PINELLAS COUNTY

COMMUNITY HEALTH IMPROVEMENT PLAN

2018-2021

Florida HEALTH
Pinellas County

Pinellas County Community Health Improvement Plan

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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 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 richer 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 key 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 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.

Building off the results from previous years, a 2018 Pinellas County CHA was developed through use of secondary data 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. It was concluded through these meetings that the main health priorities for Pinellas County should focus on access to care, behavioral health and the built environment, 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 2018-2021 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 goals, strategies, and activities within the CHIP are determined by the Community Health Action Team (CHAT), along with the assigning of 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 CHIP is meant to be used a tool that works towards a common vision of health improvement through the creation of awareness and engagement for organizations and agencies to react to the current state of health, but more so 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 important 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 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 relevant 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, compare 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

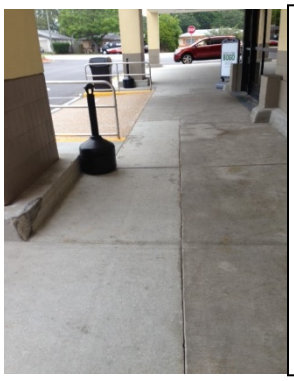
The 2018 Pinellas Community Health Assessment (CHA) collected data from both primary and secondary data sources.

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 built environment 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 own 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?

"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

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 experiences higher than state average rates of heart disease, heart attack, and 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 rates for 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 being diagnosed with 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.

Built Environment
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% report more than 5 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 was found between income and insurance status, with those who make less than $25,000 a year being 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.

Resources and Assets

<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 Goals 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. 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 participation to collectively achieve a shared image of the future. During the first CHAT meeting of 2018, the previous vision statement was presented with an explanation of its conceptualization, and subsequently voted on and reaffirmed to be maintained for the 2018-2021 CHIP.

Setting Health Priority Areas

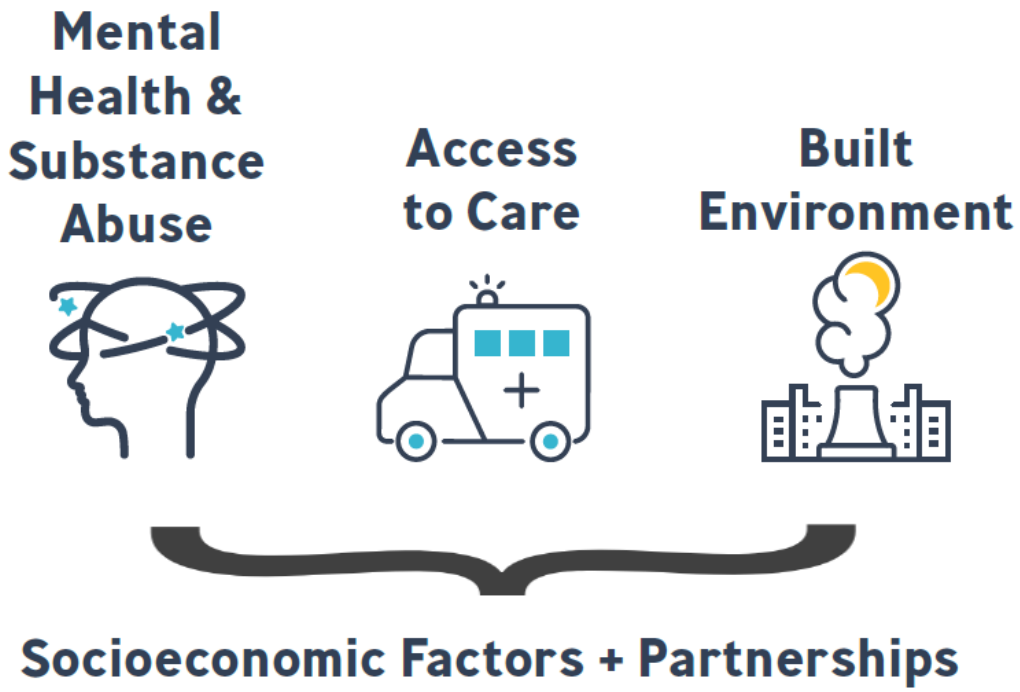
To be effective, the public health system must first help communities identify its most relevant, critical, and emerging needs, and then prioritize actions for implementation. Prioritization uses an objective rational approach to identify those problems that a community can address based on an assessment of health status and the forces of change surrounding those indicators.

