PINELLAS COUNTY
COMMUNITY HEALTH IMPROVEMENT PLAN
2018-2021
Pinellas County Community Health Improvement Plan

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Governor

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Production of the Florida Department of Health in Pinellas County

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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>
<thead>
<tr>
<th>Existing Public Health Collaboratives</th>
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<tbody>
<tr>
<td>I. Access to Care</td>
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<tr>
<td>Action and Sharing</td>
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<tr>
<td>Bold Goals Initiative: Humana</td>
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<tr>
<td>Peace4Tarpon</td>
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<tr>
<td>Pinellas County Kinship Care Collaborative</td>
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<tr>
<td>Tampa Bay Diabetes Collaborative</td>
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<tr>
<td>Women &amp; Infant and Children</td>
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<td>Healthy Start Community Action Network</td>
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<td>Action-Focused</td>
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<td>211 Tampa Bay Cares</td>
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<td>Certified Health Navigator</td>
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<td>Community Health Action Team</td>
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<td>Make a Difference</td>
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<td>Mom Care</td>
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<td>Monthly Health Workshops for Latinos</td>
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<td>Oral Health Coalition</td>
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<tr>
<td>School Nurse Committee</td>
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<tr>
<td>Tampa Bay Breastfeeding</td>
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<tr>
<td>Tampa Bay Healthcare Collaborative</td>
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<tr>
<td>West Central Florida Ryan White Council</td>
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<tr>
<td>Sharing-Focused</td>
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<td>AARP Care Coalition</td>
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<tr>
<td>Pinellas County Medical Association</td>
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<td>Pinellas County Osteopathic Medical Society</td>
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</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
- COOEBF - 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

Pinellas County Community Health Improvement Plan
### 4. Community Health

<table>
<thead>
<tr>
<th>Action and Sharing</th>
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<tr>
<td>Bold Golds Initiative: Humana</td>
<td>LIFT Health</td>
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<td>Diabetes Collaborative</td>
<td>Peace4Tarpons</td>
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<tr>
<td>Feeding Tampa Bay</td>
<td>Pinellas County Kinship Care Collaborative</td>
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<tr>
<td>Healthy St. Pete Initiative</td>
<td>School Health Advisory Committee</td>
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<td>Help Me Grow</td>
<td>St. Petersburg Police Department</td>
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<td>Humana Bold Goal</td>
<td>Tampa Bay Network to End Hunger</td>
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<td>All Children’s Hospital CHNA</td>
<td>LGBTQ + Homeless Youth Steering Committee</td>
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<td>Baby Steps to Baby Friendly</td>
<td>Mothers Own Milk- MOM</td>
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<tr>
<td>Beds for Babies</td>
<td>Open Network- health and food systems</td>
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<td>Cancer Control &amp; Chronic Disease Community Roundtable Work Group</td>
<td>Open Streets St. Pete</td>
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<td>Colorectal Cancer Community Committee</td>
<td>Pinellas Diabetes Collaborative</td>
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<td>Childhood Hunger</td>
<td>Prevent Needless Death Campaign</td>
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<td>Churches United for Healthy Congregations</td>
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<td>Community Foundation Wimauma Task Force</td>
<td>Reducing Health Disparities &amp; Infant mortality</td>
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<td>Fit to Play</td>
<td>Ryan White Care Council</td>
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<td>Food is Medicine</td>
<td>Safe Kid Coalition</td>
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<td>Health Care for the Homeless</td>
<td>Safe Kids Committee</td>
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<td>Healthy Start Coalition</td>
<td>Tampa Bay Diabetes Collaborative</td>
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<td>iPump Club</td>
<td>West Central Florida Ryan White Council</td>
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<td>Bike/Walk Tampa Bay</td>
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<td>City of St. Pete Complete Streets Committee</td>
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<td>Healthy Pinellas Consortium</td>
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<td>Refugee Advisory Board</td>
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<td>St. Petersburg Mayor’s Bicycle and Pedestrian Advisory Committee</td>
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### 5. Other

