Pinellas County:

Community Health Improvement Plan

2023-2028

Florida HEALTH
Pinellas County

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Community Health Improvement Plan
2023-2028

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Table of Contents

Introduction

Utilizing a community-wide approach to identifying health priorities and actions allows for process transparency as well as the inclusion of data based on individual and collective perceptions from those who otherwise wouldn't have a voice in the decision-making process. This approach is the hallmark for the Community Health Improvement Plan (CHIP) and Community Health Assessment (CHA), thereby leading to colorful insights that can be used to inform more effective public health initiatives.

A CHA is a compilation of community input and survey data designed to measure the health of residents while identifying critical needs and disparities through systematic, comprehensive data collection and analysis. Three core functions define the purpose of public health: assessment, policy development, and assurance. CHAs provide information for the problem and asset identification and policy formulation, implementation, and evaluation while also helping to measure how well a public health system is fulfilling its assurances.

The 2023 Pinellas County CHA is a product of existing secondary and primary data collected from more than 5,000 Pinellas residents. During this process, a Florida Department of Health in Pinellas County (DOH-Pinellas) and more than 100 community partners representing more than 30 diverse sectors of the local public health system in Pinellas County came together in April 2022 to discuss the county's definition of health and a healthy community, while identifying priority health areas to address in Pinellas. Collectively, these organizations were able to assess the 10 Essential Public Health services, including themes, strengths, and forces of change that affect Pinellas and the local public health system. The outcomes of these meetings include the decision to focus on three primary health priorities: access to health & social services, mental health & substance abuse, and health promotion & behavior. Following the analysis and prioritization of CHA data, the Pinellas County Community Health Action Team (CHAT) convened in September 2022 to guide the development of the 2023-2028 CHIP for Pinellas County.

2023 CHA

Through the CHA, public health professionals seek to answer the question, "How healthy is the community?" To answer this question, research was performed to locate both existing (secondary) health data and new (primary) data.

Primary Data

To ensure the perspectives of community members were considered, input was collected from Pinellas County residents. Primary data used in this assessment consisted of community survey and focus group discussions. The survey was made available online and via paper copies in English, Spanish, and Creole from January 3, 2022, through February 28, 2022. The survey consisted of 59 questions related to top health needs in the community, individuals' perceptions of their overall health, individuals' access to health care services, as well as social and economic determinants of health.

In November 2021, focus groups were held virtually due to the COVID-19 pandemic. A questionnaire was developed to guide the conversations which included topics related to community strengths and assets, top health problems, access to health care, and impact on health. The purpose of the focus groups was to discern between the different health experiences for Black/African American, LGBTQ+, Hispanic/Latino, children, and older adults.

Secondary Data

Secondary data were collected and analyzed by Conduent Healthy Communities Institute (HCI) and includes over 150 community indicators, spanning at least 24 topics in the areas of health, determinants of health, and quality of life. The data are primarily derived from state and national public secondary data sources.

CHA Highlights

Survey participants were asked about the top three pressing health and quality of life issues they believe should be addressed in their community. In Figure 1, the "Top Three Health Issues" were, mental health problems including suicide (41% of respondents), aging problems (38%), and being overweight (31%). The "Top Three Risky Behaviors" included illegal drug use/abuse or misuse of prescription medications (50% of respondents), alcohol abuse/drinking too much alcohol including beer, wine, spirits, or mixed drinks (47% of respondents), and distracted driving such as, texting, eating, and talking on the phone (43% of respondents). Lastly, the "Top Three Quality of Life Issues" included low crime/safe neighborhoods (45% of respondents), access to healthcare (37% of respondents), and good schools (24% of respondents).

Figure 1. Top 3 Health & Quality of Life Issues

Top 3 Health Issues	Top 3 Risky Behaviors	Top 3 Quality of Life Issues
1. Mental health problems including suicide	1. Illegal drug use/abuse or misuse of prescription medications	1. Low crime/safe neighborhoods
2. Aging problems (i.e., difficulty getting around, dementia, arthritis)	2. Alcohol abuse/drinking too much alcohol (i.e., beer, wine, spirits, mixed drinks)	2. Access to health care
3. Being overweight	3. Distracted driving (texting, eating, talking on the phone)	3. Good schools

Moving from Assessment to Planning: What is the CHIP?

The Community Health Improvement Plan (CHIP) is a long-term systemic plan providing a link between assessment and action, defining how the DOH and partnering community stakeholders will address the public health problems, and health disparities within Pinellas County. The Community Health Action Team (CHAT) determine the goals, strategies, and activities within the CHIP; and also assign organizational accountability to ensure progress towards these goals. Although a variety of tools and processes may be used to implement a CHIP, the essential ingredients are community engagement and collaborative participation.

How to Use the CHIP

Medicine tends to utilize a more reactive rather than preventative approach when it comes to addressing health, while public health favors the latter. The primary use of the CHIP is to be a tool that works towards a shared vision of health improvement through the creation of awareness and engagement for organizations and agencies to react to the current state of health. Also, the use of the CHIP is to direct preventative activities, provide education, and offer services that influence healthier behaviors while connecting residents to various resources.

