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

It is my honor to serve as CEO of AdventHealth’s Central Florida Division – North Region, which includes Flagler and Volusia counties. From the sunny beaches of Palm Coast to the bustling neighborhoods of Deltona, we are on a journey together to build healthy communities.

Thank you for taking the time to review the 2022 Community Health Needs Assessment. It is the culmination of a yearlong collaborative process spearheaded and resourced by a steering committee of leaders from community-based organizations, along with six community leaders (health equity champions), who ensured we were including voices from all populations. Your health equity champions in Volusia and Flagler worked closely with the community – they reviewed materials, identified focus groups and helped to prioritize the health needs of the areas we serve. This publication includes a summary of the focus groups, the Community Health Survey, stakeholder interviews and an analysis of population-health data.

The 2022 Community Health Needs Assessment will serve as a guide as we work together with community partners, organizations and our health equity champions in developing Community Health Plans for the communities from Palm Coast to New Smyrna Beach, Daytona Beach to Deltona, DeLand and Deltona so every person has an opportunity to attain full health potential. Together our collective vision will maximize efforts through collaboration, driving our communities to success.

Thank you again for your interest in the 2022 Community Health Needs Assessment.

Audrey Gregory, Ph.D.
President and CEO
Central Florida Division North Region
Executive Summary

Memorial Hospital West Volusia, Inc. d/b/a AdventHealth DeLand will be referred to in this document as AdventHealth DeLand or “The Hospital”. AdventHealth DeLand in DeLand, Florida conducted a community health needs assessment from August 2021 to June 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.

Hospital Health Needs Assessment Committee

AdventHealth DeLand also convened a Hospital Health Needs Assessment Committee (HHNAC). The purpose of the HHNAC was to select the needs the Hospital would address as a result of the findings in the assessment. The HHNAC made this decision by reviewing the priority needs selected by the Collaborative and the internal Hospital resources available. With this information, the HHNAC was able to determine where the Hospital could most effectively support the community.

See the Prioritization Process for a list of HHNAC members.

Data

AdventHealth DeLand, in collaboration with the Collaborative, collected both primary and secondary data. The primary data included community surveys, stakeholder interviews 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 15 aggregate issues.

See the Process and Methods for Primary and Secondary Data Sources.

Community Asset Inventory

The next step was to create a Community Asset Inventory. This inventory was designed to help the Collaborative and HHNAC 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 participated in a prioritization process that consisted of two rounds of online surveying and three facilitated discussion sessions.

See Priorities Selection for more.

The Volusia Flagler CHNA Collaborative

In order to ensure broad community input, AdventHealth DeLand took part in the Volusia/Flagler CHNA Collaborative, referred to as “The Collaborative”, to help guide the Hospital through the assessment process. The Collaborative 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 Collaborative met three times in 2021-2022. They reviewed the primary and secondary data and helped to identify the top priority needs in the community.

See the Prioritization Process for a list of Collaborative members.

The Collaborative and the HHNAC considered four factors during prioritization:

A. Alignment: Does this issue align with our mission, strategy, public health or community goals?
B. Impact on Community: What is the scope, size and seriousness of this issue? What are the consequences to the health of the community of not addressing this issue now?
C. Resources: Are there existing, effective interventions and opportunities to partner with the community to address this issue?
D. Outcome Opportunities: Can an impact on this issue be made in a demonstrable way, and will interventions have an impact on other health and social issues in the community?
2022 Community Health Needs Assessment

The plan will be completed and posted on the Hospital's website prior to May 15, 2023.

AdventHealth DeLand is part of AdventHealth, with a sacred mission of "Extending the Healing Ministry of Christ." AdventHealth strives to heal and nurture body, mind and spirit through our connected system of care.

AdventHealth was recognized for its innovative digital front-door strategy, which is making it possible for patients to seamlessly navigate their health care journey. From checking health documentation and paying a bill, to conducting a virtual urgent care visit with a provider, we are making health care easier by creating pathways to wholistic care no matter where your health journey starts.

AdventHealth DeLand is an award-winning workplace aiming to promote personal, professional and spiritual growth with its organizations that promote workplace diversity, employee engagement and professional growth.

AdventHealth DeLand has 164 beds and is one of the 15 hospitals in AdventHealth Central Florida Division. Formerly known as Florida Hospital DeLand, the organization's parent company changed the name of all wholly-owned entities to AdventHealth on January 2, 2019.

