# Community Health Needs Assessment
# Hillsborough County
# 2022

All4HealthFL
Four Counties. One Vision.

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

St Joseph's Hospital

Prepared by Conduent Healthy Communities Institute

# Table of Contents

# Letter from the All4HealthFL Collaborative

To the citizens of Hillsborough County,

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

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

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

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

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

**The All4HealthFL Collaborative**

# COMMUNITY HEALTH NEEDS ASSESSMENT
# At a Glance: Hillsborough County

## Secondary Data

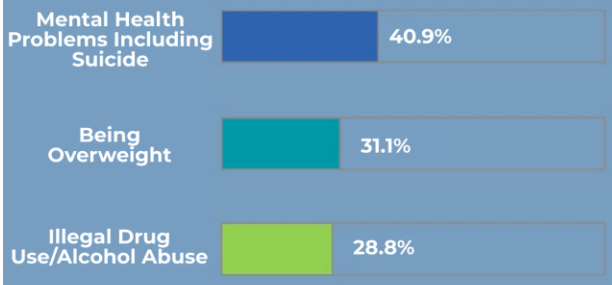
- Access to Health & Social Services
- Cancer
- Heart Disease & Stroke
- Behavioral Health (Mental Health & Substance Misuse)
- Exercise, Nutrition & Weight
- Immunizations & Infectious Diseases

## Primary Data/Community Input

### Community Health Survey

Hillsborough County had **4,540** Community Survey Respondents

**Top Health Issues:**




### Focus Group Discussions

Hillsborough County conducted **5** Focus Groups

> If there were more resources to have Primary Doctors for simple or basic problems, or ones that aren't emergencies, that would help lower the total cost of healthcare.
>
> -Focus Group Participant

## Health Equity

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

# Introduction & Purpose

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

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

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

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

## Acknowledgments

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

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

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

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

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

## All4HealthFL Collaborative

The All4HealthFL Collaborative was officially organized in 2019. This group comes together with a mutual interest to improve health by leading regional, outcome-driven health initiatives that have been prioritized through community health assessments. This process is conducted every three years and aims to identify health priorities in the community and strategies to address them. The All4HealthFL Collaborative works together to plan, implement, and evaluate strategies that are in alignment with identified health priorities. Together, the group strives to make Hillsborough, Pasco, Pinellas, and Polk counties the healthiest region in Florida.

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


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

# Evaluation of Progress Since Previous CHNA

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


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

## Collaborative Achievements

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

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

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

### Community Feedback from Preceding CHNA & Implementation Plan

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

# Demographics of Hillsborough County

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

## Geography and Data Sources

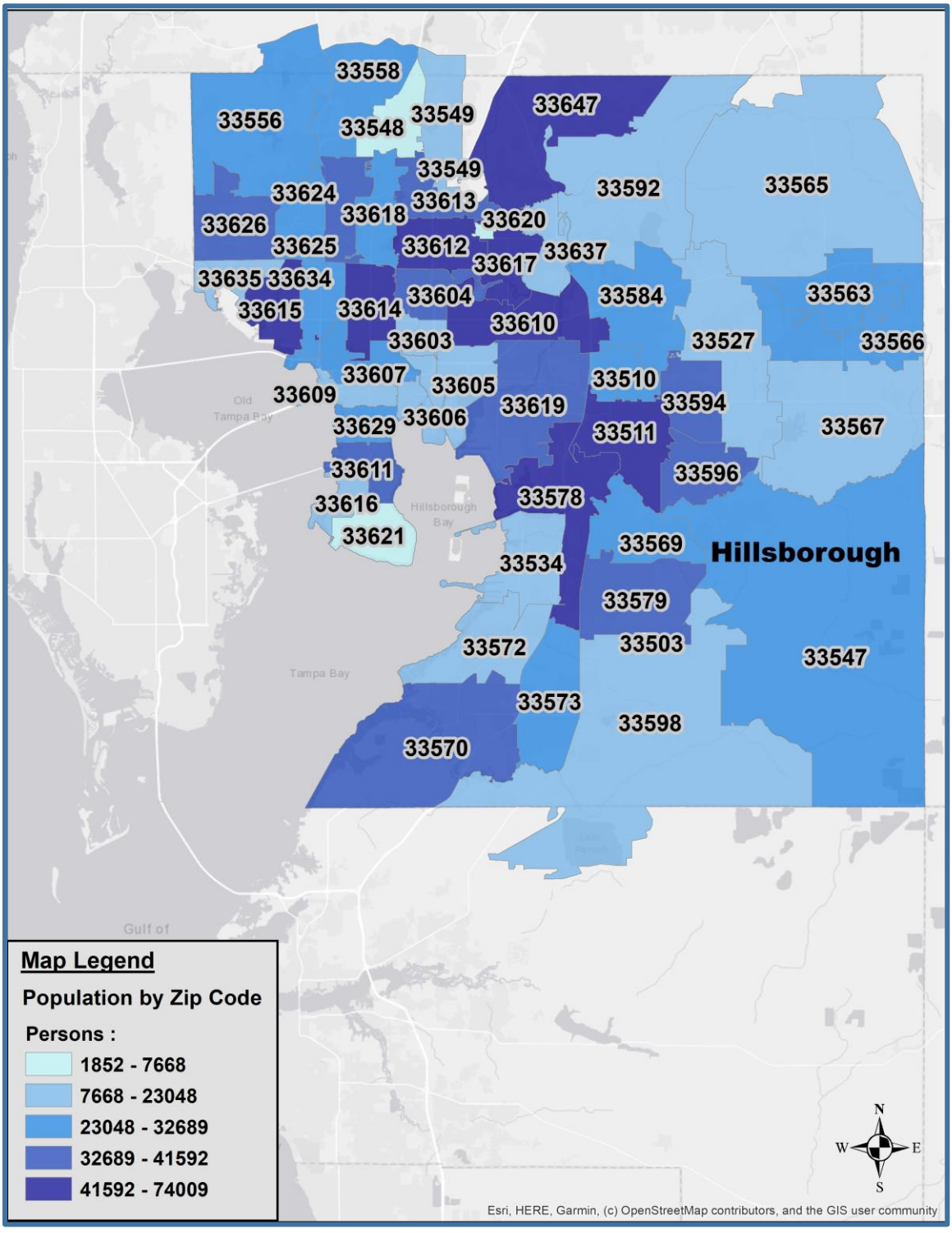
Data are presented in this section at the geographic level of Hillsborough County. County, comparisons, state, and national values are also provided, when available. All demographic estimates are sourced from Claritas Pop-Facts® (2022 population estimates)[1] and American Community Survey[2] one-year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

### Population

According to the 2022 Claritas Pop-Facts® population estimates, Hillsborough County has an estimated population of 1,519,364 persons. Figure 1 shows the population size by each ZIP code, with the darkest blue representing the ZIP codes with the largest population. Appendix A provides the actual population estimates for each ZIP code. The most populated ZIP code area within Hillsborough County is ZIP code 33647 (Tampa) with a population of 74,009.

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

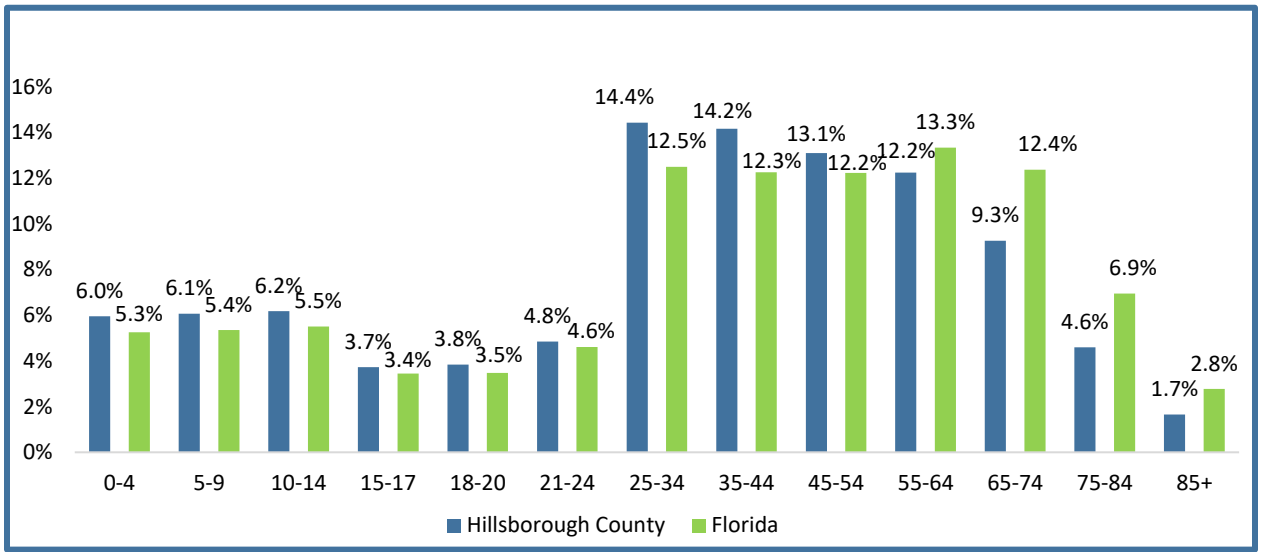
**Figure 1: Population by ZIP Code by Age Under 18: Hillsborough County**



## Age

Children (0-17) comprised (21.9%) of the population in Hillsborough County. When compared to Florida, Hillsborough County has a lower proportion of residents ages 65+ and a higher proportion of children population (age 0-17). Figure 2 shows further breakdown of age categories.

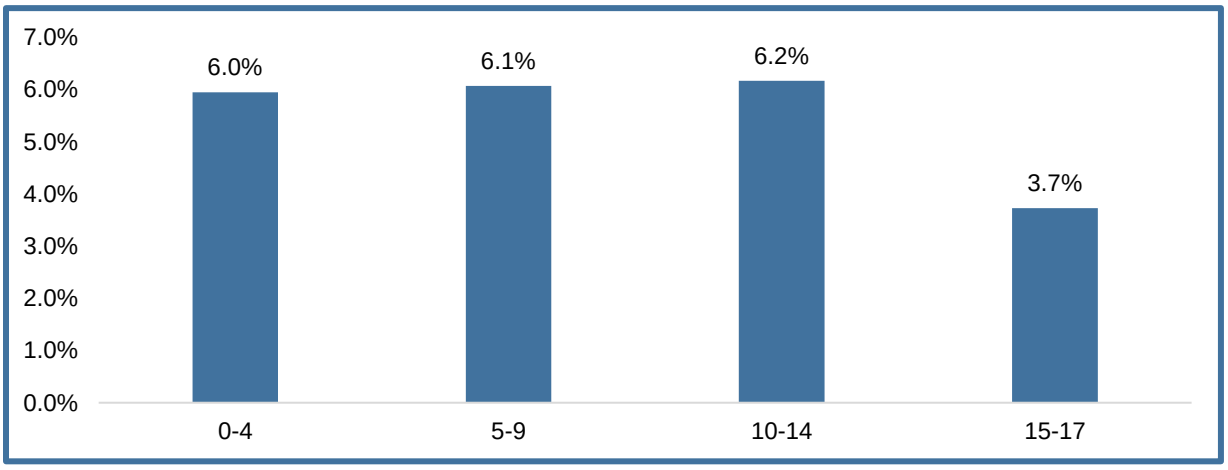
**Figure 2: Population by Age: County and State Comparisons**




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

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

**Figure 3: Population by Age Under 18: Hillsborough County**

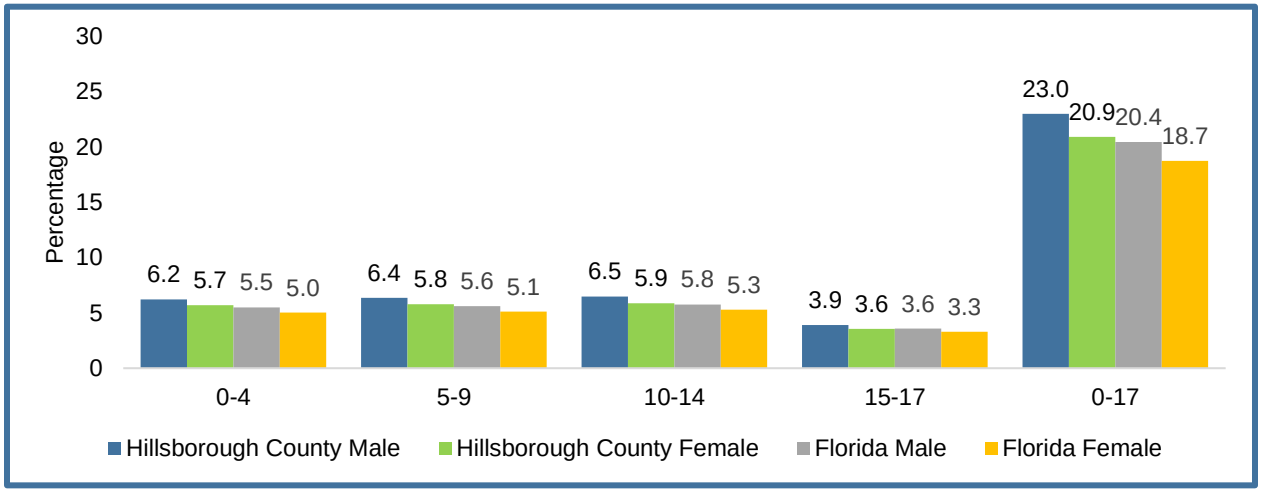



*County values- Claritas Pop-Facts® (2022 population estimates)

## Sex

Figure 4 shows the children (under 18) population of Hillsborough County by sex. In Hillsborough County, males comprise (23%) of the population, whereas females comprise (20%) of the population, which is higher in proportion when compared to males (20.4%) and females (18.7%) in Florida.

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



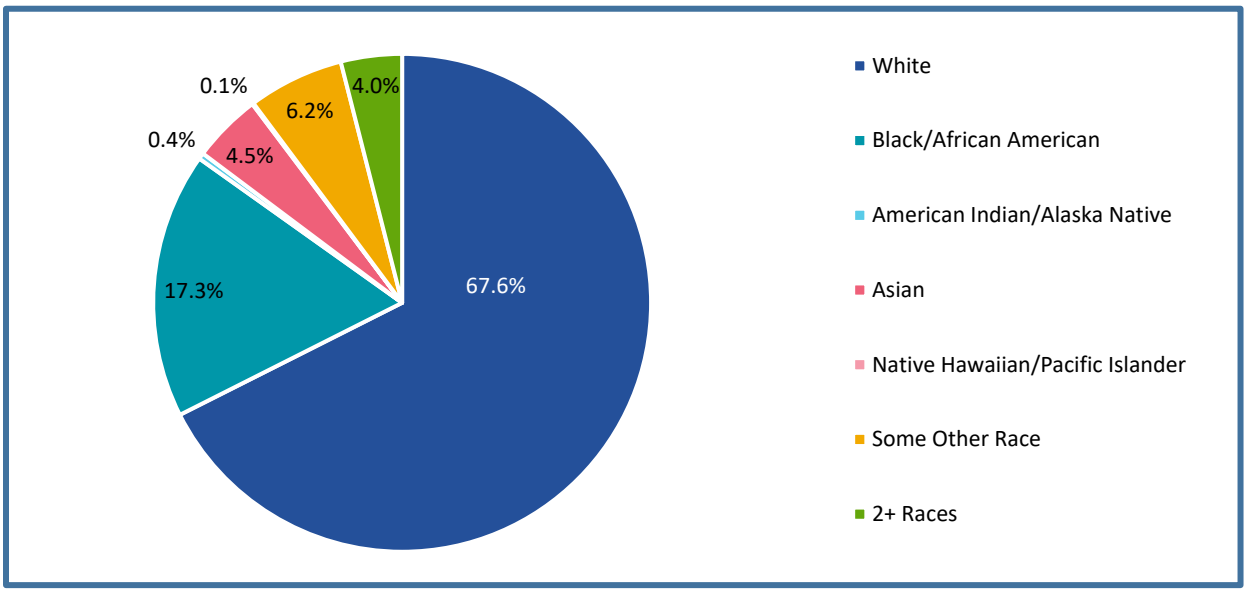

*County values- Claritas Pop-Facts® (2022 population estimates)

## Race and Ethnicity

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

The racial makeup of Hillsborough County shows (67.6%) of the population identifying as White, as indicated in Figure 5. The proportion of Black/African American community members is the second largest of all races in Hillsborough County at (17.3%).

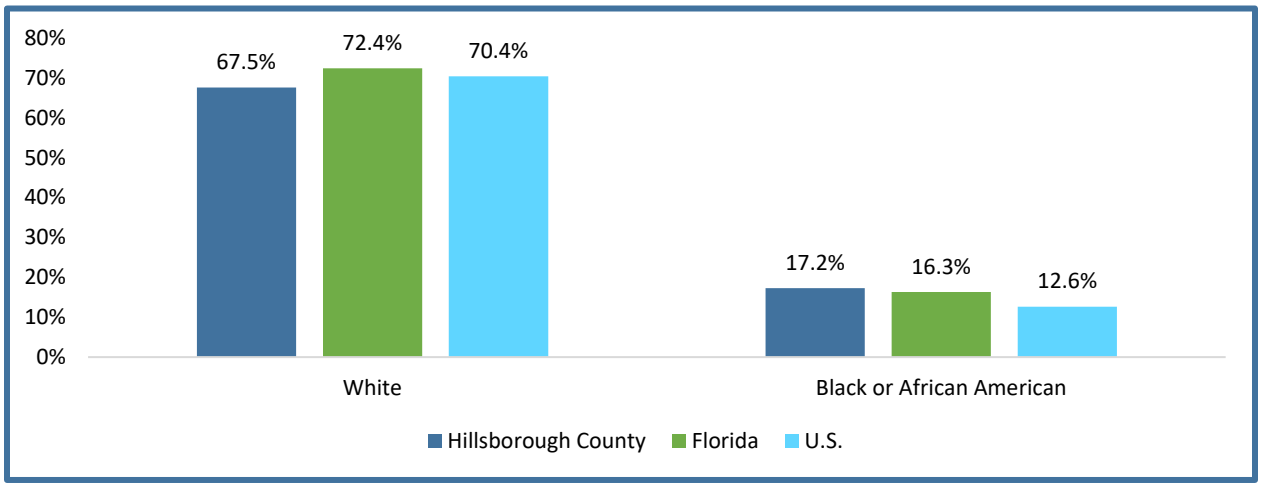
**Figure 5: Population by Race: Hillsborough County**




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

Those community members identifying as White (67.5%) represent a lower proportion of the population in Hillsborough County when compared to Florida (72.4%) and the U.S. (70.4%), while Black/African American community members in Hillsborough County represent (17.2%) a higher proportion of the population when compared to Florida (16.3%) and the U.S. (12.6%) (Figure 6).

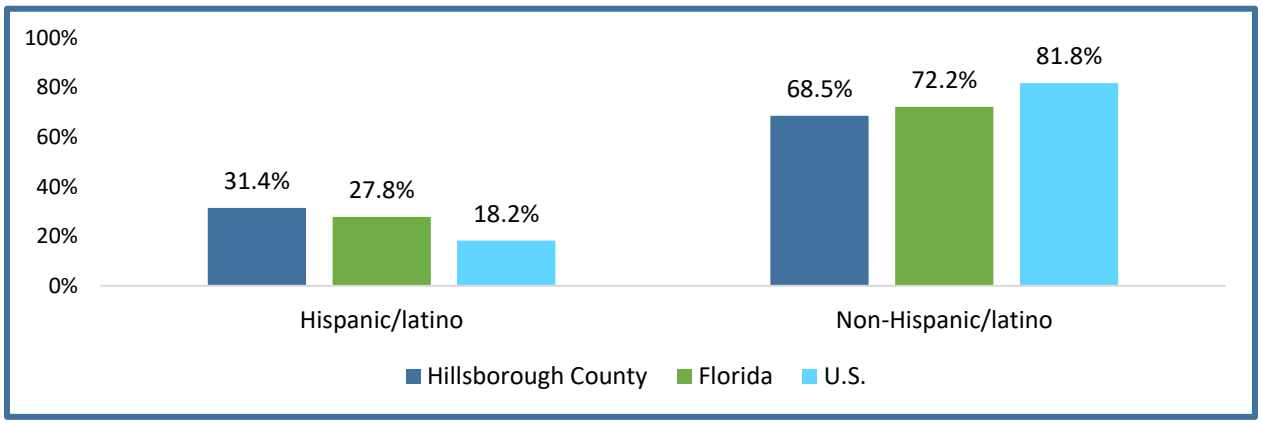
**Figure 6: Population by Race: Hillsborough County, State, and U.S. Comparisons**




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

As shown in Figure 7, (31.4%) of the population in Hillsborough County identify as Hispanic/Latino. This is a smaller proportion of the population when compared to Florida (27.8%) and the U.S. (18.2%).

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



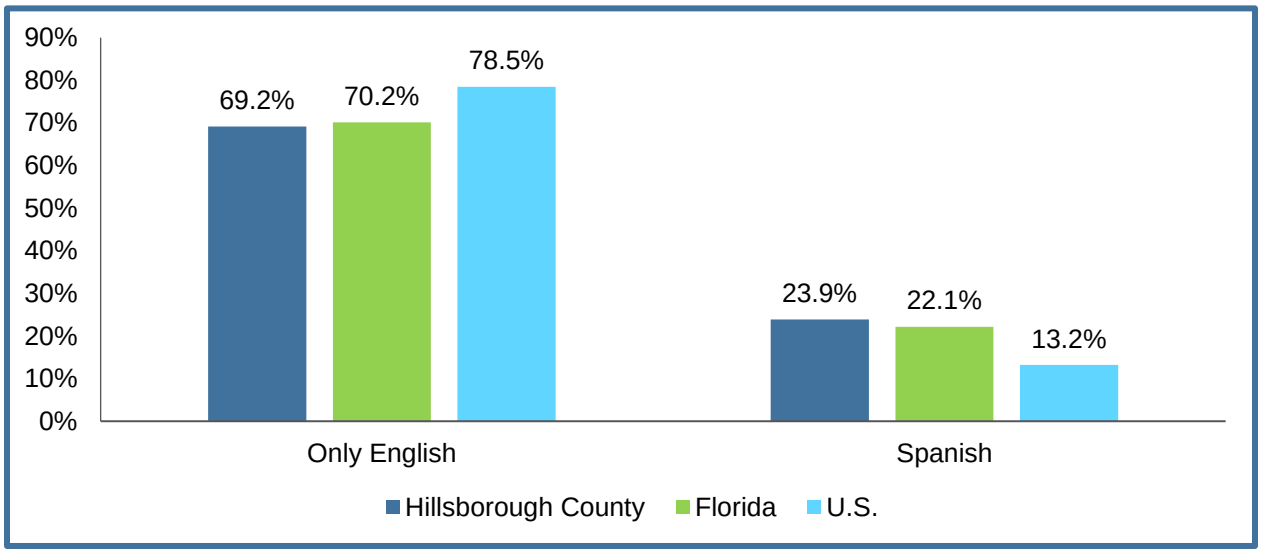

*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

## Language and Immigration

Understanding countries of origin and language spoken at home can help inform the cultural and linguistic context for the health and public health system. According to the American Community Survey, (17.9%) of residents in Hillsborough County are born outside the U.S., which is higher than the national value of (13.6%).[3]

In Hillsborough County, 69.2% of the population age five and older speak only English at home, which is lower than both the state value of (70.2%) and the national value of (78.5%) (Figure 8). This data indicates that (23.8%) of the population in Hillsborough County speak Spanish, and (1.1%) speak other languages than English at home.

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

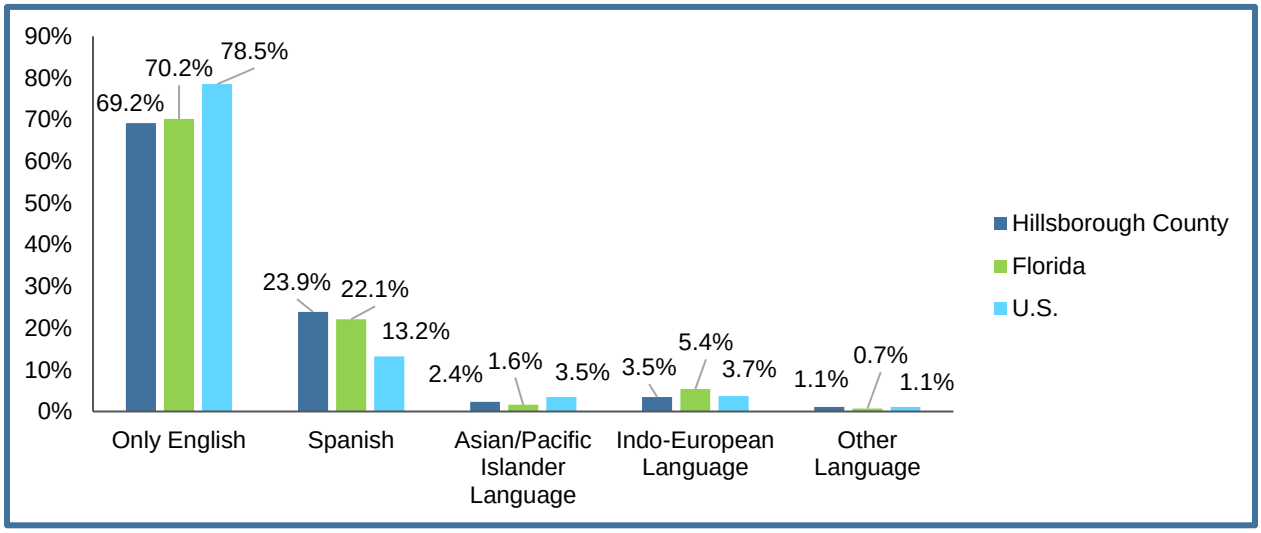



*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

[3] American Community Survey, 2016-2020

The most common languages spoken at home are English (69.2%), Spanish (23.9%), and Indo-European languages such as French, Portuguese, Russian, and Dutch[4] (3.5%) (Figure 9).

**Figure 9: Population Ages 5+ by Language Spoken at Home: County, State and U.S. Comparisons**



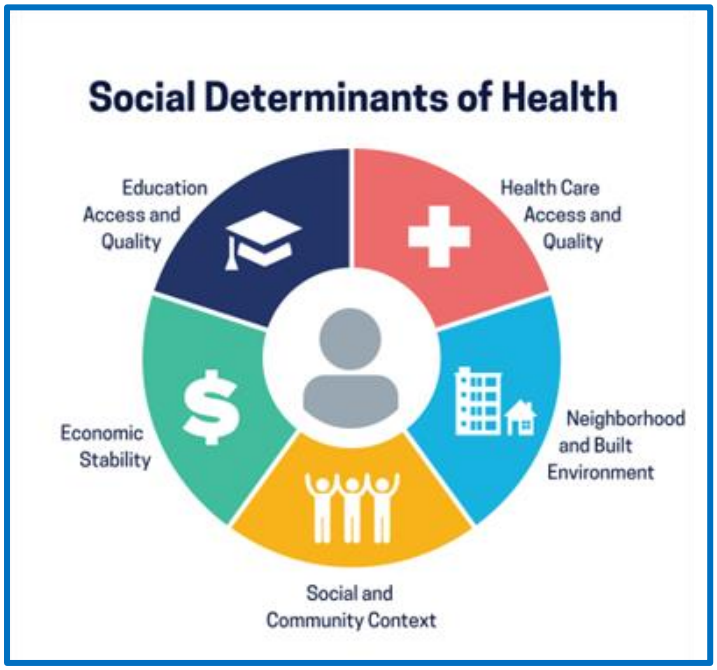

*County values- Claritas Pop-Facts® (2022 population estimates)

[4] United States Census Bureau. About Language Use in the U.S. Population (census.gov)

# Social & Economic Determinants of Health

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

**Figure 10: Healthy People 2030 Social Determinants of Health Domains**




## Geography and Data Sources

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

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

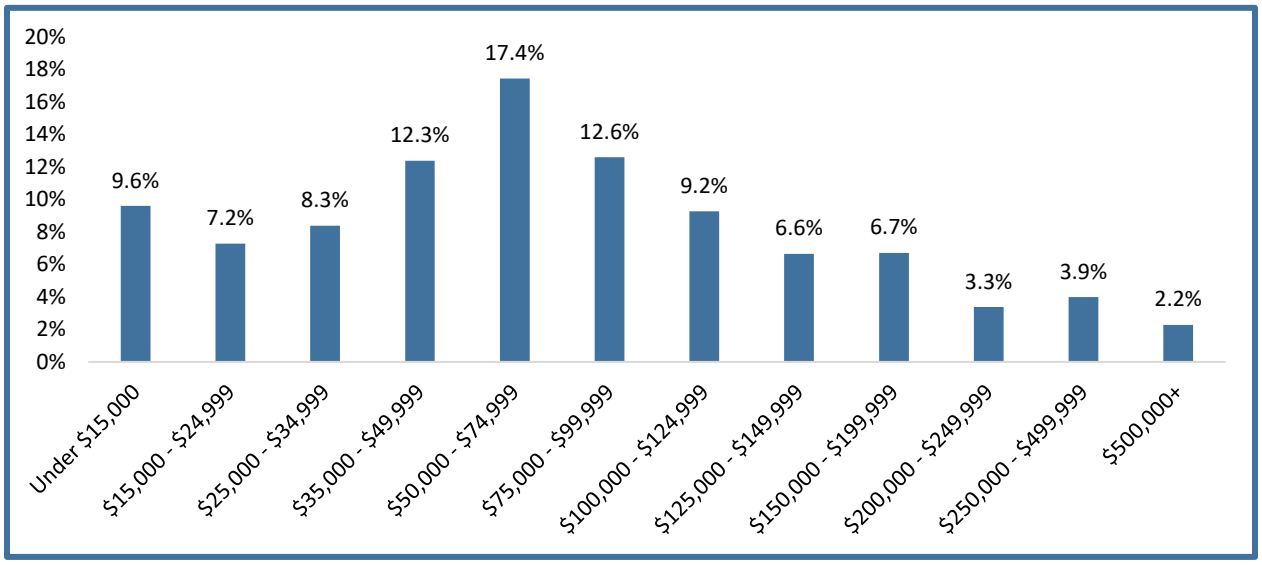
### Income

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

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

Figure 11 provides a breakdown of households by income in Hillsborough County. A household income of $50,000-$74,999 is shared by the largest proportion of households in Hillsborough County (17.5%). Households with an income of less than $15,000 make up (9.6%) of households in Hillsborough County.

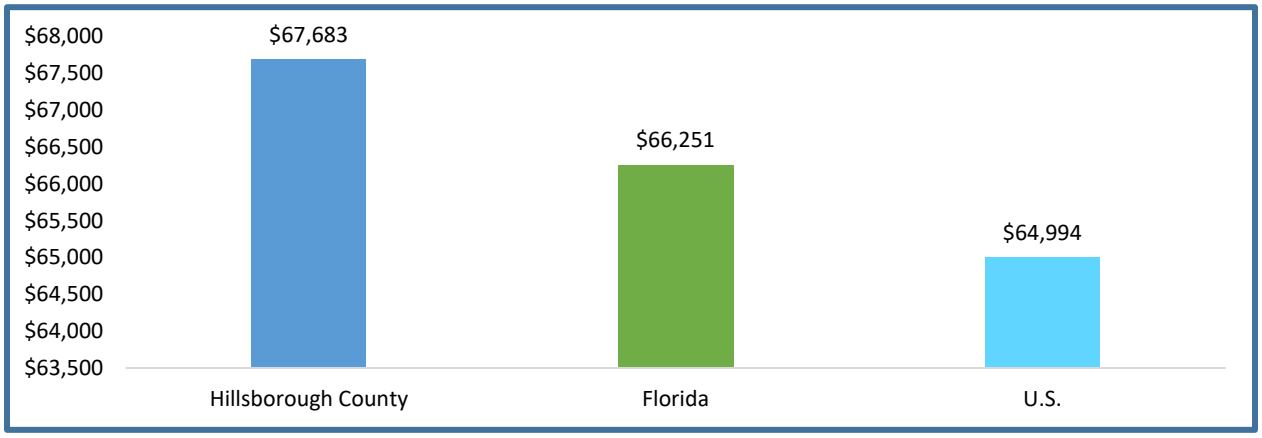
**Figure 11: Households by Income, Hillsborough County**




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

The median household income for Hillsborough County is $67,683, which is higher than the state value of $66,251 and national value of $64,994 (Figure 12).

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

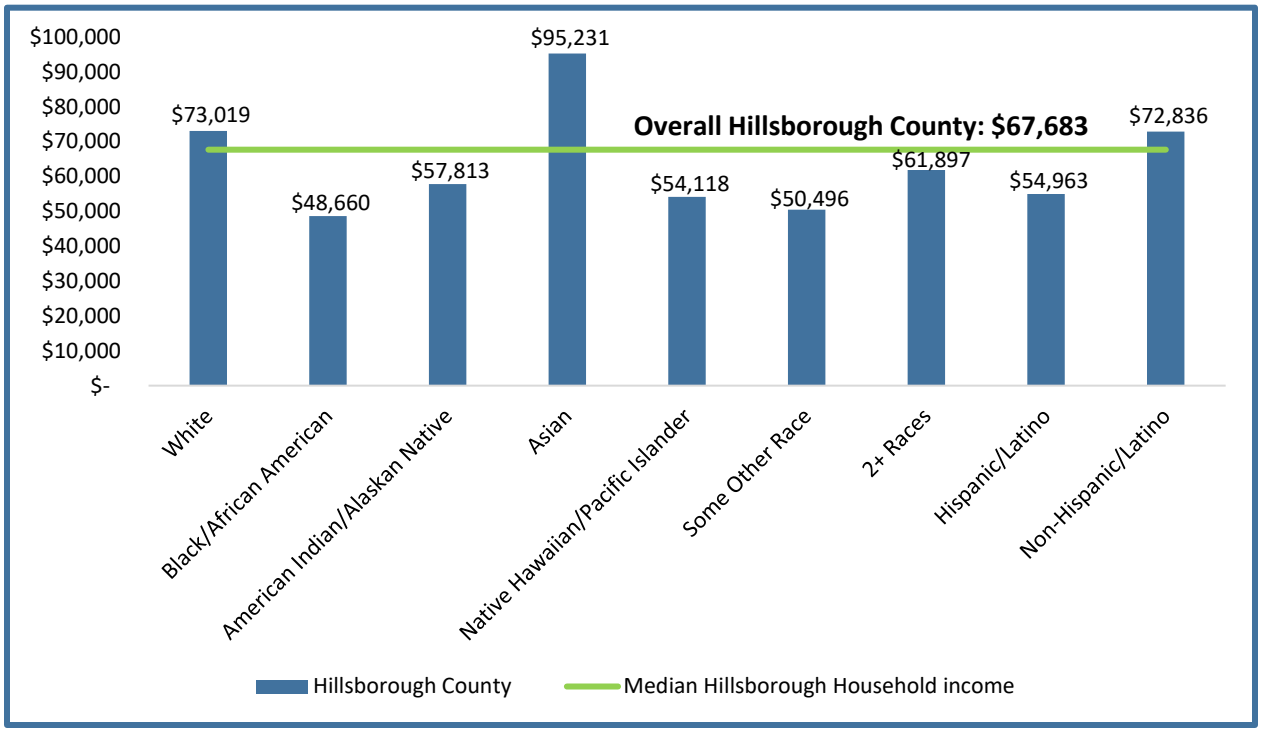



*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

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

Figure 13 shows median household income by race and ethnicity. Three racial/ethnic groups – White, Asian, and Non-Hispanic/Latino – have median household incomes above the overall median value. All other races have incomes below the overall value, with the Black/African American populations having the lowest median household income at $48,660.

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




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

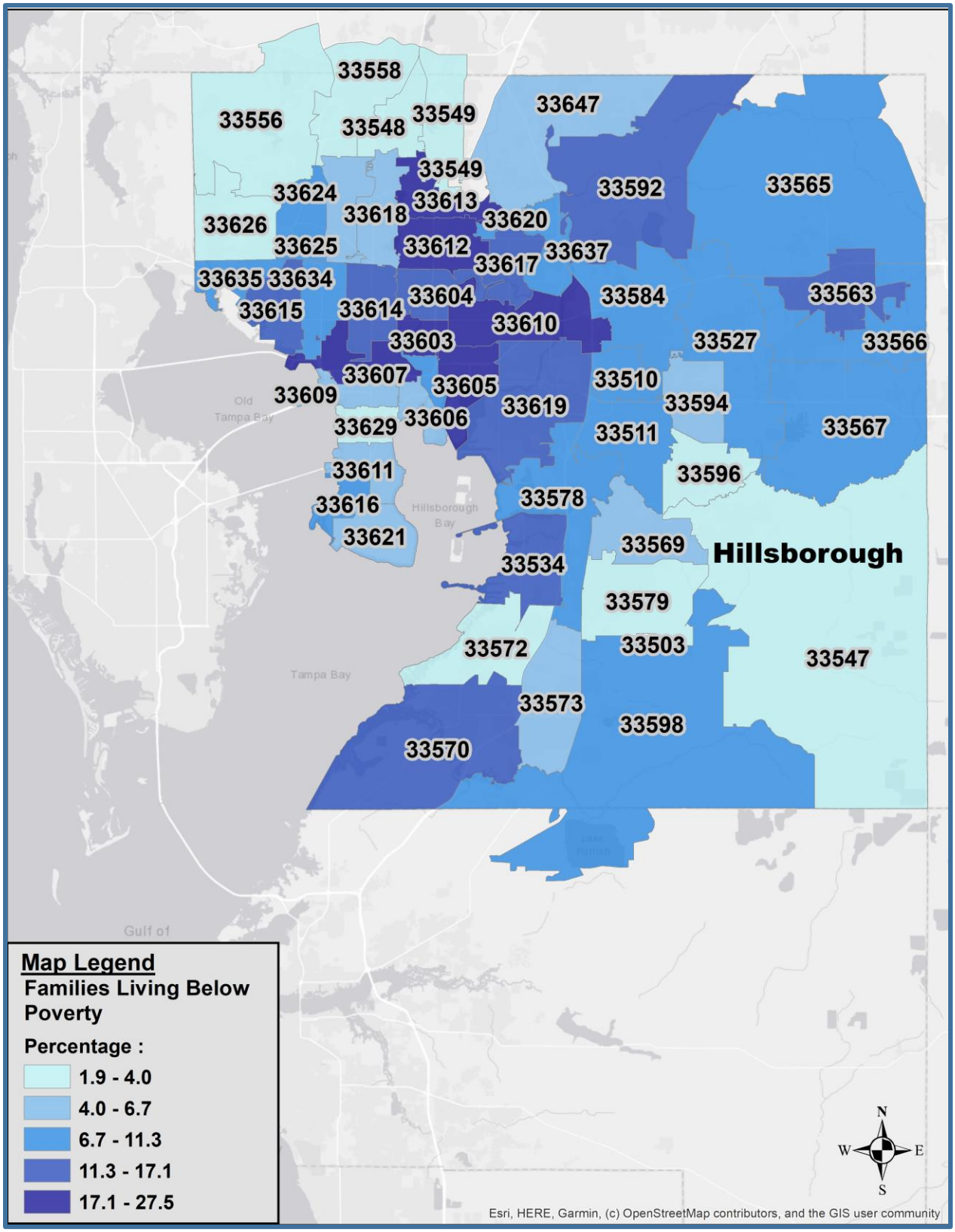
## Poverty

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

Figure 14 shows the percentage of families living below the poverty level by ZIP code. The darker blue colors represent a higher percentage of families living below the poverty level, with ZIP codes 33605 (Tampa) and 33612 (Tampa) having the highest percentages at (27.5%) and (22.1%), respectively. Overall, (9.8%) of families in Hillsborough County live below the poverty level, which is higher than both the state value of (9.3%) and the national value of (9.1%). The percentage of families living below the poverty level for each ZIP code in Hillsborough County is provided in Appendix A.

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

**Figure 14: Families Living Below The Poverty Level: Hillsborough County**



## Employment

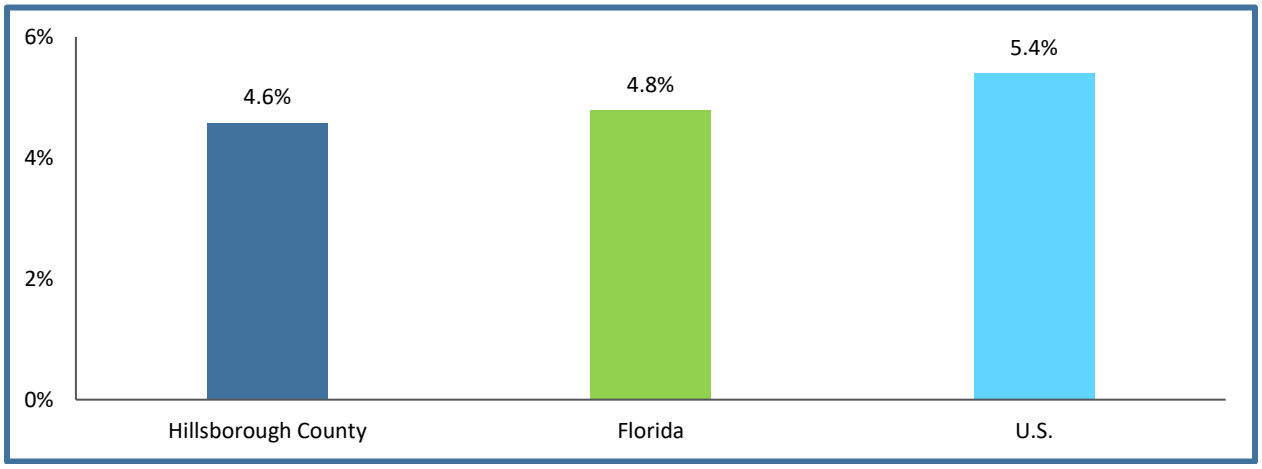
A community's employment rate is a key indicator of the local economy. An individual's type and level of employment impacts access to health care, work environment, health behaviors, and health outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast,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

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

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

Figure 15 shows the population age 16 and over who are unemployed. The unemployment rate for Hillsborough County is (4.6%), which is lower than the state value of (4.8%) and the national value of (5.4%).

