Community Health Improvement Plan Annual Report, 2016

Florida Department of Health in Pinellas County

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Introduction

This is the annual review report for the 2013 – 2017 Pinellas County Community Health Improvement Plan (CHIP), and includes the 2016-2017 Action Plans as well as a progress report on CHIP objectives. The Pinellas County CHIP is reviewed and revised each year to ensure that activities remain relevant to the county's needs.

The activities and collaborative efforts of the Florida Department of Health in Pinellas County and community partners are reflected within the report, which outlines changing resources as well as effectiveness of the plan.

Overview of the Community Health Improvement Plan (CHIP)

The Florida Department of Health in Pinellas County (DOH-Pinellas) began the community health improvement planning process in 2012. Public health stakeholders in Pinellas County convened the Community Health Action Team (CHAT) in 2012 to serve as a steering committee for local health improvement planning. CHAT examined data and feedback from Pinellas County residents as part of the 2012 Community Health Assessment to identify how the community can work together to improve health.

Using the Mobilizing for Action through Planning and Partnerships framework, CHAT identified **access to care, behavioral health, health promotion and disease prevention, and healthy communities and environments** as priority areas for the Pinellas CHIP. CHAT members and additional community stakeholders formulated goals, strategies, and objectives to address each of these priority areas. They also created an action plan that outlines how to achieve objectives. Together, these documents make up the 2012-2017 Pinellas County Community Health Improvement Plan (CHIP).

A CHIP is a long-term, systematic guide to addressing 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 residents. The **Healthy Pinellas Consortium** convened in 2013 to oversee two of the CHIP priority areas: health promotion and disease prevention and healthy communities & environments. The Consortium focuses on policy and environmental changes that help reduce obesity and chronic disease by making safe physical activity and nutritious foods accessible to all residents.

See table below for DOH-Pinellas CHIP Priority Areas and associated goals.

PRIORITY AREA	*GOAL*
Access to Care	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
	3. Reduce infant mortality and morbidity
Behavioral Health	1. Increase access to behavioral health services
	2. Reduce substance abuse among children and adults
	3. Reduce violence among children and families
Health Promotion & Disease Prevention	1. Increase the percentage of adults and children who are at a healthy weight
	2. Increase behaviors that improve chronic disease health outcomes
	3. Increase protection against the spread of infectious disease
Healthy Communities & Environments	1. Increase access to safe opportunities for physical activity
	2. Increase access to nutritious and affordable foods
	3. Establish integrated planning and assessment processes that promote health in community level policies and plans

Summary of CHIP Annual Review Meeting

CHIP objectives and activities are reviewed each year to ensure that they remain relevant to the needs of Pinellas County. We held CHIP action plan updates in June and July of 2016.

Due to the wide range of the Pinellas County CHIP priorities, each priority area has a slightly different update process. In each area, however, community partners review objectives and activities for relevant and determine whether to adopt, adapt, or abandon activities that were implemented during the preceding year.

Strategic Issue Area #1: Access to Care

DESCRIPTION: Access to Care is a cross-cutting priority area 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.

WHY IT'S IMPORTANT: Improving access to care is important to Pinellas because 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. To reduce these disparities, CHIP activities focus on mitigating social determinants of health such as inadequate transportation, cultural or linguistic barriers, technical infrastructure, and social and economic factors.

COMMUNITY PARTNERS: Key Partners in this priority area include the Pinellas Suncoast Transit Authority, Foundation for a Healthy St. Pete, St. Petersburg Police Department, Pinellas County Human Services, St. Petersburg College, the Tampa Bay Healthcare Collaborative, USFSP, and the Healthy Start Federal Project.

ANNUAL UPDATE DESCRIPTION: This priority area was updated in July 2016 during a meeting of the Access to Care work group. Activities were updated, as seen in the 2016-17 CHIP Action Plan, included as Appendix 1. Appendices 2, 3, and 4, respectively, include the Agenda, Minutes, and Sign-In sheet from the update.

CHANGING RESOURCES: Appendix 5 includes a detailed document created by community partners at the Annual Update meeting that outlines new and changing resources and community assets related to Access to Care.

An objective-level summary of progress in the Access to Care priority area is included in Figure 1.

