Florida HEALTH
Hillsborough County

Florida Department of Health in Hillsborough County

Community Health Improvement Plan 2020–2025

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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

Revisions Table

Date	Revision number	Description of Change	Pages affected	Reviewed or changed by
5/20/20	1.0	Goal for "Access to Health Services" priority area was updated	9	Consensus Steering Committee
5/20/20	2.1	Activities 11 -14 were added to "Access to Health Services" implementation plan	11	Consensus Steering Committee
5/20/20	2.2	Activities 5-9 were added to "Exercise, Nutrition and Weight (2.1)" implementation plan	13, 14	Consensus Steering Committee
8/4/20	3.1	Updated Appendix to reflect switch from monthly to quarterly meetings	34	Consensus Steering Committee
8/5/20	3.2	Updated Appendix to reflect new and former members of Steering Committee	33	CHA/CHIP Lead
9/1/20	4.0	Updated cover to address PHAB recommendation to include date of revision	Front cover	CHA/CHIP Lead
9/1/20	5.0	Numbered priority areas to address PHAB recommendation	9, 12, 15, 16, 20	CHA/CHIP Lead
9/1/20	6.0	Updated members on workgroups to staffing changes	9, 12, 15, 16, 20	CHA/CHIP Lead
9/15/20	7.0	Updated Introduction to reflect correct branding of BayCare Healthcare Systems and AdventHealth	2	CHA/CHIP Lead

Date	Revision number	Description of Change	Pages affected	Reviewed or changed by
11/3/20	8.1	SMART objectives for "Access to Health Services" and "Exercise, Nutrition and Weight" priority areas were updated to include baseline and target	9, 12, 15	Consensus Steering Committee
11/3/20	8.2	Activities in implementation plans were updated to reflect alignment with new SMART objectives	9-15	Consensus Steering Committee
11/3/20	9.0	Start and end dates on implementation plans were revised and updated according to CHIP quarterly monitoring tools	9-19, 22-23	Consensus Steering Committee
11/25/20	10.0	Infographic on the 10 Essential Public Health Services was updated to reflect 2020 version	Back cover	CHA/CHIP Lead
11/30/20	11.0	Updated chart on CHIP alignment with internal plans and initiatives to reflect DOH 2021-2025 Strategic Plan	29	DOH CHA/CHIP Lead
11/30/20	12.0	Added chart detailing alignment of CHIP goals with Healthy People 2030 objectives	32	DOH CHA/CHIP Lead
11/30/20	13.0	Updated Table of Contents page numbers	1	CHA/CHIP Lead

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INTRODUCTION

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 participating as AdventHealth), Moffitt Cancer Center, St. Joseph's Hospitals and Florida Baptist Hospital (now participating as BayCare Health System), 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, 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.

The complete CHA report, along with this CHIP report, are available by clicking here at the Florida Department of Health in Hillsborough County website. Or you can scan

Figure 1: Most Important Health Issues

DOH–Hillsborough CHIP Priority Areas and Goals

CHIP Priority Areas	Goals
Behavioral Health	To improve mental health and reduce substance abuse in adults and youth in Hillsborough, Pasco, Pinellas, and Polk counties.
Access to Health Services	To support existing efforts to increase access to health services.
Exercise, Nutrition & Weight	To reduce food insecurity through local DOH systems changes and policy initiatives related to economic development.
Health Literacy	To provide DOH staff with a health literacy initiative relevant to their jobs and personal lives and increase health literacy capacity.

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 (*for chart updated in 2020, see back cover*)

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.

IMPLEMENTATION PLANS

The results of the four MAPP assessments, community discussions and a review of assets, were used by partners to create implementation plans for the CHIP priority areas of focus. Healthy Hillsborough Steering Committee members have developed implementation plans for the priority areas Access to Health Services and Exercise, Nutrition & Weight. The implementation plans are presented below. Evidenced–based, practice–based, or promising practices were considered for each implementation plan as well as policy and system changes needed to accomplish action steps. Partners also considered how best to address social determinants of health through the implementation plans. In developing the Exercise, Nutrition and Weight (ENW) implementation plan, the steering committee sought input from local area Community Development Corporations. This was aimed at understanding their work in addressing affordable housing in their communities, as housing is a social determinant of health that is closely related to food insecurity. The second implementation plans developed in the area of Exercise, Nutrition & Weight has the goal of screening DOH-Hillsborough clients for social determinant of health and then helping clients by making referrals.

