PINELLAS COUNTY

COMMUNITY HEALTH IMPROVEMENT PLAN

2018-2022

Florida HEALTH
Pinellas County

Pinellas County Community Health Improvement Plan

Ron DeSantis
Governor

Scott Rivkees, MD
Florida State Surgeon General

Ulyee Choe, DO
Director, Florida Department of Health in Pinellas County

Production of the Florida Department of Health in Pinellas County

Report and Supplemental Materials Available at:
www.pinellashealth.com

Published December 2018
Revision 1.2 May 2020

Contents

Introduction 3
Moving from Assessment to Planning: What is the CHIP? 3
How to Use the Community Health Improvement Plan 4
Summary of Community Health Assessment 5
Primary Data 5
Secondary Data 5
Community Health Assessment Highlights 6
CHIP Methods 7
Community Engagement 7
How Partners are Held Accountable 7
Resources and Assets 7
Visioning 10
Setting Health Priority Areas 10
Development of Goals, Strategies, and Objectives 13
MAPP Steps 1 – 6 14
Priority Health Areas 15
Access to Care 16
Behavioral Health 18
Social Determinants of Health 20
Policy Component 22
Alignment with National and State Priorities: 22
Next Steps 22
Acknowledgments 23
Appendices 27
Appendix A: 2018-2022 Action Plan 27
Priority Health Area: Access to Care 28
Priority Health Area: Behavioral Health 33
Priority Health Area: Social Determinants of Health 41
Appendix B: Revisions 46

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 whom 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 Community Health Assessment (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 2018 Pinellas County CHA is a product of existing secondary and primary data collected from over 700 Pinellas residents. During this process, a Florida Department of Health in Pinellas County (DOH-Pinellas) and more than 85 community partners representing more than 30 diverse sectors of the local public health system in Pinellas County came together in July 2017 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 care, behavioral health, and the social determinants of health. Additionally, while considering socioeconomic factors and leveraging partnerships, thereby setting the framework that will guide the strategizing of the CHIP and aiding the continual process of achieving a healthier status quo for the community.

Following the Community Health Assessment, the Pinellas County Community Health Action Team (CHAT) first convened in October 2018 to guide the development of the 2018-2022 CHIP for Pinellas County.

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; they 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 Community Health Improvement Plan

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

Employers

- Understand priority health issues within the community & 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 & productivity.

Community Residents

- Understand priority health issues within the community & 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 or expertise for an event or activity, or financially help support initiatives related to health topics discussed in this Plan.

Health Care Professionals

- Understand priority health issues within the community & use this Plan to remove barriers and create solutions for identified health priorities.
- Share information from this Plan with your colleagues, staff & patients.
- Offer your time & 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 Pinellas County community.

Educators

- Understand priority health issues within the community & use this Plan and recommend resources to integrate topics of health and health factors (i.e. access to health food, physical activity, risk-behaviors, use of the health care system, etc.) into lesson plans across all subject areas such as math, science, social studies & history.
- Create a healthier school environment by aligning this Plan with school wellness plans/policies. Engage the support of leadership, teachers, parents & 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 & use this Plan to improve the health of this community.
- Understand how the Pinellas County community, & populations within the county, compared with peer counties, Florida & the U.S. population.

Faith-based Organizations

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

Summary of Community Health Assessment

The 2018 Pinellas Community Health Assessment (CHA) collected data from both primary and secondary data sources.

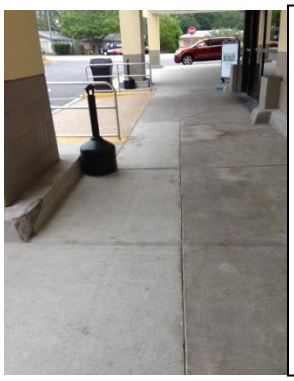
Primary Data

A **phone survey** developed by the University of South Florida College of Public Health, DOH-Pinellas, the Foundation for a Healthy St. Petersburg and multiple community stakeholders to assess a variety of health domains, including topics such as social determinants of health and neighborhood safety, was professionally administered between May-July 2017 to 702 Pinellas residents.

Photovoice, a community-based participatory research method, was also used to collect qualitative data from residents, and empower individuals to assess their communities through photographs. Participants were asked to submit photos for each of two questions: (1) In your life, what supports you feeling safe and healthy, and (2) In your life, what are barriers to feeling safe and healthy?

Secondary Data

"This was a prayer walk with community leaders in St. Pete. This moment made me feel safe and healthy. It was encouraging to see people with power taking time to care about the health and wellbeing of their community."



"I picked this photo because employees of many grocery stores locally smoke near the doors of the establishments. The ash tray cans are seen here. Many people are allergic to smoke or have chronic conditions that make breathing difficult."

Secondary data were collected from a variety of sources for the Pinellas CHA, including: **The U.S. Census Bureau**, **The Behavioral Risk Factor Surveillance System (BRFSS)**, **Bureau of Vital Statistics**, **Florida Department of Highway Safety and Motor Vehicles**, **Substance Abuse and Mental Health Services Administration (SAMHSA)** and **Florida Agency for Health Care Administration (AHCA)**.

Community Health Assessment Highlights

Chronic Disease

Pinellas County experiences are higher than state average rates of heart disease, heart attack, and the death rate from diabetes. In 2017, 1 out of 10 Pinellas adults reported being food insecure.

Cancer

Incidence rates of breast cancer, lung cancer, and skin cancer are higher than state averages, while Pinellas prostate, colorectal, and cervical cancer rates are lower than the state.

Communicable Disease

Pinellas is doing better than the state average in rates of chlamydia and HIV, while the incidence of syphilis and AIDS are higher than the state. 80% of adults report feeling sex education should be taught in schools by age 13.

Mental Health

The suicide rate in Pinellas is higher than the state average, with rates among Pinellas males nearly three times higher than females. 24.1% of adults reported a diagnosis of a depressive disorder.

