AdventHealth Carrollwood

2019 COMMUNITY HEALTH NEEDS ASSESSMENT

University Community Hospital, Inc. dba AdventHealth Carrollwood
Approved by the Hospital Board on: November 12, 2019
Director of Community Benefit:
Kimberly Williams, MPH, MS
kimberly.r.williams@adventhealth.com

Community Benefit Manager:
Adam Johnson
adam.johnson@adventhealth.com

Extending the Healing Ministry of Christ

AdventHealth

2019 Community Health Needs Assessment

Table of Contents

Acknowledgements

This report was prepared by Kimberly Williams and Adam Johnson, Community Benefit Manager with contributions from members of the AdventHealth Carrollwood Community Health Needs Assessment Committee representing health leaders in our community and AdventHealth Carrollwood leaders.

A special thanks to the Healthy Hillsborough Steering Committee for their expertise and support in the collection and analysis of the data.

We are especially grateful to all those who participated in our household surveys and key informant interviews. Their contributions made this report possible and lay the groundwork as we continue to fulfill our mission of *Extending the Healing Ministry of Christ*.

1. EXECUTIVE SUMMARY

Goals

University Community Hospital, Inc. dba AdventHealth Carrollwood will be referred to in this document AdventHealth Carrollwood or "The Hospital." AdventHealth Carrollwood in Tampa, Florida conducted a community health needs assessment in 2019. The goals of the assessment were to:

- Engage public health and community stakeholders including low-income, minority and other underserved populations
- Assess and understand the community's health issues and needs
- Understand the health behaviors, risk factors and social determinants that impact health
- Identify community resources and collaborate with community partners
- Publish the Community Health Needs Assessment
- Use assessment findings to develop and implement a 2020-2022 Community Health Plan based on AdventHealth Carrollwood's prioritized issues

Community Health Needs Assessment Committee

In order to ensure broad community input, AdventHealth Carrollwood created a Community Health Needs Assessment Committee (CHNAC) to help guide the Hospital through the assessment process. The CHNAC included representation from the Hospital, public health experts and the broad community. This included intentional representation from low-income, minority and other underserved populations.

The CHNAC met three times in 2018-2019. They reviewed the primary and secondary data, helped define the priority issues to be addressed by the Hospital, and helped develop the Community Health Plan to address the priority issues. *See Section 5 for a list of CHNAC members*.

Data

AdventHealth Carrollwood collected both primary and secondary data. The primary data included stakeholder interviews, community surveys and community focus groups.

Secondary data sources included internal Hospital utilization data (inpatient and emergency department). This utilization data showed the top reasons for visits to AdventHealth Carrollwood over the past year. In addition, we utilized publicly available data from state and nationally recognized data sources. *See Section 7 for a list of data sources.*

Primary and secondary data was then compiled and analyzed in order to identify the top 8-12 aggregate issues from the various sources of data.

Community Asset Inventory

The next step was a Community Asset Inventory. This inventory was designed to help AdventHealth Carrollwood and the CHNAC to:

- Understand existing community efforts to address the 8-12 identified issues from aggregate primary and secondary data
- Prevent duplication of efforts as appropriate. *See Section 9 for the Community Asset Inventory.*

Selection Criteria

Using the data findings and the Community Asset Inventory, the CHNAC narrowed the list of 8-12 issues to five priority issues. The CHNAC used a priority selection tool that uses clearly defined criteria to select the top issues to address. *See Section 10 for the Priority Selection Report.*

The priority selection criteria included:

A. Relevance: How important is this issue?
B. Impact: What will we achieve by addressing this issue?
C. Feasibility: Can we adequately address this issue?

Priority Issues to be Addressed

The priority issues to be addressed included:

1. Diabetes
    a. Goal 1: To increase access to diabetes education by supporting community organizations and other community stakeholders offering health education and resources
    b. Goal 2: To increase access to culturally appropriate nutritious food options in food deserts or low income/low access areas

2. Mental Health (Depression, Suicide, Lack of Social Support)
    a. Goal 1: To increase access, education and awareness related to mental health by engaging community members, public schools, community organizations and other community stakeholders
    b. Goal 2: To increase community-level partnerships to enhance local efforts to address social determinants of health that impact mental health

3. High Blood Pressure
    a. Goal 1: To increase access to early intervention programs and blood pressure management education by engaging community organizations and stakeholders
    b. Goal 2: To decrease the use of tobacco products in adults and youth in the primary service area

4. Access to Healthcare
    a. Goal 1: To implement strategies to support community efforts to improve access to primary care providers
    b. Goal 2: To increase partnerships with local community organizations with resources to offer community members assistance with gaining health insurance coverage

5. Substance Abuse (Alcoholism)
    a. Goal 1: To increase access to early intervention and treatment programs for substance abuse treatment specifically for alcoholism by creating partnerships with community organizations and stakeholders
    b. Goal 2: To increase education and awareness of substance abuse related to alcoholism by engaging community members, public schools, community organizations, and other community stakeholders

See Section 11-12 for an explanation of priority issues which were chosen as well as those not chosen.

Approvals

On December 12, 2019, the AdventHealth Carrollwood Board approved the Community Health Needs Assessment findings, priority issues and final report. A link to the 2019 Community Health Needs Assessment was posted on the Hospital's website as well as https://www.adventhealth.com/community-health-needs-assessments prior to December 31, 2019.

Next Steps

The CHNAC will work with AdventHealth Carrollwood to develop a measurable 2020-2022 Community Health Plan to address the priority issues. The plan will be completed and posted on the Hospital's website prior to May 15, 2020.

2. ABOUT: ADVENTHEALTH CARROLLWOOD

Transition to AdventHealth

In January of 2019, every wholly-owned entity across our organization adopted the AdventHealth system brand. Our identity has been unified to represent the full continuum of care our system offers. Throughout this report, we will refer to our facility by AdventHealth Carrollwood. Any reference to our 2016 Community Health Needs Assessment (CHNA) in this document will utilize our new name for consistency.

AdventHealth Carrollwood is part of AdventHealth. With a sacred mission of Extending the Healing Ministry of Christ, AdventHealth is a connected system of care for every stage of life and health. More than 80,000 skilled and compassionate caregivers in physician practices, Hospitals, outpatient clinics, skilled nursing facilities, home health agencies and hospice centers provide individualized, wholistic care. A Christian mission, shared vision, common values and service standards focus on whole-person health, and commitment to making communities healthier.

About AdventHealth Carrollwood

AdventHealth Carrollwood in Tampa, Florida is a 103-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 close to 50 Hospitals and hundreds of care sites. The Hospital offers award-winning care, earning recognition by The Leapfrog Group as a Top General Hospital two years in a row for its nationally recognized achievements in patient safety and quality, as well as recognition as One of America's Best Hospitals for Patient Safety, Stroke Care and Bariatric Surgery by the Women's Choice Award in 2019. The Hospital provides a wide variety of services including heart care, spine and orthopedics, wound care, bariatrics, a 24/7 emergency room, and 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.

3. CHOOSING THE COMMUNITY

AdventHealth Carrollwood defined its community as its Primary Service Area (PSA) from which 75-80% of its patients come. This includes Hillsborough and Pasco Counties and the zip codes 33556 - Odessa, 33558 - Lutz, 33603 - Tampa, 33604 - Tampa, 33605 - Tampa, 33607 - Tampa, 33609 - Tampa, 33610 - Tampa, 33612 - Tampa, 33613 - Tampa, 33614 - Tampa, 33615 - Tampa, 33617 - Tampa, 33618 - Tampa, 33624 - Tampa, 33625 - Tampa, 33626 - Tampa, 33634 - Tampa and 33635 - Tampa.

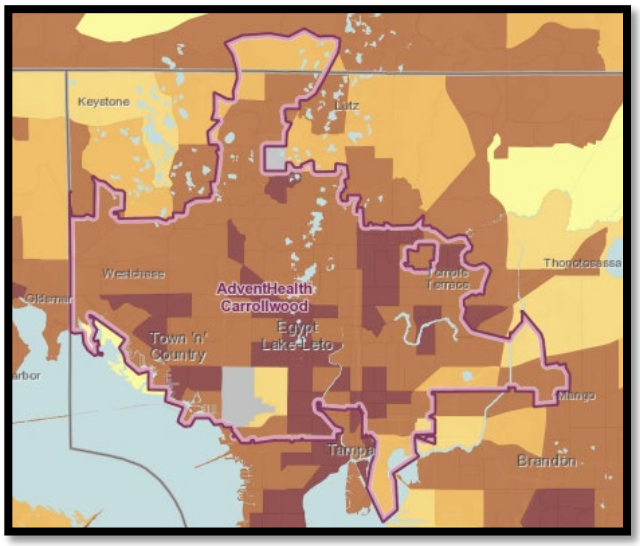
4. COMMUNITY DESCRIPTION AND DEMOGRAPHICS

In order to understand our community and the challenges faced, AdventHealth Carrollwood looked at both demographic information for the service area population, as well as available data on social determinants of health. According to the Center for Disease Control and Prevention, social determinants of health include conditions in the places where people live, learn, work and play, which affect a wide range of health risks and outcomes. A snapshot of our community demographics and characteristics is included below. *Secondary report data can be found in Appendix B.*

A total of 547,282 people live in the 164 square mile report area defined for this assessment according to the U.S. Census Bureau American Community Survey 2012-16 5-year estimates. The population density for this area, estimated at 3,318.65 persons per square mile, is greater than the national average population density of 90.88 persons per square mile.

Report Area	Total Population	Total Land Area (Square Miles)	Population Density (Per Square Mile)
AdventHealth Carrollwood	547,282	164	3,318.65
Hillsborough County, FL	1,351,087	1,020.31	1,324.19
Pasco County, FL	498,136	747.65	666.27
Florida	20,278,447	53,634.01	378.09
United States	321,004,407	3,532,315.66	90.88

The map below represents the service area where 75-80% of AdventHealth Carrollwood's patients come from.



https://ahs.engagementnetwork.org/map-room/, 8/14/2019

COMMUNITY DEMOGRAPHICS

Female 51.61%

Male 48.39%

AGE	0-4	5-17	18-24	25-34	35-44	45-54	55-64	65+
%	6.30%	15.98%	10.05%	15.89%	13.25%	13.88%	11.79%	12.85%

RACE	Caucasian	African-American	Asian	Native American / Alaska Native	Native Hawaiian /Pacific Islander	Other Race	Multiple Races
%	66.83%	21.71%	3.54%	0.40%	0.06%	4.14%	3.32%

ETHNICITY	Hispanic or Latino	Non-Hispanic
%	34%	66%

Source: US Census Bureau, Decennial Census. 2000 - 2010.

AdventHealth Carrollwood service areas averaged higher in percentages than the state of Florida averages in most of the following data indicators below, which indicates an area of highest need.

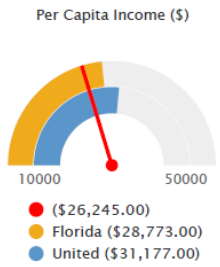
DATA INDICATOR	DESCRIPTION	ADVENTHEALTH CARROLLWOOD SERVICE AREA	FLORIDA AVERAGE
Poverty[1]	% Population in Poverty (Below 100% FPL)	20.4%	15.46%
Unemployment Rate[2]	Unemployment Rate	5.5%	2.9%
Violent Crime[3]	Violent Crime Rate (Per 100,000 Pop.)	338.8	472.1
Population with No High School Diploma[1]	% Population Age 25+ with No High School Diploma	13.7%	12.42%
Insurance[4]	Uninsured Adults-% Without Medical Insurance	17.24%	18.44%
Insurance[4]	Uninsured Children-% Without Medical Insurance	5.5%	6.58%
Food Insecurity Rate[5]	Food Insecurity Rate	15.7%	16.2%
Population with Low Food Access[6]	% Population with Low Food Access	17.26%	25.7%
Use of Public Transportation[1]	% Population Using Public Transit for Commute to Work (Age 16+)	2.44%	2%
Alcohol Consumption[7]	Estimated Adults Drinking Excessively (Age-Adjusted Percentage)	18.9%	17.1%
Tobacco Usage[7]	% Population Smoking Cigarettes (Age-Adjusted)	18.1%	18.9%

[1] US Census Bureau, American Community Survey. 2013-17. [2] US Department of Labor, Bureau of Labor Statistics. 2019 - July. [3] Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2019.[4] US Census Bureau, Small Area Health Insurance Estimates. 2017. [5] Feeding America. 2017. [6] US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2015. [7] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.

Income - Per Capita Income

The per capita income for the AdventHealth Carrollwood primary service area is $26,245.00, which is lower than the state average of $28,773.00. This includes all reported income from wages and salaries as well as income from self-employment, interest or dividends, public assistance, retirement and other sources. The per capita income in this report area is the average (mean) income computed for every man, woman and child in the specified area.

Report Area	Total Population	Total Income ($)	Per Capita Income ($)
AdventHealth Carrollwood	547,283	$14,363,562,615.00	**$26,245.00**
Hillsborough County, FL	1,351,087	$40,271,080,400.00	$29,806.00
Pasco County, FL	498,136	$13,262,367,600.00	$26,623.00
Florida	20,278,447	$583,486,218,200.00	$28,773.00
United States	321,004,407	$10,008,063,515,700.00	$31,177.00



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2013-17. Source geography: Tract

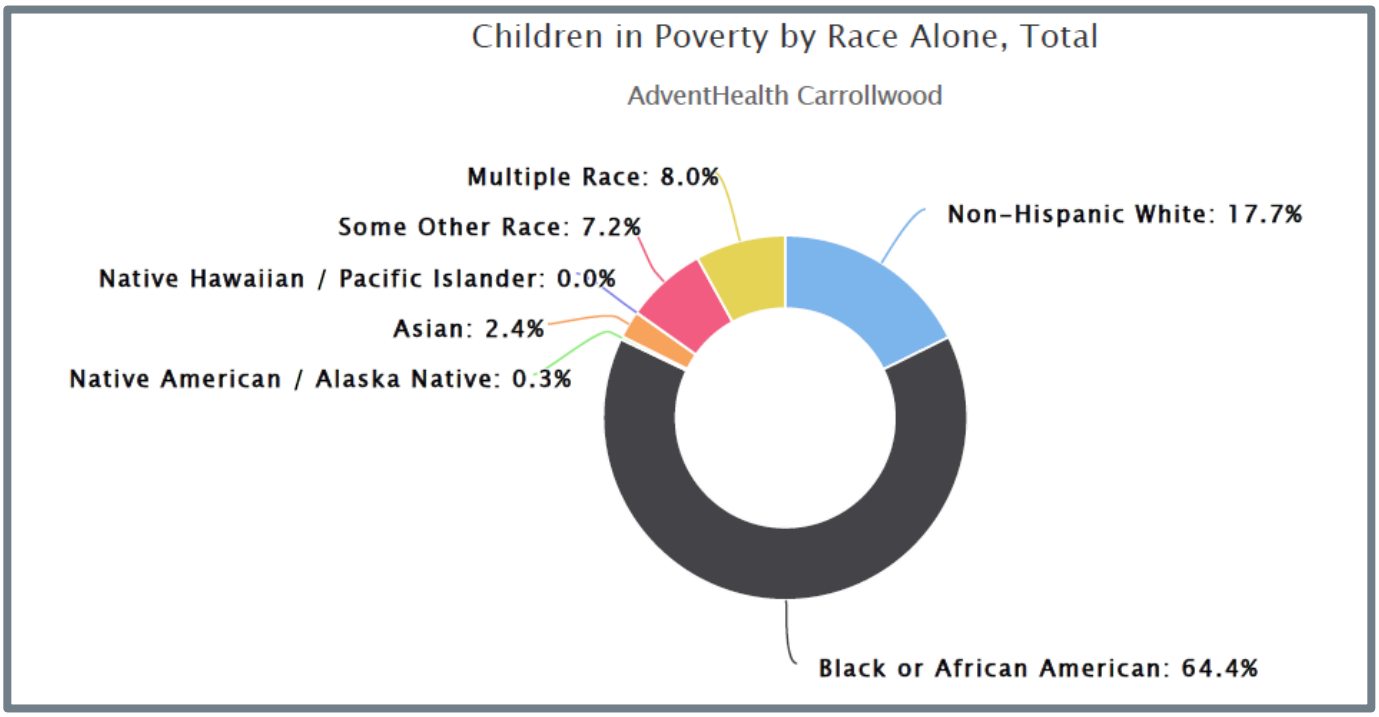
Per Capita Income by Race Alone

Report Area	White	Black or African American	Native American / Alaska Native	Asian	Native Hawaiian / Pacific Islander	Some Other Race	Multiple Race
Hillsborough County, FL	$33,143.00	$20,217.00	$35,240.00	$26,283.00	$16,208.00	$17,042.00	$19,195.00
Pasco County, FL	$27,087.00	$22,099.00	$34,456.00	$24,227.00	$28,757.00	$18,893.00	$15,838.00
Florida	$31,765.00	$17,901.00	$31,415.00	$22,993.00	$23,509.00	$18,653.00	$17,231.00
United States	$34,221.00	$21,117.00	$36,158.00	$18,822.00	$22,685.00	$17,051.00	$17,948.00

Source: US Census Bureau, American Community Survey. 2013-17

Households living with income below the Federal Poverty Level (FPL)

In the AdventHealth Carrollwood primary service area, 28.98% of children aged 0-17, or 34,789 children, are living in households with income below the Federal Poverty Level (FPL), which is higher than the state percentage of 22.29%. This indicator is relevant because poverty creates barriers to access including health services, healthy food and other necessities that contribute to poor health status.



