

AdventHealth Carrollwood 2025 Community Health Needs Assessment

Extending the Healing Ministry of Christ



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Letter from Leadership

At AdventHealth, we have a sacred mission of Extending the Healing Ministry of Christ. That obligation goes beyond our hospital walls and permeates into our communities. Our commitment is to address the health care needs of our community with a wholistic focus, one that strives to heal and restore the body, mind and spirit. We want to help our communities get well and stay well.

Every three years, AdventHealth hospitals across the nation complete a Community Health Needs Assessment. During this assessment, we talk and work with community organizations, public health experts and people like you who understand our communities best. This in-depth look at the overall health of our communities and the barriers to care they experience helps AdventHealth better understand the unique needs in the various communities we serve.

We use this information to create strategic plans that address the issues that impact our communities most. At AdventHealth, we know that a healthy community is not a “one size fits all” proposition — everyone deserves a whole health approach that meets them where they are and supports their individual health journey.

This work would not be possible without the partnership of public health experts, community organizations and countless community members who helped inform this report. Through these ongoing partnerships and collaborative efforts, AdventHealth will continue to create opportunities for better health in all the communities we serve.

In His service,

Terry Shaw



Our commitment is to address the health care needs of our community with a wholistic focus, one that strives to heal and restore the body, mind and spirit.

Executive Summary

University Community Hospital, Inc. dba AdventHealth Carrollwood will be referred to in this document as AdventHealth Carrollwood or “The Hospital.” AdventHealth Carrollwood in Tampa, Florida conducted a community health needs assessment from July 2024 to February 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.

The All4HealthFL Collaborative

To ensure broad community input, AdventHealth Carrollwood participated in the All4HealthFL 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 community members, including AdventHealth, BayCare Health System, Moffitt Cancer Center, Johns Hopkins All Children’s Hospital, Lakeland Regional Health Medical Center, Orlando Health Bayfront Hospital, Tampa General Hospital and the Florida Department of Health. This included intentional representation from those serving low-income, minority and other underserved populations. The Collaborative met seven times in 2024 – 2025. They reviewed the primary and secondary data and helped to identify the top priority needs in the community.

See Prioritization Process for a list of Collaborative members.



Data

AdventHealth Carrollwood in collaboration with the All4HealthFL Collaborative collected both primary and secondary data. The primary data included community surveys, stakeholder interviews, access audits, and community focus groups. Secondary data included internal hospital utilization data (inpatient, outpatient and emergency department). This utilization data showed the top diagnoses for visits to the Hospital in 2024. In addition, publicly available data from state and nationally recognized sources were used. Primary and secondary data were compiled and analyzed to identify the top eight 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 eight 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 participated in a prioritization process after a data review and facilitated discussion session. The identified needs were then ranked based on clearly defined criteria.

See Prioritization Process for more.

The following criteria were considered during the prioritization process:

A. Magnitude

What is the size of the problem?

B. Severity

What are the implications if this issue is not addressed?

C. Feasibility

How likely can the Hospital address this problem?

Priorities to Be Addressed

The priorities to be addressed are:

1. Mental Health
2. Economic Stability
3. Health Care Access and Quality

See Priorities Addressed for more.

Approval

On August 27, 2025, the AdventHealth Carrollwood 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 Carrollwood will collaborate with their community partners to develop a measurable implementation strategy called the 2026–2028 Community Health Plan to address the priority needs. The plan will be completed, board approved and posted on the Hospital's website prior to May 15, 2026.



About AdventHealth

AdventHealth Carrollwood 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 Carrollwood

AdventHealth Carrollwood is a 119-bed hospital located in West Hillsborough County. The hospital is a member of the faith-based AdventHealth System, providing a connected system of care in nearly a dozen states with over 50 hospitals and hundreds of care sites. The hospital offers nationally recognized and award-winning care, evidenced by earning a 4-Star Rating in Overall Hospital Quality from Centers for Medicare & Medicaid Services (CMS), consecutive "A" Hospital Safety Grades from the Leapfrog Group since 2015, and multiple Joint Commission certifications including Shoulder Replacement, Primary Stroke Center, Advanced Certification for Total Hip and Knee Replacement and Florida's First Advanced Certification in Spine Surgery. The hospital provides a wide variety of services including heart and vascular care, spine and orthopedics, digestive health, bariatrics, women's services, wound care, robotic technology, two 24/7 emergency rooms with online scheduling, in Carrollwood and Westchase, and much more. With a focus on whole-person care, skilled and compassionate caregivers provide individualized care for body, mind, and spirit. To learn more about the hospital's services, visit AdventHealthCarrollwood.com.



AdventHealth Carrollwood is a 119-bed hospital located in West Hillsborough County, providing nationally recognized and award-winning care.





Community Overview

Community Description

Located in Hillsborough County, Florida, AdventHealth Carrollwood defines its community as Hillsborough County since the Collaborative collected and analyzed the needs assessment data at the county level.