Each of us play an essential role in community health improvement. Below are some simple ways to use this plan to improve health within Pinellas County:

<u>Employers</u>

- Understand priority health issues within the community and use this plan and recommend resources to help make your business a healthy place to work!
- Educate your team about the link between employee health and productivity.

<u>Community Residents</u>

- Understand priority health issues within the community and use this plan to improve the health of your community.

- Use information from this plan to start a conversation with community leaders about health issues important to you.
- Get involved! Volunteer your time and expertise for an event, activity, or financially help support initiatives related to health topics discussed in this Plan.

Health Care Professionals

- Understand priority health issues within the community and use this plan to remove barriers and create solutions for identified health priorities.
- Share information from this plan with your colleagues, staff, and patients.
- Offer your time and expertise to local improvement efforts (committee member, content resource, etc.)
- Offer your patients appropriate counseling, education, and other preventive services in alignment with identified health needs of the community in Pinellas County.

Educators

- Understand priority health issues within the community and use this plan to recommend resources to integrate topics of health and health factors (i.e., access to healthy food, physical activity, risky behaviors, use of the health care system, etc.) into lesson plans across all subject areas such as math, science, social studies, and history.
- Create a healthier school environment by aligning this plan with school wellness plans/policies.
- Engage the support of leadership, teachers, parents, and students.

Government Officials

- Understand priority health issues within the community.
- Identify the barriers to good health in your communities and mobilize community leaders to act by investing in programs and policy changes that help members of our community lead healthier lives.

State and Local Public Health Professionals

- Understand priority health issues within the community and use this plan to improve the health of this community.
- Understand how communities and populations within Pinellas County, compare to peer counties, Florida, and the U.S. population.

Faith-based Organizations

- Understand priority health issues within the community and talk with members about the importance of overall wellness (mind, body, and spirit) and local community health improvement initiatives that support wellness.
- Identify opportunities that your organization or individual members may be able to support and encourage participation (i.e., food pantry initiatives, community gardens, youth groups geared around health priorities, etc.)

Methodology

Community Health Action Team

For the past several years, a diverse group of community partners have convened to form the Community Health Action Team (CHAT). Sectors represented on CHAT include local hospitals and health care organizations, local government, community-based organizations, social service organizations, and schools, all working to develop, implement, and monitor the CHIP.

Visioning

Healthier People in a Healthier Pinellas

The purpose of the vision statement is to provide focus and direction for community health improvement planning while also encouraging engagement to achieve a shared idea of the future collectively. At the first CHAT meeting of 2022, the previous vision statement was examined together with an explanation of its conceptualization, and subsequently voted on and reaffirmed to be maintained for the 2023-2028 CHIP.

Leveraging the Community

Community engagement is essential to creating a CHIP that ensures effective, sustainable solutions. On April 19, 2022, participants from collaborating organizations, as well as other community partners, came together to prioritize the significant health needs for Pinellas County. To better target issues regarding the most pressing health needs, the All4HealthFL Collaborative conducted a two-hour virtual prioritization session facilitated by the Tampa Bay Healthcare Collaborative (TBHC). A total of 101 individuals attended the prioritization session, representing a broad cross section of experts and organizational leaders with extensive knowledge of the health needs in the community. The meeting objectives included: reviewing analyzed health data pertaining to health needs and disparities, discussing significant health needs that were identified, gathering additional community input on health topics, and prioritizing significant health needs. An additional discussion was hosted to close out the session with generating preliminary ideas on how the broader community could collaborate to address top community health needs.

ALL4HealthFL Collaborative

The purpose of the All4HealthFL Collaborative is to unite public health agencies and organizations who share a mutual interest in improving outcome-driven health initiatives that have been prioritized through community health assessments. Membership in All4Health consists of the departments of health in Pinellas, Hillsborough, Pasco, and Polk counties in partnership with the not-for-profit hospitals in the respective counties. Together, the group strives to make West Central Florida the healthiest region in state. To learn more about the All4HealthFL Collaborative, visit http://www.all4healthfl.org/.

The group concluded and recognized access to health & social services, mental health & substance abuse, and health promotion & behavior as the primary health priorities for incorporation into the implementation plan.

Development of Goals, Strategies, and Objectives

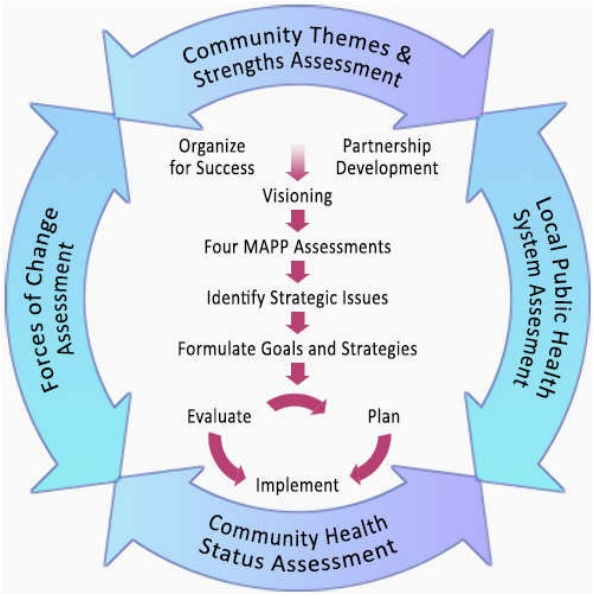
CHAT convened for a series of meetings in Fall and Winter of 2022. During those meetings, CHAT members selected one of three workgroups based upon the health priority areas to develop the goals, strategies, objectives, and activities that would drive the CHIP. Data from the CHA was provided to each group from which SMART objectives were subsequently developed and recorded.

