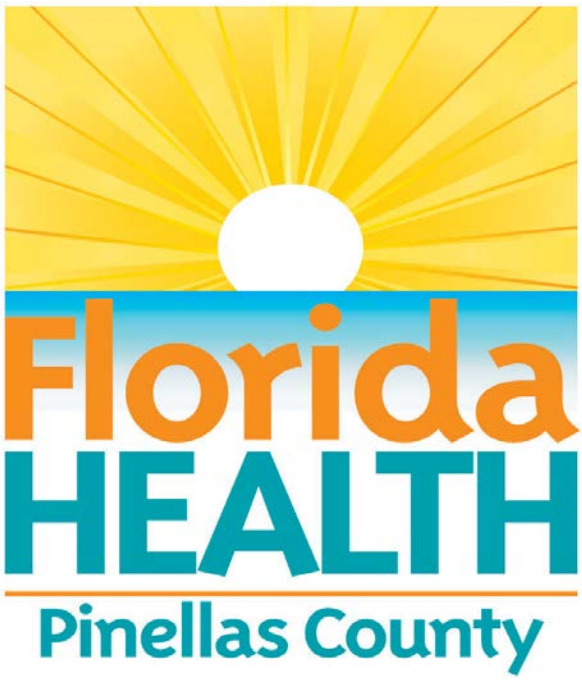

COMMUNITY HEALTH IMPROVEMENT PLAN WRAP-UP REPORT

2013-2017

Contents

Introduction

This is the wrap-up report for the 2013-2017 Pinellas County Community Health Improvement Plan (CHIP). The Pinellas County CHIP is reviewed and revised annually to ensure that activities remain relevant to the county's needs.

The activities and collaborative efforts of the Florida Department of Health in Pinellas County and community partners are reflected within the report, which outlines changing resources as well as effectiveness of the plan. While we realize that the actions and plans in the CHIP will not single-handedly solve the issues facing our community, they mark a concerted effort to improve the health and well-being of Pinellas County residents.

For some data sets, including the Behavioral Risk-Factor Surveillance Survey (BRFSS), data may be delayed or not yet released. As such, all achievements and challenges presented in this document are based on the most recently available data.

Beginning in 2019, the CHIP will change to a **two** year cycle to align with local hospitals.

Overview of the Community Health Improvement Plan (CHIP)

The Florida Department of Health in Pinellas County (DOH-Pinellas) began the community health improvement planning process in 2012. Public health stakeholders in Pinellas County convened the Community Health Action Team (CHAT) in 2012 to serve as a steering committee for local health improvement planning. CHAT examined data and feedback from Pinellas County residents as part of the 2012 Community Health Assessment to identify how the community can work together to improve health.

Using the Mobilizing for Action through Planning and Partnerships framework, community partners identified **access to care, behavioral health, health promotion and disease prevention, and healthy communities and environments** as priority areas for the Pinellas CHIP. CHAT members and additional community stakeholders formulated goals, strategies, and objectives to address each of these priority areas. They also created an action plan that outlines how to achieve objectives. Together, these documents make up the 2012-2017 Pinellas County Community Health Improvement Plan (CHIP).

A CHIP is a long-term, systematic guide to addressing public health problems in a community. The purpose of the CHIP is to define how DOH-Pinellas and the community will work together to improve the health of Pinellas County residents. The Healthy Pinellas Consortium convened in 2013 to oversee two of the CHIP priority areas: health promotion and disease prevention and healthy communities & environments. The Consortium focuses on policy and environmental changes that help reduce obesity and chronic disease by making safe physical activity and nutritious foods accessible to all residents.

See table below for Priority Areas and associated goals.

Priority Area	Goal
Access to Care	1. Provide equal access to appropriate health care services and providers
	2. Use health information technology to improve collaboration among providers and increase efficiency in services to customers
	3. Reduce infant mortality and morbidity
Behavioral Health	1. Increase access to behavioral health services
	2. Reduce substance abuse among children and adults
	3. Reduce violence among children and families
Health Promotion & Disease Prevention	1. Increase the percentage of adults and children who are at a healthy weight
	2. Increase behaviors that improve chronic disease health outcomes
	3. Increase protection against the spread of infectious disease
Healthy Communities & Environments	1. Increase access to safe opportunities for physical activity
	2. Increase access to nutritious and affordable foods
	3. Establish integrated planning and assessment processes that promote health in community level policies and plans

Summary of CHIP Wrap-Up

The purpose of this document is to review the progress made towards the goals established in the four priority areas. Over the course of the CHIP cycle, activities were reviewed a minimum of annually to ensure their relevance. During these review periods, community partners looked at the activities implemented during the preceding year. These activities were then adopted, adapted, or abandoned for the following year.

Strategic Issue Area #1: Access to Care

DESCRIPTION: Access to Care is a cross-cutting priority area focused on reducing barriers to good health and improving health outcomes. Goals to ensure equal access to care include: (1) provide equal access to appropriate health care services and providers (2) use health information technology to improve collaboration among providers and increase efficiency in services to consumers and (3) reduce infant mortality and morbidity.

WHY IT'S IMPORTANT: Improving access to care is important to Pinellas because disparities in access to care have been linked to disparities in health outcomes. Such disparities can be seen in deaths due to chronic disease and in infant mortality rates in Pinellas County. To reduce these disparities, CHIP activities focus on mitigating social determinants of health such as inadequate transportation, cultural or linguistic barriers, technical infrastructure, and social and economic factors.