Priority Area 1.1: Access to Health Services

Implementation Plan Workgroup Co–Chairs: Dr. Ayesha Johnson*, Grisel Cisneros** (DOH-Hillsborough); Harold Jackson (Tampa Family Health Centers)

Implementation Plan Workgroup Members: Dr. Ayesha Johnson*, Dr. Leslene Gordon, Allison Nguyen, Grace Liggett*, Grisel Cisneros** (DOH-Hillsborough); Kimberly Williams (AdventHealth), Colleen Mangan, Vasthi Ciceron (BayCare), Tamika Powe (Tampa General Hospital), Stephanie Sambatakos (Johns Hopkins All Children's Hospital), Jenna Davis (Moffitt Cancer Center), Harold Jackson (Tampa Family Health Centers), Sherri Gay (Suncoast Community Health Centers) **former member* ***new member*

Relevant Health Indicators:

- Navigator needs identified
- 37% of adults have an unmet health need (CHA, 2019)
- 18% of adults with children in their home have an unmet health need (CHA, 2019)
- 67% of adults have a personal doctor (BRFSS, 2016)

Goal: Promote and support services that connect community members with health and social services.

SMART Objective : By July 2025, increase the number of people trained in health and social service navigation from 22 navigators (2019) to 27 navigators annually.

Strategy: Research and Collaboration

Activities	Lead	Output (Products)	Status	Date	
				Start	End
1. Create navigator survey.	DOH	Electronic survey created	Complete	10/25/2019	11/05/2019
2. Distribute survey to patient navigators, care coordinators, etc.	Steering Committee	Feedback from navigators	In progress	11/05/2019	01/10/2020
3. Summarize survey results.	DOH	Report summary	Complete	01/10/2020	01/30/2020

Activities	Lead	Output (Products)	Status	Date	
				Start	End
4. Reaching out to identify existing navigator networks.	Steering Committee	Guests attend meeting	Complete	01/17/2020	07/01/2020
5. Invite 211, and other community partners to discuss gaps in services.	Steering Committee	Guests attend meeting	On going	01/17/2020	07/01/2020
6. Update implementation plan to include new research resulting from research and collaboration.	Steering Committee	Updated Implementation Plan	On schedule	02/21/2020	07/01/2020
7. Make policy recommendations.	Steering Committee	Policy recommendations	On schedule	07/01/2020	12/31/2020
8. Schedule at least one community resource meeting / conference for patient navigators / care coordinators, etc.	DOH	Meeting scheduled	On schedule	07/01/2020	10/31/2020
9. Explore options to collaborate with 211 to systematically update their database.	Steering committee	Systematic update framework implemented	On Schedule	03/01/2020	12/31/2020
10. Provide update to the steering committee on BayCare's resource referral Aunt Bertha platform.	Colleen Mangan / Vasthi Ciceron	Update provided at steering committee meeting.	On schedule	01/01/2021	12/21/2021

Activities	Lead	Output (Products)	Status	Date	
				Start	End
11. Engage Family Healthcare Foundation to support their efforts to share with wider audiences.	DOH	Presentation from Melanie Hall to Steering Committee. Plan to partner in facilitating	Completed	1/15/2020	7/31/2020
12. Facilitate navigation trainings through Family Healthcare Foundation.	Steering Committee	Participant training in navigation.	On schedule	08/01/2020	7/31/2025
13. Engage partners to develop a plan to collaborate between different social need referral systems and	Steering Committee	A plan to collaborate between different social need referral systems and updating community	On schedule	03/01/2020	12/31/2020
14. Develop a plan to get community member participation. *i.* Messaging *ii.* Including community members on workgroups	DOH	Logistics of inviting community members: Objectives, Outcomes Platform, incentives, etc.	On schedule	05/01/2020	12/31/2020

Priority Area 2.1: Exercise, Nutrition & Weight

Implementation Plan Workgroup Co-Chairs: Grace Liggett* (DOH-Hillsborough), Kimberly Williams (AdventHealth)

Implementation Plan Workgroup Members: Dr. Ayesha Johnson*, Dr. Leslene Gordon, Allison Nguyen, Grace Liggett*, Grisel Cisneros** (DOH-Hillsborough); Kimberly Williams (AdventHealth), Colleen Mangan, Vasthi Ciceron (BayCare), Tamika Powe (Tampa General Hospital), Stephanie Sambatakos (Johns Hopkins All Children's Hospital), Jenna Davis (Moffitt Cancer Center), Harold Jackson (Tampa Family Health Centers), Sherri Gay (Suncoast Community Health Centers) *former member **new member

Relevant Health Indicators (CHA 2019 survey):

- 33% reported food insecurity
- 39% of persons with children living in their home reported food insecurity
- Higher rates of reported food insecurity among Black non-Hispanic and Hispanic respondents

Goal: To reduce food insecurity through local DOH systems change and policy initiatives related to economic development.

