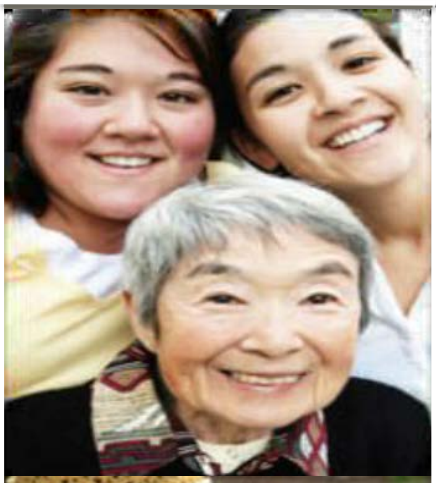

Pinellas County

COMMUNITY HEALTH IMPROVEMENT PLAN

2013 - 2017

Healthier People in a Healthier Pinellas

PINELLAS COUNTY

COMMUNITY HEALTH IMPROVEMENT PLAN

2013 - 2017

Produced by: Florida Department of Health in Pinellas County

Revised August 2015

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Executive Summary

The Florida Department of Health in Pinellas County (DOH-Pinellas) initiated the community health improvement planning process for Pinellas County in 2012, following the release of the 2012 Pinellas County Community Health Assessment. Over the past year, local public health system partners have convened a Community Health Action Team (CHAT) to guide the development of this 2013 - 2017 Community Health Improvement Plan (CHIP) for Pinellas County. A CHIP is a long-term, systematic plan to address public health problems in a community. The purpose of the CHIP is to define how DOH-Pinellas and the community will work together to improve the health of Pinellas County.

Using the Mobilizing for Action through Planning and Partnerships (MAPP) framework, CHAT identified access to care, behavioral health, health promotion and disease prevention, and healthy communities and environments as health priority areas for the Pinellas CHIP. CHAT and four health priority work teams have formulated goals, strategies, and objectives to address each of these areas. Additionally, 2013 - 2014 action plans have been revised for the 2014 – 2015 implementation period.

ACCESS TO CARE is a cross-cutting priority focused on reducing barriers to good health and improving health outcomes. Goals to ensure equal access to care include: (1) provide equal access to appropriate health care services and providers (2) use health information technology to improve collaboration among providers and increase efficiency in services to consumers and (3) reduce infant mortality and morbidity. Strategies to address these goals are standardizing training for community health workers, promoting the use of One-e-App as a common eligibility tool, and addressing disparities in infant mortality.

BEHAVIORAL HEALTH includes mental health, substance abuse, violence and other trauma. Goals to improve behavioral health outcomes include: (1) increase access to behavioral health services (2) reduce substance abuse among children and adults and (3) reduce violence among children and families. Among the strategies to address these goals is strengthening the integration of behavioral and primary health care services, advocating for changes in policy and practices related to prescription drugs, and promoting awareness related to domestic violence.

HEALTH PROMOTION AND DISEASE PREVENTION encompasses a range of health concerns including the leading causes of death in Pinellas County, cancer and heart disease. Goals to address health promotion and disease prevention include:

(1) increase the percentage of adults and children at a healthy weight (2) increase behaviors that improve chronic disease health outcomes and (3) increase protection against the spread of infectious disease. These goals will be addressed through strategies including promoting healthy eating habits and active lifestyles, increasing screening and education for chronic disease, and promoting childhood immunizations.

HEALTHY COMMUNITIES AND ENVIRONMENTS ensures access to opportunities for safe and healthy lifestyles. Goals for healthy communities and environments include (1) establish integrated planning and assessment processes to promote health in community level policies and plans (2) increase access to nutritious and affordable foods and (3) increase access to safe opportunities for physical activity. Strategies to achieve these goals include forming safe transportation linkages, promoting access to nutritious foods, and including health in the community planning process.

Over the next five 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.

As a member of the Pinellas community, we welcome your feedback and collaboration on future activities to achieve the goals set forth by CHAT. To become involved, visit www.PinellasCHAT.com or contact the Florida Department of Health in Pinellas County, Office of Performance and Quality Improvement.

I. Introduction

In 2011 and 2012, the Florida Department of Health in Pinellas County brought together the diverse entities and interests of Pinellas County to complete a Community Health Assessment (CHA). A CHA assesses the health of the population and identifies areas for health improvement. The CHA consisted of four assessments: Community Themes and Strengths Assessment, Local Public Health System Performance Assessment, Forces of Change Assessment, and Community Health Status Assessment. The Community Themes and Strengths Assessment utilized two approaches, a collaborative engagement and community survey, to better understand the perceived quality of life, current assets, and health issues of importance within the county. The collaborative engagement brought together nearly 70 community partners representing more than 30 organizations to assess the 10 Essential Public Health Services, including themes, strengths, and forces of change that affect Pinellas County and the Local Public Health System. The community survey spanned over five weeks, with more than eight hundred respondents who assessed perceived community health and quality of life issues within the county. The Forces of Change Assessment identified trends, factors, events, and other impending changes that influence the health and quality of life of Pinellas residents. It was conducted as part of the collaborative engagement previously described. The Local Public Health System Performance Assessment addressed the capacity of the local public health system and explored how the Essential Public Health Services are provided to the community. The Community Health Status Assessment determined the health status of the community through review of county-level data. This assessment also explored the socioeconomic factors influencing health and quality of life in the community, lifestyle behaviors, and how the health status of our community compares to that of other counties, the state, and the nation.

Following the Community Health Assessment, the Pinellas County Community Health Action Team (CHAT) convened in September 2012 to identify areas for health improvement and guide the development of the 2013 – 2017 Community Health Improvement Plan for Pinellas County.

Moving from Assessment to Planning: What is the CHIP?

A Community Health Improvement Plan (CHIP) is a long-term, systematic plan to address public health problems in a community. The purpose of the CHIP is to define how DOH-Pinellas and the community will work together to improve the health of Pinellas County. It provides the link between assessment and action. The CHIP was developed through collaboration among community partners to provide a framework to address the most pressing health issues in Pinellas County. The CHIP outlines goals, strategies, and objectives that the Community Health Action Team (CHAT) will address between 2013 and 2017. The CHIP action plan also identifies activities and measures to ensure progress towards these goals.

How to use the Community Health Improvement Plan

The CHIP will be used to engage the wide breadth of organizations that participate in the health and wellbeing of those residing in Pinellas County. The plan provides shared goals towards a common vision that will be used to direct activities to create *healthier people in a healthier Pinellas*. The CHIP action plans can be modified as resources, health concerns, and the environment change.

II. Methods

The Community Health Improvement Plan was developed using the Mobilizing for Action through Planning and Partnerships (MAPP) framework pictured at right. MAPP is a community-driven strategic approach to community health improvement planning developed collaboratively by the National Association of County and City Health Officials and Centers for Disease Control and Prevention.

Community Engagement

Community engagement is essential to creating a Community Health Improvement Plan that ensures effective, sustainable solutions. 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. For a complete listing of CHAT members and work team and collaborative engagement participants, see Acknowledgements in Section V.

Visioning

During the community health assessment process 24 visioning themes for community health improvement in Pinellas County were identified. Of the themes identified, the top ten emerged as:

1. Access to care
2. Coordinated system of care
3. Integrated system of care
4. Comprehensive continuum of care
5. Prevention and wellness focus
6. Chronic disease prevention
7. Expanded use of technology
8. Accessible health information and data
9. Improved quality and outcomes
10. Accountability at the individual, institutional and community levels

Using the top ten identified vision themes, CHAT members developed a vision statement for community health improvement in Pinellas County. The purpose of the vision statement is to provide focus and direction for community health improvement planning. The vision encourages participants and the community to collectively achieve a shared image of the future. The CHAT vision is:

Healthier People in a Healthier Pinellas

Setting Strategic Priorities

CHAT members utilized the Community Health Assessment results to identify strategic issues in Pinellas County. Strategic issues are those issues critical to achieving the vision of Healthier People in a Healthier Pinellas. Team members individually noted strategic issues and then grouped them into common priority areas as seen in the following table.

Chronic Disease Prevention	• chronic disease prevention • asthma hospitalizations • better management of chronic diseases • health behaviors • chronic diseases (CHF, diabetes, obesity) • obesity/diabetes/high blood pressure and cholesterol • prevention/sedentary lifestyle • adults and children who are overweight • reduce hospitalizations for preventable diseases • understanding preventative care • chronic disease prevention (diabetes prevention, partnerships with community organizations) • educate/empower community to become engaged in their wellness
Access to Care	• access to care (those with no health insurance, transportation, health education/prevention/marketing) • adults and dentists • access to care • patient-centered care • patient empowerment/engagement • insurance • accessible quality care • access to primary care (physicians, ARNPs, P.A.s, alternatives to the ER) • access to prevention and wellness • access to health and dental care • learning how to access care • investing in children's health • medical home for all people who are not eligible for health insurance/Medicaid/Medicare • education and health care to prevent and treat chronic diseases • access to preventative care • access to health care – including specialists • language and cultural competency in delivery of hospital and clinic care

Maternal/Child Health	• infant mortality and pre-term births • birth control • family planning • teen births • increase pre-contraceptive resources • infant mortality
Health Protection	• immunization rates • bacterial STDs in the I-4 corridor • STD rates • health protection
Behavioral Health	• substance abuse/addiction • mental illness/suicide • substance abuse prevention and treatment • better understand complex casual pathways • substance abuse/prescription drugs • domestic violence/child abuse • addiction/substance abuse • juvenile justice referrals • drug education and treatment programs at all levels of treatment needed (detox to in-patient) for youth and adults • the true impact stress has on a family and head of household
Education	• address summer learning loss • 4th and 8th grade reading proficiency • education • increase high school education rates
Technology	• technology • EHR integrated between healthcare providers • system of care through HIE • coordinated/comprehensive electronic medical records

Community/ Environment	• improve sidewalks and bike lanes • increase access to fresh fruits and veggies • increase funding for a health promotion focus • create/sustain safe environments • socioeconomic disparities that impact a community's health and wellness • safety • access to health food choices in a "food desert" • transportation is a huge factor in obesity • built environment • walkable communities • safe communities • promote opportunities for families to be active together • community redevelopment • livable communities • public transportation • community partnerships • research that targets certain communities

After further discussion of these common priority areas, four health priority areas emerged as being critical to achieving the vision:

1. Access to Care
2. Behavioral Health
3. Health Promotion and Disease Prevention
4. Healthy Communities and Environments

During discussion, education and technology emerged as reoccurring themes that should be addressed through strategy development in each priority area.

Development of Goals, Strategies, and Objectives

Work teams were convened for each of the four health priority areas. CHAT members and additional community stakeholders were invited to participate on work teams based upon their expertise. The work teams developed goals and strategies, and set measurable objectives based upon available data and the issues identified under *Setting Strategic Priorities*. The teams also worked to identify activities for each objective to address selected strategies. CHAT work teams met monthly between January 2013 and June 2013. Over the six-month period, draft goals, strategies, and objectives were presented to CHAT for feedback and discussion. Alignment of CHIP

objectives with local, state, and national plans is outlined in Appendix A. The final draft of goals, strategies, objectives, and suggested activities was used at the collaborative engagement during the CHIP action planning process.

Development of the Action Plan

On May 22, 2013, CHAT and work teams came together with additional community stakeholders to complete the CHIP Action Cycle. Action planning occurred through a half-day Collaborative Engagement at the St. Petersburg College EpiCenter Collaborative Labs. During this engagement, CHAT members and community stakeholders indicated available resources and discussed how these resources may be used to achieve CHIP goals and objectives. The results of this activity are listed in the table that follows.

CHAT members and community stakeholders also worked on action planning for each health priority area, including review of activities and selection of timeframes, coordinating agency, partner agencies, and process measures for monitoring and evaluation. This process resulted in a draft Action Plan for each health priority area. The Real Time Record for the Collaborative Engagement, outlining this process in detail, is located on the St. Petersburg College website at: http://www.spcollege.edu/central/collaborative/13/PCCHAT/PCCHIP_RTR.pdf.

Following the collaborative engagement, CHAT and work team members met in June 2013 to prioritize activities for the July 2013 – December 2014 Action Plan. Coordinating agencies will be contacted to review the CHIP monitoring and evaluation plan between July and December 2013. In July 2014, partners reconvened to create the 2014-15 action plan. In July and August of 2015, the action plans were revised for 2015-2016.

Over the next five 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.

Goal	Community Partner Alignment and Community Resources, 2013
ACCESS TO CARE	
Equal Access to Health Care Services and Providers	• DOH-Pinellas – Pinellas provider of medical homes for uninsured/low income • Pinellas County Health and Human Services – Primary care services, specialty care, and mobile medical unit • St. Petersburg Free Clinic – Access to adults who are uninsured • St. Joseph's Children's Hospital – Provide free well-child physicals and immunizations through the mobile medical clinic • DOH-Pinellas – Breast and Cervical Early Detection and Screening Program - Cancer screening for uninsured women, family planning services on sliding fee scale • Homeless Leadership Board – Coordination and planning for homeless services • Moffitt Cancer Center – Connecting community to health resources and agencies and increasing access to care • Pinellas KidCare Coalition – Providing insurance options for uninsured children • DOH-Pinellas – Increase access to dental care • All Children's Hospital • Tampa Bay Healthcare Collaborative – Collaborate and advocate for the healthcare underserved and work to connect these individuals with available resources • Juvenile Welfare Board – Works with 211 Tampa Bay Cares to connect people with resources; planning a study on the at risk areas of Pinellas County • 2-1-1 Tampa Bay Cares – Provide referrals for health and mental health services • Healthy Start for Pinellas – Working with KidCare to get kids insured in Pinellas County • St. Petersburg College – Networking; Community Health Worker Initiative • Hispanic Outreach Center • Lealman and Asian Neighborhood Family Center
Use of Health Information Technology to Improve Collaboration	• DOH-Pinellas – Use of direct secure messaging, health information exchange, and One E-app • USF Health – Working to implement Paperfree Florida – HItech, EHR/EMR – DSM & HIE

Reduce Infant Mortality & Morbidity	• DOH-Pinellas - Maternal & Child Health – Address issues that affect women and babies, increasing access to care and providing home visiting to interconceptual and pregnant women • Juvenile Welfare Board – Advocacy, planning, funding • All Children's Hospital • Healthy Start Coalition of Pinellas • Operation PAR
BEHAVIORAL HEALTH	
Increase Access to Behavioral Health Services	• SEDNET/PCSB – training, facilitate connections • BayCare Behavioral Health – Centralized access, primary care integration • Homeless Leadership Board – Coordination and planning of services • Juvenile Welfare Board – Funding and planning • DOH-Pinellas – Referral and counseling services • Peace4Tarpon TICI – Trauma informed care and behavioral health • Directions for Living – Provide a variety of mental health and substance abuse services • Operation PAR
Reduce Substance Abuse Among Children and Adults	• Public Defender's Office– Working to reduce incidence and effects of prescription drug abuse • WestCare – Adolescent and family prevention services, education, and family counseling • Juvenile Welfare Board – Funding and planning of services • DrugFree America Foundation – Education, advocacy, research • SEDNET/PCSB – Navigation of the healthcare system for children and families • Peace4Tarpon TICI • Healthy Start Coalition of Pinellas – PAT + Program • Operation PAR • DOH-Pinellas – Home visiting services to pregnant women and families • Substance Exposed Newborn task force • LiveFree! Substance Abuse Prevention Coalition
Reduce Violence Among Children & Families	• DOH-Pinellas – Home Visiting for pregnant women • SEDNET/PCSB - Helps children and families to navigate the healthcare system • R' Club Childcare Inc. – Provides before and after school care for children throughout Pinellas County • Juvenile Welfare Board – Funding, planning, advocacy