COMMUNITY PARTNERS: Key Partners in this priority area included Pinellas County Human Services, St. Petersburg College, the Tampa Bay Healthcare Collaborative, USF Health, the Sanderlin Center, the Juvenile Welfare Board, and the Healthy Start Federal Project.

ACHIEVEMENTS AND CHALLENGES: There were several achievements and challenges in this priority area. In terms of achievements, we: explored two data integration initiatives in Pinellas County, contributed to a decrease in the percent of low birth weight infants in Pinellas from 8.9% to 8.1%, helped reduce the Black infant mortality rate from 13.9 per 1,000 live births to 12.8 per 1,000 live births, and helped reduce the Hispanic infant mortality rate from 8.1 per 1,000 live births to 7.3 per 1,000 live births. In terms of negative trends, we did not see: a decrease in the percent of adults unable to access health care due to cost.
See table below for results on Access to Care objectives (as of June, 2017)

PINELLAS COUNTY
COMMUNITY HEALTH IMPROVEMENT PLAN 2013-2017

ACCESS TO CARE REPORT CARD

Goal	Objective (2013-2017)	Data Source	Baseline (Year)	Current Rate	Progress On Schedule ✓ Exceeding + Below Target -
1. Provide equal access to appropriate health care services and providers	1.1.1: By Dec 31, 2017, decrease the percentage of Pinellas adults who are unable to access a health care provider due to cost from 16% to 14.4%.	BRFSS	16% (2010)	16.3% (2013)	-
	1.2.1: By Dec 31, 2017, increase the number of trained Community Health Workers (CHWs) in Pinellas by 25% over baseline.	Florida CHWC/ SPC	17 (2013)	10 (2015)	-
	1.3.1: By Dec 31, 2016, decrease the percentage of Pinellas adults who believe they would receive better medical care if they belonged to a different race/ethnic group from 7% to 6.3%.	BRFSS	7% (2010)	Not collected in 2013 BRFSS	N/A
2. Use health information technology to improve collaboration among providers and increase efficiency in services to consumers	2.1.1 By Dec. 31, 2017, explore at least 2 data integration initiatives in Pinellas County.	DOH-Pinellas	0 (2015)	2 (2016)	✓
3. Reduce infant mortality and morbidity	3.1.1: By Dec 31, 2017, decrease the percentage of low-birth weight (less than 2,500 grams) infants in Pinellas from 8.9% (2010-2012) to 8%.	Florida CHARTS	8.9% (2010-2012)	8.1% (2013-15)	✓
	3.3.1: By Dec 31, 2017, reduce the infant mortality rate of Black infants in Pinellas from 13.9 per 1,000 live births to 11.5 per 1,000 live births. 3.3.2: By Dec 31, 2017, reduce the infant mortality rate of Hispanic infants in Pinellas from 8.1 per 1,000 live births to 7.3 per 1,000 live births.	Florida CHARTS	13.9 per 10,000 (2010-12) 8.1 per 1,000 (2010-12)	12.8 per 1,000 (2013-15) 7.3 per 1,000 (2012-15)	✓ ✓

Updated June 2017

Strategic Issue Area #2: Behavioral Health

DESCRIPTION: Behavioral Health includes mental health, substance abuse, violence and other trauma. Goals to improve behavioral health outcomes include: (1) increase access to behavioral health services (2) reduce substance abuse among children and adults and (3) reduce violence among children and families.

WHY IT'S IMPORTANT: Substance abuse, mental health, and violence among children and families negatively affect not only the individual, but also the community at large. In addition, behavioral health needs often go neglected and violence unreported due to barriers such as stigma. A focus on behavioral health creates an opportunity to address these barriers and improve the community's overall health and quality of life. The need to address behavioral health in Pinellas County is especially pressing. Behavioral health needs are found throughout the 2012 Pinellas Community Health Assessment. In the Community Themes and Strengths Assessment, addiction was the top health problem of concern. Similarly, alcohol and drug abuse was the most frequently selected behavior of concern. Smoking was the fifth most prevalent behavior of concern.

COMMUNITY PARTNERS: Key Partners in this priority area included BayCare, Peace4Tarpon, Directions for Living, Pinellas County Human Services, LiveFree! Coalition, Pinellas County Justice & Consumer Services, Healthy Start Coalition, Substance Exposed Newborn task force, Juvenile Welfare Board, Family Study Center at USFSP, and the Domestic Violence Task Force.

ACHIEVEMENTS AND CHALLENGES: Over the course of this CHIP cycle, we had many successes and a few challenges in improving behavioral health in Pinellas County. Positive trends included: Decreasing the age-adjusted suicide rate, reducing accidental drug or toxin-related deaths, reducing the rate of Neonatal Abstinence Syndrome, reducing the number of children in Pinellas experiencing child abuse, and reducing the domestic violence rate. Challenges included: reducing non-fatal hospitalizations for self-inflicted injuries and reducing the number of Pinellas youth who report lifetime illicit drug use.
See table below for results on Behavioral Health objectives (as of June, 2017)

