St. Anthony's Hospital

Community Health Needs Assessment – Final Report

June 7, 2013

TrippUmbach
Research • Strategy • Impact

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Introduction

St. Anthony's Hospital, in response to its community commitment, contracted with Tripp Umbach to facilitate a comprehensive Community Health Needs Assessment (CHNA). The community health needs assessment was conducted between October 2012 and June 2013. St. Anthony's Hospital is a 395-bed facility, located in St. Petersburg, FL and is also one of a network of 10 not-for-profit hospitals throughout the Tampa Bay area. St. Anthony's Hospital collaborated with outside organizations in Pinellas County during the community health needs assessment process. The following is a list of organizations that participated in the community health needs assessment process in some way:

- BayCare Health System
- South Florida Baptist Hospital
- Mease Countryside Hospital
- Mease Dunedin Hospital
- Morton Plant Hospital
- Morton Plant North Bay Hospital
- Morton Plant North Bay Recovery Center
- St. Joseph's Hospital – Main
- St. Joseph's Hospital – North
- St. Joseph's Behavioral Health Center
- St. Joseph's Children's Hospital
- St. Joseph's Women's Hospital
- BayCare Alliant Hospital
- St. Petersburg Free Clinic
- YMCA
- Community Action Stops Abuse
- Catholic Charities
- Universal Medicare/Medicaid
- Pinellas County Health Department
- Community Health Centers of Pinellas County
- One Bay Healthy Communities
- BayCare Administration
- Community Health Centers at Tarpon Springs
- St. Vincent de Paul

This report fulfills the requirements of a new federal statute established within the Patient Protection and Affordable Care Act (PPACA) requiring that non-profit hospitals conduct a CHNA every three years. The CHNA process undertaken by St. Anthony's Hospital, with project management and consultation by Tripp Umbach, included extensive input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of public health issues. Tripp Umbach worked closely with leadership from St. Anthony's Hospital and a project oversight committee, which included representatives from each of the 10 not-for-profit hospitals that comprise BayCare Health System to accomplish the assessment. BayCare Health System is a leading community-based health system in the Tampa Bay area. Composed of a network of 10 not-for-profit hospitals, outpatient facilities, and services such as imaging, lab, behavioral health, and home health care, BayCare provides expert medical care throughout a patient's lifetime. With more than 200 locations throughout

the Tampa Bay area, BayCare connects patients to a complete range of preventive, diagnostic, and treatment services for any healthcare need.

Community Definition

While community can be defined in many ways, for the purposes of this report, the St. Anthony's Hospital community is defined as 11 zip code areas in Pinellas County, Florida. (See Table 1 & Figure 1). The needs identified in this report pertain to the 11 zip code areas in Pinellas County, Florida.

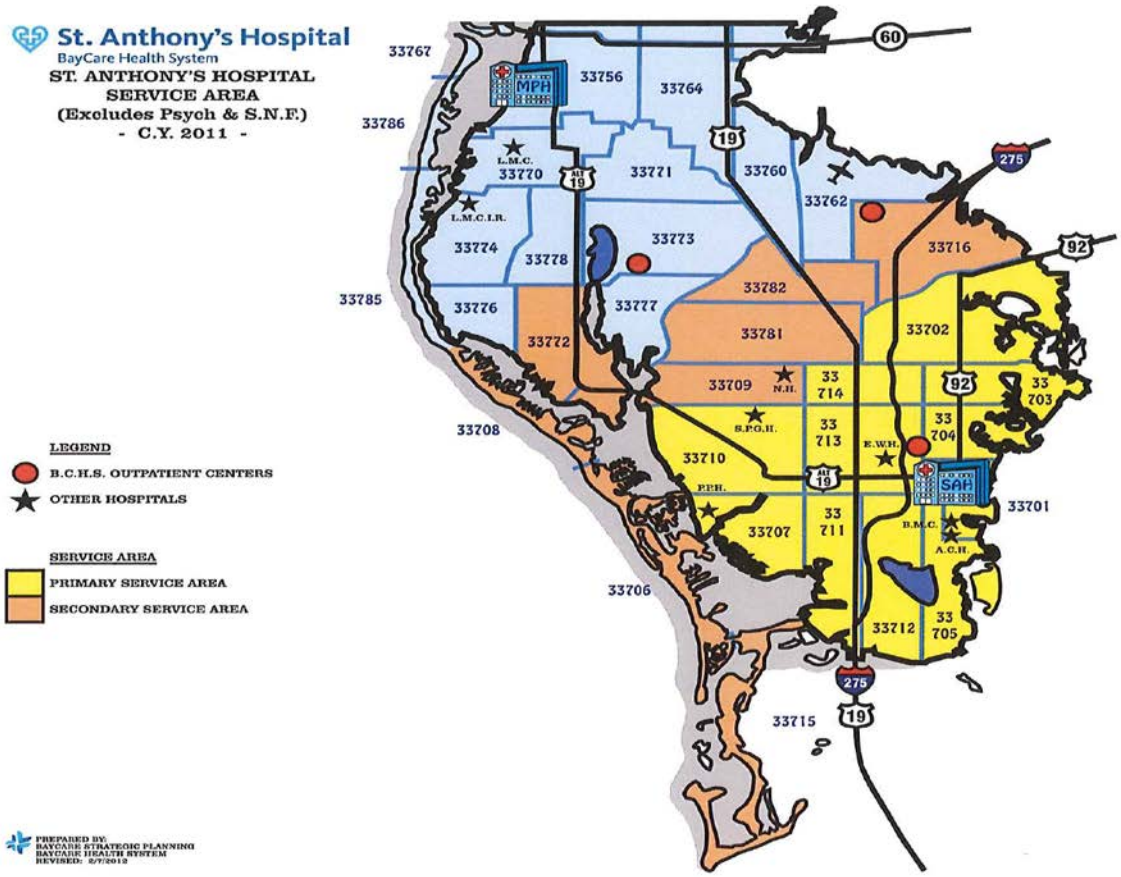
St. Anthony's Hospital Community Zip Codes

Table 1

Zip	Town	County
33701	St. Petersburg	Pinellas
33702	St. Petersburg	Pinellas
33703	St. Petersburg	Pinellas
33704	St. Petersburg	Pinellas
33705	St. Petersburg	Pinellas
33707	South Pasadena	Pinellas
33710	St. Petersburg	Pinellas
33711	St. Pete/Gulfport	Pinellas
33712	St. Petersburg	Pinellas
33713	St. Petersburg	Pinellas
33714	St. Petersburg	Pinellas

St. Anthony's Hospital Community Map

Figure 1



Consultant Qualifications

St. Anthony's Hospital contracted with Tripp Umbach, a private healthcare consulting firm headquartered in Pittsburgh, Pennsylvania to complete the community health needs assessment. Tripp Umbach is a recognized national leader in completing community health needs assessments, having conducted more than 200 community health needs assessments over the past 20 years. Today, more than one in five Americans lives in a community where Tripp Umbach has completed a community health needs assessment.

Paul Umbach, founder and president of Tripp Umbach, is among the most experienced community health planners in the United States, having directed projects in every state and internationally. Tripp Umbach has written two national guide books[1] on the topic of community health and has presented at more than 50 state and national community health conferences.

[1] A Guide for Assessing and Improving Health Status Apple Book:
http://www.haponline.org/downloads/HAP_A_Guide_for_Assessing_and_Improving_Health_Status_Apple_Book_1993.pdf and

A Guide for Implementing Community Health Improvement Programs:
http://www.haponline.org/downloads/HAP_A_Guide_for_Implementing_Community_Health_Improvement_Programs_Apple_2_Book_1997.pdf

Project Mission & Objectives

The mission of the St. Anthony's Hospital CHNA is to understand and plan for the current and future health needs of residents in in the Tampa Bay area; more specifically Pasco, Pinellas, and Hillsborough Counties. The goal of the process is to identify the health needs of the communities served by St. Anthony's Hospital today, develop a deeper understanding of these needs and identify community health priorities that advance BayCare Health System's Mission and Vision as well as the vision of St. Anthony's Hospital.

BayCare Health System Mission:

BayCare Health System will improve the health of all we serve through community-owned healthcare services that set the standard for high-quality compassionate care

BayCare Health System Vision:

BayCare will advance superior healthcare by providing an exceptional patient-centered experience

St. Anthony's Hospital Vision:

St. Anthony's Hospital will advance superior healthcare by providing an exceptional patient-centered experience with a focus on spiritual well-being

The objective of this assessment is to analyze traditional health-related indicators as well as social, demographic, economic, and environmental factors. Although the consulting team brings experience from similar communities, it is clearly understood that each community is unique. This project was developed and implemented to meet the individual project goals as defined by the project oversight committee, which included:

- Assuring that community members, including under-represented residents and those with a broad-based racial/ethnic/cultural and linguistic background are included in the needs assessment process. In addition, persons with special knowledge of or expertise in public health; federal, tribal, regional, state, or local health or other departments or agencies, with current data or other information relevant to the health needs of the community served by the hospital facility; and leaders, representatives, or members of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served by the hospital facility are included in the needs assessment process through data collection and key stakeholder interviews.

- Obtaining statistically valid information on the health status and socio-economic/environmental factors related to health of residents in the community and supplementing the general population survey data that is currently available.

- Developing accurate comparisons to baseline health measures utilizing the most current validated data.

- Developing a CHNA document as required by the Patient Protection and Affordable Care Act (PPACA) for St. Anthony's Hospital.

Methodology

Tripp Umbach facilitated and managed a comprehensive community health needs assessment on behalf of St. Anthony's Hospital resulting in the identification of community health needs. The assessment process included input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge and expertise of public health issues.

Key data sources in the community health needs assessment included:

- **Community Health Assessment Planning:** A series of meetings were facilitated by the consultants and the CHNA oversight committee consisting of leadership from St. Anthony's Hospital and collaborating areas of BayCare Health System.

- **Secondary Data:** The health of a community is largely related to the characteristics of its residents. An individual's age, race, gender, education, and ethnicity often directly or indirectly impact health status and access to care. Tripp Umbach completed comprehensive analysis of health status and socio-economic environmental factors related to the health of residents of the St. Anthony's Hospital community from existing data sources such as state and county public health agencies, the Centers for Disease Control and Prevention, County Health Rankings, Thompson Reuters, Community Needs Score (CNS), U.S. Census, Healthy Tampa Bay, Annie E. Casey, The Substance Abuse and Mental Health Services Administration (SAMHSA) and other additional data sources (See appendix A for a complete secondary data profile).

- **Interviews with Key Community Stakeholders:** Tripp Umbach worked closely with the CHNA oversight committee to identify leaders from organizations that have special knowledge and/or expertise in public and community health. Such persons were interviewed as part of the needs assessment planning process. A series of nine interviews were completed with key stakeholders in the St. Anthony's Hospital community between October and November, 2012 (See appendix B for a complete set of stakeholder responses).

- **Focus Groups with Community Residents:** Tripp Umbach worked closely with the CHNA oversight committee to ensure that community members, including under-represented residents, were included in the needs assessment planning process via four focus groups conducted by Tripp Umbach in the St. Anthony's Hospital community in April, 2013. Focus group audiences were defined by the CHNA oversight committee utilizing secondary data to identify health needs and deficits in targeted populations. Focus group audiences included:
    - Residents earning a low income that are Medicaid-ineligible

- Private behavioral health practitioners serving residents with behavioral health needs
- African American Residents
- Professionals serving homeless residents

- **Community Resource Inventory:** Tripp Umbach completed an environmental scan by collecting information from stakeholders, hospital leaders, secondary data, and Internet research to identify the community resources that are operating in the community to meet the needs identified by the CHNA. There were more than 100 community resources located in May, 2013 that meet the needs identified by stakeholders secondary data and focus groups with community residents in the St. Anthony's Hospital community (See appendix C for a complete list of community resources).

- **Final Community Health Needs Assessment Report:** A final report was developed that summarizes key findings from the assessment process and identifies top community health needs.

Key Community Health Needs

Tripp Umbach's independent review of existing data, in-depth interviews with community stakeholders representing a cross-section of agencies, and detailed input provided by four community focus groups resulted in the prioritization of three key community health needs in the St. Anthony's Hospital community. The following top community health needs were identified that are supported by secondary and/or primary data (presented in random order):

1) Improving access to affordable healthcare
2) Decreasing the prevalence of clinical health issues
3) Improving healthy behavior and environments

While there are identified health needs in the St. Anthony's Hospital sevice area; this study completed an environmental scan of the resources that are available in the county offering services that meet one or more of the needs detailed in this community health needs assessment. The resource inventory located over 100 such resources. (See Appendix C for a full copy of the Pinellas County Communtity Resource Inventory).

A summary of the top needs in the St. Anthony's Hospital community follows:

KEY COMMUNITY HEALTH NEED #1:
IMPROVING ACCESS TO AFFORDABLE HEALTHCARE

Underlying factors identified by secondary data and primary input from community stakeholders and focus groups with residents:

- **Need for increased access to affordable healthcare through insurance**
- **Availability of affordable care for the under/uninsured**
- **Availability of healthcare providers and services**
- **Communication among healthcare providers and consumers**
- **Socio-economic barriers to accessing healthcare**

Access to health services is a national issue being addressed by Healthy People 2020, among other initiatives. Healthy People 2020 is a federal initiative setting national objectives that focus on interventions that are designed to reduce or eliminate illness, disability, and premature death among individuals and communities along with other objectives on broader issues. According to Healthy People 2020, 10.3% of persons nationally were unable to obtain or

delayed needed medical care, dental care, or prescriptions in 2010. The goal is to reduce this percentage to 9% of persons nationally by the year 2020.[2]

The St. Anthony's Hospital service area shows a higher CNS value (3.6) compared with the overall CNS value for the BayCare Health System (3.5) and Pinellas County (3.3). Scores of 3.6, 3.5 and 3.3 are all above the average for the scale (3.0; the scale being from 1.0 to 5.0). The lowest CNS score for the service area is 2.5 (there are no 1.0 scores) and the highest is 4.5 (there are no scores higher than 4.5), which a greater than average number of socio-economic barriers to accessing healthcare. Furthermore, there are 7 zip code areas (33705, 33712, 33711, 33714, 33701, 33702, 33713) that have CNS scores that are above the overall average for the BayCare Health System service area (3.5), indicating greater than average socio-economic barriers to accessing healthcare.[3]

According to key stakeholders, there is a need for increased coordination of care for residents. Key stakeholders and focus group participants agree that while there are medical resources and healthcare facilities in the community; access to healthcare resources can be limited by health insurance issues and the cost of healthcare for under/uninsured, the availability of providers, communication among providers and consumers, the level of integration of mental health services in medical health settings and the prevalence of socio-economic barriers (i.e., lack of support from employers, limited transportation, etc.).

Key stakeholders and focus group participants indicated that some of the implications of the limited access that residents may have to affordable healthcare include: residents that are not able to see a physician, not being diagnosed/treated, presenting to the emergency department with preventable and/or primary health issues, receiving delayed diagnostics, chronically ill patients' healthcare being mismanaged, self-medicating, unable to afford medical bills, unhealthier with poorer health/mental health outcomes, not using a usual source of healthcare, not understanding/aware of their individual health statuses, experiencing higher preventable mortality rates, experiencing a negative impact on credit rating, lengthy waits for behavioral health services (i.e., psychiatry, substance abuse treatment, etc), increased need for crisis stabilization/intervention, distress related to unmet mental health needs, exacerbated symptoms during a Baker Act commitment, mental health placements a great distance from home and isolation from support networks and when a resident falls through the cracks they may disappear for potentially long periods of time with sometimes fatal outcomes..

[2] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=1&topic=Access%20to%20Health%20Services&objective=AHS-6.1&anchor=610 (last updated: 3/28/2013).
[3] Source: 2012 Nielson Claritas; 2012 Thomson Reuters; Bureau of Labor Statistics (October 2012)

Access to health insurance and healthcare for under/uninsured:

- ✓ Secondary data representing the St. Anthony's Hospital services area depicts insurance limitations, a decrease in adults that are insured, and resistance to seek oral health services as a result of the cost of care for the uninsured (the secondary data shows both local and national trends).

    - According to the National Health Interview Survey (NHIS), the proportion of persons under age 65 who had health (medical) insurance in the U.S. declined nearly 1.0% between 2001 and 2011, from 83.6% to 82.8%, and varied by race and ethnicity.

    - Between 2008 and 2010, there was a decline in the number of adults 18-64 years of age with health insurance in Pinellas County (from 76% to 74%).[4]

    - The uninsured rates for four zip code areas (33712, 33711, 33713, and 33707) in the St. Anthony's Hospital service area are higher than the average for the overall BayCare Health System service area (19.1%) and there are three additional zip code areas (33705, 33714 and 33701) with uninsured rates higher than the state (25%). We see some of the highest uninsured rates in the BayCare Health System in the St. Anthony's Hospital services area.[5]

    - According to Healthy People 2020, 5.8% of persons nationally were unable to obtain or delayed needed dental care in 2010. The stated goal of Healthy People 2020 related to dental care is to reduce the proportion of persons who are unable to obtain or delay in obtaining necessary dental care from 5.8% to 5.0% by 2020.

    - Females (23.3%) in Pinellas County are more than two times as likely to report not seeing a dentist in the previous year due to cost than their male counterparts (10.5%) and one in five Black residents (22.4%) report not seeing a dentist in the previous year due to cost.[6]

- ✓ According to key stakeholders and focus group participants, the number of uninsured residents has increased in recent years, which leads to limited healthcare access. According to key stakeholders and focus group participants, residents with a lower socio-economic status often cannot afford medical care and/or private-pay health insurance. There is a gap between the income level that would allow residents to purchase private-pay insurance and the Medicaid-eligible income level, leaving some residents under/uninsured. As a result, residents may not seek medical care until an issue becomes an emergency and they

[4] Source: Tampa Bay Partnership: Healthy Tampa Bay
[5] Source: 2012 Nielson Claritas; 2012 Thomson Reuters; Bureau of Labor Statistics (October 2012)
[6] Source: Tampa Bay Partnership: Healthy Tampa Bay

have to go to the emergency room due to the inability to pay for medical services elsewhere.

- Both key stakeholders and focus group participants discussed the fact that some residents may not be able to afford prescription medications (i.e., antibiotics and non-formularies for homeless residents). Additionally, focus group participants believed that many residents cannot afford healthcare (i.e., preventive care, specialty care, diagnostics, follow-up appointments/treatments, dental care, mental health care, etc.) as a result of being under/uninsured. Participants indicated that not seeking healthcare due to cost often leads to residents being diagnosed at community outreach programs or in the emergency room when symptoms are emergent and then unable to qualify for assistance and/or afford subsequent treatment/follow-up care. Focus group participants discussed the lack of consumer controls in healthcare spending due to limited information being available about the cost of health services prior to receiving services.

- Key stakeholders and focus group participants addressed the population of residents that are employed and earning an income just above Medicaid eligibility requirements. Both key stakeholders and focus group participants believed that residents earning a low income and/or those that are self-employed do not make enough money to afford private-pay health insurance. Focus group participants discussed the fact that low-wage employers that do not offer affordable health insurance plans with affordable co-pays and deductibles, which cause employees to opt out of health insurance benefits. Additionally, focus group participants felt that Medicaid eligibility requirements are too low because they are based on gross income, and not a true representation of the income that residents are taking home.

Availability of healthcare providers and services:

✓ Secondary data representing the St. Anthony's Hospital service area depicts evidence of a decrease in preventive care utilization, higher provider ratios for mental health providers, and a need for mental health and substance abuse services.

- Between 2007 and 2010, the percentage of women aged 40 and older who reported having had a mammogram in the past year decreased in Pinellas County from 63% to 61.5%.[7] According to the National Cancer Institute, women aged 40 and older should have mammograms every one to two years.[8] Similarly, between 2007 and 2010, the percentage of women aged 18 and older who had a Pap smear in the previous year

[7] Source: Tampa Bay Partnership: Healthy Tampa Bay
[8] National Cancer Institute: Retrieved from: http://www.cancer.gov/cancertopics/factsheet/detection/mammograms (last updated 7/24/2012).

decreased in Pinellas County from 63.2% to 52.4%.[9] It is important to note that the U.S. Preventive Services Task Force recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every three years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every five years.[10]

- Between 2007 and 2010, the percentage of respondents aged 50 and older who reported having had a blood stool test within the past year decreased in Pinellas County from 27.7% to 18.8%.[11] It is important to note that the U.S. Preventive Services Task Force recommends screening for colorectal cancer (CRC) using fecal occult blood testing every year, sigmoidoscopy every five years, and/or colonoscopy every 10 years, in adults, beginning at age 50 years and continuing until age 75 years.[12]

- With 242 mental health providers in Pinellas County, the provider ratio (3,786:1) is comparable to the state of FL (3,372:1).[13] Higher provider ratios often lead to lengthy wait times to secure services. Additionally, Florida ranks the second worst state in the U.S. (excluding D.C.) in mental health per capita expenditures.[14] Limited funding often restricts the length of time and quality of services provided in any industry, including mental health.