Figure 1
ACCESS TO CARE

Objective (2013-2017)	Data Source	Baseline (Year)	Current Rate	Status **On Schedule ✓ Exceeding + Below Target -**	Explanation of Status
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% to 14.4%.	BRFSS	16% (2010)	16.3% (2013)	-	We are working to improve access via new partnerships with the local transit authority, as well as via the Community Resource Bus program.
1.2.1: By Dec 31, 2017, increase the number of trained Community Health Workers (CHWs) in Pinellas by 25% over baseline.	Florida CHWC/SPC	17 (2013)	10 (2015)	-	The decrease in CHWs is due to lower participation in the survey, which has not been administered again during 2016.
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% to 6.3%.	BRFSS	7% (2010)	*Not collected in 2013 BRFSS*	*N/A*	New data for this indicator is not yet available.
2.1.1 By Dec. 31, 2017, explore at least 2 data integration initiatives in Pinellas County.	JWB	23 (2012)	2 (2016)	✓	Aiming to increase data integration in Pinellas via electronic application to the Pinellas County Health Program, as well as by tracking providers involved in Direct Trust (an HIE).
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%.	CHAR TS	8.9% (2010-2012)	8.1% (2013-2015)	✓	
3.2.1: By Dec 31, 2017, increase the percentage of births to Pinellas mother's receiving first trimester prenatal care from 79.1% (2010-2012) to 87%.					This activity was removed during the 2015 update due to duplication with 3.2.1. The removal does not affect any existing activities, as the objective wasn't slated to begin until 2015-16.
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 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 to 7.3 per 1,000 live births.	CHAR TS	13.9 per 10,000 (2010-12) 8.1 per 1,000 (2010-12)	12.8 per 1,000 (2013-15) 7.3 per 1,000 (2012-14)	✓ ✓	

Strategic Issue Area #2: Behavioral Health

DESCRIPTION: 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.

WHY IT'S IMPORTANT: Substance abuse, mental health, and violence among children and families negatively affect not only the individual, but also the community at large. In addition, behavioral health needs often go neglected and violence unreported due to barriers such as stigma. A focus on behavioral health creates an opportunity to address these barriers and improve the community's overall health and quality of life. Behavioral health needs are found throughout the 2012 Pinellas Community Health Assessment. In the Community Themes and Strengths 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.

COMMUNITY PARTNERS: Key Partners in this priority area include the Mental Health & Substance Abuse Coalition, BayCare, Peace4Tarpon, Pinellas County Human Services, Healthy Start Coalition, Substance Exposed Newborn task force, Juvenile Welfare Board, Family Study Center at USFSP, and the Domestic Violence Task Force.

ANNUAL UPDATE DESCRIPTION: Because several behavioral health-related consortia already exist in the County, the health department has linked most objectives in this priority area with existing work rather than convening an additional group. The annual update for this priority area took place via presentations at these local consortia, in addition to one-on-one check-ins with coordinating agencies. Several new activities were added to the action plan.

CHANGING RESOURCES: The County continues to fund a project that addresses high utilizers of the behavioral healthcare system. The Administrative Forum, also lead by Pinellas County Government, will be assessing transportation as a barrier to accessing behavioral health services. The Substance Exposed Newborn task force is now funding a full-time director, and will produce a 2015-16 report on trends of substance exposure to newborns.

An objective-level summary of progress in the Access to Care priority area is included in Figure 2.

Figure 2
BEHAVIORAL HEALTH

Goal	Objective (2013-2017)	Data Source	Baseline (Year)	Current Rate	Status **On Schedule ✓** **Exceeding +** **Below Target -**	Explanation of Status
1. Increase access to behavioral health services	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% to 89.4%	Behavioral Risk Factor Surveillance Survey (BRFSS)	81.3% (2010)	*Not collected in 2013 BRFSS*	*N/A*	No data available this year.
	1.2.1: By Dec 31, 2017, reduce the rate of non-fatal hospitalizations for self-inflicted injuries from 72.9 per 100,000 to 65.6 per 100,000 among Pinellas youth 12-18.	Florida CHARTS	82.0 per 100,000 (2008-10)*	91.9 per 100,000 (2012-14)	-	We are aiming to continue improving upon this measure by focusing on provider education.
	1.3.1: By Dec 31, 2017, decrease the suicide age-adjusted death rate in Pinellas from 17.7 per 100,000 to 16.2 per 100,000.	Florida CHARTS	18.0 per 100,000 (2010-12)*	17.5 per 100,000 (2013-15)	✓	We are aiming to continue improving upon this measure by gaining a better understanding of the data via an innovative partnership with our Medical Examiner's office.
2. Reduce substance abuse among children and adults.	2.1.1: By Dec 31, 2017, reduce the number of accidental drug or toxin related deaths in Pinellas from 201 to 181.	District 6 Medical Examiner Annual Report	201 (2012)	179 (2015)	+	
	2.2.1: By Dec 31, 2016, reduce the number of Pinellas youth who report lifetime illicit drug use from 31.1% to 27.9%.	FL Youth Substance Abuse Survey	31.1% (2012)	33.1% (2014)	-	Focus continues to be on educating parents, businesses, and youth on the dangers of drug use with the hopes that rates will go down in 2015.
	2.3.1: By Dec 31, 2017, reduce the rate of Neonatal Abstinence Syndrome in Pinellas from 27.1* per 1,000 births to per 24.4 per 1,000 births.	Agency for Healthcare Administration	14.5 per 1,000 births (2012)*	9.5 per 1,000 births (2013)	✓	The community now has a full- time leader for the Substance Exposed Newborn task force, who has already become involved in the CHIP.

