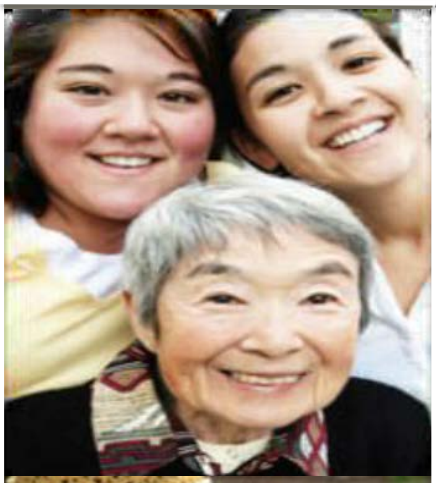

Pinellas County

COMMUNITY HEALTH IMPROVEMENT PLAN

2013 - 2017

Healthier People in a Healthier Pinellas

PINELLAS COUNTY

COMMUNITY HEALTH IMPROVEMENT PLAN

2013 - 2017

Produced by: Florida Department of Health in Pinellas County

Revised July 2016

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Executive Summary

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

Using the Mobilizing for Action through Planning and Partnerships (MAPP) framework, CHAT identified access to care, behavioral health, health promotion and disease prevention, and healthy communities and environments as health priority areas for the Pinellas CHIP. CHAT and four health priority work teams have formulated goals, strategies, and objectives to address each of these areas. Additionally, 2013 - 2014 action plans have been revised for the 2014 – 2015 implementation period.

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

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

HEALTH PROMOTION AND DISEASE PREVENTION encompasses a range of health concerns including the leading causes of death in Pinellas County, cancer and heart disease. Goals to address health promotion and disease prevention include:

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

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

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

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

I. Introduction

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

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

Moving from Assessment to Planning: What is the CHIP?

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

How to use the Community Health Improvement Plan

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

II. Methods

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

Community Engagement

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

Visioning

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

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

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

Healthier People in a Healthier Pinellas

Setting Strategic Priorities

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

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

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

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

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

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

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

Development of Goals, Strategies, and Objectives

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

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

Development of the Action Plan

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

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

Following the collaborative engagement, CHAT and work team members met in June 2013 to prioritize activities for the July 2013 – December 2014 Action Plan. Coordinating agencies will be contacted to review the CHIP monitoring and evaluation plan between July and December 2013. In July 2014, partners reconvened to create the 2014-15 action plan. In July and August of 2015, the action plans were revised for 2015-2016.

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

Goal	Community Partner Alignment and Community Resources, 2013
ACCESS TO CARE	
Equal Access to Health Care Services and Providers	• DOH-Pinellas – Pinellas provider of medical homes for uninsured/low income • Pinellas County Health and Human Services – Primary care services, specialty care, and mobile medical unit • St. Petersburg Free Clinic – Access to adults who are uninsured • St. Joseph's Children's Hospital – Provide free well-child physicals and immunizations through the mobile medical clinic • DOH-Pinellas – Breast and Cervical Early Detection and Screening Program - Cancer screening for uninsured women, family planning services on sliding fee scale • Homeless Leadership Board – Coordination and planning for homeless services • Moffitt Cancer Center – Connecting community to health resources and agencies and increasing access to care • Pinellas KidCare Coalition – Providing insurance options for uninsured children • DOH-Pinellas – Increase access to dental care • All Children's Hospital • Tampa Bay Healthcare Collaborative – Collaborate and advocate for the healthcare underserved and work to connect these individuals with available resources • Juvenile Welfare Board – Works with 211 Tampa Bay Cares to connect people with resources; planning a study on the at risk areas of Pinellas County • 2-1-1 Tampa Bay Cares – Provide referrals for health and mental health services • Healthy Start for Pinellas – Working with KidCare to get kids insured in Pinellas County • St. Petersburg College – Networking; Community Health Worker Initiative • Hispanic Outreach Center • Lealman and Asian Neighborhood Family Center
Use of Health Information Technology to Improve Collaboration	• DOH-Pinellas – Use of direct secure messaging, health information exchange, and One E-app • USF Health – Working to implement Paperfree Florida – HItech, EHR/EMR – DSM & HIE

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

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

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

III. Health Priority Areas

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

Access to Care

Why address Access to Care?

