AdventHealth Kissimmee 2025 Community Health Needs Assessment

Extending the Healing Ministry of Christ

AdventHealth

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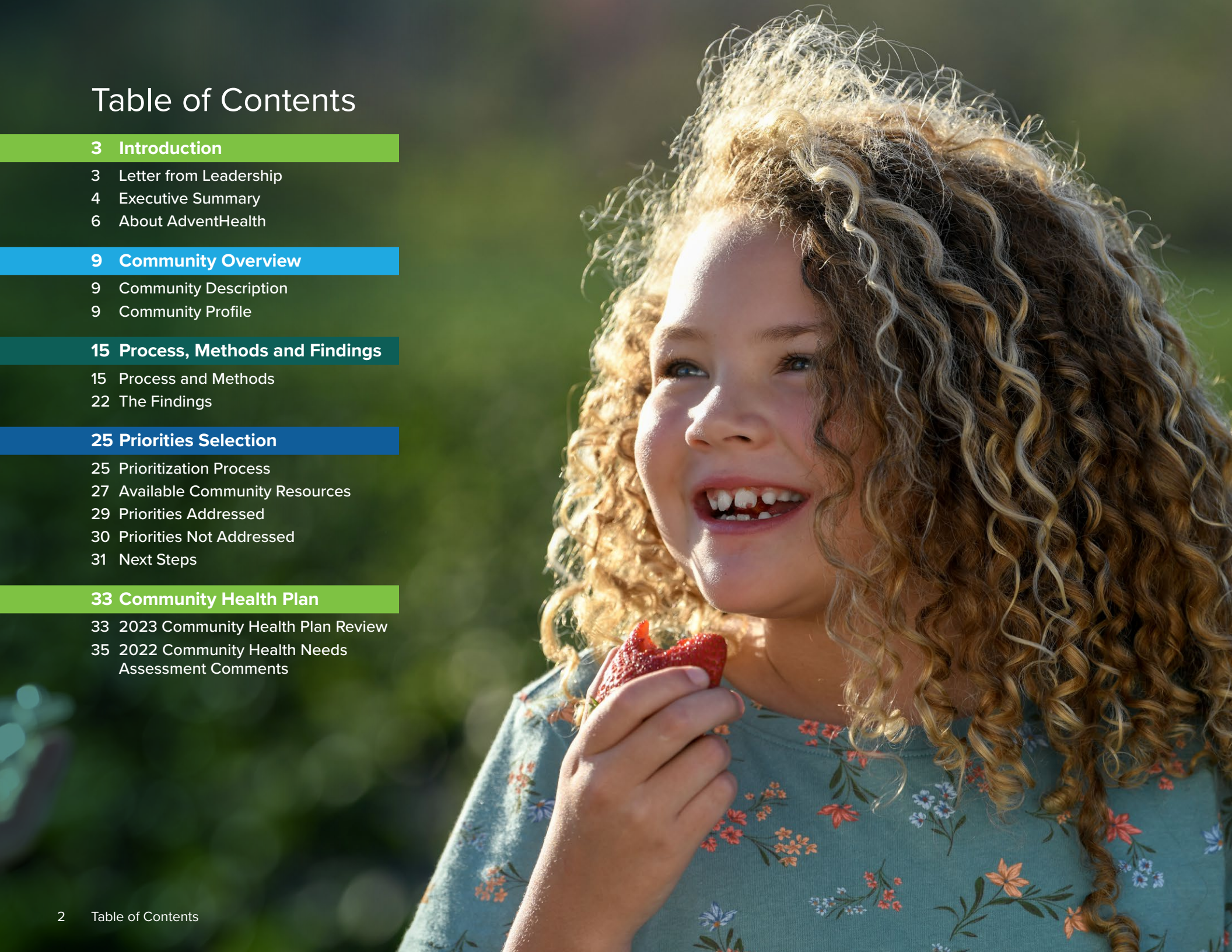


Letter from Leadership

For more than 115 years, AdventHealth has been a trusted partner in caring for our Central Florida community. It is a privilege we do not take lightly. We remain committed to providing the communities we're a part of with high-quality, whole-person care—body, mind and spirit.

We cannot do this alone. Providing whole-person care to everyone in our community can only be done by convening community partners to tackle our region's toughest challenges together.

It means developing the health care workforce of tomorrow.

It means supporting the wholistic health care needs of our community beyond the walls of our facilities—not just within them.

It means partnering with area nonprofits because we know we are stronger together.

This spirit of collaboration is the driving force behind our efforts to partner with other organizations that share our vision of a healthier Central Florida. We have worked as part of the Central Florida Collaborative, which includes Orlando Health, Aspire Health Partners, the Florida Department of Health in Orange, Osceola, Seminole and Lake counties, and the local Federally Qualified Health Centers (FQHCs), to produce this Community Health Needs Assessment to help us determine how to maximize our collaborative efforts.

Together, we are committed to designing programs and delivering services that will move the needle toward better health outcomes, ultimately bringing wholeness to our entire community.

Sincerely,

Brian Adams
AdventHealth
President and CEO
Central Florida Division

Shannon Gravitte
AdventHealth
Senior Vice President of Public Affairs
Central Florida Division

Executive Summary

Adventist Health System/Sunbelt, Inc dba AdventHealth Kissimmee will be referred to in this document as AdventHealth Kissimmee or "The Hospital." AdventHealth Kissimmee in Kissimmee, Florida conducted a community health needs assessment from May 2024 to March 2025. 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 the assessment findings to develop and implement a 2026–2028 Community Health Plan based on the needs prioritized in the assessment process.

Central Florida Collaborative

To ensure broad community input, AdventHealth Kissimmee participated in the Central Florida Collaborative (CFC) to guide the Hospital through the Community Health Needs Assessment (CHNA) process. The Collaborative served as the CHNA Committee (CHNAC) and included representation from the Hospital, public health experts, and the broader community, with intentional focus on low-income, minority, and underserved populations. The Collaborative represents Lake, Orange, Osceola, and Seminole counties and its members include the following organizations: AdventHealth, Aspire Health Partners, Community Health Centers, Florida Department of Health in Lake County, Florida Department of Health in Orange County, Florida Department of Health in Osceola County, Florida Department of Health in Seminole County, Orange Blossom Family Health, Orlando Health, Osceola Community Health Services and True Health.

The Collaborative worked with Crescendo Consulting Group, meeting regularly in 2024 and 2025 to review primary and secondary data. Diverse community partners, including non-traditional healthcare providers, contributed valuable perspectives throughout the process, ensuring that the final assessment priorities were shaped by the community's input and health needs.

See Prioritization Process for a list of CHNAC members.

Hospital Health Needs Assessment Committee

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

See Prioritization Process for a list of HHNAC members.

Data

AdventHealth Kissimmee 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, publicly available data from state and nationally recognized sources were used. Primary and secondary data was compiled and analyzed to identify the top 15 aggregated needs.

