Florida Department of Health in Pinellas County

COMMUNITY HEALTH IMPROVEMENT PLAN ANNUAL PROGRESS REPORT

2019

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Produced by:

Florida Department of Health

Pinellas County

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Introduction

The following is the annual review report for the 2018 – 2022 Pinellas County Community Health Improvement Plan (CHIP). Within this annual report are the summation of activities and collaborative efforts of the Florida Department of Health in Pinellas County and community partners. This document is a progress review of the strategies and activities that were developed implemented. The CHIP is a long-term systematic effort, which is essentially a community-driven and collectively owned health improvement plan. Thus, the primary role of the Florida Department of Health in Pinellas County is to provide administrative support, track and collect data, in addition to preparing the annual review report. At the convened Community Health Assessment Team (CHAT) meeting, there were 85 diverse groups of community partners, including state and local government agencies. Other partners represented were healthcare providers, local businesses, community groups, universities and school systems, non-profit organizations, advocacy groups, and a coalition of faith leaders; who worked together to develop and implement the 2018 CHIP. The discussion focused on identifying the sectors represented by the participants and what they considered to be the health priorities and concerns of the community. In the deliberation, the group agreed to recognize the main health priorities areas as access to care, behavioral health, and the social determinants of health. Furthermore, the health improvement plan should consider the impact of socioeconomic factors on health indicators while leveraging community partnerships to achieve the desires health outcomes.

Overview of CHIP and Annual Review Meeting

In October of 2018, the Department of Health in Pinellas County convened a meeting of the CHIP Planning Team. The Planning Team prioritized public health issues and identified resources to address them using the National Association of City and County Health Officials (NACCHO) Mobilizing for Action through Planning and Partnership (MAPP) to facilitate the CHIP process. The community stakeholders from diverse partner organizations consisting of subject matter experts utilized the four assessments of the MAPP process to improve health outcomes. Overall, the findings of the evaluation improve the efficiency, effectiveness, and performance of the public health system and provide a comprehensive view of health and quality of life in Pinellas County.

The Planning Team developed findings were presented to the Steering Committee. The Steering Committee comprised of a diverse leadership group representing 85 agencies and organizations in Pinellas County. The Steering Committee set priorities through a facilitated consensus-building process utilizing cross-cutting strategic issues emerging from the four assessments. The Steering Committee reached consensus on three health priority areas: Access to Care, Behavioral Health, and Social Determinants of Health. See the table below for the strategic issue areas and goals developed by the subject matter expert's work teams.

Over the next two years, DOH-Pinellas and the Community Health Action Team will lead Pinellas County in implementing the Community Health Improvement Plan. The community process to track the plan implementation includes scheduling four subcommittee quarterly and two general meetings. The meeting aim establishes a community process for the members to assess and revise the plan. To ensure reassessment and revision of the plan, subcommittee members provided progress updates for each activity quarterly. Also, the subcommittee members used feedback, data trend, and evaluations of activities to carry out the needed revisions. An example of notable changes to the plan included updates to the current status and targets of specific activities, the addition of new activities, and community partners. When members make a significant revision to the action plan, these revisions are noted and added to Appendix B of the CHIP. In general, the plan will be evaluated annually and updated as necessary to align with community resources, activities, and partnerships.

Strategic Issue Area	Goal
Access to Care	1. Prevent and control infectious disease 2. Improve access to comprehensive, high-quality, culturally responsive health care services for all. 3. Reduce infant and maternal mortality and morbidity, especially where disparities exist.
Behavioral Health	1. Promote behavioral health and well-being through a trauma-informed lens by ensuring access to culturally appropriate, quality mental health services through the lifespan.
Social Determinants of Health	1. Improve social and physical environments so that they promote good health for all.

2019 Progress and 2020 Revisions

Strategic Issue Area #1: Access to Care

Access to Care addresses the notion that reducing the barrier to health services such as medical care, dental care, and behavioral health care leads to decreased health care costs, good health, and improved health outcomes. Research data shows that health disparities, including difficulty with getting routine medical care because of cost, transportation, language barriers, or many other reasons, are directly linked to poor health outcomes.

Goal AC1: Improve access to comprehensive, high-quality, culturally responsive health care services for all.

Strategy AC 1.1: Increase the percentage of persons with health insurance coverage and/or a primary care provider.

Objective AC 1.1.1: By December 31, 2022, decrease the % of Pinellas adults who are unable to access a health care provider due to cost from 17% (2016) to 15%.

Key Partners: DOH-Pinellas, Community Health Centers of Pinellas, Pinellas County, TBHC, Bold Goal Health Collaborative

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.1.1	By December 31, 2022, decrease the % of Pinellas adults who are unable to access a health care provider due to cost from 17% (2016) to 15%.	17%		15%	12/31/22	▼	On Track
2020 Revisions							
"N/A"	"N/A"	"N/A"		"N/A"	"N/A"		
Rationale							
"N/A"							

Progress in 2019

Pinellas county community partners made enormous progress in 2019 towards the implementation of this CHIP objective increasing insurance enrollment events and promoting awareness of community resources, which helped residents to connect to needed services. The partners identified the top two of the largest underinsured communities and offered two enrollment events. Also, partners increase the utilization of the web-based community resources from 15, 525 to 18, 291. The objective progress is on track and is currently performing as expected.

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Access to Care* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #1: Access to Care

Goal AC1: Improve access to comprehensive, high-quality, culturally responsive health care services for all.

Strategy AC 1.2: Increase the percentage of persons with health insurance coverage and/or a primary care provider.

Objective AC 1.2.1: By December 31, 2021, decrease the % of Pinellas adults who are unable to access a health care provider due to cost from 17% (2016) to 15%.

Key Partners: CHAT-Access to Care, Chamber of Commerce, University of South Florida (USF), Free Clinics, Hospitals, Community Health Centers, Foundation for a Healthy St. Petersburg (FHSP)

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.2.1	By December 31, 2021, decrease preventable hospitalizations in under 65 from all conditions from 1,181.1 per 100,000 (2015-17) to 1,160 per 100,000	1,181.1 per 100,000		1,160 per 100,000	12/31/21	▼	Not Completed
2020 Revisions							
"N/A"	"N/A"	"N/A"		"N/A"	"N/A"		
Rationale							
"Removed"							

Progress in 2019

Pinellas county community partners made no progress in 2019 towards the implementation of this CHIP objective. The committee members elected to remove this objective as it did not fall within the current SMART goal for the health priority area. The committee placed this objective as a process measure in objective AC 1.1.1

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker

tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Access to Care* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #1: Access to Care

Goal AC 1: Improve access to comprehensive, high-quality, culturally responsive health care services for all.

Strategy AC 1.3: Increase the percentage of persons with health insurance coverage and/or a primary care provider.

Objective AC 1.3.1: By December 31, 2021, increase the administration of a financial impact analysis of improved health conditions from 0 to 1 biannually.

Key Partners: Community Health Centers of Pinellas, DOH-Pinellas, Healthy Start Coalition, Free Clinics

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.3.1	By December 31, 2021, increase the administration of a financial impact analysis of improved health conditions from 0 to 1 biannually	0	1	1	12/31/19	▲	Completed
2020 Revisions							
"N/A"	"N/A"	"N/A"		"N/A"	"N/A"		
Rationale							
"Removed"							

Progress in 2019

Pinellas county community partners made enormous progress in 2019 towards the implementation of this CHIP objective to increase the financial impact analysis of improved health outcomes. A committee partner completed an equity profile of Pinellas county and conducted a financial analysis report, resulting in a presentation to community groups. The committee achieved the target value and removed the objective.

There were no obstacles encountered in 2019 for this objective.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker

tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Access to Care* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #1: Access to Care

Goal AC1: Improve access to comprehensive, high-quality, culturally responsive health care services for all.

Strategy AC 1.3: Promote collaboration between health care, the business community, and community organizations to encourage innovative approaches to address health disparities among underserved and uninsured populations.

Objective AC 1.3.2: By December 31, 2019, increase the # of collaborative Access to Care interventions (i.e., agreements, MOUs, etc.) from 0 to 1.

Key Partners: CHAT-Access Community Health Centers, DOH-Pinellas, Hospitals, Free Clinics, Foundation for a Healthy St. Petersburg (FHSP)

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.3.2	By December 31, 2019, increase the # of collaborative Access to Care interventions (i.e., agreements, MOUs, etc.) from 0 to 1.	0	0	1	12/31/19	▲	Not Completed
2020 Revisions							
"N/A"	"N/A"	"N/A"		"N/A"	"N/A"		
Rationale							
"Removed"							

Progress in 2019

Pinellas county community partners made no progress in 2019 towards the implementation of this CHIP objective. The committee did not complete the associated activities; thus, the members elected to remove this objective as it did not fall within the current SMART goal for the health priority area.

The committee members removed the objective in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Access to Care* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #1: Access to Care

Goal AC1: Improve access to comprehensive, high-quality, culturally responsive health care services for all.

Strategy AC 1.2: Reduce the percentage of persons who are unable to obtain or delay in obtaining necessary and/or appropriate health care when they need it.

Objective AC 1.2.1: By December 31, 2022, increase the # of Community Health Workers by 20% of baseline.

Key Partners: Community Health Centers of Pinellas, DOH-Pinellas, Healthy Start Coalition, Free Clinics

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.4.1	By December 31, 2021, increase the # of Community Health Workers by 20% of baseline.	7	7	9	12/31/21	▲	Not on Track
2020 Revisions							
1.2.1	"N/A"	"N/A"		"N/A"	"N/A"		
Rationale							
"Removed"							

Progress in 2019

Pinellas county community partners made no progress in 2019 towards the implementation of this CHIP objective because there were few if any, opportunities to get Community Health Workers (CHWs) certified. The committee did not complete the associated activities; thus, the members elected to remove this objective as it did not fall within the current SMART goal for the health priority area.

The committee members changed the objective number from 1.4.1 to 1.2.1.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Access to Care* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #1: Access to Care

Goal AC 2: Reduce infant and maternal mortality and morbidity, especially where disparities exist.

Strategy AC 2.1.1: Promote the importance of prenatal care and being healthy prior to pregnancy, especially among disparate populations.