	• Drug Free America Foundation – Working to reduce and prevent drug abuse, which directly correlates to violence • Peace4Tarpon TICI • LiveFree! Substance Abuse Prevention Coalition • The Haven of RCS
HEALTH PROMOTION AND DISEASE PREVENTION	
Increase the percentage of Adults & Children Who are at Healthy Weight	• UF/IFAS – Pinellas County Extension – Outreach and education in community; provide nutrition education; encourage policy change related to healthy behaviors and worksite wellness • R'Club Childcare Inc. – Align with A Healthier Generation guidelines and before and after school care • Moffitt Healthy Kidz Program – Moffitt Cancer Center • USF Health Patient Portal & Patient Education • All Children's Hospital – Works with families to maintain healthy weight; prenatal health programs • ONE BAY: Healthy Communities – Focusing on 8 counties to increase the percentage of residents who are at a healthy weight • DOH-Pinellas - Home visiting weight management classes • Healthy Start Coalition of Pinellas Inc. • YMCA – Healthy eating and physical activity programs in after school care; diabetes prevention program to help combat chronic disease • Peace4Tarpon TICI
Increase Behaviors that Improve Chronic Disease Health Outcomes	• DOH-Pinellas – Tobacco Program • HEDIS Measures include preventive services in provision of primary care • GulfCoast North Area Health Education Center (AHEC)– Provides free tobacco cessation services • Homeless Leadership Board Planning and Coordination • All Children's Hospital • Pinellas County Extension - Nutrition Education • Moffitt Cancer Center – Work with organizations to provide cancer education and services • YMCA • Peace4Tarpon TICI • St. Petersburg Free Clinic – Comprehensive education-based model for diabetes
Increase Protection Against Spread of Infectious Diseases	• DOH-Pinellas – Promotion of immunization; STD/HIV education and prevention • St. Joseph's Children's Hospital – Immunization education and services • All Children's Hospital – immunizations, Back to School physicals

HEALTHY COMMUNITIES AND ENVIRONMENTS	
Integrate Planning and Assessment	• DOH-Pinellas – Strategic planning and community health improvement planning • Juvenile Welfare Board – Strategic alignment, planning, advocacy, and building community partnerships • Homeless Leadership Board – planning and coordination of services • Healthy Start Coalition of Pinellas • St. Petersburg College – Networking and training initiatives
Increase Access to Nutritious/Affordable Foods	• DOH-Pinellas – WIC – Advocate for farmer's market accepting EBT/SNAP • UF/IFAS – Pinellas County Extension – Works on access to nutritious foods through farmer's markets, gardens, and nutrition education • Homeless Leadership Board - Coordination and planning • All Children's Hospital – Nutrition Education programs for families • Pinellas County Schools, Food Services – Nutrition Education; provides nutritious food to children: breakfast, lunch, dinner, summer meals (breakfast and lunch)
Increase Access to Safe Physical Activity	• DOH-Pinellas – Find the Fun Now! Website; Communities Putting Prevention to work program provided fitness zones and encouraged policy change • City of Largo – Recreation programs, playgrounds, trails, pools, fitness zones • Juvenile Welfare Board – Out of school time activities • R'Club Childcare Inc. • All Children's Hospital – Safe Routes to School Program

III. Health Priority Areas

Each health priority area, a summary of the data supporting it, and related goals, strategies, and objectives are described in the pages that follow. A corresponding action plan has also been produced for each health priority area, found in Appendix B. Planned activities for 2014 and 2015 are described in detail in these action plans. Action plans for years 2016 and 2017 will be available as addendums to the 2013 – 2017 Pinellas County Community Health Improvement Plan as they become available. Updates to the CHIP and subsequent action plans will be available at the Pinellas County Community Health Action Team website, www.PinellasCHAT.com.

Access to Care

Why address Access to Care?

Addressing access to care can reduce barriers to health such as inadequate transportation, cultural or linguistic barriers, technical infrastructure, and social and economic barriers. Disparities in access to care have been linked to disparities in health outcomes. Such disparities can be seen in deaths due to chronic disease and in infant mortality rates in Pinellas County.

Community Perspective

Concerns regarding access to care were prevalent in the 2012 Pinellas County Community Health Assessment. In the Community Themes and Strengths Assessment, access to care was the most frequently cited factor needed for a healthy community, selected by 59.4% of Pinellas County Community Health Survey respondents.

Consulting the Data

- The majority of Pinellas adults (88.7%) had a personal doctor in 2010
- However, 16% of Pinellas adults could not see a doctor at least once in the past year due to cost in 2010
- 78.8% of Pinellas adults had a medical checkup in the past year in 2010
- 7.5% of Pinellas adults thought they would get better medical care if they belonged to a different race or ethnic group (2010)
- Community Health Workers presence and increased use of technology, such as the health information exchange, can help shape access to care
- The percentage of low birth weight live births (less than 2,500 grams) in Pinellas was 8.9%, higher than Florida at 8.7% (2010 – 2012)
- Only 78.0% of Pinellas women received first trimester prenatal care services (2009-2011)
- Infant mortality in Pinellas was 6.7 per 1,000 live births (6.3 per 1,000 live births FL) and for Black infants, this rate increased to 13.9 per 1,000 live births (2010 – 2012)

*Additional data, resources, and citations are listed in the 2012 Pinellas County Community Health Assessment. Data provided was obtained through Florida CHARTS, located at www.floridacharts.com.

Strategic Issue: How can we ensure equal access to health care services in Pinellas County?

Goal AC 1: Provide equal access to appropriate health care services and providers	**Strategy 1.1**: Address barriers in accessing existing health care services and consumer utilization in underserved communities. ❖ ***Objective 1.1.1****: By Dec 31, 2017, decrease the percentage of Pinellas adults who are unable to access a health care provider due to cost from 16% (2010) to 14.4%.*
	Strategy 1.2: Develop and implement a standardized training program for Community Health Workers. ❖ ***Objective 1.2.1****: By Dec 31, 2017, increase the number of trained Community Health Workers in Pinellas by 25% over baseline.*
	Strategy 1.3: Promote the completion of a cultural and linguistic competence organizational self-assessment to improve access to culturally competent care. ❖ ***Objective 1.3.1****: By Dec 31, 2016, decrease the percentage of Pinellas adults who believe they would receive better medical care if they belonged to a different race/ethnic group from 7% (2010) to 6.3%.*
Goal AC 2: Use health information technology to improve collaboration among providers and increase efficiency in services to consumers	**Strategy 2.1**: Improve communication among providers and care coordinators through data integration.* ❖ ***Objective 2.1.1****: By Dec 31, 2017, By Dec. 31, 2017, explore at least 2 data integration initiatives in Pinellas County.**
	~~**Strategy 2.2**: Improve communication among health providers and coordination of care for consumers through data sharing.~~ ❖ ~~***Objective 2.2.1****: By Dec 31, 2017, at least 50% of licensed registered Direct Secured Messaging (DSM) providers in Pinellas will be able to exchange data by using a Florida Health Information Exchange (HIE).**~~ ❖ ~~***Objective 2.2.2****: By Dec 31, 2017, no less than 25% of health services providers will be able to exchange data by using Direct Secured Messaging (DSM).**~~
Goal AC 3: Reduce infant mortality and morbidity	**Strategy 3.1**: Raise awareness among providers and consumers on the importance and benefits of being healthy prior to pregnancy. ❖ ***Objective 3.1.1****: By Dec 31, 2017, decrease the percentage of low-birth weight (less than 2,500 grams) infants in Pinellas from 8.9% (2010-2012) to 8%.*
	~~**Strategy 3.2**: Increase access to prenatal services and education.~~ ❖ ~~***Objective 3.2.1****: By Dec 31, 2017, increase the percentage of births to Pinellas mothers receiving first trimester prenatal care from 79.1% (2010-2012) to 87%.**~~
	Strategy 3.3: Address disparities in Black and Hispanic infant mortality. ❖ ***Objective 3.3.1****: By Dec 31, 2017, reduce the infant mortality rate of Black infants in Pinellas from 13.9 per 1,000 live births (2010-2012) to 11.5 per 1,000 live births.* ❖ ***Objective 3.3.2****: By Dec 31, 2017, reduce the infant mortality rate of Hispanic infants in Pinellas from 8.1 per 1,000 live births (2010-2012) to 7.3 per 1,000 live births.*

*Removed/Revised during 2015-16 update process.

Behavioral Health

Why address Behavioral Health?

Substance abuse, mental health, and violence among children and families affect not only the individual, but also the community. Further, behavioral health needs can go neglected and violence unreported due to stigma and other barriers to services. A focus on behavioral health creates an opportunity to address these barriers and improve the community's overall health and quality of life.

Community Perspective

Concern for behavioral health is found throughout the 2012 Pinellas Community Health Assessment. In the Community Themes and Strength Assessment, addiction was the top health problem of concern. Similarly, alcohol and drug abuse was the most frequently selected behavior of concern. Smoking was the fifth most prevalent behavior of concern.

Consulting the Data

- In 2010, 83.3% of Pinellas adults always or usually received the social and emotional support they needed
- The suicide age-adjusted death rate within the county was 17.7 per 100,000 population, increasing to 28.9 per 100,000 men (2009 – 2011)
- In 2012 the percentage of Pinellas youth who reported illicit drug use was 31.1%.
- In 2010, there were 153 newborn withdrawal cases in Pinellas County, up from just 22 in 2005.
- There were 201 accidental deaths due to prescription drugs in 2012
- The rate of Pinellas children 5 -11 experiencing child abuse was 18.8 compared to 11.4 per 1,000 population in Florida (2009 – 2011)
- The county domestic violence rate was 772.8 compared to 605 per 100,000 population in Florida (2009- 2011)
- The rate of non-fatal hospitalizations for self-inflicted injuries in Pinellas youth ages 12 to 18 was 72.9 per 100,000 population (2008 – 2010)

*Additional data, resources, and citations are listed in the 2012 Pinellas County Community Health Assessment. Data provided was obtained through Florida CHARTS, located at www.floridacharts.com.

Strategic Issue: How can we ensure access to behavioral health services and improve behavioral health outcomes in Pinellas County?

Goal BH 1: Increase access to behavioral health services	**Strategy 1.1**: Strengthen the integration of behavioral and primary health care service delivery. ❖ ***Objective 1.1.1****: By Dec 31, 2016, increase the percentage of Pinellas adults who always or usually receive the social and emotional support they need from 83.3% (2010) to 90%.*
	Strategy 1.2: Integrate trauma-informed care practices across care settings with emphasis on Adverse Childhood Experiences (ACEs). ❖ ***Objective 1.2.1****: By Dec 31, 2017, reduce the rate of non-fatal hospitalizations for self-inflicted injuries from 72.9 per 100,000 (2008-2010) to 65.6 per 100,000 among Pinellas youth 12-18.*
	Strategy 1.3: Engage targeted at-risk populations to better understand behavioral health care needs and prevent barriers to access. ❖ ***Objective 1.3.1****: By Dec 31, 2017, decrease the suicide age-adjusted death rate in Pinellas from 17.7 per 100,000 (2010-2012) to 16.2 per 100,000.*
Goal BH 2: Reduce substance abuse among children and adults	**Strategy 2.1**: Advocate for changes in policy and practices related to substance abuse, including more stringent regulations for prescription drugs classified as controlled substances. ❖ ***Objective 2.1.1****: By Dec 31, 2017, reduce the number of accidental drug or toxin related deaths in Pinellas from 201 (2012) to 181.*
	Strategy 2.2: Raise awareness among providers, parents, youth, and businesses on emerging substance abuse trends to improve and inform practices. ❖ ***Objective 2.2.1****: By Dec 31, 2016, reduce the number of Pinellas youth who report lifetime drug use from 31.1% (2012) to 26.1%.*
	Strategy 2.3: Increase access to substance abuse services for prenatal and postpartum women. ❖ ***Objective 2.3.1****: By Dec 31, 2017, reduce the rate of Neonatal Abstinence Syndrome in Pinellas from 27.1 per 1,000 births (2009-2011) to 24.4 per 1,000 births.*
Goal BH3: Reduce violence among children and families	**Strategy 3.1**: Promote community programs that maximize healthy development and interaction among children, families, schools, and communities. ❖ ***Objective 3.1.1****: By Dec 31, 2017, reduce the rate of Pinellas children under 18 experiencing child abuse from 24.0 per 1,000 (2012) to 16.9 per 1,000.*
	Strategy 3.2: Promote awareness, training, and advocacy to improve and inform practices related to domestic violence. ❖ ***Objective 3.2.1****: By Dec 31, 2017, reduce the domestic violence rate in Pinellas from 772.8 per 100,000 (2009-2011) to 695.5 per 100,000.*

Health Promotion and Disease Prevention

Why address Health Promotion and Disease Prevention?

Health promotion and disease prevention encompasses a range of health concerns, including chronic and infectious disease prevention and the behaviors contributing to a healthy lifestyle. Among these health concerns are the leading causes of death within Pinellas County, cancer and heart disease. Improvement in the behaviors affecting health outcomes is needed, notably the county's high rate of tobacco use and low rate of childhood immunizations.

Community Perspective

In the Community Themes and Strengths Assessment, healthy behaviors was the second most frequent factor chosen when residents were asked the top three factors needed for a healthy community. Similarly, among the top health problems of concern were obesity (#2) and chronic diseases (#3). The most frequent behaviors of concern included: poor nutrition (#2), lack of physical activity (#3), being overweight (#4), and smoking (#5).

Consulting the Data

- The leading causes of death in Pinellas County are cancer and heart disease
- Many adults do not receive routine cancer screenings – putting them at risk of late stage diagnoses
- The majority of adults, 60.1%, did not meet daily fruit and vegetable consumption recommendations and many (25.5%) are sedentary
- Nearly 20% of the adult population (19.3%) smoked tobacco in 2010
- Of the 2012 middle school students in Pinellas County, 28.1% of middle school students and 37.1% of high school students did not receive sufficient vigorous physical activity
- In 2010, 36.6% of Pinellas County adults had hypertension and 47.9% had high blood cholesterol
- In 2010, 65.9% of Pinellas County adults were either overweight or obese
- In 2009 – 2011, Pinellas County fell within the fourth quartile ranking of completing immunizations by Kindergarten

*Additional data, resources, and citations are listed in the 2012 Pinellas County Community Health Assessment. Data provided was obtained through Florida CHARTS, located at www.floridacharts.com.

Strategic Issue: How can we promote healthy lifestyles and prevent disease in Pinellas County?

Goal HPDP 1: Increase the percentage of adults and children who are at a healthy weight	**Strategy 1.1**: Promote healthy eating habits and active lifestyles in adults. ❖ ***Objective 1.1.1****: By Dec 31, 2017, decrease the percentage of Pinellas adults who are either overweight or obese from 65.6% (2010) to 59%.*
	Strategy 1.2: Promote healthy eating habits and active lifestyles in children ❖ ***Objective 1.2.1****: By Dec 31, 2017, increase the proportion of Pinellas children (1st, 3rd, 6th grade) who are at a healthy weight from 65.1% (2010 - 2011) to 71.6%.* ❖ ***Objective 1.2.2****: By Dec 31, 2017, decrease the percentage of Pinellas high school students reporting BMI at or above 95th percentile from 10.3% (2012) to 9.3%.*
Goal HPDP 2: Increase behaviors that improve chronic disease health outcomes	**Strategy 2.1**: Promote screening, education, and referral to treatment related to cancer. ❖ ***Objective 2.1.1****: By Dec 31, 2017, increase the percentage of Pinellas adults age 50 or older who received a colorectal screening in the past five years from 73.5% (2010) to 80.9%.* ❖ ***Objective 2.1.2****: By Dec 31, 2017, increase the percentage of Pinellas women age 40 or older who received a mammogram in the past year from 61.5% (2010) to 67.7%.*
	Strategy 2.2: Promote screening, education, and referral to treatment related to heart disease. ❖ ***Objective 2.2.1****: By Dec 31, 2017, decrease deaths due to heart disease in Pinellas from 155.5 per 100,000 (2010-2012) to 139.9 per 100,000.*
	Strategy 2.3: Promote activities to reduce tobacco use and exposure in adults and youth. ❖ ***Objective 2.3.1****: By Dec 31, 2017, increase the number of committed never smokers among Pinellas youth, ages 11 - 17 from 64.1% (2012) to 70.5.* ❖ ***Objective 2.3.2****: By Dec 31, 2016, decrease the percentage of Pinellas adults who are current smokers from 19.3% (2010) to 17.4%.*
Goal HPDP 3: Increase protection against the spread of infectious disease	**Strategy 3.1**: Provide targeted education on the benefits of receiving immunizations to increase the percentage of children who are fully immunized. ❖ ***Objective 3.1.1****: By Dec 31, 2017, increase the percentage of Pinellas two-year-olds who are fully immunized from 75.3% (2012/2013) to 90%.* ❖ ***Objective 3.1.2****: By Dec 31, 2017, increase the percentage of Pinellas Kindergarteners who are fully immunized from 89.8% (2012/2013) to 94%.*

Healthy Communities and Environments

Why address Healthy Communities and Environments?

