AdventHealth Wauchula
Community Health Needs Assessment
Extending the Healing Ministry of Christ
Letter From Leadership

At AdventHealth, our mission of Extending the Healing Ministry of Christ goes beyond our walls. We are committed to addressing the needs of the communities we serve with a wholistic focus—one that strives to heal and restore the body, mind and spirit.

Every three years, AdventHealth hospitals complete a Community Health Needs Assessment. We collaborate with community organizations, public health experts and people like you: those who understand our communities best. This in-depth look at the overall health of the community as well as barriers to care helps us better understand each area’s unique needs, so we can address the issues that matter most.

AdventHealth is blessed to serve communities across the United States. In big cities and small towns, our promise of wholeness is constant. We believe all people deserve to feel whole, and we are committed to meeting them wherever they are on that journey and supporting them along the way.

Work of this magnitude is not possible without the incredible partnership of public health experts, community health organizations and countless community members. It is through open dialogue and constant collaboration with these key partners that AdventHealth will bring wholeness to all communities we serve.

In His Service,
Terry Shaw
President and CEO
AdventHealth
Community Asset Inventory

The next step was to create a Community Asset Inventory. This inventory was designed to help the CHNAC understand existing community efforts to address the identified issues from aggregate primary and secondary data and to prevent duplication of efforts. See Available Community Resources for more.

Selection Criteria

The Collaborative held a prioritization meeting with community organizations and community members to rank the needs based on the data.

Data

AdventHealth Wauchula in collaboration with the Collaborative collected both primary and secondary data, in partnership with Conduent Healthy Communities Institute (HCI), an independent agency specializing in the data collection and assessment process.

The primary data included community surveys and community focus groups. In addition, public data was utilized from state and national data sources. Primary and secondary data was compiled and analyzed to identify the top eight aggregate issues. To read more about the county level findings and data highlighted in the report, please visit https://hardee.floridahealth.gov/programs-and-services/community-health-planning-and-statistics/index.html.

Selection Criteria

The Collaborative held a prioritization meeting with community organizations and community members to rank the needs based on the data.

Executive Summary

Adventist Health System/Sunbelt, Inc. d/b/a AdventHealth Wauchula will be referred to in this document as AdventHealth Wauchula or “the Hospital”. AdventHealth Wauchula in Wauchula, Florida conducted a community health needs assessment from July 2022 to November 2022. The goals of the assessment were to:

- Engage public health and community stakeholders including low-income, minority and other underserved populations.
- Assess and understand the community’s health issues and needs.
- Understand the health behaviors, risk factors and social determinants that impact health.
- Identify community resources and collaborate with community partners.
- Publish the Community Health Needs Assessment.
- Use assessment findings to develop and implement a 2023–2025 Community Health Plan based on the needs prioritized in the assessment process.

The Collaborative

AdventHealth Wauchula serves the same community as two other AdventHealth hospitals, AdventHealth Lake Placid and AdventHealth Sebring. The hospitals’ shared service area covers Hardee and Highlands Counties. The hospitals partnered with The Florida Department of Health in Highlands County and in Hardee County to complete the community health needs assessment. This group, referred to as “the Collaborative”, met 13 times in 2021-2022. They reviewed the primary and secondary data and helped to identify the top needs in the community.

Community Health Needs Assessment Committee

AdventHealth Wauchula also convened a Community Health Needs Assessment Committee (CHNAC). The purpose of the CHNAC was to select the needs the Hospital would address as a result of the findings in the assessment. The CHNAC made this decision by reviewing the priority needs selected by the Collaborative, the internal Hospital resources available, the unique demographic data of the community the hospital serves, when different from the county level data, and local resources existing in the community. With this information the CHNAC was able to determine where the Hospital could most effectively support the community. The CHNAC met five times in 2021-2022. A list of CHNAC members can be found in Prioritization Process.

Selection Criteria

Each need was ranked individually using the following criteria on a scale of 1 to 3:

A. Scope and Severity: What is the magnitude of each health issue?
B. Ability to Impact: What is the likelihood for positive impact on each health issue?

Following the prioritization of needs by the community and the Collaborative, the CHNAC reviewed data specific to the community the Hospital serves and voted unanimously for the Hospital to address the same needs that had been selected. See Prioritization Process for more.

Data

AdventHealth Wauchula in collaboration with the Collaborative collected both primary and secondary data, in partnership with Conduent Healthy Communities Institute (HCI), an independent agency specializing in the data collection and assessment process.

The primary data included community surveys and community focus groups. In addition, public data was utilized from state and national data sources. Primary and secondary data was compiled and analyzed to identify the top eight aggregate issues. To read more about the county level findings and data highlighted in the report, please visit https://hardee.floridahealth.gov/programs-and-services/community-health-planning-and-statistics/index.html.

See Process, Methods and Findings for data sources.

Community Health Needs Assessment Committee

AdventHealth Wauchula also convened a Community Health Needs Assessment Committee (CHNAC). The purpose of the CHNAC was to select the needs the Hospital would address as a result of the findings in the assessment. The CHNAC made this decision by reviewing the priority needs selected by the Collaborative, the internal Hospital resources available, the unique demographic data of the community the hospital serves, when different from the county level data, and local resources existing in the community. With this information the CHNAC was able to determine where the Hospital could most effectively support the community. The CHNAC met five times in 2021-2022. A list of CHNAC members can be found in Prioritization Process.

Selection Criteria

The Collaborative held a prioritization meeting with community organizations and community members to rank the needs based on the data.

Data

AdventHealth Wauchula in collaboration with the Collaborative collected both primary and secondary data, in partnership with Conduent Healthy Communities Institute (HCI), an independent agency specializing in the data collection and assessment process.

The primary data included community surveys and community focus groups. In addition, public data was utilized from state and national data sources. Primary and secondary data was compiled and analyzed to identify the top eight aggregate issues. To read more about the county level findings and data highlighted in the report, please visit https://hardee.floridahealth.gov/programs-and-services/community-health-planning-and-statistics/index.html.

See Process, Methods and Findings for data sources.

Community Asset Inventory

The next step was to create a Community Asset Inventory. This inventory was designed to help the CHNAC understand existing community efforts to address the identified issues from aggregate primary and secondary data and to prevent duplication of efforts. See Available Community Resources for more.

Selection Criteria

The Collaborative held a prioritization meeting with community organizations and community members to rank the needs based on the data.

Data

AdventHealth Wauchula in collaboration with the Collaborative collected both primary and secondary data, in partnership with Conduent Healthy Communities Institute (HCI), an independent agency specializing in the data collection and assessment process.