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 Collaborative understand the existing community efforts being used to address the top 15 needs identified from the aggregate primary and secondary data. This inventory was also designed to prevent duplication of efforts.

See Available Community Resources for more.

Selection Criteria

The Collaborative identified the top fifteen significant health needs of the community. The HHNAC then prioritized the top three needs, discussing each one, assessing available community resources, and considering the Hospital's own resources and strategies. Through this discussion, the Hospital determined the top three needs it is best positioned to impact.

See Prioritization Process for more.

The following criteria were considered during the prioritization process:

A. Impact on Community

What are the consequences to the health of the community of not addressing this issue now?

B. Resources

Are there existing, effective interventions and opportunities to partner with the community to address this issue?

C. Outcome Opportunities

Do interventions addressing this issue have an impact on other health and social issues in the community?

Priorities to Be Addressed

The priorities to be addressed are:

1. Mental Health
2. Pregnancy and Childbirth
3. Social Determinants of Health

See Priorities Addressed for more.

Approval

On May 21, 2025, the Hospital board approved the Community Health Needs Assessment findings, priority needs and final report. A link to the 2025 Community Health Needs Assessment was posted on the Hospital's website prior to December 31, 2025.

Next Steps

AdventHealth Kissimmee will work with the campus leadership to develop a measurable implementation strategy called the 2026–2028 Community Health Plan to address the priority needs. The plan will be completed and posted on the Hospital's website prior to May 15, 2026.

About AdventHealth

AdventHealth Kissimmee is part of AdventHealth. With a sacred mission of Extending the Healing Ministry of Christ, AdventHealth strives to heal and restore the body, mind and spirit through our connected system of care. More than 100,000 talented and compassionate team members serve over 8 million patients annually. From physician practices, hospitals and outpatient clinics to skilled nursing facilities, home health agencies and hospice centers, AdventHealth provides individualized, whole-person care at more than 50 hospital campuses and hundreds of care sites throughout nine states.

Committed to your care today and tomorrow, AdventHealth is investing in new technologies, research and the brightest minds to redefine wellness, advance medicine and create healthier communities.

In a 2020 study by Stanford University, physicians and researchers from AdventHealth were featured in the ranking of the world's top 2% of scientists. These critical thinkers are shaping the future of health care.

Amwell, a national telehealth leader, named AdventHealth the winner of its Innovation Integration Award. This telemedicine accreditation recognizes organizations that have identified connection points within digital health care to improve clinical outcomes and user experiences. 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 bills to conducting a virtual urgent care visit with a provider, we're making health care easier — creating pathways to wholistic care no matter where your health journey starts.

AdventHealth is also an award-winning workplace aiming to promote personal, professional and spiritual growth with its team culture. Recognized by Becker's Hospital Review on its "150 Top Places to Work in Healthcare" several years in a row, this recognition is given annually to health care organizations that promote workplace diversity, employee engagement and professional growth. In 2024, the organization was named by Newsweek as one of the Greatest Workplaces for Diversity and a Most Trustworthy Company in America.

AdventHealth Central Florida Division

AdventHealth's Central Florida Division encompasses 17 hospitals and ERs in four counties across metro Orlando. The world-class hospitals, combined with a comprehensive outpatient care network, see more than 5.9 million patient visits annually. AdventHealth also has an expansive research portfolio in Central Florida, with more than 675 clinical trials and studies in progress.

The organization, which has more than 33,000 Central Florida team members, has a deep commitment to serving the community, with a community investment of more than $1.59 billion in 2024.

The division's flagship campus — AdventHealth Orlando — boasts nationally and internationally recognized programs and serves as a major tertiary and quaternary referral hospital for much of the Southeast, the Caribbean and Latin America. Quality specialty care is provided through AdventHealth Institutes, which is nationally recognized in numerous specialties.

AdventHealth Orlando has been recognized by U.S. News & World Report, Healthgrades, Newsweek and the Leapfrog Group.

AdventHealth Kissimmee

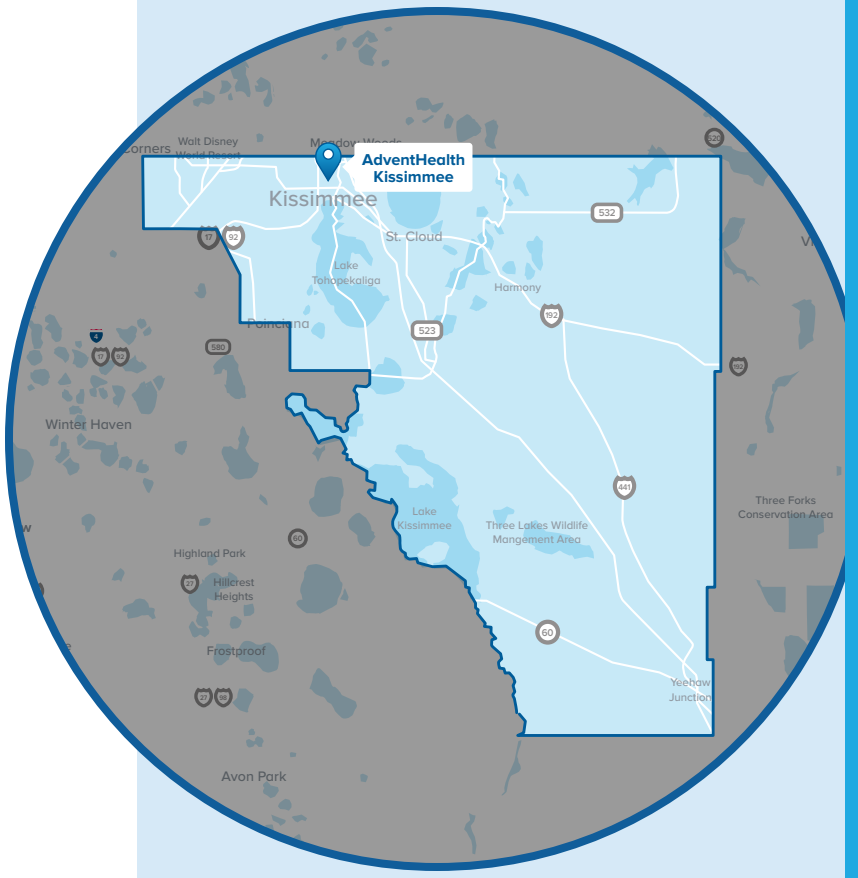
AdventHealth Kissimmee, a 282-bed acute-care community hospital located in north Osceola County, became part of the AdventHealth system in 1993. Additional hospital services include 24-hour emergency department, 24-hour critical care coverage, DNV accredited primary stroke center, dedicated outpatient endoscopy center, comprehensive health care services: cancer treatment including radiation therapy and chemotherapy, cardiac diagnostics (including diagnostic catheterizations), cardiology, diabetes, gastroenterology, inpatient and outpatient rehabilitation, minimally invasive surgery, neurology, interventional radiology, imaging (digital mammography, MRI, CT, nuclear medicine, ultrasound, diagnostic x-ray), complex wound care management, hyperbaric medicine, endoscopy for gastroenterology and pulmonology, inpatient and outpatient surgery services including breast surgery, colorectal surgery, gastrointestinal surgery, general surgery, gynecologic surgery, hand surgery, orthopedics (joints/revisions), podiatry, urology, vascular surgery and plastic surgery.

