AdventHealth Ocala 2025 Community Health Needs Assessment

Extending the Healing Ministry of Christ

AdventHealth

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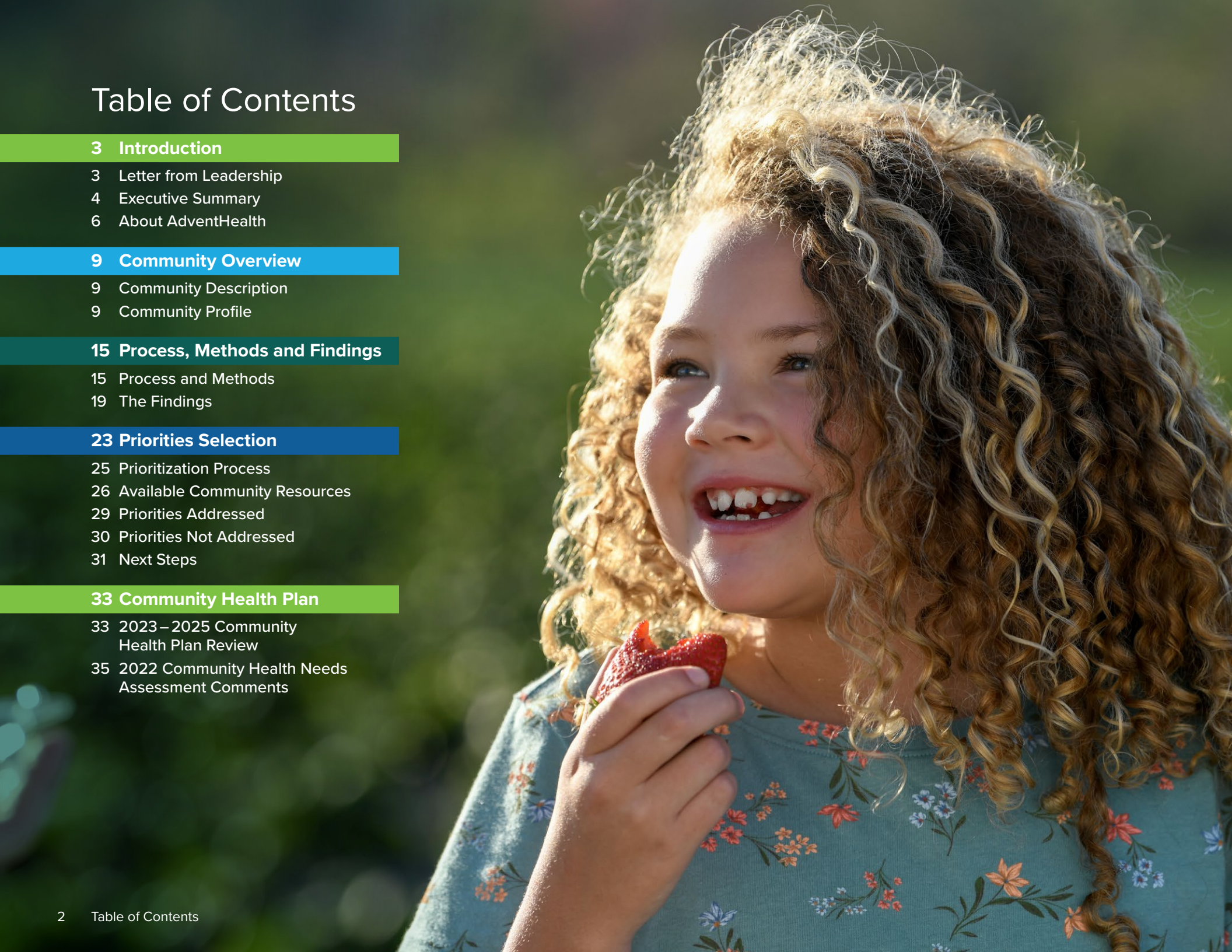


Letter from Leadership

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

Florida Hospital Ocala Inc. dba AdventHealth Ocala will be referred to in this document as AdventHealth Ocala or "The Hospital." AdventHealth Ocala in Ocala, Florida conducted a community health needs assessment from October 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.

The All4HealthFL Collaborative

To ensure broad community input, AdventHealth Ocala 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 Ocala 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 was 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. Nutrition and Healthy Eating
3. Health Care Access and Quality

See Priorities Addressed for more.