In July 2017, over 85 community partners came together with the Florida Department of Health in Pinellas to begin the process of. 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.

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 that access to care, behavioral health, and the built environment should be recognized as the main 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** (Encompassing mental health & substance use)
3. **Social Determinants of Health** (Encompassing the built environment & socioeconomic factors)

Finally, partnerships are leveraged for 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 wanted to ensure a health equity approach was incorporated 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.

Development of Goals, Strategies, and Objectives

Once the CHA was completed 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 a four-month period, CHAT members met and communicated to develop Goals, Strategies, Objectives and an Action Plan for 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 may be used to achieve CHIP Goals and Objectives. Finally, CHAT members worked on action planning for each health priority area, including 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

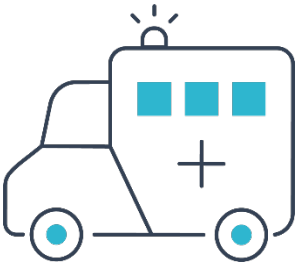
MAPP is not an agency-focused assessment process; rather, it is an interactive process that can improve the efficiency, effectiveness, and ultimately the performance of local public health systems. There are six phases of the MAPP process. The first two phases are comprised of visioning, organizing, 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 issues 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 in a continuous and interactive manner. 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	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 	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 	1. Improve social and physical environments so that they promote good health for all.

Access to Care



It is important 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 difficult to get routine medical care because of cost, transportation, language barriers or other reasons, problems that could have been caught early can result in life-threatening situations that require immediate attention, endangering lives, and putting strain on emergency services.

Goal AC 1:

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

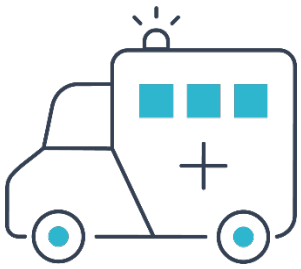
Strategy AC 1.1: Increase the percentage of persons with health insurance coverage and/or a primary care provider.

Objective AC 1.1.1: By December 31, 2021, decrease the % of Pinellas adults who are unable to access a health care provider due to cost from 17% (2016) to 15%.

Strategy AC 1.2: Increase coordination among providers and sectors for the prevention, early detection, treatment, and management of diseases to improve health outcomes.

Objective AC 1.2.1: By December 31, 2021, decrease preventable hospitalizations in under 65 from all conditions from 1,181.1 per 100,000 (2015-17) to 1,160 per 100,000.

Access to Care



Goal AC 1:

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

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

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

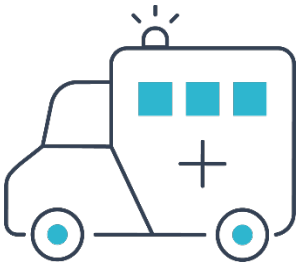
Objective AC 1.3.2: By December 31, 2019, increase the # of collaborative Access to Care interventions (i.e. agreements, MOUs, etc.) from 0 to 1.

Strategy AC 1.4: Reduce the percentage of persons who are unable to obtain or delay in obtaining necessary and/or appropriate health care when they need it.

Objective AC 1.4.1: By December 31, 2021, increase the # of Community Health Workers by 20% of baseline (TBD in Activity).

Objective AC 1.4.2: By December 31, 2021, increase the capacity of Community Health Centers to serve uninsured residents by 20% of baseline (TBD in Activity).