Creating healthy communities and environments provides opportunity for residents to live a healthy lifestyle more easily. This priority addresses the effects that the physical and built environment has on health. Access to fresh fruits and vegetables, as well as to physical activity, can improve chronic disease health outcomes and the rates of obesity within the county.

Community Perspective

Creating a healthy community and environment addresses many of the concerns found throughout the 2012 Pinellas County Community Health Assessment. The top health problems of concern within the community included obesity (#2) and chronic diseases (#3) – both influenced by the environment in which a person is living. A clean environment and safe neighborhood ranked #3 and #4 as the most important factors for a healthy community.

Consulting the Data

- 32.7% of adults believed they did not have public recreation facilities that they could access in 2010
- In 2010, 7.8% of the population was living within 500 feet of a busy roadway
- Approximately half (50.6%) of the population lived within 0.5 miles (10 minute walk) from a park in 2010
- Only 20.4% of the population lived within a 0.5 miles of an off street trail system in 2010
- Over one-quarter of adults (25.5%) disagreed or strongly disagreed that it was easy to purchase affordable fresh fruits and vegetables in their neighborhood (2010)
- Nearly all adults, 96.2%, live 5 miles or less from the grocery store where they did most of their family's grocery shopping (2010)
- Over half (54.6%) of adults do not have access to a farmers market within their neighborhood (2010)
- 41% of the county population lives within 0.5 mile of a fast food restaurant; 43.2% of the population lives within 0.5 mile of a healthy food source

*Additional data, resources, and citations are listed in the 2012 Pinellas County Community Health Assessment. Data provided was obtained through Florida CHARTS, located at www.floridacharts.com.

Strategic Issue: How can we ensure an environment that is safe and provides access to opportunities for a healthy lifestyle?

Goal HCE 1: Establish integrated planning and assessment processes that promote health in community level policies and plans	**Strategy 1.1**: Include a public health component in community planning processes to increase awareness and opportunity of the built environment's impact on healthy behaviors. ❖ ***Objective 1.1.1****: By Dec 31, 2016, increase activity related to the development of policies and plans that support individual and community health within Pinellas from a score of 82% (2012) to 90%.*
Goal HCE 2: Increase access to nutritious and affordable foods	**Strategy 2.1**: Promote options for access to nutritious foods throughout Pinellas County. ❖ ***Objective 2.1.1****: By Dec. 31, 2016, increase the percentage of Pinellas adults who meet both of the daily recommendations for fruit and vegetable consumption from 9.3% (2010) to 11.5%.* **Strategy 2.2**: Support a focused effort to increase access to nutritious and affordable foods for children ❖ ***Objective 2.2.1****: By Dec 31, 2017, increase the percentage of Pinellas middle school students who consume at least five servings of fruits and vegetables a day from 21.2% (2012/2013) to 23.3%.*
Goal HCE 3: Increase access to safe opportunities for physical activity	**Strategy 3.1**: Promote collaborative efforts to form safe transportation linkages to schools, work, home, and recreation. ❖ ***Objective 3.1.1****: By Dec 31, 2017, complete 15 transportation linkages in Pinellas through infrastructure and programming improvements.* ❖ ***Objective 3.1.2****: By Dec. 31, 2016, decrease the percentage of Pinellas adults who were sedentary, or did not participate in any leisure-time activity in the past 30 days from 25.5% (2010) to 22%.*

IV. Next Steps

CHAT members and community stakeholders will begin implementation of the Community Health Improvement Plan in July 2013 (See Appendix B: 2013 – 2014 Action Plan). Progress on activities will be evaluated annually by CHAT with updates to the action plans as needed. Program monitoring and annual evaluation updates will be available at www.PinellasCHAT.com.

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VI. Appendices

Appendix A: Alignment

Aligned National, State, and Local Measures	
Access to Care	**Alignment**
Goal AC 1: Provide equal access to appropriate health care services and providers	
Strategy 1.1	Florida SHIP Strategy AC1.1, Healthy People 2020 AHS 6, PHAB 7.1
Objective 1.1.1	Florida SHIP AC 1.1.1
Objective 1.2.1	Florida SHIP HI3.4
Strategy 1.3	Florida SHIP Goal AC7/ Strategy AC7.1, Strategy CR3.2, PHAB Measure 11.1.3 (4)
Objective 1.3.1	Florida SHIP AC7.1.2 & 1.3, Key Health Disparity Objective and Measures (Appendix E), National Prevention Strategy, 2011-2016 Pinellas County Healthy Start Service Delivery Plan: B-3-1 (2)
Goal AC 2: Use health information technology to improve collaboration among providers and increase efficiency in services to consumers	Florida SHIP Goal HI1
Strategy 2.2	Florida SHIP Strategy HI1.1
Objective 2.2.1	Florida SHIP Strategy HI1.1
Objective 2.2.2	Florida SHIP Goal HI1/Strategy HI11.1
Goal AC 3: Reduce infant mortality and morbidity	Florida SHIP Goal AC5, Healthy People 2020 MICH1.3
Strategy 3.1	Florida SHIP Strategy AC5.1, Healthy People 2020 MICH 16.1, 2011-2016 Pinellas County Healthy Start Service Delivery Plan: Strategies B-2-3, C-2-1, C-2-2
Objective 3.1.1	Healthy People 2020 MICH 8.1, 2011-2016 Pinellas County Healthy Start Service Delivery Plan: Strategy B-4-1 (5)
Strategy 3.2	Healthy People 2020 MICH – 10

Objective 3.2.1	Healthy People 2020 MICH 10.1
Strategy 3.3	Florida SHIP Strategy AC5.4, Key Health Disparity Objective and Measures (Appendix E), Healthy People 2020 MICH 1.3
Objective 3.3.1	Florida SHIP Objective AC5.4.4
Behavioral Health	**Alignment**
Goal BH 1: Increase access to behavioral health services	Florida SHIP AC 3
Strategy 1.1	Florida SHIP AC 3.1, Healthy People 2020 MHMD-5, Recommended by the Centers for Disease Control and Prevention's Community Guide
Objective 1.3.1	Healthy People 2020 MHMD-1
Goal BH 2: Reduce substance abuse among children and adults	Florida SHIP AC 3.2
Objective 2.2.1	Healthy People 2020 SA- 2.4
Goal BH3: Reduce violence among children and families	
Objective 3.1.1	Healthy People 2020 IVP 37; IVP 38
Strategy 3.2	Healthy People 2020 IVP 39
Objective 3.2.1	Healthy People 2020 IVP 39.1; IVP 39.2; IVP 39.3; IVP 39.4
Health Promotion and Disease Prevention	**Alignment**
Goal HPDP 1: Increase the percentage of adults and children who are at a healthy weight	Florida SHIP Goal CD 1, Healthy People 2020 NWS-8, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity, One Bay Regional Plan Focus
Strategy 1.1	Healthy People 2020 NWS-8, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity, One Bay Regional Plan Focus
Objective 1.1.1	Healthy People 2020 NWS-8, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity, One Bay Regional Plan Focus
Strategy 1.2	Healthy People 2020 NWS-10, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity, One Bay Regional Plan Focus
Objective 1.2.1	Florida SHIP CD 2.3.4, Healthy People 2020 NWS-10, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity, One Bay Regional Plan Focus
Objective 1.2.2	Florida SHIP CD 2.3.4, Healthy People 2020 NWS 10.3; NWS-10, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity, One Bay Regional Plan Focus

Goal HPDP 2: Increase behaviors that improve chronic disease health outcomes	Florida SHIP CD 3, Healthy People 2020 NWS D-1
Strategy 2.1	Florida SHIP CD3.2
Objective 2.1.1	Florida SHIP CD 3.2.1, Healthy People 2020 C-3; C-17
Objective 2.1.2	Florida SHIP CD 3.2.2, Healthy People 2020 C-5; C-16
Strategy 2.2	Florida SHIP CD 3.2, Healthy People 2020 HDS-1
Objective 2.2.1	Healthy People 2020 HDS; HDS-1
Strategy 2.3	Florida SHIP Goal CD4, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity
Objective 2.3.1	Florida SHIP CD 4.1.1, Healthy People 2020 TU-3
Objective 2.3.2	Florida SHIP CD 4.2.1, Healthy People 2020 TU-4, TU-5, TU-7, Recommended by the Centers for Disease Control and Prevention's Community Guide
Goal HPDP 3: Increase protection against the spread of infectious disease	Florida SHIP Goal HP1, Healthy People 2020 IID-7
Strategy 3.1	Florida SHIP Strategy HP 1.1, Healthy People 2020 IID-7, Recommended by the Centers for Disease Control and Prevention's Community Guide
Objective 3.1.1	Florida SHIP Objective HP 1.1.1, Healthy People 2020 IID-7, DOH Long Range Plan Objective 1B
Objective 3.1.2	Healthy People 2020 IID-7; IID-10
Healthy Communities and Environments	**Alignment**
Goal HCE 1: Establish integrated planning and assessment processes that promote health in community level policies and plans	Florida SHIP CR 1, Public Health Law and Policy
Strategy 1.1	Florida SHIP CR 1.1, Public Health Law and Policy
Objective 1.1.1	Florida SHIP CR 1.1, Public Health Law and Policy
Goal HCE 2: Increase access to nutritious and affordable foods	Florida SHIP CD 1.3, Healthy People 2020 NWS Objectives, Public Health Law and Policy, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity
Strategy 2.1	Florida SHIP CD 1.3, Healthy People 2020 NSW 12; NSW 13, Public Health Law and Policy, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity
Objective 2.1.1	Florida SHIP CD 1.3, Healthy People 2020 NWS 15.1; NWS 15.2, Public Health Law and Policy, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity
Strategy 2.2	Florida SHIP CD 1.3.6, Healthy People 2020 NWS 15.1; NWS 15.2, Public Health Law and Policy, CDC Winnable Battle:

	Nutrition, Physical Activity, and Obesity
Goal HCE 3: Increase access to safe opportunities for physical activity	Florida SHIP CR2.2, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity, Recommended by the Centers for Disease Control and Prevention's Community Guide
Strategy 3.1	CDC Winnable Battle: Nutrition, Physical Activity, and Obesity, Recommended by the Centers for Disease Control and Prevention's Community Guide
Objective 3.1.1	Florida SHIP CR 2.1.1; CR 2.2.2, Healthy People 2020 PA-15 (PA 15.1; PA 15.2; PA 15.3), CDC Winnable Battle: Nutrition, Physical Activity, and Obesity, Recommended by the Centers for Disease Control and Prevention's Community Guide
Objective 3.1.2	Florida SHIP CR 2.1.1; CR 2.2.2, Healthy People 2020 PA-1, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity, Recommended by the Centers for Disease Control and Prevention's Community Guide

Appendix B: 2014 – 2015 Action Plan

Access to Care		
How can we ensure equal access to health care services in Pinellas County?		
Goal AC 1: Provide equal access to appropriate health care services and providers		
Policy Component (Y/N): No		
Performance Measures		
Objectives	**Data Source**	**Frequency**
Objective 1.1.1: By Dec 31, 2017, decrease the percentage of Pinellas adults who are unable to access a health care provider due to cost from 16% (2010) to 14.4%.	BRFSS	3 years
Objective 1.2.1: By Dec 31, 2017, increase the number of trained Community Health Workers (CHWs) in Pinellas by 25% over baseline.	Florida Community Health Worker Coalition/SPC	As needed
Objective 1.3.1: By Dec 31, 2016, decrease the percentage of Pinellas adults who believe they would receive better medical care if they belonged to a different race/ethnic group from 7% (2010) to 6.3%.	BRFSS	3 years
Outcomes		
Increase in adults who had a medical checkup in the past year Increase in percentage of CHWs who have enrolled in a standardized training Implementation by at least 4 agencies of CLAS assessment and action plan At least four new partnerships developed between social service and medical agencies in Pinellas County. Establishment of a forum for dialogue about direct messaging in Pinellas County. 2 agencies have implemented CLAS assessment and action plan		

Alignment with Local, State, and National Priorities	
Obj. 1.1.1	Florida SHIP AC 1.1.1
Obj. 1.2.1	Florida SHIP HI3.4

Strategy 1.1: Address barriers in accessing existing health care services and consumer utilization in underserved communities

Objective 1.1.1: By Dec 31, 2017, decrease the percentage of Pinellas adults who are unable to access a health care provider due to cost from 16% (2010) to 14.4%.

2014 – 2015 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Maintain document detailing existing health care provider resources for low-income patients in Pinellas County and capacity of these providers	Health & Community Services	DOH-Pinellas	July 2014-June 2015	Update resource document a minimum of twice annually.
2	Collaborate with Pinellas Suncoast Transit Authority council to identify and eliminate transportation barriers in vulnerable communities and advocate for the consideration of public health in transit decisions.	DOH-Pinellas	PSTA	July 2014-June 2015	A Community Health Action Team member will serve on the PSTA Transit Advisory Committee.
3	Provide healthcare resource information to ex-offenders enrolled at the Pinellas County Ex-Offender Reentry Coalition.	DOH-Pinellas, PERC	Pinellas County	July 2014-June 2015	Work with PERC to develop a set of healthcare provider resources and share this list with program participants.
4	Share social service and healthcare information at the Metropolitan Ministries' hot meal program.	Metropolitan Ministries	Local social service and medical providers	July 2014-June 2015	Recruit at least three social service/healthcare organizations to table at the Metropolitan Ministries' hot meal program.

Strategy 1.2: Develop and implement a standardized training program for Community Health Workers.

Objective 1.2.1: By Dec 31, 2017, increase the number of trained Community Health Workers (CHWs) in Pinellas by 25% over baseline.

2014 – 2015 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Develop a Community Health Worker registry and a standardized training/professional development toolkit.	Florida Community Health Worker Coalition (Pinellas County Chapter)	St. Petersburg College	July 2014-June 2015	Determine a baseline number of Pinellas County CHWs and identify their training needs.
2	Collaborate with other agencies in Access to Care workgroup and beyond to identify groups and job positions/titles that would be good candidates for CHW training or certification.	Florida Community Health Worker Coalition	St. Petersburg College, DOH-Pinellas	July 2014-June 2015	Identify at least three new agencies with CHW-like employees who would be good candidates for CHW training/certification.

Strategy 1.3: Promote the completion of a cultural and linguistic competence organizational self-assessment to improve access to culturally competent care.					
Objective 1.3.1: By Dec 31, 2016, decrease the percentage of Pinellas adults who believe they would receive better medical care if they belonged to a different race/ethnic group from 7% (2010) to 6.3%.					
2014 – 2015 Action Plan					
Activity		**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	Promote use of the CLAS self-assessment.	Tampa Bay Healthcare Collaborative (TBHC) and DOH-Pinellas	Center for Equal Health, Moffitt Diversity, Florida Diversity Council, TBCCN	July 2014-June 2015	1. Create a concept paper 2. Support at least one organization in using the CLAS self-assessment tool (may include workshops, technical assistance, etc.)

Access to Care

How can we ensure equal access to health care services in Pinellas County?

Goal AC 2: Use health information technology to improve collaboration among providers and increase efficiency in services to consumers

Policy Component (Y/N): No

Performance Measures

Objectives	Data Source	Frequency
Objective 2.1.1: By Dec. 31, 2017, increase health provider utilization of criteria for Pinellas health and social service program eligibility by 25% over baseline.	JWB	By request
Objective 2.2.1: By Dec 31, 2017, at least 50% of licensed providers in Pinellas will be able to exchange data using direct messaging.	USF Health Regional Extension Center	By request

Outcomes

At least four new partnerships developed between social service and medical agencies in Pinellas County. Forum established for dialogue about direct messaging in Pinellas County.

Alignment with Local, State, and National Priorities	
Obj. 2.2.1	SHIP Strategy HI1.1

Strategy 2.1: Streamline the eligibility process among community partners to increase access to services.					
Objective 2.1.1: By Dec. 31, 2017, increase health provider utilization of criteria for Pinellas health and social service program eligibility by 25% over baseline.					
2014 – 2015 Action Plan					
	Activity	**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	Convene a group to explore a common eligibility tool for social services that would be used by organizations in Pinellas that serve low-income patients.	Pinellas County Health & Community Services	JWB, DOH-Pinellas, 211	July 2014 – June 2015	At least two programs will be identified to have common eligibility criteria, where eligibility for one program will by automatically qualify them for the second program.