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

Community Perspective

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

Consulting the Data

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

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

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

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

*Removed/Revised during 2015-16 update process.

Behavioral Health

Why address Behavioral Health?

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

Community Perspective

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

Consulting the Data

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

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

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

Goal BH 1: Increase access to behavioral health services	**Strategy 1.1**: Strengthen the integration of behavioral and primary health care service delivery. ❖ ***Objective 1.1.1****: By Dec 31, 2016, increase the percentage of Pinellas adults who always or usually receive the social and emotional support they need from 83.3% (2010) to 90%.*
	Strategy 1.2: Integrate trauma-informed care practices across care settings with emphasis on Adverse Childhood Experiences (ACEs). ❖ ***Objective 1.2.1****: By Dec 31, 2017, reduce the rate of non-fatal hospitalizations for self-inflicted injuries from 72.9 per 100,000 (2008-2010) to 65.6 per 100,000 among Pinellas youth 12-18.*
	Strategy 1.3: Engage targeted at-risk populations to better understand behavioral health care needs and prevent barriers to access. ❖ ***Objective 1.3.1****: By Dec 31, 2017, decrease the suicide age-adjusted death rate in Pinellas from 17.7 per 100,000 (2010-2012) to 16.2 per 100,000.*
Goal BH 2: Reduce substance abuse among children and adults	**Strategy 2.1**: Advocate for changes in policy and practices related to substance abuse, including more stringent regulations for prescription drugs classified as controlled substances. ❖ ***Objective 2.1.1****: By Dec 31, 2017, reduce the number of accidental drug or toxin related deaths in Pinellas from 201 (2012) to 181.*
	Strategy 2.2: Raise awareness among providers, parents, youth, and businesses on emerging substance abuse trends to improve and inform practices. ❖ ***Objective 2.2.1****: By Dec 31, 2016, reduce the number of Pinellas youth who report lifetime drug use from 31.1% (2012) to 26.1%.*
	Strategy 2.3: Increase access to substance abuse services for prenatal and postpartum women. ❖ ***Objective 2.3.1****: By Dec 31, 2017, reduce the rate of Neonatal Abstinence Syndrome in Pinellas from 27.1 per 1,000 births (2009-2011) to 24.4 per 1,000 births.*
Goal BH3: Reduce violence among children and families	**Strategy 3.1**: Promote community programs that maximize healthy development and interaction among children, families, schools, and communities. ❖ ***Objective 3.1.1****: By Dec 31, 2017, reduce the rate of Pinellas children under 18 experiencing child abuse from 24.0 per 1,000 (2012) to 16.9 per 1,000.*
	Strategy 3.2: Promote awareness, training, and advocacy to improve and inform practices related to domestic violence. ❖ ***Objective 3.2.1****: By Dec 31, 2017, reduce the domestic violence rate in Pinellas from 772.8 per 100,000 (2009-2011) to 695.5 per 100,000.*

Health Promotion and Disease Prevention

Why address Health Promotion and Disease Prevention?

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

Community Perspective

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

Consulting the Data

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

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

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

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

Healthy Communities and Environments

Why address Healthy Communities and Environments?

