

AdventHealth Daytona Beach 2020-2022 COMMUNITY HEALTH PLAN



Memorial Health Systems, Inc, d/b/a AdventHealth Daytona Beach

Approved by the Hospital Board on: April 16, 2020

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Extending the Healing
Ministry of Christ



2020-2022 COMMUNITY HEALTH PLAN

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Acknowledgements

This community health plan was prepared by Debi McNabb, Director Community Benefit, AdventHealth Central Florida Division – North Region, with contributions from members of AdventHealth Daytona Beach Community Health Needs Assessment Committee representing health leaders in the community and AdventHealth Daytona Beach leaders.

We are especially grateful for the internal and external partners who helped guide the development of the community health plan, which will enable our teams to continue fulfilling our mission of *Extending the Healing Ministry of Christ*.

OVERVIEW

Memorial Health Systems, Inc, d/b/a AdventHealth Daytona Beach will be referred to in this document as AdventHealth Daytona Beach or the “Hospital.”

Community Health Needs Assessment Process

AdventHealth Daytona Beach in Daytona Beach, Florida conducted a community health needs assessment in 2019. The assessment identified the health-related needs of the community including low-income, minority and other underserved populations.

In order to ensure broad community input, AdventHealth Daytona Beach created a Community Health Needs Assessment Committee (CHNAC) to help guide the Hospital through the assessment process. The CHNAC included representation from the Hospital, public health experts and the broad community. This included intentional representation from low-income, minority and other underserved populations.

The CHNAC met throughout 2018-2019. The members reviewed the primary and secondary data, helped define the priority issues to be addressed by the Hospital, and helped develop the Community Health Plan (CHP) to address the priority issues.

The CHP lists targeted interventions and measurable outcomes for each priority issue noted below. It includes resources the Hospital will commit and notes any planned collaborations between the Hospital and other community organizations and hospitals.

Priority Issues to be Addressed

The priority issues to be addressed include:

1. Adult and Youth Behavioral Health
2. Cardiovascular Diseases and Diabetes
3. Barriers to Accessing Health Care Services
4. Healthy Eating and Physical Activity
5. Social and Economic Issues (Social Determinants of Health)

See Section 3 for goals, objectives and next steps for each priority selected to be addressed.

Priority Issues not to be Addressed

The priority issues that will not be addressed include:

1. The Years of Potential Aging-related issues
2. Child and Adolescent Issues
3. Communicable and Infectious Diseases
4. Crime, Domestic Violence and Child Abuse
5. Early Childhood
6. Women’s Health, Prenatal Care and Birth Outcomes

See Section 4 for an explanation of why the Hospital is not addressing these issues.

Board Approval

On April 16, 2020, the AdventHealth Daytona Beach Board approved the Community Health Plan (CHP) goals, objectives and next steps. A link to the 2020 Community Health Plan was posted on the Hospital's website prior to May 15, 2020. The Community Health Plan can be found at <https://www.adventhealth.com/community-health-needs-assessments>.

Ongoing Evaluation

AdventHealth Daytona Beach's fiscal year is January – December. Implementation of the 2020 CHP begins upon its approval by the Board. The first annual evaluation will begin from the date of implementation through the end of the calendar year. Evaluation results will be attached to the Hospital's IRS Form 990, Schedule H. The collective monitoring and reporting will ensure the plan remains relevant and effective.

For More Information

Learn more about the Community Health Needs Assessment and CHP for AdventHealth Daytona Beach at <https://www.adventhealth.com/community-health-needs-assessments>.