AdventHealth Kissimmee, a 282-bed acute-care community hospital located in north Osceola County.

Community Overview

Community Description

Located in Osceola County, Florida, AdventHealth Kissimmee defines its community as Osceola County. The Central Florida Collaborative (CFC) selected county-level data in order to capture the needs of residents throughout the wide service area covered by the participating agencies and the Hospital service area.



According to 2023 American Community Survey, the population in the Hospital's County service area has grown 63% in the last ten years to 437,784 people. Osceola County has the highest percentage change compared to the other counties in the tri-county region.

Demographic and community profile data in this report are from publicly available data sources such as the U.S. Census Bureau and the Center for Disease Control and Prevention (CDC), unless indicated otherwise. Data are reported for Osceola County, unless listed differently. 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 37.3, lower than that of state which is 42.7 and the US, 39.

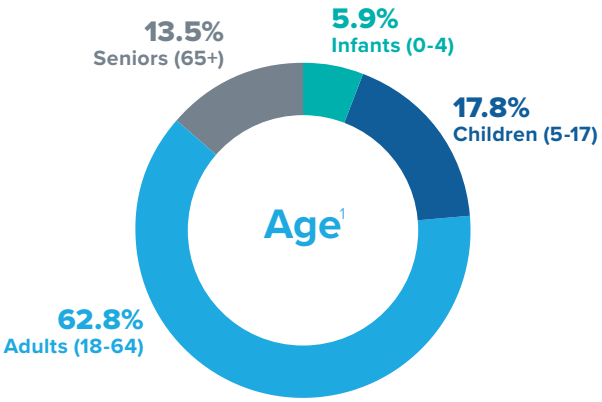
Females are the majority, representing 50.5% of the population. Adult women, 18–64 are the largest demographic in the community at 31.4%.

Children 0–17 make up 23.7% of the total population in the community. Infants, those zero to four, are 5.9% of that number. The community birth rate is 33.9 births per 1,000 women aged 15–50. This is lower than the U.S. average of 52.1, and lower than

AdventHealth Kissimmee defines its community as Osceola County.

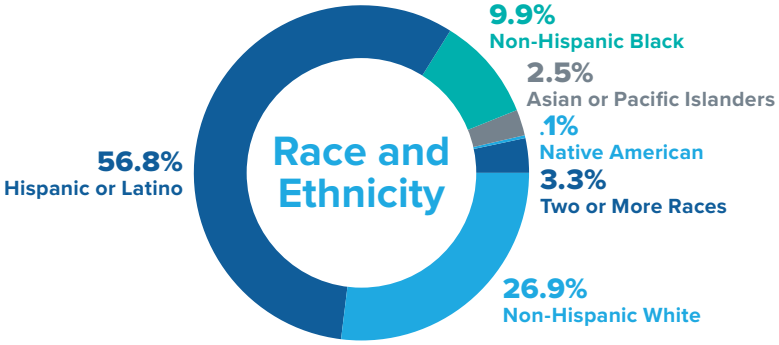
that of the state, 49.3. In the Hospital's community, 18.4% of children aged 0–4 and 20.7% of children aged 5–17 are in poverty.

Seniors, those 65 and older, represent 13.5% of the total population in the community. Females 65 and older represent 7.5% of the county's total population.



Race and Ethnicity

In the Hospital's community, 26.9% of the residents are non-Hispanic White, 9.9% are non-Hispanic Black, and Hispanic or Latino residents make up the greatest percentage at 56.8%. Residents who are of Asian descent represent 2.5% of the total population, while 0.1% are Native American and 3.3% are two or more races.



1 Statistics for all charts from US Census Bureau—American Community Survey, 2023, unless otherwise noted

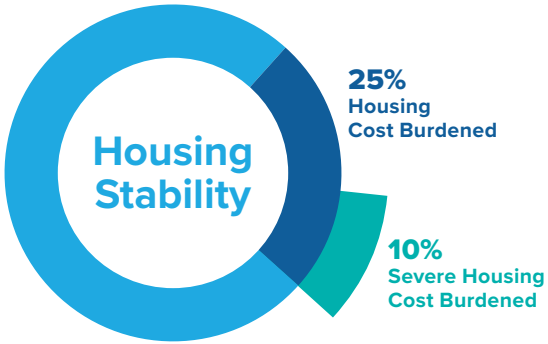
Economic Stability

Income

The median household income in the Hospital's community is $77,466. This is above the median for the state but slightly below the median for the US. Although below the US median, 10.6% of residents live in poverty, the majority of whom are under the age of 18. The Hispanic or Latino population in Osceola County presents the lowest median household income ($63,828) compared to the other Central Florida counties such as Seminole County ($68,819) or Orange County ($65,991). It is also lower than the state ($66,556) and national ($68,890) median house income.

Housing Stability

Increasingly, 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 the 50%.



2 Severe housing cost burden* | County Health Rankings & Roadmaps

Education Access and Quality

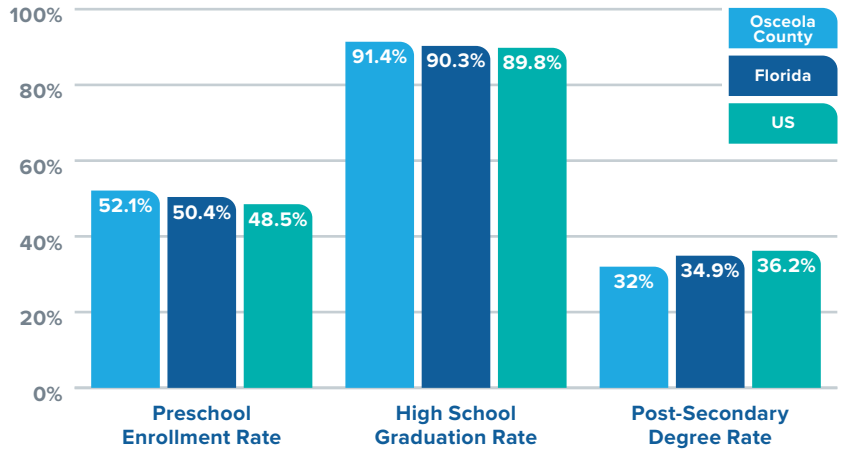
Research shows that education can be a predictor of health outcomes, as well a path to address inequality in communities.[3] Better education can lead to people having an increased understanding of their personal health and health needs. Higher education can also lead to better jobs, which can result in increased wages and access to health insurance.

