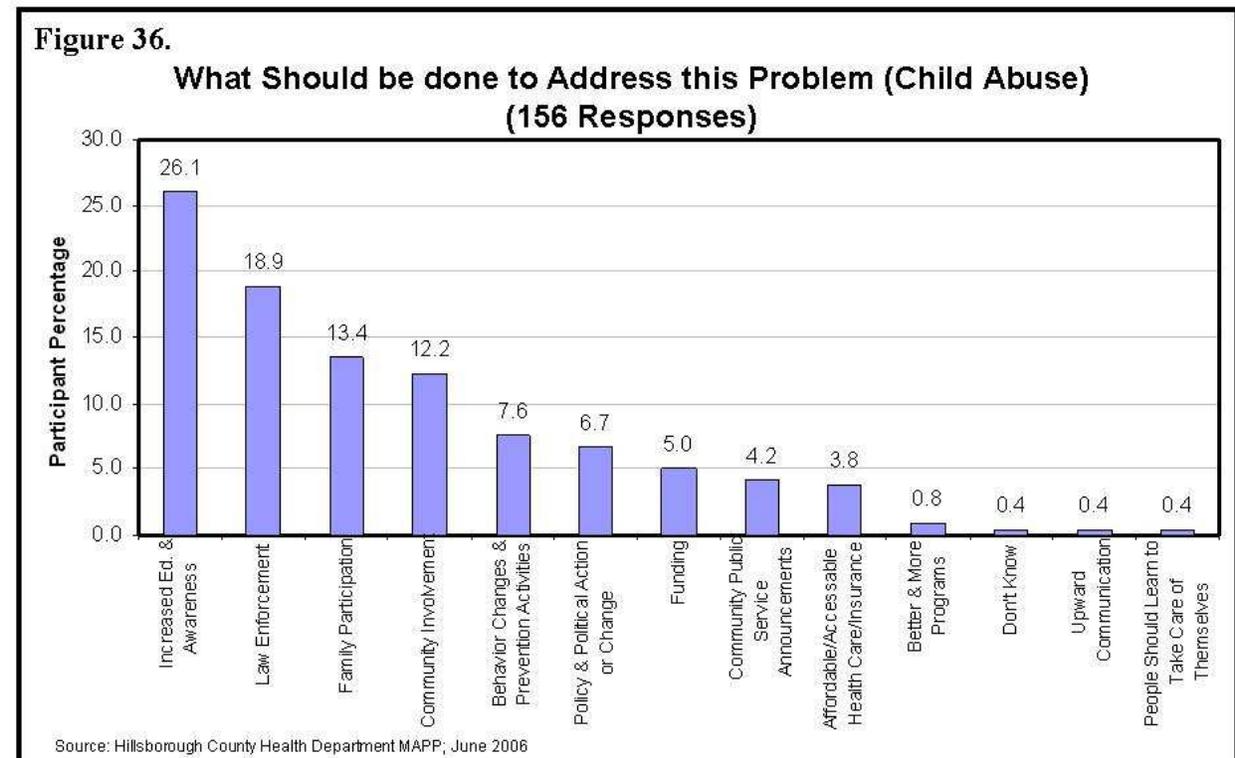
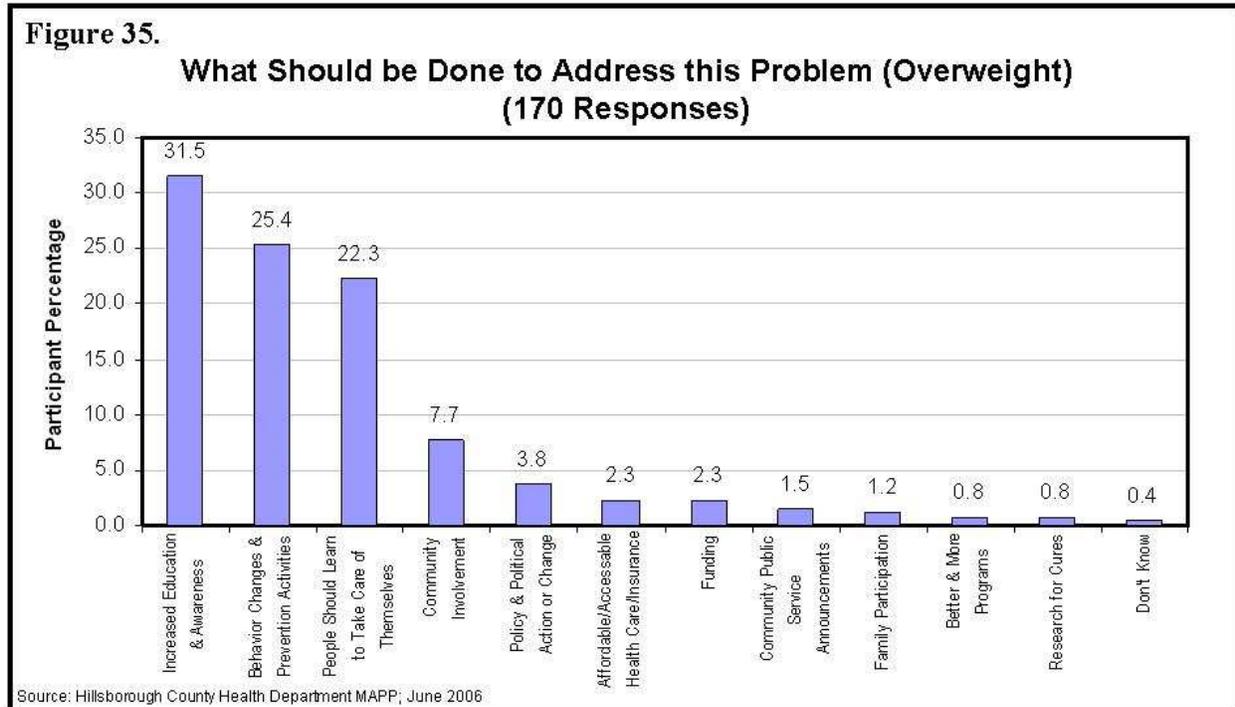
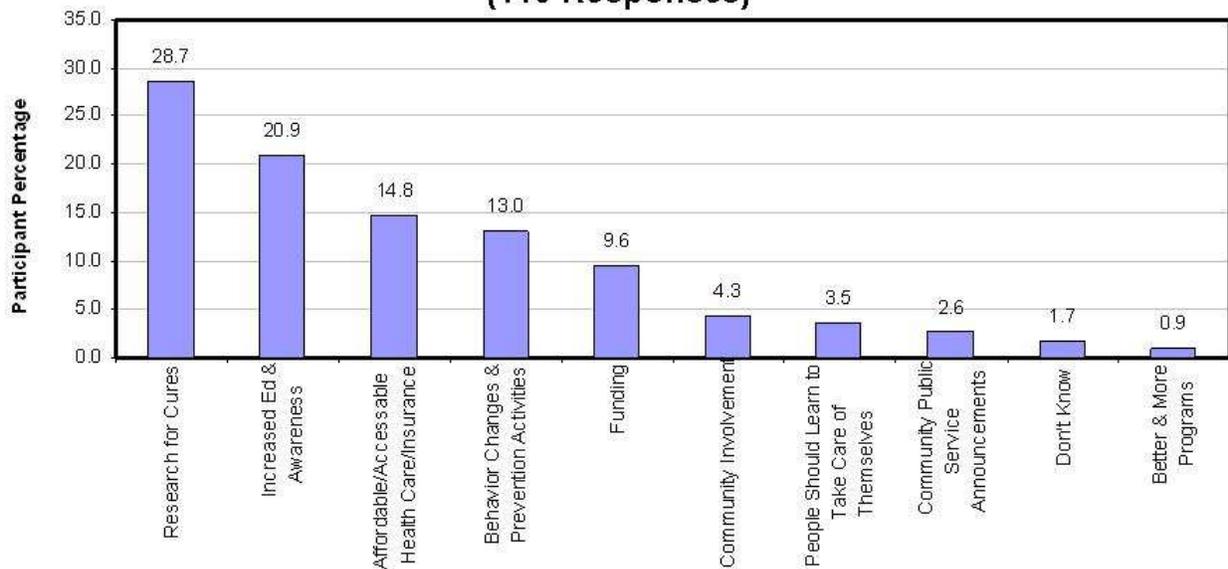


Figure 37.

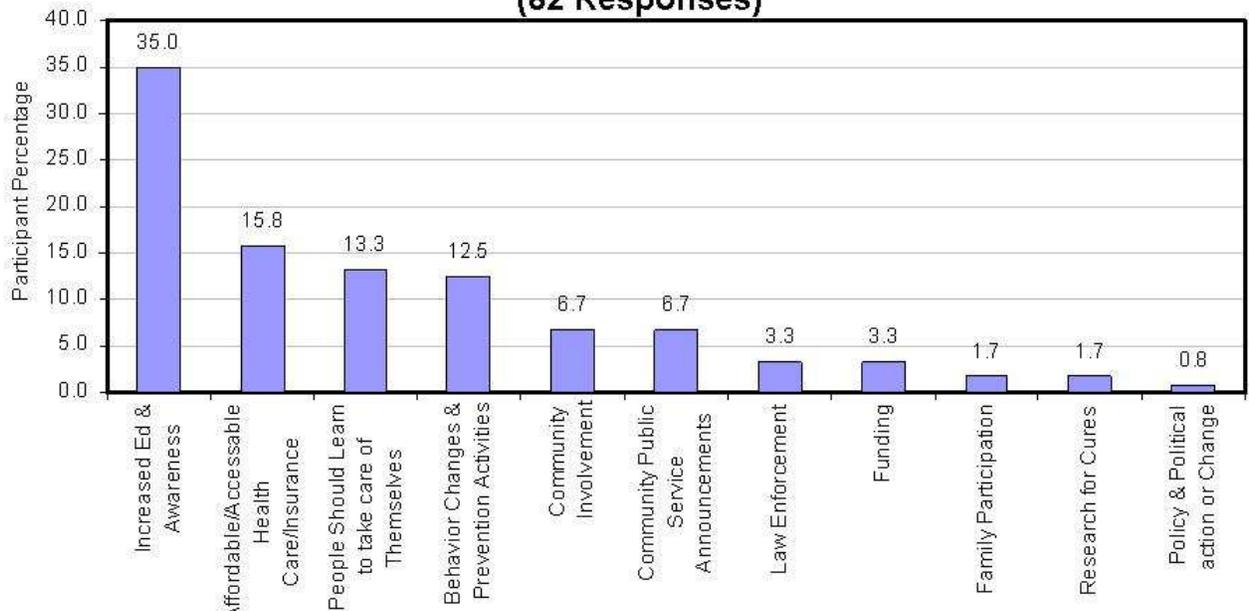
**What Should be Done to Address this Problem (Cancer)
(115 Responses)**



Source: Hillsborough County Health Department MAPP; June 2006

Figure 38.

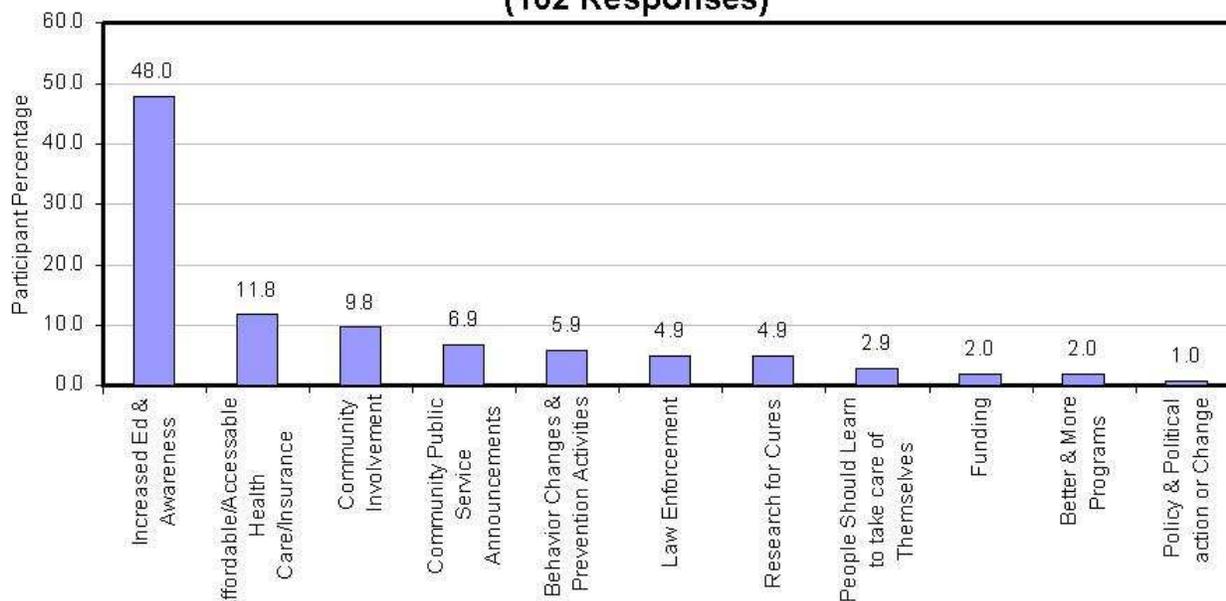
**What Should be Done to Address this Problem (Heart Disease)
(82 Responses)**



Source: Hillsborough County Health Department MAPP; June 2006

Figure 39.

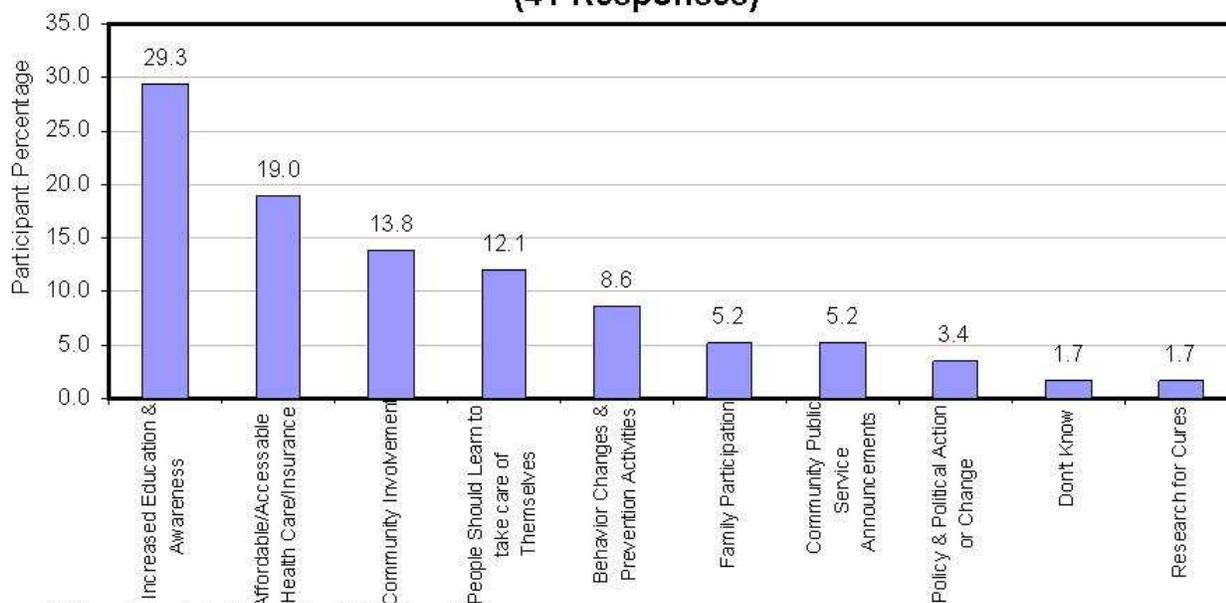
**What Should be Done to Address this Problem (HIV/AIDS)
(102 Responses)**



Source: Hillsborough County Health Department MAPP, June 2006

Figure 40.

**What Should be Done to Address this Problem (Diabetes)
(41 Responses)**



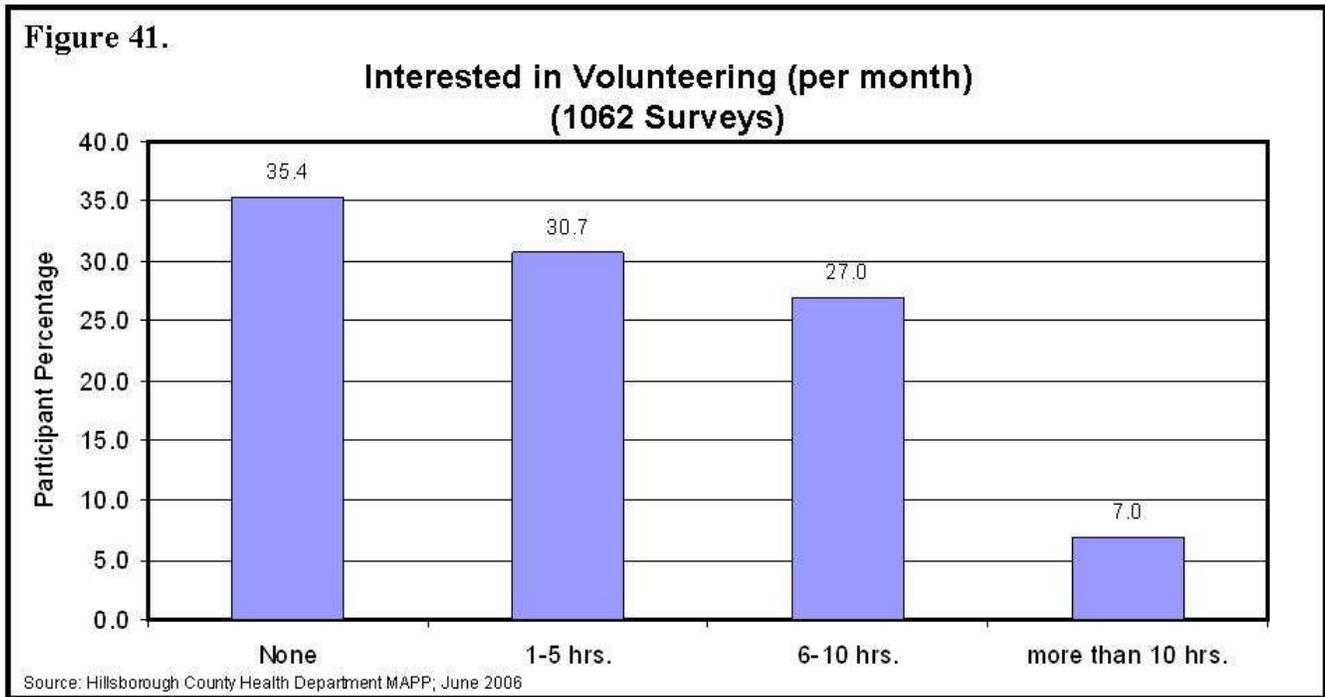
Source: Hillsborough County Health Department MAPP, June 2006

Volunteering

Survey respondents were asked about their interest in volunteering time to community services. The majority of respondents would be willing to volunteer to provide some community service (Figure 41).

