Community Health Needs Assessment
Polk County
2022

All4HealthFL
Four Counties. One Vision.

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

Winter Haven Women's Hospital

Prepared by Conduent Healthy Communities Institute

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Letter from the All4HealthFL Collaborative

To the citizens of Polk County,

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

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

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

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

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

Sincerely,

The All4HealthFL Collaborative

COMMUNITY HEALTH NEEDS ASSESSMENT
At a Glance: Polk County

Secondary Data

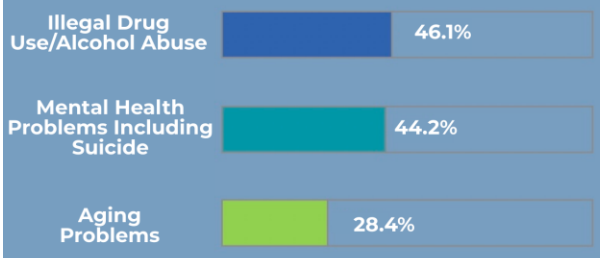
- Access to Health & Social Services
- Cancer
- Heart Disease & Stroke
- Behavioral Health (Mental Health & Substance Misuse)
- Exercise, Nutrition & Weight
- Immunizations & Infectious Diseases

Primary Data/Community Input

Community Health Survey

Polk County had **1,454** Community Survey Respondents

Top Health Issues:



Focus Group Discussions

Polk County conducted **5** Focus Groups

> We [providers] have to see patients beyond the diagnosis. They have a lot to contribute as human beings, and their journey has been difficult and their journey has been all about resistance.
>
> -Focus Group Participant

Health Equity

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

Introduction & Purpose

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

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

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

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

Acknowledgments

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

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

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

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

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

All4HealthFL Collaborative

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

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

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

Evaluation of Progress Since Previous CHNA

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

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

Collaborative Achievements

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

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

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

Community Feedback from Preceding CHNA & Implementation Plan

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

Demographics of Polk County

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

Geography and Data Sources

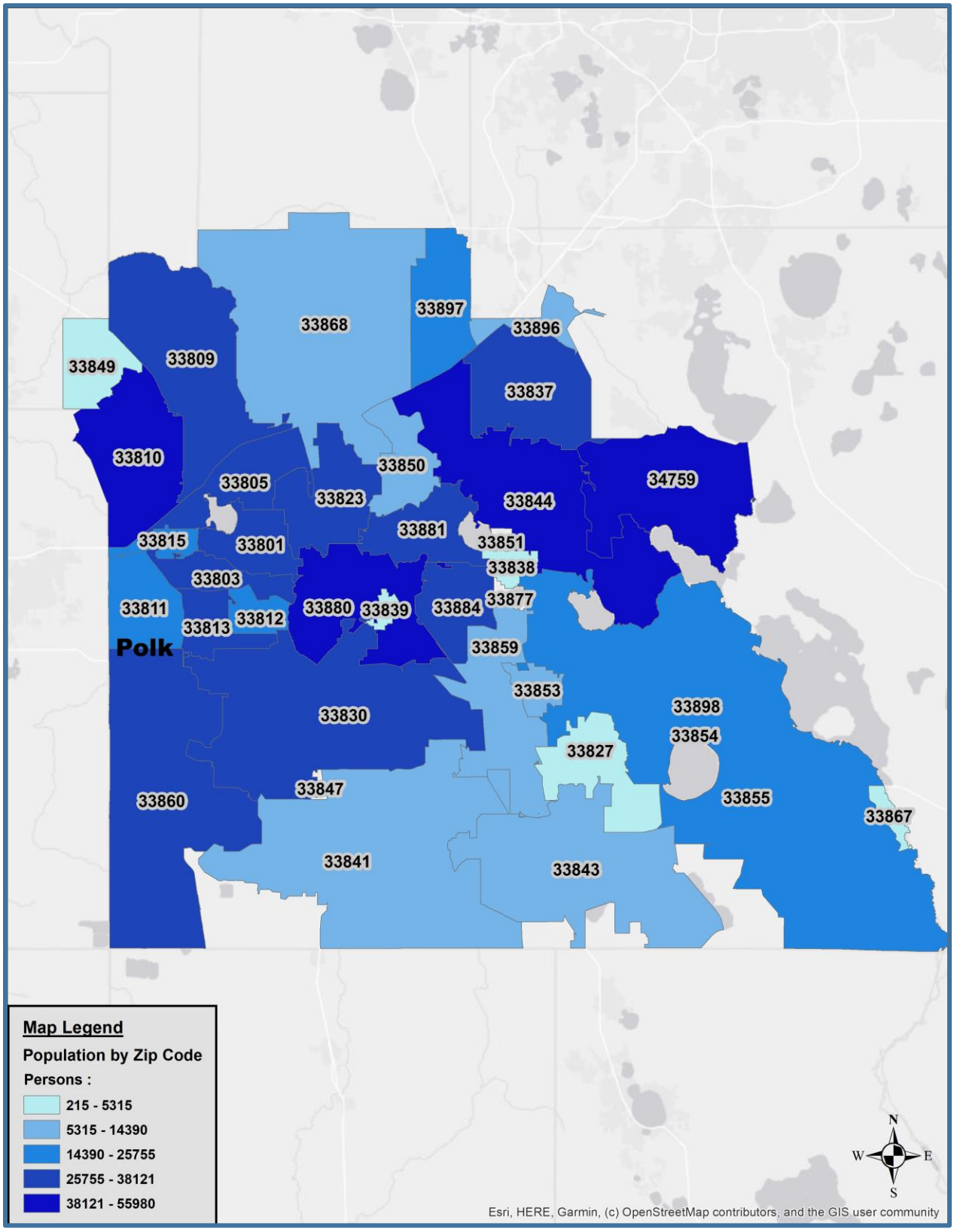
Data is presented in this section at the geographic level of Polk County. Comparisons to the county, state, and national value are also provided when available. All demographic estimates are sourced from Claritas Pop-Facts® (2022 population estimates)[1] and American Community Survey[2] one-year (2019)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

Population

According to the 2022 Claritas Pop-Facts® population estimates, Polk County has an estimated population of 753,298 persons. Figure 1 shows the population size by each ZIP code, with the darkest blue representing the ZIP codes with the largest population. Appendix A provides the actual population estimates for each ZIP code. The most populated ZIP code area within the Polk County is ZIP code 33810 (Lakeland) with a population of 55,980.

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

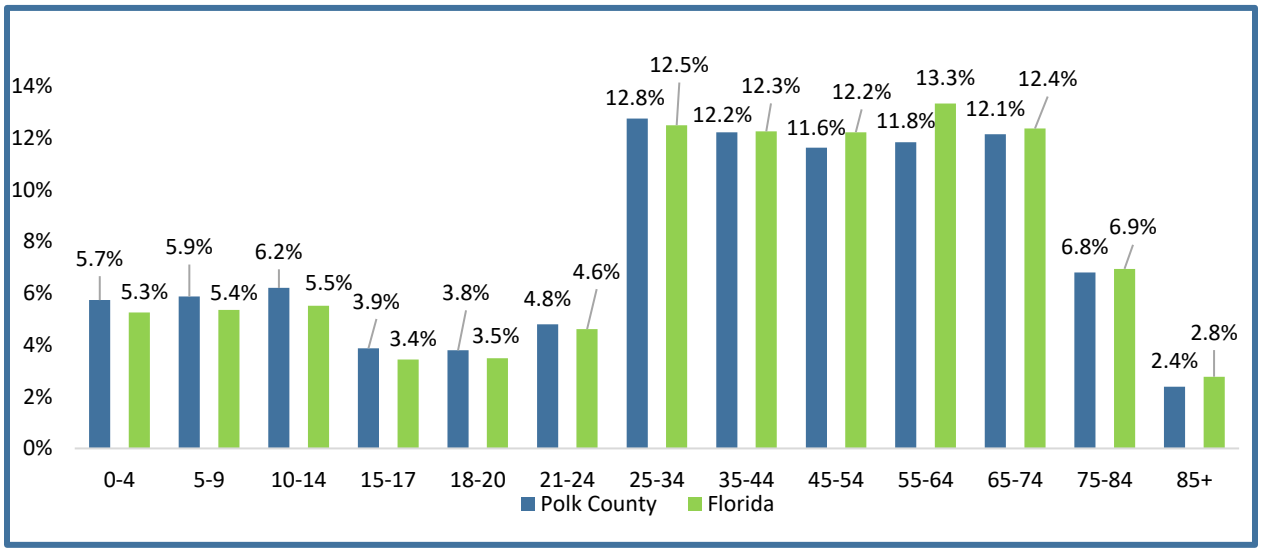
Figure 1. Population by ZIP Code: Polk County



Age

Children (0-17) comprised (21.7%) of the population in Polk County. When compared to Florida (19.6%), Polk County has higher proportion of children age (0-17). When compared to the U.S. (22.4%), Polk County has lower proportion of children population age (0-17). There are (21.3%) of residents age 65+. Polk County has lower proportion of elder population (age 65+) when compared to Florida (22.1%), and lower proportion when compared to the U.S. (16.0%). Figure 2 shows further breakdown of age categories.

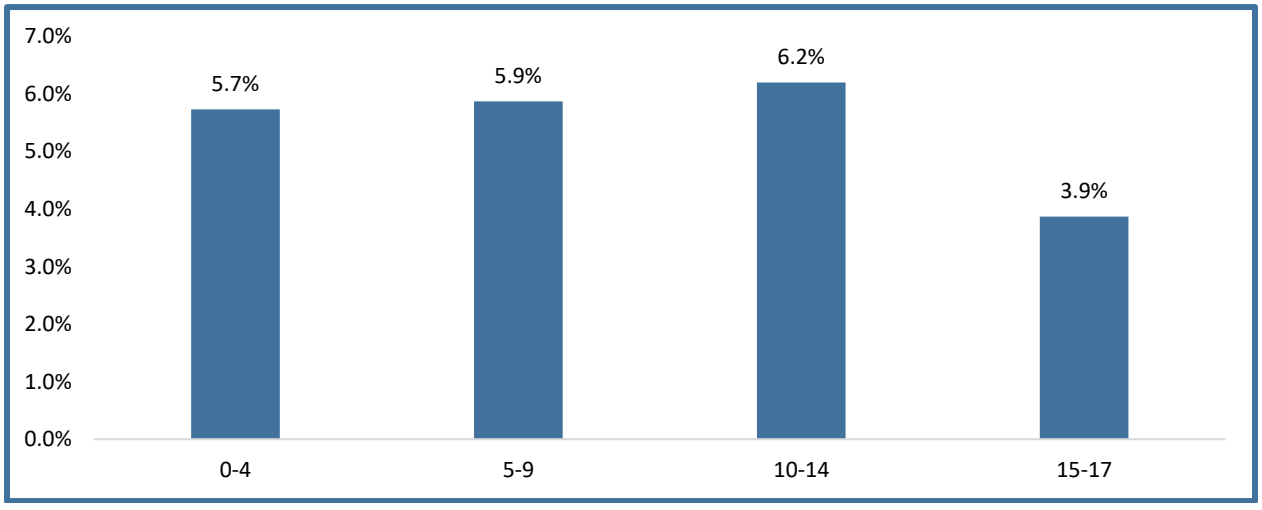
Figure 2. Population by Age: County and State Comparisons



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

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

Figure 3. Population by Age Under 18: Polk County

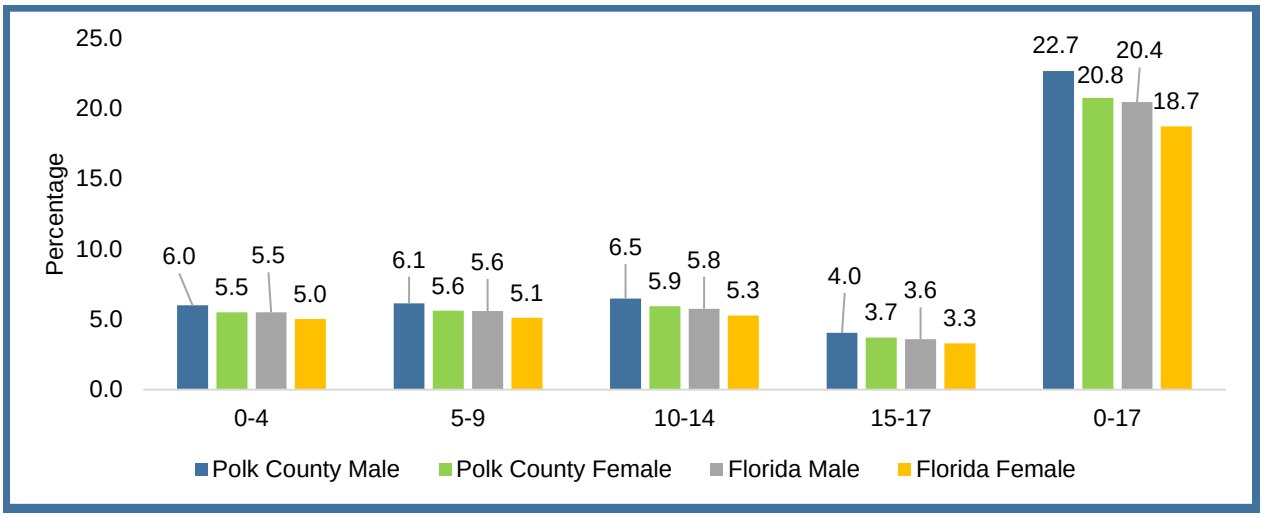


*County values- Claritas Pop-Facts® (2022 population estimates)

Sex

Figure 4 shows the children (under 18) population of Polk County by sex. In Polk County, male children comprise (22.7%) of the population, whereas female children comprise (20.8%) of the population which is higher in proportion when compared to males (20.4%) and females (18.7%) in Florida.

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



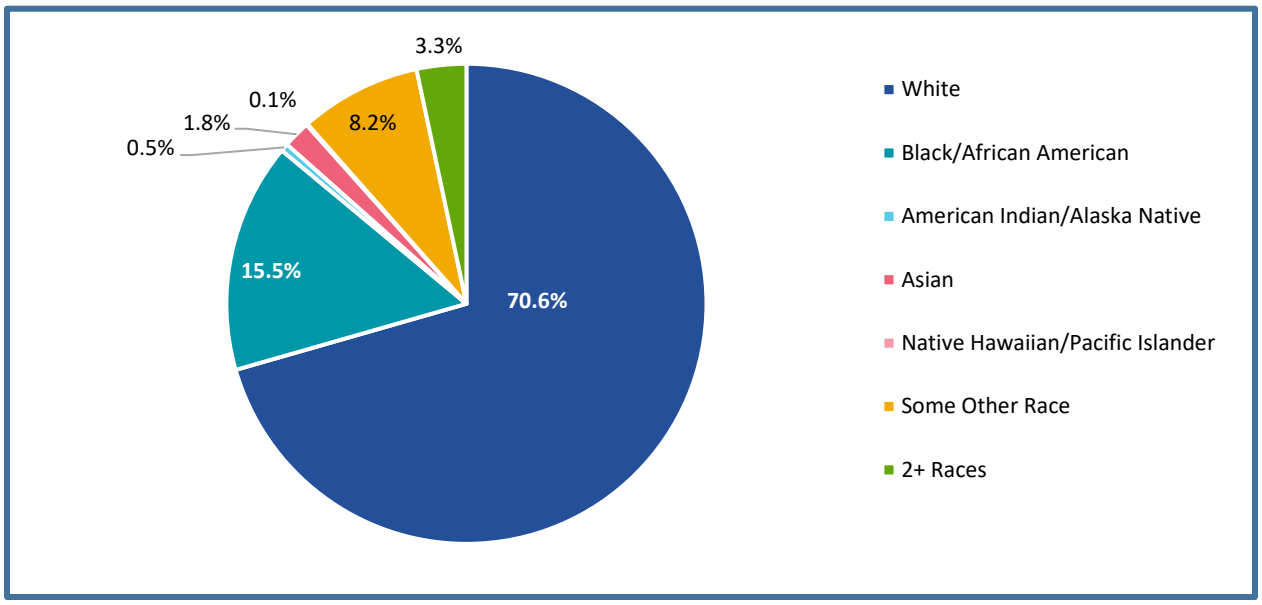
*County values- Claritas Pop-Facts® (2022 population estimates)

Race and Ethnicity

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

The racial makeup of the Polk County area shows (70.6%) of the population identifying as White, as indicated in Figure 5. The proportion of Black/African American community members is the second largest of all races in the Polk County at (15.5%).

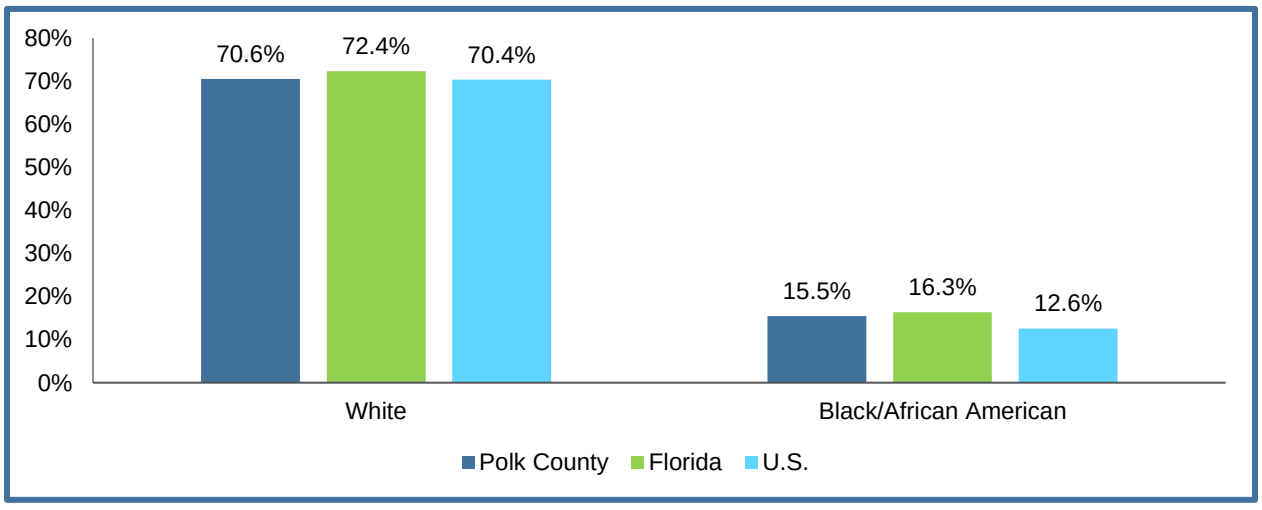
Figure 5. Population by Race: Polk County



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

Those community members identifying as White (70.6%) represent a lower proportion of the population in the Polk County when compared to Florida (72.4%) and is slightly higher when compared to the U.S. (70.4%). Black/African American (15.5%) community members represent a lower proportion of the population when compared to Florida (16.3%) and higher proportion when compared with the U.S. (12.6%) (Figure 6).

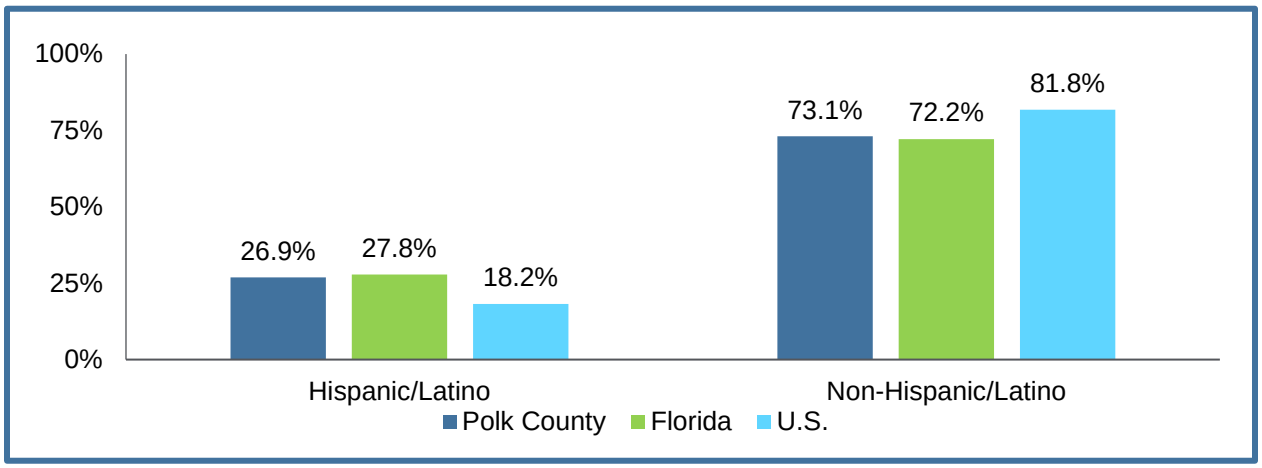
Figure 6. Population by Race: Polk County, State, and U.S. Comparisons



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

As shown in Figure 7 (26.9%) of the population in Polk County identify as Hispanic/Latino. This is a smaller proportion of the population when compared to Florida (27.8%) and larger proportion when compared with the U.S. (18.2%)

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



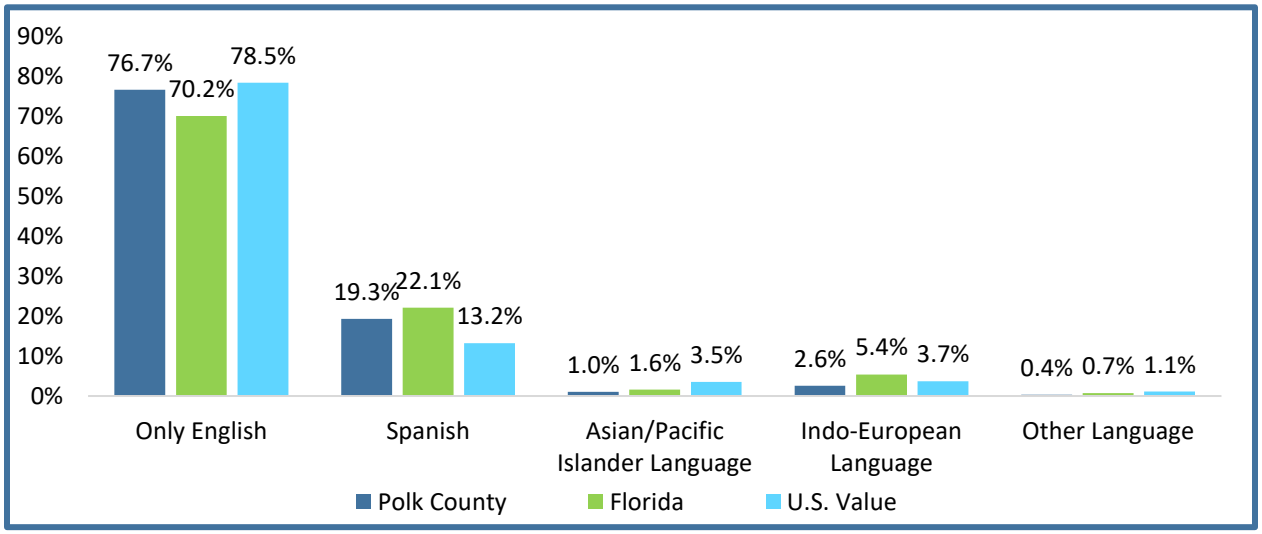
*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

Language and Immigration

Understanding countries of origin and language spoken at home can help inform the cultural and linguistic context for the health and public health system. According to the American Community Survey (10.5%) of residents in Polk County are born outside the U.S., which is lower than the national value of (13.6%).[3]

In Polk County, (76.7%) of the population age five and older speak only English at home, which is higher than the state value of (70.2%) and lower the national value of (78.5%) (Figure 8). This data indicates that (19.3%) of the population in Polk County speak Spanish, and (0.4%) speak other languages than English at home.

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

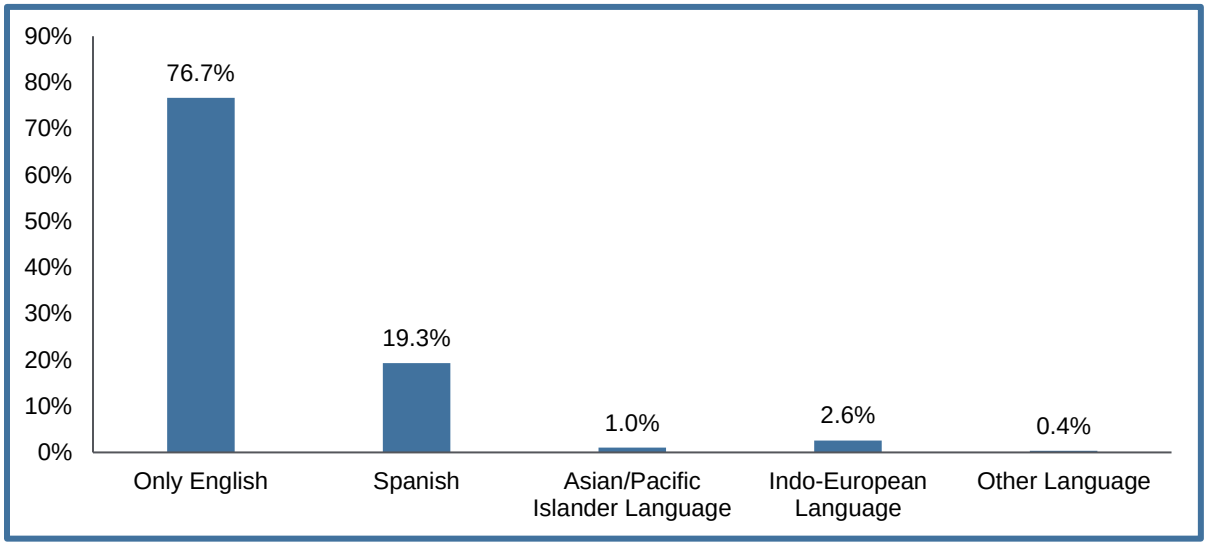


*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

[3] American Community Survey, 2016-2020

The most common languages spoken at home are English (76.7%), Spanish (19.3%), and Indo-European languages such as French, Portuguese, Russian, and Dutch[4] (2.6%) in Figure 9.

Figure 9. Population 5+ by Language Spoken at Home: Polk



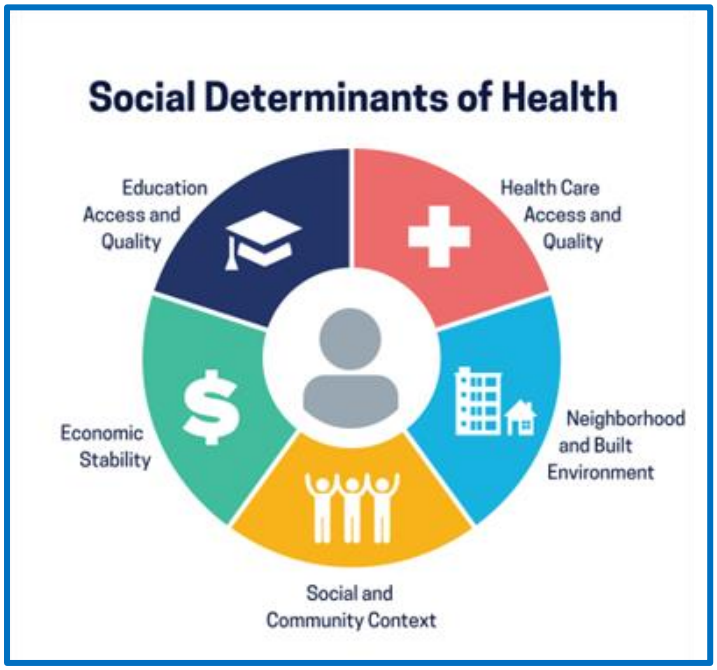
*County values- Claritas Pop-Facts® (2022 population estimates)

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

Social & Economic Determinants of Health

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

Figure 10. Healthy People 2030 Social Determinants of Health Domains



Geography and Data Sources

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

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

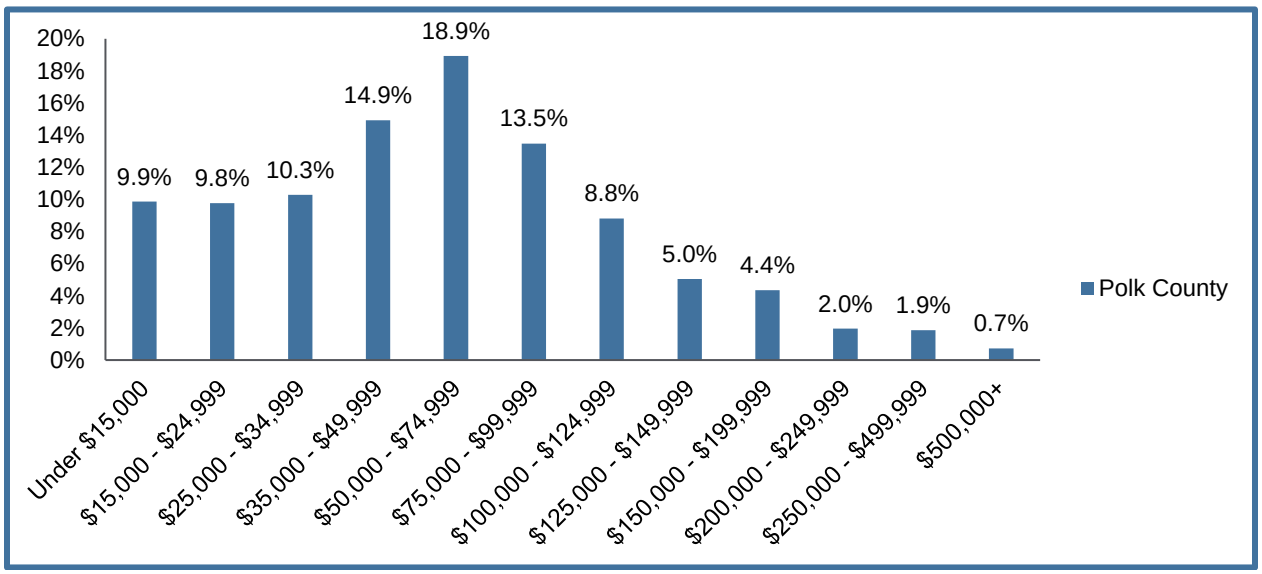
Income

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

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

Figure 11 provides a breakdown of households by income in Polk County. A household income of $50,000 - $74,999 is shared by the largest proportion of households in Polk County (18.9%). Households with an income of less than $15,000 make up (9.9%) of households in Polk County.

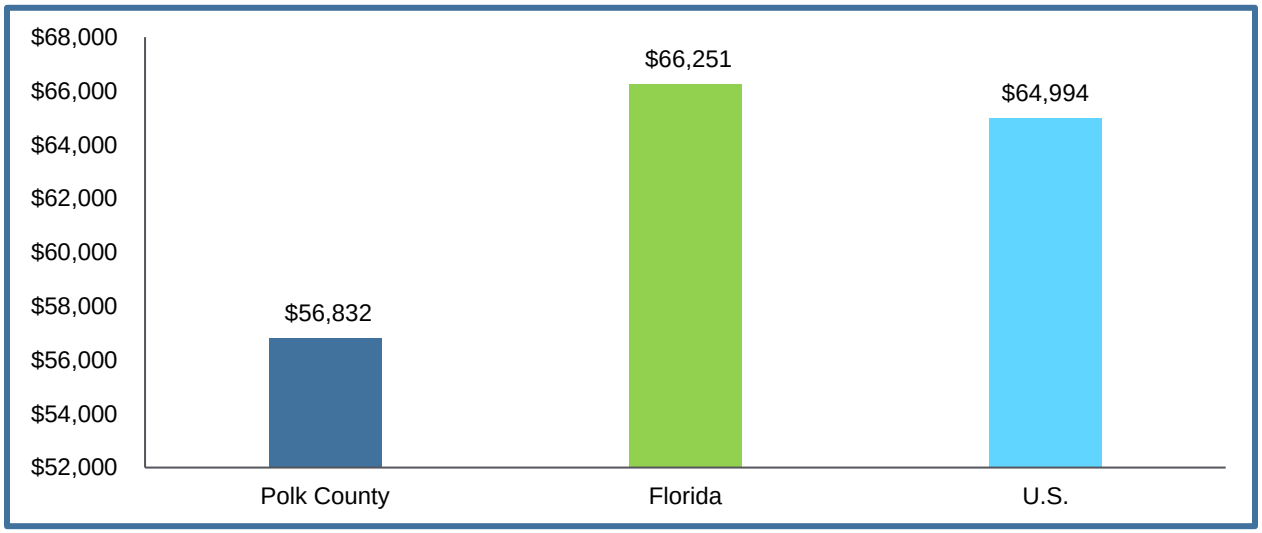
Figure 11. Households by Income, Polk County



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

The median household income for the Polk County is $56,832, which is much lower than the state value of $66,251 and national value of $64,994 (Figure 12).

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

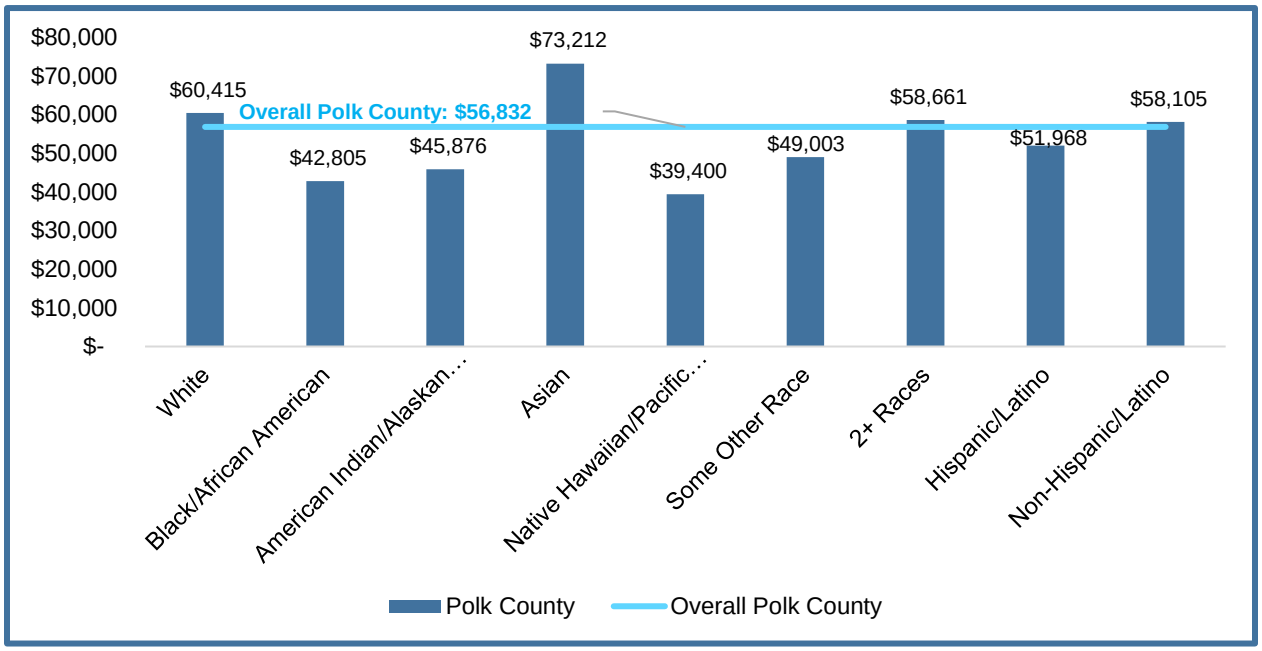


*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

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

Figure 13 shows the median household income by race and ethnicity. Four racial/ethnic groups – White, Asian, 2 or more races, and Non-Hispanic/Latino – have median household incomes above the overall median value. All other races have incomes below the overall value, with the Native Hawaiian/Pacific Islander and Black/African American populations having the lowest median household income at $39,400 and $42,805 respectively.

