Summary Report

2016 Community Health Needs Assessment Report

BayCare Alliant Hospital Service Area

Prepared for:

BayCare Alliant Hospital

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Introduction

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About This Assessment

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors and needs of older adults in the primary service area of BayCare Alliant Hospital, a long-term acute care hospital. A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. For BayCare Alliant Hospital, this information may be used to inform decisions and guide efforts to improve community health and wellness for older residents.

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

Methodology

This assessment incorporates data from both quantitative and qualitative sources:

- Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at the state and national levels.
- Qualitative data input includes primary research gathered through an Online Key Informant Survey of various community stakeholders.

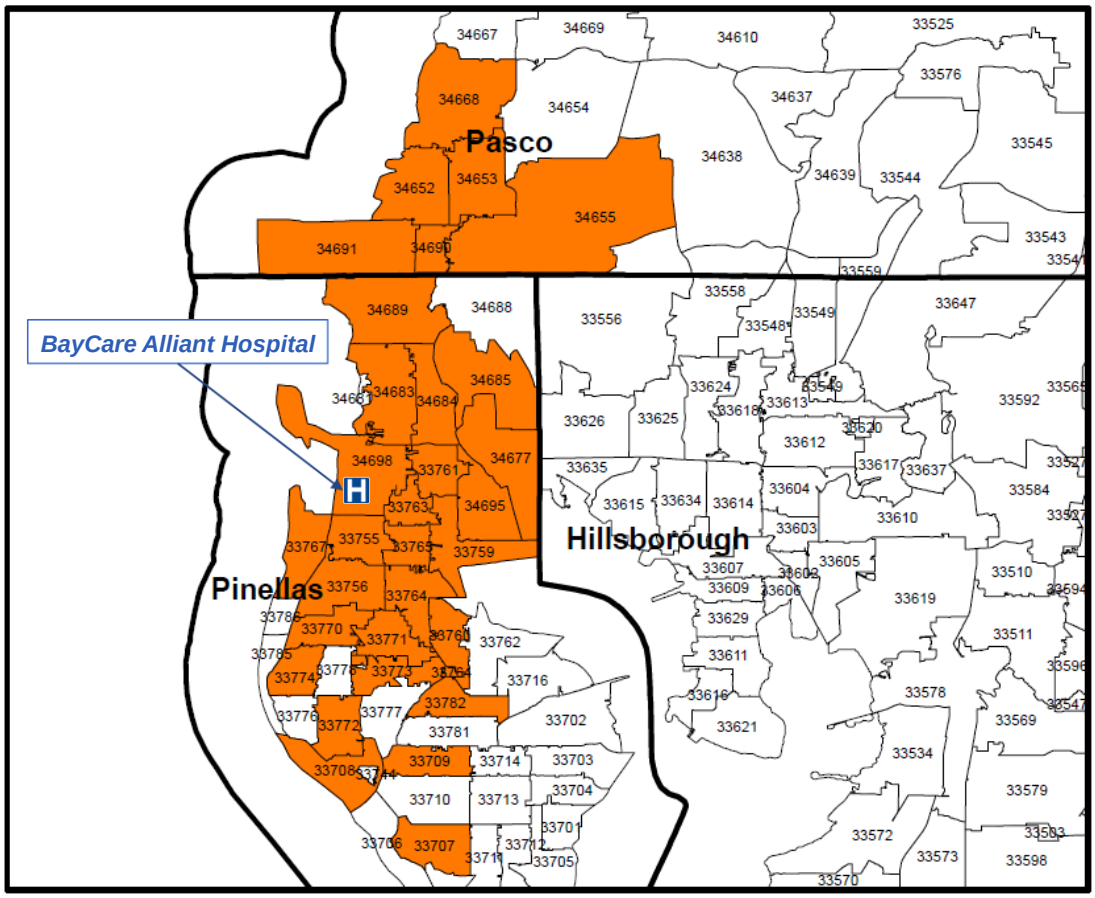
PRC Community Health Survey

Survey Instrument

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

Community Defined for This Assessment

Geographically, this report focuses on findings in the primary service area of BayCare Alliant Hospital (referred to as the “Primary Service Area” or “PSA” in this report). This area, from which 75% of the hospital’s admissions are derived, includes the following residential ZIP Codes: 33707, 33708, 33709, 33755, 33756, 33759, 33760, 33761, 33763, 33764, 33765, 33767, 33770, 33771, 33772, 33773, 33774, 33782, 34652, 34653, 34655, 34668, 34677, 34683, 34684, 34685, 34689, 34690, 34691, 34695, and 34698.



Because BayCare Alliant Hospital (as a long-term acute care hospital) primarily serves an older population, the "community" defined for the hospital is further limited to residents age 50 and older within the service area geography.

Sample Approach & Design

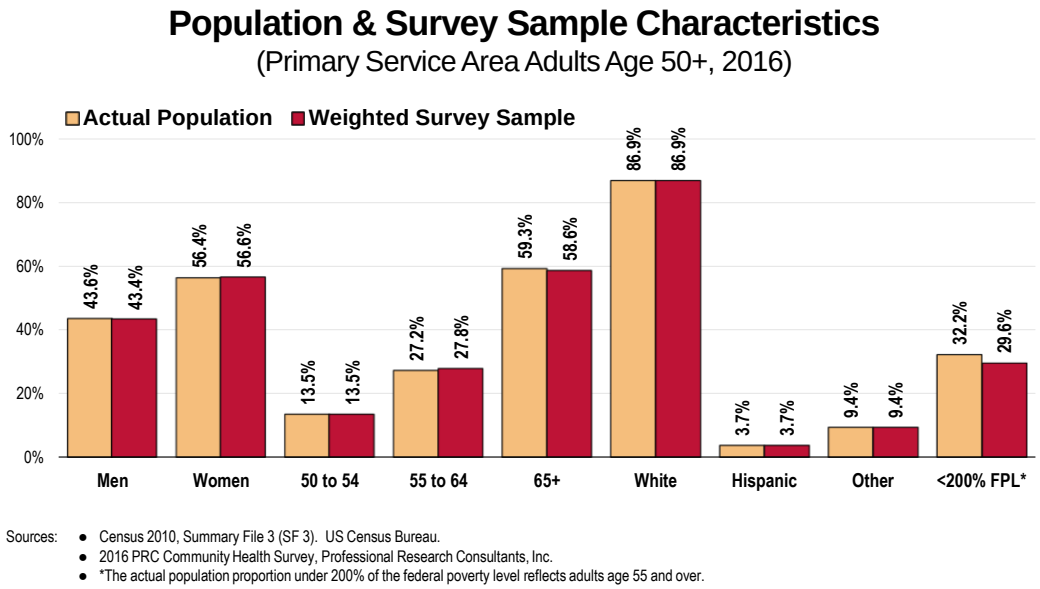
A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed a mixed-mode methodology was implemented. This included surveys conducted via telephone (landline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

The survey data for this project was extracted from a larger study sponsored by BayCare Health System. **The survey data for the appropriate ZIP Codes were drawn and limited to respondents age 50 and over to better reflect the population served by BayCare Alliant Hospital.** This resulted in a sample of 485 individuals age 50 and older in the primary service area. For statistical purposes, the maximum rate of error associated with a sample size of 485 respondents is ±4.5% at the 95 percent level of confidence. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

Sample Characteristics

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

The following chart outlines the characteristics of the primary service area sample of adults age 50 and older for key demographic variables, compared to actual population characteristics revealed in census data.



Sources:
- Census 2010, Summary File 3 (SF 3). US Census Bureau.
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc.
- *The actual population proportion under 200% of the federal poverty level reflects adults age 55 and over.

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

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members age 50 and over in the defined area with a high degree of confidence.

Online Key Informant Survey

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

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 55 community stakeholders in the primary service area took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation

Key Informant Type	Number Invited	Number Participating
Physician	33	4
Public Health Expert	6	3
Other Health Provider	45	23
Community/Business Leader	37	15
Social Services Representative	15	10

Final participation included representatives of the organizations outlined below.

- BayCare Alliant Hospital
- BayCare Health System
- Central Florida Behavioral Health Network
- City of Safety Harbor
- Department of Health in Pasco County
- Extended Care Services
- Good Samaritan Health Clinic of Pasco, Inc.
- Hill Ward Henderson
- Homeless Empowerment Program
- Mease Manor Retirement Community
- Morton Plant Mease Healthcare
- Morton Plant Rehabilitation Center
- Palm Garden of Largo
- Physicians Dialysis
- Pinellas County
- Pinellas County Government
- Pinellas County Homeless Leadership Board
- St. Petersburg Free Clinic
- Ultimate Medical Academy
- United Way of Pasco County
- West Bay of Tampa

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

Minority and other medically underserved populations represented:

> *African-Americans, Asians, the chronically ill, the disabled, the elderly, Hispanics, homeless individuals, low income*

> *residents, men, the mentally ill, Non-White residents, undocumented individuals, unemployed individuals, uninsured/underinsured community members, veterans, women*

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

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

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. **Data for the primary service area of BayCare Alliant Hospital represent a composite of Pasco and Pinellas Counties**, as obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Environmental Systems (CARES)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Community Commons
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Also note that, unless otherwise noted, **county-level secondary data represent the total population (all ages)**, and cannot be limited to older adults in the same way as the survey data presented in this report.

Benchmark Data

Florida Risk Factor Data

State-level vital statistics are provided for comparison of secondary data indicators.

Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2015 PRC National Health Survey* (and likewise limited to only adults age 50 and older); the methodological approach for the national study is identical to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2020

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

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

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

Determining Significance

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

Information Gaps

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

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

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

IRS Form 990, Schedule H Compliance

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

IRS Form 990, Schedule H (2015)	See Report Page
Part V Section B Line 3a *A definition of the community served by the hospital facility*	5
Part V Section B Line 3b *Demographics of the community*	117
Part V Section B Line 3c *Existing health care facilities and resources within the community that are available to respond to the health needs of the community*	113
Part V Section B Line 3d *How data was obtained*	5
Part V Section B Line 3e *The significant health needs of the community*	13
Part V Section B Line 3f *Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups*	Addressed Throughout
Part V Section B Line 3g *The process for identifying and prioritizing community health needs and services to meet the community health needs*	15
Part V Section B Line 3h *The process for consulting with persons representing the community's interests*	7
Part V Section B Line 3i *Information gaps that limit the hospital facility's ability to assess the community's health needs*	10

Summary of Findings

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Significant Health Needs of the Community

The following "areas of opportunity" represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in Healthy People 2020. From these data[1], opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

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

Areas of Opportunity Identified Through This Assessment	

Access to Healthcare Services	• Lack of Health Insurance [Age 50-64]
	• Barriers to Healthcare Access
	  ○ Cost of Prescriptions
	  ○ Cost of Physician Visits
	  ○ Finding a Physician
	  ○ Lack of Transportation

Cancer	• Cancer is a leading cause of death. • Cancer Incidence [All Ages] ○ Including Lung Cancer and Cervical Cancer Incidence • Skin Cancer Prevalence • Cervical Cancer Screening
Dementia, Including Alzheimer's Disease	• Dementias/Alzheimer's Disease ranked as a top concern in the Online Key Informant Survey.
Diabetes	• Prevalence of Borderline/Pre-Diabetes • Diabetes ranked as a top concern in the Online Key Informant Survey.
Heart Disease & Stroke	• Cardiovascular disease is a leading cause of death. • High Blood Pressure Management • High Blood Cholesterol Prevalence • Heart Disease & Stroke ranked as a top concern in the Online Key Informant Survey.
Mental Health	• Seeking Mental Health Services [Those with Depression] • Difficulty Obtaining Mental Health Services • Mental Health ranked as a top concern in the Online Key Informant Survey.
Oral Health	• Regular Dental Care

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

Areas of Opportunity (continued)	
Potentially Disabling Conditions	• Osteoporosis Prevalence • Caregiving
Substance Abuse	• Substance Abuse ranked as a top concern in the Online Key Informant Survey.

Prioritization of Health Needs

On September 29, 2016, BayCare Alliant Hospital convened a group of 27 hospital representatives and community stakeholders (representing a cross section of community-based agencies and organizations) to evaluate, discuss and prioritize health needs for the hospital's population and service area, based on findings of this Community Health Needs Assessment (CHNA); see Appendix II for participating agency/organizations. Professional Research Consultants, Inc. (PRC) began the meeting with a presentation of key areas of opportunity that represent the significant health needs identified from the primary and secondary research (see Areas of Opportunity above).

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

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

- **Scope & Severity —** The first rating was to gauge the magnitude of the problem in consideration of the following:
  - How many people are affected?
  - How does the local community data compare to state or national levels, or Healthy People 2020 targets?
  - To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?

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

- **Ability to Impact** — A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue. Specifically, participants were asked to consider:
  - What is the likelihood of our organization having a positive impact on this health issue?
  - This should reflect our ability to address this issue independently or in conjunction with potential community partners.

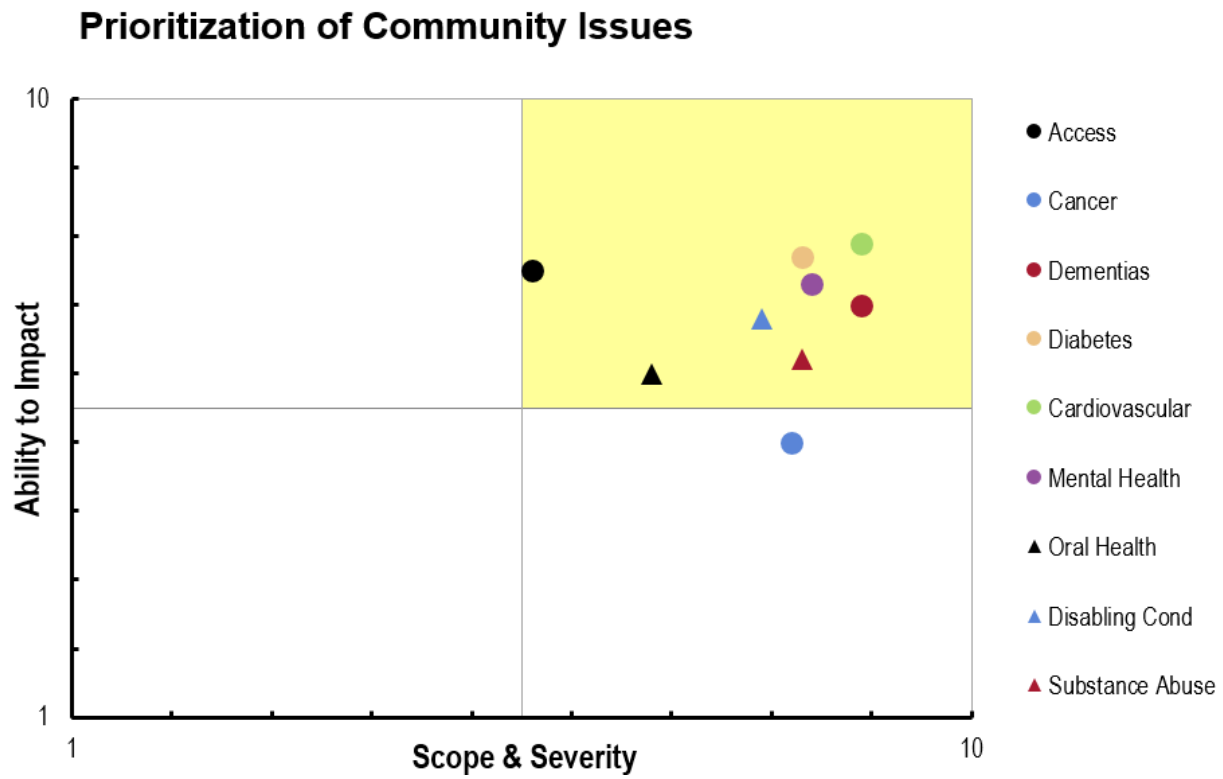
  Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact). Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

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

1. **Heart Disease & Stroke**
2. **Diabetes**

3. **Dementias, Including Alzheimer's Disease**
4. **Mental Health**
5. **Potentially Disabling Conditions**
6. **Substance Abuse**
7. **Cancer**
8. **Access to Healthcare Services**
9. **Oral Health**

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



Note: An evaluation of the work that BayCare Alliant Hospital has already implemented based on findings of the prior assessment can be found in Appendix I.

Summary Data

Comparisons With Benchmark Data

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

Reading the Data Summary Tables

In the following charts, Primary Service Area results are shown in the larger, blue column. For survey-derived indicators, this column represents the ZIP Code-defined hospital service area; for data from secondary sources, this column represents findings for the combined area of Pasco and Pinellas Counties. *Tip: Indicator labels beginning with a "%" are taken from the population-based PRC Community Health Survey; the remaining indicators are taken from secondary data sources*.

The columns to the right of the Primary Service Area column provide comparisons between local data and any available state and national findings, and Healthy People 2020 targets. Again, symbols indicate whether the Primary Service Area compares favorably (), unfavorably (), or comparably () to these external data.

Note the following:

- Blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.
- For survey-derived indicators, local and national data reflect the population age 50 and over, whereas for secondary data indicators these columns reflect all ages unless otherwise specified.

Social Determinants	Primary Service Area	PSA vs. Benchmarks		
		vs. FL	vs. US	vs. HP2020
[County] Linguistically Isolated Population (Percent)	3.0	6.6	4.7	
[County] Population in Poverty (Percent)	14.3	16.7	15.6	
[County] Population Below 200% FPL (Percent)	34.8	38.1	34.5	
[County] No High School Diploma (Age 25+, Percent)	11.2	13.6	13.7	
[County] Unemployment Rate (Age 16+, Percent)	5.1	5.4	5.3	
% [Age 50+] Worry/Stress Over Rent/Mortgage in Past Year	22.4		20.7	
Note: The Primary Service Area (PSA) data (blue column) represent combined Pasco/Pinellas County data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.		better	similar	worse

Overall Health	Primary Service Area	PSA vs. Benchmarks		
		vs. FL	vs. US	vs. HP2020
% [Age 50+] "Fair/Poor" Physical Health	24.6		24.1	
% [Age 50+] Activity Limitations	32.0		27.0	
% [Age 50+] Caregiver to a Friend/Family Member	31.3		24.2	
Note: The Primary Service Area (PSA) data (blue column) represent combined Pasco/Pinellas County data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.		better	similar	worse

Access to Health Services	Primary Service Area	PSA vs. Benchmarks		
		vs. FL	vs. US	vs. HP2020
% [Age 50-64] Lack Health Insurance	**8.8**		3.4	0.0
% [Insured 50-64] Have Coverage Through ACA	**14.2**		13.1	
% [Age 50+] Difficulty Accessing Healthcare in Past Year (Composite)	**35.8**		29.7	
% [Age 50+] Inconvenient Hrs Prevented Dr Visit in Past Year	**8.7**		9.4	
% [Age 50+] Cost Prevented Getting Prescription in Past Year	**13.6**		8.9	
% [Age 50+] Cost Prevented Physician Visit in Past Year	**10.8**		6.6	
% [Age 50+] Difficulty Getting Appointment in Past Year	**14.3**		12.0	
% [Age 50+] Difficulty Finding Physician in Past Year	**10.2**		5.2	
% [Age 50+] Transportation Hindered Dr Visit in Past Year	**8.7**		3.9	
% [Age 50+] Language/Culture Prevented Care in Past Year	**0.6**		1.8	
% [Age 50+] Low Health Literacy	**16.3**		23.0	
% [Age 50+] Skipped Prescription Doses to Save Costs	**13.5**		10.8	
[County] Primary Care Doctors per 100,000	**78.1**	72.1	75.8	
% [Age 50+] Have a Specific Source of Ongoing Care	**83.8**		78.7	95.0
% [Age 50-64] Have a Specific Source of Ongoing Care	**78.9**		80.0	89.4

Access to Health Services (continued)	Primary Service Area	PSA vs. Benchmarks		
		vs. FL	vs. US	vs. HP2020
% [Age 65+] Have a Specific Source of Ongoing Care	**87.2**		76.8	100.0
% [Age 50+] Have Had Routine Checkup in Past Year	**84.4**		78.7	
% [Age 50+] Two or More ER Visits in Past Year	**7.2**		7.8	
% [Age 50+] Rate Local Healthcare "Fair/Poor"	**9.8**		11.0	
% [Age 50+] Have Completed Advance Directive Documents	**62.9**		48.4	
Note: The Primary Service Area (PSA) data (blue column) represent combined Pasco/Pinellas County data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.		better	similar	worse

Arthritis, Osteoporosis & Chronic Back Conditions	Primary Service Area	PSA vs. Benchmarks		
		vs. FL	vs. US	vs. HP2020
% [Age 50+] Arthritis/Rheumatism	**35.7**		32.0	
% [Age 50+] Osteoporosis	**13.1**		8.7	5.3
% [Age 50+] Sciatica/Chronic Back Pain	**30.6**		27.2	
Note: The Primary Service Area (PSA) data (blue column) represent combined Pasco/Pinellas County data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.		better	similar	worse

Cancer	Primary Service Area	PSA vs. Benchmarks		
		vs. FL	vs. US	vs. HP2020
[County] Prostate Cancer Incidence per 100,000	**107.8**	118.9	131.7	
[County] Female Breast Cancer Incidence per 100,000	**117.3**	115.2	123.0	
[County] Lung Cancer Incidence per 100,000	**71.8**	64.6	63.7	
[County] Colorectal Cancer Incidence per 100,000	**38.4**	39.2	41.9	
[County] Cervical Cancer Incidence per 100,000	**8.6**	8.9	7.7	
% [Age 50+] Skin Cancer	**15.8**		11.5	
% [Age 50+] Cancer (Other Than Skin)	**12.8**		12.4	
% [Women 50-74] Mammogram in Past 2 Years	**79.5**		80.3	81.1
% [Women 50-65] Pap Smear in Past 3 Years	**59.7**		76.0	93.0
% [Age 50+] Sigmoid/Colonoscopy Ever	**75.1**		75.6	
% [Age 50+] Blood Stool Test in Past 2 Years	**40.2**		31.8	
% [Age 50-75] Colorectal Cancer Screening	**76.4**		74.5	70.5
		better	similar	worse

Note: The Primary Service Area (PSA) data (blue column) represent combined Pasco/Pinellas County data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

Chronic Kidney Disease	Primary Service Area	PSA vs. Benchmarks		
		vs. FL	vs. US	vs. HP2020
% [Age 50+] Kidney Disease	7.7		5.5	
		better	similar	worse

Note: The Primary Service Area (PSA) data (blue column) represent combined Pasco/Pinellas County data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

Dementias, Including Alzheimer's Disease	Primary Service Area	PSA vs. Benchmarks		
		vs. FL	vs. US	vs. HP2020
% [Age 50+] Increasing Confusion/Memory Loss in Past Yr	14.9		13.7	
		better	similar	worse

Note: The Primary Service Area (PSA) data (blue column) represent combined Pasco/Pinellas County data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

Diabetes	Primary Service Area	PSA vs. Benchmarks		
		vs. FL	vs. US	vs. HP2020
% [Age 50+] Diabetes/High Blood Sugar	22.9		24.3	
% [Age 50+] Borderline/Pre-Diabetes	14.7		6.7	
% [Non-Diabetes Age 50+] Blood Sugar Tested in Past 3 Years	66.3		67.0	
		better	similar	worse

Note: The Primary Service Area (PSA) data (blue column) represent combined Pasco/Pinellas County data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

Hearing & Other Sensory or Communication Disorders	Primary Service Area	PSA vs. Benchmarks		
		vs. FL	vs. US	vs. HP2020
% [Age 50+] Deafness/Trouble Hearing	17.5		14.1	
		better	similar	worse

Note: The Primary Service Area (PSA) data (blue column) represent combined Pasco/Pinellas County data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

Heart Disease & Stroke	Primary Service Area	PSA vs. Benchmarks vs. FL	vs. US	vs. HP2020
% [Age 50+] Heart Disease (Heart Attack, Angina, Coronary Disease)	14.4		11.7	
% [Age 50+] Stroke	5.6		3.7	
% [Age 50+] Congestive Heart Failure	6.1			
% [Age 50+] Blood Pressure Checked in Past 2 Years	95.7		96.8	92.6
% [Age 50+] Told Have High Blood Pressure (Ever)	58.8		53.6	26.9
% [HBP Age 50+] Taking Action to Control High Blood Pressure	91.6		97.7	
% [Age 50+] Cholesterol Checked in Past 5 Years	95.9		94.0	82.1
% [Age 50+] Told Have High Cholesterol (Ever)	58.3		51.0	13.5
% [HBC Age 50+] Taking Action to Control High Blood Cholesterol	88.4		89.4	
% [Age 50+] 1+ Cardiovascular Risk Factor	92.8		91.4	
Note: The Primary Service Area (PSA) data (blue column) represent combined Pasco/Pinellas County data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.		better	similar	worse

HIV	Primary Service Area	PSA vs. Benchmarks vs. FL	vs. US	vs. HP2020
[County] HIV Prevalence per 100,000	348.7	606.1	353.2	
% [Age 50+] Ever Tested for HIV	29.4		30.9	
Note: The Primary Service Area (PSA) data (blue column) represent combined Pasco/Pinellas County data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.		better	similar	worse

Immunization & Infectious Diseases	Primary Service Area	PSA vs. Benchmarks		
		vs. FL	vs. US	vs. HP2020
% [Age 65+] Flu Vaccine in Past Year	53.7		58.9	70.0
% [High-Risk 50-64] Flu Vaccine in Past Year	35.0		54.5	70.0
% [Age 65+] Pneumonia Vaccine Ever	73.2		76.3	90.0
% [High-Risk 50-64] Pneumonia Vaccine Ever	45.5		48.2	60.0
		better	similar	worse

Note: The Primary Service Area (PSA) data (blue column) represent combined Pasco/Pinellas County data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

Injury & Violence Prevention	Primary Service Area	PSA vs. Benchmarks		
		vs. FL	vs. US	vs. HP2020
% [Age 50+] Fell in the Past Year	27.5		29.0	
% [Age 50+] Firearm in Home	25.5		39.8	
% [Age 50+ in Homes With Firearms] Weapon(s) Unlocked & Loaded	32.2		22.9	
[County] Violent Crime per 100,000	510.6	514.6	395.5	
% [Age 50+] Victim of Violent Crime in Past 5 Years	0.5		2.2	
% [Age 50+] Perceive Neighborhood as "Slightly/Not At All Safe"	13.4		15.2	
% [Age 50+] Victim of Domestic Violence (Ever)	13.1		11.6	
		better	similar	worse

Note: The Primary Service Area (PSA) data (blue column) represent combined Pasco/Pinellas County data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

Mental Health & Mental Disorders	Primary Service Area	PSA vs. Benchmarks vs. FL	vs. US	vs. HP2020
% [Age 50+] "Fair/Poor" Mental Health	14.3		12.8	
% [Age 50+] Diagnosed Depression	17.8		19.5	
% [Age 50+] Symptoms of Chronic Depression (2+ Years)	25.5		31.0	
% [Age 50+] Have Ever Sought Help for Mental Health	26.3		28.0	
% [Those Age 50+ With Diagnosed Depression] Seeking Help	78.1		91.0	
% [Age 50+] Taking Rx/Receiving Mental Health Trtmt	14.1		15.9	
% [Age 50+] Unable to Get Mental Health Svcs in Past Yr	4.9		1.7	
% [Age 50+] Typical Day Is "Extremely/Very" Stressful	9.2		8.7	
% [Age 50+] Average <7 Hours of Sleep per Night	32.1		35.3	
Note: The Primary Service Area (PSA) data (blue column) represent combined Pasco/Pinellas County data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.		better	similar	worse

Nutrition, Physical Activity & Weight	Primary Service Area	PSA vs. Benchmarks vs. FL	vs. US	vs. HP2020
% [Age 50+] Eat 5+ Servings of Fruit or Vegetables per Day	25.7		25.8	
% [Age 50+] "Very/Somewhat" Difficult to Buy Fresh Produce	17.8		15.8	
[County] Population With Low Food Access (Percent)	25.9	26.9	23.6	

Nutrition, Physical Activity & Weight (continued)	Primary Service Area	PSA vs. Benchmarks		
		vs. FL	vs. US	vs. HP2020
% [Age 50+] Food Insecure	17.7		17.4	
% [Age 50+] 7+ Sugar-Sweetened Drinks in Past Week	23.9		20.7	
% [Age 50+] Healthy Weight (BMI 18.5-24.9)	29.1		24.9	33.9
% [Age 50+] Overweight (BMI 25+)	68.5		73.6	
% [Age 50+] Obese (BMI 30+)	33.1		36.2	30.5
% [Age 50+] Medical Advice on Weight in Past Year	27.0		24.8	
% [Overweights Age 50+] Counseled About Weight in Past Year	32.9		30.3	
% [Obese Adults Age 50+] Counseled About Weight in Past Year	48.4		46.0	
% [Overweights Age 50+] Trying to Lose Weight Both Diet/Exercise	60.1		55.7	
% [Age 50+] No Leisure-Time Physical Activity	26.4		29.1	32.6
% [Age 50+] Meeting Physical Activity Guidelines	18.9		18.7	20.1
[County] Recreation/Fitness Facilities per 100,000	10.3	9.4	9.7	
		better	similar	worse

Note: The Primary Service Area (PSA) data (blue column) represent combined Pasco/Pinellas County data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

Oral Health	Primary Service Area	PSA vs. Benchmarks		
		vs. FL	vs. US	vs. HP2020
% [Age 50+] Dental Visit in Past Year	63.0		70.1	49.0
% [Age 50+] Have Dental Insurance	56.7		60.8	
Note: The Primary Service Area (PSA) data (blue column) represent combined Pasco/Pinellas County data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.		better	similar	worse

Respiratory Diseases	Primary Service Area	PSA vs. Benchmarks		
		vs. FL	vs. US	vs. HP2020
% [Age 50+] COPD (Lung Disease)	12.1		13.7	
% [Age 50+] Currently Has Asthma	10.5		8.5	
Note: The Primary Service Area (PSA) data (blue column) represent combined Pasco/Pinellas County data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.		better	similar	worse

Sexually Transmitted Diseases	Primary Service Area	PSA vs. Benchmarks		
		vs. FL	vs. US	vs. HP2020
[County] Gonorrhea Incidence per 100,000	109.1	107.1	110.7	
[County] Chlamydia Incidence per 100,000	357.8	429.8	456.1	
% [Unmarried 50-64] 3+ Sexual Partners in Past Year	0.0		5.7	
% [Unmarried 50-64] Using Condoms	25.5		23.6	
Note: The Primary Service Area (PSA) data (blue column) represent combined Pasco/Pinellas County data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.		better	similar	worse

Substance Abuse	Primary Service Area	PSA vs. Benchmarks		
		vs. FL	vs. US	vs. HP2020
% [Age 50+] Current Drinker	57.1		56.8	
% [Age 50+] Excessive Drinker	17.0		19.0	25.4
% [Age 50+] Life Negatively Affected by Substance Abuse	36.9		35.4	
% [Age 50+] Drinking & Driving in Past Month	2.5		2.8	
% [Age 50+] Illicit Drug Use in Past Month	3.0		1.3	7.1
% [Age 50+] Ever Sought Help for Alcohol or Drug Problem	4.2		2.7	
		better	similar	worse

Note: The Primary Service Area (PSA) data (blue column) represent combined Pasco/Pinellas County data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.