**Figure 15: Population Ages 16+ Unemployed**




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

## Education

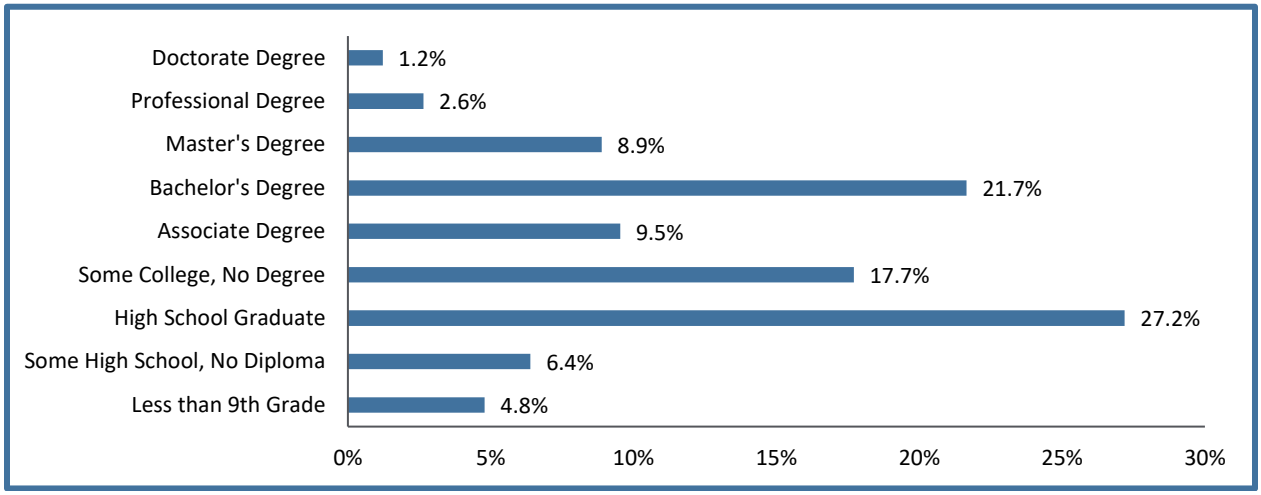
Education is an important indicator for health and well-being. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health. People with higher levels of education are likely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

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

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

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

**Figure 16: Population Ages 25+ by Education Attainment, Hillsborough County**

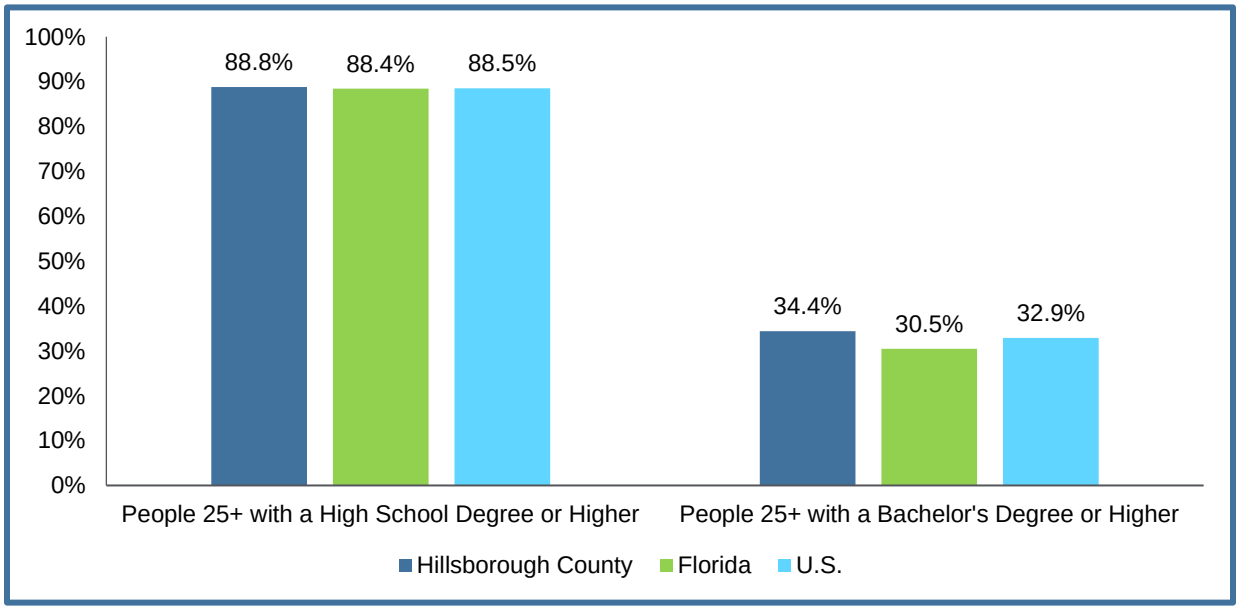



*County values- Claritas Pop-Facts® (2022 population estimates)

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

Figure 17 shows that Hillsborough County has a higher percentage of residents with a high school degree or higher (88.8%) and Bachelor's Degree or higher (34.4%) when compared to both the state and the nation value for both indicators.

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




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

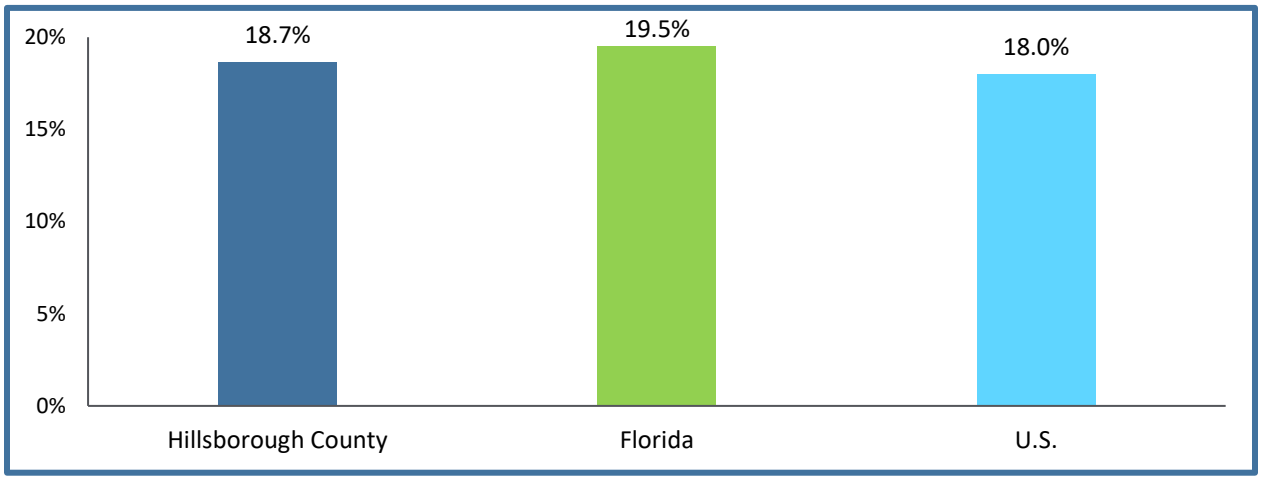
[9] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/high-school-graduation

## Housing

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

Figure 18 shows the percentage of houses with severe housing problems. This indicator measures the percentage of households with at least one of the following problems: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities. In Hillsborough County, (18.7%) of households were found to have at least one of those problems, which is lower than the state value (19.5%), but slightly higher the national value (18.0%).

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




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

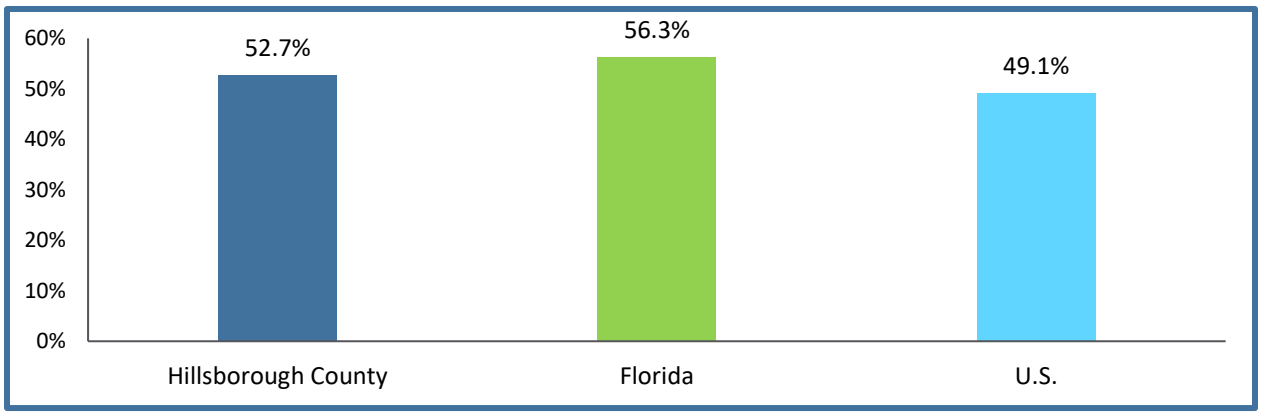
When families must spend a large portion of their income on housing, they may not have enough money to pay for things like healthy foods or health care. This is linked to increased stress, mental health problems, and an increased risk of disease.[11]

Figure 19 shows the percentage of renters who are spending 30% or more of their household income on rent. The value in Hillsborough County (52.7%) is higher than the national value (49.1%), and lower than the state value (56.3%).

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

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

**Figure 19: Renters Spending 30% or More of Household Income on Rent: County, State, U.S. Comparisons**




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

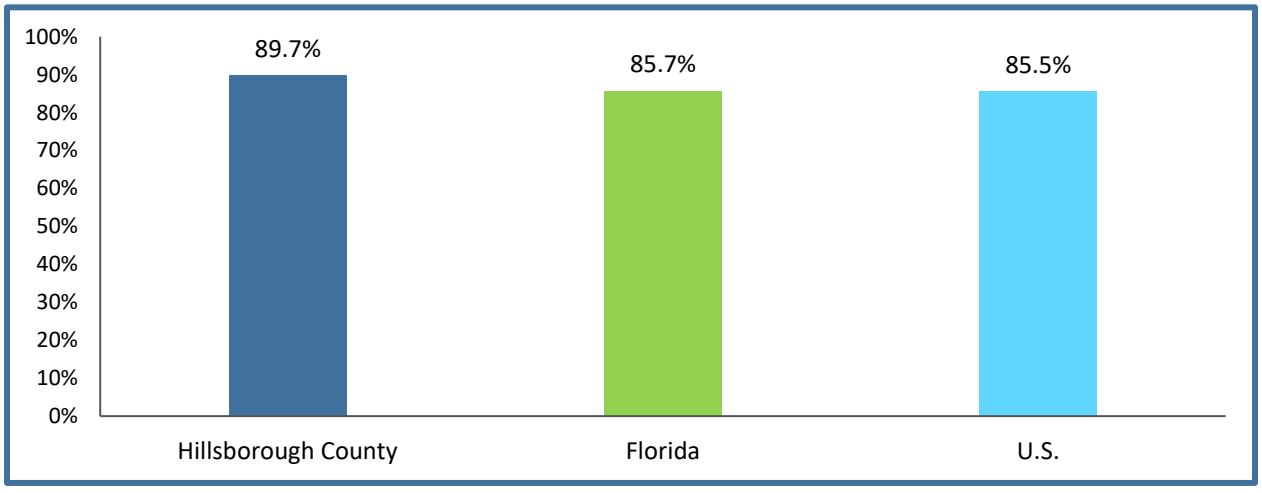
## Neighborhood and Built Environment

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

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

Figure 20 shows the percentage of households that have an internet subscription. The rate in Hillsborough County (89.7%) is higher than the state value (85.7%) and the national value (85.5%).

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




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

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

# Disparities and Health Equity

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

## Health Equity

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

## Race, Ethnicity, Age & Gender Disparities

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

### Secondary Data

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

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

[13] Klein R,. Huang D. Defining and measuring disparities, inequities, and inequalities in the Healthy People initiative. National Center for Health Statistics. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/ppt/nchs2010/41_klein.pdf

[14] Pearcy, J. & Keppel, K. (2002). A Summary Measure of Health Disparity. Public Health Reports, 117, 273-280.

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

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

The Index of Disparity analysis for Hillsborough County reveals that Black/African America and Hispanic/Latino populations are disproportionately impacted for several chronic diseases, including Diabetes, Kidney Disease, Prostate Cancer, Colon Cancer. Furthermore, Black/African American, and Hispanic/Latino populations are disproportionately impacted in the Infant Mortality Rate, and Teen Birth Rate: (aged 15-19). Lastly, Adults who currently use E-cigarettes and Melanoma Incidence rates are higher in White populations.

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

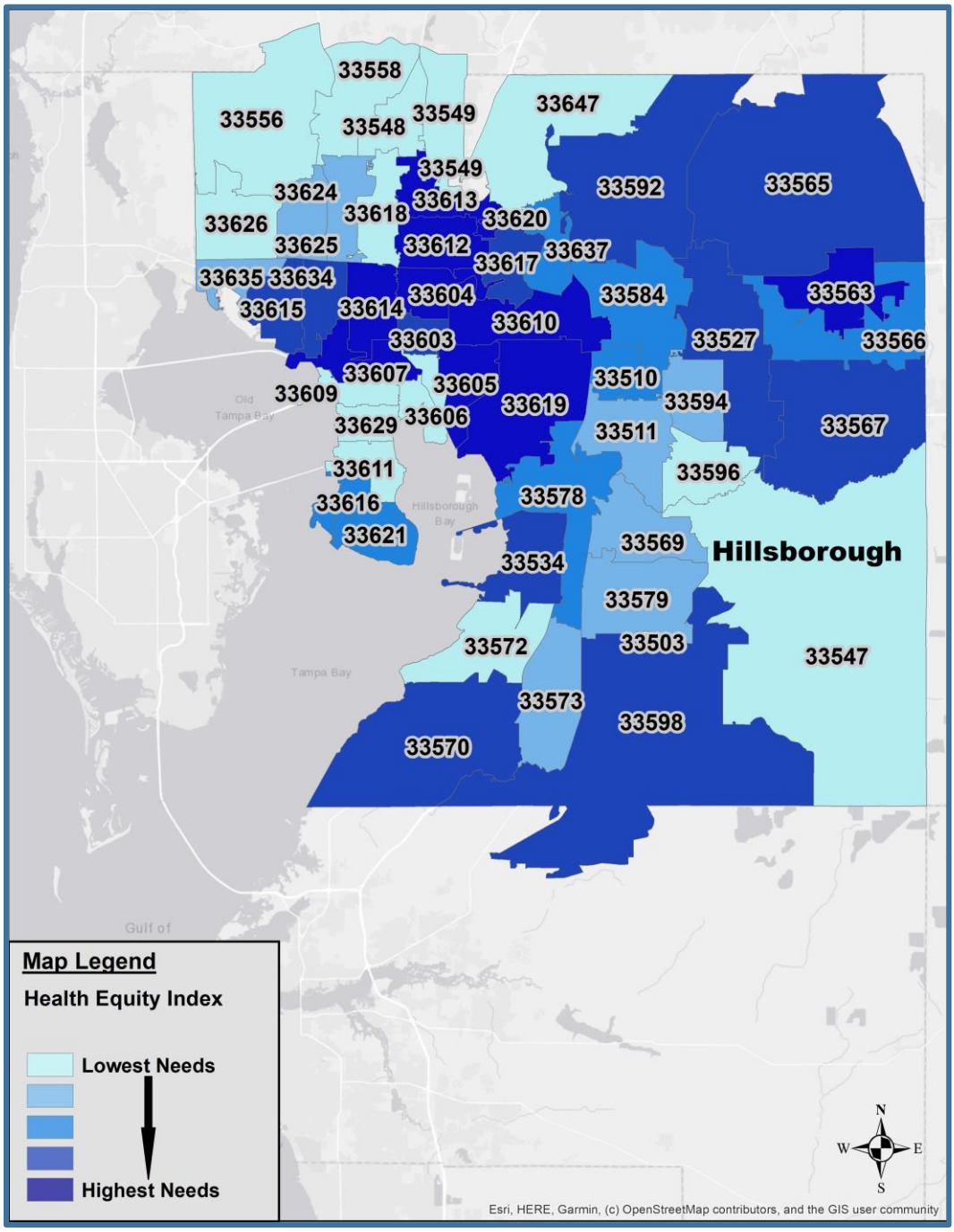
# Geographic Disparities

In addition to disparities by race, ethnicity, age, and gender, this assessment also identified specific ZIP codes/municipalities with differences in outcomes related to health and social determinants of health. Geographic disparities were identified using the Health Equity Index, Food Insecurity Index, and Mental Health Index. These indices have been developed by Conduent Healthy Communities Institute to easily identify areas of high socioeconomic need, food insecurity and mental health need. Conduent's Health Equity Index estimates areas of highest socioeconomic need correlated with poor health outcomes. Conduent's Food Insecurity Index estimates areas of low food accessibility correlated with social and economic hardship. Conduent's Mental Health Index (MHI) is a measure of socioeconomic and health factors correlated with self-reported poor mental health. For all indices, counties, ZIP codes, and census tracts with a population over 300 are assigned index values ranging from 0 to 100, with higher values indicating greater need. Understanding where there are communities with higher need is critical to targeting prevention and outreach activities.

## Health Equity Index

Conduent's Health Equity Index estimates areas of high socioeconomic need, which are correlated with poor health outcomes. ZIP codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 21. The following ZIP codes in Hillsborough County had the highest level of socioeconomic need (as indicated by the darkest shades of blue): 33605 (Tampa) and 33610 (Tampa) with index values of 96.4 and 93.5, respectively. Appendix A provides the index values for each ZIP code.

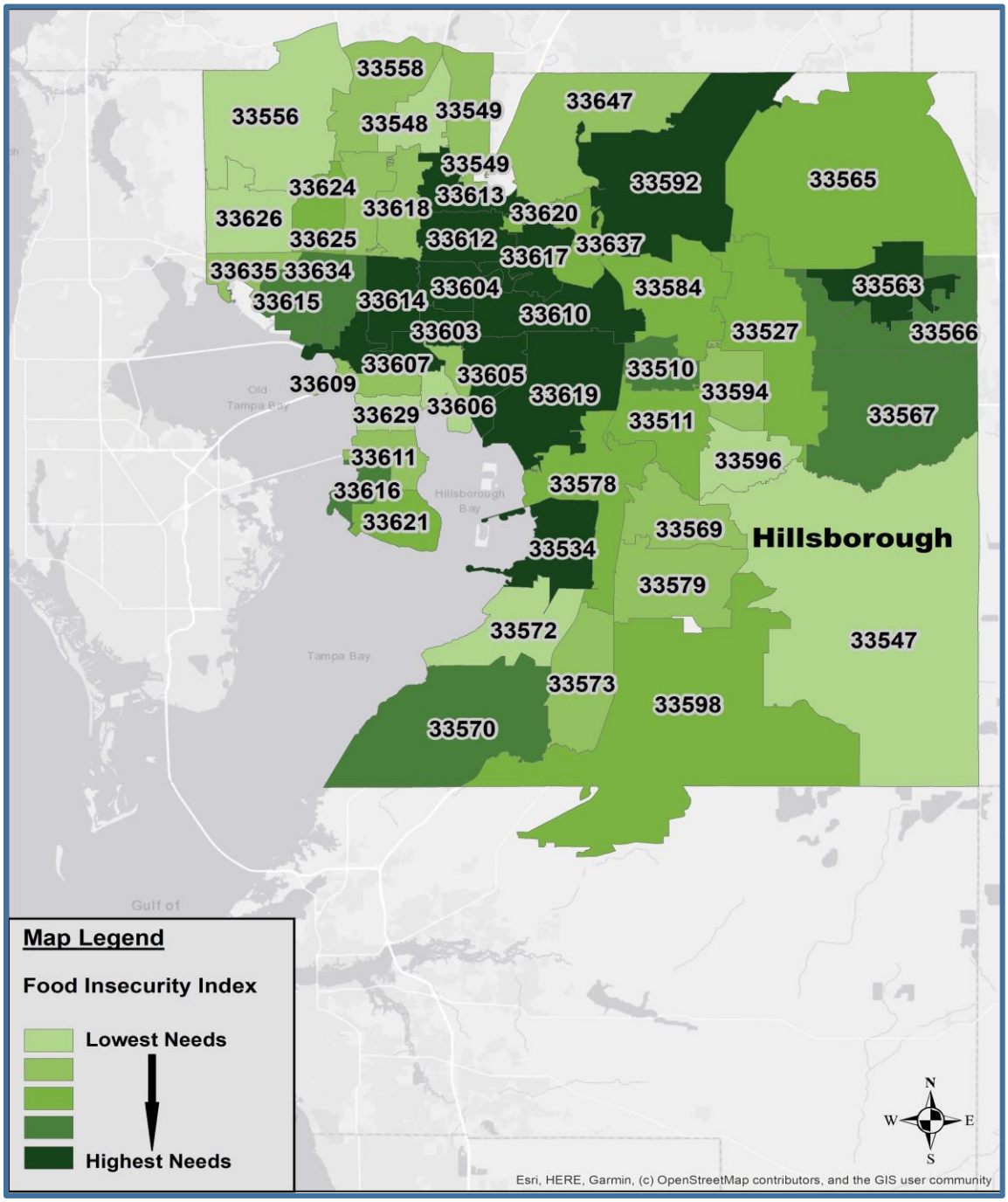
**Figure 21: Health Equity Index**



## Food Insecurity Index

Conduent's Food Insecurity Index estimates areas of low food accessibility correlated with social and economic hardship. ZIP codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 22. The following ZIP codes had the highest level of food insecurity (as indicated by the darkest shades of green): 33610 (Tampa) and 33605 (Tampa) with index values of 96.7 and 96.5, respectively. Appendix A provides the index values for each ZIP code.

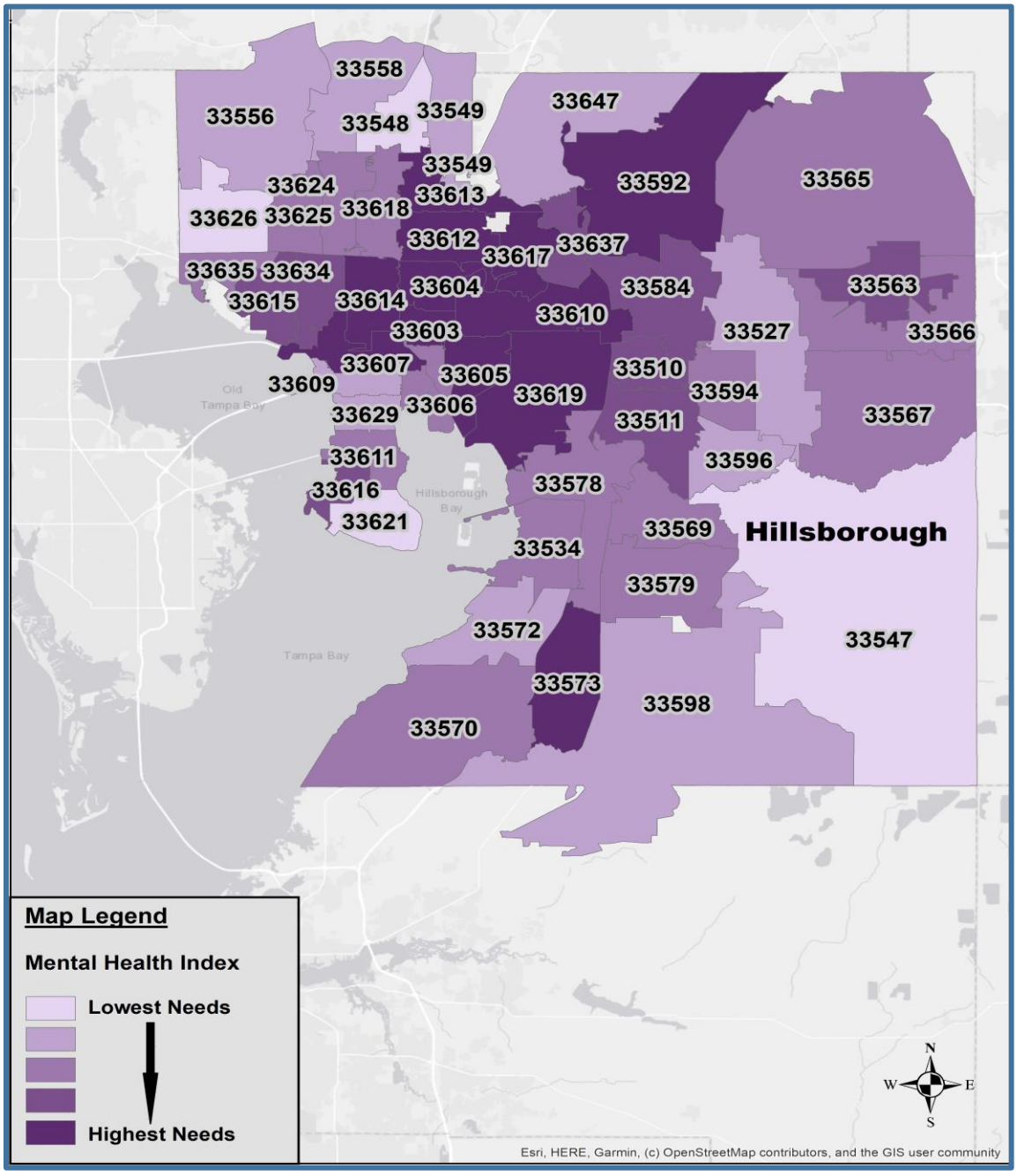
**Figure 22: Food Insecurity Index**



## Mental Health Index

Conduent's Mental Health Index (MHI) is a measure of socioeconomic and health factors correlated with self-reported poor mental health. Based on the MHI, in 2021, ZIP codes were ranked based on their index value to identify the relative levels of need, as illustrated by the map in Figure 23. The following two ZIP codes are estimated to have the highest need (as indicated by the darkest shades of purple): 33605 (Tampa) and 33573 (Sun City Center) with index value of 98.6 and 97.9, respectively. Appendix A provides the index values for highest need ZIP codes.

**Figure 23: Mental Health Index**



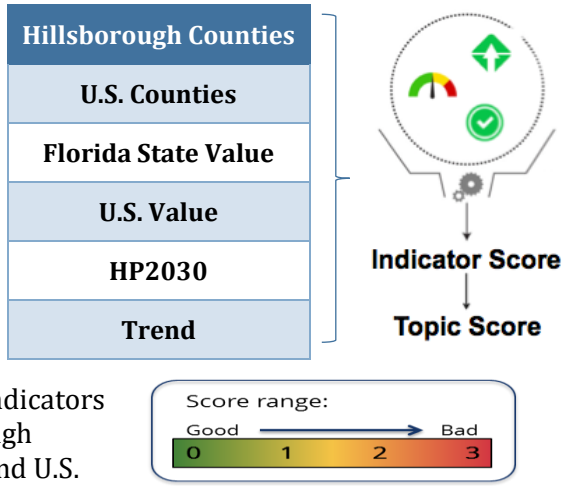
# Methodology

## Overview

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

## Secondary Data Sources & Analysis

Figure 24: Secondary Data Scoring




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

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

The analysis of national, state, and local indicators that contributed to the CHNA can be viewed in full in Appendix A. Table 2 shows the health and quality of life topic scoring results for Hillsborough County. Sexually Transmitted Infections came in as the poorest performing topic area with a score of 2.28, followed by Older Adults with a score of 1.95. Topics that received a score of 1.50 or higher were considered a significant health need. Eight topics scored at or above the threshold. Topic areas with fewer than three indicators were considered a data gap. Data gaps were specifically assessed as a part of the community survey and focus groups to ensure that, where the secondary data fell short, primary data could provide a more accurate picture of that particular health topic area.

Table 2: Secondary Data Topic Scoring Results

| Health Topic | Score |
|---|---|
| Sexually Transmitted Infections | 2.28 |
| Older Adults | 1.95 |
| Other Conditions | 1.70 |
| Mental Health & Mental Disorders | 1.68 |
| Cancer | 1.61 |
| Women's Health | 1.60 |
| Heart Disease & Stroke | 1.54 |
| Oral Health | 1.51 |
| Immunizations & Infectious Diseases | 1.47 |
| Wellness & Lifestyle | 1.40 |
| Physical Activity | 1.40 |
| Weight Status | 1.39 |
| Respiratory Diseases | 1.36 |
| Health Care Access & Quality | 1.34 |
| Children's Health | 1.28 |
| Diabetes | 1.25 |
| Maternal, Fetal & Infant Health | 1.23 |
| Tobacco Use | 1.20 |
| Alcohol & Drug Use | 1.19 |
| Prevention & Safety | 1.19 |
| Adolescent Health | 1.18 |

# Primary Data Collection & Analysis

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

## Community Survey

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

The All4HealthFL Collaborative worked extensively with community and organizational leads to market, outreach, and track survey responses to ensure an equitable representation of community voices was captured. Survey marketing and outreach efforts included email invitations, social media, and coordination of onsite paper survey distribution events in collaboration with community-based organizations. A community assessment dashboard was created to track and monitor survey respondents by ZIP code, age, gender, race, and ethnicity to ensure targeted outreach for at-risk populations. A total of 4,540 residents responded for Hillsborough County.

## Community Survey Analysis Results

Survey participants were asked about the top three pressing health and quality of life issues they believe should be addressed in their community. In Figure 25, the "Top Three Health Issues" were, mental health problems including suicide (40% of respondents), being overweight (31%), Illegal drug use/abuse or misuse of prescription medications (29%). The "Top Three Risky Behaviors" included; illegal drug use/abuse or misuse of prescription medications (45% of respondents), distracted driving such as, texting, eating, and talking on the phone (45% of respondents), and poor eating habits (42% of respondents). Lastly, the "Top Three Quality of Life Issues" included low crime/safe neighborhoods (42% of respondents), access to health care (36% of respondents), and good schools (29% of respondents).

**Figure 25: Top 3 Health & Quality of Life Issues**

## Focus Groups

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

Focus Group discussions took place in November 2021, with a total of 51 community participants. Due to the ongoing COVID-19 pandemic these discussions were conducted virtually. A questionnaire was developed to guide the conversations, which included topics such as Community Strengths & Assets, Top Health Problems, Access to Health, and Impact on Health. A list of questions utilized for focus group discussions can be found in Appendix C. To help inform an assessment of community assets, participants were asked to list and describe resources available in the community. The list of available resources is in Appendix E.

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

**Figure 26: Themes Across All Focus Groups**

| Top Health Issues | Barriers/Social Determinants of Health | Populations most impacted |
|---|---|---|
| • Healthcare Access & Quality<br>• Government/Policy<br>• Mental Health & Mental Disorders<br>• Nutrition & Healthy Eating, Weight Status<br>• Substance Abuse (alcohol & drug use) | • Built Environment<br>• Discrimination/Bias<br>• Economy<br>• Education<br>• Employment<br>• Environmental & Food Security/Access<br>• Health Behaviors (fear or stigma & knowledge or navigation of health system)<br>• Housing<br>• Lack of or limited health insurance<br>• Language/Culture<br>• Medication cost<br>• Poverty<br>• Social Environment<br>• Transportation | • Adolescents<br>• Black/African American<br>• Children<br>• Hispanic/Latino<br>• LGBTQ+ population<br>• Low-income families<br>• Migrant/Refugee/Immigrant<br>• Older adults |

# Data Synthesis & Prioritization

## Data Synthesis

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

**Figure 27: Trending Health Topics for Consideration**

## Prioritization

On May 12, 2022, participants from collaborating organizations, as well as other community partners, came together to prioritize the significant health needs for Hillsborough County. To better target issues regarding the most pressing health needs, the All4HealthFL Collaborative conducted a two-hour virtual prioritization session facilitated by the Tampa Bay Healthcare Collaborative (TBHC). A total of 61 individuals attended the prioritization session. These participants represented a broad cross section of experts and organizational leaders with extensive knowledge of health needs in the community. The meeting objectives included: review of analyzed health data pertaining to health needs and disparities, discussion of significant health needs identified, gathering input on health topics, prioritizing significant health needs, and generating preliminary ideas on how to collaborate to address top community needs. An additional discussion was hosted to close out the session with generating preliminary ideas on how the broader community could collaborate to address top community health needs.

## Process

The prioritization session included a presentation highlighting the findings from both the primary and secondary data and the resulting top health needs that were identified. Session participants were then directed to breakout groups to discuss the findings and the six health needs. Participants captured their thoughts through these breakout discussions, specifically how the health needs are impacted by SDoH. A detailed overview of discussion themes can be found in Appendix C. Discussions were supported with additional data placemats about each need area. Data placemats and an overview of discussion themes can be found in Appendix D.

Participants ranked each of the health categories individually using the dual criteria of scope and severity and ability to impact. Criteria scores were then combined to generate an overall ranking of health needs. Criteria scores were then combined to generate an overall ranking of health needs. A total of 61 individuals completed the online prioritization activity. The cumulative total score of each health topic can be seen in Table 3. The All4HealthFL Collaborative agreed with the ranking of the health topics and selected the top three prioritized health topics: Access to Health & Social Services, Behavioral Health (Mental Health & Substance Misuse), and Exercise, Nutrition & Weight.

**Table 3: Cumulative Total Score of Significant Health Topics (n=61)**

| Health Topics | Cumulative Total Score |
|---|---|
| Access to Health & Social Services | 173 |
| Behavioral Health (Mental Health & Substance Misuse) | 172 |
| Exercise, Nutrition & Weight | 167.5 |
| Heart Disease & Stroke | 146 |
| Immunizations & Infectious Diseases | 133 |
| Cancer | 132.5 |

# Prioritized Significant Health Needs

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


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

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

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

# Access to Health & Social Services

### Key Themes from Community Input

- **Thirty Six percent (36%)** of survey respondents ranked access to health care as a quality of life issue
- Gentrification/Built Environment reduces accessibility to services
- Systemic/institutional racism in healthcare dictates the type of care received
- Mistrust in healthcare due to past treatment/experiences
- Fear & trust of government and health & social services because of trauma, discrimination, immigration status
- Barriers include: transportation, lack or limited health insurance coverage (high out of pocket costs), knowledge & navigation of health system, affordable care/insurance, medication costs, long referral wait times, discrimination/racism/sexism

### Warning Indicators

- Adults without Health Insurance
- Adults with a Usual Source of Health Care
- Median Monthly Medicaid Enrollment

> If a patient has an emergency, we have to send them to the hospital and that's a bad use of services at the hospital. If there were more resources to have Primary Doctors for simple or basic problems, or ones that aren't emergencies, that would help lower the total cost of healthcare.
> -Hispanic/Latino Group Participant

## Primary Data: Community Survey & Focus Groups

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

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

trust because of experienced trauma and discrimination. Lack of or limited health insurance coverage created additional barriers to accessing medications and health services. Health Care knowledge and navigation of the health system was also mentioned throughout the focus groups. Often, participants' work and school schedules did not align with provider office hours or there were long wait times to see a specialist. Many also indicated not having transportation to get to medical appointments. Barriers to accessing care by focus group community are seen in Table 4.

**Table 4: Focus Group Overall Barriers to Accessing Care**

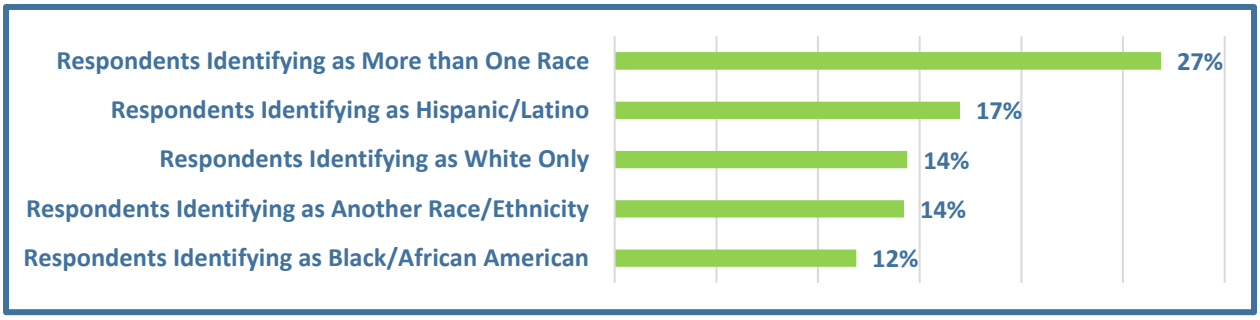
| | |
|---|---|
| **Black/African Americans** | • Fear due to experienced trauma of discrimination<br>• Lack of trust because of systemic racism<br>• Gentrification/built environment reduces accessibility to services<br>• Cost of care, insurance only available through certain employers |
| **Hispanic/Latino** | • Lack of bilingual providers/staff<br>• Fear/trust of government, health, and social services because of trauma, discrimination, or immigration status<br>• Transportation barriers |
| **LGBTQ+** | • Lack of trust in health system<br>• Lack of support programs for treating trans community<br>• Unaffordable health coverage |
| **Older Adults** | • Affordable care for daily living caregivers<br>• Fixed incomes<br>• Technological barriers<br>• Fragmented system/lack of coordinated care<br>• Transportation barriers |

> I think the problem is a lack of education among healthcare providers—whether they're working the front desk or they're doctors.
>
> -LGBTQ+ Focus Group Participant

## Barriers and Disparities: Access to Health Care Services

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

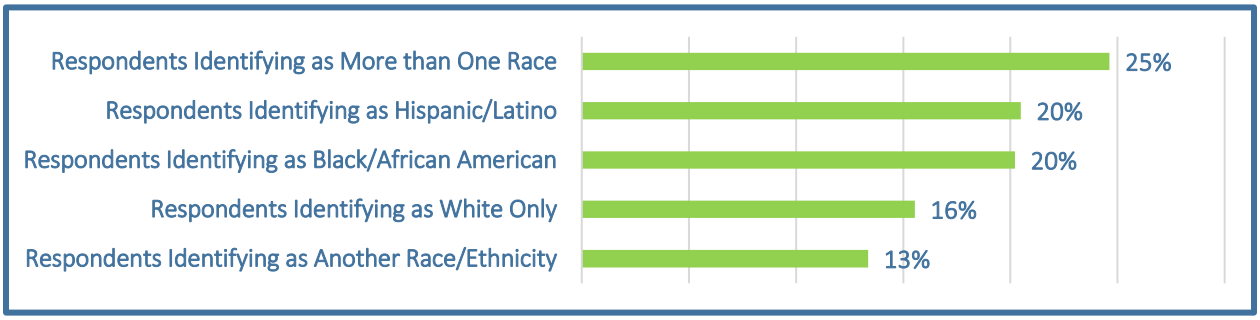
**Figure 28: Percentage of Respondents by Race/Ethnic Group with Unmet Health Needs in the Past 12 Months**




## Barriers and Disparities: Access to Dental Health Services

Access to dental health services was mentioned in the community survey as an important health issue. Twenty-three percent (23%) of survey respondents mentioned they had unmet dental needs. There were five top reasons that prevented respondents from getting the dental care they needed, which included: unable to afford to pay for care, not having insurance to cover dental care, unable to schedule an appointment when needed, unable to take time off work, and dentist offices that do not have convenient hours. The percentage of respondents by racial/ethnic group with unmet dental health needs in the past 12 months can be seen in Figure 29.

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




## Barriers and Disparities: Access to Care in the Emergency Room

Barriers in access to care for non-emergency needs was captured within the community survey. Forty-eight percent (48%) of survey respondents use the emergency room instead of going to a doctor's office or clinic for non-emergency needs. The main reasons the emergency room was used for non-emergent needs included: lack of after-hours/weekend services, long wait for an appointment with primary physician, do not have a doctor/clinic, and do not have insurance. Additional reasons why respondents visited the emergency room for non-emergent needs included: being referred by a doctor, experiencing pain, needing advice or consultation, experiencing a fall, or needing diagnostic testing.

## Secondary Data

From the secondary data scoring results, Health Care Access & Quality had the 14th data score of all topic areas, with a score of 1.34. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 5 below. See Appendix A for the full list of indicators categorized within this topic.

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

| SCORE | HEALTH CARE ACCESS & QUALITY | HILLSBOROUGH COUNTY | HP2030 | Florida | U.S. | Florida Counties | U.S. Counties | Trend |
|---|---|---|---|---|---|---|---|---|
| **2.12** | Adults without Health Insurance (2018) percent | 23 | -- | -- | 12.2 |  |  | -- |
| **1.85** | Adults with a Usual Source of Health Care (2017-2019) percent | 68.6 | -- | 72 | -- |  | -- | -- |
| **1.68** | Median Monthly Medicaid Enrollment (2020) enrollments/ 100,000 population | 21,411.1 | -- | 19,940.3 | -- |  | -- |  |

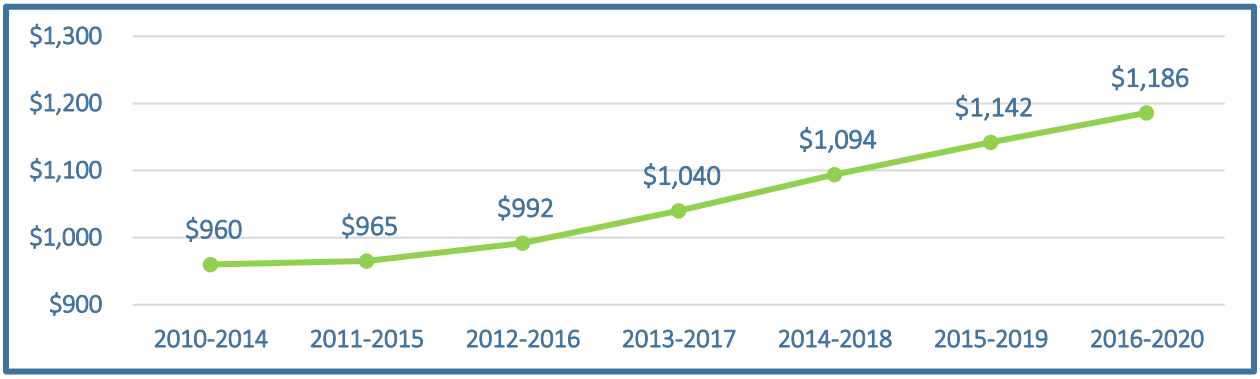
**HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.*

Adults without Health Insurance and Usual Source of Health Care are top areas of concern related to Health Care Access & Quality in Hillsborough County. The percentage of Adults without Health Insurance in Hillsborough County is (23%), which falls in the worst (25%) of counties in the nation. The indicator Adults with a Usual Source of Health Care shows the percentage of adults that report having one or more persons they think as their personal doctor or health care provider. The value for Hillsborough County, (68.6%), is in the worst (25%) of counties in the state. Furthermore, Median Monthly Medicaid Enrollments in Hillsborough County are 21,411.1 enrollments/100,000 population and trend over time is showing increasing concern.

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

Where people live is a large indicator of their health. Sixty-five percent (65%) of survey respondents say there are not affordable places to live in Hillsborough County. Secondary data indicators confirm that rental costs are rising to national highs in the Tampa Bay region. These rising rental costs are negatively impacting communities, especially those that identify as LGBTQ+ and older adults ages 65+. Figure 30 shows the trend for the Median Gross Household Rent in Hillsborough County from 2011 through 2020. In 2016-2020 Median Household Gross Rent for Hillsborough County residents was $1,186, which is higher than U.S. value of $1,096, but it is lower than state value of $1,218.

**Figure 30: Median Household Gross Rent, Hillsborough County**

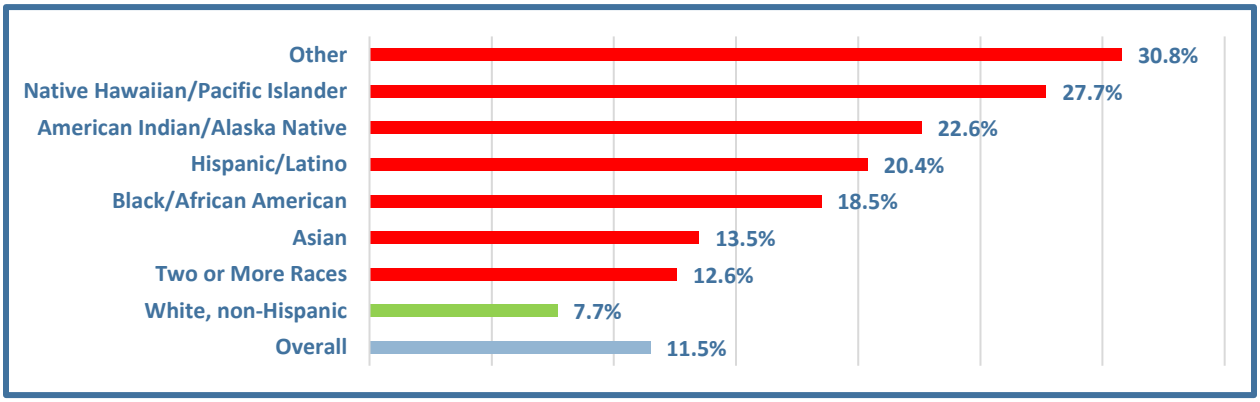



*American Community Survey, 2020*

> Quality of housing is a big problem. Houses are in bad shape with holes in the walls, and the children get sick with Asthma and Bronchitis. Housing is so expensive you will see two or three families living in one house.
>
> -Focus Group Participant

The rising rental costs are affecting all race and ethnic groups of the older adult population ages 65+. See Figure 31 for the race and ethnicity disparities by percentage that are higher than the overall 10% Hillsborough County value. The red bar in the graph represents disparity when compared to the overall Hillsborough County value and within all race/ethnicity/gender, while the green bar represents a particular race/ethnic group/gender doing better than the overall Hillsborough County value. Although White, non-Hispanic appears better than the overall county value, this population may be misrepresented or underreported.