The primary data included community surveys and community focus groups. In addition, public data was utilized from state and national data sources. Primary and secondary data was compiled and analyzed to identify the top eight aggregate issues. To read more about the county level findings and data highlighted in the report, please visit https://hardee.floridahealth.gov/programs-and-services/community-health-planning-and-statistics/index.html.

See Process, Methods and Findings for data sources.

Community Asset Inventory

The next step was to create a Community Asset Inventory. This inventory was designed to help the CHNAC understand existing community efforts to address the identified issues from aggregate primary and secondary data and to prevent duplication of efforts. See Available Community Resources for more.
Priority Issues to be Addressed

The priority issues to be addressed are:

1. Access to Healthy Foods
2. Access to Quality Health Care
3. Behavioral Health (Mental Health & Substance Misuse)

See Priorities Addressed for more.

Approval

On December 15, 2022, the AdventHealth Wauchula Board approved the Community Health Needs Assessment findings, priority issues and final report. A link to the 2022 Community Health Needs Assessment was posted on the Hospital’s website prior to December 31, 2022.

Next Steps

AdventHealth Wauchula will work with the Collaborative and the CHNAC to develop a measurable implementation strategy called the 2023-2025 Community Health Plan to address the priority issues. The plan will be completed and posted on the Hospital’s website prior to May 15, 2023.
COMMUNITY DESCRIPTION

Located in Hardee County, Florida, AdventHealth Wauchula defines its community as the Primary Service Area (PSA), the area in which 75-80% of its patient population lives. This includes three zip codes across mainly Hardee County and a small part of Polk County (0.3%). The Hospital has an overlapping PSA with both AdventHealth Lake Placid and AdventHealth Sebring. As the Hospitals have a large, shared service area, they often work in collaboration when addressing community needs.

According to the 2020 Census, the population in the AdventHealth Wauchula community has grown 1.4% in the last ten years to 113,160 people. Demographic and community profile data in this report are from publicly available data sources such as the US Census Bureau and the Center for Disease Control and Prevention unless indicated otherwise. Data are reported for the Hospital’s PSA, also referred to as the community, unless listed for a specific county. The Collaborative conducted the CHNA with a county-level approach, therefore county-level data are included throughout the CHNA report in addition to Hospital PSA-level data. Data are also provided to show how the community compares locally, in the state and at a national level for some indicators.

COMMUNITY PROFILE

Age and Sex

The median age in the Hospital’s community is 48.3, higher than that of state, which is 42.2, and that of the US, 38.2.

Females are the majority, representing 50.3% of the population. Senior aged women, 65 and older, are the largest demographic in the community at 17.3%. Senior aged men are the second largest demographic group at 15.3%.

Children are 19.1% of the total population in the community.

Infants, those zero to four, are 6.2% of that number. The community birth rate is 45.3 births per 1,000 women aged 15-50, which is lower than the US average of 51.9 and that of the state, 48.3. In the Hospital’s community, 31.8% of children aged 0-4 and 28.2% of children aged 5-17 live in poverty.
Race and Ethnicity

In the Hospital’s community, 60.8% of the residents are non-Hispanic White, 9.6% are non-Hispanic Black and 24.7% are Hispanic or Latino. Residents that are of Asian or Pacific Islander descent represent 1.5% of the total population, while 0.3% are Native American and 2.8% are two or more races.

Social Determinants of Health

According to the CDC, social determinants of health (SDOH) are the conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes. Social determinants of health are increasingly seen as the largest contributing factor to health inequities in communities throughout the country.

The Hospital categorized and analyzed SDOH data following the Healthy People 2030 model. This approach was chosen so, when possible, the Hospital could align its work with national efforts when addressing social determinants of health. For the purpose of the CHNA the Hospital will follow this model for reporting any related data.

Social and Community Context:

This focuses on topics such as community cohesion, civic participation, discrimination and incarceration.

Economic Stability:

This includes areas such as income, cost of living, food security and housing stability.

Education Access and Quality:

This focuses on topics such as high school graduation rates, enrolment in higher education, literacy and early childhood education and development.

Health Care Access and Quality:

This includes topics such as access to health care, access to primary care and health insurance coverage.

Neighborhood and Built Environment:

This includes areas like quality of housing, access to transportation, availability of healthy foods and neighborhood crime and violence.

The Healthy People 2030 place-based framework outlines five areas of SDOH:

- Economic Stability
- Food Insecurity and Housing Stability
- Education Access and Quality
- Health Care Access and Quality
- Neighborhood and Built Environment

- Income

According to the 2020 Current Population Survey, 7.1% of the population live below the poverty level.

- Economic Stability

The median household income in the Hospital’s community is $44,742. This is below the median for the state and that of the US. The poverty rate in the community is 17.6%, which is higher than the state and national rate.

- Food Insecurity and Housing Stability

People who are food insecure, having reduced quality and/or amount of food intake, may be at an increased risk of negative health outcomes. Studies have shown an increased risk of obesity and chronic disease in adults who are food insecure. Children who are food insecure have been found to have an increased risk of obesity and developmental problems compared to children who are not.

Feeding America estimates for 2020 showed the food insecurity rate in the Hospital’s community as 17.6%.

Increased evidence is showing a connection between stable and affordable housing and health. When households are cost burdened or severely cost burdened, they have less money to spend on food, health care and other necessities. Having less access can result in more negative health outcomes. Households are considered cost burdened if they spend more than 30% of their income on housing and severely cost burdened if they spend more than 50%.

Economic Stability

Income

The median household income in the Hospital’s community is $44,742. This is below the median for the state and that of the US. The poverty rate in the community is 17.6%, which is higher than the state and national rate.

Food Insecurity and Housing Stability

People who are food insecure, having reduced quality and/or amount of food intake, may be at an increased risk of negative health outcomes. Studies have shown an increased risk of obesity and chronic disease in adults who are food insecure. Children who are food insecure have been found to have an increased risk of obesity and developmental problems compared to children who are not.

Feeding America estimates for 2020 showed the food insecurity rate in the Hospital’s community as 17.6%.

Increased evidence is showing a connection between stable and affordable housing and health. When households are cost burdened or severely cost burdened, they have less money to spend on food, health care and other necessities. Having less access can result in more negative health outcomes. Households are considered cost burdened if they spend more than 30% of their income on housing and severely cost burdened if they spend more than 50%.
Education Access and Quality

Research shows education can be a predictor of health outcomes, as well as a path to address inequality in communities. Better education can lead to people having an increased understanding of their personal health and health needs. Higher education can also lead to better jobs, which can result in increased wages and access to health insurance.

In the Hospital’s community, there is an 83% high school graduation rate, which is lower than the state and national rate. The rate of people with a post-secondary degree is also lower in the Hospital’s community than both that of the state and the nation.

