Bayfront Health St. Petersburg

2022 Community Health Needs Assessment

BAYFRONT HEALTH
St. Petersburg

Table of Contents

Bayfront Health St. Petersburg – Facility Profile	4
Letter from the All4HealthFL Collaborative	7
Introduction and Purpose	9
Acknowledgments	9
Evaluation of Progress Since Previous CHNA	12
Collaborative Achievements	12
Community Feedback from Preceding CHNA and Implementation Plan	13
Demographics of Pinellas County	13
Geography and Data Sources	13
Population	13
Age	15
Sex	16
Race and Ethnicity	16
Language and Immigration	17
Social and Economic Determinants of Health	19
Geography and Data Sources	19
Income	20
Housing	26
Disparities and Health Equity	28
Geographic Disparities	29
Health Equity Index	30
Food Insecurity Index	32
Service Use Maps –Bayfront Health St. Petersburg, Inpatient	34
Bayfront Health St. Petersburg, Outpatient	36
Methodology	38
Overview	38
Secondary Data Sources and Analysis	39
Primary Data Collection and Analysis	40
Community Survey	40
Community Survey Analysis Results	40
Focus Groups	43
Data Synthesis and Prioritization	43
Data Synthesis	43
Prioritization	44
Process	45

Prioritized Significant Health Needs for Bayfront Health St. Petersburg	46
Prioritized Health Topic #1: Access to Health and Social Services	47
Primary Data: Community Survey and Focus Groups	47
Barriers and Disparities: Access to Health Care Services	49
Barriers and Disparities: Access to Dental Health Services	49
Barriers and Disparities: Access to Care in the Emergency Room	50
Secondary Data	50
Barriers and Disparities: Social Determinants of Health and Quality of Life	51
Prioritized Health Topic #2: Behavioral Health (Mental Health and Substance Misuse)	53
Primary Data: Community Survey and Focus Groups (Mental Health)	53
Secondary Data: Mental Health	55
Secondary Data	58
Prioritized Health Topic #3: Exercise, Nutrition and Weight	60
Primary Data: Focus Group	60
Secondary Data	61
Non-Prioritized Significant Health Needs	62
Non-Prioritized Health Need #1: Cancer	63
Non-Prioritized Health Need #2: Heart Disease and Stroke	64
Non-Prioritized Health Need #3: Immunizations and Infectious Diseases	65
Additional Opportunities for Impact	66
COVID-19 Pandemic	66
Community Lived Experiences Around Diversity, Equity and Inclusion	67
Conclusion	70
Appendices Summary	70
A. Secondary Data (Methodology and Data Scoring Tables)	70
B. Index of Disparity	70
C. Community Input Assessment Tools	70
D. Data Placemats	70
E. Community Partners and Resources	70
F. Partner Achievements	70

The All4HealthFL Community Health Needs Assessment is a unified effort by the region's leading healthcare providers.

The following document provides an overview of the Bayfront Heath St. Petersburg service area and includes prioritized needs for that facility. It includes a summary of key county-level demographics, an in-depth health equity profile, a summary of other research results and prioritized needs for the facility.

Bayfront Health St. Petersburg – Facility Profile

Orlando Health Overview

The Orlando Health healthcare system is one of Florida's most comprehensive private, not-for-profit healthcare organizations with a community-based network of physician practices, hospitals and outpatient care centers throughout Central Florida. As a statutory teaching hospital system, Orlando Health offers the region's only Level One Trauma Center; the area's first heart program; specialty hospitals dedicated to children, women and babies; a major cancer institute; and long-standing community hospitals.

With 3,200 beds, facilities include: Orlando Health Arnold Palmer Hospital for Children, Orlando Health Cancer Institute, Orlando Health Dr. P. Phillips Hospital, Orlando Health – Health Central Hospital, Orlando Health Horizon West Hospital, Orlando Health Orlando Regional Medical Center, Orlando Health South Lake Hospital, Orlando Health South Seminole Hospital, Orlando Health St. Cloud Hospital, Orlando Health Winnie Palmer Hospital for Women and Babies and Bayfront Health St. Petersburg. Areas of expertise include orthopedics, heart and vascular, cancer care, neurosciences, surgery, pediatric orthopedics and sports medicine, neonatology, women's health and trauma.

Bayfront Health St. Petersburg

Effective October 1, 2020, Orlando Health finalized the purchase of the 480-bed Bayfront Health St. Petersburg and its associated healthcare operations in St. Petersburg, Florida, from an affiliate of Community Health Systems, Inc. Located in Pinellas County, Florida, Bayfront Health St. Petersburg has been serving its community and the surrounding region since 1910. It is a teaching hospital that provides a diverse and comprehensive scope of services in: trauma and emergency care; orthopedics; obstetrics and gynecology; cardiac medicine and surgery (specializing in valve surgery); neurosciences (with its own epilepsy center); sports medicine; surgery and rehabilitation. More than 550 physicians are on staff with specialties ranging from open-heart surgery to fertility treatment. Additionally, Bayfront Health St. Petersburg operates an eight-bed freestanding ER in Pinellas Park.

Bayfront Health St. Petersburg is nationally accredited by The Joint Commission and maintains accreditations and certifications for: Level II trauma center, Level III regional perinatal intensive care center, primary stroke center, chest pain center and hip and knee replacement. In 2022, *U.S. News & World Report* recognized Bayfront Health St. Petersburg as high performing in treating patients with chronic obstructive pulmonary disease (COPD) and kidney failure.

In compliance with the IRS guidelines at the time of data collection for this assessment, Bayfront Health St. Petersburg defined its community as southern Pinellas County and identified it as its primary service area. The populations of this service area include all residents including vulnerable populations. Vulnerable populations are groups and communities at a higher risk for poor health as a result of barriers they experience to social, economic, political and environmental resources, as well as limitations due to illness or disability.

Underrepresented populations involved in this study included but were not limited to: adults and children living below the poverty level, homeless/transient individuals, unwed mothers, individuals in prison (both male and female), individuals living with disabilities, children and adolescents, senior citizens, caregivers, adults and children with a variety of education levels, adults and children with diverse racial identifications, undocumented individuals and healthcare professionals. Additional stakeholders were selected because of their direct understanding of community needs and issues including but not limited to: human trafficking, violence, substance use and mental health.

Pinellas
COUNTY

2022

Prepared by Conduent Healthy Communities Institute

LETTER FROM THE ALL4HEALTHFL COLLABORATIVE

To the citizens of Pinellas County,

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

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

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

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

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

The All4HealthFL Collaborative

COMMUNITY HEALTH NEEDS ASSESSMENT
At a Glance: Pinellas County

Secondary Data

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

Primary Data/Community Input

Community Health Survey

Pinellas County had **5,048** Community Survey Respondents

Top Health Issues:

Mental Health Problems Including Suicide	41.2%
Aging Problems	37.7%
Being Overweight	31.5%

Focus Group Discussions

Pinellas County conducted **5** Focus Groups

"Dealing with multiple aspects of racism, creates health issues and concerns cultural competency in terms of how you're raised, your diet, and access to healthy food options."

-Focus Group Participant

Health Equity

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

Introduction and Purpose

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

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

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

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

Acknowledgments

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

See Appendix E for the full list of collaborative members, supporting individuals, organizations, partners and vendors.

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

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

Collaborative Labs at St. Petersburg College designed and facilitated community focus group discussions. Collaborative Labs works as an extension of a business or organization's team to provide expert facilitation, customized agenda formation and strength-based activities. They are process experts that ensure an organization engagement has the right stakeholders to build the best plan for future success. Learn more at: www.CollaborativeLabs.com

All4HealthFL Collaborative

The All4HealthFL Collaborative was officially organized in 2019. This group comes together with a mutual interest to improve health by leading regional, outcome-driven health initiatives that have been prioritized through community health assessments. This process is conducted every three years and aims to identify health priorities in the community and strategies to address them.

The All4HealthFL Collaborative works together to plan, implement and evaluate strategies that are in alignment with identified health priorities. Together, the group strives to make Hillsborough, Pasco, Pinellas and Polk counties the healthiest region in Florida.

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

The All4HealthFL Collaborative also hosts and maintains https://www.all4healthfl.org/ as a community resource for the four counties comprising their combined service area.

IRS Form 990, Schedule H Compliance Listing

For not-for-profit hospitals, a CHNA serves to meet certain requirements of the Internal Revenue Service (IRS), pursuant to provisions of the Patient Protection and Affordable Care Act of 2010. The table below lists the sections, along with corresponding page numbers, that the IRS requires a CHNA to have to be compliant.

IRS Requirement	See Report Page
A definition of the community served by the hospital facility and a description of how the community was determined.	5
A description of the process and methods used to conduct the CHNA, including identification of information gaps that limit the hospital's ability to assess the community's health needs.	Appendix B
A description of how the hospital facility solicited and considered input received from persons who represent the broad interests of the community it serves.	38 - 40
A prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant needs.	44 - 46
A description of the resources potentially available to address the significant health needs identified through the CHNA.	Appendix E
An evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA to address the significant health needs identified in the hospital facility's CHNA(s).	13
Board approval or equivalent	7.25.2022

Evaluation of Progress Since Previous CHNA

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

2019 Community Health Imporement Priorities

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

Collaborative Achievements

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

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

There were 85 responses to the survey across the region. Although there were new issues that emerged around housing and poverty, the survey respondents affirmed the 2020-2022 top three focus areas of Mental Health and Substance Misuse, Access the Health Care and Exercise, Nutrition and Weight as still the most pressing issues. This data provided the collaborative an opportunity to consider increasing strategies to expand programs like Mental Health First Aid Training. Since this is the first CHNA for Bayfront Health St. Petersburg, our top priority was joining efforts with the All4HealthFL Collaborative to address needs already identified in the service area.

Community Feedback from Preceding CHNA and Implementation Plan

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

Demographics of Pinellas County

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

Geography and Data Sources

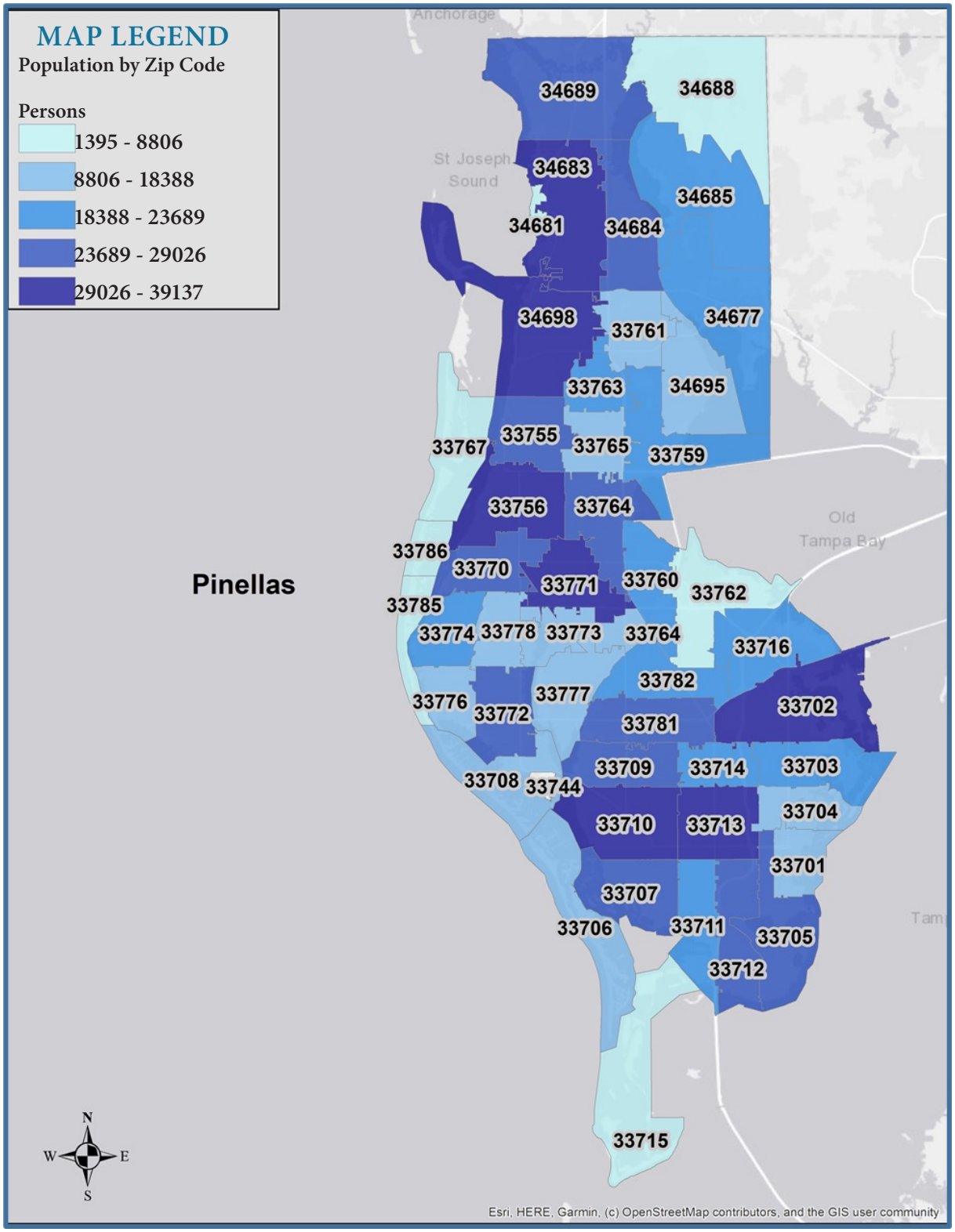
Data are presented in this section at the geographic level of Pinellas County. Comparisons to the county, state and national value are also provided when available. All demographic estimates are sourced from Clarita's Pop-Facts® (2022 population estimates)[1] and American Community Survey[2] one-year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

Population

According to the 2022 Clarita's Pop-Facts® population estimates, Pinellas County has an estimated population of 982,142 persons. Figure 1 shows the population size by each ZIP code, with the darkest blue representing the ZIP codes with the largest population. Appendix A provides the actual population estimates for each ZIP code. The most populated ZIP code area within Pinellas County is ZIP code 34698 (Dunedin) with a population of 39,137.

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

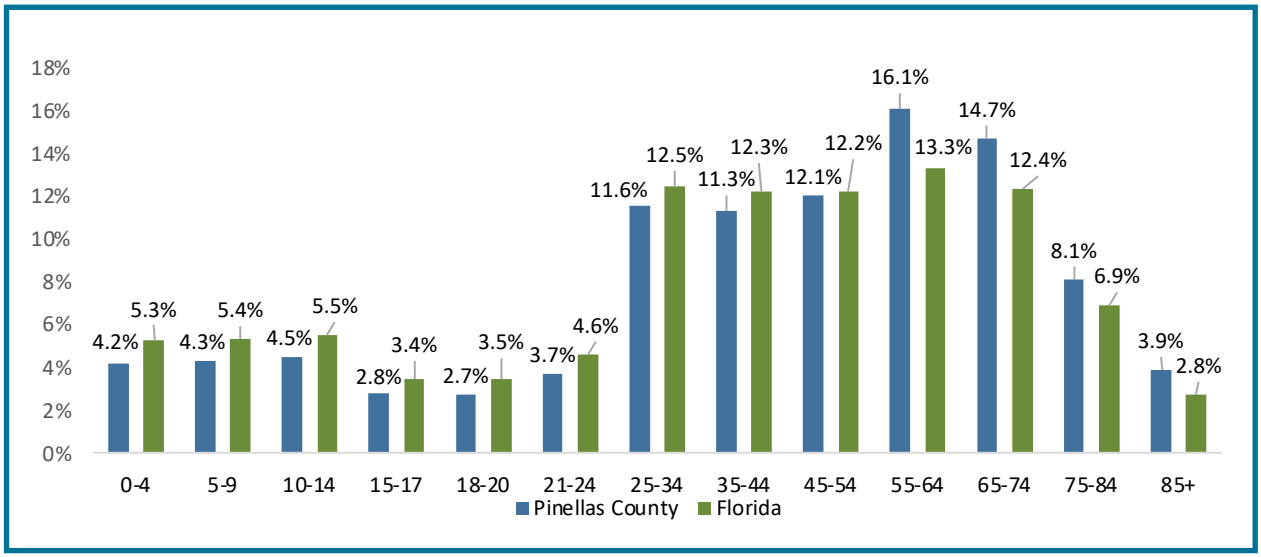
Figure 1: Population by ZIP Code by Age Under 18: Pinellas County



Age

Children (0-17) comprised 15.8% of the population in Pinellas County. When compared to Florida and the U.S., Pinellas County has lower proportion of children population (age 0-17) and a higher proportion of residents aged 65+. Figure 2 shows further breakdown of age categories.

