Florida HEALTH
Hillsborough County

Florida Department of Health in Hillsborough County

2019 Community Health Assessment

Published: March 2020

Mission

To protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts.

Vision

To be the healthiest state in the nation.

Values (ICARE)

- **I**nnovation – We search for creative solutions and manage resources wisely.
- **C**ollaboration – We use teamwork to achieve common goals and solve problems.
- **A**ccountability – We perform with integrity and respect.
- **R**esponsiveness – We achieve our mission by serving our customers and engaging our partners.
- **E**xcellence – We promote quality outcomes through learning and continuous performance improvement.

Principles

Honesty, Fairness, Devotion, Courage, and Excellence

This report is available here at the Florida Department of Health in Hillsborough County website. Or you can scan

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ACKNOWLEDGEMENTS

The Florida Department of Health in Hillsborough County's 2019 Community Health Assessment was developed by the Department's staff with the assistance of The Healthy Hillsborough Coalition and The All4HealthFL Collaborative. Generous input was provided by a diverse group of individuals representing the interests of the community including: The Healthy Hillsborough Steering Committee, The All4HealthFL Collaborative, and the other community members who took part in the community health needs survey, key informant interviews, and focus group sessions. We would like to acknowledge each of these individuals and thank them for their generosity, time and contributions.

The individuals listed below made major contributions to the planning and the completion of the health assessment and this report.

Healthy Hillsborough Steering Committee

Kimberly Williams	AdventHealth
Lisa Bell	BayCare Health System
Vasthi Ciceron	BayCare Health System
Colleen Mangan	BayCare Health System
Dr. Leslene Gordon	DOH–Hillsborough
Dr. Douglas Holt	DOH–Hillsborough
Dr. Ayesha Johnson	DOH–Hillsborough
Grace Liggett	DOH–Hillsborough
Allison Nguyen	DOH–Hillsborough
Stephanie Sambatakos	Johns Hopkins All Children's Hospital
Jenna Davis	Moffitt Cancer Center
Sonia Goodwin	Suncoast Community Health Centers
Harold Jackson	Tampa Family Health Centers
Tamika Powe	Tampa General Hospital

DOH–Hillsborough Internal Community Health Assessment Work Group

Dr. Leslene Gordon

Dr. Ayesha Johnson

Grace Liggett

Allison Nguyen

DOH–Hillsborough Additional Support Staff

Rachel Chase

Kelsey Christian

Eliot Gregos

Jylmarie Lewis

Krystal Snell

Douglas A. Zimmer

EXECUTIVE SUMMARY

The Healthy Hillsborough Coalition was formed in October 2015, with collaboration between: The Florida Department of Health in Hillsborough County (DOH-Hillsborough), Florida Hospital (Tampa and Carrollwood – now AdventHealth), Moffitt Cancer Center, St. Joseph's Hospitals and Florida Baptist Hospital (now BayCare), Suncoast Community Health Centers, Tampa Family Health Centers, and Tampa General Hospital. The coalition was created for the purpose of conducting joint community health assessment and improvement planning. The current steering committee membership includes all organizations aforementioned and Johns' Hopkins All Children's Hospital.

DOH–Hillsborough utilizes the National Association of County and City Health Officials (NACCHO)'s Mobilizing for Action through Planning and Partnerships (MAPP) model to complete its Community Health Assessment (CHA). The Assessments Phase consists of compiling and analyzing primary and secondary data through four individual assessments to evaluate the health of the community. The four assessments are The Community Health Status Assessment, The Community Themes and Strengths Assessment, The Forces of Change Assessment, and The Local Public Health System Assessment. Data from the four assessments are analyzed collectively to determine strategic issues / priority areas for the health department and local public health system to address to improve health outcomes within the jurisdiction.

Assessment 1: The Community Health Status Assessment answers the questions: *How healthy is the community? What does the health status of the community look like?* Socioeconomic data reveals that 16% of county residents, and 21% of children live in poverty. While 14% of adults do not have health insurance, and 7% of the civilian labor force is unemployed. The leading cause of death remains chronic and non-communicable diseases which is not surprising as 63% of adults are overweight or obese. The suicide rate is 13 suicides per 100,000 people. Health inequities persist as seen in the county's infant death rates as Black infants die at three-times the rate of White infants.

Assessment 2: The Community Themes and Strengths Assessment answers the questions: *What is important to the community? How is the quality of life perceived in the community? What assets does the community have that can be used to improve community health?* These three questions were mostly answered from primary data collected by a community survey, key informant interviews, and focus groups. The demographic profile of community survey respondents matched very closely to the county's demographic profile from U.S. Census data. Approximately two in five community survey respondents reported having an unmet health need, and one in four ran out of food at least once during the past 12 months. Survey respondents identified: mental health, being overweight, cancers, heart disease, stroke, and high blood pressure as the most important health issues. Key informants identified: chronic diseases, mental health, access to health care, and infectious diseases as the most important health issues. Focus group participants identified: exercise, nutrition, weight; environmental health; mental health; substance abuse; heart disease; and stroke as the most important health issues. Community assets identified include programs and services offered by hospitals and other agencies, along with aspects of the built environment such as community walkability and lighting.

Assessment 3: The Forces of Change Assessment answers the questions: *What is occurring or might occur that affects the health of the community or the local public health system? What specific threats or opportunities are generated by these occurrences?* Approximately 150 community partners conducted this assessment. Forces of change identified were: Policy & Economics, Race & Other types of Discrimination, and Technology. The rising cost of health care, the stigma surrounding behavioral health, institutional racism along with low wage jobs being replaced by technology were identified as threats to the local public health system. While telemedicine was identified as an opportunity that can help to improve the function of the local public health system.

Assessment 4: The Local Public Health System (LPHS) Assessment answers the questions: *What are the activities, competences, and capacities of the local public health system? How are the 10 Essential Public Health Services (EPHS) being provided to the community?* System partners from various sectors including: public health agencies,

hospitals, other government agencies, and local businesses responded to a survey asking them to rate the LPHS. Partners rated the system as performing with significant activity. The system performed the best in EPHS 1, monitoring health status to identify community health problems. EPHS 5, developing policies and plans that support individual and community health efforts, presented the most opportunity for improvement. Many partners were unaware of some of the activities performed by the LPHS.

Data from the assessments were presented to more than 150 community partners at the coalition's 2019 prioritization meeting. These community partners then voted and identified Mental Health; Access to Health Services; Exercise, Nutrition & Weight; Substance Use; and Diabetes as the top five health issues facing the community. The Healthy Hillsborough coalition will develop implementation plans to address Access to Health Services; and Exercise, Nutrition & Weight over the next three to five years which will be included in DOH-Hillsborough's 2020 – 2025 Community Health Improvement Plan (CHIP). Mental Health and Substance Use (Behavioral Health) will be addressed through the newly established All4HealthFL collaborative.

All4HealthFL is a newly established collaborative between departments of health in Hillsborough, Pasco, Pinellas, and Polk counties along with the not-for-profit hospitals that serve those counties. Members decided to develop a coordinated implementation plan to address Behavioral Health, the top priority across all four counties. This implementation plan will also be included in DOH-Hillsborough's 2020 – 2025 CHIP.

SUMMARY OF 2019 COMMUNITY HEALTH ASSESSMENT

Every five years DOH-Hillsborough works with community partners to assess the health of Hillsborough County. The Community Health Assessment follows a nationally-recognized framework (MAPP) and combines results from four individual assessments to help leaders prioritize the top health concerns in the county. The top health concerns from the 2019 CHA are **Behavioral Health, Access to Health Services, and Exercise, Nutrition & Weight**.

Assessment 1: Community Health Status

How healthy is the community? What does the health status of the community look like?

DATA SOURCES
FDOH's *Florida Health CHARTS*
RWJF's *County Health Rankings*
United Way's *ALICE Report*
US Census

SOCIOECONOMIC DATA:

16% of individuals and 21% of children live in poverty.

86% of adults have health insurance coverage.

7% of civilian labor force is unemployed.

HEALTH BEHAVIOR DATA:

16% of adults are current smokers.

77% of adults have had a medical checkup in the last year.

1 in 5 adults engage in heavy or binge drinking.

57% of adults are inactive or insufficiently active.

More than 96% of 7th graders received recommended immunizations.

HEALTH OUTCOME DATA:

Top causes of death: heart disease; cancer; chronic lower respiratory disease; stroke; and diabetes.

63% of adults are overweight or obese.

There are 13 suicides per 100,000 people.

There were 75 acute & 1,233 chronic Hepatitis C cases in 2019.*

Many **health inequities** exist in Hillsborough County. Health Inequities are differences in health across groups of people that are systemic, avoidable, and unjust.

- Example: Black infants die at 3x the rate of white infants (13.6 black infant deaths per 1,000 live births compared to 4.6 white infant deaths per 1,000 live births).

*Provisional data

Assessment 2: Community Themes & Strengths

What is important to the community? How is quality of life perceived in the community? What assets does the community have that can be used to improve community health?

DATA SOURCES
Community Survey (5,304 people)
Key Informant Interviews (25 people)
Focus Groups (40 people)

COMMUNITY SURVEY:

Survey respondents were 72% female with median age 35-44. The racial distribution reflected that of Hillsborough County.

In the last year...

2 in 5 had an unmet health need.

1 in 4 ran out of food.

14% had at one time been diagnosed with depression.

Most important health problems: mental health; being overweight; cancers; and heart disease, stroke & high blood pressure.

Most important factors to improve quality of life: low crime & safety; access to health care; and good schools.

Most harmful risky behaviors: drug abuse; distracted driving; and alcohol abuse.

Perceptions of community safety, health & resources vary by race/ethnicity.

KEY INFORMANT INTERVIEWS:

Important health issues: chronic diseases; mental health; access to care; and infectious diseases.

Community assets: food pantries; healthcare providers; specialized services (e.g. refugee and translation services); education programs; and mental health service providers.

Ways to address health issues: increasing access to care; education; connecting community to resources; cultural sensitivity; and expanding partnerships.

COMMUNITY FOCUS GROUPS:

Important health issues: exercise, nutrition, weight; environmental health; mental health; substance abuse; and heart disease & stroke.

Ways to address health issues: education & messaging; programs & services; access to care; and nutrition & access to food.

Assessment 3: Forces of Change

What is occurring or might occur that affects the health of the community or the local public health system? What specific threats or opportunities are generated by these occurrences?

DATA SOURCE
Discussions among 150 community partners

Threats & Opportunities

Policy & Economic	Race & Discrimination	Technology
Rising cost of health care	Stigma of behavioral health & services	Low wage jobs replaced by technology
Changes in program eligibility	Cultural barriers in health services	Telemedicine & telehealth
Population growth	Patient trauma from discrimination	
Gentrification	Stigma of seeking social services	

Assessment 4: Local Public Health System

What are the activities, competencies, and capacities of the local public health system? How are the 10 Essential Public Health Services being provided to the community?

DATA SOURCE
Survey among 46 local public health partners

Respondents were from public health agencies, hospitals, non-profits, government agencies, schools, health clinics, behavioral health services, civic & faith organizations, and local businesses. Respondents rated the public health system's activity level on the ten essential services. **ACTIVITY LEVEL (Lowest to Highest): None—> Minimal —>Moderate—> Significant—> Optimal**

Overall, the **local public health system** was rated as performing with "significant activity."

Essential Service 1—Monitor Health— scored highest performing with "significant activity."

Essential Service 5—Develop Policies—scored lowest performing with "moderate activity."

Essential Service 6—Enforce Laws—had the largest number of "don't know or unaware" responses (41%).

Essential Public Health Services & Core Functions

Priority Health Issues

Process:

On July 24, 2019, 150 community leaders discussed results from the 4 assessments and then voted on which health issues should be priorities.

Top Priorities After Voting:

1. Mental Health
2. Access to Health Services
3. Exercise, Nutrition & Weight
4. Substance Abuse
5. Diabetes
6. Maternal, Infant & Fetal health
7. Hearth Disease & Stroke
8. Immunizations & Infectious Disease
9. Cancer
10. Oral Health
11. Respiratory Disease

Top 3 Priority Health Issues:

Behavioral Health
(Mental Health & Substance Use)

Access to Health Services

Exercise, Nutrition & Weight

The top 3 priorities will be addressed through DOH-Hillsborough's Community Health Improvement Plan from 2020-2025.

COMMUNITY HEALTH ASSESSMENT PROCESS

MAPP Model

The Florida Department of Health in Hillsborough County (DOH–Hillsborough) utilized the National Association of County and City Health Officials (NACCHO)'s *Mobilizing for Action through Planning and Partnerships (MAPP)* model to complete its Community Health Assessment (CHA). The MAPP model is a community–driven strategic planning process for improving community health, and its framework helps communities to apply strategic thinking to prioritize public health issues and identify resources to address them.

The Assessments Phase consists of compiling and analyzing primary and secondary data through four individual assessments to evaluate the health of the community.

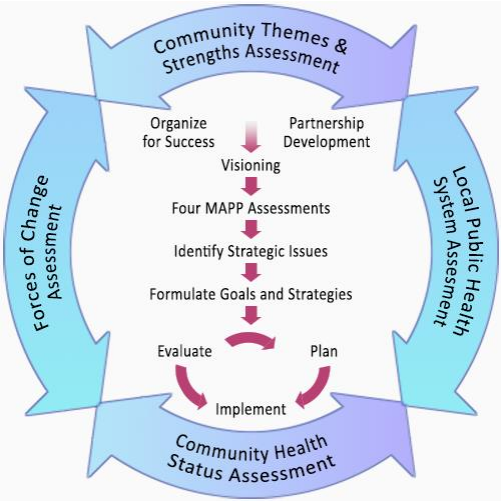


Figure 1: MAPP Academic Model

The Community Health Status Assessment provides quantitative data on the community's health condition. It answers the questions: *How healthy is the community? What does the health status of the community look like?*

The Community Themes and Strengths Assessment identifies assets in the community and issues that are important to community members. It answers the questions: *What is important to the community? How is quality of life perceived in the community? What assets does the community have that can be used to improve community health?*

The Forces of Change Assessment identifies forces that may affect a community, and the opportunities and threats associated with these forces. It answers the questions: *What is occurring or might occur that affects the health of the community or the local public health system? What specific threats or opportunities are generated by these occurrences?*

The Local Public Health System Assessment measures how well different public health system partners work together to deliver the Essential Public Health Services. It answers the questions: *What are the activities, competencies, and capacities of the local public health system? How are the 10 Essential Public Health Services being provided to the community?*

Data from the four assessments are analyzed collectively to determine strategic issues / priority areas for the health department and local public health system to address to improve health outcomes within the jurisdiction. During the Action Cycle, action plans are created for the priority areas, with specific goals, strategies, objectives, and action steps. These action plans will be incorporated into the DOH–Hillsborough's Community Health Improvement Plan (CHIP). Continuous monitoring and evaluation also occur throughout the Action Cycle Phase (NACCHO, 2016). Figure 2 is a flowchart depicting each of the four MAPP assessments and how they are used to formulate the health priorities (NACCHO, 2013).

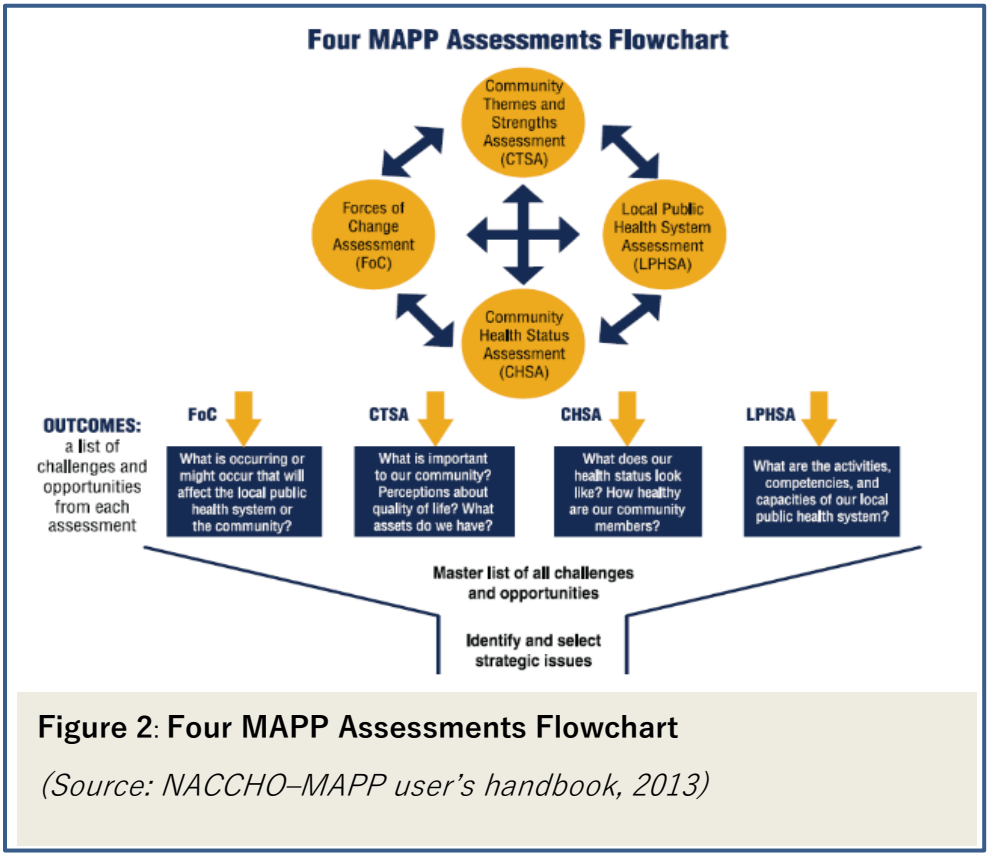


Figure 2: Four MAPP Assessments Flowchart

(Source: NACCHO–MAPP user's handbook, 2013)

Hospital and Health Center Collaboration

Not–for–profit hospitals are required to provide a benefit to the community they serve. Under the Federal Revenue Code of the Internal Revenue Service (IRS), Section 501(c) (3), not–for–profit hospitals must complete a Community Health Needs Assessment (CHNA) and Implementation Plan every three years to maintain their tax-exempt status. The CHNA is conducted to assess and identify the needs of the community, while the Implementation Plan provides the framework for addressing these needs. Federally Qualified Health Centers (FQHCs) are not–for-profit private or public entities that provide health care to medically underserved populations. Section 330 of the Public Health Service Act (42 U.S.C254b) requires that health centers demonstrate and document the needs of their target populations. Accredited health departments have similar requirements to meet the standards established

by the Public Health Accreditation Board (PHAB). Figure 3 shows the alignment between the Local Health Department, Community Hospitals, and FQHCs assessment needs.

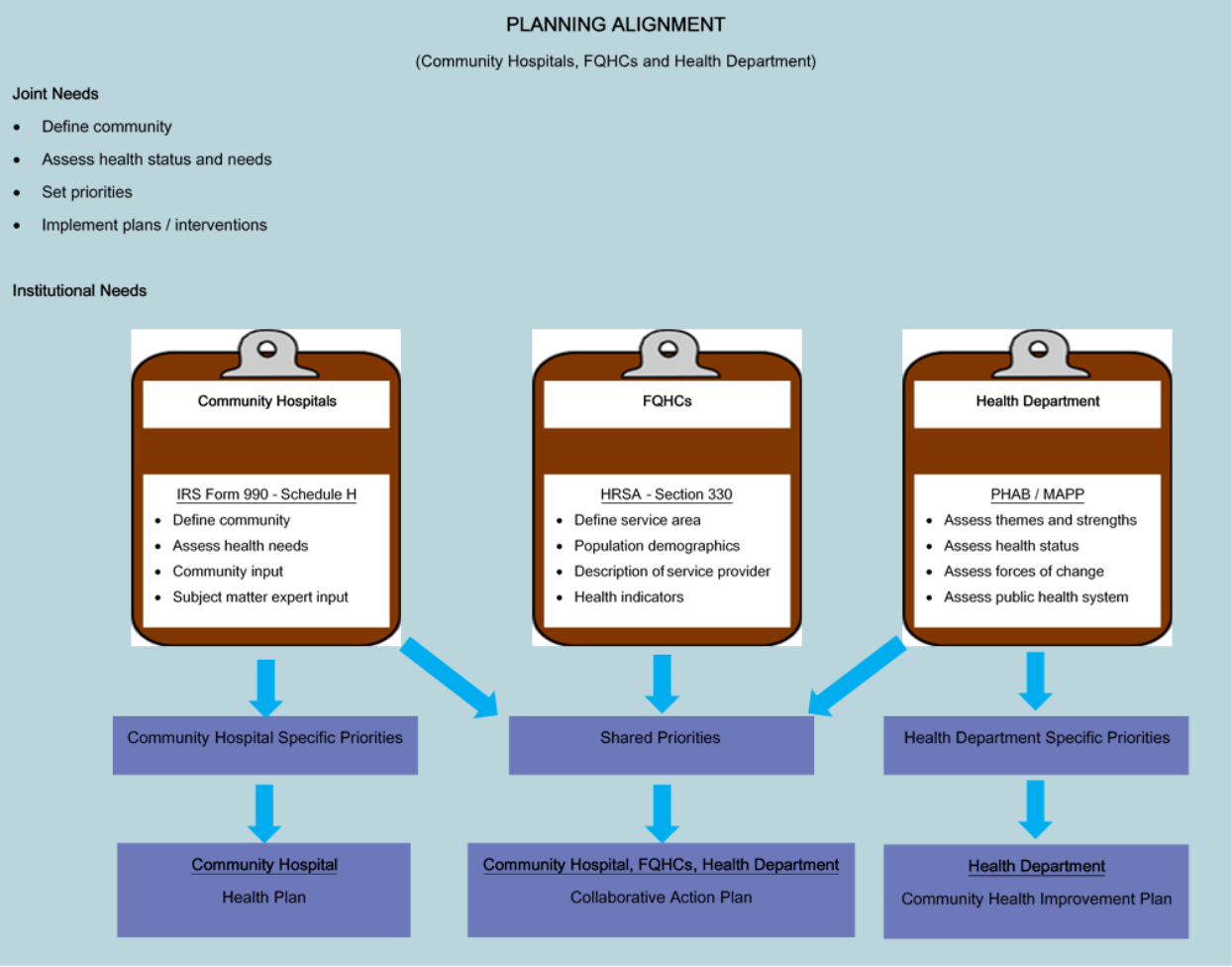


Figure 3. Planning Alignment for Healthy Hillsborough Steering Committee Members

In October 2015, DOH–Hillsborough partnered with Florida Hospital (Tampa and Carrollwood – now AdventHealth), Moffitt Cancer Center, St. Joseph's Hospitals and South Florida Baptist Hospital (now BayCare), Suncoast Community Health Centers, Tampa Family Health Centers, and Tampa General Hospital to form the Healthy Hillsborough Coalition. The coalition now includes Johns' Hopkins All Children's Hospital as well as, members from the community and other agencies throughout the county. The Healthy Hillsborough Steering

Committee met monthly between November 2018 and November 2019 to complete the CHA (Appendix A). The Action Plans created from the prioritization meeting will be incorporated into DOH–Hillsborough's CHIP and the hospitals' Implementation Plans.

Statistics and Measurement

The data in this report includes demographic and health statistics. In some instances, data are summarized as a percent. For example, 18% of the population in Hillsborough County is Black/African American, which should be interpreted as 18 out of every 100 people in Hillsborough County are Black/African American. Data may also be summarized as rates. For example, if the rate of Hepatitis A is given as 6 per 100,000 population, that should be interpreted as 6 cases (people with Hepatitis A) out of every 100,000 people in the county's population. Rates may also be given per 1,000 population, which will be specified.

COMMUNITY HEALTH STATUS ASSESSMENT

The Community Health Status Assessment (CHSA) answers the following questions: *How healthy is the community?* and *What does the health status of the community look like?* To answer these questions, existing data on demographics, health status, quality of life, risk factors, and determinants of health was compiled to provide an overview of the health status of the community. Where possible the most recent data was compared to previous years to see the county's progress over time. Additionally, new data from the 2019 community health needs survey was included as a primary data source. This 2019 community health needs survey was administered to Hillsborough County residents between February and April 2019. A total of 5,304 responses were collected.

The secondary data sources used for the CHSA include:

- Florida Department of Health, Florida Health CHARTS (www.floridacharts.com)
- United States Census, American FactFinder (https://data.census.gov/cedsci/)
- Robert Wood Johnson Foundation, County Health Rankings (www.countyhealthrankings.org/)
- United Way, Asset Limited Income Constrained Employed (ALICE) Report (www.uwof.org/alice)
- Data USA (https://datausa.io/)

Geography

Hillsborough County is located on the west coast of Florida along Tampa Bay. It includes 1,048 square miles of land area and 24 square miles of inland water area. Hillsborough County is home to three incorporated cities: Tampa, Temple Terrace, and Plant City, with Tampa being the largest and serving as the county seat. Hillsborough County has a humid subtropical climate, characterized by frequent thunderstorms during the warm and humid summer, and cool, drier winters. Figure 4 shows a map of the State of Florida, with

Hillsborough County highlighted. Hillsborough's neighboring counties are Pasco County to the north, Polk County to the east, Pinellas County to the west, and Manatee County to the south.

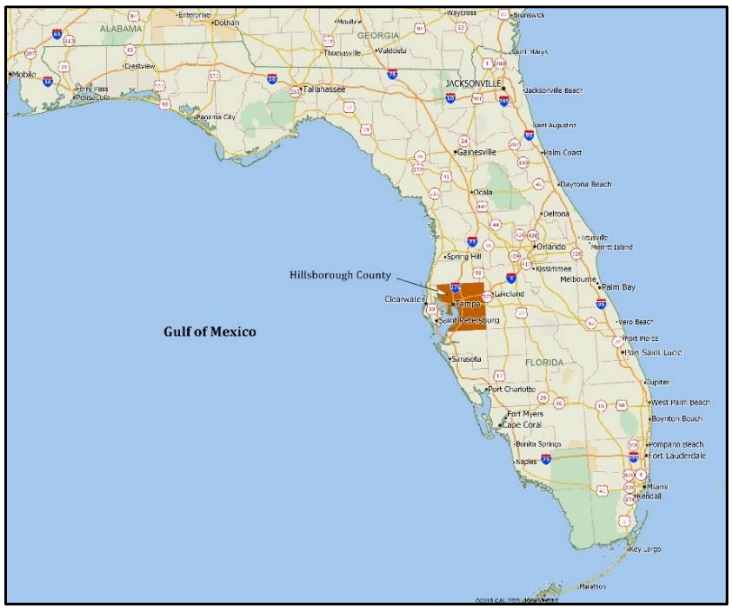


Figure 4: Hillsborough County, Florida

Demographic Characteristics

Data from the 2018 American Community Survey estimates that 1.4 million people live in Hillsborough County making it the fourth most populous county in Florida at that time. Figure 5 shows the age distribution of Hillsborough County and Florida. Hillsborough County has a somewhat higher concentration of people age 15 to 44 years (42%) when compared to the entire State of Florida (37%). Hillsborough County has a smaller percentage of people age 45 and older (40%) compared to Florida (47%). The higher concentration of people ages 15 to 44 years in Hillsborough County compared to Florida is reflected in the younger median age in the county (37.1 years) compared to the overall state (42 years). Hillsborough County, like the State of Florida, boasts a diverse mix of races and ethnicities. Its population is 75% White, 18% Black, 29% Hispanic, and 8% other races (Figure 6).

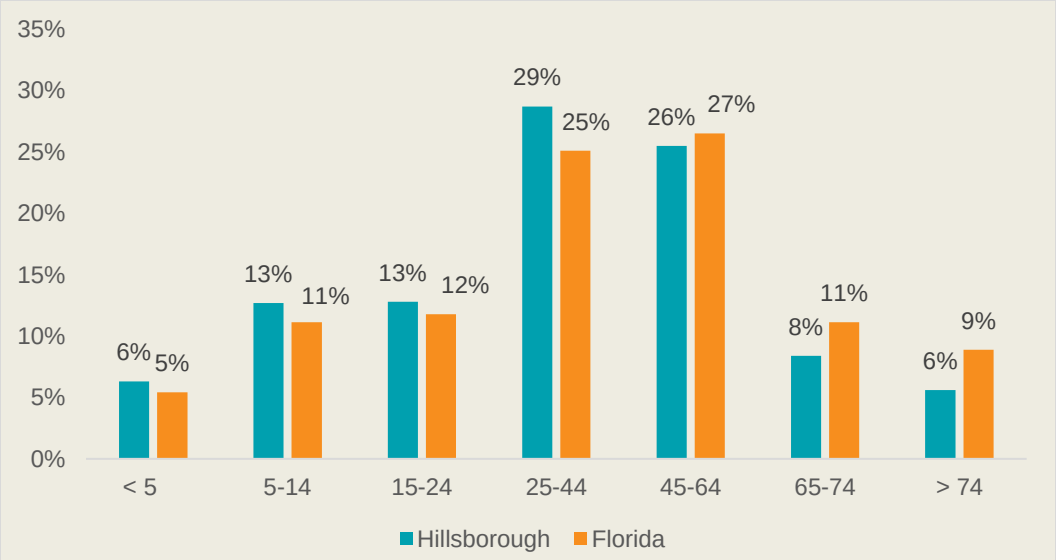


Figure 5: Population of Hillsborough County and Florida by Age

(Source: FLCHARTS, 2018)

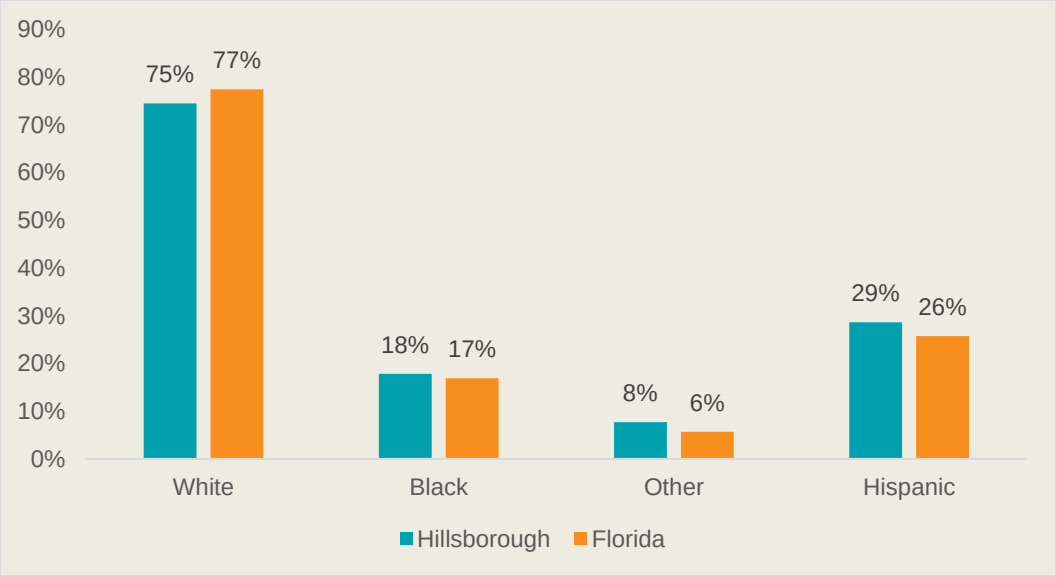


Figure 6: Population of Hillsborough County and Florida by Race and Ethnicity

(Source: FLCHARTS, 2018)

Socioeconomic Indicators

Socioeconomic indicators provide measures of housing conditions, wealth levels, and education. These indicators explain the factors that shape the demographic, health behaviors, and health outcomes of people living in the county.

Indicators listed in Table 1 for time period 2013–2017 show an improvement over the 2010–2014 time period. Most notable is the percentage of the civilian labor force which is unemployed. This percentage fell from 10.1% in 2010–2014 to 6.8% in 2013–2017. The median household income for Hillsborough County residents increased from $50,122 in 2010-2014 to $53,742 in 2013-2017. The average rate of inflation between 2014 and 2017 was 1.35%. This means that $50,122 in 2014 would be equivalent to $52,178 in 2017.

Table 1: Socioeconomic Indicators

Socioeconomic Indicators	Hillsborough		Florida
	2010-2014	2013-2017	2013-2017
Percentage of individuals below poverty level	17.2	15.7	15.5
Percentage of families below poverty level	12.9	11.5	11.1
Percentage of civilian labor force which is unemployed	10.1	6.8	7.2
Median household income	$50,122	$53,742	$50,883
Percentage of 25 years and over with no high school diploma	12.9	11.8	12.4
Percentage of population 5+ that speak English less than very well	9.9	10.6	11.8
Median age (in years)	36.4	36.8	41.8
Percentage of adults with health insurance coverage	82.3	86.1	85.1

(Source: FLCHARTS, 2017)

Note:
Hillsborough county is improving in most socioeconomic indicators.

Social Determinants of Health

The social determinants of health are the conditions in which people are born, grow, live, work, play, and age. These circumstances are shaped by the distribution of resources. The social determinants of health are responsible for the health inequities – *the unfair and avoidable differences in health status seen across various measures of difference (e.g. race, age, disability status, etc.)* in population. The conditions in the places in which people live, work and play affect their risk of experiencing poor health outcomes. These conditions are the result of many factors, which if improved, can help to make communities healthier. This is reflected by the phrase, "Place matters!". A person's ZIP code is a better predictor of their health outcomes than is their genetic code.

Poverty limits access to health services, healthy food, and safe neighborhoods. Persons with higher levels of education are more likely to have better health outcomes. Data collected from the survey shows that as household income increases, rates of provider diagnosed diabetes decrease (Figure 7).

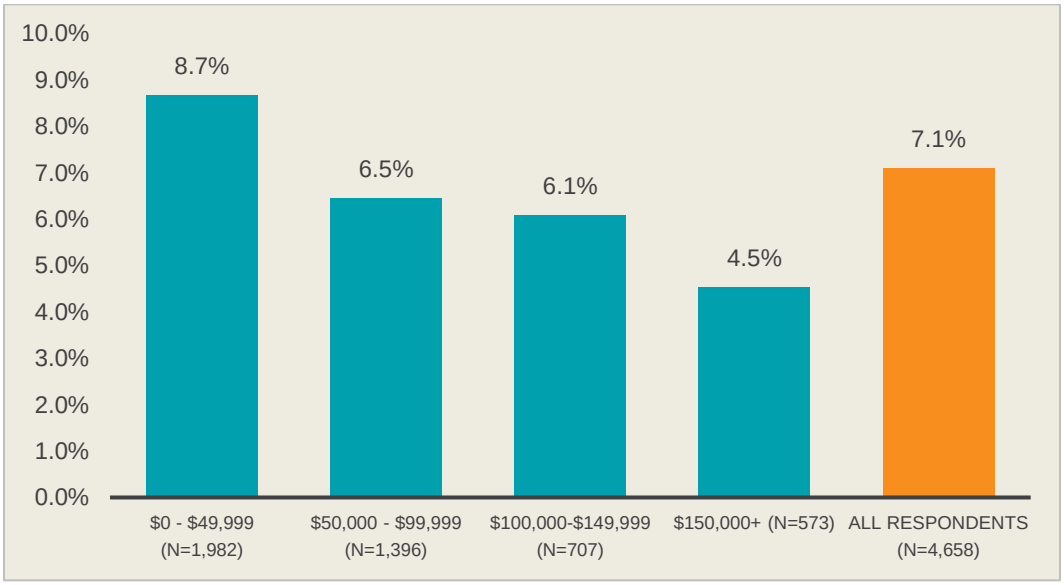


Figure 7: Provider Diagnosed Diabetes by Annual Household Income

(Source: Community Health Needs Survey, 2019)

In Hillsborough County, various social determinants of health are distributed differently across race and ethnicity, as reflected in Table 2 collected from the 2019 Community Health Needs Survey. Therefore, it is not surprising that health outcomes are also distributed differently across race and ethnicity, with minorities experiencing poorer health while having less access to the things that are needed for health. The most notable inequities are *Economic security*, and *Livelihood security and employment opportunity*. White non-Hispanics (WNH) continue to out earn their minority counterparts. Food insecurity (running out of food during the past 12 months) was reported by 34% and 38% of Black non-Hispanic (BNH) and Hispanic (Hisp.) survey respondents, respectively. These rates are twice as high as those reported by WNH respondents.

Table 2: Social Determinants of Health

Social Determinants of Health	Hillsborough				
	WNH (%)	BNH (%)	Hisp. (%)	Other (%)	Total (%)
Economic security					
Income					
$0 - $49,000	26	57	62	42	**43**
$50,000 - $99,999	33	29	26	25	**30**
$100,000 - $149,999	22	8	8	16	**15**
$150,000 or more	18	6	4	17	**12**
Livelihood security and employment opportunity					
Unemployment [not working and looking for work]	3	9	10	6	**6**
Food ran out (sometimes or often) in the past 12 months	15	34	38	26	**25**
Worried food would run out (sometimes or often) in the past 12 months	20	37	41	33	**30**
School readiness and educational attainment					
Highest level of education attained					
Less than high school	2	8	13	5	**7**
High school or GED	41	55	53	45	**47**

Social Determinants of Health	Hillsborough				
	WNH (%)	BNH (%)	Hisp. (%)	Other (%)	Total (%)
4-Year college degree	32	17	16	23	24
Graduate level or higher	24	20	17	27	22
Environmental quality					
There are good sidewalks for walking safely in my local community	61	59	55	60	59
Access to health care					
Had an unmet (medical, dental or mental) health need during the past 12 months	33	41	40	40	37
Community safety and security					
Social connectedness - I have enough people I can ask for help at anytime	82	77	75	75	79
Transportation					
Public transportation is easy to get if I need it	25	51	41	32	34

(Source: Community Health Needs Survey, 2019)

Note:

Inequities in the social determinants of health continue to place racial and ethnic minorities living in Hillsborough County at greater risk for experiencing poorer health.

Figure 8 shows ER visits for a medical emergency by race and ethnicity. Overall, 35% of respondents who used the ER in the past 12 months reported that it was due to a life-threatening emergency. This means that the other 65% used the ER for a non-life-threatening event. ER use for actual emergencies varied by race and ethnicity, with 43% of WNH using it for an emergency compared to 28%, 30% and 31% of BNH, Hispanic, and Others, respectively. ER use is a reflection of the access to preventive and primary health care services that exist within a community. This suggests that there are inequities in access to primary health care services across race and ethnicity.

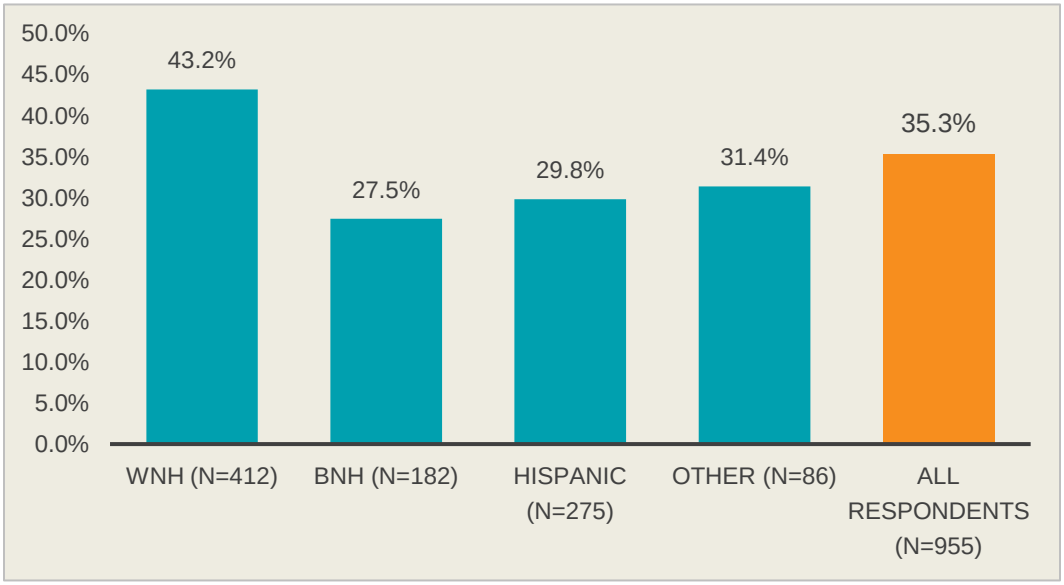


Figure 8: Percent of ER Visits for a Medical Emergency by Race and Ethnicity

(Source: Community Health Needs Survey, 2019)

Survey respondents with children living in the home reported varying rates of asthma diagnosis in those children (Figure 9). Asthma diagnosis is related to both indoor and outdoor air quality. This variation in asthma rates across race and ethnicity reflects the variation in the conditions in which children live.