Source: US Census Bureau, American Community Survey. 2013-17

5. COMMUNITY HEALTH NEEDS ASSESSMENT COMMITTEE

A Community Health Needs Assessment Committee (CHNAC) was formed to help AdventHealth Carrollwood conduct a comprehensive assessment of the community. The committee included representation from the Hospital, public health officials and the broad community as well as representation from low-income, minority and other underserved populations. The committee met quarterly throughout 2019. Current CHNAC members include:

Community Members

Name	Title	Organization	Description of Services	Low-Income	Minority	Other Underserved Populations
Lillian Wichinsky, Ph.D., LMSW	Director	USF - Office of Community Engagement and Partnerships	The Office of Community Engagement and Partnerships is to expand and strengthen university–community engagement locally and globally. They work to cultivate and nurture mutually beneficial partnerships locally and globally to enhance student access to community engaged experiential learning.			*x*
Alexander Voigt	Pastor	Carrollwood Seventh-Day Adventist Church and LifeSpring Seventh-Day Adventist Church	Community SDA church with a focus on connecting and developing the community beyond the four walls of the church.			x
Matt Spence	Chief Programs Officer	Feeding Tampa Bay	Feeding Tampa Bay, part of the national Feeding America network, focuses on providing food to the hundreds of thousands of food insecure families in the 10-county area of West Central Florida.	x	x	x

Gene Earley	Director	Hillsborough County - Health Care Services	Health Care Services focuses on the overall well-being of Hillsborough County residents through an innovative health care plan, healthy living initiative and programs to ensure effective and cost-efficient health care assistance.	x		x
Ayesha Johnson, PHD	Senior Human Services Program Specialist	Florida Department of Health - Hillsborough	To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.	x		x
Caitlyn Peacock	Executive Director	Tampa Bay Network to End Hunger	A network of more than 350 hunger fighters from all corners of the field who come together to share experiences, knowledge, and the workload in tackling hunger in the Tampa Bay area. Working together, rather than separately, is smarter, more efficient and more rewarding. The Tampa Bay Network to End Hunger Network does not just identify solutions; they implement them.	x	x	x
Teresa Kelly	Executive Director	Health Council of West Central Florida	The Health Council of West Central Florida is committed to assessing the health status and resources of area residents and assisting communities with solutions to meet emerging needs.	x	x	x
Leslene, Gordon, PHD, RD, LD/N	Community Health Director	Florida Department of Health - Hillsborough	To protect, promote and improve the health of all people in Florida through integrated state, county and community efforts.	x	x	x
Brad Cassell	Pastor	Tampa 1st Seventh Day Adventist Church	A multi-cultural and multi-generational Seventh Day Adventist Church looking to serve its community and partner with other organizations to expand the mission.			x

Clara A. Reynolds, LCSW, MBA	CEO	Crisis Center of Tampa Bay	Suicide and Crisis Hotline Rape Hotline Substance Abuse Hotline Database of more than 3,000 services that are accessible and searchable online Support line for veterans	x	x	x
Dr. Sheron Brown	Executive Director	Tampa Bay Healthcare Collaborative	The Tampa Bay Healthcare Collaborative is a membership-based, non-profit organization. It is member driven and has evolved over time in response to identified needs of the membership and the community. Membership includes health and human service organizations, businesses, healthcare providers and individuals concerned and impacted by the gaps and limitations of the current system. While TBHC does not provide direct services, collectively, member organizations provide services to meet the needs of all demographic groups and address the health care continuum.	x	x	x

Sharad Patel, MD	Physician/ Surgeon	AdventHealth Medical Group	Dr. Sharad Patel is a general surgeon in Tampa, Florida and is affiliated with multiple Hospitals in the area, including AdventHealth Carrollwood and AdventHealth Tampa. A founding member of the Free Clinic of Tampa Bay who provide physician visits with PCP and Specialists as well as X-Rays, lab work, and pharmacy services to those who don't have insurance, but have a photo ID, and make less than $52,000 for a family of four or make less than $25,000 for an individual.	x	x	x

AdventHealth Carrollwood Members

The following AdventHealth Carrollwood team members provided leadership throughout the process:

- **Erika Skula**, CEO
- **Shane Cimock**, Marketing Director
- **Latasha Mcfarlane**, Case Management Director
- **James Mcneil**, Chaplain
- **Adam Johnson**, Executive Director of Operations
- **Roma Pope**, Supervisor of Transition Specialists, AdventHealth Carrollwood/PEA Partnership
- **Kimberly Williams**, Director of Community Benefits; West Florida Division, Community Benefit Support

6. PUBLIC HEALTH

Public health was represented throughout the Community Health Needs Assessment.

Hillsborough County Public Health

Hillsborough County public health representatives participated throughout the Community Health Needs Assessment process. The Healthy Hillsborough Steering Committee (Healthy Hillsborough) was formed in October 2015 as a collaboration between the Florida Department of Health in Hillsborough County, AdventHealth West Florida Division, Moffitt Cancer Center, BayCare St. Joseph's Hospitals and South Florida Baptist Hospital, Shriner's Hospital for Children-Tampa, Suncoast Community Health Centers, Tampa Family Health Centers and Tampa General Hospital. Healthy Hillsborough was established to complete a comprehensive Community Health Assessment (CHA)/Community Health Needs Assessment (CHNA) and to identify opportunities for collaboration to collectively impact and improve the health of Hillsborough County. Nearly all the Healthy Hillsborough members represented low-income, minority and underserved populations.

Our community survey process was mobilized by the Florida Department of Health in Hillsborough County with the expertise of their Community Health Director, Dr. Leslene Gordon, who led the Healthy Hillsborough collaboration between the Florida Department of Health in Hillsborough County, AdventHealth West Florida Division, Moffitt Cancer Center, BayCare St. Joseph's Hospitals and South Florida Baptist Hospital, Shriner's Hospital for Children-Tampa, Suncoast Community Health Centers, Tampa Family Health Centers and Tampa General Hospital.

Through our Healthy Hillsborough partnership, we implemented a collaborative effort to gather community input from public health experts and vulnerable populations by conducting a joint community health needs assessment, which included a county-wide community health survey, stakeholder interviews, community focus groups and a county-wide meeting to prioritize the significant health needs for our county.

The following public health representatives from the county department of health provided leadership throughout the process:

- **Douglas A. Holt, MD., F.A.C.P.,** Director, Florida Department of Health in Hillsborough County, USF Morsani College of Medicine and College of Public Health Professor
- **Leslene Gordon, PhD, RD, LD/N**, Community Health Director, Florida Department of Health in Hillsborough County
- **Ayesha Johnson, PhD,** Senior Health Program Analyst, Office of Health Equity, Florida Department of Health in Hillsborough County
- **Allison Nguyen, MPH, MCHES ®, FCCM,** Program Manager, Office of Health Equity, Florida Department of Health in Hillsborough County

7. PRIMARY AND SECONDARY DATA SOURCES

Primary Data

a. Community Survey: Healthy Hillsborough (http://hillsborough.floridahealth.gov/programs-and-services/community-health-planning-statistics/improvement-planning/index.html) worked together to design the 2019 Community Health Needs Survey and launched a county-wide effort to engage the community to participate in the survey. The survey asked questions, which aimed to better understand feedback from community members related to barriers to accessing care (including dental care, mental health care), challenges to accessing care for children's health (including care for special needs children), health behaviors and other social determinants of health.

   Community surveys were completed on-line and in person by participants in community settings. Local community organizations played a major role in engaging community members to participate in the survey. The on-line survey link was made accessible in a variety of ways to assure barriers to participating were addressed. For example, local community centers encouraged participating by providing access to a computer and/or iPad at community events for community members to access the on-line survey. In addition, paper copies of the survey were also provided to community partners interested in providing the survey to clients on site. Community surveys were also made available at local clinics, community events, department of motor vehicle locations, and other community locations throughout Hillsborough County.

b. Stakeholder Interviews: Interviews were conducted by sending a out a link to members of our Community Health Needs Assessment Committees (CHNACs) and completed on-line. As needed, reminders were sent out to CHNAC members to complete the on-line questionnaire.

c. Focus Groups: Focus groups were conducted in partnership with the Florida Department of Health in Hillsborough County and occurred in person at the health department locations and at the University Area Community Development Center (UACDC) which resides in our AdventHealth Tampa primary service area.

Secondary Data

a. Hospital Utilization Data: Top 10 inpatient and Emergency Department diagnoses by payer Hospital utilization data was provided by our AdventHealth Carrollwood finance department. Diagnoses were placed into general category descriptions and organized in Appendix C: Hospital Utilization & Emergency Room Data.

   CHNAC members reviewed Hospital utilization data along with primary and secondary data, as well as the previously determined Florida Department of Health in Hillsborough County priority areas to identify potential trends in the health of the community members residing in the Hospital primary service areas.

b. The Engagement Network: Our secondary data was sourced from the Engagement Network. This is a national platform produced by the Center for Applied Research and Engagement Systems (CARES) at the University of Missouri. The Engagement Network hosts a national Map Room with 15,000+ data layers, a Community Health Needs Assessment reporting tool with 80+ health-related indicators and a hub network with 30+ partner organizations using CARES technology.

c. Partnership Secondary Data: In addition, secondary data was also collected in partnership with the Healthy Hillsborough Steering Committee in which data was sourced from the American Community Survey, Centers for Disease Control and Prevention, Conduent, and Healthy Communities Institute.

DATA SOURCES:

a. US Census Bureau, Decennial Census, 2000-2010
b. US Census Bureau, American Community Survey, 2013-17
c. Feeding America, 2014
d. US Census Bureau, Small Area Health Insurance Estimates, 2016
e. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, US Department of Health & Human Services, Health Indicators Warehouse, 2006-12
f. Centers for Disease Control and Prevention, National Vital Statistics System, US Department of Health & Human Services, Health Indicators Warehouse, 2006-12
g. US Department of Labor, Bureau of Labor Statistics, 2018 – August
h. Federal Bureau of Investigation, FBI Uniform Crime Reports, 2012-14
i. US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas, 2015
j. US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File, 2015
k. Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care, 2015
l. US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration, April 2016
m. US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File, March 2018
n. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2011-12
o. Centers for Disease Control and Prevention, National Vital Statistics System, Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research, 2007-10
p. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 2015
q. State Cancer Profiles, 2011-15
r. State Cancer Profiles, 2009-13
s. Centers for Medicare and Medicaid Services, 2015
t. Centers for Disease Control and Prevention, National Vital Statistics System, US Department of Health & Human Services, Health Indicators Warehouse, 2006-12
u. Centers for Disease Control and Prevention, National Vital Statistics System, 2012-16
v. Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2006-10

8. COMMUNITY COLLABORATION

The AdventHealth Carrollwood Community Health Needs Assessment is the product of a county-wide collaborative process. The Healthy Hillsborough Steering Committee (Healthy Hillsborough) was formed in October 2015 as a collaboration between the Florida Department of Health in Hillsborough County, AdventHealth West Florida Division, Moffitt Cancer Center, BayCare St. Joseph's Hospitals and South Florida Baptist Hospital, Shriner's Hospital for Children-Tampa, Suncoast Community Health Centers, Tampa Family Health Centers and Tampa General Hospital. Healthy Hillsborough was established to complete a comprehensive Community Health Assessment (CHA)/Community Health Needs Assessment (CHNA) and to identify opportunities for collaboration to collectively impact and improve the health of Hillsborough County. Nearly all the Healthy Hillsborough members represented low-income, minority and underserved populations.

The top priority of the Healthy Hillsborough collaborative efforts to assess the health of the community was that the Assessment be as conclusive and inclusive as possible. The group spent several months deciding on the most important indicators to assess through the survey instrument, the focus groups and key informant interviews and secondary data points from county, state and federal agencies. A real effort was made to reach out to all members of the Hillsborough County communities and obtain perspectives across age, race/ethnicity, gender, profession, household income, education level and geographic location. In this needs assessment process, Healthy Hillsborough formed strong partnerships with health care providers, county and state agencies, community organizations, nonprofits, media, faith-based groups and business and civic organizations.

Healthy Hillsborough led a county-wide health needs prioritization meeting and reviewed all the data with community input from the above-mentioned partnerships and prioritized the key issues according to intensity of the need, current initiatives around the issue and the potential for future collaboration. AdventHealth Carrollwood used additional data collection tools and methods, both quantitative and qualitative, to conduct a needs assessment of the factors that facilitate health and human services needs among our Hospitals' primary service area, University Area community residents.

Collaborators

- **Healthy Hillsborough Steering Committee** collectively worked together to provide resources to complete a county-wide Community Health Needs Assessment.

- **Tampa Bay Healthcare Collaborative (TBHC)**, a membership-based, non-profit organization. Membership includes health and human service organizations, businesses, healthcare providers and individuals concerned and impacted by the gaps and limitations of the current system. TBHC leading catalyst for sparking movement on health equity in Tampa Bay.

- **The University Area Community Development Corporation Inc. (University Area CDC)**, is a 501(c) (3) public/private partnership whose mission is children and family development, crime prevention, and commerce growth. Its primary focus is the redevelopment and sustainability of the at-risk areas surrounding the Tampa campus of the University of South Florida.

9. DATA SUMMARY

Primary and Secondary Data: High Level Findings

Once all primary and secondary data was collected, this was then analyzed and categorized into top priorities per source of data. These results are listed by source in the tables below.

Primary and secondary data was presented to the CHNAC. Each committee member received copies of the reports. The AdventHealth Carrollwood financial department provided admission data for inpatient and the Emergency Department including diagnosis, payer source and zip codes for 2018.

Top Priorities determined from Healthy Hillsborough Community Health Needs Assessment (CHNA) Prioritization					
1	Mental Health & Mental Disorders	**5**	Diabetes	**9**	Cancer
2	Access to Health Services	**6**	Maternal, Fetal & Infant Health	**10**	Oral Health
3	Exercise, Nutrition, & Weight	**7**	Heart Disease & Stroke	11	Respiratory Disease
4	Substance Abuse	**8**	Immunization & Infectious Disease		

Top Priorities determined from Hillsborough County Community Surveys					
1	Drug Abuse	**5**	Mental Health Problems (including suicide)		
2	Alcohol Abuse	**6**	Being Overweight		
3	Distracted Driving				
4	Cancer				

Top Priorities determined from AdventHealth Carrollwood's Primary Service Areas determined from Secondary Data provided by The Engagement Network/ Secondary Needs Assessment Tool					
1	Diabetes	**5**	Population with no high school diploma	**9**	Poverty
2	Depression (Medicare Population), Lack of Social or Emotional Support	**6**	High Blood Pressure (Adult)		
3	Infant Mortality, Low Birth Weight, Teen Births	**7**	Cancer (prostate, breast, cervical, colon and rectum)		
4	Asthma	**8**	Alcohol Consumption		

Top Priorities determined from Inpatient Hospital Utilization Data					
1	Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity	5	Diabetes	9	Weight loss surgeries (bariatric surgery)
2	Major Joint/Limb Reattachment Procedure of Upper Extremity	6	Hypertension, Heart Failure/Shock	10	Esophagitis (inflammation of the esophagus), Gastroenteritis (inflammation of the stomach), & Misc. Digestion Disorders
3	COPD, Asthma, Bronchitis, Pneumonia	7	Septicemia (Life - Threatening Infection)		
4	Cervical Spinal Fusion (surgery that joins selected bones in the neck)	8	Cellulitis (serious bacterial skin infection)		

Top Priorities determined from Emergency Department Hospital Utilization Data					
1	Chest Pain	5	Upper Respiratory Infection	9	Flu
2	Stomach Pain	6	Bronchitis	10	Fever
3	Urinary Tract Infection	7	Low Back Pain		
4	Headaches	8	Pharyngitis (Sore Throat)		

Primary and Secondary Data: Aggregate Community Health Needs

At a subsequent CHNAC meeting, the top needs identified by Hillsborough County were reviewed along with identified needs specific to AdventHealth Carrollwood's primary service area. The CHNAC compared the overarching top 11 health needs of the County with the top health needs specific to the communities nearest the Hospital (our primary service areas).