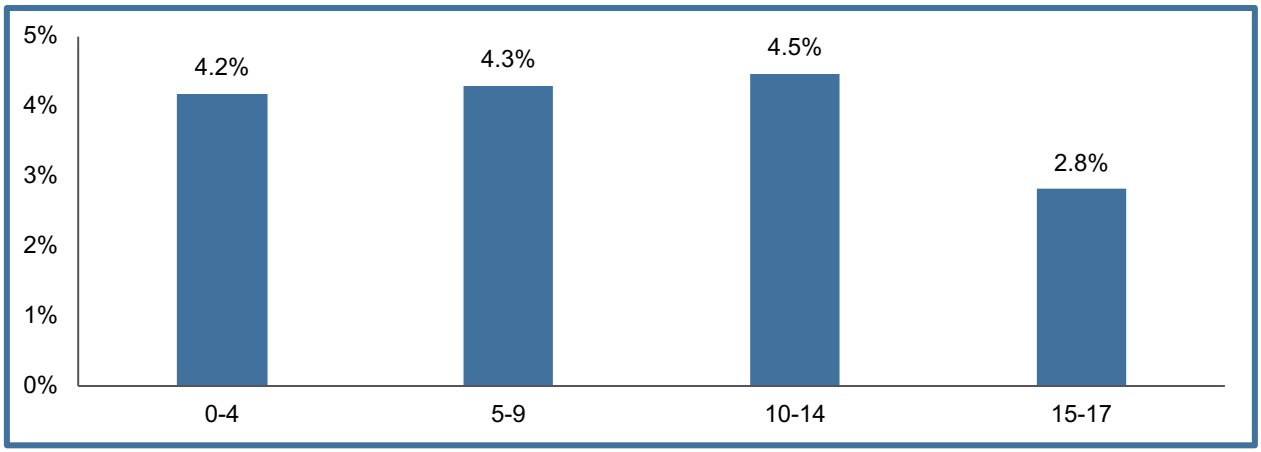
Figure 2: Population by Age: County and State Comparisons



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

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

Figure 3: Population by Age Under 18: Pinellas County

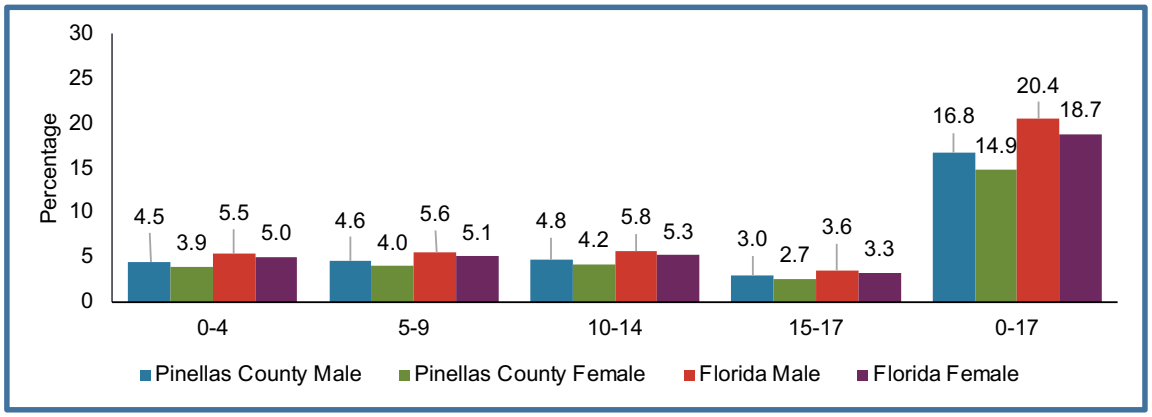


*County values- Claritas Pop-Facts® (2022 population estimates)

Sex

Figure 4 shows the children (under 18) population of Pinellas County by sex. Males comprise 16.7% of the population, whereas females comprise 14.8% of the population in the county.

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



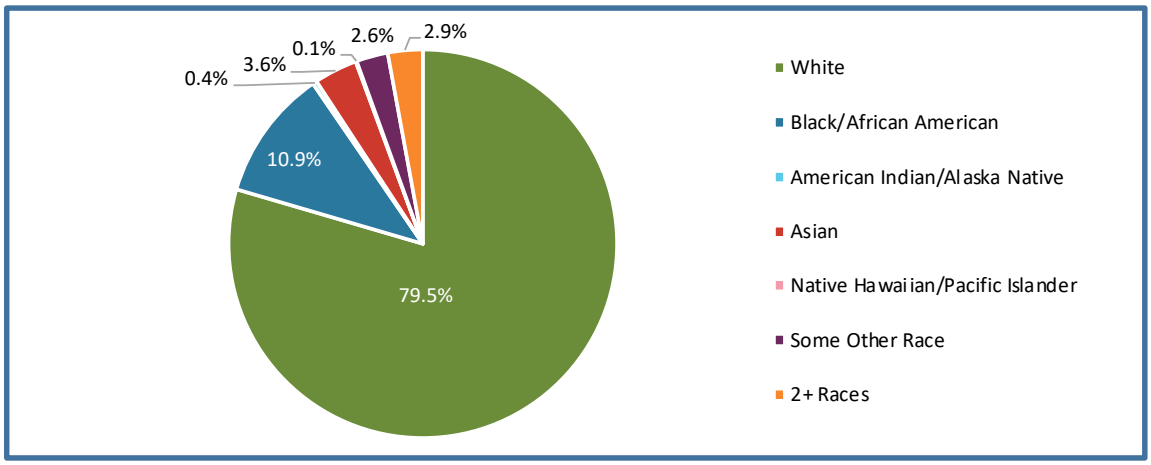
*County values- Claritas Pop-Facts® (2022 population estimates)

Race and Ethnicity

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

The racial makeup of Pinellas County area shows 79.5% of the population identifying as White, as indicated in Figure 5. The proportion of Black/African American community members is the second largest of all races in Pinellas County at 10.9%.

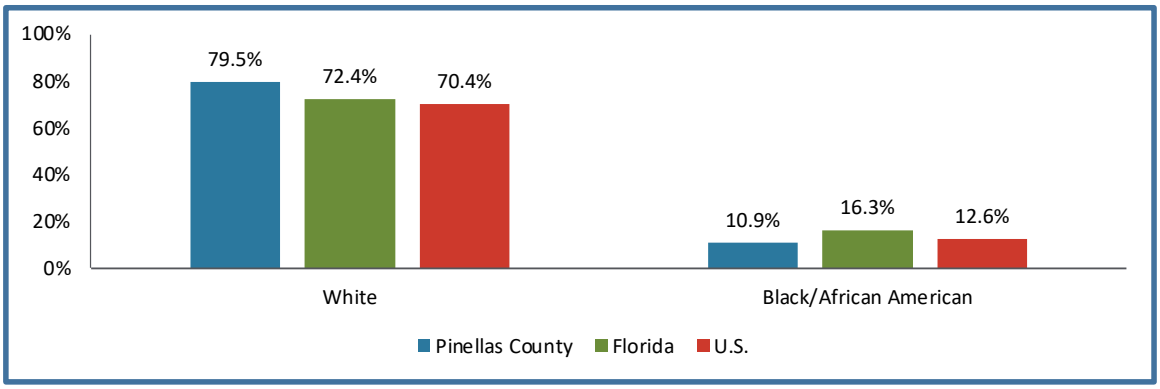
Figure 5: Population by Race: Pinellas County



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

Those community members identifying as White represent a higher proportion of the population in Pinellas County (79.5%) when compared to Florida (72.4%) and the U.S. (70.4%), while Black/African American community members represent a lower proportion of the population in Pinellas County (10.9%) when compared to Florida (16.3%) and the U.S. (12.6%) (Figure 6).

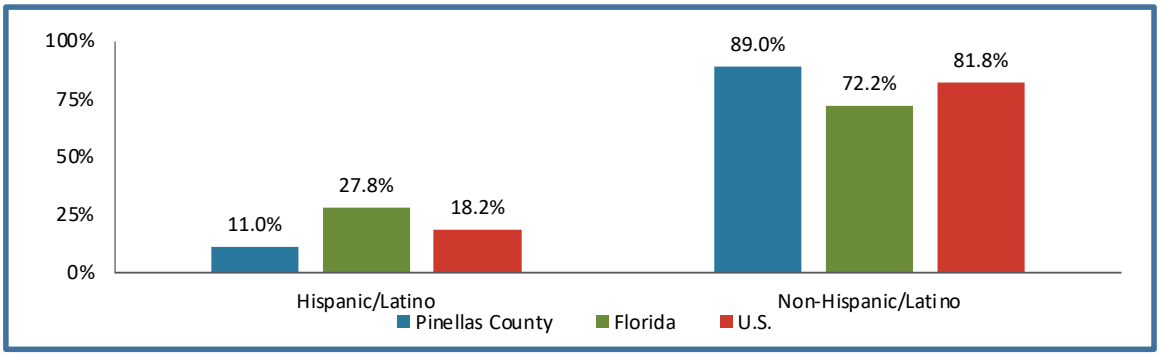
Figure 6: Population by Race: Pinellas County, State and U.S. Comparisons



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

As shown in Figure 7, 11.0% of the population in Pinellas County identify as Hispanic/Latino. This is a smaller proportion of the population when compared to Florida and the U.S.

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



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

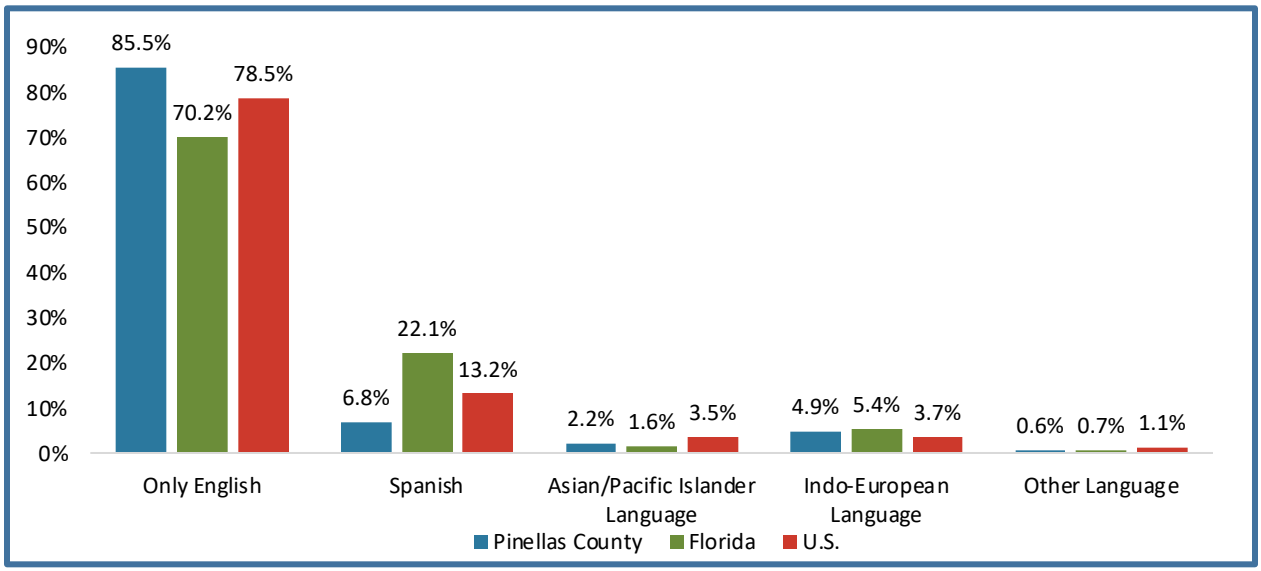
Language and Immigration

Understanding countries of origin and language spoken at home can help inform the cultural and linguistic context for the health and public health system. According to the American Community Survey, 12% of residents in Pinellas County are born outside the U.S., which is slightly lower than the national value of 13.6%.[3]

[3]American Community Survey, 2016-2020

In Pinellas County, 85.5% of the population age five and older speak only English at home, which is higher than both the state value of 70.2% and the national value of 78.5% (Figure 8). This data indicates that 6.8% of the population in Pinellas County speak Spanish and 0.6% speak languages other than English at home.

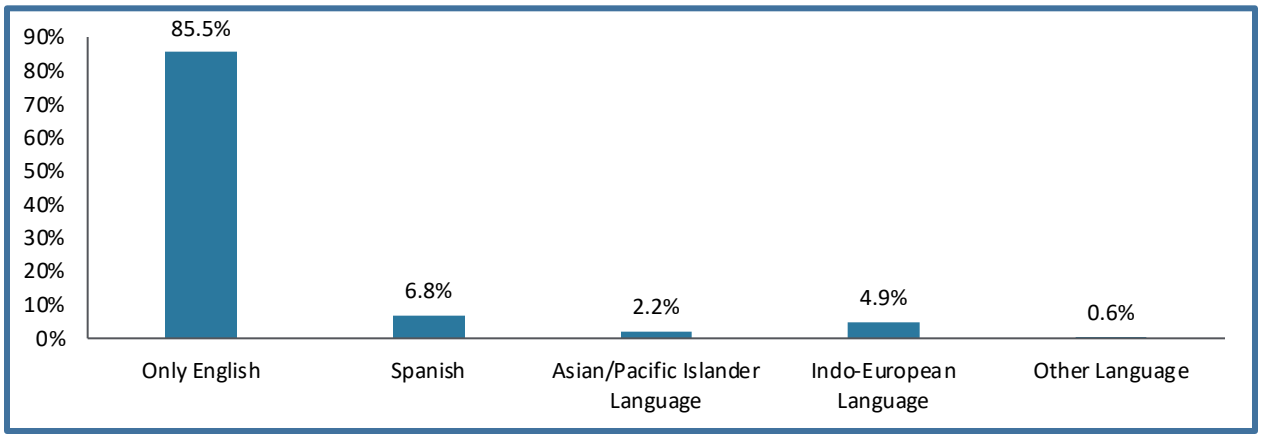
Figure 8: Population 5+ by Language Spoken at Home: County, State and U.S. Comparisons



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

The most common languages spoken at home are English (85.5%), Spanish (6.8%) and Indo-European languages such as French, Portuguese, Russian and Dutch[4] (4.9%). (Figure 9).

Figure 9: Population 5+ by Language Spoken at Home: Pinellas County



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

[4]United States Census Bureau. https://www.census.gov/topics/population/language-use/about.html

Social and Economic Determinants of Health

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

Figure 10: Healthy People 2030 Social Determinants of Health Domains

Geography and Data Sources

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

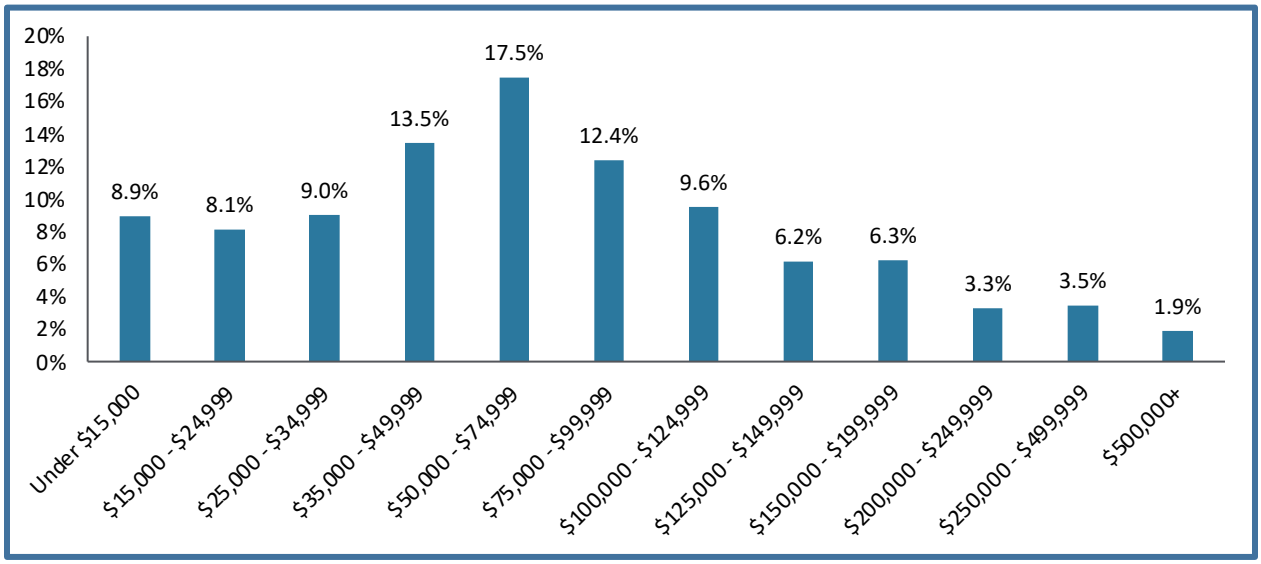
All demographic estimates are sourced from Claritas Pop-Facts® (2022 population estimates) and American Community Survey one-year (2019) or five-year (2016-2020) estimates unless otherwise indicated.