Figure 13. Median Household Income by Race/Ethnicity, Polk County



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

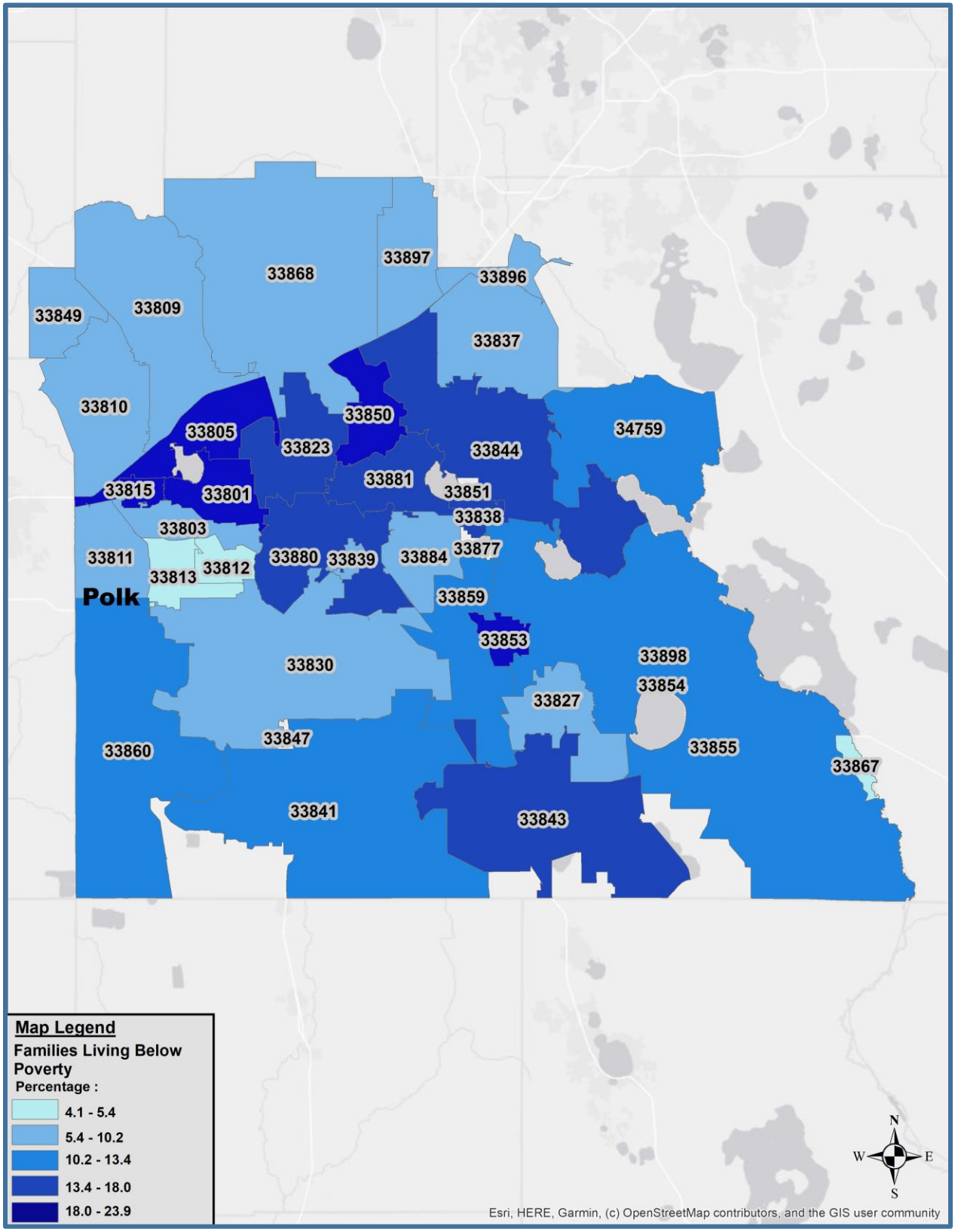
Poverty

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

Figure 14 shows the percentage of families living below the poverty level by ZIP code. The darker blue colors represent a higher percentage of families living below the poverty level, with ZIP codes 33805 (Lakeland) and 33801 (Lakeland) having the highest percentages at (23.9%) and (19.62%). Overall, (10.6%) of families in the Polk County live below the poverty level, which is higher than both the state value of (9.3%) and the national value of (9.1%). The percentage of families living below poverty for each ZIP code in Polk County is provided in Appendix A.

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

Figure 14. Families Living Below Poverty Level: Polk County



Employment

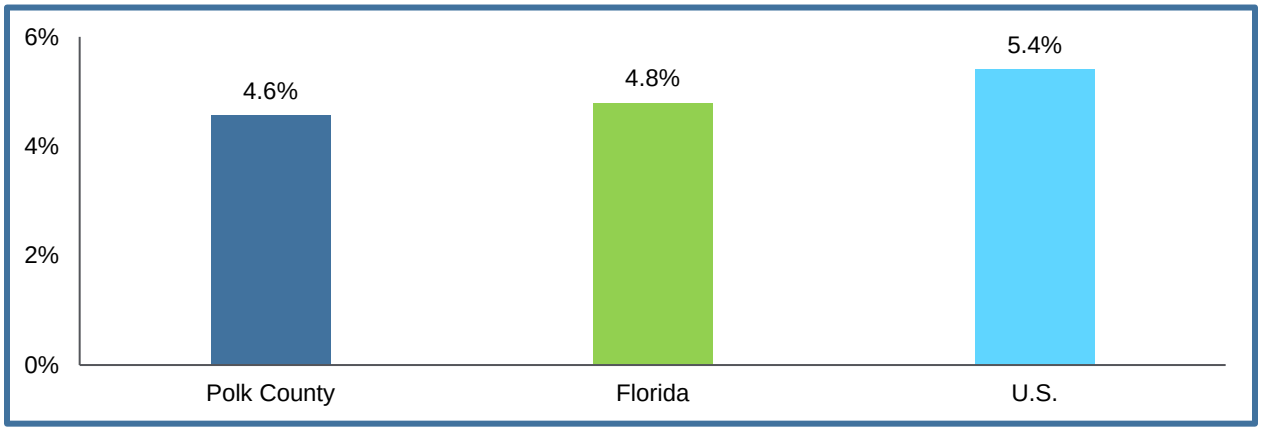
A community's employment rate is a key indicator of the local economy. An individual's type and level of employment impacts access to health care, work environment, health behaviors, and health outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast,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

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

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

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

Figure 15. Population age 16+ Unemployed



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

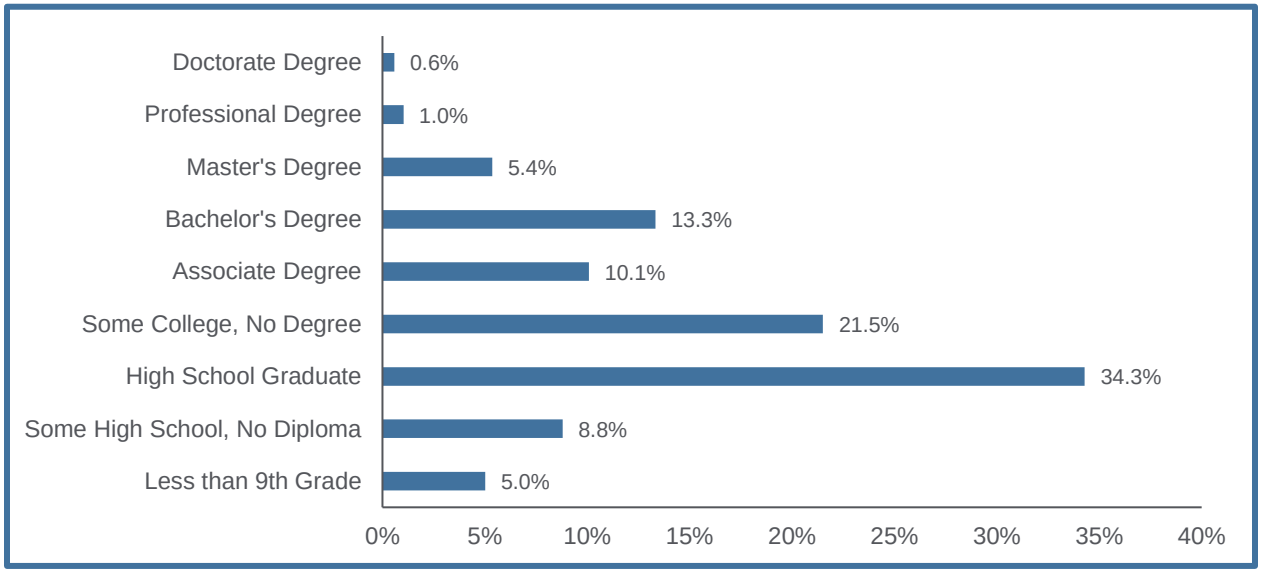
Education

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

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

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

Figure 16. Population age 25+ by Education Attainment, Polk County

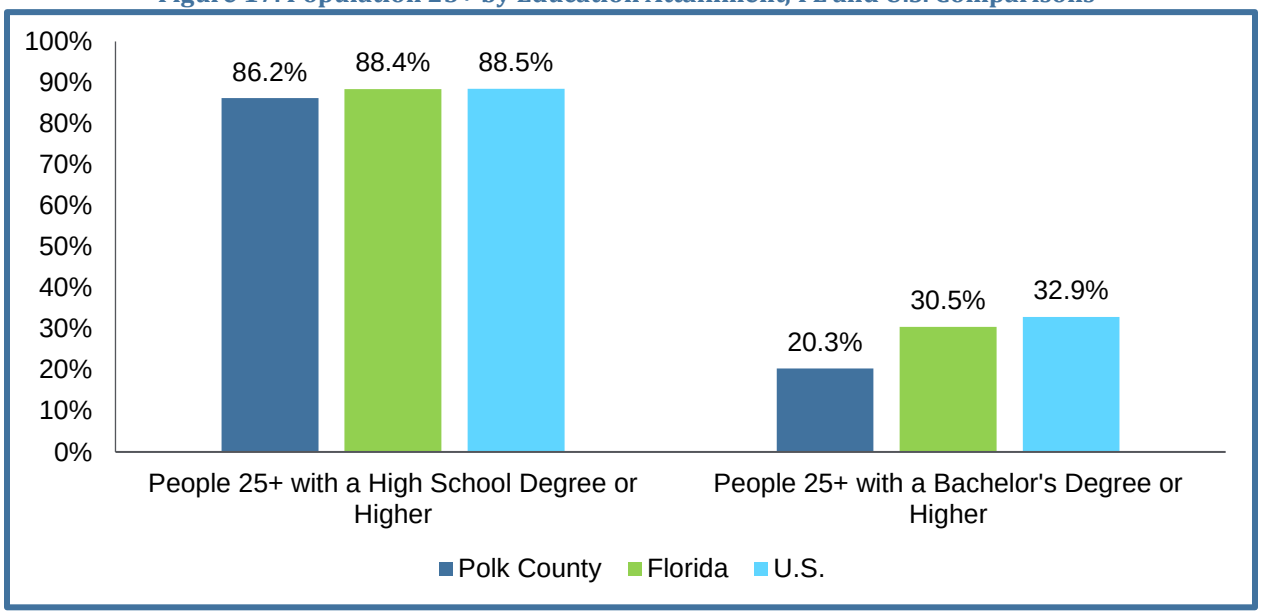


*County values- Claritas Pop-Facts® (2022 population estimates)

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

Figure 17 shows that Polk County has a lower percentage of residents with a high school degree or higher (86.2%) and Bachelor's Degree or higher (20.3%) when compared to the state and national values.

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



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

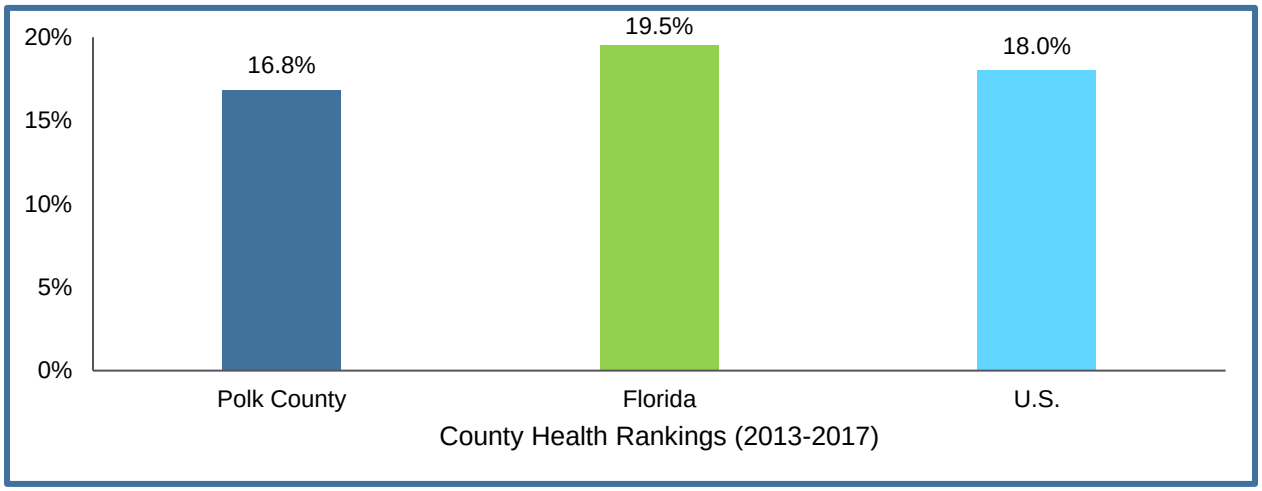
[9] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/high-school-graduation

Housing

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

Figure 18 shows the percentage of houses with severe housing problems. This indicator measures the percentage of households with at least one of the following problems: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities. In Polk County, (16.8%) of households were found to have at least one of those problems, which is lower than the state value (19.5%), but slightly higher than the national value (18.0%).

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



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

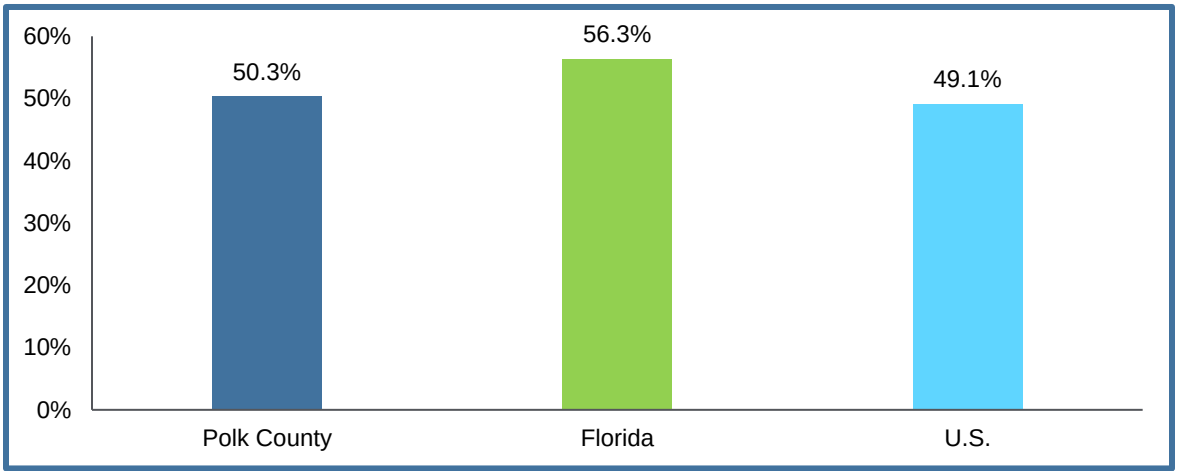
When families must spend a large portion of their income on housing, they may not have enough money to pay for things like healthy foods or health care. This is linked to increased stress, mental health problems, and an increased risk of disease.[11]

Figure 19 shows the percentage of renters who are spending 30% or more of their household income on rent. The value in Polk County, (50.3%), is higher than the national value (49.1%), and lower than the state value (56.3%).

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

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

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



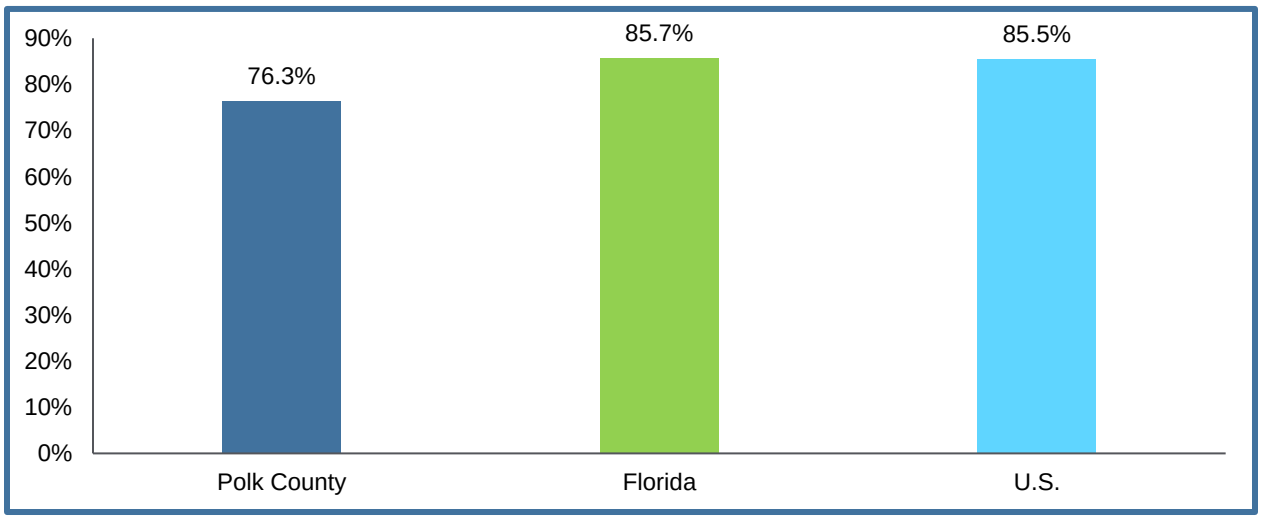
*County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

Neighborhood and Built Environment

Internet access is essential for basic health care access, including making appointments with providers, getting test results, and accessing medical records. Access to the internet is also increasingly essential for obtaining home-based telemedicine services.[12]
Internet access may also help individuals seek employment opportunities, conduct remote work, and participate in online educational activities.[12]

Figure 20 shows the percentage of households that have an internet subscription. The rate in Polk County, (76.3%), is lower than the state value (85.7%) and the national value (85.5%).

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



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

Disparities and Health Equity

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

Health Equity

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

Race, Ethnicity, Age & Gender Disparities

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

Secondary Data

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

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

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

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

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

Health Indicator	Group Negatively Impacted
Adults with Current Asthma	Black/African American, Female
Adults with Diabetes	Black/African American, Hispanic/Latino
Age-Adjusted Death Rate due to Kidney Disease	Black/African American
Age-Adjusted Death Rate due to Prostate Cancer	Black/African American, Hispanic/Latino
Age-Adjusted Death Rate due to Suicide	White, Male
Children Living Below Poverty Level	Black/African American, American Indian/Alaska Native, Other Race, Hispanic/Latino
Families Living Below Poverty Level	Black/African American, American Indian/Alaska Native, Native Hawaiian, More than one Race, Other Race, Hispanic/Latino
HIV Incidence Rate	Black/African American, Male
Infant Mortality Rate	Black/African American
Melanoma Incidence Rate	White
Oral Cavity and Pharynx Cancer Incidence Rate	White
People 65+ Living Below Poverty Level	Black/African American, Asian, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, More than on Race, Other Race, Hispanic/Latino
Per Capita Income	Black/African American, Other Race, Hispanic/Latino
Workers Commuting by Public Transportation	White, Asian, Native Hawaiian/Pacific Islander, Multiple Races

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

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

Geographic Disparities

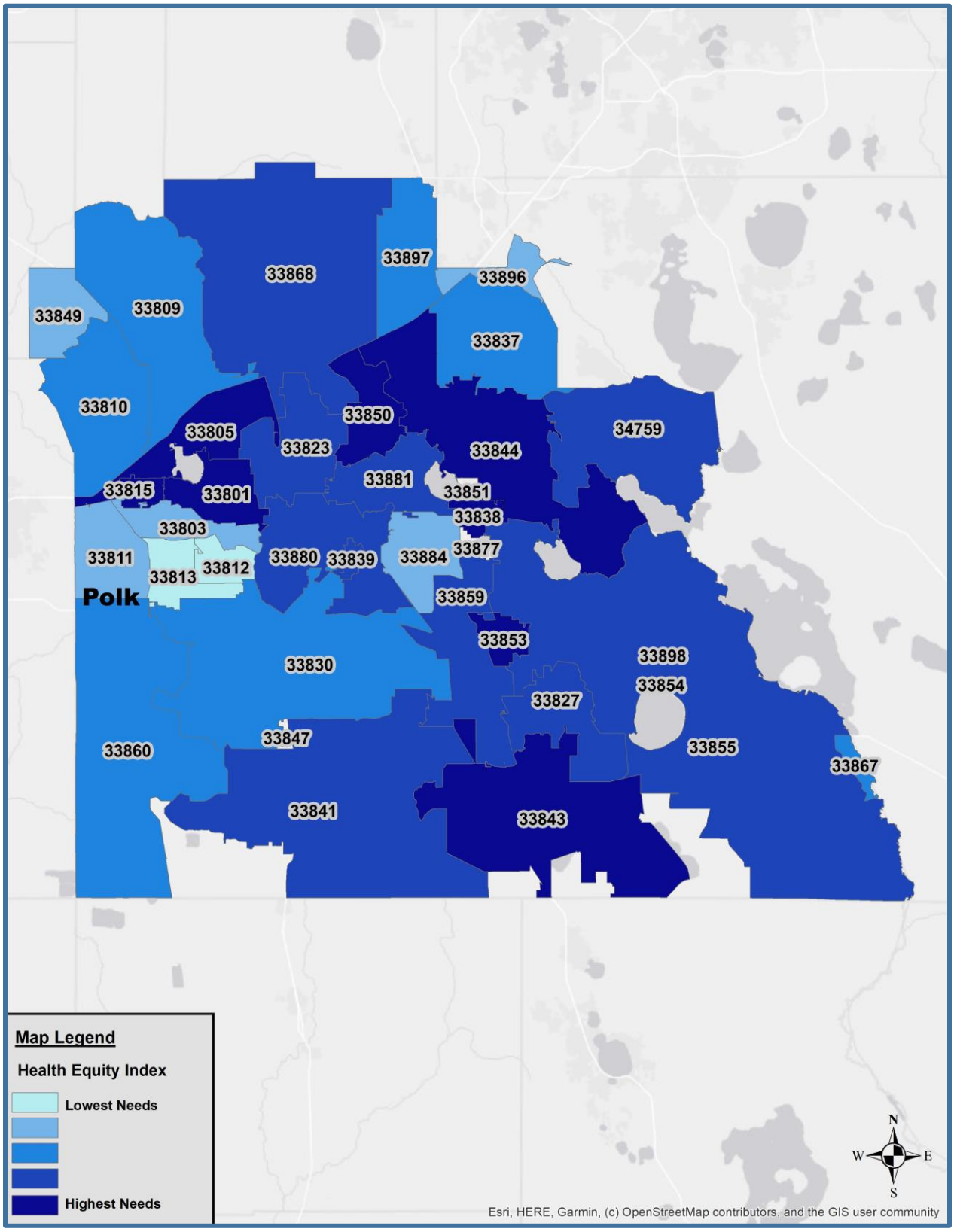
In addition to disparities by race, ethnicity, age, and gender, this assessment also identified specific ZIP codes/municipalities with differences in outcomes related to health and social determinants of health. Geographic disparities were identified using the Health Equity Index, Food Insecurity Index, and Mental Health Index. These indices have been developed by Conduent Healthy Communities Institute to easily identify areas of high socioeconomic need, food insecurity, and mental health need. Conduent's Health Equity Index estimates areas of highest socioeconomic need correlated with poor health outcomes. Conduent's Food Insecurity Index estimates areas of low food accessibility correlated with social and economic hardship. Conduent's Mental Health Index (MHI) is a measure of socioeconomic and health factors correlated with self-reported poor mental health.

For all indices, counties, ZIP codes, and census tracts with a population over 300 are assigned index values ranging from 0 to 100, with higher values indicating greater need. Understanding where there are communities with higher need is critical to targeting prevention and outreach activities.

Health Equity Index

Conduent's Health Equity Index estimates areas of high socioeconomic need, which are correlated with poor health outcomes. ZIP codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 21. The following ZIP codes in Polk County had the highest level of socioeconomic need (as indicated by the darkest shades of blue): 33853 (Lake Wales) and 33856 (Nalcrest) with index values of 93.6 and 92.8, respectively. Appendix A provides the index values for each ZIP code.

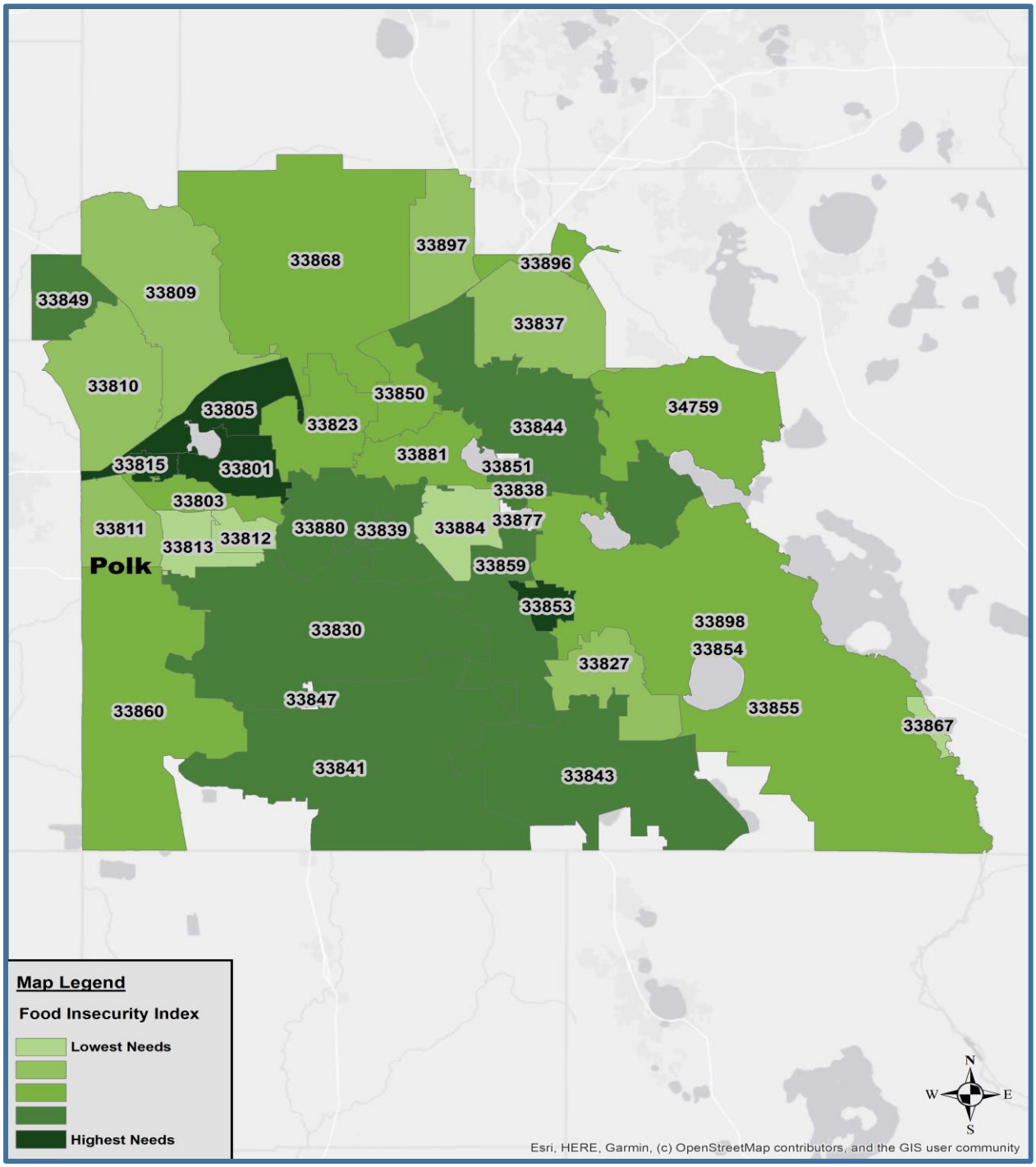
Figure 21. Health Equity Index



Food Insecurity Index

Conduent's Food Insecurity Index estimates areas of low food accessibility correlated with social and economic hardship. ZIP codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 22. The following ZIP codes had the highest level of food insecurity (as indicated by the darkest shades of green): 33805 (Lakeland) and 33815 (Lakeland) with index values of 96.7 and 96.5, respectively. Appendix A provides the index values for each ZIP code.

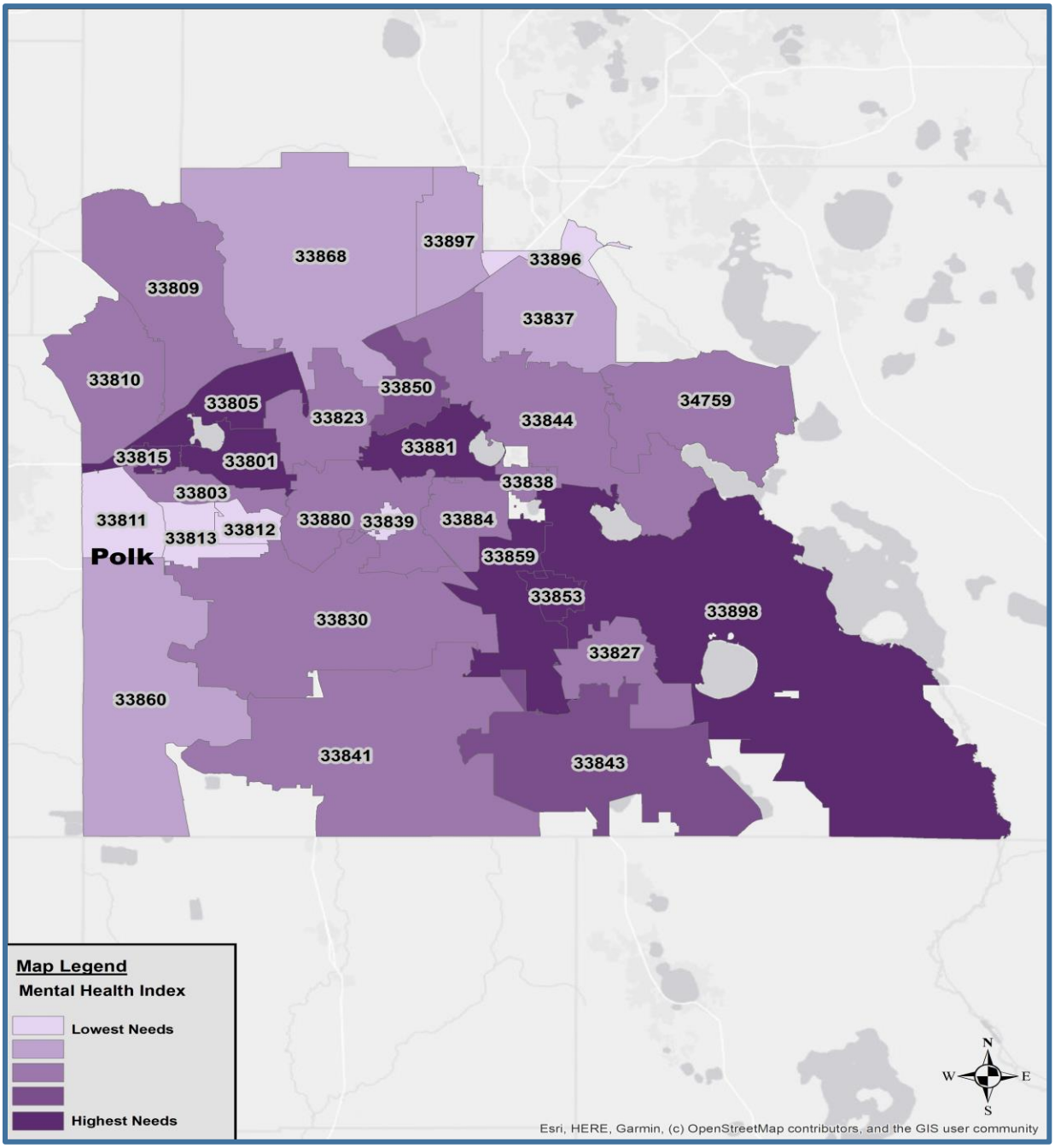
Figure 22. Food Insecurity Index



Mental Health Index

Conduent's Mental Health Index (MHI) is a measure of socioeconomic and health factors correlated with self-reported poor mental health. The MHI ZIP codes were ranked based on their index value to identify the relative levels of need, as illustrated by the map in Figure 23. The following two ZIP codes are estimated to have the highest need (as indicated by the darkest shades of purple): 33881 (Winter Haven) and 33805 (Lakeland) with index value 97.3 and 96.3 respectively. Appendix A provides the index values for high needs ZIP codes.

Figure 23. Mental Health Index



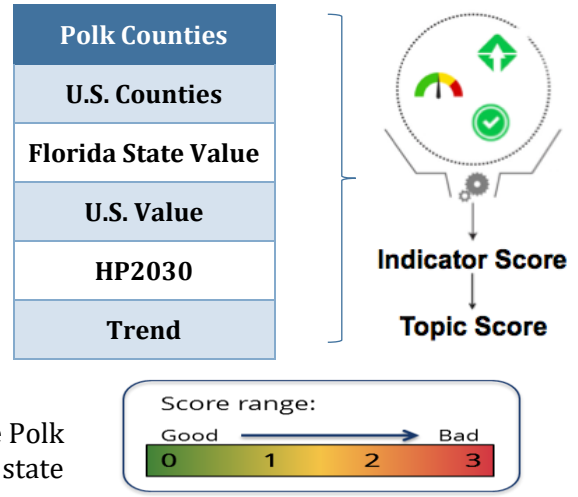
Methodology

Overview

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

Secondary Data Sources & Analysis

Figure 24. Secondary Data Scoring



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

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

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

Table 2. Secondary Data Topic Scoring Results

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

Primary Data Collection & Analysis

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

Community Survey

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

The All4HealthFL Collaborative worked extensively with community and organizational leads to market, outreach, and track survey responses to ensure an equitable representation of community voices was captured. Survey marketing and outreach efforts included email invitations, social media, and coordination of onsite paper survey distribution events in collaboration with community-based organizations. A community assessment dashboard was created to track and monitor survey respondents by ZIP code, age, gender, race, and ethnicity to ensure targeted outreach for at-risk populations. A total of 1,454 residents responded for Polk County.

Community Survey Analysis Results

Survey participants were asked about the top three pressing health and quality of life issues they believe should be addressed in their community. In Figure 25, the "Top Three Health Issues" were, mental health problems including suicide (39% of respondents), Illegal drug use/abuse or misuse of prescription medications (36%), and being overweight (33%). The "Top Three Risky Behaviors" included; illegal drug use/abuse of misuse of prescription medications (57% of respondents), poor eating habits (46% of respondents), and alcohol abuse/drinking too much alcohol (i.e. beer, wine, spirits, mixed drinks) (41% of respondents).Lastely, the "Top Three Quality of Life Issues" included low crime/safe neighborhoods (40% of respondents), access to health care (35% of respondents), and good schools (26% of respondents).

Figure 25. Top 3 Health & Quality of Life Issues

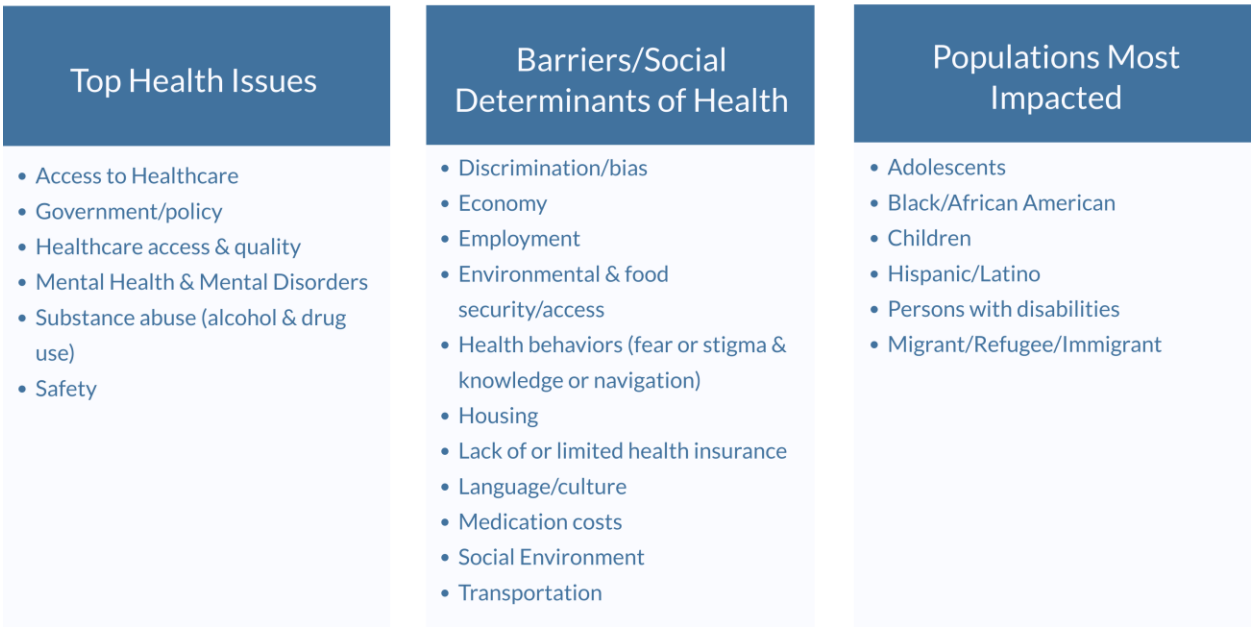
Focus Groups

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

Focus Group discussions took place in November 2021, with a total of 22 community participants. Due to the ongoing COVID-19 pandemic these discussions were conducted virtually. A questionnaire was developed to guide the conversations, which included topics such as Community Strengths & Assets, Top Health Problems, Access to Health, and Impact on Health. A list of questions utilized for focus group discussions can be found in Appendix C. To help inform an assessment of community assets, participants were asked to list and describe resources available in the community. The list of available resources is in Appendix E.