Strategy 2.2: Improve communication among health providers and coordination of care for consumers through data sharing.					
Objective 2.2.1: By Dec 31, 2017, at least 50% of licensed providers in Pinellas will be able to exchange data using direct messaging.					
2014 – 2015 Action Plan					
Activity		**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	Determine the requirements, sources, and costs for Direct Access.	USF Health	DOH-Pinellas, JWB, Pinellas County	July 2014 – June 2015	Create report detailing requirements, sources, and costs for Direct Access.

Access to Care

How can we ensure equal access to health care services in Pinellas County?

Goal AC 3: Reduce infant mortality and morbidity

Policy Component (Y/N): No

Performance Measures

Objectives	Data Source	Frequency
Objective 3.1.1: By Dec 31, 2017, decrease the percentage of low-birth weight (less than 2,500 grams) infants in Pinellas from 8.9% (2010-2012) to 8%.	Florida CHARTS	Annually
Objective 3.2.1: By Dec 31, 2017, increase the percentage of births to Pinellas mother's receiving first trimester prenatal care from 79.1% (2010-2012) to 87%.	Florida CHARTS	Annually
Objective 3.3.1: By Dec 31, 2017, reduce the infant mortality rate of Black infants in Pinellas from 13.9 per 1,000 live births (2010-2012) to 11.5 per 1,000 live births.	Florida CHARTS	Annually
Objective 3.3.2: By Dec 31, 2017, reduce the infant mortality rate of Hispanic infants in Pinellas from 8.1 per 1,000 live births (2010-2012) to 7.3 per 1,000 live births.	Florida CHARTS	Annually

Outcomes

Recruit at least three community partners to help promote health before and between pregnancies. Increase membership of the CAN and Hispanic Outreach Center. Reduce the number of infant deaths due to unsafe sleeping practices."

Alignment with Local, State, and National Priorities	
Obj. 3.1.1	Other: 2011-2016 Pinellas County Healthy Start Service Delivery Plan: Strategy B-4-1 (5)
Obj. 3.3.1	Florida SHIP Objective AC5.4.4

Strategy 3.1: Raise awareness among providers and consumers on the importance and benefits of being healthy prior to pregnancy.

Objective 3.1.1: By Dec 31, 2017, decrease the percentage of low-birth weight (less than 2,500 grams) infants in Pinellas from 8.9% (2010-2012) to 8%.

2014 – 2015 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Partner with community agencies to provide health-focused events/classes on interconceptional and pre-conception health	Sanderlin Center	Healthy Start Coalition of Pinellas, Community Health Workers Coalition, and WIC, Home Visiting Advisory Committee, Pinellas County Dental Coalition, Neighborhood Family Centers Network	July 2014 – June 2015	Sponsor at least 2 bi-annual events with community partners serving interconceptional and preconceptional women.
2	Develop a process to educate at risk youths in the community regarding the importance of their health and accessing health care services, with a focus on high schools.	Sanderlin Center	All Children's Hospital, HS Federal Project, CAN, DOH-Pinellas	July 2014 – June 2015	Conduct three focus groups with Neighborhood Family Centers to obtain input regarding engaging at risk youth in learning about their health.

2016 – 2017 Activities

- Partner with health care providers and universities to provide education and research about preconception health.
- Develop a campaign that educates women on the correlation between STDs and low-birth weight births.
- Work together with medical providers, law enforcement and health & human service agencies to address substance abuse.
- Place base initiative to identify high concentration of low birth weight infants.
- Develop policy recommendations promoting full term gestation vs. delivery prior to 39 weeks.

Strategy 3.2: Increase access to prenatal services and education.
Objective 3.2.1: By Dec 31, 2017, increase the percentage of births to Pinellas mother's receiving first trimester prenatal care from 79.1% (2010-2012) to 87%.
2016 – 2017 Activities
o Educate women about healthy start screenings and Healthy Start services o Develop a campaign to educate women on prenatal oral health care services o Work with the DOH-Pinellas Centering Pregnancy program for Hispanic women to increase enrollment. o Develop a campaign to promote Women, Infants, and Children (WIC) services.

Strategy 3.3: Address disparities in Black and Hispanic infant mortality.

Objective 3.3.1: By Dec 31, 2017, reduce the infant mortality rate of Black infants in Pinellas from 13.9 per 1,000 live births (2010-2012) to 11.5 per 1,000 live births.

Objective 3.3.2: By Dec 31, 2017, reduce the infant mortality rate of Hispanic infants in Pinellas from 8.1 per 1,000 live births (2010-2012) to 7.3 per 1,000 live births.

2014 – 2015 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Partner with ACH Community Action Network (CAN) and the Hispanic Outreach Center to identify strategies to engage and provide education to African American/Black and Hispanic/Latina women about prenatal behaviors that reduce infant mortality and low-birth weight infants.	Healthy Start Federal project	DOH-Pinellas, All Children's Hospital, USF, Women of Distinction, NAACP, St. Pete College, ACNW, Sororities, Urban League, Home Visiting Advisory Council, Healthy Start Coalition, Neighborhood Family Centers, National Council of Negro Women	July 2014 – June 2015	The Healthy Start Federal Project will have conducted at least 4 presentations, roundtable discussions in collaboration with minority community based organizations about the goals of the CAN and Hispanic Outreach Center.
2	Leverage Local Planning Team partners to address gaps in training the community on safe sleeping.	Local Planning Team	Local Planning Team partners, including JWB, DCF, Medical Examiner's Office - District 6, Healthy Start Coalition, BayCare	July 2014 – June 2015	Work with the Local Planning Team to develop and implement an action plan to reduce infant deaths due to unsafe sleeping.

2015 – 2017 Activities

- Support the efforts of Addressing Racism Achieving Health Equity (ARCHE) in identifying social factors that contribute to infant mortality and premature births
- Partner with therapeutic health agencies to educate staff about the impact of racism on healthy birth outcomes within the cultural setting.

Behavioral Health

How can we ensure access to behavioral health services and improve behavioral health outcomes in Pinellas County?

Goal BH 1: Increase access to behavioral health services

Policy Component (Y/N): No

Performance Measures

Objectives	Data Source	Frequency
Objective 1.1.1: By Dec 31, 2016, increase the percentage of Pinellas adults who always or usually receive the social and emotional support they need from 81.3% (2010) to 89.4%.	BRFSS	3 Years
Objective 1.2.1: By Dec 31, 2017, reduce the rate of non-fatal hospitalizations for self-inflicted injuries from 82.0 per 100,000 (2008-2010) to 65.6 per 100,000 among Pinellas youth 12-18.	Florida CHARTS	Annually
Objective 1.3.1: By Dec 31, 2017, decrease the suicide age-adjusted death rate in Pinellas from 17.7 per 100,000 (2009-2011) to 16.2 per 100,000.	Florida CHARTS	Annually

Outcomes

Increased number of referrals to behavioral healthcare providers. 200 doctors educated on trauma-informed care principles. 4 new organizations distributing Trauma-Informed Care materials. Identify gaps in behavioral healthcare access.

Alignment with Local, State, and National Priorities	
Obj. 1.3.1	Healthy People 2020 MHMD-1

Strategy 1.1: Strengthen the integration of behavioral and primary health care service delivery.

Objective 1.1.1: By Dec 31, 2016, increase the percentage of Pinellas adults who always or usually receive the social and emotional support they need from 81.3% (2010) to 89.4%.

2014 – 2015 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Improve the integration of primary and behavioral healthcare providers in Pinellas County.	BayCare Behavioral Health	TBD	July 2014 – June 2015	1. Identify a list of behavioral health providers who see low-income/uninsured patients and share resources with other local primary care doctors as needed. 2. Contact these providers to see whether they have relationships with local primary care doctors.

2015 – 2017 Activities

- Co-locate primary care providers in behavioral health care settings
- Co-locate behavioral health care providers in primary care settings
- Improve communication and coordination of care among providers though health information exchange
- Develop cross training programs for allied staff in primary and behavioral health care settings
- Develop an integrated system with the jails and linkage to community services upon release

Strategy 1.2: Integrate trauma-informed care practices across care settings with emphasis on Adverse Childhood Experiences (ACEs).

Objective 1.2.1: By Dec 31, 2017, reduce the rate of non-fatal hospitalizations for self-inflicted injuries from 82.0 per 100,000 (2008-2010) to 65.6 per 100,000 among Pinellas youth 12-18.

2014 – 2015 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Promote provider and agency education on trauma-informed approaches and practices via Pediatric Grand Rounds	Peace4Tarpon	National Center for Trauma-Informed Care, DOH-Pinellas	July 2014 – June 2015	Hold two trainings for providers at All Children's Hospital and/or other local pediatric care centers in Pinellas.
2	Peace4Tarpon Health & Wellness Committee, DOH-Pinellas, and Directions for Living will collaborate to distribute educational materials for providers in Pinellas County	Directions for Living	DOH-Pinellas, Peace4Tarpon	July 2014 – June 2015	300 TIC brochures distributed and 4 new distribution partners created.

2015 – 2017 Activities

- Pilot risk assessment and screening in Pinellas County Schools
- Develop cross training programs for allied staff in primary and behavioral health care settings

Strategy 1.3: Engage targeted at-risk populations to better understand behavioral health care needs and prevent barriers to access					
Objective 1.3.1: By Dec 31, 2017, decrease the suicide age-adjusted death rate in Pinellas from 17.7 per 100,000 (2010-2012) to 16.2 per 100,000.					
2014 – 2015 Action Plan					
Activity		**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	Collect suicide and behavioral health data for identified at-risk populations in Pinellas County.	Pinellas County Health & Community Services	Suncoast Health Council, DOH-Pinellas, Homeless Leadership Board, PEMHS, Operation PAR, LiveFree!, Data Collaborative Partners	July 2014 – June 2015	Completed report on suicide and behavioral health data.
2	Analyze data collected in Activity 1 and create action plans to address any areas of need.	Pinellas County Health & Community Services	Suncoast Health Council, DOH-Pinellas, Homeless Leadership Board, PEMHS, Operation PAR, LiveFree!	July 2014 – June 2015	Complete analysis and determine whether an action plan is needed.

Behavioral Health

How can we ensure access to behavioral health services and improve behavioral health outcomes in Pinellas County?

Goal BH 2: Reduce substance abuse among children and adults

Policy Component (Y/N): Yes

Performance Measures

Objectives	Data Source	Frequency
Objective 2.1.1: By Dec 31, 2017, reduce the number of accidental drug or toxin related deaths in Pinellas from 201 (2012) to 181.	District 6 Medical Examiner Annual Report	Annually
Objective 2.2.1: By Dec 31, 2016, reduce the number of Pinellas youth who report lifetime drug use from 31.1% (2012) to 27.9%.	Florida Youth Substance Abuse Survey	Biennially
Objective 2.3.1: By Dec 31, 2017, reduce the rate of Neonatal Abstinence Syndrome in Pinellas from 27.1 per 1,000 births (2009-2011) to 24.4 per 1,000 births.	Florida Agency for Healthcare Administration (AHCA)	Annually

Outcomes

Increased use of the Prescription Drug Monitoring Program (PDMP).

Alignment with Local, State, and National Priorities	
Obj. 2.2.1	Healthy People 2020 SA- 2.4

Strategy 2.1: Advocate for changes in policy and practices related to substance abuse, including more stringent regulations for prescription drugs classified as controlled substances.					
Objective 2.1.1: By Dec 31, 2017, reduce the number of accidental drug or toxin related deaths in Pinellas from 201 (2012) to 181.					
2014 - 2015 Action Plan					
Activity		**Coordinating Agency**	**Partner Agencies**	**Timeframe**	**Process Measure**
1	Coordinate a legislative agenda and sponsor legislation that requires physicians to use the PDMP.	LiveFree!/Pinellas County Justice & Consumer Services	FADAA Sheriff's Association FAC League of Cities FMA	July 2014 – June 2015	Compose amendment and seek legislative sponsor.
2	Convene a single substance abuse advisory group/oversight committee for Pinellas County.	LiveFree!/Pinellas County Justice & Consumer Services	PDAB Paraphernalia work group Pinellas County Medical Association	July 2014 – June 2015	Hold at least one meeting of the new oversight group.

Strategy 2.2: Raise awareness among providers, parents, youth, and businesses on emerging substance abuse trends to improve and inform practices.					
Objective 2.2.1: By Dec 31, 2016, reduce the number of Pinellas youth who report lifetime drug use from 31.1% (2012) to 27.9%.					
2014 – 2015 Action Plan					
Activity		**Coordinating Agency**	**Partner Agencies**	**Timeframe**	**Process Measure**
1	1. Develop and implement a campaign to educate parents, businesses, and youth on medical marijuana and the dangers of emerging designer drugs and prescription drugs	Pinellas County Justice and Consumer Services	LiveFree! Coalition, Drug Free America Foundation (DFAF)	July 2014 – December 2014	1. Educational materials distributed/parents educated. 2. Number of businesses educated. 3. Number of youth led groups who receive campaign materials.

Strategy 2.3: Increase access to substance abuse services for prenatal and postpartum women.

Objective 2.3.1: By Dec 31, 2017, reduce the rate of Neonatal Abstinence Syndrome in Pinellas from 27.1 per 1,000 births (2009-2011) to per 24.4 per 1,000 births.

2014 – 2015 Action Plan

	Activity	Coordinating Agency	Partner Agencies	Timeframe	Process Measure
1	Work with OB-GYNs to provide warnings to their patients on the dangers of substance use/abuse while pregnant and provide supports to address underlying issues.	Healthy Start Coalition	Operation PAR, Healthy Start Coalition, Birth Hospitals, BayCare, DOH-Pinellas, Motivating New Moms	July 2014 – June 2015	Increase number of providers reached (Baseline TBD).
2	Collect current data on drugs to which newborns are most frequently exposed.	Substance Exposed Newborns task force	DOH-Pinellas Healthy Families	July 2014 – June 2015	Create a report with results and analysis of data.

2015 – 2017 Activities

- Promote the use of evidence-based screening practices for prenatal substance abuse by OB/GYNs and other prenatal and postpartum providers
- Promote pregnancy testing by providers prior to prescribing prescription drugs classified as controlled substances

Behavioral Health		
How can we ensure access to behavioral health services and improve behavioral health outcomes in Pinellas County?		
Goal BH3: Reduce violence among children and families		
Policy Component (Y/N): Yes		
Performance Measures		
Objectives	**Data Source**	**Frequency**
Objective 3.1.1: By Dec 31, 2017, reduce the rate of Pinellas children under 18 experiencing child abuse from 24.0 per 1,000 (2012) to 16.9 per 1,000.	Florida Department of Children and Families	Quarterly
Objective 3.2.1: By Dec 31, 2017, reduce the domestic violence rate in Pinellas from 772.8 per 100,000 (2009-2011) to 695.5 per 100,000.	Florida CHARTS	Annually
Outcomes		
Greater number of DOH-Pinellas staff educated on DV prevention and preventive practices.; common screening policies/practices for violence and trauma		

Alignment with Local, State, and National Priorities	
Obj. 3.1.1	Healthy People 2020 IVP 37; IVP 38
Obj. 3.2.1	Healthy People 2020 IVP 39.1; IVP 39.2; IVP 39.3; IVP 39.4

Strategy 3.1: Promote community programs that maximize healthy development and interaction among children, families, schools, and communities.

Objective 3.1.1: By Dec 31, 2017, reduce the rate of Pinellas children under 18 experiencing child abuse from 24.0 per 1,000 (2012) to 16.9 per 1,000.

2014 – 2015 Action Plan

	Activity	Coordinating Agency	Partner Agencies	Timeframe	Process Measure
1	Distribute Child Safety Booklets to the community, including OB offices, child care providers, CHCs, home visiting programs, and health departments.	JWB	DOA Department of Children & Families Suncoast Center Domestic Violence Task Force	July 2014 – June 2015	Distribute plan to local birthing hospitals (St. Pete General; Bayfront Baby Place; Morton Plant Hospital - CLW; & Mease Countryside) and at least ten daycare providers.
2	Continue to hold violence/abuse response training for school health staff	DOH-Pinellas	-Juvenile Welfare Board -Child Protective Investigative Division (of the Pinellas County Sheriff's Office) -Haven of Religious Community Services	July 2014 – June 2015	Hold a minimum of one violence/abuse response training for school health staff.
3	Research violence screening tools that target families of children 0-5.	Family Study Center at USFSP	-ELC, Healthy Start, Early childhood mental health committee of FAIMH, JWB, CASA, Haven of RCS, FAIMH	July 2014 – June 2015	Identify a violence screening tool as well as organizations trained in its administration, and create a plan for its implementation.