Tobacco Use	Primary Service Area	PSA vs. Benchmarks		
		vs. FL	vs. US	vs. HP2020
% [Age 50+] Current Smoker	16.1		12.0	12.0
% [Age 50+] Someone Smokes at Home	11.6		10.7	
% [Nonsmokers Age 50+] Someone Smokes in the Home	3.5		4.1	
% [Smokers Age 50+] Received Advice to Quit Smoking	78.1		77.0	
% [Smokers Age 50+] Have Quit Smoking 1+ Days in Past Year	36.6		46.3	80.0
% [Age 50+] Smoke Cigars	4.3		2.3	0.2

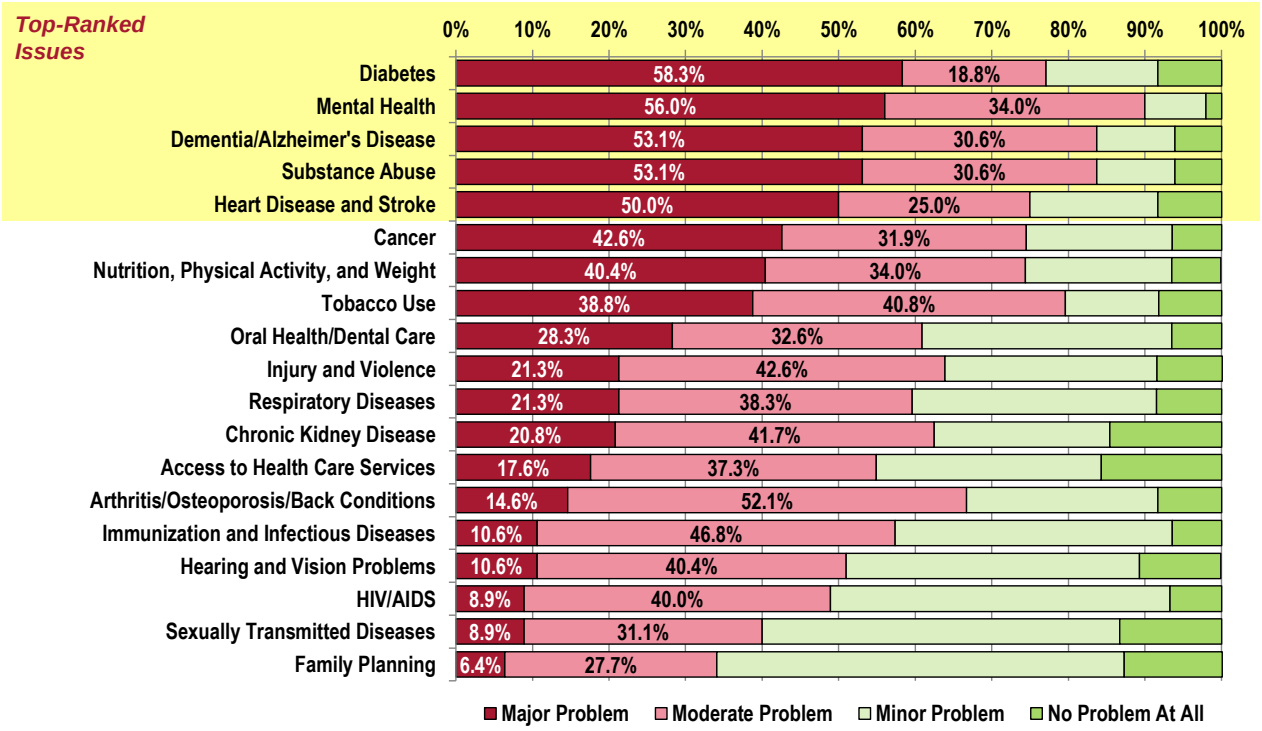
Tobacco Use (continued)	Primary Service Area	PSA vs. Benchmarks		
		vs. FL	vs. US	vs. HP2020
% [Age 50+] Use Smokeless Tobacco	0.8		2.7	0.3
% [Age 50+] Currently Use Electronic Cigarettes	4.2		3.3	
Note: The Primary Service Area (PSA) data (blue column) represent combined Pasco/Pinellas County data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.		better	similar	worse

Vision	Primary Service Area	PSA vs. Benchmarks		
		vs. FL	vs. US	vs. HP2020
% [Age 50+] Blindness/Trouble Seeing	10.0		8.3	
% [Age 50+] Eye Exam in Past 2 Years	78.3		68.9	
Note: The Primary Service Area (PSA) data (blue column) represent combined Pasco/Pinellas County data for indicators derived from secondary data sources (marked as "[County]"), and ZIP Code-defined service area information for survey-derived indicators.		better	similar	worse

Summary of Key Informant Concerns

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

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



Data Charts & Key Informant Input

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

Professional Research Consultants, Inc.

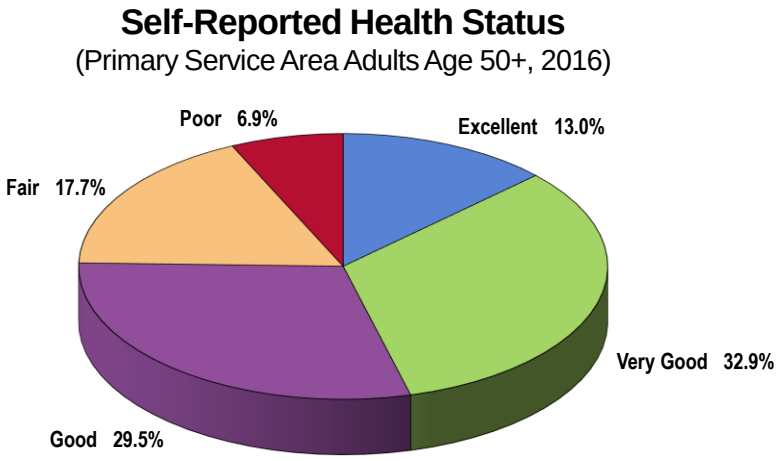
General Health Status

Overall Health Status

Self-Reported Health Status

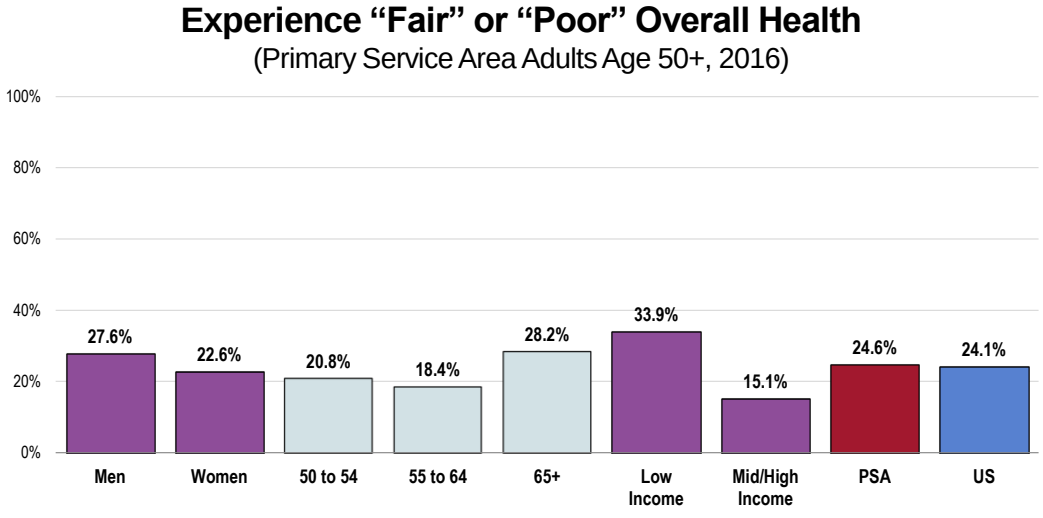
The initial inquiry of the PRC Community Health Survey asked respondents (age 50 and older) the following:

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



Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: ● Reflects respondents age 50+.

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



Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: ● Reflects respondents age 50+.
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Activity Limitations

About Disability & Health

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

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

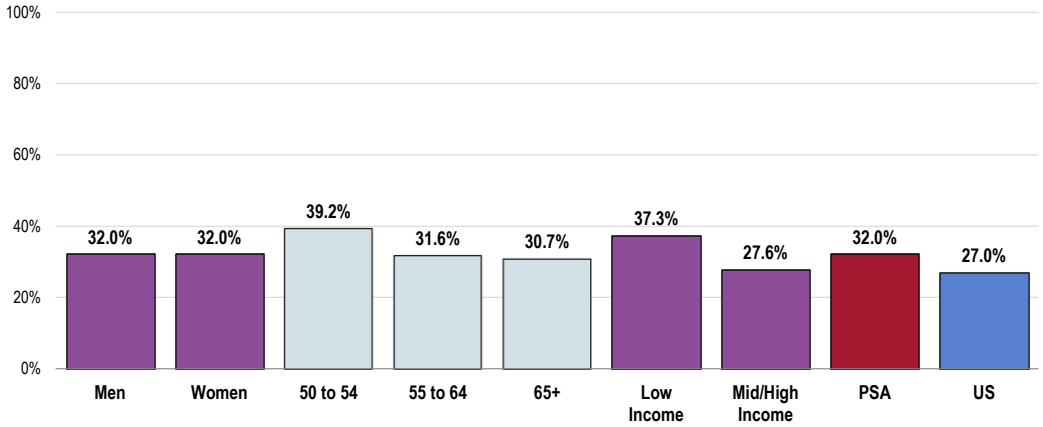
There are many social and physical factors that influence the health of people with disabilities. The following three areas for public health action have been identified, using the International Classification of Functioning, Disability, and Health (ICF) and the three World Health Organization (WHO)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

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

- Healthy People 2020 (www.healthypeople.gov)

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

Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem
(Primary Service Area Adults Age 50+, 2016)



Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]
Notes: ● Reflects respondents age 50+.
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Mental Health

About Mental Health & Mental Disorders

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

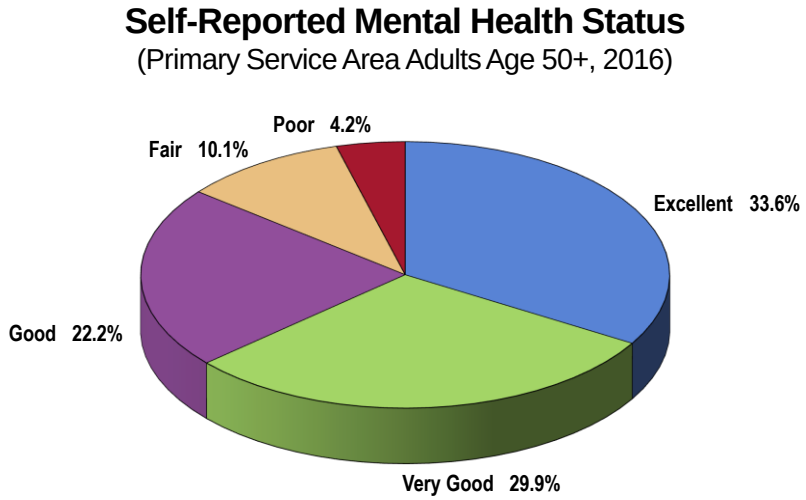
Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people's ability to participate in health-promoting behaviors. In turn, problems with physical health,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

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

- Healthy People 2020 (www.healthypeople.gov)

Self-Reported Mental Health Status

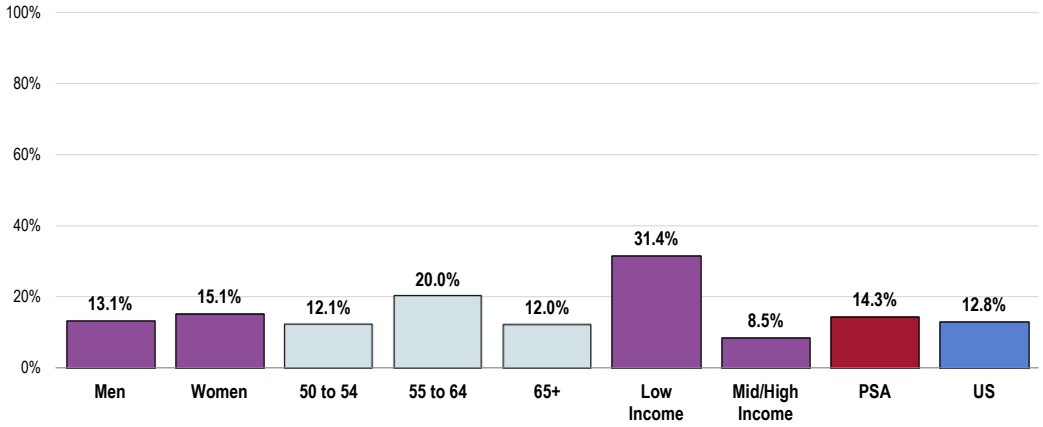
"Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair or poor?"



Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]
Notes: ● Reflects respondents age 50+.

Experience "Fair" or "Poor" Mental Health

(Primary Service Area Adults Age 50+, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 116]

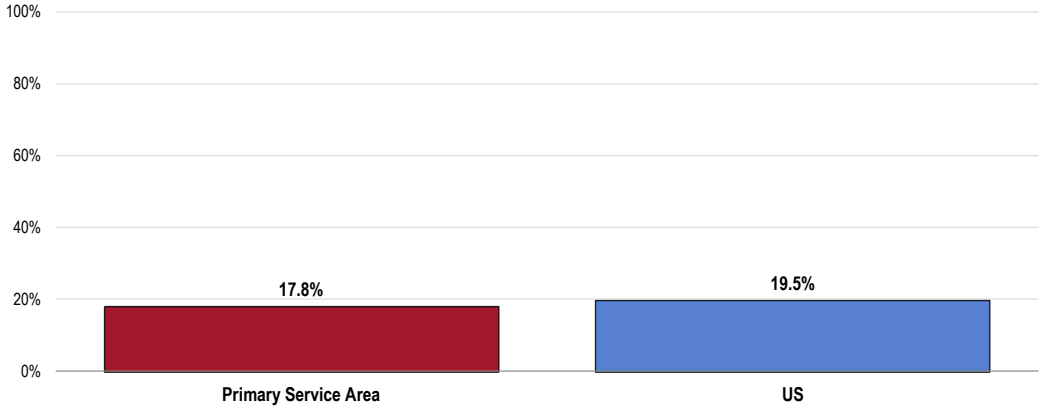
Notes:
- Reflects respondents age 50+.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Depression

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

Have Been Diagnosed With a Depressive Disorder

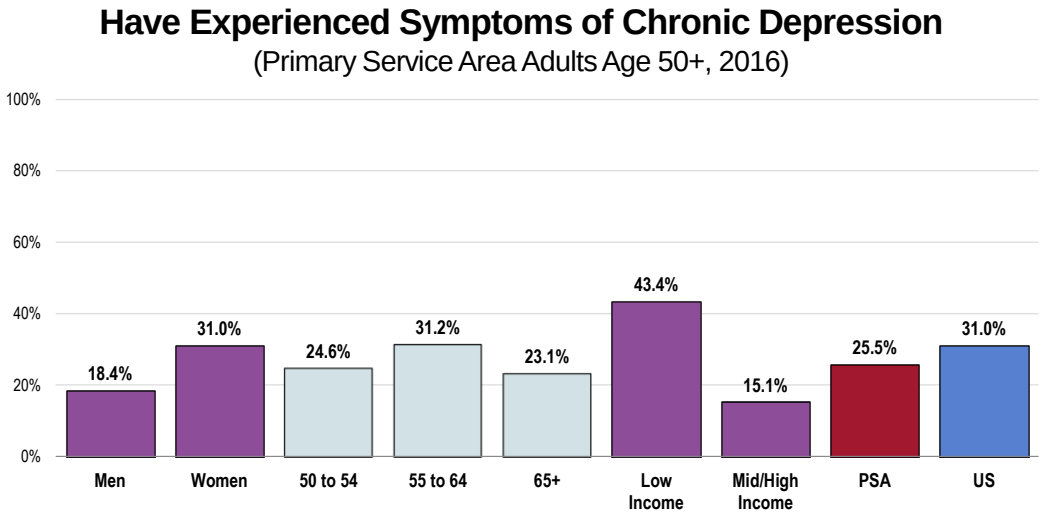
(Among Adults Age 50+)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 119]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents age 50+.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.

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



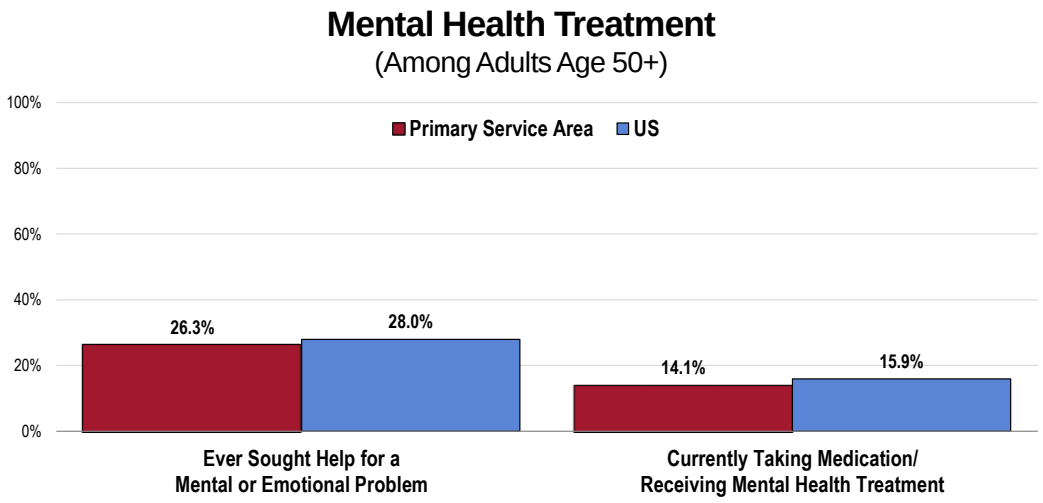
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]

Notes:
- Reflects respondents age 50+.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Mental Health Treatment

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

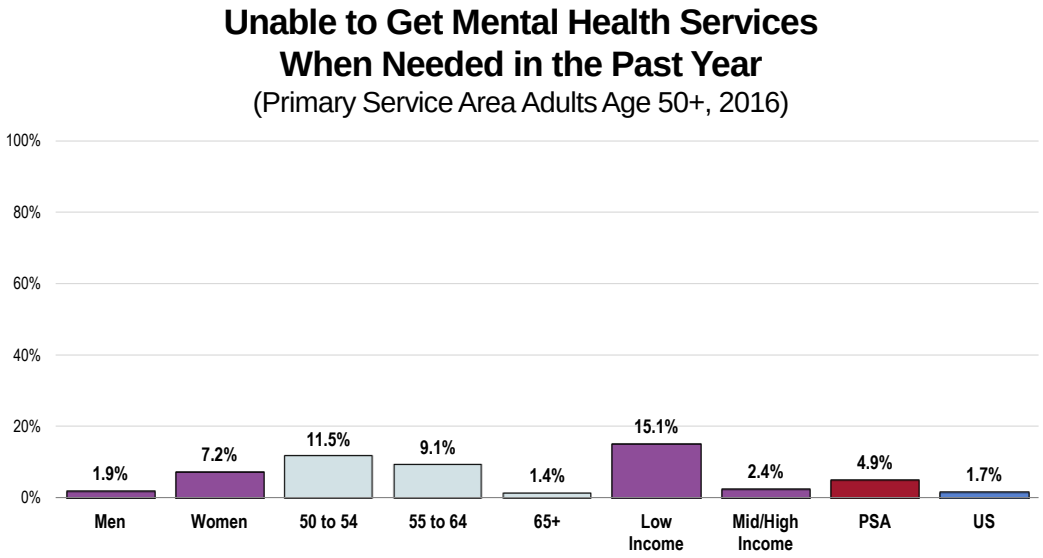
"Are you now taking medication or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem?"



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 120-121]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents age 50+.

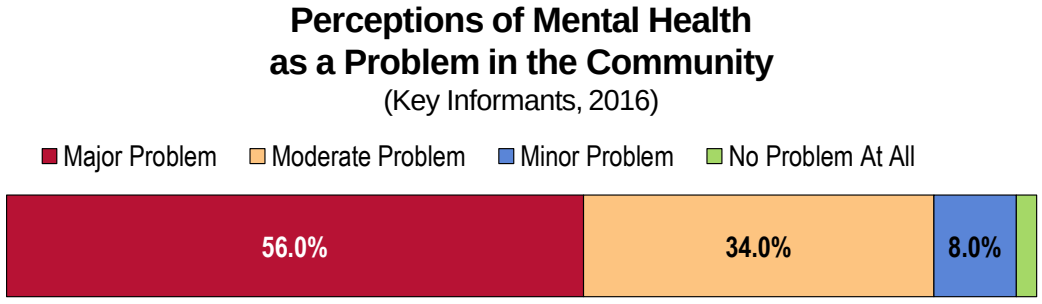
"Was there a time in the past 12 months when you needed mental health services but were not able to get them?"



Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 122]
Notes: ● Reflects respondents age 50+.
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Mental Health

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



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

Challenges

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

Access to Care/Services

It is difficult to access continuing care services for mental health treatment. Resources are thin and need grows. - Community Leader

Access to care, one portal. Too many providers without coordinated care. It's a broken system which needs to be fixed. - Community Leader

Too few resources for chronically mentally ill people. - Community Leader

Mental health diseases have not received the support needed from our medical system. Affects the ill and their family in many ways. It is also, a burden in society as mentally ill people can become homeless or be involved in criminal activity. - Other Health Provider

Life seems to have more pressures, fluid population. Questions about gender identification, drugs, alcohol, low income, lack of resources to get help and lack of mental health resource to help those who do ask for help. Lack of funds for projects. Lack of psychiatrists and counselors. - Community Leader

Access to the full range of mental health services for those without adequate funds is a continuing issue. - Other Health Provider

Access to competent care. There is a lack of a safety net for these people. - Community Leader

Proper placement of this patient population in facilities able to provide appropriate care. - Other Health Provider

Near total lack of adequate resources to diagnose and treat individuals. Mental health is close to being totally neglected as part of the health care system. Individuals living in the community who are diagnosed have very limited resources available. For those with insurance, the coverage is often very limited compared to coverage for other clinical issues. Frequently see individuals "treated" as inpatients by being put on medications which cannot be effectively managed or paid for the individual once discharged. - Other Health Provider

Florida as a whole has a problem with inadequate mental health resources. - Social Services Provider

Not enough psychiatric facilities or resources. Lack of follow up on the psych person. - Social Services Provider

Lack of beds and other resources. Lack training for police and other agencies. Lack of community health assistance to help with compliance. The criminalization of the homeless. No organized, comprehensive plan to address the homeless problem where untreated mental illness is a major problem. - Social Services Provider

Proper diagnosis, proper treatment and proper follow up. Lack of beds and qualified psychiatrists. - Social Services Provider

Not enough clinicians and facilities to keep up with demand. - Community Leader

Affordable Care/Services

There is no place for the uninsured or indigent to seek treatment. Everything comes with a fee for service. Some of these folks are so far into the disease that they cannot work so there is no money to pay… and the cycle continues. Mental health facilities are lacking, especially in Pasco. - Other Health Provider

Stigma

Poverty, shame, lack of resources, lack of government support and lack of country's willingness to accept as a disease that needs support without judgement. - Social Services Provider

Lack of Coordinated Care

Good psychiatry and psychologist working together. - Social Services Provider

Death, Disease & Chronic Conditions

Cardiovascular Disease

About Heart Disease & Stroke

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

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

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

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

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

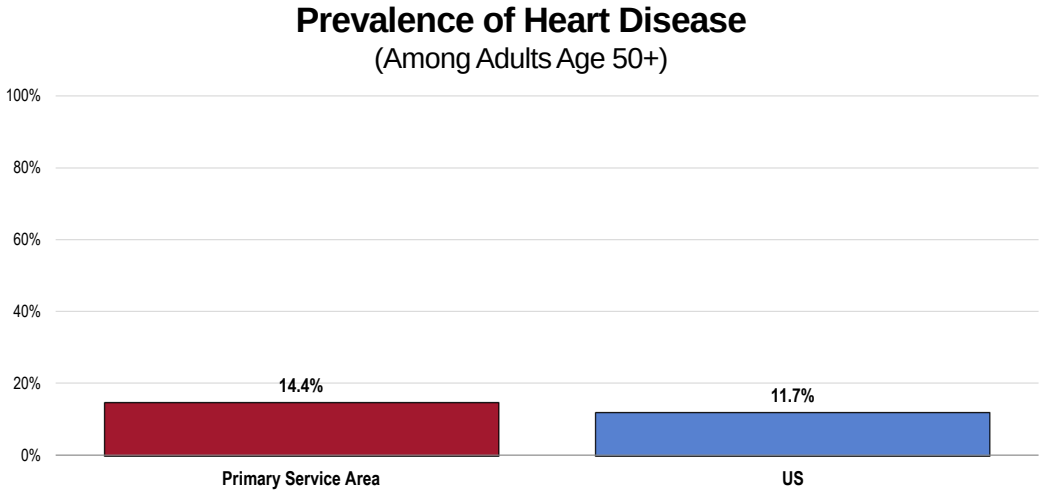
- Prevalence of risk factors
- Access to treatment
- Appropriate and timely treatment
- Treatment outcomes
- Mortality

- Healthy People 2020 (www.healthypeople.gov)

Prevalence of Heart Disease & Stroke

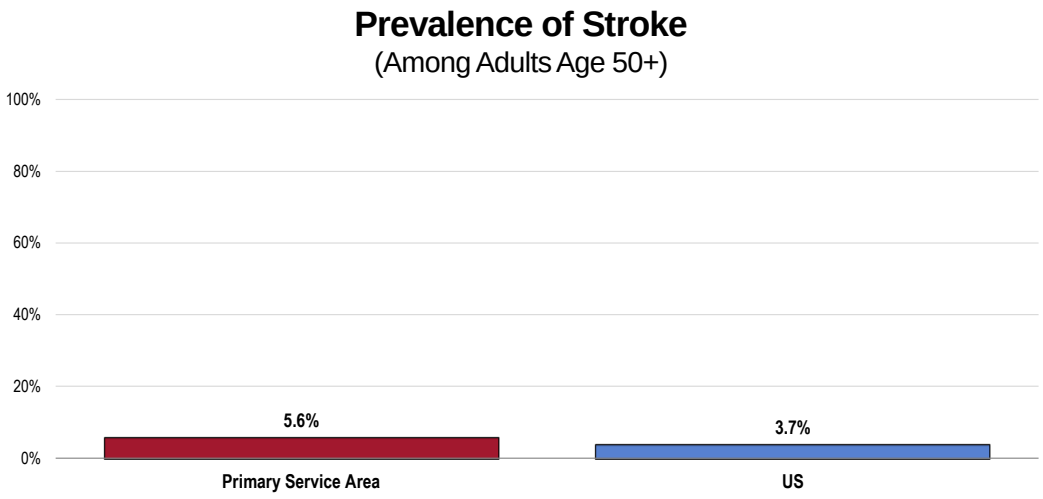
"Has a doctor, nurse or other health professional ever told you that you had: A Heart Attack, Also Called a Myocardial Infarction; or Angina or Coronary Heart Disease?" (Heart disease prevalence below is a calculated prevalence that includes those responding affirmatively to either.)

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



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 146]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents age 50+.
- Includes diagnoses of heart attack, angina or coronary heart disease.



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 35]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents age 50+..

Cardiovascular Risk Factors

About Cardiovascular Risk

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

- Healthy People 2020 (www.healthypeople.gov)

High Blood Pressure & Cholesterol Prevalence

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

- "Are you currently taking any action to help control your high blood pressure, such as taking medication, changing your diet, or exercising?"

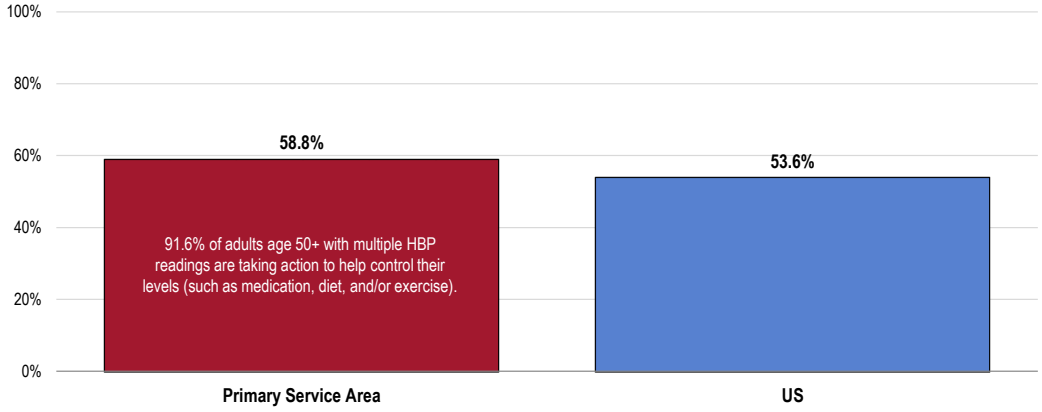
"Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?"