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, 2021, 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, 2021, 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, 2021, 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, 2021, increase breastfeeding initiation for all infants among WIC clients from 80% (2018) to 83%.

Objective AC 2.3.2: By December 31, 2021, increase breastfeeding duration for all infants among WIC clients 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 important 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 a communicable 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, 2021, 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, 2021, increase the # of trauma-informed communities from 1 (Peace4Tarpon) to 3 (Peace for Pinellas goal).

Objective BH 1.1.3: By December 31, 2021, 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, 2021, reduce the Pinellas suicide rate from 18.1 (2015-17) to 17.0.

Objective BH 1.2.2: By December 31, 2021, 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, 2021, reduce Crisis Stabilization Unit (CSU) rate of re-admission within 30 days from 12% (2018) to 10%.

Objective BH 1.3.2: By December 31, 2021, 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, 2021, 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).

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

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

Objective BH 1.4.2: By December 31, 2021, increase the number of formal collaborations (e.g. agreement, MOU, action plan, etc.) focused on mental health and/or substance use needs by 10% of baseline (TBD in Objective BH 1.4.1).

Social Determinants of Health

Per the Centers of Disease Control (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, 2021, increase the # of agencies identified and trained in Social Determinants of Health/Health Equity from 0 to 12.

Objective SDH 1.1.2: By December 31, 2021, 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, 2021, 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, 2021, 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, 2021, increase the # of Pinellas government entities that will agree to consider addressing health and equity in policies through a formalized adoption process (i.e. Resolution, Executive Order) from 0 to 3.

Objective SDH 1.3.2: By December 31, 2021, increase the # of Pinellas government entities that have adopted a "Health in All Policies" framework from 0 to 3.

Next Steps

CHAT members and community stakeholders will begin 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.

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Appendices

Appendix A: 2018-2021 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 and/or a primary care provider.				
Objective AC 1.1.1: By December 31, 2021, decrease the % of Pinellas adults who are unable to access a health care provider due to cost from 17% (2016) to 15%.				
Data Source: FL Health CHARTS (BRFSS)				
Activity		**Process Measure**	**Coordinating Agency**	**Partner Agencies**
1	Gather data on <u>why</u> community members are unable to access care	Questionnaire is developed and delivered at least 3 community outreach events by Dec. 2019	CHAT-Access to Care	DOH-Pinellas, Community Health Centers of Pinellas
2	Increase community insurance enrollment events	Community enrollment events are identified, and at least one is added to a zip code with a large un/underinsured population by Dec. 2019	CHAT-Access to Care	DOH-Pinellas, Community Health Centers of Pinellas, Pinellas County

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

Priority Health Area: Access to Care

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

Strategy AC 1.2: Increase coordination among providers and sectors for the prevention, early detection, treatment, and management of diseases to improve health outcomes.

Objective AC 1.2.1: By December 31, 2021, decrease preventable hospitalizations in under 65 from all conditions from 1,181.1 per 100,000 (2015-17) to 1,160 per 100,000.

Data Source: FL Health CHARTS (AHCA)

Activity		Process Measure	Coordinating Agency	Partner Agencies
1	Promote patient portal usage to increase information sharing among providers and sectors	At least one patient portal promotion tool is identified or developed by June 2019	DOH-Pinellas	Hospitals, Community Health Centers of Pinellas, Free Clinics
2	Increase training/education on safety of information sharing and patient portal usage	At least one training is held by Dec. 2019	CHAT- Access to Care	Hospitals, DOH-Pinellas, Community Health Centers of Pinellas, Free Clinics

Alignment	Healthy People 2020, 2018 FL State Health Improvement Plan (SHIP)
Policy Component (Y/N)	No