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

Figure 26. Themes Across All Focus Groups



Data Synthesis & Prioritization

Data Synthesis

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

Figure 27. Trending Health Topic for Consideration

Prioritization

On May 5, 2022, participants from collaborating organizations, as well as other community partners, came together to prioritize the significant health needs for Polk County. To better target issues regarding the most pressing health needs, the All4HealthFL Collaborative conducted a two-hour virtual prioritization session facilitated by the Tampa Bay Healthcare Collaborative (TBHC). A total of 75 individuals attended the prioritization session. These participants represented a broad cross section of experts and organizational leaders with extensive knowledge of health needs in the community. The meeting objectives included: review of analyzed health data pertaining to health needs and disparities, discussion of significant health needs identified, gathering input on health topics, prioritizing significant health needs, and generating preliminary ideas on how to collaborate to address top community needs. An additional discussion was hosted to close out the session with preliminary ideas on how the broader community could collaborate to address top community health needs.

Process

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

Participants ranked each of the health categories individually using the dual criteria of scope and severity and ability to impact. Criteria scores were then combined to generate an overall ranking of health needs. A total of 58 individuals completed the online prioritization activity. The cumulative total score of each health topic can be seen in Table 3. The All4HealthFL Collaborative agreed with the ranking of the health topics and selected the top three prioritized health topics: Access to Health & Social Services, Behavioral Health (Mental Health & Substance Misuse), and Exercise, Nutrition & Weight.

Table 3. Cumulative Total Score of Significant Health Topics (n=58)

Health Topics	Cumulative Total Score
Behavioral Health (Mental Health & Substance Misuse)	152.5
Access to Health & Social Services	150
Exercise, Nutrition & Weight	143.5
Immunizations & Infectious Diseases	124.5
Heart Disease & Stroke	123
Cancer	115.5

Prioritized Significant Health Needs

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

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

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

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

Access to Health & Social Services

Key Themes from Community Input

- **Thirty Five percent (35%)** of survey respondents ranked access to health care as a quality of life issue
- Rural areas have lack of awareness of available services/resources I.e. insurance enrollment assistance, technology barriers
- Employment does not allow for PTO, providers have limited appointment availability on weekends
- High deductibles, high co-pays, people falling in coverage gaps "make too much to qualify for Medicaid"
- Lack of board-certified transgender health providers
- Insurance companies dictating what treatments patients should receive as opposed to the provider
- Barriers include: transportation, language barriers (limited translation services/bilingual providers), lack of or limited health insurance coverage (high out of pocket costs), knowledge or navigation of health system, medication costs, work schedules/appointment times limited, long wait times for disability approval

Warning Indicators

- Adults without Health Insurance
- Median Monthly Medicaid Enrollment
- Adults who Visited a Dentist
- Adults with Health Insurance
- Primary Care Provider Rate

> This issue we're seeing is the timing of the clinics. We want our families working these non-livable wage jobs to go to a provider, but the providers only hours are eight to five Monday through Friday and they're working in jobs that don't allow them to take off and get paid for being off.
>
> -Black/African American Group Participant

Primary Data: Community Survey & Focus Groups

Access to Health & Social Services was a top health need identified from both the community survey and the five focus group discussions. Thirty-five percent (35%) of community respondents ranked Access to Health Care as a pressing quality of life issue. Reasons that prevented survey respondents from getting medical care they needed include: unable to schedule an appointment when needed, unable to afford to pay for care, cannot take time off work, and doctor's office that do not have convenient hours. Other barriers included: higher than anticipated co-payments, COVID-19 restrictions, quality of treatment/care, and long wait times to see a medical provider.

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

Table 4. Focus Group Overall Barriers to Accessing Care

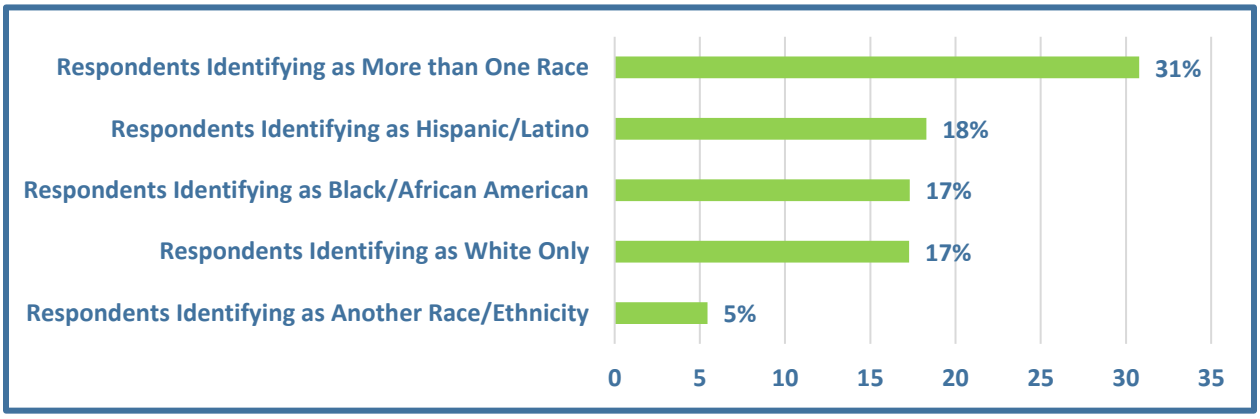
Black/African Americans	• Fear and lack of trust due to experienced trauma or discrimination and or racism • High deductibles, high co-pays, making too much to qualify for Medicaid • Gentrification and built environment reduce accessibility to services • Homeless population face barriers to care due to lack of documentation • No employer benefits such as Paid Time Off (PTO) • Lack of awareness/knowledge of available resources/services, insurance enrollment • Technology barriers
Hispanic/Latino	• Limited number of specialists and health systems take Medicaid • Fear/trust of government, health, and social services because of trauma, discrimination, or immigration status • No employer benefits such as Paid Time Off (PTO) • Lack of services for undocumented persons • Transportation barriers
LGBTQ+	• Shortage of board-certified transgender health providers and Mental Health services • Low health literacy for physicians on treating trans community • Fear and lack of trust in health system due to stereotypes, discrimination, bias • Transportation barriers
Older Adults	• Lack of availability of affordable housing • Fixed incomes, no insurance • Built environment: less services available on east side of county • Technological barriers • Stigma and cultural norms preventing from seeking assistance for all services • Transportation barriers

> I would like to advocate for other providers to get some education, knowledge, training, whatever they need because I'm the only person in East Polk county providing transgender care, but the need is so much more.
>
> -LGBTQ+ Focus Group Participant

Barriers and Disparities: Access to Health Care Services

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

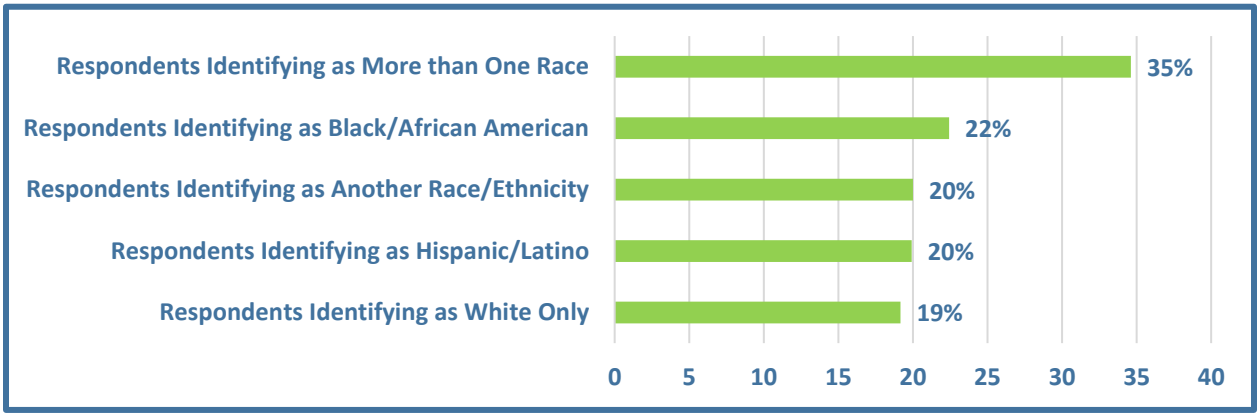
Figure 28. Percentage of Respondents by Race/Ethnic Group with Unmet Health Needs in the Past 12 Months



Barriers and Disparities: Access to Dental Health Services

Access to dental health services was mentioned in the community survey as an important health issue. Twenty-four percent (24%) of survey respondents mentioned they had unmet dental needs. There were five top reasons that prevented respondents from getting the dental care they needed which included: inability to pay for care, not having insurance to cover dental care, unable to schedule an appointment when needed, unable to take time off work, and dentist offices that do not have convenient hours. The percentage of respondents by racial/ethnic group with unmet dental health needs in the past 12 months can be seen in Figure 29.

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



Barriers and Disparities: Access to Care in the Emergency Room

Barriers in access to care for non-emergency needs was captured within the community survey. Forty-five percent (45%) of survey respondents declared using the emergency room instead of going to a doctor's office or clinic for non-emergency needs. The main reasons the emergency room was used for non-emergent needs included: lack of after-hours/weekend services, long wait for an appointment with primary physician, do not have a doctor/clinic, and do not have insurance. Additional reasons why respondents visited the emergency room for non-emergent needed included being referred by a doctor, experiencing pain, needing advice or consultation, experiencing a fall, or needing diagnostic testing.

Secondary Data

From the secondary data scoring results, Health Care Access & Quality had the 14th data score of all topic areas, with a score of 1.67 as seen in Table 2. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 5 below. See Appendix A for the full list of indicators categorized within this topic.

Table 5. Data Scoring Results for Health Care Access & Quality

SCORE	HEALTH CARE ACCESS & QUALITY	Polk County	HP2030	Florida	U.S.	Florida Counties	U.S. Counties	Trend
2.12	Adults without Health Insurance (2018) percent	25.1	---	---	12.2			---
2.03	Median Monthly Medicaid Enrollment (2020) enrollments/ 100,000 population	26508.1	---	19940.3	---		---	
1.94	Adults who Visited a Dentist (2018) percent	56.1	---	---	66.5			---

1.94	Adults with Health Insurance (2019) percent	78.4	---	80.5	87.1		---	---
1.91	Primary Care Provider Rate (2018) providers/ 100,000 population	48	---	72.2	---			
1.79	Dentist Rate (2019) dentists/ 100,000 population	34.1	---	60.8	---			
1.59	Children with Health Insurance (2019) percent	92.6	---	92.4	94.3		---	---
1.59	Clinical Care Ranking (2021) ranking	35	---	---	---		---	---
1.50	Adults with an Usual Source of Health Care (2017-2019) percent	72.2	---	72	---		---	---
1.50	Mental Health Provider Rate (2020) providers/ 100,000 population	93.4	---	169	---			

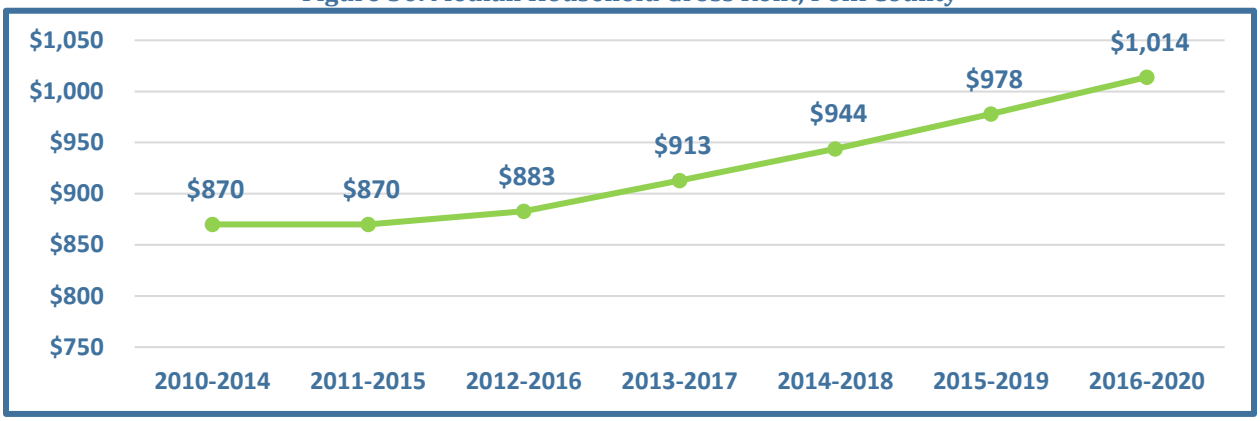
**HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.*

Adults without Health Insurance, Median Monthly Medicaid Enrollment, Adults who visited a Dentist, Adults with Health Insurance, and Primary Care Provider Rate are top areas of concern related to Health Care Access and Quality in Polk County. Adults without Health Insurance in Polk County is (25.1%), which is under the worst 25% in comparison to state values (12.2%). Furthermore, in Polk County Adults with Health Insurance (78.4%) is in the worst 25% of counties in the nation. Secondary data also reveals that the trend over time of people's Median Monthly Medicaid Enrollment in Polk County is getting worse compared to the nation. The rate of Primary Care Providers is (48%) in Polk County, which is in the less than the state value (72.2%). Table 5 shows that the Dentist Rate in Polk County (34.1 per 100,000 population) and Adults who visited a Dentist is comparatively lower than the state value (60.8 per 100,000). The other indicators of concern are Adults with a Usual Source of Health Care that shows the percentage of adults that report having one or more persons they think of as their personal doctor or health care provider. In comparison to other states in Florida Polk County is in the worst 50%. The value for Polk County (72.2%), almost the same as the national value of (72%). Lastly, the Mental Health Provider Rate in Polk County (93.4 providers/100,000 population) is lower than the Florida state (169 providers/100,000 population).

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

Where people live is a large indicator of their health. Fifty-six percent (56%) of survey respondents say there are not affordable places to live in Polk County. Secondary data indicators confirm that rental costs are rising to national highs in the Tampa Bay region. These rising rental costs are negatively impacting communities especially those that identify as LGBTQ+ and older adults 65+. Figure 30 shows the trend for the median gross household rent in Polk County from 2011 through 2020. In 2016-2020 Median Household Gross Rent of Polk County residents was $1,014 which is lower than U.S value of $1,096, and lower than state value of $1,218.

Figure 30. Median Household Gross Rent, Polk County

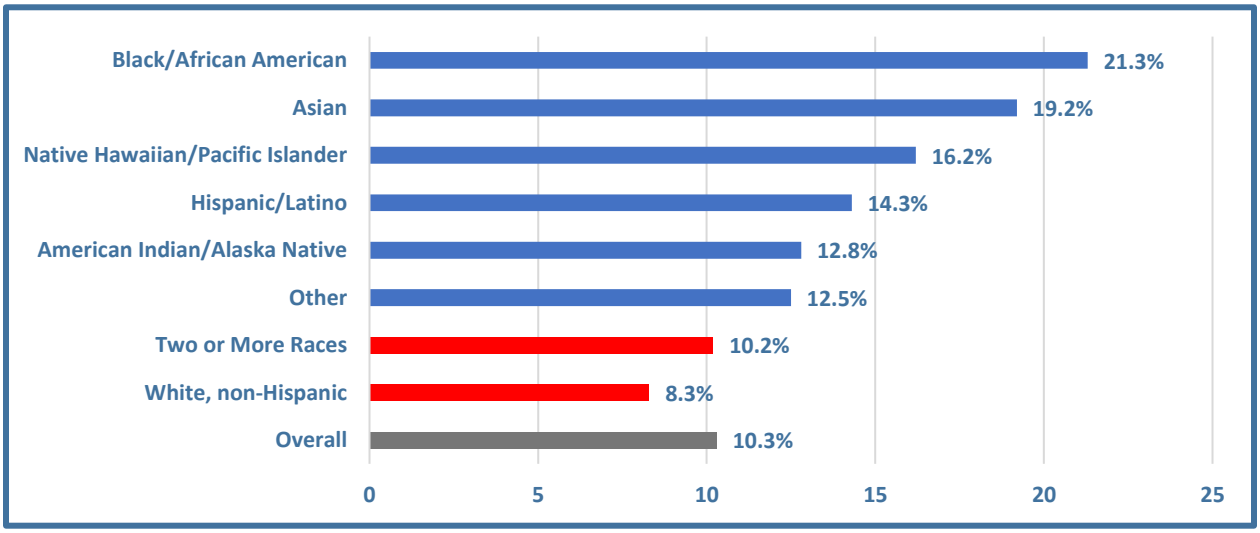


American Community Survey, 2020

> Access to affordable housing is a problem. Not everyone can pay $1,200 or $1,500 or $1,800 a month. Sometimes only one parent works with multiple children.
>
> -Hispanic/Latino Focus Group Participant

The rising rental costs are affecting all race and ethnic groups of the older adult population age 65+. See Figure 31 for the race and ethnicity disparities by percentage that are higher than the overall (10.3%) Polk County value. The red bar in the graph represents disparity when compared to the overall Polk County value and within all races/ethnicities/genders. Although White, non-Hispanic appears better than the overall county value, this population may be misrepresented or under reported.

Figure 31. Percentage of People age 65+ Living Below Poverty Level by Race/Ethnicity



American Community Survey, 2015-2019

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

Behavioral Health: Mental Health

Key Themes from Community Input

- **Thirty Nine percent (39%)** of survey respondents ranked behavioral health (mental health and substance misuse) as pressing health issues
- Top Reasons that prevented you from getting mental health care: Unable to schedule an appointment when needed, Unable to afford to pay for care, Cannot take time off work, Am not sure how to find a doctor/counselor, Unable to find a doctor/counselor who takes my insurance
- Lack of acknowledgement about mental health deterioration within transgender communities and stress impacting both physical and mental/emotional well-being
- External political factors, coupled with discrimination contribute to trauma experienced in LGBTQ+ community, Black/African American community and Hispanic/Latino community

Warning Indicators

- Age-Adjusted Death Rate due to Suicide
- Depression: Medicare Population
- Alzheimer's Disease or Dementia: Medicare Population
- Frequent Mental Distress
- Poor Mental Health: 14+ Days
- Self-Reported General Health Assessment: Good or Better
- Mental Health Provider Rate

> When we start talking about mental health, it's almost like a taboo or some type of subject that we don't want to talk about.
>
> -Focus Group Participant

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

Mental Health and Substance Misuse were identified as top health needs from the secondary data, community survey, and focus groups. The two were combined into Behavioral Health for this assessment. Thirty-nine (39%) of community survey respondents ranked Mental Health as a pressing health issue. Twenty-nine percent (29%) of community survey respondents indicated being diagnosed as having depression or anxiety. The top five reasons respondents did not seek care included: unable to access the mental health care they needed, unable to afford to pay for care, unable to schedule an appointment when needed, cannot take time off work, and do not have insurance to cover mental health care.

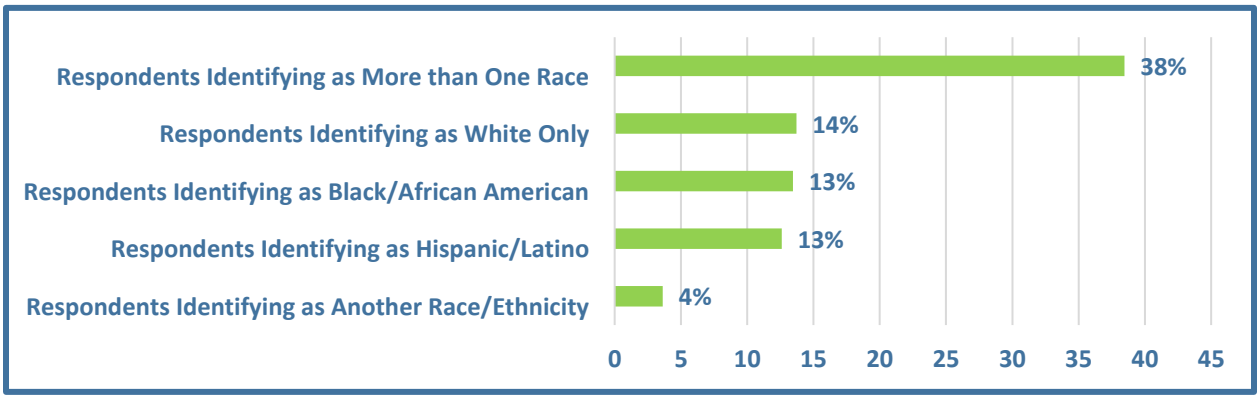
Mental Health was also a top health issue discussed during the five focus groups. Specifically, barriers to care due to fear and stigma of seeking help was mentioned frequently. Additionally, lack of affordable resources, language barriers, and long wait times to see a medical professional were

also discussed. The LGBTQ+, Black/African American, and Hispanic/Latino communities stressed the importance of political and provider acknowledgment about minority stress, discrimination, and external factors that have contributed to experienced trauma. These populations seem to experience more difficulty accessing mental health services.

Barriers and Disparities: Mental Health

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

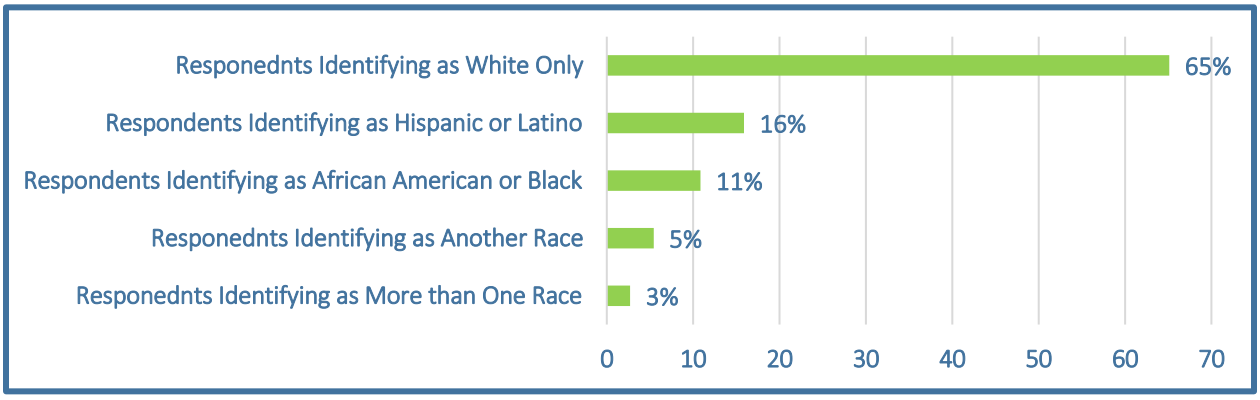
Figure 32. Percentage of Respondents by Race/Ethnic Group with Unmet Mental Health Needs in the Past 12 Months



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

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

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



Secondary Data: Mental Health

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

Table 6. Data Scoring Results for Mental Health & Mental Disorders-Polk County

SCORE	MENTAL HEALTH & MENTAL DISORDERS	Polk County	HP2030	Florida	U.S.	Florida Counties	U.S. Counties	Trend
2.38	Age-Adjusted Death Rate due to Suicide (2019) deaths/ 100,000 population	17.3	12.8	14.5	13.9		---	
2.29	Depression: Medicare Population (2018) percent	20.2	---	19.5	18.4			
2.12	Alzheimer's Disease or Dementia: Medicare Population (2018) percent	11.7	---	12.6	10.8			
2.03	Frequent Mental Distress (2018) percent	15.7	---	13.4	13			---
1.76	Poor Mental Health: 14+ Days (2018) percent	14.9	---	---	12.7			---
1.68	Self-Reported General Health Assessment: Good or Better (2017-2019) percent	75.2	---	80.3	---		---	---

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

Age Adjusted Death Rate due to Suicide, Depression and Alzheimer's Disease in Medicare population are top areas of concern related to Mental Health & Mental Disorders in Polk County. The percentage of Medicare beneficiaries treated for Alzheimer's Disease or Dementia is (11.7%) in Polk County, which falls in the worst 25% of counties in the nation. The indicator Depression: Medicare Population shows the percentage of Medicare beneficiaries who were treated for depression. The value for Polk County (20.2%), is in the worst 50% of counties in the state and nation and the trend is getting worse. Furthermore, Age-Adjusted Death Rate due to Suicide in Polk County are 17.3 deaths/100,000 population and showing definite concern in the community which is higher compared to HP 2030 Target value of 12.8 deaths/100,000 population. The other indicator of concern is Frequent Mental Distress that shows the percentage of adults who stated that their mental health, which includes stress, depression, and problems with emotions, was poor for 14 or more of the past 30 days. The value for Polk County, (15.7%), is higher than the national value of (13%). Lastly, the indicators of Poor Mental Health: 14+ Days, Self-Reported General Health Assessment: Good or Better and Mental Health Provider Rate are showing definite need in Polk County.

Alcohol and Substance Misuse

Behavioral Health: Substance Misuse

Key Themes from Community Input

- **Thirty Six percent (36%)** of survey respondents ranked illegal drug use/abuse of prescription medications and alcohol abuse/drinking too much as an important health issue to address
- Homeless population faces barriers to care because they lack documentation
- Stigma in seeking mental health services due to cultural norms

Warning Indicators

- Teens who Use Marijuana: High School Students
- Teens who Binge Drink: High School Students
- Teens who Use Alcohol
- Death Rate due to Drug Poisoning
- Health Behaviors Ranking
- Teens who have Used Methamphetamines
- Adolescents who Use Electronic Vaping: Lifetime
- Adolescents who Use Electronic Vaping: Past 30 Days
- Adults Who Currently Use E-Cigarettes
- Adults who Smoke

Secondary Data

Substance Misuse is a health topic that is analyzed from two secondary data health topics, i.e., Alcohol and Drug Use and Tobacco Use. From the secondary data scoring results, Alcohol & Drug Use had the 19th and Tobacco Use 16th highest data score of all topic areas, with a score of 1.45 and 1.52 as seen in Table 2. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 7 below. See Appendix A for the full list of indicators categorized within this topic.

Table 7. Data Scoring Results for Alcohol and Substance Misuse

SCORE	ALCOHOL & DRUG USE	Polk County	HP2030	Florida	U.S.	Florida Counties	U.S. Counties	Trend
2.00	Teens who Use Marijuana: High School Students (2020) percent	17.9	---	15.9	---		---	
1.71	Teens who Binge Drink: High School Students (2020) percent	10.7	---	9.2	---		---	
1.71	Teens who Use Alcohol (2020) percent	21.9	---	19.9	---		---	
1.59	Death Rate due to Drug Poisoning (2017-2019) deaths/ 100,000 population	20.8	---	23.6	21			
1.59	Health Behaviors Ranking (2021) ranking	36	---	---	---		---	---

1.56	Teens who have Used Methamphetamines (2020) percent	0.8	---	0.8	---	---	---	

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

From the secondary data results, there are several indicators within Alcohol and Drug Use health topic that raise concerns for Polk County. The worst performing indicator under this health topic is the Teens who Use Marijuana and Binge Drink in High School. This indicator shows the percentage of teens who reported smoking Marijuana or binge drinking at least once during the 30 days prior to the survey. In Polk County, 17.9% of teens smoke Marijuana which is higher than the state value of 15.9%, and 10.7% of teens binge drink alcohol. Furthermore, the percentage of Teens who use Alcohol in Polk County is 21.9%. Finally, trends are showing that there an increase over time in Death Rate due to Drug Poisoning (20.8%) in Polk County.

Table 8. Data Scoring Results for Tobacco Use

SCORE	TOBACCO USE	Polk County	HP2030	Florida	U.S.	Florida Counties	U.S. Counties	Trend
1.91	Adolescents who Use Electronic Vaping: Lifetime (2020) percent	29.3	---	26.4	---	---	---	
1.74	Adolescents who Use Electronic Vaping: Past 30 Days (2020) percent	15.2	---	14.5	---	---	---	
1.68	Adults Who Currently Use E-Cigarettes (2017-2019) percent	7	---	7.5	---		---	---
1.68	Adults who Smoke (2017-2019) percent	17.8	5	14.8	---		---	---

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

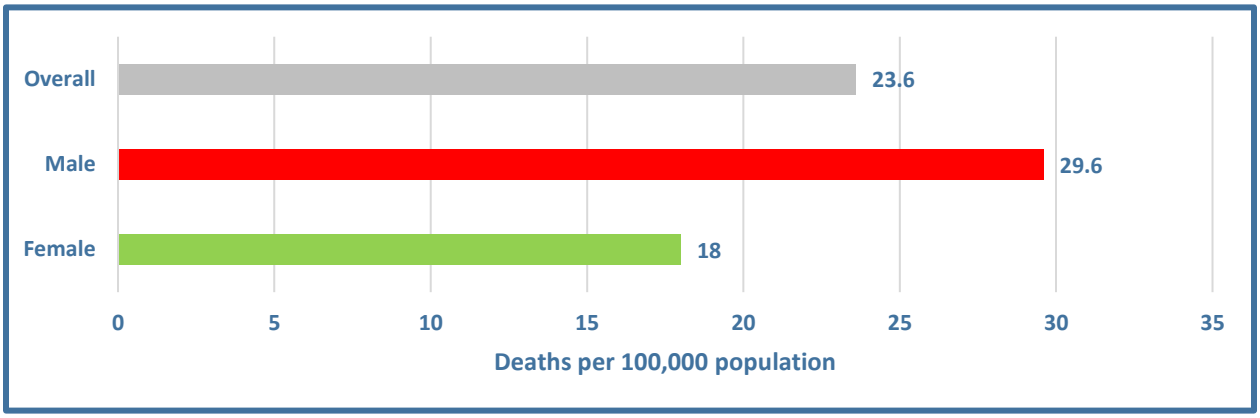
Secondary data indicators for Tobacco Use include Electronic Vaping, E-Cigarettes, and Smoking. Polk County has the high rates of adults and adolescents who vape and use e-cigarettes compared to other counties in Florida and trends over time are showing a significant increase and concerns in electronic vaping use.

Barriers and Disparities: Mental Health

Thirty-six percent (36%) of community survey respondents ranked illegal drug use/abuse of prescription medications and alcohol abuse/drinking too much as important health issues to address. In Polk County, Deaths Due to Drug Poisoning and Opioid Overdose have been an increasing concern, specifically for white males. See Age Adjusted Drug and Opioid-Involved Overdose Death Rate by Gender (Figure 34) and Race/Ethnicity in (Figure 35). In the figures below the red bars indicates values that are significantly worse than the overall value as illustrated in the gray bar. The green bar indicates values below the overall value as seen in the gray bar. The Age Adjusted Drug and Opioid-Involved Overdose Death rate per 100,000 population in Polk County (23.6) is the roughly the same as U.S. Values (23.5). See Figure 34 white males (29.6 deaths per 100,000) are more likely to experience opioid- involved deaths than females (18 deaths per 100,000 population). White males (26 deaths per 100,000 population) are also above the state value (23.6 deaths per

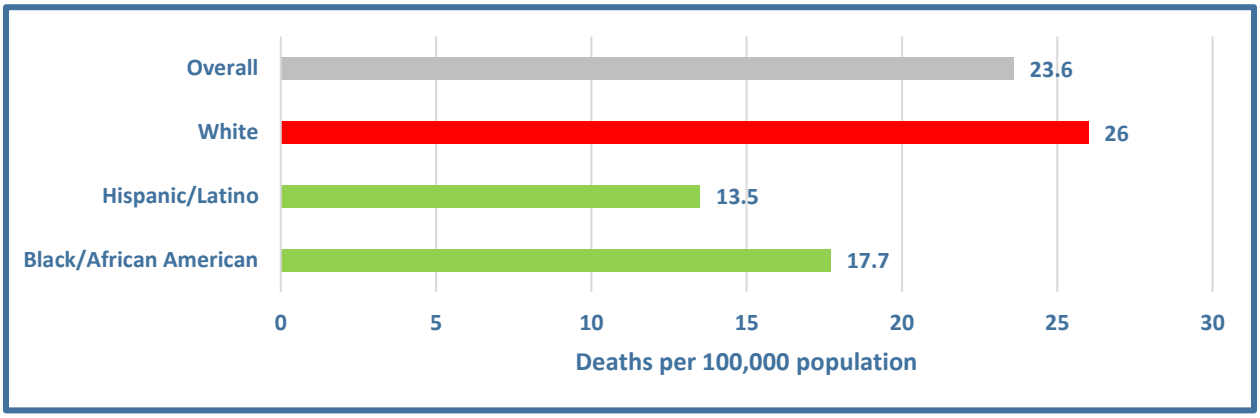
100,000 population) for opioid-involved deaths as seen in Figure 34. Figure 35 shows opioid-involved deaths rate by race/ethnicity.

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



Centers for Disease and Prevention, 2018-2020

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



Centers for Disease and Prevention, 2018-2020

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

Exercise, Nutrition & Weight

Key Themes from Community Input

- Food insecurity, inequitable access to affordable healthy food, transportation barriers, rising food costs
- Hispanic community has high rates of diabetes: more education for children starting at young ages about healthy food, exercise, available parks in the city

Warning Indicators

- Teens who are Obese: High School Students
- Children with Low Access to a Grocery Store
- Low-Income and Low Access to a Grocery Store
- WIC Certified Stores
- Teens without Sufficient Physical Activity
- Adults Who Are Obese
- Adults who are Overweight or Obese
- Adults who are Sedentary
- Farmers Market Density
- People 65+ with Low Access to a Grocery Store
- Grocery Store Density
- SNAP Certified Stores
- Food Environment Index
- Access to Exercise Opportunities
- Households with No Car and Low Access to a Grocery Store
- Recreation and Fitness Facilities
- Health Behaviors Ranking

> There's food and housing insecurities and those that are on disability they've had to wait up to two years to get full access to healthcare.
>
> -Focus Group Participant

Primary Data: Focus Group

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

Secondary Data

Secondary data for Exercise, Nutrition & Weight included Physical Activity data scoring. Physical Activity had the 9th highest data score of all topic areas as seen in Table 2. Further analysis was done to identify specific indicators of concern which include indicators with high data scores (scoring at or above the threshold of 1.50) and seen in Table 9. See Appendix A for the full list of indicators categorized within this topic.