3. Reduce violence among children and families.	3.1.1: By Dec 31, 2017, reduce the rate of Pinellas children under 18 experiencing child abuse from 24.0 per 1,000 to 16.9 per 1,000.	Department of Children and Families (DCF)	24.0 per 1,000 (2012)	16.05 per 1,000 (Sept 16)	+	
	3.2.1.: By December 31, 2017, reduce the domestic violence rate in Pinellas from 772.8 per 100,000 to 695.5 per 100,000.	Florida CHARTS	722.9 per 100,000 (2009-11)*	719.0 (2013-15)	✓	
*Indicates a rate affected by updated population data						

Strategic Issue Area #3 and #4: Health Promotion & Disease Prevention and Healthy Communities & Environments

DESCRIPTION: 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. CHIP 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.
Creating 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 advocating for health in community planning processes.
These priority areas are grouped together because they are largely monitored and addressed by the Pinellas County Healthy Pinellas Consortium, which aims to create policy, systems, and environmental change around healthy eating and physical activity.

WHY IT'S IMPORTANT: Among the health concerns captured in the Health Promotion & Disease Prevention priority area are the leading causes of death within Pinellas County, cancer and heart disease. This priority area is also important to Pinellas because of the county's high rate of tobacco use and low rate of childhood immunizations. Healthy Communities & Environments addresses the built environment, which residents ranked highly during the Community Health Assessment, and which has been documented to improve health outcomes.

COMMUNITY PARTNERS: Key Partners in these priority areas include the Pinellas County Extension Office, Pinellas County Schools, USF-Florida Prevention Research Center, YMCA, American Heart Association, Tobacco Free Florida, Pinellas Immunization Team for Community Health, All Children's Hospital, the Metropolitan Planning Organization, the City of Largo, and the City of St. Petersburg.

ANNUAL UPDATE DESCRIPTION: Activities related to the Healthy Pinellas Consortium were reviewed and approved at the June 2016 Consortium meeting. Appendix 6 includes the agenda, Appendix 7 includes the minutes, and Appendix 8 includes the sign-in sheet from this meeting.

CHANGING RESOURCES: DOH-Pinellas is working to educate the community about the Health in All Policies framework, which aims to encourage local policymakers and partners to ensure that their decisions have a positive or neutral impact on health. Appendix 9 includes a detailed document created by community partners at the update meeting that outlines new and changing resources and community assets.

An objective-level summary of progress in the Health Promotion & Disease Prevention and Healthy Communities & Environments priority areas are included in Figures 3 and 4.

Figure 3
HEALTH PROMOTION & DISEASE PREVENTION

Goal	Objective (2013-2017)	Data Source	Baseline (Year)	Current Rate	Status On Schedule ✓ Exceeding + Below Target -	Explanation of Status
1. Increase the percentage of adults and children who are at a healthy weight	1.1.1: By Dec 31, 2017, decrease the percentage of Pinellas adults who are either overweight or obese from 65.6% to 59%.	BRFSS	65.6% (2010)	61.1% (2013)	✓	
	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% to 71.6%. 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% to 9.3%.	DOH School Health Report Florida Youth Tobacco Survey	65.1% (2010-11) *67.3% (2012)***	56.2 (2013-14) *69.5% (2015)***	- +	To improve this outcome, activities are changing to focus more on policy (i.e. food and beverage policies in city and sports facilities) rather than programs. Data reports will be produced to track BMI at each grade level.
2. Increase behaviors that improve chronic disease health outcomes	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 54.1% (2010) to 59.5%.* ~~(73.5% to 80.9%)~~	BRFSS	54.1% (2010)*	57.1% (2013)	✓	
	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% to 67.7%.	BRFSS	61.5 (2010)	53.4% (2013)	-	DOH-Pinellas provides free mammograms via the Mammography Voucher Program and will continue to improve its outreach and education.