SMART Objective: By July 2025, increase the number of Healthy Hillsborough partner organizations that use a food insecurity screening tool to refer patients/clients to food resources from 5 organizations (2019) to15 organizations.

Strategy: Policy development and System changes

Activities	Lead	Output (Products)	Status	Date	
				Start	End
1. Meet with community experts in food insecurity.	DOH	Meetings convened with USF Faculty, Feeding Tampa Bay, TBNEH	Complete	10/25/2019	01/08/2020
2. Invite community-based organizations to inform strategies to address housing and other economic factors related to food insecurity.	DOH	Guests attend steering committee meeting	Complete	12/05/2019	01/17/2020

Activities	Lead	Output (Products)	Status	Date	
				Start	End
3. Update implementation plan to address food insecurity through policy development strategies related to economic development.	Steering Committee	Updated Implementation Plan	Complete	01/17/2020	05/31/2020
4. Make policy recommendations.	Steering committee	Policy recommendations	Complete	05/01/2020	05/31/2020
5. Policy: Implement food insecurity screener along with a referral system in hospitals and health centers.	Steering committee	Increase in the number of partner organizations requiring providers to use a food insecurity screening and referral system	On schedule	06/01/2020	07/31/2025
6. Assess Healthy Hillsborough Coalition organizations for screening and referral processes using Microsoft Forms	Steering committee	Data describing number of partner organizations using food insecurity screening and referral system	On schedule	08/10/2020	09/1/2020

Activities	Lead	Output (Products)	Status	Date	
				Start	End
7. Explore how to expand / implement food insecurity screener.	Steering Committee	Best practices from organizations using the screener. Plan to promote the use of the food insecurity screener.	On schedule	09/01/2020	07/31/2025
8. Develop a plan to evaluate the screening and referral process.	Steering Committee	Systematic evaluation framework	On schedule	9/01/2020	03/31/2021
9. Present to wider partnership on implementing food insecurity screener.	Steering Committee	Outreach presentations to community providers and organizations.	On schedule	07/01/2022	07/31/2025

Priority Area 2.2: Exercise, Nutrition & Weight

Implementation Plan Workgroup Co-Chairs: Grace Liggett*, Allison Nguyen (DOH-Hillsborough)

Implementation Plan Workgroup Members: Dr. Leslene Gordon, Allison Nguyen, Grace Liggett* (DOH-Hillsborough) *former member **new member

Relevant Health Indicators (CHA 2019 survey):

- 33% reported food insecurity
- 39% of persons with children living in their home reported food insecurity
- Higher rates of reported food insecurity among Black non-Hispanic and Hispanic respondents

Goal: To reduce food insecurity through local DOH systems change and policy initiatives related to economic development.

SMART Objective: By July 2025, increase the implementation of an integrated (in-person and virtual) social determinants of health screening and referral system in 4 clinics (2019) to 8 clinics in Hillsborough County Health Department.

Strategy: Policy development and System changes

Activities	Lead	Output (Products)	Status	Date	
				Start	End
1. Meet with DOH Senior Leadership to discuss to propose implementing SDOH screen in DOH clinics.	DOH	Meeting convened	Complete	03/25/2020	08/05/2020
2. Develop a virtual SDOH screening and referral process for	DOH	Plan for screening and referral process in DOH	On schedule	07/01/2020	12/31/2020
3. Implement SDOH screen in clinics.	DOH	Screenings conducted in clinics	On schedule	09/01/2020	07/31/2025
4. Report findings to steering committee.	DOH	Annual Reports	On schedule	03/01/2021	07/31/2025

Activities	Lead	Output (Products)	Status	Date	
				Start	End
5. Make policy recommendations for implementing screening tool in other organizations.	Steering committee	Best practices Policy recommendations	On schedule	09/01/2021	