Table 9. Data Scoring Results for Physical Activity

SCORE	PHYSICAL ACTIVITY	Polk County	HP2030	Florida	U.S.	Florida Counties	U.S. Counties	Trend
2.03	Children with Low Access to a Grocery Store (2015) percent	7.6	---	---	---			---
2.03	Low-Income and Low Access to a Grocery Store (2015) percent	12.8	---	---	---			---
2.03	WIC Certified Stores (2016) stores/ 1,000 population	0.1	---	---	---			---
2.00	Teens without Sufficient Physical Activity (2020) percent	85.7	---	82.3	---		---	
1.85	Adults who are Obese (2017-2019) percent	36.3	---	27	---		---	---
1.85	Adults who are Overweight or Obese (2017-2019) percent	71.4	---	64.6	---		---	---
1.85	Adults who are Sedentary (2017-2019) percent	31.7	21.2	26.5	---		---	---
1.85	Farmers Market Density (2018) markets/ 1,000 population	0	---	---	---	---	---	
1.85	People 65+ with Low Access to a Grocery Store (2015) percent	6.2	---	---	---			---
1.82	Grocery Store Density (2016) stores/ 1,000 population	0.1	---	---	---			
1.82	SNAP Certified Stores (2017) stores/ 1,000 population	0.8	---	---	---			
1.71	Food Environment Index (2021) index	7	---	6.9	7.8			
1.68	Access to Exercise Opportunities (2020) percent	78.9	---	88.7	84			---
1.68	Households with No Car and Low Access to a Grocery Store (2015) percent	2.9	---	---	---			---
1.68	Recreation and Fitness Facilities (2016) facilities/ 1,000 population	0.1	---	---	---	---	---	
1.59	Health Behaviors Ranking (2021) ranking	36	---	---	---		---	---

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

Some of the worst-performing indicators within this topic are related to the built environment and food access to children and low-income groups in Polk County. The percentage of Children with Low Access to a Grocery Store in Polk County is 7.6%, which falls in the worst 50% of counties in the state and nationally. This indicator shows the percentage of children living more than one mile from a supermarket or large grocery store if in an urban area, or more than 10 miles from a supermarket or large grocery store if in a rural area. Additionally, Farmers Market Density, Supplemental Nutritional Assistance Program (SNAP) Certified Store and Low-income and Low Access to Grocery Store are poorly performing indicators that measures food access. HCI's Food Insecurity Index®, discussed earlier in this report, can be used to help identify geographic areas of low food accessibility within the Polk County community

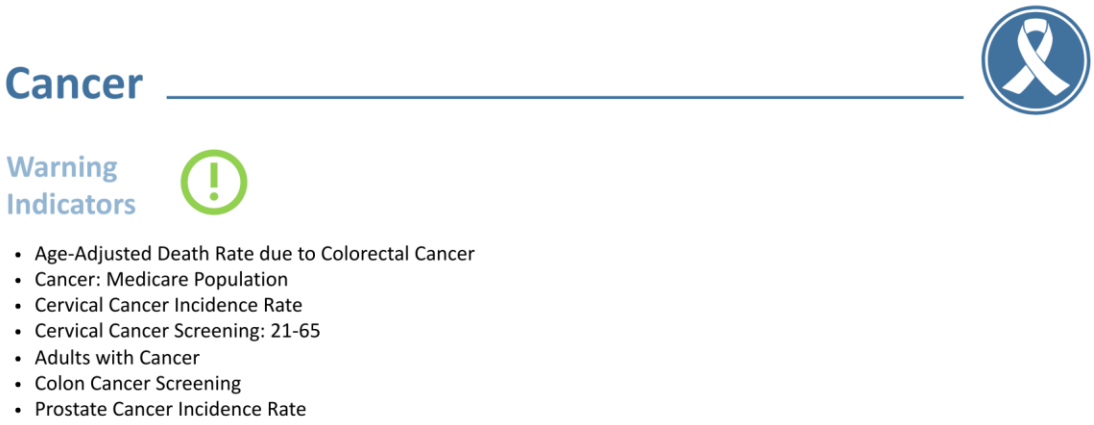
The percentage of obese adults is an indicator of the overall health and lifestyle of a community. Obesity increases the risk of many diseases and health conditions, including Heart Disease, Type 2 Diabetes, Stroke, and Cancer. In Polk County, 36.3% of adults are obese, and 71.4% adults are overweight. This is higher than the state value 64.6%, although not significantly. Other poorly performing indicators under Physical Activity health topics are the percentage of Teens without Sufficient Physical Activity (85.7%) and Adults who are Sedentary (31.7%) in Polk County. Studies have shown that sedentary lifestyles and a lack of fruits and vegetables can increase the risk of many chronic diseases including obesity, heart disease, and Type 2 diabetes.[15]

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

Non-Prioritized Significant Health Needs

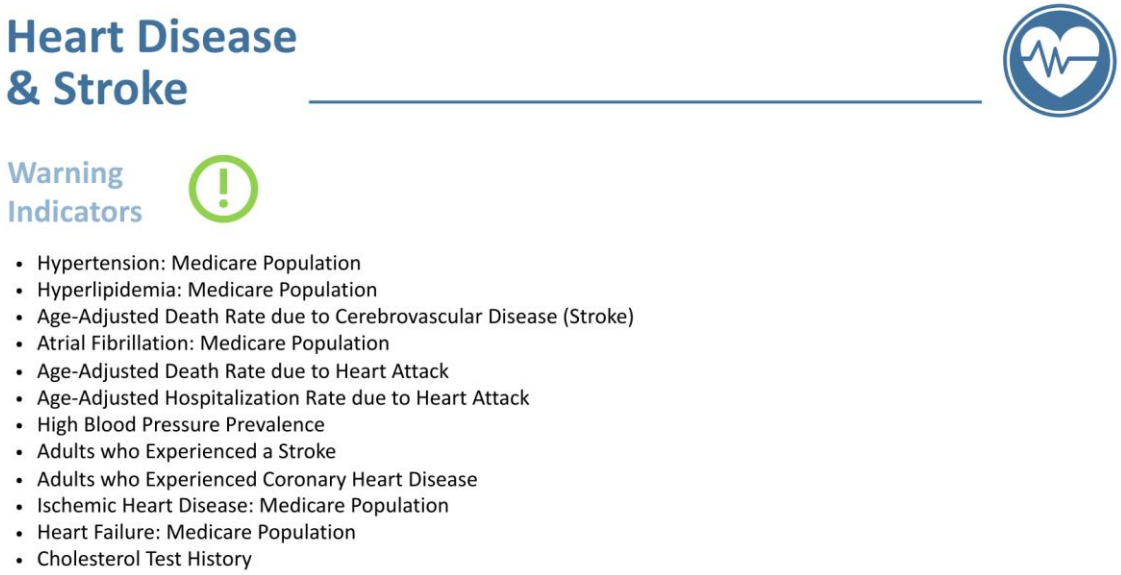
Following the rigorous community prioritization process, the following were not selected as prioritized health topics for Polk County for the next three years. Any current programming and additional efforts outside of the CHNA process to address these health issues will not be impacted by this decision.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

Non-Prioritized Health Need #1: Cancer



In Polk County, Cancer was not mentioned in focus groups and was ranked low in the community survey. Sixteen percent (16%) of survey respondents ranked Cancer as a pressing health issue and (10%) reported being told by a medical provider that they have been diagnosed. Secondary data warning indicators showed county values at or slightly above Florida and U.S. values for cervical cancer incidence rate, melanoma incidence rate, and cancer within the Medicare population.

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



Heart Disease and Stroke as a topic on its own did not come through as a top community health issue within the community survey or focus groups. In the community survey, 44% of survey respondents reported being told by a medical provider that they have hypertension and/or heart disease. The raised concern was related to nutrition and obesity and could best be addressed within the Exercise, Nutrition, and Weight health topic.

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

Immunizations and Infectious Diseases did not come up as a top issue through community feedback.

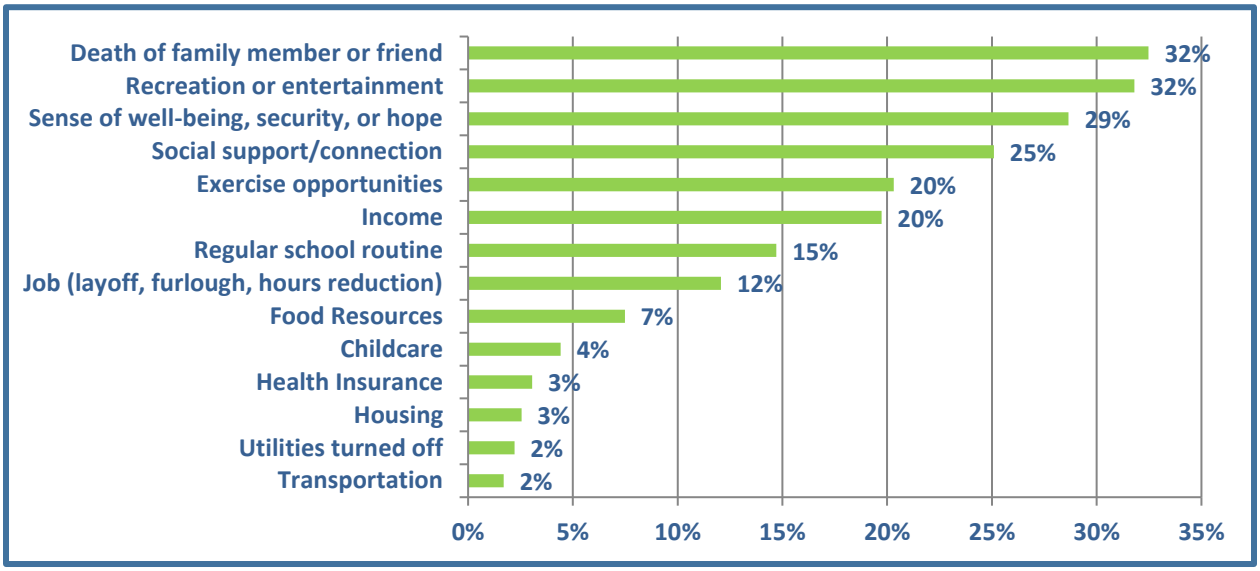
Additional Opportunities for Impact

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

COVID-19 Pandemic

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

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



Community Lived Experiences Around Diversity, Equity & Inclusion

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

Figure 37. Percentage of Respondents from Polk County who Reported Experiencing Discrimination

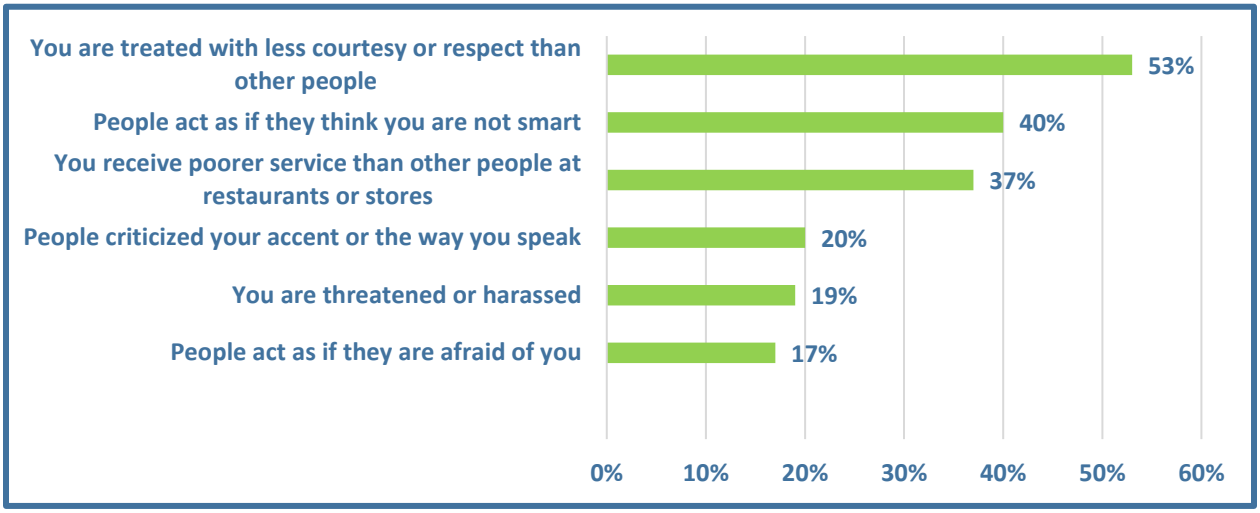


Figure 38 breaks down the percentages of reported discrimination by respondents' identity of themselves, as well as why they believe they experienced this discrimination. For example, in what ways did Hispanic/Latino community members report experiencing discrimination and what did they believe was the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

Figure 38. Percentage of Respondents who Reported Experiencing Discrimination by Discrimination Type

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

Percentage Reported Discrimination	Respondents Identify As: Non-Male, White Only	Hispanic or Latino	Black or AA	More than One Race	Another Race	LGBTQ+	65+
You are treated with less courtesy or respect than other people	50%	59%	61%	88%	56%	79%	40%
You receive poorer service than other people at restaurants or stores	31%	41%	62%	72%	48%	61%	30%
People act as if they think you are not smart	37%	45%	56%	78%	48%	62%	27%
People act as if they are afraid of you	11%	16%	34%	33%	19%	30%	8%
You are threatened or harassed	18%	22%	20%	50%	23%	44%	11%
People criticized your accent or the way you speak	12%	40%	24%	35%	42%	30%	11%
What do you believe to be the main reason(s)?	Gender, Age, Weight	Race, Ancestry or National Origin, Gender	Race, Gender, Age	Age, Some Other Aspect of Appearance, Race	Race, Ancestry or National Origin	Sexual Orientation, Gender, Age	Age, Gender, Race

Conclusion

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

Appendices Summary

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

A. Secondary Data (Methodology and Data Scoring Tables)

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

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

B. Index of Disparity

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

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

C. Community Input Assessment Tools

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

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

D. Data Placemats

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

E. Community Partners and Resources

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

F. Partner Achievements

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

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Appendix A. Secondary Data Methodology

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

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

Appendix A. Secondary Data Methodology and Data Scoring Tables

SCORE	ADOLESCENT HEALTH	UNITS	POLK COUNTY	HP2030	Florida	U.S.	MEASUREMENT PERIOD	RACE DISPARITY	Source
2.00	Teens who are Obese: High School Students	*percent*	20.3		15.4		*2020*		13
2.00	Teens who Use Marijuana: High School Students	*percent*	17.9		15.9		*2020*		22
2.00	Teens without Sufficient Physical Activity	*percent*	85.7		82.3		*2020*		13
1.97	Teen Birth Rate: 15-19	*live births/ 1,000 females aged 15-19*	24.4		16.2	16.7	*2019*		18
1.91	Adolescents who Use Electronic Vaping: Lifetime	*percent*	29.3		26.4		*2020*		23
1.74	Adolescents who Use Electronic Vaping: Past 30 Days	*percent*	15.2		14.5		*2020*		23
1.71	Teens who Binge Drink: High School Students	*percent*	10.7		9.2		*2020*		22
1.71	Teens who Use Alcohol	*percent*	21.9		19.9		*2020*		22
1.68	Teens with Asthma	*percent*	23.1		21.3		*2020*		23
1.56	Teens who have Used Methamphetamines	*percent*	0.8		0.8		*2020*		22
1.32	Adolescents who Use Smokeless Tobacco: Lifetime	*percent*	4.5		3.7		*2020*		23

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1.32	Teens who Smoke Cigarettes: High School Students	*percent*	1.9		1.5		*2020*		23
0.97	Adolescents who Use Smokeless Tobacco: Past 30 Days	*percent*	1.3		1.3		*2020*		23
SCORE	**ALCOHOL & DRUG USE**	**UNITS**	**POLK COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.00	Teens who Use Marijuana: High School Students	*percent*	17.9		15.9		*2020*		22
1.71	Teens who Binge Drink: High School Students	*percent*	10.7		9.2		*2020*		22
1.71	Teens who Use Alcohol	*percent*	21.9		19.9		*2020*		22
1.59	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	20.8		23.6	21	*2017-2019*		7
1.59	Health Behaviors Ranking	*ranking*	36				*2021*		7
1.56	Teens who have Used Methamphetamines	*percent*	0.8		0.8		*2020*		22
1.41	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	24.3		25.6	22.8	*2017-2019*		4
1.24	Adults who Binge Drink	*percent*	15.2			16.4	*2018*		3
1.12	Driving Under the Influence Arrest Rate	*arrests/ 100,000 population*	112.2		159.7		*2019*		20
1.06	Alcohol-Impaired Driving Deaths	*percent of driving deaths with*	25	28.3	22.3	27	*2015-2019*		7

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		alcohol involvement							
0.97	Adults who Drink Excessively	*percent*	12.9		18		*2017-2019*		10
SCORE	**CANCER**	**UNITS**	**POLK COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.29	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	14.5	8.9	13.1		*2017-2019*		18
2.18	Cancer: Medicare Population	*percent*	9.7		10.1	8.4	*2018*		5
2.18	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	12.2		9		*2016-2018*		32
1.94	Cervical Cancer Screening: 21-65	*Percent*	81.5	84.3		84.7	*2018*		3
1.59	Adults with Cancer	*percent*	7.8			6.9	*2018*		3
1.59	Colon Cancer Screening	*percent*	64.2	74.4		66.4	*2018*		3
1.53	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	95.3		89.6		*2016-2018*		32
1.47	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	7.4	16.9	7.4		*2017-2019*	Black (12.9) White (6.7) Hispanic/Latino (9.5)	18
1.41	Mammogram in Past 2 Years: 50-74	*percent*	72.4	77.1		74.8	*2018*		3
1.35	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	10.7	15.3	10.4		*2017-2019*		18

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1.35	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	13.8		13.5		*2016-2018*	Black (8.9) White (14.6) Hispanic/La tino (5.9)	32
1.24	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	39.4	25.1	35.3		*2017-2019*		18
1.24	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	37.6		35.6		*2016-2018*		32
1.24	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	63.7		56.6		*2016-2018*		32
1.24	Melanoma Incidence Rate	*cases/ 100,000 population*	27.7		25.2		*2016-2018*	Black (1.3) White (32) Hispanic/La tino (2.2)	32
1.12	Pap Test in Past Year	*percent*	55.1		48.4		*2016*		10
1.06	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	154.1	122.7	146.1		*2017-2019*		18
0.88	Breast Cancer Incidence Rate	*cases/ 100,000 females*	117.4		121.2		*2016-2018*		32
0.82	Mammogram in Past Year: 40+	*percent*	72.7		60.8		*2016*		10

Appendix A. Secondary Data Methodology and Data Scoring Tables

SCORE	CHILDREN'S HEALTH	UNITS	POLK COUNTY	HP2030	Florida	U.S.	MEASUREMENT PERIOD	RACE DISPARITY	Source
2.03	Child Food Insecurity Rate	*percent*	19.3		17.1	14.6	*2019*		8
2.03	Children with Low Access to a Grocery Store	*percent*	7.6				*2015*		29
1.94	Projected Child Food Insecurity Rate	*percent*	22.9		19.1		*2021*		8
1.59	Children with Health Insurance	*percent*	92.6		92.4	94.3	*2019*		1
1.47	Kindergartners with Required Immunizations	*percent*	95.7		93.5		*2020*		15
1.24	Child Abuse Rate	*cases/ 1,000 children aged 5-11*	7.4		6.6		*2019*		11
SCORE	**COMMUNITY**	**UNITS**	**POLK COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.56	Households with an Internet Subscription	*percent*	70.6		83.3	83	*2015-2019*		1
2.47	Social Associations	*membership associations/ 10,000 population*	7.5		7	9.3	*2018*		7
2.47	Workers who Drive Alone to Work	*percent*	83.4		79.1	76.3	*2015-2019*		1
2.29	Mean Travel Time to Work	*minutes*	27.8		27.8	26.9	*2015-2019*		1
2.29	Persons with an Internet Subscription	*percent*	70.2		85.7	86.2	*2015-2019*		1

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2.12	Solo Drivers with a Long Commute	*percent*	40		42.4	37	*2015-2019*		7
2.03	Median Monthly Medicaid Enrollment	*enrollments/ 100,000 population*	26508.1		19940.3		*2020*		9
2.00	Population 16+ in Civilian Labor Force	*percent*	51.8		55.2	59.6	*2015-2019*		1
2.00	Voter Turnout: Presidential Election	*percent*	73.3		77.2		*2020*		21
1.88	Domestic Violence Offense Rate	*offenses/ 100,000 population*	670.9		496.5		*2019*		20
1.88	People 25+ with a Bachelor's Degree or Higher	*percent*	20.2		29.9	32.1	*2015-2019*		1
1.85	Female Population 16+ in Civilian Labor Force	*percent*	50.2		54.3	58.3	*2015-2019*		1
1.85	Workers Commuting by Public Transportation	*percent*	0.5	5.3	1.8	5	*2015-2019*	Black (0.9) White (0.3) Asian (0.4) American Indian/Alaskan Native (1.4) Native Hawaiian/Pacific islander (0) Multiracial (0.2) Other (2) Hispanic/Latino (0.9) Male (0.5) Female (0.5)	1

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1.76	Children Living Below Poverty Level	*percent*	24.7		20.1	18.5	*2015-2019*	Black (35.2) White (16.8) Asian (16.6) American Indian/Alaskan Native (45) Native Hawaiian/Pacific islander (0) Multiracial (20.5) Other (25.9) Hispanic/Latino (30.6) Male (24.8) Female (24.7)	1
1.76	People Living Below Poverty Level	*percent*	15.8	8	14	13.4	*2015-2019*		1
1.76	Per Capita Income	*dollars*	24864		31619	34103	*2015-2019*	Black (16985) White (29943) Asian (30965) American Indian/Alaskan Native (25540) Native Hawaiian/Pacific islander	1

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								(52838) Multiracial (13104) Other (17417) Hispanic/Latino (16944)	
1.76	Single-Parent Households	*percent*	29.8		29	25.5	*2015-2019*		1
1.68	Households with No Car and Low Access to a Grocery Store	*percent*	2.9				*2015*		29
1.68	Households with One or More Types of Computing Devices	*percent*	88		91.5	90.3	*2015-2019*		1
1.68	Median Housing Unit Value	*dollars*	150800		215300	217500	*2015-2019*		1
1.59	Median Household Income	*dollars*	50584		55660	62843	*2015-2019*		1
1.59	Social and Economic Factors Ranking	*ranking*	37				*2021*		7
1.53	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	17.3		14.7		*2019*		18
1.50	Median Household Gross Rent	*dollars*	978		1175	1062	*2015-2019*		1
1.50	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	423		505	500	*2015-2019*		1

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1.41	Juvenile Justice Referral Rate	*referrals/ 10,000 population*	234.3		160.6		*2019*		19
1.41	People 25+ with a High School Degree or Higher	*percent*	85		88.2	88	*2015-2019*		1
1.32	Mortgaged Owners Median Monthly Household Costs	*dollars*	1251		1503	1595	*2015-2019*		1
1.24	Child Abuse Rate	*cases/ 1,000 children aged 5-11*	7.4		6.6		*2019*		11
1.24	Homeownership	*percent*	54.9		53.5	56.2	*2015-2019*		1
1.12	Driving Under the Influence Arrest Rate	*arrests/ 100,000 population*	112.2		159.7		*2019*		20
1.06	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	25	28.3	22.3	27	*2015-2019*		7
1.06	Consumer Expenditures: Local Public Transportation	*average dollar amount per consumer unit*	97.2		107.5	148.8	*2021*		6

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0.79	Total Employment Change	*percent*	2.6		2.2	1.6	*2018-2019*		28
0.74	Violent Crime Rate	*crimes/ 100,000 population*	288.2		382.4	379.4	*2019*		20
0.65	People 65+ Living Alone	*percent*	21.5		23.7	26.1	*2015-2019*		1
0.35	Households without a Vehicle	*percent*	5.3		6.3	8.6	*2015-2019*		1

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SCORE	COUNTY HEALTH RANKINGS	UNITS	POLK COUNTY	HP2030	Florida	U.S.	MEASUREMENT PERIOD	RACE DISPARITY	Source
1.59	Clinical Care Ranking	*ranking*	35				*2021*		7
1.59	Health Behaviors Ranking	*ranking*	36				*2021*		7
1.59	Physical Environment Ranking	*ranking*	41				*2021*		7
1.59	Social and Economic Factors Ranking	*ranking*	37				*2021*		7
1.41	Morbidity Ranking	*ranking*	33				*2021*		7
1.41	Mortality Ranking	*ranking*	25				*2021*		7
SCORE	**DIABETES**	**UNITS**	**POLK COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.38	Diabetes: Medicare Population	*percent*	31.2		27.8	27	*2018*		5
1.97	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	24.8		19.7	21.6	*2019*		18
1.85	Adults with Diabetes	*percent*	15.4		11.7		*2017-2019*	Black (31.4) White (11.8) Hispanic/La tino (18) Male (17.1) Female (13.1)	10

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SCORE	ECONOMY	UNITS	POLK COUNTY	HP2030	Florida	U.S.	MEASUREMENT PERIOD	RACE DISPARITY	Source
2.53	Unemployed Workers in Civilian Labor Force	*percent*	6		5.1	5.7	*Jul-21*		27
2.24	Homeowner Vacancy Rate	*percent*	2.6		2.3	1.6	*2015-2019*		1
2.18	Households with Cash Public Assistance Income	*percent*	2.5		2.1	2.4	*2015-2019*		1
2.03	Child Food Insecurity Rate	*percent*	19.3		17.1	14.6	*2019*		8
2.03	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	36.7		33		*2018*		31
2.03	Low-Income and Low Access to a Grocery Store	*percent*	12.8				*2015*		29
2.03	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		29
2.00	Population 16+ in Civilian Labor Force	*percent*	51.8		55.2	59.6	*2015-2019*		1
1.94	Projected Child Food Insecurity Rate	*percent*	22.9		19.1		*2021*		8
1.94	Projected Food Insecurity Rate	*percent*	15.1		13.3		*2021*		8
1.88	Mortgaged Owners Spending 30% or More	*percent*	30.6		32.2	26.5	*2019*		1

	of Household Income on Housing								
1.88	Overcrowded Households	*percent of households*	3.4		3		*2015-2019*		1
1.85	Female Population 16+ in Civilian Labor Force	*percent*	50.2		54.3	58.3	*2015-2019*		1
1.82	People 65+ Living Below Poverty Level	*percent*	9.9		10.4	9.3	*2015-2019*	Black (18.8) White (8.2) Asian (16.3) American Indian/Alaskan Native (6.3) Native Hawaiian/Pacific islander (28.1) Multiracial (15.2) Other (12.3) Hispanic/Latino (15.4) Male (8.5) Female (11.2)	1
1.82	SNAP Certified Stores	*stores/ 1,000 population*	0.8				*2017*		29
1.76	Children Living Below Poverty Level	*percent*	24.7		20.1	18.5	*2015-2019*	Black (35.2) White (16.8) Asian (16.6) American Indian/Alaskan Native (45)	1

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								Native Hawaiian/Pacific islander (0) Multiracial (20.5) Other (25.9) Hispanic/Latino (30.6) Male (24.8) Female (24.7)	
1.76	Families Living Below Poverty Level	*percent*	11.7		10	9.5	*2015-2019*	Black (19.7) White (8) Asian (8.3) American Indian/Alaskan Native (11.3) Native Hawaiian/Pacific islander (55) Multiracial (14.1) Other (15.2) Hispanic/Latino (19.1)	1
1.76	People Living Below Poverty Level	*percent*	15.8	8	14	13.4	*2015-2019*		1
1.76	Per Capita Income	*dollars*	24864		31619	34103	*2015-2019*	Black (16985) White (29943)	1

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								Asian (30965) American Indian/Alaskan Native (25540) Native Hawaiian/Pacific islander (52838) Multiracial (13104) Other (17417) Hispanic/Latino (16944)	
1.68	Food Insecurity Rate	*percent*	12.9		12	10.9	*2019*		8
1.68	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	49.1		54		*2018*		31
1.68	Households that are Below the Federal Poverty Level	*percent*	14.1		13		*2018*		31
1.68	Median Housing Unit Value	*dollars*	150800		215300	217500	*2015-2019*		1

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1.59	Median Household Income	*dollars*	50584		55660	62843	*2015-2019*		1
1.59	People Living 200% Above Poverty Level	*percent*	60.4		65.8	69.1	*2015-2019*		1
1.59	Social and Economic Factors Ranking	*ranking*	37				*2021*		7
1.50	Median Household Gross Rent	*dollars*	978		1175	1062	*2015-2019*		1
1.50	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	423		505	500	*2015-2019*		1
1.50	Renters Spending 30% or More of Household Income on Rent	*percent*	50.3		56.3	49.6	*2015-2019*		1
1.41	Consumer Expenditures: Home Rental Expenses	*average dollar amount per consumer unit*	4572.4		4431	5460.2	*2021*		6
1.35	Size of Labor Force	*persons*	330717				*Jul-21*		27
1.35	Students Eligible for the Free Lunch Program	*percent*	48.2				*2019-2020*		25
1.32	Mortgaged Owners Median Monthly Household Costs	*dollars*	1251		1503	1595	*2015-2019*		1
1.24	Consumer Expenditures: Homeowner Expenses	*average dollar amount per consumer unit*	7002.1		7675.2	8900.1	*2021*		6

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1.24	Homeownership	*percent*	54.9		53.5	56.2	*2015-2019*		1
1.06	Persons with Disability Living in Poverty (5-year)	*percent*	26		24.6	26.1	*2015-2019*		1
1.06	Severe Housing Problems	*percent*	16.8		19.5	18	*2013-2017*		7
0.79	Total Employment Change	*percent*	2.6		2.2	1.6	*2018-2019*		28

SCORE	EDUCATION	UNITS	POLK COUNTY	HP2030	Florida	U.S.	MEASUREMENT PERIOD	RACE DISPARITY	Source
2.47	4th Grade Students Proficient in Math	*percent*	44		53		*2021*		12
2.18	4th Grade Students Proficient in Reading	*percent*	42		52		*2021*		12
2.00	Student-to-Teacher Ratio	*students/ teacher*	17.6				*2019-2020*		25
1.88	People 25+ with a Bachelor's Degree or Higher	*percent*	20.2		29.9	32.1	*2015-2019*		1

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1.68	8th Grade Students Proficient in Reading	*percent*	47		52		*2021*		12
1.65	8th Grade Students Proficient in Math	*percent*	35		37		*2021*		12
1.41	High School Graduation	*percent*	86.5	90.7	90		*2019-2020*		12
1.41	People 25+ with a High School Degree or Higher	*percent*	85		88.2	88	*2015-2019*		1
1.06	Consumer Expenditures: Education	*average dollar amount per consumer unit*	842.5		1056	1492.4	*2021*	#NAME?	6
SCORE	**ENVIRONMENTAL HEALTH**	**UNITS**	**POLK COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.41	Asthma: Medicare Population	*percent*	5.9		5.2	5	*2018*		5
2.03	Adults with Current Asthma	*percent*	10.1		7.4		*2017-2019*	Black (17.8) White (9.4) Hispanic/Latino (6.4) Male (5.7) Female (14.2)	10

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2.03	Children with Low Access to a Grocery Store	*percent*	7.6				*2015*		29
2.03	Low-Income and Low Access to a Grocery Store	*percent*	12.8				*2015*		29
2.03	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		29
1.88	Overcrowded Households	*percent of households*	3.4		3		*2015-2019*		1
1.85	Farmers Market Density	*markets/ 1,000 population*	0				*2018*		29
1.85	People 65+ with Low Access to a Grocery Store	*percent*	6.2				*2015*		29
1.82	Annual Ozone Air Quality		C				*2017-2019*		2
1.82	Grocery Store Density	*stores/ 1,000 population*	0.1				*2016*		29
1.82	SNAP Certified Stores	*stores/ 1,000 population*	0.8				*2017*		29
1.71	Food Environment Index	*index*	7		6.9	7.8	*2021*		7
1.68	Access to Exercise Opportunities	*percent*	78.9		88.7	84	*2020*		7
1.68	Households with No Car and Low Access to a Grocery Store	*percent*	2.9				*2015*		29
1.68	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*		29
1.68	Teens with Asthma	*percent*	23.1		21.3		*2020*		23
1.65	Number of Extreme Heat Days	*days*	22				*2016*		26

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1.65	Number of Extreme Heat Events	*events*	5				*2016*		26
1.65	Number of Extreme Precipitation Days	*days*	35				*2016*		26
1.65	PBT Released	*pounds*	590638.2				*2019*		30
1.59	Physical Environment Ranking	*ranking*	41				*2021*		7
1.47	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.5				*2016*		29
1.24	Annual Particle Pollution		A				*2017-2019*		2
1.18	Houses Built Prior to 1950	percent	5.3		4.1	17.5	2015-2019		1
1.06	Severe Housing Problems	percent	16.8		19.5	18	2013-2017		7
SCORE	**HEALTH CARE ACCESS & QUALITY**	**UNITS**	**POLK COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.12	Adults without Health Insurance	*percent*	25.1			12.2	*2018*		3
2.03	Median Monthly Medicaid Enrollment	*enrollments/ 100,000 population*	26508.1		19940.3		*2020*		9
1.94	Adults who Visited a Dentist	*percent*	56.1			66.5	*2018*		3
1.94	Adults with Health Insurance	*percent*	78.4		80.5	87.1	*2019*		1

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1.91	Primary Care Provider Rate	*providers/ 100,000 population*	48		72.2		*2018*		7
1.79	Dentist Rate	*dentists/ 100,000 population*	34.1		60.8		*2019*		7
1.59	Children with Health Insurance	*percent*	92.6		92.4	94.3	*2019*		1
1.59	Clinical Care Ranking	*ranking*	35				*2021*		7
1.50	Adults with a Usual Source of Health Care	*percent*	72.2		72		*2017-2019*		10
1.50	Mental Health Provider Rate	*providers/ 100,000 population*	93.4		169		*2020*		7
1.32	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	81.8		120.6		*2020*		7
1.24	Adults who have had a Routine Checkup	*percent*	78.5			76.7	*2018*		3
1.24	Consumer Expenditures: Health Insurance	*average dollar amount per consumer unit*	3983.2		4247.2	4321.1	*2021*		6
SCORE	**HEART DISEASE & STROKE**	**UNITS**	**POLK COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.82	Hypertension: Medicare Population	*percent*	66.3		62.4	57.2	*2018*		5
2.53	Hyperlipidemia: Medicare Population	*percent*	62.1		59.2	47.7	*2018*		5

Appendix A. Secondary Data Methodology and Data Scoring Tables

2.44	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	60	33.4	41.4	37	*2019*		18
2.35	Atrial Fibrillation: Medicare Population	*percent*	10.3		10.1	8.4	*2018*		5
2.18	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	110		42.8		*2018*		26
1.85	Age-Adjusted Hospitalization Rate due to Heart Attack	*hospitalizations/ 10,000 population 35+ years*	33.6		29.7		*2018*		26
1.85	High Blood Pressure Prevalence	*percent*	42.2	27.7	33.5		*2017-2019*		10
1.76	Adults who Experienced a Stroke	*percent*	4.4			3.4	*2018*		3
1.76	Adults who Experienced Coronary Heart Disease	*percent*	9.3			6.8	*2018*		3
1.76	Ischemic Heart Disease: Medicare Population	*percent*	34.5		34.3	26.8	*2018*		5
1.65	Heart Failure: Medicare Population	*percent*	14.7		14.8	14	*2018*		5
1.59	Cholesterol Test History	*percent*	80.6			81.5	*2017*		3
1.41	Adults who Have Taken Medications for High Blood Pressure	*percent*	77.6			75.8	*2017*		3
1.41	High Cholesterol Prevalence: Adults 18+	*percent*	36.9			34.1	*2017*		3

Appendix A. Secondary Data Methodology and Data Scoring Tables

1.32	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	95	71.1	88.6	88	*2019*		18
1.00	Stroke: Medicare Population	*percent*	4		4.7	3.8	*2018*		5
SCORE	**IMMUNIZATIONS & INFECTIOUS DISEASES**	**UNITS**	**POLK COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.38	Chlamydia Incidence Rate	*cases/ 100,000 population*	568		525.5	551	*2019*		16
2.29	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	14.8		8.4	12.3	*2019*		18
1.91	Gonorrhea Incidence Rate	*cases/ 100,000 population*	187.7		174.9	187.8	*2019*		16
1.88	Overcrowded Households	*percent of households*	3.4		3		*2015-2019*		1
1.65	HIV Incidence Rate	*cases/ 100,000 population*	18.7		21.6		*2019*	Black (34.7) White (5.5) Hispanic/La tino (10.9) Male (16.7) Female (5.5)	14
1.65	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	33.7	11.1	33.4		*2019*		13
1.56	Syphilis Incidence Rate	*cases/ 100,000 population*	12.3		15.1	11.9	*2019*		16

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1.50	Adults 65+ with Influenza Vaccination	*percent*	57.7		58.3		*2017-2019*		10
1.47	Kindergartners with Required Immunizations	*percent*	95.7		93.5		*2020*		15
1.32	Adults 65+ with Pneumonia Vaccination	*percent*	70.3		66.8		*2017-2019*		10
1.18	Tuberculosis Incidence Rate	*cases/ 100,000 population*	1.3	1.4	1.9		*2020*		17
0.97	Persons Fully Vaccinated Against COVID-19	*percent*	50.8				*Nov 5,2021*		4
0.71	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	6.5		6	31.2	*Nov 5,2021*		24
0.44	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0		0	3.4	*Nov 5,2021*		24
SCORE	**MATERNAL, FETAL & INFANT HEALTH**	**UNITS**	**POLK COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
1.97	Teen Birth Rate: 15-19	*live births/ 1,000 females aged 15-19*	24.4		16.2	16.7	*2019*		18
1.91	Babies with Low Birth Weight	*percent*	9		8.8	8.3	*2019*		18
1.91	Mothers who Received Early Prenatal Care	*percent*	72.2		75.9	75.8	*2019*		18
1.91	Preterm Births	*percent*	10.9	9.4	10.6	10	*2019*		18
1.68	Infant Mortality Rate	*deaths/ 1,000 live births*	6.7	5	6		*2019*	Black (12.7) White (6)	18

Appendix A. Secondary Data Methodology and Data Scoring Tables

								Hispanic/Latino (6.5)	
SCORE	**MENTAL HEALTH & MENTAL DISORDERS**	**UNITS**	**POLK COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.38	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	17.3	12.8	14.5	13.9	*2019*	Black (3.5) White (15.4) Hispanic/Latino (4.1) Male (21.3) Female (4.8)	18
2.29	Depression: Medicare Population	*percent*	20.2		19.5	18.4	*2018*		5
2.12	Alzheimer's Disease or Dementia: Medicare Population	*percent*	11.7		12.6	10.8	*2018*		5
2.03	Frequent Mental Distress	*percent*	15.7		13.4	13	*2018*		7
1.76	Poor Mental Health: 14+ Days	*percent*	14.9			12.7	*2018*		3
1.68	Self-Reported General Health Assessment: Good or Better	*percent*	75.2		80.3		*2017-2019*		10
1.50	Mental Health Provider Rate	*providers/ 100,000 population*	93.4		169		*2020*		7
SCORE	**MORTALITY DATA**	**UNITS**	**POLK COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.44	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	60	33.4	41.4	37	*2019*		18