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<th>Action and Sharing</th>
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<tbody>
<tr>
<td>Foundation for a Healthy St. Petersburg – Health Equity/Population Health</td>
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<tr>
<td>Pinellas County Housing Authority- Program Coordinating</td>
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<tr>
<td>Emergency Shelter Family Task Force</td>
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<td>Pinellas County School Health Advisory Committee</td>
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<td>Tampa Bay Network to End Hunger</td>
<td>Plant Healthy St. Pete</td>
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<td>Youth Health Task Force</td>
<td>Pinellas Homeless Leadership Board</td>
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<tr>
<td>Community Service Foundation</td>
<td>Tampa Bay Health &amp; Medical Coalition</td>
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<td>LGBTQ Homeless Youth Steering Committee</td>
<td>Childhood Hunger Initiative</td>
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<td>Age-Friendly Community Initiative</td>
<td>Hunger Initiative</td>
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<tr>
<td>Concerned Organizations For Quality Education For Black Students (COGEBs)</td>
<td>Juvenile Detention Alternatives Initiative (JDAI)</td>
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<td>Healthy St. Pete</td>
<td>Community Alliance</td>
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<th>Sharing Focused</th>
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<tr>
<td>Innovation District</td>
<td>Regional Security Domestic Taskforce</td>
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<tr>
<td>JWB South County Community Council</td>
<td>School Health Advisory Committee</td>
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</table>
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 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.
## Sectors Represented

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

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**

<table>
<thead>
<tr>
<th>Priority Area</th>
<th>Goals</th>
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| **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 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.

<table>
<thead>
<tr>
<th>Strategy AC 2.1</th>
<th>Promote the importance of prenatal care and being healthy prior to pregnancy, especially among disparate populations.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective AC 2.1.1</strong>: By December 31, 2021, increase the % of births to black mothers in Pinellas receiving 1st trimester prenatal care from 70.5% (2017) to 75%.</td>
<td></td>
</tr>
<tr>
<td><strong>Objective AC 2.1.2</strong>: 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%.</td>
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</table>

<table>
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<tr>
<th>Strategy AC 2.2</th>
<th>Educate and promote awareness among community stakeholders about racial disparities in infant mortality.</th>
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<tbody>
<tr>
<td><strong>Objective AC 2.2.1</strong>: By December 31, 2021, reduce the black/white infant mortality gap from 2.2 (2015-17) to 2.0.</td>
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<tr>
<th>Strategy AC 2.3</th>
<th>Promote breastfeeding initiation and duration for all infants.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective AC 2.3.1</strong>: By December 31, 2021, increase breastfeeding initiation for all infants among WIC clients from 80% (2018) to 83%.</td>
<td></td>
</tr>
<tr>
<td><strong>Objective AC 2.3.2</strong>: By December 31, 2021, increase breastfeeding duration for all infants among WIC clients from 26% (2018) to 30%.</td>
<td></td>
</tr>
</tbody>
</table>
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).
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.
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.

Acknowledgements

COMMUNITY HEALTH ACTION TEAM MEMBERS

Becky Afonso  
*Florida Bicycle Association*

Eliana Aguilar  
*Community Member*

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*In Season Pro*

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*AIDS Healthcare Foundation*

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*AIDS Healthcare Foundation*

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*Moffitt Cancer Center*

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*Florida Voices for Health*

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*Bright Community Trust*

Jerry Wennlund  
*Personal Enrichment through Mental Health Services (PEMHS)*

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*NAMI Pinellas County*

Tasha Wilkerson  
*Suncoast Center*

Kimberly Williams  
*Advent Health North Pinellas*

Amber Windsor-Hardy  
*Advent Health North Pinellas*

Arrow Woodard  
*City of Largo*

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*DOH-Pinellas (Public Health Preparedness)*
 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)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Process Measure</th>
<th>Coordinating Agency</th>
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<tbody>
<tr>
<td>1</td>
<td>Gather data on why community members are unable to access care</td>
<td>Questionnaire is developed and delivered at least 3 community outreach events by Dec. 2019</td>
<td>CHAT-Access to Care</td>
</tr>
<tr>
<td>2</td>
<td>Increase community insurance enrollment events</td>
<td>Community enrollment events are identified, and at least one is added to a zip code with a large un/underinsured population by Dec. 2019</td>
<td>CHAT-Access to Care</td>
</tr>
</tbody>
</table>