Priority Area 3.1: Hillsborough Health Literacy Initiative					
Implementation Plan Workgroup Co-chairs: Rachel Chase					
DOH Implementation Plan Workgroup Members: Christy Altidor, Rachel Chase, Kelsey Christian, Dr. Leslene Gordon, Grace Liggett**, Allison Nguyen, Tracey Olivella Rosemberg, Noemi Padro, James Waldroff, Bonnie Watson, Brenda Wendt *former member **new member					
Relevant Indicators: Staff and organizational assessments conducted; program, policy and evaluation plans created and implemented.					
Goal: To provide DOH staff with a health literacy initiative relevant to their jobs and personal lives and increase health literacy capacity.					
SMART Objective: By June 30, 2020 have in place an agency-wide initiative to improve the health literacy capacity of the agency and of at least 80% of agency staff.					
Strategy: Social marketing assessments, Program planning, and Policy development.					
Activities	**Lead**	**Output (Products)**	**Status**	**Start**	**End**
1. Get on the agendas of PMT, SLT and other divisional meetings for surveys.	Rachel Chase	Time on meeting agendas	Complete	06/06/2018	07/15/2018

Activities	Lead	Output (Products)	Status	Start	End
2. Conduct an organizational environmental scan of health literacy for assessing current capacity.	OHE MPH intern, Rachel Chase, work-group members	Information on gaps and challenges	Complete	08/01/2018	10/31/2018
3. Survey divisional staff for health literacy awareness through a pen and paper approach at standing meetings. Gather optional staff	OHE MPH intern, Rachel Chase	Data on staff knowledge, perceptions, abilities, barriers, needs, and motivations	Complete	10/01/2018	12/31/2018
4. Interview individual staff from different divisions and staffing levels to probe deeper on findings and to inform program	OHE MPH intern, Rachel Chase	Data on staff knowledge, perceptions, abilities, barriers, needs, and motivations	Complete	01/01/2019	01/15/2019
5. Revisit internal messaging, branding, and communications plan (explore “health literacy”, definitions used etc.).	Workgroup	Updated messaging platform	Complete	03/01/2019	04/30/2019

Activities	Lead	Output (Products)	Status	Start	End
6. Meet with agency PIO and Employee Council to discuss health literacy and potential areas of alignment.	Rachel, Taylor, work-group members	Information, ideas, direction for program plan and policies identified	Complete	03/01/2019	04/30/2019
7. Develop draft program, policy, and evaluation recommendations.	OHE MPH intern, Rachel Chase, work-group members, employee council	Draft program and policy plans	Complete	05/01/2019	06/30/2019
8. Present senior leadership with the draft recommendations. Include the "emotional why", regulatory (accreditation and otherwise), fiscal and ethical considerations for integrating health literacy into the agency.	Rachel Chase, Allison Nguyen, or Dr. L. Gordon	Data summary, presentation and recommendations from senior leaders	Complete	07/01/2019	08/31/2019
9. Implement program and policy recommendations with pilot phases as appropriate.	Workgroup	New policies and/or programs	In progress	09/01/2019	06/30/2020

Activities	Lead	Output (Products)	Status	Start	End
10. Evaluate, assess and report on the programs and policies for increased capacity, effectiveness and sustainability.	Rachel Chase	Recommendations for program and policy improvements	On Schedule	04/01/2020	09/30/2020

ALL4HEALTHFL

All4HealthFL is a 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 prioritizations exercises, Behavioral Health emerged the top priority for all four counties. As such, members decided to develop a coordinated plan to address this issue across all four counties. The Implementation Plan is presented below.

Priority Area 4.1: Behavioral Health	
Implementation Plan Workgroup Co-Chairs: Dr. Ayesha Johnson* (DOH-Hillsborough); Colleen Mangan (BayCare) **former member*	
Implementation Plan Workgroup Members: All4HealthFL Collaborative	
Florida Departments of Health • Hillsborough • Pasco • Pinellas • Polk	Hospital Partners • AdventHealth • BayCare • Johns Hopkins All Children's Hospital • Lakeland Regional Hospital • Moffitt Cancer Center • Tampa General Hospital

Relevant Indicators:

- Mental Health and Substance Use both ranked as top health priorities across all four counties in their 2019 prioritization meetings.
- In the 2019 Community Health Survey:
  - Thoughts of suicide and self-harm were reported in 12% of respondents in Hillsborough, Pasco, and Pinellas, and 9% in Polk.
  - An unmet mental health need was reported by 14% of respondents in Hillsborough, 15% in Pasco, 13% in Pinellas, and 11% in Polk.
  - Four or more Adverse Childhood Experiences were reported by 35% of respondents in Hillsborough, 41% in Pasco, 40% in Pinellas, and 31% in Polk.
- In the most recent Opioid Use Dashboard on FLHealthCHARTS (2017):
  - 26 per 100,000 in Pasco County, 23 opioid overdose deaths per 100,000 people in Pinellas County, and 12 per 100,000 in both Hillsborough and Polk counties. The State rate is 22 per 100,000.
- In the most recent BRFSS data (2016):
  - The % of adults who have been told they have a depressive disorder is higher in each of the four counties than in the state overall. (Hillsborough – 15%, Pasco – 19%, Pinellas – 15%, Polk – 15%, Florida – 14%)
  - The % of adults who engage in heavy or binge drinking is higher in Hillsborough, Pasco, and Pinellas counties than in the state overall. (Hillsborough – 19%, Pasco – 19%, Pinellas – 21%, Polk – 12%, Florida – 18%)