Appendix A. Secondary Data Methodology and Data Scoring Tables

2.38	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	17.3	12.8	14.5	13.9	*2019*	Black (3.5) White (15.4) Hispanic/Latino (4.1) Male (21.3) Female (4.8)	18
2.29	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	14.5	8.9	13.1		*2017-2019*		18
2.29	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	14.8		8.4	12.3	*2019*		18
2.18	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	110		42.8		*2018*		26
1.97	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	24.8		19.7	21.6	*2019*		18
1.68	Infant Mortality Rate	*deaths/ 1,000 live births*	6.7	5	6		*2019*	Black (12.7) White (6) Hispanic/Latino (6.5)	18
1.59	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	20.8		23.6	21	*2017-2019*		7
1.53	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	17.3		14.7		*2019*		18
1.50	Life Expectancy	*years*	78.6		80.2	79.2	*2017-2019*		7
1.47	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	7.4	16.9	7.4		*2017-2019*	Black (12.9) White (6.7) Hispanic/Latino (9.5)	18

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1.41	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	24.3		25.6	22.8	*2017-2019*		4
1.41	Mortality Ranking	*ranking*	25				*2021*		7
1.35	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	10.7	15.3	10.4		*2017-2019*		18
1.35	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	11.7		9.9	12.9	*2017-2019*	Black (28.2) White (9.5) Hispanic/Latino (10.4) Male (13.1) Female (10.3)	4
1.32	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	95	71.1	88.6	88	*2019*		18
1.26	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	53.4	43.2	55.5	49.3	*2019*		18
1.24	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	39.4	25.1	35.3		*2017-2019*		18
1.06	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	154.1	122.7	146.1		*2017-2019*		18
1.06	Alcohol-Impaired Driving Deaths	*percent of driving*	25	28.3	22.3	27	*2015-2019*		7

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		deaths with alcohol involvement							
SCORE	**OLDER ADULTS**	**UNITS**	**POLK COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
3.00	Chronic Kidney Disease: Medicare Population	*percent*	33		28.2	24.5	*2018*		5
2.82	Hypertension: Medicare Population	*percent*	66.3		62.4	57.2	*2018*		5
2.53	Hyperlipidemia: Medicare Population	*percent*	62.1		59.2	47.7	*2018*		5
2.41	Asthma: Medicare Population	*percent*	5.9		5.2	5	*2018*		5
2.38	Diabetes: Medicare Population	*percent*	31.2		27.8	27	*2018*		5
2.35	Atrial Fibrillation: Medicare Population	*percent*	10.3		10.1	8.4	*2018*		5
2.29	Depression: Medicare Population	*percent*	20.2		19.5	18.4	*2018*		5
2.24	Osteoporosis: Medicare Population	*percent*	8.4		8.3	6.6	*2018*		5
2.18	Cancer: Medicare Population	*percent*	9.7		10.1	8.4	*2018*		5
2.18	COPD: Medicare Population	*percent*	14.7		13.5	11.5	*2018*		5
2.12	Alzheimer's Disease or Dementia: Medicare Population	*percent*	11.7		12.6	10.8	*2018*		5

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2.12	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	36.7		37.5	33.5	*2018*		5
1.94	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	27.5			32.4	*2018*		3
1.94	Adults 65+ with Total Tooth Loss	*percent*	17.7			13.5	*2018*		3
1.85	People 65+ with Low Access to a Grocery Store	*percent*	6.2				*2015*		29
1.82	People 65+ Living Below Poverty Level	*percent*	9.9		10.4	9.3	*2015-2019*	Black (18.8) White (8.2) Asian (16.3) American Indian/Alaskan Native (6.3) Native Hawaiian/Pacific islander (28.1) Multiracial (15.2) Other (12.3) Hispanic/Latino (15.4) Male (8.5) Female (11.2)	1
1.76	Ischemic Heart Disease: Medicare Population	*percent*	34.5		34.3	26.8	*2018*		5

Appendix A. Secondary Data Methodology and Data Scoring Tables

1.65	Heart Failure: Medicare Population	*percent*	14.7		14.8	14	*2018*		5
1.59	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	29.2			28.4	*2018*		3
1.59	Adults with Arthritis	*percent*	28.7			25.8	*2018*		3
1.59	Colon Cancer Screening	*percent*	64.2	74.4		66.4	*2018*		3
1.50	Adults 65+ with Influenza Vaccination	*percent*	57.7		58.3		*2017-2019*		10
1.32	Adults 65+ with Pneumonia Vaccination	*percent*	70.3		66.8		*2017-2019*		10
1.00	Stroke: Medicare Population	*percent*	4		4.7	3.8	*2018*		5
0.65	People 65+ Living Alone	*percent*	21.5		23.7	26.1	*2015-2019*		1
SCORE	**ORAL HEALTH**	**UNITS**	**POLK COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
1.94	Adults 65+ with Total Tooth Loss	*percent*	17.7			13.5	*2018*		3
1.94	Adults who Visited a Dentist	*percent*	56.1			66.5	*2018*		3
1.79	Dentist Rate	*dentists/ 100,000 population*	34.1		60.8		*2019*		7
1.35	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	13.8		13.5		*2016-2018*	Black (8.9) White (14.6) Hispanic/Latino (5.9)	32

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SCORE	OTHER CONDITIONS	UNITS	POLK COUNTY	HP2030	Florida	U.S.	MEASUREMENT PERIOD	RACE DISPARITY	Source
3.00	Chronic Kidney Disease: Medicare Population	*percent*	33		28.2	24.5	*2018*		5
2.24	Osteoporosis: Medicare Population	*percent*	8.4		8.3	6.6	*2018*		5
2.12	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	36.7		37.5	33.5	*2018*		5
1.76	Adults with Kidney Disease	*Percent of adults*	3.7			3.1	*2018*		3
1.59	Adults with Arthritis	*percent*	28.7			25.8	*2018*		3
1.35	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	11.7		9.9	12.9	*2017-2019*	Black (28.2) White (9.5) Hispanic/Latino (10.4) Male (13.1) Female (10.3)	4
SCORE	**PHYSICAL ACTIVITY**	**UNITS**	**POLK COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.03	Children with Low Access to a Grocery Store	*percent*	7.6				*2015*		29
2.03	Low-Income and Low Access to a Grocery Store	*percent*	12.8				*2015*		29
2.03	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*		29

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2.00	Teens without Sufficient Physical Activity	*percent*	85.7		82.3		*2020*		13
1.85	Adults Who Are Obese	*percent*	36.3		27		*2017-2019*		10
1.85	Adults who are Overweight or Obese	*percent*	71.4		64.6		*2017-2019*		10
1.85	Adults who are Sedentary	*percent*	31.7	21.2	26.5		*2017-2019*		10
1.85	Farmers Market Density	*markets/ 1,000 population*	0				*2018*		29
1.85	People 65+ with Low Access to a Grocery Store	*percent*	6.2				*2015*		29
1.82	Grocery Store Density	*stores/ 1,000 population*	0.1				*2016*		29
1.82	SNAP Certified Stores	*stores/ 1,000 population*	0.8				*2017*		29
1.71	Food Environment Index	*index*	7		6.9	7.8	*2021*		7
1.68	Access to Exercise Opportunities	*percent*	78.9		88.7	84	*2020*		7
1.68	Households with No Car and Low Access to a Grocery Store	*percent*	2.9				*2015*		29
1.68	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*		29
1.59	Health Behaviors Ranking	*ranking*	36				*2021*		7
1.47	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.5				*2016*		29

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SCORE	PREVENTION & SAFETY	UNITS	POLK COUNTY	HP2030	Florida	U.S.	MEASUREMENT PERIOD	RACE DISPARITY	Source
1.59	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	20.8		23.6	21	*2017-2019*		7
1.53	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	17.3		14.7		*2019*		18
1.26	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	53.4	43.2	55.5	49.3	*2019*		18
1.06	Severe Housing Problems	*percent*	16.8		19.5	18	*2013-2017*		7
SCORE	**RESPIRATORY DISEASES**	**UNITS**	**POLK COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.41	Asthma: Medicare Population	*percent*	5.9		5.2	5	*2018*		5
2.29	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	14.8		8.4	12.3	*2019*		18
2.18	COPD: Medicare Population	*percent*	14.7		13.5	11.5	*2018*		5
2.03	Adults with Current Asthma	*percent*	10.1		7.4		*2017-2019*	Black (17.8) White (9.4) Hispanic/Latino (6.4) Male (5.7) Female (14.2)	10

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1.91	Adolescents who Use Electronic Vaping: Lifetime	*percent*	29.3		26.4		*2020*		23
1.76	Adults with COPD	*Percent of adults*	10			6.9	*2018*		3
1.74	Adolescents who Use Electronic Vaping: Past 30 Days	*percent*	15.2		14.5		*2020*		23
1.68	Adults Who Currently Use E-Cigarettes	*percent*	7		7.5		*2017-2019*		10
1.68	Adults who Smoke	*percent*	17.8	5	14.8		*2017-2019*		10
1.68	Teens with Asthma	*percent*	23.1		21.3		*2020*		23
1.50	Adults 65+ with Influenza Vaccination	*percent*	57.7		58.3		*2017-2019*		10
1.32	Adolescents who Use Smokeless Tobacco: Lifetime	*percent*	4.5		3.7		*2020*		23
1.32	Adults 65+ with Pneumonia Vaccination	*percent*	70.3		66.8		*2017-2019*		10
1.32	Teens who Smoke Cigarettes: High School Students	*percent*	1.9		1.5		*2020*		23
1.24	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	39.4	25.1	35.3		*2017-2019*		18
1.24	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	63.7		56.6		*2016-2018*		32

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1.18	Tuberculosis Incidence Rate	*cases/ 100,000 population*	1.3	1.4	1.9		*2020*		17
0.97	Adolescents who Use Smokeless Tobacco: Past 30 Days	*percent*	1.3		1.3		*2020*		23
0.71	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	6.5		6	31.2	*5-Nov-21*		24
0.44	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0		0	3.4	*5-Nov-21*		24
SCORE	**SEXUALLY TRANSMITTED INFECTIONS**	**UNITS**	**POLK COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.38	Chlamydia Incidence Rate	*cases/ 100,000 population*	568		525.5	551	*2019*		16
1.91	Gonorrhea Incidence Rate	*cases/ 100,000 population*	187.7		174.9	187.8	*2019*		16
1.65	HIV Incidence Rate	*cases/ 100,000 population*	18.7		21.6		*2019*	Black (34.7) White (5.5) Hispanic/La tino (10.9) Male (16.7) Female (5.5)	14
1.56	Syphilis Incidence Rate	*cases/ 100,000 population*	12.3		15.1	11.9	*2019*		16

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SCORE	TOBACCO USE	UNITS	POLK COUNTY	HP2030	Florida	U.S.	MEASUREMENT PERIOD	RACE DISPARITY	Source
1.91	Adolescents who Use Electronic Vaping: Lifetime	*percent*	29.3		26.4		*2020*		23
1.74	Adolescents who Use Electronic Vaping: Past 30 Days	*percent*	15.2		14.5		*2020*		23
1.68	Adults Who Currently Use E-Cigarettes	*percent*	7		7.5		*2017-2019*		10
1.68	Adults who Smoke	*percent*	17.8	5	14.8		*2017-2019*		10
1.32	Adolescents who Use Smokeless Tobacco: Lifetime	*percent*	4.5		3.7		*2020*		23
1.32	Teens who Smoke Cigarettes: High School Students	*percent*	1.9		1.5		*2020*		23
0.97	Adolescents who Use Smokeless Tobacco: Past 30 Days	*percent*	1.3		1.3		*2020*		23
SCORE	**WEIGHT STATUS**	**UNITS**	**POLK COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.00	Teens who are Obese: High School Students	*percent*	20.3		15.4		*2020*		13
1.85	Adults Who Are Obese	*percent*	36.3		27		*2017-2019*		10
1.85	Adults who are Overweight or Obese	*percent*	71.4		64.6		*2017-2019*		10

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SCORE	WELLNESS & LIFESTYLE	UNITS	POLK COUNTY	HP2030	Florida	U.S.	MEASUREMENT PERIOD	RACE DISPARITY	Source
2.21	Frequent Physical Distress	*percent*	14.5		12.6	11	*2018*		7
2.21	Insufficient Sleep	*percent*	40.2	31.4	37.3	35	*2018*		7
1.85	High Blood Pressure Prevalence	*percent*	42.2	27.7	33.5		*2017-2019*		10
1.76	Poor Physical Health: 14+ Days	*percent*	15.6			12.5	*2018*		3
1.68	Self-Reported General Health Assessment: Good or Better	*percent*	75.2		80.3		*2017-2019*		10
1.50	Life Expectancy	*years*	78.6		80.2	79.2	*2017-2019*		7
1.41	Morbidity Ranking	*ranking*	33				*2021*		7
0.88	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1366.1		1520	1638.9	*2021*		6
SCORE	**WOMEN'S HEALTH**	**UNITS**	**POLK COUNTY**	**HP2030**	**Florida**	**U.S.**	**MEASUREMENT PERIOD**	**RACE DISPARITY**	**Source**
2.18	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	12.2		9		*2016-2018*		32
1.94	Cervical Cancer Screening: 21-65	*Percent*	81.5	84.3		84.7	*2018*		3
1.41	Mammogram in Past 2 Years: 50-74	*percent*	72.4	77.1		74.8	*2018*		3
1.35	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	10.7	15.3	10.4		*2017-2019*		18
1.12	Pap Test in Past Year	*percent*	55.1		48.4		*2016*		10

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0.88	Breast Cancer Incidence Rate	*cases/ 100,000 females*	117.4		121.2		*2016-2018*		32
0.82	Mammogram in Past Year: 40+	*percent*	72.7		60.8		*2016*		10

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

ZIP CODE	CITY	POPULATION
33801	Lakeland	38663
33803	Lakeland	31535
33805	Lakeland	28372
33809	Lakeland	33531
33810	Lakeland	56983
33811	Lakeland	26453
33812	Lakeland	16254
33813	Lakeland	38797
33815	Lakeland	16869
33823	Auburndale	35661
33827	Babson	3533
33830	Bartow	32634
33835	Bradley	393
33837	Davenport	29688
33838	Dundee	5558
33839	Eagle Lake	4080
33840	Eaton Park	493
33841	Fort Meade	10083
33843	Frostproof	13859
33844	Haines City	44063
33846	Highland City	671
33847	Hiomeland	348
33849	Kathleen	874
33850	Lake Alfred	9702
33851	Lake Hamilton	342
33853	Lake Wales	12324
33854	Lakeshore	218
33855	Indian Lake Estates	702
33856	Nalcrest	599
33859	Lake Wales	12483
33860	Mulberry	27876
33867	River Ranch	1456
33868	Polk City	14041
33877	Waverly	315
33880	Winter Haven	45130
33881	Winter Haven	36470
33884	Winter Haven	37123
33896	Davenport	14042
33897	Davenport	23042
33898	Lake Wales	18322
34759	Kissimmee	44309
	Polk County	753,298
	Florida	21,976,313
	U.S.	326,569,308

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

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

ZIP CODE	CITY	FAMILIES BELOW POVERTY LEVEL (%)
33801	Lakeland	19.62%
33803	Lakeland	8.06%
33805	Lakeland	23.01%
33809	Lakeland	8.17%
33810	Lakeland	8.05%
33811	Lakeland	6.59%
33812	Lakeland	4.32%
33813	Lakeland	2.65%
33815	Lakeland	16.20%
33823	Auburndale	12.17%
33827	Babson	6.35%
33830	Bartow	9.24%
33835	Bradley	4.95%
33837	Davenport	8.91%
33838	Dundee	14.80%
33839	Eagle Lake	8.70%
33840	Eaton Park	17.86%
33841	Fort Meade	8.79%
33843	Frostproof	11.71%
33844	Haines City	14.59%
33846	Highland City	9.30%
33847	Hiomeland	3.53%
33849	Kathleen	8.55%
33850	Lake Alfred	16.67%
33851	Lake Hamilton	7.00%
33853	Lake Wales	16.86%
33854	Lakeshore	15.15%
33855	Indian Lake Estates	8.41%
33856	Nalcrest	15.00%
33859	Lake Wales	10.21%
33860	Mulberry	10.49%
33867	River Ranch	3.23%
33868	Polk City	8.91%
33877	Waverly	8.64%
33880	Winter Haven	12.44%
33881	Winter Haven	13.52%
33884	Winter Haven	6.70%
33896	Davenport	7.71%
33897	Davenport	6.70%
33898	Lake Wales	12.84%
34759	Kissimmee	10.35%
	Polk County	10.6%
	Florida	9.3%
	U.S.	9.1%

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

Appendix B. Index of Disparity

Health Equity Index (Figure 21)

ZIP CODE	CITY	INDEX SCORE
33801	Lakeland	91.6
33803	Lakeland	49.7
33805	Lakeland	91.7
33809	Lakeland	55.9
33810	Lakeland	61.8
33811	Lakeland	42.2
33812	Lakeland	21.4
33813	Lakeland	13.5
33815	Lakeland	92.8
33823	Auburndale	72.2
33827	Babson	73.1
33830	Bartow	65.7
33837	Davenport	56
33838	Dundee	86.9
33839	Eagle Lake	71.7
33841	Fort Meade	82.7
33843	Frostproof	92
33844	Haines City	86.2
33849	Kathleen	51.2
33850	Lake Alfred	85.6
33853	Lake Wales	93.6
33855	Indian Lake Estates	78.2
33856	Nalcrest	92.8
33859	Lake Wales	78
33860	Mulberry	64.3
33867	River Ranch	62.9
33868	Polk City	69.7
33880	Winter Haven	79.1
33881	Winter Haven	82.5
33884	Winter Haven	38.7
33896	Davenport	44.8
33897	Davenport	60.2
33898	Lake Wales	76.1
34759	Kissimmee	78.6
	Polk County	61.8

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

Appendix B. Index of Disparity

Food Insecurity Index (Figure 22)

ZIP CODE	CITY	INDEX VALUE
33801	Lakeland	82.4
33803	Lakeland	56.8
33805	Lakeland	93.7
33809	Lakeland	50.7
33810	Lakeland	44.4
33811	Lakeland	38.7
33812	Lakeland	27.5
33813	Lakeland	16.1
33815	Lakeland	89.3
33823	Auburndale	53.4
33827	Babson	43
33830	Bartow	73.2
33837	Davenport	36.7
33838	Dundee	69
33839	Eagle Lake	71.8
33841	Fort Meade	75.2
33843	Frostproof	70.3
33844	Haines City	70.9
33849	Kathleen	73.6
33850	Lake Alfred	61.1
33853	Lake Wales	84.8
33855	Indian Lake Estates	28.7
33856	Nalcrest	73.9
33859	Lake Wales	73.6
33860	Mulberry	55.5
33867	River Ranch	18
33868	Polk City	62.8
33880	Winter Haven	69.7
33881	Winter Haven	65.2
33884	Winter Haven	31.8
33896	Davenport	57.1
33897	Davenport	46.3
33898	Lake Wales	60.4
34759	Kissimmee	63.2
	Polk County	47.4

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

Appendix B. Index of Disparity

Mental Health Index (Figure 23)

ZIP CODE	CITY	INDEX VALUE
33801	Lakeland	94.7
33803	Lakeland	79.2
33805	Lakeland	96.3
33809	Lakeland	82.5
33810	Lakeland	81.8
33811	Lakeland	43.5
33812	Lakeland	44.2
33813	Lakeland	50.7
33815	Lakeland	93.1
33823	Auburndale	82.1
33827	Babson	71
33830	Bartow	80.6
33837	Davenport	61.7
33838	Dundee	77.8
33839	Eagle Lake	47.2
33841	Fort Meade	78.8
33843	Frostproof	89
33844	Haines City	81.4
33850	Lake Alfred	89.1
33853	Lake Wales	93.4
33859	Lake Wales	92.8
33860	Mulberry	57
33868	Polk City	65.4
33880	Winter Haven	78.3
33881	Winter Haven	97.3
33884	Winter Haven	77.8
33896	Davenport	47.5
33897	Davenport	56.3
33898	Lake Wales	92.8
34759	Kissimmee	78.8
	Polk County	88.6

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

Appendix C. Community Input Assessment Tools

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

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

Appendix C. Community Input Assessment Tools
Community Health Survey

All4HealthFL
Four Counties. One Vision.

2022 All4HealthFL Community Health Survey

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

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

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

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

BayCare AdventHealth MOFFITT CANCER CENTER TGH Tampa General Hospital

In collaboration with: JOHNS HOPKINS All Children's Hospital

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

BAYFRONT HEALTH St. Petersburg

Lakeland Regional Health

DEMOGRAPHICS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14. **Are you**

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

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

- ☐ Yes
- ☐ No

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

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

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

☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 or more

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

- ☐ Yes
- ☐ No

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

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

CHILDRENS SECTION

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

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

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

☐ Yes ☐ No **(skip to question 22)**

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

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

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

☐ Yes ☐ No **(skip to question 24)**

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

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

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

☐ Yes ☐ No **(skip to question 26)**

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

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

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

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

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

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

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

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

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

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

--End Children's Section --

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

28. **Overall, how would you rate the health of the community in which you live? (Please choose only one)**
☐ Very unhealthy ☐ Unhealthy ☐ Somewhat healthy ☐ Healthy ☐ Very healthy
☐ Not sure

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

--Survey continues on next page --

PERSONAL HEALTH

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

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

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

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

☐ Yes ☐ No **(Skip to question 46)**

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

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

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

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

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

☐ Yes ☐ No **(Skip to question 49)**

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

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

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

☐ Yes ☐ No **(Skip to question 51)**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ADVERSE CHILDHOOD EXPERIENCES

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

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

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

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

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

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

RESOURCE LIST

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

FindHelp.org

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

United Way 211

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

National Suicide Prevention Lifeline

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

Crisis Text Line

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

Hillsborough County

Resources to Help You with Mental Health

Pasco County

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

Pinellas County

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

Polk County

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

Information on Adverse Childhood Experiences

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

Recognizing and Treating Child Traumatic Stress

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

TedTalk: How Childhood Trauma Affects Health Across a Lifetime

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

Community Engagement 4
Black/African American

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

Real-Time Record

Collaborative LABS at St. Petersburg College

EXPERT FACILITATORS IN STRATEGIC COLLABORATION

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

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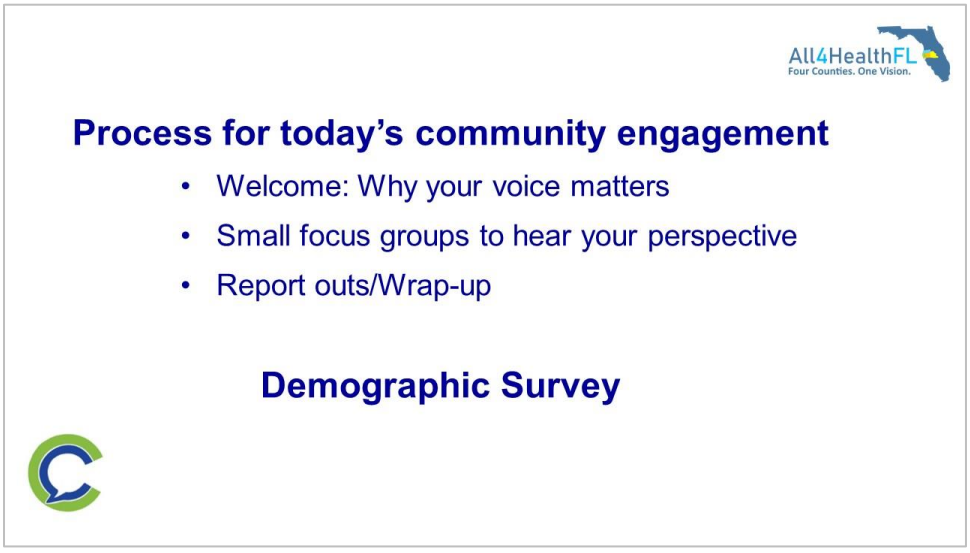
Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

Welcome

Welcome to the All4HealthFL community engagement this afternoon! St. Petersburg College Collaborative Labs is proud to be a partner today. Thank you for being here with us today.

Tina introduced the team facilitating the engagement and reviewed tips for using Zoom.



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Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

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

Hello! Thank you for being here today. The purpose of the All4HealthFL Collaborative is to improve health by leading regional, outcome-driven health initiatives that have been prioritized through community health assessments. The All4HealthFL Collaborative includes all of the not-for-profit hospitals and the department of health for Hillsborough, Pasco, Pinellas, and Polk counties.

We are so pleased to have each and every one of you present and participating in these focus groups today. We value the unique perspectives and lived experiences you bring with you today. We'll be asking you for your thoughts, opinions, and experiences about the strengths of our community, the challenges or barriers that exist to accessing care and resources, and who in our community is most impacted by those challenges.

We have the opportunity to go deep today. Let's be caring, kind, and respectful today as we share with one another, acknowledging the courage and bravery it takes to share from our personal experiences. Know that your personal identity stays within this group and will not be shared in any of our summary reports or information used to inform our efforts. Your overall feedback will help us create stronger programs and services to meet the needs of our community over the next three to four years.

Thank you again for participating with us today. We know your time is valuable and are grateful you have shared this day with us. Welcome!

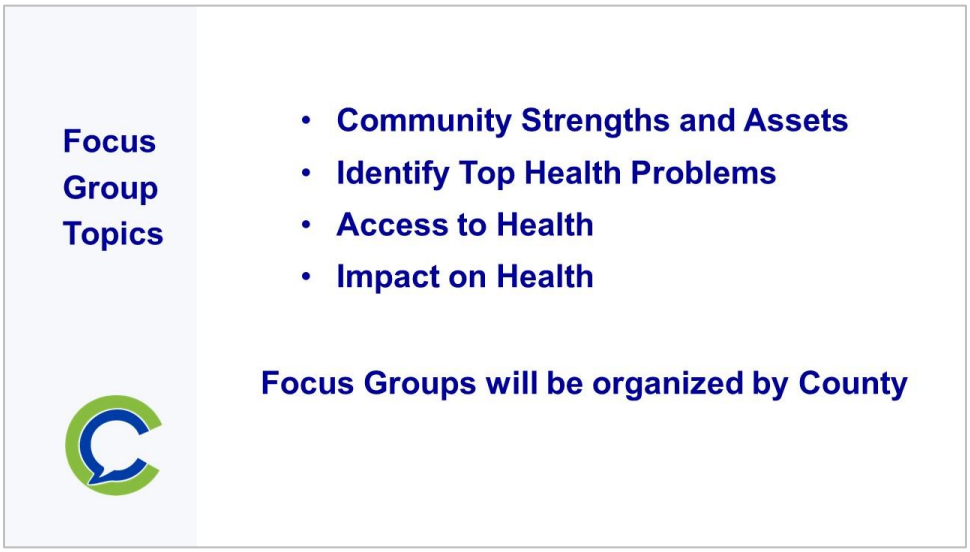
Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

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

Comments from Chat:

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

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses



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

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

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

Polk County Focus Group

Community Strengths & Assets

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

- Dr. Leslyn Borges Diaz – caring community; willing to share; expanding resources through strategic partnerships
- Tonya Akwetey – Agency Network Connection to help break down the silos within the social network; monthly meeting sharing case challenges that can be resolved quickly; 225 members in the network; more people are open to having the conversation about diversity; investment in outdoor activity
- Kimberly Pearsall – strong community history (3rd-4th generation)
- Alice Brown- strong collaboration; caring individuals; more people of color in leadership positions; Central Florida Speech and Hearing; mobile food banks
- Tonya Akwetey - We have a large faith-based community that is very involved within our county. Another strength is mostly everyone has opportunity to provide themselves a seat at the table if they choose to.

From Chat:

- Seeing and being a part of the progression of the networking of the organizations has been much better but definitely needs to continue.

Identify Top Health Problems

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

- Tonya Akwetey – lowest paid county; residents traveling to other counties to work due to salaries in Polk; transportation barriers; the hours of the clinics are limited
- Kimberly Pearsall – salary isn't reflective of educational experience, food and housing insecurity
- Leslyn – community members on disability have to wait 2 years to access full healthcare
- Alice Brown – rural areas are not aware of the services available; interact with faith-based leaders to reach vulnerable populations
- Felicia Bristol – information not shared to smaller areas

From Chat:

- More available hours and transportation

Access to Health

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

- Tonay Akwety - no
- Alice Brown- no, elderly population has limited access; food insecurity; medical coverage is limited; limited technology connection
- Felicia Bristol – no, people are unaware of the resources available; elderly population are unaware of the information; community communication is limited
- Leslyn – no; working adults can't access care due to medical stipulations; faith community leaders believe they don't need healthcare; homeless population not able to gain access

From Chat:

- No, everyone does not have access to what they need to be healthy. There is a gap a HUGE gap in our county.

Impact on Health

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

- Alice (wife, mother, grad student, community health leader) - work life balance; not taking care of yourself; mental health awareness
- Leslyn Campbell Borges Diaz - (mother, wife, immigrant, multi-racial) The stigma needs to be removed regarding mental health, lack of access to healthcare for immigrants
- Felicia Bristol – (black woman, single mother, caring for parents) caring for the community causing stress in the body; unexplained pain in the body related to stress
- Tonya Akwetey - (black, divorced, female)

From Chat:

- The stigma needs to be removed regarding mental health
- Focus on you and the little one 😊

Haitian Community Focus Group

Community Strengths & Assets

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

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

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

Identify Top Health Problems

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

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

Access to Health

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

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

Impact on Health

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

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

Wrap-Up and Next Steps

Team 4 – Polk County

Facilitator:

- Strengths: Polk is strong community with a lot of history, faith based, Agency Network Connection provides services
- Problems: rural areas not aware of social services available, low pay, transportation required to go outside of county, salaries not reflective of experience, food and housing insecurity, long wait time for those on disability to access healthcare
- Access to health: limited access for elderly, technology barriers, unawareness of resources, working but do not qualify for help,
- Impact: women serving the community and removing stigma of mental health and time for self-care

Team 5 – Haitian Community- Hillsborough/Polk

Facilitator: We talked about access to care, cultural beliefs and wellness, how the healthcare system is perceived and trust. We discussed looking a people as a whole person concept and addressing health issues from there. There are a lot of resources in the

community they are very close knit, especially in places of worship. There needs to be trust and transparency in healthcare and in obtaining services. Understand different backgrounds and the process of accessing care.

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

Community Engagement 6
Hispanic

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

Real-Time Record

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

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

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Focus Group Discussion Questions & Summary of Responses

Welcome

Facilitator, Collaborative Labs: Welcome to the All4HealthFL community engagement. I am with Collaborative Labs at St. Petersburg College, and we are facilitating today's meeting. Thank you for joining us!

introduced the team facilitating the engagement and then reviewed how to listen to the engagement in Spanish and useful features of Zoom.

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

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

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

Hello everyone, thank you for joining us today in this important conversation.

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Appendix C. Community Input Assessment Tools
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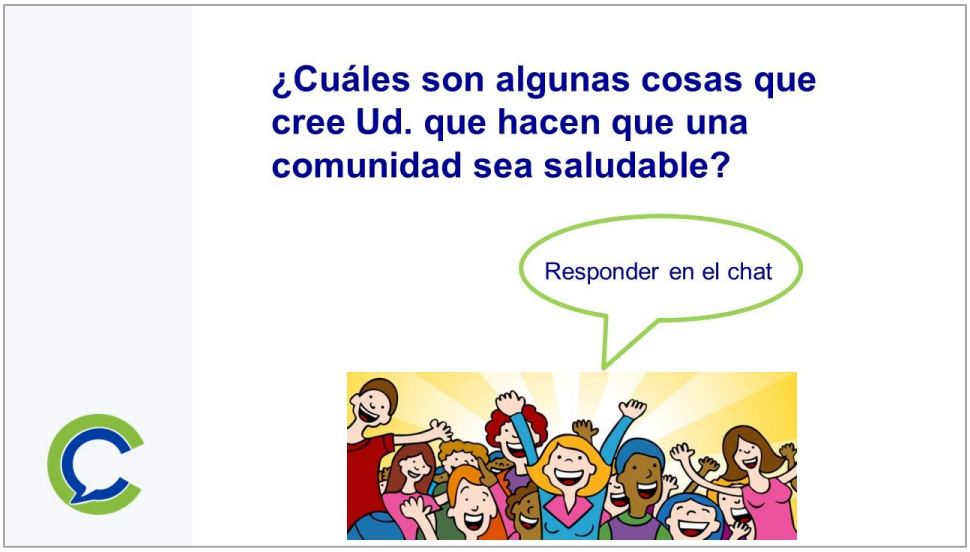
Thank you again for participating with us today. We know your time is valuable and are grateful you have shared this day with us.

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

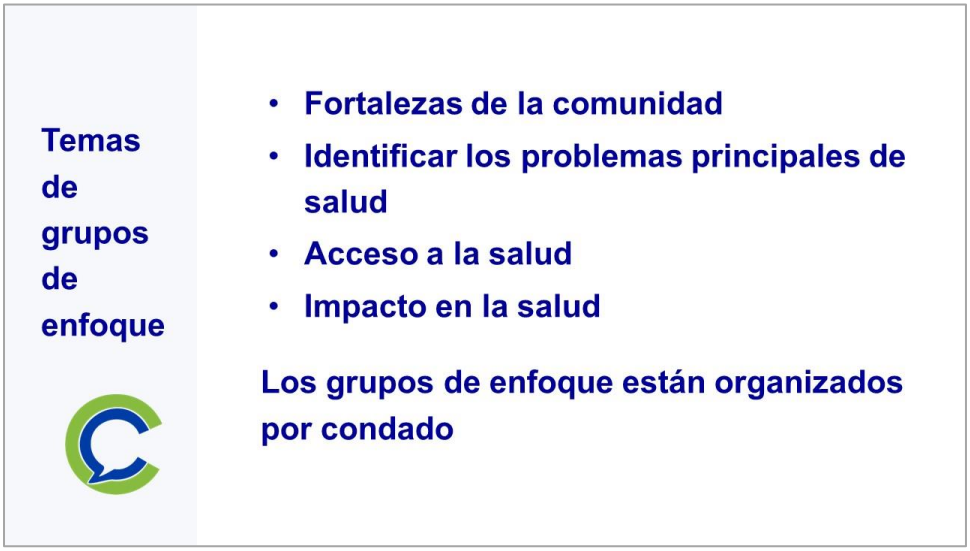


From Chat:

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

- Welcoming environment
- Education
- Access to health care
- Educacion
- Access to health care and education
- Amor, energia, solidaridad, humildad
- A united community
- Equal access to care and education on health
- Access to healthy foods
- Access to basic services gives
- Access to healthcare
- Services to be accessible
- Having a shared sense of community
- Fair and equal treatment
- Transportation services
- Seguridad, safety
- Transportation
- Que tengan acceso a salud mental, comida saludable, y acceso doctores que entiendan la comunidad
- Not being alone!
- Mental health

- Cultura - culture "la cultura cura"
- Access to health care and health plan to cover wellness programs and nutritionist professionals
- Education + Awareness + access to available resources
- Education, transportation, access to resources, parks and recreation, healthy foods
- Educacion de salud y alimentacion saludable
- Services in your own language
- Access to affordable care



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

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

Polk County Focus Group

Community Strengths & Assets

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

- Government leaders in Polk acknowledge the Spanish-speaking population
- Initiatives reaching the Spanish-speaking communities in far-reaching areas
- Community is engaged and aware of resources in the area
- The role of Spanish-owned small business in sharing information on resources.

Identify Top Health Problems

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

- Access to mental health services
- Access to affordable housing – rising costs
- Limited resources available to Medicare recipients
- Change of scope in providing healthcare regardless of plans
- Language barriers in access to healthcare and resources – especially when Internet access is required
- Access to transportation
- Education on healthy eating habits and access to health foods
- Widespread information on resources that are available
- Immigration status: correlation with access and quality of healthcare

Access to Health

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

- Computer literacy
- Transportation access
- Knowledge on preventative health resources
- Income inequality
- Reading and speaking English / Spanish-speaking personnel
- Reaching out to Spanish-speaking individuals about available organizations and resources for healthcare/social services

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

Impact on Health

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

- Appearance can lead to different treatment of individuals regardless of education and wealth – can deter accessing healthcare services or asking for services
- Racist undertones even among Hispanics based on country of origin – social status/educational background – another barrier to access services
- Fear perception also provides barrier to access.

Wrap-Up and Next Steps

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

Team 4 – Polk County

We also had people in our group that were in the community servicing the population discussed. We talked about people not having access to transportation and being treated differently due to skin color, race, or language spoken.

Also, one of the takeaways is the great and diverse resources available in Polk County. The barriers are providing information about available resources and technology challenges.