PINELLAS COUNTY
COMMUNITY HEALTH IMPROVEMENT PLAN 2013-2017

BEHAVIORAL HEALTH REPORT CARD

Goal	Objective (2013-2017)	Data Source	Baseline (Year)	Current Rate	Progress On Schedule ✓ Exceeding + Below Target -
1. Increase access to behavioral health services	1.1.1: By Dec 31, 2016, increase the percentage of Pinellas adults who always or usually receive the social and emotional support they need from 81.3% to 89.4%	Behavioral Risk Factor Surveillance Survey (BRFSS)	81.3% (2010)	*Not collected in 2013 BRFSS*	*N/A*
	1.2.1: By Dec 31, 2017, reduce the rate of non-fatal hospitalizations for self-inflicted injuries from 72.9 per 100,000 to 65.6 per 100,000 among Pinellas youth 12-18.	Florida CHARTS	82.0 per 100,000 (2008-10)*	91.9 per 100,000 (2012-14)	-
	1.3.1: By Dec 31, 2017, decrease the suicide age-adjusted death rate in Pinellas from 17.7 per 100,000 to 16.2 per 100,000.	Florida CHARTS	18.0 per 100,000 (2010-12)*	17.5 per 100,000 (2013-15)	✓
2. Reduce substance abuse among children and adults.	2.1.1: By Dec 31, 2017, reduce the number of accidental drug or toxin related deaths in Pinellas from 201 to 181.	District 6 Medical Examiner Annual Report	201 (2012)	277 (2016)	-
	2.2.1: By Dec 31, 2016, reduce the number of Pinellas youth who report lifetime illicit drug use from 31.1% to 27.9%.	FL Youth Substance Abuse Survey	31.1% (2012)	30.8% (2016)	-
	2.3.1: By Dec 31, 2017, reduce the rate of Neonatal Abstinence Syndrome in Pinellas from 27.1* per 1,000 births to 24.4 per 1,000 births.	Agency for Healthcare Administration	14.5 per 1,000 births (2012)*	9.5 per 1,000 births (2013)	✓
3. Reduce violence among children and families.	3.1.1: By Dec 31, 2017, reduce the rate of Pinellas children under 18 experiencing child abuse from 24.0 per 1,000 to 16.9 per 1,000.	Department of Children and Families (DCF)	24.0 per 1,000 (2012)	16.05 per 1,000 (Sept. 2016)	+
	3.2.1.: By December 31, 2017, reduce the domestic violence rate in Pinellas from 772.8 per 100,000 to 695.5 per 100,000.	Florida CHARTS	722.9 per 100,000 (2009-11)*	719.0 (2013-15)	✓
*Indicates a rate affected by updated population data Updated June 2017					

Strategic Issue Area #3 and #4: Health Promotion & Disease Prevention and Healthy Communities & Environments

DESCRIPTION: Health promotion and disease prevention encompasses a range of health concerns, including chronic and infectious disease prevention and the behaviors contributing to a healthy lifestyle. CHIP goals to address **health promotion and disease prevention (HPDP)** include: (1) increase the percentage of adults and children at a healthy weight (2) increase behaviors that improve chronic disease health outcomes and (3) increase protection against the spread of infectious disease. These goals will be addressed through strategies including promoting healthy eating habits and active lifestyles, increasing screening and education for chronic disease, and promoting childhood immunizations.

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

These priority areas are grouped together because they are largely monitored and addressed by the Pinellas County Healthy Pinellas Consortium, which aims to create policy, systems, and environmental change around healthy eating and physical activity.

WHY IT'S IMPORTANT: Among the health concerns captured in the Health Promotion & Disease Prevention priority area are the leading causes of death within Pinellas County, cancer and heart disease. This priority area is also important to Pinellas because of the county's high rate of tobacco use and low rate of childhood immunizations. Healthy Communities & Environments addresses the built environment, which residents ranked highly during the Community Health Assessment, and which has been documented to improve health outcomes.

COMMUNITY PARTNERS: Key Partners in these priority areas include the Pinellas County Extension Office, Pinellas County Schools, USF-Florida Prevention Research Center, YMCA, American Heart Association, Tobacco Free Florida, Pinellas Immunization Team for Community Health, All Children's Hospital, the Metropolitan Planning Organization, the City of Largo, and the City of St. Petersburg.

ACHIEVEMENTS AND CHALLENGES: In terms of successes, for HPDP our work contributed to: decreasing the percentage of adults in Pinellas who are overweight or obese, increasing the percentage of middle and high school students at a healthy weight, increasing colorectal screening rates in adults over age 50, increasing the number of committed "never smokers" among youth aged 11-17, and increasing the percentage of two-year-olds and kindergarteners who are fully immunized. For HCE we were successful in that we contributed to: increasing the

percentage of adults meeting recommendations for fruit and vegetable consumption and increasing the percentage of middle school students consuming at least five servings of fruits and vegetables daily.

In terms of challenges, for HPDP the following objectives were not met: increase the proportion of children in 1st, 3rd, and 6th grade at a healthy weight, increase the percentage of women aged 40 and over who received a mammogram in the last year, decrease deaths due to heart disease in accordance with our goal, and decrease the percentage of adults who are current smokers. For HCE, the following objectives were not met: complete 15 transportation linkages in Pinellas through infrastructure and programming improvements, and decrease the percentage of Pinellas adults who were sedentary during the last 30 days.
See tables below for results on HPDP and HCE objectives (as of June, 2017)