This very positive response may be worthy of close attention as we seek to find ways to do more with less fiscal resources. More importantly, it may support efforts to build capacity within our communities as individuals take an active role and responsibility for health promotion in their social circles, work and

school environment, while no details were given as to the specific volunteer activities or locations in which these would take place. It is evident that efforts to explore how we might actively partner with members of the community may prove to be helpful to health and service providers.



Knowledge of Public Health Agency Function and Health Disparities

To assist us in our strategic planning efforts we took the opportunity to ask those interviewed 2 additional questions that were not included for survey and focus groups respondents. We wanted to understand how much policy-makers, providers and community leaders understood about the work of the local public health department and what they understood about health disparities.

From our results we determined that these respondents have had positive but limited regular interaction with the health department. Some could list at least 1 function or role of the health department. It appeared however that many still feel that the role of public health is to provide health care to the poor. One respondent however noted that, *“People still think of the Hillsborough County Health Department as a welfare agency. We need to erase this image and show how much is done in all areas of service.”*

Some respondents had an understanding of health disparities and spoke of economic as well as racial and ethnic health disparities. Others had limited knowledge. Opinions on the issue varied. One indicated that *“it’s an age old problem with a new appeal”* another stated that, *“It seems to be the buzz word of the day, health disparities have been around forever”*. One interviewee commented that, *“I am an outspoken critic of the term. We need to move beyond disparities and talk about health inequities so that we can address the root causes..... using the term disparities points a finger at the victims, as if its their fault.... Why do we tolerate these disparities?”* He further spoke of the number of Black infant deaths as a symptom of a larger problem like a fever. *“A fever is a non-specific indicator of some specific health problem, disparities in infant mortality may similarly also be a symptom, a non-specific indicator of a problem in the system. We need to find out what is causing the fever and fix that.”*

Summary

Listening to our community is essential for identifying the important issues and formulating possible solutions. Surveys, focus groups, and interviews were used to gain feed back from members of the

community, policy makers and providers. While this was an assessment for planning purposes and not a research project, we must consider some limitations in reviewing the feedback. These included:

1. Having a relatively small sample. Therefore, while we can make some assumptions related to these results we must be mindful that the sample can not be generalized to the entire population of the county.
2. The number of focus groups. Focus groups provide an opportunity to more deeply explore issues, probe and follow-up on discussion points. Initial plans included more focus groups. Due to a variety of challenges we were only able to do 2.

Analysis of the feedback indicates that our community cares about broad quality of life issues such as safety in their neighborhoods and the quality of their children's schools. They are also concerned about child abuse and the chronic diseases that impact our lives. Their greatest disease specific concern appeared to be related to obesity and overweight. However respondents did not appear to be connecting the health behaviors that are essential for reducing obesity with this problem. Additionally, very few respondents described their individual health or the health of their community as unhealthy. This may be a concern as health indicators for many of the leading causes of morbidity and mortality in our county are high and health disparities are evident.

The community wants more active attempts on our part to gain feedback from them. They also want increased efforts to provide education to them, but we also recognized that actually changing behaviors, establishing appropriate policies and creating an environment conducive to health will present some challenges. The information gained has assisted us in identifying a need to more actively raise awareness within our community on the reality of individual and community health status. It will guide us in developing a strategic plan to address the health concerns of our community and partners. The data has also highlighted some possible approaches that may be used to engage our community so that they can be co-partners in addressing mutual public health concerns.

As noted by the Former Assistant US Surgeon General, Edward Baker, MD, MPH "...the major public health challenges since 9/11 were not just epidemiological, technical issues. The major challenges were communication. In fact, as we move into the 21st century, communication may well become the central science of public health practice." A focus will be given to communicating on these issues with all stake-holders. Steps have already been initiated to engage broad segments of the community in discussion that increase awareness on county health issues and seek solutions.

Comparison to Peer Counties

State values for health indicators are valuable comparisons, but do not compare similar populations, and thus much of the variance found in those comparisons could be easily explained by differences in race, and poverty level. Therefore a comparison to other counties whose demographics and socio-economics closely match Hillsborough County will be most valuable.

The peer counties for this report were selected from the 2000 CATCH report²⁷ published by the University of South Florida. The selection was based on four socio-demographic characteristics that most closely paralleled those of Hillsborough County. These criteria included:

- Percentage of population less than age 18,
- Percentage of population greater than age 64,
- Percentage of non-White population, and
- Percentage of families below poverty level

The peer counties selected for this comparison are: **Duval, Orange, and Polk.**

Similar to our peer counties, we have health indicators that are less favorable than the state. The State of Florida has ranked 41st in the 2006 America Health Rankings status. Therefore, our status based on these indicators could not be viewed as positive.

Table 10.

County Health Status Comparison For 2005

Health Status Indicators	Hillsborough	Duval	Orange	Polk	State
Mid-Year Population	1,137,583	865,965	1,050,939	545,064	18,018,497
Resident Live Births	16,753	12,974	16,556	7,786	226,219
Percent of Births Under 2500 Grams	9	9.6	8.9	8.6	8.8
Percent of Births Under 1500 Grams	1.7	1.9	1.6	1.9	1.6
Neonatal Deaths	104	97	81	36	1,024
Infant Mortality Rate per 1,000 Live Births	8.9	11.6	7.7	8.2	7.2
Births per 1,000 Females 10-14 (SE)	0.8	0.8	1	1.3	0.7
Births per 1,000 Females 15-19	47.4	49.5	44.9	65.4	41.9
Percent of Repeat Births to Mothers 15-19	16.9	15.5	16.3	18.8	16.1
Enteric Diseases Rate per 100,000	51.1	52.5	43.3	57.6	47.6
Enteric Diseases Rate per 1,000 Children <6 y/o	2.8	2.8	1.9	3.2	2.7
AIDS Cases per 100,000	30.4	31.3	33.6	18.9	25.8
Chlamydia Rate per 100,000	282.3	534.1	395.8	284.6	240.7
Congenital Syphilis Cases (SE)	1	4	0	1	16
Tuberculosis Rate per 100,000	7.9	9.4	8.6	9.9	6.1
Years of Potential Life Lost per 100,000 <75 y/o	7,986.70	9,712.30	7,149.30	9,283.80	8,052.10
Coronary Heart Disease Age-Adjusted Death Rate per 100,000	150.2	148.5	144	172.7	138.1

Data Source: Florida CHARTS, 2005

Table 11.**County Death Data Comparison for 2005**

Death Indicators	Hillsboro	Duval	Orange	Polk	State
Size/Population of County	1,137,583	865,965	1,050,939	545,064	18,018,497
Deaths from All Causes	8,944	6,969	6,576	5,603	170,300
Age Adjusted Death Rate Per 100,000	805.2	894.7	795	786	723.7
Total Deaths Under 65	2,716	2,482	2,220	1,463	42,944
Percent of Deaths Under 65	30.4	35.6	33.8	26.1	25.2
Infant Deaths	149	150	128	64	1,626
Infant Mortality Rate Per 1,000 live Births	8.9	11.6	7.7	8.2	7.2
HIV/AIDS Deaths	103	117	106	37	1,706
HIV/AIDS Age Adjusted Death Rate	9	13.2	10.1	7.4	9.6
Pneumonia/Influenza Deaths	101	143	157	121	2,787
Pneumonia/Influenza Age-Adj. Death Rate	9.1	18.9	20	16.2	11.3
Cancer Deaths	2,123	1,613	1,531	1,235	40,321
Cancer Age Adjusted Death Rate	191.7	207.3	184.2	172.1	172.1
Chronic Liver Disease & Cirrhosis Deaths	125	92	81	53	2,134
Chronic Liver Disease & Cirrhosis Age Adjusted Death Rate	11.1	10.9	8.4	8.2	10
Chronic Obstructive Pulmonary Disease Deaths	568	367	354	390	9,454
Chronic Obstructive Pulmonary Disease Age Adjusted Death Rate	52	48.9	45.2	51.2	38.3
Diabetes Deaths	317	249	188	141	5,181
Diabetes Age Adjusted Death Rate	28.8	32.4	22.9	19.7	21.9
Heart Disease Deaths	2,330	1,631	1,567	1,698	45,992
Heart Disease Age Adjusted Death Rate	210.4	213.8	198.1	226	186.2
Stroke Deaths	481	361	323	307	9,321
Stroke Age Adjusted Death Rate	43.5	47.4	40.8	41.3	37.6
Homicide Deaths	48	105	74	23	988
Homicide Age Adjusted Death Rate	4.1	11.7	6.7	4.3	5.8
Suicide Deaths	128	124	103	81	2,308
Suicide Age Adjusted Death Rate	11.2	14.1	10	14.3	12.2
Unintentional Injuries Deaths	533	370	373	323	8,744
Unintentional Injuries Age Adjusted Death Rate	47	43.4	37.1	58.4	45.6
Motor Vehicle Crash Deaths	227	162	177	155	3,491
Motor Vehicle Crash Age Adjusted Death Rate	19.9	18.6	16.9	29.6	19.2

Data Source: Florida CHARTS, 2005

Table 12.

County Birth Data Comparison

	Hillsboro.	Duval	Orange	Polk	STATE
	2003-05	2003-05	2003-05	2003-05	2003-05
	3-Year rate or %				
Total Births					
Total Live Births (Per 100,000 Total Population)	1,440.80	1,500.10	1,528.40	1,388.20	1,243.50
White Live Births (Per 100,000 White Population)	1,353.90	1,335.20	1,412.50	1,299.70	1,124.30
Non-White Live Births (Per 100,000 Non-White Population)	1,768.00	1,820.10	1,855.40	1,846.40	1,756.70
Births By Age of Mother					
Births to Mothers 15-44 (Per 1,000 Females 15-44)	65.8	66.6	65.7	74.5	63.6
Births to Mothers 10-18 (Per 1,000 Females 10-18)	16.5	16.6	14.9	22.3	14.4
Births to Mothers 10-14 (Per 1,000 Females 10-14)	0.8	0.9	0.7	1	0.7
Births to Mothers 15-19 (Per 1,000 Females 15-19)	47.2	50.6	43.1	65	42
Repeat Births to Mothers 15-19 (% of Teens with Prev. Birth)	15.90%	16.40%	16.70%	17.60%	15.60%
Births By Marital Status					
Births to Unwed Mothers (% of Total Births)	42.10%	43.10%	41.50%	47.80%	41.40%
Low Birth Weight					
Total Live Births <2500 Grams (% of Total Births)	8.80%	9.80%	9.20%	8.50%	8.60%
White Live Births <2500 Grams (% of White Births)	7.40%	7.40%	7.60%	7.30%	7.20%
Non-White Live Births <2500 Grams (% of Non-White Births)	12.90%	13.20%	12.60%	12.70%	12.50%
Total Live Births <1500 Grams (% of Total Births)	1.70%	2.00%	1.70%	1.70%	1.60%
White Live Births <1500 Grams (% of White Births)	1.30%	1.20%	1.20%	1.30%	1.20%
Non-White Live Births <1500 Grams (% of Non-White Births)	3.00%	3.10%	2.60%	2.90%	2.80%
Prenatal Care					
Births w/1st Trimester Prenatal (% of Births w/known PNC Status Care)	87.40%	82.00%	86.70%	66.30%	81.80%
Births w/Late or No Prenatal Care (% of Births w/known PNC Status)	2.60%	3.80%	2.90%	7.40%	4.10%
Infant Mortality					
Infant Deaths (Per 1,000 Live Births)	8.9	11	7.9	8.3	7.2
White Infant Deaths (Per 1,000 White Live Births)	6.2	7.4	5.9	6.3	5.5
Non-White Infant Deaths (Per 1,000 Non-White Live Births)	17	16.1	12.2	15.9	12.1
Total Neonatal Infant Deaths (Per 1,000 Live Births)	6.3	7	5.2	5	4.6
White Neonatal Infant Deaths (Per 1,000 White Live Births)	4.4	4.3	4.2	3.7	3.5
Non-White Neonatal Infant Deaths (Per 1,000 Non-White Live Births)	11.9	11	7.3	9.5	7.8

Data notes: Starting in 2004, trimester prenatal care began is calculated as the time elapsed from the date of the last menstrual period to the date of the first prenatal care visit. Prior to 2004, these data were obtained by direct question that noted the trimester the mother began prenatal care. Consequently, these data are not comparable to data from prior years.

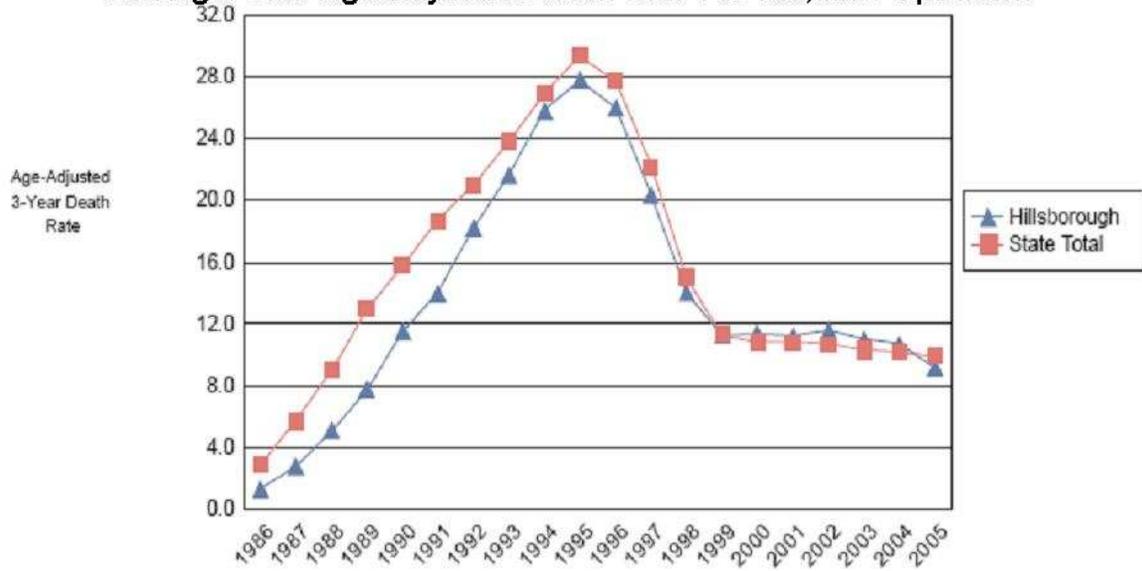
Data Source: Florida Department of Health, Office of Vital Statistics

Mortality Trends in Hillsborough County

- The advent and widespread use of highly aggressive anti-retroviral therapy (HAART) was associated with decreases in death rates due to HIV/AIDS cases in the late 1990's. Generally, mortality rates for HIV/AIDS cases remained fairly stable in the early 2000s, with a decrease in 2005 after increased CD4 testing statewide (Figure 42). The recent leveling of the trend between 1997–2003 may reflect a lack of effectiveness of therapy among some patients. Possible reasons for this include delay in diagnosis of HIV infection until severe symptoms have occurred, improper treatment after diagnosis, difficulty in adherence to medication regimens, and development of viral resistance to therapy. However, rates have started to descend again in 2004.
- Although the infant mortality rate for Hillsborough County has consistently been higher than the state, there has been a steady decline since the early 1990s. However, the gap between the state rates and those of the County have started to widen in recent years, with the county's infant mortality rates (Figure 43).
- The trend for age adjusted death rates (AADR) from injuries for Hillsborough County, which have been higher than the state, was on the downward slope until the late 1990s. Between 1999 and 2002, both the state and county rates increased, with rates mirroring each other in 2005 (Figure 44). Specifically, the trend for AADR for motor vehicle traffic crashes in the county has been on the decline since 1988 (Figure 45). However, from 1997 to 1999, there appeared to be a marked increase in the death rate for alcohol-related motor vehicle crashes and again in 2002. Fortunately, data in 2005 indicate that the rates are on the decline once again (Figure 46).
- The AADR from coronary heart disease, which has been leading cause for death for decades, is also on the decline, averaging approximately 160 deaths per 100,000 persons (Figure 47)
- Stroke, the third leading cause of death, saw a steady decline in death rates until 1993. In 1994, the rates began an upward trend and started to drop again in 2002 (Figure 48)
- The toll of diabetes on the health status of residents in the County has worsened. Death rates have been on the rise since 1988, from approximately 16 deaths per 100,000 persons to close to 30 deaths per 100,000 in 2005 (Figure 49). The trend is especially detrimental to vulnerable populations, such as Blacks, Hispanics, the elderly and those of low socioeconomic status.

Figure 42.

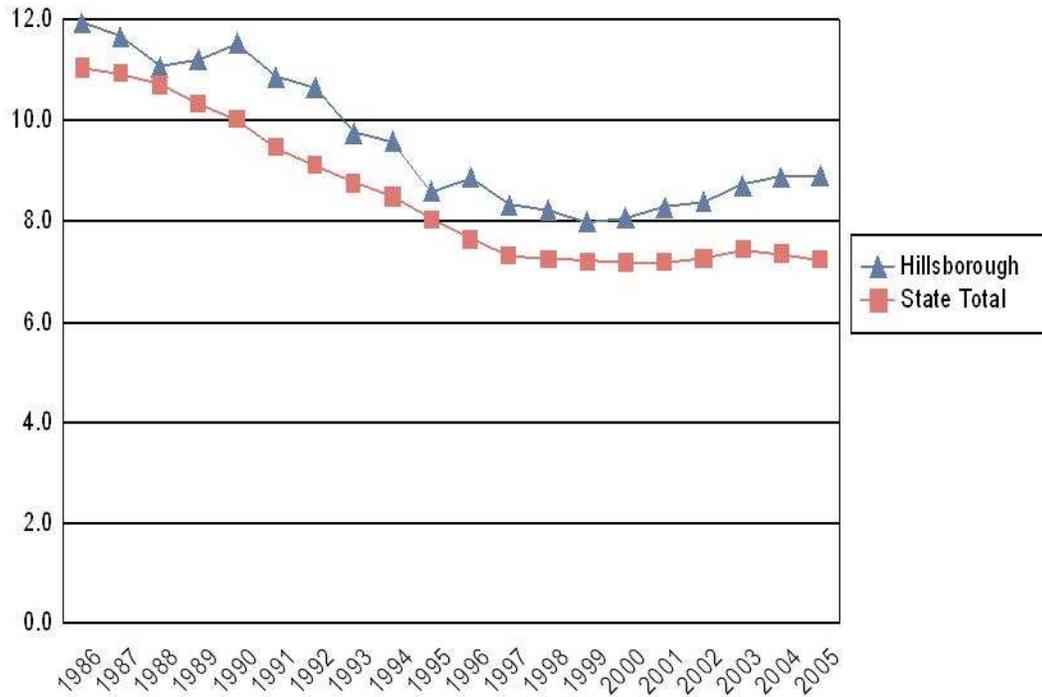
Age-Adjusted HIV/AIDS 3-Year Death Rate Rolling 3-Year Age-Adjusted Death Rate Per 100,000 Population



Data Source: Florida Vital Statistics

Figure 43.