- Individuals in Circuit 6 (Pasco and Pinellas counties) show the highest reported rates of serious thoughts of suicide compared with Florida.[15] Between 2008 and 2010, there was a slight increase in the death rate due to suicide in Pinellas County (from 17.5 to 18.5 per 100,000 pop.). While the age-adjusted death rate due to suicide has decreased between 2010 and 2011 (from 18.5 to 16.1 per 100,000 pop.); Pinellas County shows higher suicide rates than the nation.[16]

✓ According to key stakeholders and focus group participants, residents do not always have access to the health services they need (i.e., preventive healthcare, substance abuse,

[9] Source: Tampa Bay Partnership: Healthy Tampa Bay
[10] U.S. Preventive Services Task Force. Retrieved from: http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm (last updated 6/2012)
[11] Source: Tampa Bay Partnership: Healthy Tampa Bay
[12] U.S. Preventive Services Task Force. Retrieved from: http://www.cdc.gov/cancer/colorectal/basic_info/screening/guidelines.htm#2 (last updated: 2/26/2013)
[13] Source: 2012 County Health Rankings University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation
[14] Mental Health Spending: State Agency totals. Governing. http://www.governing.com/gov-data/health/mental-health-spending-by-state.html
[15] Source: SAMHSA
[16] Source: Tampa Bay Partnership: Healthy Tampa Bay

psychiatry, partial hospitalizations programs, intensive outpatient services, support groups for adolescents, discrete detoxification programs, dental health care, high-risk pregnancy services, pediatric care for homeless children, FQHC services in places like Tarpon Springs.) due to the number and location of providers, provider willingness to accept Medicaid insurance, and lack of sustainable funding for the county mobile medical unit, preventive and behavioral health programs.

- Key stakeholders and focus group participants discussed the reduction in Medicaid and Medicare reimbursements limiting the services that hospitals, mental health providers, and other organizations can provide to Medicaid-dependent residents due to a lack of funding. Focus group participants indicated that there are a limited number of providers in their communities that will accept Medicaid insurance, which causes lengthy waits for available appointments and longer travel times to available providers. Focus group participants discussed the capitation on per-diem rates that disincentivize holistic treatment (i.e., a patient makes one trip to one clinic to address multiple healthcare issues in one day). As a result, homeless residents may not get their health needs met due to an inability to return to a clinic multiple times. Additionally, there are limited local behavioral health services that may require lengthy travel times and the isolation of residents that require hospitalization from support systems due to the location of facilities.

- Focus group participants discussed the barriers to healthcare caused by the shrinking number of providers, coupled with the demand for services. Focus groups felt that a low number of mental health and substance abuse providers are sparsely located in the region. Focus group participants indicated that the reason for fewer providers in the area relates to funding and payor source as they relate to the sustainability of services in multiple venues. Funding for mental health services is consistently low, which often restricts the number of providers entering an industry, decreases program stability, leads to an ever-changing provider landscape, and maintains higher provider to population ratios.

- Focus group participants felt that patients are kept safe under 24-hour watch during a commitment, but not provided therapeutic treatment in many cases for the duration of a commitment, at an inpatient mental health facility through the Baker Act. In addition, there are a limited number of step-down programs available. While focus group participants felt that patients are kept safe; there is a need to improve the services provided to behavioral health patients at many facilities during an inpatient mental health commitment.

- Additionally, participants discussed the lack of awareness among consumers, providers, and community-based organizations about eligibility regulations to qualify for the different types of assistance/funding streams that often have very specific qualifications. If a resident is diagnosed through a program that is unaware of the different types of specific qualifications for funding streams, they may become ineligible for treatment for chronic conditions like cancer, which often leaves residents unable to secure medical treatment or be unable to afford their medical bills. This is particularly the case among homeless residents, including homeless children.

Communication among healthcare providers and consumers:

✓ Communication is important among healthcare providers and consumers in the pursuit of a healthier population. While secondary data shows that limited English proficiency is a barrier experienced by some residents in the hospital service area; it may not be as substantial as other locations in Pinellas County. However, secondary data is not readily available to gauge the effectiveness of communication in the healthcare industry; though key stakeholders and resident focus groups indicate there may be a need to improve communication among providers and consumers.

- There are four zip code areas (33714, 33702, 33713, and 33710) in the St. Anthony's Hospital service area with a percentage of residents with limited English higher than the average for Pinellas County (12.1%) and no zip code areas with a percentage higher than the average for the overall BayCare Health System Service Area (17.6%).[17]

✓ Focus group participants felt that the communication between providers and consumers may lead to misinformation, a limited understanding of individual health status, etc., and is often the result of limited cultural competency among professionals, limited professionalism, and consumer perception of the interaction.

- Focus group participants indicated that low-income residents are often unaware of their own health status. Focus group participants felt that when health information is provided, residents may not always comprehend what is provided, and understanding is not often ensured. At the same time, focus group participants felt that the amount of time physicians spent with residents was not enough to provide an adequate understanding of medical directives. Additionally, participants in the African American focus group indicated that older generations may see physicians as

[17] Source: 2012 Nielson Claritas; 2012 Thomson Reuters

an authority figure and, based on cultural values, not to be questioned. Low-income medical care often lacks consistency in providers from visit-to-visit, leading to limited continuity of care from one visit to the next, which may cause the lack of a trusting bond between low-income consumers and healthcare providers.

- Focus group participants believed that homeless children are not always being identified and/provided services due to legal limitations of treating children without parents present unless there is proof of emancipation (i.e., pregnancy). Focus group participants believed that pediatricians do not always have a solid understanding of the regulations or the chronic health needs surrounding homeless children to provide effective health services.

- Additionally, focus group participants felt that medical professionals do not always treat residents with dignity, compassion, and/or respect; when coupled with a limited trust of healthcare, providers may lead residents to avoid seeking healthcare. The low-income, African American and professionals serving homeless residents all discussed a perceived lack of professionalism and cultural competency in their interactions with medical professionals and a consequential lack of trust resulting in a general avoidance of the medical industry.

- There is often a lack of communication/follow-up between referral sources and behavioral health providers; particularly when the referral is from medical health to behavioral health due to schedules and a lack of integration with medical records between medical health and mental health industries. Additionally, residents that are committed to an inpatient mental health facility through the Baker Act often do not have access to their prescription medications due to the need to verify that medication with a physician. This is particularly the case when commitment takes place during weekend hours.

Socio-economic barriers to accessing healthcare:

- ✓ The demographic trends for the service area show a younger, less educated, lower-income population with greater diversity than the county, state, and nation.

- ✓ There are six zip code areas (33705, 33712, 33711, 33714, 33701, and 33707) that show above average poverty rates in all measures of poverty (65 +, single mothers with children, married parents with children) when compared to poverty rates for Pinellas County and the overall BayCare Health System service area. It is important to understand the areas that

have more barriers to healthcare access than the average for the county and the hospital service area.[18]

- ✓ The unemployment rate for seven of the 11 zip code areas (33705, 33712, 33711, 33714, 33701, 33702, and 33713) in the St. Anthony's Hospital service area is higher than the rate for Pinellas County (8.8%), Florida (8.5%), and the U.S. (7.9%) with the highest unemployment rate in 33711 (12.3%).[19]

- ✓ Key stakeholders and focus group participants discussed the socio-economic barriers to accessing healthcare as they relate to limited transportation options and limited employment.

    - Focus group participants discussed the limitations of transportation and the location of providers on the access residents have to health services. Public transportation is difficult to use, with lengthy commute times (i.e., out-of-county referrals), limited accommodations, buses that travel out of the area are limited, schedules and routes are not always convenient and other transportation options can be too costly. Additionally, health services are sparse (i.e., mental health providers). The location of services and transportation options make it difficult for residents that live in lower income communities to attend scheduled appointments.

    - Key Stakeholders and focus group participants discussed the trend of under/unemployment, which leads to a lack of insurance benefits (i.e., service-related employment often does not offer health insurance as a benefit). Additionally, key stakeholders and focus group participants discussed the limitations of public assistance. Specifically, when residents are gainfully employed, they often lose their health insurance coverage and any financial assistance they had, making it impossible to become self sufficient enough to afford private pay medical insurance, uninsured healthcare, etc. Key stakeholders and focus group participants also noted that preventive health services are often not available to communities with a lower socio-economic status.

- ✓ U.S. Department of Health and Human Services has set the goal to improve access to comprehensive, quality healthcare services in Healthy People 2020.[20] Access to healthcare impacts: overall physical, social, and mental health status, prevention of disease and disability, detection and treatment of health conditions, quality of life, preventable death, life expectancy. This Healthy

[18] Source: 2012 Nielson Claritas; 2012 Thomson Reuters
[19] Ibid.
[20] Source: HealthyPeople.gov. Retrieved from: www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=1 (last updated: 3/28/2013)

People 2020 topic area focuses on four components of access to care: coverage, services, timeliness, and workforce.

- Coverage: Lack of adequate coverage makes it difficult for people to get the healthcare they need and, when they do get care, burdens them with large medical bills. Current policy efforts focus on the provision of insurance coverage as the principal means of ensuring access to healthcare among the general population. Health insurance coverage helps patients get into the healthcare system. Uninsured people are: less likely to receive medical care, more likely to die early, and more likely to have a poor health status.

- Services: Improving healthcare services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Barriers to services include: lack of availability, high cost, and lack of insurance coverage. These barriers to accessing health services lead to: unmet health needs, delays in receiving appropriate care, inability to get preventive services, and hospitalizations that could have been prevented.

- Timeliness: Timeliness is the healthcare system's ability to provide healthcare quickly after a need is recognized. Measures of timeliness include: Time spent waiting in doctors' offices and emergency departments (EDs) and time between identifying a need for specific tests and treatments and actually receiving those services. Actual and perceived difficulties or delays in getting care when patients are ill or injured likely reflect significant barriers to care. Prolonged ED wait time decreases patient satisfaction, increases the number of patients who leave before being seen, and is associated with clinically significant delays in care. One cause for increased ED wait times is an increase in the number of patients going to EDs from less acutely ill patients. At the same time, there is a decrease in the total number of EDs in the United States.

- Workforce: Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. However, there has been a decrease in the number of medical students interested in working in primary care. To improve the nation's heath, it is important to increase and track the number of practicing PCPs.

KEY COMMUNITY HEALTH NEED #2:
DECREASING THE PREVALENCE OF CLINICAL HEALTH ISSUES

Underlying factors identified by secondary data and primary input from community stakeholders and focus groups with residents:

- **The prevalence of clinical indicators and areas of poorer health outcomes across clinical indicators that are correlated with race geographical location and socio-economic status.**

The prevalence of clinical health issues is related to the access that residents have to health services, the environmental and behavioral factors that impact health, as well as the awareness and personal choices of consumers. The health of a community is largely related to the prevalence and severity of clinical health indicators among residents.

Clinical health issues prevalent in St. Anthony's Hospital service area:

- ✓ The St. Anthony's Hospital service area shows higher PQI rates for 13 of the 14 PQI measures when compared with the state of Florida. The highest PQI difference is found in the hospitalization rates for Low Birth Weight between the St. Anthony's Hospital service area (13.92 per 1,000 pop.), overall BayCare Health System service area (3.05 per 1,000 pop.), and Florida (3.19 per 1,000 pop.); this is the health condition that the St. Anthony's Hospital service area shows the largest room for improvement in hospital admissions.[21]

- ✓ The St. Anthony's Hospital service area shows much higher PQI rates for all of the Diabetes PQI measures than the state, Pinellas County, and the overall BayCare Health System service area.

- ✓ The St. Anthony's Hospital service area shows a lower rate of preventable COPD admissions than Pinellas County but a higher rate than the state and the Overall BayCare Health System service area.

- ✓ The St. Anthony's Hospital service area shows the highest PQI rate of Adult Asthma, Hypertension, and Bacterial Pneumonia compared with the state, Pinellas County, and the overall BayCare Health System service area.

[21] Tripp Umbach Independent Prevention Quality Indicator Analysis

- ✓ The St. Anthony's Hospital service area shows a majority of its population as White, Non-Hispanic (64.8%); a rate similar to that seen for the country (62.8%). However, of the minorities in the St. Anthony's Hospital service area, there are nearly double the number of Black Non-Hispanic individuals (22.6% of the St. Anthony's Hospital total population) than that seen for Pinellas County (10.2%) and the country (12.3%).

- ✓ The analysis of data collected for the CHNA process present substantial clinical health issues in the majority of the St. Anthony's Hospital service area. The volume and severity of need is greater in the hospital service area than the rest of the county which presents hospital leadership with several challenges. Supporting data values can be located in the secondary data section of this report:

    - African American residents in Pinellas County tend to show worse outcomes for health with increased prevalence rates across many indicators (i.e., cancer, asthma, diabetes, heart disease, stroke, congestive heart failure, bacterial pneumonia, urinary tract infections, low birth weight, teen births and pre-term births, infant mortality, etc.).

    - There are several clinical indicators (i.e., bacterial pneumonia, urinary tract infection, dehydration, alcohol consumption, and asthma) that show higher than average rates in seven or more of the 11 zip code areas. While there are severe clinical health issues throughout the service area; this assessment shows a stratification of the frequency and severity of clinical health indicators across zip code areas that appear to be reflective of the socioeconomic indicators of the area. The areas with the highest CNS scores display a greater number of more severe clinical health issues. As CNS scores decrease in zip code areas we see a moderation of the number of clinical health issues with a decrease in the number of clinical health issues; however the rates of the clinical health issues that exist remain higher than the baseline measures for these zip codes. There are three zip code areas with the lowest level of clinical health issues coupled with the lowest CNS scores.

    - The zip codes with the lowest level of clinical health issues are: 33710 (with the exception of higher than average hospitalizations due to urinary tract infections and bacterial pneumonia and emergency room visits due to dehydration and alcohol consumption); 33704 (with the exception of higher than average hospitalizations and emergency room visits due to alcohol consumption) and 33703 (with the exception of higher than average hospitalizations and emergency room visits due to dehydration) These zip code areas are also among

the best CNS scores in the service area (from 2.5 to 2.9), indicating fewer than average barriers to accessing healthcare.

- The zip codes with a moderation in the number of clinical health issues where rates remain high are: 33702, 33713, and 33707. These zip code areas are represented in the secondary data as having greater than average rates on multiple clinical indicators (i.e., low birth weight, pre-term births, bacterial pneumonia, COPD, asthma, diabetes, urinary tract infection, dehydration, and alcohol consumption); however, the rates across clinical indicators are above the average rates for the Tampa Bay Region and the goals set by Healthy People 2020. Often though, the rates are not above the most recently reported national rate (with the exception of the rate of pre-term births). These zip code areas also have moderate CNS scores (from 3.3 to 3.6) indicating a moderate level of barriers to accessing healthcare. However, these zip code areas appear to consume a large amount of healthcare resources based on the volume of clinical issues and level of severity.

- The zip codes with the highest levels of clinical health issues are: 33705, 33712, 33711, 33714, and 33701. Theses five zip code areas are represented in the secondary data as having substantially higher than average rates across the majority of clinical health indicators. The five zip codes areas represent the top three highest rates for 20 of the 23 clinical measures this assessment analyzed at the zip code-level. They display the most severe clinical health rates that are often substantially higher than the Tampa Bay Region and the most recently reported national rates. These zip code areas also have the highest CNS scores (from 4.2 to 4.5) in the St. Anthony's Hospital service area, indicating a greater than average level of barriers to accessing healthcare. These zip code areas also appear to consume a large percentage of healthcare resources based on the volume of clinical issues and level of severity.

- There are several indicators in which Pinellas County and the St. Anthony's Hospital service area that are presented in county-level and zip code-level data gathered from Healthy Tampa Bay that have not yet or have only slightly surpassed the national benchmarks. However, there has been a substantial increase in these indicators that, if left unchecked, could become community health needs (i.e., death rate due to strokes, coronary heart disease, diabetes, infant mortality, cancer incidence/death rates, suicide rates, tuberculosis, etc.).

- ✓ Key stakeholders addressed the prevalence of chronic health indicators (i.e., diabetes, COPD, and hypertension). Key stakeholders also noted that African Americans represent a disproportionate rate of several clinical health diagnoses. Focus group participants discussed the higher rates of clinical health issues among African American residents. Focus group participants attributed the poorer health outcomes to chronic daily stressors related to housing, employment, child care, attempts to minimize the impact of racism, etc. Focus group participants felt that African American women in particular have many responsibilities and obligations, and they allow stress to wear their bodies down, which is seen as the reason for higher rates of low birth weight babies and infant mortality. Additionally, focus group participants did not believe that women always are provided or have access to information about preventive practices. Key stakeholders and focus group participants both addressed the relationship between clinical indicators (i.e., cancer, COPD, diabetes, infant mortality, low birth weight, etc.) and the access residents have to healthcare, consumer behaviors, and the impact of the environment on the prevalence of clinical indicators.

KEY COMMUNITY HEALTH NEED #3:
IMPROVING HEALTHY BEHAVIORS AND ENVIRONMENTS

Underlying factors identified by secondary data and primary input from community stakeholders and focus groups with residents:

- **Awareness and education about healthy behaviors**
- **Presence of unhealthy behaviors**
- **Chronic environmental stressors**
- **Residents resisting seeking health services**

- ✓ The health of a community largely depends on the health status of its residents. Key stakeholders and focus group participants believed that the lifestyles of some residents may have an impact on their individual health status and consequently, cause an increase in the consumption of healthcare resources. Specifically, key stakeholders and focus group participants discussed lifestyle choices (i.e., poor nutrition, inactivity, smoking, substance abuse – including alcohol and prescription drugs, etc.) that can lead to chronic illnesses (i.e., cancer, obesity, diabetes, pulmonary diseases, poor birth outcomes, including low birth weight, pre-term births, hypertension, Hepatitis C, dental issues, etc.). An increase in the number of chronic conditions diagnosed in a community can lead to a greater consumption of healthcare resources due to the need to monitor and manage such diagnoses.

- ✓ Key stakeholders and focus group participants believed that the outcomes of behaviors that negatively impact health include a lack of awareness, limited understanding and utilization of services, an increased risk of poor birth outcomes (i.e., low birth weight and pre-term births), poorer health outcomes for children, homeless residents, African American residents and residents requiring behavioral health services, undetected/untreated illnesses, children that develop poor nutritional habits, concentration of chronic conditions in lower-income communities and among homeless residents, perpetuated substance abuse, and higher preventable mortality rates.

Awareness and education about healthy behaviors:

- ✓ Key stakeholders and focus group participants reported that residents may not always be aware of healthy choices due to cultural/generational norms, limited access to preventive healthcare, and limited prevention education and community outreach in some areas. Key stakeholders believed that there is a need for increased community-based preventive programs (i.e., health education and screenings). However, both key stakeholders and focus group participants believed that where prevention education programs exist in their communities, residents are not engaging in them due to limited awareness, and a fear of being diagnosed with a chronic/terminal condition for which the treatment is inaccessible/unaffordable. Residents were not always aware of services available to them due to ineffective information dissemination, and isolation of communities with greatest needs (i.e., highest concentration of poverty, etc.). Key stakeholders and focus group participants indicated that the health and wellness of residents may be negatively impacted by a lack of effective information dissemination, education, and awareness about healthy behaviors.

Presence of unhealthy behaviors:

- ✓ When compared to the other counties in the state, Pinellas County is ranked moderately healthy at 38 out of 67 Florida counties, with a median rank of 34 on a scale of 1 to 67 (1 being the healthiest county and 67 being the most unhealthy).[22] However, a variety of data sources depict evidence of unhealthy behaviors in Pinellas County; particularly as they relate to immunization rates, smoking, alcohol consumption, non-medical use of prescription pain relievers, marijuana use, and binge drinking among teens.

    - Pinellas County shows the highest rates in every category of age and gender for emergency room visits due to acute or chronic alcohol abuse among residents that

[22] Source: 2012 County Health Rankings. University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation

are 18 years old or older. Men in Pinellas County are almost twice as likely as women in Pinellas County to visit the emergency room as a result of acute or chronic alcohol abuse. St. Anthony's Hospital service area has nine zip code areas with higher than average (24.0 per 10,000 pop.) emergency room visits due to alcohol abuse (33701-86.6, 33714-48.3, 33707-40.1, 33705-33.2, 33710-33.0, 33713-32.3, 33712-27.9, 33711-25.2, and 33704-25.0 per 10,000 pop.).