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

Community Perspective

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

Consulting the Data

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

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

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

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

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

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

Goal HCE 2: Increase access to nutritious and affordable foods

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

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

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

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

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

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

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

IV. Next Steps

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

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VI. Appendices

Appendix A: Alignment

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

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

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

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

Appendix B: 2016 – 2017 Action Plan

Access to Care

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

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

Policy Component (Y/N): No

Performance Measures

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

Outcomes

Increase in adults who had a medical checkup in the past year
Increase in percentage of CHWs who have enrolled in a standardized training
Implementation by at least 4 agencies of CLAS assessment and action plan
At least four new partnerships developed between social service and medical agencies in Pinellas County.
Establishment of a forum for dialogue about direct messaging in Pinellas County. 2 agencies have implemented CLAS assessment and action plan

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

Pinellas County CHIP: 2016-17
Access to Care

Goal	Strategy	Objective	Activity 2016-17	Process Measure 2016-17	Coordinating Agency	Partner Agencies
AC 1: Provide equal access to appropriate health care services and providers	1.1: Address barriers in accessing existing health care services and consumer utilization in underserved communities	1.1.1: By Dec 31, 2017, decrease the percentage of Pinellas adults who are unable to access a health care provider due to cost from 16% (2010) to 14.4%.	1. Promote Direct Connect Partnership between PSTA and Uber to community partners (including TD late shift). 2. Implement St. Petersburg Police Dept. Mobile Resource Bus Connection.	1. Promote program and PSTA events to a minimum of one community group per quarter. 2. Publicize mobile resource bus to community partners each month. Track and increase number of residents connected to resources during the August 2016-July 2017 CHIP period.	1. PSTA 2. Healthy St. Pete	1. Uber, DOH-Pinellas 2. Foundation for a Healthy St. Pete, DOH-Pinellas, SPPD
	1.2: Develop and implement a standardized training program for Community Health Workers.	1.2.1: By Dec 31, 2017, increase the number of trained Community Health Workers (CHWs) in Pinellas by 25% over baseline.	**Strategy met: http://flcertificationboard.org/certifications/certified-community-health-worker-cchw/**			
	1.3: Promote the completion of a cultural and linguistic competence organizational self-assessment to improve access to culturally competent care.	1.3.1: By Dec 31, 2016, decrease the percentage of Pinellas adults who believe they would receive better medical care if they belonged to a different race/ethnic group from 7% (2010) to 6.3%.	1. Implement Cultural & Linguistic Competency Initiative	1. 4 organizations complete CLC program led by TBHC.	Tampa Bay Healthcare Collaborative	Collaborative Labs USF Public Health
AC 2: Use health information technology to improve collaboration among providers and increase efficiency in services to consumers	2.1: Improve communication among providers and care coordinators through data integration.	2.1.1: -By Dec. 31, 2017, explore at least 2 data integration initiatives in Pinellas County.	1. Identify providers enrolled in Direct Trust and encourage its use as an HIE. 2. Implement electronic Pinellas County Health Program application and make available at community partner organizations.	1. Increase # of providers identified 2. Increase # organizations making electronic application available	1. DOH-Pinellas 2. Pinellas County Human Services	1. USF Health 2. DOH Pinellas, hospitals, community organizations
AC 3: Reduce infant mortality and morbidity	3.1: Raise awareness among providers and consumers on the importance and benefits of being healthy prior to pregnancy.	3.1.1: By Dec 31, 2017, decrease the percentage of low-birth weight (less than 2,500 grams) infants in Pinellas from 8.9% (2010-2012) to 8%.	1. Implement Figuring it Out for the Child. 2. Use Fetal Infant Mortality Review data to identify trends and educate women of childbearing age in Pinellas.	1. Increase the number of pregnant couples seen each year to 100. 2. Identify trends in losses and offer interventions in the form of educational materials to all 32 Pinellas OB offices and Healthy Start Care Coordinators	1. USFSP 2. Healthy Start Coalition	1. CHCP, DOH-Pinellas, Healthy Start, Mt. Zion 2. FIMR Partners
	3.3: Address disparities in Black and Hispanic infant mortality.	3.3.1: By Dec 31, 2017, reduce the infant mortality rate of Black infants in Pinellas from 13.9 per 1,000 live births (2010-2012) to 11.5 per 1,000 live births. 3.3.2: By Dec 31, 2017, reduce the infant mortality rate of Hispanic infants in Pinellas from 8.1 per 1,000 live births (2010-2012) to 7.3 per 1,000 live births.	1. Build Florida Healthy Babies Task Force.	Convene group minimum of quarterly and create action plan.	DOH-Pinellas	IFMHC, JWB, JCACH, Healthy Start