Substance Use and Abuse

More than one person in Pinellas dies every other day from an opioid-related overdose. 24.1% of adults report using some form of prescription pain reliever, with 1 in 10 using in some way not directed by their doctor.

Maternal and Child Health

While the Pinellas black infant mortality rate is decreasing, black infants are still more than twice as likely to die before their first birthday than white infants. 20% of adults report they don't know whether formula or breastmilk is better for infants.

Injury and Violence

Pinellas has had a higher rate of motor vehicle accidents than the state since 2011. 1 out of 4 adults reported having been hurt, hit or threatened by a partner or someone at home, with nearly half reported witnessing some form of domestic violence.

Social Determinant of Health

Over half of Pinellas residents live within a half-mile of a park. 7% of Pinellas adults report that crime holds them back from walking during the day, at night, that rate increases to 20%.

Oral Health

62.5% of Pinellas adults report having visited a dentist within the past year. 1 out of 5 Pinellas adults sometimes can't see a dentist because of cost, and 14% say more than five years since their last visit.

Access to Care

Nearly 15% of Pinellas adults report at least one time in the past year when they needed to see a doctor but could not due to cost. A significant relationship exists between income and insurance status, with those who make less than $25,000 a year is less likely to have health insurance.

CHIP Methods

Community Engagement

Community engagement is essential to creating a Community Health Improvement Plan (CHIP) that ensures effective, sustainable solutions. In July 2017, over 85 community partners and members convened to identify health issues to be prioritized for the 2018 CHIP. Additionally, participants listed existing local collaboratives and resources to be considered and leveraged in implementing the CHIP and addressing health in the community overall. The list was organized into sub-topics and noted whether the group/resource was more action-oriented or sharing-oriented.

How Partners are Held Accountable

Individuals and organizations are held accountable for implementing strategies outlined in the CHIP using the "who," "what," and "when" action plan. The "who" component refers to the key partners, responsible party, and designated inidivdual or organization that coordinates group members activities and report updates to the database. The "what" refers to 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 any problems arising from the CHIP implementation, partners accountability, and development of the CHIP annual progress report.

Resources and Assets

Existing Public Health Collaboratives	
I. Access to Care	
Action and Sharing Bold Goals Initiative: Humana Peace4Tarpon Pinellas County Kinship Care Collaborative Tampa Bay Diabetes Collaborative Women & Infant and Children Healthy Start Community Action Network	
Action-Focused 2II 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	Sharing-Focused AARP Care Coalition Pinellas County Medical Association Pinellas County Osteopathic Medical Society

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. 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

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. Community Health	
Action and Sharing	
Bold Golds Initiative: Humana	LIFT Health
Diabetes Collaborative	Peace4Tarpons
Feeding Tampa Bay	Pinellas County Kinship Care Collaborative
Healthy St. Pete Initiative	School Health Advisory Committee
Help Me Grow	St. Petersburg Police Department
Humana Bold Goal	Tampa Bay Network to End Hunger
Action-Focused	
All Children's Hospital CHNA	
Baby Steps to Baby Friendly	LGBTQ + Homeless Youth Steering Committee
Beds for Babies	Mothers Own Milk- MOM
Cancer Control & Chronic Disease Community	Open Network- health and food systems
Roundtable Work Group	Open Streets St. Pete
Colorectal Cancer Community Committee	Pinellas Diabetes Collaborative
Childhood Hunger	Prevent Needless Death Campaign
Churches United for Healthy Congregations	Preventable Child Death Taskforce
Community Foundation Wimauma Task Force	Reducing Health Disparities & Infant mortality
Fit to Play	Ryan White Care Council
Food is Medicine	Safe Kid Coalition
Health Care for the Homeless	Safe Kids Committee
Healthy Start Coalition	Tampa Bay Diabetes Collaborative
iPump Club	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	

5. 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	Plant Healthy St. Pete
Youth Health Task Force	Pinellas Homeless Leadership Board
Community Service Foundation	Tampa Bay Health & Medical Coalition
LGBTQ Homeless Youth Steering Committee	Childhood Hunger Initiative
Age-Friendly Community Initiative	Hunger Initiative
Concerned Organizations For Quality Education	Juvenile Detention Alternatives Initiative (JDAI)
For Black Students (COQEBS)	Community Alliance
Healthy St. Pete	
Sharing Focused	
Innovation District	Regional Security Domestic Taskforce
JWB South County Community Council	School Health Advisory Committee

Since July 2017, using existing public and private partnerships, a diverse group of community partners collaborated to convene the Community Health Action Team (CHAT). Sectors represented on CHAT include local hospitals and health care organizations, local government, community-based organizations, social service organizations, and schools, all working to develop and implement the 2018 CHIP. For a complete listing of CHAT members see Acknowledgments on page 23.

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 2018, the previous vision statement was examined together with an explanation of its conceptualization, and subsequently voted on and reaffirmed to be maintained for the 2018-2022 CHIP.

Setting Health Priority Areas

The public health system must first help communities identify its most relevant, critical, and emerging needs, and then prioritize actions for implementation to maintain effectiveness. Prioritization uses a SMART (specific, Measurable, Achievable, Relevant, and Timed) objective; a rational approach to identify those problems that are solvable, the magnitude and severity of the problem in the community, and alignment with an organization's existing priorities. In July 2017, over 85 community partners came together with the Florida Department of Health in Pinellas to begin the process of CHIP planning. During the meeting, participants were asked to identify what sector they represented, and what public health issue/priority area Pinellas should focus its attention on over the next several years. The purpose of the activity was to recognize the different sectors and topic expertise in the room and begin to identify health priorities and concerns of the community.

Additional factors considered before developing the health priority areas include the availability of community capacity and resources, existing interventions focused on the issues, and evidence that an intervention can change the problem to produce a measurable impact on the health priority area. Based on the assessment results, the development of SMART objectives support the selected health priority areas for pragmatic outcome evaluation.