Early childhood education is uniquely important and can improve the cognitive and social development of children. This helps provide the foundation for long term academic success, as well as improved health outcomes. Research on early childhood education programs shows that long-term benefits include improved health outcomes, savings in health care costs and increased lifetime earnings.

In the Hospital’s community, 30.6% of 3-4-year-olds were enrolled in preschool. This is lower than the state (51%) rate and the national rate. There is a large percentage of children in the community who may not be receiving these early foundational learnings.

Health Care Access and Quality

In 2020, 12.4% of community members aged 18-64 were found to not have health insurance. A lack of health insurance can lead to delayed care, resulting in more serious health conditions and increased treatment costs. Although health insurance coverage levels can be a strong indicator of a person’s ability to access care, there are other potential barriers that can delay care for many people.

Accessing health care requires more than just insurance, there also needs to be available health care professionals to provide care. When more providers are available in a community, access can be easier, particularly for those experiencing transportation challenges.

Routine checkups can provide an opportunity to identify potential health issues and, when needed, develop care plans. In the Hospital’s community, 78.7% of people report visiting their doctor for routine care.

---

2. Health Insurance and Access to Care (cdc.gov)
Neighborhood and Built Environment

Increasingly, a community’s neighborhoods and built environment are being shown to impact health outcomes. If a neighborhood is considered to have “low food access”, which is defined as being more than ¼ mile from your nearest supermarket in an urban area or 10 miles in a rural area, it may make it harder for people to have a healthy diet. A very low food access area is defined as being more than 1 mile from your nearest supermarket in an urban area or 20 miles in a rural area.

A person’s diet can have a significant impact on health, so access to healthy food is important. For example, the largest contributors to cardiovascular disease are obesity and type 2 diabetes, both of which can be impacted by diet. In the Hospital’s community, 45.3% of the community lives in a low food access area, while 29.6% live in a very low food access area.

Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public transportation can be essential to accessing health care, healthy food and maintaining employment. In the community, 5.1% of households do not have an available vehicle.

Social and Community Context

People’s relationships and interactions with family, friends, co-workers and community members can have a major impact on their health and well-being. When faced with challenges outside of their control, positive relationships with others can help reduce negative impacts. People can connect through work, community clubs or others to build their own relationships and social supports. There can be challenges to building these relationships when people don’t have connections to create them or there are barriers like language between groups.

In the community, 15.1% of youth aged 16-19 were reported as disconnected, which means they were neither enrolled in school nor working at the time. Also, in the community 22.6% of seniors (age 65 and older) report living alone and 4.2% of residents report having limited English proficiency. All these factors can create barriers to feeling connected in the community.
Process, Methods and Findings

The Process
The health of people living in the same community can be very different because there are so many influencing factors. To understand and assess the most important health needs of its unique community and the people in it, input was solicited directly from the community and from individuals who represent the broad interests of the community. A real effort was made to reach out to all members of the community to obtain perspectives across age, race/ethnicity, gender, profession, household income, education level and geographic location. Publicly available data was also collected and reviewed. This data helped to inform how the community fared across health, social determinants of health, and quality of life indicators, compared to other communities in Florida and the US.

To guide the assessment process and create a wholistic and collaborative approach the Hospital partnered with AdventHealth Lake Placid and AdventHealth Sebring, two facilities which also serve the same community, and the Florida Department of Health in Hardee and Highlands Counties, where the hospitals are located. The group, known as "the Collaborative", consulted and worked with the community and those who represent the interests of medically underserved, low-income and minority community members throughout the assessment and prioritization process. The Collaborative also worked with Conduent Healthy Communities Institute (HCI), an independent agency to aid in the data collection and assessment process. To read more about the county level findings and data highlighted in the report, please visit https://hardee.floridahealth.gov/programs-and-services/community-health-planning-and-statistical/index.html.

Community Input

The Collaborative collected input directly from the community and from community stakeholders, individuals working in organizations addressing the needs and interests of the community. This was collected through a community survey and focus groups.

Community Survey
- Surveys were provided in English, Spanish and Haitian Creole to anyone in the community and accessible through weblinks and QR codes.
- Surveys were shared through targeted social media posts and with community partners including public health organizations. Partners were provided links to the survey, with the request that it be sent to listservs, electronic mailing lists, they maintained and when possible shared on their own social media channels.
- Paper surveys were given to community partners to place at their organizations with the goal of reaching those who might not have access otherwise and experience barriers to responding electronically. Responses from paper surveys were recorded using survey weblinks.
- Survey responses were tracked and monitored by ZIP code, age, gender, race and ethnicity to ensure targeted outreach for at-risk populations.

Focus Groups
- Five joint focus groups were held with community residents to gain input on health and barriers to health in the community.
- Focus groups aimed to understand the different health experiences for community stakeholders, Black/African Americans, Hispanic/Latinos, Older Adults and Parents of Children. Members or representatives of these communities were selected to participate in the focus group discussions.
Access to Quality Health Care

Many people face barriers that prevent or limit access to needed health care services, which may increase the risk of poor health outcomes and health disparities. Access to health care is the timely use of personal health services to achieve the best possible health outcomes.

Inadequate health insurance coverage is one of the largest barriers to health care access and the unequal distribution of coverage contributes to disparities in health. Out-of-pocket medical care costs may lead individuals to delay or forgo needed care (such as doctor visits, dental care and medications), and medical debt is common among both insured and uninsured individuals.

Lack of health insurance coverage may negatively affect health since uninsured adults are less likely to receive preventive services for chronic conditions such as diabetes, cancer and cardiovascular disease. Similarly, children without health insurance coverage are less likely to receive appropriate treatment for conditions like asthma or critical preventive services such as dental care, immunizations and well-child visits that track developmental milestones.

Secondary Data

To inform the assessment process, Conduent HCI collected existing health-related and demographic data about the community from publicly available sources. This included over 150 community indicators; spanning at least 24 topics in the areas of health, social determinants of health and quality of life. The most current public data for the assessment was compiled and sourced from government and public health organizations including:

- US Census Bureau
- Center for Disease Control and Prevention
- US Department of Health and Human Services
- Claritas Pop-Facts
- FLCharts

The Findings

There were eight issues found in the assessment process that rose to the top. To identify the top needs, Conduent HCI reviewed and compared the findings across all three data sets; the community survey, focus groups and the secondary data. There were eight needs which overlapped across all three data sets.

Access to Healthy Foods

Access to healthy foods was a priority found in the assessment. The availability of nutrient-rich food is important to take into consideration when considering an overall healthy lifestyle. Poor availability of nutrient-dense foods, including fruits and vegetables, can be attributed to limited financial funds for obtaining these types of foods, limited availability of locations to purchase fruits and vegetables near place of residence, lack of transportation to stores that sell these food items and the convenience, affordability and ease of access to nutrient-poor food options.