Goal: To improve mental health and reduce substance abuse in adults and youth in Hillsborough, Pasco, Pinellas, and Polk counties.

SMART Objective: From January 2020 through January 2023

- Provide 16 Mental Health First Aid trainings throughout Hillsborough, Pasco, Pinellas, and Polk counties for Florida Department of Health staff, community organization personnel, law enforcement agents, community members, and others.
- Provide an additional 8 Mental Health First Aid – Youth trainings throughout Hillsborough, Pasco, Pinellas, and Polk counties for teachers, youth-serving organization personnel, juvenile justice system staff, and others.

Strategy: Equip service providers and community members with Mental Health First Aid (MHFA) training to develop the knowledge and skills needed to identify and respond to behavioral health concerns in their specific communities (both adult and youth populations).

Activities	Lead	Output (Products)	Status	Start	End
1. Develop an inventory of MHFA trainings being offered.	Grace Liggett, Vasthi Ciceron	List of where MHFA is currently being offered.	In progress	01/24/2020	02/14/2020
2. Develop an inventory of MHFA Trainers and Master Trainers.	Grace Liggett, Vasthi Ciceron	List of where MHFA is currently being offered.	In progress	01/24/2020	02/14/2020
3. Develop a list priority populations and organizations for MHFA.	Ayesha Johnson, Grace Liggett	List of priority populations and organizations and All4HealthFL contacts with plans for MHFA.	In progress	12/01/2019	06/30/2023
4. Determine current resources available for MHFA (trainers, master trainers, funds for workbooks and/or space).	All	List of resources needed.	In progress	12/01/2019	02/28/2020
5. Schedule MHFA trainings.	All	Shared schedule of trainings.	Ongoing	01/24/2020	06/30/2023
6. Explore document sharing options.	Lisa Bell	Report out on options.	In progress	01/24/2020	02/01/2020

Activities	Lead	Output (Products)	Status	Start	End
7. Explore strategies for reducing substance use.	All	Discussion on strategies that All4HealthFL can align with.	On schedule	01/01/2023	06/30/2023
8. Make policy recommendations.	All	Policy recommendations.	On schedule	01/01/2023	06/30/2023

CHIP MONITORING PLAN

Implementation Plans will be monitored for each priority area on a quarterly basis. Implementation Plan co–chairs will provide information to complete a monitoring tool provided by DOH–Hillsborough, at quarterly intervals. This monitoring tool will reflect the status of each action step within each implementation plan, and will track progress on the process and outcome indicators. Additionally, the Healthy Hillsborough Steering Committee will host an annual review meeting to review the progress made on the Healthy Hillsborough implementation plans and to make amendments as needed. The internal DOH–Hillsborough work group will review all the CHIP implementation plans and develop the CHIP annual progress report. Figure 2 provides an illustration of the CHIP implementation and monitoring process for the five-year cycle.