After a comprehensive list of objectives were obtained, CHAT members designed activities to achieve each objective based on their expertise, knowledge, and organizational resources. Common themes and methods were then identified from the objectives, which led to the creation of strategies. The final step involved developing shared comprehensive goals for each health priority area, from which the strategies were grouped. At the end of each CHAT meeting, each workgroup gave a report on their progress. Sharing information enabled stronger collaboration and allowed other partnering agencies to offer help and resources to strengthen efforts.

Over the next several years, DOH-Pinellas will facilitate and monitor progress from CHAT for the implementation of the CHIP. These efforts will be evaluated annually and updated as necessary to align with community resources, activities, and partnerships.

MAPP

MAPP is not an agency-focused assessment process, it is an interactive process that can improve efficiency, effectiveness, and ultimately the performance of local public health systems. There are six phases of the MAPP process. The first two phases consist of visioning, organizing, and partner development. Phase three is the assessment phase, encompassing four distinct assessments (Community Themes & Strengths, Local Public Health System, Community Health Status, and Forces of Change). Strategic issues are identified in phase four by converging the results of the assessments in phase three. Goals and strategies are formulated in phase five to address the problems and achieving goals of the community's vision. Phase six is the action cycle and links planning, implementation, and evaluation by building upon each activity continuously and interactively. Even though the MAPP process is iterative, the framework is flexible and can be tailored to fit the needs of the community.



Per the National Association of County & City Health Officials (NACCHO), the four MAPP assessments form the core of the MAPP process. The most recent CHA and CHIP build upon priorities identified in previous versions. Additionally, the 2023 CHA was developed to supplement data collected in 2019 CHNAs from local non-profit hospitals. These data, conducted as a requirement by the Internal Revenue Service in response to the Patient

Protection and Affordable Care Act enacted in 2010, integrates the work of public health and health care agencies to work towards a common goal.

How Partners are Held Accountable

Individuals and organizations are held accountable for implementing activities in the CHIP using the "who", "what', and "when" action plan. The "who" component refers to key partners, responsible parties, and the designated individuals or organizations that coordinate group activities and report updates to the database. The "what" refers to the strategic issue area of responsibility. The "when" refers to the target date when updates are required. The CHAT group or Steering Committee members meet quarterly to monitor the progress of the CHIP Action Plan. In addition, members are provided with the DOH-Pinellas CHIP Performance Management system, CHAT Tracker. The CHAT Tracker allow members to provide updates, and for DOH-Pinellas to hold designated partners accountable for implementing strategies. Additionally, the Performance Management Council (PMC) monthly meetings provide the opportunity to address problems arising from the CHIP implementation, partners accountability, and development of the CHIP annual progress report.

Public Health Collaboratives

Pinellas County is fortunate to have an extensive public health network. Below are some of the existing collaboratives that help create positive health outcomes for the community.

<table>
<tr><th colspan="2">Existing Public Health Collaboratives</th></tr>
<tr><td colspan="2">I. Access to Care</td></tr>
<tr><td colspan="2">Action and Sharing
Bold Goal Initiative: Humana
Peace4Tarpon
Pinellas County Kinship Care Collaborative
Tampa Bay Diabetes Collaborative
Women & Infant and Children
Healthy Start Community Action Network</td></tr>
<tr><td>Action-Focused
2ll Tampa Bay Cares
Certified Health Navigator
Community Health Action Team
Make a Difference
Mom Care
Monthly Health Workshops for Latinos
Oral Health Coalition
School Nurse Committee
Tampa Bay Breastfeeding
Tampa Bay Healthcare Collaborative
West Central Florida Ryan White Council</td><td>Sharing-Focused
AARP Care Coalition
Pinellas County Medical Association
Pinellas County Osteopathic Medical Society</td></tr>
</table>

2. Substance Use and Abuse	
Action and Sharing Operation PAR Live Free Coalition Pinellas County Kinship Care Collaborative Pinellas County Opioid Task Force	
Action-Focused Dependency Court Improvement Committee Opioid Task Force Parents as Teachers Plus (PAT+) Students Working Against Tobacco Substance Abuse Advisory Committee Substance Exposed Newborn Taskforce	Sharing Focused Live Free Coalition Referrals between Community Health Center of Pinellas and PAR Tobacco Free Coalition