Income

Income has been shown to be strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social and environmental factors. Those with greater wealth are more likely to have higher life expectancy and reduced risk of a range of health conditions including heart disease, diabetes, obesity and stroke. Poor health can also contribute to reduced income by limiting one's ability to work.[5]

Figure 11 provides a breakdown of households by income in Pinellas County. A household income of $50,000 - $74,999 is shared by the largest proportion of households in Pinellas County (17.5%). Households with an income of less than $15,000 make up 8.9% of households in Pinellas County.

Figure 11: Households by Income, Pinellas County

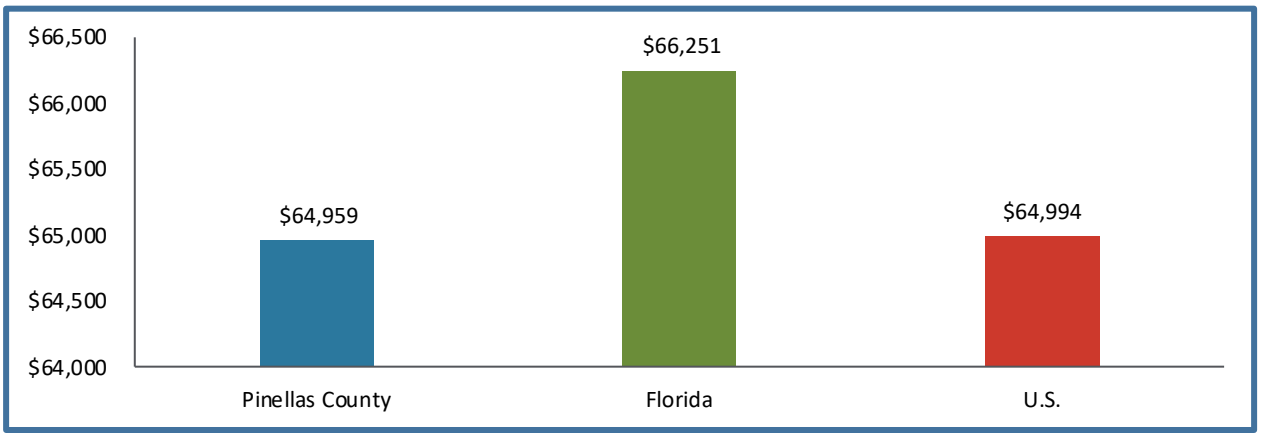


*County values- Claritas Pop-Facts® (2022 population estimates)

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

The median household income for Pinellas County is $64,959, which is lower than the state value of $66,251 and national value of $64,994 (Figure 12).

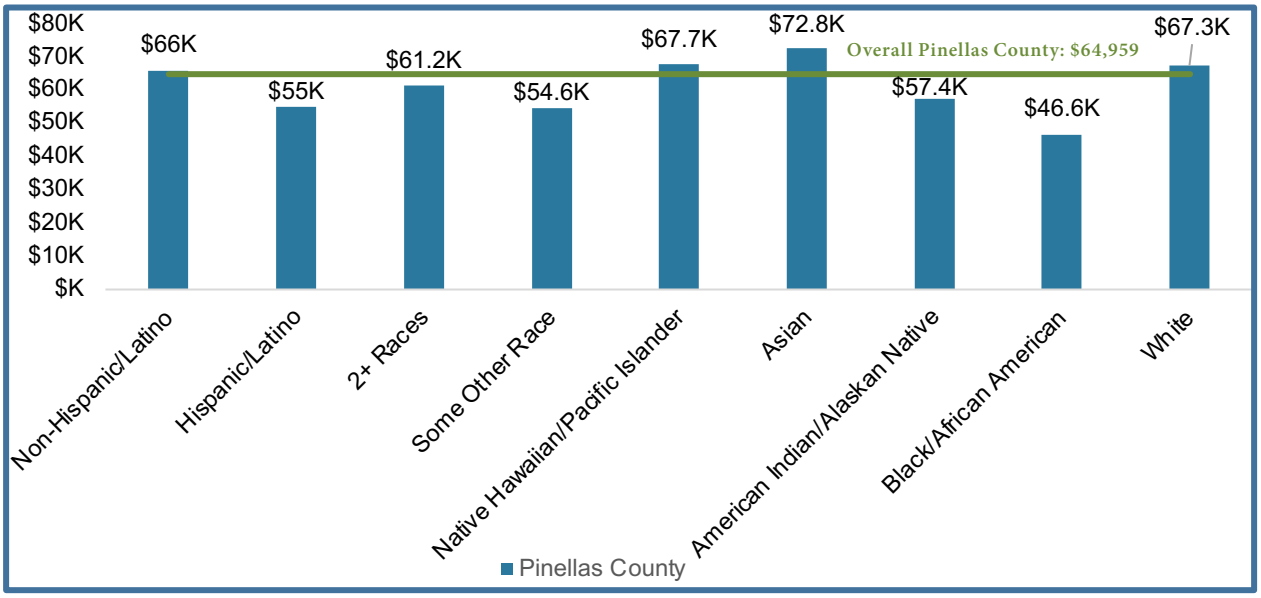
Figure 12: Households Income by: County, State and U.S. Comparisons



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

Figure 13 shows the median household income by race and ethnicity. Four racial/ethnic groups – White, Asian, Non-Hispanic/Latino and Native Hawaiian/Pacific Islander – have median household incomes above the overall median value. All other races have incomes below the overall value, with Black/African American populations having the lowest median household income at $46,614.

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



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

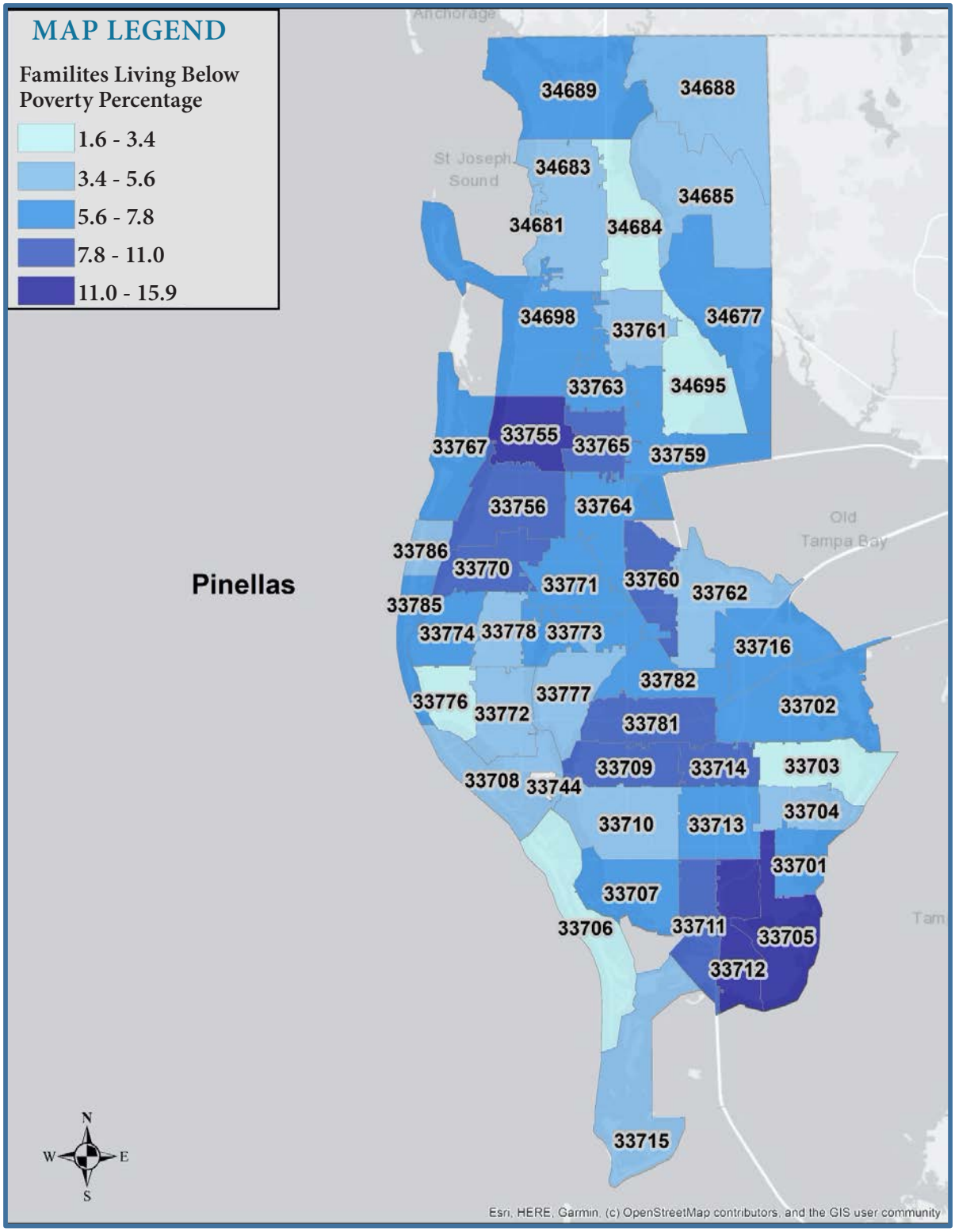
Poverty

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

Figure 14 shows the percentage of families living below the poverty level by ZIP code. The darker blue colors represent a higher percentage of families living below the poverty level, with ZIP codes 33755 (Clearwater) and 33712 (St. Petersburg) having the highest percentages at 15.9% and 14.2%, respectively. Overall, 7.0% of families in Pinellas County live below the poverty level, which is lower than both the state value of 9.3% and the national value of 9.1%. The percentage of families living below poverty for each ZIP code in Pinellas County is provided in Appendix A.

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

Figure 14: Families Living Below Poverty: Pinellas County



Employment

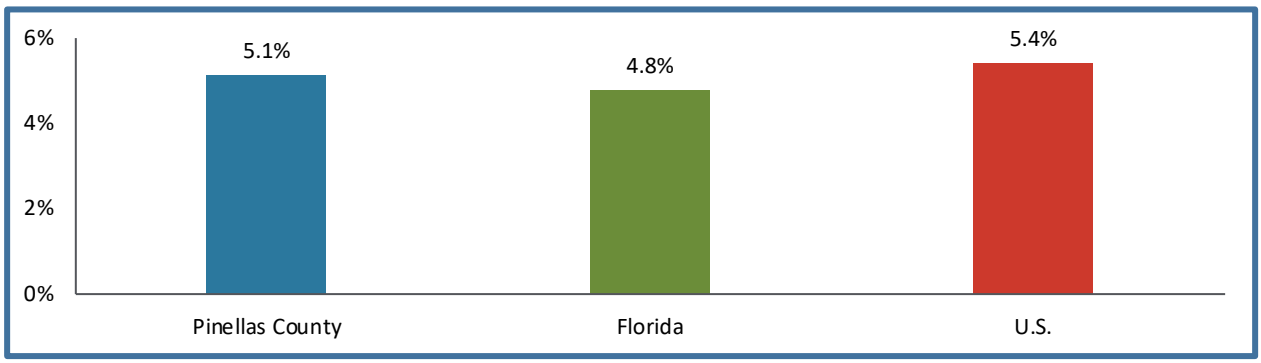
A community's employment rate is a key indicator of the local economy. An individual's type and level of employment impacts access to health care, work environment, health behaviors and health outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast,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

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

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

Figure 15 shows the population aged 16 and over who are unemployed. The unemployment rate for Pinellas County is 5.1%, which is higher than the state value of 4.8% and lower than the national value of 5.4%.

Figure 15: Population 16+ Unemployed



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

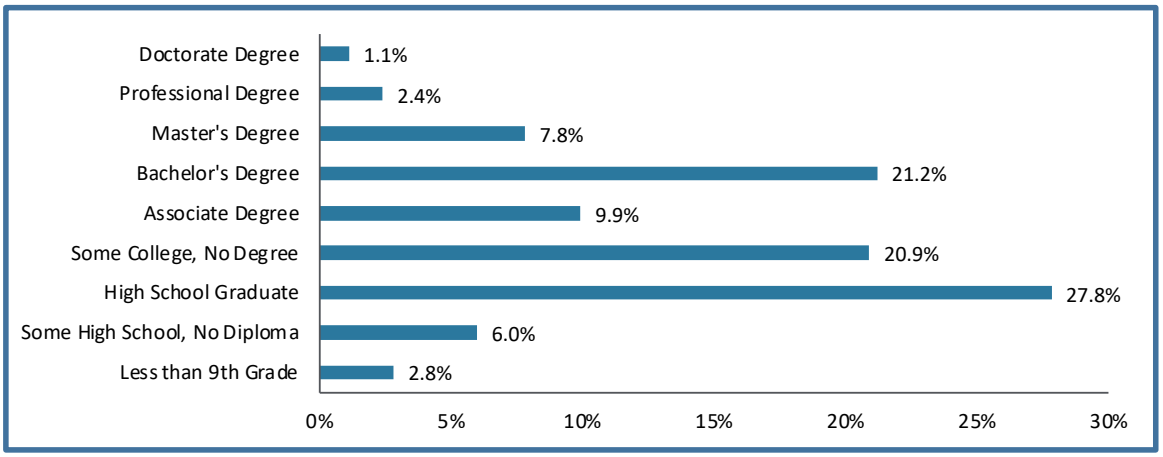
Education

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

[7]U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/employment
[8]Robert Wood Johnson Foundation, Education and Health. https://www.rwjf.org/en/library/research/2011/05/education-matters-for-health.html

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

Figure 16: Population Aged 25+ by Education Attainment, Pinellas County

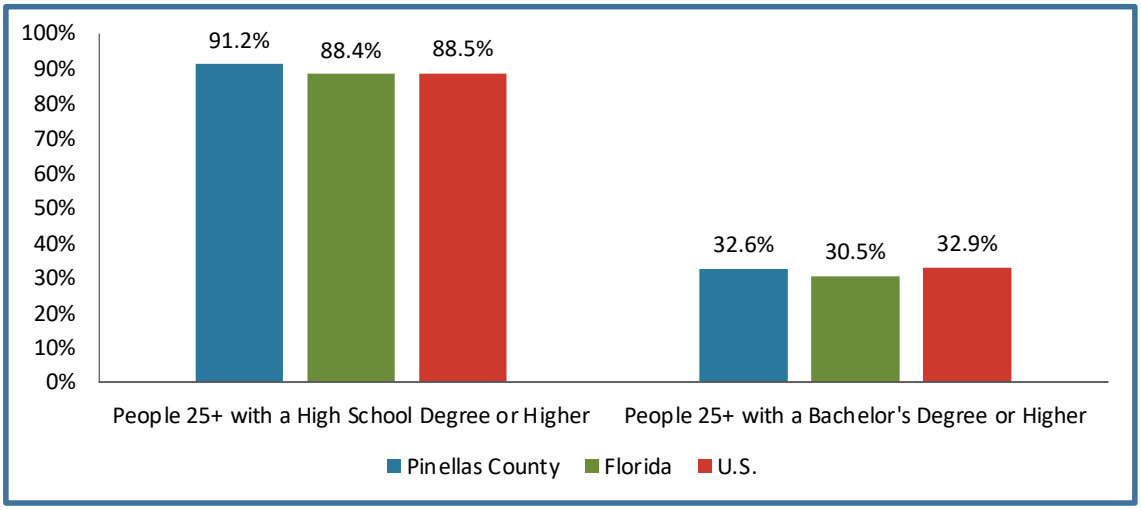


*County values- Claritas Pop-Facts® (2022 population estimates)

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

Figure 17 shows that Pinellas County has a higher percentage of residents with a high school degree and bachelor's degree when compared to the state.