Community Engagement 3
Kids Population (All Counties)

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

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

Real-Time Record

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

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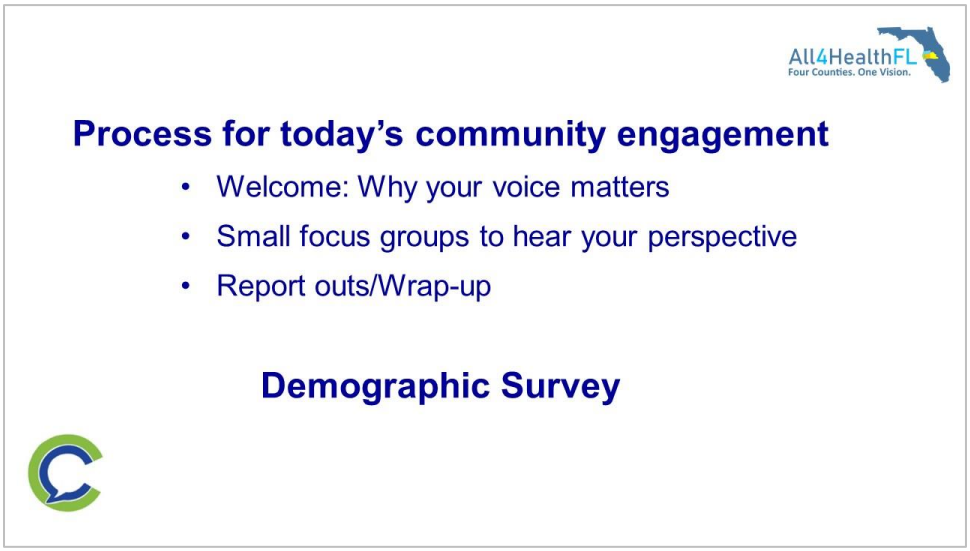

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We are so pleased to have each and every one of you present and participating in these focus groups today. We value the unique perspectives and lived experiences you bring with you today. We'll be asking you for your thoughts, opinions, and experiences about the strengths of our community, the challenges or barriers that exist to accessing care and resources, and who in our community is most impacted by those challenges.

We have the opportunity to go deep today. Let's be caring, kind, and respectful today as we share with one another, acknowledging the courage and bravery it takes to share from our personal experiences. Know that your personal identity stays within this group and will not be shared in any of our summary reports or information used to inform our efforts. Your overall feedback will help us create stronger programs and services to meet the needs of our community over the next 3-4 years.

Thank you again for participating with us today. We know your time is valuable and are grateful you have shared this day with us.

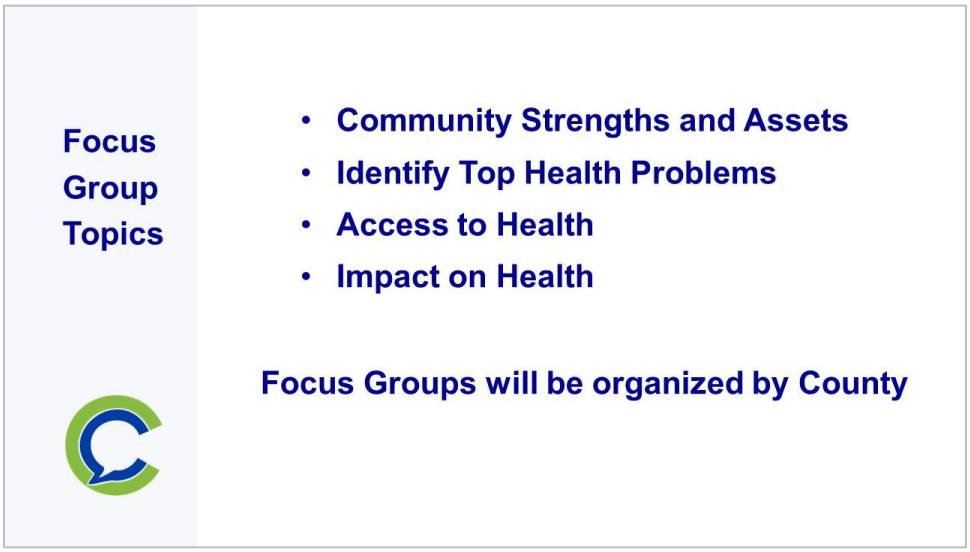
You are representing the four counties today and we are thankful for your help. We have a quick warm up activity to start with. What are some things you feel make a community healthy?

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

From Chat:

- Inclusiveness
- Support system
- Community connectedness
- Wellness efforts addressing the whole person
- Access to services
- Holistic care
- Support system - neighborhood
- Supportive relationships
- Sense of belonging
- Access to resources
- Teamwork, cultural competency
- Clean environments
- Proper nutrition
- Support for youth
- Green space, safety
- Access to proper care
- Caring individuals
- Safety
- Supportive Services
- Support and safety
- Strong families
- Safe spaces to ask questions and have discussions
- Safe, stable, nurturing parents and caregivers
- Inclusive supports
- Equality and equity
- Social support

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses



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

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

Polk County Focus Group

Community Strengths & Assets

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

- Matti Friedt – Headstart program, supporting family needs
- Alretha McKenzie – Girls & Boys Club, Girls Inc., great places for kids to find mentors; support for mental health; supporting resiliency for children; infant mental health
- Deborah Wiley – school board, offering social and emotional learning
- Denise Barnes – charter and church schools receive support from the school board, support for child safety
- Teri Saunders – quality focus on emotional well-being and trauma concerns
- David Acevedo – work groups/task groups to support children
- Roselyn Smith – Family Fundamental (toddler support); HealthyStart program promoting mental health

Identify Top Health Problems

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

- Roselyn Smith – homeless pregnant moms, limited housing support for homeless moms; essential needs not being met
- Alretha McKenzie – community trusting law enforcement; funding to support the programing
- Teri Saunders – interpersonal violence in the home; addiction and substance abuse (meth); limited residential substance abuse treatment programs with trauma focus;
- Deborah Wiley – affordable housing; transportation; funding for the school systems
- Matti Friedt – Hezel (over-the-counter meds for kids) is limited
- David Acevedo – moms using marijuana during pregnancy; unsafe sleeping conditions
- Denise Barnes - Health equity and access. Specialized services are difficult to access in Polk County and parents are having to travel to Tampa or Orlando for services.

From Chat:

- I agree with everyone's opinions, funding for programs for indigent people is a huge problem because a lot of these people don't have insurance, and that it a big requirement. So, they can't get the help they need.

Access to Health

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

- Denise Barnes – No, there are health biases. Health equity and access. Specialized services are difficult to access in Polk County and parents have to travel to Tampa or Orlando for services.; Florida is 4th or 5th lowest in the nation for wages; generational trauma
- Mattie Friedt – no, language barriers specifically in the Haitian community

- Teri Saunders – no, basic needs aren't being met
- Sherry Maczko – no, insurance needs

Impact on Health

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

- Denise Barnes (black female in urban environment) - heavy menstrual bleeding was labeled as "normal" by male doctors
- Alretha McKenzie – lack of faith in health care; family members who were labeled as hypochondriacs
- Deborah Wiley – as a school social worker, it's challenging to take a day off to care for yourself, the impact of stress
- David Acebedo – child workers have high-impact stress

Wrap-Up and Next Steps

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

Team 4 – Polk County

Facilitator:

- Strengths: support for mental health for children, resiliency of children, workgroups and task forces supporting children, for example, Healthy Start mental health program
- Problems: limited housing support, increase in homelessness with pregnant moms, violence in the home, substance abuse (meth), limited substance abuse treatment programs with a focus on trauma
- Access to health: barriers around transportation, insurance, language (Haitian), low wages (4th or 5th lowest in the nation)
- Impact: as social workers, self- and family-care is challenge and it is stressful, lack of faith in healthcare system overall (labelled "hypochondriacs")

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

Community Engagement 2
LGBTQ+

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

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

Real-Time Record

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

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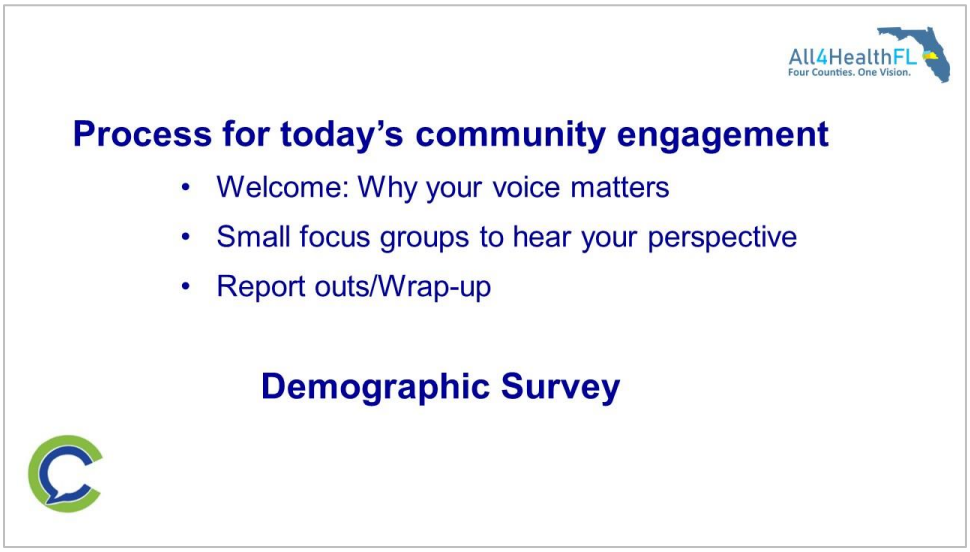
Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

Welcome

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

introduced the team facilitating the engagement and reviewed tips for using Zoom.



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

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

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

Good afternoon, thank you for joining us today. I wanted to share the purpose of today and why we asked you to be here.

The purpose of the All4HealthFL Collaborative is to improve health by leading regional, outcome-driven health initiatives that have been prioritized through community health assessments. The All4HealthFL Collaborative includes all of the not-for-profit hospitals and the department of health for Hillsborough, Pasco, Pinellas, and Polk counties.

We are so pleased to have each and every one of you present and participating in these focus groups today. We value the unique perspectives and lived experiences you bring with you today. We'll be asking you for your thoughts, opinions, and experiences about the strengths of our community, the challenges or barriers that exist to accessing care and resources, and who in our community is most impacted by those challenges.

We have the opportunity to go deep today. Let's be caring, kind, and respectful today as we share with one another, acknowledging the courage and bravery it takes to share from our personal experiences. Know that your personal identity stays within this group and will not be shared in any of our summary reports or information used to inform our efforts. Your overall feedback will help us create stronger programs and services to meet the needs of our community over the next 3-4 years.

Thank you again for participating with us today. We know your time is valuable and are grateful you have shared this day with us.

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

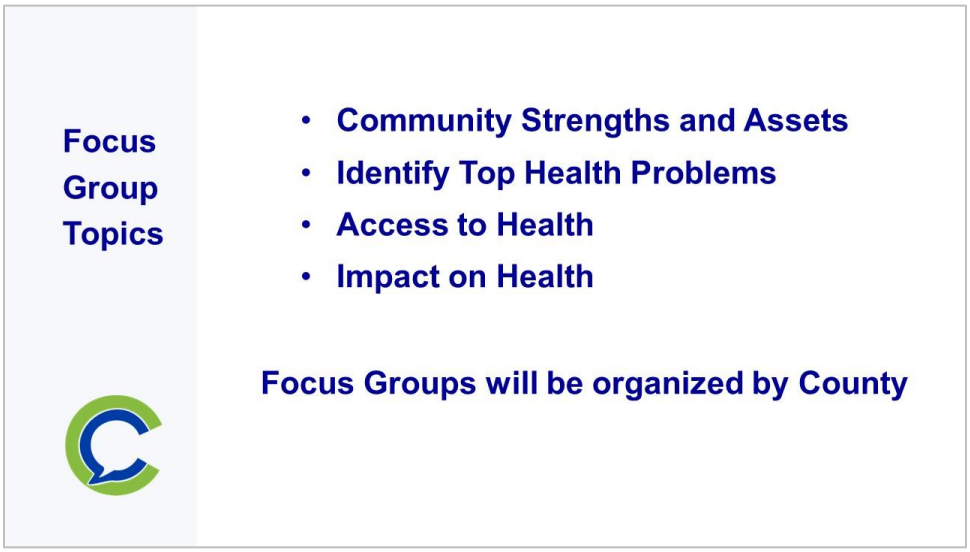
Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

From Chat:

What are some things you feel make a community healthy?

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

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses



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

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

Polk County Focus Group

Community Strengths & Assets

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

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

- More acceptance and tolerance
- An inclusive provider community for more availability of resources
- Been able to take care of specific needs and have provisions
- Inclusivity of groups as a whole
- Resiliency built through the acceptance in the United States
- Sensitive to immigrated individuals

From Chat:

- Nature, lakes, calm

Identify Top Health Problems

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

- Finding resources through barriers such as language and services
- Resources need to be in simple language/visuals with high quality
- Expanding experiences to be able to work with all individuals
- Giving a platform for patients/individuals to talk about their experiences
- Trying to separate the mental, physical, and emotional health concerns
- Misinformation and lack of importance results in disrespect
- Schools need to have resources to educate students on sexuality, mental health, and language/cultural competency
- Need to feel safe and have privacy

From Chat:

- Sometimes the translation on some websites do not give the right information

Access to Health

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

- Transportation
- Not individually tailored for what individuals have available (resources)
- Insurance issues (many don't have access to insurance)
- Understanding the move of the culture
- Barriers: language / poverty level / immigration status / time off from job
- Where you live affects your mental health level
- Mental health is not treated as a serious issue
- A matter of educating the community to have tolerance, display compassion, and dignity
- First responders need to be trained on cultural competency
- Mental health rehab centers are not readily available in county / very expensive

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

Impact on Health

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

- Did not have enough support during a transgender decision. Needed medical staff to take through step-by-step through a very complicated process
- Affected through the process, in the workplace, thoughts of non-acceptance
- After transition, have had people come alongside and share along with personal story. Given a positive reinforcement, passion, and confidence.
- Would like to have other providers to train to work with transgender community
- Support is everything
- Burn out syndrome for providers, lack of providers
- Acceptance in society
- When asking questions, are brushed off or ignored

Wrap-Up and Next Steps

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

Team 4 – Polk County

- Strengths: more acceptance and tolerance, inclusivity, resiliency from immigrants in area
- Problems: finding resources through barriers (language, services), platform needed to talk about experiences, the need to feel safe and privacy, cultural competencies within schools
- Access: transportation, insurance, language, poverty level, immigration status, time off from work, no mental health rehab centers in county
- Impacts: no support on medical decisions, including emotional decisions, acceptance needed, providers resigning because they are burned out.

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

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

Community Engagement 1
Older Adult Population

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

Real-Time Record

Collaborative LABS at St. Petersburg College

EXPERT FACILITATORS IN STRATEGIC COLLABORATION

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

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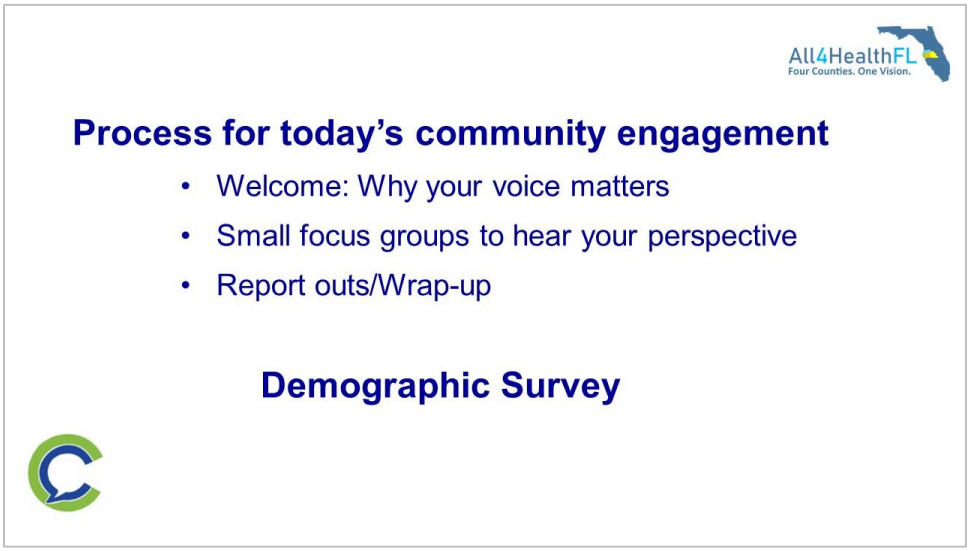
Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

Welcome

Good morning and thank you for spending part of your morning with us! *Tina introduced the team facilitating the engagement and reviewed tips for using Zoom.*



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

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Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

We are happy you are here today. We are one of the partners with All4HealthFL Collaborative. There are a number of focus groups happening this week. As you can see, there are a number of organizations you probably recognize behind this initiative.

The purpose of the All4HealthFL Collaborative is to improve health by leading regional, outcome-driven health initiatives that have been prioritized through community health assessments. The All4HealthFL Collaborative includes all of the not-for-profit hospitals and the department of health for Hillsborough, Pasco, Pinellas, and Polk counties.

We are so pleased to have each and every one of you present and participating in these focus groups today. We value the unique perspectives and lived experiences you bring with you today. We'll be asking you for your thoughts, opinions, and experiences about the strengths of our community, the challenges or barriers that exist to accessing care and resources, and who in our community is most impacted by those challenges.

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Thank you again for participating with us today. We know your time is valuable and are grateful you have shared this day with us.

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

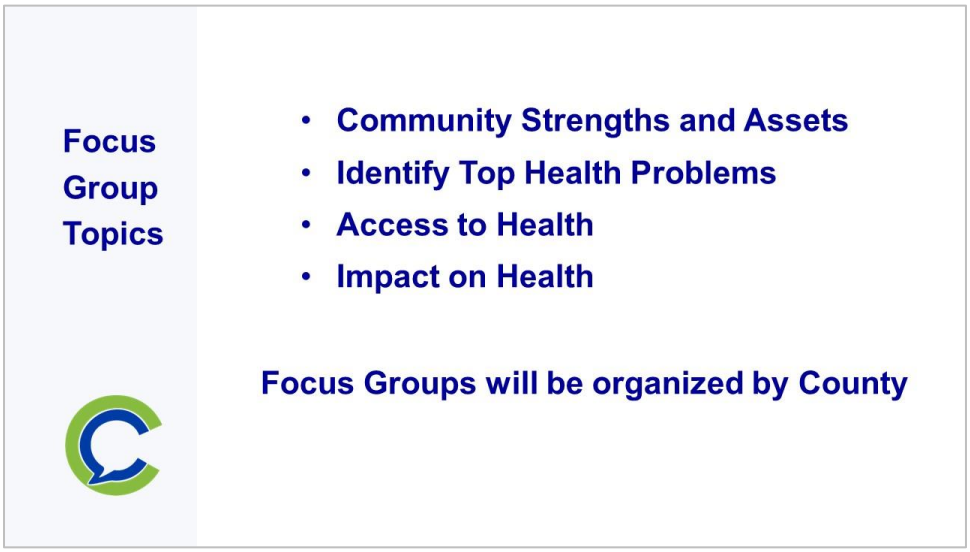
Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

From Chat:

What are some things you feel make a community healthy?

- Access to good food
- Service providers working together
- Access to health care needs
- Paying attention to the needs of the community, providing bike paths, parks, exercise areas, etc.
- Low mortality rate, low morbidity rate
- Well-informed collaborators
- Access to affordable health care and addiction services
- Access to basic life necessities food, shelter, employment, etc.
- Partnership between community organizations
- The ability to provide suggestions without fear of animosity. In other words, respectful communication.
- Ease to access healthcare
- Access to transportation
- I agree with service providers/organizations working TOGETHER.
- Outdoor-green space for recreational activities
- Affordable transportation
- Good mental health
- Getting to know neighbors and welcoming people who are not from this area
- Affordable housing
- Knowing the community resources available to meet people needs.
- Recycling efforts
- Access to mental health services
- Mental health
- Obesity
- Mental health

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses



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

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

Polk County Focus Group

Community Strengths & Assets

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

- Flexibility – using technology, making more space available, engaging other organizations to meet community needs
- Giving, folks work together to get things done (i.e., mobile food bank), collaborations, and coalitions (Injury prevention coalition)
- Forward-thinking & strong leadership
- Injury prevention coalition

From Chat:

- Parks - green space. Providing opportunities to get people outside

Identify Top Health Problems

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

- Transportation (bus routes, issue and barrier), nonprofit closed
- Affordable housing (limited availability)
- Aging in place services (homemaking, daily living, companionship, telephone assurance) - currently limited, cumbersome process
- Mental health – grant funded program ended, need additional resources
- Falls prevention initiatives and access to those programs (being offered virtually – tai chi, balanced living, etc.)
- Nutrition – availability and affordability of healthy food options (contributes to social isolation)

From Chat:

- Falls prevention initiatives and access to those programs

Access to Health

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

- No – transportation, insurance, limited income
- Older adults/seniors often don't ask for help
- RSVP volunteers vs. those who need the services
- Cultural aspect (seeking/getting mental health services – possible denial) - Black/African American
- Geography – urban vs. rural (east side of county has less services)
- General awareness, education

Appendix C. Community Input Assessment Tools
Focus Group Discussion Questions & Summary of Responses

Impact on Health

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

- Work/life balance (multiple roles and responsibilities)
- Media – news stories, world issues – need good news
- Eating healthy

Wrap-Up and Next Steps

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

Team 4 – Polk County

Facilitator:

- Strengths: flexibility using technology, making more space available, engaging other organizations, and forward-thinking and strong leadership
- Problems: aging in place services and availability, affordability of healthy food options
- Access to health: general awareness and education, cultural aspects, and money
- Impact: work/life balance, media, personal eating habits

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

Appendix C. Community Input Assessment Tools Prioritization Session Attendees

Polk County prioritization session was conducted on May 5, 2022, 75 individuals were in attendance from the organizations listed in the table below. These organizations played a pivotal role in providing feedback on significant health needs identified within the data analysis, developing preliminary ideas on ways to collaborate to address needs, and prioritizing community health needs for the next three years. The list of participating organizations and discussion feedback can be viewed in this appendix.

Participating Organizations
AdventHealth West Florida Division
Bartow Regional Medical Center
BayCare Health System/BRMC
Central Florida Behavioral Health Network (CFBHN)
CivCom: Tobacco Free Polk
Conduent Healthy Communities Institute
Feeding Tampa Bay
Florida Department of Health in Hillsborough County
Florida Department of Health in Polk County
Florida Southern College
FLVS
Gospel inc
Health Council of West Central Florida
Healthy Start Coalition of Hardee, Highlands and Polk counties
Heartland for Children
Homeless Coalition of Polk County
HSCHHP
Johns Hopkins All Children's hospital
Lakeland Police Department
Moffitt Cancer Center
Polk County Board of Commissioners
Polk County Public Schools
Polk County Sheriff's Office
Polk Vision
Potege's Multi Service Community Center Inc
Redlands Christian Migrant Association
Senior Connection Center INC.
Tampa General Hospital
UF/IFAS Extension Polk County
Winter Haven Hospital BayCare

Appendix C. Community Input Assessment Tools

Prioritization Session Questions and Summary of Responses

Access to Health Services

Breakout Room Number & Topic Area: Access—Room #1

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

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

- Emergency care is used due to lack of after-hours care options.
- Accessing to resources where they are (away from the hospital area): Transportation to primary care clinics is a concern due to the rural environment within the county.
- The differences in care between the race/ethnicities
- Cost of housing and affordability in relationship to cost of living and having to make choices.
- Not surprising statistics, but there is a higher concern with the senior population
- Finding the balance between housing, food, and medication/healthcare costs; especially from a provider/clinical educator perspective.

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

1. What social determinants are impacting this health issue?
    - Jobs that offer PTO/sick time to care for their families
    - Decreased access to school-aged children due to limited availability to take children out of schools (less half-days, etc.)
    - It is hard to believe the amount of mental health providers, as the community discusses the difficulty to get into services. Are the mental health providers concentrated to certain areas?
    - Polk county has many migrate workers that do not have healthcare insurance or care (physical, mental, and dental), transportation, and sick leave.
    - Shortage of staff within healthcare affects access.
    - More of individuals' income is being used on cost-of-living services, and there is not assistance to help those heavily impacted by inflation.

2. From your perspective, what has caused this to improve/worsen/remain the same?
    - There is a huge resource gap in healthcare options to cause a decrease in care especially in more rural areas outside of the hospitals immediate surrounding
    - Isolation does not help communities that rely on resource sharing in person.
    - There are programs that help pay for part of their high-speed internet bill if they meet requirements, but even those resources are limited due to the growth.
    - Religious and faith-based communities do a wonderful job in sharing resources, such as food distribution centers and more.

3. What efforts have you experienced that are working and how?
    - Food banks have increased for those who have food insecurities
    - Partnerships within the community help provide resources
    - Churches are opening their doors again to communities who need assistance or food
    - Getting back on track with community health needs priorities within the community, outside of COVID.
    - School(s) opened their doors to wash clothes
    - Club Success
4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
    - Look into underserved areas to provide care or open more facilities closer to the people who need them.
    - Bring awareness to healthcare groups to move underserved communities
    - More community health education opportunities

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

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

- Create culturally component resources for food services
- More collaboration efforts for groups such as healthcare systems, etc. There are plenty of people within our communities to help and guide to resources
- Frontline workers are in conversations when making decisions within leadership
- Addressing stigma within various communities to talk about the problems
- More outreach community events within areas that high risks populations within timeframes and access points that work for them (i.e., going to senior centers with access or schools during school hours).
- Expand food insecurity efforts such as food delivery
- Expanding large grocery partnership to include food delivery for underserved areas or those who have food stamps but do not have transportation.
- Programs that place mental health providers to rural areas and to ensure mental health services are being implemented those populations.
- Expand and continue Faith Community Nurses efforts to educate and screen on mental health concerns specifically.
- Expand partnerships within the communities to provide more quality community healthcare.

Breakout Room Number & Topic Area: 2- Access to Health Services

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

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

- 'Above us value' in Polk in multiple health topic areas – lots to improve
- Mixed race values were high – how can we improve comfortability in health care
- LGBT community included, and awareness has increased
- Cultural Competency is important
- Numbers and concerns have not improved since last CHNA cycle – what have we done what have we tried and why have we not expanded our reach/impact
- Housing is a concern
- Covid impact- positive or negative or both?
- Is three years enough time in between chna cycles?

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

1. What social determinants are impacting this health issue?
    - Lack of transportation-
    - Doctors are not always centrally located
    - Inability to take off work- culturally work ethic, loss of wages, fear to ask of work
    - Affordability- cost of living, not being able to afford to take off, paying rent vs. paying for treatment
    - Health Insurance trends – potential fear for the Hispanic/Latin community
2. From your perspective, what has caused this to improve/worsen/remain the same?
    - Worsening- due to cost-of-living rising vs pay rate
    - Telehealth – increased appointment availability, but is now decreasing because it is in person
    - Worsening- Covid, lots of small practices closed, many community members were trying not to use to the ER due potential exposure, etc.
3. What efforts have you experienced that are working and how?
    - Telehealth – works for some, but we do have technology gap
    - Community Navigators/Patient Navigators/Help navigating the system
    - Pop up clinics
4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
    - Cultural Competency
    - Affordable housing
    - How will Polk support

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

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

- Aligning resources and organizations – knowing what each other offering, open communication between organizations
- Multi aspect concern
- Closed referral networks- not everyone is on the same referral system
- Making sure referral sources are updated
- Free standing Ers/Urgent cares- more locations to assist in ED utilization

- Mobile medical healthcare
- Practical and relevant health education in schools

Behavioral Health (Mental Health and Substance Misuse)

Breakout Room Number & Topic Area: Room #3, Behavioral Health (Mental and Substance Misuse)

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

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

- Difficulty accessing providers during Mon-Fri working hours. Re-assess operating hours for providers to increase access to the community and as a result decrease use of ED
- Not enough services or service providers in the county for mental and substance misuse. Difficulty finding providers in times of need, delayed care. Suggestion: mobile mental health clinic.
- Costs of prescriptions forces individuals to switch to low-cost or unique alternatives. Need affordable prescriptions
- Lack of transportation is voiced as a barrier by patients who need to go to appointments. Lakeland and Winter Haven have a bus system. East Polk County has limited routes and don't run to the city. Need transportation improvements.
- The cost of healthy foods. and the transportation is bad. no busses to poinciana Polk County.
- Using the bus system is not easy; understanding where the stops are and what transfers are needed. It's time consuming.
- What are the healthy food options in the rural areas? What initiatives exist for food deserts especially in rural areas? Polk Vision may have some initiatives to address.
- Fleet Farming, non-profit agency uses volunteers' homes as gardens. The produce is picked from the home gardens and brought to a farmer's market where community can shop and purchase with EBT.

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

1. What social determinants are impacting this health issue?
    - Transportation
    - Employment
    - Access to care
    - Lack of providers

2. From your perspective, what has caused this to improve/worsen/remain the same?

- Transportation, where they live, job loss, aging parents, bullying in schools all worsen the issue. Pressures from different sources pushes individuals to use substance and worsens mental health outcomes.
- COVID losses
- Rising cost of housing, especially for renters who are unable to control increases in monthly payments. Limited assistance with housing and support for payments. People cannot keep up with inflation. The working poor have limited options, if they have a job, they then become ineligible for financial support (ex. Low-cost clinic co-pays)
- The lack of transportation, the lack of education and the lack of knowledge of the resources that exist in the community. Domestic violence has risen since COVID started. Lack of health insurance is a barrier to accessing mental health/behavioral health services.

3. What efforts have you experienced that are working and how?
    - Telehealth, mobile units, and free programs (ex. Behavioral health center) helps many patients and the community.
    - Awareness of mental health/behavioral health has increased. If the knowledge is not shared, they community doesn't know they have those challenges and may not seek care to address it.
    - Stigma is decreasing

4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
    - Each community to have a dedicated mental health center or mobile unit. Centers are limited to serve set geographic areas which limits which community members get care and in a timely manner.
    - Increase awareness of EAP
    - Create a resource guide listing all the resources (agency name, emails, phone numbers) in the county that can be shared. Findhelp.org is a great resource.

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

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

- Telehealth is a great option, in addition to increasing internet access in rural areas.
- Mobile unit, bring healthcare to where the people are. Example setting up a school bus with wi-fi and building out small booths on the bus. Getting into areas along US-92 and hotels where homeless families stay, temporary housing. Stock it with heathy snacks!
- In addition to shelf stable items at pantries, include fresh fruits and vegetables which contributes to a healthy diet and lifestyle
- Need ways to store fresh items (refrigeration) so there's no rush to give it away. Bring mobile units to food and toy drives. Face to face interaction increases use of resources and encourages the community to take advantage of the free services.
- Use green spaces to grow food. Teach youth how to grow fruits and vegetables to decrease food costs. Giving back to the earth

- Mental health first aid certifications for community leaders, churches, and school staff.
- Example: Teaching women in transitional living facilities to grow and sell produce. Used green space at the transitional living facility and farmers came in to teach the women.
- Encouraging parents, children, and families to come together around healthy eating, growing produce. Attracting families to be more involved in the community to increase use of services and bonding around living a healthier life.
- Create "meet-up" events around the county for different interest areas (ex. Postpartum moms, single dad support group, single mom support group, mentoring groups). Overall increasing the sense of community. (ex. Meet-up app)

Breakout Room Number & Topic Area: Behavioral Health (Mental Health and Substance Abuse)

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

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

- Polk County seems to have several positively trending health indicators
- Data about substance misuse is consistent with historical trends: White men seem to be affected most
    - Look into increased peer supports
- Lack of transportation to get to health services and the inability to get an appointment is a common complaint heard from community members – this has increased since COVID due to less employees working at medical facilities
- Removing/minimizing SDOH barriers will not only improve health indicators in disparate populations, but for everyone
- Many of the top health issues are related to experiencing more ACEs. Focus on prevention work and looking at holistic needs of the community
- Large need for resiliency building services in Behavioral Health to reduce need
- Need for more data, respite care, or action items to assist families with children with Special Needs
- There are some positive trends seen in the available resources in the community, but we need to raise more awareness

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

1. What social determinants are impacting this health issue?
    - The ACE scores prior to 18
        - Greater percentage of people who have experienced ACEs, but they just are not talking openly about it
    - Substance misuse is high in our area
    - Co-occurring mental health issues
    - Lack of appropriate social supports

- Need for resources and services addressing the needs of teens
- Lack of in-patient support services
- Exacerbated issues in the post-COVID era

2. From your perspective, what has caused this to improve/worsen/remain the same?
    - Polk is a large geographic area which makes transportation difficult
    - Polk County Public Schools are responsive and receptive to initiatives and would be a great partner to include
        - Prevention starts with children
    - Behavioral health education throughout a person's entire life starting in elementary
3. What efforts have you experienced that are working and how?
    - Telehealth – virtual care has alleviated some of the barriers that are seen regarding access
    - Embedding Behavioral Health supports in the schools at the elementary level
    - Community Schools have begun to look at the whole family and how their well-being affects the child.
4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
    - Offering Behavioral Health services not just to students, but to the entire family
    - Incorporating ACE surveys into care
    - So much regulation before a person can receive services; this can be a barrier to receiving care
    - Focus on SDOH
    - Multi-systemic therapy and wrap around services
    - County-wide focus on one or two areas to make a collaborative impact

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

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

- We should have interconnected resources so that our front-line providers can refer clients to SDOH resources
    - Seamless collaboration between agencies providing services
- Focus on everyone as a holistic person when providing care
- **Raising awareness of the resources that are already available to the community**
    - Examples: FindingHelpFlorida, 211, Aunt Bertha
- **Continued alignment and collaboration of partnerships focused on the prioritized health areas**
    - Multidisciplinary and cross sector collaborations are crucial
- Transparent communication from Exec leadership all the way down to front-line
- Integration and utilization of resilience building services
- More awareness and education on ACEs, integrating this education throughout the public health system
- Integrating grass roots efforts to communicate with the communities that do not communicate through internet/virtual platforms

- Increase of access to crisis stabilization and support services for Behavioral Health
- Increase in available and affordable housing (addressing SDOH)

Breakout Room Number & Topic Area: Behavioral Health (Mental Health and Substance Abuse)

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

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

- Polk County seems to have several positively trending health indicators
- Data about substance misuse is consistent with historical trends: White men seem to be affected most
    - Look into increased peer supports
- Lack of transportation to get to health services and the inability to get an appointment is a common complaint heard from community members – this has increased since COVID due to less employees working at medical facilities
- Removing/minimizing SDOH barriers will not only improve health indicators in disparate populations, but for everyone
- Many of the top health issues are related to experiencing more ACEs. Focus on prevention work and looking at holistic needs of the community
- Large need for resiliency building services in Behavioral Health to reduce need
- Need for more data, respite care, or action items to assist families with children with Special Needs
- There are some positive trends seen in the available resources in the community, but we need to raise more awareness

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

1. What social determinants are impacting this health issue?
    - The ACE scores prior to 18
        - Greater percentage of people who have experienced ACEs, but they just are not talking openly about it
    - Substance misuse is high in our area
    - Co-occurring mental health issues
    - Lack of appropriate social supports
    - Need for resources and services addressing the needs of teens
    - Lack of in-patient support services
    - Exacerbated issues in the post-COVID era
2. From your perspective, what has caused this to improve/worsen/remain the same?
    - Polk is a large geographic area which makes transportation difficult
    - Polk County Public Schools are responsive and receptive to initiatives and would be a great partner to include
        - Prevention starts with children
    - Behavioral health education throughout a person's entire life starting in elementary

3. What efforts have you experienced that are working and how?
    - Telehealth – virtual care has alleviated some of the barriers that are seen regarding access
    - Embedding Behavioral Health supports in the schools at the elementary level
    - Community Schools have begun to look at the whole family and how their well-being affects the child.
4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
    - Offering Behavioral Health services not just to students, but to the entire family
    - Incorporating ACE surveys into care
    - So much regulation before a person can receive services; this can be a barrier to receiving care
    - Focus on SDOH
    - Multi-systemic therapy and wrap around services
    - County-wide focus on one or two areas to make a collaborative impact

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

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

- We should have interconnected resources so that our front-line providers can refer clients to SDOH resources
    - Seamless collaboration between agencies providing services
- Focus on everyone as a holistic person when providing care
- **Raising awareness of the resources that are already available to the community**
    - Examples: FindingHelpFlorida, 211, Aunt Bertha
- **Continued alignment and collaboration of partnerships focused on the prioritized health areas**
    - Multidisciplinary and cross sector collaborations are crucial
- Transparent communication from Exec leadership all the way down to front-line
- Integration and utilization of resilience building services
- More awareness and education on ACEs, integrating this education throughout the public health system
- Integrating grass roots efforts to communicate with the communities that do not communicate through internet/virtual platforms
- Increase of access to crisis stabilization and support services for Behavioral Health
- Increase in available and affordable housing (addressing SDOH)

Cancer

Breakout Room Number & Topic Area: 5 - Cancer

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

Appendix C. Community Input Assessment Tools

Prioritization Session Questions and Summary of Responses

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

- Difficult to identify areas that are needy by zip code - Appreciated seeing needs by zip code – 33805. (2)
- 33805 – high level of mental health needs – why is this and how can we impact these numbers?
- Lack of awareness in the community – need to improve messaging (there are options in the community for access to care).
- Interested in connecting areas with specific needs to income levels in those areas.
- Polk will be receiving funding to combat opioid abuse.
- Is the data collected in this survey representative of the community?
- Polk Healthcare Plan is available to people who cannot afford other healthcare plans.
- How can we address underinsured population?
- Low- cost clinics are available to uninsured population – we need to make them aware.
- Transportation is available but we need to make people aware.
- Transportation needs for social outings (thinking of mental health).
- Need to increase sidewalk access in specific areas (to encourage exercise and minimize injuries).
- How can we make specific groups that are impacted aware of the increase of STIs and how to prevent or treat them?
- Informing age groups/populations affected by STIs.