3. Government/Policy	
Action and Sharing Administrative Forum City of Largo- Comprehensive Plan Update Health and Human Services Leadership Board THINK Tampa Bay	
Action-Focused Child-Abuse Death Review Culture Linguistic Competency Initiative Early Learning Coalition Fit to Play Pinellas Food System stakeholders South St Pete CRA Citizen Advisory Committee Tampa Bay Breastfeeding Transportation Disadvantaged Committee	Sharing Focused Bike/Walk Tampa Bay City of St. Pete Complete Streets Committee Healthy Pinellas Consortium Homeless Coalition Refugee Advisory Board St. Petersburg Mayor's Bicycle and Pedestrian Advisory Committee

4. Mental Health	
Action and Sharing Behavioral Health System of Care Mental Health and Substance Abuse Pinellas County Kinship Care Collaborative	
Action-Focused Clergy Roundtable COQEBS – Concerned Organization for the Quality education for Black Students Domestic Violence Task Force Early Childhood Mental Health Committee Florida Association for Mental Health Hillsborough CHAT-Behavioral Health Group National Black Child Development Initiative Project AWARE School Readiness Committee Suicide Prevention Trauma-Informed Quality Childcare Committee Youth in Crisis Youth Mental Health Taskforce Zero Suicide Initiative	Sharing Focused Mental Health Learning Community Partnership between Operation PAR and DOH regarding youth suicide and opioids Pinellas Emergency Mental Health Services

5. Community Health

Action and Sharing

- Bold Goal Initiative: Humana
- Diabetes Collaborative
- Feeding Tampa Bay
- Healthy St. Pete Initiative
- Help Me Grow
- Humana Bold Goal
- LIFT Health
- Peace4Tarpon
- Pinellas County Kinship Care Collaborative
- School Health Advisory Committee
- St. Petersburg Police Department
- Tampa Bay Network to End Hunger

Action-Focused

- All Children's Hospital CHNA
- Baby Steps to Baby Friendly
- Beds for Babies
- Cancer Control & Chronic Disease Community Roundtable Work Group
- Colorectal Cancer Community Committee
- Childhood Hunger
- Churches United for Healthy Congregations
- Community Foundation Wimauma Task Force
- Fit to Play
- Food is Medicine
- Health Care for the Homeless
- Healthy Start Coalition
- iPump Club
- LGBTQ + Homeless Youth Steering Committee
- Mothers Own Milk- MOM
- Open Network- health and food systems
- Open Streets St. Pete
- Pinellas Diabetes Collaborative
- Prevent Needless Death Campaign
- Preventable Child Death Taskforce
- Reducing Health Disparities & Infant mortality
- Ryan White Care Council
- Safe Kid Coalition
- Safe Kids Committee
- Tampa Bay Diabetes Collaborative
- West Central Florida Ryan White Council

Sharing Focused

- Bike/Walk Tampa Bay
- City of St. Pete Complete Streets Committee
- Healthy Pinellas Consortium
- Refugee Advisory Board
- St. Petersburg Mayor's Bicycle and Pedestrian Advisory Committee

6. Other

Action and Sharing

- Foundation for a Healthy St. Petersburg – Health Equity/Population Health
- Pinellas County Housing Authority- Program Coordinating
- Emergency Shelter Family Task Force
- Pinellas County School Health Advisory Committee

Action-Focused

- Tampa Bay Network to End Hunger
- Youth Health Task Force
- Community Service Foundation
- LGBTQ Homeless Youth Steering Committee
- Age-Friendly Community Initiative
- Concerned Organizations For Quality Education For Black Students (COQEBS)
- Healthy St. Pete
- Plant Healthy St. Pete
- Pinellas Homeless Leadership Board
- Tampa Bay Health & Medical Coalition
- Childhood Hunger Initiative
- Hunger Initiative
- Juvenile Detention Alternatives Initiative (JDAI)
- Community Alliance

Sharing Focused

- Innovation District
- JWB South County Community Council
- Regional Security Domestic Taskforce
- School Health Advisory Committee

Priority Health Areas at a Glance

Access to Health & Social Services

It is essential to measure and improve access to care because health disparities in access are often directly linked to disparities in health outcomes. Also, when it is challenging to get routine medical care because of cost, transportation, language barriers or other reasons, problems not caught early can result in life-threatening situations that require immediate attention, endangering lives, and putting a strain on emergency services.

Mental Health & Substance Abuse

Mental health disorders can have a powerful effect on the health of individuals, their families, and their communities. Prevention and intervention strategies may reduce the impact of mental health disorders and are essential for length and quality of life. The misuse of alcohol, over-the-counter medications, illicit drugs, and tobacco 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.

Health Promotion & Behavior

Health behaviors have a significant effect on the development of both acute and chronic diseases. Sedentary lifestyles, poor nutrition habits, and neglecting medical are behaviors that can lead to preventable negative health outcomes. Health disparities can be striking in communities with poor social determinants such as unstable housing, unsafe neighborhoods, low income, etcetera, so it is important to focus efforts where there is the most need.