According to the 2020 United States Census, the population in Hillsborough County has grown by 18.8% within ten years increasing from 1,229,224 people in 2010 to 1,459,762 in 2020. This percent increase is higher than that seen by the state of Florida as a whole (14.6%).

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 is reported for Hillsborough County, unless listed differently. Data is also provided to show how the community compares locally, in the state, and at a national level for some indicators.

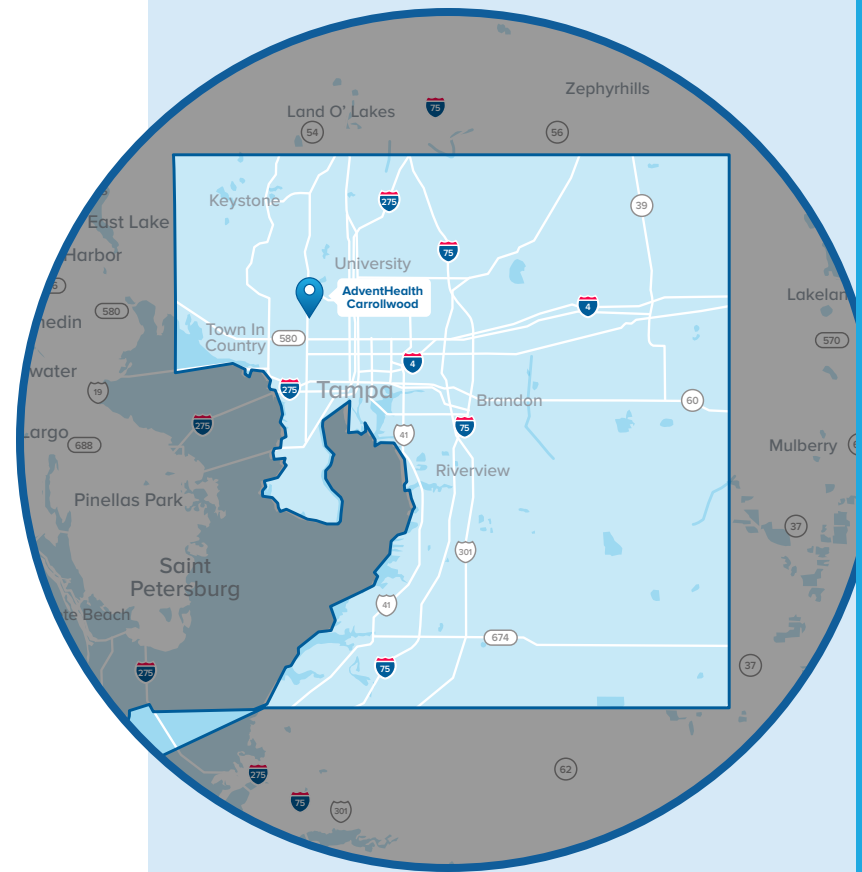
Community Profile

Age and Sex

The median age in the Hospital's community is 37.9, lower than that of the state which is 42.8 and the US, 39.2.

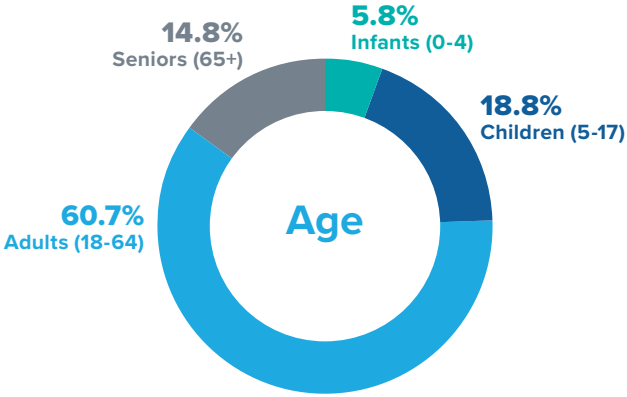
Females are the majority, representing 50.8% of the population. Young adults, ages 25–34 are the largest subset demographic in the community at 14.9%.

Children make up 24.6% of the total population in the community. Infants, those zero to four, are 5.8% of that number. The community birth rate is 11.6 births per 1,000 women of childbearing age. This is higher than the U.S. average of 11.0 and higher than that of the state, 9.9. In the Hospital's community, 17% of children aged 0–4 and 16.5% of children aged 5–17 are in poverty.



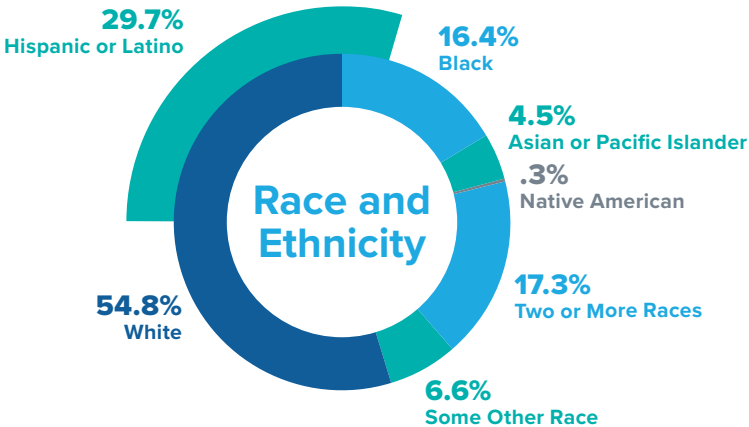
The population in Hillsborough County has grown by 18.8% within ten years.