In 2020, AdventHealth DeLand joined AdventHealth’s Virtual Enterprises Network (VEN) to enhance our ability to meet the needs of patients through virtual care. This network connects AdventHealth Institute campuses, hospital campuses and other health networks across Florida and beyond.

AdventHealth DeLand also offers specialized inpatient services, which include: Acute Inpatient Care, Individual, Family or Group Therapy, Medication Therapy and Management, Nutritional Guidance, Psychiatric Care, Relaxation Therapy, Spiritual Support, Tele-Psychiatry, Therapeutic Crafts.
COMMUNITY OVERVIEW

Community Description
Located in Volusia County, Florida, AdventHealth DeLand defines its community as the Primary Service Area (PSA), the area in which 75-80% of its patient population lives. This includes five zip codes across Volusia County.

According to the 2020 Census, the population in the AdventHealth DeLand community has grown 15.7% in the last ten years to 153,438 people. This is more than double the amount of growth in the United States since the last Census. 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. 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 42.5, higher than that of state, which is 42.2 and the US at 38.2.

Females are the majority, representing 51.8% of the population. Middle-aged women, ages 40-64, are the largest demographic in the community at 15.9%.

Children are 21.4% of the total population in the community. Infants, ages zero to four, are 5% of that number. The community birth rate is 43.3 births per 1,000 women aged 15-50. This is lower than the US average of 51.9 and that of the state, 48.3. In the Hospital's community, 11% of children aged 0-4 and 13.8% of children aged 5-17 live in poverty.
Race and Ethnicity

In the Hospital’s community, 59.9% of the residents are Non-Hispanic White, 8.8% are Non-Hispanic Black and 25% are Hispanic or Latino. Residents that are of Asian or Pacific Islander descent represent 1.7% of the total population, while 0.2% are Native American and 3.9% 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 at a 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 purposes of the CHNA, the Hospital will follow this model for reporting any related data.

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, enrollment 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.

Social and Community Context: This focuses on topics such as community cohesion, civic participation, discrimination and incarceration.

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

1. Economic Stability
2. Education Access and Quality
3. Health Care Access and Quality
4. Neighborhood and Built Environment
5. Social and Community Context

Income

The median household income in the Hospital’s community is $57,703. This is below the median for both the state and the US. The poverty rate in the community is 12.9%, which is lower than the state poverty rate but higher than the national poverty 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 15.5%.

Increased evidence is showing a connection between stable and affordable housing and health.2 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%.

1. Food Insecurity - Healthy People 2030 | health.gov
2. Map the Meal Gap 2020 Combined Modules.pdf (feedingamerica.org)
3. Severe housing cost burden* | County Health Rankings & Roadmaps
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 a 89.7% high school graduation rate, which is higher than both the state and national rate. The rate of people with a post-secondary degree however is 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 show that long-term benefits include improved health outcomes, savings in health care costs and increased lifetime earnings.

In the Hospital’s community, 41.7% of 3-4 year-olds were enrolled in preschool. This is lower than both the state (51%) and the national (47.3%) 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, 11.8% of community members 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 must also 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 develop care plans when necessary. In the Hospital’s community, 76.2% of people report visiting their doctor for routine care.
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 ½ mile from your nearest supermarket in an urban area or 10 miles in a rural area, it may make it harder for people to maintain 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, 58.3% of the community lives in a low food access area, while 28% 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 and healthy food and maintaining employment in the community. 5.2% of the 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, 5.6% 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 23.4% of seniors age 65 and older report living alone and 18% of residents report having limited English proficiency. All these factors can create barriers to feeling connected in the community.
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 also was collected to inform the assessment process. The Hospital partnered with local community organizations and stakeholders, including those in public health and those who represent the interests of medically underserved, low-income and minority community members to form the Volusia/Flagler CHNA Collaborative and to guide the assessment process. During data review sessions, community members of the Collaborative provided insight on how health conditions and areas of need were impacting those they represented. The Collaborative used the data review and discussion sessions to understand the most important health needs and barriers to health the community was facing and to guide the selection of needs to be addressed in the 2022 CHNA.

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, stakeholder interviews and focus groups.

Community Health Survey
- Provided in both English and Spanish to anyone in the community and accessible through web links and QR codes.
- Links and QR codes 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 listen, electronic mailing lists they maintained and when possible shared on their own social media channels.
- Paper surveys were given to 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 web links.

Stakeholder Interviews
- Interviews were scheduled with 50 community stakeholders who were asked to provide input on health and barriers to health that they were seeing in the community.