Objective AC 2.1.2: By December 31, 2022, increase the % of births to black mothers in Pinellas receiving 1st-trimester prenatal care from 70.5% (2017) to 75%.

Key Partners: DOH-Pinellas, Healthy Start Coalition**,** WIC & Nutrition.

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
2.1.1	By December 31, 2022, increase the % of births to black mothers in Pinellas receiving 1st-trimester prenatal care from 70.5% (2017) to 75%.	70.5%	300%	75%	12/31/22	▲	On Track
2020 Revisions							
"N/A"	"N/A"	"N/A"		"N/A"	"N/A"		
Rationale							
"N/A"							

Progress in 2019

Pinellas county community partners made enormous progress in 2019 towards the implementation of this CHIP objective to increase the percentage of births to black mothers in Pinellas receiving 1st-trimester prenatal care. The partners created a survey to measure the barriers among the target population. Also, partners distributed Healthy Start Resource Manual and marketing material available to black mothers in Pinellas receiving 1st-trimester prenatal care from a baseline of 30 to 96.

The progress made in this is exceeding expectations.

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to

DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Access to Care* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #1: Access to Care

Goal AC 2: Reduce infant and maternal mortality and morbidity, especially where disparities exist.

Strategy 2.2: Educate and promote awareness among community stakeholders about racial disparities in infant mortality.

Objective AC 2.1.2.: By December 31, 2022, increase the % of births to Hispanic mothers in Pinellas receiving 1st-trimester prenatal care from 76.6% (2017) to 77.9%.

Key Partners: DOH-Pinellas, Healthy Start Coalition, WIC & Nutrition.

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
2.1.2	By December 31, 2022, increase the % of births to Hispanic mothers in Pinellas receiving 1st-trimester prenatal care from 76.6% (2017) to 77.9%.	76.6%	300% of the baseline value	77.9%	12/31/21	▲	On Track
2020 Revisions							
"N/A"	"N/A"	"N/A"		"N/A"	"N/A"		
Rationale							
"N/A"							

Progress in 2019

Pinellas county community partners made enormous progress in 2019 towards the implementation of this CHIP objective to increase the percentage of births to Hispanic mothers in Pinellas receiving 1st-trimester prenatal care. The partners created a survey to measure the barriers among the target population. Also, partners distributed Healthy Start Resource Manual and marketing material available to Hispanic mothers in Pinellas receiving 1st-trimester prenatal care from a baseline of 30 to 96.

The progress made in this objective is exceeding expectations.

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to

DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Access to Care* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #1: Access to Care

Goal AC 2: Reduce infant and maternal mortality and morbidity, especially where disparities exist.

Strategy 2.2: Educate and promote awareness among community stakeholders about racial disparities in infant mortality.

Objective AC 2.2.1.: By December 31, 2022, reduce the black/white infant mortality gap from 2.2 (2015-17) to 2.0.

Key Partners: Healthy Start Coalition, Johns Hopkins All Children's Hospital, Tampa Bay Healthcare Collaborative (TBHC).

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
2.2.1	By December 31, 2022, reduce the black/white infant mortality gap from 2.2 (2015-17) to 2.0.	2.2%	75% of target value	2.0%	12/31/22	▼	On Track
2020 Revisions							
"N/A"	"N/A"	"N/A"		"N/A"	"N/A"		
Rationale							
"N/A"							

Progress in 2019

Pinellas county community partners made enormous progress in 2019 towards the implementation of this CHIP objective to reduce the black/white infant mortality gap. The partners created two social media content to highlight the racial disparities in health and infant mortality. Also, partners distributed and shared these two social media posts addressing racial disparities in health and infant mortality with community stakeholders from a baseline of 0 to 2. It is on track to complete to meet the target value.

The progress of the objective is performing as expected.

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker

tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Access to Care* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #1: Access to Care

Goal AC 2: Reduce infant and maternal mortality and morbidity, especially where disparities exist.

Strategy 2.3: Promote breastfeeding initiation and duration for all infants.

Objective AC 2.3.1.: By December 31, 2022, increase breastfeeding initiation for all infants from 80% (2018) to 83%.

Key Partners: Home visiting Programs, DOH-Pinellas, Healthy Start Coalition, Morton Plant Hospital.

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
2.3.1	By December 31, 2022, increase breastfeeding initiation for all infants from 80% (2018) to 83%.	80%		83%	12/31/22	▲	On Track
2020 Revisions							
"N/A"	"N/A"	"N/A"		"N/A"	"N/A"		
Rationale							
"N/A"							

Progress in 2019

Pinellas county community partners made enormous progress in 2019 towards the implementation of this CHIP objective to increase breastfeeding initiation for all infants. The partners set out to educate OB and pediatric providers about the health benefits of breastfeeding, and to increase the number of Maternal and Child Health (MCH) staff who become certified lactation counselors. Also, partners met the target of distributing Healthy Start Coalition's "breastfeeding brochures" to all 42 OB and 54 pediatric providers and conducting lactation counselor training for up to 20 MCH staff.

The progress of the objective is performing as expected.

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Access to Care* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #1: Access to Care

Goal AC 2: Reduce infant and maternal mortality and morbidity, especially where disparities exist.

Strategy 2.3: Promote breastfeeding initiation and duration for all infants.

Objective AC 2.3.1.: By December 31, 2022, increase breastfeeding initiation for all infants from 80% (2018) to 83%.

Key Partners: Tampa Bay Breastfeeding Task Force Pinellas Chapter (TBBF-Pinellas), DOH-Pinellas, Healthy Start Coalition, Chamber of Commerce, FBC, USF Research Team.

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
2.3.2	By December 31, 2022, increase breastfeeding duration for all infants from 26% (2018) to 30%	26%		30%	12/31/22	▲	On Track
2020 Revisions							
"N/A"	"N/A"	"N/A"		"N/A"	"N/A"		
Rationale							
"N/A"							

Progress in 2019

Pinellas county community partners made enormous progress in 2019 towards the implementation of this CHIP objective to increase breastfeeding duration for all infants. The partners set out to create and conduct a survey of employers in Pinellas to determine which employers meet or come close to achieving the "Breastfeeding Friendly Employer." Also, to increase the number of Pinellas employers that have lactation support programs. Survey creation and deployment are currently in progress.

The progress of the objective is performing as expected.

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Access to Care* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #2: Behavioral Health

Behavioral Health includes mental health, substance abuse, and violence among children and families. Mental disorders involve changes in thinking, mood, and behavior. Per the 2017 Pinellas Community Health Assessment, 12% of adults reported poor mental health in 14+ days out of the last 30 days. Mental health disorders can have a powerful effect on the health of individuals, their families, and their communities. Promoting and implementing prevention and early intervention strategies to reduce the impact of mental health disorders is vital for length and quality of life.

Substance abuse occurs when a person consumes in amounts or manner not otherwise prescribed by a medical professional. The misuse of alcohol, over-the-counter medications, illicit drugs, and tobacco also affect the health and well-being of millions of Americans. It is also a predictor of chronic disease and can sometimes increase the risk of someone contracting an infectious disease, such as hepatitis or HIV. In Pinellas County, the percentage of adults who are current smokers is 23.4%, there are 16.1 % of adults who abuse substances such as cocaine, heroin, methamphetamine, and 1 in 10 adults have abused prescription pain medication. The problems of violence among children and families, like those of substance abuse, mental health, negatively affect not only the individual but also the community at large. Furthermore, the neglect of behavioral health issues and violence goes unreported due to societal stigma and other barriers. A focus on behavioral health creates an opportunity to address these barriers and improve the community's overall health and quality of life.

Goal BH 1: Promote behavioral health and well-being through a trauma-informed lens, by ensuring access to culturally appropriate, quality mental health services through the lifespan.

Strategy 1.1: Increase education and awareness related to mental health and substance use.

Objective BH 1.1.1: By December 31, 2022, increase the # of community members participating in NAMI "Ending the Silence" presentations from 800 (2018) to 1,600.

Key Partners: Central Florida Behavioral Health Network (CFBHN), NAMI Pinellas, DOH, Pinellas, Local Universities & Colleges, Behavioral Health System of Care (BHSOC), Faith-Based Organizations.

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.1.1	By December 31, 2022, increase the # of community members participating in NAMI "Ending the Silence" presentations from 800 (2018) to 1,600	800	888	1600	12/31/22	▲	On Track
2020 Revisions							
"N/A"	"N/A"	"N/A"		"N/A"	"N/A"		
Rationale							
"N/A"							

Progress in 2019

Pinellas county community partners made enormous progress in 2019 towards the implementation of this CHIP objective to increase the # of community members participating in NAMI “Ending the Silence” presentations. The partners delivered the NAMI “Ending the Silence” presentations training to 888 participants from a baseline of 800 and is on track met the target value of 1600 participants by 2022.

The progress of the objective is performing as expected.

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Behavioral Health* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #2: Behavioral Health

Goal BH 1: Promote behavioral health and well-being through a trauma-informed lens, by ensuring access to culturally appropriate, quality mental health services through the lifespan.

Strategy 1.1: Increase education and awareness related to mental health and substance use.

Objective BH 1.1.2: By December 31, 2021, increase the # of trauma-informed communities from 1 (2018) to 3.

Key Partners: Peace4Pinellas Peace4Tarpon, University of South Florida St. Petersburg (USFSP), Trauma-Informed Congregations (Pastor Doug Walker).

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.1.2	By December 31, 2021, increase the # of trauma-informed communities from 1 (2018) to 3.	1	1	3	12/31/21	▲	***Not Completed***
2020 Revisions							
"N/A"	"N/A"	"N/A"		"N/A"	"N/A"		
Rationale							
"Removed"							

Progress in 2019

Pinellas county community partners made no progress in 2019 towards the implementation of this CHIP objective because there were few if any, opportunities to get work done with the trauma-informed communities. This objective has not been completed or met, and the target date has passed.

The committee members elected to remove this objective

The major obstacle was the inability to reach the trauma-informed community responsible agencies and contact persons before the expiration of the target date. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker

tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Behavioral Health* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #2: Behavioral Health

Goal BH 1: Promote behavioral health and well-being through a trauma-informed lens, by ensuring access to culturally appropriate, quality mental health services through the lifespan.