Priority Health Area: Access to Care

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

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

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

Data Source: DOH-Pinellas

Activity		Process Measure	Coordinating Agency	Partner Agencies
1	Develop Financial Impact Analysis of improvement of health conditions of Pinellas residents	A financial impact analysis is completed by Dec. 2019	DOH-Pinellas	CHAT-Access to Care, Chamber of Commerce, University of South Florida (USF), Free Clinics, Hospitals, Community Health Centers
2	Develop specific presentation for business community groups to demonstrate benefit of support and collaboration	A presentation for business community groups is developed by June 2021	DOH-Pinellas	CHAT-Access to Care, Chamber of Commerce
3	Determine organizations to receive presentation and Financial Impact Analysis (e.g. social responsibility departments, chambers of commerce, restaurant associations)	At least 3 organizations are identified and receive presentation by Dec. 2021	DOH-Pinellas	CHAT-Access to Care, Chamber of Commerce, Foundation for a Healthy St. Petersburg (FHSP)

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

Priority Health Area: Access to Care

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

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

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

Data Source: Collaborative Agencies

Activity		Process Measure	Coordinating Agency	Partner Agencies
1	Facilitate development of at least one collaborative Access to Care intervention (i.e. agreement, MOU, etc.) among un/underinsured populations	An MOU is completed between 2+ agencies to implement a collaborative intervention by Dec. 2019	CHAT-Access to Care	Community Health Centers, DOH-Pinellas, Hospitals, Free Clinics, Foundation for a Healthy St. Petersburg
2	Evaluate preliminary data of intervention	An evaluation of intervention results is completed by Dec. 2021	CHAT-Access to Care	Community Health Centers, DOH-Pinellas, Hospitals, Free Clinics, Foundation for a Healthy St. Petersburg

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

Priority Health Area: Access to Care

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

Strategy AC 1.4: Reduce the percentage of persons who are unable to obtain or delay in obtaining necessary and/or appropriate health care when they need it.

Objective AC 1.4.1: By December 31, 2021, increase the # of Community Health Workers by 20% of baseline (TBD in Activity).

Data Source: FL Certification Board

Activity		Process Measure	Coordinating Agency	Partner Agencies
1	Identify baseline of Community Health Workers (CHWs) in Pinellas	Baseline of CHWs is determined through FL Certification Board	CHAT-Access to Care	DOH-Pinellas
2	Coordinate with FL CHW Coalition for potential training/certification of additional CHWs in Pinellas	At least one training for additional CHWs is held in Pinellas	CHAT-Access to Care	Community Health Centers, DOH-Pinellas, Healthy Start Coalition, Free Clinics

Alignment	Healthy People 2020
Policy Component (Y/N)	No

Priority Health Area: Access to Care

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

Strategy AC 1.4: Reduce the percentage of persons who are unable to obtain or delay in obtaining necessary and/or appropriate health care when they need it.

Objective AC 1.4.2: By December 31, 2021, increase the capacity of Community Health Centers (CHCs) to serve uninsured residents by 20% of baseline (TBD in Activity).

Data Source: Community Health Centers of Pinellas

Activity		Process Measure	Coordinating Agency	Partner Agencies
1	Determine baseline for current CHC capacity to serve uninsured residents	Baseline for current capacity is determined	Community Health Centers of Pinellas (CHCs)	CHAT-Access to Care, DOH-Pinellas
2	Implement focus groups for recommendations to increase CHC capacity	At least 2 focus groups are conducted by Dec. 2019	CHCs	CHAT-Access to Care, DOH-Pinellas, Hospitals, Free Clinics, Tampa Bay Healthcare Collaborative (TBHC)
3	Based on recommendations, implement new procedures	At least one procedure is formally changed or added based on recommendations	CHCs	CHAT-Access to Care, DOH-Pinellas

Alignment	Healthy People 2020
Policy Component (Y/N)	Yes

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 prior to pregnancy, especially among disparate populations.