Seniors, those 65 and older, represent 14.8% of the total population in the community.



Race and Ethnicity

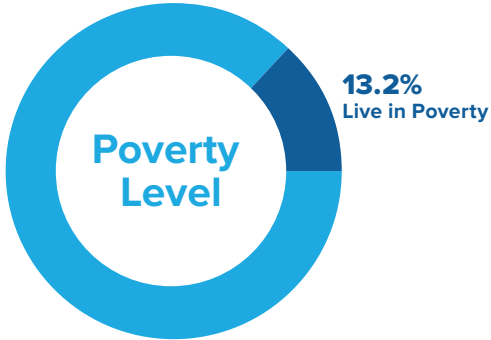
In the Hospital's community, 54.8% of the residents are White and 16.4% are Black. Residents who are of Asian or Pacific Islander descent represent 4.5% of the total population, 0.3% are Native American, 17.3% are two or more races and 6.6% identify as some other race. In the Hospital's community, 29.7% are of Hispanic or Latino ethnicity.



Economic Stability

Income

The median household income in the Hospital's community is \$75,011. This is above the median for the state and below the median for the US. In the Hospital's community, 13.2% of residents live in poverty, the majority of whom are under the age of 18.



Housing Stability

Increasingly, evidence is showing a connection between stable and affordable housing and health.¹ 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%.



¹ Severe housing cost burden* | County Health Rankings & Roadmaps

Education Access and Quality

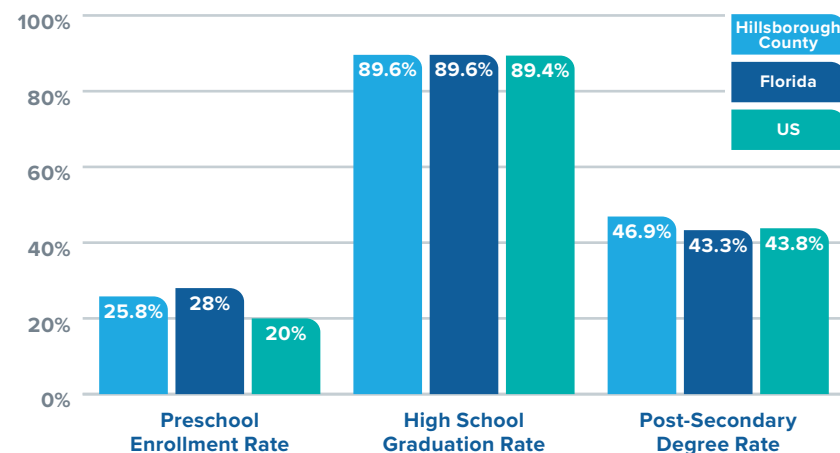
Research shows that education can be a predictor of health outcomes, as well a path to address inequality in communities.² Better education can lead to people having an increased understanding of their personal health and health needs. Higher education can also lead to better jobs, which can result in increased wages and access to health insurance.

In the Hospital's community, there is an 89.6% high school graduation rate, which is the same as the state and slightly higher than the national average. The rate of people with a post-secondary degree is higher 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.³

In the Hospital's community, 25.8% of three- and four-year olds were enrolled in preschool, which is lower than the state (28%). There is a large percentage of children in the community who may not be receiving these early foundational learnings.

Educational Attainment



² 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)

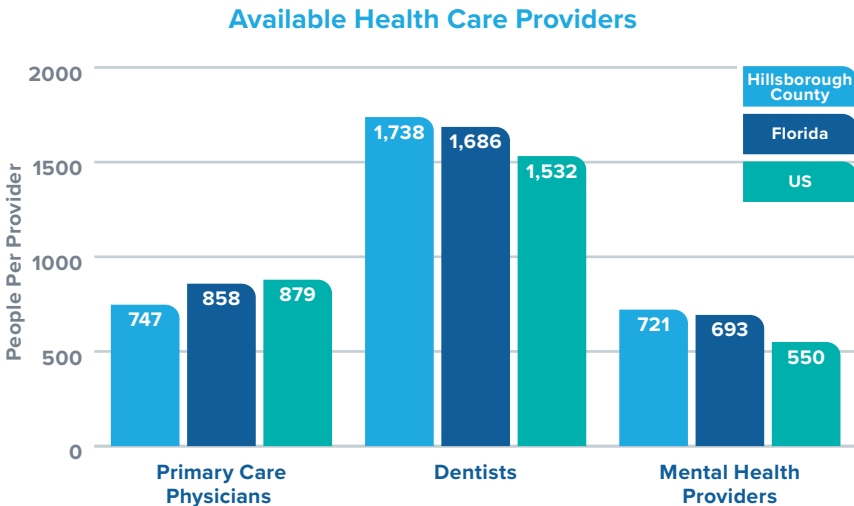
³ Early Childhood Education | U.S. Department of Health and Human Services

Health Care Access and Quality

In 2023, 16.1% of community members aged 18–64 were found to lack 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.⁴

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. Hillsborough County is performing better and has a lower person per provider ratio than the state.