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



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

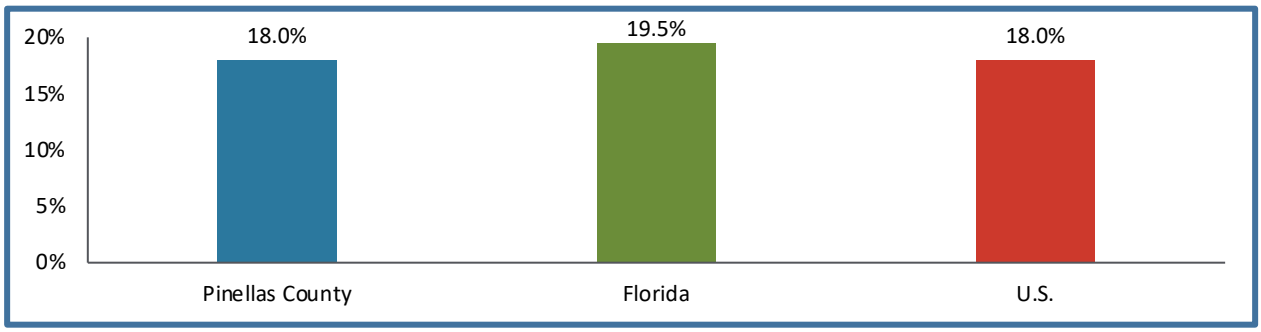
[9]U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/high-school-graduation

Housing

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

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

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

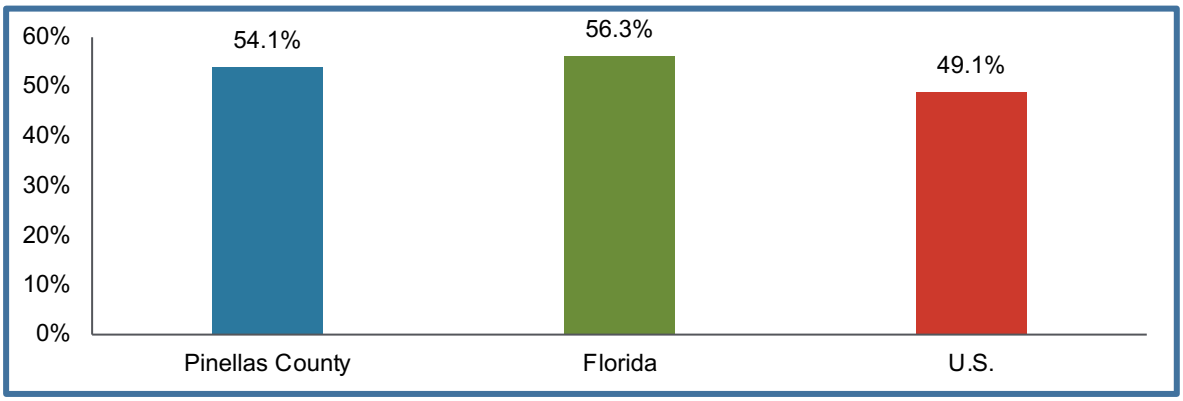


*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

When families must spend a large portion of their income on housing, they may not have enough money to pay for things like healthy foods or health care. This is linked to increased stress, mental health problems and an increased risk of disease.[11] Figure 19 shows the percentage of renters who are spending 30% or more of their household income on rent. The value in Pinellas County, 54.1%, is higher than the national value (49.1%) and lower than the state value (56.3%).

[10]County Health Rankings, Housing and Transit. https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/physical-environment/housing-and-transit
[11]U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes/reduce-proportion-families-spend-more-30-percent-income-housing-sdoh-04

Figure 19: Renters Spending 30% Or More Of Household Income On Rent: County, State, U.S. Comparisons



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

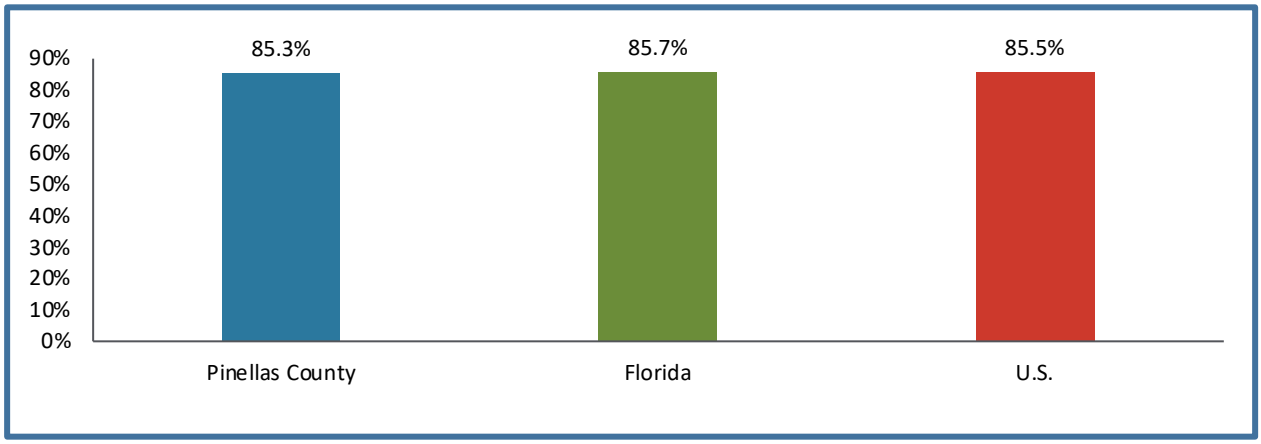
Neighborhood and Built Environment

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

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

Figure 20 shows the percentage of households that have an internet subscription. The rate in Pinellas County, 85.3%, is lower than the state value (85.7%) and lower than the national value (85.5%).

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



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

Disparities and Health Equity

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

Health Equity

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

Race, Ethnicity, Age and Gender Disparities

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

Secondary Data

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

[13]Klein R, Huang D. Defining and measuring disparities, inequities and inequalities in the Healthy People initiative. National Center for Health Statistics. Center for Disease Control and Prevention. https://www.cdc.gov/nchs/ppt/nchs2010/41_klein.pdf
[14]Pearcy, J. & Keppel, K. (2002). A Summary Measure of Health Disparity. Public Health Reports, 117, 273-280.

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

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

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

The Index of Disparity analysis for Pinellas County reveals that Black/African American and Hispanic/Latino populations are disproportionately impacted for several chronic diseases, including Diabetes, Kidney Disease and Prostate Cancer. Furthermore, Black/African American and Hispanic/Latino populations are disproportionately impacted in the Infant Mortality Rate and Teen Birth Rate: aged 15-19.

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

Geographic Disparities

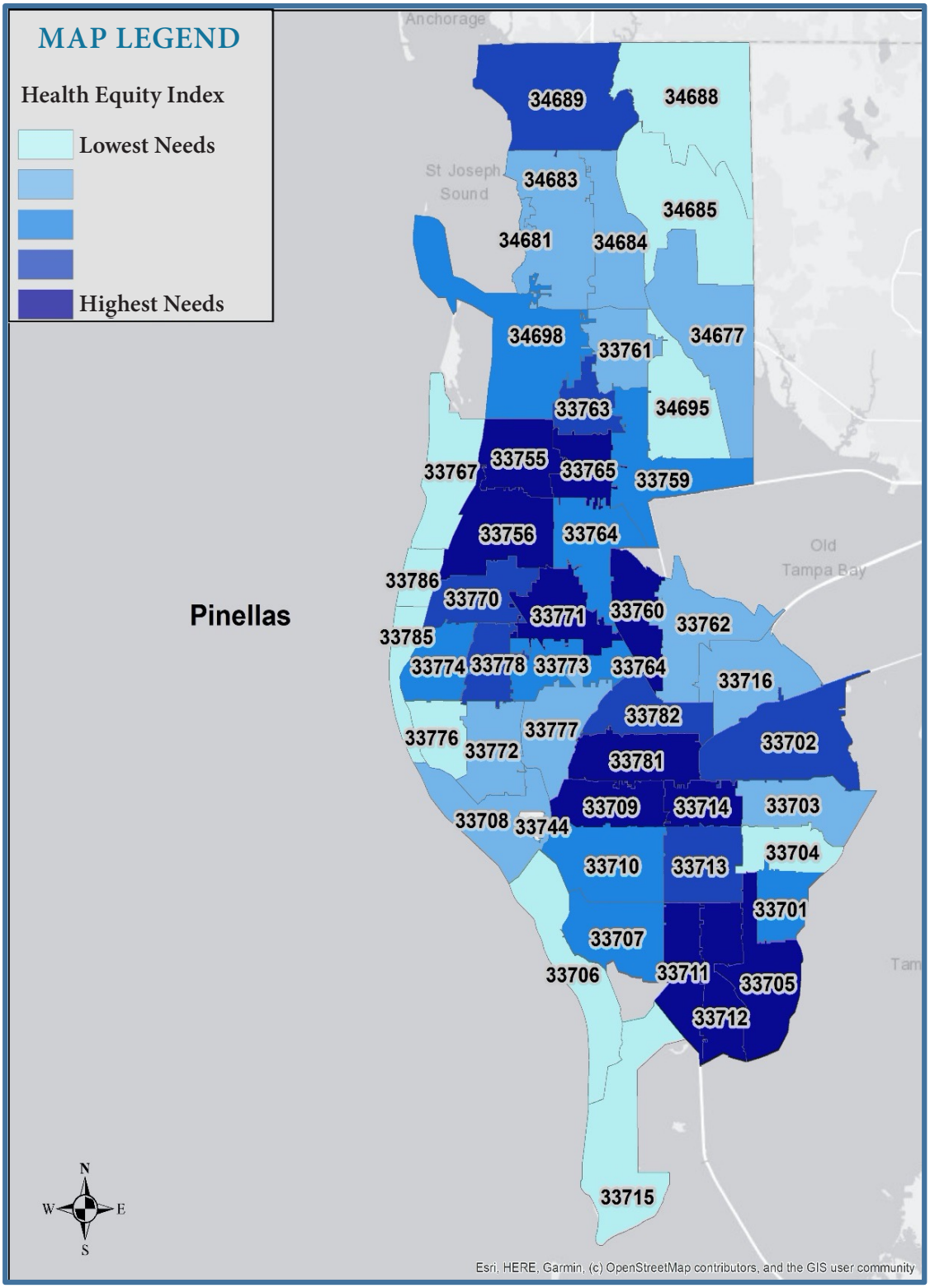
In addition to disparities by race, ethnicity, age and gender, this assessment also identified specific ZIP codes/municipalities with differences in outcomes related to health and social determinants of health. Geographic disparities were identified using the Health Equity Index, Food Insecurity

Index and Mental Health Index. These indices have been developed by Conduent Healthy Communities Institute to easily identify areas of high socioeconomic need, food insecurity and mental health need. Conduent's Health Equity Index estimates areas of highest socioeconomic need correlated with poor health outcomes. Conduent's Food Insecurity Index estimates areas of low food accessibility correlated with social and economic hardship. Conduent's Mental Health Index (MHI) is a measure of socioeconomic and health factors correlated with self-reported poor mental health. For all indices, counties, ZIP codes and census tracts with a population over 300 are assigned index values ranging from 0 to 100, with higher values indicating greater need. Understanding where there are communities with higher need is critical to targeting prevention and outreach activities.

Health Equity Index

Conduent's Health Equity Index estimates areas of high socioeconomic need, which are correlated with poor health outcomes. ZIP codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 21. The following ZIP codes in Pinellas County had the highest level of socioeconomic need (as indicated by the darkest shades of blue): 33714 (St. Petersburg) and 33711 (St. Petersburg) with index values of 85.4 and 74.9, respectively. Appendix A provides the index values for each ZIP code.

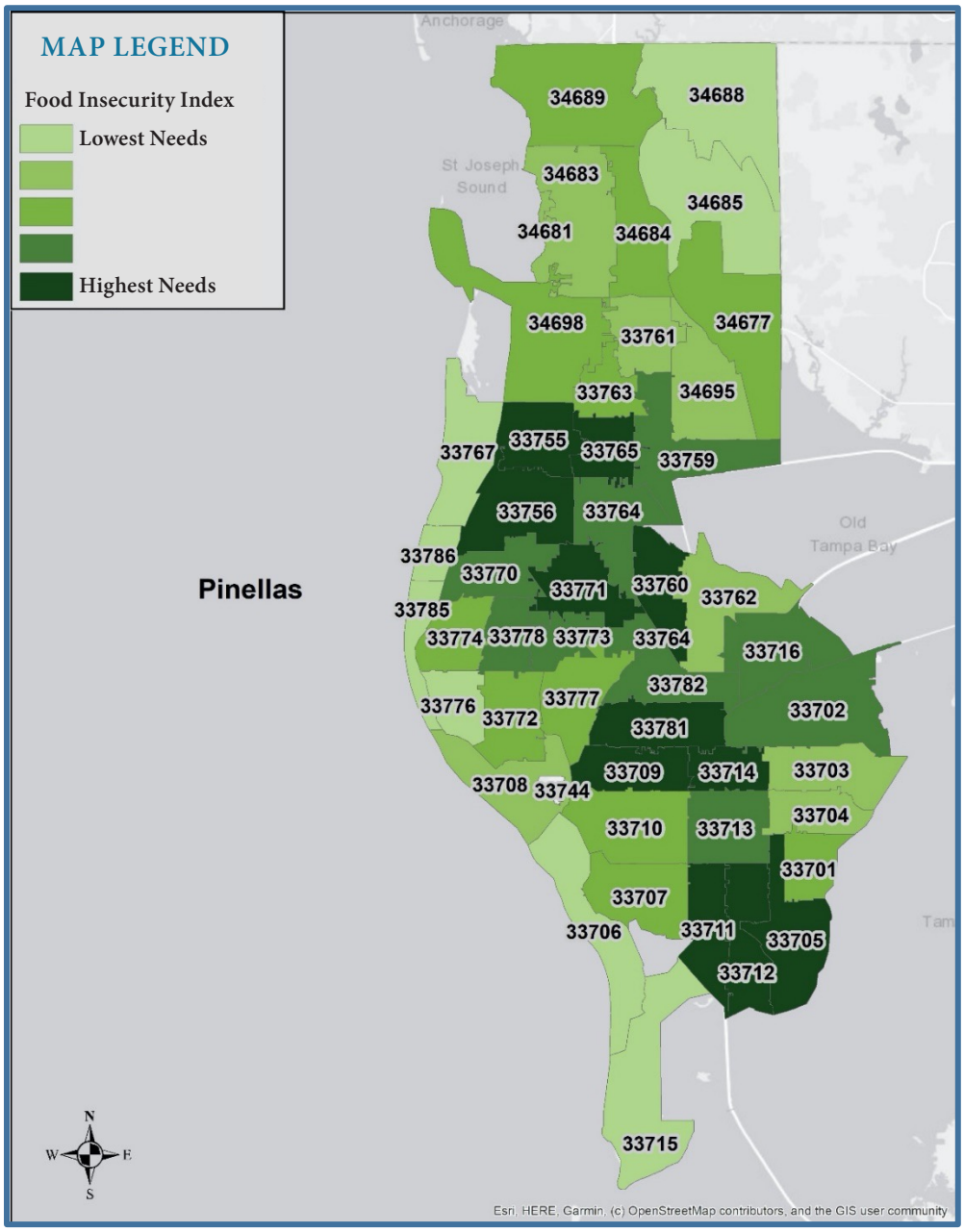
Figure 21: Health Equity Index



Food Insecurity Index

Conduent's Food Insecurity Index estimates areas of low food accessibility correlated with social and economic hardship. ZIP codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 22. The following ZIP codes had the highest level of food insecurity (as indicated by the darkest shades of green): 33712 (St. Petersburg) and 33755 (Clearwater) with index values of 89.7 and 81.9, respectively. Appendix A provides the index values for each ZIP code.