A lack of food access can also lead to food insecurity. Food insecurity is a lack of available financial resources for the purchase of food. Individuals who experience food insecurity often consume a diet that is not nutrient-rich and lacks the nutrition needed to sustain a healthy life.

Access to Quality Health Care

Many people face barriers that prevent or limit access to needed health care services, which may increase the risk of poor health outcomes and health disparities. Access to health care is the timely use of personal health services to achieve the best possible health outcomes.

Inadequate health insurance coverage is one of the largest barriers to health care access and the unequal distribution of coverage contributes to disparities in health. Out-of-pocket medical care costs may lead individuals to delay or forgo needed care (such as doctor visits, dental care and medications), and medical debt is common among both insured and uninsured individuals.

Lack of health insurance coverage may negatively affect health since uninsured adults are less likely to receive preventive services for chronic conditions such as diabetes, cancer and cardiovascular disease. Similarly, children without health insurance coverage are less likely to receive appropriate treatment for conditions like asthma or critical preventive services such as dental care, immunizations and well-child visits that track developmental milestones.

Children’s Health

Children’s health needs are unique in that both their bodies and minds are continually growing and shaping in ways that need extra care and nourishment. Health issues affecting children include food insecurity, dental care, medical care and mental health needs.
Older Adult Health

Older adults are at higher risk for chronic health problems like diabetes, osteoporosis and Alzheimer’s disease. In addition, 1 in 3 older adults fall each year and falls are a leading cause of injury for this age group. Physical activity can help older adults prevent both chronic disease and fall-related injuries. Older adults are also more likely to go to the hospital for some infectious diseases. Making sure older adults get preventive care and supportive community services can help them stay healthy.

Substance Use and Misuse

Substance use disorders can involve illicit drugs, prescription drugs, alcohol or tobacco. Opioid use disorders, which stem from the improper use of prescription drugs, have become especially problematic in recent years. Substance use disorders are linked to many health problems and overdoses can lead to emergency department visits and deaths.

Diabetes

Diabetes is a disease indicated by having high levels of uncontrolled sugar in the blood. Diabetes is the eighth leading cause of death in the United States. When diabetes goes untreated it can lead to more serious health issues such as vision loss, heart disease, stroke, nerve and kidney diseases.

Economy

A healthy economy in a community can ensure better health outcomes because a strong economy can mean more jobs, better income and greater access to health insurance coverage through employer-related benefits. Financial stress can result in poor health outcomes including physical, mental and relationship strains resulting in an overall reduced quality of life.

Mental Health and Mental Health Disorders

Mental illnesses are conditions that affect a person’s thinking, feeling, mood or behavior, such as depression, anxiety, bipolar disorder or schizophrenia. Such conditions may be occasional or long-lasting (chronic) and affect someone’s ability to relate to others and function each day. Mental health includes our emotional, psychological and social well-being. It affects how we think, feel and act. It also helps determine how we handle stress, relate to others and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.

Economy

A healthy economy in a community can ensure better health outcomes because a strong economy can mean more jobs, better income and greater access to health insurance coverage through employer-related benefits. Financial stress can result in poor health outcomes including physical, mental and relationship strains resulting in an overall reduced quality of life.

Mental Health and Mental Health Disorders

Mental illnesses are conditions that affect a person’s thinking, feeling, mood or behavior, such as depression, anxiety, bipolar disorder or schizophrenia. Such conditions may be occasional or long-lasting (chronic) and affect someone’s ability to relate to others and function each day. Mental health includes our emotional, psychological and social well-being. It affects how we think, feel and act. It also helps determine how we handle stress, relate to others and make healthy choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.
Prioritization Process

The Collaborative invited participants from numerous collaborating organizations, as well as other community partners, to narrow down the needs of the community to a list of three based on the findings from the assessment. This virtual prioritization session, on October 26, 2022, included a presentation highlighting the findings from the data and the needs that were identified. The invited participants represented a broad cross section of experts and organizational leaders with extensive knowledge of the health needs in the community. They represented the broad range of interests and needs, from public health to the economic, of underserved, low-income and minority people in the community.

Members of the Prioritization Session

Community Members
- Courtney Green, Director of Adult Education and Technical Dual Enrollment, South Florida State College
- Lenora White, Career Source Heartland
- Nancy Zachary, Director of Health, RCMA
- Maria Pearson, Director, Drug Free Hardee
- Isaac Maldonado, South Florida State College, Panther Youth Partners
- Haley Jackson, Step Up Suncoast – Parent AS teachers
- Maria Cruz, Step Up Suncoast – Parent AS teachers
- Mindy Lee, Peace River Center
- Denise Collazo, Health Center Administrator, Central Florida Healthcare
- Gregory Hall, Director of Clinical Operations, Central Florida Healthcare
- Renee Wyatt, County Commissioner, Hardee County Commissioner
- Sam Fite, Community Member, Bowling Green

Public Health Experts
- Kristin Casey, Operations Manager, DOH-Hardee
- Latoya Hinson, DOH-Hardee
- Deja Sparkman, Community Health Liaison, DOH-Hardee
- Pamela Crain, Health Educator, DOH-Highlands
- Stevie (Stefania) Sweet, Community Health Program Manager, DOH-Hardee
Following the data presentation, participants then discussed the identified needs, how the needs were impacted by the social determinants of health and the resources available to address the needs. Following discussions, the participants completed the prioritization using an online activity to rank the needs.

Each need was prioritized individually using the following criteria:

- **Scope and Severity**: How big an issue is each health issue?
  - How many people in the community are or will be impacted?
  - How does each need impact health and quality of life?
  - Has the need changed over time?

- **Ability to Impact**: Do you feel the groups taking on this work will be able to have a positive impact on each health issue?
  - Do the hospitals, health departments or community organizations have the knowledge, experience or resources to address the health need?
  - Can the need be addressed in collaboration with community partners? Are organizations already addressing the health issue?
  - Can we create clear goals to address the health need? Are those goals achievable in the next few years?

Needs were scored from 1 to 3. The higher the score, the higher a priority the participants considered it. The needs were scored as follows:

<table>
<thead>
<tr>
<th>Rank</th>
<th>Need</th>
<th>Cumulative Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Access to Quality Healthcare</td>
<td>56</td>
</tr>
<tr>
<td>2</td>
<td>Access to Healthy Foods</td>
<td>55.5</td>
</tr>
<tr>
<td>3</td>
<td>Mental Health &amp; Mental Disorders</td>
<td>54</td>
</tr>
<tr>
<td>4</td>
<td>Diabetes</td>
<td>54</td>
</tr>
<tr>
<td>5</td>
<td>Children's Health</td>
<td>53.5</td>
</tr>
<tr>
<td>6</td>
<td>Substance Use &amp; Misuse</td>
<td>51</td>
</tr>
<tr>
<td>7</td>
<td>Older Adult Health</td>
<td>49.5</td>
</tr>
<tr>
<td>8</td>
<td>Economy</td>
<td>46</td>
</tr>
</tbody>
</table>

The Collaborative supported the ranking of needs prioritized during the exercise and chose to focus on the top three; Access to Quality Health Care, Access to Healthy Foods, and Behavioral Health (Mental Health & Mental Disorders and Substance Use & Misuse). The Collaborative did choose to include some of the other interconnected needs that had been identified in the assessment in their final top three priorities.