Routine checkups can provide an opportunity to identify potential health issues and when needed develop care plans. In the Hospital’s community, 74.5% of people report visiting their doctor for routine care.



4 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.⁵ In the Hospital’s community, 34% of the community lives in a low food access area.⁶



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 estimates for 2022⁸ showed the food insecurity rate in the Hospital’s community as 12.7%

Access to public transportation is also an important part of a built environment. For people who do not have cars, reliable public

5 Heart Disease Risk Factors | CDC

6 Economic Research Service Food Environment Atlas, 2019 | USDA

7 Facts About Child Hunger | Feeding America

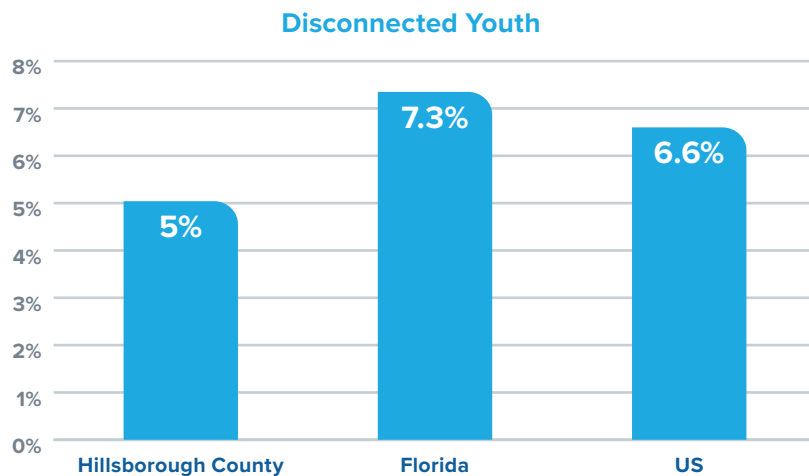
8 Map the Meal Gap 2022 | Feeding America

transportation can be essential to access health care, healthy food and steady employment. In the community, 5.8% of the households do not have an available vehicle.⁹

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.¹⁰ 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, 5% of youth aged 16–19 were reported as disconnected, meaning they were neither enrolled in school nor working at the time.



Also, in the community 24.5% of seniors (age 65 and older) report living alone and 11.9% of residents report having limited English proficiency. All these factors can create barriers to feeling connected in the community.

⁹ American Community Survey 2019-2023 Five-year Estimates | US Census Bureau

¹⁰ Social and Community Context - Healthy People 2030 | US Department of Health and Human Services

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 All4HealthFL 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 a Collaborative to guide the assessment process. The Collaborative is a regional effort through which health systems and departments of health spanning multiple counties work to improve community health by leading outcome driven initiatives addressing the needs found in the assessment. The Collaborative includes representation from the Hospital, public health experts, and community members, including AdventHealth, BayCare Health System, Moffitt Cancer Center, Johns Hopkins All Children's Hospital, Lakeland Regional Health Medical Center, Orlando Health Bayfront Hospital, Tampa General Hospital and the Florida Department of Health. This included intentional representation from those serving low-income, minority and other underserved populations.



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.

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 this 2025 Community Health Needs Assessment.

Community Input

The Collaborative collected input directly from the community and from community stakeholders, including individuals working in organizations addressing the needs and interests of the community.

Input was collected through three different means: a community health survey, stakeholder interviews, and focus groups.

Community Health Survey

- The survey was provided in English, Spanish, Haitian Creole and Russian 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. Responses from paper surveys were recorded using survey weblinks.

Stakeholder Interviews


- Participants were asked to provide input on health, and barriers to health, that they saw in the community.
- Interviews were conducted with individuals working at community organizations, including public health organizations, which work to improve the health and well-being of 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

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

Access Audits

- An access audit evaluates the accessibility and ease for community members to access services at various organizations in the community providing health care and social services. The process involves posing as a potential client or patient to evaluate the experience of accessing care and services.
- An access audit will evaluate key areas, including (but not limited to): ability to accept new patients, eligibility guidelines, wait times, referral capabilities, staff inquiry skills, and language accommodations.
- The full results can be found on the All4HealthFL website (all4healthfl.org).

A man with a beard and a blue shirt is smiling while cooking in a kitchen. He is using a wooden spoon to stir a dish in a pan. In the background, a woman and two children are sitting at a dining table, looking at a laptop. The kitchen has white cabinets and a granite countertop. There are various vegetables and a bowl of bread on the counter.

The Collaborative collected input directly from the community and from community stakeholders, including individuals working in organizations addressing the needs and interests of the community.