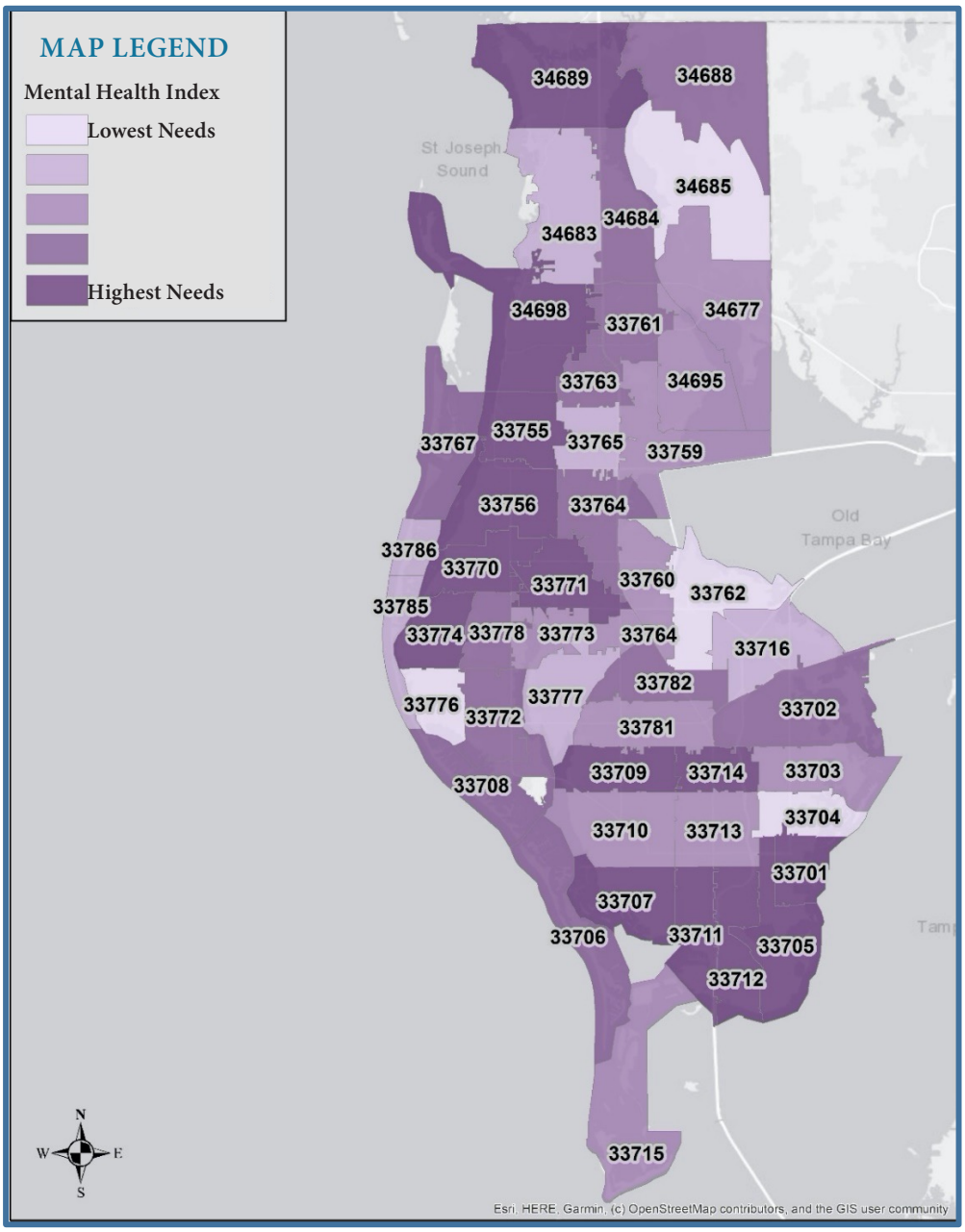
Figure 22: Food Insecurity Index



Mental Health Index

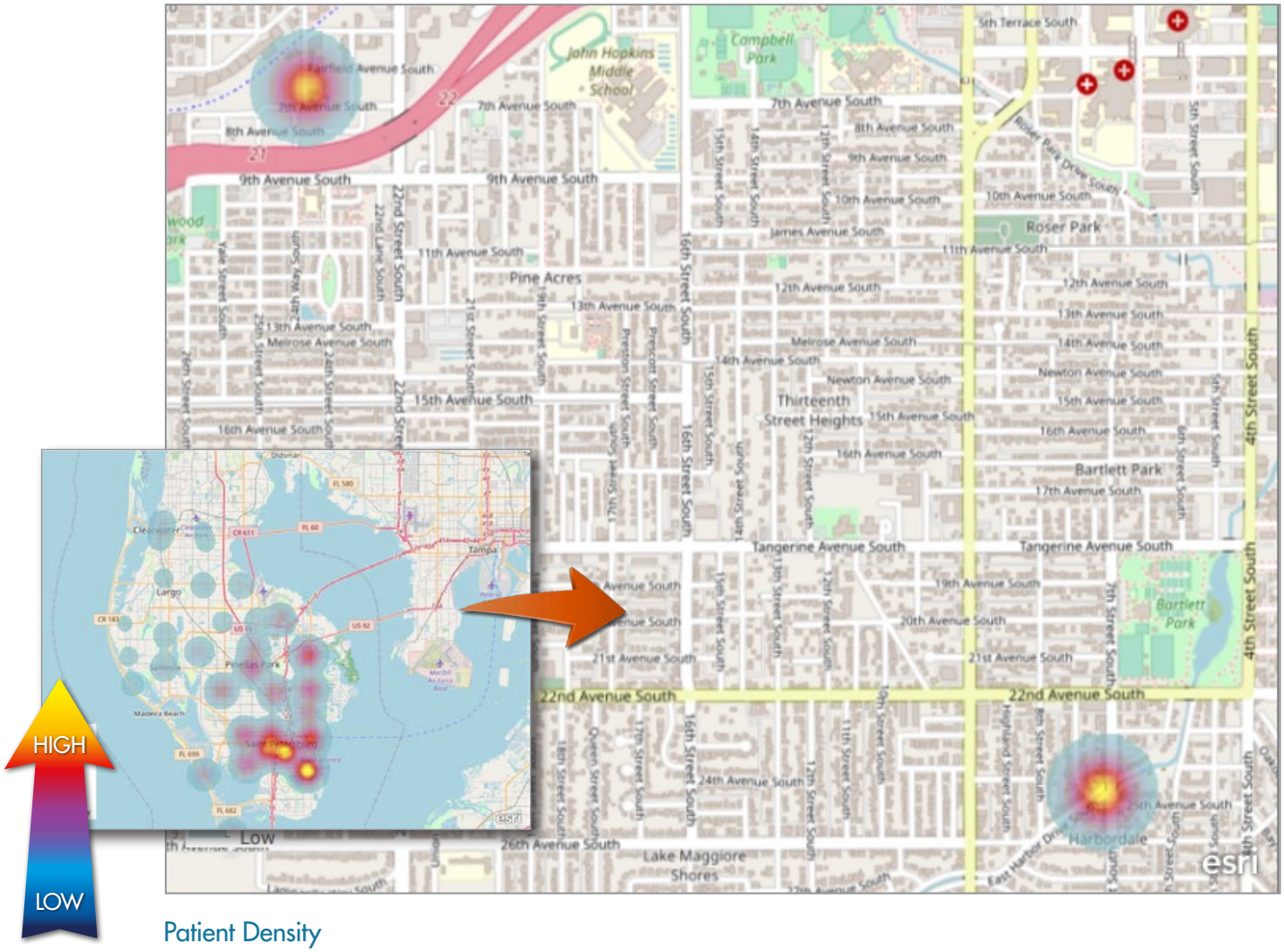
Conduent's Mental Health Index (MHI) is a measure of socioeconomic and health factors correlated with self-reported poor mental health. Based on the MHI, in 2021, ZIP codes were ranked based on their index value to identify the relative levels of need, as illustrated by the map in Figure 23. The following two ZIP codes are estimated to have the highest need (as indicated by the darkest shades of purple): 33711 and 33712 (St. Petersburg). Appendix A provides the index values for high needs ZIP codes.

Figure 23: Mental Health Index



Service Use Maps –Bayfront Health St. Petersburg, Inpatient

The following heat map illustrates the locations of this facility's uninsured patients presenting with at least one of the most common primary diagnoses (as measured by inpatient encounters) listed below. The most common services and primary diagnoses involved childbirth and related activities.



Patient Density

Measure	Value
Number of self-pay, uninsured patient visits	7,159
Number of self-pay, uninsured patient visits in hot spots	2,512
Total cost of self-pay, uninsured patient visits	$601,389,383
Total cost of self-pay, uninsured patient visits in hot spots	$143,599,246
Percent of self-pay, uninsured patient visits in the hotspot	35.1%
Note: "Hot spots" based on top five diagnoses (based on occurrences)	

Primary Diagnoses

Rank	Top 5 Based on Number of Encounters	Count	Costs	Top 5 Based on Total Charges	Count	Costs
1	LIVEBORN INFANTS ACCORD POB&TOD	1,507	$10,801,069	OTH SEPSIS	317	$68,787,070
2	OTH SEPSIS	317	$68,787,070	INTRACRANIAL INJURY	197	$40,102,899
3	OTH MATRNL DZ CE,COMPL PREGN,CHLDBR	298	$11,922,699	FX OF LOWER LEG,INCLUDING ANKLE	123	$23,718,383
4	INTRACRANIAL INJURY	197	$40,102,899	FRACTURE OF FEMUR	107	$18,505,665
5	MATRNL CARE ABNORMALTY,PELVIC ORG	193	$11,985,508	CEREBRAL INFARCTION	112	$16,601,975
Total uninsured patient visits (ALL visits – not just top 5)		**7,159**	**$601,389,383**			

Secondary Diagnoses

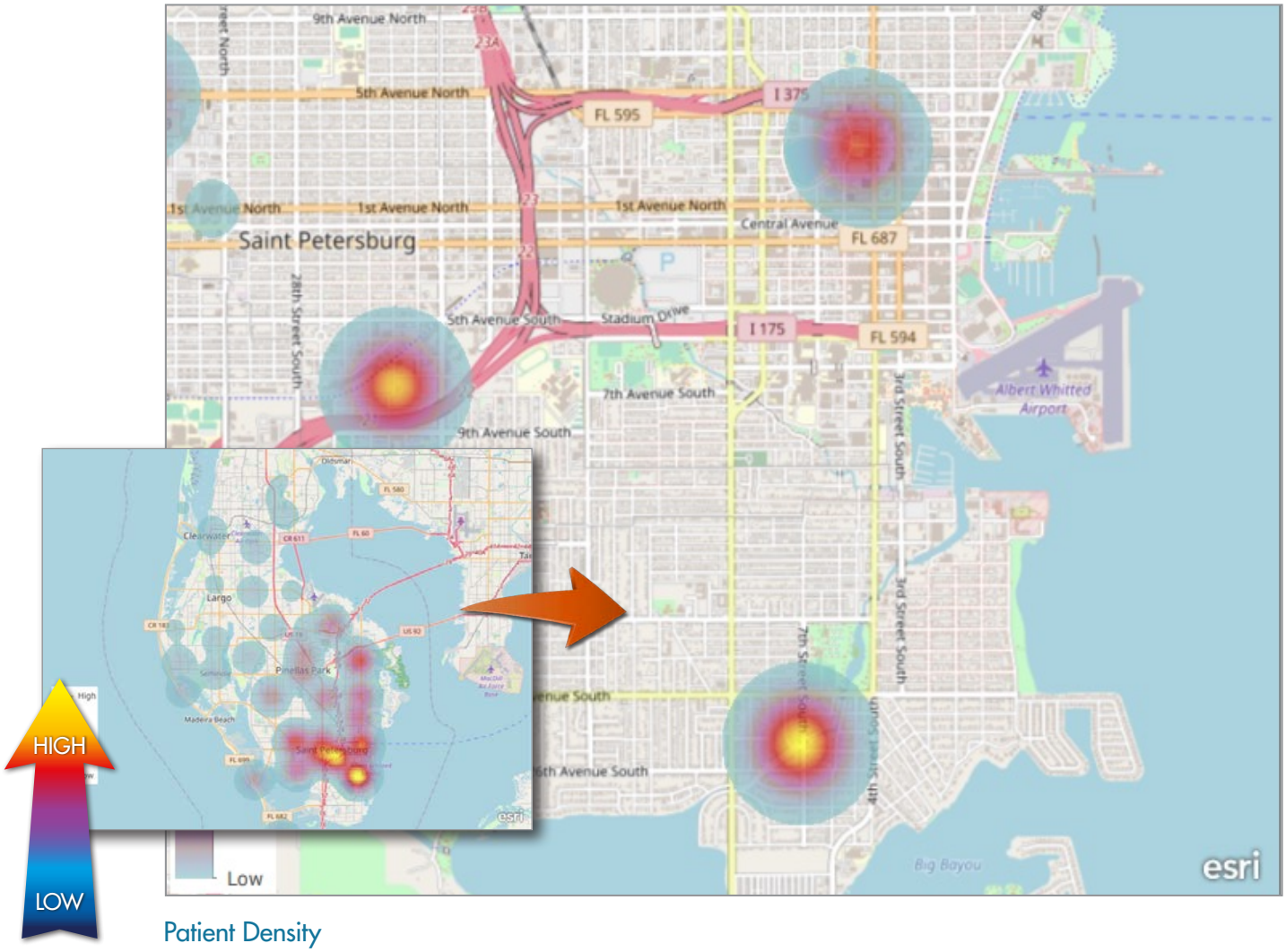
Rank	Top 5 Based on Number of Encounters	Count	Costs	Top 5 Based on Total Charges	Count	Costs
1	ACUTE POSTHEMORRHAGIC ANEM	462	$92,776,875	ACUTE POSTHEMORRHAGIC ANEM	462	$ 92,776,875
2	OTH ANEMIAS	437	$43,299,781	OTH ANEMIAS	437	$43,299,781
3	ENCTR IMMUNIZ	333	$2,210,937	CANDIDIASIS	108	$29,630,748
4	TYPE 2 DIABETES MELLITUS	307	$27,616,169	OTH SEPSIS	94	$29,440,994
5	OVERWEIGHT AND OBESITY	248	$16,388,635	TYPE 2 DIABETES MELLITUS	307	$27,616,169

Race, Ethnicity, and Age

Race	Encounters	% of Encounters	Ethnicity	Encounters	%	Age	Encounters	%
AM INDIAN-AK NATIVE	2	0.0%	HISPANIC OR LATINO	98	1.4%	Under 5	1,511	21.1%
ASIAN	40	0.6%	NONHISPANIC/LATINO	7,061	98.6%	5 to 17	26	0.4%
BLACK OR AFRICAN AM	1,087	15.2%	UNKNOWN OR NOT GIVEN	0	0.0%	17 to 24	447	6.2%
CAUCASIAN	1,997	27.9%				25 to 34	1,271	17.8%
EAST INDIAN	NA	0.0%				35 to 44	765	10.7%
HISPANIC	NA	0.0%				45 to 54	561	7.8%
NAT HAWAIIAN_OTH PAC	NA	0.0%				55 to 64	813	11.4%
ORIENTAL	NA	0.0%				65 to 74	799	11.2%
OTHER	3,802	53.1%				75 and older	966	13.5%
UNKNOWN	231	3.2%				Unknown		0.0%
Total	**7,159**	**100.0%**		**7,159**	**100.0%**		**7,159**	**100.0%**

Bayfront Health St. Petersburg, Outpatient

The following heat map illustrates the locations of this facility's uninsured patients presenting with at least one of the most common primary diagnoses (as measured by outpatient encounters) listed below. Outpatient visits were also concentrated in the near-hospital vicinity. The most common primary diagnosis was "Encounter for other special examination without complaint, suspected or reported diagnosis."



Patient Density

Measure	Value
Number of self-pay, uninsured patient visits	33,246
Number of self-pay, uninsured patient visits in hot spots	6,807
Total cost of self-pay, uninsured patient visits	$287,106,962
Total cost of self-pay, uninsured patient visits in hot spots	$14,736,806
Percent of self-pay, uninsured patient visits in the hotspot	20.5%
Note: "Hot spots" based on top five diagnoses (based on occurrences)	

Primary Diagnoses

Rank	Top 5 Based on Number of Encounters	Count	Costs	Top 5 Based on Total Charges	Count	Costs
1	ENCTR OTH SP EXAM WO COMPLANT,SUSP	2,301	$938,172	OSTEOARTHRITIS OF HIP	59	$9,425,173
2	CONTACT W/EXPOS COMMUNICABLE DZ	2,013	$714,584	LEIOMYOMA OF UTERUS	106	$8,531,643
3	ENCTR FOR SCREENING MN	974	$1,701,613	PAIN IN THROAT AND CHEST	767	$8,225,115
4	PAIN IN THROAT AND CHEST	767	$8,225,115	CHR ISCHEMIC HEART DIS-EASE	146	$7,512,385
5	OTH DISORDERS OF URINARY SYSTEM	752	$3,157,322	ATRIAL FIBRILLATION AND FLUTTER	355	$7,391,832
Total uninsured patient visits (ALL visits – not just top 5)		**33,246**	**$287,106,962**			

Secondary Diagnoses

Rank	Top 5 Based on Number of Encounters	Count	Costs	Top 5 Based on Total Charges	Count	Costs
1	NO SECONDARY DIAG	1,823	$4,455,236	DISORD OF LIPOPROTEIN METAB&OTH LIPDM	378	$8,205,572
2	TYPE 2 DIABETES MELLITUS	479	$8,127,294	TYPE 2 DIABETES MELLITUS	479	$8,127,294
3	DISORD OF LIPOPROTEIN METAB&OTH LIPDM	378	$8,205,572	LEIOMYOMA OF UTERUS	52	$4,754,474
4	OTH HYPOTHYROIDISM	320	$3,794,761	NO SECONDARY DIAG	1,823	$4,455,236
5	NICOTINE DEPENDENCE	311	$2,680,522	OTH HYPOTHYROIDISM	320	$3,794,761

Race, Ethnicity, and Age

Race	Encounters	% of Encounters	Ethnicity	Encounters	%	Age	Encounters	%
AM INDIAN-AK NATIVE	9	0.0%	HISPANIC OR LATINO	645	1.9%	Under 5	111	0.3%
ASIAN	197	0.6%	NONHISPANIC/LATINO	32,601	98.1%	5 to 17	511	1.5%
BLACK OR AFRICAN AM	7,406	22.3%	UNKNOWN OR NOT GIVEN		0.0%	17 to 24	3,123	9.4%
CAUCASIAN	11,265	33.9%				25 to 34	5,893	17.7%
EAST INDIAN	NA	0.0%				35 to 44	4,481	13.5%
HISPANIC	NA	0.0%				45 to 54	4,294	12.9%
NAT HAWAIIAN_OTH PAC	NA	0.0%				55 to 64	5,048	15.2%
ORIENTAL	NA	0.0%				65 to 74	4,410	13.3%
OTHER	12,517	37.6%				75 and older	5,375	16.2%
UNKNOWN	1,852	5.6%				Unknown		0.0%
Total	**33,246**	**100.0%**		**33,246**	**100.0%**		**33,246**	**100.0%**

Methodology

Overview

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

Dali Museum | St. Petersburg

Secondary Data Sources and Analysis

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

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

The analysis of national, state and local indicators that contributed to the CHNA can be viewed in full in Appendix A.