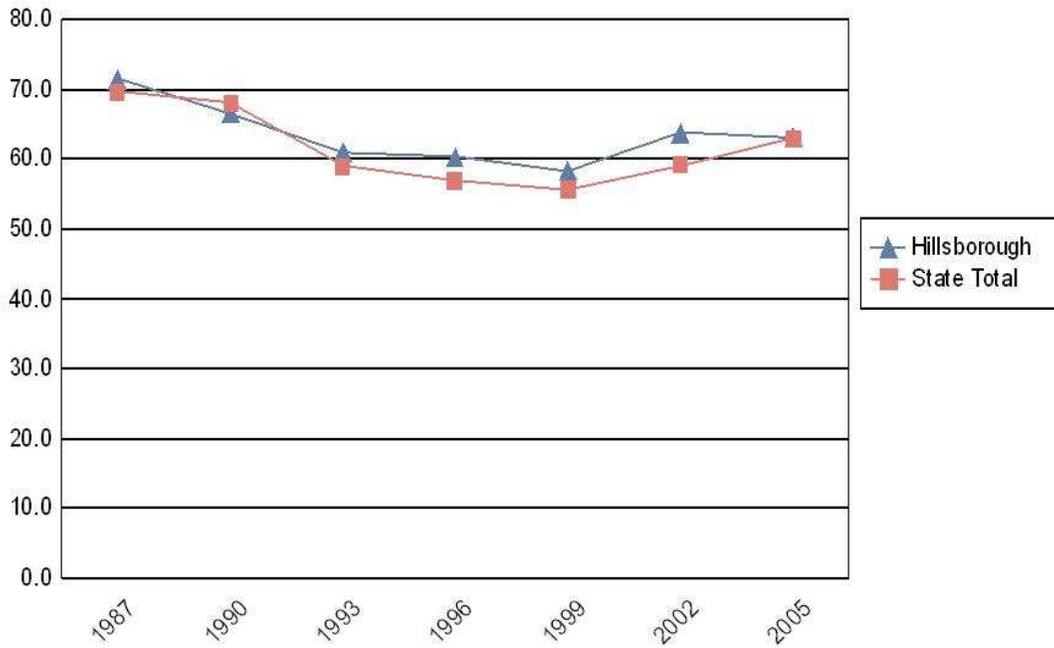
Total Infant Mortality Rate Rolling 3-Year Rate per 1,000 Live Births



Data Source: Florida Vital Statistics

Figure 44.

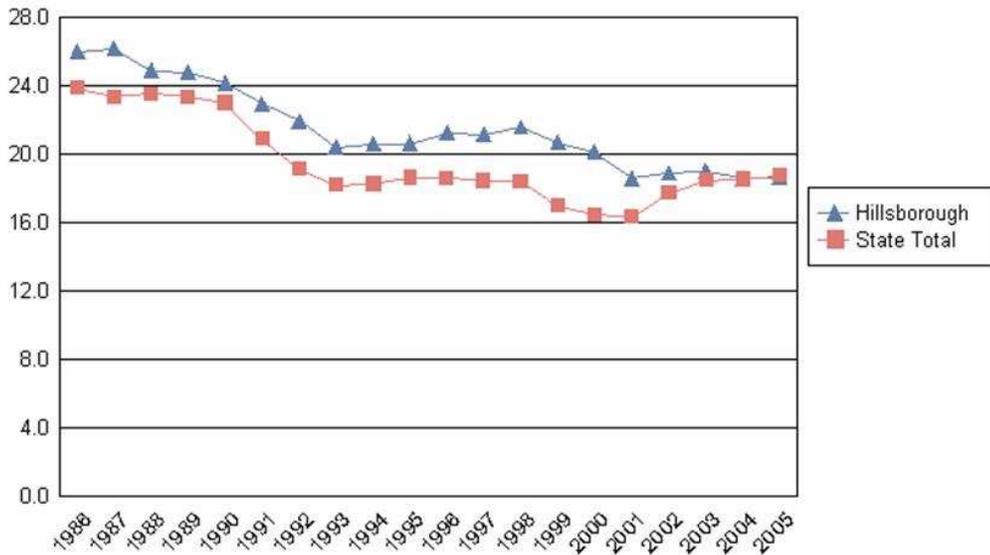
Age-Adjusted All Injuries 3-Year Death Rate Discrete 3-Year Age-Adjusted Death Rate per 100,000 Population



Data Source: Florida Vital Statistics

Figure 45.

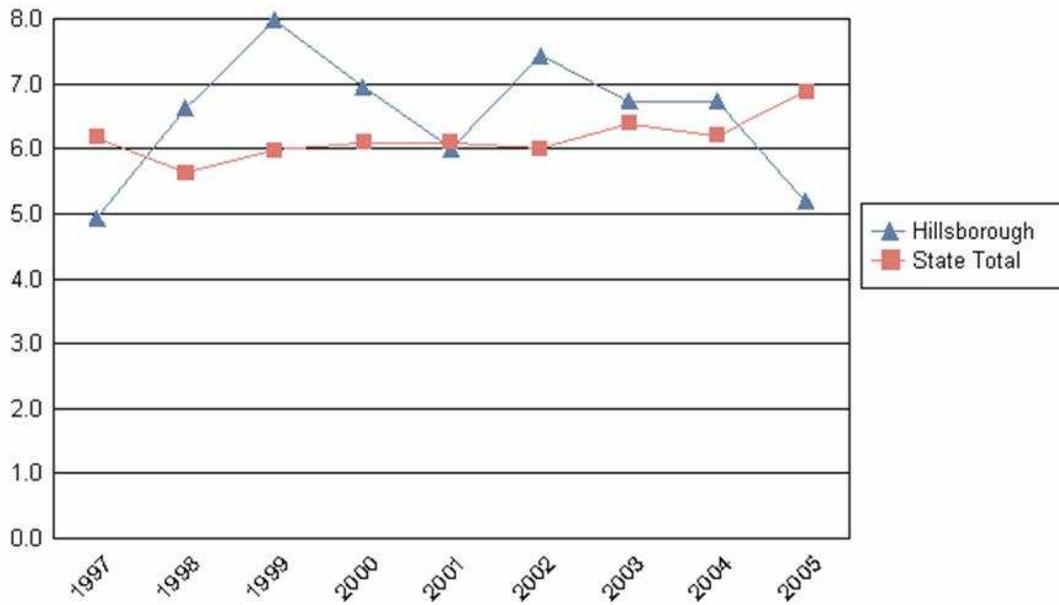
Age-Adjusted Motor Vehicle Traffic Crashes 3-Year Death Rate Rolling 3- Year Age-Adjusted Death Rate per 100,000 Population



Data Source: Florida Vital Statistics

Figure 46.

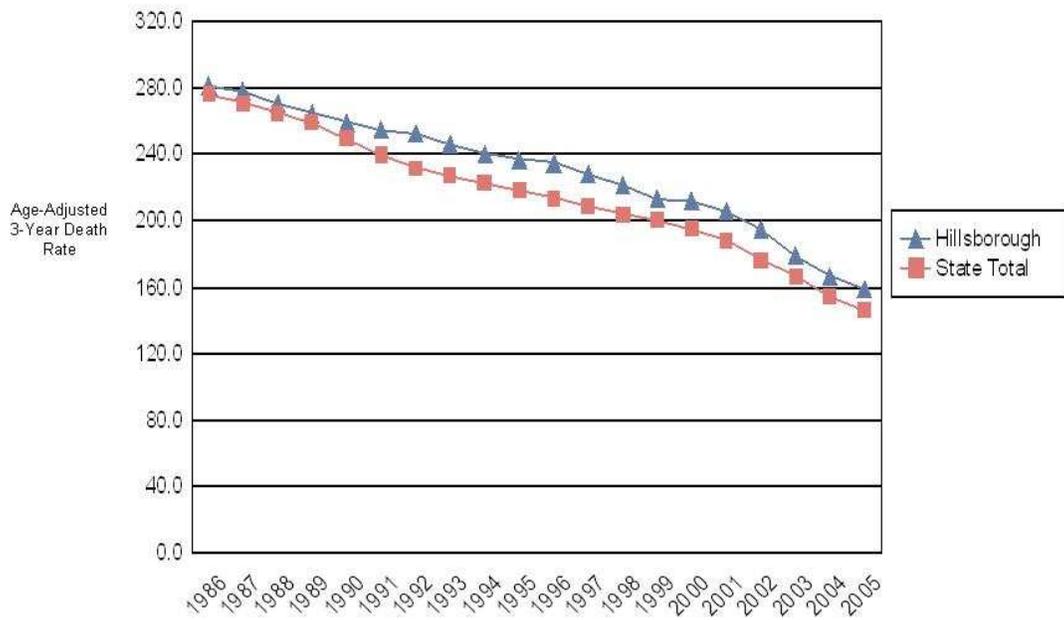
Alcohol-related Motor Vehicle Traffic Crash Deaths Single-Year Rate per 100,000 Population



Data Source: Florida Vital Statistics

Figure 47.

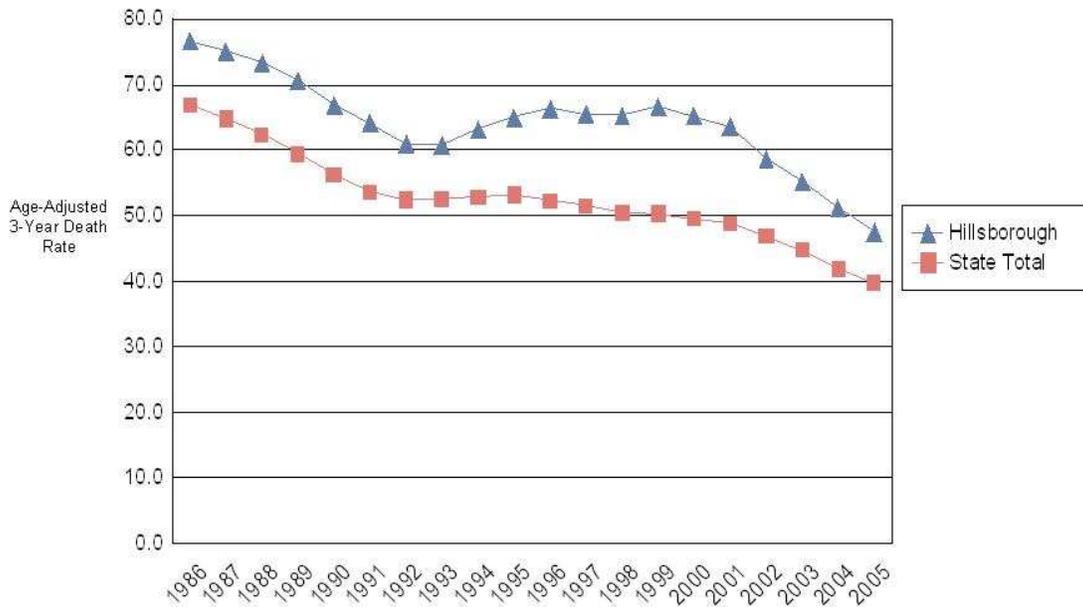
Age-Adjusted Coronary Heart Disease 3-Year Death Rate Rolling 3-Year Age-Adjusted Death Rate per 100,000 Population



Data Source: Florida Vital Statistics

Figure 48.

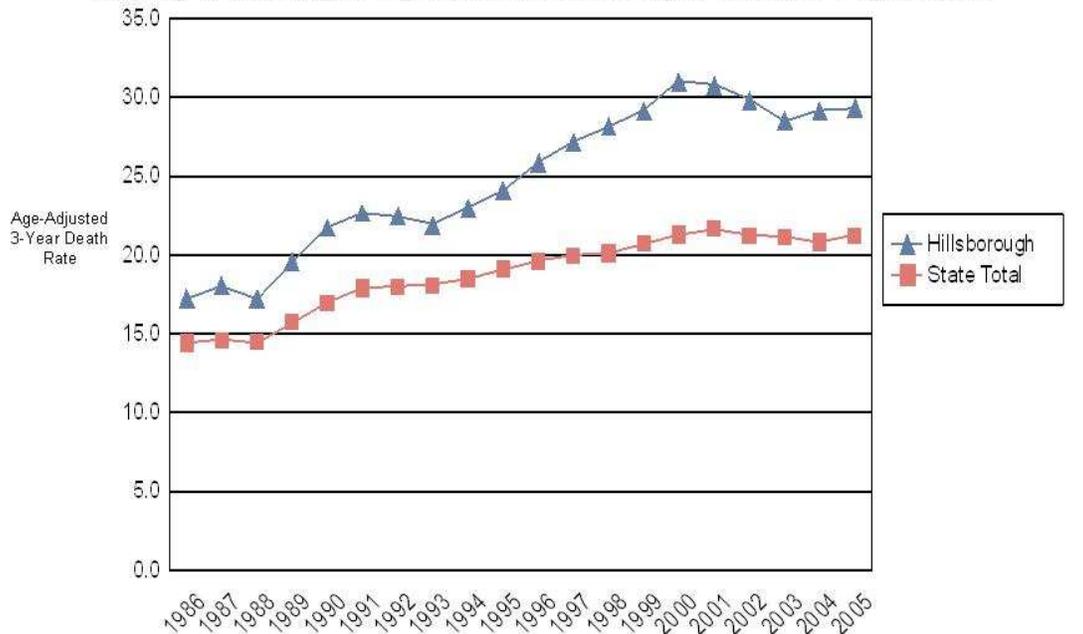
Age-Adjusted Stroke 3-Year Death Rate Rolling 3-Year Age-Adjusted Death Rate Per 100,000 Population



Data Source: Florida Vital Statistics

Figure 49.

Age-Adjusted Diabetes 3-Year Death Rate Rolling 3-Year Age-Adjusted Death Rate per 100,000 Population



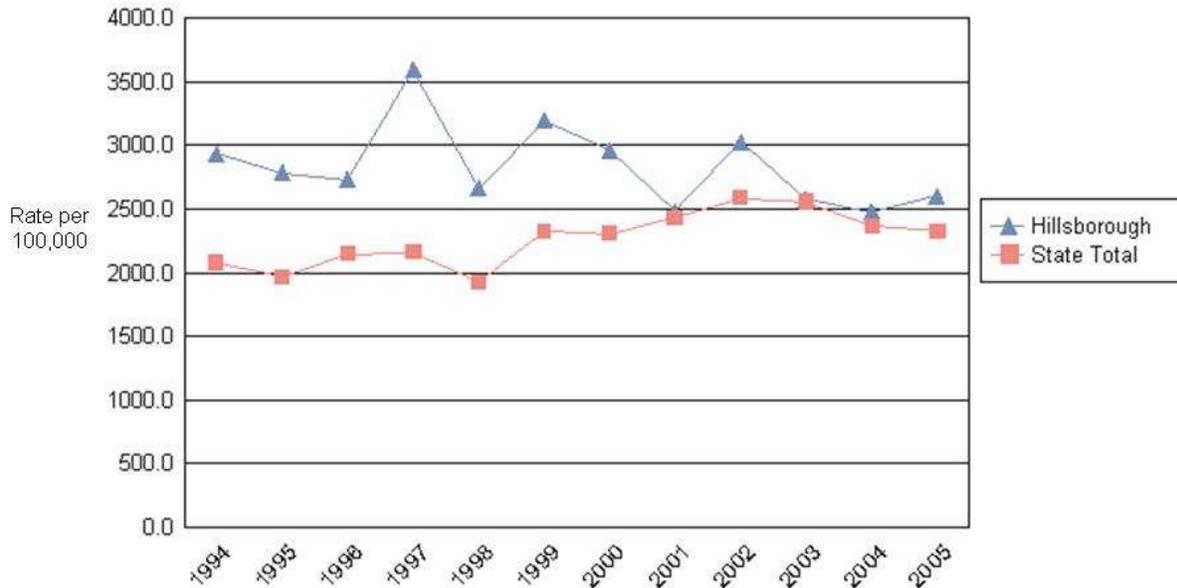
Data Source: Florida Vital Statistics

Morbidity Trends in Hillsborough County

- In regards to the morbidity trends for infectious diseases, the rates in Hillsborough County appear to be on the increase for STDs (gonorrhea, chlamydia and infectious syphilis) and AIDS cases and on the decline for HIV and TB cases.
- In 1997 there was a marked increase in the rate of STDs with a sharp decrease the following year. The rates have since been on the decline until 2005 which has started to show a slight upward trend once again (Figure 50).
- Implementation of the expanded AIDS surveillance case definition on January 1, 1993, continued to influence diagnosis and reporting of AIDS in 1994, but to a lesser degree than 1993.
- The expanded case definition included conditions that occur earlier in HIV disease and therefore includes severely immunosuppressed persons more recently infected with HIV.
- Persons diagnosed with these conditions before January 1993 were reported to CDC during 1993 and 1994, and accounted for the substantial increase in the numbers of reported cases.
- The number of AIDS cases reported in 1996 (417) declined from the number reported in 1995 (803), but remained substantially higher than the number reported in 1992 (349) (Figure 51).
- Increasingly, a diagnosis of AIDS reflects late diagnosis of HIV and limited access to treatment.
- The AIDS epidemic continued to affect primarily men who have sex with men (MSM).
- In addition, trends in estimated AIDS incidence indicate that women, Black and Hispanics and persons with heterosexually acquired HIV infections account for dynamic growth in the epidemic.
- Generally, HIV cases fluctuated in early 2000s and increased in 2002 due to increase HIV testing statewide as part of the “Get to Know Your Status” campaign. Since then, newly reported HIV case have decreased each year (Figure 52).
- The number of tuberculosis cases have been declining since 1988, although the rates still appear to be slightly higher than the state (Figure 53).

Figure 50.