Public and Community Health Experts Consulted

A total of 29 stakeholders provided their expertise and knowledge regarding their communities, including:

Name	Organization	Services Provided	Populations Served
Christine Long	Metropolitan Ministries	Social services, food, homeless resources	Homeless and low income
Carrie Zeisse	Tampa Bay Thrives	Mental health	Youth, general population
Clara Reynolds	Crisis Center of Tampa Bay	Mental health, crisis response	General population
Dr. Doug Holt	Florida Department of Health in Hillsborough County	Public health	General population
Dr. Christian Frazier	Zero Suicide Hillsborough Alliance	Mental health	General population
Dr. Dexter Frederick	BEST Academy	Health care education, mentorship	Underserved youth
Dr. Joe Bohn	University of South Florida	Public health	General population, veterans
Dr. Sarah Combs	University Area CDC	Workforce development, community engagement, social support services	Underserved
Ellsworth “Tony” Williams	Veterans Counseling Veterans	Mental health, social services	Veterans and families
Freddy Williams	Boys and Girls Club of the Suncoast	Education, social services	Underserved youth, families
Karen Barfield	Central Florida Behavioral Health Network	Behavioral health	General population
Karen Blanchette	Aspire Health Partners	Behavioral health	General population
Katie Roders Turner	Family Healthcare Foundation	Health care access	General population, low income
Kimberly Williams	Feeding Tampa Bay	Food assistance	Underserved, low income
Rene Cantu	Tampa Bay LGBTQ+ Chamber	LGBTQ+ services, advocacy	LGBTQ+
Lorena Hardwick	Feeding Tampa Bay	Food assistance	Underserved, low income
Natasha Pierre	The Set Mind Consulting	Mental health	General population
Priya Rajkumar	Metro Inclusive Health	Health care	Uninsured population
Roaya Tyson	Gracepoint	Behavioral health	General, low income, youth
Rosy Bailey	Hispanic Services Council	Education, health care access, social services	Hispanic/Latino
Sara Hendricks	USF Center for Urban Transportation Research	Safety, transportation	General population
Sherry Wheelock	Special Olympics Florida	Health and wellness, advocacy, community engagement	People with disabilities
Teresa Kelly	Health Council of West Central Florida	Public health	General population
Yvette Lewis	NAACP	Advocacy	Black/African American
Amy Haile	Champions for Children	Social services	Youth and families
Demetric Watkins	National Alliance on Mental Illness	Mental health, advocacy	General population
Josh Payne	UF/IFAS Extension of Hillsborough	Nutrition, education	General population, low income
Marissa Mowat	Healthy Start Coalition of Hillsborough County	Social services, health care, safety	Youth and families
Tammi Casigni	Dawning Family Services	Homelessness prevention, recovery	People experiencing/at risk of homelessness



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:

- U.S. Census Bureau
- Centers for Disease Control and Prevention
- Feeding America
- County Health Rankings
- The State Health Department

Hospital utilization data for uninsured or self-pay patients who visited the Hospital for emergency department, inpatient or outpatient services in 2024 were also used in the assessment. The top ten diagnosis codes were provided by the AdventHealth Information Technology team.

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 eight 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:



Cancer

Cancer is a disease in which some of the body's cells grow uncontrollably and spread to other parts of the body. Cancer can start almost anywhere in the human body, which is made up of trillions of cells. Normally, human cells grow and multiply (through a process called cell division) to form new cells as the body needs them. When cells grow old or become damaged, they die, and new cells take their place. Sometimes this orderly process breaks down and abnormal or damaged cells grow and multiply when they shouldn't. These cells may form tumors, which are lumps of tissue. Tumors can be cancerous or not cancerous (benign).



Heart Disease and Stroke

Heart disease is the leading cause of death in the U.S. and stroke rounds out the top five. The reduction of cases in these chronic conditions can potentially be lowered by focusing on maintaining a healthy blood pressure and reducing high cholesterol. Additionally, making healthy lifestyle choices, such as consuming a heart-healthy diet, refraining from smoking, and limiting alcohol intake may also help in reducing the chances of developing heart disease and stroke. Equipping people with this knowledge, and time sensitive, life-saving techniques, such as CPR, may help save lives from these conditions.





Mental Health

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



Oral Conditions

The nation's oral health has greatly improved since the 1960s, but not all Americans have equal access to these improvements. Some racial/ethnic and socioeconomic groups have worse oral health as a result of the social determinants of health—conditions in the places where people are born, live, learn, work, and play. In addition, many low-income adults do not have public dental insurance. Medicaid programs are not required to provide dental benefits to adult enrollees, so dental coverage varies widely from state to state.



Nutrition and Healthy Eating

In the United States many people lack access to healthy foods and the information needed to make healthier food choices that ultimately impact their health. Food security exists when all people have physical and economic access to sufficient safe and nutritious food that meets their dietary needs and food preferences at all times. A lack of food security has been linked to negative health outcomes in



Economic Stability

children and adults, as well as potentially causing trouble for children in schools. Additionally, convenience and cost also contribute to the choice of an unhealthy diet. Healthy People 2030 aims to increase access and awareness around healthy food choices and their link to reducing risk for chronic conditions.