Table 2 shows the health and quality of life topic scoring results for Pinellas County, with Other Conditions scored as the poorest performing topic area with a score of 1.96, followed by Older Adults with a score of 1.89. Topics that received a score of 1.50 or higher were considered a significant health need. Eleven topics scored at or above the threshold. Topic areas with fewer than three indicators were considered a data gap.

Figure 24: Secondary Data Scoring

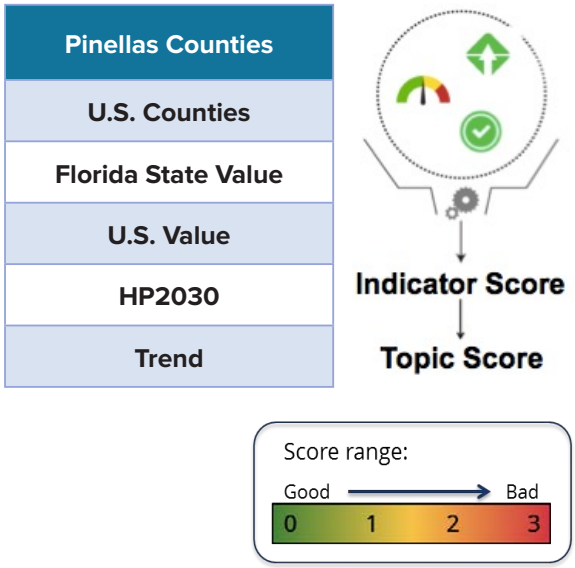


Table 2: Secondary Data Topic Scoring Results

Health Topic	Score
Other Conditions	1.96
Older Adults	1.89
Prevention & Safety	1.77
Women's Health	1.75
Mental Health & Mental Disorders	1.73
Sexually Transmitted Infections	1.71
Heart Disease & Stroke	1.67
Cancer	1.62
Alcohol & Drug Use	1.57
Children's Health	1.56
Tobacco Use	1.51
Wellness & Lifestyle	1.40
Respiratory Diseases	1.32
Physical Activity	1.26
Immunizations & Infectious Diseases	1.23
Weight Status	1.21
Oral Health	1.19
Adolescent Health	1.16
Maternal, Fetal & Infant Health	1.08
Health Care Access & Quality	1.06
Diabetes	0.89

Primary Data Collection and Analysis

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

Community Survey

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

The All4HealthFL Collaborative worked extensively with community and organizational leads to market, outreach and track survey responses to ensure an equitable representation of community voices was captured. Survey marketing and outreach efforts included email invitations, social media and coordination of onsite paper survey distribution events in collaboration with community-based organizations. A community assessment dashboard was created to track and monitor survey respondents by ZIP code, age, gender, race and ethnicity to ensure targeted outreach for at risk populations. A total of 5,048 residents responded for Pinellas County.

Community Survey Analysis Results

Survey participants were asked about the top three pressing health and quality of life issues they believe should be addressed in their community. In Figure 25, the "Top Three Health Issues" were, mental health problems including suicide (41% of respondents), aging problems (ie. difficulty getting around, dementia and arthritis) (38%) and being overweight (31%). The "Top Three Risky Behaviors" included illegal drug use/abuse or misuse of prescription medications (50% of respondents), alcohol abuse/drinking too much alcohol to include beer, wine, spirits or mixed drinks (47% of respondents) and distracted driving such as, texting, eating and talking on the phone (43% of respondents). Lastley, the "Top Three Quality of Life Issues" included low crime/safe neighborhoods (45% of respondents), access to health care (37% of respondents) and good schools (24% of respondents).

Figure 25: Top 3 Health and Quality of Life Issues

Top 3 Health Issues	Top 3 Risky Behaviors	Top 3 Quality of Life Issues
1. Mental Health problems including suicide 2. Aging Problems (i.e., difficulty getting around, dementia, arthritis) 3. Being overweight	1. Illegal drug use/abuse or misuse of prescription medications 2. Alcohol abuse/drinking too much alcohol (i.e., beer, wine, spirits, mixed drinks) 3. Distracted driving (texting, eating, talking on the phone)	1. Low crime/safe neighborhoods 2. Access to health care 3. Good schools

Focus Groups

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

Focus Group discussions took place in November 2021, with a total of 38 community participants. Due to the ongoing COVID-19 pandemic these discussions were conducted virtually. A questionnaire was developed to guide the conversations which includes topics such as Community Strengths and Assets, Top Health Problems, Access to Health and Impact on Health. A list of questions utilized for focus group discussions can be found in Appendix C. To help inform an assessment of community assets, participants were asked to list and describe resources available in the community. The list of available resources in the community is in Appendix E.

The project team captured detailed transcripts of the focus group sessions. The transcripts were analyzed using the qualitative analysis program Dedoose®2. Text was coded using a pre-designed codebook-organized by themes and analyzed for significant observations. The findings from the analysis were combined with findings from other primary and secondary data and incorporated into the Data Synthesis and Prioritized Health Needs. Themes across all focus groups are seen in Figure 26. Appendix C provides a more detailed report of the main themes that trended across the individual focus group conversations.

Figure 26: Themes Across All Focus Groups

Top Health Issues	Barriers/Social Determinants of Health	Populations Most Impacted
• Access to Healthcare • Government/Policy • Mental Health & Mental Disorders • Nutrition and Healthy Eating • Safety	• Discrimination/Bias • Economy • Employment • Environmental & Food Security/Access • Health Behaviors (fear or stigma & knowledge or navigation of health system) • Housing • Lack of or limited health insurance • Language/Culture • Medication cost • Social Environment • Transportation	• Adolescents • Black/African American • Children • Hispanic/Latino • LGBTQ+ population • Older adults

Data Synthesis and Prioritization

Data Synthesis

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

Figure 27: Trending Health Topic for Consideration

Prioritization

On April 19, 2022, participants from collaborating organizations, as well as other community partners, came together to prioritize the significant health needs. To target issues regarding the most pressing health needs impacting Pinellas County, the All4HealthFL Collaborative conducted a two-hour virtual prioritization session facilitated by the TBHC. A total of 101 individuals attended the prioritization session. These participants represented a broad cross section of experts and organizational leaders with extensive knowledge of health needs in the community. The meeting objectives included review of analyzed health data pertaining to health needs and disparities, discussion of significant health needs identified, gathering input on health topics, prioritizing significant health needs and generating preliminary ideas on how to collaborate to address top community needs.

Bending Arch | Artist: Janet Echelman | St. Petersburg

Process

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

Finally, a group ranking process was conducted to prioritize the health topics to be addressed over the next three years. The group agreed that root causes, disparities and social determinants of health would be considered for all prioritized health topics resulting from the prioritization.

Participants ranked each of the health categories individually using the dual criteria of scope and severity and ability to impact. Criteria scores were then combined to generate an overall ranking of health needs. A total of 79 individuals completed the online prioritization activity. The cumulative total score of each health topic can be seen in Table 3. The All4HealthFL Collaborative agreed with the ranking of the health topics and selected the top three prioritized health topics: Access to Health and Social Services, Behavioral Health (Mental Health and Substance Misuse) and Exercise Nutrition and Weight.

Table 3: Cumulative Total Score of Significant Health Topics (n=79)

Health Topics	Cumulative Total Score
Access to Health and Social Services	211.5
Behavioral Health (Mental Health and Substance Misuse)	205.5
Exercise, Nutrition and Weight	188.5
Immunizations and Infectious Diseases	173
Heart Disease and Stroke	169.5
Cancer	152

Prioritized Significant Health Needs for Bayfront Health St. Petersburg

Based on the prioritization exercise Bayfront Health St. Petersburg chose to focus on Acces to Care as the overarching priority. The hospital felt this priority allows them to adapt and respond in real time to emergent health issues and concerns as they arise over the next three years. Bayfront Health St. Petersburg will develop strategies specific to the relevent access issues currently facing the communities served and adjust as needed to respond to immediate access concerns. The three significant health needs for Bayfront Health St. Petersburg and Pinellas County are summarized in the following section.

2022 Prioritized Significant Health Needs

Access to Health & Social Services

Behavioral Health (Mental Health & Substance Misuse)

Exercise, Nutrition & Weight

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

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

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

Access to Health & Social Services

Key Themes from Community Input

- **Thirty Six percent (36%)** of survey respondents ranked access to health care as a quality of life issue
- Gentrification/Built Environment reduces accessibility to services
- Cultural competency training for physicians on treating the transgender community
- Fear & trust of government and health & social services because of trauma, discrimination, immigration status, systemic racism
- Barriers include: transportation, lack of or limited health insurance coverage (high out of pocket costs), knowledge & navigation of health system, affordable care/insurance, medication costs, long referral wait times, work/school schedules, increased risk of COVID through service industry jobs, disconnect between mental health care & health care access

Warning Indicators

- Adults without Health Insurance
- Median Household Gross Rent
- People 65+ Living Below Poverty

> The whole medical system is problematic for all race/ethnicities. There is a lack of knowledge in cultural competency.
>
> -Black/African American Focus Group Participant

Primary Data: Community Survey and Focus Groups

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

Focus group discussion highlighted barriers to accessing care specifically for Black/African American, Hispanic/Latino, LGBTQ+ and Older Adult. These barriers included: affordable medications and lack of or limited health insurance coverage, health care knowledge, navigation of the health system and experiencing a disconnection between health care and mental health care services was also mentioned throughout the focus groups. Often, participants' work and school schedules did not align with provider office hours or there were long wait times to see a specialist. Many also indicated not having transportation to get to medical appointments. Barriers to accessing care by focus group community are seen in Table 4.

Table 4: Focus Group Overall Barriers to Accessing Care

Black/African Americans	• Fear due to experienced trauma of discrimination • Lack of trust because of systemic racism • Gentrification/built environment reduces accessibility to services
Hispanic/Latino	• Lack of bilingual providers/staff • Discrimination because of their belief and opinion of prenatal care, disease prevention • Fear/trust of government, health and social services because of trauma, discrimination, or immigration status
LGBTQ+	• Lack of trust in health system • Lack of support programs for treating trans community
Older Adults	• Affordable care for daily living caregivers • Fixed incomes • Technological barriers • Stereotyping

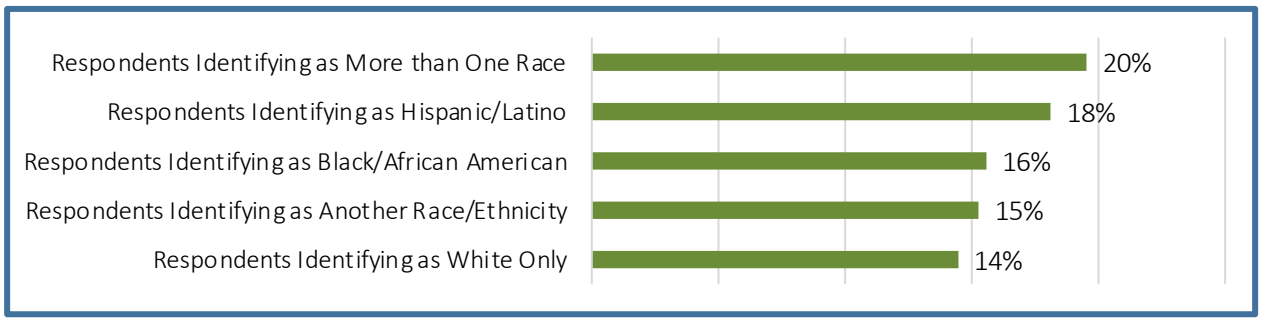
We're working with a community that is very hardworking. For them to go and see a doctor and have to lose a day of work and pay, they prefer to ignore any signal or symptom, they need options for the schedules they work.

-Hispanic/Latino Focus Group Participant

Barriers and Disparities: Access to Health Care Services

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

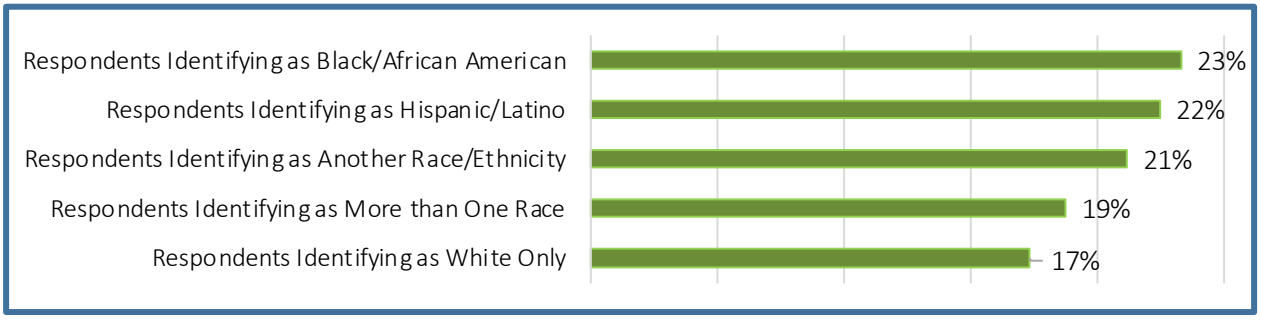
Figure 28: Percentage of Respondents by Race/Ethnic Group with Unmet Health Needs in the Past 12 Months



Barriers and Disparities: Access to Dental Health Services

Access to dental health services was mentioned in the community survey as an important health issue. Twenty-two percent (22%) of community survey respondents mentioned they had unmet dental needs. There were five top reasons that kept respondents from getting the dental care they needed which included: unable to afford to pay for care, not having insurance to cover dental care, unable to schedule an appointment when needed, unable to take time off work and dentist offices do not have convenient hours. The percentage of respondents by racial/ethnic group with unmet dental health needs in the past 12 months can be seen in Figure 29.

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



Barriers and Disparities: Access to Care in the Emergency Room

Barriers in access to care for non-emergency needs was captured within the community survey. Fifty-nine percent (59%) of survey respondents declared using the emergency room instead of going to a doctor's office or clinic for non-emergency needs. The main reasons the emergency room was used for non-emergent needs included: after hours/weekend services, long wait for an appointment with primary physician, do not have a doctor/clinic and do not have insurance. Additional reasons why respondents visited the emergency room for non-emergent needed included: being referred by a doctor, experiencing pain, needing advice or consultation, experienced a fall or needing diagnostic testing.

Secondary Data

From the secondary data scoring results, Health Care Access and Quality, also known as Access to Health and Social Services, indicator of concern was Adults without Health Insurance. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 5 below. For each indicator, there is an indicator score, county value, state value and national value (where available). Additionally, there are state and national county distributions for comparison along with indicator trend information. See Appendix A for the full list of indicators categorized within this topic.