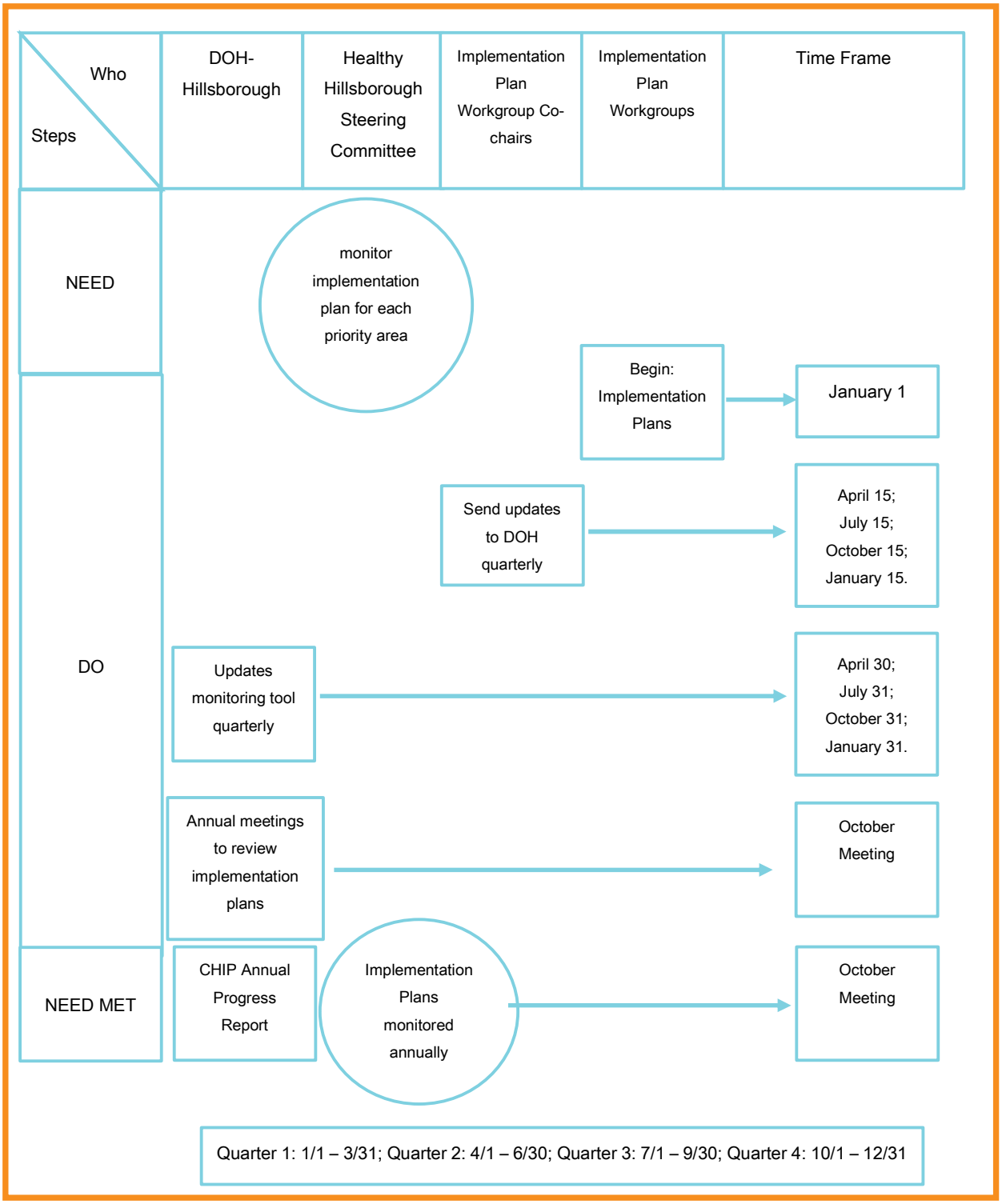


Figure 2: CHIP Implementation and Monitoring Process Map

CHIP IMPLEMENTATION PLAN MONITORING TOOL

2020 Quarter 2 Report (April 1, 2020 – June 30, 2020)

Goal:

Activity / Strategy:

Objective:

Process and Outcome Indicators Quarter 2 Tracking

Indicator	Baseline	Current (Q2)	Notes	Target (Year 1)	**Target (Year 5)**
(Process Indicator)					
(Process Indicator)					
(Process Indicator)					
(Outcome Indicator)					

Action Steps Quarter 2 Tracking

Action Step	Action Status (Complete, On Schedule, At Risk, Not on Schedule, Not Feasible)	Completed Deliverables/Outputs of Action	Key Partners	Actual Start Date	Actual Finish/ End Date	Progress Notes
1.	*See status definitions below*	*Description of any products or results of the action completed during Q1*	*Names of partners, consultants, contractors, etc. who helped carry out the action step in Q1*	*Actual start date of action step described*	*Actual finish/end date of action step described*	*Any information that would be helpful in knowing more about this action step's progress and activities in Q2*
2.						
…						
6.						

Complete = Action Step is complete on or after the target date.

On Schedule = No changes/delays and no scope changes.

At Risk = Action Step needs some attention; milestones in action step are maybe being met, but results are not as anticipated.

Not On Schedule = Action Step will not be met by the target date.

Not Feasible = Action Step has been excluded from the Action Plan.