Strategy 3.2: Promote awareness, training, and advocacy to improve and inform practices related to domestic violence.

Objective 3.2.1: By Dec 31, 2017, reduce the domestic violence rate in Pinellas from 772.8 per 100,000 (2009-2011) to 695.5 per 100,000.

2014 – 2015 Action Plan

	Activity	Coordinating Agency	Partner Agencies	Timeframe	Process Measure
1	Educate community healthcare providers on domestic violence policies and preventive practices.	Domestic Violence Task Force (DVTF)	DVTF Members DOH-Pinellas	July 2014 – June 2015	Hold at least one Being a Better Bystander training at a Pinellas health department location.

2015 – 2017 Activities

- Implement and expand plan developed between Operation PAR and the Domestic Violence Task Force for use in substance abuse treatment and outpatient settings, to include training staff about effective interventions
- Reinvest in the Elementary/Middle Peacemaker program model via Haven/CASA.

HEALTH PROMOTION AND DISEASE PREVENTION

How can we promote healthy lifestyles and prevent disease in Pinellas County?

Goal HPDP 1: Increase the percentage of adults and children who are at a healthy weight

Policy Component (Y/N): No

Performance Measures

Objectives	Data Source	Frequency
Objective 1.1.1: By Dec 31, 2017, decrease the percentage of Pinellas adults who are either overweight or obese from 65.6% (2010) to 59%.	BRFSS	3 years
Objective 1.2.1: By Dec 31, 2017, increase the proportion of Pinellas children (1st, 3rd, 6th grade) who are at a healthy weight from 65.1% (2010 - 2011) to 71.6%.	DOH School Health Report	Annually
Objective 1.2.2: By Dec 31, 2017, decrease the percentage of Pinellas high school students reporting BMI at or above 95th percentile from 10.3% (2012) to 9.3%.	YRBS	2 years

Outcomes

Increased percentage of adults who report exercising regularly.
Increased percentage of children who report exercising regularly.

Alignment with Local, State, and National Priorities	
Obj. 1.1.1	Florida SHIP Goal CD 1, Healthy People NWS-8, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity; One Bay Regional Plan Focus
Obj. 1.2.1	Florida SHIP Goal CD 1 and CD 2.3.4, Healthy People NWS-10, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity; One Bay Regional Plan Focus
Obj. 1.2.2	Florida SHIP Goal CD 1 and CD 2.3.4, Healthy People NWS-10 and NWS-10.3, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity; One Bay Regional Plan Focus

Strategy 1.1: Promote healthy eating habits and active lifestyles in adults.					
Objective 1.1.1: By Dec 31, 2017, decrease the percentage of Pinellas adults who are either overweight or obese from 65.6% (2010) to 59%.					
2014 – 2015 Action Plan					
Activity		**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	Provide educational sessions demonstrating healthy and culturally appropriate cooking and grocery shopping on a budget	Pinellas County Extension	Schools, ACH, WIC, YMCA, R' Club, Tampa Bay Network to End Hunger, Sustainable Urban Agriculture Coalition, BayCare, DOH-Pinellas	July 2014 – June 2015	Conduct three 6-week educational series annually, as documented by sign-in sheets and post-session surveys.
2	Promote usage of county parks, trails, and recreational facilities	DOH-Pinellas	Pinellas County Parks & Conservation Resources, Municipal Governments, Schools, ACH, ELC, BayCare, Veteran's Administration, YMCA	July 2014 – June 2015	Create and share park/trail maps, Find the Fun materials and other city recreational brochures with the community.

Strategy 1.2: Promote healthy eating habits and active lifestyles in children.					
Objective 1.2.1: By Dec 31, 2017, increase the proportion of Pinellas children (1st, 3rd, 6th grade) who are at a healthy weight from 65.1% (2010 - 2011) to 71.6%.					
Objective 1.2.2: By Dec 31, 2017, decrease the percentage of Pinellas high school students reporting BMI at or above 95th percentile from 10.3% (2012) to 9.3%.					
2014 – 2015 Action Plan					
	Activity	**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	Increase the number of after-school programs conducting the Alliance/MOST framework self-assessment.	Alliance for a Healthier Generation	R'Club YMCA Boys & Girls Club Parks & Rec	July 2014 – June 2015	21 programs conducting self-assessment.
2	Conduct inventory based self-assessments of Pinellas County Schools on the Alliance for Healthier Generation guidelines	Pinellas County Schools	Alliance for a Healthier Generation, DOH-Pinellas	July 2014 – June 2015	Increase in number of schools that achieve the gold, bronze or silver rating from the Alliance for a Healthier Generation.
3	Increase awareness of the importance of consuming fruits and vegetables by providing nutrition education to schools with 51% or more Free/Reduced school meal status	Pinellas County Extension	Pinellas County Schools	July 2014 – June 2015	500 students completing nutrition education program.
4	Increase number of City/County Recreation Centers with concession stands using Fun Bites Campaign to highlight healthy options.	DOH-Pinellas	WIC, Cities and County Parks and Recreation Departments	July 2014 – June 2015	2 new City/County concession stands will incorporate FUN BITES into their menus.
5	Increase the number of Early Learning Centers and organizations dealing with school-age children that have adopted evidence-based healthy eating and physical activity standards.	YMCA of St Petersburg	All Children's Hospital, Early Learning Coalition	July 2014 – June 2015	At least 6 new organizations sign on to physical activity and nutrition standards

HEALTH PROMOTION AND DISEASE PREVENTION

How can we promote healthy lifestyles and prevent disease in Pinellas County?

Goal HPDP 2: Increase behaviors that improve chronic disease health outcomes

Policy Component (Y/N): Yes

Performance Measures

Objectives	Data Source	Frequency
Objective 2.1.1: By Dec 31, 2017, increase the percentage of Pinellas adults age 50 or older who received a colorectal screening in the past five years from 73.5% (2010) to 80.9%.	BRFSS	3 years
Objective 2.1.2: By Dec 31, 2017, increase the percentage of Pinellas women age 40 or older who received a mammogram in the past year from 61.5% (2010) to 67.7%.	BRFSS	3 years
Objective 2.2.1: By Dec 31, 2017, decrease deaths due to heart disease in Pinellas from 155.5 per 100,000 (2010-2012) to 139.9 per 100,000.	Florida CHARTS	Annually
Objective 2.3.1: By Dec 31, 2017, increase the number of committed never smokers among Pinellas youth, ages 11 - 17 from 64.1% (2012) to 70.5%.	Florida Youth Tobacco Survey	Biennially
Objective 2.3.2: By Dec. 31, 2016, decrease the percentage of Pinellas adults who are current smokers from 19.3% (2010) to 17%.	BRFSS	3 years

Outcomes

Increase in number of adults educated about the importance of colorectal cancer screening.
Reduce obesity rates and increase physical activity in Pinellas County adults.
Reduce diabetes prevalence
Increased number of smoke free/tobacco free policies adopted.

Alignment with Local, State, and National Priorities	
Obj. 2.1.1	Florida SHIP CD 3.2.1, Healthy People 2020 C-3 and C-17
Obj. 2.1.2	Florida SHIP CD 3.2.2, Healthy People 2020 C-5 and C-16
Obj. 2.2.1	Healthy People 2020 HDS and HDS-1
Obj. 2.3.1	Florida SHIP CD 4.1.1, Healthy People 2020 TU-3
Obj. 2.3.2	Florida SHIP CD 4.2.1, Healthy People 2020 TU-4, TU-5, TU-7

Strategy 2.1: Promote screening, education, and referral to treatment related to cancer.					
Objective 2.1.1: By Dec 31, 2017, increase the percentage of Pinellas adults age 50 or older who received a colorectal screening in the past five years from 73.5% (2010) to 80.9%.					
2014 – 2015 Action Plan					
Activity		**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	Work with employers to educate employees about the importance of colorectal cancer screening and connect employees to screening resources	BayCare Corporate Wellness	YMCA Corporate Wellness; Gastro Florida - Mark O'Neal; USF Prevention Research Center	July 2014 – June 2015	25 employers distributing information to employees.

Strategy 2.1: Promote screening, education, and referral to treatment related to cancer.					
Objective 2.1.2: By Dec 31, 2017, increase the percentage of Pinellas women age 40 or older who received a mammogram in the past year from 61.5% (2010) to 67.7%.					
2014 – 2015 Action Plan					
	Activity	**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	Distribute educational materials to promote awareness of the Florida Breast and Cervical Cancer Early Detection Program, Mammography Voucher Program and general screening recommendations to women above 40 in Pinellas County.	DOH-Pinellas	TBCCN Partners St Pete Free Clinic Komen BayCare SW Florida Cancer Control Collaborative	July 2014 – June 2015	Distribute educational materials to at least 20 locations in Pinellas County.
2	Promote wellness programs for cancer survivors to increase overall health during recovery	YMCA of the Suncoast	Moffitt M-power, CaPSS, DOH-Pinellas, POWER Program at Morton Plant, YMCA of St. Petersburg	July 2014 – June 2015	Identify four new partners to distribute promotional materials about the LiveStrong and other wellness programs.
3	Support development and promotion of breast cancer screening-related activities under St. Pete General Hospital's action plan as required by the Commission on Cancer.	St. Petersburg General Hospital	DOH-Pinellas	November 2014 – June 2015	Hold at least two meetings with SPGH staff and assist in planning and/or publicizing at least one intervention.

Strategy 2.2: Promote screening, education, and referral to treatment related to heart disease.

Objective 2.2.1: By Dec 31, 2017, decrease deaths due to heart disease in Pinellas from 155.5 per 100,000 (2010-2012) to 139.9 per 100,000.

2014 – 2015 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Increase the number of companies in Pinellas County that are certified "Fit Friendly" by the ACA.	BayCare Corporate Wellness	American Heart Association	July 2014 – June 2015	Increase from 96 to 121 companies.
2	Refer diagnosed pre-diabetes patients at local hospitals to the CDC's National Diabetes Prevention Program, run locally as the YMCA's Diabetes Prevention Program	YMCA of St Petersburg	BayCare St. Anthony's Hospital	July 2014 – June 2015	Increase from 10 to 500 referrals

Additional activities related to heart disease reduction can be found under Goal 1, Strategy 1, lifestyle changes related to weight and physical activity.

2015 – 2017 Activities

- Provide blood pressure screenings
- Cholesterol screenings
- Coordinate and provide referral services

Strategy 2.3: Promote activities to reduce tobacco use and exposure in adults and youth.					
Objective 2.3.1: By Dec 31, 2017, increase the number of committed never smokers among Pinellas youth, ages 11 - 17 from 64.1% (2012) to 70.5%.					
2014 – 2015 Action Plan					
	Activity	**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	Create and maintain local SWAT chapters.	DOH-Pinellas – Tobacco Free Program/SWAT Coordinator	Pinellas County Schools, Tobacco Free Coalition	July 2014 – June 2015	SWAT Clubs at 15 middle/high schools will conduct at least 60 outreach activities will be completed each year.
2	Educate local policymakers on youth tobacco-related issues.	DOH-Pinellas – Tobacco Free Program/SWAT Coordinator	Pinellas County Schools TFCP Local municipalities	July 2014 – June 2015	The County SWAT Team will present to at least two municipal governments and support the passage of at least two new resolutions.

Strategy 2.3: Promote activities to reduce tobacco use and exposure in adults and youth.					
Objective 2.3.2: By Dec. 31, 2016, decrease the percentage of Pinellas adults who are current smokers from 19.3% (2010) to 17.0%.					
2014 – 2015 Action Plan					
	Activity	**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	Distribute "Quitkits" to clients who are smokers within Florida Department of Health in Pinellas clinics	DOH-Pinellas – Tobacco Free Program	Area Health Education Center (AHEC)	July 2014 – June 2015	2500 Quitkits will be distributed.
2	Conduct tobacco cessation programs within Pinellas County.	Area Health Education Center (AHEC)	DOH-Pinellas, Worksites, Cities	July 2014 – June 2015	15 6-week classes will be held throughout the county.
3	Educate local policymakers, businesses, and community organizations about tobacco use.	DOH-Pinellas	Worksites, Cities	July 2014 – June 2015	At least 4 tobacco worksite wellness policies will be adopted.

HEALTH PROMOTION AND DISEASE PREVENTION		
How can we promote healthy lifestyles and prevent disease in Pinellas County?		
Goal HPDP 3: Increase protection against the spread of infectious disease		
Policy Component (Y/N): Yes		
Performance Measures		
Objectives	**Data Source**	**Frequency**
Objective 3.1.1: By Dec 31, 2017, increase the percentage of Pinellas two-year-olds who are fully immunized from 75.3% (2012/2013) to 90%.	Florida CHARTS; Florida Department of Health Immunization Report	Annually
Objective 3.1.2: By Dec 31, 2017, increase the percentage of Pinellas Kindergarteners who are fully immunized from 89.8% (2012/2013) to 94%.	Florida CHARTS; Florida Department of Health Immunization Report	Annually
Outcomes		
Increase the number of health care providers represented on PITCH. 100% of Pinellas County providers will complete the PITCH training course. Improve Pinellas County Schools Immunization Report Card scores by 10%.		

Alignment with Local, State, and National Priorities	
Obj. 3.1.1	Florida SHIP Objective HP 1.1.1, Healthy People 2020 IID-7, Other: DOH Long Range Plan Objective 1B
Obj. 3.1.2	Healthy People 2020 IID-7 and IID-10

Strategy 3.1: Provide targeted education on the benefits of receiving immunizations to increase the percentage of children who are fully immunized.

Objective 3.1.1: By Dec 31, 2017, increase the percentage of Pinellas two-year-olds who are fully immunized from 75.3% (2012/2013) to 90%.

Objective 3.1.2: By Dec 31, 2017, increase the percentage of Pinellas Kindergarteners who are fully immunized from 89.8% (2012/2013) to 94%.

2013 – 2014 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Maintain an immunization task force with regularly scheduled meetings to address low immunization rates of children in the Pinellas community	DOH-Pinellas - Pinellas Immunization Team for Community Health (PITCH)	St. Joseph's, PCSB, MERCK, Sanofi-Pasteur, All Children's Hospital, pediatricians, YMCA, Neighborhood Family Centers, Community Health Centers, JWB	July 2014 – June 2015	Quarterly meetings conducted and documented
2	Collaborate with providers to integrate immunization education into routine client visitation	DOH-Pinellas - Pinellas Immunization Team for Community Health (PITCH)	Healthcare providers, hospitals	July 2014 – June 2015	Train a minimum of 32 health care providers and their staff
3	Implement a campaign to educate parents on the benefits of childhood immunizations	DOH-Pinellas - Pinellas Immunization Team for Community Health (PITCH)	Family support organizations, community centers, Early Learning Coalition, marketing partners, media outlets, Pinellas County Schools	July 2014 – June 2015	Conduct a minimum of 10 outreach events, presentations, or other media-related events.
4	Develop a partnership with the Pinellas County School Board to strengthen immunization record keeping (Portal/Focus)	DOH-Pinellas - Pinellas Immunization Team for Community Health (PITCH)	Pinellas County School Board	July 2014 – June 2015	Conduct at least one training for Pinellas County Schools nurses and technicians

2015 – 2017 Activities

- Work towards policy change for religious exemption
- Stricter enforcement of immunization policy within Pinellas County Schools

HEALTHY COMMUNITIES AND ENVIRONMENTS		
How can we ensure an environment that is safe and provides access to opportunities for a healthy lifestyle?		
HCE Goal 1: Establish integrated planning and assessment processes that promote health in community level policies and plans		
Policy Component (Y/N): Yes		
Performance Measures		
Objectives	**Data Source**	**Frequency**
Objective 1.1.1: By Dec 31, 2016, increase activity related to the development of policies and plans that support individual and community health within Pinellas from a score of 82% (2012) to 90%.	Community Health Assessment, Local Public Health System Performance Assessment	As needed, 3 – 5 year intervals
Outcomes		
Health element codified into a Comprehensive Plan.		