In the Hospital's community, there is a 91.4% high school graduation rate, higher than both the state, (90.3%) and national average (89.8%). The rate of people with a post-secondary degree is lower in the Hospital's community than in both the state and nation.

Early childhood education is uniquely important and can improve children's cognitive and social development. It 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.[4]

In the Hospital's community, 52.1% of three- and four-year olds were enrolled in preschool. Although higher than both the state (50.4%) and the national (48.5%) average, there is still a large percentage of children in the community who may not be receiving these early foundational learnings.

Educational Attainment



3 The influence of education on health: an empirical assessment of OECD countries for the period 1995–2015 | Archives of Public Health | Full Text (biomedcentral.com)

4 Early Childhood Education | U.S. Department of Health and Human Services

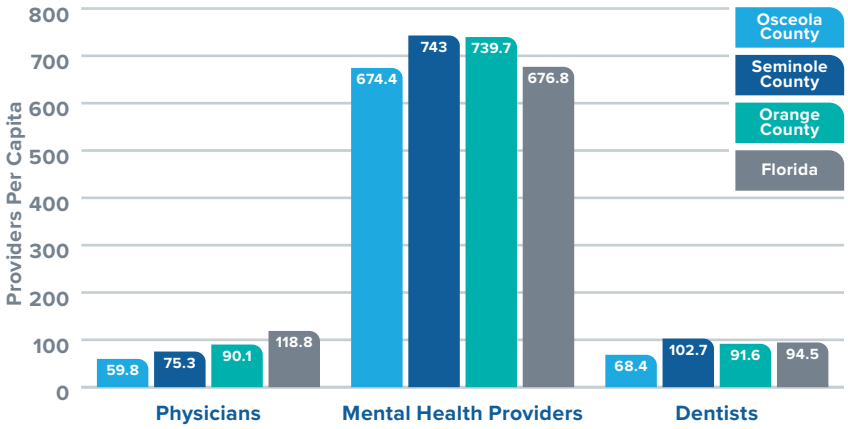
Health Care Access and Quality

In 2023, 9.1% of Osceola County residents lacked health insurance. Without access to health insurance, these individuals may experience 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.[5]

Accessing health care requires more than just insurance. There must also be health care professionals available to provide care. When more providers are available in a community access can be easier, particularly for those experiencing transportation challenges. In the county that the Hospital serves, Osceola County has the least health care providers available (59.8 primary care providers per 100,000 residents), lower than the state average (89.5).

Routine checkups can provide an opportunity to identify potential health issues and when needed develop care plans. In the Hospital's community, 74.6% of people report visiting their doctor for routine care.

Available Health Care Providers

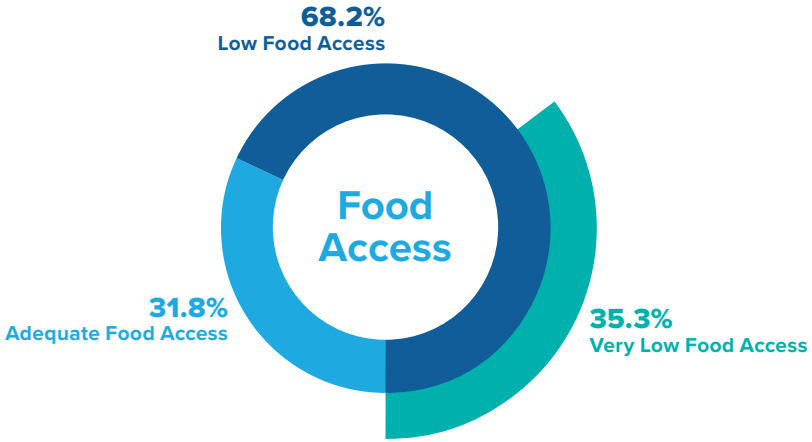


5 Health Insurance and Access to Care | CDC

Neighborhood and Built Environment

Increasingly, a community's neighborhoods and built environment are 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 the nearest supermarket in an urban area or ten 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 one 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.[6] In the Hospital's community, 68.2% of the community lives in a low food access area, while 35.3% live in a very low food access area.



People who are food insecure, who have reduced quality or 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.[7] Feeding America's latest Map the Meal Gap 2024 report, using 2022[8] data, estimates the food insecurity rate in the Hospital's community as 13.7%.

6 Heart Disease Risk Factors | CDC
7 Facts About Child Hunger | Feeding America
8 Map the Meal Gap 2022 | Feeding America

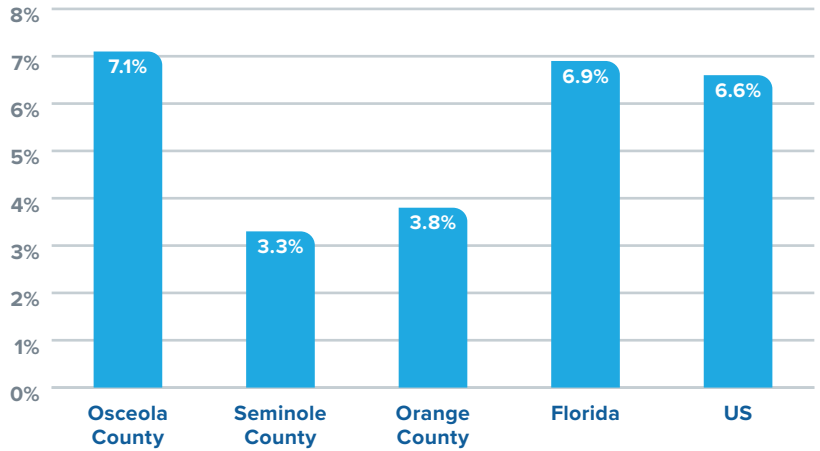
Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public transportation can be essential to access health care, healthy food and steady employment. In the community, 3.3% of the households do not have an available vehicle.

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.[9] 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.

In the community, 7.1% of youth aged 16–19 were reported as disconnected which is higher than both the state and national average (6.6%).

Disconnected Youth[10]



Also, in the community 19.6% of seniors (age 65 and older) report living alone and 9.9% of residents report having limited English proficiency. All these factors can create barriers to feeling connected in the community.

9 Social and Community Context - Healthy People 2030 | U.S. Department of Health and Human Services
10 Measure of America Report, 2024, US Census Bureau—American Community Survey, 2022

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 outcomes in communities throughout the country.

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

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

Economic Stability

Includes areas such as income, cost of living and housing stability.

Education Access and Quality

This framework 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

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

Neighborhood and Built Environment

Includes quality of housing, access to transportation, food security, and neighborhood crime and violence.