Focus Groups
- Focus groups were held with 34 small groups of community stakeholders to gain input on health and barriers to health in the community.
- A focus was on hearing from stakeholders who represent or serve communities that are underserved, under-represented, lower income and/or who are more likely to be impacted by the social determinants of health.
Public and Community Health Experts Consulted
A total of 61 stakeholders provided their expertise and knowledge regarding their community. This included all members of the Community Health Needs Assessment Committee.

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>Services Provided</th>
<th>Populations Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicole Shekhtman, Senior Vice President</td>
<td>SMA Healthcare</td>
<td>Behavioral health programs</td>
<td>Focused on uninsured populations with special programs for individuals experiencing homelessness and individuals with disabilities</td>
</tr>
<tr>
<td>Dr. Barry Trulock, founder and executive</td>
<td>Addiction Education Foundation</td>
<td>Behavioral health education</td>
<td>Focused on serving populations with substance use disorders and disabilities</td>
</tr>
<tr>
<td>Beth Schmoke, Executive Regional Director</td>
<td>AdventHealth</td>
<td>Health care</td>
<td>Serves as an advocate and organizer to create financial solutions for uninsured and underinsured patients to remain financially solvent after care</td>
</tr>
<tr>
<td>Lori Raniol, Nurse Practice Manager</td>
<td>AdventHealth</td>
<td>Health care</td>
<td></td>
</tr>
<tr>
<td>Katie Biancaniole, Diabetes Educator</td>
<td>AdventHealth</td>
<td>Health care</td>
<td></td>
</tr>
<tr>
<td>Tim Farkas, Director of Ambulatory Services</td>
<td>AdventHealth Central Florida</td>
<td>Health care</td>
<td>Vulnerable residents, minority, poverty, uninsured, underpopulated neighborhoods throughout Volusia County</td>
</tr>
<tr>
<td>Debi McNabb, Community Benefit Director</td>
<td>AdventHealth Central Florida</td>
<td>Health care</td>
<td>Vulnerable residents, minority, poverty, uninsured, underpopulated neighborhoods throughout Volusia County and Flagler</td>
</tr>
<tr>
<td>Ma Bailaduend, Community Health Program Manager</td>
<td>AdventHealth Central Florida</td>
<td>Health care</td>
<td>Social Vulnerability index zip codes Volusia and Flagler</td>
</tr>
<tr>
<td>Donna Weis, CEO</td>
<td>AdventHealth DeLand</td>
<td>Health care</td>
<td>Vulusia County residents</td>
</tr>
<tr>
<td>Wally DeAquin, COD</td>
<td>AdventHealth Palm Coast</td>
<td>Health care</td>
<td>Flagler County residents</td>
</tr>
<tr>
<td>Kathy Green, Chief Nursing Officer</td>
<td>AdventHealth Palm Coast</td>
<td>Health care</td>
<td>Flagler County residents</td>
</tr>
<tr>
<td>Leslie Giascombe, CEO &amp; Founder</td>
<td>African American Entrepreneurs Association, Inc.</td>
<td>Community leader</td>
<td>Focused on special programs for communities of color</td>
</tr>
</tbody>
</table>
Secondary Data
To inform the assessment process, the Collaborative collected existing health-related and demographic data about the community from publicly available sources. This included data on health conditions, social determinants of health and health behaviors.

The most current public data for the assessment was compiled and sourced from government and public health organizations, including:

- US Census Bureau
- The Surveillance, Epidemiology and End Results (SEER) Program database
- Health Equity Data Analysis (HEDA) system (University of Minnesota)
- County Health Rankings
- The State Health Department
- Other proprietary and internally developed database

The Findings
There were 17 issues found in the assessment process that rose to the top. Needs that are SDOH related are grouped accordingly.

Economic Stability

- Housing:
  - Access to affordable, quality housing
  - Affordable housing for "cost-burdened" homeowners and renters

- Food Security:
  - Access to nutritious, affordable food

- Workforce:
  - Workforce needs and labor supply
  - Initiatives supporting households in ‘extreme’ poverty

- Childcare:
  - Quality, affordable childcare
  - Childcare services for special needs children

Health Care Access and Quality

- Mental Health Care:
  - Mental health outpatient services for children under age 18
  - Improve mental health and substance use disorder transition care for inmates being released from jail
  - Behavioral health initiatives to prevent suicide among targeted populations (e.g., youth)
  - Mental health outpatient services for adults
  - Recruiting and retaining mental health providers

Substance Use:
- Substance use disorder treatment programs

System Infrastructure:
- Systems to improve the ability of schools, the justice system, health care providers and public health departments to safely share information

Health Care Access:
- Outpatient medical and mental health care services for children with special needs
- Increase the percentage of people who have health insurance
- Additional services to address cancer, heart disease and diabetes
Prioritization Process

The Collaborative, through data review and discussion, narrowed down the needs of the community to a list of three priorities. Community partners in the Collaborative represented the broad range of interests and needs, from public health to the economic, of underserved, low income and minority people in the community. In the Spring of 2022, the Collaborative met three times to review and discuss the collected data and select the top community needs.