After discussions concluded about the similarities and differences of the health needs data, as well as other experiences with providing care and services to address these identified health needs, committee members were then asked to select their top five issues by voting anonymously (list were provided) and the results were then shared with the larger group. Committee members agreed on their top five priorities and the potential for pulling together community resources and partnerships to develop specific, measurable, attainable, relevant and time-based goals to develop a collaborative community health plan.

Aggregate Priorities				
	Priority Issue	Ethnic Group	Age Group	Specific Geographic Area
1	**Diabetes**	Underserved, minority, low-income populations	Adults age 20 and older	33604, 33607, 33610, 33612, 33614, 33615
2	**Mental Health (Depression, Suicide, Lack of Social Support)**	Underserved, low – income populations	Adults age 18 and older	33604, 33605, 33607, 33610, 33612, 33613, 33614, 33615, 33617, 33618, 33624
3	**High Blood Pressure**	Underserved, minority, low-income populations, community focus.	Adults age 18 and older	33604, 33605, 33607, 33610, 33612, 33613, 33614, 33615, 33617, 33618, 33624
4	**Access to Care**	Underserved, minority, low-income populations, community focus.	Adults age 18 and older	33604, 33605, 33607, 33610, 33612, 33613, 33614, 33615, 33617, 33618, 33624
5	**Substance Abuse (Alcoholism)**	Underserved, minority, low-income populations, community focus.	Adults age 18 and older	33604, 33605, 33607, 33610, 33612, 33613, 33614, 33615, 33617, 33618, 33624
6	**Education (Social Determinant of Health)**	Underserved, minority, low-income populations, community focus.	Adults age 25 and older	33604, 33605, 33607, 33610, 33612, 33613, 33614, 33615, 33617, 33618, 33624
7	**Asthma**	Underserved, low – income, populations	Adults age 18 and older	33604, 33605, 33607, 33610, 33612, 33613, 33614, 33617
8	**Poverty**	Underserved, minority, low-income populations, community focus.	All ages	33604, 33605, 33607, 33610, 33612, 33613, 33614, 33615, 33617, 33618, 33624
9	**Infant Mortality, Low Birth Weight, Teen Births**	Underserved, minority, low-income populations	Newborns (under age 1), teenagers between the ages of 15 - 19	33603, 33604, 33605, 33607, 33610, 33612, 33613, 33614, 33615, 33617, 33624
10	**Cancer (prostate, breast, cervical, colon and rectum)**	Underserved, minority, low-income populations	All ages	33604, 33605, 33607, 33612, 33613, 33614, 33615, 33617, 33618, 33624, 33625

10. COMMUNITY ASSET INVENTORY

In order to help AdventHealth Carrollwood's CHNAC determine the community health priorities where they could make a meaningful difference, the Hospital conducted a Community Asset Inventory related to the top ten identified community health needs in the Hospital's primary service area. The inventory was designed to help the CHNAC narrow the 10 health needs to the five (5) priority issues.

COMMUNITY ASSET INVENTORY		
Top Issues Defined by Primary/Secondary Data	**Current Community Programs**	**Current Hospital Programs**
Access to Healthcare	Free Clinic of Tampa Bay (Busch Blvd) (1323 Busch Blvd) Judeo Christian Clinics Hillsborough County Health Plan Tampa Family Clinics Suncoast Community Care Early Steps (Department of Health) Department of Health - Family Planning, HIV/AIDS, and Infectious Disease USF Clinic Street Runs Mount Calvary SDA Church - Calvary Community Clinic Tampa Family Health Care, USF Bridge Clinic BayCare Mobile Medical Unit Suncoast Community Health Centers School Partnerships - Tampa Family/VACDC/Mort Elementary - Bridge Clinic Hunger Action Alliance - Center for the Advancement of Food Security and Healthy Communities Back to School Program Screening & Education	AdventHealth Carrollwood: Back to School Bash program sponsorship Collaboration with the Free Clinic of Tampa Bay Accepts Hillsborough County Health Plan Medicare/Medicaid Enrollment Services Charity Care Provided by Hospital
Diabetes	Tampa 1st SDA Church: - C.H.I.P. Full Plate, CREATION - Distributing Fresh produce to our community weekly - Health-Screening (Periodic) Feeding Tampa Bay - Nutrition Ed - Fresh Produce Distribution USF Health - Bridge Clinic - Public Health	AdventHealth Carrollwood: Food is Health (FiH) Program Diabetes Teaching classes and screening programs

	- Nursing - Dean Rich - Free diabetes Class - KABS pharmacy - Weekly Brandon Rph: Sharon Fleming Sanoti - Bristol-Meyer-Squibb - Patient assistance programs for free insulin for qualifying patients YMCA - Tampa Family Health Center - Diabetes Programs Meals on Wheels Community Health Screening - Health Department - Free Insulin - Wal-Mart - Discount insulin Metropolitan Ministries - They are skilled in helping to alleviate this issue, Hospital should consider partnering with them. - Model to consider - Medically tailored meals (Minn/St. Paul) Department of Health Hillsborough - DPP - Diabetes Prevention Program - DSME - Diabetes Self-Management Program JGH + BayCare – DEEP - HCHCP - Free Classes	
Alcohol Consumption	USF Community Plan - (Students) Gracepoint (Substance Abuse General) USF Substance Abuse Forum AA/NA Detox Clinic/Rehab A.C.T.S. White Sands Treatment (Tampa) Riverside Recovery of Tampa Turning Point of Tampa Local Churches Metropolitan Ministries	
Depression	2-1-1/Crisis Center St. Joe's Postpartum Support Groups - AdventHealth Zephyrhills? - AdventHealth Tampa Hospice Grief Counseling Gracepoint DACCO ACTS St. Joe's Behavioral Health FQGC's have co-located BH space in primary care USF Center for Health/Wellness USF School of Social Work Tampa Community Hospital - Mental Health Veterans Administration - James A. Haley	AdventHealth Carrollwood: Provides Grief Counseling space in AdventHealth Carrollwood Lobby

	NAMI	
High Blood Pressure	Tampa First Seventh-day Adventist Church - C.H.I.P. Full Plate, CREATION - Distributing Fresh produce to our community weekly - Health-Screening (Periodic) Feeding Tampa Bay - Nutrition Ed - Fresh Produce Distribution Questions: How does the Hospital work/partner/collaborate with trained and certified health coaches who have extended programs? - They are skilled in helping to alleviate this issue Department of Health Hillsborough - BP Prevention Class HCHCP - Free Classes on high BP - Free Clinic – located in Tampa Bay (1323 West Busch Blvd) Judeo Christian Clinic - Community Focused Calvary Community Clinic - Community Screenings - Patient Assistance Program with Manufacturer (medications) for patients to access free/discounted meds USF Health - Nursing - Medical School	AdventHealth Carrollwood: Food is Health (FiH) Program Partnership with Free Clinic of Tampa Bay CREATION Health Outreach Community screening programs
Education (Social Determinant of Health)	School District of Hillsborough County - Adult Basic Education/GED Program	Hospital does not directly address this priority
Asthma	Tampa Bay Asthma Coalition - Hosts asthma education classes/workshops - Volunteer team does home visits to assess the environment and reduce triggers	Pediatric physicians diagnose and treat childhood asthma
Poverty	University Area Community Development Corporation (UACDC) - Workforce Training Initiatives - STEPS for Success Program 2-1-1/Crisis Center	Hospital provides charity care

Infant Mortality, Low Birth Weight, Teen Births	Florida Department of Health in Hillsborough County in partnership with the Healthy Start Coalition of Hillsborough County - Healthy Start Program (Care coordination, nutrition counseling, psychosocial counseling, parenting support, childbirth education, breastfeeding education and support)	Hospital partners with Johns Hopkins All Children's Hospital to provide advance pediatric care in the AdventHealth Carrollwood ER
Cancer (Prostate, Breast, Cervical, Colon, and Rectum)	Florida Department of Health in Hillsborough County - Breast and Cervical Cancer Early Detection Program (free or reduced costs screening for women) Moffitt Cancer Center - MPOWER Program (Community based education on how to prevent cancer)	Hospital offers prostate and colorectal screenings for men

11. PRIORITY SELECTION

Priority Selection using the Rating & Prioritizing Key Health Issues Worksheet

The top 10 issues identified from the CHNAC data review of household data, key informant survey responses and the top inpatient and ED admissions data were reviewed and discussed again alongside the Community Asset Inventory to identify the top priorities.

The Rating & Prioritizing Key Health Issues Worksheet shown below was utilized to throughout the discussion. The criteria were incorporated into a discussion format to guide the conversation and help the CHNAC to rate each priority.

1. Relevance: How important is this issue?
2. Impact: What will we achieve by addressing this issue?
3. Feasibility: Can we adequately address this issue?

RATING & PRIORITIZING KEY HEALTH ISSUES

Step 1: **List Key Issues**	**Step 2:** Rate Against Selection Criteria (1= lowest priority; 2= medium; 3= high; 4=highest)						**Step 3:** Total Rating	
	RELEVANT *How important is the issue?*		**IMPACTFUL** *What will we achieve by addressing this issue?*		**FEASIBLE** *Can we adequately address this issue?*			
	• Size of problem (ex. % population) • Severity of problem (ex. Cost to treat, lives lost) • Urgency to solve problem; community concern • Linked to other important issues		• Availability of solutions/proven strategies • Builds on or enhances current work • Significant consequences of not addressing issue now		• Availability of resources (staff, community partners, time, money) to address issue • Political capacity/will • Community/social acceptability • Appropriate socio-culturally • Can identify easy, short-term wins			
Education (Social Determinant of Health)	1	+	1	+	1	=	3	
Asthma	1	+	2	+	2	=	5	
Poverty	4	+	1	+	1	=	6	
Infant Mortality, Low Birth Weight, Teen Births	3	+	1	+	2	=	6	
Cancer (prostate, breast, cervical, colon and rectum)	1	+	2	+	2	=	5	
Diabetes	4	+	4	+	4	=	12	
Mental Health (Depression, Suicide, Lack of Social Support)	4	+	4	+	4	=	12	
High Blood Pressure	4	+	3	+	4	=	11	
Access to Care	4	+	4	+	4	=	12	
Substance Abuse (Alcoholism)	4	+	3	+	4	=	11	

RATIONALE FOR COMMUNITY ISSUES THE HOSPITAL WILL ADDRESS		
Relevance	**Impact**	**Feasibility**
1. Diabetes		
In the AdventHealth Carrollwood primary service area (PSA), 10% of adults have been diagnosed with diabetes, which is higher than the state average of 9%. Diabetes is the seventh leading cause of death in the U.S. affecting 29 million people. More than 80 million people in the U.S. are pre-diabetic meaning they are at an increased risk of developing diabetes in the next few years.	C.H.I.P. Full Plate, CREATION Life, Distributing Fresh produce to our community, Health-Screenings (Periodic), Nutrition Education, Bridge Clinic When diabetes goes untreated it can lead to more serious health issues such as vision loss, heart disease, stroke, nerve and kidney diseases.	The community has numerous resources to address this issue. Tampa First SDA Church, Feeding Tampa Bay, USF Health, Florida Department of Health in Hillsborough County
2. Mental Health (Depression, Suicide, Lack of Social Support)		
In the AdventHealth Carrollwood PSA, the rate of death due to self-harm (suicide) is 13 per 100,000 population. Furthermore, about 21% of the Medicare-fee-for-service PSA population are depressed, which is higher that the state average of 19%. Mental health disorders are the 11th leading cause of death in the United States for all age groups and the second leading cause of death among people age 25 to 34. The burden of mental illness in the United States is among the highest of all diseases, and mental disorders are among the most common causes of disability for adults, children, and adolescents.	St. Joe's Postpartum Support Groups, Hospice Grief Counseling, Referrals to mental health providers When mental health disorders are untreated, those affected are at high risk for many unhealthy and unsafe behaviors, including alcohol or drug abuse, violent or self-destructive behavior, and suicide.	There are many resources to address this issues and community partners to coordinate services with. 2-1-1/Crisis Center, Gracepoint DACCO, ACTS, St. Joe's Behavioral Health, USF Center for Health/Wellness, USF School of Social Work, Tampa Community Hospital - Mental Health, Veterans Administration - James A. Haley, NAMI
3. High Blood Pressure		
In the AdventHealth Carrollwood PSA, approximately 30% of adults have high blood pressure, which is higher than the state average of 28%. One in three adults in the U.S. have high blood pressure, a leading risk factor for heart disease and stroke, and only half of diagnosed individuals have their blood pressure under control.	C.H.I.P. Full Plate, CREATION Life, Distributing Fresh produce to our community, Community Health-Screening (Periodic), Nutrition Education, Blood Pressure Prevention Class, Free Clinics, Patient Assistance Program with Manufacturer (medications) for patients to access free/discounted meds High blood pressure often doesn't present symptoms because of this it is referred to as the "silent killer."	There are many resources to address this issues and community partners to coordinate services with. Tampa First SDA Church, Feeding Tampa Bay, Judeo Christian Clinic, Florida Department of Health in Hillsborough County, USF Health
4. Access to Care		
In the AdventHealth Carrollwood PSA, 17% of adults and 5% of children are uninsured or without medical insurance. Additionally, 28% of adults do not have a regular doctor which is higher than the state average of 25%. Access to health care is the equitable use of health services to achieve the highest level of health. Barriers to accessing health care services include	FQHCs and free clinics, Hillsborough County Health Plan (county-run health insurance), Early Steps Program, Family Planning services, HIV/AIDS testing and treatment, and Infectious Disease, BayCare Mobile Medical Unit, School Partnerships - Tampa Family/VACDC/Mort Elementary Failure to overcome access to care barriers leads to delayed care, health	There are many resources to address this issues and community partners to coordinate services with. Free Clinic of Tampa Bay, Judeo Christian Clinics, Tampa Family Clinics, Suncoast Community Health Centers, Florida Department of Health in Hillsborough County, USF Bridge Clinic, Mount Calvary SDA Church, Hunger Action Alliance - Center for the

cost of care, insurance coverage, availability of services and culturally competent care.	complications and financial burdens. Accessing health care services is vital to prevent and treat diseases thereby reducing the likelihood of disability and premature death.	Advancement of Food Security and Healthy Communities,
5. Substance Abuse (Alcoholism)		
In the AdventHealth Carrollwood PSA, 19% of adults aged 18 and above drank excessively which is higher than the state average of 17%. Substance abuse is the repeated use of harmful mind-altering substances such as drugs and alcohol. Underage drinking, or alcohol consumption by those under the age of 21, has been linked to death from alcohol poisoning, suicide, unintentional injury and alcohol dependence later in life. In the U.S., excessive alcohol use was the cause of 1 in 10 deaths among adults between the ages of 20-64. In 2010, people under the age of 21 accounted for 189,000 ER visits for injuries and other conditions related to alcohol use.	USF Substance Abuse Forum, Detox Clinic/Rehab, Alcoholics Anonymous Groups, Substance Abuse Services at Specialty Facilities Excessive use of alcohol can have immediate health effects, including unintentional injury, violence, alcohol poisoning, risky sexual behaviors and miscarriage among pregnant women. It can also have long-term health effects, including high blood pressure, heart disease, liver disease, dementia, depression and cancer.	The community has the ability to partner to maximize the resources available. Metropolitan Ministries, A.C.T.S., Riverside Recovery of Tampa, Turning Point of Tampa, Local Churches, White Sands Treatment Center, Gracepoint

RATIONALE FOR COMMUNITY ISSUES THE HOSPITAL WILL NOT ADDRESS		
Relevance	**Impact**	**Feasibility**
1. Education (Social Determinant of Health)		
In the AdventHealth Carrollwood PSA, 14% of the total population aged 25 and above do not have a high school diploma. Education is a social determinant of health and is linked to health outcomes. Individuals with more education on average live longer and healthier lives compared to individuals with less schooling.	Adult Basic Education/GED Program Individuals without a high school diploma are more likely to work low-paying and high-risk jobs with limited or non-existent health benefits. This can lead to unmet medical needs, unstable housing, and low food access.	The local school district is the sole provider of GED programming. School District of Hillsborough County
2. Asthma		
In the AdventHealth Carrollwood PSA, 13% of adults have asthma. Asthma is a chronic condition when the airways in the lungs are always inflamed. It is a prevalent problem exacerbated by poor environmental conditions.	Host asthma education classes/workshops; Volunteer team does home visits to assess the environment and reduce triggers The inflammation causes coughing, wheezing, chest tightness and shortness of breath.	Tampa Bay Asthma Coalition
3. Poverty		
In the AdventHealth Carrollwood PSA, 20% of the community is below 100% of the federal poverty level ($25,750 for a family of 4 in 2019). One of the greatest public health challenges is addressing poverty. Those living in poverty may face competing priorities between paying for basic needs such as housing and food or paying for medical care.	Workforce Training Initiatives; STEPS for Success Program Poverty increases the likelihood of an individual developing poor health. In reverse, poor health can also trap an individual in poverty.	University Area Community Development Corporation (UACDC); 2-1-1/Crisis Center
4. Infant Mortality, Low Birth Weight, Teen Births		
In the AdventHealth Carrollwood PSA, the infant mortality rate is 8 deaths per 1,000 births. Infant mortality is the death of an infant before their first birthday. In 2017, more than 22,000 infants died in the U.S. The causes of infant mortality include birth defects, maternal pregnancy complications, sudden infant death syndrome, low birth weight and injuries such as suffocation.	Healthy Start Program (Care coordination, nutrition counseling, psychosocial counseling, parenting support, childbirth education, breastfeeding education and support)	Florida Department of Health in Hillsborough County in partnership with the Healthy Start Coalition of Hillsborough County
5. Cancer (prostate, breast, cervical, colon and rectum)		
In the AdventHealth Carrollwood PSA, the cancer mortality rate is 161 deaths per 100,000 population. Cancer is the second leading cause of death in the U.S. Screening tools are an effective way to detect cancer early and increases chances of survival.	Breast and Cervical Cancer Early Detection Program (free or reduced costs screening for women); MPOWER Program (Community based education on how to prevent cancer)	Florida Department of Health in Hillsborough County; Moffitt Cancer Center

12. PRIORITY ISSUES TO BE ADDRESSED

The following five issues **WILL BE** addressed for the following reasons below:

a. Magnitude and severity of the problem.
b. Community's capacity and willingness to act on the issue.
c. Ability to have a measurable impact on the issue.
d. Availability of Hospital and community resources.
e. Hospital's ability to contribute finances and resources to address the health concern.

