Community Health Needs Assessment
Pinellas County
2022

All4HealthFL
Four Counties. One Vision.

In collaboration with:
Johns Hopkins All Children's Hospital
Florida Health Pasco County
Florida Health Hillsborough County
Florida Health Pinellas County
Florida Health Polk County
Bayfront Health St. Petersburg
AdventHealth
BayCare
TGH Tampa General Hospital
Moffitt Cancer Center
Lakeland Regional Health

Mease Dunedin Hospital

Prepared by Conduent Healthy Communities Institute

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Letter from the All4HealthFL Collaborative

To the citizens of Hillsborough County,

We are proud to present the 2022 All4HealthFL Collaborative Community Health Needs Assessment (CHNA) for Pinellas County.

The All4HealthFL Collaborative members include AdventHealth, BayCare Health System, Bayfront Health St. Petersburg, Moffitt Cancer Center, Johns Hopkins All Children's Hospital, Lakeland Regional Health, Tampa General Hospital, and The Florida Department of Health in Hillsborough, Pinellas, Pasco, and Polk counties. The purpose of the collaborative is to improve health by leading regional outcome-driven health initiatives that have been prioritized through community health assessments.

We would like to extend our sincere gratitude to the volunteers, community members, community organizations, local government, and the many others who devoted their time, input, and resources to the 2022 Community Health Needs Assessment and prioritization process.

The collaborative is keenly aware that working together we can provide greater benefit to individuals in our community who need our support to improve their health and well-being. Over the next few months, we will be developing a detailed implementation plan around the top health needs identified in this report that will drive our joint efforts.

Thank you for taking the time to read the All4HealthFL 2022 Community Health Needs Assessment.

The All4HealthFL Collaborative

COMMUNITY HEALTH NEEDS ASSESSMENT
At a Glance: Pinellas County

Secondary Data

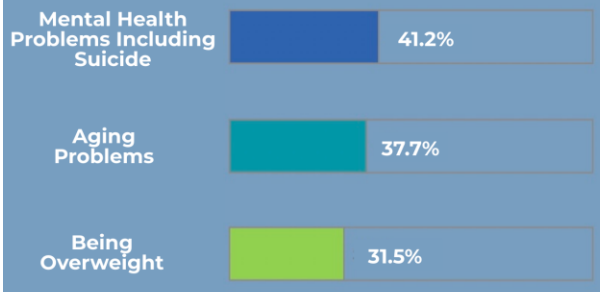
- Access to Health & Social Services
- Cancer
- Heart Disease & Stroke
- Behavioral Health (Mental Health & Substance Misuse)
- Exercise, Nutrition & Weight
- Immunizations & Infectious Diseases

Primary Data/Community Input

Community Health Survey

Pinellas County had **5,048** Community Survey Respondents

Top Health Issues:



Focus Group Discussions

Pinellas County conducted **5** Focus Groups

> "Dealing with multiple aspects of racism, creates health issues and concerns cultural competency in terms of how you're raised, your diet, and access to healthy food options."
>
> -Focus Group Participant

Health Equity

The All4HealthFL Collaborative was intentional in creating community assessments and forums to understand different groups' unique experiences and perceptions around diversity, equity, and inclusion. Focus groups consisted of community residents and organizations from the Black/African American/Haitian populations, Children, Hispanic/Latino, LGBTQ+, and Older Adults.

Introduction & Purpose

The purpose of this Community Health Needs Assessment (CHNA) is to offer a comprehensive understanding of health needs, barriers to accessing care, and Social Determinants of Health (SDoH). The priorities identified in this report help to guide a collaborative approach in planning efforts to improve the health and quality of life of residents in the community.

This CHNA was completed through a collaborative effort that integrated the process of the hospitals and community partners serving Pinellas County including: AdventHealth, BayCare Health System, Bayfront Health St. Petersburg, Johns Hopkins All Children's Hospital, and the Florida Department of Health in Pinellas County. The All4HealthFL Collaborative partnered with Conduent Healthy Communities Institute (HCI) to conduct this 2022 CHNA.

This report includes a description of the community demographics and population served. It also includes the process and methods used to obtain, analyze, and synthesize primary and secondary data and identify the significant health needs in the community. Special attention has been given to the needs of vulnerable populations, unmet health needs or gaps in services, and input from the community.

Findings from this report will be used to identify, develop, and target initiatives to provide and connect patients with resources to improve these health challenges in the community.

Acknowledgments

The Pinellas County community was a key stakeholder in the development of the CHNA. Community organizations, leaders, and residents assisted in identifying health and social care barriers of children and families living in the community. The All4HealthFL Collaborative members spearheaded development of the community survey and its outreach and marketing, facilitated focus groups, and united organizations for the purpose of improving health outcomes. In addition, the Collaborative commissioned three organizations to support the 2022 CHNA process.
See Appendix E for the full list of Collaborative members, supporting individuals, organizations, partners, and vendors.

Conduent Healthy Communities Institute (HCI) supported report preparation. HCI works with clients across the nation to drive community health outcomes by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing monitoring systems, and implementing performance evaluation processes. To learn more about Conduent HCI, please visit www.conduent.com/community-population-health.

Tampa Bay Healthcare Collaborative (TBHC) was selected to facilitate the prioritization sessions for each county. TBHC is a member-driven organization whose mission is to promote and advance health equity through increasing awareness, building capacity, and fostering collaboration. TBHC helps the underserved by connecting organizations, at no cost, within the health equity ecosystem to collaborate more effectively to reach vulnerable populations using TBHC Collaborate, an online platform, to elevate collaboration among members. To learn more about TBHC visit http://tampabayhealth.org/.

Collaborative Labs at St. Petersburg College designed and facilitated community focus group discussions. Collaborative Labs works as an extension of a business or organization's team to

provide expert facilitation, customized agenda formation, and strength-based activities. They are process experts that ensure an organization engagement has the right stakeholders to build the best plan for future success. Learn more at: www.CollaborativeLabs.com

All4HealthFL Collaborative

The All4HealthFL Collaborative was officially organized in 2019. This group comes together with a mutual interest to improve health by leading regional, outcome-driven health initiatives that have been prioritized through community health assessments. This process is conducted every three years and aims to identify health priorities in the community and strategies to address them.

The All4HealthFL Collaborative works together to plan, implement, and evaluate strategies that are in alignment with identified health priorities. Together, the group strives to make Hillsborough, Pasco, Pinellas, and Polk counties the healthiest region in Florida.

The Collaborative consists of individuals from the following organizations and agencies:

The All4HealthFL Collaborative also hosts and maintains the All4HealthFL Community Data Platform as a community resource for the four counties comprising their combined service area.

Evaluation of Progress Since Previous CHNA

The CHNA process should be viewed as a three-year cycle to evaluate the impact of actions taken to address priority areas. This step affirms organizations' focus and targets efforts during the next CHNA cycle. The top three health priorities for Pinellas County from the 2019 CHNA were Access to Health Care, Behavioral Health, and Exercise, Nutrition & Weight.

Implementation strategies for these health topics shifted in response to the COVID-19 pandemic. Innovative strategies were adopted to continue building capacity for addressing the community health needs.

Collaborative Achievements

In 2019, the county health departments and health systems came together to partner on a single Community Health Needs Assessment for the Tampa Bay region. Those organizations, now united as All4HealthFL Collaborative, came together under the belief that the important health challenges our community faced were best assessed and addressed as one. The work of the Collaborative culminated in a set of priorities that are guiding the community health initiatives of organizations across Hillsborough, Pasco, Pinellas, and Polk counties.

While implementation of our community benefit plans was already underway, the Collaborative understood all too well the tremendous impact COVID-19 had on our communities. It was important to take a moment and understand how the ground shifted in terms of community health needs because of the ongoing pandemic. With that in mind, a short survey was deployed from May through June 2020 asking community partners and experts how COVID-19 brought to light new issues or reinforced existing issues facing the health needs of the community.

There were 85 responses to the survey across the region. Although there were new issues that emerged around housing and poverty, the survey respondents affirmed the 2020-2022 top three focus areas of Mental Health and Substance Misuse, Access the Health Care, and Exercise, Nutrition and Weight as still the most pressing issues. This data provided the Collaborative an opportunity to consider increasing strategies to expand programs like Mental Health First Aid Training.

Community Feedback from Preceding CHNA & Implementation Plan

Community Health Needs Assessment reports from 2019 were published on the All4HealthFL website. Additional community comments and feedback were obtained during the 2019 county-level prioritization sessions as well as via email. In post-prioritization evaluations, the community voiced their desire to have more opportunity to process and discuss data and findings from the assessment process before participating in prioritization activities. As a result of this feedback, the six virtual prioritization sessions that were hosted as part of the Collaborative's 2022 assessment were intentionally designed to create space and opportunity for facilitated discussions around overall assessment findings as well as specific health topics.

Demographics of Pinellas County

The demographics of a community significantly impact its health profile. Different racial, ethnic, age, and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts. The following section explores the demographic profile of the community residing in Pinellas County.

Geography and Data Sources

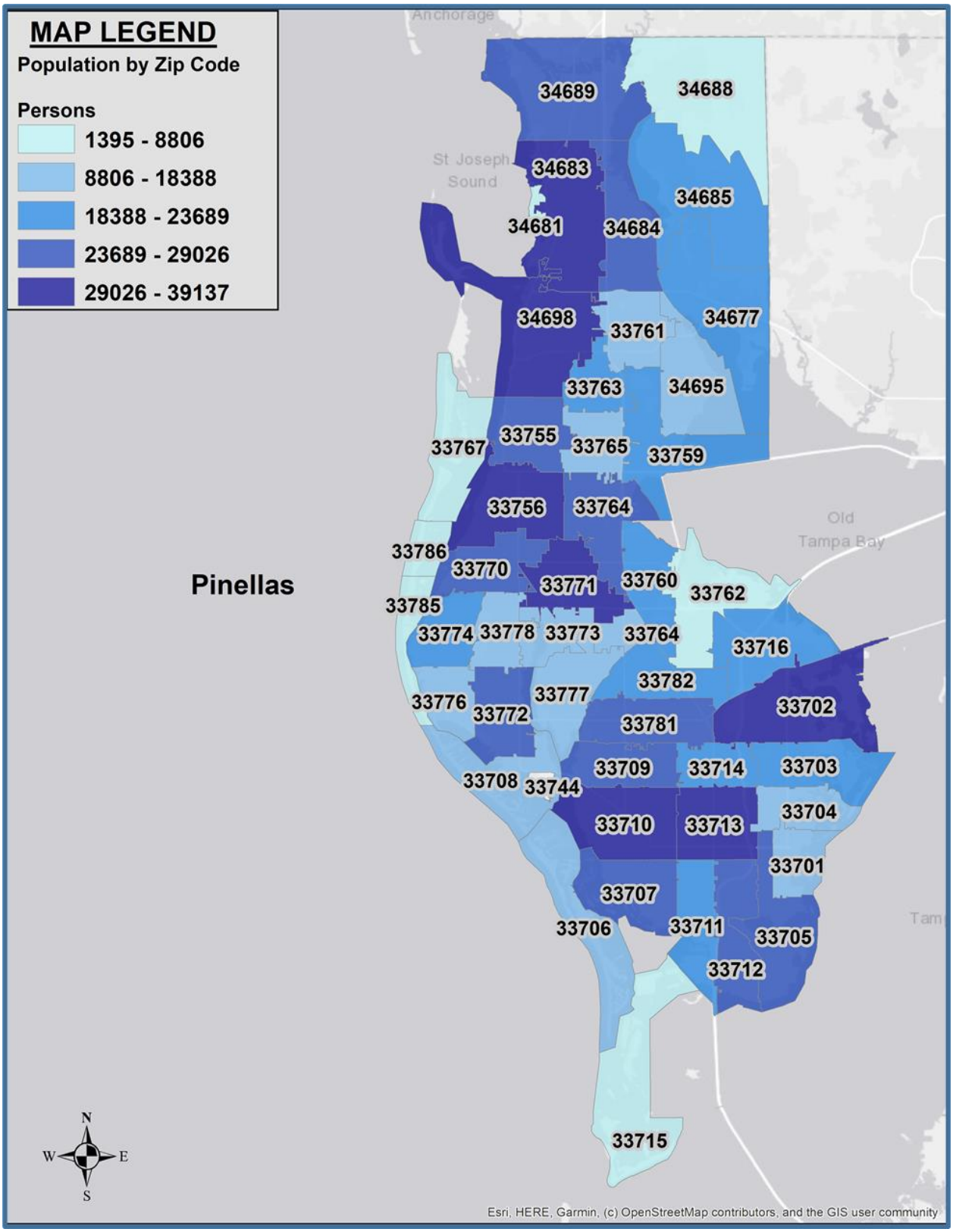
Data are presented in this section at the geographic level of Pinellas County. Comparisons to the county, state, and national value are also provided when available. All demographic estimates are sourced from Clarita's Pop-Facts® (2022 population estimates)[1] and American Community Survey[2] one-year (2019) or five-year (2016-2020) estimates unless otherwise indicated.

Population

According to the 2022 Clarita's Pop-Facts® population estimates, Pinellas County has an estimated population of 982,142 persons. Figure 1 shows the population size by each ZIP code, with the darkest blue representing the ZIP codes with the largest population. Appendix A provides the actual population estimates for each ZIP code. The most populated ZIP code area within Pinellas County is ZIP code 34698 (Dunedin) with a population of 39,137.

[1] All4HealthFL online platform. https://www.all4healthfl.org/demographicdata
[2] American Community Survey. https://www.census.gov/programs-surveys/acs

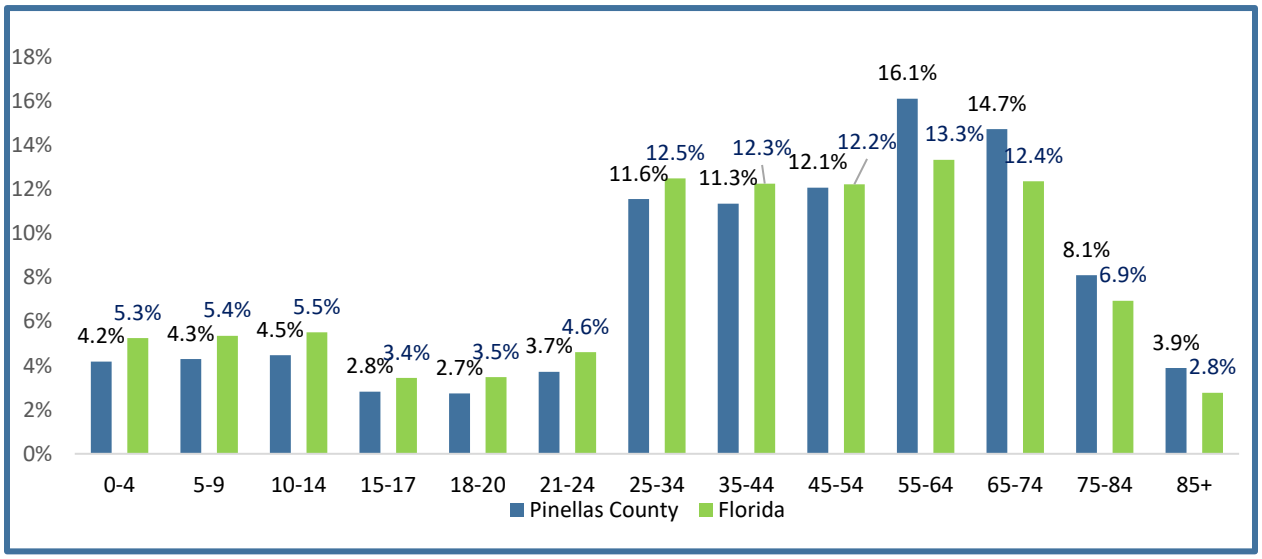
Figure 1: Population by ZIP Code by Age Under 18: Pinellas County



Age

Children (0-17) comprised 15.8% of the population in Pinellas County. When compared to Florida and the U.S., Pinellas County has lower proportion of children population (age 0-17) and a higher proportion of residents aged 65+. Figure 2 shows further breakdown of age categories.

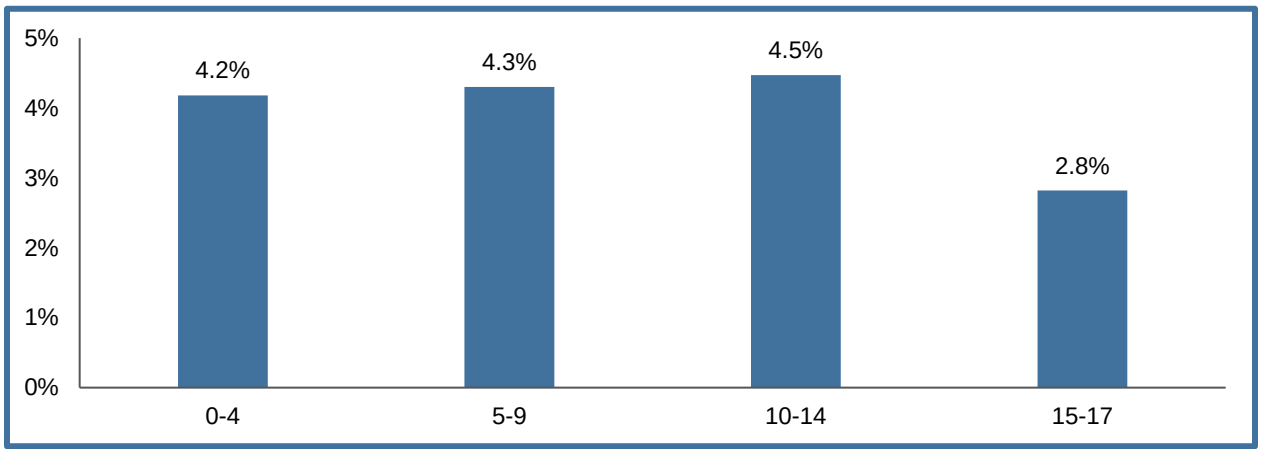
Figure 2: Population by Age: County and State Comparisons



*County and state values- Claritas Pop-Facts® (2022 population estimates)

Figure 3 shows the population of Pinellas County by age group under 18 years.

Figure 3: Population by Age Under 18: Pinellas County

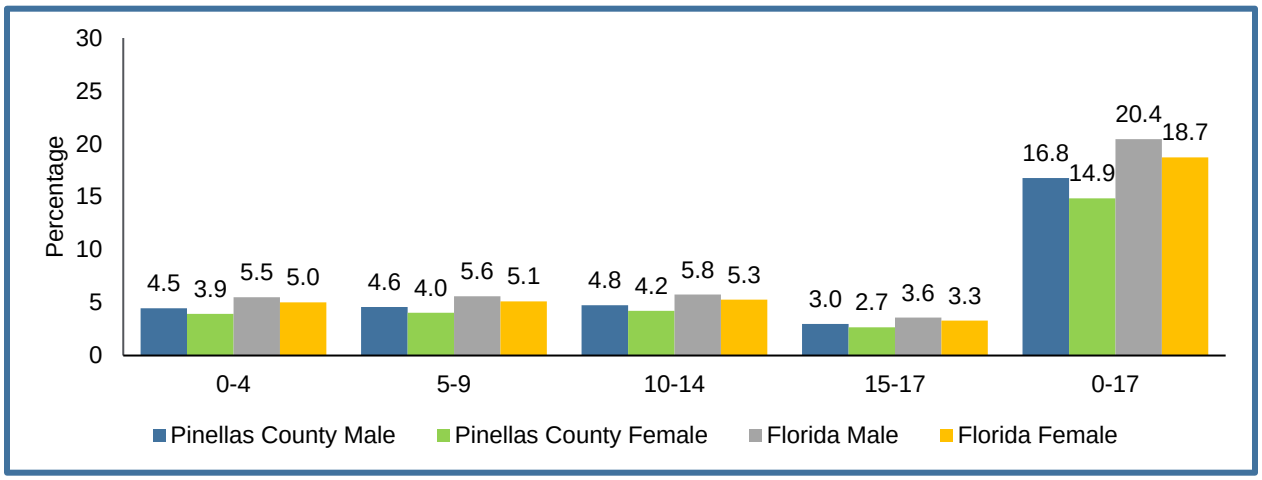


*County values- Claritas Pop-Facts® (2022 population estimates)

Sex

Figure 4 shows the children (under 18) population of Pinellas County by sex. Males comprise 16.7% of the population, whereas females comprise 14.8% of the population in the county.

Figure 4: Population by Sex Under 18: County and State Comparisons



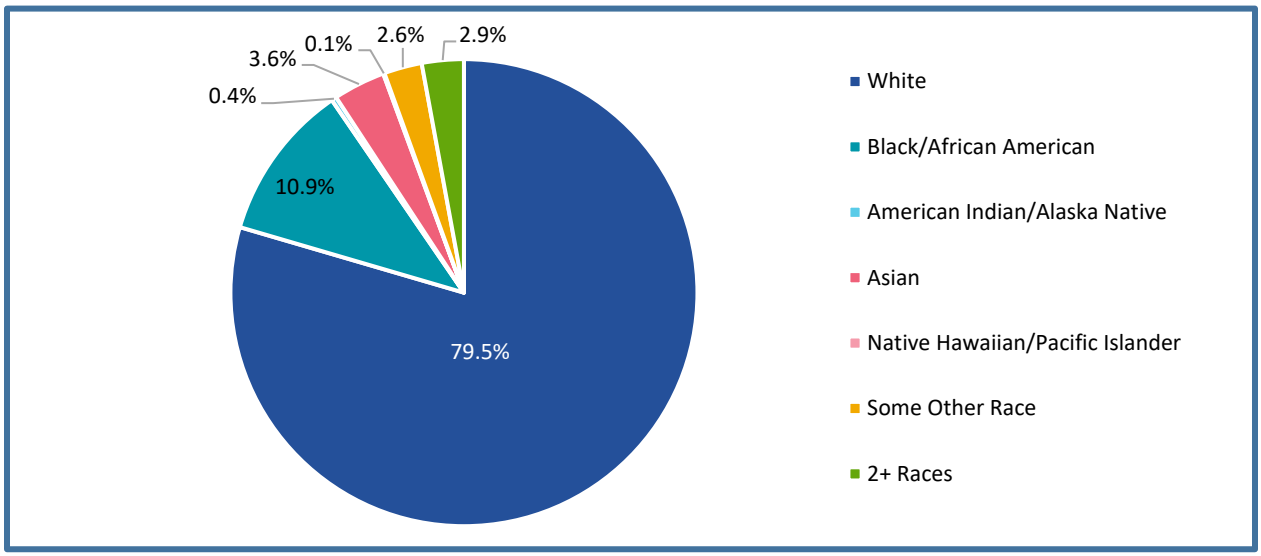
*County values- Claritas Pop-Facts® (2022 population estimates)

Race and Ethnicity

The racial and ethnic composition of a population is important in planning for future community needs: particularly for schools, businesses, community centers, health care, and childcare. Analysis of health and social determinants of health data by race/ethnicity can also help identify disparities in housing, employment, income, and poverty.

The racial makeup of Pinellas County area shows 79.5% of the population identifying as White, as indicated in Figure 5. The proportion of Black/African American community members is the second largest of all races in Pinellas County at 10.9%.

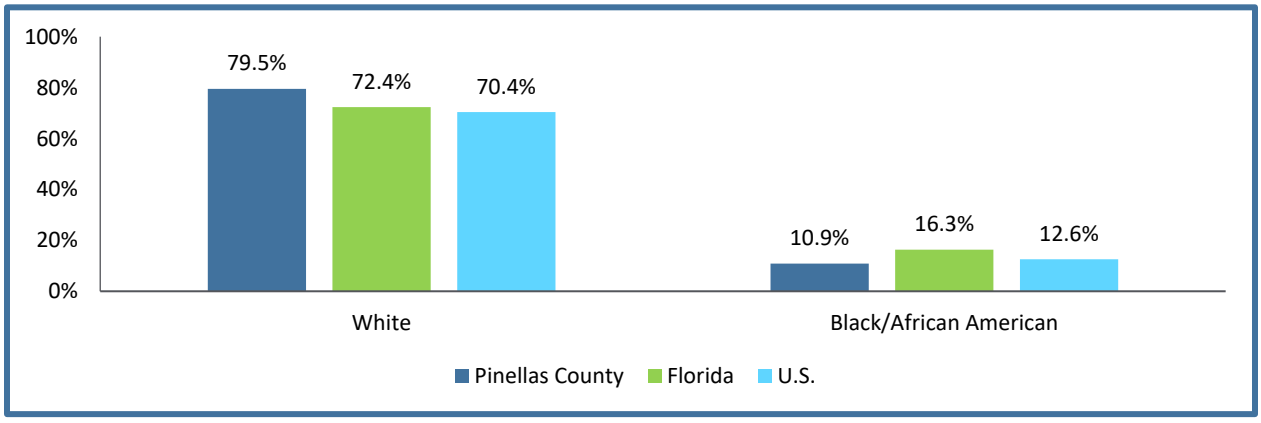
Figure 5: Population by Race: Pinellas County



*County values- Claritas Pop-Facts® (2022 population estimates)

Those community members identifying as White represent a higher proportion of the population in Pinellas County (79.5%) when compared to Florida (72.4%) and the U.S. (70.4%), while Black/African American community members represent a lower proportion of the population in Pinellas County (10.9%) when compared to Florida (16.3%) and the U.S. (12.6%) (Figure 6).

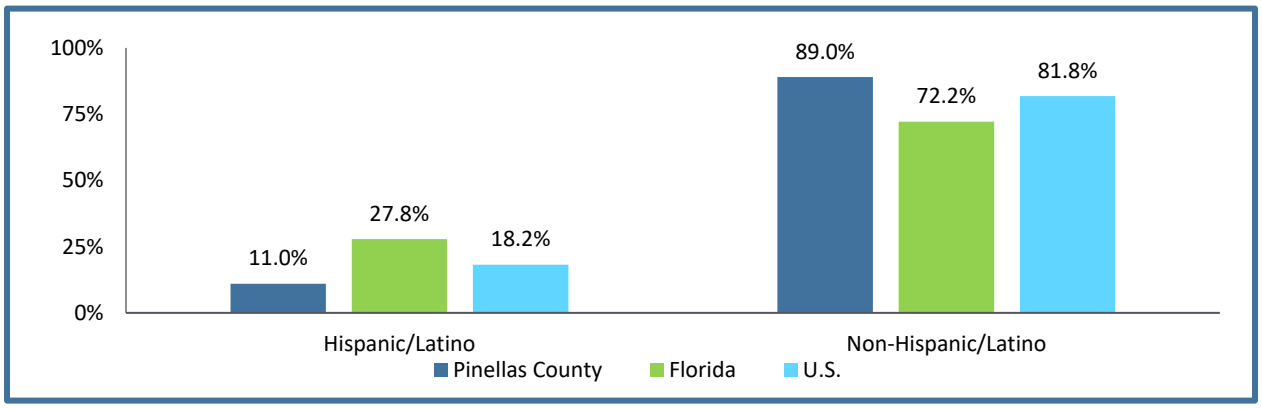
Figure 6: Population by Race: Pinellas County, State, and U.S. Comparisons



*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

As shown in Figure 7, 11.0% of the population in Pinellas County identify as Hispanic/Latino. This is a smaller proportion of the population when compared to Florida and the U.S.

Figure 7: Population by Ethnicity: Pinellas County, State, and U.S. Comparisons



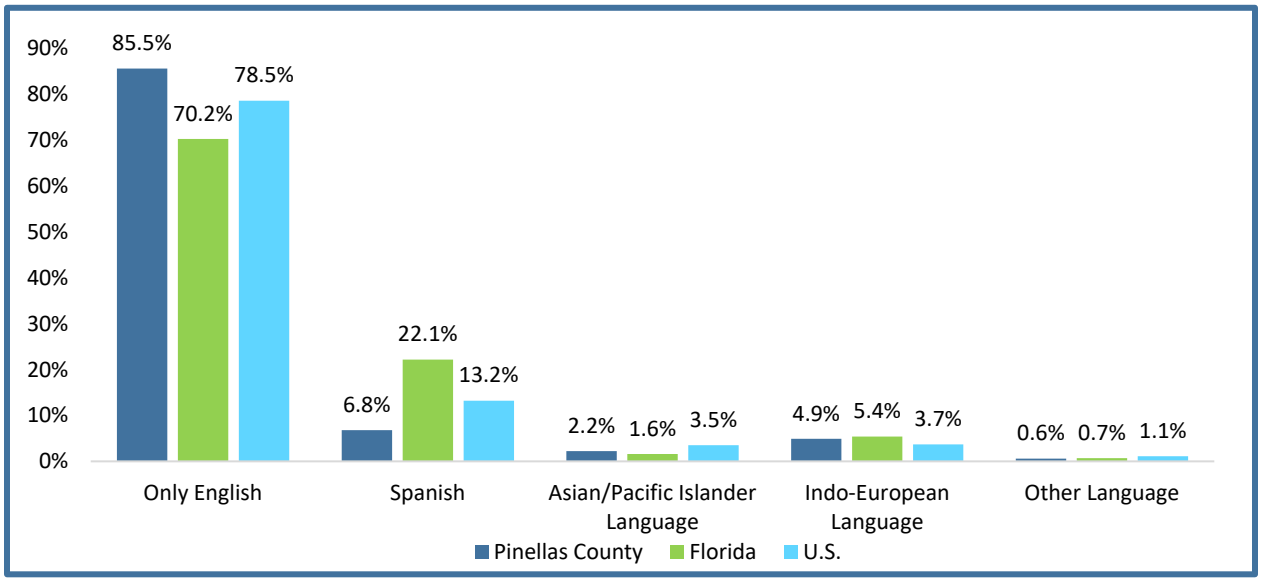
*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

Language and Immigration

Understanding countries of origin and language spoken at home can help inform the cultural and linguistic context for the health and public health system. According to the American Community Survey, 12% of residents in Pinellas County are born outside the U.S., which is slightly lower than the national value of 13.6%.[3]

In Pinellas County, 85.5% of the population age five and older speak only English at home, which is higher than both the state value of 70.2% and the national value of 78.5% (Figure 8). This data indicates that 6.8% of the population in Pinellas County speak Spanish, and 0.6% speak languages other than English at home.

Figure 8: Population 5+ by Language Spoken at Home: County, State and U.S. Comparisons

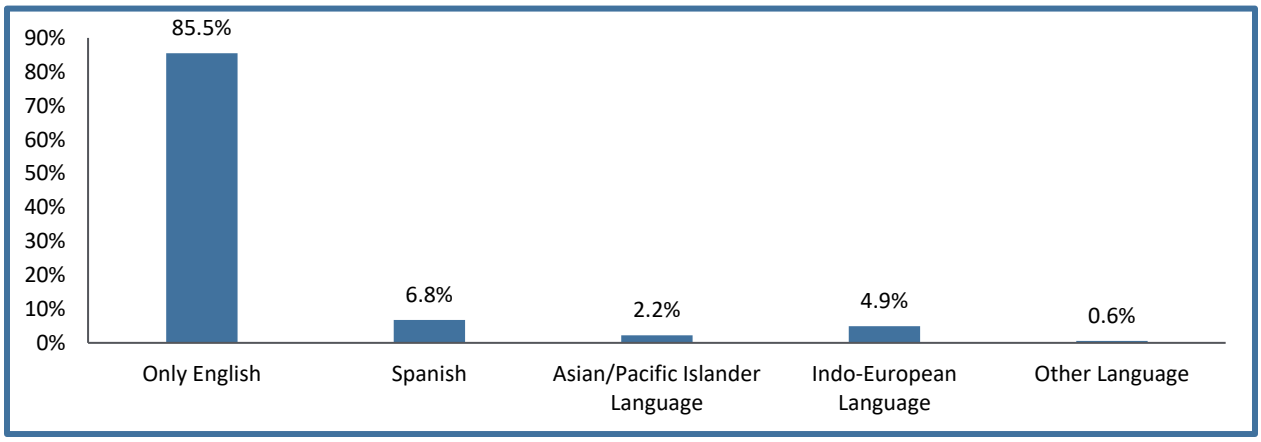


*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

[3] American Community Survey, 2016-2020

The most common languages spoken at home are English (85.5%), Spanish (6.8%), and Indo-European languages such as French, Portuguese, Russian, and Dutch[4] (4.9%). (Figure 9).

Figure 9: Population 5+ by Language Spoken at Home: Pinellas County



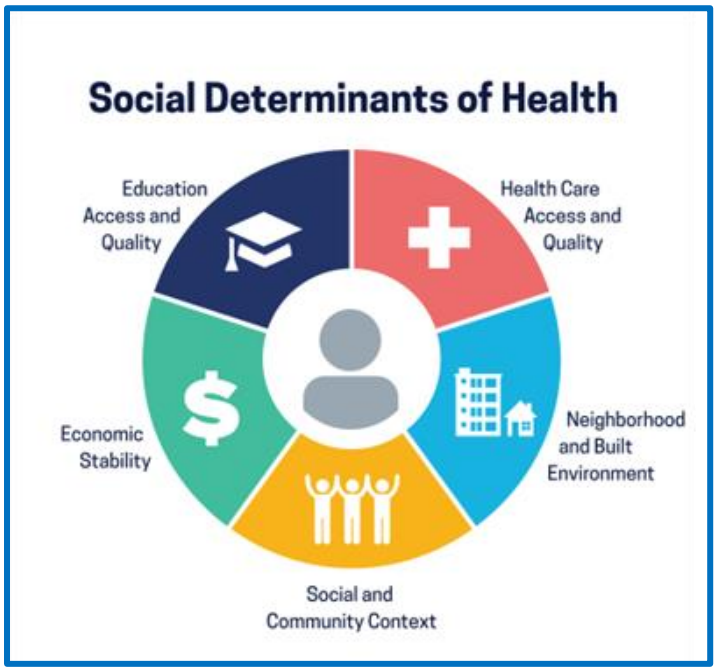
*County values- Claritas Pop-Facts® (2022 population estimates)

[4] United States Census Bureau. https://www.census.gov/topics/population/language-use/about.html

Social & Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health impacting the Pinellas County communities. Social determinants are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. The Social Determinants of Health (SDOH) can be grouped into five domains. Figure 10 shows the Healthy People 2030 Social Determinants of Health domains (Healthy People 2030, 2022).

Figure 10: Healthy People 2030 Social Determinants of Health Domains



Geography and Data Sources

Data in this section are presented at various geographic levels (ZIP code and/or county) depending on data availability. When available, comparisons to county, state, and/or national values are provided. It should be noted that county level data can sometimes mask what could be going on at the ZIP code level in many communities. While indicators may be strong when examined at a higher level, ZIP code level analysis can reveal disparities.

All demographic estimates are sourced from Claritas Pop-Facts® (2022 population estimates) and American Community Survey one-year (2019) or five-year (2016-2020) estimates unless otherwise indicated.

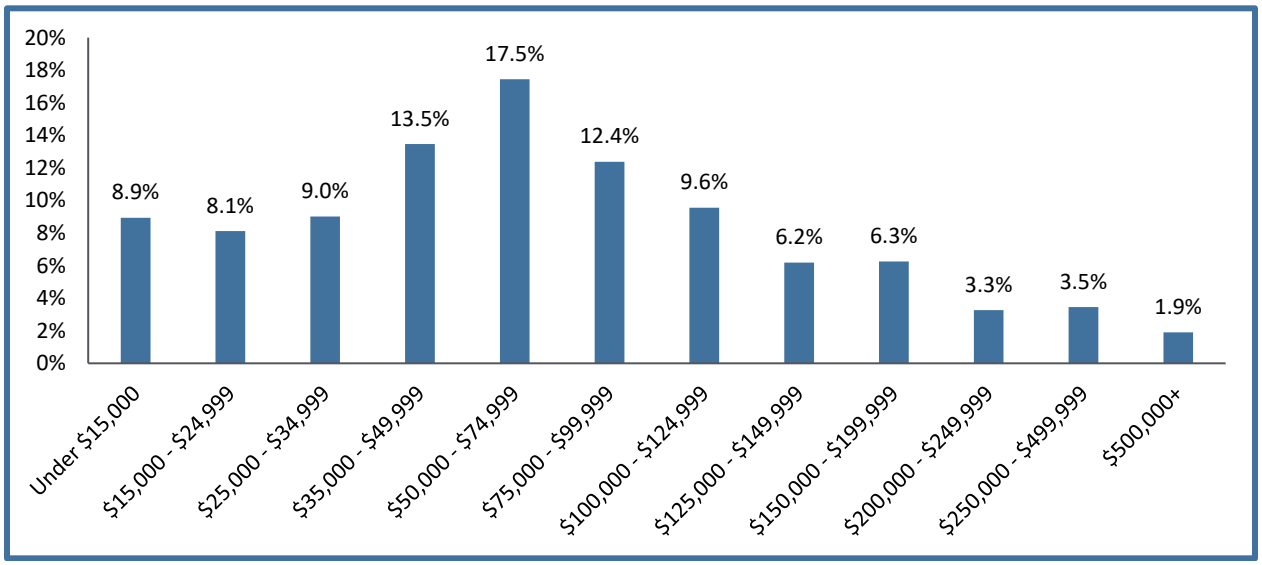
Income

Income has been shown to be strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social, and environmental factors. Those with greater wealth are more likely to have higher life expectancy and reduced risk of a range of health conditions

including heart disease, diabetes, obesity, and stroke. Poor health can also contribute to reduced income by limiting one's ability to work.[5]

Figure 11 provides a breakdown of households by income in Pinellas County. A household income of $50,000 - $74,999 is shared by the largest proportion of households in Pinellas County (17.5%). Households with an income of less than $15,000 make up 8.9% of households in Pinellas County.

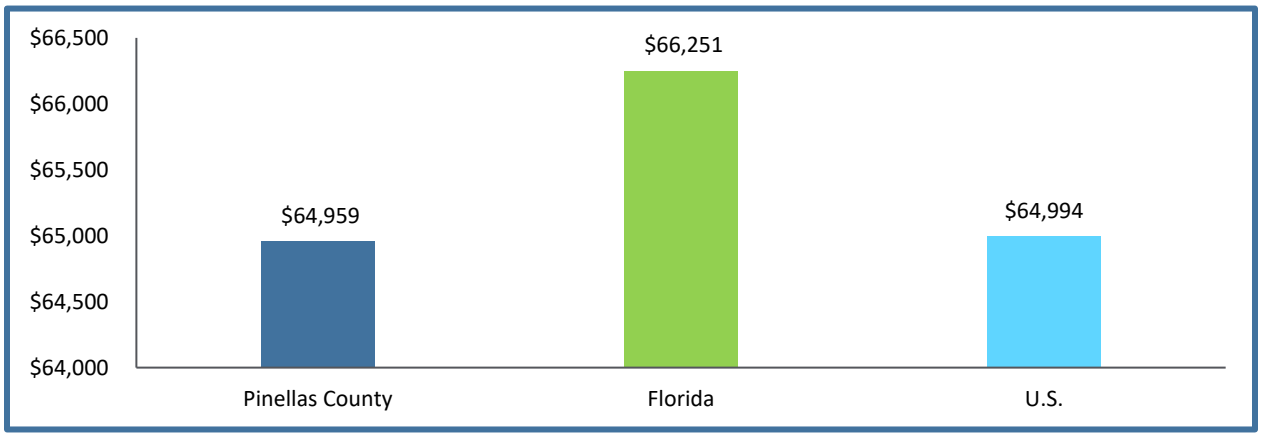
Figure 11: Households by Income, Pinellas County



*County values- Claritas Pop-Facts® (2022 population estimates)

The median household income for Pinellas County is $64,959, which is lower than the state value of $66,251 and national value of $64,994 (Figure 12).

Figure 12: Households Income by: County, State and U.S. Comparisons



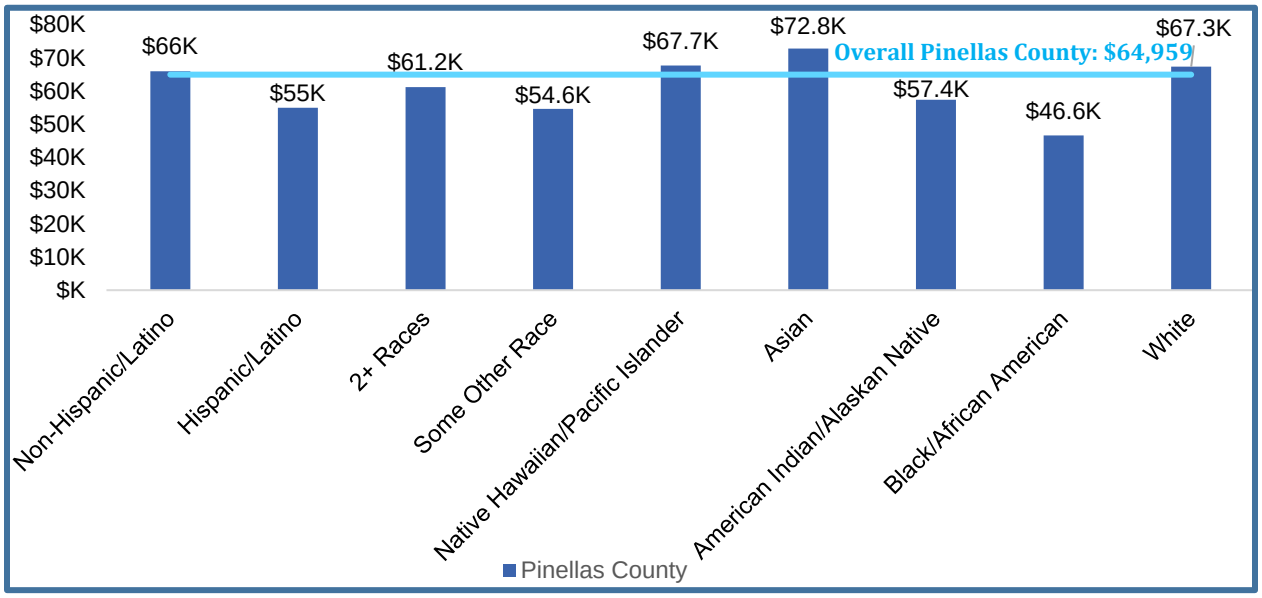
*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

Figure 13 shows the median household income by race and ethnicity. Four racial/ethnic groups – White, Asian, Non-Hispanic/Latino, and Native Hawaiian/Pacific Islander – have median household

[5] Robert Wood Johnson Foundation. Health, Income, and Poverty. https://www.rwjf.org/en/library/research/2018/10/health--income-and-poverty-where-we-are-and-what-could-help.html

incomes above the overall median value. All other races have incomes below the overall value, with Black/African American populations having the lowest median household income at $46,614.

Figure 13: Median Household Income by Race/Ethnicity, Pinellas County



*County values- Claritas Pop-Facts® (2022 population estimates)

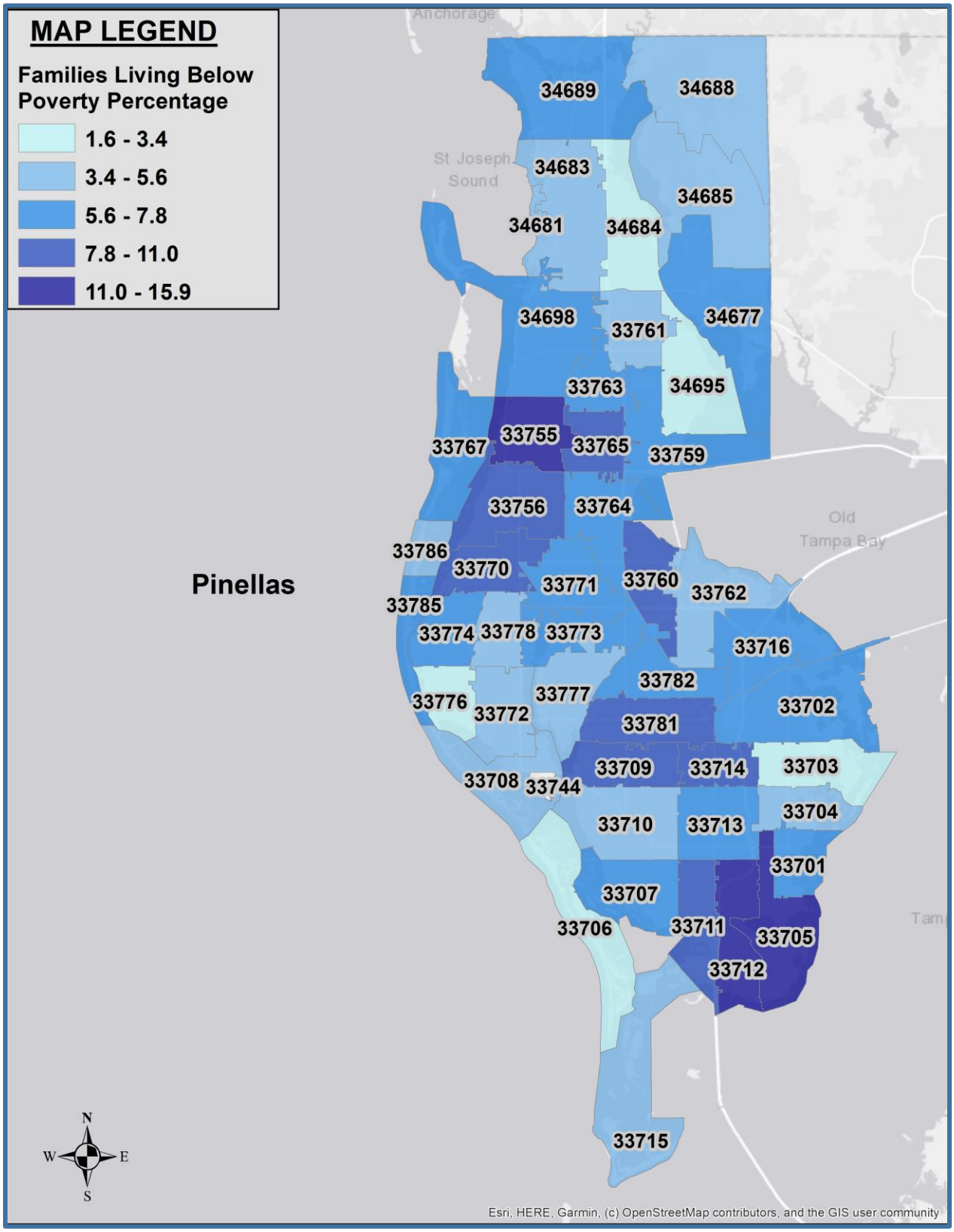
Poverty

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. People living in poverty are less likely to have access to health care, healthy food, stable housing, and opportunities for physical activity. These disparities mean people living in poverty are more likely to experience poorer health outcomes and premature death from preventable diseases.[6]

Figure 14 shows the percentage of families living below the poverty level by ZIP code. The darker blue colors represent a higher percentage of families living below the poverty level, with ZIP codes 33755 (Clearwater) and 33712 (St. Petersburg) having the highest percentages at 15.9% and 14.2%, respectively. Overall, 7.0% of families in Pinellas County live below the poverty level, which is lower than both the state value of 9.3% and the national value of 9.1%. The percentage of families living below poverty for each ZIP code in Pinellas County is provided in Appendix A.