PINELLAS COUNTY

COMMUNITY HEALTH IMPROVEMENT PLAN 2013-2017

HEALTH PROMOTION & DISEASE PREVENTION REPORT CARD

Goal	Objective (2013-2017)	Data Source	Baseline (Year)	Current Rate	Progress On Schedule ✓ Exceeding + Below Target -
1. Increase the percentage of adults and children who are at a healthy weight	1.1.1: By Dec 31, 2017, decrease the percentage of Pinellas adults who are either overweight or obese from 65.6% to 59%.	BRFSS	65.6% (2010)	61.1% (2013)	✓
	1.2.1: By Dec 31, 2017, increase the proportion of Pinellas children (1st, 3rd, 6th grade) who are at a healthy weight from 65.1% to 71.6%.	DOH School Health Report	65.1% (2010-11)	59.8% (2014-15)	-
	1.2.2: By Dec 31, 2017, increase the percentage of Pinellas middle and high school students who are at a healthy weight from 67.3% (2012) to 73.4%.**	Florida Healthiest Weight Profile	*67.3% (2012)***	69.5% (2015)**	+
2. Increase behaviors that improve chronic disease health outcomes	2.1.1: By Dec 31, 2017, increase the percentage of Pinellas adults age 50 or older who received a colorectal screening in the past five years from 54.1% (2010) to 59.5%.* ~~(73.5% to 80.9%)~~	BRFSS	54.1% (2010)*	57.1% (2013)	✓
	2.1.2: By Dec 31, 2017, increase the percentage of Pinellas women age 40 or older who received a mammogram in the past year from 61.5% to 67.7%.	BRFSS	61.5 (2010)	53.4% (2013)	-
	2.2.1: By Dec 31, 2017, decrease deaths due to heart disease in Pinellas from 155.3 per 100,000 to 139.9 per 100,000.	Florida CHARTS	155.3 per 100,000 (2010-12)	151.9 per 100,000 (2013-15)	-
	2.3.1: By Dec 31, 2017, increase the number of committed never smokers among Pinellas youth, ages 11 - 17 from 64.1% to 70.5%.	Florida Youth Tobacco Survey	64.1% (2012)	69% (2014)	✓
	2.3.2: By Dec. 31, 2016, decrease the percentage of Pinellas adults who are current smokers from 19.3% to 17.0%.	BRFSS	19.3 (2010)	19.4% (2013)	-
3. Increase protection against the spread of infectious disease	3.1.1: By Dec 31, 2017, increase the percentage of Pinellas two-year-olds who are fully immunized from 75.3% to 90%. 3.1.2: By Dec 31, 2017, increase the percentage of Pinellas Kindergarteners who are fully immunized from 89.8% to 94%.	Florida CHARTS	75.3% (2012) 89.8% (2010-12)	84.8% (2015) 92.1% (2014-16)	✓

*Indicates a rate affected by updated population data
**Objective updated 2016
Updated June 2017

PINELLAS COUNTY

COMMUNITY HEALTH IMPROVEMENT PLAN 2013-2017

HEALTHY COMMUNITIES & ENVIRONMENTS REPORT CARD

Goal	Objective (2013-2017)	Data Source	Baseline (Year)	Current Rate	Progress On Schedule ✓ Exceeding + Below Target -
1. Establish integrated planning and assessment processes that promote health in community level policies and plans	1.1.1: By Dec 31, 2016, increase activity related to the development of policies and plans that support individual and community health within Pinellas from a score of 82% to 90%.	Community Health Assessment	82% (2012)	*Available 2017*	*N/A*
2. Increase access to nutritious and affordable foods	2.1.1: By Dec 31, 2016, increase the percentage of Pinellas adults who meet both of the daily recommendations for fruit and vegetable consumption from 9.3% to 11.5%.	BRFSS	9.3% (2010)	18.9% (2013)	✓
	2.2.1: By Dec 31, 2017, increase the percentage of Pinellas middle school students who consume at least five servings of fruits and vegetables a day from 21.2% to 23.3%.	Pinellas County Schools	21.2% (2012-13)	21.8% (2015-16)	✓
3. Increase access to safe opportunities for physical activity	3.1.1: By Dec 31, 2017, complete 15 transportation linkages in Pinellas through infrastructure and programming improvements.	MPO	0 (2012)	0 (2015)	-
	3.1.2: By Dec 31, 2016, decrease the percentage of Pinellas adults who were sedentary, or did not participate in any leisure-time activity in the past 30 days from 25.5% to 22%.	BRFSS	25.5 (2010)	27.7% (2013)	-

Updated June 2017

Conclusion

The CHIP serves as a roadmap for continuous health improvement by providing a framework for the chosen strategic issue areas. It is not intended to be an exhaustive or static document. We evaluate progress on an ongoing basis through quarterly CHIP implementation reports and quarterly discussion by community partners. Going forward, we will continue to conduct annual reviews and revisions based on input from partners and create CHIP annual reports each year. When the CHIP cycle ends, we will collaborate once more with our community partners in summer 2017 to identify opportunities for improvement, analyze local priorities, and refocus on areas of need.

Next Steps

With so many challenges and successes over the last cycle, identifying new priorities and next steps is crucial to continuing the good work accomplished by CHAT and DOH-Pinellas community partners. To that end, the 2017 DOH-Pinellas Community Health Assessment will involve conducting a telephone survey of Pinellas County residents to ascertain more about their health practices and what they believe to be substantial challenges facing our county's health. This community survey is supported by the Foundation for a Healthy St. Petersburg and will produce a wealth of information. During the summer of 2017 we will conduct a meeting for prioritizing needs, and a new Community Health Assessment will be published this fall. Based upon this information, we will move forward into the new CHIP cycle with fresh input and insights from our community, and carry forward lessons learned from this CHIP cycle's challenges and successes.

