Summary Report

2016 Community Health Needs Assessment

St. Joseph's Hospitals Service Area

Prepared for St. Joseph's Hospitals:
St. Joseph's Hospital
St. Joseph's Hospital–North
St. Joseph's Hospital–South
St. Joseph's Hospital Behavioral Health Center
St. Joseph's Children's Hospital
St. Joseph's Women's Hospital

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Introduction

About This Assessment

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors and needs of community residents. A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. For St. Joseph's Hospitals, this information may be used to inform decisions and guide efforts to improve community health and wellness.

This assessment, part of a broader, system-wide effort undertaken by BayCare Health System, was conducted by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from both quantitative and qualitative sources:

- Quantitative data input includes primary research (the PRC Community Health Survey, as well as supplemental convenience sample surveys) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at the state and national levels.

- Qualitative data input includes primary research gathered through an Online Key Informant Survey of various community stakeholders.

PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by BayCare Health System and PRC.

Community Defined for This Assessment

This report focuses on findings in the calculated service area of the St. Joseph's Hospitals (including St. Joseph's Hospital, St. Joseph's Hospital–North, St. Joseph's Hospital–South, St. Joseph's Hospital Behavioral Health Center, St. Joseph's Children's Hospital, and St. Joseph's Women's Hospital). This area, referred to in this report as the "SJH Service Area" or "SJH," is the area from which 75% of the combined hospitals' admissions are derived, and includes 87 residential ZIP Codes.
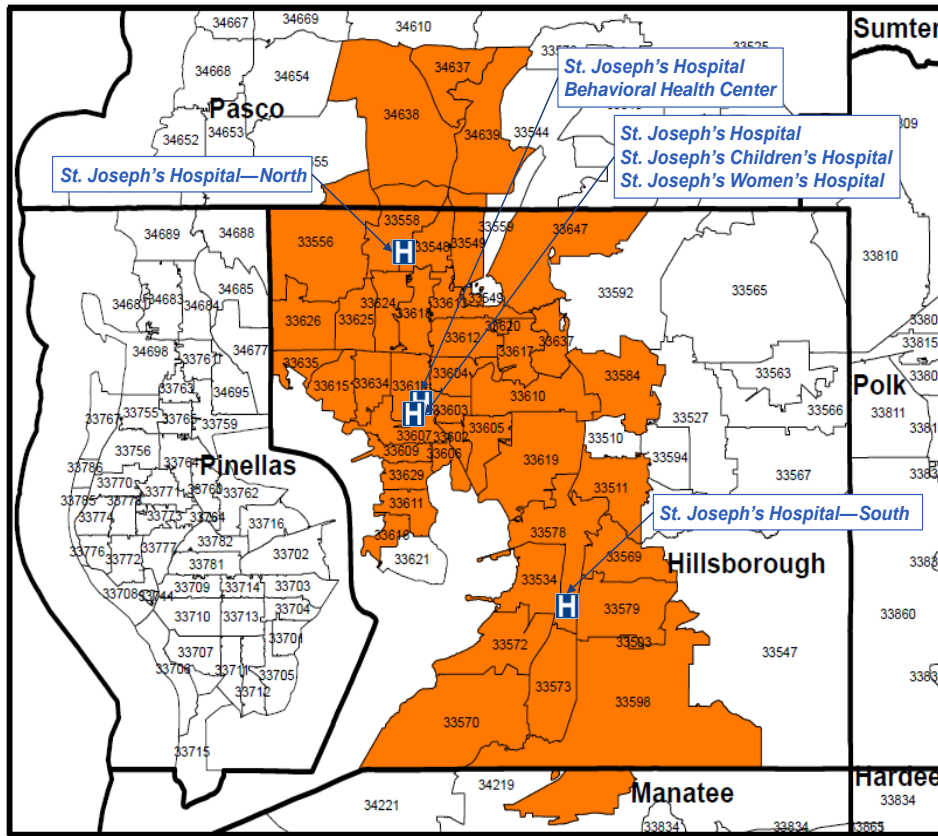
Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed a mixed-mode methodology was implemented. This included surveys conducted via telephone (landline and cell phone), as well as through online questionnaires.

The population sample achieved in the SJH Service Area consisted of 406 individuals age 18 and older. For statistical purposes, the maximum rate of error associated with a sample size of this size is ±4.9% at the 95 percent level of confidence. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. And, while this random sampling of the population produces a highly representative sample, it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias.

The following chart outlines the characteristics of the SJH Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's healthcare needs, and these children are not represented demographically in this chart.]

Population & Survey Sample Characteristics
(SJH Service Area, 2016)
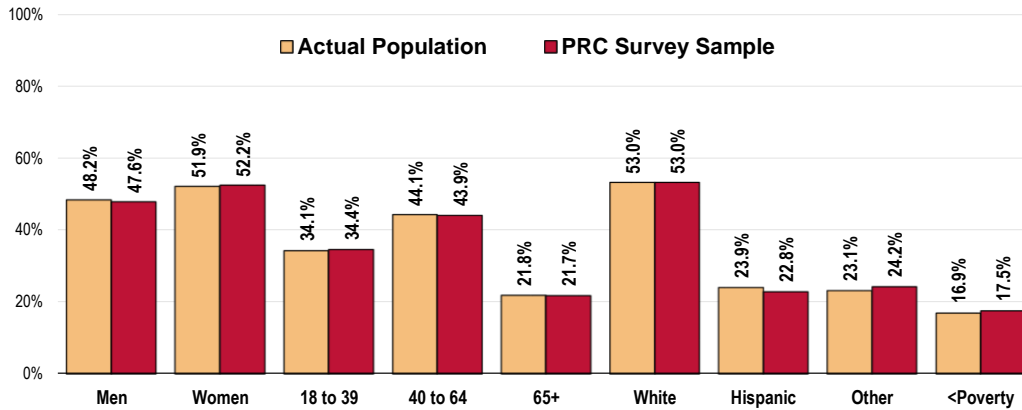
Sources:
- Census 2010, Summary File 3 (SF 3). US Census Bureau.
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household *(e.g., the 2016 guidelines place the poverty threshold for a family of four at $24,300 annual household income or lower)*. In sample segmentation: "**low income**" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice the poverty threshold; "**mid/high income**" refers to those households living on incomes which are twice or more the federal poverty level.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

Supplemental Convenience Sample Survey

In 2016, the Florida Department of Health in Hillsborough County administered the Healthy Hillsborough Survey to thousands of Hillsborough County residents. This report also incorporates select questions from a subset of the data collected in this survey (presented in the "High-Need Areas" section of this report), limiting the data to those collected as paper surveys among residents living in ZIP Codes identified as high-need ZIP Codes. *These handout surveys constitute a "convenience sample," a non-probability sample that is not necessarily representative of the targeted population and is limited in generalizability.*

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented as part of this process. A list of recommended participants was provided by St. Joseph's Hospitals; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 70 community stakeholders in the SJH Service Area took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation		
Key Informant Type	Number Invited	Number Participating
Physician	48	18
Public Health Representative	9	7
Other Health Provider	23	12
Social Services Provider	22	14
Community Leader	63	19

Final participation included representatives of the organizations outlined below.

- American Cancer Society
- BayCare Health System
- BayCare Medical Group
- Brighton Gardens of Tampa
- Catholic Charities Free and Charitable Clinics
- Catholic Charities, Diocese of St. Petersburg, Inc.
- Chapters Health System
- Crisis Center of Tampa Bay
- Department of Health–Hillsborough County
- Drug Abuse Comprehensive Coordinating Office, Inc.
- Emergency Medical Associates of Tampa Bay
- Florida Department of Health in Hillsborough County
- Florida Pediatric Associates
- HCC Foundation
- Healthy Start Coalition of Hillsborough County
- Hillsborough County Healthcare Services
- Hillsborough County Public Schools
- In Season Pro LLC
- Judeo Christian Health Clinic, Inc.
- Meals on Wheels
- Orthopaedic Medical Group of Tampa Bay
- Pediatric Cardiology Associates
- Special Olympics Florida Healthy Community Tampa Bay
- St. Joseph's Hospital
- The Mosaic Corporation
- The Salvation Army
- The Woman's Group
- University Area CDC
- University of South Florida
- Women's Care Florida
- YMCA

Through this process, input was gathered from several individuals whose organizations work with low-income, minority populations, or other medically underserved populations.

Minority/medically underserved populations represented:

> *Acute/chronically ill, African-American, Asian, autistic, children, criminal offenders, disabled, elderly, English as a second language, Hispanic, HIV individuals, homebound, homeless, residents without transportation, LGBT, low income, Medicare/Medicaid, mentally ill, morbidly obese, pregnant teenagers, rural residents, substance abusers, teens, undocumented, uninsured/underinsured, veterans, victims of abuse*

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input from participants regarding their opinions and perceptions of the health of the residents in the area. Thus, these findings are not necessarily based on fact.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for St. Joseph's Hospitals represent findings for Hillsborough County, as obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Environmental Systems (CARES)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- Community Commons
- Florida Department of Public Health
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- Truven Health Analytics and Dignity Health
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services

- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Benchmark Data

State Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data are reported in the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trend Data* published by the Centers for Disease Control and Prevention and the US Department of Health & Human Services. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2015 PRC National Health Survey*; the methodological approach for the national study is identical to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2020

Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. The Healthy People initiative is grounded in the principle that setting national objectives and monitoring progress can motivate action. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:

- Encourage collaborations across sectors.
- Guide individuals toward making informed health decisions.
- Measure the impact of prevention activities.

Healthy People 2020 is the product of an extensive stakeholder feedback process that is unparalleled in government and health. It integrates input from public health and prevention experts, a wide range of federal, state and local government officials, a consortium of more than 2,000 organizations, and perhaps most importantly, the public. More than 8,000 comments were considered in drafting a comprehensive set of Healthy People 2020 objectives.

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level) using question-specific samples and response rates. For secondary data indicators (which do not carry sampling error, but might be subject to reporting error), "significance," for the purpose of this report, is determined by a 5% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest.   It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — might not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are medical conditions that are not specifically addressed.

IRS Form 990, Schedule H Compliance

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Form 990 Schedule H, the following table cross-references related sections.

IRS Form 990, Schedule H (2015)	See Report Page
Part V Section B Line 3a *A definition of the community served by the hospital facility*	5
Part V Section B Line 3b *Demographics of the community*	150
Part V Section B Line 3c *Existing health care facilities and resources within the community that are available to respond to the health needs of the community*	145
Part V Section B Line 3d *How data was obtained*	5
Part V Section B Line 3e *The significant health needs of the community*	14
Part V Section B Line 3f *Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups*	Addressed Throughout
Part V Section B Line 3g *The process for identifying and prioritizing community health needs and services to meet the community health needs*	15
Part V Section B Line 3h *The process for consulting with persons representing the community's interests*	8
Part V Section B Line 3i *Information gaps that limit the hospital facility's ability to assess the community's health needs*	11

Summary of Findings

Significant Health Needs of the Community

The following "areas of opportunity" represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in Healthy People 2020. From these data*, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community stakeholders (key informants) giving input to this process.

Areas of Opportunity Identified Through This Assessment	

Access to Healthcare Services	• Barriers to Access
	  ○ Inconvenient Office Hours
	  ○ Cost of Prescriptions
	  ○ Cost of Physician Visits
	  ○ Appointment Availability
	  ○ Finding a Physician
	  ○ Lack of Transportation
	  ○ Language/Culture
	• Skipping/Stretching Prescriptions
	• Difficulty Accessing Children's Healthcare
	• Specific Source of Ongoing Medical Care
	• Routine Medical Care (Adults & Children)

Cancer	• Cancer is a leading cause of death. • Cancer Incidence ○ Including Lung Cancer, Female Breast Cancer, Prostate Cancer, Colorectal Cancer, Cervical Cancer • Cancer Prevalence (Non-Skin) • Cervical Cancer Screening
Diabetes	• Diabetes Deaths • Prevalence of Diabetes • Prevalence of Borderline/Pre-Diabetes • Diabetes ranked as a top concern in the Online Key Informant Survey.
Heart Disease & Stroke	• Cardiovascular disease is a leading cause of death. • Heart Disease Deaths • Blood Pressure Screening • High Blood Pressure Prevalence • High Blood Cholesterol Prevalence • Overall Cardiovascular Risk • Heart Disease & Stroke ranked as a top concern in the Online Key Informant Survey.
HIV/AIDS	• HIV/AIDS Deaths • HIV Prevalence

—continued on next page—

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* *Data considered include the population-based PRC Community Health Survey, indicators from public health and other existing data sets, as well as input from community stakeholders through the Online Key Informant Survey.*

Areas of Opportunity (continued)	
Infant Health & Family Planning	● Low-Weight Births ● Infant Mortality ● Teen Births
Injury & Violence	● Unintentional Injury Deaths ○ Including Motor Vehicle Crash Deaths ● Violent Crime Experience
Mental Health	● Prevalence of Diagnosed Depression ● Stress ● Difficulty Obtaining Mental Health Services ● Mental Health ranked as a top concern in the Online Key Informant Survey.
Nutrition, Physical Activity & Weight	● Difficulty Accessing Fresh Produce ● Low Food Access ● Food Insecurity ● Obesity ● Children's Physical Activity ● Nutrition, Physical Activity & Weight ranked as a top concern in the Online Key Informant Survey.
Oral Health	● Regular Dental Care (Adults & Children)
Potentially Disabling Conditions	● Activity Limitations ● Arthritis Prevalence [Age 50+]
Respiratory Diseases	● Chronic Lower Respiratory Disease (CLRD) Deaths ● Pneumonia/Influenza Deaths ● Asthma Prevalence [Children]
Sexually Transmitted Diseases	● Gonorrhea Incidence ● Chlamydia Incidence
Substance Abuse	● Drinking & Driving ● Illicit Drug Use ● Personally Impacted by Substance Abuse (Self or Other's) ● Substance Abuse ranked as a top concern in the Online Key Informant Survey.
Tobacco Use	● Environmental Tobacco Smoke Exposure at Home ○ Including Among Households With Children & Nonsmokers ● Cigar Smoking Prevalence ● Smokeless Tobacco Prevalence

Prioritization of Health Needs, Representing Significant Health Needs

On August 22, 2016, St. Joseph's Hospitals convened a meeting of 73 hospital representatives and community stakeholders (representing a cross-section of community-based agencies and organizations) to evaluate, discuss and prioritize health needs for the hospital service area, based on findings of this Community Health Needs Assessment (CHNA); see Appendix III for participating agencies/organizations. Professional Research Consultants, Inc. (PRC) began the meeting with a presentation of key areas of opportunity that represent significant health needs as identified by the primary and secondary research (see Areas of Opportunity above).

Following the data review, PRC answered any questions and facilitated a group dialogue allowing participants to further comment and address any of the health needs discussed. Participants were then provided an overview of the prioritization exercise that followed.

In order to assign priority to the identified health needs (i.e., Areas of Opportunity), a wireless audience response system was used in which each participant was able to register his/her ratings using a small remote keypad. The participants were asked to evaluate each health issue along two criteria:

Scope & Severity — The first rating was to gauge the magnitude of the problem in consideration of the following:

- How many people are affected?
- How do we compare to state or national levels, or Health People 2020 targets?
- To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?

Ratings were entered on a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).

Ability to Impact — A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue. Specifically, participants were asked to consider:

- What is the likelihood of our organization having a positive impact on this health issue?
- This should reflect our ability to address this issue independently or in conjunction with potential community partners.

Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

Individuals' ratings for each tested health need were averaged for each tested health issue, and then these composite criteria scores were averaged to produce an overall score. This process yielded the following prioritized list of community health needs:

1. **Mental Health**

2. **Access to Healthcare Services**

3. **Diabetes**

4. **Heart Disease & Stroke**

5. **Nutrition, Physical Activity & Weight**

6. **Infant Health & Family Planning**

7. **Cancer**

8. **Substance Abuse**

9. **Respiratory Diseases**

10. **Tobacco Use**

11. **HIV/AIDS**

12. **Sexually Transmitted Diseases**

13. **Oral Health**

14. **Injury & Violence**

15. **Potentially Disabling Conditions**

Plotting these overall scores in a matrix illustrates the intersection of the Scope & Severity and the Ability to Impact scores. Below, those issues placing in the upper right (shaded) quadrant represent health needs rated as most severe, with the greatest ability to impact.

Prioritization of Community Issues
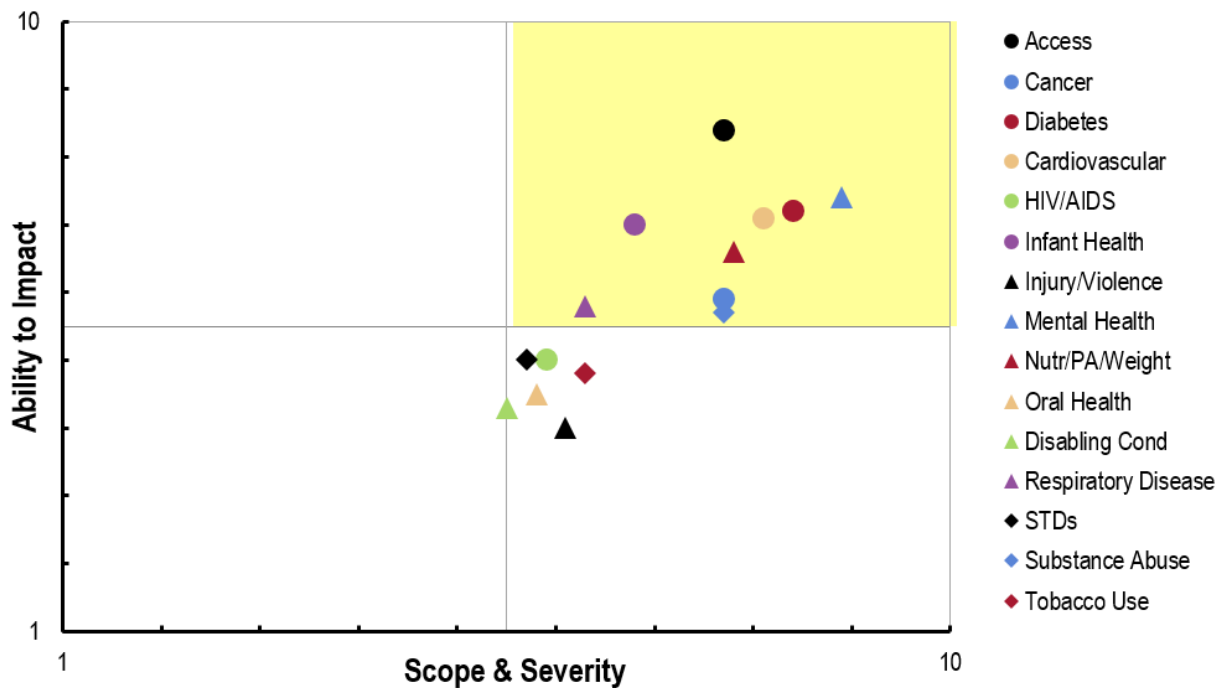
While the hospital will likely not implement strategies for all of these health needs, the results of this prioritization exercise will be used to inform the development of St. Joseph's Hospitals Implementation Plan to address the top health needs of the hospital's service area in the coming years.

Note: An evaluation of the work that St. Joseph's Hospitals has already implemented based on findings of the prior assessment can be found in the Appendix.

Summary Data

Comparisons With Benchmark Data

The following tables provide an overview of indicators in the SJH Service Area. These data are grouped to correspond with the Focus Areas presented in Healthy People 2020.

Reading the Data Summary Tables

■ In the following charts, SJH Service Area results are shown in the larger, blue column. For survey-derived indicators, this column represents the ZIP Code–defined hospital service area; for data from secondary sources, this column represents findings for Hillsborough County as a whole. *Tip: Indicator labels beginning with a "%" are taken from the population-based PRC Community Health Survey; the remaining indicators are taken from secondary data sources.*

■ The columns to the right of the service area column provide comparisons between local data and any available regional, state and national findings, and Healthy People 2020 targets. Symbols indicate whether the SJH Service Area compares favorably (☼), unfavorably (☻), or comparably (☁) to these external data.

Note the following:

- Blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

- The "BayCare Area" is a regional benchmark representing CHNA service areas for BayCare member hospitals residing in Hillsborough, Pinellas and Pasco Counties. For survey-derived indicators, this is a composite of ZIP Codes served by these hospitals (see map); for secondary data indicators, it represents the combined whole of Hillsborough, Pasco, and Pinellas Counties.

Social Determinants	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
[County] Linguistically Isolated Population (Percent)	5.2	⛈️ 4.0	☀️ 6.6	⛈️ 4.7	
[County] Population in Poverty (Percent)	17.2	⛈️ 15.7	☁️ 16.7	⛈️ 15.6	
[County] Population Below 200% FPL (Percent)	37.6	☁️ 36.1	☁️ 38.1	⛈️ 34.5	
[County] Children Below 200% FPL (Percent)	48.1	☁️ 45.9	☁️ 49.2	⛈️ 44.2	
[County] No High School Diploma (Age 25+, Percent)	12.9	⛈️ 12.0	☀️ 13.6	☀️ 13.7	
[County] Unemployment Rate (Age 16+, Percent)	5.0	☀️ 5.4	☀️ 5.4	☀️ 5.3	
% Worry/Stress Over Rent/Mortgage in Past Year	38.8	☁️ 34.8		⛈️ 31.6	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

	better	similar	worse
	☀️	☁️	⛈️

Overall Health	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
% "Fair/Poor" Physical Health	17.3	☁️ 20.3	☁️ 19.3	☁️ 18.3	
% Activity Limitations	30.3	☁️ 29.6	⛈️ 22.4	⛈️ 20.0	
% Caregiver to a Friend/Family Member	24.5	☁️ 25.4		☁️ 20.9	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

	better	similar	worse
	☀️	☁️	⛈️

Access to Health Services	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
% [Age 18-64] Lack Health Insurance	11.3	☁ 11.5	☀ 22.8	☁ 10.1	🌧 0.0
% [Insured 18-64] Have Coverage Through ACA	9.8	☁ 9.3		☁ 10.8	
% Difficulty Accessing Healthcare in Past Year (Composite)	48.0	☁ 45.6		🌧 35.0	
% Inconvenient Hrs Prevented Dr Visit in Past Year	20.3	☁ 16.9		🌧 14.4	
% Cost Prevented Getting Prescription in Past Year	22.0	☁ 19.5		🌧 9.5	
% Cost Prevented Physician Visit in Past Year	19.4	☁ 17.9		🌧 11.5	
% Difficulty Getting Appointment in Past Year	25.6	🌧 20.9		🌧 15.4	
% Difficulty Finding Physician in Past Year	18.7	☁ 16.8		🌧 8.7	
% Transportation Hindered Dr Visit in Past Year	12.5	☁ 10.8		🌧 5.0	
% Language/Culture Prevented Care in Past Year	5.1	☁ 5.8		🌧 1.7	
% Low Health Literacy	26.3	☁ 24.6		☁ 23.3	
% Skipped Prescription Doses to Save Costs	20.4	☁ 18.4		🌧 10.2	
% Difficulty Getting Child's Healthcare in Past Year	16.9	☁ 11.1		🌧 3.9	
[County] Primary Care Doctors per 100,000	78.1	☁ 77.3	☀ 70.3	☁ 74.5	
% [Age 18+] Have a Specific Source of Ongoing Care	68.3	☁ 71.4		🌧 74.0	🌧 95.0

Access to Health Services (continued)	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
% [Age 18-64] Have a Specific Source of Ongoing Care	63.0	☁ 66.2		🌧 73.1	🌧 89.4
% [Age 65+] Have a Specific Source of Ongoing Care	86.0	☁ 83.3		☀ 76.8	🌧 100.0
% Have Had Routine Checkup in Past Year	65.8	☁ 70.2	🌧 73.0	☁ 70.5	
% Child Has Had Checkup in Past Year	78.9	☁ 78.1		🌧 89.3	
% Two or More ER Visits in Past Year	12.0	☁ 9.9		☁ 8.5	
% Rate Local Healthcare "Fair/Poor"	15.5	☁ 16.7		☁ 14.2	
% Have Completed Advance Directive Documents	34.6	🌧 42.1		☁ 33.7	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

☀ better   ☁ similar   🌧 worse

Arthritis, Osteoporosis & Chronic Back Conditions	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
% [50+] Arthritis/Rheumatism	40.5	☁ 38.2		🌧 32.0	
% [50+] Osteoporosis	11.5	☁ 11.7		☁ 8.7	🌧 5.3
% Sciatica/Chronic Back Pain	23.5	☁ 27.0		☁ 19.4	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

☀ better   ☁ similar   🌧 worse

Cancer	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
[County] Cancer (Age-Adjusted Death Rate per 100,000)	163.4	similar 163.4	similar 155.9	similar 163.6	similar 161.4
[County] Prostate Cancer Incidence per 100,000	137.7	worse 118.8	worse 118.9	similar 131.7	
[County] Female Breast Cancer Incidence per 100,000	122.7	similar 119.5	worse 115.2	similar 123.0	
[County] Lung Cancer Incidence per 100,000	70.2	similar 71.2	worse 64.6	worse 63.7	
[County] Colorectal Cancer Incidence per 100,000	44.5	worse 40.7	worse 39.2	worse 41.9	
[County] Cervical Cancer Incidence per 100,000	10.1	worse 9.3	worse 8.9	worse 7.7	
% Skin Cancer	8.8	similar 11.7	similar 8.9	similar 7.7	
% Cancer (Other Than Skin)	10.5	similar 9.7	worse 7.2	similar 7.7	
% [Women 50-74] Mammogram in Past 2 Years	81.2	similar 78.3	similar 78.5	similar 80.3	similar 81.1
% [Women 21-65] Pap Smear in Past 3 Years	74.6	similar 69.4	similar 79.5	worse 84.8	worse 93.0
% [Age 50+] Sigmoid/Colonoscopy Ever	80.7	similar 79.1	better 69.9	similar 75.6	
% [Age 50+] Blood Stool Test in Past 2 Years	37.7	similar 40.4	better 19.9	similar 31.8	
% [Age 50-75] Colorectal Cancer Screening	80.1	similar 79.1	better 66.6	similar 74.5	better 70.5

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

Legend: ☀ better | ☁ similar | 🌧 worse

Chronic Kidney Disease	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
[County] Kidney Disease (Age-Adjusted Death Rate per 100,000)	10.7	(worse) 10.1	(similar) 10.8	(better) 13.2	
% Kidney Disease	5.3	(similar) 6.0	(similar) 3.8	(similar) 3.6	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

better (sun) similar (cloud) worse (rain)

Dementias, Including Alzheimer's Disease	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
[County] Alzheimer's Disease (Age-Adjusted Death Rate per 100,000)	21.2	(worse) 18.2	(worse) 17.0	(better) 24.2	
% [Age 45+] Increasing Confusion/Memory Loss in Past Yr	14.8	(similar) 13.7		(similar) 12.8	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

better (sun) similar (cloud) worse (rain)

Diabetes	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
[County] Diabetes Mellitus (Age-Adjusted Death Rate per 100,000)	21.5	(similar) 21.6	(worse) 19.2	(similar) 21.1	(similar) 20.5
% Diabetes/High Blood Sugar	16.7	(similar) 16.3	(worse) 11.2	(similar) 14.5	
% Borderline/Pre-Diabetes	12.9	(similar) 11.4		(worse) 5.7	
% [Non-Diabetes] Blood Sugar Tested in Past 3 Years	55.5	(similar) 49.9		(similar) 55.1	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

better (sun) similar (cloud) worse (rain)

Family Planning	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
[County] Teen Births per 1,000 (Age 15-19)	42.1	worse 38.9	worse 36.1	worse 36.6	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

	better	similar	worse

Hearing & Other Sensory or Communication Disorders	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
% Deafness/Trouble Hearing	8.6	similar 11.2		similar 8.6	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

	better	similar	worse

Heart Disease & Stroke	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
[County] Diseases of the Heart (Age-Adjusted Death Rate per 100,000)	165.5	similar 158.9	worse 151.4	similar 169.1	worse 156.9
[County] Stroke (Age-Adjusted Death Rate per 100,000)	33.0	worse 31.1	similar 31.4	better 36.5	better 34.8
% Heart Disease (Heart Attack, Angina, Coronary Disease)	7.4	similar 8.9		similar 6.9	
% Heart Attack	4.9	similar 5.6	similar 5.3	similar 4.0	
% Angina/Coronary Heart Disease	4.7	similar 5.6	similar 5.4	similar 5.2	
% Congestive Heart Failure	4.4	similar 3.6			

Heart Disease & Stroke (continued)	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
% Stroke	3.4	☁ 4.6	☁ 3.4	☁ 2.6	
% Blood Pressure Checked in Past 2 Years	87.7	☁ 89.4		🌧 93.6	🌧 92.6
% Told Have High Blood Pressure (Ever)	44.2	☁ 45.3	🌧 34.6	🌧 36.5	🌧 26.9
% [HBP] Taking Action to Control High Blood Pressure	94.1	☁ 92.7		☁ 92.5	
% Cholesterol Checked in Past 5 Years	85.6	☁ 83.7	☀ 79.5	☁ 87.4	☀ 82.1
% Told Have High Cholesterol (Ever)	40.2	☁ 40.6		🌧 33.5	🌧 13.5
% [HBC] Taking Action to Control High Blood Cholesterol	79.5	☁ 82.0		☁ 84.2	
% 1+ Cardiovascular Risk Factor	88.0	☁ 87.8		🌧 83.0	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

☀ better	☁ similar	🌧 worse

HIV	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
[County] HIV/AIDS (Age-Adjusted Death Rate per 100,000)	4.3	🌧 3.8	☁ 4.4	🌧 2.1	🌧 3.3
[County] HIV Prevalence per 100,000	573.8	🌧 454.0	☀ 606.1	🌧 353.2	
% [Age 18-44] HIV Test in the Past Year	36.0	☁ 28.8		☀ 21.3	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

☀ better	☁ similar	🌧 worse

Immunization & Infectious Diseases	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
% [Age 65+] Flu Vaccine in Past Year	49.5	☁ 50.9	☁ 53.1	☁ 58.9	🌧 70.0
% [High-Risk 18-64] Flu Vaccine in Past Year	50.3	☁ 42.8		☁ 48.0	🌧 70.0
% [Age 65+] Pneumonia Vaccine Ever	69.7	☁ 73.5	☁ 66.9	☁ 76.3	🌧 90.0
% [High-Risk 18-64] Pneumonia Vaccine Ever	44.1	☁ 40.3		☁ 38.7	🌧 60.0

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

	☀ better	☁ similar	🌧 worse

Injury & Violence Prevention	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
[County] Unintentional Injury (Age-Adjusted Death Rate per 100,000)	44.9	☁ 46.9	🌧 40.1	🌧 39.7	🌧 36.4
[County] Motor Vehicle Crashes (Age-Adjusted Death Rate per 100,000)	12.2	☁ 12.0	☁ 12.0	🌧 10.6	☁ 12.4
% [Age 45+] Fell in the Past Year	29.5	☁ 29.7		☁ 28.2	
[County] Firearm-Related Deaths (Age-Adjusted Death Rate per 100,000)	10.2	☀ 11.0	☀ 11.9	☁ 10.4	🌧 9.3
% Firearm in Home	25.9	☁ 28.0		☀ 33.8	
% [Homes With Children] Firearm in Home	29.8	☁ 29.5		☁ 31.0	
% [Homes With Firearms] Weapon(s) Unlocked & Loaded	22.6	☁ 30.1		☁ 20.4	
[County] Homicide (Age-Adjusted Death Rate per 100,000)	5.4	🌧 5.1	☀ 6.3	☁ 5.2	☁ 5.5

Injury & Violence Prevention (continued)	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
[County] Violent Crime per 100,000	394.3	☀ 455.5	☀ 514.6	☁ 395.5	
% Victim of Violent Crime in Past 5 Years	6.2	☁ 4.0		🌧 2.3	
% Perceive Neighborhood as "Slightly/Not At All Safe"	18.3	☁ 18.1		☁ 15.3	
% Victim of Domestic Violence (Ever)	18.2	☁ 16.7		☁ 15.1	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

	☀ better	☁ similar	🌧 worse

Maternal, Infant & Child Health	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
[County] No Prenatal Care in First Trimester (Percent)	17.9	☀ 22.8	☀ 27.7	☁ 17.3	☀ 22.1
[County] Low Birthweight Births (Percent)	9.0	☁ 8.8	☁ 8.7	🌧 8.2	🌧 7.8
[County] Infant Death Rate per 1,000 Live Births	8.3	☁ 7.9	🌧 7.0	🌧 6.5	🌧 6.0

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

	☀ better	☁ similar	🌧 worse

Mental Health & Mental Disorders	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
% "Fair/Poor" Mental Health	12.9	☁ 14.3		☁ 15.5	
% Diagnosed Depression	20.9	☁ 20.0	🌧 16.2	☁ 17.9	
% Symptoms of Chronic Depression (2+ Years)	30.7	☁ 29.6		☁ 29.9	
[County] Suicide (Age-Adjusted Death Rate per 100,000)	13.0	☀ 15.6	☀ 14.0	☁ 12.7	🌧 10.2
% Have Ever Sought Help for Mental Health	31.3	☁ 30.2		☁ 27.4	
% [Those With Diagnosed Depression] Seeking Help	91.7	☀ 84.1		☁ 91.7	
% Taking Rx/Receiving Mental Health Trtmt	15.2	☁ 15.6		☁ 13.6	
% Unable to Get Mental Health Svcs in Past Yr	8.0	☁ 6.0		🌧 4.4	
% Typical Day Is "Extremely/Very" Stressful	19.8	☁ 17.4		🌧 11.7	
% Average <7 Hours of Sleep per Night	39.9	☁ 38.0		☁ 39.5	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

☀ better	☁ similar	🌧 worse

Nutrition, Physical Activity & Weight	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
% Eat 5+ Servings of Fruit or Vegetables per Day	28.3	☁ 26.8		☁ 27.4	
% "Very/Somewhat" Difficult to Buy Fresh Produce	33.6	🌧 28.5		🌧 21.9	

Nutrition, Physical Activity & Weight (continued)	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
Population With Low Food Access (Percent)	31.0	(worse) 28.3	(worse) 26.9	(worse) 23.6	
% Food Insecure	39.0	(worse) 32.5		(worse) 25.9	
% 7+ Sugar-Sweetened Drinks in Past Week	20.5	(similar) 23.7		(better) 30.2	
% Healthy Weight (BMI 18.5-24.9)	34.5	(similar) 30.5		(similar) 32.9	(similar) 33.9
% Overweight (BMI 25+)	63.0	(similar) 66.5	(similar) 62.2	(similar) 65.2	
% Obese (BMI 30+)	33.9	(similar) 34.3	(worse) 26.2	(similar) 33.4	(similar) 30.5
% Medical Advice on Weight in Past Year	23.5	(similar) 25.0		(similar) 20.4	
% [Overweights] Counseled About Weight in Past Year	30.8	(similar) 30.8		(similar) 27.1	
% [Obese Adults] Counseled About Weight in Past Year	48.2	(similar) 45.8		(similar) 40.8	
% [Overweights] Trying to Lose Weight Both Diet/Exercise	63.2	(similar) 62.9		(similar) 57.0	
% No Leisure-Time Physical Activity	26.6	(similar) 27.5	(similar) 23.7	(similar) 27.9	(better) 32.6
% Meeting Physical Activity Guidelines	24.9	(similar) 21.7	(better) 19.9	(similar) 23.6	(better) 20.1
[County] Recreation/Fitness Facilities per 100,000	12.5	(better) 11.3	(better) 9.4	(better) 9.7	
% Child [Age 2-17] Physically Active 1+ Hours per Day	25.5	(similar) 34.3		(worse) 47.9	
			(better)	(similar)	(worse)

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

Oral Health	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
% [Age 18+] Dental Visit in Past Year	56.6	☁ 55.5	🌧 61.9	🌧 67.2	☀ 49.0
% Child [Age 2-17] Dental Visit in Past Year	76.5	☁ 73.3		🌧 90.7	☀ 49.0
% Have Dental Insurance	70.2	☀ 63.8		☁ 66.5	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

	☀ better	☁ similar	🌧 worse

Respiratory Diseases	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
[County] CLRD (Age-Adjusted Death Rate per 100,000)	43.2	☁ 44.2	🌧 38.8	☁ 41.4	
[County] Pneumonia/Influenza (Age-Adjusted Death Rate per 100,000)	11.3	🌧 9.9	🌧 9.2	☀ 15.1	
% COPD (Lung Disease)	10.5	☁ 11.6	☁ 7.6	☁ 9.5	
% [Adult] Currently Has Asthma	9.9	☁ 9.2	☁ 8.0	☁ 9.5	
% [Child 0-17] Currently Has Asthma	15.7	☁ 10.4		🌧 6.5	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

	☀ better	☁ similar	🌧 worse

Sexually Transmitted Diseases	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
[County] Gonorrhea Incidence per 100,000	142.8	⛈ 125.2	⛈ 107.1	⛈ 110.7	
[County] Chlamydia Incidence per 100,000	578.0	⛈ 463.3	⛈ 429.8	⛈ 456.1	
% [Unmarried 18-64] 3+ Sexual Partners in Past Year	15.3	⛅ 9.4		⛅ 10.3	
% [Unmarried 18-64] Using Condoms	40.2	⛅ 34.4		⛅ 44.5	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

	☀ better	⛅ similar	⛈ worse

Substance Abuse	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
[County] Cirrhosis/Liver Disease (Age-Adjusted Death Rate per 100,000)	10.0	☀ 12.8	☀ 11.0	⛅ 10.2	⛈ 8.2
% Current Drinker	62.3	⛅ 58.4	⛈ 54.4	⛅ 59.7	
% Excessive Drinker	27.2	⛅ 24.4		⛅ 22.2	⛅ 25.4
% Life Negatively Affected by Substance Abuse	37.9	⛅ 37.9		⛈ 32.2	
% Drinking & Driving in Past Month	9.1	⛅ 6.2		⛈ 4.1	
[County] Drug-Induced Deaths (Age-Adjusted Death Rate per 100,000)	13.5	☀ 18.0	⛅ 13.7	☀ 14.6	⛈ 11.3
% Illicit Drug Use in Past Month	9.5	⛈ 6.2		⛈ 3.0	⛅ 7.1
% Ever Sought Help for Alcohol or Drug Problem	8.3	☀ 5.0		☀ 4.1	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

	☀ better	⛅ similar	⛈ worse

Tobacco Use	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
% Current Smoker	14.1	☁ 16.1	☀ 17.7	☁ 14.0	☁ 12.0
% Someone Smokes at Home	18.4	☁ 15.0		🌧 10.2	
% [Nonsmokers] Someone Smokes in the Home	10.7	☁ 8.4		🌧 3.9	
% [Household With Children] Someone Smokes in the Home	20.8	☁ 16.8		🌧 10.2	
% Smoke Cigars	9.6	☁ 7.7		🌧 3.6	🌧 0.2
% Use Smokeless Tobacco	6.2	☁ 5.2	🌧 2.8	🌧 3.0	🌧 0.3
% Currently Use Electronic Cigarettes	6.4	☁ 6.0		☁ 3.8	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

☀ better   ☁ similar   🌧 worse

Vision	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
% Blindness/Trouble Seeing	7.6	☁ 9.3	☁ 6.0	☁ 7.3	
% Eye Exam in Past 2 Years	66.0	☁ 65.1		☀ 59.3	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

☀ better   ☁ similar   🌧 worse

Summary of Key Informant Concerns

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 20 health issues is a problem in their own community, using a scale of "major problem," "moderate problem," "minor problem" or "no problem at all."   The following chart summarizes their responses; these findings are also outlined throughout this report, along with the qualitative input describing reasons for their concerns.

Key Informants: Relative Position of Health Topics as Problems in the Community

Top-Ranked Issues

Issue	Major Problem	Moderate Problem
Mental Health	73.0%	25.4%
Diabetes	51.7%	29.3%
Substance Abuse	50.8%	35.6%
Heart Disease and Stroke	48.4%	27.4%
Nutrition, Physical Activity, and Weight	46.2%	38.5%
Oral Health/Dental Care	40.3%	38.7%
Dementia/Alzheimer's Disease	36.2%	43.1%
Injury and Violence	30.0%	45.0%
Access to Health Care Services	28.4%	43.3%
HIV/AIDS	28.1%	31.6%
Infant and Child Health	27.4%	40.3%
Cancer	26.2%	45.9%
Sexually Transmitted Diseases	25.0%	33.3%
Tobacco Use	22.0%	45.8%
Family Planning	20.0%	41.7%
Chronic Kidney Disease	18.2%	34.5%
Immunization and Infectious Diseases	15.8%	36.8%
Respiratory Diseases	15.0%	38.3%
Arthritis/Osteoporosis/Back Conditions	11.9%	40.7%
Hearing and Vision Conditions	5.6%	38.9%

■ Major Problem □ Moderate Problem □ Minor Problem □ No Problem At All

Data Charts &
Key Informant Input

The following sections present data from multiple sources, including the random sample PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey. Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.

Professional Research Consultants, Inc.

General Health Status

Overall Health Status

Self-Reported Health Status

The initial inquiry of the (random sample, population-based) PRC Community Health Survey asked respondents the following:

"Would you say that in general your health is: excellent, very good, good, fair or poor?"

Self-Reported Health Status
(SJH Service Area, 2016)
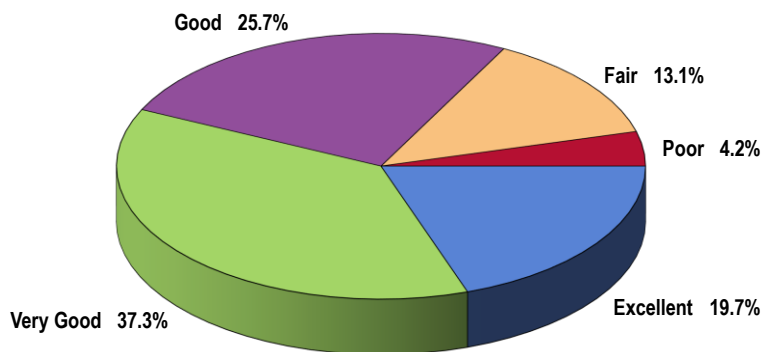
Good 25.7%
Fair 13.1%
Poor 4.2%
Excellent 19.7%
Very Good 37.3%

Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: ● Asked of all respondents.

The following charts further detail "fair/poor" overall health responses in the SJH Service Area in comparison to benchmark data, as well as by basic demographic characteristics (namely by gender, age groupings, income [based on poverty status], and race/ethnicity).

Experience "Fair" or "Poor" Overall Health

	SJH	BayCare Area	FL	US
	17.3%	20.3%	19.3%	18.3%
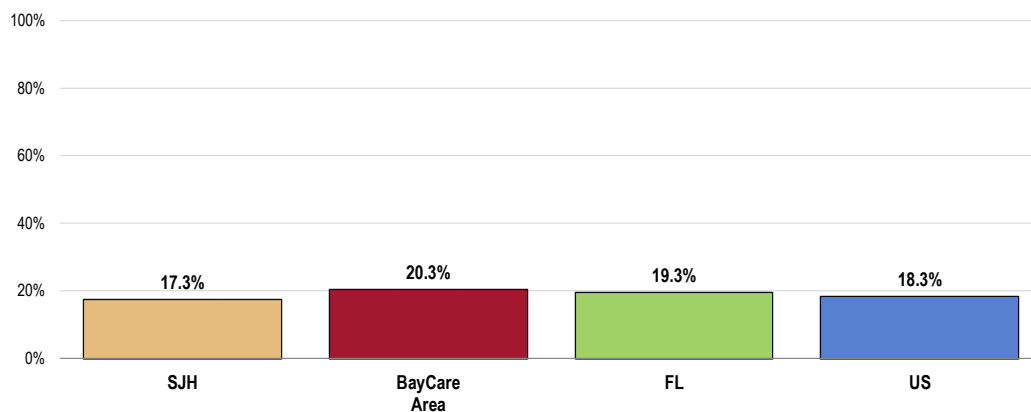
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Experience "Fair" or "Poor" Overall Health
(SJH Service Area, 2016)

Category	Percentage
Men	16.0%
Women	18.6%
18 to 39	5.3%
40 to 64	20.6%
65+	28.8%
Low Income	28.4%
Mid/High Income	9.1%
White	16.9%
Hispanic	13.6%
Other	22.3%
SJH	17.3%

Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; and "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Activity Limitations

About Disability & Health

An individual can get a disabling impairment or chronic condition at any point in life. Compared with people without disabilities, people with disabilities are more likely to:

- Experience difficulties or delays in getting the health care they need.
- Not have had an annual dental visit.
- Not have had a mammogram in past 2 years.
- Not have had a Pap test within the past 3 years.
- Not engage in fitness activities.
- Use tobacco.
- Be overweight or obese.
- Have high blood pressure.
- Experience symptoms of psychological distress.
- Receive less social-emotional support.
- Have lower employment rates.

There are many social and physical factors that influence the health of people with disabilities. The following three areas for public health action have been identified, using the International Classification of Functioning, Disability, and Health (ICF) and the three World Health Organization (WHO) principles of action for addressing health determinants.