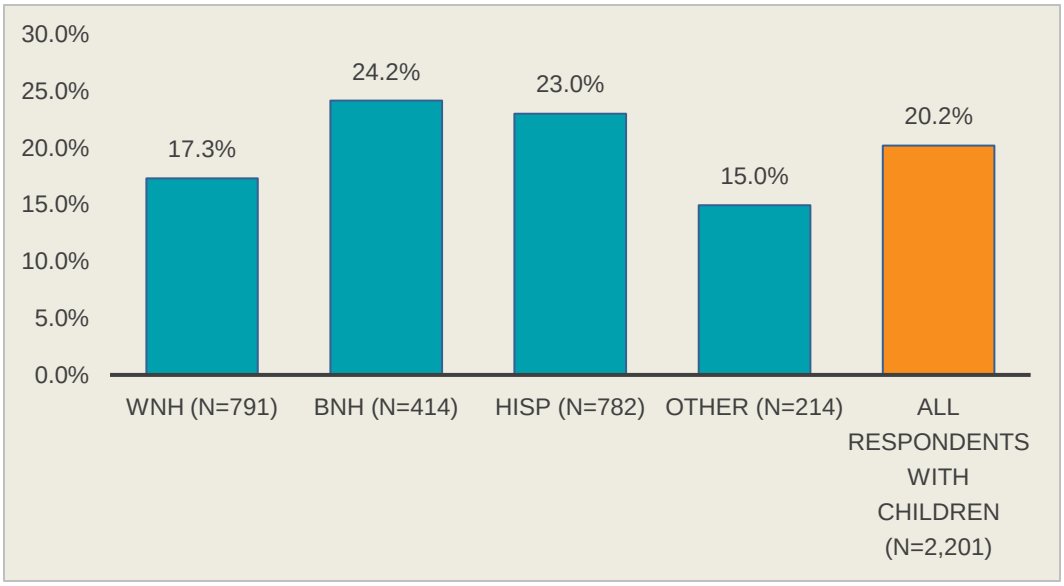


Figure 9: Children Living at Home with Asthma by Race and Ethnicity

(Source: Community Health Needs Survey, 2019)

Clinical & Health Resources Available

The resources available in a community provide an understanding on how its resident can seek and obtain health care. Clinical resources available such as dentists, physicians, and hospital beds in Hillsborough County are comparable to the State of Florida (Table 3). However, only 67% of county residents have a personal doctor compared to 75% in the state (Table 4). Seventy-two percent of county residents had a medical check-up during the past year. While 17% of residents were unable to see a doctor during the past 12 months due to cost.

Table 3: Clinical Resources Available

Clinical Resources Available	Hillsborough	Florida
	Rate Per 100,000	Rate Per 100,000
Providers*		
Total Licensed Dentists (Fiscal Year)	61.45	55.82
Total Licensed Physicians (Fiscal Year)	398.38	310.61
Total Licensed Family Practice Physicians (Fiscal Year)	18.59	19.19
Facilities		
Total Hospital Beds	300.01	308.17
Total Acute Care Beds	254.07	248.95
Total Specialty Beds	45.94	59.17
Total Nursing Home Beds	278.66	399.75

*Fiscal year (July – Jun). *(Source: FLCHARTS, 2018)*

Table 4: Health Resources Available

Health Resources Available	Hillsborough	Florida
	Percent	Percent
Health Care Access & Coverage		
Adults who have a personal doctor	67%	72%
Adults who had a medical checkup in the past year	72%	77%
Adults who could not see a doctor in the past year due to cost	17%	17%

(Source: FLCHARTS, 2018)

Quality of Life

Quality of life indicators provide an understanding of the standard of health, comfort, and happiness experienced by residents. Indicators in Table 5 show that the perceived quality of life is improving over time for Hillsborough County residents. Premature death, measured in years of life lost (YLL), gives an estimate of the average years a person would have lived had he or she not died prematurely. In Hillsborough County this improved from 7,601 YLL in 2013 to 7,000 in 2019. Physical and mental health indicators have remained consistent, with

residents reporting an average of four days of poor mental health and four days of poor physical health during the past 30 days.

Table 5: Quality of Life

Quality of Life Indicators	Hillsborough			Florida
	2013	2016	2019	2019
Premature death *(years of life lost)*	7,601	6,900	7,000	6,800
Poor or fair health *(percent)*	17%	17%	19%	19%
Poor physical health days *(during the past 30 days)*	4.0	3.7	3.9	3.8
Poor mental health days *(during the past 30 days)*	4.1	4.0	4.0	3.8
Low birthweight *(percent)*	9%	9%	9%	9%

(Source: County Health Rankings, 2019)

Note:
Quality of Life in Hillsborough County has remained consistent over time.

Behavioral Risk Factors

Behavioral risk factors provide estimates of the prevalence of various risky health behaviors and health outcomes (Table 6). Of note is the slight decrease in the percentage of adults who engaged in binge drinking between 2007 and 2013. However, between 2013 and 2016 this percentage increased. Since 2013, more than half of all adults in Hillsborough County have reported to being inactive or insufficiently active. Further, less than half of all adults in the county met the aerobic exercise recommendations in 2016. The county continues to have relatively high percentages of adults who are overweight or obese. There has been a reduction in the percentage of adults who are current smokers since 2007 (from 22% to 16%). This is reflected in the increasing percentages of persons who tried to quit at least once during the past year.

Table 6: Behavioral Risk Factors

Behavioral Risk Factors	Hillsborough				Florida
	2007 (%)	2010 (%)	2013 (%)	2016 (%)	2016 (%)
Alcohol Consumption					
Adults who engage in heavy or binge drinking	20	16	15	19	18
Injury Prevention					
Adults who always or nearly always use a seatbelt when riding in a car	-	97	94	95	95
Marijuana Use					
Adults who used marijuana or hashish during the past 30 days	-	-	-	10	7
Physical Activity, Weight & Nutrition					
Adults who are inactive or insufficiently active	-	-	53	56	57
Adults who meet aerobic recommendations	-	-	52	46	45
Adults who are overweight or obese	64	65	67	64	63
Tobacco Use & Exposure					
Adults who are current smokers	22	20	18	16	16
Adult current smokers who tried to quit at least once in the past year	49	65	69	63	62
Adults who currently use e-cigarettes	-	-	-	5	5
Adults who are former e-cigarette users	-	-	-	16	16

(Source: FLCHARTS, 2016)

Note:

The percent of adult smokers who make attempts to quit is increasing over time.

Environmental Health Indicators

Environmental health indicators help to provide an understanding of the physical conditions in the environment that affect human health (Table 7) and provide estimates of the prevalence of various related health outcomes (Table 8).

Air pollution – particulate matter measures the density of fine particulate matter in the air. Hillsborough County's performance in this measure is among the best in Florida and is better than in the state overall. Housing continues to be a problem, with 20% of county residents reporting severe housing problems including: overcrowding, high housing cost, lack of kitchen facilities, or lack of plumbing facilities.

There are slight improvements in respiratory illness, which is related to air quality and housing conditions. The percentages of adults who currently have asthma, and who have ever been told they had asthma, show slight improvements over time.

Table 7: Environmental Health Indicators

Environmental Health Indicators	Hillsborough			Florida
	2013	2016	2019	2019
Pollution				
Air pollution - particulate matter	8	10.9	7.1	8.2
Drinking water violations	no	yes	yes	no data
Driving alone to work	80%	80%	80%	79%
Housing				
Severe housing problems		21%	20%	21%

(Source: County Health Rankings, 2019)

Table 8: Environmental Health Outcomes

Environmental Health Outcomes	Hillsborough				Florida
	2007	2010	2013	2016	2016
Asthma					
Adults who currently have asthma	6.9%	8.6%	9.2%	7.7%	6.7%
Adults who have ever been told they had asthma	-	-	15.1%	12.1%	11.0%

Environmental Health Outcomes	Hillsborough				Florida
	2007	2010	2013	2016	2016
Injury Prevention					
Adults 45 years of age and older who had a fall-related injury in the past 12 months	-	-	-	9.4%	9.9%

(Source: FLCHARTS, 2019)

Social & Mental Health

Social and mental health indicators provide an understanding of county residents' emotional, psychological, and social well-being. Rates of crime and domestic violence are lower in Hillsborough County compared to Florida. However, rates of alcohol-suspected motor vehicle crashes and crash injuries are higher in the county compared to the state. Suicide rates continue to be a concern, but, they are comparable to state rates (Table 9).

Table 9: Social & Mental Health

Social & Mental Health (2016-2018)	Hillsborough	Florida
3-Yr Rate (per 100,000 population)		
Crime and Domestic Violence		
Domestic Violence Offenses	487.0	514.3
Burglary	283.9	422.2
Aggravated Assault	202.8	280.4
Motor Vehicle Theft	139.9	205.8
Robbery	57.5	90.0
Forcible Sex Offenses	38.9	54.4
Rape	24.3	38.8
Murder	4.5	5.3
Alcohol-suspected Motor Vehicle Crashes		
Alcohol-suspected Motor Vehicle Crashes	68.0	49.5
Alcohol-suspected Motor Vehicle Crash Injuries	30.4	24.0
Alcohol-suspected Motor Vehicle Crash Deaths	2.5	2.5
Suicide		
Suicide (Age-Adjusted Death rate)	12.9	14.5
Mental disorders		
Hospitalizations for mental disorders	685.0	958.4
Hospitalizations for mood and depressive disorders	345.2	480.2

Social & Mental Health (2016-2018)	Hillsborough	Florida
3-Yr Rate (per 100,000 population)		
Hospitalizations for mental disorders age 75 or older	285.1	347.8
Hospitalizations for mental disorders age under 18	267.6	526.2

(Source: FLCHARTS, 2019)

Note:

Hillsborough County had fewer residents hospitalized for mental health disorders compared to Florida. But had more alcohol-suspected motor-vehicle crashes.

Maternal & Child Health

Maternal and child health indicators provide an understanding of access to health services and resources available to women, infants, and children. These indicators also help to identify gaps in programs and services that promote health in these populations.

Disparities across race and ethnicity can be seen in birth-related issues including infant death, preterm birth, and low birthweight. Infant death refers to the death of an infant during its first year of life. Preterm birth refers to an infant being born before completing 37 weeks of gestation, while low birthweight refers to an infant being born weighing less than 2,500 grams. In 2018, infant death rates were 4.8, 10.6, and 7.8 per 1,000 live births among White, Black, and Hispanic women, respectively. Rates among Black, and Hispanic women are higher than the Healthy People 2020 Maternal, Infant, and, Child Health Goal 1.3 (MICH-1.3) of 6.0 deaths per 1,000 live births. In 2018, the percent of preterm births were 9.2%, 13.2%, and 9.1% among White, Black, and Hispanic women respectively. Rates among Black women are higher than the Healthy People 2020 MICH-9.1 target of 9.4% of births being preterm. In 2018, the percent of infants born with low birthweight were 7.7%, 13.2%, and 7.7% among White, Black, and Hispanic women respectively. The percent among Black women is much higher than the Healthy People 2020 MICH-8.1 target of 7.8%. While the percent of births to who mothers who received adequate prenatal care is higher in Hillsborough County when compared to the State of Florida, the percentages in Hillsborough County fall below the

Healthy People 2020 MICH-10.2 target of 83.2%. Table 10 shows the 2016-2018 3-year rolling rates for maternal and child health measures.

Table 10: Maternal & Child Health

Maternal & Child Health (2016-2018)	Hillsborough				Florida
3-Yr Figures	White	Black	Hisp.	All	All
Births					
Average Number of Births Each Year	12,257	3,738	5,478	17,290	22,3368
Births to Mothers Ages 15-44 per 1,000 Female Population	58.8	62.2	62.2	58.9	59
Births to Mothers Ages 15-19 per 1,000 Female Population	17.7	27.4	23.7	18.8	18.2
Infant Deaths					
Infant Deaths (0-364 days) per 1,000 Births	4.6	13.6	7.2	6.7	6.1
Preterm Birth					
Percent of Births occurring at less than 37 weeks of gestation	9.0	13.7	9.2	10.0	10.2
Low Birthweight					
Percent of Live Births Under 2,500 Grams	7.5	14.0	7.8	9.1	8.7
Prenatal Care					
Percent of Births with Prenatal Care Starting in First Trimester	83.8	80.9	81.0	83.2	77.4
Percent of Births with Adequate Prenatal Care	76.0	75.0	73.8	75.8	70.5

(Source: FLCHARTS, 2019)

Note:
Black babies continue to experience poorer birth outcomes.

Death, Illness & Injury

Table 11 provides an overview of selected causes of death between 2016 and 2018. Heart disease continues to account for the largest proportion of deaths followed very closely by cancer. Disparities across race and ethnicity can be seen in rates of death due to stroke

and diabetes. The HIV/AIDS death rate is much higher among Black residents compared to White and Hispanic residents.

Table 11: Select Causes of Death

Select Causes of Death (2016-2018)	Hillsborough				Florida
3-Year Age-Adjusted Death Rates (per 100,000 population)	White	Black	Hispanic	All Races	All Races
Total Deaths	723.2	818.3	601.4	728.0	684.6
Heart Disease	165.1	188.3	131.7	166.1	148.9
Cancer	155.4	174.9	122.4	156.3	149.0
Chronic Lower Respiratory Disease	44.1	26.8	24.6	41.4	39.2
Stroke	28.2	44.7	27.4	30.5	39.7
Diabetes	17.4	36.9	21.8	19.7	20.4
Motor Vehicle Crashes	14.8	14.5	16.8	14.5	15.0
Pneumonia/Influenza	12.4	17.2	12.5	12.8	9.7
Cirrhosis	11.5	5.2	7.8	10.2	11.9
HIV/AIDS	1.6	11.0	2.1	3.0	3.3

(Source: FLCHARTS, 2019)

Note:
Black residents experience higher rates of death due to diabetes and HIV/AIDS.

Infectious Disease

Infectious diseases continue to be a cause of preventable death and illness. Vaccination rates among 7th grade students in Hillsborough County have consistently been above 96% since 2013. Rates of diagnoses of infectious diseases, sexually transmitted diseases, and HIV/AIDS continue to be higher among Black residents compared to White and Hispanic residents (Table 12).

Table 12: Infectious Diseases

Infectious Diseases Rates of Diagnosis	Hillsborough		
(per 100,000 population, 2017)	White	Black	Hispanic
Hepatitis B	13.6	21.8	3.9
Hepatitis C	86.6	61.3	41.0
Tuberculosis	0.4	5.9	1.6
(per 100,000 population, 2018)	WNH	BNH	Hispanic
Sexually Transmitted Diseases (STDs)			
Early Syphilis	17.5	62.5	27.6
Gonorrhea	62.9	414.8	79.3
Chlamydia	231.4	1234.5	368.6
HIV/AIDS			
HIV	11.2	58.9	24.9
AIDS	6.3	27.9	8.4

(Source: FLCHARTS, 2019; HIV/AIDS Epi Profile, 2019)

Note:

Black residents experience higher rates of STDs and HIV/AIDS.

COMMUNITY THEMES AND STRENGTHS ASSESSMENT

The Community Themes and Strengths Assessment answers the following questions: *What is important to the community? How is the quality of life perceived in the community?* and *What assets does the community have that can be used to improve its health?* This assessment identifies community thoughts, experiences, opinions, and concerns in addition to key health issues perceived by the community and the key factors to improve quality of life. Data for this assessment was collected via the 2019 Community Health Needs Survey, Focus Groups, and Key Informant Interviews.

2019 Community Health Needs Survey

The community health needs survey was designed through the collaboration of the organizations represented on the Healthy Hillsborough steering committee. The survey was available in both English and Spanish for residents of Hillsborough County. A copy of the survey is included in Appendix C. Staff from collaborating organizations went to various locations in the county including DMV offices, FQHCs, and WIC clinics. Additionally, advertisements and a press release were issued to encourage residents to participate online. The survey was administered between February and April 2019. A total of 5,304 surveys were collected. Statistics were calculated for the survey using STATA® version 15.

Focus Groups

Four focus groups were conducted at various locations throughout the county. Three of these groups were conducted in English and one in Spanish. In total, 40 residents participated in these groups. A copy of the focus group guide questions can be found in Appendix D.

Key Informant Interviews

A total of 20 key informant interviews were held with DOH–Hillsborough partners and stakeholders. Participants were selected to represent the broad interests of the public health community in Hillsborough County. These interviews were conducted both in-person and by telephone. Interview questions can be found in Appendix E and the complete list of participants can be found in Appendix F.

Community Health Needs Survey Data

Demographic Summary

Survey respondents were overwhelmingly female (72%) and had a median age of 35 to 44 years. Respondents were representative of the county's population with respect to the distribution of race and ethnicity. Overall, 82% of survey respondents speak English at home, while 14% speak Spanish and 4% speak another language. Among those whose main language at home is not English, less than half (40%) reported that they speak English "very well" while 22% reported that they speak English "well". Among all survey respondents, 6% reported that they speak English "not well" or "not at all."

Overall, 95% of respondents reported having at least a high school diploma or GED. Approximately half (48%) reported having a 2-year or 4-year college degree. The median household income among survey respondents was between $50,000 and $75,000. Figure 10 shows the distribution of survey respondents across county ZIP codes. The five ZIP codes identified as having the highest socioeconomic need accounted for 15% of survey responses. These include ZIP codes along the I-4 corridor along with those representing South County.

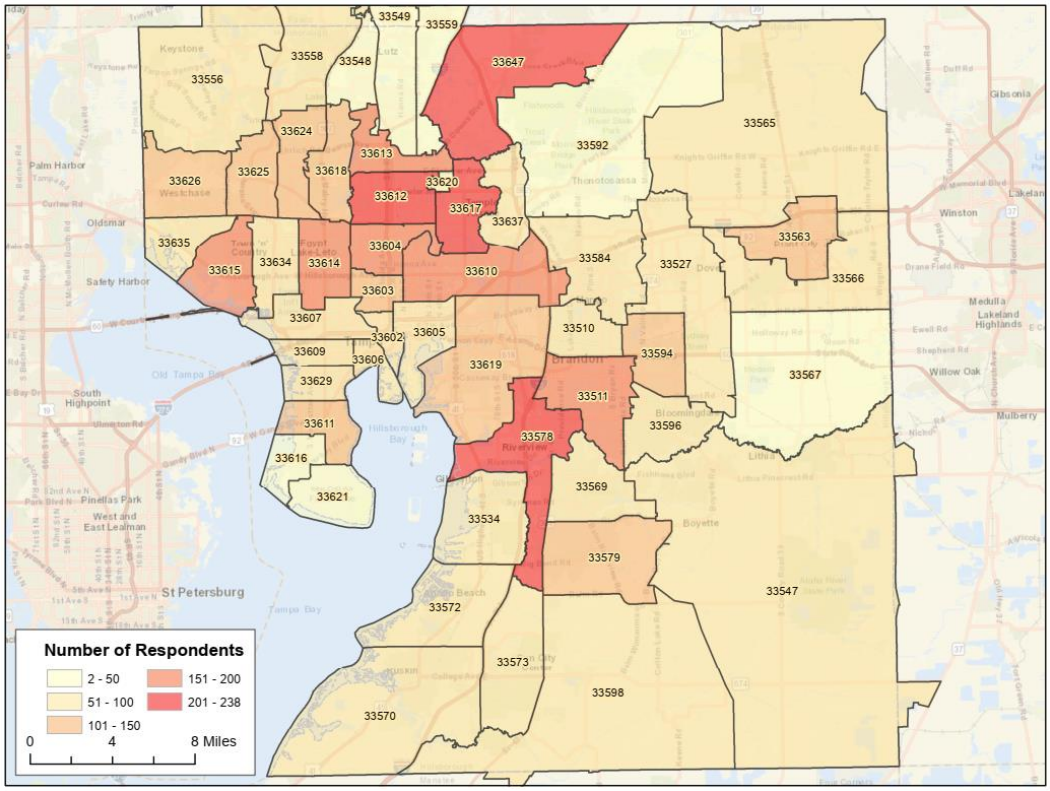


Figure 10: Geographic Distribution of Survey Respondents

Community and Personal Health

Less than half the respondents rated the overall health of their community as "very healthy" (10%) or "healthy" (33%). Almost one–in–five (17%) rated their community as "unhealthy" or "very unhealthy". Respondents were more likely to view their own health as better than the health of the community in which they live. While 43% rated their community as "very healthy" or "healthy", 53% rated their own personal health that way. Respondents' perceptions of the health of their community have declined slightly since the 2015/2016 CHA. At that time, 47% of respondents rated their community as "healthy" or "very healthy". With respect to their personal health, current perceptions are also worse than the 2015/2016 CHA. At that time, 61% of respondents rated their own personal health as "healthy" or "very healthy". Personal health rating was similar across race and ethnicity. Differences in rating

could be seen across household income, with health rating increasing with income (Figure 11).

Survey respondents were also asked about unmet health needs. A respondent is considered to have an unmet health need if they responded "yes" to needing medical, dental or mental health care during the past 12 months but not getting it. Approximately two-in-five (37%) reported having an unmet health need during the past 12 months. And almost one-in-five (18%) reported having a child with an unmet health need during the past 12 months. Among respondents who reported using the emergency room during the past 12 months, 35% reported that it was due to a life-threatening emergency [data not shown].

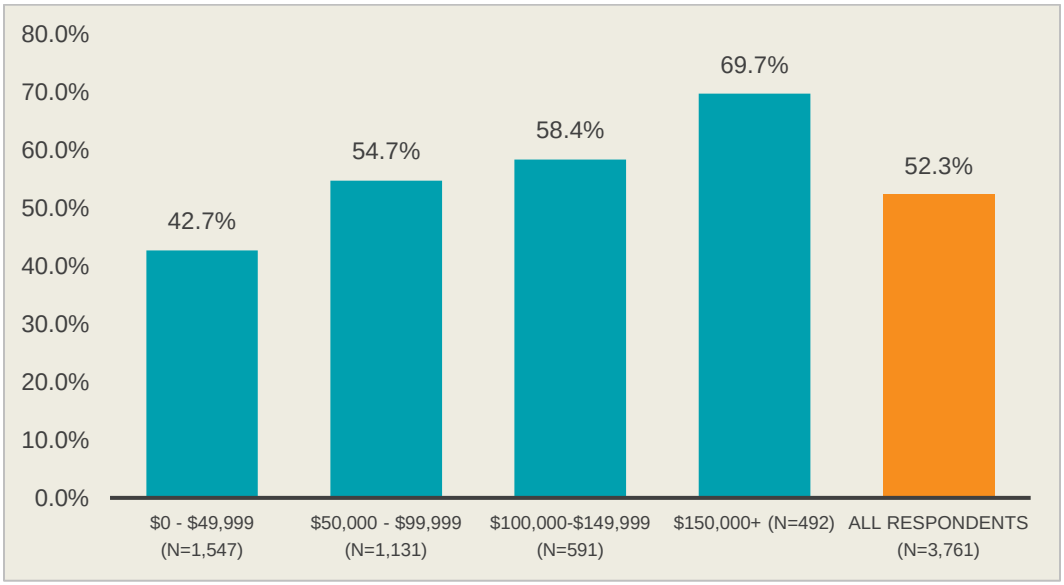


Figure 11: Personal Health Rated as "Healthy" or "Very Healthy"

Nutrition

The survey included questions on nutrition and food insecurity. Three-in-four (75%) respondents reported eating fast food at least once during the past 7 days. Rates of fast food consumption were higher among Black non-Hispanic respondents (Figure 12). Among respondents who had children living in their home, 43% reported that children ate fast food

every week and 28% reported that children drink sugar-sweetened sodas, energy drinks, or sports drinks every day (Figure 13).

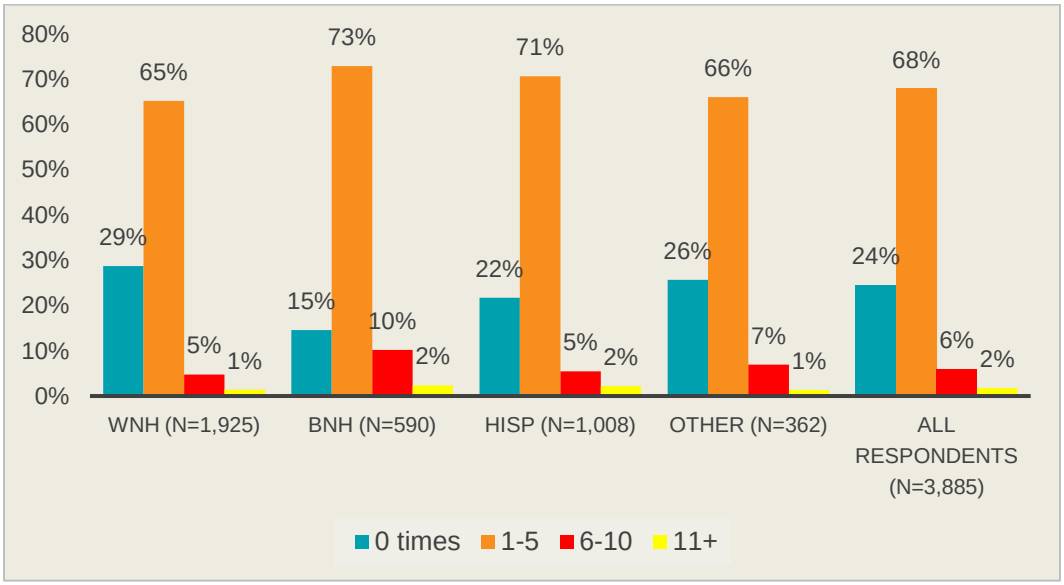


Figure 12: Frequency of Fast Food Consumption by Race and Ethnicity

A relatively large percentage of survey respondents reported food insecurity (Figure 14). Three-in-ten (30%) reported that during the past 12 months they were worried that their food would run out before they would have enough money to buy more. One-in-four (25%) reported that their food did run out before they were able to buy more. Rates of food insecurity were different across race and ethnicity with Black non-Hispanic and Hispanic respondents reporting higher rates of food insecurity.

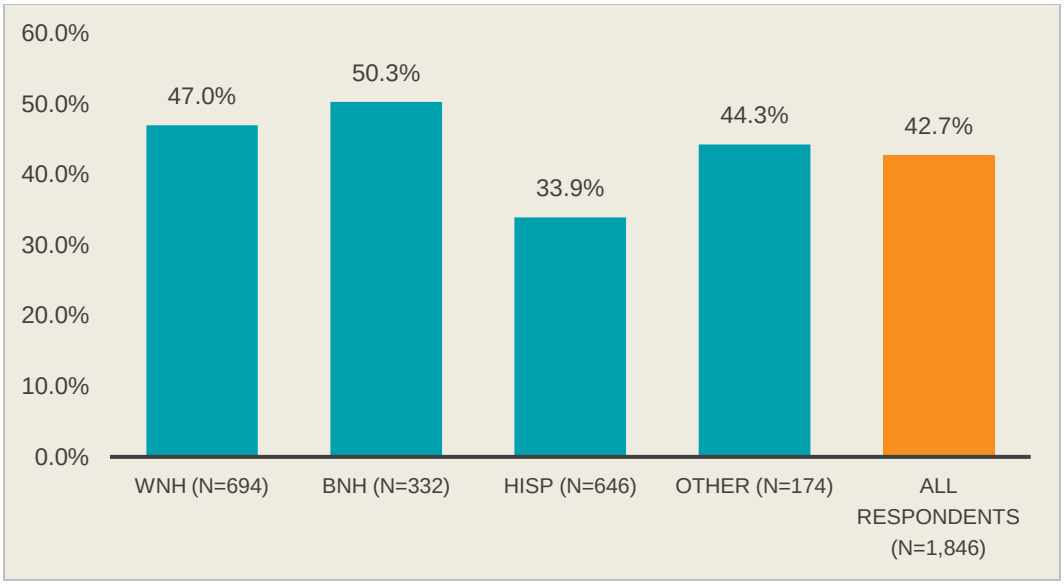


Figure 13: Children's Weekly Fast Food consumption by Race and Ethnicity

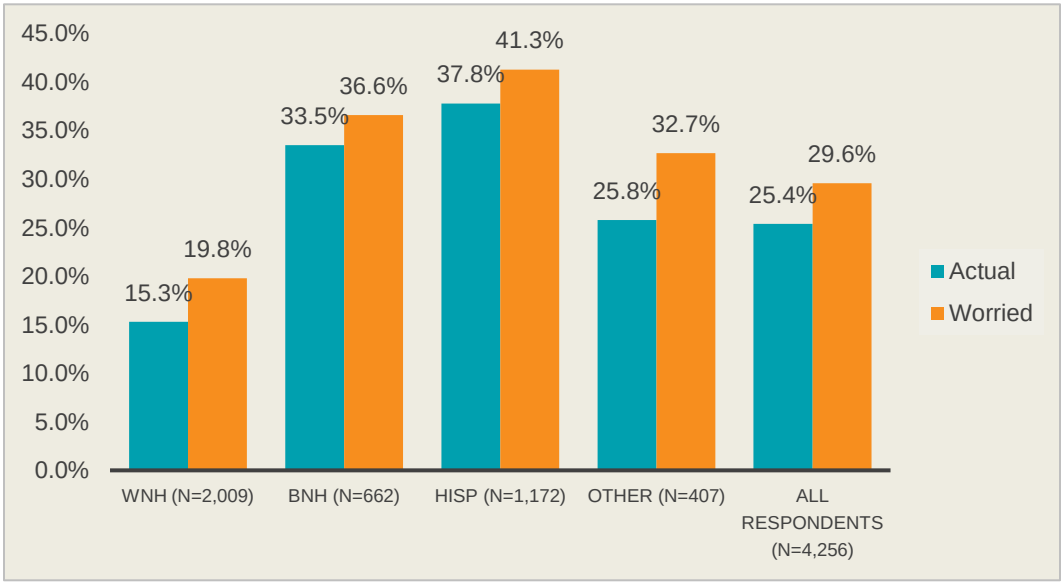


Figure 14: Food Insecurity by Race and Ethnicity

Behavioral Health

Behavioral health refers to mental health and substance use. Provider diagnosed depression was 14% among survey respondents, with racial and ethnic disparities (Figure 15). While there were disparities in provider diagnosed depression, the percentages of respondents reporting having had thoughts of suicide and self-harm were relatively consistent across race and ethnicity with an overall rate of 12%. There were 13.5% of survey respondents who reported an unmet mental health need. This was defined as responding "yes" to the question: *Was there a time in the past 12 months that you needed mental health care but did not get the care you needed?* The percentages of respondents with unmet mental health needs were consistent across race and ethnicity. Among respondents with children living in the home, 6% reported that their child had an unmet mental health need during the past 12 months. And while unmet mental health needs were consistent across race and ethnicity, there were disparities across race and ethnicity among the percentages of respondents who had *children* with unmet mental health needs (Figure 16).

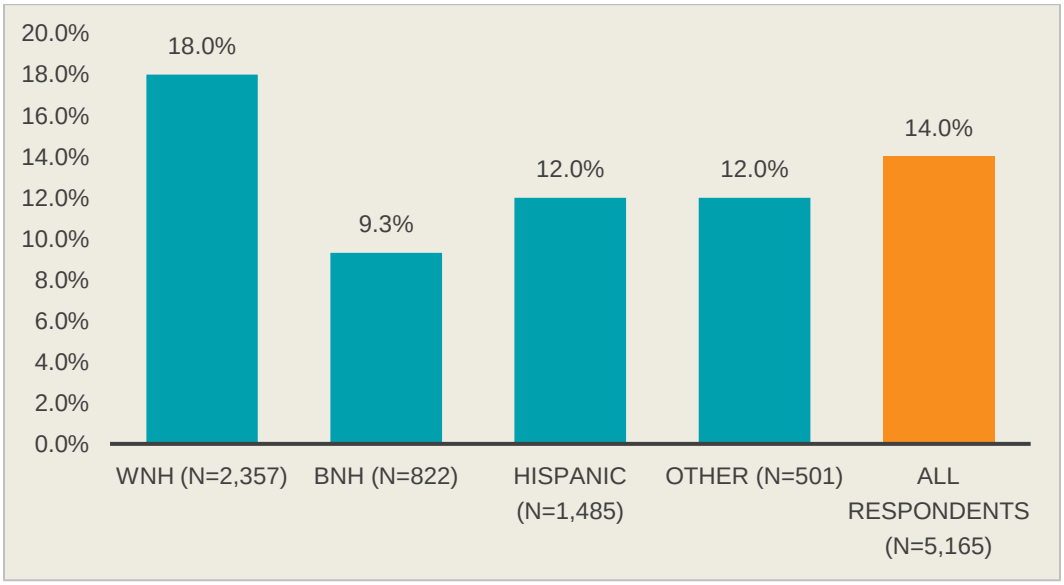


Figure 15: Provider Diagnosed Depression by Race and Ethnicity

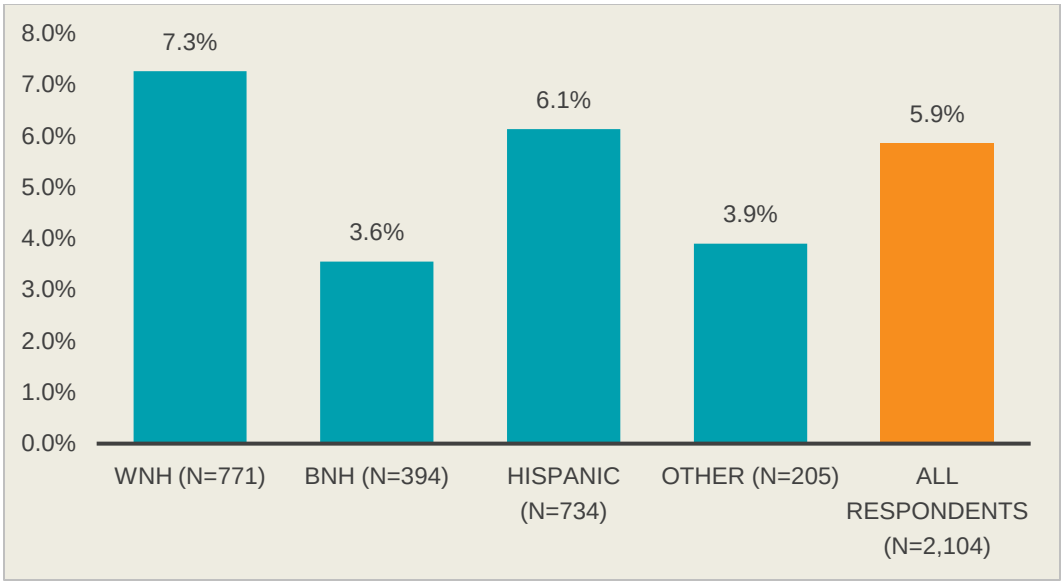


Figure 16: Percentage of Homes with Children having an Unmet Mental Health Need by Race and Ethnicity

The percentage of respondents who reported misusing a prescription during the past 12 months was relatively low (4%). However, there were disparities across race and ethnicity with 6% of BNH respondents reporting prescription misuse compared to 3% of WNH and 4% of Hispanic respondents.

Rates of smoking cigarettes were 11% among all respondents. Rates of smoking were 10%, 13% and 10% among WNH, BNH and Hispanic respondents respectively. Approximately one-in-twenty (5%) respondents reported vaping or using e-cigarettes. Rates of vape and e-cigarette use were consistent across race and ethnicity.

Respondents were asked about Adverse Childhood Experiences (ACEs). ACEs are potentially traumatic events occurring during childhood that can have lasting negative effects on health, well-being and opportunity. These experiences range from physical, emotional, or sexual abuse to parental divorce or incarceration. Three or more ACEs indicates an increased risk for long term negative outcomes such as: injury, sexually transmitted infections, maternal and child health problems, diabetes, and suicide. Most respondents (70%) reported at least one ACE, while nearly half (43%) experienced at least three ACEs (Figure 17).

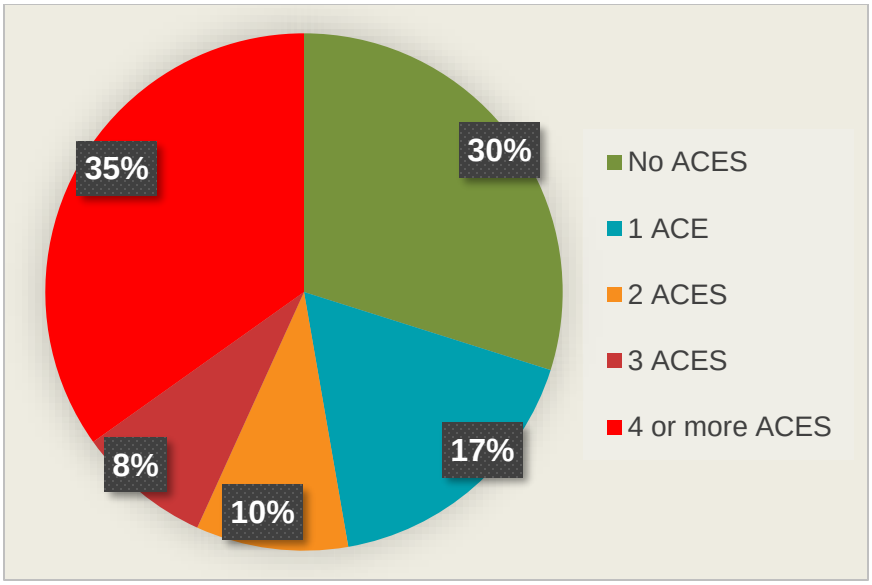


Figure 17: ACEs among Survey Respondents

Community Perception of Most Important Health Problems

Survey respondents ranked cancers as the most important health problem facing Hillsborough County, followed by mental health and child abuse. The most commonly mentioned health problem was mental health problems including suicide followed by being overweight and cancers. In the 2015/2016 CHA, being overweight was ranked as both the most important health problem and was the most commonly reported health problem. In the 2015/2016 CHA mental health was ranked as the 4th most important health problem. It is notable that child abuse / neglect was the 9th most frequently mentioned important health problem on the 2015/2016 CHA, and it was the 3rd most frequently mentioned on the current survey. On the current survey respondents also identified being overweight, heart disease / stroke / high blood pressure, and aging problems among the most important health problems. Table 13 shows the community's perception of the most important health problems along with current data related to those issues.

Table 13: Community Perception of Most Important Health Problem

Health Problem	Most Important (%)	Total Mentions (%)	Additional Notes
Mental Health Problems Including Suicide	13	36	-Depression diagnosis: 14% (CHA, 2019)
Being Overweight	10	30	-Adults in Hillsborough County who are overweight: 37% (BRFSS, 2016)
Cancers	16	29	-Cancer diagnosis: 5% (CHA, 2019)
Heart Disease / Stroke / High Blood Pressure	8	25	-Heart Disease: 3% -Stroke:0.9% -High Blood Pressure diagnosis: 20% (CHA, 2019)
Child Abuse / Neglect	10	23	-Children ages 5 – 11 experiencing abuse: 807 per 100,000 population 5-11 (Florida Safe Families, 2018)
Domestic Violence / Rape / Sexual Assault	5	22	-Domestic violence offenses: 477 per 100,000 (Florida Department of Law Enforcement, 2018) -Forcible sex offenses: 43 per 100,000 population (Florida Department of Law Enforcement, 2018)
Diabetes / High Blood Sugar	6	21	-Diabetes diagnosis: 7% (CHA, 2019)
Clean Environment / Air and Water Quality	7	18	-Adults who currently have asthma: 8% (BRFSS, 2016)
Aging Problems (for example: difficulty getting around, dementia, arthritis)	7	18	-Adults over 65 limited in some way because of arthritis – 26% (BRFSS, 2013) -Age-adjusted death rate from Alzheimer's disease: 37 per 100,000 population (Vital Statistics, 2018)
Motor Vehicle Crash Injuries	5	14	-Motor vehicle crashes: 2010 per 100,000 population (Department of Highway Safety and Motor Vehicles, 2017)
Tobacco Use / E-cigarettes / Vaping	3	14	-Cigarette smoking: 11% -E-cigarette use of vaping: 5% (CHA, 2019)

Health Problem	Most Important (%)	Total Mentions (%)	Additional Notes
HIV/AIDS / Sexually Transmitted Disease	3	11	-Persons living with HIV: 530 per 100,000 population (Florida Department of Health: HIV Section, 2018) -Bacterial STDs rates: 834 per 100,000 population (Florida Department of Health: Bureau of Communicable Diseases, 2018)
Gun-Related Injuries	3	11	-Hospitalizations for non-fatal firearm injuries: 8.4 per 100,000 population (Florida Agency for Health Care Administration, 2018)
Dental Problems	1	5	Unmet dental health need: 26% (CHA, 2019)
Homicide	1	5	-Age-adjusted homicide death rate: 5.3 per 100,000 population (Vital Statistics, 2018)
Teenage Pregnancy	0	3	-Repeat births to mothers ages 15 – 17: 8% (Vital Statistics, 2018)
Respiratory / Lung Disease	0	3	-Hospitalizations due to CLRD: 325 per 100,000 population (Florida Agency for Health Care Administration, 2018)
Infant Death	1	3	-Infant death rate: 6 per 1,000 live births (Vital Statistics, 2018)
Infectious Diseases Like Hepatitis and TB	0	3	-Tuberculosis incidence: 2 per 100,000 population (Florida Department of Health: Tuberculosis Section, 2018) -Hepatitis A incidence: 6 per 100,000 population (Florida Department of Health: Merlin, 2018)

(multiple answers possible, ranked by total mentions)

Factors that Improve Quality of Life in the Community

Low crime / safe neighborhood was ranked the most important factor to improve quality of life (Table 14). It was also the most frequently mentioned factor to improve quality of life in a community. Forty-three percent (43%) of respondents identified low crime and safe neighborhoods among factors which improve the quality of life in a community, followed by

access to health care (32%), good schools (30%), and good jobs / healthy economy (27%). This distribution of responses is similar to responses given in the 2015/2016 CHA, with access to health care being mentioned more frequently on this survey as compared to the 2015/2016 CHA.