Policy Alignment

There are several policy components, notably the Health in All Policies (HiAP) and Health Equity, which support the objectives outlined in the Pinellas County health priority areas. The HiAP is an example of a collaborative approach in Pinellas County to make healthy choices the most easily accessible choices. The HiAP approach prioritizes health considerations in decision-making processes to shape how proposed programs can potentially impact health outcomes for community members. The Health Equity initiative is a policy component that provides the imperative for accomplishing health objectives, as well as reshaping the social determinants of health in Pinellas County.

The following are examples of policy changes to accomplish the identified health objectives. Pinellas County use of the *State Housing Initiative Partnership (SHIP)* policy section 420.907-9079, Florida Statutes to meet the HOME Program 25% match requirement, which provides down payment and closing cost for the very low-, low- and moderate-income households, homeless, and the special needs population. The *Complete Street* policy 1.1.5 improves zoning and transportation by requiring Pinellas County to coordinate road improvement plans with the needs of local residents in terms of historic and community preservation. Pinellas Park City Council use of HiAP *Health Impact Assessment* Policy Resolution No. 19-20 for the remediation of brownfields in low-income neighborhoods and communities of color considering the impact policies have on health inequalities and social determinants of health.

Plan Alignment

The DOH-Pinellas staff and CHAT members reviewed the 2023-2028 Pinellas County CHIP making sure it is aligned with the following national and state health priorities and plans:

- The 2022-2026 Florida Department of Health State Health Improvement Plan (SHIP)
- The U.S. Department of Health and Human Services Healthy People 2030.
- Pinellas Florida Healthy Babies (FHB) Action Plan
- SAMHSA, Pinellas County Opioid Task Force (PCOTF) Strategic Plan
- 2022-2024 DOH-Pinellas Strategic Plan

All objectives under a specific goal were reviewed to determine alignment with the respective national and state guidelines. Thus, the SMART objectives align with the current above-stated national and state policies and standards as enumerated in the tables listed below in the appendices on pages 19-30.

Next Steps

CHAT members began the implementation of the CHIP in January 2023. Progress on activities will be evaluated annually, and revisions and updates to the action plans will be edited and updated as needed.

Acknowledgments

The 2023-2028 CHIP would not have been possible without the help of the following organizations:

- Area Agency on Aging
- Evara Health
- Guided Results
- Healthy Start Coalition
- NAMI Pinellas County
- Operation PAR
- Pinellas County
- Pinellas County Schools
- St. Pete College
- Suncoast Center
- Humana
- USF College of Public Health
- AdventHealth
- Tyer Temple United Methodist Church
- Suncoast Health Council
- 211 Tampa Bay Cares, Inc
- Vincent House
- Juvenile Welfare Board
- The Health Council
- Sunshine Health
- Directions for Living
- Johns Hopkins All Children's Hospital
- Foundation for Healthy St. Pete
- Department of Juvenile Justice
- BayCare
- Moffitt Cancer Center
- Peace4Tarpon
- Children's Home Network
- Gulfcoast North Area Health Ed. Center
- HCA Healthcare
- DOH-Pinellas
- City of St. Pete
- Lutheran Services Florida
- TBHC
- Central FL Behavioral Health Network
- City of Pinellas Park
- Phoenix House
- Empath Health
- USF St. Pete
- Pinellas Co Planning Department
- PCDUTF
- Windmoor Healthcare
- Isaiah's Place Inc.
- WellCare

Appendix A: CHIP Outline

Priority 1: Access to Health & Social Services

Goal	**1.1**	**Increase access to comprehensive, high-quality health care and social services**
Strategy	**1.1.1**	Leverage resources and relationships to improve the capacity for health service attainment
OBJECTIVE	**1.1.1.1**	By Dec. 31, 2028, decrease the percentage of Pinellas County residents without health insurance from 13.2% (2019) to 11%.
	1.1.1.2	By Dec. 31, 2028, decrease the rate of preventable hospitalizations under 65 from all conditions single year, 2020, from 816.9 to 800.
Goal	**1.2**	**Decrease infant and maternal mortality and morbidity, especially where disparities exist**
Strategy	**1.2.1**	Increase the number of available services for expecting mothers
OBJECTIVE	**1.2.1.1**	By Dec. 31, 2028, decrease the infant mortality gap (Aged 0-354 days) between Black and White populations single year (2021) from 2.4 (Black 6.3, White 3.9) to 2.1.
Strategy	**1.2.2**	Connect organizations with families to increase utilization
OBJECTIVE	**1.2.2.1**	By Dec. 31, 2028, Increase the Women Infant Children (WIC) overall breastfeeding duration at six months from 35.7% to 40%.
Goal	**1.3**	**Improve social and physical environments so that they promote good health for all**
Strategy	**1.3.1**	Provide education and training
OBJECTIVE	**1.3.1.1**	By December 31, 2028, increase the # of organizations identified and trained in Social Determinants of Health/Health Equity from 20 to 30.