Additional Progress and Comments Quarter 2 Tracking

Additional Progress and Comments
Additional comments on the overall progress of implementation plan activities during Q1. Example notes include: partner contributions, facilitating factors of success, barriers/issues encountered, plans to overcome barriers/issues, unanticipated outcomes, and overall progress and comments.
Overarching Themes
-Health Equity (Health Disparities and Social Determinants of Health)
-Encouraging Healthy Behaviors
-Improving Health Collaboration

CHIP ALIGNMENT WITH INTERNAL PLANS AND INITIATIVES

CHIP Priority Area	Goal / Strategy	DOH-Hillsborough Strategic Plan 2021-2025
Access to Health Services	**Goal:** To support existing efforts to increase access to health services. • **Strategy:** Research and Collaboration.	Long Healthy Life Emerging Health Threats
Exercise, Nutrition & Weight (2.1 and 2.2)	**Goal:** To reduce food insecurity through local DOH systems change and policy initiatives related to economic development. • **Strategy:** Policy development.	Health Equity
Hillsborough Health Literacy Initiative	**Goal:** To provide DOH staff with a health literacy initiative relative to their jobs and personal lives to increase health literacy capacity. • **Strategy:** Social marketing assessments, Program planning, and Policy development.	Health Equity Effective Agency Processes

CHIP ALIGNMENT WITH STATE AND NATIONAL GOALS

DOH–Hillsborough CHIP 2020-2025	Florida Department of Health State Health Improvement Plan (SHIP) 2017-2021	National Prevention Strategy: America's Plan for Better Health and Wellness	HHS Action Plan to Reduce Racial and Ethnic Disparities: A Nation Free of Disparities in Health and Health Care
Priority Area: Exercise, Nutrition & Weight **Goal:** Reduce food insecurity through policy initiatives related to economic development.	**Priority Area: Healthy Weight, Nutrition & Physical Activity** **Goal:** Improve the food environment and nutrition habits across the lifespan to increase healthy weight.	**Priority Areas: Healthy Eating, Active Living**	**Priority Area: Advance Health, Safety, and Well-Being of the American People**
Priority Area: Health Literacy: **Goal:** Provide DOH staff with a health literacy initiative to increase health literacy capacity.	**Priority Area: Health Equity** **Goal:** Strengthen the capacity of state and local agencies and other organizations to work collaboratively with communities to reduce disparities in Social Determinants of Health and advance Health Equity.	**Priority Areas: Healthy Eating, Active Living**	**Priority Area: Transform Health Care**

CHIP ALIGNMENT WITH PARTNERS' PLANS AND INITIATIVES

DOH-Hillsborough Community Health Improvement Plan	AdventHealth	BayCare	Johns' Hopkins All Children's Hospital	Moffitt Cancer Center	Suncoast Community Health Centers	Tampa Family Health Centers	Tampa General Hospital
Behavioral Health	X	X	X		X	X	X
Access to Health Services		X		X	X	X	X
Exercise, Nutrition, and Weight	X	X	X			X	X

CHIP ALIGNMENT WITH HEALTHY PEOPLE 2030 OBJECTIVES

CHIP Goals by Priority Area	Healthy People 2030 Objectives
Behavioral Health **Goal:** To improve mental health and reduce substance abuse in adults and youth in Hillsborough, Pasco, Pinellas and Polk counties.	**Objective** MHMD-03: Increase the proportion of children with mental health problems who get treatment **Objective** MHMD-07: Increase the proportion of people with substance use and mental health disorders who get treatment for both **Objective** MHMD-04: Increase the proportion of adults with serious mental illness who get treatment
Access to Health Services **Goal:** To support existing efforts to increase access to health services.	**Objective** AHS-04 : Reduce the proportion of people who can't get medical care when they need it **Objective** AHS-07: Increase the proportion of people with a usual primary care provider **Objective** AHS-01: Increase the proportion of people with health insurance
Exercise, Nutrition & Weight **Goal:** To reduce food insecurity through local DOH systems change and policy initiatives related to economic development.	**Objective** NWS-01: Reduce household food insecurity and hunger **Objective** AHS-07: Increase the proportion of people with a usual primary care provider **Objective** MHMD-07: Increase the proportion of people with substance use and mental health disorders who get treatment for both
Hillsborough Health Literacy Initiative **Goal:** To provide DOH staff with a health literacy initiative relative to their jobs and personal lives to increase health literacy capacity.	**Objective** HC/HITR01: Increase the health literacy of the population

***Source**: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [Sep 25 2020].*

APPENDIX

Healthy Hillsborough Steering Committee

Members

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
Grisel Cisneros**	DOH-Hillsborough
Stephanie Sambatakos	Johns Hopkins All Children's Hospital
Jenna Davis	Moffitt Cancer Center
Sherri Gay	Suncoast Community Health Centers, Inc.
Sonia Goodwin	Suncoast Community Health Centers, Inc.
Harold Jackson	Tampa Family Health Centers
Tamika Powe	Tampa General Hospital
Melanie Hall**	Family Healthcare Foundation