Health Care Access and Quality

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



Neighborhood and Built Environment

Where people live can potentially directly impact their physical and mental health. Individuals living in areas with high crime rates, poor environmental conditions, and unsafe paths of travel are disadvantaged due to the lack of healthy lifestyle opportunities compared to those living in safe neighborhoods.



Priorities Selection

The Collaborative, through data review and discussion, prioritized the health needs of the community to a list of three. Community partners on 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. During the spring of 2025, the Collaborative met to review and discuss the collected data and select the top community needs.

Members of the Collaborative included:

Community Members

- Marcellina Adonis, Calvary Community Clinic
- Kimberly Williams, Feeding Tampa Bay
- Demetric Watkins, National Alliance on Mental Illness Hillsborough
- Aria Garling, Seniors in Service
- Josh Payne, UF/IFAS Extension of Hillsborough
- Pamela Bradford, UF/IFAS Extension of Hillsborough
- Makenna Casebolt, Special Olympics Florida
- Junia LaFleur, First University Seventh Day Adventist Church
- Candice Foster, The Well Tampa/Health Matters Pharmacy
- Dr. Kelli Agrawal, Cove Behavioral Health
- Dhalia Bumbaca, WellBuilt City
- Jody Thorson, Tampa YMCA
- Dawn Kita, Tampa YMCA
- Isabela Solis, Family Healthcare Foundation
- Karen Barfield, Central Florida Behavioral Health Network
- Kayla Wilson, Gulfcoast North AHEC
- Patricia Townsend, Crisis Center of Tampa Bay
- Dr. Timothy Walker, James A. Haley VA
- Susan Morgan, Gracepoint Wellness
- Wyatt Deihl, CAN Community Health
- Stephanie Krager, The Phoenix Tampa



Community partners on 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.



- Regina Roig-Romero, Champions for Children
- Mari Nicole Esquinaldo, Boys and Girls Club Suncoast
- Kelly Hall, Judeo Christian Clinic
- Lauri Wright, University of South Florida
- Frank Crum, City of Tampa
- Ashley McPhie, Tampa Family Health Center
- Cyndie Cunningham, Cove Behavioral Health
- Christine Long, Metropolitan Ministries
- Antoinette Hagley, Cove Behavioral Health
- Antonio Byrd, Hillsborough Homeless Initiative
- Julaina Webber, Gulfcoast North AHEC

AdventHealth Team Members

- Elizabeth Guckes, AdventHealth Carrollwood
- Romel Charles, AdventHealth Carrollwood/AdventHealth Riverview
- Alexander Angellakis, AdventHealth Tampa
- Jordan Smith, AdventHealth Riverview
- McKenzie Doll, AdventHealth Tampa and Carrollwood Foundation
- Logan Foster, AdventHealth Tampa and Carrollwood Foundation
- Megan Miller, AdventHealth Riverview Foundation
- Kristen McCall, AdventHealth Foundation
- Nicholas Burgess, AdventHealth Foundation
- Dean Whaley, AdventHealth Strategic Partnerships and Community Engagement
- Alyssa Smith, AdventHealth Community Benefit
- Alison Grooms, AdventHealth Community Benefit
- Lauren Phillips-Koen, AdventHealth Community Benefit
- Amberhope Montero AdventHealth Community Benefit

Public Health Experts

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Prioritization Process

To identify the top needs the Collaborative participated in a prioritization session. During the session, the data behind each need was reviewed, followed by a discussion of the need, the impact it had on the community, and the resources available to address it. Collaborative members then ranked the needs via an online survey.

The Collaborative members (n=116) were asked to select the top needs they thought the Hospital should address in the community.

The following criteria were considered during the prioritization process:

A. Magnitude

What is the size of the problem?

B. Severity

What are the implications if this issue is not addressed?

C. Feasibility

How likely can the Hospital address this problem?

The following needs rose to the top during the Collaborative’s discussion and prioritization session. The needs were ranked using the modified Hanlon method where they are scored on a scale of 1 to 5 based on magnitude, severity, and feasibility. The lower the overall score, the more pressing the health need is to address.

Top Identified Needs	Score	Rank
Health Care Access and Quality	7.84	1
Mental Health	9.11	2
Economic Stability	11.39	3
Nutrition and Healthy Eating	11.88	4
Neighborhood and Built Environment	15.97	5
Heart Disease and Stroke	16.89	6
Oral Conditions	17.39	7
Cancer	19.62	8



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 Collaborative chose which priorities to address.