Social and Community Context

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

Process, Methods and Findings

Process and Methods

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, the Hospital in partnership with the Collaborative solicited input 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 and ethnicity, gender, profession, household income, education level and geographic location. The Collaborative also collected publicly available and internal hospital utilization data for review.

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 Central Florida Collaborative to guide the assessment process. The Collaborative is a regional effort through which health systems, federally qualified health centers and departments of health spanning four counties work to improve community health by leading outcome driven initiatives addressing the needs found in the assessment.

A real effort was made to reach out to all members of the community to obtain perspectives across age, race and ethnicity, gender, profession, household income, education level and geographic location.

The Collaborative includes representation from:

- AdventHealth
- Aspire Health Partners
- Community Health Centers
- Florida Department of Health in:
  - Lake County
  - Orange County
  - Osceola County
  - Seminole County
- Orange Blossom Family Health
- Orlando Health
- Osceola Community Health Services
- True Health

During data review sessions, 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 2025 CHNA.

Community Input

The Collaborative gathered input from the community and stakeholders, including organizations addressing community needs. Input was collected through a community survey, stakeholder interviews, and focus groups. Crescendo Consulting Group, a third-party consultant, facilitated data collection for all partners, including AdventHealth.

Community Health Survey

- A total of 2,754 surveys were collected with 2,523 from Lake (517), Orange (948), Osceola (502) and Seminole (556) counties.
- The survey was provided in English, Haitian Creole, Portuguese, Chinese Mandarin and Spanish to anyone in the community and accessible through weblinks 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 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 who experience barriers to responding electronically.

Stakeholder Survey

- Interviews were scheduled with 106 stakeholders working at community organizations, including public health organizations, that work to improve the health and well-being of the community.
- Participants were asked to provide input on health, and barriers to health, that they saw in the community.
- Efforts were focused on stakeholders who represent or serve underserved, underrepresented communities that are lower income, and are more likely to be impacted by the social determinants of health.

Focus Groups

- Focus groups were held with 29 groups of community members to gain input on health and barriers to health in the community.

Public and Community Health Experts Consulted

The Central Florida Collaborative served as the CHNAC. The Collaborative provided their expertise and knowledge regarding the community throughout the process. The Collaborative consisted of organizations representing the community, public health, low-income, minority, and other underserved populations.

The following chart contains members of the Central Florida Collaborative who provided strategic leadership throughout the CHNA and/or served as stakeholders. A total of 44 stakeholders provided their expertise and knowledge regarding their communities, including:

Name	Organization	Services Provided	Populations Served
JB Boonstra, Executive Director, Community Advocacy	AdventHealth Corporate	Health Care	Social Vulnerability Index zip codes Lake, Orange, Osceola and Seminole
Mari Torres-Luengas RN, Director, Community Health and Advocacy	AdventHealth Central Florida Division	Health Care	Social Vulnerability Index zip codes Lake, Orange, Osceola and Seminole
Rebecca Desir, Senior Manager, Community Advocacy	AdventHealth Central Florida Division	Health Care	Social Vulnerability Index zip codes Lake, Orange, Osceola and Seminole
Yoli Evans, Senior Manager, Community Advocacy	AdventHealth Central Florida Division	Health Care	Social Vulnerability Index zip codes Lake, Orange, Osceola and Seminole
Carolina Paez, Program Manager, Community Health	AdventHealth Central Florida Division	Health Care	Social Vulnerability Index zip codes Lake, Orange, Osceola and Seminole
Elizabeth Aulner, Program Manager, Community Health	AdventHealth Central Florida Division	Health Care	Social Vulnerability Index zip codes Lake, Orange, Osceola and Seminole
Sarah Dowlatram, Project Coordinator, Community Health	AdventHealth Central Florida Division South Region	Health Care	Social Vulnerability Index zip codes Lake, Orange, Osceola and Seminole
Babette Hankey, President and Chief Executive Officer	Aspire Health Partners	Behavioral Health Care	Provides behavioral health care to residents of service area
Christine Suehle, Chief of Staff	Aspire Health Partners	Behavioral Health Care	Provides behavioral health care to residents of service area
Shannon Robinson, Senior Vice President of Medical Services	Aspire Health Partners	Behavioral Health Care	Provides behavioral health care to residents of service area
Scott Griffiths, Chief Administrative Officer	Aspire Health Partners	Behavioral Health Care	Provides behavioral health care to residents of service area

Name	Organization	Services Provided	Populations Served
Yaberci Perez-Cubillan, Chief Program Officer	Aspire Health Partners	Behavioral Health Care	Provides behavioral health care to residents of service area
Erin Martin, Vice President, Residential and Crisis Services	Aspire Health Partners	Behavioral Health Care	Provides behavioral health care to residents of service area
Debra Andree, MD, President and Chief Executive Officer	Community Health Centers	Health Care	Provides medical care to low-income and uninsured residents
Maureen Ferguson, Director of Government Relations and Grant Management	Community Health Centers	Health Care	Provides medical care to low-income and uninsured residents
Esmeralda Batiz, President Outreach and Marketing Director	Community Health Centers	Health Care	Provides medical care to low-income and uninsured residents
Aaron Kissler, Administrator, County Health Officer	Florida Department of Health –Lake County	Health Care/Public Health	Provides medical care to low-income and uninsured residents
Melaine Chin, Health Consultant	Florida Department of Health –Lake County	Health Care/Public Health	Provides medical care to low-income and uninsured residents
Priscilla Nunez, Public Health Educator	Florida Department of Health –Lake County	Health Care/Public Health	Provides medical care to low-income and uninsured residents
Dhanya Lotfallah, CHIP Facilitator	Florida Department of Health –Orange County	Health Care/Public Health	Provides medical care to low-income and uninsured residents
Robert Karch, MD, MPH, FAAP, Health Officer and Director	Florida Department of Health –Orange County	Health Care/Public Health	Provides medical care to low-income and uninsured residents
James Pate, Manager Performance and Quality Improvement	Florida Department of Health –Orange County	Health Care/Public Health	Provides medical care to low-income and uninsured residents
Ana McDougall, Senior Health Operation Manager	Florida Department of Health –Osceola County	Health Care/Public Health	Provides medical care to low-income and uninsured residents
Vianca McCluskey, Administrator, County Health Officer	Florida Department of Health –Osceola County	Health Care/Public Health	Provides medical care to low-income and uninsured residents
Jason Martinez, Chief Population Officer	Florida Department of Health –Osceola County	Health Care/Public Health	Provides medical care to low-income and uninsured residents
Ethan Johnson, DrPH, MPH, Health Officer and Administrator	Florida Department of Health –Seminole County	Health Care/Public Health	Provides medical care to low-income and uninsured residents