- "Are you currently taking any action to help control your high cholesterol, such as taking medication, changing your diet, or exercising?"

Prevalence of High Blood Pressure

(Among Adults Age 50+)

Healthy People 2020 Target = 26.9% or Lower



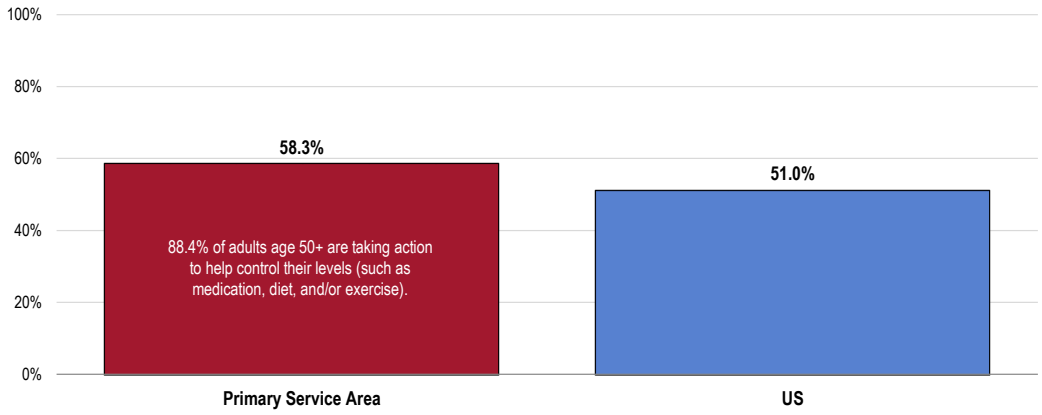
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 43, 147]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective HDS-5.1]

Notes:
- Reflects respondents age 50+.

Prevalence of High Blood Cholesterol

(Among Adults Age 50+)

Healthy People 2020 Target = 13.5% or Lower



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

Notes:
- Reflects respondents age 50+.

About Cardiovascular Risk

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

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

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

Three health-related behaviors contribute markedly to cardiovascular disease:

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

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

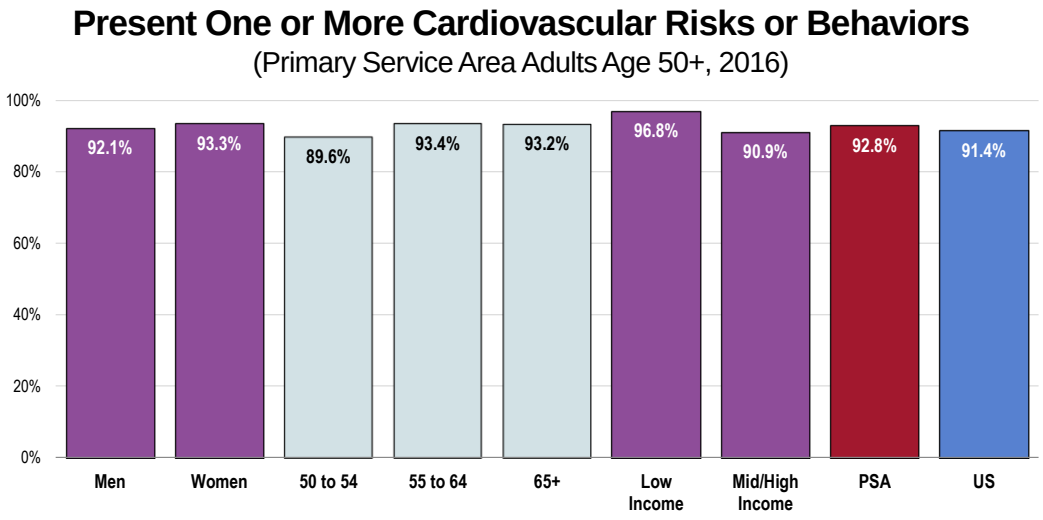
Tobacco use. Smokers have twice the risk for heart attack of nonsmokers. Nearly one-fifth of all deaths from cardiovascular disease, or about 190,000 deaths a year nationally, are smoking-related.

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

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

Total Cardiovascular Risk

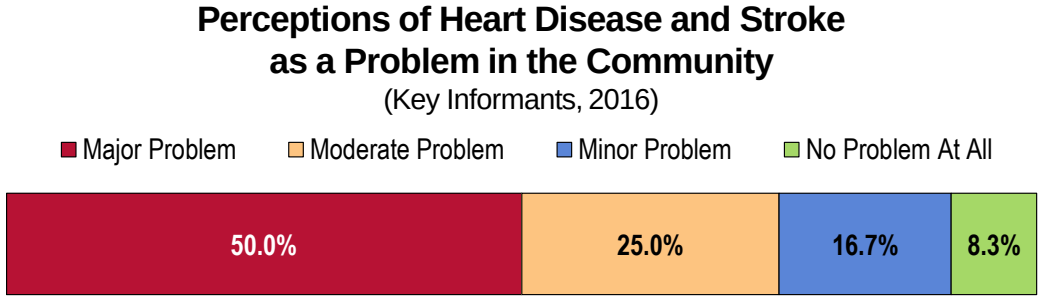
The following chart reflects the percentage of Primary Service Area adults age 50 and over who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol. See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the Modifiable Health Risk section of this report.



Sources: • 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 149]
Notes: • Reflects respondents age 50+.
• Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) hypertension; 4) high blood cholesterol; and/or 5) being overweight/obese.
• Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Heart Disease & Stroke

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



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

Top Concerns

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

Aging Population

Age of population. - Physician

Aged population, diagnosis is noted often. - Other Health Provider

We serve an elderly individual and they are eating fast food because they don't want to cook for one or two. They do not know alternatives for eating healthy to prevent this. We also have a very sedentary society. In my department there are 16 people on my floor and I am the only one that works out regularly - Other Health Provider

This again, is a symptom of the aging population in our area. I would only consider it a major problem because of the amount of people that are touched by these issues. - Community Leader

Elder population. - Community Leader

Incidence/Prevalence

Personal experience, anecdotal evidence and national trends particularly with stroke. - Social Services Provider

Not a unique issue for our community, but for our country with this being one of the major health issues nationally. - Other Health Provider

It affects so many. - Other Health Provider

Obesity

Obesity. - Social Services Provider

Obesity, diabetes, high blood pressure, stress, poor lifestyle, lack of exercise and frequency. - Social Services Provider

Obesity and sedentary lifestyle. - Community Leader

Leading Cause of Death

Highest cause of death can be changed by behavior and environment. - Public Health Representative

Leading cause of death. - Other Health Provider

Cancer

About Cancer

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

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

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

- Breast cancer (using mammography)
- Cervical cancer (using Pap tests)
- Colorectal cancer (using fecal occult blood testing, sigmoidoscopy, or colonoscopy)

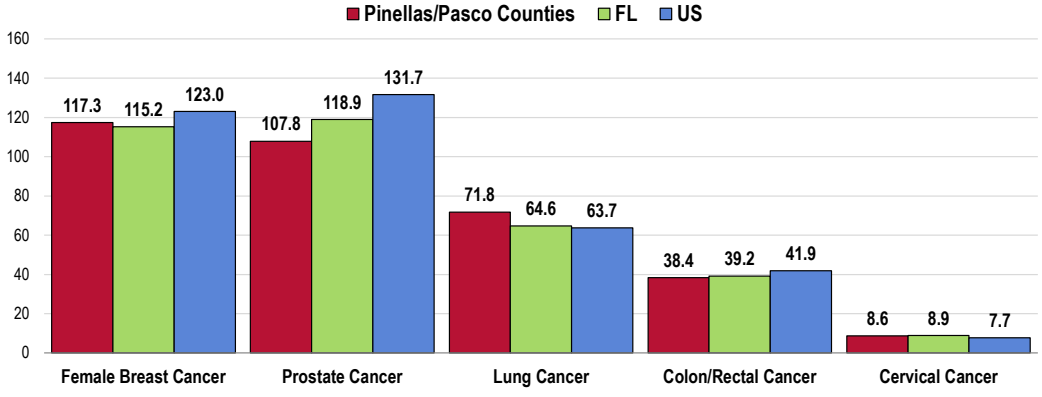
- Healthy People 2020 (www.healthypeople.gov)

Cancer Incidence

Incidence rates (or case rates) reflect the number of newly diagnosed cases in a given population in a given year, regardless of outcome. They are usually expressed as cases per 100,000 population per year. Here, these rates are also age-adjusted. *(Note that this represents secondary data for the combined area of Pasco and Pinellas Counties, and represents diagnoses among all ages.)*

Cancer Incidence Rates by Site

(Annual Average Age-Adjusted Incidence per 100,000 Population, 2008-12)



Sources:
- State Cancer Profiles.
- Retrieved August 2016 from Community Commons at http://www.chna.org.

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

Cancer Risk

About Cancer Risk

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

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

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

Cancer Screenings

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

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

Female Breast Cancer Screening

About Screening for Breast Cancer

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

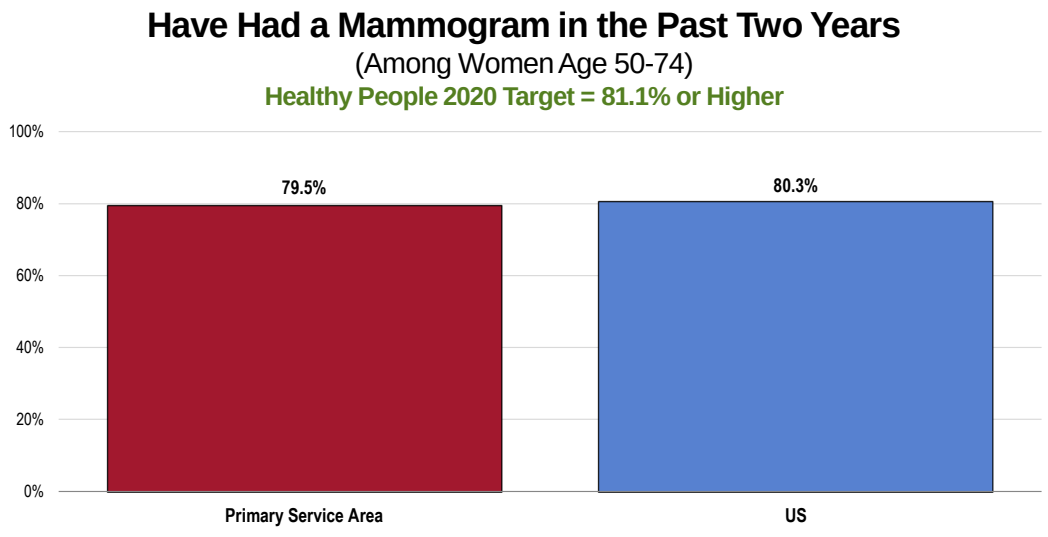
Rationale: The USPSTF found fair evidence that mammography screening every 12-33 months significantly reduces mortality from breast cancer. Evidence is strongest for women age 50-69, the age group generally included in screening trials. For women age 40-49, the evidence that screening mammography reduces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

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

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

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

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



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 151]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-17]

Notes:
- Reflects female respondents age 50 to 74.

Cervical Cancer Screenings

About Screening for Cervical Cancer

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

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

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

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

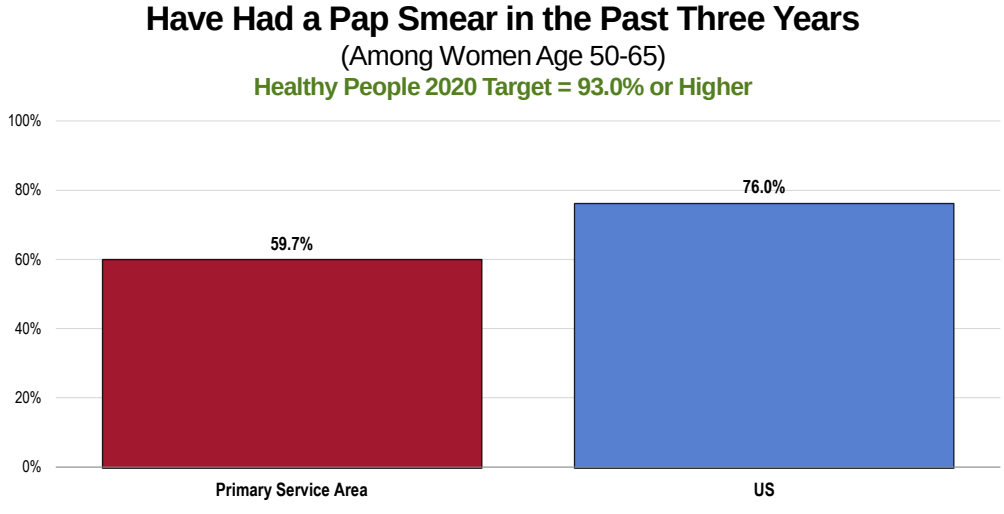
The USPSTF recommends against routine Pap screening in women who have had a total hysterectomy for benign disease.

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

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

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

Cervical Cancer Screening: "A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?" (Calculated below among women age 50 to 65 indicating screening within the past 3 years.)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 152]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-15]

Notes:
- Reflects female respondents age 50 to 65.

Colorectal Cancer Screenings

About Screening for Colorectal Cancer

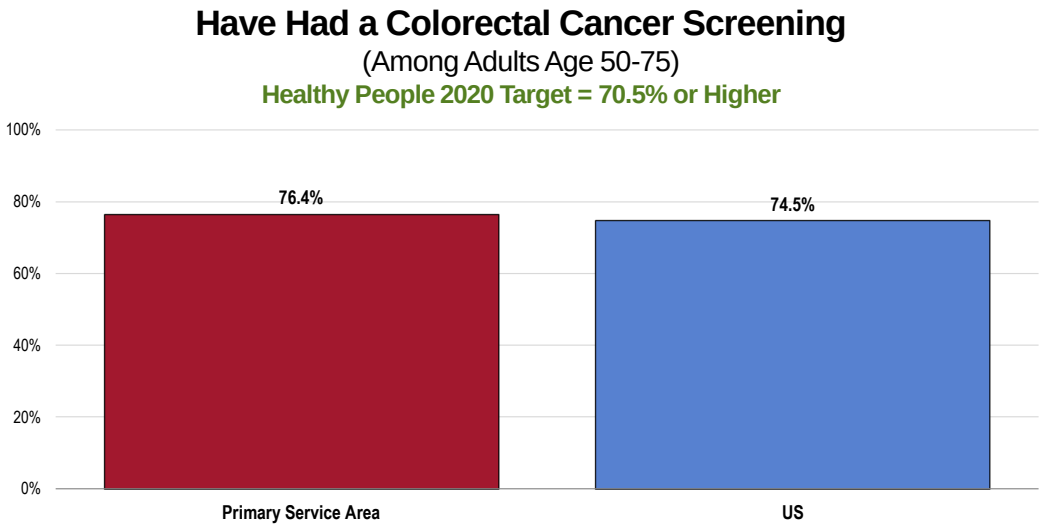
The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years.

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

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

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

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

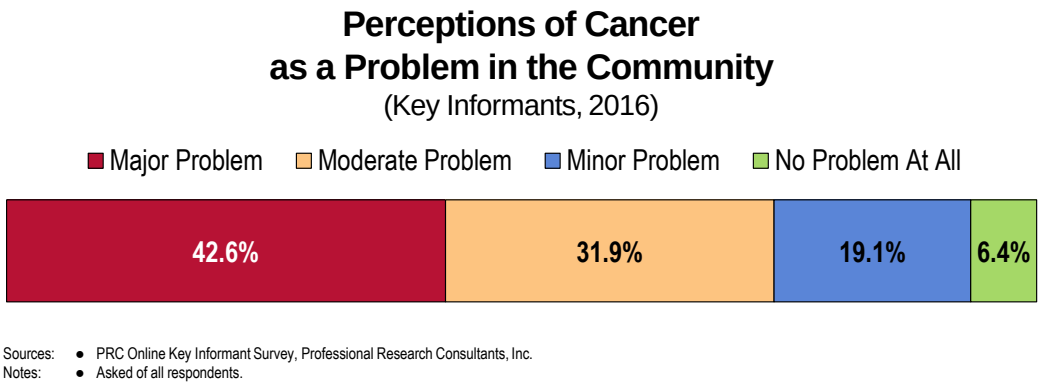


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 155]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective C-16]

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

Key Informant Input: Cancer

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



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

Top Concerns

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

Incidence/Prevalence

So many people diagnosed. - Social Services Provider

Common diagnosis, many patients in the hospital have been diagnosed with lung, pancreatic, breast, liver, prostate, ovarian, and uterine cancer. - Social Services Provider

In my small office alone we have had out of 30 employees, 9 cancer cases and of course beyond that we all know people diagnosed virtually every year. - Social Services Provider

High rates of cancer and often can be prevented. - Public Health Representative

High rate of bladder cancer. - Physician

This diagnosis is common in the patient population we care for. - Other Health Provider

It affects so many. - Other Health Provider

Prevalence of skin cancer is increasing throughout Florida. Care in Pinellas County would be enhanced by a stronger relationship with Moffitt Cancer Center. - Other Health Provider

Aging Population

I teach the 60 to 99 year olds and I see lots of this age group requiring chemo. I'm so surprised at the volume and I think skin is one of the greatest causes of the cancer. I know my own mother doesn't think she needs sunscreen or pap smears. My 21 year old son doesn't remember to put sunscreen on thoroughly and he got pretty severely sunburned last weekend. I think generally the populous described here doesn't buy into the dangers the sun presents. - Other Health Provider

Aging population, lots of sun and large low income population. - Community Leader

Elder population. Palliative care needed more than provided now. Family sensitivity. - Community Leader

Affordable Care/Services

Cost of treatments is high and transportation for daily radiation is non-existent including from the American Cancer Society. - Social Services Provider

Respiratory Disease

About Asthma & COPD

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

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

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

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

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

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

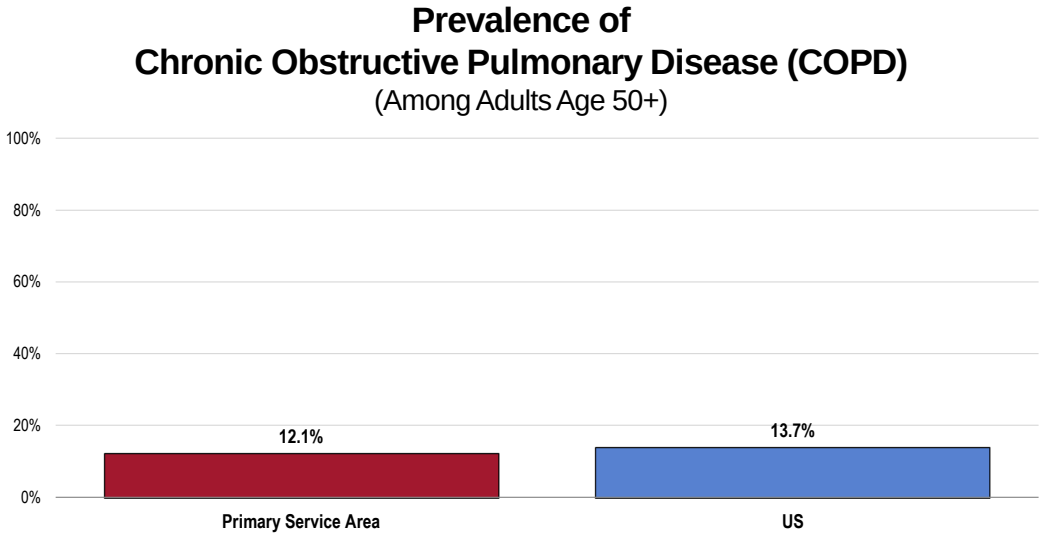
- Healthy People 2020 (www.healthypeople.gov)

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

Prevalence of Respiratory Diseases

COPD

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

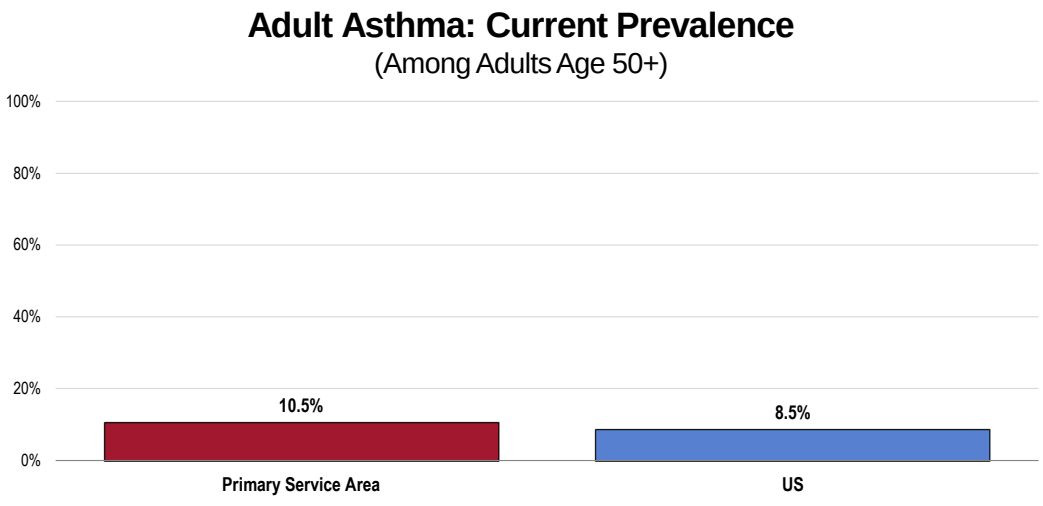


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 24]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents age 50+.
- Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

Asthma

"Have you ever been told by a doctor, nurse, or other health professional that you had asthma?" and "Do you still have asthma?" (Calculated below as a prevalence of adults age 50 and over who have ever been diagnosed with asthma and who still have asthma ["current asthma"]).

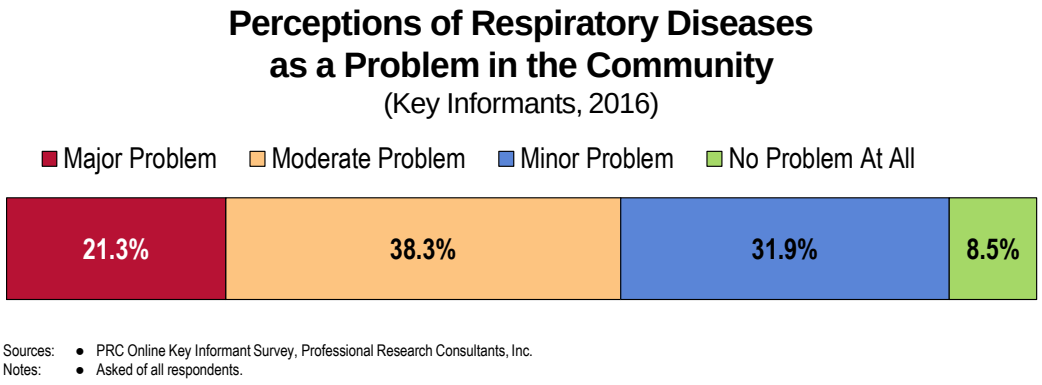


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 156]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents age 50+.
- Includes those who have ever been diagnosed with asthma, and who report that they still have asthma.

Key Informant Input: Respiratory Disease

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



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

Top Concerns

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

Tobacco Use

Smoking is number one, older patients that have been in the war or exposed at work to chemicals, obesity and congestive heart failure. - Social Services Provider

Smoking, allergies and asthma that goes untreated, smog. - Community Leader

Affordable Care/Services

Medications are too expensive and people fall into the donut hole with MCR earlier in the year. Not enough education and people panic. Script for Ativan would be nice for those with COPD and tapering steroids is only a "Band-Aid" fix. - Social Services Provider

Aging Population

Aged population, frequent diagnosis. Pulmonary is a leading cause of return-to-hospital visits. - Other Health Provider

Influenza & Pneumonia Vaccination

About Influenza & Pneumonia

Acute respiratory infections, including pneumonia and influenza, are the 8th leading cause of death in the nation, accounting for 56,000 deaths annually…. On average, influenza leads to more than 200,000 hospitalizations and 36,000 deaths each year. The 2009 H1N1 influenza pandemic caused an estimated 270,000 hospitalizations and 12,270 deaths … between April 2009 and March 2010.

- Healthy People 2020 (www.healthypeople.gov)

Flu Vaccinations

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

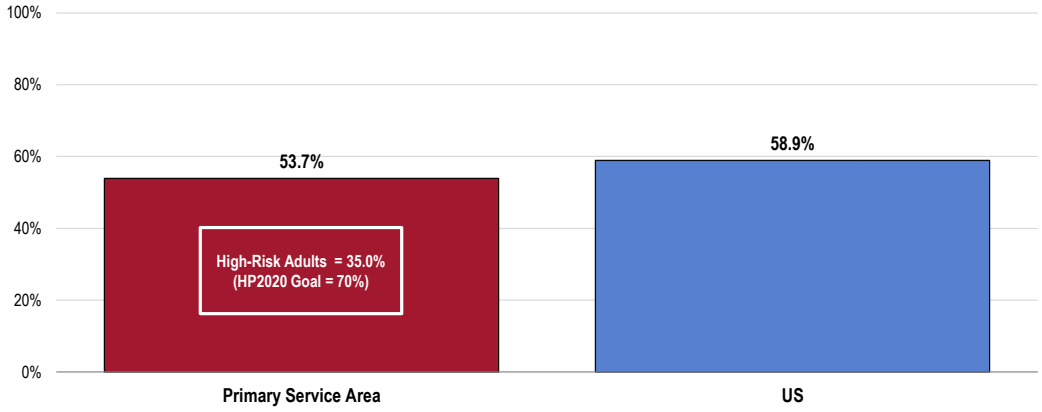
"A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's lifetime and is different from the seasonal flu shot. Have you ever had a pneumonia shot?"

Chart columns below show these findings among those age 65+. Percentages for "high-risk" adults age 50-64 in the Primary Service Area are also shown; here, "high-risk" includes adults who report having been diagnosed with heart disease, diabetes or respiratory disease.

Older Adults: Have Had a Flu Vaccination in the Past Year

(Among Adults Age 65+)

Healthy People 2020 Target = 70.0% or Higher



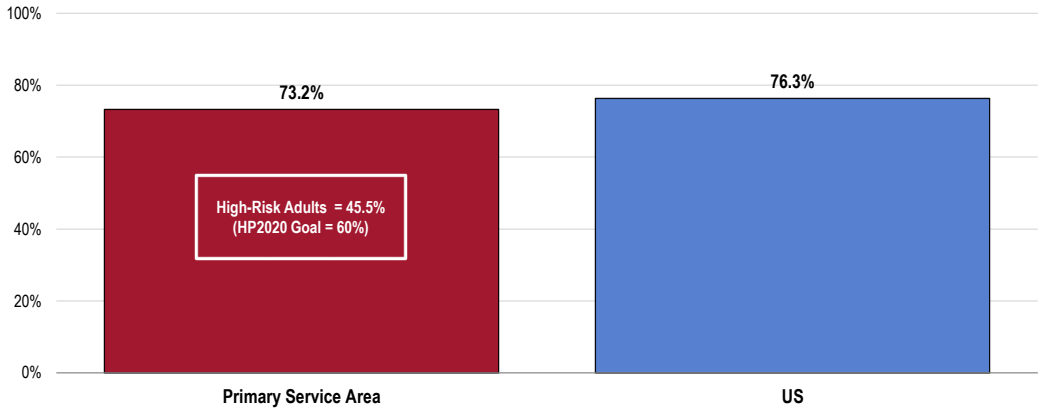
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 163-164]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective IID-12.12]

Notes:
- Reflects respondents 65 and older.
- "High-Risk" includes adults age 50 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.
- Includes FluMist as a form of vaccination.

Older Adults: Have Ever Had a Pneumonia Vaccine

(Among Adults Age 65+)

Healthy People 2020 Target = 90.0% or Higher



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 165-166]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives IID-13.1, IID-13.2]

Notes:
- Reflects respondents 65 and older.
- "High-Risk" includes adults age 50 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.

Injury & Violence

About Injury & Violence

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

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

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

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

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

Numerous factors can affect the risk of unintentional injury and violence, including individual behaviors, physical environment, access to health services (ranging from pre-hospital and acute care to rehabilitation), and social environment.

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

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

Efforts to prevent violence may focus on:

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

- Healthy People 2020 (www.healthypeople.gov)

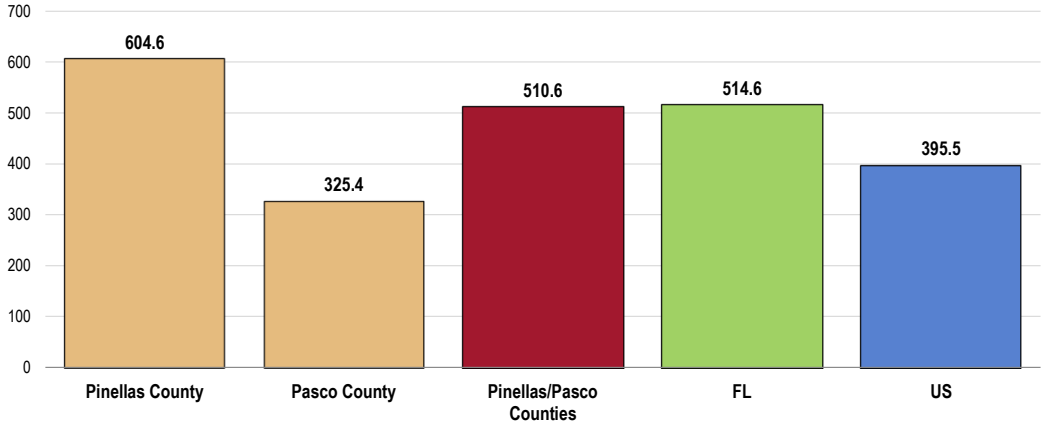
Intentional Injury (Violence)

Violent Crime

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

Violent Crime

(Rate per 100,000 Population, 2010-12)



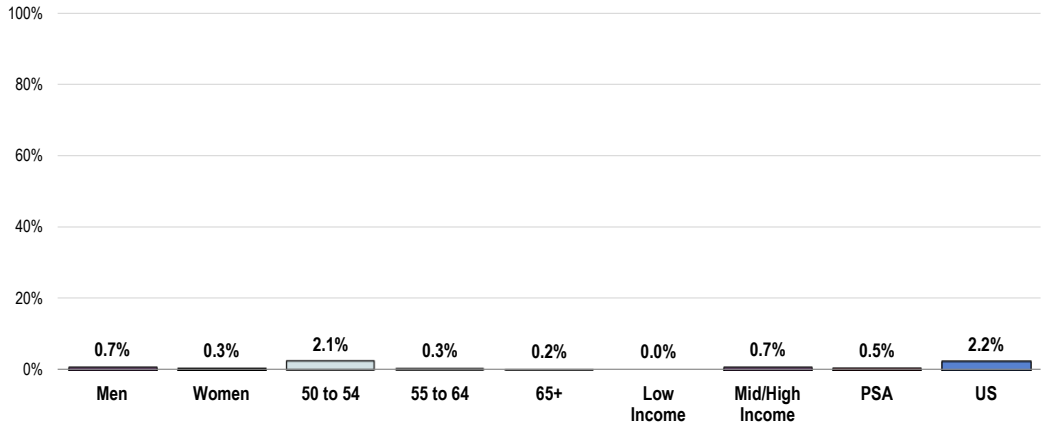
Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Retrieved August 2016 from Community Commons at http://www.chna.org.