Members of the Volusia/Flagler CHNA Collaborative included:

Community Partners
- David Allin, Mayor, City of Palm Coast, leader of city government.
- David Ayers, General Manager, Flagler Broadcasting, radio hosts several public health radio shows.
- Carrie Baird, CEO, Flagler Cares/One Voice for Volusia, community impact organizations that facilitate public health projects.
- Pam Birbolo, Executive Director, Flagler DARS, recovery community organization.
- Andy Dale, Commissioner, Flagler County Board of County Commissioners, leader of county government.
- Amanda Lasocki, Vice President of Operations, United Way of Volusia-Flagler Counties, part of leadership team at a local grantmaking organization.
- Courtney Edgcomb, President, United Way of Volusia-Flagler Counties, a leader at a local grantmaking organization.
- John Fanelli, Coordinator of Student Supports and Services, Flagler Schools, responsible for student discipline and liaison with the Department of Juvenile Justice.
- Brandy Williams, Coordinator of Counseling Services, Flagler Schools, leads the school behavioral health team.
- Andrew Williams, Vice President of Flagler Services, SMA Healthcare, Flagler leader of largest public behavioral health provider in Flagler County.
- Alvin Jackson, City Manager, City of Bunnell, leader of city government.
- Cheryl Massaro, Board Member, Flagler County School Board, leader of the county school board.
- Myra Middleton, Retired educator, community leader and activist.
- Shelley Ragland, President, Flagler NAACP, the leadership of local community advocacy organization.
- Kathy Gover, Chief Nursing Of fcers, AdventHealth Palm Coast, leadership of AdventHealth Palm Coast.
- Nicole Sharbone, Senior Vice President Clinical Services, SMA Healthcare, part of leadership of largest public behavioral health provider in Flagler County.
Community Members (continued)

- Robin King, CEO, CareerSource Flagler Volusia, leader of workforce development board.
- DJ Lebo, CEO, Early Learning Coalition of Flagler and Volusia, leader of early childhood agency responsible for volunteer pre-K and subsidized childcare programs.
- Mamie Oatis, Community Director, Food Brings Hope, is part of the leadership of the community-based organization and community activist.
- Jeff White, Executive Director, Volusia/Flagler Coalition for the Homeless, leader of the continuum of care for homeless services in the region.
- Kelvin Miller, General Manager, Votran, leader of the county transportation system.
- Mike Delahanty, Detective, New Smyrna Beach Police Department and law enforcement are involved in homeless services.
- Kelly Amy, Manager of Strategic Partnerships, Volusia County Schools, representative of Volusia County School district.
- Dona Butler, Director of Community Services, County of Volusia, leader of county-operated health and social service programs.

AdventHealth Team Members

- Wally DeAquino, COO, AdventHealth Palm Coast
- Debi McNabb, Community Benefit Director, AdventHealth Central Florida Division North
- Ida Babazadeh, Community Health Program Manager, AdventHealth Central Florida Division North
- David Weiss, CEO, AdventHealth DeLand

Public Health Experts

- Steve Bickel, Medical Director, Department of Health in Flagler County, leading HIV clinic.
- Bob Snyder, Health Officer, Department of Health in Flagler County, leader of county public health organization.
- Ethan Johnson, Assistant County Health Department Director, Department of Health in Volusia County, part of the leadership at Volusia County public health organization.
- Danyell Wilson-Howard, Ph.D., Associate Professor & Project Lead; Health Disparities Liaison, Bethune-Cookman University; Department of Health in Volusia County, professor and public health expert working on health equity projects.

During these discussions, the decision was made to group multiple needs together, so similar or related needs could be addressed under one priority. After the Collaborative grouped the related needs, it decided to address everything that had been found under three county level priorities.