Approval

On August 14, 2025, the AdventHealth Ocala 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 Ocala will work with the CHNAC 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 Ocala 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 Ocala

AdventHealth Ocala is a 385-bed full-service community hospital that opened in 1898. In August 2018, AdventHealth Ocala became a part of the AdventHealth network. The facility is 640,000 square feet and sits on 15-acres. Within the hospital network there are three 24/7 ER facilities, one onsite and two offsite, to better meet the needs of Marion County. The onsite ER has both an adult and children's emergency department that has over 50 combined beds with the ability to treat many conditions and injuries. The two offsite ER's, AdventHealth TimberRidge ER and AdventHealth Belleview ER are both 24-hour full-service emergency departments with all private rooms and AdventHealth TimberRidge ER was the first offsite ER in the state of Florida. The hospital offers many inpatient services including, labor and delivery through The Baby Place®, level II NICU, Orthopedic unit, comprehensive cardiovascular surgery unit, neuro unit and a wound care center. AdventHealth Ocala is accredited with The Joint Commission and has received recognition from the American Heart Association and American Stroke Association. They are accredited by the American College of Cardiology in Chest Pain, Heart Failure, Cardiac Cath Lab, Electrophysiology, Transcatheter Valve Certified and awarded the HeartCARE™ Center designation. They are also a Certified Advanced Primary Stroke Center as well as a Center of Excellence in Robotic and Hernia Surgery.

AdventHealth Ocala is a 385-bed full-service community hospital that opened in 1898.

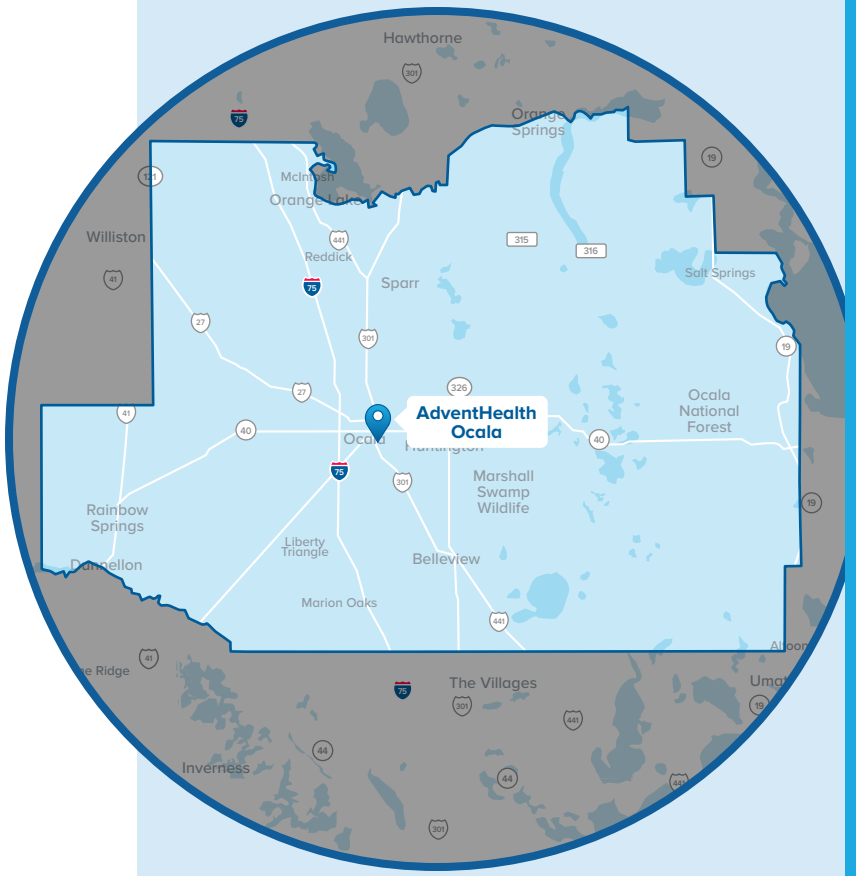
Community Overview

Community Description

Located in Marion County, Florida, AdventHealth Ocala defines its community as Marion 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 Marion County has grown by 13.5% within ten years increasing from 331,298 people in 2010 to 375,908 in 2020. This percent increase is just under that seen by the state of Florida as a whole.