Behavioral Health

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

Goal BH 1: Increase access to behavioral health services

Policy Component (Y/N): No

Performance Measures

Objectives	Data Source	Frequency
Objective 1.1.1: By Dec 31, 2016, increase the percentage of Pinellas adults who always or usually receive the social and emotional support they need from 81.3% (2010) to 89.4%.	BRFSS	3 Years
Objective 1.2.1: By Dec 31, 2017, reduce the rate of non-fatal hospitalizations for self-inflicted injuries from 82.0 per 100,000 (2008-2010) to 65.6 per 100,000 among Pinellas youth 12-18.	Florida CHARTS	Annually
Objective 1.3.1: By Dec 31, 2017, decrease the suicide age-adjusted death rate in Pinellas from 17.7 per 100,000 (2009-2011) to 16.2 per 100,000.	Florida CHARTS	Annually

Outcomes

Increased number of referrals to behavioral healthcare providers. 200 doctors educated on trauma-informed care principles. 4 new organizations distributing Trauma-Informed Care materials. Identify gaps in behavioral healthcare access.

Alignment with Local, State, and National Priorities

Obj. 1.3.1	Healthy People 2020 MHMD-1

Pinellas County CHIP: 2016-17
Behavioral Health

Goal	Strategy	Objective	Activity 2016-17	Process Measure 2016-17	Coordinating Agency	Partner Agencies
BH 1: Increase access to behavioral health services	1.1: Strengthen the integration of behavioral and primary health care service delivery.	1.1.1: By Dec 31, 2016, increase the percentage of Pinellas adults who always or usually receive the social and emotional support they need from 81.3% (2010) to 89.4%.	1. Continue implementation of pilot program to engage and provide services to the top 33 utilizers of Pinellas County's public Baker Act and jail facilities.	1 a. #/% Clients engaged and enrolled in pilot b.. #/% of clients who receive therapy indicated in treatment plan	Pinellas County Human Services; Administrative Forum	Local Behavioral Health providers
	1.2: Integrate trauma-informed care practices across care settings with emphasis on Adverse Childhood Experiences (ACEs).	1.2.1: By Dec 31, 2017, reduce the rate of non-fatal hospitalizations for self-inflicted injuries from 82.0 per 100,000 (2008-2010) to 65.6 per 100,000 among Pinellas youth 12-18.	1. Promote provider and agency education on trauma-informed approaches and practices.	1. Hold two trainings for providers in Pinellas County.	1. Peace4Tarpon	1. National Center for Trauma-Informed Care, DOH-Pinellas
	1.3: Engage targeted at-risk populations to better understand behavioral health care needs and prevent barriers to access	1.3.1: By Dec 31, 2017, decrease the suicide age-adjusted death rate in Pinellas from 17.7 per 100,000 (2010-2012) to 16.2 per 100,000.	1. Examine Pinellas County suicide data to identify additional trends or areas of concern.	1. Analyze data and determine the need for an in-depth report.	1. Pinellas County	1. BayCare, DOH-Pinellas