- **Improve the conditions of daily life** by: encouraging communities to be accessible so all can live in, move through, and interact with their environment; encouraging community living; and removing barriers in the environment using both physical universal design concepts and operational policy shifts.
- **Address the inequitable distribution of resources among people with disabilities and those without disabilities** by increasing: appropriate health care for people with disabilities; education and work opportunities; social participation; and access to needed technologies and assistive supports.
- **Expand the knowledge base and raise awareness about determinants of health for people with disabilities** by increasing: the inclusion of people with disabilities in public health data collection efforts across the lifespan; the inclusion of people with disabilities in health promotion activities; and the expansion of disability and health training opportunities for public health and health care professionals.
- Healthy People 2020 (www.healthypeople.gov)

"Are you limited in any way in any activities because of physical, mental or emotional problems?"

Limited in Activities in Some Way
Due to a Physical, Mental or Emotional Problem
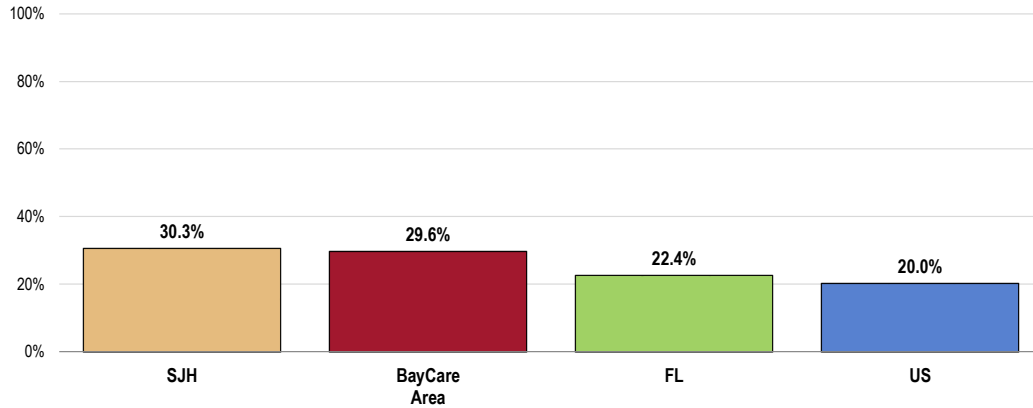
Bar chart values:
- SJH: 30.3%
- BayCare Area: 29.6%
- FL: 22.4%
- US: 20.0%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Limited in Activities in Some Way
Due to a Physical, Mental or Emotional Problem
(SJH Service Area, 2016)
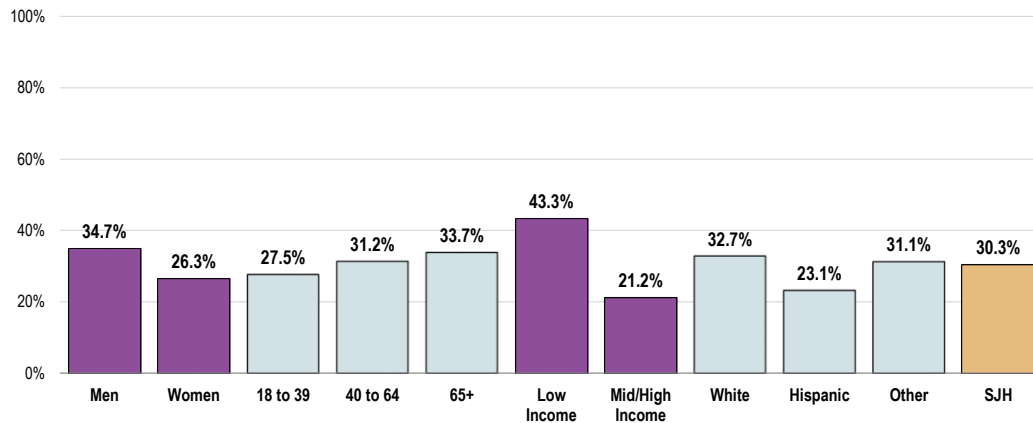
Bar chart values:
- Men: 34.7%
- Women: 26.3%
- 18 to 39: 27.5%
- 40 to 64: 31.2%
- 65+: 33.7%
- Low Income: 43.3%
- Mid/High Income: 21.2%
- White: 32.7%
- Hispanic: 23.1%
- Other: 31.1%
- SJH: 30.3%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; and "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Mental Health

About Mental Health & Mental Disorders

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death. Mental illness is the term that refers collectively to all diagnosable mental disorders. Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases.

Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person's ability to participate in treatment and recovery.

The existing model for understanding mental health and mental disorders emphasizes the interaction of social, environmental, and genetic factors throughout the lifespan. In behavioral health, researchers identify: **risk factors**, which predispose individuals to mental illness; and **protective factors**, which protect them from developing mental disorders. Researchers now know that the prevention of mental, emotional, and behavioral (MEB) disorders is inherently interdisciplinary and draws on a variety of different strategies. Over the past 20 years, research on the prevention of mental disorders has progressed. The major areas of progress include evidence that:

- MEB disorders are common and begin early in life.
- The greatest opportunity for prevention is among young people.
- There are multiyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment.
- The incidence of depression among pregnant women and adolescents can be reduced.
- School-based violence prevention can reduce the base rate of aggressive problems in an average school by 25 to 33%.
- There are potential indicated preventive interventions for schizophrenia.
- Improving family functioning and positive parenting can have positive outcomes on mental health and can reduce poverty-related risk.
- School-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes.
- Interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression in children and increasing effective parenting.
- Some preventive interventions have benefits that exceed costs, with the available evidence strongest for early childhood interventions.
- Implementation is complex, it is important that interventions be relevant to the target audiences.
- In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

- Healthy People 2020 (www.healthypeople.gov)

Self-Reported Mental Health Status

"Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair or poor?"

Self-Reported Mental Health Status
(SJH Service Area, 2016)
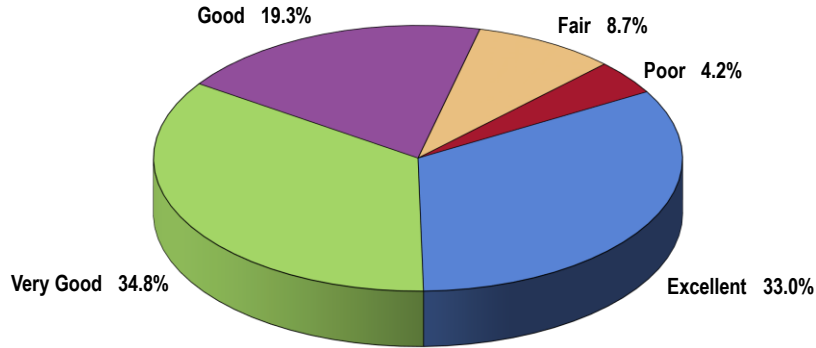
Good 19.3% Fair 8.7% Poor 4.2% Excellent 33.0% Very Good 34.8%

Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
Notes: • Asked of all respondents.

Experience "Fair" or "Poor" Mental Health
(SJH Service Area, 2016)
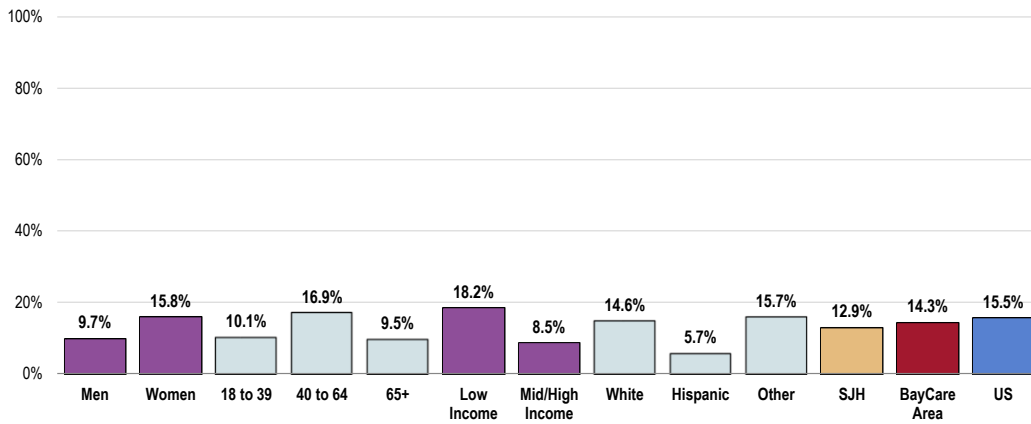
Men	9.7%
Women	15.8%
18 to 39	10.1%
40 to 64	16.9%
65+	9.5%
Low Income	18.2%
Mid/High Income	8.5%
White	14.6%
Hispanic	5.7%
Other	15.7%
SJH	12.9%
BayCare Area	14.3%
US	15.5%

Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
Notes: • Asked of all respondents.
• Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; and "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Depression

Diagnosed Depression: "Has a doctor or other healthcare provider ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?"

Have Been Diagnosed With a Depressive Disorder

Category	Percentage
SJH	20.9%
BayCare Area	20.0%
FL	16.2%
US	17.9%
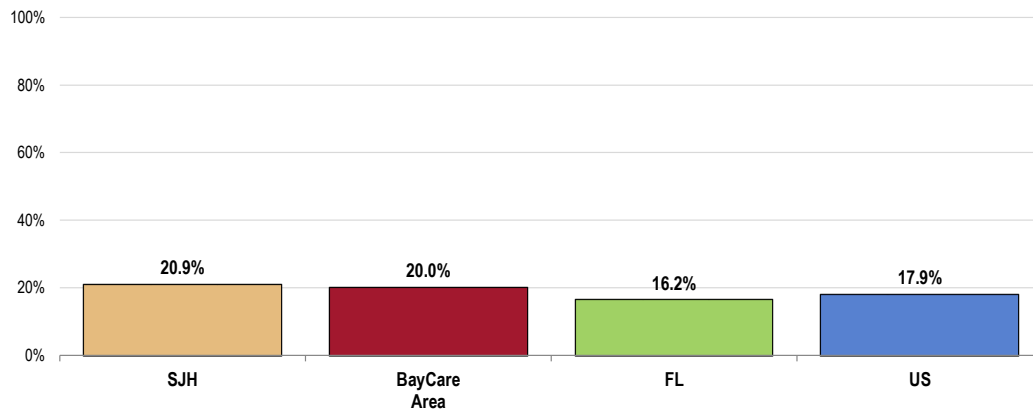
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 119]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.

Symptoms of Chronic Depression: "Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?"
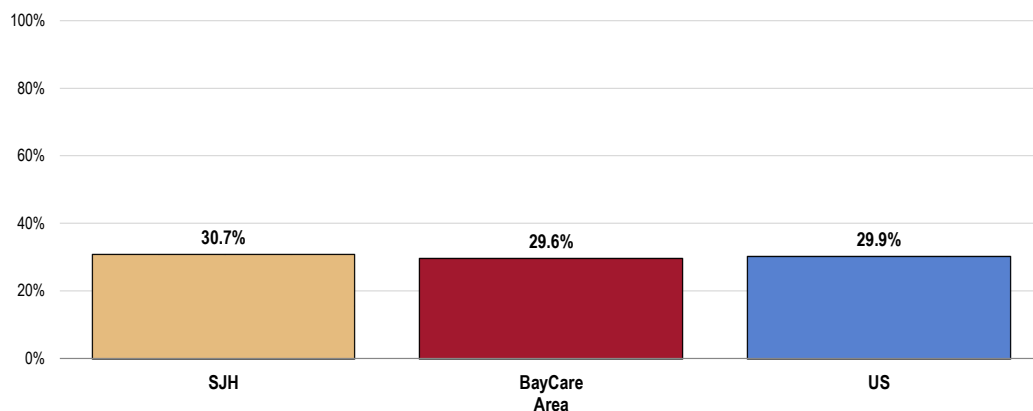
Have Experienced Symptoms of Chronic Depression

Category	Percentage
SJH	30.7%
BayCare Area	29.6%
US	29.9%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Have Experienced Symptoms of Chronic Depression
(SJH Service Area, 2016)
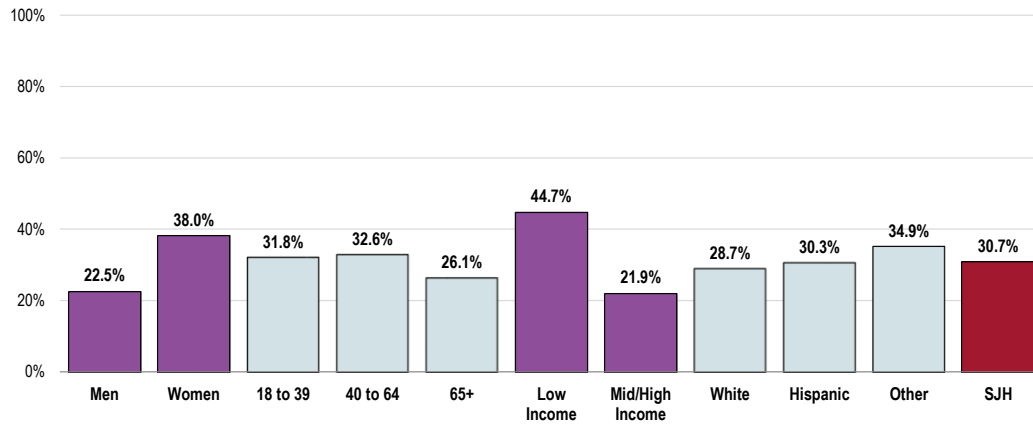
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]
Notes: ● Asked of all respondents.
● Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; and "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Suicide

The following chart outlines the most current age-adjusted mortality rates attributed to suicide in our population.

(Refer to "Leading Causes of Death" for an explanation of the use of age-adjusting for these rates.)

Suicide: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 10.2 or Lower
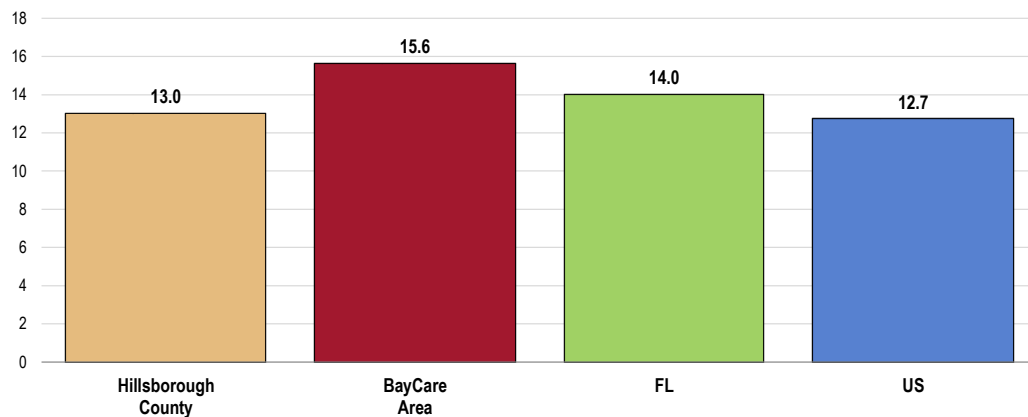
Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MHMD-1]
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Mental Health Treatment

"Have you ever sought help from a professional for a mental or emotional problem?"

"Are you now taking medication or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem?"

Mental Health Treatment

Legend: ☐ SJH ■ BayCare Area ■ US

Ever Sought Help for a Mental or Emotional Problem:
- SJH: 31.3%
- BayCare Area: 30.2%
- US: 27.4%

Currently Taking Medication/ Receiving Mental Health Treatment:
- SJH: 15.2%
- BayCare Area: 15.6%
- US: 13.6%
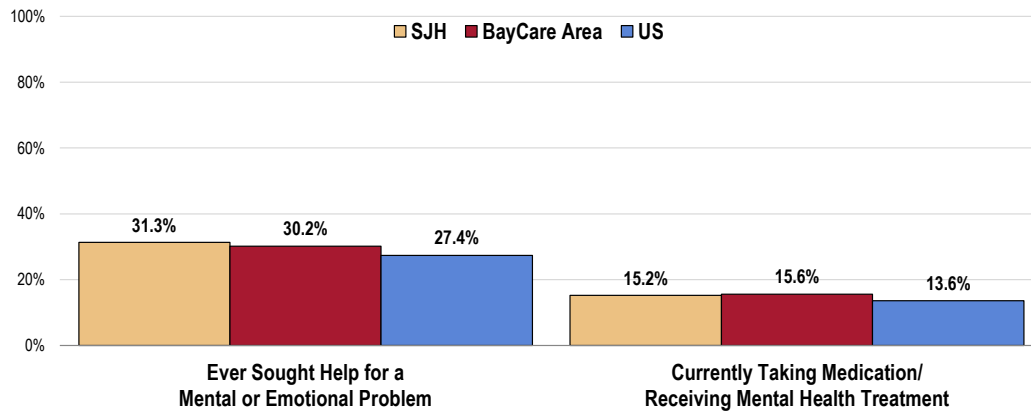
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 120-121]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Reflects the total sample of respondents.

"Was there a time in the past 12 months when you needed mental health services but were not able to get them?"

Unable to Get Mental Health Services When Needed in the Past Year
(SJH Service Area, 2016)

- Men: 3.6%
- Women: 11.9%
- 18 to 39: 13.6%
- 40 to 64: 7.6%
- 65+: 0.0%
- Low Income: 12.5%
- Mid/High Income: 5.9%
- White: 4.7%
- Hispanic: 14.1%
- Other: 8.7%
- SJH: 8.0%
- BayCare Area: 6.0%
- US: 4.4%
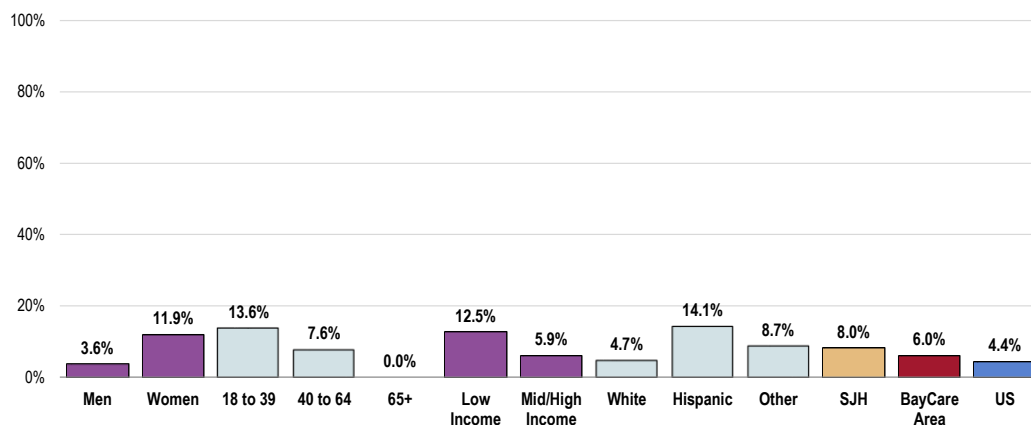
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 122]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; and "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Mental Health

The following chart outlines key informants' perceptions of the severity of *Mental Health* as a problem in the community:

Perceptions of Mental Health
as a Problem in the Community
(Key Informants, SJH Service Area, 2016)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All

73.0%	25.4%	

Sources: ● PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Challenges

Among those rating this issue as a "major problem," the following represent what key informants see as the main challenges for persons with mental illness:

Access to Care/Services

Need more community resources for mental health. More program options and affordable options are needed. – Social Services Provider

Waiting lists can be as long as six months for access to service. Capacity is limited. Clients do not have resources. Lack of recognition that mental health is a community concern and not a failing or weakness of an individual. – Public Health Representative

Getting the care they need in a timely and affordable way. – Physician

No access. Only Gracepoint as a resource. They are overrun with patients. They do not provide free care. Patients usually stop their medications when they feel better; and without a provider to oversee their care, they continue without care. – Other Health Provider

Outpatient care and coordination. – Other Health Provider

Lack of adequate resources, very limited number of providers. – Physician

Limited resources. – Public Health Representative

Lack of availability and lack of payers. – Physician

Lack of access to mental health services. – Social Services Provider

In Hillsborough County access to quality, affordable mental health counseling is challenging. Access to prescription medication for those with mental illness is also challenging. – Social Services Provider

Access to care. – Community Leader

Lack of resources, co-payment and deductibles. Medication costs, pharmaceutical. – Community Leader

Getting access to good quality care, especially in the outpatient arena. – Physician

There is a lack of resources for Mental Health. Patients with mental health issues are unable to obtain available resources due to mental health issues. There is a social stigma that accompanies mental illness. – Social Services Provider

Lack of access, resources. – Physician

Availability for services for the seriously mentally ill is very limited, with many of these folks on the streets with no treatment. – Community Leader

There are not currently enough providers to meet the needs of the number of requiring mental health services. Additionally, service provision is often costly and unavailable for those who are most vulnerable, those in low wage jobs and shift workers. – Other Health Provider

Access to evaluation and treatment, follow-up. Insurance limitations, access to medication. Adolescent and child psych is limited, especially as an outpatient. – Physician

Denial/Stigma

Stigma, lack of insurance access to best practice providers. – Physician

Stigmas surrounding mental health issues and people making the effort to seek the help they need and then finding providers that will take him. – Social Services Provider

Stigma associated with mental health. The cost for receiving counseling from licensed counselors. – Public Health Representative

Stigma of disease and reluctance to seek help. Patient, family inability to recognize mental health conditions. Cost barriers, lack of treatment providers. – Community Leader

Lack of Funding

Florida is 49th in the country for per capita funding. Majority of funding in Acute Care. It's like only having an Emergency Room to treat all form of illness. – Other Health Provider

No funding for psychological services, even though there is evidence that therapy is effective. Children on Medicaid have few resources for mental health, especially therapy. Limited adult care as well. – Community Leader

Mental health funding is not adequate to support increasing mental health issues in our community. – Public Health Representative

No access to care at all unless funded. – Physician

Insurance Issues

Insurance coverage for services that are desperately needed. – Physician

The lack of integrated insurance coverage for those with physical conditions who need to access mental health services in an outpatient basis, especially those with chronic conditions including obesity and all of its complications with heart disease. – Community Leader

They do not have insurance and cannot afford the services needed. – Social Services Provider

Co-Occurrences

I believe that behavioral health is a big issue that impacts general health. – Other Health Provider

Multi-factorial. – Public Health Representative

Prevalence/Incidence

This is the most crucial issue. – Community Leader

Mentally ill walking the street. – Public Health Representative

Medicare/Medicaid

The single biggest issue facing the state of Florida due to complete failure to accept Medicaid and coordinate funding to address the mental health crisis. – Social Services Provider

Death, Disease & Chronic Conditions

Leading Causes of Death

Distribution of Deaths by Cause

Cancers and cardiovascular disease (heart disease and stroke) are leading causes of death in the community.

Leading Causes of Death
(Hillsborough County, 2014)
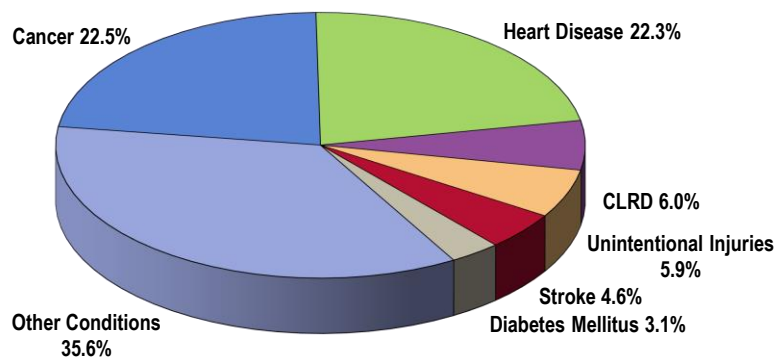
- Cancer 22.5%
- Heart Disease 22.3%
- CLRD 6.0%
- Unintentional Injuries 5.9%
- Stroke 4.6%
- Diabetes Mellitus 3.1%
- Other Conditions 35.6%

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- CLRD is chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

In order to compare mortality in the county with other localities (in this case, the state and the United States), it is necessary to look at *rates* of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these "age-adjusted" rates provides the most valuable means of gauging mortality against benchmark data, as well as *Healthy People 2020* targets.

The following chart outlines annual average age-adjusted death rates per 100,000 population for selected causes of death in the county. (For infant mortality data, see *Birth Outcomes & Risks* in the Births section of this report.)

Age-Adjusted Death Rates for Selected Causes
(2012-2014 Deaths per 100,000 Population)

	Hillsborough County	BayCare Area	Florida	US	HP2020
Diseases of the Heart	165.5	158.9	151.4	169.1	156.9*
Malignant Neoplasms (Cancers)	163.4	163.4	155.9	163.6	161.4
Unintentional Injuries	44.9	46.9	40.1	39.7	36.4
Chronic Lower Respiratory Disease (CLRD)	43.2	44.2	38.8	41.4	n/a
Cerebrovascular Disease (Stroke)	33.0	31.1	31.4	36.5	34.8
Diabetes Mellitus	21.5	21.6	19.2	21.1	20.5*
Alzheimer's Disease	21.2	18.2	17	24.2	n/a
Drug-Induced	13.5	18.0	13.7	14.6	11.3
Intentional Self-Harm (Suicide)	13.0	15.6	14.0	12.7	10.2
Motor Vehicle Deaths	12.2	12.0	12.0	10.6	12.4
Pneumonia/Influenza	11.3	9.9	9.2	15.1	n/a
Kidney Disease	10.7	10.1	10.8	13.2	n/a
Firearm-Related	10.2	11.0	11.9	10.4	9.3
Cirrhosis/Liver Disease	10.0	12.8	11.0	10.2	8.2
Homicide/Legal Intervention	5.4	5.1	6.3	5.2	5.5
HIV/AIDS	4.3	3.8	4.4	2.1	3.3

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov.

Note:
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population and coded using ICD-10 codes.
- *The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart; the Diabetes target is adjusted to reflect only diabetes mellitus-coded deaths.

Cardiovascular Disease

About Heart Disease & Stroke

Heart disease is the leading cause of death in the United States, with stroke following as the third leading cause. Together, heart disease and stroke are among the most widespread and costly health problems facing the nation today, accounting for more than $500 billion in healthcare expenditures and related expenses in 2010 alone. Fortunately, they are also among the most preventable.

The leading modifiable (controllable) risk factors for heart disease and stroke are:

- High blood pressure
- High cholesterol
- Cigarette smoking
- Diabetes
- Poor diet and physical inactivity
- Overweight and obesity

The risk of Americans developing and dying from cardiovascular disease would be substantially reduced if major improvements were made across the US population in diet and physical activity, control of high blood pressure and cholesterol, smoking cessation, and appropriate aspirin use.

The burden of cardiovascular disease is disproportionately distributed across the population. There are significant disparities in the following based on gender, age, race/ethnicity, geographic area, and socioeconomic status:

- Prevalence of risk factors
- Access to treatment
- Appropriate and timely treatment
- Treatment outcomes
- Mortality

Disease does not occur in isolation, and cardiovascular disease is no exception. Cardiovascular health is significantly influenced by the physical, social, and political environment, including: maternal and child health; access to educational opportunities; availability of healthy foods, physical education, and extracurricular activities in schools; opportunities for physical activity, including access to safe and walkable communities; access to healthy foods; quality of working conditions and worksite health; availability of community support and resources; and access to affordable, quality healthcare.

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease.   The following charts outline age-adjusted mortality rates for heart disease and for stroke in our community.

Heart Disease: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 156.9 or Lower (Adjusted)
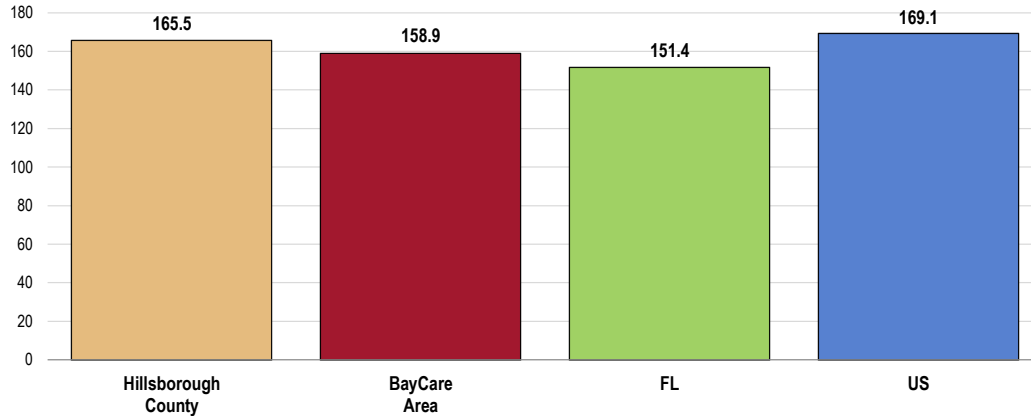
Hillsborough County	BayCare Area	FL	US
165.5	158.9	151.4	169.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-2]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart.

Stroke: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 34.8 or Lower
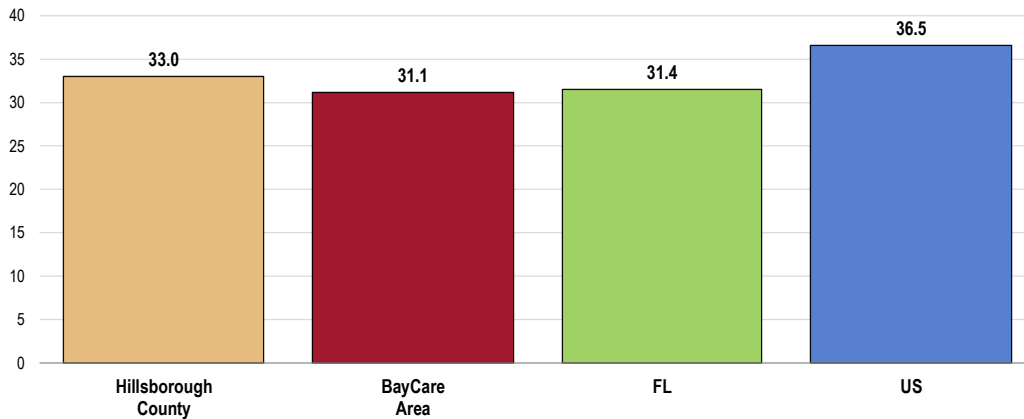
Hillsborough County	BayCare Area	FL	US
33.0	31.1	31.4	36.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-3]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Heart Disease & Stroke

"Has a doctor, nurse or other health professional ever told you that you had: A Heart Attack, Also Called a Myocardial Infarction; or Angina or Coronary Heart Disease?" (Heart disease prevalence below is a calculated prevalence that includes those responding affirmatively to either.)

"Has a doctor, nurse or other health professional ever told you that you had a stroke?"

Prevalence of Heart Disease

SJH	BayCare Area	US
7.4%	8.9%	6.9%
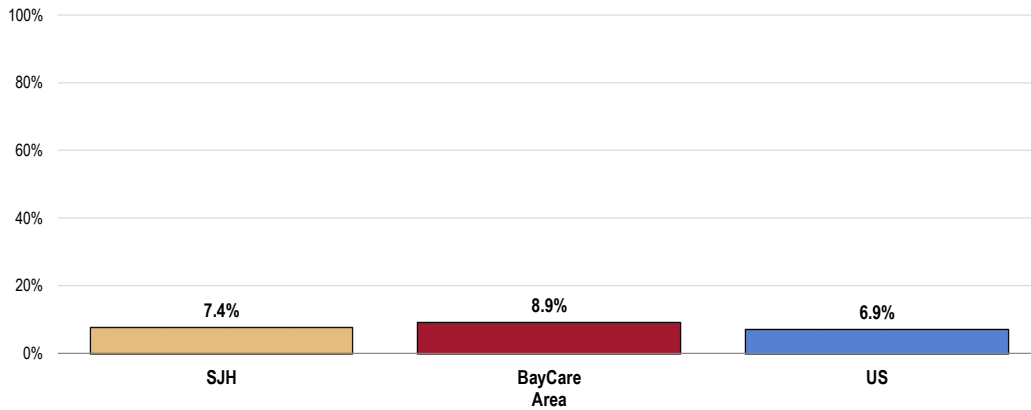
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 146]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.
● Includes diagnoses of heart attack, angina or coronary heart disease.

Prevalence of Stroke

SJH	BayCare Area	FL	US
3.4%	4.6%	3.4%	2.6%
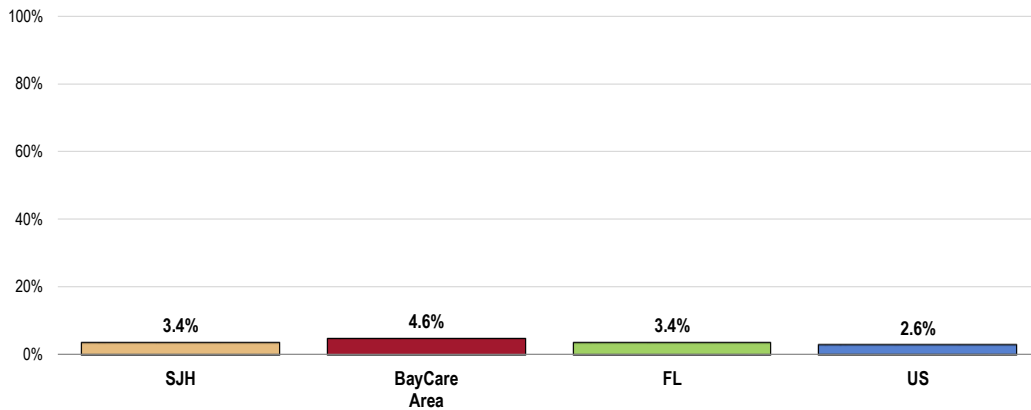
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 35]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.
Notes: ● Asked of all respondents.

Cardiovascular Risk Factors

About Cardiovascular Risk

Controlling risk factors for heart disease and stroke remains a challenge. High blood pressure and cholesterol are still major contributors to the national epidemic of cardiovascular disease. High blood pressure affects approximately 1 in 3 adults in the United States, and more than half of Americans with high blood pressure do not have it under control. High sodium intake is a known risk factor for high blood pressure and heart disease, yet about 90% of American adults exceed their recommendation for sodium intake.

- Healthy People 2020 (www.healthypeople.gov)

High Blood Pressure & Cholesterol Prevalence

"Have you ever been told by a doctor, nurse or other health care professional that you had high blood pressure?"

"Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?"

Prevalence of High Blood Pressure
Healthy People 2020 Target = 26.9% or Lower

Area	SJH	BayCare	FL	US
	44.2%	45.3%	34.6%	36.5%
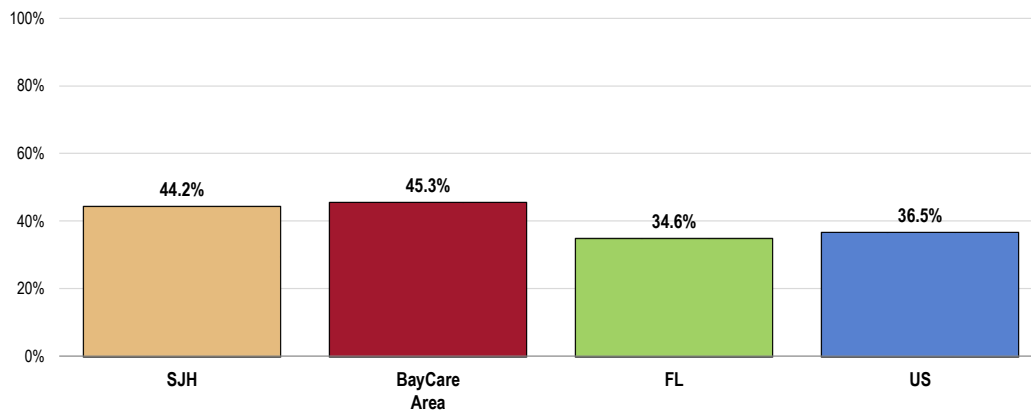
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 43, 147]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-5.1]

Notes:
- Asked of all respondents.

Prevalence of High Blood Cholesterol
Healthy People 2020 Target = 13.5% or Lower

	SJH	BayCare Area	US
	40.2%	40.6%	33.5%
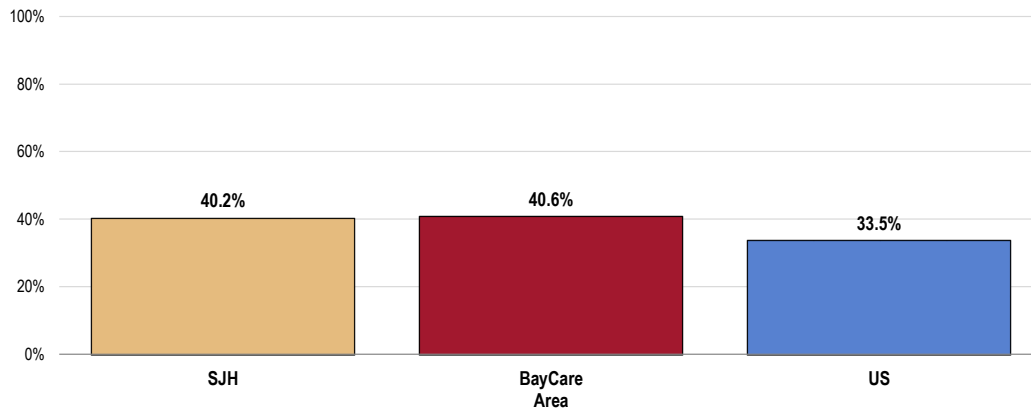
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 46, 148]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-7]

Notes:
- Asked of all respondents.

About Cardiovascular Risk

Individual level risk factors which put people at increased risk for cardiovascular diseases include:

- High Blood Pressure
- High Blood Cholesterol
- Tobacco Use
- Physical Inactivity
- Poor Nutrition
- Overweight/Obesity
- Diabetes

- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Three health-related behaviors contribute markedly to cardiovascular disease:

Poor nutrition. People who are overweight have a higher risk for cardiovascular disease. Almost 60% of adults are overweight or obese. To maintain a proper body weight, experts recommend a well-balanced diet which is low in fat and high in fiber, accompanied by regular exercise.

Lack of physical activity. People who are not physically active have twice the risk for heart disease of those who are active. More than half of adults do not achieve recommended levels of physical activity.

Tobacco use. Smokers have twice the risk for heart attack of nonsmokers. Nearly one-fifth of all deaths from cardiovascular disease, or about 190,000 deaths a year nationally, are smoking-related. Every day, more than 3,000 young people become daily smokers in the US

Modifying these behaviors is critical both for preventing and for controlling cardiovascular disease. Other steps that adults who have cardiovascular disease should take to reduce their risk of death and disability include adhering to treatment for high blood pressure and cholesterol, using aspirin as appropriate, and learning the symptoms of heart attack and stroke.

- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Total Cardiovascular Risk

The following chart reflects the percentage of adults in the SJH Service Area who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol. See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the Modifiable Health Risk section of this report.

Present One or More Cardiovascular Risks or Behaviors
(SJH Service Area, 2016)

	Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Hispanic	Other	SJH	BayCare Area	US
	94.6%	82.0%	80.1%	91.5%	93.0%	91.6%	87.1%	85.4%	93.1%	89.4%	88.0%	87.8%	83.0%
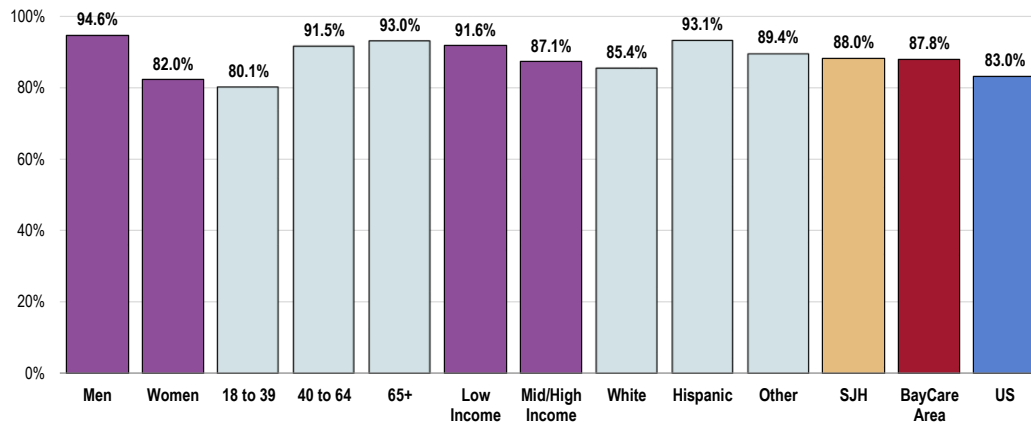
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 149]
Notes: ● Asked of all respondents.
● Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; and "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants' perceptions of the severity of *Heart Disease & Stroke* as a problem in the community:

Perceptions of Heart Disease and Stroke
as a Problem in the Community
(Key Informants, SJH Service Area, 2016)

■ Major Problem   ■ Moderate Problem   ■ Minor Problem   ■ No Problem At All

Major Problem	Moderate Problem	Minor Problem	No Problem At All
48.4%	27.4%	17.7%	6.5%
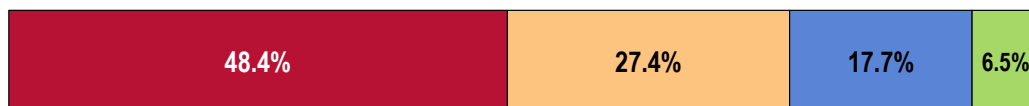
Sources: ● PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

Highly prevalent, but limited prevention efforts. We have great resources to treat and minimal efforts at impactful prevention. – Physician

Tampa Bay is above the national average for percentage of adults with heart disease, 5.5% over national, 4.4%, percent of adults with high BP, 50% over 28% percent of adults with high cholesterol, 44% over 38%, heart disease mortality rate. – Community Leader

Incidence data. – Public Health Representative

The numbers of persons affected is the primary reason. – Public Health Representative

Large number of victims. – Physician

Federally Qualified Health Center Partners report this is a major health problem among their patient population. Additionally, heart disease is the leading cause of mortality for Hillsborough County. – Social Services Provider

Leading Cause of Death

I know way too many people who have died from a heart attack or stroke. – Community Leader

CV diseases remain among the leading cause of death nationally, which is mirrored locally. The demographics of an aging population and associated risk factors. Obesity, lack of exercise, inadequate control of blood pressure and cholesterol. – Community Leader

Again many admissions due to heart disease; it's the nation's number one killer. People need to make better nutrition and healthy lifestyle changes to improve health. – Social Services Provider

Major cause of death and morbidity. – Public Health Representative

Cause of death. – Physician

Leading cause of global death, likely also Hillsborough County's leading cause. – Community Leader

Co-Occurrences

I believe heart disease and stroke are major problems due to the high rates of hypertension and obesity in our community. – Social Services Provider

People do not eat properly or exercise enough. – Community Leader

Heart disease is often an extension of diabetes and obesity. I also am aware of a higher incidence of heart disease among lower income minorities. – Community Leader

Health Education

Lack of understanding, fear of unknown and silent killer. No access, cardiologist not available for free care. – Other Health Provider

Lack of knowledge on how to build a healthy foundation and focus on preventative care. – Community Leader

Aging Population

Aging population more often affected, also linked to diet and life style. – Public Health Representative

Disease Management

Monitoring and medication. – Other Health Provider

Obesity

The obesity epidemic. – Public Health Representative

Cancer

About Cancer

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half will be alive in five years. Yet, cancer remains a leading cause of death in the United States, second only to heart disease.

Many cancers are preventable by reducing risk factors such as: use of tobacco products; physical inactivity and poor nutrition; obesity; and ultraviolet light exposure. Other cancers can be prevented by getting vaccinated against human papillomavirus and hepatitis B virus. In the past decade, overweight and obesity have emerged as new risk factors for developing certain cancers, including colorectal, breast, uterine corpus (endometrial), and kidney cancers. The impact of the current weight trends on cancer incidence will not be fully known for several decades. Continued focus on preventing weight gain will lead to lower rates of cancer and many chronic diseases.

Screening is effective in identifying some types of cancers (see US Preventive Services Task Force [USPSTF] recommendations), including:

- Breast cancer (using mammography)
- Cervical cancer (using Pap tests)
- Colorectal cancer (using fecal occult blood testing, sigmoidoscopy, or colonoscopy)
- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Cancer Deaths

The following chart illustrates age-adjusted cancer mortality (all types) in the area.