[6] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability/reduce-proportion-people-living-poverty-sdoh-01

Figure 14: Families Living Below Poverty: Pinellas County



Employment

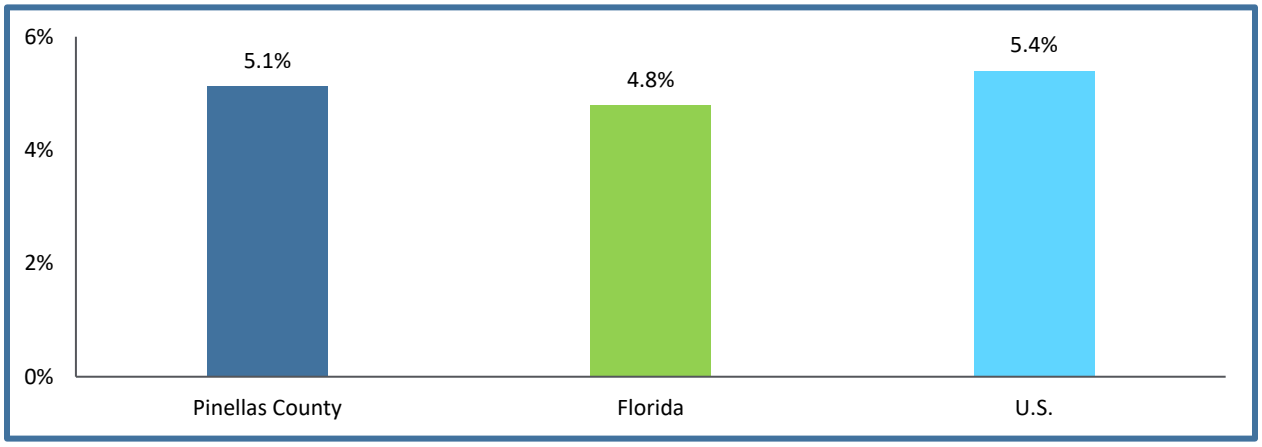
A community's employment rate is a key indicator of the local economy. An individual's type and level of employment impacts access to health care, work environment, health behaviors, and health outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, poor or unstable work and working conditions are linked to poor physical and mental health outcomes. [7]

Unemployment and underemployment can limit access to health insurance coverage and preventive care services. Underemployment is described as involuntary part-time employment, poverty-wage employment, and insecure employment.[7]

Type of employment and working conditions can also have significant impacts on health. Work-related stress, injury, and exposure to harmful chemicals are examples of ways employment can lead to poorer health.[7]

Figure 15 shows the population aged 16 and over who are unemployed. The unemployment rate for Pinellas County is 5.1%, which is higher than the state value of 4.8% and lower than the national value of 5.4%.

Figure 15: Population 16+ Unemployed



*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

Education

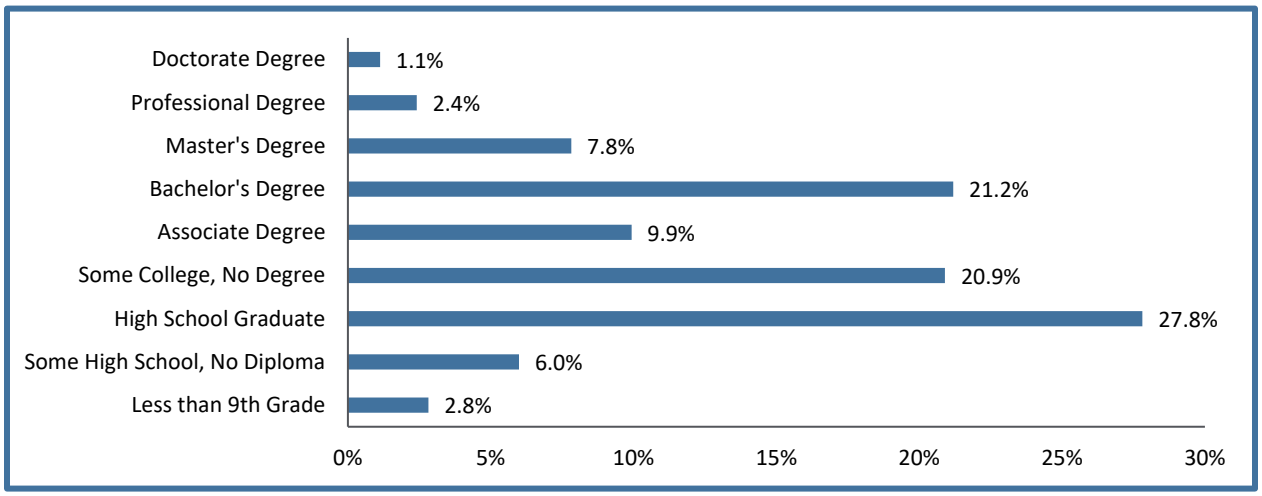
Education is an important indicator for health and wellbeing. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health. People with higher levels of education are likely to live longer, to experience better health outcomes, and practice health-promoting behaviors.[8]

Figure 16 shows the percentage of the population 25 years or older by educational attainment.

[7] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/employment

[8] Robert Wood Johnson Foundation, Education and Health. https://www.rwjf.org/en/library/research/2011/05/education-matters-for-health.html

Figure 16: Population Aged 25+ by Education Attainment, Pinellas County

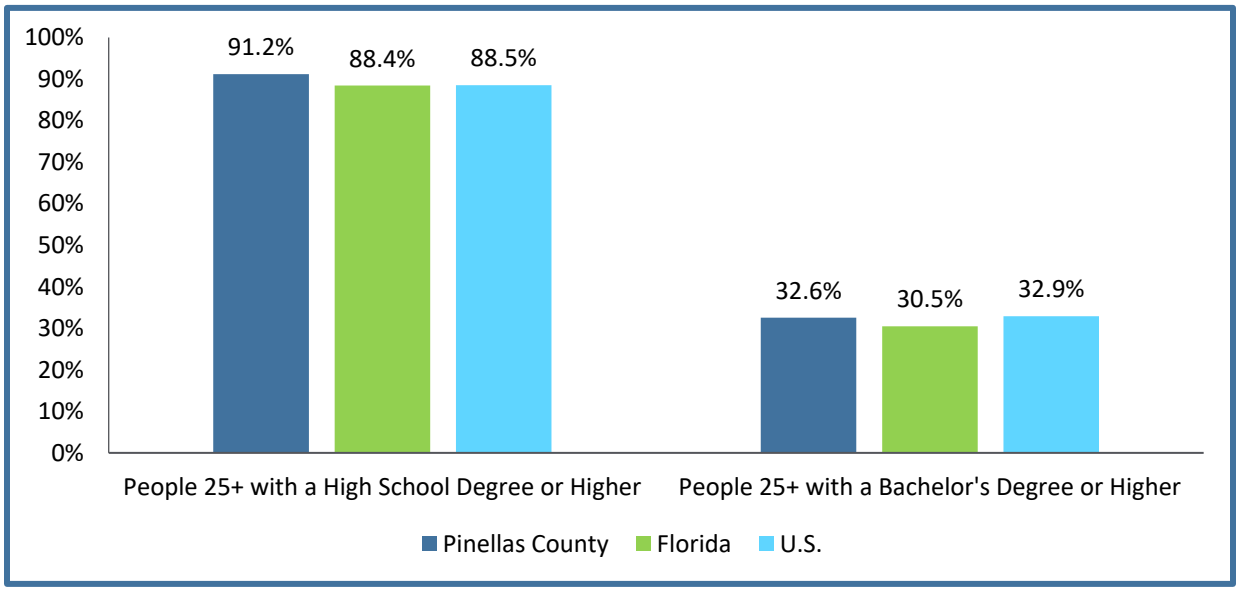


*County values- Claritas Pop-Facts® (2022 population estimates)

Another indicator related to education is on-time high school graduation. A high school diploma is a requirement for many employment opportunities and for higher education. Not graduating high school is linked to a variety of negative health impacts, including limited employment prospects, low wages, and poverty.[9]

Figure 17 shows that Pinellas County has a higher percentage of residents with a high school degree and bachelor's degree when compared to the state.

Figure 17: Population 25+ by Education Attainment, FL and U.S. Comparisons



*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

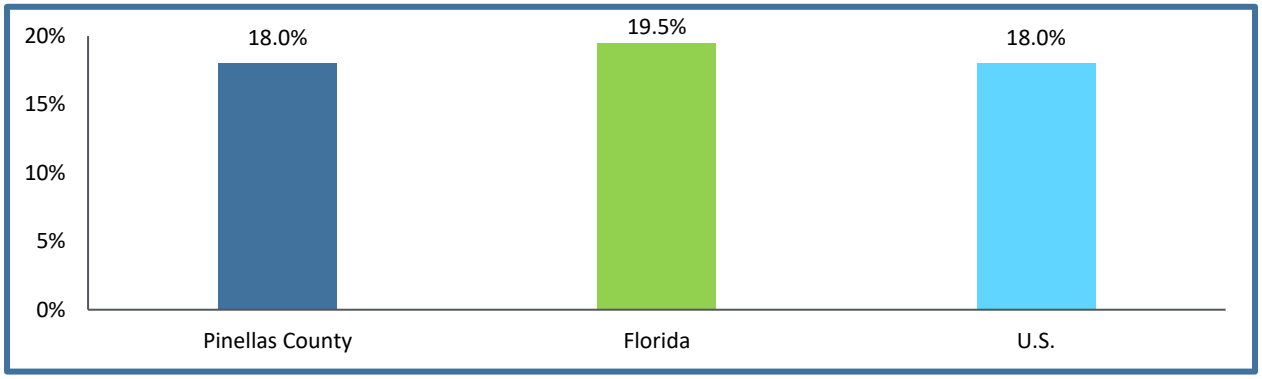
[9] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/high-school-graduation

Housing

Safe, stable, and affordable housing provides a critical foundation for health and wellbeing. Exposure to health hazards and toxins in the home can cause significant damage to an individual or family's health.[10]

Figure 18 shows the percentage of houses with severe housing problems. This indicator measures the percentage of households with at least one of the following problems: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities. In Pinellas County, 18.0% of households were found to have at least one of those problems, which is lower than the state value (19.5%), but the same as the national value (18.0%).

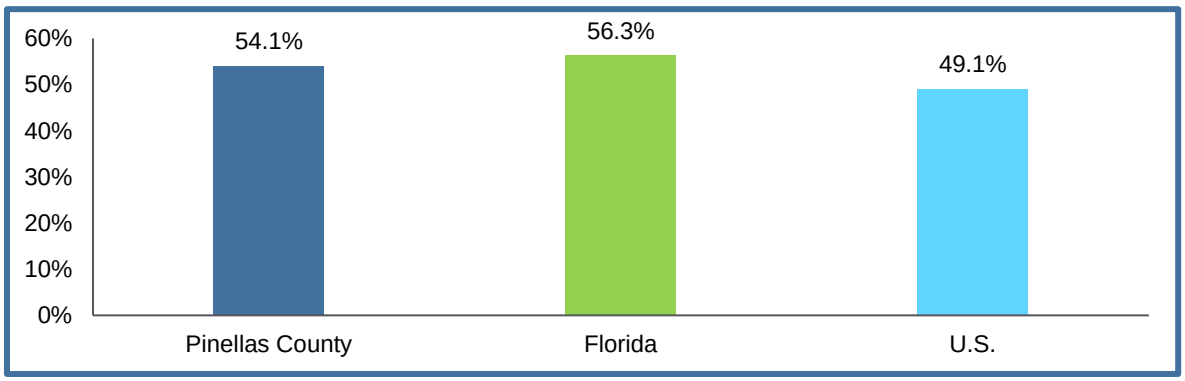
Figure 18: Severe Housing Problems: County, State, and U.S. Comparisons



*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

When families must spend a large portion of their income on housing, they may not have enough money to pay for things like healthy foods or health care. This is linked to increased stress, mental health problems, and an increased risk of disease.[11] Figure 19 shows the percentage of renters who are spending 30% or more of their household income on rent. The value in Pinellas County, 54.1%, is higher than the national value (49.1%), and lower than the state value (56.3%).

Figure 19: Renters Spending 30% Or More Of Household Income On Rent: County, State, U.S. Comparisons



*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

[10] County Health Rankings, Housing and Transit. https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/physical-environment/housing-and-transit

[11] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes/reduce-proportion-families-spend-more-30-percent-income-housing-sdoh-04

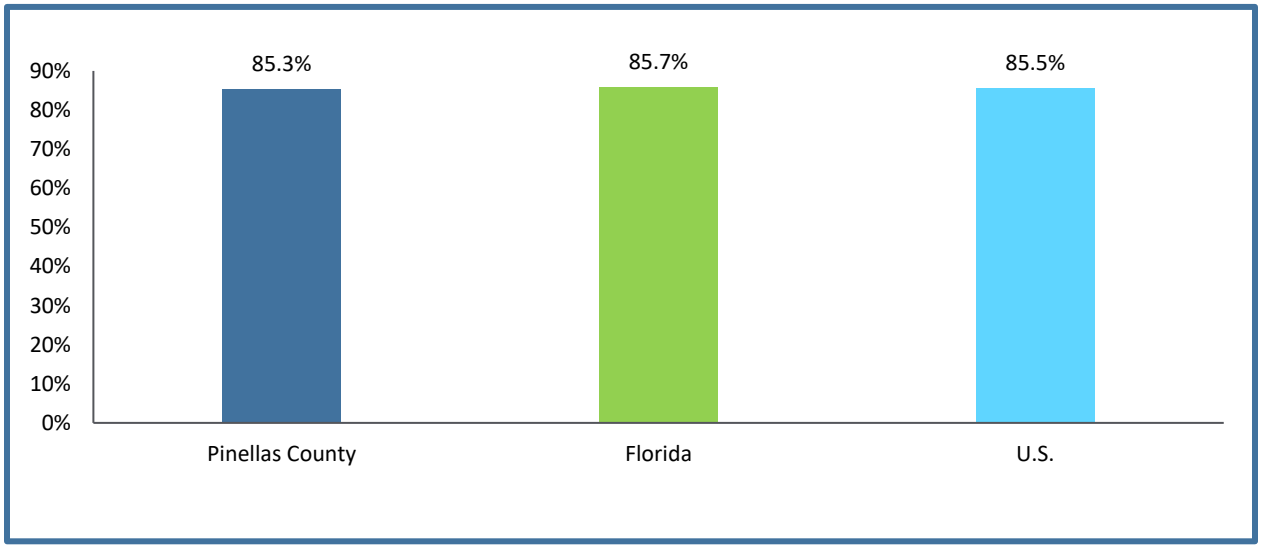
Neighborhood and Built Environment

Internet access is essential for basic health care access, including making appointments with providers, getting test results, and accessing medical records. Access to the internet is also increasingly essential for obtaining home-based telemedicine services.[12]

Internet access may also help individuals seek employment opportunities, conduct remote work, and participate in online educational activities.[12]

Figure 20 shows the percentage of households that have an internet subscription. The rate in Pinellas County, 85.3%, is lower than the state value (85.7%) and lower than the national value (85.5%).

Figure 20: Households with an Internet Subscription: County, State and U.S. Comparison



[12] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/neighborhood-and-built-environment/increase-proportion-adults-broadband-internet-hchit-05

Disparities and Health Equity

Identifying disparities by population groups and geography helps to inform and focus priorities and strategies. Understanding disparities also helps us better understand root causes that impact health in a community and inform action towards health equity.

Health Equity

Health equity is the fair distribution of health determinants, outcomes, and resources across communities.[13] National trends have shown that systemic racism, poverty, and gender discrimination have led to poorer health outcomes for groups such as Black/African American, Hispanic/Latino, Indigenous, populations, communities with incomes below the federal poverty level, and the LGBTQ+ communities.

Race, Ethnicity, Age & Gender Disparities

Primary and secondary data revealed significant community health disparities by race, ethnicity, age, and gender that is included throughout this report. It is important to note that the data is presented to show differences and distinctions by population groups. The All4HealthFL Collaborative was intentional in creating community assessments and forums to understand different groups' unique experiences and perceptions around diversity, equity, and inclusion. Focus group forums consisted of community residents from various race, ethnicity, age, and gender groups to include Black/African American, Haitian/Creole, Children, Hispanic/Latino, LGBTQ+ population, and older adults.

Secondary Data

Community health disparities were assessed in the secondary data using the Index of Disparity[14] analysis, which identifies disparities based on how far each subgroup (by race, ethnicity, or gender) is from the overall county value. For more detailed methodology related to the Index of Disparity, see Appendix B.

Table 1 below identifies secondary data indicators with a statistically significant race, ethnicity, or gender disparity for Pinellas County, based on the Index of Disparity.

[13] Klein R, Huang D. Defining and measuring disparities, inequities, and inequalities in the Healthy People initiative. National Center for Health Statistics. Center for Disease Control and Prevention. https://www.cdc.gov/nchs/ppt/nchs2010/41_klein.pdf
[14] Pearcy, J. & Keppel, K. (2002). A Summary Measure of Health Disparity. Public Health Reports, 117, 273-280.

Table 1: Indictors with Significant Race, Ethnicity or Gender Disparities

Health Indicator	Groups Disproportionately Impacted
Age-Adjusted Death Rate due to Motor Vehicle Collisions	Black/African American, Male
Adults Who Currently Use E-Cigarettes	Black/African American, Hispanic/Latino
Age-Adjusted Death Rate due to Diabetes	Black/African American, Hispanic/Latino, Male
Age-Adjusted Death Rate due to Kidney Disease	Black/African American, Hispanic/Latino, Male
Age-Adjusted Death Rate due to Prostate Cancer	Black/African American
Babies with Low Birth Weight	Black/African American
Children Living Below Poverty Level	Black/African American, Hispanic/Latino, More than one Race
Families Living Below Poverty Level	Black/African American, American Indian/Alaska Native, Multiple Races, Other Race, Hispanic/Latino
HIV Incidence Rate	Black/African American, Hispanic/Latino, Male
Infant Mortality Rate	Black/African American, Hispanic/Latino
Melanoma Incidence Rate	White
People 65+ Living Below Poverty Level	Black/African American, Asian, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Multiple Races, Other Race, Hispanic/Latino
Teen Birth Rate: 15-19	Black/African American, Hispanic/Latino
Workers Commuting by Public Transportation	White, Asian

The Index of Disparity analysis for Pinellas County reveals that Black/African American and Hispanic/Latino populations are disproportionately impacted for several chronic diseases, including Diabetes, Kidney Disease, Prostate Cancer. Furthermore, Black/African American, and Hispanic/Latino populations are disproportionately impacted in the Infant Mortality Rate and Teen Birth Rate: aged 15-19.

Additionally, table 1 provides examples of significant race and ethnicity disparities across various measures of poverty. Disparities can be associated with poorer health outcomes for these groups that are disproportionately impacted. Some indicators include Families Living Below Poverty Level, Children Living Below Poverty Level and People aged 65+ Living Below Poverty Level.

Geographic Disparities

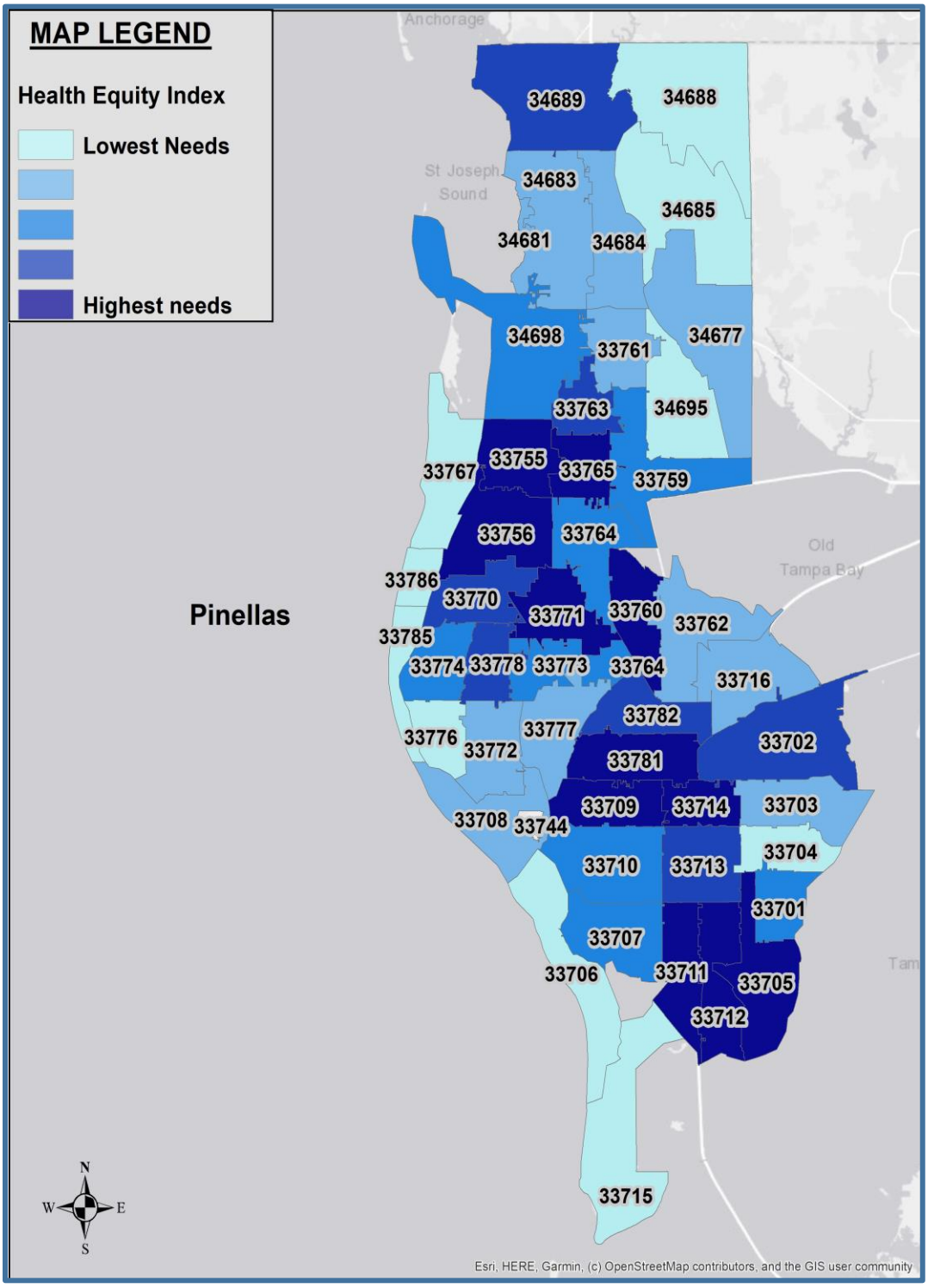
In addition to disparities by race, ethnicity, age, and gender, this assessment also identified specific ZIP codes/municipalities with differences in outcomes related to health and social determinants of health. Geographic disparities were identified using the Health Equity Index, Food Insecurity Index, and Mental Health Index. These indices have been developed by Conduent Healthy Communities Institute to easily identify areas of high socioeconomic need, food insecurity and mental health need. Conduent's Health Equity Index estimates areas of highest socioeconomic need correlated with poor health outcomes. Conduent's Food Insecurity Index estimates areas of low food

accessibility correlated with social and economic hardship. Conduent's Mental Health Index (MHI) is a measure of socioeconomic and health factors correlated with self-reported poor mental health. For all indices, counties, ZIP codes, and census tracts with a population over 300 are assigned index values ranging from 0 to 100, with higher values indicating greater need. Understanding where there are communities with higher need is critical to targeting prevention and outreach activities.

Health Equity Index

Conduent's Health Equity Index estimates areas of high socioeconomic need, which are correlated with poor health outcomes. ZIP codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 21. The following ZIP codes in Pinellas County had the highest level of socioeconomic need (as indicated by the darkest shades of blue): 33714 (St. Petersburg) and 33711 (St. Petersburg) with index values of 85.4 and 74.9, respectively. Appendix A provides the index values for each ZIP code.

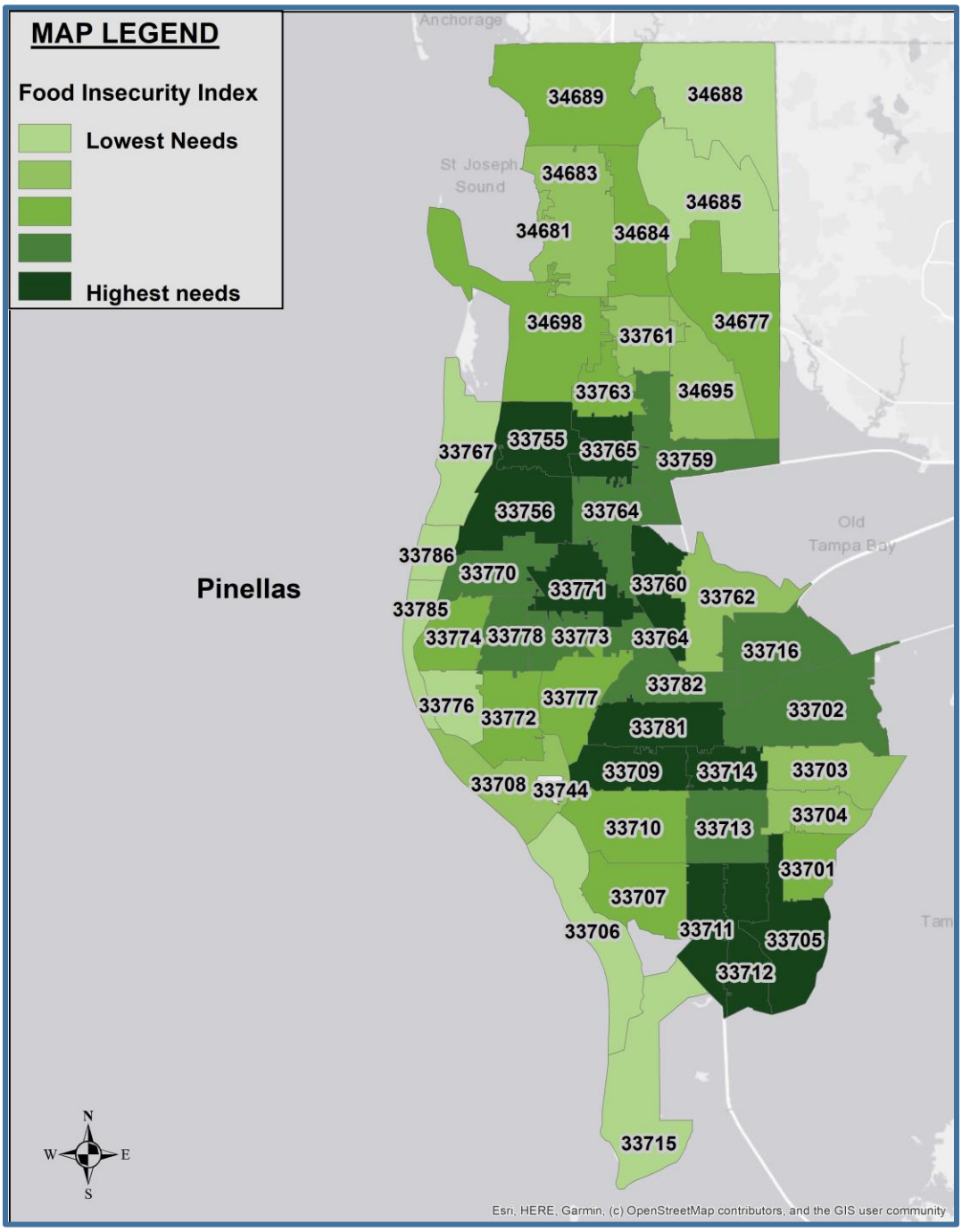
Figure 21: Health Equity Index



Food Insecurity Index

Conduent's Food Insecurity Index estimates areas of low food accessibility correlated with social and economic hardship. ZIP codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 22. The following ZIP codes had the highest level of food insecurity (as indicated by the darkest shades of green): 33712 (St. Petersburg) and 33755 (Clearwater) with index values of 89.7 and 81.9, respectively. Appendix A provides the index values for each ZIP code.

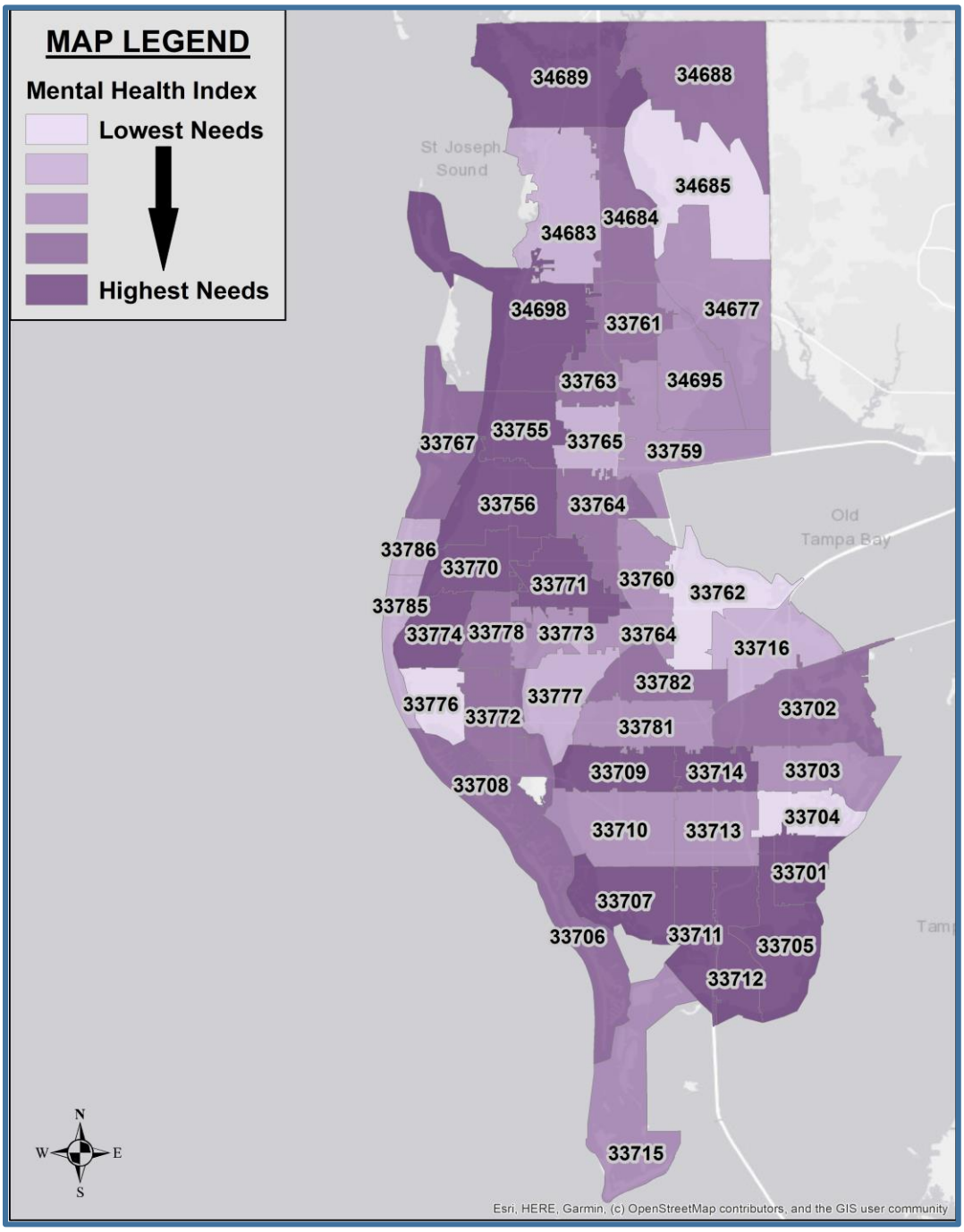
Figure 22: Food Insecurity Index



Mental Health Index

Conduent's Mental Health Index (MHI) is a measure of socioeconomic and health factors correlated with self-reported poor mental health. Based on the MHI, in 2021, ZIP codes were ranked based on their index value to identify the relative levels of need, as illustrated by the map in Figure 23. The following two ZIP codes are estimated to have the highest need (as indicated by the darkest shades of purple): 33711 and 33712 (St. Petersburg). Appendix A provides the index values for high needs ZIP codes.

Figure 23: Mental Health Index



Methodology

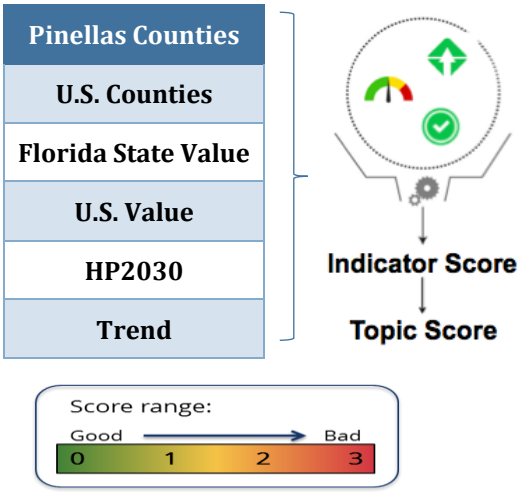
Overview

Primary and secondary data were collected and analyzed to inform the 2022 CHNA. Primary data consisted of focus group discussions and a community survey. The secondary data included indicators of health outcomes, health behaviors and social determinants of health. The methods used to analyze each type of data are outlined below. The findings from each data source were then synthesized and organized by health topic to present a comprehensive overview of health needs in Pinellas County.

Secondary Data Sources & Analysis

Secondary data used for this assessment were collected and analyzed with the All4HealthFL Community Dashboard developed by Conduent Healthy Communities Institute (HCI). The Community Dashboard includes over 150 community indicators, spanning at least 24 topics in the areas of health, social determinants of health, and quality of life. The data are primarily derived from state and national public secondary data sources. HCI's Data Scoring Tool® was used to systematically summarize multiple comparisons across the Community Dashboard to rank indicators based on highest need. For each indicator, the Pinellas County value was compared to a distribution of Florida and US counties, state and national values, Healthy People 2030, and significant trends (Figure 24).

Figure 24: Secondary Data Scoring



Indicators are rolled up into health and quality of life topic areas, then ranked. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected from other communities, and changes in methodology over time.

The analysis of national, state, and local indicators that contributed to the CHNA can be viewed in full in Appendix A.

Table 2 shows the health and quality of life topic scoring results for Pinellas County, with Other Conditions scored as the poorest performing topic area with a score of 1.96, followed by Older Adults with a score of 1.89. Topics that received a score of 1.50 or higher were considered a significant health need. Eleven topics scored at or above the threshold. Topic areas with fewer than three indicators were considered a data gap.

Table 2: Secondary Data Topic Scoring Results

Health Topic	Score
Other Conditions	1.96
Older Adults	1.89
Prevention & Safety	1.77
Women's Health	1.75
Mental Health & Mental Disorders	1.73
Sexually Transmitted Infections	1.71
Heart Disease & Stroke	1.67
Cancer	1.62
Alcohol & Drug Use	1.57
Children's Health	1.56
Tobacco Use	1.51
Wellness & Lifestyle	1.40
Respiratory Diseases	1.32
Physical Activity	1.26
Immunizations & Infectious Diseases	1.23
Weight Status	1.21
Oral Health	1.19
Adolescent Health	1.16
Maternal, Fetal & Infant Health	1.08
Health Care Access & Quality	1.06
Diabetes	0.89

Primary Data Collection & Analysis

To ensure the perspectives of community members were considered, input was collected from Pinellas County residents. Primary data used in this assessment consisted of focus group discussions, and a community survey. These findings expanded upon the information gathered from the secondary data analysis.

Community Survey

Community input was collected via a survey that was made available online and via paper copies in English, Spanish, and Haitian Creole from January 3, 2022, through February 28, 2022. The survey consisted of 59 questions related to top health needs in the community, individuals' perceptions of their overall health, individuals' access to health care services, as well as social and economic determinants of health. The list of survey questions is available in Appendix C.

The All4HealthFL Collaborative worked extensively with community and organizational leads to market, outreach, and track survey responses to ensure an equitable representation of community voices was captured. Survey marketing and outreach efforts included email invitations, social media, and coordination of onsite paper survey distribution events in collaboration with community-based organizations. A community assessment dashboard was created to track and monitor survey respondents by ZIP code, age, gender, race, and ethnicity to ensure targeted outreach for at risk populations. A total of 5,048 residents responded for Pinellas County.

Community Survey Analysis Results

Survey participants were asked about the top three pressing health and quality of life issues they believe should be addressed in their community. In Figure 25, the "Top Three Health Issues" were, mental health problems including suicide (41% of respondents), aging problems (ie. difficulty getting around, dementia, and arthritis) (38%), and being overweight (31%). The "Top Three Risky Behaviors" included illegal drug use/abuse or misuse of prescription medications (50% of respondents), alcohol abuse/drinking too much alcohol to include beer, wine, spirits, or mixed drinks (47% of respondents), and distracted driving such as, texting, eating, and talking on the phone (43% of respondents). Lastley, the "Top Three Quality of Life Issues" included low crime/safe neighborhoods (45% of respondents), access to health care (37% of respondents), and good schools (24% of respondents).

Figure 25: Top 3 Health & Quality of Life Issues

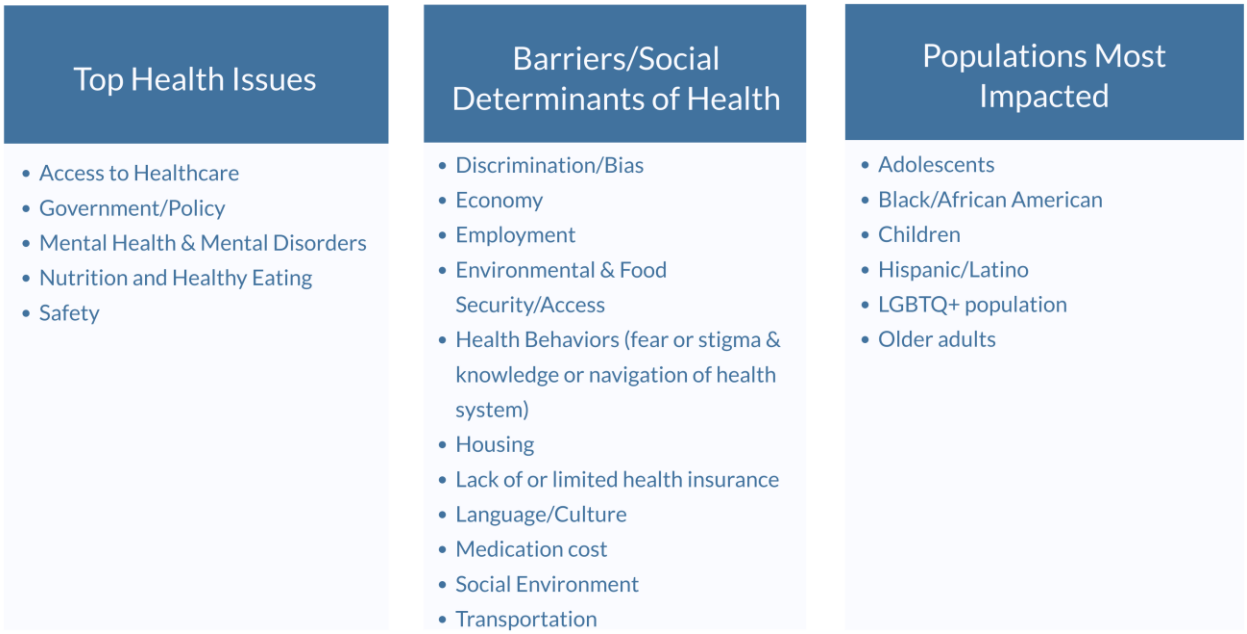
Focus Groups

The All4HealthFL Collaborative partnered with Collaborative Labs at St. Petersburg College in Clearwater, Florida to conduct five focus group discussions to gain deeper understanding of health issues impacting residents living in Pinellas County. Focus groups aimed to understand the different health experiences for Black/African American, LGBTQ+, Hispanic/Latino, Children, and Older Adults. Members of these communities were selected to participate in the focus group discussions.

Focus Group discussions took place in November 2021, with a total of 38 community participants. Due to the ongoing COVID-19 pandemic these discussions were conducted virtually. A questionnaire was developed to guide the conversations which includes topics such as Community Strengths & Assets, Top Health Problems, Access to Health, and Impact on Health. A list of questions utilized for focus group discussions can be found in Appendix C. To help inform an assessment of community assets, participants were asked to list and describe resources available in the community. The list of available resources in the community is in Appendix E.

The project team captured detailed transcripts of the focus group sessions. The transcripts were analyzed using the qualitative analysis program Dedoose®2. Text was coded using a pre-designed codebook-organized by themes and analyzed for significant observations. The findings from the analysis were combined with findings from other primary and secondary data and incorporated into the Data Synthesis, and Prioritized Health Needs. Themes across all focus groups are seen in Figure 26. Appendix C provides a more detailed report of the main themes that trended across the individual focus group conversations.

Figure 26: Themes Across All Focus Groups



Data Synthesis & Prioritization

Data Synthesis

All forms of data may present strengths and limitations. Each data source used in this CHNA process was evaluated based on such strengths and limitations and should be kept in mind when reviewing this report. Each health topic presented a varying scope and depth of quantitative data indicators and qualitative findings. For both quantitative and qualitative data, immense efforts were made to include as wide a range of secondary data indicators, focus group participants, and community survey participants as possible. To gain a comprehensive understanding of the significant health needs for Pinellas County, the findings from all three data sets were compared and studied simultaneously. The secondary data scores, focus group themes, and survey responses were considered equally important in understanding the health issues of the community. The top health needs identified from data sources were analyzed for areas of overlap. Six health issues were identified as significant health needs across all three data sources and were used for further prioritization. Figure 27 shows the final six trending health topics for consideration.

Figure 27: Trending Health Topic for Consideration

Prioritization

On April 19, 2022, participants from collaborating organizations, as well as other community partners, came together to prioritize the significant health needs. To target issues regarding the most pressing health needs impacting Pinellas County, the All4HealthFL Collaborative conducted a two-hour virtual prioritization session facilitated by the TBHC. A total of 101 individuals attended the prioritization session. These participants represented a broad cross section of experts and organizational leaders with extensive knowledge of health needs in the community. The meeting objectives included review of analyzed health data pertaining to health needs and disparities, discussion of significant health needs identified, gathering input on health topics, prioritizing significant health needs, and generating preliminary ideas on how to collaborate to address top community needs.

Process

The prioritization session included a data presentation highlighting findings from both the primary and secondary data and the resulting top health needs that were identified. Session participants were then directed to breakout groups to discuss the findings and the six health needs. Participants captured their thoughts through these breakout discussions, specifically how the health needs are impacted by SDoH. A detailed overview of discussion themes can be found in Appendix C. Finally, a group ranking process was conducted to prioritize the health topics to be addressed over the next three years. The group agreed that root causes, disparities, and social determinants of health would be considered for all prioritized health topics resulting from the prioritization.

Participants ranked each of the health categories individually using the dual criteria of scope and severity and ability to impact. Criteria scores were then combined to generate an overall ranking of health needs. A total of 79 individuals completed the online prioritization activity. The cumulative total score of each health topic can be seen in Table 3. The All4HealthFL Collaborative agreed with the ranking of the health topics and selected the top three prioritized health topics: Access to Health & Social Services, Behavioral Health (Mental Health & Substance Misuse), and Exercise Nutrition & Weight.

Table 3: Cumulative Total Score of Significant Health Topics (n=79)

Health Topics	Cumulative Total Score
Access to Health & Social Services	211.5
Behavioral Health (Mental Health & Substance Misuse)	205.5
Exercise, Nutrition & Weight	188.5
Immunizations & Infectious Diseases	173
Heart Disease & Stroke	169.5
Cancer	152

Prioritized Significant Health Needs

The three significant health needs are summarized in the following section.

2022 Prioritized Significant Health Needs

Access to Health & Social Services

Behavioral Health (Mental Health & Substance Misuse)

Exercise, Nutrition & Weight

Each prioritized health topic includes key themes from community input and secondary data warning indicators. The warning indicators shown for certain health topics are above the 1.50 threshold for Pinellas County and indicate areas of concern. See the legend below for how to interpret the distribution gauges and trend icons used within the data scoring results tables.

	Indicates the county fell in the bottom 10% of all counties in the distribution. The county fares worse than 90% of all counties in the distribution.
	Indicates the county is in the top 30% of all counties in the distribution. The county fares better than 70% of all counties in the distribution.
	The indicator is trending up, significantly, and this is not the ideal direction.
	The indicator is trending up and this is not the ideal direction.
	The indicator is trending down, signifcantly, and this is the ideal direction.
	The indicator is trending down and this is the ideal direction.
	The indicator is trending up, significantly, and this is the ideal direction.
	The indicator is trending up and this is the ideal direction.

Prioritized Health Topic #1: Access to Health & Social Services

Access to Health & Social Services

Key Themes from Community Input

- **Thirty Six percent (36%)** of survey respondents ranked access to health care as a quality of life issue
- Gentrification/Built Environment reduces accessibility to services
- Cultural competency training for physicians on treating the transgender community
- Fear & trust of government and health & social services because of trauma, discrimination, immigration status, systemic racism
- Barriers include: transportation, lack of or limited health insurance coverage (high out of pocket costs), knowledge & navigation of health system, affordable care/insurance, medication costs, long referral wait times, work/school schedules, increased risk of COVID through service industry jobs, disconnect between mental health care & health care access

Warning Indicators

- Adults without Health Insurance
- Median Household Gross Rent
- People 65+ Living Below Poverty

> The whole medical system is problematic for all race/ethnicities. There is a lack of knowledge in cultural competency.
> -Black/African American Focus Group Participant

Primary Data: Community Survey & Focus Groups

Access to Health & Social Services was a top health need identified from both the community survey and the five focus group discussions. Thirty-six percent (36%) of community survey respondents ranked Access to Health Care as a pressing quality of life issue. Reasons that kept survey respondents from getting medical care they needed included: unable to schedule an appointment when needed, unable to afford to pay for care, cannot take time off work, and doctor's office does not have convenient hours. Other barriers included: Medicaid changes, higher than anticipated co-payments, COVID-19 restrictions, and long wait times to see a medical provider.

Focus group discussion highlighted barriers to accessing care specifically for Black/African American, Hispanic/Latino, LGBTQ+, and Older Adult. These barriers included: affordable

medications and lack of or limited health insurance coverage, health care knowledge, navigation of the health system, and experiencing a disconnection between health care and mental health care services was also mentioned throughout the focus groups. Often, participants' work and school schedules did not align with provider office hours or there were long wait times to see a specialist. Many also indicated not having transportation to get to medical appointments. Barriers to accessing care by focus group community are seen in Table 4.