The Collaborative participated in a prioritization process based on the Delphi method that consisted of two rounds of online surveying and three facilitated discussion sessions. The needs were then evaluated with the AdventHealth priority criteria, which considered four factors:

- A. Alignment: Does this issue align with public health or community goals?
- B. Impact on Community: What is the scope, size and seriousness of this issue? What are the consequences to the health of the community of not addressing this issue now?
- C. Resources: Are there existing effective interventions and opportunities to partner with the community to address this issue?
- D. Outcome Opportunities: Can an impact on this issue be made in a demonstrable way and will interventions have an impact on other health and social issues in the community?

The Collaborative than grouped all the needs identified in the assessment under one of the following priorities:

Access to Behavioral Health Services

Behavioral health for the Collaborative’s priorities includes addressing both mental health and substance use disorder related needs. The access barriers faced by youth, adults and seniors are unique and require specific actions to address these issues equitably. This priority includes the needs identified around:

- Mental health
- Substance use disorder
- Access for particular populations including children, adults and seniors
Economic and Social Barriers

The Collaborative will address the housing, income and education related needs under this priority. Economic and social barriers have a profound impact on health and wellness. Equitable access to affordable quality housing, quality childcare and stable income are critical components. These barriers are sometimes more challenging for people with special needs. This priority includes the needs identified around:

• Affordable quality housing
• Income supports
• Affordable quality childcare
• Health insurance

System Infrastructure

The systems created to support health and stability often include inadvertent barriers that prevent people in need from equitably accessing needed services and supports. Systems need the ability to safely share information with one another and raise community awareness of local resources. This priority includes the needs identified around:

• Awareness of resources
• Ability to access services
• Ability to safely share information across sectors
• Systemic barriers to health insurance

Behavioral Health: Drug and Substance Use

Substance use disorders can involve illicit drugs, prescription drugs or alcohol. 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.

Early Childhood Education

Early childhood education describes the period of learning that takes place from birth to eight years old. There are several types of early education programs, including those that are federal, state or privately funded. Early childhood, particularly the first five years of life, impacts long-term social, cognitive, emotional and physical development. Healthy development in early childhood helps prepare children for the educational experiences of kindergarten and beyond.

Community Engagement in Available Resources and Services

Community engagement is the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest or similar situations to address issues affecting the well-being of those people. Community engagement can also bring environmental and behavioral changes that will improve the health of the community and its members. This is achieved through partnerships that help mobilize resources and influence systems.

The Hospital Health Needs Assessment Committee (HHNAC) met to review the priorities selected by the Collaborative and to identify the needs the Hospital would select during a facilitated discussion. The HHNAC reviewed the data behind the Collaborative’s priorities and the local available resources to address them in the community. The HHNAC also considered the Hospital’s current resources and strategies to find ways to most effectively address the needs.

Members of the HHNAC included:

• David Weis, CEO, AdventHealth DeLand
• Lori Rankin, Nurse Practice Manager, AdventHealth DeLand
• Robin Roper, Foundation Director, AdventHealth DeLand and AdventHealth Fish Memorial
• Daniel Camarata, Senior Chaplain, AdventHealth DeLand
• Kathleen Kennybrook, Emergency Department Director, AdventHealth DeLand
• Susan Lattore, Community Care RN, CFD-N
• Carie Bard, CEO, Flagler Cares/One Voice for Volusia
• Deborah McLaffey, Community Benefit Director, AdventHealth Central Florida Division North Region
• Ida Babazadeh, Community Health Program Manager, AdventHealth Central Florida Division North Region

The HHNAC used the established AdventHealth criteria to evaluate the needs and data behind them to select their priorities. The HHNAC did not use the same grouping as the CHNAC when evaluating the needs. The Hospital is focused on three priorities and will not directly address needs related to mental health, housing and income, which are included in the Collaborative’s priorities. The Hospital will focus on the following priorities.

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The Hospital Health Needs Assessment Committee (HHNAC) met to review the priorities selected by the Collaborative and to identify the needs the Hospital would select during a facilitated discussion. The HHNAC reviewed the data behind the Collaborative’s priorities and the local available resources to address them in the community. The HHNAC also considered the Hospital’s current resources and strategies to find ways to most effectively address the needs.