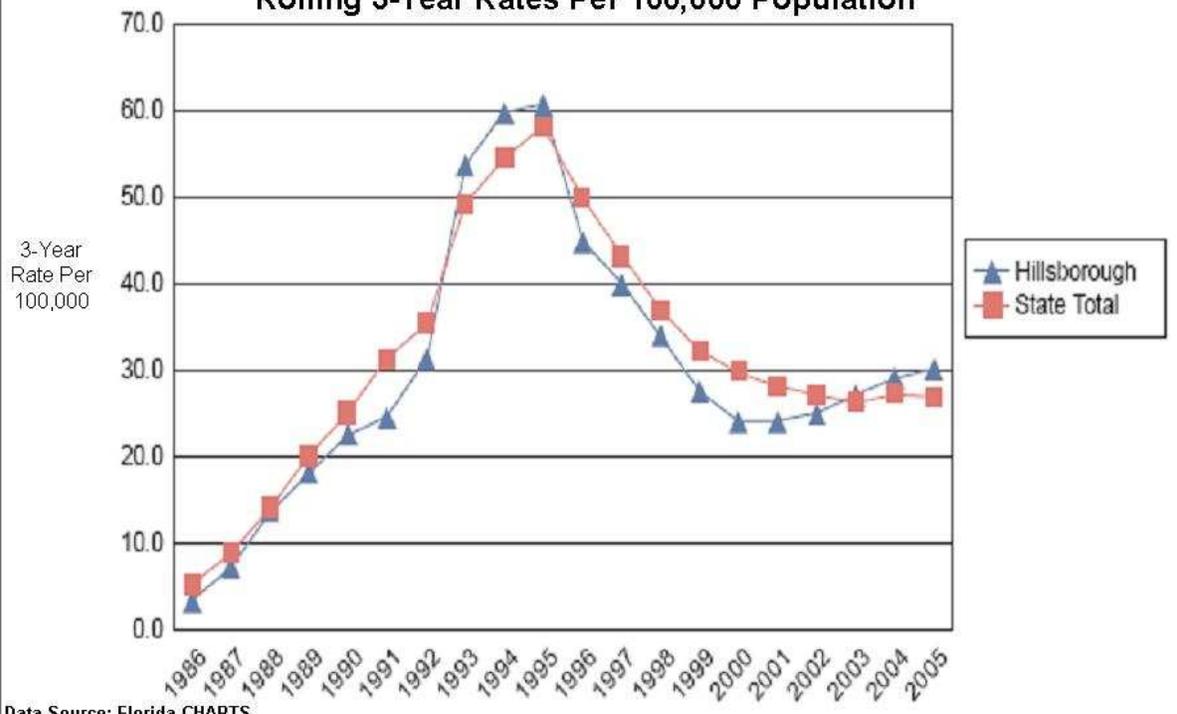
Total Gonorrhea, Chlamydia & Infectious Syphilis Rolling 3-Year Rate per 100,000 Population



Data Source: Florida CHARTS

Figure 51.

AIDS Cases Rolling 3-Year Rates Per 100,000 Population



Data Source: Florida CHARTS

Figure 52.

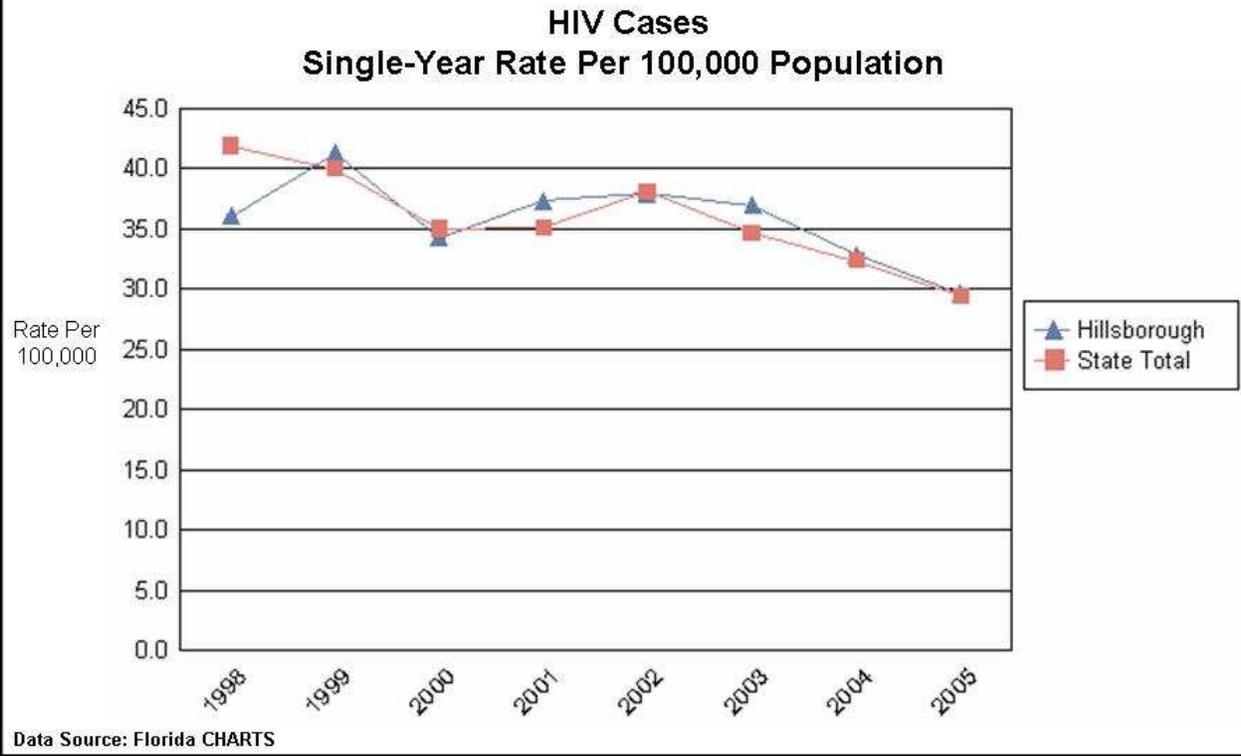
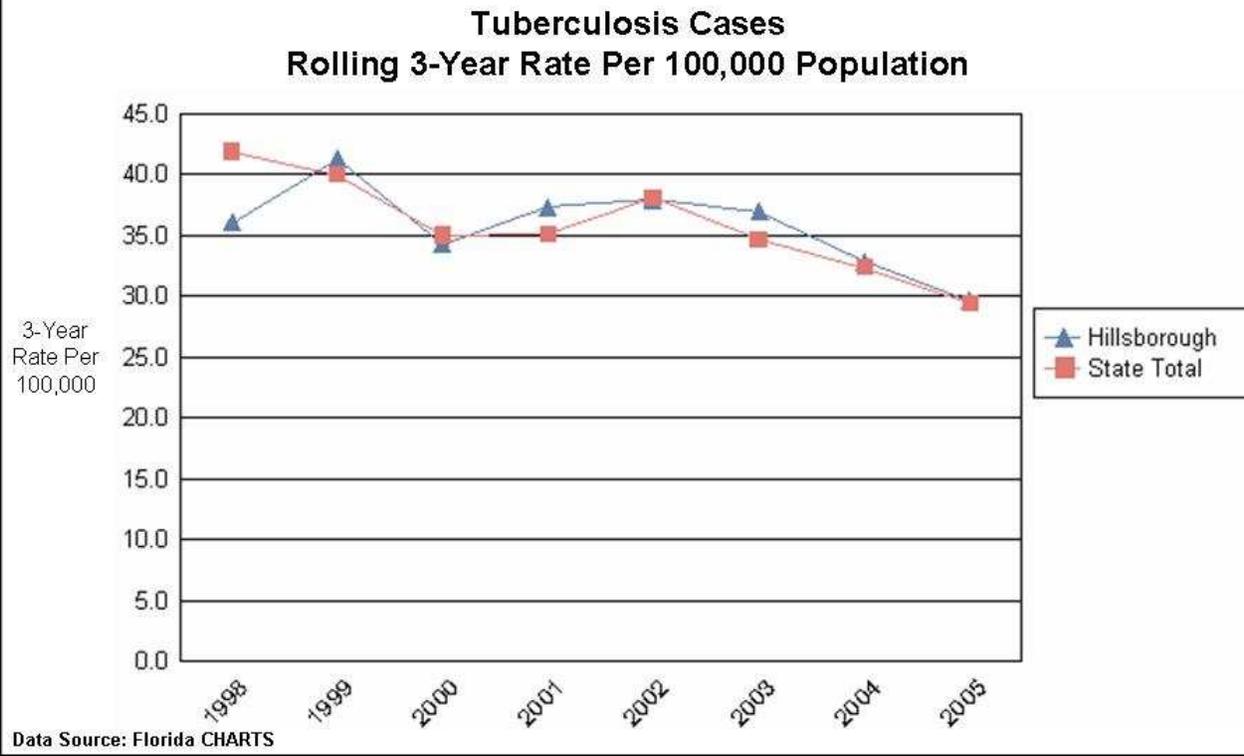


Figure 53.



Healthy People 2010 Goals & Objectives

In January 2000, the Department of Health and Human Services launched *Healthy People 2010*, a comprehensive, nationwide initiative that provides benchmarks for the progress of the health of America for the next 10 years, with supporting objective in disease prevention and health promotion. Used as a tool that identifies the most significant preventable threats to public health, *Healthy People 2010* builds on similar initiatives pursued over the past 2 decades. Two overarching goals; 1). Increase quality and years of healthy live, and eliminate health disparities; 2). Serve as a guide for developing objectives that will actually measure progress.

Progress towards Healthy People 2010 Goals

How does Hillsborough County compare to the *Healthy People 2010* objectives? Over the years, significant changes have been made to the county's chronic disease profile. Hillsborough County ranks favorably close (achieved and/or surpassed the HP 2010 objective) in regards to deaths from coronary heart disease, prostate cancer, cervical cancer, skin cancer, chronic lower respiratory disease and diabetes. Rates of deaths from stroke and breast cancer are still falling and are close to mirroring the HP 2010 goals of 48 deaths and 22.3 deaths per 100,000 people, respectively.

Hillsborough County Chronic Disease Profile					
Indicator	Year(s)	Avg. Annual Number of Events	Age-Adjusted Rate ¹	State Age-Adjusted Rate	U.S. Healthy People 2010 Goal ³
Coronary Heart Disease					
Deaths	2002-04	1,761	166.4	154.6	166
Hospitalizations	2002-04	6,338	586.9	710.4	
Stroke					
Deaths	2002-04	541	51.3	41.9	48
Hospitalizations	2002-04	3,905	365.2	331	
Heart Failure					
Deaths	2002-04	56	5.3	6.9	
Hospitalizations from congestive heart failure	2002-04	3,130	293.9	317.6	
Lung Cancer					
Deaths	2002-04	565	52.8	52.5	44.9
Incidence	2000-02	824	81.6	73.9	
Percent of Adults who currently smoke	2002		22.80%	22.20%	12%
Colorectal Cancer					
Deaths	2002-04	207	19.4	16.5	13.9
Incidence	2000-02	568	56.6	53	
Percent of Adults 50 and over who have ever had a sigmoidoscopy	2002		50.10%	52.60%	50%
Percent of Adults 50 and over who have had a blood stool test in past two years	2002		23.70%	33.50%	50%
Breast Cancer					
Deaths	2002-04	146	24.5	22.8	22.3
Incidence	2000-02	677	122.9	122.2	
Prostate Cancer					
Deaths	2002-04	107	25.7	21.8	28.8

Incidence	2000-02	714	158.7	150.3	
Cervical Cancer					
Deaths	2002-04	14	2.4	2.6	2
Incidence	2000-02	60	11	10.5	
Percent of adult (18+) women who have had a pap test in past three years	2002		84.50%	82.20%	90%
Skin Cancer					
Deaths	2002-04	25	2.3	2.8	2.5
Incidence	2000-02	170	16.6	16.2	
Chronic Lower Respiratory Diseases (CLRD)					
Deaths	2002-04	482	45.7	38.1	60
CLRD Hospitalizations	2002-04	3,877	359.6	358.5	
Percent of Adults (18+) with asthma	2002		9.10%	10.70%	
Asthma Hospitalizations ⁴	2002-04	8,195	755.1	631	
Diabetes					
Deaths	2002-04	309	29.2	20.8	45
Hospitalizations ⁴	2002-04	20,118	1,862.60	1,851.30	
Hospitalizations from amputation due to diabetes ⁴	2002-04	278	25.7	24.8	18
Percent of Adults who have ever been told by a doctor that they have diabetes	2002		6.30%	8.20%	
Behavioral Risk Factors (BRFSS) Data (Percent of Adults...)					
Who have been told by a doctor or other health professional that their blood pressure is high	2002		25.10%	27.70%	
Who have been told by a doctor or other health professional their blood cholesterol is high	2002		36.90%	35.20%	17%
Who have had their cholesterol checked in last two years (of those ever measured)	2002		80.90%	83.10%	
With NO regular moderate physical activity	2002		56.70%	55.10%	
With NO regular vigorous physical activity	2002		75.10%	75.60%	
Who engage in no leisure-time physical activity	2002		27.40%	26.40%	20%
Who consume < 5 servings of fruits and vegetables per day	2002		76.80%	74.30%	
Who are overweight (BMI >25)	2002		34.30%	35.10%	
Who are obese (BMI >=30)	2002		24.30%	22.30%	15%

¹All Age-Adjusted rates are 3-year rates and are calculated using the 2000 Standard US Population. These rates also use July 1 Florida population estimates from the Florida Legislature, Office of Economic and Demographic Research. Click for trend graph. Trends not available for BRFSS data.

Age-adjusted cancer incidence rates are not displayed for fewer than 10 cases (NA)

Hillsborough County Communicable Disease Profile

Indicator:	Year(s)	Avg. Annual Number of Events	Age- Adjusted/or 3-Yr Rate ¹	State Age- Adjusted/or 3-Yr Rate	U.S. Healthy People 2010 Goal ³
HIV/AIDS					
Deaths	2002-04	117	10.7	10.2	0.7
New AIDS Cases	2002-04	333	30.6	29.9	1
Chlamydia					
New Cases	2002-04	3,147	289	246	3%
Gonorrhea					
New Cases	2002-04	1,584	146	114	19
Infectious Syphilis					
New Cases	2002-04	41	3.8	3.9	0.2
Tuberculosis					
New Cases	2002-04	66	6.1	6.2	1
Hepatitis A					
New Cases	2002-04	44	4.1	3.2	4.5
Hepatitis B					
New Cases	2002-04	63	5.8	3.5	2.4-3.8 ⁵

⁵ Rates are based on age groups

Appendix 1 – Survey Instrument

Instructions for Survey Facilitators and staff

Background

The Hillsborough County Health Department is currently completing a community health assessment. One aspect of this assessment includes surveys that are to be completed by our clients and many members of the community. Surveys will be distributed at all Hillsborough County Health Department clinics, vital statistics and a number of locations in Hillsborough County. Information gained from this survey will help us to understand the needs of our clients and the community and enable us to provide services that best meet these needs. Your assistance is vital to the success of this effort.

Your Role

You (the Survey Facilitators) have been provided with an envelope with a total of 25 surveys, 10 English and 10 Spanish and 5 Haitian Creole. Please assign front desk staff or reception staff to ask clients as they come in to complete a survey while they are in the waiting area. One survey and a separate optional Personal Information Form should be handed to the client/customer. Staff should ask the client/customer if they are willing to assist us by completing the survey and explain to the client that their comments on the survey will help the health department to provide better services. Also explain that refusal to complete the survey will in no way affect their eligibility to get the services they are seeking today! The client/customer should be asked to return the completed survey to the front desk/reception staff, Remember to thank them for their help.

The survey is self-administered which means that you should not be completing the form for the client/customer. They must complete the surveys by themselves, in the language they prefer.

Only one adult (18 and older) member per family should complete a survey.

Return the completed surveys to the Survey Facilitators (Clinic Manager, WIC supervisor etc.) The survey Facilitators will return all completed surveys in the self addressed envelope that has been provided, to Douglas Zimmer in Community Health. Please return all completed surveys to Community Health by _____. We are requesting that 20 surveys be completed and returned to us.

Thank you for help
Dr. Leslene Gordon
Community Health Director



Jeb Bush
Governor

M. Rouy François, M.D., M.S.P.H., Ph.D.
Secretary

Community Health Survey

Please take a few minutes to complete the survey below. You must be 18 years or older to complete this survey. The purpose of this survey is to get your opinions about community health problems in Hillsborough County. The Hillsborough County Health Department will use the results of this survey and other information to identify the most pressing problems which can be addressed through community action. If you have previously completed a survey, you do not have to complete another. **Remember... your opinion is important!** Thank you and if you have any questions, please contact Hillsborough County Health Department, Community Health, (813) 307-8015, ext 7108.

1. In the following list, what do you think are **the three most important factors for a "Healthy Community?"** (Those factors which most improve the quality of life in a community.)

Check only three (3):

- | | |
|---|---|
| <input type="checkbox"/> Good place to raise children | <input type="checkbox"/> Strong family life |
| <input type="checkbox"/> Low crime / safe neighborhoods | <input type="checkbox"/> Healthy behaviors and lifestyles |
| <input type="checkbox"/> Low level of child abuse | <input type="checkbox"/> Low adult death and disease rates |
| <input type="checkbox"/> Good schools | <input type="checkbox"/> Low infant deaths |
| <input type="checkbox"/> Access to health care | <input type="checkbox"/> Religious or spiritual values |
| <input type="checkbox"/> Parks and recreation | <input type="checkbox"/> Access to good or reliable health information |
| <input type="checkbox"/> Clean environment | <input type="checkbox"/> Disaster Preparedness (example; natural disasters, epidemic) |
| <input type="checkbox"/> Affordable housing | <input type="checkbox"/> Other: (please specify) |
| <input type="checkbox"/> Arts and cultural events | _____ |
| <input type="checkbox"/> Affordable Health Insurance | _____ |
| <input type="checkbox"/> Excellent race relations | _____ |
| <input type="checkbox"/> Good jobs and healthy economy | _____ |

2. In the following list, what do you think are **the three important "health problems"** in our community? (Those problems which have the greatest impact on overall community health.)

Check only three (3):

- | | | |
|---|--|---|
| <input type="checkbox"/> Aging problems (example; hearing/vision loss, arthritis) | <input type="checkbox"/> Heart disease and stroke | <input type="checkbox"/> Infant Death |
| <input type="checkbox"/> Cancers | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Rape / sexual assault |
| <input type="checkbox"/> Child abuse / neglect | <input type="checkbox"/> Human Immunodeficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS) | <input type="checkbox"/> Respiratory / lung disease |
| <input type="checkbox"/> Dental problems | <input type="checkbox"/> Homicide | <input type="checkbox"/> Sexually Transmitted Disease (STD) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Infectious Diseases (example; hepatitis, TB) | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Motor vehicle crash injuries | <input type="checkbox"/> Teenage pregnancy |
| <input type="checkbox"/> Firearm-related injuries | | <input type="checkbox"/> Other: (please specify) |
| <input type="checkbox"/> Being Overweight | | _____ |
| <input type="checkbox"/> Mental health problems | | _____ |

Which of the three health problems you selected above do you think is the most important?

What do you think should be done to address this health problem in our community?

What barriers do you see, if any, in implementing your solution?

Who in our community needs to be involved in the solution?

Hillsborough County Health Department • Community Health •
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3. In the following list, what do you think are **the three most important “risky behaviors”** in our community? (Those behaviors which have the greatest impact on overall community health.)