**Figure 31: Percentage of People Ages 65+ Living Below Poverty Level by Race/Ethnicity**




*American Community Survey, 2015-2019*

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

### Behavioral Health: Mental Health

#### Key Themes from Community Input

- **41%** of survey respondents ranked behavioral health (mental health and substance misuse) as pressing health issues
- Top Reasons that prevented you from getting mental health care: Unable to afford to pay for care; Unable to schedule an appointment when needed; Am not sure how to find a doctor / counselor; Unable to find a doctor / counselor who takes my insurance; Do not have insurance to cover mental health care
- Barriers to care: stigma / fear seeking help, language barriers, shortage of affordable resources, long wait times
- COVID-19 exacerbated mental health illnesses
- Generational differences in understanding of mental health, more education is needed
- Lack of acknowledgement of trauma people have experienced by just trying to arrive to this country

#### Warning Indicators

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

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

Mental Health and Substance Misuse were identified as top health needs from the secondary data, community survey, and focus groups. The two were combined into Behavioral Health for this assessment. Forty-one percent (41%) of community survey respondents ranked Mental Health as a pressing health issue. Thirty-one percent (31%) of community survey respondents indicated being diagnosed as having depression or anxiety. The top five reasons respondents cited include: unable to access the mental health care they needed included inability to afford to pay for care, unable to schedule an appointment when needed, cannot take time off work, and do not have insurance to cover mental health care. Additional reasons cited by survey respondents included experiencing long wait times for scheduling an appointment, doctors' offices did not take new patients, and trust and fear of the health system due to COVID-19.

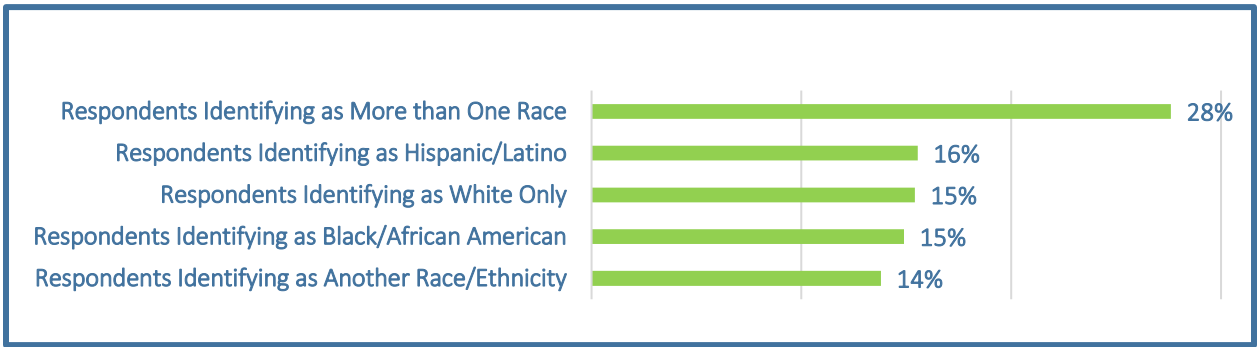
Mental Health was also a top health issue discussed during the focus group discussion. Specifically, barriers to care due to fear and stigma of seeking help was mentioned frequently. For many, the COVID-19 pandemic exacerbated mental health illnesses. Additionally, lack of affordable resources, language barriers, and long wait times to see a medical professional were also discussed. The LGBTQ+, Black/African American, and Hispanic/Latino communities stressed the importance of political and provider acknowledgment about minority stress, discrimination, and external factors

that have contributed to experienced trauma. These populations seem to experience more difficulty accessing mental health services.

## Barriers and Disparities: Mental Health

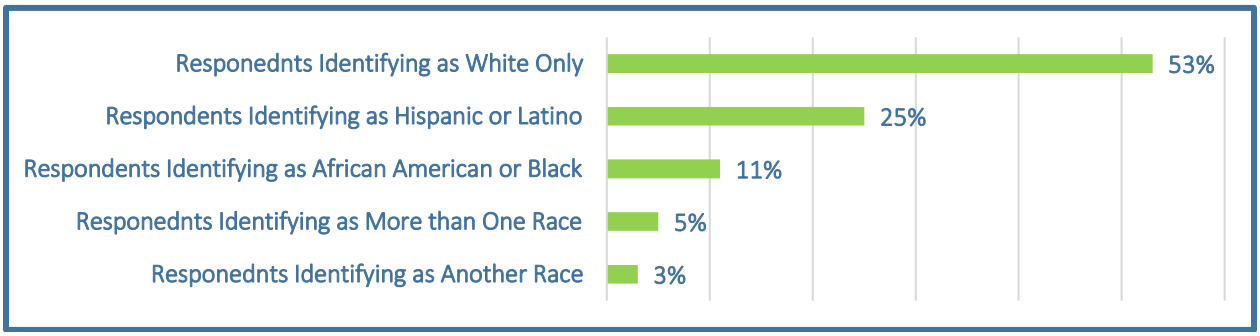
Figure 32 shows the percentage of respondents by race/ethnic group with unmet mental health needs within the past 12 months.

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




The community survey captured a question about Adverse Childhood Experiences (ACEs). ACE scores can help health providers tell the likelihood of increased risk of psychological and medical problems. As an individual's ACE score increases so does the risk of disease and social and emotional problems. In Hillsborough County, 16% of survey respondents reported experiencing four or more ACEs before age 18. The top five reported ACEs included: parent(s) were separated or divorced, lived with anyone who was a problem drinker or alcoholic, parent(s) or adult verbally harmed them (swear, insult, or put down), lived with anyone who was depressed, mentally ill, or suicidal, and/or parent(s) or adult physically harmed you (slap, hit, kick, etc.). The percentage of respondents by race/ethnic group who reported experiencing four or more ACEs are seen in Figure 33.

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




## Secondary Data: Mental Health

Warning indicators for Mental Health & Mental Disorders included Depression in the Medicare Population and Alzheimer's Disease or Dementia. See Table 6 for additional warning indicators from the secondary data analysis.

**Table 6: Data Scoring Results for Mental Health & Mental Disorders-Hillsborough County**

| SCORE | MENTAL HEALTH & MENTAL DISORDERS | Hillsborough County | HP2030 | Florida | U.S. | Florida Counties | U.S. Counties | Trend |
|---|---|---|---|---|---|---|---|---|
| **3.0** | Depression: Medicare Population (2018) percent | 22 | -- | 19.5 | 18.4 |  |  |  |
| **2.71** | Alzheimer's Disease or Dementia: Medicare Population (2018) percent | 14.4 | -- | 12.6 | 10.8 |  |  |  |
| **1.56** | Age-Adjusted Death Rate due to Suicide (2019) deaths/ 100,000 population | 14.1 | 12.8 | 14.5 | 13.9 |  | -- |  |

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

Depression and Alzheimer's Disease in Medicare population are top areas of concern related to Mental Health & Mental Disorders in Hillsborough County. The percentage of Medicare beneficiaries treated for Alzheimer's Disease or Dementia is 14.4% in Hillsborough County, which falls in the worst 25% of counties in both the state and nation. The indicator Depression: Medicare Population shows the percentage of Medicare beneficiaries who were treated for depression. The value for Hillsborough County, 22%, is in the worst 25% of counties in the state and nation. Furthermore, Age-Adjusted Death Rate due to Suicide in Hillsborough County are 14.1 deaths/100,000 population and showing definite concern in the community which is higher compared to HP 2030 Target value of 12.8 deaths/100,000 population.

> It doesn't matter whether you're an indigent patient or you have Medicare, or the best insurance in the world — there's not enough people to provide psychiatric care.
>
> -LGBTQ+ Focus Group Participant

## Alcohol and Substance Misuse

### Behavioral Health: Substance Misuse

**Key Themes from Community Input**

- **29%** of survey respondents ranked illegal drug use/abuse of prescription medications and alcohol abuse/drinking too much as an important health issue to address
- Deaths due to drug poisoning and opioid overdose is an increasing concern
- COVID-19 has helped remove stigma attached to seeking help

**Warning Indicators**

- Adults who Binge Drink
- Driving Under the Influence Arrest Rate
- Adults who Drink Excessively
- Adolescents who Use Electronic Vaping: Past 30 Days
- Adults who Smoke

## Secondary Data

Substance Misuse is a health topic that is analyzed from two secondary data health topics, i.e., Alcohol, Drug Use, and Tobacco Use. From the secondary data scoring results, Alcohol & Drug Use had the 19th and Tobacco Use had the 18th highest data score of all topic areas, with a score of 1.19 and 1.20, respectively. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 7 below. See Appendix A for the full list of indicators categorized within this topic.

**Table 7: Data Scoring Results for Alcohol & Drug Use**

| SCORE | ALCOHOL & DRUG USE | Hillsborough County | HP2030 | Florida | U.S. | Florida Counties | U.S. Counties | Trend |
|---|---|---|---|---|---|---|---|---|
| **1.76** | Adults who Binge Drink (2018) percent | 16.9 | -- | -- | 16.4 |  |  | -- |
| **1.59** | Driving Under the Influence Arrest Rate (2019) arrests/ 100,000 population | 237.5 | -- | 159.7 | -- |  | -- |  |
| **1.5** | Adults who Drink Excessively (2017-2019) percent | 17.1 | -- | 18 | -- |  | -- | -- |

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

Twenty-nine percent (29%) of community survey respondents ranked illegal drug use/abuse of prescription medications and alcohol abuse/drinking too much as important health issues to address. From the secondary data results, there are several indicators within Alcohol and Drug Use health topic that raise concerns for Hillsborough County. The worst performing indicator under this

health topic is the Adults who Binge Drink. This indicator shows the percentage of adults who reported binge drinking at least once during the 30 days prior to the survey. Male binge drinking is defined as five or more drinks on one occasion, and female binge drinking is four or more on one occasion. In Hillsborough County, 16.9% of Adults who Binge Drink, which is higher than the national value of 16.4%. Furthermore, the percentage of Adults who Drink Excessively in Hillsborough County is 17.1%. Finally, the percentage of arrests that involve Driving Under the Influence is higher in Hillsborough County (237.5 arrests per 100,000 population) than in Florida (159.7 arrests per 100,000 population).

**Table 8: Data Scoring Results for Tobacco Use**

| SCORE | TOBACCO USE | Hillsborough County | HP2030 | Florida | U.S. | Florida Counties | U.S. Counties | Trend |
|---|---|---|---|---|---|---|---|---|
| **1.68** | Adolescents who Use Electronic Vaping: Past 30 Days (2020) percent | 12.6 | -- | 14.5 | -- | -- | -- |  |
| **1.5** | Adults who Smoke (2017-2019) percent | 16 | 5 | 14.8 | -- |  | -- | -- |

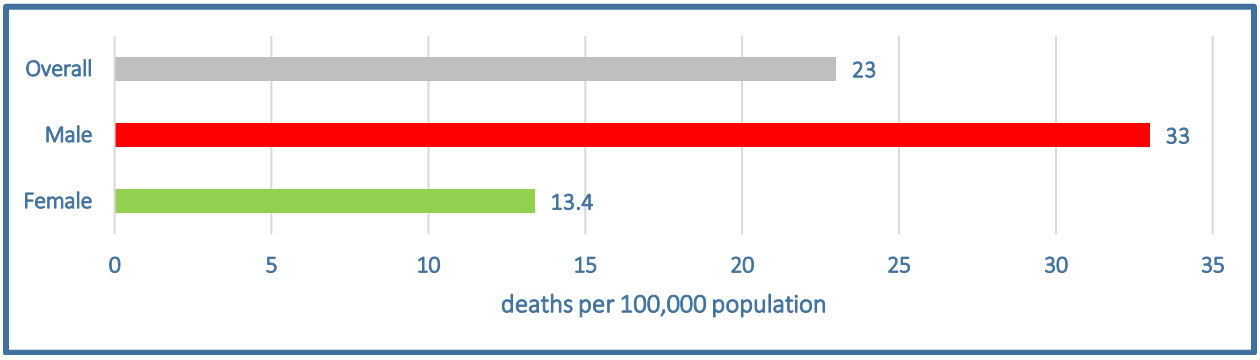
**HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.*

From the secondary data results, one indicator in Tobacco Use topic areas raises concern for Hillsborough County. This indicator shows the percentage of 6th-12th grade students who have used electronic vaping in the 30 days prior to the survey. The county has lower rates of Adolescents who Use Electronic Vaping: Past 30 days compared to Florida state, however trend over time is showing significant increase in the use of electronic vaping in adolescents.

## Barriers and Disparities: Mental Health

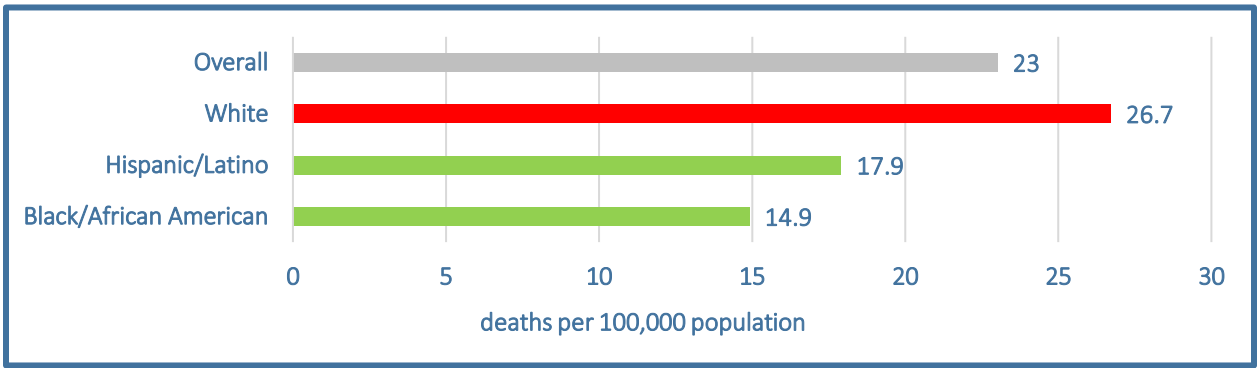
Thirty percent (30%) of community survey respondents ranked illegal drug use/abuse of prescription medications and alcohol abuse/drinking too much as important health issues to address. In Hillsborough County, Deaths Due to Drug Poisoning and Opioid Overdose have been an increasing concern, specifically for white males. See Age-Adjusted Drug and Opioid-Involved Overdose Death Rate by Gender (Figure 34) and Race/Ethnicity in (Figure 35). In the figures below the red bars indicates significantly worse than the overall value (gray bar). The green bar indicates below overall value (gray bar). Age-Adjusted Drug and Opioid-Involved Overdose Death rate per 100,000 population in Hillsborough County (23) are the same as U.S. value of (23.5). See (Figure 34) males (33) are twice as likely to experience opioid- involved deaths than females (13.4). (Figure 35) shows opioid-involved deaths rate by race/ethnicity. Overall, white populations (26.7) experience a higher rate of drug and opioid-involved deaths per 100,000 population then other race/ethnicities and the overall Hillsborough County value (23).

**Figure 34: Age-Adjusted Drug and Opioid-Involved Death Rate by Gender**




*Centers for Disease Control and Prevention, 2018-2020*

**Figure 35: Age Adjusted Drug and Opioid-Involved Death Rate by Race/Ethnicity**




*Centers for Disease Control and Prevention, 2018-2020*

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

### Exercise, Nutrition & Weight

#### Key Themes from Community Input

- Built Environment: inequitable access to affordable healthy food & physical activity opportunities
- Nutritional awareness
- Food insecurity, inequitable access to affordable healthy food, transportation barriers, rising food costs

#### Warning Indicators

- Teens without Sufficient Physical Activity
- Farmers Market Density
- SNAP Certified Stores
- Adults Who Are Obese
- Adults who are Overweight or Obese
- Children with Low Access to a Grocery Store
- Fast Food Restaurant Density
- Adults who are Sedentary
- Low-Income and Low Access to a Grocery Store
- Consumer Expenditures: Fast Food Restaurants
- Frequent Physical Distress
- Insufficient Sleep

> Poverty affects access to healthy living for children. Being a parent is really hard (to teach proper nutrition) because they have so much going on. It's just easier and less expensive to make unhealthy food.
>
> -Children's Focus Group Participant

### Primary Data: Focus Group

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

### Secondary Data

Secondary data for Exercise, Nutrition & Weight included Physical Activity data scoring. Physical Activity had the 11th highest data score of all topic areas. Further analysis was done to identify specific indicators of concern, which include indicators with high data scores (scoring at or above the threshold of 1.50) and seen in Table 9. See Appendix A for the full list of indicators categorized within this topic.

### Table 9: Data Scoring Results for Physical Activity

| SCORE | PHYSICAL ACTIVITY | Hillsborough County | HP2030 | Florida | U.S. | Florida Counties | U.S. Counties | Trend |
|---|---|---|---|---|---|---|---|---|
| **2.0** | Teens without Sufficient Physical Activity (2020) percent | 83.4 | -- | 82.3 | -- |  | -- |  |
| **1.85** | Farmers Market Density (2018) markets/1,000 population | 0 | -- | -- | -- | -- | -- |  |
| **1.82** | SNAP Certified Stores (2017) stores/1,000 population | 0.7 | -- | -- | -- |  |  |  |
| **1.68** | Adults who are Obese (2017-2019) percent | 30.2 | -- | 27 | -- |  | -- | -- |
| **1.68** | Adults who are Overweight or Obese (2017-2019) percent | 68.8 | -- | 64.6 | -- |  | -- | -- |
| **1.68** | Children with Low Access to a Grocery Store (2015) percent | 6 | -- | -- | -- |  |  | -- |
| **1.53** | Fast Food Restaurant Density (2016) restaurants/1,000 population | 0.6 | -- | -- | -- |  |  |  |
| **1.5** | Adults who are Sedentary (2017-2019) percent | 27.4 | 21.2 | 26.5 | -- |  | -- | -- |
| **1.5** | Low-Income and Low Access to a Grocery Store (2015) percent | 7.5 | -- | -- | -- |  |  | -- |

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

**Table 10: Data Scoring Results for Wellness & Lifestyle**

| SCORE | WELLNESS & LIFESTYLE | Hillsborough County | HP2030 | Florida | U.S. | Florida Counties | U.S. Counties | Trend |
|---|---|---|---|---|---|---|---|---|
| **1.94** | Consumer Expenditures: Fast Food Restaurants (2021) average dollar amount per consumer unit | 1,645.4 | -- | 1,520 | 16,38.9 |  |  | -- |
| **1.68** | Frequent Physical Distress (2018) percent | 12.9 | -- | 12.6 | 11 |  |  | -- |
| **1.5** | Insufficient Sleep (2018) percent | 37.6 | 31.4 | 37.3 | 35 |  |  | -- |

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

One of the worst performing indicators under Physical Activity health topics is percentage of Teens Without Sufficient Physical Activity (83.4%) in Hillsborough County. Studies have shown that sedentary lifestyles and a lack of fruits and vegetables can increase the risk of many chronic diseases, including obesity, heart disease and Type 2 diabetes.[15]

The percentage of obese adults is an indicator of the overall health and lifestyle of a community. Obesity increases the risk of many diseases and health conditions, including heart disease, Type 2 diabetes, stroke, and cancer. In Hillsborough County, 30.2% of adults are obese, and 68.8% adults are Overweight. This is higher than the state values, although not significantly.

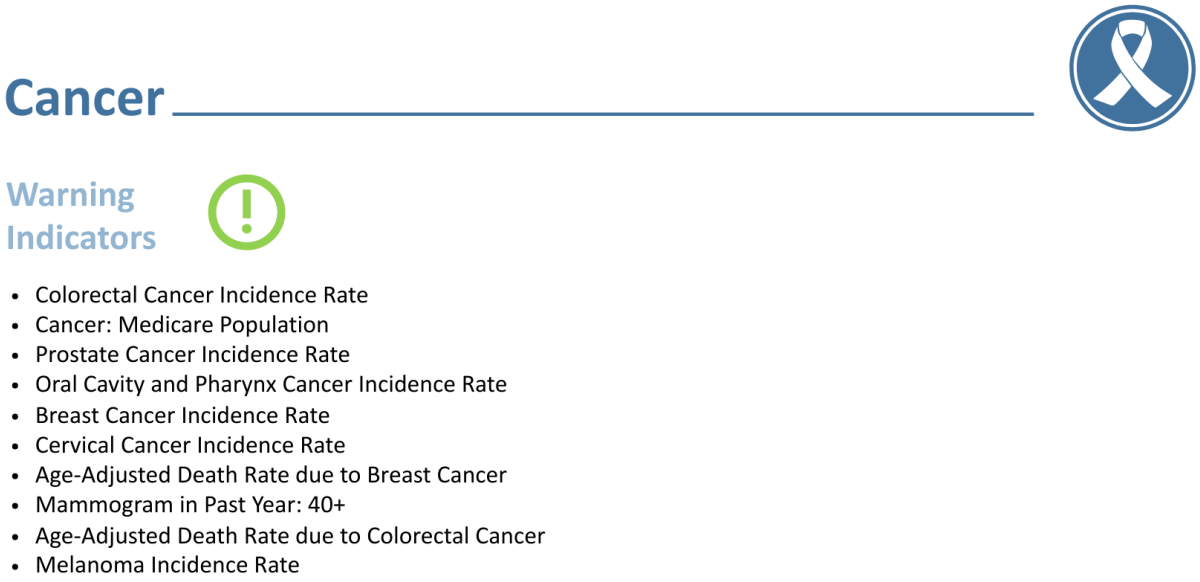
Other worst-performing indicators within this topic category are related to the built environment such as Children with Low Access to a Grocery Store. The percentage of Children with Low Access to a Grocery Store is 6%, which falls in worst 50% counties in both Florida and the U.S. This indicator shows the percentage of children living more than one mile from a supermarket or large grocery store if in an urban area, or more than 10 miles from a supermarket or large grocery store if in a rural area. Additionally, Farmers Market Density, SNAP Certified Store and Low-income and Low access to Grocery store are poorly performing indicators that measure food access. HCI's Food Insecurity Index®, discussed earlier in this report, can be used to help identify geographic areas of low food accessibility within Hillsborough County community.

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

# Non-Prioritized Significant Health Needs

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

## Non-Prioritized Health Need #1: Cancer




In Hillsborough County, Cancer was not mentioned in focus groups and was ranked low in the community survey. Seventeen percent (17%) of survey respondents ranked Cancer as a pressing health issue and 10% reported being told by a medical provider that they have been diagnosed. Secondary data warning indicators showed county values at or slightly above Florida and U.S. values for cervical cancer incidence rate, melanoma incidence rate, and cancer within the Medicare population.

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

### Heart Disease & Stroke

#### Warning Indicators

- Stroke: Medicare Population
- Atrial Fibrillation: Medicare Population
- Ischemic Heart Disease: Medicare Population
- Adults who Have Taken Medications for High Blood Pressure
- Hyperlipidemia: Medicare Population
- Hypertension: Medicare Population
- Age-Adjusted Hospitalization Rate due to Heart Attack
- Age-Adjusted Death Rate due to Coronary Heart Disease

Heart Disease and Stroke as a topic on its own did not come through as a top community health issue within the community survey or focus groups. Although 36% of survey respondents reported being told by a medical provider that they have hypertension and/or heart disease, the raised concern was related to nutrition and obesity, and could best be addressed within the Exercise, Nutrition, and Weight health topic.

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

### Immunizations & Infectious Diseases

#### Warning Indicators

- Chlamydia Incidence Rate
- Syphilis Incidence Rate
- Gonorrhea Incidence Rate
- HIV Incidence Rate
- Overcrowded Households
- Adults 65+ with Pneumonia Vaccination

Immunizations and Infectious Diseases did not come up as a top issue through community feedback. A secondary data warning indicator of concern includes Syphilis Incidence Rate in Hillsborough County (22.9 cases per 100,000 population) in 2020, which is over the U.S. value (11.9 cases per 100,000 population) and the Florida value of (16.2 cases per 100,000 population). There are opportunities to improve education on prevention of syphilis incidence rates as cases in Hillsborough County have increased gradually since 2017.

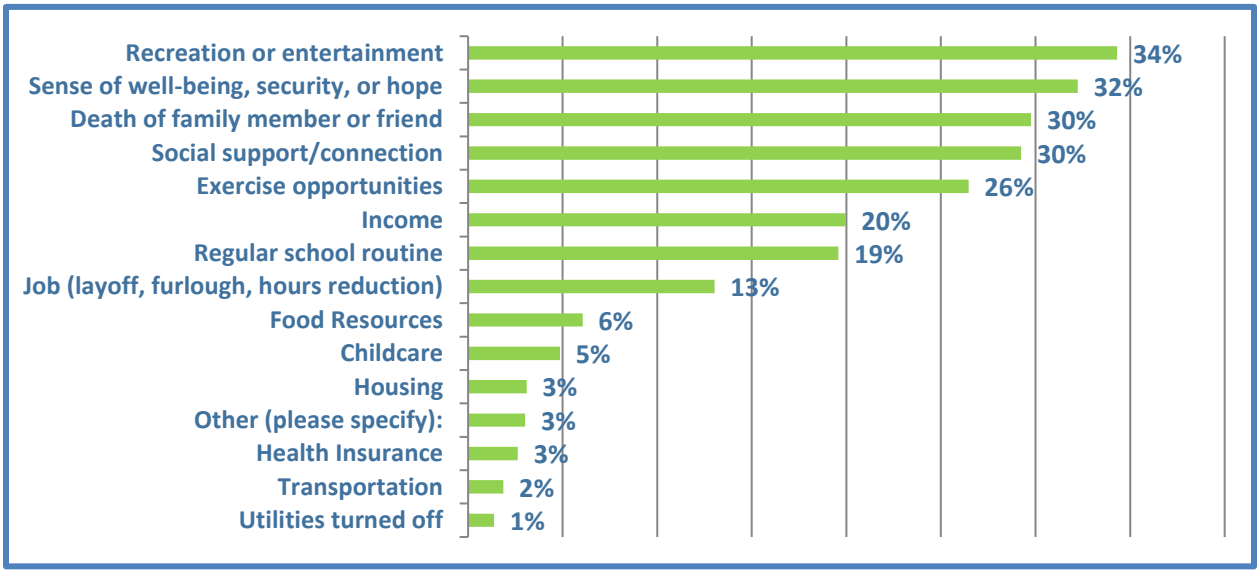
# Additional Opportunities for Impact

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

## COVID-19 Pandemic

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

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



## Community Lived Experiences Around Diversity, Equity & Inclusion

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

**Figure 37: Percentage of Respondents from Hillsborough County who Reported Experiencing Discrimination**

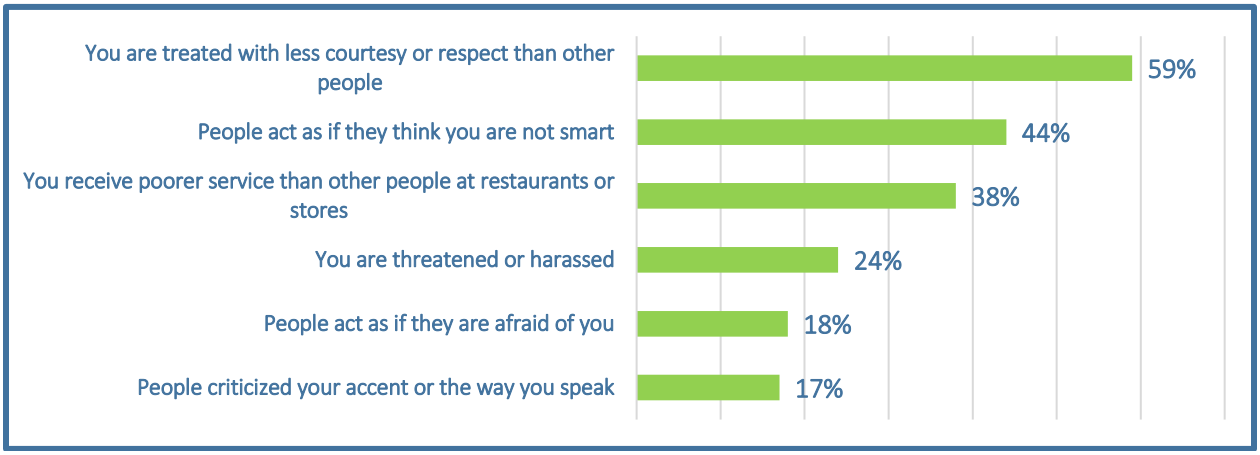
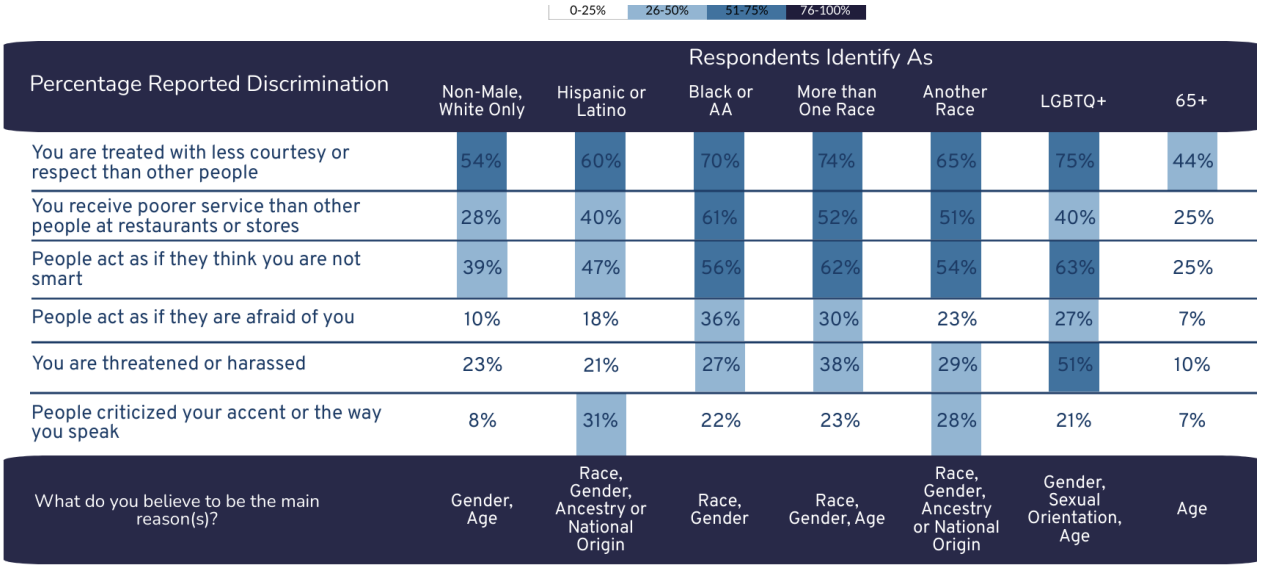



Figure 38 breaks down the percentages of reported discrimination by respondents' identity of themselves, as well as why they believe they experienced this discrimination. For example, in what ways did Hispanic/Latino community members report experiencing discrimination and what did they believe was the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

**Figure 38: Percentage of Respondents who Reported Experiencing Discrimination by Discrimination Type**




# Conclusion

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

# Appendices Summary

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

## A. Secondary Data (Methodology and Data Scoring Tables)

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

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

## B. Index of Disparity

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

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

## C. Community Input Assessment Tools

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

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

## D. Data Placemats

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

## E. Community Partners and Resources

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

## F. Partner Achievements

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

# Appendix Table of Contents

# Appendix A. Secondary Data Methodology

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

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

# Appendix A. Secondary Data Methodology and Data Scoring Tables

| SCORE | ADOLESCENT HEALTH | UNITS | HILLSBOROUGH COUNTY | HP2030 | Florida | U.S. | MEASUREMENT PERIOD | RACE DISPARITY | Source |
|---|---|---|---|---|---|---|---|---|---|
| **2.03** | Teens with Asthma | *percent* | 25.2 | | 21.3 | | *2020* | | 23 |
| **2.00** | Teens without Sufficient Physical Activity | *percent* | 83.4 | | 82.3 | | *2020* | | 13 |
| **1.68** | Adolescents who Use Electronic Vaping: Past 30 Days | *percent* | 12.6 | | 14.5 | | *2020* | | 23 |
| **1.35** | Teens who Use Alcohol | *percent* | 20.3 | | 19.9 | | *2020* | | 22 |
| **1.26** | Adolescents who Use Smokeless Tobacco: Lifetime | *percent* | 3.7 | | 3.7 | | *2020* | | 23 |
| **1.24** | Adolescents who Use Electronic Vaping: Lifetime | *percent* | 21.7 | | 26.4 | | *2020* | | 23 |
| **1.09** | Teens who have Used Methamphetamines | *percent* | 0.5 | | 0.8 | | *2020* | | 22 |
| **0.97** | Teen Birth Rate: 15-19 | *live births/ 1,000 females aged 15-19* | 16.7 | | 16.2 | 16.7 | *2019* | Black (26.4) White (15.3) Hispanic/Latino (23.4) | 18 |
| **0.82** | Teens who are Obese: High School Students | *percent* | 13.5 | | 15.4 | | *2020* | | 13 |
| **0.82** | Teens who Use Marijuana: High School Students | *percent* | 11.9 | | 15.9 | | *2020* | | 22 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **0.79** | Adolescents who Use Smokeless Tobacco: Past 30 Days | *percent* | 1.1 | | 1.3 | | *2020* | | 23 |
| **0.79** | Teens who Smoke Cigarettes: High School Students | *percent* | 1.1 | | 1.5 | | *2020* | | 23 |
| **0.53** | Teens who Binge Drink: High School Students | *percent* | 7.5 | | 9.2 | | *2020* | | 22 |
| **SCORE** | **ALCOHOL & DRUG USE** | **UNITS** | **HILLSBOROUGH COUNTY** | **HP2030** | **Florida** | **U.S.** | **MEASUREMENT PERIOD** | **RACE DISPARITY** | **Source** |
| **1.76** | Adults who Binge Drink | *percent* | 16.9 | | | 16.4 | *2018* | | 3 |
| **1.59** | Driving Under the Influence Arrest Rate | *arrests/ 100,000 population* | 237.5 | | 159.7 | | *2019* | | 20 |
| **1.50** | Adults who Drink Excessively | *percent* | 17.1 | | 18 | | *2017-2019* | | 10 |
| **1.35** | Teens who Use Alcohol | *percent* | 20.3 | | 19.9 | | *2020* | | 22 |
| **1.24** | Alcohol-Impaired Driving Deaths | *percent of driving deaths with alcohol involvement* | 26 | 28.3 | 22.3 | 27 | *2015-2019* | | 7 |
| **1.24** | Death Rate due to Drug Poisoning | *deaths/ 100,000 population* | 18.2 | | 23.6 | 21 | *2017-2019* | | 7 |
| **1.24** | Health Behaviors Ranking | *ranking* | 12 | | | | *2021* | | 7 |
| **1.09** | Teens who have Used Methamphetamines | *percent* | 0.5 | | 0.8 | | *2020* | | 22 |
| **0.82** | Teens who Use Marijuana: High School Students | *percent* | 11.9 | | 15.9 | | *2020* | | 22 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **0.71** | Age-Adjusted Drug and Opioid-Involved Overdose Death Rate | *Deaths per 100,000 population* | 18.4 | | 25.6 | 22.8 | *2017-2019* | | 4 |
| **0.53** | Teens who Binge Drink: High School Students | *percent* | 7.5 | | 9.2 | | *2020* | | 22 |
| **SCORE** | **CANCER** | **UNITS** | **HILLSBOROUGH COUNTY** | **HP2030** | **Florida** | **U.S.** | **MEASUREMENT PERIOD** | **RACE DISPARITY** | **Source** |
| **2.47** | Colorectal Cancer Incidence Rate | *cases/ 100,000 population* | 41.2 | | 35.6 | | *2016-2018* | | 32 |
| **2.18** | Cancer: Medicare Population | *percent* | 9.9 | | 10.1 | 8.4 | *2018* | | 5 |
| **2.18** | Prostate Cancer Incidence Rate | *cases/ 100,000 males* | 99 | | 89.6 | | *2016-2018* | | 32 |
| **2.12** | Oral Cavity and Pharynx Cancer Incidence Rate | *cases/ 100,000 population* | 14.8 | | 13.5 | | *2016-2018* | | 32 |
| **2.00** | Breast Cancer Incidence Rate | *cases/ 100,000 females* | 132.2 | | 121.2 | | *2016-2018* | | 32 |
| **2.00** | Cervical Cancer Incidence Rate | *cases/ 100,000 females* | 10 | | 9 | | *2016-2018* | | 32 |
| **1.82** | Age-Adjusted Death Rate due to Breast Cancer | *deaths/ 100,000 females* | 11 | 15.3 | 10.4 | | *2017-2019* | Black (16) White (9.3) Hispanic/Latino (7.5) | 18 |
| **1.82** | Mammogram in Past Year: 40+ | *percent* | 55.5 | | 60.8 | | *2016* | | 10 |
| **1.71** | Age-Adjusted Death Rate due to Colorectal Cancer | *deaths/ 100,000 population* | 14.5 | 8.9 | 13.1 | | *2017-2019* | | 18 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **1.65** | Melanoma Incidence Rate | *cases/ 100,000 population* | 25.3 | | 25.2 | | *2016-2018* | Black (0.8) White (30.3) Hispanic/Latino (4) | 32 |
| **1.47** | Colon Cancer Screening | *percent* | 16.4 | | 16 | | *2016* | Black (4.4) White (17.7) Hispanic/Latino (20.9) | 10 |
| **1.41** | Cervical Cancer Screening: 21-65 | *Percent* | 83.7 | 84.3 | | 84.7 | *2018* | | 3 |
| **1.35** | Age-Adjusted Death Rate due to Lung Cancer | *deaths/ 100,000 population* | 37.8 | 25.1 | 35.3 | | *2017-2019* | | 18 |
| **1.35** | Lung and Bronchus Cancer Incidence Rate | *cases/ 100,000 population* | 60.3 | | 56.6 | | *2016-2018* | | 32 |
| **1.29** | Pap Test in Past Year | *percent* | 50.3 | | 48.4 | | *2016* | | 10 |
| **1.06** | Age-Adjusted Death Rate due to Cancer | *deaths/ 100,000 population* | 152 | 122.7 | 146.1 | | *2017-2019* | | 18 |
| **1.00** | Age-Adjusted Death Rate due to Prostate Cancer | *deaths/ 100,000 males* | 6.9 | 16.9 | 7.4 | | *2017-2019* | Black (13.1) White (5.9) Hispanic/Latino (6) | 18 |
| **0.88** | Adults with Cancer | *percent* | 6.3 | | | 6.9 | *2018* | | 3 |
| **0.88** | Mammogram in Past 2 Years: 50-74 | *percent* | 78.7 | 77.1 | | 74.8 | *2018* | | 3 |
| | | | | | | | | | |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