Objective AC 2.1.1: By December 31, 2021, 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	Coordinating Agency	Partner Agencies
1	Implement survey of barriers among target population	A survey is developed and administered to at least 50 black mothers by Dec. 2019	WIC & Nutrition	DOH-Pinellas, CHAT-Access to Care, Healthy Start Coalition
2	Promote insurance/health care programs pre-, during and post- pregnancy	Healthy Start Resource Manual and marketing material for these programs is distributed to at least 30 health providers (e.g. pregnancy testing sites, pediatricians, OB/GYNs)	Healthy Start Coalition	WIC & Nutrition, DOH-Pinellas, CHAT-Access to Care

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 prior to pregnancy, especially among disparate populations.

Objective AC 2.1.2: By December 31, 2021, 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	Coordinating Agency	Partner Agencies
1	Implement survey of barriers among target population	A bilingual survey is developed and administered to at least 50 black mothers by Dec. 2019	WIC & Nutrition	DOH-Pinellas, CHAT-Access to Care, 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 is distributed to at least 30 health providers (e.g. pregnancy testing sites, pediatricians, OB/GYNs)	Healthy Start Coalition	WIC & Nutrition, DOH-Pinellas, CHAT-Access to Care

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, 2021, 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	Coordinating 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 3 social media posts is developed	DOH-Pinellas	Healthy Start Coalition, Johns Hopkins All Children's Hospital, CHAT-Access to Care, 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 3 education opportunities are delivered to community members	DOH-Pinellas	JWB, Healthy Start Coalition, Johns Hopkins All Children's Hospital, CHAT-Access to Care, 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, 2021, increase breastfeeding initiation for all infants from 80% (2018) to 83%.

Data Source: WIC & Nutrition (FL WISE)

Activity		Process Measure	Coordinating 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	Healthy Start Coalition	Home Visiting Programs, DOH-Pinellas
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. 2019	DOH-Pinellas	Healthy Start Coalition, Morton Plant Hospital

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, 2021, increase breastfeeding duration for all infants from 26% (2018) to 30%.

Data Source: WIC & Nutrition (FL WISE)

Activity		Process Measure	Coordinating Agency	Partner Agencies
1	Establish a baseline of the number of larger employers in Pinellas that have lactation support programs	Baseline established for larger employers in Pinellas (e.g. Pinellas County Schools, Publix, HCA, HSN, City & County Government, Law Enforcement, Tampa Bay Times)	Tampa Bay Breastfeeding Task Force Pinellas Chapter (TBBF-Pinellas)	DOH-Pinellas, CHAT-Access to Care, Healthy Start Coalition, Chamber of Commerce
2	Engage with and increase the number of Pinellas employers that have lactation support programs	Number of employers with lactation support programs increased from baseline	TBBF-Pinellas	DOH-Pinellas, CHAT-Access to Care, 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, 2021, 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	Coordinating Agency	Partner Agencies
1	Increase capacity of trainers	At least 2 more individuals are trained in delivering "Ending the Silence"	NAMI Pinellas	Central Florida Behavioral Health Network (CFBHN)
2	Identify areas that have not received training (i.e. gaps)	List developed of areas that did not receive training in 2018	CHAT-Behavioral Health	NAMI Pinellas, DOH-Pinellas
3	Deliver trainings	Deliver trainings to at least 1,6000 participants by Dec. 2021	NAMI Pinellas	CFBHN, DOH-Pinellas, Local Universities & Colleges
4	Provide referrals at trainings to other educational opportunities (e.g. Mental Health First Aid)	Reference material for at least one other behavioral health-related education opportunity available at all "Ending the Silence" trainings	CHAT-Behavioral Health	CFBHN, Behavioral Health System of Care (BHSOC), Faith-Based Organizations

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, 2021, increase the # of trauma-informed communities from 1 (2018) to 3.