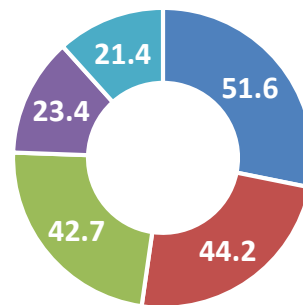
CHP PRIORITY 1

Adult & Youth Behavioral Health

Behavioral health includes mental health as well as substance use disorders and other addictive behaviors. Currently, the percentage of Volusia County adults who have had 14 or more poor mental health days in the last month is higher than that of Florida (15.7% in Volusia compared to 11.4% in Florida).¹ The percentage of adults limited by mental or emotional problems as well as the percentage of adults with depressive disorder in Volusia County is higher than the state average. Additionally, the suicide rate is increasing and higher than the Florida average.² Heavy/binge drinking has increased in Volusia County among White adults from 2010 to 2016. Alcohol-suspected traffic crash deaths increased in Volusia County at a rate that is higher than the state of Florida. If youth start using substances at an earlier age, their chances are greater of continuing to use substances and developing substance use problems later in life. The percent of student alcohol use is higher than the state average. Volusia County's rate of both opioid-involved overdose hospitalizations as well as the rate of death from opioid overdoses has increased and exceeds the Florida rate. The percent of Volusia County adults who smoke is significantly higher than the state average. Cigarette and marijuana use among Volusia County middle and high school students is higher than that of Florida.

AdventHealth Daytona Beach recognizes the important link between good mental health and good overall health. Fifty percent of all lifetime cases of mental illness begin by age 14 and 75% by age 24. Mental health disorders can disrupt school performance, harm relationships and lead to suicide (the third leading cause of death among adolescents). Barriers such as not recognizing the symptoms early on, or fear of labeling and stigma regarding mental health disorders, inhibit some adolescents and families

Survey Snapshot: Top Five Health Issues You are Most Concerned About



- #1 Addiction (alcohol or drug)
- #2 Homelessness
- #3 Mental health problems
- #4 Unemployment
- #5 Child abuse/neglect

Source: 2019 Community Health Survey

¹ 2016 Florida Behavioral Risk Factor Surveillance System
² 2016 Florida Behavioral Risk Factor Surveillance System

from seeking help. Addressing these barriers, will help overcome the challenges that can be related to mental health issues, which can improve overall health and personal well-being.

Goal	Establish a multi-agency referral and communication management system in Volusia/Flagler County to effectively connect individuals in need to behavioral health care services (see Appendix A).
Objective	Support the development of a pilot project to connect health and behavioral health systems through utilization of a referral and communication management system launched by the end of year two. At least 50 referrals will be made through the system by the end of year three.
Goal	Provide special programs for at-risk students in the Daytona Beach area.
Objective	Support a before school club with a faculty sponsor to focus on providing youth opportunities for self-development, inspire youth to grow into healthy well-balanced adults. The before school club serves 30 at risk middle school young men annually at Campbell Middle School.
Objective	Provide support to PACE Center for Girls through educational sessions provided quarterly by AdventHealth Daytona Beach team.
Goal	Increase the number of individuals who have access to Tobacco Cessation support.
Objective	Increase the number of individuals participating in free Tools to Quit and Better Breathers tobacco cessation programs through identifying partners and hosting classes in community at offsite locations for an increase by at least 30% more than the number of participants in 2019 (69).

Hospital Contributions

- Provide financial resources to support the development of a pilot multi-agency referral and communication management system in Volusia/Flagler County
- Provide financial support for targeted youth programming
- Partner with Northeast Florida Area Health Education Center (AHEC) to provide Tools to Quit programs
- Provide digital communication to promote Tools to Quit and Better Breathers Class

Community Partners

- A collaborative of community organizations—including hospitals and health care providers, county government, public schools, and behavioral health care providers—in Flagler/Volusia that will launch the referral and communication management system
- C.A.T.A.L.Y.S.T. Global Youth Initiatives
- PACE Center for Girls
- Northeast Florida Area Health Education Center (AHEC)

CHP PRIORITY 2

Cardiovascular Diseases & Diabetes

Heart disease, stroke and diabetes are three of the eight leading causes of death and account for more than 30% of deaths in Volusia County. Volusia County’s hospitalization rate for coronary heart disease, congestive heart failure and stroke are higher than that of Florida and highest among the Black populations. The death rate for coronary heart disease and heart failure in Volusia County are both higher than the state average. The death rate from diabetes has increased in Volusia County and is higher than the state average and highest among Black populations. The rate of preventable hospitalizations for adults under 65-years old from diabetes is increasing in Volusia County and is higher than the state average. There are four health risk behaviors—lack of exercise or physical activity, poor nutrition, tobacco use and drinking too much alcohol—that contribute significantly to the high risk of chronic diseases. By addressing these behaviors that contribute to the illness and early deaths related to cardiovascular disease and diabetes, increased life span and improved quality of life could be attained in Volusia County.