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 Marion 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

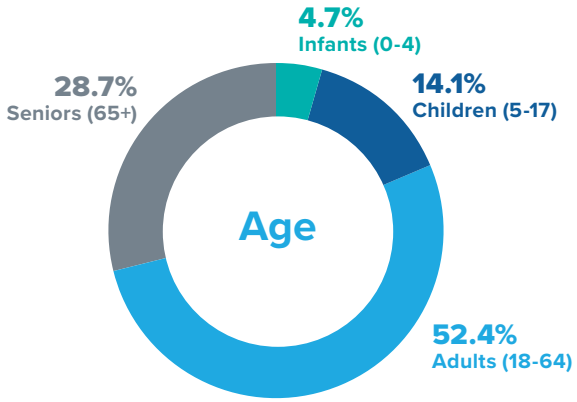
The median age in the Hospital's community is 47.7, slightly higher than that of state which is 42.8 and the US, 39.2.

Females are the majority, representing 51.7% of the population. Senior adults, ages 65 to 74 are the largest subset demographic in the community at 15.5%.

Children make up 18.8% of the total population in the community. Infants, those zero to four, are 4.7% of that number. The community birth rate is 9.2 births per 1,000 women. This is lower than the U.S. average of 11.0 and lower than that of the state, 9.9. In the Hospital's community, 25.8% of children aged 0–4 and 22.3% of children aged 5–17 are in poverty.

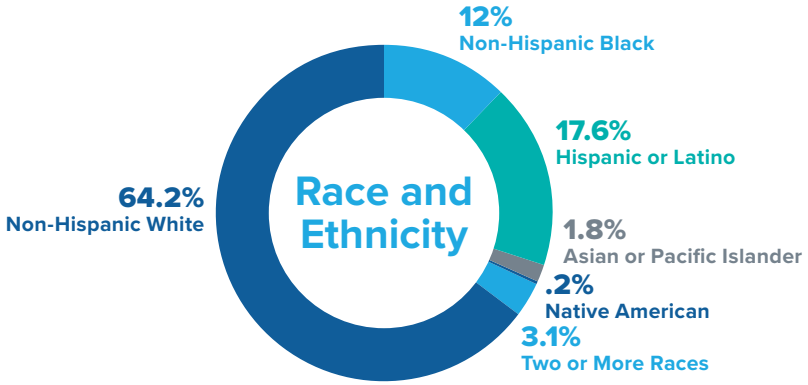
The population in Marion County has grown by 13.5% within ten years increasing from 331,298 people in 2010 to 375,908 in 2020.

Seniors, those 65 and older, represent 28.7% of the total population in the community.



Race and Ethnicity

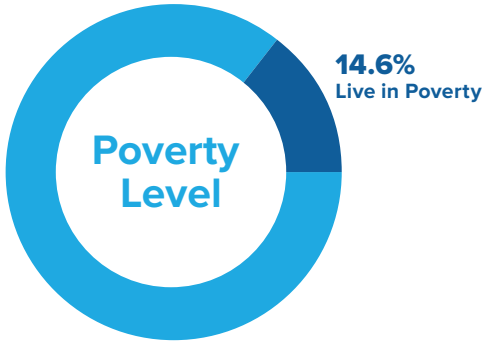
In the Hospital's community, 64.2% of the residents are non-Hispanic White, 12% are non-Hispanic Black and 17.6% are Hispanic or Latino. Residents who are of Asian or Pacific Islander descent represent 1.8% of the total population, while 0.2% are Native American and 3.1% are two or more races.



Economic Stability

Income

The median household income in the Hospital's community is $58,535. This is below the median for both the state and the US. Although below the median, 14.6% 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

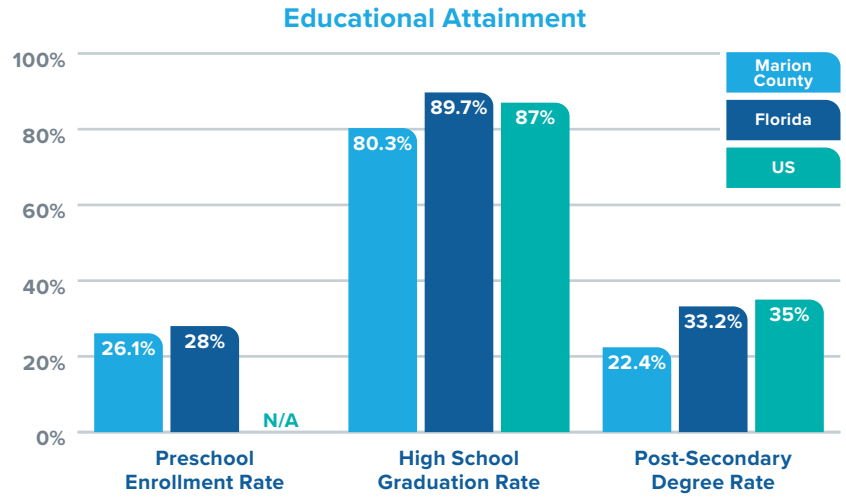
Education Access and Quality

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 80.3% high school graduation rate, which is lower than both that of the state, (89.7%) and national average (87%). The rate of people with a post-secondary degree is also lower in the Hospital's PSA 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, 26.1% of three- and four-year olds were enrolled in preschool. Although lower than the state (28.0%), there is still a large percentage of children in the community who may not be receiving these early foundational learnings.