Data Source: Peace4Pinellas

Activity		Process Measure	Coordinating Agency	Partner Agencies
1	Engage Peace4Pinellas and Peace4Tarpon	At least one representative from each has attended a CHAT meeting	CHAT-Behavioral Health	Peace4Pinellas, Peace4Tarpon
2	Identify opportunities to communicate trauma-informed practices to the public	At least 3 opportunities are identified and implemented by Dec. 2019	DOH-Pinellas, CHAT-Behavioral Health	Peace4Pinellas, Peace4Tarpon, University of South Florida St. Petersburg (USFSP), Trauma-Informed Congregations (Pastor Doug Walker)

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

Objective BH 1.1.3: By December 31, 2021, reduce the proportion of drug-related accidental deaths from 2.2% (2016) to 1.5%.

Data Source: District 6 Medical Examiner's Annual Report

Activity		Process Measure	Coordinating 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	Pinellas County Opioid Task Force (PCOTF)	Pinellas County Human Services, Drug Free America Foundation, Operation PAR
2	Increase awareness/prevention messaging targeting youth	Identify at least 2 opportunities for messaging toward youth and ensure at least one CHAT member is present at PCOTF regular meetings	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 better understand behavioral health needs.

Objective BH 1.2.1: By December 31, 2021, reduce the Pinellas suicide rate from 18.1 (2015-17) to 17.0.

Data Source: FL Health CHARTS (Vital Statistics)

Activity		Process Measure	Coordinating 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 2 public forums surrounding mental health by Dec. 2021	CHAT-Behavioral Health	JWB, BHSOC, Zero Pinellas, DOH-Pinellas, Council of Neighborhood Associations (CONA)
2	Promote and increase Mental Health First Aid training	Ensure at least one training is offered and delivered to non-agency community members, as well as teachers and law enforcement, first responders	CFBHN	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 better understand behavioral health needs.

Objective BH 1.2.2: By December 31, 2021, 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	Coordinating Agency	Partner Agencies
1	Determine baseline for universal screenings offered in Pinellas	Universal screening baseline is established by June 2019	CHAT-Behavioral Health	CFBHN, DOH-Pinellas, JWB, BHSOC
2	Identify points of contact for potential screening sites, especially among at-risk populations (using JWB data)	At least one point of contact is identified in North and South County	CHAT-Behavioral Health	Hospitals, Community Health Centers of Pinellas, CONA, Law Enforcement, First Responders, Local Business Owners, Churches United for Healthy Congregations (CUFHC), Boys & Girls Club
3	Identify single screen for Mental Health/Substance Abuse for adult, young adult, high school, school age, birth-five and pregnant	At least one screen is identified for each age group	CHAT-Behavioral Health	DOH-Pinellas, JWB, BHSOC, USFSP
4	Research existing applicable grants, funding options, etc. in the county	A scan of funding options is completed by Dec. 2019	CHAT-Behavioral Health	JWB, BHSOC, DOH-Pinellas

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, 2021, reduce Crisis Stabilization Unit (CSU) rate of re-admission within 30 days from 12% (2018) to 10%.

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

Activity		Process Measure	Coordinating Agency	Partner Agencies
1	Identify outpatient care coordinators for transition care	At least 2 care coordinators identified	PEMHS	Suncoast Center, Directions for Living, Local CSUs, Hospitals
2	Locate outpatient care coordinators in inpatient locations to engage in outpatient services	At least 2 care coordinators placed in inpatient locations	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, 2021, 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	Coordinating Agency	Partner Agencies
1	Determine baseline of existing formal agreements/MOUs between behavioral health providers in Pinellas	Baseline number is determined by June 2019	CHAT-Behavioral Health	PEMHS, Suncoast Center, Directions for Living, BHSOC, JWB
2	Facilitate completion of MOU between behavioral health providers	At least one MOU is completed between 2+ behavioral health providers	CHAT-Behavioral Health	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, 2021, 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	Coordinating Agency	Partner Agencies
1	Identify baseline for number of SOAR evaluations administered in Pinellas	Baseline is identified for number of SOAR evaluations administered	PEMHS, CHAT-Behavioral Health	Suncoast Center, Directions for Living, BHSOC
2	Train more providers in SOAR evaluation administration	At least one SOAR training is delivered by Dec. 2019	PEMHS, CHAT-Behavioral Health	Suncoast Center, Directions for Living, BHSOC