Priority #1: Diabetes
Description of the problem: Diabetes is the seventh leading cause of death in the U.S. affecting 29 million people. More than 80 million people in the U.S. are pre-diabetic meaning they are at an increased risk of developing diabetes in the next few years. When diabetes goes untreated it can lead to more serious health issues such as vision loss, heart disease, stroke, nerve and kidney diseases. In the AdventHealth Carrollwood primary service area (PSA), 10% of adults have been diagnosed with diabetes, which is higher than the state average of 9%.

Priority #2: Mental Health (Depression, Suicide, Lack of Social Support)
Description of the problem: The burden of mental illness in the United States is among the highest of all diseases, and mental disorders are among the most common causes of disability for adults, children, and adolescents. When mental health disorders are untreated, those affected are at high risk for many unhealthy and unsafe behaviors, including alcohol or drug abuse, violent or self-destructive behavior and suicide. Mental health disorders are the 11th leading cause of death in the United States for all age groups and the second leading cause of death among people age 25 to 34. In the AdventHealth Carrollwood PSA, the rate of death due to self-harm (suicide) is 12.92 per 100,000 population. Furthermore, about 21% of the Medicare-fee-for-service primary service area (PSA) population are depressed, which is higher that the state Medicare-fee-for-service population average of 19%.

Priority #3: High Blood Pressure
Description of the problem: One in three adults in the U.S. have high blood pressure, a leading risk factor for heart disease and stroke and only half of diagnosed individuals have their blood pressure under control. High blood pressure often does not present symptoms because of this it is referred to as the "silent killer." In the AdventHealth Carrollwood PSA, approximately 30% of adults have high blood pressure, which is higher than the state average of 28%.

Priority #4: Access to Healthcare
Description of the problem: Access to health care is the equitable use of health services to achieve the highest level of health. Barriers to accessing health care services include cost of care, insurance coverage, availability of services and culturally competent care. Failure to overcome these barriers leads to delayed care, health complications and financial burdens. Accessing health care services is vital to prevent and treat diseases thereby reducing the likelihood of disability and premature death. In the AdventHealth Carrollwood PSA, 17% of adults

and 5% of children are uninsured or without medical insurance. Additionally, 28% of adults do not have a regular doctor, which is higher than the state average of 25%.

Priority #5: Substance Abuse (Alcoholism)
Description of the problem: Substance abuse is the repeated use of harmful mind-altering substances such as drugs and alcohol. This CHNAC will focus specifically on the abuse and misuse of alcohol. Excessive use of alcohol can have immediate health effects, including unintentional injury, violence, alcohol poisoning, risky sexual behaviors and miscarriage among pregnant women. It can also have long-term health effects, including high blood pressure, heart disease, liver disease, dementia, depression and cancer. Underage drinking, or alcohol consumption by those under the age of 21, has been linked to death from alcohol poisoning, suicide, unintentional injury and alcohol dependence later in life. In the U.S., excessive alcohol use was the cause of 1 in 10 deaths among adults between the ages of 20-64. In 2010, people under the age of 21 accounted for 189,000 Emergency Department visits for injuries and other conditions related to alcohol use. In the AdventHealth Carrollwood PSA, 19% of adults aged 18 and above drank excessively, which is higher than the state average of 17%.

13. PRIORITY ISSUES THAT WILL NOT BE ADDRESSED

The following five issues **WILL NOT** be addressed for the following reasons below:

Potential challenges or barriers to addressing the need such as:

(1) The CHNAC felt that the issue/concern should not be addressed as an individual problem but can be indirectly impacted positively by first addressing multiple issues selected above by the Hospital CHNAC.

(2) CHNAC's did not perceive the ability to have a measurable impact on the issue with the current resources available to the community and the Hospital.

Priority #1: Education (Social Determinant of Health)
Description of the problem: Education, and educational attainment, is a social determinant of health and is linked to health outcomes. Individuals with more education on average live longer and healthier lives compared to individuals with less schooling. In the AdventHealth Carrollwood PSA, 14% of the total population aged 25 and above do not have a high school diploma.
Reason(s) priority was not selected: The CHNAC 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.

Priority #2: Asthma
Description of the problem: Asthma is a chronic condition when the airways in the lungs are always inflamed. The inflammation causes coughing, wheezing, chest tightness and shortness of breath. In the AdventHealth Carrollwood PSA, 13% of adults have asthma.
Reason(s) priority was not selected: The CHNAC 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.

Priority #3: Poverty
Description of the problem: One of the greatest public health challenges is addressing poverty. Poverty increases the likelihood of an individual developing poor health. In reverse, poor health can also trap an individual in poverty. For example, those living in poverty may face competing priorities between paying for basic needs such as housing and food or paying for medical care. In the AdventHealth Carrollwood PSA, 20% of the community is below 100% of the federal poverty level ($25,750 for a family of 4 in 2019).
Reason(s) priority was not selected: The CHNAC 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.

Priority #4: Infant Mortality, Low Birth Weight, Teen Births
Description of the problem: Infant mortality is the death of an infant before their first birthday. In 2017, more than 22,000 infants died in the U.S. The causes of infant mortality include birth defects, maternal pregnancy complications, sudden infant death syndrome, low birth weight and

injuries such as suffocation. In the AdventHealth Carrollwood PSA, the infant mortality rate is 8 deaths per 1,000 births.
Reason(s) priority was not selected: The CHNAC felt that the issue should not be addressed as an individual problem but can be indirectly impacted positively by first addressing access to health care selected above by the Hospital CHNAC.

Priority #5: Cancer (prostate, breast, cervical, colon and rectum)
Description of the problem: Cancer is the second leading cause of death in the U.S. Screening tools are an effective way to detect cancer early and increases chances of survival. In the AdventHealth Carrollwood PSA, the cancer mortality rate is 161 deaths per 100,000 population.
Reason(s) priority was not selected: The CHNAC felt that cancer should not be addressed as an individual problem but can be indirectly impacted positively by first addressing access to healthcare, one of the priority issues selected above by the Hospital CHNAC.

14. NEXT STEPS

The CHNAC will work with AdventHealth Carrollwood and other community partners to develop a measurable Community Health Plan for 2020-2022 to address the priority issues. For each priority, specific goals will be developed including measurable outcomes, intervention strategies and the resources necessary for successful implementation.

Evidence based strategies will be reviewed to determine the most impactful and effective interventions. For each goal, a review of policies that can support or deter progress will be completed with consideration of opportunities to make an impact. The plan will be reviewed quarterly with an annual assessment of progress. A presentation of progress on the plan will also be presented to the Hospital board annually.

A link to the Community Health Plan will be posted on AdventHealth.com prior to May 15, 2020.

15. WRITTEN COMMENTS REGARDING 2016 NEEDS ASSESSMENT

We posted a link to the most recently conducted CHNA and most recently adopted implementation strategy 2016 on our Hospital website as well as AdventHealth.com prior to May 15, 2017 and **have not** received any written comments.

16. REVIEW OF STRATEGIES UNDERTAKEN IN THE 2017 COMMUNITY HEALTH PLAN

AdventHealth Carrollwood conducts an annual evaluation of the progress made from the implementation strategies from the Community Health Plan. The evaluation is reported to the IRS in Form 990. The following is a summary of progress made on our most recently adopted plan.

Priority #1: Diabetes/Obesity/Nutrition Gap Prevalence

2016 Description of the Issue: Obesity is related to diabetes, poor nutrition and access to healthy food. These health indicators may indicate an unhealthy lifestyle and put individuals at risk for future health issues. Advent Health Carrollwood is addressing the nutritional needs of those in communities designated as food deserts or low income/low access. There are high levels of diabetes and obesity in these communities due to the lack of access to food and access to nutritional foods. Advent Health Carrollwood is uniquely positioned to address this need through its Food Is Medicine program.

Cumulative Update: Advent Health Carrollwood partnered with local community organizations to address the nutritional needs of those in communities designated as food deserts or low income/low access with the Food is Health® Program (formally known as Food is Medicine).

- The Food is Health® program increases health and lifestyle educational opportunities, provides free health screenings, and access to healthy produce and dry goods. The program was implemented in 12 sites and in seven food deserts. A total of 12 diabetes and obesity courses were facilitated with at least 10 participants attending each class. According to the data from the health screenings, 45% of participants had a decrease in blood sugar, which increased from last year's 42% reduction in blood sugar. Also, 38% of participants had a decrease in BMI. In addition, we have launched new strategies for marketing our free FiH classes to the community and hope to engage our community in much more effective ways to encourage participation. This program is not possible without strong partnerships with health education providers, local fresh produce vendors and other community-based organizations who are boots on the ground addressing social determinants of health.

Priority #2: Access to Health (Elderly/Seniors Barriers)

2016 Description of the Issue: Advent Health Carrollwood (ACW) is addressing the increasing social isolation, barriers to health access and food insecurity issues facing the senior population in its service area.

Cumulative Update: The goals for this strategy were to create and collaborate on health/nutrition programs and increase access for seniors as well as collaborate with community experts in senior health to reduce the impact of social isolation and related health indicators.

- The Hospital partnered with the Senior Connection Center and the Health Services Advisory Group to offer health and nutrition related classes to seniors participating in the Food is Health® program. The classes focused on chronic diseases, such as diabetes, and were offered at churches, community, and senior centers in food deserts and/or low income/low access communities. In addition, the Hospital established a new partnership with the Health Council of West Central Florida to discuss additional ways to help address social isolation in the elderly/senior population.

Priority #3: Childhood Obesity

2016 Description of the Issue: With 1.1 million children in Florida classified as obese, Advent Health Carrollwood wants to encourage healthier lifestyle and dietary habits with youth in its service area. The journey to better choices will lead to decreased need for healthcare treatments for chronic diseases in the future.

Cumulative Update: The Hospital partnered with the American Diabetes Association (ADA) to host a pilot Morning Mile Program (before-school walking program) at two Title I schools in their PSA for 2018–2019 school year.

- The American Diabetes Association (ADA), in partnership with Fitzness International, LLC, oversees the management of the Morning Mile (MM) program in SW Florida. The ADA implements and manages the program in schools on behalf of sponsors and adds a nutrition education component to increase its impact on school children. The Hospital sponsored two schools for the 2018-2019 school year – Dunbar Elementary Magnet School and Sligh Middle Magnet School. In 2019, our goal exceeded expectations with 95% of the student population participating in the program.

Priority #4 Family Support

2016 Description of the Issue: Current environmental factors, such as sub-standard housing, multi-generational families under one roof, un-or underemployment and lack of consistent access to food and healthy food may put individuals at risk for further health issues. In Hillsborough County, the eighth largest public-school system in the country, more than 3,000 children are self-identified as homeless. This has impact on their physical, emotional and behavioral health as well as that of their families. Advent Health Carrollwood is creating a collaborative to prevent and ease the health impacts of this environmental issue.

Cumulative Update: The goal of this strategy was to convene community experts to create a model for ensuring physical and emotional health support for homeless children in public schools through stable housing and health support resources.

- The Hospital partnered with a local elementary school, Egypt Lake, to donate approximately 50 backpacks ($1,250 donated amount) filled with school supplies for the school year to ensure that children in the economically disadvantaged category had the tools they needed to achieve success in school. Egypt Lake Elementary has a predominately Hispanic student population (92%), and 94% of their students are considered economically disadvantaged. Hospital employees from 11 departments competed a total of 110 hours to fill backpacks and deliver them to the students at school. In addition, the Hospital adopted 50 families from Egypt Lake elementary school for the holidays and collected $3,000 in employee donations to purchase over 150 toys for students/families.

APPENDIX A:
PRIMARY DATA SURVEY
& PRIMARY DATA RESULTS

Healthy Hillsborough 2019 Community Health Needs Survey

Our local not-for-profit Hospitals and the department of health want to hear from you! The results of this survey will be used to help us to understand your community health concerns so that improvements can be made. We encourage you to take 15 minutes to fill out the survey below. Your voice is important to ensure these organizations have the best understanding of the needs of our community. The survey will be available until April 21, 2019. Thank you!

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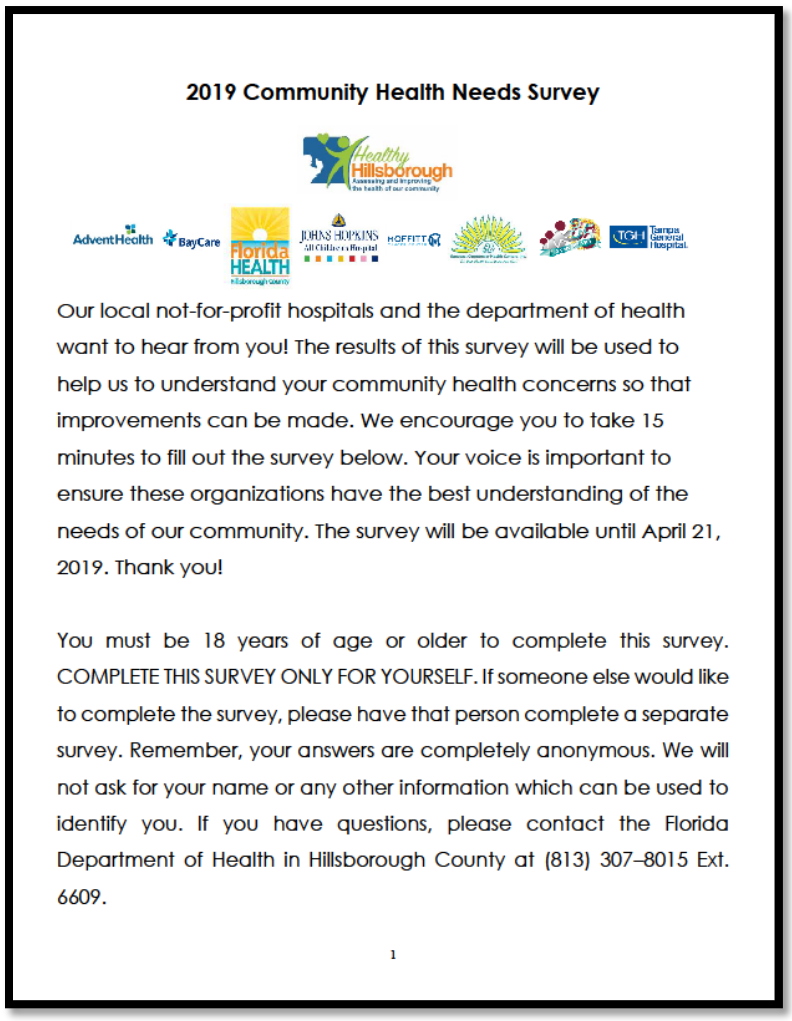

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1

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Demographic Information

These first few questions tell us about you. They will be used only to help us better understand the people who live in your community so that we can provide better health care services. This information will not be used to identify you.