Name	Organization	Services Provided	Populations Served
Paula Koehler, Program Manager	Florida Department of Health –Seminole County	Health Care/Public Health	Provides medical care to low-income and uninsured residents
Patricia Mondragon, Program Manager	Florida Department of Health –Seminole County	Health Care/Public Health	Provides medical care to low-income and uninsured residents
Commissioner Bakari Burns, President and Chief Executive Officer	Orange Blossom Family Health	Health Care	Provides medical care to low-income and uninsured residents
Sandra McClellan, Vice President, Administrative Services	Orange Blossom Family Health	Health Care	Provides medical care to low-income and uninsured residents
Lainie Fox Ackerman, AVP, External Affairs and Community Benefit	Orlando Health	Health Care	Provides medical care to low-income and uninsured residents
Sara Osborne, Senior Director, Community Benefit	Orlando Health	Health Care	Provides medical care to low-income and uninsured residents
Alyson Olinzock, Manager, Community Benefit	Orlando Health	Health Care	Provides medical care to low-income and uninsured residents
Mary Hignight, Community Benefit Specialist	Orlando Health	Health Care	Provides medical care to low-income and uninsured residents
Shannon McElroy, Health Equity Coordinator	Orlando Health	Health Care	Provides medical care to low-income and uninsured residents
Belinda Johnson-Cornett, Chief Executive Officer	Osceola Community Health Services	Health Care	Provides medical care to low-income and uninsured residents
Ivan Agosto, Director of Strategy and Growth	Osceola Community Health Services	Health Care	Provides medical care to low-income and uninsured residents
Janelle Dunn, Chief Executive Officer	True Health	Health Care	Provides medical care to low-income and uninsured residents
Aleia Roberts, Director of Government and Community Engagement	True Health	Health Care	Provides medical care to low-income and uninsured residents
Daniel Adeyemo, Director of IT	True Health	Health Care	Provides medical care to low-income and uninsured residents
Jafet Rios, Regional Director of Operations	True Health	Health Care	Provides medical care to low-income and uninsured residents

Secondary Data

To inform the assessment process, the Hospital collected existing health-related and demographic data about the community from public sources. This included data on health conditions, social determinants of health and health behaviors.

The most current publicly available data for the assessment was compiled and sourced from government and public health organizations including, but not limited to:

- American Community Survey
- Bureau of Vital Statistics
- Feeding America
- Florida Agency for Health Care Administration
- Florida Behavioral Risk Factor Surveillance System
- Florida Department of Children and Families
- Florida Department of Education
- FLHealthCHARTS
- Florida Drug-Related Outcomes Surveillance & Tracking (FROST) System
- Florida Youth Tobacco Survey
- National Low Income Housing Coalition. Out of Reach Reports
- United Way ALICE
- US Department of Agriculture, Economic Research Services — Food Access Research Atlas
- US Department of Housing and Urban Development
- University of Miami (FL) Medical School, Florida Cancer Data System

The Findings

To identify the top needs, the Collaborative analyzed the data collected across all sources. At the conclusion of the data analysis, there were fifteen needs that rose to the top. These needs were identified as being the most prevalent in the community and frequently mentioned among community members and stakeholders.

The significant needs identified in the assessment process included:

Economic Stability

Economic Stability refers to the ability of individuals and families to consistently meet their basic needs—such as food, housing, employment, and childcare—without financial hardship. It plays a crucial role in overall well-being, as financial insecurity can lead to stress, poor health outcomes, and limited access to essential resources.

The following needs fall under Economic Stability:

1. **Affordable Housing, Including for Older Adults**—providing access to safe, stable, and affordable housing options, particularly for vulnerable populations such as seniors, to prevent homelessness and housing instability.
2. **Jobs with Livable Wages**—creating employment opportunities that offer fair pay and benefits, allowing workers to support themselves and their families while avoiding financial distress.
3. **Affordable Childcare Services**—ensuring that families, especially working parents, have access to cost-effective, high-quality childcare, enabling them to maintain employment while fostering early childhood development.

Health Care Access and Quality

Health Care Access and Quality refers the availability, affordability, and equity of health care services. It also includes the quality of care a patient receives, regardless of their insurance status.

The following needs fall under Health Care Access and Quality:

4. **Mental Health, with a focus on access to outpatient mental health services**—refers to having the ability to get mental health services such as therapy, counseling, or psychiatric care without staying in a hospital ensuring that individuals regardless of their insurance status can obtain care.
5. **Improved care coordination among healthcare providers**—is the process of organizing patient care activities to ensure that patients receive safe, effective, and timely care. Care coordination can lead to better health outcomes by reducing unnecessary tests and procedures.
6. **Pregnancy and Childbirth**—includes a variety of programs and services that aim to improve access to care and support for pregnant and postpartum individuals.
7. **Better communication between healthcare organizations and nonprofits**—refers to trying to improve communication between healthcare organizations and nonprofits. Key strategies include establishing dedicated points of contact, utilizing clear and consistent communication channels, sharing data and needs openly, collaborating on program development, and building strong, ongoing relationships through regular meetings and joint initiatives, all aimed at better coordinating services and maximizing impact for vulnerable populations.
8. **Case management for complex medical and social needs**—refers to a collaborative process where a dedicated professional coordinates and organizes various healthcare and social services for individuals with intricate health conditions and significant social challenges, aiming to optimize their well-being by addressing all aspects of their needs through assessment, planning, implementation, monitoring, and advocacy.

9. **Programs for chronic disease prevention and education**—focuses on increasing awareness of prevention and treatment options for chronic illnesses.

10. **Behavioral health services for the uninsured**—refers to providing behavioral care for individuals who do not have health insurance which is aimed at treating mental health disorders, substance abuse issues, and an array of emotional and behavioral challenges.

Neighborhood and Built Environment

Neighborhood and Built Environment refers to the physical, environmental, and social conditions of a community.

The following needs fall under Neighborhood and Built Environment:

11. **Food Security, with a Focus on Affordable, Healthy Foods**—ensuring that individuals and families have consistent access to nutritious and affordable food options, reducing the risk of hunger and diet-related health conditions.

12. **Accessible transportation for medical appointments and public needs**—refers to a transportation system that can be used by individuals with disabilities, older adults, and others with unique needs, allowing them to access and utilize public transit services with the same ease.

Social and Community Context

Social and Community Context refers to the environment and relationships within which people live, work, and interact with others, including the connections between individuals and institutions like social, cultural, and religious groups, essentially encompassing the broader societal factors that influence people's lives and experiences.

The following needs fall under Social and Community Context:

13. **Support for vulnerable populations**—includes providing care, resources, and protection to groups of individuals who face higher risks of discrimination, illness, and other disadvantages.

14. **Improved health literacy resources**—improved health literacy resources are materials and tools that help individuals understand and use health information to make decisions and take actions to improve their health.