	2.2.1: By Dec 31, 2017, decrease deaths due to heart disease in Pinellas from 155.3 per 100,000 to 139.9 per 100,000.	Florida CHARTS	155.3 per 100,000 (2010-2012)	151.9 per 100,000 (2013-2015)	–	The American Heart Association has a new initiative aimed at training the community in CPR, and the YMCA is making referrals to the Diabetes Prevention Program.
	2.3.1: By Dec 31, 2017, increase the number of committed never smokers among Pinellas youth, ages 11 - 17 from 64.1% to 70.5%.	Florida Youth Tobacco Survey	64.1% (2012)	69% (2014)	✓	
	2.3.2: By Dec. 31, 2016, decrease the percentage of Pinellas adults who are current smokers from 19.3% to 17.0%.	BRFSS	19.3 (2010)	19.4% (2013)	–	In addition to smoking cessation resources, the county's Students Working Against Tobacco group continues to present to local politicians to advocate for policy change.
3. Increase protection against the spread of infectious disease	1.2.3: By Dec 31, 2017, increase the percentage of Pinellas two-year-olds who are fully immunized from 75.3% to 90%. 1.2.4: By Dec 31, 2017, increase the percentage of Pinellas Kindergarteners who are fully immunized from 89.8% to 94%.	Florida CHARTS	75.3% (2012) 89.8% (2010-12)	84.8% (2015) 92.1% (2014-16)	✓	

*Indicates a rate affected by updated population data
**Objective updated 2016

Figure 4
HEALTHY COMMUNITIES & ENVIRONMENTS

Goal	Objective (2013-2017)	Data Source	Baseline (Year)	Current Rate	Status On Schedule ✓ Exceeding + Below Target -	Explanation of Status
1. Establish integrated planning and assessment processes that promote health in community level policies and plans	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% to 90%.	Community Health Assessment	82% (2012)	*Available 2017*	*N/A*	
2. Increase access to nutritious and affordable foods	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% to 11.5%.	BRFSS	9.3% (2010)	18.9% (2013)	+	
	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% to 23.3%.	Pinellas County Schools	21.2% (2012-13)	*21.8% (2015-16)*	✓	
3. Increase access to safe opportunities for physical activity	1.2.5: By Dec 31, 2017, complete 15 transportation linkages in Pinellas through infrastructure and programming improvements. 1.2.6: 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% to 22%.	MPO BRFSS	0 (2012) 25.5 (2010)	*Not yet available* 27.7% (2013)	*N/A* -	This outcome is being addressed via improving County infrastructure of cycle and pedestrian safety as well as park and trail access. In addition, DOH-Pinellas is now maintaining a list of areas where the community can participate in free physical activity.

Revisions

After careful review of the goals, objectives, strategies and measures of the 2015-2016 CHIP action plans with community partners, revisions to the CHIP were recommended based on the following parameters:

- Measurability
- Connection to five-year CHIP objectives
- New opportunities for collaboration

Appendix 1 contains the revised CHIP as agreed upon by community partners.

Accomplishments

Highlighted below are accomplishments in two priority areas that include improvements in outcome data as well as activities that were met successfully during the 2015-16 CHIP implementation cycle.

ACCESS TO CARE

Goal: Provide equal access to appropriate health care services and providers.
Objective: 1.2.1: By Dec 31, 2017, increase the number of trained Community Health Workers (CHWs) in Pinellas by 25% over baseline.
Strategy: Develop and implement a standardized training program for Community Health Workers.

Accomplishment: The strategy for certifying community health workers was met. The Community Health Workers Coalition will continue certifying workers via curriculum used in Miami-Dade. The intended completion date is August 2017. We will continue to promote CHW certification and we're grateful for St. Pete College's partnership in this activity.

HEALTHY COMMUNITIES & ENVIRONMENTS
Goal: Establish integrated planning and assessment processes that promote health in community level policies and plans
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% to 90%.
Strategy: Include a public health component in community planning processes to increase awareness and opportunity of the built environment's impact on healthy behaviors.

Accomplishment: During the 2015-16 CHIP cycle, we connected with two cities – St. Petersburg and Largo – to introduce and provide education about the Health in All Policies approach. We are also using the CHIP to help educate other community decisionmakers about public health priorities in their areas.

Conclusion

The CHIP serves as a roadmap for continuous health improvement by providing a framework for the chosen strategic issue areas. It is not intended to be an exhaustive or static document. We will evaluate progress on an ongoing basis through quarterly CHIP implementation reports and quarterly discussion by community partners. Going forward, we will continue to conduct annual reviews and revisions based on input from partners and create CHIP annual reports each year.