**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)

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<tr>
<td>1</td>
<td>Promote patient portal usage to increase information sharing among providers and sectors</td>
<td>At least one patient portal promotion tool is identified or developed by June 2019</td>
<td>DOH-Pinellas</td>
</tr>
<tr>
<td>2</td>
<td>Increase training/education on safety of information sharing and patient portal usage</td>
<td>At least one training is held by Dec. 2019</td>
<td>CHAT- Access to Care</td>
</tr>
</tbody>
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**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

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<tr>
<td>1</td>
<td>Develop Financial Impact Analysis of improvement of health conditions of Pinellas residents</td>
<td>A financial impact analysis is completed by Dec. 2019</td>
<td>DOH-Pinellas</td>
</tr>
<tr>
<td>2</td>
<td>Develop specific presentation for business community groups to demonstrate benefit of support and collaboration</td>
<td>A presentation for business community groups is developed by June 2021</td>
<td>DOH-Pinellas</td>
</tr>
<tr>
<td>3</td>
<td>Determine organizations to receive presentation and Financial Impact Analysis (e.g. social responsibility departments, chambers of commerce, restaurant associations)</td>
<td>At least 3 organizations are identified and receive presentation by Dec. 2021</td>
<td>DOH-Pinellas</td>
</tr>
</tbody>
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**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

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<tbody>
<tr>
<td>1</td>
<td>Facilitate development of at least one collaborative Access to Care intervention (i.e. agreement, MOU, etc.) among un/underinsured populations</td>
<td>An MOU is completed between 2+ agencies to implement a collaborative intervention by Dec. 2019</td>
<td>CHAT-Access to Care</td>
</tr>
<tr>
<td>2</td>
<td>Evaluate preliminary data of intervention</td>
<td>An evaluation of intervention results is completed by Dec. 2021</td>
<td>CHAT-Access to Care</td>
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**Alignment**

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**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

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<tr>
<td>1</td>
<td>Identify baseline of Community Health Workers (CHWs) in Pinellas</td>
<td>Baseline of CHWs is determined through FL Certification Board</td>
<td>CHAT-Access to Care</td>
</tr>
<tr>
<td>2</td>
<td>Coordinate with FL CHW Coalition for potential training/certification of additional CHWs in Pinellas</td>
<td>At least one training for additional CHWs is held in Pinellas</td>
<td>CHAT-Access to Care</td>
</tr>
</tbody>
</table>

**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

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<tbody>
<tr>
<td>1</td>
<td>Determine baseline for current CHC capacity to serve uninsured residents</td>
<td>Baseline for current capacity is determined</td>
<td>Community Health Centers of Pinellas (CHCs)</td>
</tr>
<tr>
<td>2</td>
<td>Implement focus groups for recommendations to increase CHC capacity</td>
<td>At least 2 focus groups are conducted by Dec. 2019</td>
<td>CHCs</td>
</tr>
<tr>
<td>3</td>
<td>Based on recommendations, implement new procedures</td>
<td>At least one procedure is formally changed or added based on recommendations</td>
<td>CHCs</td>
</tr>
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**Alignment**

<table>
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<th>Policy Component (Y/N)</th>
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### 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)

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<tr>
<td>1</td>
<td>Implement survey of barriers among target population</td>
<td>A survey is developed and administered to at least 50 black mothers by Dec. 2019</td>
<td>WIC &amp; Nutrition</td>
</tr>
<tr>
<td>2</td>
<td>Promote insurance/health care programs pre-, during and post-pregnancy</td>
<td>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)</td>
<td>Healthy Start Coalition</td>
</tr>
</tbody>
</table>

**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)

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<td>1</td>
<td>Implement survey of barriers among target population</td>
<td>WIC &amp; Nutrition</td>
<td>DOH-Pinellas, CHAT-Access to Care, Healthy Start Coalition</td>
</tr>
<tr>
<td></td>
<td>A bilingual survey is developed and administered to at least 50 black mothers by Dec. 2019</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Promote insurance/health care programs pre-, during and post- pregnancy</td>
<td>Healthy Start Coalition</td>
<td>WIC &amp; Nutrition, DOH-Pinellas, CHAT-Access to Care</td>
</tr>
<tr>
<td></td>
<td>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)</td>
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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)