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

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

Victim of a Violent Crime in the Past Five Years

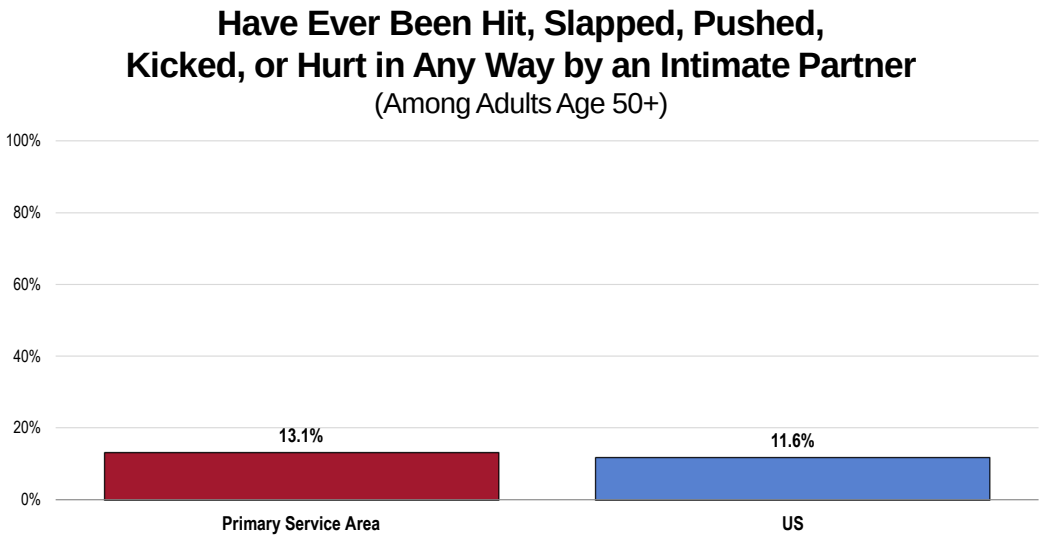
(Primary Service Area Adults Age 50+, 2016)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 49]

Notes:
- Reflects respondents age 50+.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

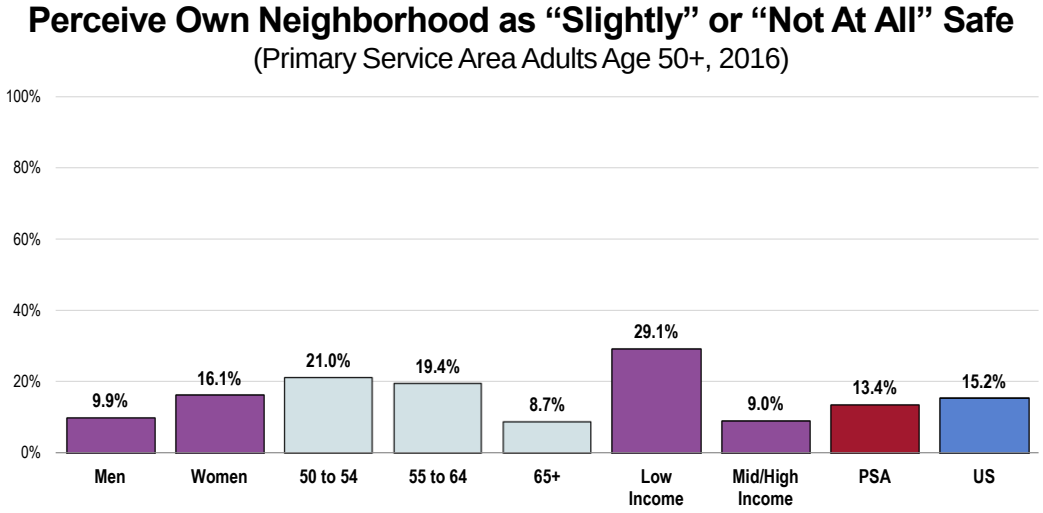
Intimate Partner Violence: **"The next questions are about different types of violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered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



Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 50]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Reflects respondents age 50+.

Neighborhood Safety

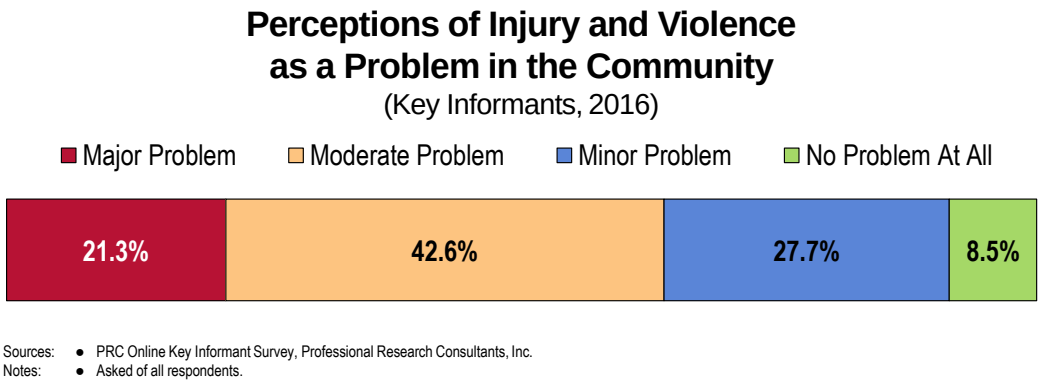
"How safe from crime do you consider your neighborhood to be? Would you say: extremely safe, quite safe, slightly safe, or not at all safe?"



Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 48]
Notes: ● Reflects respondents age 50+.
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Injury & Violence

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



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

Top Concerns

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

Incidence/Prevalence

Prevalence of preventable injury and violence are higher than I wish they were. - Other Health Provider

Ongoing problem. - Community Leader

The events in the last couple of weeks in Orlando are examples. - Community Leader

Gun Violence

Too much gun violence and domestic violence. - Community Leader

Lack of Focus on the Problem

In the intervention and breaking the cycle areas. - Social Services Provider

Poverty

As our population becomes poorer, so does our care for each other. Violence grows. - Community Leader

Diabetes

About Diabetes

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

Diabetes mellitus:

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

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

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

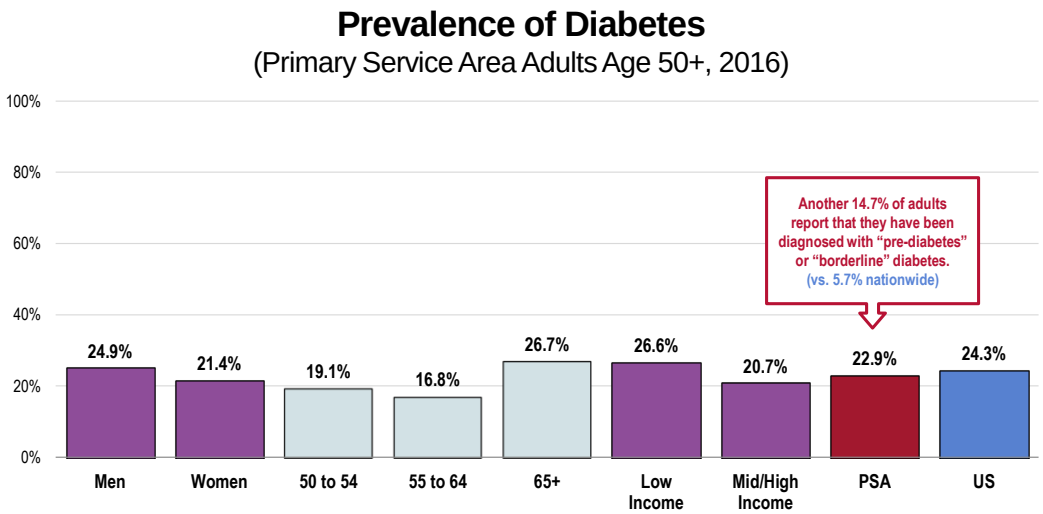
Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals.

- Healthy People 2020 (www.healthypeople.gov)

Prevalence of Diabetes

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

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

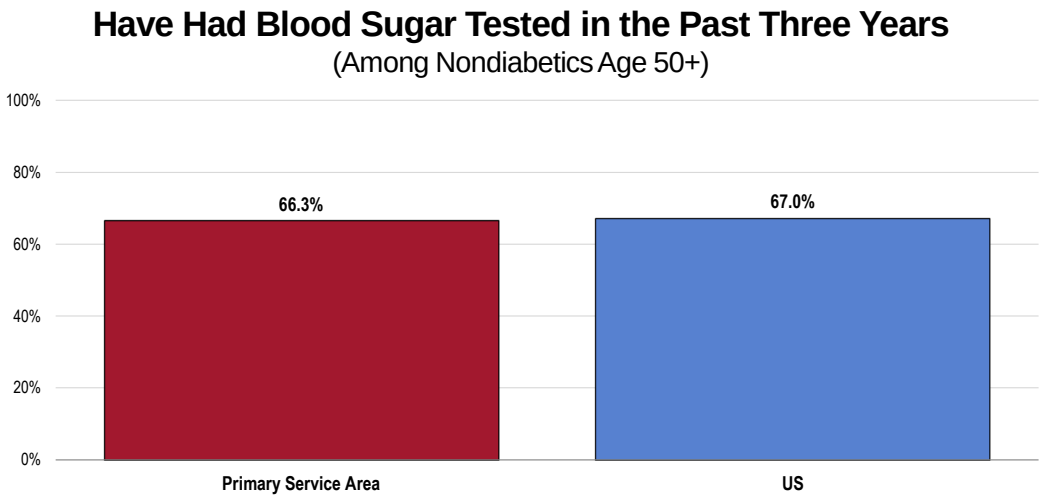


Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]

Notes:
- Reflects respondents age 50+.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Excludes gestational diabetes (occurring only during pregnancy).

Diabetes Testing

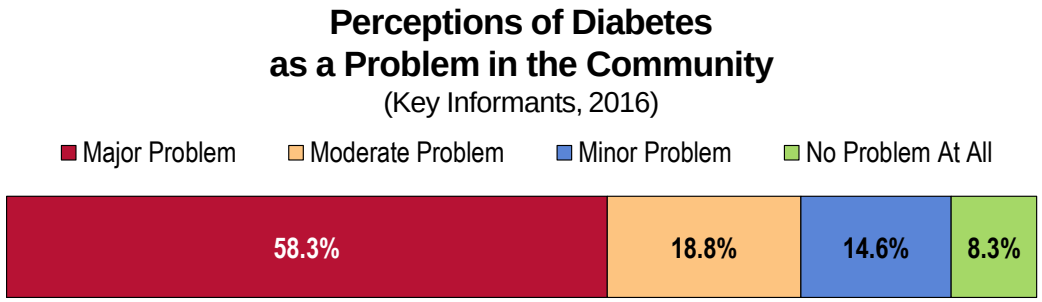
"Have you had a test for high blood sugar or diabetes within the past three years?"



Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 39]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Asked of respondents age 50+ who have not been diagnosed with diabetes.

Key Informant Input: Diabetes

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



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

Challenges

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

Disease Management

Uncontrolled diabetes can cause damage to many organs and become debilitating. The increase in the overall cost of healthcare. - Other Health Provider

Maintenance and drug affordability. - Community Leader

Lack of follow up on the diabetic person, not watching their sugars or not being able to afford medications due to cost. - Social Services Provider

Maintenance, education and cost. - Social Services Provider

Access to Care/Services

Limited support for Type 1 diabetes. Limited prevention for Type 2. - Social Services Provider

Better healthcare for at risk population. - Community Leader

People with diabetes and no insurance have little to no access to resources for supplies and medications and education. - Social Services Provider

Finding competent physicians. - Community Leader

Financial barriers to prevention of a wide spread health threat. - Community Leader

Lifestyle

Behavior change and management, coordinated and holistic care. - Other Health Provider

Over eating and complacency. - Other Health Provider

Low income often leads to poor eating habits, school lunches, supersized foods and sedentary lifestyle. - Community Leader

Diagnosis/Treatment

Placement of this diagnosis in skilled or long term care facilities. - Other Health Provider

Under diagnosis and poor compliance with treatment. - Physician

First, diagnosis, second, denial, third, poor eating habits and education on nutrition. Fourth, poverty and access to medicine and supplies. - Social Services Provider

Incidence/Prevalence

Number of patients with the disease and the other health issues that accompany this diagnosis. - Other Health Provider

It is the biggest diagnosis we treat at the free clinic in Pasco. - Other Health Provider

Health Education

Lack of understanding of the disease and its consequences and unwillingness to accept personal responsibility for life choices that lead to or exacerbate the individual's personal situation. - Other Health Provider

Alzheimer's Disease

About Dementia

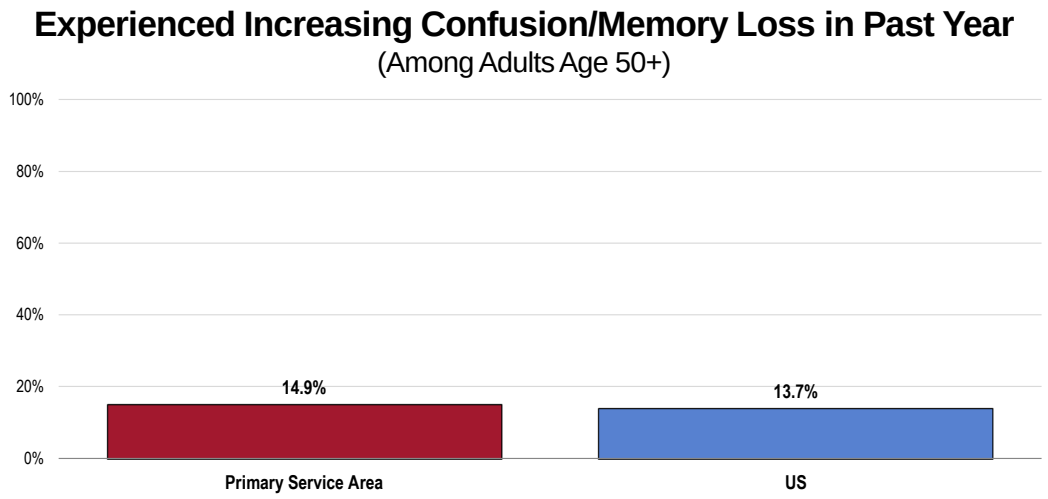
Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—to such an extent that it interferes with a person's daily life. Dementia is not a disease itself, but rather a set of symptoms. Memory loss is a common symptom of dementia, although memory loss by itself does not mean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

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

- Healthy People 2020 (www.healthypeople.gov)

Confusion & Memory Loss

"During the past 12 months, have you experienced confusion or memory loss that is happening more often or getting worse?"

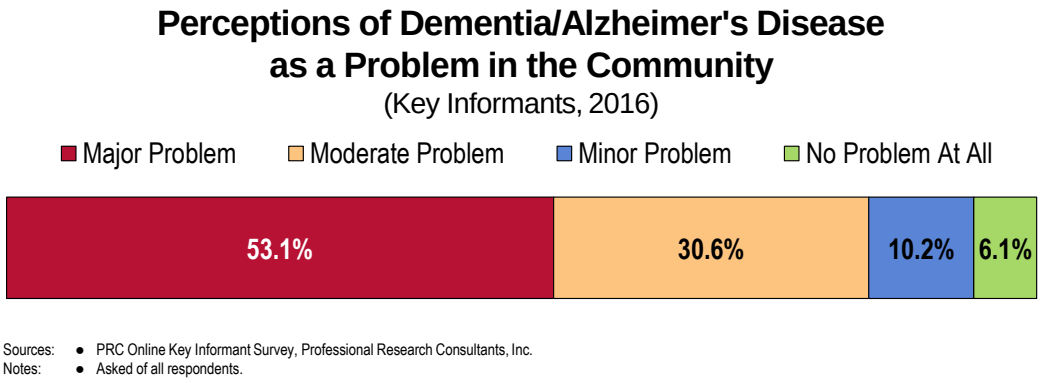


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 127]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents age 50+.

Key Informant Input: Dementias, Including Alzheimer's Disease

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



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

Top Concerns

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

Aging Population

Our large senior population is greatly affected by dementia and caregiver resources for assisting families to maintain loved ones at home are limited. - Community Leader

We have an elderly population in Pinellas and Pasco. - Social Services Provider

Average age in Pinellas County is quite high and dementia diagnosis nationally is on a significant rise, lack of facilities. - Social Services Provider

Elder population, need more resources and help for caregivers. - Community Leader

Aged population. Common issue with the patient population we serve. - Other Health Provider

With such an older population, Alzheimer's has got to be a major diagnosis for both counties. - Other Health Provider

We have an aging population and many people who cannot afford proper care for these issues. - Community Leader

Aging population that is living longer. - Community Leader

Incidence/Prevalence

It affects so many. - Other Health Provider

The increasing numbers of those that have the diseases and the strain on the caregivers that provide the care. - Community Leader

So many people diagnosed. More to come. - Social Services Provider

Several years ago, we learned that there are approximately 40,000 Alzheimer's disease victims. Waiting lists for services are long. We provide assistance to people at end stage when care is most expensive rather than early when home care is a viable option. - Community Leader

Growing diagnosis, limited long term care options that are affordable. - Other Health Provider

Impact on Families/Caregivers

I know at least six people that have parents with Alzheimer's. I sometimes wonder if they really have the right criteria to define Alzheimer's. I think in the old days, we just would have said grandma is getting forgetful. - Other Health Provider

Number of individuals affected, devastation to families, lack of care alternatives or options and length of time its affects impact individuals and families. - Other Health Provider

Because so many people with Alzheimer's remain at home alone or managed by family. Also those who still drive. A patient can thrive with a structured environment like a memory care unit. However, this takes money and funding, and many patients end up living in nursing homes. - Social Services Provider

Access to Providers

> *Few providers or skilled units. - Other Health Provider*

Lack of Funding

> *Limited funding and resources for patients and families. - Other Health Provider*

Kidney Disease

About Chronic Kidney Disease

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

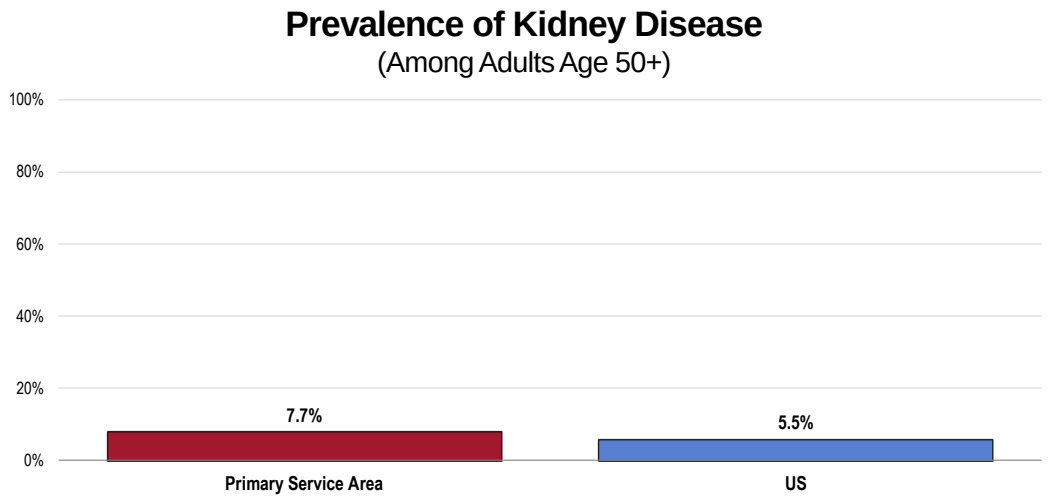
Genetic determinants have a large influence on the development and progression of chronic kidney disease. It is not possible to alter a person's biology and genetic determinants; however, environmental influences and individual behaviors also have a significant influence on the development and progression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

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

- Healthy People 2020 (www.healthypeople.gov)

Prevalence of Kidney Disease

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

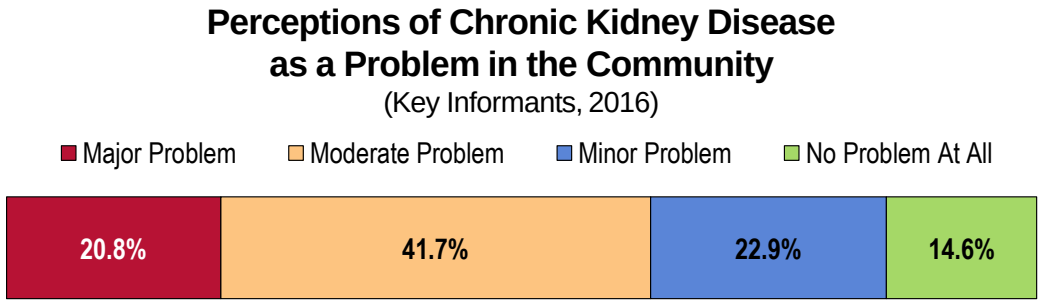


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 32]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents age 50+.

Key Informant Input: Chronic Kidney Disease

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



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

Top Concerns

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

Access to Care/Services

Limited number of dialysis centers. - Social Services Provider

If a patient has straight Medicare and patient is not diagnosed with ESRD, MCR won't pay for HD if needed thus patients stay in acute setting longer than needed strictly for HD. - Social Services Provider

Comorbidities

Because of diabetes, unmanaged, chronic and the amount of obese people in the United States and locally. - Social Services Provider

Incidence/Prevalence

Number of patients that we see with this diagnosis. - Other Health Provider

Aging Population

Aged population, frequent issue noted. - Other Health Provider

Potentially Disabling Conditions

About Arthritis, Osteoporosis & Chronic Back Conditions

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

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

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

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

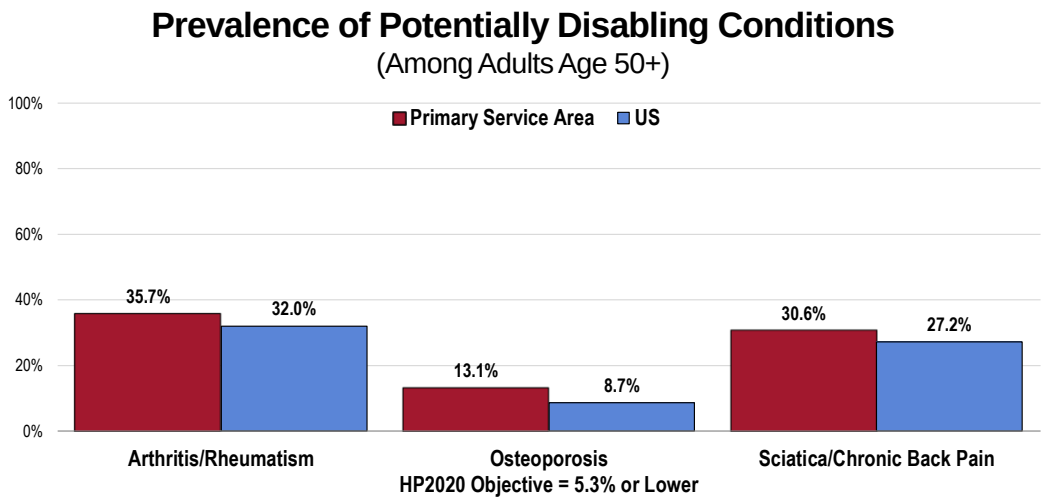
Arthritis, Osteoporosis, & Chronic Back Conditions

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

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

"Would you please tell me if you have ever suffered from or been diagnosed with sciatica or chronic back pain?"

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

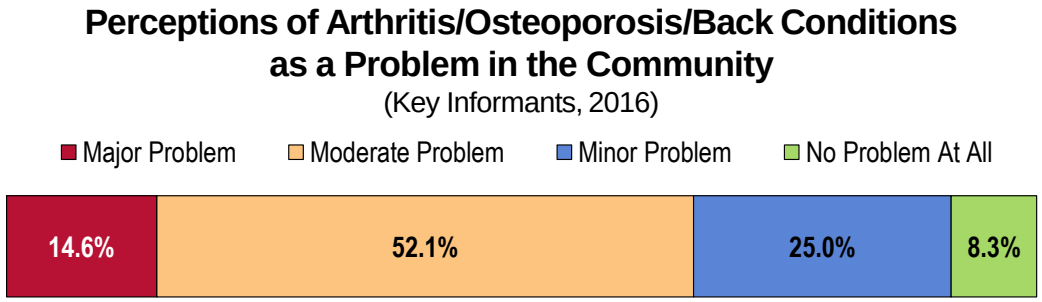


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 28, 161-162]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AOCBC-10]

Notes:
- Reflects respondents age 50+.

Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions

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



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

Notes:
- Asked of all respondents.

Top Concerns

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

Aging Population

Elderly population. - Physician

Aged population, affects many of our patients. - Other Health Provider

Two age groups, elderly and their problems. We have an elderly population which is growing. Large, financially limited and economically lower class that do manual labor and are usually uninsured and often injured during work. - Community Leader

Incidence/Prevalence

Everyone I meet seems to have arthritis. So many women I meet have osteoporosis and are afraid of injections so are eating spinach to help their bones. - Social Services Provider

These are debilitating conditions that affect quality of life and increase the risk of falls. - Other Health Provider

Vision & Hearing Impairment

Vision Trouble

About Vision

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

Hearing Trouble

About Hearing & Other Sensory or Communication Disorders

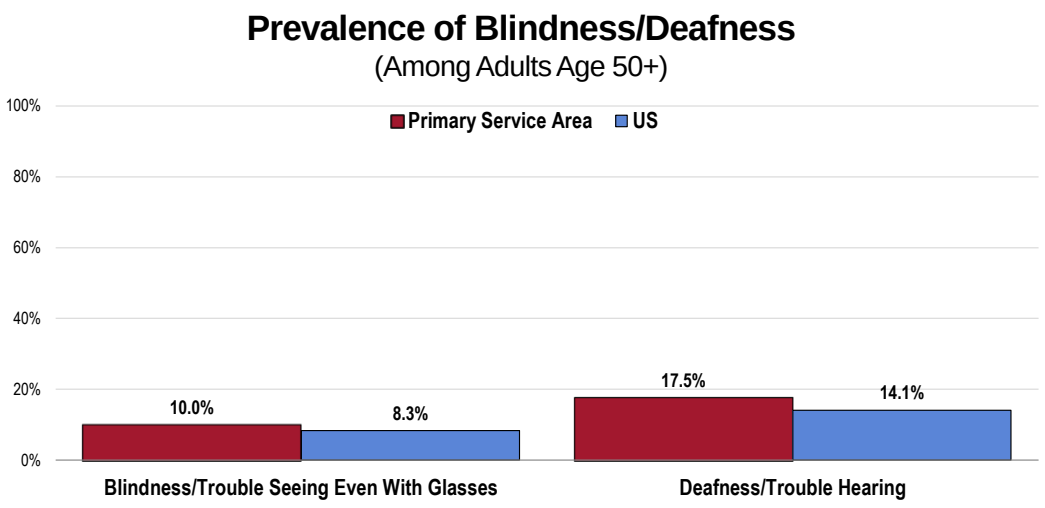
An impaired ability to communicate with others or maintain good balance can lead many people to feel socially isolated, have unmet health needs, have limited success in school or on the job. Communication and other sensory processes contribute to our overall health and well-being. Protecting these processes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

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

- Healthy People 2020 (www.healthypeople.gov)

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

"Would you please tell me if you have ever suffered from or been diagnosed with deafness or trouble hearing?"

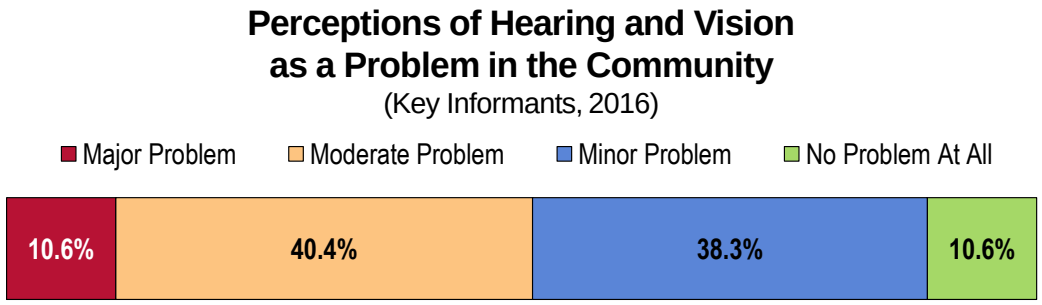


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 25-26]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents age 50+.

Key Informant Input: Vision & Hearing

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



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

Notes:
- Asked of all respondents.