The CHIP will continue to change and evolve over time as new information and insight emerge at the local, state and national levels. By working together, we can have a significant impact on the community's health, growing closer to our vision of *Healthier People in a Healthier Pinellas.*

Pinellas County CHIP: 2016-17
Access to Care

Goal	Strategy	Objective	Activity 2016-17	Process Measure 2016-17	Coordinating Agency	Partner Agencies	Outcome Measure(s)
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	Adults who had a medical checkup in the past year
	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/**				15% of identified CHWs have enrolled in or completed a standardized training
	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	CLC cohort completed

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	At least four new partnerships developed between social service and medical agencies in Pinellas County.
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	• Reduce teen pregnancy rates in Pinellas • Reduce teen STD rates in Pinellas • Reduced rate of low birth rate babies in sample group of FOFC • Decrease in child deaths
	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	Increase membership of the CAN and Hispanic Outreach Center. Reduce the number of infant deaths due to unsafe sleeping practices. Increase percentage of Pinellas mothers receiving prenatal care.

Pinellas County CHIP: 2016-17
Behavioral Health

Goal	Strategy	Objective	Activity 2016-17	Process Measure 2016-17	Coordinating Agency	Partner Agencies	Outcome Measure(s)
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	Increased integration among behavioral healthcare 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	200 health professionals educated on trauma-informed care principles 4 new organizations distributing Trauma-Informed Care materials
	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	Identify gaps in behavioral healthcare access.

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 Countil	Identify opportunities for policy change.
	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	Improved understanding of emerging designer drugs among youth and adults.
	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	More information available on NAS in Pinellas County.

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	Common screening policies/practices for violence and trauma
	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	Greater number of DOH-Pinellas staff educated on DV prevention and preventive practices.

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

Goal	Strategy	Objective	Activity 2016-17	Process Measure 2016-17	Coordinating Agency	Partner Agencies	Outcome Measure(s)
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)	Increased percentage of adults who report exercising regularly.
	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	Increased percentage of children who report exercising regularly. Increase number of children who report eating recommended daily values of fruits and vegetables.

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	Number of adults educated about the importance of colorectal cancer screening.
		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	Adults who have had a clinical breast exam
	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.	Reduce obesity rates and increase physical activity in Pinellas County adults Reduce diabetes prevalence.
		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	Increased number of students involved in SWAT Increase in the number of SWAT outreach activities

	2.3: Promote activities to reduce tobacco use and exposure in adults and youth.	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	Increased number of smoke free/tobacco free policies adopted Increased # of new partnerships
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, Faithbased Nursing, Medical associations 4. DOH-Pinellas Community Rec Centers/Municipalities	Increase the number of health care providers represented on PITCH 100% of Pinellas County providers will complete the training course Improve Pinellas County Schools Immunization Report Card scores by 10%

Pinellas County CHIP: 2016-17
Healthy Communities & Environments

Goal	Strategy	Objective	Activity 2016-17	Process Measure 2016-17	Coordinating Agency	Partner Agencies	Outcome Measure(s)
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	Health in All Policies approach codified in at least one city or county.
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	Adults at a healthy weight
	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)	Students at a healthy weight

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	Increased park attendance and trail use. Increase in adults and children reporting regular physical activity

PINELLAS COUNTY
COMMUNITY HEALTH IMPROVEMENT PLAN
ACCESS TO CARE UPDATE 2016

Access to Care Work Team

Thursday, July 21, 2016

1:30 p.m. - 3:30 p.m.

Florida Department of Health in Pinellas
Mid-County Health Department
Environmental Health Conference Room
8751 Ulmerton Road, Largo, FL 33771

AGENDA

1:30-1:45 p.m.	Welcome and Introductions	All
1:45-2:00 p.m.	CHA/CHIP Background & CHIP Status Report	Jocelyn Howard & Community Partners
2:00-2:30 p.m.	What's Changed?	All
2:30– 3:15 p.m.	CHIP Activity Update	All
3:15-3:30 p.m.	Next Steps/Wrap-up	Jocelyn Howard

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http://www.pinellaschat.com/

PINELLAS COUNTY

COMMUNITY HEALTH IMPROVEMENT PLAN

UPDATE 2016

CHAT/Access to Care Work Team

Thursday, July 21, 2016
1:30PM – 3:30PM

Florida Department of Health in Pinellas
Mid-County Health Department
8751 Ulmerton Road, Largo, FL 33771

MINUTES

Welcome & Introductions	Dr. Ulyee Choe

Jocelyn convened the meeting. She shared that this is the last action plan update for the current CHIP action cycle, which ends in 2017. Dr. Choe welcomed attendees and provided an overview of the upcoming CHNA process, which will start again at the end of this year. DOH-Pinellas received a grant from the Foundation for a Healthy St. Petersburg to complete a comprehensive health assessment; goals include 10,000 survey responses from community members that will provide zip code-level data. This data will serve as a supplement to the BRFSS survey, which has a sample size of only about 500 for Pinellas County.