- ✓ Between 2007 and 2011, hospitalization rates related to alcohol have increased consistently in Pinellas County (from 9.1 to 9.4 per 10,000 pop.) with five zip codes in the St. Anthony's Hospital service area showing above the Tampa Bay average (8.5 per 10,000 pop.) hospitalization rates (33701-19.4, 33714-11.8, 33704-10.7, 33713-9.6, and 33707-9.4 per 10,000 pop.). Men in Pinellas County are also more likely to be hospitalized due to acute or chronic alcohol abuse.

- Pinellas County shows the highest rate of non-medical use of prescription pain relievers compared to Florida (4.43% of the population aged 12 and older).

- Pinellas County showed an increase between 2008 and 2009 in the percentage of high school students who used marijuana one or more times during the 30 days before the survey was administered (from 20.2% to 20.9%).

- ✓ Nutrition and weight status are national issues being addressed by Healthy People 2020. According to Healthy People 2020:
  - 35.7% of persons 20+ years were obese in 2010. The goal is to reduce this percentage by the year 2020 to 30.5% of persons nationally.[23]
  - 31.6% of adults 18+ years old nationally are not engaging in any leisure-time physical activity in 2011.[24]

- The rate of adults who eat fruits and vegetables in Pinellas County has declined from 30% in 2002 to 26.3% in 2007. Men (18.1%) are much less likely to eat fruits and vegetables than women (33.7%) in Pinellas County.[25]

- While Pinellas County saw a decrease in the obesity rate from 27.7% to 24% from 2007 to 2010, men are slightly more likely to be obese (27.5%), with one in five

[23] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=29&topic=Nutrition%20and%20Weight%20Status&objective=NWS-9&anchor=141 (last updated: 3/28/2013).
[24] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=33&topic=Physical%20Activity&objective=PA-1&anchor=200 (last updated: 3/28/2013).
[25] Source: Tampa Bay Partnership: Healthy Tampa Bay

women being obese (20.8%). Also in Pinellas County, one in four residents that are 18 to 44 years old (25.1%) and one in five residents that are 65+ years old (21.9%) are obese. [26]

- Between 2007 and 2010, the percentage of adults who are overweight increased in Pinellas County from 35.5% to 41.6%. Women are less likely to be overweight than men in Pinellas County (33.9% and 49.8% respectively). [27]

- From the County Health Rankings database, Pinellas County ranks 54 out of 67 for community safety (67 being the unhealthiest ranking for Florida); worse than Hillsborough (49) and Pasco (23) counties.[28] Often, the level of safety in a community has an impact on the activity level of residents due to a resistance to recreate outside if crime is high, the built environment does not support outdoor activity, etc.

✓ Key stakeholders and focus group participants discussed the prevalence of chronic conditions (i.e., diabetes, cancer, COPD, adult and childhood obesity) due to lifestyle choices (i.e., lack of physical exercise, substance abuse, etc.). Focus group participants indicated that residents do not always have access to healthy options due to time constraints and limited access to healthy nutrition (i.e., public school menu, local grocery stores that do not carry healthy produce, chronic homelessness, lack of funding at homeless shelters, etc.). Focus group participants discussed the cost of healthy produce as it is related to the speed with which it expires and the size of a family, which together may cause fresh produce to be unaffordable for some residents. Residents requiring behavioral health services may not always have access to a detoxification facility that is as discrete as they would like and/or close enough to be convenient. Additionally, focus group participants believed that women may not always be aware of preventive practices that lead to healthier babies (i.e., stress reduction, etc.). Key stakeholders and focus group participants discussed substance abuse and specifically prescription drug abuse and the related increased chronic illness costs. Focus group participants discussed the prevalence of chronic illness among homeless residents as a result of substance abuse, lack of consistent healthcare, poor management of chronic illness and a lack of hygienic living environments.

[26] Ibid.
[27] Ibid.
[28] Source: 2012 County Health Rankings. University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation

Chronic environmental stressors:

- ✓ Key stakeholders and focus group participants discussed the prevalence of chronic environmental stressors in the St. Anthony's Hospital Community. Specifically, key stakeholders and focus group participants discussed the unemployment rate in the area, the prevalence of low-wage employment and low eligibility requirements of public assistance, which lead residents to be incapable of attaining self sufficiency. Additionally, the African American focus group participants discussed the stressors faced by women and professional women in particular that have many responsibilities and obligations and they allow stress to wear the bodies down when coupled with the chronic daily stressors seen as an inextricable part of daily life (i.e., poor housing conditions, maintaining employment, child care, attempts to minimize the impact of racism, etc.) the result is believed to be the cause of higher rates of low birth weight babies and infant mortality. Homeless residents are faced with chronic environmental stressors such as, securing shelter, limited hygiene, theft of property including medications, drug addiction, stigma associated with homelessness, etc. Key stakeholders and focus group participants discussed the belief that there is a link between environmental stressors and the health of residents.

Residents are resisting seeking health services:

- ✓ Key stakeholders and focus group participants discussed the resistance of residents to seek primary, preventive, and behavioral healthcare due to drug abuse/addiction, cultural practices, misinformation about the need/importance, lack of incentive, limitations of transportation, inability to afford services, fear of diagnosis without access to follow-up treatment, lack of discretion in substance abuse treatment, and limited trust for professionals in the healthcare industry. Residents often prefer home remedies to formal healthcare. According to key stakeholders and focus group participants, the result of residents resisting healthcare services is delayed diagnostics, increased preventable hospitalizations, greater consumption of medical resources, and poorer health outcomes.

- ✓ The U.S. Department of Health and Human Services has set the goal to promote health and reduce chronic disease risk through the consumption of healthier diets and achievement and maintenance of healthy body weights through Healthy People 2020.[29] The objectives also emphasize that efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities.

[29] Source: U.S. Department of Health and Human Services: Healthy People 2020; Found at: (www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicId=29)

- Diet reflects the variety of foods and beverages consumed over time and in settings such as worksites, schools, restaurants, and the home. Interventions to support a healthier diet can help ensure that individuals have the knowledge and skills to make healthier choices and healthier options are available and affordable.

- Social factors thought to influence diet include knowledge and attitudes, skills, social support, societal and cultural norms, food and agricultural policies, food assistance programs, and economic price systems.

- Access to and availability of healthier foods can help people follow healthier diets. For example, better access to retail venues that sell healthier options may have a positive impact on a person's diet; these venues may be less available in low-income or rural neighborhoods. The places where people eat appear to influence their diet. For example, foods eaten away from home often have more calories and are of lower nutritional quality than foods prepared at home. Marketing also influences people's, particularly children's, food choices.

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

Conclusions and Recommended Next Steps

The community needs identified through the St. Anthony's Hospital community health needs assessment process are not all related to the provision of traditional medical services provided by medical centers. However, the top needs identified in this assessment do "translate" into a wide variety of health-related issues that may ultimately require hospital services. For example, limited access to affordable health insurance leaves residents underinsured or uninsured, which can cause an increase in the use of emergency medical services for non-emergent issues and residents that resist seeking medical care until their symptoms become emergent due to the inability to pay for routine treatment and/or preventive care.

St. Anthony's Hospital, working closely with community partners, understands that the community health needs assessment document is only a first step in an ongoing process. It is vital that ongoing communication and a strategic process follow this assessment. Collaboration and partnership are strong in the community. It is important to expand existing partnerships and build additional partnerships with multiple community organizations to develop strategies to address the top identified needs. There are consistent deficits in the St. Anthony's Hospital community as it relates to access to affordable healthcare, the prevalence of clinical health issues, and behaviors and environments that impact health. The vast majority of the St. Anthony's Hospital community is faced with a higher concentration of poverty, severe clinical conditions, and a large portion of the service area that is faced with higher than average socio-economic barriers to accessing healthcare. Strategic discussions among hospital leadership as well as community leadership will need to consider the inter-relationship of the chronic issues facing the St. Anthony's Hospital community. It will be important to determine the cost, effectiveness, future impact, and limitations of any best practices methods. Implementation plans will have to give top priority to those strategies that will have the greatest influence in more than one need area to effectively address the needs of residents. Tripp Umbach recommends the following actions be taken by the hospital sponsors in close partnership with community organizations over the next six to nine months.

Recommended Action Steps:

- ❑ Work at the hospital level to translate the top identified community health issues into an individual hospital implementation plan.
- ❑ Present the CHNA results and subsequent Implementation plan to the hospital board for adoption and implementation.
- ❑ Make the community health needs assessment results widely available and encourage open commentary to community residents by placing it on the hospital website, the

website for BayCare Health System, and making a hard copy of the full CHNA report available upon request in the lobby of the hospital.

- ❑ Within three years' time, conduct an updated community health needs assessment to evaluate community effectiveness on addressing top needs and to identify new community needs.

Secondary Data

Tripp Umbach worked collaboratively with St. Anthony's Hospital to develop a secondary data process focused on three phases: collection, analysis, and evaluation. Tripp Umbach obtained information on the demographics, health status, socio-economic, and environmental factors related to health and needs of residents from the multi-community service area of the St. Anthony's Hospital. The process developed accurate comparisons to the state baseline of health measures utilizing the most current validated data. In addition to demographic data, specific attention was focused on the development of a key community health index factor: Community Need Index (CNS).

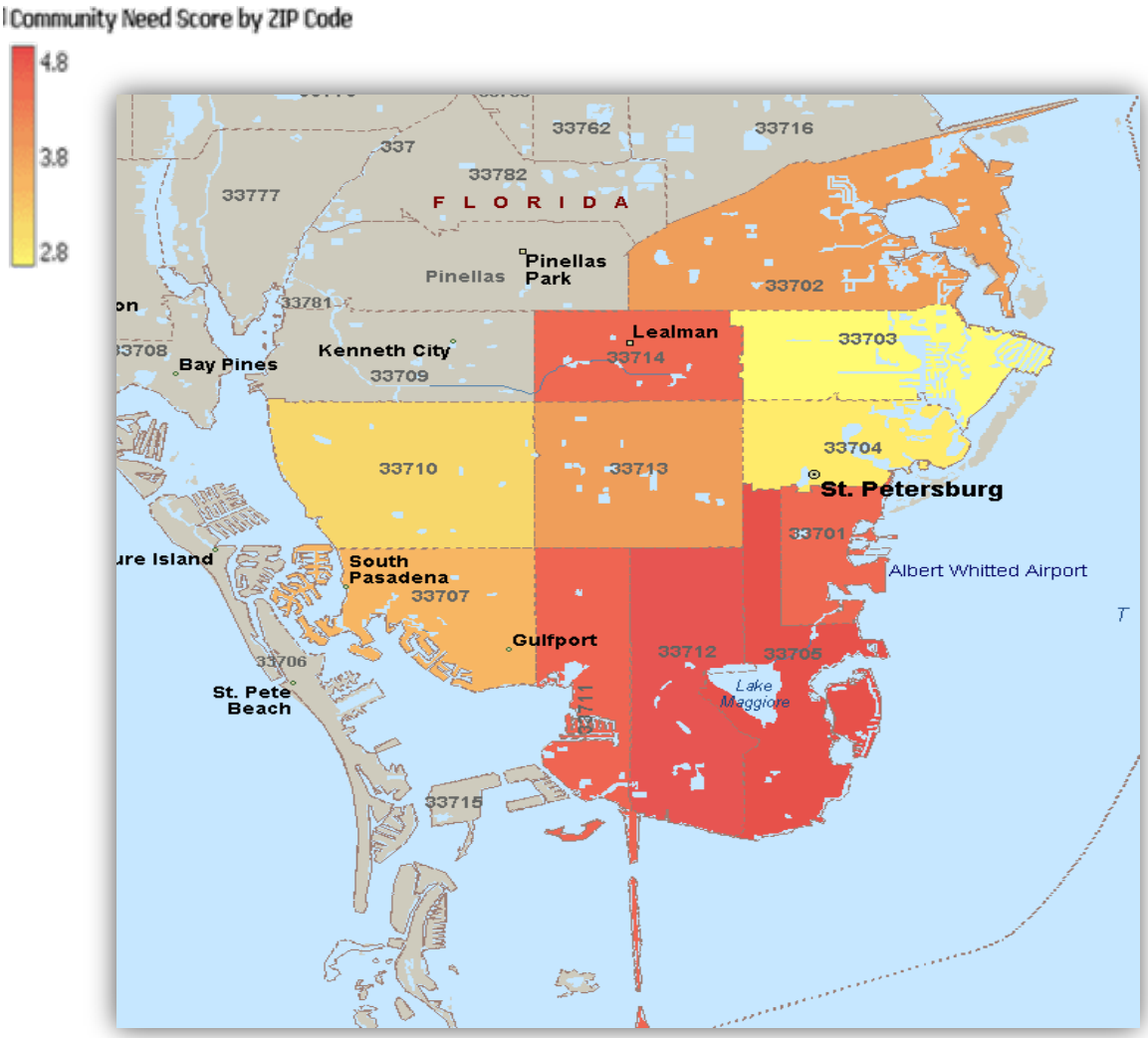
St. Anthony's Hospital Overall Study Area

The St. Anthony's Hospital community is located in St. Petersburg, FL, and is defined as a zip code geographic area based on 75% of the hospital's inpatient volumes. The St. Anthony's Hospital community consists of 11 zip code areas (see Table 2 & Figure 2).

Table 2: St. Anthony's Hospital Community Zip Code Definition

Zip	Town	County
33701	St. Petersburg	Pinellas
33702	St. Petersburg	Pinellas
33703	St. Petersburg	Pinellas
33704	St. Petersburg	Pinellas
33705	St. Petersburg	Pinellas
33707	South Pasadena	Pinellas
33710	St. Petersburg	Pinellas
33711	St. Petersburg/Gulfport	Pinellas
33712	St. Petersburg	Pinellas
33713	St. Petersburg	Pinellas
33714	St. Petersburg	Pinellas

Figure 2: St. Anthony's Hospital Community Geographic Definition



** Darker shading indicates greater barriers to healthcare access*

Community Need Index (CNI)

Catholic Health East (CHE) utilizes licensed data products from Thomson Reuters and Solucient, particularly the Claritas (now Nielsen) demographics. Catholic Health East, using the publically made methodology used by Catholic Healthcare West (CHW) to calculate the community need values, chose to calculate the values themselves and to provide the community need scores (CNS) to their partner facilities as a non-commercial product.

Catholic Health East duplicates the methodology used by CHW as closely as it is done by CHW; using the same nine measures to generate the same five barrier scores using quintiles and using them to calculate the CNS.

The data may differ in the years and sources used or the rounding at certain stages in the calculations. CNS is the term used to differentiate itself from CNI due to these possible differences.

All of this year's component demographics are based on the 2012 Nielsen demographics at the zip code level, with the exception of percent uninsured, which is from Truven Health Analytics' "Insurance Coverage Estimates" module.

The five prominent socio-economic barriers to community health quantified in CNS include: Income, Insurance, Education, Culture/Language, and Housing. CNS quantifies the five socio-economic barriers to community health utilizing a five-point index scale where a score of 5 indicates the greatest need and 1, the lowest need.

- ✓ The St. Anthony's Hospital service area shows a higher CNS value (3.6) compared with the overall CNS value for the BayCare Health System (3.5) and Pinellas County (3.3). Scores of 3.6, 3.5 and 3.3 are all above the average for the scale (3.0; the scale being from 1.0 to 5.0). which indicates a greater than average number of socio-economic barriers to accessing healthcare.

  - Eight of the 11 zip code areas in the St. Anthony's Hospital service area show CNS values equal to or greater than the median for the scale. The lowest CNS score for the service area is 2.5 (there are no 1.0 scores) and the highest is 4.5 (there are no scores higher than 4.5), which indicates moderate socio-economic barriers to accessing healthcare for residents.

  - There are seven zip code areas (33705, 33712, 33711, 33714, 33701, 33702, 33713) that have CNS scores that are above the overall average for the BayCare Health System service area (3.5), indicating greater than average socio-economic barriers to accessing healthcare.

  - There are six zip code areas (33705, 33712, 33711, 33714, 33701 and 33707) that show above average poverty rates in all measures of poverty (65 +, single mothers with children, married parents with children) when compared to poverty rates for Pinellas County and the overall BayCare Health System service area. It is important to understand the areas that have more barriers to healthcare access than the average for the county and the hospital service area.

  - The unemployment rate for seven of the 11 zip code areas (33705, 33712, 33711, 33714, 33701, 33702, and 33713) in the St. Anthony's Hospital service area is higher than the rate for Pinellas County (8.8%), Florida (8.5%), and the U.S. (7.9%), with the highest unemployment rate in 33711 (12.3%).

- The uninsured rate for four zip code areas (33712, 33711, 33713, and 33707) in the St. Anthony's Hospital service area are higher than the average for the overall BayCare Health System service area (19.1%) and there are three additional zip code areas (33705, 33714, and 33701) with uninsured rates higher than the state (25%). We see some of the highest uninsured rates in the BayCare Health System in the St. Anthony's Hospital services area.

- There are four zip code areas (33714, 33702, 33713, and 33710) in the St. Anthony's Hospital service area, with a percentage of residents with limited English higher than the average for Pinellas County (12.1%), and no zip code areas with a percentage higher than the average for the overall BayCare Health System Service Area (17.6%).

Table 3: St. Anthony's Hospital Service Area CNS Indicators and CNS Scores

Zip	City	County	Inc Rank	Educ Rank	Cult Rank	Insur Rank	Hous Rank	CNS
33705	St. Petersburg	Pinellas	4	4	4	5	5	4.5
33712	St. Petersburg	Pinellas	4	4	4	5	5	4.4
33711	St. Pete/Gulfport	Pinellas	4	4	5	5	4	4.2
33714	St. Petersburg	Pinellas	3	4	4	5	5	4.2
33701	St. Petersburg	Pinellas	4	3	4	5	5	4.2
33702	St. Petersburg	Pinellas	3	3	4	4	4	3.6
33713	St. Petersburg	Pinellas	3	3	4	4	4	3.6
33707	South Pasadena	Pinellas	3	2	4	4	4	3.3
33710	St. Petersburg	Pinellas	2	2	4	4	3	2.9
33704	St. Petersburg	Pinellas	2	1	4	3	4	2.7
33703	St. Petersburg	Pinellas	2	2	4	3	2	2.5
St. Anthony's Hospital Service Area*			**3.1**	**2.9**	**3.9**	**4.1**	**4.0**	**3.6**

**Weighted Average*
Source: 2012 Nielson Claritas. 2012 Thomson Reuters. Bureau of Labor Statistics (October 2012)

Prevention Quality Indicators Index (PQI)

The Prevention Quality Indicators index (PQI) was developed by the Agency for Healthcare Research and Quality (AHRQ). The AHRQ model was applied to quantify the PQI within the BayCare Health System market and Florida. The PQI index identifies potentially avoidable hospitalizations for the benefit of targeting priorities and overall community health.

The quality indicator rates are derived from inpatient discharges by zip code using ICD diagnosis and procedure codes. There are 14 quality indicators. Lower index scores represent fewer admissions for each of the PQIs.

- ✓ The St. Anthony's Hospital service area shows higher PQI rates for 13 of the 14 PQI measures when compared with the state of Florida. The highest PQI difference is found in the hospitalization rates for Low Birth Weight between the St. Anthony's Hospital service area (13.92 per 1,000 pop.), overall BayCare Health System service area (3.05 per 1,000 pop.), and Florida (3.19 per 1,000 pop.); this is the health condition that the St. Anthony's Hospital service area shows the largest room for improvement in hospital admissions.

  - The St. Anthony's Hospital service area shows only one PQI measure that is lower than the state (Angina Without Procedure), indicating better prevention of this condition in the St. Anthony's Hospital service area compared to the state.

  - The highest PQI difference between the St. Anthony's Hospital service area and Florida is for Low Birth Weight; this is the health condition that the St. Anthony's Hospital service area shows the largest room for improvement in hospital admissions compared to the state of Florida. The rate of low birth weight preventable hospital admissions is 3.19 for the state of Florida; for the St. Anthony's Hospital service area, the rate is 13.92. The rate of low birth weight preventable hospital admissions is more the four times higher in the St. Anthony's Hospital service area than Florida.

  - The St. Anthony's Hospital service area shows much higher PQI rates for all of the Diabetes PQI measures than the state, Pinellas County, and the overall BayCare Health System service area.

  - The St. Anthony's Hospital service area shows a lower rate of preventable COPD admissions than Pinellas County, but a higher rate than the state and the Overall BayCare Health System service area.

  - The St. Anthony's Hospital service area shows the highest PQI rate of Adult Asthma, Hypertension, and Bacterial Pneumonia compared with the state, Pinellas County, and the overall BayCare Health System service area.

  - The St. Anthony's Hospital service area shows a low PQI rate for Angina Without Procedure; however it is still higher than the rate seen for Pinellas County.