1. In which county do you live? Please choose one:

- ☐ Hillsborough
- ☐ Pasco
- ☐ Pinellas
- ☐ Polk
- ☐ Sarasota
- ☐ Other

2. In which ZIP code do you live? Please write in: _____

3. What is your age? Please choose only one:

- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 74
- ☐ 75 or older

4. Are you of Hispanic or Latino origin or descent? Please choose one?

- ☐ Yes, Hispanic or Latino
- ☐ No, not Hispanic or Latino
- ☐ Prefer not to answer

5. Which race best describes you? Please choose only one?

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ More than one race
- ☐ Other
- ☐ Prefer not to answer

6. Do you identify your gender as:

- ☐ Male
- ☐ Female
- ☐ Transgender: Male to Female
- ☐ Transgender: Female to Male
- ☐ Other/Gender non-conforming

7. Which of the following best describes your sexual orientation? Please choose only one:

- ☐ Heterosexual
- ☐ Gay or lesbian
- ☐ Bisexual
- ☐ Other

8. What language do you MAINLY speak at home? Please check only one:

- ☐ Arabic
- ☐ Chinese
- ☐ English
- ☐ French
- ☐ German
- ☐ Haitian Creole
- ☐ Russian
- ☐ Spanish
- ☐ Vietnamese
- ☐ Other

9. How well do you speak English? Please choose only one:

- ☐ Very well
- ☐ Well
- ☐ Not Well
- ☐ Not at all

10. What is the highest level of school that you have completed? Please choose only one:

- ☐ Less than high school
- ☐ Some high school, but no diploma
- ☐ High school diploma (GED)
- ☐ Some college, no degree
- ☐ 2-year college degree
- ☐ 4-year college degree
- ☐ Graduate-level degree or higher
- ☐ None of the above

11. How much total combined money did all people living in your home earn last year? Please choose only one:

- ☐ $0 to $9,999
- ☐ $10,000 to $24,999
- ☐ $25,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 to $124, 999
- ☐ $125,000 to $149,999
- ☐ $150,000 to $174, 999
- ☐ $175,000 to $199,999
- ☐ $200,000 and up
- ☐ Prefer not to answer

12. Which of the following best describes your current relationship status? Please choose only one:

- ☐ Married
- ☐ In a domestic partnership or civil union
- ☐ Widowed
- ☐ Single, but living with a significant other

- ☐ Divorced
- ☐ Single, never married
- ☐ Separated

13. Which of the following categories best describes your employment status? Please choose only one:

- ☐ Employed, working full-time
- ☐ Student
- ☐ Employed, working part-time
- ☐ Retired
- ☐ Not employed, looking for work
- ☐ Disabled, not able to work
- ☐ Not employed, NOT looking for work

14. What transportation do you most often to go places? Please choose only one:

- ☐ I drive my own car
- ☐ Someone drives me
- ☐ I take the bus
- ☐ I walk
- ☐ I ride a bicycle
- ☐ I take a taxi cab
- ☐ I ride a motorcycle or scooter
- ☐ I take an Uber/Lyft
- ☐ Some other way

15. Are you:

- ☐ A veteran
- ☐ In Active Duty
- ☐ National Guard/Reserve
- ☐ None of these- **SKIP TO QUESTION 17**

16. If veteran, active duty or national guard/reserve, are you receiving care at the VA?

- ☐ Yes
- ☐ No

17. How do you pay for most of your health care? Please choose only one:

- ☐ I pay cash/I don't have insurance
- ☐ TRICARE
- ☐ Medicare or Medicare HMO
- ☐ Indian Health Services
- ☐ Medicaid or Medicaid HMO
- ☐ Commercial health insurance (HMO, PPO)
- ☐ Veteran's Administration
- ☐ Some other way

18. Including yourself, how many people currently live in your home? Please choose only one:

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6 or more

19. Are you a caregiver to an adult family member who cannot care for themselves in your home?

- ☐ Yes
- ☐ No

20. Including yourself, how many people 65 years or older currently live in your home? Please choose only one:

- ☐ None
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6 or more

21. How many CHILDREN (under age 18) currently live in your home? Please choose only one:

- ☐ None- **SKIP to Q33**
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6 or more

If you selected 'None', skip the Children's Health section and go to Question 33

Children's Health

22. Was there a time in the PAST 12 MONTHS when children in your home needed medical care but did NOT get the care you needed?

- ☐ Yes
- ☐ No- **SKIP TO QUESTION 24**

23. What is the MAIN reason they didn't get the medical care they needed? Please choose only one:

- ☐ Can't afford it/Costs too much
- ☐ I had transportation problems
- ☐ I don't have a doctor
- ☐ I don't know where to go
- ☐ I had trouble getting an appointment
- ☐ I don't have health insurance

- ☐ Other

24. Was there a time in the PAST 12 MONTHS when children in your home needed DENTAL care but did NOT get the care you needed?

- ☐ Yes
- ☐ No- **SKIP TO QUESTION 26**

25. What is the MAIN reason they didn't get the dental care they needed? Please choose only one:

- ☐ Can't afford it/Costs too much
- ☐ I had transportation problems
- ☐ I don't have a doctor
- ☐ I don't know where to go
- ☐ I had trouble getting an appointment
- ☐ I don't have health insurance
- ☐ Other

26. Was there a time in the PAST 12 MONTHS when children in your home needed mental health care but did NOT get the care you needed?

- ☐ Yes
- ☐ No- **SKIP TO QUESTION 28**

27. What is the MAIN reason they didn't get the mental health care they needed? Please choose only one:

- ☐ Can't afford it/Costs too much
- ☐ I had transportation problems
- ☐ I don't have a doctor
- ☐ I don't know where to go
- ☐ I had trouble getting an appointment
- ☐ I don't have health insurance
- ☐ Other

28. I feel safe walking in the neighborhood.

- ☐ Yes- **SKIP TO QUESTION 30**
- ☐ No

29. If you answered "no", CHECK ALL reasons you do not feel safe walking:

- ☐ Traffic
- ☐ No sidewalks
- ☐ Poor condition of roads or sidewalks
- ☐ Dogs not on a leash
- ☐ Stopped by police
- ☐ Violent crime or theft

30. Check all the health issues children in your home have faced. CHECK ALL THAT APPLY:

- ☐ My children have not faced any health issues
- ☐ Allergies
- ☐ Asthma
- ☐ Bullying
- ☐ Unintentional injuries or accidents that required immediate medical care (such as a concussion from playing sports)
- ☐ Behavioral Health/Mental Health
- ☐ Children overweight
- ☐ Children underweight
- ☐ Birth-related (such as low birthweight, prematurity, prenatal, and others)
- ☐ Dental Problems (such as cavities, root canals, extractions, surgery, and others)
- ☐ Autism
- ☐ Child abuse/child neglect
- ☐ Diabetes/Pre-diabetes/High Blood sugar
- ☐ Using drugs or alcohol
- ☐ Using tobacco, e-cigarettes, or vaping
- ☐ Teen pregnancy
- ☐ Sexually transmitted disease
- ☐ Other (please specify)

31. Check all the special needs children in your home have faced. CHECK ALL THAT APPLY:

- ☐ My children do not have any special needs
- ☐ Attention deficit/hyperactivity disorder (AD/HD)
- ☐ Autism/pervasive development disorder (PDD)a
- ☐ Blindness/visual impairment
- ☐ Cerebral palsy
- ☐ Child who uses a wheelchair or walker
- ☐ Deaf/hearing loss
- ☐ Developmental delay (dd0
- ☐ Down syndrome
- ☐ Emotional disturbance
- ☐ Epilepsy/seizure disorder
- ☐ Intellectual disability (formerly mental retardation)
- ☐ Learning disabilities/differences
- ☐ Speech and language impairments
- ☐ Spina bifida
- ☐ Traumatic brain injury
- ☐ Other (please specify)

32. Do any children in your home:

	Yes	No	Not Sure
Know how to swim			
Wear a bike/skate helmet			

Children under age 8 use a car/booster seat			
Wear a seatbelt at all times			
Have access to pool where you live			
Receive all shoots to prevent disease			
Have a history of being bullied (including social media)			
Receiving gun safety education			
Use sunscreen			
Eat at least 3 servings of fruits and vegetables everyday			
Exercise at least 60 minutes every day			
Get 8 hours or more sleep every night			
Eat fast food every week			
Drink sugary-sweetened sodas, energy drinks, or sports drinks ever day			
Eat junk food every day			

Stay home from school 5 or more days a year because of health issues			
Need regular access to a school nurse			
Attend a public or charter school			

Community Health

These next questions are about your view or opinion of the community in which you live.

33. Overall how would you rate the health of the community in which you live? Please choose only one:

- ☐ Very unhealthy
- ☐ Unhealthy
- ☐ Somewhat healthy
- ☐ Healthy
- ☐ Very healthy
- ☐ Not sure

34. Please read the list of risky behaviors listed below. Which three do you believe are the most harmful to the overall health of your community?

- Alcohol abuse
- Dropping out of school
- Drug abuse
- Lack of exercise
- Poor eating habits
- Not getting “shots” to prevent disease
- Not hearing helmets
- Not using seat belts/not using child safety
- Tobacco use/e-cigarettes/vaping
- Unsafe sex including not using birth control
- Distracted driving (texting, eating, talking on the phone)
- Not locking up guns
- Not seeing a doctor while you are pregnant

In order, select which three behaviors you think are:

1- Most Harmful _____

2- Second Most Harmful _____

3- Third Most Harmful _____

35. Read the list of health problems and think about your community. Which do you believe are most important to address to improve the health of your community?

• Aging Problems (for example: difficulty getting around, dementia, arthritis)
• Cancers
• Child Abuse / Neglect
• Clean Environment / Air and Water Quality
• Dental Problems
• Diabetes / High Blood Sugar
• Domestic Violence / Rape / Sexual Assault
• Gun-Related Injuries
• Being Overweight
• Mental Health Problems Including Suicide
• Heart Disease / Stroke / High Blood Pressure
• HIV/AIDS / Sexually Transmitted Diseases (STDs)
• Homicide
• Infectious Diseases Like Hepatitis and TB
• Motor Vehicle Crash Injuries
• Infant Death
• Respiratory / Lung Disease
• Teenage Pregnancy
• Tobacco Use / E-cigarettes / Vaping

In order, select which three health problems you think are:

1- Most Harmful _____

2- Second Most Harmful _____

3- Third Most Harmful _____

36. Please read the list of factors below. Which do you believe are most important to improve the quality of life in a community?

• Good Place to Raise Children
• Low Crime / Safe Neighborhoods
• Good Schools

• Access to Health Care
• Parks and Recreation
• Clean Environment / Air and Water Quality
• Low-Cost Housing
• Arts and Cultural Events
• Low-Cost Health Insurance
• Tolerance / Embracing Diversity
• Good Jobs and Healthy Economy
• Strong Family Life
• Access to Low-Cost, Healthy Food
• Healthy Behaviors and Lifestyles
• Sidewalks / Walking Safety
• Public Transportation
• Low Rates of Adult Death and Disease
• Low Rates of Infant Death
• Religious or Spiritual Values
• Disaster Preparedness
• Emergency Medical Services
• Access to Good Health Information

In order, select which three factors you think are:

1- Most Harmful _____

2- Second Most Harmful _____

3- Third Most Harmful _____

37. Below are some statements about your local community. Please tell us how much you agree or disagree with each of the following statements:

	Agree	Disagree	Not sure
Drug abuse is a problem in my community.			
I have no problem getting the health care services I need			

We have great parks and recreational facilities			
Public transportation is easy to get to if I need it			
There are plenty of jobs available for those who want them			
Crime in my areas is a serious problem			
Air pollution is a problem in my community			
I feel safe in my own neighborhood			
There are affordable places to live in my neighborhood			
The quality of healthcare is good in my neighborhood			
There are good sidewalks for walking safely			
I am able to get healthy food easily			

Community Health

38. Below are some statements about your connections with the people in your life. Please tell us how much you agree or disagree with each of the following statements:

	Agree	Disagree	Not sure

I am happy with my friendships and relationships			
I have enough people I can ask for help at any time			
My relationships are as satisfying as I would want them to be			

39. Over the past 12 months, how often have you had thoughts that you would be better off dead or of hurting yourself in some way?

- Not at all
- Several days
- More than half the days
- Nearly every day

d.

If you would like help with or would like to talk about these issues, please call the National Suicide Prevention Hotline at 1-800-273-8255.

40. In the past 12 months, I worried about whether our food would run out before we got money to buy more. Please choose only one:

- Often true
- Sometimes true
- Never true

41. In the past 12 months, the food that we bought just did not last, and we did not have money to get more. Please choose only one:

- Often true
- Sometimes true
- Never true

42. In the last 12 months, did you or anyone living in your home ever get emergency food from a church, a food pantry, or a food bank, or eat in a soup kitchen?

- Yes
- No

e.

43. Now think about the past 7 days. In the past 7 days, how many times did you eat fast food? Include fast food meals eaten at work, at home, or at fast-food restaurants, carryout or drive-through:

_____

44. Has there been any time in the past 2 years when you were living on the street, in a car, or in a temporary shelter?

- Yes
- No

45. Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as part of a household?

- Yes
- No

46. In the past 12 months, has your utility company shut off your service for not paying your bills?

- Yes
- No

47. In the past 12 months, have you used a prescription pain medicine (morphine, codeine, hydrocodone, oxycodone, methadone, or fentanyl) without a doctor's prescription or differently than how a doctor told you to use it?

- Yes
- No

f.

Personal Health

These next questions are about your personal health and your opinions about getting health care in your community.

48. Overall, how would you rate YOUR OWN PERSONAL health? Please choose only one:

- Very unhealthy
- Unhealthy
- Somewhat healthy
- Healthy
- Very healthy
- Not sure

49. In the past 12 months, how did your health change? Please choose only one:

- Got better
- Stayed about the same
- Got worse

g.

50. Was there a time in the PAST 12 MONTHS when you needed medical care but did NOT get the care you needed?

- Yes
- No- **SKIP TO QUESTION 52**

51. What is the MAIN reason you didn't get the medical care you needed? Please choose only one:

- Can't afford it/Costs too much
- I had transportation problems

- I don't have a doctor
- I don't know where to go
- I had trouble getting an appointment
- I don't have health insurance
- Other

52. Thinking about your MENTAL health, which includes stress, depression, and problems with emotions, how would you rate your overall mental health? Please choose only one:

- Excellent
- Very good
- Good
- Fair
- Poor

h.

53. Was there a time in the PAST 12 MONTHS when you needed mental health care but did NOT get the care you needed?

- Yes
- No- **SKIP TO QUESTION 55**

54. What is the MAIN reason you didn't get the mental health care you needed? Please choose only one:

- Can't afford it/Costs too much
- I had transportation problems
- I don't have a doctor
- I don't know where to go
- I had trouble getting an appointment
- I don't have health insurance
- Other

55. Was there a time in the PAST 12 MONTHS when you needed DENTAL care but did NOT get the care you needed?

- Yes
- No- **SKIP TO QUESTION 57**

56. What is the MAIN reason you didn't get the dental care you needed? Please choose only one:

- Can't afford it/Costs too much
- I had transportation problems
- I don't have a doctor
- I don't know where to go
- I had trouble getting an appointment
- I don't have health insurance
- Other

57. In the past 12 months, have you gone to a hospital emergency room (ER) about your own health?

- Yes
- No, I have not gone to a hospital ER in the past 12 months

If 'NO', skip to question 60

58. Please enter the number of times you have gone to a hospital emergency room (ER) about your own health in the past 12 months: _____

59. What is the MAIN reason you used the emergency room INSTEAD of going to a doctor's office or clinic? Please choose only one:

- ☐ After hours/Weekend
- ☐ I don't have a doctor/clinic
- ☐ Long wait for an appointment with my regular doctor
- ☐ Cost
- ☐ Emergency/Life-threatening
- ☐ I don't have insurance
- ☐ Other

60. Have you ever been told by a doctor or other medical provider that you had any of the following health issues? CHECK ALL THAT APPLY:

- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ HIV/AIDS
- ☐ Heart disease
- ☐ High blood pressure/High cholesterol
- ☐ Obesity
- ☐ Stroke
- ☐ None of these

61. How often do you smoke? Please choose only one:

- ☐ I do not smoke cigarettes
- ☐ I smoke about one pack per day
- ☐ I smoke less than one pack per day
- ☐ I smoke more than one pack per day

62. How often do you vape or use e-cigarettes? Please choose one:

- ☐ I do not vape or smoke e-cigarettes
- ☐ I vape or smoke e-cigarettes everyday
- ☐ I vape or smoke e-cigarettes on some days

The final questions are about events that happened during your childhood. This information will allow us to better understand how problems that may occur early in life can have a health impact later in life. This is a sensitive topic and some people may feel uncomfortable with these questions. If you prefer not to answer these questions, you may skip them. For these questions, please think back to the time BEFORE you were 18 years of age.

63. Did you live with anyone who was depressed, mentally ill, or suicidal?

- Yes
- No

64. Did you live with anyone who was a problem drinker or alcoholic?

- Yes
- No

65. Did you live with anyone who used illegal street drugs or who abused prescription medications?

- Yes
- No

66. Did you live with anyone who served time or was sentenced to serve time in a prison, jail or other correctional facility?

- Yes
- No

67.Were your parents separated or divorced?