| SCORE | CHILDREN'S HEALTH | UNITS | HILLSBOROUGH COUNTY | HP2030 | Florida | U.S. | MEASUREMENT PERIOD | RACE DISPARITY | Source |
|---|---|---|---|---|---|---|---|---|---|
| **1.68** | Children with Low Access to a Grocery Store | *percent* | 6 | | | | *2015* | | 29 |
| **1.41** | Children with Health Insurance | *percent* | 93.6 | | 92.4 | 94.3 | *2019* | | 1 |
| **1.32** | Kindergartners with Required Immunizations | *percent* | 95.2 | | 93.5 | | *2020* | | 15 |
| **1.15** | Child Food Insecurity Rate | *percent* | 15.6 | | 17.1 | 14.6 | *2019* | | 8 |
| **1.06** | Child Abuse Rate | *cases/ 1,000 children aged 5-11* | 6.9 | | 6.6 | | *2019* | | 11 |
| **1.06** | Projected Child Food Insecurity Rate | *percent* | 18.5 | | 19.1 | | *2021* | | 8 |
| | | | | | | | | | |
| **SCORE** | **COMMUNITY** | **UNITS** | **HILLSBOROUGH COUNTY** | **HP2030** | **Florida** | **U.S.** | **MEASUREMENT PERIOD** | **RACE DISPARITY** | **Source** |
| **2.65** | Solo Drivers with a Long Commute | *percent* | 45.1 | | 42.4 | 37 | *2015-2019* | | 7 |
| **2.47** | Mean Travel Time to Work | *minutes* | 28.1 | | 27.8 | 26.9 | *2015-2019* | | 1 |
| **2.35** | Social Associations | *membership associations/ 10,000 population* | 7 | | 7 | 9.3 | *2018* | | 7 |
| **2.21** | Median Household Gross Rent | *dollars* | 1142 | | 1175 | 1062 | *2015-2019* | | 1 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| **2.21** | Mortgaged Owners Median Monthly Household Costs | *dollars* | 1540 | | 1503 | 1595 | *2015-2019* | | 1 |
| **2.06** | Single-Parent Households | *percent* | 30.1 | | 29 | 25.5 | *2015-2019* | | 1 |
| **1.85** | Median Monthly Owner Costs for Households without a Mortgage | *dollars* | 474 | | 505 | 500 | *2015-2019* | | 1 |
| **1.68** | Median Monthly Medicaid Enrollment | *enrollments/ 100,000 population* | 21411.1 | | 19940.3 | | *2020* | | 9 |
| **1.68** | Voter Turnout: Presidential Election | *percent* | 76.8 | | 77.2 | | *2020* | | 21 |
| **1.65** | Workers Commuting by Public Transportation | *percent* | 1.4 | 5.3 | 1.8 | 5 | *2015-2019* | Black (4.1) White (0.6) Asian (1.9) American Indian/Alaskan Native (1.6) Native Hawaiian/Pacific islander (4.5) Multiracial (2.7) Other (0.8) Hispanic/Latino (1.2) | 1 |
| **1.59** | Consumer Expenditures: Local Public Transportation | *average dollar amount per consumer unit* | 117.9 | | 107.5 | 148.8 | *2021* | | 6 |
| **1.59** | Driving Under the Influence Arrest Rate | *arrests/ 100,000 population* | 237.5 | | 159.7 | | *2019* | | 20 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| **1.41** | Homeownership | *percent* | 53.1 | | 53.5 | 56.2 | *2015-2019* | | 1 |
| **1.41** | Social and Economic Factors Ranking | *ranking* | 19 | | | | *2021* | | 7 |
| **1.35** | People 65+ Living Alone | *percent* | 24.7 | | 23.7 | 26.1 | *2015-2019* | | 1 |
| **1.24** | Alcohol-Impaired Driving Deaths | *percent of driving deaths with alcohol involvement* | 26 | 28.3 | 22.3 | 27 | *2015-2019* | | 7 |
| **1.24** | People Living Below Poverty Level | *percent* | 14.6 | 8 | 14 | 13.4 | *2015-2019* | | 1 |
| **1.18** | Domestic Violence Offense Rate | *offenses/ 100,000 population* | 465.8 | | 496.5 | | *2019* | | 20 |
| **1.06** | Child Abuse Rate | *cases/ 1,000 children aged 5-11* | 6.9 | | 6.6 | | *2019* | | 11 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **1.06** | Children Living Below Poverty Level | *percent* | 19.8 | | 20.1 | 18.5 | *2015-2019* | Black (31.8) White (9.8) Asian (8.9) American Indian/Alaskan Native (5.7) Native Hawaiian/Pacific islander (13.8) Multiracial (18.3) Other (29) Hispanic/Latino (26.7) | 1 |
| **1.06** | Households without a Vehicle | *percent* | 6.5 | | 6.3 | 8.6 | *2015-2019* | | 1 |
| **1.06** | Persons with an Internet Subscription | *percent* | 89.5 | | 85.7 | 86.2 | *2015-2019* | | 1 |
| **1.00** | Age-Adjusted Death Rate due to Motor Vehicle Collisions | *deaths/ 100,000 population* | 13.9 | | 14.7 | | *2019* | | 18 |
| **1.00** | Total Employment Change | *percent* | 2 | | 2.2 | 1.6 | *2018-2019* | | 28 |
| **0.97** | Households with No Car and Low Access to a Grocery Store | *percent* | 1.4 | | | | *2015* | | 29 |
| **0.97** | Median Housing Unit Value | *dollars* | 216300 | | 215300 | 217500 | *2015-2019* | | 1 |
| **0.88** | Juvenile Justice Referral Rate | *referrals/ 10,000 population* | 158.2 | | 160.6 | | *2019* | | 19 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| **0.88** | Workers who Drive Alone to Work | *percent* | 79.1 | | 79.1 | 76.3 | *2015-2019* | | 1 |
| **0.79** | Households with an Internet Subscription | *percent* | 87.6 | | 83.3 | 83 | *2015-2019* | | 1 |
| **0.79** | Households with One or More Types of Computing Devices | *percent* | 93.7 | | 91.5 | 90.3 | *2015-2019* | | 1 |
| **0.76** | Female Population 16+ in Civilian Labor Force | *percent* | 60.2 | | 54.3 | 58.3 | *2015-2019* | | 1 |
| **0.76** | Population 16+ in Civilian Labor Force | *percent* | 61.2 | | 55.2 | 59.6 | *2015-2019* | | 1 |
| **0.71** | Median Household Income | *dollars* | 58884 | | 55660 | 62843 | *2015-2019* | | 1 |
| **0.71** | People 25+ with a High School Degree or Higher | *percent* | 88.7 | | 88.2 | 88 | *2015-2019* | | 1 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| **0.53** | Per Capita Income | *dollars* | 32343 | | 31619 | 34103 | *2015-2019* | | 1 |
| **0.44** | Violent Crime Rate | *crimes/ 100,000 population* | 253 | | 382.4 | 379.4 | *2019* | | 20 |
| **0.18** | People 25+ with a Bachelor's Degree or Higher | *percent* | 33.5 | | 29.9 | 32.1 | *2015-2019* | | 1 |
| | | | | | | | | | |
| **SCORE** | **COUNTY HEALTH RANKINGS** | **UNITS** | **HILLSBOROUGH COUNTY** | **HP2030** | **Florida** | **U.S.** | **MEASUREMENT PERIOD** | **RACE DISPARITY** | **Source** |
| **1.76** | Physical Environment Ranking | *ranking* | 65 | | | | *2021* | | 7 |
| **1.41** | Clinical Care Ranking | *ranking* | 27 | | | | *2021* | | 7 |
| **1.41** | Morbidity Ranking | *ranking* | 19 | | | | *2021* | | 7 |
| **1.41** | Social and Economic Factors Ranking | *ranking* | 19 | | | | *2021* | | 7 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| **1.24** | Health Behaviors Ranking | *ranking* | 12 | | | | *2021* | | 7 |
| **1.24** | Mortality Ranking | *ranking* | 9 | | | | *2021* | | 7 |
| | | | | | | | | | |
| **SCORE** | **DIABETES** | **UNITS** | **HILLSBOROUGH COUNTY** | **HP2030** | **Florida** | **U.S.** | **MEASUREMENT PERIOD** | **RACE DISPARITY** | **Source** |
| **1.68** | Diabetes: Medicare Population | *percent* | 28.6 | | 27.8 | 27 | *2018* | | 5 |
| **1.15** | Adults with Diabetes | *percent* | 10.9 | | 11.7 | | *2017-2019* | | 10 |
| **0.91** | Age-Adjusted Death Rate due to Diabetes | *deaths/ 100,000 population* | 19.3 | | 19.7 | 21.6 | *2019* | Black (43.6) White (19.2) Hispanic/Latino (22.9) | 18 |
| | | | | | | | | | |
| **SCORE** | **ECONOMY** | **UNITS** | **HILLSBOROUGH COUNTY** | **HP2030** | **Florida** | **U.S.** | **MEASUREMENT PERIOD** | **RACE DISPARITY** | **Source** |
| **2.21** | Median Household Gross Rent | *dollars* | 1142 | | 1175 | 1062 | *2015-2019* | | 1 |
| **2.21** | Mortgaged Owners Median Monthly Household Costs | *dollars* | 1540 | | 1503 | 1595 | *2015-2019* | | 1 |
| **1.88** | People 65+ Living Below Poverty Level | *percent* | 11.1 | | 10.4 | 9.3 | *2015-2019* | Black (19.1) White (7.4) Asian (9.2) American | 1 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Indian/Alaskan Native (28.9) Native Hawaiian/Pacific islander (26.5) Multiracial (14.6) Other (23.1) Hispanic/Latino (20) | |
| **1.85** | Median Monthly Owner Costs for Households without a Mortgage | *dollars* | 474 | | 505 | 500 | *2015-2019* | | 1 |
| **1.82** | Renters Spending 30% or More of Household Income on Rent | *percent* | 52.2 | | 56.3 | 49.6 | *2015-2019* | | 1 |
| **1.82** | SNAP Certified Stores | *stores/ 1,000 population* | 0.7 | | | | *2017* | | 29 |
| **1.76** | Consumer Expenditures: Homeowner Expenses | *average dollar amount per consumer unit* | 8047.4 | | 7675.2 | 8900.1 | *2021* | | 6 |
| **1.59** | Families Living Below Poverty Level | *percent* | 10.6 | | 10 | 9.5 | *2015-2019* | Black (19.2) White (5.6) Asian (5.8) American Indian/Alaskan Native (12.7) Native Hawaiian/Pacific islander | 1 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | (6) Multiracial (13.8) Other (18.1) Hispanic/Latino (16.9) | |
| **1.59** | Severe Housing Problems | *percent* | 18.7 | | 19.5 | 18 | *2013-2017* | | 7 |
| **1.53** | Mortgaged Owners Spending 30% or More of Household Income on Housing | *percent* | 29.1 | | 32.2 | 26.5 | *2019* | | 1 |
| **1.53** | Overcrowded Households | *percent of households* | 3.1 | | 3 | | *2015-2019* | | 1 |
| **1.53** | Students Eligible for the Free Lunch Program | *percent* | 50.4 | | | | *2019-2020* | | 25 |
| **1.50** | Households that are Below the Federal Poverty Level | *percent* | 13.7 | | 13 | | *2018* | | 31 |
| **1.50** | Low-Income and Low Access to a Grocery Store | *percent* | 7.5 | | | | *2015* | | 29 |
| **1.41** | Consumer Expenditures: Home Rental Expenses | *average dollar amount per consumer unit* | 4787.9 | | 4431 | 5460.2 | *2021* | | 6 |
| **1.41** | Homeownership | *percent* | 53.1 | | 53.5 | 56.2 | *2015-2019* | | 1 |
| **1.41** | Social and Economic Factors Ranking | *ranking* | 19 | | | | *2021* | | 7 |
| **1.35** | Homeowner Vacancy Rate | *percent* | 1.8 | | 2.3 | 1.6 | *2015-2019* | | 1 |
| **1.32** | Households that are Above the Asset Limited, Income Constrained, | *percent* | 58.1 | | 54 | | *2018* | | 31 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| | Employed (ALICE) Threshold | | | | | | | | |
| **1.32** | WIC Certified Stores | *stores/ 1,000 population* | 0.1 | | | | *2016* | | 29 |
| **1.24** | People Living Below Poverty Level | *percent* | 14.6 | 8 | 14 | 13.4 | *2015-2019* | | 1 |
| **1.24** | Persons with Disability Living in Poverty (5-year) | *percent* | 26.2 | | 24.6 | 26.1 | *2015-2019* | | 1 |
| **1.15** | Child Food Insecurity Rate | *percent* | 15.6 | | 17.1 | 14.6 | *2019* | | 8 |
| **1.15** | Food Insecurity Rate | *percent* | 11.6 | | 12 | 10.9 | *2019* | | 8 |
| **1.15** | Unemployed Workers in Civilian Labor Force | *percent* | 4.7 | | 5.1 | 5.7 | *Jul-21* | | 27 |
| **1.06** | Children Living Below Poverty Level | *percent* | 19.8 | | 20.1 | 18.5 | *2015-2019* | Black (31.8) White (9.8) Asian (8.9) American Indian/Alaskan Native (5.7) Native Hawaiian/Pacific islander (13.8) Multiracial (18.3) | 1 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Other (29) Hispanic/Latino (26.7) | |
| **1.06** | Projected Child Food Insecurity Rate | *percent* | 18.5 | | 19.1 | | *2021* | | 8 |
| **1.06** | Projected Food Insecurity Rate | *percent* | 13.3 | | 13.3 | | *2021* | | 8 |
| **1.06** | Size of Labor Force | *persons* | 798983 | | | | *Jul-21* | | 27 |
| **1.00** | Total Employment Change | *percent* | 2 | | 2.2 | 1.6 | *2018-2019* | | 28 |
| **0.97** | Households that are Asset Limited, Income Constrained, Employed (ALICE) | *percent* | 28.2 | | 33 | | *2018* | | 31 |
| **0.97** | Median Housing Unit Value | *dollars* | 216300 | | 215300 | 217500 | *2015-2019* | | 1 |
| **0.88** | People Living 200% Above Poverty Level | *percent* | 66.3 | | 65.8 | 69.1 | *2015-2019* | | 1 |
| **0.76** | Female Population 16+ in Civilian Labor Force | *percent* | 60.2 | | 54.3 | 58.3 | *2015-2019* | | 1 |
| **0.76** | Population 16+ in Civilian Labor Force | *percent* | 61.2 | | 55.2 | 59.6 | *2015-2019* | | 1 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| **0.71** | Households with Cash Public Assistance Income | *percent* | 2 | | 2.1 | 2.4 | *2015-2019* | | 1 |
| **0.71** | Median Household Income | *dollars* | 58884 | | 55660 | 62843 | *2015-2019* | | 1 |
| **0.53** | Per Capita Income | *dollars* | 32343 | | 31619 | 34103 | *2015-2019* | | 1 |

| SCORE | EDUCATION | UNITS | HILLSBOROUGH COUNTY | HP2030 | Florida | U.S. | MEASUREMENT PERIOD | RACE DISPARITY | Source |
|---|---|---|---|---|---|---|---|---|---|
| **1.82** | 4th Grade Students Proficient in Math | percent | 50 | | 53 | | 2021 | | 12 |
| **1.82** | 4th Grade Students Proficient in Reading | percent | 49 | | 52 | | 2021 | | 12 |
| **1.76** | Consumer Expenditures: Education | average dollar amount per consumer unit | 1257.8 | | 1056 | 1492.4 | 2021 | #NAME? | 6 |
| **1.65** | 8th Grade Students Proficient in Reading | percent | 50 | | 52 | | 2021 | | 12 |
| **1.65** | Student-to-Teacher Ratio | students/ teacher | 16.5 | | | | 2019-2020 | | 25 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **1.24** | High School Graduation | percent | 88.8 | 90.7 | 90 | | 2019-2020 | | 12 |
| **0.71** | 8th Grade Students Proficient in Math | percent | 42 | | 37 | | 2021 | | 12 |
| **0.71** | People 25+ with a High School Degree or Higher | percent | 88.7 | | 88.2 | 88 | 2015-2019 | | 1 |
| **0.18** | People 25+ with a Bachelor's Degree or Higher | percent | 33.5 | | 29.9 | 32.1 | 2015-2019 | | 1 |
| | | | | | | | | | |
| **SCORE** | **ENVIRONMENTAL HEALTH** | **UNITS** | **HILLSBOROUGH COUNTY** | **HP2030** | **Florida** | **U.S.** | **MEASUREMENT PERIOD** | **RACE DISPARITY** | **Source** |
| **2.41** | Asthma: Medicare Population | *percent* | 6.5 | | 5.2 | 5 | *2018* | | 5 |
| **2.18** | Annual Ozone Air Quality | | F | | | | *2017-2019* | | 2 |
| **2.03** | Teens with Asthma | *percent* | 25.2 | | 21.3 | | *2020* | | 23 |
| **1.85** | Adults with Current Asthma | *percent* | 8.9 | | 7.4 | | *2017-2019* | | 10 |
| **1.85** | Farmers Market Density | *markets/ 1,000 population* | 0 | | | | *2018* | | 29 |
| **1.82** | SNAP Certified Stores | *stores/ 1,000 population* | 0.7 | | | | *2017* | | 29 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| **1.76** | Physical Environment Ranking | *ranking* | 65 | | | | *2021* | | 7 |
| **1.68** | Children with Low Access to a Grocery Store | *percent* | 6 | | | | *2015* | | 29 |
| **1.65** | Number of Extreme Heat Days | *days* | 24 | | | | *2016* | | 26 |
| **1.65** | Number of Extreme Precipitation Days | *days* | 34 | | | | *2016* | | 26 |
| **1.59** | Severe Housing Problems | *percent* | 18.7 | | 19.5 | 18 | *2013-2017* | | 7 |
| **1.53** | Fast Food Restaurant Density | *restaurants/ 1,000 population* | 0.6 | | | | *2016* | | 29 |
| **1.53** | Overcrowded Households | *percent of households* | 3.1 | | 3 | | *2015-2019* | | 1 |
| **1.50** | Low-Income and Low Access to a Grocery Store | *percent* | 7.5 | | | | *2015* | | 29 |
| **1.35** | PBT Released | *pounds* | 186949.1 | | | | *2019* | | 30 |
| **1.32** | People 65+ with Low Access to a Grocery Store | *percent* | 2.8 | | | | *2015* | | 29 |
| **1.32** | WIC Certified Stores | *stores/ 1,000 population* | 0.1 | | | | *2016* | | 29 |
| **1.24** | Annual Particle Pollution | | A | | | | *2017-2019* | | 2 |
| **1.18** | Houses Built Prior to 1950 | *percent* | 5.1 | | 4.1 | 17.5 | *2015-2019* | | 1 |
| **1.15** | Grocery Store Density | *stores/ 1,000 population* | 0.2 | | | | *2016* | | 29 |
| **1.00** | Food Environment Index | *index* | 7.7 | | 6.9 | 7.8 | *2021* | | 7 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| **0.97** | Households with No Car and Low Access to a Grocery Store | *percent* | 1.4 | | | | *2015* | | 29 |
| **0.97** | Recreation and Fitness Facilities | *facilities/ 1,000 population* | 0.1 | | | | *2016* | | 29 |
| **0.62** | Access to Exercise Opportunities | *percent* | 93.7 | | 88.7 | 84 | *2020* | | 7 |
| | | | | | | | | | |
| **SCORE** | **HEALTH CARE ACCESS & QUALITY** | **UNITS** | **HILLSBOROUGH COUNTY** | **HP2030** | **Florida** | **U.S.** | **MEASUREMENT PERIOD** | **RACE DISPARITY** | **Source** |
| **2.12** | Adults without Health Insurance | *percent* | 23 | | | 12.2 | *2018* | | 3 |
| **1.85** | Adults with a Usual Source of Health Care | *percent* | 68.6 | | 72 | | *2017-2019* | | 10 |
| **1.68** | Median Monthly Medicaid Enrollment | *enrollments/ 100,000 population* | 21411.1 | | 19940.3 | | *2020* | | 9 |
| **1.41** | Adults who have had a Routine Checkup | *percent* | 77.3 | | | 76.7 | *2018* | | 3 |
| **1.41** | Adults who Visited a Dentist | *percent* | 62.1 | | | 66.5 | *2018* | | 3 |
| **1.41** | Adults with Health Insurance | *percent* | 81.8 | | 80.5 | 87.1 | *2019* | | 1 |
| **1.41** | Children with Health Insurance | *percent* | 93.6 | | 92.4 | 94.3 | *2019* | | 1 |
| **1.41** | Clinical Care Ranking | *ranking* | 27 | | | | *2021* | | 7 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| **1.41** | Consumer Expenditures: Health Insurance | *average dollar amount per consumer unit* | 4175.9 | | 4247.2 | 4321.1 | *2021* | | 6 |
| **1.26** | Dentist Rate | *dentists/ 100,000 population* | 58.9 | | 60.8 | | *2019* | | 7 |
| **1.15** | Primary Care Provider Rate | *providers/ 100,000 population* | 82.9 | | 72.2 | | *2018* | | 7 |
| **0.62** | Mental Health Provider Rate | *providers/ 100,000 population* | 182.9 | | 169 | | *2020* | | 7 |
| **0.26** | Non-Physician Primary Care Provider Rate | *providers/ 100,000 population* | 150.6 | | 120.6 | | *2020* | | 7 |
| | | | | | | | | | |
| **SCORE** | **HEART DISEASE & STROKE** | **UNITS** | **HILLSBOROUGH COUNTY** | **HP2030** | **Florida** | **U.S.** | **MEASUREMENT PERIOD** | **RACE DISPARITY** | **Source** |
| **2.71** | Stroke: Medicare Population | *percent* | 5.4 | | 4.7 | 3.8 | *2018* | | 5 |
| **2.47** | Atrial Fibrillation: Medicare Population | *percent* | 9.4 | | 10.1 | 8.4 | *2018* | | 5 |
| **2.47** | Ischemic Heart Disease: Medicare Population | *percent* | 33.6 | | 34.3 | 26.8 | *2018* | | 5 |
| **2.12** | Adults who Have Taken Medications for High Blood Pressure | *percent* | 73.3 | | | 75.8 | *2017* | | 3 |
| **2.00** | Hyperlipidemia: Medicare Population | *percent* | 54.6 | | 59.2 | 47.7 | *2018* | | 5 |
| **1.94** | Hypertension: Medicare Population | *percent* | 62.4 | | 62.4 | 57.2 | *2018* | | 5 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| **1.85** | Age-Adjusted Hospitalization Rate due to Heart Attack | *hospitalizations/ 10,000 population 35+ years* | 33.2 | | 29.7 | | *2018* | | 26 |
| **1.62** | Age-Adjusted Death Rate due to Coronary Heart Disease | *deaths/ 100,000 population* | 93.3 | 71.1 | 88.6 | 88 | *2019* | | 18 |
| **1.29** | Heart Failure: Medicare Population | *percent* | 14.3 | | 14.8 | 14 | *2018* | | 5 |
| **1.15** | High Blood Pressure Prevalence | *percent* | 33.3 | 27.7 | 33.5 | | *2017-2019* | | 10 |
| **1.06** | Cholesterol Test History | *percent* | 81.8 | | | 81.5 | *2017* | | 3 |
| **1.06** | High Cholesterol Prevalence: Adults 18+ | *percent* | 34.5 | | | 34.1 | *2017* | | 3 |
| **0.88** | Adults who Experienced a Stroke | *percent* | 3.4 | | | 3.4 | *2018* | | 3 |
| **0.88** | Adults who Experienced Coronary Heart Disease | *percent* | 6.8 | | | 6.8 | *2018* | | 3 |
| **0.56** | Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke) | *deaths/ 100,000 population* | 30.9 | 33.4 | 41.4 | 37 | *2019* | | 18 |
| **0.53** | Age-Adjusted Death Rate due to Heart Attack | *deaths/ 100,000 population 35+ years* | 38.3 | | 42.8 | | *2018* | | 26 |
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# Appendix A. Secondary Data Methodology and Data Scoring Tables

| SCORE | IMMUNIZATIONS & INFECTIOUS DISEASES | UNITS | HILLSBOROUGH COUNTY | HP2030 | Florida | U.S. | MEASUREMENT PERIOD | RACE DISPARITY | Source |
|---|---|---|---|---|---|---|---|---|---|
| **2.74** | Chlamydia Incidence Rate | *cases/ 100,000 population* | 631.9 | | 525.5 | 551 | *2019* | | 16 |
| **2.44** | Syphilis Incidence Rate | *cases/ 100,000 population* | 18.3 | | 15.1 | 11.9 | *2019* | | 16 |
| **2.26** | Gonorrhea Incidence Rate | *cases/ 100,000 population* | 196.4 | | 174.9 | 187.8 | *2019* | | 16 |
| **1.68** | HIV Incidence Rate | *cases/ 100,000 population* | 19.7 | | 21.6 | | *2019* | Black (51.9) White (7.6) Hispanic/Latino (15.9) | 14 |
| **1.53** | Overcrowded Households | *percent of households* | 3.1 | | 3 | | *2015-2019* | | 1 |
| **1.50** | Adults 65+ with Pneumonia Vaccination | *percent* | 67 | | 66.8 | | *2017-2019* | | 10 |
| **1.32** | Kindergartners with Required Immunizations | *percent* | 95.2 | | 93.5 | | *2020* | | 15 |
| **1.32** | Tuberculosis Incidence Rate | *cases/ 100,000 population* | 1.5 | 1.4 | 1.9 | | *2020* | | 17 |
| **1.15** | Adults 65+ with Influenza Vaccination | *percent* | 60.9 | | 58.3 | | *2017-2019* | | 10 |
| **1.15** | Age-Adjusted Death Rate due to Influenza and Pneumonia | *deaths/ 100,000 population* | 10.7 | | 8.4 | 12.3 | *2019* | | 18 |
| **1.06** | COVID-19 Daily Average Incidence Rate | *cases per 100,000 population* | 8.5 | | 6 | 31.2 | *Nov 5,2021* | | 24 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| **0.97** | Persons Fully Vaccinated Against COVID-19 | *percent* | 54.8 | | | | *Nov 5,2021* | | 4 |
| **0.97** | Salmonella Infection Incidence Rate | *cases/ 100,000 population* | 20.3 | 11.1 | 33.4 | | *2019* | | 13 |
| **0.44** | COVID-19 Daily Average Case-Fatality Rate | *deaths per 100 cases* | 0 | | 0 | 3.4 | *Nov 5,2021* | | 24 |
| | | | | | | | | | |
| **SCORE** | **MATERNAL, FETAL & INFANT HEALTH** | **UNITS** | **HILLSBOROUGH COUNTY** | **HP2030** | **Florida** | **U.S.** | **MEASUREMENT PERIOD** | **RACE DISPARITY** | **Source** |
| **1.68** | Mothers who Received Early Prenatal Care | *percent* | 78.4 | | 75.9 | 75.8 | *2019* | | 18 |
| **1.35** | Infant Mortality Rate | *deaths/ 1,000 live births* | 6.6 | 5 | 6 | | *2019* | Black (13.4) White (5.2) Hispanic/Latino (7.4) | 18 |
| **1.26** | Babies with Low Birth Weight | *percent* | 8.7 | | 8.8 | 8.3 | *2019* | Black (14.3) White (7) Hispanic/Latino (7.3) | 18 |
| **0.97** | Teen Birth Rate: 15-19 | *live births/ 1,000 females aged 15-19* | 16.7 | | 16.2 | 16.7 | *2019* | Black (26.4) White (15.3) Hispanic/Latino (23.4) | 18 |
| **0.91** | Preterm Births | *percent* | 9.9 | 9.4 | 10.6 | 10 | *2019* | | 18 |
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# Appendix A. Secondary Data Methodology and Data Scoring Tables

| SCORE | MENTAL HEALTH & MENTAL DISORDERS | UNITS | HILLSBOROUGH COUNTY | HP2030 | Florida | U.S. | MEASUREMENT PERIOD | RACE DISPARITY | Source |
|---|---|---|---|---|---|---|---|---|---|
| **3.00** | Depression: Medicare Population | *percent* | 22 | | 19.5 | 18.4 | *2018* | | 5 |
| **2.71** | Alzheimer's Disease or Dementia: Medicare Population | *percent* | 14.4 | | 12.6 | 10.8 | *2018* | | 5 |
| **1.56** | Age-Adjusted Death Rate due to Suicide | *deaths/ 100,000 population* | 14.1 | 12.8 | 14.5 | 13.9 | *2019* | | 18 |
| **1.41** | Poor Mental Health: 14+ Days | *percent* | 13.9 | | | 12.7 | *2018* | | 3 |
| **1.32** | Frequent Mental Distress | *percent* | 14 | | 13.4 | 13 | *2018* | | 7 |
| **1.15** | Self-Reported General Health Assessment: Good or Better | *percent* | 81.6 | | 80.3 | | *2017-2019* | | 10 |
| **0.62** | Mental Health Provider Rate | *providers/ 100,000 population* | 182.9 | | 169 | | *2020* | | 7 |
| | | | | | | | | | |
| **SCORE** | **MORTALITY DATA** | **UNITS** | **HILLSBOROUGH COUNTY** | **HP2030** | **Florida** | **U.S.** | **MEASUREMENT PERIOD** | **RACE DISPARITY** | **Source** |
| **1.82** | Age-Adjusted Death Rate due to Breast Cancer | *deaths/ 100,000 females* | 11 | 15.3 | 10.4 | | *2017-2019* | Black (16) White (9.3) Hispanic/Latino (7.5) | 18 |
| **1.71** | Age-Adjusted Death Rate due to Colorectal Cancer | *deaths/ 100,000 population* | 14.5 | 8.9 | 13.1 | | *2017-2019* | | 18 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| **1.62** | Age-Adjusted Death Rate due to Coronary Heart Disease | *deaths/ 100,000 population* | 93.3 | 71.1 | 88.6 | 88 | *2019* | | 18 |
| **1.56** | Age-Adjusted Death Rate due to Suicide | *deaths/ 100,000 population* | 14.1 | 12.8 | 14.5 | 13.9 | *2019* | | 18 |
| **1.35** | Age-Adjusted Death Rate due to Lung Cancer | *deaths/ 100,000 population* | 37.8 | 25.1 | 35.3 | | *2017-2019* | | 18 |
| **1.35** | Infant Mortality Rate | *deaths/ 1,000 live births* | 6.6 | 5 | 6 | | *2019* | Black (13.4) White (5.2) Hispanic/Latino (7.4) | 18 |
| **1.24** | Alcohol-Impaired Driving Deaths | *percent of driving deaths with alcohol involvement* | 26 | 28.3 | 22.3 | 27 | *2015-2019* | | 7 |
| **1.24** | Death Rate due to Drug Poisoning | *deaths/ 100,000 population* | 18.2 | | 23.6 | 21 | *2017-2019* | | 7 |
| **1.24** | Mortality Ranking | *ranking* | 9 | | | | *2021* | | 7 |
| **1.15** | Age-Adjusted Death Rate due to Influenza and Pneumonia | *deaths/ 100,000 population* | 10.7 | | 8.4 | 12.3 | *2019* | | 18 |
| **1.15** | Life Expectancy | *years* | 79.6 | | 80.2 | 79.2 | *2017-2019* | | 7 |
| **1.06** | Age-Adjusted Death Rate due to Cancer | *deaths/ 100,000 population* | 152 | 122.7 | 146.1 | | *2017-2019* | | 18 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| **1.00** | Age-Adjusted Death Rate due to Motor Vehicle Collisions | *deaths/ 100,000 population* | 13.9 | | 14.7 | | *2019* | | 18 |
| **1.00** | Age-Adjusted Death Rate due to Prostate Cancer | *deaths/ 100,000 males* | 6.9 | 16.9 | 7.4 | | *2017-2019* | Black (13.1) White (5.9) Hispanic/Latino (6) | 18 |
| **0.91** | Age-Adjusted Death Rate due to Diabetes | *deaths/ 100,000 population* | 19.3 | | 19.7 | 21.6 | *2019* | Black (43.6) White (19.2) Hispanic/Latino (22.9) | 18 |
| **0.91** | Age-Adjusted Death Rate due to Unintentional Injuries | *deaths/ 100,000 population* | 49.9 | 43.2 | 55.5 | 49.3 | *2019* | | 18 |
| **0.71** | Age-Adjusted Drug and Opioid-Involved Overdose Death Rate | *Deaths per 100,000 population* | 18.4 | | 25.6 | 22.8 | *2017-2019* | | 4 |
| **0.65** | Age-Adjusted Death Rate due to Kidney Disease | *deaths/ 100,000 population* | 9.1 | | 9.9 | 12.9 | *2017-2019* | Black (17.3) White (8) Hispanic/Latino (6.9) | 4 |
| **0.56** | Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke) | *deaths/ 100,000 population* | 30.9 | 33.4 | 41.4 | 37 | *2019* | | 18 |
| **0.53** | Age-Adjusted Death Rate due to Heart Attack | *deaths/ 100,000 population 35+ years* | 38.3 | | 42.8 | | *2018* | | 26 |
| | | | | | | | | | |
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# Appendix A. Secondary Data Methodology and Data Scoring Tables

| SCORE | OLDER ADULTS | UNITS | HILLSBOROUGH COUNTY | HP2030 | Florida | U.S. | MEASUREMENT PERIOD | RACE DISPARITY | Source |
|---|---|---|---|---|---|---|---|---|---|
| **3.00** | Depression: Medicare Population | *percent* | 22 | | 19.5 | 18.4 | *2018* | | 5 |
| **2.71** | Alzheimer's Disease or Dementia: Medicare Population | *percent* | 14.4 | | 12.6 | 10.8 | *2018* | | 5 |
| **2.71** | Stroke: Medicare Population | *percent* | 5.4 | | 4.7 | 3.8 | *2018* | | 5 |
| **2.65** | Chronic Kidney Disease: Medicare Population | *percent* | 29.8 | | 28.2 | 24.5 | *2018* | | 5 |
| **2.65** | Rheumatoid Arthritis or Osteoarthritis: Medicare Population | *percent* | 37.7 | | 37.5 | 33.5 | *2018* | | 5 |
| **2.47** | Atrial Fibrillation: Medicare Population | *percent* | 9.4 | | 10.1 | 8.4 | *2018* | | 5 |
| **2.47** | Ischemic Heart Disease: Medicare Population | *percent* | 33.6 | | 34.3 | 26.8 | *2018* | | 5 |
| **2.47** | Osteoporosis: Medicare Population | *percent* | 7.9 | | 8.3 | 6.6 | *2018* | | 5 |
| **2.41** | Asthma: Medicare Population | *percent* | 6.5 | | 5.2 | 5 | *2018* | | 5 |
| **2.18** | Cancer: Medicare Population | *percent* | 9.9 | | 10.1 | 8.4 | *2018* | | 5 |
| **2.00** | COPD: Medicare Population | *percent* | 14.3 | | 13.5 | 11.5 | *2018* | | 5 |
| **2.00** | Hyperlipidemia: Medicare Population | *percent* | 54.6 | | 59.2 | 47.7 | *2018* | | 5 |
| **1.94** | Hypertension: Medicare Population | *percent* | 62.4 | | 62.4 | 57.2 | *2018* | | 5 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| **1.88** | People 65+ Living Below Poverty Level | *percent* | 11.1 | | 10.4 | 9.3 | *2015-2019* | Black (19.1) White (7.4) Asian (9.2) American Indian/Alaskan Native (28.9) Native Hawaiian/Pacific islander (26.5) Multiracial (14.6) Other (23.1) Hispanic/Latino (20) | 1 |
| **1.68** | Diabetes: Medicare Population | *percent* | 28.6 | | 27.8 | 27 | *2018* | | 5 |
| **1.50** | Adults 65+ with Pneumonia Vaccination | *percent* | 67 | | 66.8 | | *2017-2019* | | 10 |
| **1.41** | Adults 65+ who Received Recommended Preventive Services: Females | *percent* | 29.4 | | | 28.4 | *2018* | | 3 |
| **1.41** | Adults 65+ who Received Recommended Preventive Services: Males | *percent* | 32.1 | | | 32.4 | *2018* | | 3 |
| **1.35** | People 65+ Living Alone | *percent* | 24.7 | | 23.7 | 26.1 | *2015-2019* | | 1 |
| **1.32** | People 65+ with Low Access to a Grocery Store | *percent* | 2.8 | | | | *2015* | | 29 |
| **1.29** | Heart Failure: Medicare Population | *percent* | 14.3 | | 14.8 | 14 | *2018* | | 5 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| **1.24** | Adults 65+ with Total Tooth Loss | *percent* | 14 | | | 13.5 | *2018* | | 3 |
| **1.15** | Adults 65+ with Influenza Vaccination | *percent* | 60.9 | | 58.3 | | *2017-2019* | | 10 |
| **0.88** | Adults with Arthritis | *percent* | 24 | | | 25.8 | *2018* | | 3 |
| | | | | | | | | | |
| **SCORE** | **ORAL HEALTH** | **UNITS** | **HILLSBOROUGH COUNTY** | **HP2030** | **Florida** | **U.S.** | **MEASUREMENT PERIOD** | **RACE DISPARITY** | **Source** |
| **2.12** | Oral Cavity and Pharynx Cancer Incidence Rate | *cases/ 100,000 population* | 14.8 | | 13.5 | | *2016-2018* | | 32 |
| **1.41** | Adults who Visited a Dentist | *percent* | 62.1 | | | 66.5 | *2018* | | 3 |
| **1.26** | Dentist Rate | *dentists/ 100,000 population* | 58.9 | | 60.8 | | *2019* | | 7 |
| **1.24** | Adults 65+ with Total Tooth Loss | *percent* | 14 | | | 13.5 | *2018* | | 3 |
| | | | | | | | | | |
| **SCORE** | **OTHER CONDITIONS** | **UNITS** | **HILLSBOROUGH COUNTY** | **HP2030** | **Florida** | **U.S.** | **MEASUREMENT PERIOD** | **RACE DISPARITY** | **Source** |
| **2.65** | Chronic Kidney Disease: Medicare Population | *percent* | 29.8 | | 28.2 | 24.5 | *2018* | | 5 |
| **2.65** | Rheumatoid Arthritis or Osteoarthritis: Medicare Population | *percent* | 37.7 | | 37.5 | 33.5 | *2018* | | 5 |
| **2.47** | Osteoporosis: Medicare Population | *percent* | 7.9 | | 8.3 | 6.6 | *2018* | | 5 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| **0.88** | Adults with Arthritis | *percent* | 24 | | | 25.8 | *2018* | | 3 |
| **0.88** | Adults with Kidney Disease | *Percent of adults* | 3.1 | | | 3.1 | *2018* | | 3 |
| **0.65** | Age-Adjusted Death Rate due to Kidney Disease | *deaths/ 100,000 population* | 9.1 | | 9.9 | 12.9 | *2017-2019* | Black (17.3) White (8) Hispanic/Latino (6.9) | 4 |
| | | | | | | | | | |
| **SCORE** | **PHYSICAL ACTIVITY** | **UNITS** | **HILLSBOROUGH COUNTY** | **HP2030** | **Florida** | **U.S.** | **MEASUREMENT PERIOD** | **RACE DISPARITY** | **Source** |
| **2.00** | Teens without Sufficient Physical Activity | *percent* | 83.4 | | 82.3 | | *2020* | | 13 |
| **1.85** | Farmers Market Density | *markets/ 1,000 population* | 0 | | | | *2018* | | 29 |
| **1.82** | SNAP Certified Stores | *stores/ 1,000 population* | 0.7 | | | | *2017* | | 29 |
| **1.68** | Adults Who Are Obese | *percent* | 30.2 | | 27 | | *2017-2019* | | 10 |
| **1.68** | Adults who are Overweight or Obese | *percent* | 68.8 | | 64.6 | | *2017-2019* | | 10 |
| **1.68** | Children with Low Access to a Grocery Store | *percent* | 6 | | | | *2015* | | 29 |
| **1.53** | Fast Food Restaurant Density | *restaurants/ 1,000 population* | 0.6 | | | | *2016* | | 29 |
| **1.50** | Adults who are Sedentary | *percent* | 27.4 | 21.2 | 26.5 | | *2017-2019* | | 10 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| **1.50** | Low-Income and Low Access to a Grocery Store | *percent* | 7.5 | | | | *2015* | | 29 |
| **1.32** | People 65+ with Low Access to a Grocery Store | *percent* | 2.8 | | | | *2015* | | 29 |
| **1.32** | WIC Certified Stores | *stores/ 1,000 population* | 0.1 | | | | *2016* | | 29 |
| **1.24** | Health Behaviors Ranking | *ranking* | 12 | | | | *2021* | | 7 |
| **1.15** | Grocery Store Density | *stores/ 1,000 population* | 0.2 | | | | *2016* | | 29 |
| **1.00** | Food Environment Index | *index* | 7.7 | | 6.9 | 7.8 | *2021* | | 7 |
| **0.97** | Households with No Car and Low Access to a Grocery Store | *percent* | 1.4 | | | | *2015* | | 29 |
| **0.97** | Recreation and Fitness Facilities | *facilities/ 1,000 population* | 0.1 | | | | *2016* | | 29 |
| **0.62** | Access to Exercise Opportunities | *percent* | 93.7 | | 88.7 | 84 | *2020* | | 7 |
| | | | | | | | | | |
| **SCORE** | **PREVENTION & SAFETY** | **UNITS** | **HILLSBOROUGH COUNTY** | **HP2030** | **Florida** | **U.S.** | **MEASUREMENT PERIOD** | **RACE DISPARITY** | **Source** |
| **1.59** | Severe Housing Problems | *percent* | 18.7 | | 19.5 | 18 | *2013-2017* | | 7 |
| **1.24** | Death Rate due to Drug Poisoning | *deaths/ 100,000 population* | 18.2 | | 23.6 | 21 | *2017-2019* | | 7 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| **1.00** | Age-Adjusted Death Rate due to Motor Vehicle Collisions | *deaths/ 100,000 population* | 13.9 | | 14.7 | | *2019* | | 18 |
| **0.91** | Age-Adjusted Death Rate due to Unintentional Injuries | *deaths/ 100,000 population* | 49.9 | 43.2 | 55.5 | 49.3 | *2019* | | 18 |
| | | | | | | | | | |
| **SCORE** | **RESPIRATORY DISEASES** | **UNITS** | **HILLSBOROUGH COUNTY** | **HP2030** | **Florida** | **U.S.** | **MEASUREMENT PERIOD** | **RACE DISPARITY** | **Source** |
| **2.41** | Asthma: Medicare Population | *percent* | 6.5 | | 5.2 | 5 | *2018* | | 5 |
| **2.03** | Teens with Asthma | *percent* | 25.2 | | 21.3 | | *2020* | | 23 |
| **2.00** | COPD: Medicare Population | *percent* | 14.3 | | 13.5 | 11.5 | *2018* | | 5 |
| **1.85** | Adults with Current Asthma | *percent* | 8.9 | | 7.4 | | *2017-2019* | | 10 |
| **1.68** | Adolescents who Use Electronic Vaping: Past 30 Days | *percent* | 12.6 | | 14.5 | | *2020* | | 23 |
| **1.50** | Adults 65+ with Pneumonia Vaccination | *percent* | 67 | | 66.8 | | *2017-2019* | | 10 |
| **1.50** | Adults who Smoke | *percent* | 16 | 5 | 14.8 | | *2017-2019* | | 10 |
| **1.35** | Age-Adjusted Death Rate due to Lung Cancer | *deaths/ 100,000 population* | 37.8 | 25.1 | 35.3 | | *2017-2019* | | 18 |
| **1.35** | Lung and Bronchus Cancer Incidence Rate | *cases/ 100,000 population* | 60.3 | | 56.6 | | *2016-2018* | | 32 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

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|---|---|---|---|---|---|---|---|---|---|
| **1.32** | Tuberculosis Incidence Rate | *cases/ 100,000 population* | 1.5 | 1.4 | 1.9 | | *2020* | | 17 |
| **1.26** | Adolescents who Use Smokeless Tobacco: Lifetime | *percent* | 3.7 | | 3.7 | | *2020* | | 23 |
| **1.24** | Adolescents who Use Electronic Vaping: Lifetime | *percent* | 21.7 | | 26.4 | | *2020* | | 23 |
| **1.24** | Adults with COPD | *Percent of adults* | 7.5 | | | 6.9 | *2018* | | 3 |
| **1.15** | Adults 65+ with Influenza Vaccination | *percent* | 60.9 | | 58.3 | | *2017-2019* | | 10 |
| **1.15** | Adults Who Currently Use E-Cigarettes | *percent* | 5.7 | | 7.5 | | *2017-2019* | Black (0.2) White (9) Hispanic/Latino (3) | 10 |
| **1.15** | Age-Adjusted Death Rate due to Influenza and Pneumonia | *deaths/ 100,000 population* | 10.7 | | 8.4 | 12.3 | *2019* | | 18 |
| **1.06** | COVID-19 Daily Average Incidence Rate | *cases per 100,000 population* | 8.5 | | 6 | 31.2 | *Nov 5,2021* | | 24 |
| **0.79** | Adolescents who Use Smokeless Tobacco: Past 30 Days | *percent* | 1.1 | | 1.3 | | *2020* | | 23 |
| **0.79** | Teens who Smoke Cigarettes: High School Students | *percent* | 1.1 | | 1.5 | | *2020* | | 23 |
| **0.44** | COVID-19 Daily Average Case-Fatality Rate | *deaths per 100 cases* | 0 | | 0 | 3.4 | *Nov 5,2021* | | 24 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

| SCORE | SEXUALLY TRANSMITTED INFECTIONS | UNITS | HILLSBOROUGH COUNTY | HP2030 | Florida | U.S. | MEASUREMENT PERIOD | RACE DISPARITY | Source |
|---|---|---|---|---|---|---|---|---|---|
| **2.74** | Chlamydia Incidence Rate | *cases/ 100,000 population* | 631.9 | | 525.5 | 551 | *2019* | | 16 |
| **2.44** | Syphilis Incidence Rate | *cases/ 100,000 population* | 18.3 | | 15.1 | 11.9 | *2019* | | 16 |
| **2.26** | Gonorrhea Incidence Rate | *cases/ 100,000 population* | 196.4 | | 174.9 | 187.8 | *2019* | | 16 |
| **1.68** | HIV Incidence Rate | *cases/ 100,000 population* | 19.7 | | 21.6 | | *2019* | Black (51.9) White (7.6) Hispanic/Latino (15.9) | 14 |
| | | | | | | | | | |
| **SCORE** | **TOBACCO USE** | **UNITS** | **HILLSBOROUGH COUNTY** | **HP2030** | **Florida** | **U.S.** | **MEASUREMENT PERIOD** | **RACE DISPARITY** | **Source** |
| **1.68** | Adolescents who Use Electronic Vaping: Past 30 Days | *percent* | 12.6 | | 14.5 | | *2020* | | 23 |
| **1.50** | Adults who Smoke | *percent* | 16 | 5 | 14.8 | | *2017-2019* | | 10 |
| **1.26** | Adolescents who Use Smokeless Tobacco: Lifetime | *percent* | 3.7 | | 3.7 | | *2020* | | 23 |
| **1.24** | Adolescents who Use Electronic Vaping: Lifetime | *percent* | 21.7 | | 26.4 | | *2020* | | 23 |
| **1.15** | Adults Who Currently Use E-Cigarettes | *percent* | 5.7 | | 7.5 | | *2017-2019* | Black (0.2) White (9) | 10 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Hispanic/Latino (3) | |
| **1.15** | Adults Who Currently Use E-Cigarettes | *percent* | 5.7 | | 7.5 | | *2017-2019* | Black (0.2) White (9) Hispanic/Latino (3) | 10 |
| **0.79** | Adolescents who Use Smokeless Tobacco: Past 30 Days | *percent* | 1.1 | | 1.3 | | *2020* | | 23 |
| **0.79** | Teens who Smoke Cigarettes: High School Students | *percent* | 1.1 | | 1.5 | | *2020* | | 23 |
| | | | | | | | | | |
| **SCORE** | **WEIGHT STATUS** | **UNITS** | **HILLSBOROUGH COUNTY** | **HP2030** | **Florida** | **U.S.** | **MEASUREMENT PERIOD** | **RACE DISPARITY** | **Source** |
| **1.68** | Adults Who Are Obese | *percent* | 30.2 | | 27 | | *2017-2019* | | 10 |
| **1.68** | Adults who are Overweight or Obese | *percent* | 68.8 | | 64.6 | | *2017-2019* | | 10 |
| **0.82** | Teens who are Obese: High School Students | *percent* | 13.5 | | 15.4 | | *2020* | | 13 |
| | | | | | | | | | |
| **SCORE** | **WELLNESS & LIFESTYLE** | **UNITS** | **HILLSBOROUGH COUNTY** | **HP2030** | **Florida** | **U.S.** | **MEASUREMENT PERIOD** | **RACE DISPARITY** | **Source** |
| **1.94** | Consumer Expenditures: Fast Food Restaurants | *average dollar amount per consumer unit* | 1645.4 | | 1520 | 1638.9 | *2021* | | 6 |
| **1.68** | Frequent Physical Distress | *percent* | 12.9 | | 12.6 | 11 | *2018* | | 7 |
| **1.50** | Insufficient Sleep | *percent* | 37.6 | 31.4 | 37.3 | 35 | *2018* | | 7 |
| **1.41** | Morbidity Ranking | *ranking* | 19 | | | | *2021* | | 7 |
| **1.24** | Poor Physical Health: 14+ Days | *percent* | 13.3 | | | 12.5 | *2018* | | 3 |