Top Concerns

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

Aging Population

I learned this year from a 92 year old Sunday school that he had cataracts and a torn retina for many years of sun exposure as a child growing up on a farm in Indiana. His ophthalmologist told him that was why. I think most people don't wear sunglasses and do not know this. Also, many people with hearing difficulties of old age or otherwise are going to get new hearing aids twice a year because of dissatisfaction with what they get. Not sure the businesses are knowledgeable. - Other Health Provider

These can be a major problem because they isolate seniors and make it harder for them to live independently. Many people also then begin to have secondary problems such as medication errors when these problems worsen. The medications for these vision conditions can be very costly. - Community Leader

Hearing Aids

So many hearing aid sales persons with poor products. Eye is available on every corner. - Social Services Provider

Infectious Disease

About Immunization & Infectious Diseases

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

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

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

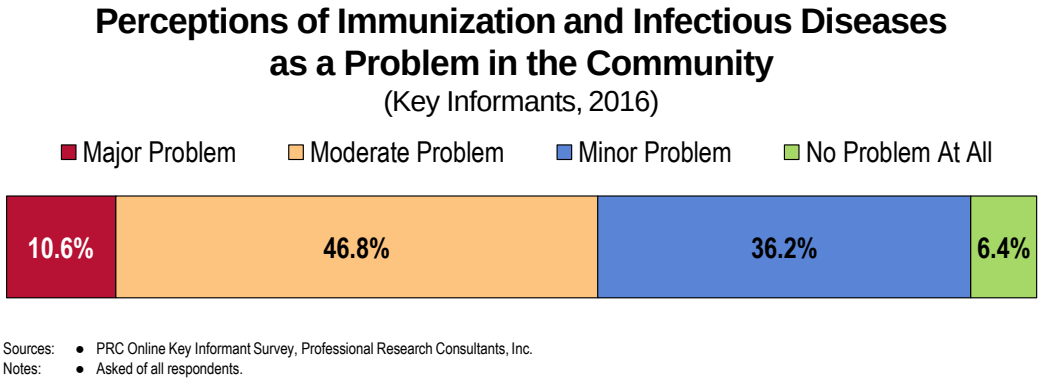
- Proper use of vaccines
- Antibiotics
- Screening and testing guidelines
- Scientific improvements in the diagnosis of infectious disease-related health concerns

- Healthy People 2020 (www.healthypeople.gov)

Immunization & Infectious Diseases

Key Informant Input: Immunization & Infectious Diseases

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



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

Top Concerns

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

Health Education

> *Limited education of risks and benefits to patients. - Other Health Provider*
> *Need more focus. - Physician*

HIV

About HIV

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

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

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

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

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

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

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

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

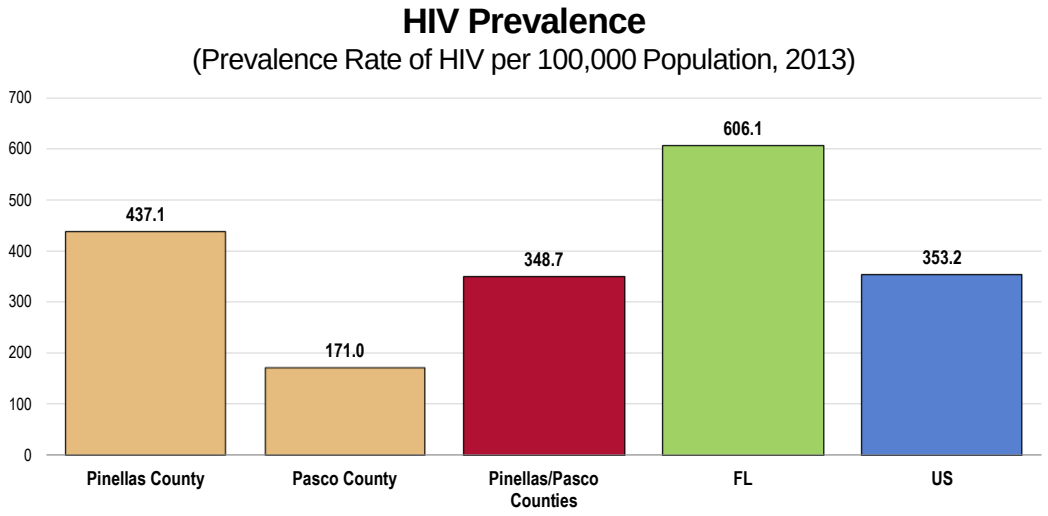
- Linking to and staying in treatment.
- Increasing the availability of ongoing HIV prevention interventions.
- Providing prevention services for their partners.

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

- Healthy People 2020 (www.healthypeople.gov)

HIV Prevalence

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

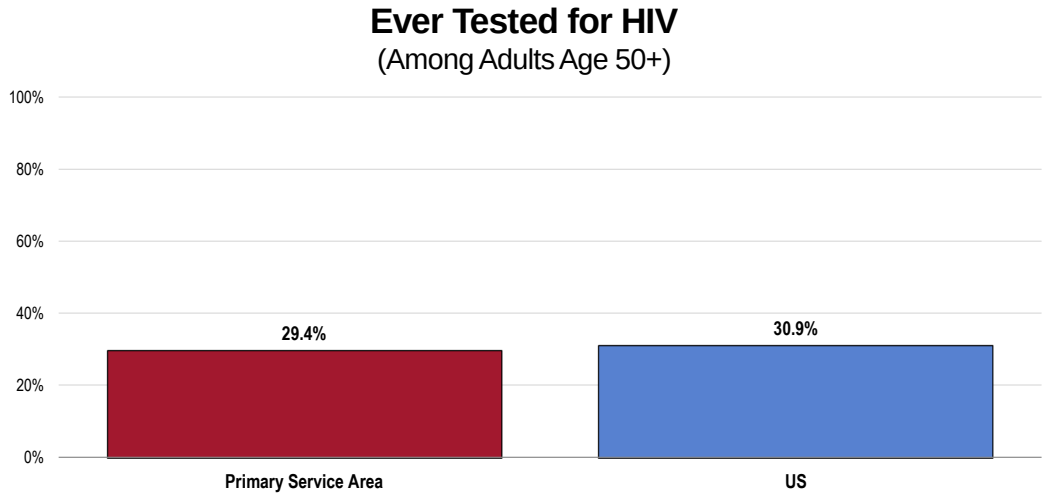


Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Retrieved August 2016 from Community Commons at http://www.chna.org.

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

HIV Testing

"Not counting tests you may have had when donating or giving blood, when was the last time you were tested for HIV?"

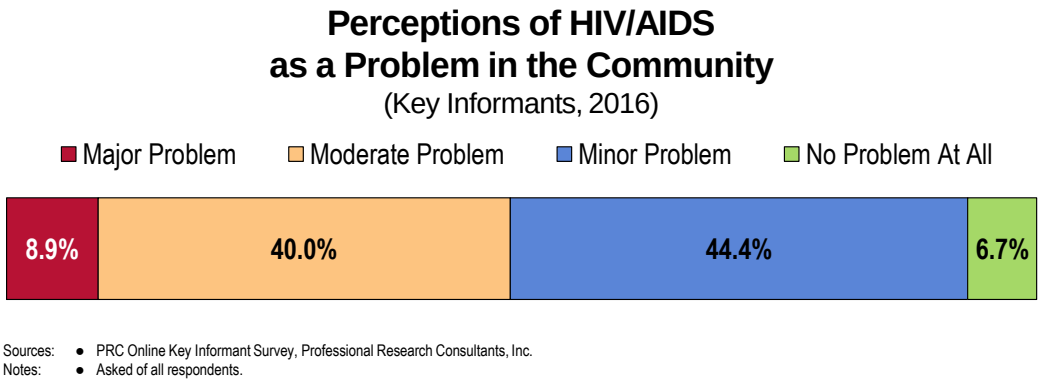


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 167]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents age 50+.

Key Informant Input: HIV/AIDS

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



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

Top Concerns

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

Access to Care/Services

> *Need more resources. - Physician*
>
> *Need more testing, education and attention. - Community Leader*

Poverty

> *Fluid population and low income population. - Community Leader*

Sexually Transmitted Diseases

About Sexually Transmitted Diseases

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

Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the US…. Several factors contribute to the spread of STDs.

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

Chlamydia & Gonorrhea

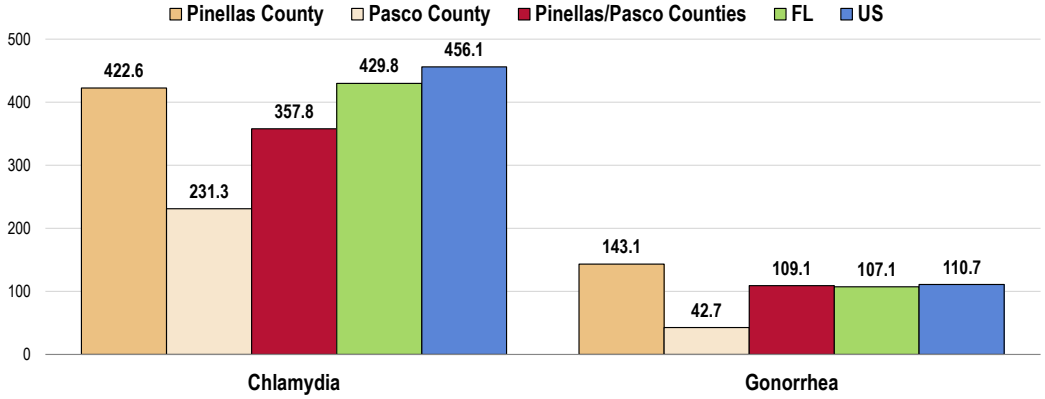
Chlamydia. Chlamydia is the most commonly reported STD in the United States; most people who have chlamydia don't know it since the disease often has no symptoms.

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

The following chart outlines local incidence for these STDs.

Chlamydia & Gonorrhea Incidence

(Incidence Rate per 100,000 Population, 2014)



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

Notes:
- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Safe Sexual Practices

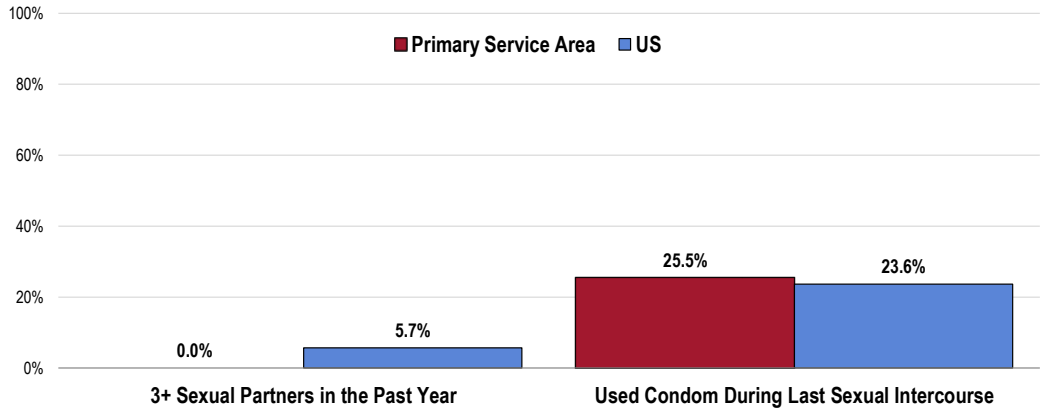
"During the past 12 months, with how many people have you had sexual intercourse?"

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

Each of these is reported below only among adults who are unmarried and between the ages of 50 and 64.

Sexual Risk

(Unmarried Adults Age 50-64)

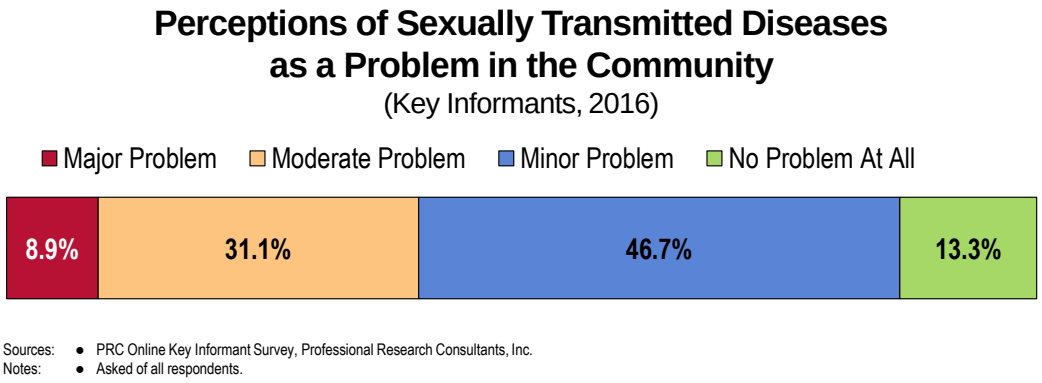


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 97-98]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects unmarried respondents between the ages of 50 and 64.

Key Informant Input: Sexually Transmitted Diseases

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



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

Top Concerns

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

Incidence/Prevalence

> *Because they are debilitating and are spread sexually, which is hard to control, as many people do not believe this will happen to them leading to unsafe sexual practices. The country is still struggling with the taboo of STD's, and conservative beliefs prevent education and discussion that can help this from happening. - Social Services Provider*

Alcohol/Drug Use

> *Transient society, drug and alcohol problems, human trafficking, sex trade. - Community Leader*

Lack of Focus on the Problem

> *Need more focus. - Physician*

Modifiable Health Risks

Actual Causes Of Death

About Contributors to Mortality

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

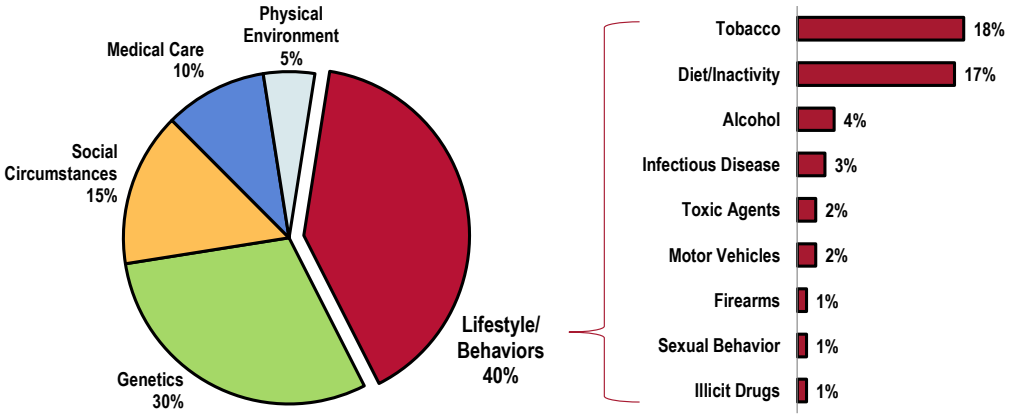
The most prominent contributors to mortality in the United States in 2000 were **tobacco** (an estimated 435,000 deaths), **diet and activity** patterns (400,000), **alcohol** (85,000), **microbial agents** (75,000), **toxic agents** (55,000), **motor vehicles** (43,000), **firearms** (29,000), **sexual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

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

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

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

Factors Contributing to Premature Deaths in the United States



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

Nutrition, Physical Activity & Weight

Nutrition

About Healthful Diet & Healthy Weight

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

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

Americans with a healthful diet:

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

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

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

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

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

Social factors thought to influence diet include:

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

Daily Recommendation of Fruits/Vegetables

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

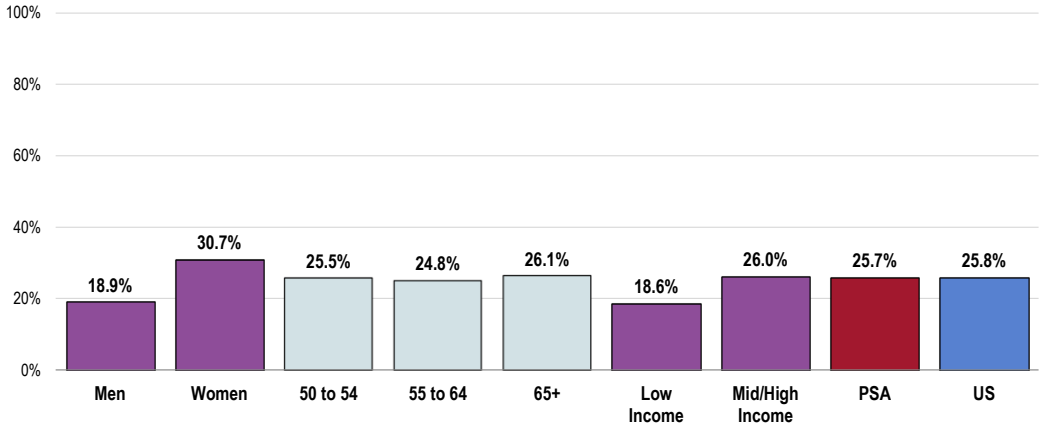
"Now I would like you to think about the foods you ate or drank yesterday. Include all the foods you ate, both at home and away from home. How many servings of fruit or fruit juices did you have yesterday?"

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

The questions above are used to calculate daily fruit/vegetable consumption for adults age 50+ at the respondent level. The proportion reporting having 5 or more servings per day is shown below.

Consume Five or More Servings of Fruits/Vegetables Per Day

(Primary Service Area Adults Age 50+, 2016)

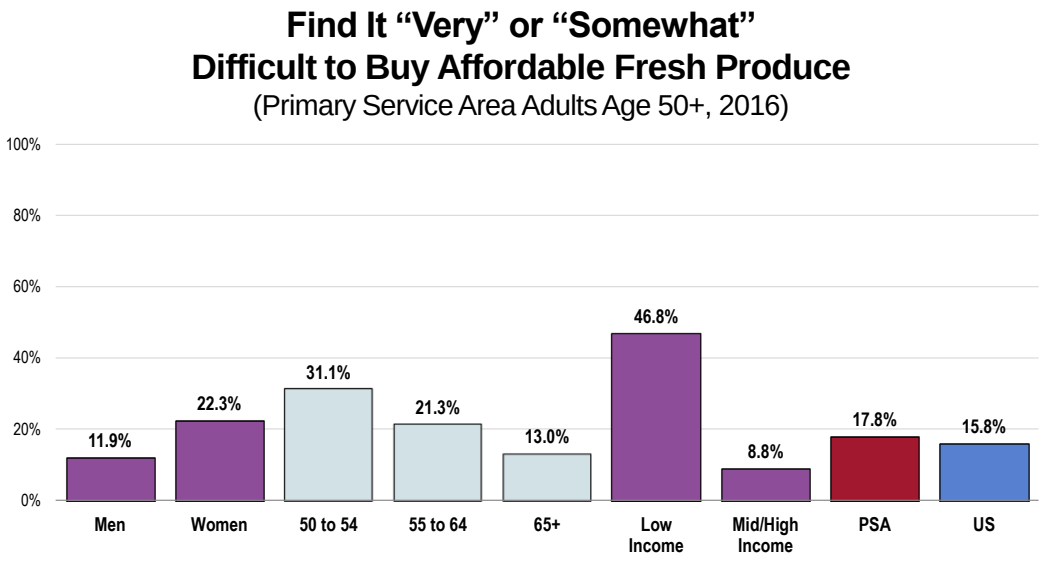


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 168]

Notes:
- Reflects respondents age 50+.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- For this issue, respondents were asked to recall their food intake on the previous day.

Access to Fresh Produce

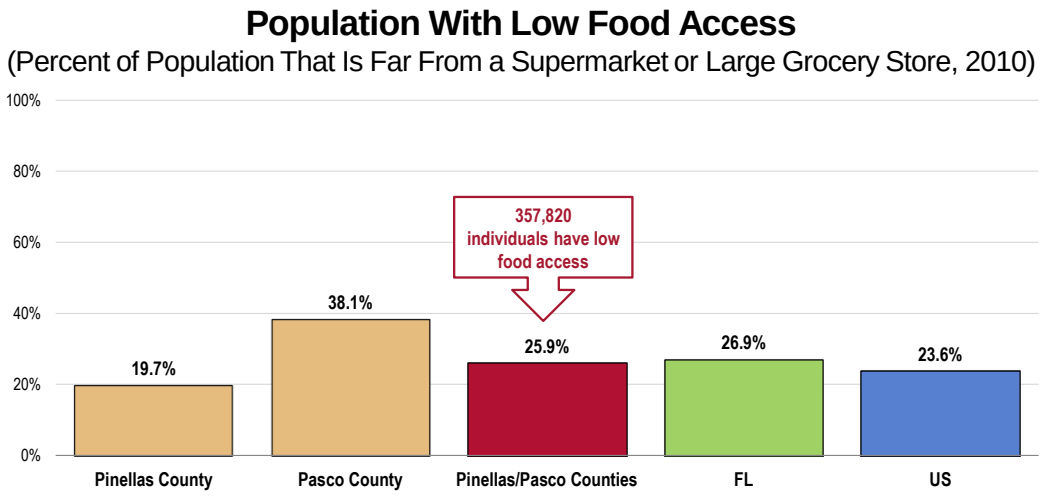
"How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford — would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?"



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 103]

Notes:
- Reflects respondents age 50+.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

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



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Retrieved August 2016 from Community Commons at http://www.chna.org.

Notes:
- This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as low-income areas where a significant number or share of residents is far from a supermarket, where "far" is more than 1 mile in urban areas and more than 10 miles in rural areas. This indicator is relevant because it highlights populations and geographies facing food insecurity.

Physical Activity

About Physical Activity

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

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

Leisure-Time Physical Activity

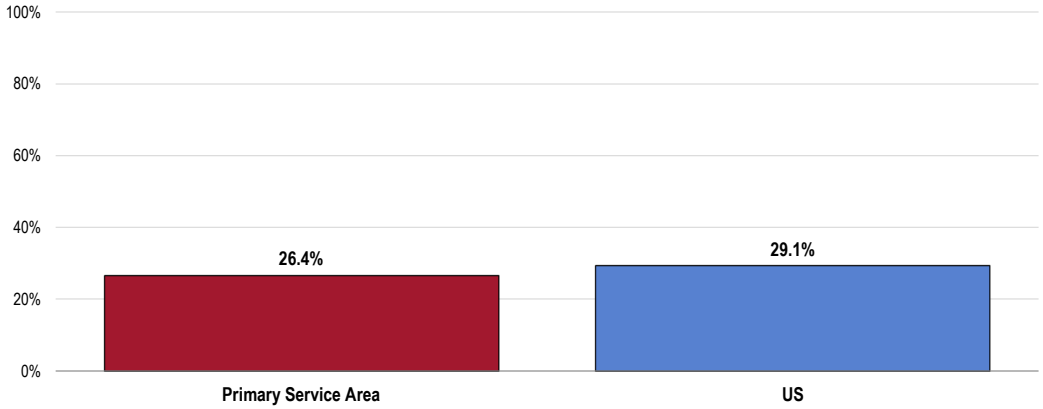
Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

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

No Leisure-Time Physical Activity in the Past Month

(Among Adults Age 50+)

Healthy People 2020 Target = 32.6% or Lower



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 106]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-1]

Notes:
- Reflects respondents age 50+.

Recommended Levels of Physical Activity

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

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

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

Meeting Physical Activity Recommendations

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

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

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

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

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

Respondents were also asked about strengthening exercises:

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

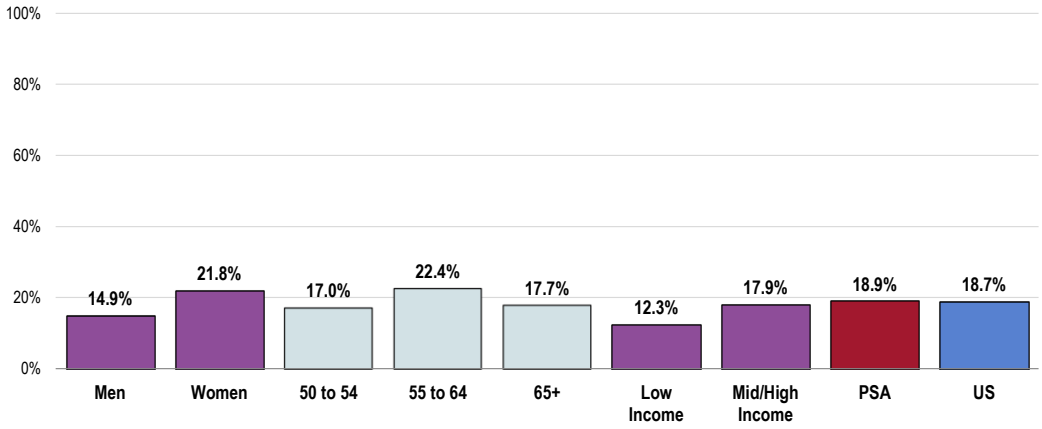
"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activity:

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

Meets Physical Activity Recommendations

(Primary Service Area Adults Age 50+, 2016)

Healthy People 2020 Target = 20.1% or Higher



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 174]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective PA-4]

Notes:
- Reflects respondents age 50+.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Meeting both guidelines is defined as the number of persons age 50+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity *and* report doing physical activities specifically designed to strengthen muscles at least twice per week.

Weight Status

About Overweight & Obesity

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

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

- Healthy People 2020 (www.healthypeople.gov)

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

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

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

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

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

Adult Weight Status

"About how much do you weigh without shoes?"

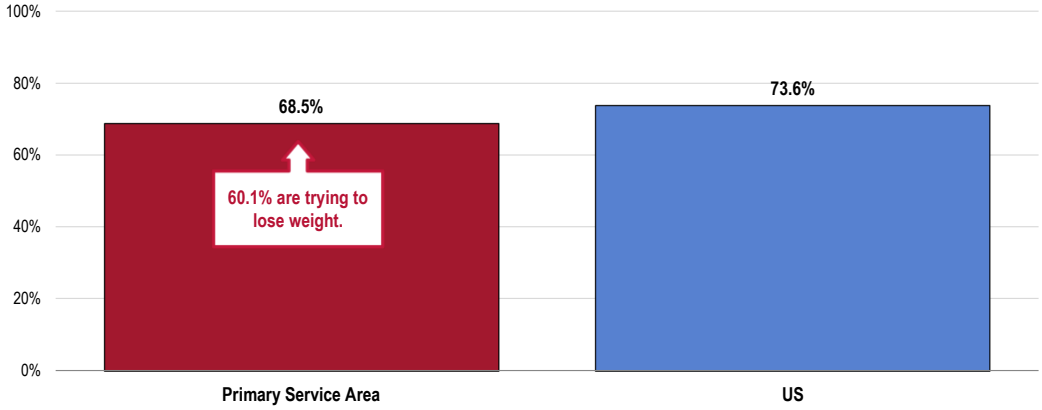
"About how tall are you without shoes?"

"Are you now trying to lose weight?"

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population age 50 and older who is at a healthy weight, or who is overweight or obese (see table above).

Prevalence of Total Overweight

(Percent of Adults Age 50+ With a Body Mass Index of 25.0 or Higher)



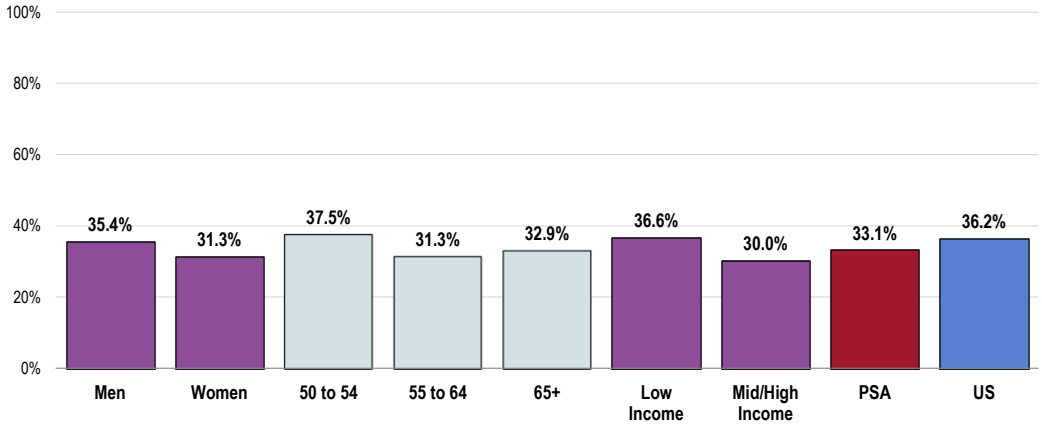
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 176-177]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Based on reported heights and weights, reflects respondents age 50+.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

Prevalence of Obesity

(Percent of Adults Age 50+ With a BMI of 30.0 or Higher; Primary Service Area, 2016)

Healthy People 2020 Target = 30.5% or Lower

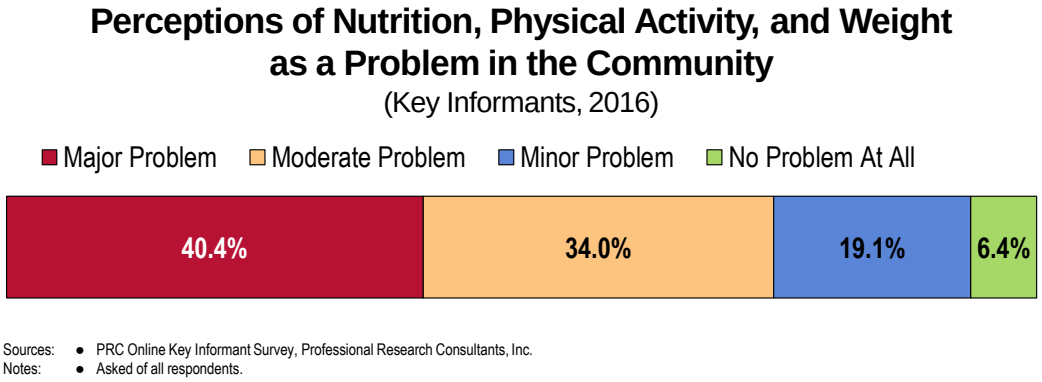


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 176]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective NWS-9]

Notes:
- Based on reported heights and weights, reflects respondents age 50+.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Key Informant Input: Nutrition, Physical Activity & Weight

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



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

Top Concerns

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

Access to Healthy Food

To eat healthy it is expensive. I think some cooking classes on interesting, inexpensive ways to cook healthy would be very appealing. I think a scale in each department or readily accessible like they have in public would be welcome to those that are trying to work toward a goal. - Other Health Provider

Society, school system that does not require PE and has unhealthy school lunches. - Community Leader

Access and lack of interest, desire and availability of carbohydrate rich foods. Less available access to healthy fruits and vegetables. - Social Services Provider

It is a world-wide epidemic. Eating healthy is expensive. Many of our patients state they would love to eat healthy but cannot afford it. We need more "community gardens" or co-ops in Pasco especially West Pasco. - Other Health Provider

Lifestyle

Supporting people trying to maintain a healthy lifestyle which is key to disease prevention. - Community Leader

Behavioral change is difficult; nutrition, physical activity and weight are significant issues for enhanced health. Food insecurity leads to poor health choices. - Other Health Provider

Obesity

Society is obese with food portions and not enough physical activity. - Social Services Provider

Increase in obesity and health related issues associated with obesity. - Other Health Provider

Lack of Coordinated Care

Hard to describe, too many factors and too many working on the same problem without coordination. - Community Leader

Insufficient Physical Activity

We are sedentary, fat and lazy. - Social Services Provider

Substance Abuse

About Substance Abuse

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

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

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

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

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

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

- Healthy People 2020 (www.healthypeople.gov)

Alcohol Use

Excessive Drinkers. Excessive drinking reflects the number of persons aged 50 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) or who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

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

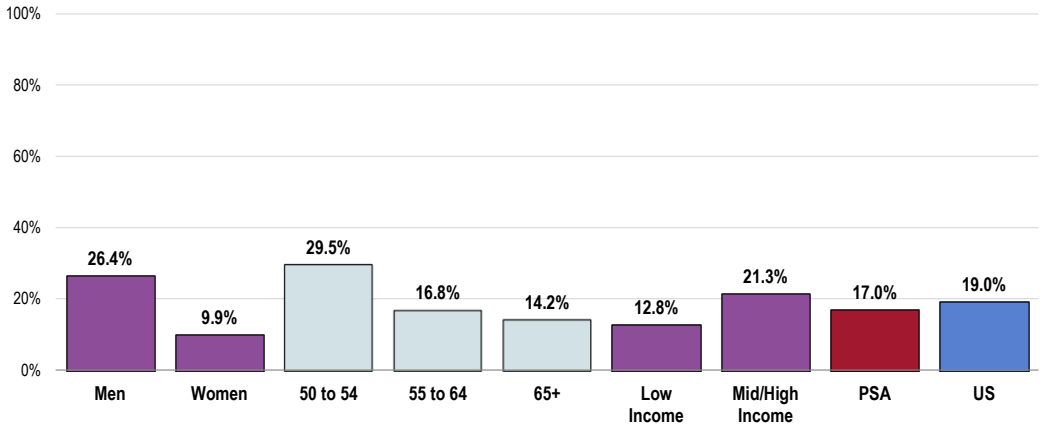
"On the day(s) when you drank, about how many drinks did you have on the average?"