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

- How do we respond to someone who has been diagnosed with cancer? After prevention testing has diagnosed cancer what is being done to help that individual navigate the system and get treatment?
- People have a difficult time navigating the system when seeking preventative testing or care. (2)
- Speaking with the community to help understand hesitancy in seeking preventative care.
- Increase education on why vaccines like the HPV vaccine are important to prevention.
- Need to do more to encourage people to participate in exercise.
- Educating men on the importance of cancer prevention strategies.
- Educating community that smoking/tobacco (and vaping) can increase the risk several types of cancer.
- Dentist as educators for HPV vaccination.
- Melanoma – Florida needs more education starting from a young age on the importance of using sunscreen/other prevention methods.

1. What social determinants are impacting this health issue?
   - Education

2. From your perspective, what has caused this to improve/worsen/remain the same?
3. What efforts have you experienced that are working and how?
4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?

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

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

- **Behavioral Health**
- Putting together tactical planning with other organizations – forming groups within BH.
- How can we used blended funding streams to accomplish more?
- How can we train, recruit, and retain people in the BH field?
- Collaboration - linking people with mental health issues and substance abuse to care
- Addressing co-occurring conditions
- Increasing access to broadband
- Using mobile units – getting BH care out to the community
- Behavioral "CPR" – sensitizing the community to BH, at home, within faith groups – mental health first aid
- **Access to care**
- Providing health services at accessible locations (mobile unit) - Meeting people where they are
- Educate community on Polk Healthcare Plan (through mobile unit)
- integrate faith-based community to engage and participate
- increasing the availability in time of day and days of the week
- United Way's 2-1-1 is underutilized, how can be partnered to integrate, and enhance navigation to all resources regardless of where they are accessed. Create a "navigation" system. Local health care safety net is underutilized, how can we leverage United Way/2-1-1
- Target 5 of the most impoverished schools based on data, coordinate mobile clinics and pilot at those locations to target and engage with the families
- Use data to drive decision-making
- **Exercise, Nutrition, & Weight**
- Funding is not available to support infrastructure for programs in this area
- Low ability to impact affordability of healthy foods
- Targeting overweight or obese youth with funding to connect them with sports/exercise activities

Exercise, Nutrition, and Weight

Breakout Room Number & Topic Area: #7 Exercise, Nutrition, & Weight

Appendix C. Community Input Assessment Tools

Prioritization Session Questions and Summary of Responses

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

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

- Confirmed what we already thought was happening, for example with the LGBTQ+ community and discrimination
- No surprises in the data, seeing similar topics as last CHNA – access, mental health, weight/nutrition
- New topic for this CHNA – immunizations & infectious disease, related to COVID-19
- Information is consistent with what we see on the ground
- Appreciate information on transgender population – often lumped together with LGBT, but trans have different needs than the LGB community
- COVID has worsened several health factors – access (physician offices closed, transition to virtual visits, availability), being isolated exacerbates mental health issues

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

1. What social determinants are impacting this health issue?
    - Food insecurity is a social determinant that impacts health of our communities – if they don't have access to food, they likely don't have access to other necessities, like medication, etc.
    - Cheaper to buy fast food/not healthy food than healthy foods (fruits & vegetables)
    - Lower educational attainment – people must work 2 jobs to make ends meet, don't have the time or energy to exercise, and seek out healthy foods – contributes to obesity
    - Polk is a rural area – nothing is very close – lack of public transportation to get people to healthy foods
2. From your perspective, what has caused this to improve/worsen/remain the same?
    - COVID had an impact
    - Lack of access to internet/lack of education on how to use the internet
3. What efforts have you experienced that are working and how?
    - Talking about it and raising community awareness
    - Still experiencing impacts from pandemic – better understand our marginalized populations
    - Partnerships with Feeding Tampa Bay
    - Trying to get into the schools to provide food pantries in schools
    - BayCare hospitals have been giving food to at-risk patients as they are discharged until they can get hooked up with a food bank
    - Less stigma around food insecurity – more people are accessing food banks, more community conversations
4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?

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

Appendix C. Community Input Assessment Tools

Prioritization Session Questions and Summary of Responses

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

- Top needs: 1) Behavioral Health, 2) Access to Health & Social Services, 3) Exercise, Nutrition & Weight
- Working with established organizations, like Feeding Tampa Bay – looking at other ways we can impact more people with food insecurity through partnerships with large organizations and local churches/food banks
- Continue to collaborate with community partners to make sure the messages are getting out – sharing information on community resources available to the clients your agency serves (e.g., someone comes in for food insecurity, they may also need resources for behavioral health – providers need to know what is available so they can refer clients)
- Partnerships with CFHC to bring food to migrant communities / partnerships with Peace River Center to refer migrant families for behavioral health care
- Leveraging/supporting organizations who are already doing the work
- Health fairs with health/cultural organizations to provide education and resources
- Organizations need to make sure they stay in touch with other agencies and are aware of what is going on and who is doing what – stay active in the community
- Organizations supporting each other to fill in gaps in care
- Focus on prevention (can be hard to prove & hard to fund) – more cost-effective

Breakout Room Number & Topic Area: Room #8, Exercise, Nutrition, & Weight

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

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

- Reason for using ER rather than accessing a doctor stood out (having to go during odd hours). Found it odd that there wasn't something in place to fill this gap.
- Medicare plans, the individuals do not understand what their plans cover and what they do not.
- Some urgent care facilities do not take some Medicare plans, so the individuals must go to the ER
- Many people do not understand how discrimination affects health- happy to see it listed in the data.
- Surprising to see Florida Southern College was one of the darkest zip codes (highest needs) because many students are affluent.
- Depression in Medicare patients (worse after COVID).
- Age impacted by food insecurity (18-35) was shocking
- 70% are not eating 3 servings of fruits and vegetables
- Transportation as an SDoH

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

Appendix C. Community Input Assessment Tools

Prioritization Session Questions and Summary of Responses

1. What social determinants are impacting this health issue?
    - Access to healthy options
    - Transportation
    - Age range (18-35) was surprising- potentially due to high homeless population
    - Senior population
    - Income
    - Rising cost of housing
    - Safe areas for kids to play may be lacking, or they are so focused on other activities that the kids may not be going out playing
    - Education (lack of about healthy nutrition)
2. From your perspective, what has caused this to improve/worsen/remain the same?
    - Covid- worsen
    - Inflation-worsen
    - Lack of safe infrastructure (sidewalks, parks, etc.)- worsen
    - Increase in population- worsen
    - Not sure if services will be able to keep up with increased population
3. What efforts have you experienced that are working and how?
    - Senior Connection Center- started providing virtual classes to seniors during Covid (help increase interaction when Covid led to more social isolation)
    - Virtual options have opened to members who could not travel to location before (overcame transportation barriers)
    - Trust issue with vaccine and healthcare in general (specifically among minority races and ethnic groups)
    - Social media (positive and negative)
    - Beauty shop food pantry uses FB Live to spread the word about giving out food, or blood pressure checks, or insurance talks (etc.)
    - Having support for Seniors from CARES Act
4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
    - Education and building trust with individuals
    - Literacy in all forms to meet people where they are
    - Simplify healthcare in general
    - Train the next generation coming into the healthcare system in health literacy
    - Share recipes with food handouts
    - Programs need to be sustainable

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

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

- Behavioral Health
    - Education about prevalence of mental health for everyone
    - Using trusted sites, partnerships, and providers to spread education and promote behavioral health programs
    - Ending stigma\Changing language around mental health

- Mental Health First Aid USA course (get community members trained, offer this to healthcare workers as CEUs/CMEs)
- Access to behavioral health programs and promotion of these programs
- Partnership between different organizations
- Organizations promoting "de-stressors" through comedic strip emails, music, positive verbiage, and affirmations

- Access to Healthcare
  - Teach the public to ask three questions ("Ask me 3" program through IHI.org) every time they go to the doctor to promote individuals getting more involved in their own care
  - Physicians who speak primary language of individual seeking care
  - Increasing cultural competence for both provider and patients
  - Explaining/educating the different aspects of healthcare (i.e., difference between doctor vs. nurse practitioner vs. P.A.)
  - High increase in using Urgent Care/ER possibly due to provider office hours do not open during hours that are convenient for working individuals
- Exercise, Nutrition, and Weight
  - Required physical education for all students
  - Mobile units with an exercise instructor that can teach a pop-up exercise class
  - "Health squad unit" in high schools- program where students are taught how to prep and make healthy foods, etc. Concept is promoted throughout the school.
  - Grocery store scavenger hunts for students to get students involved in reading labels, checking out different healthy foods, etc.

Heart Disease and Stroke

Breakout Room Number & Topic Area: Room 9, heart disease and Stroke

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

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

- Theme recognized across data presented- paid time off is a huge issue; the lack of PTO and flexible schedules impacts the most vulnerable, jobs with hourly wages, no/little benefits
- Data shown does not paint a full picture of the County- transportation, behavioral health, capacity, etc.
- There was a large amount of data- where does funding come from to address these items? third party, gov't, private party, **where do we start?**
- Polk County process- Hospital funding (revenue) given to state/county gov't and then leveraged for federal funding to expand Medicare/Medicaid- does that increase the resident eligible for state assistance?

- Group thought- not sure if there is a way to address system issues to serve all those who have a need in an equitable way
- Polk County has indigent healthcare program, that includes behavioral health services, they want to stretch those dollars/impact
- Lack of access to healthcare (Haines City- spelling?)- Dental access is noted issue, capacity, must book months out or go elsewhere, which includes transportation and other barriers
- Transportation- older adults, family/caretakers for older adults- does the system provide the knowledge to navigate the system easily? (Knowing what resources available/access to those resources are, Medicare management, language (access/barrier))
- Breakout Room Theme: Navigating the system to get services that are available, while navigating the capacity issues/accessibility of services/resources that aren't in place

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

1. What social determinants are impacting this health issue?
    - Data is not surprising, more ED visits for heart failure and uncontrolled blood pressure with age—Can early education help prevent this?
    - Capacity (scheduling appt to being seen), transportation to and from appointments/care centers, wait times
    - Education & internet access (scheduling appointments, connecting with healthcare facilities, navigating getting connected to the system
    - Racial Demographic- Hispanics lower hypertensions scores and exercise- not the expected relation- **is that because they are not being seen/diagnosed**
    - Stress plays a role in heart health- did COVID and ability to exercise impact these numbers
        - Education on importance of exercise, mental wellness, and heart health
    - Income- relation to income, internet access, insurance, and how that compile and impacts health; income related to timely access to information (masks, vaccine, internet access to news, healthcare education)
2. From your perspective, what has caused this to improve/worsen/remain the same?
    - COVID – stress with navigating a pandemic, changing patterns, hard to engage in information sharing, preventative visits, etc. with potential loss of internet access in this time
    - Fear, relating to lack of education, in seeking healthcare during COVID
    - Population is typically getting older
    - Data & resources are there, how do we connect the **entire** population (aging population and those who don't have high-speed internet) to those resources. Digital Divide.
        - Most folks have phones- where is the disconnect
    - Worsening- type of employment (farm workers, blue collar, etc.) insurance has high copay, high deductibles, not insurance together, that greatly

contributes to overall access to healthcare- that same population was heavily impacted to job/wage changes with COVID
- Telemedicine, Community Paramedicine is growing- can help with scheduling and cost barriers

3. What efforts have you experienced that are working and how?
   - Polk Co Government Mobile Health Clinic- model works, needs more **marketing** so folks know when and where it is. Additional vendors attend with health care resources and food. New city every month (2 events a month)
   - Polk Vision- Know and Grow (giving students iPad, Computers and teaching them how to navigate portals
   -
4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
   - Healthcare system in Polk Co needs more capacity (more clinicians)
   - Access

Takeaway: Polk County would benefit from additional provider capacity and access. For the resources that do exist in the county, there is a disconnect between what services are available and how residents are informed and connected to those resources-general navigation access.

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

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

- 1. Behavioral Health; 2. Access to Healthcare; 3. Exercise, Nutrition, & Weight
- For all:
  - Education (not school system) – let the public know when access grows, what services are available and when
  - Hub- one location with available resources (dentist, BH, PCPs) all in one place
    - Transportation to and from
  - Mobile services- reduce transportation barrier even if you can't have a physical building there
- Exercise/Nutrition/Healthy Weight- Early & preventative education specifically related to nutrition, cultural adapted & inclusive education in schools (PE & nutritional education in elementary schools) Importance of walking. Promote parks and rec, walking trails, sidewalks, places for residents to be outside. Make outside space available to more residents.
  - Lakeland does a fairly good job of this, but what about rest of the county?
  - This would positively impact long-term health outcomes
  - Food Truck events- could market education services there
  - Education partners- school system, health education/physical ed is required, but where is health education? There does not seem to be consistent place for this statewide curriculum.
  - Faith Based Partners have done well in promoting and leaning into this space.
  - Use and partner with trusted community partners

- Access:
  - Dental access- East Polk Co has had limited access
  - We need to explore bringing services to where people are
    - Community School Model- access to services at the school,
    - Where else can this be done?
    - Bring providers to community sites (schools, faith-based orgs, community centers)
    - Unincorporated Polk Co- could target to work with schools and faith-based organizations
    - **This is reliant on working with community partners.**
    - Reach out to faith-based organizations with community leaders. They can be the keystone to community efforts.
    - Educate residents on correlation between dental and physical and behavioral health and SDOH
      - Both those impacted by these things and those less impacted by these things
- Education Ideas:
  - Educate Community leaders at community hubs (train the trainer type model of education)
  - Block Party! Invite community leaders, resources/providers, and open space for conversation

Immunizations & Infectious Diseases

Breakout Room Number & Topic Area: Immunization & Infectious Disease

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

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

- Not **good hours** stood out, people would have gone if the offices were open. This was seen a few times in addition to not having a provider, or being able to get in early enough and ending up in ED
- Seeing Lake Wales as highest need for food insecurity stood out. It was interesting to see the high need in the area.
- The social determinants of health were important; especially how individuals felt they were treated. Interesting slides on how they felt.
- Considering at health indicators, historically Polk was above certain metrics, and we remain above national and state metrics
- Interesting that syphilis is becoming more prominent in Polk County

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

1. What social determinants are impacting this health issue?

- **Education** would be one; increasing awareness of immunizations; people don't have enough information. For example, healthy start works with DJJ for a "Let's Talk Night" for kids between 12-18 twice a month. One of the slides shown is re: infectious diseases. Kids are shocked to know how high some STDs are and what is incurable vs. curable. They also get educated on the services at health dept like contraception and testing. The survey feedback from kids is that they had no idea about the information or where to go
- **Broadband access**; less access for people of color; less access to internet for self-research
- **Issues with stigma** for example stigma impacting HIV which is high in Black population; are there less conversations happening? Young Black males and older Black women.
- Availability of **social media** heightens ability to share our opinions and how people view immunizations
- Social media can have a negative impact on immunizations; there is more opinions that are not based on fact or science
-

2. From your perspective, what has caused this to improve/worsen/remain the same?
   - **COVID** has caused people to look at other vaccines differently. For example, **concerns/hesitation around the COVID vaccine** transferred to others
   - COVID may have **reduced number of people going to get vaccines** (less people going out to get them)
   - We can say that this area has gotten worse (both immunization and infectious disease) according to data
   - Strong agreement about COVID impacting this
   - **Misinformation** transmitted online and through social media
3. What efforts have you experienced that are working and how?
   - From the standpoint of immunizations, (COVID and others) the health dept has been doing several **community outreaches events**; **collab with county** on their bus; they are able to give vaccines on communities that the bus goes to; there is also a **mobile unit** at health dept that can request vaccines and provide Onsight, mainly COVID, Hep A, flu shots; **taking vaccines to the people**
   - **Attending community health fairs** to provide education has also been happening
   - **A teen summit** invited the health dept to provide testing to teens for STDs

4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
   - **Internet access and affordability** to everyone would help with education
   - **More readily available education** on the resources such as internet access; for example, there is a program that provides access to internet, but it advertised online (if you don't have access…you wouldn't know that)
   - The health dept is already doing a lot, but **making sure people know about it**; not a lot of people are coming to some of the food distribution or vaccine events
   - Important resources and offering take a while, it's important to **build relationships**; people view (health dept) as govt and lack trust; it takes time. **Having a Spanish speaking team member** helps connect better

- When COVID came, high number of attendees at first, but perspective on numbers change, you win the battles one by one, a small number showing up is still a small number impacted
- **More community partners** that can help us decide where to go and have conversations. **Earning trust of community leaders** and having mutual invites to sit at each other's table to **work together on addressing SDOH**.
- **Finding ways to get into high schools** to share information would be beneficial. This age group needs this information, and they are not getting it.
- With recent changes and deep scrutiny of curriculum in high schools, it's going to be different (re: education to high schoolers)
- **Access to public transportation** can be a barrier. Not being able to get physically to a location can be a hindrance

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

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

- Developing educational materials on the subjects
- Recruit health care providers from all levels
- Re: BH…effort needs to be put in to removing the negative stigma around need for assistance; increasing access points via brick & mortar and telehealth; directory of available providers would be great, especially if they can narrow down on a specific need/area that they are looking for; strong focus on prevention and building resiliency.

- Re: resiliency and prevention… (Peace River Center Symposium) a panel of providers discussed need to teach children; we want parents to do it. We need to teach our kids to be strong, and that it's okay not to be the best or be rewarded; Re-teach kids and view families with children as foundation
- Teaching coping mechanisms to our kids is vital

- Re: access to healthcare…16% of population is uninsured and **not having insurance** is a definite obstacle, identifying ways to **connect health care plan** and partners who provide **free care**; state needs to **promote Medicaid**, lack of funding is huge
- Creation of more partnerships for transportation; and free transportation would be helpful
- Access to **free internet** to increase telehealth access; internet would alleviate transportation issue as well

- Re: exercise, nutrition & weight
- Partnerships in places that are high risk would be helpful,
- Working to educate as needed
- Removing barriers to opening resources such as food pantries; Polk Vision is working on this with the Food Council. Seeing that grow would be a great resource
- Gym membership costs can put a barrier for people who could benefit from instructed exercise; same with dietician/nutritionist, those costs can be a huge barrier

- Some people don't feel safe in their neighborhood. A solution could be more neighborhood associations watching out for crime.
- Increasing parks/places that the community can get together and be outside
- Promote children to exercise and reduce screen time; data shows we get heavier the older we get. Anything to promote exercise and healthy living in youth would be beneficial
- educating people on healthier options for donations to food pantries; if you're hungry, you are going to eat what is given and it's not always good options
- Offering classes (nutrition) both in person and online so that you meet need for transportation and/or digital access.
- Hospitals in other counties have given prescriptions for food, and sending patients home with food that helps meet their needs
- On the school level, more time needs to be spent educating kids on healthy choices. Much of their diet consists of quick and easy things. Homemade healthier options not available with working parents
- (What could be brought to Polk from other counties?) There have been county-wide campaigns that focus on nutrition, ones that have success have leaders from county as champion; need to get high profile leaders to jump on.
- incentivizing healthier options with govt support
- thinking as a county as to how we can make exercise the fun choice, ex. In a subway somewhere they painted piano on the stairs, and it made it fun for people to take the stairs.
- in grocery stores, removing candy from checkout and putting in healthy options for kids to ask for
- maybe community-based exercise programs that cater to a community's needs/preferences could be helpful
- a calendar of resources/programs especially highlighting fun, interactive options in safe locations (especially for unsafe neighborhoods, where can they go)
- Reduce stigma of overweight, kids in school who are overweight are then less likely to exercise; helping everyone feel comfortable would be good

Breakout Room Number & Topic Area: Immunization & Infectious Disease

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

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

- Not **good hours** stood out, people would have gone if the offices were open. This was seen a few times in addition to not having a provider, or being able to get in early enough and ending up in ED
- Seeing Lake Wales as highest need for food insecurity stood out. It was interesting to see the high need in the area.
- The social determinants of health were important; especially how individuals felt they were treated. Interesting slides on how they felt.
- Considering at health indicators, historically Polk was above certain metrics, and we remain above national and state metrics
- Interesting that syphilis is becoming more prominent in Polk County

Appendix C. Community Input Assessment Tools

Prioritization Session Questions and Summary of Responses

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

1. What social determinants are impacting this health issue?
    - **Education** would be one; increasing awareness of immunizations; people don't have enough information. For example, healthy start works with DJJ for a "Let's Talk Night" for kids between 12-18 twice a month. One of the slides shown is re: infectious diseases. Kids are shocked to know how high some STDs are and what is incurable vs. curable. They also get educated on the services at health dept like contraception and testing. The survey feedback from kids is that they had no idea about the information or where to go
    - **Broadband access**; less access for people of color; less access to internet for self-research
    - **Issues with stigma** for example stigma impacting HIV which is high in Black population; are there less conversations happening? Young Black males and older Black women.
    - Availability of **social media** heightens ability to share our opinions and how people view immunizations
    - Social media can have a negative impact on immunizations; there is more opinions that are not based on fact or science
    -
2. From your perspective, what has caused this to improve/worsen/remain the same?
    - **COVID** has caused people to look at other vaccines differently. For example, **concerns/hesitation around the COVID vaccine** transferred to others
    - COVID may have **reduced number of people going to get vaccines** (less people going out to get them)
    - We can say that this area has gotten worse (both immunization and infectious disease) according to data
    - Strong agreement about COVID impacting this
    - **Misinformation** transmitted online and through social media
3. What efforts have you experienced that are working and how?
    - From the standpoint of immunizations, (COVID and others) the health dept has been doing several **community outreaches events**; **collab with county** on their bus; they are able to give vaccines on communities that the bus goes to; there is also a **mobile unit** at health dept that can request vaccines and provide Onsight, mainly COVID, Hep A, flu shots; **taking vaccines to the people**
    - **Attending community health fairs** to provide education has also been happening
    - **A teen summit** invited the health dept to provide testing to teens for STDs

4. From your perspective, what community/systems level aspects need to change to positively impact lives and improve data?
    - **Internet access and affordability** to everyone would help with education
    - **More readily available education** on the resources such as internet access; for example, there is a program that provides access to internet, but it advertised online (if you don't have access…you wouldn't know that)

- The health dept is already doing a lot, but **making sure people know about it**; not a lot of people are coming to some of the food distribution or vaccine events
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What are potential ways organizations can work together to transform the conditions we discussed earlier?

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- Reduce stigma of overweight, kids in school who are overweight are then less likely to exercise; helping everyone feel comfortable would be good

Appendix D. Data Placemats

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

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

POLK COUNTY DEMOGRAPHICS

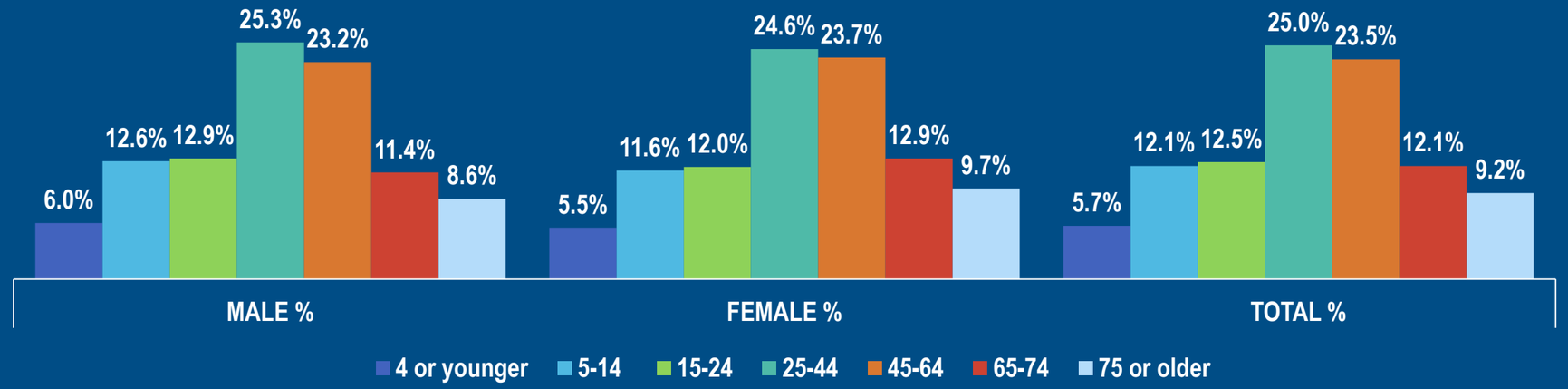
753,298 People

Median Age
40.7

49.0% Male

51.0% Female

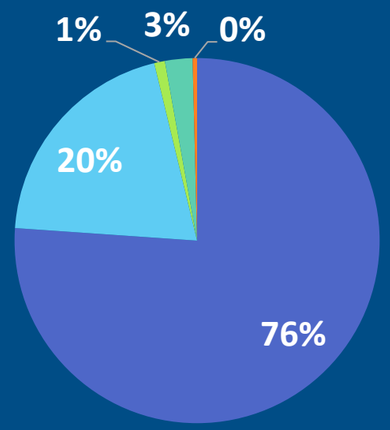
POLK COUNTY POPULATION BY AGE AND GENDER 2021



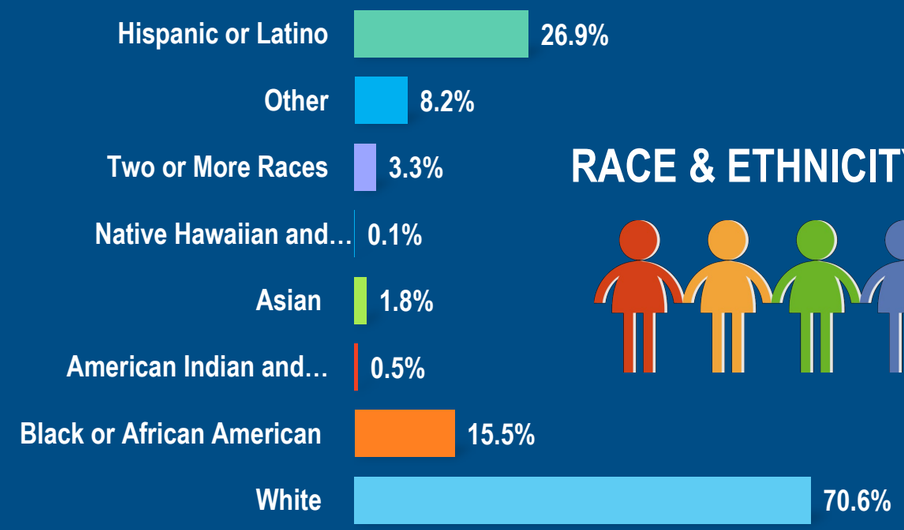
Level of Education, Age 25+	Polk County	Florida	U.S.
Less than 9th Grade	5.0%	4.6%	4.8%
9th to 12th Grade, No Diploma	8.8%	7.0%	6.6%
High School Graduate or G.E.D	34.3%	28.5%	26.9
Some College, No Degree	21.5%	19.5%	20.0%
Associate's Degree	10.1%	9.9%	8.6%
Bachelor's Degree	13.3%	19.2%	20.3%
Graduate or Professional Degree	7.0%	11.3%	12.8%

10.0% Of the Population Foreign Born

Population Age 5+ by Language Spoken at Home



RACE & ETHNICITY



9.1% Of the Population are Veterans

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Sources: Data.Census.gov; All4HealthFL.org

POLK COUNTY ECONOMIC BREAKDOWN

Median Household Income

$56,832

With a $21.86 Mean Hourly Wage, 2020

Lakeland – Winter Haven Data

Unemployment Rate

4.6% Age 16+, 2022

Workers by Means of Transportation to Work, 2022	Polk County	Florida
Worked at Home	4.0%	6.6%
Walked	0.9%	1.5%
Bicycle	0.5%	.6%
Carpooled	8.7%	9.2%
Drove Alone	83.8%	78.6%
Public Transport	0.5%	1.7%
Other	1.7%	1.8%

16.6% Of Individuals are Below Poverty Level

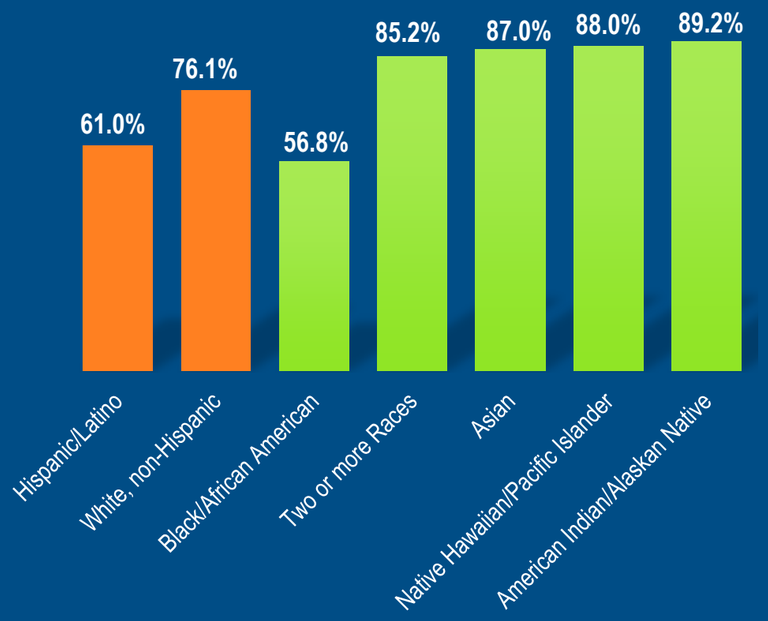
25.1% Population Change 2010-2022

$194,663

Median Property Value

7.2% Growth 2010-2021

Persons with Internet Subscription by Race/Ethnicity, 2015-2019



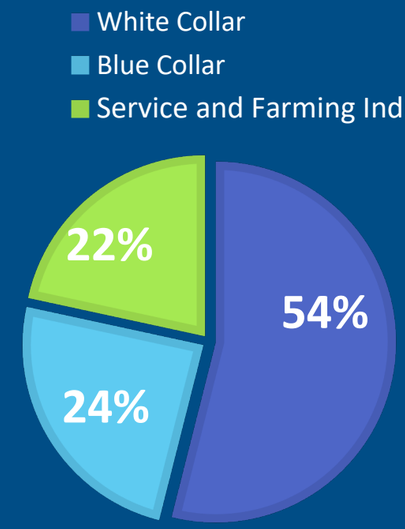
70.1%

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

Some of The Top Losses Include:

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

POLK EMPLOYED CIVILIAN 16+ BY OCCUPATION GROUP



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

ACCESS TO HEALTH & SOCIAL SERVICES POLK COUNTY

48 Primary Care Providers
rate per 100,000 population

34 Dentists
rate per 100,000 population

93 Mental Health Providers
rate per 100,000 population

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

Low-income populations in Polk County are federally designated Primary Care, Mental Health and/or Dental Provider Shortage Areas

78.4% Of adults with health insurance, 2019

72.2% Of adults who have a personal doctor, 2019

31.4% Of high school students have not visited a doctor's office in the past 12 months, 2020

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

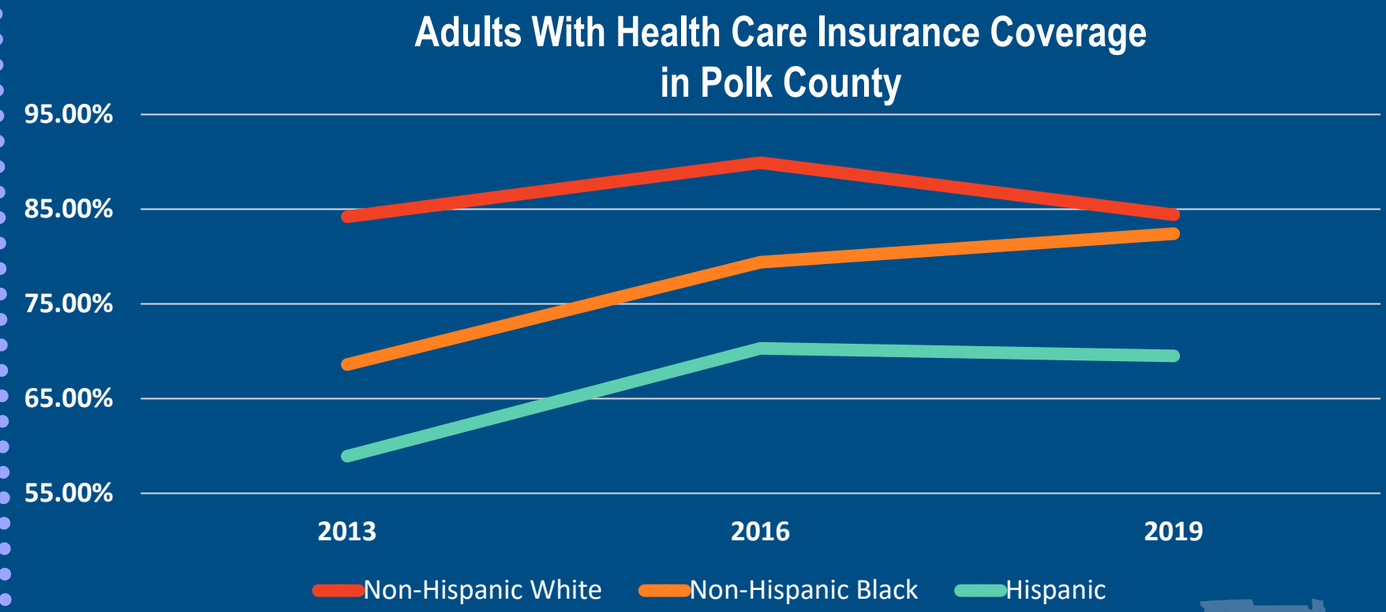
"Was there a time in the last 12 months when you needed medical care but did not get the care you needed?"

20.2% Responded 'Yes'

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

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

92.8% Of children in Polk County have health insurance, 2019



Sources: All4HealthFL.org, FLHealthCharts.gov; CHNA Survey Data; https://www.data.hrsa.gov

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BEHAVIORAL HEALTH POLK COUNTY

(Mental Health and Substance Misuse)

39% Of survey respondents ranked mental health as the most pressing health issue

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

34.3% of Middle School Students Report having used alcohol or illicit drugs in their lifetime

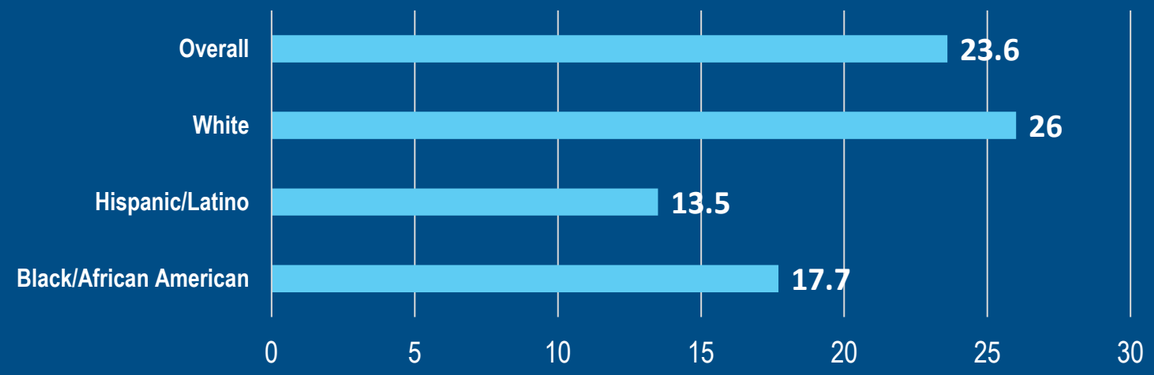
12.9% of Adults engage in heavy or binge drinking

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

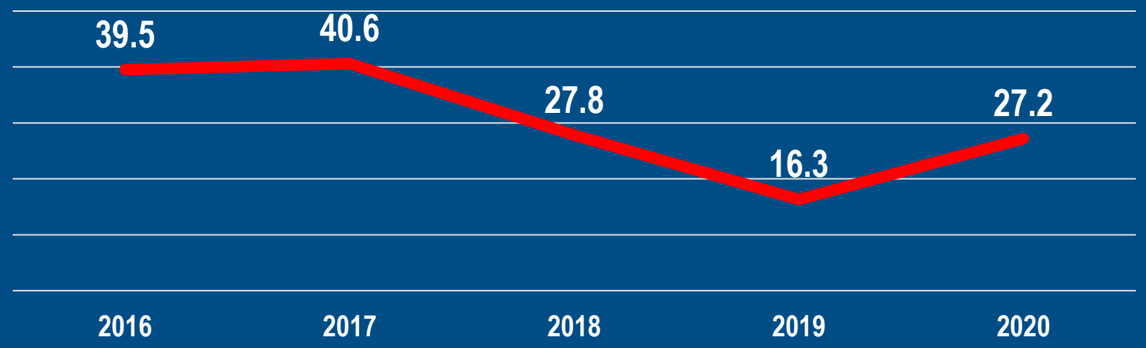
53.7% of High School Students Report having used alcohol or illicit drugs in their lifetime

- **34.7%** of high school students have used a vaporizer/E-cigarette, 2018
- **16.4%** of middle school students have used a vaporizer/E-cigarette, 2018
- **17.8%** of adults currently smoke cigarettes, 2017-2019

Age-Adjusted Drug and Opioid Involved Overdose Death Rate, 2018-2020



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



11.8% of survey respondents indicated they had thoughts that they would be better off dead or of hurting themselves in some way for several days, more than half of the days or nearly every day over the last 12 months.