Table 4: Focus Group Overall Barriers to Accessing Care

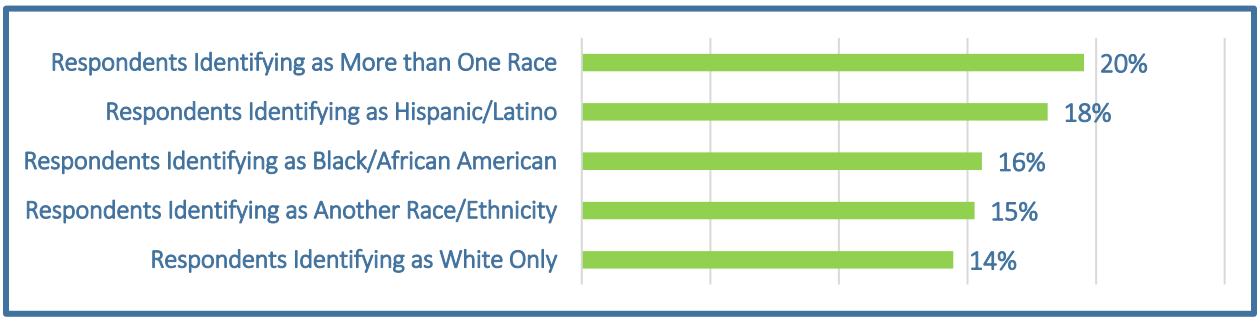
Black/African Americans	• Fear due to experienced trauma of discrimination • Lack of trust because of systemic racism • Gentrification/built environment reduces accessibility to services
Hispanic/Latino	• Lack of bilingual providers/staff • Discrimination because of their belief and opinion of prenatal care, disease prevention • Fear/trust of government, health, and social services because of trauma, discrimination, or immigration status
LGBTQ+	• Lack of trust in health system • Lack of support programs for treating trans community
Older Adults	• Affordable care for daily living caregivers • Fixed incomes • Technological barriers • Stereotyping

> We're working with a community that is very hardworking. For them to go and see a doctor and have to lose a day of work and pay, they prefer to ignore any signal or symptom, they need options for the schedules they work.
>
> -Hispanic/Latino Focus Group Participant

Barriers and Disparities: Access to Health Care Services

For community survey respondents who indicated they experienced unmet health needs within the past 12 months, a percentage was calculated for each race and ethnic group to better understand the racial inequities. The percentage of respondents by racial/ethnic group with unmet health needs in the past 12 months can be seen in Figure 28.

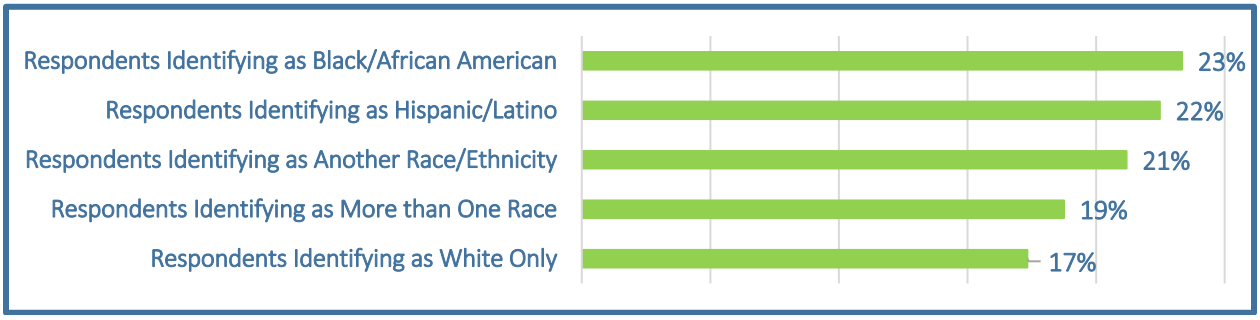
Figure 28: Percentage of Respondents by Race/Ethnic Group with Unmet Health Needs in the Past 12 Months



Barriers and Disparities: Access to Dental Health Services

Access to dental health services was mentioned in the community survey as an important health issue. Twenty-two percent (22%) of community survey respondents mentioned they had unmet dental needs. There were five top reasons that kept respondents from getting the dental care they needed which included: unable to afford to pay for care, not having insurance to cover dental care, unable to schedule an appointment when needed, unable to take time off work, and dentist offices do not have convenient hours. The percentage of respondents by racial/ethnic group with unmet dental health needs in the past 12 months can be seen in Figure 29.

Figure 29: Percentage of Respondents by Race/Ethnic Group with Unmet Dental Health Needs in the Past 12 Months



Barriers and Disparities: Access to Care in the Emergency Room

Barriers in access to care for non-emergency needs was captured within the community survey. Fifty-nine percent (59%) of survey respondents declared using the emergency room instead of going to a doctor's office or clinic for non-emergency needs. The main reasons the emergency room was used for non-emergent needs included: after hours/weekend services, long wait for an appointment with primary physician, do not have a doctor/clinic, and do not have insurance. Additional reasons why respondents visited the emergency room for non-emergent needed included: being referred by a doctor, experiencing pain, needing advice or consultation, experienced a fall, or needing diagnostic testing.

Secondary Data

From the secondary data scoring results, Health Care Access & Quality, also known as Access to Health & Social Services, indicator of concern was Adults without Health Insurance. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 5 below. For each indicator, there is an indicator score, county value, state value, and national value (where available). Additionally, there are state and national county distributions for comparison along with indicator trend information. See Appendix A for the full list of indicators categorized within this topic.

Table 5: Data Scoring Results for Health Care Access & Quality

SCORE	HEALTH CARE ACCESS & QUALITY	Pinellas County	HP2030	Florida	U.S.	Florida Counties	U.S. Counties	Trend
1.76	Adults without Health Insurance (2018) percent	18.7	--	--	12.2			--

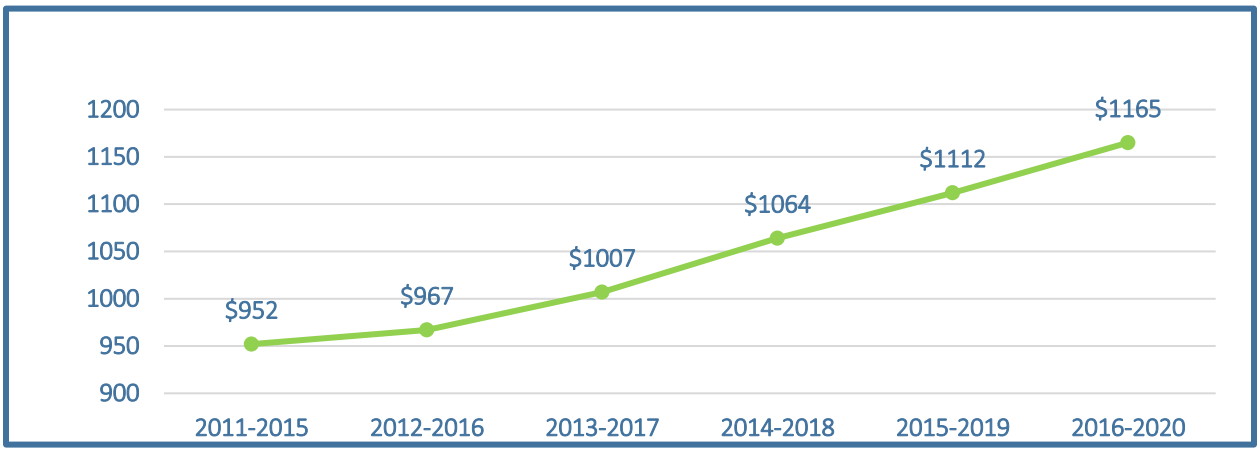
**HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.*

Barriers and Disparities: Social Determinants of Health & Quality of Life

The percentage of Adults without Health Insurance in Pinellas County is 18.7%. For this indicator, which shows the percentage of adults aged 18-64 that do not have any kind of health insurance coverage, Pinellas is in the worst 25% of all counties in the nation. Medical costs in the United States are extremely high, so people without health insurance may not be able to afford medical treatment or prescription drugs. They are also less likely to get routine checkups and screenings, so if they do become ill, they will not seek treatment until the condition is more advanced and therefore more difficult and costly to treat. Many small businesses are unable to offer health insurance to employees due to rising health insurance premiums.

Where people live is a large indicator of their health. Sixty-nine percent (69%) of community survey respondents say there are not affordable places to live in Pinellas County. Secondary data indicators confirm that rental costs are rising to national highs in the Tampa Bay region. These rising rental costs are negatively impacting communities especially those that identify as LGBTQ+ and older adults 65+. Figure 30 shows the trend for the median gross household rent in Pinellas County from 2011 through 2020. In 2016-2020 median household gross rent for Pinellas County residents was $1,165 which is higher than U.S value of $1,096, but it is lower than state value of $1,218.

Figure 30: Median Household Gross Rent, Pinellas County

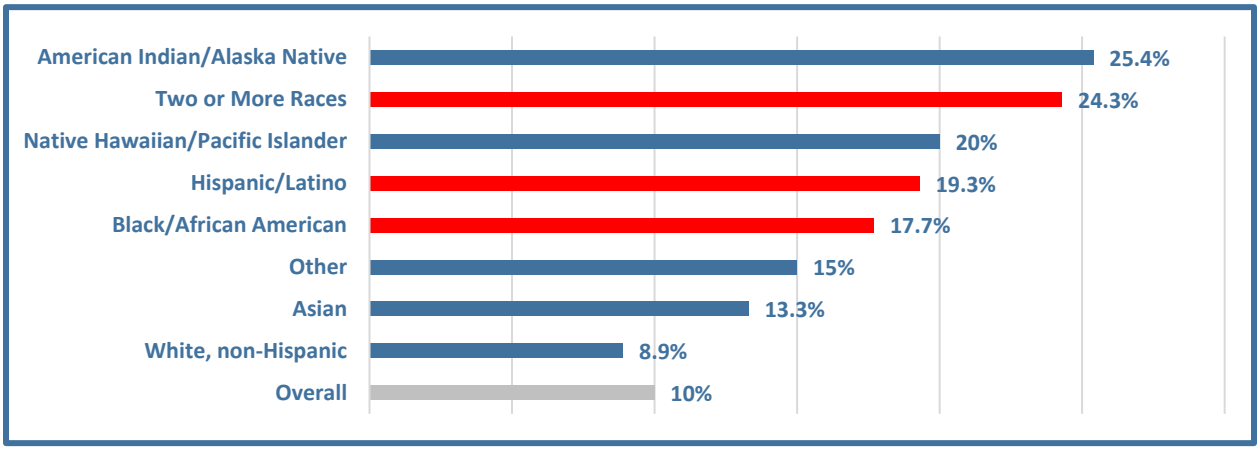


American Community Survey, 2020

> LGBTQ+ people also tend to have a harder time finding a safe place to live and affordable house, especially trans people.
> - LGBTQ+ Focus Group Participant

The rising rental costs are affecting all race and ethnic groups of the older adult population 65+. See Figure 31 for the race and ethnicity disparities by percentage that are higher than the over the overall 10% Pinellas County value. The blue color indicates no significant difference with the overall value and the red bars indicates significantly worse than the overall value. People identifying as Hispanic/Latino, Black/African American, or as Two or More Races seem to be affected by poverty significantly worse than other racial and ethnic groups in Pinellas County.

Figure 31: People Aged 65+ Living Below Poverty Level by Race/Ethnicity



American Community Survey, 2015-2019

Prioritized Health Topic #2: Behavioral Health (Mental Health & Substance Misuse)

Behavioral Health: Mental Health

Key Themes from Community Input

- **Forty One percent (41%)** of survey respondents ranked behavioral health (mental health and substance misuse) as pressing health issues
- Top Reasons that prevented you from getting mental health care: Unable to afford to pay for care, Unable to schedule an appointment when needed, Cannot take time off work, Do not have insurance to cover mental health care, Other (including) Long wait lists, not taking new patients, out of pocket costs, COVID, trust in providers, stigma
- Lack of acknowledgement about minority stress impacting both physical and mental/emotional well-being
- External political factors, coupled with discrimination contribute to trauma experienced in LGBTQ+ community, Black/African American and Hispanic/Latino community

Warning Indicators

- Alzheimer's Disease or Dementia: Medicare Population
- Depression: Medicare Population
- Age-Adjusted Death Rate due to Suicide
- Frequent Mental Distress

Primary Data: Community Survey & Focus Groups (Mental Health)

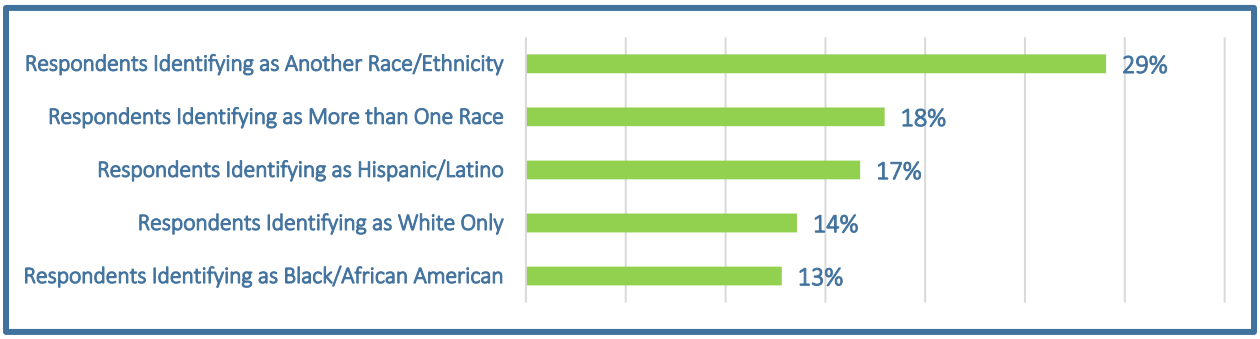
Mental Health and Substance Misuse were identified as top health needs from the secondary data, community survey, and focus groups. The two were combined into Behavioral Health for this assessment. Forty-one percent (41%) of community survey respondents ranked Mental Health as a pressing health issue. Thirty-two percent (32%) of community survey respondents indicated being diagnosed as having depression or anxiety. The top five reasons respondents cited include: unable to access the mental health care they needed included: unable to afford to pay for care, unable to schedule an appointment when needed, cannot take time off work, and do not have insurance to cover mental health care. Additional reasons cited by survey respondents included: experiencing long wait times for scheduling an appointment, doctors' offices did not take new patients, and trust and fear of the health system due to COVID-19.

Mental Health was also a top health issue discussed during the five focus groups. Specifically, barriers to care due to fear and stigma of seeking help was brought up. Additionally, lack of affordable resources and long wait times to see a medical professional were also discussed. The LGBTQ+, Black/African American, and Hispanic/Latino communities stressed the importance of political and provider acknowledgment about minority stress, discrimination, and external factors that have contributed to experienced trauma. These populations seem to experience more difficulty accessing mental health services.

Barriers and Disparities: Mental Health

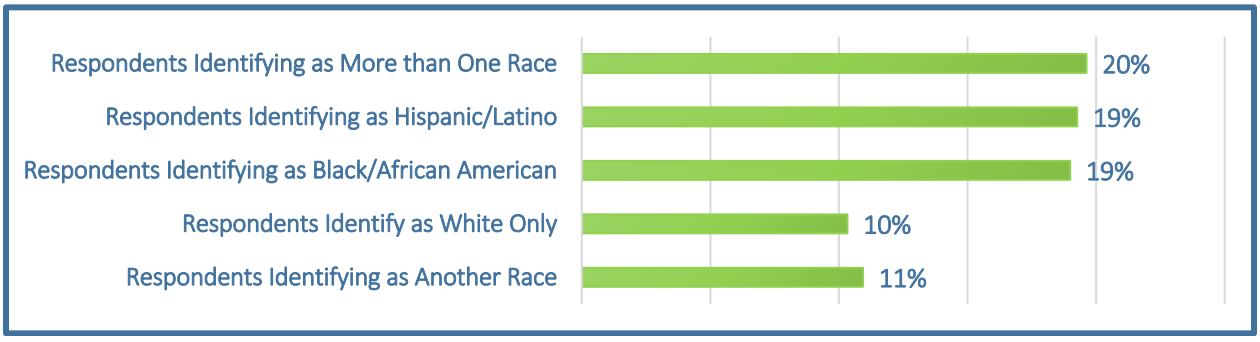
Figure 32 shows the percentage of respondents by race/ethnic group with unmet mental health needs within the past 12 months.

Figure 32: Percentage of Respondents by Race/Ethnic Group with Unmet Mental Health Needs in the Past 12 Months



The community survey captured a question about Adverse Childhood Experiences (ACEs). ACE scores can help health providers tell the likelihood of increased risk of psychological and medical problems. As an individual's ACE score increases so does the risk of disease, social, and emotional problems. In Pinellas County, 19% of survey respondents reported experiencing four or more ACEs before age 18. The top five reported ACEs included: parent(s) were separated or divorced, lived with anyone who was a problem drinker or alcoholic, parent(s) or adult verbally harmed them (swear, insult, or put down), lived with anyone who was depressed, mentally ill, or suicidal, and/or parent(s) or adult physically harmed you (slap, hit, kick, etc.). The percentage of respondents by race/ethnic group who reported experiencing four or more ACEs are seen in Figure 33.

Figure 33: Percentage of Respondents by Race/Ethnic Group who Reported Experiencing 4 or More ACEs



Secondary Data: Mental Health

From the secondary data scoring results, Mental Health & Mental Disorders had the 5th highest data score of all topic areas. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 6 below. See Appendix A for the full list of indicators categorized within this topic.

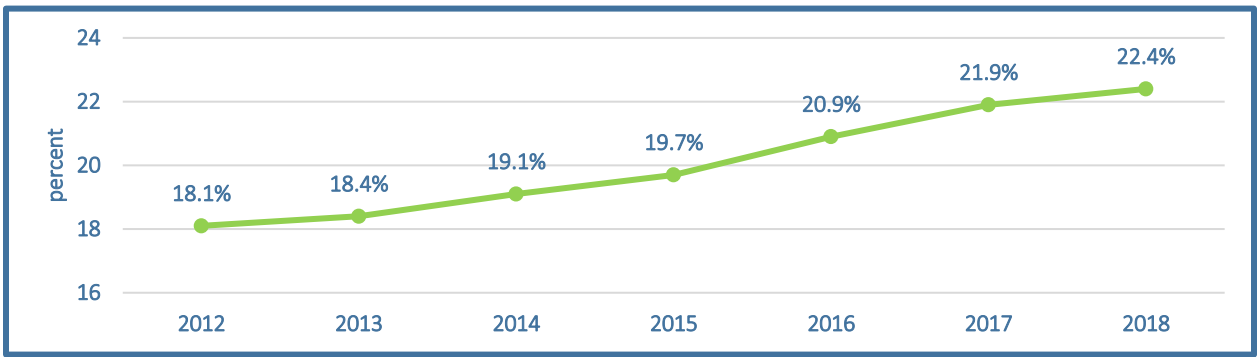
Table 6: Data Scoring Results for Behavioral Health (Mental Health)-Pinellas County

SCORE	MENTAL HEALTH & MENTAL DISORDERS	Pinellas County	HP2030	Florida	U.S.	Florida Counties	U.S. Counties	Trend
3.00	Alzheimer's Disease or Dementia: Medicare Population (2018) percent	14.2	--	12.6	10.8			
3.00	Depression: Medicare Population (2018) percent	22.4	--	19.5	18.4			
1.79	Age-Adjusted Death Rate due to Suicide (2019) deaths/ 100,000 population	16.6	12.8	14.5	13.9		--	
1.50	Frequent Mental Distress (2018) percent	14.7	--	13.4	13			--

*HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Alzheimer's Disease and Depression in Medicare population are top areas of concern related to Mental Health & Mental Disorders in Pinellas County. The percentage of Medicare beneficiaries treated for Alzheimer's disease or dementia is 14.2% in Pinellas County, which is in the worst 25% of counties in both the state and nation. The indicator Depression: Medicare Population shows the percentage of Medicare beneficiaries who were treated for depression. Figure 34 shows the increasing percentage of depression among the Medicare population. The value for Pinellas County, 22.4%, is in the worst 25% of counties in the state and nation. Furthermore, Age-Adjusted Death Rate due to Suicide in Pinellas County are 16.6 deaths/100,000 population. The other indicator of concern is Frequent Mental Distress that shows the percentage of adults who stated that their mental health, which includes stress, depression, and problems with emotions, was poor for 14 or more of the past 30 days. The value for Pinellas County, 14.7%, is higher than the national value of 13%.

Figure 34: Depression Percentage in Medicare Population From 2012-2018



Centers for Medicare & Medicaid Services, 2018

> Mental health should be easier to access for an affordable price. It's a problem, especially in the LGBTQ+ community. Obviously, we have higher rates of mental health suicidal thoughts.
>
> -LGBTQ+ Focus Group Participant

Alcohol and Substance Misuse

Behavioral Health: Substance Misuse

Key Themes from Community Input

- **Thirty percent (30%)** of survey respondents ranked illegal drug use/abuse of prescription medications and alcohol abuse/drinking too much as an important health issue to address
- Deaths due to drug poisoning and opioid overdose is an increasing concern
- COVID-19 has helped remove stigma attached to seeking help

Warning Indicators

- Death Rate due to Drug Poisoning
- Age-Adjusted Drug and Opioid-Involved Overdose Death Rate
- Adults who Drink Excessively
- Adults who Binge Drink
- Driving Under the Influence Arrest Rate
- Adults Who Currently Use E-Cigarettes
- Adolescents who Use Electronic Vaping: Lifetime
- Adolescents who Use Electronic Vaping: Past 30 Days
- Adults who Smoke

Secondary Data

Substance Misuse is a health topic that is analyzed from two secondary data health topics, i.e., Alcohol, Drug Use and Tobacco Use. From the secondary data scoring results, Alcohol & Drug Use had the 9th and Tobacco Use had the 11th highest data score of all topic areas. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 7 below. See Appendix A for the full list of indicators categorized within this topic.

Table 7: Data Scoring Results for Alcohol and Substance Misuse

SCORE	ALCOHOL & DRUG USE	Pinellas County	HP2030	Florida	U.S.	Florida Counties	U.S. Counties	Trend
3.00	Death Rate due to Drug Poisoning (2017-2019) deaths/ 100,000 population	32.5	--	23.6	21			
2.29	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate (2018-2020) Deaths per 100,000 population	43.2	--	27.8	23.5			--
2.03	Adults who Drink Excessively (2017-2019) percent	24.2	--	18	--		--	--
1.94	Adults who Binge Drink (2018) percent	17.1	--	--	16.4			--
1.88	Driving Under the Influence Arrest Rate (2019) arrests/ 100,000 population	235.2	--	159.7	--		--	--

*HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

In the community survey 30% of respondents ranked illegal drug use/abuse of prescription medications and alcohol abuse/drinking too much as important health issues to address. From the secondary data results, there are several indicators within Alcohol and Drug Use health topic that raise concerns for Pinellas County. The worst performing indicator under this health topic is the Death Rate due to Drug Poisoning. In Pinellas County, there were 32.5 deaths due to drug poisoning per 100,000 people in 2017-2019, which is higher than both the state and national values, and in the worst 25% of counties in the U.S. White males in the county are twice as likely to experience opioid involved deaths than females. Additionally, Age-Adjusted Drug and Opioid-Involved Overdose Death Rate in Pinellas County is 43.2 deaths per 100,000 population. Other indicators of concern are related to alcohol use and include both behavioral and outcome measures. The percentage of adults in the county who drink excessively (24.2%), and binge drink (17.1%) is higher than the Florida state and are among the worst 25% of counties in the state. Finally, the percentage of arrests that involve driving under the influence is higher in Pinellas County (235.2 arrests per 100,000 population) than in Florida (159.7 arrests per 100,000 population).

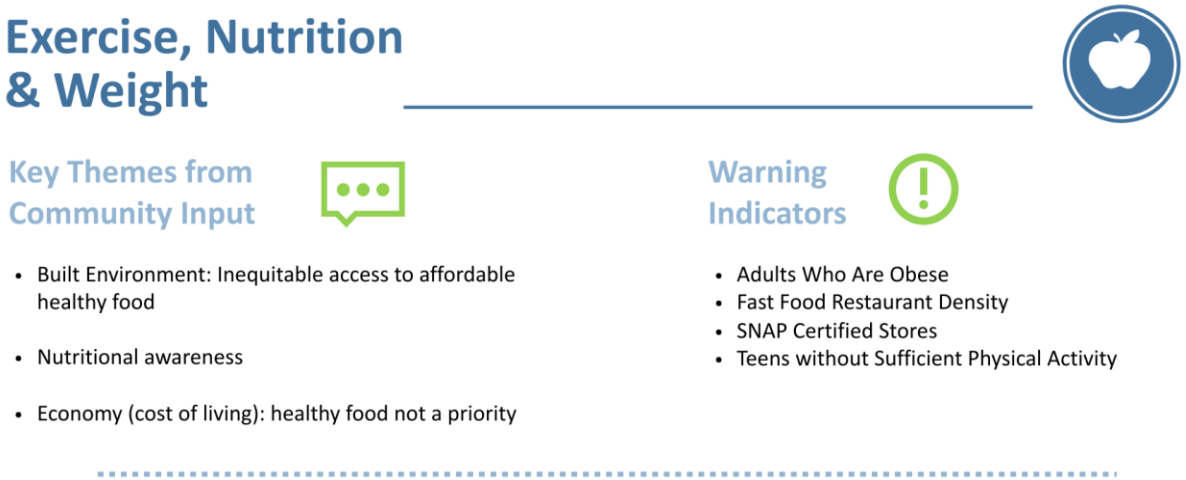
Table 8: Data Scoring Results for Tobacco Use

SCORE	TOBACCO USE	Pinellas County	HP2030	Florida	U.S.	Florida Counties	U.S. Counties	Trend
2.03	Adults Who Currently Use E-Cigarettes (2017-2019) percent	8.9	--	7.5	--		--	--
1.91	Adolescents who Use Electronic Vaping: Lifetime (2020) percent	29.7	--	26.4	--	--	--	--
1.91	Adolescents who Use Electronic Vaping: Past 30 Days (2020) percent	18.9	--	14.5	--	--	--	--
1.85	Adults who Smoke (2017-2019) percent	19.7	5	14.8	--		--	--

*HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

From the secondary data results, there are several indicators in Tobacco Use topic areas that raise concern. Pinellas County has the highest rates of adults and adolescents who vape and use e-cigarettes compared to other counties in Florida.

Prioritized Health Topic #3: Exercise, Nutrition, & Weight



> For South St. Pete, not every parent wants to stand to get access to free food. What they want is access to the same quality of food that everyone else in other areas have access to.
>
> -Black/African American Focus Group Participant

Primary Data: Focus Group

Focus group discussions identified built environment as a topic of concern. Specifically, inequitable access to affordable healthy foods was cited. Participants also mentioned the need for nutritional awareness and cultural competency due to some racial/ethnic groups not prioritizing healthy eating.

Secondary Data

Secondary data for Exercise, Nutrition & Weight included Physical Activity data scoring. Physical Activity had the 14th highest data score of all topic areas indicating, a definite need in Pinellas County. Further analysis was done to identify specific indicators of concern which include indicators with high data scores (scoring at or above the threshold of 1.50) and seen in Table 9. See Appendix A for the full list of indicators categorized within this topic.

Table 9: Data Scoring Results for Physical Activity

SCORE	PHYSICAL ACTIVITY	Pinellas County	HP2030	Florida	U.S.	Florida Counties	U.S. Counties	Trend
2.00	Fast Food Restaurant Density (2016) restaurants/ 1,000 population	0.7	--	--	--			
1.82	SNAP Certified Stores (2017) stores/ 1,000 population	0.8	--	--	--			--
1.65	Teens without Sufficient Physical Activity (2020) percent	81.2	--	82.3	--		--	
1.50	Adults Who Are Obese (2017-2019) percent	28.4	--	27	--		--	--
1.50	Farmers Market Density (2018) markets/ 1,000 population	0	--	--	--	--	--	--
1.50	People 65+ with Low Access to a Grocery Store (2015) percent	2.8	--	--	--			--

*HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Some of the worst performing indicators within this topic are related to the built environment and food access. The number of fast-food restaurants per 1,000 people in Pinellas County is in the worst 25% of counties in Florida, and trending in a negative direction. The indicator SNAP Certified Stores shows the number of stores per 1,000 population certified to accept Supplemental Nutrition Assistance Program benefits, including supermarkets, convenience stores, warehouse club stores, and specialized food stores. While the value for Pinellas County is increasing in a desirable direction, the county still performs in the worst 50% of counties in the state. Other poorly performing indicators that are measures of food access include Farmers Market Density and People 65+ with Low Access to Grocery Store. HCI's Food Insecurity Index®, discussed earlier in this report, can be used to help identify geographic areas of low food accessibility within Pinellas County community.

Other poorly performing indicators under Physical Activity health topics are percentage of Teens without Sufficient Physical Activity (81.2%) and Adults who are Obese (28.4%) in Pinellas County. Studies have shown that sedentary lifestyles and a lack of fruits and vegetables can increase the risk of many chronic diseases including obesity, heart disease and type 2 diabetes.[15]

[15] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/nutrition-and-healthy-eating

Non-Prioritized Significant Health Needs

Following the rigorous community prioritization process, the following were not selected as prioritized health topics for Pinellas County for the next three years. Any current programming and additional efforts outside of the CHNA process to address these health issues will not be impacted by this decision. Future initiatives related to the prioritized health needs will likely have positive impact on the non-prioritized health needs as many topics overlap.

Non-Prioritized Health Need #1: Cancer

Cancer

Warning Indicators

- Melanoma Incidence Rate
- Adults with Cancer
- Cancer: Medicare Population
- Cervical Cancer Incidence Rate
- Oral Cavity and Pharynx Cancer Incidence Rate
- Pap Test in Past Year
- Mammogram in Past Year: 40+
- Prostate Cancer Incidence Rate
- Breast Cancer Incidence Rate
- Mammogram in Past 2 Years: 50-74
- Age-Adjusted Death Rate due to Breast Cancer

Cancer was not identified as a top health concern by focus group participants nor community survey respondents. Seventeen percent (17%) of survey respondents ranked cancer as a pressing health issue and 11% reported being told by a medical provider that they have been diagnosed with cancer. Secondary data warning indicators of concern included Melanoma Incidence Rate which was 32.7 cases per 100,000 population for 2016-2018 which is higher than the Florida state value of 25.2 cases per 100,000 population.

Non-Prioritized Health Need #2: Heart Disease & Stroke

Heart Disease & Stroke

Warning Indicators

- Ischemic Heart Disease: Medicare Population
- Atrial Fibrillation: Medicare Population
- Stroke: Medicare Population
- Hyperlipidemia: Medicare Population
- Hypertension: Medicare Population
- Age-Adjusted Death Rate due to Coronary Heart Disease
- High Blood Pressure Prevalence
- Adults who Experienced a Stroke
- Adults who Experienced Coronary Heart Disease
- Heart Failure: Medicare Population

Heart Disease and Stroke as a topic on its own did not come through as a top community health issue within the community survey or focus groups. Although 41% of survey respondents reported being told by a medical provider that they have hypertension and/or heart disease, the raised concern was related to nutrition and obesity, and could best be addressed within the Exercise, Nutrition, and Weight health topic.

Non-Prioritized Health Need #3: Immunizations & Infectious Diseases

Immunizations & Infectious Diseases

Warning Indicators

- Syphilis Incidence Rate
- Kindergartners with Required Immunizations
- Tuberculosis Incidence Rate
- HIV Incidence Rate
- Overcrowded Households
- Chlamydia Incidence Rate

Immunizations and Infectious Diseases did not come up as a top issue through community feedback. A secondary data warning indicator of concern includes Syphilis Incidence Rate in Pinellas County (21.9 cases per 100,000 population) in 2020 which is over the U.S value (11.9 cases per 100,000 population) and the Florida value of (16.2 cases per 100,000 population). There are opportunities to improve education on prevention of syphilis incidence rates as cases in Pinellas County have increased gradually since 2017.

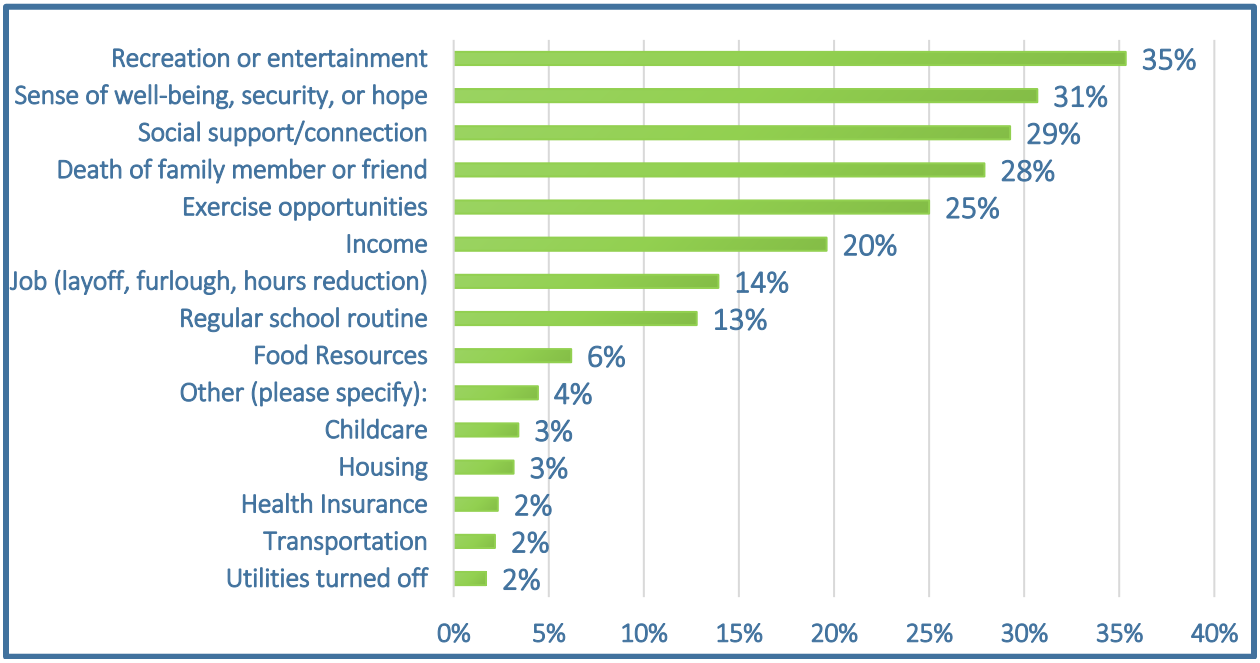
Additional Opportunities for Impact

When possible, data from the community survey was analyzed by demographic factors to help identify vulnerable groups that may be at higher health risks in Pinellas County. This data was used to support the prioritization process and provides additional community context to consider alongside the secondary data. It is important to note that not all differences have been included in this report, as the report focuses primarily on the prioritized health topics.

COVID-19 Pandemic

The community survey served to assess the impact of the COVID-19 pandemic by asking respondents to report the losses they have experienced since the start of the pandemic. Recreation or entertainment was the top loss reported, followed by sense of well-being, security, or hope, and social support/connection. There were many that also reported death of a family member or friend. See Figure 36 for the complete list of reported losses related to COVID-19. These types of experienced losses can help to pinpoint where the community is going to need special attention and assistance to recover.

Figure 36: Percentage of Respondents Who Reported Experienced Losses Related to COVID-19



Community Lived Experiences Around Diversity, Equity & Inclusion

For the 2022 CHNA process, the All4HealthFL Collaborative included a survey question to specifically assess experiences of discrimination by community respondents. In addition to understanding the overall experiences of discrimination, the Collaborative wanted to understand different groups' unique experiences and their perception of why they felt they were discriminated against. Figure 37 shows the percentage of survey respondents who reported experiencing discrimination by discrimination type.

Figure 37: Percentage of Respondents from Pinellas County Who Reported Experiencing Discrimination by Discrimination Type

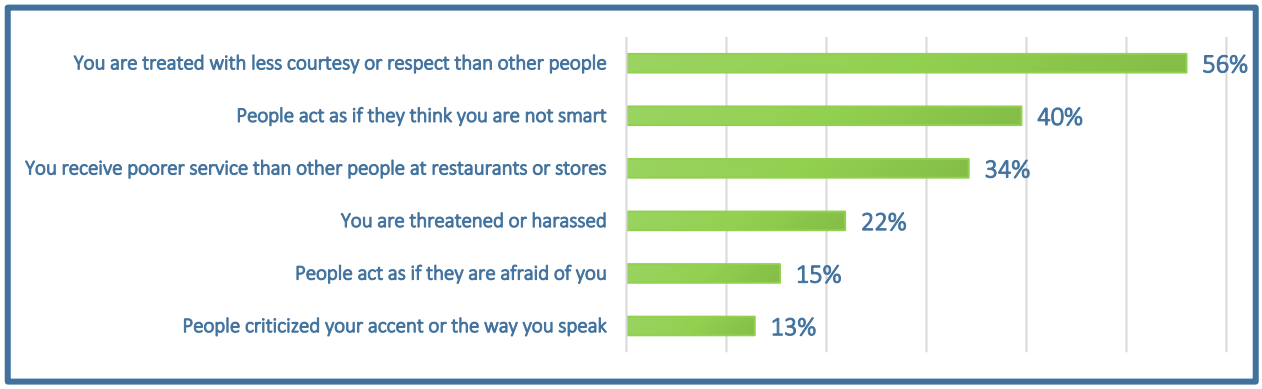


Figure 38 breaks down the percentages of reported discrimination by respondents' identity of themselves, as well as why they believe they experienced this discrimination. For example, in what ways did Hispanic/Latino community members report experiencing discrimination and what did they believe was the main reason they were discriminated against? The highest level of discrimination they reported having experienced was being treated with less courtesy or respect than others. Hispanic/Latino respondents indicated they felt they had experienced this type of discrimination because of their ancestry or national origin, their gender, and/or their race. These two charts were provided to participants at the prioritization session to inform and deepen conversations and to garner additional feedback around addressing health inequities in Pinellas County.

Figure 38: Percentage of Respondents Who Reported Experiencing Discrimination by Discrimination Type

0-25% | 26-50% | 51-75% | 76-100%

Percentage Reported Discrimination	Respondents Identify As: Non-Male, White Only	Hispanic or Latino	Black or AA	More than One Race	Another Race	LGBTQ+	65+
You are treated with less courtesy or respect than other people	53%	59%	67%	68%	73%	74%	39%
You receive poorer service than other people at restaurants or stores	29%	38%	61%	43%	52%	45%	22%
People act as if they think you are not smart	38%	43%	58%	43%	54%	52%	23%
People act as if they are afraid of you	9%	18%	35%	25%	29%	21%	8%
You are threatened or harassed	20%	23%	23%	32%	35%	44%	11%
People criticized your accent or the way you speak	8%	28%	21%	15%	41%	15%	6%
What do you believe to be the main reason(s)?	Gender, Age	Ancestry or National Origins, Gender, Race	Race, Gender	Gender, Race	Race, Ancestry or National Origins	Gender, Sexual Orientation	Age, Gender

Conclusion

The preceding community health needs assessment (CHNA) describes barriers to health faced by the community, putting its priority health areas into focus and providing information necessary to all levels of stakeholders to build upon each other's work. The All4HealthFL Collaborative has established clear priorities based on the results of this community health assessment to improve health outcomes for residents in Pinellas County. Over the next year, the Collaborative will work together on the development of strategies to address the priorities outlined in the report. These strategies will inform the All4HealthFL Community Health Improvement Plan for Pinellas County.

Appendices Summary

The following support documents are shared separately on the All4HealthFL website.

A. Secondary Data (Methodology and Data Scoring Tables)

A detailed overview of the Conduent HCI data scoring methodology and indicator scoring results from the secondary data analysis.

- Secondary Data Methodology and Data Scoring Tables
- Population Estimates for each ZIP code (Demographic Section)
- Families Below poverty by ZIP code (Social & Economic Determinants of Health Section)

B. Index of Disparity

Conduent's health equity index of disparity tools utilized to analyze secondary data.

- Healthy Equity Index
- Food Insecurity Index
- Mental Health Index

C. Community Input Assessment Tools

Quantitative and qualitative community feedback data collection tools that were vital in capturing community feedback during this collaborative CHNA:

- Community Health Survey
- Focus Group Discussion Questions and Summary of Responses
- Prioritization Session Attendee Organizations
- Prioritization Session Questions & Summary of Responses

D. Data Placemats

- Access to Health & Social Services
- Behavioral Health (Mental Health & Substance Misuse)
- Exercise, Nutrition & Weight
- Immunizations & Infectious Diseases
- Maternal, Fetal, and Infant Health
- Respiratory Diseases

E. Community Partners and Resources

The tables in this section acknowledge community partners and organizations who supported the CHNA process.

F. Partner Achievements

This section highlights All4HealthFL Collaborative organization specific achievements in addressing health needs identified from the 2019-2021 CHNA cycle.

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Appendix A. Secondary Data Methodology

This section contains secondary data methodology and population data by ZIP code.