Table 4: St. Anthony's Hospital Service Area PQI Rates Higher than the BayCare Health System Service Area

Prevention Quality Indicators (PQI)	St. Anthony's Hospital Service Area	BayCare Health System	Pinellas County	Florida
Low Birth Weight Rate (PQI 9)	13.92	3.05	6.55	3.19
Bacterial Pneumonia Admission Rate (PQI 11)	1.81	1.34	1.65	1.22
Lower Extremity Amputation Rate Among Diabetic Patients (PQI 16)	2.05	1.67	1.77	1.61
Urinary Tract Infection Admission Rate (PQI 12)	1.16	1.01	1.26	0.87
Diabetes Long-Term Complications Admission Rate (PQI 3)	1.34	1.11	1.18	1.09
Chronic Obstructive Pulmonary Disease Admission Rate (PQI 5)	1.15	1.02	1.19	0.94
Hypertension Admission Rate (PQI 7)	0.59	0.47	0.51	0.44
Adult Asthma Admission Rate (PQI 15)	0.65	0.57	0.63	0.51
Diabetes Short-Term Complications Admission Rate (PQI 1)	0.48	0.38	0.43	0.34
Perforated Appendix Admission Rate (PQI 2)	0.33	0.22	0.25	0.22
Uncontrolled Diabetes Admission Rate (PQI 14)	0.19	0.14	0.13	0.13
Congestive Heart Failure Admission Rate (PQI 8)	2.28	2.15	2.35	2.23
Dehydration Admission Rate (PQI 10)	0.30	0.26	0.28	0.26

Source: Florida Hospital Association Data – Calculations by Tripp Umbach

Demographic Profile – Key Findings:

- ✓ The population in the St. Anthony's Hospital service area is projected to decline at a rate of 2.3% by 2017.
- ✓ The St. Anthony's Hospital service area shows the highest rates of middle-aged individuals (aged 35-54) compared to the other age categories and this rate is higher than that seen for Pinellas County, Florida, or the U.S.
- ✓ The St. Anthony's Hospital service area shows a lower average annual household income than the county, state, and nation ($53,694).
- ✓ Individuals in the St. Anthony's Hospital service area pursue higher education at a lower rate than seen for across Pinellas County, Florida, or the U.S.

- ✓ The St. Anthony's Hospital service area shows a majority of its population as White, Non-Hispanic (64.8%); a rate similar to that seen for the country (62.8%). However, of the minorities in the St. Anthony's Hospital service area, there are nearly double the number of Black Non-Hispanic individuals (22.6% of the St. Anthony's Hospital total population) than that seen for Pinellas County (10.2%) and the country (12.3%).

County Health Rankings – Key Findings:

Florida has 67 counties; therefore, the rank scale for Florida is 1 to 67 (1 being the healthiest county and 67 being the most unhealthy). The median rank is 34.

- ✓ While Pinellas County encompasses the St. Anthony's Hospital service area, rankings for the three counties served by the BayCare Health System are shown below to provide perspective. Most of the rankings for the three counties were not extreme (i.e., most healthy or most unhealthy).

- ✓ Pinellas County may be considered the "healthiest" county as it shows the most ranks in the top 10 (four of the 21 measures); clinical care, diet and exercise, access to care, and the built environment. The best rankings for the region are found in Pinellas County.

- ✓ With 242 Mental health providers in Pinellas County, the provider ratio (3,786:1) is comparable to the state of FL (3,372:1).[30]

- ✓ Pinellas County (54) ranks worse than Hillsborough (49) and Pasco (23) Counties for community safety.

Disease Prevalence, Health Behaviors, and National Benchmarks

Data for disease prevalence and health behaviors were obtained from Healthy Tampa Bay and compared to national benchmarks set in Healthy People 2020.

HealthyTampaBay.com is a web-based source of population data and community health information. This site is provided by ONE BAY: Healthy Communities, an initiative focused on uniting the eight-county Tampa Bay region around a culture of health. This site follows the

[30] Source: 2012 County Health Rankings University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation

release of the How Healthy is Tampa Bay?: An Assessment of Our Region's Health report and includes over 100 indicators linked to real-time updates.

Healthy People 2020 provides science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time in order to encourage collaborations across communities and sectors, empower individuals toward making informed health decisions, and measure the impact of prevention activities.

- ✓ The stated goal of Healthy People 2020 related to **health insurance** is to increase the proportion of persons with medical insurance (from 83.2% in 2008 to 100% by 2020)[31]
    - Between 2008 and 2010, there was a decline in the number of adults 18-64 years of age with health insurance in Pinellas County (from 76% to 74%).[32]
    - According to the National Health Interview Survey (NHIS), the proportion of persons under age 65 who had health (medical) insurance in the U.S. declined nearly 1.0% between 2001 and 2011, from 83.6% to 82.8%, and varied by race and ethnicity.
- ✓ According to Healthy People 2020, 5.8% of persons nationally were unable to obtain or delayed needed **dental care** in 2010. The stated goal of Healthy People 2020 related to dental care is to reduce the proportion of persons who are unable to obtain or delay in obtaining necessary dental care from 5.8% to 5.0% by 2020.
    - Females (23.3%) in Pinellas County are more than two times as likely to report not seeing a dentist in the previous year due to cost than their male counterparts (10.5%) and one in five Black residents (22.4%) report not seeing a dentist in the previous year due to cost.[33]
- ✓ Between 2007 and 2010, the percentage of women aged 40 and over who reported having a **mammogram** in the past year decreased in Pinellas County (from 63% to 61.5%).[34] According to the National Cancer Institute, women age 40 and over should have mammograms every one to two years.[35]

[31] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=1&topic=Access%20to%20Health%20Services&objective=AHS-1.1&anchor=11 (last updated: 3/28/2013)
[32] Source: Tampa Bay Partnership: Healthy Tampa Bay
[33] Ibid.
[34] Ibid.
[35] National Cancer Institute: Retrieved from: http://www.cancer.gov/cancertopics/factsheet/detection/mammograms (last updated 7/24/2012).

- ✓ Similarly, between 2007 and 2010, the percentage of women aged 18 and over who had a **Pap smear** in the previous year decreased in Pinellas County from 63.2% to 52.4%.[36] It is important to note that the U.S. Preventive Services Task Force recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every three years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every five years.[37]

- ✓ Between 2007 and 2010, the percentage of respondents aged 50 and over who reported having had a blood stool test within the past year decreased in Pinellas County (from 27.7% to 18.8%).[38] It is important to note that the U.S. Preventive Services Task Force recommends **screening for colorectal cancer** (CRC) using fecal occult blood testing (every year), sigmoidoscopy (every five years), and/or colonoscopy (every 10 years), in adults, beginning at age 50 years and continuing until age 75 years.[39]

- ✓ **Low birth weight** is a national issue being addressed by Healthy People 2020. According to Healthy People 2020, 8.1% of babies born in the U.S. in 2010 were considered having a low birth weight. The goal is to reduce this percentage by the year 2020 to 7.8% of live births nationally.[40]
    - The rate of low birth weight births has been increasing in Pinellas County between 2009 and 2010 (from 8.0% to 9.1%).[41] Pinellas County shows the highest PQI for low birth weight (6.55 per 1,000 pop.) in the region and St. Anthony's Hospital service area shows higher admission rates for low birth weight (4.11 per 1,000 pop) than the overall BayCare Health System service area (3.05 per 1,000 pop.) and Florida (3.19 per 1,000 pop.). [42] This assessment shows that in 2010, six zip code areas (33711-16.6, 33705-15.9, 33712-13.7, 33707-11.3, 33702-11.2, and 33713-10.6) had percentages of low birth weight babies higher than average for Pinellas County (8.8%) and the entire Tampa Bay region (8.6%).

    - More recent data published on the Healthy Tampa Bay website shows a decrease from 2010 to 2011, which suggests those percentages may be lower as of 2011[43]

[36] Source: Tampa Bay Partnership: Healthy Tampa Bay
[37] U.S. Preventive Services Task Force. Retrieved from: http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm (last updated 6/2012)
[38] Source: Tampa Bay Partnership: Healthy Tampa Bay
[39] U.S. Preventive Services Task Force. Retrieved from: http://www.cdc.gov/cancer/colorectal/basic_info/screening/guidelines.htm#2 (last updated: 2/26/2013)
[40] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=26&topic=Maternal,%20Infant,%20and%20Child%20Health&objective=MICH-8.1&anchor=92105 (last updated: 3/28/2013).
[41] Source: 2012 Kids Count; The Annie E. Casey Foundation
[42] Tripp Umbach Independent Prevention Quality Indicator Analysis
[43] Note: Every decennial census year, the U.S. Census Bureau alters census tract boundaries to coincide with the updated population figures. In the CHARTS vital statistics query systems, where census tract data is available, any

(33711-11.1%, 33705-11.2%, 33712-15.0%, 33707-7.1%, 33702-10.8%, and 33713-10.6), with all zip code areas remaining higher than average except 33707 and zip code 33712 being the only area to experience an increase. Also, African Americans are disproportionately more likely (14.4%) to give birth to a baby with low birth weight than any other race in Pinellas County (Hispanic-6.3% and White-7.5%).[44]

- ✓ Women 18+ are significantly more likely to visit the emergency room due to **urinary tract infections** than their male counterparts in Pinellas County (79.2 and 88.9 per 10,000 pop. respectively). Similarly, women are twice as likely to be hospitalized due to urinary tract infections than their male counterparts in Pinellas County (33.0 and 15.6 per 10,000 pop. respectively). There are nine zip codes in the St. Anthony's Hospital service area that show a higher than the average Tampa Bay Area hospitalization rate (22.5 per 10,000 pop.) for urinary tract infections (33712-39.2, 33705-34.6, 33714-33.8, 33707-33.2, 33711-32.8, 33701-32.1, 33713-31.2, 33710-30.7, and 33702-27.1 per 10,000 pop.) and six zip codes with higher than average ER visit rates (102.1 per 10,000 pop.) for urinary tract infections (33712-176.0, 33705-161.0, 33714-155.8, 33711-150.6, 33713-118.2, and 33701-117.4 per 10,000 pop.). African American residents visit the emergency room (199.7 per 10,000 pop.) and are hospitalized (40.2 per 10,000 pop.) for urinary tract infections at a rate that is almost two times the rate for residents of other ethnicities in Pinellas County.[45]

- ✓ **Chronic obstructive pulmonary disease** (COPD) is a national issue being addressed by Healthy People 2020. According to Healthy People 2020: The age adjusted hospitalization rate for COPD among persons 45+ years old was 56.0 per 10,000 pop. in 2007. The goal is to reduce this rate by the year 2020 to 50.1 per 10,000 pop. nationally.[46] Additionally, the age adjusted emergency department visits for COPD among persons 45+ years old was 81.7 per 10,000 pop. in 2007. The goal is to reduce this rate by the year 2020 to 57.3 per 10,000 pop. nationally.[47]
    - Between 2007 and 2011, the annual age-adjusted emergency department visit rate for COPD increased in Pinellas County (from 12.0 to 15.1 per 10,000 pop.). African American residents visit the emergency room due to COPD at a slightly greater rate

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year previous to 2011 will use 2000 census tract boundaries, and any data from 2011 onward will use the 2010 census tract boundaries. Data from like-numbered census tracts may not be comparable between the 2000 and 2010 tract boundaries. Source: Source: CHARTS Vital Statistics Query Systems http://www.floridacharts.com/FLQuery/Birth/BirthRpt.aspx

[44] Source: Tampa Bay Partnership: Healthy Tampa Bay

[45] Ibid.

[46] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=36&topic=Respiratory%20Diseases&objective=RD-11&anchor=244 (last updated: 3/28/2013).

[47] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=36&topic=Respiratory%20Diseases&objective=RD-12&anchor=245 (last updated: 3/28/2013).

in Pinellas County (23.2 per 10,000 pop.) than any other ethnicity. Between 2009 and 2011, there were eight zip code areas in the St. Anthony's Hospital service area with higher emergency room visit rates for COPD than the Tampa Bay area average of 14.6 per 10,000 pop. (33701-39.7, 33714-32.1, 33705-23.5, 33712-20.9, 33713-19.6, and 33711-16.7per 10,000 pop.). [48]

- Between 2007 and 2011, the hospitalization rate for COPD in Pinellas County increased slightly from 28.4 to 30.0 per 10,000 pop. Between 2009 and 2011, there were five zip code areas in the St. Anthony's Hospital service area with higher than the Tampa Bay area average (32.7 per 10,000 pop.) hospitalization rates for COPD (33714-64.5, 33701-43.4, 33713-41.1, 33702-37.0, and 33707-35.2 per 10,000 pop.). [49]

✓ Between 2007 and 2011, the emergency room visit rate due to **bacterial pneumonia** has increased steadily in Pinellas County (from 12.6 to 14.6 per 10,000 pop.). There are nine zip codes in the St. Anthony's Hospital service area that show a rate higher than the average Tampa Bay Area hospitalization rate (25.1 per 10,000 pop.) for bacterial pneumonia (33705-48.7, 33712-43.8, 33714-43.3, 33713-39.1, 33711-37.9, 33707-37.7, 33702-34.9, 33701-34.6, and 33710-34.5 per 10,000 pop.) and eight zip codes with higher than average ER visit rates (13.5 per 10,000 pop.) for bacterial pneumonia (33705-29.9, 33701-29.2, 33712-26.8, 33711-24.4, 33714-19.3, 33713-18.5, 33707-15.7, and 33702-15.5 per 10,000 pop.). African American residents are the most likely to visit the emergency room (29.8 per 10,000 pop.) due to bacterial pneumonia than residents of other ethnicities in Pinellas County (Asian-4.9, Hispanic or any race- 10.2 and White, non-Hispanic- 14.2 per 10,000 pop.). [50]

✓ Between 2007 and 2011, emergency room visits related to **congestive heart failure** have increased in Pinellas County (from 2.0 to 3.1 per 10,000 pop.). There are three zip codes in the St. Anthony's Hospital service area that show a higher than average for the Tampa Bay Area hospitalization rate (30.6 per 10,000 pop.) due to congestive heart failure (33712-47.1, 33705-39.3, and 33711-37.0 per 10,000 pop.) and four zip codes with higher than average ER visit rates (3.1 per 10,000 pop.) due to congestive heart failure (33712-6.4, 33705-5.4, 33711-5.4, and 33701-4.3 per 10,000 pop.). In Pinellas County, African American residents visit the emergency room for congestive heart failure at three times the rate (9.2 per 10,000 pop. with the next highest rate being for White residents 3.1 per 10,000 pop.) as residents of other ethnicities and are hospitalized at twice the rate (54.4 per 10,000 pop., with the next highest rate being for White residents at 23.7 per 10,000 pop.) as residents of other ethnicities. [51]

[48] Source: Tampa Bay Partnership: Healthy Tampa Bay
[49] Ibid.
[50] Ibid.
[51] Ibid.

- ✓ The death rate related to **diabetes** is a national issue being addressed by Healthy People 2020. According to Healthy People 2020, the age-adjusted death rate nationally was 70.7 per 100,000 pop. in 2010. The goal is to reduce this rate to 65.8 per 100,000 pop. nationally by the year 2020.[52]
  - While the percentage of adults who have been diagnosed with diabetes is not as high as the national rate, it did increase between 2007 and 2010 in Pinellas County from 8.7% to 12.4%. African American residents are diagnosed with diabetes at a rate that is more than four times (66.3 per 10,000 pop.) residents of other ethnicities in Pinellas County (Hispanic-13.5 and White 18.6). As a result, African American residents have higher rates across all measures of diabetes, including age-adjusted death rates (38.9 per 100,000 pop., Hispanic-13.5, and White 18.6 per 100,000 pop.). More recent data suggests that African American residents have experienced an increase in 2011 in the age-adjusted death rate in Pinellas County to 57.5 per 100,000 pop.[53]
  - There are seven zip codes that register higher than the Tampa Bay average hospitalization rates (21.5 per 10,000 pop.) for adults 18+ years old between 2009 and 2011 (33712-44.6, 33711-44.5, 33701-36.2, 33705-33.9, 33714-33.0, 33713-26.1, and 33702-22.9 per 10,000 pop.); four above the average (6.7 per 10,000 pop.) for short-term complications of diabetes (33711-13.6, 33712-13.3, 33701-11.7, and 33714-10.6 per 10,000 pop.); seven above the average (11.8 per 10,000 pop.) for long-term complications of diabetes (33712-25.2, 33711-23.1, 33705-22.0, 33714-18.8, 33701-18.1, 33713-14.9, and 33702-13.3 per 10,000 pop.); seven above the average (19.0 per 10,000 pop.) for ER visit rate due to diabetes (33701-55.5, 33712-47.6, 33711-44.9, 33705-40.1, 33713-29.3, 33714-24.0, and 33707-20.4 per 10,000 pop.), and four above the average (2.1 per 10,000 pop.) for ER visit rate due to uncontrolled diabetes (33701-7.9, 33705-5.1, 33712-4.8, and 33711-4.1 per 10,000 pop.).[54]

- ✓ **Pediatric asthma** is a national issue being addressed by Healthy People 2020. According to Healthy People 2020, the hospitalization rate for asthma among children less than five years old was 41.4 per 10,000 pop. in 2007. The goal is to reduce this rate by the year 2020 to 18.1 per 10,000 pop. nationally.[55] Additionally, the Emergency department visits for asthma

[52] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=8&topic=Diabetes&objective=D-3&anchor=346 (last updated: 3/28/2013).
[53] Source: Tampa Bay Partnership: Healthy Tampa Bay
[54] Ibid.
[55] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=36&topic=Respiratory%20Diseases&objective=RD-2.1&anchor=234284 (last updated: 3/28/2013).

among children less than five years old was 132.8 per 10,000 pop. in 2007. The goal is to reduce this rate by the year 2020 to 95.6 per 10,000 pop. nationally.[56]

- The emergency department visit rate for pediatric asthma has been highest in Pinellas County when compared to the surrounding counties. Between 2007 and 2011, the emergency department visits for asthma among children 0-17 years old in Pinellas County increased from 95.9 to 104.4 per 10,000 pop. Between 2009 and 2011, the emergency department visits for asthma among children 0-4 years old in Pinellas County was 155.8 per 10,000 pop. African American children visit the emergency room due to asthma at a greater rate in Pinellas County (303.9 per 10,000 pop.) than any other ethnicity, with Hispanic children being the next highest rate (67.5 per 10,000 pop.). Between 2009 and 2011, there were eight zip code areas in the St. Anthony's Hospital service area with higher than the Tampa Bay area average (93.3 per 10,000 pop.) emergency room visit rates for pediatric asthma (33711-343.2, 33705-310.2, 33712-282.7, 33701-237.4, 33714-132.3, 33707-122.6, 33713-115.4, and 33702-102.4 per 10,000 pop.).[57]
- The hospitalization rate for pediatric asthma has also been highest in Pinellas County when compared to the surrounding counties. In between 2007 and 2011, the emergency department visits for asthma among children 0-17 years old in Pinellas County increased from 95.9 to 104.4 per 10,000 pop. Between 2009 and 2011, the hospitalization rate for asthma among children 0-4 years old in Pinellas County was 34.7 per 10,000 pop. African American children are hospitalized due to asthma at a greater rate in Pinellas County (44.9 per 10,000 pop.) than any other ethnicity, with Hispanic children being the next highest rate (13.7 per 10,000 pop.). Between 2009 and 2011, there were eight zip code areas in the St. Anthony's Hospital service area with higher than the Tampa Bay area average (18.6 per 10,000 pop.) hospitalization rates for pediatric asthma (33711-60.8, 33712-48.8, 33705-45.9, 33701-40.7, 33702-23.1, 33714-23.0, 33713-22.8, and 33707-21.8 per 10,000 pop.).[58]

✓ **Adult asthma** is a national issue being addressed by Healthy People 2020. According to Healthy People 2020, the age-adjusted hospitalization rate for asthma among children and adults five–64 years old was 11.1 per 10,000 pop. in 2007. The goal is to reduce this rate by the year 2020 to 8.6 per 10,000 pop. nationally.[59] Additionally, the age-adjusted emergency department visits for asthma among children and adults five–64 years old was 57.0 per

[56] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=36&topic=Respiratory%20Diseases&objective=RD-3.1&anchor=235287 (last updated: 3/28/2013).
[57] Source: Tampa Bay Partnership: Healthy Tampa Bay
[58] Ibid
[59] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=36&topic=Respiratory%20Diseases&objective=RD-2.2&anchor=234285 (last updated: 3/28/2013).