Alignment with Local, State, and National Priorities	
Obj. 1.1.1	Florida SHIP CR 1.1, Other: Public Health Law and Policy; Pinellas County MPO Transportation Plan

Strategy 1.1: Include a public health component in community planning processes to increase awareness and opportunity of the built environment's impact on healthy behaviors.

Objective 1.1.1: By Dec 31, 2016, increase activity related to the development of policies and plans that support individual and community health within Pinellas from a score of 82% (2012) to 90%.

2014 – 2015 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Attend county level planning and development meetings (e.g. MPO).	DOH-Pinellas	Pinellas County Strategic Planning and Initiatives, Pinellas County MPO	July 2014 – June 2015	4 meetings will be attended, to include Bicycle & Pedestrian Advisory Committee.
2	Create and provide information on topics related to public health, development, the built environment, and community well-being.	DOH-Pinellas	Pinellas County Strategic Planning and Initiatives	July 2014 – June 2015	3 presentations, data briefs, or technical reports will be delivered.
3	Advocate for a health element within the County Comprehensive Plan and municipal plans.	DOH-Pinellas	City of St. Petersburg, Suncoast Health Council, Comm. Health Centers of Pinellas, Juvenile Welfare Board, Pinellas Extension, Pinellas Parks and Conservation	July 2014 – June 2015	2 meetings or events advocating for the importance of a health element in comprehensive plans will be conducted.

HEALTHY COMMUNITIES AND ENVIRONMENTS		
How can we ensure an environment that is safe and provides access to opportunities for a healthy lifestyle?		
HCE Goal 2: Increase access to nutritious and affordable foods		
Policy Component (Y/N): No		
Performance Measures		
Objectives	**Data Source**	**Frequency**
Objective 2.1.1: By Dec. 31, 2016, increase the percentage of Pinellas adults who meet both of the daily recommendations for fruit and vegetable consumption from 9.3% (2010) to 11.5%.	BRFSS	3 years
Objective 2.2.1: By Dec 31, 2017, increase the percentage of Pinellas middle school students who consume at least five servings of fruits and vegetables a day from 21.2% (2012/2013) to 23.3%.	Pinellas County Schools	Annually
Outcome Measures		
To be determined		

Alignment with Local, State, and National Priorities	
Obj. 2.1.1	Florida SHIP CD 1.3, Healthy People 2020 NWS 15.1; NWS 15.2, Other: Public Health Law and Policy; CDC Winnable Battle: Nutrition, Physical Activity, and Obesity
Obj. 2.2.1	Florida SHIP CD 1.3.6, Healthy People 2020 NWS 15.1 and NWS 15.2, Other: Public Health Law and Policy; CDC Winnable Battle: Nutrition, Physical Activity, and Obesity

Strategy 2.1: Promote options for access to nutritious foods throughout Pinellas County.					
Objective 2.1.1: By Dec. 31, 2016, increase the percentage of Pinellas adults who meet both of the daily recommendations for fruit and vegetable consumption from 9.3% (2010) to 11.5%.					
2014 – 2015 Action Plan					
	Activity	**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	Create environmental awareness of produce stands, farmer's market locations, and community/school gardens through print material and social media (e.g. bus route maps, trail maps and Find the Fun Now website).	Pinellas County	Pinellas County Extension, PSTA	July 2014 – June 2015	3 media outlets promoting produce stands and farmers market location (e.g. PSTA route maps, Find the Fun Now!, Pinellas trail maps).
2	Create opportunity for SNAP recipients to receive nutrition education and healthy recipes.	Pinellas County Extension	Tampa Bay Network to End Hunger, Urban Food Park, WIC, Community Centers, Neighborhood Family Centers	July 2014 – June 2015	200 SNAP participants completing nutrition education program.

Strategy 2.2: Support a focused effort to increase access to nutritious and affordable foods for children.

Objective 2.2.1: By Dec 31, 2017, increase the percentage of Pinellas middle school students who consume at least five servings of fruits and vegetables a day from 21.2% (2012/2013) to 23.3%.

2014 – 2015 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Increase number of school vegetable gardens.	Pinellas County Extension	Pinellas County Extension, Pinellas County Schools, R' Club, YMCA, Parent Teacher Associations, St. Pete Garden Club, Dunedin Community Garden	July 2014 – June 2015	5 new school gardens will be created.
2	Ensure support and increase awareness of the school dinner program.	Pinellas County Schools Food Service	YMCA, R' Club, City Parks and Recreation Departments	July 2014 – June 2015	Establish school dinner sites.
3	Promotion of new "Snack Well" Guidelines created by Department of Agriculture.	Pinellas County Schools Food Service	DOH-Pinellas	July 2014 – June 2015	Create brochure/flyer to be given to students to inform parents on new guidelines.

2015 – 2017 Activities

- Include policies for healthy eating in school settings, including providing additional fruits and vegetables at no additional cost when a full meal is purchased
- Increase awareness and ensure continued support of the Weekend Meal Program

HEALTHY COMMUNITIES AND ENVIRONMENTS		
How can we ensure an environment that is safe and provides access to opportunities for a healthy lifestyle?		
HCE Goal 3: Increase access to safe opportunities for physical activity		
Policy Component (Y/N): No		
Performance Measures		
Objectives	**Data Source**	**Frequency**
Objective 3.1.1: By Dec 31, 2017, complete 15 transportation linkages in Pinellas through infrastructure and programming improvements.	Pinellas County Strategic Planning and Initiatives; Pinellas County MPO	As Needed
Objective 3.1.2: By Dec. 31, 2016, decrease the percentage of Pinellas adults who were sedentary, or did not participate in any leisure-time activity in the past 30 days from 25.5% (2010) to 22%.	BRFSS	3 years
Outcome Measures		
Increased park attendance and trail use. Increase in adults and children reporting regular physical activity.		

Alignment with Local, State, and National Priorities	
Obj. 3.1.1	Florida SHIP CR 2.1.1 and CR 2.2.2, Healthy People 2020 PA-15 (PA 15.1; PA 15.2; PA 15.3), Other: CDC Winnable Battle: Nutrition, Physical Activity, and Obesity; Recommended by the Centers for Disease Control and Prevention's Community Guide
Obj. 3.1.2	Florida SHIP CR 2.1.1 and CR 2.2.2, Healthy People 2020 PA-1, Other: CDC Winnable Battle: Nutrition, Physical Activity, and Obesity; Recommended by the Centers for Disease Control and Prevention's Community Guide

Strategy 3.1: Promote collaborative efforts to form safe transportation linkages to schools, work, home, and recreation.

Objective 3.1.1: By Dec 31, 2017, complete 15 transportation linkages in Pinellas through infrastructure and programming improvements.

Objective 3.1.2: By Dec. 31, 2016, decrease the percentage of Pinellas adults who were sedentary, or did not participate in any leisure-time activity in the past 30 days from 25.5% (2010) to 22%.

2014 – 2015 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Collaborate with the county government, municipal governments and the Metropolitan Planning Organization (MPO) to create environmental improvements within Pinellas County that focus on safe physical activity	Pinellas County Metropolitan Planning Organization	Municipal Governments, Pinellas County Strategic Planning and Initiatives	July 2014 – June 2015	Complete 5 environmental improvements that focus on safe physical activity within Pinellas County
2	Increase Auxiliary Ranger Program volunteer efforts to increase visible safety presence on the trail to all municipalities that house the trail.	Pinellas County	Auxiliary Rangers, United Way, Service Organizations, faith-based organizations	July 2014 – June 2015	Increase number of volunteer hours by 10%.
3	Create a list of city/county parks and recreational areas where the community can participate in free or low cost areas for physical activity.	DOH-Pinellas	Auxiliary Rangers, City and County Municipalities	July 2014 – June 2015	Brochure/flyer created and number distributed

2015 – 2017 Activities

- Provide community outreach and education to remove impediments that deter use of trails, bike lanes and sidewalks
- Remove some of the barriers to walking or biking to school (heavy backpacks, no lockers, locked bike rack access) by implementing technology solutions (iPads, kindle textbooks) and process improvements.
- Create new opportunities (i.e. running clubs, etc.) at summer recreation programs to teach skills and encourage participation in physical activity

Appendix C: 2015 – 2016 Action Plan

Access to Care		
How can we ensure equal access to health care services in Pinellas County?		
Goal AC 1: Provide equal access to appropriate health care services and providers		
Policy Component (Y/N): No		
Performance Measures		
Objectives	**Data Source**	**Frequency**
Objective 1.1.1: By Dec 31, 2017, decrease the percentage of Pinellas adults who are unable to access a health care provider due to cost from 16% (2010) to 14.4%.	BRFSS	3 years
Objective 1.2.1: By Dec 31, 2017, increase the number of trained Community Health Workers (CHWs) in Pinellas by 25% over baseline.	Florida Community Health Worker Coalition/SPC	As needed
Objective 1.3.1: By Dec 31, 2016, decrease the percentage of Pinellas adults who believe they would receive better medical care if they belonged to a different race/ethnic group from 7% (2010) to 6.3%.	BRFSS	3 years
Outcomes		
Increase in adults who had a medical checkup in the past year Increase in percentage of CHWs who have enrolled in a standardized training Implementation by at least 4 agencies of CLAS assessment and action plan At least four new partnerships developed between social service and medical agencies in Pinellas County. Establishment of a forum for dialogue about direct messaging in Pinellas County. 2 agencies have implemented CLAS assessment and action plan		

Alignment with Local, State, and National Priorities	
Obj. 1.1.1	Florida SHIP AC 1.1.1
Obj. 1.2.1	Florida SHIP HI3.4

Strategy 1.1: Address barriers in accessing existing health care services and consumer utilization in underserved communities

Objective 1.1.1: By Dec 31, 2017, decrease the percentage of Pinellas adults who are unable to access a health care provider due to cost from 16% (2010) to 14.4%.

2015 – 2016 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Local health providers will collaborate with PSTA to promote community and provider involvement in transportation decisions (via PSTA Planning Committee meetings).	PSTA	DOH-Pinellas, St. Pete Free Clinic; TBHC; City of St. Pete; Community Health Centers	July 2015 – June 2016	a) PSTA will notify DOH-Pinellas and other local health providers each time there is an opportunity for public input b) Health providers will publicize the opportunity accordingly in order to keep up with proposed changes prior to implementation.
2	Implement the St. Petersburg Police Dept. Mobile Resource Bus Connection program.	City of St. Petersburg	DOH-Pinellas; USFSP; SPPD; SPC; BayCare; SunCoast Center	July 2015 – June 2016	a) Provide resource connections to at least 75 residents b) Hold intern training in September 2015
3	Gather information regarding actual access of medical care for those newly insured under the Affordable Care Act.	TBHC, DOH-Pinellas	Pinellas County; Insurance carriers	July 2015 – June 2016	a) Identify top 3 local insurance carriers b) Gather data regarding access of medical care c) Use this information to determine next steps (targeted education, etc.)

Strategy 1.2: Develop and implement a standardized training program for Community Health Workers.					
Objective 1.2.1: By Dec 31, 2017, increase the number of trained Community Health Workers (CHWs) in Pinellas by 25% over baseline.					
2015 – 2016 Action Plan					
	Activity	**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	Enroll individuals for CHW trainings in Pinellas and conduct trainings.	SPC	DOH-Pinellas	July 2015 – June 2016	a) Determine a baseline number of Pinellas County CHWs and identify their training needs. b) Number of trainings conducted.
2	Collaborate with other agencies in Access to Care workgroup and beyond to identify groups and job positions/titles that would be good candidates for CHW training or certification.	SPC	DOH-Pinellas	July 2015 – June 2016	Identify at least three new agencies with CHW-like employees who would be good candidates for CHW training/certification.

Strategy 1.3: Promote the completion of a cultural and linguistic competence organizational self-assessment to improve access to culturally competent care.					
Objective 1.3.1: By Dec 31, 2016, decrease the percentage of Pinellas adults who believe they would receive better medical care if they belonged to a different race/ethnic group from 7% (2010) to 6.3%.					
2015 – 2016 Action Plan					
Activity		**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	Promote use of the CLAS self-assessment.	Tampa Bay Healthcare Collaborative (TBHC) TBHC - Health Equity Committee	Community Tampa Bay, Collaborative Labs at St. Petersburg College	July 2015 – June 2016	5 organizations will participate in CLC cohort led by TBHC. Additional funding opportunities will be explored.

Access to Care		
How can we ensure equal access to health care services in Pinellas County?		
Goal AC 2: Use health information technology to improve collaboration among providers and increase efficiency in services to consumers		
Policy Component (Y/N): No		
Performance Measures		
Objectives	**Data Source**	**Frequency**
Objective 2.1.1: By Dec. 31, 2017, explore at least 2 data integration initiatives in Pinellas County.	DOH-Pinellas	By request
Outcomes		
At least four new partnerships developed between social service and medical agencies in Pinellas County.		

Alignment with Local, State, and National Priorities	
Obj. 2.2.1	SHIP Strategy HI1.1

Strategy 2.1: Streamline the eligibility process among community partners to increase access to services.

Objective 2.1.1: By Dec. 31, 2017, increase health provider utilization of criteria for Pinellas health and social service program eligibility by 25% over baseline.

2015 – 2016 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Use IT to strengthen linkages to healthcare providers for clients of the Family Support Initiative.	JWB	TBD	July 2015 – June 2016	Develop a mechanism to identify FSI clients who have been successfully connected to healthcare.
	Convene workgroup to identify data integration initiatives.	DOH-Pinellas	JWB, Pinellas County, 211 Tampa Bay Cares, USF	July 2015 – June 2016	Facilitate quarterly check-ins between IT workgroup to provide updates and identify future opportunities for collaboration.
	Identify and connect Pinellas County pediatricians & OB providers to a health information exchange with data integration.	USF-Health	Pinellas County pediatricians and OB providers.	July 2015 – June 2016	Increase the number of providers connected via HIE in Pinellas County.
	Install Care Connect software among identified providers.	Pinellas County Human Services	Specified Behavioral Health providers in Pinellas County.	July 2015 – June 2016	#/% of specified Behavioral Health providers onboarded to the HIE service

Access to Care

How can we ensure equal access to health care services in Pinellas County?

Goal AC 3: Reduce infant mortality and morbidity

Policy Component (Y/N): No

Performance Measures

Objectives	Data Source	Frequency
Objective 3.1.1: By Dec 31, 2017, decrease the percentage of low-birth weight (less than 2,500 grams) infants in Pinellas from 8.9% (2010-2012) to 8%.	Florida CHARTS	Annually
Objective 3.2.1: By Dec 31, 2017, increase the percentage of births to Pinellas mother's receiving first trimester prenatal care from 79.1% (2010-2012) to 87%.	Florida CHARTS	Annually
Objective 3.3.1: By Dec 31, 2017, reduce the infant mortality rate of Black infants in Pinellas from 13.9 per 1,000 live births (2010-2012) to 11.5 per 1,000 live births.	Florida CHARTS	Annually
Objective 3.3.2: By Dec 31, 2017, reduce the infant mortality rate of Hispanic infants in Pinellas from 8.1 per 1,000 live births (2010-2012) to 7.3 per 1,000 live births.	Florida CHARTS	Annually

Outcomes

Reduce teen pregnancy rates in Pinellas
Reduce teen STD rates in Pinellas
Decrease in child deaths

Alignment with Local, State, and National Priorities	
Obj. 3.1.1	Other: 2011-2016 Pinellas County Healthy Start Service Delivery Plan: Strategy B-4-1 (5)
Obj. 3.3.1	Florida SHIP Objective AC5.4.4

Strategy 3.1: Raise awareness among providers and consumers on the importance and benefits of being healthy prior to pregnancy.

Objective 3.1.1: By Dec 31, 2017, decrease the percentage of low-birth weight (less than 2,500 grams) infants in Pinellas from 8.9% (2010-2012) to 8%.

2015 – 2016 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Implement Figuring it Out for the Child.	USFSP	Referral Sources: • CHCP • DOH-Pinellas • Healthy Start • Mt. Zion	July 2015 – June 2016	Increase the number of pregnant couples seen each year to 100.
2	Use Fetal Infant Mortality Review data to identify trends and educate women of childbearing age in Pinellas.	Healthy Start	TBD	July 2015 – June 2016	Identify trends in losses and offer interventions in the form of educational materials to all 32 Pinellas OB offices and Healthy Start Care Coordinators.