Strategy 1.1: Increase education and awareness related to mental health and substance use.

Objective BH 1.1.2: By December 31, 2022, reduce the proportion of drug-related accidental deaths from 2.2% (2016) to 1.5%.

Key Partners: Pinellas County Opioid Task Force (PCOTF), Pinellas County Human Services, Drug-Free America Foundation, Operation PAR.

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.1.2	By December 31, 2022, reduce the proportion of drug-related accidental deaths from 2.2% (2016) to 1.5%.	2.2%	100%	1.5%	12/31/22	▼	On Track
2020 Revisions							
"N/A"	"N/A"	"N/A"		"N/A"	"N/A"		
Rationale							
"N/A"							

Progress in 2019

Pinellas county community partners made enormous progress in 2019 towards the implementation of this CHIP objective to reduce the proportion of drug-related accidental deaths from 2.2% (2016) to 1.5%. The partners Increased the frequency and modality of information shared with the public by bridging the gap and ensuring at least a member of the community resented by their membership of the CHAT is present in Pinellas County Opioid Task Force (PCOTF) meetings to improve interaction and information exchange. Also, the partners met the target value from a baseline of 0 to 14 meetings for the objectives. The committee members added new activity that promotes education on how to access and use free NARCAN.

The progress of the objective is performing as expected.

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Behavioral Health* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #2: Behavioral Health

Goal BH 1: Promote behavioral health and well-being through a trauma-informed lens, by ensuring access to culturally appropriate, quality mental health services through the lifespan.

Strategy 1.2: Engage targeted at-risk populations to better understand behavioral health needs.

Objective BH 1.2.1: By December 31, 2022, reduce the Pinellas suicide rate from 18.1 (2015-17) to 17.0.

Key Partners: JWB, BHSOC, Zero Pinellas, DOH-Pinellas, Council of Neighborhood Associations (CONA) Pinellas County Schools, CHAT-Behavioral Health, BHSOC, Law Enforcement, First Responders, Local Business Owners, Churches United for Healthy Congregations (CUFHC), Boys & Girls Club.

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.2.1	BH 1.2.1: By December 31, 2022, reduce the Pinellas suicide rate from 18.1 (2015-17) to 17.0.	18.1%	50%	17.0%	12/31/22	▼	On Track
2020 Revisions							
"N/A"	"N/A"	"N/A"		"N/A"	"N/A"		
Rationale							
"N/A"							

Progress in 2019

Pinellas county community partners made enormous progress in 2019 towards the implementation of this CHIP objective to reduce the Pinellas suicide rate from 18.1 (2015-17) to 17.0. The partners connected with local leaders to hold or help coordinate at least six public forums surrounding mental health by Dec. 2021. Also, the partners met 50 % of the target value from a baseline of 0 to 3 out of 6 public forums activities scheduled for the objective.

The committee members are making progress in the action to promote and increase mental health first aid training offered to teachers, law enforcement, first responders, and community members to promote mental wellness and reduce the suicide rate.

The progress of the objective is performing as expected.

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Behavioral Health* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #2: Behavioral Health

Goal BH 1: Promote behavioral health and well-being through a trauma-informed lens, by ensuring access to culturally appropriate, quality mental health services through the lifespan.

Strategy 1.2: Engage targeted at-risk populations to better understand behavioral health needs.

Objective BH 1.2.2: By December 31, 2022, increase the number of establishments offering universal mental health screenings by 10% from baseline.

Key Partners: JWB, BHSOC, Zero Pinellas, DOH-Pinellas, Council of Neighborhood Associations (CONA) Pinellas County Schools, CHAT-Behavioral Health, BHSOC, Law Enforcement, First Responders, Local Business Owners, Churches United for Healthy Congregations (CUFHC), Boys & Girls Club.

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.2.2	BH 1.2.2: By December 31, 2022, increase the number of establishments offering universal mental health screenings by 10% from baseline.	Baseline	PHQ 9 = 59,030 CSSR =75, 265	10% from baseline	12/31/22	▲	On Track
2020 Revisions							
"N/A"	"N/A"	"N/A"		"N/A"	"N/A"		
Rationale							
"N/A"							

Progress in 2019

Pinellas county community partners made enormous progress in 2019 towards the implementation of this CHIP objective to increase the number of establishments offering universal mental health screenings by 10% from baseline. Also, the partners added the additional activities of identifying the at-risk youth and adult population to target for mental health needs and substance use disorder needs.

The committee members are making progress towards increasing the number of establishments offering universal mental health screenings because it now has 22 establishments 10 of these are sharing the requested data with the following numbers of screen performed: PHQ 9 = 59,030. CSSR =75, 265

The progress of the objective is performing as expected.

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Behavioral Health* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #2: Behavioral Health

Goal BH 1: Promote behavioral health and well-being through a trauma-informed lens, by ensuring access to culturally appropriate, quality mental health services through the lifespan.

Strategy 1.3: Connect individuals to effective and affordable behavioral health treatment.

Objective BH 1.3.1: By December 31, 2021, reduce the Crisis Stabilization Unit (CSU) rate of readmission within 30 days from 12% (2018) to 10%.

Key Partners: Suncoast Centers, Directions for Living, Local CSUs, Hospitals

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.3.1	By December 31, 2021, reduce the Crisis Stabilization Unit (CSU) rate of readmission within 30 days from 12% (2018) to 10%.	12		10	12/31/21	▼	Not Completed
2020 Revisions							
"N/A"	"N/A"	"N/A"		"N/A"	"N/A"		
Rationale							
"Removed"							

Progress in 2019

Pinellas county community partners made no progress in 2019 towards the implementation of this CHIP objective because there were few if any, opportunities to reduce the Crisis Stabilization Unit (CSU) rate of readmission within 30 days from 12% (2018) to 10%. This objective has not been completed or met.

The committee members elected to remove this objective

The committee did not have the capacity and opportunities to implement the objectives. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Behavioral Health* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #2: Behavioral Health

Goal BH 1: Promote behavioral health and well-being through a trauma-informed lens, by ensuring access to culturally appropriate, quality mental health services through the lifespan.

Strategy 1.3: Connect individuals to effective and affordable behavioral health treatment.

Objective BH 1.3.1: By December 31, 2022, expand access to Mobile Crisis Response Team for ages 25 and younger by 10% from baseline.

Key Partners: Suncoast, PEMHS, Suncoast Center, Directions for Living, Local CSUs, Hospitals

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.3.1	By December 31, 2022, expand access to Mobile Crisis Response Team for ages 25 and younger by 10% from baseline	300	300	330	12/31/22	▲	On Track
2020 Revisions							
"N/A"	"N/A"	"N/A"		"N/A"	"N/A"		
Rationale							
"N/A"							

Progress in 2019

Pinellas county community partners made enormous progress in 2019 towards the implementation of this CHIP objective to expand access to the Mobile Crisis Response Team for ages 25 and younger by 10% from baseline. Also, the partners performed activities that increased access to the Mobile Crisis Response Team and thus increased the number of people served by it.

The committee members are making progress in expanding access to the Mobile Crisis Response Team for ages 25 and younger by 10% from baseline. The committee established a baseline of 300, and the target set as 330.

The progress of the objective is performing as expected.

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Behavioral Health* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #2: Behavioral Health

Goal BH 1: Promote behavioral health and well-being through a trauma-informed lens, by ensuring access to culturally appropriate, quality mental health services through the lifespan.

Strategy 1.3: Connect individuals to effective and affordable behavioral health treatment.

Objective BH 1.3.2: By December 31, 2022, increase the number of Memorandums of Understanding (MOUs) between behavioral health providers by 10% of baseline.

Key Partners: Operation PAR, PEMHS, Suncoast Center, Directions for Living, BHSOC, JWB, DOH-Pinellas, Pinellas County.

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.3.2	By December 31, 2022, increase the number of Memorandums of Understanding (MOUs) between behavioral health providers by 10% of baseline	Baseline		10% from baseline	12/31/21	▲	On Track
2020 Revisions							
"N/A"	"N/A"	"N/A"		"N/A"	"12/31/22"		
Rationale							
Members identified the need to change the target date.							

Progress in 2019

Pinellas county community partners made enormous progress in 2019 towards the implementation of this CHIP objective to increase the number of Memorandums of Understanding (MOUs) between behavioral health providers by 10% of the baseline. Also, the partners performed activities helped to determine existing formal agreements/MOUs between behavioral health providers in Pinellas and to facilitate the completion of MOU between behavioral health providers. Besides, members identified the need to change the target date from 12/31/21 to 12/31/22.

The baseline number for formal agreements/MOUs between behavioral health providers in Pinellas was determined to be 12.

The progress of the objective is performing as expected.

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Behavioral Health* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #2: Behavioral Health

Goal BH 1: Promote behavioral health and well-being through a trauma-informed lens, by ensuring access to culturally appropriate, quality mental health services through the lifespan.

Strategy 1.3: Connect individuals to effective and affordable behavioral health treatment.

Objective BH 1.3.3: By December 31, 2022, increase the number of Supplemental Social Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR) evaluations administered by 10% of baseline.

Key Partners: PEMHS, Pinellas County Human Services, Suncoast Center, Directions for Living, BHSOC.

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.3.3	By December 31, 2022, increase the number of Supplemental Social Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR) evaluations administered by 10% of baseline.	Baseline		10% from baseline	12/31/21	▲	On Track
2020 Revisions							
"N/A"	"N/A"	"N/A"		"N/A"	"12/31/22"		
Rationale							
Members identified the need to change the target date from 12/31/21 to 12/31/22.							

Progress in 2019

Pinellas county community partners made enormous progress in 2019 towards the implementation of this CHIP objective to increase the number of Supplemental Social Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR) evaluations administered by 10% of baseline. Also, the partners performed activities that Identified baseline for the number of SOAR evaluations conducted in Pinellas and plan to train more providers in SOAR evaluation administration. Besides, members identified the need to change the target date from 12/31/21 to 12/31/22.

The progress of the objective is performing as expected.