15. **Linguistically and culturally appropriate healthcare resources**—refers to medical services that are delivered in a way that respects and responds to a patient's cultural beliefs, practices, and preferred language, ensuring they can fully understand and participate in their healthcare decisions.

Priorities Selection

Prioritization Process

The Collaborative and the Hospital, through data review and discussion, narrowed the health needs of the community to a list of 15. Community partners of 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 January 2025, the Collaborative met to review and discuss the collected data and select the top community needs.

Members of the CHNAC included:

AdventHealth Team Members

- Shannon Gravitte, Senior Vice President Public Affairs, AdventHealth Central Florida Division
- JB Boonstra, Executive Director Community Advocacy, AdventHealth Corporate
- Mari Torres-Luengas RN, Director Community Health and Advocacy, AdventHealth Central Florida Division
- Rebecca Desir, Senior Manager Community Advocacy, AdventHealth Central Florida Division
- Yoli Evans, Senior Manager Community Advocacy, AdventHealth Central Florida Division
- Sarah Dowlatram, Project Coordinator Community Health, AdventHealth Central Florida Division
- Elizabeth Aulner, Program Manager Community Health, AdventHealth Central Florida Division
- Carolina Paez, Program Manager Community Health, AdventHealth Central Florida Division
- Quincy Semexan, Rehabilitation Supervisor Occupational Therapy, AdventHealth Central Florida Division

Aspire Health Partners Team Members

- Babette Hankey, President and Chief Executive Officer
- Christine Suehle, Chief of Staff
- Shannon Robinson, Senior Vice President of Medical Services
- Scott Griffiths, Chief Administrative Officer

Community partners on the CHNAC represented the broad range of interests and needs, from public health to the economic, of underserved, low-income and minority people in the community.

- Yaberci Perez-Cubillan, Chief Program Officer
- Erin Martin, Vice President, Residential and Crisis Services

Community Health Centers Team Members

- Debra Andree, MD, President and Chief Executive Officer
- Maureen Ferguson, Director of Government Relations and Grant Management
- Esmeralda Batiz, Outreach Manager

Florida Department of Health Lake County Team Members

- Aaron Kissler, MPH, Administrator, County Health Officer
- Melaine Chin, Health Consultant
- Priscilla Nunez, Public Health Educator

Florida Department of Health Orange County Team Members

- Dhanya Lotfallah, CHIP Facilitator
- Robert Karch, MD, MPH, FAAP, Health Officer and Director
- James Pate, Manager Performance and Quality Improvement

Florida Department of Health Osceola County Team Members

- Ana McDougall, Senior Health Operation Manager
- Vianca McCluskey, Administrator, County Health Officer
- Jason Martinez, Chief Population Officer

Florida Department of Health Seminole County Team Members

- Ethan Johnson, DrPH, MPH, Health Officer and Administrator
- Paula Koehler, Program Manager
- Patricia Mondragon, Program Manager

Orange Blossom Family Health Team Members

- Commissioner Bakari Burns, President and Chief Executive Officer
- Sandra McClellan, Vice President, Administrative Services

Orlando Health Team Members

- Lainie Fox Ackerman, AVP, External Affairs and Community Benefit
- Sara Osborne, Senior Director, Community Benefit
- Alyson Olinzock, Manager, Community Benefit
- Mary Hignight, Community Benefit Specialist
- Shannon McElroy, Health Equity Coordinator

Osceola Community Health Services Team Members:

- Belinda Johnson-Cornett, Chief Executive Officer
- Ivan Agosto, Director of Strategy and Growth

True Health Team Members

- Janelle Dunn, Chief Executive Officer
- Aleia Roberts, Director of Government and Community Engagement
- Daniel Adeyemo, Director of IT
- Jafet Rios, Regional Director of Operations

After the Collaborative narrowed the needs to a list of 15 identified needs, the Community Health team presented them to the Hospital Health Needs Assessment Committee (HHNAC). During the prioritization session, the HHNAC reviewed the data behind each need, followed by a discussion on the impact on the community and the sustainability of potential solutions.

Members of the HHNAC included:

- Brian Adams, President and CEO, AdventHealth Central Florida Division
- Tricia Edris, Chief Innovation and Partnerships Officer, AdventHealth Central Florida Division
- Shannon Gravitte, Senior Vice President Public Affairs, AdventHealth Central Florida Division
- Sharon Line-Clary, Senior Vice President Community Impact and Partnership Engagement, AdventHealth Central Florida Division
- JB Boonstra, Executive Director Community Advocacy, AdventHealth Corporate
- Mari Torres-Luengas RN, Director Community Health and Advocacy, AdventHealth Central Florida Division
- Rebecca Desir, Senior Manager Community Advocacy, AdventHealth Central Florida Division

HHNAC members worked collectively to narrow the list to the three most critical health priorities, considering the following criteria:

A. Impact on Community

What are the consequences to the health of the community of not addressing this issue now?

B. Resources

Are there existing, effective interventions and opportunities to partner with the community to address this issue?

C. Outcome Opportunities

Do interventions addressing this issue have an impact on other health and social issues in the community?

After thorough discussion and evaluation, the top three priority areas identified were:

1. Mental Health
2. Pregnancy and Childbirth
3. Social Determinants of Health

Following the prioritization process, division-level senior leadership presented these selected priorities to campus leadership for further review and alignment with hospital initiatives. This step ensured that hospital campuses were engaged in the process and positioned to address these priorities effectively within their communities. Campus leadership agreed with division-level senior leadership in the selected priorities.

Available Community Resources

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.

Top Priorities	Current Community Programs	Current Hospital Programs
Pregnancy and Childbirth	• Healthy Start Coalition of Osceola County • Osceola Pregnancy Center • COPE (Creating Opportunities for Parenting Education)—Osceola School District	
Mental Health	• Park Place • Aspire Health Partners	• AdventHealth Medical Group Counseling • AdventHealth Behavioral Health
Social Determinants of Health	• Florida Department of Education MyACCESS • Salvation Army • Orange Blossom Family Health • Osceola Community Health Services • True Health	• AdventHealth Education Benefit Program (Guild) • AdventHealth Care Connectors

Priorities Addressed

The priorities to be addressed include:

Mental Health

Mental health continues to be a significant concern in the Hospital's community, with a growing number of residents reporting poor mental health outcomes. According to the Centers for Disease Control and Prevention PLACES, data indicates that 19.3% of adult residents in the hospital's community have been told that they had a depressive disorder, while 17.1% report poor mental health overall. Despite the growing awareness of mental health challenges, access to care remains a barrier for many individuals, leading to untreated conditions and worsening health outcomes. By prioritizing mental health access, the hospital will align with local, state, and national initiatives to expand services, reduce stigma, and improve the availability of resources for those in need. Over the next three years, efforts will focus on enhancing community partnerships, increasing provider capacity, and integrating mental health services within primary care settings to ensure equitable access for all residents.