10,000 pop. in 2007. The goal is to reduce this rate by the year 2020 to 49.7 per 10,000 pop. nationally.[60]

- Between 2007 and 2010, the percentage of adults reporting having been diagnosed with asthma increased in Pinellas County (from 8.8% to 9.3%). Women are twice as likely to visit the emergency room for asthma than their male counterparts in Pinellas County (51.7 and 24.5 per 10,000 pop. respectively). African American residents of all ages visit the emergency room due to asthma at a greater rate in Pinellas County (105.7 per 10,000 pop.) than any other ethnicity. The emergency department visit rate for adult asthma has been highest in Pinellas County when compared to the surrounding counties. Between 2007 and 2011, the emergency department visits for adult asthma among persons 18+ years old in Pinellas County increased from 35.8 to 38.4 per 10,000 pop. African American residents visit the emergency room due to asthma at a greater rate in Pinellas County (105.7 per 10,000 pop.) than any other ethnicity, with Hispanic residents being the next highest rate (37.2 per 10,000 pop.). Between 2009 and 2011, there were seven zip code areas in the St. Anthony's Hospital service area with higher than the Tampa Bay area average (35.5 per 10,000 pop.) emergency room visit rates for adult asthma (33705-100.0, 33701-89.6, 33711-88.3, 33712-85.0, 33714-59.4, 33713-43.3, and 33707-36.5 per 10,000 pop.).[61]
- Between 2007 and 2011, the hospitalization rate for adult asthma in Pinellas County increased slightly from 12.1 to 12.6 per 10,000 pop. African American residents are hospitalized due to asthma at a greater rate in Pinellas County (30.6 per 10,000 pop.) than any other ethnicity, with Hispanic residents being the next highest rate (12.5 per 10,000 pop.). Between 2009 and 2011, there were six zip code areas in the St. Anthony's Hospital service area with higher than the Tampa Bay area average (13.6 per 10,000 pop.) hospitalization rates for adult asthma (33705-32.0, 33711-25.1, 33701-21.2, 33712-20.6, 33714-18.4, and 33702-14.2 per 10,000 pop.).[62]

✓ **Hypertension** is a national issue being addressed by Healthy People 2020. According to Healthy People 2020, the age-adjusted percentage of adults 18+ years old with hypertension was 29.9% between 2005 and 2008. The goal is to reduce this percentage by the year 2020 to 26.9% nationally.[63]

[60] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=36&topic=Respiratory%20Diseases&objective=RD-3.2&anchor=235288 (last updated: 3/28/2013).
[61] Source: Tampa Bay Partnership: Healthy Tampa Bay
[62] Ibid
[63] Source: HealthyPeople.gov. Retrieved from: http://healthypeople.gov/2020/Data/SearchResult.aspx?topicid=21&topic=Heart%20Disease%20and%20Stroke&objective=HDS-5.1&anchor=513961 (last updated: 3/28/2013).

- ✓ Between 2007 and 2011, the annual age-adjusted emergency room visit rate for persons 18+ years old experiencing **dehydration** increased only slightly in Pinellas County from 10.4 to 10.8 per 10,000 pop. with residents 85+ being the most likely to visit the emergency room due to dehydration (30.6 per 10,000 pop.). Between 2009 and 2011, there were 10 zip code areas in the St. Anthony's Hospital service area with higher than the Tampa Bay area average (9.5 per 10,000 pop.) emergency room visit rates for dehydration (33713-17.2, 33712-17.1, 33714-16.6, 33701-16.3, 33710-13.1, 33707-12.3, 33703-12.2, 33711-12.1, 33702-11.3, and 33705-11.1 per 10,000 pop.). However, during the same period (2007 to 2011), the annual age-adjusted hospitalization rate for persons 18+ years old experiencing dehydration decreased in Pinellas County from 7.3 to 5.5 per 10,000 pop., with residents 85+ being the most likely to be hospitalized due to dehydration (50.3 per 10,000 pop.). Between 2009 and 2011, there were eight zip code areas in the St. Anthony's Hospital service area with higher than the Tampa Bay area average (6.5 per 10,000 pop.) hospitalization rates for dehydration (33701-10.7, 33705-9.7, 33714-9.3, 33711-9.1, 33712-9.1, 33707-7.9, 33703-7.5, and 33713-7.0 per 10,000 pop.).[64]

- ✓ The death rate related to **strokes** is a national issue being addressed by Healthy People 2020. According to Healthy People 2020, the age-adjusted death rate nationally was 39.1 per 100,000 pop. in 2010. The goal is to reduce this rate by the year 2020 to 33.8 per 100,000 pop. nationally.[65]
  - The death rate due to a stroke has decreased between 2008 and 2010 in Pinellas County from 27.9 to 25.1 per 100,000 pop. Black residents are at a greater risk of stroke-related death (40.5 per 100,000 pop.) than any other ethnicity in the tri-county area (Hispanic-18.2 and White-23.9 per 100,000 pop.). Women are at a slightly greater risk of death related to a stroke than their male counterparts in Pinellas County (25.7 and 23.7 per 100,000 pop. respectively).[66]

- ✓ The death rate related to **coronary heart disease** is a national issue being addressed by Healthy People 2020. According to Healthy People 2020, the age-adjusted death rate nationally was 113.6 per 100,000 pop. in 2010. The goal is to reduce this rate by the year 2020 to 100.8 per 100,000 pop. nationally.[67]
  - While the age-adjusted death rate due to coronary heart disease in Pinellas County (105.0 per 100,000 pop.) was similar to the national rate in 2010, the death rate in

[64] Source: Tampa Bay Partnership: Healthy Tampa Bay
[65] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=21&topic=Heart%20Disease%20and%20Stroke&objective=HDS-3&anchor=509 (last updated: 3/28/2013).
[66] Source: Tampa Bay Partnership: Healthy Tampa Bay
[67] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=21&topic=Heart%20Disease%20and%20Stroke&objective=HDS-2&anchor=604 (last updated: 3/28/2013).

Pinellas County increased in 2011 to 111.5 per 100,000 pop. Additionally, the death rate for men (147.1 per 100,000 pop.) and African American residents (147.5 per 100,000 pop.) in Pinellas County is greater than the national and county averages.

- ✓ African American residents in Pinellas County tend to show worse outcomes for health with increased prevalence across many indicators (i.e., cancer, asthma, diabetes, heart disease, stroke, congestive heart failure, bacterial pneumonia, urinary tract infections, low birth weight, teen births, and pre-term births, etc.).
  - Many forms of cancer in the tri-county area show a greater diagnosis rate among African American residents when compared to residents of other ethnicities. As a result, African American residents have higher rates across many measures of cancer. [68]

- ✓ **Pre-term live births** (less than 37 weeks gestation) are a national issue being addressed by Healthy People 2020. According to Healthy People 2020, the percentage of total pre-term live births nationally was 12.0% in 2010. The goal is to reduce this rate by the year 2020 to 11.4% nationally.[69]
  - While the percentage of pre-term births has decreased in Pinellas County between 2009 and 2011 (from 13.1% to 12.7%), the rate is higher than the national average. Additionally, African American residents in Pinellas County give birth to pre-term babies more often (17%) than any other racial group.[70] In 2010, there were six zip code areas in the St. Anthony's Hospital service area with higher than the Tampa Bay area average (12.9%) pre-term births (33711-26.1%, 33712-19.7%, 33705-17.7%, 33702-15.6%, 33707-14.6% , and 33713-14.3%).
  - While the birth rate for females aged 15-19 years of age has decreased between 2008 and 2010 in Pinellas County (41.58 to 32.7 per 1,000 live births), African American (73.1 per 1,000 live births) residents display teen birth rates that are two times the rates seen among other ethnicities in the county (less than 36.1 per 1,000 live births). [71]

- ✓ **Infant mortality** is a national issue being addressed by Healthy People 2020. According to Healthy People 2020, the infant (less than one year) mortality rate nationally was 6.6 per 1,000 live births in 2008. The goal is to reduce this rate by the year 2020 to 6.0 per 1,000 live births nationally.[72]

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[68] Source: Tampa Bay Partnership: Healthy Tampa Bay
[69] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=26&topic=Maternal,%20Infant,%20and%20Child%20Health&objective=MICH-9.1&anchor=93911 (last updated: 3/28/2013).
[70] Source: Tampa Bay Partnership: Healthy Tampa Bay
[71] Ibid.
[72] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=26&topic=Maternal,%20Infant,%20and%20Child%20Health&objective=MICH-1.3&anchor=85899 (last updated: 3/28/2013).

- Infant mortality has been historically higher in Pinellas County than Florida. Between 2009 and 2010, there was an increase in the rate of infant mortality among White infants (from 5.4 to 6.6 per 1,000 live births), whereas there was a decrease among Non-White infants (from 17.1 to 14.5 per 1,000 live births). While there was a decrease in the rate of infant mortality among Non-White infants, the rate in 2010 was still more than double that of White infants.[73] The infant mortality rate decreased between 2008 and 2009 in Pinellas County from 9.3 to 8.3 per 1,000 live births and then increased again between 2009 and 2010 from 8.3 to 8.6 per 1,000 live births.[74] In 2011, the infant mortality rate among African American infants was two times that of the county rate (13.9 and 6.6 per 1,000 live births respectively).

✓ **Cancer** is a national issue being addressed by Healthy People 2020. According to Healthy People 2020, the age-adjusted death rate overall for cancer nationally was 172.8 per 100,000 pop. in 2010. The goal is to reduce this rate by the year 2020 to 160.6 per 100,000 pop. nationally, breast cancer (22.1 per 100,000 pop.) goal of 20.6 per 100,000 pop., lung cancer (47.6 per 100,000 pop.) 2020 goal of 45.5 [75]

- With an age-adjusted death rate for all cancers at 167.9 per 100,000 pop.; Pinellas County is slightly above the Healthy People 2020 goal. However, African American residents in Pinellas County show an age-adjusted death rate due to cancer (202.8 per 100,000 pop.) that is higher than any other racial group in the county (white residents show the next highest rate at 162.8 per 100,000 pop.) and higher than the national rate.[76]
- Between 2005 and 2008, there was an increase in the incidence rate for breast cancer in Pinellas County (from 120.1 to 123 per 100,000 pop) accompanied by a slight increase in the death rate from 20.7 to 20.9 per 100,000 pop. African American women show a higher death rate due to breast cancer than any other ethnicity in Pinellas County (27.1 per 100,000 pop.). More recent data shows the death rate increasing for African American females with breast cancer in 2011 (28.8 per 100,000 pop.).[77]
- With an age-adjusted death rate from lung cancer of 51.1 per 100,000 pop.; Pinellas County is near the Healthy People 2020 goal.
- Between 2005 and 2008, the cervical cancer incidence rate increased slightly in Pinellas County from 7.0 to 7.5 per 100,000 pop.[78]

[73] Source: 2012 Kids Count; The Annie E. Casey Foundation
[74] Source: Tampa Bay Partnership: Healthy Tampa Bay
[75] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=5&topic=Cancer&objective=C-1&anchor=318 (last updated: 3/28/2013).
[76] Source: Tampa Bay Partnership: Healthy Tampa Bay
[77] Ibid.
[78] Ibid.

- Between 2006 and 2008, there was an increase in the age-adjusted incidence rate for oral cavity and pharynx cancer in Pinellas County from 12.6 to 13.8 per 100,000 pop.[79]

✓ The **suicide** rate is a national issue being addressed by Healthy People 2020. According to Healthy People 2020, the age-adjusted death rate due to suicide nationally was 12.1 per 100,000 pop. in 2010. The goal is to reduce this rate by the year 2020 to 10.2 per 100,000 pop. nationally. [80]

- Individuals in Circuit 6 (Pasco and Pinellas counties) show the highest reported rates of serious thoughts of suicide compared with Florida.[81] Between 2008 and 2010, there was a slight increase in the death rate due to suicide in Pinellas County (from 17.5 to 18.5 per 100,000 pop.). While the age-adjusted death rate due to suicide has decreased between 2010 and 2011 (from 18.5 to 16.1 per 100,000 pop.); Pinellas County shows higher suicide rates than the nation. White residents are more than three times as likely to commit suicide (18.4 per 100,000 pop.) than any other racial group (African American residents are the next highest rate at 5.0 per 100,000 pop.). [82]

✓ **Tuberculosis** is a national issue being addressed by Healthy People 2020. According to Healthy People 2020: There were 4.9 new cases per 100,000 pop. nationally in 2005. The goal is to reduce this rate by the year 2020 to 1.0 per 100,000 pop. nationally. [83]

- While Pinellas County was close to the Healthy People 2020 goal, between 2009 and 2010, the tuberculosis incidence rate increased (from 1.9 to 3.6 per 100,000 pop.). [84]

✓ **Immunization** rates are a national issue being addressed by Healthy People 2020. According to Healthy People 2020, 95% of children in kindergarten nationwide had the required vaccinations for the 2007-2008 school year. [85]

- The immunization rate for kindergarten students in Pinellas County has steadily declined since 2007 (93.4%) to only 89.3% of the kindergarteners being fully immunized in 2010, which has increased to 90.3% in 2011. [86]

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[79] Ibid.
[80] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=28&topic=Mental%20Health%20and%20Mental%20Disorders&objective=MHMD-1&anchor=124 (last updated: 3/28/2013).
[81] Source: SAMHSA
[82] Source: Tampa Bay Partnership: Healthy Tampa Bay
[83] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=23&topic=Immunization%20and%20Infectious%20Diseases&objective=IID-29&anchor=557 (last updated: 3/28/2013).
[84] Source: Tampa Bay Partnership: Healthy Tampa Bay
[85] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=23&topic=Immunization%20and%20Infectious%20Diseases&objective=IID-10.5&anchor=564805 (last updated: 3/28/2013).
[86] Source: 2012 Kids Count; The Annie E. Casey Foundation

- ✓ **Tobacco** use is a national issue being addressed by Healthy People 2020. According to Healthy People 2020, 19.3% of adults 18+ years old reported cigarette smoking in 2010. The goal is to reduce this percentage by the year 2020 to 12.0% of persons nationally.[87]
  - Between 2007 and 2010, Pinellas County saw an increase in the number of residents that smoke (from 18% to 19.3%). Slightly more females report smoking cigarettes than men in Pinellas County (22.1% and 16.2% respectively).[88]
  - Circuit 6 (Pasco and Pinellas counties) shows the highest rate of any tobacco product use and the second highest rate of cigarette use when compared with Florida. This is may be related to the fact that Circui 6 shows the lowest rates of individuals who perceive the greatest risks of smoking.[89]

- ✓ **Substance abuse** is a national issue being addressed by Healthy People 2020. According to Healthy People 2020:
  - 8.4% of teens age 12-17 years reported binge drinking in 2010.[90]
  - 4.3% of persons 12+ years old nationally reported non-medical use of prescription pain relievers in the previous year[91]
  - 7.4% of adolescents 12-17 years old nationally reported using marijuana in the previous 30 days in 2011[92]

  - Between 2007 and 2010, there was an increase in the number of adults who reported heavy or binge drinking during the previous 30-day period in Pinellas County (from 12.8% to 16.4%), with men being approximately three times more likely than women (25.5% and 8.2% respectively), and one in four residents that are 18-44 years old (25.6%) to reporting heavy or binge drinking within the last 30 days.[93]

[87] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=41&topic=Tobacco%20Use&objective=TU-1.1&anchor=285350 (last updated: 3/28/2013).
[88] Source: Tampa Bay Partnership: Healthy Tampa Bay
[89] Source: SAMHSA
[90] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=40&topic=Substance%20Abuse&objective=SA-14.4&anchor=260957 (last updated: 3/28/2013).
[91] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=40&topic=Substance%20Abuse&objective=SA-19.1&anchor=277340 (last updated: 3/28/2013).
[92] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=40&topic=Substance%20Abuse&objective=SA-13.2&anchor=276952 (last updated: 3/28/2013).
[93] Source: Tampa Bay Partnership: Healthy Tampa Bay

- Circuit 6 (Pasco and Pinellas counties) shows the highest rates of alcohol use in the past month, but the lowest rates of binge alcohol use in the past month as compared with Florida.[94]

- Pinellas County shows the highest rates in every category of age and gender for emergency room visits due to acute or chronic **alcohol** abuse among residents that are 18+ years old. Men in Pinellas County are almost twice as likely as women in Pinellas County to visit the emergency room as a result of acute or chronic alcohol abuse. St. Anthony's Hospital service area has nine zip code areas with higher than average (24.0 per 10,000 pop.) emergency room visits due to alcohol abuse (33701-86.6, 33714-48.3, 33707-40.1, 33705-33.2, 33710-33.0, 33713-32.3, 33712-27.9, 33711-25.2, and 33704-25.0 per 10,000 pop.).[95]

- Between 2007 and 2011, hospitalization rates related to **alcohol** have increased consistently in Pinellas County (from 9.1 to 9.4 per 10,000 pop.), with five zip codes in the St. Anthony's Hospital service area showing above the Tampa Bay average (8.5 per 10,000 pop.) hospitalization rates (33701-19.4, 33714-11.8, 33704-10.7, 33713-9.6, and 33707-9.4 per 10,000 pop.). Men in Pinellas County are also more likely to be hospitalized due to acute or chronic alcohol abuse.[96]

- Circuit 6 (Pasco and Pinellas counties) shows the highest rate of non-medical use of **prescription pain relievers** compared to Florida (4.43% of the population aged 12 and older).[97]

- Pinellas County showed an increase between 2008 and 2009 in the percentage of high school students who used **marijuana** one or more times during the 30 days before the survey was administered (from 20.2% to 20.9%).[98]

✓ **Nutrition and weight status** are national issues being addressed by Healthy People 2020. According to Healthy People 2020:

  - 35.7% of persons 20+ years were obese in 2010. The goal is to reduce this percentage by the year 2020 to 30.5% of persons nationally.[99]

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[94] Source: SAMHSA
[95] Source: Tampa Bay Partnership: Healthy Tampa Bay
[96] Ibid.
[97] Source: SAMHSA
[98] Source: Tampa Bay Partnership: Healthy Tampa Bay
[99] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=29&topic=Nutrition%20and%20Weight%20Status&objective=NWS-9&anchor=141 (last updated: 3/28/2013).

- 31.6% of adults 18+ years old nationally are not engaging in any leisure-time physical activity in 2011.[100]

- The rate of adults who eat **fruits and vegetables** in Pinellas County (30% to 26.3%) has declined from 2002-2007. Men (18.1%) are much less likely to eat fruits and vegetables than women (33.7%) in Pinellas County.[101]

- While Pinellas County saw a decrease in the **obesity** rate from 27.7% to 24% from 2007 to 2010, men are slightly more likely to be obese (27.5%) with one in five women being obese (20.8%). Also in Pinellas County, one in four residents that are 18 to 44 years old (25.1%) and one in five residents that are 65+ years old (21.9%) is obese.[102]

- Between 2007 and 2010, the percentage of adults who are **overweight** increased in Pinellas County from 35.5% to 41.6%. Women are less likely to be overweight than men in Pinellas County (33.9% and 49.8% respectively).[103]

- Pinellas County (54 out of 67) ranks worse than Hillsborough (49) and Pasco (23) counties for **community safety**.[104]

2012 Kids Count – Key Findings:

- ✓ While the rate of low birth weight births has been increasing in Pinellas County between 2009 and 2010 (from 8.0% to 9.1%), the admission rate for low birth weight is much lower in the St. Anthony's hospital area than the county (according to PQI analysis).

- ✓ Infant mortality has been historically higher in Pinellas County than Florida. Between 2009 and 2010, there was an increase in the rate of infant mortality among White infants (from 5.4 to 6.6 per 1,000 live births), whereas there was a decrease among Non-White infants (from 17.1 to 14.5 per 1,000 live births). While there was a decrease in the rate of infant mortality among Non-White infants, the rate in 2010 was still more than double that of White infants.

[100] Source: HealthyPeople.gov. Retrieved from: http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=33&topic=Physical%20Activity&objective=PA-1&anchor=200 (last updated: 3/28/2013).
[101] Source: Tampa Bay Partnership: Healthy Tampa Bay
[102] Ibid.
[103] Ibid.
[104] Source: 2012 County Health Rankings. University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation

- ✓ The immunization rate for kindergarten students in Pinellas County has steadily declined since 2007 (93.4%) to only 89.3% of the kindergarteners being fully immunized in 2010.

Substance Abuse and Mental Health Services Administration (SAMHSA) – Key Findings

The Substance Abuse and Mental Health Services Administration (SAMHSA) gathers region-specific data from the entire United States in relation to substance use (alcohol and illicit drugs) and mental health.

Every state is parceled into regions defined by SAMHSA. The regions are defined in the '2008-2010 National Survey on Drug Use and Health Substate Region Definitions'.

Data concerning alcohol use, illicit drug use, and psychological distress for the various regions of the study area are shown here.