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 | US Department of Health and Human Services

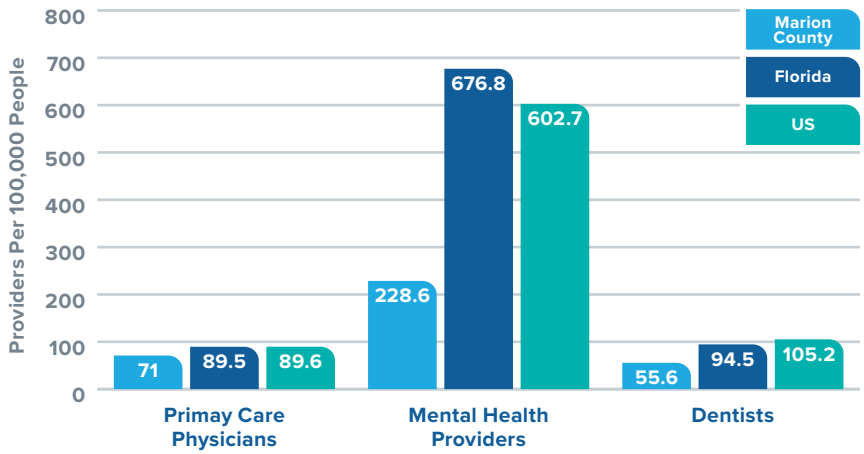
Health Care Access and Quality

In 2023, 20.3% 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. In the counties that the Hospital serves, Marion County has less primary care providers available 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, 79.3% of people report visiting their doctor for routine care.

Available Health Care Providers

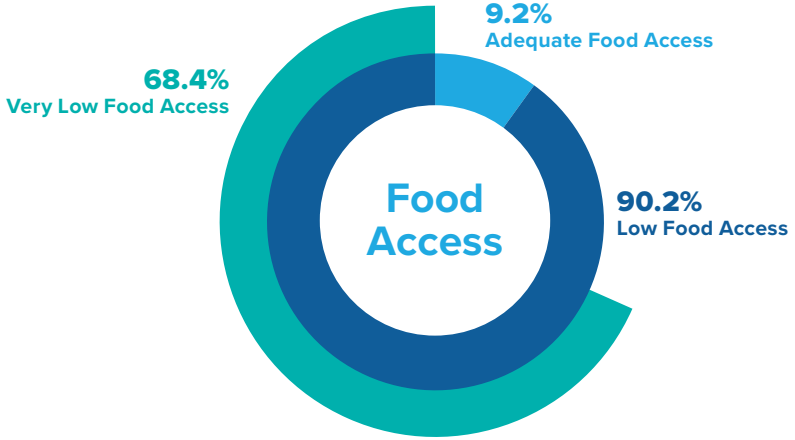


4 Health Insurance and Access to Care | CDC

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, 90.2% of the community lives in a low food access area, while 68.4% 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.[6] Feeding America estimates for 2023,[7] showed the food insecurity rate in the Hospital's community as 14.9%.

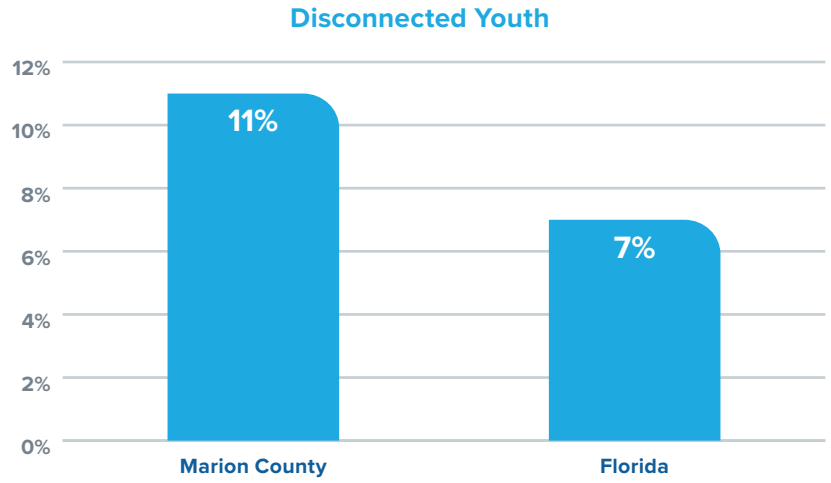
5 Heart Disease Risk Factors | CDC
6 Facts About Child Hunger | Feeding America
7 Map the Meal Gap 2023 | Feeding America