Following the Collaborative’s selection, the Hospital convened a Community Health Needs Assessment Committee (CHNAC) to review the priorities selected by the Collaborative and to identify the needs the Hospital would select. The CHNAC reviewed the data behind the Collaborative’s priorities and the unique demographic data of the community the Hospital serves, when different from county level data. The CHNAC also considered the Hospital’s PSA-level secondary data, local community resources available, as well as the Hospital’s current resources and strategies to find ways to prioritize and address the needs most effectively.

Having reviewed the selections and the supporting data from the Collaborative, the CHNAC voted unanimously for the Hospital to address the same needs that had been selected by the Collaborative. Through a unified approach in addressing the same needs as the Collaborative, the belief is that the Hospital will have a greater impact in addressing the needs of the community.
Members serving on the CHNAC were selected to provide their expertise and knowledge regarding the unique communities served by the Hospital. These individuals were relied on to represent the interests of the populations they serve and ensure their voices were at the table.

### CHNAC Members

<table>
<thead>
<tr>
<th>Name, Title</th>
<th>Organization</th>
<th>Services Provided</th>
<th>Populations Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nancy Christensen, Vice President</td>
<td>AdventHealth Medical Group</td>
<td>Health care</td>
<td>Provides primary care and specialty medical services to the general population.</td>
</tr>
<tr>
<td>Dottie Robinson, Executive Assistant</td>
<td>AdventHealth Sebring, Lake Placid and Wauchula</td>
<td>Health care</td>
<td>Serves the general population through hospital health care and emergency department services.</td>
</tr>
<tr>
<td>Jason Durkiewicz, Chief Executive Officer</td>
<td>AdventHealth Sebring, Lake Placid and Wauchula</td>
<td>Health care</td>
<td>Serves the general population through hospital health care and emergency department services.</td>
</tr>
<tr>
<td>Randy Sakell, Former Chief Executive Officer</td>
<td>AdventHealth Sebring, Lake Placid and Wauchula</td>
<td>Health care</td>
<td>Serves the general population through hospital health care and emergency department services.</td>
</tr>
<tr>
<td>Rosalie Oliver, Vice President/Chief Financial Officer</td>
<td>AdventHealth West Florida Region</td>
<td>Health care</td>
<td>Serves the general population through hospital health care and emergency department services.</td>
</tr>
<tr>
<td>Terri Bryant, Former Director of Case Management</td>
<td>AdventHealth Sebring, Lake Placid and Wauchula</td>
<td>Health care</td>
<td>Serves the general population through hospital health care and emergency department services.</td>
</tr>
<tr>
<td>Bobbie Clark, Wellness Center Supervisor</td>
<td>AdventHealth Sebring, Lake Placid and Wauchula</td>
<td>Health care</td>
<td>Serves the general population through hospital health care and emergency department services and through wellness activities.</td>
</tr>
<tr>
<td>Ambrosho Morant, CREATION Life Community Health Specialist</td>
<td>AdventHealth Sebring, Lake Placid and Wauchula</td>
<td>Health care and health education programs</td>
<td>Serves the general population through hospital health care, emergency department services, and community health education.</td>
</tr>
<tr>
<td>Linda Lynch, Director of Pastoral Care</td>
<td>AdventHealth Sebring, Lake Placid and Wauchula</td>
<td>Health care and pastoral care</td>
<td>Serves the general population through hospital health care, emergency department services, and pastoral care.</td>
</tr>
<tr>
<td>Becky McIntyre, Home Health/Wellness/Diabetes/CREATION Life Director</td>
<td>AdventHealth Sebring, Lake Placid and Wauchula</td>
<td>Health care</td>
<td>Serves the general population through hospital health care and emergency department services.</td>
</tr>
</tbody>
</table>

### Services Provided

- Focus on inpatients within hospitals
- Emergency department services
- General population through hospital health care and emergency department services
- Community benefit programs are focused on low-income, minority, and underserved populations
- Division office for AdventHealth hospitals that serve the general population through hospital health care and emergency department services but community benefit programs are focused on low-income, minority, and underserved populations
- Division office for AdventHealth hospitals that serve the general population through hospital health care and emergency department services
- Patient Engagement Advisors
- Focus on inpatients within hospitals
- Focus on inpatients within hospitals

### Populations Served

- Underserved populations
- General population through hospital health care and emergency department services
- General population through hospital health care and emergency department services
- Patient Engagement Advisors
- Health care
- Health care
- Health care
- Health care
- Health care
- Health care
- Health care
- Health care
- Health care
- Health care
- Health care
- Health care
- Health care
- Health care
- Health care
- Health care
- Health care
- Health care
### CHNAC Members continued