- **Pinellas County Data Scoring Results**
- **Population Estimates for each ZIP code**
- **Families Below Poverty Line by ZIP code**

Appendix A. Secondary Data Methodology and Data Scoring Tables

SCORE	ADOLESCENT HEALTH	UNITS	PINELLAS COUNTY	HP2030	Florida	U.S.	MEASUREMENT PERIOD	RACE DISPARITY	Source
1.91	Adolescents who Use Electronic Vaping: Lifetime	*percent*	29.7		26.4		*2020*		23
1.91	Adolescents who Use Electronic Vaping: Past 30 Days	*percent*	18.9		14.5		*2020*		23
1.65	Teens without Sufficient Physical Activity	*percent*	81.2		82.3		*2020*		13
1.41	Teens who Use Marijuana: High School Students	*percent*	17.7		15.9		*2020*		22
1.18	Teens who Use Alcohol	*percent*	19.6		19.9		*2020*		22
1.09	Adolescents who Use Smokeless Tobacco: Lifetime	*percent*	3.1		3.7		*2020*		23
1.09	Teen Birth Rate: 15-19	*live births/ 1,000 females aged 15-19*	16.2		16.2	16.7	*2019*	Black (31.7) White (9) Hispanic/Latino (17.7)	18
1.09	Teens who have Used Methamphetamines	*percent*	0.2		0.8		*2020*		22
0.97	Teens who are Obese: High School Students	*percent*	11.5		15.4		*2020*		13
0.97	Teens who Smoke Cigarettes: High School Students	*percent*	1.4		1.5		*2020*		23

Appendix A. Secondary Data Methodology and Data Scoring Tables

0.79	Adolescents who Use Smokeless Tobacco: Past 30 Days	*percent*	0.8		1.3		*2020*		23
0.53	Teens who Binge Drink: High School Students	*percent*	7.2		9.2		*2020*		22
0.53	Teens with Asthma	*percent*	17		21.3		*2020*		23
SCORE	**ALCOHOL & DRUG USE**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
3.00	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	32.5		23.6	21	*2017-2019*		7
2.29	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	43.2		27.8	23.5	*2018-2020*	Black (21.3) White (40.3) Hispanic/Latino (19.8)	4
2.03	Adults who Drink Excessively	*percent*	24.2		18		*2017-2019*		10
1.94	Adults who Binge Drink	*percent*	17.1			16.4	*2018*		3
1.88	Driving Under the Influence Arrest Rate	*arrests/ 100,000 population*	235.2		159.7		*2019*		20
1.41	Health Behaviors Ranking	*ranking*	19				*2021*		7
1.41	Teens who Use Marijuana: High School Students	*percent*	17.7		15.9		*2020*		22
1.18	Teens who Use Alcohol	*percent*	19.6		19.9		*2020*		22

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1.09	Teens who have Used Methamphetamines	*percent*	0.2		0.8		*2020*		22
0.53	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	21.4	28.3	22.3	27	*2015-2019*		7
0.53	Teens who Binge Drink: High School Students	*percent*	7.2		9.2		*2020*		22
SCORE	**CANCER**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.47	Melanoma Incidence Rate	*cases/ 100,000 population*	32.7		25.2		*2016-2018*	Black (2.1) White (35.7)	32
2.29	Adults with Cancer	*percent*	9			6.9	*2018*		3
2.18	Cancer: Medicare Population	*percent*	10.1		10.1	8.4	*2018*		5
2.12	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	9.5		9		*2016-2018*		32
2.00	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	16.3		13.5		*2016-2018*		32
2.00	Pap Test in Past Year	*percent*	40.8		48.4		*2016*		10
1.94	Mammogram in Past Year: 40+	*percent*	60		60.8		*2016*		10
1.94	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	89		89.6		*2016-2018*		32
1.82	Breast Cancer Incidence Rate	*cases/ 100,000 females*	130.2		121.2		*2016-2018*		32

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1.59	Mammogram in Past 2 Years: 50-74	*percent*	71.3	77.1		74.8	*2018*		3
1.53	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	10.9	15.3	10.4		*2017-2019*		18
1.41	Colon Cancer Screening	*percent*	65.9	74.4		66.4	*2018*		3
1.24	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	39.5	25.1	35.3		*2017-2019*		18
1.24	Cervical Cancer Screening: 21-65	*Percent*	84.1	84.3		84.7	*2018*		3
1.18	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	34.3		35.6		*2016-2018*		32
1.12	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	6.5	16.9	7.4		*2017-2019*	Black (16) White (6.2) Hispanic/La tino (6.5	18
1.06	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	148.8	122.7	146.1		*2017-2019*		18
1.06	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	61.4		56.6		*2016-2018*		32
0.71	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	12.1	8.9	13.1		*2017-2019*		18
SCORE	**CHILDREN'S HEALTH**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.00	Kindergartners with Required Immunizations	*percent*	92.2		93.5		*2020*		15
1.88	Child Abuse Rate	*cases/ 1,000 children aged 5-11*	12.4		6.6		*2019*		11

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1.50	Child Food Insecurity Rate	*percent*	16.5		17.1	14.6	*2019*		8
1.41	Children with Health Insurance	*percent*	93.5		92.4	94.3	*2019*		1
1.41	Projected Child Food Insecurity Rate	*percent*	19.1		19.1		*2021*		8
1.15	Children with Low Access to a Grocery Store	*percent*	2.6				*2015*		29
SCORE	**COMMUNITY**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.38	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	545		505	500	*2015-2019*		1
2.18	Social Associations	*membership associations/ 10,000 population*	7.3		7	9.3	*2018*		7
2.12	People 65+ Living Alone	*percent*	30.1		23.7	26.1	*2015-2019*		1
2.06	Single-Parent Households	*percent*	30.6		29	25.5	*2015-2019*		1
2.06	Total Employment Change	*percent*	0.6		2.2	1.6	*2018-2019*		28
2.03	Median Household Gross Rent	*dollars*	1112		1175	1062	*2015-2019*		1
2.03	Mortgaged Owners Median Monthly Household Costs	*dollars*	1490		1503	1595	*2015-2019*		1
1.88	Child Abuse Rate	*cases/ 1,000 children aged 5-11*	12.4		6.6		*2019*		11

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1.88	Driving Under the Influence Arrest Rate	*arrests/ 100,000 population*	235.2		159.7		*2019*		20
1.71	Domestic Violence Offense Rate	*offenses/ 100,000 population*	617.8		496.5		*2019*		20
1.65	Population 16+ in Civilian Labor Force	*percent*	54.9		55.2	59.6	*2015-2019*		1
1.59	Households without a Vehicle	*percent*	7.7		6.3	8.6	*2015-2019*		1
1.47	Workers Commuting by Public Transportation	*percent*	1.7	5.3	1.8	5	*2015-2019*	Black (4.9) White (1) Asian (1.1) American Indian/Alaskan Native (3.4) Native Hawaiian/Pacific islander (8.9) Multiracial (3.1) Other (2) Hispanic/Latino (3.4)	1
1.41	Persons with an Internet Subscription	*percent*	85.9		85.7	86.2	*2015-2019*	Black (72.2) White (87.8) Asian (91.9) American Indian/Alaskan Native	1

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								(82) Native Hawaiian/Pacific islander (92.2) Multiracial (86.9) Other (82.7) Hispanic/Latino (82.2)	
1.29	Solo Drivers with a Long Commute	*percent*	33.8		42.4	37	*2015-2019*		7
1.24	Consumer Expenditures: Local Public Transportation	*average dollar amount per consumer unit*	101.4		107.5	148.8	*2021*		6
1.24	Homeownership	*percent*	53.6		53.5	56.2	*2015-2019*		1
1.24	Juvenile Justice Referral Rate	*referrals/ 10,000 population*	187.6		160.6		*2019*		19
1.24	Median Household Income	*dollars*	54090		55660	62843	*2015-2019*	Black (39080) White (56696) Asian (59894) American Indian/Alaskan Native (49091) Multiracial	1

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								(51601) Other (45634) Hispanic/Latino (46567)	
1.24	Social and Economic Factors Ranking	*ranking*	15				*2021*		7
1.15	Households with an Internet Subscription	*percent*	83.2		83.3	83	*2015-2019*		1
1.15	Households with One or More Types of Computing Devices	*percent*	90.4		91.5	90.3	*2015-2019*		1
1.15	Median Housing Unit Value	*dollars*	201200		215300	217500	*2015-2019*		1
1.12	Mean Travel Time to Work	*minutes*	24.5		27.8	26.9	*2015-2019*		1
1.00	Female Population 16+ in Civilian Labor Force	*percent*	54.7		54.3	58.3	*2015-2019*		1
0.97	Households with No Car and Low Access to a Grocery Store	*percent*	0.9				*2015*		29
0.97	Median Monthly Medicaid Enrollment	*enrollments/ 100,000 population*	16074.3		19940.3		*2020*		9
0.97	Violent Crime Rate	*crimes/ 100,000 population*	345.5		382.4	379.4	*2019*		20
0.88	Voter Turnout: Presidential Election	*percent*	79.3		77.2		*2020*		21

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0.71	Workers who Drive Alone to Work	*percent*	77.9		79.1	76.3	*2015-2019*	Black (75.6) White (79.2) Asian (75.2) American Indian/Alaskan Native (69.4) Native Hawaiian/Pacific islander (77.4) Multiracial (72.9) Other (72.8) Hispanic/Latino (72.4)	1
0.53	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	11.6		14.7		*2019*	Black (23.3) White (10.6) Hispanic/Latino (10.1) Male (18.8) Female(6.3)	18
0.53	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	21.4	28.3	22.3	27	*2015-2019*		7

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0.53	People 25+ with a Bachelor's Degree or Higher	*percent*	31.7		29.9	32.1	*2015-2019*	Black (19) White (33.3) Asian (41.9) American Indian/Alaskan Native (17.3) Native Hawaiian/Pacific islander (35.9) Multiracial (32.5) Other (24.2) Hispanic/Latino (26.2)	1
0.53	People 25+ with a High School Degree or Higher	*percent*	91.3		88.2	88	*2015-2019*	Black (84.8) White (93.2) Asian (82.4) American Indian/Alaskan Native (81.7) Native Hawaiian/Pacific islander	1

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								(93) Multiracial (88.1) Other (85.9) Hispanic/Latino (82.9)	
0.53	People Living Below Poverty Level	*percent*	12.2	8	14	13.4	*2015-2019*	Black (23.5) White (10) Asian (10.9) American Indian/Alaskan Native (20.6) Native Hawaiian/Pacific islander (9) Multiracial (18.6) Other (11.9) Hispanic/Latino (16.6)	1
0.35	Children Living Below Poverty Level	*percent*	16.9		20.1	18.5	*2015-2019*	Black (36.5) White (10.5) Asian (15.8) American Indian/Alaskan Native	1

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								(13.5) Native Hawaiian/Pacific islander (0) Multiracial (22.5) Other (10.9) Hispanic/Latino (20.8)	
0.18	Per Capita Income	*dollars*	35196		31619	34103	*2015-2019*	Black (21119) White (39411) Asian (31353) American Indian/Alaskan Native (38810) Native Hawaiian/Pacific islander (31455) Multiracial (15663) Other (22418) Hispanic/La	1

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								tino (24143)	
SCORE	**COUNTY HEALTH RANKINGS**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
1.41	Health Behaviors Ranking	*ranking*	19				*2021*		7
1.41	Mortality Ranking	*ranking*	29				*2021*		7
1.24	Clinical Care Ranking	*ranking*	11				*2021*		7
1.24	Morbidity Ranking	*ranking*	10				*2021*		7
1.24	Physical Environment Ranking	*ranking*	10				*2021*		7
1.24	Social and Economic Factors Ranking	*ranking*	15				*2021*		7
SCORE	**DIABETES**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
1.15	Adults with Diabetes	*percent*	10.7		11.7		*2017-2019*		10
1.06	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	19.2		19.7	21.6	*2019*	Black (42.2) White (18.3) Hispanic/Latino (27.1)	18

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								Male (27.1) Female(14)	
0.47	Diabetes: Medicare Population	*percent*	24.2		27.8	27	*2018*		5
SCORE	**ECONOMY**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.38	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	545		505	500	*2015-2019*		1
2.12	People 65+ Living Below Poverty Level	*percent*	10		10.4	9.3	*2015-2019*	Black (17.7) White (8.9) Asian (13.3) American Indian/Alaskan Native (25.4) Native Hawaiian/Pacific islander (20) Multiracial (24.3) Other (15) Hispanic/Latino (19.3)	1
2.06	Total Employment Change	*percent*	0.6		2.2	1.6	*2018-2019*		28

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2.03	Median Household Gross Rent	*dollars*	1112		1175	1062	*2015-2019*		1
2.03	Mortgaged Owners Median Monthly Household Costs	*dollars*	1490		1503	1595	*2015-2019*		1
2.00	Renters Spending 30% or More of Household Income on Rent	*percent*	53.3		56.3	49.6	*2015-2019*		1
1.82	SNAP Certified Stores	*stores/ 1,000 population*	0.8				*2017*		29
1.71	Households with Cash Public Assistance Income	*percent*	2.4		2.1	2.4	*2015-2019*		1
1.68	Food Insecurity Rate	*percent*	12.6		12	10.9	*2019*		8
1.68	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	34.6		33		*2018*		31
1.65	Population 16+ in Civilian Labor Force	*percent*	54.9		55.2	59.6	*2015-2019*		1
1.59	Overcrowded Households	*percent of households*	1.9		3		*2015-2019*		1
1.59	Projected Food Insecurity Rate	*percent*	14.2		13.3		*2021*		8
1.50	Child Food Insecurity Rate	*percent*	16.5		17.1	14.6	*2019*		8
1.41	Homeowner Vacancy Rate	*percent*	2.3		2.3	1.6	*2015-2019*		1
1.41	Mortgaged Owners Spending 30% or More of	*percent*	29.5		32.2	26.5	*2019*		1

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	Household Income on Housing								
1.41	Projected Child Food Insecurity Rate	*percent*	19.1		19.1		*2021*		8
1.41	Severe Housing Problems	*percent*	18		19.5	18	*2013-2017*		7
1.32	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	54.1		54		*2018*		31
1.32	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		29
1.24	Consumer Expenditures: Homeowner Expenses	*average dollar amount per consumer unit*	7346.1		7675.2	8900.1	*2021*		6
1.24	Homeownership	*percent*	53.6		53.5	56.2	*2015-2019*		1
1.24	Median Household Income	*dollars*	54090		55660	62843	*2015-2019*	Black (39080) White (56696) Asian (59894) American Indian/Alaskan Native (49091) Multiracial (51601) Other (45634)	1

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								Hispanic/Latino (46567)	
1.24	Social and Economic Factors Ranking	*ranking*	15				*2021*		7
1.15	Households that are Below the Federal Poverty Level	*percent*	11.3		13		*2018*		31
1.15	Low-Income and Low Access to a Grocery Store	*percent*	3.9				*2015*		29
1.15	Median Housing Unit Value	*dollars*	201200		215300	217500	*2015-2019*		1
1.06	Consumer Expenditures: Home Rental Expenses	*average dollar amount per consumer unit*	4192.9		4431	5460.2	*2021*		6
1.06	Size of Labor Force	*persons*	515290				*Jul-21*		27
1.00	Female Population 16+ in Civilian Labor Force	*percent*	54.7		54.3	58.3	*2015-2019*		1
1.00	Students Eligible for the Free Lunch Program	*percent*	43.1				*2019-2020*		25
0.76	Unemployed Workers in Civilian Labor Force	*percent*	4.4		5.1	5.7	*Jul-21*		27
0.53	People Living 200% Above Poverty Level	*percent*	69.4		65.8	69.1	*2015-2019*		1

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0.53	People Living Below Poverty Level	*percent*	12.2	8	14	13.4	*2015-2019*	Black (23.5) White (10) Asian (10.9) American Indian/Alaskan Native (20.6) Native Hawaiian/Pacific islander (9) Multiracial (18.6) Other (11.9) Hispanic/Latino (16.6)	1
0.53	Persons with Disability Living in Poverty (5-year)	*percent*	23.4		24.6	26.1	*2015-2019*		1
0.35	Children Living Below Poverty Level	*percent*	16.9		20.1	18.5	*2015-2019*	Black (36.5) White (10.5) Asian (15.8) American Indian/Alaskan Native (13.5) Native Hawaiian/Pacific islander (0)	1

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								Multiracial (22.5) Other (10.9) Hispanic/Latino (20.8)	
0.18	Families Living Below Poverty Level	*percent*	7.8		10	9.5	*2015-2019*		1
0.18	Per Capita Income	*dollars*	35196		31619	34103	*2015-2019*	Black (21119) White (39411) Asian (31353) American Indian/Alaskan Native (38810) Native Hawaiian/Pacific islander (31455) Multiracial (15663) Other (22418) Hispanic/Latino (24143)	1

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SCORE	**EDUCATION**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.00	8th Grade Students Proficient in Math	*percent*	28		37		*2021*		12
1.65	8th Grade Students Proficient in Reading	*percent*	50		52		*2021*		12
1.65	Student-to-Teacher Ratio	*students/ teacher*	16.4				*2019-2020*		25
1.29	4th Grade Students Proficient in Math	*percent*	61		53		*2021*		12
1.24	Consumer Expenditures: Education	*average dollar amount per consumer unit*	957.7		1056	1492.4	*2021*		6
1.18	4th Grade Students Proficient in Reading	*percent*	55		52		*2021*		12
0.88	High School Graduation	*percent*	91.5	90.7	90		*2019-2020*		12
0.53	People 25+ with a Bachelor's Degree or Higher	*percent*	31.7		29.9	32.1	*2015-2019*	Black (19) White (33.3) Asian (41.9) American Indian/Alaskan Native (17.3) Native Hawaiian/Pacific islander (35.9) Multiracial	1

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								(32.5) Other (24.2) Hispanic/Latino (26.2)	
0.53	People 25+ with a High School Degree or Higher	*percent*	91.3		88.2	88	*2015-2019*	Black (84.8) White (93.2) Asian (82.4) American Indian/Alaskan Native (81.7) Native Hawaiian/Pacific islander (93) Multiracial (88.1) Other (85.9) Hispanic/Latino (82.9)	1
SCORE	**ENVIRONMENTAL HEALTH**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.24	Asthma: Medicare Population	*percent*	5.6		5.2	5	*2018*		5

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2.03	Adults with Current Asthma	*percent*	10.6		7.4		*2017-2019*		10
2.00	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.7				*2016*		29
1.94	Number of Extreme Heat Events	*events*	8				*2016*		26
1.82	SNAP Certified Stores	*stores/ 1,000 population*	0.8				*2017*		29
1.65	Number of Extreme Heat Days	*days*	44				*2016*		26
1.65	Number of Extreme Precipitation Days	*days*	29				*2016*		26
1.59	Overcrowded Households	*percent of households*	1.9		3		*2015-2019*		1
1.50	Farmers Market Density	*markets/ 1,000 population*	0				*2018*		29
1.50	People 65+ with Low Access to a Grocery Store	*percent*	2.8				*2015*		29
1.47	Houses Built Prior to 1950	*percent*	6.5		4.1	17.5	*2015-2019*		1
1.41	Severe Housing Problems	*percent*	18		19.5	18	*2013-2017*		7
1.35	PBT Released	*pounds*	844.2				*2019*		30
1.32	Annual Ozone Air Quality		B				*2017-2019*		2
1.32	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		29
1.24	Annual Particle Pollution		A				*2017-2019*		2
1.24	Physical Environment Ranking	*ranking*	10				*2021*		7

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1.15	Children with Low Access to a Grocery Store	*percent*	2.6				*2015*		29
1.15	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*		29
1.15	Low-Income and Low Access to a Grocery Store	*percent*	3.9				*2015*		29
0.97	Households with No Car and Low Access to a Grocery Store	*percent*	0.9				*2015*		29
0.97	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*		29
0.65	Food Environment Index	*index*	7.9		6.9	7.8	*2021*		7
0.62	Access to Exercise Opportunities	*percent*	97.2		88.7	84	*2020*		7
0.53	Teens with Asthma	*percent*	17		21.3		*2020*		23
SCORE	**HEALTH CARE ACCESS & QUALITY**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
1.76	Adults without Health Insurance	*percent*	18.7			12.2	*2018*		3
1.41	Children with Health Insurance	*percent*	93.5		92.4	94.3	*2019*		1
1.41	Consumer Expenditures: Health Insurance	*average dollar amount per consumer unit*	4168.1		4247.2	4321.1	*2021*		6
1.32	Adults with a Usual Source of Health Care	*percent*	76.1		72		*2017-2019*		10

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1.24	Adults who Visited a Dentist	*percent*	65.1			66.5	*2018*		3
1.24	Adults with Health Insurance	*percent*	82.3		80.5	87.1	*2019*	Black (81) White (84) Asian (78.2) Multiracial (82) Other (72.3) Hispanic/Latino (74.9)	1
1.24	Clinical Care Ranking	*ranking*	11				*2021*		7
1.15	Primary Care Provider Rate	*providers/ 100,000 population*	87.8		72.2		*2018*		7
1.06	Adults who have had a Routine Checkup	*percent*	79.6			76.7	*2018*		3
0.97	Median Monthly Medicaid Enrollment	*enrollments/ 100,000 population*	16074.3		19940.3		*2020*		9
0.44	Mental Health Provider Rate	*providers/ 100,000 population*	208.5		169		*2020*		7
0.26	Dentist Rate	*dentists/ 100,000 population*	72.3		60.8		*2019*		7
0.26	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	135		120.6		*2020*		7
SCORE	**HEART DISEASE & STROKE**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.65	Ischemic Heart Disease: Medicare Population	*percent*	34.4		34.3	26.8	*2018*		5

Appendix A. Secondary Data Methodology and Data Scoring Tables

2.35	Atrial Fibrillation: Medicare Population	*percent*	10.1		10.1	8.4	*2018*		5
2.24	Stroke: Medicare Population	*percent*	5.1		4.7	3.8	*2018*		5
2.18	Hyperlipidemia: Medicare Population	*percent*	58		59.2	47.7	*2018*		5
1.94	Hypertension: Medicare Population	*percent*	61.2		62.4	57.2	*2018*		5
1.91	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	93.9	71.1	88.6	88	*2019*		18
1.85	High Blood Pressure Prevalence	*percent*	39.4	27.7	33.5		*2017-2019*		10
1.76	Adults who Experienced a Stroke	*percent*	4.2			3.4	*2018*		3
1.76	Adults who Experienced Coronary Heart Disease	*percent*	9.3			6.8	*2018*		3
1.65	Heart Failure: Medicare Population	*percent*	14.7		14.8	14	*2018*		5
1.41	High Cholesterol Prevalence: Adults 18+	*percent*	37			34.1	*2017*		3
1.35	Age-Adjusted Hospitalization Rate due to Heart Attack	*hospitalizations/ 10,000 population 35+ years*	32.2		29.7		*2018*		26
1.24	Adults who Have Taken Medications for High Blood Pressure	*percent*	78.6			75.8	*2017*		3

Appendix A. Secondary Data Methodology and Data Scoring Tables

1.03	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	31.7	33.4	41.4	37	*2019*		18
0.88	Cholesterol Test History	*percent*	84			81.5	*2017*		3
0.53	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	36.7		42.8		*2018*		26
SCORE	**IMMUNIZATIONS & INFECTIOUS DISEASES**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.44	Syphilis Incidence Rate	*cases/ 100,000 population*	22.5		15.1	11.9	*2019*		16
2.00	Kindergartners with Required Immunizations	*percent*	92.2		93.5		*2020*		15
1.88	Tuberculosis Incidence Rate	*cases/ 100,000 population*	2.4	1.4	1.9		*2020*		17
1.82	HIV Incidence Rate	*cases/ 100,000 population*	20		21.6		*2019*	Black (44.6) White (11.3) Hispanic/Latino (25.9)	14
1.59	Overcrowded Households	*percent of households*	1.9		3		*2015-2019*		1
1.50	Chlamydia Incidence Rate	*cases/ 100,000 population*	470.7		525.5	551	*2019*		16
1.15	Adults 65+ with Influenza Vaccination	*percent*	62.6		58.3		*2017-2019*		10
1.09	Gonorrhea Incidence Rate	*cases/ 100,000 population*	157.6		174.9	187.8	*2019*		16

Appendix A. Secondary Data Methodology and Data Scoring Tables

0.97	Adults 65+ with Pneumonia Vaccination	*percent*	76.7		66.8		*2017-2019*		10
0.97	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	20.4	11.1	33.4		*2019*		13
0.79	Persons Fully Vaccinated Against COVID-19	*percent*	59.3				*Nov 5,2021*		4
0.44	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	7.2		8.4	12.3	*2019*		18
0.44	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0		0	3.4	*Nov 5,2021*		24
0.18	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	5.2		6	31.2	*Nov 5,2021*		24
SCORE	**MATERNAL, FETAL & INFANT HEALTH**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
1.21	Mothers who Received Early Prenatal Care	*percent*	80.5		75.9	75.8	*2019*		18
1.21	Preterm Births	*percent*	9.9	9.4	10.6	10	*2019*		18
1.09	Teen Birth Rate: 15-19	*live births/ 1,000 females aged 15-19*	16.2		16.2	16.7	*2019*	Black (31.7) White (9)Hispanic/ Latino (17.7)	18
1.00	Infant Mortality Rate	*deaths/ 1,000 live births*	5.4	5	6		*2019*	Black (14.3) White (3.9)Hispanic/Latino (6.4)	18

Appendix A. Secondary Data Methodology and Data Scoring Tables

0.91	Babies with Low Birth Weight	*percent*	8		8.8	8.3	*2019*	Black (14.3) White (6.1)Hispanic/Latino (6)	18
SCORE	**MENTAL HEALTH & MENTAL DISORDERS**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
3.00	Alzheimer's Disease or Dementia: Medicare Population	*percent*	14.2		12.6	10.8	*2018*		5
3.00	Depression: Medicare Population	*percent*	22.4		19.5	18.4	*2018*		5
1.79	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	16.6	12.8	14.5	13.9	*2019*		18
1.50	Frequent Mental Distress	*percent*	14.7		13.4	13	*2018*		7
1.24	Poor Mental Health: 14+ Days	*percent*	13.4			12.7	*2018*		3
1.15	Self-Reported General Health Assessment: Good or Better	*percent*	81.8		80.3		*2017-2019*		10
0.44	Mental Health Provider Rate	*providers/ 100,000 population*	208.5		169		*2020*		7
SCORE	**OLDER ADULTS**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
3.00	Alzheimer's Disease or Dementia: Medicare Population	*percent*	14.2		12.6	10.8	*2018*		5

Appendix A. Secondary Data Methodology and Data Scoring Tables

3.00	Depression: Medicare Population	*percent*	22.4		19.5	18.4	*2018*		5
2.65	Chronic Kidney Disease: Medicare Population	*percent*	29.4		28.2	24.5	*2018*		5
2.65	Ischemic Heart Disease: Medicare Population	*percent*	34.4		34.3	26.8	*2018*		5
2.53	Osteoporosis: Medicare Population	*percent*	9.1		8.3	6.6	*2018*		5
2.35	Atrial Fibrillation: Medicare Population	*percent*	10.1		10.1	8.4	*2018*		5
2.24	Asthma: Medicare Population	*percent*	5.6		5.2	5	*2018*		5
2.24	Stroke: Medicare Population	*percent*	5.1		4.7	3.8	*2018*		5
2.18	Cancer: Medicare Population	*percent*	10.1		10.1	8.4	*2018*		5
2.18	Hyperlipidemia: Medicare Population	*percent*	58		59.2	47.7	*2018*		5
2.12	People 65+ Living Alone	*percent*	30.1		23.7	26.1	*2015-2019*		1
2.12	People 65+ Living Below Poverty Level	*percent*	10		10.4	9.3	*2015-2019*	Black (17.7) White (8.9) Asian (13.3) American Indian/Alaskan Native (25.4) Native Hawaiian/Pacific	1

Appendix A. Secondary Data Methodology and Data Scoring Tables

								islander (20) Multiracial (24.3) Other (15) Hispanic/Latino (19.3)	
2.12	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	36.7		37.5	33.5	*2018*		5
2.00	COPD: Medicare Population	*percent*	14.3		13.5	11.5	*2018*		5
1.94	Hypertension: Medicare Population	*percent*	61.2		62.4	57.2	*2018*		5
1.65	Heart Failure: Medicare Population	*percent*	14.7		14.8	14	*2018*		5
1.59	Adults with Arthritis	*percent*	30			25.8	*2018*		3
1.50	People 65+ with Low Access to a Grocery Store	*percent*	2.8				*2015*		29
1.41	Colon Cancer Screening	*percent*	65.9	74.4		66.4	*2018*		3
1.24	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	31.2			28.4	*2018*		3
1.24	Adults 65+ with Total Tooth Loss	*percent*	14			13.5	*2018*		3
1.15	Adults 65+ with Influenza Vaccination	*percent*	62.6		58.3		*2017-2019*		10
1.41	Colon Cancer Screening	*percent*	65.9	74.4		66.4	*2018*		3

Appendix A. Secondary Data Methodology and Data Scoring Tables

1.06	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	32.5			32.4	*2018*		3
0.97	Adults 65+ with Pneumonia Vaccination	*percent*	76.7		66.8		*2017-2019*		10
0.47	Diabetes: Medicare Population	*percent*	24.2		27.8	27	*2018*		5
SCORE	**ORAL HEALTH**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.00	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	16.3		13.5		*2016-2018*		32
1.24	Adults 65+ with Total Tooth Loss	*percent*	14			13.5	*2018*		3
1.24	Adults who Visited a Dentist	*percent*	65.1			66.5	*2018*		3
0.26	Dentist Rate	*dentists/ 100,000 population*	72.3		60.8		*2019*		7
SCORE	**OTHER CONDITIONS**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.65	Chronic Kidney Disease: Medicare Population	*percent*	29.4		28.2	24.5	*2018*		5
2.53	Osteoporosis: Medicare Population	*percent*	9.1		8.3	6.6	*2018*		5
2.12	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	36.7		37.5	33.5	*2018*		5

Appendix A. Secondary Data Methodology and Data Scoring Tables

1.76	Adults with Kidney Disease	*Percent of adults*	3.5			3.1	*2018*		3
1.59	Adults with Arthritis	*percent*	30			25.8	*2018*		3
1.12	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	10.1		9.9	12.9	*2017-2019*	Black (25.4) White (9) Hispanic/Latino (10.2)	4
SCORE	**PHYSICAL ACTIVITY**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.00	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.7				*2016*		29
1.82	SNAP Certified Stores	*stores/ 1,000 population*	0.8				*2017*		29
1.65	Teens without Sufficient Physical Activity	*percent*	81.2		82.3		*2020*		13
1.50	Adults Who Are Obese	*percent*	28.4		27		*2017-2019*		10
1.50	Farmers Market Density	*markets/ 1,000 population*	0				*2018*		29
1.50	People 65+ with Low Access to a Grocery Store	*percent*	2.8				*2015*		29
1.41	Health Behaviors Ranking	*ranking*	19				*2021*		7
1.32	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		29
1.15	Adults who are Overweight or Obese	*percent*	63.8		64.6		*2017-2019*		10

Appendix A. Secondary Data Methodology and Data Scoring Tables

1.15	Children with Low Access to a Grocery Store	*percent*	2.6				*2015*		29
1.15	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*		29
1.15	Low-Income and Low Access to a Grocery Store	*percent*	3.9				*2015*		29
0.97	Adults who are Sedentary	*percent*	22	21.2	26.5		*2017-2019*		10
0.97	Households with No Car and Low Access to a Grocery Store	*percent*	0.9				*2015*		29
0.97	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*		29
0.65	Food Environment Index	*index*	7.9		6.9	7.8	*2021*		7
0.62	Access to Exercise Opportunities	*percent*	97.2		88.7	84	*2020*		7
SCORE	**PREVENTION & SAFETY**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
3.00	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	32.5		23.6	21	*2017-2019*		7
2.12	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	72.3	43.2	55.5	49.3	*2019*		18
1.41	Severe Housing Problems	*percent*	18		19.5	18	*2013-2017*		7
0.53	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	11.6		14.7		*2019*	Black (23.3) White (10.6) Hispanic/La	18

Appendix A. Secondary Data Methodology and Data Scoring Tables

								tino (10.1) Male (18.8) Female(6.3)	
SCORE	**RESPIRATORY DISEASES**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.24	Asthma: Medicare Population	*percent*	5.6		5.2	5	*2018*		5
2.03	Adults Who Currently Use E-Cigarettes	*percent*	8.9		7.5		*2017-2019*		10
2.03	Adults with Current Asthma	*percent*	10.6		7.4		*2017-2019*		10
2.00	COPD: Medicare Population	*percent*	14.3		13.5	11.5	*2018*		5
1.91	Adolescents who Use Electronic Vaping: Lifetime	*percent*	29.7		26.4		*2020*		23
1.91	Adolescents who Use Electronic Vaping: Past 30 Days	*percent*	18.9		14.5		*2020*		23
1.88	Tuberculosis Incidence Rate	*cases/ 100,000 population*	2.4	1.4	1.9		*2020*		17
1.85	Adults who Smoke	*percent*	19.7	5	14.8		*2017-2019*		10
1.76	Adults with COPD	*Percent of adults*	9.3			6.9	*2018*		3
1.24	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	39.5	25.1	35.3		*2017-2019*		18
1.15	Adults 65+ with Influenza Vaccination	*percent*	62.6		58.3		*2017-2019*		10

Appendix A. Secondary Data Methodology and Data Scoring Tables

1.09	Adolescents who Use Smokeless Tobacco: Lifetime	*percent*	3.1		3.7		*2020*		23
1.06	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	61.4		56.6		*2016-2018*		32
0.97	Adults 65+ with Pneumonia Vaccination	*percent*	76.7		66.8		*2017-2019*		10
0.97	Teens who Smoke Cigarettes: High School Students	*percent*	1.4		1.5		*2020*		23
0.79	Adolescents who Use Smokeless Tobacco: Past 30 Days	*percent*	0.8		1.3		*2020*		23
0.53	Teens with Asthma	*percent*	17		21.3		*2020*		23
0.44	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	7.2		8.4	12.3	*2019*		18
0.44	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0		0	3.4	*Nov 5,2021*		24
0.18	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	5.2		6	31.2	*Nov 5,2021*		24
SCORE	**SEXUALLY TRANSMITTED INFECTIONS**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.44	Syphilis Incidence Rate	*cases/ 100,000 population*	22.5		15.1	11.9	*2019*		16
1.82	HIV Incidence Rate	*cases/ 100,000 population*	20		21.6		*2019*	Black (44.6) White	14

Appendix A. Secondary Data Methodology and Data Scoring Tables

								(11.3) Hispanic/Latino (25.9)	
1.50	Chlamydia Incidence Rate	*cases/ 100,000 population*	470.7		525.5	551	*2019*		16
1.09	Gonorrhea Incidence Rate	*cases/ 100,000 population*	157.6		174.9	187.8	*2019*		16
SCORE	**TOBACCO USE**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.03	Adults Who Currently Use E-Cigarettes	*percent*	8.9		7.5		*2017-2019*		10
1.91	Adolescents who Use Electronic Vaping: Lifetime	*percent*	29.7		26.4		*2020*		23
1.91	Adolescents who Use Electronic Vaping: Past 30 Days	*percent*	18.9		14.5		*2020*		23
1.85	Adults who Smoke	*percent*	19.7	5	14.8		*2017-2019*		10
1.09	Adolescents who Use Smokeless Tobacco: Lifetime	*percent*	3.1		3.7		*2020*		23
0.97	Teens who Smoke Cigarettes: High School Students	*percent*	1.4		1.5		*2020*		23
0.79	Adolescents who Use Smokeless Tobacco: Past 30 Days	*percent*	0.8		1.3		*2020*		23

Appendix A. Secondary Data Methodology and Data Scoring Tables

SCORE	WEIGHT STATUS	UNITS	PINELLAS COUNTY	HP2030	Florida	U.S.	MEASUREMENT PERIOD	RACE DISPARITY	Source
1.50	Adults Who Are Obese	*percent*	28.4		27		*2017-2019*		10
1.15	Adults who are Overweight or Obese	*percent*	63.8		64.6		*2017-2019*		10
0.97	Teens who are Obese: High School Students	*percent*	11.5		15.4		*2020*		13
SCORE	**WELLNESS & LIFESTYLE**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
1.85	High Blood Pressure Prevalence	*percent*	39.4	27.7	33.5		*2017-2019*		10
1.50	Insufficient Sleep	*percent*	38	31.4	37.3	35	*2018*		7
1.50	Life Expectancy	*years*	79.2		80.2	79.2	*2017-2019*	Black (74.86) White (79.06) Asian (88.37) American Indian/Alaskan Native (96.7) Hispanic/Latino (84.78)	7
1.41	Poor Physical Health: 14+ Days	*percent*	14.2			12.5	*2018*		3
1.32	Frequent Physical Distress	*percent*	12.5		12.6	11	*2018*		7

Appendix A. Secondary Data Methodology and Data Scoring Tables

1.24	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1426.8		1520	1638.9	*2021*		6
1.24	Morbidity Ranking	*ranking*	10				*2021*		7
1.15	Self-Reported General Health Assessment: Good or Better	*percent*	81.8		80.3		*2017-2019*		10
SCORE	**WOMEN'S HEALTH**	**UNITS**	**PINELLAS COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.12	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	9.5		9		*2016-2018*		32
2.00	Pap Test in Past Year	*percent*	40.8		48.4		*2016*		10
1.94	Mammogram in Past Year: 40+	*percent*	60		60.8		*2016*		10
1.82	Breast Cancer Incidence Rate	*cases/ 100,000 females*	130.2		121.2		*2016-2018*		32
1.59	Mammogram in Past 2 Years: 50-74	*percent*	71.3	77.1		74.8	*2018*		3
1.53	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	10.9	15.3	10.4		*2017-2019*		18
1.24	Cervical Cancer Screening: 21-65	*Percent*	84.1	84.3		84.7	*2018*		3

Appendix A. Secondary Data Methodology
Population Estimates for each Zip Code (Figure 1)

ZIP CODE	CITY	POPULATION
33701	Saint Petersburg	18,204
33702	Saint Petersburg	32,346
33703	Saint Petersburg	23,689
33704	Saint Petersburg	16,330
33705	Saint Petersburg	28,221
33706	Saint Petersburg	16,444
33707	Saint Petersburg, Gulfport, South Pasadena, Saint Pete Beach, Bear Creek	25,580
33708	Saint Petersburg, Madeira Beach, North Redington Beach, Redington Shore	16,180
33709	Saint Petersburg, Kenneth City, Pinellas Park, Seminole, Lealman	27,559
33710	Saint Petersburg	33,593
33711	Saint Petersburg, Gulfport	19,921
33712	Saint Petersburg	27,185
33713	Saint Petersburg	31,220
33714	Saint Petersburg, Pinellas Park, Lealman	20,713
33715	Saint Petersburg, Tierra Verde	8,110
33716	Saint Petersburg, Pinellas Park, Gandy	19,079

ZIP CODE	CITY	POPULATION
33755	Clearwater, Dunedin	27,576
33756	Clearwater, Belleair, Largo, Belleair Bluffs	33,093
33759	Clearwater	19,628
33760	Largo, Pinellas Park, Highpoint	20,974
33761	Clearwater, Safety Harbor	18,263
33762	Saint Petersburg, Feather Sound, Largo, Pinellas Park, Highpoint	5,917
33763	Clearwater, Dunedin	19,324
33764	Clearwater, Largo, Pinellas Park	28,075
33765	Clearwater	13,807
33767	Clearwater, Dunedin	8,496
33770	Largo, Belleair Bluffs, Harbor Bluffs	25,885
33771	Largo	33,588
33772	Seminole	24,039
33773	Largo, Pinellas Park	18,090
33774	Largo, Ridgecrest	18,707
33776	Seminole	12,462
33777	Seminole, Bardmoor, Pinellas Park	18,388
33778	Largo, Seminole, Ridgecrest	14,764

Appendix A. Secondary Data Methodology
Population Estimates for each Zip Code (Figure 1)

ZIP CODE	CITY	POPULATION
33781	Pinellas Park, Lealman	27,479
33782	Pinellas Park	22,354
33785	Indian Rocks Beach, Indian Shores	5,560
33786	Belleair Beach, Belleair Shore	1,564
34677	Oldsmar, East Lake	23,189
34681	Palm Harbor	1,395
34683	Palm Harbor, Dunedin	33,537

ZIP CODE	CITY	POPULATION
34684	Palm Harbor	26,901
34685	East Lake, Oldsmar	19,579
34688	Tarpon Springs, East Lake	8,806
34689	Tarpon Springs	29,026
34695	Safety Harbor	18,165
34698	Dunedin	39,137
	Pinellas County	982,142
	Florida	21,976,313
	U.S.	326,569,308

*County index values are calculated separately from zip code index values, and the two should not be compared to each other. While index values range from 0-100 at both the county and zip code level, zip code index values represent the percentile of each zip code among all U.S. zip codes, while county index values represent the percentile of each county among all U.S. counties

Appendix A. Secondary Data Methodology
Families Below Poverty by Zip Code (Figure 14)

ZIP CODE	CITY	FAMILIES BELOW POVERTY LEVEL (%)
33701	Saint Petersburg	7.8%
33702	Saint Petersburg	7.0%
33703	Saint Petersburg	3.4%
33704	Saint Petersburg	4.0%
33705	Saint Petersburg	13.3%
33706	Saint Petersburg	2.5%
33707	Saint Petersburg, Gulfport, South Pasadena, Saint Pete Beach, Bear Creek	6.0%
33708	Saint Petersburg, Madeira Beach, North Redington Beach, Redington Shore	4.6%
33709	Saint Petersburg, Kenneth City, Pinellas Park, Seminole, Lealman	8.8%
33710	Saint Petersburg	4.8%
33711	Saint Petersburg, Gulfport	10.4%
33712	Saint Petersburg	14.2%
33713	Saint Petersburg	7.9%
33714	Saint Petersburg, Pinellas Park, Lealman	10.6%
33715	Saint Petersburg, Tierra Verde	4.5%
33716	Saint Petersburg, Pinellas Park, Gandy	6.4%
33755	Clearwater, Dunedin	15.9%

ZIP CODE	CITY	FAMILIES BELOW POVERTY LEVEL (%)
33756	Clearwater, Belleair, Largo, Belleair Bluffs	11.1%
33759	Clearwater	6.2%
33760	Largo, Pinellas Park, Highpoint	9.0%
33761	Clearwater, Safety Harbor	5.7%
33762	Saint Petersburg, Feather Sound, Largo, Pinellas Park, Highpoint	5.2%
33763	Clearwater, Dunedin	6.6%
33764	Clearwater, Largo, Pinellas Park	6.3%
33765	Clearwater	9.3%
33767	Clearwater, Dunedin	6.5%
33770	Largo, Belleair Bluffs, Harbor Bluffs	9.1%
33771	Largo	5.9%
33772	Seminole	4.9%
33773	Largo, Pinellas Park	5.9%
33774	Largo, Ridgecrest	7.2%
33776	Seminole	1.7%
33777	Seminole, Bardmoor, Pinellas Park	5.6%
33778	Largo, Seminole, Ridgecrest	5.6%
33781	Pinellas Park, Lealman	9.1%

Appendix A. Secondary Data Methodology
Families Below Poverty by Zip Code (Figure 14)

ZIP CODE	CITY	FAMILIES BELOW POVERTY LEVEL (%)
33782	Pinellas Park	6.4%
33785	Indian Rocks Beach, Indian Shores	6.4%
33786	Belleair Beach, Belleair Shore	4.0%
34677	Oldsmar, East Lake	5.8%
34681	Palm Harbor	5.0%
34683	Palm Harbor, Dunedin	4.2%
34684	Palm Harbor	2.9%
34685	East Lake, Oldsmar	5.5%
34688	Tarpon Springs, East Lake	5.2%
34689	Tarpon Springs	6.4%
34695	Safety Harbor	2.1%
34698	Dunedin	7.4%
	Pinellas County	7.0%
	Florida	9.3%
	U.S.	9.1%

*County index values are calculated separately from zip code index values, and the two should not be compared to each other. While index values range from 0-100 at both the county and zip code level, zip code index values represent the percentile of each zip code among all U.S. zip codes, while county index values represent the percentile of each county among all U.S. counties

Appendix B. Index of Disparity

Health Equity Index (Figure 21)

ZIP CODE	CITY	INDEX SCORE
33701	Saint Petersburg	31
33702	Saint Petersburg	45.2
33703	Saint Petersburg	17.6
33704	Saint Petersburg	10.5
33705	Saint Petersburg	61
33706	Saint Petersburg	14.3
33707	Saint Petersburg, Gulfport, South Pasadena, Saint Pete Beach, Bear Creek	39.9
33708	Saint Petersburg, Madeira Beach, North Redington Beach, Redington Shore	17.8
33709	Saint Petersburg, Kenneth City, Pinellas Park, Seminole, Lealman	63.5
33710	Saint Petersburg	31
33711	Saint Petersburg, Gulfport	74.9
33712	Saint Petersburg	72.2
33713	Saint Petersburg	49.9
33714	Saint Petersburg, Pinellas Park, Lealman	85.4
33715	Saint Petersburg, Tierra Verde	7.9
33716	Saint Petersburg, Pinellas Park, Gandy	23.5
33755	Clearwater, Dunedin	73.7
33756	Clearwater, Belleair, Largo, Belleair Bluffs	72.2
33759	Clearwater	36
33760	Largo, Pinellas Park, Highpoint	67.6
33761	Clearwater, Safety Harbor	19.2
33762	Saint Petersburg, Feather Sound, Largo, Pinellas Park, Highpoint	16.5
33763	Clearwater, Dunedin	49.5
33764	Clearwater, Largo, Pinellas Park	38.8
33765	Clearwater	62
33767	Clearwater, Dunedin	10.1
33770	Largo, Belleair Bluffs, Harbor Bluffs	57.2
33771	Largo	61.3
33772	Seminole	26.6
33773	Largo, Pinellas Park	37.6
33774	Largo, Ridgecrest	42.6
33776	Seminole	10.5
33777	Seminole, Bardmoor, Pinellas Park	25.5
33778	Largo, Seminole, Ridgecrest	45.2
33781	Pinellas Park, Lealman	62.9
33782	Pinellas Park	51.2
33785	Indian Rocks Beach, Indian Shores	12.7
33786	Belleair Beach, Belleair Shore	9.9
34677	Oldsmar, East Lake	20.9
34681	Palm Harbor	20.4
34683	Palm Harbor, Dunedin	19.3
34684	Palm Harbor	23.8
34685	East Lake, Oldsmar	10.8
34688	Tarpon Springs, East Lake	8.6
34689	Tarpon Springs	47.3
34695	Safety Harbor	13.3
34698	Dunedin	39.4
-	**Pinellas county**	21.2

*County index values are calculated separately from zip code index values, and the two should not be compared to each other. While index values range from 0-100 at both the county and zip code level, zip code index values represent the percentile of each zip code among all U.S. zip codes, while county index values represent the percentile of each county among all U.S. counties.

Appendix B. Index of Disparity

Food Insecurity Index (Figure 22)

ZIP CODE	CITY	INDEX VALUE
33701	Saint Petersburg	33.7
33702	Saint Petersburg	51
33703	Saint Petersburg	23.9
33704	Saint Petersburg	14.8
33705	Saint Petersburg	73.1
33706	Saint Petersburg	6.7
33707	Saint Petersburg, Gulfport, South Pasadena, Saint Pete Beach, Bear Creek	39.1
33708	Saint Petersburg, Madeira Beach, North Redington Beach, Redington Shore	17.3
33709	Saint Petersburg, Kenneth City, Pinellas Park, Seminole, Lealman	63.1
33710	Saint Petersburg	36.2
33711	Saint Petersburg, Gulfport	80.3
33712	Saint Petersburg	89.7
33713	Saint Petersburg	51.2
33714	Saint Petersburg, Pinellas Park, Lealman	81.6
33715	Saint Petersburg, Tierra Verde	0.7
33716	Saint Petersburg, Pinellas Park, Gandy	46
33755	Clearwater, Dunedin	81.9
33756	Clearwater, Belleair, Largo, Belleair Bluffs	69.4
33759	Clearwater	54.4
33760	Largo, Pinellas Park, Highpoint	68
33761	Clearwater, Safety Harbor	27.5
33762	Saint Petersburg, Feather Sound, Largo, Pinellas Park, Highpoint	13.9
33763	Clearwater, Dunedin	40.3
33764	Clearwater, Largo, Pinellas Park	48
33765	Clearwater	67.3
33767	Clearwater, Dunedin	1.9
33770	Largo, Belleair Bluffs, Harbor Bluffs	60
33771	Largo	67.5
33772	Seminole	38.5
33773	Largo, Pinellas Park	50
33774	Largo, Ridgecrest	39.6
33776	Seminole	12.6
33777	Seminole, Bardmoor, Pinellas Park	39
33778	Largo, Seminole, Ridgecrest	48.9
33781	Pinellas Park, Lealman	64.2
33782	Pinellas Park	49.2
33785	Indian Rocks Beach, Indian Shores	5.4
33786	Belleair Beach, Belleair Shore	2.5
34677	Oldsmar, East Lake	31.9
34681	Palm Harbor	18.3
34683	Palm Harbor, Dunedin	27.8
34684	Palm Harbor	35.9
34685	East Lake, Oldsmar	12.1
34688	Tarpon Springs, East Lake	8.3
34689	Tarpon Springs	37.3
34695	Safety Harbor	16.2
34698	Dunedin	40.4
	PINELLAS COUNTY	26.4

*County index values are calculated separately from zip code index values, and the two should not be compared to each other. While index values range from 0-100 at both the county and zip code level, zip code index values represent the percentile of each zip code among all U.S. zip codes, while county index values represent the percentile of each county among all U.S. counties.

Appendix B. Index of Disparity

Mental Health Index (Figure 23)

ZIP CODE	CITY	INDEX VALUE
33701	Saint Petersburg	94
33702	Saint Petersburg	84.2
33703	Saint Petersburg	73.1
33704	Saint Petersburg	52
33705	Saint Petersburg	95.2
33706	Saint Petersburg	81.6
33707	Saint Petersburg, Gulfport, South Pasadena, Saint Pete Beach, Bear Creek	92.4
33708	Saint Petersburg, Madeira Beach, North Redington Beach, Redington Shore	81.6
33709	Saint Petersburg, Kenneth City, Pinellas Park, Seminole, Lealman	90.8
33710	Saint Petersburg	70.4
33711	Saint Petersburg, Gulfport	97
33712	Saint Petersburg	96.8
33713	Saint Petersburg	75.5
33714	Saint Petersburg, Pinellas Park, Lealman	91.7
33715	Saint Petersburg, Tierra Verde	70.2
33716	Saint Petersburg, Pinellas Park, Gandy	62
33755	Clearwater, Dunedin	92.9
33756	Clearwater, Belleair, Largo, Belleair Bluffs	95.4
33759	Clearwater	76.2
33760	Largo, Pinellas Park, Highpoint	72
33761	Clearwater, Safety Harbor	80.4
33762	Saint Petersburg, Feather Sound, Largo, Pinellas Park, Highpoint	49.5
33763	Clearwater, Dunedin	87.4
33764	Clearwater, Largo, Pinellas Park	82.1
33765	Clearwater	60.9
33767	Clearwater, Dunedin	81.4
33770	Largo, Belleair Bluffs, Harbor Bluffs	92.6
33771	Largo	94
33772	Seminole	84.4
33773	Largo, Pinellas Park	74.4
33774	Largo, Ridgecrest	91.6
33776	Seminole	56.5
33777	Seminole, Bardmoor, Pinellas Park	60.4
33778	Largo, Seminole, Ridgecrest	84.8
33781	Pinellas Park, Lealman	77.9
33782	Pinellas Park	85.3
33785	Indian Rocks Beach, Indian Shores	63.4
33786	Belleair Beach, Belleair Shore	64.1
34677	Oldsmar, East Lake	73.9
34683	Palm Harbor, Dunedin	64
34684	Palm Harbor	86.5
34685	East Lake, Oldsmar	50.2
34688	Tarpon Springs, East Lake	81.6
34689	Tarpon Springs	95
34695	Safety Harbor	69.4
34698	Dunedin	89.2
-	**PINELLAS COUNTY**	97.9

*County index values are calculated separately from zip code index values, and the two should not be compared to each other. While index values range from 0-100 at both the county and zip code level, zip code index values represent the percentile of each zip code among all U.S. zip codes, while county index values represent the percentile of each county among all U.S. counties.

Appendix C. Community Input Assessment Tools

This section contains tools that were used to collect community feedback during the CHNA process.

- **Community Health Assessment**
- **Focus Group Discussion Questions and Summary of Responses**
- **Prioritization Session Attendee Organizations**
- **Prioritization Session Questions and Summary of Responses**

Appendix C. Community Input Assessment Tools
Community Health Survey

All4HealthFL
Four Counties. One Vision.

2022 All4HealthFL Community Health Survey

This community health survey is supported by the All4HealthFL Collaborative comprised of local not-for-profit hospitals and the departments of health in Hillsborough, Pasco, Pinellas, and Polk counties. Our goal is to understand the health needs of the community members we serve. Your feedback is important for us to implement programs that will benefit everyone in the community.