Appendix 1: Action Plans

Pinellas County CHIP: 2016-17
Access to Care

Goal	Strategy	Objective	Activity 2016-17	Process Measure 2016-17	Coordinating Agency	Partner Agencies	Outcome Measure(s)
AC 1: Provide equal access to appropriate health care services and providers	1.1: Address barriers in accessing existing health care services and consumer utilization in underserved communities	1.1.1: By Dec 31, 2017, decrease the percentage of Pinellas adults who are unable to access a health care provider due to cost from 16% (2010) to 14.4%.	1. Promote Direct Connect Partnership between PSTA and Uber to community partners (including TD late shift). 2. Implement St. Petersburg Police Dept. Mobile Resource Bus Connection.	1. Promote program and PSTA events to a minimum of one community group per quarter. 2. Publicize mobile resource bus to community partners each month. Track and increase number of residents connected to resources during the August 2016-July 2017 CHIP period.	1. PSTA 2. Healthy St. Pete	1. Uber, DOH-Pinellas 2. Foundation for a Healthy St. Pete, DOH-Pinellas, SPPD	Adults who had a medical checkup in the past year
	1.2: Develop and implement a standardized training program for Community Health Workers.	1.2.1: By Dec 31, 2017, increase the number of trained Community Health Workers (CHWs) in Pinellas by 25% over baseline.	**Strategy met: http://flcertificationboard.org/certifications/certified-community-health-worker-cchw/**				15% of identified CHWs have enrolled in or completed a standardized training
	1.3: Promote the completion of a cultural and linguistic competence organizational self-assessment to improve access to culturally competent care.	1.3.1: By Dec 31, 2016, decrease the percentage of Pinellas adults who believe they would receive better medical care if they belonged to a different race/ethnic group from 7% (2010) to 6.3%.	1. Implement Cultural & Linguistic Competency Initiative	1. 4 organizations complete CLC program led by TBHC.	Tampa Bay Healthcare Collaborative	Collaborative Labs USF Public Health	CLC cohort completed

AC 2: Use health information technology to improve collaboration among providers and increase efficiency in services to consumers	2.1: Improve communication among providers and care coordinators through data integration.	2.1.1: -By Dec. 31, 2017, explore at least 2 data integration initiatives in Pinellas County.	1. Identify providers enrolled in Direct Trust and encourage its use as an HIE. 2. Implement electronic Pinellas County Health Program application and make available at community partner organizations.	1. Increase # of providers identified 2. Increase # organizations making electronic application available	1. DOH-Pinellas 2. Pinellas County Human Services	1. USF Health 2. DOH Pinellas, hospitals, community organizations	At least four new partnerships developed between social service and medical agencies in Pinellas County.
AC 3: Reduce infant mortality and morbidity	3.1: Raise awareness among providers and consumers on the importance and benefits of being healthy prior to pregnancy.	3.1.1: By Dec 31, 2017, decrease the percentage of low-birth weight (less than 2,500 grams) infants in Pinellas from 8.9% (2010-2012) to 8%.	1. Implement Figuring it Out for the Child. 2. Use Fetal Infant Mortality Review data to identify trends and educate women of childbearing age in Pinellas.	1. Increase the number of pregnant couples seen each year to 100. 2. Identify trends in losses and offer interventions in the form of educational materials to all 32 Pinellas OB offices and Healthy Start Care Coordinators	1. USFSP - Lisa Negrini 2. Healthy Start Coalition - Michele Schaefer	1. CHCP, DOH-Pinellas, Healthy Start, Mt. Zion 2. FIMR Partners	• Reduce teen pregnancy rates in Pinellas • Reduce teen STD rates in Pinellas • Reduced rate of low birth rate babies in sample group of FOFC • Decrease in child deaths
	3.3: Address disparities in Black and Hispanic infant mortality.	3.3.1: By Dec 31, 2017, reduce the infant mortality rate of Black infants in Pinellas from 13.9 per 1,000 live births (2010-2012) to 11.5 per 1,000 live births. 3.3.2: By Dec 31, 2017, reduce the infant mortality rate of Hispanic infants in Pinellas from 8.1 per 1,000 live births (2010-2012) to 7.3 per 1,000 live births.	1. Build Florida Healthy Babies Task Force.	Convene group minimum of quarterly and create action plan.	DOH-Pinellas	IFMHC, JWB, JCACH, Healthy Start	Increase membership of the CAN and Hispanic Outreach Center. Reduce the number of infant deaths due to unsafe sleeping practices. Increase percentage of Pinellas mothers receiving prenatal care.

Pinellas County CHIP: 2016-17
Behavioral Health

Goal	Strategy	Objective	Activity 2016-17	Process Measure 2016-17	Coordinating Agency	Partner Agencies	Outcome Measure(s)
BH 1: Increase access to behavioral health services	1.1: Strengthen the integration of behavioral and primary health care service delivery.	1.1.1: By Dec 31, 2016, increase the percentage of Pinellas adults who always or usually receive the social and emotional support they need from 81.3% (2010) to 89.4%.	1. Continue implementation of pilot program to engage and provide services to the top 33 utilizers of Pinellas County's public Baker Act and jail facilities.	1 a. #/% Clients engaged and enrolled in pilot b.. #/% of clients who receive therapy indicated in treatment plan	Pinellas County Human Services; Administrative Forum	Local Behavioral Health providers	Increased integration among behavioral healthcare providers.
	1.2: Integrate trauma-informed care practices across care settings with emphasis on Adverse Childhood Experiences (ACEs).	1.2.1: By Dec 31, 2017, reduce the rate of non-fatal hospitalizations for self-inflicted injuries from 82.0 per 100,000 (2008-2010) to 65.6 per 100,000 among Pinellas youth 12-18.	1. Promote provider and agency education on trauma-informed approaches and practices.	1. Hold two trainings for providers in Pinellas County.	1. Peace4Tarpon	1. National Center for Trauma-Informed Care, DOH-Pinellas	200 health professionals educated on trauma-informed care principles 4 new organizations distributing Trauma-Informed Care materials
	1.3: Engage targeted at-risk populations to better understand behavioral health care needs and prevent barriers to access	1.3.1: By Dec 31, 2017, decrease the suicide age-adjusted death rate in Pinellas from 17.7 per 100,000 (2010-2012) to 16.2 per 100,000.	1. Examine Pinellas County suicide data to identify additional trends or areas of concern.	1. Analyze data and determine the need for an in-depth report.	1. Pinellas County	1. BayCare, DOH-Pinellas	Identify gaps in behavioral healthcare access.