For the BayCare Health System service area, the regions are defined as follows:

- ❑ **Circuit 6: Pasco and Pinellas counties**
- ❑ **Circuit 13: Hillsborough County**

- ✓ Circuit 6 shows the highest rates of alcohol use in the past month, but the lowest rates of binge alcohol use in the past month as compared with Florida.
  - Circuit 6 shows the lowest rate of individuals that perceive the risks associated with having five or more drinks per week compared with individuals in Florida.
- ✓ Circuit 6 shows low rates of individuals reporting alcohol dependence or needing but not receiving treatment for alcohol dependence; Florida shows higher rates for both of these concerns.
- ✓ Circuit 6 shows the highest rate of any tobacco product use and the second highest rate of cigarette use when compared with Florida and the other circuit in the study area.
  - This may be related to the fact that Circuit 6 shows the lowest rates of individuals who perceive the great risks of smoking.
- ✓ Circuit 6 shows the lowest rates of individuals that perceive great risk associated with smoking marijuana, while at the same time showing the lowest marijuana usage rate compared with Florida. Generally, these values are negatively correlated; it may tell us that there is simply little exposure and usage of marijuana in this county.
- ✓ Circuit 6 shows the highest rate of non-medical use of prescription pain relievers compared to Florida (4.43% of the population aged 12 and older).

- ✓ Individuals in Circuit 6 report needing but not receiving treatment for illicit drug dependence less than individuals in Florida.

- ✓ Individuals in Circuit 6 shows the highest reported rates of serious thoughts of suicide compared with Florida.

Additional data and greater detail related to the secondary data analysis of the St. Anthony's Hospital service area is available in Appendix A.

Key Stakeholder Interviews

Data Collection:

The following qualitative data were gathered during individual interviews with nine stakeholders of the St. Anthony's Hospital area as identified by an advisory committee of executive leadership. St. Anthony's Hospital is a 395-bed hospital and also one of a network of 10 not-for-profit hospitals throughout the Tampa Bay area. Each interview was conducted by a Tripp Umbach consultant and lasted approximately 60 minutes. All respondents were asked the same set of questions previously developed by Tripp Umbach and reviewed by the St. Anthony's Hospital executive leadership project team.

Summary of Stakeholder Interviews:

What community do you represent professionally?

Of the nine key stakeholder respondents representing residents in the communities served by St. Anthony's Hospital, the places stakeholders mentioned when asked what community they represent professionally are: Pinellas County, South Pinellas County, Mid and Southern Pinellas County, Tampa Bay area, eight-county Tampa Bay region, and the homeless and working poor population (in order of most mentioned).

Your position in the community?

Of the nine respondents, there was a diverse representation of positions held in the community. Those positions represented included professionals: with special knowledge of or expertise in public health; departments and agencies with current data and other information relevant to the health needs of the community and representatives of medically underserved, low-income, and minority populations, and populations with chronic disease needs, in the community served by St. Anthony's Hospital. Specifically, the following professionals were represented among the stakeholders interviewed:

- Faith Community Nurse
- Executive Director of a free clinic
- President/CEO of the YMCA of Greater St. Petersburg
- Substance Abuse Liaison and Advocate
- COO of Catholic Charities
- Concurrent Review Nurse
- Director Pinellas County Health Department
- Director of Business Development for Community Health Centers of Pinellas County
- Project Manager for the One Bay Healthy Communities Initiative

How would you describe a healthy community?

The two themes identified upon review of the stakeholders' collective definitions of a "healthy community" are: resident wellness including access to healthcare and a community's ability to support and meet the needs of residents.

Resident wellness including access to healthcare was identified by six stakeholders as significant to the definition of a healthy community. Specifically, stakeholders mentioned the following elements relating to residents' wellness and access to healthcare that a healthy community should have:

- Access to appropriate healthcare, dental care, and community health education for all residents.
- An emphasis on health equity.
- Opportunity for a healthy life accessible to all members.
- Access to healthcare services that focuses on both treatment and prevention for all members of the community.
- Equal access to healthcare at a reasonable price.
- Residents that maximize their own potential to be healthy.
- People that are healthy and an environment that supports healthy people.
- An emphasis on personal responsibility for individual healthcare and the capacity for residents to be actively involved in their own personal healthcare processes.
- Residents that are participating in prevention and well care.
- A population that is inclined toward physical activity.

A community's ability to support and meet the needs of residents was identified by five stakeholders as significant to the definition of a healthy community. Specifically, stakeholders mentioned the following elements relating to the community's ability to support and meet the needs of residents that a healthy community should have:

- All systems in the community work together for citizens to get what they need to thrive, grow, and be empowered.
- An upfront investment of resources in health that ensures a strong future for the entire community.
- Senior services including transportation, mentor program, programs to help them get around and remind them to get to appointments and just checking in on them, activities to keep their lives more normal.
- Safety, access to healthy produce, education, housing, and recreational outlets.

What are some specific health need trends locally/regionally?

The two themes identified upon review of the specific health need trends identified most often by stakeholders are: Chronic illness and unhealthy behaviors.

Chronic illness was identified by seven stakeholders as a local or regional health trend. Specifically, stakeholders mentioned the following health need trends that relate to chronic illness:

- The obesity epidemic is a top priority.
- Significant number of patients with hypertension.
- An increase in diabetic patients and the need for health education regarding diabetes.
- African American adults in our community bear a disproportionate burden of the type two diabetes disease.
- African American teens in the St. Petersburg area are twice as likely to be overweight than their non-African American peers.
- Chronic Obstructive Pulmonary Disease.

Unhealthy behaviors was identified by five stakeholders as a local or regional health trend. Specifically, stakeholders mentioned the following health need trends that relate to unhealthy behaviors:

- Substance abuse
- Prescription drug abuse
- Drug and alcohol abuse
- Lack of follow-up care
- Increase in chronic disease due to lifestyle choices
- High rate of accidental deaths

Which target populations locally/regionally do you believe have such health needs?

Stakeholders identified the target populations they felt had a greater risk of having increased health needs. Stakeholders identified (in order of most mentioned) residents that are: Under/uninsured (e.g., Low-income residents that are Medicaid-ineligible), working poor, chronically ill (e.g., diabetic, obese, etc.), homeless, African American, children, seniors 50+, unemployed, non-English speaking, and general population.

In order to improve the health of communities, please talk about some of the strengths / resources that communities locally/regionally have to build upon. List strengths / resources that can be built on and describe how those strengths / resources could be used.

The nine stakeholders interviewed identified the following strengths/resources and their benefits:

- Collaboration;
- Healthcare organizations support community programs;
- There are evidence-based programs available to residents in the community;
- There are opportunites for outside physical/recreational activities;
- Multiple healthcare resources in Pinellas County (i.e., health department, hospitals, free clinic, etc.);
- Abundant information resources; and
- Hospital consolidation leading to increased efficiencies.

In your opinion, what do you think are the two most pressing health needs facing residents in local/regional communities you serve, especially the underserved? Please explain why.

The nine stakeholders interviewed identified the following as the top health needs facing underserved residents in local/regional communities:

- Limited access to healthcare as it relates to:
    - Lack of adequate insurance
    - Under/unemployment, which leads to no insurance benefits (i.e., service-related employment)
    - Resident awareness about what is available
    - Lack of preventive healthcare for low-income and under/uninsured
- Unhealthy behaviors related to:
    - Chronic illness
    - Substance abuse
    - Limited awareness

- Chronic illness related to:
  - Obesity
  - Diabetes
  - Due to limited prevention screening and education
- Behavioral health as it relates to:
  - Depression
  - Suicide
  - Substance abuse
  - Limited services due to a lack of funding for services

In response to the issues that were identified, who do you think is best able to address these issues / problems? How do you think they could address these issues / problems?

Out of nine stakeholders, four stakeholders were either unsure or did not provide a valid response. Of the five stakeholders that responded: two believed collaboration and partnerships would be required. The parties stakeholders felt are best poised to address the identified health needs are:

- The Public Health Department, though there are limited funds
- Local commissions that address health issues in the community
- Community providers
- Government officials
- Hospitals and Hospital policy makers
- County municipalities
- Employers

Do you believe there are adequate local/regional resources available to address these issues / problems? If no, what are your recommendations?

Of the nine responses, four stakeholders responded that they believe there are adequate resources available in the St. Anthony's Hospital service area to address the aforementioned issues/problems. Two stakeholders did not believe adequate resources were available and three stakeholders were either unsure or did not provide a valid response. Several stakeholders offered the following recommendations:

- Private organizations must become invested to make the necessary impact
- Need more collaboration among local and county governments
- Connections to the resources that are available is key.

Do you see any emerging community health needs, especially among underserved populations, that were not mentioned previously? (Please be as specific as possible)

Stakeholders identified the following emerging health needs among underserved populations in the communities they serve:

- Autism spectrum and behavioral diagnoses are becoming more prevalent.
- Childhood obesity is increasing.
- Chronic Disease Management for low-income populations: while resources may be available; there seems to be limited awareness and access to those resources for residents at a lower socio-economic level.

- Medical issues that will increase the need for resources are becoming more prevalent (e.g., pre-diabetes and the medically underserved population), which poses a threat to future resources.
- Urban communities need better inner-city planning to become more walkable and develop the infrastructure that will supports physical activity.
- Mental health: Tampa Bay area has a high rate of depression. There are severe mental health problems in the area and little capacity to address the issues that exist.
- Florida Medicaid: The state has cut funding significantly, causing residents to resist seeking medical care. People are much sicker than before when they enter the healthcare system and also don't get adequate follow-up care.
- After age 21, low-income residents have limited access to inpatient treatment and follow-up care.
- Pharmacy needs for uninsured patients: Prescription assistance is not always readily available.

Any additional comments or questions?

There were no additional comments or questions posed by stakeholders.

Focus Groups with Community Residents

Tripp Umbach facilitated four focus groups with residents in the St. Anthony's Hospital community. Approximately 44 residents from the St. Anthony's Hospital community participated in focus groups in April 2013, each providing direct input related to top community health needs of themselves, their families, and communities.

INTRODUCTION:

The following qualitative data were gathered during four discussion groups conducted with target populations that were defined by St. Anthony's Hospital leadership. Each group was conducted by Tripp Umbach consultants, and participants were provided a $20 gift card incentive. The discussion groups were conducted using a discussion guide previously created by Tripp Umbach and reviewed by St. Anthony's Hospital leadership.

The goal of the focus group process is that each participant feels comfortable and speaks openly so that they contribute to the discussion. It was explained to participants that there are no wrong answers, just different experiences and points of view. This process ensures that each participant shares their experiences from their point of view, even if it is different from what others have said. Specifically, focus group participants were asked to identify and discuss what they perceived to be the top health issues and/or concerns in their communities. The focus group process gathers valuable qualitative and anecdotal data regarding the broad health interests of the communities served by the medical facilities within the St. Anthony's Hospital service area. Focus group input is subject to the limitations of the identified target populations (i.e., vocabulary, perspective, knowledge, etc.), and therefore, is not factual and inherently subjective in nature.

The focus group audiences were:

- ✓ Residents earning a low income that are Medicaid-ineligible
  - Conducted at Community Health Centers at Tarpon Springs (Tarpon Springs, FL) on April 5, 2013
- ✓ Private behavioral health practitioners serving residents with behavioral health needs
  - Conducted at BayCare Administrative Building (Clearwater, FL) on April 4, 2012
- ✓ African American Residents
  - Conducted at St. Anthony's Hospital (St. Petersburg, FL) on April 11, 2012
- ✓ Professionals serving homeless residents
  - Conducted at St. Vincent de Paul (St. Petersburg, FL) on April 4, 2012

LOW-INCOME MEDICAID-INELIGIBLE RESIDENTS (PASCO AND PINELLAS COUNTIES)

The purpose of this discussion group was to identify community health needs and concerns affecting residents that are Low-income and Medicaid-ineligible in those counties where this population is concentrated in the BayCare Health System service area (i.e., Pasco and Pinellas), as well as ways to address the health concerns of this population.

PROBLEM IDENTIFICATION:

During the discussion group process, Low-income and Medicaid-ineligible residents discussed four community health needs and concerns in their communities. These were:

1. **Access to Healthcare**
2. **Behaviors that impact health**
3. **Impact of socio-economic status**
4. **Lack of Mental health services**

ACCESS TO HEALTHCARE:

The Low-income Medicaid-ineligible residents perceived that access to healthcare in their communities is limited in the areas of availability, communication, cost, dental care, insurance coverage, specialists, and transportation.

Perceived Contributing Factors:

- Participants of the focus group felt that the availability of specialty care in their area is limited due to the high cost of appointments. Participants mentioned that as a result of not seeking specialty care, residents are choosing to not see their doctors and are not being diagnosed or treated.
- Participants mentioned that residents in their area are not always able to afford physician appointments to fill necessary prescription medications that are required on an ongoing basis to treat chronic illnesses (i.e., diabetes, COPD, tooth extraction, etc.). Residents are getting sicker and/or administering treatment to themselves (i.e., tooth extraction).
- Participants felt that care for the uninsured in the area is simply not affordable, there are limited options for the under/uninsured; medications, diagnostic testing, treatments, doctor visits, etc. are inaccessible.
- Participants of the group identified the specific concern of testing being unaffordable even at sliding-scale fee clinics. It was mentioned that testing is a separate fee than co-payments, and that having both costs can sometimes be too much for individuals and/or families. Participants mentioned that it was their understanding that residents are not always informed of the costs of the testing and are billed for the procedures after, at which time they are not able to pay. Participants mentioned that this is more the case for in-home testing. The impact of the high costs and miscommunications is that residents choose not to seek care if they are unaware of how much it will cost them.

- Residents felt that there is a lack of insurance coverage for individuals who do not qualify for Medicaid and those that cannot afford private-pay insurance.
- Participants were under the impression that private-pay insurance can cost as much as $800 per month. On the other hand, participants feel that Medicaid is calculated based on an individual's gross income (before taxes are taken out) and thus, individuals don't end up having enough to cover healthcare costs after taxes are taken out.
- One participant mentioned and others agreed that residents in the area are forced to choose the care that they receive based on cost; an individual may have enough money to see their doctor, but not enough money to fill the prescriptions for the treatment of their care, and follow-up visits or specialist doctor visits are extremely difficult to hold. Participants identified the direct impact that this has on the health of individuals in the area as being individuals not seeking necessary care and treatment, and thus, become unhealthier.
- Another participant mentioned that they are sometimes torn between paying for private insurance coverage or just the fines associated with no insurance coverage.
- Many of the participants felt that even residents with Medicaid coverage have difficulties finding doctors that will accept their insurance. Participants were under the impression that some doctors request two forms of Medicaid, and those specialists rarely, to never, take individuals with Medicaid coverage.
- A handful of individuals in the focus group expressed a concern over poor communication between healthcare providers, insurance coverage organizations, and patients.
- Specifically, residents felt that professionals do not always communicate with under/uninsured residents adequately (Medicaid determination, diagnosis, fees, referrals, resources, etc.).
- Participants specifically spoke of Medicaid termination and that if this occurs, they are under the impression that communication back with the covered individual is lacking. One participant spoke specifically of her Medicaid coverage being cancelled, she not being informed and needing to go to a local hospital ER for her chronic illness medications (diabetes and lung issues).

Mitigating Resources:

Low-income Medicaid-ineligible residents in Pasco and Pinellas Counties identified the following existing resources in their communities that they felt could improve the access to care:

- Medicaid coverage for children – Participants felt that children have adequate healthcare coverage in their area.
- Medicare coverage is widely accepted.
- Unemployment – This might be an option for some, but is not nearly enough to cover healthcare costs.
- Sliding-scale clinics – Participants mentioned this as a resource, but fees can be confusing.
- Good Samaritan Clinics (one specifically mentioned in Pasco County) – May offer free care, but only serves patients that are residents of that county.
- Referral/specialist list from primary care doctor – but information is often times, inaccurate or outdated.

- 2-1-1 phone service offers information over the phone.
- Internet searches.
- Health department offers sliding-scale fee services (preventive care, medical care).
- The Harbor offers behavioral health services.
- Participants of the group mentioned that some physicians, when pressed, refer patients directly to a specialist which saves patients the hassle of having to find a specialist that is available and taking their insurance.

Group Suggestions/Recommendations:

Participants of the focus group offered the following as possible solutions to help improve the access to healthcare in their communities.

- ***Inform patients of the costs associated with their care; testing, sliding-scale clinics, multiple doctor appointments, specialist costs:*** Participants mentioned that they are billed after their care or testing and they were never informed of the additional fees. Participants also mentioned confusion with the fees associated with the sliding-scale clinics.

- ***Tighten the lines of communication between patients and their providers:*** Participants did not feel that residents in the area are given enough advance notice of insurance termination. Participants felt that this should be communicated to patients earlier and better. Also, patients felt that information that is provided by their doctors is sometimes inaccurate (i.e., specialist/referral lists). Having a clearer system to refer patients through would be beneficial for all parties.

- ***Increase the number of health facilities:*** Participants were concerned that there were not enough healthcare facilities (hospitals, doctor offices, etc.) in their area and that possibly, with more facilities, individuals in the community would attend to their health on a more regular and even preventive way.

- ***Offer more affordable and accessible insurance coverage options:*** Participants felt that the requirements for Medicaid are difficult to fit into (23- to 32-hour work week, tight income levels). Participants felt that expanding the Medicaid coverage options would help a large percentage of the individuals in need.

- ***Offer more affordable medication options:*** Participants felt that once an individual has been diagnosed with a chronic condition, their medications should be easier and cheaper to obtain. Offering programs through local pharmacies to reduce the costs of regular medications would be very helpful for many of the residents of the area.

BEHAVIORS THAT IMPACT HEALTH:

Low-income Medicaid-ineligible residents in Pasco and Pinellas Counties felt that healthy behaviors in their communities are limited by resident awareness, access to healthy options, individual choices, and availability of knowledge of preventive screening services.

Perceived Contributing Factors:

- The first concern mentioned by participants of the group in relation to behaviors impacting health was poor health decisions by residents (smoking, substance abuse, etc.). Participants mentioned that such unhealthy behaviors affect not only the individual, but also the larger community.
- Participants felt that chronic conditions are correlated with poor lifestyle choices (i.e., smoking and cancer).
- Participants felt that some preventive care measures, specifically eye care, are difficult (or even impossible) to find in their area.
- Participants were aware of the beneficial aspects of preventive care; reducing time and costs of health concerns down the line.
- Participants were concerned about the high costs of preventive healthcare in their area.
- Participants mentioned that a negative impact of high costs for preventive care is that residents are then not seeking preventive care measures.
- Participants felt that a major reason why preventive healthcare is not pursued in their area is due to lack of facilities that offer preventive care services.
- Participants of the group felt that due to poor lifestyle choices, as well as high costs of and limited access to preventive care, residents are not seeking care, which then leads to higher rates of chronic health conditions such as diabetes and cancer.
- Participants felt that many serious health conditions are found "too late" in their area due to lack of preventive care services.
- A few participants mentioned difficulty in seeing a dentist for regular checkups; and that sometimes, dental concerns escalated to the point of extracting teeth on their own.

Mitigating Resources:

Participants of the focus group (Low-income Medicaid-ineligible residents in Pasco and Pinellas Counties) identified the following existing resources in their communities that they felt could improve the practice of healthy behavior:

- Participants mentioned that the Health Department offers checkups for residents, but that it is on a sliding-scale fee schedule and that sometimes residents are unable to pay.
- One participant mentioned that female preventive care (i.e., mammograms) can be covered by the government.
- Medicaid covers children for everything.
- The Harbor in Port Richey is an organization that assists residents with substance abuse difficulties.

- Phone services (2-1-1 or 4-1-1) give residents information of resources in the area (shelters, clinics, etc.).
- Participants mentioned that Internet searching is a good avenue to find resources in their area.
- A list from a community center was also mentioned as a resource for residents in the area.

Group Suggestions/Recommendations:

Low-income Medicaid-ineligible residents offered the following as possible solutions to help improve the practice of healthy behavior in their communities:

- ***Educate children and adults of healthy life decisions:*** Participants were concerned about smoking in their area. Participants mentioned that teaching children the negative impacts of smoking will aid in reducing the rates of smoking in the future. Participants also mentioned that adults hold misconceptions concerning the negative impacts of smoking and that these misconceptions need to be corrected, possibly through educational seminars throughout the community.

- ***Offer more preventive healthcare facilities:*** Participants mentioned that there is nowhere to go for eye care in their area. Participants felt that it would be helpful to have more facilities in their area that aid patients in screening and preventive care. Also, participants mentioned that it would be helpful to have more healthy behavior options (recreational centers, healthy food options, etc.).

- ***Focus efforts more on preventive care:*** Participants were under the impression that their healthcare happens more after a condition has become an issue. Participants felt that focusing efforts on screenings and testing for conditions such as diabetes could drastically reduce healthcare costs and residents' time and energy in trying to better their health.

- ***Reduce exposure to unhealthy options:*** Participants of the group felt that being around or having unhealthy options in their region is detrimental for the community's health. Participants thought that having restrictions on unhealthy behaviors (i.e., designated smoking areas) could help make their community healthier.