Cancer: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 161.4 or Lower
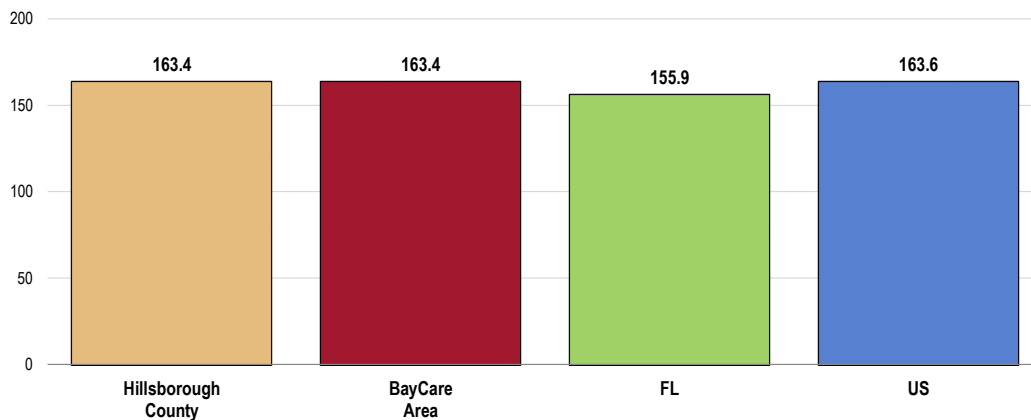
	Hillsborough County	BayCare Area	FL	US
	163.4	163.4	155.9	163.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-1]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Lung cancer is by far the leading cause of cancer deaths in the area. Other leading sites include breast cancer among women, prostate cancer among men, and colorectal cancer (both genders).

Age-Adjusted Cancer Death Rates by Site
(2012-2014 Annual Average Deaths per 100,000 Population)

	Hillsborough County	BayCare Area	Florida	US	HP2020
ALL CANCERS	163.4	163.4	155.9	163.6	161.4
Lung Cancer	45.4	48.6	42.7	43.4	45.5
Female Breast Cancer	20.7	20.4	19.9	20.9	20.7
Prostate Cancer	19.0	15.7	17.2	19.2	21.8
Colorectal Cancer	14.6	13.6	13.6	14.6	14.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov

Cancer Incidence

Incidence rates (or case rates) reflect the number of newly diagnosed cases in a given population in a given year, regardless of outcome. They are usually expressed as cases per 100,000 population per year. Here, these rates are also age-adjusted.

Cancer Incidence Rates by Site
(Annual Average Age-Adjusted Incidence per 100,000 Population, 2008-2012)
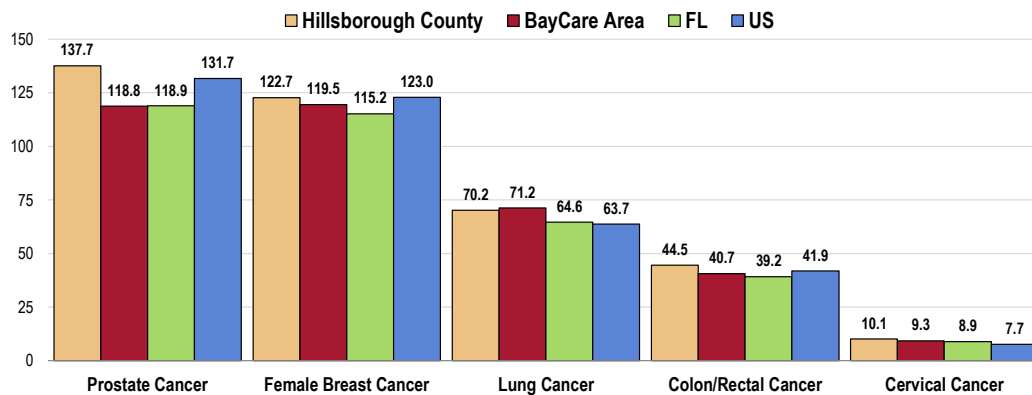
Sources:
- State Cancer Profiles.
- Retrieved May 2016 from Community Commons at http://www.chna.org.

Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Cancer Risk

About Cancer Risk

Reducing the nation's cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.

- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor's checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

Screening levels in the community were measured in the PRC Community Health Survey relative to: female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).

Female Breast Cancer Screening

About Screening for Breast Cancer

The US Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women age 40 and older.

Rationale: The USPSTF found fair evidence that mammography screening every 12-33 months significantly reduces mortality from breast cancer. Evidence is strongest for women age 50-69, the age group generally included in screening trials. For women age 40-49, the evidence that screening mammography reduces mortality from breast cancer is weaker, and the absolute benefit of mammography is smaller, than it is for older women. Most, but not all, studies indicate a mortality benefit for women undergoing mammography at ages 40-49, but the delay in observed benefit in women younger than 50 makes it difficult to determine the incremental benefit of beginning screening at age 40 rather than at age 50.

The absolute benefit is smaller because the incidence of breast cancer is lower among women in their 40s than it is among older women. The USPSTF concluded that the evidence is also generalizable to women age 70 and older (who face a higher absolute risk for breast cancer) if their life expectancy is not compromised by comorbid disease. The absolute probability of benefits of regular mammography increase along a continuum with age, whereas the likelihood of harms from screening (false-positive results and unnecessary anxiety, biopsies, and cost) diminish from ages 40-70. The balance of benefits and potential harms, therefore, grows more favorable as women age. The precise age at which the potential benefits of mammography justify the possible harms is a subjective choice. The USPSTF did not find sufficient evidence to specify the optimal screening interval for women age 40-49.

- US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Breast Cancer Screening: **"A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?"** (Calculated below among women age 50 to 74 indicating screening within the past 2 years.)

Have Had a Mammogram in the Past Two Years
(Among Women Age 50-74)
Healthy People 2020 Target = 81.1% or Higher

SJH	BayCare Area	FL	US
81.2%	78.3%	78.5%	80.3%
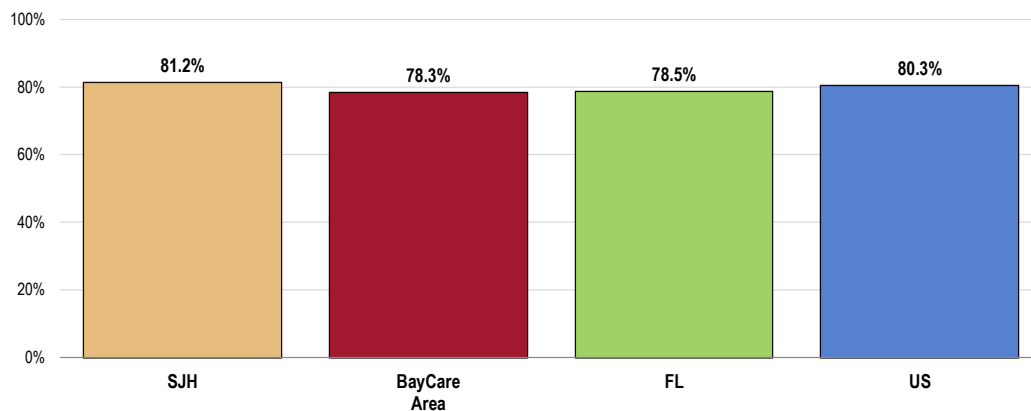
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 151]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-17]

Notes:
- Reflects female respondents 50-74.

Cervical Cancer Screenings

About Screening for Cervical Cancer

The US Preventive Services Task Force (USPSTF) strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.

Rationale: The USPSTF found good evidence from multiple observational studies that screening with cervical cytology (Pap smears) reduces incidence of and mortality from cervical cancer. Direct evidence to determine the optimal starting and stopping age and interval for screening is limited. Indirect evidence suggests most of the benefit can be obtained by beginning screening within 3 years of onset of sexual activity or age 21 (whichever comes first) and screening at least every 3 years. The USPSTF concludes that the benefits of screening substantially outweigh potential harms.

The USPSTF recommends against routinely screening women older than age 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer.

Rationale: The USPSTF found limited evidence to determine the benefits of continued screening in women older than 65. The yield of screening is low in previously screened women older than 65 due to the declining incidence of high-grade cervical lesions after middle age. There is fair evidence that screening women older than 65 is associated with an increased risk for potential harms, including false-positive results and invasive procedures. The USPSTF concludes that the potential harms of screening are likely to exceed benefits among older women who have had normal results previously and who are not otherwise at high risk for cervical cancer.

Rationale: The USPSTF found fair evidence that the yield of cytologic screening is very low in women after hysterectomy and poor evidence that screening to detect vaginal cancer improves health outcomes. The USPSTF concludes that potential harms of continued screening after hysterectomy are likely to exceed benefits.

- US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Cervical Cancer Screening: **"A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?"** (Calculated below among women age 21 to 65 indicating screening within the past 3 years.)

Have Had a Pap Smear in the Past Three Years
(Among Women Age 21-65)
Healthy People 2020 Target = 93.0% or Higher

Category	Percentage
SJH	74.6%
BayCare Area	69.4%
FL	79.5%
US	83.8%
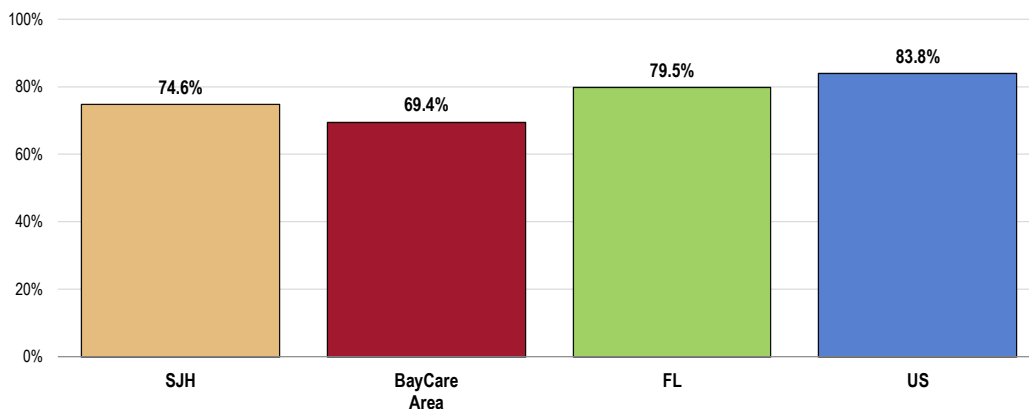
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 152]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-15]

Notes:
- Reflects female respondents age 21 to 65.

Colorectal Cancer Screenings

About Screening for Colorectal Cancer

The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years.

The evidence is convincing that screening for colorectal cancer with fecal occult blood testing, sigmoidoscopy, or colonoscopy detects early-stage cancer and adenomatous polyps. There is convincing evidence that screening with any of the three recommended tests (FOBT, sigmoidoscopy, colonoscopy) reduces colorectal cancer mortality in adults age 50 to 75 years. Follow-up of positive screening test results requires colonoscopy regardless of the screening test used.

- US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Colorectal Cancer Screening: **"Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?"** and **"A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?"** (Calculated below among both genders age 50 to 75 indicating fecal occult blood testing within the past year and/or sigmoidoscopy/colonoscopy [lower endoscopy] within the past 10 years.)

Have Had a Colorectal Cancer Screening
(Among Adults Age 50-75)
Healthy People 2020 Target = 70.5% or Higher

Area	Percentage
SJH	80.1%
BayCare	79.1%
FL	66.6%
US	74.5%
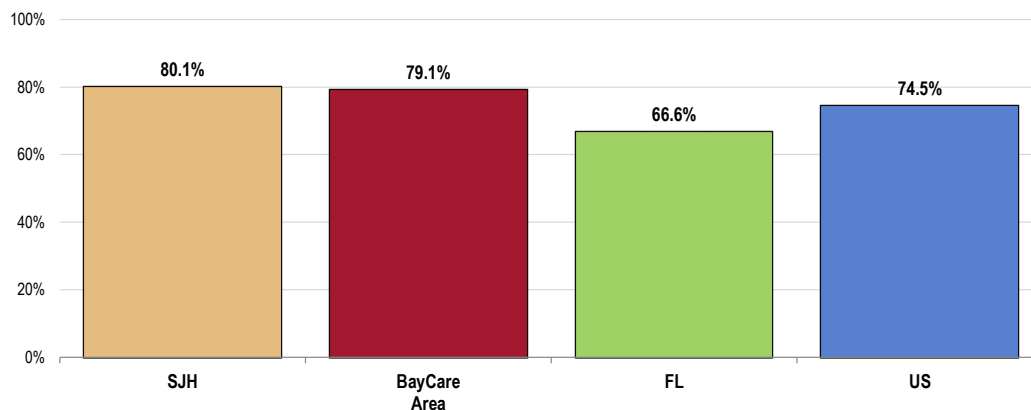
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 155]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-16]

Notes:
- Asked of all respondents age 50 through 75.
- In this case, the term "colorectal screening" refers to adults age 50-75 receiving a FOBT (fecal occult blood test) in the past year and/or a lower endoscopy (sigmoidoscopy/colonoscopy) in the past 10 years.

Key Informant Input: Cancer

The following chart outlines key informants' perceptions of the severity of *Cancer* as a problem in the community:

Perceptions of Cancer
as a Problem in the Community
(Key Informants, SJH Service Area, 2016)
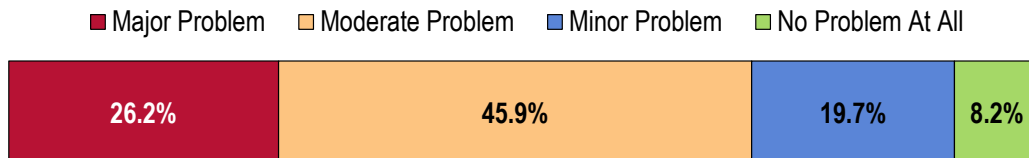
■ Major Problem   ▢ Moderate Problem   ■ Minor Problem   ▢ No Problem At All

Major Problem	Moderate Problem	Minor Problem	No Problem At All
26.2%	45.9%	19.7%	8.2%

Sources: ● PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

It affects almost every single person in this county in one way or another and is the number one cause of death in the US – Community Leader

Health indicator data shows high incidence. – Public Health Representative

The sheer numbers and many could be mitigated by lifestyle choices. – Social Services Provider

Cancer will affect a high number of people in their lifetime, one out of three. Environment, lifestyle, and bad luck or factors. Screening and treatment are important, and there are some prevention measures. – Public Health Representative

Approximately, 1 out of 2 men and 1 out of 3 women in the US will be personally diagnosed with cancer in their lifetime. In Hillsborough County, cancer is the second leading cause of death. Incidence for specific cancers, breast, cervical, colorectal. – Social Services Provider

We see quite a bit in the hospitals. – Physician

Increasing ranks of cancer. Our community needs to focus on education, screening, early detection and treatment. – Social Services Provider

Aging Population

We have an aging community and multiple, multiple cancer specialty centers, free standing cancer evaluation and treatment centers. – Physician

Our area has a large and growing senior citizen population. Decade ago, this was primarily a snow bird population, spending 3-6 months in our area. These snow birds sought non-emergency care in their home state. Recently retirees are staying. – Community Leader

Diagnosis/Treatment

Cancer is a menacing disease that often is undetected and/or untreated in its early stages. This presents one of the reasons why individuals who either don't utilize healthcare coverage or don't have healthcare coverage. – Other Health Provider

Late stage cancer diagnosis due to lack of availability and/or affordability of specialists and diagnostics for uninsured, low-income patients. Lack of resources for undocumented patients. – Social Services Provider

Leading Cause of Death

I hear about more and more people dying with cancer. – Other Health Provider

Number two cause of death. – Physician

Affordable Care/Services

> *The access to cancer treatment is very difficult for uninsured and underinsured. – Community Leader*

Tobacco Use

> *Our community is above the national average for tobacco use and expenditures. – Community Leader*

Respiratory Disease

About Asthma & COPD

Asthma and chronic obstructive pulmonary disease (COPD) are significant public health burdens. Specific methods of detection, intervention, and treatment exist that may reduce this burden and promote health.

Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life threatening. Symptoms of asthma include wheezing, coughing, chest tightness, and shortness of breath. Daily preventive treatment can prevent symptoms and attacks and enable individuals who have asthma to lead active lives.

COPD is a preventable and treatable disease characterized by airflow limitation that is not fully reversible. The airflow limitation is usually progressive and associated with an abnormal inflammatory response of the lung to noxious particles or gases (typically from exposure to cigarette smoke). Treatment can lessen symptoms and improve quality of life for those with COPD.

The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Because of the cost to the healthcare system, the burden of respiratory diseases also falls on society; it is paid for with higher health insurance rates, lost productivity, and tax dollars. Annual healthcare expenditures for asthma alone are estimated at $20.7 billion.

Asthma. The prevalence of asthma has increased since 1980. However, deaths from asthma have decreased since the mid-1990s. The causes of asthma are an active area of research and involve both genetic and environmental factors.

Risk factors for asthma currently being investigated include:

- Having a parent with asthma
- Sensitization to irritants and allergens
- Respiratory infections in childhood
- Overweight

Asthma affects people of every race, sex, and age. However, significant disparities in asthma morbidity and mortality exist, in particular for low-income and minority populations. Populations with higher rates of asthma include: children; women (among adults) and boys (among children); African Americans; Puerto Ricans; people living in the Northeast United States; people living below the Federal poverty level; and employees with certain exposures in the workplace.

While there is not a cure for asthma yet, there are diagnoses and treatment guidelines that are aimed at ensuring that all people with asthma live full and active lives.

- Healthy People 2020 (www.healthypeople.gov)

[NOTE: COPD was changed to chronic lower respiratory disease (CLRD) with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.]

Age-Adjusted Respiratory Disease Deaths

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis.

Pneumonia and influenza mortality is also illustrated in the following charts. For prevalence of vaccinations against pneumonia and influenza, see also *Immunization & Infectious Disease*.

CLRD: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)
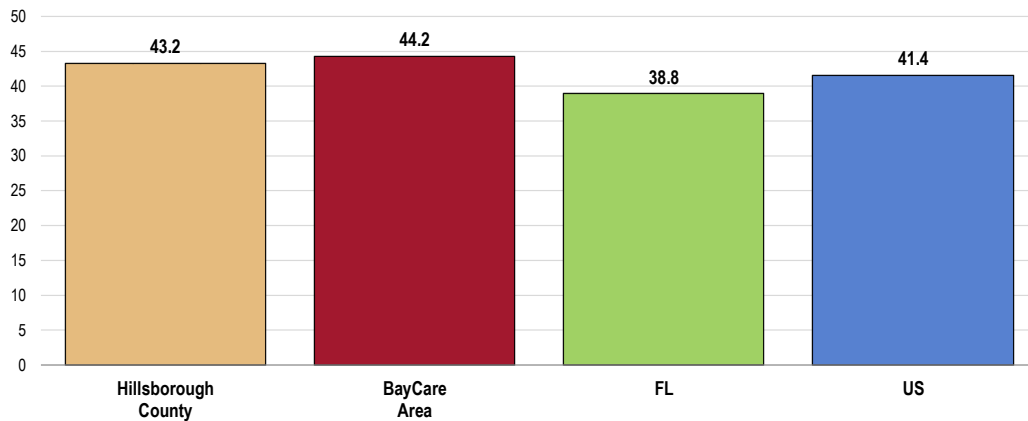
Hillsborough County	BayCare Area	FL	US
43.2	44.2	38.8	41.4

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
● CLRD is chronic lower respiratory disease.

Pneumonia/Influenza: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)
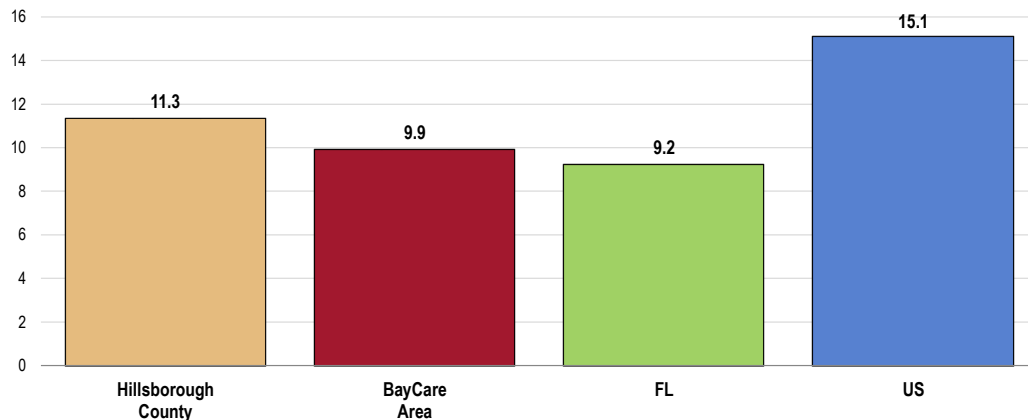
Hillsborough County	BayCare Area	FL	US
11.3	9.9	9.2	15.1

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Respiratory Diseases

COPD

"Would you please tell me if you have ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema?"

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)

	SJH	BayCare Area	FL	US
	10.5%	11.6%	7.6%	9.5%
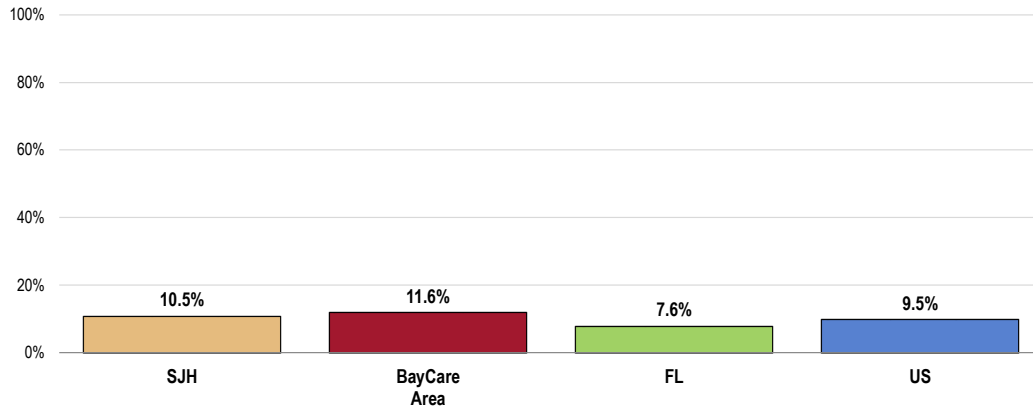
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 24]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

Asthma

Adults: **"Have you ever been told by a doctor, nurse, or other health professional that you had asthma?"** and **"Do you still have asthma?"** (Calculated below as a prevalence of all adults who have ever been diagnosed with asthma and who still have asthma ["current asthma"].)

Children: **"Has a doctor or other health professional ever told you that this child had asthma?"** and **"Does this child still have asthma?"** (Calculated below as a prevalence of all children who have ever been diagnosed with asthma and who still have asthma ["current asthma"].)

Adult Asthma: Current Prevalence

SJH	BayCare Area	FL	US
9.9%	9.2%	8.0%	9.5%
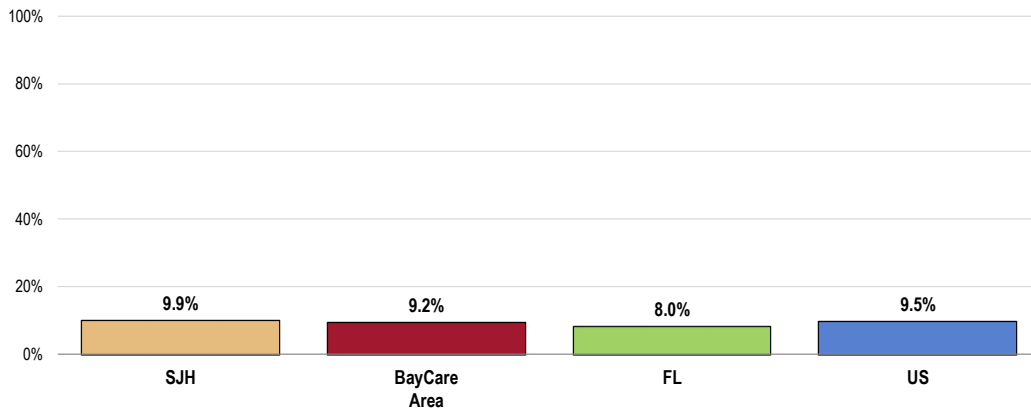
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 156]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.

Notes:
- Asked of all respondents.
- Includes those who have ever been diagnosed with asthma, and who report that they still have asthma.

Childhood Asthma: Current Prevalence
(Among Parents of Children Age 0-17)

SJH	BayCare Area	US
15.7%	10.4%	6.5%
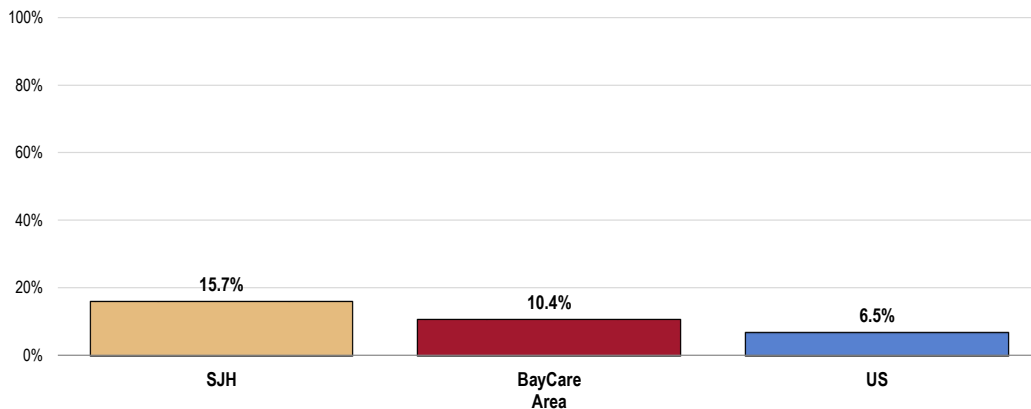
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 157]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.
- Includes children who have ever been diagnosed with asthma, and whom are reported to still have asthma.

Key Informant Input: Respiratory Disease

The following chart outlines key informants' perceptions of the severity of *Respiratory Disease* as a problem in the community:

**Perceptions of Respiratory Diseases
as a Problem in the Community**
(Key Informants, SJH Service Area, 2016)
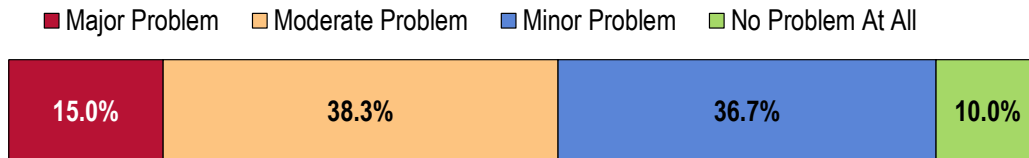
■ Major Problem ☐ Moderate Problem ■ Minor Problem ☐ No Problem At All

| 15.0% | 38.3% | 36.7% | 10.0% |

Sources: ● PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

High incidence of asthma, COPD and such. – Social Services Provider

Asthma in children is increasing and with higher number of Emergency Room visits and hospitalizations. Adherence to treatment and understanding of the disease is an issue. Adult respiratory diseases are debilitating. – Public Health Representative

COPD, smoking. – Physician

Environmental Contributors

Poor environmental protection, less regulation. – Community Leader

Health Education

Asthma. Poor understanding of what asthma is, what triggers are in the home and school. What medications are available and how medications should be taken. – Physician

Injury & Violence

About Injury & Violence

Injuries and violence are widespread in society. Both unintentional injuries and those caused by acts of violence are among the top 15 killers for Americans of all ages. Many people accept them as "accidents," "acts of fate," or as "part of life." However, most events resulting in injury, disability, or death are predictable and preventable.

Injuries are the leading cause of death for Americans ages 1 to 44, and a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status. More than 180,000 people die from injuries each year, and approximately 1 in 10 sustains a nonfatal injury serious enough to be treated in a hospital emergency department.

Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to:

- Premature death
- Disability
- Poor mental health
- High medical costs
- Lost productivity

The effects of injuries and violence extend beyond the injured person or victim of violence to family members, friends, coworkers, employers, and communities.

Numerous factors can affect the risk of unintentional injury and violence, including individual behaviors, physical environment, access to health services (ranging from pre-hospital and acute care to rehabilitation), and social environment (from parental monitoring and supervision of youth to peer group associations, neighborhoods, and communities).

Interventions addressing these social and physical factors have the potential to prevent unintentional injuries and violence. Efforts to prevent unintentional injury may focus on:

- Modifications of the environment
- Improvements in product safety
- Legislation and enforcement
- Education and behavior change
- Technology and engineering

Efforts to prevent violence may focus on:

- Changing social norms about the acceptability of violence
- Improving problem-solving skills (for example, parenting, conflict resolution, coping)
- Changing policies to address the social and economic conditions that often give rise to violence

- Healthy People 2020 (www.healthypeople.gov)

Leading Causes of Accidental Death

Leading causes of accidental death in the area include the following:

Leading Causes of Accidental Death
(Hillsborough County, 2012-2014)
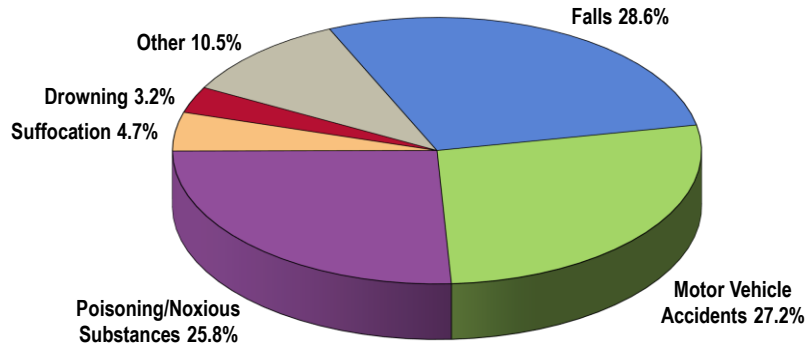
- Falls 28.6%
- Other 10.5%
- Drowning 3.2%
- Suffocation 4.7%
- Poisoning/Noxious Substances 25.8%
- Motor Vehicle Accidents 27.2%

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

The following chart outlines age-adjusted mortality rates for unintentional injury in the area.

Unintentional Injuries: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 36.4 or Lower
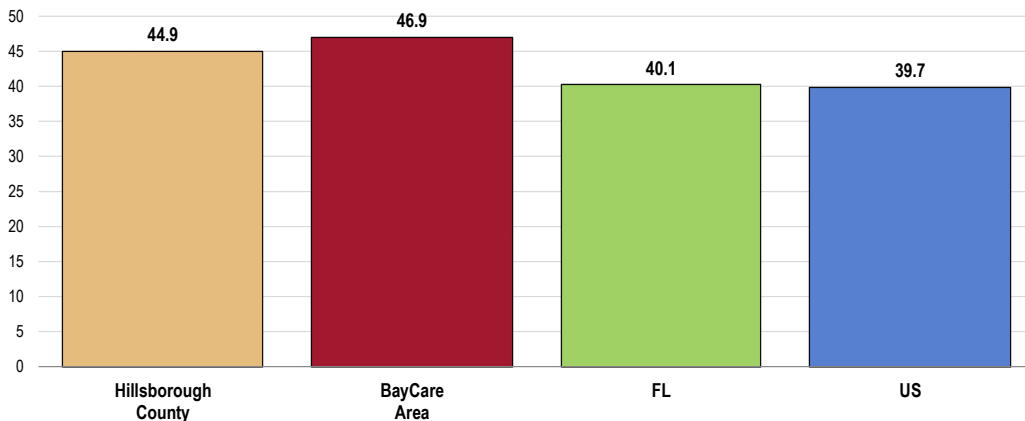
	Hillsborough County	BayCare Area	FL	US
	44.9	46.9	40.1	39.7

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-11]
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Age-Adjusted Deaths for Selected Injury-Related Causes

The following chart outlines age-adjusted mortality rates for drug-induced deaths and motor vehicle crash deaths.
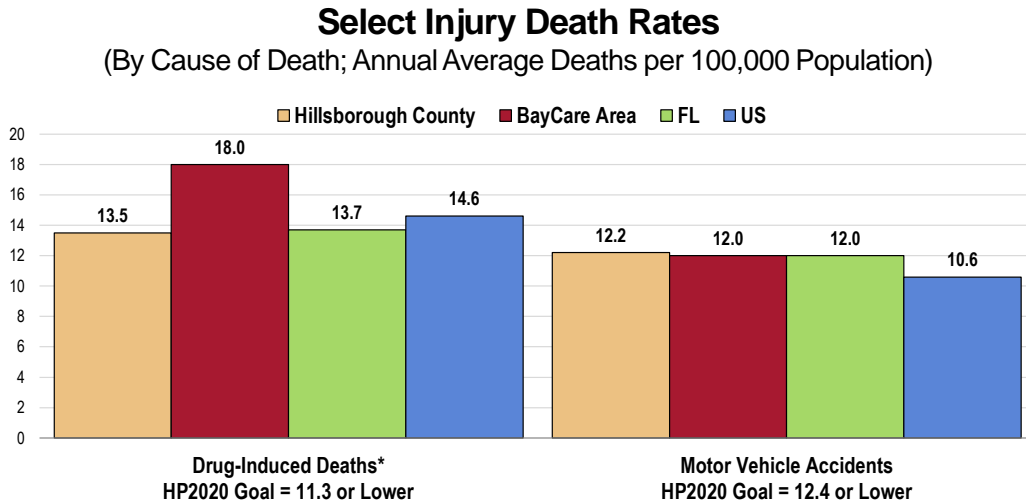
Select Injury Death Rates
(By Cause of Death; Annual Average Deaths per 100,000 Population)

Legend: ☐ Hillsborough County ■ BayCare Area ☐ FL ■ US

	Drug-Induced Deaths* HP2020 Goal = 11.3 or Lower	Motor Vehicle Accidents HP2020 Goal = 12.4 or Lower
Hillsborough County	13.5	12.2
BayCare Area	18.0	12.0
FL	13.7	12.0
US	14.6	10.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-13.1, IVP-23.2, SA-12]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- *Drug-induced deaths include both intentional and unintentional drug overdoses.

Intentional Injury (Violence)

Homicide

Age-adjusted mortality attributed to homicide is shown below.
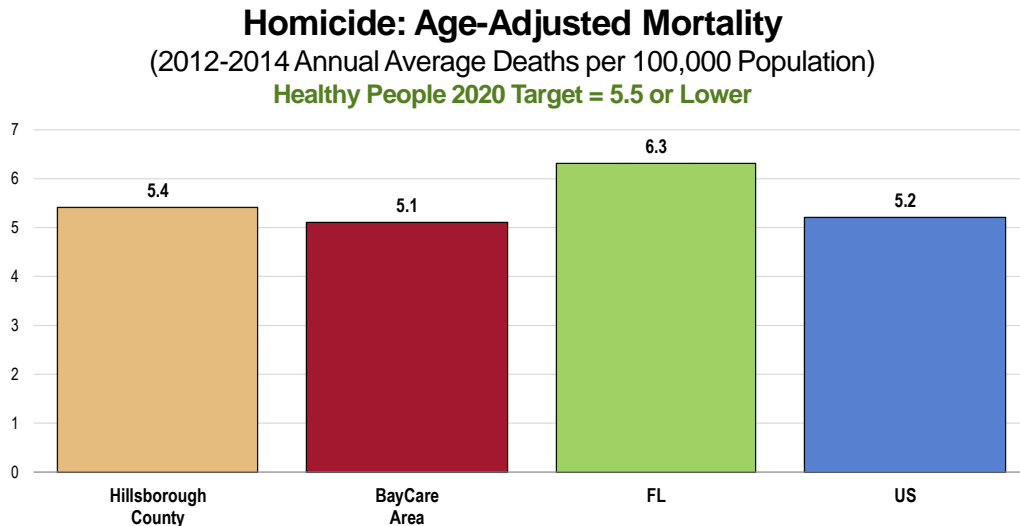
Homicide: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 5.5 or Lower

Hillsborough County	BayCare Area	FL	US
5.4	5.1	6.3	5.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IVP-29]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Violent Crime

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault. Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

Violent Crime
(Rate per 100,000 Population, 2010-2012)

Hillsborough County	BayCare Area	FL	US
394.3	455.5	514.6	395.5
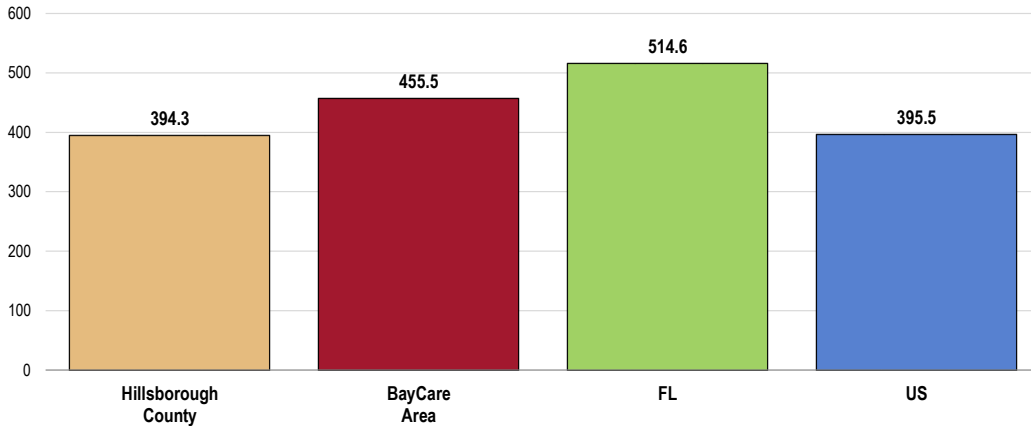
Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Retrieved May 2016 from Community Commons at http://www.chna.org.

Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics, but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

Violent Crime Experience: **"Have you been the victim of a violent crime in your area in the past 5 years?"**

Victim of a Violent Crime in the Past Five Years
(SJH Service Area, 2016)

Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Hispanic	Other	SJH	BayCare Area	US
7.3%	5.1%	10.7%	3.2%	3.7%	14.5%	1.3%	2.7%	10.9%	9.4%	6.2%	4.0%	2.3%
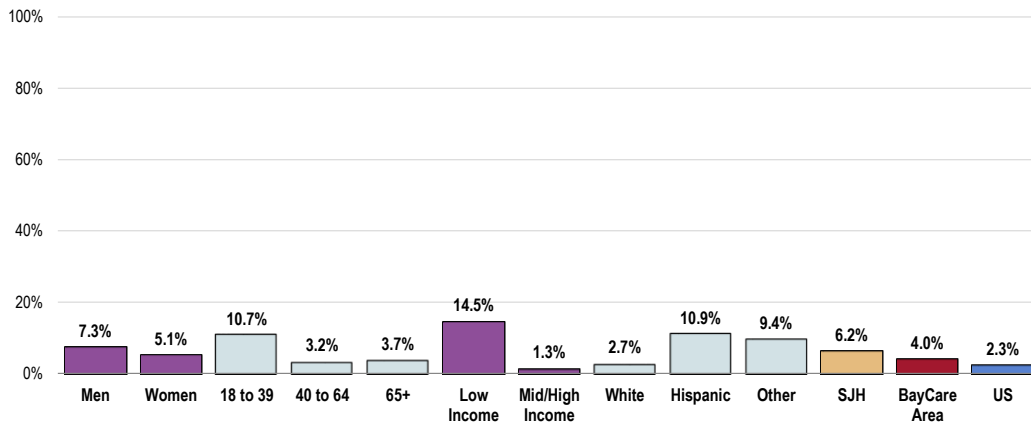
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 49]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; and "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Intimate Partner Violence: **"The next questions are about different types of violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?"**

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner

	SJH	BayCare Area	US
	18.2%	16.7%	15.1%
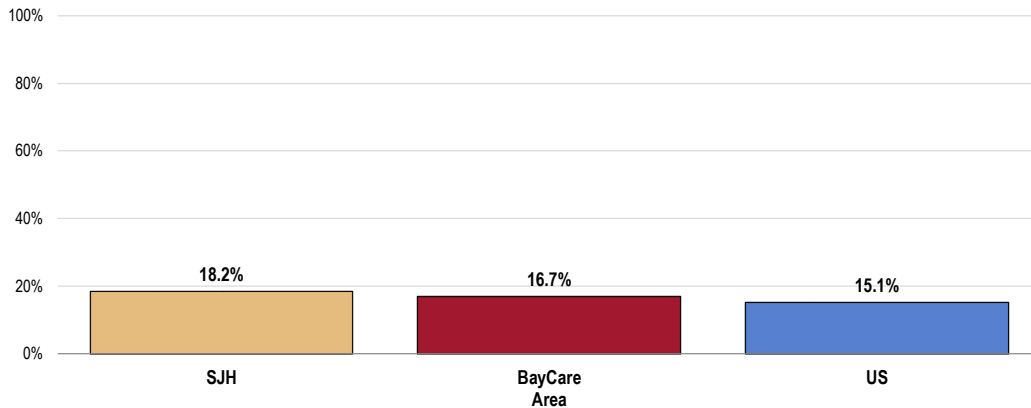
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 50]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Neighborhood Safety

"How safe from crime do you consider your neighborhood to be? Would you say: extremely safe, quite safe, slightly safe, or not at all safe?"

Perceive Own Neighborhood as "Slightly" or "Not At All" Safe

	SJH	BayCare Area	US
	18.3%	18.1%	15.3%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 48]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Perceive Own Neighborhood as "Slightly" or "Not At All" Safe
(SJH Service Area, 2016)
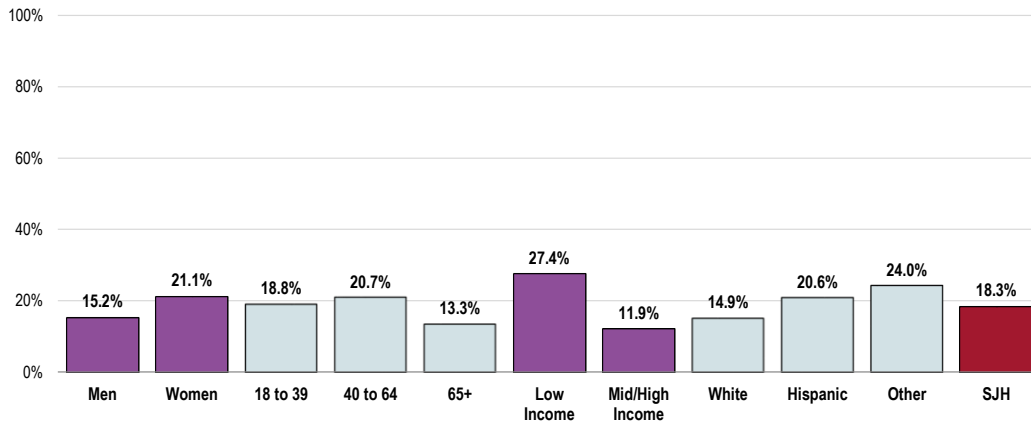
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 48]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; and "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Injury & Violence

The following chart outlines key informants' perceptions of the severity of *Injury & Violence* as a problem in the community:

Perceptions of Injury and Violence
as a Problem in the Community
(Key Informants, SJH Service Area, 2016)
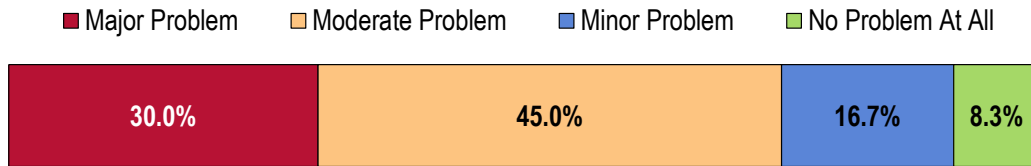
■ Major Problem □ Moderate Problem ■ Minor Problem □ No Problem At All

30.0%	45.0%	16.7%	8.3%

Sources: ● PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

Practicing in a large community hospital, we see quite a lot. – Physician

In the target population that I serve, injury from violence including domestic violence and human trafficking, many of the survivors have difficulty accessing health care. – Social Services Provider

Almost daily incident being reported in the media. – Public Health Representative

Every day in the news, there is a crime committed. – Other Health Provider

In areas of Hillsborough County we have seen a significant rise in community violence including gun violence, violent crimes, bullying, domestic violence and contributing factors such as substance abuse. – Social Services Provider

Injury and violence are two distinct phenomena; impossible to summarize together. Suicide, homicide, domestic violence, accidental injuries, have specific epidemiologies. – Community Leader

Many traumas coming into Emergency Room and Intensive Care Units. Constantly here the Bay Flight helicopter flies over my house. – Social Services Provider

Comorbidities

Associated with other indicators of overall health. – Public Health Representative

Drowning

Drowning is the number one cause of death in the one to four year olds. – Public Health Representative

Socioeconomic Status

Economic depression and low wage employment. – Community Leader

Suicide

We have a very high suicide rate. – Physician

Vulnerable Populations

Poor and homeless people we serve are subject to violence at an alarming level. – Community Leader

Diabetes

About Diabetes

Diabetes mellitus occurs when the body cannot produce or respond appropriately to insulin. Insulin is a hormone that the body needs to absorb and use glucose (sugar) as fuel for the body's cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur, leading to the development of serious, disabling complications. Many forms of diabetes exist; the three common types are Type 1, Type 2, and gestational diabetes. Effective therapy can prevent or delay diabetic complications.

Diabetes mellitus:

- Lowers life expectancy by up to 15 years.
- Increases the risk of heart disease by 2 to 4 times.
- Is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness.

The rate of diabetes mellitus continues to increase both in the United States and throughout the world. Due to the steady rise in the number of persons with diabetes mellitus, and possibly earlier onset of type 2 diabetes mellitus, there is growing concern about the possibility that the increase in the number of persons with diabetes mellitus and the complexity of their care might overwhelm existing healthcare systems.