BH 2: Reduce substance abuse among children and adults	2.1: Advocate for changes in policy and practices related to substance abuse, including more stringent regulations for prescription drugs classified as controlled substances.	2.1.1: By Dec 31, 2017, reduce the number of accidental drug or toxin related deaths in Pinellas from 201 (2012) to 181.	1. Maintain connection with Administrative Forum and Regional Council and track their work on policy-related advocacy.	1. Check in a minimum of quarterly.	1. DOH-Pinellas	Administrative Forum, Regional Countil	Identify opportunities for policy change.
	2.2: Raise awareness among providers, parents, youth, and businesses on emerging substance abuse trends to improve and inform practices.	2.2.1: By Dec 31, 2016, reduce the number of Pinellas youth who report lifetime drug use from 31.1% (2012) to 27.9%.	1. Implement a campaign to educate **parents, businesses, and youth** on medical marijuana and the dangers of emerging designer drugs and prescription drugs	1. Educational materials distributed/parents educated 2. Number of businesses educated 3. Number of youth led groups who receive campaign materials	LiveFree/Pinellas County Justice & Consumer Services	LiveFree! Coalition members	Improved understanding of emerging designer drugs among youth and adults.
	2.3: Increase access to substance abuse services for prenatal and postpartum women.	2.3.1: By Dec 31, 2017, reduce the rate of Neonatal Abstinence Syndrome in Pinellas from 27.1 per 1,000 births (2009-2011) to per 24.4 per 1,000 births.	1. Work with OB-GYNs to provide warnings to their patients on the dangers of substance use/abuse while pregnant and provide supports to address underlying issues. 2. Collect current data on drugs to which newborns are most frequently exposed.	1. Offer education and materials to all 32 OB providers in Pinellas County. 2. Produce a 2015-16 report on trends of substance exposure to newborns.	1. Healthy Start Coalition 2. Substance Exposed Newborns task force; USFSP	1. Operation PAR, Healthy Start Coalition, Birth Hospitals, BayCare, DOH-Pinellas, Motivating New Moms 2. Healthy Families	More information available on NAS in Pinellas County.

BH 3: Reduce violence among children and families	3.1: Promote community programs that maximize healthy development and interaction among children, families, schools, and communities.	3.1.1: By Dec 31, 2017, reduce the rate of Pinellas children under 18 experiencing child abuse from 24.0 per 1,000 (2012) to 16.9 per 1,000.	1. Promote JWB's Prevent Needless Deaths campaign. 2. Hold trauma informed care trainings for local MCH care providers.	1. Distribute booklets to local birthing hospitals (St. Pete General; Bayfront Baby Place; Morton Plant Hospital - CLW; & Mease Countryside) and at least ten daycare providers. 2. At least three trainings held in Pinellas (one at DOH-Pinellas)	1. JWB 2. USFSP, Peace4Tarpon	1.Hillsborough Children's Board; Local MCH providers and agencies 2.DOH-Pinellas	Common screening policies/practices for violence and trauma
	3.2: Promote awareness, training, and advocacy to improve and inform practices related to domestic violence.	3.2.1.: By December 31, 2017, reduce the domestic violence rate in Pinellas from 772.8 per 100,000 (2009-2011) to 695.5 per 100,000	1. Educate community healthcare providers on domestic violence policies and preventive practices.	1. Hold at least two Being a Better Bystander trainings countywide.	1. Domestic Violence Task Force	1. DVTF partners	Greater number of DOH-Pinellas staff educated on DV prevention and preventive practices.

Pinellas County CHIP: 2016-17
Health Promotion & Disease Prevention

Goal	Strategy	Objective	Activity 2016-17	Process Measure 2016-17	Coordinating Agency	Partner Agencies	Outcome Measure(s)
HPDP 1: Increase the percentage of adults and children who are at a healthy weight	1.1: Promote healthy eating habits and active lifestyles in adults.	1.1.1: By Dec 31, 2017, decrease the percentage of Pinellas adults who are either overweight or obese from 65.6% (2010) to 59%.	1. Provide educational sessions to DOH-Pinellas clients demonstrating healthy and culturally appropriate cooking and grocery shopping on a budget. 2. Promote usage of county parks, trails, and recreational facilities. 3. Implement Diabetes Prevention Program referral project. 4. Implement Humana Vitality in Pinellas County Schools. 5. Explore data sharing between DOH-Pinellas and hospital systems regarding obesity rates.	1. Conduct four education series annually for DOH clients, as documented by sign-in sheets and post-session surveys. 2. DOH-Pinellas collaborates with recreation departments to update brochures annually and disseminate 1500 brochures to the community. 3. Increase referrals in Pinellas County by 50% through physician letter campaign, AMA partnership, etc. 4. Increase Silver Status from 18% - 30%. Hold at least one meeting to explore data sharing regarding rate of obese patients in BayCare hospital system.	1. UF/IFAS Extension Pinellas County 2. DOH-Pinellas 3. YMCA (Kieran Gabel) 4. PCS (Peggy Johns) 5. DOH-Pinellas	1. DOH-Pinellas 2. Pinellas County Parks & Conservation Resources, Municipal Governments 3. BayCare 4. YMCA, Physicians, Walgreens 5. BayCare (Dr. Cynthia Miller)	Increased percentage of adults who report exercising regularly.
	1.2: Promote healthy eating habits and active lifestyles in children.	1.2.1: By Dec 31, 2017, increase the proportion of Pinellas children (1st, 3rd, 6th grade) who are at a healthy weight from 65.1% (2010 - 2011) to 71.6%. 1.2.2: 1.2.2: By Dec 31, 2017, increase the percentage of Pinellas middle and high school students who are at a healthy weight from 67.3% (2012) to 73.4%.**	1. Conduct inventory based self-assessments of Pinellas County Schools on the Alliance for Healthier Generation guidelines 2. Create data report of BMI at each grade level.	1. 1. Increase in number of schools that adopt Alliance for a Healthier Generation standards. 2. Analyze BMI data starting at 3rd grade.	1. Pinellas County Schools 2. Pinellas County Schools	1. Alliance for a Healthier Generation, DOH-Pinellas 2. DOH-Pinellas	Increased percentage of children who report exercising regularly. Increase number of children who report eating recommended daily values of fruits and vegetables.