Pinellas County CHIP: 2016-17
Behavioral Health

Goal	Strategy	Objective	Activity 2016-17	Process Measure 2016-17	Coordinating Agency	Partner Agencies
BH 2: Reduce substance abuse among children and adults	2.1: Advocate for changes in policy and practices related to substance abuse, including more stringent regulations for prescription drugs classified as controlled substances.	2.1.1: By Dec 31, 2017, reduce the number of accidental drug or toxin related deaths in Pinellas from 201 (2012) to 181.	1. Maintain connection with Administrative Forum and Regional Council and track their work on policy-related advocacy.	1. Check in a minimum of quarterly.	1. DOH-Pinellas	Administrative Forum, Regional Council
	2.2: Raise awareness among providers, parents, youth, and businesses on emerging substance abuse trends to improve and inform practices.	2.2.1: By Dec 31, 2016, reduce the number of Pinellas youth who report lifetime drug use from 31.1% (2012) to 27.9%.	1. Implement a campaign to educate **parents, businesses, and youth** on medical marijuana and the dangers of emerging designer drugs and prescription drugs	1. Educational materials distributed/parents educated 2. Number of businesses educated 3. Number of youth led groups who receive campaign materials	LiveFree/Pinellas County Justice & Consumer Services	LiveFree! Coalition members
	2.3: Increase access to substance abuse services for prenatal and postpartum women.	2.3.1: By Dec 31, 2017, reduce the rate of Neonatal Abstinence Syndrome in Pinellas from 27.1 per 1,000 births (2009-2011) to per 24.4 per 1,000 births.	1. Work with OB-GYNs to provide warnings to their patients on the dangers of substance use/abuse while pregnant and provide supports to address underlying issues. 2. Collect current data on drugs to which newborns are most frequently exposed.	1. Offer education and materials to all 32 OB providers in Pinellas County. 2. Produce a 2015-16 report on trends of substance exposure to newborns.	1. Healthy Start Coalition 2. Substance Exposed Newborns task force; USFSP	1. Operation PAR, Healthy Start Coalition, Birth Hospitals, BayCare, DOH-Pinellas, Motivating New Moms 2. Healthy Families
BH 3: Reduce violence among children and families	3.1: Promote community programs that maximize healthy development and interaction among children, families, schools, and communities.	3.1.1: By Dec 31, 2017, reduce the rate of Pinellas children under 18 experiencing child abuse from 24.0 per 1,000 (2012) to 16.9 per 1,000.	1. Promote JWB's Prevent Needless Deaths campaign. 2. Hold trauma informed care trainings for local MCH care providers.	1. Distribute booklets to local birthing hospitals (St. Pete General; Bayfront Baby Place; Morton Plant Hospital - CLW; & Mease Countryside) and at least ten daycare providers. 2. At least three trainings held in Pinellas (one at DOH-Pinellas)	1. JWB 2. USFSP, Peace4Tarpon	1.Hillsborough Children's Board; Local MCH providers and agencies 2.DOH-Pinellas
	3.2: Promote awareness, training, and advocacy to improve and inform practices related to domestic violence.	3.2.1.: By December 31, 2017, reduce the domestic violence rate in Pinellas from 772.8 per 100,000 (2009-2011) to 695.5 per 100,000	1. Educate community healthcare providers on domestic violence policies and preventive practices.	1. Hold at least two Being a Better Bystander trainings countywide.	1. Domestic Violence Task Force	1. DVTF partners

HEALTH PROMOTION AND DISEASE PREVENTION

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

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

Policy Component (Y/N): No

Performance Measures

Objectives	Data Source	Frequency
Objective 1.1.1: By Dec 31, 2017, decrease the percentage of Pinellas adults who are either overweight or obese from 65.6% (2010) to 59%.	BRFSS	3 years
Objective 1.2.1: By Dec 31, 2017, increase the proportion of Pinellas children (1st, 3rd, 6th grade) who are at a healthy weight from 65.1% (2010 - 2011) to 71.6%.	DOH School Health Report	Annually
Objective 1.2.2: By Dec 31, 2017, decrease the percentage of Pinellas high school students reporting BMI at or above 95th percentile from 10.3% (2012) to 9.3%.	YRBS	2 years

Outcomes

Increased percentage of adults who report exercising regularly.
Increased percentage of children who report exercising regularly.