Check only three (3):

- | | |
|---|--|
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Dropping out of school | <input type="checkbox"/> Not using birth control |
| <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Not using seat belts / child safety seats |
| <input type="checkbox"/> Lack of exercise | <input type="checkbox"/> Unsafe sex |
| <input type="checkbox"/> Poor eating habits | <input type="checkbox"/> Other: (please specify) |
| <input type="checkbox"/> Not getting “shots” to prevent disease | _____ |
| <input type="checkbox"/> Racism | _____ |

4. How would you rate our community as a “Healthy Community?”

Very unhealthy Unhealthy Somewhat healthy Healthy Very healthy

5. How would rate your own personal health?

Very unhealthy Unhealthy Somewhat healthy Healthy Very healthy

6. What do you think are the three best ways for the Health Department to regularly share health information (e.g. Information on controlling high blood pressure etc)?

Check only three (3):

- | | |
|---|---|
| <input type="checkbox"/> When you visit the health department | <input type="checkbox"/> In a newsletter |
| <input type="checkbox"/> Local newspaper | <input type="checkbox"/> Group in your community (church or social) |
| <input type="checkbox"/> At a health fair | <input type="checkbox"/> At your doctors office |
| <input type="checkbox"/> TV | <input type="checkbox"/> Radio |
| <input type="checkbox"/> On the health department website | <input type="checkbox"/> Other: (please specify) |
| | _____ |

7. What do you think is the best way for the Health Department to share information on special events occurring in your community with you?

Check only one (1):

- | | |
|---|---|
| <input type="checkbox"/> When you visit the health department | <input type="checkbox"/> In a newsletter |
| <input type="checkbox"/> Local newspaper | <input type="checkbox"/> Group in your community (church or social) |
| <input type="checkbox"/> At a health fair | <input type="checkbox"/> At your doctors office |
| <input type="checkbox"/> TV | <input type="checkbox"/> Radio |
| <input type="checkbox"/> On the health department website | <input type="checkbox"/> Other: (please specify) |
| | _____ |

8. Are you interested in volunteering your time to community service? Yes _____
No _____

9. Approximately how many hours per month?

None 1 - 5 hours 6 - 10 hours Over 10 hours

9. Approximately how many hours per month do you currently volunteer your time to community service? (e.g., schools, voluntary organizations, churches, hospitals)

None 1 - 5 hours 6 - 10 hours Over 10 hours

These last few questions tell us about you. They will be used only to help us understand our population and target information effectively. This information will not be used to identify you.

10. Zip code where you live: _____

11. Age: ___ 18 - 25
 ___ 26 - 39
 ___ 40 - 54
 ___ 55 - 64
 ___ 65 or over

12. Sex: ___ Male ___ Female

13. Ethnic group which you most identify with:

___ African American / Black
___ Asian / Pacific Islander
___ Hispanic / Latino
___ Native American
___ White / Caucasian
___ Other _____

14. Marital Status:

___ Married
___ Single

15. Education

___ Less than high school
___ High school diploma or GED
___ College degree or higher
___ Other _____

16. Including yourself, how many people live in the household:

___ Children (under 18 years old)
___ Adults (over 18 years old)

17. Household income

___ Less than \$20,000
___ \$20,000 to \$29,999
___ \$30,000 to \$49,999
___ Over \$50,000

18. How do you pay for your health care?

(check all that apply)

___ Pay Cash (no insurance)
___ Health insurance (example; private insurance, Health Maintenance Organization (HMO) Blue Shield)
___ Medicaid
___ Medicare
___ Veterans' Administration
___ Indian Health Services
___ Other _____

19. Where / how did you get this survey:

(check one)

___ Church
___ Community Meeting
___ Grocery Store / Shopping Mall
___ Mail
___ Newspaper
___ Newsletter
___ Personal Contact
___ Workplace
___ Other

Please share your name, phone number and address with us on the enclosed card if you are willing to volunteer your time to assist with community events in the future.

Thank you very much for your response!

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Personal Information Form

Optional

Please share your name, phone number and address with us if you are willing to volunteer your time to assist with community events in the future.

Name _____

Address _____

Day Time Phone Number _____

Personal Information Form

Optional

Please share your name, phone number and address with us if you are willing to volunteer your time to assist with community events in the future.

Name _____

Address _____

Day Time Phone Number _____

Appendix 2 – Focus Group Questions

1. ICEBREAKER
2. What have you seen as some helpful services and resources that have positively affected the health of the resident in our community?
3. We have provided some pens and paper for this question. I would like you to jot down three things that you think are the main health problems/issues in the community.
4. Out of the list provided can you please share with us, which one of these problems do you consider to be the most important one in our community?
5. What do you think should be done to address this problem?
6. What problems, if any do you see to implementing a project to prevent this problem in our community?
7. How would you suggest overcoming these problems?
8. What do you believe is the best way for the HCHD to regularly share health information or information about these health problems with your community?
9. If you could give one piece of advice, what advice would you give to the HCHD when addressing these health problems?
10. (After any clarification by note-take) Are there any other thoughts on health issues in our community that we may have left out in this discussion?

NEW Topics:

Additional Notes:

Non-Verbal Cues:

2/27/2006

Participant Information

Name _____ Date _____

Gender Female Male

Race White Black American Indian or Alaska Native
 Asian or Pacific Islander Other

Ethnicity Hispanic Non-Hispanic

Age 18-24 25-44 45-64 65+

How many years of schooling do you have? (circle one)

6 7 8 9 10 11 12 13 14 15 16 17 18+

How long have you been a member of the community?

<3 years 3-9 years 10+ years

Geographical area: urban rural suburban

What is your zipcode? _____

Which do you identify with? Choose only one.

At-Large Community Member

(Men, Women, Elderly, Teens, Physically Impaired, etc.)

Community Leader

(Aldermen, Clergy, Organization Leaders, Newspaper Editors, etc.)

Agencies

(Extension, Aging, Food Stamps, Meals on Wheels, United Way, Red Cross, Food Pantries, etc.)

School

(Teachers, Administrators, School Bd. Members, Food Svc. Personnel, etc.)

Health Professional

(Dietitians, Nutritionists, Physicians, Dentists, Nurses, Psychologists, Social Workers, Health Educators, etc.)

Market

(Supermarkets, Food Stores, Cafeterias, Restaurants, Street Vendors, Farmers' Markets, etc.)

Other

Appendix 3 - Interview Questions

In-depth Interviews

Introduction

- Describe Community Health Assessment Project
- Let respondent know their responses remain anonymous
- Explain, selected as an informed respondent because of the role as policy maker or provider
- Discussion time is @ 1hr
- Will send results when all groups are completed

1. a. What has been your experience with the local health department?

- b. What do you think is the role of the health department?

2. In your opinion what are the three main health problems/issues in Hillsborough County?

3. a). Of the health problems you noted, which do you consider the most important?

- b). Why?

In-depth Interviews

- 8). What do you believe is the best way for the Hillsborough County Health Department to regularly share health or information about health problems with our community?

- 9). Are there any other thoughts on health issues in our community that you would like to discuss or bring to our attention?

New Topics/Question for Providers and Policy Makers:

You are probably aware of HP 2010, the nationwide health promotion and disease prevention agenda. The 2 overarching goals of this agenda are to 1. Increase quality and years of healthy life and 2. Eliminate health disparities.

- 1) a. What do you know or understand about health disparities?

- b. How can these issues be best addressed in our county?

In-depth Interviews

Additional Notes:

In-depth Interviews

Nonverbal Cues:

Participant Information

Name:			Date:	
Gender	Female	Male		
Ethnicity	Hispanic	Non-Hispanic		
Race				
White	Black	American Indian or Alaska Native	Asian or Pacific Islander	Other
How long have you lived or served in the Hillsborough County Community?				
> 3 yrs.	3-9 yrs.	10+ yrs.		
Geographical Area				
Urban	Rural	Suburban		

Thank you!

Appendix 4 – Media Chart

Media Outlet	Type of Coverage/Topic Health or Health Related	Frequency/Segment Length	Audience/No. Reached
Television			
Channel 3	One per month special	Every 30 day / 30 minutes	1.5 Million
	Infrequent doctor interviews	Infrequent / 30 Minutes or less	
Channel 8	Regularly scheduled health segments	Week days	1.5 Million
	Health panels for call-in	Infrequently	
	Breaking or topical news	As occurs	
Channel 9	Regularly scheduled health related topics	Daily / 2-3 minutes	Over 1 million
	Breaking or topical news	As occurs	
Channel 10	Regularly scheduled health segments	Week days	
	Breaking or topical news	As occurs	
Channel 13	Regularly scheduled health segments	Week days	
Channel 16	Daily health segments	Week days	
	Specials	As they occur / 30 minutes	
Channel 19	No regularly scheduled programming	none	
Channel 20	No regularly scheduled programming	none	
Channel 22	No regularly scheduled programming	none	
Channel 28	Regularly schedule health related topics	daily	
Channel 38	No local programming	none	
Channel 44	Breaking or topical news	As occurs	
Newspaper			
Tampa Tribune	Regular Sunday item	Weekly	527,400 daily 682,200 Sundays
	“4 YOU”	Weekly magazine insert	
	Breaking or topical news	As occurs	
St. Petersburg Times	Health Times	Weekly	679,600 daily 847,000 Sundays
	Breaking or topical news	As occurs	
LaGaceta	Breaking or topical news	As occurs	18,000 +
Florida Sentinel	Breaking or topical news	As occurs	25,000 – 30,000
* Radio			
Am Stations	40		Average listening coverage 10,000 – 100,000
FM Stations	36		
Spanish targeted	7		
Greek targeted	2		
Health Specific Programs	Call-in, panels, topical health new, hosted by provider of health products	Weekday 1-4 hours	

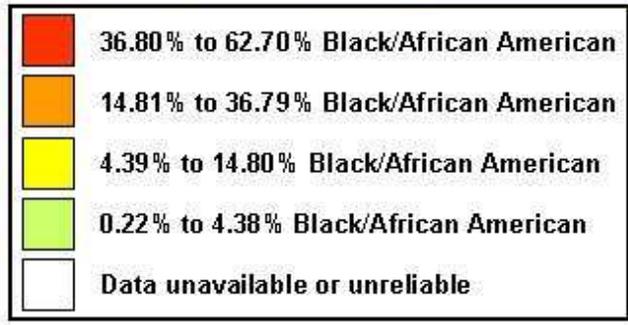
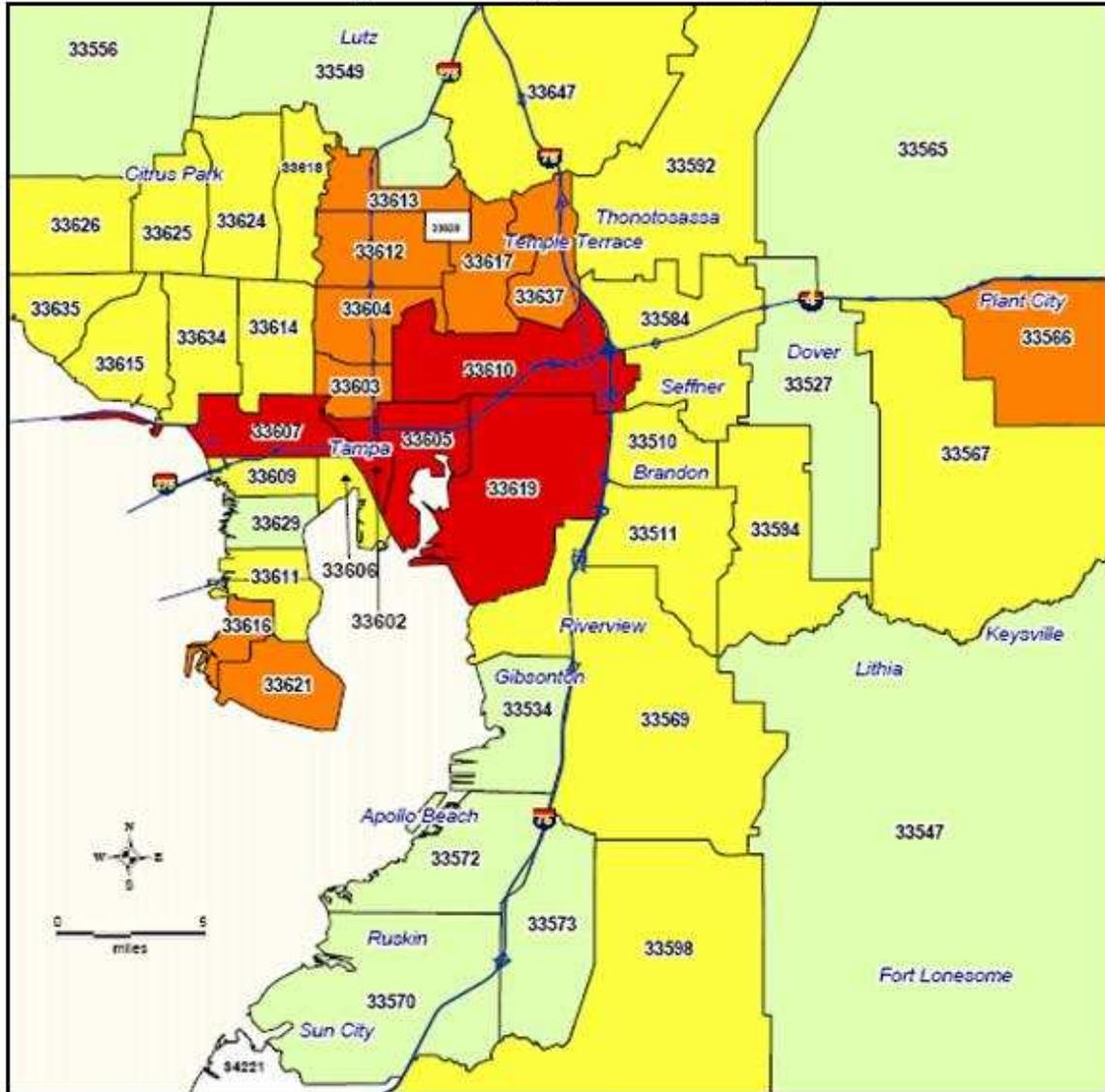
Source: US Department of Health & Human Services Public Health Service

* Radio: There are 40 AM Radio stations in the Tampa Bay area
There are 35 FM Radio Stations in the Tampa Bay area
There are 120 Digital satellite radio stations available in the area that have both AM and FM programming
Only 2 AM stations – WHNA and WTMY list health programming, however, these are primarily to market in-house “healthy” products and is not wide ranging in terms of health topics
Most of the stations have new segment at least hourly throughout the programming day that will present health news, breaking stories.
Many of the “talk radio” programming at most stations will also occasionally focus some time on breaking health news or community event to raise awareness or health issues.
Advertising for health or health-related events are available for a fee

Appendix 5 – Geographic Maps of Hillsborough County

Map 1.

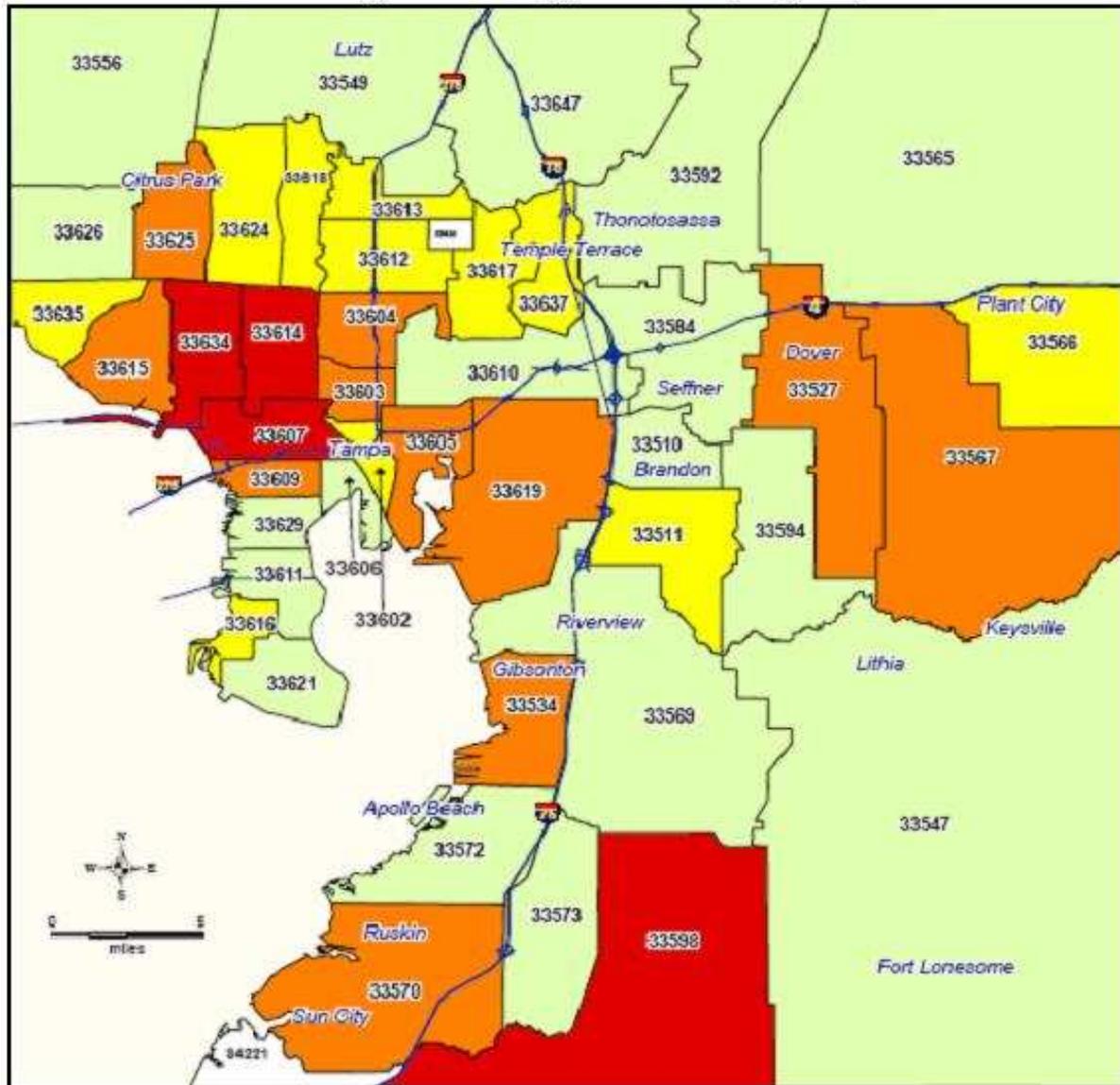
Black/African-Americans as Percent of Population Hillsborough County, Florida, by Zip Code



Data Source: 2000 US Census, SF3, P.6

Map 2.