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

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

Data Source: JWB

Activity		Process Measure	Coordinating Agency	Partner Agencies
1	Review existing groups working to address mental health and/or substance use	A list/database of existing groups is created	JWB	CHAT-Behavioral Health, BHSOC, Pinellas County, DOH-Pinellas
2	Identify formal collaborations (i.e. agreements, MOUs, etc.) among groups addressing mental health and/or substance use	Formal collaborations are identified for groups in list/database	CHAT-Behavioral Health	JWB, BHSOC, 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 1.4: Improve coordination between community stakeholders and partners to encourage innovative approaches to address substance use and behavioral health needs.

Objective BH 1.4.2: By December 31, 2021, increase the number of formal collaborations (e.g. agreement, MOU, action plan, etc.) focused on mental health and/or substance use needs by 10% of baseline (TBD in Objective BH 1.4.1).

Data Source: Collaborative Agencies

Activity		Process Measure	Coordinating Agency	Partner Agencies
1	Identify populations served, number of initiatives and partners involved for groups identified in Objective BH 1.4.1	Details are identified for all groups in Objective BH 1.4.1 list/database	CHAT-Behavioral Health, JWB	DOH-Pinellas, BHSOC
2	Create behavioral health funding map for Pinellas	A funding map is created by Dec. 2019	Pinellas County, CHAT-Behavioral Health	BHSOC, JWB
3	Facilitate formal collaboration (i.e. agreement, MOU) among groups with similar aims	At least one MOU is completed between 2+ behavioral health entities	CHAT-Behavioral Health	DOH-Pinellas, BHSOC, JWB, Pinellas County

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, 2021, increase the # of agencies identified and trained in Social Determinants of Health/Health Equity from 0 to 12.

Data Source: CHAT- Social Determinants of Health

Activity		Process Measure	Coordinating Agency	Partner Agencies
1	a) Update Collaborative Partners List (2018 CHIP p. 7-9) b) Use list to identify potential agencies	Identified at least 12 potential agencies.	DOH-Pinellas	CHAT-Social Determinants of Health, Foundation for a Healthy St. Petersburg (FHSP)
2	Identify existing/appropriate training(s) focused on social determinants and health equity	Identified at least two potential trainings (e.g. presentations, workshops)	DOH-Pinellas	CHAT-Social Determinants, FHSP, Tampa Bay Healthcare Collaborative (TBHC), HiAP-Pinellas Working Group
3	Deliver trainings	Delivered at least 12 trainings by Dec. 2021	DOH-Pinellas, FHSP	HiAP-Pinellas Working Group

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, 2021, increase the # of trusted thought leaders outside of the CHAT engaged around issues related to health equity and social determinants from 0 to 12.

Data Source: CHAT- Social Determinants of Health

Activity		Process Measure	Coordinating Agency	Partner Agencies
1	Identify thought/opinion leaders in community through actor mapping process	Identified at least 12 opinion leaders for engagement	CHAT-Social Determinants	Unite Pinellas, DOH-Pinellas, FHSP, Suncoast Health Council
2	Set up focus groups/town hall meetings engage community in conversation about needs and barriers	Set up 2 focus groups/town halls per year	FHSP, DOH-Pinellas	Unite Pinellas, CHAT-Social Determinants
3	Engage leaders on issues related to health equity and social determinants through 1:1 or group encounters	Met and discussed social determinants/health equity with at least 12 identified thought leaders by Dec. 2021	DOH-Pinellas, FHSP	Unite Pinellas, CHAT-Social Determinants, City of St. Pete, 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, 2021, increase the # of formal collaborations (i.e. agreements, MOUs, etc.) focused on youth and/or aging populations from 0 to 1.