# Appendix A. Secondary Data Methodology and Data Scoring Tables

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **1.15** | High Blood Pressure Prevalence | *percent* | 33.3 | 27.7 | 33.5 | | *2017-2019* | | 10 |
| **1.15** | Life Expectancy | *years* | 79.6 | | 80.2 | 79.2 | *2017-2019* | | 7 |
| **1.15** | Self-Reported General Health Assessment: Good or Better | *percent* | 81.6 | | 80.3 | | *2017-2019* | | 10 |
| | | | | | | | | | |
| **SCORE** | **WOMEN'S HEALTH** | **UNITS** | **HILLSBOROUGH COUNTY** | **HP2030** | **Florida** | **U.S.** | **MEASUREMENT PERIOD** | **RACE DISPARITY** | **Source** |
| **2.00** | Breast Cancer Incidence Rate | *cases/ 100,000 females* | 132.2 | | 121.2 | | *2016-2018* | | 32 |
| **2.00** | Cervical Cancer Incidence Rate | *cases/ 100,000 females* | 10 | | 9 | | *2016-2018* | | 32 |
| **1.82** | Age-Adjusted Death Rate due to Breast Cancer | *deaths/ 100,000 females* | 11 | 15.3 | 10.4 | | *2017-2019* | Black (16) White (9.3) Hispanic/Latino (7.5) | 18 |
| **1.82** | Mammogram in Past Year: 40+ | *percent* | 55.5 | | 60.8 | | *2016* | | 10 |
| **1.41** | Cervical Cancer Screening: 21-65 | *Percent* | 83.7 | 84.3 | | 84.7 | *2018* | | 3 |
| **1.29** | Pap Test in Past Year | *percent* | 50.3 | | 48.4 | | *2016* | | 10 |

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

| ZIP CODE | CITY | POPULATION |
|---|---|---|
| **33510** | Brandon, FL | 32689 |
| **33511** | Brandon, FL | 61916 |
| **33527** | Dover, FL | 19535 |
| **33534** | Gibsonton, FL | 19057 |
| **33547** | Lithia, FL | 31157 |
| **33548** | Lutz, FL | 7668 |
| **33549** | Lutz, FL | 19314 |
| **33556** | Odessa, FL | 29847 |
| **33558** | Lutz, FL | 26715 |
| **33563** | Plant City, FL | 29430 |
| **33565** | Plant City, FL | 20365 |
| **33566** | Plant City, FL | 24304 |
| **33567** | Plant City, FL | 14126 |
| **33569** | Riverview, FL | 28934 |
| **33570** | Ruskin, FL | 33567 |
| **33572** | Apollo Beach, FL | 20965 |
| **33573** | Sun City Center, FL | 25265 |
| **33578** | Riverview, FL | 55169 |
| **33579** | Riverview, FL | 39493 |
| **33584** | Seffner, FL | 30301 |
| **33592** | Thonotosassa, FL | 12611 |
| **33594** | Valrico, FL | 38896 |
| **33596** | Valrico, FL | 34132 |
| **33598** | Wimauma, FL | 23048 |
| **33602** | Tampa, FL | 16846 |
| **33603** | Tampa, FL | 21070 |
| **33604** | Tampa, FL | 39200 |
| **33605** | Tampa, FL | 19668 |
| **33606** | Tampa, FL | 21796 |
| **33607** | Tampa, FL | 30139 |
| **33609** | Tampa, FL | 18050 |
| **33610** | Tampa, FL | 47990 |
| **33611** | Tampa, FL | 34125 |
| **33612** | Tampa, FL | 48479 |
| **33613** | Tampa, FL | 37074 |
| **33614** | Tampa, FL | 52098 |
| **33615** | Tampa, FL | 48443 |
| **33616** | Tampa, FL | 16494 |
| **33617** | Tampa, FL | 49159 |
| **33618** | Tampa, FL | 27645 |
| **33619** | Tampa, FL | 41592 |
| **33620** | Tampa, FL | 5606 |
| **33621** | Tampa, FL | 1852 |
| **33624** | Tampa, FL | 41450 |
| **33625** | Tampa, FL | 31843 |
| **33626** | Tampa, FL | 35932 |
| **33629** | Tampa, FL | 25741 |
| **33634** | Tampa, FL | 25146 |
| **33635** | Tampa, FL | 19663 |
| **33637** | Tampa, FL | 19657 |

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

| | | |
|---|---|---|
| **33647** | Tampa, FL | 74009 |
| | | |
| | | |

| | | |
|---|---|---|
| | Hillsborough County | 1,519,364 |
| | Florida | 21,976,313 |
| | U.S. | 326,569,308 |

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

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

| ZIP CODE | CITY | FAMILIES BELOW POVERTY LEVEL (%) |
|---|---|---|
| **33510** | Brandon, FL | 7.6% |
| **33511** | Brandon, FL | 8.0% |
| **33527** | Dover, FL | 11.3% |
| **33534** | Gibsonton, FL | 14.7% |
| **33547** | Lithia, FL | 4.0% |
| **33548** | Lutz, FL | 1.9% |
| **33549** | Lutz, FL | 3.2% |
| **33556** | Odessa, FL | 2.5% |
| **33558** | Lutz, FL | 2.6% |
| **33563** | Plant City, FL | 12.7% |
| **33565** | Plant City, FL | 8.3% |
| **33566** | Plant City, FL | 8.6% |
| **33567** | Plant City, FL | 8.9% |
| **33569** | Riverview, FL | 6.0% |
| **33570** | Ruskin, FL | 12.4% |
| **33572** | Apollo Beach, FL | 3.8% |
| **33573** | Sun City Center, FL | 5.0% |
| **33578** | Riverview, FL | 7.9% |
| **33579** | Riverview, FL | 3.3% |
| **33584** | Seffner, FL | 9.7% |
| **33592** | Thonotosassa, FL | 12.5% |
| **33594** | Valrico, FL | 6.7% |
| **33596** | Valrico, FL | 2.0% |
| **33598** | Wimauma, FL | 10.2% |
| **33602** | Tampa, FL | 10.5% |
| **33603** | Tampa, FL | 18.8% |
| **33604** | Tampa, FL | 17.1% |
| **33605** | Tampa, FL | 27.5% |
| **33606** | Tampa, FL | 6.4% |
| **33607** | Tampa, FL | 19.1% |
| **33609** | Tampa, FL | 6.4% |
| **33610** | Tampa, FL | 19.4% |
| **33611** | Tampa, FL | 6.3% |
| **33612** | Tampa, FL | 22.1% |
| **33613** | Tampa, FL | 19.7% |
| **33614** | Tampa, FL | 15.1% |
| **33615** | Tampa, FL | 12.2% |
| **33616** | Tampa, FL | 9.3% |
| **33617** | Tampa, FL | 16.6% |
| **33618** | Tampa, FL | 4.9% |
| **33619** | Tampa, FL | 15.7% |
| **33620** | Tampa, FL | 7.7% |
| **33621** | Tampa, FL | 4.8% |
| **33624** | Tampa, FL | 5.6% |
| **33625** | Tampa, FL | 8.4% |
| **33626** | Tampa, FL | 3.4% |
| **33629** | Tampa, FL | 3.3% |
| **33634** | Tampa, FL | 10.7% |
| **33635** | Tampa, FL | 10.6% |

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

| | | |
|---|---|---|
| **33637** | Tampa, FL | 11.3% |
| **33647** | Tampa, FL | 6.5% |
| | Hillsborough County | 9.8% |
| | Florida | 9.3% |
| | U.S. | 9.1% |

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

# Appendix B. Index of Disparity

## Health Equity Index (Figure 21)

| ZIP CODE | CITY | INDEX SCORE |
|---|---|---|
| **33510** | Brandon, FL | 46.3 |
| **33511** | Brandon, FL | 37.9 |
| **33527** | Dover, FL | 76.8 |
| **33534** | Gibsonton, FL | 77.2 |
| **33547** | Lithia, FL | 5.2 |
| **33548** | Lutz, FL | 5.5 |
| **33549** | Lutz, FL | 15.5 |
| **33556** | Odessa, FL | 5.9 |
| **33558** | Lutz, FL | 8.4 |
| **33563** | Plant City, FL | 83 |
| **33565** | Plant City, FL | 65.4 |
| **33566** | Plant City, FL | 58.7 |
| **33567** | Plant City, FL | 76 |
| **33569** | Riverview, FL | 26 |
| **33570** | Ruskin, FL | 66.5 |
| **33572** | Apollo Beach, FL | 9.2 |
| **33573** | Sun City Center, FL | 34.2 |
| **33578** | Riverview, FL | 42.9 |
| **33579** | Riverview, FL | 24 |
| **33584** | Seffner, FL | 58.5 |
| **33592** | Thonotosassa, FL | 75.6 |
| **33594** | Valrico, FL | 32 |
| **33596** | Valrico, FL | 6.7 |
| **33598** | Wimauma, FL | 79 |
| **33602** | Tampa, FL | 16.6 |
| **33603** | Tampa, FL | 80.6 |
| **33604** | Tampa, FL | 88.3 |
| **33605** | Tampa, FL | 96.4 |
| **33606** | Tampa, FL | 11.6 |
| **33607** | Tampa, FL | 85.7 |
| **33609** | Tampa, FL | 15.7 |
| **33610** | Tampa, FL | 93.5 |
| **33611** | Tampa, FL | 14.2 |
| **33612** | Tampa, FL | 92.2 |
| **33613** | Tampa, FL | 90.3 |
| **33614** | Tampa, FL | 90.7 |
| **33615** | Tampa, FL | 70.7 |
| **33616** | Tampa, FL | 46.6 |
| **33617** | Tampa, FL | 77.4 |
| **33618** | Tampa, FL | 10.5 |
| **33619** | Tampa, FL | 87.7 |
| **33620** | Tampa, FL | 92 |
| **33621** | Tampa, FL | 54.6 |
| **33624** | Tampa, FL | 23.4 |
| **33625** | Tampa, FL | 31.1 |
| **33626** | Tampa, FL | 3.6 |
| **33629** | Tampa, FL | 1.6 |
| **33634** | Tampa, FL | 72.8 |
| **33635** | Tampa, FL | 23.3 |
| **33637** | Tampa, FL | 51.2 |
| **33647** | Tampa, FL | 14 |

# Appendix B. Index of Disparity

| | | |
|---|---|---|
| | **Hillsborough County** | **27.5** |

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

# Appendix B. Index of Disparity

## Food Insecurity Index (Figure 22)

| ZIP CODE | CITY | INDEX VALUE |
|---|---|---|
| **33510** | Brandon, FL | 57.2 |
| **33511** | Brandon, FL | 52.4 |
| **33527** | Dover, FL | 42.1 |
| **33534** | Gibsonton, FL | 72.2 |
| **33547** | Lithia, FL | 13.3 |
| **33548** | Lutz, FL | 4.5 |
| **33549** | Lutz, FL | 21.4 |
| **33556** | Odessa, FL | 5.4 |
| **33558** | Lutz, FL | 17.6 |
| **33563** | Plant City, FL | 80.4 |
| **33565** | Plant City, FL | 40.7 |
| **33566** | Plant City, FL | 53.8 |
| **33567** | Plant City, FL | 51.9 |
| **33569** | Riverview, FL | 29 |
| **33570** | Ruskin, FL | 46.1 |
| **33572** | Apollo Beach, FL | 9.2 |
| **33573** | Sun City Center, FL | 20.4 |
| **33578** | Riverview, FL | 51.8 |
| **33579** | Riverview, FL | 26.9 |
| **33584** | Seffner, FL | 52.7 |
| **33592** | Thonotosassa, FL | 74.2 |
| **33594** | Valrico, FL | 40.5 |
| **33596** | Valrico, FL | 9.5 |
| **33598** | Wimauma, FL | 40.4 |
| **33602** | Tampa, FL | 26.1 |
| **33603** | Tampa, FL | 84.8 |
| **33604** | Tampa, FL | 90.9 |
| **33605** | Tampa, FL | 96.5 |
| **33606** | Tampa, FL | 8.7 |
| **33607** | Tampa, FL | 83.3 |
| **33609** | Tampa, FL | 19.5 |
| **33610** | Tampa, FL | 96.7 |
| **33611** | Tampa, FL | 31.8 |
| **33612** | Tampa, FL | 95.6 |
| **33613** | Tampa, FL | 90.1 |
| **33614** | Tampa, FL | 94.6 |
| **33615** | Tampa, FL | 62.2 |
| **33616** | Tampa, FL | 71.6 |
| **33617** | Tampa, FL | 88.9 |
| **33618** | Tampa, FL | 21.2 |
| **33619** | Tampa, FL | 83.8 |
| **33620** | Tampa, FL | 39.2 |
| **33621** | Tampa, FL | 54 |
| **33624** | Tampa, FL | 35.3 |
| **33625** | Tampa, FL | 41.8 |
| **33626** | Tampa, FL | 10.7 |
| **33629** | Tampa, FL | 9.4 |
| **33634** | Tampa, FL | 70.9 |
| **33635** | Tampa, FL | 34.6 |
| **33637** | Tampa, FL | 57.2 |
| **33647** | Tampa, FL | 23.1 |
| | **Hillsborough County** | **41.2** |

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

# Appendix B. Index of Disparity

## Mental Health Index (Figure 23)

| ZIP CODE | CITY | INDEX VALUE |
|---|---|---|
| **33510** | Brandon, FL | 73.2 |
| **33511** | Brandon, FL | 67.5 |
| **33527** | Dover, FL | 39.4 |
| **33534** | Gibsonton, FL | 59.9 |
| **33547** | Lithia, FL | 18.9 |
| **33548** | Lutz, FL | 22 |
| **33549** | Lutz, FL | 39.7 |
| **33556** | Odessa, FL | 27.5 |
| **33558** | Lutz, FL | 41.2 |
| **33563** | Plant City, FL | 76.6 |
| **33565** | Plant City, FL | 56.2 |
| **33566** | Plant City, FL | 54.5 |
| **33567** | Plant City, FL | 58.8 |
| **33569** | Riverview, FL | 60.3 |
| **33570** | Ruskin, FL | 64.4 |
| **33572** | Apollo Beach, FL | 36.6 |
| **33573** | Sun City Center, FL | 97.9 |
| **33578** | Riverview, FL | 54.2 |
| **33579** | Riverview, FL | 48.3 |
| **33584** | Seffner, FL | 77.7 |
| **33592** | Thonotosassa, FL | 87.6 |
| **33594** | Valrico, FL | 62.1 |
| **33596** | Valrico, FL | 30.2 |
| **33598** | Wimauma, FL | 37.7 |
| **33602** | Tampa, FL | 64.3 |
| **33603** | Tampa, FL | 89 |
| **33604** | Tampa, FL | 92.1 |
| **33605** | Tampa, FL | 98.6 |
| **33606** | Tampa, FL | 53.3 |
| **33607** | Tampa, FL | 95.5 |
| **33609** | Tampa, FL | 36.1 |
| **33610** | Tampa, FL | 96.8 |
| **33611** | Tampa, FL | 63.5 |
| **33612** | Tampa, FL | 96.7 |
| **33613** | Tampa, FL | 89.2 |
| **33614** | Tampa, FL | 85.4 |
| **33615** | Tampa, FL | 81.4 |
| **33616** | Tampa, FL | 71.5 |
| **33617** | Tampa, FL | 90.1 |
| **33618** | Tampa, FL | 53.5 |
| **33619** | Tampa, FL | 86.5 |
| **33621** | Tampa, FL | 0.9 |
| **33624** | Tampa, FL | 61.4 |
| **33625** | Tampa, FL | 55.7 |
| **33626** | Tampa, FL | 20 |
| **33629** | Tampa, FL | 29.9 |
| **33634** | Tampa, FL | 67.3 |
| **33635** | Tampa, FL | 53 |
| **33637** | Tampa, FL | 69.4 |
| **33647** | Tampa, FL | 38.6 |
| | **Hillsborough County** | **82.7** |

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

# Appendix C. Community Input Assessment Tools

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

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

# Appendix C. Community Input Assessment Tools
## Community Health Survey

All4HealthFL
Four Counties. One Vision.

### 2022 All4HealthFL Community Health Survey

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

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

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

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

BayCare AdventHealth MOFFITT CANCER CENTER TGH Tampa General Hospital

In collaboration with: JOHNS HOPKINS All Children's Hospital

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

BAYFRONT HEALTH St. Petersburg

Lakeland Regional Health

## DEMOGRAPHICS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14. **Are you**

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

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

- ☐ Yes
- ☐ No

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

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

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

☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or more

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

- ☐ Yes
- ☐ No

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

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

## CHILDRENS SECTION

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

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

**20. Was there a time in the PAST 12 MONTHS when children in your home needed medical care but did NOT get the care they needed?**

☐ Yes ☐ No **(skip to question 22)**

**21. What are some reasons that kept them from getting the medical care they needed? (Choose all that apply)**

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

**22. Was there a time in the PAST 12 MONTHS when children in your home needed dental care but did NOT get the care they needed?**

☐ Yes ☐ No **(skip to question 24)**

**23. What are some reasons that kept them from getting the dental care they needed? (Choose all that apply)**

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

**24. Was there a time in the PAST 12 MONTHS when children in your home needed mental and/or behavioral health care but did NOT get the care they needed?**

☐ Yes ☐ No **(skip to question 26)**

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

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

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

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

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

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

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

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

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

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

**--End Children's Section --**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**--Survey continues on next page --**

## PERSONAL HEALTH

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

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

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

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

☐ Yes ☐ No **(Skip to question 46)**

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

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

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

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

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

☐ Yes ☐ No **(Skip to question 49)**

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

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

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

☐ Yes ☐ No **(Skip to question 51)**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# ADVERSE CHILDHOOD EXPERIENCES

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

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

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

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

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

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

# RESOURCE LIST

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

### FindHelp.org

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

### United Way 211

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

### National Suicide Prevention Lifeline

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

### Crisis Text Line

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

### Hillsborough County

Resources to Help You with Mental Health

### Pasco County

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

### Pinellas County

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

### Polk County

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

### Information on Adverse Childhood Experiences

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

### Recognizing and Treating Child Traumatic Stress

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

### TedTalk: How Childhood Trauma Affects Health Across a Lifetime

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

# Community Engagement 4
# Black/African American

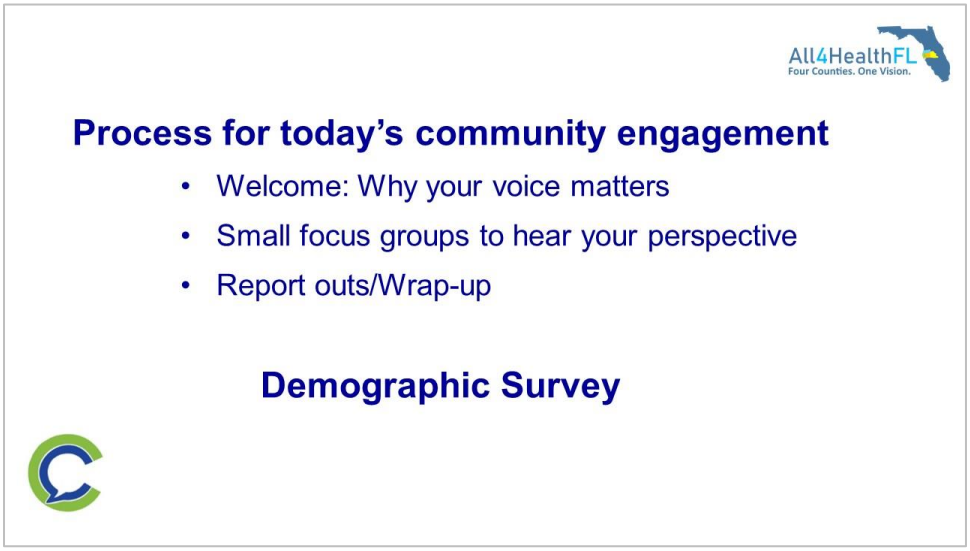
**Real-Time Record**

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

Collaborative LABS
at St. Petersburg College
EXPERT FACILITATORS IN STRATEGIC COLLABORATION

# Table of Contents

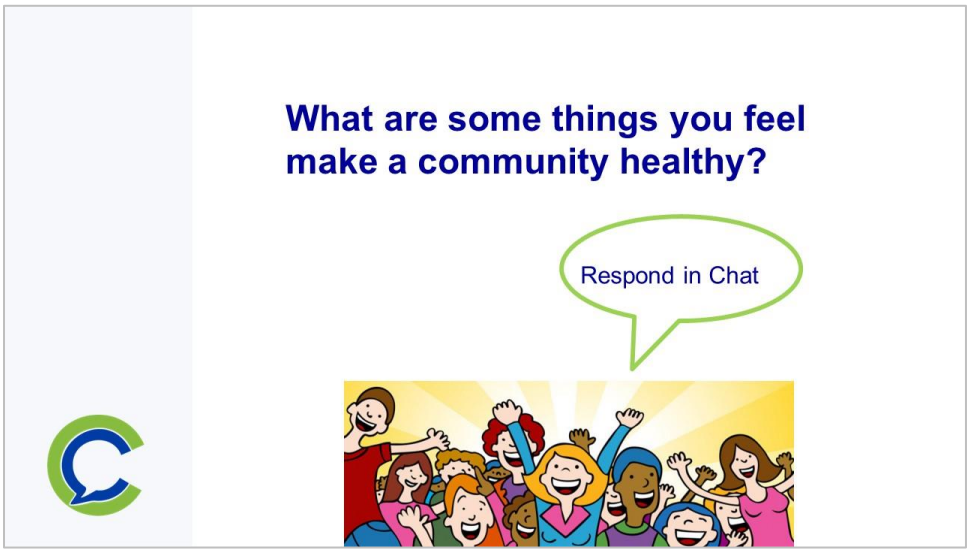
# Welcome




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

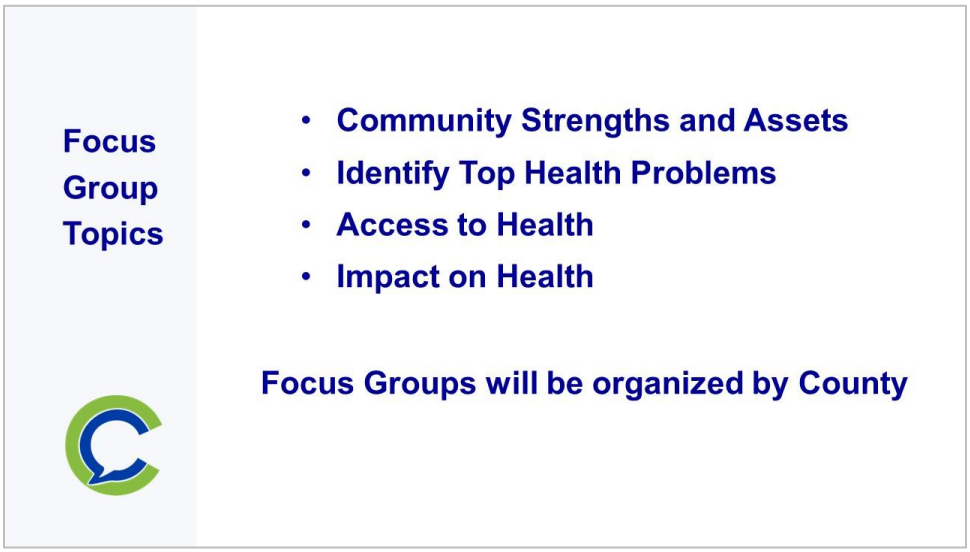
We also have a demographic survey we ask you to complete to tell us about yourself, which will be used later to understand diversity of the focus group. Everything is anonymous and there will be no names in the final report. Perspective of entire community.


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




*Comments from Chat:*

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




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


*Tina reviewed the breakout process and participants moved into breakout groups by county for discussions and feedback.*

# Hillsborough County Focus Group

## Community Strengths & Assets

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

- Working and dealing with African American Community...when someone is in distress there is someone there to hold that person and offer words of encouragement and guidance to help them. The village.
- African American people tend to turn to each other and keep your business to ourselves. The most valuable person in that community is the Pastor – spiritually get us through anything so faith is the way out.
- You have churches with spiritual guidance and someone you can turn to. People can speak to a Pastor (black males' stigma - walk away from mental health). Sharing with a doctor is difficult. People have more trust in their pastors.
- There are so many things you can do around here – something for everyone...shopping, restaurants, walking, events at Armature Works, artwork, food, events.

## Identify Top Health Problems

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

- Resources are key – food banks, mental health, community education to prevent food deserts, physical fitness, eating habits, lack of education
- People just don't have access to go to the grocery store...further away. Having that healthy food needs to be accessible. Summer camps, after school programs, rec centers
- Physical activity is hard if there isn't something available...need rec centers, to start raising awareness, and have a day of exercise. This can become a cultural norm
- Elder population is working to survive and stay alive and care for their family. Don't look at physical part...don't have a lot of gyms in our community...have to travel or have time or can't afford. People are working two to three jobs.
- Eating – just grab something and just go.
- Lack of education and people are buying non-nutritious foods. Shelves are empty.
- Food deserts – you don't have Publix or Walmart – you have Dollar Trees
- Missing education everywhere. Schools, work, church, signs, posters, (more liquor stores rather than produce stores), no gyms.
- Teacher and recruitment diversity in the schools – to promote diversity in the community. Hiring people of color. Black male role models are missing.
- Mentoring is missing! Being a product of your environment (black males grow up with no father in their lives). Instead of turning to the streets.
- More visibility of healthy places and signs. Words of encouragement and guidance throughout this whole thing.
- Healthwise – Trader Joes/Sprouts/Publix don't come to our neighborhood. If it's not around, you if you don't see it...does that make it okay? No, it's not okay. Pathway they go to is not acceptable. If you build it, we can gain acknowledgement and success.
- Need more quality job opportunities to help people be sustainable, productive citizens. Ex-convicts can't get good jobs and go back to the streets. If someone is backed in a corner – they tend to do anything by any means necessary – whether legal or not.

- Need affordable housing.
- The challenges we face were created by human beings – How do we get humans to collaborate effectively with one another while leaving out the bureaucracy?

## Access to Health

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

- No, certain jobs and insurance for healthcare are not accessible.
- Depends upon the person. People with disabilities, transportation needs.
- Yes, because the resources are there and there are all these little programs (transportation – little programs that folks may not know about)
- Knowledge (if you don't know it's there) goes back to resources, communications, and education, but they don't know.
- Community outreach programs come in to teach them how to apply for jobs.
- Healthcare vs. work. If you have a person on Medicaid, the minute they find a job for 20 hours a week their Medicaid gets cut off...may keep benefits for child but their benefits get cut off. A lot of these jobs are hiring part time, not full time. You don't get enough hours to get benefits. If you are making even 15 dollars an hour, that check becomes less when they take out benefits. I will just sit at home to keep some health benefits.
- You have to have the strength and perseverance. Human beings set up systems that get in the way of other human beings.
- Galvanizing the population (15%)

## Impact on Health

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

- All of the above. We need to erase and throw away all the "-isms"...including sexism. Females are going through a whole lot of things and can't afford (males too). Co-pays make it difficult. Some health systems lack compassion or concern for the people.
- The external factors that have an impact on health is this collective thinking that identity has an impact on health. If we could wave the wand and release these ideas about identities and what they mean, it would get us farther down the road.
- We are indirectly telling people that "because of your zip code...you can predict someone's health." It is a self-fulfilling prophesy.
- If you look at the way society, government, and businesses are making money off certain zip codes and are guiding if they will get extra dollars and benefits and funds...are the funds really reaching the community. Sad that the zip codes dictate it – but are we getting the progress from it. People are still struggling and not getting ahead.
- We had to fight to get Covid testing and brought the police bat mobile to our community, and we had to tell them to take this out of our community now. People weren't coming to get Covid testing because they thought it was a set up.
- Our centers have burglar bars, most of our parks have rats and feces and everything. Why should I care about my health if no one else does?
- Racism exists – systematic or institutional. Thought he was drunk…it is a diabetic episode. All plays a part society.
- Academics – stress of schoolwork and takes a toll.

- Black people are just tired. My people have no hope. You can have all the pastors and mentors, but you still have to go to work and not get ahead. But if your mind is not right to endure. Cleansing of the soul. People have to see and know that you care and be apart. You just can't show up at Thanksgiving and give out hams or give out a backpack.

# Haitian Community Focus Group

## Community Strengths & Assets

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

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

## Identify Top Health Problems

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

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

## Access to Health

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

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

## Impact on Health

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

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

# Wrap-Up and Next Steps


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

# Community Engagement 6
# Hispanic

**Real-Time Record**

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

Collaborative LABS
at St. Petersburg College
EXPERT FACILITATORS IN STRATEGIC COLLABORATION

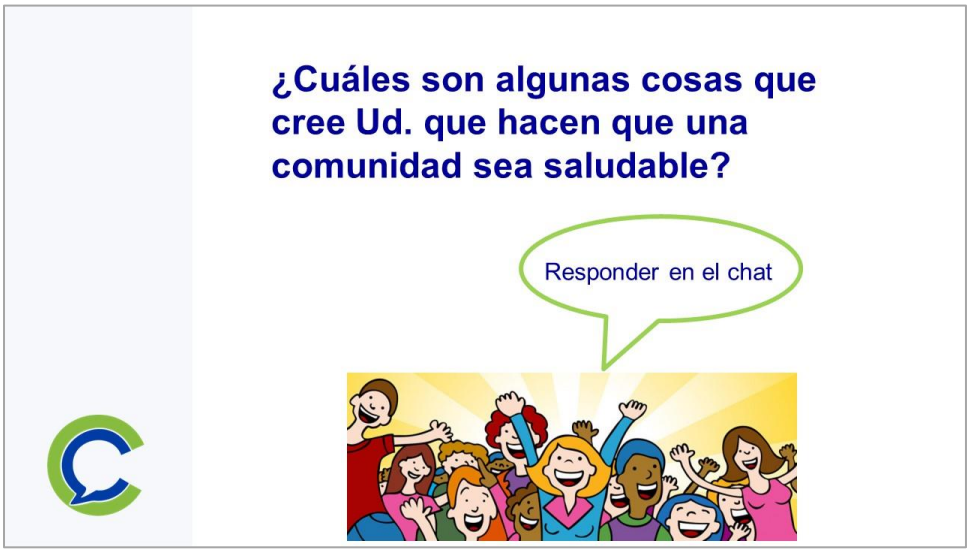
# Table of Contents

# Welcome

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

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

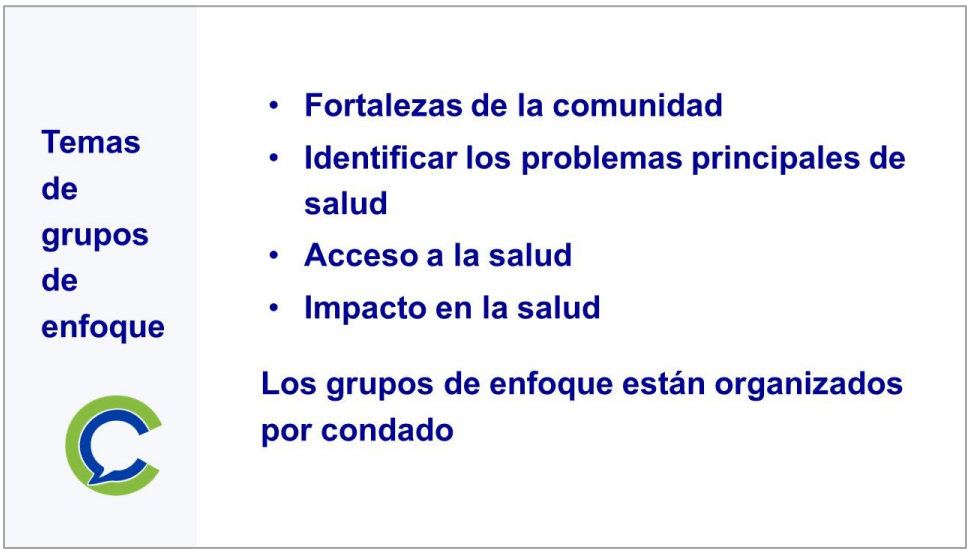

We have a quick warm up activity to start with. What are some things you feel make a community healthy? Please respond in chat.



***From Chat:***

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

- Welcoming environment
- Education
- Access to health care
- Educacion
- Access to health care and education
- Amor, energia, solidaridad, humildad
- A united community
- Equal access to care and education on health
- Access to healthy foods
- Access to basic services gives
- Access to healthcare
- Services to be accessible
- Having a shared sense of community
- Fair and equal treatment
- Transportation services
- Seguridad, safety
- Transportation
- Que tengan acceso a salud mental, comida saludable, y acceso doctores que entiendan la comunidad
- Not being alone!
- Mental health
- Cultura - culture "la cultura cura"
- Access to health care and health plan to cover wellness programs and nutritionist professionals
- Education + Awareness + access to available resources
- Education, transportation, access to resources, parks and recreation, healthy foods
- Educacion de salud y alimentacion saludable
- Services in your own language
- Access to affordable care



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


*Tina reviewed the breakout process and participants moved into breakout groups by county for discussions and feedback.*

# Hillsborough County Focus Group

## Community Strengths & Assets

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

- The people are beautiful, kind, and happy. You feel like family, they're happy about the services provided.
- They are very appreciative of our time and assistance. As you assist, you also feel good about the work you're doing.
- It feels like a community and that helps with the work that is being done.
- Working with immigrant communities who are very appreciative.
- The community wants to be educated and to learn.

***From Chat:***

- Trabajo en Pasco County Dade City.
- Hola, no se si me puedn ver, oir?
- wow que emocion yo trabaje en Mulberry hace mucho tiempo <3

## Identify Top Health Problems

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

- Access to mental health. We do not have a lot of providers that do not understand the community. Transportation can be an issue for some of our community members. Having someone who can share the same language and culture is valuable.
- Access to primary care is needed. More resources to have primary care providers to avoid sending patients who are undocumented to the ED. Important to have providers who are bilingual.
- Transportation. If people have better access to transportation to go to health clinics and take care of their health.
- The outpatient clinics do not have laboratory services and need to send patients to the hospital. Where do we refer these patients to when they need to see a subspecialist? Not only undocumented immigrants, but also Americans who do not have health insurance.
- Housing is an issue – poor living conditions, 2-3 families need to live in the same household because they are too expensive or undocumented.
- Nutrition: access to nutrition. Some people are not able to purchase fresh food, and it can be expensive.
- Addiction: alcohol
- Undocumented women are giving birth at home. Some children do not have resources for being undocumented.
- Undocumented children not receiving Pre-K and fall behind in school
- Special-needs schools are limited
- List of resources for the community would be helpful

***From Chat:***

- Necesitamos mas escuelas para ninos especiales. Donde los ninos puedan capacitarlos para que puedan ser independientes.
- She can call me Laura Resendez of Suncoast Community Health Center (813)349-7748 Pasco County Focus Group

## Access to Health

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

- Not everyone has the same access to health - lack of money, lack of legal documents, lack of family support.
- Use the church as a support system.
- Use the resources from the community to provide support in a consistent manner, such as the church promoting resources in the community.
- Not knowing resources in the community may impact health.
- There is a lack of resources, even food. While there are many food banks and resources, they're not always used.
- When families come from one country to the next, their way of eating changes and it may affect weight gain.

## Impact on Health

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

- Language barrier
- As healthcare workers, make sure that the patients understand the services being provided and what to expect at discharge
- As healthcare providers, the system does not help; sometimes we only have 15 minutes to talk to patients and it does not provide us enough time to engage with our patients to provide a thorough visit and review of system.
- The type of jobs (migrant workers) work Monday-Sunday and their job does not allow the flexibility to take the day off for a doctor's appointment.
- Educate our community on mental health and stigmas

# Wrap-Up and Next Steps

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

### Team 1 – Hillsborough County

We had a lot of providers in our group, and we talked about resources that are lacking in the community and providing a resource list.

Everyone was passionate about the changes they want for the community and the populations they serve. One of the key pieces was coming together for the community.


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

# Community Engagement 3
# Kids Population (All Counties)

**Real-Time Record**

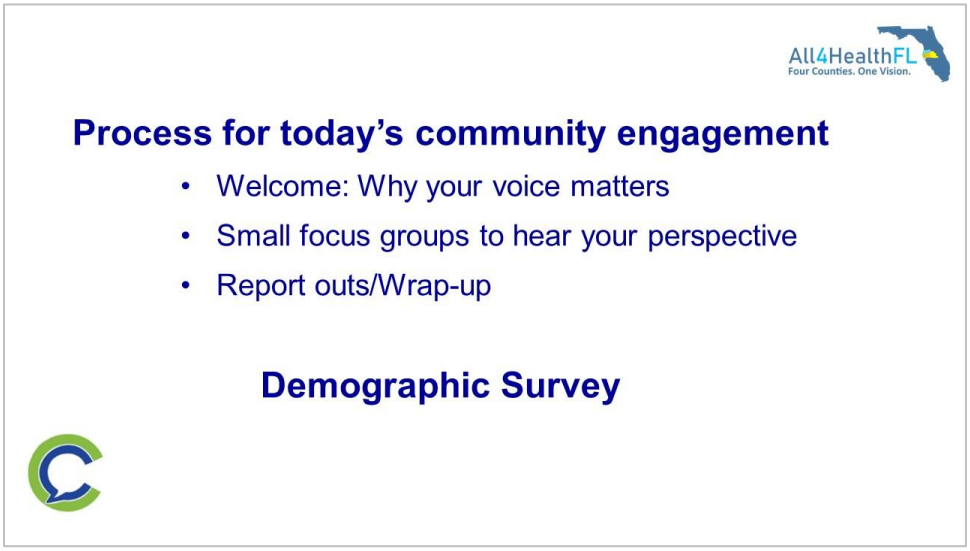
November 16, 2021, 9:00am-10:30am

Collaborative LABS
at St. Petersburg College
EXPERT FACILITATORS IN STRATEGIC COLLABORATION

# Table of Contents

## Welcome

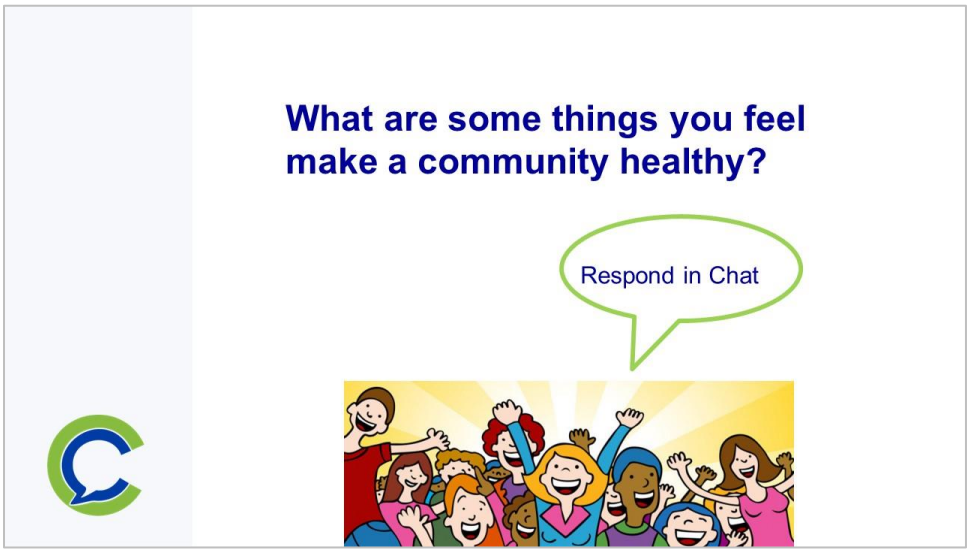

Good morning, it is good to see you today! Collaborative Labs is proud to support the All4Health Collaborative. Thank you for being with us.




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

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

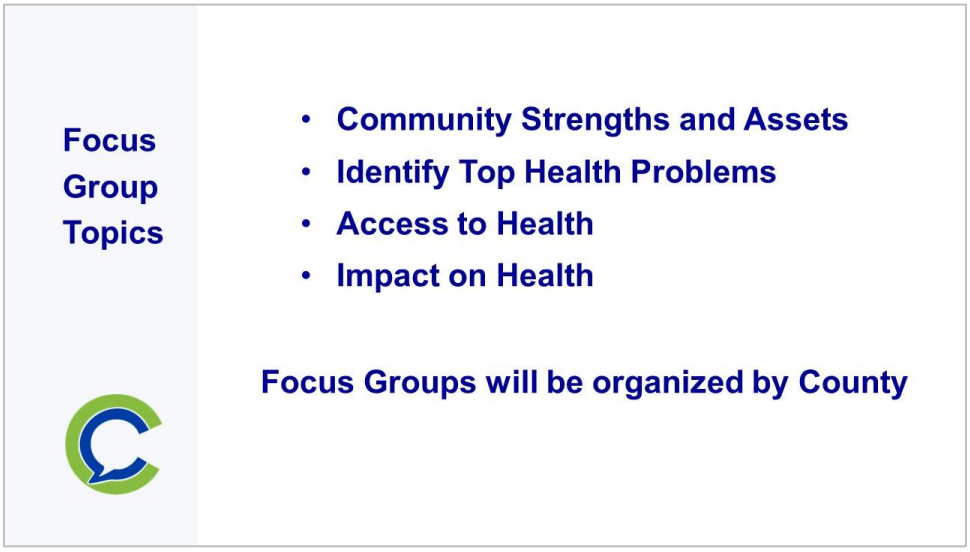

You are representing the four counties today and we are thankful for your help. We have a quick warm up activity to start with. What are some things you feel make a community healthy?