Table 14: Factors that Improve Quality of Life

Factors that Improve Quality of Life	Most Important (%)	Total Mentions (%)
Low Crime / Safe Neighborhoods	20	43
Access to Health Care	13	32
Good Schools	8	30
Good Jobs and Healthy Economy	7	27
Good Place to Raise Children	14	25
Low-Cost Health Insurance	6	19
Clean Environment / Air and Water Quality	5	17
Strong Family Life	5	16
Healthy Behaviors and Lifestyles	4	16
Access to Low-Cost, Healthy Food	2	13
Low-Cost Housing	4	13
Religious or Spiritual Values	4	8
Parks and Recreation	1	7
Tolerance / Embracing Diversity	1	7
Public Transportation	1	6
Access to Good Health Information	1	5
Sidewalks / Walking Safety	1	5
Emergency Medical Services	1	4
Arts and Cultural Events	0	3
Disaster Preparedness	0	1
Low Rates of Adult Death and Disease	0	1
Low Rates of Infant Death	0	1

(multiple answers possible, ranked by total mentions)

Risky Behaviors

Table 15 shows the ranking of risky behaviors. Drug abuse was ranked as the most harmful risky behavior (34%) and it was the most frequently mentioned risky behavior (60%). Distracted driving (43%), alcohol abuse (40%) and poor eating habits (31%) were also mentioned frequently as harmful risky behaviors. This is similar to the 2015/2016 CHA where drug abuse, alcohol abuse, and poor eating habits were the most frequently mentioned risky behaviors.

Table 15: Most Harmful Risky Behaviors

Risky Behaviors	Most Harmful (%)	Total Mentions (%)
Drug abuse	34	60
Distracted driving (texting, eating, talking on the phone)	17	43
Alcohol abuse	11	40
Poor eating habits	9	31
Tobacco use / E-cigarettes / Vaping	6	27
Lack of exercise	5	22
Not locking up guns	5	15
Unsafe sex including not using birth control	3	14
Not getting "shots" to prevent disease	4	14
Dropping out of school	3	11
Not using seat belts/not using child safety seats	1	10
Not wearing helmets	1	4
Not seeing a doctor while you are pregnant	1	4

(multiple answers possible, ranked by total mentions)

Perception of Local Community

Most respondents feel safe in their neighborhoods (79%) and are able to get healthy foods easily (73%). However, 13% reported not feeling safe in their neighborhoods, and 22% are not able to get healthy foods easily (Table 16). While most survey respondents had a

positive opinion of their local community, there were statements which had similar numbers of respondents agreeing and disagreeing indicating varying degrees of perceptions of communities' health across the county. Almost equal numbers of respondents agreed and disagreed that there are affordable places to live in their neighborhood. This was also true of the statement "there are plenty of jobs available for those who want them." The differences in perception of neighborhood walkability was notable. Almost 60% of respondents agreed that there are sidewalks for walking safely, while 36% disagreed with that statement. Notable, too, is the high percentage of respondents who weren't sure about drug abuse, air quality and crime in their local community (see Table 16). Responses to these statements are similar to responses on the 2015/2016 CHA.

Table 16: Perception of Local Community

Community Perception	Agree (%)	Disagree (%)	Not Sure (%)
I feel safe in my own neighborhood.	79	13	7
I am able to get healthy food easily.	73	22	5
I have no problem getting the health care services I need.	66	25	8
We have great parks and recreational facilities.	62	25	13
There are good sidewalks for walking safely.	59	36	5
The quality of health care is good in my neighborhood.	56	22	22
Drug abuse is a problem in my community.	53	20	27
There are affordable places to live in my neighborhood.	41	44	15
There are plenty of jobs available for those who want them.	38	37	25
Public transportation is easy to get to if I need it.	34	47	19
Air pollution is a problem in my community.	28	47	25
Crime in my area is a serious problem.	27	50	22

(ranked by "agree")

Note:
Community health rating has improved over time, while personal health rating has declined.

Perception of the local community varied across race and ethnicity (see Table 17). A larger percentage of WNH respondents agreed that they are able to get healthy food easily (80%) compared to 68%, 65%, and 69% of BNH, Hisp., and Other respondents respectively. A larger percentage of WNH (71%) and BNH (68%) respondents agreed that they have no problem getting the health care that they need compared to 60% and 62% of Hispanic and Other respondents respectively. Even though 68%, 60% and 62% of BNH, Hisp., and Other (respectively) respondents agreed that they had no problem getting the health care services that they needed, only 48%, 49% and 51% (respectively) agreed that the quality of health care is good in their neighborhood. This is unlike the comparable percentages of WNH who both agreed that they had no problem getting the health care services that they needed (71%), and that the quality of health care was good in their neighborhood (65%). Perceptions of the availability of jobs, and public transportation also varied across race and ethnicity.

Table 17: Perception of Local Community across Race and Ethnicity

Community Perception	Percent (%) who Agree			
	WNH (n=2,070)	BNH (n=682)	Hisp. (n=1,205)	Other (n=425)
I feel safe in my own neighborhood.	84	79	72	77
I am able to get healthy food easily.	80	68	65	69
I have no problem getting the health care services I need.	71	68	60	62
We have great parks and recreational facilities.	66	62	56	61
There are good sidewalks for walking safely.	61	59	55	60
The quality of health care is good in my neighborhood.	65	48	49	51
Drug abuse is a problem in my community.	57	45	52	50
There are affordable places to live in my neighborhood.	44	37	40	41
There are plenty of jobs available for those who want them.	43	33	35	33
Public transportation is easy to get to if I need it.	25	51	41	32
Air pollution is a problem in my community.	24	30	32	27
Crime in my area is a serious problem.	25	30	28	28

Focus Groups

Focus group participants discussed issues related to the health of their communities. In addition to being asked to identify the most pressing health issues, they were asked to share ways to address the identified health issues. They were also asked to describe barriers to addressing the identified health issues and ways to overcome the perceived barriers.

Most focus group participants reported being satisfied with the quality of life in their community. Their feedback aligned with the health issues identified on the health survey and the feedback given by key informants, with many participants mentioning exercise, nutrition and weight. Participants also discussed environmental health issues including having clean streets, the need for animal control for stray animals, and pest control. The need for mental health services for servicemen and youth was also discussed.

Important Health Issues Identified (ordered by most frequently mentioned)

- Exercise, Nutrition & Weight
- Environmental Health
- Mental Health & Mental Disorders (for servicemen & youth)
- Substance Abuse
- Heart Disease & Stroke
- Access to Health Services (for older adults and Spanish speakers)
- Safety (older adults)

Participants were asked to think about the assets in their communities that promote health. Responses included programs and services, but participants most frequently identified design features of the community. Design features included community safety, lighting and sidewalk design. They discussed the need for even sidewalks and enforcement of standards for residents with disabilities.

Community Assets Identified (ordered by most frequently mentioned)

- Design features (lighting, sidewalks)
- Shade / Tree coverage
- Public Libraries
- Community Centers

Participants were also asked for their opinions on how to address the health issues that they identified, along with anticipated barriers to addressing the issues and ways to overcome these barriers.

To address health issues, participants most frequently cited education and messaging. Participants showed overwhelming endorsement of these strategies when discussing how to address nutrition. Participants also indicated the need for programs and services along with greater access to care. Interestingly, participants commented on the need for regulation enforcement, especially as it relates to animal control.

Addressing Health Issues (ordered by most frequently mentioned)

- Education / Messaging
- Programs & Services
- Access to Care
- Nutrition / Access to Food
- Regulation Enforcement

Barriers to addressing health issues were identified. Some participants, drawing from their own experiences, shared that not all services (federal and state) communicate with Spanish-speakers and that eligibility requirements can prevent many from qualifying for various programs and services. To overcome these barriers, focus group participants cited the need for increased education, cultural competency and policy change.

Key Informant Interviews

DOH-Hillsborough staff conducted interviews with 20 key informants. Key informants represented special populations (veterans, persons living with disabilities, refugees), health care providers, faith leaders, community leaders, academic institutions, financial institutions, and social services. They were asked to identify the top health issues, the factors contributing to the identified health issues, and the groups that are affected most by those health issues. Key informants were also asked to comment on community assets that help to address the health issues, barriers to accessing health care, and factors to consider when addressing community needs.

Key informants identified chronic diseases (diabetes, hypertension, asthma), behavioral health, and access to health care as the top three health issues. They cited low health literacy, financial need, and culture as the top three factors that contribute to the existing health issues. Culture was referenced as it relates to its influence on health-seeking behavior. Groups that are most affected are low income, racial and ethnic minorities, and special populations. Special populations are veterans, persons living with disabilities, refugees, and non-traditional students. These groups face specific challenges related to the lack of transportation, language and cultural barriers and income / eligibility gaps.

Important Health Issues Identified (ordered by most frequently mentioned)

- Chronic Diseases (e.g. diabetes, hypertension, asthma)
- Behavioral Health / Mental Health
- Access to Health Care
- Infectious Diseases
- Maternal & Infant Health
- Housing
- Growing Population of Older Adults

Key informants identified many community strengths that help to address the health issues identified. These assets include food pantries, health care providers, specialized services (refugee services, translation services), education programs, and the availability of mental health care providers. Key informants also noted that many health care providers offer services on a sliding fee scale for the community. They noted that there is a need for increased access to care and education. Notably, a few key informants commented that the need is based on a lack of engagement with services and not a lack of resources. In addressing the health needs of the community, key informants noted that it is important to consider cultural sensitivity, mental health, and expanding partnerships between organizations across sectors. A list of key informants is provided in Appendix F.

Community Resources / Asset Inventory

Healthy Hillsborough community partners, focus group participants, and key informants provided a list of assets to promote the community's health. Some assets relate to accessing services, while other assets are community classes and education programs offered.

Social Services

Hillsborough County - https://www.hillsboroughcounty.org

- Social Services
- Recreation & Culture

Hillsborough County Libraries – https://www.hcplc.org

Crisis Center of Tampa Bay – https://www.crisiscenter.com

Behavioral Health

- The resources listed below are organizations that offer behavioral health services.

Organization	Program / Services	Website
Agency for Community Treatment Services (ACTS)	Behavioral health treatment services	https://www.actsfl.org/
AdventHealth	Grief counselling, Mental Health First Aid	https://www.adventhealth.com
BayCare Health System	Behavioral health treatment services, Mental Health First Aid	https://Baycare.org
Drug Abuse Comprehensive Coordinating Office (DACCO)	Behavioral health treatment services	https://dacco.org
Crisis Center of Tampa Bay	Crisis intervention	https://www.crisiscenter.com
GracePoint	Behavioral health treatment services	https://www.gracepointwellness.org
Hillsborough County Health plan	Behavioral Health Taskforce	https://www.hillsboroughcounty.org
Hillsborough County Anti –Drug Alliance	Community resources for treatment	http://hcada.com
Northside Mental Health Center	Behavioral health treatment services	www.northsidebhc.org
Phoenix House Florida - Tampa	Behavioral health treatment services	https://phoenixfl.org
Safe & Sound Hillsborough	Mental Health First Aid	https://safeandsoundhillsborough.org

Organization	Program / Services	Website
Success 4 Kids & Families	Behavioral health services for children	https://www.s4kf.org
Tampa General Hospital	Mental Health First Aid	https://www.tgh.org

Access to Health Services; Immunization & Infectious Diseases; Cancer; Oral Health; Respiratory Illness

The organizations below offer a wide range of services related to Access to Health Services, Immunization & Infectious Diseases, Cancer, Oral Health, and Respiratory Illness. These include primary health care services, screenings and referrals, vaccination programs etc.

Organization	Program/Services	Website
AdventHealth	Primary care, Screenings	https://www.adventhealth.com
BayCare Health System	Primary care, Screenings, Virtual health care kiosks	https://Baycare.org
Crisis Center of Tampa Bay	Referrals	https://www.crisiscenter.com
DOH-Hillsborough	Specialty care, Screenings	http://hillsborough.flhealth.gov
Family Healthcare Foundation	Referrals	https://familyhealthcarefdn.org
Hillsborough County Public Schools	Referrals	https://www.sdhc.k12.fl.us
Hillsborough County Sunshine Line	Transportation to health care services	https://www.hillsboroughcounty.org/government/departments/sunshine-line
Hispanic Health Council	Support for services	https://www.hispanicservicescouncil.org

Organization	Program/Services	Website
Johns Hopkins All Children's Hospital	Services for children	https://www.hopkinsallchildrens.org
Judeo Christian Health Clinic	Primary care	www.judeochristianhealthclinic.org
Moffitt Cancer Center	Cancer screenings, Treatment	https://moffitt.org
Suncoast Community Health Centers	Primary care, Screenings	http://suncoast-chc.org
Tampa Family Health Centers	Primary care, Screenings	https://www.tampafamilyhc.com
Tampa General Hospital	Primary care, Screenings, Virtual health care kiosks	https://www.tgh.org
Tampa Bay Healthcare Collaborative	Community resources for services	https://tampabayhealth.org

Exercise, Nutrition & Weight; Diabetes; Heart Disease & Stroke

The organizations below offer a wide range of services related to Exercise, Nutrition & Weight, Diabetes, and Heart Disease & Stroke. These include nutrition & fitness education programs, medically tailored meals, as well as health care services.

Organization	Programs / Services	Website
AdventHealth	Nutrition & fitness education programs, Medical care	https://www.adventhealth.com
BayCare Health System	Nutrition & fitness education programs, Medical care	https://Baycare.org
DOH-Hillsborough	Nutrition education programs	http://hillsborough.flhealth.gov
Feeding Tampa Bay	Medically tailored meals	https://feedingtampabay.org

Organization	Programs / Services	Website
Tampa Family Health Centers	Medically tailored meals	https://www.tampafamilyhc.com
Tampa General Hospital	Nutrition & fitness education programs, Medical care	https://www.tgh.org
YMCA	Nutrition & fitness education programs	https://www.tampaymca.org

Maternal, Fetal & Infant Health

The organizations below offer a wide range of services related to Maternal, Fetal & Infant Health. These include nutrition programs, parenting education classes and other support programs, as well as health care service referrals.

Organization	Program s/ Services	Website
DOH-Hillsborough	WIC	http://hillsborough.flhealth.gov/
Healthy Start	Maternal & child support services	http://healthystartcoalition.org
REACHUP, Inc.	Family support services	https://www.reachupincorporated.org
Tampa General Hospital	Nutrition & fitness education programs, Medical care	https://www.tgh.org

FORCES OF CHANGE ASSESSMENT

The Forces of Change Assessment (FOCA) identifies the forces and associated opportunities and threats that can affect the community and the local public health system, either now or in the future. Forces can be trends, factors, or events.

- ***Trends*** are patterns over time, such as migration into and out of a community or growing disillusionment with government.
- ***Factors*** are discrete elements, such as a community's large ethnic population, an urban setting, or a jurisdiction's proximity to a major waterway.
- ***Events*** are one-time occurrences, such as a hospital closure, a natural disaster, or the passage of new legislation.

The FOCA answers the following questions:

- What is occurring or might occur that affects the health of the community or the local public health system?
- What specific threats or opportunities are generated by these occurrences?

The Healthy Hillsborough Collaborative held its Community Health Needs Assessment prioritization meeting on July 24, 2019. Approximately 150 persons attended. Meeting attendees included partners representing local not-for-profit hospitals, federally qualified health centers, community-based organizations, and universities. There were also students and community residents in attendance. The results of the Community Health Status and the Community Themes and Strengths Assessments were presented at this meeting. Attendees were assigned to one of 15 groups in which they conducted the Forces of Change Assessment. In their groups, attendees brainstormed a list of forces of change as defined above. Each of the 15 groups then selected one force on which to focus by identifying

opportunities and threats generated by the selected force of change. Results were captured by Think Tank software provided by Collaborative Labs of St. Petersburg Community College.

Afterwards, the DOH-Hillsborough internal workgroup evaluated the group activity reports and classified related forces of change into themes.

RESULTS

The forces of change identified by meeting attendees were grouped into three overarching themes:

- Policy & Economics
- Concerns about Race & Other Types of Discrimination
- Technology

Policy & Economics. Teams identified forces of change related to providing services and opportunities related to policies that can affect health. The rising cost of health care, and policy changes were also identified as threats to community health. Some program eligibility requirements affect an individual's ability to access health services. Eligibility requirements for health care organizations to maintain their not-for-profit status were also identified as threats, as some requirements increase the barriers that hospitals face in providing care. The need for social policy to address gentrification was also identified. It is well-documented that community development can have the negative impact of displacing the most vulnerable residents. Additionally, population growth was identified as both a threat and an opportunity. Population growth presents the opportunity for industry and development. However, due to the increase in natural disasters, population growth can be due to the migration of already vulnerable and marginalized individuals. Health care providers need to be prepared to serve a more diverse clientele and provide more culturally appropriate trauma-informed care. This may require institutionalized policy change for providing care.

Concerns about Race & Other Types of Discrimination. The stigma related to seeking behavioral health care was identified as a threat to improving population health. This does, however, provide an opportunity for education to change community perception.

Additionally, stigma was identified as a threat to seeking help in general, for health care, and for social services. There needs to be a shift, so that needing any type of help is no longer perceived negatively by the public. As population growth results in a more diverse clientele, providers need to be sensitive to the need for cultural humility to address institutional barriers to accessing care, which may add to already existing patient trauma. Participants also discussed structural racism and the need to ensure that equity is addressed in all policies. While at the same time ensuring that policies, plans and programs are developed with advocacy on behalf of groups that can be easily left out of conversations.

Technology. Technology was identified as both a threat and an opportunity. Technological advances could see many jobs being replaced. Loss of employment, a significant life event for anyone, can have especially dire financial repercussions for residents who are already disadvantaged. Conversely, technological advancements can also be a communal asset. Technological innovations have been increasingly utilized to improve access to health services through the implementation of telehealth services.

In the 2015/2016 CHA the top three forces identified were: Political change/Policy consequences, Affordability of Health Care, and Holistic health/Social determinants of health. Policy change/Policy consequences, Health Care Reform, and Economic have consistently been identified as forces of change. The effect of natural disasters and population growth are also being identified more readily as Forces of Change that could affect the local public health system.

Note:

Forces of change identified have been consistent over time. Rising costs, increased homelessness, and natural disasters have strained the local public health system.

LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

The purpose of the Local Public Health System Assessment (LPHSA) is to improve public health system performance. The LPHSA answers the following questions:

- What are the activities, competencies, and capacities of the public health system?
- How are the ten Essential Public Health Services being provided to the community?

The Local Public Health System (LPHS) includes all public, private, and voluntary entities that contribute to public health activities within a given area. It is a network of entities with differing roles, relationships, and interactions. All entities within a LPHS contribute to the health and well–being of the community. Example entities include: hospitals, public health agencies, not-for-profit organizations, nursing homes, community centers, mental health service providers, laboratories, schools, employers, elected officials, faith institutions, law enforcement, and tribal health, among many others.

The LPHSA provides a framework to measure or assess the capacity and performance of a public health system using the Ten Essential Public Health Services as the standard for measurement. The Ten Essential Public Health Services describe the public health activities that should be undertaken in all local communities. Figure 18 shows the Ten Essential Public Health Services (EPHS) within the context of three core public health functions: Assessment, Policy Development, and Assurance.

Figure 18: Essential Public Health Services and Core Functions

DOH–Hillsborough distributed an electronic survey to system partners. Forty-six system partners, from nine different sectors, were included in the analysis (Figure 19). Partners were asked to rate the local public health system's performance in each of the EPHS. Scores range from 0 to 100 with higher scores depicting greater performance in each area (Table 18). An average rating for each EPHS was calculated and then an overall average was calculated. Calculations did not include the responses of partners who indicated "don't know / unaware of activities". The results are presented in Table 19.

Table 18: Summary of LPHSA Response Options

Optimal Activity (76 – 100%)	The public health system is doing absolutely everything possible for this activity, and there is no need for improvement.
Significant Activity (51 – 75%)	The public health system participates a great deal in this activity and there is opportunity for minor improvement.
Moderate Activity (26 – 50%)	The public health system somewhat participates in this activity and there is opportunity for greater improvement.
Minimal Activity (1 – 25%)	The public health system provides limited activity and there is opportunity for substantial improvement.
No Activity (0%)	The public health system does not participate in this activity at all.
Don't know / Unaware	Don't know how the public health system performs this activity.

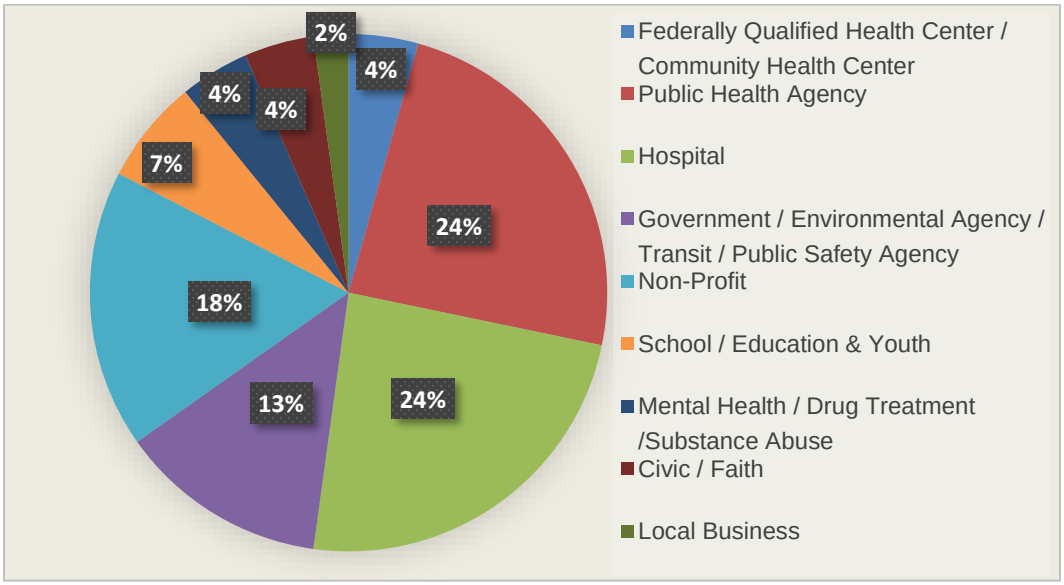


Figure 19: Sectors Represented on LPHSA

Overall, partners rated the local public health system as performing with significant activity (51-75%) in most of the ten essential public health services (Figure 20, Table 19). The best performing measure is essential public health service 1 (Monitor health status), and the service presenting the most opportunity for improvement is essential public health service 5 (Develop policies / plans). EPHS 1 is related to the core function of assessment shown in Figure 18. EPHS 5 relates to the core function of policy development (Figure 18). It is notable that essential public health services 1 and 5 had the fewest persons responding, "don't know / unaware of activities" (7% and 0% respectively) whereas almost 50% of partners responded "don't know / unaware of activities" when rating essential public health service 6 (Enforce laws).

Figure 21 shows the ranking of the Essential Public Health Services in 2010, 2015 and 2019. Each bar represents the average rating of how partners rated the Local Public Health System's performance in each Essential Public Health Service. In 2015, the LPHS was also rated to be performing with "significant activity". However, at that time partners rated Essential Public Health Services 1, 2 (Diagnose and investigate) and 6 to be occurring at "optimal activity". In that iteration, Essential Public Health Service 2 scored the best with "optimal activity" and EPHS 9 (Evaluate services) presented the most opportunity for improvement even with a relatively high rating; operating with "significant activity".

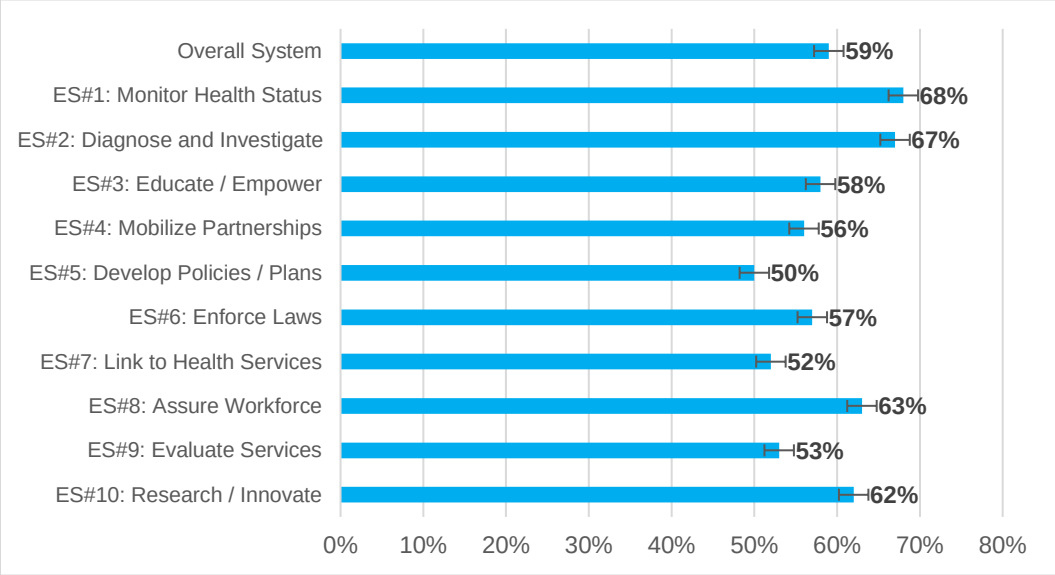


Figure 20: Summary of EPHS Performance Scores

Table 19: Summary of LPHSA Results

EPHS #	Description	Activity Level	Mean Rating (%) *	Don't Know
EPHS 1	Monitor Health Status to Identify Community Health Problems	Significant	68	7%
EPHS 2	Diagnose and Investigate Health Problems and Health Hazards	Significant	67	20%
EPHS 3	Inform, Educate, and Empower People about Health Issues	Significant	58	17%
EPHS 4	Mobilize Community Partnerships to Identify and Solve Health Problems	Significant	56	11%
EPHS 5	Develop Policies and Plans that Support Individual and Community Health Efforts	Moderate	50	0%
EPHS 6	Enforce Laws and Regulations that Protect Health and Ensure Safety	Significant	57	41%
EPHS 7	Link People to Needed Personal Health Services and Ensure Safety	Significant	52	11%
EPHS 8	Assure a Competent Public Health and Personal Health Care Workforce	Significant	63	33%
EPHS 9	Evaluate Effectiveness, Accessibility, and Quality of Personal and Population–Based Health Services	Significant	53	28%
EPHS 10	Research for New Insights and Innovative Solutions to Health Problems	Significant	62	24%
Overall		**Significant**	**59**	

** excludes responses "don't know / unaware of activities"*

Figure 21: Ranking of the Essential Public Health Services (2010, 2015, 2019)

Note:

The Local Public Health System has been consistently rated as performing with significant activity. It continues to perform best in Essential Public Health Services 1 and 2. The Essential Public Health Services which have the most opportunity for improvement have changed over time.

IDENTIFYING HEALTH PRIORITIES

The Healthy Hillsborough Coalition held its Community Health Needs Assessment prioritization meeting on July 24, 2019. Approximately 150 persons attended. Meeting attendees included partners representing local not-for-profit hospitals, federally qualified health centers, community-based organizations, and universities. There were also students and community residents in attendance. Of note was the attendance of partners not traditionally associated with health and not traditionally involved in health improvement planning. In attendance were representatives from the county's Metropolitan Planning Organization and Planning Commission, local churches and local businesses. The results of the Community Health Status, and Community Themes and Strengths Assessments were presented at this meeting. Additionally, the Forces of Change Assessment was conducted at the meeting as well.

Meeting attendees had the opportunity to review the data, and vote on the priority areas. The top ten health priorities identified through this process, in priority order, are shown below in Table 20. The complete collaborative meeting report can be found in Appendix G.

Table 20: Health Priorities

Priority	Area
1	Behavioral Health (Mental Health & Substance Abuse)
2	Access to Health Services
3	Exercise, Nutrition & Weight
4	Diabetes
5	Maternal, Fetal & Infant Health
6	Heart Disease & Stroke
7	Immunization & Infectious Disease
8	Cancer
9	Oral Health
10	Respiratory Disease

CONCLUSION & NEXT STEPS

This report reflects the collaboration and hard work of many community partners, including members of the Hillsborough community, representatives from local hospitals, local government, nonprofit organizations, community leaders, community clinics, and schools. The Community Health Assessment (CHA) provided an opportunity for stakeholders to collaborate in a strategic planning process to better understand complex health issues and dialogue on priorities and proposed solutions.

In response to the findings, action plans will be created relevant to the priority areas that were identified by partners, and a Community Health Improvement Plan will be developed (Figure 22). Healthy Hillsborough will collaborate on action plans for Access to Health Services and Exercise, Nutrition & Weight; priority areas 2 and 3 respectively. Behavioral Health will be addressed through All4HealthFL, a joint four-county collaborative described in the next chapter. Health Literacy, a priority from the 2016–2020 CHIP will continue to be addressed in the 2020–2025 CHIP.

Additional actions include making the CHA available to members of the community, implementation and monitoring of action plan interventions, continued support of hospital needs assessment efforts, and ongoing facilitation of the Healthy Hillsborough collaborative. DOH-Hillsborough will issue a press release when the CHA is published. Additionally, copies of the CHA will be sent to community partners and made available in DOH-Hillsborough clinics. Efforts will be made to keep partners and the public engaged in the Community Health Improvement Plan and related activities. This includes annual updates to the CHA as new data becomes available.

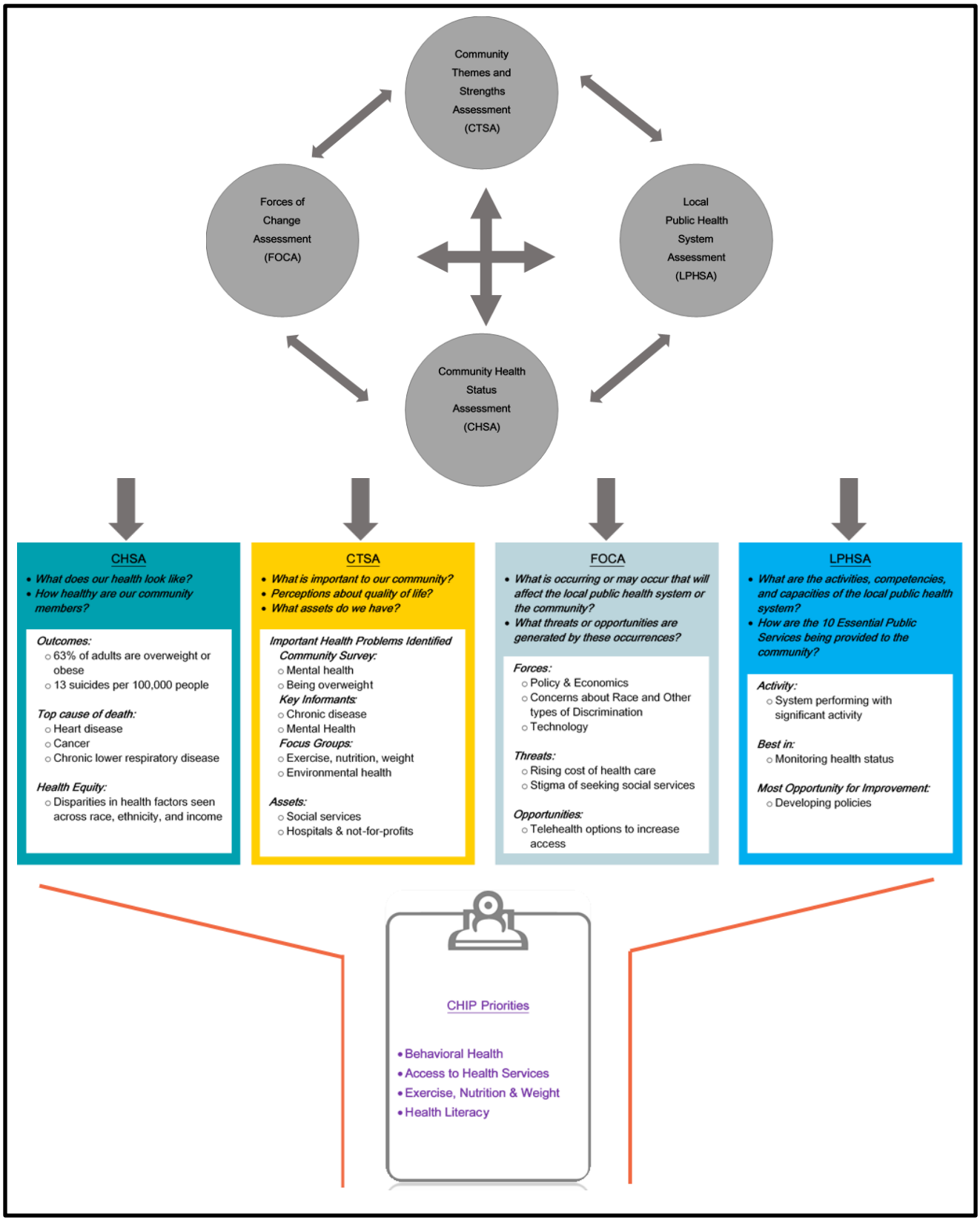


Figure 22: 2019 Hillsborough Community Health Assessment Flow Chart

ALL4HEALTHFL

All4HealthFL is a newly established collaborative between departments of health in Hillsborough, Pasco, Pinellas, and Polk counties along with the not-for-profit hospitals that serve those counties. As each county conducted their prioritization exercises, Behavioral Health emerged as the top priority for all four counties. As such, members decided to develop a coordinated plan to address Behavioral Health across all four counties.

APPENDICES

Appendix A. Healthy Hillsborough Steering Committee

Healthy Hillsborough Steering Committee Members

Name	Role	Agency
Kimberly Williams	Community Benefit Director	AdventHealth
Lisa Bell	Community Benefit Director	BayCare Health System
Vasthi Ciceron	Community Outreach Coordinator	BayCare Health System
Colleen Mangan	Community Benefit Analyst	BayCare Health System
Dr. Douglas Holt	Director	DOH–Hillsborough
Dr. Leslene Gordon	Community Health Director	DOH–Hillsborough
Dr. Ayesha Johnson	CHA / CHIP Lead	DOH–Hillsborough
Grace Liggett	Health Educator Consultant	DOH–Hillsborough
Allison Nguyen	Program Manager, Office of Health Equity	DOH–Hillsborough
Stephanie Sambatakos	Community Health Improvement Supervisor	Johns Hopkins All Children's Hospital
Jenna Davis	Community Benefit Coordinator	Moffitt Cancer Center
Sonia Goodwin	Chief Operations Officer	Suncoast Community Health Centers
Harold Jackson	Community Relations Liaison	Tampa Family Health Centers
Tamika Powe	Health Educator	Tampa General Hospital

Steering Committee Meeting Dates

2018

July 31	November 14	December 7

2019

January 15	February 11	February 27	March 11
March 26	April 8	April 23	May 13
May 28	June 10	June 25	July 8
August 14	September 10	September 24	November 1
December 6			

2020

January 17	February 21

Appendix B. Community Prioritization Meeting Attendees

First Name	Last Name	Job Title	Organization
Amina	Ahmed	Health Educator Consultant	Florida Department of Health in Pasco County
Vicki	Anzalone	Founder/CEO	Where Love Grows Inc.
Stephanie	Arguello	WALK IN	Advent Health
Kristina	Arocena	Administrative Assistant I	Florida Department of Health in Hillsborough County
Kenisha	Avery	Program Manager	Moffitt
Juliana	Azeredo	Graduate Assistant	University of South Florida College of Public Health
Erica	Bader	Emergency Department Clinician	TGH
Rosy	Bailey	Project Director	Hispanic Services Council
Vickie	Ballin	Community Health Program Coordinator	BayCare
Karen	Barfield	Community Manager	Central Florida Behavioral Health Network
Jimmy	Baumgartner	Director of Operations	BayCare
Joshua	Baumgartner	Senior VP Advocacy	Greater Tampa Chamber of Commerce
Shawntaye	Beato	Contract Manager Supervisor	Children's Board of Hillsborough County
Lisa	Bell	Community Benefit Manager	BayCare Health System
Kelly	Bell	Executive Director	Judeo Christian Health Clinic
Katherine	Benson	Assistant County Attorney	Hillsborough County Attorney's Office
Joe	Bohn	Assistant Professor & Director, Community Engagement	USF College of Public Health
Pamela	Bradford	Extension Agent II/ EFNEP Supervisor	University of Florida IFAS - Hillsborough County Extension
Brenda	Breslow	Director of Programs	Healthy Start Coalition
Sandra	Brooks	CMO - SJWH/SJCH	BayCare Health System

First Name	Last Name	Job Title	Organization
Sheron	Brown	WALK IN	Tampa Bay Health Care Collaborative
Brooke	Bull	Trauma PI Coordinator	Tampa General Hospital
Hugh	Campbell	President	AC4S Technologies
Janessa	Canals-Alonso	Director of Patient Care Services	BayCare
Elizabeth	Cardenase	Compliance Service Division Director	Hillsborough County
Roxanne	Carlucci	Marketing Project Manager	AdventHealth Tampa
Alberto	Castano	WALK IN	
Mandy	Chan	Health Educator	Florida Department of Health in Hillsborough County
Peter	Charvat	Chief Medical Officer	BayCare
Rachel	Chase	Health Educator Consultant	Florida Department of Health in Hillsborough County
Kelsey	Christian	Health Educator Consultant	Florida Department of Health in Hillsborough County
Kim	Christine	Administrator, Community Wellness	Tampa General Hospital
Jessica	Chung	Nurse Practitioner	Dr. Jessica Chung, LLC
Gloria	Ciani	FCN Coordinator	BayCare SJH
Vasthi	Ciceron	Community Outreach Coordinator	BayCare
Christina	Ciereck	Financial Administrator	Florida Department of Health in Hillsborough County
Heather	Coats	Community Health Supervisor	BayCare Health System
Phillip	Conti	Health Care Services Manager	Health Care Services
James	Cote	Senior Vice President of Ambulatory Services	BayCare Health System
Jenna	Davis	Community Benefit Coordinator	Moffitt Cancer Center
Keri	Eisenbeis	Vice President	BayCare
Anthony	Escobio	WALK IN	
Dahlia	Estien	Office Supervisor	Tampa General Hospital

First Name	Last Name	Job Title	Organization
Khaliah	Fleming	Research Partnership Program Coordinator	Moffitt
Megan	Folts	Policy & Program Compliance Manager	Early Learning Coalition of Hillsborough County
Brittney	Frazier	WALK IN	AFMFL
Yvonne	Fry		
Gina	Gallo	VP, Planning & Operations	United Way Suncoast
Tom	Garthwaite	Director of Operations	SJH / BayCare
Sherri	Gay	Eligibility Enrollment Specialist Program Manager	Suncoast Community Health Centers, Inc.
Gordon	Gillette	Chief Executive Officer	Early Learning Coalition of Hillsborough County
Hannah	Goble	Regional Area Manager	Early Learning Coalition of Hillsborough County
Justine	Griffin	WALK IN	Tampa Bay Times
Chantel	Griffin-Stampfer	Manager, Diversity Outreach	Moffitt Cancer Center
Kimberly	Guy	SVP, Market Leader	BayCare Health System
CR	Hall	Board Member	BayCare
Anna	Hamby	Supervisor	St. Jose
Brooke	Hansen	Medical Anthropologist	University of South Florida
Richelle	Hoeves	WALK IN	Advent Health
Douglas	Holt	Health Officer	Florida Department of Health in Hillsborough County
Carlos	Irizarry	RN, Pastor	Wholesome Community Ministries
Harold	Jackson	Community Relations Liaison	Tampa Family Health Centers
Olivia	James-Glasgow	Administrative Assistant III	Florida Department of Health in Hillsborough County
Adam	Johnson	Executive Director of Operations	AdventHealth Carrollwood
Ayesha	Johnson	CHA / CHIP lead	Florida Department of Health in Hillsborough County
Christopher	Jones	Director, Transcare	Crisis Center of Tampa Bay
Allison	Kaczmarek	WALK IN	

First Name	Last Name	Job Title	Organization
Teresa	Kelly	Executive Director	Health Council of West Central Florida
Karen	Kerr	President, SFBH	BayCare
Mahmooda	Khaliq Pasha	Assistant Professor	University of South Florida/WHO Collaborating Center on Social Marketing and Soc
Jessica	Labrador	Graduate Student	University of South Florida/ College of Public Health
Kori	Lannaman	Student	The University of Tampa
Dawn	Lewis	Trauma Program Manager	Tampa General Hospital
Grace	Liggett	Health Educator Consultant	Florida Department of Health in Hillsborough County
Andrew	Lim	WALK IN	USF College of Public Health
Christine	Long	Chief Programs Officer	Metropolitan Ministries
Jomar	Lopez	Community Health Educator	Moffitt Cancer Center
Lazjee	Lyles	Internal Communications Coordinator	BayCare
Pam	Malone-Quarles	Director	SJWH
Colleen	Mangan	Community Benefit Analyst	BayCare Health System
Rosely	Marmolejos	Community Benefit Secretary	BayCare
Mary	Martinasek	Public health professor	University of Tampa
Chance	Martinez	Community Outreach Coordinator	BayCare Health System
Arianna	Mason	Student	University of Tampa
Joanne	Mayers	Chief Nursing Officer - East Region	BayCare Health System
Kristina	Melling	Senior Program Planner and QA Data Manager	Senior Connection Center
Brian	Miller	Environmental Health Director	Florida Department of Health in Hillsborough County
Leah	Millette	Community Benefit Coordinator	BayCare
Phil	Minden	President	St. Joseph's Hospital South

First Name	Last Name	Job Title	Organization
Cathy	Moore RN	Nurse Manager RN	Tampa General Hospital-Healthpark Pediatrics
Cindy	Morris	Assistant Director	Florida Department of Health in Hillsborough County
Sarah	Naumowich	President	St. Joseph's Children's & Women's Hospital
Julia	Neely	Community Outreach Coordinator	BayCare
Erica	Nelson	Community Manager	University Area CDC
Allison	Nguyen	Program Manager, Office of Health Equity	Florida Department of Health in Hillsborough County
Lindsey	North	Director Care Coordination East/Polk	BayCare Health System
Michele	Ogilvie	Executive Planner	Hillsborough MPO
Demi	Ollivierre	WALK IN	Dr. Jessica Chung LLC
Pedro	Parra	Principal Planner	The Planning Commission
Ryan	Pedigo	Public Health Preparedness Director	Florida Department of Health in Hillsborough County
Jackie	Perez	Case Manager	The Outreach Clinic
Melissa	Poage	President of the Board of Directors	The Outreach Clinic
Tamika	Powe	Community Health Educator	Tampa General Hospital
Allison	Rapp	Special Projects Manager	Health Council of West Central Florida
Lisa	Razler	Regional Communications Manager	BayCare
Mireja	Renard	WALK IN	BayCare
Laura	Resendez	Migrant Outreach Coordinator	Suncoast Community Health Center
Clara	Reynolds	CEO	Crisis Center of Tampa Bay
Wade	Reynolds	WALK IN	Hillsborough MPO
Joseph	Rivera	Assistant Vice President Mission and Ministry	AdventHealth
Monica	Rodriguez	Marketing of Sales Administration	CarePlus Health Plans
Jason	Rodriguez	WALK IN	BayCare

First Name	Last Name	Job Title	Organization
Bruce	Rodwell	Board member	St. Joseph's Hospital
Maria	Russ	WALK IN	Hillsborough County Public Schools
Gail	Ryder	Vice President of Behavioral Health	BayCare Health System
Stephanie	Sambatakos	Community Health Improvement Supervisor	Johns Hopkins All Children's Hospital
Anthony	Santucci	Director, Behavioral Health Nursing	BayCare Health System
Tali	Schneider	WALK IN	USF Health
Kim	Scifres	Senior Manager	Crowe
Karen	Serrano	Health Educator	Feeding Tampa Bay
Peggie	Sherry	CEO	Faces of Courage Cancer Camps
Viviam	Sifontes	CTNE	Moffitt Cancer Center
Jane	Simon	Senior Gift Officer, National Grants	Johns Hopkins All Children's Hospital
Candice	Simon	Public and Community Health Director	REACHUP, Inc.
Kimberly	Simon	WALK IN	
Erika	Skula	WALK IN	Advent Health
Kevin	Sneed	Dean, Sr. Associate VP	USF College of Pharmacy, USF Health
Laura	Sosa	Family Support Worker	Florida Department of Health in Hillsborough County
Alisia	Sowden	Health Service Representative	Florida Department of Health in Hillsborough County
Matt	Spence	Chief Programs Officer	Feeding Tampa Bay
Samantha	Spoto	Epidemiologist	Florida Department of Health in Hillsborough County
HCI	Team Member	Public Health Consultant	Healthy Communities Institute
HCI	Team Member	Public Health Consultant	Healthy Communities Institute
HCI	Team Member	Public Health Consultant	Healthy Communities Institute
Kristina	Thomas		

First Name	Last Name	Job Title	Organization
Tonia	Torres	Community Programs Coordinator	Feeding Tampa Bay
Rena	Upshaw-Frazier	Board Member	BayCare
Sandra	Villarini	Administrative Assistant	Florida Department of Health in Hillsborough County
Martha	Vinas	Chief Operating Officer	Cigna
Kitty	Wallace	Garden Coordinator	Tampa Heights Community Garden
Colleen	Walters	VP, Mission and Ethics	BayCare
Virginia	Warren	Florida Epidemic Intelligence Fellow	Florida Department of Health in Hillsborough County
Jennifer	Waskovich	Health Promotion and Education Program Manager	Florida Department of Health in Hillsborough County
Kevin	Watler	Public Information Officer	Florida Department of Health in Hillsborough County
Bonnie	Watson	WIC/Nutrition Director	Florida Department of Health in Hillsborough County
Lou Ann	Watson	WALK IN	BayCare
Seema	Weinstein	Manager, TGH Psychology Neuropsychology	Tampa General Hospital
Ashley	Wendt	Public Health Consultant	Healthy Communities Institute
Linda	Wilkerson	Faith Community Nurse Manager	St. Joseph's/SFBH
Kimberly	Williams	Director, Community Benefit	AdventHealth West Florida Division
Teri	Wilson	Director Case Management	Tampa General Hospital
Amber	Windsor-Hardy	Community Health Coordinator	AdventHealth
Darlene	Winterkorn	Faith Community Nursing Coordinator	BayCare
Lori	Yarbrough	Board Member	St. Joseph Baptist Board
Lena	Young Green	Board Chair	Tampa Heights Junior Civic Association

Appendix C. Community Health Needs Survey

2019 Community Health Needs Survey

Our local not-for-profit hospitals and the department of health want to hear from you! The results of this survey will be used to help us to understand your community health concerns so that improvements can be made. We encourage you to take 15 minutes to fill out the survey below. Your voice is important to ensure these organizations have the best understanding of the needs of our community. Thank you!