29% of survey respondents were diagnosed by a medical provider with Depression or Anxiety

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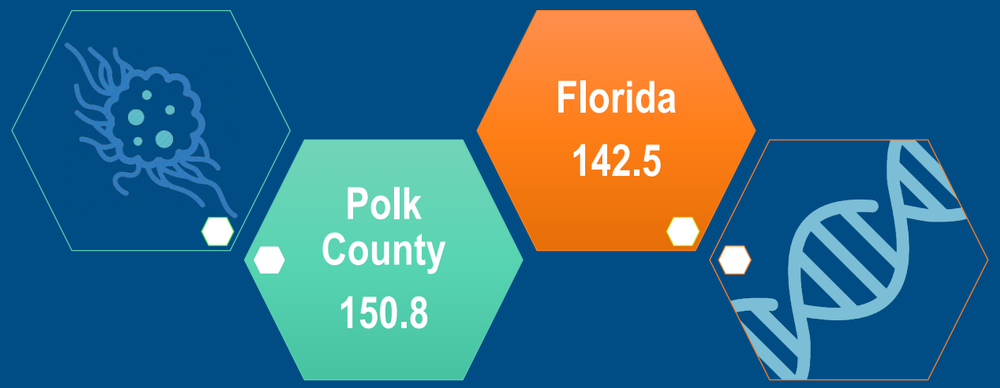
Sources: All4HealthFL.org, FLHealthCharts.gov; CHNA Survey Data; Florida Youth Substance Abuse Survey

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

CANCER POLK COUNTY

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



Adults who currently smoke cigarettes, 2017- 2019

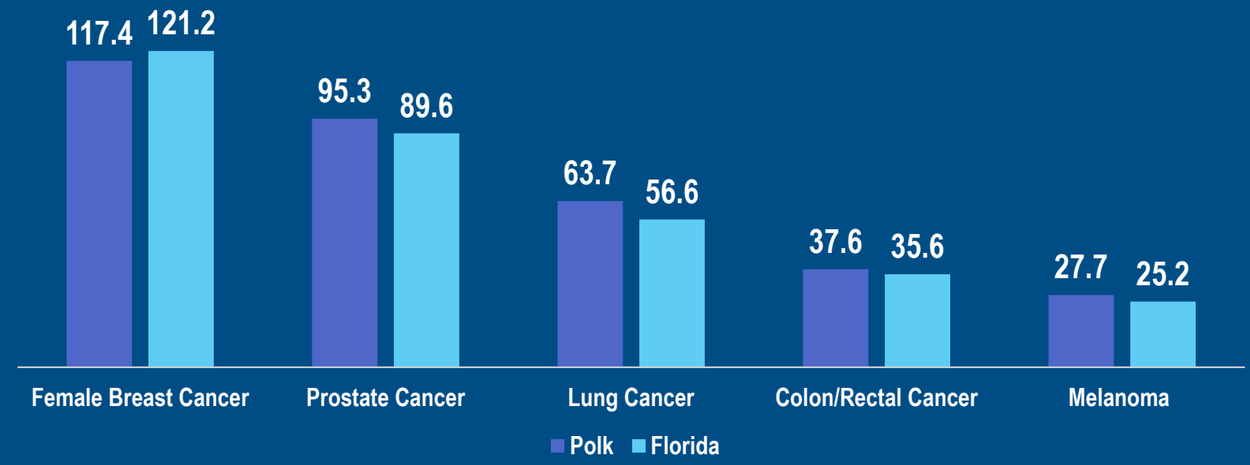
Polk County	17.8%
Florida	14.8%

16% of survey respondents ranked Cancer as a most pressing health issue

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

Sources: All4HealthFL.org, FLHealthCharts.gov; CHNA Survey Data

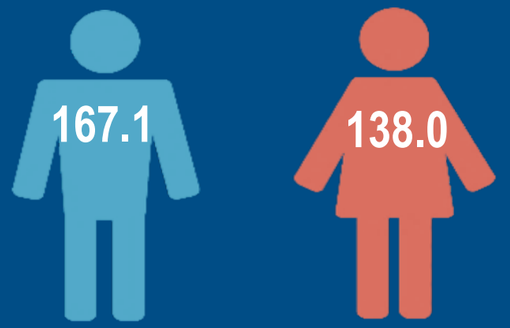
CANCER INCIDENCE RATE: POLK COUNTY
(Average age-adjusted per 100,000 population, 2016-18)



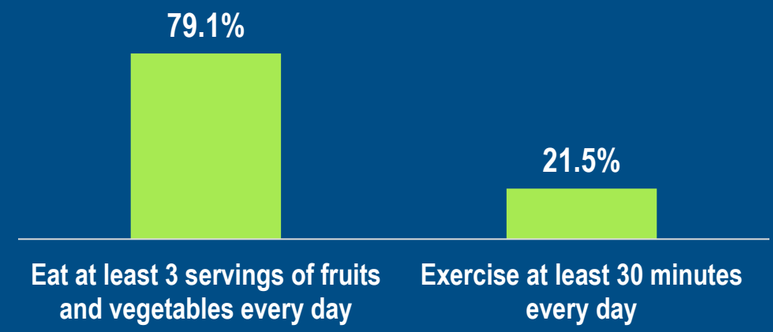
CANCER DEATH RATES BY TYPE
(Average age-adjusted deaths per 100,000 population, 2018-2020)

Type of Cancer	Polk County	Florida
Female Breast Cancer	21.0	18.7
Prostate Cancer	16.0	16.5
Lung Cancer	37.8	33.6
Colon/Rectal Cancer	13.5	12.6

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



Cancer Prevention Indicator:
Survey respondents who answered "NO" to the following



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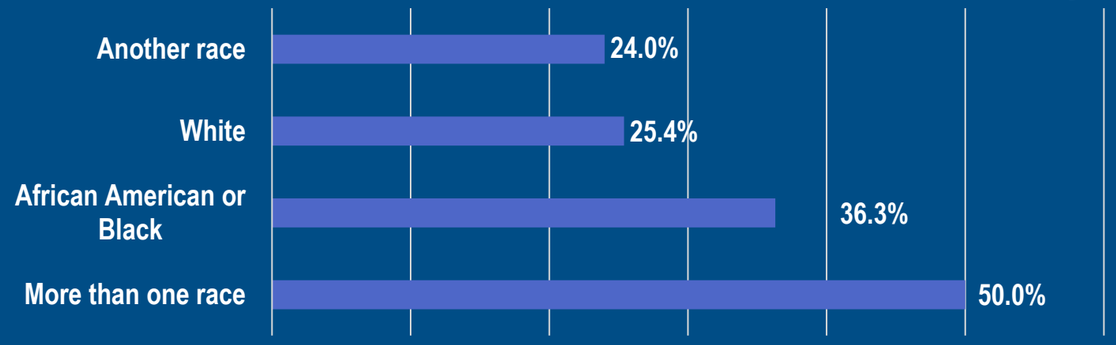
EXERCISE, NUTRITION & WEIGHT POLK COUNTY

28.7% of survey respondents self-reported food insecure

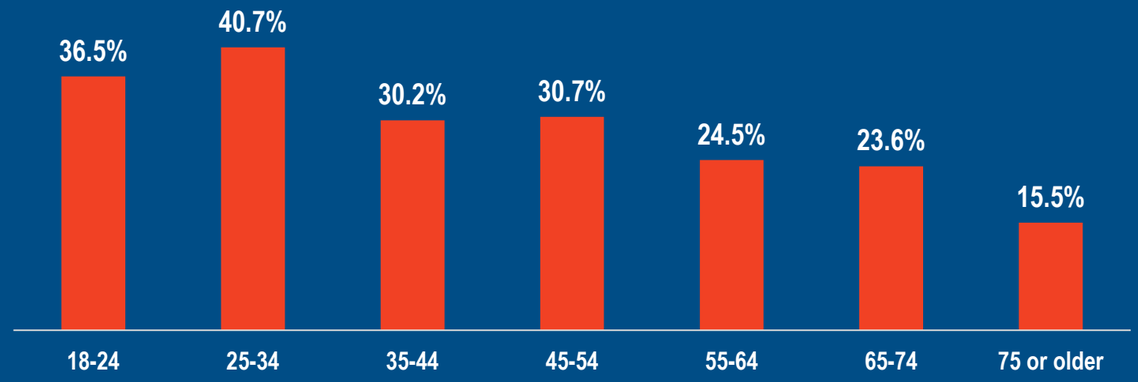
Survey Respondents Food Insecurity by Race



20.1% responded 'yes'

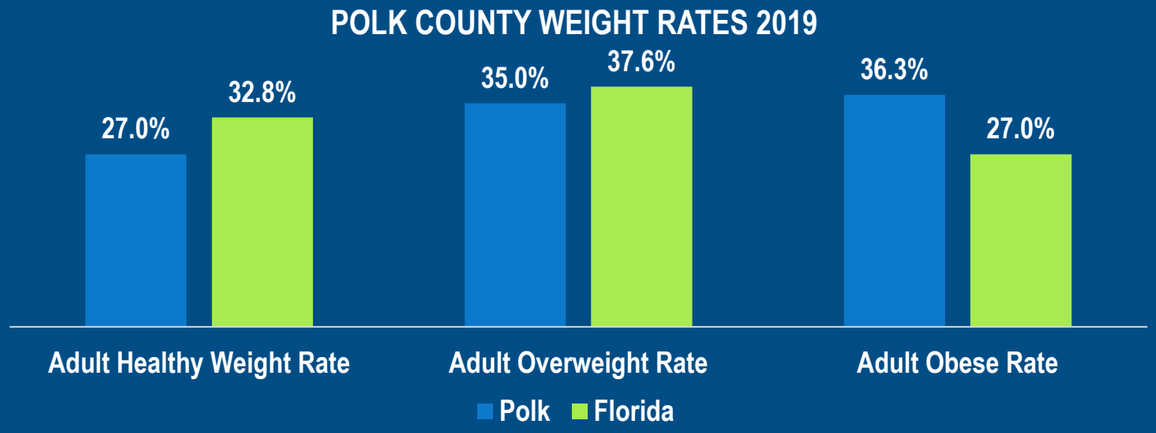
In the last 12 months, did you or anyone living in your home ever get emergency food from a church, a food pantry, or a food bank, or eat in a soup kitchen?

Food Insecure Individuals by Age



45.6%	Respondents who disagreed with the statement "There are good sidewalks for walking safely in my neighborhood"
25.7%	Respondents who disagreed with the statement "We have great parks and recreational facilities"
28.0%	Respondents who disagreed with the statement "I am able to get healthy food easily"
16.0%	Respondents who disagreed with the statement "I feel safe in my own neighborhood"

POLK COUNTY WEIGHT RATES 2019



Survey respondents who answered "NO" to the following:

79.1% Eat at least 3 servings of fruits and vegetables every day

21.5% Exercise at least 30 minutes every day

15.4%	Adults who have ever been told they have diabetes, 2019
424.4	Age adjusted ED visits from diabetes, 3 year rolling 2018-20, rate per 100k

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Sources: FLHealthCharts.gov; CHNA Survey Data

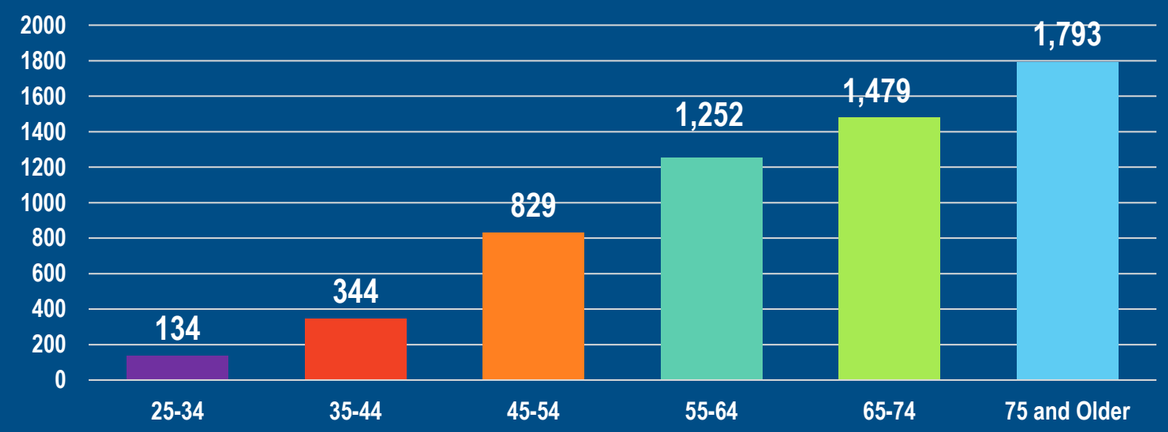
HEART DISEASE & STROKE POLK COUNTY

5,840

Emergency Department Visits that include a diagnosis of Heart Failure, Sampling of two Polk Hospitals, 2021

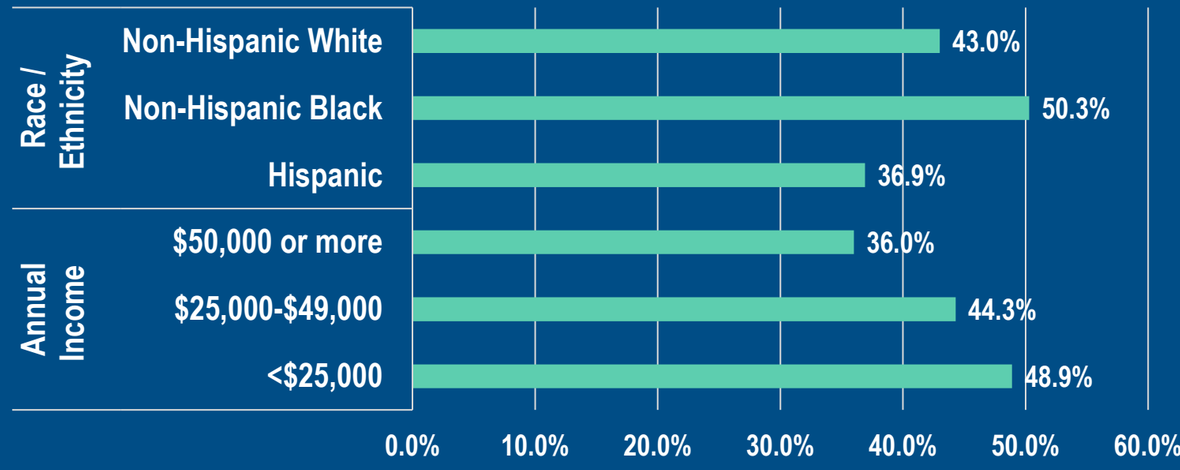
AGE-ADJUSTED DEATHS FROM HEART DISEASES, RATE PER 100,000 POPULATION, 3-YEAR ROLLING, 2018-2020

EMERGENCY DEPARTMENT VISITS THAT INCLUDED A DIAGNOSIS OF HEART FAILURE BY AGE (Sampling of two Polk hospitals, 2021)



Sources: FLHealthCharts.gov; CHNA Survey Data

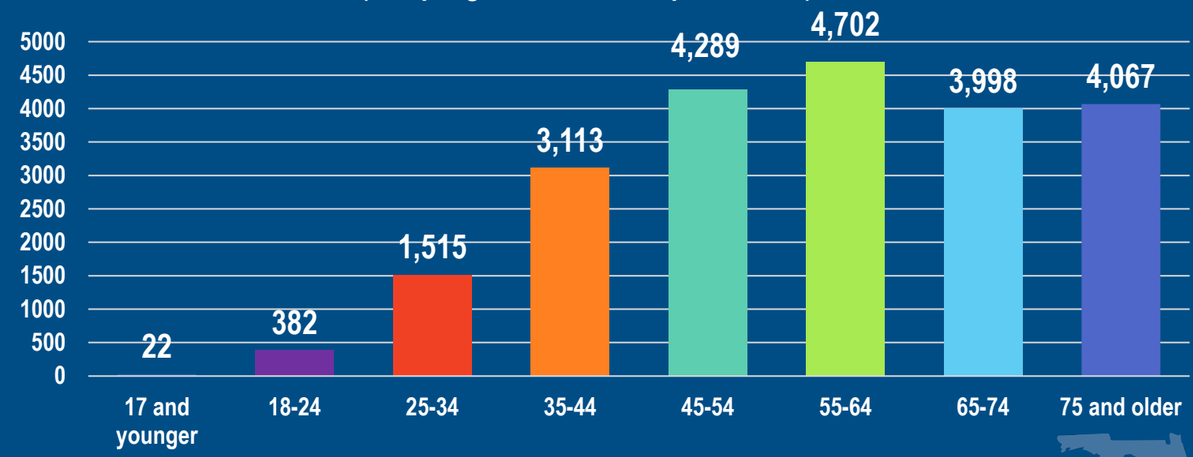
POLK ADULTS WHO HAVE EVER BEEN TOLD THEY HAVE HYPERTENSION, 2019



44% Of survey respondents told by a medical provider they have Hypertension and/or Heart Disease

4.2% Adults who experienced a stroke, 2019

EMERGENCY DEPARTMENT VISITS THAT INCLUDED UNCONTROLLED BLOOD PRESSURE / HYPERTENSION BY AGE (Sampling of two Polk hospitals, 2021)



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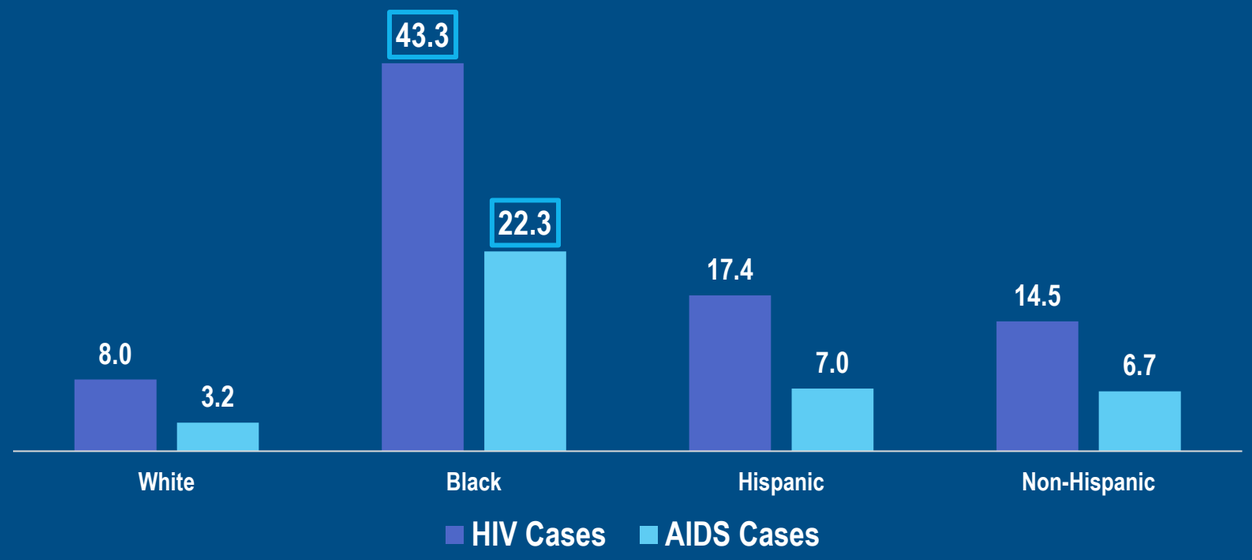
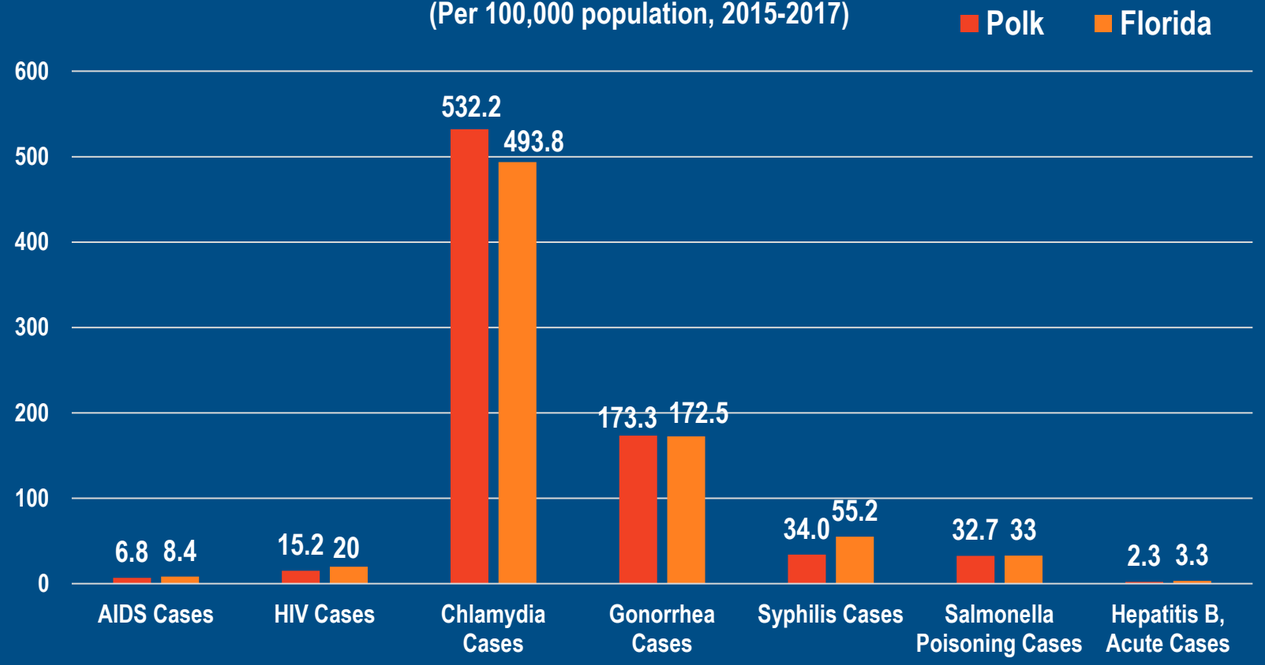
IMMUNIZATION & INFECTIOUS DISEASE POLK COUNTY

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

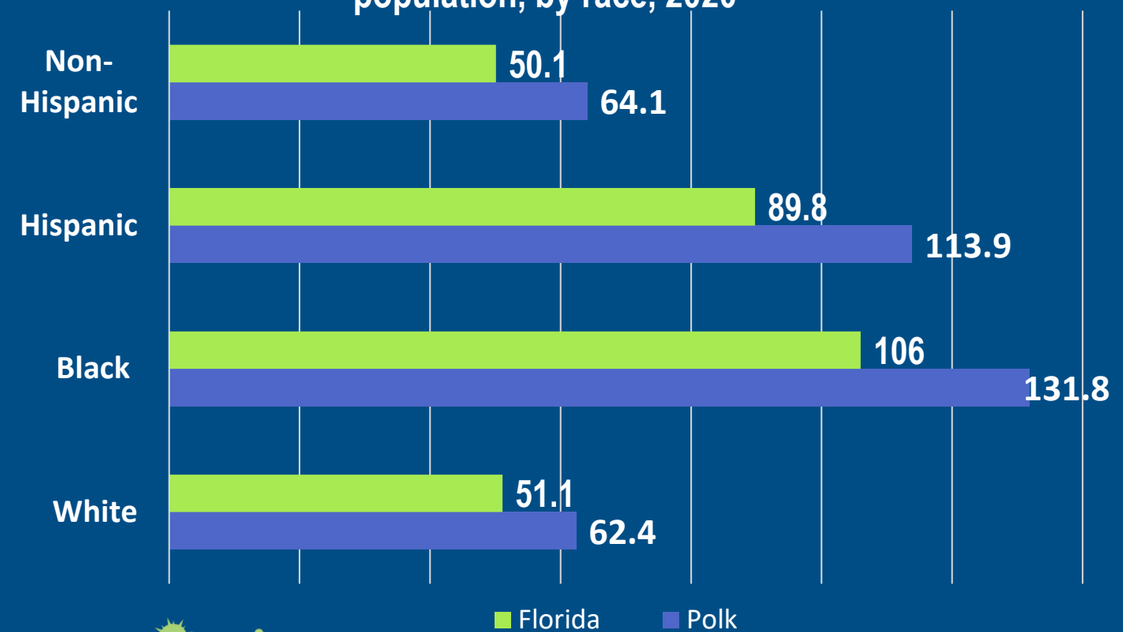


REPORTABLE AND INFECTIOUS DISEASES
(Per 100,000 population, 2015-2017)



Sources: FLHealthCharts.gov; CHNA Survey Data

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



56.6% Persons fully vaccinated against COVID-19

33.7%	Adults who received a flu shot in the past year, 2019
90.9%	Two-year olds fully immunized, 2019
96.3%	Kindergarten children fully immunized, 2021

All4HealthFL
Four Counties. One Vision.

Appendix E. Community Partners and Resources

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

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

Polk County
All4HealthFL Collaborative Members & Teams

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

COLLABORATIVE ORGANIZATION LEADING MEMBERS

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

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

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

SUPPORTING ORGNAIZATIONS

NAMES OF SUPPORTING ORGANIZATIONS
Bartow Church Service Center
Career Source Polk
Central Florida Health Care
Florida Southern College
Frostproof Care Center
God's Pantry
Gospel Inc.
Grant Career Technical Education Center
Health Council of West Central Florida
Melanin Families Matter
Moffitt Cancer Center
Mt. Tabor Baptist Church
NAMI Polk
Peace River Center
Polk County Indigent Care
Polk County Public Schools
Polk State College
Polk Vision

Salvation Army Social Services Winter Haven
The Mission of Winter Haven
United Way of Central Florida
WeCare of Central Florida

Polk County
Community Partners & Organizations

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

Community Partner Organizations
Bartow Church Service Center
Career Source Polk
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Polk Vision
Salvation Army Social Services Winter Haven
The Mission of Winter Haven
United Way of Central Florida
WeCare of Central Florida

Appendix F. Partner Achievements

BayCare Health System: WHHBRMC

Behavioral Health

Mental Health First Aid:

By providing Mental Health First Aid (MHFA) classes, Winter Haven Hospital and Bartow Regional Medical Center focused on increasing community awareness to identify someone in mental health distress. Adult and pediatric classes were held across the community. MHFA was offered to a combination of social service providers, community members, and faith leaders who have multiple touch points with individuals living in the Winter Haven Hospital and Bartow Regional Medical Center service areas. To date nearly 500 individuals have been trained across our four-county service area.

Behavioral Health Liaisons:

Winter Haven Hospital and Bartow Regional Medical Center added a Behavioral Health Therapist to expand access to behavioral health and substance misuse services by assisting with education and linkage to community resources. The Behavioral Health Therapist acts as a liaison, meeting the patient and family in their time of need, providing education, therapeutic support, and assisting with navigating various avenues of behavioral health services.

Cordico Application Service:

BayCare and the Winter Haven Police Department joined forces to implement a real-time wellness application designed to connect first responders and their families to resources to support mental, physical, and relational wellness. In return, BayCare's Employee Assistance Program managed the directory of eligible providers. As of December 2021, the application had a total of 147 downloads with the most accessed information being Officer Wellness Tool Kit, Therapist Finder, and Peer Support.

Access to Health Services

Medication Assistance Program (MAP):

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

Find Help Florida:

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

Appendix F. Partner Achievements

BayCare Health System: WHHBRMC

Health Care Navigators:

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

Exercise, Nutrition, and Weight

Food Insecurity (HEALing Bags/School Pantries):

In response to the high level of food insecurity in BayCare's service areas, programs to expand access to food have become a major priority for the system. One of the ways BayCare has worked to combat food insecurity is by offering Healing Bags, a three-day supply of non-perishable food, to patients that have been screened and identified as food insecure. Since its inception, 55,779 patients have been screened with 4,463 receiving a Healing Bag from a BayCare hospital. The second way BayCare is working to address food insecurity is through partnership with Feeding Tampa Bay to supply 42 schools across its service area with an onsite food pantry for the students and their families. There are currently 7 school-based pantries in the Winter Haven Hospital and Bartow Regional Medical Center service area.

Healthy Living Coach Program:

To address the health concerns that come with chronic conditions such diabetes or obesity, BayCare implemented a healthy living coach program. The healthy living coach is a staff member of community health clinics that provide nutritional and diabetes support education for their clients. They work with the clients to create health goals and plans to better manage their weight and diabetes to improve health outcomes. BayCare has five healthy living coaches between Pinellas, Pasco, and Polk counties.

Community Health Team:

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

BayCare Kids Wellness and Safety Center:

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

Appendix F. Partner Achievements

AdventHealth West Florida Division

All4HealthFL IS Review of 2019-2022 Goals, Strategies, Objectives, & Progress

For More Information on Community Benefit Programs: [Programs and Partnerships | AdventHealth West Florida Community Benefit]

Priority Area: Exercise, Nutrition, and Weight

Distributed ***$33,850*** of fresh fruit and vegetables to low-income residents living in food deserts.

AdventHealth Food is Health® is a community program for people who don't have the means or transportation to add fresh vegetables and fruits into their diet. The overall goal of the AdventHealth Food is Health® program is to reach into our communities and make connections to improve overall health and wellness of adults living in food deserts or low-income/low-access areas.

The program combines health education classes, health screenings, and fresh fruits and vegetables to improve the health and wellbeing of participants. It is implemented in communities where families have limited access to fresh fruits and vegetables. Through partnerships with education partners, AdventHealth supports health education classes on topics such as diabetes, obesity, nutrition, and cancer. In addition, AdventHealth nurses provide free health screenings which check participant's blood pressure, blood glucose, and body mass index (BMI). After every class, each person receives a $10 produce voucher used to purchase fresh fruits and vegetables from an on-site mobile produce truck, local grocer, or produce stand.

Since 2020, AdventHealth has conducted the AdventHealth Food is Health® program virtually and in person and achieved the following outcomes in Hillsborough, Pinellas, and Pasco counties:

- Coordinated 33 nutrition class series in food deserts educating 586 adults on healthy living
- Participants redeemed 3,385 produce vouchers equaling $33,850 of fresh fruit and vegetables improving access to diverse and healthy food options
- Launched AdventHealth Food is Health® Youth expanding access to healthy food and nutrition education to children and teens

Additional summary: The AdventHealth Food is Health® program is provided at no cost for community members who do not have the means or transportation to include fresh vegetables and fruits in their diet. Food is Health® reaches into communities to improve the overall health and wellness of adults living in food deserts or lowincome/low-access areas. AdventHealth is committed to working together with local community organizations and stakeholders to implement effective strategies to address obesity and access to healthy food in communities.

Appendix F. Partner Achievements

AdventHealth West Florida Division

Partnerships for the AdventHealth Food is Health Program include:

AdventHealth and Feeding Tampa Bay

- Lauren Key, Senior Executive Officer, Consumer Strategy, AdventHealth West Florida Division serves as a board member on the Feeding Tampa Bay Executive Board. Reference: Board of Directors - Feeding Tampa Bay

Priority Area: Behavioral Health

Trained over 150 adults in Mental Health First Aid

Adult Mental Health First Aid (MHFA) teaches individuals how to identify, understand, and respond to signs of mental illness and substance use disorders. The 8-hour training gives individuals the skills to reach out and provide initial support to adults who may be experiencing a mental health or substance use challenge and help connect them to the appropriate care. Research has demonstrated that MHFA helps to reduce stigma associated with mental health and substance use disorders.

AdventHealth, along with the other partners of the All4HealthFL collaborative, have made teaching MHFA a major objective to help combat stigma. Since 2020, AdventHealth has conducted virtual and in-person MHFA classes and achieved the following outcomes in Hillsborough, Pinellas, and Pasco counties:

- Trained four team members as MHFA Instructors in the Adult Curriculum
- Facilitated 13 certification classes training 122 adults to recognize and safely intervene in mental health crises

Behavioral Health Partnership

The partnership between AdventHealth and Concert Health is based on Collaborative Care—an evidence-based approach to improving behavioral health care by identifying and treating conditions such as anxiety and depression in the primary care setting. More than 60% of Concert Health patients see a 50% reduction in their depression or anxiety symptoms within 90 days. This flexible, patient-centered approach will allow AdventHealth physicians to practice whole-person care through a high-touch model that addresses both mental and physical health.

Reference: AdventHealth Launches Collaborative Care Program with Concert Health to Expand Whole Health Care – Concert Health

AdventHealth expands access to mental health services in Tampa Bay

Reference: AdventHealth expands access to mental health services in Tampa Bay | AdventHealth West Florida Media Resources | AdventHealth

Appendix F. Partner Achievements

AdventHealth West Florida Division

AdventHealth announced the expansion of its mental health focus outside of the primary care setting during a press conference with Tampa Bay Thrives and additional community partners. The health system will be expanding its care to provide same-day access to a mental health clinician at 10 AdventHealth Express Care at Walgreens locations across Tampa Bay via telehealth. Currently, AdventHealth physician practices at AdventHealth Care Pavilion New Tampa connect patients with expert mental health clinicians to receive same-day behavioral health treatment, via phone or video visit, from the privacy of their home.

Note: Please make the necessary wordsmithing (for better flow) to the information below. This information was pulled from a few tables and press releases.

To assist with pulling more information, please refer to the full Community Health Plan located at: [Final 2019 CHNA Template (adventhealth.com)]

American Heart Association (AHA) Hands-Only Community CPR

AdventHealth Tampa is committed to working together with local community organizations and stakeholders to implement effective strategies to reduce the burden of heart disease and stroke by providing health education in the community, increasing access to community health screenings and connecting community members to resources to help manage blood pressure and cholesterol.

AdventHealth has been working to increase the number of Hospital-sponsored American Heart Association (AHA) community CPR out-of-hospital bystander classes for adults and youth from a baseline of zero to five by the end of year three (December 31, 2022).

The AdventHealth Community Benefit team members were trained by the American Heart Association in Community CPR to implement the train-the-trainer model throughout the community. Classes are provided for free to community members (churches, schools, after-school programs, community organizations, etc.). In addition to be trained to save a life of someone challenged with an immediate heart event, community members are also trained to train other community members in community CPR and are provided with a free Hands Only CPR kit at completion of the class.

Appendix F. Partner Achievements

AdventHealth West Florida Division

What is Hands Only CPR?

- Hands-Only CPR is CPR without rescue breaths.
- Hands-Only means giving chest compressions to keep someone alive.
- Hands-Only CPR is intended for adults, teens, and children over the age of 8 years old.

With 70 percent of all out-of-hospital cardiac arrests happening at home, if you're called on to perform Hands-Only CPR, you'll likely be trying to save the life of someone you know and love.

Hands-Only CPR carried out by a bystander has been shown to be as effective as CPR with breaths in the first few minutes during an out-of-hospital sudden cardiac arrest for an adult victim

As of May 2022, the following accomplishments have been achieved.

- A total of 15 AdventHealth Team Members Instructor trained to teach the Community CPR Train-The-Trainer community classes.
- Developed training presentation and implemented 12 classes
- Number of adults trained: 146
- Partnered with local school districts and youth agencies to train 500 high school aged youth
- Number of youths trained by trainees: 6,000

Tobacco Cessation

Accomplishments from 2020-2022 Community Health Plans (As of May 2022)

AdventHealth partnered with Area Health Education Centers (AHEC) in Hillsborough, Pinellas, and Pasco, County to connect patients and community members to tobacco cessation classes. Furthermore, the AdventHealth Patient Engagement Advisors (PEA)/Care 360 teams created a streamlined referral process to enroll over 1,051 identified AdventHealth patients into AHEC's tobacco cessation classes and connect them to resources to quit.