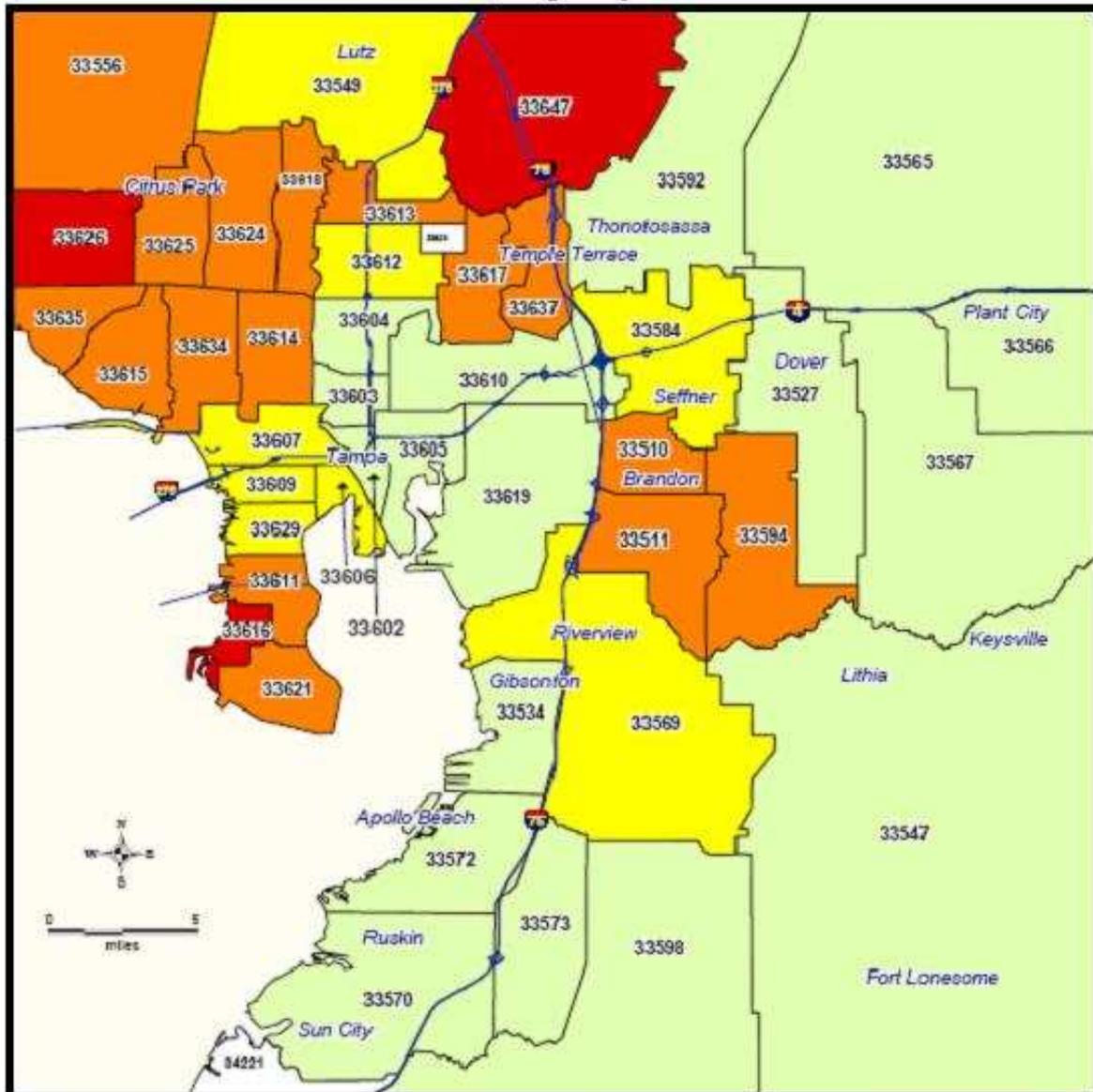
Hispanics/Latinos as Percent of Population Hillsborough County, Florida, by Zip Code



Data Source: 2000 US Census, SF3, P.7

Map 3.

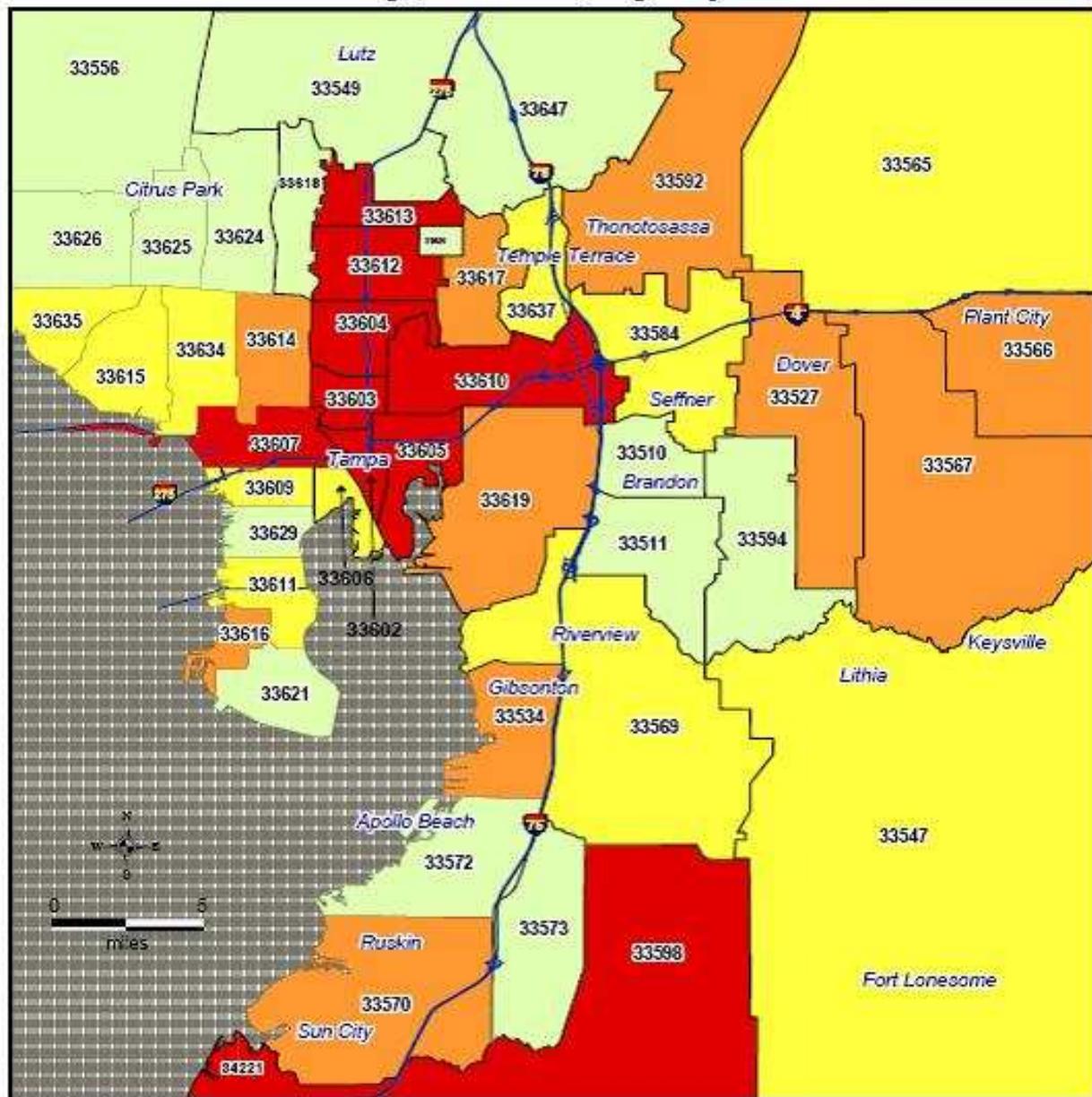
Asians as Percent of Population Hillsborough County, Florida, by Zip Code



Data Source: 2000 US Census, SF3, P.7

Map 4.

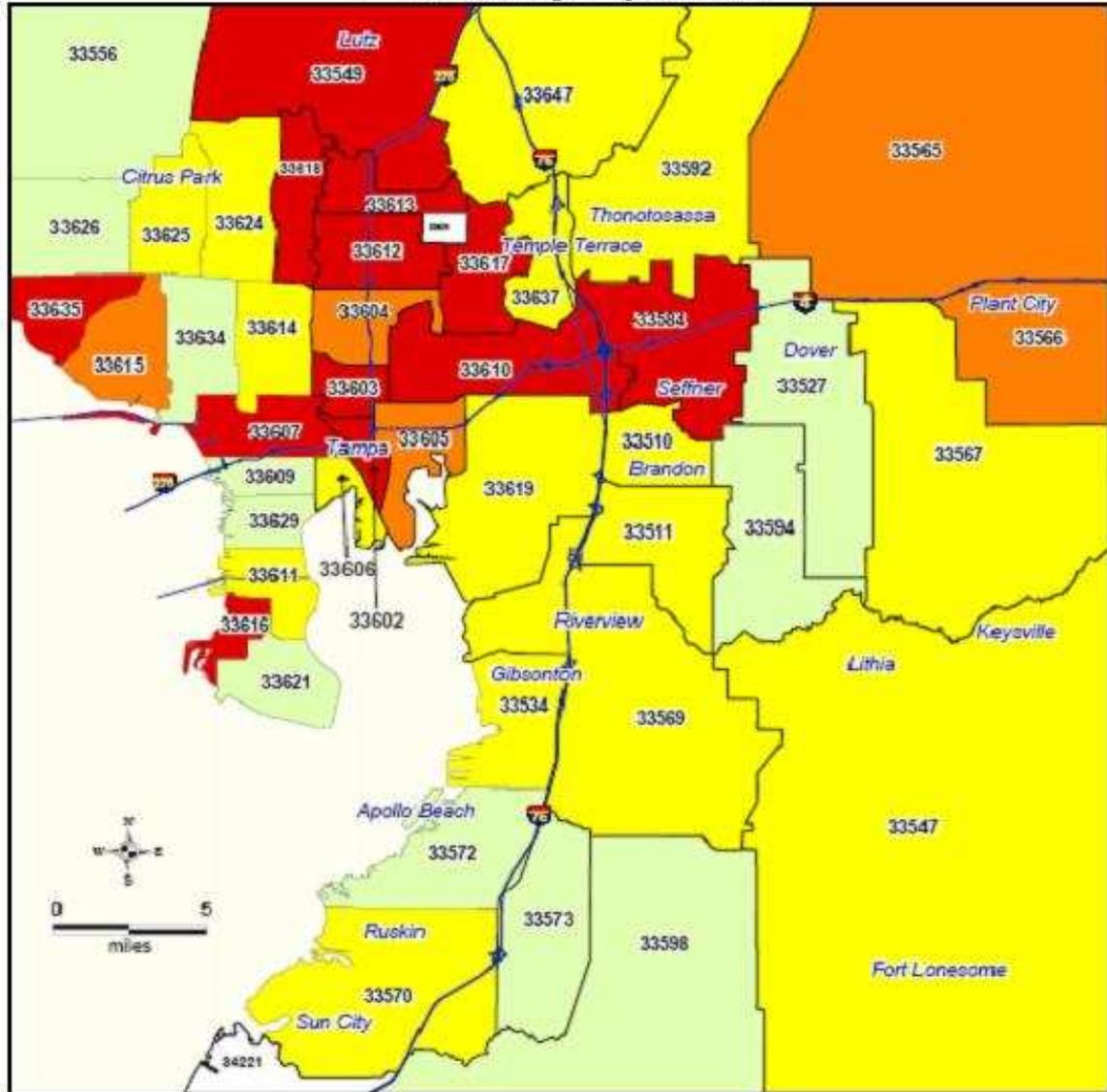
Percent of Population in Poverty Hillsborough County, Florida, by Zip Code



Data Source: 2000 US Census, SF3, P.7

Map 5.

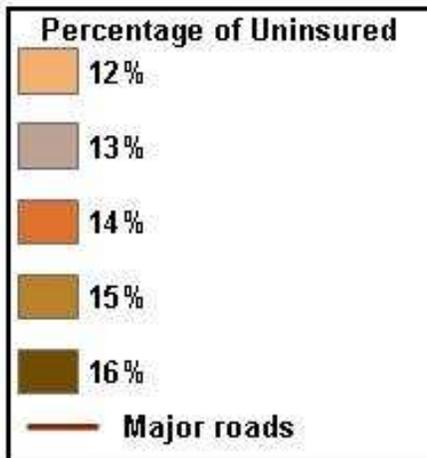
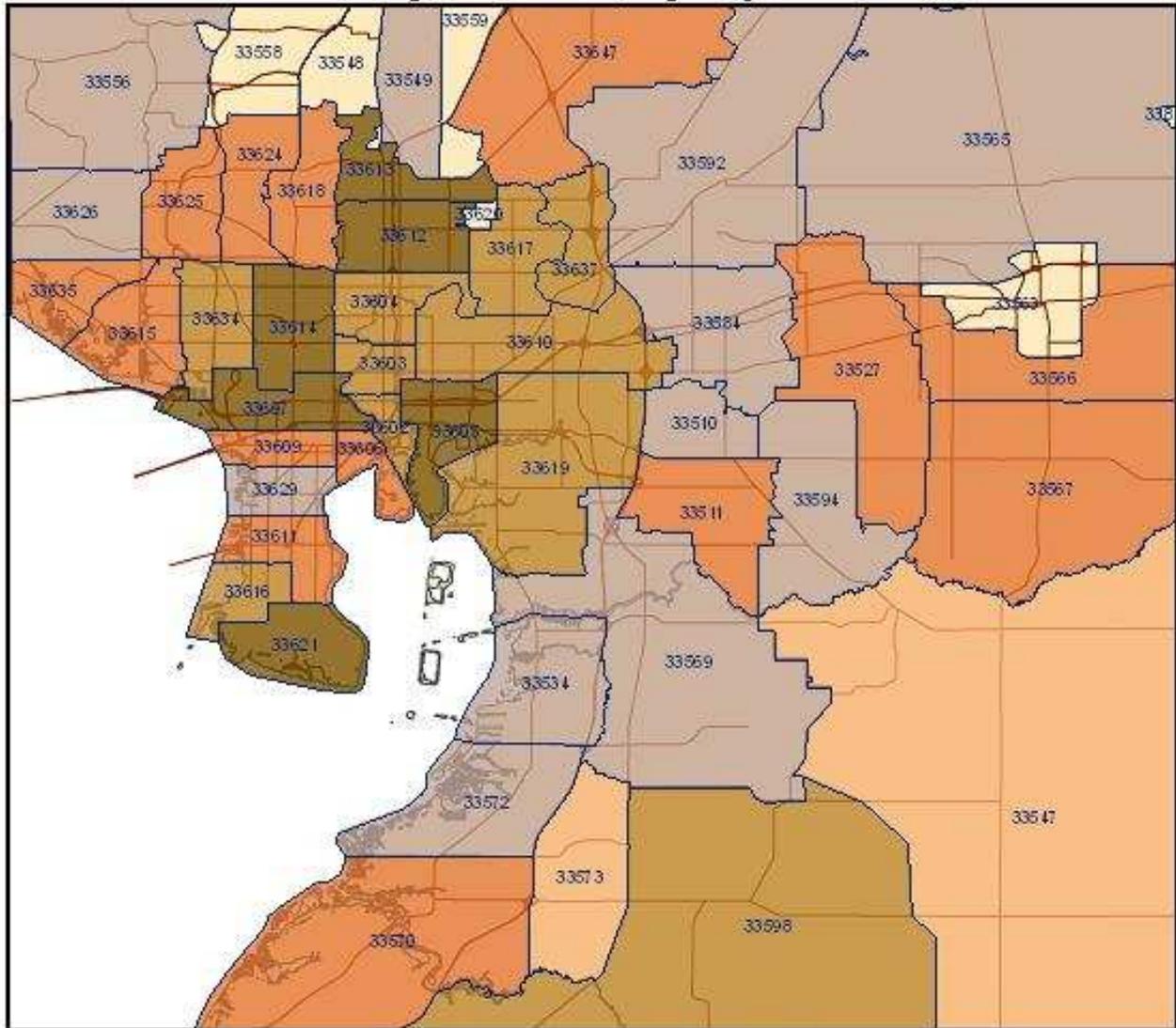
Percent of Poverty Families with Children that are Headed by Single Females with Children Birth Through 4 years of Age Hillsborough County, Florida, by Zip Code



Data Source: 2000 US Census, Data Engine, SF3, P.90

Map 6.

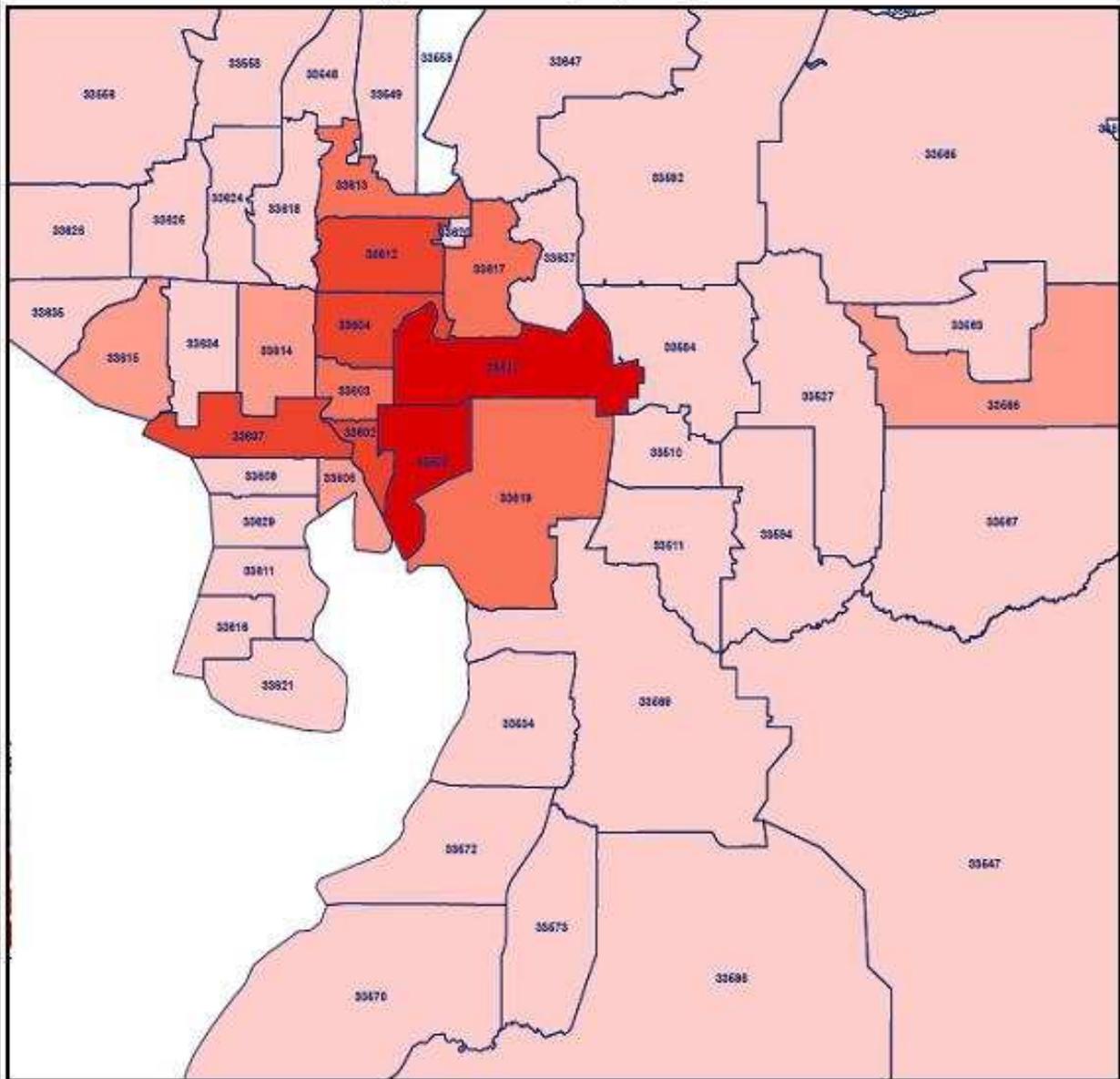
Percent of Population Uninsured Hillsborough County, Florida, by Zip Code



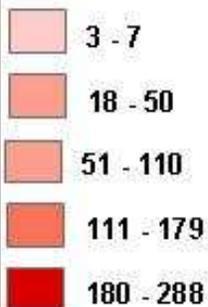
Data Source: 2000 US Census, Data Engine, SF3, P.90

Map 8.