IMPACT OF SOCIO-ECONOMIC STATUS:

Participants of the focus group (Low-income Medicaid-ineligible residents of Pasco or Pinellas Counties) perceived that an individuals' socio-economic status (i.e., income, employment, etc.) was a large factor in their access to healthcare in their area.

Perceived Contributing Factors:

- Participants were under the impression that getting a medical appointment is much more difficult for an individual who is under/uninsured, because medical providers that accept under/uninsured residents are limited.

- Participants mentioned that many jobs in the area are sales-based, and are therefore dependent on commission. With the economy on the rocks, residents' incomes are being negatively impacted.
- Participants of the group mentioned that unemployment is a problem in the area and that job openings are scarce.
- Participants felt that employers in the area avoid offering health insurance plans to employees by hiring multiple part-time employees instead of paying for one full-time employee with health benefits.
- Participants expressed concern over underemployment in the area due to residents working part-time jobs.
- As mentioned previously, participants felt that the income requirements for assistance do not seem fair and they felt that assistance is determined by gross income levels of residents, not taking into consideration life expenses.
- Participants also mentioned that for many residents, minimum wage is the norm.

Mitigating Resources:

Participants of the group identified the following existing resources in their communities that they felt mitigate the impact of socio-economic status on residents' health, they included:

- Medicaid
- The select few healthcare providers that accept under/uninsured patients

Group Suggestions/Recommendations:

Participants of the focus group (Low-income Medicaid-ineligible residents of Pasco or Pinellas Counties) offered the following solutions to improve the impact of socio-economic status on health.

- ***Offer more services for the under/uninsured populations:*** Participants mentioned that finding and receiving care when an individual has limited coverage is difficult to impossible. Participants felt that providing more facilities for under/uninsured individuals would allow for a healthier community via more screening, preventive care, and necessary care.

- ***Expand Medicaid coverage:*** Participants felt that loosening the requirements necessary to qualify for Medicaid would aid many individuals that are currently under/uninsured to have coverage and therefore able to seek care.

MENTAL HEALTH:

Participants of the group touched on the fact that the availability of mental health services is a concern for their community.

Perceived Contributing Factors:

- Participants felt that mental health is an expansive concern that is actually a global concern.
- Participants were under the impression that a large contributor to inadequate mental health services in their area and in the United States is limited funding from the government.
- Participants mentioned specific concerns for mental health services for children and that these are not provided through normal government health coverage.
- One area of concern that participants mentioned was a perception of limited behavioral health services in their immediate area and that the closest services require some form of transportation to access.

Mitigating Resources:

Low-income Medicaid-ineligible residents of Pasco or Pinellas Counties were aware of a handful of resources in their area that could assist in providing information concerning mental health services, and few that actually provide mental health services in their area.

- A community clinic list of providers; but participants were under the impression that the list was often times inaccurate.
- One participant did mention a facility on Belcher that is a mental health facility, but this is very far away.
- The Good Samaritan Clinic.

Participants were under the impression that mental healthcare is better provided for in Pasco than Pinellas County.

Group Suggestions/Recommendations:

Participants of the group offered the following solutions to improve the availability of mental healthcare services in their area:

- ***Allocate more funds to mental health:*** Participants felt that funding for mental health services in their area is lacking. Participants felt that increasing the funds available for mental health services in their area could improve the health of their community in various ways; helping the individuals with mental health concerns, getting treatment for those in need, and potentially making a safer community through these efforts.

- ***Provide clear information concerning mental health resources:*** Participants mentioned that a list is available of mental health providers, but that it is often inaccurate. Participants felt that an accurate list of providers could be helpful not only to residents in need of mental health services, but also helpful for families of those residents.

- ***Healthcare providers to be more understanding when mental health referrals are warranted:*** Participants felt that it is sometimes difficult to get a referral from a doctor for a mental health concern. Participants mentioned that not having to pressure their doctor for a referral many times would be helpful in order to more readily seek mental health care.

PRIVATE BEHAVIORAL HEALTH PRACTITIONERS SERVING INSURED RESIDENTS

The purpose of this discussion group was to identify community health needs and concerns affecting residents that are insured, but have behavioral health needs in the BayCare Health System service area (i.e., Pinellas, Hillsborough and Pasco County), as well as ways to address the health concerns of this population.

PROBLEM IDENTIFICATION:

During the discussion group process, Private behavioral health practitioners discussed two community health needs and concerns for homeless residents in their communities. These were:

1. **Access to behavioral healthcare for both adults and children**
2. **Gaps in services to homeless residents**

ACCESS TO BEHAVIORAL HEALTHCARE FOR BOTH ADULTS AND CHILDREN:

Private behavioral health practitioners perceived that access to behavioral healthcare in their communities may be limited for both adults and adolescents in the areas of availability, barriers to accessibility, appropriate levels of care, resource navigation, increased demand, and the distance between facilities/resources.

Perceived Contributing Factors:

- Participants believed that there are a limited number of substance abuse treatment programs for both adults and adolescents.
- Participants believed there were not enough support groups for adolescents (i.e., self-help, peer-support, 12-step, substance abuse/abstinence issues, behavioral health issues, GLTB issues, etc.). As a result, adolescents are being referred to adult narcotics anonymous and alcoholics anonymous groups.
- Participants felt that they are seeing an increase in depression among adolescents.
- Participants have seen an increase in the level of substance abuse among their patients, particularly prescription medication (i.e., hydrocodone, Xanax, Ritalin, etc.). Participants felt that the increase is due to the ease of access (i.e., pain clinics, parent's medicine cabinet, etc.) and an increased awareness of the effects of different types of medications. Many substitute therapies are also addictive.
- Adult residents that are addicted to a substance and require a more intensive treatment level than outpatient treatment offers (i.e., one visit per week) are difficult to refer due to the limited number of programs available and their concern about discretion.
- Partial hospitalization, intensive outpatient programs, and psychiatric services that are in the community are inadequate to meet the demand for these types of services; with a limited number of partial hospitalization beds, and no intensive outpatient services participants that they were aware of. As a result, there are lengthy waiting lists to secure services and/or services

are not available, leading to the need for crisis intervention and/or hospitalization between referral and intake due to a lack of access to the appropriate level of care and/or needed medication.

- When appropriate treatment and referral resources are not available for residents, they experience distress (i.e., parents of children/adolescents needing more intense behavioral healthcare and/or substance abuse services)
- Baker Act facilities and/or crisis stabilization units serve primarily as a holding area to keep patients safe. Residents are not receiving therapeutic treatment while committed. Due to funding, there are no step-down programs residents can be enrolled in upon discharge from crisis stabilization units. Due to liability issues, the prescribing physician must be consulted to validate all prescription medications, resulting in a period of up to 72 hours when residents may not have access to their medications (i.e., psychotropic and medical medications). One result of limited access to medications can be the exacerbation of symptoms (i.e., psychological, medical, etc.). There are not many options for Baker Act facilities, which can lead residents to be avoidant of crisis stabilization if they have a negative experience.
- When an intensive outpatient program or partial hospitalization resource is identified for adolescents/adults, it is often located a great distance from their community, limiting treatment options like exposure therapy, family counseling, visitation, etc.
- Often, it can be difficult to secure help for residents with behavioral health diagnoses before they have escalated to a point of losing control and are arrested or require commitment to an institution in accordance with the Baker Act. Participants felt that the reason for this is that there are greater resources devoted to the penal system and psychiatric institutions, and less resources devoted to preventive services (i.e., intensive outpatient and partial hospitalization), causing a gap in services that could prevent escalation.

Mitigating Resources:

Private behavioral health practitioners identified the following existing resources in their communities that they felt could improve the access to behavioral healthcare:

- Self-harm (i.e., cutting) has decreased among adolescent girls treated by participants in recent years.
- While inadequate to meet the demand, there are some resources in the community for adolescents (i.e., Turning Pointe, Operation PAR, The Harbor, Metropolitan Charities, etc.).
- Where psychiatrists are available, there are several very good resources.
- More intensive psychiatric service will be possible (i.e., more than 15 minutes if needed).
- There are facilities for Baker Act commitments (i.e., PEMHS for adolescents and St. Anthony's Hospital for adults).
- There are ways to digitally communicate with referring physicians that is HIPAA-compliant (i.e., Dropbox and secured email).

Group Suggestions/Recommendations:

Private behavioral health practitioners offered the following as possible solutions to help improve the access to behavioral healthcare in their communities.

- ***Increase access to the appropriate level of behavioral health treatment:*** Participants believed that there are gaps in the level and relevancy of services provided to adults and adolescents prior to crisis stabilization and/or arrest. Participants recommended that funding begin to focus on more preventive services like intensive outpatient treatment and partial hospitalization to provide a continuum of services, as well as less expensive treatment options to residents requiring behavioral health services and providers.

- ***Increase the effectiveness of psychiatric services:*** Participants believed that there are a limited number of psychiatrists in their communities, causing lengthy waits for initial medication referrals, and other medical professionals to begin writing prescriptions for psychotropic medications. Participants recommended that the number of trained professionals (i.e., psychiatrist) be increased in the community.

INFORMATION AND REFERRAL RESOURCES:

Private behavioral health practitioners perceived that improved access to information and referral resources in their communities are limited by integration between medical and behavioral health providers, up-to-date referral information/resources and the connectivity among behavioral health providers.

Perceived Contributing Factors:

- There is limited integration with the medical industry. Specifically, if a physician refers a resident it can be difficult, and often not possible to follow-up with the referring physician with any questions and/or updates.
- There is limited information about what resources exist in the community. What information is available it is often out-of-date, disorganized, and not user-friendly.
- The behavioral health service landscape changes so often that it can be difficult to stay abreast of program closures and openings enough to be aware of where to refer residents.
- Private practitioners are often disconnected from the informal non-profit information networks due to proximity and limited time to attend meetings.
- The limitations of the referral network can cause residents to have unmet behavioral health needs due to the gaps in services, limited communication, and limited discretion inherent in behavioral health programs.

Mitigating Resources:

Private behavioral health practitioners identified the following existing resource in their communities that they felt could improve access to information and referral resources:

- There are resources available that may not be as accurate as necessary (i.e., 2-1-1 by phone and Internet searches on the computer).

Group Suggestions/Recommendations:

Private behavioral health practitioners offered the following as possible solutions to help improve access to information and referral resources in their communities:

- ***Increase connectivity and integration with medical practices:*** Participants felt that there is a lack of communication among behavioral health resources, which can lead residents to experience unmet needs. Specifically, practitioners are not able to follow-up with referring physicians with questions and/or updates due to the schedules of both parties. Participants felt that if behavioral health were more integrated with medical health, communication would be less of an issue. If practitioners could share medical records in an EMR environment that was HIPAA-compliant, it would reduce some of the communication issues and increase continuity of care.

- ***Increase connectivity with other practitioners:*** Participants felt that private practitioners are often disconnected from one another and the non-profit behavioral health industry. Participants recommended a virtual environment/venue through which behavioral health practitioners could communicate about resources, diagnosis, etc.

AFRICIAN AMERICAN RESIDENT FOCUS GROUP INPUT

The purpose of this discussion group was to identify community health needs and concerns affecting African American residents that are at risk of poorer health outcomes in the BayCare Health System service area, as well as ways to address the health concerns of this population.

PROBLEM IDENTIFICATION:

During the discussion group process, African Americans discussed three community health needs and health concerns in their communities. The following concerns listed are in no particular order:

1. **Affording Healthcare Services**
2. **Cultural Inequalities (cultural differences)**
3. **Environmental Needs (housing needs and overall living expenses)**

AFFORDING HEALTHCARE SERVICES

Perceived Contributing Factors:

- There are underlying issues which cause focus group participants to have a decline in their health. Environmental factors such as unemployment, not being able to pay the bills, and the living expenses associated with raising a family cause stress, which leads to a decline in one's physical health.

- With health services and care being unaffordable and unobtainable for focus group participants, women must be advocates for themselves. It is reported that women need to be educated on many health topics, especially if they self-diagnose. It was important for group members when care is obtained; questions are posed to healthcare providers. This is especially important for older women who were raised not to question authority. Overall, it was important for African American women to keep open lines of communication with their healthcare providers and organization.

- Some focus group participants reported that citizens born outside of the United States do not have high stress levels compared to U.S.-born citizens. There is a perception that women have higher life/work expectations and professional working women are often more stressed. Women wear many hats (male and female roles), thus leading to high stress levels. Unfortunately, stress leads to many health issues and women who can't afford health services to eliminate or reduce the effects of stress have little to no options than to struggle with the pain and outcome.

- Families are struggling to maintain their employment status and many are unable to obtain adequate wages to provide for their families. A number of participants stated that health insurance was not available to them because they did not have the economic means to purchase coverage.

- Lack of health coverage is a significant problem for those in the community and high cost is one of the main reasons participants do not obtain healthcare services and/or have health insurance.

- Many low-paying employers do not provide insurance coverage to their employees. Participants felt the need for good health insurance coverage but without sufficient funds, health insurance coverage was unobtainable.

- Healthcare centers are available, but obtaining services can be difficult. There are health insurance restrictions that make obtaining care cumbersome.

- While some health services are available to those in the community, transportation is often an associated part of accessing available care. Transportation options (buses) are limited, and tend to be more costly if health services are being sought are out of the area. With transportation funding cuts, buses operate on a limited schedule and within a limited neighboring section. Other forms of transportation such as taxis are too costly for those on a limited income.

Group Suggestions/Recommendations:

The following were provided as potential solutions from African American women to help improve the overall access to healthcare services in their communities.

- ***Expanding services that are accessible and user-friendly:*** Create health services that do not have "red tape" and administrative policies that often make seeking care difficult. Many in the community would be more likely to use health service screenings if care was quick and easy.

- ***Disseminating health information:*** Health clinics could provide information seminars or educational sessions more readily. Healthcare recipients are looking for more than flyers and information on a pamphlet for disease information and management. They seek personal interaction with healthcare providers who can discuss and field questions on different healthcare topics.

- ***Expand health fairs:*** Currently, health fairs are conducted in the community, however; coordinating efforts with other regional and local health organizations and healthcare providers' offices could expand the current health fair to draw more attention and people to the event. In the African American community, selecting a central location for disseminating information is vital since health centers are not typically available in one certain neighborhood.

- ***Collaborating with community organizations:*** Community-based organizations should work with more community groups to effectively keep community residents well informed on health topics and community events. Organizations should share information about other community groups in order to keep communications open to the public. African American women reported that education, outreach, and advocacy are important in accessing healthcare services.

CULTURAL INEQUALITIES (CULTURAL DIFFERENCES)

Perceived Contributing Factors:

- Many healthcare professionals are often insensitive towards patients of different racial and ethnic backgrounds. There is a perception that healthcare professionals do not care for their patients and often treat patients quickly and without much compassion in order to quickly treat the next patient.
- Care received is often quick, hasty, and without empathy. Healthcare professionals speak in demeaning tones and manners and often do not allow patients to fully comprehend the diagnosis. There is a sense that quality treatment is often reserved for patients who are adequately insured and who are also well-educated.
- Physicians are not well-trained to interact with patients because they do not have the same cultural background. There is a perception that patients are treated differently based on their speaking mannerisms, and at times, their clothing attire. Focus group participants are sensitive to the care they receive from healthcare providers because they believe that healthcare providers would rather put a "Band-Aid" on the issue instead of eliminating the problem and/or addressing the root of the issue.

Group Suggestions/Recommendations:

The following were provided as potential solutions from African American women to help healthcare providers interact and better understand the needs of those in the community they serve.

- ***Cultural sensitivity training:*** Healthcare providers should be required to attend a cultural awareness program that assists them on how to interact appropriately with their patients. Some healthcare providers may not be aware of the poor treatment they provide and/or their demeanor when providing care to their patients.
- ***Patience:*** Reminding healthcare professionals that their patients are not educated in the healthcare field. Compassion, an open dialogue, and basic communications are needed for patients who seek to keep communication open and honest. Trust is important for focus group participants and they acknowledged that trust cannot be built within a small timeframe.

ENVIRONMENTAL NEEDS (HOUSING NEEDS AND OVERALL LIVING EXPENSES)

African Americans stated that environmental needs such as affordable housing and the overall living costs contributed to the decline of many healthy individuals in their communities.

Perceived Contributing Factors:

- African American women are often concerned about their ability to afford adequate housing, eating healthy, and maintaining a normal lifestyle. It is often very difficult to eat healthy on a

limited income. Fresh foods and healthy foods are frequently expensive and are not available at their local grocery stores. Many families must consider whether they should buy more food (unhealthy food options) or less food (healthy food options) for the same dollar amount. Most families prefer and would like to eat healthier; however, affordability plays a major role in that option.

- Some health facilities provide information on changing, living, and eating healthy. Having information and being educated on this front would support those seeking a healthy lifestyle change.
- Safe, clean, and affordable housing options for families is very limited in the region. The living conditions in many homes are deplorable, and many are poorly maintained by the government and/or landlords.
- The group believed there is a connection between living in a safe and clean environment (i.e., housing and environment) with the health of oneself. Living healthy to some group members is not purely the food you eat, but also the ability to live in an environment that supports being healthy.
- Some of the female participants expressed the need for more government assistance. The expense of living and raising a family is costly, and current government cuts will make the standard of living more difficult for families and single mothers to maintain.

Group Suggestions/Recommendations:

The following were provided as potential solutions from African American women to help improve the environmental needs in their communities.

- ***Information distribution and access:*** Hospitals can provide information to their patient population, thus, alleviating some of the costs that are associated with educating the population. Being well-informed and educated on healthy eating habits and maintaining these habits could reduce and eliminate the need for some prescription medication and its dependency.

- ***Creating a healthy environment:*** Having a clean and welcoming environment such as well-maintained sidewalks, available parks, and recreational space would provide individuals, families, and their children with an opportunity to exercise and interact with those in their communities (maintaining a healthy body and soul).

- ***Streamlining services and better organization collaboration:*** There are many government and social agencies that are available to help families, parents, and single people meet the standard of living set by the government. However, agencies and organizations could collaborate to eliminate duplication of services and to provide a better service experience for recipients. Many in the group sensed organizations are often fragmented and are often not well informed of other agencies and the services they provide. Eliminating duplicated services would funnel those wanted dollars into other needed or newly created programs.

PROFESSIONALS SERVING HOMELESS RESIDENTS

The purpose of this discussion group was to identify community health needs and concerns affecting residents that are homeless in those counties where this population is concentrated in the BayCare Health System service area (i.e., Pinellas and Hillsborough), as well as ways to address the health concerns of this population. While Hillsborough County was discussed briefly, there were no professionals that attended the group from Hillsborough County.

PROBLEM IDENTIFICATION:

During the discussion group process, professionals serving homeless residents discussed three community health needs and concerns for homeless residents in their communities. These were:

1. **Access to primary, preventive, dental, and mental health care**
2. **Behaviors that impact health**
3. **Gaps in services to homeless residents**

ACCESS TO PRIMARY, PREVENTIVE, DENTAL, AND MENTAL HEALTH CARE:

Professionals serving homeless residents perceived that access to primary, preventive, dental, and mental health care in their communities may be limited in the areas of availability, barriers to accessibility, prevention, resource navigation, treatment after diagnosis, restrictive funding, consistent healthcare, trust, staff and patient interaction, training, and awareness.

Perceived Contributing Factors:

- Many homeless residents receive diagnoses and no treatment. Where and how homeless residents are diagnosed with a disease impacts their ability to secure treatment due to funding and Medicaid reimbursement regulations. If a homeless resident or service provider is unaware of how to navigate the resources that are available effectively, they may become ineligible for services at some point because they have accessed a different service, or received a diagnosis at an access point that cannot also help with treatment options, etc. Several examples were provided (i.e., A homeless woman was diagnosed with cancer at a health screening offered by a local church. Providers are not able to get her treatment covered by funding due to where she was diagnosed. If, instead, the church had set up a program with the Florida Breast and Cervical Cancer Early Detection Program, she would have qualified for a variety of treatment programs).
- If funding is not available to address specific needs, then providers are less likely to be able to address the need.
- Homeless children are not always being identified or served. (Public schools often see homeless children.)
- Many homeless residents have chronic health issues that have never been treated and/or managed on a consistent basis.