Members of the HHNAC included:

• David Weis, CEO, AdventHealth DeLand
• Lori Rankin, Nurse Practice Manager, AdventHealth DeLand
• Robin Roper, Foundation Director, AdventHealth DeLand and AdventHealth Fish Memorial
• Daniel Camarata, Senior Chaplain, AdventHealth DeLand
• Kathleen Kennybrook, Emergency Department Director, AdventHealth DeLand
• Susan Lattore, Community Care RN, CFD-N
• Carie Bard, CEO, Flagler Cares/One Voice for Volusia
• Deborah McLaffey, Community Benefit Director, AdventHealth Central Florida Division North Region
• Ida Babazadeh, Community Health Program Manager, AdventHealth Central Florida Division North Region

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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 HHNAC chose which priorities to address.

### Available Community Resources

<table>
<thead>
<tr>
<th>Top Issues</th>
<th>Current Community Programs</th>
<th>Current Hospital Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Services</td>
<td>• Adult Mental Health</td>
<td>• SMA Healthcare Adult Outpatient Substance Abuse Program (DOP) and Mental Health Counseling; Medication Assisted Treatment/Psychiatric Medication Outpatient Program</td>
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<tr>
<td></td>
<td>• Adult Substance</td>
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<td></td>
<td>• Issues specific to older adults (ages 75+)</td>
<td>• Alcoholics Anonymous Meeting Locations</td>
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<td>• Atlantic Center for the Arts</td>
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<td>• Baker Act receiving facilities</td>
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<td></td>
<td>• Break the Cycle Outpatient Program</td>
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<td></td>
<td></td>
<td>• Recovery Support Specialized Peers at Halifax Health ER</td>
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<td></td>
<td></td>
<td>• Faith based counseling</td>
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<tr>
<td></td>
<td></td>
<td>• Lutheran and private counseling opportunities</td>
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<td></td>
<td></td>
<td>• Halifax Health</td>
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<td></td>
<td></td>
<td>• Special Needs across Veteran Societies</td>
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<td></td>
<td>• Healthy Start Coalition of Flagler &amp; Volusia Counties, Inc.</td>
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<td>• Substance Exposed Residences Task Force</td>
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<td></td>
<td>• Family Place and Healthy Families</td>
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<td></td>
<td></td>
<td>• Heroin detoxification</td>
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<td></td>
<td>• Halifax Health Sheriff</td>
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</table>
|                                |                                                                                            | • Halifax Health Sheriff                    
|                                |                                                                                            | • Long Live Love Foundation                                                             |
|                                |                                                                                            | • Mental Health & Substance Abuse Support Group                                          |
|                                |                                                                                            | • Police Department                                                                      |
|                                |                                                                                            | •书法 用字                                                                 |
|                                |                                                                                            | • SMA Treatment at the Volusia County Corrections Department                              |
|                                |                                                                                            | • Enrollment Program Industries                                                          |
|                                |                                                                                            | • Participants with developmental disabilities or co-occurring disorders                  |
|                                |                                                                                            | • Child Red 24-hour Crisis Stabilization and Detox Services and Screenings                 |
|                                |                                                                                            | • Healthy County Support Groups                                                          |
|                                |                                                                                            | • Children/Community Based Care                                                          |
|                                |                                                                                            | • Café Dialogues and cards and Problem Solving Teams                                    |
|                                |                                                                                            | • Mental Health and Substance Abuse Support Group                                       |
|                                |                                                                                            | • Behavioral Health Services                                                             |
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|                                |                                                                                            | • Special Needs across Veteran Societies                                                 |
|                                |                                                                                            | • Substance Exposed Residences Task Force                                                 |
Top Issues
- Economic and Social Barriers – access to health care services, social and economic issues

Current Community Programs
- ACCESS (Medicaid, Requests for Assistance)
- African American Entrepreneurs Association (AAEA)
- Boys & Girls Clubs of Volusia/Flagler Counties
- CareerSource Flagler-Volusia
- Council on Aging services for seniors
- Department of Children & Families
- Eastealinks
- Family Health Source
- Family Resource Community
- FBI Community, Inc (Food Brings Hope, Homes bring hope)
- First Step Shelter
- Florida Shots
- Florida Breast and Cervical Cancer Prevention/Early Detection Program
- Florida United Methodist Children’s Home
- Good Samaritan Clinic
- Greater Urban Life Center
- Habitat for Humanity of Greater Volusia County
- Halifax Health and other partners providing Healthcare to the homeless
- Halifax Health Community Clinics
- Halifax Urban Ministries mobile locations, schools and community partners