We encourage you to take 15 minutes to fill out the survey below. Survey results will be available and shared broadly in the community within the next year. The responses that you provide will remain anonymous and not be attributed to you personally in any way. Your participation in this survey is completely voluntary and greatly appreciated.

Thank you for your time and feedback. Together we can improve health outcomes for all.

If you have any questions or concerns regarding this survey, please contact Corinna Kelley by email at corinna.kelley@conduent.com.

BayCare AdventHealth MOFFITT CANCER CENTER TGH Tampa General Hospital

In collaboration with: JOHNS HOPKINS All Children's Hospital

Florida HEALTH Pinellas County Florida HEALTH Hillsborough County Florida HEALTH Polk County Florida HEALTH Pasco County

BAYFRONT HEALTH St. Petersburg

Lakeland Regional Health

DEMOGRAPHICS

Please answer a few questions about yourself so that we can see how different types of people feel about local health issues.

1. **In which county do you live? (Please choose only one)**
   ☐ Hillsborough ☐ Pasco ☐ Pinellas ☐ Polk ☐ Sarasota ☐ Other

2. **In which ZIP code do you live? (Please write in)**
   _____

3. **What is your age? (Please choose only one)**
   ☐ 18 to 24 ☐ 25 to 34 ☐ 35 to 44 ☐ 45 to 54 ☐ 55 to 64 ☐ 65 to 74 ☐ 75 or older

4. **Are you of Hispanic or Latino origin or descent? (Please choose only one)**
   ☐ Yes, Hispanic or Latino ☐ No, not Hispanic or Latino ☐ Prefer not to answer

5. **Which race best describes you? (Please choose only one)**
   ☐ More than one race
   ☐ American Indian or Alaska Native
   ☐ Native Hawaiian or Pacific Islander
   ☐ I identify in another way: _____
   ☐ African American or Black
   ☐ Asian
   ☐ White
   ☐ Prefer not to answer

6. **What is your current gender identity? (Please choose only one)**
   ☐ Man
   ☐ Woman
   ☐ Trans Man/Trans Masculine Spectrum
   ☐ I identify in another way (Please Specify): _____
   ☐ Trans Woman/ Trans Feminine Spectrum
   ☐ Non-Binary/ Genderqueer
   ☐ Prefer not to answer

7. **Do you identify as LGBTQ+?**
   ☐ Yes ☐ No ☐ Prefer not to answer

8. **What language do you MAINLY speak at home? (Please choose only one)**
   ☐ Arabic ☐ Russian ☐ French
   ☐ Haitian Creole ☐ English ☐ Vietnamese
   ☐ Chinese ☐ Spanish ☐ German
   ☐ I speak another language (Please specify): _____

9. **How well do you speak English? (Please choose only one)**
   ☐ Very Well ☐ Well ☐ Not Well ☐ Not at All

10. **What is the highest level of school that you have completed? (Please choose only one)**
    ☐ Less than high school ☐ Some high school, but no diploma ☐ High school diploma or GED
    ☐ Some college, no degree ☐ Vocational/Technical School ☐ Associate degree
    ☐ Bachelor's degree ☐ Master's/Graduate or professional degree or higher

11. **How much total combined money did <u>all</u> people living in your home earn last year? (Please choose only one)**

☐ $0 to $9,999 ☐ $10,000 to $19,999 ☐ $20,000 to $29,999
☐ $30,000 to $39,999 ☐ $40,000 to $49,999 ☐ $50,000 to $59,999
☐ $60,000 to $69,999 ☐ $70,000 to $79,000 ☐ $80,000 to $89,999
☐ $90,000 to $99,999 ☐ $100,000 to $124,999 ☐ $125,000 to $149,999
☐ $150,000 or more ☐ Prefer not to answer

12. **Which of the following categories best describes your employment status? (Choose all that apply)**

☐ Employed, working full–time ☐ Retired
☐ Employed, working part–time ☐ Disabled, not able to work
☐ Not employed, looking for work ☐ Student (If so, what school: _____)
☐ Not employed, NOT looking for work

13. **What transportation do you use most often to go places? (Please choose only one)**

☐ I drive a car ☐ Someone drives me
☐ I take the bus ☐ I walk
☐ I ride a bicycle ☐ I take a taxi/cab
☐ I ride a motorcycle or scooter ☐ I take an Uber/Lyft
☐ Some other way

14. **Are you**

☐ A Veteran ☐ National Guard/Reserves
☐ In Active Duty ☐ None of the above **(Skip to question 16)**

15. **If Veteran, Active Duty, National Guard, or Reserves, are you receiving care at the VA?**

☐ Yes ☐ No

16. **How do you pay for most of your health care? (Please choose only one)**

☐ I pay cash / I don't have insurance ☐ TRICARE
☐ Medicare or Medicare HMO ☐ Indian Health Services
☐ Medicaid or Medicaid HMO ☐ Veteran's Administration
☐ Marketplace insurance plan
☐ County health plan
☐ Commercial health insurance (from Employer)
☐ I pay another way: _____

17. **Including yourself, how many people currently live in your home? (Please choose only one)**

☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or more

18. **Are you a caregiver to an adult family member who cannot care for themselves in your home?**

☐ Yes ☐ No

19. **How many CHILDREN (under age 18) currently live in your home? (Please choose only one)**

☐ None **(Skip to question 28)** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or more

CHILDRENS SECTION

(Please only answer questions in this section if you have children under the age of 18 living in your home. If you do not, please skip to Question 28 in the next section.)

The goal of the next question is to understand what you think are the most important HEALTH needs for children in your community. Please answer the next question about children who live in your community, not just your children.

20. **Was there a time in the PAST 12 MONTHS when children in your home needed medical care but did NOT get the care they needed?**
☐ Yes ☐ No **(skip to question 22)**

21. **What are some reasons that kept them from getting the medical care they needed? (Choose all that apply)**
☐ Am not sure how to find a doctor
☐ Cannot take time off work
☐ Cannot take child out of class
☐ Doctor's office does not have convenient hours
☐ Unable to schedule an appointment when needed
☐ Unable to find a doctor who knows or understands my culture, identity, or beliefs
☐ Unable to afford to pay for care
☐ Unable to find a doctor who takes my insurance
☐ Do not have insurance to cover medical
☐ Transportation challenges
☐ Other (please specify): _____

22. **Was there a time in the PAST 12 MONTHS when children in your home needed dental care but did NOT get the care they needed?**
☐ Yes ☐ No **(skip to question 24)**

23. **What are some reasons that kept them from getting the dental care they needed? (Choose all that apply)**
☐ Am not sure how to find a dentist
☐ Cannot take time off work
☐ Cannot take child out of class
☐ Dentist's office does not have convenient hours
☐ Unable to schedule an appointment when needed
☐ Unable to find a dentist who knows or understands my culture, identity, or beliefs
☐ Unable to afford to pay for care
☐ Unable to find a dentist who takes my insurance
☐ Do not have insurance to cover dental care
☐ Transportation challenges
☐ Other (please specify): _____

24. **Was there a time in the PAST 12 MONTHS when children in your home needed mental and/or behavioral health care but did NOT get the care they needed?**
☐ Yes ☐ No **(skip to question 26)**

25. What are some reasons that kept them from getting the mental and/or behavioral health care they needed? (Choose all that apply)

- ☐ Am not sure how to find a doctor/counselor
- ☐ Unable to afford to pay for care
- ☐ Unable to find a doctor / counselor who takes my insurance
- ☐ Cannot take time off work
- ☐ Do not have insurance to cover mental health care
- ☐ Cannot take child out of class
- ☐ Doctor/counselor's office does not have convenient hours
- ☐ Afraid of what people might think
- ☐ Unable to schedule an appointment when needed
- ☐ Transportation challenges
- ☐ Unable to find a doctor/counselor who knows or understands my culture, identity, or beliefs
- ☐ Other (please specify) _____

--Children's Section Continues on Next Page --

The goal of the next question (Question 26) is to understand what you think are the most important HEALTH needs for children in your community. Please answer the next question about children who live in your community, not just your children.

In this survey "community" refers to the primary areas where your children live, play, learn and get services.

26. When you think about the most important HEALTH needs for children in your community, please select the top 3 most important health needs to address. If you think of a health concern that is not listed here, please write it in under "other". (Please choose only 3)

Please choose only 3	
☐	Accidents and Injuries
☐	Asthma
☐	Respiratory Health Other than Asthma (RSV, cystic fibrosis)
☐	Dental Care
☐	Diabetes
☐	Drug or Alcohol Use
☐	Eye Health (vision)
☐	Healthy Pregnancies and Childbirth (not teen pregnancy)
☐	Immunizations (common childhood vaccines, like mumps, measles, chicken pox, etc.)
☐	Infectious Diseases (including COVID-19)
☐	Special Needs (Physical / Chronic / Behavioral / Developmental / Emotional)
☐	Medically Complex
☐	Attention-Deficit/Hyperactivity Disorder (ADHD)
☐	Mental or Behavioral Health
☐	Healthy Food / Nutrition
☐	Obesity
☐	Physical activity
☐	Safe Sex Practices and Teen Pregnancy
☐	Sexual Identity of Child
☐	Suicide Prevention
☐	Vaping, Cigarette, Cigar, Cigarillo, or E-cigarette Use
☐	Other (please specify concern):

The goal of the next question (Question 27) is to understand what you think are OTHER important needs or concerns that affect child health in your community. Please answer the next question about children who live in your community, not just your children.

27. When you think about OTHER important needs or concerns that affect child health in your community, please rank the top 3 critical needs or concerns most important to address. If you think of a concern that is not listed here, please write it under "other". (Please choose only 3)

Please choose only 3	
☐	Access to benefits (Medicaid, WIC, SNAP/Food Stamps)
☐	Access to or cost of childcare
☐	Bullying and other stressors in school
☐	Domestic violence, child abuse and/or child neglect
☐	Crime and community violence
☐	Educational needs
☐	Family member alcohol or drug use
☐	Housing
☐	Human trafficking
☐	Hunger or access to healthy food
☐	Lack of employment opportunities
☐	Legal problems
☐	Language Barriers
☐	Parenting education (parenting skills for child development)
☐	Safe neighborhoods and places for children to play
☐	Social media
☐	Traffic safety
☐	Transportation challenges
☐	Other (please specify concern):

--End Children's Section --

These next questions are about your view or opinion of the community in which you live.
In this survey "community" refers to the primary areas where you live, shop, play work, and get services

28. Overall, how would you rate the health of the community in which you live? (Please choose only one)

☐ Very unhealthy ☐ Unhealthy ☐ Somewhat healthy ☐ Healthy ☐ Very healthy
☐ Not sure

29. Please read the list of <u>risky behaviors</u> listed below. Which 3 do you believe are the most harmful to the overall health of your community? (Please choose only 3)

<u>Please choose only 3</u>	
☐	Alcohol abuse/drinking too much alcohol (beer, wine, spirits, mixed drinks)
☐	Dropping out of school
☐	Illegal drug use/abuse or misuse of prescription medications
☐	Lack of exercise
☐	Poor eating habits
☐	Not getting "shots" to prevent disease
☐	Not wearing helmets
☐	Not using seat belts/not using child safety seats
☐	Vaping, Cigarette, Cigar, Cigarillo, or E-cigarette Use
☐	Unsafe sex including not using birth control
☐	Distracted driving (texting, eating, talking on the phone)
☐	Not locking up guns
☐	Not seeing a doctor while you are pregnant

30. **Read the list of <u>health problems</u> and think about your community. Which of these do you believe are most important to address to improve the health of your community? (Please choose only 3)**

<u>Please choose only 3</u>	
☐	Aging Problems (for example: difficulty getting around, dementia, arthritis)
☐	Cancers
☐	Child Abuse / Neglect
☐	Clean Environment / Air and Water Quality
☐	Climate Change
☐	Dental Problems
☐	Diabetes / High Blood Sugar
☐	Domestic Violence / Rape / Sexual Assault / Human Trafficking
☐	Gun-Related Injuries
☐	Being Overweight
☐	Mental Health Problems Including Suicide
☐	Illegal Drug Use/Abuse of Prescription Medications and Alcohol Abuse/Drinking Too Much
☐	Heart Disease / Stroke / High Blood Pressure
☐	HIV/AIDS / Sexually Transmitted Diseases (STDs)
☐	Homicide
☐	Infectious Diseases Like Hepatitis, TB, and COVID-19
☐	Motor Vehicle Crash Injuries
☐	Infant Death
☐	Respiratory / Lung Disease
☐	Teenage Pregnancy

31. **Please read the list below. Which do you believe are the 3 most important factors to improve the quality of life in a community? (Please choose only 3)**

Please choose only 3	
☐	Good Place to Raise Children
☐	Low Crime / Safe Neighborhoods
☐	Good Schools
☐	Access to Health Care
☐	Parks and Recreation
☐	Clean Environment / Air and Water Quality
☐	Low-Cost Housing
☐	Arts and Cultural Events
☐	Low-Cost Health Insurance
☐	Tolerance / Embracing Diversity
☐	Good Jobs and Healthy Economy
☐	Strong Family Life
☐	Access to Low-Cost, Healthy Food
☐	Healthy Behaviors and Lifestyles
☐	Sidewalks / Walking Safety
☐	Public Transportation
☐	Religious or Spiritual Values
☐	Disaster Preparedness
☐	Emergency Medical Services
☐	Access to Good Health Information
☐	Strong Community/Community Knows and Supports Each Other

32. Below are some statements about your local community. Please tell us if you agree or disagree with each statement.

	Agree	Disagree	Not Sure
Illegal drug use/prescription medicine abuse is a problem in my community.	☐	☐	☐
I have no problem getting the health care services I need.	☐	☐	☐
We have great parks and recreational facilities.	☐	☐	☐
Public transportation is easy to get to if I need it.	☐	☐	☐
There are plenty of jobs available for those who want them.	☐	☐	☐
Crime is a problem in my community.	☐	☐	☐
Air pollution is a problem in my community	☐	☐	☐
I feel safe in my community.	☐	☐	☐
There are affordable places to live in my community.	☐	☐	☐
The quality of health care is good in my community.	☐	☐	☐
There are good sidewalks for walking safely.	☐	☐	☐
I am able to get healthy food easily.	☐	☐	☐

33. Below are some statements about your connections with the people in your life. Please tell us if you agree or disagree with each statement.

	Agree	Disagree	Not Sure
I am happy with my friendships and relationships	☐	☐	☐
I have enough people I can ask for help at any time	☐	☐	☐
My relationships and friendships are as satisfying as I would want them to be	☐	☐	☐

34. Over the past 12 months, how often have you had thoughts that you would be better off dead or of hurting yourself in some way? (Please choose only one)

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

If you would like help with or would like to talk about these issues, please call the National Suicide Prevention Hotline at 1-800-273-8255.

35. **In the past 12 months, I worried about whether our food would run out before we got money to buy more. (Please choose only one)**
☐ Often true ☐ Sometimes true ☐ Never true

36. **In the past 12 months, the food that we bought just did not last, and we did not have money to get more. (Please choose only one)**
☐ Often true ☐ Sometimes true ☐ Never true

37. **In the last 12 months, did you or anyone living in your home ever get emergency food from a church, a food pantry, or a food bank, or eat in a soup kitchen?**
☐ Yes ☐ No

38. **Do you eat at least 5 cups of fruits or vegetables every day?**
☐ Yes ☐ No

39. **How many times a week do you usually do 30 minutes or more of moderate-intensity physical activity or walking that increases your heart rate or makes you breathe harder than normal? (Please choose only one)**
☐ 5 or more times a week ☐ 3-4 times a week ☐ 1-2 times a week ☐ none

40. **Has there been any time in the past 2 years when you were living on the street, in a car, or in a temporary shelter?**
☐ Yes ☐ No

41. **Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay?**
☐ Yes ☐ No

42. **In the past 12 months, has your utility company shut off your service for not paying your bills?**
☐ Yes ☐ No

--Survey continues on next page --

PERSONAL HEALTH

These next questions are about your personal health and your opinions about getting health care in your community. In this survey "community" refers to the primary areas where you live, shop, work, and get services.

43. Overall, how would you rate YOUR OWN PERSONAL health? (Please choose only one)

☐ Very unhealthy ☐ Unhealthy ☐ Somewhat healthy ☐ Healthy ☐ Very healthy
☐ Not sure

44. Was there a time in the PAST 12 MONTHS when you needed medical care but did NOT get the care you needed?

☐ Yes ☐ No **(Skip to question 46)**

45. What are some reasons that kept you from getting medical care? (Choose all that apply)

☐ Unable to schedule an appointment when needed
☐ Unable to find a doctor who takes my insurance
☐ Doctor's office does not have convenient hours
☐ Do not have insurance to cover medical care
☐ Unable to find a doctor who knows or understands my culture, identity, or beliefs
☐ Am not sure how to find a doctor
☐ Unable to afford to pay for care
☐ Transportation challenges
☐ Cannot take time off work
☐ Other (please specify)_____

46. Thinking about your MENTAL health, which includes stress, depression, and problems with emotions, how would you rate your overall mental health? (Please choose only one)

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Not Sure

47. Was there a time in the PAST 12 MONTHS when you needed mental health care but did NOT get the care you needed?

☐ Yes ☐ No **(Skip to question 49)**

48. What are some reasons that kept you from getting mental health care? (Choose all that apply)

☐ Am not sure how to find a doctor / counselor
☐ Unable to schedule an appointment when needed
☐ Do not have insurance to cover mental health care
☐ Unable to find a doctor / counselor who takes my insurance
☐ Doctor / counselor office does not have convenient hours
☐ Unable to find a doctor / counselor who knows or understands my culture, identity, or beliefs
☐ Unable to afford to pay for care
☐ Transportation challenges
☐ Fear of family or community
☐ Cannot take time off work
☐ Other (please specify):_____

49. Was there a time in the PAST 12 MONTHS when you needed DENTAL care but did NOT get the care you needed?

☐ Yes ☐ No **(Skip to question 51)**

50. What are some reason(s) that kept you from getting dental care? (Choose all that apply)

- ☐ Unable to schedule an appointment when needed
- ☐ Do not have insurance to cover dental care
- ☐ Dentist office does not have convenient hours
- ☐ Unable to find a dentist who takes my insurance
- ☐ Unable to find a dentist who knows or understands my culture, identity, or beliefs
- ☐ Am not sure how to find a dentist
- ☐ Unable to afford to pay for care
- ☐ Transportation challenges
- ☐ Cannot take time off work
- ☐ Other _____

51. In the past 12 months, how many times have you gone to a hospital emergency room (ER) about your own health? (Please choose only one)

☐ 1time ☐ 2 times ☐ 3-4 times ☐ 5-9 times ☐ 10 or more times

☐ I have not gone to a hospital ER in the past 12 months **(Skip to question 53)**

52. What are the MAIN reason(s) you used the emergency room INSTEAD of going to a doctor's office or clinic? (Choose all that apply)

- ☐ After hours / Weekend
- ☐ Long wait for an appointment with my regular doctor
- ☐ Emergency / Life-threatening situation
- ☐ Other
- ☐ I don't have a doctor / clinic
- ☐ Cost
- ☐ I don't have insurance

53. Have you ever been told by a doctor or other medical provider that you had any of the following health issues? (Choose all that apply)

Cancer	☐
Depression or Anxiety	☐
Diabetes / High Blood Sugar	☐
HIV / AIDS	☐
COPD	☐

Heart disease	☐
High blood pressure / Hypertension	☐
Obesity	☐
Stroke	☐
None of These	☐

54. How often do you use any of the following products: chewing tobacco, snuff, snus, dip, cigarettes, cigars or little cigars? (Please choose only one)

- ☐ I do not use these products
- ☐ Once a day
- ☐ On some days
- ☐ More than once a day

55. How often do you use any of the following electronic vapor products: e-cigarettes, e-cigars, e-hookahs, e-pipes, hookah pens, vape pipes, and vape pens? (Please choose only one)

- ☐ I do not use these products
- ☐ Once a day
- ☐ On some days
- ☐ More than once a day

56. Have you experienced any losses related to the COVID-19 pandemic? (Choose all that apply)

- ☐ None
- ☐ Income
- ☐ Health Insurance
- ☐ Childcare
- ☐ Social support/connection
- ☐ Recreation or entertainment
- ☐ Exercise opportunities
- ☐ Utilities turned off
- ☐ Job (layoff, furlough, hours reduction)
- ☐ Housing
- ☐ Transportation
- ☐ Regular school routine
- ☐ Sense of well-being, security, or hope
- ☐ Food Resources
- ☐ Death of family member or friend
- ☐ Other (please specify): _____

57. In your day-to-day life how often have any of the following things happened to you?

	At least once a week	**A few times a month**	**A few times a year**	**Never**
You are treated with less courtesy or respect than other people	☐	☐	☐	☐
You receive poorer service than other people at restaurants or stores	☐	☐	☐	☐
People act as if they think you are not smart	☐	☐	☐	☐
People act as if they are afraid of you	☐	☐	☐	☐
You are threatened or harassed	☐	☐	☐	☐
People criticized your accent or the way you speak	☐	☐	☐	☐

58. What do you think is the main reason(s) for these experiences? (Choose all that apply)

- ☐ Your Ancestry or National Origins
- ☐ Your Race
- ☐ Your Religion
- ☐ Your Weight
- ☐ Some other Aspect of Your Physical Appearance
- ☐ Your Education or Income Level
- ☐ Your Gender
- ☐ Your Age
- ☐ Your Height
- ☐ Your Sexual Orientation
- ☐ A physical disability
- ☐ I have not had these experiences

ADVERSE CHILDHOOD EXPERIENCES

The final question is about ACEs, adverse childhood experiences, that happened during your childhood. This information will allow us to better understand how problems that may occur early in life can have a health impact later in life. This is a sensitive topic, and some people may feel uncomfortable with these questions. If you prefer not to answer these questions, you may skip them.

For this question, please think back to the time BEFORE you were 18 years of age.

59. From the list of events below, please check the box next to events you experienced BEFORE the age of 18. (Choose all that apply)

- ☐ Lived with anyone who was depressed, mentally ill, or suicidal
- ☐ Lived with anyone who was a problem drinker or alcoholic
- ☐ Lived with anyone who used illegal street drugs or who abused prescription medications
- ☐ Lived with anyone who served time or was sentenced to serve time in prison, jail, or other correctional facility
- ☐ Parents were separated or divorced
- ☐ Parents or adults experienced physical harm (slap, hit, kick, etc.)
- ☐ Parent or adult physically harmed you (slap, hit, kick, etc.)
- ☐ Parent or adult verbally harmed you (swear, insult, or put down)
- ☐ Adult or anyone at least 5 years older touched you sexually
- ☐ Adult or anyone at least 5 years older made you touch them sexually
- ☐ Adult or anyone at least 5 years older forced you to have sex

Thank you for taking the time to participate in this community survey. Your feedback and insight are vital as we work to improve and address issues impacting our community's health.

--Helpful community resource information is provided on the next page --

RESOURCE LIST

Please find the list of community resources used for this Community Health Needs Assessment Survey.

FindHelp.org

Search and connect to support. Financial assistance, food pantries, medical care, and other free or reduced-cost help starts here.

United Way 211

Simply call 211 to speak to someone now, or search by location for online resources and more contact information.

National Suicide Prevention Lifeline

The Lifeline provides 24/7, free and confidential support for people in distress and prevention and crisis resources for you or your loved ones.
1-800-273-8255

Crisis Text Line

Crisis Text Line provides free, 24/7 support via text message. We're here for everything: anxiety, depression, suicide, school.
Text HOME to 741741

Hillsborough County

Resources to Help You with Mental Health

Pasco County

National Alliance on Mental Illness, Pasco County
NAMI Pasco, an affiliate of the National Alliance on Mental Illness is a 501(c)3 not-for-profit organization that provides free support, advocacy, outreach, and education to those with mental health conditions and their loved ones.

Pinellas County

National Alliance on Mental Illness, Pinellas County
NAMI (National Alliance on Mental Illness) Pinellas supports individuals & loved ones affected by mental illness so that they can build better lives.

Polk County

Peace River Center
Peace River Center's Mobile Crisis Response Team (MCRT) is a free 24-hour community resource available to anyone experiencing emotional distress.
The free 24-hour Crisis Line is (863) 519-3744 or (800) 627-5906.

Information on Adverse Childhood Experiences

PACEs Connection
PACEs Connection is a social network that recognizes the impact of a wide variety of adverse childhood experiences (ACEs) in shaping adult behavior and health, and that promotes trauma-informed and resilience-building practices and policies in all families, organizations, systems and communities.

Recognizing and Treating Child Traumatic Stress

Learn about the signs of traumatic stress, its impact on children, treatment options, and how families and caregivers can help.

TedTalk: How Childhood Trauma Affects Health Across a Lifetime

Nadine Burke Harris reveals a little-understood, yet universal factor in childhood that can profoundly impact adult-onset disease

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

Community Engagement 4Black/African American

Real-Time Record

November 16, 2021, 2:00pm-3:30pm

Collaborative LABS at St. Petersburg College

EXPERT FACILITATORS IN STRATEGIC COLLABORATION

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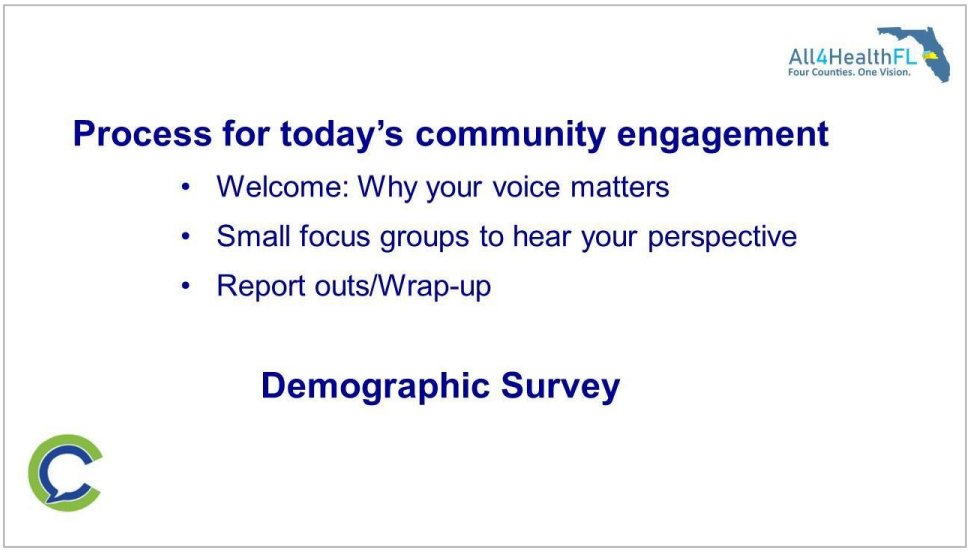
Welcome

Facilitator, Collaborative Labs: Welcome to the All4HealthFL community engagement this afternoon! St. Petersburg College Collaborative Labs is proud to be a partner today. Thank youfor being here with us today.



Today, we will hear why your voice matters, break out into focus groups, and then hear reports from the groups and wrap up.

We also have a demographic survey we ask you to complete to tell us about yourself, which willbe used later to understand diversity of the focus group. Everything is anonymous and there will be no names in the final report. Perspective of entire community.

Hello! Thank you for being here today. The purpose of the All4HealthFL Collaborative is to improve health by leading regional, outcome-driven health initiatives that have been prioritized through community health assessments. The All4HealthFL Collaborative includes all of the not-for-profit hospitals and the department of health for Hillsborough, Pasco, Pinellas, and Polk counties.

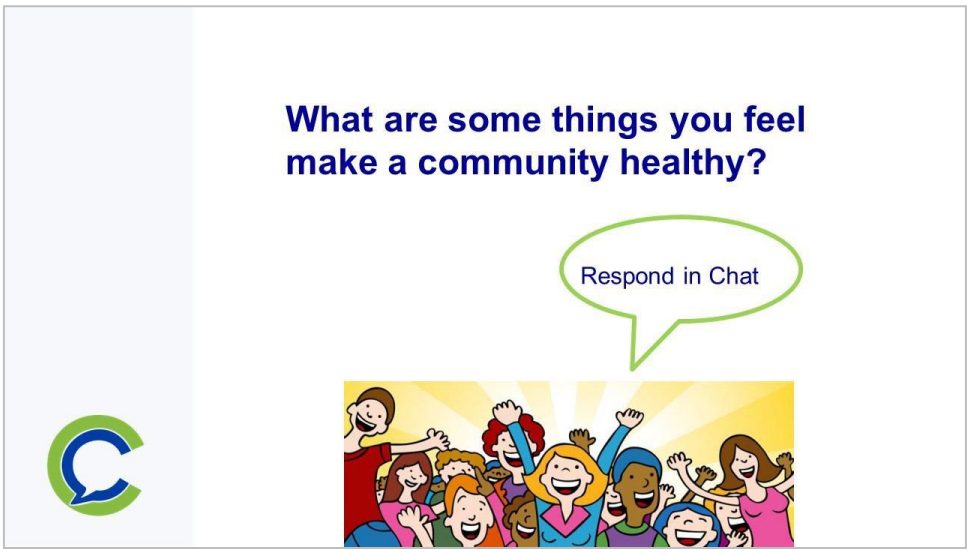
We are so pleased to have each and every one of you present and participating in these focus groups today. We value the unique perspectives and lived experiences you bring with you today. We'll be asking you for your thoughts, opinions, and experiences about the strengths ofour community, the challenges or barriers that exist to accessing care and resources, and who in our community is most impacted by those challenges.

We have the opportunity to go deep today. Let's be caring, kind, and respectful today as weshare with one another, acknowledging the courage and bravery it takes to share from our personal experiences. Know that your personal identity stays within this group and will not be

shared in any of our summary reports or information used to inform our efforts. Your overall feedback will help us create stronger programs and services to meet the needs of our community over the next three to four years.

Thank you again for participating with us today. We know your time is valuable and are gratefulyou have shared this day with us. Welcome!

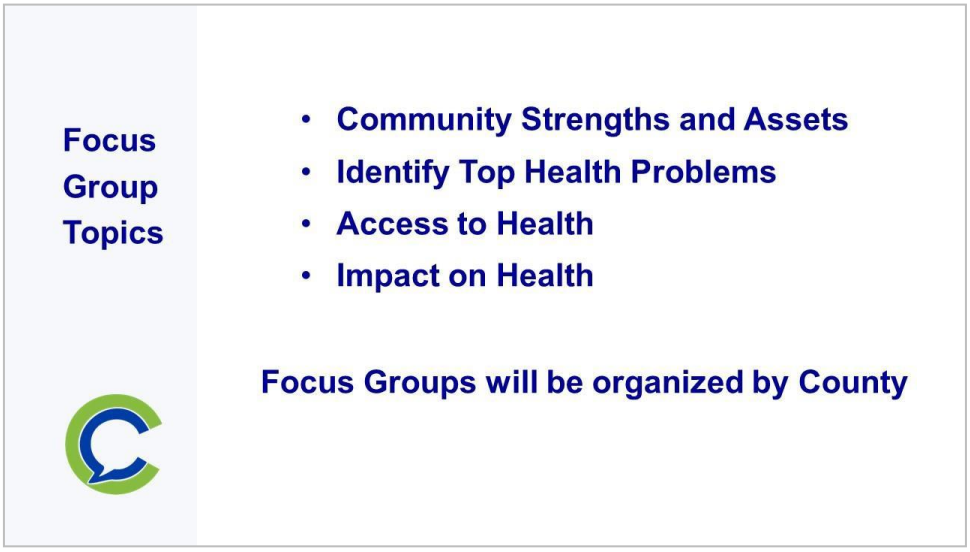
We have a quick warm up activity to start with. What are some things you feel make a community healthy?



Comments from Chat:

- The feeling of being safe
- Time with people who are good for us
- Mental wellbeing and working together for the same outcome
- Access to free mental health services
- A healthy community needs access to health care
- Us come together
- Communities that are not food deserts.
- Arts and Culture
- Communication
- Access to healthcare
- Communication with one another
- Education pro-active healthcare
- Agreed. Communication.
- Food Banks
- Equitable access
- Opportunities
- Definitely the networking and communication of all the above
- Healthy workplace

- Having community outreach programs that continue to target the homeless and thosenot open to visiting hospitals
- Drug-free community



These are our topics for today and we have four counties represented and a bonus Haitian community.

Pinellas County Focus Group

Community Strengths & Assets

What is something that you enjoy about your community or is a strength of your community?

- Togetherness (neighbor native), village concept (huge loss for youth), caring neighbors
- Walkable community, easy access to businesses
- Working with those dedicated to common goals
- Building homes (Habitat for Humanity) - adding value
- Access to healthcare facilities – beyond hospitals, clinics – developed in our community
- Tight-knit, good communication, willing to ask for help

From Chat:

- Growth in the city in itself
- The blue card is good but some of the services that are needed that the blue carddoes not provide

Identify Top Health Problems

What do you see as the 2-3 most important issues that must be addressed toimprove health and quality of life in your community?

- Limited healthcare services
- Housing – lack of availability; affordable housing, stressful process to find adequate housing and additional fees (1st and last deposit, application fee, background checks, etc.)
- Mental health services
- Alcohol and drug abuse assistance
- Awareness of need – accountability and follow-through, application
- Language and literacy barriers
- Economic development – things available for sustainability
- Infrastructure to sustain healthy lifestyle
- A need to reimagine how the community functions as its core

From Chat:

- Being in the hospital, some services that are needed as an outpatient are limited
- Continuing education on routine examinations
- Affordable housing
- Witnessed yesterday brown and black folks with language and literacy barriers
- There is a problem with compliance of individuals not following up with providers as instructed, even when things are set up and medications are provided prior to discharge along with education

Access to Health

Do you think everyone has access to what they need to be healthy?

- Income – access to resources; greater or less access, lack of finances
- Self-advocacy and healthy lifestyle (preventative measures)
- Resources – availability of and utilization of programs and services
- Level of awareness
- Public and personal distrust
- Community buy-in

From Chat:

- Economic status plays a major role
- The resources are there but getting people to take part in the programs available is the barrier, now how do we go about getting the public to participate in the things isthe problem

Impact on Health

What external factors do you feel have an impact on your health, based on aspectsof your identity?

- Black man – fear of what may happen, judgement? Created stress – impacted jobsand clients pursued (did some personal work)
- Racism as a black woman – media, portrayal and what is happening to others; mental health is impacted; stigma associated with mental health
- Always trying to uphold the role of being a strong leader as a black women can be stressful
- Black man, parent of two children – provision of child support; stress of comparison and trying to prove self ("man, figure it out"), time consuming, low income, cycle of trying to make it
- Work environment and working conditions
- Cost of medication; having to prioritize food/medicine
- Adequate income sometimes limiting access to needed services; stressful

From Chat:

- Public and personal distrust and a lack of finances will lead many to stay away from seeking assistance regardless of if the help is there…
- Applaud Audrey for being her own self advocate
- We need more people that look like you to assist
- Always trying to uphold the role of being a strong leader as a black women can be stressful

Haitian Community Focus Group

Community Strengths & Assets

What is something that you enjoy about your community or is a strength of your community?

- (Two mentions) Resources: A lot of resources, not a lot of awareness of those resources and making sure people trust us when using those resources.
- Assets: People don't know where to find them and how to use them when they're struggling.
- Connection: We work with sister churches and work with one another to serve the community. People feel comfortable in the church.
- School resources: Resources are available even to online services, such as financialaid, mental health, and tutoring.

Identify Top Health Problems

What do you see as the 2-3 most important issues that must be addressed toimprove health and quality of life in your community?

- (3 mentions) Suicide/mental health/wellbeing: especially among teens in high school/college, stress and anxiety that goes unaddressed, isolation. Not enough services for children transitioning from school to school (e.g., elementary to middle, middle to high).
- Chronic diseases: diabetes, cardiovascular disease, especially in the minority community.
- (2 mentions) Food insecurity: lots of food deserts, just liquor stores; need land to plant vegetables and raise animals, too many dollar stores
- Access to care: high cost of drugs, low access to pharmaceuticals
- Transportation: Roads are not safe to walk, no sidewalks in some areas, no crosswalks in others
- (2 mentions) Stigma – black men don't want to go to the doctor and be told something is wrong, there's a fear and a stigma, pride, "they don't tell me what I don't know. I don't want to know." Harder for men than for women.
- Physical well-being: lower stigma associated with going to the doctor
- (2 mentions) Trust: Tuskegee and other betrayals among black community, the painof black men and women is not trusted by doctors or rated as truthful

Access to Health

Do you think everyone has access to what they need to be healthy?

- (2 mentions) Cost of care: people lack insurance, the cost of the care with or without insurance may be too much, providers should offer various options for payment evenif they have insurance.
- (2 mentions) Knowledge/Access: People may not know how much the cost is or how to approach paying. People don't know if they will even see a doctor.
- Stigma: people don't know and don't want to ask how to get care
- Food: providers don't speak about health differently than people may understand.
- Quality of care: providers may work quantity over quality
- (2 mentions) Trust: people don't trust free clinics "They're gonna want something," will wait until they end up in the ER, "they see you for five seconds, don't like your insurance, and treat you differently."

- Whole person care: providers need to ask about things beyond your physical health: how to pay, if you need prayer, if you are doing okay, exercise, are you taking care of yourself

Impact on Health

What external factors do you feel have an impact on your health, based on aspectsof your identity?

- (3 mentions) Culture: "We don't seek help, there is no mental health, we take care of this in the family." In Haitian culture, we have alternative treatments (e.g., herbaltea) we depend on before we go to the doctor.
- Delay of care: care is put off for chronic conditions and mental health until it is toolate and not prevented.
- (3 mentions) Cost: only went to doctor if it was absolutely necessary because funds were tight, even with insurance, weighing the cost of the care with taking care of family, "I'd rather not pay hundreds of dollars to then be told to buy some pills." A lot of people are only paid monthly, so when the money goes short at the end of themonth, you aren't thinking about going to the doctor, you never want your kids or your family to know you're broke. We didn't have notebooks, we had slate and scratched it off when we were done.
- Insurance: only those with full-time jobs and/or a college education have insurance
- Time of care: parents don't want kids to miss school
- Being female: there are things you are not taught that you should be taught as a woman
- (2 mentions) Dentistry: we used salt to brush our teeth because we didn't have toothpaste. I didn't go to dentist until my spouse forced me to, "Why would I pay someone to brush my teeth?"
- Knowledge: if we are not familiar with the language of health, then I'm afraid you're trying to trick me.
- Fear/stigma/(shame?): when you don't have care as a kid, you don't want to go to find out how bad it has become
- *Copy comment about AdventHealth and collaborative for support and assistance, great quote to use for report (Grace comment at the end)

Wrap-Up and Next Steps

Welcome back! We are now going to share some of the "golden nuggets" from each of the breakout groups.

Team 3 – Pinellas County

Strengths: togetherness and caring of community members, working together on dedicated goals, service providers, and good communication

- Problems: housing, mental health services, awareness of need, literacy barriers, economic need, and infrastructure to support a healthy lifestyle
- Access to health: personal distrust, community buy-in and self-advocacy

- Impact: fear, judgement, comparison to others, stereotypes and expectations, incomesthat do not allow you to qualify for needed services

Thank you all for your participation today and providing your stories. Your information will be collected into community health needs assessment. Have a wonderful day!

Community Engagement 6Hispanic

Real-Time Record

November 17, 2021, 2:00pm-3:30pm

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Welcome

Facilitator, Collaborative Labs: Welcome to the All4HealthFL community engagement. I amwith Collaborative Labs at St. Petersburg College, and we are facilitating today's meeting. Thankyou for joining us!

Today we will hear why your voice matters, break out into focus groups, and then hear reports from the groups and wrap up.

We also have a demographic survey we ask you to complete to tell us about yourself, which willbe used later to understand diversity of the focus group. Everything is anonymous and there will be no names in the final report. Perspective of entire community.

Hello everyone, thank you for joining us today in this important conversation.

The purpose of the All4HealthFL Collaborative is to improve health by leading regional, outcome-driven health initiatives that have been prioritized through community health assessments. The All4HealthFL Collaborative includes all of the not-for-profit hospitals and thedepartment of health for Hillsborough, Pasco, Pinellas, and Polk counties.

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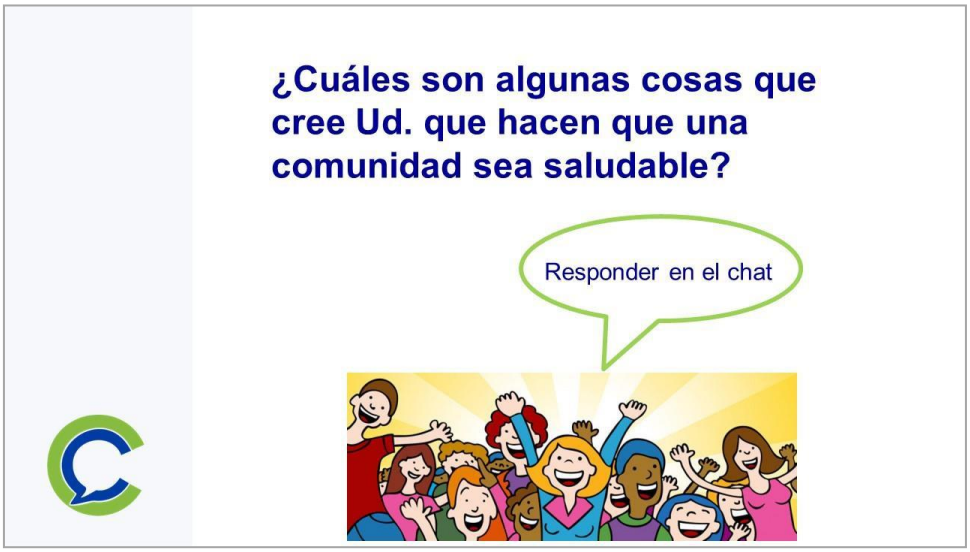
Thank you again for participating with us today. We know your time is valuable and are gratefulyou have shared this day with us.

We have a quick warm up activity to start with. What are some things you feel make a community healthy? Please respond in chat.

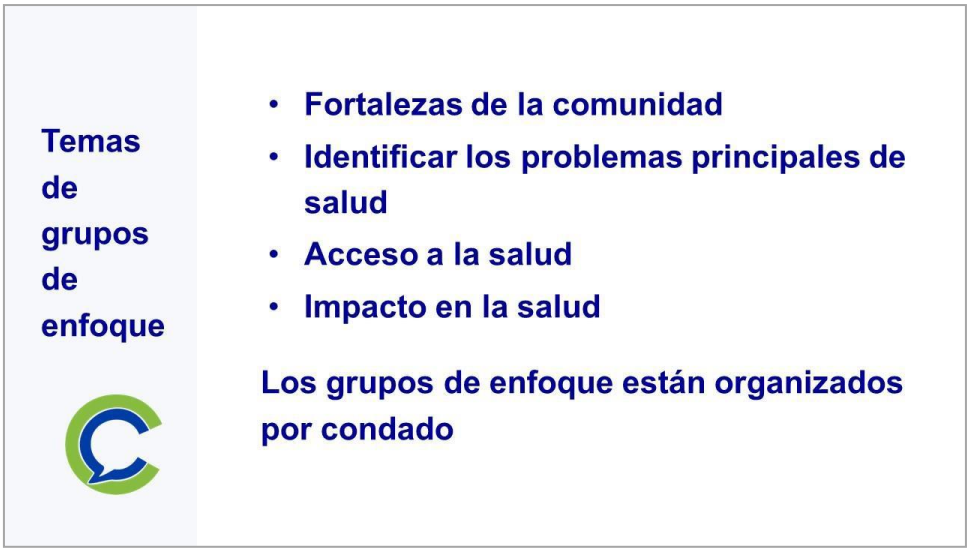


From Chat:

¿Cuáles son algunas cosas que cree Ud. que hacen que una comunidad sea saludable?

- Welcoming environment
- Education
- Access to health care
- Educacion
- Access to health care and education
- Amor, energia, solidaridad, humildad
- A united community
- Equal access to care and education on health
- Access to healthy foods
- Access to basic services gives
- Access to healthcare
- Services to be accessible
- Having a shared sense of community
- Fair and equal treatment
- Transportation services

- Seguridad, safety
- Transportation
- Que tengan acceso a salud mental, comida saludable, y acceso doctores que entiendanla comunidad
- Not being alone!
- Mental health
- Cultura - culture “la cultura cura”
- Access to health care and health plan to cover wellness programs and nutritionist professionals
- Education + Awareness + access to available resources
- Education, transportation, access to resources, parks and recreation, healthy foods
- Educacion de salud y alimentacion saludable
- Services in your own language
- Access to affordable care



These are our topics for today and we have four counties represented.

Pinellas County Focus Group

Community Strengths & Assets

What is something that you enjoy about your community or is a strength of your community?

- The number of parks and recreation available
- Sense of not feeling alone. Sense of community at a countywide level
- Pinellas schools, Health Department, County – information in both languages
- Internal diversity as LatinX community
- Change in food diversity and sense of culture
- TB Rays – diverse team, very involved within the community

From Chat:

- I enjoy the diversity of food and the community surrounding it

Identify Top Health Problems

What do you see as the 2-3 most important issues that must be addressed toimprove health and quality of life in your community?

- Health care system for the elderly is very fragmented. Information and services are very confusing. Not enough in Spanish.
- Hispanic community suffers from the same problems as the rest of the communities. Mental health is at the extreme.

- Too many expenses - don't take medications or follow up health care because of paying for other things. English speaking community has more access to entities thathelp them. There is a need for entities that help both.
- The information is very fragmented, especially for those that do not speak English asa primary language. I would add the stigma of talking about communicable diseases especially those sexually transmitted or related to drug use. Family is important to our community and if you can't speak to family, you can feel isolated.
- Latino patients wait a long time to get tested for HIV - drugs are too expensive.
- Hospice - patients come in telling everything that has happened to them through the process.
- Microaggressions - patients hear comments in the hospital that prevent the patient from pursuing medical care.
- Educate providers from first responders to doctors.
- Immunizations and physical exams for children in school - because of COVID and families who have recently moved to the area, they don't know the requirements, and the children will not be able to get into school.

Access to Health

Do you think everyone has access to what they need to be healthy?

- No, there is a PCP crisis, health insurance under the Affordable Care Act has a high premium.
- I can tell you that some clients would rather make the effort to speak English than ask for a Spanish speaking provider or translator. They may feel they are not going to get the same attention as their English-speaking counterparts. Their whole demeanor changes when I speak to them in Spanish, and they feel they are going toget the attention that others get.
- Diabetes programs are not enough
- Access challenges when medical diagnosis is made early.
- Access in Spanish is not enough
- Housing assistance - have to fill out a form that is confusing English and Spanish; difficult to fill out.
- Lack of cultural access
- Medicaid correspondence is difficult to understand
- Language is obsolete in medical media
- Lack of trust in government agencies and police - there should be assistance in locations away from these two agencies

Impact on Health

What external factors do you feel have an impact on your health, based on aspectsof your identity?