2016 – 2017 Activities

- Partner with health care providers and universities to provide education and research about preconception health.
- Develop a campaign that educates women on the correlation between STDs and low-birth weight births.
- Work together with medical providers, law enforcement and health & human service agencies to address substance abuse.
- Place base initiative to identify high concentration of low birth weight infants.
- Develop policy recommendations promoting full term gestation vs. delivery prior to 39 weeks.

Strategy 3.3: Address disparities in Black and Hispanic infant mortality.					
Objective 3.3.1: By Dec 31, 2017, reduce the infant mortality rate of Black infants in Pinellas from 13.9 per 1,000 live births (2010-2012) to 11.5 per 1,000 live births.					
Objective 3.3.2: By Dec 31, 2017, reduce the infant mortality rate of Hispanic infants in Pinellas from 8.1 per 1,000 live births (2010-2012) to 7.3 per 1,000 live births.					
2015 – 2016 Action Plan					
	Activity	**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	ACH Community Action Network (CAN) will identify strategies to engage and provide education to African American/Black and Hispanic/Latina women about prenatal behaviors that reduce infant mortality and low-birth weight infants.	Healthy Start Federal project director	DOH-Pinellas, All Children's Hospital, USF, Women of Distinction, NAACP, St. Pete College, ACNW, Sororities, Urgan League, Home Visiting Advisory Council, Healthy Start Coalition, Neighborhood Family Centers, National Council of Negro Women	July 2015 – June 2016	The Healthy Start Federal Project will conduct at least 10 community presentations in the 5 high-risk Pinellas zip codes.

Behavioral Health

How can we ensure access to behavioral health services and improve behavioral health outcomes in Pinellas County?

Goal BH 1: Increase access to behavioral health services

Policy Component (Y/N): No

Performance Measures

Objectives	Data Source	Frequency
Objective 1.1.1: By Dec 31, 2016, increase the percentage of Pinellas adults who always or usually receive the social and emotional support they need from 81.3% (2010) to 89.4%.	BRFSS	3 Years
Objective 1.2.1: By Dec 31, 2017, reduce the rate of non-fatal hospitalizations for self-inflicted injuries from 82.0 per 100,000 (2008-2010) to 65.6 per 100,000 among Pinellas youth 12-18.	Florida CHARTS	Annually
Objective 1.3.1: By Dec 31, 2017, decrease the suicide age-adjusted death rate in Pinellas from 17.7 per 100,000 (2009-2011) to 16.2 per 100,000.	Florida CHARTS	Annually

Outcomes

Increased number of referrals to behavioral healthcare providers. 200 doctors educated on trauma-informed care principles. 4 new organizations distributing Trauma-Informed Care materials. Identify gaps in behavioral healthcare access.

Alignment with Local, State, and National Priorities	
Obj. 1.3.1	Healthy People 2020 MHMD-1

Strategy 1.1: Strengthen the integration of behavioral and primary health care service delivery.					
Objective 1.1.1: By Dec 31, 2016, increase the percentage of Pinellas adults who always or usually receive the social and emotional support they need from 81.3% (2010) to 89.4%.					
2015 – 2016 Action Plan					
	Activity	**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	Implement a pilot program to engage and provide services to the top 33 utilizers of Pinellas County's public Baker Act and jail facilities.	Pinellas County Human Services; Administrative Forum	Local Behavioral Health providers	July 2015 – June 2016	a. #/% Clients engaged and enrolled in pilot b.. #/% of clients who receive therapy indicated in treatment plan

Strategy 1.2: Integrate trauma-informed care practices across care settings with emphasis on Adverse Childhood Experiences (ACEs).

Objective 1.2.1: By Dec 31, 2017, reduce the rate of non-fatal hospitalizations for self-inflicted injuries from 82.0 per 100,000 (2008-2010) to 65.6 per 100,000 among Pinellas youth 12-18.

2015 – 2016 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Promote provider and agency education on trauma-informed approaches and practices.	Peace4Tarpon	National Center for Trauma-Informed Care, DOH-Pinellas	July 2015 – June 2016	Hold two trainings for providers in Pinellas County.

2015 – 2017 Activities

- Pilot risk assessment and screening in Pinellas County Schools
- Develop cross training programs for allied staff in primary and behavioral health care settings

Strategy 1.3: Engage targeted at-risk populations to better understand behavioral health care needs and prevent barriers to access					
Objective 1.3.1: By Dec 31, 2017, decrease the suicide age-adjusted death rate in Pinellas from 17.7 per 100,000 (2010-2012) to 16.2 per 100,000.					
2015 – 2016 Action Plan					
	Activity	**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	Assess transportation as a barrier to accessing healthcare and explore ways to improve transportation for low income individuals to get to health appointments.	Pinellas County	PSTA	July 2015 – June 2016	Analyze data and determine the most appropriate form for reporting the information.
2	Examine Pinellas County suicide data to identify additional trends or areas of concern.	Pinellas County	DOH-Pinellas	July 2015 – June 2016	Analyze data and determine the need for an in-depth report.

Behavioral Health

How can we ensure access to behavioral health services and improve behavioral health outcomes in Pinellas County?

Goal BH 2: Reduce substance abuse among children and adults

Policy Component (Y/N): Yes

Performance Measures

Objectives	Data Source	Frequency
Objective 2.1.1: By Dec 31, 2017, reduce the number of accidental drug or toxin related deaths in Pinellas from 201 (2012) to 181.	District 6 Medical Examiner Annual Report	Annually
Objective 2.2.1: By Dec 31, 2016, reduce the number of Pinellas youth who report lifetime drug use from 31.1% (2012) to 27.9%.	Florida Youth Substance Abuse Survey	Biennially
Objective 2.3.1: By Dec 31, 2017, reduce the rate of Neonatal Abstinence Syndrome in Pinellas from 27.1 per 1,000 births (2009-2011) to 24.4 per 1,000 births.	Florida Agency for Healthcare Administration (AHCA)	Annually

Outcomes

More information available on NAS in Pinellas County.

Alignment with Local, State, and National Priorities	
Obj. 2.2.1	Healthy People 2020 SA- 2.4

Strategy 2.1: Advocate for changes in policy and practices related to substance abuse, including more stringent regulations for prescription drugs classified as controlled substances.					
Objective 2.1.1: By Dec 31, 2017, reduce the number of accidental drug or toxin related deaths in Pinellas from 201 (2012) to 181.					
2015 - 2016 Action Plan					
Activity		**Coordinating Agency**	**Partner Agencies**	**Timeframe**	**Process Measure**
1	*Administrative Forum/Regional Council*	*Administrative Forum/Regional Council*	*Administrative Forum/Regional Council*	July 2015 – June 2016	TBD

Strategy 2.2: Raise awareness among providers, parents, youth, and businesses on emerging substance abuse trends to improve and inform practices.					
Objective 2.2.1: By Dec 31, 2016, reduce the number of Pinellas youth who report lifetime drug use from 31.1% (2012) to 27.9%.					
2015 – 2016 Action Plan					
Activity		**Coordinating Agency**	**Partner Agencies**	**Timeframe**	**Process Measure**
1	1. Develop and implement a campaign to educate parents, businesses, and youth on medical marijuana and the dangers of emerging designer drugs and prescription drugs	Pinellas County Justice and Consumer Services	LiveFree! Coalition, Drug Free America Foundation (DFAF)	July 2015 – June 2016	1. Educational materials distributed/parents educated. 2. Number of businesses educated. 3. Number of youth led groups who receive campaign materials.

Strategy 2.3: Increase access to substance abuse services for prenatal and postpartum women.

Objective 2.3.1: By Dec 31, 2017, reduce the rate of Neonatal Abstinence Syndrome in Pinellas from 27.1 per 1,000 births (2009-2011) to per 24.4 per 1,000 births.

2015 – 2016 Action Plan

	Activity	Coordinating Agency	Partner Agencies	Timeframe	Process Measure
1	Work with OB-GYNs to provide warnings to their patients on the dangers of substance use/abuse while pregnant and provide supports to address underlying issues.	Healthy Start Coalition	Operation PAR, Healthy Start Coalition, Birth Hospitals, BayCare, DOH-Pinellas, Motivating New Moms	July 2015 – June 2016	Offer education and materials to all 32 OB providers in Pinellas County.
2	Collect current data on drugs to which newborns are most frequently exposed.	Substance Exposed Newborns task force, USFSP	DOH-Pinellas Healthy Families	July 2015 – June 2016	Establish a baseline and begin regular data collection.

2015 – 2017 Activities

- Promote the use of evidence-based screening practices for prenatal substance abuse by OB/GYNs and other prenatal and postpartum providers
- Promote pregnancy testing by providers prior to prescribing prescription drugs classified as controlled substances

Behavioral Health		
How can we ensure access to behavioral health services and improve behavioral health outcomes in Pinellas County?		
Goal BH3: Reduce violence among children and families		
Policy Component (Y/N): Yes		
Performance Measures		
Objectives	**Data Source**	**Frequency**
Objective 3.1.1: By Dec 31, 2017, reduce the rate of Pinellas children under 18 experiencing child abuse from 24.0 per 1,000 (2012) to 16.9 per 1,000.	Florida Department of Children and Families	Quarterly
Objective 3.2.1: By Dec 31, 2017, reduce the domestic violence rate in Pinellas from 772.8 per 100,000 (2009-2011) to 695.5 per 100,000.	Florida CHARTS	Annually
Outcomes		
Greater number of DOH-Pinellas staff educated on DV prevention and preventive practices. Common screening policies/practices for violence and trauma		

Alignment with Local, State, and National Priorities	
Obj. 3.1.1	Healthy People 2020 IVP 37; IVP 38
Obj. 3.2.1	Healthy People 2020 IVP 39.1; IVP 39.2; IVP 39.3; IVP 39.4

Strategy 3.1: Promote community programs that maximize healthy development and interaction among children, families, schools, and communities.					
Objective 3.1.1: By Dec 31, 2017, reduce the rate of Pinellas children under 18 experiencing child abuse from 24.0 per 1,000 (2012) to 16.9 per 1,000.					
2015 – 2016 Action Plan					
	Activity	**Coordinating Agency**	**Partner Agencies**	**Timeframe**	**Process Measure**
1	Promote JWB's Prevent Needless Deaths campaign.	JWB	Hillsborough Children's Board; Local MCH providers and agencies	July 2015 – June 2016	Distribute booklets to local birthing hospitals (St. Pete General; Bayfront Baby Place; Morton Plant Hospital - CLW; & Mease Countryside) and at least ten daycare providers.
2	Hold trauma informed care trainings for local MCH care providers.	USFSP, Peace4Tarpon	DOH-Pinellas	July 2015 – June 2016	At least three trainings held in Pinellas (one at DOH-Pinellas)

Strategy 3.2: Promote awareness, training, and advocacy to improve and inform practices related to domestic violence.

Objective 3.2.1: By Dec 31, 2017, reduce the domestic violence rate in Pinellas from 772.8 per 100,000 (2009-2011) to 695.5 per 100,000.

2015 – 2016 Action Plan

	Activity	Coordinating Agency	Partner Agencies	Timeframe	Process Measure
1	Educate community healthcare providers on domestic violence policies and preventive practices.	Domestic Violence Task Force (DVTF)	DVTF Members DOH-Pinellas	July 2015 – June 2016	Hold at least one Being a Better Bystander training at a Pinellas health department location.

2015 – 2017 Activities

- Implement and expand plan developed between Operation PAR and the Domestic Violence Task Force for use in substance abuse treatment and outpatient settings, to include training staff about effective interventions
- Reinvest in the Elementary/Middle Peacemaker program model via Haven/CASA.

HEALTH PROMOTION AND DISEASE PREVENTION

How can we promote healthy lifestyles and prevent disease in Pinellas County?

Goal HPDP 1: Increase the percentage of adults and children who are at a healthy weight

Policy Component (Y/N): No

Performance Measures

Objectives	Data Source	Frequency
Objective 1.1.1: By Dec 31, 2017, decrease the percentage of Pinellas adults who are either overweight or obese from 65.6% (2010) to 59%.	BRFSS	3 years
Objective 1.2.1: By Dec 31, 2017, increase the proportion of Pinellas children (1st, 3rd, 6th grade) who are at a healthy weight from 65.1% (2010 - 2011) to 71.6%.	DOH School Health Report	Annually
Objective 1.2.2: By Dec 31, 2017, decrease the percentage of Pinellas high school students reporting BMI at or above 95th percentile from 10.3% (2012) to 9.3%.	YRBS	2 years

Outcomes

Increased percentage of adults who report exercising regularly.
Increased percentage of children who report exercising regularly.
Increase number of children who report eating recommended daily values of fruits and vegetables.

Alignment with Local, State, and National Priorities	
Obj. 1.1.1	Florida SHIP Goal CD 1, Healthy People NWS-8, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity; One Bay Regional Plan Focus
Obj. 1.2.1	Florida SHIP Goal CD 1 and CD 2.3.4, Healthy People NWS-10, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity; One Bay Regional Plan Focus
Obj. 1.2.2	Florida SHIP Goal CD 1 and CD 2.3.4, Healthy People NWS-10 and NWS-10.3, CDC Winnable Battle: Nutrition, Physical Activity, and Obesity; One Bay Regional Plan Focus

Strategy 1.1: Promote healthy eating habits and active lifestyles in adults.					
Objective 1.1.1: By Dec 31, 2017, decrease the percentage of Pinellas adults who are either overweight or obese from 65.6% (2010) to 59%.					
2015 – 2016 Action Plan					
	Activity	**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	Provide educational sessions to DOH-Pinellas clients demonstrating healthy and culturally appropriate cooking and grocery shopping on a budget.	Pinellas County Extension	DOH-Pinellas	July 2015 – June 2016	Conduct four education series annually for DOH clients, as documented by sign-in sheets and post-session surveys.
2	Promote usage of county parks, trails, and recreational facilities.	DOH-Pinellas	Pinellas County Parks & Conservation Resources, Municipal Governments	July 2015 – June 2016	DOH-Pinellas collaborates with recreation departments to update brochures annually and disseminate 1500 brochures to the community.

Strategy 1.2: Promote healthy eating habits and active lifestyles in children.					
Objective 1.2.1: By Dec 31, 2017, increase the proportion of Pinellas children (1st, 3rd, 6th grade) who are at a healthy weight from 65.1% (2010 - 2011) to 71.6%.					
Objective 1.2.2: By Dec 31, 2017, decrease the percentage of Pinellas high school students reporting BMI at or above 95th percentile from 10.3% (2012) to 9.3%.					
2015 – 2016 Action Plan					
Activity		**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	Conduct inventory based self-assessments of Pinellas County Schools on the Alliance for Healthier Generation guidelines	Pinellas County Schools	Alliance for a Healthier Generation, DOH-Pinellas	July 2015 – June 2016	Increase in number of schools that adopt Alliance for a Healthier Generation standards.
2	Increase the number of healthy food and beverage policies in City & County recreation locations	DOH-Pinellas	WIC, Cities and County Parks and Recreation Departments	July 2015 – June 2016	7 new City/County concession stands will update policies and incorporate FUN BITES into their menus

HEALTH PROMOTION AND DISEASE PREVENTION

How can we promote healthy lifestyles and prevent disease in Pinellas County?