Table 5: Data Scoring Results for Health Care Access and Quality

SCORE	HEALTH CARE ACCESS and QUALITY	Pinellas County	HP2030	Florida	U.S.	Florida Counties	U.S. Counties	Trend
1.76	Adults without Health Insurance (2018) percent	18.7	--	--	12.2			--

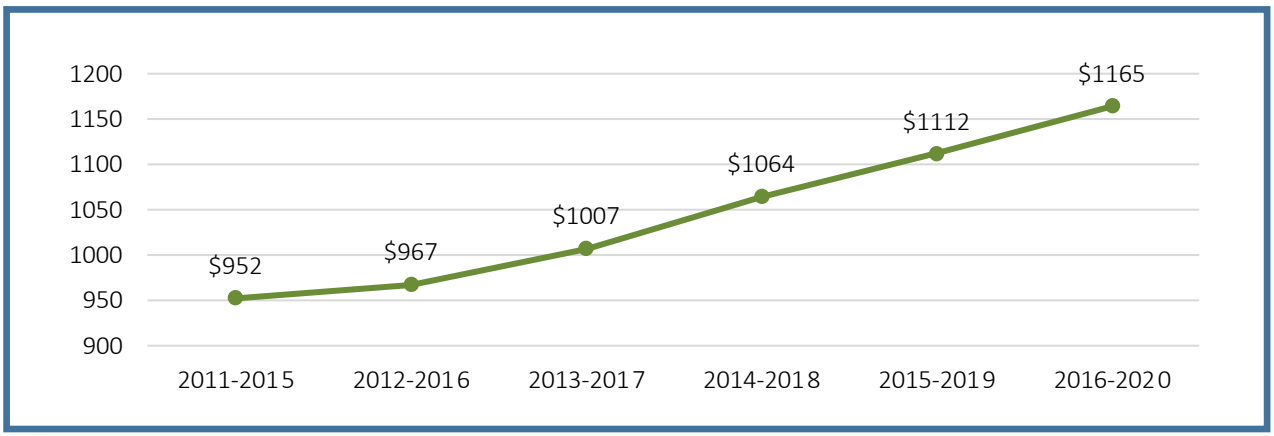
*HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

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

The percentage of Adults without Health Insurance in Pinellas County is 18.7%. For this indicator, which shows the percentage of adults aged 18-64 that do not have any kind of health insurance coverage, Pinellas is in the worst 25% of all counties in the nation. Medical costs in the United States are extremely high, so people without health insurance may not be able to afford medical treatment or prescription drugs. They are also less likely to get routine checkups and screenings, so if they do become ill, they will not seek treatment until the condition is more advanced and therefore more difficult and costly to treat. Many small businesses are unable to offer health insurance to employees due to rising health insurance premiums.

Where people live is a large indicator of their health. Sixty-nine percent (69%) of community survey respondents say there are not affordable places to live in Pinellas County. Secondary data indicators confirm that rental costs are rising to national highs in the Tampa Bay region. These rising rental costs are negatively impacting communities especially those that identify as LGBTQ+ and older adults 65+. Figure 30 shows the trend for the median gross household rent in Pinellas County from 2011 through 2020. In 2016-2020 median household gross rent for Pinellas County residents was $1,165 which is higher than U.S. value of $1,096, but it is lower than state value of $1,218.

Figure 30: Median Household Gross Rent, Pinellas County

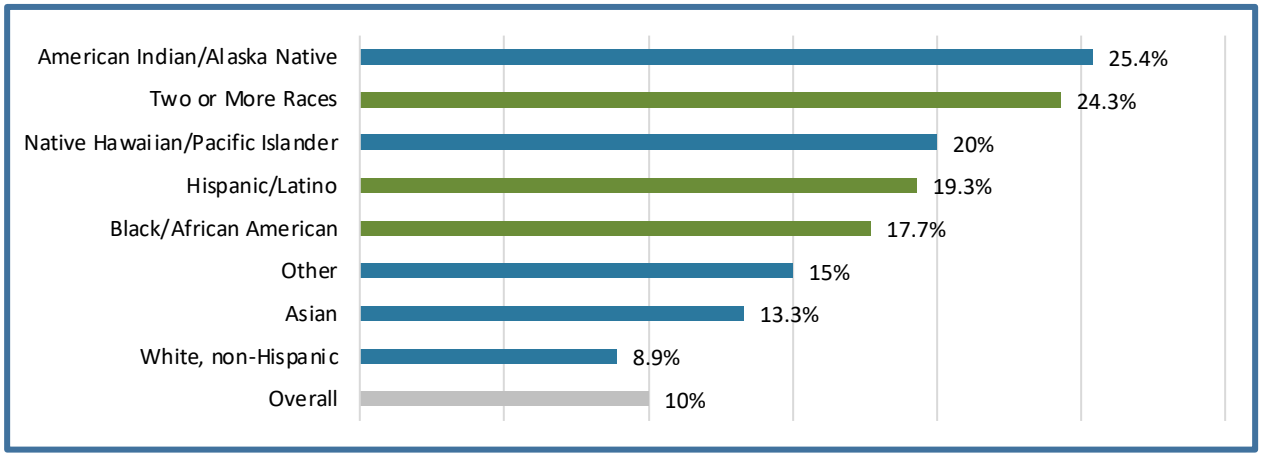


American Community Survey, 2020

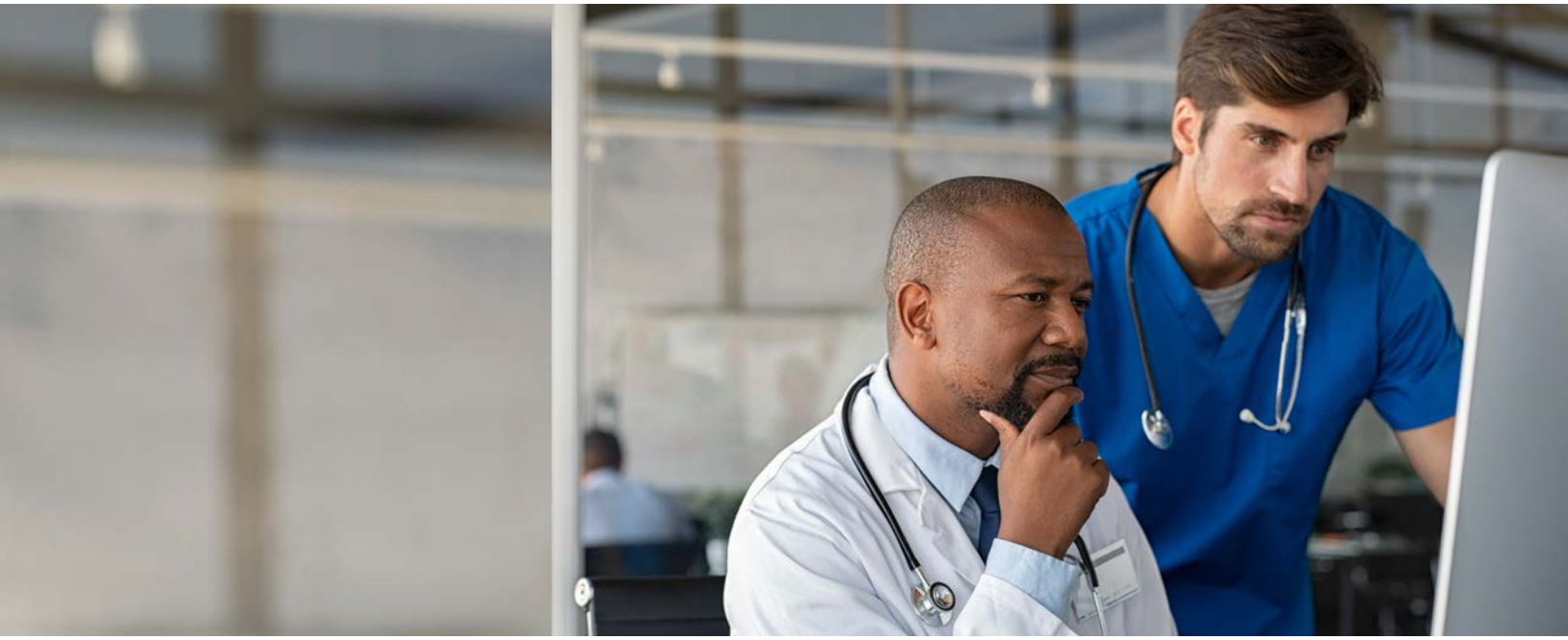
> LGBTQ+ people also tend to have a harder time finding a safe place to live and affordable house, especially trans people.
>
> -LGBTQ+ Focus Group Participant

The rising rental costs are affecting all race and ethnic groups of the older adult population 65+. See Figure 31 for the race and ethnicity disparities by percentage that are higher than the over the overall 10% Pinellas County value. The blue color indicates no significant difference with the overall value and the red bars indicates significantly worse than the overall value. People identifying as Hispanic/Latino, Black/African American or as Two or More Races seem to be affected by poverty significantly worse than other racial and ethnic groups in Pinellas County.

Figure 31: People Aged 65+ Living Below Poverty Level by Race/Ethnicity



American Community Survey, 2015-2019



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

Behavioral Health: Mental Health

Key Themes from Community Input

- **Forty One percent (41%)** of survey respondents ranked behavioral health (mental health and substance misuse) as pressing health issues
- Top Reasons that prevented you from getting mental health care: Unable to afford to pay for care, Unable to schedule an appointment when needed, Cannot take time off work, Do not have insurance to cover mental health care, Other (including) Long wait lists, not taking new patients, out of pocket costs, COVID, trust in providers, stigma
- Lack of acknowledgement about minority stress impacting both physical and mental/emotional well-being
- External political factors, coupled with discrimination contribute to trauma experienced in LGBTQ+ community, Black/African American and Hispanic/Latino community

Warning Indicators

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

Primary Data: Community Survey and Focus Groups (Mental Health)

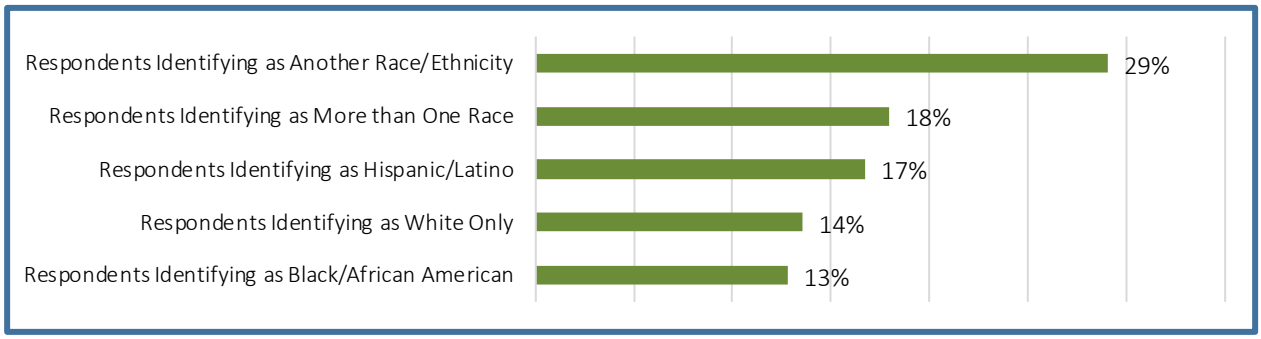
Mental Health and Substance Misuse were identified as top health needs from the secondary data, community survey and focus groups. The two were combined into Behavioral Health for this assessment. Forty-one percent (41%) of community survey respondents ranked Mental Health as a pressing health issue. Thirty-two percent (32%) of community survey respondents indicated being diagnosed as having depression or anxiety. The top five reasons respondents cited include: unable to access the mental health care they needed included: unable to afford to pay for care, unable to schedule an appointment when needed, cannot take time off work and do not have insurance to cover mental health care. Additional reasons cited by survey respondents included: experiencing long wait times for scheduling an appointment, doctors' offices did not take new patients and trust and fear of the health system due to COVID-19.

Mental Health was also a top health issue discussed during the five focus groups. Specifically, barriers to care due to fear and stigma of seeking help was brought up. Additionally, lack of affordable resources and long wait times to see a medical professional were also discussed. The LGBTQ+, Black/African American and Hispanic/Latino communities stressed the importance of political and provider acknowledgment about minority stress, discrimination and external factors that have contributed to experienced trauma. These populations seem to experience more difficulty accessing mental health services.

Barriers and Disparities: Mental Health

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

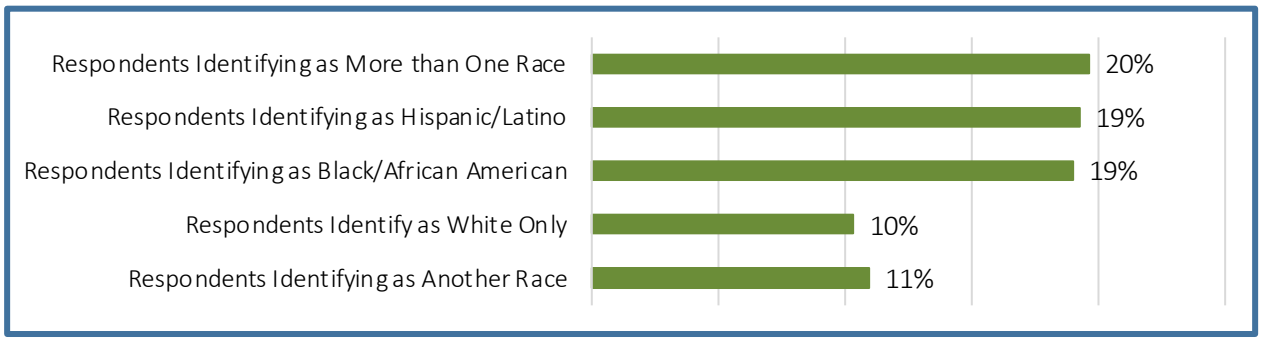
Figure 32: Percentage of Respondents by Race/Ethnic Group with Unmet Mental Health Needs in the Past 12 Months



The community survey captured a question about Adverse Childhood Experiences (ACEs). ACE scores can help health providers tell the likelihood of increased risk of psychological and medical problems. As an individual's ACE score increases so does the risk of disease, social and emotional problems.

In Pinellas County, 19% of survey respondents reported experiencing four or more ACEs before age 18. The top five reported ACEs included: parent(s) were separated or divorced, lived with anyone who was a problem drinker or alcoholic, parent(s) or adult verbally harmed them (swear, insult, or put down), lived with anyone who was depressed, mentally ill, or suicidal and/or parent(s) or adult physically harmed you (slap, hit, kick, etc.). The percentage of respondents by race/ethnic group who reported experiencing four or more ACEs are seen in Figure 33.

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



Secondary Data: Mental Health

From the secondary data scoring results, Mental Health and Mental Disorders had the 5th highest data score of all topic areas. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 6 below. See Appendix A for the full list of indicators categorized within this topic.

Table 6: Data Scoring Results for Behavioral Health (Mental Health)-Pinellas County

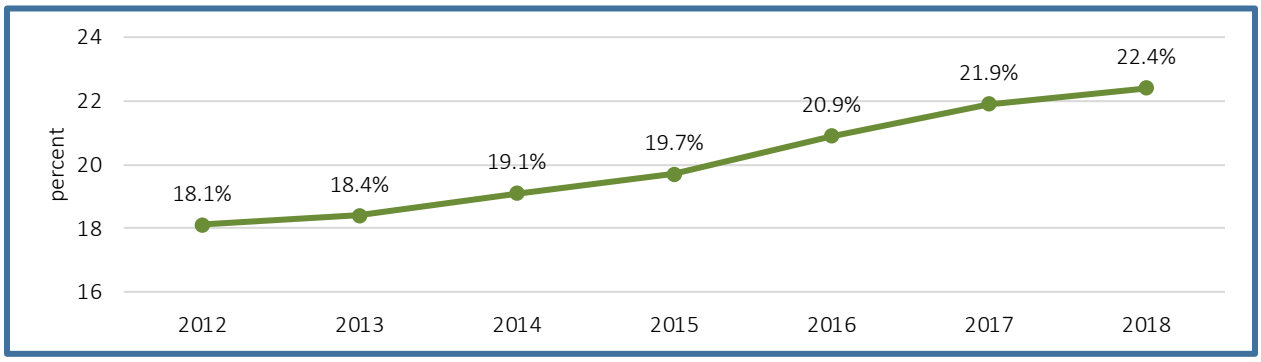
SCORE	MENTAL HEALTH and MENTAL DISORDERS	Pinellas County	HP2030	Florida	U.S.	Florida Counties	U.S. Counties	Trend
3.00	Alzheimer's Disease or Dementia: Medicare Population (2018) percent	14.2	--	12.6	10.8			
3.00	Depression: Medicare Population (2018) percent	22.4	--	19.5	18.4			
1.79	Age-Adjusted Death Rate due to Suicide (2019) deaths per 100,000 population	16.6	12.8	14.5	13.9		--	
1.50	Frequent Mental Distress (2018) percent	14.7	--	13.4	13			--

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

Alzheimer's Disease and Depression in Medicare population are top areas of concern related to Mental Health and Mental Disorders in Pinellas County. The percentage of Medicare beneficiaries treated for Alzheimer's disease or dementia is 14.2% in Pinellas County, which is in the worst 25% of counties in both the state and nation. The indicator Depression: Medicare Population shows the percentage of Medicare beneficiaries who were treated for depression. Figure 34 shows the increasing percentage of depression among the Medicare population. The value for Pinellas County, 22.4%, is in the worst 25% of counties in the state and nation. Furthermore, Age-Adjusted Death Rate due to Suicide in Pinellas County are 16.6 deaths per 100,000 population. The other indicator of concern is Frequent Mental Distress that shows the percentage of adults who stated that their mental health, which includes stress,

depression and problems with emotions, was poor for 14 or more of the past 30 days. The value for Pinellas County, 14.7%, is higher than the national value of 13%.