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<tbody>
<tr>
<td>1</td>
<td>Create social media content to be shared with various community stakeholders focused on racial disparities in infant mortality</td>
<td>Content for at least 3 social media posts is developed</td>
<td>DOH-Pinellas</td>
</tr>
<tr>
<td>2</td>
<td>Use zip code data (JWB, Census) to educate targeted audiences about racial disparities in health and infant mortality</td>
<td>At least 3 education opportunities are delivered to community members</td>
<td>DOH-Pinellas</td>
</tr>
</tbody>
</table>

**Alignment**

<table>
<thead>
<tr>
<th>Policy Component (Y/N)</th>
<th>Pinellas Florida Healthy Babies (FHB) Action Plan</th>
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<tbody>
<tr>
<td>Y</td>
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</table>

Pinellas County Community Health Improvement Plan
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)

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<tbody>
<tr>
<td>1</td>
<td>Educate OB and pediatric providers about the health benefits of breastfeeding</td>
<td>Healthy Start Coalition’s “breastfeeding brochures” are distributed to all 42 OB and 54 pediatric providers in Pinellas</td>
<td>Healthy Start Coalition</td>
</tr>
<tr>
<td>2</td>
<td>Increase the number of Maternal and Child Health (MCH) staff who become certified lactation counselors</td>
<td>Lactation counselor training conducted for up to 20 MCH staff by Dec. 2019</td>
<td>DOH-Pinellas</td>
</tr>
</tbody>
</table>

**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)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Process Measure</th>
<th>Coordinating Agency</th>
<th>Partner Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Establish a baseline of the number of larger employers in Pinellas that have lactation support programs</td>
<td>Baseline established for larger employers in Pinellas (e.g. Pinellas County Schools, Publix, HCA, HSN, City &amp; County Government, Law Enforcement, Tampa Bay Times)</td>
<td>Tampa Bay Breastfeeding Task Force Pinellas Chapter (TBBF-Pinellas)</td>
</tr>
<tr>
<td>2</td>
<td>Engage with and increase the number of Pinellas employers that have lactation support programs</td>
<td>Number of employers with lactation support programs increased from baseline</td>
<td>TBBF-Pinellas</td>
</tr>
</tbody>
</table>

**Alignment**

<table>
<thead>
<tr>
<th>Policy Component (Y/N)</th>
<th>Pinellas FHB Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pinellas FHB Action Plan</td>
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</tr>
</tbody>
</table>
**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

<table>
<thead>
<tr>
<th>Activity</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Increase capacity of trainers</td>
<td>At least 2 more individuals are trained in delivering “Ending the Silence”</td>
<td>NAMI Pinellas</td>
</tr>
<tr>
<td>2</td>
<td>Identify areas that have not received training (i.e. gaps)</td>
<td>List developed of areas that did not receive training in 2018</td>
<td>CHAT-Behavioral Health</td>
</tr>
<tr>
<td>3</td>
<td>Deliver trainings</td>
<td>Deliver trainings to at least 1,600 participants by Dec. 2021</td>
<td>NAMI Pinellas</td>
</tr>
<tr>
<td>4</td>
<td>Provide referrals at trainings to other educational opportunities (e.g. Mental Health First Aid)</td>
<td>Reference material for at least one other behavioral health-related education opportunity available at all “Ending the Silence” trainings</td>
<td>CHAT-Behavioral Health</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Activity</th>
<th>Process Measure</th>
<th>Coordinating Agency</th>
<th>Partner Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Engage Peace4Pinellas and Peace4Tarpon</td>
<td>At least one representative from each has attended a CHAT meeting</td>
<td>CHAT-Behavioral Health</td>
</tr>
<tr>
<td>2</td>
<td>Identify opportunities to communicate trauma-informed practices to the public</td>
<td>At least 3 opportunities are identified and implemented by Dec. 2019</td>
<td>DOH-Pinellas, CHAT-Behavioral Health</td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Activity</th>
<th>Process Measure</th>
<th>Coordinating Agency</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Increase frequency and modality of information shared with the public</td>
<td>Align education and awareness efforts with PCOTF Strategic Plan by ensuring at least one CHAT member is present at PCOTF regular meetings</td>
<td>Pinellas County Opioid Task Force (PCOTF)</td>
</tr>
<tr>
<td>2</td>
<td>Increase awareness/prevention messaging targeting youth</td>
<td>Identify at least 2 opportunities for messaging toward youth and ensure at least one CHAT member is present at PCOTF regular meetings</td>
<td>Pinellas County Opioid Task Force (PCOTF)</td>
</tr>
</tbody>
</table>