HPDP 2: Increase behaviors that improve chronic disease health outcomes	2.1: Promote screening, education, and referral to treatment related to cancer.	2.1.1: By Dec 31, 2017, increase the percentage of Pinellas adults age 50 or older who received a colorectal screening in the past five years from 73.5% (2010) to 80.9%.	1. Examine disparities in colorectal cancer incidence, conduct research with priority populations, and implement multilevel interventions using the community-based prevention marketing framework.	1. Meet bimonthly to implement program and track progress	1. USF-Florida Prevention Research Center	1. DOH-Pinellas, DOH-Hillsborough, Community Health Worker Coalition, community members, American Cancer Society, Blue Cross Blue Shield, Moffitt, Florida Cancer Data System, Southwest Florida Cancer Collaborative	Number of adults educated about the importance of colorectal cancer screening.
		2.1.2: By Dec 31, 2017, increase the percentage of Pinellas women age 40 or older who received a mammogram in the past year from 61.5% (2010) to 67.7%.	1. Distribute educational materials to promote awareness of the Florida Breast and Cervical Cancer Early Detection Program, Mammography Voucher Program and general screening recommendations to women above 40 in Pinellas County.	1. Educate community via at least 20 locations in Pinellas County from July 2016-June 2017.	1. DOH-Pinellas	1. TBCCN Partners St Pete Free Clinic Komen BayCare SW Florida Cancer Control Collaborative	Adults who have had a clinical breast exam
	2.2: Promote screening, education, and referral to treatment related to heart disease.	2.2.1: By Dec 31, 2017, decrease deaths due to heart disease in Pinellas from 155.5 per 100,000 (2010-2012) to 139.9 per 100,000.	1. Train 7% of the Pinellas County population in Hands-OnlyTM CPR training via education in the community and in schools. 2. Refer diagnosed prediabetes patients at local hospitals to the CDC's National Diabetes Prevention Program, run locally as the YMCA's Diabetes Prevention Program.	1. Increase number of citizens educated by 7%; establish baseline of bystander CPR data from local emergency response services. 2. Increase number of regularly referring providers (physician offices, health systems) by 30 between the SunCoast and St. Pete regions.	1. American Heart Association 2. YMCA of St. Pete, YMCA of the Suncoast	1. Healthy St. Pete, AHA board, BayCare, DOH-Pinellas, Pinellas County Schools 2. Local physicians and hospital systems.	Reduce obesity rates and increase physical activity in Pinellas County adults Reduce diabetes prevalence.
		2.3.1: By Dec 31, 2017, increase the number of committed never smokers amount Pinellas youth, ages 11 - 17 from 64.1% (2012) to 70.5%.	1. Create and maintain local SWAT chapters. 2. Survey tobacco retail outlets about point of sale advertising.	1. SWAT Clubs at 10 middle/high schools will conduct at least 50 outreach activities will be completed each year. 2. The DOH Pinellas Tobacco Program will survey 300 local retailers in Pinellas county.	DOH-Pinellas –Tobacco Free Program/SWAT Coordinator	Pinellas County Schools, Tobacco Free Coalition	Increased number of students involved in SWAT Increase in the number of SWAT outreach activities