Figure 34: Depression Percentage in Medicare Population From 2012-2018



Centers for Medicare & Medicaid Services, 2018

> Mental Health should be easier to access for an affordable price. It's a problem, especially in the LGBTQ+ community. Obviously, we have higher rates of mental health suicidal thoughts.
>
> -LGBTQ+ Focus Group Participant

Behavioral Health: Substance Misuse

Key Themes from Community Input

- **Thirty percent (30%)** of survey respondents ranked illegal drug use/abuse of prescription medications and alcohol abuse/drinking too much as an important health issue to address
- Deaths due to drug poisoning and opioid overdose is an increasing concern
- COVID-19 has helped remove stigma attached to seeking help

Warning Indicators

- Death Rate due to Drug Poisoning
- Age-Adjusted Drug and Opioid-Involved Overdose Death Rate
- Adults who Drink Excessively
- Adults who Binge Drink
- Driving Under the Influence Arrest Rate
- Adults Who Currently Use E-Cigarettes
- Adolescents who Use Electronic Vaping: Lifetime
- Adolescents who Use Electronic Vaping: Past 30 Days
- Adults who Smoke

Secondary Data

Substance Misuse is a health topic that is analyzed from two secondary data health topics, i.e., Alcohol, Drug Use and Tobacco Use. From the secondary data scoring results, Alcohol and Drug Use had the 9th and Tobacco Use had the 11th highest data score of all topic areas. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 7 below. See Appendix A for the full list of indicators categorized within this topic.

Table 7: Data Scoring Results for Alcohol and Substance Misuse

SCORE	ALCOHOL and DRUG USE	Pinellas County	HP2030	Florida	U.S.	Florida Counties	U.S. Counties	Trend
3.00	Death Rate due to Drug Poisoning (2017-2019) deaths per 100,000 population	32.5	--	23.6	21			
2.29	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate (2018-2020) deaths per 100,000 population	43.2	--	27.8	23.5			--
2.03	Adults who Drink Excessively (2017-2019) percent	24.2	--	18	--		--	--
1.94	Adults who Binge Drink (2018) percent	17.1	--	--	16.4			--
1.88	Driving Under the Influence Arrest Rate (2019) arrests per 100,000 population	235.2	--	159.7	--		--	--

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

In the community survey 30% of respondents ranked illegal drug use/abuse of prescription medications and alcohol abuse/drinking too much as important health issues to address. From the secondary data results, there are several indicators within Alcohol and Drug Use health topic that raise concerns for Pinellas County. The worst performing indicator under this health topic is the Death Rate due to Drug Poisoning. In Pinellas County, there were 32.5 deaths due to drug poisoning per 100,000 people in 2017-2019, which is higher than both the state and national values and in the worst 25% of counties in the U.S. White males in the county are twice as likely to experience opioid involved deaths than females. Additionally, Age-Adjusted Drug and Opioid-Involved Overdose Death Rate in Pinellas County is 43.2 deaths per 100,000 population. Other indicators of concern are related to alcohol use and include both behavioral and outcome measures. The percentage of adults in the county who drink excessively (24.2%), and binge drink (17.1%) is higher than the Florida state and are among the worst 25% of counties in the state. Finally, the percentage of arrests that involve driving under the influence is higher in Pinellas County (235.2 arrests per 100,000 population) than in Florida (159.7 arrests per 100,000 population).

Table 8: Data Scoring Results for Tobacco Use

SCORE	TOBACCO USE	Pinellas County	HP2030	Florida	U.S.	Florida Counties	U.S. Counties	Trend
2.03	Adults Who Currently Use E-Cigarettes (2017-2019) percent	8.9	--	7.5	--		--	--
1.91	Adolescents who Use Electronic Vaping: Lifetime (2020) percent	29.7	--	26.4	--	--	--	--
1.91	Adolescents who Use Electronic Vaping: Past 30 Days (2020) percent	18.9	--	14.5	--	--	--	--
1.85	Adults who Smoke (2017-2019) percent	19.7	5	14.8	--		--	--

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

From the secondary data results, there are several indicators in Tobacco Use topic areas that raise concern. Pinellas County has the highest rates of adults and adolescents who vape and use e-cigarettes compared to other counties in Florida.

Prioritized Health Topic #3: Exercise, Nutrition and Weight

Exercise, Nutrition & Weight

Key Themes from Community Input

- Built Environment: Inequitable access to affordable healthy food
- Nutritional awareness
- Economy (cost of living): healthy food not a priority

Warning Indicators

- Adults Who Are Obese
- Fast Food Restaurant Density
- SNAP Certified Stores
- Teens without Sufficient Physical Activity

> For South St. Pete, not every parent wants to stand to get access to free food. What they want is access to the same quality of food that everyone else in other areas have access to.
>
> -Black/African American Focus Group Participant

Primary Data: Focus Group

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

Secondary Data

Secondary data for Exercise, Nutrition and Weight included Physical Activity data scoring. Physical Activity had the 14th highest data score of all topic areas indicating, a definite need in Pinellas County. Further analysis was done to identify specific indicators of concern which include indicators with high data scores (scoring at or above the threshold of 1.50) and seen in Table 9. See Appendix A for the full list of indicators categorized within this topic.

Table 9: Data Scoring Results for Physical Activity

SCORE	PHYSICAL ACTIVITY	Pinellas County	HP2030	Florida	U.S.	Florida Counties	U.S. Counties	Trend
2.00	Fast Food Restaurant Density (2016) restaurants per 1,000 population	0.7	--	--	--			
1.82	SNAP Certified Stores (2017) stores per 1,000 population	0.8	--	--	--			--
1.65	Teens without Sufficient Physical Activity (2020) percent	81.2	--	82.3	--		--	
1.50	Adults Who Are Obese (2017-2019) percent	28.4	--	27	--		--	--
1.50	Farmers Market Density (2018) markets per 1,000 population	0	--	--	--	--	--	--
1.50	People 65+ with Low Access to a Grocery Store (2015) percent	2.8	--	--	--			--

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

Some of the worst performing indicators within this topic are related to the built environment and food access. The number of fast-food restaurants per 1,000 people in Pinellas County is in the worst 25% of counties in Florida and trending in a negative direction. The indicator SNAP Certified Stores shows the number of stores per 1,000 population certified to accept Supplemental Nutrition Assistance Program benefits, including supermarkets, convenience stores, warehouse club stores and specialized food stores. While the value for Pinellas County is increasing in a desirable direction, the county still performs in the worst 50% of counties in the state. Other poorly performing indicators that are measures of food access include Farmers Market Density and People 65+ with Low Access to Grocery

Store. HCI's Food Insecurity Index®, discussed earlier in this report, can be used to help identify geographic areas of low food accessibility within Pinellas County community.

Other poorly performing indicators under Physical Activity health topics are percentage of Teens without Sufficient Physical Activity (81.2%) and Adults who are Obese (28.4%) in Pinellas County. Studies have shown that sedentary lifestyles and a lack of fruits and vegetables can increase the risk of many chronic diseases including obesity, heart disease and type 2 diabetes.[15]

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

Non-Prioritized Significant Health Needs

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

Non-Prioritized Health Need #1: Cancer

Cancer

Warning Indicators

- Melanoma Incidence Rate
- Adults with Cancer
- Cancer: Medicare Population
- Cervical Cancer Incidence Rate
- Oral Cavity and Pharynx Cancer Incidence Rate
- Pap Test in Past Year
- Mammogram in Past Year: 40+
- Prostate Cancer Incidence Rate
- Breast Cancer Incidence Rate
- Mammogram in Past 2 Years: 50-74
- Age-Adjusted Death Rate due to Breast Cancer

Cancer was not identified as a top health concern by focus group participants nor community survey respondents. Seventeen percent (17%) of survey respondents ranked cancer as a pressing health issue and 11% reported being told by a medical provider that they have been diagnosed with cancer. Secondary data warning indicators of concern included Melanoma Incidence Rate which was 32.7 cases per 100,000 population for 2016-2018 which is higher than the Florida state value of 25.2 cases per 100,000 population.

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

Heart Disease & Stroke

Warning Indicators

- Ischemic Heart Disease: Medicare Population
- Atrial Fibrillation: Medicare Population
- Stroke: Medicare Population
- Hyperlipidemia: Medicare Population
- Hypertension: Medicare Population
- Age-Adjusted Death Rate due to Coronary Heart Disease
- High Blood Pressure Prevalence
- Adults who Experienced a Stroke
- Adults who Experienced Coronary Heart Disease
- Heart Failure: Medicare Population

Heart Disease and Stroke as a topic on its own did not come through as a top community health issue within the community survey or focus groups. Although 41% of survey respondents reported being told by a medical provider that they have hypertension and/or heart disease, the raised concern was related to nutrition and obesity, and could best be addressed within the Exercise, Nutrition and Weight health topic.

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

Immunizations & Infectious Diseases

Warning Indicators

- Syphilis Incidence Rate
- Kindergartners with Required Immunizations
- Tuberculosis Incidence Rate
- HIV Incidence Rate
- Overcrowded Households
- Chlamydia Incidence Rate

Immunizations and Infectious Diseases did not come up as a top issue through community feedback. A secondary data warning indicator of concern includes Syphilis Incidence Rate in Pinellas County (21.9 cases per 100,000 population) in 2020 which is over the U.S. value (11.9 cases per 100,000 population) and the Florida value of (16.2 cases per 100,000 population). There are opportunities to improve education on prevention of syphilis incidence rates as cases in Pinellas County have increased gradually since 2017.

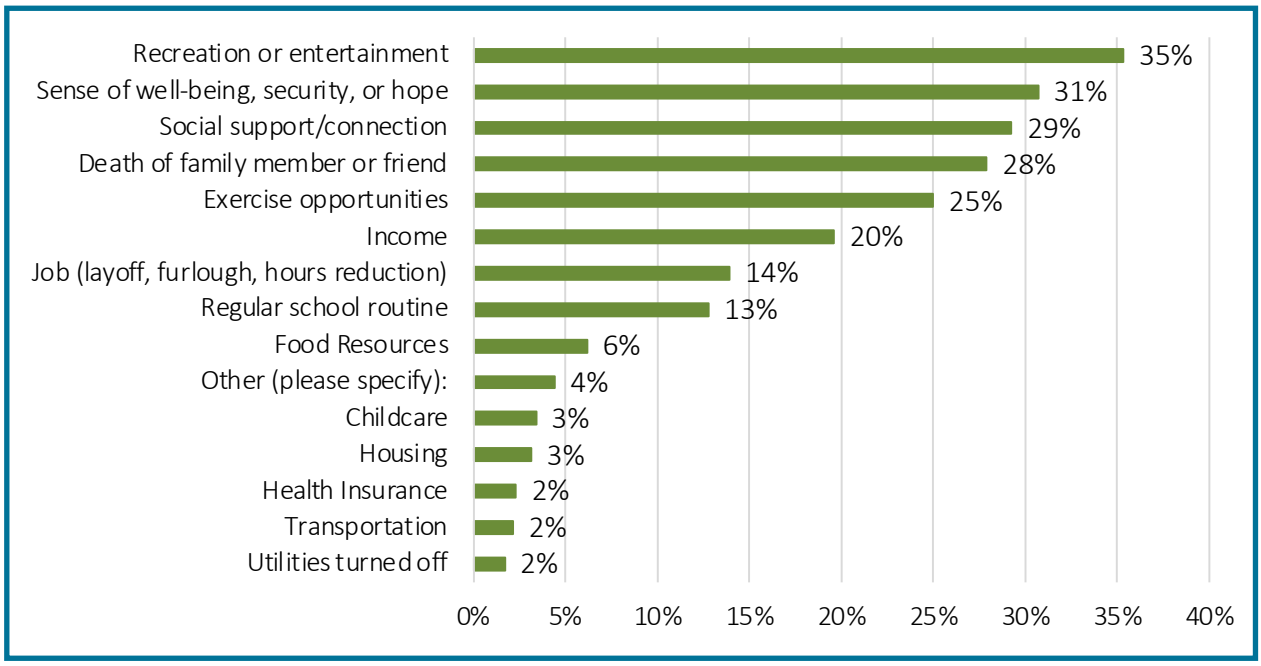
Additional Opportunities for Impact

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

COVID-19 Pandemic

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

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



Community Lived Experiences Around Diversity, Equity and Inclusion

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

Figure 37: Percentage of Respondents from Pinellas County Who Reported Experiencing Discrimination by Discrimination Type

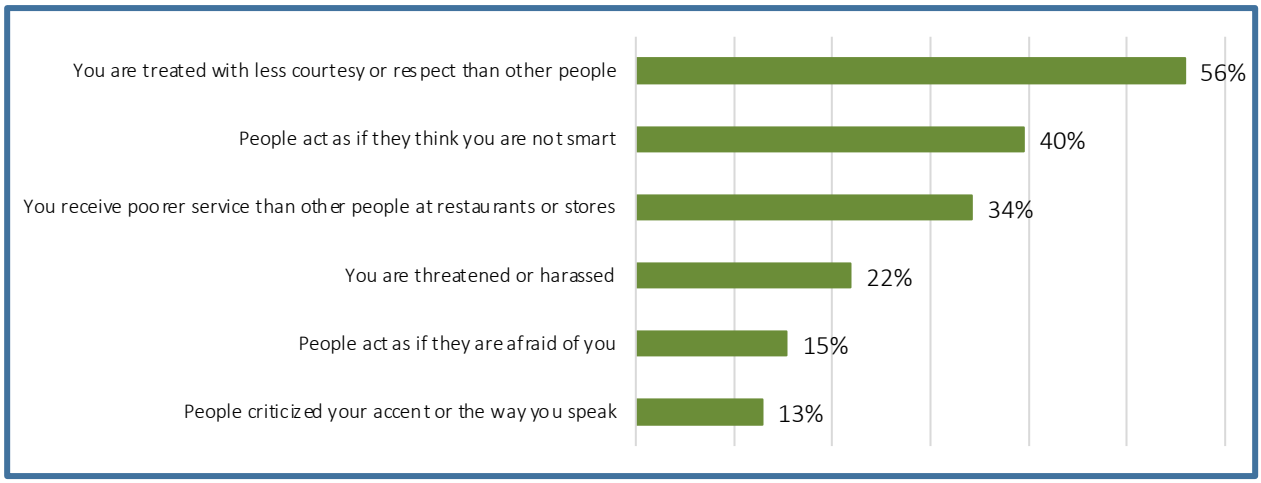


Figure 38 breaks down the percentages of reported discrimination by respondents' identity of themselves, as well as why they believe they experienced this discrimination. For example, in what ways did Hispanic/Latino community members report experiencing discrimination and what did they believe was the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

Figure 38: Percentage of Respondents Who Reported Experiencing Discrimination by Discrimination Type

0-25% | 26-50% | 51-75% | 76-100%

Percentage Reported Discrimination	Respondents Identify As						
	Non-Male, White Only	Hispanic or Latino	Black or AA	More than One Race	Another Race	LGBTQ+	65+
You are treated with less courtesy or respect than other people	53%	59%	67%	68%	73%	74%	39%
You receive poorer service than other people at restaurants or stores	29%	38%	61%	43%	52%	45%	22%
People act as if they think you are not smart	38%	43%	58%	43%	54%	52%	23%
People act as if they are afraid of you	9%	18%	35%	25%	29%	21%	8%
You are threatened or harassed	20%	23%	23%	32%	35%	44%	11%
People criticized your accent or the way you speak	8%	28%	21%	15%	41%	15%	6%
What do you believe to be the main reason(s)?	Gender, Age	Ancestry or National Origins, Gender, Race	Race, Gender	Gender, Race	Race, Ancestry or National Origins	Gender, Sexual Orientation	Age, Gender

Conclusion

The preceding community health needs assessment (CHNA) describes barriers to health faced by the community, putting its priority health areas into focus and providing information necessary to all levels of stakeholders to build upon each other's work. The All4HealthFL Collaborative has established clear priorities based on the results of this community health assessment to improve health outcomes for residents in Pinellas County. Over the next year, the collaborative will work together on the development of strategies to address the priorities outlined in the report. These strategies will inform the All4HealthFL Community Health Improvement Plan for Pinellas County. For additional information and the appendix, please reference the All4HealthFL Community Health Needs Assessment available at https://www.all4healthfl.org/.

Faces | Artist: BASK | St. Petersburg

Appendices Summary

The following support documents are shared separately on the All4HealthFL website located at https://www.all4healthfl.org/.

A. Secondary Data (Methodology and Data Scoring Tables)

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

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

B. Index of Disparity

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

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

C. Community Input Assessment Tools

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

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

D. Data Placemats

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

E. Community Partners and Resources

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

F. Partner Achievements

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