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Behavioral Health* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #2: Behavioral Health

Goal BH 1: Promote behavioral health and well-being through a trauma-informed lens, by ensuring access to culturally appropriate, quality mental health services through the lifespan.

Strategy 1.4: Improve coordination between community stakeholders and partners to encourage innovative approaches to address substance use and behavioral health needs.

Objective BH 1.4.1: By June 30, 2019, increase the annual review of existing groups working to address mental health and/or substance use needs from 0 to 1/year.

Key Partners: JWB, BHSOC, DOH-Pinellas, Pinellas County, CHAT-Behavioral Health.

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.4.1	By June 30, 2019, increase the annual review of existing groups working to address mental health and/or substance use needs from 0 to 1/year.	0	1	1	06/30/19	▲	Completed
2020 Revisions							
"N/A"	"N/A"	"N/A"		"N/A"	"N/A"		
Rationale							
"Removed"							

Progress in 2019

Pinellas county community partners made enormous progress in 2019 towards the implementation of this CHIP objective to increase the annual review of existing groups working to address mental health and/or substance use needs from 0 to 1/year. This objective has been completed or met.

The committee members elected to remove this objective

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, *CHAT Tracker*. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to

DOH-Pinellas by individual committee members. The department operationalized The *CHAT Tracker* tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Behavioral Health* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #2: Behavioral Health

Goal BH 1: Promote behavioral health and well-being through a trauma-informed lens, by ensuring access to culturally appropriate, quality mental health services through the lifespan.

Strategy 1.4: Connect individuals to effective and affordable behavioral health treatment.

Objective BH 1.4.2: By December 31, 2021, increase the number of formal collaborations (e.g., agreement, MOU, action plan, etc.) focused on mental health and/or substance use needs by 10% of baseline.

Key Partners: Health in All Policies (HiAP) Action Team: Foundation for a Healthy St. Petersburg (FHSP), City of St. Petersburg, City of Pinellas Park, Pinellas County Government.

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.4.2	By December 31, 2021, increase the number of formal collaborations (e.g., agreement, MOU, action plan, etc.) focused on mental health and/or substance use needs by 10% of baseline	Baseline		10% from baseline	12/31/21	▲	Not Completed
2020 Revisions							
"N/A"	"N/A"	"N/A"		"N/A"	"N/A"		
Rationale							
"Removed"							

Progress in 2019

Pinellas county community partners made no progress in 2019 towards the implementation of this CHIP objective. The lack of progress is because there were few, if any, opportunities to increase the number of formal collaborations (e.g., agreement, MOU, action plan, etc.) focused on mental health and/or substance use needs by 10% of baseline. This objective has not been completed or met.

The committee members elected to remove this objective

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Behavioral Health priority* area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #3: Social Determinants of Health

The social determinants of health are defined by the Centers for Disease Control and Prevention (CDC) as conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes. Some of these conditions are but not limited to Income, housing, neighborhood safety, or quality education. Research shows that the effects of health disparities are glaring in communities with poor social determinants of health (SDOH) such as poor housing conditions, unsafe neighborhoods, low income, and substandard education. Evidence-based practice suggests that poverty limits access to healthy foods and affordability of safe neighborhoods and having a higher level of education is a positive predictor of better health outcomes. It is essential to address conditions of poor SDOH to facilitate improved individual and population health in addition to advancing health equity. Additionally, there is an imperative to address SDOH in our community because this creates social and physical environments, which promote good health for all.

Goal SDH 1: Improve social and physical environments so that they promote good health for all.

Strategy 1.1: Educate, train, engage, and empower stakeholders to increase understanding of social determinants and catalyze community action to address health inequities.

Objective SDH 1.1.1: By December 31, 2022, increase the # of organizations identified and trained in Social Determinants of Health/Health Equity from 12 to 20.

Key Partners: Health in All Policies (HiAP) Action Team: Foundation for a Healthy St. Petersburg (FHSP), City of St. Petersburg, City of Pinellas Park, Pinellas County Government.

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.1.1	By December 31, 2021, increase the # of agencies identified and trained in Social Determinants of Health/Health Equity from 0 to 12.	0	12	12	12/31/21	▲	Completed
2020 Revisions							
1.1.1	By December 31, 2022, increase the # of organizations identified and trained in Social Determinants of Health/Health Equity from 12 to 20.	12		20	12/31/22		
Rationale							
Members identified the need to be inclusive by using “Organizations,” increase the target value and increase the target date.							

Progress in 2019

Pinellas county community partners made enormous progress in 2019 towards the implementation of this CHIP objective to increase the # of organizations identified and trained in Social Determinants of Health/Health Equity from 12 to 20. Also, partners identified a baseline of 12 partner organizations who received training on Social Determinants of Health/Health Equity. Members identified the need to be inclusive by using “Organizations,” instead of “Agencies” and also increased the target from 0 to 12 to “12 to 20” and increase the target date.

The progress of the objective is performing as expected.

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Social Determinants of Health* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #3: Social Determinants of Health

Goal SDH 1: Improve social and physical environments so that they promote good health for all.

Strategy 1.1: Educate, train, engage, and empower stakeholders to increase understanding of social determinants and catalyze community action to address health inequities.

Objective SDH 1.1.2: By December 31, 2022, increase the # of organizations identified and trained in Social Determinants of Health/Health Equity from 0 to 12.

Key Partners: Unite Pinellas, DOH-Pinellas, FHSP, CHAT-Social Determinants, City of St. Pete, City of Pinellas Park, Pinellas County Government.

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.1.2	By December 31, 2022, increase the # of trusted thought leaders outside of the CHAT engaged around issues related to health equity and social determinants from 0 to 12.	0	4	12	12/31/22	▲	On Track
2020 Revisions							
"N/A"	"N/A"	"N/A"		"N/A"	"N/A"		
Rationale							

Progress in 2019

Pinellas county community partners made enormous progress in 2019 towards the implementation of this CHIP objective to increase the # of trusted thought leaders outside of the CHAT engaged around issues related to health equity and social determinants from 0 to 12. This objective is on track. Also, there are additional activities in this objective that are still in progress, including setting up focus groups/town hall meetings engage the community in a conversation about needs and barriers; the committee has done three out of five focus groups. Besides, the committee also worked on engaging leaders on issues related to health equity and social determinants through 1:1 or group encounters; the current status is four rounds of discussions conducted towards the target of 12.

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Social Determinants of Health* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #3: Social Determinants of Health

Goal SDH 1: Improve social and physical environments so that they promote good health for all.

Strategy 1.2: Increase formal collaboration across multiple sectors, especially between those whose work has an impact on the health of Pinellas residents.

Objective SDH 1.2.1: By December 31, 2022, increase the # of formal collaborations (i.e., agreements, MOUs, etc.) focused on youth and/or aging populations from 0 to 1.

Key Partners: Moffitt Cancer Center Tobacco Prevention Program**,** Area Agency on Aging, Pinellas County Government, Neighborly Care Network, Pinellas Opportunity Council, Gulf Coast Jewish Family Community Services, Florida Blue, Bay Care, DOEA, other CBOs, and municipalities.

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.2.1	By December 31, 2021, increase the # of formal collaborations (i.e., agreements, MOUs, etc.) focused on youth and/or aging populations from 0 to 1	0	75%	1	12/31/21	▲	On Track
2020 Revisions							
"N/A"	By December 31, 2022, increase the # of formal collaborations (i.e., agreements, MOUs, etc.) focused on youth and/or aging populations from 0 to 1	"N/A"		"N/A"	"12/31/22"		
Rationale							
Members identified the need to increase the target date from 12/31/21 to 12/31/22.							

Progress in 2019

Pinellas county community partners made enormous progress in 2019 towards the implementation of this CHIP objective to increase by December 31, 2022, the # of formal collaborations (i.e., agreements, MOUs, etc.) focused on youth and/or aging populations from 0 to 1. The members identified the need to increase the target date from 12/31/2021 to 12/31/2022.

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Social Determinants of Health* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #3: Social Determinants of Health

Goal SDH 1: Improve social and physical environments so that they promote good health for all.

Strategy 1.2: Increase formal collaboration across multiple sectors, especially between those whose work has an impact on the health of Pinellas residents.

Objective SDH 1.2.2: By December 31, 2022, increase the # of formal collaborations (i.e., agreements, MOUs, etc.) focused on youth and/or aging populations from 0 to 1.

Key Partners: Cohort of Champions-Director of Urban Affairs, DOH-Pinellas, FHSP, TBHC, Suncoast Health Council.

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.2.2	By December 31, 2021, increase # of formal collaborations (i.e., agreements, MOUs, etc.) focused on the working-age population from 0 to 1	0		1	"12/31/21"	▲	On Track
2020 Revisions							
"N/A"	By December 31, 2022, increase # of formal collaborations (i.e., agreements, MOUs, etc.) focused on the working-age population from 0 to 1	"N/A"		"N/A"	12/31/2022		
Rationale							
Members identified the need to increase the target date from 12/31/21 to 12/31/22.							

Progress in 2019

Pinellas county community partners made enormous progress in 2019 towards the implementation of this CHIP objective to increase # of formal collaborations (i.e., agreements, MOUs, etc.) focused on the working-age population from 0 to 1. Besides, the committee worked on a # of goals/priorities identified for each initiative in the database; the current status is 13 out of 14 # of goals/priorities met. Also, more work is needed to complete the activity aimed at finalizing a formal agreement between at least two entities. The committee addressed health equity in the working-age group, defined as ages 18 to 64. The members identified the need to increase the target date from 12/31/2021 to 12/31/2022.

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Social Determinants of Health* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #3: Social Determinants of Health

Goal SDH 1: Improve social and physical environments so that they promote good health for all.

Strategy 1.3: Create sustainable structures and mechanisms that integrate health and equity considerations across local government plans and processes.

Objective SDH 1.3.1: By December 31, 2022, increase the # of Pinellas government entities that will agree to consider addressing health and equity in policies through a formalized adoption process (i.e., Resolution, Executive Order) from 0 to 5.

Key Partners: Health in All Policies (HiAP) Action Team.