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, 4.9% 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.[8] 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, 11% 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 24.4% of seniors (age 65 and older) report living alone and 5.4% of residents report having limited English proficiency. All these factors can create barriers to feeling connected in the community.

8 Social and Community Context - Healthy People 2030 | U.S. 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 the broad community, 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 the 2025 CHNA.

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: the community health survey, the stakeholder survey, 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 Survey

- Participants were asked to provide input on health, and barriers to health, that they saw in the community.
- Surveys were sent to individuals working at community organizations, including public health organizations, that 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

- Four 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 American, LGBTQ+, Hispanic/Latino, Children and Older Adults. Members or representatives of these communities were selected to participate in the focus group discussions.

Public and Community Health Experts Consulted

A total of 23 stakeholders provided their expertise and knowledge regarding their communities, including:

Name	Organization	Services Provided	Populations Served
Beth McCall	Marion County Children's Alliance	Social services for children	Youth
Carson Pennypacker	Veterans Association	Social services	Veterans and families
Christy Jergens	Department of Health — Marion	Health care, public health	Underinsured, low-income population
Debra Velez	Marion County Hospital District	Health care, public health	General population
Erika Skula	AdventHealth Ocala	Health care	General population
George Asencio	FreeD.O.M. Clinic	Free dental, optical and medical care	Underserved, uninsured, minority members
Helen Urie	Marion County Parks and Recreation	Recreational spaces and activities	General population
Jess Majoros	Marion County Parks and Recreation	Recreational spaces and activities	General population
Jesse Blaire	Ocala Fire Rescue	Public service	General population
Loretha Tolbert-Rich	Tolbert-Rich and Associated	Health care navigation services	Underserved, uninsured, underinsured, minority
Monica DaSilva	Department of Health – Marion	Health care and public health	Underinsured, low-income population
Paula Burns	Heart of Florida Health Center	FQHC, health care and public health	Uninsured, underinsured, low-income, minority populations
Rebecca Elliott	UF/IFAS Extension	Health education	General population
Rob Balmes	Ocala/Marion County Transportation Planning Organization	Transportation services	General population
Rebecca Hallman	Langley Health Services	FQHC, health care and public health	Uninsured, underinsured, low-income, minority populations
Lynn Irish	Salvation Army	Basic needs and supplies	Homeless and low-income populations
Hilary Jackson	Marion County Children's Alliance	Social services for children	Youth
Billye Mallory	AdventHealth	Health care	General population
Jennifer Martinez	Marion Senior Services	Social services	Senior adults
Amy O'Brien	HCA Florida Ocala Hospital	Health care	General population
Faye Peraza	AdventHealth	Health care	General population
Lizette Satuny	Suwanee River Area Health Education Center (AHEC)	Tobacco cessation classes	General population
David Willis, MD	Marion County Medical Society	Health care	General population

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:

- US 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 was 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 non-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.

Injury Prevention

Unintentional injuries are the leading causes of death in the younger populations within the United States. This topic includes motor vehicle accidents, falls, drug overdoses, and violence. Educating and implementing safety initiatives may help reduce the incidence of unintentional injuries.

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 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.

Economic Stability

According to the 2023 U.S. Census data, just over 10% of the population lives in poverty. With the current economic rise in the cost of living, many people are unable to afford their basic needs such as housing, food, and health care. Without the ability to pay for these basic needs, individuals and families are at greater risk for poor health outcomes and quality of life.

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 to the lack of healthy lifestyle opportunities compared to those living in safe neighborhoods.

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.