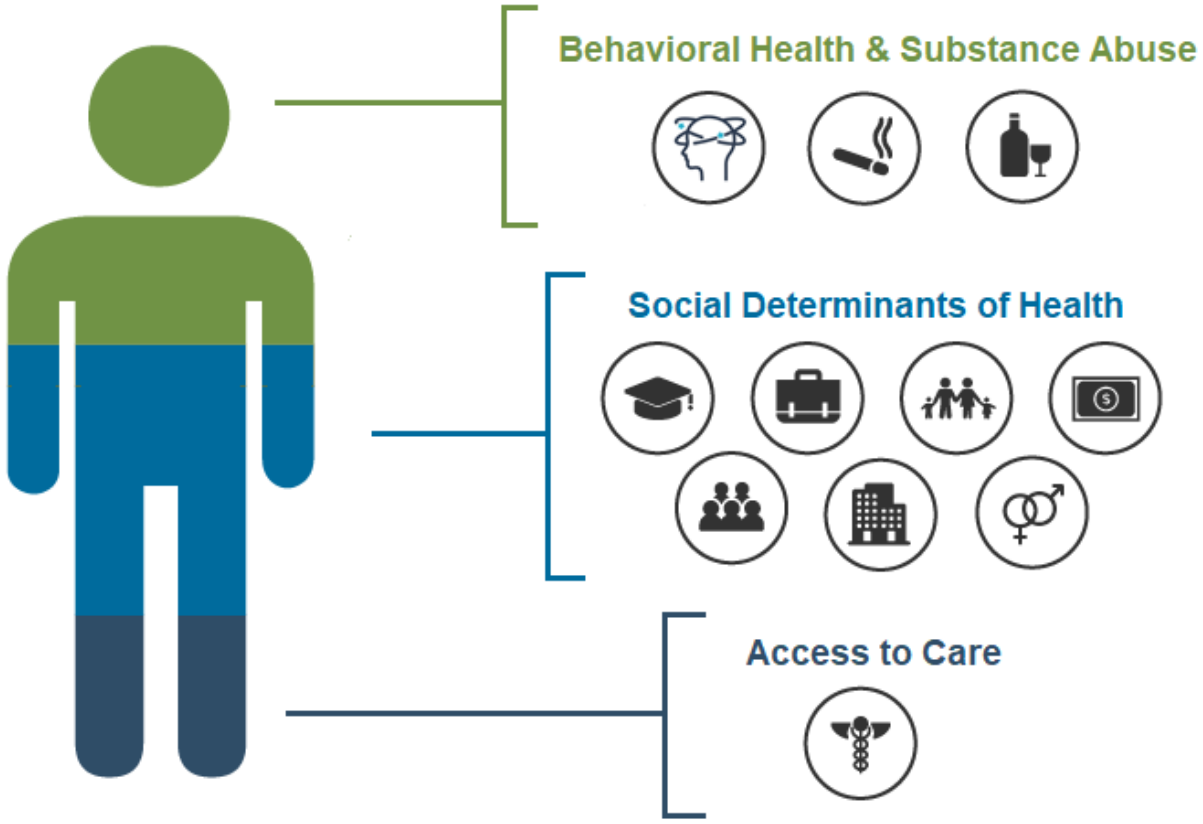
Sectors Represented		
Aging	Hospital	Planning and economic development
Children and families	Housing (low-income)	Prevention services
Free dental for low income populations	Infant/family mental health	Public health
Health and human services	Law enforcement	Ryan White (HIV/AIDS)
Health research and evaluation	Mental health	School district
Health care	Non-profits	Social sector
Higher education	Parks and recreation	Trauma-informed community

Health Issues of Interest			
Access to health services for all	HIV in women of color	Population health	Substance uses—social norms
Cancer patient survivorship	Hygiene education	Providing care to those most in need	Community mental and physical health and well-being (trauma-informed)
Childhood obesity	Infant mortality	Reproductive health (starting in adolescence)	Access to mental health services
Diabetes prevention	Inter-conceptional health (baby spacing)	Safe sleep for babies	Violence
Food insecurity/hunger	Mental health	School health	Suicide prevention
Free access to dental for those with low income	Mental health for youth/ young adults	Seniors (isolation)	Including health policies in urban design/ planning/place-making
Health equity	Nursing education	Youth tobacco use	Infant—family mental health
Health in the built environment	Opioid/heroin use	Inclusive safer sex education	Behavioral health
Health policy—early childhood and childcare centers	Oral health	HIV/AIDS prevention/ care	
Helping children and families to live healthy	Physical activity		

After further discussion of these common priority areas, five health priority areas emerged as being critical to achieving health and a healthy community:

The group concluded and recognized access to care, behavioral health & substance abuse, and the social determinants of health as the primary health priorities and that a health improvement plan should consider socioeconomic factors and leverage partnerships to achieve results. Based on these recommendations, the CHIP moved forward with three health priority areas:

1. **Access to Care**
2. **Behavioral Health & Substance Abuse**
3. **Social Determinants of Health** (Encompassing built environment & socioeconomic factors)



Finally, the goal is to leverage partnerships for the implementation of the CHIP through the Community Health Action Team (CHAT). Also, noting the importance of emphasizing equity in all aspects of health, the group opted to incorporate a health equity approach across the CHIP by highlighting health disparities to be addressed throughout the plan, rather than create a health equity priority area. Both the CHA and the CHIP, based on the Mobilizing for Action through Planning and Partnerships (MAPP) framework, employed a community-driven strategic approach to community health improvement planning. Based on the assessment results, the identification of strategies and goals draw on the development of SMART objectives used to measure progress and success.

Development of Goals, Strategies, and Objectives

Once the CHA was complete, and priority health areas were identified, work teams were convened for each of the three health priority areas, making up the CHAT. Community members and stakeholders were invited to participate in the CHAT and select work teams based on their expertise. Over four months, CHAT members met and communicated to develop Goals, Strategies, Objectives, and an Action Plan for the implementation of the CHIP.