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.3.1	By December 31, 2021, increase the # of Pinellas government entities that will agree to consider addressing health and equity in policies through a formalized adoption process (i.e., Resolution, Executive Order) from 0 to 3.	0	4	3	12/31/21	▲	On Track
2020 Revisions							
"N/A"	By December 31, 2022, increase the # of Pinellas government entities that will agree to consider addressing health and equity in policies through a formalized adoption process (i.e., Resolution, Executive Order) from 0 to 5.	0		5	12/31/22		
Rationale							
Members identified the need to increase the target value from three to five and target date 12/31/2021 to 12/31/2022.							

Progress in 2019

Pinellas county community partners made enormous progress in 2019 towards the implementation of this CHIP objective to increase the # of Pinellas government entities that will agree to consider addressing health and equity in policies through a formalized adoption process (i.e., Resolution, Executive Order) from 0 to 5. The current status is four out of five # of local governments met, three out of five # of local representatives approached, and three out of five CHA data presented to at least one representative of each chosen government entity. The members identified the need to increase the target date from 12/31/2021 to 12/31/2022 and the target value from three to five.

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Social Determinants of Health* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Strategic Issue Area #3: Social Determinants of Health

Goal SDH 1: Improve social and physical environments so that they promote good health for all.

Strategy 1.3: Create sustainable structures and mechanisms that integrate health and equity considerations across local government plans and processes.

Objective SDH 1.3.2: By December 31, 2022, increase the # of Pinellas government entities that have adopted a "Health in All Policies" framework from 0 to 5.

Key Partners: Health in All Policies (HiAP) Action Team.

2019 Performance							
Objective Number	**Objective**	**Baseline**	**Performance**	**Target Value**	**Target Date**	**Trend[1]**	**Status[1]**
1.3.2	By December 31, 2021, increase the # of Pinellas government entities that have adopted a "Health in All Policies" framework from 0 to 3.	0	3	3	12/31/21	▲	On Track
2020 Revisions							
1.3.2	By December 31, 2022, increase the # of Pinellas government entities that have adopted a "Health in All Policies" framework from 0 to 5	0		5	12/31/22		
Rationale							
Members identified the need to increase the target value and target date.							

Progress in 2019

Pinellas county community partners made enormous progress in 2019 towards the implementation of this CHIP objective to increase the # of Pinellas government entities that have adopted a "Health in All Policies" framework from 0 to 5. Besides, the committee worked to improve the # of policies, programs, and projects planned. The current status is three out of five the # of policies, programs, and projects designed and 32 out of 36 # of mapped processes and health and equity insertions into policies, programs, plans, or projects. The members identified the need to increase the target date from 12/31/2021 to 12/31/2022 and the target value from three to five.

There were no obstacles encountered in 2019 for this objective. The committee members made no revisions to the objectives in 2019.

How Targets Were Monitored

This target is monitored internally and updated using the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. Progress updates to the database is provided by the partner organizations, responsible agency, and contact person assigned to the objective or sent directly to DOH-Pinellas by individual committee members. The department operationalized The CHAT Tracker tool using a summary of data formatted in an excel spreadsheet scorecard made available to the *Social Determinants of Health* priority area members.

Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address any problems arising from the CHIP implementation and directly monitors the CHIP performance measures as part of the regular quarterly PMC review meetings.

Trend and Status Descriptions

***Trend Descriptions:**

- ▲ = Data trend is upward and in the desired direction for progress
- ▼ = Data trend is downward and in the desired direction for progress
- ▲ = Data trend is upward and in the undesired direction for progress
- ▼ = Data trend is downward and in the undesired direction for progress

****Status Descriptions:**

- **On Track** = Objective progress is exceeding expectations or is performing as expected at this point in time
- **Not on Track** = Objective progress is below expectations at this point in time
- **Decision Required** = Objective is at risk of not completing/meeting goal. Management decision is required on mitigation/next steps.
- **Completed** = Objective has been completed or has been met and the target date has passed
- **Not Completed** = Objective has not been completed or has not been met and the target date has passed

New Objectives

New Objective Number	New Objective	Baseline	Target Value	Target Date
AC 1.2.1	By December 31, 2021, decrease preventable hospitalizations in under 65 from all conditions from 1,181.1 per 100,000 (2015-17) to 1,160 per 100,000	1,181.1 per 100,000	1,160 per 100,000	12/31/21
New Objective Rationale				
The committee members elected to remove this objective as it did not fall within the current SMART goal for the health priority area. The committee placed this objective as a process measure in objective AC 1.1.1				

New Objective Number	New Objective	Baseline	Target Value	Target Date
AC 1.3.1	By December 31, 2021, increase the administration of a financial impact analysis of improved health conditions from 0 to 1 biannually	0	1	12/31/21
New Objective Rationale				
The committee achieved the target value and removed the objective.				

New Objective Number	New Objective	Baseline	Target Value	Target Date
AC 1.3.2	By December 31, 2019, increase the # of collaborative Access to Care interventions (i.e., agreements, MOUs, etc.) from 0 to 1.	0	1	12/31/19
New Objective Rationale				
The members elected to remove this objective as it did not fall within the current SMART goal for the health priority area.				

New Objective Number	New Objective	Baseline	Target Value	Target Date
AC 1.4.2 changed to AC 1.2.1	By December 31, 2021, increase the # of Community Health Workers by 20% of baseline.	7	9	12/31/21
New Objective Rationale				
There were few, if any, opportunities to get Community Health Workers (CHWs) certified. The committee did not complete the associated activities; thus, the members elected to remove this objective				

New Objective Number	New Objective	Baseline	Target Value	Target Date

BH 1.1.2	By December 31, 2021, increase the # of trauma-informed communities from 1 (2018) to 3.	1	3	12/31/21

New Objective Rationale

There were few if any, opportunities to get work done with the trauma-informed communities because of the inability to reach the trauma-informed community responsible agencies and contact persons before the expiration of the target date

New Objective Number	New Objective	Baseline	Target Value	Target Date
BH 1.3.1	By December 31, 2021, reduce the Crisis Stabilization Unit (CSU) rate of readmission within 30 days from 12% (2018) to 10%.	12	10	12/31/21

New Objective Rationale

There were few, if any, opportunities to reduce the Crisis Stabilization Unit (CSU) rate of readmission within 30 days from 12% (2018) to 10%. This objective has not been completed or met. The committee members elected to remove this objective. The members did not have the capacity and opportunities to implement the objective.

New Objective Number	New Objective	Baseline	Target Value	Target Date
BH 1.3.2	By December 31, 2022, increase the number of Memorandums of Understanding (MOUs) between behavioral health providers by 10% of baseline	Baseline	10% of baseline	12/31/22

New Objective Rationale

Members identified the need to change the target date from 12/31/21 to 12/31/22.

New Objective Number	New Objective	Baseline	Target Value	Target Date
BH 1.3.3	By December 31, 2022, increase the number of Supplemental Social Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR) evaluations administered by 10% of baseline	Baseline	10% of baseline	12/31/22

New Objective Rationale

Members identified the need to change the target date from 12/31/21 to 12/31/22.

New Objective Number	New Objective	Baseline	Target Value	Target Date
BH 1.4.2	By December 31, 2021, increase the number of formal collaborations (e.g., agreement, MOU, action plan, etc.) focused on mental health and/or substance use needs by 10% of baseline	Baseline	10% of baseline	12/31/21

New Objective Rationale

There were few if any, opportunities to increase the number of formal collaborations (e.g., agreement, MOU, action plan, etc.) focused on mental health and/or substance use needs by 10% of baseline. This objective has not been completed or met. The committee members elected to remove this objective.

New Objective Number	New Objective	Baseline	Target Value	Target Date
SDH 1.1.1	By December 31, 2022, increase the # of organizations identified and trained in Social Determinants of Health/Health Equity from 12 to 20.	12	20	12/31/22

New Objective Rationale

Members identified the need to be inclusive by using "Organizations" in place of "agencies." Also, to increase the target value of 12 to 20 and increase the target date from 12/31/21 to 12/31/22.

New Objective Number	New Objective	Baseline	Target Value	Target Date
SDH 1.2.1	By December 31, 2022, increase the # of formal collaborations (i.e., agreements, MOUs, etc.) focused on youth and/or aging populations from 0 to 1	0	1	12/31/22

New Objective Rationale

Members identified the need to increase the target date from 12/31/21 to 12/31/22.

New Objective Number	New Objective	Baseline	Target Value	Target Date
SDH 1.2.2	By December 31, 2022, increase # of formal collaborations (i.e., agreements, MOUs, etc.) focused on the working-age population from 0 to 1	0	1	12/31/22

New Objective Rationale

Members identified the need to increase the target date from 12/31/21 to 12/31/22.

New Objective Number	New Objective	Baseline	Target Value	Target Date
SDH 1.3.1	By December 31, 2022, increase the # of Pinellas government entities that will agree to consider addressing health and equity in policies through a formalized adoption process (i.e., Resolution, Executive Order) from 0 to 5.	0	5	12/31/22

New Objective Rationale

Members decided to increase the target value from three to five and target date 12/31/2021 to 12/31/2022.

New Objective Number	New Objective	Baseline	Target Value	Target Date
SDH 1.3.2	By December 31, 2022, increase the # of Pinellas government entities that have adopted a "Health in All Policies" framework from 0 to 5	0	5	12/31/22

New Objective Rationale

Members decided to increase the target value from three to five and target date 12/31/2021 to 12/31/2022.

Accomplishments

Goal	Objective	Accomplishment
Promote behavioral health and well-being through a trauma-informed lens, by ensuring access to culturally appropriate, quality mental health services through the lifespan	By December 31, 2022, reduce the Pinellas suicide rate from 18.1 (2015-17) to 17.0.	In 2019, community members identified additional stakeholders for partnership, held mental health and substance abuse public forums, and mental health first aid training.

Why This Accomplishment is Important for Our Community

Behavioral health encompasses mental health and substance use disorders. Mental health is an integral part of overall health, i.e., emotional, psychological, and social well-being. Mental disorders such as anxiety and depression involve changes in thinking, mood, or behavior. Substance abuse describes a pattern where a person consumes a substance in amounts or ways not approved by medical professionals. Pinellas County initiatives addressed behavioral health and suicide by promoting mental health awareness campaigns, utilizing a trauma-informed lens, tackling adverse childhood experiences (ACEs), preventing the misuse of alcohol, drugs, and tobacco, and developing culturally appropriate care through a life span.