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

Excessive Drinkers

(Primary Service Area Adults Age 50+, 2016)

Healthy People 2020 Target = 25.4% or Lower



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 189]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-15]

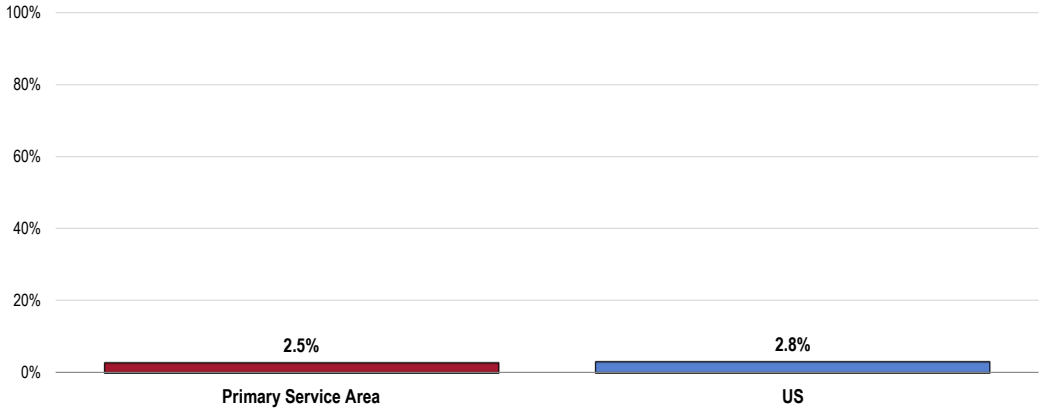
Notes:
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Excessive drinking reflects the number of persons aged 50 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

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

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

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

(Among Adults Age 50+)

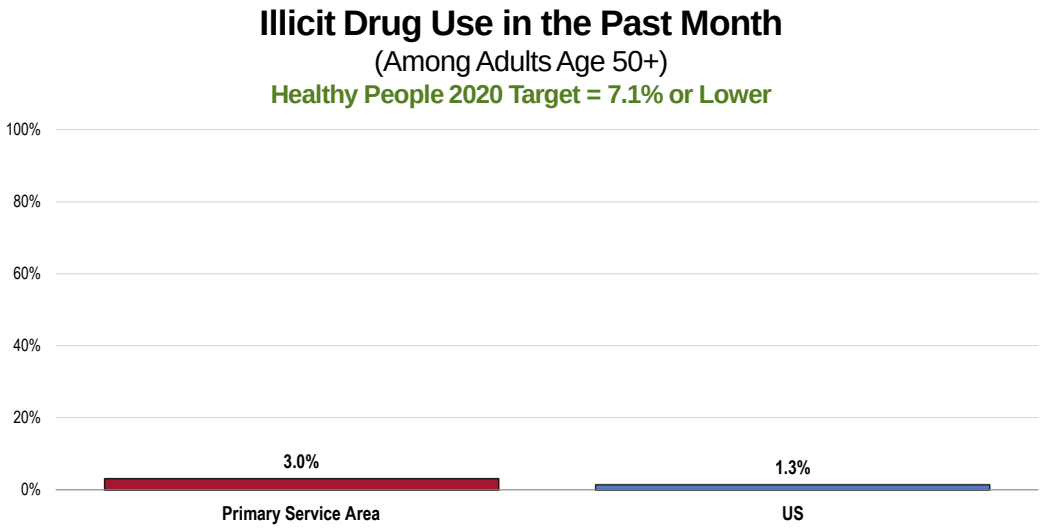


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 66]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents age 50+.

Illicit Drug Use

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

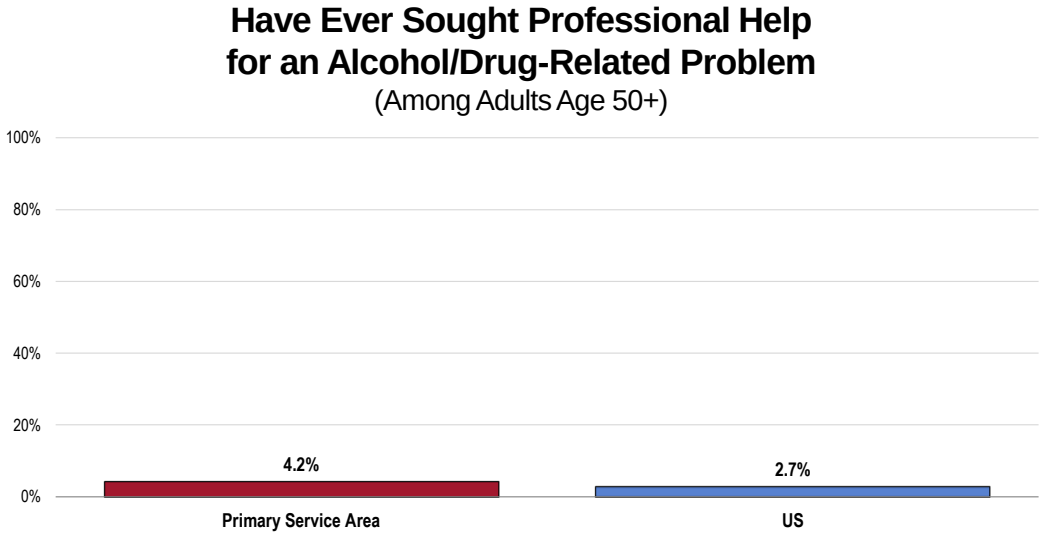


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 67]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective SA-13.3]

Notes:
- Reflects respondents age 50+.

Alcohol & Drug Treatment

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

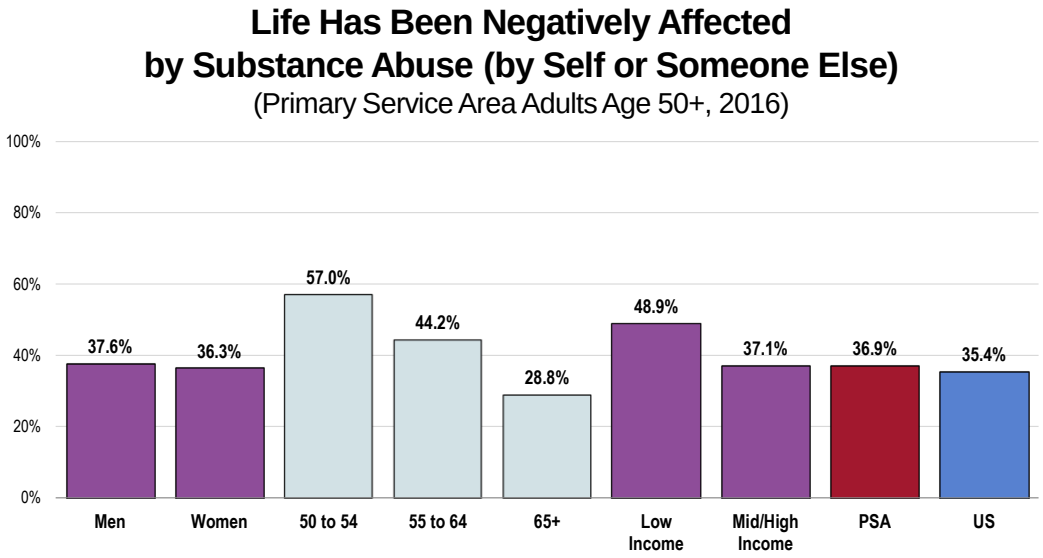


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 68]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents age 50+.

Personal Impact of Substance Abuse

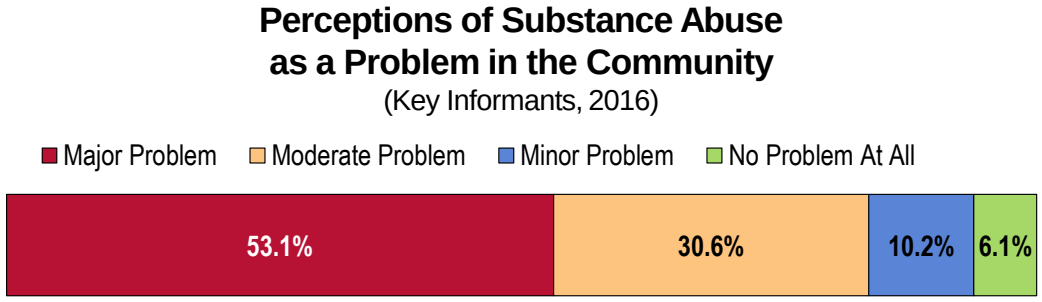
"To what degree has your life been negatively affected by your own or someone else's substance abuse issues, including alcohol, prescription, and other drugs? Would you say: A great deal, somewhat, a little, or not at all?"



Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 69]
Notes: ● Reflects respondents age 50+.
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Substance Abuse

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



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

Barriers to Treatment

Among those rating this issue as a "major problem," the greatest barriers to accessing substance abuse treatment are viewed as:

Access to Care/Services

I don't know what the barriers are, but I do know that it is impacting nursing care in a big way. I don't know what makes it so available to everyone, but it is. - Other Health Provider

Lack of available resources. It's also very difficult to discharge patients with history of IVDA who need continued IV antibiotic therapy. - Community Leader

Limited access for those with no resources. - Other Health Provider

Not readily available outpatient resources. - Physician

Not enough resources or education. - Social Services Provider

Affordable Care/Services

Cost of treatment and lack of coverage for those who need it most. - Other Health Provider

Money, adequate treatment options and poverty. - Community Leader

Financial barriers to access to treatment services. - Community Leader

Proper diagnosis, available quality facilities at affordable rates. - Social Services Provider

Lack of Funding

Federal spending/state spending, taboo, shaming, it's not my problem, conservative thinking and expectations of those who use, as well as judgments against those who are using. This country believes that everyone should help themselves, no matter what childhood or resources a person experiences. The root of the cause of the addiction is what is needed to be solved, and this is difficult to tackle. Because mental health is considered a weakness and people may choose to hide with addiction, which has a ripple effect on the entire family unit and the individual's life. Once a person is in the hole it is very hard to get out. This person will keep drinking until they die and/or their health is destroyed. Many patients live on ventilators for long periods of time because of this illness which has alienated the patient from family and friends; and the healthcare system has to solve the problem without anyone to speak for the patient. - Social Services Provider

Incidence/Prevalence

It affects so many. - Other Health Provider

Readily available, often used when mental health medications are not available, transient society. Lack of treatment programs. Lack of dual diagnosis programs in the area. - Community Leader

Health Education

There is not enough education for the public. The costs are expensive and the drugs are cheap on the streets. People have to want to be clean in order to do so. It's a choice, but it's an illness too. This is a world-wide epidemic also. - Other Health Provider

Criminalization

The criminalization of addiction. The popularity of binge drinking. Lack of options for uninsured. Drug court is a good thing. - Social Services Provider

Lack of Coordination

Coordination with agencies. - Community Leader

Denial/Stigma

Recognition and affordable care. - Community Leader

Most Problematic Substances

Key informants (who rated this as a "major problem") clearly identified **alcohol** as the most problematic substance abused in the community, followed by **heroin/other opioids** and **cocaine/crack**.

Most Problematic Substances				
	Most Problematic	Second-Most Problematic	Third-Most Problematic	**Total Mentions**
Alcohol	54.5%	18.2%	9.1%	**9**
Heroin or Other Opioids	18.2%	36.4%	9.1%	**7**
Cocaine or Crack	18.2%	0.0%	36.4%	**6**
Synthetic Drugs (e.g. Bath Salts, K2/Spice)	0.0%	9.1%	27.3%	**4**
Prescription Medications	9.1%	18.2%	0.0%	**3**
Club Drugs (e.g. MDMA, GHB, Ecstasy, Molly)	0.0%	18.2%	0.0%	**2**
Methamphetamines or Other Amphetamines	0.0%	0.0%	9.1%	**1**
Over-The-Counter Medications	0.0%	0.0%	9.1%	**1**

Tobacco Use

About Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General's report on tobacco was released in 1964.

Tobacco use causes:

- Cancer
- Heart disease
- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)
- Premature birth, low birth weight, stillbirth, and infant death

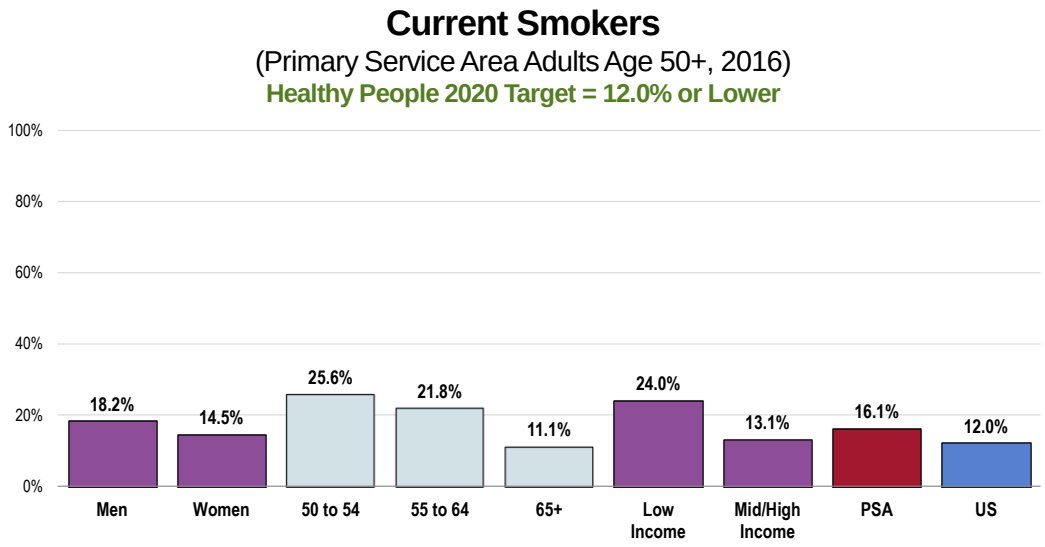
There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children….

Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

- Healthy People 2020 (www.healthypeople.gov)

Cigarette Smoking

"Do you now smoke cigarettes every day, some days, or not at all?"



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-1.1]

Notes:
- Reflects respondents age 50+.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Includes regular and occasion smokers (every day and some days).

Smoking Cessation

About Reducing Tobacco Use

Preventing tobacco use and helping tobacco users quit can improve the health and quality of life for Americans of all ages. People who stop smoking greatly reduce their risk of disease and premature death. Benefits are greater for people who stop at earlier ages, but quitting tobacco use is beneficial at any age.

Many factors influence tobacco use, disease, and mortality. Risk factors include race/ethnicity, age, education, and socioeconomic status. Significant disparities in tobacco use exist geographically; such disparities typically result from differences among states in smoke-free protections, tobacco prices, and program funding for tobacco prevention.

- Healthy People 2020 (www.healthypeople.gov)

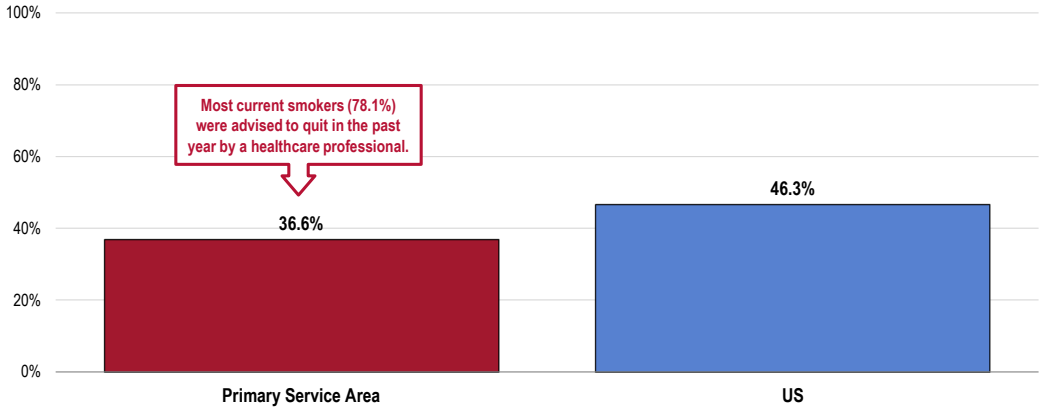
"In the past 12 months, has a doctor, nurse or other health professional advised you to quit smoking?" (Asked of respondents who smoke every day or on some days.)

"During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?" (Asked of respondents who smoke every day.)

Have Stopped Smoking for One Day or Longer in the Past Year in an Attempt to Quit Smoking

(Among Everyday Smokers Age 50+)

Healthy People 2020 Target = 80.0% or Higher

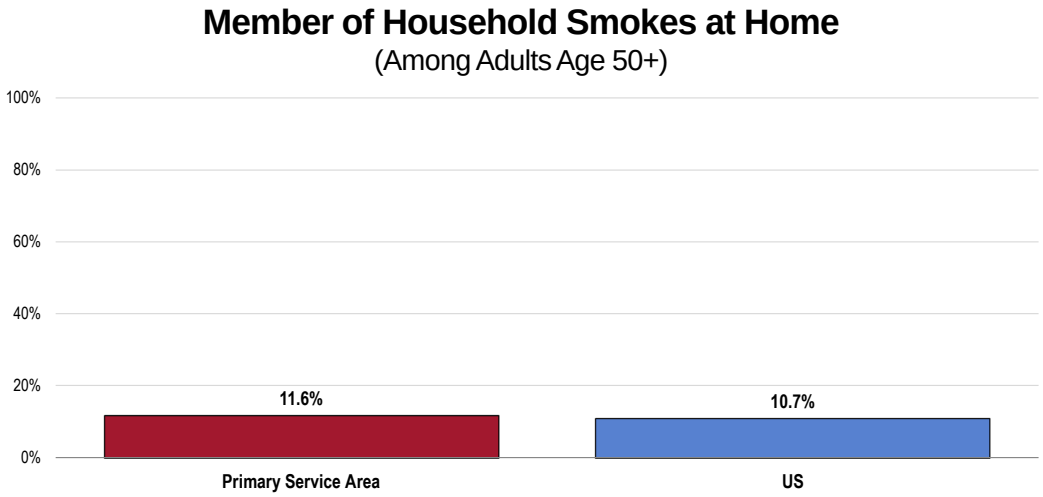


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 56-57]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective TU-4.1]

Notes:
- Asked of respondents age 50+ who smoke cigarettes every day.

Secondhand Smoke

"In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars or pipes anywhere in your home on an average of four or more days per week?"

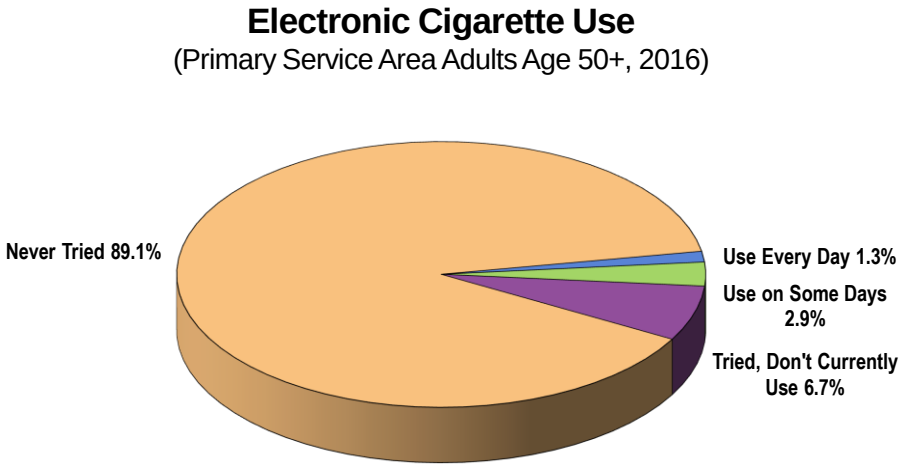


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 58]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents age 50+.
- "Smokes at home" refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more times per week in the past month.

E-Cigarette Use

"The next question is about electronic cigarettes, also known as e-cigarettes. These are battery-operated devices that simulate traditional cigarette smoking, but do not involve the burning of tobacco. The cartridge or liquid "e-juice" used in these devices produces vapor and comes in a variety of flavors. Have you ever used an electronic cigarette?"



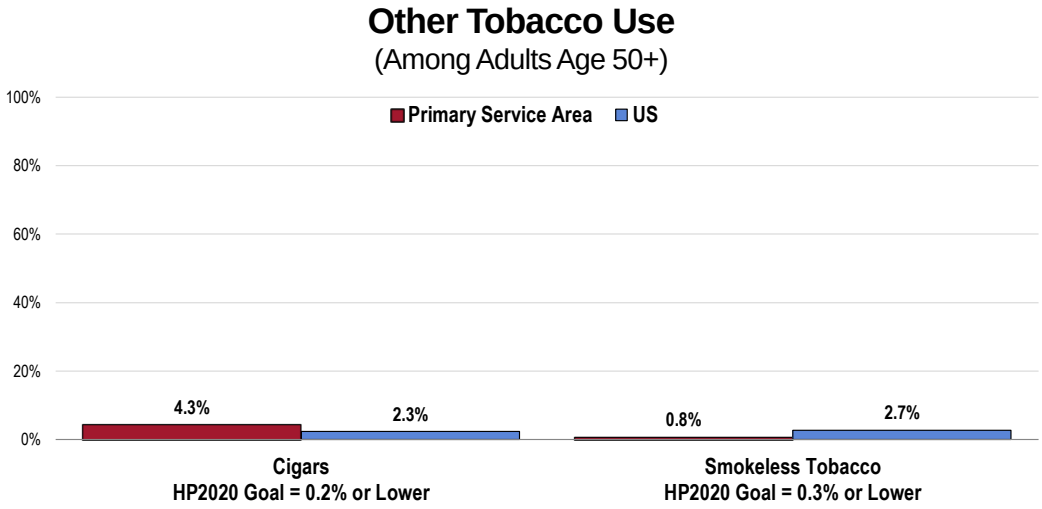
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 208]

Notes:
- Reflects respondents age 50+.

Other Tobacco Use

"Do you currently use chewing tobacco, snuff, or snus every day, some days, or not at all?"

"Do you now smoke cigars every day, some days, or not at all?"

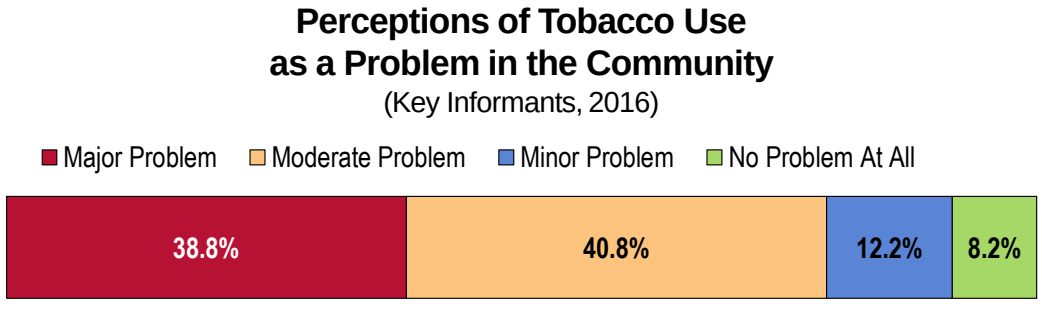


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 53, 60]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objectives TU-1.2, TU-1.3]

Notes:
- Reflects respondents age 50+.
- Smokeless tobacco includes chewing tobacco or snuff.

Key Informant Input: Tobacco Use

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



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

Notes:
- Asked of all respondents.

Top Concerns

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

Incidence/Prevalence

Not unique issue to our community but in general population. For individuals who have become addicted, increase the incentives to stop by adjusting insurance premiums if cessation programs are implemented and followed. - Other Health Provider

Smoking and chewing is still happening, even with all of the education that is out there. Years ago, it was cool to smoke; now it is not so much. Even with the price of cigarettes as high as it is- it is not deterring enough. - Other Health Provider

Increase in tobacco use with limited paid for cession funded programs. - Other Health Provider

It affects so many. - Other Health Provider

Wide abuse of a terrible substance. - Community Leader

It is still is fashionable to smoke. - Community Leader

Based on patients that we are seeing admitted to our hospitals as well as the incidence of COPD in our community. - Community Leader

Lifestyle

Because of the effects on a person's lifestyle and health. Because tobacco is available and legal. I think the number of new smokers are reducing, but the effects of long term smokers are still part of our healthcare system and dollars. - Social Services Provider

Comorbidities

Leads to significant health problems. - Social Services Provider

Denial/Stigma

Tobacco addiction and resistance from smokers to quit. - Physician

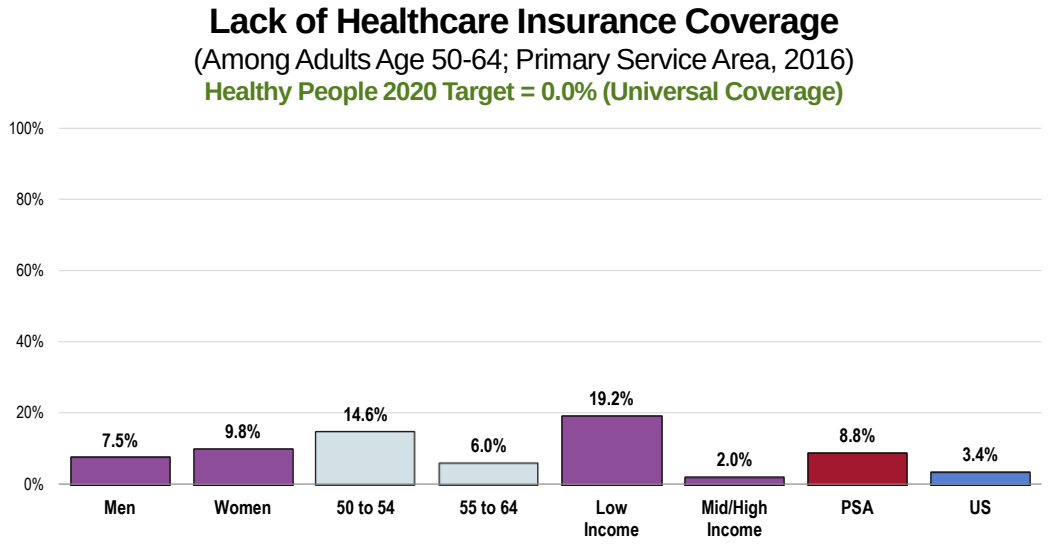
Access to Health Services

Lack of Health Insurance Coverage (Age 50 to 64)

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources. Here, lack of health insurance coverage reflects respondents age 50 to 64 (thus excluding the Medicare population) who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

"Do you have any government-assisted healthcare coverage, such as Medicare, Medicaid (or another state-sponsored program), or VA/military benefits?"

"Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself; or, you do not have health insurance and pay for health care entirely on your own?"