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>Organization</th>
<th>Services Provided</th>
<th>Populations Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donna Fox, Business Operations Manager</td>
<td>CareerSource Heartland</td>
<td>Workforce programs</td>
<td>Employment services and skills training for job seekers of the general population</td>
</tr>
<tr>
<td>Ann McCarty, Chief Programs Officer</td>
<td>CareerSource Heartland</td>
<td>Workforce programs</td>
<td>Employment services and skills training for job seekers of the general population</td>
</tr>
<tr>
<td>Bethany Cox, Tobacco Program Director</td>
<td>Central Florida Area Health Education Center (AHEC)</td>
<td>Health education and prevention programs</td>
<td>Health education and tobacco prevention programs for general public</td>
</tr>
<tr>
<td>Denise Collazo, Health Center Administrator</td>
<td>Central Florida Health Care- Avon Park</td>
<td>Health care</td>
<td>Federally qualified health center that provides health services to low-income, uninsured and underserved adults and children</td>
</tr>
<tr>
<td>Elizabeth Silva, PCMH Navigator</td>
<td>Central Florida Health Care</td>
<td>Health care</td>
<td>Federally qualified health center that provides health services to low-income, uninsured and underserved adults and children</td>
</tr>
<tr>
<td>Carissa Marine, Chief Executive Officer</td>
<td>Champion for Children Foundation</td>
<td>Parent and caregiver programs</td>
<td>Provides abuse and neglect prevention programs for children and families of the general population</td>
</tr>
<tr>
<td>Maria Pearson, Director</td>
<td>Champion for Children Foundation</td>
<td>Parent and caregiver programs</td>
<td>Provides abuse and neglect prevention programs for children and families of the general population</td>
</tr>
<tr>
<td>Tessa Hickey, Director of Nursing</td>
<td>DOH – Highlands</td>
<td>Health/wellness and youth substance use prevention</td>
<td>Provides health education and advocacy for substance use prevention for families and youth of the general population</td>
</tr>
<tr>
<td>Mary Moore, RDN, Program Director</td>
<td>DOH – Highlands</td>
<td>Health care and public health</td>
<td>Focus on rural, minority adults and teens by providing health care services, health education, and employment readiness skills</td>
</tr>
<tr>
<td>Melissa Thibodeau, Executive Director</td>
<td>Healthy Start Coalition of Highlands, Highlands and Polk County</td>
<td>Pregnant women, children and family prevention programs</td>
<td>Provides prevention and healthy development programs for pregnant women, children and families</td>
</tr>
<tr>
<td>Aisha Alyaide, Executive Director</td>
<td>Heartland ChildWellness</td>
<td>Health and youth substance use prevention</td>
<td>Prevention education programs regarding substance use targeted for youth</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>Organization</th>
<th>Services Provided</th>
<th>Populations Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noey Flores, Highlands County Commissioner</td>
<td>Highlands County Board of County Commissioners</td>
<td>County leadership</td>
<td>Carries out the polices and enforces regulations for the general population of Highlands County</td>
</tr>
<tr>
<td>Jimi Sessions, Executive Director</td>
<td>Highlands Help Center</td>
<td>Workforce services</td>
<td>Provides food and other services to the homeless and at-risk populations</td>
</tr>
<tr>
<td>Deirdre Avinco, Program Director</td>
<td>Healthy Families Highlands County</td>
<td>Parent and caregiver programs</td>
<td>Provides parent and caregiver programs to the general population</td>
</tr>
<tr>
<td>Charles Edwards, Executive Director</td>
<td>Healthy Start Coalition of Highlands, Highlands and Polk County</td>
<td>Pregnant women, children and family prevention programs</td>
<td>Provides prevention and healthy development programs for pregnant women, children and families</td>
</tr>
<tr>
<td>Ingra Gardner, Director of Community Programs</td>
<td>Highlands County Board of County Commissioners</td>
<td>County leadership</td>
<td>Carries out the polices and enforces regulations for the general population of Highlands County</td>
</tr>
<tr>
<td>Dennis Williams, County Veteran Services Officer</td>
<td>Highlands County Veteran Services Office</td>
<td>Veteran’s services</td>
<td>Provides resources and programs for veterans residing in Highlands County</td>
</tr>
</tbody>
</table>
Current Hospital Programs
Provides primary and specialty care services for the general population and low-income children ages 5 to 18.

Current Community Programs
Mental and behavioral health programs specifically targeted for youth.

United Way of Central Florida
Education programs focused on serving the underserved populations.

Senior services
Congregate meals, independent living resources, and health education for senior citizens of Highlands County.

Community Health Needs Assessment
As part of the assessment process, a list of resources or organizations addressing the top needs in the community was created. Although not a complete list, it helped to show where there were gaps in support and opportunities for partnership in the community when the CHNAC chose which priorities to address.

Available Community Resources

<table>
<thead>
<tr>
<th>Access to Healthy Foods</th>
<th>Current Community Programs</th>
<th>Hospital Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• AdventHealth's Life after Cancer course</td>
<td>• Dr. William Chen with Chen Dental, a local dentist that provides free dental services</td>
<td>• AdventHealth's Life after Cancer course</td>
</tr>
<tr>
<td>• AdventHealth’s Chronic Disease Self-Management course</td>
<td>• Hardee County Department of Health’s school-based sealant program</td>
<td>• AdventHealth’s Chronic Disease Self-Management course</td>
</tr>
<tr>
<td>• AdventHealth’s Community Sport Clinic</td>
<td>• Hardee County Department of Health’s program to assist individuals in obtaining insurance coverage through SHAP-Ed and Medicaid</td>
<td></td>
</tr>
</tbody>
</table>
### Top Issues

#### Behavioral Health (Mental Health & Mental Disorders and Substance Use & Misuse)
- Heartland for Children offers free Mental Health First Aid classes.
- Peace River Center offers free Mental Health First Aid classes.
- Tri County Human Services program to strengthen families that provides prevention resources for substance abuse or at-risk kids.
- Peace River Center’s Victim Services offers free counseling for survivors of sexual assault for ages 12 and up.
- Hardee County Department of Health’s Tobacco Free Florida program.
- Hardee County Department of Health’s Student’s Working Against Tobacco program.
- Hardee County Department of Health’s SWAT clubs to target tobacco use.
- Drug Free Hardee organization.
- Teen Pregnancy Prevention Alliance (TPPA).
- Hardee County Department of Health’s Healthy Chances events at local junior high schools.
- Peace River Center Middle Crisis Unit.

- AdventHealth’s free Mental Health First Aid classes.
- AdventHealth’s Mood and Anxiety Recovery Seminar.
- AdventHealth’s Nedley Optimize Your Brain course.

#### Current Community Programs
- Hardee County Department of Health programs and services.
- Central Florida Health Care’s primary care services.
- NuHope Elder Care.
- Senior Connection Center.
- Heartland Bikes programs for the transportation disadvantaged.

- Central Florida Health Care’s primary care services.
- NuHope Elder Care.
- Senior Connection Center.
- Heartland Bikes programs for the transportation disadvantaged.

#### Current Hospital Programs
- AdventHealth Wauchula in partnership with the Alzheimer’s Association offers The 10 Warning Signs of Alzheimer’s Disease program.
- AdventHealth Wauchula in partnership with the Alzheimer’s Association offers the Brain Bus program.
- AdventHealth Wauchula in partnership with the Senior Connection Center offers free fitness classes for seniors.
- AdventHealth Wauchula’s Wellness Center offers the Silver Sneakers fitness classes.

#### Diabetes
- Hardee County Department of Health’s Tobacco Free Florida program.
- Hardee County Department of Health’s Student’s Working Against Tobacco program.
- Hardee County Department of Health’s SWAT clubs to target tobacco use.
- Drug Free Hardee organization.
- Teen Pregnancy Prevention Alliance (TPPA).
- Hardee County Department of Health’s Healthy Chances events at local junior high schools.
- Peace River Center Middle Crisis Unit.

- AdventHealth 8-week Reversing Diabetes program offered at Avon Park Seventh Day Adventist Church.
- AdventHealth Wauchula’s free Dodging Diabetes Class.
- AdventHealth offers free diabetes and gestational diabetes classes.
- AdventHealth in partnership with Central Florida Area Health Education Center offers free tobacco cessation classes and nicotine replacement therapies.