People from minority populations are more frequently affected by type 2 diabetes. Minority groups constitute 25% of all adult patients with diabetes in the US and represent the majority of children and adolescents with type 2 diabetes.

Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals.

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Diabetes Deaths

Age-adjusted diabetes mortality for the area is shown in the following chart.

Diabetes: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 20.5 or Lower (Adjusted)
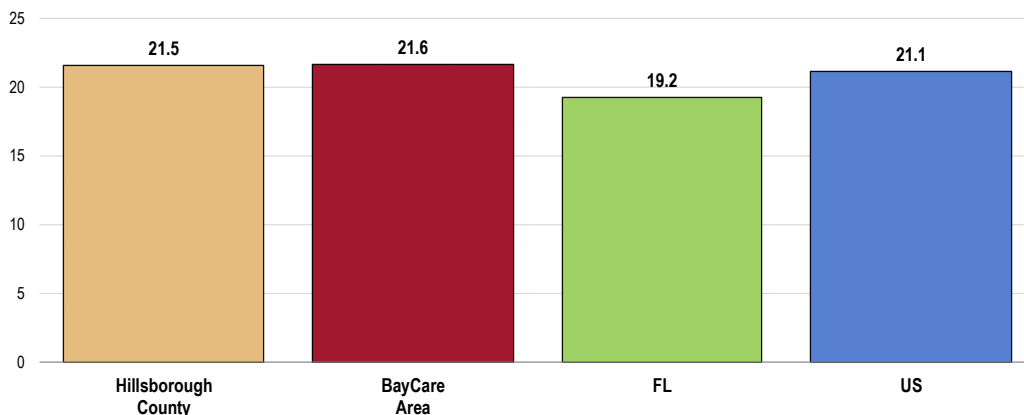
Hillsborough County	BayCare Area	FL	US
21.5	21.6	19.2	21.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective D-3]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

Prevalence of Diabetes

"Have you ever been told by a doctor that you have diabetes? (If female, add: not counting diabetes only occurring during pregnancy?)"

"Have you ever been told by a doctor or other health professional that you have pre-diabetes or borderline diabetes? (If female, add: other than during pregnancy?)"

Prevalence of Diabetes
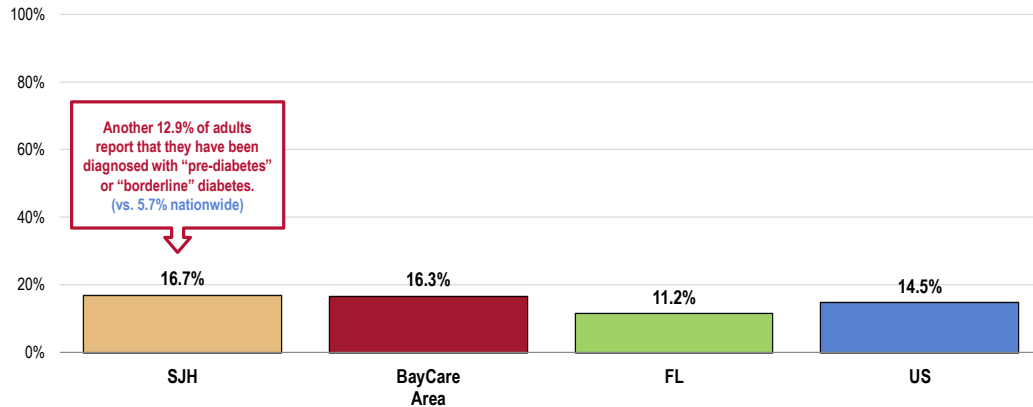
Another 12.9% of adults report that they have been diagnosed with "pre-diabetes" or "borderline" diabetes. (vs. 5.7% nationwide)

- SJH: 16.7%
- BayCare Area: 16.3%
- FL: 11.2%
- US: 14.5%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.

Notes:
- Asked of all respondents.

Prevalence of Diabetes
(SJH Service Area, 2016)
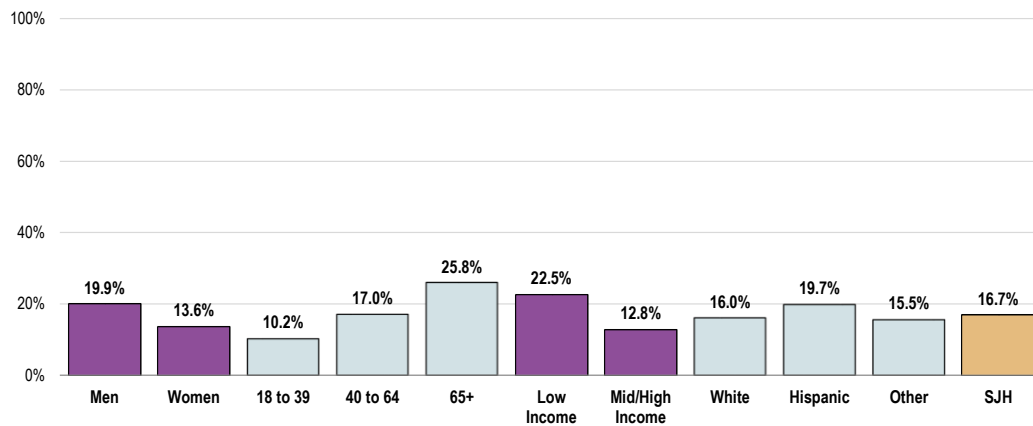
- Men: 19.9%
- Women: 13.6%
- 18 to 39: 10.2%
- 40 to 64: 17.0%
- 65+: 25.8%
- Low Income: 22.5%
- Mid/High Income: 12.8%
- White: 16.0%
- Hispanic: 19.7%
- Other: 15.5%
- SJH: 16.7%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; and "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Excludes gestational diabetes (occurring only during pregnancy).

Diabetes Testing

"Have you had a test for high blood sugar or diabetes within the past three years?"

Have Had Blood Sugar Tested in the Past Three Years
(Among Nondiabetics)
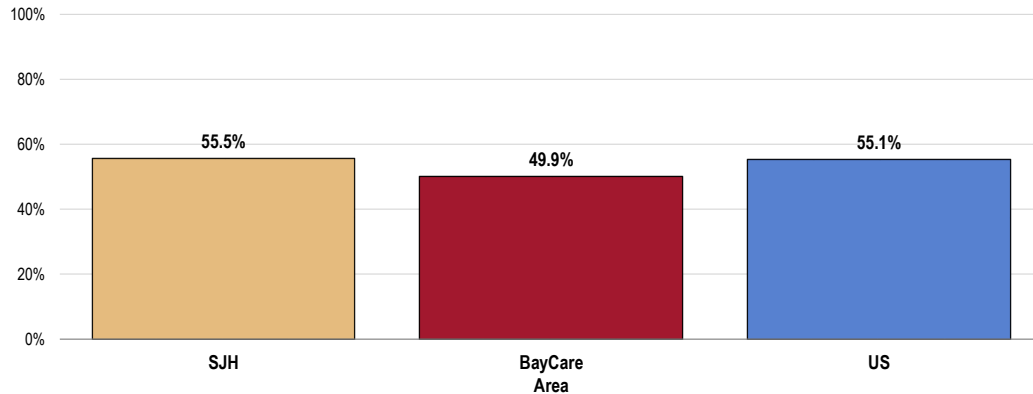
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 39]
               ● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of respondents who have not been diagnosed with diabetes.

Key Informant Input: Diabetes

The following chart outlines key informants' perceptions of the severity of *Diabetes* as a problem in the community:

Perceptions of Diabetes
as a Problem in the Community
(Key Informants, SJH Service Area, 2016)
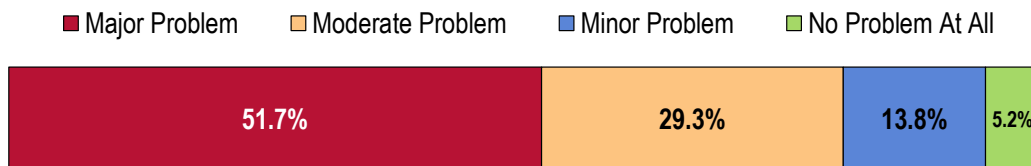
■ Major Problem   ■ Moderate Problem   ■ Minor Problem   ■ No Problem At All

51.7%	29.3%	13.8%	5.2%

Sources: ● PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Challenges

Among those rating diabetes as a "major problem," the biggest challenges for people with diabetes are seen as:

Disease Management

> *Knowing how to properly manage their diabetes. Carb counting, eating healthy food, change of lifestyle. Access to diabetes medication and equipment needed. – Social Services Provider*

> *Receiving services and resources that focus on behavioral changes, instead of just medication. – Public Health Representative*

> *Adherence to care, medication and diet. Understanding the disease. – Public Health Representative*

Ongoing monitoring and medication. – Other Health Provider

Non-compliance, medication cost, lack of knowledge, lifestyle and funds. – Other Health Provider

Diabetes management and weight control. – Social Services Provider

Accepting diabetes is a chronic disease that needs ongoing daily commitment to ensure long-term health benefits. – Physician

Weight and controlling the diabetes. – Other Health Provider

Biggest challenge is preventing diabetes as well as knowing how to manage diabetes especially for Hispanics and African Americans. – Social Services Provider

Health Education

Access to nutritional education, lack of access to inexpensive insulin, need for ongoing education about a chronic disease. – Other Health Provider

The challenge for people is the unfamiliarity with the disease. There is insufficient knowledge of and communication about what the disease is, how it's treated, and what can be done to help avoid the onset. – Other Health Provider

Not being well informed or understanding dietary behavior changes. Not understanding the impact this disease can have on their health, lack of awareness. – Public Health Representative

Biggest challenge is preventing diabetes, as well as knowing how to manage diabetes- especially for Hispanics and African Americans. – Social Services Provider

Nutrition education. – Community Leader

Prevalence/Incidence

It is an epidemic and we need to educate people young and old about the dangers of not eating properly or exercising. – Community Leader

Diabetes is a growing problem and the unknown number of people with pre-diabetes makes this a significant community health concern. – Community Leader

Individuals with chronic disease like diabetes continue to increase, access with minimum fees to education is needed in specific areas of the community where the obesity rate is high. – Public Health Representative

Increasing numbers of diabetes. – Social Services Provider

I have consulted with Florida Hospital on the primary health risk in urban Tampa and know that it is diabetes. I also witness how many poorer people struggle with obesity because of limited diet choices. – Community Leader

Access to Healthful Food

Affordable and access to fresh food versus fast food. High rates of diabetes exist where there are known food deserts. – Social Services Provider

Access and priority to healthy foods and safe places to be physically active. I see this as a significant issue in the more rural areas of the county. – Social Services Provider

Obesity

Obesity and lack of exercise leading to Type One diabetes in both children and adults. – Community Leader

Affordable Care/Services

Cost of medication, deductibles and pharmaceuticals. – Community Leader

Co-Occurrences

Poverty, generational, is the critical impact in this area and access, education to reduce diabetes is critical. – Social Services Provider

Lifestyle

Maintaining the healthy lifestyle behaviors. – Public Health Representative

Alzheimer's Disease

About Dementia

Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—to such an extent that it interferes with a person's daily life. Dementia is not a disease itself, but rather a set of symptoms. Memory loss is a common symptom of dementia, although memory loss by itself does not mean a person has dementia. Alzheimer's disease is the most common cause of dementia, accounting for the majority of all diagnosed cases.

Alzheimer's disease is the 6th leading cause of death among adults age 18 years and older. Estimates vary, but experts suggest that up to 5.1 million Americans age 65 years and older have Alzheimer's disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat and prevent Alzheimer's disease are found.

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Alzheimer's Disease Deaths

Age-adjusted Alzheimer's disease mortality is outlined below.

Alzheimer's Disease: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)

	Hillsborough County	BayCare Area	FL	US
Mortality rate	21.2	18.2	17.0	24.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Confusion & Memory Loss

Adults Age 45 and Older: "During the past 12 months, have you experienced confusion or memory loss that is happening more often or getting worse?"

Experienced Increasing Confusion/Memory Loss in Past Year
(Among Respondents Age 45 and Older)

- SJH: 14.8%
- BayCare Area: 13.7%
- US: 12.8%
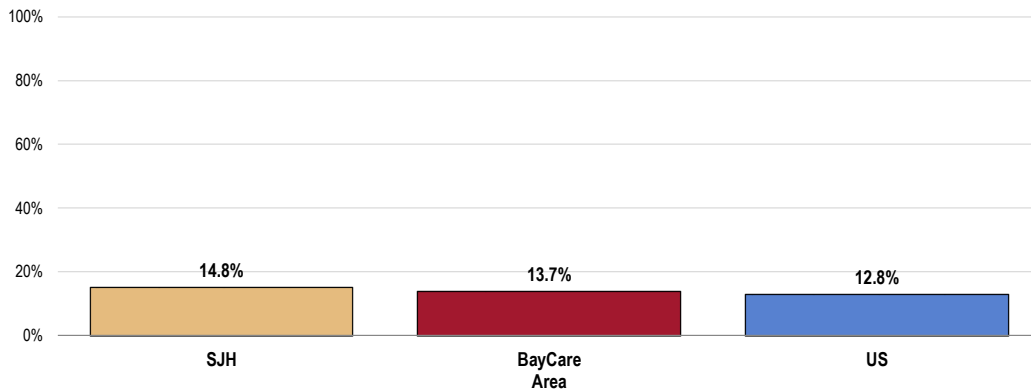
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 127]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of those respondents age 45 and older.

Key Informant Input: Dementias, Including Alzheimer's Disease

The following chart outlines key informants' perceptions of the severity of *Dementias, Including Alzheimer's Disease* as a problem in the community:

Perceptions of Dementia/Alzheimer's Disease as a Problem in the Community
(Key Informants, SJH Service Area, 2016)

Major Problem / Moderate Problem / Minor Problem / No Problem At All

- Major Problem: 36.2%
- Moderate Problem: 43.1%
- Minor Problem: 17.2%
- No Problem At All: 3.4%

Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Aging Population

Lack of coordinated care for the elderly creates confusion and over- or under- medication. – Other Health Provider

Large elderly population. – Community Leader

There is an aging population is this area. The dementia/Alzheimer's not only impacts the individual who suffers, but also the caregivers. There then presents burden on finances, as well as mental health of the caregiver. – Other Health Provider

Namely because of the number of elderly citizens and because Hillsborough County has focused areas treating people living with dementia/Alzheimer's. – Community Leader

Aging population is more vulnerable and our county's 65-plus are growing at over four percent a year. – Public Health Representative

We have an aging population and limited access to best practices. – Physician

Prevalence/Incidence

Either the incidence of this condition is increasing, or there is increased focus on its prevalence. Burden of caring for loved ones often falls to families which have not planned for long-term care, or have limited financial means. – Community Leader

Seems like I hear more and more cases and people faced with the disease. – Community Leader

The rise of dementia is massive and unknown. Access to affordable care is critically important and making sure quality care is paramount. – Social Services Provider

There are lots of silver alerts, every day. Dementia/Alzheimer's is being identified in younger and younger groups. We need a more dementia-friendly city. I believe Sarasota is doing similar movement; the senior population is expected to more than double. – Social Services Provider

Health Education

Lack of awareness. – Social Services Provider

Lack of information regarding resources. – Public Health Representative

Access to Care/Services

We have very limited inpatient residential services for this patient type. – Other Health Provider

Access to Providers

Access to geriatricians is very challenging. Very few doctors are involved in the specialty, and families have a difficult course navigating this problem. – Physician

Affordable Care/Services

Lack of affordable facilities. – Community Leader

Impact on Families/Caregivers

The resources to assist people with dementia are limited; caregivers are overburdened. – Social Services Provider

Kidney Disease

About Chronic Kidney Disease

Chronic kidney disease and end-stage renal disease are significant public health problems in the United States and a major source of suffering and poor quality of life for those afflicted. They are responsible for premature death and exact a high economic price from both the private and public sectors. Nearly 25% of the Medicare budget is used to treat people with chronic kidney disease and end-stage renal disease.

Genetic determinants have a large influence on the development and progression of chronic kidney disease. It is not possible to alter a person's biology and genetic determinants; however, environmental influences and individual behaviors also have a significant influence on the development and progression of chronic kidney disease. As a result, some populations are disproportionately affected. Successful behavior modification is expected to have a positive influence on the disease.

Diabetes is the most common cause of kidney failure. The results of the Diabetes Prevention Program (DPP) funded by the national Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) show that moderate exercise, a healthier diet, and weight reduction can prevent development of type 2 diabetes in persons at risk.

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Kidney Disease Deaths

Age-adjusted kidney disease mortality is described in the following chart.
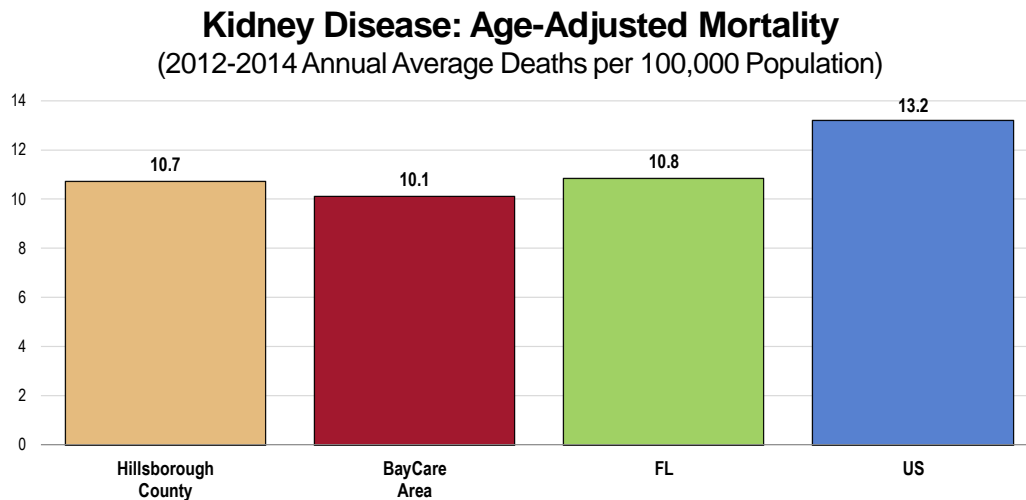
Kidney Disease: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)

	Hillsborough County	BayCare Area	FL	US
Value	10.7	10.1	10.8	13.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Kidney Disease

"Would you please tell me if you have ever suffered from or been diagnosed with kidney disease?"

Prevalence of Kidney Disease

SJH	5.3%
BayCare Area	6.0%
FL	3.8%
US	3.6%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 32]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Key Informant Input: Chronic Kidney Disease

The following chart outlines key informants' perceptions of the severity of *Chronic Kidney Disease* as a problem in the community:
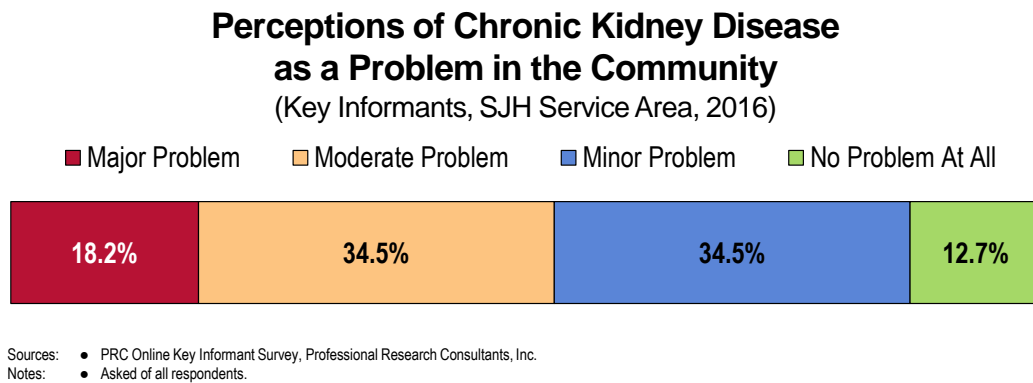
Perceptions of Chronic Kidney Disease as a Problem in the Community
(Key Informants, SJH Service Area, 2016)

■ Major Problem   □ Moderate Problem   ■ Minor Problem   ■ No Problem At All

Major Problem	Moderate Problem	Minor Problem	No Problem At All
18.2%	34.5%	34.5%	12.7%

Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

I have a funeral coming up for a chronic kidney disease person and am aware of our how limited his mobility has been over the last few years. – Community Leader

Dialysis. – Other Health Provider

Chronic kidney disease is a major problem in my community and is influenced by poor and improper nutrition and dietary lifestyles. Food deserts exist in some segments of the city and county. – Other Health Provider

We see this quite a lot in the hospitals. – Physician

Access to Care/Services

Access to care or lack of knowledge about resources related to disease. – Public Health Representative

Affordable Care/Services

While there are several services and resources, they are quite expensive. Those living within or just above poverty level cannot access this service. Nephrology is very limited. – Other Health Provider

Comorbidities

Chronic kidney disease is frequently related to diabetes, which is on an increase. It comes on quietly over time. – Public Health Representative

Vulnerable Populations

The specific numbers and problems of renal disease among African-American men. – Social Services Provider

Potentially Disabling Conditions

About Arthritis, Osteoporosis & Chronic Back Conditions

There are more than 100 types of arthritis. Arthritis commonly occurs with other chronic conditions, such as diabetes, heart disease, and obesity. Interventions to treat the pain and reduce the functional limitations from arthritis are important, and may also enable people with these other chronic conditions to be more physically active.   Arthritis affects 1 in 5 adults and continues to be the most common cause of disability. It costs more than $128 billion per year. All of the human and economic costs are projected to increase over time as the population ages. There are interventions that can reduce arthritis pain and functional limitations, but they remain underused. These include: increased physical activity; self-management education; and weight loss among overweight/obese adults.

Osteoporosis is a disease marked by reduced bone strength leading to an increased risk of fractures (broken bones). In the United States, an estimated 5.3 million people age 50 years and older have osteoporosis. Most of these people are women, but about 0.8 million are men. Just over 34 million more people, including 12 million men, have low bone mass, which puts them at increased risk for developing osteoporosis. Half of all women and as many as 1 in 4 men age 50 years and older will have an osteoporosis-related fracture in their lifetime.

Chronic back pain is common, costly, and potentially disabling. About 80% of Americans experience low back pain in their lifetime. It is estimated that each year:

- 15%-20% of the population develop protracted back pain.
- 2-8% have chronic back pain (pain that lasts more than 3 months).
- 3-4% of the population is temporarily disabled due to back pain.
- 1% of the working-age population is disabled completely and permanently as a result of low back pain.

Americans spend at least $50 billion each year on low back pain. Low back pain is the:

- 2nd leading cause of lost work time (after the common cold).
- 3rd most common reason to undergo a surgical procedure.
- 5th most frequent cause of hospitalization.

Arthritis, osteoporosis, and chronic back conditions all have major effects on quality of life, the ability to work, and basic activities of daily living.

- Healthy People 2020 (www.healthypeople.gov)

Arthritis, Osteoporosis, & Chronic Back Conditions

"Would you please tell me if you have ever suffered from or been diagnosed with arthritis or rheumatism?" (Reported below among only those age 50+.)

"Would you please tell me if you have ever suffered from or been diagnosed with osteoporosis?" (Reported below among only those age 50+.)

"Would you please tell me if you have ever suffered from or been diagnosed with sciatica or chronic back pain?" (Reported below among all adults age 18+.)

See also *Activity Limitations* in the General Health Status section of this report.

Prevalence of Potentially Disabling Conditions

Legend: SJH, BayCare Area, US

- Arthritis/Rheumatism (50+): 40.5%, 38.2%, 32.0%
- Osteoporosis (50+) HP2020 Objective = 5.3% or Lower: 11.5%, 11.7%, 8.7%
- Sciatica/Chronic Back Pain (18+): 23.5%, 27.0%, 19.4%
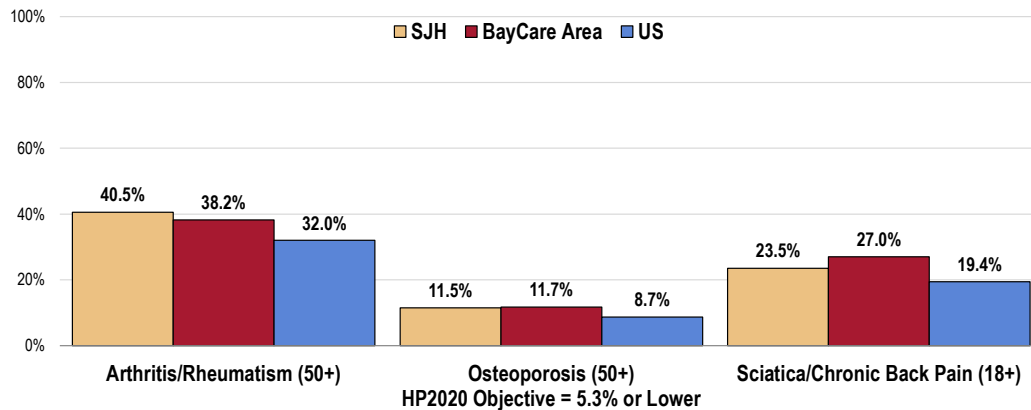
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 28, 161-162]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AOCBC-10]

Notes:
- The sciatica indicator reflects the total sample of respondents; the arthritis and osteoporosis columns reflect adults age 50+.

Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions

The following chart outlines key informants' perceptions of the severity of *Arthritis, Osteoporosis & Chronic Back Conditions* as a problem in the community:

Perceptions of Arthritis/Osteoporosis/Back Conditions as a Problem in the Community
(Key Informants, SJH Service Area, 2016)

Legend: Major Problem, Moderate Problem, Minor Problem, No Problem At All

Major Problem	Moderate Problem	Minor Problem	No Problem At All
11.9%	40.7%	37.3%	10.2%

Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

I have spoken to many people in the community regarding these issues. – Other Health Provider

My contact with retired low-income women, I'm keenly aware of their complaints and the level of chronic pain many live with. – Community Leader

Chronic pain. – Physician

Access to Care/Services

With various joint and back issues, orthopedics is very limited and expensive. Most clinics require a major down payment, $3000, for uninsured services. The technology is available, just not to those with no insurance/money. – Other Health Provider

Aging Population

> *This is a disease usually of the aging population. When treated, it is frequently with over the-counter medications, ASA or Tylenol, which if used in too high of doses has their own issues or with prescription pain medications. – Public Health Representative*

Pain Management

> *Lack of non-addictive pain approaches. – Physician*

Vision & Hearing Impairment

Vision Trouble

About Vision

Vision is an essential part of everyday life, influencing how Americans of all ages learn, communicate, work, play, and interact with the world. Yet millions of Americans live with visual impairment, and many more remain at risk for eye disease and preventable eye injury.

The eyes are an important, but often overlooked, part of overall health. Despite the preventable nature of some vision impairments, many people do not receive recommended screenings and exams. A visit to an eye care professional for a comprehensive dilated eye exam can help to detect common vision problems and eye diseases, including diabetic retinopathy, glaucoma, cataract, and age-related macular degeneration.

These common vision problems often have no early warning signs. If a problem is detected, an eye care professional can prescribe corrective eyewear, medicine, or surgery to minimize vision loss and help a person see his or her best.

Healthy vision can help to ensure a healthy and active lifestyle well into a person's later years. Educating and engaging families, communities, and the nation is critical to ensuring that people have the information, resources, and tools needed for good eye health.

- Healthy People 2020 (www.healthypeople.gov)

Hearing Trouble

About Hearing & Other Sensory or Communication Disorders

An impaired ability to communicate with others or maintain good balance can lead many people to feel socially isolated, have unmet health needs, have limited success in school or on the job. Communication and other sensory processes contribute to our overall health and well-being. Protecting these processes is critical, particularly for people whose age, race, ethnicity, gender, occupation, genetic background, or health status places them at increased risk.

Many factors influence the numbers of Americans who are diagnosed and treated for hearing and other sensory or communication disorders, such a social determinants (social and economic standings, age of diagnosis, cost and stigma of wearing a hearing aid, and unhealthy lifestyle choices). In addition, biological causes of hearing loss and other sensory or communication disorders include: genetics; viral or bacterial infections; sensitivity to certain drugs or medications; injury; and aging.

As the nation's population ages and survival rates for medically fragile infants and for people with severe injuries and acquired diseases improve, the prevalence of sensory and communication disorders is expected to rise.

- Healthy People 2020 (www.healthypeople.gov)

"Would you please tell me if you have ever suffered from or been diagnosed with blindness or trouble seeing, even when wearing glasses?"

"Would you please tell me if you have ever suffered from or been diagnosed with deafness or trouble hearing?"
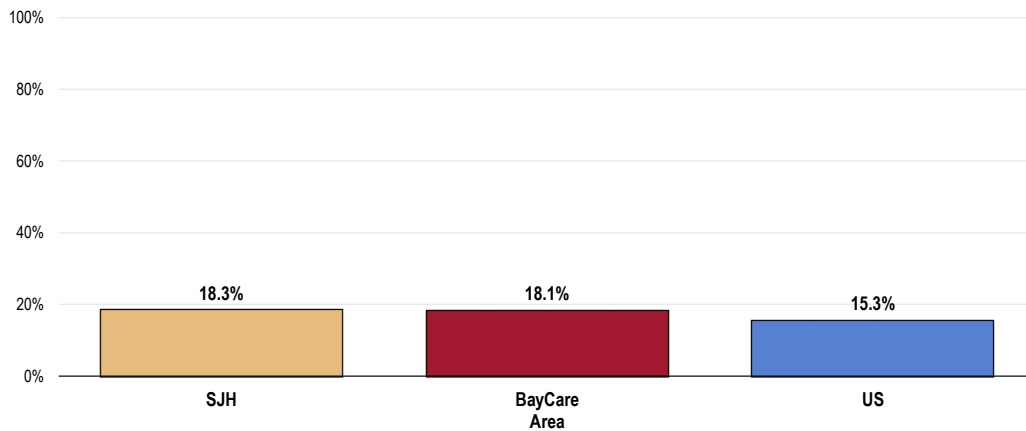
Prevalence of Blindness/Deafness
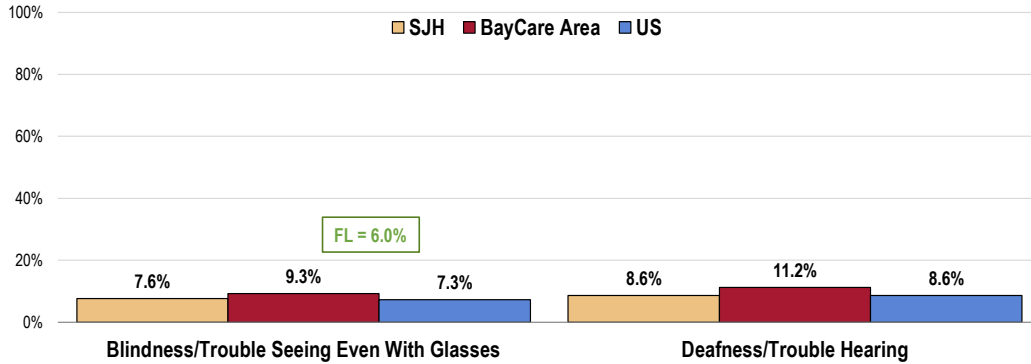
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 25-26]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.

Notes:
- Reflects the total sample of respondents.

Key Informant Input: Vision & Hearing

The following chart outlines key informants' perceptions of the severity of *Vision & Hearing* as a problem in the community:

Perceptions of Vision and Hearing
as a Problem in the Community
(Key Informants, SJH Service Area, 2016)
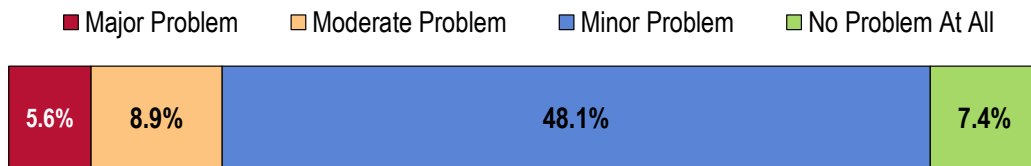
Major Problem	Moderate Problem	Minor Problem	No Problem At All
5.6%	8.9%	48.1%	7.4%

Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Affordable Care/Services

> *For patients with no or limited funding, there is difficulty accessing hearing evaluations, aids; and same with vision. – Community Leader*

> *These are not items covered by Medicare/Medicaid. I have heard time and time again that many seniors cannot afford a new hearing aid battery, or a new aid because one broke. This is extremely devastating. – Social Services Provider*

Infectious Disease

About Immunization & Infectious Diseases

The increase in life expectancy during the 20th century is largely due to improvements in child survival; this increase is associated with reductions in infectious disease mortality, due largely to immunization. However, infectious diseases remain a major cause of illness, disability, and death. Immunization recommendations in the United States currently target 17 vaccine-preventable diseases across the lifespan.

People in the US continue to get diseases that are vaccine-preventable. Viral hepatitis, influenza, and tuberculosis (TB) remain among the leading causes of illness and death across the nation and account for substantial spending on the related consequences of infection.

The infectious disease public health infrastructure, which carries out disease surveillance at the national, state, and local levels, is an essential tool in the fight against newly emerging and re-emerging infectious diseases. Other important defenses against infectious diseases include:

- Proper use of vaccines
- Antibiotics
- Screening and testing guidelines
- Scientific improvements in the diagnosis of infectious disease-related health concerns

Vaccines are among the most cost-effective clinical preventive services and are a core component of any preventive services package. Childhood immunization programs provide a very high return on investment. For example, for each birth cohort vaccinated with the routine immunization schedule, society:

- Saves 33,000 lives.
- Prevents 14 million cases of disease.
- Reduces direct healthcare costs by $9.9 billion.
- Saves $33.4 billion in indirect costs.
- Healthy People 2020 (www.healthypeople.gov)

Immunization & Infectious Diseases

Key Informant Input: Immunization & Infectious Diseases

The following chart outlines key informants' perceptions of the severity of *Immunization & Infectious Diseases* as a problem in the community:

**Perceptions of Immunization and Infectious Diseases
as a Problem in the Community**
(Key Informants, SJH Service Area, 2016)

■ Major Problem   □ Moderate Problem   ■ Minor Problem   □ No Problem At All

Major Problem	Moderate Problem	Minor Problem	No Problem At All
15.8%	36.8%	36.8%	10.5%

Sources: ● PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Childhood Immunization

> *The low rates of two-year-old immunizations. – Public Health Representative*

> *More parents are seeking exemptions to childhood immunizations. We have had outbreaks of vaccine-preventable diseases in our county: Pertussis, chickenpox. Other areas are seeing mumps and measles. – Public Health Representative*

Health Education

> *Children are not receiving immunizations, due to lack of education and awareness, as well as adults and elderly population. – Social Services Provider*

> *Lack of immunizations in adults, due to lack of access to care, as well as knowledge deficits. – Community Leader*

Access to Care/Services

> *One health department available for the entire county to provide, oversee and manage immunizations. Size of Rhode Island, very underfunded, despite a place the size of Rhode Island, third largest school district in the state. – Community Leader*

HPV

> *Many young adolescents are not getting immunized against HPV because of parental beliefs. – Physician*

Influenza & Pneumonia Vaccination

About Influenza & Pneumonia

Acute respiratory infections, including pneumonia and influenza, are the 8th leading cause of death in the nation, accounting for 56,000 deaths annually. Pneumonia mortality in children fell by 97% in the last century, but respiratory infectious diseases continue to be leading causes of pediatric hospitalization and outpatient visits in the US. On average, influenza leads to more than 200,000 hospitalizations and 36,000 deaths each year. The 2009 H1N1 influenza pandemic caused an estimated 270,000 hospitalizations and 12,270 deaths (1,270 of which were of people younger than age 18) between April 2009 and March 2010.

- Healthy People 2020 (www.healthypeople.gov)

Flu Vaccinations

"There are two ways to get the seasonal flu vaccine, one is a shot in the arm and the other is a spray, mist, or drop in the nose called FluMist®. During the past 12 months, have you had either a seasonal flu shot or a seasonal flu vaccine that was sprayed in your nose?"

"A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's lifetime and is different from the seasonal flu shot. Have you ever had a pneumonia shot?"

Chart columns below show these findings among those age 65+.

Older Adults: Have Had a Flu Vaccination in the Past Year
(Among Adults Age 65+)
Healthy People 2020 Target = 70.0% or Higher
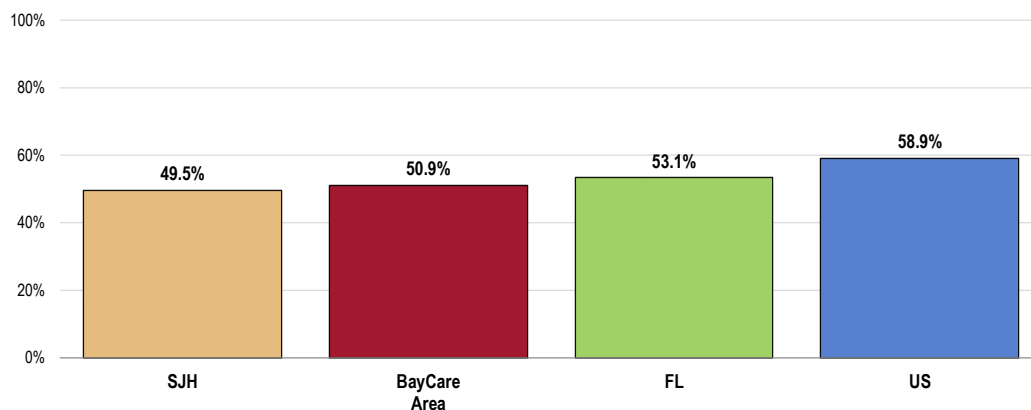
	SJH	BayCare Area	FL	US
	49.5%	50.9%	53.1%	58.9%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 163-164]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-12.12]

Notes:
- Reflects respondents 65 and older.
- "High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.
- Includes FluMist as a form of vaccination.

Older Adults: Have Ever Had a Pneumonia Vaccine
(Among Adults Age 65+)
Healthy People 2020 Target = 90.0% or Higher
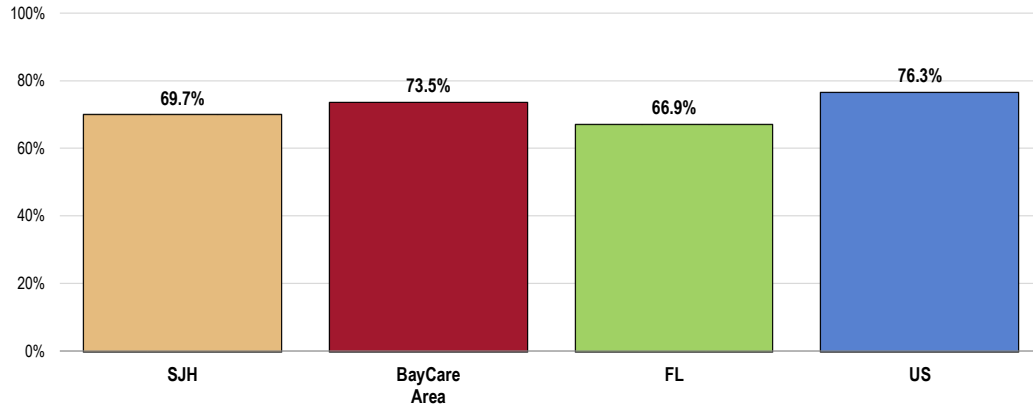
Bar chart showing: SJH 69.7%, BayCare 73.5%, FL 66.9%, US 76.3%

Area

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 165-166]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives IID-13.1, IID-13.2]

Notes:
- Reflects respondents 65 and older.
- "High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.

HIV

About HIV

The HIV epidemic in the United States continues to be a major public health crisis. An estimated 1.1 million Americans are living with HIV, and 1 in 5 people with HIV do not know they have it. HIV continues to spread, leading to about 56,000 new HIV infections each year.

HIV is a preventable disease, and effective HIV prevention interventions have been proven to reduce HIV transmission. People who get tested for HIV and learn that they are infected can make significant behavior changes to improve their health and reduce the risk of transmitting HIV to their sex or drug-using partners. More than 50% of new HIV infections occur as a result of the 21% of people who have HIV but do not know it.

In the era of increasingly effective treatments for HIV, people with HIV are living longer, healthier, and more productive lives. Deaths from HIV infection have greatly declined in the United States since the 1990s. As the number of people living with HIV grows, it will be more important than ever to increase national HIV prevention and healthcare programs.

There are gender, race, and ethnicity disparities in new HIV infections:

- Nearly 75% of new HIV infections occur in men.
- More than half occur in gay and bisexual men, regardless of race or ethnicity.
- 45% of new HIV infections occur in African Americans, 35% in whites, and 17% in Hispanics.

Improving access to quality healthcare for populations disproportionately affected by HIV, such as persons of color and gay and bisexual men, is a fundamental public health strategy for HIV prevention. People getting care for HIV can receive:

- Antiretroviral therapy
- Screening and treatment for other diseases (such as sexually transmitted infections)
- HIV prevention interventions
- Mental health services
- Other health services

As the number of people living with HIV increases and more people become aware of their HIV status, prevention strategies that are targeted specifically for HIV-infected people are becoming more important. Prevention work with people living with HIV focuses on:

- Linking to and staying in treatment.
- Increasing the availability of ongoing HIV prevention interventions.
- Providing prevention services for their partners.

Public perception in the US about the seriousness of the HIV epidemic has declined in recent years. There is evidence that risky behaviors may be increasing among uninfected people, especially gay and bisexual men. Ongoing media and social campaigns for the general public and HIV prevention interventions for uninfected persons who engage in risky behaviors are critical.

- Healthy People 2020 (www.healthypeople.gov)

HIV/AIDS Deaths

The following chart outlines age-adjusted mortality rates for the area in comparison with state and national rates.

HIV/AIDS: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 3.3 or Lower
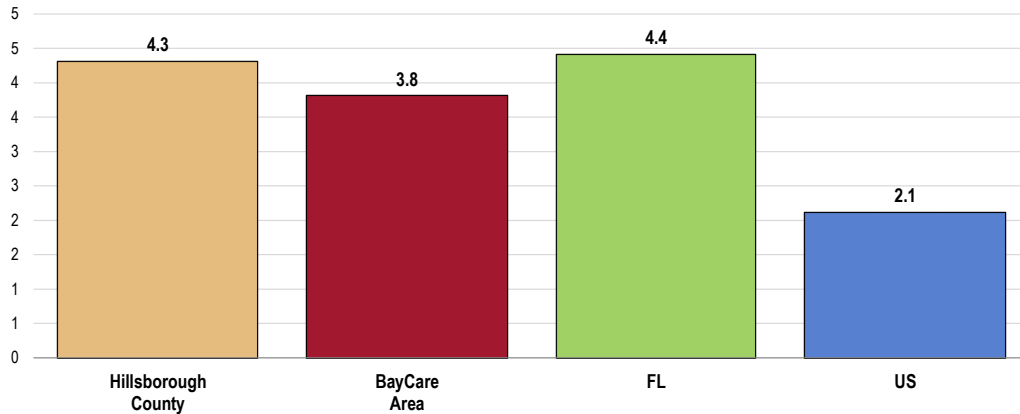
Hillsborough County	BayCare Area	FL	US
4.3	3.8	4.4	2.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HIV-12]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

HIV Prevalence

The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in the area.

HIV Prevalence
(Prevalence Rate of HIV per 100,000 Population, 2013)
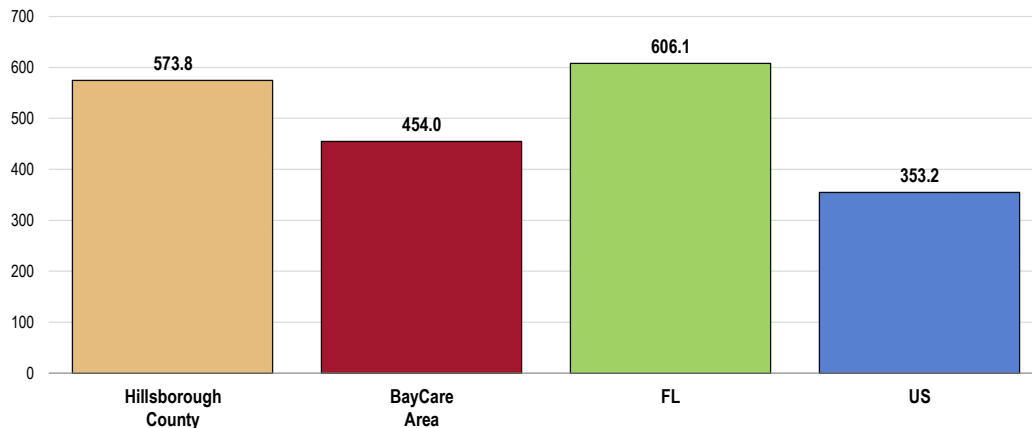
Hillsborough County	BayCare Area	FL	US
573.8	454.0	606.1	353.2

Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Retrieved May 2016 from Community Commons at http://www.chna.org.

Notes:
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.