The short-term impact of the initiatives increased community engagement in mental health conversations, decreased the stigma, and improved behavioral healthcare-seeking behaviors. Also, we believe that these initiatives in the long-term will mitigate the suicide rate.

The initiative is working in Pinellas County because of the multi-sector engagement from behavior health, healthcare, law enforcement, social services, academia, community-based organizations, and faith leaders. We held a listening section attended by over 200 participants and vendors, followed by two behavioral public forums held in high-risk neighborhoods with community members leading the “speak up” sessions. Also, partners organized mental health first aid training for teachers, law enforcement, first responders, and community members.

Clinically, we increased the number of establishments offering universal mental health screenings. We have 22 establishments; 10 of these are sharing the requested data with the following amounts of screen performed: Patient Health Questionnaire PHQ 9 – which objectifies and assesses the degree of depression and identify who is at risk for depression = 59,030. Columbia- Suicide Severity Rating Scale – which queries about suicidal ideation, behavior, and improves the specificity of screening CSSR =75, 265. These primary and secondary screens are part of the suicide risk identification process that leads to the success of the initiatives in our community.

Goal	Objective	Accomplishment
Improve social and physical environments so that they promote good health for all	By December 31, 2022, increase the # of Pinellas government entities that have adopted a “Health in All Policies” framework from 0 to 5.	In 2019, Pinellas County completed several process mapping, health, and equity considerations inserted into a government entity's policies, programs, plans, and projects.

Why This Accomplishment is Important for Our Community

The physical and social environments that promote good health for all are part of the social determinants of health. By definition, these determinants are conditions in the places where people are born, live, learn,

work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. A positive social determinant contributes to good health or to improving health while a negative social determinant has the opposite effect, causes, or contributes to ill health. The public health problem addressed is the health impact of inequalities, inequities, and negative social determinants of health in Pinellas County.

The initiative used to solve the problem is the Health in All Policies (HiAP). The HiAP is an approach to improving the health of all people by incorporating health considerations into decision-making across sectors. HiAP brings together decision-makers from local County and city governments and community partners to collaboratively develop policies, programs, and services that promote health for all county and city residents.

We used the HiAP initiative to address the problem of adverse social determinants of health by restructuring existing and proposed County and city development policies so that all factors contributing to the health and well-being of all community members considered. Thus, regardless of the socioeconomic status or zip code where people live, work, learn and play, HiAP improves the health of all people by incorporating health considerations into decision-making across sectors and policy areas so that the most accessible choice becomes the healthy choice.

The initiative is working in Pinellas County because community partners approach local governments, city councils, and mayors with a completed Health impact assessment. For example, Pinellas Park City Council unanimously approved Resolution No. 19-20, which recognizes the data and recommendations provided by the HiAP team's health impact assessment (HIA) on the remediation of potential brownfields sites in the City of Pinellas Park. Brownfields are sites that create environmental issues, be they vacant, inhabited, abandoned or in use, due to either their current use, past use, or the ecological problems of the site. Besides, brownfields blight neighborhoods create a perception of danger, pose health risks such as cancer, heart disease, lung diseases such as asthma, and poor maternal health from contaminants, which decreases property value contributing to negative social determinants of health. Also, Pinellas County will continue to advocate for more city councils to adopt HiAP into all policies, programs, plans, or projects. This policy position will eliminate the improper placement of polluting facilities in low-income neighborhoods and communities of color through a careful consideration of the impact policies have on health inequalities and exacerbation of health inequities.

Conclusion

The CHIP serves as a health compass for a continuous health improvement process for the local public health system by providing a framework for the chosen strategic health priority areas. By design, the CHIP document is iterative and thus not an exhaustive and static text. We will evaluate progress on an ongoing basis through quarterly CHIP implementation reports and quarterly discussion by community partners. We will assemble quarterly updates, conduct annual reviews, and provide revisions based on input from partners in addition to creating the CHIP annual reports by February of each year. The CHIP will continue to change and evolve to meet the community needs as new information and insight emerge at the local, state, and national levels.

Through the CHIP public-private partnership and collaboration, we can have a significant impact on the community's health by improving where we live, work, and play. These efforts will allow us to realize the vision of a healthier Pinellas County.

Appendices

Appendix A: Annual CHIP Review Meeting Agenda

Florida Department of Health in Pinellas County
Annual CHIP Review Meeting
Center for Health Equity, 2333 34th Street South St. Petersburg, FL 33711
Meeting Location Room Main Event Hall
February 25th, 2020, 2:00 p.m. – 4:00 p.m.

AGENDA

Purpose:
Annual CHIP Review Meeting to monitor implementation of the CHIP, review and assign action plans, and recognize practices with improved performance.

	Topic	Lead
1:45 - 2:00	Arrival and Networking	**Dr. Nosakhare Idehen**
2:00 - 2:05	Introduction	**Christopher Gallucci**
2:05 - 2:10	Welcome to the Equity Center	**Marcus Brooks**
2:10 - 2:15	Keynote Welcome	**Dr. Ulyee Choe**
2:15 - 2:25	Community Health Update	**Christopher Gallucci**
2:25 - 2:40	CHIP Overview	**Dr. Nosakhare Idehen**
2:40 - 3:00	Social Determinants of Health: Census 101	**Corey A. Gray**
3:00 - 3:10	Break	**Dr. Nosakhare Idehen**

2020 1st Quarter Update on the Priority Health Areas: Access to Care Behavioral Health Social Determinants of Health		
3:10 - 3:15	CHIP Framework Refresher	**Christopher Gallucci**
3:15 - 3:50	CHIP Implementation Updates: • Provide Status Updates/CHAT Activity Tracker • Update Objectives, Activities, Process Measures, and Indicators	**Subcommittees**
3:50 - 4:00	Next Steps, Group Feedback/Questions, and Wrap-Up: • Upcoming Community Events • Adjourn	**Christopher Gallucci / Dr. Nosakhare Idehen**

CHAT/CHIP Contact Info

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Appendix B: Sign-in Sheet

Florida Department of Health in Pinellas County
Annual CHIP Review Meeting
Center for Health Equity, 2333 34th Street South St. Petersburg, FL 33711
Meeting Location Room Main Event Hall
February 25th, 2020, 2:00 p.m. – 4:00 p.m.
Sign-In Sheet

Purpose:
Annual CHIP Review Meeting to monitor implementation of the CHIP, review and assign action plans, and recognize practices with improved performance.

***Members**

Position	In Attendance	Position	In Attendance
Health Officer (Chair)	Dr. Ulyee Choe	Accreditation Liaison	Christopher Gallucci
Executive Management Team		QI Plan Lead	Shanya Turner
Assistant Director of Health	Gayle Guidash	Strategic Plan Lead	Shanya Turner
Executive Comm Health Nursing Director	Elizabeth Smith	CHIP Lead	Dr. Nosakhare Idehen
Health Services Manager	Valerie Lee		
HiAP Program Manager	Heath Kirby		

**Note: A quorum of two-thirds of members is required.*

Attendees *(e.g., community partners, additional CHD staff)*

Name	Organization	Name	Organization
Cory Gray	Pinellas Co.Planning Dept	Caitlin Murphy	Pinellas County
Vecelia Johnson	Wellcare	Jodi M Groth	Pinellas County Human Services
Daphne Green	City of Pinellas Park	Kimberly R. Williams	AdventHealth
Kimberlee Leslie	BayCare	Damia Kelly	Directions for Living
Dayle VanderWerff	Phoenix House	Donna Marley	St. Pete College
Laurie Elbow	Suncoast Center	Bobbie Hudson	Pinellas County Sheriff Office
Daphne Lampley	Operation PAR	Jason Martino	Area Agency on Aging
Dr. Sheron Brown	Tampa Bay Healthcare Collab.	Jo Dee Nicosia	CFBHN
Denise Whitfield	NAMI	Joe Santini	Comm. Health Centers of Pinellas
H. Miller	Pinellas County	Cherry Kerr	St. Pete College Human Services
Lisa Ullven	Guilded Results LLC	Sarah Miller	CFBHN

Appendix C: Minutes

Department of Health in Pinellas County
Annual CHIP Review Meeting
Center for Health Equity, 2333 34th Street South St. Petersburg, FL 33711
Meeting Location Room Main Event Hall
February 25th, 2020, 2:00 p.m. – 4:00 p.m.
Minutes

Speaker	Topic	Discussion
Dr. Nosakhare Idehen	Arrival and Networking	Dr. Idehen received the community members and CHD staff at the door, asked them to sign the attendance sign-in sheet, and take a seat in the meeting hall with the tables arranged according to the different health priority areas: Access to Care, Behavioral Health, and Social Determinants of Health. Also, he encouraged the attendees to use this time to network, meet other community partners that they have not previously met, and learn about the member and the organization that they represent.
Christopher Gallucci	Introduction	Mr. Christopher Gallucci formally welcomed all attendees to the Annual CHIP Review Meeting. He directed their attention to the agenda, the CHAT Activity Tracker, and the health priority area-specific CHIP Implementation worksheet on their tables. Besides, Mr. Gallucci went over a few housekeeping rules. He introduced Mr. Marcus Brooks, the Community Impact Manager at the Foundation for a Healthy St. Petersburg, to provide a welcome to the Equity Center.
Marcus Brooks	Welcome to the Equity Center	Mr. Brooks welcomed all attendees to the Foundation for a Healthy St. Petersburg, the Equity Center, which they call Idea space. He stated that the center opened in 1987 but just moved months ago to this new facility on the South Side of town. Mr. Brooks noted that the Foundation for a Healthy St. Petersburg is a private foundation working with the communities of Pinellas County to eradicate inequality, achieve health equity, and improve population health. The Foundation serves as a social innovation that inspires and empowers people, organizations, ideas, and relationships to incubate solutions, which ensure that every person equitably reaches optimal health and well-being. Besides, addressing health equity for all speaks to complete health: Mental

Speaker	Topic	Discussion
		Physical Environmental Enjoyment Stress containment Also, he stated that the Equity Center Idea space provides the open space, bring together open minds and facilitate the platform for collaboration across Multi-Sector Public, Private, Faith, Nonprofit Open Hearts and Minds Speakers Who Inspire Beyond Diversity Provide Data Build Capacity Invest in Policy Evaluate Listen Learn To end differences in health due to social or structural disadvantages and to improve population health. We do this through: inspiring people, ideas, information exchange, multi-sector organizations, and relationships. Finally, he oriented the attendees to amenities available at the center, wished everyone a successful CHAT meeting, and agreed to make himself available at the end of the meeting for a facility tour for interested members.