Work team members at DOH-Pinellas used CHAT feedback and available data to identify potential Goals and Strategies for each priority health area, aligning with national, state and local plans, as well as CHIPs of county health departments with similarly sized populations. These potential Goals and Strategies were presented to the CHAT, and work teams revised, added, and deleted information to help prioritize the final CHIP Goals and Strategies.

Work teams were then presented with secondary and primary data available through the Pinellas CHA to identify potential Objectives reflecting the CHIP's Goals and Strategies. CHAT members indicated available resources and discussed how these resources might be used to achieve CHIP Goals and Objectives. Finally, CHAT members worked on action planning for each health priority area, including the development of activities and selection of timeframes, coordinating agency, partner agencies, and process measures for monitoring and evaluation.

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

MAPP Steps 1 – 6

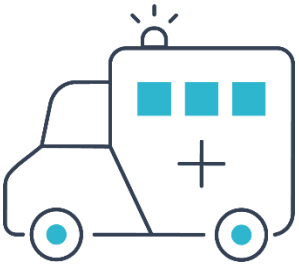
MAPP is not an agency-focused assessment process; instead, it is an interactive process that can improve the efficiency, effectiveness, and ultimately, the performance of local public health systems. There are six phases of the MAPP process. The first two phases comprise of visioning, organizing, and 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 2018 CHA was developed to supplement data collected in 2016 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.

Priority Health Areas

Priority Area	Goals
Access to Care	1. Improve access to comprehensive, high-quality, culturally responsive health care services for all. 2. 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.

Access to Care



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.

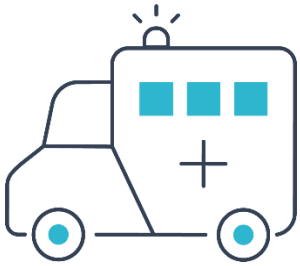
Goal AC 1:

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%.

Access to Care



Goal AC 2:

Reduce infant and maternal mortality and morbidity, especially where disparities exist.

Strategy AC 2.1: Promote the importance of prenatal care and being healthy prior to pregnancy, especially among disparate populations.

Objective AC 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%.

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%.

Strategy AC 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.

Strategy AC 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%.

Objective AC 2.3.2: By December 31, 2022, increase breastfeeding duration for all infants from 26% (2018) to 30%.

Behavioral Health

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 essential for length and quality of life. 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.

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 BH 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.

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

Strategy BH 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.

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

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 BH 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.

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 (TBD in Activity).

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 (TBD in Activity).

Social Determinants of Health

Per the Centers for Disease Control and Prevention (CDC), Conditions in the places where people live, learn, work, and play affect a wide range of health risks and outcomes. Health disparities can be striking in communities with poor social determinants such as unstable housing, unsafe neighborhoods, low income, etc. Poverty can limit access to healthy foods and safe neighborhoods, while better education is a predictor of better health.

Goal SDH 1:

Improve social and physical environments so that they promote good health for all.

Strategy SDH 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.

Objective SDH 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.

Social Determinants of Health

Goal SDH 1:

Improve social and physical environments so that they promote good health for all.

Strategy SDH 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.

Objective SDH 1.2.2: By December 31, 2022, increase the # of formal collaborations (i.e. agreements, MOUs, etc.) focused on the working age population from 0 to 1.

Strategy SDH 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.

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.

Policy Component:

There are several policy components, notably the Health in All Policy (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 to make the healthy choice the most easily accessible choice. The HiAP approach prioritizes health considerations in decision-making processes to shape how proposed programs can potentially impact health outcomes for the community members. The Health Equity initiative is a policy component that provides the imperative for accomplishing health priority objectives. Also, it reshapes 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 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 on the remediation of brownfields in low-income neighborhoods and communities of color considerating the impact policies have on health inequalities and social determinants of health

Alignment with National and State Priorities:

The DOH-Pinellas staff and the CHAT members reviewed the 2018-2022 Pinellas County CHIP making sure it is aligned the following national and state health priorities guiding principle:

- The 2017- 2021 Florida Department of Health's State Health Improvement Plan (SHIP)
- The U.S. Department of Health and Human Services Healthy People 2020.
- Metro County CHIP
- Pinellas Florida Healthy Babies (FHB) Action Plan
- SAMHSA, Pinellas County Opioid Task Force (PCOTF) Strategic Plan
- Public Health Institute (PHI) Health in All Policies (HiAP) Guide, HiAP-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 27 - 46.

Next Steps

CHAT members and community stakeholders began the implementation of the Community Health Improvement Plan in January 2019. Progress on activities will be evaluated annually by CHAT, with revisions and updates to the action plans made as needed.

Acknowledgments

MEMBERS OF THE COMMUNITY HEALTH ACTION TEAM

Becky Afonso
Florida Bicycle Association

Eliana Aguilar
Community Member

Melissa Andress
Pinellas County Schools, Domestic Violence Task Force

Lael Arango
Great Explorations Children's Museum

Naomi Ardjomand-Kermani
Suncoast Health Council

Rosy Bailey
In Season Pro

Will Baldwin
St. Petersburg College (Manners Housing Foundation)

Katherine Barbera
AIDS Healthcare Foundation

Kate Bauer-Jones
Early Learning Coalition

Denise Benavides
American Cancer Society

Pervinder Birk
DOH-Pinellas (Administration)

Joe Bohn, Ph.D.
University of South Florida College of Public Health

Denyve Boyle
Community Foundation of Tampa Bay

Morgan Brandt
City of Dunedin

Jessica Brown
Public Defender's Office

Lisa Brown
DOH-Pinellas (Healthy Start)

Kimberly Brown-Williams
Johns Hopkins All Children's Hospital

Debbie Buschman
Public Defender's Office

Ulyee Choe, D.O.
DOH-Pinellas (Director)

Dianne Clark
Operation PAR

Mary Beth Crouch
Humana Community Management

Shari Crowe
BayCare Health System

Lucas Cruse
The city of St. Petersburg

Marcos Darcy
St. Vincent de Paul

Sunny Davis
DOH-Pinellas (Tobacco Prevention)