**Alignment**

<table>
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<td>No</td>
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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)

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<th>Activity</th>
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<tbody>
<tr>
<td>1</td>
<td>Identify people of influence in local neighborhoods to promote neighborhood “speak ups” surrounding mental health</td>
<td>Connect with local leaders to hold or help coordinate at least 2 public forums surrounding mental health by Dec. 2021</td>
<td>CHAT-Behavioral Health</td>
</tr>
<tr>
<td>2</td>
<td>Promote and increase Mental Health First Aid training</td>
<td>Ensure at least one training is offered and delivered to non-agency community members, as well as teachers and law enforcement, first responders</td>
<td>CFBHN</td>
</tr>
</tbody>
</table>

**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

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

**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 readmission within 30 days from 12% (2018) to 10%.

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

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<tbody>
<tr>
<td>1</td>
<td>Identify outpatient care coordinators for transition care</td>
<td>At least 2 care coordinators identified</td>
<td>PEMHS</td>
</tr>
<tr>
<td>2</td>
<td>Locate outpatient care coordinators in inpatient locations to engage in outpatient services</td>
<td>At least 2 care coordinators placed in inpatient locations</td>
<td>PEMHS</td>
</tr>
</tbody>
</table>

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

<table>
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<tr>
<th>Activity</th>
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<tbody>
<tr>
<td>1</td>
<td>Determine baseline of existing formal agreements/MOUs between behavioral health providers in Pinellas</td>
<td>Baseline number is determined by June 2019</td>
<td>CHAT-Behavioral Health</td>
</tr>
<tr>
<td>2</td>
<td>Facilitate completion of MOU between behavioral health providers</td>
<td>At least one MOU is completed between 2+ behavioral health providers</td>
<td>CHAT-Behavioral Health</td>
</tr>
</tbody>
</table>

**Alignment**

**Policy Component (Y/N)**

SAMHSA, 2012-2017 Pinellas CHIP

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

<table>
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<tr>
<th>Activity</th>
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</tr>
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<tbody>
<tr>
<td>1</td>
<td>Identify baseline for number of SOAR evaluations administered in Pinellas</td>
<td>Baseline is identified for number of SOAR evaluations administered</td>
<td>PEMHS, CHAT-Behavioral Health</td>
</tr>
<tr>
<td>2</td>
<td>Train more providers in SOAR evaluation administration</td>
<td>At least one SOAR training is delivered by Dec. 2019</td>
<td>PEMHS, CHAT-Behavioral Health</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
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<th>Process Measure</th>
<th>Coordinating Agency</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Review existing groups working to address mental health and/or substance use</td>
<td>A list/database of existing groups is created</td>
<td>JWB</td>
</tr>
<tr>
<td>2</td>
<td>Identify formal collaborations (i.e. agreements, MOUs, etc.) among groups addressing mental health and/or substance use</td>
<td>Formal collaborations are identified for groups in list/database</td>
<td>CHAT-Behavioral Health</td>
</tr>
</tbody>
</table>

**Alignment**

<table>
<thead>
<tr>
<th>Policy Component (Y/N)</th>
<th>SAMHSA, 2012-2017 Pinellas CHIP</th>
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<tbody>
<tr>
<td>No</td>
<td></td>
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</tbody>
</table>
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