- Last administration president - there was a lot of conversation about public charge policy to obtain citizenship or residency - because of the immigration process, Hispanics are afraid to even go to the pharmacy to pick up medicine.
- Hospice - not having citizenship or residency impacted how much Hispanics sought help.

- Sense of family unity - society in general sees the family unit as the immediate family. Family unit that includes everyone equally - in-laws, grandchildren, etc.
- Schools - provider for grandchildren, they are not recognized.
- Alzheimer's Society - want to help. Few Hispanics know these organizations exist.
- No positive or negative stereotypes limit access to medical care.
- Patient does not always have family members nearby
- Not all Latino families are large.
- Economic status
- Large majority of the Hispanic community works in the hospitality field
- Having work schedules that offer time to be able to get to medical appointments
- Feeling of responsibility
- Discrimination and/or prejudice - sense that the person is illegal. They are refused services.

Impact on Health

What external factors do you feel have an impact on your health, based on aspectsof your identity?

- Appearance can lead to different treatment of individuals regardless of education and wealth – can deter accessing healthcare services or asking for services
- Racist undertones even among Hispanics based on country of origin – social status/educational background – another barrier to access services
- Fear perception also provides barrier to access.

Wrap-Up and Next Steps

Welcome back! We are now going to share some of the "golden nuggets" from each of the breakout groups.

Team 3 – Pinellas County

We talked about fear in the Latinx community that prevents accessing healthcare, language access and understanding the technical terms, cultural humility, and the fragmentation in the system that prevents community access.

Thank you all for your participation today. Your information will be collected into community health needs assessment. Have a wonderful day!

Community Engagement 3 Kids Population (All Counties)

Real-Time Record

November 16, 2021, 9:00am-10:30am

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Identify Top Health Problems....7
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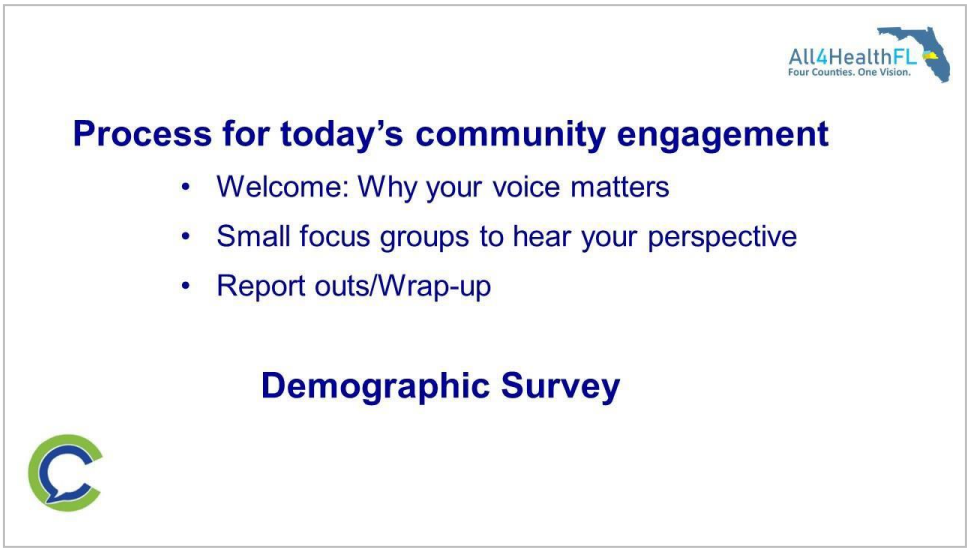
Impact on Health....8
Wrap-Up and Next Steps....8

Welcome

Facilitator, Collaborative Labs: Good morning, it is good to see you today! CollaborativeLabs is proud to support the All4Health Collaborative. Thank you for being with us.



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We also have a demographic survey we ask you to complete to tell us about yourself, which willbe used later to understand diversity of the focus group. Everything is anonymous and there will be no names in the final report.

Good morning, everyone! Thank you for being here this morning. The purpose of the All4HealthFL Collaborative is to improve health by leading regional, outcome-driven health initiatives that have been prioritized through community health assessments. The All4HealthFLCollaborative includes all of the not-for-profit hospitals and the department of health for Hillsborough, Pasco, Pinellas, and Polk counties.

We are so pleased to have each and every one of you present and participating in these focus groups today. We value the unique perspectives and lived experiences you bring with you today. We'll be asking you for your thoughts, opinions, and experiences about the strengths ofour community, the challenges or barriers that exist to accessing care and resources, and who in our community is most impacted by those challenges.

We have the opportunity to go deep today. Let's be caring, kind, and respectful today as weshare with one another, acknowledging the courage and bravery it takes to share from our personal experiences. Know that your personal identity stays within this group and will not beshared in any of our summary reports or information used to inform our efforts. Your overall feedback will help us create stronger programs and services to meet the needs of our community over the next 3-4 years.

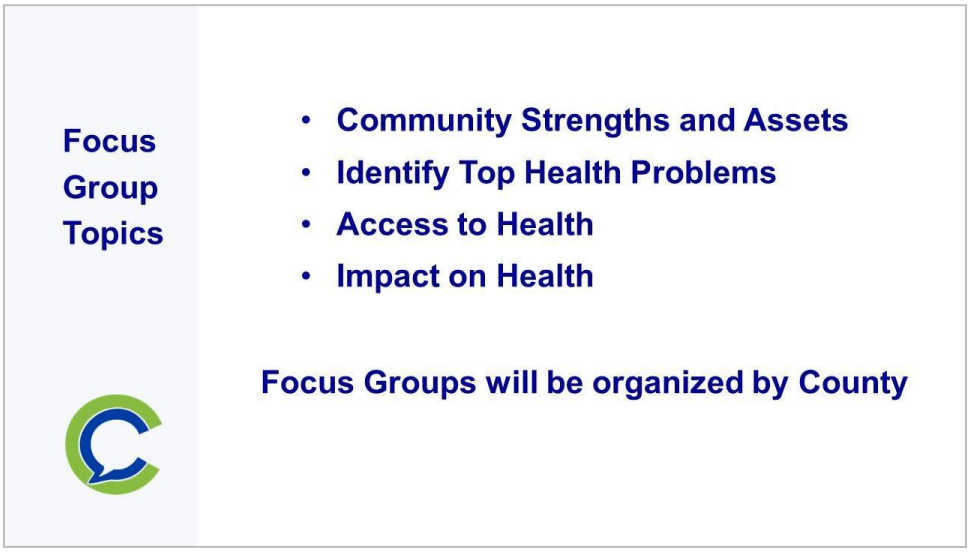
Thank you again for participating with us today. We know your time is valuable and are gratefulyou have shared this day with us.

You are representing the four counties today and we are thankful for your help. We have a quick warm up activity to start with. What are some things you feel make a community healthy?

From Chat:

- Inclusiveness
- Support system
- Community connectedness
- Wellness efforts addressing the whole person
- Access to services
- Holistic care
- Support system - neighborhood
- Supportive relationships
- Sense of belonging
- Access to resources
- Teamwork, cultural competency
- Clean environments
- Proper nutrition
- Support for youth
- Green space, safety
- Access to proper care

- Caring individuals
- Safety
- Supportive Services
- Support and safety
- Strong families
- Safe spaces to ask questions and have discussions
- Safe, stable, nurturing parents and caregivers
- Inclusive supports
- Equality and equity
- Social support



These are our topics for today and we have four counties represented; All4Health representsthe four counties.

Tina reviewed the breakout process and participants moved into breakout groups by county fordiscussions and feedback.

Pinellas County Focus Group

Community Strengths & Assets

What is something that you enjoy about your community or is a strength of your community?

- Availability and accessibility of resources
- Resource rich – Pinellas has a lot of programs and services to support a child's development and support families, personal support system
- Partnerships with rec centers and the school system

From Chat:

- I like the availability of resources; I feel that they are accessible
- That there are many partnerships that utilize rec centers and other community locations that make things accessible to families. At the school district, we have many before, during, and after school activities

Identify Top Health Problems

What do you see as the 2-3 most important issues that must be addressed toimprove health and quality of life in your community?

- Mental health – behavior issues, trauma, results of Covid. Providers learning to manage behaviors and fill the gap.
- Middle and high school kids (mental health) – transportation issues, not enough counselors for number of kids
- Teens (mental health) - access to providers to learn more and be better trained about mental health – it is a general pediatric problem, provide more resources
- Substance abuse
- Eating disorders
- Access to quality early learning (early childcare, 0-3 years) that is affordable and accessible (transportation and enrollment)
- Covid has brought more awareness of mental health issues
- Housing: in St. Petersburg, lack affordability of housing causes displacement, which results in lack of continuity in child's life
- Safety: gunshots and murders/violence a part of everyday life, which causes stress on young people's mind. Safety in school is also an issue.
- Child abuse and domestic violence cases up
- Kids need to be taught tools to about how to deal with emotions and talk openly about and normalize mental health (fear around stigma, expense)
- School is limited about how they present mental health presentations, not having the "right" people to present material

From Chat:

- Mental health
- Eating disorders
- I agree with the mental health

- Mental Health, substance abuse,
- Assistance with access to care
- Housing, education, mental health
- Safety
- Broad lens
- Child abuse and domestic violence cases are up as well.
- Have we considered asking our Youth how they believe it could be presented?
- It's difficult in a town hall for people even adults to ask questions

Access to Health

Do you think everyone has access to what they need to be healthy?

- On the providers' side, there are insurance barriers – Medicare/Medicaid, there is less training or appropriate training for issues; private pay list has "better" providers – in mental health and eating disorders (167% increase)
- Affordability, access to transportation, trust factor/relationship building needs to happen
- Inadequate sleep affects children's health
- Dealing with racism, cultural competency
- Healthy food: access to good quality food everyone has (St. Pete)
- In the Hispanic community, supplement with food that families are accustomed to culturally
- In the Hispanic community, there are language barriers to getting care and services

From Chat:

- Food deserts are an issue…good point.

Impact on Health

What external factors do you feel have an impact on your health, based on aspectsof your identity?

- As person born in Caribbean, racism is high on the list. People are uncomfortable talking about it and appearance dictates treatment of a person, which causes anxiety. Roots of it need to be addressed.
- Gender/gender identity, women paid less in male-based institutions – children experiencing the same issues with different tools
- Racism is a public health crisis. There is a lot of racism in Pinellas County. Lack of affordable housing has displaced the black community that impacts the quality of life. Address racism as a community. White doctors ignore patients based on color ofskin and biases. Kids feel the pressure of race.
- Education is a huge issue. Inequity in the quality of education based on zip code and location of school.
- Jobs/lack of jobs; higher arrest rates without same level of legal defense makes it harder to put food on the table for a family

Wrap-Up and Next Steps

Welcome back! We are now going to share some of the "golden nuggets" from each of the breakout groups.

Team 3 – Pinellas County

Strengths: the community is resource-rich with a lot of programs and services andpartnerships

- Problems: mental health – providers need to learn to manage behaviors, providers needto be better trained and accessible, and kids need to be taught how to deal with emotions, and normalize mental health, access to quality early learning and childcare that is affordable
- Access to health: there are insurance barriers that affect the quality of care, access to good quality food, language barriers in the Hispanic community make it difficult to get care and services and they give up
- Impact: racism is a public health crisis in Pinellas County, the lack of affordable housing leads to displacement that impacts quality of life, doctors ignore patients based on biases, the quality of education based on location, gender, lack of jobs.
- elled "hypochondriacs")

Thank you all for your participation today. Your information will be confidential and provided to our vendor to do some data analysis to make changes in our communities. Have a wonderful day!

Community Engagement 2LGBTQ+

Real-Time Record

November 15, 2021, 2:00pm-3:30pm

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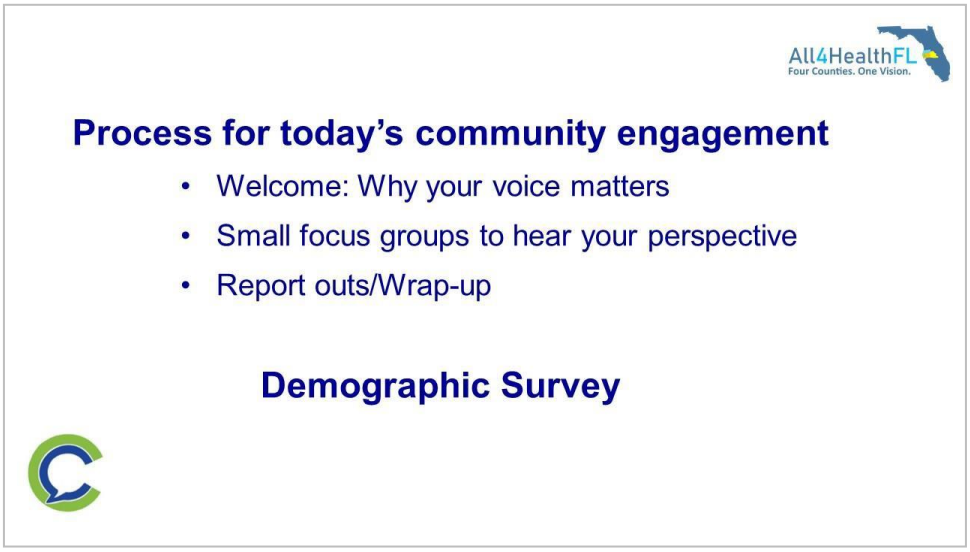
Welcome

Facilitator, Collaborative Labs: Welcome everyone, we are happy to have you on our calltoday. Thank you for joining us!



Today, we will hear why your voice matters, break out into focus groups, and then hear reports from the groups and wrap up.

We also have a demographic survey we ask you to complete to tell us about yourself, which willbe used later to understand diversity of the focus group. Everything is anonymous and there will be no names in the final report.

Good afternoon, thank you for joining us today. I wanted to share the purpose of today andwhy we asked you to be here.

The purpose of the All4HealthFL Collaborative is to improve health by leading regional, outcome-driven health initiatives that have been prioritized through community health assessments. The All4HealthFL Collaborative includes all of the not-for-profit hospitals and thedepartment of health for Hillsborough, Pasco, Pinellas, and Polk counties.

We are so pleased to have each and every one of you present and participating in these focus groups today. We value the unique perspectives and lived experiences you bring with you today. We'll be asking you for your thoughts, opinions, and experiences about the strengths ofour community, the challenges or barriers that exist to accessing care and resources, and who in our community is most impacted by those challenges.

We have the opportunity to go deep today. Let's be caring, kind, and respectful today as weshare with one another, acknowledging the courage and bravery it takes to share from our personal experiences. Know that your personal identity stays within this group and will not beshared in any of our summary reports or information used to inform our efforts. Your overall feedback will help us create stronger programs and services to meet the needs of our community over the next 3-4 years.

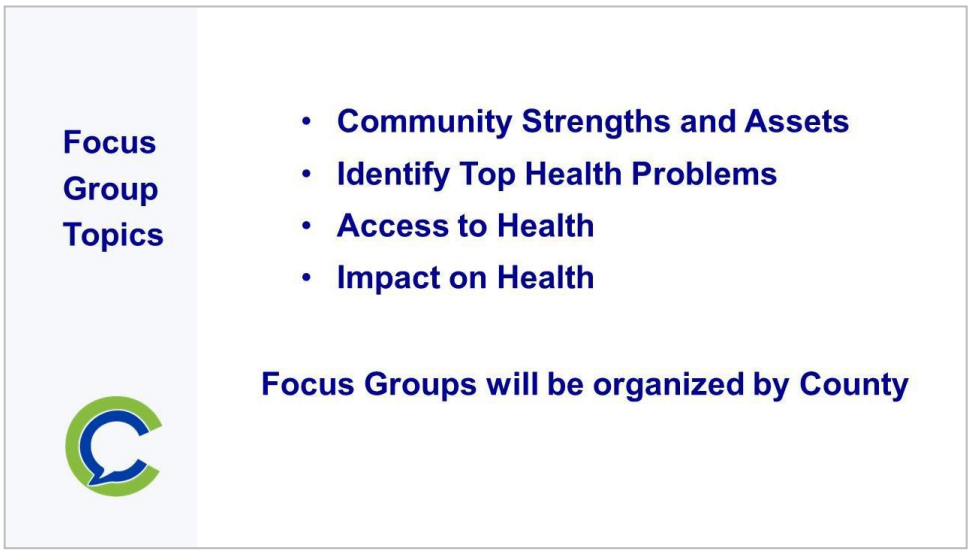
Thank you again for participating with us today. We know your time is valuable and are gratefulyou have shared this day with us.

We have a quick warm up activity to start with. What are some things you feel make a community healthy?

From Chat:

What are some things you feel make a community healthy?

- Improved education and access to resources
- Accessibility to care
- Access to fresh food
- Diversity
- Diversity and inclusion
- Inclusivity
- Equity in healthcare
- Access to quality education, safety, transportation, physical health, and healthcare
- Equity in resources and equity in access to those resources



These are our topics for today and we have four counties represented.

Pinellas County Focus Group

Community Strengths & Assets

What is something that you enjoy about your community or is a strength of your community?

- Local businesses, St. Pete is a unique home; supportive, helpful, outreach as an identity; family
- Visibility, pride of living in the city and an open environment, lot to take advantageof in the area for quality of life
- Desire to do good, quality of life
- Overlapping of the circles of community, connectedness, and willingness to include others
- Facebook groups help with local events and organizations and streamline info

Identify Top Health Problems

What do you see as the 2-3 most important issues that must be addressed toimprove health and quality of life in your community?

- Accuracy of info – get it out, repeat the info, direct it to the community, build trust
- Let the communities know about resources, screenings
- Mental health access and affordability – make it easier to get healthcare, especially when you are dealing with symptoms; the in LGBTQ+ community has higher rates of mental health issues and housing issues
- Equity and access - focus on local and personal – a lot of people don't have access
- Equal protection under the law
- To improve quality of life, you have to connect the personal stories to the data

From Chat:

- Equity and Access
- Accurate information, meeting communities where they are so they can tap into that access
- Mental health access and affordability
- Affordable housing
- Equal protection under the law

Access to Health

Do you think everyone has access to what they need to be healthy?

- Money, jobs – not having a career job to afford insurance
- Location
- Health literacy basics, selecting a health care plan is confusing – reeducation on being a healthy individual
- Finding a doctor who is familiar with trans care; healthcare providers do not know how to serve the LGBTQ+ community

- Trans patients not feeling comfortable seeking healthcare
- Financially - affording good food, transportation to healthcare, and jobs that allow you to schedule appointments
- Kinds of access is determined by your community
- Childcare

From Chat:

- I'm trying to think of anything other than "money" and I really can't...
- Childcare; I'm so lucky I don't have children

Impact on Health

What external factors do you feel have an impact on your health, based on aspectsof your identity?

- Political climate/societal factors - 94% negatively impacted with the way we are talking about LGBTQ issues; people are exhausted about talking about issues and ithas an impact on health
- People that are not accepting of LGBTQ lifestyle can impact lives and health
- Gatekeepers/decision-makers – people with power and responsibility not being partof the planning, connecting, and creating the solution
- Covid – high number of LGBTQ being in the service industry – more insecurity in jobs

Wrap-Up and Next Steps

Welcome back! We are now going to share some of the "golden nuggets" from each of the breakout groups.

Team 3 – Pinellas County

- Strengths: community is supportive, helpful, visible, desires to do good, and provides a good quality of life
- Challenges: accuracy of health information, mental health access and affordability, connecting the personal stories to the data
- Access: money and jobs that provide health plans, healthcare literacy and understanding options, finding doctors that are familiar with trans care and issues around it
- Impacts: political and societal factors that result in exhaustion and mental toll of dealing with issues related to being LGBTQ, decision makers and gatekeepers having power and responsibility that are not part of the planning and connecting to those who are making the solutions.

Thank you all for your participation today. Your information will be collected into community health needs assessment and have a great impact. Have a wonderful day!

Community Engagement 1Older Adult Population

Real-Time Record

November 15, 2021, 9:00am-10:30am

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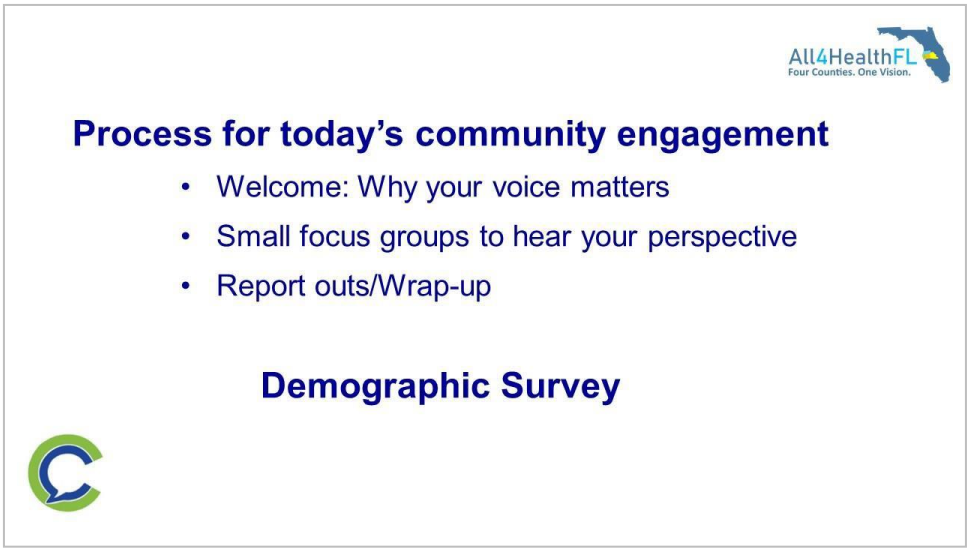
Welcome

Facilitator, Collaborative Labs: Good morning and thank you for spending part of your morning with us!



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We also have a demographic survey we ask you to complete to tell us about yourself, which willbe used later to understand diversity of the focus group. Everything is anonymous and there will be no names in the final report.

We are happy you are here today. We are one of the partners with All4HealthFL Collaborative. There are a number of focus groups happening this week. As you can see, there are a number of organizations you probably recognize behind this initiative.

The purpose of the All4HealthFL Collaborative is to improve health by leading regional, outcome-driven health initiatives that have been prioritized through community health assessments. The All4HealthFL Collaborative includes all of the not-for-profit hospitals and thedepartment of health for Hillsborough, Pasco, Pinellas, and Polk counties.

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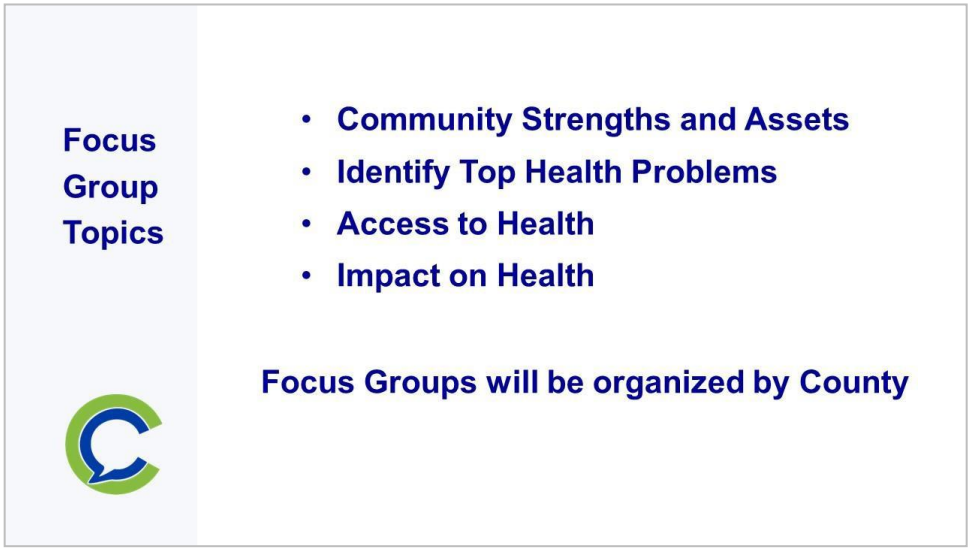
Thank you again for participating with us today. We know your time is valuable and are gratefulyou have shared this day with us.

You are representing the four counties today and we are thankful for your help. We have a quick warm up activity to start with. What are some things you feel make a community healthy?

From Chat:

What are some things you feel make a community healthy?

- Access to good food
- Service providers working together
- Access to health care needs
- Paying attention to the needs of the community, providing bike paths, parks, exercise areas, etc.
- Low mortality rate, low morbidity rate
- Well-informed collaborators
- Access to affordable health care and addiction services
- Access to basic life necessities food, shelter, employment, etc.
- Partnership between community organizations
- The ability to provide suggestions without fear of animosity. In other words, respectful communication.
- Ease to access healthcare
- Access to transportation
- I agree with service providers/organizations working TOGETHER.
- Outdoor-green space for recreational activities
- Affordable transportation
- Good mental health
- Getting to know neighbors and welcoming people who are not from this area
- Affordable housing
- Knowing the community resources available to meet people needs.
- Recycling efforts
- Access to mental health services
- Mental health
- Obesity
- Mental health



These are our topics for today and we have four counties represented.

Pinellas County Focus Group

Community Strengths & Assets

What is something that you enjoy about your community or is a strength of your community?

- Nice people in community who care for people
- Community feeling, diversity, small town feel, neighbors

- Medical care

From Chat:

- I like the multiple transportation systems available. It is generally easy to get around.
- I like the diversity.
- Small town feel, many community events that bring people together
- As a senior citizen, I am most pleased with the services provided to us in this area of Florida. I grew up here and have really enjoyed seeing the direction our community has traveled.
- We enjoy the neighbor and are friendly with our neighbors. Locally a lot of activitiesto use.
- Close knit Greek community
- Seminole has grown in the last 20 years in an orderly fashion.
- It seems the medical community is attracting excellent practitioners.
- A lot of activities for all ages.
- Excellent medical facilities locally. Caring doctors.
- Weather!

Identify Top Health Problems

What do you see as the 2-3 most important issues that must be addressed toimprove health and quality of life in your community?

- Young people should work to pay taxes and support infrastructure
- Affordability of healthcare
- Infrastructure issues
- Housing costs
- Access to mental services – combine physical and mental healthcare for a better level of service at a lower cost
- The healthcare system is difficult to work in and it is hard to find out how to get helpin the community – there is no budget for getting into the community and informing citizens
- Having continuous healthcare, for example, the high cost of COBRA makes it too expensive to have healthcare during a job change or loss. Make healthcare easierand affordable.

From Chat:

- Affordability of healthcare.
- Some infrastructural issues, public utilities and some continued drainage issues. Hardto address.
- Mental health clinics easy access, affordable healthcare
- Housing costs (understanding it seems to be a national issue).
- Getting information to homebound clients
- Problem - increased traffic
- Quicker and better access to mental health services
- Lack of information needs to be publicized, public presentations at community gatherings; get into the many mobile home places.
- Problem - increased cost of food and gas

- I would like to see the RAM concept (Remote Area Medicine) in Pinellas. I would like to see the integration of mental health care and primary care. Integration here is the key concept.
- Affordable help with activities of daily living for people with dementia and their caregivers

Access to Health

Do you think everyone has access to what they need to be healthy?

- Remote area medicine (RAM) – ability to get healthcare when they need it; it is not always due to geographic distance
- Appointments are difficult to get to

From Chat:

- Sometimes the challenge is trying to get an appointment. If you are referred out,you might have to wait up to 6 weeks for an appointment
- There is no way to learn of all services in the community; people do not understand where to go for help.
- The issues are, of course, how to pay for expansion and so forth. I believe it is avery complicated issue.
- I think that some people don't have the access to transportation, appointments are hard to get

Impact on Health

What external factors do you feel have an impact on your health, based on aspectsof your identity?

- Being older, there is lessened communication with others, family may be in another state, and we are losing friends and people looking out for you. Isolation.
- Stereotyping of older people based on physical appearance
- Fixed income vs. increasing costs of healthcare
- Lack of education about healthcare - seniors may be technologically behind or have access to internet, publication of local newspapers has been cut back to two times/week (online the other days)

From Chat:

- I am careful to make sure that health care professionals take into account age whenI get medical care. Mostly they do. But not always.
- I feel that, as I get older, “some” professionals and staff seem to feel my cognitive abilities are declined at the same rate as my physical abilities. This stereotype, along with so many others (race, disability, etc.), are ingrained but can be helped with training. By and large, staff want to be helpful and aren’t aware of these biases.
- Continuing inflation makes it very difficult to find care many cannot afford & do not know where to go for assistance.
- I suspect there is an issue with the lack of public information for many of these problems.
- We know that a biopsychosocial approach is important generally in medical care. This is even more true with older adults. However, I have yet to have medical professionals ask me about "social" part of biopsychosocial assessments. The "psychological" part is very cursory.
- Need multiple ways to relay information to the public, more community events to inform.
- We feel lucky, as our primary asks all those questions at each annual visit that is longer than a regular follow-up visit.
- I will say my PCP has asked me about how I spend free time in retirement.
- James' comments are 100% correct!
- Need more focus on nutrition and healthy cooking to maintain health, i.e., cooking demo, etc.
- Lack of education; the cultural people come from is very different than just "landing"in a new community - many cannot cope with such a drastic change & hesitate to find out about such things as Senior Centers, etc.
- It seems a bit as though, if you are not technologically trained, you are at a great disadvantage in finding information. I believe there needs to be more focus in public areas (local television and radio), with these bits of information.
- An example - the *Tampa Bay Times* no longer covers this subject; it is only published 2x a week now; technology is impossible - cannot afford a computer & know where to take lessons, etc.
- The lack of local newspapers is a great disadvantage.
- Public libraries used to be more used, as well.
- Not sure how Spectrum and/or Comcast can help here, but they used to have channels with "community bulletin board info"
- Consider expanding the school system and SPC adult side to provide the classes freeor at a lower cost.
- Many folks I meet do have a radio - but there is no publication as to where programsare on.

Wrap-Up and Next Steps

Welcome back! We are now going to share some of the "golden nuggets" from each of the breakout groups.

Team 3 – Pinellas County

- Strengths: small town/neighborhood feel, with caring people and diversity
- Problems: affordability and accessibility of healthcare, need to combine physical and mental healthcare for a better level of service
- Access to health: remote area medicine (RAM) – the ability to get healthcare when needed, appointments are difficult to get to
- Impact: lessened communication with and support from friends and family, and lackof education about healthcare – seniors may be technologically behind or have limited access to the Internet

Thank you all for your participation today. Your information will be collected into community health needs assessment. Have a wonderful day!

Appendix C. Community Input Assessment Tools Prioritization Session Attendees

Pinellas County prioritization session was conducted on April 19, 2022, 77 individuals were in attendance from the organizations listed in the table below. These organizations played a pivotal role in providing feedback on significant health needs identified within the data analysis, developing preliminary ideas on ways to collaborate to address needs, and prioritizing community health needs for the next three years. The list of participating organizations and discussion feedback can be viewed in this appendix.

Participating Organizations	
AdventHealth	Mease Hospitals (BayCare Health System)
American Heart Association	Metro Inclusive Health
BayCare Health System	Moffitt Cancer Center
Bayfront Health St. Petersburg	Morton Plant Mease Health Care Board of Directors
CARD-USF	NAMI Pinellas County
Central Florida Behavioral Health Network	One Community Grocery Co-op
City of Clearwater	Orlando Health
Clearwater Free Clinic, Inc.	PEMHS
Clearwater Urban Leadership Coalition	Pinellas County Human Services
Colonial Management Group	Pinellas County School Board
Community Dental Clinic	Pinellas County Schools, Strategic Partnerships
Conduent Healthy Communities Institute	Sickle Cell Disease Association/ St. Petersburg, FL
Conviva Care Centers	SkyBuilders 4 All
Evara Health	St Petersburg College
FDOH/ Pinellas County Urban League	St. Anthony's Hospital/BayCare Health System
Feeding Pinellas	St. Pete Free Clinic Health Center
Feeding Tampa Bay	St. Petersburg College
Florida Department of Health in Hillsborough County	Suncoast Center
Florida Department of Health in Pinellas County	Suncoast Health Council
Forward Pinellas	Tampa General Hospital
Foundation for a Healthy St. Petersburg	Tarpon Springs Shepherd Center
Healthy Hemp Outlet	Tampa Bay Healthcare Collaborative
Humana	The Salvation Army
Johns Hopkins All Children's Hospital	UF/IFAS Extension FNP
Juvenile Welfare Board of Pinellas County	Veterans Counseling Veterans Inc
LifeStar Living	YMCA of the Suncoast

Appendix C. Community Input Assessment Tools

Prioritization Session Questions and Summary of Responses

Access to Health Services

Breakout Room #1 Access to Health Services

Breakout 1, Part 1: *Discuss significant health needs identified within the data analysis and feedback gathered from the community*

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDoH?

- 33712 and surrounding areas has many concerns for poverty
- 33709 high for every category to include the need for food access which falls within the Feeding Pinellas
- 69% do not have affordable places to live and that are moving into homelessness, including high amount of seniors
- There has not been a huge change since 2013 census maps (within the last 15 years): housing, employment, etc.
- There is major concern for backward sliding for homelessness within the area
- 41% say mental health is a pressing health issue. There are access issues to include insurance
- High percentages of the population using the ER with nonemergent needs
- What percent of the ER visits have cost-share, which often encourage ER as a path to coverage?

Breakout 1, Part 2: *Gather Community Input especially from public health experts and vulnerable populations*

1) **What social determinants are impacting this health issue?**
    - Affordability and availability of appointments; long wait times for appointments
    - Environment availability: childcare, transportation, and taking off work are huge barriers
    - Cognitive barriers: they are avoiding healthcare until they are extremely ill
    - Mental and behavioral health are the base for many of the issues mentioned
2) **From your perspective, what has caused this to improve/worsen/remain the same?**
    - Pandemic has increased childcare issues
    - Telehealth services have helped access for some
    - Maintaining Medicaid through pandemic efforts
    - Housing has become worse which was associated with mental health
    - Food insecurity has been a rising concern for many
    - Anxiety and depression have caused more grinding and breaking with teeth, as people are not seeking help as much
3) **What efforts have you experienced that are working and how?**
    - Nonprofits are working together to provide resources for the community to connect community members to have an easier navigation of services.
    - Increase collaboration between mental health providers and decreasing unnecessary competition.
    - Creating a clear entry to those within the community that everyone can and will access
    - Decreasing wait times for mental health services

- Increased telehealth services from all levels to increase tools to expand access

4) **From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?**
    - Non-organization specific tool to help build data to help community members better flow through the various health services
    - Increase communication to address different languages and technology skills to access information and services
    - More qualified navigators/advocates to help those in crisis
    - Increase more resources to single residents (compared to family assistance)
    - In person access and understanding to Medicaid is lacking or nonexistent
    - Communication for Medicaid is lacking and lengthy
    - Note: Include more homelessness data on placemats

Breakout 2: *Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs*

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- Maintaining communication about access to refer participants/patients to other needed services
- All services are integrated and having a walk-in place to have navigators to gain accesses to services, like the empowerment centers
- Having a better understanding of how to find access to food, which can help with the exercise, nutrition, and weight.
- Addressing fear and the lack of communication skills by having a layout of what to expect within their appointment.
- Increase behavior change marketing within Pinellas County to approach individuals and systems
- Continue efforts around decreasing the stigma related to mental health and food insecurity services.

Breakout Room #2 Access to Health Services

Breakout 1, Part 1: *Discuss significant health needs identified within the data analysis and feedback gathered from the community*

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDoH?

- Reports on discrimination- micro aggression, multiple populations- people may be afraid to experience the discrimination
- High level stated they are not treated with the same courtesy as others
- Feelings of mistrust with the health system
- Increase of depression in the Medicare population
- AA and black population low for in need of mental health- surprising
- Stigmatism
- Technology is barrier

Breakout 1, Part 2: *Gather Community Input especially from public health experts and vulnerable populations*

Appendix C. Community Input Assessment Tools

Prioritization Session Questions and Summary of Responses

1) What social determinants are impacting this health issue?
    - Digital Gap – not have accessing to internet, or technology
    - Lack of health insurance – decreasing coverage among minorities
    - Providing more options to access the care- space a work potentially, accessing care
    - Health literacy – navigating the health system, impacts their ability to understand what providers saying/medication information are - Knowing how to discuss issues w/providers and feeling empowered to do so
    - learning how to be comfortable with the uncomfortable.
2) From your perspective, what has caused this to improve/worsen/remain the same?
    - Flexibility in the employment setting - in recent times has improved, remote able positions, but some other jobs are not able to offer this
    - Increasing access to care- local, and state level – goes hand and hand with employment / remained the same
    - Economic factor – cost/inflation, ability to live in Pinellas and afford care – worsen- has put pressure on other factors/insurance
3) What efforts have you experienced that are working and how?
    - Covid has increased our technology, can improve / Telehealth
    - Labor market, job choice and benefits
    - Addition of clinics in retail space (CVS, Walgreens, etc.) – COVID vaccines for example
    - Coordinated care- positions who help navigate the system (patient navigator, case manager)
    - Pop up sites are also a positive feature such as covid testing/vaccinations, health screenings at public events, etc.
4) From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
    - **Increasing coordinated care, and cultural competency (easy to understand documents, etc.)**
    - **Community representation on the provider side- helps to bridge the gap**

Breakout 2: *Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs*

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- Broaden scope – bring into police departments, parks & rec, etc.- not just health systems with other health systems, etc. –also on a political level (state, and local level) – multiple level advocacy
- Increase outreach- target high level organizations (large employers, faith-based organizations, schools, etc.), branch information network
- Look at how the 3 topics intersect – what high level organizations can work together for these to connect
- Utilizing our front level workers- what are people communicating them as concerns
- Increased education- organizational or capacity building – increased training, having open conversations on hard topics in a safe environment

Appendix C. Community Input Assessment Tools

Prioritization Session Questions and Summary of Responses

Behavioral Health (Mental Health and Substance Misuse)

Breakout Room #3. Behavioral Health (Mental Health and Substance Misuse)

Breakout 1, Part 1: ***Discuss significant health needs identified within the data analysis and feedback gathered from the community***

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDoH?

- Lack of economic opportunity
- Lack of prevention education in the community
- Access issues: hours of service, inability to take time off work
- ACE's data: parent separation, problems with drinking
- Zip Codes of high need were not surprising

Breakout 1, Part 2: ***Gather Community Input especially from public health experts and vulnerable populations***

1) What social determinants are impacting this health issue?
    - Social isolation and loneliness
    - Large retirement community and many people coming to Pinellas to "escape" without support
    - Veterans/family- lack of resources for families of Veterans leading to generational trauma, Vet Center has eligibility requirements for treatment, Blue Star Families trying to get data of Veteran population living in Pinellas, Women Vets do not have resources leading to homelessness due to not addressing MST, Women of Color have different experiences due to intersectionality and compounding identities (disproportionately homeless, MST), lack of cultural competence in the VA leads to lack of trust (Women Veterans have 50% more suicides than nonwomen Veterans. MST is the main driver)
2) From your perspective, what has caused this to improve/worsen/remain the same?
    - Policy/lack of policy, leadership
    - Lack of understanding of concepts like SDOH, health equity
    - COVID-19 measures: initially more people turning to unhealthy coping skills; provided more awareness of these issues (policy has yet to follow, and resources are needed due to provider shortages)
    - Veteran/military population: high rates of suicide ideation, inability to get access to care, more stressors during COVID-19, homeless Veteran disbursement is $700
    - Economic concerns: cost of housing, affordability, homelessness leading to more stressors
    - Increase in First Responder suicide rates
3) What efforts have you experienced that are working and how?
    - St. Pete Free Clinic: all policies and practices governed by trauma informed approach, leads to higher patient satisfaction with 20% increase (more dignified, respected form of treatment)
    - Trauma Informed Care and Mental Health First Aid programs in the community
    - Pinellas Hope: housing shelter, respite program

- Drug Court Outcomes: justice system has improved their policy for drug court, 988, Veteran Treatment Court (partnership with the VA for substance use disorder treatment, but gaps in treatment for families of Vets), crisis intervention team for mental health (coordination with police)

4) From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
    - Justice/Legal System: decriminalization of substance use disorder and utilizing public health approach to treat these health issues
    - Improving the Workforce/Employer family friendly and health policies, Foster Care System, More Peer-to-Peer support
    - Addressing the technology divide and negative outcomes

Key Takeaways:

Importance of addressing mental health using an intersectional lens, especially in the Veteran population but more specifically Veterans families that lack access.

Trauma informed care proves effective, and decriminalization of substance use disorder by utilizing public health framework to treat these health issues.

Breakout 2: *Generate (Idea Bank)* preliminary ideas on how to collaborate with each other and health systems to address the top community needs

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- Access to Health & Social Services
    - More flexible hours aside from 8-5
    - Get ALIGNED on Social Health Access Referral Processes and platforms. How can EHR/EMR integrate better with Community Health, non-profit, and government supports to be aware of gaps & effective programs?
    - Technological advances/telemedicine from the pandemic need to be sustained and built upon how we can better provide medical appointments virtually and for folks who can't access for 8-5 hours
    - Better education for healthcare providers on sickle cell
    - Knowledge/navigation: people largely unaware of available resources, mailings to people moving into the community regarding community resources
- Behavioral Health (Mental and Substance Abuse)
- Exercise, Nutrition, & Weight
    - Food insecurity deeply tied into nutrition and impacts future generations' poor health outcomes
- General Ideas/Population-specific:
    - Veterans and their families: we must be intentional in creating federal, state, county, public organization collaborative efforts to address behavioral health, substance use disorder, access to health/social services
    - More collaboration with Faith-based organizations
    - Sickle Cell: unsure which category it belongs in but has wide ranging effects (mental health, & creates health disparities)
    - All4Health dashboard doesn't include families of Veterans

Appendix C. Community Input Assessment Tools

Prioritization Session Questions and Summary of Responses

Breakout Room # 4 Behavioral Health (Mental Health & Substance Misuse)

Breakout 1, Part 1: ***Discuss significant health needs identified within the data analysis and feedback gathered from the community***

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the **SDoH**?

- Behavioral Health
  - Individuals turned away due to lack of available services / providers
  - Strongly related to medical health & care plan compliance
  - Strong correlation between substance abuse and mental health
  - Need for legislation to allow counselors to bill Medicare
- Barriers to Access
  - Time off work, cost, transportation, availability of appointment are barriers across all types of health
- Adverse Childhood Experience (ACE)
  - High scores as a community
  - Impact on health, especially behavioral health, and continuum of care
- Discrimination
  - Impact on EDI practices, acts as a barrier
  - "Why would I seek care if I think I'm going to be discriminated against?"
- Social Determinants of Health
  - We deal with health downstream when it should be upstream
  - Found the "More than one race" correlation very interesting
- Food insecurity
  - Illness is strongly related to diet

Breakout 1, Part 2: ***Gather Community Input especially from public health experts and vulnerable populations***

1. What social determinants are impacting this health issue?
   - Cultural differences
     - How different cultures view mental health / different opinions
   - Destigmatizing access
     - Substance use is equally stigmatized
   - Money / economic stability
     - Job, income & insurance status are linked
     - Care needs to be affordable
     - Money is first spent on necessities, and mental health is secondary
   - Affordable housing
     - Rent is increasing in Pinellas County
2. From your perspective, what has caused this to improve/worsen/remain the same?
   - COVID-19 has worsened mental health
     - COVID raised awareness, increased demand, same lack of providers
   - Telehealth
     - Internet access can still be a barrier
3. What efforts have you experienced that are working and how?
   - St. Anthony Nurse/St. Pete Police PATH (Police Assisting the Homeless) Program
     - Helps keep people out of ER

- Police department social work team
    - Repeat engagement are worked with to connect with individuals for mental health

4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
    - Destigmatizing
        - Public services announcements help raise awareness and lower stigma
    - Public/Private collaboration
        - Working across counties and systems to provide patient centered care

Breakout 2: *Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs*

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- Access to Health & Social Services
    - Pinellas County Coordinated Access Model
        - Primarily behavioral health, but also connects to social services
        - Call number, case manager connects you to provider / appointment (1.5+ years out)
    - Family Services Initiative
        - Helps connect individuals and families to social services
- Behavioral Health (Mental Health & Substance Abuse)
    - You Good Campaign
        - Behavioral health campaign improves access to mental health services
- Exercise, Nutrition & Weight
    - Family Nutrition at UF/IFAS
        - Using SNAP dollars best, cooking, gardening, and other classes
- General
    - Collaboration update meetings to discuss and learn what different organizations are doing

Appendix C. Community Input Assessment Tools

Prioritization Session Questions and Summary of Responses

Cancer

Breakout Room # 5. Cancer

Breakout 1, Part 1: *Discuss significant health needs identified within the data analysis and feedback gathered from the community*

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDoH?

- 69% of respondents said that they can't afford somewhere to live. If you don't have a safe, secure housing situation, it is challenging to focus on other areas of health.
- Transportation jumped out – we can schedule appointments, etc., but if a person can't get to and from where they need to go, they can't access the care they need. Transportation issues lead to medical non-compliance.
- 67% of respondents had full time jobs but they still struggled with accessing housing/ transportation.
- Transportation is a major issue – good infrastructure is not available (takes a long time to get anywhere, many can't afford Uber). Care providers in medical field schedules cater to those who can get a day off work (providers only offer appointments from 9-5)
- 53% of those who responded had a master's/bachelor's degree. The survey respondents are from populations that experiences much less barriers. For other community members it would be even more profound.
    - "We may just be seeing the tip of the iceberg"
    - Regarding the respondent population having more education -- A lot of times the barrier in navigating social services is in literacy (e.g., knowing how to access different services). People get overwhelmed completing applications, turning in documents, having the necessary documents. We have educated individuals experiencing these barriers according to the survey, but among populations with less education the issue is likely even bigger.
        - There is no repository that holds information to help people get to where they need for help.
- Use of ER. The ERs don't charge if individual doesn't have the funds. The problem with ER utilization is that takes resources away from emergency needs. Education on how access to non-emergency care is key.
    - This issue extends to the barriers posed by limited doctor's office hours. For those who experiences challenges in being able to take time of work – the ER is open 24/7, making it more accessible.

Breakout 1, Part 2: *Gather Community Input especially from public health experts and vulnerable populations*

1) What social determinants are impacting this health issue?
    - Florida did not expand Medicaid. Adults 18+ fall through the cracks. When it comes to cancer diagnoses – they may experience delays getting care. When they go in, the cancer is more advanced. If after diagnosis, the time it takes to get benefits is often unbelievable—increase delays in care.
    - Because of COVID-19, people were staying in and not getting diagnosed/treatment out of fear of catching the virus.

- Cultural competency. Doctors treat individuals differently and don't alter care needs depending on the risks of specific populations, using a one-size-fits all approach.
- On high melanoma rates -- Getting an appointment with a dermatologist is not easy. The capacity of dermatologists is limited. If someone is on Medicaid or uninsured, getting in and having to self-pay or find a specialist that accepts Medicaid is difficult. For HPV, getting vaccination rates up is important
    - Increasing vaccination rates among male adolescents is key.