Mary-Lou Dickson
Community Law Program

Jaime Dixon
Foundation for a Healthy St. Petersburg

Laurie Elbow
Suncoast Center

Jennifer Engel
AIDS Healthcare Foundation

Tracy Enright
Johns Hopkins All Children's Hospital

Khaliah Fleming
Moffitt Cancer Center

Brittney Frazier
Allegany Franciscan Ministries

Melissa Fuller
Department of Juvenile Justice

Christopher Gallucci
DOH-Pinellas (Community Health)

Katrina Gordon
City of Largo

Jane Grannis
Pinellas County

Jodi Groth
Pinellas County Human Services

Gayle Guidash
DOH-Pinellas (Assistant Director)

Ericka Guy
Community Member

Marina Habib
Healthy Community Tampa Bay

Maggie Hall
DOH-Pinellas (Public Information)

Germeen Hanna
Florida Dream Center

Ray Hensley
DOH-Pinellas (Maternal & Child Health)

Carrie Hepburn
Community Member

Karen Hodge
DOH-Pinellas (Dental Services)

Bill Horton
Community Member/Consultant

Ashley Hoskins
DOH-Pinellas (Public Health Preparedness)

Victor Hubert
DOH-Pinellas (Healthy Families)

Nosakhare Idehen, MD, MHA.
DOH-Pinellas (Community Health)

Jennifer Ireland
BayCare Health System

Nan Jensen
UF IFAS Extension

Patti Johnson
Vice Mayor, City of Pinellas Park

Mary Ann Keller
AIDS Healthcare Foundation

Cheryl Kerr
St. Petersburg College

Lara Khoury
City of Largo

Edward Kucher
Community Health Centers of Pinellas

Daphne Lampley
Operation PAR

Valarie Lee
DOH-Pinellas (Breast & Cervical)

Kim Lehto
City of St. Petersburg, Healthy St. Pete

Jomar López
Moffitt Cancer Center

Quinn Lundquist
Community Member

Jacki Malone
University of South Florida St. Petersburg (USFSP) Family Study Center

Jason Martino
Area Agency on Aging

Cindy McNulty
Healthy Start Coalition

Sarah Miller
Central Florida Behavioral Health Network

Tamela Monroe
Advent Health North Pinellas

Katie Murphy
Gulfcoast North Area Health Education Center

Cassidy Mutnansky
City of St. Petersburg, Healthy St. Pete

Lisa Negrini
USFSP Family Study Center

Jo Dee Nicosia
Central Florida Behavioral Health Network

Lisa Nugent
Suncoast Health Council

Marisa Pfalzgraf
DOH-Pinellas (Information Technology)

Stephanie Reed
Pinellas County Human Services

Elizabeth Rugg
Suncoast Health Council

Stephanie Sambatakos
Johns Hopkins All Children's Hospital

Barbara Sarver
DOH-Pinellas (WIC & Nutrition)

Karen Serrano Arce
Feeding Tampa Bay

Deborah Shaffer
DOH-Pinellas (School Health)

Donna Sicilian
Pinellas County Schools

Kyle Simpson
The city of St. Petersburg

Z'Kera Sims
Moffitt Cancer Center

Elizabeth Smith
DOH-Pinellas (Community Health/Nursing)

Michelle Stemler
American Cancer Society

Giovanna Taylor
St. Petersburg College

Mark Trujillo
UF IFAS Extension

Lisa Ullven
Guided Results

Ana Urueta
DOH-Pinellas (Public Health Preparedness)

Melissa Van Bruggen
DOH-Pinellas (Clinical Services)

Courtney Vandenberg
Pinellas County Board of County Commissioners

Katie Vicsik
Florida Voices for Health

Frank Wells
Bright Community Trust

Jerry Wennlund
Personal Enrichment through Mental Health Services (PEMHS)

Denise Whitfield
NAMI Pinellas County

Tasha Wilkerson
Suncoast Center

Kim Leslie
Morton Plant

Shanya Turner
DOH-Pinellas (Community Health)

Julia Neely
BayCare Health

Heath Kirby
DOH-Pinellas (Community Health)

Ruth Power
Department of Juvenile Justice

Daphne Green
City of Pinellas Park

Kimberly Williams
Advent Health North Pinellas

Amber Windsor-Hardy
Advent Health North Pinellas

Arrow Woodard
City of Largo

Kaila Yeager
DOH-Pinellas (Public Health Preparedness)
Tammy Hiller
City of Pinellas Park

Caitlin Murphy
City of Pinellas Park

Karen Yatchum
Pinellas County

Micki Thompson
211 Tampa Bay Cares

Alexandra Stocks
Vincent House

Susan Fontaine
Faith *Community Nursing Ambassador*

Appendices

Appendix A: 2018-2022 Action Plan

Priority Health Area: Access to Care				
Goal AC 1: 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 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%.				
Data Source: FL Health CHARTS (BRFSS)				
Activity		**Process Measure**	**Responsible Agency**	**Partner Agencies**
1	Increase insurance enrollment events.	Identify the top 2 largest underinsured communities and offer enrollment events by Dec. 2022.	DOH-Pinellas, St. Pete Free Clinic	DOH-Pinellas, Community Health Centers of Pinellas, Pinellas County
2	Promote the awareness/utilization of community resources to increase the residents' ability to connect to needed services.	Increase yearly utilization of web-based community resource directories (211 Tampa Bay Cares and Tampa Bay Health resources) by 10% from 18,291 to 20,120 by Oct. 2022	Tampa Bay 211 Cares, TBHC	DOH-Pinellas, TBHC, Bold Goal Health Collaborative

Alignment	Healthy People 2020, Metro County CHIPs
Policy Component (Y/N)	No

Priority Health Area: Access to Care

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

Strategy AC 2.1: Promote the importance of prenatal care and being healthy before pregnancy, especially among disparate populations.