Data Source: Collaborative Agencies

Activity		Process Measure	Coordinating Agency	Partner Agencies
1	Track initiatives focused on youth and/or aging populations	A list/database of existing initiatives is created	CHAT-Social Determinants, Area Agency on Aging	Safe Routes to School (SRTS), Bike/Ped Advisory Committee (BPAC), CHAT-Social Determinants, JWB
2	Identify strategic goals and priorities for potential collaboration	Goals/priorities identified for each initiative in database	CHAT-Social Determinants, Area Agency on Aging	SRTS, Pinellas County Schools, JWB
3	Formalize collaboration of initiatives with similar aims	A completed formal agreement between 2+ entities	Collaborative Agencies	CHAT-Social Determinants, DOH-Pinellas
4	Initiate at least one priority project surrounding youth and/or aging populations	A project plan is developed by Dec. 2021	Collaborative Agencies	CHAT-Social Determinants, DOH-Pinellas

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, 2021, 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	Coordinating Agency	Partner Agencies
1	Track initiatives addressing social determinants of health and/or health equity in the working age population	A list/database of existing initiatives is created	CHAT-Social Determinants	FHSP, TBHC, Suncoast Health Council
2	Identify strategic goals and priorities for potential collaboration	Goals/priorities identified for each initiative in database	CHAT-Social Determinants	DOH-Pinellas, FHSP, TBHC, Suncoast Health Council
3	Formalize collaboration of initiatives with similar aims	A completed formal agreement between 2+ entities	Collaborative Agencies	CHAT-Social Determinants, DOH-Pinellas
4	Initiate at least one priority project surrounding youth and/or aging populations	A project plan is developed by Dec. 2021	Collaborative Agencies	CHAT-Social Determinants, DOH-Pinellas

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, 2021, increase the # of Pinellas government entities that will agree to consider addressing health and equity in policies through a formalized adoption process (i.e. Resolution, Executive Order) from 0 to 3.

Data Source: DOH-Pinellas (HiAP-Pinellas)

Activity		Process Measure	Coordinating Agency	Partner Agencies
1	Choose a local government based upon population at large or health disparities	At least 3 local governments are chosen	DOH-Pinellas	CHAT-Social Determinants
2	Approach city councils/commissions or mayor	At least 3 local government representatives are approached	HiAP-Pinellas Working Group	DOH-Pinellas
3	Promote with education based on CHA	CHA data is presented to at least one representative of each chosen government entity	HiAP-Pinellas Working Group	DOH-Pinellas

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, 2021, increase the # of Pinellas government entities that have adopted a "Health in All Policies" framework from 0 to 3.

Data Source: DOH-Pinellas (HiAP-Pinellas)

Activity		Process Measure	Coordinating Agency	Partner Agencies
1	Select local government policy and/or process	At least one policy and/or process is selected per government entity	HiAP-Pinellas Working Group, DOH-Pinellas	CHAT-Social Determinants, City of St. Petersburg, City of Pinellas Park, Pinellas County Government
2	Conduct process evaluation to understand where health and equity considerations could be inserted/formalized	Process evaluation is completed for each selected process and/or policy	HiAP-Pinellas Working Group, DOH-Pinellas	City of St. Petersburg, City of Pinellas Park, Pinellas County Government
3	Recommend inserting health and equity considerations as appropriate.	Health and equity recommendations are made to at least one decision-making representative of each government entity	HiAP-Pinellas Working Group, DOH-Pinellas	City of St. Petersburg, City of Pinellas Park, Pinellas County Government

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

Appendix B: Revisions

Any revisions made to the Pinellas Community Health Improvement Plan by the CHAT and/or community stakeholders will be recorded in future versions of the CHIP.