***From Chat:***

- Inclusiveness
- Support system
- Community connectedness
- Wellness efforts addressing the whole person
- Access to services
- Holistic care
- Support system - neighborhood
- Supportive relationships
- Sense of belonging

- Access to resources
- Teamwork, cultural competency
- Clean environments
- Proper nutrition
- Support for youth
- Green space, safety
- Access to proper care
- Caring individuals
- Safety
- Supportive Services
- Support and safety
- Strong families
- Safe spaces to ask questions and have discussions
- Safe, stable, nurturing parents and caregivers
- Inclusive supports
- Equality and equity
- Social support




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


*Tina reviewed the breakout process and participants moved into breakout groups by county for discussions and feedback.*

# Hillsborough County Focus Group

## Community Strengths & Assets

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

- Vast network of providers in this community, collaborative spirit, integrated services
- Folks that support each other, geographic, partner organizations, emphasis on holistic, well-rounded services that are inclusive
- Parks and sidewalks and a place for children
- Youth programs, soccer leagues – infuse life skills
- Schools, education, food, resources, clothing
- Supportive parents, advocate for this

***From Chat:***

- Safe places to go to encourage independence. Sidewalks, parks.
- Connections with mentors (coaches, other kids)

## Identify Top Health Problems

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

- To do our own assessment: Hillsborough County infant mortality is sentinel event for our community. Maternal health, access to health care, continuum of care across life span.
- Mental health (through pandemic) for parents and children. Destigmatize mental health.
- Mental health – social-emotional support, mental health training and working in collaboration with community partners. Facilities focused on kids' mental health.
- Mental health related to family and parenting skills (parent support groups)

- Affordable housing - safe
- Community assessment for childcare – needed for children and families. High-quality childcare development.
- Food
- Poverty – not enough access to healthcare, safe and healthy foods, obesity (only have access to unhealthy) and more physical activities in kids. Nutrition is very important.
- Support for children on cognitive delays spectrum.
- Parents don't have respite services for those who have physical or developmental disabilities.
- It is important for parents to teach their kids to be open with their emotions

***From Chat:***

- I would add public safety and infrastructure. Clean water, sidewalks, proper lighting, etc.

## Access to Health

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

- In school settings we have more resources to nutrition and physical activity but there needs to be more education and enthusiasm – make it fun and create buy-in.
- How do you change a habit with the parents and children related to eating healthy? Peer pressure from other parents and kids. It's parenting culture in general. High-income/low-income.
- Social media can have a very negative effect on children and adolescences. How can we combat that as a community to celebrate who they are? Early image is influenced in children and may influence decisions to have a eating disorder or pop culture to vape.
- Poverty effects access to healthy living for children.
- Being a parent is really hard (to teach proper nutrition) because they have so much going on. It's just easier and less expensive to make unhealthy food. A lot of parents need support with this. Health is related to what you put into your body.
- There needs to be more attention and education on nutrition.
- It is important to have work/life balance across a community (life includes health and personal growth).

## Impact on Health

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

- There are little things you don't know about our children's lives. Especially confusion on LGBTQ. Social media impacts us.
- Social media effected my eating habits and behavioral habits – hours and hours lying in bed on tik tok (promoting bad behaviors). Whenever kids are together, they are just watching tik tok and not relating to each other in any way.
- LGBTQ, race, or other issues around a person's identity – certain issues for communities to grapple with. I am concerned that we "attach an identity" to our communities and we don't want to put our children in a box and not be able to excel because of a label.
- Children don't understand all the labels. Some become extreme one way or another. Sometimes adults influence children with labels. Kids learn a lot from what they hear

and see and if their parents are acting a certain way...make sure you are teaching your kids
- Screen time/social media can be a predictor of health (eyesight, health, always on your phone).
- Social media has also caused children to be more respectful of all the communities – less prejudice.
- Health care providers and educators should shift the way we deliver information to kids – appealing to the values of kids – generations are changing.
- Culture and community
- Community health assessment – training health providers: the issue of medical school and resident training is very important – social influencers of health or structural forces of health.
- Getting community – parents, churches, coaches, mentors - to engage their children in these tremendous services we have funded. Schools with food pantries, kids have somewhere to go and safe to walk.
- Awareness, wrap-around support, education. Make medical and community aware of what is available! Grass roots, school districts, faith based, clinics, childcare providers, rec centers. We can't do it on our own! How do we put them all together? Big holistic approach to save a community.
- Those of us who work for agencies – funding is restrictive and spending so much time doing reports and doing metrics and it makes it harder to talk about the needs in this community in a collaborative way.

## Wrap-Up and Next Steps

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

### Team 1 – Hillsborough County

Strengths: network of providers in community, collaborative spirit, support of each other, partner organizations, youth programs, education, clothing, and food resources, supportive parents

- Problems: infant mortality, mental health and the need to destigmatize and provide facilities and education, affordable housing, high quality childcare needed, poverty - access to healthcare, obesity, nutrition, support for cognitive delays, respite for parents providing 24-hour care
- Access to health: resources in school settings, changing healthy eating habits, work/life balance for parents, fun/exercise
- Impact: social media impacts holistic person, children not understanding labels from community, healthcare providers need information about social factors for kids and to relate to children and parents, train the community at large on social influencers and structures of health, awareness of wrap around support, services and education community wide.


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

# Community Engagement 2
# LGBTQ+

**Real-Time Record**

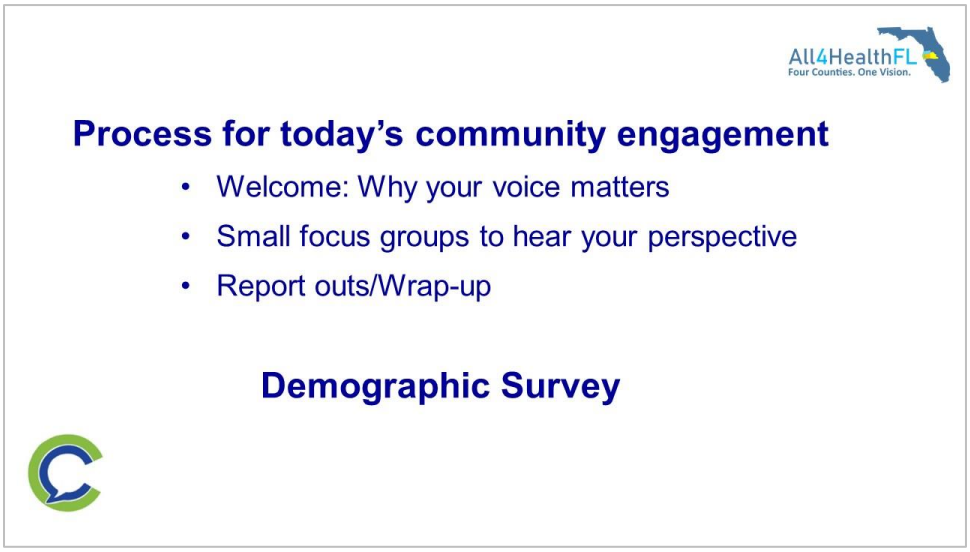
November 15, 2021, 2:00pm-3:30pm

Collaborative LABS
at St. Petersburg College
EXPERT FACILITATORS IN STRATEGIC COLLABORATION

# Table of Contents

# Welcome

Welcome everyone, we are happy to have you on our call today. Thank you for joining us!

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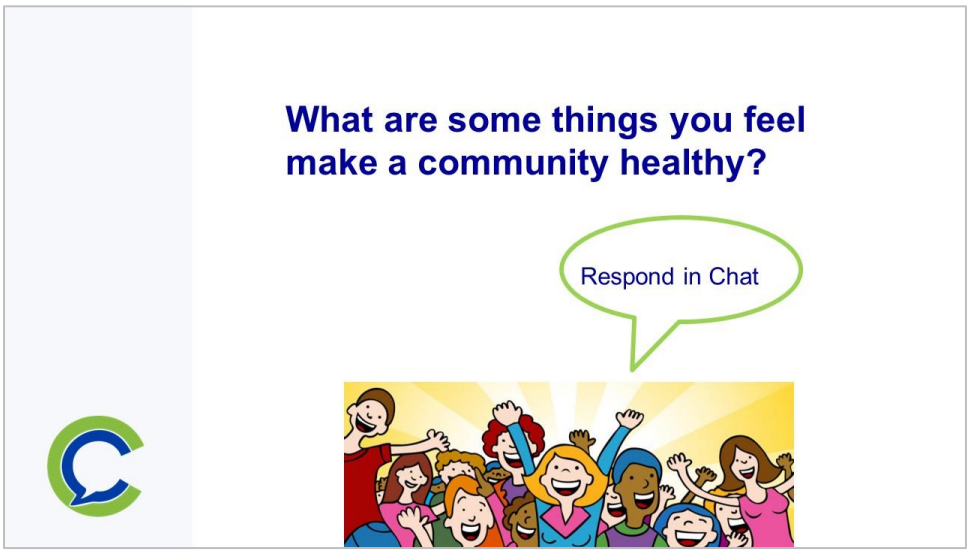
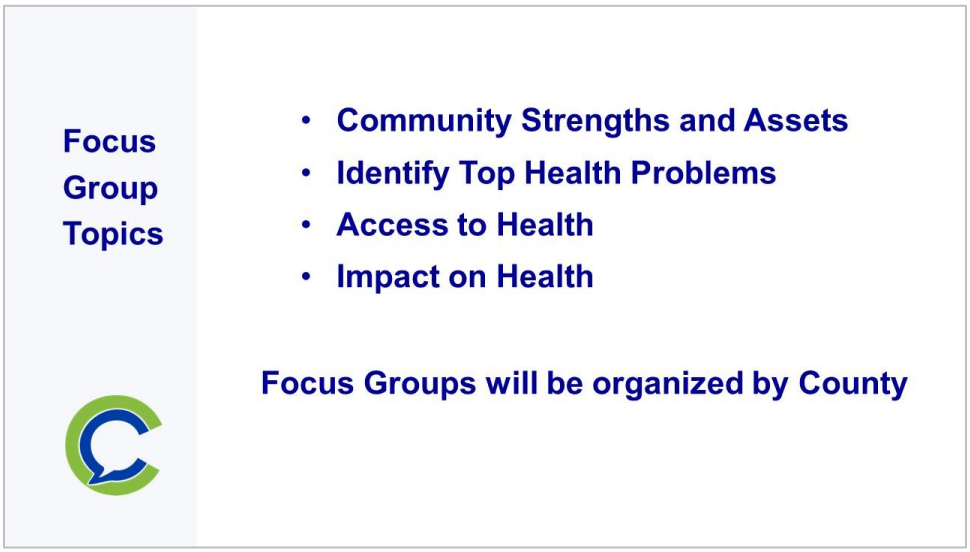



***From Chat:***
What are some things you feel make a community healthy?

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




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


## Hillsborough County Focus Group

## Community Strengths & Assets

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

- Channelside area – Community which I love and the condo where I live. We recently transitioned by board to members of the community. Gay-friendly community in the heart of Tampa.
- There are so many outdoor activities and always some inclusivity in our community.
- I love how Tampa is very diverse and has a rich culture. Well-known for parades, sharing many backgrounds and beliefs. Rich culture of Spanish and Italian immigrants and empower that through food and travel.
- Hillsborough County rich in substance abuse resources and health resources.
- Don't know where to access mental health for psychiatry.

## Identify Top Health Problems

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

- Obesity and mental health. Obesity is the root of many other health problems.
- Transportation: Access to public i.e., would love to see our area more walkable and transportation options.
- Mental health was impacted by Covid
- Insurance is a huge one for the population we serve
- Affordable housing is first and without it healthcare falls by the wayside
- Mental health
- Cost of everything going up. Eating healthy is very expensive.

## Access to Health

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

- Insurance. Very fortunate to have Hillsborough County Health Plan for the working poor. Not accessible to everyone.
- Even with those with insurance – access. We don't have enough physicians to care for our patients. Without enough physicians – care costs rise. Cost of medication is high. Medical staff shortages – physicians and nurses.
- Numerous things: Transportation. Working class that still can't afford health insurance. In some rural areas, there is not enough access to resources.
- To be happy and healthy is also expensive – to be able to afford healthy foods.
- Better bike lanes so people will feel safe, exercise, and help with transportation!
- Ability to do telehealth has been a plus from the pandemic. Convenient for everybody in Florida to access

## Impact on Health

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

- When I was younger, I went to my doctor and asked for prep so I wouldn't contract HIV to be extra safe. I felt extremely judged when I asked that. Physician said don't have sex and don't be the way that you are. If that happens, people may not go see another doctor. I searched for the right doctor. Being judged for your race or being gay.
- Not being comfortable with physicians who are judgmental of race, ageism, sexuality.
- 62-year-old Asian, physician
- Lack of education among health care providers on gender identification. Physicians can be proud and need to refer to others who are more educated.
- Courses on domestic abuse, specifically dealing with sexual minorities
- Physicians should be required to learn more about gender identity and sexual identity in their coursework and license renewals.
- We need to do social research regarding what happened to justice. How is health affected and include people in the community to design research and get funding on how to learn more related to factors. Education of physician and patients, there are so many things we don't know. It is hard to ask for something.
- Stigma can apply to many things – ageism (we need to have grace with one another too)
- Role of education and support from the institution regarding data and access to data
- How committed is the institution with DEI (diversity, equity, and inclusion)?
- Get involved with Diverse Chambers of Commerce to talk about DEI.
- Options in Tampa – culture, mental health and substance abuse, exercise opportunities, etc.
- To provide education for our health care providers – front desk/doctors
- Provide access to health care – transportation, healthier foods (veggie vans to schools).
- DEI Training – putting your words where your mouth is.

***Chat: Other Comments***

- tampabaylgbtchamber.org has a calendar for all LGBT related events: pride, festivals, conferences, supplier diversity, etc.
- justice@tampabaylgbtchamber.org 813-687-4993

## Wrap-Up and Next Steps

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

### Team 1 – Hillsborough County

- Strengths: Tampa is gay-friendly and inclusive, there are many outdoor activities, rich culture, rich in health resources and substance abuse resources
- Problems: obesity, which causes other health problems, transportation, affordable housing, costs going up
- Access: healthcare is not accessible to everyone, medical staff shortages, transportation
- Impacts: DEI (diversity, equity, and inclusion) training needed in healthcare


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

## Attendees

Andrew Grimmer
Ant Avila
Chance Martinez
Jenniffer Taylor
Jessica Quintero
Julia Delmerico
Justice Gennari
Karen Barfield
Lucila Ramiro
Mandy Keyes
Marina D'Amato
Meena Mohan
Nathan Bruemmer
Nina Borders
Robyn Larson
Sara Osborne
Tom Panagopoulos
Topher Larkin
Yazmin Castellano

# Community Engagement 1
# Older Adult Population

## Real-Time Record

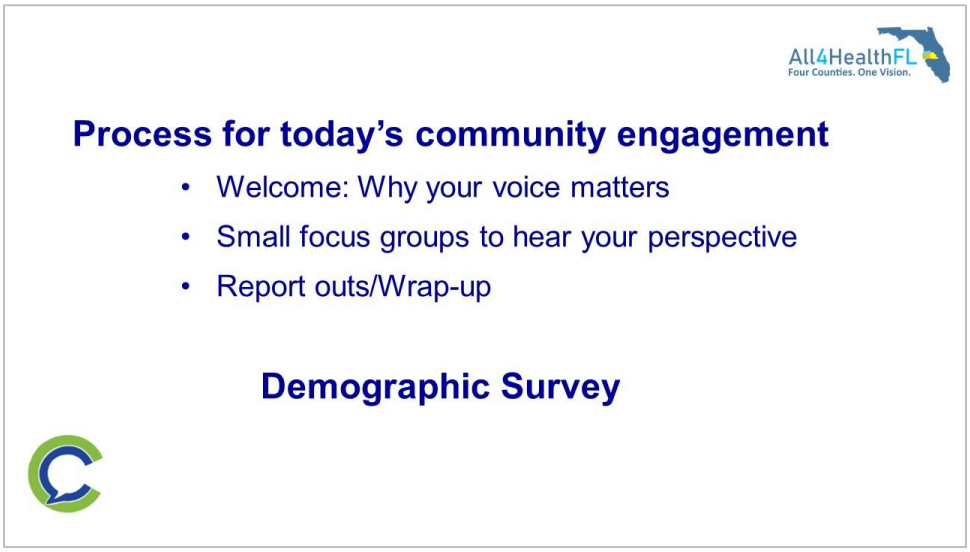
November 15, 2021, 9:00am-10:30am

Collaborative LABS
at St. Petersburg College
EXPERT FACILITATORS IN STRATEGIC COLLABORATION

# Table of Contents

# Welcome


Good morning and thank you for spending part of your morning with us!




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

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

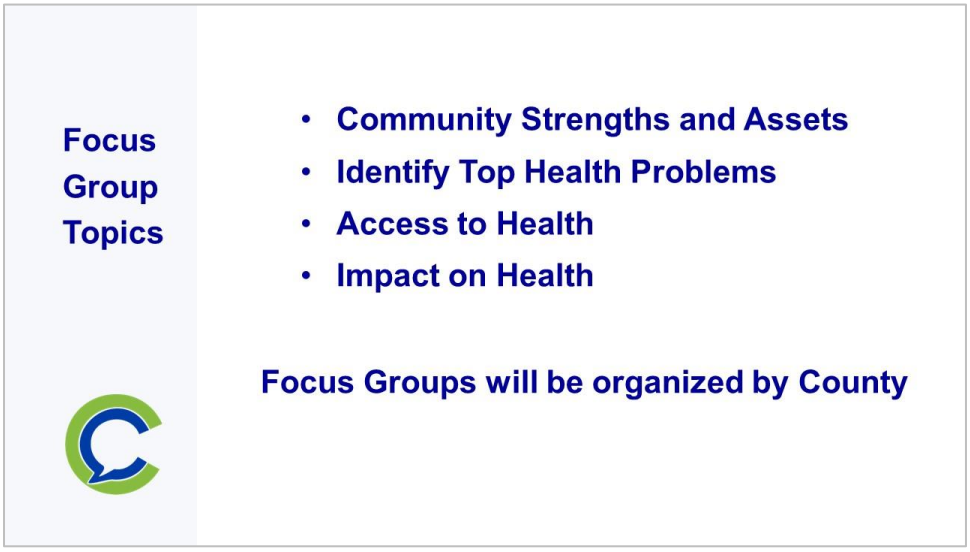

You are representing the four counties today and we are thankful for your help. We have a quick warm up activity to start with. What are some things you feel make a community healthy?


***From Chat:***

What are some things you feel make a community healthy?

- Access to good food
- Service providers working together
- Access to health care needs
- Paying attention to the needs of the community, providing bike paths, parks, exercise areas, etc.
- Low mortality rate, low morbidity rate
- Well-informed collaborators
- Access to affordable health care and addiction services
- Access to basic life necessities food, shelter, employment, etc.
- Partnership between community organizations
- The ability to provide suggestions without fear of animosity. In other words, respectful communication.

- Ease to access healthcare
- Access to transportation
- I agree with service providers/organizations working TOGETHER.
- Outdoor-green space for recreational activities
- Affordable transportation
- Good mental health
- Getting to know neighbors and welcoming people who are not from this area
- Affordable housing
- Knowing the community resources available to meet people needs.
- Recycling efforts
- Access to mental health services
- Mental health
- Obesity
- Mental health




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


*Tina reviewed the breakout process and participants moved into breakout groups by county for discussions and feedback.*

# Hillsborough County Focus Group

## Community Strengths & Assets

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

- Zoom for seniors – help with depression
- USF Medical Clinics – medical school and types of folks you can see
- Alzheimer institute in close proximity
- Hillsborough county aging services great job with seniors – support groups with Alzheimer and other dementia
- Good location for exercise, workout and all that and you can go and walk around and enjoy it for seniors. Good access for wheelchair bound.
- Environment has so much green space and health services. Get outside in nature.
- Moffit Cancer Center world-renowned treatment center
- Developmental centers through Hillsborough County - 15 of them
- Tampa Family Health Clinics
- Classes with Senior Connections and USF Connections

***From Chat:***

- I should have also mentioned Hillsborough's Aging Services as well. They have been a godsend.

## Identify Top Health Problems

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

- Better transportation for those who don't have a car. Need transit system, especially in Brandon to get to appointment without relying upon someone else.
- More health presentations to teach about Covid & Vaccine information.
- Access to nutritious food. Underserved neighborhoods. Food Deserts.
- Electric cart/tram system for seniors only
- How difficult it is to get care that is coordinated in any way (across providers)
- Sometimes staff in an office that drops the ball. May not be as well trained as they should be for coordinated health.
- Have doctors focus on preventative care to lower risks
  - Stay active, get involved, exercise
  - A lot of disinformation out there (e.g., challenges presented on covid. More medical people out there explaining it.)
- Don't feel safe out there with those unvaccinated.
- Working in an underserved hospital – Food Deserts, Dollar Tree shopping causes poor nutrition, Homeless Services – Coordinated/Communication/Connectivity between multiple providers has to be so strong. It is heart breaking to see seniors getting into dementia and asking them to navigate a system that is an extremely large ask. Communication between provider and consumer that is extremely simple.
- A person needs to be extremely alert with what is going on with their own body and do their own background and research. Doctors don't give us enough time.

## Access to Health

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

- Alzheimer's Association did a poll of people of color and we found that 40-50% felt they were discriminated against by the health industry when expressing issues of cognitive changes. They felt dismissed.
- People who are alone need people to check on them. They need to meet and have family and others.
- Access to care – people are blowing off what they are expressing to providers. Could be discrimination or ignorance.
- There is a deficit of front-line providers in the medical field who are well trained or supported by – for cognitive disorders. Getting them to refer properly.
- Universal health system – everyone having access.
- Sometimes you have to put your foot down and demand what you need regarding to health care.
- Humana is a good provider

## Impact on Health

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

- Health Literacy. Tackling it for our entire population. Connectivity.
- For me being active – it keeps me mentally healthy. All kinds of classes and activities.
- Very active, dinner, store, bridge, prompted me to say, "Come to my house." Getting together with friends and expand your mind. Active on computer. Shopping is exercise. Walk.

- Pickle Ball three days per week. Phase 10 and Bridge. Walking trail with H.C. Center.
- Genetic factors help as well. Predisposed. Many of my ancestors live to be very old. Ancestor who lived to be 104. Centurions.
- Economic identity. If you have jingle in your pocket, you get better services than others. We don't have too many deserts over here because we are fortunate.
- Live in a place where they are safe.
- If you have resources, you have a leg up.
- People should have more education in these issues.
- Discrimination in healthcare – African American. Black people being treated for pain and treated as though they just want pain medication. Within 2 blocks you have the poorest neighborhoods and no access.
- Sales pitches on foods that are not good for you.
- Traffic and television has a great impact. Pharmaceuticals.
- Computer and Facebook and different sites where young people and elders are getting their information. Dictating what will be provided.

***From Chat:***

- Area Agency on Aging Pasco-Pinellas is a great resource for those two counties. They are located in St. Petersburg.

## Wrap-Up and Next Steps

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

### Team 1 – Hillsborough County

Strengths: Zoom for seniors, University of South Florida medical clinics, indoor and outdoor options for exercising, classes for seniors

- Problems: transportation, health presentations needed, food deserts, difficulty in getting coordinated healthcare across providers, need for preventative care, disinformation, unvaccinated people
- Access to health: Alzheimer's Association study showed 40-50% of people of color felt discriminated against and dismissed when expressing issues of cognitive changes, people who live alone need to be checked on, have access to care, a deficit of front-line providers trained in cognitive disorders
- Impact: health literacy, connectivity, economic identity, discrimination in healthcare (African Americans treated as if they just want pain medication), the Internet and Facebook providing health information


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

# Appendix C. Community Input Assessment Tools Prioritization Session Attendees

Hillsborough County prioritization session was conducted on May 12, 2022, 89 individuals were in attendance from the organizations listed in the table below. These organizations played a pivotal role in providing feedback on significant health needs identified within the data analysis, developing preliminary ideas on ways to collaborate to address needs, and prioritizing community health needs for the next three years. The list of participating organizations and discussion feedback can be viewed in this appendix.

| Participating Organizations | |
|---|---|
| Advent Health | Judeo Christian Health Clinic |
| American Cancer Society | Metro Inclusive Health |
| Bartow Regional Medical Center | Moffitt Cancer Center |
| BayCare Health System | Northside Behavioral Health Center |
| CARD USF | OASIS Opportunities |
| central Florida Behavioral Health Network | RGA Advisory |
| Childrens Board of Hillsborough County | Tampa Bay Thrives |
| Conduent Healthy Communities Institute | Tampa Fire Rescue |
| Cove Behavioral Health, Inc | Tampa General Hospital |
| Dawning Family Services | The Family Healthcare Foundation |
| Feeding Tampa Bay | The Salvation Army Tampa Area Command |
| Florida Department of Health in Hillsborough County | The Skills Center |
| Gulfcoast North AHEC | Transcare\Crisis Center of Tampa Bay |
| Hillsborough County Government | UF IFAS Extension-EFNEP |
| Hillsborough County Public Schools | University Area CDC |
| Hispanic Services Council | Urban League of Hillsborough County |
| IDEA Public Schools | Ybor Youth Clinic |
| Johns Hopkins All Children's Hospital | |

# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

## Access to Health Services

**Breakout Room 1: Access to Healthcare services**

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

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

- Fear and Discrimination
  - Mentioned frequently, but not cited as a major barrier as access to services
- *Substance abuse & Mental Health*
  - Access to care is still a major problem. Insurance acceptance remains an issue.
  - Constant need for primary care and stable housing
- Emergency Room and Urgent Care Utilization
  - Long lines and overuse limit access
- Syphilis rate
  - Rates typically move incrementally, but this rate seems to be increasing faster

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

1. What social determinants are impacting this health issue?
   - Scheduling
     - Employment, childcare, hours
     - Limited providers in certain areas of care
   - "183 Mental health providers for 100,00 in population"
     - Too few providers, too much demand. Most availability, least accessibility.
     - Large need, but still difficult to access
     - Staffing the clinicians remains a barrier. Workforce crisis / staffing shortages permeates behavioral health.
   - Cost of living
     - Inflation and housing costs are rising, but income isn't growing to match
   - "19% of people don't have health insurance"
     - A luxury that is influenced by income
2. From your perspective, what has caused this to improve/worsen/remain the same?
   - COVID-19 Pandemic
     - People have delayed treatment and are sicker because of it
   - Hours of operation
     - Parents have to leave work and pull children out because school, work, and clinic hours all overlap.
     - Health services offered on weekends or late-night help increase access
   - Funding for SAMH services

- Additional funding associated with COVID-19
- Economic Crisis
  - Primary care may be accessible, but specialty care that requires transportation remains difficult.

3. What efforts have you experienced that are working and how?
   - **Baycare**, Children's Board, and Mobile immunization clinic / physicals
     - Accessible, affordable, and effective.
     - More federal funding, staffing, and other support could help this immensely
   - Food Insecurity
     - YMCA Veggie van co-locating at clinic
     - Free pantry for patients to get food without question and with dignity
   - FLDOH, Immunization and health education collaboration at treatment facilities
     - Especially helpful for transient populations
   - School partnership
     - Students and parents are often always there, so school / health partnerships can be very effective
4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
   - Specialty care areas
     - Providers are willing to provide volunteer services in primary care, but the same can't be said for specialty care, especially because of the complexity and cost of specialty care
   - More providers
     - Tampa Family Health Clinic can only serve so many people
   - Diversity, Equity, and Inclusion among providers
   - Limited amount of information on providers in community
     - Low visibility of small, free clinics
     - Little access to eligibility criteria

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

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

1. Access to Health Care
   - Adding eligibility criteria to All4HealthFL website to give providers a centralized location to refer clients to smaller organizations
   - Wellness Connection – referral process and information sharing efforts is easy
   - Community Paramedicine programs
   - Provider volunteerism – sharing information with providers on how they can give back, educating providers where they can volunteer and compartmentalize the services to abate fears of overextension
2. Behavioral Health
   - Tampa Bay Thrives – connects behavioral health providers and congregate mental health resources

- Adult Mental Health First Aid Training

3. Exercise, Nutrition & Weight
   - Paid Sick leave for staff
   - Evaluation of personnel policies to ensure equitable employment
     - An interagency summit to discuss creating more equitable personnel policies

**Breakout Room 2: Access to Health Services**

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

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

- Sad when reflecting on 'not moving' the needle for Behavioral Health- more work to be done
- Not surprising that access to healthcare can be a barrier- we have not been able to meet the needs
- Unable to afford nutritious food- can families afford the foods? Costs may be a factor; inflation is continuing to add to this concern. Sometimes families do not have a choice to the foods they are offered
- Information on food banks- are we tracking for fresh vegetables and fruits? Can make larger partnerships/ reach out to farmers? We can be proactive or 'out of box' for this growing concern
- Cost of housing can affect access to care- priorities (people are making a choice)
- What impact telehealth has?

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

1. What social determinants are impacting this health issue?
   - Lack of access to nutritious food, lack of transportation, inflation
   - Supply Chain Concern
   - Environment around the individuals- cannot access a 'navigator' to help connect them to the resources (social services)
   - Living in rural area
   - Lack of flexible work hours
   - Staff shortage- lack of professionals
   - Economic stability- hourly rates

2. From your perspective, what has caused this to improve/worsen/remain the same?
   - Telehealth- lots of individuals have internet, is this assisting with access? Are people questioning the quality? Number of devices in the home/ sharing laptops/tablets? Remain the same- were able to keep services going but not everyone has access, improved with those who were already established, are telehealth pcps are options? Barrier because there is no personal connection-
   - Rapid population growth in Hillsborough- worsen

- Lack of providers will worsen with the rapid population growth – worsen
- Worsen- employers are not pushing preventive health
- **Remained the same- the difficulty to navigate the system**
- **Increased communication- improved**

3. What efforts have you experienced that are working and how?
   - Nurse Navigators
   - Positions in hospitals/community that helping people connect with resources
   - Different forms of urgent cares for access
   - Walgreen clinics- pop up clinic
4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
   - **Continuing to align efforts**
   - **Resource bases – awareness**
   - **Collaboration**
   - **Rounding Call- calls for discharge planning, work the case as a collaboration "huddle"**
   - **Focus on the community, and wellness on the community- getting hospital leadership on board**
   - **Work with smaller non for profits to help with connectiveness and communication**

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

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

- County Health Plans- connecting patients/individuals to the resources – how can we make this process easier for community members?
- Behavioral Health works to connect with the County Plans
- More funding to Navigators for the assistance is helping individuals connect with the resources
- Update to date information for resources- Find Help works to make sure the resource is still working
- Collaboration within organizations, and with external partners
- Implement daily huddle with the primary players with high need patients
- Wrap around services
- Increased patient advocacy and increased transparency
- Tampa Well- Community trail- exercise is medicine referral - lifestyle medicine coaches
- Increased relationships with providers and clients

## Behavioral Health (Mental Health and Substance Misuse)

# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

**Breakout Room 5: Behavioral Health (Mental Health and Substance Misuse)**

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

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

- The highest needs seem concentrated in the same zip codes (food insecurity map compared to the mental health/substance abuse map look similar). It speaks to lack of resources across the board in those zip codes.
- There is a lack of focus on behavioral health. There doesn't seem to be enough providers. Behavioral health issues also have a downstream effect on health.
- On lack of access to care, the primary issue (at least in the Hispanic community) is fear. COVID affected access to care in limiting availability and because people were fearful of contracting COVID.
    - The pandemic brought to light mistrust in the community among black team members/co-workers. When vaccines became available, many team members refused to get vaccinated.

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

1. What social determinants are impacting this health issue?
    - Among the Hispanic community, fear of contracting COVID-19 was a determinant. People couldn't isolate because they lived with others. They didn't have anywhere else to go. Some were living in shacks.
        - There are infrastructure issues. Lack of access to internet for children to continue school has mental health effects. Children had to do their homework from the car to access internet.
    - Poverty/economics impacts this issue. If you have money, you can access high speed internet, food, other services. There is still stigma attached to seeking help for mental health, in addition to there not being enough providers. People are expected to "tough it out" on their own when they have mental health issues. Eating disorders were up during the pandemic, among girls especially. Being on social media all day/social isolation may have drove up eating disorders. The impact of social isolation during the pandemic is wide-reaching, but all the issues can't be pinned on the effects of the pandemic.
2. From your perspective, what has caused this to improve/worsen/remain the same?
    - Social isolation of the pandemic compounded all these issues. The effects were seen especially in the older population (e.g., not able to see parent in nursing home for year+, contributing to a decline in health).
    - Food distribution went up ~600% during COVID, and even then, we were still not able to reach everyone who needed food assistance.
3. What efforts have you experienced that are working and how?
    a. Surge in telehealth improved access to behavioral healthcare for some. When it comes to behavioral health, telehealth can feel less threatening.

4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
    a. On the lack of infrastructure in South County – the pandemic brought to light the fact that the county commissioners had a lot of work to do to address the needs of that community. That started to happen right away during the pandemic.
    b. There is a gap in access to telehealth/internet and in access to the tech resources or tech-literacy.
        i. Telehealth shines a light on the need for provider capacity. You need to have providers to be able provide that care. Some patients are not tech-savvy (older generations, for example).
            1. Providers also need to have cultural humility.
    c. There is a continuing need on the employer side to acknowledge mental health concerns, and the need to prioritize that w/ their team member.

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

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

- Access to Health & Social Services
    - We need to provide services where people are (e.g., providing services within a Walmart or at a local church). This will increase access to services.
    - The more we do to build networks that can connect people to social services (e.g., FindHelp, Unite Us) can help. We need to coordinate on a resource referral network (not have all orgs use different services). Individuals should know where to go to access resources.
- Behavioral Health (Mental Health & Substance Misuse)
    - We need in school counselors to provide children the help they need when they need it. Each school should have at least one behavioral/mental health counselor that can provide care when it's needed.
- Exercise, Weight, Nutrition
    - Nutrition should be taught in school. Children can bring what the learned in school home.
- There are non-profits/organizations across the county working to address these issues, but the organizations seem siloed. We could work more collaboratively to address the issues. We need to figure out a non-threatening way to collaborate that maintains organizational identity/purpose.

**Breakout Room 6: Behavioral Health**

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

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

- The on-going issue with stigma related to behavioral health. The challenge of people understanding mental health resources and access of services, mental health literacy.

The need for education on mental health to providers and helping them understand ACEs. Also, the trauma of educating about mental health in our immigrant population.

- The different categories of needs that were shared. Appreciated the bigger concepts that lead into larger health problems - the connection the data showed to SDOHs – such as food insecurity. Appreciated seeing those bigger issues/concepts reflected in the survey.
- The issue of access seemed to be a big issue, the issue of providers not accepting insurances. Psychiatrist are begging to make changes to accepting more insurances. Focus on outpatient resources (the need to).

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

1. What social determinants are impacting this health issue?
    - Access (to care, to everything), access to internet as well. So much has gone virtual and this becomes a barrier.
    - Economic stability – this is a big one. We are seeing huge amounts of crisis in behavioral health even at our feeding sites. There is so much correlation to economic stability.
    - Substance Use
    - Affordable housing, lack of access to healthy food. Is there a way to have a resource connection? There may be, but this would help.

2. From your perspective, what has caused this to improve/worsen/remain the same?
    - COVID, COVID, COVID
    - Housing crisis, food inflation, the stretching of household budgets
    - Increase in population without any increase/expansion of resources. The shift in population regarding economic status. A lot of displacement dur to the economic challenges.

3. What efforts have you experienced that are working and how?
    - Increase the collaboration of social services working together. Connecting with the community to better understand what services are available to connect clients to those services.
    - The MAT program – medication assistance treatment program
    - The needle exchange program (initiation of this program in the county)
    - MHFA – mental health 1st aid programs
    - Tampa Bay Thrives – pilot to implement behavioral health urgent care; Tampa general has a model. Hope this will be successful once we can get the word out on this. A press conference is happening soon.
4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
    - Collaboration – we cannot do this on our own! Working together to make a difference!!!!
    - Addressing the prevalence of fear and how people are being treated when they get services.
    - Addressing the issue of stigma of mental health. Many do not access mental health due to the stigma. Stigma makes people feel like a failure. Then, when we

do this let's have a place for people to go. A central hub for behavioral care and other services – in one central location, with extended care. Care navigation – have this available.

- Address the terrible reimbursement rates from Medicaid. Many providers do not want to become Medicaid providers because of this poor rate. Can we lobby on this? What can we do locally to address this?
- Take mental health as serious as we do other areas of our health!!!
- There are a lot of policies in place that make addressing mental health very difficult. Understanding how changes to these policies and processes truly impact those that need the services.

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

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

- Networks that connect care providers together – for example Unite Us. Make sure we are connecting folk to the services they need. Looking at how we can utilize those platforms to connect more.
- Develop a virtual centralized resource; a virtual resource center that we can use to connect and network with each other. Keeping virtual resources updated, this is hard to do.
- Organization all doing MHFA, organizations such as FTB and the schools. Working together to have more organizations provide MHFA will help reduce stigma, awareness, and share resources as well. Getting local businesses involved, sharing the same messages to reduce the stigma of mental health.
- FTB - Integrate nutrition into how food is being distributed. Overcoming the challenge of getting people interested in this approach.
- Partnerships with MORE Health and TGH to implement (relaunch) exercise, nutrition programs – Healthy and FIT for Life. Collaborating with other organizations to make it successful.
- Getting organizations to adopt the Unite Us platform.
- Educating the younger generations to teach them the importance of eating healthy, exercising, and nutrition. This may help impact the family.
- Making nutrition education programs more affordable or at no cost to families. Tampa General Hospital is working to reduce costs to families interested in receiving education.
- More collaboration between organizations to focus on *education* as an early prevention tool to address exercise, nutrition, and weight.
- AdventHealth has expanded their Food is Health (FiH) program to include a youth FiH component. This cannot be successful without expanding partnerships to help engage the community and get them to be interested in the education, in addition to the healthy food they receive from the program. The program is at no cost.

## Cancer

**Breakout Room 3: Cancer**

# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

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

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

- Not surprising as many of the barriers to healthcare access are widely known (i.e., transportation, working hours conflicting with appointment availability)
- Stigma in seeking care amongst communities of color due to generational treatment by healthcare systems (COVID-19 vaccination showed this fear)
- Survey respondents are largely high educated: are we missing information needed from those that don't have bachelor's / master's degrees

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

1. What social determinants are impacting this health issue? Cancer
    - All SDOH are impacting cancer: environmental factors (walkability, safety, exercise), education (nutritional literacy), employment (environmental hazards)
    - "Product of our own environment" quick production of food leads to harmful exposure (i.e., pesticides in food, not focusing on sexual health education in school)
    - Lack of knowledge: services are available, but people are unaware
    - Asset limited ALICE: transportation barriers, having to work multiple jobs
2. From your perspective, what has caused this to improve/worsen/remain the same?
    - Cancer death rates (148.4 Hillsborough) increasing over timeà melanoma awareness has increased over time/difficulties in Black community understanding the importance of sun safety
    - Environment plays a huge part: as far as individual responsibility, not getting care in time to mitigate things happening to them
    - Laziness: people are not paying attention on how to take care of themselves (some disagreement within group) i.e., transportation barriers, systemic racism in hiring practices/healthcare systems (intentionally placing doctors in areas of high need)
3. What efforts have you experienced that are working and how?
    - Intentionally putting doctors where they are needed/where gaps in access to healthcare exist
    - Exposure/true enforcement of information: lead exposure at work plant brought to public's attention
    - Mobile health: meeting people where they are i.e., blood pressure/glucose screenings, COVID-19 vaccinations
        - Mobile food distribution provided by Feeding Tampa Bay helps people have access to food
        - Advent Health has a community-based program providing health information on various topics that is paired with health screenings and access to fresh produce - the UF EFNEP program partners with them to bring nutrition education to participants and over time we see

improvements in health indicators such as blood pressure rates, blood sugar, weight, etc.

4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
   - **Education**: distrust within communities of medical system (misinformation, fear)
   - **More community-based health centers** in limited resource areas AND for those centers to offer care along with patient education - TFHC has a lot of sites already
   - **Health equity:** Forward thinking in how we treat different races: health providers need to understand health outcomes are different for different people due to genetic makeup

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

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

Top 3 Prioritized Health Issues-1. Access to Health Care; 2. Behavioral Health; 3. Exercise, Nutrition, & Weight

- Mobile care units bringing services to people
- Community-based health centers have opportunity to be more than care providers: i.e., serving as hubs to engage larger community through community gardening (brings opportunity to address nutrition/behavioral health issues)
- Utilizing city and county parks during the week after work hours for exercise classes engaging faith-based communities too
- Expanding food distribution areas/pantries to more areas: work areas like airports
- Tampa Bay Thrives: work coming out of this with potential to engage folks through food distribution efforts in addressing behavioral health
- Telehealth: breaks down many barriers i.e., transportation, childcare & exposes other barriers
- Access is almost a "catch-all" but isn't necessarily the real issue: 7-8 hospitals on this call alone that have established walk-in clinics
- Local health systems need to act as conveners: not duplicating efforts but central point person to convene orgs doing the work

**Breakout Room 4: Cancer**

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

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

- Affordability around food, access to care. Acts as a barrier to utilizing and receiving care. Use of ED is a big issue since it's costly and uses a lot of community resources. Better use of resources to use other access points (PCPs, clinics, etc.). Comfortability with providers

- Concern about use of ED for everyday care. It's overwhelming for providers. It's easy to access but very costly. Other options are available to use. Lack of trust as a deterrent to seeing a doctor
- Used to think ED correlates to lack of medical home but it's an inability to schedule an appointment.
- Difficulty getting an appointment to see a provider. Didn't realize trust is a barrier to seeing a doctor. Community should be able to trust their doctors/providers
- Don't want to wait for an appointment and transportation is an issue
- Cost of living causes certain things to be out of reach, ex. Ability to purchase healthy food
- Overall cost of living (inflation) was eye opening and how many people it's affecting. Ability to find and keep housing
- Question: Do we have a percentage of respondents who are food insecure? Please follow up with Dr. Gordon (DOH). Food insecurity has come up as an issue
- Question: Do we have the cancer death rates by type broken down by race?

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

1. What social determinants are impacting this health issue?
    - 83% of respondents exercise every day – is surprising. Usually, exercise is low. Eating and smoking stood out
    - People are eating out and h=not having a full understanding of what's in our food (ex. Preservatives)
    - Smoking was higher than FL
    - Higher percentage of breast cancer. Women take more cancer as opposed to men with prostate cancer
2. From your perspective, what has caused this to improve/worsen/remain the same?
    - Do not believe that many respondents are exercising. Technology and social media have made many lazier
    - Over 70% of respondents are highly educated females which may be why exercise is high
    - Exercise may have increased during COVID because people were getting outside more during lockdown (ex. Walking, biking, purchasing exercise equipment)
    - From data collected in the community from nutrition education, not many people are exercising 30 minutes per day
3. What efforts have you experienced that are working and how?
    - How can we help with low dose CT screening (lung cancer)? ~$99. How can we help increasing screening the community? Screening platform not in place with PCP. Need more awareness
    - Stigma attached to smoking. Can catch lung cancer earlier for more improved health outcomes if screening is increased
    - Look for grants that offer free screenings; easy to schedule, go and get results. More willing to go
    - If cancer is detected, want to make sure treatment is covered (esp. if uninsured).

- Opportunities for affordable/free screening is needed
- Educate PCPs to send patients for CT screenings to increase awareness. Catching it early, improves health outcomes.