HIV Testing

"Not counting tests you may have had when donating or giving blood, when was the last time you were tested for HIV?" (Reported below only among adults age 18 to 44.)

Tested for HIV in the Past Year
(Among Adults Age 18-44)
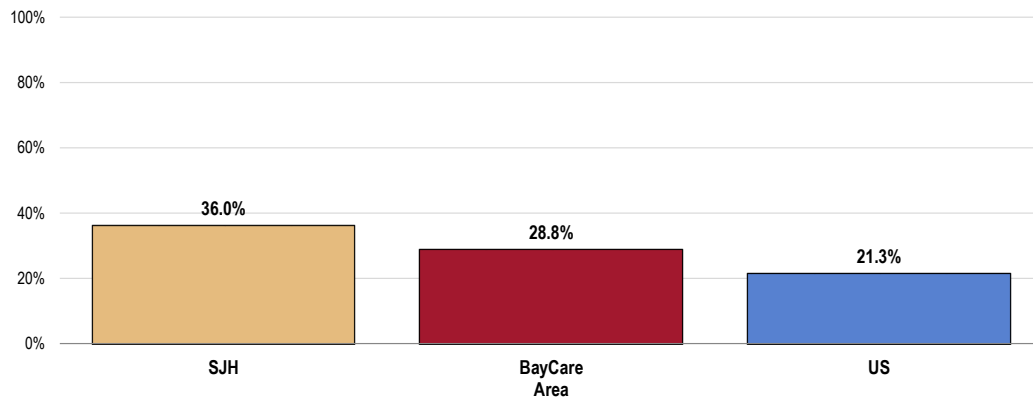
Sources:	● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 167]
	● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes:	● Reflects respondents age 18 to 44.

Key Informant Input: HIV/AIDS

The following chart outlines key informants' perceptions of the severity of *HIV/AIDS* as a problem in the community:

Perceptions of HIV/AIDS
as a Problem in the Community
(Key Informants, SJH Service Area, 2016)
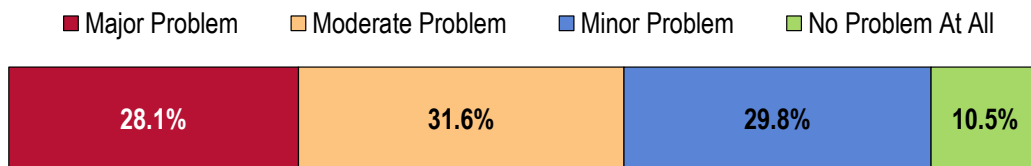
■ Major Problem   □ Moderate Problem   ■ Minor Problem   □ No Problem At All

28.1%	31.6%	29.8%	10.5%

Sources:	● PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes:	● Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

> *The high HIV/AIDS rates in Hillsborough County. – Community Leader*

> *High number of cases in the state of Florida. – Community Leader*

> *University area community has one of the highest rates of HIV. – Community Leader*

> *In 2014, of the 67 counties, HC ranked tenth for gonorrhea, eighth in chlamydia, fifth in syphilis, and fourth in the number of*

new HIV cases. – Public Health Representative

The high rates of infection in this community, coupled with the dwindling governmental resources. – Public Health Representative

I believe HIV is a major problem, due to increasing rates in the state of Florida. – Social Services Provider

Huge increase in HIV infection. Lack of resources and treatment for heroin leads to more risk. – Other Health Provider

Incidence and prevalence data. – Public Health Representative

Health Education

Ignorance. – Social Services Provider

Education vacuum, sexual lifestyle and carelessness. – Other Health Provider

Affordable Care/Services

Medications and drug cost. – Community Leader

Denial/Stigma

Reluctance to be tested and adherence to care when diagnosed. – Public Health Representative

Sexually Transmitted Diseases

About Sexually Transmitted Diseases

STDs refer to more than 25 infectious organisms that are transmitted primarily through sexual activity. Despite their burdens, costs, and complications, and the fact that they are largely preventable, STDs remain a significant public health problem in the United States. This problem is largely unrecognized by the public, policymakers, and health care professionals. STDs cause many harmful, often irreversible, and costly clinical complications, such as: reproductive health problems; fetal and perinatal health problems; cancer; and facilitation of the sexual transmission of HIV infection.

Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the US. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. Several factors contribute to the spread of STDs.

Biological Factors. STDs are acquired during unprotected sex with an infected partner. Biological factors that affect the spread of STDs include:

- **Asymptomatic nature of STDs**. The majority of STDs either do not produce any symptoms or signs, or they produce symptoms so mild that they are unnoticed; consequently, many infected persons do not know that they need medical care.
- **Gender disparities**. Women suffer more frequent and more serious STD complications than men do. Among the most serious STD complications are pelvic inflammatory disease, ectopic pregnancy (pregnancy outside of the uterus), infertility, and chronic pelvic pain.
- **Age disparities**. Compared to older adults, sexually active adolescents ages 15 to 19 and young adults ages 20 to 24 are at higher risk for getting STDs.
- **Lag time between infection and complications**. Often, a long interval, sometimes years, occurs between acquiring an STD and recognizing a clinically significant health problem.

Social, Economic and Behavioral Factors. The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, historical experience with segregation and discrimination exacerbates these factors. Social, economic, and behavioral factors that affect the spread of STDs include: racial and ethnic disparities; poverty and marginalization; access to healthcare; substance abuse; sexuality and secrecy (stigma and discomfort discussing sex); and sexual networks (persons "linked" by sequential or concurrent sexual partners).

- Healthy People 2020 (www.healthypeople.gov)

Chlamydia & Gonorrhea

Chlamydia. Chlamydia is the most commonly reported STD in the United States; most people who have chlamydia don't know it since the disease often has no symptoms.

Gonorrhea. Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

The following chart outline local incidence for these STDs.

Chlamydia & Gonorrhea Incidence
(Incidence Rate per 100,000 Population, 2014)
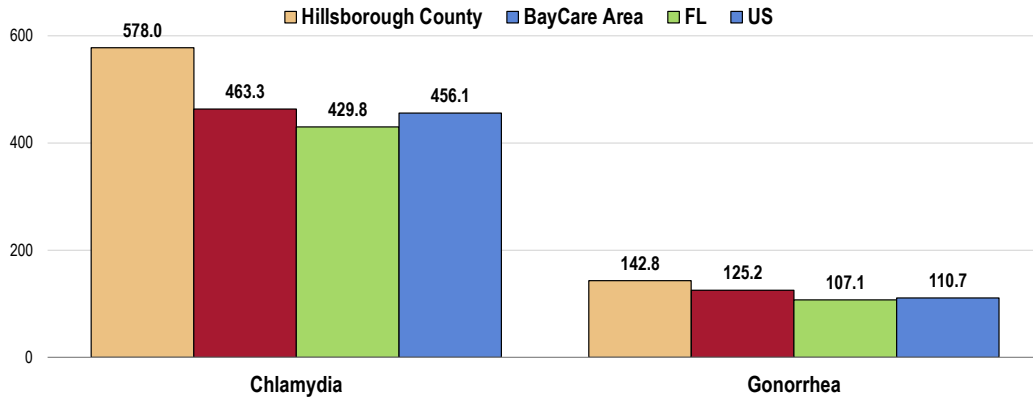
Sources: ● Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
● Retrieved May 2016 from Community Commons at http://www.chna.org.
Notes: ● This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Safe Sexual Practices

Sexual Partners

"During the past 12 months, with how many people have you had sexual intercourse?"

"Was a condom used the last time you had sexual intercourse?"

Each of these is reported below only among adults who are unmarried and between the ages of 18 and 64.

Sexual Risk
(Unmarried Adults Age 18-64)
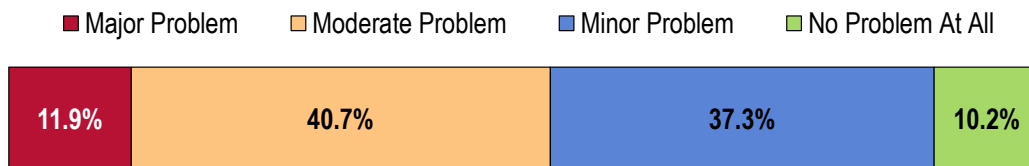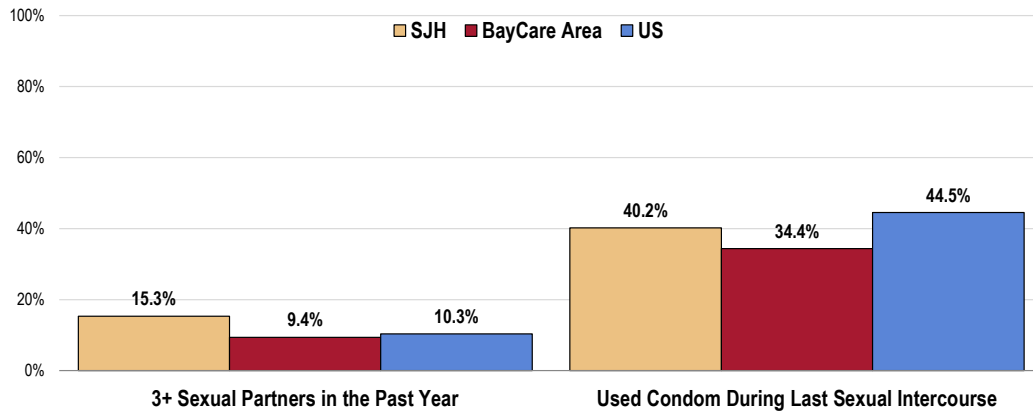

Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 97-98]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Reflects unmarried respondents under the age of 65.

Key Informant Input: Sexually Transmitted Diseases

The following chart outlines key informants' perceptions of the severity of *Sexually Transmitted Diseases* as a problem in the community:

Perceptions of Sexually Transmitted Diseases as a Problem in the Community
(Key Informants, SJH Service Area, 2016)

■ Major Problem ☐ Moderate Problem ■ Minor Problem ■ No Problem At All

Major Problem	Moderate Problem	Minor Problem	No Problem At All
25.0%	33.3%	33.3%	8.3%
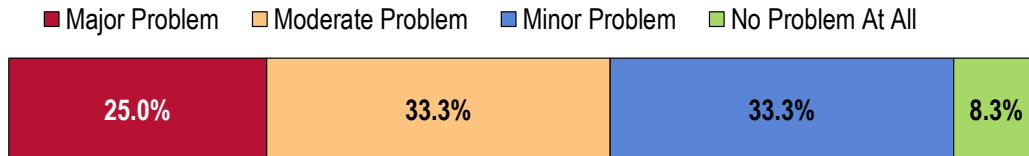
Sources: ● PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

Sixteen to 24-year-olds in our community have a high incidence of STD's. Syphilis has continued to increase. Lack of education and information as part of health education. – Public Health Representative

High rates of syphilis, GC, chlamydia and HIV in our community. – Community Leader

Stats on STD's. – Public Health Representative

High statistic rates. – Community Leader

High rates in the community. – Public Health Representative

Health Education

Access to both information and resources are not readily available. Planned Parenthood has come under recent attack and funding has dried up for them limiting their ability to provide these services. – Community Leader

Lack of basic sexual education for youth. Internet- specifically adult porn sites- are providing youth with bulk of sexual health knowledge. – Other Health Provider

Teens and young adults are not educated on how to prevent STD's and where to receive services. School district does not teach comprehensive sex education. – Public Health Representative

Lack of education, rising cases among youth. – Community Leader

Access to Services

One health department for the entire county. – Community Leader

Co-Occurrences

Associated with other risky behaviors, in addition to direct impacts. – Public Health Representative

Births

About Infant & Child Health

Improving the well-being of mothers, infants, and children is an important public health goal for the US. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. Many factors can affect pregnancy and childbirth, including pre-conception health status, age, access to appropriate healthcare, and poverty.

Infant and child health are similarly influenced by socio-demographic factors, such as family income, but are also linked to the physical and mental health of parents and caregivers. There are racial and ethnic disparities in mortality and morbidity for mothers and children, particularly for African Americans. These differences are likely the result of many factors, including social determinants (such as racial and ethnic disparities in infant mortality; family income; educational attainment among household members; and health insurance coverage) and physical determinants (i.e., the health, nutrition, and behaviors of the mother during pregnancy and early childhood).

- Healthy People 2020 (www.healthypeople.gov)

Prenatal Care

Early and continuous prenatal care is the best assurance of infant health. Receipt of timely prenatal care (care initiated during the first trimester of pregnancy) is outlined in the following chart.

Lack of Prenatal Care in the First Trimester
(Percentage of Live Births, 2007-2010)
Healthy People 2020 Target = 22.1% or Lower
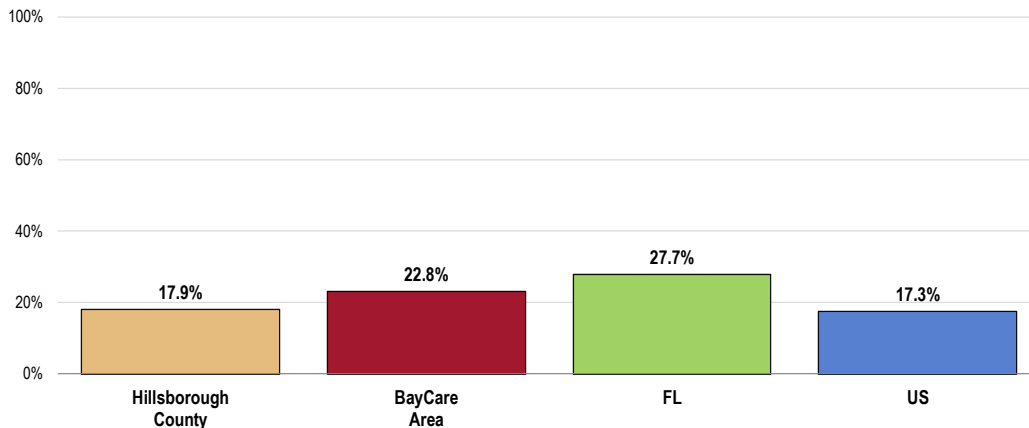
Hillsborough County	BayCare Area	FL	US
17.9%	22.8%	27.7%	17.3%

Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.
- Retrieved May 2016 from Community Commons at http://www.chna.org.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-10.1]

Note:
- This indicator reports the percentage of women who do not obtain prenatal care during their first trimester of pregnancy. This indicator is relevant because engaging in prenatal care decreases the likelihood of maternal and infant health risks. This indicator can also highlight a lack of access to preventive care, a lack of health, knowledge insufficient provider outreach, and/or social barriers preventing utilization of services.

Birth Outcomes & Risks

Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight. Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable. Births of low-weight infants are described below.
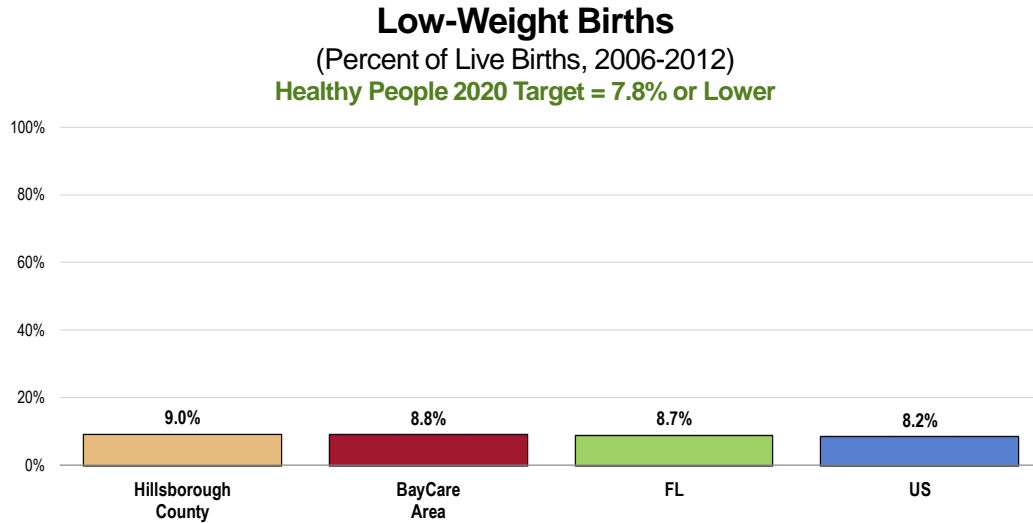
Low-Weight Births
(Percent of Live Births, 2006-2012)
Healthy People 2020 Target = 7.8% or Lower

Hillsborough County	9.0%
BayCare Area	8.8%
FL	8.7%
US	8.2%

Sources:
● Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.
● Retrieved May 2016 from Community Commons at http://www.chna.org.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-8.1]

Note:
● This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. These rates are outlined in the following chart.
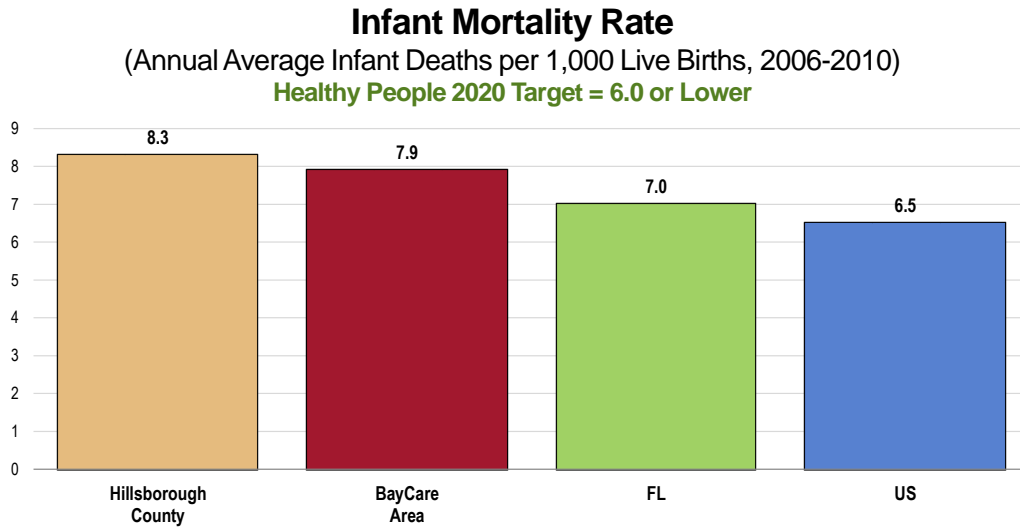
Infant Mortality Rate
(Annual Average Infant Deaths per 1,000 Live Births, 2006-2010)
Healthy People 2020 Target = 6.0 or Lower

Hillsborough County	BayCare Area	FL	US
8.3	7.9	7.0	6.5

Sources: • Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.
• Retrieved May 2016 from Community Commons at http://www.chna.org.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective MICH-1.3]
Notes: • Infant deaths include deaths of children under 1 year old.
• This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

Key Informant Input: Infant & Child Health

The following chart outlines key informants' perceptions of the severity of *Infant & Child Health* as a problem in the community:
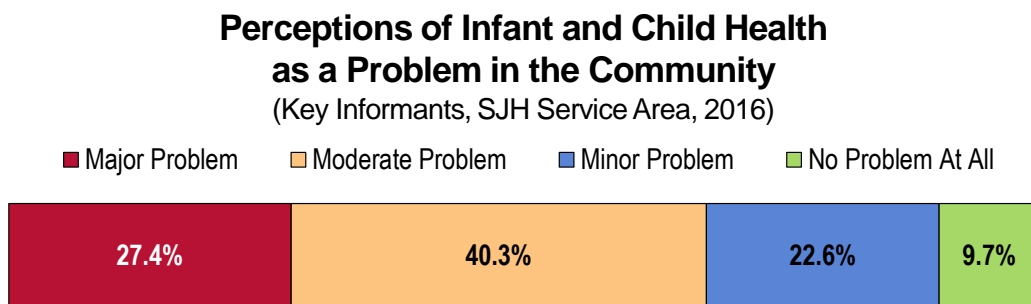
Perceptions of Infant and Child Health as a Problem in the Community
(Key Informants, SJH Service Area, 2016)

■ Major Problem   □ Moderate Problem   ■ Minor Problem   □ No Problem At All

Major Problem	Moderate Problem	Minor Problem	No Problem At All
27.4%	40.3%	22.6%	9.7%

Sources: • PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: • Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

Our nonwhite infant mortality and prematurity is unacceptably high. – Public Health Representative

The high infant mortality rate in the area. – Public Health Representative

Rates of infant mortality, prematurity and SUIDs. – Social Services Provider

Leads to unhealthy adolescents and adults. – Public Health Representative

When we compare our child health indicators to the national average, we are performing poorly on every one of them. Especially with mental health and children with medical complexities. – Community Leader

University area has one of the highest infant mortality death rates and child removal rates of Hillsborough County. – Community Leader

The US has the poorest birth outcomes compared to similar countries. Infant mortality rates in Hillsborough County and the State are high. Black infant morbidity and mortality are almost double the rates of other population groups. – Public Health Representative

Affordable Care/Services

Co-payment, deductibles and decrease in pediatricians, pediatric nurse practitioners and specialists compared to our increasing infant, child and adolescent population. – Community Leader

Transportation

Transportation is the biggest barrier to care. – Other Health Provider

Vulnerable Populations

Anytime you have a large population of people living in poverty there is going to be a concern for proper nutrition and medical attention. – Community Leader

Racial disparity and infant mortality. – Social Services Provider

Family Planning

Births to Teen Mothers

About Teen Births

The negative outcomes associated with unintended pregnancies are compounded for adolescents. Teen mothers:

- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately $3,500 less per year, when compared with those who delay childbearing.
- Receive nearly twice as much Federal aid for nearly twice as long.

Similarly, early fatherhood is associated with lower educational attainment and lower income. Children of teen parents are more likely to have lower cognitive attainment and exhibit more behavior problems. Sons of teen mothers are more likely to be incarcerated, and daughters are more likely to become adolescent mothers.

- Healthy People 2020 (www.healthypeople.gov)

The following chart describes local teen births.
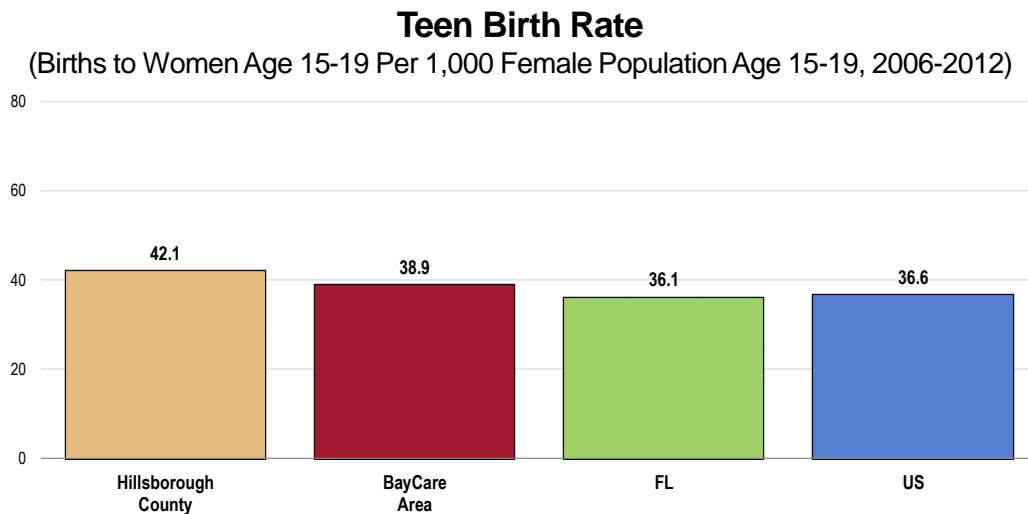
Teen Birth Rate
(Births to Women Age 15-19 Per 1,000 Female Population Age 15-19, 2006-2012)

Hillsborough County	BayCare Area	FL	US
42.1	38.9	36.1	36.6

Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.
- Retrieved May 2016 from Community Commons at http://www.chna.org.

Notes:
- This indicator reports the rate of total births to women under the age of 15 - 19 per 1,000 female population age 15 - 19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

Key Informant Input: Family Planning

The following chart outlines key informants' perceptions of the severity of *Family Planning* as a problem in the community:

Perceptions of Family Planning
as a Problem in the Community
(Key Informants, SJH Service Area, 2016)
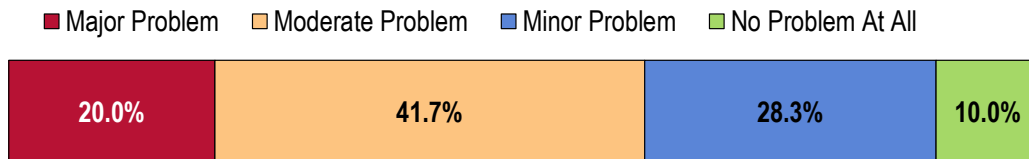
■ Major Problem　□ Moderate Problem　■ Minor Problem　□ No Problem At All

20.0%	41.7%	28.3%	10.0%

Sources:　● PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes:　● Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

Many hospitals limit the type of services including abortions, sterilizations and, in some cases, contraception. In addition, many OBGYN physicians do not perform these services, as well. – Community Leader

Fertility in Tampa Bay has poor services that are both not of high quality compared to outcomes in the rest of the country and limited in both scope of services provided, as well as locations. – Community Leader

Long-lasting birth control is difficult to obtain. Daily oral birth control is not practical for many populations. – Other Health Provider

Health Education

Lack of community knowledge on prevention strategies. More resources to better educate community members is needed. – Community Leader

Education. – Community Leader

Family planning is a major problem in many communities because generally we do not want to talk about directives until we absolutely have to address it and by that point, decisions can be based on emotions rather than thoughtful planning. – Community Leader

Unplanned Pregnancies

Florida is 49th in US in Family Planning. Fifty-two percent of births are unplanned. – Social Services Provider

Unwanted pregnancy has a ripple effect on health of other family members and secondary effects on public health. – Public Health Representative

Affordable Care/Services

Services are limited for the low-income residents. Access may be difficult. – Public Health Representative

Lack of both public and providers' knowledge of Title X and Family Planning Waiver. – Social Services Provider

Access to Providers

Few high-risk specialists and OB/GYNs in the community, related to the population. – Community Leader

Prevalence/Incidence

Been presented as an area of concern at multiple community health meetings I've attended. – Social Services Provider

Modifiable Health Risks

Actual Causes Of Death

About Contributors to Mortality

A 1999 study (an update to a landmark 1993 study), estimated that as many as 40% of premature deaths in the United States are attributed to behavioral factors. This study found that behavior patterns represent the single-most prominent domain of influence over health prospects in the United States. The daily choices we make with respect to diet, physical activity, and sex; the substance abuse and addictions to which we fall prey; our approach to safety; and our coping strategies in confronting stress are all important determinants of health.

The most prominent contributors to mortality in the United States in 2000 were **tobacco** (an estimated 435,000 deaths), **diet and activity** patterns (400,000), **alcohol** (85,000), **microbial agents** (75,000), **toxic agents** (55,000), **motor vehicles** (43,000), **firearms** (29,000), **sexual behavior** (20,000), and **illicit use of drugs** (17,000). Socioeconomic status and access to medical care are also important contributors, but difficult to quantify independent of the other factors cited. Because the studies reviewed used different approaches to derive estimates, the stated numbers should be viewed as first approximations.

These analyses show that smoking remains the leading cause of mortality. However, poor diet and physical inactivity may soon overtake tobacco as the leading cause of death. These findings, along with escalating healthcare costs and aging population, argue persuasively that the need to establish a more preventive orientation in the US healthcare and public health systems has become more urgent.

- Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, Phd, MSc; Julie L. Gerberding, MD, MPH. "Actual Causes of Death in the United States." JAMA, 291(2004):1238-1245.

While causes of death are typically described as the diseases or injuries immediately precipitating the end of life, a few important studies have shown that the actual causes of premature death (reflecting underlying risk factors) are often preventable.

Factors Contributing to Premature Deaths in the United States
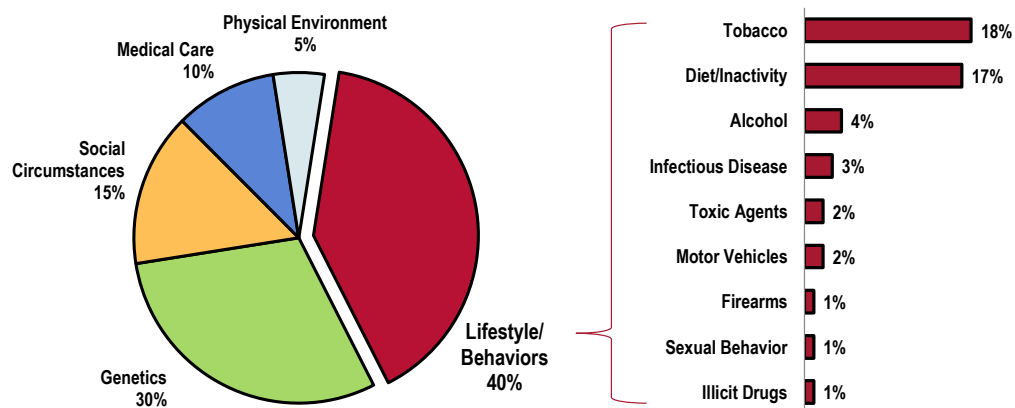
Sources: ● "The Case For More Active Policy Attention to Health Promotion"; (McGinnis, Williams-Russo, Knickman) Health Affairs. Vol. 32. No. 2. March/April 2002.
"Actual Causes of Death in the United States": (Ali H. Mokdad, PhD; James S. Marks, MD, MPH; Donna F. Stroup, PhD, MSc; Julie L. Gerberding, MD, MPH.) JAMA. 291 (2000) 1238-1245.

Nutrition, Physical Activity & Weight

Nutrition

About Healthful Diet & Healthy Weight

Strong science exists supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities.

The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

Americans with a healthful diet:

- Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, low-fat or fat-free milk or milk products, and lean meats and other protein sources.
- Limit the intake of saturated and trans fats, cholesterol, added sugars, sodium (salt), and alcohol.
- Limit caloric intake to meet caloric needs.

Diet and body weight are related to health status. Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions, including: overweight and obesity; malnutrition; iron-deficiency anemia; heart disease; high blood pressure; dyslipidemia (poor lipid profiles); type 2 diabetes; osteoporosis; oral disease; constipation; diverticular disease; and some cancers.

Diet reflects the variety of foods and beverages consumed over time and in settings such as worksites, schools, restaurants, and the home. Interventions to support a healthier diet can help ensure that:

- Individuals have the knowledge and skills to make healthier choices.
- Healthier options are available and affordable.

Social Determinants of Diet. Demographic characteristics of those with a more healthful diet vary with the nutrient or food studied. However, most Americans need to improve some aspect of their diet.

Social factors thought to influence diet include:

- Knowledge and attitudes
- Skills
- Social support
- Societal and cultural norms
- Food and agricultural policies
- Food assistance programs
- Economic price systems

Physical Determinants of Diet. Access to and availability of healthier foods can help people follow healthful diets. For example, better access to retail venues that sell healthier options may have a positive impact on a person's diet; these venues may be less available in low-income or rural neighborhoods.

The places where people eat appear to influence their diet. For example, foods eaten away from home often have more calories and are of lower nutritional quality than foods prepared at home.

Marketing also influences people's—particularly children's—food choices.

- Healthy People 2020 (www.healthypeople.gov)

Daily Recommendation of Fruits/Vegetables

To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

"Now I would like you to think about the foods you ate or drank yesterday. Include all the foods you ate, both at home and away from home. How many servings of fruit or fruit juices did you have yesterday?"

"How many servings of vegetables did you have yesterday?"

The questions above are used to calculate daily fruit/vegetable consumption for adults at the respondent level. The proportion reporting having 5 or more servings per day is shown below.

Consume Five or More Servings of Fruits/Vegetables Per Day
(SJH Service Area, 2016)

Men	20.8%	
Women	35.3%	
18 to 39	33.0%	
40 to 64	24.2%	
65+	28.3%	
Low Income	33.9%	
Mid/High Income	25.8%	
White	25.8%	
Hispanic	36.2%	
Other	26.2%	
SJH	28.3%	
BayCare Area	26.8%	
US	27.4%	
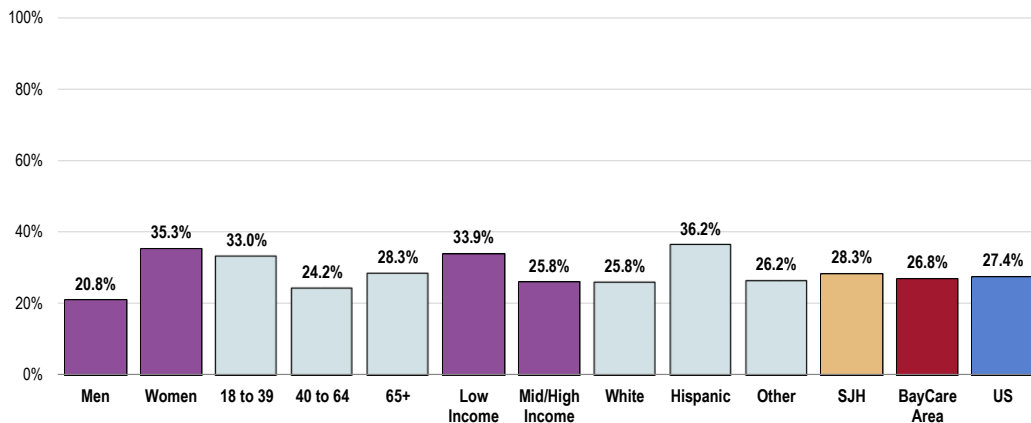
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 168]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; and "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
● For this issue, respondents were asked to recall their food intake on the previous day.

Access to Fresh Produce

**"How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford —
would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?"**

**Find It "Very" or "Somewhat"
Difficult to Buy Affordable Fresh Produce**
(SJH Service Area, 2016)
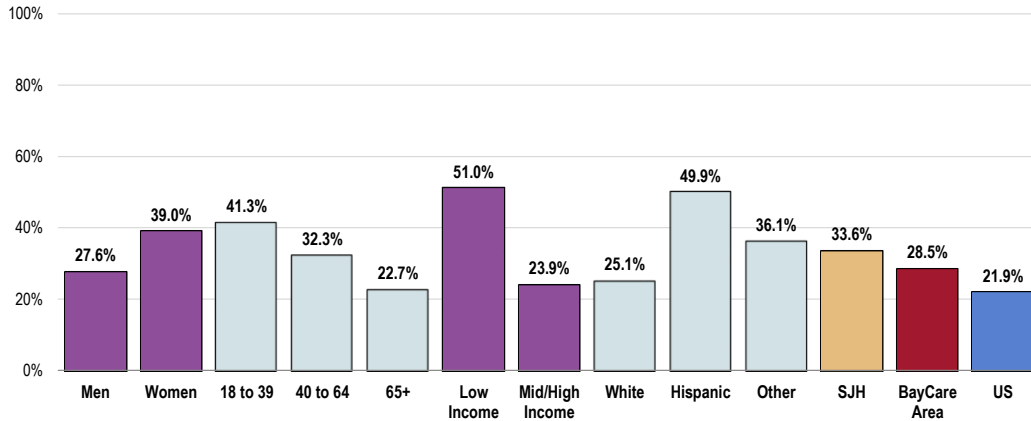
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; and "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

A food desert is defined as a low-income area where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas. The chart for this indicator below is based on US Department of Agriculture data.

Population With Low Food Access
(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2010)
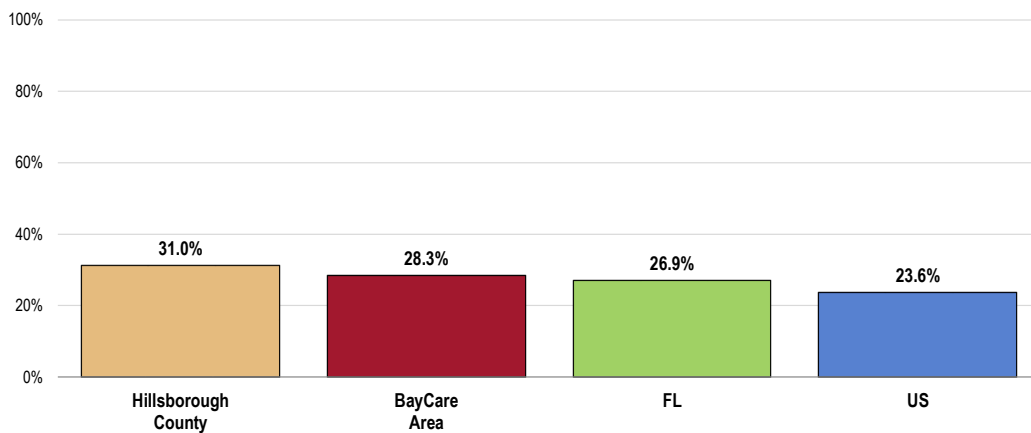
Sources: ● US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
● Retrieved May 2016 from Community Commons at http://www.chna.org.
Notes: ● This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as low-income areas where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas. This indicator is relevant because it highlights populations and geographies facing food insecurity.

Physical Activity

About Physical Activity

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults and older adults, physical activity can lower the risk of: early death; coronary heart disease; stroke; high blood pressure; type 2 diabetes; breast and colon cancer; falls; and depression. Among children and adolescents, physical activity can: improve bone health; improve cardiorespiratory and muscular fitness; decrease levels of body fat; and reduce symptoms of depression. For people who are inactive, even small increases in physical activity are associated with health benefits.

Personal, social, economic, and environmental factors all play a role in physical activity levels among youth, adults, and older adults. Understanding the barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity.

Factors **positively** associated with adult physical activity include: postsecondary education; higher income; enjoyment of exercise; expectation of benefits; belief in ability to exercise (self-efficacy); history of activity in adulthood; social support from peers, family, or spouse; access to and satisfaction with facilities; enjoyable scenery; and safe neighborhoods.

Factors **negatively** associated with adult physical activity include: advancing age; low income; lack of time; low motivation; rural residency; perception of great effort needed for exercise; overweight or obesity; perception of poor health; and being disabled. Older adults may have additional factors that keep them from being physically active, including lack of social support, lack of transportation to facilities, fear of injury, and cost of programs.

Among children ages 4 to 12, the following factors have a positive association with physical activity: gender (boys); belief in ability to be active (self-efficacy); and parental support.

Among adolescents ages 13 to 18, the following factors have a positive association with physical activity: parental education; gender (boys); personal goals; physical education/school sports; belief in ability to be active (self-efficacy); and support of friends and family.

Environmental influences positively associated with physical activity among children and adolescents include:

- Presence of sidewalks
- Having a destination/walking to a particular place
- Access to public transportation
- Low traffic density
- Access to neighborhood or school play area and/or recreational equipment

People with disabilities may be less likely to participate in physical activity due to physical, emotional, and psychological barriers. Barriers may include the inaccessibility of facilities and the lack of staff trained in working with people with disabilities.

- Healthy People 2020 (www.healthypeople.gov)

Leisure-Time Physical Activity

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

"During the past month, other than your regular job, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?"

No Leisure-Time Physical Activity in the Past Month
Healthy People 2020 Target = 32.6% or Lower

26.6%	27.5%	23.7%	27.9%
SJH	BayCare Area	FL	US
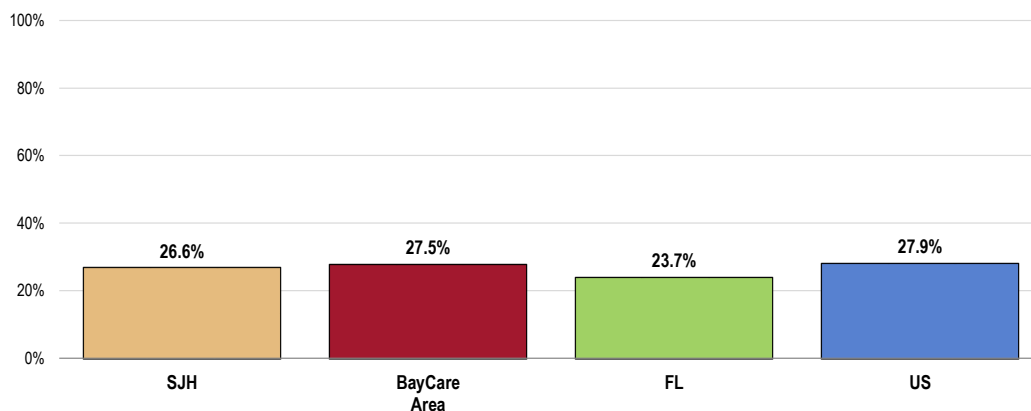
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 106]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

Notes:
- Asked of all respondents.

Recommended Levels of Physical Activity

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity aerobic physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. The guidelines also recommend that adults do muscle-strengthening activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

- 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

Meeting Physical Activity Recommendations

To measure physical activity frequency, duration and intensity, respondents were asked:

"During the past month, what type of physical activity or exercise did you spend the most time doing?"

"And during the past month, how many times per week or per month did you take part in this activity?"

"And when you took part in this activity, for how many minutes or hours did you usually keep at it?"

Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes.

Respondents were also asked about strengthening exercises:

"During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups or push-ups, and those using weight machines, free weights, or elastic bands."

"Meeting physical activity recommendations" includes adequate levels of <u>both</u> aerobic and strengthening activity:

- Aerobic activity is at least 150 minutes per week of light to moderate activity or 75 minutes per week of vigorous physical activity or an equivalent combination of both; **and**
- Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.

Meets Physical Activity Recommendations
(SJH Service Area, 2016)
Healthy People 2020 Target = 20.1% or Higher

Category	Value
Men	27.5%
Women	22.7%
18 to 39	23.3%
40 to 64	24.6%
65+	27.3%
Low Income	14.1%
Mid/High Income	31.7%
White	25.3%
Hispanic	24.6%
Other	23.7%
SJH	24.9%
BayCare Area	21.7%
FL	19.9%
US	23.6%
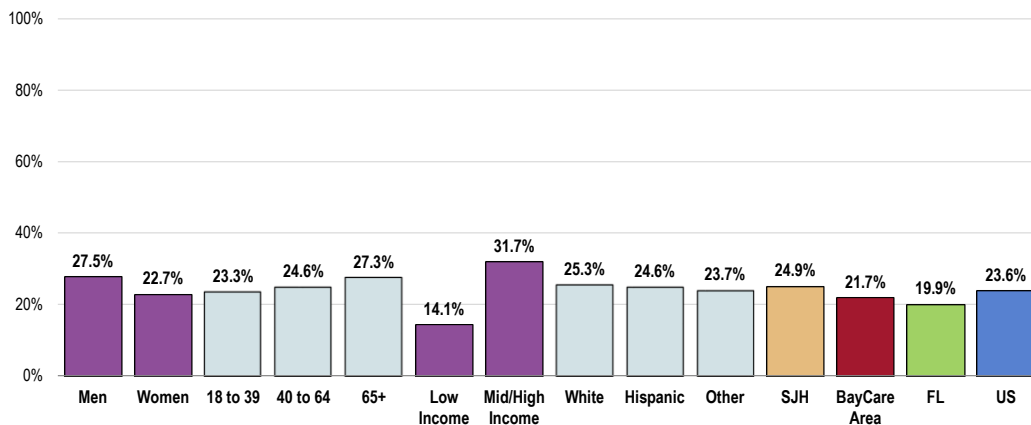
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 174]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-4]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; and "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity <u>and</u> report doing physical activities specifically designed to strengthen muscles at least twice per week.

Children's Physical Activity

"During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?"

Child Is Physically Active for One or More Hours per Day
(Among Children Age 2-17)
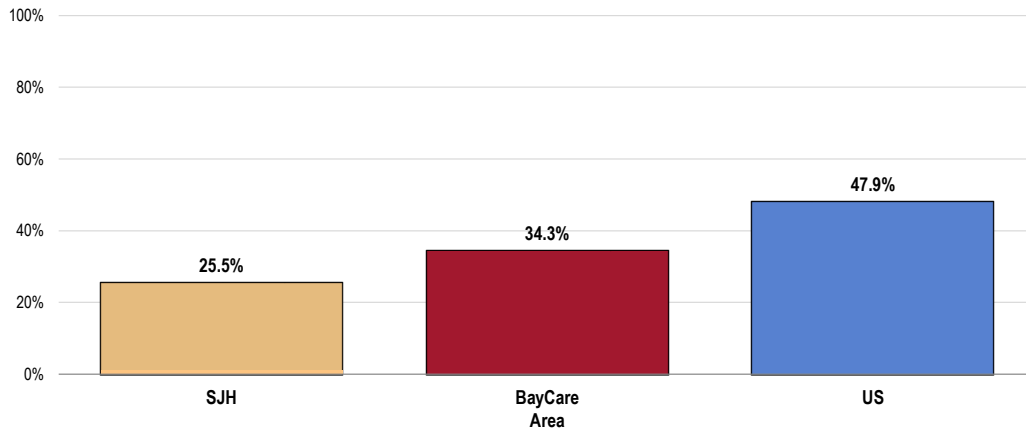
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 142]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children age 2-17 at home.
- Includes children reported to have one or more hours of physical activity on each of the seven days preceding the survey.