	2.3: Promote activities to reduce tobacco use and exposure in adults and youth.	2.3.2: By Dec. 31, 2016, decrease the percentage of Pinellas adults who are current smokers from 19.3% (2010) to 17.0%.	1. Distribute "Quitkits" to clients who are smokers within Florida Department of Health in Pinellas clinics 2. Educate local policymakers, businesses, and community organizations about tobacco use. 3. Meet quarterly with Tobacco Free Campus Task Force at local universities/colleges.	1. 2500 Quitkits will be distributed 2.At least 2 tobacco worksite wellness policies will be adopted 3. Minimum of four meetings will be held.	1. DOH-Pinellas – Tobacco Free Program 2.DOH-Pinellas 3. DOH-Pinellas	1. Area Health Education Center (AHEC) 2. Worksites, Housing 3. St. Petersburg College	Increased number of smoke free/tobacco free policies adopted Increased # of new partnerships
HPDP 3: Increase protection against the spread of infectious disease	3.1: Provide targeted education on the benefits of receiving immunizations to increase the percentage of children who are fully immunized.	3.1.1: By Dec 31, 2017, increase the percentage of Pinellas two-year-olds who are fully immunized from 75.3% (2012/2013) to 90%. 3.1.2: By Dec 31, 2017, increase the percentage of Pinellas Kindergarteners who are fully immunized from 89.8% (2012/2013) to 94%.	1. Assess (or Strengthen) Current Partnership for Collaboration and Define Roles and Responsibilities 2. Market use of State Immunization Information Systems (IIS) 3. Identify and conduct effective outreach and educational activities 4. Develop/adopt/adapt consistent messaging plan	1. Documentation of quarterly meetings and development of sharepoint/web portal 2. Quarterly updates of educational opportunities and percentage of providers using IIS in Pinellas County 3. Quarterly updates on parent surveys, educational materials, schedule of outreach events, and vaccine administration 4. Quarterly updates on messaging plan progress, and development of toolkit materials	DOH-Pinellas	1. DOH-Pinellas PITCH Pinellas County Schools Amercian Cancer Society/Cancer Collaborative JWB Municipality Leaders (support) 2. DOH-Pinellas State Immunization – Field Staff State Immunizations – FLSHOTS (training staff) FLSHOTS vendor (marketing partner) PITCH (support) 3. DOH-Pinellas Pinellas County Schools PITCH Community Health Centers/FQHC Moffitt Cancer Center ACS/Cancer Collaborative, Additional support: OB/GYNs, Nursing Schools, Faithbased Nursing, Medical associations 4. DOH-Pinellas	Increase the number of health care providers represented on PITCH 100% of Pinellas County providers will complete the training course Improve Pinellas County Schools Immunization Report Card scores by 10%

Pinellas County CHIP: 2016-17
Healthy Communities & Environments

Goal	Strategy	Objective	Activity 2016-17	Process Measure 2016-17	Coordinating Agency	Partner Agencies	Outcome Measure(s)
HCE 1: Establish integrated planning and assessment processes that promote health in community level policies and plans	1.1: Include a public health component in community planning processes to increase awareness and opportunity of the built environment's impact on healthy behaviors.	1.1.1: By Dec 31, 2016, increase activity related to the development of policies and plans that support individual and community health within Pinellas from a score of 82% (2012) to 90%.	1. Educate policymakers on "health in all policies" and HIA, including topics related to public health, development, the built environment. 2. Support the inclusion of a health component in local policies and plans.	1. 3 meetings or events advocating for the importance of a health element in comprehensive plans will be conducted; Research conducted on when and how local policies are updated. 2. Health written into at least three city and/or county plans or policy.	1. DOH-Pinellas 2. DOH-Pinellas	1. City and county governments, MPO 2. City and county governments, MPO	Health in All Policies approach codified in at least one city or county.
HCE 2: Increase access to nutritious and affordable foods	2.1: Promote options for access to nutritious foods throughout Pinellas County.	2.1.1: By Dec 31, 2016, increase the percentage of Pinellas adults who meet both of the daily recommendations for fruit and vegetable consumption from 9.3% (2010) to 11.5%.	1. Support development of local city policies related to food access. 2. Promote healthy and affordable food options to communities countywide.	1. Assist at least one city with identifying model language to implement mobile produce vending and/or healthy corner stores. 2. Promote healthy vending via adoption of AHA guidelines for healthy vending by businesses; Good Neighbor Store designations adopted by a minimum of 2 stores.	1. DOH-Pinellas 2. DOH-Pinellas	1. Municipal governments 2. AHA, Municipal Governments	Adults at a healthy weight
	2.2: Support a focused effort to increase access to nutritious and affordable foods for children.	2.2.1: By Dec 31, 2017, increase the percentage of Pinellas middle school students who consume at least five servings of fruits and vegetables a day from 21.2% (2012/2013) to 23.3%.	1. Promote Smart Snacks in Schools. 2. Implementation of Fun Bites program. 3. Implement new grant (pending funding) for nutrition education.	1. Training and handbook developed; increase from 75% to 100% compliance by June 2017. 2. At least two municipalities will implement Fun Bites (little league, café, etc.) 3. Gardening, Myplate, general nutrition education implemented in elementary schools	1. Pinellas County Schools (Peggy Johns) 2. DOH-Pinellas 3. UF IFAS Extension Office (Nan Jensen)	1. DOH-Pinellas (PICH grant); Alliance for a Healthier Generation 2. Healthy St. Pete (Gillian Cutro) 3. Pinellas County Schools (Peggy Johns)	Students at a healthy weight

HCE 3: **Increase access to safe opportunities for physical activity**	3.1: Promote collaborative efforts to form safe transportation linkages to schools, work, home, and recreation.	3.1.1: By Dec 31, 2017, complete 15 transportation linkages in Pinellas through infrastructure and programming improvements. 3.1.2: By Dec 31, 2016, decrease the percentage of Pinellas adults who were sedentary, or did not participate in any leisure-time activity in the past 30 days from 25.5% (2010) to 22%.	1. Increase the number of infrastructure improvements for bicycle and pedestrian safety as well as park and trail access. 2. Maintain and update a list of city/county parks and recreational areas where the community can participate in free or low cost areas for physical activity.	1. Complete 5 environmental improvements that focus on safe physical activity within Pinellas County, including an increase of Auxiliary Ranger hours. 2. Brochure/flyer updated at least once per year and number distributed	1. MPO 2. DOH-Pinellas	1. City & County Governments, DOH-Pinellas, Pinellas County Parks and Conservation. 2. City and County Municipalities, 211-Tampa Bay Cares	Increased park attendance and trail use. Increase in adults and children reporting regular physical activity