4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
   - Partner to increase awareness of screening options for lung cancer and other cancers. Working together to overcome barriers (transportation, access points). Having hospitals and other health agencies work together
   - Inform other organizations that screening is available so they can share with clients. Emphasize free/low-cost screening options. DOH does social needs screening and they would love to share where they can be screened for lung cancer
   - Need lower cost healthy food options
   - Knowing the types of food to purchase, how to shop on a budget, have a strategy when grocery shopping

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

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

- Education around community resources (access to healthcare, behavioral health, exercise/nutrition/weight) especially in specified zip codes (33605, 33610, 33612)
- A lot of people don't know and understand, letting people know what's available (educating the community)
- Healthcare navigation is helpful but there's difficulty when it's someone from the outside trying to help. Trust issue needs to be resolved for the community to feel comfortable with navigators. Can navigators be community leaders, faith congregations as opposed to hospital staff
- Providers meet quarterly and share updates on what's going on in their organization. Increasing communication with the community and between health care organizations on what services are available
- Mobile services are effective but it's hard to get on the list as a stop. Challenges include staffing with mobile clinics. Homeless residents not having an ID is a barrier as well as other documents (birth certificates)
- Many people are using Walgreens/CVS clinic. Can they be incorporated into programs to increase use of PCPs and other services (screenings). Some have kiosks to sign people up for insurance. Locations can be convenient for the community
- Salvation Army (largest shelter for homeless, offer respite programs) recuperation after surgery. Partner w/ USF Nursing – interns help clients with recovery (medication adherence), will have on-site medical clinic on property so clients can have access to care and limit use of emergency services
- Preventing individuals who identify as two or more races from falling through the cracks in the community services provided

## Exercise, Nutrition, and Weight

# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

**Breakout Room 9: Exercise, Nutrition, & Weight**

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

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

- The repetition of zip codes for lack of access across the board. Need to make it easier for those individuals to get help in these zip codes that continue to arise as areas in need.
- Not a lot of resources tailored to these individuals in these zip code. Need to have resources to meet people where they are at. Transportation is a large barrier in these areas.
- Health care navigation is needed as people may not know what they are applying for or how to access services.
- Intersection of awareness in navigation- need to make sure it is getting to these people in these populations. Resources exist but may not be effectively getting to the individuals in these communities.
- Lack of affordability related to housing- oftentimes leads to these other categories being less of a priority when this is such a large priority.
- Access to sustainable living wage- issue to attaining affordable housing and other needs. How is "affordable" defined? Need system and policy change.

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

1. What social determinants are impacting this health issue?
    - Over 60% of participants who responded to the surveys had an AA degree or higher, but in East Tampa and North Tampa, education is a big issue. Think that the problem is much worse than what was represented in the data.
    - Same issue was brought up by other attendees in the group.
    - Racial divide when it comes to income
    - Sidewalks- need to address the physical infrastructure to help access places to allow for physically activity. Need to increase this accessibility, including bike paths. This might be a policy issue that can be addressed.
    - Curious to know why participants responded that they did not eat the recommended number of fruits and vegetables?
    - High food insecurity co-occurring with overweight and obesity- wondering what types of food they're consuming? Lack of access to farmer's markets and areas of healthy foods.
    - Curious to know how weight was measured for this data (was its BMI)?
    - Many participants are unaware they can double their SNAP benefits when visiting the farmers market for produce. Myth/idea that fruits and vegetables are unaffordable compared to fast food (etc.)
2. From your perspective, what has caused this to improve/worsen/remain the same?
    - Rising cost of housing and increase food costs has caused the issue to worsen.
    - Lack of access to appropriate infrastructure has caused it to remain the same.

- A lot of societal/environmental factors outside of individual's control has exacerbated the issue.
- Sharing knowledge alone does not work. Approach has not changed. Need to shift approach to come up with resolutions tailored to communities that work for them. This has caused the issue to stay the same.
- Hard to engage in self- care activities when under so many external/societal and environmental stressors.
- Mental health struggles can make it hard to focus on increasing healthy behaviors and mental health has worsened this issue.
- Curious to know what the data is like from 3 years ago? Curious to see what has improved and what has not? Would not be efficient to continue doing what has not worked. Need to get to the root cause of concerns.
- Inflation has affected cost of food which has caused this issue to worsen.

3. What efforts have you experienced that are working and how?
   - Teaching people to cook and healthy nutrition
   - Community approach to co-centering
4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
   - Structural approach that is multi-level needs to be put into place because there needs to be an increase in significant opportunities to make it easier.
   - Need to employ the members of the community to design the program (not just to take the surveys and for research purposes)
   - Lack of community-engaged work (need community buy-in)
   - Spending a large sum of money versus spending a few dollars frequently (lack of education on this). For example, spending money on produce and then don't eat it and it must be thrown away whereas spending a few dollars on fast food that is eaten right away but spending more frequently.

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

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

- Access to Health Care
  - Encouraging partners to work together for community centered projects and give more time to see more community level change (sticking with the projects over time to be able to show a change)
  - Greater awareness of these issues among local and state decision makers (in terms of the needs identified from data). Educating local decision makers about these needs.
  - Coalition policy for individuals to be able to afford care and health services
  - Limited opportunity to access to social services when there is break in the system so that individuals needing to be deemed disable are not done so (can lead to all the other issues discussed as well)
  - Community groups led by the community members in their area. Grants/funding given to the communities instead of large institutions leading (institutions can support) but shifting power for communities to lead on the projects and take ownership. (Resources should be poured into the community instead of outsiders coming in and saying "we are doing these programs for *you*")

- Identify community champion to lead projects and get community buy-in and lead their own programs.
- Noted that these are the same issues we've addressed three years ago. Were the results from the programs used to address these issues measurable? What were the outcomes? Getting community more involved in their own care instead of the larger institutions and organizations leading.

- Behavioral Health
  - Greater awareness of this among local and state decision makers (in terms of the needs needed from data). Educating local decision makers about these needs.
  - Policy change needed to make it easier for individuals to get the resources they need (currently a broken system)
  - Community groups led by the community members in their area. Grants/funding given to the communities instead of large institutions leading (institutions can support) but shifting power for communities to lead on the projects and take ownership. (Resources should be poured into the community instead of outsiders coming in and saying "we are doing these programs for *you*")
  - Noted that these are the same issues we've addressed three years ago. Were the results from the programs used to address these issues measurable? What were the outcomes? Getting community more involved in their own care instead of the larger institutions and organizations leading.

- Exercise, Nutrition, and Weight
  - Urban agriculture (urban farming) and teaching community members nutrition and introducing them to new foods they may have not had before. Additionally, the physical activity that goes into tending to the urban farm will help increase physical activity.
  - Greater awareness of this among local and state decision makers (in terms of the needs needed from data). Educating local decision makers about these needs.
  - Community groups led by the community members in their area. Grants/funding given to the communities instead of large institutions leading (institutions can support) but shifting power for communities to lead on the projects and take ownership. (Resources should be poured into the community instead of outsiders coming in and saying "we are doing these programs for *you*")
  - Noted that these are the same issues we've addressed three years ago. Were the results from the programs used to address these issues measurable? What were the outcomes? Getting community more involved in their own care instead of the larger institutions and organizations leading.

**Breakout Room 10- Exercise, Nutrition, & Weight**

**Breakout 1, Part 1:** ***Discuss significant health needs identified within the data analysis and feedback gathered from the community (15 min)***

# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

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

- Accessing health care and navigating the system – a universal theme
- Not much has changed from the last time we did a CHNA, we still have opportunity to make improvements. Need to focus on key opportunities
- Disparities in data – fragmentation of health care system, people in community notice the disparities, not just us in health care
- Heat mapping- expecting poorer health outcomes from south county area, surprised to see much need in central county Tampa area
- Impact of the economy on opportunities- same in some ways, but worse in others, Effects of pandemic and rising housing costs
- Transportation was identified as a barrier- built environment
- Population growth in some areas not supported by transportation infrastructure. Are bus routes located in areas of need?
- Room for improvement in comparison to other major cities, does not seem sufficient to get people to job they need, services
- Transportation and housing are some of the biggest needs and services
- Certain areas of Tampa are not being served with sufficient transportation
- Focus groups feedback- Need to make sure our solutions and actions will help the populations that need it. Need to tailor to different groups, also with methods of communication. Would like to see more sensitivity to communication for key populations

**Breakout 1, Part 2: *Gather Community Input especially from public health experts and vulnerable populations (20 min)***

- What social determinants are impacting this health issue? *(4 min)*
  - There are differences in how we respond to issues based on generation. Younger generation has less stigma on accessing services
  - US compared to other countries lacks in many health areas (obesity rate is higher)- how do we make this a priority in our country and community?
- From your perspective, what has caused this to improve/worsen/remain the same? *(4 min)*
- Surprised that we didn't see an increase in exercise rates amidst the pandemic
- Exercise promotion should be a collaborative approach, many partners working together
- Also need more access to affordable exercise opportunities (gyms can be expensive)
- Many people talk about wanting exercise, but access is an issue (cost, transportation)
- What efforts have you experienced that are working and how? *(4 min)*
- Focus on food banks, esp. for schools, supported by corporate community
- Positive impact in schools

- Parent/teacher nights are offering food banks, help people feel comfortable using food banks, normalizing access to food banks, destigmatizing use of food banks.
- Feeding Tampa Bay is everywhere in community, widespread support
- Exercise percentage very low- Lots being done around food access, but it seems exercise promotion has taken a back seat.
- Al Lopez Park- lots of people exercising, diversity. Would be great to see this replicated in other areas.
- Tampa Bay Thrives- a collaboration of multiple providers to address mental health. Acute needs due to pandemic
- Denver, CO – most parks density for city
- From your perspective, what community/systems level aspects need to change to positively impact lives and improve data? *(4 min)*
- There is an opportunity to target certain age groups, as younger generation seems more comfortable and has less stigma around food banks, therapy, etc.
- Can we extend park hours? Exercise equipment for loan?
- Need improved sidewalks and feelings of safety in neighborhood
- Bus passes to get to gym, just like with health care appts
- Health care includes infrastructure- not just providers
- Many parents work long hours and can't fit in exercise
- Need more equitable access to neighborhood parks, resources. Where are the places where people feel unsafe? What are the barriers to feeling safe?
- We need a champion for exercise education- who would that be? How can we match the approach of Feeding Tampa Bay, as an example?

**Breakout 2: *Generate (Idea Bank) preliminary ideas on how to collaborate with each other and health systems to address the top community needs (15 min)***

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

- **Top 3 Prioritized Health Issues- 1. Access to Health Care; 2. Behavioral Health; 3. Exercise, Nutrition, & Weight**
- **Access to Health Care**
- Maximize remote telehealth capability- Can we have access in centers throughout the community? Locate services and access points in strategic areas. Where are the existing community spaces where people already go? How can we get them connected to confidential, safe care?
- Replicate the model of "Higi stations"- Insert health care touch points in community (airports, grocery stores, community centers), would be very nice if near green spaces to entertain kids
- **Behavioral Health**
- Tampa Bay Thrives has an opportunity to be the mental health champion in Hillsborough
- Lack of providers- Is there a way to coordinate with providers in surrounding areas to increase access? There are many providers, but funding/payment is a barrier.
- Is there a way to coordinate with private providers in Tampa area? There is a duty to provide care to all We have an opportunity to influence providers to do better
- Youth/LGBTQ Mental Health- Need to figure out administrative aspects, while there is a passion among some providers to provide this care

- Increase telehealth opportunities, we have third party providers (Better help) who can provide support to a larger group of providers
- **Exercise, Nutrition, & Weight**
- Need for an exercise champion- collaboration among organizations (just as Feeding Tampa Bay is recognized as the champion)
- One Bike- restored bikes made available in community.
- How do we get exercise equipment to people who don't have them?
- Can volunteers/org's come together to build bikes, get them out in the community
- Boards for Bro's – giving out skateboards for kids
- Organize volunteer opportunities to promote exercise
- Who could a good community champion be? YMCA? Who is in exercise community? Can we form a coalition of exercise partners?

## Heart Disease and Stroke

**Breakout Room 7: Heat Disease and Stroke**

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

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

- Data identifies a known trend in the community- shows the need for socialized medicine
- The zip code maps showed the high needs were in the same zip codes across the issues identified.
- Access to mental health care for children and adults and paying specific attention to access in our minority communities.
- The changes in tech that have occurred due to the pandemic have reduced the interaction between pt. and providers. The tech to access virtual healthcare may not be available to everyone.
- People not having access to computers have reduced access to healthcare.

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

1. What social determinants are impacting this health issue?
    - Access to healthy food
    - Access to a healthy lifestyle (places to exercise)
    - Cost of healthy foods
    - Education of what foods are healthy and how to have a healthy lifestyle
    - Built environment – living in an unsafe area or area without access to exercise contributes to an unhealthy lifestyle
    - Age of people: generational difference in food. What they eat.
2. From your perspective, what has caused this to improve/worsen/remain the same?
    - Cost of things and convenience factors are causing this to get worse
    - Improving parks and trails in the county is improving access to exercise

- Pandemic possibly contributing to adverse outcomes due to reduced healthcare access/visits
- Increase in behavioral health issues could increase smoking rates contributing to heart disease and stroke

3. What efforts have you experienced that are working and how?
   - Improving parks and trails.
   - Differences in neighborhood improvements- systemic issue
   - Food distribution is helping the community
4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
   - Until we Hold politicians and elected officials accountable for the things they could change. We need funding to measure and capture the issues.
   - Citizens need to be a part of the process to make a change.
   - Evaluation of existing programs
   - More structured curriculum and access to healthy foods and options in schools. More education about choices they make now and the impact they have on their future.
   - Improving access to care
   - More education about the awareness and signs of heart disease and stroke to look for.

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

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

- Having the right people provide education to various populations and the right curriculum taught in school (s&s of heart disease and stroke)
- Orgs is vested in eliminating the disparity by hiring people that specialize in this.
- Orgs engaging stakeholders through appropriate education for specific demographic. Utilizing influential people in the community
- Evaluation of existing programs to improve what is already in the community
- Orgs need to work together
- Improving provider knowledge of community-based and other programs. The disconnect between providers and community organizations and/or health navigators.
- Improving access to primary care for preventative care.
- Orgs and community groups need to stop working alone and pull resources through a collaborative effort to improve community issues.
- Funding for CHW to work in the general community to help residents to navigate the healthcare system
- Policy to sustain social services and secure funding

**Breakout Room 8: Heart Disease and Stroke**

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

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

- Breakouts by zip codes are eye opening.
- Having the ability to easily access healthy choices would impact making choices in the community
- Language barriers continue to impact offering health resources and education
- Need to go back to the basics with educational messaging
- Transportation is a barrier for health access
- Lack of information and knowledge (language barriers)
- Economic disparities
- Time constrictions
- Childcare barriers for families
- How do we impact the basics that impact health, safety, time…?
- Domestic violence increased during the pandemic, mental health services are needed

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

1. What social determinants are impacting this health issue?
    - Lack of opportunity for healthy foods as well as the cost of healthy foods (access and cost)
    - Understanding the role of nutrition (education)
    - Education related to physical activity
    - Food literacy and how to incorporate strategies that are culturally appropriate
    - Having the right leaders and advocates for different populations (finding the right voice)
2. From your perspective, what has caused this to improve/worsen/remain the same?
    - Pandemic made negative impact on this health issue
    - Lack of education and understanding
    - Understanding family history and medical history
    - COVID related cardiac complications
    - Stress contributes to this health concern
3. What efforts have you experienced that are working and how?
    - Education being offered to examine the relationship with food and how to make healthy choices
    - Providing resources how to find health food choices
    - Provide motivation and access for physical activities
    - Tampa Well program, supports community gardens (includes several community partners)
    - Tampa Well application project (launching soon)
4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
    - Better system in place to share resources, more centralized
    - Commitment as a county to lower heart disease, all partners focus on making this change. All work towards the same goal.

# Appendix C. Community Input Assessment Tools

## Prioritization Session Questions and Summary of Responses

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

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

- Support task forces already working in these spaces
- Communication is key, strong partnerships
- Meet people where they are and when they are available (weekends)
- Education is key, knowing the resources
- Focus on foundational projects and programs
- Creativity in expanding wellness activities (health in all policies)
- How do we improve the health environment?
- The whole community looks at health (leaders from all sectors involved)
- Resource rich county, collectively increase impact with likeminded organizations
- How can we impact the exercise and nutrition health focus?
- Build on programming within the schools and the food pantries
- More communication regarding resources, more sharing

## Immunizations & Infectious Diseases

**Breakout Room Number & Topic Area: 11: Immunizations & Infectious Diseases**

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

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

- Not new that people don't have access to services, and we still haven't found a way to increase access
- Behavioral health data is nothing new
- Surprised cancer rates higher in Tampa
- What exactly is food insecurity (definition)
- Not surprised about heart dis
- Loss of recreation was ranked as a higher issue of concern than loss of security and hope (maybe due to how question was asked)
- Saw many of the same things from last survey (common themes) – they continue to be issues and are hard to resolve
- Surprised not to see sexual health and reproductive health in initial data especially since majority of respondents identified as female
- Not as large of a subset of population due to virtual format of needs assessment

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

1. What social determinants are impacting this health issue?
    - Not having access to education

- May not be aware of access
- Food is more of a priority

2. From your perspective, what has caused this to improve/worsen/remain the same?
    - The pandemic
    - Domino effect of inflation
3. What efforts have you experienced that are working and how?
    - Focus of screening for social needs when accessing care (but still working on implementation)
    - COVID vaccination and testing rates (through efforts by everybody – local and state level)
4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
    - Multi-sector efforts (ex: different agencies, organizations, DOT, MPO)
    - More effective ways to inform people about access to care and services
    - Comprehensive sexuality education in all schools
    - Higher threshold for coverage, longer periods of coverage for Medicaid enrolled patients
    - Easier way to navigate the system (i.e., make system user friendly)
    - Make STI screening a part of care
    - PrEP access and reduced cost
    - Targeting campaigns for PrEP for some of the most affected groups through health promotion utilizing social marketing

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

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

- Multi-sector efforts need to be diverse in the planning process
- New marketing campaigns (billboards, radio spots, etc.) with quick, reliable information
- See what county resources must get better control over Medicaid (ex: extend time)
- Implement a higher threshold for coverage, longer periods of coverage for Medicaid enrolled patients through HCAB
- Offer incentives for the providers to accept Medicaid; increase reimbursement
- Remove Medicare and Medicaid restrictions on providers

**Breakout Room12: Immunizations and Infectious Diseases**

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

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

- When I look information presented, immunization is a big deal, not just during COVID.
- Seems the focus is related to COVID
- A lot of the issues seem to be impacted by the pandemic
- Sense of security or hope were "gone" from the pandemic
- Top losses were pretty much all mental health related – big theme around different categories
- Stigma and lack of education on mental health
- Not everyone has access to learning what mental health is
- Mostly focused on COVID, syphilis, other diseases
- There's a new generation of "non-vexers" for fear that getting vaccinated will cause new diseases.
- A lot of people feel that vaccines will cause autism, for example
- There should be education around vaccinations and autism for the general community
- There should be more information to tie in the increase of COVID and syphilis diseases in the community.
- There should be an answer as to why or why not those losses important enough to learn
- Information is missing – what are the rates of people getting vaccinated or not
- What are those reasons why people are not getting a vaccine – those social determinants
- They need to show how vaccines have helped over the years
- Some people don't even know what smallpox is, because of the vaccine
- Many people don't know what/why
- Consider self-awareness as agency, not as individual – it's important to be perceived with the why to be addressed
- This is a "Google society"
- It's important to understand the trauma, experiments – the loss of trust or fear when something new comes along – they might fear they are an experiment

Page Break

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

1. What social determinants are impacting this health issue?
    - Internet access to make appointments for medical visits plays a part
    - Education on HIV, lack of comprehensive sex education
    - Lack of education of mis/dis-information, and identifying that
    - Language barrier – health literacy, understanding the health care system
    -

Page Break

2. From your perspective, what has caused this to improve/worsen/remain the same?
    - Mis/dis-information has worsened, and cause vaccine fear
    - They used to do immunizations in school, and when they stopped doing them in school, they would do it in a community center where it would be announced.

- That doesn't happen today
- The fear/impact of immigration for the Hispanic population – the fear of getting deported if going to get any help
- A lot of people felt they didn't know what was true and what wasn't
- It seemed like back in the day we all got immunizations without question, and with COVID many people questioned it
- I go to a drive-thru to eat their food and not necessarily know what's in it.
- The fast paced in development of the vaccine caused mistrust
- Technology being so advanced things come out a lot faster than they did 20-30 yrs. ago
- There's a lot of trust in the other vaccines because of having been there for many years – unintended consequence
- Acknowledgement – it was an experimental process with the COVID vaccine
- Dealing with somewhat younger people, this is "information age", we underestimate when we say the lack of information – implicit bias
- Perceptions are that are widely held

Page Break

3. What efforts have you experienced that are working and how?
    - We have community health workers, so they work where they live, and talk to people like it's their neighbors with up-to-date information
    - Armed with true and latest information
    - Promotors are completely mobile – will go help apply for food stamps, etc.
    - Share information of where to go get the COVID vaccine
    - Trust is extremely important
    - The access questions to get the vaccine were very long
    - Professionals setting up the vaccine cohort did not have the proper technology to help community members get information

Page Break

4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
    - Explain how everything works in a way that everyone can understand
    - Being transparent with information about vaccine
    - Prioritization of population for roll-out of vaccine – farm worker, food worker

Page Break

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

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

- From the pediatric side it seems that children get less research and funding, so cancer should be the most important
- Shocked that cancer was at the bottom

- That needs to change as children are our future, so we need to make sure that there is prioritization for that
- Adding to children – mental health started at an early age should be key for dealing with it later in life
- De-stigmatize it – be more open to talking about issues – make it normal to speak about children getting sick, having cancer, dealing with mental health issues.
- Kids don't have the coping mechanism to deal with certain issues – help them with it
- Bring more awareness to it – the school district should do a better job of dealing with these issues, not put a band-aid on it
- Deal with trauma at a young age to avoid having teenagers commit suicide
- Teaching or having the curriculum for mindful techniques how to deal with hard situations – anxiety, mental strain they may be experiencing
- Pushing for comprehensive health classes that will address mental health, exercise and weight, nutrition, etc.
- If we start addressing a message early on, it will also make an impact
- Access to healthcare in reaching young people – career cares – having more healthcare providers where they can "see themselves"
- We have limited resources when it comes to technology, information, so collaboration between the healthcare organizations to bring that to the community is key.
- Increasing of mobile services to communities with lack of transport, and bringing it outside of business/working hours
- The need for telehealth - for medical and behavioral health services, bring it in their language – can even look internationally for it
- Identify information that children no longer have access to, and make it modern to share

# Appendix D. Data Placemats

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

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

# HILLSBOROUGH COUNTY DEMOGRAPHICS

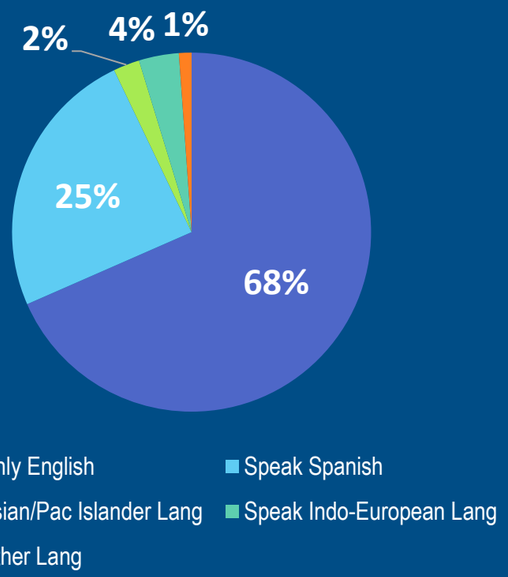
1,519,364 People

Median Age
38.5

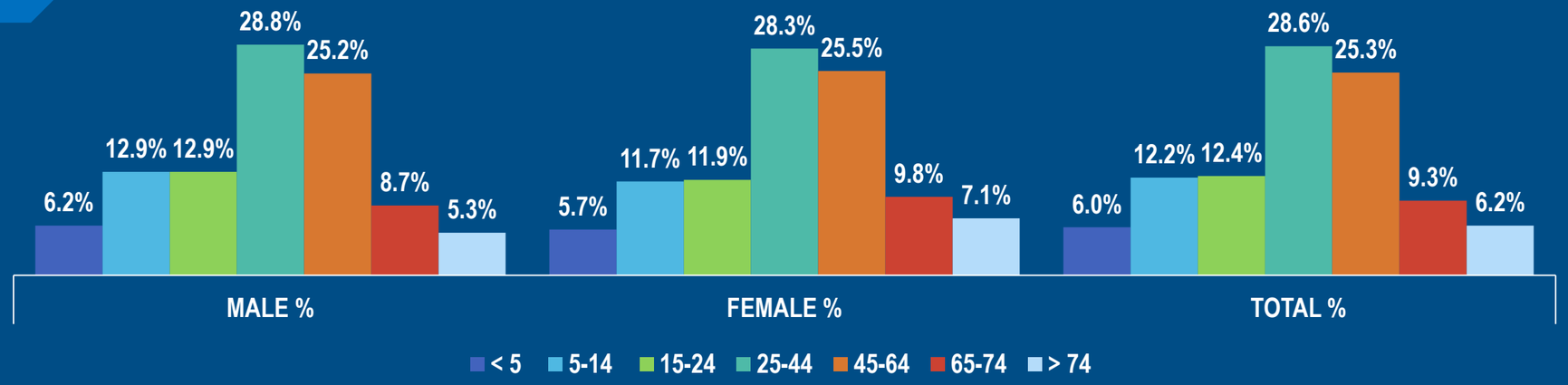
48.9% Male

51.1% Female

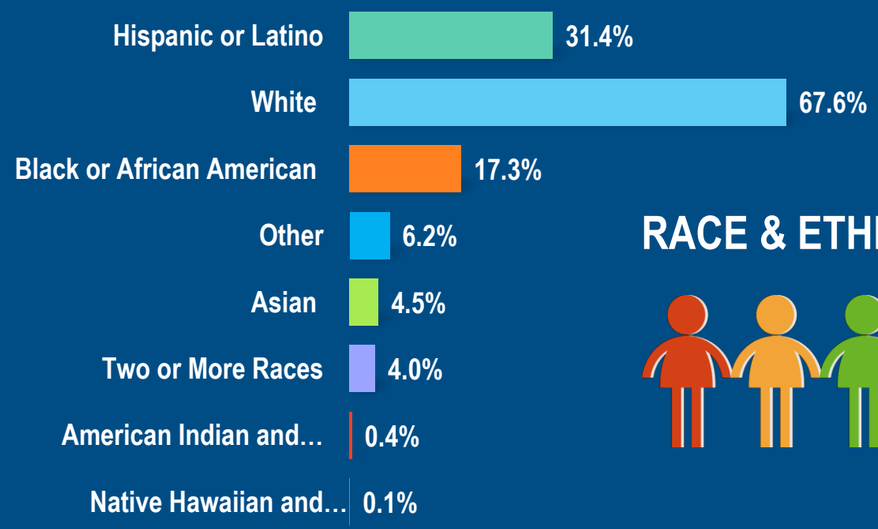
## Population Age 5+ by Language Spoken at Home




## HILLSBOROUGH COUNTY POPULATION BY AGE AND GENDER 2021




| Level of Education, Age 25+ | Hillsborough County | Florida | U.S. |
|---|---|---|---|
| Less than 9th Grade | 4.8% | 4.6% | 4.8% |
| 9th to 12th Grade, No Diploma | 6.4% | 7.0% | 6.6% |
| High School Graduate or G.E.D | 27.2% | 28.5% | 26.9 |
| Some College, No Degree | 17.7% | 19.5% | 20.0% |
| Associate's Degree | 9.5% | 9.9% | 8.6% |
| Bachelor's Degree | 21.7% | 19.2% | 20.3% |
| Graduate or Professional Degree | 12.7% | 11.3% | 12.8% |




## RACE & ETHNICITY

23.6% Population Change 2010-2022

17.6% Of the Population Foreign Born

7.6% Of the Population are Veterans



Sources: Data.Census.gov; All4HealthFL.org

# HILLSBOROUGH COUNTY ECONOMIC BREAKDOWN

## Median Household Income

$67,683

With a $24.89 Mean Hourly Wage, 2020

Tampa-St. Petersburg-Clearwater Data

## Unemployment Rate

4.6% Age 16+, 2022

89.5%

Have Internet Subscriptions

## Inflation Rate

10.2%

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

15.2% Of Individuals are Below Poverty Level

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

71.7%

Of the Total Number of Survey Respondents Experienced One or More Losses Due to COVID

**Some of The Top Losses Include:**

- Recreation or Entertainment
- Sense of Well-being, security, or hope
- Death of family or friend
- Exercise opportunities
- Income

23.6%

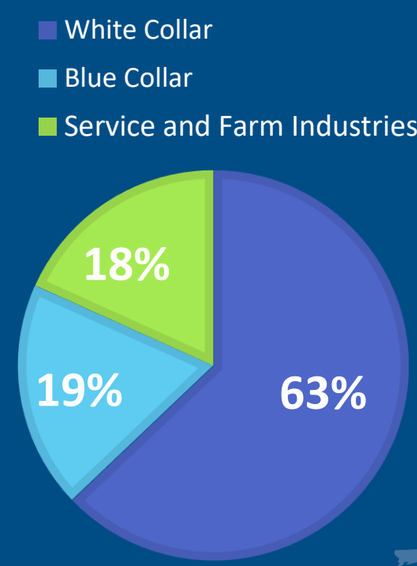
Population Change 2010-2022

$262,584

Median Property Value

20.1% Growth 2010-2021

## HILLSBOROUGH EMPLOYED CIVILIAN 16+ BY OCCUPATION GROUP

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

# HILLSBOROUGH COUNTY
# ACCESS TO HEALTH & SOCIAL SERVICES

**83** personal care providers rate per 100,000 population

**59** dentists per rate per 100,000 population

**183** mental health providers rate per 100,000 population

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

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

- East Mango
- East Tampa/Ybor City
- Egypt Lake
- Plant City/Dover
- Southwest Hillsborough
- Sun Bay
- Tampa/Brandon/Riverview
- Town N Country
- West Tampa
- West University Area

**81.8%** Of adults with health insurance, 2019

**68.6%** Of adults who have a personal doctor, 2019

**36.0%** Of high school students have not visited a doctor's office in the past 12 months, 2020

**15.7** Preventable hospitalizations under 65 from dental conditions, 3 year rolling 2018-20, rate per 100,000

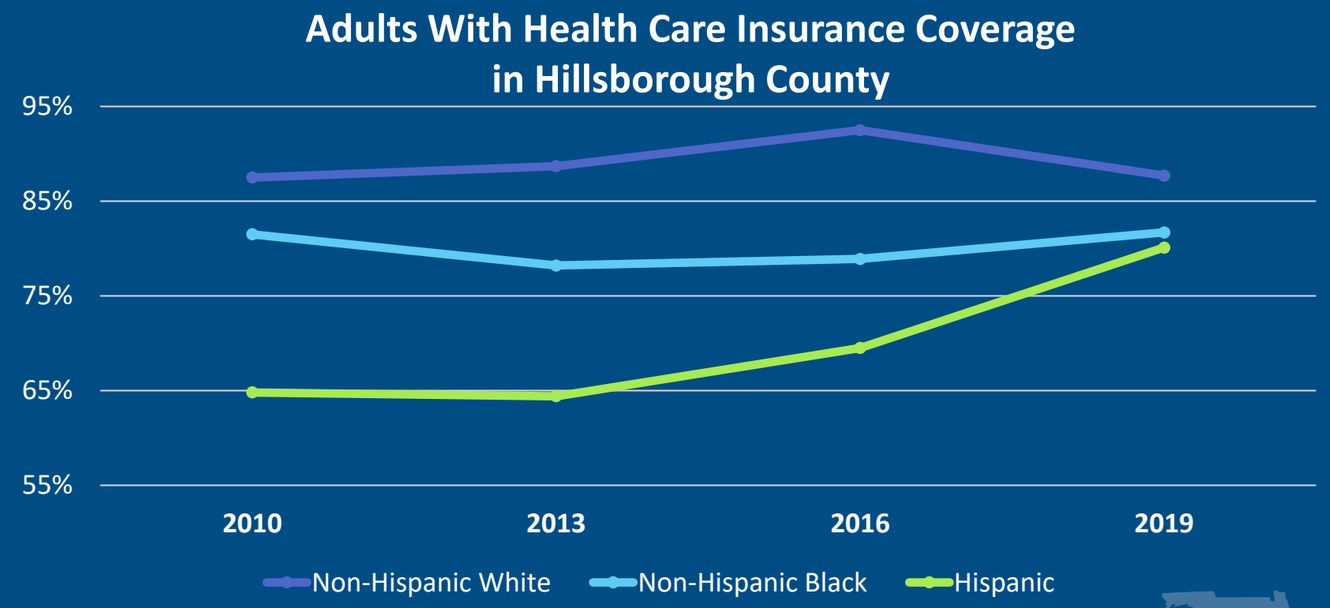
"Was there a time in the last 12 months when you needed medical care but did not get the care you needed?"

**19.2%** Responded 'Yes'

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

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

**93.7%** Of children in Hillsborough County have health insurance, 2019

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2019 Community Survey; Florida Health Charts; 2019 Health Resources and Services Administration

# BEHAVIORAL HEALTH HILLSBOROUGH COUNTY

(Mental Health and Substance Misuse)

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

**16%** Of survey respondents reported experiencing 4 or more Adverse Childhood Experiences (ACEs) before age 18

**32.1%** of Middle School Students Report having used alcohol or illicit drugs in their lifetime

**17.1%** of Adults engage in heavy or binge drinking

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

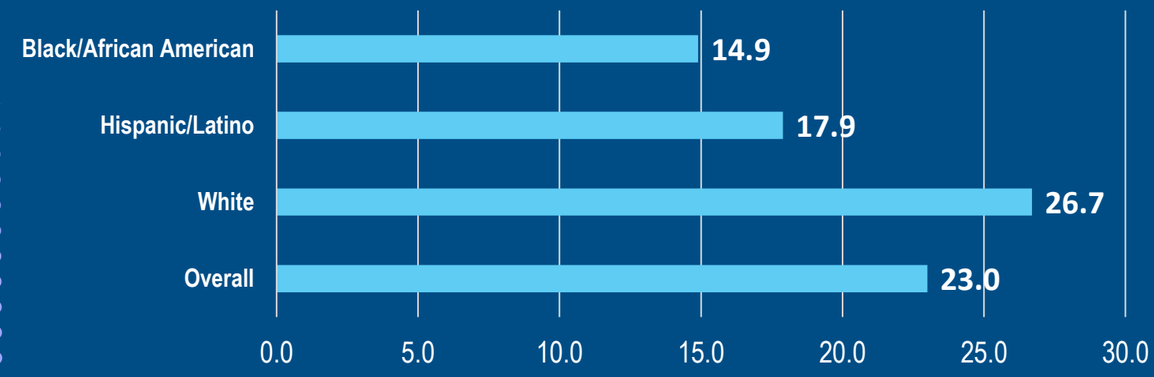
**48.5%** of High School Students Report having used alcohol or illicit drugs in their lifetime

**34.3%** of high school students have used a vaporizer/E-cigarette, 2018

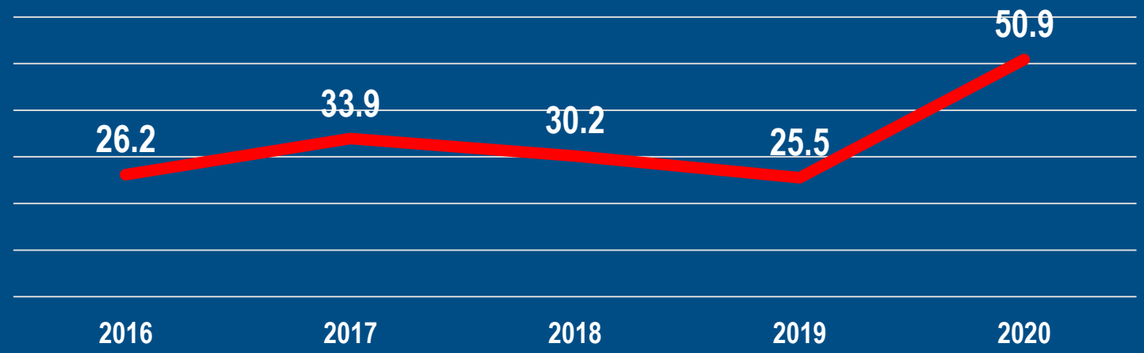
**11.4%** of middle school students have used a vaporizer/E-cigarette, 2018

**16.0%** of adults currently smoke cigarettes, 2017-2019

## Age-Adjusted Drug and Opioid Involved Overdose Death Rate Per 100,000 Population, 2018-2020




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




**15%** of survey respondents indicated they had thoughts that they would be better off dead or of hurting themselves in some way for several days, more than half of the days or nearly every day over the last 12 months.

**31%** of survey respondents were diagnosed by a medical provider with Depression or Anxiety.

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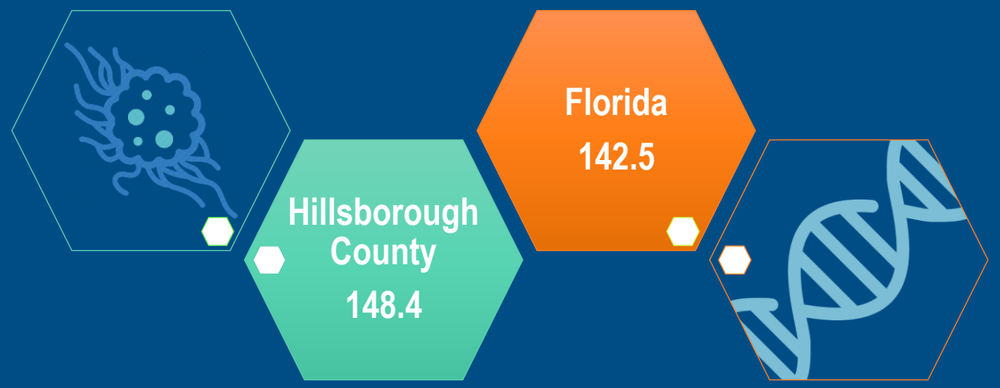
Sources: All4HealthFL.org, FLHealthCharts.gov; CHNA Survey Data; Florida Youth Substance Abuse Survey

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

# CANCER HILLSBOROUGH COUNTY

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




Adults currently smoke cigarettes, 2017- 2019

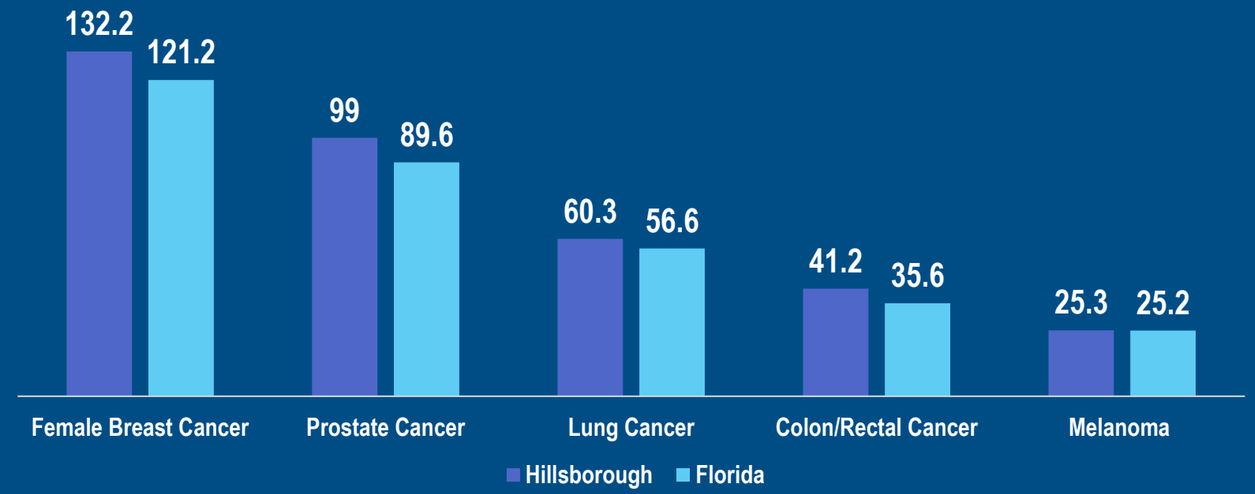
| | |
|---|---|
| Hillsborough County | 16.0% |
| Florida | 14.8% |

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

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


2019 Community Survey; Florida Health Charts

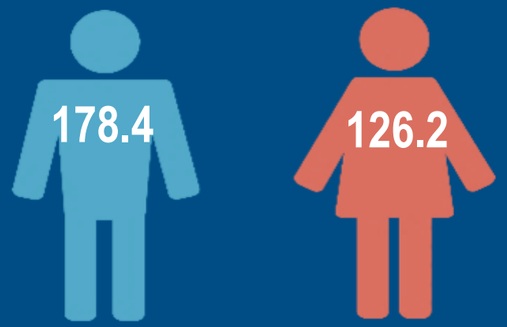
## CANCER INCIDENCE RATE: HILLSBOROUGH COUNTY
(Average age-adjusted per 100,000 population, 2016-18)



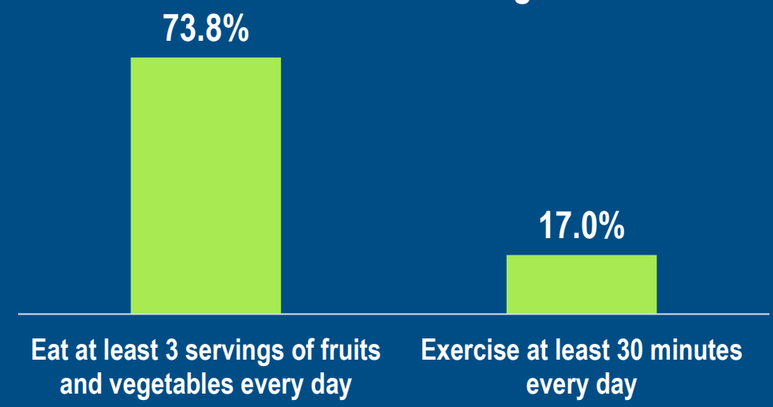

## CANCER DEATH RATES BY TYPE
(Average age-adjusted deaths per 100,000 population, 2018-2020)

| Type of Cancer | Hillsborough County | Florida |
|---|---|---|
| Female Breast Cancer | 18.5 | 18.7 |
| Prostate Cancer | 16.0 | 16.5 |
| Lung Cancer | 36.3 | 33.6 |
| Colon/Rectal Cancer | 14.4 | 12.6 |

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




## Survey respondents who answered "NO" to the following:

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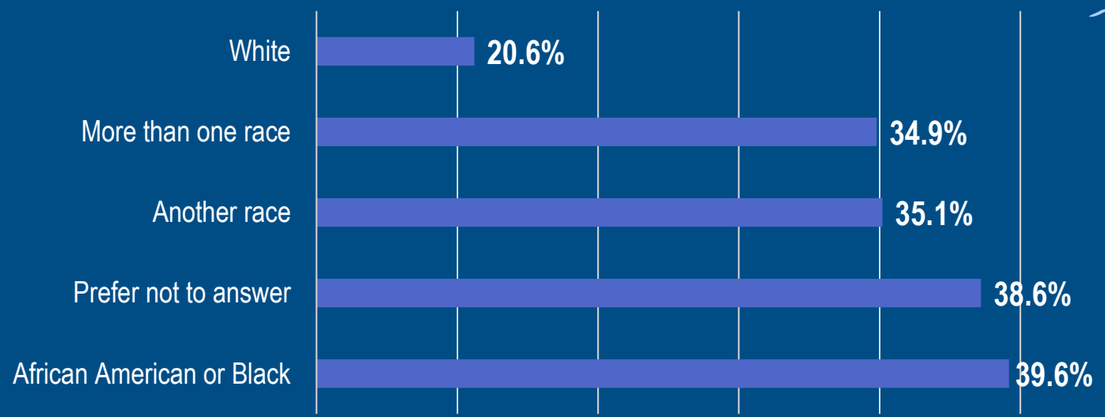
# EXERCISE, NUTRITION & WEIGHT HILLSBOROUGH COUNTY