Attendees then introduced themselves and answered the question, *"If you could know one thing about the community that you don't know now, what would it be?"*

- Alizza Punzalan-Randle, JHACH: What can we do to improve continuity of care for children – to better link medical and social resources?
- Mark Trujillo, UF IFAS: More specific data on fruit and vegetable consumption; for example, where do SNAP recipients buy their produce?
- Melissa Van Bruggen, DOH-Pinellas: What do patients want when it comes to health information technology? We often discuss this from a provider perspective but haven't necessarily asked patients.
- Marisa Pfalzgraf, DOH-Pinellas: How many providers are currently members of Direct Trust (a patient data-sharing program)?
- Curtis Holloman, Foundation for a Healthy St. Pete: Community data to help direct future Foundation goals.
- Dr. Choe: Improved method of selecting local priority areas, as well as better alignment towards reaching these goals.
- Lynda Leedy, JWB: Data that would allow us to target specific neighborhoods with interventions like teen pregnancy/infant mortality prevention, versus taking a blanket approach. Even though these issues are improving overall, some neighborhoods aren't seeing a change.
- Lisa Negrini: Ways to address disparities of resources that address infant mortality.
- Eliana Aguilar, DOH-Pinellas: Data about infant mortality and STDs on a zip code level, as well as inventory of peer education in these issue areas.
- Gayle Guidash: Better understanding of why ADAP patients with HIV have such poor pickup rates – is it transportation? Also information on code enforcement for healthy houses, which is currently difficult to collect because Pinellas has so many municipalities.
- Lori James, TBHC: Better understanding of the social determinants of health and how these affect access to care.
- Liz Winter, BayCare: Better collaboration overall, when it comes to data-sharing and services.
- Bob Costello, BayCare: A shared definition of primary care. Also, a more scientific way (cost-

savings, etc.) to identify priority areas; currently, this selection is very subjective. Finally, a better understanding of true predictors of health status: what can we address that will have the most overall impact (pyramid model)?

CHA/CHIP Background & Status Report	Jocelyn Howard

Jocelyn reviewed the MAPP model and CHA/CHIP process. The current CHIP ends in 2017, so the MAPP cycle will begin again this winter. DOH-Pinellas will be working to align with the local not-for-profit hospitals on future CHNAs, which the hospitals must also complete. Jocelyn's **PowerPoint presentation is attached to the minutes** and includes a report of CHIP objective data outcomes.

Three CHIP activities were highlighted: the Community Resource Bus (Access to Care 1.1.1), which recently received funding from the Foundation for a Healthy St. Pete. A program manager will be hired soon so that the program can expand its reach. Next, Lori James spoke about the Cultural & Linguistic Competency cohort, which also received Foundation funding. TBHC will be looking for five organizations to participate in the pilot program. Finally, Eliana Aguilar presented about the new Healthy Babies initiative, aimed at reducing infant mortality (Access to Care 3.1.1). **Handout attached**.

What's Changed? Activity	All

Each team took some time to brainstorm and record policy, funding, leadership, and other changes over the past year that might affect their Goal area. **'What's Changed?' results are attached in handout form**.

CHIP Update	All

Each group reviewed the 2015-16 CHIP action plan and determined whether to Adopt, Adapt, or Abandon these activities as well as brainstorm potential new activities for 2016-17. Attendees were asked to focus on measurability and on choosing outcome measures that linked activities to 5-year CHIP objectives. At the end of the update, each group submitted a proposed CHIP action plan for 2016-17. Jocelyn is doing individual follow up and will share these with the group by 8/5.

Community Partner Updates/Wrap-up	Jocelyn Howard

Alizza Punzalan-Randle of Johns Hopkins All Children's Hospital (JHACH) shared an update on their Community Health Needs Assessment, which was recently completed and can be viewed here: https://www.hopkinsallchildrens.org/community/in-the-community/community-health-needs-assessment

Bob Costello also shared an update on BayCare's needs assessment, which is in progress. It involves seven total assessments in the Pinellas/Hillsborough/Pasco areas. PRC, the consultant completing the research, collected 1700 community surveys. All data will be posted online by PRC at the end of the process.