You must be 18 years of age or older to complete this survey. COMPLETE THIS SURVEY ONLY FOR YOURSELF. If someone else would like to complete the survey, please have that person complete a separate survey. Remember, your answers are completely anonymous. We will not ask for your name or any other information which can be used to identify you. If you have questions, please contact the Florida Department of Health in Hillsborough County at (813) 307–8015 Ext. 6609.

These first few questions tell us about you. They will be used only to help us better understand the people who live in your community so that we can provide better health care services. This information will not be used to identify you.

1. **In which county do you live? (Please choose only one)**
   ☐ Hillsborough ☐ Pasco ☐ Pinellas ☐ Polk ☐ 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)**
   ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
   ☐ Native Hawaiian or Pacific Islander ☐ White ☐ More than one race
   ☐ Other ☐ Prefer Not to Answer

6. **Do you identify your gender as?**
   ☐ Male ☐ Female ☐ Transgender: Male to Female ☐ Transgender: Female to Male
   ☐ Other /Gender non-Conforming

7. **Which of the following best describes your sexual orientation? (Please choose only one)**
   ☐ Heterosexual (Straight) ☐ Gay or Lesbian ☐ Bisexual ☐ Other

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

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 (GED)
    ☐ Some college, no degree ☐ 2 – Year College Degree ☐ 4 – Year College Degree
    ☐ Graduate -Level Degree or Higher ☐ None of the above

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 $24,999
- ☐ $25,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 to $124,999
- ☐ $125,000 to $149,999
- ☐ $150,000 to $174,999
- ☐ $175,000 to $199,999
- ☐ $200,000 and up
- ☐ Prefer not to answer

12. Which of the following best describes your current relationship status? (Please choose only one)

- ☐ Married
- ☐ In a domestic partnership or civil union
- ☐ Widowed
- ☐ Single, but living with a significant other
- ☐ Divorced
- ☐ Single, never married
- ☐ Separated

13. Which of the following categories best describes your employment status? (Please choose only one)

- ☐ Employed, working full–time
- ☐ Student
- ☐ Employed, working part–time
- ☐ Retired
- ☐ Not employed, looking for work
- ☐ Disabled, not able to work
- ☐ Not employed, NOT looking for work

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

- ☐ I drive my own 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

15. Are you: (Please choose only one)

- ☐ A veteran
- ☐ In Active Duty
- ☐ National Guard/Reserve
- ☐ None of these (**Skip to question 17**)

16. If you are a veteran, active duty or national guard/reserve, are you receiving care at the VA? (Please choose only one)

- ☐ Yes
- ☐ No

17. 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
- ☐ Commercial health insurance (HMO, PPO)
- ☐ Veteran's Administration
- ☐ Some other way

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

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 or more

19. Are you a caregiver to an adult family member who cannot care for themselves in your home? (Please choose only one)

☐ Yes ☐ No

20. Including yourself, how many people 65 years or older currently live in your home? (Please choose only one)

☐ None ☐ 1 ☐ 2 ☐3 ☐ 4 ☐ 5 ☐ 6 or more

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

☐ None **(Skip to question 33)** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or more

22. 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 24)**

23. What is the MAIN reason they didn't get the medical care they needed? (Please choose only one)

☐ Can't afford it / Costs too much
☐ I had transportation problems
☐ I don't have a doctor
☐ I don't know where to go
☐ I had trouble getting an appointment
☐ I don't have health insurance
☐ Other

24. 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 26)**

25. What is the MAIN reason they didn't get the dental care they needed? (Please choose only one)

☐ Can't afford it / Costs too much
☐ I had transportation problems
☐ I don't have a dentist
☐ I don't know where to go
☐ I had trouble getting an appointment
☐ I don't have dental insurance
☐ Other

26. Was there a time in the PAST 12 MONTHS when children in your home needed mental health care but did NOT get the care they needed?

☐ Yes ☐ No **(Skip to question 28)**

27. What is the MAIN reason they didn't get the mental health care they needed? (Please choose only one)

- ☐ Can't afford it / Costs too much
- ☐ I had transportation problems
- ☐ I don't have a doctor / counselor
- ☐ I don't know where to go
- ☐ I had trouble getting an appointment
- ☐ I don't have health insurance
- ☐ Other

28. I feel safe walking in my neighborhood

☐ Yes **(Skip to question 30)** ☐ No

29. If you answered "no", <u>check all</u> the reasons you do not feel safe walking:

- ☐ Traffic
- ☐ Dogs not on a leash
- ☐ No sidewalks
- ☐ Stopped by police
- ☐ Poor condition of roads and sidewalks
- ☐ Violent crime or theft

30. Check all the health issues children in your home have faced (CHECK ALL THAT APPLY)

My children have not faced any health issues	☐
Allergies	☐
Asthma	☐
Bullying	☐
Unintentional injuries or accidents that required immediate medical care (such as a concussion from playing sports)	☐
Behavioral Health / Mental health	☐
Children overweight	☐
Children underweight	☐
Birth-related (such as low birthweight, prematurity, prenatal, and others)	☐
Dental Problems (such as cavities, root canals, extractions, surgery, and others)	☐
Autism	☐
Child abuse / child neglect	☐
Diabetes / Pre-diabetes / High Blood Sugar	☐
Using drugs or alcohol	☐
Using tobacco, e-cigarettes, or vaping	☐
Teen pregnancy	☐
Sexually Transmitted Disease	☐
Other (please specify)	☐

31. Check all the special needs children in your home have faced (CHECK ALL THAT APPLY)

My children do not have any special needs	☐
Attention deficit / hyperactivity disorder (AD/HD)	☐
Autism / pervasive development disorder (PDD)	☐
Blindness / visual impairment	☐
Cerebral palsy	☐
Child who uses a wheelchair or walker	☐
Deaf / hearing loss	☐
Developmental delay (DD)	☐
Down syndrome	☐
Emotional disturbance	☐
Epilepsy / Seizure disorder	☐
Intellectual disability (formerly mental retardation)	☐
Learning disabilities / differences	☐
Speech and language impairments	☐
Spina bifida	☐
Traumatic brain injury	☐
Other (please specify)	☐

32. Do any children in your home…

	Yes	No	Not Sure
Know how to swim	☐	☐	☐
Wear a bike/skate helmet	☐	☐	☐
Use a car/booster seat (under age 8)	☐	☐	☐
Wear a seatbelt at all times	☐	☐	☐
Have access to a pool where you live	☐	☐	☐
Receive all shots to prevent disease	☐	☐	☐
Have a history of being bullied (including social media)	☐	☐	☐
Receive gun safety education	☐	☐	☐
Use Sunscreen	☐	☐	☐

Eat at Least 3 Servings of Fruits and Vegetables Every Day	☐	☐	☐
Exercise at Least 60 Minutes Every Day	☐	☐	☐
Get 8 Hours or More of Sleep Every Night	☐	☐	☐
Eat Fast Food Every Week	☐	☐	☐
Drink Sugary-Sweetened Sodas, Energy Drinks, or Sports Drinks Every Day	☐	☐	☐
Eat Junk Food Every Day	☐	☐	☐
Stay Home from School 5 or More Days a Year Because of Health Issues	☐	☐	☐
Need Regular Access to a School Nurse	☐	☐	☐
Attend a Public or Charter School	☐	☐	☐

These next questions are about your view or opinion of the community in which you live.

33. 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

34. Please read the list of <u>risky behaviors</u> listed below. Which three do you believe are the most harmful to the overall health of your community? Mark which you think are:

1 Most harmful; 2 Second-most harmful; 3 Third-most harmful

Please mark **only three**, using 1, 2 and 3

	Your Top 3	Example
Alcohol abuse		
Dropping out of school		
Drug abuse		1
Lack of exercise		
Poor eating habits		
Not getting "shots" to prevent disease		
Not wearing helmets		
Not using seat belts / not using child safety seats		3

	Your Top 3	Example
Tobacco use / E-cigarettes / Vaping		2
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		

35. 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? Mark which you think are:

1 Most important; 2 Second-most important; 3 Third-most important

Please mark **only three**, using 1, 2 and 3

	Your Top 3	Example
Aging Problems (for example: difficulty getting around, dementia, arthritis)		
Cancers		
Child Abuse / Neglect		1
Clean Environment / Air and Water Quality		
Dental Problems		
Diabetes / High Blood Sugar		
Domestic Violence / Rape / Sexual Assault		
Gun-Related Injuries		
Being Overweight		
Mental Health Problems Including Suicide		3
Heart Disease / Stroke / High Blood Pressure		2
HIV/AIDS / Sexually Transmitted Diseases (STDs)		
Homicide		
Infectious Diseases Like Hepatitis and TB		
Motor Vehicle Crash Injuries		
Infant Death		

	Your Top 3	Example
Respiratory / Lung Disease		
Teenage Pregnancy		
Tobacco Use / E-cigarettes / Vaping		

36. Please read the list of factors below. Which do you believe are most important to improve the quality of life in a community? Mark which you think are:
1 Most important; 2 Second-most important; 3 Third-most important

Please mark **only three**, using 1, 2 and 3

	Your Top 3	Example
Good Place to Raise Children		
Low Crime / Safe Neighborhoods		
Good Schools		1
Access to Health Care		
Parks and Recreation		
Clean Environment / Air and Water Quality		
Low-Cost Housing		
Arts and Cultural Events		3
Low-Cost Health Insurance		2
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		
Low Rates of Adult Death and Disease		
Low Rates of Infant Death		
Religious or Spiritual Values		

	Your Top 3	Example
Disaster Preparedness		
Emergency Medical Services		
Access to Good Health Information		

37. Below are some statements about your local community. Please tell us how much you agree or disagree with each statement.

	Agree	Disagree	Not Sure
Drug 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 in my area is a serious problem.	☐	☐	☐
Air pollution is a problem in my community	☐	☐	☐
I feel safe in my own neighborhood.	☐	☐	☐
There are affordable places to live in my neighborhood.	☐	☐	☐
The quality of health care is good in my neighborhood.	☐	☐	☐
There are good sidewalks for walking safely.	☐	☐	☐
I am able to get healthy food easily.	☐	☐	☐

38. Below are some statements about your connections with the people in your life. Please tell us how much 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 are as satisfying as I would want them to be	☐	☐	☐

39. 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?

☐ 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.

40. **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

41. **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

42. **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? (Please choose only one)**
☐ Yes ☐ No

43. **Now think about the past 7 days. In the past 7 days, how many times did you eat fast food? Include fast food meals eaten at work, at home, or at fast-food restaurants, carryout or drive-through. (Please choose only one)**
___ # of times in past 7 days

44. **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? (Please choose only one)**
☐ Yes ☐ No

45. **Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as part of a household? (Please choose only one)**
☐ Yes ☐ No

46. **In the past 12 months has your utility company shut off your service for not paying your bills? (Please choose only one)**
☐ Yes ☐ No

47. **In the past 12 months, have you used a prescription pain medicine (morphine, codeine, hydrocodone, oxycodone, methadone, or fentanyl) without a doctor's prescription or differently than how a doctor told you to use it? (Please choose only one)**
☐ Yes ☐ No

These next questions are about your personal health and your opinions about getting health care in your community.

48. **Overall, how would you rate YOUR OWN PERSONAL health? (Please choose only one)**
☐ Very unhealthy ☐ Unhealthy ☐ Somewhat healthy ☐ Healthy ☐ Very healthy ☐ Not sure

49. In the past 12 months, how did your health change? (Please choose only one)

☐ Got better ☐ Stayed about the same ☐ Got worse

50. Was there a time in the PAST 12 MONTHS when you needed medical care but did NOT get the care you needed? (Please choose only one)

☐ Yes ☐ No **(Skip to question 52)**

51. What is the MAIN reason you didn't get the medical care you needed? (Please choose only one)

☐ Can't afford it / Costs too much
☐ I had transportation problems
☐ I don't have a doctor
☐ I don't know where to go
☐ I had trouble getting an appointment
☐ I don't have health insurance
☐ Other

52. 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

53. In the past 12 months, how did your mental health change? (Please choose only one)

☐ Got better ☐ Stayed about the same ☐ Got worse

54. Was there a time in the PAST 12 MONTHS when you needed mental health care but did NOT get the care you needed? (Please choose only one)

☐ Yes ☐ No **(Skip to question 56)**

55. What is the MAIN reason you didn't get the mental health care you needed? (Please choose only one)

☐ Can't afford it / Costs too much
☐ I had transportation problems
☐ I don't have a doctor / counselor
☐ I don't know where to go
☐ I had trouble getting an appointment
☐ I don't have health insurance
☐ Other

56. Was there a time in the PAST 12 MONTHS when you needed DENTAL care but did NOT get the care you needed? (Please choose only one)

☐ Yes ☐ No **(Skip to question 58)**

57. What is the MAIN reason you didn't get the dental care you needed? (Please choose only one)

☐ Can't afford it / Costs too much
☐ I had transportation problems
☐ I don't have a dentist
☐ I don't know where to go
☐ I had trouble getting an appointment
☐ I don't have dental insurance
☐ Other

58. **In the past 12 months, how many times have you gone to a hospital emergency room (ER) about your own health?**

☐ Yes ☐ I have not gone to a hospital ER in the past 12 months **(Skip to question 61)**

59. **Please enter the number of time you have gone to a hospital emergency room (ER) about your own health <u>in the past 12 months</u>:** # of times in the past 12 months _____

60. **What is the MAIN reason you used the emergency room INSTEAD of going to a doctor's office or clinic? (Please choose only one)**

☐ 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

61. **Have you ever been told by a doctor or other medical provider that you had any of the following health issues? (CHECK ALL THAT APPLY)**

Cancer	☐	Heart disease	☐
Depression	☐	High blood pressure / Hypertension	☐
Diabetes	☐	Obesity	☐
HIV / AIDS	☐	Stroke	☐

62. **How often do you smoke? (Please choose only one)**

☐ I do not smoke cigarettes
☐ I smoke about one pack per day
☐ I smoke less than one pack per day
☐ I smoke more than one pack per day

63. **How often do you vape or use e-cigarettes? (Please choose only one)**

☐ I do not vape or smoke e-cigarettes
☐ I vape or smoke e-cigarettes on some days
☐ I vape or smoke e-cigarettes everyday

The final questions are about events 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 these questions, please think back to the time BEFORE you were 18 years of age.

BEFORE you were 18 years of age:

64. Did you live with anyone who was depressed, mentally ill, or suicidal?

☐ Yes ☐ No

65. Did you live with anyone who was a problem drinker or alcoholic?

☐ Yes ☐ No

66. Did you live with anyone who used illegal street drugs or who abused prescription medications?

☐ Yes ☐ No

67. Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?

☐ Yes ☐ No

68. Were your parents separated or divorced?

☐ Yes ☐ No

69. How often did your parents or adults in your home slap, hit, kick, punch, or beat each other up?

☐ Never ☐ Once ☐ More than once

70. How often did a parent or adult in your home hit, beat, kick, or physically hurt you in any way?

☐ Never ☐ Once ☐ More than once

71. How often did a parent or adult in your home swear at you, insult you, or put you down?

☐ Never ☐ Once ☐ More than once

72. How often did an adult or anyone at least 5 years older than you touch you sexually?

☐ Never ☐ Once ☐ More than once

73. How often did an adult or anyone at least 5 years older than you try to make you touch them sexually?

☐ Never ☐ Once ☐ More than once

74. How often did an adult or anyone at least 5 years older than you force you to have sex?

☐ Never ☐ Once ☐ More than once

If you would like help with or would like to talk about these issues, please call the National Hotline for Child Abuse at 1-800-4-A-CHILD (1-800-422-4453).

That concludes our survey. Thank you for participating! Your feedback is important.

Appendix D. Focus Group Questions

Introductory Question:

Let's start off by going around the room and introducing ourselves. Please tell us your name, one healthy thing you like to do, and why.

Questions:

1. Take a minute and think about your life and the community where you live. Think about the things that contribute to the quality of life in your community. How satisfied are you with the quality of life in your community?
2. What assets does your community have that can help to improve the health and quality of life where you live?
3. Can you tell me what you think of the top 3 health issues that you consider to be the most important one in your community?
4. What do you think should be done to address these problems?
5. What difficulties, if any, do you see to implementing a project to prevent these problems in your community?
6. How would you suggest overcoming these difficulties?
7. What do you think of when you hear the term 'health equity'? OR What does 'health equity' mean to you?

Closing Question:

Is there anything else that you would like to share before we end our discussion for the day?

Appendix E. Key Informant Interview Questions

Name:	
Email:	
Organization:	
Title:	
Resident County:	

Question 1: Could you tell me a little about yourself, your background, and your organization? If applicable, please share the following in your response:

- What is your organization's mission?
- Does your organization provide direct care or operate as an advocacy organization?

Question 2: We would like your perspective on the major health needs/issues in the community. Please share the following in your response:

- What are the top priority health issues that your organization is dealing with?
- What do you think are the factors that are contributing to these health issues?

Question 3: Which groups in your community appear to struggle the most with these issues you've identified and how does it impact their lives? Please consider the following in your response:

- Are there specific challenges that impact low-income, underserved/uninsured persons experience?
- Are there specific challenges that impact different racial or ethnic groups in the community?
- Are there specific challenges that impact different groups based on age or gender in the community?

Question 4: What barriers or challenges might prevent someone in the community from accessing care? (Examples might include lack of transportation, lack of health insurance coverage, language/cultural barriers, etc.)

Question 5: Could you tell me about some of the strengths and resources in your community that address these issues, such as groups, initiatives, services, or programs? (If including specific organizations in response, please include name and type of program)

Question 6: What services or programs do you feel could potentially have the greatest impact on the needs that you've identified?

Question 7: Is there anything additional that should be considered for assessing the needs of the community?

Appendix F. Key Informant Interview Participants

Name	Title	Organization
Charity Carlisle	Emergency / Intervention Director	AdventHealth Carrollwood
Kitty Wallace	Community Gardener	Coalition of Community Gardens
Howard Siegel	Rabbi	Congregation Kol Ami
Ernest Coney	Chief Executive Officer	CDC of Tampa
Mary Lynn Ulrey	Chief Executive Officer	DACCO
Florence Ackey	Refugee Health Clinic Supervisor	DOH-Hillsborough
Bradley Frearson	Retired Veteran	DOH-Hillsborough
Rolfe Thompson	Vice President & Controller	GTE Financial
Jane Murphy	Executive Director	Healthy Start
Dr. Karl Debate	Department Chair Health Sciences Division	Hillsborough Community College
Commissioner Lesley 'Les' Miller	Chairman Board of County Commissioners	Hillsborough County
Monica Rodriguez	Chair	Latino Coalition of Hillsborough County
Candice Simon	Public & Community Health Director	Reach UP Inc.
Marina Habib	Community Outreach Manager	Special Olympics Florida
Terrence Beck	Chief Operations Officer	Tampa Family Health Centers
Monica Rider	Chief Medical Officer	Tampa Family Health Centers
Lena Young-Green	Founder / Co-Founder	Tampa Heights Junior Civic Association / Coalition of Community Gardens
Hassan Sultan	Imam	The Muslim Connection
Dr. Tricia Penniecook	Vice Dean Education College of Public Health	University of South Florida
Dexter Frederick	Pediatrician & Internist	Veteran's Administration
Carlos Irizarry	Senior Pastor	Wholesome Church Ministries

Appendix G: Community Health Needs Prioritization Hillsborough County Meeting Record

July 24, 2019

Real-time Record

Executive Summary

Over 150 Hillsborough County Community Leaders representing multiple organizations gathered on July 24, 2019 at the Steinbrenner Field Pavilion for the Hillsborough County Community Health Needs Assessment – Prioritization Exercise. The event began with a welcome by Dr. Douglas Holt, Director of Department of Health – Hillsborough followed by the viewing of a short video called "Every Voice Matters." After the video, consultants from Healthy Communities Institute shared a data presentation from the Community Health Needs Assessment.

Participants were then randomly assigned to one of 11 Focus Areas to further review data presented in the form of data placements and answer questions as a team about the data. After brainstorming, focus area teams reported out their findings to the rest of the group.

After enjoying lunch, participants were asked to brainstorm possible Forces of Change, select a top overarching Force of Change for their team, and take a deeper dive to explore Opportunities and Threats.

The event was concluded with a polling prioritization exercise where participants individually determined the Scope & Severity and Ability to Impact on a scale of 1 to 10 for each of these 11 Focus Areas. The averages of the two criteria were tabulated and a prioritized list of the focus areas was created:

Hillsborough County Community Health Needs Prioritization List

Focus Area	Average
Mental Health & Mental Disorders	8.47
Access to Health Services	8.28
Exercise, Nutrition, & Weight	7.82
Substance Abuse	7.505
Diabetes	6.88
Maternal, Fetal, & Infant Health	6.85
Heart Disease & Stroke	6.725
Immunization & Infectious Disease	6.61
Cancer	6.365
Oral Health	6.11
Respiratory Disease	5.52

Welcome and Introductions

Dr. Douglas Holt, Director, DOH-Hillsborough

Rebecca Watson, Collaborative Labs: Good morning, everyone! I must tell you, I spent much of my career as a teacher, so I am very awake in the morning; you're going to have to give me some more energy! *Participants gave an enthusiastic greeting.* My name is Rebecca Watson; on behalf of Collaborative Labs, I'd like to welcome you to the Community Health Needs Prioritization for Hillsborough County. To formally welcome us, I'd like to invite up Dr. Douglass Holt, Director, DOH-Hillsborough.

Dr. Douglass Holt, Director, DOH-Hillsborough: Thank you everyone for coming and for your time. Thank you very much for your participation. Your input and opinion really matter; it's critical. We have one person here on behalf of a state representative; I would like to recognize them. Is anyone else here

on behalf of our elected officials? *There were no additional representatives of elected officials.*

Dr. Holt: Let me recognize our partners. They came together as the steering committee and did the initial hard work to put together our community health assessment. That is just the beginning; it is all about an improvement plan. How do we, in a joint effort, improve the opportunity for everyone?

We will look at a lot of data and some of the outcomes that we look at today as the opportunity to improve. We got input from 5,000 residents. On behalf of the participants, I'd like to thank our sponsors. Let's give them all a real appreciation. *Applause.*

I would also like to recognize the team I work with at the Florida Department of Health.

I am kind of an old timer in this effort. I see a lot of familiar faces here. This was the first example in the state of where groups came together to work collaboratively. I am very proud of our past efforts and look forward to the ones in the future. The end result will be a community health improvement plan so that each organization will know what we are jointly working on and the aspects they will focus themselves on. With that said, let's get to work.

"Every Voice Matters"

Rebecca Watson, SPC Collaborative Labs

Rebecca: Thank you, Dr. Holt. We will take up that charge and get to work here. One mention that Dr. Holt made was that we will be looking at a lot of data today. We will start that look at the data with a video presentation of qualitative data. It was put together with Video Voice. I will share a bit about it. Video Voice is a concept that provides an opportunity for a diverse group of community members to give voice to the issues and realities they see and face every day in an effort to affect change and engage folks to create solutions. What you will see here is a unique design that has our county residents sharing their voices and thoughts about their realities.

Participants viewed the video *Every Voice Matters*.

Rebecca: I want to recognize the team that made this video. What spoke to me was the humanity that is present in healthcare. Thank you to everyone in this room who helped put this video together.

Data Presentation

Ashley Wendt and Caroline Cahill, Healthy Communities Institute

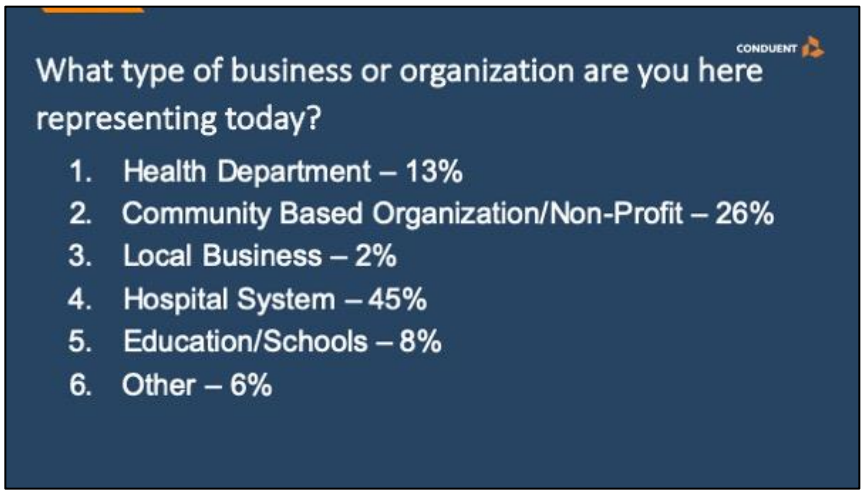
Rebecca: We want to keep going with the sharing of data. Data creates awareness; that awareness informs your engagement and your actions. We have more data to share. Later on, you will have an opportunity to start having conversations about what the data is saying and what you need to do next.

In a moment, we will hear from Ashley Wendt, who will walk us through the data. Once that is done, we will take a short break and then move into the breakout sessions. We will break for lunch around noon, then we will engage in an activity called Forces of Change and then we will do a prioritization session. We will wrap up with some remarks and next steps.

With that, I'd like to welcome Ashley Wendt from the Healthy Communities Institute.

Ashley Wendt, Public Health Consultant, HCI: Good morning! I am here from South Carolina, but I have spent time working in community health in this area. I have been in community health for about 14 years.

We are a large group today; we do not have time to introduce everyone, so I would like for you to answer this polling question about where you are here from.

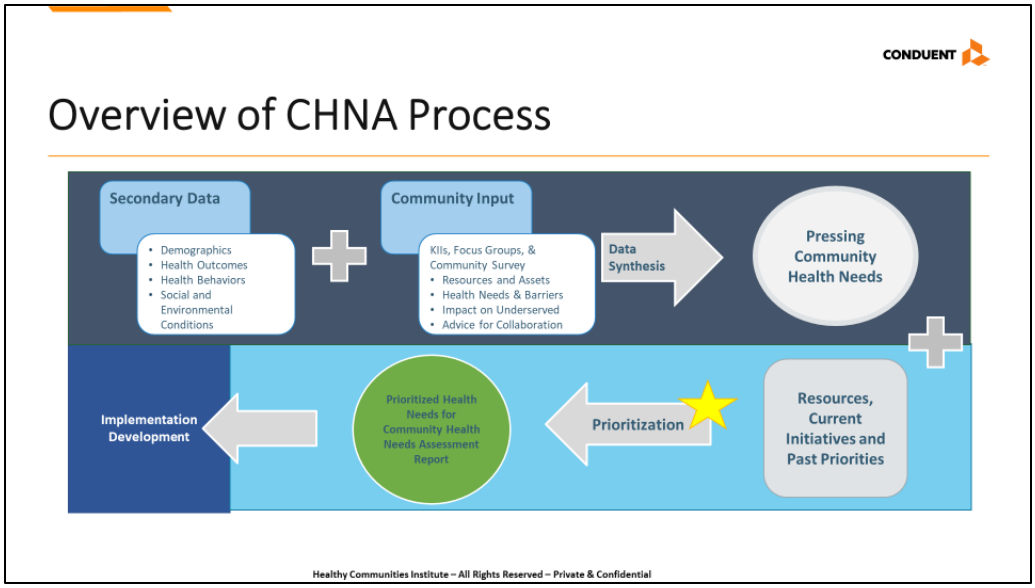


What type of business or organization are you here representing today?
• **Hopsital System** – **45%** • **Community Based Organization/Non-Profit** – **26%** • **Health Department** – **13%**

Ashley: As expected, the hospital system is the largest group, followed by community-based organization/non-profit.

Ashley: We like to bring that public health component to the conversation and the work that we do.

Ashley: There are lots of processes that go on in the community to collect data. As of late, you guys have been really collaborative in this process. Our goal here today is, we are casting a wide net for all the data we collected. Hillsborough County got a little over 5,000 respondents. It is a really robust set of data. Today's presentation is meant to be the 30,000-foot view, looking down, trying to understand what the key health needs are for Hillsborough County.



Ashley: As I mentioned, this is a part of the CHNA process. Today, we are at the prioritization stage.

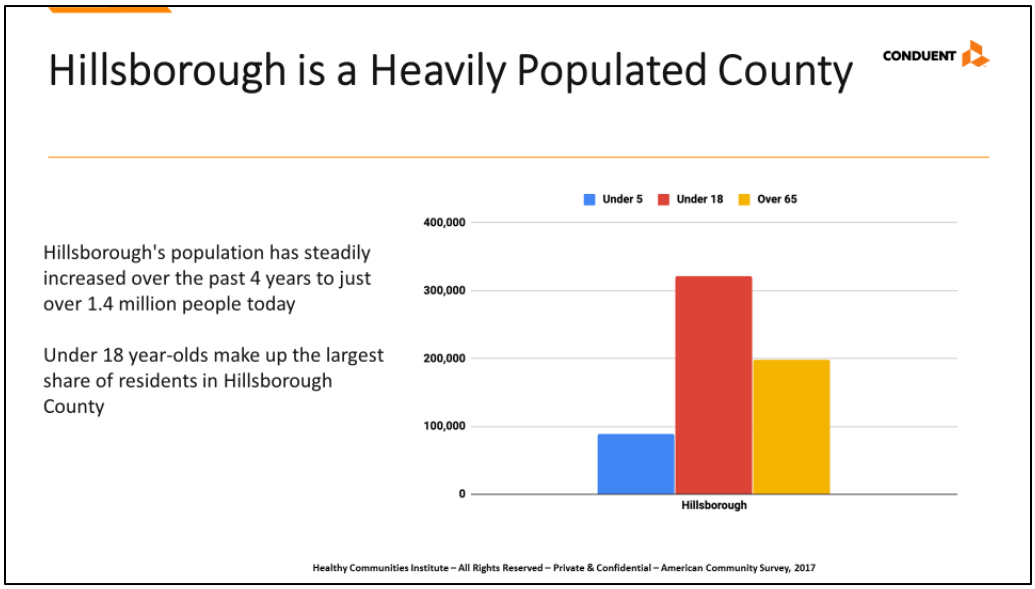
I'd like to introduce Caroline Cahill, who will review the Hillsborough County demographics.

Caroline Cahill, MPH, Research Associate, Health Communities Institute: We're first going to briefly review demographics.

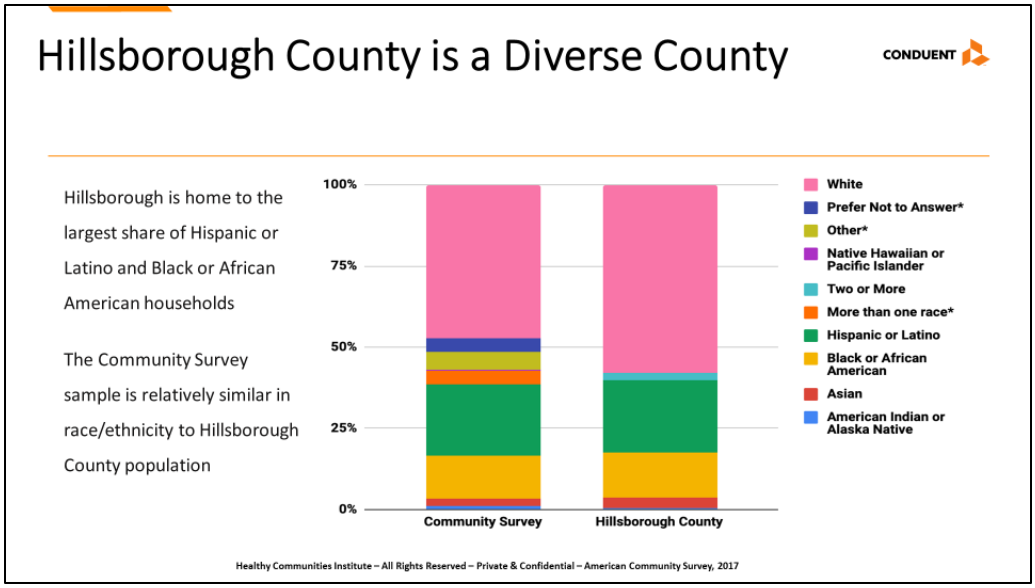
Demographics is a foundational part of describing a community and its population, and critical to forming further insights into the health needs of a

community. Different race, ethnic, age, and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts.

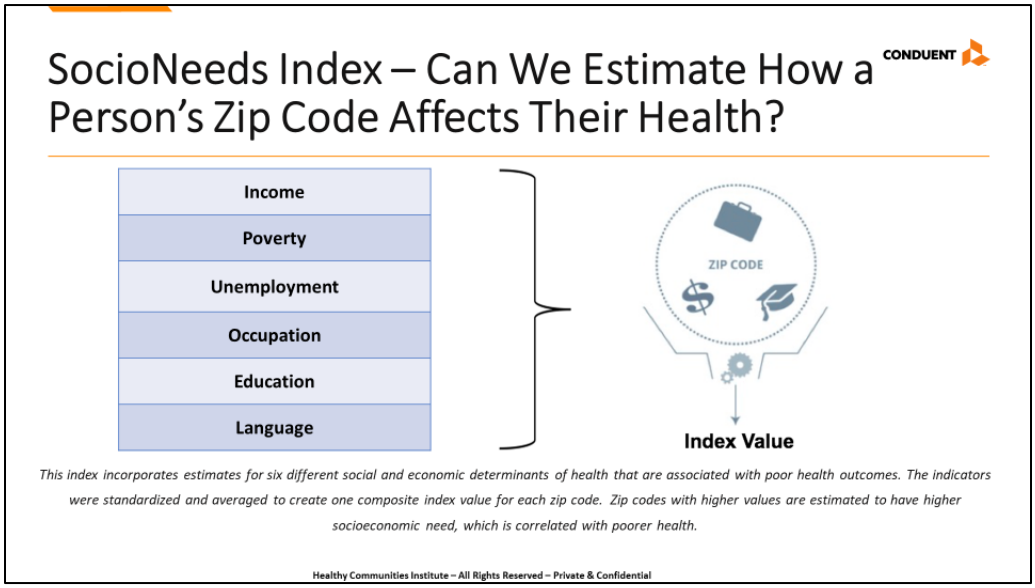
We're first going to briefly review some basic county demographics to provide context for the data synthesis and prioritization. Demographic estimates on the following slides are sourced from both the community survey and secondary data sources, such as the American Community Survey and U.S. Census Bureau from the most recent period of measure available unless otherwise indicated.



Caroline: Hillsborough's population in 2017 was estimated to be just over 1.4 million people and the Under 18 subset of the population makes of the largest share of residents when looking at the breakdown of the population by age.



Caroline: Throughout the service area, the population share of white residents is the highest, followed by Hispanic or Latino, then Black or African American. This is well mirrored in the community survey as well.

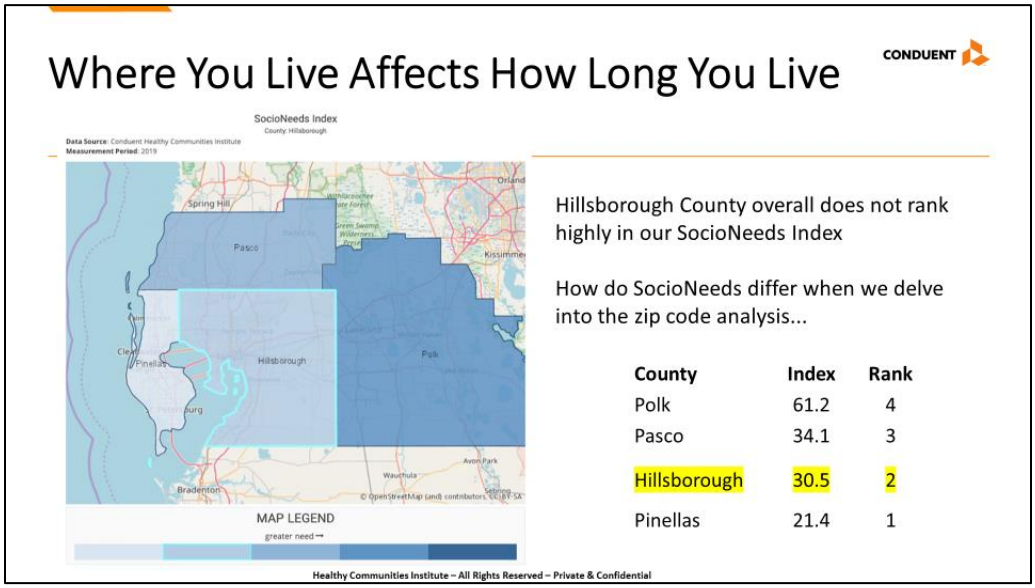


Caroline: When we talk about a person's health or the health of a community, a lot of numbers are thrown into the mix. We know rates of asthma and diabetes, percentages of residents who are food insecure or lack appropriate access to health services. When creating a healthier community, discussing all of these topics is necessary, but when we want to understand why

one side of town is healthier than the other, then what number is the best number to know? To answer that question, it's location, location, location.