Priority 2: Mental Health & Substance Abuse

Goal	**2.1**	**Improve mental and behavioral health, substance use disorder wellness, and resources across the lifespan.**
Strategy	**2.1.1**	Raise awareness and educate
OBJECTIVE	**2.1.1.1**	By December 31, 2028, reduce the Pinellas suicide from 16.6 per 100,000 (2021) to 14 per 100,000 people.
Strategy	**2.1.2**	Expand access to medical resources
OBJECTIVE	**2.1.2.1**	By December 31, 2028, reduce the accidental drug overdose deaths count from 524 (2020) to 500 people.

Priority 3: Health Promotion & Behavior

Goal	**3.1**	**Promote the attainment and maintenance of health through nutrition, physical activity, and healthy lifestyle behaviors.**
Strategy	**3.1.1**	Utilize resources to educate and raise awareness
OBJECTIVE	**3.1.1.1**	By December 31, 2028, increase the % of children in kindergarten & 7th grade who get the recommended doses of vaccines against vaccine-preventable diseases from 90.3% (2021) to 95%.
	3.1.1.2	By Dec. 31, 2028, reduce the percentage of adults who smoke from 19.7% to 15%.
Strategy	**3.1.2**	Promote health messaging campaigns
OBJECTIVE	**3.1.2.1**	By Dec. 31, 2028, reduce the % of adolescents that use electronic vaping from 29.7% to 20%.
Strategy	**3.1.3**	Utilize preventative measures via education and health screenings
	3.1.3.1	By December 31, 2028, decrease the cancer age-adjusted death rate gap between black and white from 30/100,000 to 20/100,000 persons.
	3.1.3.2	By December 31, 2028, decrease the number of obese adults in Pinellas from 28.5% to 27%.

Appendix B: Action Plan

Priority Health Area: Access to Health & Social Services				
Goal 1.1: Increase access to comprehensive, high-quality health care and social services.				
Strategy 1.1.1: Leverage resources and relationships to improve the capacity for health service attainment				
Objective 1.1.1.1: By Dec. 31, 2028, decrease the percentage of Pinellas County residents without health insurance from 13.2% (2019) to 11%.				
Data Source: FLCharts				
	Activity	**Process Measure**	**Responsible Agency**	**Partner Agencies**
1	Increase the # of individuals served by healthcare marketplace navigators	# of individuals	Evara Health	Baycare, Healthy Start Coalition, Urban League, United Way, Pinellas County Human Services
2	Increase # of outreach opportunities (locations, times, mobile events, etc.)	# of outreach opportunities	Baycare	Evara Health, Healthy Start Coalition, Urban League, United Way, Pinellas County Human Services

Alignment	Healthy People 2030; 2022 Pinellas Strategic Plan (SIP) 1.1, 2.1
Policy Component (Y/N)	No

Priority Health Area: Access to Health & Social Services				
Goal 1.1: Increase access to comprehensive, high-quality health care and social services.				
Strategy 1.1.1: Leverage resources and relationships to improve the capacity for health service attainment				
Objective 1.1.1.2: By Dec. 31, 2028, decrease the rate of preventable hospitalizations under 65 from all conditions single year, 2020, from 816.9 to 800.				
Data Source: FLCharts				
Activity		**Process Measure**	**Responsible Agency**	**Partner Agencies**
1	Increase # of referrals from hospitals to medical homes	# of referrals	Evara Health	Baycare, Healthy Start Coalition, Urban League, United Way, Pinellas County Human Services
2	Navigate ER patients without insurance to a medical home	# of ER patients	Baycare	Evara Health, Healthy Start Coalition, Urban League, United Way, Pinellas County Human Services
3	Improve access to primary/preventative care by meeting people where they are	# of people met	Baycare	Evara Health, Healthy Start Coalition, Urban League, United Way, Pinellas County Human Services

Alignment	2022 FL State Health Improvement Plan (SHIP) ISV2
Policy Component (Y/N)	No

Priority Health Area: Access to Health & Social Services				
Goal 1.2: Decrease infant and maternal mortality and morbidity, especially where disparities exist.				
Strategy 1.2.1: Increase the number of available services for expecting mothers				
Objective 1.2.1.1: By Dec. 31, 2028, decrease the infant mortality gap (Aged 0-354 days) between Black and White populations single year (2021) from 2.4 (Black 6.3, White 3.9) to 2.1.				
Data Source: FLCharts				
Activity		**Process Measure**	**Responsible Agency**	**Partner Agencies**
1	Increase the # of doula services	# of doula services provided	JHACH	Healthy Start Coalition, WIC
2	Increase the # of case management/program services	# of case management/program services	JHACH	Healthy Start Coalition, WIC
3	Increase access to first timers prenatal care for black/brown women	# of women	JHACH	Healthy Start Coalition, WIC
4	Increase # of educational opportunities	# of educational opportunities	JHACH	Healthy Start Coalition, WIC