Weight Status

About Overweight & Obesity

Because weight is influenced by energy (calories) consumed and expended, interventions to improve weight can support changes in diet or physical activity. They can help change individuals' knowledge and skills, reduce exposure to foods low in nutritional value and high in calories, or increase opportunities for physical activity. Interventions can help prevent unhealthy weight gain or facilitate weight loss among obese people. They can be delivered in multiple settings, including healthcare settings, worksites, or schools.

The social and physical factors affecting diet and physical activity (see Physical Activity topic area) may also have an impact on weight. Obesity is a problem throughout the population. However, among adults, the prevalence is highest for middle-aged people and for non-Hispanic black and Mexican American women. Among children and adolescents, the prevalence of obesity is highest among older and Mexican American children and non-Hispanic black girls. The association of income with obesity varies by age, gender, and race/ethnicity.

- Healthy People 2020 (www.healthypeople.gov)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared (inches^2)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

- Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Classification of Overweight and Obesity by BMI	BMI (kg/m^2)
Underweight	<18.5
Healthy Weight	18.5 – 24.9
Overweight, not Obese	25.0 – 29.9
Obese	≥30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

Adult Weight Status

"About how much do you weigh without shoes?"

"About how tall are you without shoes?"

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).

Prevalence of Total Overweight (Overweight or Obese)
(Percent of Adults With a Body Mass Index of 25.0 or Higher)

SJH	BayCare Area	FL	US
63.0%	66.5%	62.2%	65.2%
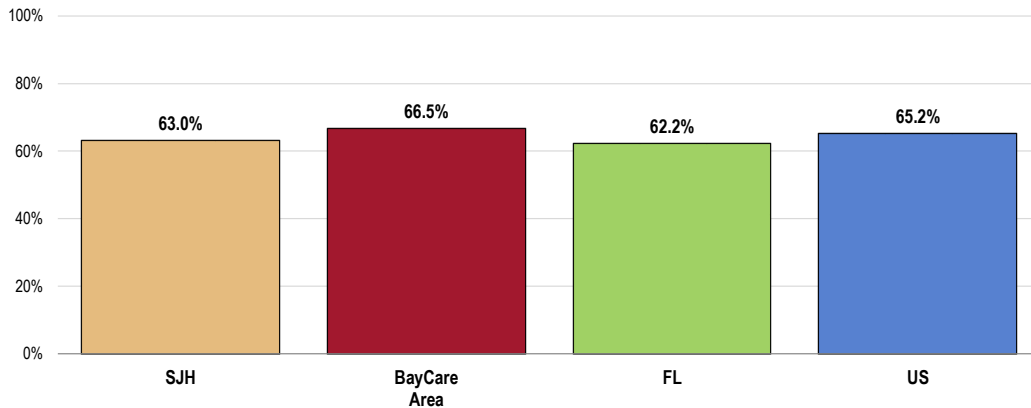
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 176-177]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Obesity
(Percent of Adults With a Body Mass Index of 30.0 or Higher)
Healthy People 2020 Target = 30.5% or Lower
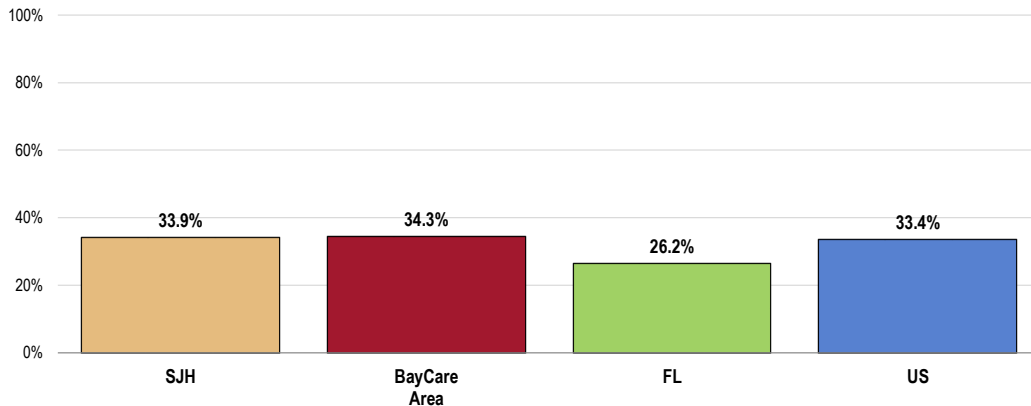
SJH	BayCare Area	FL	US
33.9%	34.3%	26.2%	33.4%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 176]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Prevalence of Obesity
(Percent of Adults With a BMI of 30.0 or Higher; SJH Service Area, 2016)
Healthy People 2020 Target = 30.5% or Lower
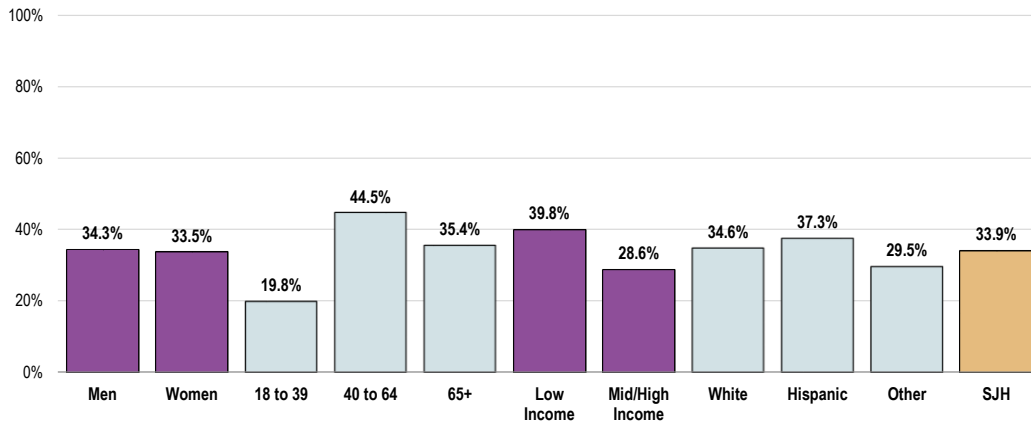
	Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Hispanic	Other	SJH
	34.3%	33.5%	19.8%	44.5%	35.4%	39.8%	28.6%	34.6%	37.3%	29.5%	33.9%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 176]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]

Notes:
- Based on reported heights and weights, asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; and "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants' perceptions of the severity of *Nutrition, Physical Activity & Weight* as a problem in the community:

Perceptions of Nutrition, Physical Activity, and Weight as a Problem in the Community
(Key Informants, SJH Service Area, 2016)

■ Major Problem ■ Moderate Problem ■ Minor Problem ■ No Problem At All

Major Problem	Moderate Problem	Minor Problem	No Problem At All
46.2%	8.5%	10.8%	4.6%

Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Obesity

Behavior change is difficult. And while this is important, the factors that lead to obesity are complex and go beyond only individual behavior change. MD's do not refer their overweight and obese patients to the professional who is trained to treat it. – Public Health Representative

Obesity epidemic in our youth and adults. – Community Leader

Obesity is an epidemic. – Physician

Obese and overweight adults and youth as a result of inactivity and poor nutrition. – Social Services Provider

Obesity is a big concern. Nutrition and physical activity impact the weight. Obesity impacts heart disease and diabetes. – Public Health Representative

Lifestyle

The entire American culture embraces excess, and now overweight is our new norm. – Physician

Public health behavioral modification initiatives are often insufficient to overcome long-ingrained habits, cultural norms and marketing strategies. Lack of time and access to facilities preclude sustaining regular exercise regimens. – Community Leader

Living a healthy lifestyle, education. – Social Services Provider

Normalizing physical activity and healthy eating behaviors. – Public Health Representative

Young people live on their phones and computers and don't exercise enough. This is a huge problem in our community and in this country. – Community Leader

Access to Care/Services

No resources for people to engage. – Public Health Representative

Availability of culturally relevant services and identified best practices for specific populations. Also coordination of such services. – Other Health Provider

Evaluation of nutritional, weight problems in children. Limited access to detailed education and counseling for families on strategies and solutions for problems identified. Resources for healthy meal choices in certain communities. – Physician

Access to Healthful Food

Healthy foods such as fresh fruits and vegetables are more expensive, less readily available and not as convenient as fast foods. Many of the challenges around this issue are both cultural and related to lifestyle. – Other Health Provider

Lack of healthy foods available to indigent families in our community. – Social Services Provider

Access to fresh, healthy affordable food. Access to safe parks and green spaces. Dangerous roads that prevent walking and biking. Reduced PE and recess in public schools. – Social Services Provider

Not enough access to healthy food options and priority to reaching the people that need it the most. Not enough affordable, accessible farmers markers, need for healthier work sites, better access to safe places to be physically active. – Social Services Provider

Built Environment

Lack of safe places to exercise and do physical activity outdoors, cost and availability of programs. Ready and affordable healthy food options. Lack of strong physical education programs in schools and cultural barriers. – Social Services Provider

Prevalence/Incidence

Big issue in all communities. – Other Health Provider

Comorbidities

Leads to many chronic diseases. – Public Health Representative

Health Education

Lack of understanding by the population. – Physician

Substance Abuse

About Substance Abuse

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime
- Homicide
- Suicide

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have gradually shifted the research community's perspective on substance abuse. There is now a deeper understanding of substance abuse as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

Improved evaluation of community-level prevention has enhanced researchers' understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings.

A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. Improvements have focused on the development of better clinical interventions through research and increasing the skills and qualifications of treatment providers.

- Healthy People 2020 (www.healthypeople.gov)

Related Age-Adjusted Mortality

Cirrhosis/Liver Disease. Heavy alcohol use contributes to a significant share of liver disease, including cirrhosis. The chart below outlines age-adjusted mortality for cirrhosis/liver disease in the area.

Drug-Induced Deaths. Drug-induced deaths include all deaths for which drugs are the underlying cause, including those attributable to acute poisoning by drugs (drug overdoses) and deaths from medical conditions resulting from chronic drug use (e.g., drug-induced Cushing's syndrome). A "drug" includes illicit or street drugs (e.g., heroin and cocaine), as well as legal prescription and over-the-counter drugs; alcohol is not included. These deaths may also be either intentional (e.g., suicide) or unintentional (accidental). The chart below outlines local age-adjusted mortality for drug-induced deaths.

Cirrhosis/Liver Disease: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 8.2 or Lower
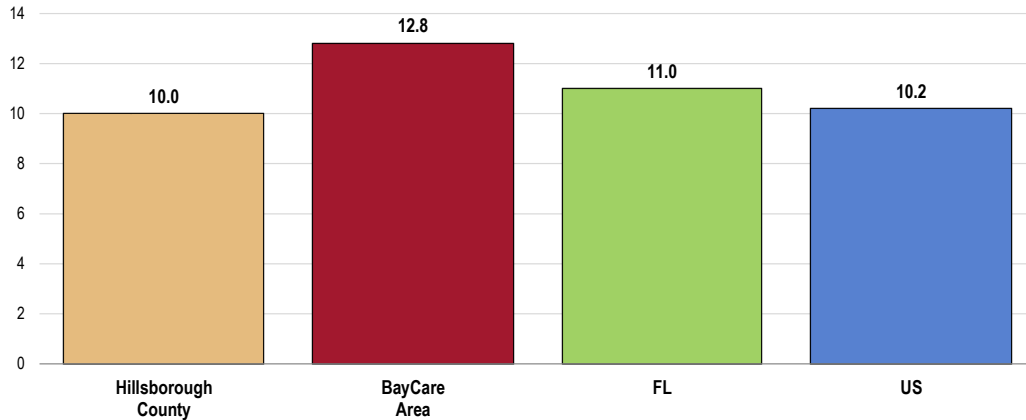
Chart showing values:
- Hillsborough County: 10.0
- BayCare Area: 12.8
- FL: 11.0
- US: 10.2

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-11]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Drug-Induced Deaths: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 11.3 or Lower
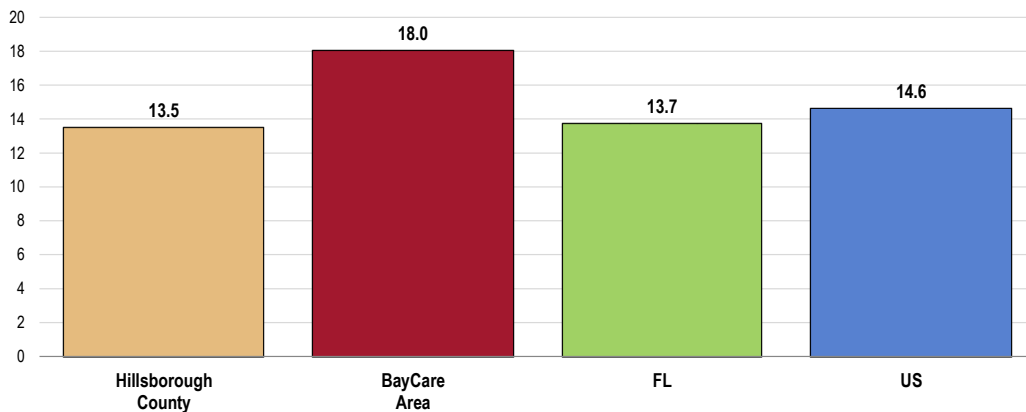
Chart showing values:
- Hillsborough County: 13.5
- BayCare Area: 18.0
- FL: 13.7
- US: 14.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted May 2016.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-12]

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Alcohol Use

Excessive Drinkers. Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) or who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

"During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?"

"On the day(s) when you drank, about how many drinks did you have on the average?"

"Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)/4 (if female) or more drinks on an occasion?"

Excessive Drinkers
(SJH Service Area, 2016)
Healthy People 2020 Target = 25.4% or Lower

Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Hispanic	Other	SJH	BayCare Area	US
32.7%	22.0%	36.3%	24.8%	18.9%	23.3%	32.5%	25.5%	31.7%	26.8%	27.2%	24.4%	22.2%
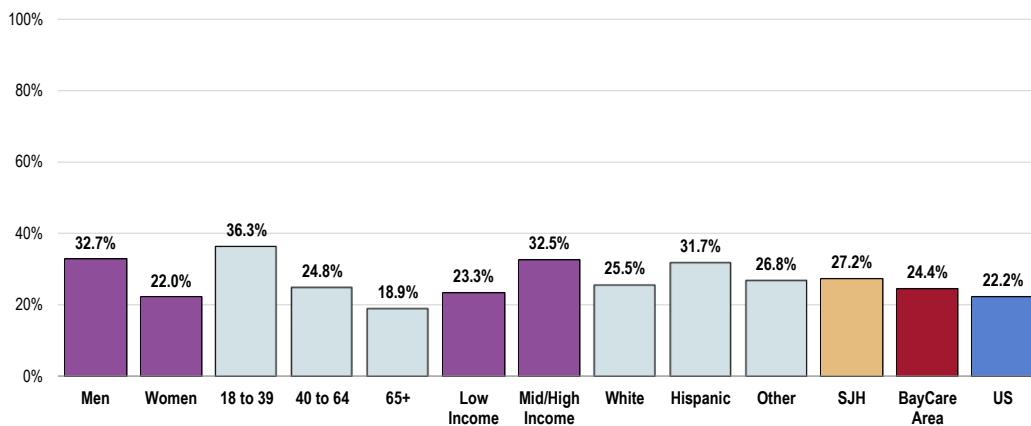
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 189]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-15]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "NH White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; and "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Excessive drinking reflects the number of persons aged 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

Drinking & Driving. As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that the actual incidence of drinking and driving in the community is likely higher.

"During the past 30 days, how many times have you driven when you've had perhaps too much to drink?"

Have Driven in the Past Month
After Perhaps Having Too Much to Drink

Area	Percentage
SJH	9.1%
BayCare Area	6.2%
US	4.1%
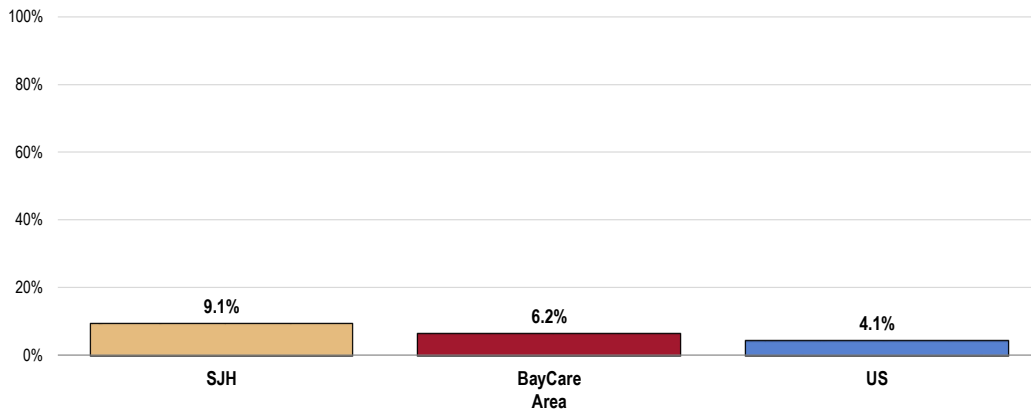
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 66]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Illicit Drug Use

"During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?"

Illicit Drug Use in the Past Month
Healthy People 2020 Target = 7.1% or Lower

Area	Percentage
SJH	9.5%
BayCare Area	6.2%
US	3.0%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 67]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-13.3]

Notes:
- Asked of all respondents.

Alcohol & Drug Treatment

"Have you ever sought professional help for an alcohol or drug-related problem?"

Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem

SJH	BayCare Area	US
8.3%	5.0%	4.1%

Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 68]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Personal Impact of Substance Abuse

"To what degree has your life been negatively affected by your own or someone else's substance abuse issues, including alcohol, prescription, and other drugs? Would you say: a great deal, somewhat, a little, or not at all?"

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)
(SJH Service Area, 2016)

Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Hispanic	Other	SJH	BayCare Area	US
34.9%	40.6%	38.1%	41.2%	31.9%	41.6%	35.8%	41.8%	38.0%	28.8%	37.9%	37.9%	32.2%

Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 69]
Notes: ● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; and "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Substance Abuse

The following chart outlines key informants' perceptions of the severity of *Substance Abuse* as a problem in the community:

Perceptions of Substance Abuse
as a Problem in the Community
(Key Informants, SJH Service Area, 2016)
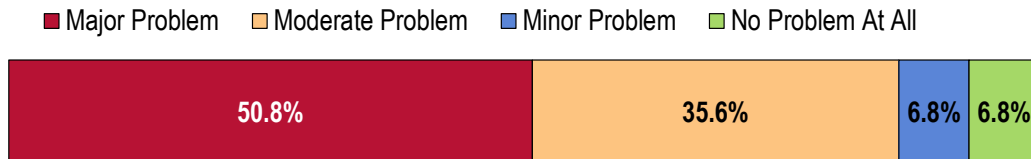
■ Major Problem   ☐ Moderate Problem   ■ Minor Problem   ☐ No Problem At All

50.8%	35.6%	6.8%	6.8%

Sources: ● PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Barriers to Treatment

Among those rating this issue as a "major problem," the greatest barriers to accessing substance abuse treatment are viewed as:

Access to Care/Services

Lack of facilities. – Physician

Few facilities, low reimbursement for providers, high deductibles and co-payments. – Community Leader

High-quality treatment is difficult to access. Insurance coverage is very limited for treatment. – Community Leader

Limited resources; access is problematic. Identification is poor and primary care does not screen for it like they do diabetes or cancer. – Other Health Provider

Not enough treatment centers. No detox facilities, unavailability of beds for patients in a timely fashion. – Social Services Provider

Limited programs. – Physician

No insurance and lack of money to access the needed services. – Social Services Provider

Denial/Stigma

The greatest barrier is likely the individual his/herself. – Physician

Convincing the homeless to seek help. – Social Services Provider

Stigma of substance abuse, number of detox beds, transportation. – Social Services Provider

Impact on Families

The overarching effect on the families and community. – Public Health Representative

Destructive for individual and families. – Public Health Representative

Lack of Funding

Access and funding of the system is broken. Funding is lacking. – Social Services Provider

Lack of funding and lack of knowledge on how to screen, refer and treat. – Physician

Pain Management

Inadequate pain management therapy or inappropriate prescribing of addictive medications often leads to drug-seeking behavior, narcotic dependence, and chronic substance abuse. Biggest barrier is lack of access to quality trained treatment providers. – Community Leader

Prevalence/Incidence

Seeing more heroin and opioid abuse across the board. Spice and other synthetic substances in youth. – Community Leader

Transportation

Lack of transportation and new, innovative, home and community-based outpatient treatment options. – Other Health Provider

Co-Occurrences

Evidence shows at least some of those with mental health conditions self-medicated. – Public Health Representative

Most Problematic Substances

Key informants (who rated this as a "major problem") clearly identified **alcohol** as the most problematic substance abused in the community (both on first mention, and in total mention after three opportunities to respond). **Prescription medications**, **heroin/other opioids** and **synthetic drugs** were also frequently mentioned in total.

Problematic Substances as Identified by Key Informants			
	Most Problematic	Second-Most Problematic	Third-Most Problematic	Total Mentions
Alcohol	50.0%	17.4%	10.0%	**18**
Prescription Medications	12.5%	26.1%	20.0%	**13**
Heroin or Other Opioids	16.7%	21.7%	10.0%	**11**
Synthetic Drugs (e.g. Bath Salts, K2/Spice)	0.0%	26.1%	20.0%	**10**
Methamphetamines or Other Amphetamines	8.3%	0.0%	15.0%	**5**
Marijuana	0.0%	8.7%	10.0%	**4**
Cocaine or Crack	4.2%	0.0%	10.0%	**3**
Hallucinogens or Dissociative Drugs (e.g. Ketamine, PCP, LSD, DXM)	4.2%	0.0%	0.0%	**1**
Inhalants	4.2%	0.0%	0.0%	**1**
Over-The-Counter Medications	0.0%	0.0%	5.0%	**1**

Tobacco Use

About Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964.

Tobacco use causes:

- Cancer
- Heart disease
- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)
- Premature birth, low birth weight, stillbirth, and infant death

There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

- Healthy People 2020 (www.healthypeople.gov)

Cigarette Smoking

"Do you now smoke cigarettes every day, some days, or not at all?"
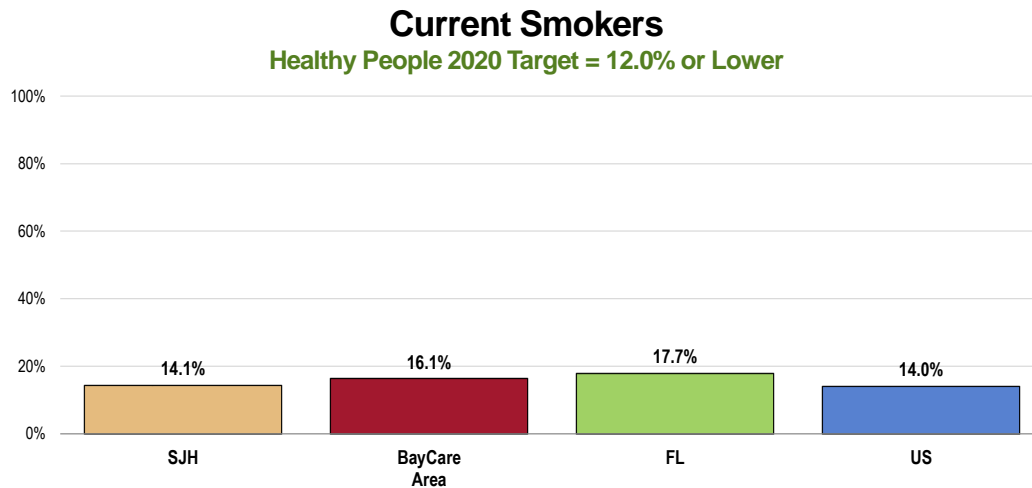
Current Smokers
Healthy People 2020 Target = 12.0% or Lower

	SJH	BayCare Area	FL	US
Current Smokers	14.1%	16.1%	17.7%	14.0%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

Current Smokers
(SJH Service Area, 2016)
Healthy People 2020 Target = 12.0% or Lower
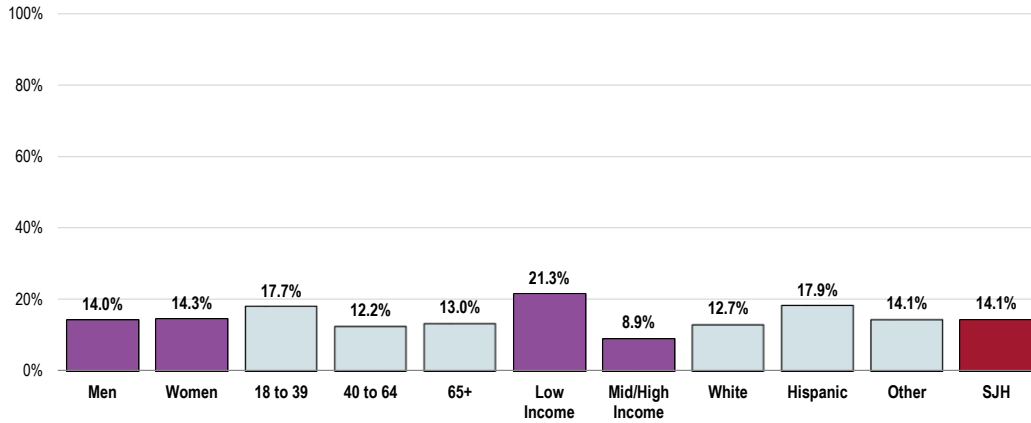
| Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Hispanic	Other	SJH
14.0%	14.3%	17.7%	12.2%	13.0%	21.3%	8.9%	12.7%	17.9%	14.1%	14.1%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; and "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Includes regular and occasion smokers (every day and some days).

Secondhand Smoke

"In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars or pipes anywhere in your home on an average of four or more days per week?"

Member of Household Smokes at Home

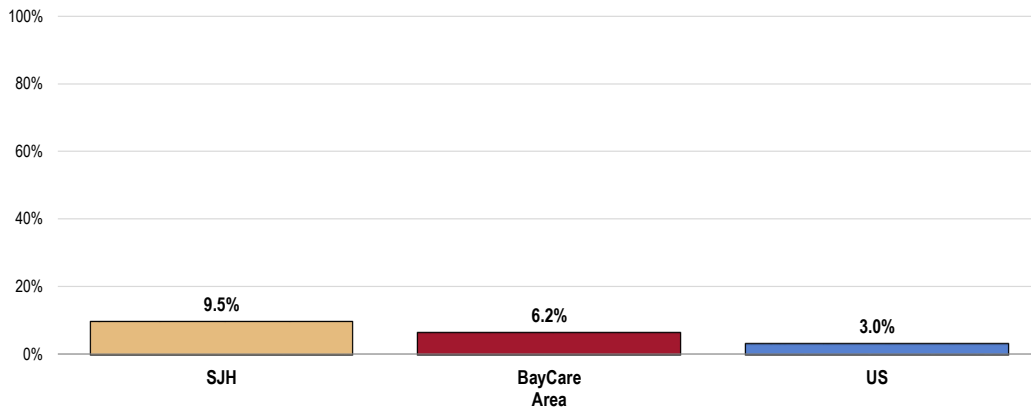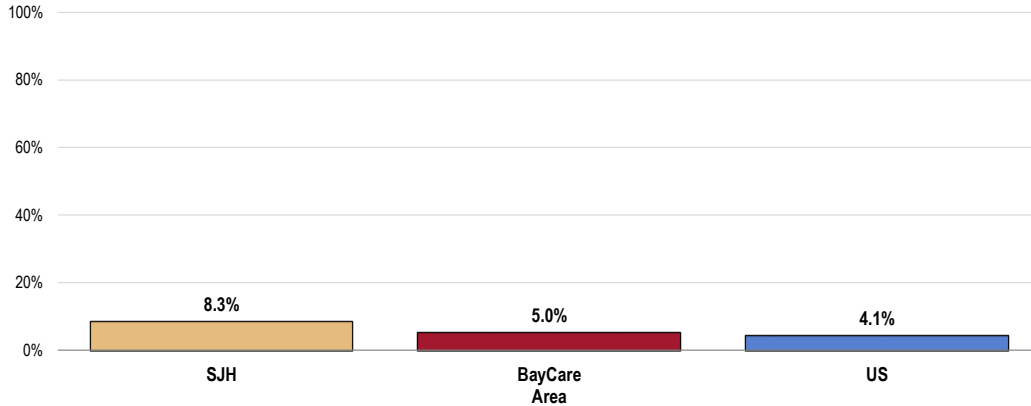| SJH	BayCare Area	US
18.4%	15.0%	10.2%
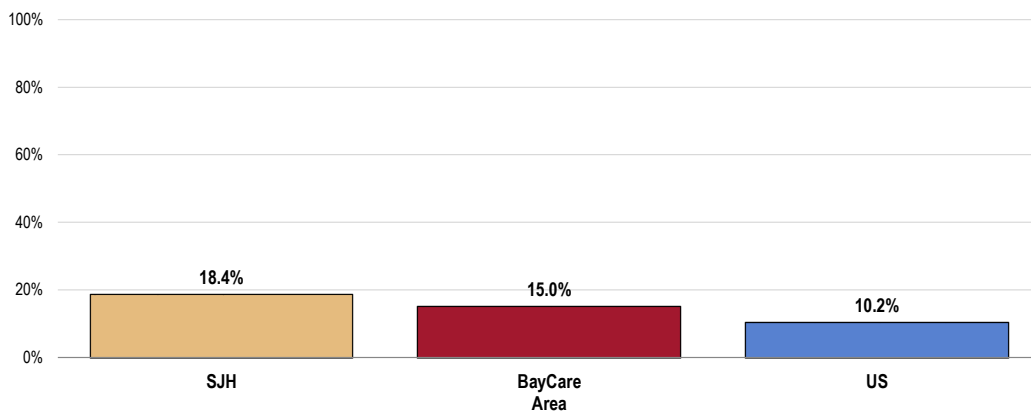
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 58, 184]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

E-Cigarette Use

"The next question is about electronic cigarettes, also known as e-cigarettes. These are battery-operated devices that simulate traditional cigarette smoking, but do not involve the burning of tobacco. The cartridge or liquid "e-juice" used in these devices produces vapor and comes in a variety of flavors. Have you ever used an electronic cigarette?"

Electronic Cigarette Use
(SJH Service Area, 2016)

Use Every Day 1.2%

Use on Some Days 5.2%

Tried, Don't Currently Use 10.8%

Never Tried 82.9%
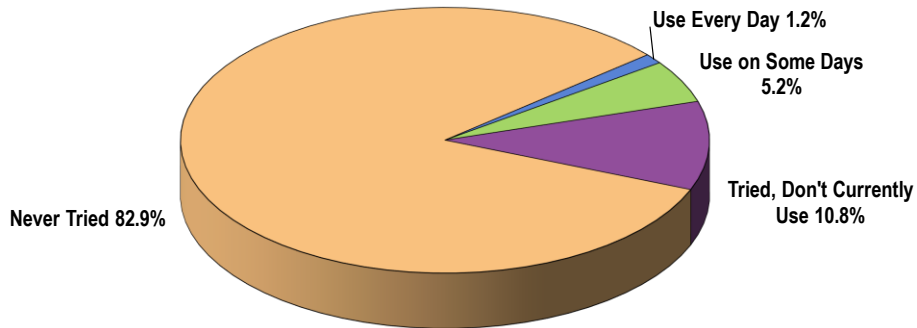
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 208]
Notes: • Asked of all respondents.

Other Tobacco Use

"Do you now smoke cigars every day, some days, or not at all?"

"Do you currently use chewing tobacco, snuff, or snus every day, some days, or not at all?"

Other Tobacco Use

☐ SJH ■ BayCare Area ☐ US

FL = 2.8%

	Cigars	Smokeless Tobacco
SJH	9.6%	6.2%
BayCare Area	7.7%	5.2%
US	3.6%	3.0%

Cigars
HP2020 Goal = 0.2% or Lower
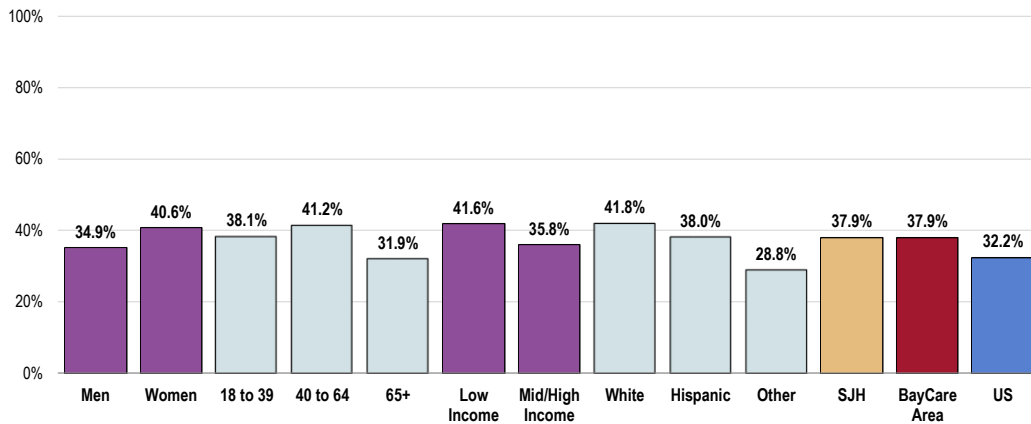
Smokeless Tobacco
HP2020 Goal = 0.3% or Lower
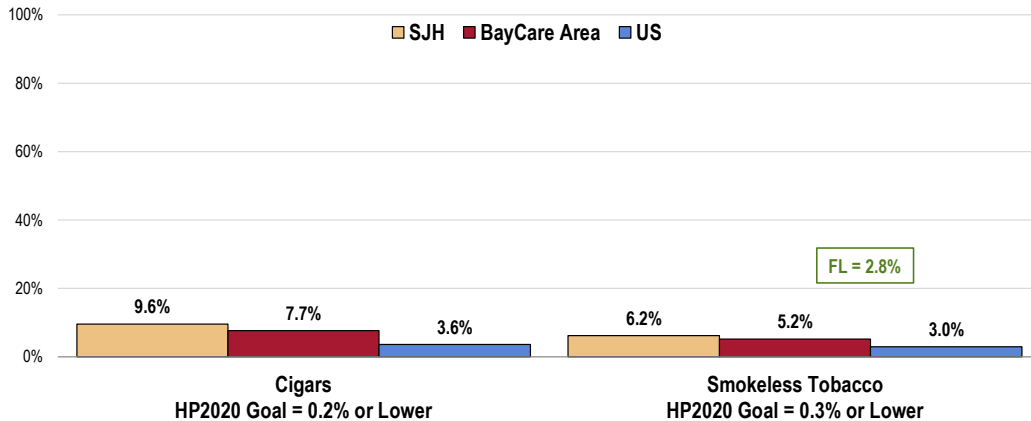
Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 59-60]
• 2015 PRC National Health Survey, Professional Research Consultants, Inc.
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.
• US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives TU-1.2, TU-1.3]
Notes: • Reflects the total sample of respondents.
• Smokeless tobacco includes chewing tobacco or snuff.

Key Informant Input: Tobacco Use

The following chart outlines key informants' perceptions of the severity of *Tobacco Use* as a problem in the community:

Perceptions of Tobacco Use
as a Problem in the Community
(Key Informants, SJH Service Area, 2016)

■ Major Problem   ☐ Moderate Problem   ■ Minor Problem   ■ No Problem At All

22.0%	45.8%	22.0%	10.2%

Sources: ● PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Prevalence/Incidence

> *Increase rates of tobacco usage in community. – Social Services Provider*
>
> *Rampant use. – Physician*
>
> *Stats on tobacco use. – Public Health Representative*

Leading Cause of Death

> *Still a major killer, although we are making progress. – Community Leader*
>
> *Leads to increased morbidity and mortality. – Physician*

Youth

> *Tobacco addiction is a problem that starts with our youth. Not enough education and information is available to counterbalance the marketing and peer pressure of these products. Young people have the feeling of "it is not going to happen to me". – Other Health Provider*
>
> *Younger people lack insight. – Physician*

Co-Occurrences

> *Major risk factor for cancer and pulmonary disease. – Public Health Representative*

Lifestyle

> *Living a healthy lifestyle, and education on impact of tobacco. – Social Services Provider*

Access to Health Services

Lack of Health Insurance Coverage (Age 18 to 64)

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources. Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus excluding the Medicare population) who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

"Do you have any government-assisted healthcare coverage, such as Medicare, Medicaid, or VA/military benefits?"

"Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself; or, you do not have health insurance and pay for health care entirely on your own?"
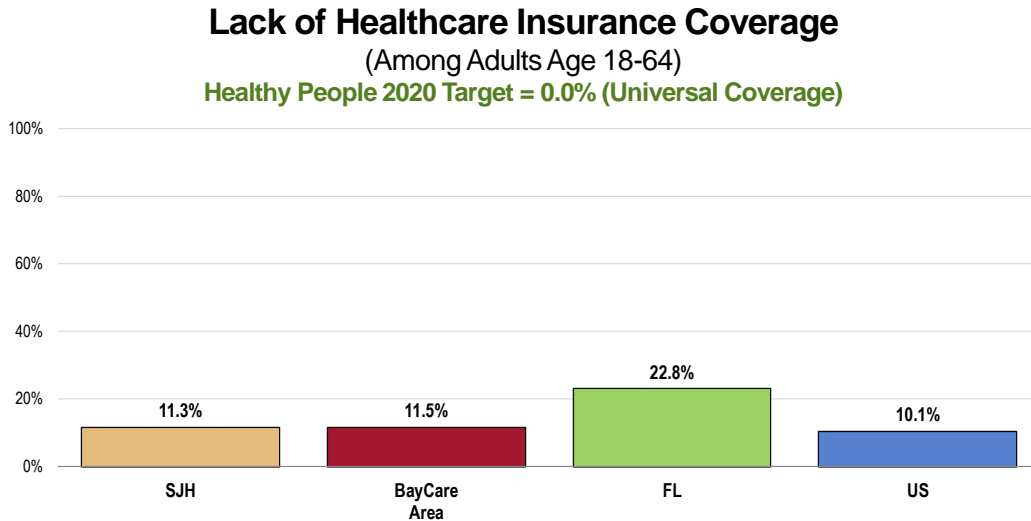
Lack of Healthcare Insurance Coverage
(Among Adults Age 18-64)
Healthy People 2020 Target = 0.0% (Universal Coverage)

	SJH	BayCare Area	FL	US
	11.3%	11.5%	22.8%	10.1%

Sources:
● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-1]
Notes:
● Asked of all respondents under the age of 65.

Lack of Healthcare Insurance Coverage
(Among Adults Age 18-64; SJH Service Area, 2016)
Healthy People 2020 Target = 0.0% (Universal Coverage)
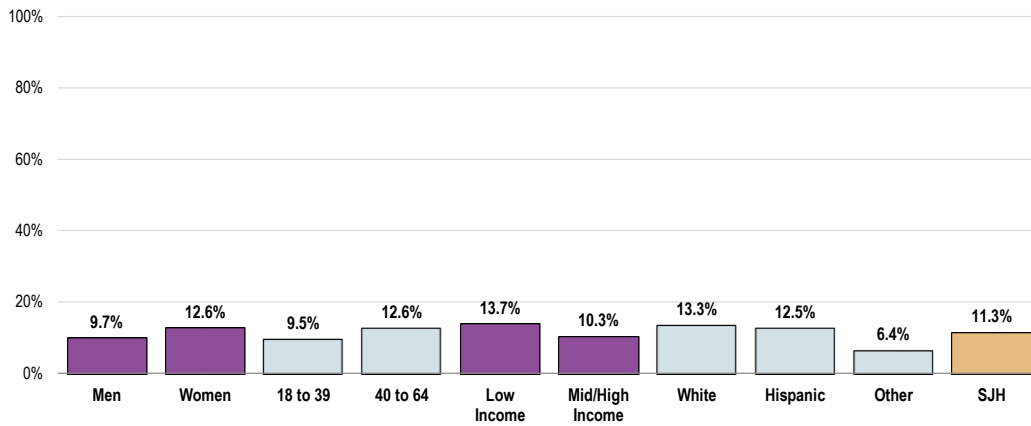
Category	Percentage
Men	9.7%
Women	12.6%
18 to 39	9.5%
40 to 64	12.6%
Low Income	13.7%
Mid/High Income	10.3%
White	13.3%
Hispanic	12.5%
Other	6.4%
SJH	11.3%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-1]

Notes:
- Asked of all respondents under the age of 65.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; and "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Difficulties Accessing Healthcare

About Access to Healthcare

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

- Healthy People 2020 (www.healthypeople.gov)

Barriers to Healthcare Access

To better understand healthcare access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

"Was there a time in the past 12 months when…

- … you needed medical care, but had **difficulty finding a doctor**?"
- … you had difficulty getting an **appointment** to see a doctor?"
- … you needed to see a doctor, but could not because of the **cost**?"
- … a **lack of transportation** made it difficult or prevented you from seeing a doctor or making a medical appointment?"
- … you were not able to see a doctor because the **office hours were not convenient**?"
- … you needed a **prescription medicine**, but did not get it because you could not afford it?"
- … you were not able to see a doctor due to **language or cultural differences**?"

Percentages reflect the total population, regardless of whether medical care was needed or sought.

Barriers to Access Have Prevented Medical Care in the Past Year

Legend: SJH | BayCare Area | US

|	Getting a Dr Appointment	Cost (Prescriptions)	Cost (Doctor Visit)	Inconvenient Office Hours	Finding a Doctor	Lack of Transportation	Language/ Culture
SJH	25.6%	22.0%	19.4%	20.3%	18.7%	12.5%	5.1%
BayCare Area	20.9%	19.5%	17.9%	16.9%	16.8%	10.8%	5.8%
US	15.4%	9.5%	11.5%	14.4%	8.7%	5.0%	1.7%
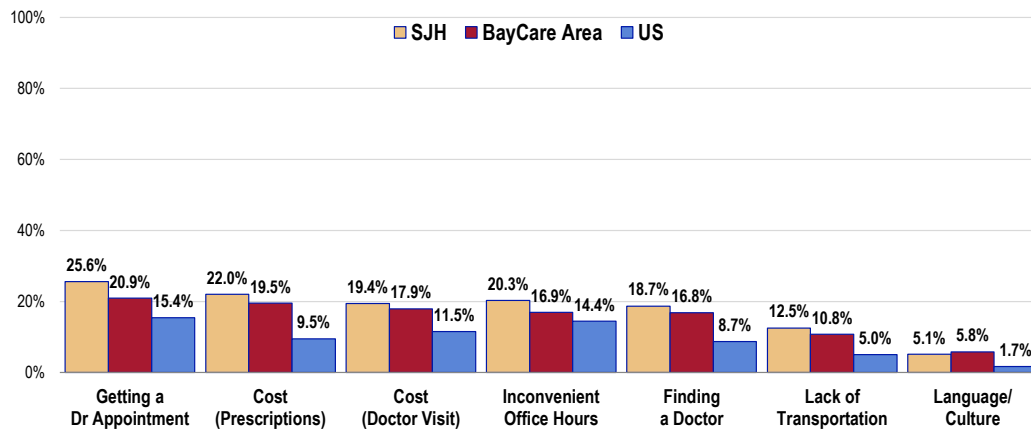
Sources:
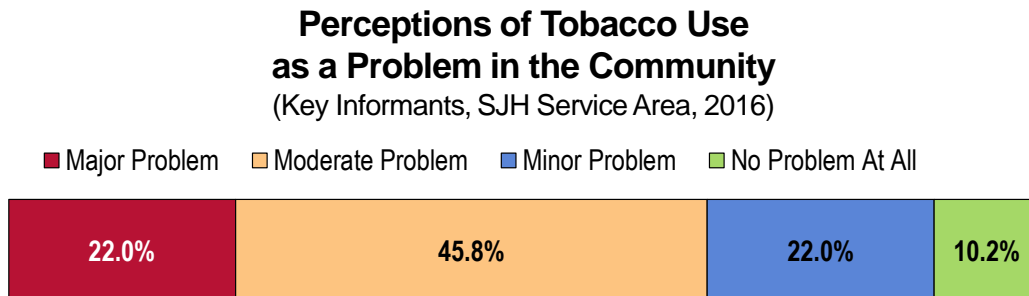- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-13]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

The following charts reflect the composite percentage of the total population experiencing problems accessing healthcare in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year
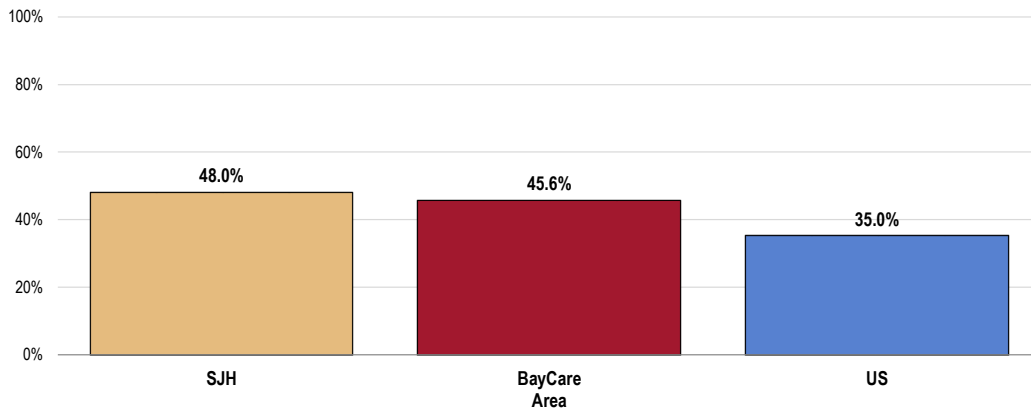
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 194]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.
● Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year
(SJH Service Area, 2016)
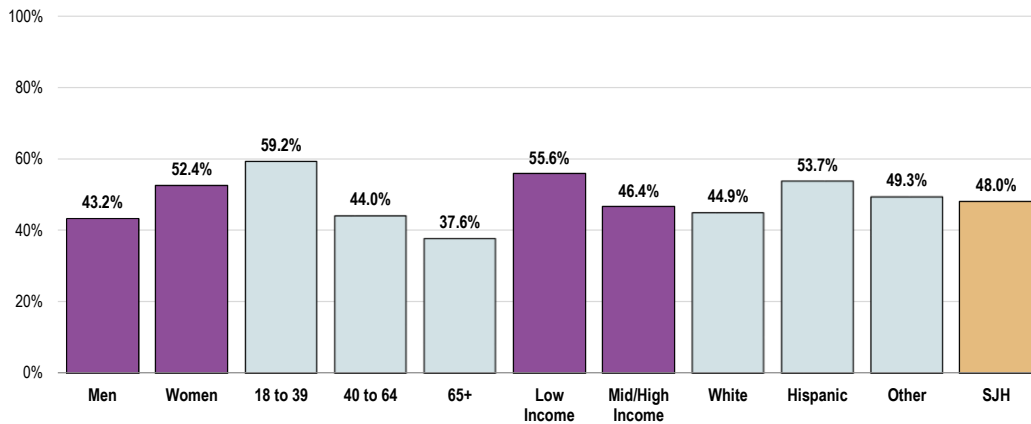
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 194]
Notes: ● Asked of all respondents.
● Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; and "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Accessing Healthcare for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly-selected child in their household.