- Hardee County Department of Health’s Tobacco Free Florida program.
- Hardee County Department of Health’s Student’s Working Against Tobacco program.
- Hardee County Department of Health’s SWAT clubs to target tobacco use.
- Drug Free Hardee organization.
- Teen Pregnancy Prevention Alliance (TPPA).
- Hardee County Department of Health’s Healthy Chances events at local junior high schools.
- Peace River Center Middle Crisis Unit.

- AdventHealth offers a community sports clinic one per year in an underserved area of the community.
- AdventHealth offers community sports clinics one per year in an underserved area of the community.

#### Children’s Health
- Florida Department of Children and Families (DCF) Medicaid Assistance programs for pregnant women, parents, and caretaker relatives of children.
- Hardee County Department of Health’s Women, Infants, and Children (WIC) program.
- Redlands Christian Migrant Association (RCMA) Early Head Start program.
- Hardee County Department of Health’s Healthy Start program.

- Florida Department of Children and Families (DCF) Medicaid Assistance programs for pregnant women, parents, and caretaker relatives of children.
- Hardee County Department of Health’s Women, Infants, and Children (WIC) program.
- Redlands Christian Migrant Association (RCMA) Early Head Start program.
- Hardee County Department of Health’s Healthy Start program.

- AdventHealth offers a community sports clinic once per year in an underserved area of the community.

#### Economy
- Florida Department of Children and Families’ Temporary Cash Assistance program.
- CareerSource Heartland’s Career Services program.
- Hardee Help Center’s Emergency Financial Assistance program.
- Florida Division of Vocational Rehabilitation Services.
- Ridge Area ABC community services.
- South Florida State College’s adult education and career services.
- Highland County Housing Office down payment assistance.
- Florida Non-Profit Housing Inc. rent and utilities assistance.

- Florida Department of Children and Families’ Temporary Cash Assistance program.
- CareerSource Heartland’s Career Services program.
- Hardee Help Center’s Emergency Financial Assistance program.
- Florida Division of Vocational Rehabilitation Services.
- Ridge Area ABC community services.
- South Florida State College’s adult education and career services.
- Highland County Housing Office down payment assistance.
- Florida Non-Profit Housing Inc. rent and utilities assistance.

- AdventHealth 8-week Reversing Diabetes program offered at Avon Park Seventh Day Adventist Church.
- AdventHealth Wauchula’s free Dodging Diabetes Class.
- AdventHealth offers free diabetes and gestational diabetes classes.
- AdventHealth in partnership with Central Florida Area Health Education Center offers free tobacco cessation classes and nicotine replacement therapies.

- AdventHealth offers a community sports clinic once per year in an underserved area of the community.

- AdventHealth offers a community sports clinic once per year in an underserved area of the community.
Priorities Addressed

Access to Healthy Foods

Access to quality healthy food was a top need prioritized during the assessment. In Hardee County, one-quarter of residents live in an area where there is low access to a grocery store, which can make having a healthy, nutrient-dense diet more challenging. Almost one-fifth (20%) of community survey respondents reported that within the past 12 months, the food they had purchased from the store did not last and they did not have the money to purchase more. Also, more than a quarter (28.6%) of community survey respondents shared they were worried that they would run out of food before they had money to buy more. Respondents also expressed concern about increasing food prices.

Access to Quality Health Care

Access to quality health care was a top need identified when surveying the community. More than one-third (39%) of community survey respondents reported accessing care in the emergency department for non-emergency needs. While 14.5% of respondents shared that they needed medical care in the last 12 months, but they did not receive it. Additionally, more than one-fifth (21%) reported that they needed dental care in the last 12 months but did not receive the care they needed. Some of the top barriers that prevented care included cost, inability to schedule an appointment, inability to take time off work, transportation barriers, lack of health insurance coverage, lack of trust in providers and an inability to find a doctor who accepts certain types of health insurance.

Inadequate health insurance coverage is one of the largest barriers to health care access and the unequal distribution of coverage contributes to disparities in health. Out-of-pocket medical care costs may lead individuals to delay or forgo needed care (such as doctor visits, dental care and medications), and medical debt is common among both insured and uninsured individuals. Hardee County falls within the lower 25% of counties in both the state of Florida and in the US for adults who do not have any kind of health insurance coverage. Hardee County also has a lower rate of primary care providers (11 per 100,000) compared to the state (57 providers per 100,000). Focusing on access to quality health care will help align local efforts and resources to create targeted strategies to improve access for Hardee County residents.

Behavioral Health (Mental Health & Mental Disorders and Substance Use & Misuse)

In Hardee County, secondary data found in the assessment showed the age-adjusted death rate due to suicide is 19.9 per 100,000, this is almost one and a half times that of the state (13.1 per 100,000) and the US (13.5 per 100,000). The assessment also found more than ten percent (11.5%) of survey respondents were unable to access mental health resources when needed in the last 12 months. The top reasons cited were inability to pay for care, stigma associated with mental health issues and lack of knowledge on how to access a mental health doctor or counselor.

Inadequate health insurance coverage is one of the largest barriers to health care access for Hardee County residents.

In Hardee County, secondary data found in the assessment showed the age-adjusted death rate due to suicide is 19.9 per 100,000, this is almost one and a half times that of the state (13.1 per 100,000) and the US (13.5 per 100,000). The assessment also found more than ten percent (11.5%) of survey respondents were unable to access mental health resources when needed in the last 12 months. The top reasons cited were inability to pay for care, stigma associated with mental health issues and lack of knowledge on how to access a mental health doctor or counselor.

Substance use and misuse also emerged as a top concern, reflected in both primary and secondary data sources. Binge drinking in teens was cited as a specific concern in the primary data, for males this is five or more drinks on one occasion and four or more on one occasion for females. Secondary data showed just over 12% of teens reported binge drinking, higher than the state rate of 9.2%. The assessment also found in secondary data a higher percentage of teens who have used methamphetamine in Hardee County (2.6%), than the state rate (0.8%). Awareness and the need to address behavioral health issues, including mental health, mental health disorders, substance use and substance misuse, has been growing in the country. By including this topic area as a priority, the Hospital will work collaboratively with community partners to create better outcome opportunities over the next three years.
In Hardee County, a key indicator of concern regarding children’s health is the Child Food Insecurity Rate. This rate in Hardee County is 21.9, which is higher than the rate for the state of Florida at 17.1, and the US at 14.6. While Children’s Health was identified as a significant health need in secondary data analysis and was a trending topic of concern expressed through focus group conversations, it was ranked fifth out of eight significant health needs. Primary data results showed 27.6% of respondents expressed inability to access the healthcare their children needed in the last year and 6.9% shared they were not able to access the needed mental and/or behavioral health care their children needed.