Alignment	2022 Pinellas SIP 1.1; 2022 FL SHIP MCH2
Policy Component (Y/N)	No

Priority Health Area: Access to Health & Social Services				
Goal 1.2: Decrease infant and maternal mortality and morbidity, especially where disparities exist.				
Strategy 1.2.2: Connect organizations with families to increase utilization				
Objective 1.2.2.1: By Dec. 31, 2028, Increase the Women Infant Children (WIC) overall breastfeeding duration at six months from 35.7% to 40%.				
Data Source: WIC & Nutrition (FL WISE)				
Activity		**Process Measure**	**Responsible Agency**	**Partner Agencies**
1	Increase # of case management	# of case management	JHACH	Healthy Start Coalition, WIC, Federal Healthy Start, Evara Health, Healthy Families
2	Increase # of doula service utilization	# of doula service utilization	JHACH	Healthy Start Coalition, WIC, Federal Healthy Start, Evara Health, Healthy Families
3	Connect with daycares to identify needs for parents and children	# of daycares	Healthy Start Coalition	WIC, Federal Healthy Start, Evara Health, Healthy Families, JHACH
4	Increase access to supportive care and services for families and children	# of services utilized	Healthy Start Coalition	WIC, Federal Healthy Start, Evara Health, Healthy Families, JHACH

Alignment	2022 Pinellas SIP 1.1; 2022 FL SHIP MCH2
Policy Component (Y/N)	No

Priority Health Area: Access to Health & Social Services				
Goal 1.3: Improve social and physical environments so that they promote good health for all				
Strategy 1.3.1: Provide education and training				
Objective 1.3.1.1: By December 31, 2028, increase the # of organizations identified and trained in Social Determinants of Health/Health Equity from 20 to 40.				
Data Source: CHAT (Foundation for a Healthy St. Pete)				
Activity		**Process Measure**	**Responsible Agency**	**Partner Agencies**
1	Convene a multi-sector stakeholder group to develop and implement recommendations to increase access and coordination to social and human services	# of meetings	Foundation for Healthy St. Pete	Orlando Health, Urban League, UNITE Pinellas
2	Deliver SDOH/health equity training to identified agencies	# of trainings	FHSP	Orlando Health, Urban League, UNITE Pinellas
3	Identify gaps in agencies and provide training	# of trainings	FHSP	Orlando Health, Urban League, UNITE Pinellas

Alignment	Local organizations
Policy Component (Y/N)	No

Priority Health Area: Mental Health & Substance Abuse				
Goal 2.1: Improve mental and behavioral health, substance use disorder wellness, and resources across the lifespan.				
Strategy 2.1.1: Raise awareness and educate				
Objective 2.1.1.1: By December 31, 2028, reduce the Pinellas suicide from 16.6 per 100,000 (2021) to 14 per 100,000 people.				
Data Source: FLCharts				
Activity		**Process Measure**	**Responsible Agency**	**Partner Agencies**
1	Increase suicide awareness & prevention by offering and conducting community education and presentations for at-risk populations	# of community presentations	Zero Suicide Partnership of Pinellas, NAMI	Suncoast Center, Behavioral Health Systems of Care
2	Increase the # of attendees to suicide prevention & awareness events	# of attendees	Zero Suicide Partnership of Pinellas, NAMI	Suncoast Center, Behavioral Health Systems of Care
3	Increase the # of PHQ-9 depression scales administered to youth and adults	# of administered depression scales	Zero Suicide Partnership of Pinellas, NAMI	Suncoast Center, Behavioral Health Systems of Care
4	Increase the # of suicide prevention safety plans	# of suicide prevention safety plans	Zero Suicide Partnership of Pinellas, NAMI	Suncoast Center, Behavioral Health Systems of Care
5	Expand the current F.S. 383.402	Legislative champion	JWB	Suncoast Center, Behavioral Health Systems of Care, Zero Suicide, NAMI
6	Ensure alignment of strategic goals and plans across key stakeholders	Alignment obtained	JWB	Suncoast Center, Behavioral Health Systems of Care, Zero Suicide, NAMI

Alignment	2022 FL SHIP MW4
Policy Component (Y/N)	Yes

Priority Health Area: Mental Health & Substance Abuse				
Goal 2.1: Improve mental and behavioral health, substance use disorder wellness, and resources across the lifespan.				
Strategy 2.1.2: Expand access to medical resources				
Objective 2.1.2.1: By December 31, 2028, reduce the accidental drug overdose deaths count from 524 (2020) to 500 people.				
Data Source: FLCharts				
Activity		**Process Measure**	**Responsible Agency**	**Partner Agencies**
1	Place Naloxone kits at CHO locations to expand access	# of locations	DOH-Pinellas	JWB, Pinellas County Opioid Taskforce, Windmoor
2	Expand Alliance for Healthy Communities into Pinellas County	# of partners	JWB	DOH-Pinellas, PCOTF