Goal HPDP 2: Increase behaviors that improve chronic disease health outcomes

Policy Component (Y/N): Yes

Performance Measures

Objectives	Data Source	Frequency
Objective 2.1.1: By Dec 31, 2017, increase the percentage of Pinellas adults age 50 or older who received a colorectal screening in the past five years from 73.5% (2010) to 80.9%.	BRFSS	3 years
Objective 2.1.2: By Dec 31, 2017, increase the percentage of Pinellas women age 40 or older who received a mammogram in the past year from 61.5% (2010) to 67.7%.	BRFSS	3 years
Objective 2.2.1: By Dec 31, 2017, decrease deaths due to heart disease in Pinellas from 155.5 per 100,000 (2010-2012) to 139.9 per 100,000.	Florida CHARTS	Annually
Objective 2.3.1: By Dec 31, 2017, increase the number of committed never smokers among Pinellas youth, ages 11 - 17 from 64.1% (2012) to 70.5%.	Florida Youth Tobacco Survey	Biennially
Objective 2.3.2: By Dec. 31, 2016, decrease the percentage of Pinellas adults who are current smokers from 19.3% (2010) to 17%.	BRFSS	3 years

Outcomes

Increase in number of adults educated about the importance of colorectal cancer screening.
Reduce obesity rates and increase physical activity in Pinellas County adults.
Reduce diabetes prevalence
Increased number of smoke free/tobacco free policies adopted
Increased number of students involved in SWAT
Increase in the number of SWAT outreach activities
Adults who have had a clinical breast exam

Alignment with Local, State, and National Priorities

Obj. 2.1.1	Florida SHIP CD 3.2.1, Healthy People 2020 C-3 and C-17
Obj. 2.1.2	Florida SHIP CD 3.2.2, Healthy People 2020 C-5 and C-16
Obj. 2.2.1	Healthy People 2020 HDS and HDS-1
Obj. 2.3.1	Florida SHIP CD 4.1.1, Healthy People 2020 TU-3
Obj. 2.3.2	Florida SHIP CD 4.2.1, Healthy People 2020 TU-4, TU-5, TU-7

Strategy 2.1: Promote screening, education, and referral to treatment related to cancer.					
Objective 2.1.1: By Dec 31, 2017, increase the percentage of Pinellas adults age 50 or older who received a colorectal screening in the past five years from 73.5% (2010) to 80.9%.					
2015 – 2016 Action Plan					
	Activity	**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	Examine disparities in colorectal cancer incidence, conduct research with priority populations, and implement multilevel interventions using the community-based prevention marketing framework.	USF-Florida Prevention Research Center	DOH-Pinellas, DOH-Hillsborough, Community Health Worker Coalition, community members, American Cancer Society, Blue Cross Blue Shield, Moffitt, Florida Cancer Data System, Southwest Florida Cancer Collaborative	July 2015 – June 2016	Meet bimonthly to implement program and track progress.

Strategy 2.1: Promote screening, education, and referral to treatment related to cancer.					
Objective 2.1.2: By Dec 31, 2017, increase the percentage of Pinellas women age 40 or older who received a mammogram in the past year from 61.5% (2010) to 67.7%.					
2015 – 2016 Action Plan					
	Activity	**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	Distribute educational materials to promote awareness of the Florida Breast and Cervical Cancer Early Detection Program, Mammography Voucher Program and general screening recommendations to women above 40 in Pinellas County.	DOH-Pinellas	TBCCN Partners St Pete Free Clinic Komen BayCare SW Florida Cancer Control Collaborative	July 2015 – June 2016	Distribute educational materials to at least 20 locations in Pinellas County.
2	Promote wellness programs for cancer survivors to increase overall health during recovery	YMCA of the Suncoast	DOH-Pinellas, YMCA of St. Petersburg	July 2015 – June 2016	Identify four new partners to distribute promotional materials about the LiveStrong and other wellness programs

Strategy 2.2: Promote screening, education, and referral to treatment related to heart disease.

Objective 2.2.1: By Dec 31, 2017, decrease deaths due to heart disease in Pinellas from 155.5 per 100,000 (2010-2012) to 139.9 per 100,000.

2015 – 2016 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Train 7% of the Pinellas County population in Hands-OnlyTM CPR training via education in the community and in schools.	American Heart Association	AHA board, BayCare, DOH-Pinellas, Pinellas County Schools	July 2015 – June 2016	Increase number of citizens educated; establish baseline of bystander CPR data from local emergency response services
2	Refer diagnosed prediabetes patients at local hospitals to the CDC's National Diabetes Prevention Program, run locally as the YMCA's Diabetes Prevention Program	YMCA of St Pete - Danielle Mauck	Baycare St. Anthony's	July 2015 – June 2016	Increase referrals from 500 to 750.

Additional activities related to heart disease reduction can be found under Goal 1, Strategy 1, lifestyle changes related to weight and physical activity.

2015 – 2017 Activities

- Provide blood pressure screenings
- Cholesterol screenings
- Coordinate and provide referral services

Strategy 2.3: Promote activities to reduce tobacco use and exposure in adults and youth.					
Objective 2.3.1: By Dec 31, 2017, increase the number of committed never smokers among Pinellas youth, ages 11 - 17 from 64.1% (2012) to 70.5%.					
2015 – 2016 Action Plan					
	Activity	**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	Create and maintain local SWAT chapters.	DOH-Pinellas – Tobacco Free Program/SWAT Coordinator	Pinellas County Schools, Tobacco Free Coalition	July 2015 – June 2016	SWAT Clubs at 10 middle/high schools will conduct at least 50 outreach activities will be completed each year.
2	Educate local target audiences about point of sale advertising.	DOH-Pinellas – Tobacco Free Program/SWAT Coordinator	Cities, Schools, Interest Groups	July 2015 – June 2016	The County SWAT Team will present to at least three target audience groups.

Strategy 2.3: Promote activities to reduce tobacco use and exposure in adults and youth.					
Objective 2.3.2: By Dec. 31, 2016, decrease the percentage of Pinellas adults who are current smokers from 19.3% (2010) to 17.0%.					
2015 – 2016 Action Plan					
	Activity	**Coordinating Agency**	**Proposed Partner Agencies**	**Timeframe**	**Process Measure**
1	Distribute "Quitkits" to clients who are smokers within Florida Department of Health in Pinellas clinics	DOH-Pinellas – Tobacco Free Program	Area Health Education Center (AHEC)	July 2015 – June 2016	2500 Quitkits will be distributed
2	Educate local policymakers, businesses, and community organizations about tobacco use.	DOH-Pinellas	Worksites, Housing	July 2015 – June 2016	At least 2 tobacco worksite wellness policies will be adopted

3	Meet quarterly with Tobacco Free Campus Task Force at local universities/colleges.	DOH-Pinellas	St. Petersburg College	July 2015 – June 2016	Minimum of four meetings will be held.

HEALTH PROMOTION AND DISEASE PREVENTION		
How can we promote healthy lifestyles and prevent disease in Pinellas County?		
Goal HPDP 3: Increase protection against the spread of infectious disease		
Policy Component (Y/N): Yes		
Performance Measures		
Objectives	**Data Source**	**Frequency**
Objective 3.1.1: By Dec 31, 2017, increase the percentage of Pinellas two-year-olds who are fully immunized from 75.3% (2012/2013) to 90%.	Florida CHARTS; Florida Department of Health Immunization Report	Annually
Objective 3.1.2: By Dec 31, 2017, increase the percentage of Pinellas Kindergarteners who are fully immunized from 89.8% (2012/2013) to 94%.	Florida CHARTS; Florida Department of Health Immunization Report	Annually
Outcomes		
Increase the number of health care providers represented on PITCH. 100% of Pinellas County providers will complete the PITCH training course. Improve Pinellas County Schools Immunization Report Card scores by 10%.		

Alignment with Local, State, and National Priorities	
Obj. 3.1.1	Florida SHIP Objective HP 1.1.1, Healthy People 2020 IID-7, Other: DOH Long Range Plan Objective 1B
Obj. 3.1.2	Healthy People 2020 IID-7 and IID-10

Strategy 3.1: Provide targeted education on the benefits of receiving immunizations to increase the percentage of children who are fully immunized.

Objective 3.1.1: By Dec 31, 2017, increase the percentage of Pinellas two-year-olds who are fully immunized from 75.3% (2012/2013) to 90%.

Objective 3.1.2: By Dec 31, 2017, increase the percentage of Pinellas Kindergarteners who are fully immunized from 89.8% (2012/2013) to 94%.

2015 – 2016 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Maintain an immunization task force with regularly scheduled meetings to address low immunization rates of children in the Pinellas community	DOH-Pinellas - Pinellas Immunization Team for Community Health (PITCH)	St. Joseph's, PCSB, MERCK, Sanofi-Pasteur, All Children's Hospital, pediatricians, YMCA, Neighborhood Family Centers, Community Health Centers, JWB	July 2015 – June 2016	Quarterly meetings conducted and documented
2	Collaborate with providers to integrate immunization education into routine client visitation	DOH-Pinellas - Pinellas Immunization Team for Community Health (PITCH)	Healthcare providers, hospitals	July 2015 – June 2016	Train a minimum of 32 health care providers and their staff
3	Implement a campaign to educate parents on the benefits of teen and childhood immunizations	DOH-Pinellas - Pinellas Immunization Team for Community Health (PITCH)	Family support organizations, community centers, Early Learning Coalition, marketing partners, media outlets, Pinellas County Schools	July 2015 – June 2016	Conduct a minimum of 10 outreach events, presentations, or other media-related events.
4	Develop a partnership with the Pinellas County School Board to strengthen immunization record keeping (Portal/Focus)	DOH-Pinellas - Pinellas Immunization Team for Community Health (PITCH)	Pinellas County School Board	July 2015 – June 2016	Conduct at least one training for Pinellas County Schools nurses and technicians

2015 – 2017 Activities

- Work towards policy change for religious exemption
- Stricter enforcement of immunization policy within Pinellas County Schools

HEALTHY COMMUNITIES AND ENVIRONMENTS

How can we ensure an environment that is safe and provides access to opportunities for a healthy lifestyle?

HCE Goal 1: Establish integrated planning and assessment processes that promote health in community level policies and plans

Policy Component (Y/N): Yes

Performance Measures

Objectives	Data Source	Frequency
Objective 1.1.1: By Dec 31, 2016, increase activity related to the development of policies and plans that support individual and community health within Pinellas from a score of 82% (2012) to 90%.	Community Health Assessment, Local Public Health System Performance Assessment	As needed, 3 – 5 year intervals

Outcomes

Health in All Policies approach codified in at least one city or county.

Alignment with Local, State, and National Priorities	
Obj. 1.1.1	Florida SHIP CR 1.1, Other: Public Health Law and Policy; Pinellas County MPO Transportation Plan

Strategy 1.1: Include a public health component in community planning processes to increase awareness and opportunity of the built environment's impact on healthy behaviors.

Objective 1.1.1: By Dec 31, 2016, increase activity related to the development of policies and plans that support individual and community health within Pinellas from a score of 82% (2012) to 90%.

2015 – 2016 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Educate policymakers on "health in all policies" and HIA, including topics related to public health, development, the built environment.	DOH-Pinellas	City of St. Petersburg, Healthy Pinellas Consortium, Juvenile Welfare Board, PSTA	July 2015 – June 2016	3 meetings or events advocating for the importance of a health element in comprehensive plans will be conducted; Research conducted on when and how local policies are updated.
2	Support the inclusion of a health element in local Comprehensive Plans.	DOH-Pinellas	City of Largo, Others	July 2015 – June 2016	Health element codified into at least one city or county Comprehensive Plan.

HEALTHY COMMUNITIES AND ENVIRONMENTS		
How can we ensure an environment that is safe and provides access to opportunities for a healthy lifestyle?		
HCE Goal 2: Increase access to nutritious and affordable foods		
Policy Component (Y/N): No		
Performance Measures		
Objectives	**Data Source**	**Frequency**
Objective 2.1.1: By Dec. 31, 2016, increase the percentage of Pinellas adults who meet both of the daily recommendations for fruit and vegetable consumption from 9.3% (2010) to 11.5%.	BRFSS	3 years
Objective 2.2.1: By Dec 31, 2017, increase the percentage of Pinellas middle school students who consume at least five servings of fruits and vegetables a day from 21.2% (2012/2013) to 23.3%.	Pinellas County Schools	Annually
Outcome Measures		
Adults at a healthy weight Students at a healthy weight Increased park attendance and trail use. Increase in adults and children reporting regular physical activity		

Alignment with Local, State, and National Priorities	
Obj. 2.1.1	Florida SHIP CD 1.3, Healthy People 2020 NWS 15.1; NWS 15.2, Other: Public Health Law and Policy; CDC Winnable Battle: Nutrition, Physical Activity, and Obesity
Obj. 2.2.1	Florida SHIP CD 1.3.6, Healthy People 2020 NWS 15.1 and NWS 15.2, Other: Public Health Law and Policy; CDC Winnable Battle: Nutrition, Physical Activity, and Obesity

Strategy 2.1: Promote options for access to nutritious foods throughout Pinellas County.

Objective 2.1.1: By Dec. 31, 2016, increase the percentage of Pinellas adults who meet both of the daily recommendations for fruit and vegetable consumption from 9.3% (2010) to 11.5%.

2015 – 2016 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Support development of local city policies related to food access.	DOH-Pinellas	Municipal governments	July 2015 – June 2016	Assist at least one city with identifying model language to implement mobile produce vending and/or healthy corner stores.
2	Promote healthy and affordable food options to communities countywide, with a priority for those located within food deserts	DOH-Pinellas	Pinellas County Extension, PSTA	July 2015 – June 2016	Incorporate EBT into three new farmer's markets.

Strategy 2.2: Support a focused effort to increase access to nutritious and affordable foods for children.

Objective 2.2.1: By Dec 31, 2017, increase the percentage of Pinellas middle school students who consume at least five servings of fruits and vegetables a day from 21.2% (2012/2013) to 23.3%.

2015 – 2016 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Promotion of new "Snack Well" Guidelines created by Department of Agriculture	Pinellas County Schools, PICH	DOH-Pinellas	July 2015 – June 2016	Create brochure/flyer to be given to students to inform parents on new guidelines
2	Implement PEP program in 12 Pinellas County middle schools.	All Children's Hospital	Pinellas County Schools	July 2015 – June 2016	Track and increase the number of students receiving nutrition and culinary education in Pinellas County.

2015 – 2017 Activities

- Include policies for healthy eating in school settings, including providing additional fruits and vegetables at no additional cost when a full meal is purchased
- Increase awareness and ensure continued support of the Weekend Meal Program

HEALTHY COMMUNITIES AND ENVIRONMENTS		
How can we ensure an environment that is safe and provides access to opportunities for a healthy lifestyle?		
HCE Goal 3: Increase access to safe opportunities for physical activity		
Policy Component (Y/N): No		
Performance Measures		
Objectives	**Data Source**	**Frequency**
Objective 3.1.1: By Dec 31, 2017, complete 15 transportation linkages in Pinellas through infrastructure and programming improvements.	Pinellas County Strategic Planning and Initiatives; Pinellas County MPO	As Needed
Objective 3.1.2: By Dec. 31, 2016, decrease the percentage of Pinellas adults who were sedentary, or did not participate in any leisure-time activity in the past 30 days from 25.5% (2010) to 22%.	BRFSS	3 years
Outcome Measures		
Increased park attendance and trail use. Increase in adults and children reporting regular physical activity.		

Alignment with Local, State, and National Priorities	
Obj. 3.1.1	Florida SHIP CR 2.1.1 and CR 2.2.2, Healthy People 2020 PA-15 (PA 15.1; PA 15.2; PA 15.3), Other: CDC Winnable Battle: Nutrition, Physical Activity, and Obesity; Recommended by the Centers for Disease Control and Prevention's Community Guide
Obj. 3.1.2	Florida SHIP CR 2.1.1 and CR 2.2.2, Healthy People 2020 PA-1, Other: CDC Winnable Battle: Nutrition, Physical Activity, and Obesity; Recommended by the Centers for Disease Control and Prevention's Community Guide

Strategy 3.1: Promote collaborative efforts to form safe transportation linkages to schools, work, home, and recreation.

Objective 3.1.1: By Dec 31, 2017, complete 15 transportation linkages in Pinellas through infrastructure and programming improvements.

Objective 3.1.2: By Dec. 31, 2016, decrease the percentage of Pinellas adults who were sedentary, or did not participate in any leisure-time activity in the past 30 days from 25.5% (2010) to 22%.

2015 – 2016 Action Plan

	Activity	Coordinating Agency	Proposed Partner Agencies	Timeframe	Process Measure
1	Increase the number of infrastructure improvements for bicycle and pedestrian safety as well as park and trail access.	MPO	Municipal Governments, DOH-Pinellas, Pinellas County Parks and Conservation.	July 2015 – June 2016	Complete 5 environmental improvements that focus on safe physical activity within Pinellas County, including an increase of Auxiliary Ranger hours.
2	Maintain and update a list of city/county parks and recreational areas where the community can participate in free or low cost areas for physical activity.	DOH-Pinellas	City and County Municipalities	July 2015 – June 2016	Brochure/flyer updated at least once per year and number distributed

2015 – 2017 Activities

- Provide community outreach and education to remove impediments that deter use of trails, bike lanes and sidewalks
- Remove some of the barriers to walking or biking to school (heavy backpacks, no lockers, locked bike rack access) by implementing technology solutions (iPads, kindle textbooks) and process improvements.
- Create new opportunities (i.e. running clubs, etc.) at summer recreation programs to teach skills and encourage participation in physical activity