Objective AC 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%.

Data Source: FL Health CHARTS (Vital Statistics)

Activity		Process Measure	Responsible Agency	Partner Agencies
1	Implement survey of barriers among the target population.	A survey is developed and administered to at least 50 black mothers by Dec. 2022.	WIC & Nutrition	DOH-Pinellas, Healthy Start Coalition
2	Promote insurance/health care programs pre-, during, and post- pregnancy.	Healthy Start Resource Manual and bilingual marketing material for these programs are distributed to at least 30 health providers by Dec. 2022.	Healthy Start Coalition	WIC & Nutrition, DOH-Pinellas

Alignment	2018 FL SHIP
Policy Component (Y/N)	No

Priority Health Area: Access to Care

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

Strategy AC 2.1: Promote the importance of prenatal care and being healthy before pregnancy, especially among disparate populations.

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%

Data Source: FL Health CHARTS (Vital Statistics)

Activity		Process Measure	Responsible Agency	Partner Agencies
1	Implement survey of barriers among the target population	A bilingual survey is developed and administered to at least 50 Hispanic mothers by Dec. 2022.	WIC & Nutrition	DOH-Pinellas, Healthy Start Coalition
2	Promote insurance/health care programs pre-, during and post- pregnancy	Healthy Start Resource Manual and bilingual marketing material for these programs are distributed to at least 30 health providers by Dec. 2022.	Healthy Start Coalition	WIC & Nutrition, DOH-Pinellas

Alignment	2018 FL SHIP
Policy Component (Y/N)	No

Priority Health Area: Access to Care

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

Strategy AC 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.

Data Source: FL Health CHARTS (Vital Statistics)

Activity		Process Measure	Responsible Agency	Partner Agencies
1	Create social media content to be shared with various community stakeholders focused on racial disparities in infant mortality.	Content for at least three social media posts is developed by Dec. 2022.	DOH-Pinellas	Healthy Start Coalition, Johns Hopkins All Children's Hospital, Tampa Bay Healthcare Collaborative (TBHC)
2	Use zip code data (JWB, Census) to educate targeted audiences about racial disparities in health and infant mortality.	At least three education opportunities are delivered to community members by Dec. 2022.	DOH-Pinellas	Healthy Start Coalition, Johns Hopkins All Children's Hospital, Tampa Bay Healthcare Collaborative (TBHC)

Alignment	Pinellas Florida Healthy Babies (FHB) Action Plan
Policy Component (Y/N)	No

Priority Health Area: Access to Care				
Goal AC 2: Reduce infant and maternal mortality and morbidity, especially where disparities exist.				
Strategy AC 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%.				
Data Source: WIC & Nutrition (FL WISE)				
Activity		**Process Measure**	**Responsible Agency**	**Partner Agencies**
1	Educate OB and pediatric providers about the health benefits of breastfeeding.	Healthy Start Coalition's "breastfeeding brochures" are distributed to all 42 OB and 54 pediatric providers in Pinellas by Dec. 2022.	Healthy Start Coalition	Community Health Centers, DOH-Pinellas, Healthy Start Coalition, Free Clinics
2	Increase the number of Maternal and Child Health (MCH) staff who become certified lactation counselors.	Lactation counselor training conducted for up to 20 MCH staff by Dec. 2022.	Morton Plant Hospital	Healthy Start Coalition

Alignment	Pinellas FHB Action Plan
Policy Component (Y/N)	No

Priority Health Area: Access to Care

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

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

Objective AC 2.3.2: By December 31, 2022, increase breastfeeding duration for all infants from 26% (2018) to 30%.

Data Source: WIC & Nutrition (FL WISE)

	Activity	Process Measure	Responsible Agency	Partner Agencies
1	Create and survey employers in Pinellas to determine which employers meet or come close to meeting the "Breastfeeding Friendly Employer" criteria.	At least 30 large employers will be given the survey along with a cover letter summarizing the initiative by Dec. 2022.	Tampa Bay Breastfeeding Task Force Pinellas Chapter (TBBF-Pinellas)	DOH-Pinellas, Healthy Start Coalition, Chamber of Commerce, FBC, USF Research Team
2	Engage with and increase the number of Pinellas employers that have lactation support programs.	Increase the number of employers with lactation support programs by at least ten by Dec. 2022.	TBBF-Pinellas	DOH-Pinellas, Healthy Start Coalition, WIC & Nutrition, Chamber of Commerce

Alignment	Pinellas FHB Action Plan
Policy Component (Y/N)	No

Priority Health Area: 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 BH 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.

Data Source: NAMI Pinellas

Activity		Process Measure	Responsible Agency	Partner Agencies
1	Increase the capacity of trainers.	At least two more individuals are trained in delivering "Ending the Silence" by Dec. 2022.	NAMI Pinellas	Central Florida Behavioral Health Network (CFBHN)
2	Identify areas that have not received training (i.e., gaps).	Develop a list of areas that did not receive training in 2018 by Dec. 2022.	NAMI Pinellas	DOH-Pinellas
3	Deliver training.	Deliver training to at least 1,600 participants by Dec. 2022.	NAMI Pinellas	CFBHN, DOH-Pinellas, Local Universities & Colleges

Alignment	SAMHSA, Pinellas County Opioid Task Force (PCOTF) Strategic Plan
Policy Component (Y/N)	No

Priority Health Area: 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 BH 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%.

Data Source: Peace4Pinellas

Activity		Process Measure	Responsible Agency	Partner Agencies
1	Increase frequency and modality of information shared with the public.	Align education and awareness efforts with PCOTF Strategic Plan by ensuring at least one CHAT member is present at PCOTF regular meetings by Dec. 2022.	Pinellas County Opioid Task Force (PCOTF)	Pinellas County Human Services, Drug-Free America Foundation, Operation PAR, Phoenix House
2	Promote education on access and use of free NARCAN	Hold or help coordinate at least 2 public forums educating people on how to access and use free NARCAN by Dec. 2022.	Pinellas County Opioid Task Force (PCOTF)	Pinellas County Human Services, Drug-Free America Foundation, Operation PAR, Phoenix House
3	Increase awareness/prevention messaging targeting youth.	Identify at least two opportunities for messaging toward youth by Dec. 2022.	Pinellas County Opioid Task Force (PCOTF)	Pinellas County Schools, Johns Hopkin's All Children's Hospital (JHACH), LiveFree!