Children’s health is of utmost importance, but the Collaborative decided that instead of focusing on it as a stand-alone priority area, children would be a target population group to focus on among all the priority areas.

Economy

In Hardee County 17.1% of families reported living below the poverty level in the primary data findings. This percentage is higher than both the state (9.3%) and national (9.1%) values. Seven percent of respondents reported being worried that they may not have stable housing in the next two months. Community respondents shared that job availability is scarce and low wage jobs are not appealing. They also expressed concern for rising food prices and housing costs.

While a strong economy is important in the overall health needs of the community, the CHNAC did not perceive this priority area as one that could be easily addressed within the three-year CHP cycle. It was voted the lowest in the ability to impact category in the prioritization meeting. Therefore, the Hospital will not work to address this priority area in the upcoming CHP.

Older Adult Health

The primary data collection revealed that respondents felt aging problems, such as difficulty getting around, dementia and arthritis, were top concerns. They also shared that there were no specialists, such as neurologists, in rural areas that encompass Hardee County and that specialists such as these are needed as individuals age.

Transportation challenges were also shared as an area of concern for this population, specifically those who are mobility challenged.

Participants in the prioritization selection meeting felt the top three priority areas chosen were significant and easier to address with the resources available and therefore, the Hospital will not be addressing Older Adult Health directly in the upcoming CHP.

Diabetes

Diabetes was one of the top important health issues identified by community survey respondents. Nineteen percent of survey respondents reported being told by their doctor they had diabetes. Focus group participants did not identify diabetes as a top health issue. Participants stated that sometimes individuals with diabetes may be asymptomatic, and it can be too late by the time they seek care.

Secondary data for Hardee County showed diabetes among the Medicare population is at 39%, higher than the state of Florida average of 27.8% and the US value of 27%. The non-Medicare eligible adult population in Hardee County also has a higher rate (15.5%) than the state’s value of 11.7%. Diabetes was not selected as a priority by the Hospital as there are other community partners who are addressing this need. The Hospital will support these efforts where possible and hopes to address diabetes indirectly through the access to healthy foods priority.
COMMUNITY HEALTH PLAN

Next Steps
The Hospital will work with the Collaborative and other community partners to develop a measurable Community Health Plan for 2023-2025 to address the priority issues. For each priority, specific goals will be developed including measurable outcomes, intervention strategies and the resources necessary for successful implementation. Evidence based strategies will be reviewed to determine the most impactful and effective interventions. For each goal, a review of policies that can support or deter progress will be completed with consideration of opportunities to make an impact. The plan will be reviewed quarterly with an annual assessment of progress. A presentation of progress on the plan will also be presented to the Hospital board annually. A link to the Community Health Plan will be posted on AdventHealth.com prior to May 15, 2023.
The Hospital evaluates the progress made on the implementation strategies from the Community Health Plan annually. The following is a summary of progress made on our most recently adopted plan. The full evaluation is available upon request.

Mental Health (Behavioral Health)

In the 2019 assessment, mental health was identified as a priority. Suicide is the 11th leading cause of death in the United States for all age groups and the second leading cause of death among people aged 25 to 34. In the Hospital's community, the rate of death due to suicide is higher than the state average. When mental health disorders are untreated, those affected are at high risk for many unhealthy and unsafe behaviors, including alcohol or drug abuse, violent or self-destructive behavior and suicide. The Hospital focused its efforts on increasing education and building community level networks for mental health support.

Transportation

Transportation was also a priority in the assessment. In the Hospital’s community, almost 4% of the population use public transportation as their primary means of travel to work. A lack of reliable transportation or an inadequate public transportation system prevents those who do not own a car or have consistent transportation from accessing health care which can result in rescheduled or missed appointments and delayed care. Transportation services can also create challenges for people to find healthy food when living in low food access areas impacting their overall health.

The Hospital also selected transportation as a priority in the assessment. In the Hospital’s community, almost 4% of the population use public transportation as their primary means of travel to work. A lack of reliable transportation or an inadequate public transportation system prevents those who do not own a car or have consistent transportation from accessing health care which can result in rescheduled or missed appointments and delayed care. Transportation services can also create challenges for people to find healthy food when living in low food access areas impacting their overall health.

Cardiovascular Disease

The Hospital also chose cardiovascular disease as a priority in the assessment. In the Hospital’s community 5% of adults had been told they have coronary heart disease or angina. The assessment also found a slightly higher rate of death due to heart disease in the community than compared to the state rate. Heart disease is the leading cause of death in the US, responsible for one in four deaths annually. The major risk factors for heart disease are high blood pressure, high cholesterol levels, excessive body weight and having an unhealthy diet. By managing blood pressure and cholesterol, eating a healthy diet and incorporating physical activity daily, the risk of developing heart disease could be greatly reduced. Smoking is also a major risk factor for cardiovascular disease. It was found that 22% of adults in the community smoke.

In part, the Hospital has focused on increasing education and access to cessation classes to address this priority. The Hospital has formed a partnership with the Central Florida Area Health Education Center (AHEC) to support a number of tobacco education and cessation initiatives. This includes establishing a referral network to connect patients with tobacco cessation classes and free internet-based smoking cessation programs. The work with AHEC was part of a collaborative effort between the Hospital, AdventHealth Sebring and AdventHealth Lake Placid, all of which serve the same community. The Hospital supported AHEC through marketing efforts, referrals and by hosting two classes on the campus. The Hospital also developed and launched a paid volunteer program through which team members can volunteer at local organizations which are addressing the priority.

Education (Social Determinant of Health)

Education was also chosen as a priority in the assessment. Educational attainment is a social determinant of health and can be an indirect factor in people’s health outcomes. Research shows education can be a predictor of health outcomes, as well as a path to address inequality in communities. Better education can lead to people having an increased understanding of their personal health and health needs. Higher education can also lead to better jobs, which can bring in increased wages and access to health insurance. In the Hospital’s community, 17% of the population was found to not have a high school diploma or equivalency.

Efforts to address education were part of a collaborative effort between the Hospital, AdventHealth Sebring and AdventHealth Lake Placid, all of which serve the same community. The Hospital has focused on building partnerships with community organizations which support the priority. Through these efforts, the Hospital has partnered with South Florida State College and donated funds to help pay for the cost of the General Educational Development (GED) exam for those community members unable to afford the cost of the test.
2019 Community Health Needs Assessment Comments

We posted a link to the most recently conducted CHNA and most recently adopted implementation strategy on our hospital website as well as AdventHealth.com prior to May 15, 2020 and have not received any written comments.