Alignment with Local, State, and National Priorities

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

Pinellas County CHIP: 2016-17
Health Promotion & Disease Prevention

Goal	Strategy	Objective	Activity 2016-17	Process Measure 2016-17	Coordinating Agency	Partner Agencies
HPDP 1: Increase the percentage of adults and children who are at a healthy weight	1.1: Promote healthy eating habits and active lifestyles in adults.	1.1.1: By Dec 31, 2017, decrease the percentage of Pinellas adults who are either overweight or obese from 65.6% (2010) to 59%.	1. Provide educational sessions to DOH-Pinellas clients demonstrating healthy and culturally appropriate cooking and grocery shopping on a budget. 2. Promote usage of county parks, trails, and recreational facilities. 3. Implement Diabetes Prevention Program referral project. 4. Implement Humana Vitality in Pinellas County Schools. 5. Explore data sharing between DOH-Pinellas and hospital systems regarding obesity rates.	1. Conduct four education series annually for DOH clients, as documented by sign-in sheets and post-session surveys. 2. DOH-Pinellas collaborates with recreation departments to update brochures annually and disseminate 1500 brochures to the community. 3. Increase referrals in Pinellas County by 50% through physician letter campaign, AMA partnership, etc. 4. Increase Silver Status from 18% - 30%. Hold at least one meeting to explore data sharing regarding rate of obese patients in BayCare hospital system.	1. UF/IFAS Extension Pinellas County 2. DOH-Pinellas 3. YMCA (Kieran Gabel) 4. PCS (Peggy Johns) 5. DOH-Pinellas	1. DOH-Pinellas 2. Pinellas County Parks & Conservation Resources, Municipal Governments 3. BayCare 4. YMCA, Physicians, Walgreens 5. BayCare (Dr. Cynthia Miller)
	1.2: Promote healthy eating habits and active lifestyles in children.	1.2.1: By Dec 31, 2017, increase the proportion of Pinellas children (1st, 3rd, 6th grade) who are at a healthy weight from 65.1% (2010 - 2011) to 71.6%. 1.2.2: 1.2.2: By Dec 31, 2017, increase the percentage of Pinellas middle and high school students who are at a healthy weight from 67.3% (2012) to 73.4%.**	1. Conduct inventory based self-assessments of Pinellas County Schools on the Alliance for Healthier Generation guidelines 2. Create data report of BMI at each grade level.	1. 1. Increase in number of schools that adopt Alliance for a Healthier Generation standards. 2. Analyze BMI data starting at 3rd grade.	1. Pinellas County Schools 2. Pinellas County Schools	1. Alliance for a Healthier Generation, DOH-Pinellas 2. DOH-Pinellas