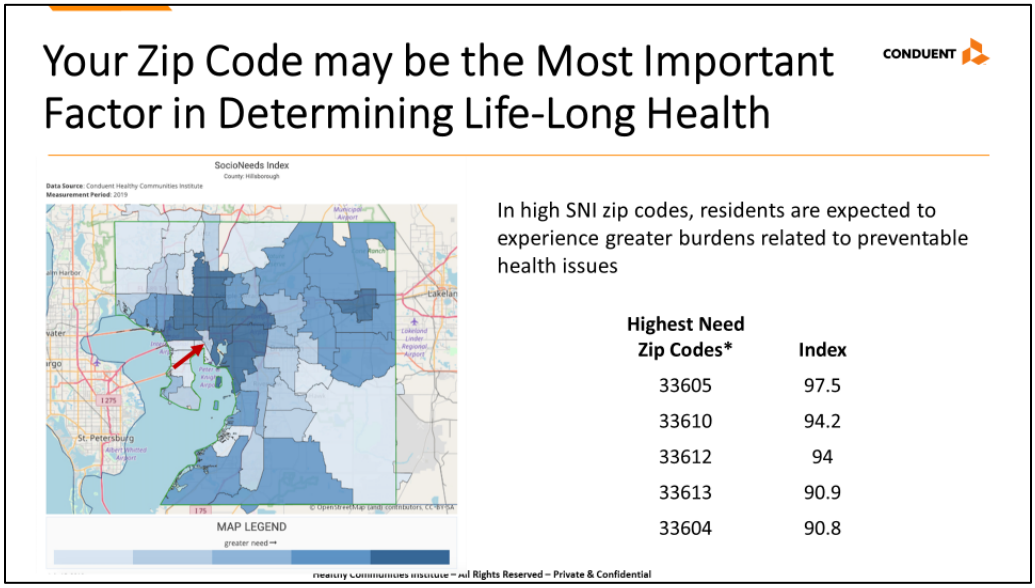
There are many demographic and population factors that have an influence on health, and we'll continue to delve deeper. However, the SocioNeeds Index, developed here at HCI, is a summary measure of socioeconomic need that has been correlated with poor health outcomes, including preventable hospitalizations and premature death. We created this index, because evidence has shown that a person's zip code is the most important number to determine their lifelong health.

The SocioNeeds Index incorporates estimates for 6 different social and economic determinants of health for all zip codes across the United States. These indicators, covering Income, Poverty, Unemployment, Occupation, Educational Attainment, and Linguistic Barriers, were standardized and averaged to create one composite index value for each zip code and county, which ranges from 0 to 100. Locales with higher values are estimated to have the highest socioeconomic need and are correlated with poor health outcomes, such as premature death and preventable hospital visits.

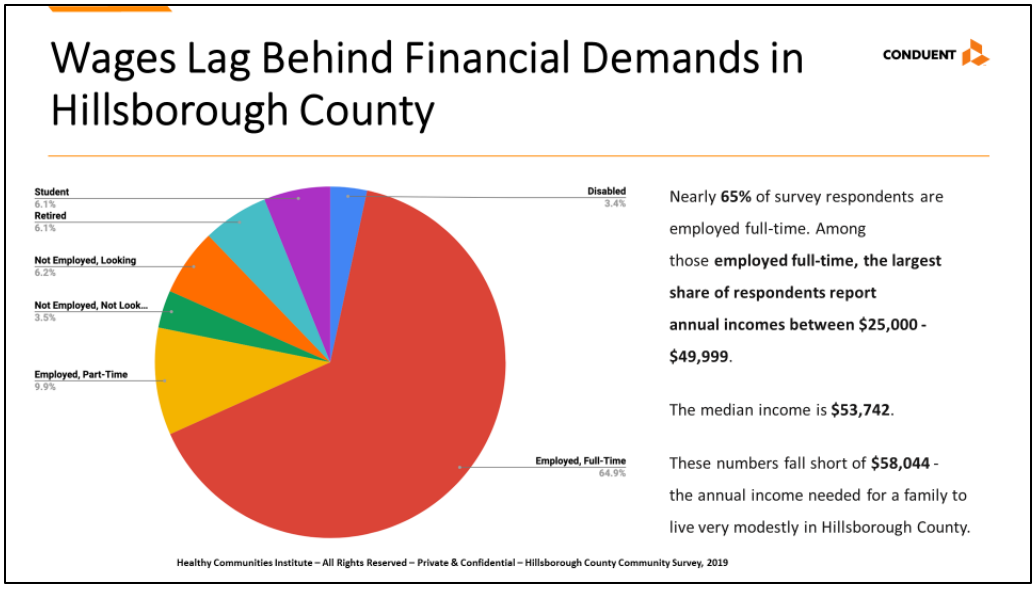


Caroline: Hillsborough is ranked as having the second lowest socioeconomic need compared to its neighboring counties. This means that individuals living in Hillsborough generally have higher levels of quality of life and less burdens of preventable disease.

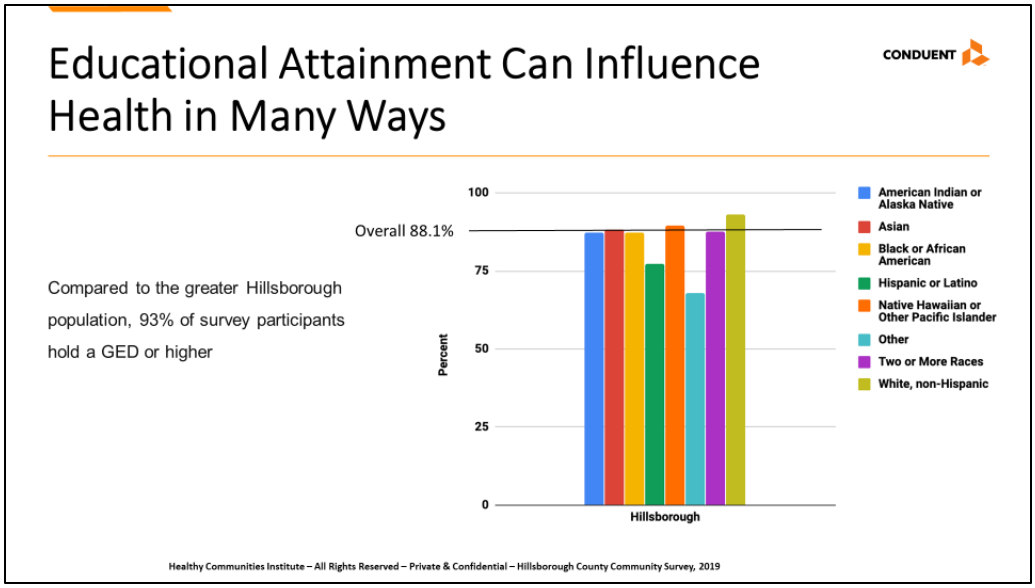
So, we know how the overall county fairs; let's look at Hillsborough at the zip code level.



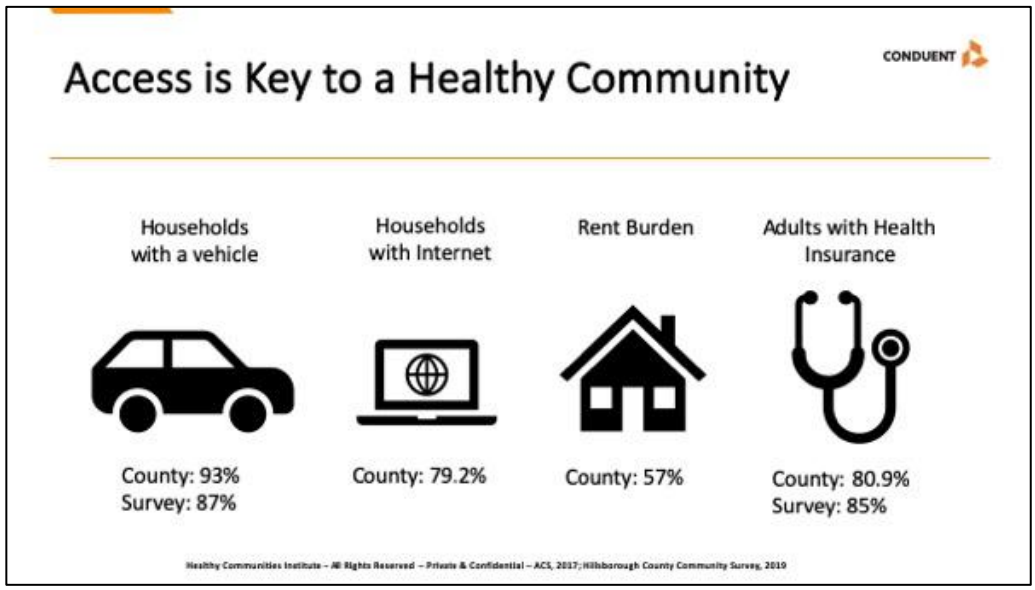
Caroline: The zip codes with the highest socioeconomic need in Hillsborough are 33605, 33610 33612, 33613, 33604. Residents in these zip codes are expected to have higher rates of preventable diseases and higher rates of poverty-related indicators, such as unemployment or lower wage jobs. The red arrow on the map points to a pocket within Hillsborough County of high socioeconomic need. Also, keep in mind when reviewing community survey data that 15% of the survey population resides in the 5 highest need zip codes.



Caroline: Unfortunately, wages lag behind the financial demands of living in Hillsborough County. While nearly 65% of Hillsborough County Community Survey respondents are employed full-time, the largest share of those individuals earn between $25,000-$49,000 annually. Additionally, according to the American Community Survey, the median household income in Hillsborough County is just over $53,000. For a family to live comfortably in Hillsborough County, their annual income must be above $58,000 – this shows an earnings gap of nearly $5,000 for the average household in Hillsborough County. Hillsborough County is uniquely vulnerable to financial hardships, environmental extremes, and an aging population dependent on caregivers.

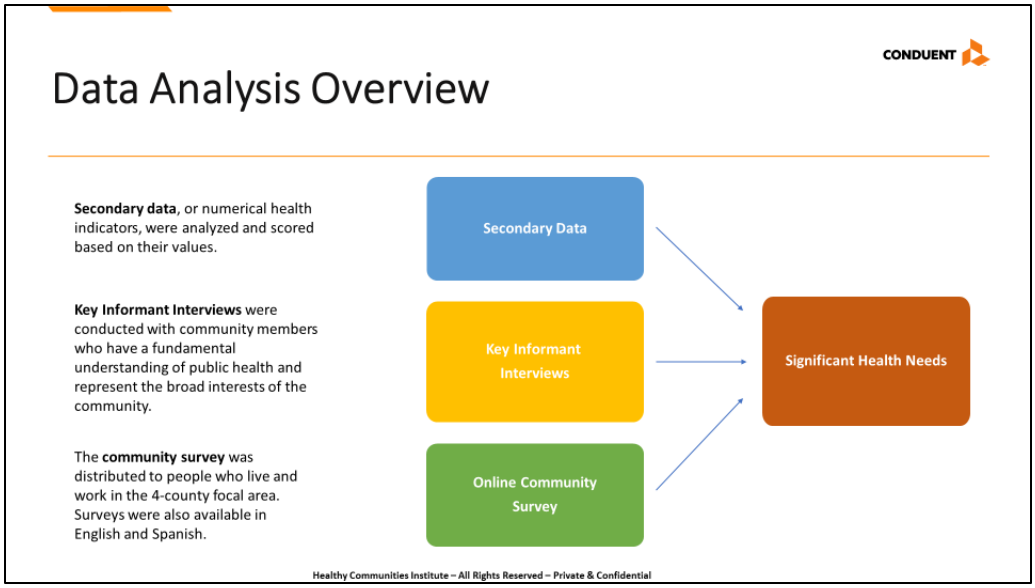


Caroline: Hillsborough County is quite disparate when looking into post-high-school educational attainment. Education plays an important role in community health as it can lead to higher-paying jobs, which enable people to obtain health care when needed, provide themselves and their families with more nutritious foods, and live in safer and healthier homes and neighborhoods with supermarkets, parks and places to exercise—all of which can promote good health by making it easier to adopt and maintain healthy behaviors.

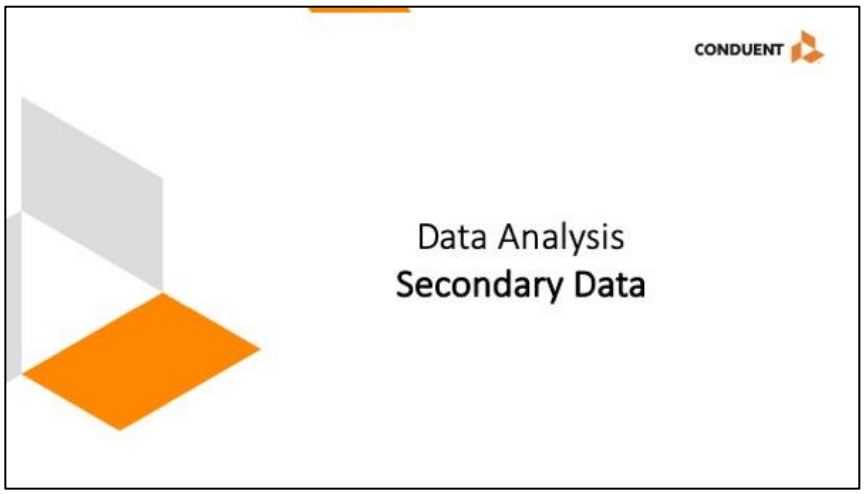


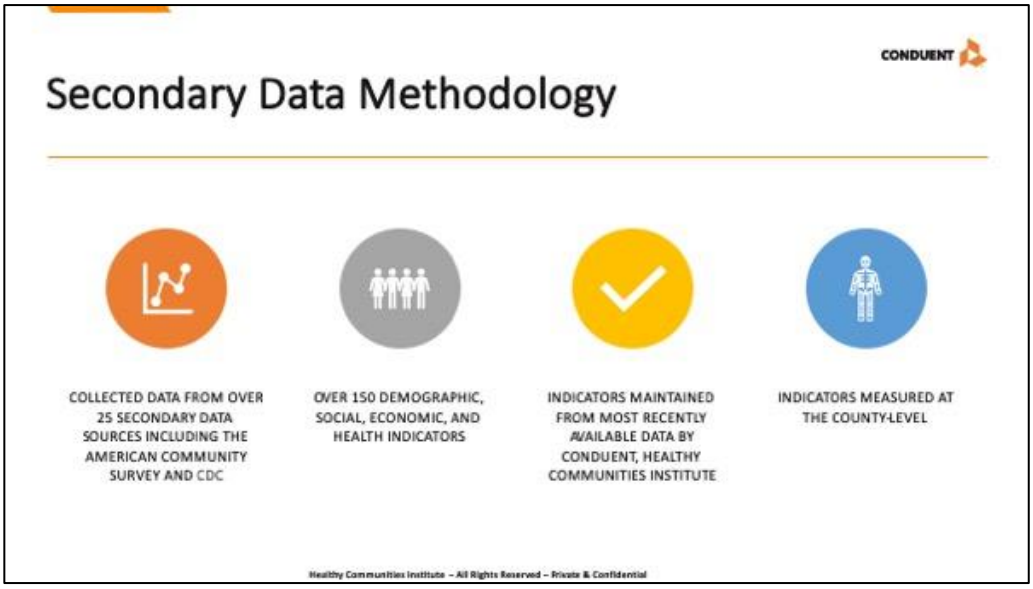
Caroline: We also know access to specific services is key to creating a healthy community. These include access to transportation and household vehicles, internet access at home, affordable rental housing and access to health care through health insurance. Here in

Hillsborough County, 57% of residents experience rent burden, and this indicates the percentage of renters who spend 30% or more of their income on rent.

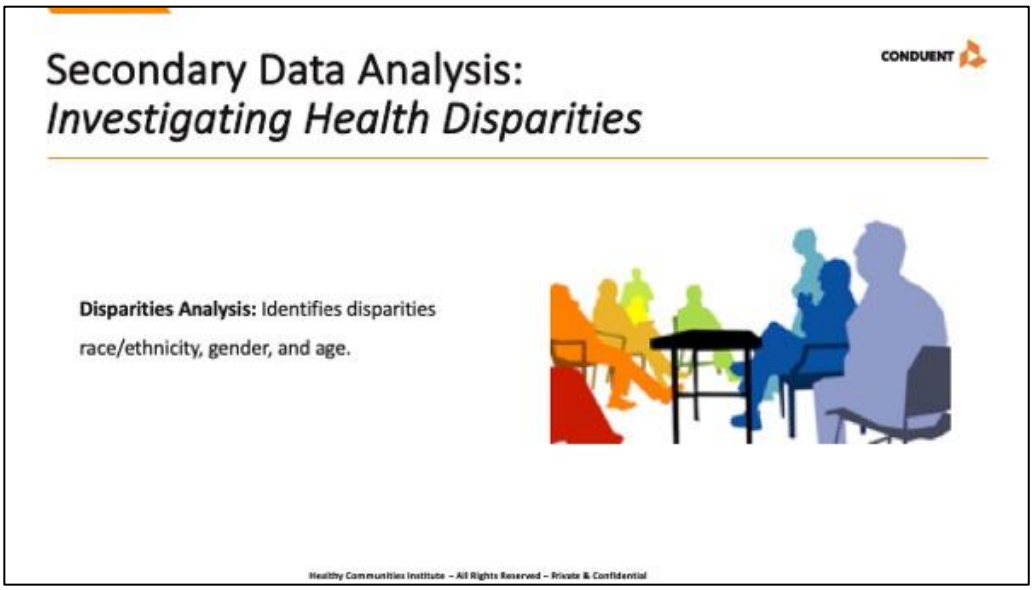


Caroline: We'll start off with secondary data analysis methods and findings, then move on to primary data. The primary geographical unit of analysis for the secondary data is the county: this has the best data availability for most health-related topics. In addition, collaboration with local governing agencies and community programming tend to occur at this level. To determine the significant health needs, we incorporated findings from secondary data, key informant interviews, and an online community survey.



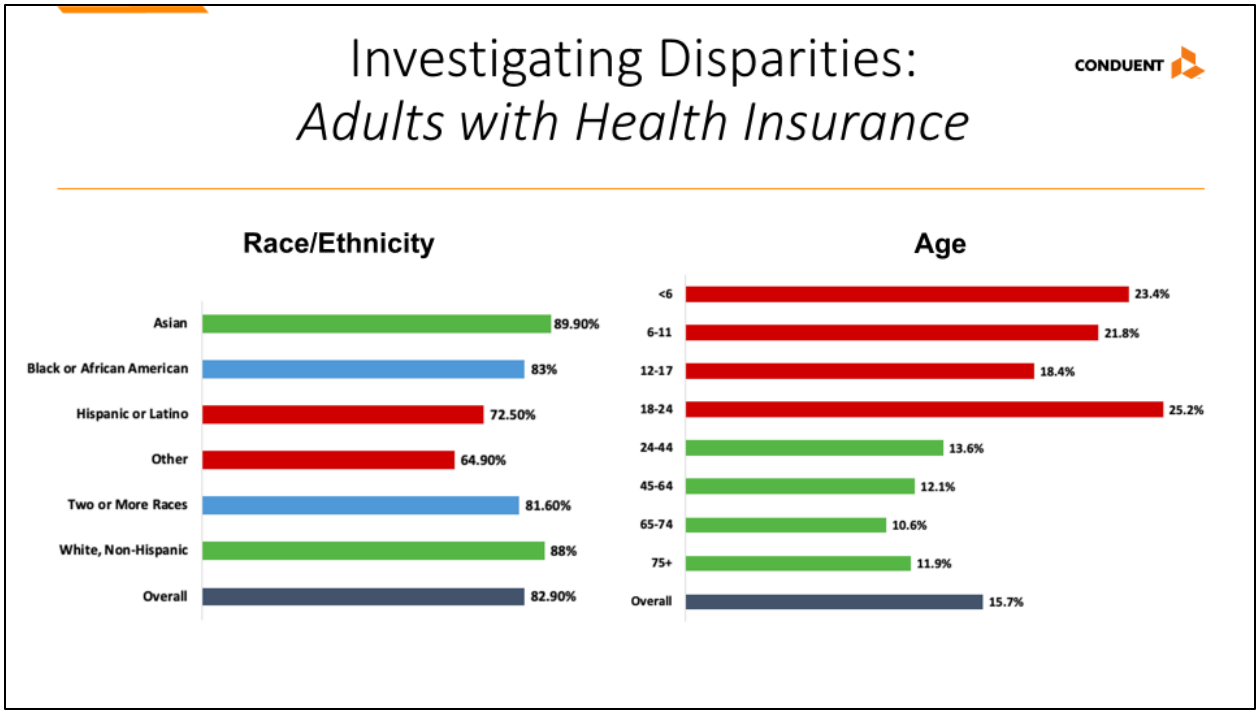


Caroline: The source for the secondary data is HCI's health and socioeconomic indicators database, which will soon be a publicly available data platform open to this collaborative and that will be maintained by Conduent Healthy Communities Institute. Researchers on this team reviewed over 150 health and health-related indicators from over 25 sources including the CDC and FL Health Charts.

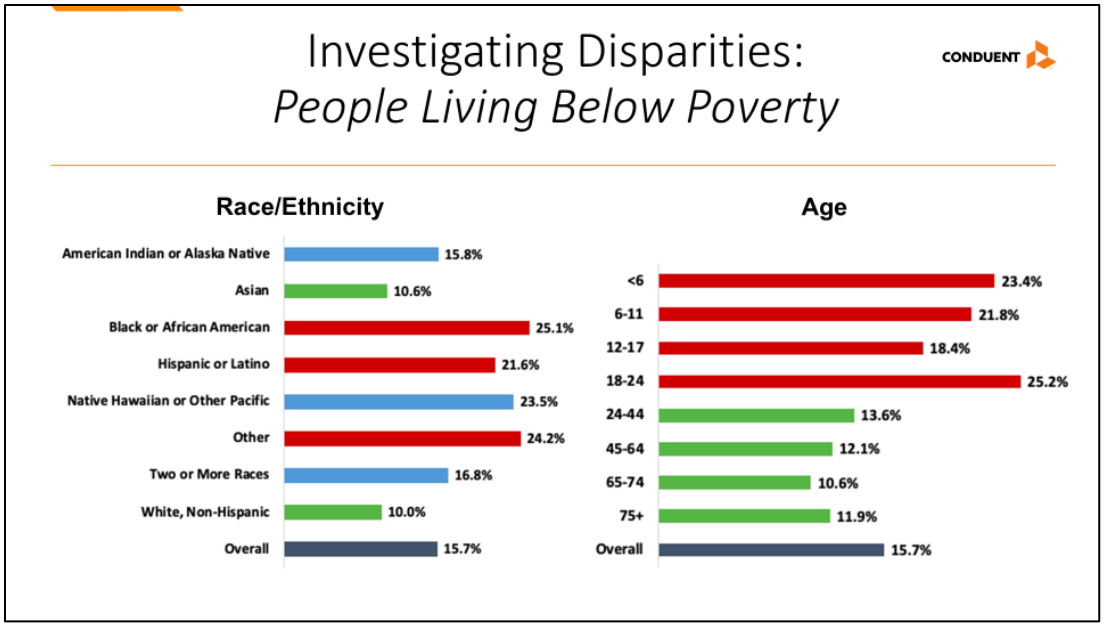


Caroline: Over the next 6 slides, you can explore the socio-economic status indicators that show greater disparities among all sub-population categories. An important part of the CHNA process is to identify health disparities, the needs of vulnerable populations, and unmet health needs or gaps in services. To that end, we will examine some basic disparities. In the secondary data, there are two distinct ways that health disparities were identified. The first mentioned was the SocioNeeds Index, which identifies disparities by geographical location. The second is through our subpopulation disparities analysis, which identifies disparities among race, ethnicity, age, and gender.

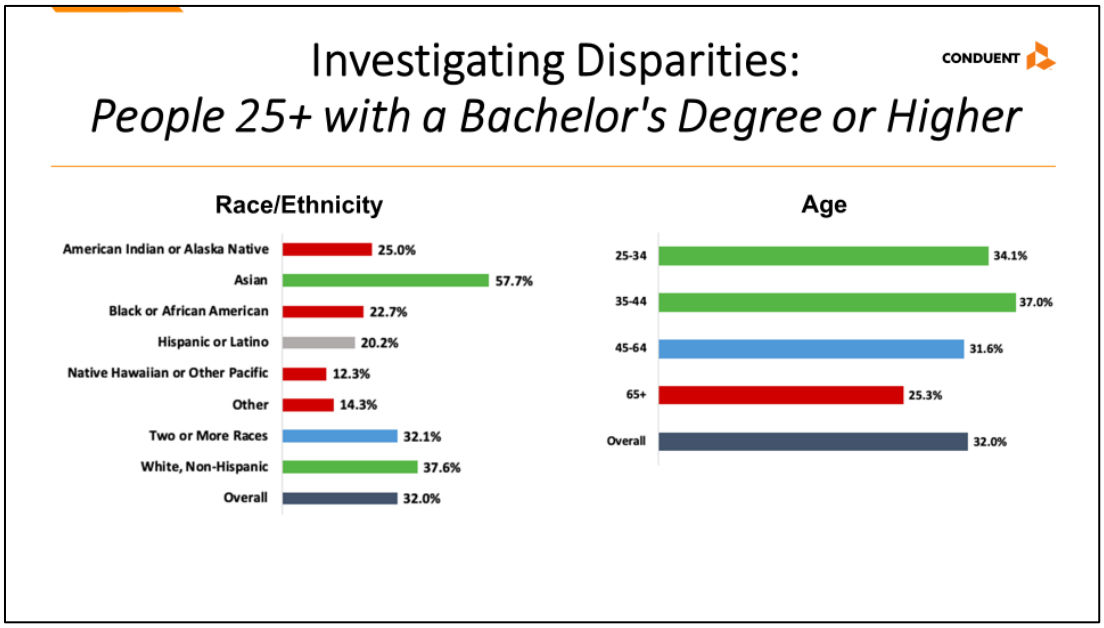
Many of these indicators are in the economy, education, and transportation categories. Similar to the demographic indicators highlighted at the beginning of this presentation, Black or African American, Hispanic or Latino, and Older Adults tend to have a greater disparity from the overall population.



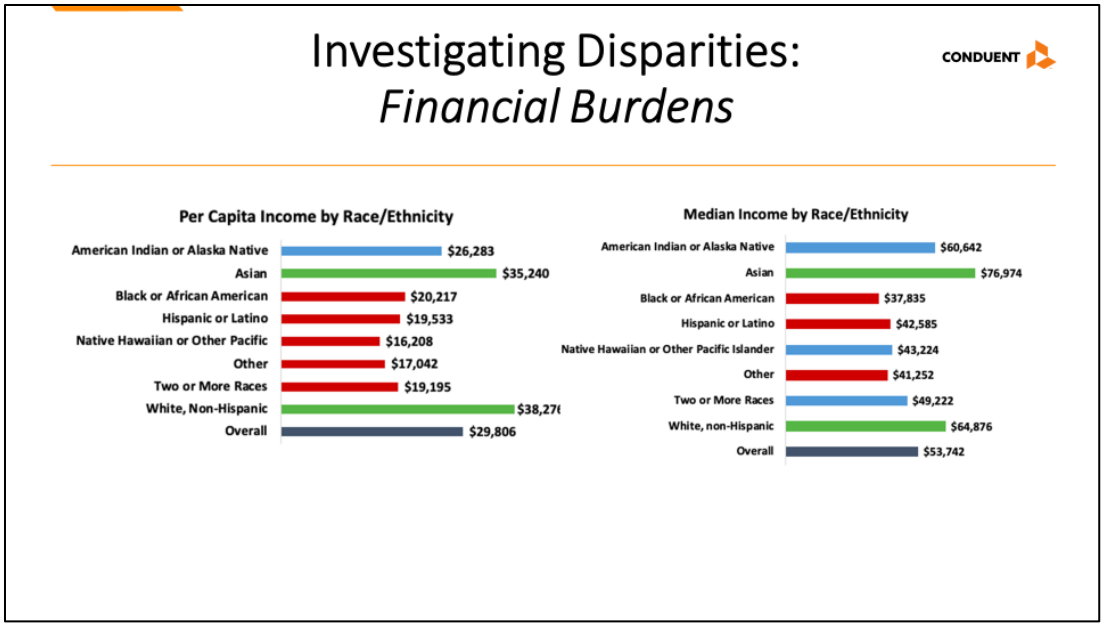
Caroline: Subpopulations that are paired with the RED bars on the charts experience greater disparities from the overall population. For example, on this slide, individuals who identify their race and ethnicity as Hispanic or Latino and Other, under the age of 24, tend to have lower rates of health insurance coverage than the overall population. Conversely, sub-populations paired with GREEN bars on the chart perform better than the overall population for a given health indicator. Thus, individuals between the ages of 45-64 have higher rates of health insurance coverage than the overall population.



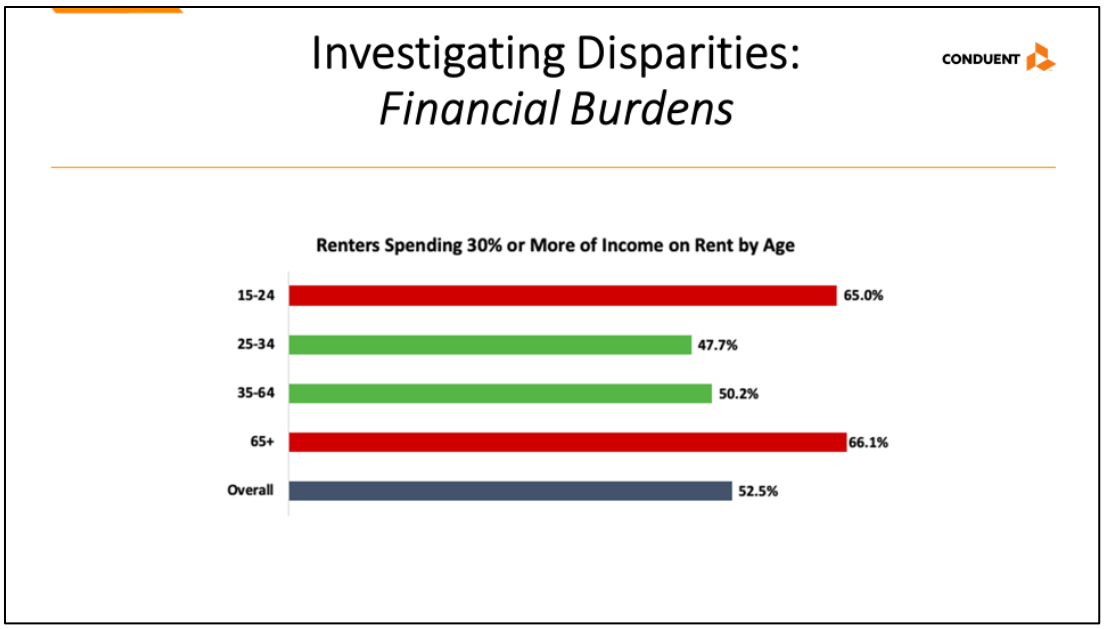
Caroline: When focusing on communities in poverty, there is a greater burden among Black or African Americans, Hispanic or Latinos, Other Races, and individuals under the age of 24.



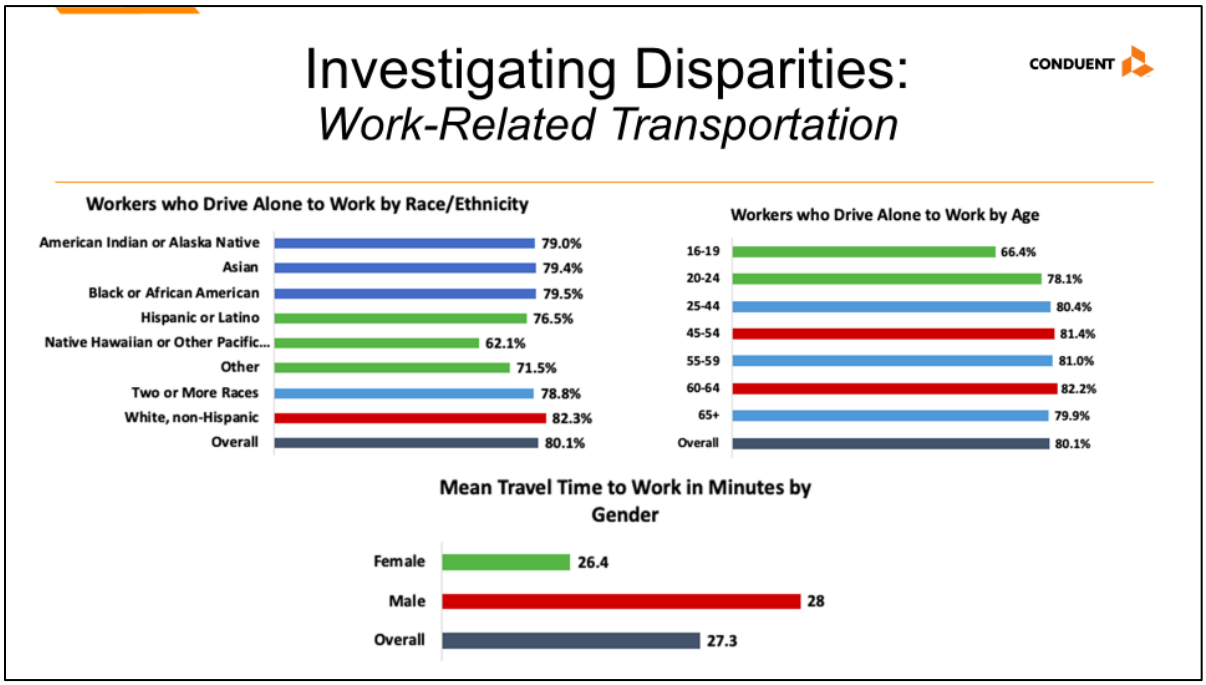
Caroline: Overall, bachelor's degree attainment is low for Hillsborough with just about 1/3 of the population 25 or older holding a bachelor's degree. Multiple race and ethnicity sub-populations, and older adults tend to have less access or opportunity to have completed a bachelor's degree or higher.



Caroline: When investigating per capita income and median household income, similar sub-populations are more negatively affected: Black or African Americans, Hispanic or Latino, Native Hawaiian or other Pacific Islander, Other race category, and two or more races.



Caroline: 15-24-year-olds and over-65-year-olds are more likely to spend more than 30% of their income on rent. With a limited income, paying a high rent may not leave enough money for other expenses, such as food, transportation and medical.



Caroline: Commuting time and driving alone to work consumes more fuel and resources than other modes of transportation, such as carpooling, public transportation, biking, and walking. Driving alone also increases traffic congestion, especially in areas of greater population density. Non-Hispanic Whites, 45-54-year-olds, and 60-64-year-olds are most likely to drive alone to work. Additionally, Men are more likely to have longer commute times than women.

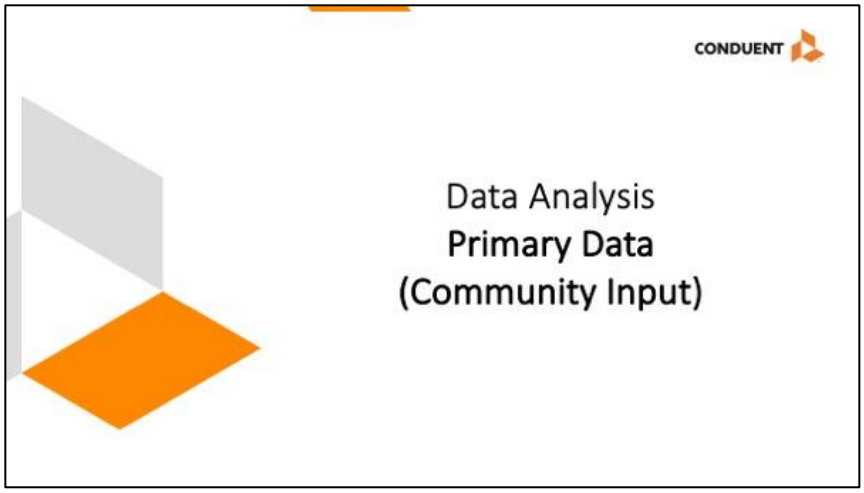
This concludes our analysis into demographic and secondary socioeconomic data. Again, I would like to stress that the secondary data analysis and disparities analysis is simply one part of the CHNA process to identify significant health needs and should neither be given more weight nor less consideration than the primary data surveying and analysis. We are confident in our secondary data analysis to lay the foundation from which to begin to synthesize results with the community survey and key informant interviews.

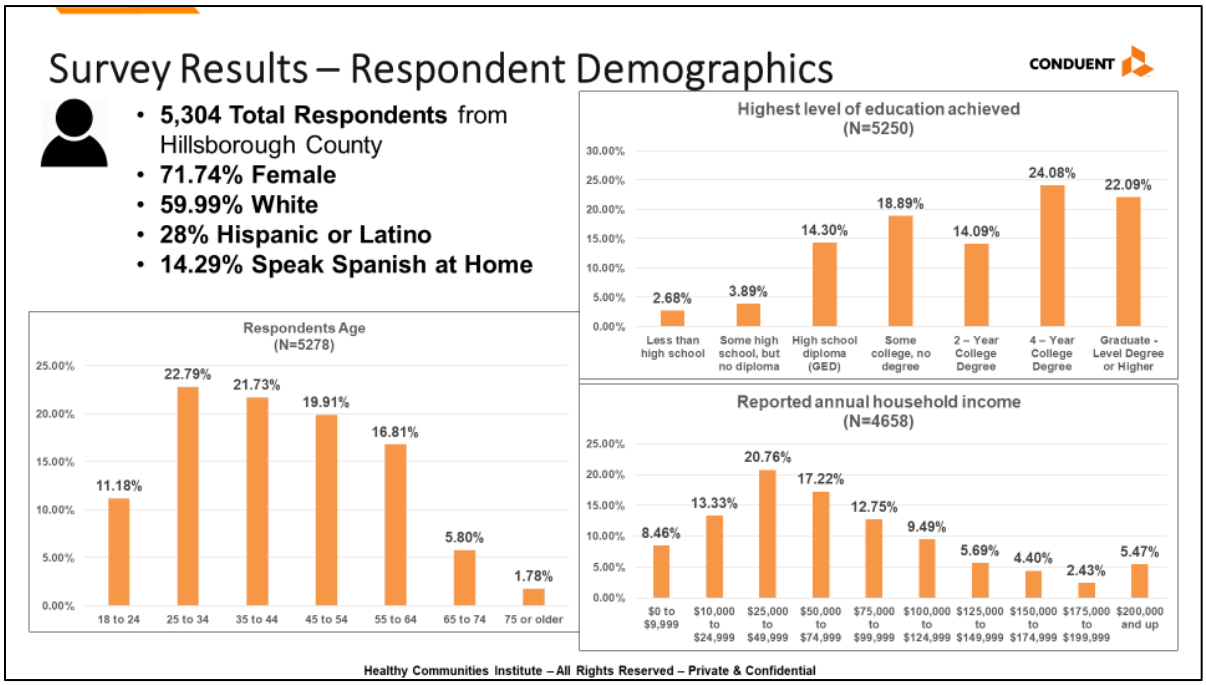
That's quite a lot of information to cover so quickly. So, feel free to take a quick moment of reflection before I pass it back to Ashley to cover primary data collection, analysis, and prioritization planning.

Are there any questions?

Speaker: What was the sample size?

Caroline: It is national data; we did not collect this data. The primary service data that Ashley will present was just over 5,000 people. The main data I presented is from national and state sources from other departments; those sources are quite large.



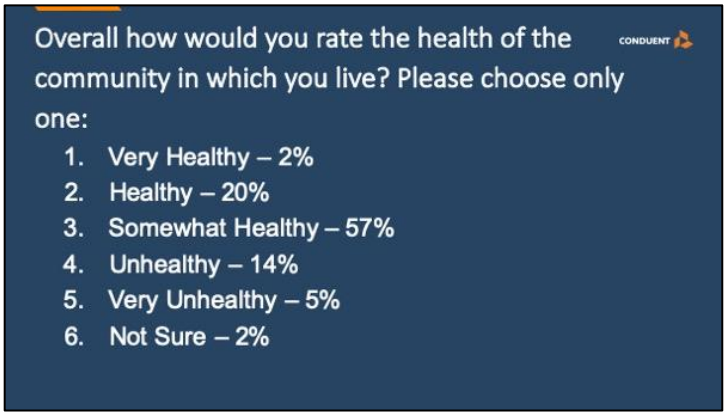


Ashley: The secondary data analysis is more a compilation of the state and national data sets. What I will move into now, talking about the particular Hillsborough data, we had 5,304 total respondents. There were a little over 71 questions on this survey. As Caroline mentioned, the reflection of the

demographics is pretty spot-on. It means we're very good at getting the survey out there, so thank you to all the partners and the team that got this survey out there.

You guys do have some strong university representation here, which speaks to the younger population and the higher education. As far as earnings, 37% earn less than $50,000 for household income. Reflecting back again to some of the data Caroline spoke to, a family really needs to be closer to $60,000 to live comfortably.

We will do a couple more quick survey questions.