**26.1%** of survey respondents self-reported food insecure


## Survey Respondents Food Insecurity by Race




**39.6%** Respondents who disagreed with the statement "There are good sidewalks for walking safely in my neighborhood"

**24.3%** Respondents who disagreed with the statement "We have great parks and recreational facilities"

**22.8%** Respondents who disagreed with the statement "I am able to get healthy food easily"

**15.9%** Respondents who disagreed with the statement "I feel safe in my own neighborhood"

Survey respondents who answered "NO" to the following:

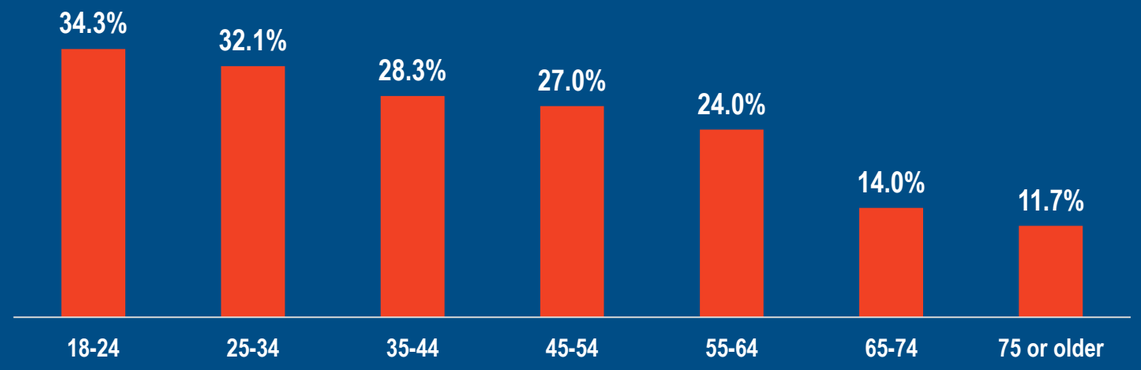
**73.8%** Eat at least 3 servings of fruits and vegetables every day

**17.0%** Exercise at least 30 minutes every day

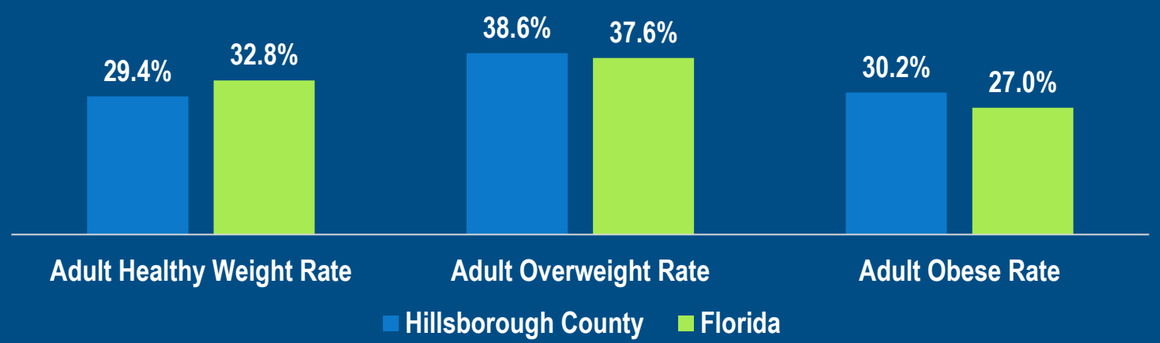
**11.9%** responded 'yes'

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

## Food Insecure Individuals by Age




## HILLSBOROUGH COUNTY WEIGHT RATES 2019




**10.9%** Adults who have ever been told they have diabetes, 2019

**216.0** Age adjusted ED visits from diabetes, 3 year rolling 2018-20, rate per 100k

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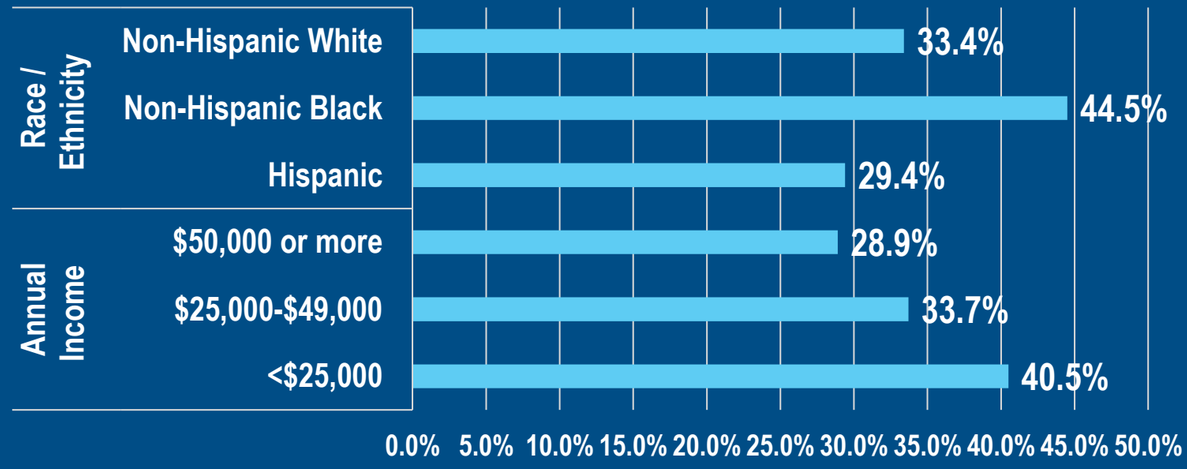
2019 Community Survey; Florida Health Charts

# HEART DISEASE & STROKE HILLSBOROUGH COUNTY

**8,835**

Emergency Department Visits that include a diagnosis of Heart Failure, Sampling of five Hillsborough Hospitals, 2021

## HILLSBOROUGH ADULTS WHO HAVE EVER BEEN TOLD THEY HAVE HYPERTENSION, 2019

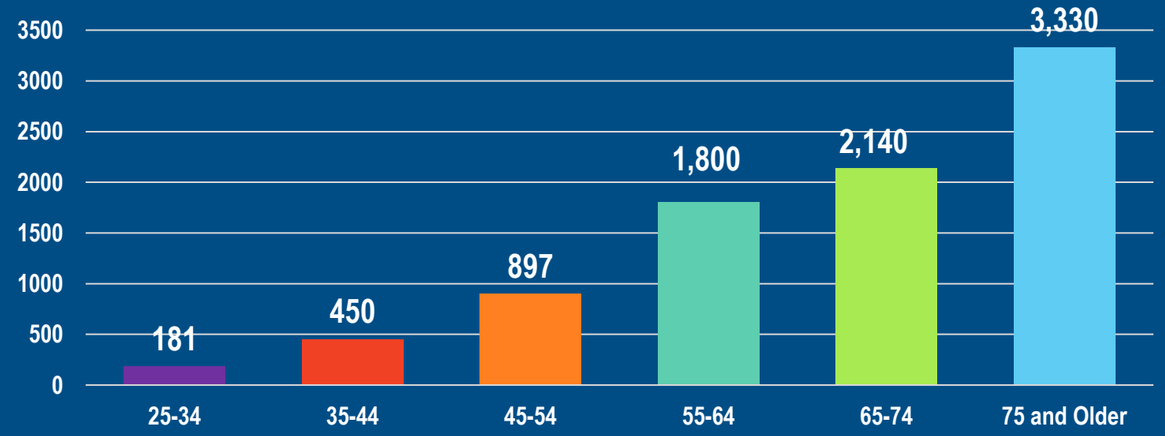



## AGE-ADJUSTED DEATHS FROM HEART DISEASES, RATE PER 100,000 POPULATION, 3-YEAR ROLLING, 2018-2020

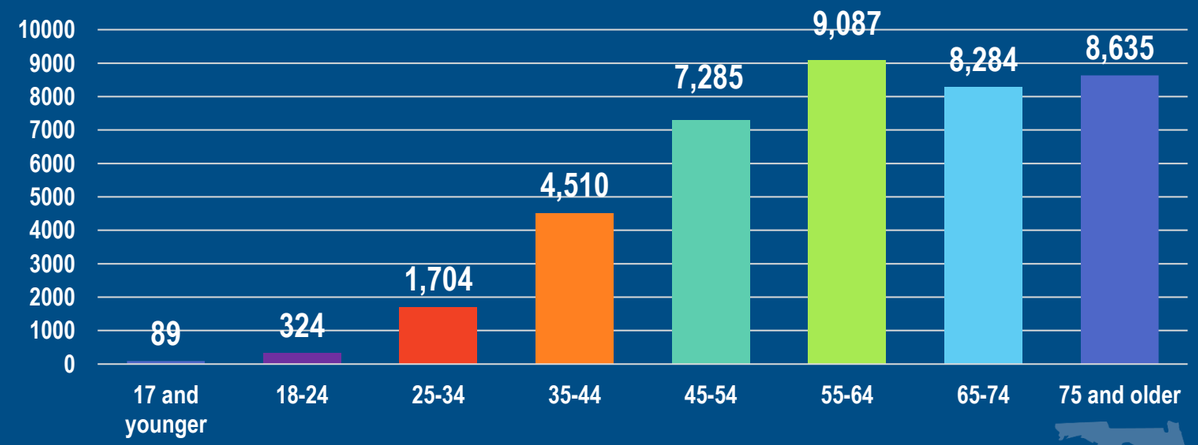

**36.0%** Of survey respondents told by a medical provider they have Hypertension and/or Heart Disease

**3.2%** Adults who experienced a stroke, 2019

## EMERGENCY DEPARTMENT VISITS THAT INCLUDED A DIAGNOSIS OF HEART FAILURE BY AGE
(Sampling of five Hillsborough hospitals, 2021)




## EMERGENCY DEPARTMENT VISITS THAT INCLUDED UNCONTROLLED BLOOD PRESSURE / HYPERTENSION BY AGE
(Sampling of five Hillsborough hospitals, 2021)




Sources: FLHealthCharts.gov; CHNA Survey Data



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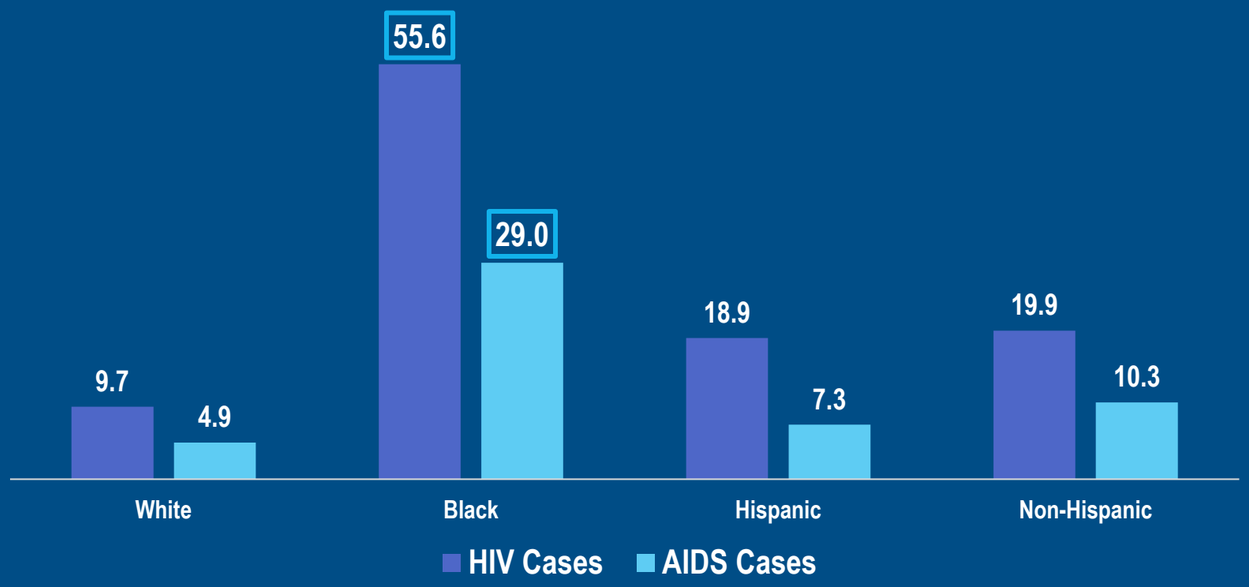
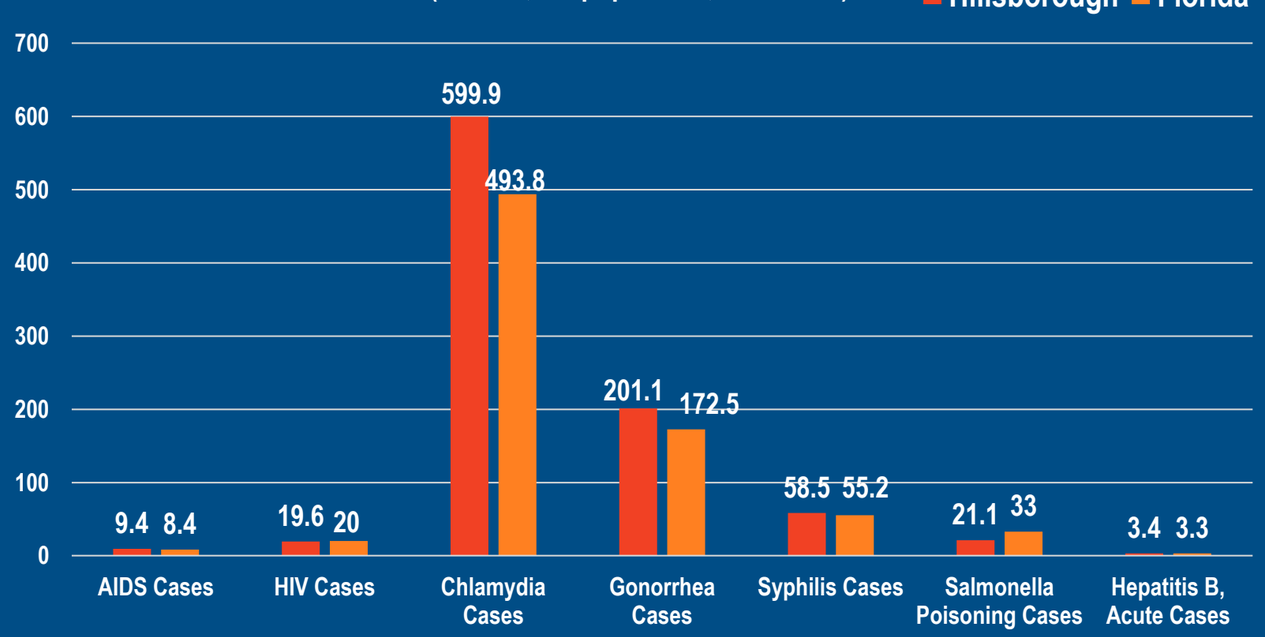
# IMMUNIZATION & INFECTIOUS DISEASE HILLSBOROUGH COUNTY

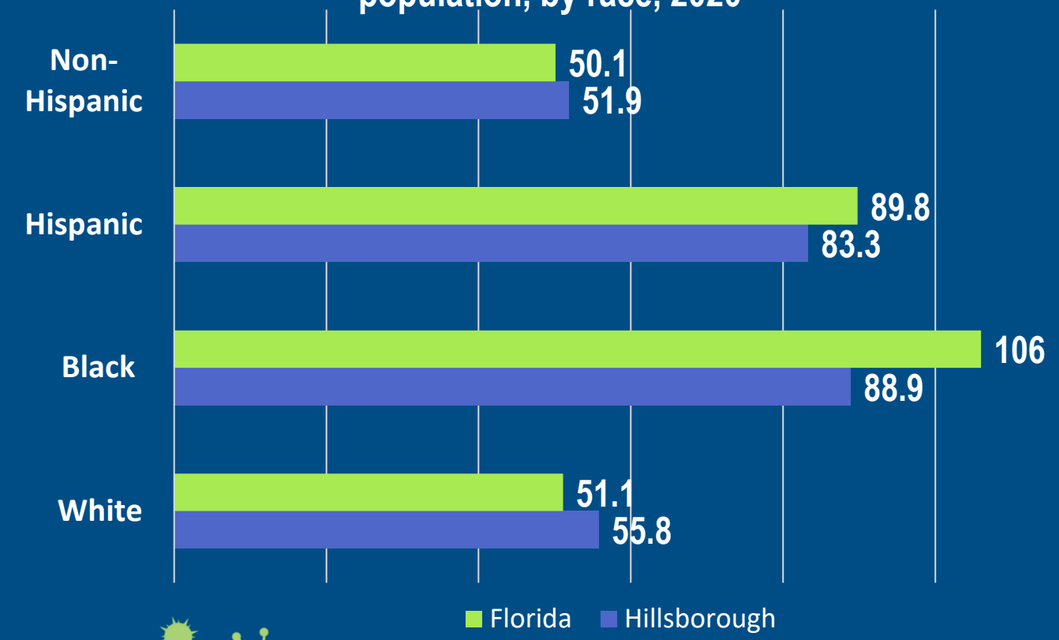
## DISPARITIES IN HIV/AIDS DIAGNOSES
(Per 100,000 population, 2018-2020)




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




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




**62.2%** Persons fully vaccinated against COVID-19

| | |
|---|---|
| 33.9% | Adults who received a flu shot in the past year, 2019 |
| 86.2% | Two-year olds fully immunized, 2019 |
| 95.8% | Kindergarten children fully immunized, 2021 |

Sources: FLHealthCharts.gov; CHNA Survey Data



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# Appendix E. Community Partners and Resources

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

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

# Hillsborough County
# All4HealthFL Collaborative Members & Teams

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

### COLLABORATIVE ORGANIZATION LEADING MEMBERS

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

| | | | |
|---|---|---|---|
| **Kelci Tarascio** | MPH, CPH | Community Outreach Coordinator – Pinellas County | BayCare Health System |
| **Kellie Gilmore** | | Community Health and Wellness Manager | Johns Hopkins All Children's Hospital |
| **Keri Kozicki** | MPH | Community Health Program Coordinator | BayCare Health System |
| **Kimberly Berfield** | | Vice President, Government Affairs and Community Health | Johns Hopkins All Children's Hospital |
| **Kimberly Brown-Williams** | | Project Director and Interim Principal Investigator, Healthy Start | Johns Hopkins All Children's Hospital |
| **Kimberly Williams** | | Director of Community Benefit | AdventHealth |
| **Krista Cunningham** | MPH, CPH | Community Outreach Coordinator – Hillsborough County | Baycare Health System |
| **Kristen Smith** | MS, HS-BCP | Community Outreach Coordinator – Polk County | Baycare Health System |
| **Laine Fox-Ackerman** | | | Orlando Health |
| **Lauren Springfield** | MA, MBA | Director of Community Health | Lakeland Regional Health |
| **Leah Gonzalez** | MPH | Community Benefit Coordinator | Baycare Health System |
| **Lisa Bell** | MPH | Community Benefit Director | BayCare Health System |
| **Megan Carmichael** | | Community Health Promotion Program Manager | Department of Health Pasco County |
| **Nathanael Stanley** | PhD | Applied Research Scientist Community Benefit Specialist | Moffitt Cancer Center |
| **Nosakhare Idehen** | MD, Ph.D, MHA, RN | | Florida Department of Health in Pinellas County |
| **Sara Hawkins** | MS, CHES | Community Health Program Manager | AdventHealth |

| | | | |
|---|---|---|---|
| **Sara Osborne** | MSHSA | Senior Director Community Benefit | Bayfront Health System |
| **Stephanie Arguello** | MPH, RYT-200 | Director of Community Health | AdventHealth |
| **Stephanie Sambatakos** | MSEd | Community Health Improvement Supervisor | Johns Hopkins All Children's Hospital |
| **Tamika Powe** | MPH, MCHES, CDP | Manager, Community Benefit & Health Education Manager | Tampa General Hospital |
| **Tatiyana Badal** | | Public Health Educator | Florida Department of Health in Pasco County |
| **Taylor Freeman** | BS | Public Health Planner | Florida Department of Health in Polk County |
| **Tom Panagopoulos** | MPH | Minority Health & Health Equity Coordinator | Florida Department of Health in Pasco County |

### FOCUS GROUP SUPPORTING INDIVIDUALS AND OR ORGANIZATIONS

| Names/Organizations | Names/Organizations | Names/Organizations |
|---|---|---|
| Alicia Gomez Fuego | Hannah Miller | Natasha Njuki |
| Abigail Perez | Ivory Granger | Olivia Ellard |
| Alma Vega | James Ruman | Priscilla Velez |
| Alora Saab | Jeannine Laurence | Ralphe Jean-Poix |
| Alretha McKenzie | Jessica Estévez | Robyn Larson |
| Brianna Iorfino | Justice Gennari | Rosa Veronica Ortiz |
| Carlos Irizarry | Karen Barfield | Roseanne Cupoli |
| Carolina Jones | Keith Bell Jr. | Roselyn Smith |
| Cheri Bollinger Shore Magnet Elementary | Kenia Aguilar | Sherry Maczko |
| Colette O'Keeffe-Boggs | Kimberly Monahan | Stephanie De La Hoz |
| Corinna kelley | Kristy Croom Tucker | Teri Saunders |
| Crystal Fabricius | Laura Recendez | Tewabech Genet Stewart |
| Danielle Boussani | Liliana Ramirez | Tomas de Brigard |
| Dawn Pacheco | Lourdes Bernier | Tonya Randolph |
| Denise Barnes | Lucila Ramiro | Vasthi Ciceron |
| Diane Cortes | MaDonna Dietsch | Viola Cange |

| | | |
|---|---|---|
| Evelie Geffrard | Makeba Huntington-Symons | Willie Gorrell |
| Florence revolus | Maria Melendez | Yvette Guzman |
| Fontaine Fosco | Matti Garcia Friedt | Yvette Lewis |
| George Wilkins | Meagan Smithyman | |
| Hannah Aghassi | Michelle Ascanio | |

# Hillsborough County
# Community Partners & Organizations

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

| Hillsborough County Partner Organizations |
|---|
| Bay News 9 |
| Feeding Tampa Bay |
| Gulf Coast Jewish Family Services |
| Hillsborough Community College |
| Hillsborough Hope |
| La Esperanza Clinic |
| Metropolitan Ministries |
| Moffitt Program for Outreach, Wellness, Education and Resources (M-POWER) |
| NAACP Hillsborough |
| REACHUP, Inc. |
| Rebuilding Tampa Bay Together |
| San Jose Mission |
| Specially Fit |
| Tampa Bay Healthcare Collaborative |
| Tampa Bay Network to End Hunger |
| Tampa Bay Thrives |
| Tampa General Medical Group (TGMG) |
| Tampa Housing Authority |
| Tampa Metropolitan Area YMCA |
| Tampa Office of Black Affairs |
| University Area Community Development Center (UACDC) |
| University of South Florida |
| University of Tampa |

# Appendix F. Partner Achievements

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

- **BayCare Health System- SFBH**
- **BayCare Health System- SJH**
- **Tampa General Hospital**
- **AdventHealth**

# Appendix F. Partner Achievements

## BayCare Health System: South Florida Baptist Hospital

# Behavioral Health

### Mental Health First Aid (MHFA):

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

### Behavioral Health Liaisons:

Recognizing that Behavioral Health needs among hospital patients are varied and that hospitalization itself is stressful, BayCare hired Behavioral Health Liaisons in many hospitals across our system. Behavioral Health Liaisons are trained therapists who work with a wide variety of patients to offer care and connect them to resources beyond their hospital stay. Our liaisons help patients with issues from anxiety over a new diagnosis to complex substance use disorders, often facilitating follow up care with outpatient providers. Since implementation, the South Florida Baptist Hospital liaison served 367 patients.

### Tampa Bay Thrives:

In response to addressing mental health and substance use issues across the region, support from South Florida Baptist Hospital aided with the launch Tampa Bay Thrives in 2020. The areas of focus for Tampa Bay Thrives include navigation, 24/7 phone access to behavioral health navigation staffed by mental health professionals who will assess needs and direct people to get the right help. Access, virtual short-term counseling with licensed mental health professionals for those who need immediate attention as they wait for future appointments with local providers. Lastly, Tampa Bay Thrives seeks to remove the stigma of seeking mental health treatment so those in need feel as comfortable seeking treatment as they would for physical health concerns.

# Access to Health Services

### Medication Assistance Program (MAP):

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

### Find Help Florida:

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

# Appendix F. Partner Achievements

## BayCare Health System: South Florida Baptist Hospital

be used by anyone in the community to search for resources that meet their needs. Since implementation, there have been over 67,000 searches for resources via FindHelp Florida.

### Health Care Navigators:

BayCare Health Care Navigators are available to offer free, unbiased, one on one assistance to all individuals. They can assist in helping individuals understand their health insurance options through federal programs such as the Health Insurance Marketplace, and access assistance through community and state programs including Medicaid, and Florida Kid Care. In addition, the BayCare Health Care Navigators can assist with medication assistance requests, health insurance literacy, and financial concerns. BayCare Health Care Navigators are located at BayCare hospitals in Hillsborough, Pinellas, Pasco, and Polk County.

# Exercise, Nutrition, and Weight

### Food Insecurity (HEALing Bags/School Pantries):

In response to the high level of food insecurity in BayCare's service areas, programs to expand access to food have become a major priority for the system. Through a robust partnership with Feeding Tampa Bay, BayCare has implemented multiple food insecurity initiatives increase access to healthy, nutritious foods. The first of these being HEALing bags, the only program of its kind in the region, and state. HEALing Bags are comprised of a three-day supply of non-perishable food to patients that have been screened and identified as food insecure. Since its inception, 55,779 patients have been screened with 4,463 receiving a Healing Bag from a BayCare hospital. The second way BayCare is working to address food insecurity is through partnership with Feeding Tampa Bay is by supplying 42 schools across its service area with an onsite food pantry for the students and their families. Fifteen of these school pantries are located in Hillsborough County.

### Community Health Team:

BayCare's Community Health Team develops community partnerships with area agencies, providing wellness education and disease prevention screenings directly into area neighborhoods. The COVID-19 pandemic prevented the team from being onsite with many partners, despite these challenges, the Community Health Team was able to participate in 283 events and was able to promote better health to more than 3,941 people since January 2020.

### BayCare Kids Wellness and Safety Center:

For more than 30 years, BayCare Kids Wellness and Safety Center has been committed to keeping kids and families healthy, safe, and informed through a multifaceted outreach approach focusing on community education, unintentional injury prevention, children's health and wellness, and legislative advocacy. Since 2020, the BayCare Kids Wellness and Safety Center educated more than 123,914 children and their families through community programs and events across BayCare's footprint.

# Appendix F. Partner Achievements

## BayCare Health System: St. Joseph's Hospital

# Behavioral Health

### Mental Health First Aid (MHFA):

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

### Behavioral Health Liaisons:

Recognizing that Behavioral Health needs among hospital patients are varied and that hospitalization itself is stressful, BayCare hired Behavioral Health Liaisons in many hospitals across our system. Behavioral Health Liaisons are trained therapists who work with a wide variety of patients to offer care and connect them to resources beyond their hospital stay. Our liaisons help patients with issues from anxiety over a new diagnosis to complex substance use disorders, often facilitating follow up care with outpatient providers. Since implementation, St. Joseph's Hospital's liaisons have served 1,263 individuals.

### Salvation Army Beds for Behavioral Health:

BayCare partnered with The Salvation Army of Tampa Area Command Homeless Shelter to provide transient individuals with a respite space to begin caring for their Behavioral Health needs once discharged from the hospital. Clients can stay in a Salvation Army bed for 30 nights to help with stabilization and getting connected with substance misuse resources in the community in addition to establishing a recovery plan. Since implementation in 2020, over 170 individuals have been referred to from BayCare's Behavioral Health Case Management Department and have utilized this program.

# Access to Health Services

### Medication Assistance Program (MAP):

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

### Find Help Florida:

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

### San Jose Mission Clinic & La Esperanza Clinic:

# Appendix F. Partner Achievements

## BayCare Health System: St. Joseph's Hospital

St. Joseph's Hospitals in partnership with Catholic Charities provide support for San Jose Mission Clinic and La Esperanza clinic. Both clinics provide free services to uninsured patients who are below the 200% poverty threshold. St. Joseph's Hospitals provided part-time nurse care coordinators, a nurse practitioner and resource assistants to support the clinics as well as diabetes, hypertension, and other clinic supplies.

### BayCare Kids Mobile Medical Clinic:

The Mobile Medical Clinic was established in 2004, with the goal of addressing the community-wide problem of reduced immunization compliance among young children. The mobile unit travels throughout the county to high need areas and provides services that include immunizations, well child physicals, vaccine record checks, developmental screening, hearing screenings, vision screenings, and fluoride varnish treatments along with health and safety education. Since starting the 2020 Implementation cycle, BayCare Kids Mobile Medical Clinic has provided services to 6,824 medically needy children.

# Exercise, Nutrition, and Weight

### Food Insecurity (HEALing Bags/School Pantries):

In response to the high level of food insecurity in BayCare's service areas, programs to expand access to food have become a major priority for the system. Through a robust partnership with Feeding Tampa Bay, BayCare has implemented multiple food insecurity initiatives increase access to healthy, nutritious foods. The first of these being HEALing bags, the only program of its kind in the region, and state. HEALing Bags are comprised of a three-day supply of non-perishable food to patients that have been screened and identified as food insecure. Since its inception, 55,779 patients have been screened with 4,463 receiving a Healing Bag from a BayCare hospital, and 1,021 of these within the walls of St. Joseph's Hospitals. The second way BayCare is working to address food insecurity is through partnership with Feeding Tampa Bay is by supplying 42 schools across its service area with an onsite food pantry for the students and their families. Fifteen of these school pantries are located in Hillsborough County.

### Community Health Team:

BayCare's Community Health Team develops community partnerships with area agencies, providing wellness education and disease prevention screenings directly into area neighborhoods. The COVID-19 pandemic prevented the team from being onsite with many partners, despite these challenges, the Community Health Team was able to participate in 283 events and was able to promote better health to more than 3,941 people since January 2020.

### BayCare Kids Wellness and Safety Center:

For more than 30 years, BayCare's Kids Wellness and Safety Center has been committed to keeping kids and families healthy, safe, and informed through a multifaceted outreach approach focusing on community education, unintentional injury prevention, children's health and wellness, and legislative advocacy. Since 2020, the BayCare's Wellness and Safety Center educated more than 123,914 children and their families through community programs and events across BayCare's footprint.

# Appendix F. Partner Achievements

# Tampa General Hospital

# Behavioral Health

### Mental Health First Aid:

Since the preceding Community Health Needs Assessment, Tampa General Hospital began offering Adult Mental Health First Aid classes to the community. Over the course of this time, Tampa General Hospital has sponsored the cost to train 4 additional team members as Adult Mental Health First Aid instructors. By providing Mental Health First Aid classes, Tampa General Hospital focused on increasing community awareness to identify someone in mental health distress. Adult Mental Health First Aid was offered to a combination of team members, social service providers, community members, and faith leaders who have multiple touch points with individuals living in the Tampa General Hospital service areas. To date, Tampa General Hospital instructors have trained over 200 people.

### Coordinated Regional Harm Reduction Continuum (CRHRC):

The Coordinated Regional Harm Reduction Continuum (CRHRC) at Tampa General Hospital includes work in structural competency; race/racism and medicine; social determinants of health; healthcare disparities; the role of medical anthropologists in clinical spaces; co-development of medical pathways with patients, physicians, and social scientists; patient centered care; gender, diversity, equity, and inclusion; and the role of the environment and climate in health/health outcomes.

The CRHRC is anchored by the Building Integrated Recovery for Drug users into Emergency medicine (BRIDGE) and the IDEA Tampa Syringe Services Program. Both programs provide mental health services including crisis stabilization, brief cognitive behavioral therapy, motivational interviewing, strengths-based needs assessments. Medication for opioid use disorder (MOUD) is provided to BRIDGE patients in the ED. The IDEA program offers telehealth MOUD induction and continued treatment, as well as Hepatitis C, STI and wound care. Further, free Narcan, a medication used to reverse an opioid overdose, is provided to all appropriate ED patients, and all IDEA patients. Tampa General Hospital also has a dedicated treatment pathway for pregnant and postpartum moms, along with an office based opioid treatment (OBOT) clinic for opioid use disorder (OUD) and medication assistance for other conditions. To date, the BRIDGE and IDEA programs have provided services to almost 8,000 community members.

### Community Directed Giving:

Tampa General Hospital has dedicated funds to several community partners to meet behavioral health needs. These funds are used to reduce barriers and expand behavioral health services to underserved populations. A few examples include Gracepoint, The American Foundation for Suicide Prevention, The Salvation Army, Starting Right Now, and Tampa Pride. These organizations help create a network of varying services to support the population(s) that have the greatest unmet needs in our community.

# Appendix F. Partner Achievements

# Tampa General Hospital

### Access to Health Services :

TGH Virtual Care

Tampa General Hospital provides access urgent care, primary care, and specialty care through virtual telehealth options. The telehealth and connected care service, TGH Virtual Care, is available 24/7/365 and helps remove socioeconomic barriers, enhances quality of care, and expands access to care. Funding received for telehealth services also allows Tampa General Hospital to offer TGH Virtual Care to underserved/uninsured populations as well as provides funding for telehealth advancements in the care of COVID-19 patients. In addition, Tampa General Hospital will use the funding for various projects that expand services from its ambulatory settings to the hospital. This includes providing telehealth kits to local schools, churches and not for profit groups. The kits will remain at the respective organizations and will be used to provide virtual care to their patrons, many of whom may struggle to access healthcare otherwise. Since 2019, Tampa General hospital has treated over 179,000 patients virtually.

### TGH Navigators:

Tampa General Hospital partners with organizations to train Certified Application Counselors (CAC) and navigators to assist with increased awareness among the uninsured about affordable health care coverage options available and assist consumers through and beyond the Marketplace enrollment process. To date, Tampa General Hospital has 6 Certified Application Counselors and 3 licensed navigators who serve the community.

### BRIDGE and IDEA Programs:

Building Integrated Recovery for Drug users into Emergency medicine (BRIDGE) and the IDEA Tampa Syringe Services Programs assist with access to health services. Transportation vouchers are provided to community members receiving care. Medication for opioid use disorder (MOUD) is provided to BRIDGE patients in the ED. The IDEA program offers telehealth MOUD induction and continued treatment, as well as Hepatitis C, STI and wound care. Further, free Narcan, a medication used to reverse an opioid overdose, is provided to all appropriate ED patients, and all IDEA patients. Tampa General Hospital also has a dedicated treatment pathway for pregnant and postpartum moms, along with an office based opioid treatment (OBOT) clinic for opioid use disorder (OUD) and medication assistance for other conditions. To date, the BRIDGE and IDEA programs have provided services to almost 8,000 community members.

### Community Directed Giving:

Tampa General Hospital has dedicated funds to several community partners to meet access to health service's needs. These funds are used to reduce barriers and expand health services to underserved populations. A few examples include American Cancer Society, March of Dimes. Ronald McDonald House, Outreach Free Clinic and Resource Center and USF's Band-Aids for Bridge. These organizations help create a network of varying services to support the population(s) that have the greatest unmet needs in our community.

# Appendix F. Partner Achievements

# Tampa General Hospital

### Exercise, Nutrition, and Weight:

Home Base Warrior Health & Fitness Program

The Warrior Health and Fitness empowers Warriors to take control of their physical well-being, help them overcome pre-existing injuries, and provide a portal for more complex care for those in need of treatment for the invisible wounds. Warrior Health & Fitness is designed to help Veterans improve their physical health and well-being through supervised physical exercise, nutrition, stress management and the benefits of a healthy lifestyle.

### Food Rx Program:

Tampa General Hospital, in partnership with Florida Blue and Feeding Tampa Bay, have launched the Food RX Program. The intent of Food RX is to provide food insecure patients with diet-related health conditions routine access to nutritious foods onsite at their medical facilities, targeted to improve health outcomes. Nutritious non-perishable food and fresh produce will be provided through weekly access to FTB's Groceries on the Go mobile grocery store.

### TampaWell:

TampaWell, activated by Tampa General Hospital in partnership with the City of Tampa, is a revolutionary health and wellness initiative with the goal of making Tampa the ultimate wellness destination in the United States. Our mission at Tampa General Hospital is to empower communities and transform lives. TampaWell is the embodiment of this mission. This endeavor focuses not only on preventative health to reduce chronic disease and prevent individuals from experiencing repeated hospitalizations; it also supports the city's most at-risk residents by addressing underlying social factors that impact health. This multi-year effort focuses on three areas: Regular movement, healthy eating and access to healthy food, and positive mental health.

### Exercise is Medicine:

The vision of Exercise is Medicine® (EIM), a global health initiative managed by the American College of Sports Medicine (ACSM), is to make physical activity assessment and promotion a standard in clinical care, connecting health care with evidence-based physical activity resources for people everywhere and of all abilities. EIM encourages physicians and other health care providers to include physical activity when designing treatment plans and to refer patients to evidence-based exercise programs and qualified exercise professionals. EIM is committed to the belief that physical activity promotes optimal health and is integral in the prevention and treatment of many medical conditions.

### The Veggie Van:

Tampa General Hospital, in partnership with the YMCA makes fresh fruits and vegetables available with the The Veggie Van. This mobile marketplace increases access to fresh fruits and vegetables to the working poor and those living below the poverty line. Increased access means fewer individuals

# Appendix F. Partner Achievements

# Tampa General Hospital

living in food deserts will go hungry. Food deserts are urban neighborhoods without ready access to fresh, healthy, and affordable food.

### Community Health & Wellness Team:

Tampa General Hospital's Community Health & Wellness team works in collaboration with community organizations to provide education, screenings, and referrals to individuals in the community. The Community Health & Wellness team offers screenings for cholesterol, glucose, blood pressure, BMI, and diabetes, along with health-related lectures and disease specific, evidenced based programs. The Community Health & Wellness team continues to grow their catalog of education and services to meet the needs of individuals across Tampa General Hospital's service area.

### Community Directed Giving:

Tampa General Hospital has dedicated funds to several community partners to meet needs related to exercise, nutrition, and weight. These funds are used to reduce barriers, aid, education, and services to underserved populations. A few examples include Feeding Tampa Bay, Girls on the Run, Specially Fit, University Area Community Development Center and Where Love Grows. These organizations help create a network of varying services to support the population(s) that have the greatest unmet needs in our community

# Appendix F. Partner Achievements

## AdventHealth West Florida Division

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

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

#### Priority Area: Exercise, Nutrition, and Weight

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

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

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

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

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

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

# Appendix F. Partner Achievements

## AdventHealth West Florida Division

Partnerships for the AdventHealth Food is Health Program include:

AdventHealth and Feeding Tampa Bay

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

### Priority Area: Behavioral Health

Trained over 150 adults in Mental Health First Aid

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

AdventHealth, along with the other partners of the All4HealthFL collaborative, have made teaching MHFA a major objective to help combat stigma. Since 2020, AdventHealth has conducted virtual and in-person MHFA classes and achieved the following outcomes in Hillsborough, Pinellas, and Pasco counties:

- Trained four team members as MHFA Instructors in the Adult Curriculum
- Facilitated 13 certification classes training 122 adults to recognize and safely intervene in mental health crises

### Behavioral Health Partnership

The partnership between AdventHealth and Concert Health is based on Collaborative Care—an evidence-based approach to improving behavioral health care by identifying and treating conditions such as anxiety and depression in the primary care setting. More than 60% of Concert Health patients see a 50% reduction in their depression or anxiety symptoms within 90 days. This flexible, patient-centered approach will allow AdventHealth physicians to practice whole-person care through a high-touch model that addresses both mental and physical health.

Reference: AdventHealth Launches Collaborative Care Program with Concert Health to Expand Whole Health Care – Concert Health

### AdventHealth expands access to mental health services in Tampa Bay

Reference: AdventHealth expands access to mental health services in Tampa Bay | AdventHealth West Florida Media Resources | AdventHealth

# Appendix F. Partner Achievements

## AdventHealth West Florida Division

AdventHealth announced the expansion of its mental health focus outside of the primary care setting during a press conference with Tampa Bay Thrives and additional community partners. The health system will be expanding its care to provide same-day access to a mental health clinician at 10 AdventHealth Express Care at Walgreens locations across Tampa Bay via telehealth. Currently, AdventHealth physician practices at AdventHealth Care Pavilion New Tampa connect patients with expert mental health clinicians to receive same-day behavioral health treatment, via phone or video visit, from the privacy of their home.

Note: Please make the necessary wordsmithing (for better flow) to the information below. This information was pulled from a few tables and press releases.

To assist with pulling more information, please refer to the full Community Health Plan located at: [Final 2019 CHNA Template (adventhealth.com)]

### American Heart Association (AHA) Hands-Only Community CPR

AdventHealth Tampa is committed to working together with local community organizations and stakeholders to implement effective strategies to reduce the burden of heart disease and stroke by providing health education in the community, increasing access to community health screenings and connecting community members to resources to help manage blood pressure and cholesterol.

AdventHealth has been working to increase the number of Hospital-sponsored American Heart Association (AHA) community CPR out-of-hospital bystander classes for adults and youth from a baseline of zero to five by the end of year three (December 31, 2022).

The AdventHealth Community Benefit team members were trained by the American Heart Association in Community CPR to implement the train-the-trainer model throughout the community. Classes are provided for free to community members (churches, schools, after-school programs, community organizations, etc.). In addition to be trained to save a life of someone challenged with an immediate heart event, community members are also trained to train other community members in community CPR and are provided with a free Hands Only CPR kit at completion of the class.

# Appendix F. Partner Achievements

## AdventHealth West Florida Division

**What is Hands Only CPR?**

- Hands-Only CPR is CPR without rescue breaths.
- Hands-Only means giving chest compressions to keep someone alive.
- Hands-Only CPR is intended for adults, teens, and children over the age of 8 years old.

With 70 percent of all out-of-hospital cardiac arrests happening at home, if you're called on to perform Hands-Only CPR, you'll likely be trying to save the life of someone you know and love.

Hands-Only CPR carried out by a bystander has been shown to be as effective as CPR with breaths in the first few minutes during an out-of-hospital sudden cardiac arrest for an adult victim

As of May 2022, the following accomplishments have been achieved.

- A total of 15 AdventHealth Team Members Instructor trained to teach the Community CPR Train-The-Trainer community classes.
- Developed training presentation and implemented 12 classes
- Number of adults trained: 146
- Partnered with local school districts and youth agencies to train 500 high school aged youth
- Number of youths trained by trainees: 6,000

### Tobacco Cessation

**Accomplishments from 2020-2022 Community Health Plans (As of May 2022)**

AdventHealth partnered with Area Health Education Centers (AHEC) in Hillsborough, Pinellas, and Pasco, County to connect patients and community members to tobacco cessation classes. Furthermore, the AdventHealth Patient Engagement Advisors (PEA)/Care 360 teams created a streamlined referral process to enroll over 1,051 identified AdventHealth patients into AHEC's tobacco cessation classes and connect them to resources to quit.