Access to Care Work Team Sign-In Sheet
Pinellas County CHIP Update
July 21, 2016

INITIAL	NAME	ORGANIZATION	EMAIL
	Alisa Barksdale	American Diabetes Association	abarksdale@diabetes.org
	Alizza Punzalan-Randle	All Children's Hospital	Alizza.Punzalan-Randle@~~allkids.org~~ jhmi.edu
cannot attend	Carrie Hepburn	Tampa Bay Healthcare Collaborative	director@tampabayhealth.org
cannot attend	Cheryl Kerr	SPC	kerr.cheryl@spcollege.edu
	Christina Vongsyprasom	DOH-Pinellas	Christina.Vongsyprasom@flhealth.gov
cannot attend	Cindy McNulty	Healthy Start Coalition of Pinellas	cmcnulty@healthystartpinellas.org
	Curtis Holloman	Foundation for a Healthy St. Petersburg	curtis@healthystpete.foundation
cannot attend	Daphne Lampley	Operation PAR	dlampley@operpar.org
cannot attend	Denise Groesbeck	Juvenile Welfare Board	dgroesbeck@jwbpinellas.org
cannot attend	Denise Kerwin	SPC	kerwin.denise@spcollege.edu
	Dora Komninos	Domestic Violence Task Force	dluv122@aol.com
cannot attend	Edward Perry	211 Tampa Bay Cares	edwardp@211tampabay.org
	Eliana Aguilar	DOH-Pinellas	eliana.aguilar@flhealth.gov
	Elizabeth Rugg	Suncoast Health Council	erugg@thehealthcouncil.org
	Elizabeth Smith	DOH-Pinellas	elizabeth.smith@flhealth.gov
	Elizabeth Winter	BayCare	elizabeth.winter@baycare.org
cannot attend	Gary Hendrickson	USF Health	ghendric@health.usf.edu
	Gayle Guidash	DOH-Pinellas	gayle.guidash@flhealth.gov
	Joe Santini	Community Health Centers	jsantini@hcnetwork.org
	Kim Brasher	City of St. Petersburg	Kim.Brasher@stpete.org
	Kimberly Brown-Williams	Healthy Start Federal	Kbrownw1@jhmi.edu
	Lisa Negrini	Family Study Center - USFSP	lnegrini@usfsp.edu
	Lori James	Tampa Bay Healthcare Collaborative	manager@tampabayhealth.org
	Lounell Britt	Sanderlin Center	Lcbritt38@yahoo.com
	Lynda Leedy	JWB	lleedy@jwbpinellas.org
cannot attend	Maridelys Detres	Healthy Start Pinellas	mdetres@healthystartpinellas.org
	Marilyn Turman	PSTA	MTurman@psta.net

APPENDIX 4

INITIAL	NAME	ORGANIZATION	EMAIL
MP	Marisa Pfalzgraf	DOH-Pinellas	Marisa.Pfalzgraf@flhealth.gov
MT	Mark Trujillo	IFAS	MT@ufl.edu
	Mary Jo Plews	Healthy Start Coalition of Pinellas	mjplews@healthystartpinellas.org
MVB	Melissa Van Bruggen	DOH-Pinellas	melissa.vanbruggen@flhealth.gov
	Michelle Schaefer	Healthy Start Coalition of Pinellas	mtschaefer@healthystartpinellas.org
	Randy Russell	Foundation for a Healthy St. Petersburg	randy@healthystpete.foundation
	Ray Hensley	DOH-Pinellas	ray.hensley@flhealth.gov
	Robert Costello	BayCare	bob.costello@baycare.org
cannot attend	Stephanie Reed	Pinellas County Human Services	sreed2@pinellascounty.org
	Susan Easter	St. Petersburg Free Clinic	susan.easter@stpetersburgfreeclinic.org
UC	Dr. Ulyee Choe	DOH-Pinellas	ulyee.choe@flhealth.gov
	Quinn Lundquist	DOH-Pinellas	quinn.lundquist@flhealth.gov
	Liz Winter	BayCare	Elizabeth.Winter@baycare.org
	Bob Costello	BayCare	bob.costello@baycare.org
AW	Andrew Walker	Minority Health Coalition,	andydrewmwalker@gmail.com

"WHAT'S CHANGED?" ACTIVITY
Access to Care Work Group
Pinellas Community Health Improvement Plan Update 2016

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

- PSTA program: $1 Uber to nearest bus stop, available August 1st. Direct Connect partnership.
- Navigator program received continued funding
- Foundation for a Healthy St. Pete grant funding awarded
  - TBHC Cultural & Linguistic Competency pilot program
  - St. Petersburg Community Resource Bus program
- Telemedicine becoming more widely used – i.e. BayCare Anywhere

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

- Florida Department of Health in-house Health Information Exchange (HIE) to become active soon, which will facilitate information sharing between providers
- Need identified to investigate telemedicine opportunities
- Microsoft HealthVault free client portal to be used at FDOH
- Noted that USF Health and Pinellas County representatives were absent, though they've both reported updates on programming (offering direct support services at no charge for technical assistance with the new MACRA Quality Outcome payment models and connecting Family Support Initiative clients with primary care, respectively)