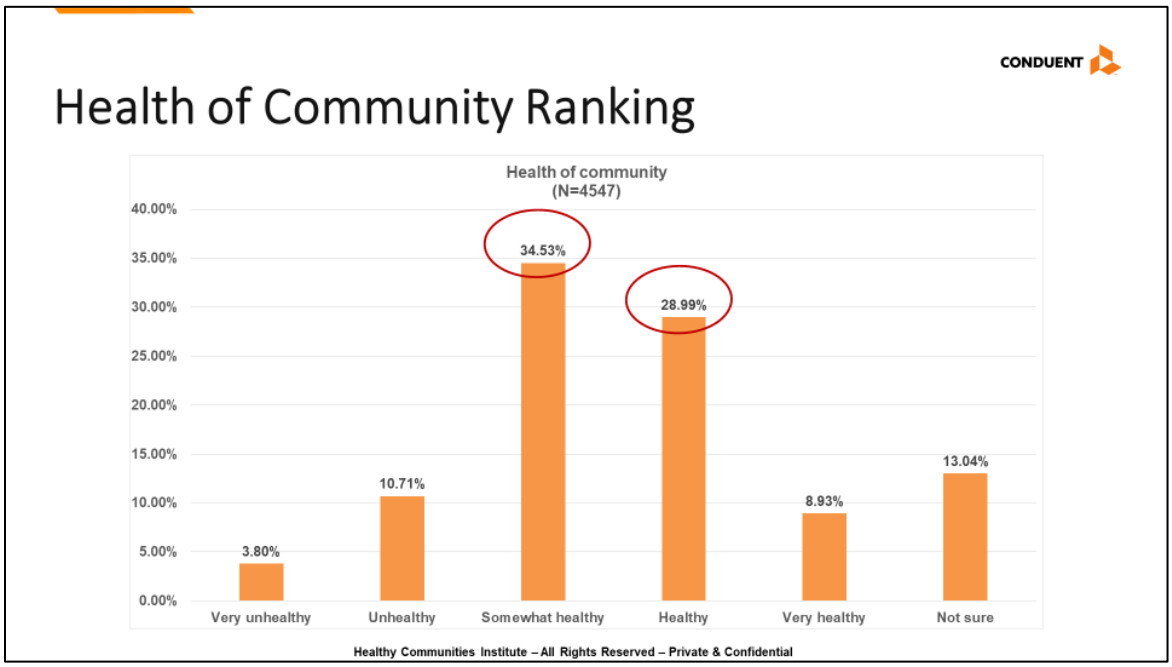
How would you rate the health of your community?
• **Somewhat healthy** – **57%** • **Healthy** – **20%** • **Unhealthy** – **14%**

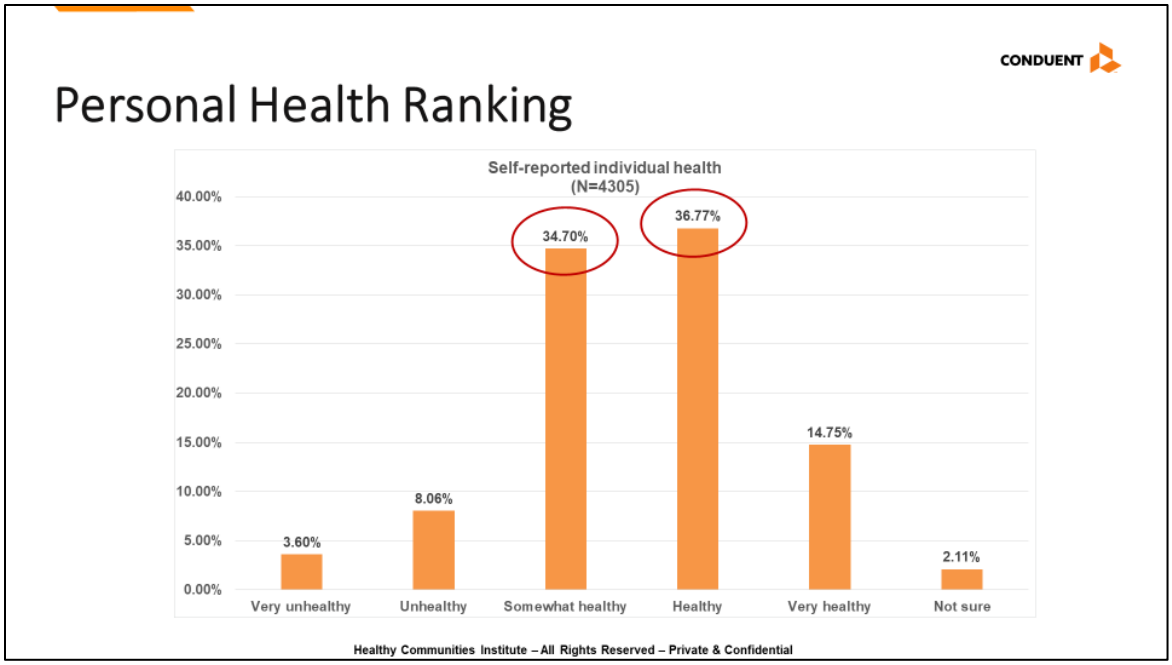
Ashley: We are mostly reporting that we think our community is Somewhat Healthy. Right after that, is 20% rating it Healthy.

Now, tell us how you would rate your personal health.

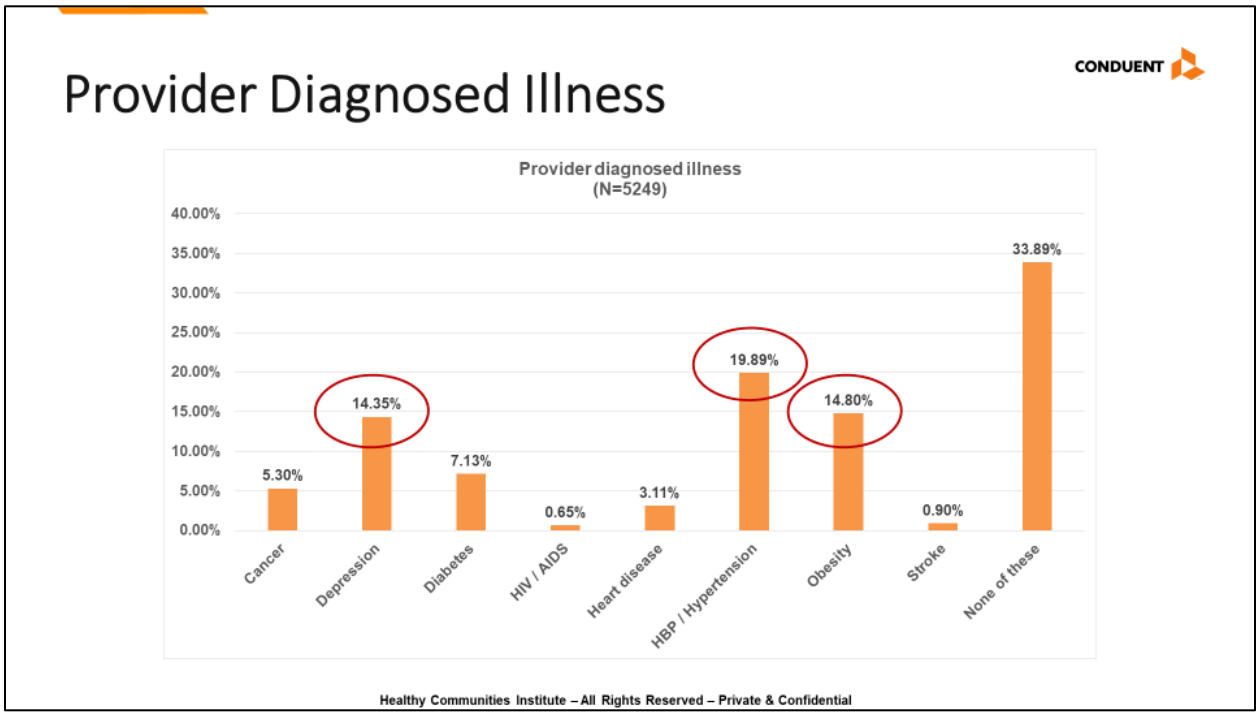
How would you rate your own personal health?
• **Healthy—48%** • **Somewhat healthy—32%** • **Very healthy—16%**

Ashley: We are a bit more generous with our personal health ranking. Don't worry, the responses in the survey were just as critical. Here are those results.

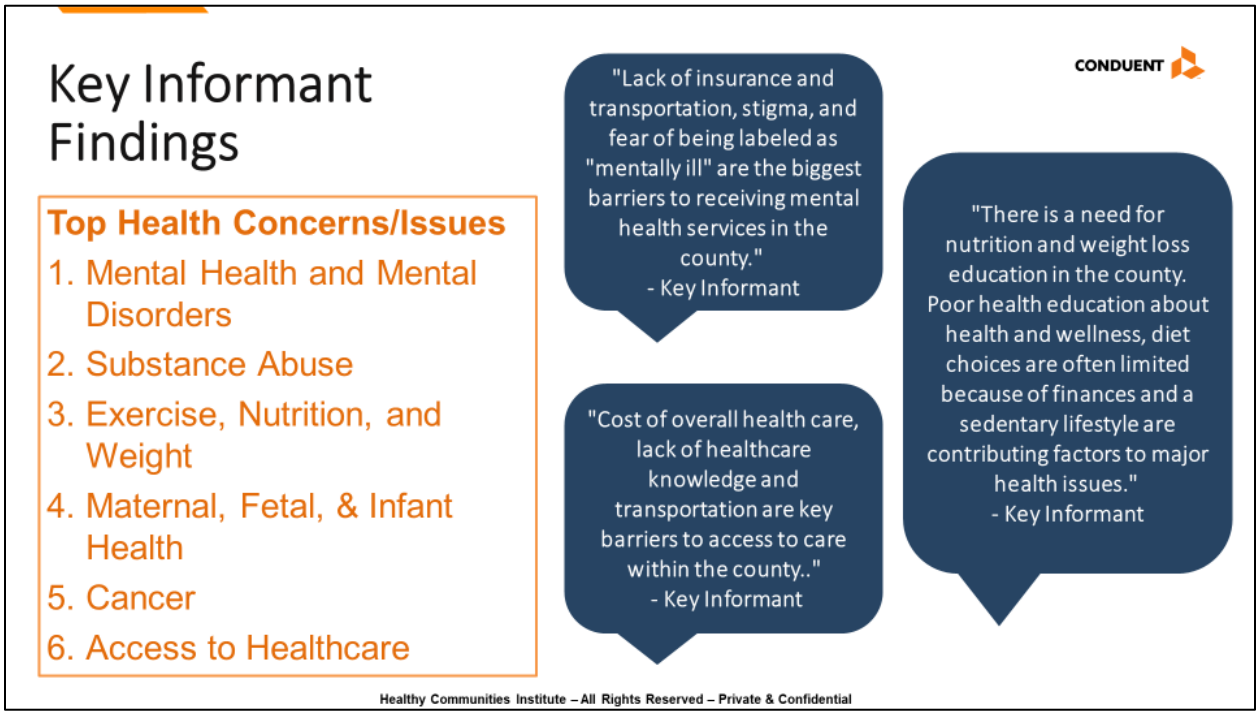




Ashley: So, keep in mind, we are a bit more generous evaluating our own health than the community health.



Ashley: These are a couple of survey questions we wanted to highlight.



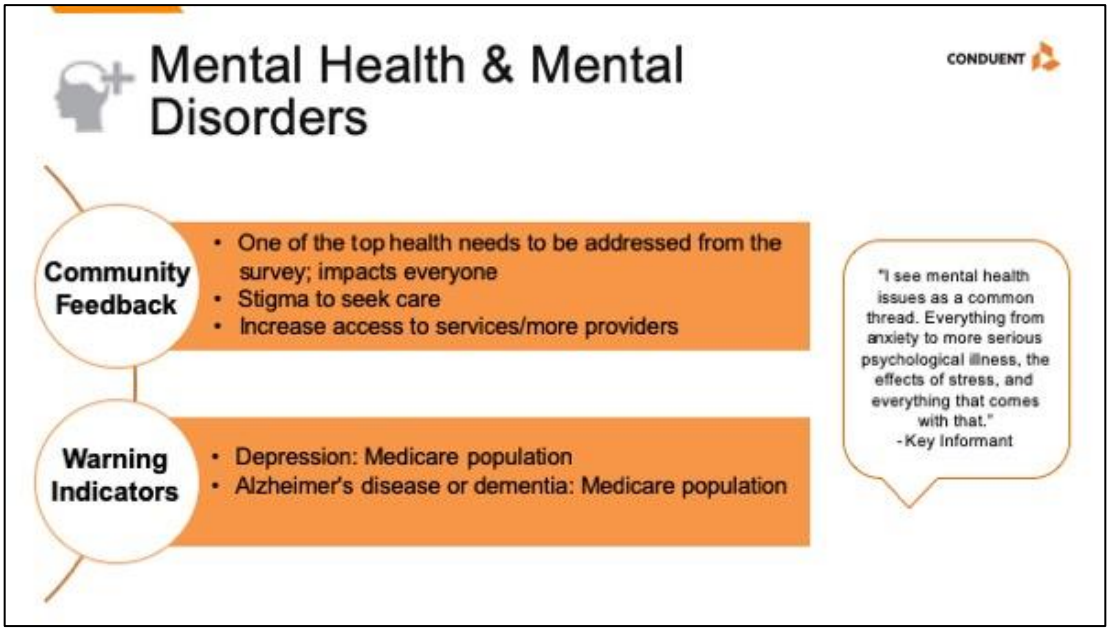
Ashley: This moves us into some of our qualitative findings, including some of the comments we pulled out.

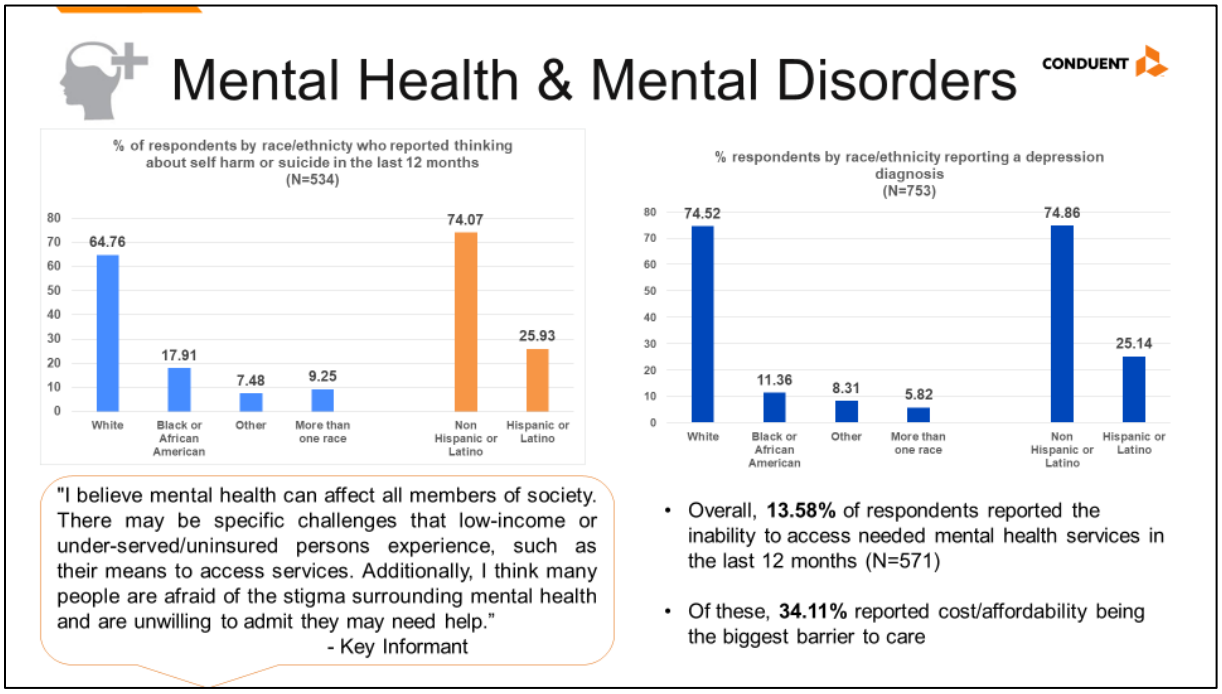
Ashley: There was also a robust series of focus groups in the community.

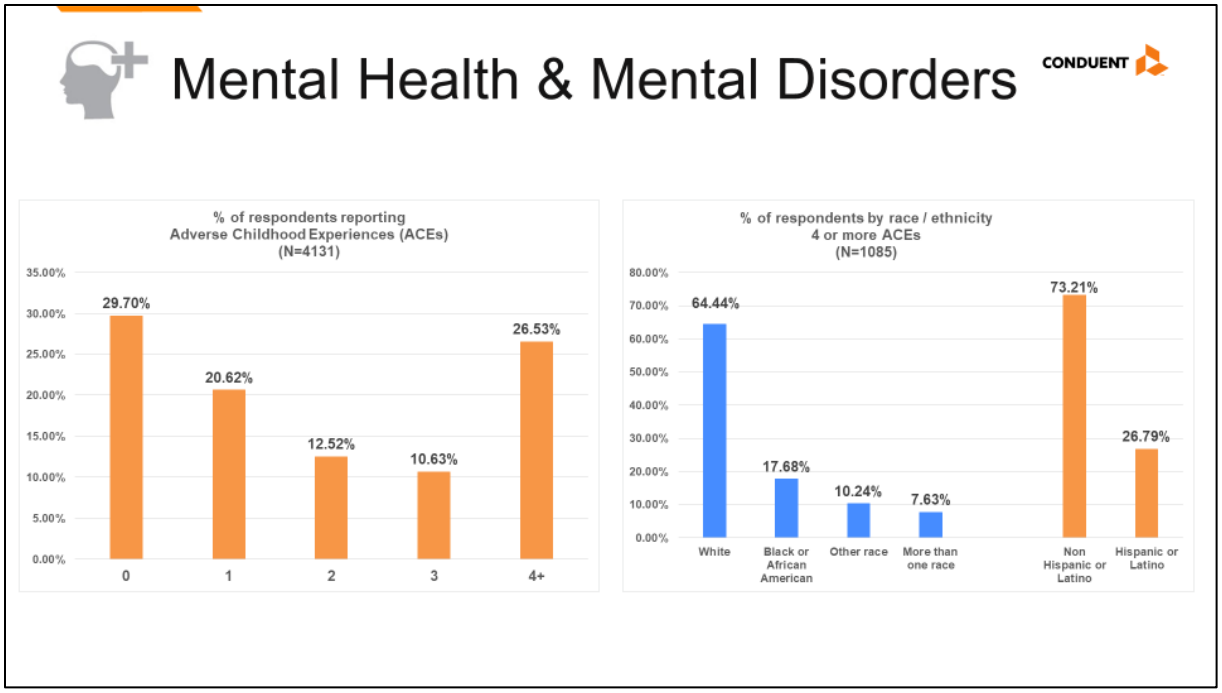
We are starting to see a trend across our data sets, which is very good.

Ashley: For the first time, these are the 11 health categories for your consideration today. These all came from gleaning the top health needs from the survey findings and the focus group findings. At the end of the day today, we will come back and think about these 11 categories for prioritization and voting.

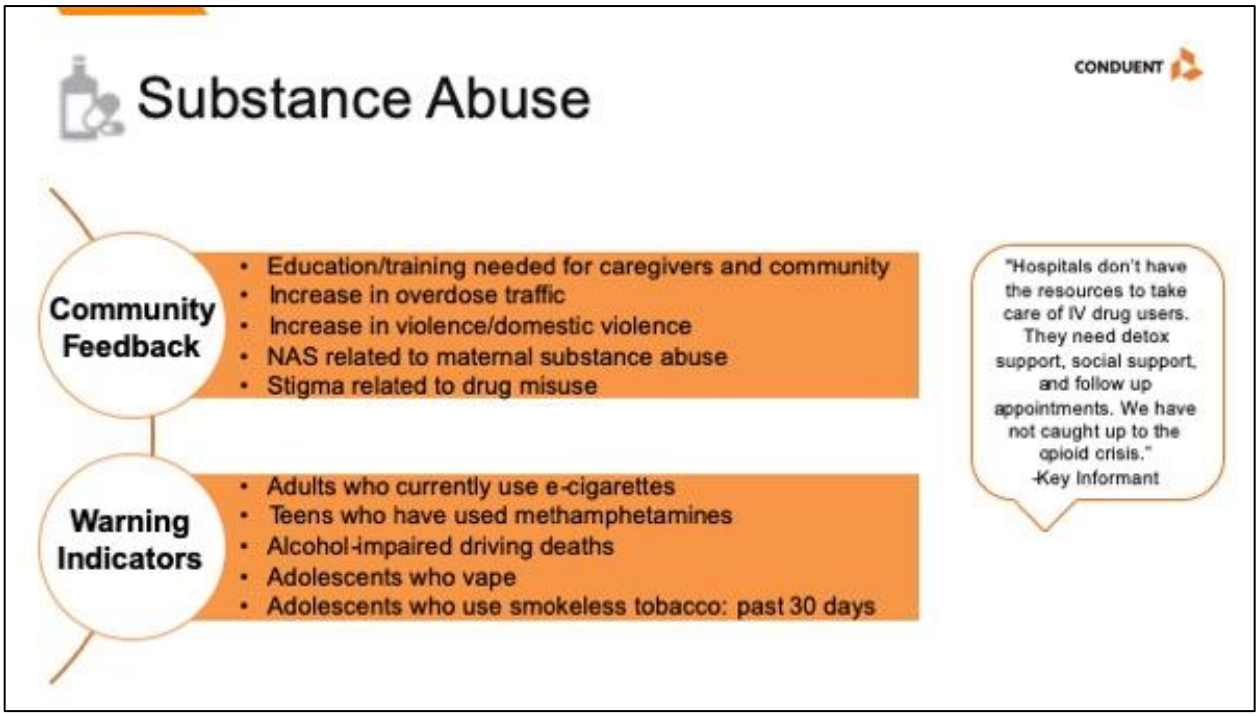
Ashley: The following slides will discuss data on each of the eleven categories. For each category, the first slide contains community feedback, warning indicators, and supporting information from key informants. The second slide includes supporting data. When we break out in our discussion groups, we will dive deeper into some of the specifics of the data.





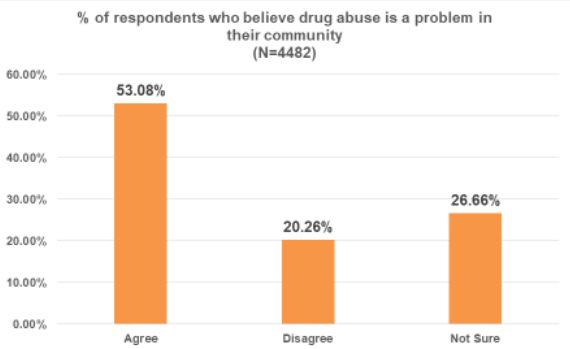


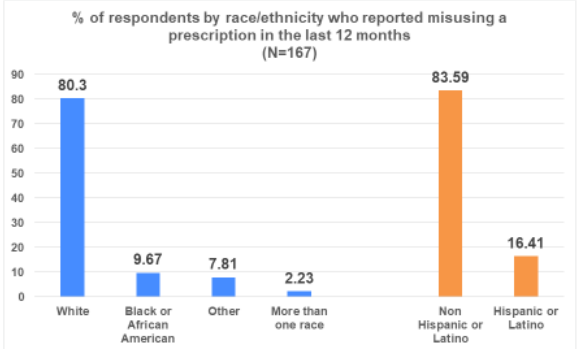
Ashley: How many of you have heard of ACEs? Adverse Childhood Experiences–we are starting to realize how much ACEs can affect health as an adult. ACEs include abuse, parents with depression, or a parent in prison.



Substance Abuse

CONDUENT





- Overall, **10.67%** of respondents are smokers (N=446)
- **5.23%** of respondents reported Vaping e-cigarettes (N=217)
- **3.83%** of respondents reported misusing prescription drugs (N=167)

"There is an increase in drug overdose and trauma volume in the county. Pregnant women with substance abuse disorders has become an emerging issue."
– Key Informant

Cancer

CONDUENT

Community Feedback

- Delayed care because of a fear of cancer diagnosis
- Aging population
- Uninsured/underinsured barrier to care/treatment

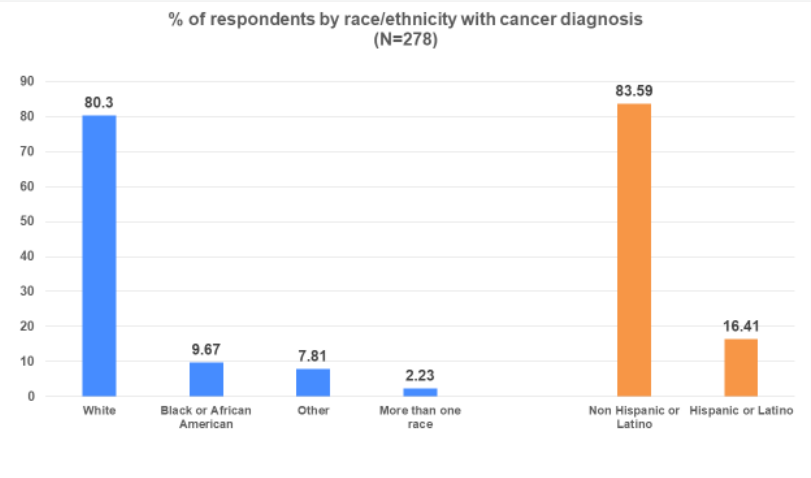
Warning Indicators

- Breast cancer incidence rate
- Age-adjusted death rate due to colorectal cancer
- Melanoma incidence rate

"Sometimes even though they feel a lump, they don't want to get a mammogram because they are afraid of what it could mean."
-Key Informant

Cancer

CONDUENT



"Lack of health insurance prevents many people from being admitted into cancer centers for treatment or other services."
- Key Informant

Exercise, Nutrition, & Weight

CONDUENT

Community Feedback

- Top concerns from survey and key informants
- Food insecurity in relation to chronic disease
- Affordability of healthy foods
- Inactivity/sedentary lifestyle

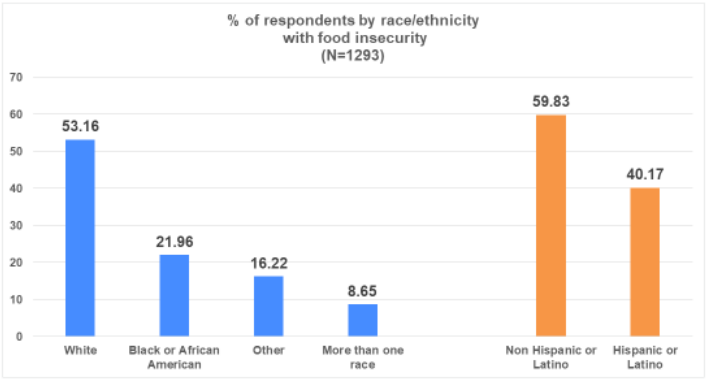
Warning Indicators

- Fast food restaurant density
- Teens who are obese: high school students
- Farmers market density
- SNAP certified stores
- Teens without sufficient physical activity

"Some of the factors that are contributing to this are poor diet quality, easily accessible high fat and high sugar convenience foods, less accessible fresh fruits and vegetables, cost of produce vs. convenience foods, and time."
– Key Informant

Exercise, Nutrition, & Weight

CONDUENT



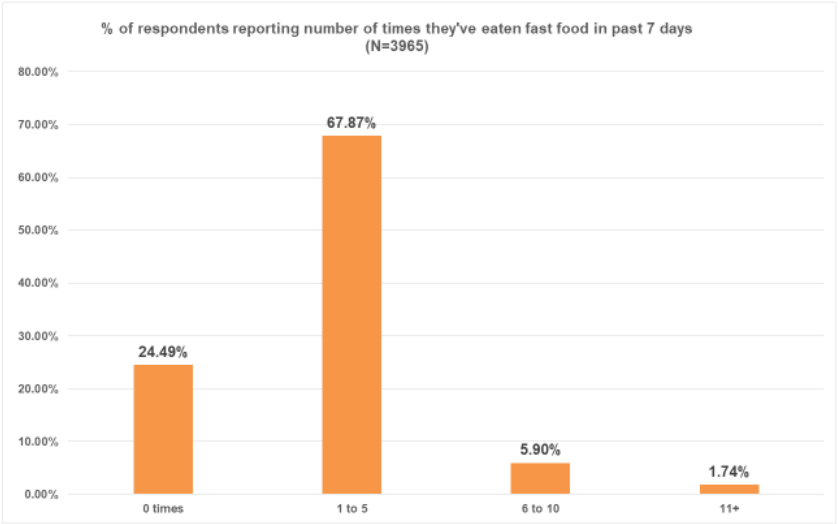
"Low income individuals struggle with access and affordability of healthy foods".

– Key Informant

- Overall, **29.59%** of respondents reported some type of food insecurity (N=1293)
- **35.2%** of respondents with children in their home reported some type of food insecurity (N=602)
- **30.57%** of respondents with children reported that in the last 12 months, food they bought just did not last, and they did not have money to get more
- **15.02%** of respondents with children in their home reported that someone in their home received emergency food from a food bank in the last 12 months

Exercise, Nutrition, & Weight

CONDUENT



"Obesity is one of a health issues we are working through. Obesity can lead to physical, social and emotional struggles for kids. Helping parents to help their children maintain a healthy weight. I don't think there is enough support and awareness on the school district level."

-Key Informant

Ashley: Please note that the data is self-reported, which can indicate a variance in diagnosis among communities. The individual side of seeing a physician and receiving a diagnosis is a small portion of the community who actually has chronic diseases. Many are living with undiagnosed chronic diseases.

Heart Disease & Stroke

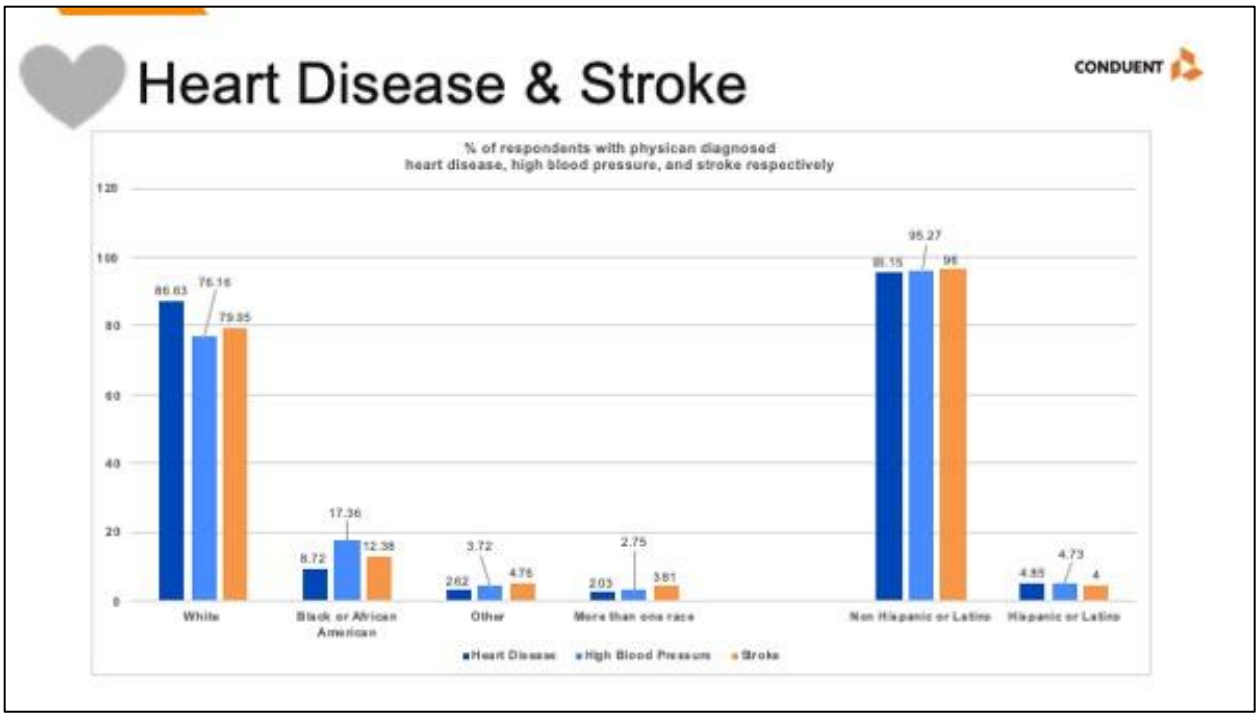
CONDUENT

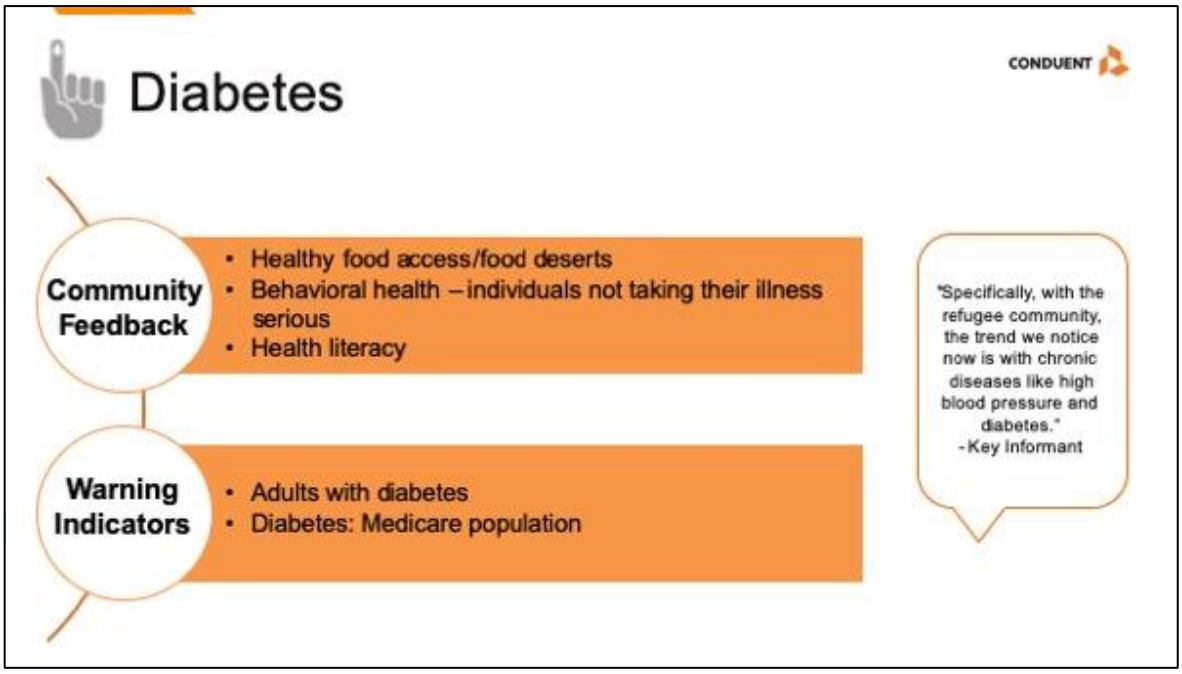
Community Feedback

- Condition not being addressed
- Barriers to healthy food
- Addressing health literacy/lack of knowledge

Warning Indicators

- Stroke: Medicare population
- Atrial fibrillation: Medicare population
- Ischemic heart disease: Medicare population
- High blood pressure prevalence



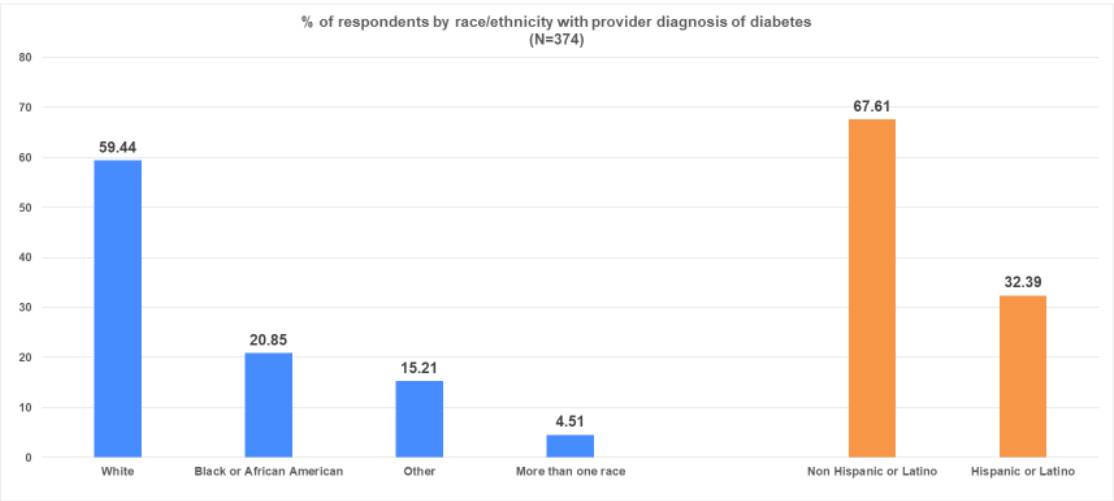


Speaker: On the previous slide, it seems to indicate to me that 80% of the white respondents said they were diagnosed with stroke.

Ashley: Of the people who have received a diagnosis, the percentage of those respondents who were white is 79.05%.

Diabetes

CONDUENT



Immunizations & Infectious Disease

CONDUENT

Community Feedback

- Sexually transmitted infections
- Health literacy/community education about immunizations/shots

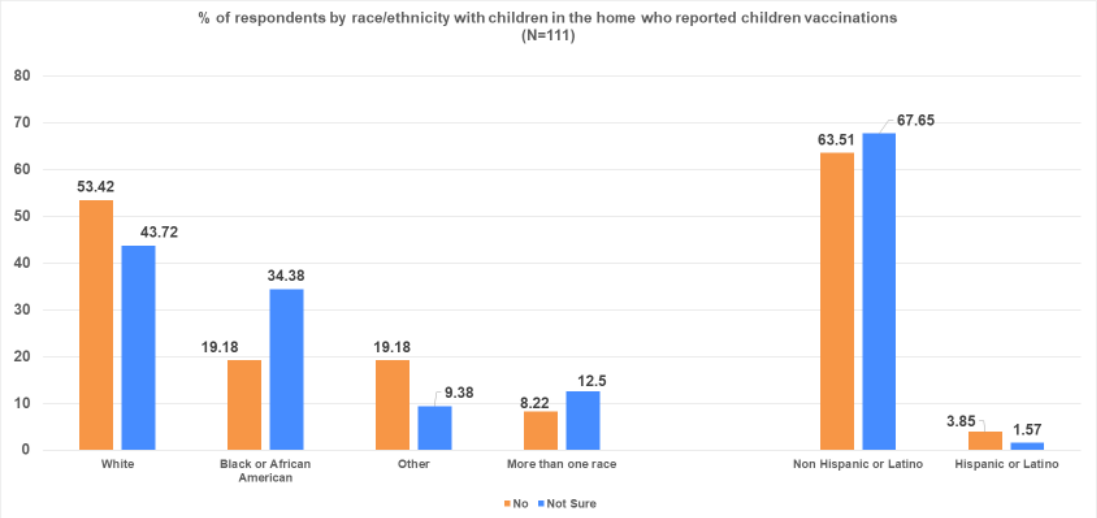
Warning Indicators

- Chlamydia incidence rate
- Gonorrhea incidence rate
- Syphilis incidence rate
- Age-adjusted death rate due to influenza/pneumonia

"Cultural barriers and health literacy issues are contributing factors to increasing rates of disease in the community. There is a need for education surrounding the care and treatment of diseases."
-Key Informant

Immunizations & Infectious Disease

CONDUENT



Respiratory Disease

CONDUENT

Community Feedback

- Environmental challenges such as mold

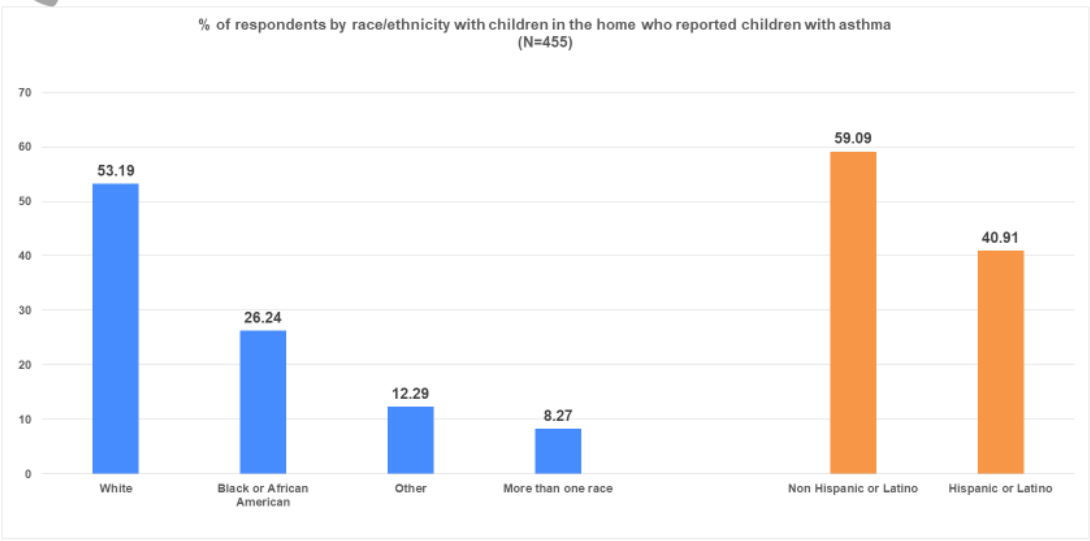
"There is a large amount of old housing stock in East Tampa. These deteriorating buildings mean asthma is a growing concern." -Key Informant

Warning Indicators

- Asthma: Medicare population
- COPD: Medicare population
- Age-adjusted death rate due to influenza and pneumonia
- Adults 65+ with influenza vaccine
- Teens with asthma

Respiratory Disease

CONDUENT



Maternal, Fetal, & Infant Health

CONDUENT

Community Feedback

- Young/teen motherhood
- Infant mortality
- Barriers to Family Planning/LARCs
- Chronic disease among pregnant women
- Women with substance abuse/NAS

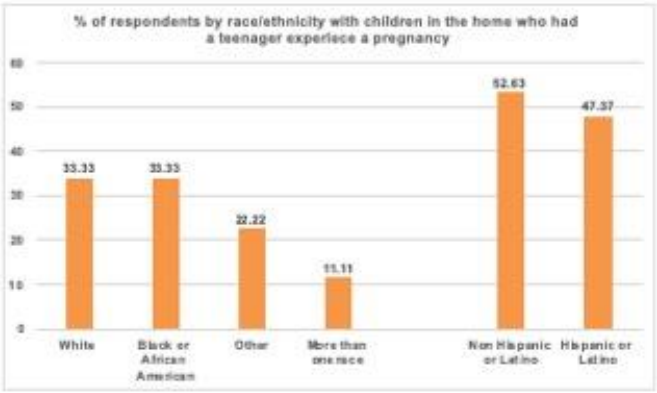
Warning Indicators

- Babies with low birth weight

"Chronic health conditions in pregnant mothers. Contributing factors include lack of a medical home prior to pregnancy to treat chronic conditions due to lack of health insurance or Medicaid...built environment... and toxic stress."