Leading Causes of Death		#	%
1	Heart disease	1,734	23.3
2	Cancer	1,560	21.0
3	Chronic lower respiratory disease	554	7.4
4	Stroke	457	6.1
5	Unintentional injury	377	5.1
6	Alzheimer's Disease	309	4.2
7	Diabetes	240	3.2
8	Septicemia	132	1.8

Source: Florida Health Charts

Goal Reduce the incidence of diabetes among youth.

Objective Implement a diabetes education program for 75% of third graders in identified elementary schools during the 2020-2021 school year. Provide nutritional student education program in Holly Hill.

Goal Provide CREATION Life educational sessions for area residents.

Objective 75% of CREATION Life session attendees will demonstrate an improvement in knowledge and/or attitude after completing a session. Provide sessions four times per year, for 100 participants annually.

Goal Provide free diabetes, nutrition and physical activity education and support to area residents. Develop a Center of Excellence for Diabetes by year three.

Objective | Engage 500 residents in educational sessions and support group activities annually.

Hospital Contributions

- Provide a curriculum, materials and trainers for diabetes education program
- Provide staff support to implement CREATION Life educational sessions
- Provide digital communication to promote CREATION Life program to community
- Provide digital communication to promote educational sessions and support groups
- Provide staff trainers for education session and to facilitate support groups

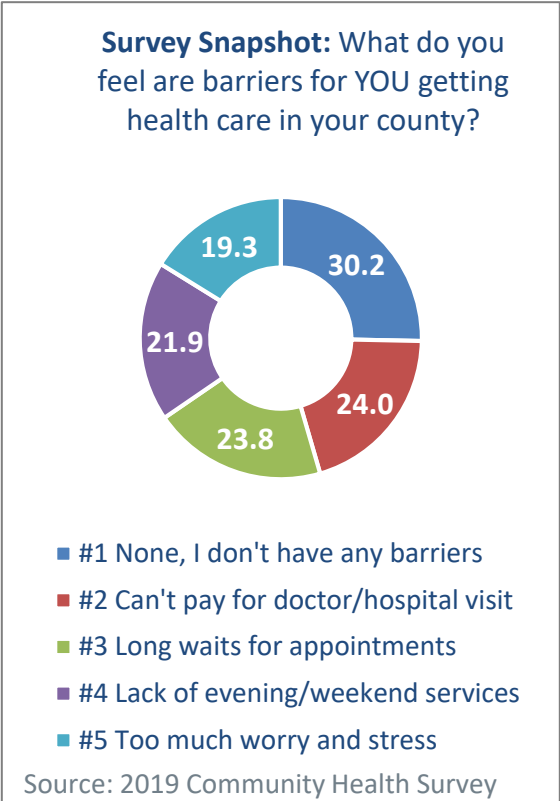
Community Partners

- Volusia County Schools
- Churches

CHP PRIORITY 3

Barriers to Health Care Services

Barriers to accessing health care services include high cost, the lack of availability and insurance coverage. This is a priority because Volusia County has a lower ratio of primary care physicians, dentists and mental health providers to the population than the state average. Additionally, the percentage of Volusia County adults with a personal doctor is lower than that of Florida. Volusia County has a higher percentage of births that are covered by Medicaid compared to the that of the state. Within this population in Volusia County, rates for Black and Hispanic births covered by Medicaid are higher than other groups. Volusia County health resources per 100,000 population are lower than the state average in the categories of physicians, internists, OB/GYNs and pediatricians. In Volusia County there are barriers to access for individuals who: live in poverty; experience homelessness; are from certain racial/ethnic groups; who live in certain areas of the county; and those without health insurance. By increasing access to health care Volusia County residents will be empowered to reach their full potential, which can positively affect their quality of life and the overall well-being of the community.