- Yes
- No

68. How often did your parents or adults in your home slap, hit, kick, punch, or beat each other up?

- Never
- Once
- More than once

69. How often did a parent or adult in your home hit, beat, kick, or physically hurt you in any way?

- Never
- Once
- More than once

70. How often did a parent or adult in your home swear at you, insult you, or put you down?

- Never
- Once
- More than once

71. How often did an adult or anyone at least 5 years older than you touch you sexually?

- Never
- Once
- More than once

72. How often did an adult or anyone at least 5 years older than you try to make you touch them sexually?

- Never
- Once
- More than once

73. How often did an adult or anyone at least 5 years older than you force you to have sex?

- ☐ Never
- ☐ Once
- ☐ More than once

If you would like help with or would like to talk about these issues, please call the National Hotline for Child Abuse at 1-800-4-A-CHILD (1-800-422-4453).

That concludes our survey. Thank you for participating!

Your feedback is important.

COMMUNITY HEALTH SURVEY RESULTS

Community surveys were completed in collaboration with the Healthy Hillsborough Collaborative CHNA partnership. Surveys were administered in paper format as well as online. Surveys were offered in both English and Spanish languages.

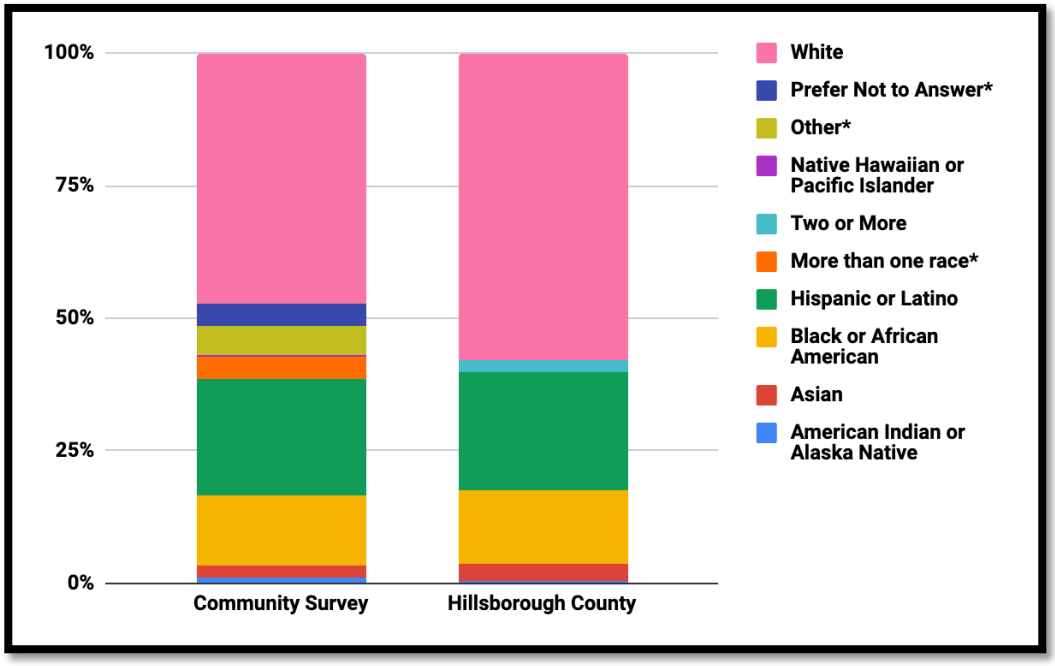
The aggregate results are shown below.

Survey Results – Respondent Demographics

A total of 5,304 Hillsborough County residents participated in the collaborative Community Health Needs Assessment (CHNA) survey. Roughly 72% of community residents who participated in the survey were female and approximately 28% were male.

- **5,304 Total Respondents** from Hillsborough County
- **71.74% Female**
- **59.99% White**
- **28.73% Hispanic or Latino**
- **14.29% Speak Spanish at Home**

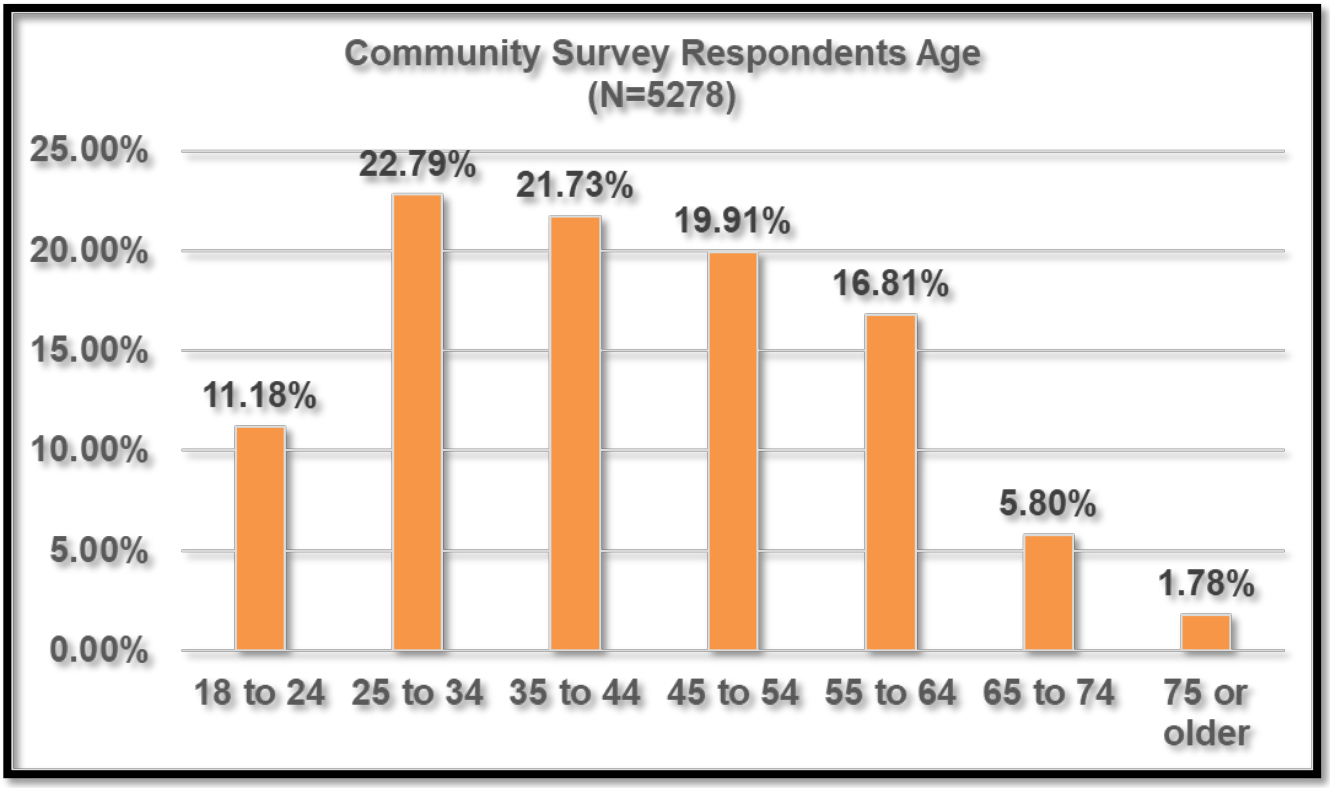
Below, graph 1. shows community residents participation in the survey by race/ethnicity relative to the population in Hillsborough County, Florida. Hillsborough County is home to the largest share of Hispanic or Latino and Black or African American households. The Community Survey sample is relatively similar in race/ethnicity to Hillsborough County population.



Graph 1. CHNA survey participation by race/ethnicity in Pasco County, Florida

COMMUNITY HEALTH SURVEY RESULTS CONTINUED

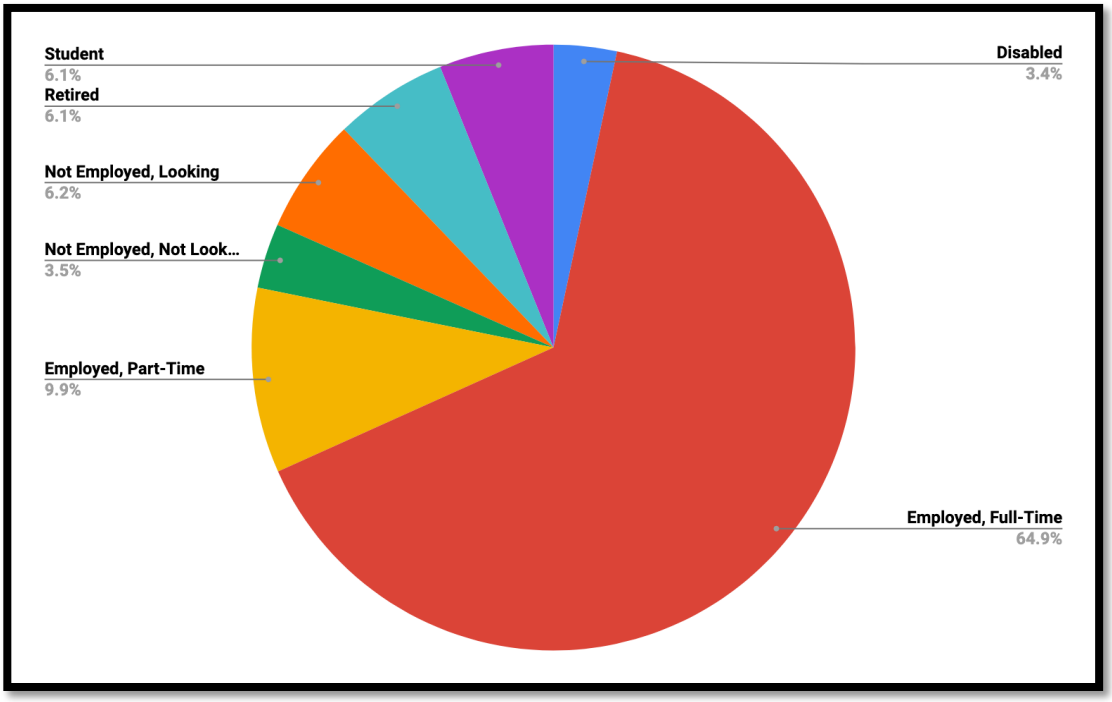
Below, graph 2. shows the age ranges of survey participants. Nearly half of the respondents were between the ages of 25 to 44 years of age.



Graph 2. CHNA survey participation by age in Hillsborough County, Florida.

COMMUNITY HEALTH SURVEY RESULTS CONTINUED

HOUSEHOLD ANNUAL INCOME



Nearly 65% of survey respondents are employed full-time. Among those employed full-time, the largest share of respondents report annual incomes between $25,000 - $49,999. The median income is $53,742. These numbers fall short of $58,044 - the annual income needed for a family to live very modestly in Hillsborough County.

COMMUNITY HEALTH SURVEY RESULTS CONTINUED

The tables below provide additional demographics and survey results about survey participants in the CHNA survey. CHNA survey results were useful in helping the Healthy Hillsborough collaborative partnership better understand our communities and identify priority areas of need to address in our Community Health Plans.

HEALTH INSURANCE STATUS

How do you pay for most of your health care?	
I pay cash / I don't have insurance	15.23%
TRICARE	2.44%
Medicare or Medicare HMO	8.45%
Indian Health Services	0.20%
Medicaid or Medicaid HMO	7.15%
Commercial health insurance (HMO, PPO)	56.75%
Veteran's Administration	1.10%
Some other way	8.67%

EMPLOYMENT STATUS

Employed, working full–time	64.59%
Student	6.27%
Employed, working part–time	10.00%
Retired	5.96%
Not employed, looking for work	6.31%
Disabled, not able to work	3.35%
Not employed, NOT looking for work	3.52%

MARITAL STATUS	
MARRIED	47.57%
IN A DOMESTIC PARTNERSHIP OR CIVIL UNION	3.28%
SINGLE, BUT LIVING WITH A SIGNIFICANT OTHER	9.50%
SINGLE, NEVER MARRIED	23.72%
SEPARATED	2.93%
WIDOWED	2.37%
DIVORCED	10.63%

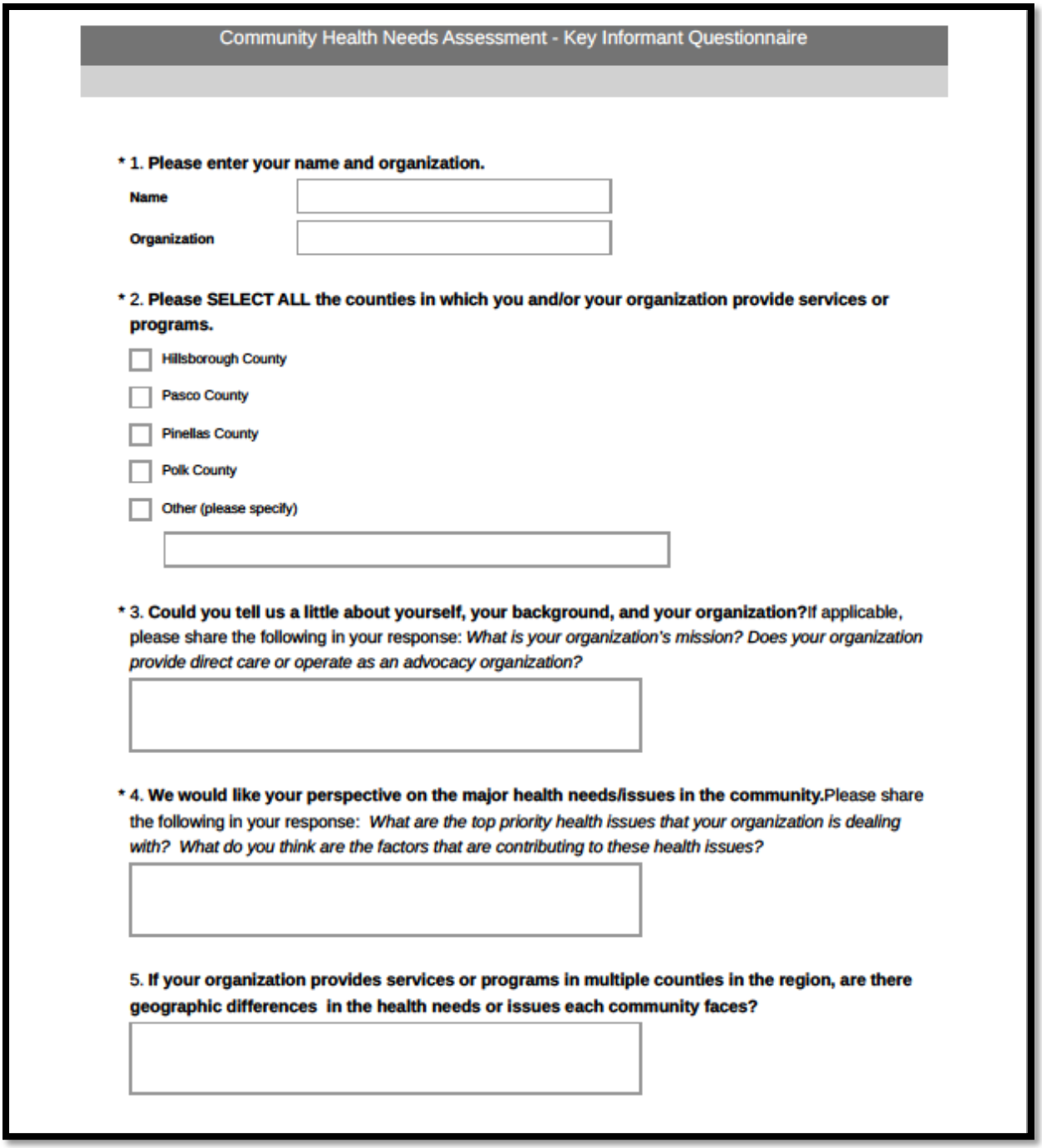
COMMUNITY HEALTH SURVEY QUESTION	SURVEY RESULTS			
Demographic Questions				
Zip Code	The community survey was administered in Hillsborough County, with emphasis on highest needs zip codes (as defined by the Healthy Communities Institute (HCI) Socioneeds index). Highest need zip codes are: 33605, 33610, 33612, 33613, 33604.			
Languages Spoken at Home	English	81.81%	Arabic Chinese French German Haitian Creole Russian Spanish Vietnamese Other	0.43% 0.22% 0.08% 0.12% 0.40% 0.14% 14.72% 0.22% 1.88%
Including yourself, how many people currently live in your home? Please choose only one:	1 13.92% 2 31.58% 3 19.61%		4 5 6 or more	18.51% 9.41% 6.96%
How many CHILDREN (under age 18) currently live in your home? Please choose only one:	None 1 2 3	56.46% 18.52% 14.86% 6.41%	4 5 6 or more	2.27% 0.88% 0.58%
Are you a caregiver to an adult family member who cannot care for themselves in your home?	Yes	7.93%	No	92.07%
Gender	Male Female	26.91% 72.46%	Transgender: Male to Female Transgender: Female to Male Other/Gender non-Conforming	0.10% 0.10% 0.43%
Highest Education Level	Less than high school Some high school, but no diploma High school diploma (GED) None of the above	2.67% 3.91% 14.44% 0.47%	Some college, no degree 2 – Year College Degree 4 – Year College Degree Grad - Level Degree or Higher	19.10% 14.08% 23.96% 21.37%
Age	18 to 24 25 to 34 35 to 44 45 to 54	11.42% 23.12% 21.52% 19.59%	55 to 64 65 to 74 75 or older	16.86% 5.81% 1.67%
Ethnicity	Yes, Hispanic or Latino No, not Hispanic or Latino	28.73% 67.20%	Prefer not to answer	4.07%
Race	American Indian or Alaska Native Asian Black or African American Native Hawaiian or Pacific Islander	1.21% 3.03% 16.87% 0.44%	White More than one race Other Prefer Not to Answer	60.40% 5.33% 7.39% 5.33%