Maternal, Fetal, & Infant Health

CONDUENT



"There is an emerging cycle of young motherhood, often resulting in not finishing school, being unemployed and enduring domestic violence."
- Key Informant

"Maternal depression and stress. Contributing factors include difficulty in accessing mental health services especially during pregnancy; toxic stress in family and community; adverse childhood events and their impact on later adult mental health."
- Key Informant

Access to Health Services

CONDUENT

Community Feedback

- Top priority from key informants
- Barriers such as transportation, insurance, and cost
- Need for more culturally competent care/language
- Health literacy
- Increased access to substance abuse/mental health care

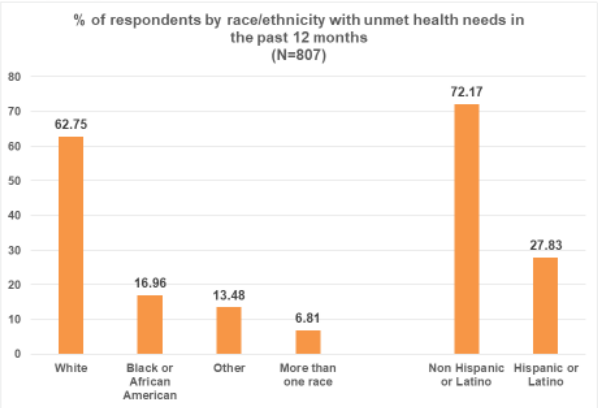
Warning Indicators

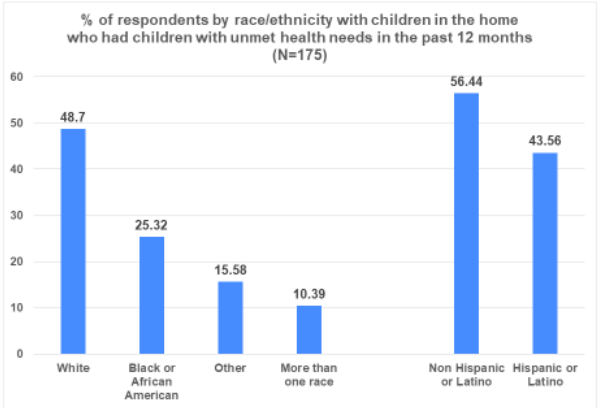
- Adults with a usual source of health care
- Children with health insurance
- Median monthly Medicaid enrollment

"Depending on where you live in Hillsborough...you just don't have access. In some parts of the county it is an economic issue."
-Key Informant

Access to Health Services

CONDUENT





- **18.93%** of respondents who needed medical care in the past 12 months but didn't receive it (N=807)
- **7.69%** of respondents with children in the home reported having children who needed medical care in the past 12 months but didn't receive it (N=175)

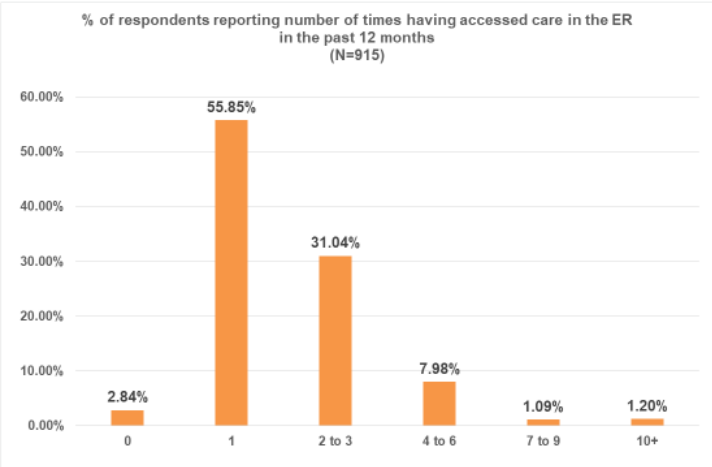
Ashley: Access to health care ties into all the other categories. This can be related to cost, insurance, and health literacy. People who have insurance may not know how to use it. Even educated people struggle with copays and deductibles. Transportation challenges also affect access.

Access to Health Services

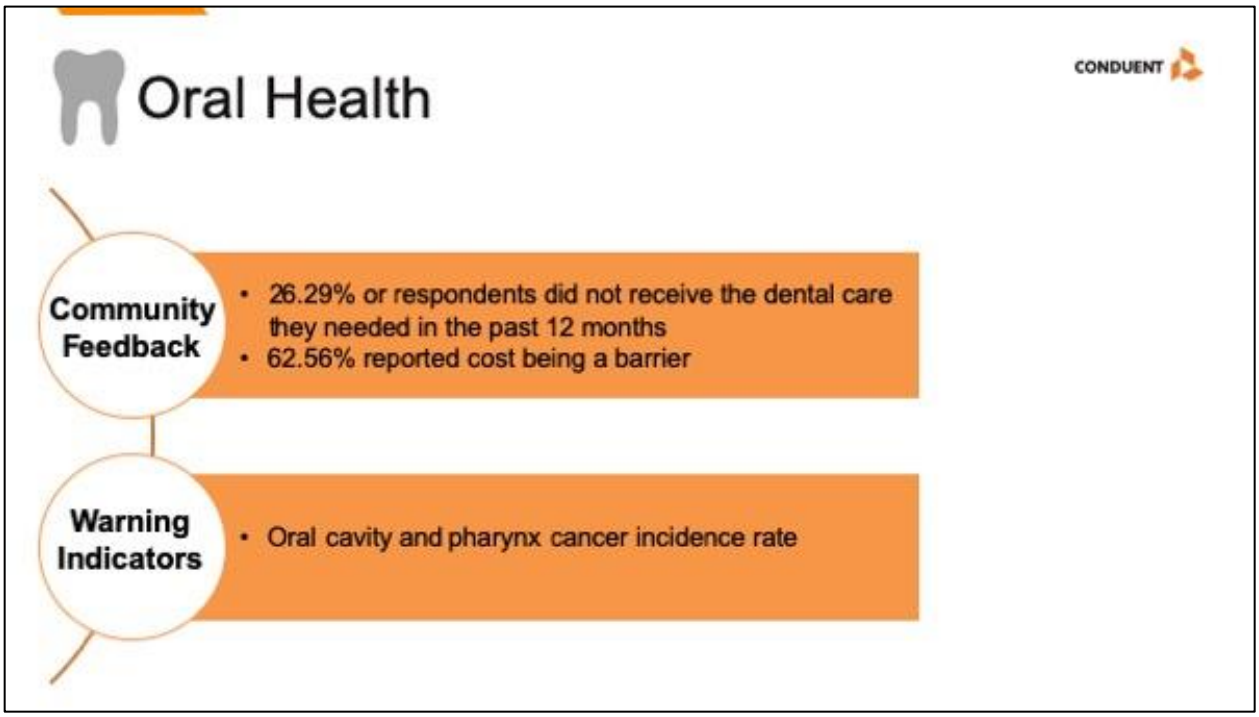
CONDUENT

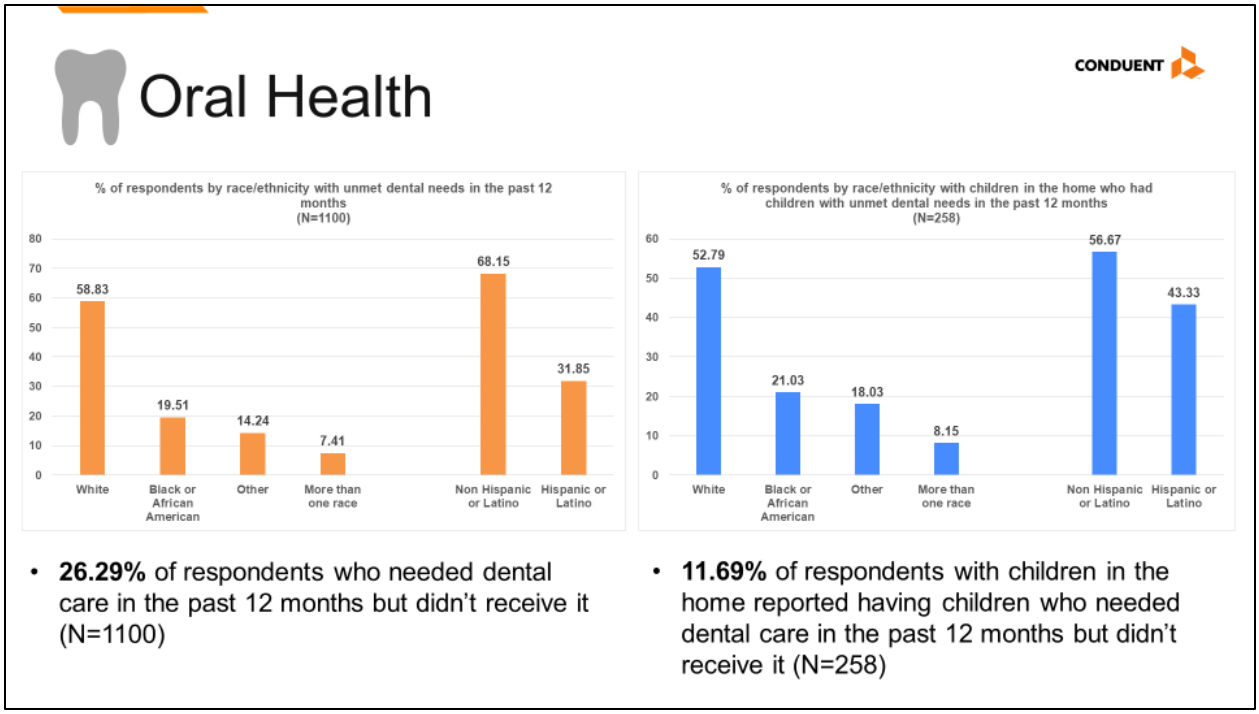
- **23.22%** of respondents had accessed care in the ER in the past 12 months (N=979)
- Why they accessed care in the ER
  - **37.94%** Emergency or Life-threatening situation

"Many people are employed yes but they still can't afford their portion of the health insurance copay."
- Key Informant



Ashley: I wanted to highlight emergency room (ER) utilization. 23% of respondents had accessed care in an ER in past 12 months. We asked them why; about 40% went to the ER because of actual emergencies. The majority went for non-emergency reasons. This can be due to a lack of insurance, or because of the limited hours of primary care physicians. Regardless, there is potential for intervention.





Ashley: Again, this was the 30,000-foot level looking at our data. We do have time for one or two questions, but we will also be around for the rest of the afternoon as you breakout into groups.

Speaker: For a number of the categories, do you have a mechanism to determine which are out of proportion to what the demographics relate to? Second question, the thing that struck me was the graduation rate from high school and the post-high school percentage and that being probably what is driving a fair amount of what we are seeing as far as access issues.

Can you speak to how this data looks at the drivers of some of these healthcare outcomes we are seeing?

Ashley: Sure, that is actually the point of the deeper dive this afternoon. We will have all this date in front of you. To start to tease out some of those questions, what are some of the social determinants of health – whether it is graduation rates, the zip code – how are those larger issues influencing the outcomes and the data?

Back to your first point about race and ethnicity. Again, this was more of a superficial analysis. We were mostly looking at frequency of respondents. We had that sampling from our secondary data analysis that Caroline presented. There is more opportunity to dive into the points you are making as we dive into the next stage here.

Rebecca: Thank you, Ashley and Caroline. You will have an opportunity later today to dig into this data a bit more.

The participants took a short break.

Rebecca: I am going to invite Lisa Bell up to frame the technique we will use and to also share a few key points following the data presentation you just saw.

Lisa Bell, Manager, Community Benefit, Baycare: On the community survey, people often just put the survey out there, you get what you get, and analyze it from there. This time, we took a very intentional approach to gathering this data. Each week, we would get a report of who responded, and we would benchmark that data for representativeness of the population. In Hillsborough County, we really nailed representativeness. If you saw, for example, that 27% had high school degrees and were Hispanic—we mirrored that. Each week, we would look at the data, and then target the areas we needed. The over 5,000 responses are representative of the population of Hills County.

Secondly, all the data in the slide set, you will receive electronically afterwards. Additionally, you will see all the end values from the presentation. When Ashley was talking about 750 respondents out of 5,000 and then the race/ethnicity breakdown from there—you will receive all of that.

Now, we will ask you to dig deeper. When each of us sits down to work on our strategic implementation plan, we will use this input to inform a lot of that work.

Participatory analysis—you will use a data placemat with a variety of data points. It is high-level data, but very compelling data points. We will dig a lot deeper into that data. As the researchers mentioned earlier, we will be wandering around the room to answer questions.

Breakout Session – Focus Group

Tina Fischer and Rebecca Watson, SPC Collaborative Labs

Rebecca: I want to get you set up for the activity. I have a couple of pieces of information to share with you. Let me give you an overview. There are four things you will do. The first is, you will go to your team area and discover your focus area. Every team station has one focus area. You team will be looking at 1 of those 11 areas. The second thing is, you will take a look at those data placemats. Then, you want to discuss and answer the questions. Finally, we will ask you as a group to summarize your thoughts. We will hear a brief report out from every team at the end.

The way to know your team is to look on your agenda; it will have a table number listed in the green box.

Rebecca explained how to use ThinkTank.

Breakout Sessions – Team Reports

Tina Fischer, Manager, Collaborative Labs: Good morning; I am Tina Fischer – Rebecca had to leave for a luncheon, so I will be taking over from here.

Teams 1 & 2: Mental Health & Mental Disorders

Team 1

Team 2

Top 2-3 Overarching Thoughts/Ideas for this Topic for the Report Out

These are the top ideas brainstormed by Teams 1 & 2.

1. Don't have enough mental health first aid early on and this is not shared with all stakeholders, including parents and students.
2. We need to elevate mental health first aid to CPR status.
3. More early mental health education and intervention is needed in the school system.
4. Health care for mental health is not inclusive and high quality. Incomplete medical records for patients.
5. Find ways for non-profits to be able to better market the resources that they provide.
6. Reduce the stigma and normalize the conversation around mental health to make people feel safe/secure in searching out and receiving treatment.
7. Maybe establish a "mental health hub" for resources

What about this data surprises you? What stands out? What are the data telling us about health in our community?

1. Relationship between veterans and suicides using firearms
2. Veterans are at an extremely high risk
3. 25-44 is the greatest rate of age in Hillsborough County
4. The difficulty of accessing care and the stigma that is often attached to seeking treatment
5. Surprised that the number 12.3% thinking they would "be better off dead" is not higher. So many people on the elderly population are isolated socially.
6. Correlation between number of people available to help and satisfaction with relationships
7. Military population is trying to help in 25-44 age range through ED but not really getting the help they need
8. The rising number of respondents aged 75 and older that have utilized the ED for mental health issues (including suicide)
9. Children who are in foster care that need mental health services and the number of foster parents who also need mental health services as well
10. Suicide rate chart is showing an issue with gun control policies
11. The data is telling us that we still have a lot of work to do.
12. More data needed on this topic area
13. The data shows that there is a lot of unmet need in the community
14. People can have good insurance and still not have access to services
15. Mental Health is often an underlying issue for so many other problems.

16. We take so a medical approach more often than we refer to counseling and other non-medical services
17. Cultural norms also play a role in accessing mental health care
18. Stigma is not listed in data sources—this is surprising since stigma is a major issue
19. More ACEs = more thoughts of suicide or hurting themselves
20. There are some great resources in the area but because of budget issues they may not be able to market and get the word out about the services that they provide
21. Not getting help for mental health is leading to future issues and creating a cyclical pattern of mental health
22. People may not be correlating aces with their mental health and feelings of depression

What factors may explain some of the trends/data we are seeing?

1. Military base located in Tampa may be resulting in high rates of military suicide
2. One of the highest age ranges for ED utilization is 35-44 and this could be related to the stress of managing the home, family, children, work, etc. They may have aging parents that they are trying to care for as well.
3. People who have financial struggles are not able to cope with all the other things that they may face in life. Maybe consider a "tiered" system for addressing mental health.
4. There is a correlation between the use of firearms in Florida and in Hillsborough County. Guns are easily accessible and so often a person's mental health status is not considered when they are purchasing the firearm.
5. 17-year-olds and younger may not be accessing services and utilizing the ED due to being on their parent's insurance and they may not want their parents to know that they are struggling with mental illness
6. People need more awareness of the services that are available and how to access them.
7. Substance abuse rates increasing may be increasing mental health rates
8. No connection between mental health and substance abuse assistance programs/ silos
9. High cost for medical services that are not addressing all patients needs
10. High use of ED for health care is not inclusive care
11. Low health literacy and how to care for self as preventative medicine
12. Poor relationship or no relationship with a health care provider
13. No support system to help with care
14. Poor transportation so unable to get to care
15. Do not want to use health insurance for mental health care due to stigma
16. Finding doctor for treatment/wait list and quality of treatment

17. Medication not always paired with therapy
18. Lack of knowledge on how to assess someone with depression or mental health concerns. Lack of knowledge of services/where to go if they know someone who needs care
19. Over-parenting and children not building skills as they grow up.
20. Higher workload and expectations leading to anxiety.

Does this lead to new questions? What more do we want to know? What additional context do we need?

1. Use same sample for data comparison/ data from same years
2. What data is available for access to care? Hard to gather data from those who are not accessing it. Need to dive deeper into this area.
3. In the chart with ED visits it would be great to determine the causes of the visits (how many were suicide, etc.)
4. How do we know what interventions are actually working
5. What are all the barriers to access to care (insurance coverage, stigma, employee knowledge, resources in various areas of county)
6. How many of the people seen in the ED for Mental Health related issues went on to attempt/complete suicide
7. What facilities are available for services? In what areas of the county?
8. When are people coming to ER? Is ER used more often when other services are not open?
9. Is ED a call for help?
10. For ED visits: what was the breakdown between men and women and a breakdown of how many women were pregnant when they presented to the ED for mental health related issues
11. Attempted suicide data/rates
12. Since Mental Health is often silent, what strategies can be used to better recognize issues earlier
13. Do providers know the signs of mental illness?
14. Mental Health services within all schools in the county
15. How do you convince someone that they need more mental health services?
16. Data on bullying rates as a part of aces

Speaker, Team 1: Our first overarching theme was to elevate mental health first aid to CPR status in terms of accessibility and acceptability. Our second was a mental health resources hub for easy access, no matter where someone is.

Speaker, Team 2: Our response is – ditto. We talked about that there is not enough mental health first aid early on. They are starting it in the school system, but really, even in the doctors' offices, having the conversations, making it the norm to ask someone if they are considering suicide. It is really educating people on just asking that basic question.

We also talked about healthcare for mental health is not inclusive or high quality. The data is difficult. What we are seeing on the sheet is 2016, 2017, 2018 and 2019 data, so it was really hard to make some of the assumptions we wanted to make because it's not just one data set. Having some more information would be helpful.

Teams 3 & 4: Substance Abuse

Team 3

Team 4

Top 2-3 Overarching Thoughts/Ideas for this Topic for the Report Out

These are the top ideas brainstormed by Teams 3 & 4.

1. There is a need for more resources and information on available services for treatment and education on substance use.
2. Overall, this is a very high priority and needs to be carefully addressed while considering social determinants for the community/person. Need for identifying initial causes of "stress" or compounding factors that lead individuals to using/abusing substances.
3. Social (high-risk behaviors are social norms), economic, and marketing influences impact substance use.
4. Mental health is often associated with substance use. There is a need for better access to mental health providers and reduced stigma for seeking mental health treatment.
5. There is an overall need to provide education and referring resources to providers. Training for providers to know what to ask, how to start the conversation with patients, what's "really" going on in their life. There is a need for providers to understand how to explore these questions and referral sources for their communities/patients. Potential policy changes

What about this data surprises you? What stands out? What are the data telling us about health in our community?

1. Thought the percentage of poverty would be higher
2. Surprised by the low rate of current smokers in Hillsborough
3. Adult substance use is the most significant group according to ED data
4. Confusion as to why children/students are represented on data placemat. Is there a connection between adult parents SUD?
5. Overall binge drinking percentage is surprisingly high
6. What is the overall trend in nicotine-products? Vaping may have replaced cigarette use.
7. There is a misconception about the harm of vaping.
8. Surprised with ED visits for Substance Use age level. Highest group is 45-54 years
9. Alarming that 46% of survey participants with children also smoke in the home.
10. Is there a missing data point on middle school cigarette use?
11. Rates of illicit drug use doubles between middle and high school
12. General data shows a concern for 1 in 5 high school students using illicit drugs. Not "just" alcohol

What factors may explain some of the trends/data we are seeing?

1. Economics – the type of housing you live in, lack of affordable housing.

2. Alcohol skews the numbers in terms of substance use; it is not an illicit drug. Could be separated for more clarity.
3. How does ZIP code impact vape/e-cig use? Starter kits for e-cigs and cost of refills is significant.
4. How does the availability of cannabis-related products impact marijuana use among youth? Among adults?
5. Social and cultural practices. Alcohol is normalized in many settings; seeing other people in their community using alcohol.
6. Factors may include previous medical uses of opioids, but that leading to more use / heroin use…
7. Over prescribing may lead to substance abuse after disease/prescription
8. High school culture in the past has been about alcohol parties. Now in high school, due to social media making people constantly connected, teens do not need to gather in groups and drink for social connection. Substance use is more small groups or solitary (marijuana). Vaping is the cool thing now in middle and high school. How do parents deal with issues that did not exist in their youth (e.g. social media/vaping)?
9. Lack of education with disposing prescription drugs
10. Substance abuse is connected to behavioral/mental health. Can be a form of escape.
11. Social media is impacting mental health which is leading to substance use.
12. New technology / disposal bags
13. Coping/self-medication for mental health issues.
14. Youth are accessing opioids and other drugs through parents' use.
15. Prescriptions left over from older adults/parents in the home
16. Youth and adults are prescribed and over-prescribed prescription drugs (sometimes Adderall, etc.) And distributing or using inappropriately.
17. Poverty, lack of transportation, not being able to deal with/ support families… These are social determinants that lead to substance use and abuse
18. Access to treatment for substance use disorder is limited by access to healthcare and health insurance. Access is an issue especially for adolescents.
19. Trauma effecting/ fueling epidemic
20. Over-access to substances in affluent areas where youth and adults have extra resources.
21. Providers not supplying mental health/ behavioral health (or limited in what resources can be provided)
22. Lack of community provider knowledge/ understanding of substance abuse

23. No policies to back up

Does this lead to new questions? What more do we want to know? What additional context do we need?

1. How has nicotine-use shifted with vaping/e-cigarettes in youth? In adults?
2. How has marijuana-use trends changed with increased access to cannabis-related products?
3. How have these trends changed over time? In the last 5-10 years?
4. How do we get policies to give providers resources, education about what to do/ where to refer / what services to refer
5. How are we going to deal with the storage of providers (psychologist) / how are we going to attract students to this health specialty
6. What resources are available for substance use treatment? Preventive education? In schools? Communities? Where are the gaps in services?
7. There is a need for anti-vaping education and marketing/commercials (similar to cigarette campaigns).
8. How do we shorten the wait times to be seen by a provider (mental health professional)?
9. The trends adults are experiencing are related to their upbringing, which is different from the upbringing of current youth. The treatment approach may be different. Youth now are experiencing unique mental health challenges that will impact them throughout their life. Generational-specific treatment options are needed.
10. What is the rate of comorbidity between mental health and substance use disorder?
11. Insufficient mental providers and access
12. Need for/ to address social determinants and how they compound or interact with substance use/abuse
13. Utilization of "mid-level" practitioners (NP, PA)
14. Who is prescribing opioids? Do they have access to previous opioid-related criminal charges? Mental health records and family history of patients?
15. Try to address the underlying issues (depression), support parents and families. Community organizations need more training on mental health issues/ substance abuse. Education for where to refer

Speaker, Team 3: We really came up with a few things. The first thing we talked about is the need to educate providers on how to screen for substance abuse and what to do once you identify substance abuse. Another issue we came up

with was the need to have additional drop sites for prescription medications. The need to include social determinants—housing issues, poverty, access to food—that needs to be included. How do we address those issues and where do we get funding? Mental health and substance abuse are often co-occurring; we need to not silo those.

Speaker, Team 4: We hit on a few other things, and ditto on a couple they mentioned. There is a need for resources and information on treatment and education. We were looking at vaping—the idea that vaping is not as bad as cigarettes. When we look at the statistics for children, there needs to be more information available to them. We looked at the social and marketing impact. To come up with a plan, the reason why adults may be abusing substances can be entirely different than for students. Our society has changed so much in the past 5-10 years. Of course, that ties in to the mental health issue. A need for better access and reducing the stigma.

Team 5: Cancer

Top 2-3 Overarching Thoughts/Ideas for this Topic for the Report Out

These are the top ideas brainstormed by Team 5.

1. Simple, cultural-specific messaging surrounding healthy lifestyles, screenings, and resources, and best modes of communication
2. There is a need to dive deeper into the data related to age, geography (zip code and census tract), gender, cultural and ethnicity

What about this data surprises you? What stands out? What are the data telling us about health in our community?

1. The percentage of smokers - thought it would be higher than is reported
2. Hillsborough County is higher than the state for cancer death rate
3. Breast cancer death rate is not surprising
4. Men have higher cancer death rate than women
5. Not surprising that Blacks/AA have a higher cancer death rate

6. All cancer incidence rates in Hillsborough are higher than the state except melanoma
7. The childhood risk factor data is not surprising because of knowing the demographics from the survey

What factors may explain some of the trends/data we are seeing?

1. Aging population
2. Women tend to seek medical care more than men so men may have later stages of cancer
3. The cultural masculinity affects men seeking care
4. Environment (where you live) affects these rates
5. Education
6. Lack of resources and knowledge, access to care
7. Financial burdens
8. Lack of transportation to receive care
9. Understanding the oncology terminology - lack of health literacy
10. Genetic factors and comorbidities
11. Easier access to alcohol, spice, cigarettes, etc. In lower income communities. More convenient stores and fast food restaurants
12. Lacking access to medical providers in order to get cancer screenings
13. Lacking education in the community (specifically Black community) surrounding skin cancer
14. Lack of healthy lifestyles (food, exercise, etc.)

Does this lead to new questions? What more do we want to know? What additional context do we need?

1. Age breakdown of the data
2. Gender and race/ethnicity breakdown to target efforts
3. Zip code or census tract level data
4. Investigate which community programs are working vs. Not working. Program improvements and collaborations
5. Need of cultural competency in related to messaging and medical providers
6. How does referrals work (for screenings, diagnosis, etc.)
7. Include cancer screening data and trends
8. Need an understanding of county shift of demographics and geography
9. How does the migrant and farmworker community fit in to the data

10. How long have these patients been living in Hillsborough? Hillsborough has a high amount of transplants
11. How does Hillsborough compare to other counties?

Speaker: Within 1,000 square miles of Hillsborough County, our county has been able to outpace the state of Florida as it related to cancer deaths and many types of cancer. The solution is simple, cultural-specific messaging surrounding healthy lifestyles, screenings, and resources, and best modes of communication. Also, there is a need to dive deeper into the data related to age, geography (zip code and census tract), gender, culture, and ethnicity.

Teams 6 & 7: Exercise, Nutrition, & Weight

Team 6

Team 7

Top 2-3 Overarching Thoughts/Ideas for this Topic for the Report Out

These are the top ideas brainstormed by Teams 6 & 7.

1. People may not understand the definition of what is junk food and what is good exercise, better education on this could help (culturally sensitive education)
2. Generally, everything is going to worsen. Social media, electronics increase obesity. We are falling behind. We need lot of education and outreach and money!
3. Our topic looked at two separate problems: exercise/nutrition/obesity and food insecurity. These issues tend to affect the same population.

4. How to build each individual community to connect to each other. Going back to basic; family table, helping each other in the community
5. This is a key health issue related to/affecting most other categories of health priorities we are discussing today

What about this data surprises you? What stands out? What are the data telling us about health in our community?

1. Food insecure 25-34-year-olds not getting enough food
2. 40% of respondents with children in the home is a serious issue
3. Very surprise that parents are not giving junk food
4. Poverty and obesity go together, but also a correlation with poverty and food insecurity. Obesity rates doubled in 20 years with high schoolers.
5. They want to get healthy foods but can't based on financial assistance
6. 65 yo not indicate for food insecure
7. Surprised 70% say no to junk food every day, what do parents consider junk food?
8. Surprised only 32% said their kids don't exercise daily
9. Sugary drinks may not be soda, but energy drinks or sport drinks
10. Lack of knowledge, age and related issue could be from foreign born?
11. Surprise not higher rates of "safe parks and recreational facilities" compare to lower obesity rate
12. Good to see 87% feel safe in their neighborhood, positive finding
13. 27% food insecure but only 12% received emergency food. Is it from access, knowledge, transportation, capacity of the organizations providing food?
14. Eating junk food trend upward on stats obesity

What factors may explain some of the trends/data we are seeing?

1. In Wimauma, see a food desert area where people can get to Dollar General or convenience stores before getting to a grocery store
2. Time to cook healthy meals versus fast food
3. In South County the kids are outside more because they can't afford the electronic games
4. 36% feel there aren't good sidewalks, some families in urban areas may not feel comfortable letting kids outside. What age does it become safe at?
5. Fast food is most calorically dense and more affordable, go to that when funds are limited, can lead to obesity
6. Electronics causing obesity

7. Lack of safe neighborhood, streets may cause children not to go out
8. Cost of sports engagement, recreational facilities to be active
9. Lack of awareness that may be available for sports, recreational facilities
10. Poverty in area- food insecure
11. Need to focus on cultural component of education for how they traditionally eat or prepare food
12. Education could present a problem. Low education may result in low income to provide health foods
13. Lack of education on how to cook healthy, is being lost in today
14. Life skills not taught in school anymore; how to cook, budgeting skill

Does this lead to new questions? What more do we want to know? What additional context do we need?

1. Opportunity for businesses to reach out to people without healthy food access for education or providing food
2. Explanations of how people interpret the questions, what do exercise and junk food mean to them
3. Follow up question: If you felt food insecure, what did you do?
4. Weight—is the weight explained by definition? They understand?
5. Better understand the differences in who answered Qs 42,43,44 - big difference between 42 and 43
6. Do we know the age, or understanding literacy level of the survey questions
7. Probably not good representation of migrant population in survey. They have different needs and may not show up to a food pantry or other services because of concerns about immigration
8. Does the question ask about tech school? Some tech school graduates get higher income
9. Could the survey ask about nearby food pantry or would have gone to one
10. Other information on food insecure of various age groups, based on survey. Lack of representation on 65 yo and older group

Speaker, Team 6: Overall, we figured we will see a lot more issues with this because of our sedentary lifestyles and use of electronics. We need to bring back life skills in the school system. How to eat healthy, weight, exercise – we've lost that because we don't have multigenerational in the home anymore or talk to neighbors. We don't all have parks and fields near us. Unfortunately,

a lot of this will worsen. We need to education and have more resources, which means more money.

Speaker, Team 7: We looked at this issue – it is kind of two different issues. Even though obesity can disproportionately affect some of our poorer areas, as can food insecurity, but they are different.

What is junk food? People define that differently. What exactly define exercise? We need more information there. The food insecurity issue is another one. Some of our members pointed out that a lot of the groups that feel the most food insecure are not responding to the survey; for example, migrant populations. Obesity and nutrition and education is all linked to the other issues—diabetes, heart disease, etc.

Teams 8 & 9: Heart Disease & Stroke

Team 8

Team 9

Top 2-3 Overarching Thoughts/Ideas for this Topic for the Report Out

These are the top ideas brainstormed by Teams 8 & 9.

1. Need to strengthen community cohesion and education on risk factors and resources.
2. We need more data to make recommendations (particularly around sub categories (e.g. Demographic data such as age, ethnicity, literacy, zip code) and prevention.
3. Data is showing a lack of access to care and education about what is actually healthy.

4. Early intervention is needed at all access points - schools, etc. Be sure to reduce social stigma.
5. Before implementing interventions, there should be root cause analyses.
6. It's important to remember these problems are generational and we can't just do superficial solutions.

What about this data surprises you? What stands out? What are the data telling us about health in our community?

1. Surprised that Hispanic population exceed the African American population
2. Number of foreign born - expected to increase - linguistic
3. ED visits for uncontrolled blood pressure - numbers are surprising - interested to know what would be the reasons for that
4. Think about the lifestyle of the community and seeing what the data shows - lack of nutrition for children
5. Emphasizes the need for preventive care and education.
6. Disparities are surprising - looking and comparing at race.
7. Surprised about people's perception about what foods are healthy.
8. Surprised by the uncontrolled blood pressure ED visits for 45-64 age group
9. Not surprised by the ED number for hypertension. It solidifies the need for preventative care and access to care.
10. Younger population has high rates with hypertension
11. Interested in why numbers would be high
12. How does the incidence of ED visits and death rate relate to demographics and age? Where can we intervene?
13. People are using the ER for primary care.
14. There is an extremely high number of 45-to-64-year-olds visiting the ED for hypertension but a really low number of actual heart attacks in that age range.

What factors may explain some of the trends/data we are seeing?

1. People are using ERs as primary care.
2. Lifestyle issues starting in childhood - lack of healthy food/nutrition
3. Access to care issues - transportation
4. Is transportation the problem? Is it because the ER is free and the ER won't charge.
5. Lack of insurance - cost of care issues
6. Education is needed - health literacy

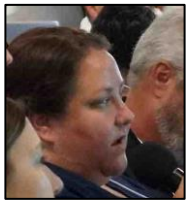
7. Elderly are dying from the disease because they are not getting the proper care because they are on a fixed budget. Also, it hurts their pride to have bills and not be able to pay them.
8. Affordability of proper medicine.
9. Nutrition and diet
10. Health literacy
11. Some great providers in Hillsborough County - hard to get to services
12. Afraid to hear what the doctor has to say - outcomes - prevents people from seeking care
13. Behavioral health and social service reasons: putting off care, other priorities in life that are more critical
14. Housing cost
15. Cultural Competency - when discussing diet and other factors - explaining disease process
16. Food deserts
17. Connecting care with where people are living - overcoming food insecurity, etc.
18. Cultural- and gender-based differences in approaching health. What is health? What is sick? Men sometimes wait until they are in more critical condition
19. Women are more proactive about health.
20. Having the resources to take care of yourself
21. Look beyond prescriptions for the solution to solving health issues - lifestyle changes
22. Need to address the cause not the symptoms
23. Concerns on side effects to medication - medication compliance
24. I think we have moved away from teaching what is proper nutrition. There are huge misconceptions about what is nutritious. They are advertising factors that affect this.
25. We aren't teaching people what is actually healthy. We are listening to corporations.
26. Lack of social capital/social cohesion; big county lot of transient people; social support/connectivity
27. Fad diets with no research backing
28. People feeling alienated - increased in depression/co-morbidities
29. Eating fast food due to matter of convenience or because lack of knowledge about what is healthy.
30. Providers perspective - so many people to see - little time to educate
31. Economic need. I run from my one job to another. Don't have time to be healthy.
32. Healthier foods and options are more expensive than unhealthy options.
33. Exercise numbers: IF kids are bad, adults are probably way worse.

34. Need to increase sense of community
35. Is there any PE anymore?
36. Primary care shortage across nations.
37. Church engagement
38. Is the problem isn't availability. It's whether people can get in when they need to and whether can pay
39. Language barriers

Does this lead to new questions? What more do we want to know? What additional context do we need?

1. Deeper dive in to the "why" - higher rates of ED use - numbers of people vs number of visits
2. Some may define a definition of "healthy" - deeper dive in to the responses - children's
3. What is the capacity for primary care and specialty care in our community?
4. Is there a disparity based on types of insurance and ability to pay?
5. IT would be interesting to see this data broken out at the zip level
6. What can be done to strengthen social cohesion in our communities?
7. More info about exercise and nutrition habits for ALL residents
8. Should we be rolling back the "virtualization" of physical education?
9. Connection to resources - access to internet, etc.
10. Is there a way to drill down to understand the cultural factors?
11. Are we underreporting the perspectives of cultural minorities?
12. Should we be determining health priorities based on this data given its bias?
13. WE need to ask about preventative habits. (do you go to an annual physical, do you have a primary care physician?)

Speaker, Team 8: We talked about the overall pervasive need being community cohesiveness and needing to underline community resources. There needs to be cohesion in the strategy. Early intervention and prevention are important—education and access.



Speaker, Team 9: We came to a lot of the same conclusions as the last team, with the need to strengthen the community and educate about risk factors and have resources throughout the community. We need a little more information to make our recommendations, looking at the data, such as how is junk food defined.

Obviously, prevention. We have gotten away from prevention; we need to get back to that. It is a key aspect. Also, access to primary care. The data shows lacking access to care and education about what is actually healthy. We have also decided that early intervention is needed at all access points, such as schools, to ensure we are reducing that social stigma.

Team 10: Diabetes

Top 2-3 Overarching Thoughts/Ideas for this Topic for the Report Out

These are the top ideas brainstormed by Team 10.

1. Parents perceptions related to exercise and diet habits may be different than reality
2. Access to resources/Cost/Food insecurity might be barriers
3. We would like to explore further the correlation between residents having a primary care provider and uncontrolled diabetes ED visits.

What about this data surprises you? What stands out? What are the data telling us about health in our community?

1. Adolescent obesity rates may be even higher based on data collected through county schools.
2. High rates of morbidity from diabetes in the AA/Black community
3. Lack of fruits vegetable consumed/lack of exercise
4. Maybe 60 minutes per day is too high of an expectation
5. Exercise diet/habits may differ between home, school, etc.
6. % of high school students with diabetes is higher in the county than in the state

What factors may explain some of the trends/data we are seeing?

1. Education/Awareness
2. Busy schedules of working parents, difficulty to cook healthy meals with limited time and resources
3. Strategic advertisement of unhealthy foods in low income zip codes.
4. 15.7 percent of residents living in poverty may contribute to diabetes rates
5. Some refugee children are experiencing chronic disease before coming to the U.S., difficulty adapting to processed foods, access to cultural foods might be more difficult
6. Cultural diets/habits
7. Knowledge of food labels
8. Not wanting to know of health issues/not wanting to take medications or being okay with taking lifetime medications
9. Multiple caregivers with different diet habits providing food
10. Stress eating

Does this lead to new questions? What more do we want to know? What additional context do we need?

1. Education/Awareness is there. How do they perceive their health risks? What motivates residents (children and adults) to change?
2. Are there undiagnosed residents?
3. Are providers following a standard of care?
4. What caused the huge decrease in ED visits between 55-64 and 65-74?
5. Are copays still an issue?
6. Are there communication issues between patients and providers related to medications and other issues?

Speaker: We saw the connection between exercise, weight, and diabetes, particularly within the child population. There seems to be a difference between the school data on childhood obesity and the survey results; we could address that disconnect.

Overarchingly, resources, access to food, cost of food, and the poverty rate were all factors in people having access to healthy food. With the adult population, we looked at the

correlation between having a primary care provider and instances of diabetes. Primary care and preventative care would reduce the instance of diabetes in the community.

Team 11: Immunization & Infectious Disease

Top 2-3 Overarching Thoughts/Ideas for this Topic for the Report Out

These are the top ideas brainstormed by Team 11.

1. A lot of what we can't figure out could be due to untreated behavioral health
2. Recognizing health behavior as distinct from mental health
3. We want to understand more of the underlying data - demographics, geography etc.

What about this data surprises you? What stands out? What are the data telling us about health in our community?