2) From your perspective, what has caused this to improve/worsen/remain the same?
    - COVID-19/pandemic has exacerbated barriers to access to care. There was already limited capacity, and with social distancing, limited numbers allowed in waiting rooms, etc., it has become worse.
    - From a transportation perspective -- older people have a hard time getting around. That can contribute to the rise in cancer. People can't get to the doctor or get the care they need, and as a result they may be getting diagnoses when it's too late.
    - When looking at the needs of the underserved, particularly regarding the transportation and housing issues, we need to make efforts to meet people where they are. As health care providers, we often expect individuals to come to us, but how do we go into the community (so community members don't have to travel). Healthcare should be more available to the underserved communities in this way.
    - Hospitals are still restricting visitors. People may be reticent to go to the hospital knowing their family members cannot visit.
3) What efforts have you experienced that are working and how?
    - Education, including community meetings not in the hospital, that talk about these issues can help.
        - Getting into the schools to provide education can help. Have community gardens to encourage healthy behaviors, etc.
    - There is a need for a common information site. It is difficult to understand what your solutions are unless you have one place to go to be understand which resources are available.
4) From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
    - Access. We don't have reliable, convenient transportation. Non-profits that provide transportation assistance could provide rides to healthcare to improve access.
    - Testing and screening for everyone.
    - A place to go to know how to access care – for example, a one-stop website to know where you can get a mammogram, for example.
    - Incentives for testing (like the blood bus providing gift cards).
    - Breaking down siloes across the non-profits. FindHelp.Org provides a hub for community-based resources.
    - Communicating at a literacy level everyone can understand and engage with.

Breakout 2: *Generate (Idea Bank)* preliminary ideas on how to collaborate with each other and health systems to address the top community needs

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- The resources are out there. Community based orgs need to find a focus -- a concise focus in what they excel at (e.g., nutrition security). If we support each other collectively/collaboratively, it will increase our bandwidth. We need to think less competitively.

- Salvation Army – worked with 211 in this area. We need to know which specialty each agency/provider has and how to better collaborate with each other and find the touch points. 211 has connections with many agencies. People may not know to call 211 for a listing of agencies to meet their needs.
- On the county level, each department is siloed. It is a struggle to work across departments/agencies.

- Need to work together better!
  - Agencies want to keep their identify, but we need to increase partnering w/ other orgs.
  - The more we invest into meeting people where they are at, the more successful we will be. We need to work with faith-based orgs that are trusted, services outside of the clinical setting (barbers, for example).

Breakout Room # 6. Cancer

Breakout 1, Part 1: ***Discuss significant health needs identified within the data analysis and feedback gathered from the community***

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDoH?

Income, financial means to access to health care

- Access to health care-work schedules
- Discrimination experiences
- Data informed with "covid lens"
- Rental costs-housing affordability, skyrocketed since survey
- Anxiety-mental health stress the last 3 years
- Access to food-5 food deserts in Pinellas, not much has changed since the last survey, why? Need better plan
- Surprised about the lack of dental care as a health concern-infection
- Vision and hearing also lack of care
- We have work to do-health equity is huge!

Breakout 1, Part 2: ***Gather Community Input especially from public health experts and vulnerable populations***

1. What social determinants are impacting this health issue?
   - Based on Race- have a higher Cancer death rate
   - Smoking and Lung Cancer
   - Male death rate significantly higher
   - Food access- 3 servings daily-fruits and vegetables
   - 19% smokers (older people smoking?)
   - Is prostate an age cancer?
   - Are these older people cancers?
   - Behavior is a key factor
   - Need prevention data-see what's working?
   - Florida Health Chart viewed (late stage)
2. From your perspective, what has caused this to improve/worsen/remain the same?
   - Screening for cancers (smoking)
   - Early screenings for breast cancer have been very successful
   - Cultural competency

- Healthcare navigation to screening and someone helps you along the way to navigate through the process
- Create a path to prevention

3. What efforts have you experienced that are working and how?
    - Mobile screening for intervention
    - Healthcare navigator to screening
4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
    - Free access to quality medical care
    - Access for all
    - Rethink qualifications to access care
    - Make it the norm in school that there is community access to care
    - Advocate the health care system-start education early in life
    - More education for cancer screening
    - How can we provide more resources for bilingual

Breakout 2: *Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs*

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- **Access to Care**
- Push for more accessible hours for employees who have insurance.
- Make changes in our own organizations
- General funds for social service safety nets for constituents
- Find out how to navigate access
- Medicaid expansion-show data on how it will provide relief for the community
- Individuals access for medical records-education for continued care
- Universal release form for medical records
- Overcome barriers to access for medical records (fatigue from having to fill out forms repeatedly
- **Mental Health**
- Help navigate services-long wait times, after hours services
- Finding appropriate care
- Exercise, Nutrition, Weight

Appendix C. Community Input Assessment Tools

Prioritization Session Questions and Summary of Responses

Exercise, Nutrition, and Weight

Breakout Room # 7. Exercise, Nutrition, and Weight

Breakout 1, Part 1: ***Discuss significant health needs identified within the data analysis and feedback gathered from the community***

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDoH?

- Access to Health Care- Use of the word "lack of trust" among most all the groups. What is perceived as a 'lack of trust" with health providers? Would like to know more.
- Access to Health Care- Many parents bring children to school without immunizations because they do not trust the health care system. They fear that there may be something in the immunization that they are not being made aware of that may cause more trouble to child.
- Access to Health Care- We, as a hospital system, could be creating a sense of distress through our own physical nature as a hospitalist system.
- Access to Health Care- Comments about not being able to access appointments- think there may be a lack of understanding about how to get to that point of care rather than the care not being available.
- Access to Health Care- Suggestion that the Health Department explain to community why children need immunization shots and the Covid vaccine but should be explained in terms that lay people can understand and not in medical, scientific terms.
- Access to Health Care- Sometimes people need someone to help walk them through getting the access to care and meeting people where they are.
- Access to Health Care- barriers may include transportation, lack of internet access, substance abuse or mental health issues can cause a struggle to even get out of bed, individuals who are homeless may not be able to get to where they need to get the care or may have a fear of it.
- Looking at the indicators of all the categories, it shows we may not be getting better over time so it poses the question, are we making an impact and if not, how can we pivot to improve? Is it pandemic related, a sign of the times, or a call to action to keep doing what we are doing to try to improve?
- Some responses to the above questions were education, pandemic, and many things going on in the lives of the community members.

Breakout 1, Part 2: ***Gather Community Input especially from public health experts and vulnerable populations***

1) What social determinants are impacting this health issue?

- Parents are working crazy hours and are afraid to miss work (mainly due to pandemic) and are working so much that they may not have time or access to exercise or eat healthy.
- Lack of transportation
- Noticed that food insecurity was mainly among young adult population (18-24 yr.).
- Pinellas has a great park infrastructure but doesn't have a means to get people to access these.
- How do we get people to use the infrastructure that is already in place?
- Trust factor is involved because if people do not feel safe in their neighborhoods and parks

then there will always be an issue using these facilities.

2) From your perspective, what has caused this to improve/worsen/remain the same?
- Stress of jobs/ children.
- Depression- reduced energy and emotional eating of non-nutritious foods.
- Single parents may put children's nutrition priorities over their own and then they eat what is left available.
- Financial stress
- Increased use of food pantries, even among individuals who have never had to do this before.

3) What efforts have you experienced that are working and how?
- Triathlon partnership with schools is working. St. Anthony's identifies kids to participate in their triathlon. Need to increase this intervention.
- Screenings at hospital level to provide nutrition bags for patients at discharge at St. Anthony's is working but need to increase the scale of the programs.
- When programs are focused on the family unit (parents and children) work best.
- Nutrition/weight loss programs that can be qualified through insurance is also helpful.

4) From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
- Need more collaboration across organizations to increase access to programs.
- Need a program for parents with Medicaid, that are like the programs offered for the children, so that the parents can participate with their children.

Breakout 2: *Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs*

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- **Access to Health-**
  - Health Navigators going door to door using iPads to record and provide information. Help individuals to access the information and get them connected to the resources they need.
- **Behavioral Health/Mental Health/Substance Misuse-**
  - Monthly Pinellas County Behavioral System of Care meeting that includes partners from different areas (not just behavioral health providers). Need to look at who we are inviting and can expand this. Take information from meeting into community and go out into community to advocate funding and increase capacity in services.
  - Need more convening meetings across different agencies/systems to conversate about what's available and how to coordinate.

- **Exercise, Nutrition, Weight-**
  - Modeling parents getting involved with kids for programs (i.e., walking clubs).
  - "Walking school bus program"- parents get together and walk kids to school.
  - Ideal goal is for this to be the norm so that others will want to join in.
  - Not separating out health needs in convening meetings but talk about health in general since these all typically intersect.

Appendix C. Community Input Assessment Tools

Prioritization Session Questions and Summary of Responses

Breakout Room # 8. Exercise, Nutrition, and Weight

Breakout 1, Part 1: *Discuss significant health needs identified within the data analysis and feedback gathered from the community*

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDoH?

- Same issues, nothing is getting fixed (at least not quickly)
- Same areas and same needs, no sustainable plan of action
- Not surprising at all, challenge is reaching those areas that need the help

Breakout 1, Part 2: *Gather Community Input especially from public health experts and vulnerable populations*

1. What social determinants are impacting this health issue?
    - Disproportionate amount of respondents based on race
    - Would like to see better representation of median income
    - Health being put on backburner; they can't focus on it due to other issues such as housing

2. From your perspective, what has caused this to improve/worsen/remain the same?
    - Pandemic, rise of cost of everyday things, transportation issues

3. What efforts have you experienced that are working and how?
    - Door to door is a better way to reach communities (Red Wagon Campaign); meeting people where they are
    - Outreach in general, people not aware of services available to them (health fairs, community events)
    - Way for non-profits to advertise better, getting the information out there, need to on-going and current

4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
    - Policies, are preventing us from doing good, need to be revisited
    - Proper linkage to other areas, closed loop referral system
    - Involvement and engagement of stakeholders from the beginning of the process, tend to have more buy-in
    - Stakeholders are quick to tell us what to do, but then no one takes it on, needs to be accountability
    - Communication: failure to communicate on our end to the community
- Make it a collaborative effort, people/groups can speak up on projects they are willing to take on; helps eliminate silos, allows groups working on same ideas to work together

Breakout 2: *Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs*

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- Hosting community events, free to attend, in areas not normally in (1k, 5k, etc.)
- Find a way to destigmatize weight; be inclusive in what is being shown as an example
- Start small – tasks at home that get them moving, helps build confidence; use advertising to show examples
- Food – ideas of healthy food people might already have

- Exercise – incorporate into daily activities (walking vs driving, taking stairs)

Heart Disease and Stroke

Breakout Room # 9. Heart Disease and Stroke

Breakout 1, Part 1: ***Discuss significant health needs identified within the data analysis and feedback gathered from the community***
What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDOH?

- Value the survey asking about multi-racial and including important information and details.
- Confidence in medical providers and understanding this is a concern for many people.
- Access to health services and the long wait time for appointments. Do we have enough providers? Is funding an issue to support the number of providers needed.
- High cancer rates in Pinellas County is alarming compared to the state and national average.
- Cervical cancer rates are alarming. Linking this to the vaccine rates to prevent cervical cancer.
- Overall concerns with vaccine implementation.
- Rental and house rates are concerning.
- Nutrition challenges direct correlation to the heart disease rates.
- Access to care is concerning, unable to schedule appointments when needed. Disconnect and continued challenges navigating the process to be seen by medical providers.
- Stigma for mental health for those seeking care.
- Employment information would be interesting to add to the survey moving forward for future surveys. Take a deeper dive into salary/hourly/shift positions and the challenges in making medical appointments.

Breakout 1, Part 2: ***Gather Community Input especially from public health experts and vulnerable populations***

1) What social determinants are impacting this health issue?
    - AA higher rate of heart disease relates back to lack of access and knowledge
    - Access to specialist is challenging, high co-pays, more expensive medications
    - Medications are complicated and often takes multiple visits to adjust meds and dosages
    - Healthy eating is a direct correlation to these rates. Access to health foods can be challenging.
2) From your perspective, what has caused this to improve/worsen/remain the same?
    - COVID created challenges with people not keeping up with medical appointments

- Heart disease can be "silent killer" people may not be aware they are having health/heart problems. Preventive care is not a priority especially if symptoms are not present.
- Stress contributes to this health challenge. The SDOH of health can cause great stress in one's life (food security, being financially stable, transportation challenges)

3) What efforts have you experienced that are working and how?
   - Barber shop and beauty shop health education programs. Meeting people where they live and frequent (places of trust).

4) From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
   - More cultural/diverse programs that include healthy eating information and resources. Need sustainable solutions.
   - Improved Access
   - Information is presented in easy to understand formats, including videos
   - Health literacy should be a priority in getting the information out to the community
   - Meet people where they are, use of social media.

Breakout 2: *Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs*

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- Hours of care to be extended to meet the needs of the community.
- Funding free clinic (off hours in the community)- multi-level, multi-resources, include dental, hearing, food available- Cigna wellness Center model
- Evaluate ROI for these services
- One central location (one Hub) for resources, multiple organization involved
- 211 is underutilized, challenges have contributed to the under utilization
- Transportation partners for medical resources
- Education for the community at large regarding stigmas (health conditions, race, accessing services, mental health)
- Overall experiences in seeking medical help needs to improve, will help with people wanting to access care.

Breakout Room # 10. Heart Disease and Stroke

Breakout 1, Part 1: *Discuss significant health needs identified within the data analysis and feedback gathered from the community*

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDoH?

- Those who identify as mixed race/ other race are disproportionality affected by health issues.
- Even with all the education that we provide, heart disease is still so prevalent.
- The data shows that behavioral health is impacting overall health and is exacerbate by the COVID-19 pandemic.
- We need to listen to the populations we serve and focus on those issues
- Mental health needs are not being meant due to long wait times and insurance issues. These people are turning to the ER instead

- Not enough mental health providers in the area to serve our population. People cannot afford mental health and other services due to the pervasive housing crisis
- How does housing data match up with health indicators broken out based on property ownership vs. rental. Corporate rental entity vs. privately owned rental properties.
- What is the intersectionality of the data as it related to frontline providers?

- What is the extent to the miscommunication on housing support and how that affect individual ability to afford other expenses? What are the parts of this intersectionality

Breakout 1, Part 2: ***Gather Community Input especially from public health experts and vulnerable populations***

1. What social determinants are impacting this health issue?
    - Food insecurity and access to food
    - Diagnoses and access to care
    - Stigma and misinformation and mistrust
    - Healthcare navigation and health literacy and appt. availability
    - Receiving regular primary and preventative care
    - Built environment and transportation/ public transportation
    - Access to technology
2. From your perspective, what has caused this to improve/worsen/remain the same?
    - Cost of living is a barrier, especially for older populations on a fixed income
    - Lack of transportation
    - Lack of relevant data on this issue
    - Education has helped increased awareness and culturally competent education
    - Navigating the healthcare system is a big barrier for individuals
    - Lack of communication between providers that are not in the same system
    - Lack of cultural competency among providers
    - COVID-19 has exacerbated heart issue and caused stress
    - Providers are very busy and not able to make meaningful connection with their pt.
    - Need more providers and support provided to those providers
    - Social service workforce needs to earn more income
    - Providers not always willing to take Medicare/Medicaid pt. because of low payments
3. What efforts have you experienced that are working and how?
    - Caring support workers- contact pt. in between appt. to ask pts. If they need anything or if they have questions. Make pt. feel comfortable asking question.
    - CHW's build relationship with the community and provide holistic care to family's
    - Accountable care organizations work to provide preventative care
    - Field health navigators are becoming more popular across service areas. provider that faces to face interaction and allow the pt. to have a point of contact that is not a healthcare provider and can build a confident relationship
    - Early health literacy
    - Paying people well helps with employee attrition
    - Expanding Medicaid

4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
    - Incentivize workers in the healthcare field such as paying off loans.
    - Improving the workforce with easy to access training programs and consistent and streamlined programs that are equitable and EASIER to use.
    - We need to do something about the housing crisis
    - Targeted campaigns at the community level such as the Hep A Vaccine campaign (using health navigators and CHWs).
    - Up to date data on our specific communities. Building on existing community programs

Breakout 2: *Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs*

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- Increasing collaboration among providers (this happens in behavioral health with the CFBHN and Wellness connection and the behavioral health system of care meetings) but need to do this in the other areas of health. Could do separate meetings and then come together as a large group to talk about the intersections
- Increase the collaboration between behavioral health and physical health providers
- Develop relationship between providers to improve the transition of care
- School based health centers that include mental health and other services. Including telehealth opportunities. Comprehensive health centers in schools.
- Increasing the number of hours of mental health curriculum in schools.
- Community programs to improve mental health literacy in our communities and help individual be self-advocates
- Engage in faith-based organizations

Immunizations & Infectious Diseases

Breakout Room #11. Immunizations & Infectious Diseases

Breakout 1, Part 1: *Discuss significant health needs identified within the data analysis and feedback gathered from the community*

What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDoH?

- A lot of mental health needs presented – education focused on physical, what about holistic approach? Are they teaching children mental health education?
- Immunizations & ID – stats about babies being born with syphilis - with focus on covid, have we lost our focus on other ID and the immunizations available?
- General categories of needs haven't changed much from the prior CHNA – would like to know if we made any progress in the existing categories
- Zip codes – 33714 zip code was in the highest in majority of categories – cost of homes / SES correlation

Appendix C. Community Input Assessment Tools

Prioritization Session Questions and Summary of Responses

- What would a focus on overall healthy behaviors have on diseases and mental health?
- Idea of access and availability
- minority pop looking for nontraditional hours
    - participant's wife works in specialty and a lot of people visit on Saturdays
- What are new ways that we can address the repeat needs?
    - Precision public health
- People are using technology to engage in risky behaviors – as tech progresses, so should our responses
- Are there any health departments or healthcare offices in the zip codes that were the darkest / highest need?
- Can we use education to combat fear?
- Needs to be a mix of education and trust building to make impact in the community – utilize community leadership to build trust (example of community policing, where police officers would take cars home, so community members knew where the police lived)

Breakout 1, Part 2: *Gather Community Input especially from public health experts and vulnerable populations*

1) What social determinants are impacting this health issue?
    - Economic driven to a degree; disparity on the graphs between ethnicity/race
    - Education
    - What happens to you or around you as a child makes an impact on your life as an adult
    - Rate of HIV/AIDS infection – much higher in the African American community – would like a deeper data dive – gender, LGBTQ+, zip code
    - Housing and the cost of housing; the financial struggle people are experiencing to maintain housing
    - Noticed low level of flu vaccines in 2019

2) From your perspective, what has caused this to improve/worsen/remain the same?
    - Market rate for housing/space has tripled
    - Caused displacement for a lot of people
    - With the growth of St Pete, is that also bringing increased services and funding?
    - HIV/AIDS – large increase in the past few years of cases in black / African American community
    - Resource rich, coordination poor in Pinellas County
    - Locate services within communities – need creative ways
        - Ex – nurse navigators in low-income housing
    - Using the school as a hub for resources – embedding requirements for health screenings
    - Focus on teaching children whole body care (mind and body)
    -
3) What efforts have you experienced that are working and how?

4) From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?

Breakout 2: *Generate (Idea Bank)* *preliminary ideas on how to collaborate with each other and health systems to address the top community needs*

Appendix C. Community Input Assessment Tools

Prioritization Session Questions and Summary of Responses

Reminder – Top 3 needs are:
1. Access to Health & Social Services
2. Behavioral Health (Mental Health and Substance Misuse)
3. Exercise, Nutrition, and Weight

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- Co-locating health / mental health providers and housing providers
    - Homeless empowerment program has a collab with ARNP onsite
- Funding for locations in heart of high need areas that focus on removing fear to make people comfortable with their healthcare (first step into health journey)
    - Identify local orgs already in those areas
- Continue/expand partnerships with orgs in the community
- Identify local community leaders to be champions for the programs and be at the table when creating programs

Breakout Room #12. Immunization and Infectious Disease

Breakout 1, Part 1: *Discuss significant health needs identified within the data analysis and feedback gathered from the community (15 min)*
What stands out for you about each area of need as you hear the data presentation? or What are your initial thoughts about the connection between the data and the SDoH?

- What are the underlying factors? Goes back to eating right, exercise, social support
- Developmental assets
- Work on developing community leaders, support
- Who are our natural mentors in the community?
- Hard to find doctors that certain populations feel comfort with
- Incentive cultural awareness
- Need additional resources for dentist (share space at different times)
- Community kitchens (culturally relevant recipes), shared spaces
- Maximize key themes (using our resources to the max)
- Surprised by the lack of housing security concerns
- We often don't associate housing with healthcare
- Access to health care, dental care, behavioral health is common theme, transportation
- Access is more than having insurance, we need to have care available at more convenient times (7 AM – 11 PM)
- Some pediatric providers are offering longer hours
- Many people rely on the ER due to "convenience" of time (not all can access doctors during "business hours")
- Big copy differential for ER and urgent care
- Telehealth bringing value, increasing access
- Dental services from state health plan, long wait times (not many take the insurance)
- Need for personal advocacy in getting needs met
- Hard to get timely appts, especially with dental

- Many providers behind in appts
- Top risky behaviors/concerns are affecting populations most in need of advocates for care (experiencing several barriers to care); some people felt discounted, not treated well, not heard by providers; affecting most vulnerable populations
- Need for advocates, care coaches

Breakout 1, Part 2: *Gather Community Input especially from public health experts and vulnerable populations (25 min)*

1. What social determinants are impacting this health issue?
    - Cultural aspects, babies not getting fully immunized
    - At DOH, saw trend of Hispanic/Latinx community babies not getting childhood immunization. They were not in daycare; parents did not see the need. Not accessing systems that require immunization early. Leads to a system of thinking that believes immunizations are not important/needed
    - Minority populations choosing not to get vaccinated for COVID, need for trust building in medical community
    - COVID vaccination journey shed light on the mistrust of health care providers, history of mistrust emerged
    - Don't tend to have PCP's, don't' get checkups, not getting vaccines
    - Let's keep politics out of public health!
    - We do a better job immunizing kids than adults. Many adults hesitant to vaccinate.
    - High vaccine rates for kids, adult rates much lower (flu is a high risk for our aging population); perhaps bc vaccines are required for kids for schools/immigration, etc.
2. From your perspective, what has caused this to improve/worsen/remain the same?
    - Many vaccines are very expensive (esp. without insurance)
    - Past trauma combined with expensive cost of vaccines (ex, shingles, Hep B)
3. What efforts have you experienced that are working and how?
    - Free vaccines, widespread availability
    - State vaccine registry (FL Shots); would be helpful to know that all pharmacies, clinics are contributing data; helps with tracking accurate records "The more you use the systems, the better the data gets"
4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
    - Keep politics out of public health
    - Listen to what barriers are for specific populations
    - Learn more about cultural differences and beliefs (beliefs in natural healing/medicine)

Breakout 2: *Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs (20 min)*

What are potential ways organizations can work together to transform the conditions we discussed earlier?

- Top priority areas- Access to Health Services, Behavioral Health, Exercise/Nutrition/Weight
- Incentivizing – access to services (tax breaks for sharing office space, scholarships for health-related fields/health navigators, free cultural training/awareness activities, more than just CEU's)

- Cooking demos with free meals
- New doctors commit to time at a clinic, esp. underserved areas/low access areas (define areas and care needed)
- Focus group with providers! How to expand hours?
- Shared space
- Extended hours
- Access goes beyond health insurance
- Developmental assets – weave throughout systems (coaches, teachers, scout leaders, faith community, other leaders in community)
- Transportation and lack of- challenges ongoing
- Mass transportation is not great in Pinellas (multiple connecting buses, not convenient, takes too long to get from A to B)
- Ride share and other options not known/used
- How can we leverage technology? Access can be a barrier, but it's becoming less expensive. Can help us meet people where they are at
- Physically getting to places seems to have gotten harder

- Many people have smart phones, can help increase access via telehealth

Appendix D. Data Placemats

Placemats were utilized during prioritization session breakout discussions to discuss thoughts about quantitative and qualitative data collected and analyzed. A placemat was created for each health topic.

- **Access to Health and Social Services**
- **Behavioral Health**
- **Cancer**
- **Exercise, Nutrition, and Weight**
- **Heart Disease and Stroke**
- **Immunizations and Infectious Diseases**

PINELLAS COUNTY DEMOGRAPHICS

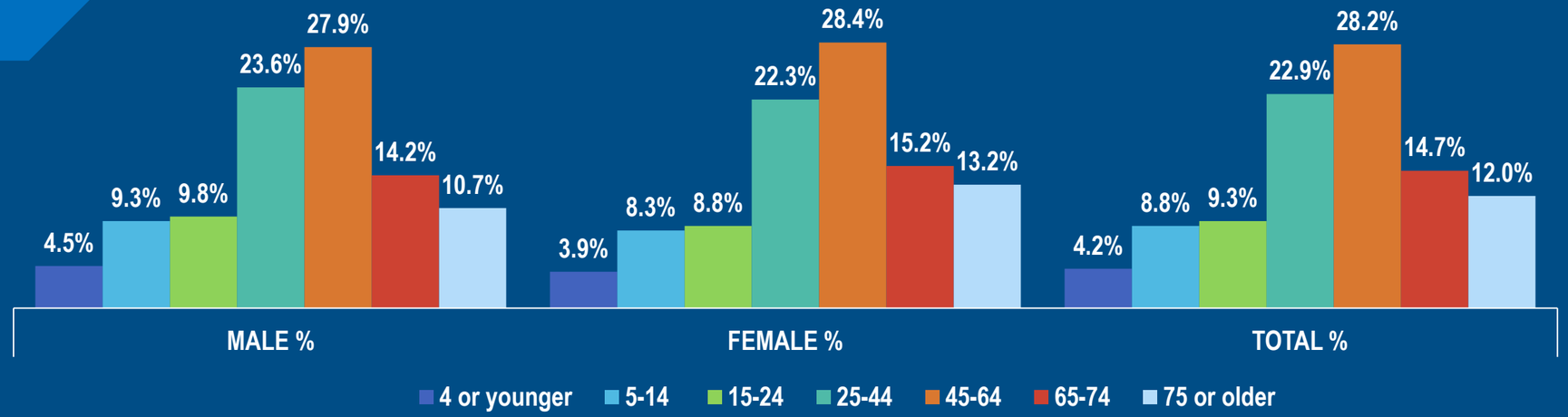
982,142 People

Median Age
49.0

48.0% Male

52.0% Female

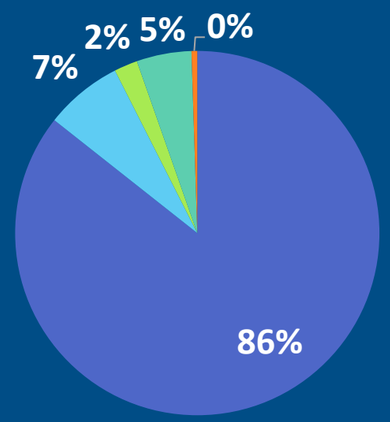
PINELLAS COUNTY POPULATION BY AGE AND GENDER 2021



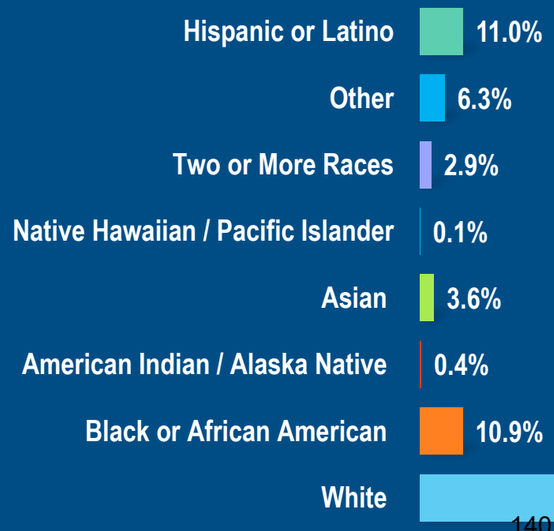
Level of Education, Age 25+	Pinellas County	Florida	U.S.
Less than 9th Grade	2.8%	4.6%	4.8%
9th to 12th Grade, No Diploma	6.0%	7.0%	6.6%
High School Graduate or G.E.D	27.8%	28.5%	26.9
Some College, No Degree	20.9%	19.5%	20.0%
Associate's Degree	9.9%	9.9%	8.6%
Bachelor's Degree	21.2%	19.2%	20.3%
Graduate or Professional Degree	11.4%	11.3%	12.8%

12.1% Of the Population Foreign Born

Population Age 5+ by Language Spoken at Home



RACE & ETHNICITY



9.7% Of the Population are Veterans

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Sources: Data.Census.gov; All4HealthFL.org

PINELLAS COUNTY ECONOMIC BREAKDOWN

Median Household Income

$64,959

With a $24.89 Mean Hourly Wage, 2020

Unemployment Rate

5.1% Age 16+, 2022

Workers by Means of Transportation to Work, 2022	Pinellas County	Florida
Worked at Home	7.7%	6.6%
Walked	1.6%	1.5%
Bicycle	.6%	.6%
Carpooled	9.2%	9.2%
Drove Alone	78.3%	78.6%
Public Transport	1.2%	1.7%
Other	1.4%	1.8%

7.2% Population Change 2010-2022

$241,892 Median Property Value

16.8% Growth 2010-2021

85.9% Have Internet Subscriptions

Inflation Rate

10.2%

12-month percentage changes Tampa-St. Petersburg-Clearwater Data

13.0% Of Individuals are Below Poverty Level

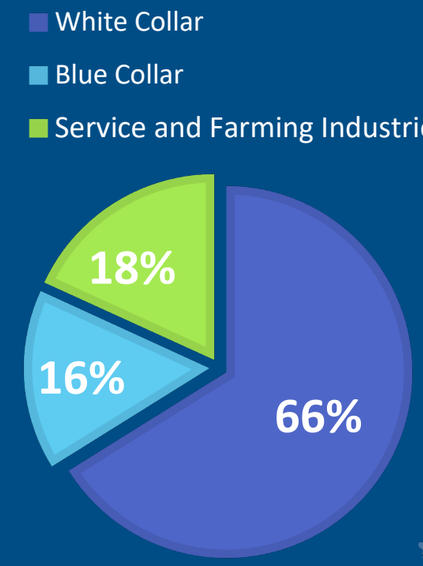
70.4%

Of the total number of survey respondents experienced one or more losses due to COVID

Some of the top losses include:

- Recreation or entertainment
- Sense of well-being, security, or hope
- Death of family or friend
- Exercise opportunities
- Income

PINELLAS EMPLOYED CIVILIAN 16+ BY OCCUPATION GROUP



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Sources: All4HealthFL.org, FLHealthCharts.gov; U.S. Bureau of Labor Statistics: bls.gov

ACCESS TO HEALTH & SOCIAL SERVICES PINELLAS COUNTY

88 Primary Care Providers
rate per 100,000 population

59 Dentists
rate per 100,000 population

209 Mental Health Providers
rate per 100,000 population

> *We're working with a community that is very hardworking. For them to go and see a doctor and have to lose a day of work and pay, they tend to ignore any signal or symptom, they need options for the schedules they work.*
>
> -Hispanic/Latinx Group Participant

Low-income populations in the following cities are federally designated Primary Care and/or Dental Provider Shortage Areas

- Bayview
- Clearwater
- Largo
- Pinellas Park
- St. Petersburg
- Tarpon Springs

All of Pinellas County is considered a Mental Health Provider shortage area.

82.3%	Of adults with health insurance, 2019
76.1%	Of adults who have a personal doctor, 2019
24.7%	Of high school students have not visited a doctor's office in the past 12 months, 2020
14.5	Preventable hospitalizations under 65 from dental conditions, 3 year rolling 2018-20, rate per 100,000

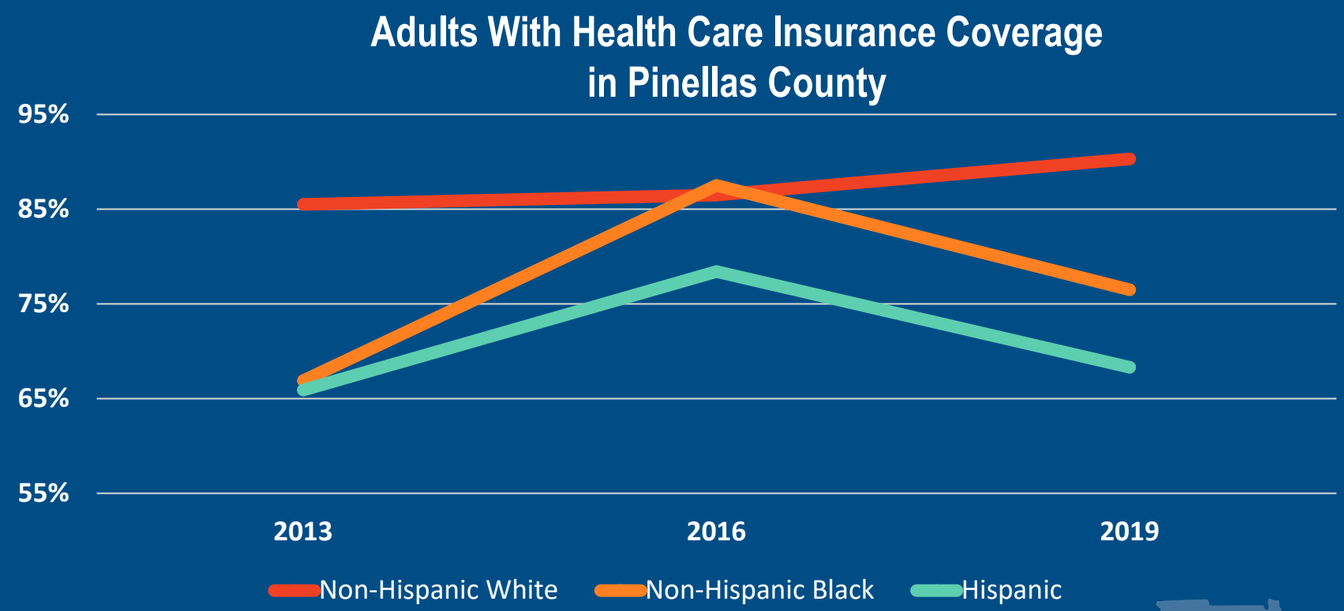
"Was there a time in the last 12 months when you needed medical care but did not get the care you needed?"

18.2% Responded 'Yes'

Top 5 Reasons Why Respondents Say They Didn't Get The Medical Care They Needed

1. Unable to schedule an appointment when needed
2. Unable to afford to pay for care
3. Cannot take time off work
4. Doctor's office does not have convenient hours
5. Unable to find a doctor who takes my insurance

93.5% Of children in Pinellas County have health insurance, 2019



Sources: All4HealthFL.org, FLHealthCharts.gov; CHNA Survey Data; https://www.data.hrsa.gov

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BEHAVIORAL HEALTH PINELLAS COUNTY

(Mental Health and Substance Misuse)

41% Of survey respondents ranked mental health as the most pressing health issue

19% Of survey respondents reported experiencing 4 or more Adverse Childhood Experiences (ACEs) before age 18

30.1% of Middle School Students Report having used alcohol or illicit drugs in their lifetime

24.2% of Adults engage in heavy or binge drinking

34.1 Alcohol-Confirmed Motor Vehicle Traffic Crashes per 100,000 Pop.

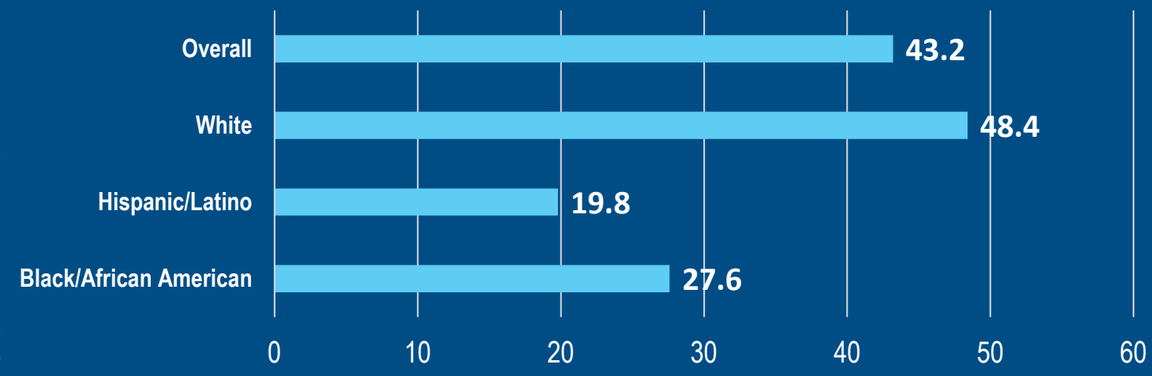
50.6% of High School Students Report having used alcohol or illicit drugs in their lifetime

41.3% of high school students have used a vaporizer/E-cigarette, 2018

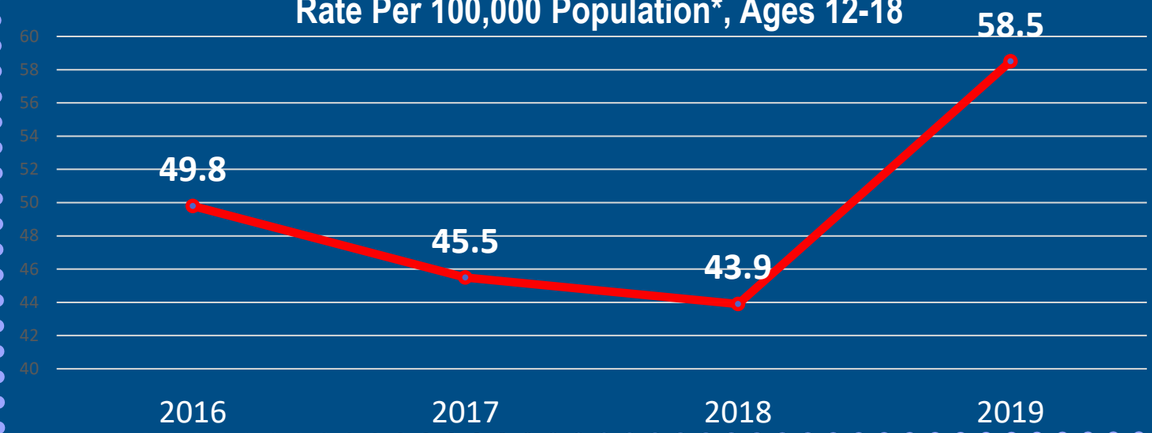
17.7% of middle school students have used a vaporizer/E-cigarette, 2018

19.7% of adults currently smoke cigarettes, 2017-2019

Age-Adjusted Drug and Opioid Involved Overdose Death Rate, 2018-2020



Pinellas Hospitalizations for Eating Disorders Rate Per 100,000 Population*, Ages 12-18



11.5% of survey respondents indicated they had thoughts that they would be better off dead or of hurting themselves in some way for several days, more than half of the days or nearly every day over the last 12 months.

34% of survey respondents were diagnosed by a medical provider with Depression or Anxiety

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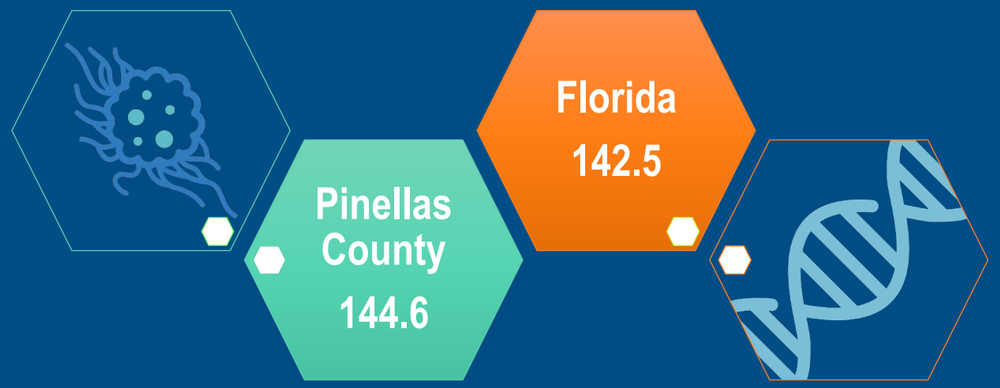
Sources: All4HealthFL.org, FLHealthCharts.gov; CHNA Survey Data; Florida Youth Substance Abuse Survey

*Simply described, **rate** is the number of individuals hospitalized per 100,000 members of the community; Hospitalization numbers do not include visits to the Emergency Department

CANCER PINELLAS COUNTY

CANCER DEATH RATE
(Age-adjusted per 100,000 population, 2018-2020)



Adults who currently smoke cigarettes, 2017- 2019

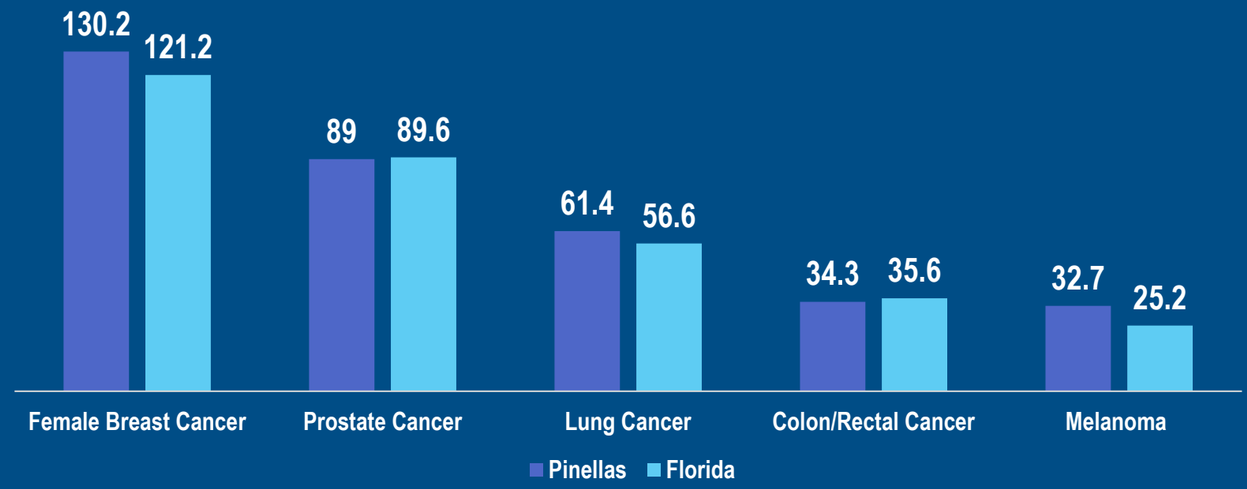
Pinellas County	19.7%
Florida	14.8%

17% of survey respondents ranked Cancer as a most pressing health issue

CANCER DEATH RATE IN PINELLAS BY RACE/ETHNICITY
(Age-adjusted per 100,000 population, 2018-2020)

Sources: All4HealthFL.org, FLHealthCharts.gov; CHNA Survey Data

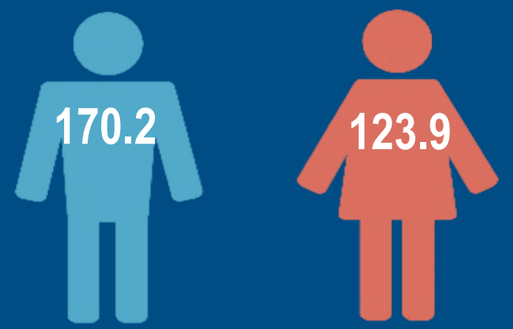
CANCER INCIDENCE RATE: PINELLAS COUNTY
(Average age-adjusted per 100,000 population, 2016-18)



CANCER DEATH RATES BY TYPE
(Average age-adjusted deaths per 100,000 population, 2018-2020)

Type of Cancer	Pinellas County	Florida
Female Breast Cancer	19.6	18.7
Prostate Cancer	15.4	16.5
Lung Cancer	36.1	33.6
Colon/Rectal Cancer	12.1	12.6

CANCER DEATH RATE BY GENDER
(Age-Adjusted per 100,000 Population, 2018-2020)



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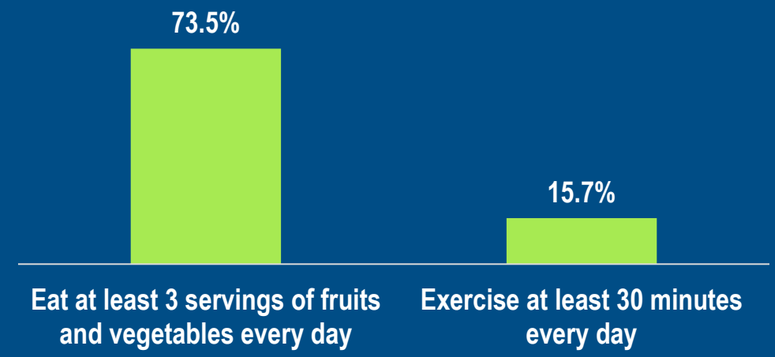
Cancer Prevention Indicator:
Survey respondents who answered "NO" to the following



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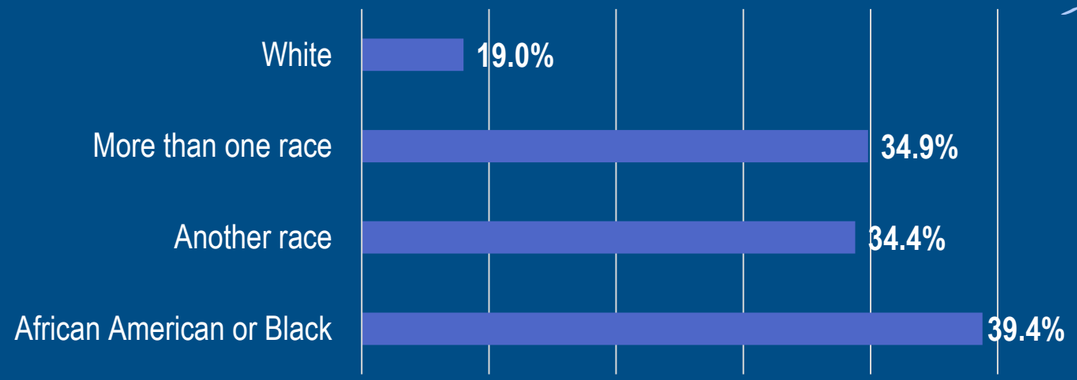
EXERCISE, NUTRITION & WEIGHT PINELLAS COUNTY

22.8% of survey respondents self-reported food insecure

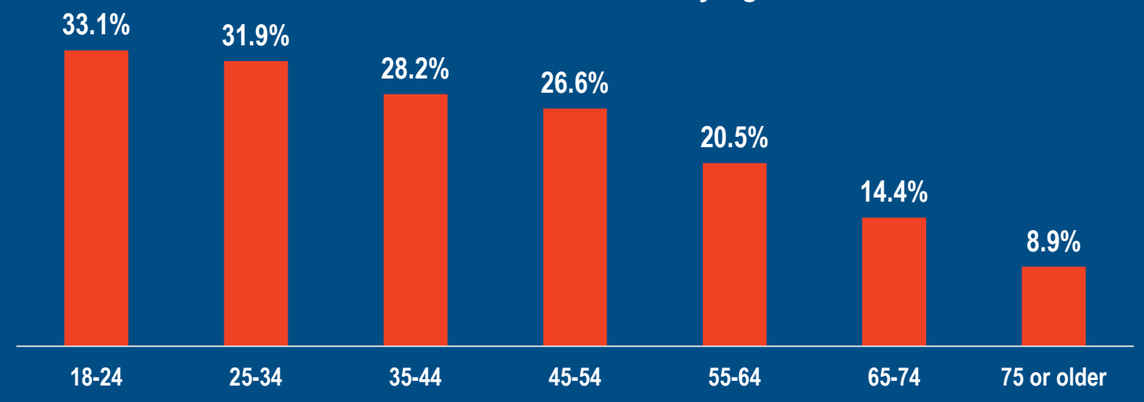
Survey Respondents Food Insecurity by Race



12.0% responded 'yes'

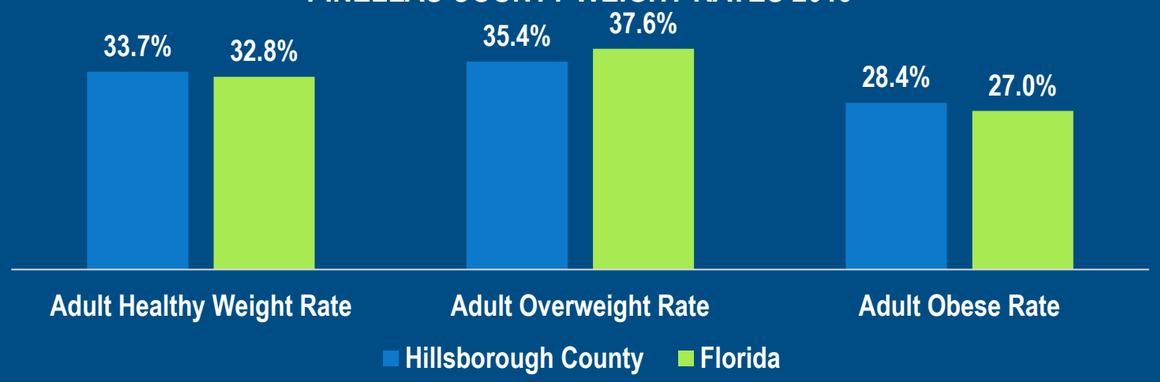
In the last 12 months, did you or anyone living in your home ever get emergency food from a church, a food pantry, or a food bank, or eat in a soup kitchen?