HIV/AIDS Case Frequency for Blacks Hillsborough County, Florida, by Zip Code



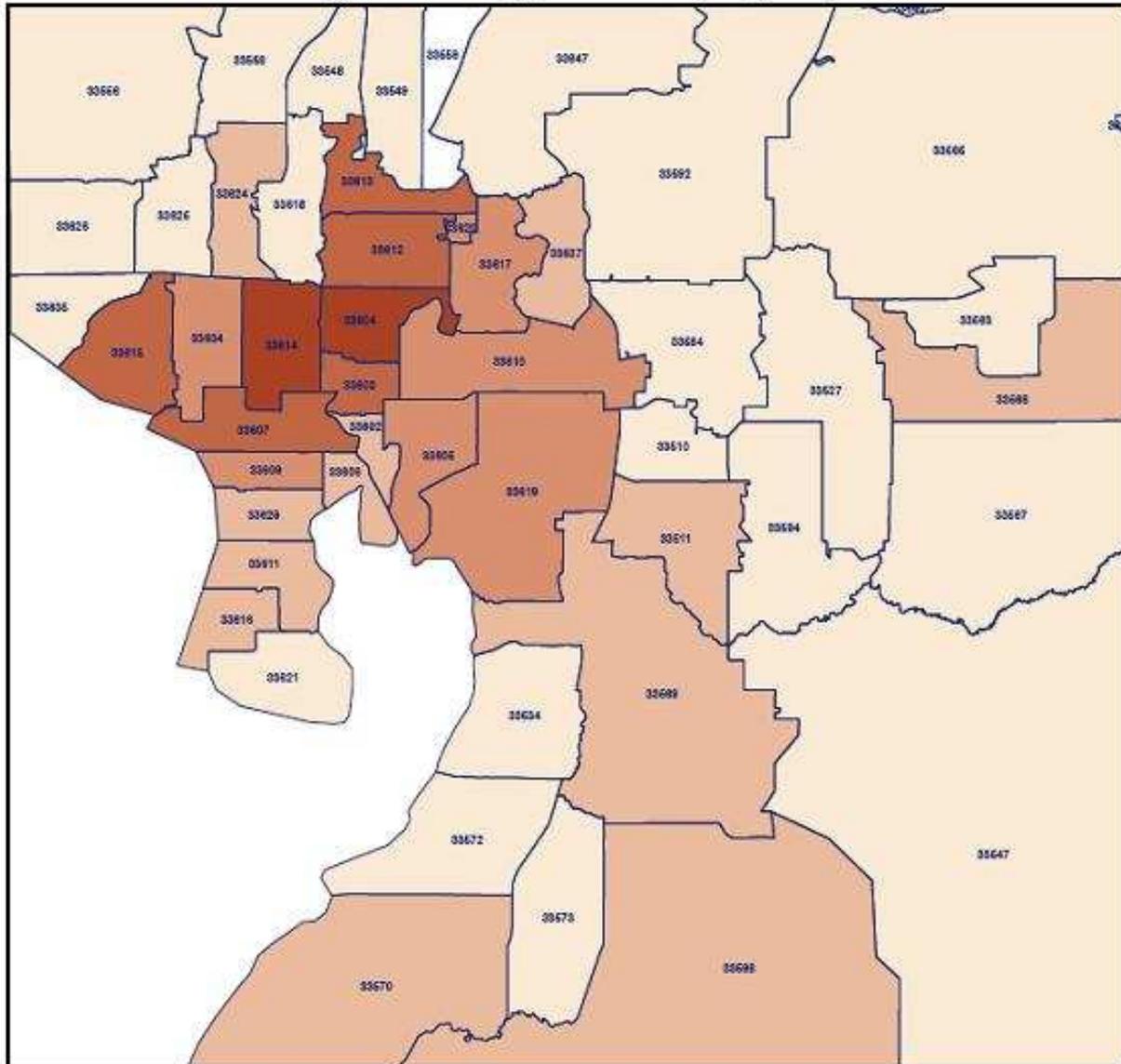
Black HIV Frequency



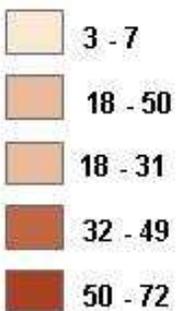
Data Source: 2000 US Census, Data Engine

Map9.

HIV/AIDS Case Frequency for Hispanics Blacks Hillsborough County, Florida, by Zip Code



Hispanic HIV Frequency



Data Source: 2000 US Census, Data Engine

Appendix 6 - 2006 Florida Youth Tobacco Survey

2006 Florida Youth Tobacco Survey

Hillsborough County

Changes and Trends from 2000 to 2006



The Florida Youth Tobacco Survey (FYTS) is a statewide, school-based confidential survey that has been conducted annually since 1998. The FYTS collects information regarding the statewide prevalence of tobacco use, attitudes, and related behaviors among middle and high school students throughout Florida and tracks those behaviors over time. The FYTS has been administered annually at the state level since 1998 and has been administered at the county level in 2000, 2002, and 2006. With three years of county level data, we are now able to track changes within each county.

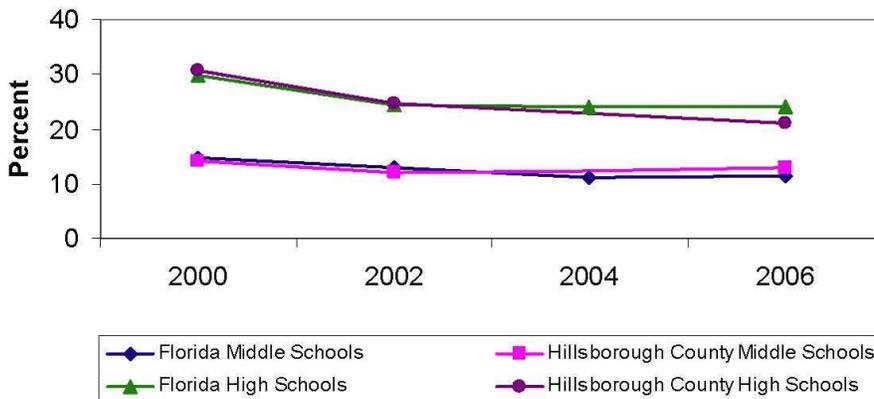
In Hillsborough County, 1096 middle school students and 766 high school students in 29 public schools completed the 2006 FYTS. This report presents the county level data in 2000, 2002, and 2006. State and county prevalence from 2000 and 2002 were included for comparison. The county level data and state level data are weighted to represent the entire population of Hillsborough County public middle and high school students and Florida public middle and high school students respectively. These data can be used by county health departments, school districts, and other community organizations and citizens to estimate the magnitude of youth tobacco use in Hillsborough County, as well as to compare tobacco use, attitudes, and related behaviors in Hillsborough County to those for Florida as a whole.

Current Tobacco Use

Current Tobacco Use

Current tobacco use is defined as having used any form of tobacco, on one or more of the past 30 days. Any form of tobacco includes cigarettes, cigars, smokeless or chewing tobacco, and specialty tobacco such as pipe tobacco, Bidis (small brown cigarettes from India), or Kreteks more commonly known as "clove cigarettes." Overall tobacco use among Hillsborough County middle school students has decreased by 8.8 percent from 14.2 percent in 2000 to 13.0 percent in 2006. Overall tobacco use among Hillsborough County high school students has decreased by 31.4 percent from 30.6 percent in 2000 to 21.0 percent in 2006.

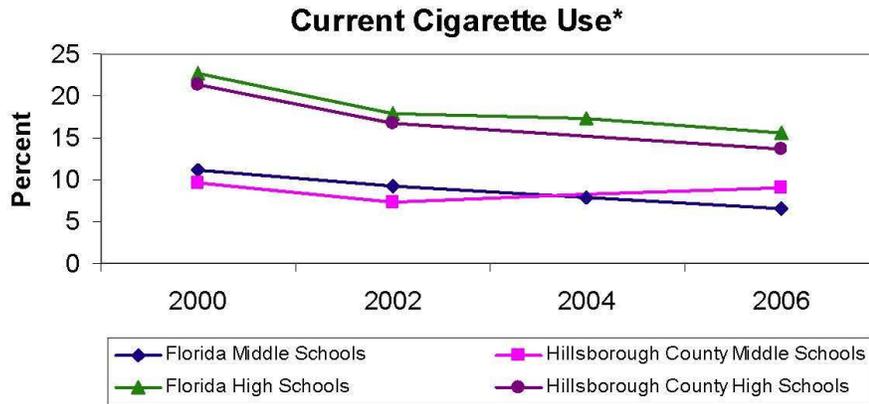
Current Use of Any form of Tobacco*



*Data are available only where point estimates are shown.

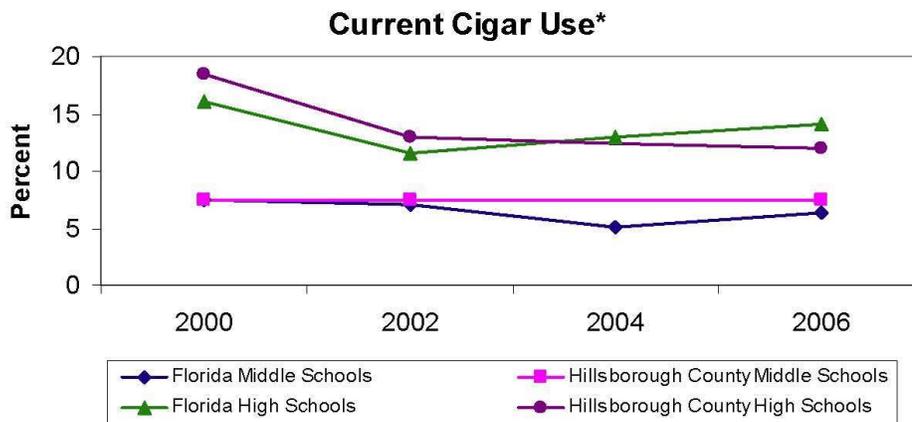
Current Cigarette Use

Current cigarette use is defined as having smoked a cigarette on one or more of the past 30 days. The prevalence of cigarette use among Hillsborough County middle school students has decreased by 5.1 percent from 9.6 percent in 2000 to 4.5 percent in 2006. The prevalence of cigarette use among Hillsborough County high school students has decreased by 36.2 percent from 21.3 percent in 2000 to 13.6 percent in 2006.



Current Cigar Use

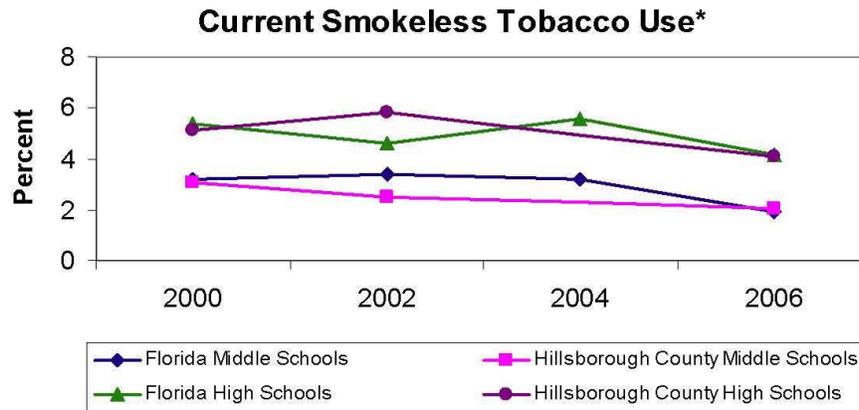
Current cigar use is defined as having smoked a cigar on one or more of the past 30 days. The prevalence of cigar use among Hillsborough County middle school students has remained stable at 7.5 percent from 2000 to 2006. The prevalence of cigar use among Hillsborough County high school students has decreased by 34.8 percent from 18.4 percent in 2000 to 12.0 percent in 2006.



*Data are available only where point estimates are shown.

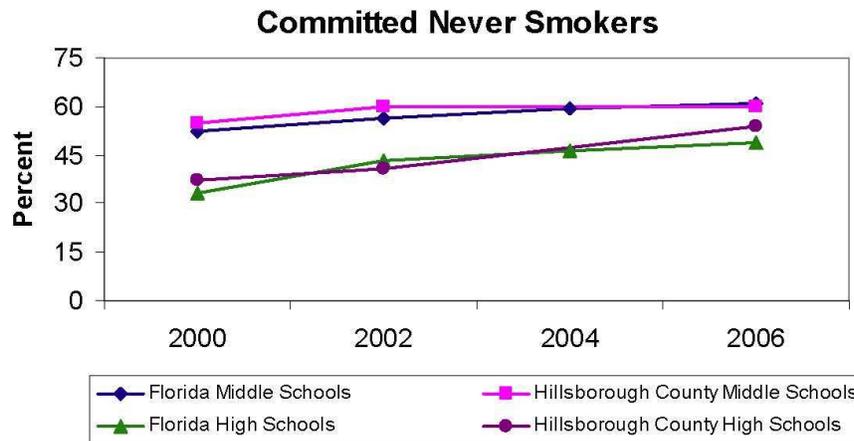
Current Smokeless Tobacco Use

Current smokeless tobacco use is defined as having used smokeless tobacco on one or more of the past 30 days. The prevalence of smokeless tobacco use among Hillsborough County middle school students has decreased by 34.0 percent from 3.1 percent in 2000 to 2.0 percent in 2006. The prevalence of smokeless tobacco use among Hillsborough County high school students has decreased by 19.6 percent from 5.1 percent in 2000 to 4.1 percent in 2006.



“Committed Never Smoker”

“Committed never smokers” are students who have never smoked a cigarette and state they will definitely not smoke a cigarette in the future or if a friend offered one. The prevalence of “committed never smokers” in Hillsborough County middle schools has increased by 8.7 percent from 55.1 percent in 2000 to 59.9 percent in 2006. The prevalence of “committed never smokers” in Hillsborough County high schools has increased by 44.5 percent from 37.4 percent in 2000 to 54.0 percent in 2006.



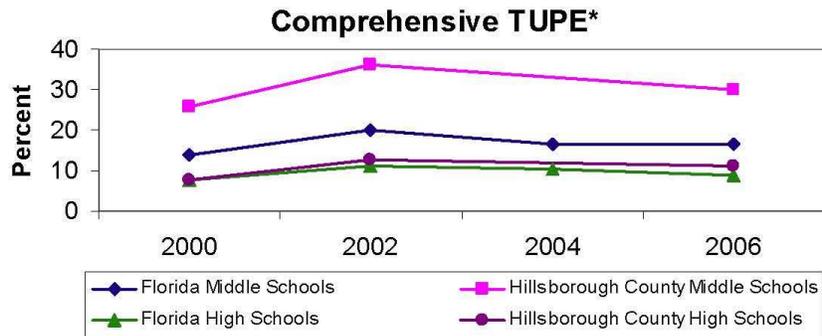
*Data are available only where point estimates are shown.

Tobacco Use Prevention Education (TUPE)

To assess the amount of tobacco use prevention education (TUPE) students receive, survey respondents were asked about what they have learned in the past year in school regarding tobacco. Five questions related to TUPE were asked. Students were asked if they had learned: 1) about tobacco use; 2) about reasons why people of their age smoke; 3) that most people of the same age do not smoke; 4) ways to say "no"; and 5) about the negative effects of smoking, such as yellowed teeth, wrinkles, or bad smell.

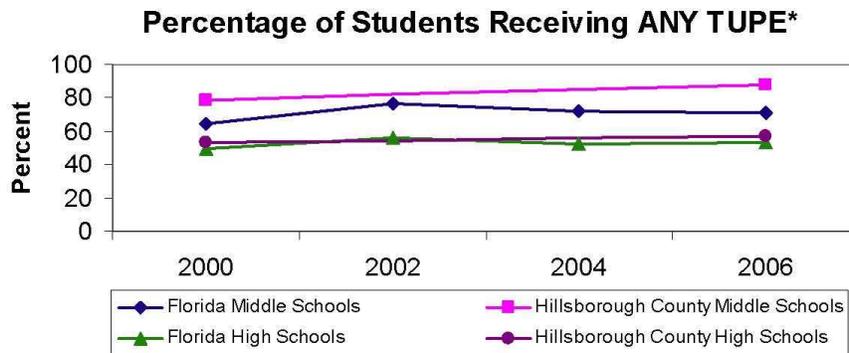
Comprehensive TUPE

Students who respond they have been taught about all five of the above-mentioned topics during the past school year are considered having received comprehensive TUPE. Middle school students in Hillsborough County show a 16.2 percent increase of receiving comprehensive TUPE from 25.7 percent in 2000 to 29.9 percent in 2006. High school students in Hillsborough County show a 47.5 percent increase of receiving comprehensive TUPE from 7.6 percent in 2000 to 11.2 percent in 2006.



Any TUPE

Students who respond that they have been taught about any one of the above-mentioned topics are considered having received "Any TUPE." Middle school students in Hillsborough County show an 11.4 percent increase of receiving "any TUPE" from 78.8 percent in 2000 to 87.8 percent in 2006. High school students in Hillsborough County show a 7.3 percent increase of receiving "any TUPE" from 53.1 percent in 2000 to 57.0 percent in 2006.