"Was there a time in the past 12 months when you needed medical care for this child, but could not get it?"

Had Trouble Obtaining Medical Care for Child in the Past Year
(Among Parents of Children 0-17)

Parents with trouble obtaining medical care for their child mainly reported barriers due to cost or lack of insurance coverage. Inconvenient office hours and long waits for appointments were also mentioned.

- SJH: 16.9%
- BayCare Area: 11.1%
- US: 3.9%
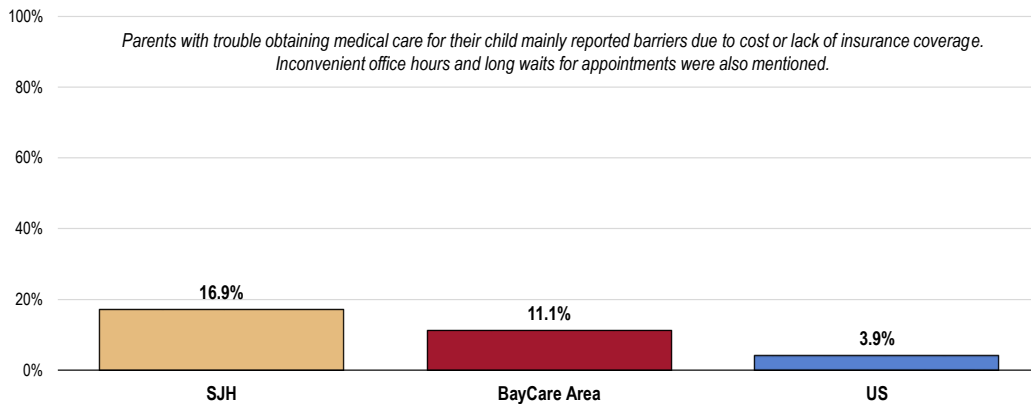
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 136-137]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

Key Informant Input: Access to Healthcare Services

The following chart outlines key informants' perceptions of the severity of *Access to Healthcare Services* as a problem in the community:

Perceptions of Access to Healthcare Services as a Problem in the Community
(Key Informants, SJH Service Area, 2016)

- Major Problem: 28.4%
- Moderate Problem: 43.3%
- Minor Problem: 19.4%
- No Problem At All: 9.0%
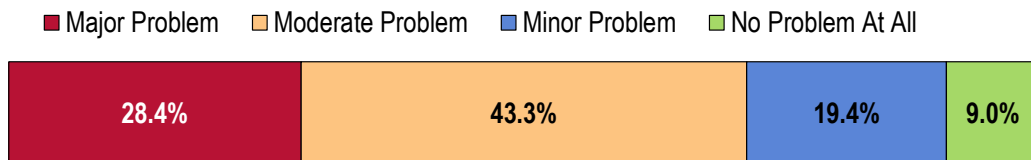
Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

Too often, people are not able to access the healthcare services they truly need. The most significant barrier to this is affordability. Even if someone has health insurance- whether, private, ACA, or Medicaid/Medicare- copays can still be a barrier. – Social Services Provider

Unfunded, underinsured and illegals have very limited access to health care in our community. Our free clinics have capacity limits and individuals often will utilize Emergency Rooms for health care. – Public Health Representative

Unavailability of appointment scheduling in a timely fashion and or scheduling of diagnostic testing and equipment. – Social Services Provider

Unsure because many resources are available. More assessment work needs to be done. – Social Services Provider

The biggest challenge related to accessing health care services in our community is not knowing how to access free or affordable health for non-emergency issues. – Social Services Provider

Access to Endocrinology is significantly challenging. – Physician

Far fewer primary care physicians available to care for the community leading to difficulty getting physician appointments and delayed care. – Physician

Individuals in the community use 911 as their primary care doctor as they do not know where they can go to get services and, or they are illegal in the country or do not have health insurance so they believe 911 is the only option. – Community Leader

Poverty, under-employment, lack of transportation options, homelessness. Medicaid and Medicare reimbursements not keeping pace with costs thus reducing provider availability. – Community Leader

Insurance Issues

Co-payments and deductibles. – Community Leader

So many are under- or un-insured and cannot afford to purchase insurance, even through the Affordable Care Act plans. Also, although more primary care is available than previously, the specialty care and diagnostic work up is limited. – Other Health Provider

The number of uninsured residents in Hillsborough County is still very high. Those that do not qualify for Medicaid and cannot afford the insurance marketplace are most affected. For children, the increased cost of full-pay Florida Kid Care is a problem. – Social Services Provider

Lack of insurance, cost of health care and no access for undocumented. – Other Health Provider

Behavioral Health

Limited resources for mental health services. – Physician

Mental health is a major problem and is the root cause for most healthcare risks and societal concerns. Chronic and infectious diseases, injuries, substance abuse, violence, suicide, sick days, loss of productivity, unemployment, school attendance. – Community Leader

Medicaid

The lack of Medicaid expansion and/or a living wage make preventive and chronic care all but unavailable to a very large population. The results are extreme, early age death, loss of critical parenting years, loss of family income, surcharge premiums. – Community Leader

Transportation

Transportation to health care and lack of non-traditional hours. Lack of medical home forces adults to use Emergency Room for routine care. – Other Health Provider

One of the biggest concerns in this area is transportation. It can take individuals hours to get to and from the doctor and thus they may not go for critical check-ups. Only when something is seriously wrong and sometimes not even then. – Community Leader

Type of Care Most Difficult to Access

Key informants (who rated this as a "major problem") most often identified **mental health care** as the most difficult to access in the community (both on first mention, as well as in total mention after three opportunities to respond).

Medical Care Difficult to Access Locally as Identified by Key Informants				
	Most Difficult to Access	Second-Most Difficult to Access	Third-Most Difficult to Access	Total Mentions
Mental Health Care	52.9%	23.5%	11.8%	15
Dental Care	35.3%	11.8%	5.9%	9
Substance Abuse Treatment	0.0%	29.4%	11.8%	7
Primary Care	11.8%	0.0%	17.6%	5
Chronic Disease Care	0.0%	17.6%	11.8%	5
Specialty Care	0.0%	5.9%	17.6%	4
Pain Management	0.0%	5.9%	11.8%	3
Urgent Care	0.0%	5.9%	5.9%	2
Prenatal Care	0.0%	0.0%	5.9%	1

Health Literacy

To measure respondents' ability to understand health-related information, respondents were asked the following questions:

"How often is health information written in a way that is easy for you to understand? Would you say: always, nearly always, sometimes, seldom, or never?"

"How often do you need to have someone help you read health information? Would you say: always, nearly always, sometimes, seldom, or never?"

"How often is health information spoken in a way that is easy for you to understand? Would you say: always, nearly always, sometimes, seldom, or never?"

"In general, how confident are you in your ability to fill out health forms yourself? Would you say: extremely confident, somewhat confident, or not at all confident?

Low health literacy is defined here as those respondents who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

Low Health Literacy
(SJH Service Area, 2016)

Men	27.8%
Women	25.0%
18 to 39	36.5%
40 to 64	18.5%
65+	26.8%
Low Income	36.2%
Mid/High Income	19.3%
White	21.0%
Hispanic	41.2%
Other	23.5%
SJH	26.3%
BayCare Area	24.6%
US	23.3%
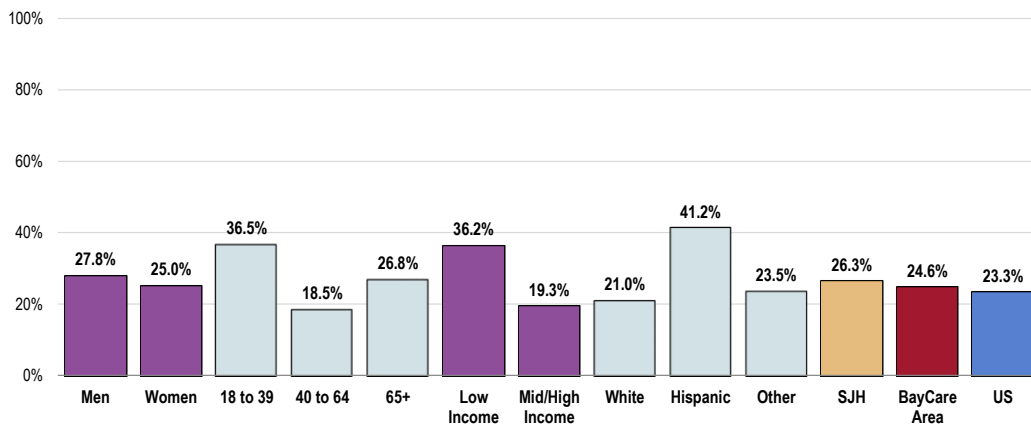
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 195]
Notes: ● Asked of all respondents.
           ● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
           ● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; and "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
           ● Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

Primary Care Services

About Primary Care

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

- Healthy People 2020 (www.healthypeople.gov)

Access to Primary Care

This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Access to Primary Care
(Number of Primary Care Physicians per 100,000 Population, 2012)

	Value
Hillsborough County	78.1
BayCare Area	77.3
FL	70.3
US	74.5
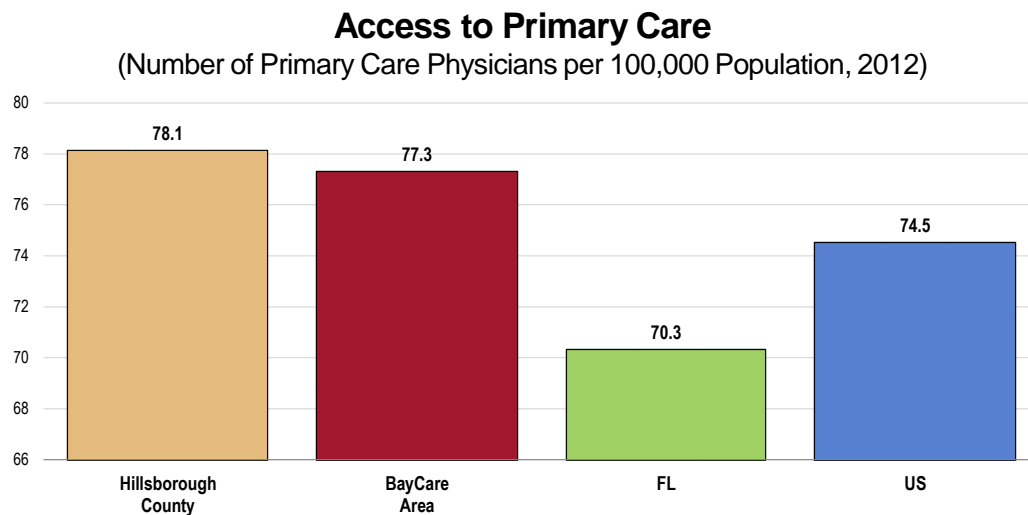
Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Retrieved May 2016 from Community Commons at http://www.chna.org.

Notes:
- This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Specific Source of Ongoing Care

Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of "patient-centered medical homes" (PCMH).

"Is there a particular place that you usually go to if you are sick or need advice about your health?"

"What kind of place is it: a medical clinic, an urgent care center/walk-in clinic, a doctor's office, a hospital emergency room, military or other VA healthcare, or some other place?"

The following chart illustrates the proportion of SJH Service Area population with a specific source of ongoing medical care. Note that a hospital emergency room is not considered a specific source of ongoing care in this instance.

Have a Specific Source of Ongoing Medical Care
(SJH Service Area, 2016)
Healthy People 2020 Target = 95.0% or Higher

Men	Women	18 to 39	40 to 64	65+	Low Income	Mid/High Income	White	Hispanic	Other	SJH	BayCare Area	US
63.0%	73.0%	54.8%	69.4%	86.0%	68.7%	68.0%	69.0%	67.3%	68.4%	68.3%	71.4%	74.0%
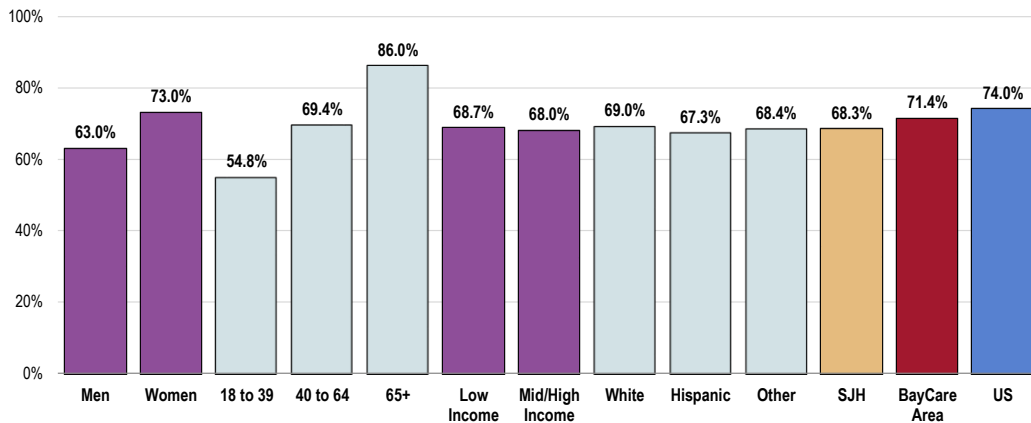
Sources:
● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 191-193]
● US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-5.1]
Notes:
● Asked of all respondents.
● Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; and "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Utilization of Primary Care Services

Adults: "A routine checkup is a general physical exam, not an exam for a specific injury, illness or condition. About how long has it been since you last visited a doctor for a routine checkup?"

Children: "About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?"

Have Visited a Physician for a Checkup in the Past Year
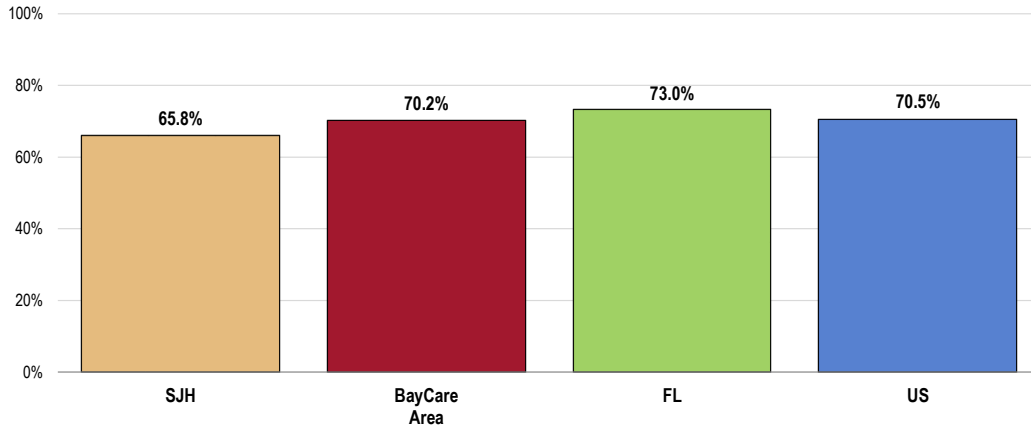
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2014 Florida data.
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Child Has Visited a Physician
for a Routine Checkup in the Past Year
(Among Parents of Children 0-17)
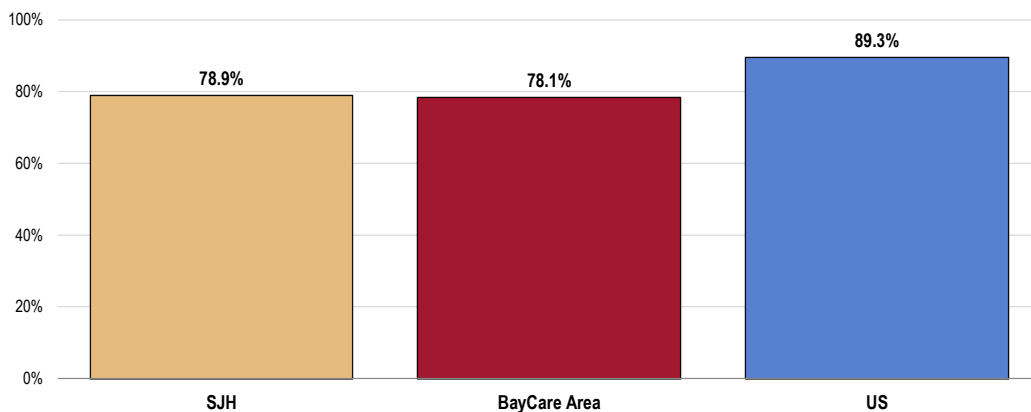
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 138]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

Emergency Room Utilization

"In the past 12 months, how many times have you gone to a hospital emergency room about your own health? This includes ER visits that resulted in a hospital admission." (Responses below reflect the percentage with two or more visits in the past year.)

Have Used a Hospital
Emergency Room More Than Once in the Past Year

	SJH	BayCare Area	US
	12.0%	9.9%	8.5%
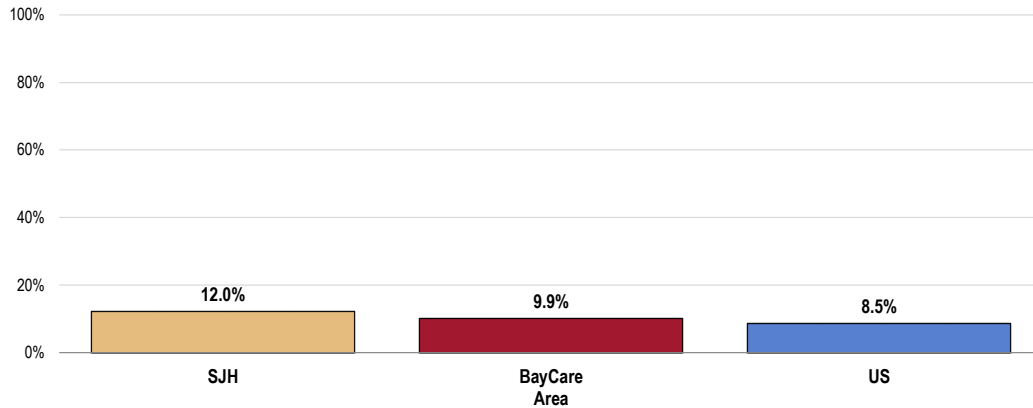
Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 22-23]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Oral Health

About Oral Health

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include: **tobacco use; excessive alcohol use;** and **poor dietary choices**.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures.

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.

- Healthy People 2020 (www.healthypeople.gov)

Dental Care

"About how long has it been since you last visited a dentist or a dental clinic for any reason?"

Have Visited a Dentist or
Dental Clinic Within the Past Year
(SJH Service Area, 2016)
Healthy People 2020 Target = 49.0% or Higher

	Value
Men	57.2%
Women	56.1%
18 to 39	54.5%
40 to 64	55.2%
65+	62.3%
Low Income	37.0%
Mid/High Income	70.8%
White	60.4%
Hispanic	58.1%
Other	46.1%
SJH	56.6%
BayCare Area	55.5%
FL	61.9%
US	67.2%
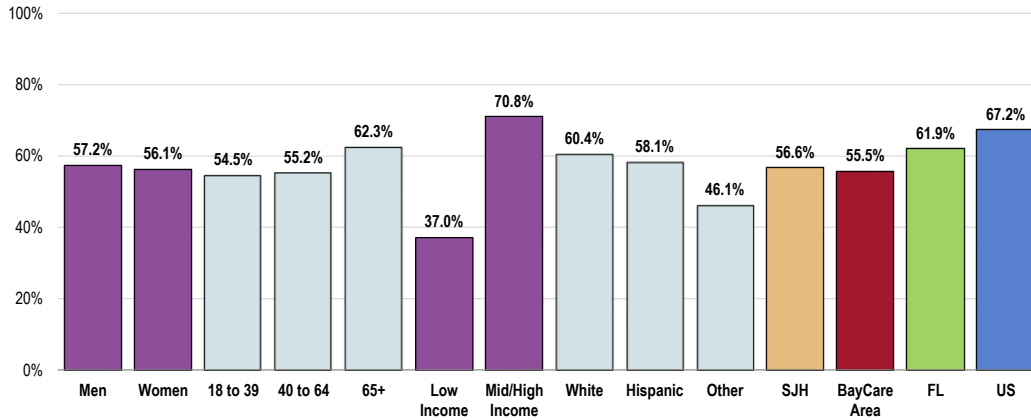
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]

Notes:
- Asked of all respondents.
- Hispanics can be of any race. Other race categories are non-Hispanic categorizations (e.g., "White" reflects non-Hispanic White respondents).
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 199% of the federal poverty level; and "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Dental Insurance

"Do you currently have any health insurance coverage that pays for at least part of your dental care?"

Have Insurance Coverage
That Pays All or Part of Dental Care Costs

	Value
SJH	70.2%
BayCare Area	63.8%
US	66.5%
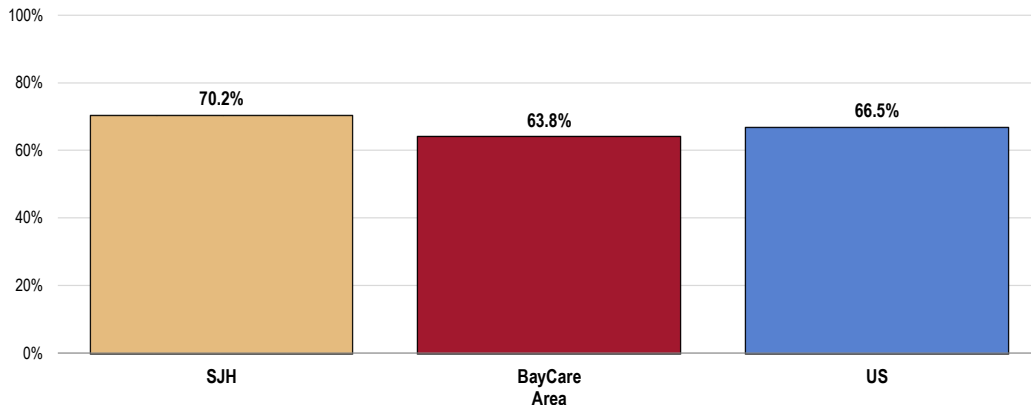
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Key Informant Input: Oral Health

The following chart outlines key informants' perceptions of the severity of *Oral Health* as a problem in the community:

Perceptions of Oral Health
as a Problem in the Community
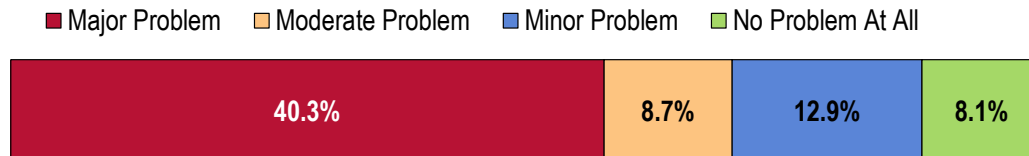(Key Informants, SJH Service Area, 2016)

■ Major Problem □ Moderate Problem ■ Minor Problem □ No Problem At All

40.3%	8.7%	12.9%	8.1%

Sources: ● PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: ● Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Affordable Care/Services

Very limited free and reduced cost services available for people that can't afford market rate care. – Community Leader

Dental care, even with insurance is expensive. It is prohibitive for those without resources. There are very limited free or reduced services, especially for adults. – Public Health Representative

Access to affordable dental care. Lack of dental providers accepting Medicaid. – Social Services Provider

Lack of affordable care for acute conditions and no access to preventive care. – Other Health Provider

Affordability of care. Lack of understanding regarding relationship of oral health to overall physical well-being. – Community Leader

Especially in communities with low income families. – Other Health Provider

Medicaid

We have terrible access to dental care for Medicaid and underfunded patients. Some of the worst in the nation. – Community Leader

Medicaid does not adequately cover dental expenses. – Social Services Provider

Oral health is a major challenge in our community. Even those who have Medicaid cannot find a doctor who is accepting new patients. Dental prices are very high and most go without. – Other Health Provider

The largest issue is the low number of Medicaid providers. In addition there are very low cost options and most insurance companies provide limited preventative services. We recently completed an oral health community assessment, administering surveys. – Other Health Provider

Florida is one of the worst states in the country for oral health and there are not enough Medicaid providers to provide service to those who need it. Oral health needs to be incorporated into general/preventative wellness. – Social Services Provider

Access to Care/Services

The lack of access for so many residents, especially children. – Public Health Representative

Lack of education. Lack of access. Cost of dental insurance. Cost for dental services. – Public Health Representative

The population I serve has difficulty accessing dental care, due to not having insurance. – Social Services Provider

Prevalence/Incidence

Over-abundance of children with dental problems. – Public Health Representative

Vision Care

"When was the last time you had an eye exam in which the pupils were dilated? This would have made you temporarily sensitive to bright light." (Responses in the following chart represent those with an eye exam within the past 2 years.)

See also *Vision & Hearing* in the Death, Disease & Chronic Conditions section of this report.

Had an Eye Exam in the Past Two Years During Which the Pupils Were Dilated
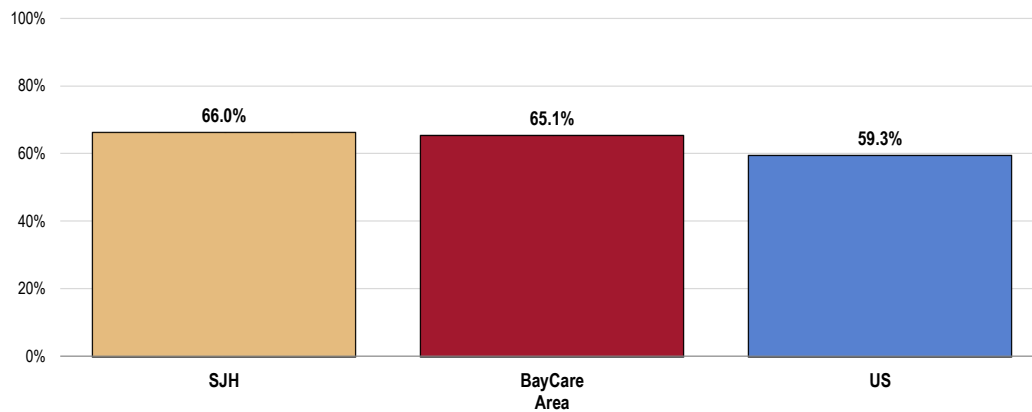
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 19]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Local Resources

Perceptions of Local Healthcare Services

"How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair or poor?" (Combined "fair/poor" responses are outlined in the following chart.)

Perceive Local Healthcare Services as "Fair/Poor"

	SJH	BayCare Area	US
	15.5%	16.7%	14.2%

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Key Informants' Perceptions of Resources Available to Address the Significant Health Needs

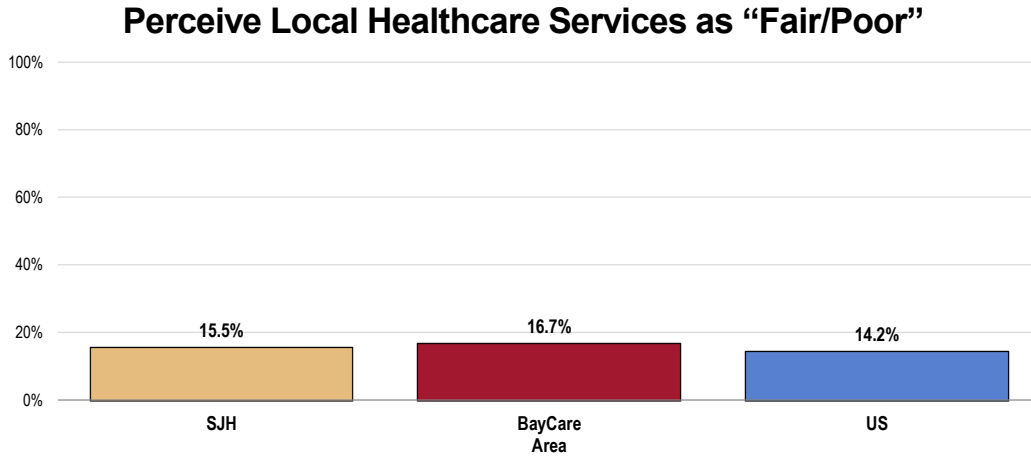The following represents potential measures and resources (such as programs, organizations, and facilities in the community) noted by key informants as available to address the significant health needs identified in this report. This list reflects only input from participants in the Online Key Informant Survey and therefore is not to be considered to be exhaustive or necessarily an all-inclusive list of available resources. This section only outlines those resources mentioned in conducting the Online Key Informant Survey as part of preparing this Community Health Needs Assessment.

Access to Healthcare Services

BayCare Behavioral Health
Brandon Regional Medical Center
Bridge Clinic
Casa Chiapas
Catholic Charities Free Clinics
CDC of Tampa, Inc.
Children's Board
Christian-Judeo Health Clinic
Clinics
Community Health Centers
Doctor's Office
Family Healthcare Foundation
Federally Qualified Health Centers
Free Clinics
Health Department
Healthy Start
Hillsborough County Department of Health
Hillsborough Healthcare
Hispanic Services Council
Hospitals
Indigent Health Care Plan
Judeo Christian Clinic
Outreach Clinic
Pediatric Friendly Facilities
Reach Up, Inc.
School System
St. Joseph's Hospital
Suncoast Community Health Center
Tampa Family Health Center
University Area CDC Get Moving Program
Urgent Care
Walk in Clinics

Arthritis, Osteoporosis & Chronic Back Conditions

AA/NA
BayCare Wellness
Physical Therapy
YMCA

Cancer

American Cancer Association
American Cancer Society
BayCare
Cancer Centers of America
Cancer Specialist Center
Children's Cancer Center
Diagnostic Centers
Federally Qualified Health Centers
Florida Cancer Institute
Gulfcoast North Area Health Education
Health Department
Hillsborough County Department of Health
Hospitals
Moffit
Pediatric Cancer Association
PITCH
Screening Programs
Southwest Florida Cancer Control Collaborative
St. Joseph's Hospital
Tampa Bay Community Cancer Network
Tampa General Hospital

Chronic Kidney Disease

Dialysis Centers
Doctor's Office
Hospitals

Dementias, Including Alzheimer's Disease

Aging Solutions
ALF's
Alzheimer's Association
Assisted Living Facilities
Aston Gardens
Baycare Knox Village
Byrd Center
Department of Elder Affairs Memory Disorder Clinics
Doctor's Office
Gracepoint

Hospitals
Mental Health Providers
Morton Plant Mease Health Care
Northside Mental Health Center
Physical Therapy
St. Anthony's Hospital
Suncoast Community Health Center
University
University of Florida
University of South Florida
Veterans Affairs

Diabetes

6th Medical Group
American Diabetes Association
BayCare
Diabetes Institute
Diabetes Self-Management/Prevention Program
Doctor's Office
Endocrinologists
Federally Qualified Health Centers
Florida Department of Health
Florida Hospital
Free Clinics
Government
Health Department
Health Educators
Hillsborough County Department of Health
Hospitals
Medicare
Moffit
Parks and Recreation Department
Private Sector Funding
Publix
St. Joseph's Hospital
Suncoast Community Health Center
Tampa Family Health Center
Tampa General Hospital
University Area CDC Get Moving Program
University of South Florida
YMCA

Family Planning

Doctor's Office
DOH Family Planning Clinic
Federally Qualified Health Centers
Head Start
Health Department
Healthy Start
Hillsborough County Department of Health

Planned Parenthood
School System
Suncoast Community Health Center
Tampa Family Health Center
University of South Florida
WIC Program
Women's Center of Hyde Park

Hearing & Vision

Lions Club

Heart Disease & Stroke

American Heart Association
BayCare
BayCare Education Seminars
Cardiac Rehab Centers
Clinics
Community Health Centers
Doctor's Office
Federally Qualified Health Centers
Florida Hospital
HCA
Health Educators
Hillsborough County Department of Health
Home Health Providers
Hospitals
Insurance Company
Parks and Recreation Department
Pepin Heart Institute
Specialists
St. Joseph's Hospital
Tampa General Hospital
University of South Florida
Urgent Care
YMCA

HIV/AIDS

AIDS Institute
DACCO
Doctor's Office
Francis House
Health Department
Hillsborough County Department of Health
Hospitals
Metro Charities
Metro Wellness
Planned Parenthood
Reach Up, Inc.
Ryan White Program
Specialists
St. Joseph's Hospital

Tampa Family Health Center
University of South Florida
USF Youth Clinic
Ybor Youth Clinic
Youth Education Services Program

Immunization & Infectious Diseases

Back to School Community Coalition
BayCare
Child Advocacy
Health Department
Hillsborough County Department of Health
PITCH
St. Joseph's Hospital
Tampa Family Health Center
University of South Florida

Infant & Child Health

Champions for Children
Children's Board
Chiles Center
Community Health Centers
Complex Chronic Pediatric Center
Doctor's Office
Federally Qualified Health Centers
Genesis
Government
Health Department
Healthy Babies and Healthy Families
Healthy Start
Hillsborough County Department of Health
Hillsborough Healthcare
Hospitals
March of Dimes
Reach Up, Inc.
Tampa General Hospital
Targeted Outreach for Pregnant Women Act
University of South Florida
Walk in Clinics
WIC Program

Injury & Violence

BayCare
BayCare Behavioral Health
Crisis Center
Domestic Violence Hotlines
Family Resource Centers
Fast Track Urgent Care Center
Judeo Christian Clinic
Law Enforcement
Safe and Sound Violence Prevention Program

Shelters
SPRING
St. Joseph's Hospital
Tampa General Hospital
YMCA

Mental Health

BayCare
BayCare Behavioral Health
BayCare Life Management
Baycare Mental Health the Harbors
BayCare Northside
Central Florida Behavioral Health
Chrysallis
CMHC
Crisis Center
Crisis Center of Tampa Bay
DACCO
Doctor's Office
Early Childhood Council
Employee Assistance Programs
Governor and Florida Legislature
Grace Mental Health Center
Gracepoint
Group Homes
Gulf Coast Jewish Family and Community Services
HCA
Hillsborough County Division of Children's Services
Hillsborough County Health Plan
Hospitals
Leadership at the Local Level
Macdonald Training Center
Mental Health Providers
Mobile Integrated Health
Morton Plant Mease Health Care
Northside Mental Health Center
St. Joseph's Hospital
Success 4 Kids and Families
Suncoast Community Health Center
Tampa Bay Behavioral Health
Tampa General Hospital
University of South Florida

Nutrition, Physical Activity & Weight

All Children's
BayCare
Children's Board
County Neighborhood Center
Doctor's Office
Florida Department of Health

Florida Hospital
Food Banks
Health Department
Healthy Hillsborough Collaborative
Hillsborough County Department of Health
Hillsborough County Schools
Hospitals
Jewish Family Services
Judeo Christian Clinic
Livestrong
Metropolitan Ministries
MORE Health
Nutrition Services
Parks and Recreation Department
Salvation Army
School System
St. Joseph's Hospital
Suncoast Community Health Center
Weight Loss Center
Weight Watchers
YMCA

Oral Health

Dentistry From the Heart
Doctor's Office
Erwin Dental Clinic
Faith-Based Organizations
Federally Qualified Health Centers
Free Clinics
Greater Tampa Bay Oral Health Coalition
Hillsborough Community College
Hillsborough County Dental Research Clinic
Hillsborough County Oral Health Coalition
Judeo Christian Clinic
MORE Health
School System
Suncoast Community Health Center
Tampa Bay Healthcare Collaborative Initiative
Tampa Family Health Center
WIC Program

Respiratory Diseases

Community Health Centers
Doctor's Office
Health Department
Pulmonology
School System
St. Joseph's Hospital

Sexually Transmitted Diseases

Community Health Centers

Crisis Center
Doctor's Office
Federally Qualified Health Centers
Health Department
Hillsborough County Department of Health
Hospitals
Metro Wellness
Planned Parenthood
Reach Up, Inc.
School System
Suncoast Community Health Center
Tampa Family Health Center
University of South Florida
Ybor Youth Clinic
Youth Education Services Program

Substance Abuse

ACTS
BayCare
Center for Women
Central Florida Behavioral Health
Crisis Center of Tampa Bay
DACCO
Fairwinds Treatment Center
Governor and Florida Legislature
Gracepoint
Hillsborough County Anti-Drug Alliance
Inpatient Rehabilitation
Jail
Law Enforcement
Metropolitan Ministries
Operation PAR
Phoenix House
St. Joseph's Hospital
Tampa General Hospital
Turning Point
University of South Florida

Tobacco Use

AHEC
American Cancer Society
American Lung Association
Community Education
Doctor's Office
Health Department
Hillsborough County Department of Health
Moffit
Quit Programs
Quitline

Community Characteristics

As part of the broader system-wide assessment, a variety of existing population data for the region's counties was consulted. Because the SJH Service Area is predominantly within Hillsborough County, the following data outline population characteristics for the county derived from census data. For comparison, the "BayCare Area" benchmark in these charts includes the entirety of Hillsborough, Pasco and Pinellas Counties.

This section also highlights areas within the community identified as "high-need," including the results in these areas derived from supplemental handout surveys.

Population Characteristics

Land Area, Population Size & Density

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density.

Total Population
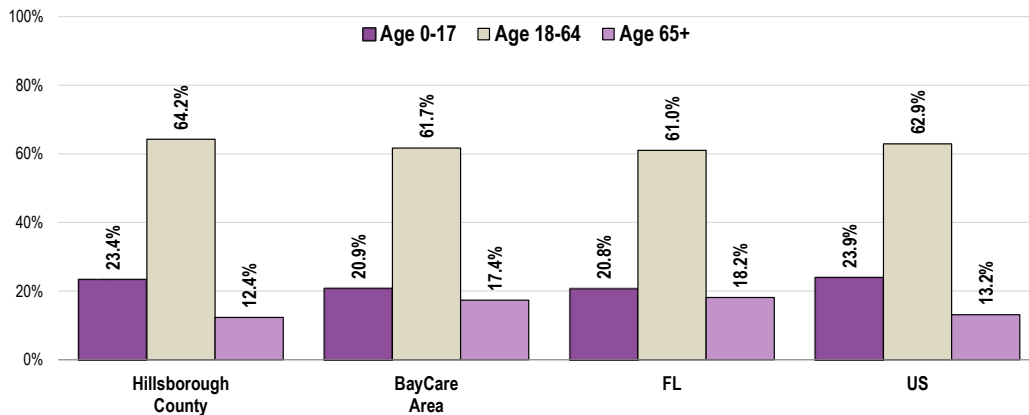(Estimated Population, 2010-2014)

	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
Hillsborough County	1,279,668	1,020.25	1,254.27
BayCare Area	2,677,443	2,041.76	1,311.34
Florida	19,361,792	53,630.83	361.02
United States	314,107,083	3,531,932.26	88.93

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved May 2016 from Community Commons at http://www.chna.org.

Age

It is important to understand the age distribution of the population as different age groups have unique health needs which should be considered separately from others along the age spectrum.

### Total Population by Age Groups, Percent
(2010-2014)

Age 0-17 ■ Age 18-64 □ Age 65+ ■

	Age 0-17	Age 18-64	Age 65+
Hillsborough County	23.4%	64.2%	12.4%
BayCare Area	20.9%	61.7%	17.4%
FL	20.8%	61.0%	18.2%
US	23.9%	62.9%	13.2%

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved May 2016 from Community Commons at http://www.chna.org.

Race & Ethnicity

The following charts illustrate the racial and ethnic makeup of our community. Note that ethnicity (Hispanic or Latino) can be of any race.

Total Population by Race Alone, Percent
(2010-2014)
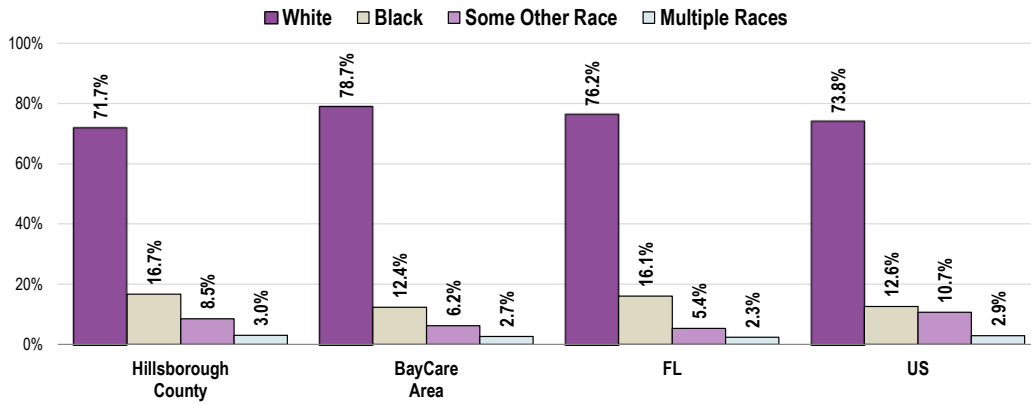
Sources: • US Census Bureau American Community Survey 5-year estimates.
          • Retrieved May 2016 from Community Commons at http://www.chna.org.

Social Determinants of Health

About Social Determinants

Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.

● Healthy People 2020 (www.healthypeople.gov)

Poverty

The following chart outlines the proportion of our population below the federal poverty threshold, as well as below 200% of the federal poverty level, in comparison to state and national proportions.
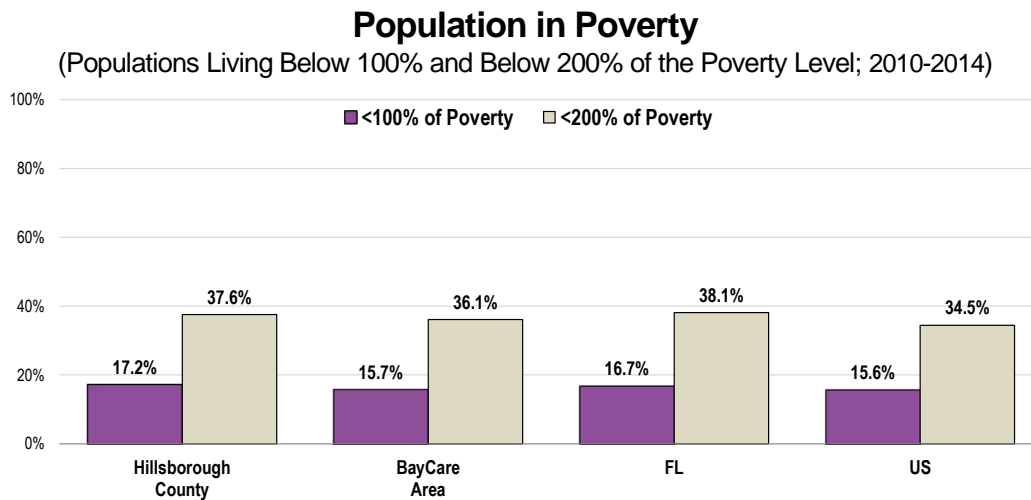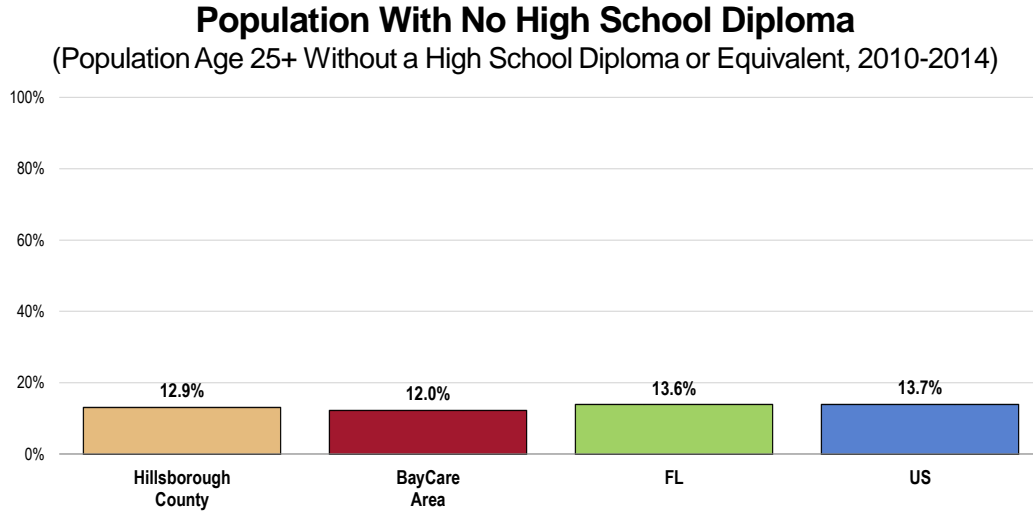
Population in Poverty
(Populations Living Below 100% and Below 200% of the Poverty Level; 2010-2014)

	Hillsborough County	BayCare Area	FL	US
<100% of Poverty	17.2%	15.7%	16.7%	15.6%
<200% of Poverty	37.6%	36.1%	38.1%	34.5%

Sources: ● US Census Bureau American Community Survey 5-year estimates.
● Retrieved May 2016 from Community Commons at http://www.chna.org.
Notes: ● Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Education

Education levels are reflected in the proportion of our population without a high school diploma.