Current Hospital Programs
- Hope Place
- Bridge of Hope
- Health Equity Zones – collaborative community partner efforts
- Health Navigators to help with insurance coverage access
- Hispanic Health Initiatives
- Jesus Clinic
- One Voice for Volusia/Flagler Cares
- Our Two Stories, Inc., DBA Backpack Buddies
- Project WARM (Women Assisting Recovering Mothers)
- Speech and Language Therapy (SALT)
- Salvation Army
- Supplemental Nutrition Assistance Program (SNAP) (food stamps)
- Sports leagues
- The Early Learning Coalition of Flagler and Volusia Counties, Inc.
- The House Next Door
- United Way of Volusia-Flagler Counties: Grants to community organizations; Community Impact; ALICE Report (Asset Limited, Income Constrained, Employed); Volunteer Income Tax Assistance (VITA) 2
- Volusia-Flagler County Coalition for the Homeless
- Volusia Volunteers in Medicine Clinic

Top Issues
- System Infrastructure
- Action for Healthy Kids
- Alliance for Healthier Generation
- Brevard- Cocoa- Melbourne- University of Florida: Pandemic: Win Initiative
- County and City Recreation Departments
- More than 50 miles of multi-use trails
- Mayor’s Fitness Challenges
- EPIC Behavioral Healthcare
- Family Health Source
- Good Samaritan Clinic
- Healthy Volusia and Partnerships with the Florida Department of Health
- Jesus Clinic
- Local churches
- Local colleges
- Local hospitals
- Local schools
- Volusia-Flagler Volusia system
- Northeast Florida AHEC (Diabetes and Smoking Cessation)
- One Voice for Volusia/Flagler Cares
- The Community Connector
- Nurtition app
- Popularity and ease of use of fitness and health tracking “apps”
- Seminars and education programs offered by the hospitals and health departments (ie. 5210)
- School Health Advisory Committee (SHAC)
- VCAn
- Volusia County Moms
- Volusia County Schools
- Volusia Volunteers in Medicine Clinic
- Workout Wellness
Priorities Addressed

Behavioral Health: Drug and Substance Use

Fentanyl deaths in Volusia County increased 2.5% from 2013 to 2019, and opioid-related deaths doubled from 2019 to 2020. Compared to the state, Volusia County has higher rates of substance overdose deaths per 100,000, including fentanyl, cocaine, heroin and meth. Volusia County also has higher rates than the state for vaping (tobacco and marijuana), alcohol, binge drinking and marijuana use. Awareness of and the need to address substance use, as well as a growing fentanyl crisis, has been increasing in the country. By addressing alcohol and drug use as a priority, the Hospital can align with local, state and national efforts for resources to create better outcomes opportunities over the next three years.

Early Childhood Education

The assessment showed that the percentage of youth ready for kindergarten at entry has declined in Volusia County, although it is still higher than that of the state. According to public data, only 50.2% of toddlers are enrolled in preschool, which helps prepare youth for kindergarten and beyond. The Hospital prioritized early childhood education because of the foundation it provides for better health and long-term outcomes for all residents.

Community Engagement on Available Resources and Services

Data in the assessment highlighted how complicated the health care system can be to understand and navigate, even for those who work within the industry. Many stakeholders discussed how disconnected different parts of the health care system are, leading to a lack of care coordination between different providers and a low awareness in the community of what services and resources are available. Word-of-mouth tends to be the best method to share information, especially in priority populations. The Hospital hopes to improve the health of the community by increasing community engagement and awareness of the resources and services available that improve health and connecting residents to them.
There is a growing need in Volusia County to increase the available resources addressing mental health needs. The assessment found the percentage of adults reporting poor mental health is slowly increasing statewide, as well as in Volusia County. However, Volusia County rates are notably higher than statewide rates (17.2% and 13.8%, respectively). Volusia County also lags behind the statewide average for both mental health providers and adult psychiatric beds.

The mental health needs of the community are significant, but the HHNAC did not perceive the ability to impact the issue with existing Hospital resources at this time.

The need for safe and affordable housing and increased wages in the community is significant. More than one-third of homeowners (about 34%) and over half of renters (about 55%) are paying over 30% of their income towards housing. The median price of homes also increased 18.8% from November 2020 to November 2021. The assessment also found that Black residents are twice as likely to be living below the federal poverty level as their White counterparts, and the poverty rates of Other Race and Hispanic residents are also notably higher than White and Non-Hispanic residents.

The HHNAC did not perceive the ability to have a measurable impact on these issues within the three years allotted for the Community Health Plan with the current resources available to the Hospital at this time.
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.
2020 Community Health Plan Review

The Hospital evaluates the progress made on the implementation strategies from the Community Health Plan annually. The following is a summary of progress made out our recently adopted plan. The full evaluation is available upon request.