Top Needs	Current Community Programs		Current Hospital Programs
Health Care Access and Quality	<ul style="list-style-type: none"> Tampa Family Health Centers (FQHC) Family Healthcare Foundation 	<ul style="list-style-type: none"> Calvary Community Clinic (free clinic) GRACE Community Clinic (free clinic) 	<ul style="list-style-type: none"> Support groups for chronic diseases AdventHealth's Care 360 program to connect patients to health care and social services at discharge Whole Health Hub Mobile mammography bus Community screening events
Mental Health	<ul style="list-style-type: none"> National Alliance on Mental Illness (NAMI) Tampa Bay Thrives Area Health Education Centers (AHEC)/Tobacco Free Florida Florida Department of Health Narcan distribution 	<ul style="list-style-type: none"> Veterans Counseling Veterans Zero Suicide Alliance Hillsborough The Phoenix Tampa Cove Behavioral Health 	<ul style="list-style-type: none"> AdventHealth sponsored Mental Health First Aid Classes Gracepoint collaboration for behavioral health visits
Economic Stability	<ul style="list-style-type: none"> Tampa Corporation to Develop Communities (Tampa CDC) University Area Corporation to Develop Communities (UACDC) 	<ul style="list-style-type: none"> Feeding Tampa Bay job training programs Metropolitan Ministries job training Boys and Girls Club 	<ul style="list-style-type: none"> Sponsorship for workforce development programs
Nutrition and Healthy Eating	<ul style="list-style-type: none"> Feeding Tampa Bay Florida Department of Health Diabetes Self-Management program UF/IFAS Extension nutrition education Homegrown Hillsborough 	<ul style="list-style-type: none"> WellBuilt Cities Kinship Market Meals on Wheels YMCA Veggie Van Tungett Produce and Citrus 	<ul style="list-style-type: none"> AdventHealth Food is Health® Food pantry donations Support groups
Neighborhood and Built Environment	<ul style="list-style-type: none"> USF Center for Transportation Research and Safety Tampa Bay Network to End Hunger 	<ul style="list-style-type: none"> Hillsborough Transit Authority Hillsborough Parks and Recreation 	None

Top Needs	Current Community Programs		Current Hospital Programs
Heart Disease and Stroke	<ul style="list-style-type: none"> American Heart Association 	<ul style="list-style-type: none"> YMCA Blood Pressure Self-Monitoring Program 	<ul style="list-style-type: none"> Support groups Community Hands-Only CPR Stroke education
Oral Conditions	<ul style="list-style-type: none"> Tampa Family Health Centers (FQHC) 		None
Cancer	<ul style="list-style-type: none"> American Cancer Society Tampa Bay Community Cancer Network 	<ul style="list-style-type: none"> Breast and Cervical Cancer Early Detection Program YMCA LIVESTRONG Program 	<ul style="list-style-type: none"> Support groups Breast cancer outreach and education Community screening events Mobile mammography bus





By including mental health as a priority, the Hospital can align to local, state, and national efforts for resource collaboration to influence improved outcomes over the next three years.

Priorities Addressed

The priorities to be addressed include:



Mental Health

Mental health and mental disorders, including behavioral health and substance misuse, were identified as top health needs from the secondary data, community survey, and focus groups. About 28% of survey respondents reported being diagnosed with depression or anxiety. Additionally, focus group participants cited a need for clarity in navigating mental health programming and services. Secondary data showed an increased trend in the percentage of middle school (26.9%) and high-school (41.9%) students who reported using any alcohol or illicit drugs in their lifetime. Nearly 60% of community survey respondents ranked mental health as the most pressing issue to address in the community. Awareness and the need to address mental and behavioral health has been growing in the country and locally. By including mental health as a priority, the Hospital can align to local, state, and national efforts for resource collaboration to influence improved outcomes over the next three years.



Economic Stability

Economic stability impacts an individual's physical and mental health. In the Hospital's community, 35% of residents are housing cost-burdened, or paying over 30% of their income to housing costs. In Hillsborough County, 13.2% of residents are living below the federal poverty level and 31% fall into the ALICE (Asset Limited, Income Constrained, Employed) household category. ALICE households are those earning above the federal poverty level but still struggling to afford necessities for optimal quality of life. In Hillsborough, 12.7% of residents are food insecure and community survey respondents ranked access to low-cost, healthy food as one of the most important factors to improve quality of life. The Collaborative chose this as a priority to address since economic stability impacts multiple aspects of health.



Health Care Access and Quality

Access to quality health care was ranked number one in the prioritization session amongst the other identified health needs affecting Hillsborough County. An important factor in access to care involves having an adequate number of providers in a community. The ratio of people to primary care providers in Hillsborough County is 747:1 which is better than that of the state 858:1. Hillsborough County has a ratio of people to dental providers of 1,738:1 compared to Florida at 1,686:1, performing worse than the state. Similarly, the ratio for people to mental health providers in Hillsborough County is 721:1 compared to the Florida at 693:1. Inadequate health insurance coverage is one of the largest barriers to health care access and the unequal distribution of coverage contributes to disparities in health. The percentage of adults ages 19-64 that do not have health insurance coverage in Hillsborough County is 16.1%, slightly lower than the state of Florida at 17.5%. By focusing on access to care, the Hospital will align local efforts and resources to create targeted strategies to improve access for Hillsborough County residents.



Priorities Not Addressed

The priorities not to be addressed include:



Cancer is the second leading cause of death in Hillsborough County with a death rate of 164.5 per 100,000 population. However, the Collaborative did not choose cancer as a priority to address, instead focusing on issues that can prevent cancer or increase early detection through screenings and medical care. By addressing these other priorities, the Collaborative aims to increase its impact on overall health outcomes, including cancer rates.