Population With No High School Diploma
(Population Age 25+ Without a High School Diploma or Equivalent, 2010-2014)

	100%	80%	60%	40%	20%	0%
Hillsborough County					12.9%	
BayCare Area					12.0%	
FL					13.6%	
US					13.7%	

Sources: • US Census Bureau American Community Survey 5-year estimates.
          • Retrieved May 2016 from Community Commons at http://www.chna.org.
Notes: • This indicator is relevant because educational attainment is linked to positive health outcomes.

High-Need Communities

ZIP Codes Identified as High Need

High-need areas in the SJH Service Area were identified using the Community Health Needs Index (CNI). The CNI score was developed by Dignity Health (formerly known as Catholic Healthcare West [CHW]) and Truven Health Analytics. This index aggregates five socioeconomic indicators that contribute to health disparity: income, culture, education, insurance, and housing. Each ZIP Code is assigned a score of 1 (low need) to 5 (high need) for each of the five indicators which are averaged to yield the CNI score for that area. The scores are then compared to the index, which is based on national need, and separated into groups ranging from highest need to lowest need.

Research indicates a strong correlation between high CNI scores and hospital admission rates. Residents who live in areas with the highest need were twice as likely to experience preventable hospitalization for manageable conditions (i.e. ear infections, pneumonia...).
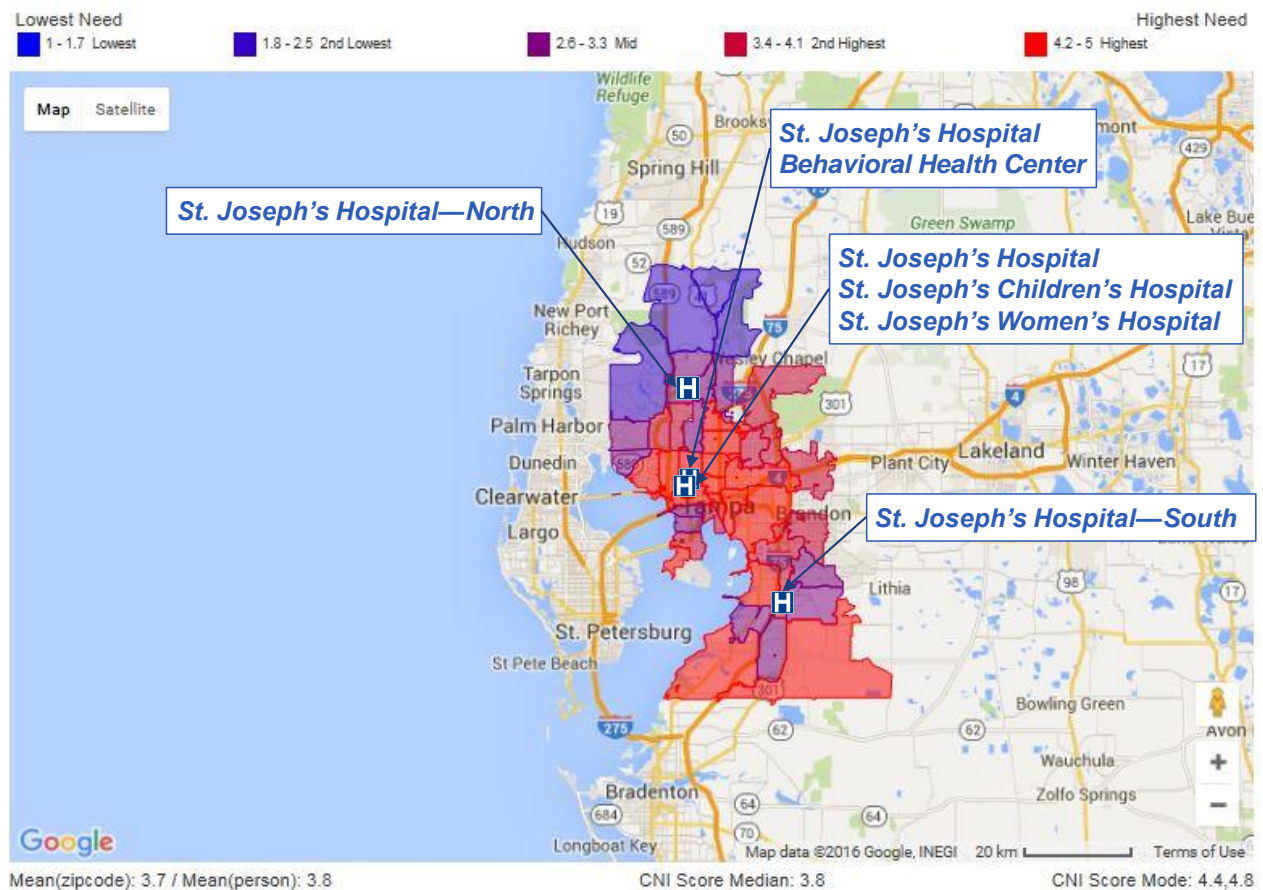
ZIP Code–specific CNI scores are outlined in the following table (note that none of the SJH Service Area ZIP Codes falls in the "lowest" need category).

Community Need Index (CNI) Scores for SJH Service Area ZIP Codes

| | 4.2 - 5 Highest Need | | 3.4 - 4.1 2nd Highest | | 2.6 - 3.3 Mid | | 1.8 - 2.5 2nd Lowest | | 1 - 1.7 Lowest |

	Zip Code	CNI Score	Population	City	County	State
	33605	5	17552	Tampa	Hillsborough	Florida
	33607	5	24395	Tampa	Hillsborough	Florida
	33612	5	44086	Tampa	Hillsborough	Florida
	33598	4.8	16025	Wimauma	Hillsborough	Florida
	33603	4.8	19302	Tampa	Hillsborough	Florida
	33610	4.8	42048	Tampa	Hillsborough	Florida
	33613	4.8	33726	Tampa	Hillsborough	Florida
	33619	4.8	37188	Tampa	Hillsborough	Florida
	33604	4.6	35968	Tampa	Hillsborough	Florida
	33614	4.6	47962	Tampa	Hillsborough	Florida
	33534	4.4	14928	Gibsonton	Hillsborough	Florida
	33570	4.4	25156	Ruskin	Hillsborough	Florida
	33616	4.4	14596	Tampa	Hillsborough	Florida
	33620	4.4	5338	Tampa	Hillsborough	Florida
	33634	4.4	21926	Tampa	Hillsborough	Florida
	33602	4.2	13173	Tampa	Hillsborough	Florida
	33615	4.2	44032	Tampa	Hillsborough	Florida
	33617	4	44079	Tampa	Hillsborough	Florida
	33625	4	26477	Tampa	Hillsborough	Florida
	33637	4	16198	Tampa	Hillsborough	Florida
	33511	3.8	55180	Brandon	Hillsborough	Florida
	33584	3.8	26674	Seffner	Hillsborough	Florida
	33578	3.6	43356	Riverview	Hillsborough	Florida
	33606	3.6	18432	Tampa	Hillsborough	Florida
	33611	3.6	30641	Tampa	Hillsborough	Florida
	33624	3.4	37878	Tampa	Hillsborough	Florida

	ZIP	CNI	Population	City	County	State
🟥	33647	3.4	65231	Tampa	Hillsborough	Florida
🟪	33549	3.2	16737	Lutz	Hillsborough	Florida
🟪	33609	3.2	16405	Tampa	Hillsborough	Florida
🟪	33618	3.2	25991	Tampa	Hillsborough	Florida
🟪	33635	3.2	16862	Tampa	Hillsborough	Florida
🟪	33569	3	24412	Riverview	Hillsborough	Florida
🟪	33558	2.8	22467	Lutz	Hillsborough	Florida
🟪	33572	2.8	16198	Apollo Beach	Hillsborough	Florida
🟪	33626	2.8	30983	Tampa	Hillsborough	Florida
🟪	33548	2.6	6368	Lutz	Hillsborough	Florida
🟪	33573	2.6	20827	Sun City Center	Hillsborough	Florida
🟪	33579	2.6	30582	Riverview	Hillsborough	Florida
🟪	33629	2.6	23863	Tampa	Hillsborough	Florida
🟦	34638	2.4	24437	Land O Lakes	Pasco	Florida
🟦	34637	2.2	7040	Land O Lakes	Pasco	Florida
🟦	33556	2	24998	Odessa	Hillsborough	Florida
🟦	34639	1.8	26173	Land O Lakes	Pasco	Florida

The following ZIP Codes do not have a CNI Score assigned (e.g., PO Boxes): 33503, 33508, 33509, 33550, 33568, 33571, 33575, 33583, 33586, 33595, 33601, 33622, 33623, 33630, 33631, 33646, 33650, 33655, 33660, 33661, 33662, 33663, 33664, 33672, 33673, 33674, 33675, 33677, 33679, 33680, 33681, 33682, 33684, 33685, 33686, 33687, 33688, 33689, 33690, 33694, 33697.

🟥 **4.2 - 5** Highest Need 🟥 **3.4 - 4.1** 2nd Highest 🟪 **2.6 - 3.3** Mid 🟦 **1.8 - 2.5** 2nd Lowest 🟦 **1 - 1.7** Lowest

Input From High-Need Communities (Convenience Sample Survey)

To better understand vulnerable populations, the data presented in this section represent a subsample of the Florida Department of Health in Hillsborough County's *Healthy Hillsborough Survey*. Here, these data are limited to those collected through handout surveys among residents living in high-need ZIP Codes (those with CNI scores of 3.4 or higher, as described above) within the SJH Service Area (representing 986 respondents) and within the county (representing 1,142 respondents).

The following charts represent findings from these handout surveys among residents of high-need areas; it is important to note that, as a "convenience sample," this is a non-probability sample that is not necessarily representative of the targeted population and is limited with regard to generalizability. *[In contrast, survey data presented in previous sections of this report are from the scientific, random-sample population survey that is representative and generalizable.]*

Perceptions of Health

Overall how would you rate the <u>health of the community</u> where you live? very unhealthy; unhealthy; somewhat unhealthy; healthy; very healthy

How would you rate <u>your own personal</u> health? very unhealthy; unhealthy; somewhat unhealthy; healthy; very healthy

In the last year, would you say <u>your</u> overall health has: gotten better; stayed about the same; gotten worse?

In general, how would you rate your overall mental and emotional health? excellent; very good; good; fair; poor

In the last year, would you say your emotional and mental health has: gotten better; stayed about the same; gotten worse?
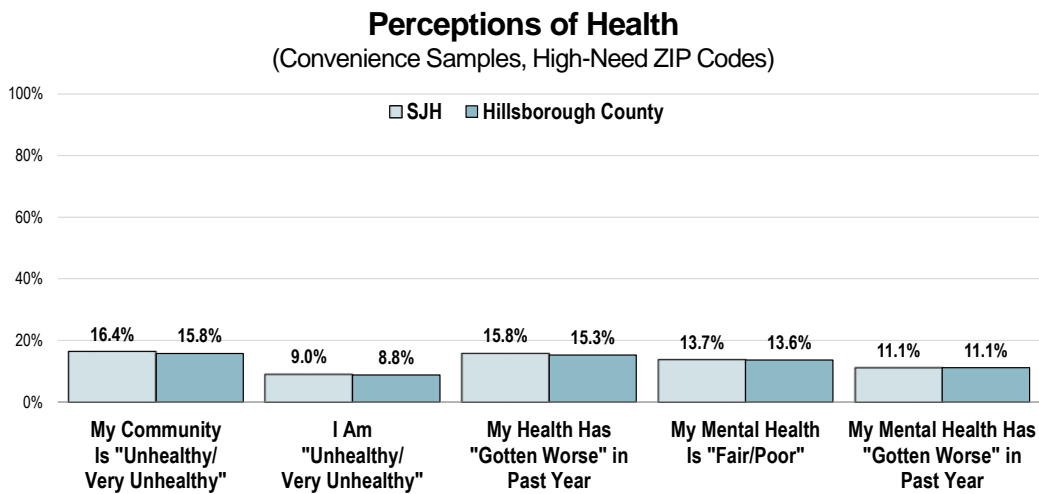
Perceptions of Health
(Convenience Samples, High-Need ZIP Codes)

Legend: □ SJH ■ Hillsborough County

Category	SJH	Hillsborough County
My Community Is "Unhealthy/Very Unhealthy"	16.4%	15.8%
I Am "Unhealthy/Very Unhealthy"	9.0%	8.8%
My Health Has "Gotten Worse" in Past Year	15.8%	15.3%
My Mental Health Is "Fair/Poor"	13.7%	13.6%
My Mental Health Has "Gotten Worse" in Past Year	11.1%	11.1%

Sources: ● 2016 Healthy Hillsborough Survey (subsample data), Florida Department of Health in Hillsborough County
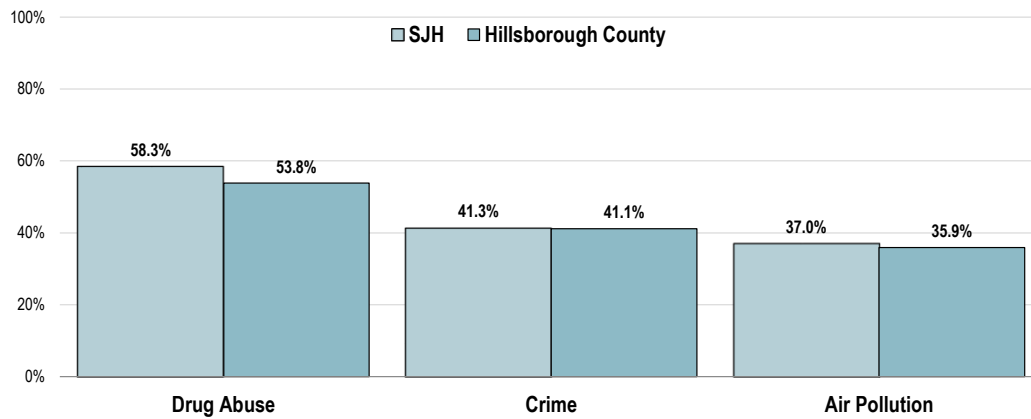Notes: ● Data are derived from handout surveys administered at various locations in high-need ZIP Codes.

Access to Healthcare

How do you pay for most of your health care? Please choose only one: I pay cash/don't have insurance; Medicare (or Medicare HMO); Medicaid (or Medicaid HMO); commercial health insurance (private insurance, HMO, PPO); Veteran's Administration; TRICARE; Indian Health Services; some other way

Was there a time in the past 12 months when you needed medical care but did <u>not</u> get the care you needed? yes; no
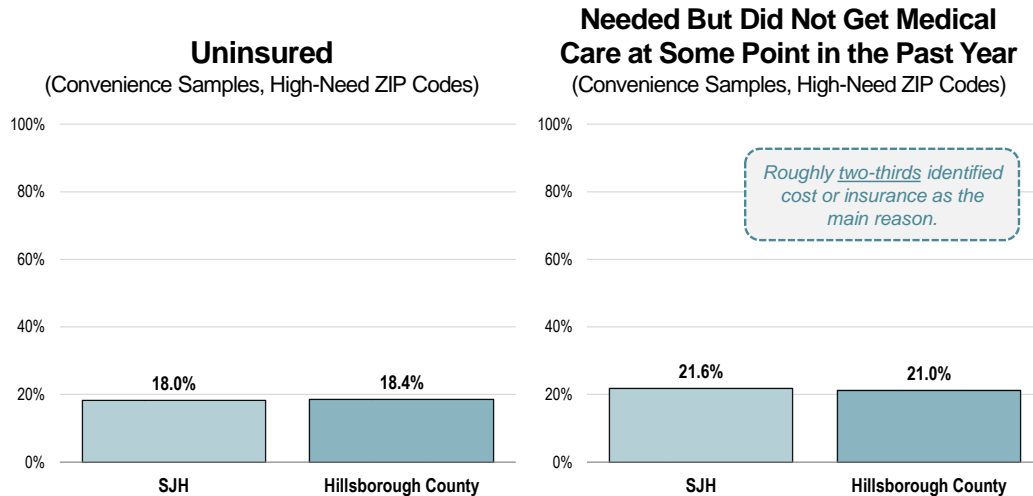
Uninsured
(Convenience Samples, High-Need ZIP Codes)

Needed But Did Not Get Medical Care at Some Point in the Past Year
(Convenience Samples, High-Need ZIP Codes)

Roughly <u>two-thirds</u> identified cost or insurance as the main reason.

	Uninsured	
SJH	18.0%	
Hillsborough County		18.4%

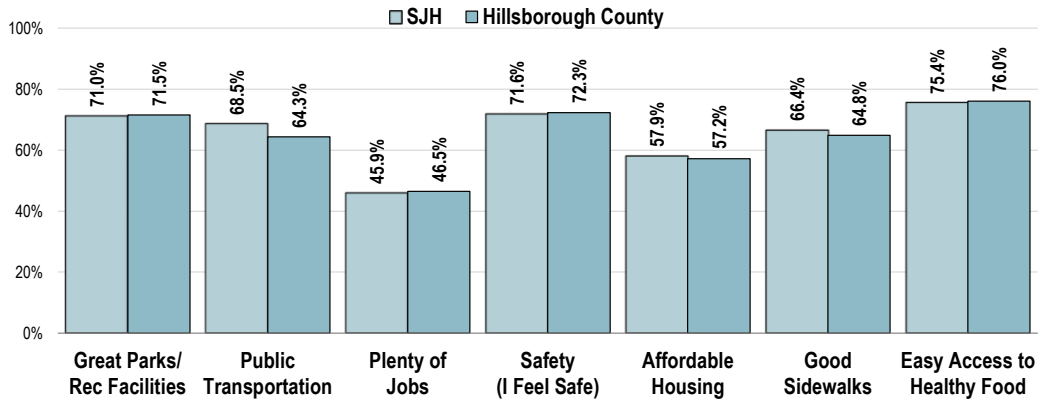|	Needed But Did Not Get	
SJH	21.6%	
Hillsborough County		21.0%

Sources: ● 2016 Healthy Hillsborough Survey (subsample data), Florida Department of Health in Hillsborough County
Notes: ● Data are derived from handout surveys administered at various locations in high-need ZIP Codes.

Below are some statements about your local community. You may agree with some and disagree with others. Please tell us how much you agree or disagree with each statement: strongly agree; somewhat agree; neither agree nor disagree; somewhat disagree; strongly disagree

- **The quality of health care in my neighborhood is good.**

- **I have no problem getting the health care services I need.**

"Strongly" or "Somewhat" Agree
That My Community/Neighborhood Has:
(Convenience Samples, High-Need ZIP Codes)
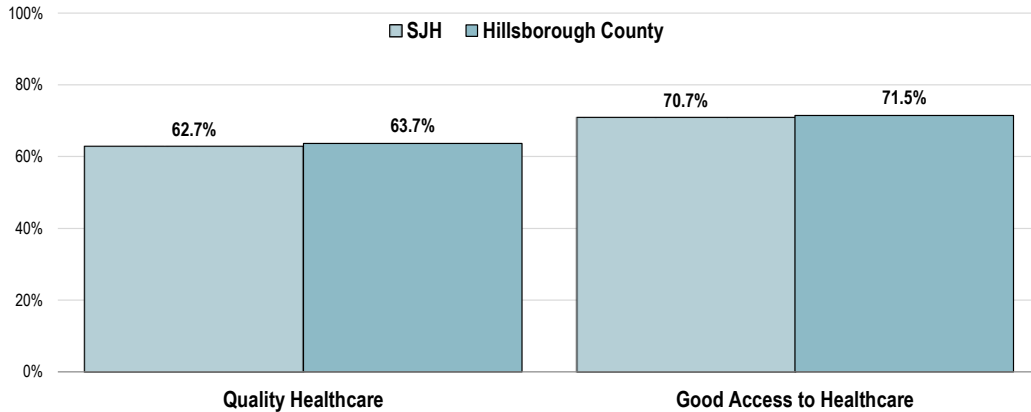
Sources: ● 2016 Healthy Hillsborough Survey (subsample data), Florida Department of Health in Hillsborough County
Notes: ● Data are derived from handout surveys administered at various locations in high-need ZIP Codes.

"Most Important" Health Issues

In the handout surveys, respondents were presented with a list of 21 health issues and were asked to identify which they feel is the most important, second-most important and third-most important in their own community. The following chart illustrates the health issues receiving the top responses as #1, #2 and #3 choices in each area.

"Most Important"
Health Problems in My Community
(Convenience Samples, High-Need ZIP Codes)

	SJH	Hillsborough County
Cancer	#1	#1
Diabetes	#2 (tie)	#2
Being Overweight	#2 (tie)	#3
Teen Pregnancy	#3	

Sources: ● 2016 Healthy Hillsborough Survey (subsample data), Florida Department of Health in Hillsborough County
Notes: ● Data are derived from handout surveys administered at various locations in high-need ZIP Codes.

Risky Behaviors

"Most Important" Risky Behaviors that Impact Community Health

In the handout surveys, respondents were presented with a list of 11 behaviors and were asked to identify which they feel is the most important, second-most important and third-most important in having an impact on overall community health. The following chart illustrates the behaviors receiving the top responses as #1, #2 and #3 choices in each area.

"Most Important" Risky Behaviors
That Impact Health in My Community
(Convenience Samples, High-Need ZIP Codes)

	SJH	Hillsborough County
Drug Abuse	#1	#1
Alcohol Abuse	#2	#2
Unsafe Sex	#3	#3

Sources: ● 2016 Healthy Hillsborough Survey (subsample data), Florida Department of Health in Hillsborough County
Notes: ● Data are derived from handout surveys administered at various locations in high-need ZIP Codes.

How often do you smoke? I do not smoke cigarettes; I smoke less than one pack per day; I smoke about one pack per day; I smoke more than one pack per day

Currently Smoke Cigarettes
(Convenience Samples, High-Need ZIP Codes)
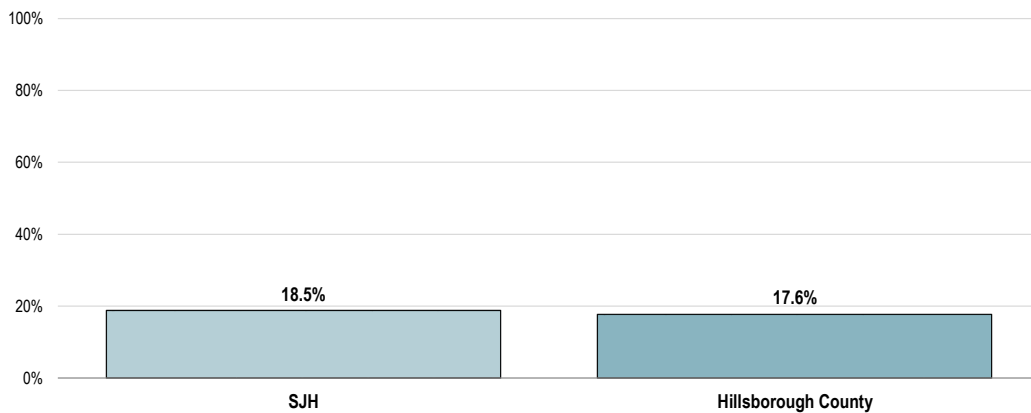
SJH: 18.5% Hillsborough County: 17.6%

Sources: ● 2016 Healthy Hillsborough Survey (subsample data), Florida Department of Health in Hillsborough County
Notes: ● Data are derived from handout surveys administered at various locations in high-need ZIP Codes.

Community Problems

Below are some statements about your local community. You may agree with some and disagree with others. Please tell us how much you agree or disagree with each statement: strongly agree; somewhat agree; neither agree nor disagree; somewhat disagree; strongly disagree

- **Drug abuse is a problem in my community.**

- **Crime in my area is a serious problem.**

- **Air pollution is a problem in my community.**

"Strongly" or "Somewhat" Agree
That the Following Are Problems Where I Live
(Convenience Samples, High-Need ZIP Codes)

Sources: ● 2016 Healthy Hillsborough Survey (subsample data), Florida Department of Health in Hillsborough County
Notes: ● Data are derived from handout surveys administered at various locations in high-need ZIP Codes.

"Most Important" Issue to Address to Improve Quality of Life

In the handout surveys, respondents were presented with a list of 19 factors and were asked to identify which they feel is the most important, second-most important and third-most important to address in their own community to improve quality of life. The following chart illustrates the factors receiving the top responses as #1, #2 and #3 choices in each area.

"Most Important" Factors to
Improve Quality of Life in My Community
(Convenience Samples, High-Need ZIP Codes)

	SJH	Hillsborough County
Good Place to Raise Children	#1	#1
Good Schools	#2	#2
Jobs/Economy	#3	#3

Sources: ● 2016 Healthy Hillsborough Survey (subsample data), Florida Department of Health in Hillsborough County
Notes: ● Data are derived from handout surveys administered at various locations in high-need ZIP Codes.

Community Attributes

Below are some statements about your local community. You may agree with some and disagree with others. Please tell us how much you agree or disagree with each statement: strongly agree; somewhat agree; neither agree nor disagree; somewhat disagree; strongly disagree

- **We have great parks and recreational facilities.**

- **Public transportation is readily available to me if I need it.**

- **There are plenty of jobs available for those who want them.**

- **I feel safe in my own neighborhood.**

- **There are affordable places to live in my neighborhood.**

- **There are good sidewalks for walking safely.**

- **I am able to get healthy food easily.**

"Strongly" or "Somewhat" Agree
That My Community/Neighborhood Has:
(Convenience Samples, High-Need ZIP Codes)

Sources: ● 2016 Healthy Hillsborough Survey (subsample data), Florida Department of Health in Hillsborough County
Notes: ● Data are derived from handout surveys administered at various locations in high-need ZIP Codes.

Prevalence of Chronic Conditions

Have you ever been told by a doctor or other medical provider that you had any of the following health issues? cancer; depression; diabetes; heart disease; high blood pressure/hypertension; obesity; stroke
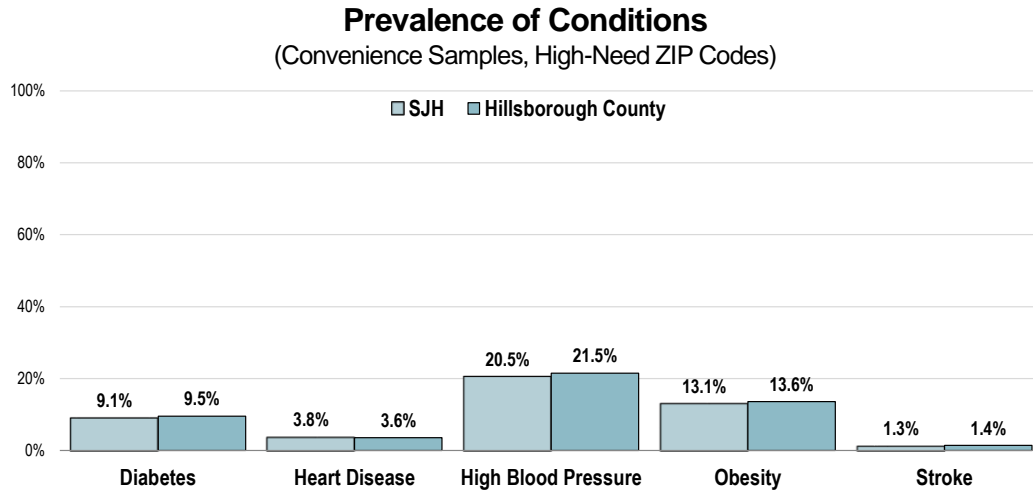
Prevalence of Conditions
(Convenience Samples, High-Need ZIP Codes)

Sources: ● 2016 Healthy Hillsborough Survey (subsample data), Florida Department of Health in Hillsborough County
Notes: ● Data are derived from handout surveys administered at various locations in high-need ZIP Codes.

Appendices

Professional Research Consultants, Inc.

Appendix I: Evaluation of Past Work

St. Joseph's Hospitals

(St. Joseph's Hospital, St. Joseph's Children's Hospital, St. Joseph's Women's Hospital, St. Joseph's Hospital-North, St. Joseph's Hospital-South)

Evaluation of Cycle 1 (2014-2016) Community Health Needs Assessment

Prepared in May 2016

Based on its most recent community health needs assessment (CHNA), St. Joseph's Hospitals are committed to addressing the following significant community needs:

1) Improving access to affordable health care
2) Decreasing the prevalence of clinical health issues
3) Improving healthy behavior and environments

KEY HIGHLIGHTS / ACCOMPLISHMENTS:

Progress was made to address each of the key health needs as prioritized within the 2013 Community Health Needs Assessment. Efforts were specifically dedicated to the following action step categories during Cycle-1 (2014-2016) with highlighted activities as noted below:

Improve access to and coordination of mental health services.

- BayCare is actively recruiting psychiatrists in an effort to expand access: 1 has been recruited for St. Joseph's Behavioral Health Center (expected August 2016) and 1 new outpatient psychiatrist is now shared between Clearwater & Tampa.
- Tele-psychiatry services are active in St. Joseph's Hospital's Emergency Department (and for inpatient consults).
- Mental health services are now co-located with primary care in pilot locations.
- A management services agreement with Northside Mental Health Center is now in place and is working according to plan to increase access in Hillsborough County.
- Ongoing initiatives continue focused to increase the community's awareness to recognize when someone is in mental health distress. "Mental Health First Aid" adult and pediatric-specific classes are provided throughout the community to increase awareness.

Continue advocacy outreach efforts to expand access

- Navigators are in place across BayCare to facilitate enrollment in marketplace plans. Outreach activities continue (by navigators) to encourage enrollment in health insurance plans across various community locations. Team members are also available to interview uninsured patients in the hospitals and assist insured patients needing assistance for copays/deductibles (by phone or by appointment). The number of people served continues to increase.

Continue to implement the Medical Home Model through BayCare Medical Group (BMG) and the hospital division.

- BayCare continues to provide services through the chronic complex clinic and HIV clinics as part of the medical home model implementation.

Enhance cancer prevention and treatment initiatives.

- Community outreach efforts continue across the health system to encourage the community to understand risk factors and to promote early detection of various types of cancer.
- BayCare sites have signed the "80% by 2018" pledge with the American Cancer Society to promote appropriate colorectal cancer screening in 80% of age-appropriate community members by 2018.
- St. Joseph's lung cancer screening program has provided 183 lung cancer screenings with 9 lung cancer findings (as of 3/11/2016). Stage distribution at diagnosis for the patients screened (for the most recent annual time periods available) is improving.
- St. Joseph's Hospitals' campuses remain tobacco-free (and maintain the incentives offered to team members for not smoking). Various smoking cessation programs are offered throughout BayCare.
- Collaborative efforts continue across BayCare to provide mammography services to the under-served.

Improve care coordination and outcomes for heart failure (CHF) patients.

- Efforts to provide consistent care to treat heart failure across BayCare are ongoing. St. Joseph's launched the heart failure outpatient clinic model within Cycle-1.
- Efforts are underway to provide consistent patient education materials as well as to develop clinical scorecards and evidence-based measure order sets across locations.
- St. Joseph's Hospital (Main campus) is piloting a "CHF-designated floor" initiative. Key elements of the pilot are to implement specialized CHF education and training for staff. An ARNP (outcomes care coordinator) has been hired specific to the CHF population.
- Various initiatives are underway to decrease readmissions across BayCare including daily inpatient rounds; post-discharge phone calls; utilization of faith community nurses; increased referrals to palliative care; establishment of heart failure support groups and nurse practitioner-led transitions of care programs. Sites continue to monitor, analyze and report CHF readmission & length of stay (LOS) metrics.

Enhance stroke prevention and recognition initiatives.

- Hospitals are making significant progress to increase the percentage of patients appropriately receiving thrombolytic therapy (for eligible patients).
- The first meeting of the newly formed "BayCare Stroke Collaborative" took place on 8/15/2015 with defined goals to identify best practices; standardize education and increase BayCare's community presence.
- In August 2015, a system-wide neuro-focused Facebook campaign took place which included the online stroke risk assessment; warning signs of a stroke; and the importance of a primary stroke center.

- Efforts are underway to launch consumer-focused marketing tactics to promote stroke awareness across the system in May 2016.

Enhance services to improve birth outcomes.

- St. Joseph's Hospitals continue to partner with Healthy Start, March of Dimes, Florida Perinatal Quality Collaborative and Reach Up Hillsborough County to implement best practices and to improve birth outcomes. St. Joseph's Hospitals actively participate in The Florida Perinatal Quality Collaborative initiatives to decrease morbidity and mortality in maternity and newborn patients.
- Efforts continue to expand the use of donor human milk at St. Joseph's Women's Hospital and St. Joseph's Children's Hospital to reduce all morbidities in extreme low birth weight infants.
- BayCare hospitals continue to partner with the Attorney General's office and statewide agencies to address the needs of infants born with neonatal abstinence syndrome by improving education and outreach. During Cycle-1, a grant was awarded to place case managers in all 3 BayCare NICUs (including St. Joseph's Children's Hospital) to work with addicted moms who give birth to addicted children. Permanent funding has been secured.

Evaluate and align services offered to patients with diabetes to improve health outcomes for diabetic patients.

- Collaborative relationships with the YMCA are in place to refer patients diagnosed with pre-diabetes and to possibly help the YMCA with pre-diabetes nutrition classes.
- The San Jose Mission Clinic (SJMC) and La Esperanza Clinic continue to treat, educate and care manage underserved diabetic patients in Eastern Hillsborough County. In collaboration with Catholic Charities, a 3-year strategic & operational plan was prepared for La Esperanza Clinic, resulting in a $300K grant from Allegany Franciscan Ministries for the 2016-2019 period. The SJMC plan will also be developed in collaboration with Catholic Charities.
- The outpatient diabetes management collaborative continues to work together to standardize outpatient education and services across BayCare.
- In building on a BayCare-wide initiative in 2014 to implement a diabetic ketoacidosis protocol, a 'Hyperglycemia Power Plan' is integrated within the Electronic Health Record. It was piloted at St. Joseph's Hospital-North in January 2016 and is now rolling out across BayCare. This will provide for a single standard of care for patients with hyperglycemia across BayCare.

Improve care coordination and support initiatives to reduce readmissions.

- All hospitals continue to strive to reduce readmissions (specific efforts are underway to decrease readmissions from heart failure, diabetes, COPD and other pulmonary diseases).
- In 2014, St. Joseph's Hospital participated in the WCFAAA Collaborative and a community-based care transitions program to reduce re-hospitalizations. The Emergency Department case management model was launched in Q2, 2014 to link patients with community resources to reduce reliance on the Emergency Department for care.
- The transitions of care pharmacy service launched through a St. Joseph's Hospital pilot in 2015. The

program utilizes pharmacists to place calls to patients following hospital discharge to assist with medication safety; to increase patient medication/disease state understanding and to encourage follow-up and continuity of care post-discharge. The St. Joseph's Hospital program is successfully contributing to a reduction in readmissions for those patients included in the pilot.

- Medication assistance was provided to 553 patients from January 2014 - March 2016 through the BayCare Indigent Drug Reimbursement Program across St. Joseph's Hospitals. The value of pharmaceuticals provided for free to patients/hospital bills credited for this time period was $1,927,972.

Facilitate access to transportation services for those in need.

- St. Joseph's Hospitals continue to facilitate and/or directly provide transportation to patients who are not able to afford it post-discharge

Increase access to (and coordination of) educational services and preventive/wellness care.

- BayCare continues to offer a variety of outreach educational events and screenings to increase awareness about important health issues and to improve the health of the community.
- St. Joseph's Children's Hospital continues to provide the Mobile Medical Bus to improve access to pediatric healthcare and provides well-child physicals; immunizations; hearing, vision and oral health screenings; community referrals and assistance with applying for Medicaid and Florida Kidcare in Hillsborough County.
- Faith Community Nurses continue to contribute far-reaching positive impact on the communities served by St. Joseph's Hospitals and continues to expand.

Continue to offer education and assistance with end of life care and directives through chaplains, mission team, Faith Community Nurses, Palliative care and Hospice.

- Palliative care models continue to expand throughout BayCare Health System.
- Enhancements are underway to strengthen the palliative care model at St. Joseph's Hospital (Main campus). An Advanced Registered Nurse Practitioner has been hired and credentialed. Recruitment and interviews for a physician continue for the program. Referrals to the social worker for palliative care screening continues to be an effective process.

ITEMS NOT ADDRESSED

While St. Joseph's Hospitals continue to drive and support activities to address the 3 key priority health needs as identified in the 2013 Community Health Needs Assessment, based on the 990 reporting requirements, hospital leaders were asked to ascertain the needs that were identified through the 2013 assessment process that they did not feel they could meet, and then, provide a rationale for the decisions. The following need was identified as not being met by any of the five St. Joseph's Hospitals during the Cycle-1 reporting period *(text is extracted directly from the 2013 CHNA final report for St. Joseph's Hospitals as prepared by Tripp Umbach)*:

Developmental disabilities:

While hospital leaders are interested in this issue, and are interested in further evaluating the barriers that residents with developmental disabilities and their families experience when seeking services,

none of the five St. Joseph's Hospitals currently have the expertise, resources, and/or provider based to provide these services in a sustainable way. Because the primary needs within the community have dictated that financial and human resources of the five St. Joseph's Hospitals are utilized for diagnostic, therapeutic, medical, behavioral health and surgical care, hospital leaders have determined that developmental disabilities services could be better met by existing providers, allowing available resources to remain focused on the existing and planned health services. However, the need as identified has increased awareness and may be further evaluated.

LESSONS LEARNED

Based on the lessons learned from the Cycle-1 period, St. Joseph's Hospitals are committed to integrating the following improvements to the Cycle-2 (2017-2019) efforts:

- **Narrow the focus:** Focus actions and work activity on a select number of key priorities. Mobilize the energy of the organization to target efforts to address these important health issues and provide regular communication on progress to key stakeholders.
- **Enhance outcome measures:** Ensure that the majority (if not all) key objectives have measureable and quantifiable indicators to evaluate the effectiveness of the related actions.
- **Enhance collaborative partnerships:** Extend continuous efforts to reach out to community organizations (and within BayCare Health System) to identify opportunities to collaborate to improve the health of the community.

COLLABORATIVE EFFORTS

Healthy Hillsborough is collaboration between the Florida Department of Health (DOH)–Hillsborough, Hillsborough County non-profit hospitals (including St. Joseph's Hospitals and South Florida Baptist Hospital), Suncoast Community Health Centers and Tampa Family Health Centers. Healthy Hillsborough was established in October 2015 to complete a comprehensive Community Health Needs Assessment (CHNA) and to identify opportunities to potentially collaborate to improve the health of the community. The Healthy Hillsborough Steering Committee considered detail from the assessment findings and the stakeholder feedback to designate the following three areas of focus for potential collaboration across the county for the next five years. Work groups are forming focused on these three areas.

- Obesity
- Mental Health / Substance Abuse
- Access

St. Joseph's Hospitals are active participants in all aspects of the Healthy Hillsborough collaboration. The Healthy Hillsborough areas of focus are being integrated into St. Joseph's Hospitals' CHNA activities as appropriate.

In addition to collaborating with other external community providers and organizations, St. Joseph's Hospitals continue to collaborate with other BayCare hospitals to combine efforts and to adopt best practices to improve the health of the community. In January 2016, BayCare Health System established a Community Benefit Council (on which St. Joseph's Hospitals' leadership actively participates) to develop, monitor, and validate

BayCare's Community Benefit activity to ensure that all BayCare entities are meeting the health care needs of the community.

COMMUNITY FEEDBACK

St. Joseph's Hospitals made the CHNA document publicly available in 2013 through the hospital and BayCare websites. St. Joseph's Hospitals did not receive any feedback related to the CHNA or 990 documents.

Appendix II: Child-Related Indicators

To facilitate an understanding of the needs of children and adolescents in the service area, the following tables isolate those measures collected through this assessment that directly relate to children's health issues.

Social Determinants	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
[County] Children Below 200% FPL (Percent)	48.1	☁ 45.9	☁ 49.2	🌧 44.2	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

☀ better   ☁ similar   🌧 worse

Access to Health Services	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
% Difficulty Getting Child's Healthcare in Past Year	16.9	☁ 11.1		🌧 3.9	
% Child Has Had Checkup in Past Year	78.9	☁ 78.1		🌧 89.3	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

☀ better   ☁ similar   🌧 worse

Family Planning	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
[County] Teen Births per 1,000 (Age 15-19)	42.1	🌧 38.9	🌧 36.1	🌧 36.6	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

☀ better   ☁ similar   🌧 worse

Injury & Violence Prevention	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
% [Homes With Children] Firearm in Home	29.8	☁ 29.5		☁ 31.0	
[County] Violent Crime per 100,000	394.3	☀ 455.5	☀ 514.6	☁ 395.5	
% Perceive Neighborhood as "Slightly/Not At All Safe"	18.3	☁ 18.1		☁ 15.3	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

☀ better ☁ similar 🌧 worse

Maternal, Infant & Child Health	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
[County] No Prenatal Care in First Trimester (Percent)	17.9	☀ 22.8	☀ 27.7	☁ 17.3	☀ 22.1
[County] Low Birthweight Births (Percent)	9.0	☁ 8.8	☁ 8.7	🌧 8.2	🌧 7.8
[County] Infant Death Rate per 1,000 Live Births	8.3	☁ 7.9	🌧 7.0	🌧 6.5	🌧 6.0

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

☀ better ☁ similar 🌧 worse

Nutrition, Physical Activity & Weight	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
% "Very/Somewhat" Difficult to Buy Fresh Produce	33.6	🌧 28.5		🌧 21.9	
Population With Low Food Access (Percent)	31.0	🌧 28.3	🌧 26.9	🌧 23.6	
% Food Insecure	39.0	🌧 32.5		🌧 25.9	
% Child [Age 2-17] Physically Active 1+ Hours per Day	25.5	☁ 34.3		🌧 47.9	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

	☀ better	☁ similar	🌧 worse

Oral Health	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
% Child [Age 2-17] Dental Visit in Past Year	76.5	☁ 73.3		🌧 90.7	☀ 49.0

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

	☀ better	☁ similar	🌧 worse

Respiratory Diseases	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
% [Child 0-17] Currently Has Asthma	15.7	☁ 10.4		🌧 6.5	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

	☀ better	☁ similar	🌧 worse

Tobacco Use	SJH Service Area	SJH Service Area vs. Benchmarks			
		vs. BayCare Area	vs. FL	vs. US	vs. HP2020
% [Household With Children] Someone Smokes in the Home	20.8	☁ 16.8		🌧 10.2	

Note: The SJH Service Area data (blue column) represent county-level data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.	🌞 better	☁ similar	🌧 worse

Appendix III: Agencies/Organizations Giving Input to Health Need Prioritization

The following agencies/organizations reviewed the assessment findings and participated in the hospital's prioritization exercise:

- American Cancer Society
- American Heart Association
- BayCare Health System
- BayCare Medical Group
- Catholic Charities
- Community Partners Consulting Services
- Florida Department of Health
- Freedom Health
- Healthy Start Coalition
- Hillsborough Community College
- Hillsborough County Health Department
- Hispanic Services Council
- Meals on Wheels
- Pediatrix Medical Group
- ReachUp
- SunCoast Community Health Centers, Inc.
- Tampa Hillsborough Homeless Initiative
- University of South Florida
- Women's Care Florida
- YMCA