Goal	Align with community health partners to connect First Step Shelter residents (adult homeless population) with care coordination to increase access to care and improve health outcomes.
Objective	Participate in Shelter Health Services Task Force to coordinate screening and health service access.
Objective	Provide health screenings and care coordination to 100% of shelter residents through partnerships with other health partners.

Goal	Improve health and social outcomes for Community Care program participants. (see Appendix B).
Objective	Increase new admissions to the Community Care program by over 5% annually (70 in 2019).
Objective	Identify the gaps in specialty care and work to engage specialists to fill those gaps to support Community Care participants.
Objective	Provide \$3,000 in support annually to provide services to the targeted top 5% of self-pay Daytona Beach vulnerable population.
Objective	Assess the need to provide a Whole Health Coordinator to make home visits and to educate Community Care patients regarding available health care benefits, community resources and referrals. Perform screenings to reveal medical, psychosocial and spiritual needs of assigned members and connect to relevant resources and referrals. Assess the need by end of year one and provide Whole Health Coordinator year two.
Goal	Increase the number of individuals who have access to necessary health care services.
Objective	Identify the gaps in specialty care and work to engage specialists to fill those gaps to support Volunteers in Medicine.
Objective	Provide \$5000 in support annually to Volunteers in Medicine (free clinic) in Daytona Beach.
Objective	Provide 1,300 vouchers for no-cost labs and diagnostics to be redeemed annually by patients referred through the Jesus Clinic and Volunteers in Medicine Clinic to increase access to primary care for uninsured at-risk individuals. (In 2019 1,252 vouchers were provided.)

Hospital Contributions

- Community Care team to attend Shelter Health Services bi-monthly meetings at First Step Shelter
- Provide staff resources to engage specialists in the community
- Provide financial resources to support Community Care
- Provide financial resources to share the cost of Whole Health Coordinator between Volusia AdventHealth facilities
- Provide financial support and vouchers to two Volusia County Free Clinics

Community Partners

- Shelter Health Services Task Force including SMA Healthcare, Halifax Health, First Step Shelter, Department of Health in Volusia County, Catholic Charities
- Area specialty care providers
- Volunteers in Medicine (free clinic)
- Jesus Clinic (free clinic)

CHP PRIORITY 4

Healthy Eating & Physical Activity

In Volusia County the percentage of adults who are sedentary has increased since 2007 and is higher than that of the state. The percent of Volusia County adults, middle and high schoolers who are obese has increased and is higher than the state average. More than 70% of Volusia County middle and high school students lack vigorous physical activity. The availability of healthy, affordable foods contributes to a person’s diet and risk of related chronic disease. According to the

CDC, fewer than one in 10 children and adults eat the recommended daily amount of vegetables. Inactivity during childhood and adolescence increases the likelihood of being inactive as an adult. Adults who are less active are at greater risk of dying of heart disease and developing diabetes, colon

cancer and high blood pressure. Half of American youth aged 12-21 are not vigorously active on a regular basis and 14% of young people report no recent physical activity. Participation in all types of physical activity declines with both age and grade in school. Through education and increased access to healthy foods, community members are positioned to achieve and maintain a healthy weight and lifestyle, which are critical components to overall health outcomes.

Middle School and High School Students Without Sufficient Vigorous Physical Activity

Students Without Sufficient Vigorous Physical Activity	Volusia 2014	Volusia 2016
	Percent	Percent
Middle School Students	70.7	75.6
High School Students	76.7	77.5

Source: Florida Department of Health, Florida Youth Tobacco Survey (FYTS)

Goal | Increase physical activity and healthy eating among vulnerable residents.

Objective | Provide mentorship and education about healthy eating and physical activity to 75% of Boys & Girls Clubs members at two area clubs four times annually.

Objective | Work with the AdventHealth Daytona Beach Pastoral Care team to collaborate with Perrine’s Produce to provide fresh produce to children at area schools and the local Boys & Girls Club.