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

- Nancy Baez, Lutheran Services of Florida
- Jeremiah Alberico, SMA Healthcare
- Jennifer Martinez, Marion Senior Services
- Racheal Franklin, Office of the State Attorney
- Julie Rada, SMA Healthcare
- Beth McCall, Marion County Children's Alliance
- Lynn Irish, Salvation Army
- Betsy Weber, Marion Sexual Assault Center
- Robin Lanier, SMA Healthcare
- Terence Thomas, SMA Healthcare
- Cheryl Martin, Marion County Community Services
- Helen Urie, Marion County Community Services
- Brody Gashaw, Langley Health Services
- Carson Pennypacker, Department of Veterans Affairs
- Athea Walters, Community Member
- Martha Dominguez, Empath Marion County Hospice
- Loretha Tolbert-Rich, Community Member
- John Podkamorski, National Alliance on Mental Illness (NAMI)
- Hilary Jackson, Marion County Children's Alliance
- Sabra Lunday, From the Heart
- Sandra Landers, Community Member
- Mary Catalan-Conver, Marion Senior Services
- Cindy Irving, Marion County Sheriff's Office
- Samantha Poulin, Universal Health Services, Inc.
- Wendy Resnick, UF Health
- Heather James, Estella Byrd Whitman Wellness & Community Resources Center Inc.
- Tyrone Edwards, Marion County Fire Rescue

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.

- Jesse Blaire, Ocala Fire Rescue
- Jessica Majoros, Marion County Parks and Recreation
- David Willis, Marion County Medical Society
- Travis McAllister, SMA Healthcare
- Andrea Simmons, Marion County Public Schools
- Rachael Seets, Marion County Community Services
- Latoya Artis, Community Member
- Barbara Fitos, Community Member
- Steven Leilich, National Alliance on Mental Illness (NAMI)

AdventHealth Team Members

- Brad Mclarty, Cardiopulmonary Rehab Manager, AdventHealth Ocala
- Alyssa Smith, Community Health Program Manager, AdventHealth West Florida Division
- Lauren Phillips-Koen, Community Health Coordinator, AdventHealth West Florida Division
- Chad Houchin, Director of Rehabilitation and Wellness Services, AdventHealth Ocala
- Billye Mallory, Community Relations Manager. AdventHealth Ocala
- Erika Skula, CEO, AdventHealth Ocala
- Faye Peraza, AVP Human Resources, AdventHealth Ocala
- Dean Whaley, Executive Director Strategic Partnerships, AdventHealth West Florida Division
- Alison Grooms, Community Health Program Manager, AdventHealth West Florida Division

Public Health Experts

- Craig Ackerman, Department of Health — Marion
- Rebecca Elliott, UF/IFAS Extension
- Jennifer Tartaglia, Department of Health — Marion
- Amy O'Brien, HCA Healthcare
- Tracey Sapp, Department of Health — Marion
- Sherry Duncan, Department of Health — Marion
- Christy Jergens, Department of Health — Marion
- Nina Mattei, Department of Health — Marion
- Randy Ming, Department of Health — Marion
- Monica DaSilva, Department of Health — Marion
- Jessica Cole, Marion County Hospital District
- Curt Bromund, Marion County Hospital District
- Paula Burns, Heart of Florida Health Center
- Debra Velez, Marion County Hospital District

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=57) 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 receiving the most votes were considered the highest priority. The needs were ranked using the modified Hanlon method where they are scored 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	10.77	1
Mental Health	11.69	2
Nutrition and Healthy Eating	11.92	3
Economic Stability	13.71	4
Injury Prevention	14.20	5
Heart Disease and Stroke	16.41	6
Neighborhood and Built Environment	19.46	7
Cancer	20.49	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
Cancer	• The Cancer Alliance of Marion County	• H.U.G.S. Charities Fund	• Medical care • Support groups
Heart Disease and Stroke	• American Heart Association's Hands-Only CPR program • Avante Group for cardiac rehab	• Heart of Florida Health Center • Langley Health Services	• Medical care and cardiac rehab • Support groups
Mental Health	• National Alliance on Mental Illness (NAMI)	• SMA Healthcare • Suwanee River AHEC's tobacco cessation classes	• AdventHealth sponsored Mental Health First Aid Classes • Gracepoint Medical Group collaboration program for behavioral health visits
Injury Prevention	• DOH—Marion's Safe Kids program		• Fall prevention education for seniors and at-risk patients
Nutrition and Healthy Eating	• DOH—Marion's diabetes and health education classes • Marion County Hospital District's Diabetes Empowerment Education Program and Strong People Living Well	• YMCA • UF/IFAS Extension nutrition education classes	• AdventHealth's Diabetes Navigator • AdventHealth Food is Health® • Support groups
Economic Stability	• CareerSource Marion's workforce development programs • Central Florida Community Action Agency's R.I.S.E Program	• One Stop Workforce Connection • Marion County Hospital District's Active Marion Project (AMP) • United Way Strong Families class	None
Health Care Access and Quality	• Department of Health—Marion's health care services for underserved • FreeD.O.M. Clinic USA	• Heart of Florida Health Center's health care clinic (FQHC) • Langley Health Services (FQHC) • Marion County Hospital District's chronic disease education classes	• AdventHealth's Care 360 program to refer patients into health care and social services at discharge • AdventHealth's free screening services at DOH—Marion and Marion County Hospital District's classes • Support groups for chronic diseases
Neighborhood and Built Environment	• Interfaith Emergency Services (gas vouchers for medical appointments)	• Marion Transit Services • Salvation Army	None