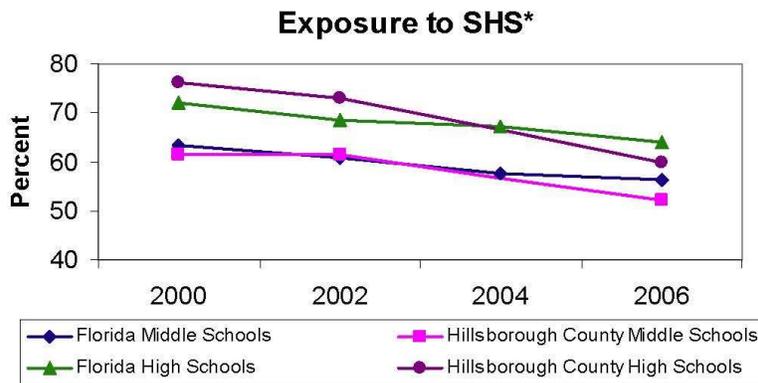
*Data are available only where point estimates are shown.

Secondhand Smoke Exposure

Secondhand smoke (SHS), also known as environmental tobacco smoke (ETS), refers to a combination of side-stream smoke (smoke that is emitted from the end of a lit cigarette, pipe, or cigar) and main-stream smoke (smoke exhaled by a smoker). SHS is the third leading cause of preventable death in the United States.¹ In 2003, Florida passed the Florida Clean Indoor Air Act, which bans smoking in workplaces to try to reduce the number of Floridians negatively impacted by the effects of SHS.

Exposure to Secondhand Smoke

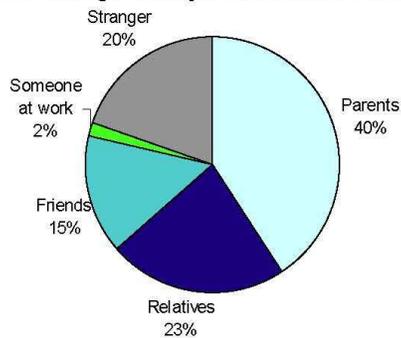
The prevalence of exposure to SHS among Hillsborough County middle school students has decreased by 15.2 percent from 61.6 percent in 2000 to 52.3 percent in 2006. The prevalence of exposure to SHS among Hillsborough County high school students has decreased by 21.2 percent from 76.1 percent in 2000 to 60.0 percent in 2006.



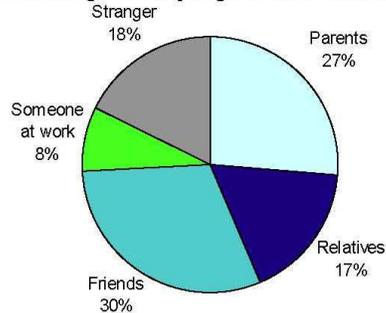
Source of Secondhand Smoke Exposure: 2006 Survey Data

The two charts below show the different people who were the source of SHS exposure for both Hillsborough County middle and high school students. Middle school students were most likely to be exposed to SHS by their parents while high school students were most likely to be exposed to SHS by their friends.

Hillsborough County Middle School Students



Hillsborough County High School Students

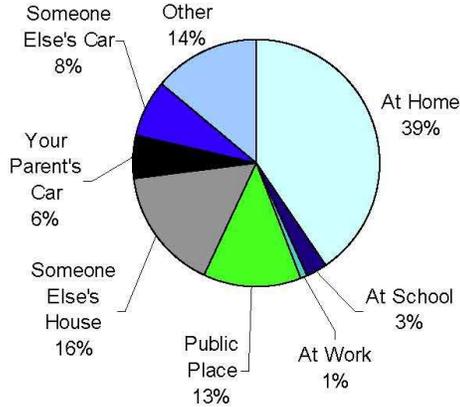


¹ "Secondhand Smoke, Who is at Risk?" Florida Department of Health, Division of Environmental Health, 2006.
 *Data are available only where point estimates are shown.

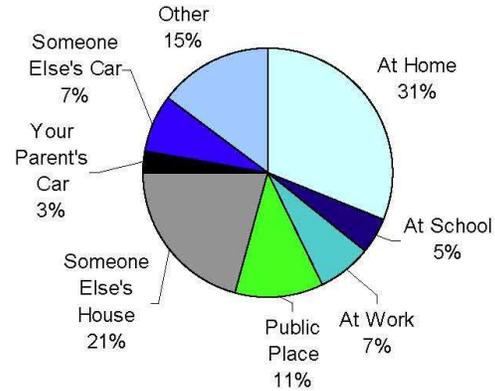
Location of Secondhand Smoke Exposure: 2006 Survey Data

The two charts below show the locations in which Hillsborough County middle and high school students were exposed to SHS. Both middle and high school students were most likely to be exposed to SHS at home.

Hillsborough County Middle School Students



Hillsborough County High School Students

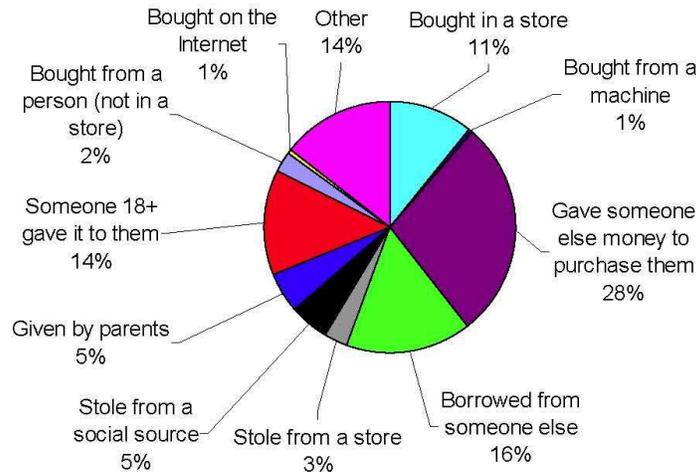


Tobacco Sources

Source of Cigarettes for Minors

Students are asked on the FYTS how they usually acquire their cigarettes. This analysis has been limited to students who are minors, or less than 18 years of age. The chart below shows how Hillsborough County minors (in either middle or high school) acquire cigarettes. Hillsborough County minors are most likely to get their cigarettes by giving someone else money to purchase them.

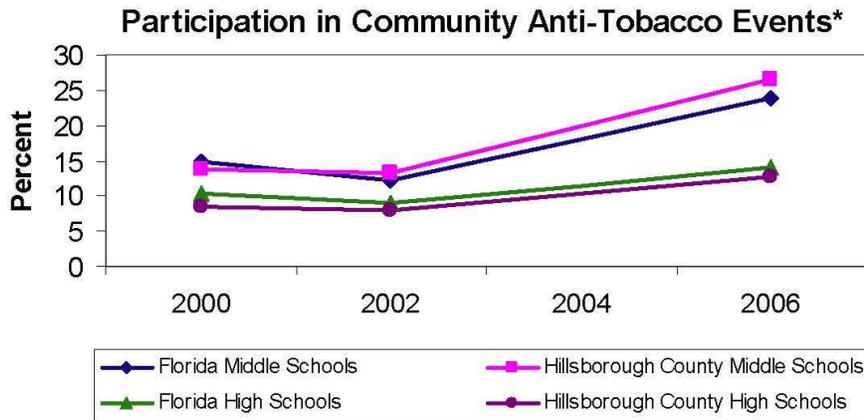
Cigarette Sources for Minors



Anti-Tobacco Activism

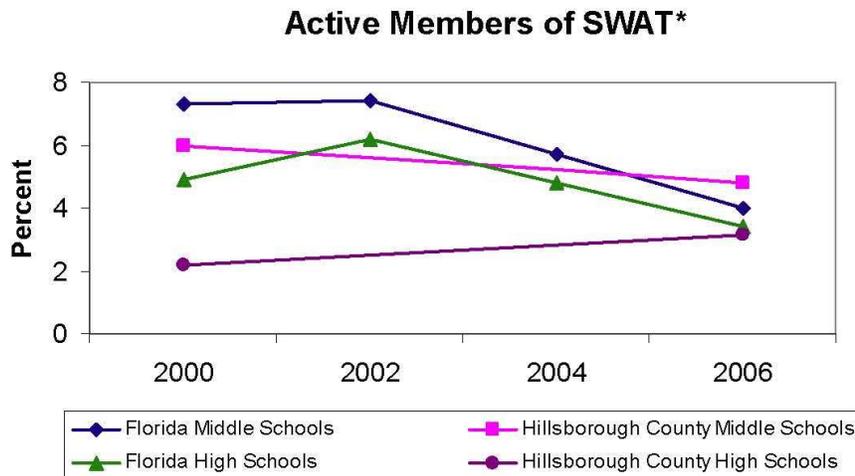
Participation in an Anti-Tobacco Community Event

The prevalence of Hillsborough County middle school students' participation in anti-tobacco community events has increased by 92.1 percent from 13.8 percent in 2000 to 26.5 percent in 2006. The prevalence of Hillsborough County high school students' participation in anti-tobacco community events has increased by 51.2 percent from 8.4 percent in 2000 to 12.7 percent in 2006.



Students Working Against Tobacco (S.W.A.T.)

The prevalence of Hillsborough County middle school students who served as active members of S.W.A.T. has decreased by 19.8 percent from 6.0 percent in 2000 to 4.8 percent in 2006. The prevalence of Hillsborough County high school students who served as active members of S.W.A.T. has increased by 43.5 percent from 2.2 percent in 2000 to 3.2 percent in 2006.

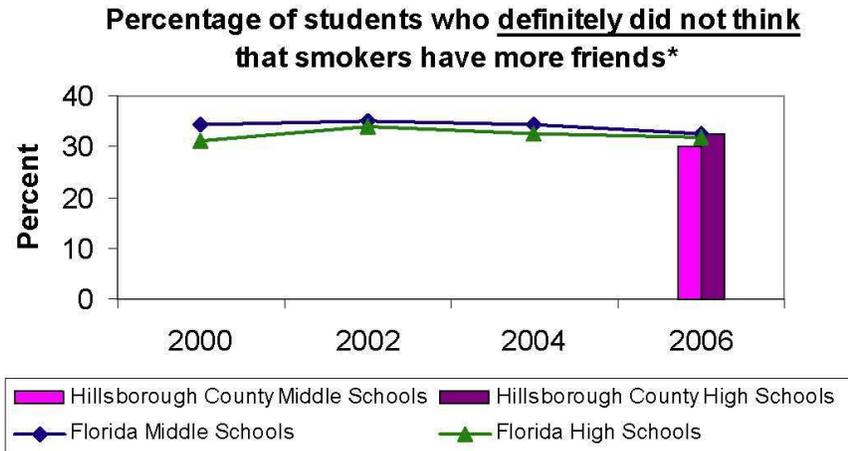


*Data are available only where point estimates are shown.

Social Attitudes

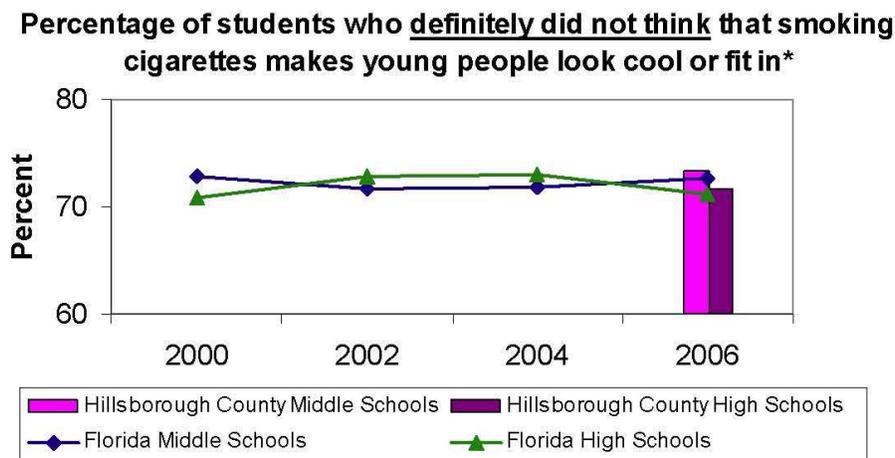
Perception that Smokers have More Friends

Students are asked on the FYTS whether or not they believe that young people who smoke have more friends. The chart below shows the percentage of students who report that they “definitely do not think” that smokers have more friends. In 2006, 30.2 percent of Hillsborough County middle school students and 32.5 percent of Hillsborough county high school students believed that smokers “definitely do not” have more friends.



Perception that Smokers Look Cool or Fit In

Students are asked on the FYTS whether or not they believe that smoking helps young people “look cool” or “fit in.” The chart below shows the percentage of students who report that they “definitely do not think” that smoking helps young people look cool or fit in. In 2006, 73.3 percent of Hillsborough County middle school students and 71.7 percent of Hillsborough County high school students believed that smoking “definitely does not” help young people “fit in” or “look cool.”

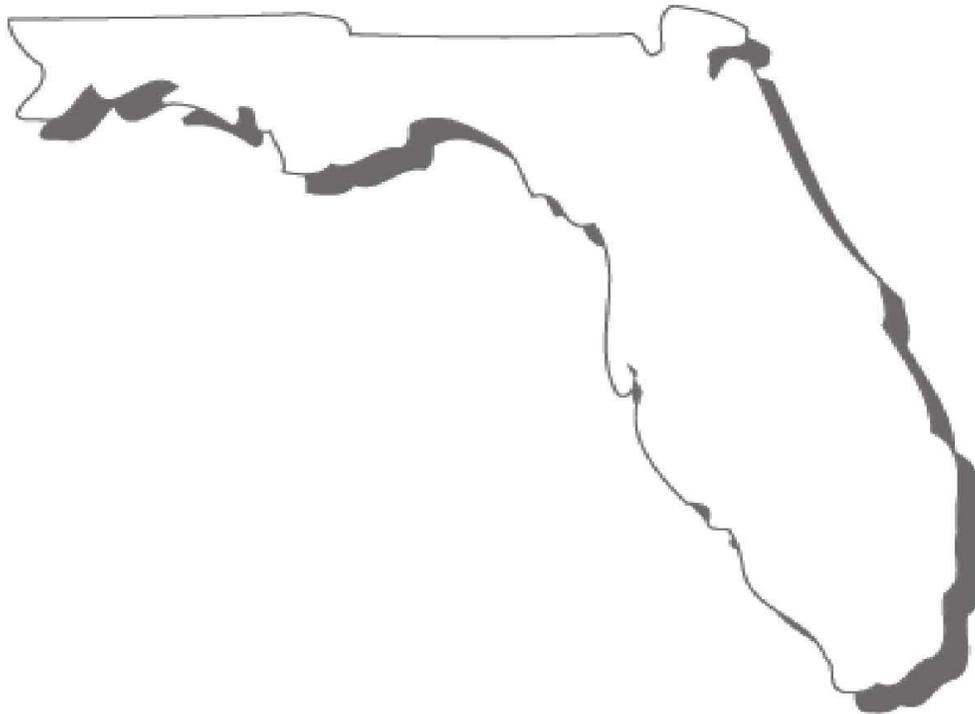


*Data are available only where point estimates are shown.

Hillsborough County: 2006 at a Glance

Indicator	Middle School				High School			
	Hillsborough County %	95 % CI	State %	95 % CI	Hillsborough County %	95 % CI	State %	95 % CI
Smoked cigarettes on one or more of the past 30 days	9.1	(7.3 - 10.9)	6.6	(6.1 - 7.1)	13.6	(11.0 - 16.2)	15.5	(14.7 - 16.3)
Smoked cigars on one or more of the past 30 days	7.5	(5.9 - 9.1)	6.3	(5.9 - 6.8)	12.0	(9.6 - 14.4)	14.0	(13.3 - 14.7)
Used smokeless tobacco one or more of the past 30 days	2.0	(1.2 - 2.9)	1.9	(1.7 - 2.2)	4.1	(2.6 - 5.6)	4.2	(3.8 - 4.5)
Used any form of tobacco on one or more of the past 30 days	13.0	(10.9 - 15.0)	11.3	(10.6 - 12.0)	21.0	(17.9 - 24.0)	23.9	(22.9 - 25.0)
Have never smoked a cigarette and will definitely not smoke a cigarette in the future or if a friend offered one	59.9	(56.8 - 62.9)	60.9	(59.8 - 61.9)	54.0	(50.1 - 58.0)	48.6	(47.5 - 49.8)
Exposed to second hand smoke during the past 7 days	52.3	(49.2 - 55.3)	56.3	(55.1 - 57.6)	60.0	(56.2 - 63.7)	64.1	(63.0 - 65.3)
Received Comprehensive tobacco use prevention education (TUPE)	29.9	(27.1 - 32.6)	16.7	(15.6 - 17.8)	11.2	(8.8 - 13.6)	8.8	(8.2 - 9.4)
Received any tobacco use prevention education (TUPE)	87.8	(85.8 - 89.8)	71.3	(69.6 - 72.9)	57.0	(53.2 - 60.7)	53.3	(51.9 - 54.6)
Participated in a community event	26.5	(23.9 - 29.1)	23.8	(23.0 - 24.6)	12.7	(10.2 - 15.2)	14.1	(13.5 - 14.7)
Served as an active member of SWAT	4.8	(3.5 - 6.1)	4.0	(3.6 - 4.4)	3.2	(1.9 - 4.4)	3.4	(3.1 - 3.7)
Definitely did not think that smokers have more friends	30.2	(27.4 - 33.0)	32.6	(31.8 - 33.4)	32.5	(28.9 - 36.0)	32.0	(31.2 - 32.9)
Definitely did not think that smoking helps young people "look cool" or "fit in"	73.3	(70.6 - 76.0)	72.6	(71.9 - 73.4)	71.7	(68.3 - 75.2)	71.1	(70.3 - 71.9)

2006 Hillsborough County Florida Youth Tobacco Survey Report



The collection and reporting of county-level survey data would not have been possible without the collaboration and tireless efforts of many. We thank our colleagues at: Florida Department of Health; Florida Department of Children and Families; Florida Department of Education; Florida Department of Juvenile Justice; Florida's Executive Office of the Governor, Office of Drug Control; The Centers for Disease Control and Prevention, Office on Smoking and Health; and ORC Macro. Special thanks go to our friends in the County Healthy Departments and local School District Offices. Most especially we thank the principals, teachers, and students who participated in the survey and made this information possible.

For more information about the FYTS, please contact: Ms. Jamie Weitz, M.S., Florida Youth Survey Coordinator, at (850) 245-4444, extension 2424 or by e-mail at Jamie_Weitz@doh.state.fl.us. Also, visit our website at: http://www.doh.state.fl.us/disease_ctrl/epi/Chronic_Disease/FYTS/Intro.htm .



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