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

**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

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

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

<table>
<thead>
<tr>
<th>Activity</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify thought/opinion leaders in community through actor mapping process</td>
<td>Identified at least 12 opinion leaders for engagement</td>
<td>CHAT-Social Determinants</td>
</tr>
<tr>
<td>2</td>
<td>Set up focus groups/town hall meetings engage community in conversation about needs and barriers</td>
<td>Set up 2 focus groups/town halls per year</td>
<td>FHSP, DOH-Pinellas</td>
</tr>
<tr>
<td>3</td>
<td>Engage leaders on issues related to health equity and social determinants through 1:1 or group encounters</td>
<td>Met and discussed social determinants/health equity with at least 12 identified thought leaders by Dec. 2021</td>
<td>DOH-Pinellas, FHSP</td>
</tr>
</tbody>
</table>

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

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<tbody>
<tr>
<td>1</td>
<td>Track initiatives focused on youth and/or aging populations</td>
<td>A list/database of existing initiatives is created</td>
<td>CHAT-Social Determinants, Area Agency on Aging</td>
</tr>
<tr>
<td>2</td>
<td>Identify strategic goals and priorities for potential collaboration</td>
<td>Goals/priorities identified for each initiative in database</td>
<td>CHAT-Social Determinants, Area Agency on Aging</td>
</tr>
<tr>
<td>3</td>
<td>Formalize collaboration of initiatives with similar aims</td>
<td>A completed formal agreement between 2+ entities</td>
<td>Collaborative Agencies</td>
</tr>
<tr>
<td>4</td>
<td>Initiate at least one priority project surrounding youth and/or aging populations</td>
<td>A project plan is developed by Dec. 2021</td>
<td>Collaborative Agencies</td>
</tr>
</tbody>
</table>

**Alignment**

<table>
<thead>
<tr>
<th>Policy Component (Y/N)</th>
<th>Institute of Medicine (IOM) 5 Key Elements of a HiAP Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
</tr>
</tbody>
</table>
### 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

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Track initiatives addressing social determinants of health and/or health equity in the working age population</td>
<td>A list/database of existing initiatives is created</td>
<td>CHAT-Social Determinants</td>
</tr>
<tr>
<td>2</td>
<td>Identify strategic goals and priorities for potential collaboration</td>
<td>Goals/priorities identified for each initiative in database</td>
<td>CHAT-Social Determinants</td>
</tr>
<tr>
<td>3</td>
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<tr>
<td>4</td>
<td>Initiate at least one priority project surrounding youth and/or aging populations</td>
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<td>Collaborative Agencies</td>
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**Alignment**

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<th>Policy Component (Y/N)</th>
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<tbody>
<tr>
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<td>No</td>
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</tbody>
</table>
**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)

<table>
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<tbody>
<tr>
<td>1</td>
<td>Choose a local government based upon population at large or health disparities</td>
<td>At least 3 local governments are chosen</td>
<td>DOH-Pinellas</td>
</tr>
<tr>
<td>2</td>
<td>Approach city councils/commissions or mayor</td>
<td>At least 3 local government representatives are approached</td>
<td>HiAP-Pinellas Working Group</td>
</tr>
<tr>
<td>3</td>
<td>Promote with education based on CHA</td>
<td>CHA data is presented to at least one representative of each chosen government entity</td>
<td>HiAP-Pinellas Working Group</td>
</tr>
</tbody>
</table>

**Alignment**

<table>
<thead>
<tr>
<th>Alignment</th>
<th>IOM 5 Key Elements of a HiAP Approach, HiAP-Pinellas Strategic Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy Component (Y/N)</td>
<td>Yes</td>
</tr>
</tbody>
</table>
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)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Process Measure</th>
<th>Coordinating Agency</th>
<th>Partner Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Select local government policy and/or process</td>
<td>At least one policy and/or process is selected per government entity</td>
<td>HiAP-Pinellas Working Group, DOH-Pinellas</td>
</tr>
<tr>
<td>2</td>
<td>Conduct process evaluation to understand where health and equity considerations could be inserted/formalized</td>
<td>Process evaluation is completed for each selected process and/or policy</td>
<td>HiAP-Pinellas Working Group, DOH-Pinellas</td>
</tr>
<tr>
<td>3</td>
<td>Recommend inserting health and equity considerations as appropriate.</td>
<td>Health and equity recommendations are made to at least one decision-making representative of each government entity</td>
<td>HiAP-Pinellas Working Group, DOH-Pinellas</td>
</tr>
</tbody>
</table>

**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.