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 37.8% of survey respondents have been diagnosed with depression or anxiety. Additionally, focus group participants cited a need for increased affordable mental health programming and services. Secondary data showed an increased trend in the percentage of middle school (31.6%) and high-school (50.6%) students who reported using any alcohol or illicit drugs in their lifetime. Over fifty percent (58.4%) of community survey respondents ranked mental health as a problem 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 and mental disorders as a priority, the Hospital can align to local, state, and national efforts for resource collaboration and to create better outcome opportunities over the next three years.[9]

Nutrition and Healthy Eating

In Marion County, 38.4% of adults are obese. This is higher than the state values, although not significantly. Additionally, the food insecurity rate in Marion County is 14.9% according to Feeding America's 2023 data.[10] According to Feeding America, food insecurity is when people cannot access the food they need to live healthy and good quality lives. Thirty-five percent (35.8%) of Marion County residents surveyed reported themselves as food insecure and 84.4% stated that they do not eat at least three servings of fruits and vegetables every day. An unhealthy diet can lead to lifelong chronic and costly illnesses, thereby choosing this as a priority, the Hospital can collaborate with other community organizations to address this issue.

9 American Community Survey Data 5 Year (2023) | US Census Bureau
10 Map the Meal Gap 2023 | Feeding America

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 Marion County. An important factor in access to care involves having an adequate number of providers in a community. The rate of primary care providers in Marion County is 164.5 (per 100,000 population) which is slightly lower than that of the state at 261.2 (per 100,000 population). Marion County has a rate of dental providers at 37.1 compared to Florida at 61.5. Similarly, the rate for mental health providers in Marion County is 84.1 compared to the Florida rate of 133.2. 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 Marion County is 20.3%, slightly higher 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 Marion County residents.[11]

11 Medical Doctors (MD, Physicians)—Ten Year Report | FL Health CHARTS

Priorities Not Addressed

The priorities not to be addressed include:

Cancer

Though cancer is the second leading cause of death, and the death rate in Marion County due to cancer is slightly higher than that of the state, (148.8 versus 138.3 per 100,000 population respectively), the Collaborative did not select it as a top issue to address. Other priorities were voted as more important and feasible for the Hospital to make impact through collaborations and partnership programming.

Heart Disease and Stroke

Heart disease and stroke as a topic on its own did not come through as one of the top three issues to be addressed. Though, it is the leading cause of death, and 39.1% of survey respondents were told by a medical provider that they have hypertension and/or heart disease, the Collaborative did not perceive this a top issue to be addressed. The Collaborative did not select this as a priority as there are already several other community organizations actively addressing this need in the community who are better positioned to make an impact.

Injury Prevention

Throughout the assessment, unintentional injuries, specifically due to falls, was a common concern among participants. Survey respondents noted that Marion County was number one in the state due to deaths from falls. With the large elderly population that resides in Marion County, increasing cases of falls are a concern for many residents. The Collaborative agreed that this is an issue but decided that some of the other priority areas were more concerning and should be prioritized over falls to be addressed.

Economic Stability

In the Hospital's community, 26% of residents are housing cost-burdened, or paying over 30% of their income to housing costs. According to the community survey, 37.9% of respondents reported being worried they would not have stable housing in the next two months. Additionally, 14.6% of Marion County residents are living below the federal poverty level and 37% 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. The exceeding cost of living in the community is significant, however, the Collaborative did not perceive the ability to have a measurable impact on the issue within the three years allotted for the Community Health Plan with the current resources available to the community and the Hospital at this time.[12]

Neighborhood and Built Environment

Marion County is the 5th largest county by land in the state. There are many rural areas throughout the area, making neighborhood and built environment an issue for many residents. During the assessment transportation was often cited as a barrier to receiving care. In Marion County 4.9% of households do not own a vehicle. Access to transportation significantly limits access to health and health care, and while this is an issue, the Collaborative felt addressing other needs was more feasible.