Priority 1: Adult & Youth Behavioral Health

In the 2018 CHNA, the Hospital addressed adult and youth behavioral health as a priority. Substance abuse and mental health can be closely linked, the Hospital also included mental health strategies as a way to address substance use. During the assessment, data showed Volusia County often had higher rates of alcohol and substance use-related incidents than the state. This included higher rates of alcohol-suspected motor vehicle crashes and deaths due to opioid overdoses. There was also a higher suicide rate in the county than in the state. Volusia County also had a higher percentage of adults with a depressive disorder than the state.

Since adopting the plan, the Hospital has engaged with over 30 community organizations and neighborhood leaders to form a collective and comprehensive approach for leveraging new and existing resources in the Spring Hill neighborhood. The goal is to establish a “Health Equity Zone” in the targeted neighborhood by creating social determinants of health. The program provides a personalized level of care that helps address barriers that can impact health. Since the beginning of 2021, 85 new patients were enrolled in the program.

Priority 2: Cardiovascular Diseases and Diabetes

Cardiovascular diseases and diabetes were also a priority. Volusia County was found to have higher death rates for heart failure, coronary heart disease and stroke than the state during the assessment. There was also a higher rate of preventable hospitalizations for adults under 65 from diabetes. The death rate from diabetes in the county was also higher than the state rate, with the highest rate among Non-Hispanic Blacks.

The Hospital has focused on the impact of education and lifestyle as an avenue to addressing these conditions in the community. In 2021, the Hospital offered annual screenings, education on healthy eating and chronic disease prevention to more than 90 people. The Hospital has also launched a wellness program designed specifically for children and teens, which empowers them to be healthier through understanding their choices.

Priority 3: Barriers to Accessing Health Care Services

The Hospital also chose to address barriers to accessing health care services as a priority. The 2018 assessment showed that Volusia County faces lower health care resources and providers than elsewhere in the state. This lower ratio of doctors, internists, mental health and other health care providers compared to the number of people who seek them can be a barrier to receiving care when you need it. Volusia County residents were also less likely to have a personal doctor than others statewide. These factors can contribute to unnecessary emergency room visits when care is delayed, which can have more serious outcomes, particularly for individuals who are uninsured or underinsured.

As part of the effort to address this, AdventHealth Medical Group Internal Medicine at Deland expanded its hours beginning January 4, 2021 to Monday through Friday from 7:00 am to 7:00 pm to meet the need for extended hours in the community. The Hospital also increased admissions to the Community Care program, which provides no-cost education, care coordination services and home visits to patients who may be vulnerable or more greatly impacted by social determinants of health. The program provides a personalized level of care that helps address barriers that can impact health. Since the beginning of 2021, 85 new patients were enrolled in the program.

Priority 4: Healthy Eating & Physical Activity

Healthy eating and physical activity were also a priority for the Hospital after the assessment found increasing rates of inactivity and obesity compared to previous years in Volusia County. This was found in both children and adults and can have a negative impact on health in the short and long term. By addressing this preventatively through education on healthy eating and physical activity, the Hospital hopes to improve the long-term health of the community.

The Hospital focused its efforts on children and young adults through a partnership with a local Boys and Girls Club in the area. Starting in 2021, after a COVID-19 delay, the Hospital had multiple educational sessions working with almost 50% of the membership at the club on gardening, physical activity rock painting, creative problem solving with puzzles and physical activity. The Hospital also provided funding to make up for a USDA grant shortfall and provide club members with daily fresh fruit and whole grain snacks.

Priority 5: Social and Economic Issues

Social and economic issues became a priority after the 2018 assessment showed that Volusia County residents were behind others in the state when looking at quality of life indicators. This included Volusia County residents having a lower median household income, a higher percentage of residents in poverty and a lower high school graduation rate than the state. There is also a lower per capita income and higher food insecurity rate than the state. It was also found that more than 30% of the households in the county spend over 30% of their income on housing.

The goal to establish a “Health Equity Zone” in the Spring Hill neighborhood includes making accessible the resources needed to create financial stability, a key factor of good health. The Hospital is working to identify housing, employment and other financial stability barriers in the area through discussions with community and neighborhood leaders. The next step will be to develop a long range plan to help increase the financial stability of Spring Hill residents.
2019 Community Health Needs Assessments 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 12, 2020 and have not received any written comments.