Speaker	Topic	Discussion
Dr. Ulyee Choe	Keynote Welcome	Dr. Ulyee Choe, the Health officer, director, and Chair of the Executive Management Team, started by welcoming all community partners and CHD staff who have worked tirelessly throughout the year to implement the Pinellas County CHIP. The director reminded the group to always focus on the conditions that make a healthy community. A community is where all residents have access to: • Quality Education • Safe and Healthy Homes • Adequate Employment • Transportation • Physical Activity, and Nutrition • Quality Health Care and Health Equity. He noted that according to the County Health Ranking, 40% of the factors that determine health outcomes is the social and economic factor. Furthermore, he stated that one of the three health priorities for the CHIP should be the Social determinants of health. The conditions in the environments in which people are born, live, learn, work, play, worship, and age. These SDOH conditions affect a wide range of health, functioning, and quality-of-life outcomes and risks. Also, Dr. Choe stated that the Department of Health in Pinellas continues to use the Mobilizing for Action through Planning and Partnerships (MAPP) process to assess the public health issues in the community and identify resources to address them. He referenced the four contiguous counties of Pasco, Pinellas, Polk, and Hillsborough that formed the CHNA Collaborative and the current health priority of mental health, which is also one of the three health priorities in Pinellas CHIP. In the Area of Access to care, the Dept continues to work collaboratively with community partners to man the resource bus hosted in different at-risk communities to increase awareness and utilization of available healthcare resources at the CHD and other community organizations. Dr. Choe thanked all attendees and encouraged them to work diligently to implement the CHIP goals and objectives to accomplish the vision of *Healthier People in a Healthier Pinellas.*

Speaker	Topic	Discussion
Christopher Gallucci	Community Health Update: • Item 1: VA suicide prevention/access to care • Item 2: Mental health/ Substance abuse forum • Item 3: Presentation of primary survey data and qualitative responses to mental health and opioid forum.	Mr. Gallucci started with a vote of thanks, Mr. Marcus Brooks, and the Foundation for a Healthy St. Pete for providing us with this space. He noted that the foundation had done a lot for our community, and we cannot thank them enough for the valuable services they provide to our community members, as well as the support they provide to the department of health in Pinellas. Also, Mr. Gallucci, thank Dr. Choe, the Director of Health for leading the charge for the CHAT, his passion for the social determinants of health, Adverse Childhood Experiences (ACEs), Health equity, and mental health issues in the community. Furthermore, he thanks all attendees for coming today, and for their continued engagement and valued feedback. Mr. Gallucci noted that the goals of the meeting, which includes the CHIP annual review, to share progress on our CHIP, and to network and share information since collaboration is essential to our public health mission. He emphasized that the dept cannot do this alone; that is why this community health action team is an invaluable platform and an excellent opportunity to engage and update one another on the current CHIP goals and future areas of collaborations. Furthermore, Mr. Gallucci provided updates on action items from the last meeting, which include the presentation from community partners: Melissa Hall, a suicide prevention coordinator, from Bay Pines regarding suicide prevention initiatives and Bay Pine's efforts towards Access to care. Besides, Mr. Gallucci stated that the group also heard from Dr. Bohn, deputy director of the DrPH program at USF, who talked about his initiative, which culminated in the 2019 Pinellas Mental Health and Substance Use Action Forum. He went further to describe how Dr. Bohn presented primary survey data and qualitative responses to the forum regarding mental health and the opioid crisis, which an emerging public health problem in our county and across the country.

Speaker	Topic	Discussion
		Mr. Gallucci shared some exciting news with the group, starting with the department's health in all policies (HiAP) initiative that is underway (funded by the Foundation for a Healthy St. Pete) in collaboration with the city of St. Pete, Pinellas park, and Pinellas County government. He noted that the HiAP initiative uses a public health 3.0 design by taking a policy approach to public health, which can induce downstream systemic change, rather than the individual approach through clinical services or patient education. Adding that effort to collaborate with City's council governments lead to resolutions that will incorporate HIAs into current and future policies, plans, projects, and programs. In a collaboration between the dept, NACCHO, and the foundation for a healthy St. Pete, the dept will host the HiAP national conference in February or January 2021. According to Mr. Gallucci, the focus isn't just to highlight and brag about the work the department is doing in Pinellas County, but it's a way to discuss our best practice processes. The HiAP initiative is a relatively new concept that doesn't have a lot of precedents or best practices to guide the process. The department will use our experience to inform others and provide a roadmap for setting up HiaP in our agencies Besides, he stated that Pinellas would be a best practice model that others across the country can potentially adopt. The HiAP initiative is groundbreaking stuff that will put our County in the national spotlight as public health moves towards this 3.0 model. Mr. Gallucci cautioned that the department is still in the planning stages, so he wanted to gauge interest within this room to see who would be interested in Pinellas County hosting the HiAP national conference? Most of the attendees raised their hands. Besides, he noted that NACCHO would be sending out a poll on our behalf so the department can estimate numbers since it needs to choose a venue based on expected attendance.

Speaker	Topic	Discussion
		Next, Mr. Gallucci welcomed Dr. Nosakhare Idehen, the CHA | CHIP Coordinator, to the podium.
Dr. Nosakhare Idehen	CHIP Overview	Dr. Idehen thanked Mr. Gallucci, and once again welcomed all attendees to the meeting. Beginning his overview, he displayed the logo for the Pinellas County Community Health Action Team (CHAT). He used the opportunity to welcome the community members who were joining the group for the first time and others who returned after a long time of absence. He informed everyone that the CHAT forum is a working group of DOH-Pinellas and community stakeholders. Members of the group Dr. Idehen noted include state and local government agencies, healthcare providers, local businesses, and community groups. Besides, the group also includes universities and school systems, non-profit organizations, advocacy groups, and a coalition of faith leaders working together to address health problems and health disparities in Pinellas county. Next, Dr. Idehen displayed the image of the Pinellas County Community Health Improvement Plan (CHIP) ***Published December 2018 *** Revision 1.1. He stated that the publication is a 5-year CHIP that sets out goals for Pinellas County public health system, which is an action plan and road map document to build a healthier community. Also, he reiterated the three Health Priority Areas of the CHIP: Access to Care, Behavioral Health & Substance Abuse, Social Determinants of Health. Noting for much of 2019, the CHAT Meetings have leaned in heavily on Behavioral Health & Substance Abuse. Besides, the CHAT forum will continue to do so in our Involvement with community partners, and the Community Health Needs Assessment, otherwise known as the "*Collaborative*." According to Dr. Idehen, the group in much of 2019 has worked to reduce the stigma associated with mental health and substance abuse that prevents people from seeking appropriate care. Thus, he stated that "any stigma still

Speaker	Topic	Discussion
		connected with mental illnesses or substance addiction continues to prevent people from life-saving treatment options." Also, Dr. Idehen pointed out that the progress made in 2019 in addressing behavioral health objectives were made possible due to the collaboration with several partner agencies, including • NAMI – National Alliance on Mental Illness • CFBHN – Central Florida Behavioral Health Network • PCOTF – Pinellas County Opioid Task Force • Operation PAR – Operation Parental Awareness and Responsibility • JWB – Juvenile Welfare Board • PEMHS – Personal Enrichment through Mental Health Services (PEMHS) • BHSOC – Behavioral Health Systems of Care • Bold Goals Behavioral Health and Faith Initiatives • Directions for living • Phoenix House • Vincent House • Suncoast Center • Zero Suicide group Dr. Idehen also highlighted another area of success in 2019 as the formation of the CHNA "Collaborative" with the moniker "All4healthFL". The collaborative consists of Pasco, Pinellas, Polk, Hillsborough counties to present a united front of "Four Counties, One Vision," pulling resources together to address health priorities in the contiguous counties. One such joint health issue is Behavioral Health (Mental Health & Substance Abuse). Some of the activities receiving attention are Mental Health First Aid Training and raising awareness about Adverse Childhood Experiences (ACEs). Addressing a second health priority, Dr. Idehen talked about the social determinants of health as those conditions in places where people are born, live, learn, work, play, worship, and age, which impacts health outcomes. Some of the most critical SDOH are housing, social services, geographical location, and education. He explained that the W.H.O. created its commission on SDOH

Speaker	Topic	Discussion
		in 2005-2008 to address the social factors that lead to ill-health and health inequities. Thus, in the CHIP we tackled SDOH in 2019 in the following ways: • Economic stability – employment, food insecurity, housing, and poverty • Education – early childhood, high school, higher education, and literacy • Social and community context – voting, census count, discrimination and incarceration • Health and health care- access to care and health literacy • Neighborhood and built environment – clean housing, safe neighborhood, crime and violence Dr. Idehen talked about the relationship between social determinants of health and health equity. He opined that the leading cause of health inequity is the gap in socioeconomic factors and other inequalities. He gave examples of these indicators as systemic and structural racism, income and wealth disparity, housing, employment, education, transportation, physical and social environment, and unequal access to healthcare resources. Besides, he noted that individual behaviors, such as smoking, diet, alcohol, and drugs, are undoubted causes of health inequities but only to the extent that these factors are caused by precipitating drivers of the SDOH. As an illustration, he pointed to examples in the CHIP where activities were in progress to address the SDOH factors. • SDOH 1.1.2: Set up town hall meetings to engage the community in the conversation about needs and barriers • SDOH 1.2.1: Initiate at least one priority project surrounding youth population • SDOH 1.3.2: Conduct process mapping and insert health and equity consideration into department decision-making processes Addressing the relationship between health policies and the social determinants of health, Dr. Idehen explained to the group that health policies influence what the community can achieve with the CHIP by impacting: SES, social and