Social Determinant Questions				
In the past 12 months, I worried about whether our food would run out before we got money to buy more.	Yes	29.99%	No	70%
In the past 12 months, the food that we bought just did not last, and we did not have money to get more.	Yes	45.35%	No	74.22%
Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as part of a household? (Please choose only one)	Yes	12.26%	No	87.74%
In the past 12 months has your utility company shut off your service for not paying your bills? (Please choose only one)	Yes	7.83%	No	92.17%
Was there a time in the PAST 12 MONTHS when you needed medical care but did NOT get the care you needed? (Please choose only one)	Yes	19.00%	No	81.00%
What is the MAIN reason you didn't get the medical care you needed? (Please choose only one)	Can't afford it / Costs too much I had transportation problems I don't have a doctor	47.88% 2.62% 4.99%	I don't know where to go I had trouble getting an appointment I don't have health insurance Other	2.62% 9.35% 15.21% 17.33%
I feel safe in my own neighborhood.	Agree Disagree	78.76% 13.54%	Not Sure	7.71%
I am happy with my friendships and relationships	Agree Disagree Not Sure	87.57% 8.62% 3.80%		
I have enough people I can ask for help at any time	Agree Disagree Not Sure	78.32% 16.67% 5.01%		
My relationships are as satisfying as I would want them to be	Agree Disagree Not Sure	78.09% 16.32% 5.59%		

Targeted interviews with community stakeholders were used to gather information and opinions from persons who represent the broad interests of the community served by the Hospital. A total of 23 interviews were completed in June through July 2019.

Stakeholders were identified by the Healthy Hillsborough Collaborative partnership and contacted by email with an electronic link to the interview questions shown below. Stakeholders represented leaders and/or representatives of organizations that serve low – income, minority, and other underserved populations.

STAKEHOLDER INTERVIEW QUESTIONS



Community Health Needs Assessment - Key Informant Questionnaire

* 1. **Please enter your name and organization.**

Name

Organization

* 2. **Please SELECT ALL the counties in which you and/or your organization provide services or programs.**

- Hillsborough County
- Pasco County
- Pinellas County
- Polk County
- Other (please specify)

* 3. **Could you tell us a little about yourself, your background, and your organization?** If applicable, please share the following in your response: *What is your organization's mission? Does your organization provide direct care or operate as an advocacy organization?*

* 4. **We would like your perspective on the major health needs/issues in the community.** Please share the following in your response: *What are the top priority health issues that your organization is dealing with? What do you think are the factors that are contributing to these health issues?*

5. **If your organization provides services or programs in multiple counties in the region, are there geographic differences in the health needs or issues each community faces?**

* 6. **Which groups in your community appear to struggle the most with these issues you've identified and how does it impact their lives?** Please consider the following in your response:*Are there specific challenges that impact low-income, under-served/uninsured persons experience? Are there specific challenges that impact different racial or ethnic groups in the community? Are there specific challenges that impact different groups based on age or gender in the community?*

* 7. **What barriers or challenges might prevent someone in the community from accessing health care or social services?** *(Examples might include lack of transportation, lack of health insurance coverage, language/cultural barriers, etc.)*

* 8. **Could you tell us about some of the strengths and resources in your community that address these issues, such as groups, initiatives, services, or programs?** *(if including specific organizations in response, please include name and type of program)*

* 9. **What services or programs do you feel could potentially have the greatest impact on the needs that you've identified?**

* 10. **Is there anything additional that should be considered for assessing the needs of the community?**

You have completed the interview questions! Please send any comments or questions to Courtney Kaczmarsky by email at courtney.kaczmarsky@conduent.com.
Thank you very much for your time and cooperation. Have a great day!

STAKEHOLDER SURVEY RESULTS

The following top health needs emerged from the stakeholder interviews below:

1. Exercise, Nutrition, and Weight
2. Cancer
3. Mental Health & Mental Disorders
4. Substance Abuse
5. Maternal, Fetal, & Infant Health
6. Access to Health Services

Some key quotes/comments from Hillsborough County Stakeholders are provided below:

Health Topics	
Exercise, Nutrition, and Weight	"There is a need for nutrition and weight loss education in the county. Poor health education about health and wellness, diet choices often limited because of finances and a sedentary lifestyle are contributing factors to major health issues." "People need better nutrition. They might be able to get food, but not healthy food. The major contributing factors are education and transportation." Healthy food is an issue in low income communities. Access to healthy food is not available; it's a lot of fast food. Working to bring more healthy foods into the neighborhoods. From the assets side of it, we have a farmer's market on 22nd street and Sanwa and I'm interested in trying to connect these two to try to create some kind of co-op or bodega type store to get fresh foods in the community. They are also interested in getting grocery stores to label their foods with cards that tell people "Great for high-blood pressure!" to get people to explore other foods. Nutrition education and weight loss are top issues. Contributing factors are busy lives lead to fast food meals. Many fad diets create confusion over what approach is best for healthy eating and healthy weight maintenance. Also stress management is needed as most employees work long days meeting the needs of students and the many demands of being an educator. Low income individuals struggle with access and affordability of healthy foods Obesity is one of a health issues we are working through. Obesity can lead to physical, social and emotional struggles for kids. Helping parents to help their children maintain a healthy weight. I don't think there is enough support and awareness on the school district level. Some of the factors that are contributing to this are poor diet quality, easily accessible high fat and high sugar convenience foods, less accessible fresh fruits and vegetables, cost of produce vs. convenience foods, and time.
Diabetes	"Specifically, with the refugee community, the trend we notice now is with chronic diseases (high blood pressure, diabetes, few cancer/TB/STD)."

Access to Health Services	"We need access to health care and access to healthy foods, these things working in tandem are definitely the two main things that keep me up. We have the assets, but they haven't been organized to make this area a true destination place and a "community of choice". "There is a need for education to the general community about how to access health care and the benefits of coverage. Generally educating the community about the ramifications of not expanding Medicaid would be helpful." "Many people are employed yes but they still can't afford their portion of the health insurance copay. Many companies in the past would pay for health insurance. Now, they may only pay part and even if it is three-fourths, people can't afford that. People retire or leave work and they can't afford to continue having health insurance, so they are not accessing the primary care needed to maintain their health before issues progress." "East Tampa has always had a lack of direct access to health care – a lack of physicians, primary, specialty & tertiary facilities as well as outpatient services and laboratory services" "Depending on where you live in Hillsborough, if you live in East Tampa, West Tampa, North Tampa; and some parts of South County, not the affluent parts – you just don't have access. And particularly in South County, these are not minorities, these are white people who just don't have access. Is it a racial thing? Yes, depending on where you live but really it seems that income determines your access to health care. In some parts of the county it is an economic issue." "Trying to access the health system can be overwhelming. I have spoken to students who do have health insurance, but they don't understand it. It is a complicated system. What is and isn't covered? Which doctor can they see? Even using the ER for primary care because they are not aware that they shouldn't." Cultural sensitivity training, because if you hit a wall with a cultural barrier you won't get anywhere with that client. We see things two different ways based on our upbringing and culture, and we can each think of it as fact. How someone is going to prevent or treat their medical condition depends on their perception of the condition. We need to also understand religious considerations. For instance, it is currently Ramadan and people observing Ramadan fast during the day. It is important to make their appointments for bloodwork early in the morning so we can have a successful blood draw, otherwise it will create frustration for both the patient and staff. Some cultures may be prone to take herbs along with whatever medications you prescribe them, and it is important to know that for drug interactions. We always think we know it all as the provider, and a provider may know how the human body works, but all the knowledge isn't worth anything if the patient with the body doesn't work with them. It takes consideration and respect to know where someone is coming from not only physically but emotionally. Another barrier is how groups perceive time. We commonly work with three groups of refugees- Cuban, Congolese, and Middle Eastern. Usually people from the Middle East/Asia are past oriented, meaning they prefer to use remedies and do things from their ancestors/keep things how they've always been done. People from western civilizations are future oriented, so they want the most recent research/treatments. Africans tend to be present oriented since their focus is general ensuring their basic needs are taken care of, and they will focus only on what a doctor tells them to do now, not what they need to do in a few months. I am currently working with providers to provide a cultural orientation for them to have a better understanding how to work with these groups and ask questions in a way that will allow them to get the answers they need. It is important providers temporarily invest

	time now to learn about the patient and their cultural differences to make a difference in the level of care they can provide to their patients in the long term. Insurance – huge numbers falling through the cracks and not able to afford insurance.
Cancer	"Cancer affects many people today. I am a 3-time cancer survivor. Fortunately, I can get into Moffitt. A lot of people can't get into Moffitt or a cancer center because their insurance doesn't allow them to go there." "Specifically, with the refugee community, the trend we notice now is with chronic diseases (high blood pressure, diabetes, few cancer/TB/STD). Seniors are a group that experiences Cancer at a higher rate. " There are more common challenges among low income and racial or ethnic groups. HIV, Infant mortality, Cancer in the aged.
Mental Health & Mental Disorders	Lack of insurance and transportation, stigma, and fear of being labeled as "mentally ill" are the biggest barriers to receiving mental health services in the county. "Access to mental health resources is a problem regardless of income, ethnic groups, gender or age. Even patients with good insurance lack access. "The mental health crisis and opioid crisis is crushing Hospitals." The community does not have the physical facilities or workers to take care of those with mental health issues. Hospitals don't have the resources to take care of IV drug users. They need detox support, social support, and follow up appointments. "We have not caught up to the opioid crisis." Mental health and substance abuse disorders are present everywhere so there are no differences amongst the different communities. I think that as a community, we need to get over the "stigma" of mental health and make it a society where individuals are open to discuss their issues without fear. I believe mental health can affect all members of society. There may be specific challenges that low-income or under-served/uninsured persons experience, such as their means to access services. Additionally, I think many people are afraid of the stigma surrounding mental health and are unwilling to admit they may need help. I see mental health issues as a common thread. Everything from anxiety to more serious psychological illness, the effects of stress, and everything that comes with that.
Substance Abuse	"There is an increase in drug overdose and trauma volume in the county. Pregnant women with substance abuse disorders has become an emerging issue. " "The mental health crisis and opioid crisis is crushing Hospitals." " The community does not have the physical facilities or workers to take care of those with mental health issues. Hospitals don't have the resources to take care of IV drug users. They need detox support, social support, and follow up appointments." "Families also don't want to identify drug problems. There is still a lot of stigma that I would like to see decrease."

	Mental health and substance abuse disorders are present everywhere so there are no differences amongst the different communities Education: Internal trainings for caregivers (e.g., how to identify someone who abuses drugs) and external trainings for the community (e.g., “Stop the bleed”, fever control for babies, immunizations, how to use Narcan kits, and teaching families about how to provide immediate treatment during an overdose.)
Heart Disease & Stroke	There has been an increase in stroke volume.
Immunizations & Infectious Disease Themes	"Cultural barriers and health literacy issues are contributing factors to increasing rates of disease in the community. There is a need for education surrounding the care and treatment of diseases. " "We see pediatric patients with parents who need training (e.g., on wound care, immunizations, etc.)" "Specifically, with the refugee community, the trend we notice now is with chronic diseases (high blood pressure, diabetes, few cancer/TB/STD)."
Respiratory Disease Quotes	"Asthma: Factors - There is a large amount of old housing stock in East Tampa. These deteriorating buildings means asthma is a growing concern."
Maternal, Fetal, & Infant Health	"There has been an increase in teen motherhood. Difficulty in accessing mental health services, and toxic stress within the family can lead to mental depression for pregnant women. Infant bed sharing has been cited as an issue related to increase in sleep-related infant deaths due to accidental suffocation and strangulation in bed. " "There is an emerging cycle of young motherhood, often resulting in not finishing school, being unemployed and enduring domestic violence." "Cycle of teen motherhood among Spanish speakers. Black women – higher rates of chronic health conditions for those with poor pregnancy outcomes; higher Medicaid rates; higher odds ratios for lack of support and depression; short inter-pregnancy interval. Hispanic women – higher rates of no insurance and lack of access to health care; fear of accessing available services due to immigration status; high rates of hypertension for those with poor pregnancy outcomes." "Chronic health conditions (hypertension, diabetes and obesity) in pregnant mothers. Contributing factors include lack of a medical home prior to pregnancy to treat chronic conditions due to lack of health insurance or Medicaid which ends 8-weeks post-partum; built environment which limits ability for health lifestyle choices; food deserts and food insecurity; toxic stress; epigenetic influences on obesity and other chronic conditions." "Maternal depression and stress. Contributing factors include difficulty in accessing mental health services especially during pregnancy; toxic stress in family and community; adverse childhood events and their impact on later adult mental health." "Neonatal Abstinence Syndrome infants. Contributing factors are maternal substance use disorder; lack of residential treatment slots for pregnant women; needed support services for NAS infants and families post-discharge."

COMMUNITY FOCUS GROUP SURVEY RESULTS

In partnership with the Hillsborough County Health Department, focus groups were conducted to gather information and opinions from community members who are served by the Hospital. A total of 4 focus groups were completed in June through July 2019. Three were conducted at the Hillsborough County Health Department (2 – in English, 1 in Spanish) and one was conducted at the University Area Community Development Center (University of South Florida, College of Public Health Students assisted with conducting focus groups at this location).

Focus group participants discussed the following questions below:

Hillsborough County Community Health Assessment Focus Group Questions

Introductory Question:

Let's start off by going around the room and introducing ourselves. Please tell us your name, one healthy thing you like to do, and why.

Questions:

1. Take a minute and think about your life and the community where you live. Think about the things that contribute to the quality of life in your community. How satisfied are you with the quality of life in your community?
2. What assets does your community have that can help to improve the health and quality of life where you live?
3. Can you tell me what you think are the top 3 health issues in your community?
4. What do you think should be done to address these problems?
5. What difficulties, if any, do you see to implementing a project to prevent these problems in your community?
2. How would you suggest overcoming these difficulties?
3. What do you think of when you hear the term 'health equity'? OR What does 'health equity' mean to you?
4. Closing Question: Is there anything else that you would like to share before we end our discussion for the day?

The following quotes/thoughts/comments emerged from the community focus groups:

WHAT ASSETS DOES YOUR COMMUNITY HAVE THAT CAN HELP TO IMPROVE THE HEALTH AND QUALITY OF LIFE WHERE YOU LIVE?

Physical/Design

- Lighting is huge. You can run in your neighborhoods in the evening, that's huge.
- Community center
- Public Library
- Meeting places
- Shade/Tree coverage/well-groomed surroundings
- Proximity to goods & services
- MacDill area
- Grocery stores close-by

Programs/Services

- Daycare and after school care.
- Exercise opportunities
- Free health education classes
- Church ministries/Charity organizations
- County health plan
- FQHCs/Health centers offering discounted services
- The women's center/Dental bus
- Well Built Bikes

Other

- Owning a car
- People

Lacking/Need to improve

- Farmer's markets
- Cleaner streets
- Transportation options
- Homeless hang around Trinity cafe

MOST IMPORTANT HEALTH ISSUES

Environmental Health

- Stray animals
- Pests: mosquitoes, ants, roaches, snakes
- Trash

Nutrition

- Affordable healthy food options
- Knowing how to prepare healthy meals
- More fresh markets
- Too many fast food restaurants

Behavioral Health

- Mental Health: particularly among servicemen, for youth
- Alcohol addiction
- Substance abuse
- Delinquency

Chronic Disease

- Diabetes
- Heart disease
- Chronic disease

Obesity

- Weight management

Safety

- Uneven sidewalks
- ADA access
- Swimming/Drownings
- Car accidents
- Community walkability

Access to health care

- Having good health insurance / Cost of prescriptions
- Access to health care
- Dental care

Other

- Street noise
- Homelessness
- Illnesses associated with mold
- Access to good schools
- Income inequality
- Transportation

Notable Comments

- The negative perception of needing help is changing to a more positive one.
- My community doesn't feel like a community
- Sometimes I am afraid to go to the Hospital because I don't know how much I will have to pay.