Alignment	SAMHSA, PCOTF Strategic Plan
Policy Component (Y/N)	No

Priority Health Area: 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 BH 1.2: Engage targeted at-risk populations to understand behavioral health needs better.

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

Data Source: FL Health CHARTS (Vital Statistics)

Activity		Process Measure	Responsible Agency	Partner Agencies
1	Identify people of influence in local neighborhoods to promote neighborhood "speak ups" surrounding mental health.	Connect with local leaders to hold or help coordinate at least two public forums surrounding mental health by Dec. 2022.	Pinellas Bold Goals Behavioral Health & Faith Initiative	JWB, BHSOC, Zero Pinellas, DOH-Pinellas, Council of Neighborhood Associations (CONA)
2	Promote mental health wellness and reduce substance use disorders among youths	Hold at least 2 youth town hall to help the youth to build resilience and stress coping strategies by Dec. 2022.	CFBHN	Pinellas Bold Goals Behavioral Health & Faith Initiative, CFBHN, Community and Faith Leaders Coalition of Pinellas County
3	Promote and increase Mental Health First Aid training.	Ensure at least one training is offered to teachers, law enforcement, and first responders by Dec. 2022.	NAMI Pinellas	Pinellas County Schools, CHAT-Behavioral Health, BHSOC, Law Enforcement, First Responders

Alignment	SAMHSA, 2012-2017 Pinellas CHIP
Policy Component (Y/N)	No

Priority Health Area: 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 BH 1.2: Engage targeted at-risk populations to understand behavioral health needs better.

Objective BH 1.2.2: By December 31, 2022, increase the number of establishments offering universal mental health screenings by 10% from baseline (TBD in Activity 1).

Data Source: CHAT- Behavioral Health

Activity		Process Measure	Responsible Agency	Partner Agencies
1	Determine a baseline for universal screenings offered in Pinellas.	Universal screening baseline is established by Aug 2019.	CFBHN	CFBHN, DOH-Pinellas, JWB, BHSOC
2	Identify the at-risk senior pop. to target for mental health needs	At least 2 at-risk senior population is identified by Dec. 2022.	NAMI Pinellas	NAMI Pinellas, Phoenix House, PEMHS, Suncoast Center, Directions for Living, Local CSUs, Hospitals
3	Identify the at-risk youth pop. to target for mental health needs	At least 2 at-risk youth population is identified by Dec. 2022.	CFBHN	CFBHN, CFBHN, DOH-Pinellas, JWB, BHSOC
4	Identify the at-risk youth and adult pop. to target for substance use disorder needs	At least 2 at-risk youth and adult population is identified by Dec 2022.	Operation PAR	Operation Par, Phoenix House, CFBHN, DOH-Pinellas, JWB, BHSOC
5	Identify points of contact for potential screening sites, in at-risk pop. (using JWB data).	At least one point of contact is identified in North, Mid, and South County by Dec. 2022.	DOH-Pinellas	Hospitals, Community Health Centers of Pinellas, CONA, Law Enforcement, First Responders, Local Business Owners, Churches United for Healthy Congregations (CUFHC), Boys & Girls Club
6	Identify a single screen for Mental Health/Substance Abuse for adult, young adult, high school, school age, birth-age five, & pregnant.	At least one screening is identified for each age group by Dec. 2022.	CFBHN	DOH-Pinellas, JWB, BHSOC, USFSP, CFBHN

Alignment	SAMHSA, 2012-2017 Pinellas CHIP
Policy Component (Y/N)	No

Priority Health Area: 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 BH 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.

Data Source: Personal Enrichment through Mental Health Services (PEMHS)

Activity		Process Measure	Responsible Agency	Partner Agencies
1	Identify outpatient care coordinators for transition care.	At least two care coordinators identified by Dec. 2022.	Suncoast, PEMHS	Suncoast Center, Directions for Living, Local CSUs, Hospitals
2	Locate outpatient care coordinators in inpatient locations to engage in outpatient services.	At least two care coordinators are placed in inpatient locations by Dec. 2022.	PEMHS	Suncoast Center, Directions for Living, Local CSUs, Hospitals

Alignment	SAMHSA, 2012-2017 Pinellas CHIP
Policy Component (Y/N)	Yes

Priority Health Area: 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 BH 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 (TBD in Activity).

Data Source: Collaborative Agencies

Activity		Process Measure	Responsible Agency	Partner Agencies
1	Determine the baseline of existing formal agreements/MOUs between behavioral health providers in Pinellas.	Baseline number is determined by Dec. 2022	Operation PAR	PEMHS, Suncoast Center, Directions for Living, BHSOC, JWB
2	Facilitate completion of MOU between behavioral health providers.	At least one MOU is completed between two behavioral health providers by Dec. 2022.	Operation PAR	PEMHS, Suncoast Center, Directions for Living, BHSOC, JWB, DOH-Pinellas, Pinellas County

Alignment	SAMHSA, 2012-2017 Pinellas CHIP
Policy Component (Y/N)	No

Priority Health Area: 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 BH 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 (TBD in Activity).