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-1]

Notes:
- Reflects respondents age 50 to 64.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Difficulties Accessing Healthcare

About Access to Healthcare

Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

- Healthy People 2020 (www.healthypeople.gov)

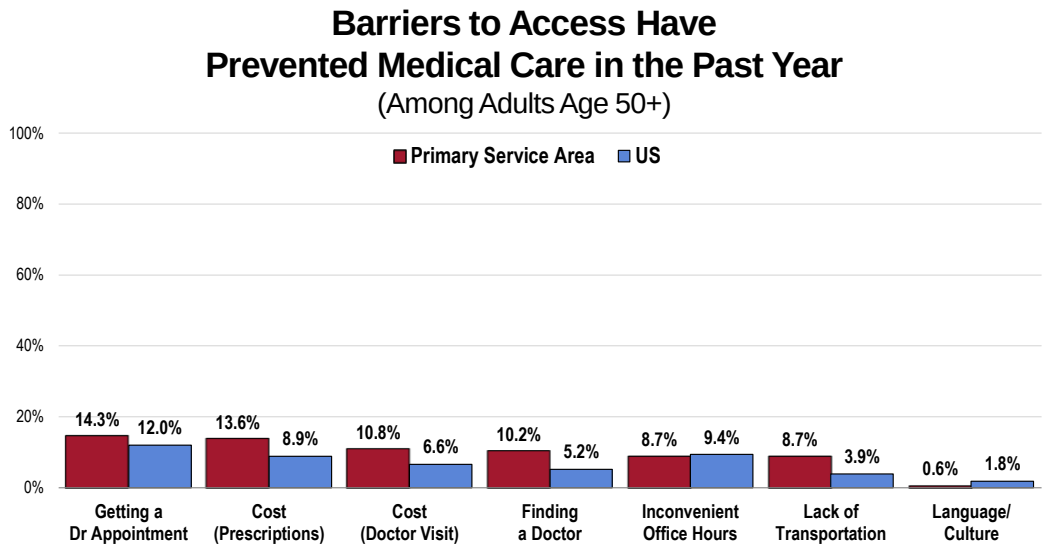
Barriers to Healthcare Access

To better understand healthcare access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

"Was there a time in the past 12 months when…

- … you needed medical care, but had **difficulty finding a doctor**?"
- … you had difficulty getting an **appointment** to see a doctor?"
- … you needed to see a doctor, but could not because of the **cost**?"
- … a **lack of transportation** made it difficult or prevented you from seeing a doctor or making a medical appointment?"
- … you were not able to see a doctor because the **office hours were not convenient**?"
- … you needed a **prescription medicine**, but did not get it because you could not afford it?"
- … you were not able to see a doctor due to **language or cultural differences**?"

Percentages reflect respondents age 50+, regardless of whether medical care was needed or sought.

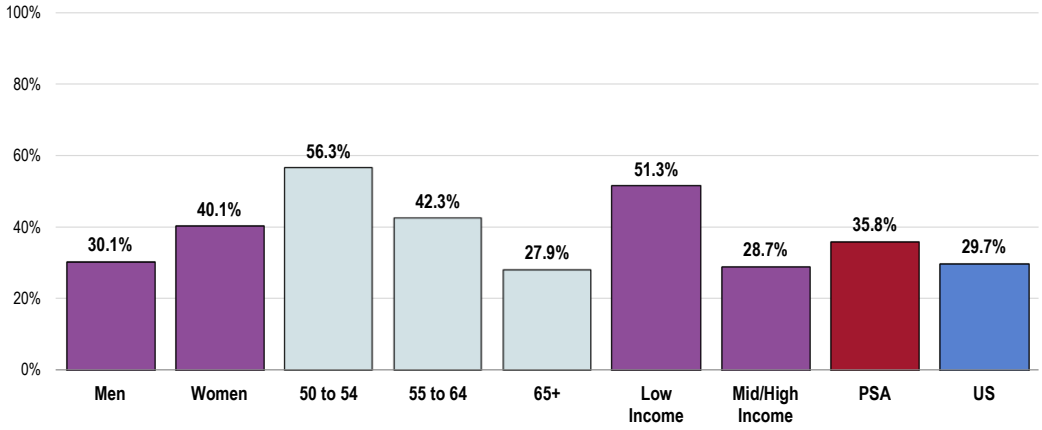


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-13]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents age 50+.

The following chart reflects the composite percentage of the total population age 50 and over experiencing problems accessing healthcare in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.

Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year
(Primary Service Area Adults Age 50+, 2016)

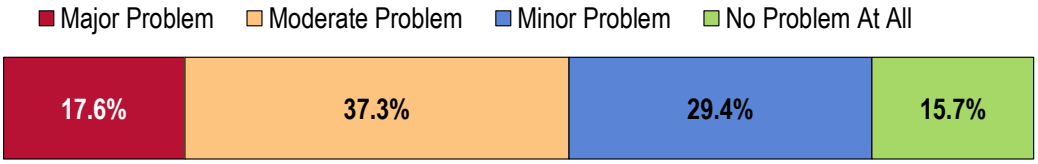


Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 194]
Notes: ● Reflects respondents age 50+.
● Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.
● Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Key Informant Input: Access to Healthcare Services

The following chart outlines key informants' perceptions of the severity of *Access to Healthcare Services* as a problem in the community:

Perceptions of Access to Healthcare Services as a Problem in the Community
(Key Informants, 2016)



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

Top Concerns

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

Affordable Care/Services

> *Affordability in meeting premiums, reduced employer participation and doctor participation. - Community Leader*
>
> *Lack of insurance. - Other Health Provider*
>
> *Insurance issues. - Physician*

Medical Homes

> *Need for medical homes for everyone where healthcare is available and affordable. - Social Services Provider*

Long Waits

> *There are long wait lists for desperately needed services and assistance for chronically ill seniors. There are wait lists for developmentally disabled as well. - Community Leader*

Transportation

> *Transportation and affordability. - Social Services Provider*

Behavioral Health Services

> *Mental illness and substance abuse. - Social Services Provider*

Type of Care Most Difficult to Access

Key informants (who rated this as a "major problem") most often identified **mental health care** and **substance abuse treatment** as the most difficult to access in the community (when given three opportunities to respond). On first mention, mental health was most often identified, followed by chronic disease care, and primary care.

Medical Care Difficult to Access Locally

	Most Difficult to Access	Second-Most Difficult to Access	Third-Most Difficult to Access	**Total Mentions**
Mental Health Care	66.7%	0.0%	16.7%	5
Substance Abuse Treatment	0.0%	50.0%	33.3%	5
Chronic Disease Care	16.7%	16.7%	0.0%	2
Specialty Care	0.0%	33.3%	0.0%	2
Dental Care	0.0%	0.0%	33.3%	2
Primary Care	16.7%	0.0%	0.0%	1
Palliative Care	0.0%	0.0%	16.7%	1

Health Literacy

To measure respondents' ability to understand health-related information, respondents were asked the following questions:

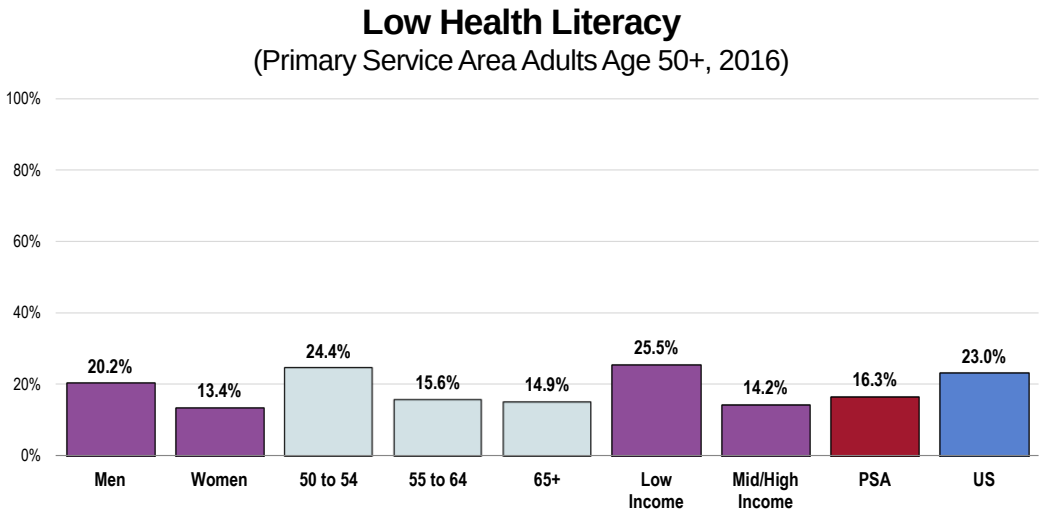
"How often is health information written in a way that is easy for you to understand? Would you say: always, nearly always, sometimes, seldom, or never?"

"How often do you need to have someone help you read health information? Would you say: always, nearly always, sometimes, seldom, or never?"

"How often is health information spoken in a way that is easy for you to understand? Would you say: always, nearly always, sometimes, seldom, or never?"

"In general, how confident are you in your ability to fill out health forms yourself? Would you say: extremely confident, somewhat confident, or not at all confident?

Low health literacy is defined here as those respondents who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 195]

Notes:
- Reflects respondents age 50+.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- Respondents with low health literacy are those who "seldom/never" find written or spoken health information easy to understand, and/or who "always/nearly always" need help reading health information, and/or who are "not at all confident" in filling out health forms.

Primary Care Services

About Primary Care

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

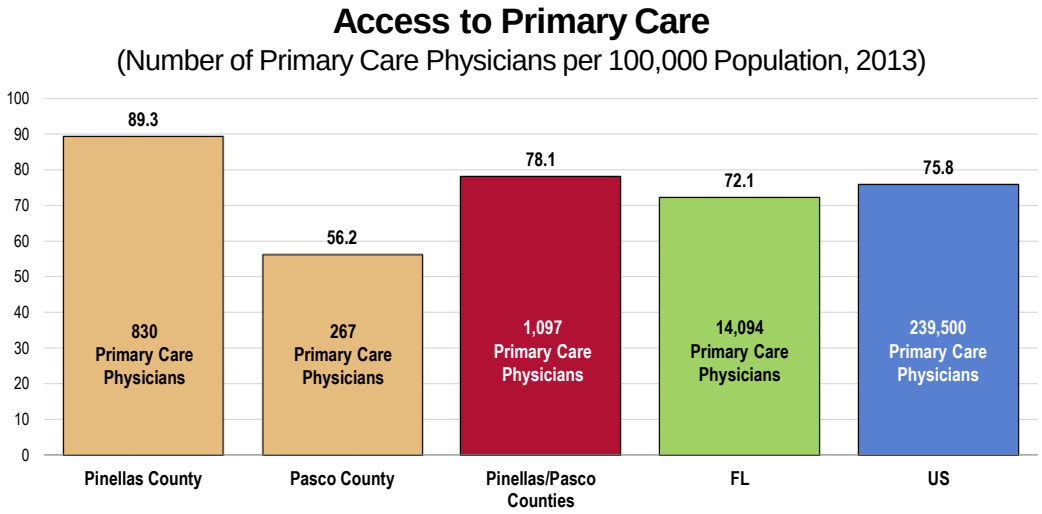
- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: **prevent** illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or **detect** a disease at an earlier, and often more treatable, stage (secondary prevention).

- Healthy People 2020 (www.healthypeople.gov)

Access to Primary Care

This indicator is relevant because a shortage of health professionals contributes to access and health status issues.



Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Retrieved August 2016 from Community Commons at http://www.chna.org.

Notes:
- This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Specific Source of Ongoing Care

Having a specific source of ongoing care includes having a doctor's office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of "patient-centered medical homes" (PCMH).

"Is there a particular place that you usually go to if you are sick or need advice about your health?"

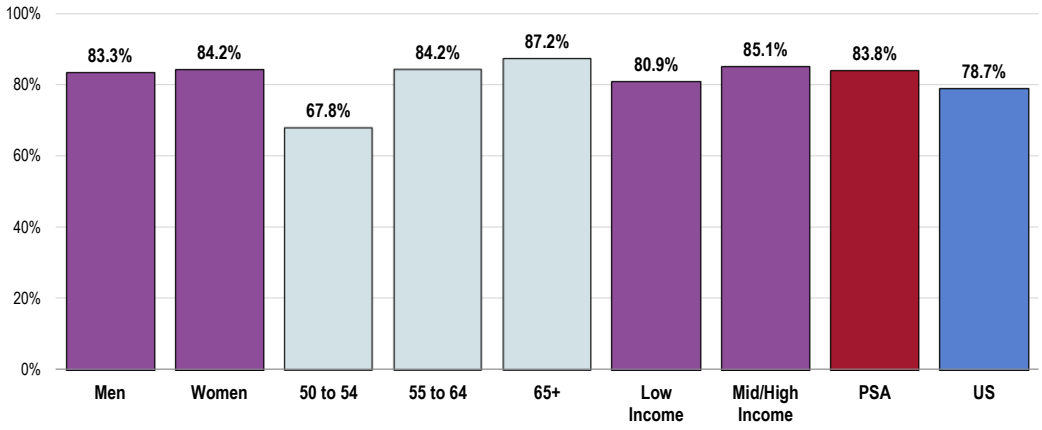
"What kind of place is it: a medical clinic, an urgent care center/walk-in clinic, a doctor's office, a hospital emergency room, military or other VA healthcare, or some other place?"

The following chart illustrates the proportion of the Primary Service Area population age 50+ with a specific source of ongoing medical care. Note that a hospital emergency room is not considered a specific source of ongoing care in this instance.

Have a Specific Source of Ongoing Medical Care

(Primary Service Area Adults Age 50+, 2016)

Healthy People 2020 Target = 95.0% or Higher

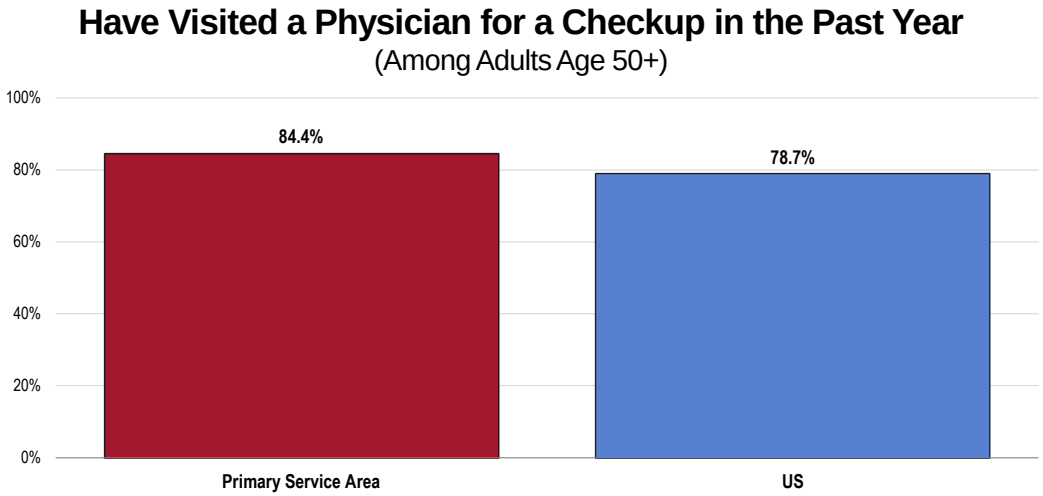


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 191-193]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective AHS-5.1]

Notes:
- Reflects respondents age 50+.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Utilization of Primary Care Services

"A routine checkup is a general physical exam, not an exam for a specific injury, illness or condition. About how long has it been since you last visited a doctor for a routine checkup?"

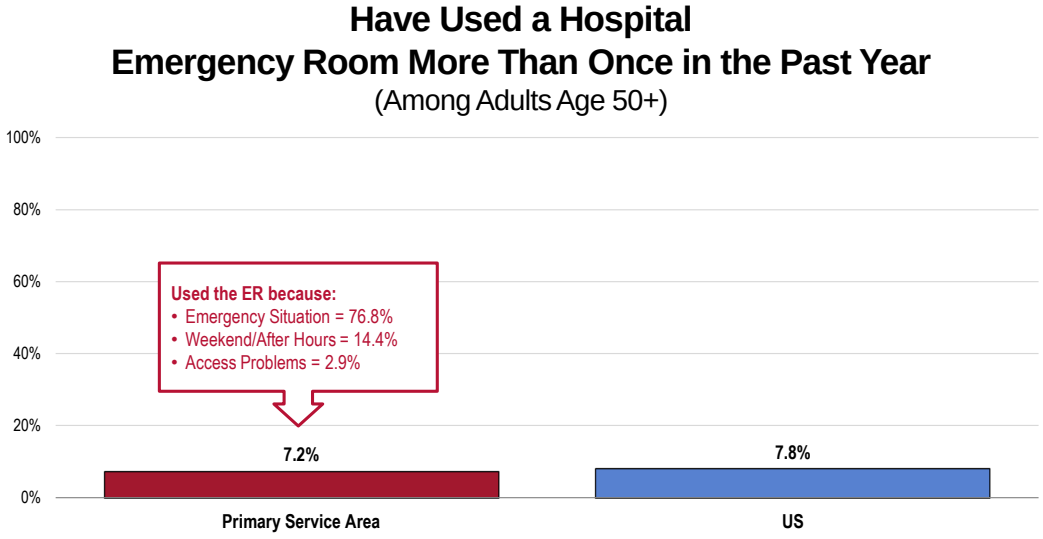


Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Reflects respondents age 50+.

Emergency Room Utilization

"In the past 12 months, how many times have you gone to a hospital emergency room about your own health? This includes ER visits that resulted in a hospital admission." (Responses below reflect the percentage with two or more visits in the past year.)

"What is the main reason you used the emergency room instead of going to a doctor's office or clinic?"



Sources: ● 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 22-23]
● 2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: ● Reflects respondents age 50+.

Oral Health

About Oral Health

Oral health is essential to overall health. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include: **tobacco use; excessive alcohol use;** and **poor dietary choices**.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person's ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Barriers that can limit a person's use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures.

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.

- Healthy People 2020 (www.healthypeople.gov)

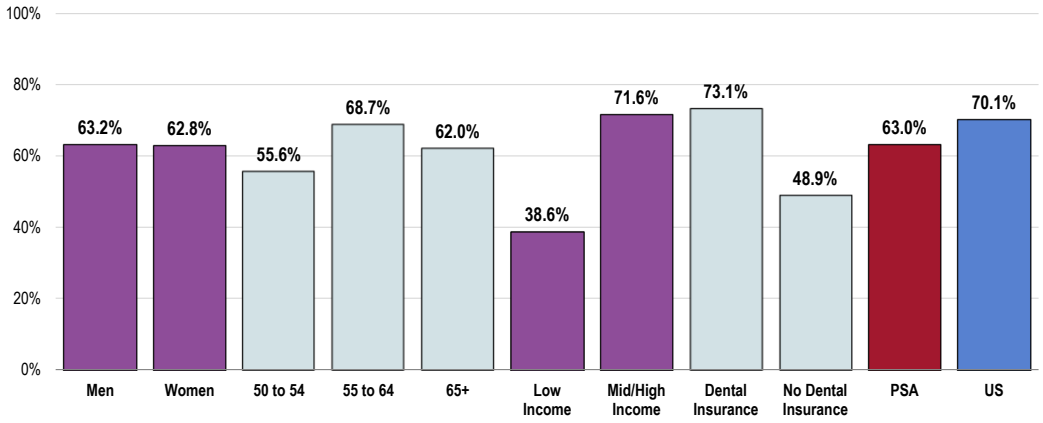
Dental Care

"About how long has it been since you last visited a dentist or a dental clinic for any reason?"

Have Visited a Dentist or Dental Clinic Within the Past Year

(Primary Service Area Adults Age 50+, 2016)

Healthy People 2020 Target = 49.0% or Higher



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
- US Department of Health and Human Services. Healthy People 2020. December 2010. http://www.healthypeople.gov [Objective OH-7]

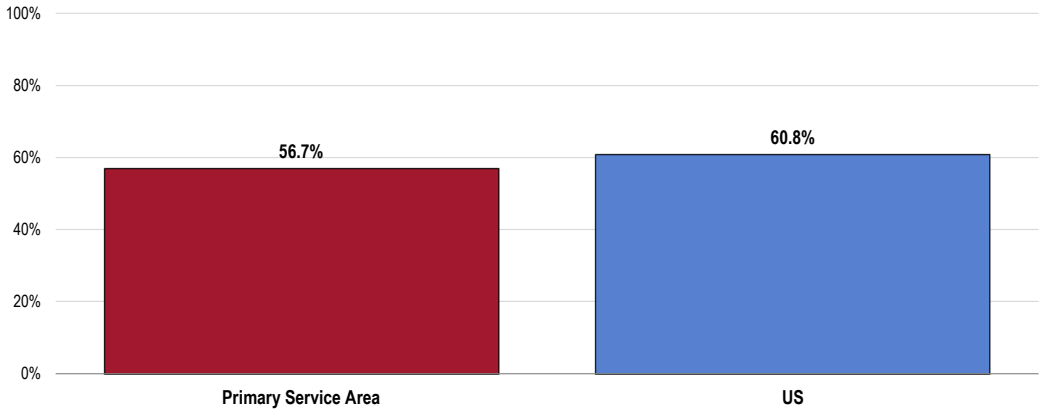
Notes:
- Reflects respondents age 50+.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Dental Insurance

"Do you currently have any health insurance coverage that pays for at least part of your dental care?"

Have Insurance Coverage That Pays All or Part of Dental Care Costs

(Among Adults Age 50+)

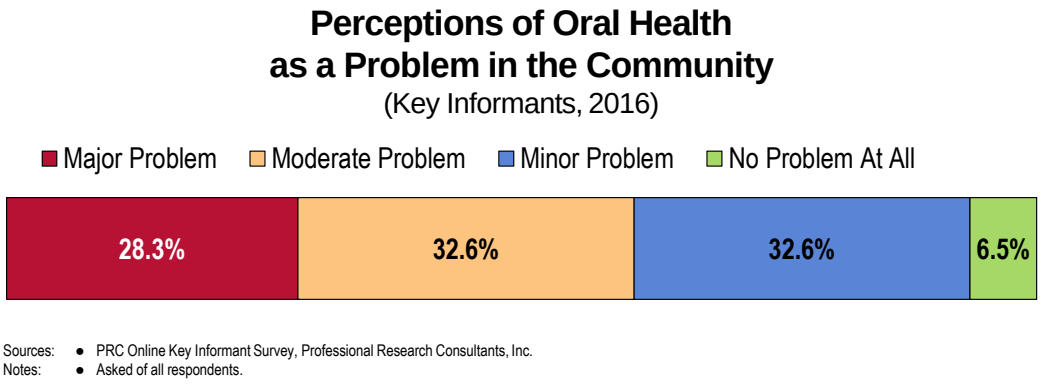


Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents age 50+.

Key Informant Input: Oral Health

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



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

Top Concerns

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

Affordable Care/Services

Community members without insurance or the means to pay for dental services are left with very limited options. - Other Health Provider

Dental Care is expensive. There are few options for the poor to seek dental treatment. Once extractions are taken care of, then what? They can't afford dentures. Not only dental care but affordable dentures as well. Not having a nice smile makes a person feel less confident. Sometimes they're not employable due to their teeth. It is indeed sad. Our Veterans do not have dental coverage unless they are disabled. - Other Health Provider

There is inadequate access to dental care for those who cannot afford it. It is a major problem not only for oral health, but for overall health. - Other Health Provider

Lack of opportunities for those who are uninsured. - Community Leader

Access to dentists for low income is limited. Medicaid is limited. Need to expand help for the poor. - Community Leader

There are few available resources for the poor to obtain quality dental care. - Social Services Provider

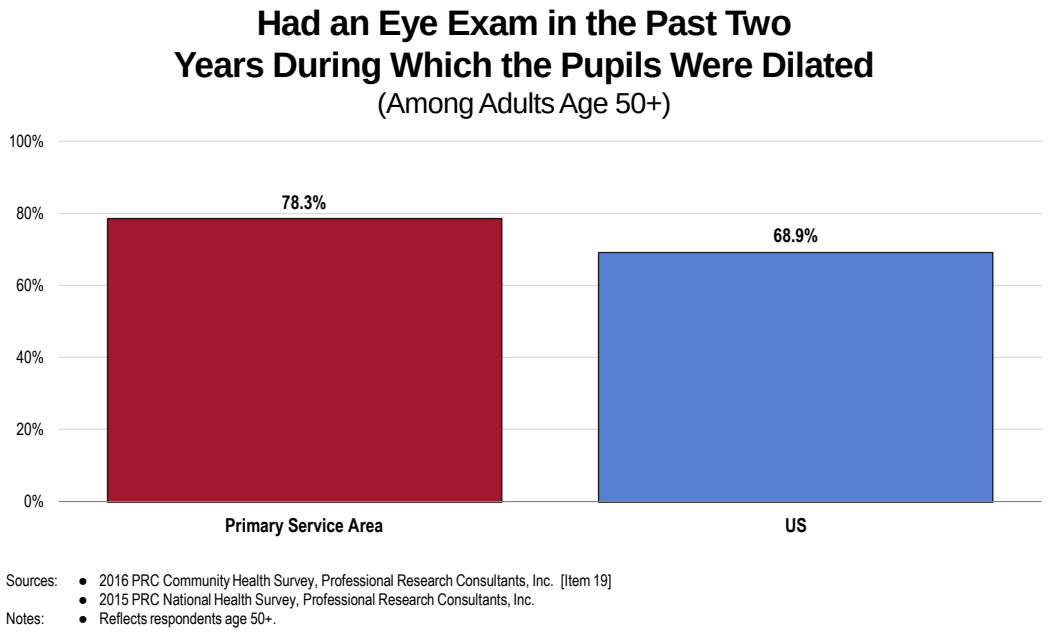
Limited resource for seniors and low income families. - Other Health Provider

Very few Medicaid dentists. Almost no resources for the uninsured. - Social Services Provider

Vision Care

"When was the last time you had an eye exam in which the pupils were dilated? This would have made you temporarily sensitive to bright light." (Responses in the following chart represent those with an eye exam within the past 2 years.)

See also *Vision & Hearing* in the Death, Disease & Chronic Conditions section of this report.



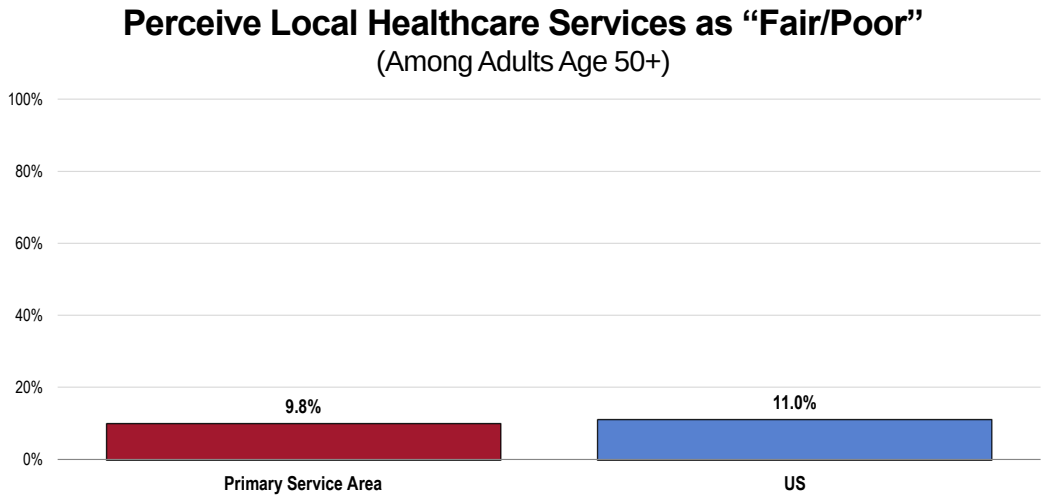
Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 19]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents age 50+.

Local Resources

Perceptions of Local Healthcare Services

"How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair or poor?" (Combined "fair/poor" responses are outlined in the following chart.)



Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents age 50+.

Key Informants' Perceptions of Resources Available to Address the Significant Health Needs

The following represents potential measures and resources (such as programs, organizations, and facilities in the community) noted by key informants as available to address the significant health needs identified in this report. This list reflects only input from participants in the Online Key Informant Survey and therefore is not to be considered to be exhaustive or necessarily an all-inclusive list of available resources. This section only outlines those resources mentioned in conducting the Online Key Informant Survey as part of preparing this Community Health Needs Assessment.