- Medical staff does not always have the proper training to effectively communicate and interact with homeless residents. Additionally, both health- and non-health-related providers often do not have a complete enough understanding of the culture of poverty and homelessness to effectively help homeless residents.
- Pediatricians often do not understand the multiple chronic needs of children being raised in homeless families.
- Often, medical providers will not take high-risk patients (i.e., homeless mothers and/or mothers addicted to a substance).
- There is a lack of focus on prevention, and there are limited preventive healthcare options for homeless residents.
- When homeless residents are receiving healthcare services, there are times the medications cannot be obtained due to limited assistance for the brand type and/or access to a non-compete clinic with free medication options. This is often the case with antibiotics and non-formulary medications.
- County mobile medical facilities exist, however; the van is often unavailable due to limited funding or being broken down and in need of repairs. However, staff will provide services on-site if there is a traditional setting available. There are some communities that do not have access to medical care without the county mobile medical unit, due to limited medical resources (i.e., Tarpon Springs). There is supposed to be a 330(h) service operating in the town of Tarpon Springs that has been defunct for several years.
- There are liability risks associated with medical professionals offering medical care in non-traditional settings in the community (i.e., the library).
- The county mobile medical unit and the community health centers cannot provide services in the same areas.
- It is likely that funding will continue to decrease for health services to the homeless.
- There are not enough primary care doctors in the state and they are leaving due to the risk of lawsuits and cost of practice insurance.
- Reimbursement rates do not incentivize the provision of holistic healthcare. If a center provides mental health, dental health, and medical healthcare during the same day to one resident, the maximum they will be reimbursed is $100. If the same center offered the aforementioned services on three separate days, they could be reimbursed up to $300 or $100 each day. However, homeless residents are not always able to return to the physician's office on a regular basis.
- The lack of dental health among homeless residents often causes medical health issues.
- Homeless residents with mental illness are often not getting the treatment they require (i.e., medications, therapy, etc.) due to a lack of services, limited service integration, and a lack of training among medical professionals.
- Homeless children cannot be treated by a pediatrician with the exception of pregnant girls and mothers, leaving many children without access to a doctor.
- Local hospitals are not as involved in homeless services as they once were.

Mitigating Resources:

Professionals serving homeless residents identified the following existing resources in their communities that they felt could improve the access to primary, preventive, dental, and mental health care:

- All Children's Hospital has identified homeless childrens' health needs as a community health need.
- Providers of services to the homeless collaborate well in Pinellas County.
- Service providers coax and encourage homeless residents to participate in their own healthcare.
- There are programs that help connect homeless residents to a medical home.
- There are literary resources and training available to help staff better understand the behaviors and needs of homeless residents (i.e., Bridges out of Poverty).
- BayCare has maintained a homeless diversion program in their emergency department.
- There are free services available in the community (i.e., health centers, mobile medical, health department, dental hygiene, etc.).

Group Suggestions/Recommendations:

Professionals serving homeless residents offered the following as possible solutions to help improve the access to primary, preventive, dental, and mental health care in their communities.

- ***Improve access to medical care:*** Participants believed that the homeless residents could have increased access to preventive and specialty care if local hospitals would partner with organizations that serve homeless residents to provide a set number of services for free or at a reduced cost. Also, participants believed that funding needs to be increased for the staffing and maintenance of the mobile medical unit to ensure it is operational and able to provide services regularly.

- ***Increase preventive efforts:*** Participants believed that there is limited focus on the prevention of health issues among the homeless residents and more of a focus on reactive acute care. Participants believed that local medical facilities would save money if they shifted their focus to prevention and early detection efforts among homeless residents.

- ***Increase the identification and services to homeless children:*** Participants believed that the school setting was the best place for homeless children to be identified and served. Participants recommended school-based health clinics that would provide medical and dental services to all students and their families. Also, participants believed that legislative measures should be taken to allow a pediatrician to see, diagnose, and treat a homeless child when there is no parent/guardian available.

- ***Funding for services should be increased at the state level:*** Participants believed that there is a need for legislative lobbying for an increase~~d~~ in funding for behavioral health services, prevention services, and Medicaid-based services. Participants were under the impression that

hospitals have a lobbying presence at the state legislature, which could help make funding increases a reality. Also, participants recommended developing a fund for homeless residents to tap into when no other program could cover their health need. Participants felt that hospitals and insurance companies could join forces with foundations to develop this fund.

- ***Increase the awareness of hospitals:*** Participants believed that hospitals would become engaged in the healthcare issues of the homeless population if they were aware of the amount of money homeless residents cost the local hospitals through the use of the emergency room and unpaid medical bills. Participants recommended making local hospitals aware of the cost to engage their support in resolving some of the health needs of homeless residents.

BEHAVIORS THAT IMPACT HEALTH:

Professionals serving homeless residents perceived that healthy behaviors in their communities are limited by resident awareness, access to healthy options, individual choices, behavior, and personal responsibility.

Perceived Contributing Factors:

- When funding is available to secure medical appointments and diagnostic tests for homeless residents, often providers have to then coax residents to schedule and attend appointments because homeless residents often lack trust in the medical industry, may be abusing substances illegally, experience discomfort around healthcare providers and/or in facilities that are not welcoming, individual circumstances (i.e., may be hiding from someone, etc.).
- The rate for prescription drug abuse in Pinellas County is high; making it difficult for hospice services to ensure a homeless resident is not in pain due to a typically high tolerance for narcotic compounds used in many pain medications.
- The behavior of homeless residents can be more destructive than other populations seen in the local hospitals, which can lead to reservations about all homeless people on hospital grounds.
- Homeless residents often make lifestyle choices (i.e., substance abuse, smoking, etc.) which may lead to chronic illnesses (i.e., Hepatitis C, dental health issues, etc.).
- Homeless residents often sell their medication or it is taken from them. It can be difficult for homeless residents to protect and hide medications.

Mitigating Resources:

Professionals serving homeless residents identified the following existing resources in their communities that they felt could improve the practice of healthy behavior:

- Service providers and shelters are striving to address dietary concerns with education and consultation.
- Some programs offer healthcare coordinators that will attend the first medical appointments with residents.

Group Suggestions/Recommendations:

Professionals serving homeless residents offered the following as a possible solution to help improve the practice of healthy behavior in their communities:

- ***Healthy behaviors could be incentivized:*** Participants felt that homeless residents are more likely to choose to improve their healthy behaviors if they have an incentive to do so. Participants recommended making healthy behaviors more fun, supportive, and engaging.

GAPS IN SERVICES FOR HOMELESS RESIDENTS:

Professionals serving homeless residents perceived that services for homeless residents impacted the health status of homeless residents in the following ways: program availability, loss of homeless residents in the service industry, poor health outcomes, and chronic illnesses.

Perceived Contributing Factors:

- Funding drives program specifications and eligibility requirements. Often, the funding that is available is very specific to situations, individual circumstances, and access points; which restricts the access many homeless residents have to healthcare resources.
- Often, homeless residents are treated differently than other patients at medical facilities due to the stigma associated with strong body odor, misbehavior of past patients with similar circumstances, mental illness, etc. Local medical facilities are not welcoming to homeless residents, and often, call security when a homeless resident is on the premises.
- Collaborative efforts in Hillsborough County may not be as effective as it needs to be.
- While service providers strive to work together to meet the needs of homeless residents in Pinellas County, there are times when the communication and/or network among providers breaks down and needs are not met. At these times, homeless residents may fall through the cracks and disappear from the service industry for lengthy periods of time. Often, when homeless residents resurface in the service industry, it is through an acute episode that has had negative consequences (i.e., overdose, police arrest, death, etc.).

Mitigating Resources:

Professionals serving homeless residents identified the following existing resource in their communities that they felt mitigate the impact of gaps in services to homeless residents on consequential health status:

- Service providers in Pinellas County collaborate on a monthly basis to identify the most efficient use of available resources.

Group Suggestions/Recommendations:

Professionals serving homeless residents did not offer solutions to improve the impact of gaps in services to homeless residents on the consequential health status of homeless residents in their communities.

APPENDIX A

Secondary Data Profile

St. Anthony's Hospital
November, 2012-May, 2013

APPENDIX B

Key Stakeholder Interview Response Set

St. Anthony's Hospital
October-November, 2012

1. How would you describe a healthy community?

1. All systems in community work together for citizens to get what they need – basics to survive and tools to thrive and grow and be empowered; also, addresses economic, political, physical issues – all of these work together. Education = key to this.
2. Access to appropriate healthcare, dental care and community health education.
3. A healthy community is an informed community that places health equity and equal opportunity for participation above all else. The opportunity for a healthy life must be accessible for all members. This upfront investment of resources ensures a strong future for our entire community.
4. Community where people find a meaningful existence in terms of jobs and culture and have access to things that enrich their lives.
5. A healthy community would be a community where there is access to healthcare services that focuses on both treatment and prevention for all members of the community;
6. Having access to healthcare at a reasonable price. Healthy community of senior citizens? Where there are resources once they are home – transportation, mentor program, programs to help them get around and remind them to get to appointments and just checking in on them, activities to keep their lives more normal.
7. The places where people live maximizes their potential to be healthy. Healthcare is accessible to all. People are healthy and the environment supports healthy people. There are social determinants of health also safety, access to healthy produce, education, and housing.
8. Everyone has equal access to healthcare. Community as a whole is emphasizing personal responsibility for their own healthcare and being active in their healthcare. Taking advantage of prevention and well care. A healthy community does not have billboards that advertise wait times in Emergency Rooms.
9. Vibrant, safe, walkable, with accessible parks and healthy foods. There is a population that is inclined toward physical activity. There is a healthy economy.

2. What are some specific health need trends locally/regionally?

1. Obesity, hypertension, diabetes.
2. Many more diabetic patients, significant number of patients with hypertension.
3. Certainly, the overweight/obesity epidemic is our top priority. We have been strategically developing evidence-based programs in partnership with our national association and local partners to address chronic disease prevention, particularly those with obesity as an indicator. Our Y has also been working tirelessly to end health disparities, specifically with the African American population and low- to moderate-income families. African American adults in our community are three times more likely to die from health complications related to type 2 diabetes and bear a disproportionate burden of the disease. African American teens in the St. Petersburg area are twice as likely to be overweight than their peers. In Pinellas county, the African American population is more than double the state average. In two of the neighborhoods our Y serves, African Americans account for over 80% of the population.
4. COPD, substance abuse.
5. Lack of capacity for dental care, education of treatment of diabetes and high blood pressure, mental illness, wound care, and substance abuse.
6. Acute care setting – huge gap in services, in hospital – good planning with social worker but once discharged, there's nothing to continue to motivate them to continue to go to physician's appointment.

7. Cancer has become the number four killer chronic disease. The uninsured has increased significantly over the last two years. Survey showed top needs in the county are D/A substance abuse, chronic disease, and behavioral health. Chronic disease due to lifestyles, accidental deaths. Pinellas county is small and densely populated, violence is high and suicide rates are high. Pinellas county is an aging county. Poverty is an indicator of poor overall health due to the economic barriers that exist in areas of highly concentrated poverty (five zones have been identified of highest concentration of poverty in the county.
8. Specialty care is a huge access issue for the underserved, uninsured, underinsured, working poor. Behavioral healthcare and its integration with primary care. Access to dental care (preventive, surgical, and treatment). Even those with health insurance do not have a dental component.
9. Lack of health insurance causes a lack of access to healthcare. Obesity is an issue that causes high-cholesterol, diabetes, etc. Substance abuse particularly with prescription drugs.

3. Which target populations locally/regionally do you believe have such health needs?

1. Underinsured or no insurance at all.
2. Those who fall through the cracks – no Medicaid, Medicare, not poor enough to qualify for county health plan, middle-class falling.
3. Children, seniors, African Americans, those with pre-diabetes, those recently diagnosed with cancer, hypertensive patients, adults with a BMI greater than 25. Currently 65.2% of the population of Pinellas County is considered overweight with 36% qualifying as obese.
4. Chronically unemployed, many people who exist on the margins, some kind of social services, but healthcare is difficult to access.
5. The working poor and the homeless and anyone without health insurance.
6. Patients in the 75+ range, Medicaid and welfare population.
7. Uninsured; Residents in areas of the highest concentration of poverty.
8. Chronically ill, homeless and non-English speaking. Subset of patients that go for behavioral health treatment because it is required in order to receive meds but they do not seek medical care.
9. African Americans (Obesity and infant mortality); General population; 50-60 year olds that have retired.

4. In order to improve the health of communities, please talk about some of the strengths / resources that communities locally/regionally have to build upon. List strengths / resources that can be built on and describe how those strengths / resources could be used.
Strength #1:

1. Strong collaborations between all organizations
2. Free clinic doing a lot of good, meeting significant amount of primary healthcare needs
3. Current evidence-based programming can and should be leveraged among partnering organizations to prevent further proliferation of preventable chronic disease. The YMCA's Diabetes Prevention Program is one example of available programming that is currently available. It is only through strategic partnerships that this program can reach its fullest impact potential.
4. Health Dept needs to expand its services
5. Multiple access to healthcare throughout Pinellas County. This avoids the transportation issue.
6. Social Services question.
7. Rich in resources with info sharing.

8. Community health centers. Six locations in community. Looking at expanding. Provide care regardless of ability to pay. Really begin to change people's health outcomes. We have the capacity. Working with hospitals. They refer uninsured patients with no medical home to our health center. If we could expand to include insured patients with no medical home. Currently, not very good for insured with no medical home.
9. Increased collaborations recently formed that share information across geographies and that movement is gaining momentum.

Strength #2:

1. BayCare supporting outside organizations such as Faith Community Nursing.
2. Wonderful park system with many outdoor opportunities, walking/running/biking + great YMCA creating more outreach.
3. Access to fitness facilities and outdoor recreation. YMCA membership & programming is offered on a sliding-scale based on qualifying income. The City of St. Petersburg's Parks and Recreation department offers free access to outdoor fitness equipment, playgrounds, pools, trails, and blue ways. Both of these resources are available in the City of St. Petersburg proper, through strategic partnering we believe that same services can and should be available throughout the rest of Pinellas county, especially in the smaller cities and towns that may lack the resources on their own.
4. No answer.
5. Collaborations.
6. Social Services question.
7. Transportation is available in Southern Pinellas.
8. Hospitals have access to specialists, more so than community health centers. Our patients don't see a specialist unless they end up in the hospital. If we could get our patients seen by specialists, it could go a long way to prevent hospital stays. How could that be better optimized?
9. Hospital consolidation increasing which leads to efficiencies and allows issues to be better identified and addressed.

5. In your opinion, what do you think are the two most pressing health needs facing residents in local/regional communities you serve, especially the underserved? Please explain why.

Community Issue #1:

1. Limited finances - huge homeless population, behavioral health population.
2. Access to specialty medical care (physicians and diagnostics/outpatient).
3. Overweight/Obesity. Again 65.2% of the population in our county is overweight with 36% being obese. It is critical that we curb the epidemic or we will continue to see a rise in the number of persons developing chronic conditions.
4. Affordable housing
5. Need for follow-up care. People are released from the ER or hospital that have no insurance and there is little to no follow-up.
6. Social services question.
7. Service industry in the area – are lower paying jobs with out insurance benefits.
8. Community as a whole, awareness that medical is not just treatment but also prevention. There is a mindset that you only need to go to the doctor when you are sick. As a result, the community is sicker and heavier. And by the time they do see a doctor they are so sick that it is detrimental to them and costly to the community.
9. Obesity/pre-diabetic and diabetic – stems largely from the lack of education and prevention.

Community Issue #2:

1. Individuals not having the correct information about what services are out there. This is also because a lack of trust.
2. Lack of coverage for dental care.
3. Preventive Healthcare. It's vital to ensuring early diagnosis and treatment of certain health conditions prior to them becoming chronic. Many of the LMI population does not have access to preventive care/diagnostic testing.
4. Unemployment - at least 9% in the area, many who want to work but are unable to find work.
5. The underserved have generally had no preventive care and they are high risk.
6. Social services question.
7. There is limited collaboration among counties. Substance abuse was the number one issue recognized in the health survey across Pinellas County, with prescription drug use and overdosing. There are not enough resources for mental health and substance abuse services. The services that do exist are stigmatized, have waiting lists and are apart from primary medical facilities.
8. Community messaging and branding. Difficult time educating the community and getting them to appreciate the message being given about immunizations. Billboards saying that you can text the ER to find out wait times is sending the wrong message. Healthy foods are not as available as other choices.
9. Behavioral health – depression impacts a persons health and may increase risk for drug use. There is a larger vet population and higher senior rates in the community all of which tend to have higher rates of depression and suicide.

6. In response to the issues that were identified, who do you think is best able to address these issues/problems? How do you think they could address these issues/problems?

1. Public Health Dept. and some of the organizations mentioned previously are doing their best with the funds they have; also NAACP health commission is new to the area and are doing their best to address health issues in the community.
2. Unsure.
3. There is no one organization that can solve our communities health crisis. It is imperative that private, public, and non-profit entities partner to form a collaborative team to address our community's growing health needs. It is my belief that our strengths can be combined for optimal success and the highest level of achievable impact to be realized.
4. No answer.
5. Collaboration of Community providers, Government Officials, and Hospital policymakers.
6. Social services question.
7. n/a.
8. Pinellas has 28-32 municipalities, and it is not easy to get anything done locally to change laws. Engage local officials on what we value as healthcare. Hospitals can put pressure on those advertising ER wait times, letting them know that is the wrong message to send. It's the for profit hospitals that pay for the billboards.
9. Any organization that deals directly with these population (i.e., federally qualified clinics, YMCAs, free clinics, etc.); Behavioral health-Employers need to provide better coverage to employees and better educate employees; Hospitals can make diabetics more aware of the resources that are available to them.

7. **do you believe there are adequate local/regional resources available to address these issues/ problems? If no, what is your recommendations?**
    1. See above.
    2. Unsure.
    3. Yes, however, private organizations must become invested now in order to make the necessary impact.
    4. No answer.
    5. Lack of capacity for respite beds and for preventive care.
    6. Social services question.
    7. No. Need more collaboration among local and county governments.
    8. Yes.
    9. Connections to the resources that exist is key. Need a movement to educate the messes however, which would require marketing and branding dollars. The message is out there but it is not being received or implemented. Reaching children in the schools is a longer term solution, whereas shorter term don't know.

8. **Do you see any emerging community health needs, especially among underserved populations, that were not mentioned previously? (Please be as specific as possible)**
    1. Childhood obesity – just starting to see the effects and this is going to increase; autism spectrum/behavioral issues becoming more prevalent.
    2. Most prevalent ones touched upon.
    3. Chronic Disease Management for LMI populations. The resources, for the most part, are available. Most don't know where to turn. We believe, again, that private health organizations and employers must be both informed and become willing to partner/refer to/support the non-profits taking the lead in addressing these needs.
    4. Mental health is an issue - Tampa/St. Pete - one of the highest rates of depression in the nation.
    5. More severe mental health problems and little capacity to assist.
    6. Florida Medicaid - state has cut back significantly, so people are now much sicker than before when they enter the healthcare system and also don't get adequate follow-up care; welfare patient - need to transfer to higher level of care, very difficult to get them accepted into hospital systems; pediatric patients have access but once they hit 21, services are essentially cut off.
    7. No answer.
    8. Number of women giving birth to babies with addiction issues. Abusing prescription drugs and narcotics. Pharmacy needs for uninsured patients. Prescription assistance applications. Reduces who they provide it too. Currently, it is only available to patients on the County's indigent health plan. County Commissioner's wanted to take fluoride out of in the water. They did and it will cause dental issues. Maybe the new administration can get that turned around.
    9. Pre-diabetic and the underserved are larger numbers and will increase the need for resources. Also need better inner-city planning to make communities walkable and developing the infrastructure that supports physical activity.

9. **Please describe your vision of what the health status locally/regionally should be in within five-10 years?**
    1. Does not see it improving; No one knows what is going to happen with the impact of healthcare reform/ going to need to go through growing pains to get to a better place.

2. Sees status will probably get worse because she doesn't see increasing funding sources from county or local government; BayFront medical center is being merged into a for-profit medical center and she sees this as a risk.
3. The YMCA of Greater St. Petersburg believes that the Healthy People 2020 objectives give a clear and reasonable blueprint for a successful tomorrow.
4. Healthcare access will improve under the President's plan for low-income individuals
5. Greater access to preventive healthcare, effective collaborations that treat body, mind, and spirit.
6. Sees status declining; employers used to pay a large chunk of health insurance. This now falls on the shoulders of the average worker (paying high deductibles) and they now tend to ignore health problems until things are too severe.
7. There will be health insurance for all and improved health outcomes. Healthcare will become more preventive and less reactive.
8. Total paradigm shift from how the residents think about health. People don't realize what is available. Families don't know about resources that county offers or that they may be eligible for medical insurance.
9. That this region will become nationally known for its commitment to become healthier

10. Do you have any existing data resources (such as reports, survey data, etc.) that you think would be beneficial to use in our research?

1. Has stats on number of individuals served during screenings.
2. No
3. Yes
4. No
5. No
6. No, not allowed to release data
7. No
8. Economic Impact on Poverty; Community health indicators report (any county in country); BRFSS stat's health dept website infant mortality, health and prevention data. Public
9. No

Would you be willing to get us a copy or tell us how to access these documents?

1. Yes
2. n/a
3. Yes
4. n/a
5. n/a
6. n/a
7. n/a
8. n/a
9. n/a

11. Any additional comments or questions?

APPENDIX C

Community Resource Inventory

St. Anthony's Hospital
May, 2013