Speaker	Topic	Discussion
		physical environment, behaviors, ease of access and use of medical services. As an illustration, he gave examples of how *regulatory health policies* help to standardize and control types of behavior any group of people may carry out. Another example is *allocative health policies,* which relate to cost-shifting between the states and commonwealth, or public and private sectors or between the well-off and the needy members of society to meet the public-good objectives. In conclusion, Dr. Idehen noted that the task before the community members is to use the objectives and activities laid out in the CHIP to address the three priority areas so that, in the end, we can create a society in which all people live long, healthy lives. Dr. Idehen stated that in line with the tradition to promote open communication and create opportunities for sharing and networking amongst all of the CHAT community partners, the next speaker would expand on the connection of social policy and funding. Precisely, his presentation highlights how the 2020 Census will shape funding for many socioeconomic programs, including healthcare programs in our community for the next decade. Dr. Idehen welcomed Mr. Corey Gray, a planner in the Pinellas County Planning Department, who coordinates the 2020 Census Effort for Pinellas County to the podium.
Corey A. Gray	Social Determinants of Health: Census 101	Mr. Corey thanked Dr. Idehen for allowing him to address the community partners about the 2020 Census. Then, he asked the audience what they've heard about the census. The audience gave several responses. Also, he asked a rhetorical question why does the U.S Constitution mandate having a count every ten years? Mr. Gray said he would address this and a few other issues in the course of the presentation. • Why we take a census and why it matters to our local community • How to fill out the census form • Why you shouldn't be afraid to be counted in the census • How you can help the census bureau spread the word.

Speaker	Topic	Discussion
		Mr. Gray stated that the census is a 10-year "Roll Call." A count of the U.S. population, and a snapshot of population characteristics. Besides, America gets one chance each decade to count its population. Census data determines everything from seats in U.S. Congress to billions in federal funding for local programs. Getting an accurate count in Pinellas County for the 2020 U.S. Census is critical for our community. On the question of why centers matter to the community, Mr. Gray opined that The United States determines political representation across its 50 states by getting an accurate count of the population. That's why the U.S. Constitution empowers the government to conduct an official count of the population every ten years to ensure fair representation. Besides, population changes documented in the census also drive redistricting: that is, revising the geographic boundaries where people elect their representatives, from U.S. House of Representatives down to city council. Furthermore, Mr. Gray noted that like voting, taking the census is a civic duty. Also, it is crucial to remember that census data also determines how the federal gov distributes billions in funding. Mr. Gray explained the funding tied to census count more, stating that in 2016, Florida received more than $44B through 55 top federal programs that are guided by census data, according to a study by George Washington University. Also, he stated that census population data help guide everything from affordable housing grants to federal highway projects, and many other programs in the social determinants of health priority area in Pinellas county CHIP. The population count of communities, counties, and state directly impacts funding for local programs - billions of dollars are at stake Mr. Gray discussed a host of SDOH programs that are funded and guided by census data: • WIC, SNAP & other assistance programs

Speaker	Topic	Discussion
		• Public transit & highway projects • Head Start & school meal programs • Medicaid, Medicare Part B & children's health insurance • Affordable housing & community development • Federal Pell Grants & education programs The census, according to Mr. Gray, is conducted by the federal government through the U.S. Census Bureau. The agency sends out invitations to take the census online. Census takers will go door to door for those who don't respond. Also, he added that the Pinellas County Local Complete Count Committee are trusted local leaders in government, non-profits, agencies, and the business community. The goal of this committee he added, was to encourage everyone in Pinellas County to take the census by explaining why it matters to the community. Furthermore, the timeline for the census starts in March when the bureau Census Bureau will send every household in America an invitation to respond online. Everyone will receive a mail inviting them to complete the poll online three times, if no response, then before an enumerator shows up at your door, most likely around May. Mr. Gray reminded everyone that the 2020 census is the nation's first online census. Still, for those who may have concerns about filling out the survey online, or who don't have reliable internet access, there are other ways to take it. He noted that households that do not complete the online census after the initial mailing would automatically receive a paper questionnaire in their

Speaker	Topic	Discussion
		mailbox. There is also a 1-800 number for those who need any unique accommodation. He opined that the preferred method for taking the count is online; there is a paper form and over the phone options. Mr. Gray also acknowledged that some specific communities have historically experienced undercounting, and help is needed from community members to change the status quo. Also, he pointed out that the community partners should encourage the youth population in their 20s is among the groups less likely to complete the census. Mr. Gray spoke to the fears people have about completing the form. He stated that answering all or any question is voluntary. The form asks these questions: • First/last name of people in the house • Sex, age & race/ethnicity • Number of people in the house (including babies) • Homeowner or renter He stressed that there is no question about citizenship. Besides, he added that the goal of the count is just to get an accurate headcount and some basic demographic information. Mr. Gray revisited the challenges of the undercounted communities and stated that these are census tracts with a low self-response rate during the 2010 census. Overall, Pinellas County had a 76% response rate – that is, 76% of residents mailed back their survey. These undercounted communities generally had a response of 70% or less, which means 30% or more of residents did not respond.

Speaker	Topic	Discussion
		Due to the challenges with undercounted communities, the Complete Count Committee consists of diverse voices from around Pinellas County who know how much the census means to our community. Mr. Gray also stated that another way this census 101 is necessary and relevant to the goals of Pinellas CHIP is that it creates temporary jobs for community members that offer: • Weekly Pay • Flexible Hours • Paid Training • Pay starts at $17 an hour in Pinellas! Finally, he encouraged everyone to visit the PinellasCensus.org Census2020@pinellascounty.org and find ways to collaborate with the Pinellas Complete Count Committee so that together, we can make Pinellas count.
Dr. Nosakhare Idehen	Break	Dr. Idehen thanked Mr. Gray for the very informative discussion about the census count, drawing the link between social policies, funding, and the ability of community partners to deliver on the CHIP goals. Besides, Dr. Idehen was excited that the census offered jobs to community members, stating that we just don't go and ask community members to take the survey, fill out this form, and call them to participate in events. Still, it is a great day when we can go to them with jobs, money in their pocket to improve the conditions in the places where they are born, live, work, play and pray – their SDOH. Dr. Idehen informed everyone about taking a 10 minutes bio break and that upon return, Mr. Christopher Gallucci will guide the group into the CHIP implementation updates by an initial refresher of the overall CHIP framework.
Christopher Gallucci	CHIP Framework Refresher	Mr. Gallucci welcomed everyone back from the break. Speaking of A CHIP framework refresher, he noted how Dr. Idehen and himself gave a lecture to students in the MPH program regarding the CHIP/CHA process and the creation of goals, strategies, and objectives. Mr. Gallucci noted that what they found is that those engaged in public health typically take for

Speaker	Topic	Discussion
		granted that not many people have a clear idea of what these terms mean, and often get confused. He observed that the biggest challenge to creating these plans is the understanding of the terminologies, which then acts as a barrier to writing and brainstorming within the groups. In their experience with the MPH students, Mr. Gallucci further explained the students and their professors struggled a lot with the public health industry jargon. Adding that after helping the students develop their own goals, strategies, and objectives for their semester projects, he and Dr. Idehen successfully helped the students to eliminate some confusion. Also, he hoped that going over the CHIP refresher today will similarly be beneficial to this group. Mr. Gallucci explained that: • Priority Health Areas - challenges we want to address in the community • Goal – Defines the desired result - the direction • Strategy – The method used to accomplish the goal • Objective - The concrete steps taken with the strategy, SMART, data Furthermore, he gave examples, including one that used a baseball analogy: Goal: To become a professional baseball player in the MLB Strategy: Improve athletic performance Objective 1: Increase the number of strikeouts thrown in one season from 50 to 75 by September 2020. Activity: Increase the number of pitching practice sessions from 75 to 100 Measure: # of practice sessions Objective 2: Reduce the number of days of reported shoulder pain by 30% by October 2020 through Activity: Participate in physical therapy

Speaker	Topic	Discussion
		Measure: # of physical therapy sessions per month Activity: Daily stretching of shoulder Measure: # of days stretched Finally, Mr. Gallucci encouraged everyone to split into the three respective health priority area groups and discuss with one another current activities and progress in reaching the objective. Besides, committee members can recommend updates, make changes, edits, set the target date, or value higher, remove an activity entirely, and add new activities as desired. Facilitators were on hand to help each group as needed.
Subcommittees	CHIP Implementation Updates: Update on the Priority Health Areas: Access to Care Behavioral Health Social Determinants of Health • Recognition of Improved Performance • Provide Status Updates/ CHAT Activity Tracker • Updates objectives, Activities, Process Measures, and Indicators	Committee members led this session. Members were actively engaged, deliberated, and recognized practices that resulted in improved performance and high performers meeting targets. The members removed some objectives, changed others, added new activities, changed a few target values, and target dates. At the end of the subcommittee breakout session, the groups handed over the completed worksheet to Dr. Idehen.
Christopher Gallucci	Next Steps, Group Feedback/Questions, and Wrap-Up: Upcoming Community Events	Mr. Gallucci stated that the next steps begin with Dr. Idehen updating the CHAT Tracker and CHIP with the recommendations. He encouraged members to continue to send activity updates, target value metrics, and all other information through emails, direct phone calls to the department, and also through the responsible agency/contact person for the activity.

Speaker	Topic	Discussion
		He took questions from by members, provided a wrap-up, and announced upcoming community events. One crucial feedback was about the meeting venue. Members opined that although they welcomed the change of the meeting venue today to the Equity Center in the heart of the community, however, the disadvantage is that the location is not as convenient. Many suggested the venue change might explain the lower attendance rate today compared to previous meetings. The majority of the members present agreed that it is better to hold future meetings at the Department of Health in Pinellas County, Mid County location, 8751 Ulmerton Rd, Largo, FL 33771.
Dr. Nosakhare Idehen	Adjourn	The meeting adjourned with the next meeting date/time set for 05/18/2020, 2: 00 PM – 4: 00 PM

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