**former member* ***new member*

Meeting Dates

2018

July 31 November 14 December 7

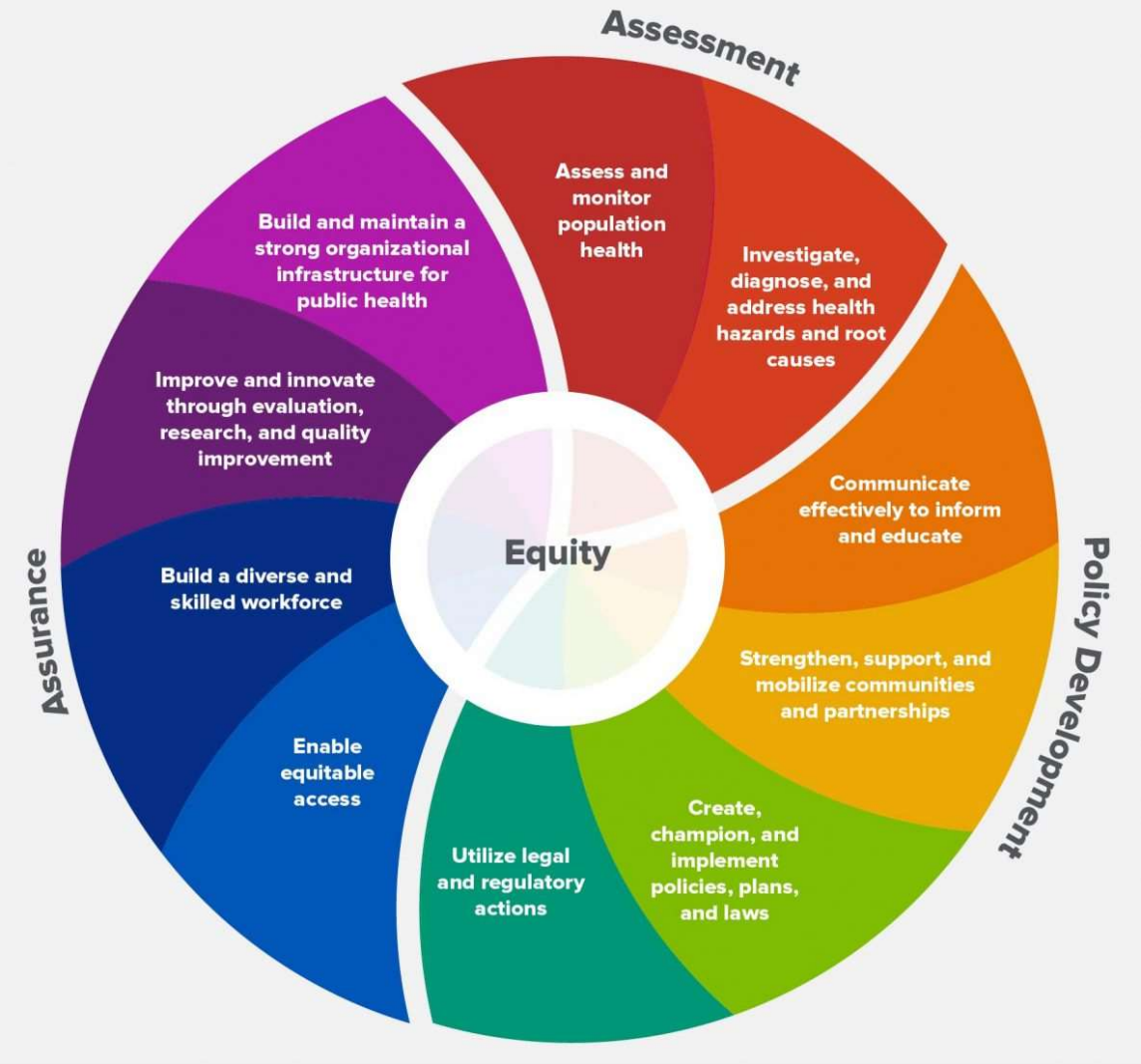
2019

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	May 5	June 2
July 7	August 4	November 3	

INSIDE OF BACK COVER



The 10 Essential Public Health Services and Core Functions

Source: Center for Disease Control and Prevention and National Public Health Performance Standards (revised 2020)