1. The number of children in Hills Co. below age of 5
2. The number of children far exceeds those enrolled in early learning programs...Is there an access problem?
3. Educational levels of the population are alarming; sets foundation for cultural challenges
4. HIV rates climbing amongst the AA community and associated HIV infection rates/new rates
5. Chlamydia cases are sky high.
6. What's going on in the 2-5-year age that increases vaccination rates so much? Kids are at higher risk at younger ages
7. Data does not represent pockets in the county- specific geographies need to be known
8. With all the vaccination locations readily available it is surprising that more aren't vaccinated

What factors may explain some of the trends/data we are seeing?

1. What explains the large racial disparity in HIV cases? Opioids? Unprotected sex?
2. Stigma- re: HIV care and men getting care for ANYTHING

3. Having an understanding that there is care available
4. Why aren't people accessing? Money, transportation, time, can't take time off of work. Is the access equitable? Are the ads and commercials reaching your demographic in the manner it should?
5. How can we assist in helping people get the care that they need?
6. Transient populations are a huge factor for populations around USF
7. Don't have enough physicians/clinicians that can talk about uncomfortable issues. Also, cultural competency plays in.
8. All goes back to equity and basic human relationships within clinical care (going when something is wrong, not preventive and wellness focused)
9. Lack of general understanding of the value of prevention. We need the math on ROI.
10. Generally the behavioral side is not included in the process. The issues they come to the doctor with are not clinical.
11. Lack of addressing the person- their mental health. Misunderstanding of mental health care that it means depression, anxiety, etc., rather than behavioral counseling. Could be disease based or not. Too much stigma involved.
12. Lack of ability to bill for helping people manage their health behavior in absence of mental health disorder?

Does this lead to new questions? What more do we want to know? What additional context do we need?

1. Who are the underlying demographics?
2. Want to know more about who are these people affected?
3. Wondering how long some infections go undiagnosed - symptoms aren't always obvious

Speaker: Let me start with commenting on the data. There was a tremendous interest in knowing more about the rise in HIV and Chlamydia. A lot of what we are seeing is due to untreated behavioral health. Also, recognizing that health behavior is distinct from mental health behavior. Some of the resistance is due to health-related behaviors.

Team 12: Respiratory Disease

Top 2-3 Overarching Thoughts/Ideas for this Topic for the Report Out

These are the top ideas brainstormed by Team 12.

1. Need for more health literacy
2. Need more year to year data on trends for all forms of smoking and related environmental factors
3. More specific data on what is meant by allergies

What about this data surprises you? What stands out? What are the data telling us about health in our community?

1. Number of people reporting children with allergies
2. ED visits for nicotine dependence vs asthma
3. Percentage of HS smoker is low
4. FL statistics vs Hills county statistics

What factors may explain some of the trends/data we are seeing?

1. Poor air quality - auto emissions
2. Climate fluctuations
3. Smoking decreased attributed to health literacy and ban on advertising
4. Health literacy on nicotine dependence
5. Access, cost of medication, health literacy
6. Lack of affordable and accessible housing
7. Appropriate avenues/resources for assistance with environmental housing issues for renters
8. Smoking bans in public places

Does this lead to new questions? What more do we want to know? What additional context do we need?

1. More data on old housing in East Tampa
2. What environmental factors contribute to allergies and asthma?
3. More data on environmental toxins

4. More data on rural vs urban areas; What toxins are causing respiratory issues in certain areas?
5. What is meant by “Allergies”?
6. Need more data on trends for all forms of smoking over time - vaping, hookah, marijuana use, tobacco, etc.
7. Need more data on under aged smokers - self reporting vs parents reporting
8. What other professions, outside of health care professionals, should be included in Respiratory Health discussions?

Speaker: We had a lot of discussion and came down to a common factor of the need for more health literacy and understanding of what you are being asked. We mentioned all forms of data because the data forms we looked at only mentioned cigarettes. There are other sources of environmental smoke that children are exposed to – vaping, marijuana. We also wanted to know more about what is affecting the asthma and allergy numbers.

Team 13: Maternal, Fetal, & Infant Health

Top 2-3 Overarching Thoughts/Ideas for this Topic for the Report Out

These are the top ideas brainstormed by Team 13.

1. Concept of community health worker. Meeting people where they're at, finding out what matters, and creating solutions with them. What is the culturally-appropriate response and how can we deliver it?
2. Looking deeper into the outcomes. Let the data guide our strategy to improve outcomes.
3. Taking ownership of one's health. How can we help people understand the importance of their health and care about themselves?
4. Identify the strengths as opposed to deficits

What about this data surprises you? What stands out? What are the data telling us about health in our community?

1. Surprised the breastfeeding rate is higher compared to the state rate
2. The disparities are high for births to young mothers and low birthweight
3. Surprised births to mothers within third trimester and no prenatal care are lower compared to state
4. Curious as to the trend for teen birth rate. Is it decreasing?
5. Surprised the median age is 37.1
6. Pregnancy interval of less than 18 months is high. Curious as to trend and status quo
7. Prevalence of health disparities among black/African-Americans and other minority populations
8. Idea that misinformation and cause of disparities could be reduced with education.
9. Need more community education around prenatal care, nutrition, etc.
10. Need to determine what in Black/African-American community is not being addressed. Is access the problem or just education?
11. Look at outcomes and provide care earlier to reduce negative health outcomes
12. How do we reach out earlier with intervention
13. How can we help young mothers overcome fear and access resources? How can we overcome cost and income as a barrier?
14. How did you differentiate between race and ethnicity in the survey?

What factors may explain some of the trends/data we are seeing?

1. People aren't getting care until they're pregnant
2. Highest graduation level is high school graduate/GED. Correlates to earning potentials. Ability to access care is extremely low when tied to income/education.
3. Ability to even know the resources are available
4. Median household income seems high but how many average people are in the household
5. Medi8an income is skewed by young individuals who may still live with their parents.
6. How does the population receive information? Need to strategize how to access certain minority populations to capture their opinions for the survey. Who is the spokesperson for those communities?
7. Cultural trends for minorities communities are tied to who is delivering the information to them. Is it someone who "looks like me"? Lack of trust in healthcare system. Counterculture
8. Activate community health workers. Instead of looking at deficits identify strengths

9. What is the percentage of people who are foreign-born?
10. Huge factor is insured vs uninsured. More willing to go to educational classes if they have access via insurance. Transportation and language barriers. Fear of deportation related to citizenship/legal status.

Does this lead to new questions? What more do we want to know? What additional context do we need?

1. Like to see more trend data, maybe past 3 or 5 years to help us see if we're improving over time
2. Looking where we're doing well and investigate why and how. Focus on what's working and sharing those with communities that are struggling
3. Start with what's working and build upon to educate further
4. Going back to target population and dig deeper to understand why they're not getting care and other barriers
5. Are the current resources in the community being utilized. If not, what is the barrier, stigma? Transportation?
6. How do we meet people where they're at and provide them with what they need at the time?
7. Language barriers. Need more Spanish, Creole, and Portuguese speakers to provide education.
8. How much knowledge/awareness does the community have about their help? Free services are available, but it needs to be valued. The individual needs to find that it's important to their health
9. Fear to face their health issues. Take ownership of their health
10. Take different approaches to education. Fear tactics do not work. Find out what they care about, what matters. Find representatives of the target population.
11. What type of messaging is available? Encourage community and family support?
12. Find out why a person is non-complaint with their care and how can we meet them where they are?
13. Teens need to hear messages from people who look like them or individuals they can relate to. Peer to peer education/advocacy.

Speaker: We had a very rich discussion. The biggest takeaways were exploring the concept of community health workers – meeting people where they are at and having someone talk to the community that is reflective of the community.

Also, about cultural competence being so important. For example, there was actually a higher-than-average breastfeeding rate than the state average – let's start with what is working. Where do we already have those opportunities and strengths?

Team 14: Access to Health Services

Top 2-3 Overarching Thoughts/Ideas for this Topic for the Report Out

These are the top ideas brainstormed by Team 14.

1. Recommend education about how to utilize and access services and this to needs to happen out in the community.
2. How can we incentivize providers to move into the communities that need them the most?
3. Look into options for medical transportation assistance in high need areas.

What about this data surprises you? What stands out? What are the data telling us about health in our community?

1. 48% of individuals cannot afford makes sense...what was in 'other'
2. Interested in how many people indicated cost as a barrier, however, data also says these folks should be having a hard time accessing care based on provider shortage area
3. Are there any incentives in the low-income areas for providers to set up clinics?
4. Providers in the low-income areas may have greater no shows due to increased barriers in care.

What factors may explain some of the trends/data we are seeing?

1. Low income areas face greater barriers to care
2. Parents are not able to take children to providers. Even if they had a car, they may not have gas or time to make the appointment if the provider is too far away. Transportation options may not be good for them or convenient.
3. Lack of education of the need for preventative care and positive health care behaviors. Accountability on the side of the parents to ensure this for their children.
4. 'Healthy' means something different to each generation and to each culture. We need deeper education about what is healthy, what are healthy behaviors.
5. Accountability for parents often comes from a pediatrician. Without that strong pediatrician providing advice and medical expertise, the parents are left on their own to make these decisions.
6. Provider time is limited due high patient...we many provider shortage areas in the community.

Does this lead to new questions? What more do we want to know? What additional context do we need?

1. How can we make doctors more available to those in hard to reach areas?
2. What are the barriers to the providers who are practicing in this area?
3. It looks like individuals in the data are insured, but many report that cost is still an issue...what can be done to alleviate this issue?
4. What is the correlation between those having trouble getting an appointment and transportation problems?
5. Recommend identify new ways to get out into the community to provide medical services.

Speaker: We realized that education is probably one of the biggest components of that access to healthcare. There is a high percentage of people who are not accessing primary care. How do we meet them where they are at and educate them there? We also looked at how can we reach out to providers. What about the areas with a lack of providers? How do we incentivize providers to come into those areas? Also, medical transportation in those high-need areas. How can we get access

to transportation? The Sunshine Line is a great resource for seniors – how can we get something like that for Medicare recipients?

Team 15: Oral Health

Top 2-3 Overarching Thoughts/Ideas for this Topic for the Report Out

These are the top ideas brainstormed by Team 15.

1. Case load of providers per individuals in the dental field.
2. Hours and locations of dental providers and how patients access those services.
3. Overall health and dental education of the public.
4. Awareness of community-based services and costs.

What about this data surprises you? What stands out? What are the data telling us about health in our community?

1. High patient load is surprising—1 per 1440.
2. The number of people that do not know where to access dental care.
3. It stands out that it appears we do not have enough dentists in the area.
4. There is a high number of people going to emergency dept for dental care.
5. Following up from #4 is that people are not getting preventative dental care.
6. Are people not able to afford dental insurance or do they not know where to get dental care?
7. Do people not know that self-pay is more cost effective than insured services for some individuals for preventative care (i.e. Cleanings)?
8. It's surprising that the fear associated with going to the dentist is not addressed/described in the data.
9. Curious if the 8% of individuals who had trouble getting an appointment is related to the shortage of dentists, or is this related to after-hours accessibility?
10. Relating to #9, individuals with dental insurance may access insurance through a work benefit plan. If someone works 8a-5p they may only be able to access dental care outside of their working hours…the ED is open all the time.

11. This data may not address the individuals who work part time jobs or jobs that do not carry a dental insurance benefit. Outside of work are people able to access dental insurance. If so, do they know how?
12. College students commonly fall within the Medicaid gap and cannot access dental care.
13. Colleges have student health services but may not necessarily have dentists on staff specifically for students. This does not include dental students but refers to access to dental cleanings and preventative care.
14. There are access gaps between students (i.e. International students and U.S. students).
15. Transportation access was surprising.

What factors may explain some of the trends/data we are seeing?

1. Does this relate back to health education, access to healthy foods, and lack of nutrition for children to have healthy teeth and gums?
2. Do the less affluent areas have a lack of dentists in these areas as compared to affluent areas?
3. Parents may feel that dental care is not as important for younger children due to the fact that they have baby teeth that will fall out.
4. Parents may not be aware of proper dental care practices and home dental care techniques.
5. Transportation challenges makes it more difficult for parents to access dental care - preventative as well as treatment.
6. Oral health is one of the most over looked health areas. People always think of their bodily health but do not realize that poor oral health can be an early indicator of overall health problems. People do not realize that tongue abscesses and oral health problems can quickly lead to greater health issues.
7. People do not know that a tooth brush needs to be changed out. If your toothbrush is in rough condition, it needs to be changed out.
8. Lack of education in school and children not getting home economics and basic health classes.
9. Low income relates back to all of these health issues.

Does this lead to new questions? What more do we want to know? What additional context do we need?

1. Is there a certain percentage or amount of charity care that dentists are required to provide? (similar to attorneys with the Florida Bar Association) Additionally, if so, do they get around this charity care rule by stating that Medicaid patients qualify in this category?
2. Does food insecurity lead to poorer dental health outcomes?
3. Even if people know what they need/should eat, does food access and cost relate back to these issues? It's cheaper to eat at fast food places than places with fresh fruits and vegetables. Again, considering the zip codes, food deserts and food swamps contribute to poor dental health.
4. We are seeing this from a large community point of view. Can we see this data broken down by zip code: how many dental providers are there by zip code?
5. Can we see this data broken down by zip codes but at different socio-ecological levels? (This way we can look at this data from a systematic level…are schools and larger organizations missing opportunities to help these communities?)

Speaker: We were concerned with the case loads of providers in the dental field. Is there a dental provider shortage across the county or in certain pockets?

We were also concerned with the hours and locations of dentists.

Overall health and dental education of the public – we thought this was key. We are interested to see what type of oral hygiene education is being offered.

An awareness of community-based services and cost. We weren't sure if people could not afford dental insurance, which is relatively cheap, or paying for emergencies without insurance.

Tina: A lot of rich discussion. I appreciate all of your input. We have two things left on our agenda after lunch. We will jump into Forces of Change at 12:40 and right after that, we will do the prioritization exercise. You can have some conversations during lunch, and then you will get to do some polling again on scope and severity and ability to impact. It will be exciting to see those results.

The participants enjoyed lunch.

Forces of Change

Dr. Ayesha Johnson, CHA/CHIP Lead, DOH-Hillsborough

Tina: At this time, I would like to invite Dr. Ayesha Johnson up to explain our next activity.

Dr. Ayesha Johnson, CHA/CHIP Lead, DOH-Hillsborough: That was some awesome lunch; thank you to those who provided it. Our next activity is another team activity. We will assess forces in our environment. This answers the question: What is occurring or may occur that affects the health of our community? There are trends, or patterns over time. Discrete elements, such as ethnicity or proximity to a bridge or highway. Events – closure of hospital, natural disaster. As an example, during 2016, participants identified the passage of the Affordable Care Act as a political event.

You will brainstorm as many forces of change as you can, and then decide to break one down further by looking at strengths, threats, and opportunities. From the example, a threat to the community was people being overwhelmed and not going for care, which presents an

opportunity to teach people how to navigate the health system. At your tables are examples, and we will be floating around to help with questions.

Tina: Thank you, let's give her a round of applause.

Tina explained how to use ThinkTank.

Forces of Change – Team Reports

Top Overarching Force of Change to further brainstorm Threats & Opportunities

These are the top ideas brainstormed by the participants.

1. Changing laws (certificate of need for building hospitals repealed)
2. Stigma of any health issue
3. Cultural competence
4. Funding
   a. Tax code changes
5. Population growth in Central Florida
6. Access
7. Gentrification and housing issues (including policy) leading to greater access issues. People are getting pushed out.
8. Elections (how districts are drawn)
9. Increase in consumerism - mobile clinics and building clinics in areas further out (remote/rural). Telehealth, standalone EDs
10. Low median income
11. Technological advancements
12. Technology
13. Increase in Discrimination and Racism
14. Insurance marketplace
15. Economic Development/Income Disparities

Brainstorm Forces of Change

These are the additional ideas brainstormed by the participants.

1. Climate Change

2. Hurricane
3. Constant immigration
4. Population Growth/Projections
5. Improved transportation system
6. Cost of living
7. Epidemics (Zika, EEE)
8. Elections
9. Population expansion
10. Law, policy
11. The Internet of things
12. Climate change
13. High homeless populations
14. Aging population
15. Increasing cost of healthcare
16. Gentrification
17. Health literacy
18. Environmental change
19. Terrorism
20. Fear of immigration enforcement
21. The possible repeal of the ACA
22. Rising sea levels
23. Birth rates
24. Economics
25. Impact of hurricanes and aftermath (e.g. Panama City)
26. Pandemics
27. Concentration of Wealth
28. Aging population
29. Growth of community "outnumbering" resources
30. Affordable housing
31. Requirements around funding or ability to receive monies
32. Lack of providers or proximity to providers
33. Fear of immigrants
34. Certificate of need deregulation (legislative changes that affect delivery of healthcare)
35. New technology
36. Funding changes

37. Fear of terror threats
38. Increased rates of nicotine
39. Mental Health
40. Hurricanes
41. Economic Depression
42. Displacements from storms
43. Increased rates of opioid use
44. Growing rise in the aging population
45. Political changes that affect healthcare
46. Political change
47. Social Media
48. Lack of affordable housing
49. Political distain for health care
50. Sustainability, cost of living
51. Business agendas
52. Medicare for all is in the news
53. Social isolation
54. Social Cohesiveness
55. Cultural Diversity
56. Transportation
57. Transportation
58. Uncertainty of political influence
59. Diversity change in the population
60. Roe vs Wade
61. Cost of healthcare; economic strain
62. Refugee population increases
63. Environment/Disasters
64. Transportation and gentrification
65. Health Insurance changes
66. Transportation issues
67. LGBTQ+
68. Relocation of low-income housing
69. MacDill closing???
70. Immigration Policy
71. Elimination of certificate of need

72. Growing number of retirees; increased burden on SS/Medicare; longer lifespans
73. Generational influences
74. Housing cost
75. Political and Policy Landscape
76. Population growth
77. Political Landscape
78. Migration movement from Brazil, Vietnam, Somali and other countries
79. Awareness/marketing of resources
80. Use of social media and technology advancements
81. Shrinkage of workforce in healthcare
82. Upcoming local, state and federal elections
83. Increase in prices of housing/renting (affordable housing)
84. Elections
85. Infrastructure
86. Apocalypse
87. Criminal Justice Reform
88. Social Justice
89. Gentrification
90. Stress
91. Global Warming
92. Funding allocation (changes)
93. Government response to the opioid crisis statewide and nationally
94. Unemployment rates
95. Changing licensure regulations
96. 2020 election
97. Economic disparities, even within one neighborhood
98. Technology and social media rise
99. Regulation of insurance policies (coverage for different services for example in-patient vs out-patient)
100. Increase in mental health issues
101. Humanity, lack of human touch
102. Healthcare policy
103. Unexpected disasters (hurricane, mass casualty)
104. Population Migration to Florida
105. The spread of mis-information via social media

106. Behavioral health is getting "cooler"
107. Education; school system
108. Cost of education
109. Increase in acts of violence (gun violence and school communities) affects communities in different ways
110. Plant based movement
111. Food insecurity is a hot topic too
112. Generational divide
113. Innovation (use of AI and analytics)
114. Automated vehicles
115. Hurricanes/Disaster Preparedness
116. Technology
117. The growing digital divide between various groups (low income, aging)
118. Certificate of Need Repeal for hospitals
119. Opioid Crisis/Mental Health Awareness/Increase in substance abuse
120. Medical Marijuana
121. Affordable Care Act unknowns
122. Affordable Housing
123. Transportation (Lack of)
124. Shifting in demographics, aging population
125. Education system change (superintendent and sales tax increase)
126. Funding of health priority in school system
127. Poverty
128. Policy and low-income populations
129. Access to more people
130. Increased access and benefits
131. Insurance marketplace
132. Economic Development/Income Disparities

Team 1: Elections (How Districts are Drawn)

Consider the top force of change you selected. What specific OPPORTUNITIES are generated by this force?

1. Awareness that EVERY election counts. Local, State, and Federal
2. Hold those that are elected accountable

3. Increased knowledge about who is running for office
4. Recruiting candidates who represent the population
5. Knowing your district/representative area
6. Knowing the candidates that are aware of community health needs
7. People need to support the initiatives of candidates that they believe in....support them financially if possible

Consider the top force of change you selected. What specific THREATS are generated by this force?

1. Apathy
2. Ignorance
3. Partisanship
4. Barriers to getting to polls
5. More citizenship training for children and adults
6. Disenfranchisement
7. Immigration policy
8. Voter Rights
9. Who is not voting and why?
10. How resources are determined and allocated
11. Non-profit funding

Team 2: Stigma of Any Health Issue

Consider the top force of change you selected. What specific OPPORTUNITIES are generated by this force?

1. Education
2. Explore the greatest stigmas in our community, educate the community
3. Enhanced and detailed patient/doctor conversations about health issues to get to the root issues
4. Collaboration between community members
5. New initiatives to allow people to be anonymous while sharing their health/mental health concerns
6. Incentives for those who speak out about their health issue.
7. Increase number of mobile crisis units and market these services.

8. Community messages/mass media through different avenues, including buses and billboards.
9. Teen support groups.
10. Culturally competent education material/communication.
11. Employees/staffing that meets patients' cultural needs. Lead to feelings of safety/security when speaking to health care provider
12. Increase the exposure in the community leading to acceptance in the community.

Consider the top force of change you selected. What specific THREATS are generated by this force?

1. Underreporting of health issues
2. Under-treatment of health/mental health concerns because of reduced reporting
3. Negative health outcomes
4. Homelessness as a result of not treating mental health problems—leads to unemployment
5. Increased debt
6. Lack of health prevention services causing major health issues
7. Increased substance abuse
8. Isolation
9. Increased abuse due to parents not accepting child's health concern
10. Higher incarceration
11. Increased suicide rates

Team 3: Funding

Consider the top force of change you selected. What specific OPPORTUNITIES are generated by this force?

1. Change tax code for donations
2. Better coordination in grants (streamlining requirements)
3. Collaborations with like-minded organizations, maybe better use of resources
4. Pooling data collection efforts or access to public databases
5. Universal outcomes
6. Creative ways for individuals to receive services
7. Insurance companies partnerships
8. Partnerships with hospitals, counties
9. Increase Medicaid reimbursement rates

Consider the top force of change you selected. What specific THREATS are generated by this force?

1. Tax code changes
2. Growth in the community cannot be met with the resources available
3. Requirements of grants (i.e. Compliance, data, outcomes measures)
4. Benefit to donors / grantor
5. Government funding / formulas
6. Spreading grant monies "thin" or redirect which may reduce impact
7. Individual desire to seek better health
8. Social determinants of health, medical or political
9. Medical expenses
10. Type of insurance accepted
11. Medicaid rates

Team 4: Population Growth in Central Florida

Consider the top force of change you selected. What specific OPPORTUNITIES are generated by this force?

1. Innovation and diverse thinking.
2. Growing workforce.
3. More income and tax revenue, possibly driving economic improvement through business development and infrastructure growth.
4. Economic development
5. Increased collaboration across sectors and organizations with common goals.
6. Community-based solutions (e.g. Community gardens)
7. Charter schools to increase education equity
8. Increased representation in the House of Representatives (increased voice in national policy).
9. Better public transportation.

Consider the top force of change you selected. What specific THREATS are generated by this force?

1. More uninsured residents.
2. Gentrification.
3. Scarcity in healthcare providers and resources.
4. Environmental impact (air quality, green space, recreational amenities, farm/agri. production space, etc.).
5. Increased cost of living and lack of affordable housing.
6. Increased food insecurity.
7. Cultural and language barriers and sensitivity due to diversity.
8. Scarcity in quality education resources.
9. Worsening traffic/ commute times/ transportation options.
10. Stress in communities and individuals

Team 5: Insurance Marketplace

Consider the top force of change you selected. What specific OPPORTUNITIES are generated by this force?

1. Increased access and benefits
2. Extended benefits (e.g. dependents up to age 26)
3. Increase health insurers
4. Medicaid expansion
5. Increase taxes to cover costs
6. Reimburse providers based on quality of care

Consider the top force of change you selected. What specific THREATS are generated by this force?

1. Technology changes
2. Not being able to afford insurance, copays, deductibles, etc.
3. Income requirements
4. CMS reimbursements

Team 6: Technology

Consider the top force of change you selected. What specific OPPORTUNITIES are generated by this force?

1. Telehealth
2. Basic life skills
3. Health data to increase health information; watches, electronics
4. Education relating to weight, nutrition, exercise
5. Ai interaction for elderly population, decrease social isolation
6. Early prevention using technology; reaching where they are at
7. Learning programs on physical activity, and nutrition education
8. Scribe in doctor visit to allow doctor to have better communication with patients
9. Health information exchange; allow patient's health to follow with them from doctor to doctor

Consider the top force of change you selected. What specific THREATS are generated by this force?

1. Personal data breaches
2. Human isolation
3. Misinformation, incorrect information on internet
4. Lack of ease on website
5. Misdiagnose on telehealth, better to go in person
6. As technology advances, decrease the human touch. Lack of human interaction; office visit using telehealth

Team 7: Changing Laws (certificate of need for building hospitals repealed)

Consider the top force of change you selected. What specific OPPORTUNITIES are generated by this force?

1. Lower cost for patients through allowing overnight stays in ambulatory surgery centers, expanding powers of RNs
2. Price transparency with competition from new hospitals/surgery centers

3. Quality for hospitals will be extra important due to competition (for conditions where patients can make a choice)

Consider the top force of change you selected. What specific THREATS are generated by this force?

1. Hospitals don't need to be built in area of need, may lead to less hospitals in underserved areas and saturation in areas with more resources
2. Hospitals with EDs will have lower profits if higher profit non-emergency surgeries move to smaller facilities (will need to be subsidized by government to stay open)

Team 8: Increase in Discrimination and Racism

Consider the top force of change you selected. What specific OPPORTUNITIES are generated by this force?

1. Increase awareness and building understanding.
2. Ensuring representativeness and advocacy for groups typically left out of the conversations
3. Structural Racism - Health in all policies review - ensuring equity is addressed in all policies
4. Provider education/cultural competency among all sectors
5. Reducing language barriers - Adding Creole

Consider the top force of change you selected. What specific THREATS are generated by this force?

1. Political environment
2. Understanding of people who can always learn more - this is a lifelong learning opportunity - people often think they have a full understanding, but don't
3. Segmented - reduction in understanding of other cultures and demographic groups causes gap in disparities and equity
4. Funding - issue
5. Hate Crimes, Violence, issues with safety, mental health, disparity, economic issues/disparity increase
6. Loss of talent, potential

7. Lot of training needed - how to implement that/lack of funding - people are always resistant
8. How to make an impact on those resistant to change.

Team 9: Gentrification and Housing Issues (including Policy) Leading to Greater Access Issues (People are getting pushed out)

Consider the top force of change you selected. What specific OPPORTUNITIES are generated by this force?

1. Telehealth
2. Mobile healthcare
3. Reimbursement for telehealth
4. Reimbursement for healthy food
5. Non-traditional healthcare delivery mechanisms
6. Focus on increasing access to wellness/health
7. Reimbursement or incentives for health/wellness programs
8. Fix the roads!
9. Investment in infrastructure (better planning—public health focused—"well cities")
10. True housing reform as a part of a community plan
11. Improving access to grocery stores or food markets or food trucks or stocking the available stores with healthy food
12. Improved lighting
13. Alternate modes of transportation

Consider the top force of change you selected. What specific THREATS are generated by this force?

1. Lack of nutrition and healthcare
2. Food deserts
3. Isolation
4. Worse mental health
5. Lack of access to services in general
6. Dispersed communities
7. Segregation
8. Growth of economic gap between rich and poor
9. Reduced consciousness of disparity
10. Homeless population growth

11. Increased infectious disease
12. Overpopulation

Team 10: Technological Advancement

Consider the top force of change you selected. What specific OPPORTUNITIES are generated by this force?

1. Access to more people
2. Targeting positive messages to specific populations
3. Electronic medical records, devices, apps
4. Telehealth
5. Reduce costs
6. Rapid access/convenience
7. Research- access to the most update scope of care and medications

Consider the top force of change you selected. What specific THREATS are generated by this force?

1. Cybersecurity
2. Lack of access to the internet
3. Barriers of the aging population
4. Barriers of rural populations
5. Access to electronic devices
6. Distracted driving
7. Unreliable news and health resources
8. Access to connectivity
9. Cost of devices and internet access
10. Lack of technology training
11. Impacts to economy

Team 11: Access

Consider the top force of change you selected. What specific OPPORTUNITIES are generated by this force?

1. Support for the notion for a minimum wage increase
2. Mobile strategies/telehealth

3. Input into transportation improvements to improve access
4. Policies to increase equity
5. More covered services in insurance policies
6. General medical insurance/culture that includes total body - dental, eye services and mental health, for example
7. Increased medical/health literacy and awareness of services available
8. Creative incentivizing to change behavior and engage in care
9. Uber health, etc.

Consider the top force of change you selected. What specific THREATS are generated by this force?

1. A giant storm would uncover all kinds of cracks in the system
2. Increasing costs
3. Finite resources
4. Not enough care providers
5. Uninsured, under-insured and high co-pays make it impossible for many to access care
6. Multiple insurances to cover the whole body
7. Political changes and decisions
8. A emerging disease outbreak
9. Competing and increasing costs for other life responsibilities—housing, etc.

Team 12: Cultural Competence

Consider the top force of change you selected. What specific OPPORTUNITIES are generated by this force?

1. Opening of dialogue to learn from, with and about that reduced barriers and increases health literacy
2. Less instances of assumptions. Increased personal growth (individual and institution),
3. Opportunity for better quality of live for community as a whole; building and expanding community; caring for each other; building connections
4. Building, increasing, establishing advocacy

Consider the top force of change you selected. What specific THREATS are generated by this force?

1. Demand of allocation of limited resources

2. Self-preservation
3. Us vs them
4. Lack of tolerance and inclusivity

Team 13: Increase in Consumerism – mobile clinics and building clinics in areas further out (remote/rural), Telehealth, standalone EDs

Consider the top force of change you selected. What specific OPPORTUNITIES are generated by this force?

1. Increase accessibility to health care services which will address barrier of transportation. May increase trust and feeling safe (to avoid stigma). Removes barrier of childcare as well. Decreases costs. You can reach people further away.
2. Find the right provider who may speak the same language as you and be culturally competent. Improves compliance overall and engagement in care.
3. People can text-in and receive a response from a health professional which increases access.

Consider the top force of change you selected. What specific THREATS are generated by this force?

1. Lack of trust with telehealth and technology. Privacy concerns. Generational, younger populations feel more comfortable with technology. How do we make it affordable? Can it be covered by Medicaid/Medicare? Sometimes individual rejects technology.
2. Resistance from providers to learn and use technology
3. Is the technology reliable and safe? Still many issues with privacy - don't want identity theft
4. Insurance reimbursement for copays related to medical technology and telehealth.
5. Limited availability of mobile clinic (for example only once a month)
6. Standalone EDs don't do enough to provide care for diabetes for example providing prescriptions. Cost is also a barrier.

Team 14: Low Median Income

Consider the top force of change you selected. What specific OPPORTUNITIES are generated by this force?

1. One-cent sales tax increase for transportation…mostly focused on transit will benefit low income populations
2. State law allowing Medicaid patients to utilize ride share services (Uber/LYFT) to get to and from medical transportation needs.
3. Opportunity to increase telehealth services and increase policies improving coverage of these services

Consider the top force of change you selected. What specific THREATS are generated by this force?

1. Allocation of resources are being reduced for these populations
2. Certificate of Need Repeal - health care services moving into high income areas instead of low income. May affect non-profit hospitals who are required to take in low income populations. Patients with ability to pay/have adequate coverage often offset costs of low-income patients.
3. Reimbursement is lower for Medicare/Medicaid populations.
4. Availability of affordable housing has a significant impact on rent costs and can increase cases of homelessness.
5. One-cent sales tax for transportation - lawsuit pending related to language of amendment surrounding allocation of dollars

Team 15: Economic Development

Consider the top force of change you selected. What specific OPPORTUNITIES are generated by this force?

1. Household increased income
2. Increased access to services
3. More jobs
4. Greater awareness of services, programs, and all of the above
5. Greater stability
6. Less stress
7. Greater economic development creates resources, access to services, and increased access to healthcare
8. More opportunities for fresh fruits and vegetables

9. Ability to plan for transportation and walkable areas
10. Ability to afford better options

Consider the top force of change you selected. What specific THREATS are generated by this force?

1. Gentrification
2. Disrupts existing communities and structures
3. Can create low paying jobs
4. Transportation planning issues
5. Increased stress

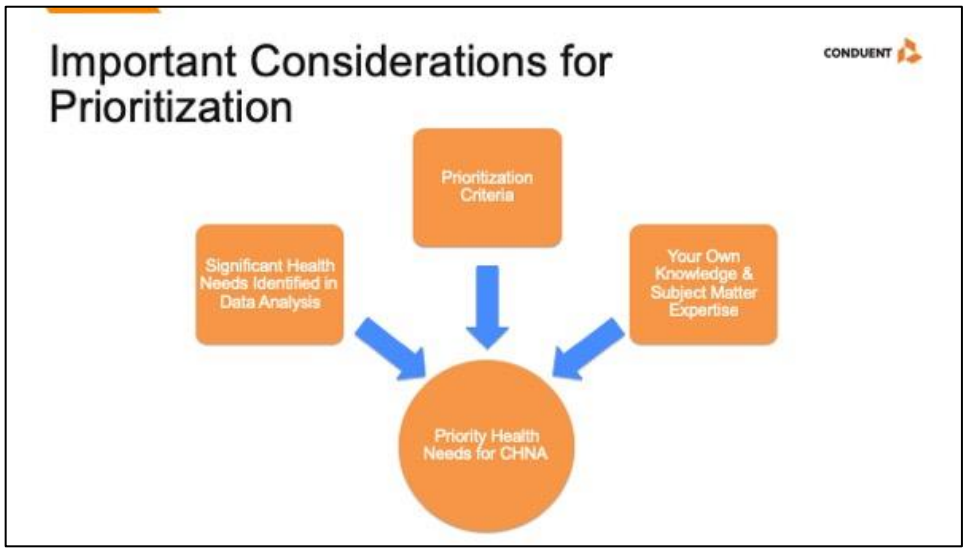
Dr. Johnson: From our last cycle, discussing the Affordable Care Act and the opportunities helped us make our plans to help sign people up for insurance and to teach people how to navigate the health system. We do value the input and the information will really help us.

Prioritization Session

Ashley Wendt, Healthy Communities Institute

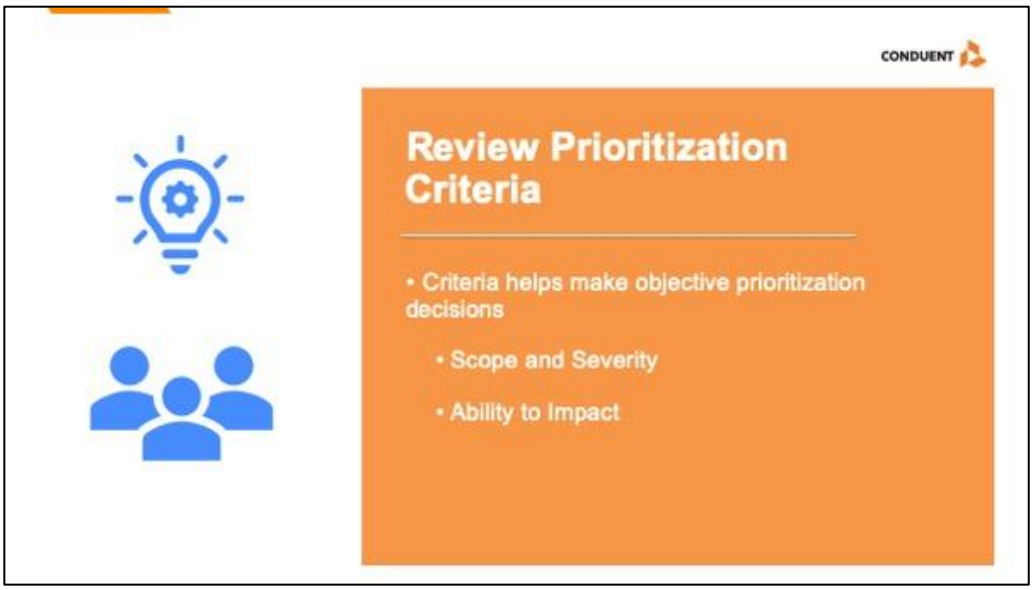
Tina: Now, we are ready for the final exercise. We will do some polling on scope and severity and impact.

Ashley: I want to move you mentally back into this process for prioritization where we will look at the 11 categories from this morning.



Ashley: A few important considerations: the 11 health categories; I will review the prioritization criteria; and then, your own knowledge and expertise. We have a diverse group here today, and we want all your different input.

Ashley: A reminder of the 11 top community health needs.



Ashley: I do want to briefly review the criteria we will use as we prioritize. With scope and severity, we want you to think about how pervasive this issue is in your community. With ability to impact, how easily can we impact or address this health need in the cycle that is coming up in the next three years.

We have a series of slides that we will go through and ask you to vote, first on scope and severity and then on ability to impact.

Tina: Now we have the dubious honor of calculating these results in real time. While we do, I am going to invite Liora up to show you a demo. Let's give her a round of applause.

Liora Fiksel, CHI, demonstrated the platform for a CHI partnership in North Carolina.

Tina: The results are in! This is the 11 areas prioritized by you all today. This is the average of the score between scope and severity and ability to impact.

Focus Area	Average
Mental Health & Mental Disorders	8.47
Access to Health Services	8.28
Exercise, Nutrition, & Weight	7.82
Substance Abuse	7.505
Diabetes	6.88
Maternal, Fetal, & Infant Health	6.85
Heart Disease & Stroke	6.725
Immunization & Infectious Disease	6.61
Cancer	6.365
Oral Health	6.11
Respiratory Disease	5.52

Tina: You will receive a copy of the Real-time Record after today. All this information, along with photos, will be delivered to you.

I have three things left. On your tables, there is a Collaborative Labs call to action card, if you would like to partner with us on any other endeavors.

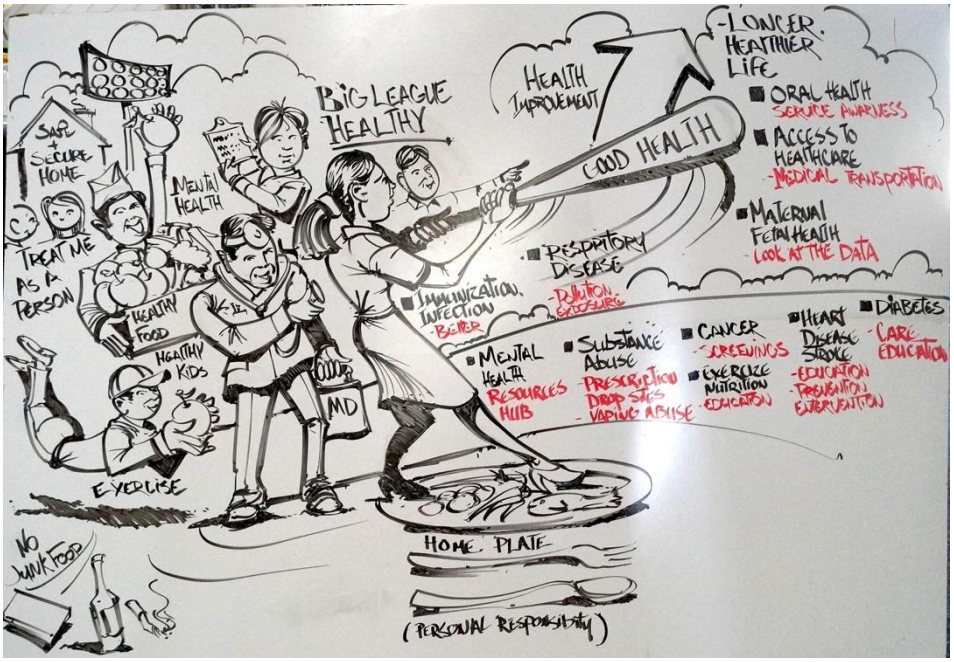
Artwork

Tina: I would like to bring our artist Jonathan up so he can talk through his illustration.

Jonathan: It's pretty cool to draw at Steinbrenner Field; I will remember this. Coming in here, I said, let's play with baseball. So, we started with the idea of big league healthy. What does it take to have good health? It starts with the home plate – get it, *home* plate? *Applause.* Home plate is the analogy for the

personal responsibilities. I can put some vegetables on my plate. I can take responsibly for some of those things. But just like a big leaguer, you have an entourage – doctors, grocery stores, mental health services. All those things factor into how I perform. Then, we think about kids. What can we do for kids? Start them off with healthful food and exercise so they can be big-league healthy. That's pretty much it. Thank you.

Tina: Jonathan will take this to full-color, and it will be a part of your Real-time Record.



Final Comments/Next Steps

Tina: Dr. Johnson will say a few words to close.

Dr. Johnson: There are evaluations in your folders; please take the time to fill them out. There are also comment cards in the middle of the tables if you want to add anything else.

This has indeed been a productive day, wouldn't you say? *Applause.* First, we walked through our data with our HCI consultants, so we thank you for that. Then, we analyzed what surprised us about the data. Then, we further brainstormed forces of change, and finally, we worked together to prioritize.

People are already working on plans for these focus areas. I really want to thank everybody for coming today. Now is when the work actually begins – we want everyone to stay engaged. Thank you for taking pretty much a whole day to sit here with us and decide how to best support our community.

INSIDE OF BACK COVER

The Essential Public Health Services and Core Functions

Source: Center for Disease Control and Prevention and National Public Health Performance Standards (January 2015)