12 Meet ALICE | UnitedForALICE

Next Steps

The CHNAC 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 – 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 Care

In the 2022 CHNA, the Hospital addressed access to care as a priority. During the assessment over half (54%) of the survey respondents ranked access to care as the most important factor contributing to a healthy community. Additionally, the rate for primary care, mental health, and dental providers was lower than that in the state. The assessment also noted that the percentage of adults between the ages of 18-64 who do not have health insurance was slightly higher than the state of Florida (20.5% versus 19.4%). Inadequate health insurance coverage is one of the largest barriers to health care access.

Since adopting the plan, the Hospital, as part of AdventHealth's West Florida Division, partnered with the American Heart Association to support free Hands-Only CPR trainings for community members. These classes were taught in schools, churches, and other locations. Over the course of the plan, the Division sponsored 76 classes and trained 7,254 people.

Priority 2: Behavioral Health — Mental Health and Substance Misuse

The data from the 2022 CHNA showed that in the Hospital's community, 18.7% of residents had depression, while 14.3% of residents reported poor mental health. Survey respondents (51.9%) ranked drug abuse as the behavior with the greatest negative impact

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

on overall health. One of the most concerning trends that was noted was deaths due to drug overdoses, which was one of the highest rates for counties in Florida (62.8 per 100,000). During this time Marion County also saw a higher percentage of adults who smoked, with 18.3% of adults in Marion County smoking compared to 14.8% for the state of Florida. By addressing this issue, the Hospital hoped to help reduce some of these staggering numbers overall.

To address this need, the Hospital, as part of AdventHealth's West Florida Division, partnered with an organization called Safe and Sound Hillsborough, to sponsor Mental Health First Aid classes for participants in the community. The classes were taught at the Department of Health—Marion and SMA Healthcare, among other locations. The Division sponsored 21 classes for 307 participants during the 2023—2025 CHP. 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 further resources. Additionally, AdventHealth Ocala, in partnership with Suwanee River Area Health Education Center (AHEC) taught tobacco cessation classes for a total of 30 participants over the course of the plan.

Priority 3: Wellness and Primary Prevention

Prevention means intervening before health effects occur, through measures such as vaccinations, altering risky behaviors (poor eating habits, tobacco use) and banning substances known to be associated with a disease or health condition. The committee chose to focus on wellness and primary prevention in the last CHNA cycle, specifically focusing on the areas of community safety and injury prevention, life skills education, and healthy behaviors and responsible health decision-making. During this time, a lower percentage of adults were overweight in Marion County compared to the state (31.8% versus 37.6%), but a greater percentage reported being obese (35.0% versus 27.0%), and over two thirds of adults reported being sedentary in Marion County, with only 30.2% meeting muscle strengthening recommendations.

As part of the effort to address this, the Hospital implemented the AdventHealth Food is Health® program in Marion County. The AdventHealth Food is Health® program serves to overcome barriers in accessing healthy foods for those underserved populations in the community by partnering with health educators and produce vendors to provide participants with nutrition education and free produce after each class. In Marion County, the Hospital partnered with the DOH—Marion, the Marion County Hospital District, and Farming 4 U for this program. As part of the AdventHealth West Florida Division, the Hospital contributed to 140 class series, 3,012 participants, and 95,242 pounds of produce distributed across the Division. In addition to this program, AdventHealth Ocala partnered with DOH—Marion and the Marion County Hospital District to offer free health screenings to participants at the beginning and end of each of their chronic disease self-management programs. Through this partnership, the Hospital delivered 109 free screenings to participants over the course of the plan.

Priority 4: Healthy Aging

In the previous needs assessment, the demographic data in Marion County showed that the representation of the older population is higher than the state of Florida as a whole, with 28.9% of the population being over the age of 65 compared to Florida at 20.5%. Older adults are at higher risk for chronic health problems like diabetes, osteoporosis, and Alzheimer's disease. Physical activity can help older adults prevent both chronic disease and fall-related injuries. Making sure older adults get preventive care and supportive community services can help them stay healthy. Providing services for patients and families affected by Alzheimer's disease and dementia emerged as an important topic to address in the Hospital's community. The data showed that 12.4% of the population age 65 and older in Marion County received a probable diagnosis of Alzheimer's disease.

To address this need the Hospital partnered with Marion County Hospice to provide free dementia caregiver workshops at our hospital location. At the time of this report, two workshops had been completed for seven participants at AdventHealth Ocala with many more planned for the last year of the health plan.

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

Florida Hospital Ocala, Inc. dba AdventHealth Ocala

CHNA Approved by the Hospital board on: August 14, 2025

For questions or comments, please contact
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