Data Source: PEMHS

Activity		Process Measure	Responsible Agency	Partner Agencies
1	Identify baseline for a number of SOAR evaluations administered in Pinellas.	The baseline is identified for a number of SOAR evaluations administered by Dec. 2022	PEMHS, Pinellas County Human Services	Suncoast Center, Directions for Living, BHSOC
2	Train more providers in SOAR evaluation administration	At least one SOAR training is delivered by Dec. 2022.	PEMHS, Pinellas County Human Services	Suncoast Center, Directions for Living, BHSOC

Alignment	SAMHSA, 2012-2017 Pinellas CHIP
Policy Component (Y/N)	No

Priority Health Area: Social Determinants of Health				
Goal SDH 1: Improve social and physical environments so that they promote good health for all.				
Strategy SDH 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 agencies identified and trained in Social Determinants of Health/Health Equity from 12 to 20.				
Data Source: CHAT- Social Determinants of Health				
Activity		**Process Measure**	**Responsible Agency**	**Partner Agencies**
1	Deliver SDOH/health equity trainings to identified agencies.	Deliver 8 trainings by Dec. 2022.	DOH-Pinellas	Healthy Start Initiative
2	Create an evaluation tool to measure the effectiveness of SDOH/health equity trainings	Administer 8 evaluation test by Dec. 2022	DOH-Pinellas	Health in All Policies (HiAP) Action Team

Alignment	Public Health Institute (PHI) Health in All Policies (HiAP) Guide, HiAP-Pinellas Strategic Plan
Policy Component (Y/N)	No

Priority Health Area: Social Determinants of Health

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

Strategy SDH 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.

Data Source: CHAT- Social Determinants of Health

Activity		Process Measure	Responsible Agency	Partner Agencies
1	Identify thought/opinion leaders in the community through the mapping process.	Identify at least 12 opinion leaders for engagement by Dec. 2022.	FHSP	DOH-Pinellas, Unite Pinellas, Suncoast Health Council
2	Set up focus groups/town hall meetings engage the community in a conversation about needs and barriers.	Set up five focus groups/town halls by Dec. 2022.	FHSP	Unite Pinellas, DOH-Pinellas
3	Engage leaders on issues related to health equity and social determinants through 1:1 or group encounters.	Meet and discuss social determinants/health equity with at least 12 identified thought leaders by Dec. 2022.	FHSP	United Pinellas, City of St. Petersburg, City of Pinellas Park, Pinellas County Government

Alignment	PHI HiAP Guide, HiAP-Pinellas Strategic Plan
Policy Component (Y/N)	No

Priority Health Area: Social Determinants of Health

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

Strategy SDH 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 or aging populations from 0 to 1.

Data Source: Collaborative Agencies

Activity		Process Measure	Responsible Agency	Partner Agencies
1	Track initiatives focused on youth or aging populations.	A list/database of existing initiatives is created by Sept 2022.	Area Agency on Aging	Safe Routes to School (SRTS), Bike/Ped Advisory Committee (BPAC), JWB, Pinellas County Government
2	Identify strategic goals and priorities for potential collaboration.	# of goals/priorities identified for each initiative in the database by Dec. 2022.	Area Agency on Aging	SRTS, Pinellas County Schools, JWB, Pinellas County Government
3	Formalize collaboration of initiatives with similar aims.	A completed formal agreement between at least two entities by Dec. 2020.	DOH-Pinellas	Pinellas County Government
4	Initiate at least one priority project surrounding youth or aging populations.	One project plan is developed by Dec. 2022.	DOH-Pinellas	Pinellas County Government

Alignment	Institute of Medicine (IOM) 5 Key Elements of a HiAP Approach
Policy Component (Y/N)	No

Priority Health Area: Social Determinants of Health

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

Strategy SDH 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 the working age population from 0 to 1.

Data Source: Collaborative Agencies

Activity		Process Measure	Responsible Agency	Partner Agencies
1	Track initiatives addressing social determinants of health or health equity in the working age population (18-64 years).	A list/database of existing initiatives is created by Sept. 2022.	Cohort of Champions-Director of Urban Affairs	DOH-Pinellas, FHSP, TBHC, Suncoast Health Council

Alignment	IOM 5 Key Elements of a HiAP Approach
Policy Component (Y/N)	No

Priority Health Area: Social Determinants of Health

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

Strategy SDH 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.

Data Source: DOH-Pinellas (HiAP-Pinellas)

Activity		Process Measure	Responsible Agency	Partner Agencies
1	Choose a local government based upon the population at large or health disparities.	At least six local governments are chosen by Dec. 2022	DOH-Pinellas	Health in All Policies (HiAP) Action Team
2	Approach city councils/commissions or mayor.	At least six local government representatives are approached by Dec. 2022	DOH-Pinellas	Health in All Policies (HiAP) Action Team
3	Promote education based on CHA.	CHA data is presented to at least one representative of each chosen government entity by Dec. 2022	DOH-Pinellas	Health in All Policies (HiAP) Action Team

Alignment	IOM 5 Key Elements of a HiAP Approach, HiAP-Pinellas Strategic Plan
Policy Component (Y/N)	Yes

Priority Health Area: Social Determinants of Health

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

Strategy SDH 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.

Data Source: DOH-Pinellas (HiAP-Pinellas)

Activity		Process Measure	Responsible Agency	Partner Agencies
1	Select local government policy or process.	At least one policy, program, project, plan is selected per government entity (City of St. Pete, City of Pinellas Park, Pinellas County Government) by Dec. 2022 for health impact assessment.	DOH-Pinellas	Health in All Policies (HiAP) Action Team
2	Conduct process mapping and insert health and equity considerations into departments' decision-making processes.	Process mapping completed and health and equity considerations inserted into government entities policies, programs, plans, or projects by Dec. 2022	DOH-Pinellas	Health in All Policies (HiAP) Action Team

Alignment	IOM 5 Key Elements of a HiAP Approach, HiAP-Pinellas Strategic Plan
Policy Component (Y/N)	Yes

Appendix B: Revisions

Revisions to the CHIP were made after careful review of the goals, objectives, strategies, and measures of the 2018 – 2022 CHIP revision 1.2. May 2020. Sections revised include the title page, SMART goals, narrative on policy changes, alignment with state and national priorties, and partner accountability. Recommended changes were made based on the following parameters:

- Availability of data and resources
- Community readiness
- Evident progress
- Alignment of goals