Access to Healthcare Services

Arc of Tampa Bay
Area Agency on Aging
Clearwater Free Clinic
Community Dental Clinic
Community Health Centers
Empath Health
Homeless Empowerment Project
Mobile Health Units
Pinellas County Health Department

Arthritis, Osteoporosis & Chronic Back Conditions

Doctor's Office
Hospitals
Pain Clinics
Suncoast Internal Medicine Consultants

Cancer

American Cancer Society
BayCare Health System
Cancer Patient Support Services
Dermatology Clinics
Doctor's Office
Empath Health
Florida Cancer Specialists
Health Department
Hospice
Hospitals
MD Anderson
Melanoma Mondays
Moffitt
Morton Plant Hospital
Morton Plant Mease Healthcare
Premiere
St. Anthony's Hospital

Chronic Kidney Disease

BayCare Alliant Hospital
Comprehensive Bedside
Davita
Fresenius
Hospitals
Kindred

Dementias, Including Alzheimer's Disease

211
ACLF
Adult Day Care
Alzheimer's Association
Alzheimer's Care Units
Arden Courts
Area Agency on Aging
Assisted Living Facilities
Assisted Living Memory Units
Brookdale
Byrd Center
Cares of Pasco
Doctor's Office
Easy Living/Aging Wisely
Elder Attorneys
Family/Friends
Gulf Coast Jewish Family Services
Horizon Bay
Hospice
Hospitals
Inn by the Pond
Largo Health and Rehab
Long-Term Care Centers
Menorah Manor
Morton Plant Hospital
National Alzheimer's Association
Neighborly Care Network
Nursing Homes
Online Resources

Powell Clinic
Respite Care
St. Anthony's Hospital
Support Groups
USF Alzheimer's Research

Diabetes

BayCare Health System
BayCare Turley Clinic
Clearwater Free Clinic
County
Diabetic Education
Doctor's Office
Faith Community Nursing Initiative
Free Clinic
HCA
Hospitals
Morton Plant North Bay Hospital
Online Resources
Publix
St. Anthony's Hospital
St. Petersburg Free Clinic
University of Florida Extension Services
Wellness Centers
YMCA

Hearing & Vision

Audiology Department
Hearing Center
Lighthouse
Morton Plant
The Lions
Veterans Affairs

Heart Disease & Stroke

American Heart Association
BayCare Health System
Diabetes Association
Doctor's Office
HCA
Home Health Care
Hospitals
Media
Morton Plant Hospital
Morton Plant North Bay Hospital
Nutrition Services
Online Resources
Premiere
RMCBP

HIV/AIDS

Hospitals
Pinellas County Health Department

Immunization & Infectious Diseases

CDC

Injury & Violence

Domestic Violence Shelters
Law Enforcement
Neighborhood Projects
Pinellas Hope
Project FAST
YMCA

Mental Health

Adler
Area Agency on Aging
Baker Act Medical Center of Trinity
BayCare Health System
Boley Centers
Clearwater Free Clinic
Community Mental Health Centers
Directions for Living
Doctor's Office
Fairwinds Treatment Center
Jewish Family Center
Largo Medical Center
Morton Plant Hospital
Morton Plant Mease Healthcare
NAMI
Nursing Homes
PEMHS
St. Anthony's Hospital
Suncoast Center
The Harbors
Windmoor

Nutrition, Physical Activity & Weight

American Heart Association
BayCare Health System
Doctor's Office
Jenny Craig
Morton Plant Hospital
Morton Plant Mease Healthcare
Nutra Systems
Online Resources
Parks and Recreation
Pinellas County Health Department
School System

St. Petersburg Free Clinic
University of Florida Extension Services
Weight Watchers
YMCA

Oral Health

Clearwater Free Clinic
Community Health Centers
Doctor's Office
Good Samaritan Clinic of Pasco
Health Department
Homeless Empowerment Project
PHSC
Pinellas County Health Department
Smile Faith Foundation
St. Petersburg Free Clinic

Respiratory Diseases

CHF Clinic
COPD Education
Doctor's Office
Hospitals
Sleep Study Department
Wellness Centers

Sexually Transmitted Diseases

Community Clinic
County
HIV/AIDS Case Management
Hospitals
Law Enforcement

Substance Abuse

AA/NA
BayCare Health System
Fairwinds Treatment Center
Homeless Empowerment Project
Hospitals
Morton Plant Hospital
Operation PAR
Private Facilities
Support Groups
Turning Point
Westcare
Windmoor

Tobacco Use

Community Resources
Doctor's Office
Gulfcoast AHEC
Health Department
Hospitals
Media
Medications
Patch
Public Health Awareness
Smoke-Free Work Places
Smoking Cessation Programs
State of Florida

Community Characteristics

A variety of existing population data for the region's counties was consulted. Because the BayCare Alliant Hospital primary service area is predominantly within Pinellas and Pasco counties, the following data outline population characteristics for the two-county area derived from census data.

This section also highlights areas within the community identified as "high-need."

Professional Research Consultants, Inc.

Population Characteristics

Land Area, Population Size & Density

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density.

Total Population
(Estimated Population, 2010-14)

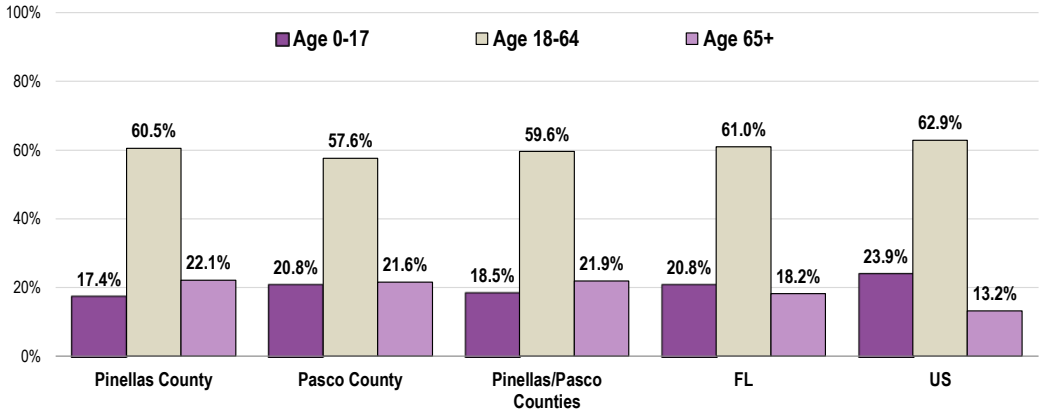
	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
Pinellas County	925,030	273.79	3,378.61
Pasco County	472,745	747.72	632.25
Pinellas/Pasco Counties	1,397,775	1,021.51	1,368.34
Florida	19,361,792	53,630.83	361.02
United States	314,107,083	3,531,932.26	88.93

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved August 2016 from Community Commons at http://www.chna.org.

Age

It is important to understand the age distribution of the population as different age groups have unique health needs which should be considered separately from others along the age spectrum.

Total Population by Age Groups, Percent
(2010-14)



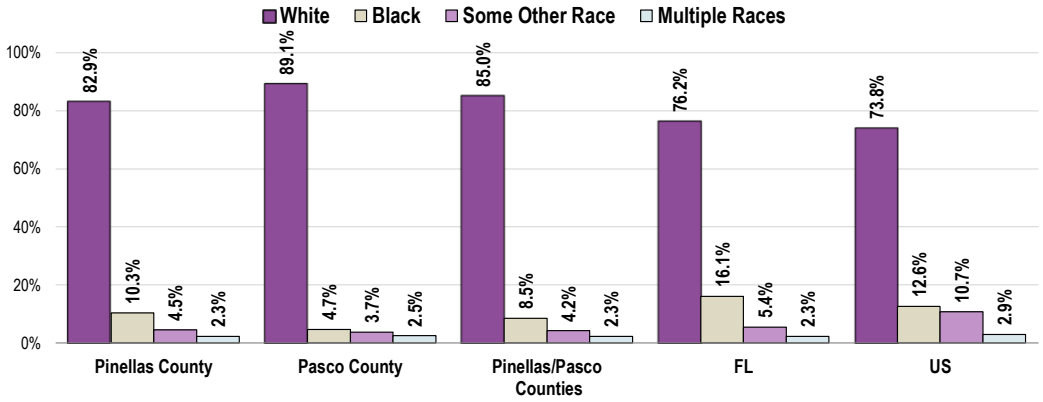
Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved August 2016 from Community Commons at http://www.chna.org.

Race & Ethnicity

The following charts illustrate the racial and ethnic makeup of our community. Note that ethnicity (Hispanic or Latino) can be of any race.

Total Population by Race Alone, Percent

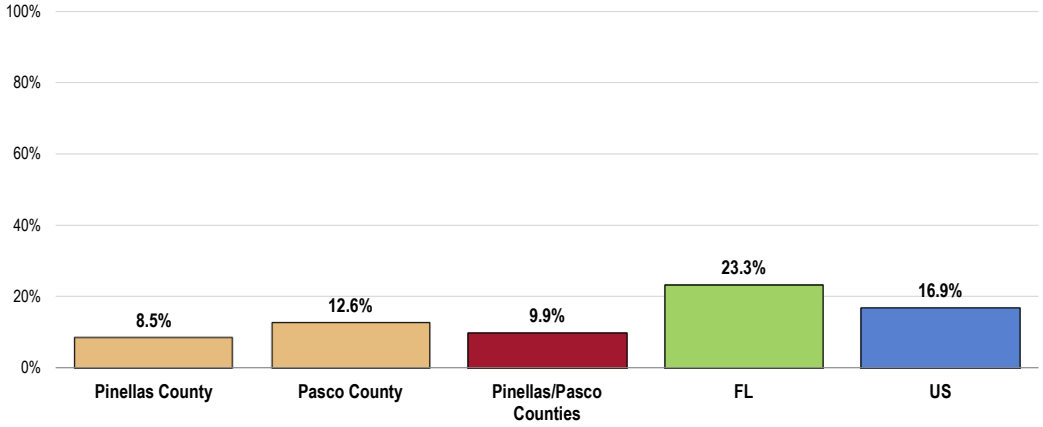
(2010-14)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved August 2016 from Community Commons at http://www.chna.org.

Hispanic Population

(2010-14)



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved August 2016 from Community Commons at http://www.chna.org.

Notes:
- Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

Social Determinants of Health

About Social Determinants

Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.

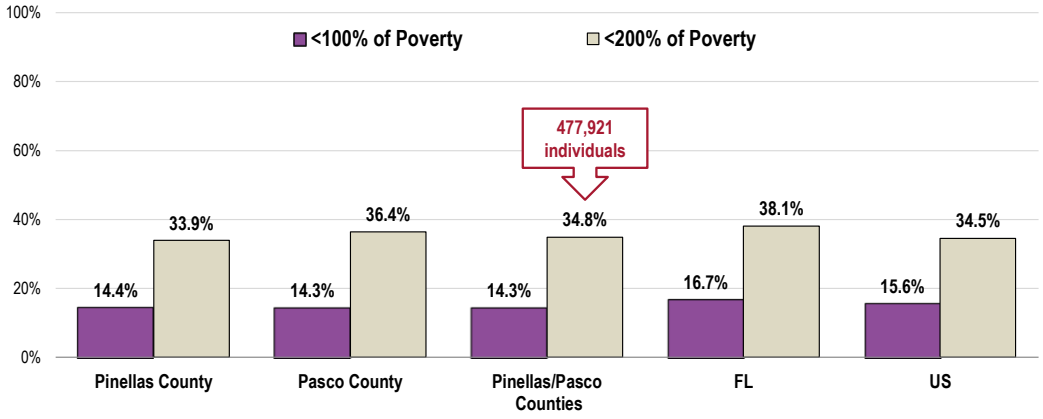
- Healthy People 2020 (www.healthypeople.gov)

Poverty

The following chart outlines the proportion of our population below the federal poverty threshold, as well as below 200% of the federal poverty level, in comparison to state and national proportions.

Population in Poverty

(Populations Living Below 100% and Below 200% of the Poverty Level; 2010-14)

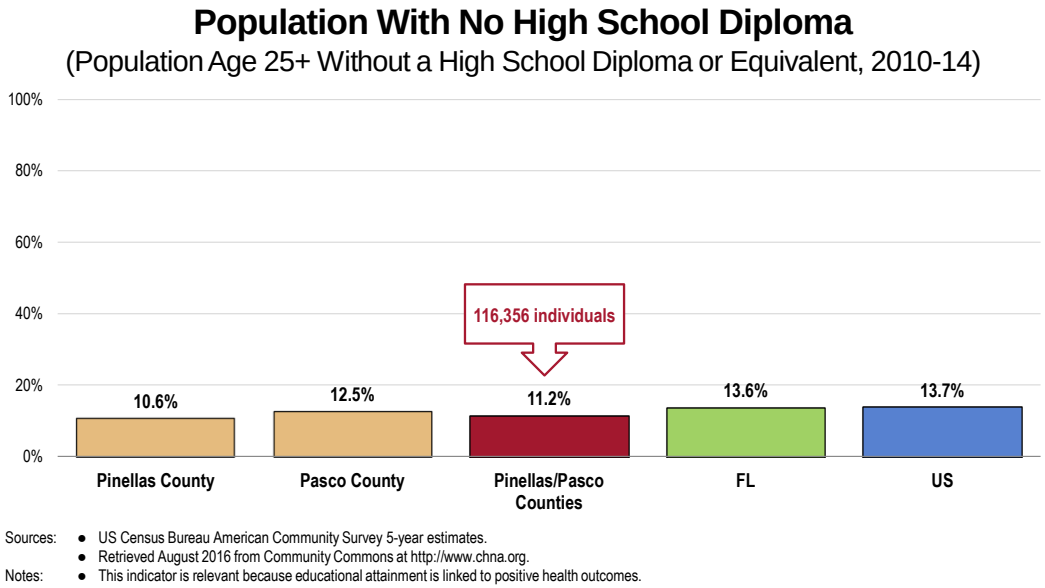


Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved August 2016 from Community Commons at http://www.chna.org.

Notes:
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Education

Education levels are reflected in the proportion of our population without a high school diploma.



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Retrieved August 2016 from Community Commons at http://www.chna.org.

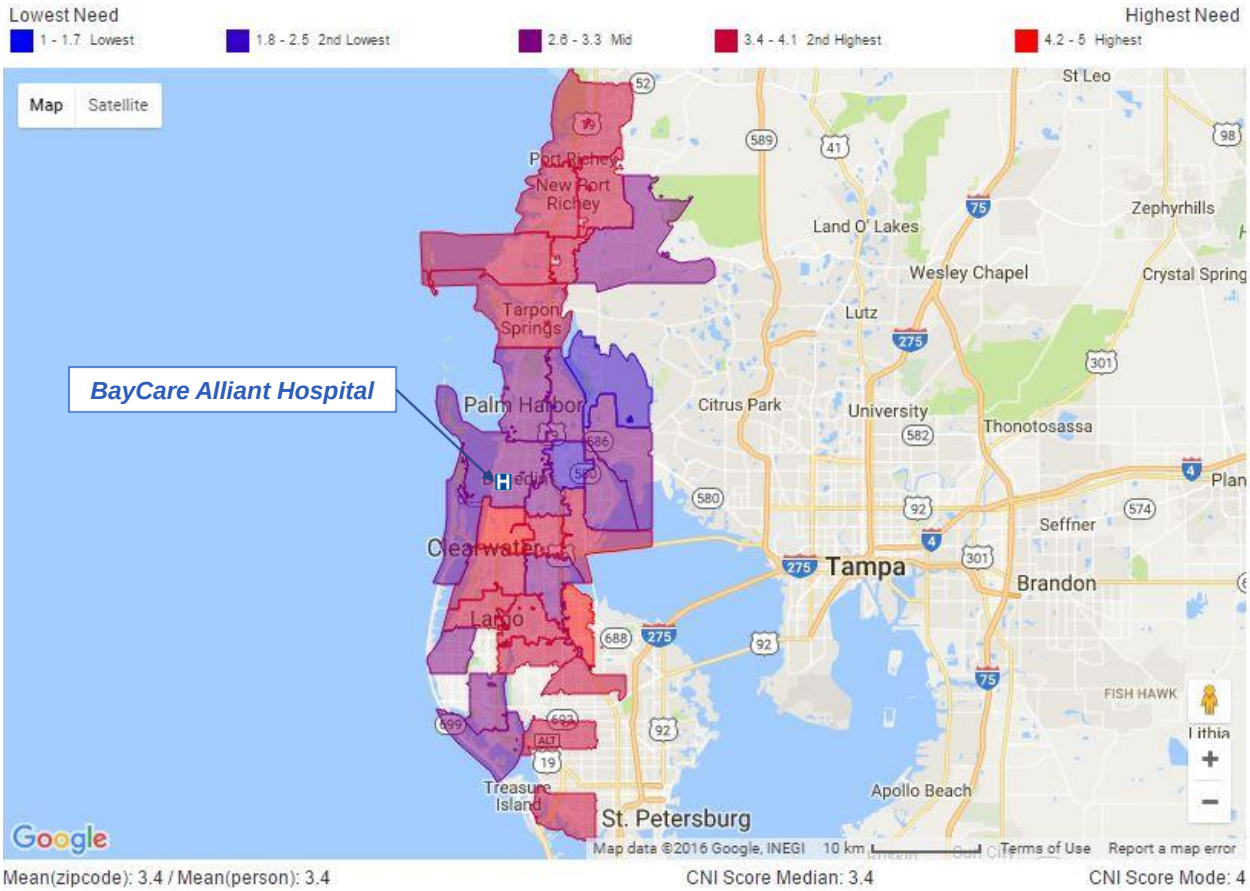
Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.

High-Need Communities

ZIP Codes Identified as High Need

High-need areas in the BayCare Alliant Hospital Service Area were identified using the Community Health Needs Index (CNI). The CNI score was developed by Dignity Health and Truven Health Analytics. This index aggregates five socioeconomic indicators that contribute to health disparity among the total population: income, culture, education, insurance, and housing. Each ZIP Code is assigned a score of 1 (low need) to 5 (high need) for each of the five indicators which are averaged to yield the CNI score for that area. The scores are then compared to the index, which is based on national need, and separated into groups ranging from highest need to lowest need.

Research indicates a strong correlation between high CNI scores and hospital admission rates. Residents who live in areas with the highest need were twice as likely to experience preventable hospitalization for manageable conditions (i.e. ear infections, pneumonia...).



Mean(zipcode): 3.4 / Mean(person): 3.4 CNI Score Median: 3.4 CNI Score Mode: 4

ZIP Code–specific CNI scores are outlined in the following table (note that none of the BayCare Alliant Hospital Service Area ZIP Codes falls in the "lowest" need category).

Community Need Index (CNI) Scores for BayCare Alliant Service Area ZIP Codes

Zip Code	CNI Score	Population	City	County	State
33755	4.6	26558	Clearwater	Pinellas	Florida
33760	4.2	19323	Clearwater	Pinellas	Florida
33709	4.0	26719	Saint Petersburg	Pinellas	Florida
33756	4.0	32244	Clearwater	Pinellas	Florida
33771	4.0	32120	Largo	Pinellas	Florida
34668	4.0	41543	Port Richey	Pasco	Florida
34690	4.0	12898	Holiday	Pasco	Florida
34691	4.0	21221	Holiday	Pasco	Florida
33759	3.8	18420	Clearwater	Pinellas	Florida
33765	3.8	13427	Clearwater	Pinellas	Florida
33770	3.8	25318	Largo	Pinellas	Florida
34652	3.8	23321	New Port Richey	Pasco	Florida
34653	3.6	29785	New Port Richey	Pasco	Florida
33707	3.4	25158	Saint Petersburg	Pinellas	Florida
33773	3.4	17294	Largo	Pinellas	Florida
33782	3.4	21280	Pinellas Park	Pinellas	Florida
34689	3.4	27009	Tarpon Springs	Pinellas	Florida
33708	3.2	15736	Saint Petersburg	Pinellas	Florida
34677	3.2	21886	Oldsmar	Pinellas	Florida
33763	3.0	18730	Clearwater	Pinellas	Florida
33764	3.0	26267	Clearwater	Pinellas	Florida
34698	3.0	37666	Dunedin	Pinellas	Florida
33767	2.8	7952	Clearwater Beach	Pinellas	Florida
33774	2.8	18160	Largo	Pinellas	Florida
34684	2.8	26290	Palm Harbor	Pinellas	Florida
33772	2.6	23257	Seminole	Pinellas	Florida
34655	2.6	40626	New Port Richey	Pasco	Florida
34683	2.6	32029	Palm Harbor	Pinellas	Florida
34695	2.6	17776	Safety Harbor	Pinellas	Florida
33761	2.4	18058	Clearwater	Pinellas	Florida
34685	2.2	18911	Palm Harbor	Pinellas	Florida

4.2 - 5 Highest Need **3.4 - 4.1** 2nd Highest **2.6 - 3.3** Mid **1.8 - 2.5** 2nd Lowest **1 - 1.7** Lowest

Appendices

Professional Research Consultants, Inc.

Appendix I: Evaluation of Past Work

BayCare Alliant Hospital

Evaluation of Cycle 1 (2014-2016) Community Health Needs Assessment

Prepared in July 2016

BayCare Alliant Hospital (BAH), a 48-bed long-term acute care hospital, accepts patients who are in need of treatment for diagnoses related to cardiac care, complex medical/multi-system failures, infectious disease issues, rehabilitation needs, respiratory care, ventilator weaning, and wound care. Based on its most recent community health needs assessment (CHNA), BayCare Alliant Hospital is committed to addressing the following significant community needs:

1) Improving access to necessary medical care
2) Communication and education

KEY HIGHLIGHTS / ACCOMPLISHMENTS:

Progress was made to address each of the key health needs as prioritized within the 2013 Community Health Needs Assessment. Efforts were specifically dedicated to the following action step categories during Cycle-1 (2014-2016) with highlighted activities as noted below:

Increase and develop new services to improve access to necessary medical care

- BAH invested in and constructed a 6-bed ICU which began accepting patients in January 2016. The hospital's leadership recognized that there was a community need for increased access to high-quality care for chronically critically ill patients. The new ICU has enabled the hospital to increase access by admitting a new pool of patients in need of services provided by an ICU. In particular, the ICU has increased access for those residing in acute care hospital ICUs and for ventilator patients.
- Through the support of BayCare Health System, BAH has additionally invested in capabilities which will allow it to launch unbilled e-ICU services in the 4th quarter of 2016. E-ICU services will further increase access by allowing the hospital to admit patients needing the highest levels of care and monitoring. The e-ICU will provide 24-hour monitoring, improved clinician response time, and numerous other health benefits. Patients will receive no additional charge for these services.
- The hospital developed the Healing Touch Program in 2015. This is an unbilled therapeutic service provided by certified clinicians that allows hospital patients to calm anxieties and increase relaxation levels. The program additionally assists with pain mitigation to supplement the effects of pharmaceuticals.
- The Restorative Care Program was implemented in 2015. The Restorative Care Program is an unbilled service provided by Patient Care Technicians trained in basic physical, occupational, and speech therapy techniques. The program increases the one-on-one time patients receive from clinicians and improves the patient experience. Team Members functioning within the program are in addition to the hospital's nursing, physical, occupational, and speech therapists.

- In 2015, the hospital began conducting weekly interdisciplinary physician rounds requiring attendance from the physician and interdisciplinary team at the same time and day each week. These rounds are in addition to the customary physician rounds and allow patients and families much more time to speak with the physician and entire disciplinary team (pharmacy, infection control, quality, dietician, case management, social services, and others).
- A Skilled Nursing Facility (SNF) Collaborative was formed between the hospital and a group of high-quality SNFs. The collaborative established relationships with SNFs who agreed to provide the capabilities to accept patients of higher acuity versus what is customarily provided at SNFs. This has helped to increase access at both BAH (due to new discharge options available) and the group of SNFs.
- Numerous capital investments have been made in addition to the 6-bed ICU with the goal of increasing access and care for certain patient populations. For example, funds have been expended for bariatric beds, bariatric chairs, and a vein illuminator to increase access and care for the bariatric population.

Increase utilization of charitable funds by community members in need

- Numerous BAH patients lack the coverage and funds to secure adequate dialysis services upon discharge from the facility. The hospital has endeavored to assist these patients to the extent possible by assisting with these costs. The hospital is expecting to increase its FY 2014-2016 charitable care costs for post-discharge dialysis services by 32% versus FY 2011-2013. This program has additionally increased access to and choice of nursing homes for these patients.
- The hospital has increased the variety of uses of its charitable funds. For example, during FY 2014-2016 in order to facilitate a safe discharge the hospital devoted charitable funds to patient rent, utilities, transportation, pharmaceuticals, sponsorships, and other charitable causes.

Develop a formal fundraising strategy

- A formal fundraising policy and procedure was established which included:
  - A formal explanation of the fundraising strategy (post discharge treatment, nutritional support, durable equipment, outpatient services, transportation, pharmaceuticals, and other services).
  - Guidelines for utilization of funds (patient income, assets, and other determinants).
  - A formal application and the establishment of a review committee for disbursements.
  - A description of potential sources of donations and strategy for procurement.
- The historical number of patients and resources committed by the Charity Fund were determined and reviewed.
- An annual goal and three-year fundraising goal was established. Annual fundraising goals were determined to be 10 percent of the beginning year balance.
- New fundraising sources were established. The hospital was successful in obtaining funds from these sources which included physicians and vendors.
- Fundraising tasks were assigned to various team members (Chairperson, Treasurer, Secretary,

and others) and departments including admissions, marketing, human resources and social services.

- Progress towards the annual goal and 3 year goal was examined on a quarterly basis.

Increase awareness of the availability of the BAH Charity Fund

- The community was made aware of the availability of the Charity Fund through various mechanisms including:
  - An annual giving campaign.
  - Communications to all physicians on staff, Board of Directors, vendors, health system team members, and numerous other parties.
  - Communication through participation in numerous community events and through various sponsorships.
  - Communication by the Admissions department and Social Services to potential candidates.
  - New materials, mailings, and opportunities for on-line giving.
  - Quarterly Shining Star receptions held at the hospital where success stories are invited to return to the facility celebrate their achievements.

Develop outreach plan to increase communication and awareness

- In 2014, the hospital formally defined what information it would like to communicate, the goals for outreach activities, and the amount of outreach and education provided annually (date, type of event, audience, estimated attendance, purpose and accomplishment).
- The hospital embarked on an aggressive one year campaign at the beginning of 2015 to increase communication and awareness about the services provided at a long-term acute care hospital. In particular, the hospital created awareness about its enhanced ability to accept chronically critically ill patients upon completion of its new 6-bed ICU. During the campaign, hospital leadership and the marketing department traveled to the majority of Tampa Bay area hospitals and met with social service departments, case management departments, medical groups, and numerous other key areas.
- New marketing materials were created related to chronically critically ill patients and the 6-bed ICU. These materials were made available to the health system and community through various mechanisms.
- BAH increased its attendance at vendor fairs and community events such as the Workers Compensation Annual Conference and Chamber of Commerce awards ceremony where the hospital was voted the City's Large Business of the Year.
- The hospital provided seminars to explain the various services available at long-term acute care facilities.
- BAH increased its participation on committees and in meetings of referring hospitals and the health system in order to educate those groups on what services are available at BAH. For example, BAH participated in the Post-acute Steering Committee of the Health System and in weekly "length of stay" meetings at referring facilities.

- Marketing efforts were made in communicating new unbilled services provided at BAH including the Healing Touch Program and Restorative Care Program.
- Sponsorship levels were increased in FY 2014–2016 versus FY 2011-2013 to increase communication and awareness of the 6-bed ICU, new programs, and long-term acute care services.
- BAH is participating as both a member and member of the Board of Directors of the National Long-Term Acute Care Hospital Association (NALTH) in order to gain insights on methods to increase awareness and communication.

ITEMS NOT ADDRESSED

BayCare Alliant Hospital continues to drive and support activities to address the 2 key priority health needs of improved access and communication/education as identified in the 2013 Community Health Needs Assessment.

As referenced in the 2013 CHNA, care coordination was identified as a priority health need that was not fully addressed within the Cycle-1 CHNA Implementation Plan for BayCare Alliant Hospital. While hospital leaders are strongly interested in this issue and are interested in further evaluating the challenges with respect to care coordination, due to its small size as a 48-bed hospital BayCare Alliant does not currently have the staff, expertise, and resources to launch a substantial wide-scale effort regarding this need. The hospital did address a portion of this need through its establishment of the previously referenced Skilled Nursing Facility Collaborative. In addition, the hospital established physician rounds, inter-disciplinary rounds, and a concurrent review process to discuss barriers to discharge. Lastly, the hospital established a pre-assessment evaluation for review by the admission committee to assess appropriate level of care at the hospital based on prior care at the referring hospital.

The need for an increase in long-term chronic vent facilities was not addressed by BayCare Alliant Hospital as this community need falls significantly out of scope of the hospital's responsibilities and is not congruous with the hospital's mission. Hospital leaders remain interested in this issue and did meet to provide advice to others considering the establishment of new long-term vent facilities in the community. In addition, the hospital indirectly reduced the need for the facilities through improved ventilator weaning and outcomes at BayCare Alliant.

The need for improved information and education related to insurances was also not met. Hospital leadership is interested in this issue; however, the facility is not permitted to tell patients what insurance is "best" for them. The hospital continues to explain to potential patients what types of insurances are accepted at the hospital. The hospital also assists in obtaining estimates of remaining coverage and it refers patients to available sources of information.

LESSONS LEARNED

In applying the lessons learned from the Cycle-1 period, BayCare Alliant Hospital is committed to integrating the following improvements to the Cycle-2 (2017-2019) efforts:

- Enhance outcome measures: Ensure that the all key objectives have measureable and

quantifiable indicators to evaluate the effectiveness of the related actions.

- Establish required completion dates and responsible parties for all action steps.
- Enhance hospital-wide engagement through increased communication to all hospital departments by BayCare Alliant's leadership. Hospital leadership will ensure that all departments are engaged in the process from establishment of the implementation to plan to completion of the action steps.

COLLABORATIVE EFFORTS

BayCare Alliant Hospital is committed to engaging with community partners and partners within its health system to improve the health of the community. During the next cycle, BayCare Alliant Hospital will continue to enhance these relationships to address community health needs.

In an effort to provide oversight and direction of the 2014-2016 CHNA and implementation plan, a group of the health system's hospitals created a Community Health Needs (CHN) Board Committee. This committee, comprised of community stake holders, hospital board members and hospital leadership was instrumental in developing community partnerships as well as ensuring accountability for the implementation strategy. The CHN Committee also helped to identity opportunities for enhanced collaboration within the community. In January 2016, BayCare Health System also established a Community Benefit Council to develop, monitor, and validate BayCare's Community Benefit activity to ensure that all BayCare entities are meeting the health care needs of the community. As the smallest hospital in a large health system, BayCare Alliant Hospital is uniquely positioned to collaborate with these groups and with other BayCare hospitals to combine efforts and to adopt best practices to improve the health of the community.

COMMUNITY FEEDBACK

BayCare Alliant Hospital made the CHNA document publicly available in 2013 through the hospital and BayCare websites. The hospital did not receive any feedback related to the CHNA or 990 documents.

Appendix II: Agencies/Organizations Giving Input to Health Need Prioritization

The following agencies/organizations reviewed the assessment findings and participated in the hospital's prioritization exercise:

- BayCare Alliant
- BayCare Health System
- BayCare Rehab
- Brookdale Freedom Square & Seminole Pavilion
- Central Florida Behavioral Health Network
- City of Dunedin
- Community Health Centers of Pinellas County
- Comprehensive HealthCare of Clearwater
- East Bay Rehab
- Genesis Health Care – Sunset Point
- Largo Health & Rehab
- MJ Fashions & Gifts
- Morton Plant Hospital
- Palm Garden
- Pinellas County Human Services
- Special Needs Lawyers, PA
- Trinity Regional Rehab
- Ultimate Medical Academy