Pinellas County CHIP: 2016-17
Health Promotion & Disease Prevention

Goal	Strategy	Objective	Activity 2016-17	Process Measure 2016-17	Coordinating Agency	Partner Agencies
HPDP 2: Increase behaviors that improve chronic disease health outcomes	2.1: Promote screening, education, and referral to treatment related to cancer.	2.1.1: By Dec 31, 2017, increase the percentage of Pinellas adults age 50 or older who received a colorectal screening in the past five years from 73.5% (2010) to 80.9%.	1. Examine disparities in colorectal cancer incidence, conduct research with priority populations, and implement multilevel interventions using the community-based prevention marketing framework.	1. Meet bimonthly to implement program and track progress	1. USF-Florida Prevention Research Center	1. DOH-Pinellas, DOH-Hillsborough, Community Health Worker Coalition, community members, American Cancer Society, Blue Cross Blue Shield, Moffitt, Florida Cancer Data System, Southwest Florida Cancer Collaborative
		2.1.2: By Dec 31, 2017, increase the percentage of Pinellas women age 40 or older who received a mammogram in the past year from 61.5% (2010) to 67.7%.	1. Distribute educational materials to promote awareness of the Florida Breast and Cervical Cancer Early Detection Program, Mammography Voucher Program and general screening recommendations to women above 40 in Pinellas County.	1. Educate community via at least 20 locations in Pinellas County from July 2016-June 2017.	1. DOH-Pinellas	1. TBCCN Partners St Pete Free Clinic Komen BayCare SW Florida Cancer Control Collaborative
	2.2: Promote screening, education, and referral to treatment related to heart disease.	2.2.1: By Dec 31, 2017, decrease deaths due to heart disease in Pinellas from 155.5 per 100,000 (2010-2012) to 139.9 per 100,000.	1. Train 7% of the Pinellas County population in Hands-OnlyTM CPR training via education in the community and in schools. 2. Refer diagnosed prediabetes patients at local hospitals to the CDC's National Diabetes Prevention Program, run locally as the YMCA's Diabetes Prevention Program.	1. Increase number of citizens educated by 7%; establish baseline of bystander CPR data from local emergency response services. 2. Increase number of regularly referring providers (physician offices, health systems) by 30 between the SunCoast and St. Pete regions.	1. American Heart Association 2. YMCA of St. Pete, YMCA of the Suncoast	1. Healthy St. Pete, AHA board, BayCare, DOH-Pinellas, Pinellas County Schools 2. Local physicians and hospital systems.
	2.3: Promote activities to reduce tobacco use and exposure in adults and youth.	2.3.1: By Dec 31, 2017, increase the number of committed never smokers amount Pinellas youth, ages 11 - 17 from 64.1% (2012) to 70.5%.	1. Create and maintain local SWAT chapters. 2. Survey tobacco retail outlets about point of sale advertising.	1. SWAT Clubs at 10 middle/high schools will conduct at least 50 outreach activities will be completed each year. 2. The DOH Pinellas Tobacco Program will survey 300 local retailers in Pinellas county.	DOH-Pinellas –Tobacco Free Program/SWAT Coordinator	Pinellas County Schools, Tobacco Free Coalition
		2.3.2: By Dec. 31, 2016, decrease the percentage of Pinellas adults who are current smokers from 19.3% (2010) to 17.0%.	1. Distribute "Quitkits" to clients who are smokers within Florida Department of Health in Pinellas clinics 2. Educate local policymakers, businesses, and community organizations about tobacco use. 3. Meet quarterly with Tobacco Free Campus Task Force at local universities/colleges.	1. 2500 Quitkits will be distributed 2.At least 2 tobacco worksite wellness policies will be adopted 3. Minimum of four meetings will be held.	1. DOH-Pinellas – Tobacco Free Program 2.DOH-Pinellas 3. DOH-Pinellas	1. Area Health Education Center (AHEC) 2. Worksites, Housing 3. St. Petersburg College
HPDP 3: Increase protection against the spread of infectious disease	3.1: Provide targeted education on the benefits of receiving immunizations to increase the percentage of children who are fully immunized.	3.1.1: By Dec 31, 2017, increase the percentage of Pinellas two-year-olds who are fully immunized from 75.3% (2012/2013) to 90%. 3.1.2: By Dec 31, 2017, increase the percentage of Pinellas Kindergarteners who are fully immunized from 89.8% (2012/2013) to 94%.	1. Assess (or Strengthen) Current Partnership for Collaboration and Define Roles and Responsibilities 2. Market use of State Immunization Information Systems (IIS) 3. Identify and conduct effective outreach and educational activities 4. Develop/adopt/adapt consistent messaging plan	1. Documentation of quarterly meetings and development of sharepoint/web portal 2. Quarterly updates of educational opportunities and percentage of providers using IIS in Pinellas County 3. Quarterly updates on parent surveys, educational materials, schedule of outreach events, and vaccine administration 4. Quarterly updates on messaging plan progress, and development of toolkit materials	DOH-Pinellas	1. DOH-Pinellas PITCH Pinellas County Schools Amercian Cancer Society/Cancer Collaborative JWB Municipality Leaders (support) 2. DOH-Pinellas State Immunization – Field Staff State Immunizations – FLSHOTS (training staff) FLSHOTS vendor (marketing partner) PITCH (support) 3. DOH-Pinellas Pinellas County Schools PITCH Community Health Centers/FQHC Moffitt Cancer Center ACS/Cancer Collaborative, Additional support: OB/GYNs, Nursing Schools,

**Updated 2016

HEALTHY COMMUNITIES AND ENVIRONMENTS

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

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

Policy Component (Y/N): Yes

Performance Measures

Objectives	Data Source	Frequency
Objective 1.1.1: By Dec 31, 2016, increase activity related to the development of policies and plans that support individual and community health within Pinellas from a score of 82% (2012) to 90%.	Community Health Assessment, Local Public Health System Performance Assessment	As needed, 3 – 5 year intervals

Outcomes

Health element codified into a Comprehensive Plan.