Objective | Provide \$4,000 in support annually to the Boys & Girls Clubs, as part of Regional strategic partnership, to provide daily fresh fruit and whole grain snacks to club members.

Goal | Implement a community education event in the Holly Hill Community.

Objective | Plan and implement a community education event(s) at Pictona (pickleball facility) in Holly Hill reaching at least 200 community residents to take place over the course of three years.

Hospital Contributions

- Provide financial support to Boys & Girls Club to provide healthy snacks
- Assign staff to implement education and facilitate physical activities at the Boys & Girls Club
- Assign staff to plan and implement a community education event

Community Partners

- Boys & Girls Clubs of Volusia/Flagler Counties
- Pictona
- Perrine's Produce

CHP PRIORITY 5

Social & Economic Issues

Healthy People 2020 highlights the importance of addressing Social Determinants of Health by including them in one of the four overarching goals for the decade. According to the National County Health Rankings, “Social and Economic Factors” account for more than 40% of what affects one’s health. As a result of this information, AdventHealth Daytona Beach has selected social and economic issues as a priority. Moreover, in Volusia County both the median household income and per capita income are lower than the state average. The percentage of Volusia County individuals living in poverty is slightly higher than that of Florida. More than 30% of Volusia County households are considered to be housing burdened, which is defined as spending more than 30% of their income on housing. Based on the average hourly wage, it is estimated that workers in eight of the top 20 industries in Volusia County are housing burdened. The number of individuals in Volusia County counted during the Point-in-Time count (annual count of individuals experience homelessness following HUD guidelines) was higher in 2019 than 2018. Volusia County’s percentage of single parent households is higher than the state average. The number of homeless students in Volusia County has been increasing since 2016. The percentage of elementary and middle school students eligible for free/reduced price lunches in Volusia County is higher than the state average. Eligibility for free/reduced price lunches is a proxy measure for low-income. The Volusia County high school graduation rate is lower than that in the state.



Goal | Increase access to income and health insurance coverage for vulnerable individuals.

Objective

Provide access to a SOAR Processor (SSI/SSDI Outreach, Access, and Recovery) through partnership to assist eligible Community Care patients with submitting successful applications for SSI/SSDI benefits (to including income and Medicaid/Medicare).

Hospital Contributions

- Provide financial resources to fund SOAR processor at Flagler Cares (position funded by three AdventHealth facilities (AdventHealth Daytona Beach, AdventHealth New Smyrna Beach, AdventHealth Fish Memorial))

Community Partners

- Flagler Cares SOAR Program

PRIORITIES THAT WILL NOT BE ADDRESSED

The Community Health Needs Assessment also identified the following priority health needs that will not be addressed. These specific issues and an explanation of why the Hospital is not addressing them, are listed below.

1. The Years of Potential Aging-related issues

- The data collected for individuals 65 and older did not demonstrate significant negative trends or negative comparison to state data. The only indicator of concern noted was suicide rate for individuals over 65, which will be addressed through the prioritization of adult behavioral health. There are numerous initiatives in place to provide services to this target population. In order to avoid duplicating efforts, our Hospital opted not to address this issue.

2. Child and Adolescent Issues

- The most significant childhood issues are addressed through other priority issues (behavioral health, access to services, healthy eating and physical activity).

3. Communicable and Infectious Diseases

- The data collected did not demonstrate significant negative trends or comparison data. Many issues noted in the indicators of concern will be addressed through the prioritization of access to health care services.

4. Crime, Domestic Violence and Child Abuse

- The data collected did not demonstrate significant negative trends or a negative comparison to state data. Many issues noted in the indicators of concern will be addressed through the prioritization of social and economic issues.

5. Early Childhood

- There are significant efforts already in place to address this target population. In order to avoid duplicating efforts, our Hospital opted not to address this issue.

6. Women's Health, Prenatal Care & Birth Outcomes

- There are significant efforts already in place to address this target population. Many of the indicators of concern will be addressed through the prioritization of access to health care services. In order to avoid duplicating efforts, our Hospital opted not to address this issue.