Goal AC 3: Reduce infant mortality and morbidity

- Florida Healthy Babies
  - New initiative led by FDOH, including the creation of a Healthy Babies task force
- Prevent Needless Deaths
  - Creation of Safe Sleep task force
- Figuring it Out for the Child
  - Coparenting intervention
  - continuing referrals
  - 1st time AA parents
  - Entering second year (of five) of an NIH study
- Infant Family Mental Health Center
  - USFSP and JHACH partnership
  - Serving 0-5 children and families
  - Focusing on support system for new moms, using a trauma-informed approach
  - Identifying determinants of health for children
- JHACH Resident's Program
  - Focus on toxic stress and trauma

APPENDIX 6

Healthy Pinellas Consortium Meeting

June 16, 2016

1:30 pm - 3:00 pm

LOCATION:

Mid-County Health Center

8751 Ulmerton Road, Largo

Outside Conference Room

VISION

To become one of the healthiest counties in Florida by creating a culture of health and wellness.

MISSION

Making the healthy choice the easy choice by encouraging policy, environmental and systems changes in the community

OBJECTIVE

The Healthy Pinellas Consortium aims to convene, connect and communicate through partnerships that leverage resources to establish healthy communities and programs. The purpose of the Consortium is to encourage children and adults in Pinellas County to choose active living and nutritious selections for a better future.

AGENDA

1:30 - 1:40	Welcome and Introductions
1:40 - 1:50	Review of Community Health Improvement Plan (CHIP)
1:50 - 2:50	Update CHIP Activities for 2016-17 (workgroups)
2:50 - 3:00	Announcements and Adjourn

2016 Meeting Schedule

Meetings to begin at 1:30pm

September 15, 2016 November 17, 2016

For more information, email Megan.Carmichael@flhealth.gov or call (727) 588-4040 ext. 3118

MEETING MINUTES

Healthy Pinellas Consortium

Pinellas Community Health Improvement Plan Update 2016

June 16, 2016

1:30 – 3PM – Mid County Health Department

Welcome and Introductions

- Megan Carmichael welcomed attendees and introduced Jocelyn Howard to lead CHIP update of the Health Promotion & Disease Prevention and Healthy Communities & Environments priority areas.

Review of Community Health Improvement Plan (CHIP)

- Jocelyn presented a PowerPoint update of CHIP activities and progress (PowerPoint attached).

- Attendees separated into goal workgroups based on their area of expertise. Each group conducted a "What's Changed?" brainstorming exercise to identify policy, program, and funding changes over the past year that impact CHIP goal areas (composite document attached). The three groups included:

    - Goal HCE 1 & 3: Establish integrated planning and assessment processes that promote health in community-level policies and plans; Increase access to safe opportunities for physical activity.

    - Goal HCE 2: Increase access to nutritious and affordable foods.

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

2016-2017 CHIP Activities (workgroups)

- Attendees reviewed current CHIP action plans and determined whether to adapt, adopt, or abandon action plan items from 2015-16.

Announcements and Adjourn

- Megan and Jocelyn will follow up with new draft action plans (attached) and request feedback from attendees.

"WHAT'S CHANGED?" ACTIVITY
Healthy Pinellas Consortium
Pinellas Community Health Improvement Plan Update 2016

Goal HCE 1 & 3: Establish integrated planning and assessment processes that promote health in community-level policies and plans; Increase access to safe opportunities for physical activity.

- Countywide transportation impact fees have changed to multi-modal fees, which means the money can be used for bike lanes, sidewalks, etc. instead of just roads.
- PICH Grant
  - Increased # of fitness zones
  - Wayfinding signs project
- More outdoor opportunities for activity
  - Courtney Campbell trail
  - Duke Energy trail connecting to Pinellas Trail
- St. Pete changed ordinance related to mobile produce and promoted healthy corner stores
- Increased access to healthy and affordable snacks at concession stands

Goal HCE 2: Increase access to nutritious and affordable foods.

- City of St. Pete
  - Leadership change
  - Small funding
  - Policy changes
    - Good Neighbor Store – corner store designation
    - Healthy Vending in partnership with American Heart Association
    - Mobile produce ordinance
- Dept. of Health
  - Bon Secours Health Partnership
    - SNAP $/Food & vegetable voucher program (needs additional funding to expand)
- American Heart Association
  - Local community health plan started
  - Staff to implement plan
  - Procurement policy/corporate food policy
- UF IFAS Extension
  - Funding to assist gardens
  - Technical assistance
  - Early Learning Coalition policy changes (HEPA standards)

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

- Pinellas County Schools
  - PE to be held daily (previously, only 3x per week)
  - Grant funding promoted healthy eating in middle school