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

Pinellas County CHIP: 2016-17
Healthy Communities & Environments

Goal	Strategy	Objective	Activity 2016-17	Process Measure 2016-17	Coordinating Agency	Partner Agencies
HCE 1: Establish integrated planning and assessment processes that promote health in community level policies and plans	1.1: Include a public health component in community planning processes to increase awareness and opportunity of the built environment's impact on healthy behaviors.	1.1.1: By Dec 31, 2016, increase activity related to the development of policies and plans that support individual and community health within Pinellas from a score of 82% (2012) to 90%.	1. Educate policymakers on "health in all policies" and HIA, including topics related to public health, development, the built environment. 2. Support the inclusion of a health component in local policies and plans.	1. 3 meetings or events advocating for the importance of a health element in comprehensive plans will be conducted; Research conducted on when and how local policies are updated. 2. Health written into at least three city and/or county plans or policy.	1. DOH-Pinellas 2. DOH-Pinellas	1. City and county governments, MPO 2. City and county governments, MPO
HCE 2: Increase access to nutritious and affordable foods	2.1: Promote options for access to nutritious foods throughout Pinellas County.	2.1.1: By Dec 31, 2016, increase the percentage of Pinellas adults who meet both of the daily recommendations for fruit and vegetable consumption from 9.3% (2010) to 11.5%.	1. Support development of local city policies related to food access. 2. Promote healthy and affordable food options to communities countywide.	1. Assist at least one city with identifying model language to implement mobile produce vending and/or healthy corner stores. 2. Promote healthy vending via adoption of AHA guidelines for healthy vending by businesses; Good Neighbor Store designations adopted by a minimum of 2 stores.	1. DOH-Pinellas 2. DOH-Pinellas	1. Municipal governments 2. AHA, Municipal Governments
	2.2: Support a focused effort to increase access to nutritious and affordable foods for children.	2.2.1: By Dec 31, 2017, increase the percentage of Pinellas middle school students who consume at least five servings of fruits and vegetables a day from 21.2% (2012/2013) to 23.3%.	1. Promote Smart Snacks in Schools. 2. Implementation of Fun Bites program. 3. Implement new grant (pending funding) for nutrition education.	1. Training and handbook developed; increase from 75% to 100% compliance by June 2017. 2. At least two municipalities will implement Fun Bites (little league, café, etc.) 3. Gardening, Myplate, general nutrition education implemented in elementary schools	1. Pinellas County Schools (Peggy Johns) 2. DOH-Pinellas 3. UF IFAS Extension Office (Nan Jensen)	1. DOH-Pinellas (PICH grant); Alliance for a Healthier Generation 2. Healthy St. Pete (Gillian Cutro) 3. Pinellas County Schools (Peggy Johns)
HCE 3: Increase access to safe opportunities for physical activity	3.1: Promote collaborative efforts to form safe transportation linkages to schools, work, home, and recreation.	3.1.1: By Dec 31, 2017, complete 15 transportation linkages in Pinellas through infrastructure and programming improvements. 3.1.2: By Dec 31, 2016, decrease the percentage of Pinellas adults who were sedentary, or did not participate in any leisure-time activity in the past 30 days from 25.5% (2010) to 22%.	1. Increase the number of infrastructure improvements for bicycle and pedestrian safety as well as park and trail access. 2. Maintain and update a list of city/county parks and recreational areas where the community can participate in free or low cost areas for physical activity.	1. Complete 5 environmental improvements that focus on safe physical activity within Pinellas County, including an increase of Auxiliary Ranger hours. 2. Brochure/flyer updated at least once per year and number distributed	1. MPO 2. DOH-Pinellas	1. City & County Governments, DOH-Pinellas, Pinellas County Parks and Conservation. 2. City and County Municipalities, 211-Tampa Bay Cares