APPENDIX A: Referral and Communication Management System

THE APPROACH

Referrals are limited in scope. Referrals are only made

Implement a referral and communication engagement system, using a web-based technology platform that complies with all privacy, confidentiality and security protocols, to automate the referral process and facilitate interagency communication and care coordination. The framework shall be compliant with the Health Insurance Portability and Accountability Act (HIPAA), the Children's Online Privacy Protection Act (COPPA), the Family Educational Rights and Privacy Act (FERPA), and other critical national privacy requirements for Personally Identifiable Information (PII). The system will be encrypted and secured to best industry standards, allowing for secure submission and communication for all referrals.

PROBLEM TO ADDRESS

Service providers often connect individuals, including their own customers, to other agencies that provide services outside of their scope of services. This is most often done in two ways:

1. Customer is given information about other services and the customer is responsible for accessing those services
2. The agency completes a referral (often a paper form that is emailed or faxed to the agency) to make a referral for services

With either process, the customer is left to navigate through a complicated system in order to receive the services they need. Often their failure to connect with critical services creates a crisis situation resulting in the need for more costly interventions.

These current referral practices have many limitations:

- Referral resolution is unknown. In most cases, there is no intentional follow-up made on referrals. Organizations that make referrals don't know if individuals are able to successfully access services.
- Referrals are unidirectional and there is very little care coordination. Communication and coordination between service agencies is not common or easy. When more than one service agency is concurrently serving the same customer, all agencies may not know about each other and they rarely communicate or collaborate. Agency policies regarding confidentiality, release of information practices, and protocols for sharing client information via email are often in conflict. Communication via email or phone rarely becomes part of the customer's case record. None of the typical options for communication are real time, nor are the case records typically kept up to date in real time.
- Referral networks are incomplete and informal. The types of referrals made are limited by each person's knowledge of available services. These referrals are also often limited to the referrer's knowledge of the other agency's personnel, preferring a direct connection.
- Referrals are limited in scope. Referrals are only made for services that are identified by the customer or the service provider as a need without a formal needs' assessment or screening process prior to the referral completion.

APPENDIX B: Community Care Program

WHAT IS COMMUNITY CARE?

The Community Care Program is a free program of AdventHealth. The Community Care interdisciplinary team includes a Registered Nurse, a Licensed Clinical Social Worker, student interns at the Master's and Bachelor's level and a Medical Director. The team provides home visits at no charge, focusing on educating patients and families on preventative care and reduce barriers related to the social determinants of health. The goal is to reduce emergency room visits and hospital admissions by managing chronic disease and improving outcomes.

WHO QUALIFIES FOR COMMUNITY CARE SERVICES?

Volusia and Flagler County residents with at least 3 encounters (Emergency Room visits or admissions to the Clinical Decision or Inpatient Units) in the AdventHealth Regional System in the last year. (If only ED visits with no inpatient admissions, 5 or more ED visits in the last year in the AdventHealth Regional System)

- Patients who are uninsured or who have West Volusia Hospital Authority, or AdventHealth Care Advantage (all product lines)
- Patients who have the potential and willingness to change and learn how to live a healthier lifestyle
- Patients who are identified during the screening process as having a need that can be met by Community Care

WHAT IS THE DIFFERENCE BETWEEN HOME HEALTH AND COMMUNITY CARE?

Home Health provides skilled nursing and therapies (hands-on care) to patients in their homes. Community Care does not provide hands-on care. Community Care provides education, support and care coordination.

HOME VISIT SERVICES

- Supportive counseling related to stress, anxiety and loss issues due to chronic diseases
- Guidance regarding local community resources and assistance with referral paperwork
- Assistance with connections to medical transportation.
- Education to ensure medications are taken as prescribed
- Assistance with developing a plan that ensures medical compliance (such as making and attending follow up appointments)
- Encouragement to maintain healthy lifestyle changes through diet, exercise and improved coping skills
- Education to encourage patients to monitor home vital signs; equipment such as blood pressure cuffs and scales may be provided