HOW SHOULD WE ADDRESS SOME OF THESE PROBLEMS?

Education/Messaging
- Advertisements, education, highlighting the positive
- Policy & Culture change
- Reducing the stigma of mental health
- Using the road safely – for different types of users
- Making things easier to read

Access to Care
- More services utilizing a sliding scale
- Free mental health services
- Co-located services
- Reproductive health services

Programs & Services
- Having events using the trails
- Rent-a-bike events
- Garbage: pick up during the day, recycling, trash cans
- Animal Control

Nutrition/Access to Food
- More grocery stores
- Nutrition education/cooking classes

Regulation Enforcement
- Community associations to regulate activities
- More policemen

Notable Comments:
- We need to change the perception like we did with smoking and it is no longer viewed as "cool"

BARRIERS, TO IMPLEMENTING PROGRAMS TO ADDRESS THE IDENTIFIED HEALTH ISSUES

Policy
- Eligibility requirements
- Services should communicate with Spanish speakers
- Government, Money. Big companies
- Employees should have PTO
- Clinics having extended hours

Education & Outreach

- People not able to apply information correctly
- The stigma of using services
- Education system is failing children
- Lack of community support for programs

Funding
- Lack of funding
- People would have to be willing to pay more taxes

HOW TO OVERCOMES THESE BARRIERS

Policy Changes
- Repeal Citizens United.
- Write your governor.
- Don't villainize the persons who need help – like substance abusers
- Being able to intervene earlier – i.e. not after someone is charged with vehicular manslaughter but from the first DUI.

Education
- Incorporate newer technologies
- Cultural competency

Expanded Benefits/Finances
- Improve salaries esp. state employees
- Health insurance to cover more services

APPENDIX B:
SECONDARY DATA REPORT

AdventHealth Carrollwood
Needs Assessment Report - Quick Facts

Location
AdventHealth Carrollwood (Service Area)

Demographics

Data Indicator	Indicator Variable	Location Summary	State Average
Population Age 65+	Total Population	547,283	20,278,447
	Population Age 65+	70,350	3,926,889
	Percent Population Age 65+	12.85%	19.36%
Population Age 0-18	Total Population	547,283	20,278,447
	Population Age 0-17	121,926	4,111,582
	Percent Population Age 0-17	22.28%	20.28%
Population Age 18-64	Total Population	547,283	20,278,447
	Population Age 18-64	355,007	12,239,976
	Percent Population Age 18-64	64.87%	60.36%
Total Population	Total Population	547,282	20,278,447
	Total Land Area (Square Miles)	164	53,634.01
	Population Density (Per Square Mile)	3,318.65	378.09
Change in Total Population	Total Population, 2000 Census	472,840	15,982,378
	Total Population, 2010 Census	513,616	18,801,310
	Total Population Change, 2000-2010	40,776	2,818,932
	Percent Population Change, 2000-2010	8.62%	17.64%
Female Population	Total Population	547,283	20,278,447
	Female Population	282,441	10,364,086
	Percent Female Population	51.61%	51.11%
Hispanic Population	Total Population	547,282	20,278,447

	Non-Hispanic Population	361,225	15,263,432
	Percent Population Non-Hispanic	66%	75.27%
	Hispanic or Latino Population	186,057	5,015,015
	Percent Population Hispanic or Latino	34%	24.73%
Male Population	Total Population	547,283	20,278,447
	Male Population	264,842	9,914,361
	Percent Male Population	48.39%	48.89%

Social & Economic Factors

Data Indicator	Indicator Variable	Location Summary	State Average
Violent Crime	Total Population	543,046	19,536,492
	Violent Crimes	1,840	92,236
	Violent Crime Rate (Per 100,000 Pop.)	**338.8**	472.1
Population with No High School Diploma	Total Population Age 25+	370,349	14,396,066
	Population Age 25+ with No High School Diploma	50,792	1,787,348
	Percent Population Age 25+ with No High School Diploma	**13.7%**	12.42%
Poverty - Population Below 100% FPL	Total Population	542,189.31	19,858,469
	Population in Poverty	110,377.04	3,070,972
	Percent Population in Poverty	**20.4%**	15.46%
Insurance - Uninsured Adults	Total Population Age 18 - 64	357,709	12,071,750
	Population with Medical Insurance	296,043	9,845,200
	Percent Population with Medical Insurance	82.8%	81.56%
	Population Without Medical Insurance	61,667	2,226,550
	Percent Population Without Medical Insurance	**17.24%**	18.44%
Insurance - Uninsured Children	Total Population Under Age 19	136,837	4,291,510
	Population with Medical Insurance	129,311	4,009,046
	Percent Population with Medical Insurance	94.5%	93.42%
	Population Without Medical Insurance	7,525	282,464
	Percent Population Without Medical Insurance	**5.5%**	6.58%

Income - Per Capita Income	Total Population	547,283	20,278,447
	Total Income ($)	$14,363,562,615.00	$583,486,218,200.00
	Per Capita Income ($)	**$26,245.00**	$28,773.00
Unemployment Rate	Labor Force	283,433	10,266,145
	Number Employed	267,830	9,965,503
	Number Unemployed	15,602	300,642
	Unemployment Rate	**5.5%**	2.9%
Lack of Social or Emotional Support	Total Population Age 18+	386,972	14,682,954
	Estimated Population Without Adequate Social / Emotional Support	82,810	3,127,469
	Crude Percentage	21.4%	21.3%
	Age-Adjusted Percentage	**21.4%**	21.2%
Teen Births	Female Population Age 15 - 19	18,082	597,095
	Births to Mothers Age 15 - 19	761	21,555
	Teen Birth Rate (Per 1,000 Population)	**42.07**	36.1
Food Insecurity Rate	Total Population	525,555	19,893,297
	Food Insecure Population, Total	82,480	3,227,600
	Food Insecurity Rate	**15.7%**	16.2%
Poverty - Children Below 100% FPL	Total Population	542,189	19,858,469
	Population Under Age 18	120,035	4,044,879
	Population Under Age 18 in Poverty	34,789	901,772
	Percent Population Under Age 18 in Poverty	**28.98%**	22.29%

Physical Environment

Data Indicator	Indicator Variable	Location Summary	State Average
Use of Public Transportation	Total Population Employed Age 16+	262,210	8,907,171
	Population Using Public Transit for Commute to Work	6,392	180,231
	Percent Population Using Public Transit for Commute to Work	**2.44%**	2%
Population with Low Food Access	Total Population	513,615	18,801,310
	Population with Low Food Access	88,628	4,831,135
	Percent Population with Low Food Access	**17.26%**	25.7%

Clinical Care

Data Indicator	Indicator Variable	Location Summary	State Average
Access to Dentists	Total Population, 2015	563,605	20,271,272
	Dentists, 2015	306	11,304
	Dentists, Rate per 100,000 Pop.	**54.4**	55.8
Cancer Screening - Sigmoidoscopy or Colonoscopy	Total Population Age 50+	115,122	5,497,252
	Estimated Population Ever Screened for Colon Cancer	71,650	3,628,186
	Crude Percentage	62.2%	66%
	Age-Adjusted Percentage	**59.3%**	61.5%
Cancer Screening - Mammogram	Total Medicare Enrollees	33,308	1,861,794
	Female Medicare Enrollees Age 67-69	2,964	161,850
	Female Medicare Enrollees with Mammogram in Past 2 Years	1,853	109,429
	Percent Female Medicare Enrollees with Mammogram in Past 2 Year	**62.5%**	67.6%
Cancer Screening - Pap Test	Female Population Age 18+	294,622	11,566,352
	Estimated Number with Regular Pap Test	231,817	8,894,525
	Crude Percentage	78.7%	76.9%
	Age-Adjusted Percentage	**78.6%**	78.8%
Facilities Designated as Health Professional Shortage Areas	Primary Care Facilities	1	138
	Mental Health Care Facilities	1	125
	Dental Health Care Facilities	1	127
	Total HPSA Facility Designations	3	390

Lack of Prenatal Care	Total Births	28,602.04	906,594
	Mothers Starting Prenatal Care in First Semester	21,169.17	603,986
	Mothers with Late or No Prenatal Care	5,128.11	250,800
	Prenatal Care Not Reported	2,304.77	51,808
	Percentage Mothers with Late or No Prenatal Care	**17.9%**	27.7%
Federally Qualified Health Centers	Total Population	323,257	18,801,310
	Number of Federally Qualified Health Centers	13	406
	Rate of Federally Qualified Health Centers per 100,000 Population	**4.02**	2.16
Lack of a Consistent Source of Primary Care	Survey Population (Adults Age 18+)	373,369	14,671,272
	Total Adults Without Any Regular Doctor	104,471	3,638,104
	Percent Adults Without Any Regular Doctor	**28%**	24.80%
Preventable Hospital Events	Total Medicare Part A Enrollees	27,782	1,506,764
	Ambulatory Care Sensitive Condition Hospital Discharges	16,945	80,828
	Ambulatory Care Sensitive Condition Discharge Rate	**61**	53.6

Health Behaviors

Data Indicator	Indicator Variable	Location Summary	State Average
Alcohol Consumption	Total Population Age 18+	386,972	14,682,954
	Estimated Adults Drinking Excessively	72,002	2,334,590
	Estimated Adults Drinking Excessively (Crude Percentage)	18.6%	15.9%
	Estimated Adults Drinking Excessively (Age-Adjusted Percentage)	**18.9%**	17.1%
Physical Inactivity	Total Population Age 20+	418,787	15,678,149
	Population with no Leisure Time Physical Activity	90,223	3,874,964
	Percent Population with no Leisure Time Physical Activity	**21.1%**	23.6%
Tobacco Usage - Current Smokers	Total Population Age 18+	386,972.36	14,682,954
	Total Adults Regularly Smoking Cigarettes	70,989.75	2,642,932
	Percent Population Smoking Cigarettes (Crude)	18.3%	18%
	Percent Population Smoking Cigarettes (Age-Adjusted)	**18.1%**	18.9%

Health Outcomes

Data Indicator	Indicator Variable	Location Summary	State Average
Mortality - Lung Disease	Total Population	552,382	19,929,487
	Average Annual Deaths, 2007-2011	243	11,363
	Crude Death Rate (Per 100,000 Pop.)	44.06	57.02
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**42.7**	38.55
Mortality - Unintentional Injury	Total Population	552,382	19,929,487
	Average Annual Deaths, 2010-2014	268	10,015
	Crude Death Rate (Per 100,000 Pop.)	48.52	50.25
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**47.14**	44.43
Mortality - Heart Disease	Total Population	552,382	19,929,487
	Average Annual Deaths, 2010-2014	948	44,078
	Crude Death Rate (Per 100,000 Pop.)	171.56	221.17
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**163.3**	149.9
High Blood Pressure (Adult)	Total Population (Age 18+)	386,972	14,682,954
	Total Adults with High Blood Pressure	116,457	4,155,276
	Percent Adults with High Blood Pressure	**30.09%**	28.3%
Cancer Incidence - Lung	Estimated Total Population	57,669	2,771,859
	New Cases (Annual Average)	369	16,548
	Cancer Incidence Rate (Per 100,000 Pop.)	**64.1**	59.7
Mortality - Premature Death	Total Population	513,615	56,417,393
	Total Premature Death, 2014-2016	1,880	256,433
	Total Years of Potential Life Lost,2014-2016 Average	35,453	4,112,576
	Years of Potential Life Lost, Rate per 100,000 Population	**6,903**	7,290
Cancer Incidence - Prostate	Estimated Total Population (Male)	27,517	1,300,513
	New Cases (Annual Average)	317	12,667
	Cancer Incidence Rate (Per 100,000 Pop.)	**115.5**	97.4
Cancer Incidence - Breast	Estimated Total Population (Female)	30,881	1,330,172
	New Cases (Annual Average)	373	15,430

	Cancer Incidence Rate (Per 100,000 Pop.)	**121**	116
Cancer Incidence - Cervix	Estimated Total Population (Female)	27,999	1,048,314
	New Cases (Annual Average)	28	933
	Cancer Incidence Rate (Per 100,000 Pop.)	**10.3**	8.9
Cancer Incidence - Colon and Rectum	Estimated Total Population	57,252	2,653,116
	New Cases (Annual Average)	230	9,790
	Cancer Incidence Rate (Per 100,000 Pop.)	**40.3**	36.9
Obesity	Total Population Age 20+	418,453	15,687,277
	Adults with BMI > 30.0 (Obese)	107,257	4,162,381
	Percent Adults with BMI > 30.0 (Obese)	**25.4%**	26.6%
Overweight	Survey Population (Adults Age 18+)	355,993	14,014,811
	Total Adults Overweight	118,960	5,146,693
	Percent Adults Overweight	**33.4%**	36.7%
Diabetes (Adult)	Total Population Age 20+	419,875	15,705,775
	Population with Diagnosed Diabetes	43,740	1,715,434
	Population with Diagnosed Diabetes, Age-Adjusted Rate	**9.9%**	9.22%
Poor General Health	Total Population Age 18+	386,972	14,682,954
	Estimated Population with Poor or Fair Health	65,474	2,525,468
	Crude Percentage	16.9%	17.2%
	Age-Adjusted Percentage	**16.6%**	15.9%
Mortality - Suicide	Total Population	552,382	19,929,487
	Average Annual Deaths, 2010-2014	74	3,063
	Crude Death Rate (Per 100,000 Pop.)	13.43	15.37
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**12.92**	14.09
Mortality - Homicide	Total Population	552,382	19,929,487
	Average Annual Deaths, 2010-2014	31	1,202
	Crude Death Rate (Per 100,000 Pop.)	5.63	6.03
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**5.63**	6.39
Mortality - Cancer	Total Population	552,382	19,929,487

	Average Annual Deaths, 2010-2014	946	43,286
	Crude Death Rate (Per 100,000 Pop.)	171.34	217.19
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**160.9**	152.86
Mortality - Stroke	Total Population	552,382	19,929,487
	Average Annual Deaths, 2010-2014	193	10,042
	Crude Death Rate (Per 100,000 Pop.)	34.93	50.39
	Age-Adjusted Death Rate (Per 100,000 Pop.)	**33.73**	33.87
High Cholesterol (Adult)	Survey Population (Adults Age 18+)	324,561	11,691,020
	Total Adults with High Cholesterol	133,204	4,898,256
	Percent Adults with High Cholesterol	**41.04%**	41.90%
Heart Disease (Adult)	Survey Population (Adults Age 18+)	373,184	14,681,551
	Total Adults with Heart Disease	14,678	822,348
	Percent Adults with Heart Disease	**3.9%**	5.6%
Depression (Medicare Population)	Total Medicare Fee-for-Service Beneficiaries	41,597	2,222,669
	Beneficiaries with Depression	8,914	420,851
	Percent with Depression	**21.4%**	18.9%
Poor Dental Health	Total Population (Age 18+)	379,425	14,682,954
	Total Adults with Poor Dental Health	65,579	2,635,605
	Percent Adults with Poor Dental Health	**17.3%**	18%
Infant Mortality	Total Births	35,454	1,133,160
	Total Infant Deaths	294	7,932
	Infant Mortality Rate (Per 1,000 Births)	**8.3**	7
Low Birth Weight	Total Live Births	152,117	1,585,346
	Low Weight Births (Under 2500g)	13,450	137,925
	Low Weight Births, Percent of Total	**8.84%**	8.7%
Asthma Prevalence	Survey Population (Adults Age 18+)	373,083	14,756,311
	Total Adults with Asthma	48,200	1,841,437
	Percent Adults with Asthma	**12.9%**	12.5%

https://ahs.engagementnetwork.org, 1/9/2019

APPENDIX C:
HOSPITAL UTILIZATION
& EMERGENCY ROOM DATA

Below are the top 10 diagnoses for AdventHealth Carrollwood in 2018.

Emergency Department

1. Chest Pain
2. Stomach Pain
3. Urinary Tract Infection
4. Headaches
5. Upper Respiratory Infection
6. Bronchitis
7. Low Back Pain
8. Pharyngitis (Sore Throat)
9. Flu
10. Fever

Inpatient Admissions

1. Major Hip and Knee Joint Replacement or Reattachment of Lower Extremity
2. Major Joint/Limb Reattachment Procedure of Upper Extremity
3. COPD, Asthma, Bronchitis, Pneumonia
4. Cervical Spinal Fusion (surgery that joins selected bones in the neck)
5. Diabetes
6. Hypertension, Heart Failure/Shock
7. Septicemia (Life - Threatening Infection)
8. Cellulitis (serious bacterial skin infection)
9. Weight loss surgeries (bariatric surgery)
10. Esophagitis (inflammation of the esophagus), Gastroenteritis (inflammation of the stomach), & Misc. Digestion Disorders