Pregnancy and Childbirth

Maternal health remains a top concern, with disparities in prenatal care access, birth outcomes, and postpartum support disproportionately affecting underserved populations. In the hospital's service area, data reveals significant gaps in early prenatal care and maternal morbidity rates, highlighting the need for targeted interventions. Addressing pregnancy and childbirth as a priority will involve expanding access to prenatal and postnatal care, increasing maternal education efforts, and ensuring that all expectant mothers receive the necessary support for safe and healthy deliveries. Additionally, this priority will focus on reducing socioeconomic disparities in birth outcomes by fostering partnerships with local organizations, supporting maternal health initiatives, and providing culturally competent care. By improving access to maternal healthcare services, the hospital aims to support healthier pregnancies and ensure better health outcomes for both mothers and newborns.

Social Determinants of Health

Recognizing that health outcomes are shaped by more than just medical care, the hospital has prioritized Social Determinants of Health (SDOH) to address broader systemic factors that impact community well-being. Data highlights significant challenges related to multiple needs that address the social determinants of health, all of which contribute to health inequities. By addressing these key areas, the hospital seeks to implement community-based strategies that connect individuals to essential resources, improve health literacy, and support long-term wellness. Partnerships with local agencies, community organizations, and government programs will be strengthened to enhance affordable housing initiatives, expand transportation services, increase access to nutritious foods, and improve management of chronic conditions. The goal is to create sustainable solutions that promote health equity and improve overall quality of life for vulnerable populations.

Priorities Not Addressed

The Hospital acknowledges the significance of Health Care Access and Quality and Social and Community Context but will not prioritize the following needs due to resource limitations, scope of services, or the availability of external organizations that are better positioned to address them.

The priorities not to be addressed include:

Health Care Access and Quality

1. **Improved Care Coordination Among Healthcare Providers**—While the Hospital strives for internal care coordination, comprehensive system-wide integration among all healthcare providers, including external specialists and community health centers, requires broader regional collaboration. This level of coordination is best led by healthcare networks, accountable care organizations (ACOs), or state health agencies that oversee multi-system integration.
2. **Better Communication Between Healthcare Organizations and Nonprofits**—The Hospital engages with nonprofit organizations on specific initiatives but does not have the infrastructure to serve as a centralized communication hub between all healthcare providers and nonprofits. Effective coordination in this space requires a dedicated coalition, community health collaborative, or governmental entity to facilitate structured partnerships.
3. **Case Management for Complex Medical and Social Needs**—The Hospital's case management team works with patients who have complex medical and social needs, providing care coordination and support. However, this need was not chosen as a priority for the current CHNA cycle due to other pressing health needs and resource allocation.
4. **Behavioral Health Services for the Uninsured**—The Hospital offers some behavioral health services but cannot fully address the demand for uninsured patients due to funding constraints and provider shortages. Expanding access to behavioral health care for uninsured individuals requires policy changes, increased public funding, and partnerships with community mental health organizations that can provide sliding-scale or free services.

Social and Community Context

5. **Support for Vulnerable Populations**—While the Hospital provides medical care and referrals to social services, it does not have the infrastructure to comprehensively address social determinants such as housing, food security, or long-term financial assistance. These areas require sustained efforts from government agencies, nonprofit organizations, and community-based programs specializing in social services.
6. **Improved Health Literacy Resources**—The Hospital offers patient education materials, but large-scale health literacy efforts, such as community-wide educational campaigns and curriculum development, fall outside its direct priorities. Public health departments, libraries, and local advocacy groups are better positioned to lead and expand these efforts.
7. **Linguistically and Culturally Appropriate Healthcare Resources**—While the Hospital provides interpreter services and translated materials for common languages in the region, it lacks the capacity to fully implement culturally tailored health programs for all communities. Expanding these resources requires broader policy changes and collaborations with community organizations that specialize in culturally competent care.

Next Steps

The Collaborative will work with the Hospital and other community partners to develop a measurable Community Health Plan for 2026 – 2028 to address the priority needs. 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 annually to the Hospital board.

A link to the Community Health Plan will be posted on AdventHealth.com prior to May 15, 2026.

Community Health Plan

2023 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 on our most recently adopted plan. The full evaluation is available upon request.

Priority 1: Mental Health Outreach and Treatment

In the 2022 CHNA, the Hospital addressed mental health outreach and treatment as a priority. Mental health outreach and treatment were identified as top needs from the CHNA. This includes mental health crisis services and community awareness of available resources, mental health outpatient services capacity, behavioral health outpatient services for children, mental health inpatient bed capacity, mental health and substance use disorder transition care for inmates being released from jail, and mental health stigma reduction. There is a growing need in Orange, Osceola and Seminole County to increase the available resources addressing mental health needs.

Since adopting the plan, the Hospital has prioritized expanding mental health services through targeted funding and strategic partnerships. In 2023, the Hospital awarded funding through our Collaborative Community Council to four organizations, with funds being disbursed quarterly over a three-year award cycle. These investments support crisis response programs, outpatient behavioral health expansion, and community education efforts aimed at increasing mental health awareness and reducing stigma.

The Hospital evaluates the progress made on the implementation strategies from the Community Health Plan annually.

Priority 2:
Social Determinants of Health — Workforce Development

Workforce development was identified as a priority. While Osceola County had an unemployment rate of 3.2% in 2022, the overall workforce size had contracted. Even in sectors with higher employment levels, workforce reliability remained a challenge due to employees needing time off to address personal or family health concerns.

According to the CDC, social determinants of health (SDOH) encompass the conditions in which people live, learn, work, and play, impacting a wide range of health risks and outcomes. These factors are increasingly recognized as major contributors to health inequities across communities.

Given the significance of this need and the available resources, the hospital prioritized addressing social determinants of health through workforce development. Strengthening the local workforce is expected to reduce housing burdens and support other critical priorities, such as increasing access to care and improving mental health outcomes.

Workforce development also remained a priority focus area as part of the Hospital's broader commitment to addressing social determinants of health. In 2024, the Hospital allocated funding across six workforce development programs designed to increase career readiness and job placement opportunities. These programs focus on high-demand industries such as healthcare, skilled trades, and job training services aimed at increasing economic mobility and reducing financial insecurity. Funding supported initiatives that provided career coaching, technical certifications, and workforce training to community members, with targeted efforts to assist underserved populations in securing sustainable employment.

2022 Community Health Needs Assessment Comments

We posted a link to the most recently conducted CHNA and the most recently adopted implementation strategy, 2023 Community Health Plan, on our hospital website as well as on adventhealth.com prior to May 15, 2023, and have not received any written comments.

AdventHealth

Adventist Health System/Sunbelt, Inc dba AdventHealth Kissimmee

CHNA Approved by the Hospital board on: May 21, 2025

For questions or comments, please contact
AdventHealth Central Florida Division's Community Health Team
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