Food Insecure Individuals by Age



29.0%	Respondents who disagreed with the statement "There are good sidewalks for walking safely in my neighborhood"
9.6%	Respondents who disagreed with the statement "We have great parks and recreational facilities"
19.9%	Respondents who disagreed with the statement "I am able to get healthy food easily"
12.8%	Respondents who disagreed with the statement "I feel safe in my own neighborhood"

PINELLAS COUNTY WEIGHT RATES 2019



Survey respondents who answered "NO" to the following:

73.5% Eat at least 3 servings of fruits and vegetables every day

15.7% Exercise at least 30 minutes every day

10.7%	Adults who have ever been told they have diabetes, 2019
210.4	Age adjusted ED visits from diabetes, 3 year rolling 2018-20, rate per 100k

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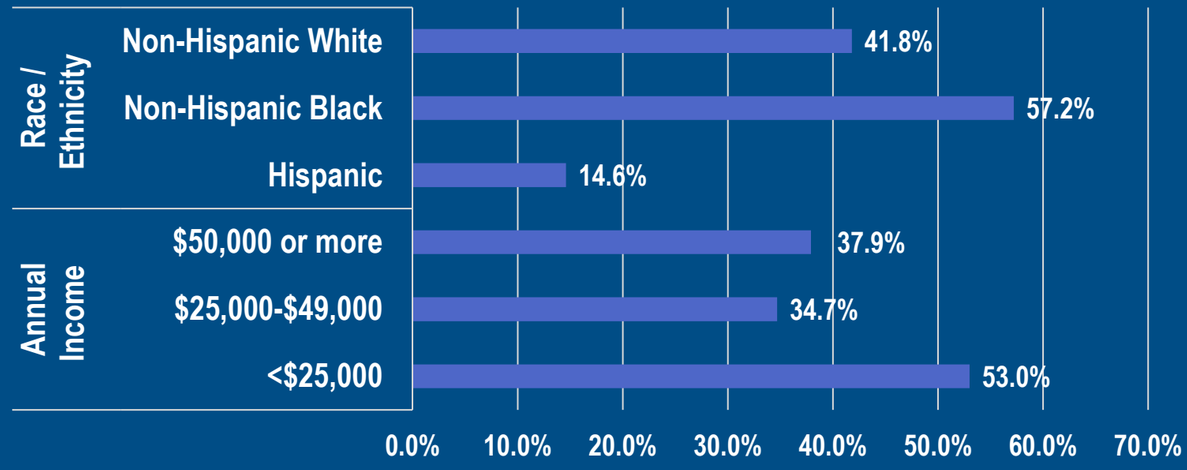
Sources: FLHealthCharts.gov; CHNA Survey Data

HEART DISEASE & STROKE PINELLAS COUNTY

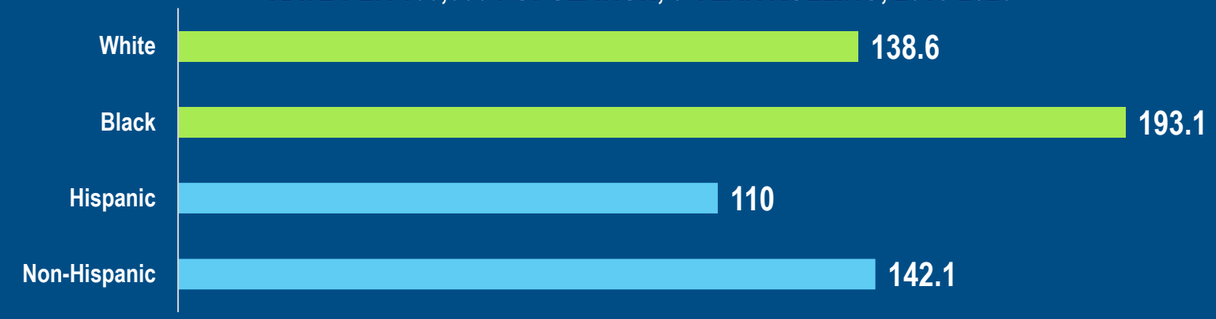
12,936

Emergency Department Visits that include a diagnosis of Heart Failure, Sampling of Four Pinellas Hospitals, 2021

PINELLAS ADULTS WHO HAVE EVER BEEN TOLD THEY HAVE HYPERTENSION, 2019



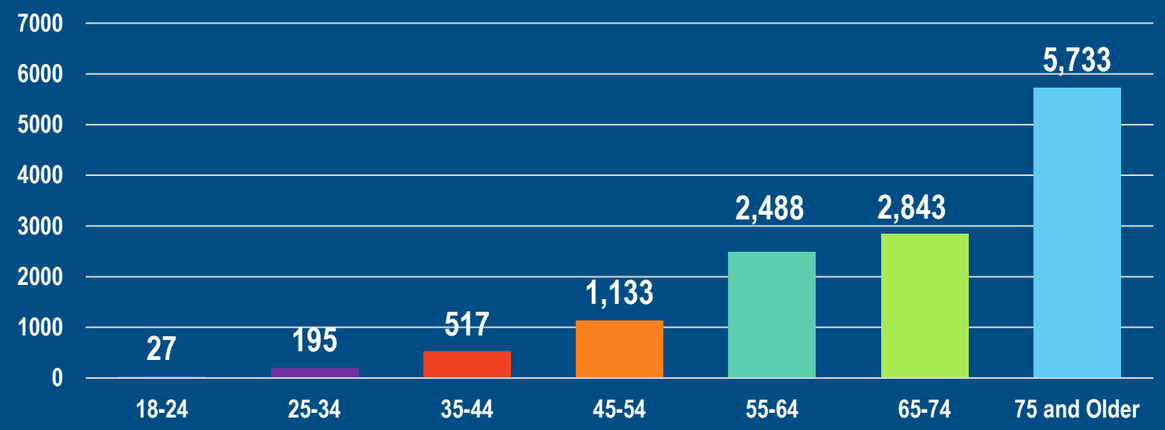
AGE-ADJUSTED DEATHS FROM HEART DISEASES, RATE PER 100,000 POPULATION, 3-YEAR ROLLING, 2018-2020



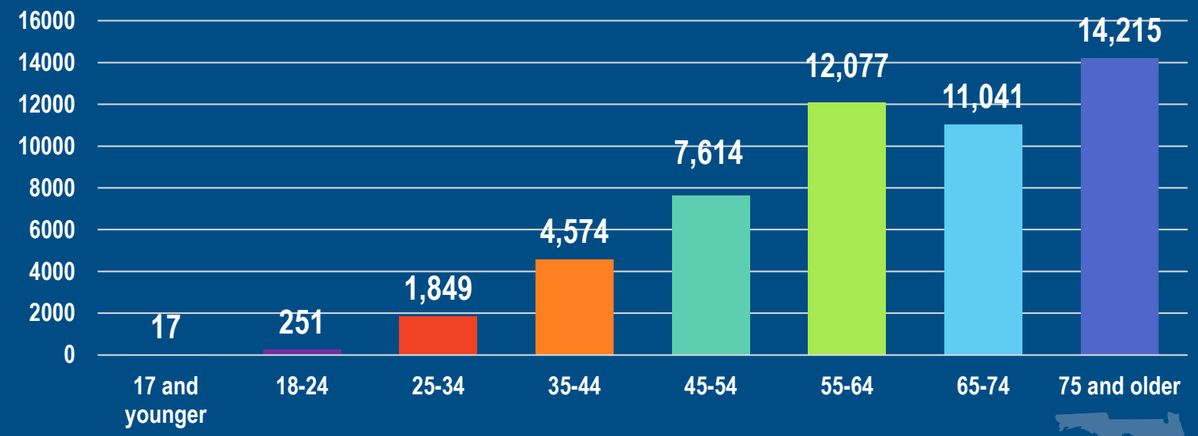
41% Of survey respondents told by a medical provider they have Hypertension and/or Heart Disease

4.2% Adults who experienced a stroke, 2019

EMERGENCY DEPARTMENT VISITS THAT INCLUDED A DIAGNOSIS OF HEART FAILURE BY AGE (Sampling of four Pinellas hospitals, 2021)



EMERGENCY DEPARTMENT VISITS THAT INCLUDED UNCONTROLLED BLOOD PRESSURE / HYPERTENSION BY AGE (Sampling of four Pinellas hospitals, 2021)

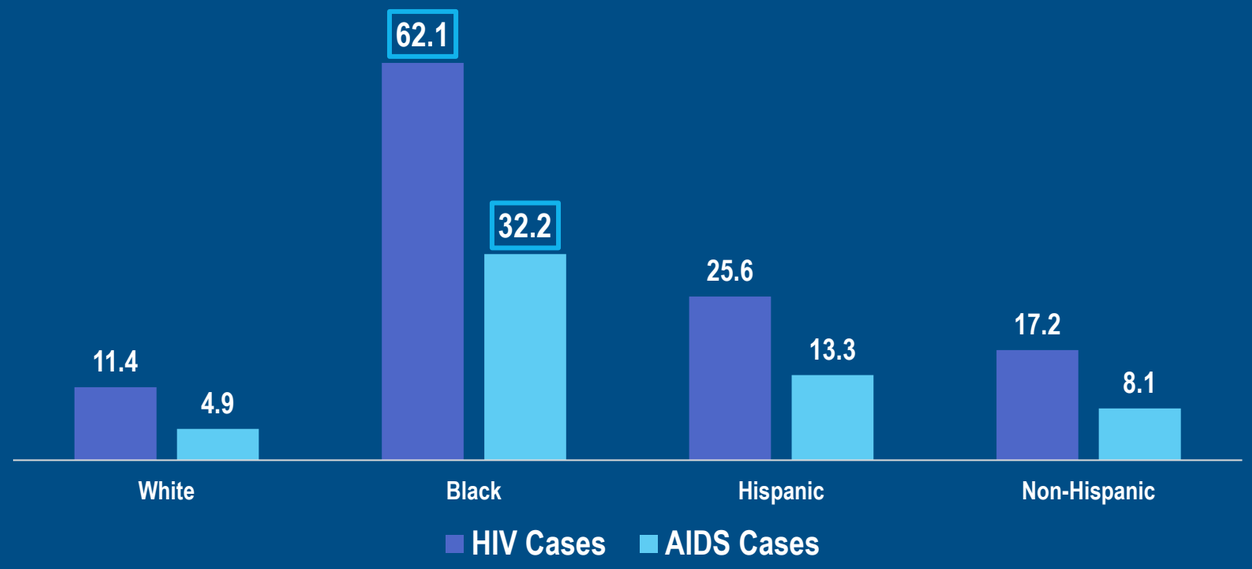


Sources: FLHealthCharts.gov; CHNA Survey Data

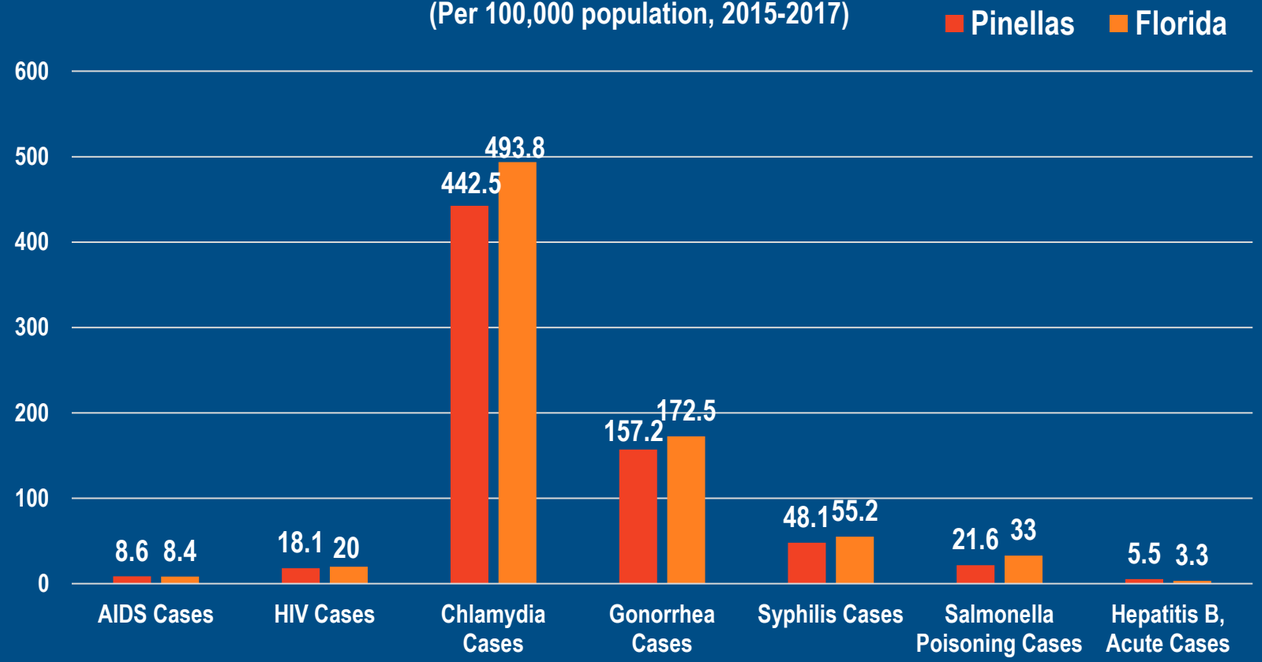
All4HealthFL
Four Counties. One Vision.

IMMUNIZATION & INFECTIOUS DISEASE PINELLAS COUNTY

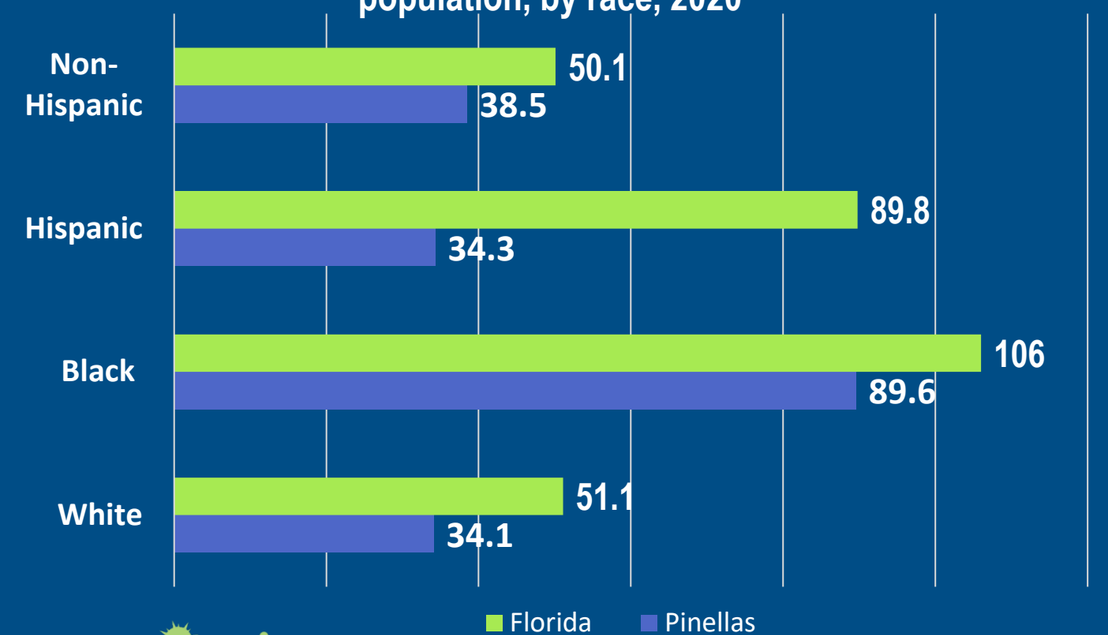
DISPARITIES IN HIV/AIDS DIAGNOSES
(Per 100,000 population, 2018-2020)



REPORTABLE AND INFECTIOUS DISEASES
(Per 100,000 population, 2015-2017)



Age-adjusted deaths from COVID-19, rate per 100,000 population, by race, 2020



64.1% Persons fully vaccinated against COVID-19

42.6%	Adults who received a flu shot in the past year, 2019
84.7%	Two-year olds fully immunized, 2019
92.2%	Kindergarten children fully immunized, 2021

Sources: FLHealthCharts.gov; CHNA Survey Data

All4HealthFL
Four Counties. One Vision.

Appendix E. Community Partners and Resources

This section contains a listing of names of organizations and partners who contributed to the CHNA process.

- **All4HealthFL Collaborative Members and Supporting Teams**
- **Community Partners and Organizations**

Appendix E. Community Partners and Resources

The All4HealthFl collaborative gratefully acknowledges the participation of a dedicated group of organizations and individuals that gave generously of their time and expertise to help guide this CHNA report.

ALL4HEALTHFL COLLABORATIVE LEADING MEMBERS

First & Last Name	Credentials	Title	Organization
Allison Nguyen	MPH, MCHES	Program Manager – The Office of Health Equity	Florida Department of Health in Hillsborough County
Alyssa Smith	MPH	Community Benefit Coordinator	AdventHealth
Bradlie Nabours	MPH, CPH	Project Evaluator, Healthy Start Government & Community Affairs	Johns Hopkins All Children's Hospital
Brittany Lynn	MPH, CPH	Corporate Wellness Account Manager	BayCare Health System
Chedeline Apollon	MPH, CPH	Senior Human Services Program Specialist – The Office of Health Equity	Florida Department of Health in Hillsborough County
Christopher Gallucci	DHSc, MPH, CPH	Public Health Services Manager	Florida Department of Health in Pinellas County
Colleen Mangan	MPH	Community Benefit Data Analyst	BayCare Health System
DAmato Marina		Health Education Consultant/CHA/CHIP Coordinator	Florida Department of Health in Pasco County
Jenna Levine	MPH, CPH	Director of Public Health Planning	Department of Health Polk County
Katie Deasaro	BS	Community Outreach Coordinator – Pasco County	BayCare Health System
Kayla Wilson	MPH, CPH	Community Benefit Specialist	BayCare Health System
Kelci Tarascio	MPH, CPH	Community Outreach Coordinator – Pinellas County	BayCare Health System
Kellie Gilmore		Community Health and Wellness Manager	Johns Hopkins All Children's Hospital
Keri Kozicki	MPH	Community Health Program Coordinator	BayCare Health System
Kimberly Berfield		Vice President, Government Affairs and Community Health	Johns Hopkins All Children's Hospital
Kimberly Brown-Williams		Project Director and Interim Principal Investigator, Healthy Start	Johns Hopkins All Children's Hospital
Kimberly Williams		Director of Community Benefit	AdventHealth
Krista Cunningham	MPH, CPH	Community Outreach Coordinator – Hillsborough County	Baycare Health System

Appendix E. Community Partners and Resources

Kristen Smith	MS, HS-BCP	Community Outreach Coordinator – Polk County	Baycare Health System
Laine Fox-Ackerman			Orlando Health
Lauren Springfield	MA, MBA	Director of Community Health	Lakeland Regional Health
Leah Gonzalez	MPH	Community Benefit Coordinator	Baycare Health System
Lisa Bell	MPH	Community Benefit Director	BayCare Health System
Megan Carmichael		Community Health Promotion Program Manager	Department of Health Pasco County
Nathanael Stanley	PhD	Applied Research Scientist Community Benefit Specialist	Moffitt Cancer Center
Nosakhare Idehen	MD, Ph.D, MHA, RN		Florida Department of Health in Pinellas County
Sara Hawkins	MS, CHES	Community Health Program Manager	AdventHealth
Sara Osborne	MSHSA	Senior Director Community Benefit	Bayfront Health System
Stephanie Arguello	MPH, RYT-200	Director of Community Health	AdventHealth
Stephanie Sambatakos	MSEd	Community Health Improvement Supervisor	Johns Hopkins All Children's Hospital
Tamika Powe	MPH, MCHES, CDP	Manager, Community Benefit & Health Education Manager	Tampa General Hospital
Tatiyana Badal		Public Health Educator	Florida Department of Health in Pasco County
Taylor Freeman	BS	Public Health Planner	Florida Department of Health in Polk County
Tom Panagopoulos	MPH	Minority Health & Health Equity Coordinator	Florida Department of Health in Pasco County

FOCUS GROUP SUPPORTING INDIVIDUALS

Names/Organizations	Names/Organizations	Names/Organizations
Audrey Beaton	Gladys Evan	Kyle Olle
Barbara White	Gloria Campbell	Lisa DePaolo
Barbara Williams	Iliana Santana Ramos	Lottie Cuthbertson
Bryan Voliton	Irisann Moon	Mandy Keyes
Candace Gioia	Jacqueline (Diane) Morris	Maria Pepe
Christie Bruner	James Moon	Michael Otto
David Hill	jfrank	Nathan Bruemmer
David Kinnard	Joe Santini	Noliyanda James
David Lomaka	Julia Delmerico	Petra Stanton

Appendix E. Community Partners and Resources

Denise Whitfield	Kevin Dorsey	Rebeca Prado
Dr. Sheron Brown	Kim Saberi	Terri Lipsey Scott
Eliseo Santana	Kimberly Brown-Williams	Tiffany scurlock

Appendix E. Community Partners and Resources

The All4HealthFl collaborative gratefully acknowledges the participation of a dedicated group of organizations and individuals that gave generously of their time and expertise to help guide this CHNA report.

Pinellas County Partner Organizations		
211 Tampa Bay Cares	Gulfcoast Jewish Family Services	Pinellas County School Board
Access Community Services	Gulfcoast North Area Health Education Center	Pinellas County Sheriff's Office
Access Florida	HCA Healthcare	Pinellas County Urban League
Agency for Persons with Disabilities	HCR Manor	Pinellas Hope
American Heart Association	Health Council of West Central Florida	Pinellas Sheriff's Police Athletic League
Area Agency on Aging of Pasco-Pinellas, Inc.	Healthy St. Pete	Pinellas Suncoast Transit Authority
Behavioral Health Systems of Care	Healthy Start Coalition of Pinellas County	R'Club Child Care
Boys and Girls Club	Healthy Start Federal Project	Red Cross
City of Largo	Homeless Empowerment Program (HEP)	Salvation Army
City of St. Petersburg	InterCultural Advocacy Institute	Seniors in Service of Tampa Bay
Clearwater Free Clinic	Johns Hopkins All Children's Hospital	St. Petersburg College
Clearwater Urban Leadership Coalition (CULC)	Juvenile Welfare Board of Pinellas County	St. Petersburg Free Clinic
Community Dental Clinic	Largo Medical Center	St. Petersburg Police Department
Domestic Violence Task Force of Pinellas County	Lighthouse Pinellas	St. Vincent de Paul
Early Learning Coalition	Limitless Leader Inc.	Suncoast Center Inc.
Ending the HIV Epidemic Council	Local Food Project	Suncoast Health Council
Evara Health	Lutheran Services Florida	Suncoast Hospice
Family Resources	Mothers Against Drunk Driving	Tampa Bay Healthcare Collaborative
Feeding Tampa Bay	NAMI Pinellas County Florida, Inc.	University of Florida IFAS Extension
Florida Center for Community Design & Research	Neighborhood Family Centers	University of South Florida College of Public Health
Florida Consumer Action Network	Operation PAR	Veterans Counseling Veterans
Florida Hospital North Pinellas	Peace for Tarpon	YMCA of St. Petersburg
Forward Pinellas	Pinellas County Health and Human Services	YMCA of the Suncoast

Appendix E. Community Partners and Resources

Foundation for a Healthy St Petersburg	Pinellas County Housing Authority	
Fresh Initiatives Supply Hub	Pinellas County Planning Department	
Greater Ridgecrest Area Youth Development Initiative - Pinellas County Housing Authority		

Appendix F. Partner Achievements

This section highlights the All4HealthFL Collaborative organizations achievements towards addressing the health topics from the 2019-2021 CHNA cycle.

Florida Department of Health-Mental Health First Aid

Since the preceding CHNA, the Florida Department of Health in Pinellas County adopted an objective activity to promote and increase mental health first aid training. The process measure was to ensure that at least three training courses are offered to teachers, law enforcement, first responders, community members by December 31st, 2022. FDOH- Pinellas has met this objective.

The agency actively engaged our community partners to provide mental health first aid training to nurses at the department of health, city employees, firefighters, and community members. For example, one of our community partners, the City of Largo, provided the Housing Division and Community Standards staff (Code Enforcement) with mental health first aid training. All new hires at the City's Fire Department receive 4 hours of mental health first aid training. In 2020, the City's Fire Department also completed department-wide mental health training.

The Fire Department's peer support team is required to have 8 hours of mental health training each year. Due to the COVID-19 pandemic restrictions and social distancing rules, mental health first aid training was conducted via video conferences in 2020. The City of Largo also completed another round of a 4-hour mental health first aid training session on March 4TH, 2021 with Dr. Benson, Chief Psychologist with Tampa Bay Psychology Associates.

AdventHealth West Florida Division-Mental Health First Aid

Since the preceding CHNA, AdventHealth West Florida division, comprised of 11 not-for-profit hospitals spanning 7 counties, planned to provide a total of 33 Adult Mental Health First Aid classes. In May of 2021, AdventHealth West Florida division sponsored the cost to train 4 team members as Adult Mental Health First Aid instructors.

BayCare Health System-Mental Health First Aid

By providing Mental Health First Aid (MHFA) classes, BayCare focused on increasing community awareness to identify and address someone in mental health distress. Adult and Pediatric classes were held across the community. To date, BayCare has provided 35 classes, training over 500 individuals across our four-county service area.

MHFA was offered to a combination of social service providers, community members, and faith leaders who have multiple touch points with individuals living in BayCare's service area. A few of these organizations are: Pasco County Government, Suncoast YMCA, St. Pete Youth Farm, Hillsborough HOPE, Metropolitan Ministries, The Spring of Tampa Bay, Boys & Girls Club, Pinellas HOPE, St. Pete Chamber of Commerce, NAMI Pinellas, Central Florida Health Care, Prince of Peace Catholic Church, Hope Grove, The Mission, Restoration Church, and Hillsborough County Department of Children's Services.

Appendix F. Partner Achievements

BayCare Health System: Mease Countryside and Mease Dunedin Hospitals

Behavioral Health

Mental Health First Aid:

By providing Mental Health First Aid classes, Mease Countryside and Mease Dunedin Hospitals focused on increasing community awareness to identify someone in mental health distress. Adult and Pediatric classes were held across the community. MHFA was offered to a combination of social service providers, community members, and faith leaders who have multiple touch points with individuals living in the Mease Countryside and Mease Dunedin Hospital service areas. To date nearly 500 individuals have been trained across our four-county service area.

Behavioral Health Liaisons:

Mease Countryside and Mease Dunedin Hospitals added a Behavioral Health Therapist to expand access to behavioral health and substance misuse services by assisting with education and linkage to community resources. The Behavioral Health Therapist acts as a liaison, meeting the patient and family in their time of need, providing education, therapeutic support, and assisting with navigating various avenues of behavioral health services.

Salvation Army:

BayCare partnered with Salvation Army to provide transient individuals with a respite space to begin caring for their behavioral health needs once discharged from the hospital. Clients can stay in a Salvation Army bed for 30 nights to help with stabilization and getting connected with substance misuse resources in the community. This partnership allows individuals to begin a recovery plan that can help lead to a sustainable path to long-term recovery.

Access to Health Services

Medication Assistance Program (MAP):

BayCare has developed and implemented a Medication Assistance Program. MAP is designed to assist patients and community members in finding available resources to help offset the cost of medication. Patients and community members receive assistance with affordable medications that they might have otherwise had to prioritize over other social or economic needs or go without taking. The MAP program has saved individuals $14,230,479 as of May 2022.

FindHelp Florida:

FindHelp Florida is an online platform that connects people with resources they need such as stable housing, access to food, transportation, or affordable healthcare among many other needs. In response to the growing need in our communities, BayCare partnered with FindHelp Florida to integrate their platform into the Cerner electronic medical record to help connect patients to organizations that can provide needed resources and services. BayCare has also created a public

Appendix F. Partner Achievements

BayCare Health System: Mease Countryside and Mease Dunedin Hospitals

FindHelp site that can be used by anyone in the community to search for resources that meet their needs.

Community Directed Giving:

Mease Countryside and Mease Dunedin Hospitals have dedicated funds to several community partners to meet access to health care needs. These funds are used to expand healthcare services on site at various organizations that provide services to underserved populations. A few examples are Clearwater Free Clinic, Homeless Empowerment Program, community-based health clinics such as Willa Carson Health and Wellness Center and La Clinica Guadalupana, and the Community Dental Clinic. These organizations help create a network of varying healthcare services to support the population(s) that have the greatest unmet needs in our community.

Exercise, Nutrition, and Weight

Food Insecurity (Healing Bags/School Pantries):

In response to the high level of food insecurity in BayCare's service areas, programs to expand access to food have become a major priority for the system. One of the ways BayCare has worked to combat food insecurity is by offering Healing Bags, a three-day supply of non-perishable food, to patients that have been screened and identified as food insecure. Since its inception, 55,779 patients have been screened with 4,463 receiving a Healing Bag from a BayCare hospital. The second way BayCare is working to address food insecurity is through partnership with Feeding Tampa Bay to supply 42 schools across its service area with an onsite food pantry for the students and their families. There are currently 6 school-based pantries in the Mease Hospitals' service areas.

Healthy Living Coach Program:

To address the health concerns that come with chronic conditions such diabetes or obesity, BayCare implemented a Healthy Living Coach program. The Healthy Living Coach is a staff member of community health clinics that provide nutritional and diabetes support education for their clients. They work with the clients to create health goals and plans to better manage their weight and diabetes to improve health outcomes. BayCare has five Healthy Living Coaches between Pinellas, Pasco, and Polk counties.

Community Health Team:

Our BayCare Community Health Team works in collaboration with community organizations to provide education, screenings, and referrals to individuals in the community. Community Health Team can offer screenings for cholesterol, HDL, Glucose, blood pressure, BMI, and Diabetes risk assessment. The Community Health team continues to grow their screenings to meet the needs of individuals across Mease Countryside and Mease Dunedin Hospitals' service areas.

Appendix F. Partner Achievements

BayCare Health System: Morton Plant Hospital

Behavioral Health

Mental Health First Aid:

By providing Mental Health First Aid classes, Morton Plant Hospital focused on increasing community awareness to identify someone in mental health distress. Adult and Pediatric classes were held across the community. MHFA was offered to a combination of social service providers, community members, and faith leaders who have multiple touch points with individuals living in the Morton Plant Hospital service area. To date nearly 500 individuals have been trained across our four-county service area.

Behavioral Health Liaisons:

Morton Plant Hospital added a Behavioral Health Therapist to expand access to behavioral health and substance misuse services by assisting with education and linkage to community resources. The Behavioral Health Therapist acts as a liaison, meeting the patient and family in their time of need, providing education, therapeutic support, and assisting with navigating various avenues of behavioral health services.

Salvation Army:

BayCare partnered with Salvation Army to provide transient individuals with a respite space to begin caring for their behavioral health needs once discharged from the hospital. Clients can stay in a Salvation Army bed for 30 nights to help with stabilization and getting connected with substance misuse resources in the community. This partnership allows individuals to begin a recovery plan that can help lead to a sustainable path to long-term recovery.

Access to Health Services

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FindHelp Florida:

FindHelp Florida is an online platform that connects people with resources they need such as stable housing, access to food, transportation, or affordable healthcare among many other needs. In response to the growing need in our communities, BayCare partnered with FindHelp Florida to integrate their platform into the Cerner electronic medical record to help connect patients to organizations that can provide needed resources and services. BayCare has also created a public FindHelp site that can be used by anyone in the community to search for resources that meet their needs.

Appendix F. Partner Achievements

BayCare Health System: Morton Plant Hospital

Community Directed Giving:

Morton Plant Hospital has dedicated funds to several community partners to meet access to health care needs. These funds are used to expand healthcare services on site at various organizations that provide services to underserved populations. A few examples are Clearwater Free Clinic, Homeless Empowerment Program, community-based health clinics such as Willa Carson Health and Wellness Center and La Clinica Guadalupana, and the Community Dental Clinic. These organizations help create a network of varying healthcare services to support the population(s) that have the greatest unmet needs in our community.

Exercise, Nutrition, and Weight

Food Insecurity (Healing Bags/School Pantries):

In response to the high level of food insecurity in BayCare's service areas, programs to expand access to food have become a major priority for the system. One of the ways BayCare has worked to combat food insecurity is by offering Healing Bags, a three-day supply of non-perishable food, to patients that have been screened and identified as food insecure. Since its inception, 55,779 patients have been screened with 4,463 receiving a Healing Bag from a BayCare hospital. The second way BayCare is working to address food insecurity is through partnership with Feeding Tampa Bay to supply 42 schools across its service area with an onsite food pantry for the students and their families. There are currently 6 school-based pantries in the Morton Plant Hospital service area.

Healthy Living Coach Program:

To address the health concerns that come with chronic conditions such diabetes or obesity, BayCare implemented a Healthy Living Coach program. The Healthy Living Coach is a staff member of community health clinics who provides nutritional and diabetes support education for their clients. They work with the clients to create health goals and plans to better manage their weight and diabetes to improve health outcomes. BayCare has five Healthy Living Coaches between Pinellas, Pasco, and Polk counties.

Community Health Team:

Our BayCare Community Health Team works in collaboration with community organizations to provide education, screenings, and referrals to individuals in the community. Community Health Team can offer screenings for cholesterol, HDL, Glucose, blood pressure, BMI, and Diabetes risk assessment. The Community Health team continues to grow their screenings to meet the needs of individuals across Morton Plant Hospital's service area.

Appendix F. Partner Achievements

BayCare Health System: St. Anthony's Hospital

Behavioral Health

Mental Health First Aid (MHFA):

By providing MHFA classes, St. Anthony's Hospital focused on increasing community awareness to identify and address someone in mental health distress. Adult and Pediatric classes were held across the community. MHFA was offered to a combination of social service providers, community members, and faith leaders who have multiple touch points with individuals living in St. Anthony's service areas. To date nearly 500 individuals have been trained across our four-county service area.

Behavioral Health Liaisons:

St. Anthony's Hospital added a Behavioral Health Therapist to expand access to behavioral health and substance misuse services by assisting with education and linkage to community resources. The Behavioral Health Therapist acts as a liaison, meeting the patient and family in their time of need, providing education, therapeutic support, and assisting with navigating various avenues of behavioral health services.

Homeless Supportive Services:

St. Anthony's Hospital has dedicated funding to two programs that serve the homeless population while addressing behavioral health. The first program provides an APRN to two different homeless shelters on a scheduled basis to provide primary care and encourage people towards a sustainable healthcare solution. The second program has a BayCare nurse making weekly visits with a St. Petersburg Police Officer to provide field-based preventative care for often hard to reach, unhoused people. Both programs have shown great success in building a relationship with this underserved population while improving health outcomes.

Access to Health Services

Medication Assistance Program (MAP):

BayCare has developed and implemented a Medication Assistance Program. MAP is designed to assist patients and community members in finding available resources to help offset the cost of medication. Patients and community members receive assistance with affordable medications that they might have otherwise had to prioritize over other social or economic needs or go without taking. The MAP program has saved individuals $14,230,479 as of May 2022.

FindHelp Florida:

FindHelp Florida is an online platform that connects people with resources they need such as stable housing, access to food, transportation, or affordable healthcare among many other needs. In response to the growing need in our communities BayCare partnered with FindHelp Florida to integrate their platform into the Cerner electronic medical record to help connect patients to organizations that can provide needed resources and services. BayCare has also created a public FindHelp site that can be used by anyone in the community, to search for resources that meet their needs.

Appendix F. Partner Achievements

BayCare Health System: St. Anthony's Hospital

Barbershop Pilot Program:

As an innovative way to reach underserved populations, St. Anthony's Hospital piloted a barbershop program. BayCare worked with two barbershops and a salon to provide health education and screening events to those that may not have received these services through traditional means. Those that were determined to be high-risk were referred to preventative courses, and the screening events brought together several community partners to meet the needs of the barbershop clients.

Exercise, Nutrition, and Weight

Food Insecurity (Healing Bags/School Pantries):

In response to the high level of food insecurity in BayCare's service areas, programs to expand access to food have become a major priority for the system. One of the ways BayCare has worked to combat food insecurity is by offering Healing Bags, a three-day supply of non-perishable food, to patients that have been screened and identified as food insecure. Since its inception, 55,779 patients have been screened with 4,463 receiving a Healing Bag from a BayCare hospital. The second way BayCare is working to address food insecurity is through partnership with Feeding Tampa Bay to supply 42 schools across its service area with an onsite food pantry for the students and their families. There are currently 6 school-based pantries in the St. Anthony's Hospital service area.

Healthy Living Coach Program:

To address the health concerns that come with chronic conditions such diabetes or obesity, BayCare implemented a Healthy Living Coach program. The Healthy Living Coach is a staff member of community health clinics that provide nutritional and diabetes support education for their clients. They work with the clients to create health goals and plans to better manage their weight and diabetes to improve health outcomes. BayCare has five Healthy Living Coaches between Pinellas, Pasco, and Polk counties.

Meek and Mighty

St. Anthony's Hospital hosts an annual triathlon to challenge the community and put their athletic skills to the test. One of the components is the Meek and Mighty event, a modified triathlon course for youth and adults. This year, we had students from Woodlawn Elementary School train with our Children's Wellness and Safety Team to prepare for the event at the end of April. Students learned how to safely ride a bike, swim, and practice transitioning between the activities. The 13 students that participated gained valuable experience in teamwork, confidence, and challenging themselves to achieve a goal.

Appendix F. Partner Achievements

AdventHealth West Florida Division

All4HealthFL IS Review of 2019-2022 Goals, Strategies, Objectives, & Progress

For More Information on Community Benefit Programs: [Programs and Partnerships | AdventHealth West Florida Community Benefit]

Priority Area: Exercise, Nutrition, and Weight

Distributed ***$33,850*** of fresh fruit and vegetables to low-income residents living in food deserts.

AdventHealth Food is Health® is a community program for people who don't have the means or transportation to add fresh vegetables and fruits into their diet. The overall goal of the AdventHealth Food is Health® program is to reach into our communities and make connections to improve overall health and wellness of adults living in food deserts or low-income/low-access areas.

The program combines health education classes, health screenings, and fresh fruits and vegetables to improve the health and wellbeing of participants. It is implemented in communities where families have limited access to fresh fruits and vegetables. Through partnerships with education partners, AdventHealth supports health education classes on topics such as diabetes, obesity, nutrition, and cancer. In addition, AdventHealth nurses provide free health screenings which check participant's blood pressure, blood glucose, and body mass index (BMI). After every class, each person receives a $10 produce voucher used to purchase fresh fruits and vegetables from an on-site mobile produce truck, local grocer, or produce stand.

Since 2020, AdventHealth has conducted the AdventHealth Food is Health® program virtually and in person and achieved the following outcomes in Hillsborough, Pinellas, and Pasco counties:

- Coordinated 33 nutrition class series in food deserts educating 586 adults on healthy living
- Participants redeemed 3,385 produce vouchers equaling $33,850 of fresh fruit and vegetables improving access to diverse and healthy food options
- Launched AdventHealth Food is Health® Youth expanding access to healthy food and nutrition education to children and teens

Additional summary: The AdventHealth Food is Health® program is provided at no cost for community members who do not have the means or transportation to include fresh vegetables and fruits in their diet. Food is Health® reaches into communities to improve the overall health and wellness of adults living in food deserts or lowincome/low-access areas. AdventHealth is committed to working together with local community organizations and stakeholders to implement effective strategies to address obesity and access to healthy food in communities.

Appendix F. Partner Achievements

AdventHealth West Florida Division

Partnerships for the AdventHealth Food is Health Program include:

AdventHealth and Feeding Tampa Bay

- Lauren Key, Senior Executive Officer, Consumer Strategy, AdventHealth West Florida Division serves as a board member on the Feeding Tampa Bay Executive Board. Reference: Board of Directors - Feeding Tampa Bay

Priority Area: Behavioral Health

Trained over 150 adults in Mental Health First Aid

Adult Mental Health First Aid (MHFA) teaches individuals how to identify, understand, and respond to signs of mental illness and substance use disorders. The 8-hour training gives individuals the skills to reach out and provide initial support to adults who may be experiencing a mental health or substance use challenge and help connect them to the appropriate care. Research has demonstrated that MHFA helps to reduce stigma associated with mental health and substance use disorders.

AdventHealth, along with the other partners of the All4HealthFL collaborative, have made teaching MHFA a major objective to help combat stigma. Since 2020, AdventHealth has conducted virtual and in-person MHFA classes and achieved the following outcomes in Hillsborough, Pinellas, and Pasco counties:

- Trained four team members as MHFA Instructors in the Adult Curriculum
- Facilitated 13 certification classes training 122 adults to recognize and safely intervene in mental health crises

Behavioral Health Partnership

The partnership between AdventHealth and Concert Health is based on Collaborative Care—an evidence-based approach to improving behavioral health care by identifying and treating conditions such as anxiety and depression in the primary care setting. More than 60% of Concert Health patients see a 50% reduction in their depression or anxiety symptoms within 90 days. This flexible, patient-centered approach will allow AdventHealth physicians to practice whole-person care through a high-touch model that addresses both mental and physical health.

Reference: AdventHealth Launches Collaborative Care Program with Concert Health to Expand Whole Health Care – Concert Health

AdventHealth expands access to mental health services in Tampa Bay

Reference: AdventHealth expands access to mental health services in Tampa Bay | AdventHealth West Florida Media Resources | AdventHealth

Appendix F. Partner Achievements

AdventHealth West Florida Division

AdventHealth announced the expansion of its mental health focus outside of the primary care setting during a press conference with Tampa Bay Thrives and additional community partners. The health system will be expanding its care to provide same-day access to a mental health clinician at 10 AdventHealth Express Care at Walgreens locations across Tampa Bay via telehealth. Currently, AdventHealth physician practices at AdventHealth Care Pavilion New Tampa connect patients with expert mental health clinicians to receive same-day behavioral health treatment, via phone or video visit, from the privacy of their home.

Note: Please make the necessary wordsmithing (for better flow) to the information below. This information was pulled from a few tables and press releases.

To assist with pulling more information, please refer to the full Community Health Plan located at: [Final 2019 CHNA Template (adventhealth.com)]

American Heart Association (AHA) Hands-Only Community CPR

AdventHealth Tampa is committed to working together with local community organizations and stakeholders to implement effective strategies to reduce the burden of heart disease and stroke by providing health education in the community, increasing access to community health screenings and connecting community members to resources to help manage blood pressure and cholesterol.

AdventHealth has been working to increase the number of Hospital-sponsored American Heart Association (AHA) community CPR out-of-hospital bystander classes for adults and youth from a baseline of zero to five by the end of year three (December 31, 2022).

The AdventHealth Community Benefit team members were trained by the American Heart Association in Community CPR to implement the train-the-trainer model throughout the community. Classes are provided for free to community members (churches, schools, after-school programs, community organizations, etc.). In addition to be trained to save a life of someone challenged with an immediate heart event, community members are also trained to train other community members in community CPR and are provided with a free Hands Only CPR kit at completion of the class.

Appendix F. Partner Achievements

AdventHealth West Florida Division

What is Hands Only CPR?

- Hands-Only CPR is CPR without rescue breaths.
- Hands-Only means giving chest compressions to keep someone alive.
- Hands-Only CPR is intended for adults, teens, and children over the age of 8 years old.

With 70 percent of all out-of-hospital cardiac arrests happening at home, if you're called on to perform Hands-Only CPR, you'll likely be trying to save the life of someone you know and love.

Hands-Only CPR carried out by a bystander has been shown to be as effective as CPR with breaths in the first few minutes during an out-of-hospital sudden cardiac arrest for an adult victim

As of May 2022, the following accomplishments have been achieved.

- A total of 15 AdventHealth Team Members Instructor trained to teach the Community CPR Train-The-Trainer community classes.
- Developed training presentation and implemented 12 classes
- Number of adults trained: 146
- Partnered with local school districts and youth agencies to train 500 high school aged youth
- Number of youths trained by trainees: 6,000

Tobacco Cessation

Accomplishments from 2020-2022 Community Health Plans (As of May 2022)

AdventHealth partnered with Area Health Education Centers (AHEC) in Hillsborough, Pinellas, and Pasco, County to connect patients and community members to tobacco cessation classes. Furthermore, the AdventHealth Patient Engagement Advisors (PEA)/Care 360 teams created a streamlined referral process to enroll over 1,051 identified AdventHealth patients into AHEC's tobacco cessation classes and connect them to resources to quit.