Heart Disease and Stroke as a topic on its own did not come through as one of the top three issues to be addressed. In Hillsborough County, it is the leading cause of death and 32.1% of survey respondents reported being told by a medical provider that they have hypertension and/or heart disease. The Collaborative decided that addressing preventative factors that affect heart disease, such as access to care, would be a more effective strategy to address heart disease and stroke.



Throughout the assessment, access to care was identified as a top issue, but specifically access to dental care was noted as a common concern among community members. In the community survey, 19.8% of survey respondents reported that they needed dental care and did not receive it within the past 12 months, citing reasons such as inability to afford care and schedule appointments when needed. Hillsborough County has a ratio of people to dental providers of 1,738:1 compared to Florida at 1,686:1. While the Collaborative agreed that oral conditions is an important issue to address, they felt that prioritizing access to care, inclusive of dental care access, was the most impactful option.



In Hillsborough County, 30% of adults are obese, which is slightly higher than the state at 28%. According to Feeding America, food insecurity is when people cannot access the food they need to live healthy and good quality lives. The food insecurity rate in Hillsborough County is 12.7% according to Feeding America's 2022 data. In Hillsborough County, 74% of survey respondents stated that they do not eat at least three servings of fruits and vegetables every day. The Collaborative chose not to focus on this priority as access to food and basic needs is encompassed in economic stability.



Hillsborough County has a projected population growth of 18% from 2020 to 2032. During the assessment, transportation was cited as a barrier to accessing care and the projected population growth could further strain current public transportation systems. In Hillsborough County, 5.8% of households do not own a vehicle. This can make transportation and accessing resources difficult. Poor access to transportation significantly limits access to health and health care, and while this is an issue, the Collaborative felt addressing other needs were more feasible.



Next Steps

The Hospital will collaborate with 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 – 2025 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: Access to Health and Social Services

In 2022, Access to Health & Social Services was a top health need identified from both the community survey and focus group discussions. Thirty-six percent (36%) of community survey respondents ranked Access to Health Care as a pressing quality of life issue. Reasons that prevented survey respondents from getting medical care they needed included: unable to schedule an appointment when needed, unable to afford to pay for care, cannot take time off work, and doctors' offices that do not have convenient hours. Other barriers included: Medicaid changes, higher than anticipated co-payments, COVID-19 restrictions and long wait times to see a medical provider. Adults without health insurance and a usual source of health care are top areas of concern related to health care access & quality in Hillsborough County. The percentage of adults without health insurance in Hillsborough County was 23%, which fell in the lowest quartile of counties in the nation.

Since adopting the plan, the Hospital participated in a division wide program, AdventHealth Food is Health®, that provides series-based nutrition education and culturally appropriate, nutritious foods to participants in low income/low access areas in the hospital's community. The program involves collaborations from a variety of community partners, including subject matter experts providing



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



nutrition education, mobile produce vendors, and sites in the community where classes are held. Since the start of the 2023–2025 Community Health Plan, the West Florida Division has distributed 95,242 pounds of produce to 2,064 participants and their families. The Hospital also collaborated with the American Heart Association to provide free Hands-Only CPR demonstrations to members of the community. Across the division, Hands-Only CPR demonstrations have been provided for 7,254 participants.



Priority 2: Behavioral Health — Mental Health and Substance Misuse

Mental health and substance misuse were identified as top health needs from the secondary data, community survey and focus groups. About 31% of survey respondents reported being diagnosed with depression or anxiety. Thirty percent (30%) of community survey respondents ranked illegal drug use/abuse of prescription medications and alcohol abuse/drinking too much as important health issues to address. In Hillsborough County, deaths due to drug poisoning and opioid overdose have been an increasing concern. Secondary data showed an increased trend in the percentage of 6th–12th grade students who have used electronic vaping in the 30 days prior to the survey.

The Hospital focused its efforts on increasing education and building community level networks for mental health support. As part of this effort, the Hospital partnered with Safe and Sound Hillsborough to provide free Mental Health First Aid classes to community members. This division-wide initiative has sponsored 21 classes for 307 participants since the start of this Community Health Plan. Additionally, 91.4% of participants shared that after attending the class, they felt confident to utilize their new skills in reducing the stigma of mental health by discussing the topic with someone struggling and connecting them to resources. The Hospital provided several sponsorships supporting 736 community members with needed mental health services through partner organizations such as The Phoenix, Metropolitan Ministries, National Alliance on Mental Illness, and the Zero Suicide Alliance of Hillsborough.



2022 Community Health Needs Assessment Comments

We posted a link to the most recently conducted CHNA and the most recently adopted implementation strategy on our hospital website as well as on [AdventHealth.com](https://www.adventhealth.com) prior to May 15, 2023 and have not received any written comments.



University Community Hospital, Inc. dba AdventHealth Carrollwood

CHNA Approved by the Hospital board on: August 27, 2025

For questions or comments, please contact
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