Alignment	2022 Pinellas SIP 1.2; 2022 FL SHIP MW3
Policy Component (Y/N)	No

Priority Health Area: Health Promotion & Behavior				
Goal 3.1: Promote the attainment and maintenance of health through nutrition, physical activity, and healthy lifestyle behaviors.				
Strategy 3.1.1: Utilize resources to educate and raise awareness				
Objective 3.1.1.1: By December 31, 2028, increase the % of children in kindergarten & 7th grade who get the recommended doses of vaccines against vaccine-preventable diseases from 90.3% (2021) to 95%.				
Data Source: FLSHOTS				
Activity		**Process Measure**	**Responsible Agency**	**Partner Agencies**
1	Develop educational materials for dissemination	# of materials disseminated	DOH-Pinellas	DOH-Pinellas
2	Form a coalition of obstetric & pediatric providers to address vaccination through exam room education	Coalition formed	DOH-Pinellas	DOH-Pinellas
3	Increase number of organizations providing culturally competent education and administration of vaccines in underserved communities	# of organizations	DOH-Pinellas	DOH-Pinellas

Alignment	2022 Pinellas SIP 3.1; HP 2030
Policy Component (Y/N)	No

Priority Health Area: Health Promotion & Behavior				
Goal 3.1: Promote the attainment and maintenance of health through nutrition, physical activity, and healthy lifestyle behaviors.				
Strategy 3.1.1: Utilize resources to educate and raise awareness				
Objective 3.1.1.2: By Dec. 31, 2028, reduce the percentage of adults who smoke from 19.7% to 15%.				
Data Source: FLCharts				
Activity		**Process Measure**	**Responsible Agency**	**Partner Agencies**
1	Increase access to *Quit Your Way* services	# of clients utilizing services	DOH-Pinellas	AHA, AHEC
2	Increase the # of organizations utilizing electronic referral systems	# of organizations	DOH-Pinellas	AHA, AHEC
3	Promote comprehensive smokefree policies in the indoor area, workplaces, multiunit housing, and public places	# of opportunities for promotion	DOH-Pinellas	AHA, AHEC

Alignment	HP 2030; 2022 FL SHIP CD5
Policy Component (Y/N)	Yes

Priority Health Area: Health Promotion & Behavior				
Goal 3.1: Promote the attainment and maintenance of health through nutrition, physical activity, and healthy lifestyle behaviors.				
Strategy 3.1.2: Promote health messaging campaigns				
Objective 3.1.2.1: By Dec. 31, 2028, reduce the % of adolescents that use electronic vaping from 29.7% to 20%.				
Data Source: FL Youth Substance Abuse Survey				
Activity		**Process Measure**	**Responsible Agency**	**Partner Agencies**
1	Increase health communication campaign targeting youth	# of campaigns	DOH-Pinellas	AHA, AHEC
2	Maintain ten or more SWAT clubs in schools	# of schools	DOH-Pinellas	AHA, AHEC
3	Promote comprehensive smokefree policies in the indoor area, workplaces, multiunit housing, and public places	# of opportunities for promotion	DOH-Pinellas	AHA, AHEC

Alignment	HP 2030
Policy Component (Y/N)	Yes

Priority Health Area: Health Promotion & Behavior				
Goal 3.1: Promote the attainment and maintenance of health through nutrition, physical activity, and healthy lifestyle behaviors.				
Strategy 3.1.3: Utilize preventative measures via education and health screenings				
Objective 3.1.3.1: By December 31, 2028, decrease the cancer age-adjusted death rate gap between black and white from 30/100,000 to 20/100,000 persons.				
Data Source: FLCharts				
Activity		**Process Measure**	**Responsible Agency**	**Partner Agencies**
1	Increase the # of adults screened for breast and cervical	# of adults	DOH-Pinellas	Moffitt Cancer Center
2	Increase the # of adults screened for colorectal cancer	# of adults	DOH-Pinellas	Moffitt Cancer Center
3	Implement culturally responsive community education that explains the benefit of healthy living	# of educational opportunities	DOH-Pinellas	Moffitt Cancer Center
4	Increase the # of initial doses of HPV in adolescents ages 13 to 17	# of doses	DOH-Pinellas	Moffitt Cancer Center

Alignment	2022 Pinellas SIP 2.1; HP 2030; 2022 FL SHIP CD1
Policy Component (Y/N)	No

Priority Health Area: Health Promotion & Behavior				
Goal 3.1: Promote the attainment and maintenance of health through nutrition, physical activity, and healthy lifestyle behaviors.				
Strategy 3.1.3: Utilize preventative measures via education and health screenings				
Objective 3.1.3.2: By December 31, 2028, decrease the number of obese adults in Pinellas from 28.5% to 27%.				
Data Source: FLCharts				
Activity		**Process Measure**	**Responsible Agency**	**Partner Agencies**
1	Increase the # of Pinellas adults and youth with a healthy BMI	# of adults and youth	DOH-Pinellas	Moffitt Cancer Center
2	Nutritional screenings for adults and children	# of screenings	DOH-Pinellas	Moffitt Cancer Center
3	Increase the number of physical activities and nutrition courses available at low to no cost through municipal venues (i.e., libraries)	# of activities and courses	DOH-Pinellas	Moffitt Cancer Center
4	Increase the # of farmers markets that accept SNAP in low socioeconomic neighborhoods	# of farmers markets	DOH-Pinellas	Moffitt Cancer Center

Alignment	HP 2030; 2022 FL SHIP CD6
Policy Component (Y/N)	No